- Prior authorization for a non-preferred agent in any category will be given only if there has been a trial of the preferred brand/generic equivalent or preferred formulation of the active ingredient, at a therapeutic dose, that resulted in a partial response with a documented intolerance.

- Prior authorization of a non-preferred isomer, pro-drug, or metabolite will be considered with a trial of a preferred parent drug of the same chemical entity, at a therapeutic dose, that resulted in a partial response with documented intolerance or a previous trial and therapy failure, at a therapeutic dose, with a preferred drug of a different chemical entity indicated to treat the submitted diagnosis. (The required trial may be overridden when documented evidence is provided that the use of these preferred agent(s) would be medically contraindicated.)

- Unless otherwise specified, the listing of a particular brand or generic name includes all legend forms of that drug. OTC drugs 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.

- The use of pharmaceutical samples will not be considered when evaluating the members' medical condition or prior prescription history for drugs that require prior authorization.

- Quantity limits may apply. Refer to the Limits List at http://www.dhhr.wv.gov/bms/Pharmacy/Documents/DrugLimitationSummary.pdf

- Acronyms
  - CL - Requires clinical PA. For detailed clinical criteria, please refer to: http://www.dhhr.wv.gov/bms/Pharmacy/Pages/pac.aspx
  - NR - New drug has not been reviewed by P & T Committee
  - AP - Non-preferred and selected preferred drugs, where indicated, are subject to auto-PA criteria. See PA criteria column.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ACNE AGENTS, TOPICAL[AP]			
	ANTI-INFECTIVE		
	clindamycin gel, lotion, medicated swab, solution erythromycin gel, solution	ACZONE (dapsone) AKNE-MYCIN (erythromycin) AZELEX (azelaic acid) CLEOCIN-T (clindamycin) CLINDACIN PAC (clindamycin) CLINDAGEL (clindamycin) clindamycin foam erythromycin medicated swab EVOCLIN (clindamycin) FABIOR (tazarotene) KLARON (sulfacetamide) OVACE/PLUS (sulfacetamide) sodium sulfacetamide 10% cleansing gel sulfacetamide cleanser sulfacetamide cleanser ER sulfacetamide shampoo sulfacetamide suspension	Thirty (30) day trials each of one (1) preferred retinoid and two (2) unique chemical entities in two (2) other subclasses, including the generic version of the requested non-preferred agent, are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. In cases of pregnancy, a trial of retinoids will *not* be required. For Members eighteen (18) years of age or older, a trial of retinoids will *not* be required.
	RETINOIDS		
	RETIN-A (tretinoin) TAZORAC (tazarotene)	adapalene ATRALIN (tretinoin) AVITA (tretinoin) DIFFERIN (adapalene) RETIN-A MICRO (tretinoin) tretinoin cream, gel tretinoin gel micro	PA required for members eighteen (18) years of age or older for Retinoids sub-class.
	KERATOLYTICS		
	benzoyl peroxide cleanser Rx & OTC, 10% cream OTC, gel Rx & OTC, lotion OTC, wash OTC	BENZEFOAM (benzoyl peroxide) BENZEFOAM ULTRA (benzoyl peroxide) BENZEPRO (benzoyl peroxide) benzoyl peroxide cloths, medicated pads, microspheres cleanser BP 10-1 (benzoyl peroxide) BP WASH 7% LIQUID DELOS (benzoyl peroxide) DESQUAM-X (benzoyl peroxide) LAVOCLEN (benzoyl peroxide) PACNEX/HP/LP (benzoyl peroxide) PANOXYL-4, -8 OTC (benzoyl peroxide) PERSA-GEL OTC (benzoyl peroxide) SASTID (sulfur)	Acne kits are non-preferred.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		SULPHO-LAC (sulfur)	
		COMBINATION AGENTS	
	erythromycin/benzoyl peroxide	ACANYA (clindamycin phosphate/benzoyl peroxide) AVAR/-E/LS (sulfur/sulfacetamide) BENZACLIN GEL (benzoyl peroxide/ clindamycin) BENZAMYCIN PAK (benzoyl peroxide/ erythromycin) benzoyl peroxide/clindamycin gel benzoyl peroxide/urea CERISA (sulfacetamide sodium/sulfur) CLARIFOAM EF (sulfacetamide/sulfur) CLENIA (sulfacetamide sodium/sulfur) DUAC (benzoyl peroxide/clindamycin) EPIDUO (adapalene/benzoyl peroxide)* INOVA 4/1, 5/2 (benzoyl peroxide/salicylic acid) NEUAC (clindamycin phosphate/benzoyl peroxide) NUOX (benzoyl peroxide/sulfur) PRASCION (sulfacetamide sodium/sulfur) SE 10-5 SS (sulfacetamide/sulfur) SSS 10-4 (sulfacetamide /sulfur) SSS 10-5 foam (sulfacetamide /sulfur) sulfacetamide sodium/sulfur cloths, lotion, pads, suspension sulfacetamide/sulfur wash/cleanser sulfacetamide/sulfur wash kit sulfacetamide sodium/sulfur/ urea SUMADAN/XLT (sulfacetamide/sulfur) SUMAXIN/TS (sulfacetamide sodium/sulfur) VELTIN (clindamycin/tretinoin)* ZIANA (clindamycin/tretinoin)*	Thirty (30) day trials each of one (1) preferred retinoid and two (2) unique chemical entities in two (2) other subclasses, including the generic version of the requested non-preferred agent, are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. In cases of pregnancy, a trial of retinoids will *not* be required. For Members eighteen (18) years of age or older, a trial of retinoids will *not* be required. In addition, thirty (30) day trials of combinations of the corresponding preferred single agents available are required before non-preferred combination agents will be authorized. *PA required for combination agents with Retinoid products for members eighteen (18) years of age or older.
ALZHEIMER'S AGENTS[AP]			
		CHOLINESTERASE INHIBITORS	
	donepezil 5 and 10 mg	ARICEPT (donepezil)* donepezil 23 mg EXELON CAPSULE (rivastigmine) EXELON PATCH (rivastigmine) galantamine galantamine ER	A thirty (30) day trial of a preferred agent is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		RAZADYNE (galantamine) RAZADYNE ER (galantamine) rivastigmine	Prior authorization is required for members up to forty-five (45) years of age if there is no diagnosis of Alzheimer's disease. *Aricept 23mg tablets will be authorized if the following criteria are met: 1. There is a diagnosis of moderate-to-severe Alzheimer's Disease **and** 2. There has been a trial of donepezil 10mg daily for at least three (3) months and donepezil 20mg daily for an additional one (1) month.
	NMDA RECEPTOR ANTAGONIST		
	NAMENDA (memantine)	NAMENDA XR (memantine)	
ANALGESICS, NARCOTIC LONG ACTING (Non-parenteral)[AP]			
	fentanyl transdermal morphine ER tablets	AVINZA (morphine) BUTRANS* (buprenorphine) CONZIP ER (tramadol) DOLOPHINE (methadone) DURAGESIC (fentanyl) EXALGO ER (hydromorphone) EMBEDA (morphine/naltrexone) hydromorphone ER KADIAN (morphine) methadone tablet, solution and concentrate** methadone solutabs morphine ER capsules (generic for Avinza) morphine ER capsules (generic for Kadian) MS CONTIN (morphine) NUCYNTA ER (tapentadol) OPANA ER (oxymorphone) oxycodone ER** OXYCONTIN (oxycodone) oxymorphone ER** RYZOLT ER (tramadol) tramadol ER ULTRAM ER (tramadol) XARTEMIS XR (oxycodone/ acetaminophen)	Six (6) day trials each of the preferred unique long acting chemical entities are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PDL form is present. A six (6) day trial of the generic form of the requested non-preferred agent, if available, is required before the non-preferred agent will be authorized. *Butrans will be authorized if the following criteria are met: 1. Diagnosis of moderate to severe chronic pain requiring continuous around-the-clock analgesia **and** 2. Patient cannot take oral medications and has a diagnosis of chronic pain **and** 3. Needs analgesic medication for an extended period of time **and**

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		ZOHYDRO ER (hydrocodone)	4. Has had a previous trial of a non-opioid analgesic medication* **and** 5. Previous trial of one (1) opioid medication* **and** 6. Current total daily opioid dose is less than or equal to (≤) 80mg morphine equivalents daily or dose of transdermal fentanyl is less than or equal to (≤) 12.5mcg/hr **and** 7. Patient is not currently being treated with buprenorphine. *Requirement is waived for patients who cannot swallow ****Exception:** Methadone, oxycodone ER and oxymorphone ER will be authorized without a trial of the preferred agents if a diagnosis of cancer is submitted.
ANALGESICS, NARCOTIC SHORT ACTING (Non-parenteral)[AP]			
	APAP/codeine butalbital/APAP/caffeine/codeine codeine hydrocodone/APAP 2.5/325 mg, 5/325 mg, 7.5/325 mg,10/325 mg hydrocodone/APAP solution hydrocodone/ibuprofen hydromorphone tablets morphine oxycodone oxycodone/APAP oxycodone/ASA pentazocine/naloxone ROXICET SOLUTION (oxycodone/ acetaminophen) ROXICODONE TABLETS (oxycodone) tramadol tramadol/APAP	ABSTRAL (fentanyl) ACTIQ (fentanyl) butalbital/ASA/caffeine/codeine butorphanol CAPITAL W/CODEINE (APAP/codeine) DEMEROL (meperidine) dihydrocodeine/ APAP/caffeine dihydrocodeine/ASA/caffeine DILAUDID (hydromorphone) fentanyl FENTORA (fentanyl) FIORICET W/ CODEINE (butalbital/APAP/caffeine/codeine) FIORINAL W/ CODEINE (butalbital/ASA/caffeine/codeine) hydrocodone/APAP 5/300 mg, 7/5/300 mg, 10/300 mg hydromorphone liquid hydromorphone suppositories IBUDONE (hydrocodone/ibuprofen)	Six (6) day trials of at least four (4) chemically distinct preferred agents (based on narcotic ingredient only), including the generic formulation of the requested non-preferred agent, are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. Fentanyl lozenges and Onsolis will only be authorized for a diagnosis of cancer and as an adjunct to a long-acting agent. Neither will be authorized for monotherapy. **Limits:** Unless the patient has escalating cancer pain or another diagnosis supporting increased quantities of short-acting opioids, all

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		LAZANDA (fentanyl) Levorphanol MAXIDONE ((hydrocodone/APAP) MAGNACET (oxycodone/APAP) meperidine NORCO (hydrocodone/APAP) NUCYNTA (tapentadol) ONSOLIS (fentanyl) OPANA (oxymorphone) OXECTA (oxycodone) oxycodone/ASA oxycodone/ibuprofen OXYIR (oxycodone) oxymorphone pentazocine/APAP PERCOCET (oxycodone/APAP) PERCODAN (oxycodone/ASA) PRIMLEV (oxycodone/APAP) REPREXAIN (hydrocodone/ibuprofen) RYBIX ODT (tramadol) SUBSYS (fentanyl) SYNALGOS-DC (dihydrocodeine/ASA/ caffeine) TREZIX (dihydrocodeine/ APAP/caffeine) TYLENOL W/CODEINE (APAP/codeine) TYLOX (oxycodone/APAP) ULTRACET (tramadol/APAP) ULTRAM (tramadol) VICODIN 5/300 mg, 7.5 /300 mg,10/300 mg VICOPROFEN (hydrocodone/ibuprofen) VOPAC (codeine/acetaminophen) XODOL (hydrocodone/acetaminophen) XOLOX (oxycodone/APAP) ZAMICET (hydrocodone/APAP) ZYDONE (hydrocodone/acetaminophen)	short acting solid forms of the narcotic analgesics are limited to 120 tablets per thirty (30) days for the purpose of maximizing the use of longer acting medications to prevent unnecessary breakthrough pain in chronic pain therapy. Immediate-release tramadol is limited to 240 tablets per thirty (30) days.
ANDROGENIC AGENTS			
	ANDRODERM (testosterone) ANDROGEL (testosterone) TESTIM (testosterone)	AXIRON (testosterone) FORTESTA (testosterone) testosterone gel VOGELXO (testosterone)	The non-preferred agents will only be authorized if one (1) of the exceptions on the PA form is present.
ANESTHETICS, TOPICAL[AP]			

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	lidocaine lidocaine/prilocaine xylocaine	EMLA (lidocaine/prilocaine) LIDAMANTLE (lidocaine) LIDAMANTLE HC (lidocaine/hydrocortisone) lidocaine/hydrocortisone SYNERA (lidocaine/tetracaine)	Ten (10) day trials of each of the preferred topical anesthetics are required before a non-preferred topical anesthetic will be authorized unless one (1) of the exceptions on the PA form is present
ANGIOTENSIN MODULATORS[AP]			
	ACE INHIBITORS		
	benazepril captopril enalapril fosinopril lisinopril quinapril ramipril	ACCUPRIL (quinapril) ACEON (perindopril) ALTACE (ramipril) EPANED* (enalapril) LOTENSIN (benazepril) MAVIK (trandolapril) moexipril perindopril PRINIVIL (lisinopril) trandolapril UNIVASC (moexipril) VASOTEC (enalapril) ZESTRIL (lisinopril)	Fourteen (14) day trials of each of the preferred agents in the corresponding group, with the exception of the Direct Renin Inhibitors, are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. *Epaned will be authorized if the following critieria are met unless one (1) of the exceptions on the PA form is present: 1 Diagnosis of hypertension, symptomatic heart failure or asymptomatic left ventricular dysfunction; **AND** a Patient is less than seven (7) years of age; **OR** b Patient is unable to ingest a solid dosage form (eg. an oral tablet or capsule) due to documented oral-motor difficulties or dysphagia.
	ACE INHIBITOR COMBINATION DRUGS		
	benazepril/amlodipine benazepril/HCTZ captopril/HCTZ enalapril/HCTZ fosinopril/HCTZ lisinopril/HCTZ quinapril/HCTZ	ACCURETIC (quinapril/HCTZ) CAPOZIDE (captopril/HCTZ) LOTENSIN HCT (benazepril/HCTZ) LOTREL (benazepril/amlodipine) moexipril/HCTZ PRINZIDE (lisinopril/HCTZ) TARKA (trandolapril/verapamil) trandolapril/verapamil	

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		UNIRETIC (moexipril/HCTZ) VASERETIC (enalapril/HCTZ) ZESTORETIC (lisinopril/HCTZ)	
	ANGIOTENSIN II RECEPTOR BLOCKERS (ARBs)		
	BENICAR (olmesartan) irbesartan losartan MICARDIS (telmisartan) valsartan	ATACAND (candesartan) AVAPRO (irbesartan) candesartan COZAAR (losartan) DIOVAN (valsartan) EDARBI (azilsartan) eprosartan telmisartan TEVETEN (eprosartan)	
	ARB COMBINATIONS		
	AZOR (olmesartan/amlodipine) BENICAR-HCT (olmesartan/HCTZ) EXFORGE (valsartan/amlodipine) EXFORGE HCT (valsartan/amlodipine/HCTZ) irbesartan/HCTZ losartan/HCTZ MICARDIS-HCT (telmisartan/HCTZ) valsartan/HCTZ	ATACAND-HCT (candesartan/HCTZ) AVALIDE (irbesartan/HCTZ) candesartan/HCTZ DIOVAN-HCT (valsartan/HCTZ) EDARBYCLOR (azilsartan/chlorthalidone) HYZAAR (losartan/HCTZ) telmisartan/amlodipine telmisartan HCTZ TEVETEN-HCT (eprosartan/HCTZ) TRIBENZOR (olmesartan/amlodipine/HCTZ) TWYNSTA (telmisartan/amlodipine) valsartan/amlodipine	
	DIRECT RENIN INHIBITORS		
		AMTURNIDE (aliskiren/amlodipine/HCTZ) TEKAMLO (aliskiren/amlodipine) TEKTURNA (aliskiren) TEKTURNA HCT (aliskiren/HCTZ) VALTURNA (aliskiren/valsartan)	A thirty (30) day trial of one (1) preferred ACE, ARB, or combination agent, at the maximum tolerable dose, is required before Tekturna will be authorized unless one (1) of the exceptions on the PA form is present. Amturnide, Tekamlo, Tekturna HCT or Valturna will be authorized if the criteria for Tekturna are met and the patient also needs the other agents in the combination.
ANTI-ALLERGENS, ORAL			

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		GRASTEK (timothy grass pollen allergen extract) RAGWITEK (short ragweed pollen allergen extract)	Full PA Criteria for this category may be found on the BMS Website: http://www.dhhr.wv.gov/bms/Pharmacy/Pages/pac.aspx
ANTIANGINAL & ANTI-ISCHEMIC			
		RANEXA (ranolazine)[AP]	Ranexa will be authorized for patients with angina who are also taking a calcium channel blocker, a beta blocker, or a nitrite as single agents or a combination agent containing one (1) of these ingredients.
ANTIBIOTICS, GI			
	metronidazole tablet neomycin TINDAMAX (tinidazole)	ALINIA (nitazoxanide) DIFICID (fidaxomicin)* FLAGYL (metronidazole) FLAGYL ER (metronidazole ER) metronidazole capsule paromomycin tinidazole VANCOCIN (vancomycin)** vancomycin XIFAXAN (rifaximin)***	A fourteen (14) day trial of a preferred agent is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. *Dificid will be authorized if: 1. There is a diagnosis of severe *C. difficile* infection **and** 2. There is no response to prior treatment with vancomycin for ten (10) to fourteen (14) days. **Vancocin (brand) will be authorized after a fourteen (14) day trial of metronidazole for *C. difficile* infections of mild to moderate severity unless one (1) of the exceptions on the PA form is present. **Vancocin (brand) will be authorized for severe *C. difficile* infections with no previous trial of metronidazole. ***Xifaxan 200mg will be authorized for traveler's diarrhea if 1. There is a diagnosis of *E. coli*

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			diarrhea **and** 2. Patient is from twelve (12) up to eighteen (18) years of age, or is eighteen (18) years of age or older **and** 3. Has failed a ten (10) day trial of ciprofloxacin. ***Xifaxan 550mg will be authorized for hepatic encephalopathy if: 1. There is a diagnosis of hepatic encephalopathy **and** 2. Patient is eighteen (18) years of age or older, **and** 3. Patient has a history of and current treatment with lactulose.
ANTIBIOTICS, INHALED			
	BETHKIS (tobramycin) tobramycin (Sandoz generic)	CAYSTON (aztreonam) TOBI (tobramycin) TOBI PODHALER tobramycin (all generics except Sandoz)	A twenty-eight (28) day trial of the preferred agent and documentation of therapeutic failure is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.
ANTIBIOTICS, TOPICAL			
	bacitracin gentamicin sulfate mupirocin ointment	ALTABAX (retapamulin) BACTROBAN (mupirocin) CENTANY (mupirocin) CORTISPORIN (bacitracin/neomycin/polymyxin/HC) mupirocin cream neomycin/polymyxin/pramoxine	Ten (10) day trials of at least one (1) preferred agent, including the generic formulation of a requested non-preferred agent, are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.
ANTIBIOTICS, VAGINAL			
	clindamycin cream METROGEL (metronidazole)	AVC (sulfanilamide) CLEOCIN CREAM (clindamycin) CLEOCIN OVULE (clindamycin) CLINDESSE (clindamycin) metronidazole VANDAZOLE (metronidazole)	A trial, the duration of the manufacturer's recommendation, of each of the preferred agents is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ANTICOAGULANTS			
	INJECTABLE[CL]		
	FRAGMIN (dalteparin) LOVENOX (enoxaparin)	ARIXTRA (fondaparinux) enoxaparin fondaparinux INNOHEP (tinzaparin)	Trials of each of the preferred agents will be required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.
	ORAL		
	COUMADIN (warfarin) ELIQUIS (apixaban)[AP]* PRADAXA (dabigatran)[AP]** warfarin XARELTO (rivaroxaban)[AP]***		*Eliquis will be authorized for the following indications: 1. Non-valvular atrial fibrillation **or** 2. Deep vein thombrosis (DVT) and pulmonary embolism (PE) **or** 3. DVT prophylaxis if treatment is limited to thirty-five (35) days for hip replacement surgeries or twelve (12) days for knee replacement surgeries. **Pradaxa will be authorized for the following indications: 1. Non-valvular atrial fibrillation **or** 2. To reduce the risk of recurrent DVT and PE in patients who have previously been treated **or** 3. Treatment of acute DVT and PE in patients who have been treated with a parenteral anticoagulant for five (5) to (10) days**.** ***Xarelto will be authorized for the following indications:: 1. Non-valvular atrial fibrillation **or** 2. DVT, and PE, and reduction in risk of recurrence of DVT and PE **or** 1. DVT prophylaxis if treatment is limited to thirty-five (35) days

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			for hip replacement surgeries or twelve (12) days for knee replacement surgeries.
ANTICONVULSANTS			
	ADJUVANTS		
	carbamazepine carbamazepine ER carbamazepine XR CARBATROL (carbamazepine) DEPAKOTE SPRINKLE (divalproex) divalproex divalproex ER EPITOL (carbamazepine) FELBATOL (felbamate) GABITRIL (tiagabine) lamotrigine levetiracetam oxcarbazepine tablets TEGRETOL XR (carbamazepine) topiramate TRILEPTAL SUSPENSION (oxcarbazepine) valproic acid VIMPAT(lacosamide)[AP]* zonisamide	APTIOM (eslicarbazepine) BANZEL(rufinamide) DEPAKENE (valproic acid) DEPAKOTE (divalproex) DEPAKOTE ER (divalproex) divalproex sprinkle EQUETRO (carbamazepine) FANATREX SUSPENSION (gabapentin) felbamate FYCOMPA (perampanel) KEPPRA (levetiracetam) KEPPRA XR (levetiracetam) LAMICTAL (lamotrigine) LAMICTAL CHEWABLE (lamotrigine) LAMICTAL ODT (lamotrigine) LAMICTAL XR (lamotrigine) lamotrigine dose pack lamotrigine ER levetiracetam ER ONFI (clobazam) ** ONFI SUSPENSION (clobazam) ** oxcarbazepine suspension OXTELLAR XR (oxcarbazepine) POTIGA (ezogabine) QUDEXY XR (topiramate ER) SABRIL (vigabatrin) STAVZOR (valproic acid) TEGRETOL (carbamazepine) tiagabine TOPAMAX (topiramate) topiramate ER TRILEPTAL TABLETS (oxcarbazepine) TROKENDI XR (topiramate) ZONEGRAN (zonisamide)	A fourteen (14) day trial of one (1) 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 (1) of the exceptions on the PA form is present. A thirty (30) day trial of one (1) of the preferred agents in the corresponding group is required for patients with a diagnosis other than seizure disorders unless one (1) of the exceptions on the PA form is present. Non-preferred anticonvulsants will be authorized for patients on established therapies with a diagnosis of seizure disorders with no trials of preferred agents required. In situations where AB-rated generic equivalent products are available, "Brand Medically Necessary" must be hand-written by the prescriber on the prescription in order for the brand name product to be reimbursed. *Vimpat will be approved as monotherapy or adjunctive therapy for members seventeen (17) years of age or older with a diagnosis of partial-onset seizure disorder.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			Onfi will be authorized if the following criteria are met: 1. Adjunctive therapy for Lennox-Gastaut **or 2. Generalized tonic, atonic or myoclonic seizures **and** 3. Previous failure of at least two (2) non-benzodiazepine anticonvulsants and previous failure of clonazepam. (For continuation, prescriber must include information regarding improved response/effectiveness with this medication)
	BARBITURATES[AP]		
	phenobarbital primidone	MEBARAL (mephobarbital) MYSOLINE (primidone)	
	BENZODIAZEPINES[AP]		
	clonazepam DIASTAT (diazepam rectal) diazepam tablets	clonazepam ODT diazepam rectal gel KLONOPIN (clonazepam) VALIUM TABLETS (diazepam)	
	HYDANTOINS[AP]		
	DILANTIN 30mg (phenytoin) PEGANONE (ethotoin) phenytoin capsules, chewable tablets, suspension	DILANTIN (phenytoin) DILANTIN INFATABS (phenytoin) PHENYTEK (phenytoin)	
	SUCCINIMIDES		
	CELONTIN (methsuximide) ethosuximide syrup ZARONTIN (ethosuximide) capsules	ethosuximide capsules ZARONTIN (ethosuximide) syrup	
ANTIDEPRESSANTS, OTHER			
	MAOIs[AP]		
		MARPLAN (isocarboxazid) NARDIL (phenelzine) PARNATE (tranylcypromine) phenelzine tranylcypromine	Patients stabilized on MAOI agents will be grandfathered.
	SNRIS[AP]		

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	duloxetine capulses venlafaxine ER capsules	CYMBALTA (duloxetine) desvenlafaxine ER desvenlafaxine fumarate ER EFFEXOR XR (venlafaxine) FETZIMA (levomilnacipran) KHEDEZLA (desvenlafaxine) PRISTIQ (desvenlafaxine) venlafaxine IR VENLAFAXINE ER TABLETS (venlafaxine)	A thirty (30) day trial each of a preferred agent and an SSRI is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.
	SECOND GENERATION NON-SSRI, OTHER[AP]		
	bupropion IR bupropion SR bupropion XL mirtazapine trazodone	APLENZIN (bupropion hbr) BRINTELLIX (vortioxetine) EMSAM (selegiline) FORFIVO XL (bupropion) nefazodone OLEPTRO ER (trazodone) REMERON (mirtazapine) WELLBUTRIN (bupropion) WELLBUTRIN SR (bupropion) WELLBUTRIN XL (bupropion) VIIBRYD (vilazodone hcl)	
	SELECTED TCAs		
	imipramine hcl	imipramine pamoate TOFRANIL (imipramine hcl) TOFRANIL PM (imipramine pamoate)	A twelve (12) week trial of imipramine hcl is required before a non-preferred TCA will be authorized unless one (1) of the exceptions on the PA form is present.
ANTIDEPRESSANTS, SSRIs[AP]			
	citalopram escitalopram tablets fluoxetine capsules, solution fluvoxamine paroxetine sertraline	BRISDELLE (paroxetine) CELEXA (citalopram) escitalopram solution fluvoxamine ER fluoxetine tablets LEXAPRO (escitalopram) LUVOX CR (fluvoxamine) PAXIL (paroxetine) PAXIL CR (paroxetine) paroxetine ER PEXEVA (paroxetine) PROZAC (fluoxetine) SARAFEM (fluoxetine)	Thirty (30) day trials each of two (2) of the preferred agents are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. Upon hospital discharge, patients admitted with a primary mental health diagnosis who have been stabilized on a non-preferred SSRI will receive an authorization to continue that drug.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		ZOLOFT (sertraline)	
ANTIEMETICS[AP]			
	5HT3 RECEPTOR BLOCKERS		
	ondansetron ODT, solution, tablets	ANZEMET (dolasetron) granisetron GRANISOL (granisetron) ondansetron vials SANCUSO (granisetron) ZOFRAN (ondansetron) ZUPLENZ (ondansetron)	A three (3) day trial of a preferred agent is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. PA is required for ondansetron when limits are exceeded.
	CANNABINOIDS		
		CESAMET (nabilone) dronabinol 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 three (3) day trials of conventional treatments such as promethazine or ondansetron and are eighteen (18) years of age or older. Marinol (dronabinol) will only be authorized for: 1. The treatment of anorexia associated with weight loss in patients with AIDS or cancer and unresponsive to megestrol **or** 2. The prophylaxis of chemotherapy induced nausea and vomiting unresponsive to three (3) day trials of ondansetron or promethazine for patients from eighteen (18) up to sixty-five (65) years of age.
	SUBSTANCE P ANTAGONISTS		
	EMEND (aprepitant)		
ANTIFUNGALS, ORAL			

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	clotrimazole fluconazole* nystatin terbinafine [CL]	ANCOBON (flucytosine) DIFLUCAN (fluconazole) flucytosine GRIFULVIN V TABLET (griseofulvin) griseofulvin GRIS-PEG (griseofulvin) itraconazole ketoconazole** LAMISIL (terbinafine) MYCELEX (clotrimazole) MYCOSTATIN Tablets (nystatin) NIZORAL (ketoconazole) NOXAFIL (posaconazole) ONMEL (itraconazole) ORAVIG (miconazole) SPORANOX (itraconazole) VFEND (voriconazole) voriconazole suspension voriconazole tablets	Non-preferred agents will be authorized only if one (1) 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 six (6) years of age for the treatment of tinea capitis. **Ketoconazole will be authorized if the following criteria are met: 1. Diagnosis of one of the following fungal infections: blastomycosis, coccidioidomycosis, histoplasmosis, chromomycosis, or paracoccidioidomycosis **and** 2. Documented failure or intolerance of all other diagnosis-appropriate antifungal therapies, i.e. itraconazole, fluconazole, flucytosine, etc **and** 3. Baseline assessment of the liver status including alanine aminotransferase (ALT), aspartate aminotransferase (AST), total bilirubin, alkaline phosphatase, prothrombin time, and international normalized ration (INR) before starting treatment **and** 4. Weekly monitoring of serum ALT for the duration of treatment (If ALT values increase to a level above the upper limit of normal or 30% above baseline, or if the patient

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			develops symptoms of abnormal liver function, treatment should be interrupted and a full set of liver tests be obtained. Liver tests should be repeated to ensure normalization of values.) **and** 5. Assessment of all concomitant medications for potential adverse drug interactions with ketoconazole. Ketoconazole will not be authorized for treatment for fungal infections of the skin and nails
ANTIFUNGALS, TOPICAL[AP]			
	ANTIFUNGALS		
	econazole ketoconazole cream, shampoo MENTAX (butenafine) miconazole (OTC) nystatin	CICLODAN (ciclopirox) ciclopirox ERTACZO (sertaconazole) EXELDERM (sulconazole) EXTINA (ketoconazole) JUBLIA (efinaconazole) ketoconazole foam KETODAN (ketoconazole) LOPROX (ciclopirox) LUZU (luliconazole) MYCOSTATIN (nystatin) NAFTIN CREAM (naftifine) NAFTIN GEL (naftifine) NIZORAL (ketoconazole) OXISTAT (oxiconazole)* PEDIPIROX-4 (ciclopirox) PENLAC (ciclopirox) VUSION (miconazole/petrolatum/zinc oxide) XOLEGEL (ketoconazole)	Fourteen (14) day trials of two (2) of the preferred agents are required before one (1) of the non-preferred agents will be authorized unless one (1) of the exceptions on the PA form is present. If a non-preferred shampoo is requested, a fourteen (14) day trial of one (1) preferred product (ketoconazole shampoo) is required. *Oxistat cream will be authorized for children up to thirteen (13) years of age for tinea corporis, tinea cruris, tinea pedis, and tinea (pityriasis) versicolor.
	ANTIFUNGAL/STEROID COMBINATIONS		
	clotrimazole/betamethasone nystatin/triamcinolone	KETOCON PLUS (ketoconazole/hydrocortisone) LOTRISONE (clotrimazole/betamethasone)	
ANTIHYPERTENSIVES, SYMPATHOLYTICS			

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	CATAPRES-TTS (clonidine) clonidine tablets	clonidine patch NEXICLON XR (clonidine) CATAPRES TABLETS (clonidine)	A thirty (30) day trial of each preferred unique chemical entity in the corresponding formulation is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.
ANTIHYPERURICEMICS			
	ANTIMITOTICS		
		COLCRYS (colchicine)*	A thirty (30) day trial of one (1) of the preferred agents for the prevention of gouty arthritis attacks (colchicine/probenecid, probenecid, or allopurinol) is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. *In the case of acute gouty attacks, a ten (10) day supply (twenty (20) tablets) of Colcrys will be authorized per ninety (90) days.
	ANTIMITOTIC-URICOSURIC COMBINATION		
	colchicine/probenecid		
	URICOSURIC		
	probenecid		
	XANTHINE OXIDASE INHIBITORS		
	allopurinol	ULORIC (febuxostat) ZYLOPRIM (allopurinol)	
ANTIMIGRAINE AGENTS, OTHER[AP]			
		CAMBIA (diclofenac)	Three (3) day trials of each unique chemical entity of the preferred Triptan agents are required before Cambia will be authorized unless (1) of the exceptions on the PA form is present.
ANTIMIGRAINE AGENTS, TRIPTANS[AP]			
	TRIPTANS		

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	IMITREX NASAL SPRAY (sumatriptan) IMITREX INJECTION (sumatriptan)[CL] naratriptan rizatriptan sumatriptan tablets	AMERGE (naratriptan) AXERT (almotriptan) FROVA (frovatriptan) IMITREX tablets (sumatriptan) MAXALT (rizatriptan) MAXALT MLT (rizatriptan) RELPAX (eletriptan) rizatriptan ODT sumatriptan nasal spray/injection* SUMAVEL (sumatriptan) zolmitriptan zolmitriptan ODT ZOMIG (zolmitriptan) ZOMIG ZMT (zolmitriptan)	Three (3) day trials of each unique chemical entity of the preferred agents are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. Quantity limits apply for this drug class. Three (3) day trials of each preferred agent will be required before Imitrex injection is authorized. *AP does not apply to nasal spray or injectable sumatriptan.
	TRIPTAN COMBINATIONS		
		TREXIMET (sumatriptan/naproxen sodium)	
ANTIPARASITICS, TOPICAL[AP]			
	NATROBA (spinosad) permethrin 5% cream permethrin 1% lotion (OTC) pyrethrins-piperonyl butoxide OTC SKLICE (ivermectin) ULESFIA (benzyl alcohol)	EURAX (crotamiton) LICE EGG REMOVER OTC (benzalkonium chloride) lindane malathion OVIDE (malathion) Spinosad	Trials of the preferred agents (which are age and weight appropriate) are required before non-preferred agents will be authorized unless one (1) of the exceptions on the PA form is present.
ANTIPARKINSON'S AGENTS			
	ANTICHOLINERGICS		
	benztropine trihexyphenidyl	COGENTIN (benztropine)	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.
	COMT INHIBITORS		
		COMTAN (entacapone) entacapone TASMAR (tolcapone)	
	DOPAMINE AGONISTS		
	pramipexole ropinirole	MIRAPEX (pramipexole) MIRAPEX ER (pramipexole) NEUPRO (rotigotine)	Mirapex, Mirapex ER, Requip, and Requip XL will be authorized for a diagnosis of Parkinsonism with no

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		REQUIP (ropinirole) REQUIP XL (ropinirole) ropinirole ER	trials of preferred agents required.
	OTHER ANTIPARKINSON'S AGENTS		
	amantadine[AP] bromocriptine carbidopa/levodopa selegiline STALEVO (levodopa/carbidopa/entacapone)	AZILECT (rasagiline) ELDEPRYL (selegiline) levodopa/carbidopa ODT levodopa/carbidopa/entacapone carbidopa LODOSYN (carbidopa) PARCOPA (levodopa/carbidopa) PARLODEL (bromocriptine) SINEMET (levodopa/carbidopa) ZELAPAR (selegiline)	Amantadine will be authorized only for a diagnosis of Parkinsonism.
ANTIPSORIATICS, TOPICAL			
	calcipotriene ointment TACLONEX (calcipotriene/ betamethasone) TAZORAC (tazarotene)	calcipotriene cream calcipotriene solution calcipotriene/betamethasone ointment CALCITRENE (calcipotriene) calcitriol DOVONEX (calcipotriene) SORILUX (calcipotriene) VECTICAL (calcitriol)	Thirty (30) day trials of two (2) preferred unique chemical entities are required before non-preferred agents will be authorized unless one (1) of the exceptions on the PA form is present.
ANTIPSYCHOTICS, ATYPICAL			
	SINGLE INGREDIENT		
	ABILIFY (aripiprazole)[AP] * ABILIFY MAINTENA (aripiprazole)**[CL] clozapine FANAPT (iloperidone) [AP] INVEGA SUSTENNA (paliperidone)**[CL] LATUDA (lurasidone) [AP] olanzapine quetiapine*** AP for the 25mg Tablet Only RISPERDAL CONSTA (risperidone) ** [CL] risperidone SAPHRIS (asenapine)[AP] ziprasidone	ADASUVE (loxapine) clozapine ODT CLOZARIL (clozapine) FANAPT TITRATION PACK (iloperidone) FAZACLO (clozapine) GEODON (ziprasidone) GEODON IM (ziprasidone) INVEGA (paliperidone) olanzapine IM** olanzapine ODT RISPERDAL (risperidone) SEROQUEL (quetiapine) SEROQUEL XR (quetiapine) VERSACLOZ (clozapine) ZYPREXA (olanzapine) ZYPREXA IM (olanzapine)** ZYPREXA RELPREVV (olanzapine)	A fourteen (14) day trial of a preferred generic agent is required before a Preferred Brand will be authorized. All antipsychotic agents require prior authorization for children up to six (6) years of age. Non-preferred agents will be authorized if the following criteria have been met: 1. A fourteen (14) day trial of a preferred generic agent **and** 2. Two (2) fourteen (14) day trials of additional preferred products unless one (1) of the

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			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 FDA recommended dosages. * Abilify will be prior authorized via electronic PA for MDD if the following criteria are met: 1. The patient is eighteen (18) years of age or older **and** 2. Diagnosis of Major Depressive Disorder (MDD) **and** 3. Prescribed as adjunctive therapy with buproprion, an SSRI agent or an SNRI agent **and** 4. The daily dose does not exceed 15mg **All injectable antipsychotic products require clinical prior authorization and will be approved on a case-by-case basis. ***Quetiapine 25mg will be authorized: 1. For a diagnosis of schizophrenia **or** 2. For a diagnosis of bipolar disorder **or** 3. When prescribed concurrently with other strengths of Seroquel in order to achieve therapeutic treatment levels. ***Quetiapine 25mg will not be authorized for use as a sedative hypnotic.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	ATYPICAL ANTIPSYCHOTIC/SSRI COMBINATIONS		
		olanzapine/fluoxetine SYMBYAX (olanzapine/fluoxetine)	
ANTIVIRALS, ORAL			
	ANTI HERPES		
	acyclovir valacyclovir	famciclovir FAMVIR (famciclovir) SITAVIG (acyclovir) VALTREX ZOVIRAX (acyclovir)	Five (5) day trials each of the preferred agents are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.
	ANTI-INFLUENZA		
	RELENZA (zanamivir) TAMIFLU (oseltamivir)	FLUMADINE (rimantadine) rimantadine	The anti-influenza agents will be authorized only for a diagnosis of influenza.
ANTIVIRALS, TOPICAL[AP]			
	ZOVIRAX CREAM (acyclovir)	ABREVA (docosanol) acyclovir ointment DENAVIR (penciclovir) ZOVIRAX OINTMENT (acyclovir)	A five (5) day trial of the preferred agent will be required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.
BETA BLOCKERS[AP]			
	BETA BLOCKERS		
	acebutolol atenolol betaxolol bisoprolol metoprolol metoprolol ER nadolol pindolol propranolol propranolol ER sotalol timolol	BETAPACE (sotalol) BYSTOLIC (nebivolol) CORGARD (nadolol) HEMANGEOL (propranolol)* INDERAL LA (propranolol) INDERAL XL (propranolol) INNOPRAN XL (propranolol) KERLONE (betaxolol) LEVATOL (penbutolol) LOPRESSOR (metoprolol) SECTRAL (acebutolol) TENORMIN (atenolol) TOPROL XL (metoprolol) ZEBETA (bisoprolol)	Fourteen (14) day trials each of three (3) chemically distinct preferred agents, including the generic formulation of the requested non-preferred agent, are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. *Hemangeol will be authorized for the treatment of proliferating infantile hemangioma requiring systemic therapy.
	BETA BLOCKER/DIURETIC COMBINATION DRUGS		

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	atenolol/chlorthalidone bisoprolol/HCTZ metoprolol/HCTZ nadolol/bendroflumethiazide propranolol/HCTZ	CORZIDE (nadolol/bendroflumethiazide) DUTOPROL (metoprolol ER/HCTZ ER) 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[AP]			
	oxybutynin IR oxybutynin ER TOVIAZ (fesoterodine) VESICARE (solifenacin)	DETROL (tolterodine) DETROL LA (tolterodine) DITROPAN XL (oxybutynin) ENABLEX (darifenacin) flavoxate GELNIQUE (oxybutynin) MYRBETRIQ (mirabegron) OXYTROL (oxybutynin) SANCTURA (trospium) SANCTURA XR (trospium) tolterodine tolterodine ER trospium trospium ER	A thirty (30) day trial of each of the chemically distinct preferred agents is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.
BONE RESORPTION SUPPRESSION AND RELATED AGENTS			
	BISPHOSPHONATES		
	alendronate tablets	ACTONEL (risedronate) ACTONEL WITH CALCIUM (risedronate/ calcium) alendronate solution ATELVIA (risedronate) BINOSTO (alendronate) BONIVA (ibandronate) DIDRONEL (etidronate) etidronate FOSAMAX TABLETS (alendronate) FOSAMAX PLUS D (alendronate/vitamin D) Ibandronate risedronate	A thirty (30) day trial of the preferred agent is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.
	OTHER BONE RESORPTION SUPPRESSION AND RELATED AGENTS		
	calcitonin	EVISTA (raloxifene)	Evista will be authorized for

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		FORTEO (teriparatide) FORTICAL (calcitonin) MIACALCIN (calcitonin) raloxifene	postmenopausal women with osteoporosis or at high risk for invasive breast cancer.
BPH TREATMENTS			
	5-ALPHA-REDUCTASE (5AR) INHIBITORS		
	finasteride	AVODART (dutasteride) CIALIS 5 mg (tadalafil) PROSCAR (finasteride)	Thirty (30) day trials each of at least two (2) chemically distinct preferred agents, including the generic formulation of the requested non-preferred agent, are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.
	ALPHA BLOCKERS		
	alfuzosin doxazosin tamsulosin terazosin	CARDURA (doxazosin) CARDURA XL (doxazosin) FLOMAX (tamsulosin) HYTRIN (terazosin) RAPAFLO (silodosin) UROXATRAL (alfuzosin)	
	5-ALPHA-REDUCTASE (5AR) INHIBITORS/ALPHA BLOCKER COMBINATION		
		JALYN (dutasteride/tamsulosin)	Concurrent thirty (30) day trials of dutasteride and tamsulosin are required before the non-preferred agent will be authorized.
BRONCHODILATORS, BETA AGONIST[AP]			
	INHALATION SOLUTION		
	ACCUNEB (albuterol)* albuterol	BROVANA (arformoterol) levalbuterol metaproterenol PERFOROMIST (formoterol) 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 (1) of the exceptions on the PA form is present. *No PA is required for Accuneb for children up to five (5) years of age.
	INHALERS, LONG-ACTING		

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	FORADIL (formoterol) SEREVENT (salmeterol)	ARCAPTA (indacaterol maleate)	Thirty (30) day trials each of the preferred agents are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.
	INHALERS, SHORT-ACTING		
	PROAIR HFA (albuterol) PROVENTIL HFA (albuterol)	MAXAIR (pirbuterol) VENTOLIN HFA (albuterol) XOPENEX HFA (levalbuterol)	Xopenex Inhalation Solution will be authorized for twelve (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 IR, ER terbutaline	metaproterenol VOSPIRE ER (albuterol)	
CALCIUM CHANNEL BLOCKERS[AP]			
	LONG-ACTING		
	amlodipine diltiazem ER felodipine ER nifedipine ER verapamil ER	ADALAT CC (nifedipine) CALAN SR (verapamil) CARDENE SR (nicardipine) CARDIZEM CD, LA (diltiazem) COVERA-HS (verapamil) diltiazem LA DYNACIRC CR (isradipine) ISOPTIN SR (verapamil) MATZIM LA (diltiazem) nisoldipine NORVASC (amlodipine) PLENDIL (felodipine) PROCARDIA XL (nifedipine) SULAR (nisoldipine) TIAZAC (diltiazem) verapamil ER PM VERELAN/VERELAN PM (verapamil)	Fourteen (14) day trials each of the preferred agents are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.
	SHORT-ACTING		
	diltiazem verapamil	CALAN (verapamil) CARDIZEM (diltiazem)	

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		isradipine nicardipine nifedipine nimodipine NIMOTOP (nimodipine) NYMALIZE SOLUTION (nimodipine) PROCARDIA (nifedipine)	
CEPHALOSPORINS AND RELATED ANTIBIOTICS[AP]			
	BETA LACTAMS AND BETA LACTAM/BETA-LACTAMASE INHIBITOR COMBINATIONS		A five (5) day trial of the preferred agent is required before a non-preferred agent is authorized unless one (1) of the exceptions on the PA form is present.
	amoxicillin/clavulanate IR	amoxicillin/clavulanate ER AUGMENTIN (amoxicillin/clavulanate) AUGMENTIN XR (amoxicillin/clavulanate) MOXATAG (amoxicillin)	
	CEPHALOSPORINS		
	cefaclor cefadroxil capsule, tablet cefdinir cefuroxime tablet cephalexin capsule, suspension	CEDAX (ceftibuten) cefaclor ER tablet cefadroxil suspension cefditoren cefpodoxime cefprozil ceftibuten capsule, suspension CEFTIN (cefuroxime) cefuroxime suspension cephalexin tablet KEFLEX (cephalexin) OMNICEF (cefdinir) RANICLOR (cefaclor) SPECTRACEF (cefditoren) SUPRAX (cefixime)	
COLONY STIMULATING FACTORS			
	LEUKINE (sargramostim) NEUPOGEN (filgrastim)	NEULASTA (pegfilgrastim)	A thirty (30) day trial of one (1) of the preferred agents is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.
COPD AGENTS			
	ANTICHOLINERGIC[AP]		

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	ATROVENT HFA (ipratropium) ipratropium SPIRIVA (tiotropium)	TUDORZA (aclidinium)	A thirty (30) day trial of tiotropium is required before a non-preferred agent will be authorized.
	ANTICHOLINERGIC-BETA AGONIST COMBINATIONS[AP]		
	albuterol/ipratropium COMBIVENT RESPIMAT (albuterol/ipratropium)	ANORO ELLIPTA (umeclidinium/vilanterol) DUONEB (albuterol/ipratropium)	A thirty (30) day trial of a preferred agent is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. *Anoro Ellipta will be authorized if the following criteria are met: 1) Patient must be eighteen (18) years of age or older; **AND** 2) Patient must have had a diagnosis of COPD; **AND** 3) Patient must have had a thirty (30) day trial of a LABA or a combination drug containing a LABA; **AND** 4) Patient must have had a **concurrent thirty (**30) day trial with a long-acting anticholinergic; Prior-authorization will be denied for patients with a sole diagnosis of asthma.
	PDE4 INHIBITOR		
		DALIRESP (roflumilast)	Daliresp will be authorized if the following criteria are met: 1. Patient is forty (40) years of age or older **and** 2. Diagnosis of severe chronic obstructive pulmonary disease (COPD) associated with chronic bronchitis and multiple exacerbations requiring systemic glucocorticoids in the preceding six (6) months **and** **3.** Concurrent therapy with an inhaled corticosteroid and long-acting bronchodilator and

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			evidence of compliance **and** **4.** No evidence of moderate to severe liver impairment (Child-Pugh Class B or C) **and** 5. No concurrent use with strong cytochrome P450 inducers (rifampicin, phenobarbital, carbamazepine or phenytoin).
CYTOKINE & CAM ANTAGONISTS[CL]			
ANTI-TNFs			Ninety (90) day trials of two (2) of the preferred anti-TNF agents are required before a non-preferred **anti-TNF** or "**Other**" agent will be authorized unless one (1) of the exceptions on the PA form is present. *Additional criteria for this category may be found on the BMS Website: http://www.dhhr.wv.gov/bms/Pharmacy/Pages/pac.aspx
	ENBREL (etanercept) * HUMIRA (adalimumab) *	CIMZIA (certolizumab pegol) SIMPONI (golimumab)	
OTHERS			
		ACTEMRA syringe (tocilizumab) KINERET (anakinra) ORENCIA syringe (abatacept) OTEZLA (apremilast)* STELARA syringe (ustekinumab) XELJANZ (tofacitinib)*	
EPINEPHRINE, SELF-INJECTED			
	AUVI-Q (epinephrine) epinephrine	ADRENACLICK (epinephrine) EPIPEN (epinephrine) EPIPEN JR (epinephrine)	A non-preferred agent will be authorized upon documentation showing the patient's inability to follow the instructions, or the patient's failure to understand the training for both preferred agents.
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 (1) of the exceptions on the PA form is present. Erythropoiesis agents will be authorized if the following criteria are met: 1. Hemoglobin or Hematocrit less than 10/30 respectively. For renewal, hemoglobin or hematocrit levels greater than

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			12/36 will require dosage reduction or discontinuation. Exceptions will be considered on an individual basis after medical documentation is reviewed. (Lab oratory values must be dated within six (6) weeks of request.) **and** 2. Transferrin saturation ≥ 20%, ferritin levels ≥100 mg/ml, or on concurrent therapeutic iron therapy. (Laboratory values must be dated within three (3) weeks of request. For re-authorization, transferrin saturation or ferritin levels are not required if the patient has been responsive to the erythropoietin agent **and** 3. For HIV-infected patients, endogenous serum erythropoietin level must be ≤ 500mU/ml to initiate therapy **and** 4. No evidence of untreated GI bleeding, hemolysis, or Vitamin B-12, iron or folate deficiency.
FLUOROQUINOLONES (Oral)[AP]			
	CIPRO SUSPENSION (ciprofloxacin) ciprofloxacin levofloxacin tablet	AVELOX (moxifloxacin) CIPRO TABLETS (ciprofloxacin) CIPRO XR (ciprofloxacin) ciprofloxacin ER ciprofloxacin suspension FACTIVE (gemifloxacin) LEVAQUIN (levofloxacin) levofloxacin solution moxifloxacin NOROXIN (norfloxacin) ofloxacin	A five (5) day trial of a preferred agent is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.
GLUCOCORTICOIDS, INHALED[AP]			
	GLUCOCORTICOIDS		

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	ASMANEX (mometasone) PULMICORT RESPULES (budesonide)* QVAR (beclomethasone)	AEROSPAN (flunisolide) ALVESCO (ciclesonide) budesonide FLOVENT HFA (fluticasone) FLOVENT Diskus (fluticasone) PULMICORT FLEXHALER (budesonide)	Thirty (30) day trials of each of the preferred agents are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. *Pulmicort Respules are preferred for children up to nine (9) years of age. A prior authorization will be required for children nine (9) years of age or older, and for individuals unable to use an MDI. Brand Pulmicort Respules are preferred over the generic formulation.
	GLUCOCORTICOID/BRONCHODILATOR COMBINATIONS		
	ADVAIR (fluticasone/salmeterol) ADVAIR HFA (fluticasone/salmeterol) DULERA (mometasone/formoterol) SYMBICORT(budesonide/formoterol)	BREO ELLIPTA (fluticasone/vilanerol)	Thirty (30) day trials of each of the preferred agents are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. For a diagnosis of COPD, thirty (30) day trials of each of the preferred agents in this category indicated for COPD are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.
GROWTH HORMONE[CL]			
	GENOTROPIN (somatropin) NORDITROPIN (somatropin)	HUMATROPE (somatropin) INCRELEX (mecasermin) NUTROPIN (somatropin) NUTROPIN AQ NUTROPIN AQ PENS (somatropin) OMNITROPE (somatropin) SAIZEN (somatropin) SEROSTIM (somatropin) TEV-TROPIN (somatropin)	A trial of each preferred agents is required before a non-preferred agent will be authorized unless one (1) 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

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		ZORBTIVE (somatropin)	the duration of the existing PA.
***H. PYLORI* TREATMENT**			
	Please use individual components: preferred PPI (omeprazole or pantoprazole) amoxicillin tetracycline metronidazole clarithromycin bismuth	HELIDAC (bismuth/metronidazole/tetracycline) lansoprazole/amoxicillin/clarithromycin OMECLAMOX-PAK (omeprazole/amoxicillin/clarithromycin) PREVPAC (lansoprazole/amoxicillin/clarithromycin) PYLERA (bismuth/metronidazole/tetracycline)	A trial of the preferred agent or individual preferred components of the non-preferred agent (with omeprazole or pantoprazole) at the recommended dosages, frequencies and duration is required before the brand name combination packages will be authorized unless one (1) of the exceptions on the PA form is present.
HEPATITIS B TREATMENTS			
	EPIVIR HBV (lamivudine) TYZEKA (telbivudine)	adefovir BARACLUDE (entecavir) entecavir HEPSERA (adefovir) lamivudine HBV	A thirty (30) day trial of the preferred agent is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.
HEPATITIS C TREATMENTS[CL]			
	HARVONI (ledipasvir/sofosbuvir)* PEGASYS (pegylated interferon) PEG-INTRON (pegylated interferon) RIBASPHERE 200mg ribavirin	COPEGUS (ribavirin) INFERGEN (consensus interferon) OLYSIO (simeprevir)* REBETOL (ribavirin) RIBAPAK (ribavirin) RIBASPHERE 400mg, 600mg (ribavirin) ribavirin dose pack SOVALDI (sofosbuvir)* VICTRELIS (boceprevir)*	For patients starting therapy in this class, a trial of the preferred agent of a dosage form is required before a non-preferred agent of that dosage form will be authorized. *Full PA criteria may be found on the BMS Website: http://www.dhhr.wv.gov/bms/Pharmacy/Pages/pac.aspx
HYPERPARATHYROID AGENTS[AP]			
	HECTOROL (doxercalciferol) paricalcitol capsule	doxercalciferol capsule doxercalciferol injection paricalcitol injection SENSIPAR (cinacalcet) ZEMPLAR (paricalcitol)	A thirty (30) day trial of a preferred agent will be required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.
HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS			
	INJECTABLE		

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	BYETTA (exenatide)[AP] VICTOZA (liraglutide) [AP]	BYDUREON (exenatide)* TANZEUM (albiglutide) SYMLIN (pramlintide) **	A thirty (30) day trial of one (1) preferred agent with a chemical entity distinct from the requested non-preferred agent will be required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. All agents (preferred and non-preferred) require a previous history of a thirty (30) day trial of metformin. For concurrent insulin use, all agents will be approved in six (6) month intervals. For re-authorizations, documentation that HgBA1C levels have decreased by at least 1% or are maintained at ≤8% is required. HgBA1C levels submitted must be for the most recent thirty (30) day period. (Concurrent therapy with a bolus insulin is contraindicated.) *Bydureon will not be authorized with insulin therapy of any kind. **Symlin will be authorized with a history of bolus insulin utilization in the past ninety (90) days with no gaps in insulin therapy greater than thirty (30) days.
	ORAL [AP]		
	JANUMET (sitagliptin/metformin)[AP] JANUVIA (sitagliptin) [AP] JENTADUETO (linagliptin/metformin) [AP] TRADJENTA (linagliptin) [AP]	JANUMET XR (sitagliptin/metformin)* KAZANO (alogliptin/metformin) KOMBIGLYZE XR (saxagliptin/metformin) * NESINA (alogliptin) ONGLYZA (saxagliptin) OSENI (alogliptin/pioglitazone)	Thirty (30) day trials of each chemically distinct preferred agent are required before a non-preferred agent will be approved. All agents (preferred and non-preferred) require a previous history of a thirty (30) day trial of metformin.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			For concurrent insulin use, all agents will be approved in six (6) month intervals. For re-authorizations, documentation that HgBA1C levels have decreased by at least 1% or are maintained at ≤8% is required. HgBA1C levels submitted must be for the most recent thirty (30) day period. *Janumet XR and Kombiglyze XR will be authorized after thirty (30) day trials of the preferred combination agents.
HYPOGLYCEMICS, INSULIN AND RELATED AGENTS			
	HUMALOG (insulin lispro) HUMALOG MIX VIALS (insulin lispro/lispro protamine) HUMULIN VIALS (insulin) LANTUS (insulin glargine) LEVEMIR (insulin detemir) NOVOLIN (insulin) NOVOLOG (insulin aspart) NOVOLOG MIX (insulin aspart/aspart protamine)	APIDRA (insulin glulisine)[AP] HUMALOG PEN/KWIKPEN (insulin lispro) HUMALOG MIX PENS (insulin lispro/lispro protamine) HUMULIN PENS (insulin)	Apidra will be authorized if the following criteria are met: 1. Patient is four (4) years of age or older; **and** 2. Patient is currently on a regimen including a longer acting or basal insulin, **and** 3. Patient has had a trial of a similar preferred agent, Novolog or Humalog, with documentation that the desired results were not achieved. Humulin pens and Humalog Mix pens will be authorized only for patients who cannot utilize vials due to impaired vision or dexterity.
HYPOGLYCEMICS, MEGLITINIDES			
	MEGLITINIDES		
	nateglinide PRANDIN (repaglinide)	repaglinide STARLIX (nateglinide)	A thirty (30) day trial of a preferred agent is required before a non-preferred agent will be authorized, unless one (1) of the exceptions on the PA form is present.
	MEGLITINIDE COMBINATIONS		

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		PRANDIMET (repaglinide/metformin)	
HYPOGLYCEMICS, MISCELLANEOUS			
	WELCHOL (colesevelam)[AP]		Welchol will be authorized for add-on therapy for type 2 diabetes when there is a previous history of a thirty (30) day trial of an oral agent (sulfonylurea, thiazolidinedione (TZD) or metformin).
HYPOGLYCEMICS, SGLT2			
		FARXIGA (dapagliflozin) INVOKANA (canagliflozin)	Invokana and Farxiga will be authorized for six (6) months if the following criteria are met, unless one (1) of the exceptions on the PA form is present: 1. Diagnosis of Type 2 Diabetes **and** 2. Thirty (30) day trial of metformin or metformin combination and at least one (1) other agent in the sulfonylurea class or a preferred agent from the basal insulins, TZD, DPP4, or GLP1 classes within the past six (6) months **and** 3. HgBA1C levels are equal or less than (≤) 10.5% **and** 4. Glomerular filtration rate is greater than or equal to (≥) 45 ml/min/1.73m2 for Invokana **or** ≥ 60ml/min/1.73cm^2 for Farxiga **and** 5. Prior authorizations will be issued at six (6) month intervals if HgBA1C levels are less than or equal to (≤) 8% after treatment. HgBA1C levels submitted must be for the most recent thirty (30) day period.
HYPOGLYCEMICS, TZD[AP]			

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	THIAZOLIDINEDIONES		
	pioglitazone	ACTOS (pioglitazone) AVANDIA (rosiglitazone)	A thirty (30) day trial of the preferred agent is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.
	TZD COMBINATIONS		
		ACTOPLUS MET (pioglitazone/ metformin) ACTOPLUS MET XR (pioglitazone/ metformin) AVANDAMET (rosiglitazone/metformin) AVANDARYL (rosiglitazone/glimepiride) DUETACT (pioglitazone/glimepiride) pioglitazone/glimepiride pioglitazone/ metformin	Patients are required to use the components of Actoplus Met and Duetact separately. Exceptions will be handled on a case-by-case basis.
IMMUNE GLOBULINS, IV[CL]			
	BIVIGAM (human immunoglobulin gamma) CARIMUNE NF NANOFILTERED (human immunoglobulin gamma) CYTOGAM (human cytomegalovirus immune globulin) FLEBOGAMMA DIF (human immunoglobulin gamma) GAMASTAN S-D VIAL (human immunoglobulin gamma) GAMMAGARD LIQUID (human immunoglobulin gamma) GAMMAGARD S-D (human immunoglobulin gamma) GAMUNEX-C (human immunoglobulin gamma) GAMMAPLEX (human immunoglobulin gamma) HEPAGAM B (hepatitis b immune globulin (human)) HIZENTRA (human immunoglobulin gamma) VARIZIG (varicella zoster immune globulin (human))	GAMMAKED (human immunoglobulin gamma) OCTAGAM (human immunoglobulin gamma) PRIVIGEN (human immunoglobulin gamma)	Immune globulin agents will be authorized according to FDA approved indications. A trial of a preferred agent is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.
IMMUNOMODULATORS, ATOPIC DERMATITIS[AP]			
	ELIDEL (pimecrolimus)[AP]	PROTOPIC (tacrolimus)	A thirty (30) day trial of a preferred medium or high potency topical corticosteroid is required before coverage of Elidel will be

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			considered; additionally, a thirty (30) day trial of Elidel is required before Protopic will be considered, unless one (1) of the exceptions on the PA form is present.
IMMUNOMODULATORS, TOPICAL & GENITAL WARTS AGENTS			
	ALDARA (imiquimod) CONDYLOX GEL (podofilox)	CONDYLOX SOLUTION (podofilox) imiquimod podofilox VEREGEN (sinecatechins) ZYCLARA (imiquimod)*	A thirty (30) day trial of both preferred agents is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. *Zyclara will be authorized for a diagnosis of actinic keratosis.
IMMUNOSUPPRESSIVES, ORAL			
	Azathioprine cyclosporine cyclosporine, modified mycophenolate mofetil PROGRAF (tacrolimus) RAPAMUNE (sirolimus) sirolimus	ASTAGRAF XL (tacrolimus) AZASAN (azathioprine) CELLCEPT (mycophenolate mofetil) IMURAN (azathioprine) MYFORTIC (mycophenolic acid) mycophenolic acid NEORAL (cyclosporine, modified) SANDIMMUNE (cyclosporine) tacrolimus ZORTRESS (everolimus)	A fourteen (14) day trial of a preferred agent is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.
INTERMITTENT CLAUDICATION[AP]			
	Cilostazol pentoxifylline	PLETAL (cilostazol)	A thirty (30) day trial of one of the preferred agents will be required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.
INTRANASAL RHINITIS AGENTS[AP]			
	ANTICHOLINERGICS		
	Ipratropium	ATROVENT(ipratropium)	Thirty (30) day trials each of one (1) of the nasal anti-cholinergic, one (1) of the antihistamine, and one (1) of the corticosteroid preferred agents are required before a non-preferred anti-cholinergic will be authorized

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			unless one (1) of the exceptions on the PA form is present.
	ANTIHISTAMINES		
	ASTEPRO (azelastine) PATANASE (olopatadine)	azelastine olopatadine	Thirty (30) day trials of each preferred intranasal antihistamines and a thirty (30) day trial of one (1) of the preferred intranasal corticosteroids are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.
	COMBINATIONS		
		DYMISTA (azelastine / fluticasone)	A concurrent thirty (30) day trial of each of the preferred components is required before Dymista will be authorized unless one (1) of the exceptions on the PA form is present.
	CORTICOSTEROIDS		
	fluticasone propionate NASONEX (mometasone)	BECONASE AQ (beclomethasone) budesonide FLONASE (fluticasone propionate) flunisolide NASACORT AQ (triamcinolone) OMNARIS (ciclesonide) QNASL (beclomethasone) RHINOCORT AQUA (budesonide) triamcinolone VERAMYST (fluticasone furoate) ZETONNA (ciclesonide)	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 (1) of the exceptions on the PA form is present.
IRRITABLE BOWEL SYNDROME			
	AMITIZA (lubiprostone)[CL]* LINZESS (linaclotide) [CL]**	LOTRONEX (alosetron)	Thirty (30) day trial of the preferred agent is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. *Amitiza will be prior authorized for patients if the following criteria are met:

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			1. Diagnosis of chronic idiopathic constipation, with less than three spontaneous bowel movements per week **or** 2. Female with a diagnosis of Irritable Bowel Syndrome with Constipation (IBS-C) **or** 3. Diagnosis of opioid induced constipation accompanied by a diagnosis of non-cancer chronic pain (Diagnosis of chronic pain must be documented with diagnostic studies, if appropriate.) **and each of the following:** 1. Patient is eighteen (18) years of age or older, **and** 2. Documented failure of an increase in dietary fiber/dietary modification, **and** 3. Documented failure of at least fourteen (14) days of therapy each with osmotic and bulk forming laxatives, **and** 4. Appropriate screening for colon cancer, history of bowel obstruction, hepatic or renal disease, hypothyroidism, pelvic floor abnormalities, and spinal cord abnormalities. **Linzess will be authorized if the following criteria are met: 1. Diagnosis of chronic idiopathic constipation, with less than three spontaneous bowel movements per week; **or** 2. Diagnosis of Irritable Bowel Syndrome with Constipation (IBS-C); **and each of the following** 3. Patient is eighteen (18) years

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			of age or older **and** 4. Documented failure of an increase in dietary fiber/dietary modification **and** 5. Documented failure of at least fourteen (14) days of therapy each with osmotic and bulk forming laxatives **and** 6. Appropriate screening for colon cancer, history of bowel obstruction, hepatic or renal disease, hypothyroidism, pelvic floor abnormalities, and spinal cord abnormalities.
LAXATIVES AND CATHARTICS			
	COLYTE GOLYTELY packet NULYTELY peg 3350	HALFLYTELY-BISACODYL KIT GOLYTELY solution MOVIPREP OSMOPREP PREPOPIK SUPREP	Thirty (30) day trials each of the preferred agents are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.
LEUKOTRIENE MODIFIERS			
	ACCOLATE (zafirlukast) montelukast	SINGULAIR (montelukast) zafirlukast ZYFLO (zileuton)	Thirty (30) day trials each of the preferred agents are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.
LIPOTROPICS, OTHER (Non-statins)[AP]			
	BILE ACID SEQUESTRANTS		
	cholestyramine colestipol tablets	COLESTID (colestipol) colestipol granules KYNAMRO (mipomersen) QUESTRAN (cholestyramine) WELCHOL (colesevelam)*	A twelve (12) week trial of one (1) of the preferred agents is required before a non-preferred agent in the corresponding category will be authorized. *Welchol will be authorized for add-on therapy for type 2 diabetes when there is a previous history of a thirty (30) day trial of an oral agent (metformin, sulfonylurea or

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			thiazolidinedione (TZD)). See HYPOGLYCEMICS, MISCELLANEOUS.
	CHOLESTEROL ABSORPTION INHIBITORS		
	ZETIA (ezetimibe) [AP]		Zetia will be authorized with prior use of a HMG-CoA reductase inhibitor within the previous six (6) months.
	FATTY ACIDS		
		LOVAZA (omega-3-acid ethyl esters)[AP] omega-3 acid ethyl esters VASCEPA (icosapent ethyl)	Lovaza and Vascepa will be authorized when the patient is intolerant or not responsive to, or not a candidate for, nicotinic acid or fibrate therapy.
	FIBRIC ACID DERIVATIVES		
	fenofibrate 54mg & 160mg fenofibrate micronized 67mg, 134mg & 200mg gemfibrozil	ANTARA (fenofibrate) FENOGLIDE (fenofibrate) FIBRICOR (fenofibric acid) fenofibrate 43mg, 130mg fenofibrate 50mg, 150mg fenofibrate nanocrystallized 48mg, 145mg fenofibric acid LIPOFEN (fenofibrate) LOFIBRA (fenofibrate) LOPID (gemfibrozil) TRICOR (fenofibrate nanocrystallized) TRIGLIDE (fenofibrate) TRILIPIX (fenofibric acid)	
	NIACIN		
	niacin NIACOR (niacin) NIASPAN (niacin) SLO-NIACIN (niacin)	niacin ER	
LIPOTROPICS, STATINS[AP]			
	STATINS		
	atorvastatin CRESTOR (rosuvastatin) lovastatin pravastatin simvastatin[CL*]	ALTOPREV (lovastatin) fluvastatin LESCOL (fluvastatin) LESCOL XL (fluvastatin) LIPITOR (atorvastatin) LIVALO (pitavastatin) MEVACOR (lovastatin)	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 (1) of the exceptions on the PA form

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		PRAVACHOL (pravastatin) ZOCOR (simvastatin)*	is present. *Zocor/simvastatin 80mg tablets will require a clinical PA
	STATIN COMBINATIONS		
		ADVICOR (lovastatin/niacin) amlodipine/atorvastatin CADUET (atorvastatin/amlodipine) LIPTRUZET (atorvastatin/ezetimibe) SIMCOR (simvastatin/niacin ER) VYTORIN (simvastatin/ezetimibe)*	Thirty (30) day concurrent trials of the appropriate single agents are required before a non-preferred Statin combination will be authorized. *Vytorin will be authorized only after an insufficient response to the maximum tolerable dose of atorvastatin after twelve (12) weeks, unless one (1) of the exceptions on the PA form is present. Vytorin 80/10mg tablets will require a clinical PA
MACROLIDES/KETOLIDES			
	KETOLIDES		
		KETEK (telithromycin)	Requests for telithromycin will be authorized if there is documentation of the use of any antibiotic within the past twenty-eight (28) days.
	MACROLIDES		
	azithromycin BIAXIN XL (clarithromycin) clarithromycin erythromycin base	BIAXIN (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 (1) of the exceptions on the PA form is present.
MULTIPLE SCLEROSIS AGENTS[AP]			
	INTERFERONS		

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	AVONEX (interferon beta-1a)[AP] AVONEX PEN (interferon beta-1a)[AP] EXTAVIA KIT (interferon beta-1b)[AP]	BETASERON KIT (interferon beta-1b)[AP] EXTAVIA VIAL (interferon beta-1b)[AP] REBIF (interferon beta-1a)[AP] REBIF REBIDOSE (interferon beta-1a)[AP]	A diagnosis of multiple sclerosis and a thirty (30) day trial of a preferred agent in the corresponding class (interferon or non-interferon) will be required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.
	NON-INTERFERONS		
	COPAXONE 20 mg (glatiramer)[AP]	AMPYRA (dalfampridine)[CL]* AUBAGIO (teriflunomide)[CL]** COPAXONE 40 mg (glatiramer) GILENYA (fingolimod)[CL]*** TECFIDERA (dimethyl fumarate)[CL]****	*Ampyra will be authorized if the following criteria are met: 1. Diagnosis of multiple sclerosis **and** 2. No history of seizures **and** 3. No evidence of moderate or severe renal impairment **and** 4. A thirty (30) day trial of a preferred agent in the corresponding **and** 5. Initial prescription will be authorized for thirty (30) days only. **Aubagio will be authorized if the following criteria are met: 1. Diagnosis of relapsing multiple sclerosis **and** 2. A thirty (30) day trial of a preferred agent in the corresponding class **and** 3. Measurement of transaminase and bilirubin levels within the (6) months before initiation of therapy and ALT levels at least monthly for six (6) months after initiation of therapy **and** 4. Complete blood cell count (CBC) within six (6) months before initiation of therapy **and** 5. Female patients must have a negative pregnancy test before initiation of therapy and be

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			established on a reliable method of contraception if appropriate **and** 6. Patient is from eighteen (18) up to sixty-five (65) years of age **and** 7. Negative tuberculin skin test before initiation of therapy ***Gilenya will be authorized if the following criteria are met: A diagnosis of a relapsing form of multiple sclerosis **and** 1. Medication is prescribed by a neurologist **and** 2. A thirty (30) day trial of a preferred agent in the corresponding class **and** 3. Dosage is limited to one (1) tablet per day. (AP does not apply.) ****Tecfidera will be authorized if the following criteria are met: 1. Diagnosis of relapsing multiple sclerosis **and** **2.** A thirty (30) day trial of a preferred agent in the corresponding class **and** 3. Complete blood count (CBC) within six (6) months of initiation of therapy and six months after initiation **and** 4. Complete blood count (CBC) annually during therapy
NEUROPATHIC PAIN[AP]			
	capsaicin OTC duloxetine gabapentin capsules, solution LIDODERM (lidocaine)[AP]**	CYMBALTA (duloxetine) gabapentin tablets GRALISE (gabapentin)* HORIZANT (gabapentin) lidocaine patch LYRICA CAPSULE (pregabalin)***	A trial of a preferred agent in the corresponding dosage form (oral or topical) will be required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		LYRICA SOLUTION (pregabalin)*** NEURONTIN (gabapentin) QUTENZA (capsaicin) SAVELLA (milnacipran)**** ZOSTRIX OTC (capsaicin)	present. *Gralise will be authorized if the following criteria are met: 1. Diagnosis of post herpetic neuralgia **and** 2. Trial of a tricyclic antidepressant for a least thirty (30) days **and** 3. Trial of gabapentin immediate release formulation (positive response without adequate duration) **and** 4. Request is for once daily dosing with 1800mg. maximum daily dosage. **Lidoderm patches will be authorized for a diagnosis of post-herpetic neuralgia. ***Lyrica will be authorized if the following criteria are met: 1. Diagnosis of seizure disorders or neuropathic pain associated with a spinal cord injury **or** 2. Diagnosis of fibromyalgia, postherpetic neuralgia, or diabetic neuropathy AND a history of a trial of duloxetine at the generally accepted maximum therapeutic dose of 60 mg/day OR gabapentin at a therapeutic dose range between 900mg and 2,400mg per day for thirty (30) days within the previous twenty-four (24) month period or an intolerance due to a potential adverse drug-drug interaction, drug-disease interaction, or intolerable side effect (In cases of renal impairment, doses may

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			be adjusted based on the degree of impairment.) ****Savella will be authorized for a diagnosis of fibromyalgia or a previous thirty (30) day trial of a drug that infers fibromyalgia: duloxetine, gabapentin, amitriptyline or nortriptyline.
NSAIDS[AP]			
	NON-SELECTIVE		
	diclofenac (IR, SR) etodolac IR flurbiprofen ibuprofen (Rx and OTC) INDOCIN SUSPENSION (indomethacin) indomethacin ketoprofen ketorolac nabumetone naproxen (Rx and OTC) piroxicam sulindac	ANAPROX (naproxen) ANSAID (flurbiprofen) CATAFLAM (diclofenac) CLINORIL (sulindac) DAYPRO (oxaprozin) diflunisal DUEXIS (famotidine/ibuprofen) etodolac SR FELDENE (piroxicam) fenoprofen INDOCIN SUPPOSITORIES (indomethacin) indomethacin ER ketoprofen ER meclofenamate mefenamic acid MOTRIN (ibuprofen) NALFON (fenoprofen) NAPRELAN (naproxen) NAPROSYN (naproxen) oxaprozin PONSTEL (meclofenamate) SPRIX (ketorolac) tolmetin VOLTAREN (diclofenac) ZIPSOR (diclofenac potassium) ZORVOLEX (diclofenac)	Thirty (30) day trials of each of the preferred agents are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.
	NSAID/GI PROTECTANT COMBINATIONS		
		ARTHROTEC (diclofenac/misoprostol) diclofenac/misoprostol VIMOVO (naproxen/esomeprazole)	
	COX-II SELECTIVE		

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	meloxicam	CELEBREX (celecoxib) MOBIC (meloxicam)	COX-II Inhibitor agents will be authorized if the following criteria are met: Patient has a history or risk of a serious GI complication **or** Agent is requested for treatment of a chronic condition **and** 1. Patient is 70 years of age or older, **or** 2. Patient is currently on anticoagulation therapy**.**
	TOPICAL		
	VOLTAREN GEL (diclofenac)*[AP]	diclofenac solution FLECTOR PATCH (diclofenac) PENNSAID (diclofenac)	Thirty (30) day trials of each of the preferred oral NSAIDS are required before a topical NSAID gel or solution will be authorized unless one (1) of the exceptions on the PA form is present. Flector patches will be authorized for a diagnosis of acute strain, sprain or injury after a five (5) day trial of one (1) of the preferred oral NSAIDs and for a maximum duration of fourteen (14) days unless one (1) of the exceptions on the PA form is present. *Voltaren Gel will be authorized if the following criteria are met: 1. Thirty (30) day trials of two (2) of the preferred oral NSAIDs, **or**. 2. The patient is on anticoagulant therapy **or** 3. The patient has had a GI bleed or ulcer diagnosed in the last 2 years. Prior authorizations will be limited to 100 grams per month.
OPHTHALMIC ANTIBIOTICS[AP]			

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	bacitracin/polymyxin ointment ciprofloxacin* erythromycin gentamicin MOXEZA (moxifloxacin)* ofloxacin* polymyxin/trimethoprim sulfacetamide tobramycin VIGAMOX (moxifloxacin)*	AZASITE (azithromycin) bacitracin BESIVANCE (besifloxacin) BLEPH-10 (sulfacetamide) CILOXAN (ciprofloxacin) GARAMYCIN (gentamicin) gatifloxacin ILOTYCIN (erythromycin) levofloxacin NATACYN (natamycin) neomycin/bacitracin/polymyxin neomycin/polymyxin/gramicidin NEOSPORIN (neomycin/polymyxin/gramicidin) OCUFLOX (ofloxacin) POLYTRIM (polymyxin/trimethoprim) sulfacetamide ointment TOBREX (tobramycin) ZYMAR (gatifloxacin) ZYMAXID (gatifloxacin)	Three (3) day trials of each of the preferred agents are required before non-preferred agents will be authorized unless one (1) of the exceptions on the PA form is present. The American Academy of Ophthalmology guidelines on treating bacterial conjunctivitis recommend as first line treatment options: erythromycin ointment, sulfacetamide drops, or polymyxin/trimethoprim drops. *A prior authorization is required for the fluoroquinolone agents for patients up to twenty-one (21) years of age unless there has been a trial of a first line treatment option within the past ten (10) days.
OPHTHALMIC ANTIBIOTIC/STEROID COMBINATIONS[AP]			
	BLEPHAMIDE (prednisolone/sulfacetamide) BLEPHAMIDE S.O.P. (prednisolone/ sulfacetamide) neomycin/polymyxin/dexamethasone sulfacetamide/prednisolone TOBRADEX SUSPENSION (tobramycin/ dexamethasone)	MAXITROL (neomycin/polymyxin/ dexamethasone) neomycin/bacitracin/polymyxin/ hydrocortisone neomycin/polymyxin/hydrocortisone PRED-G (prednisolone/gentamicin) TOBRADEX OINTMENT (tobramycin/ dexamethasone) TOBRADEX ST (tobramycin/ dexamethasone) tobramycin/dexamethasone suspension ZYLET (loteprednol/tobramycin)	Three (3) day trials of each of the preferred agents are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.
OPHTHALMICS FOR ALLERGIC CONJUNCTIVITIS[AP]			
	ALAWAY (ketotifen) ALREX (loteprednol) cromolyn ketotifen PATADAY (olopatadine) ZADITOR OTC (ketotifen) ZYRTEC ITCHY EYE (ketotifen)	ALAMAST (pemirolast) ALOCRIL (nedocromil) ALOMIDE (lodoxamide) azelastine BEPREVE (bepotastine) CROLOM (cromolyn) ELESTAT (epinastine) EMADINE (emedastine) epinastine	Thirty (30) day trials of each of three (3) of the preferred agents are required before a non-preferred agent will be authorized, unless one (1) of the exceptions on the PA form is present.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		LASTACAFT (alcaftadine) OPTICROM (cromolyn) OPTIVAR (azelastine) PATANOL (olopatadine)	
OPHTHALMICS, ANTI-INFLAMMATORIES- IMMUNOMODULATORS			
		RESTASIS (cyclosporine)	Restasis will be authorized if the following criteria are met: 1.) Patient must be 16 years of age or greater; **AND** 2.) Prior Authorization must be requested by an ophthalmologist or optometrist; **AND** 3.) Clinically diagnosed tear deficiency due to ocular inflammation in patients with keratoconjunctivitis sicca or dry eye syndrome (also known as dry eye); **AND** 4.) Patient must have a functioning lacrimal gland; **AND** 5.) Patient using artificial tears at least 4 times a day over the last 30 days; **AND** 6.) Patient must not have an active ocular infection
OPHTHALMIC ANTI-INFLAMMATORIES[AP]			
	dexamethasone diclofenac fluorometholone flurbiprofen ketorolac prednisolone acetate	ACULAR (ketorolac) ACULAR LS (ketorolac) ACUVAIL (ketorolac tromethamine) BROMDAY (bromfenac) bromfenac DUREZOL (difluprednate) FLAREX (fluorometholone) FML (fluorometholone) FML FORTE (fluorometholone) FML S.O.P. (fluorometholone) ILEVRO (nepafenac) LOTEMAX DROPS, OINTMENT (loteprednol) LOTEMAX GEL (loteprednol)	Five (5) day trials of each of the preferred agents are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		MAXIDEX (dexamethasone) NEVANAC (nepafenac) OMNIPRED (prednisolone) OZURDEX (dexamethasone) PRED FORTE (prednisolone) PRED MILD (prednisolone) prednisolone sodium phosphate PROLENSA (bromfenac) RETISERT (fluocinolone) TRIESENCE (triamcinolone) VEXOL (rimexolone) XIBROM (bromfenac)	
OPHTHALMICS, GLAUCOMA AGENTS			
	COMBINATION AGENTS		A non-preferred agent will only be authorized if there is an allergy to the preferred agents.
	COMBIGAN (brimonidine/timolol) dorzolamide/timolol SIMBRINZA (brinzolamide/brimonidine)	COSOPT (dorzolamide/timolol) COSOPT PF (dorzolamide/timolol)	
	BETA BLOCKERS		
	BETOPTIC S (betaxolol) carteolol levobunolol metipranolol timolol	BETAGAN (levobunolol) betaxolol BETIMOL (timolol) ISTALOL (timolol) OPTIPRANOLOL (metipranolol) TIMOPTIC (timolol)	
	CARBONIC ANHYDRASE INHIBITORS		
	AZOPT (brinzolamide) dorzolamide	TRUSOPT (dorzolamide)	
	PARASYMPATHOMIMETICS		
	PHOSPHOLINE IODIDE (echothiophate iodide)	pilocarpine	
	PROSTAGLANDIN ANALOGS		
	latanoprost TRAVATAN-Z (travoprost)	LUMIGAN (bimatoprost) RESCULA (unoprostone) travoprost XALATAN (latanoprost) ZIOPTAN (tafluprost)	
	SYMPATHOMIMETICS		
	ALPHAGAN P 0.15% Solution (brimonidine) brimonidine 0.2%	ALPHAGAN P 0.1% Solution (brimonidine) apraclonidine brimonidine 0.15% IOPIDINE (apraclonidine)	

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
OPIATE DEPENDENCE TREATMENTS			
	SUBOXONE FILM (buprenorphine/naloxone)[CL] VIVITROL (naltrexone) [CL] naloxone	EVZIO (naloxone) SUBOXONE TABLETS (buprenorphine/naloxone) buprenorphine/naloxone tablets ZUBSOLV (buprenorphine/naloxone)	Suboxone PA criteria is available at http://www.dhhr.wv.gov/bms/Pharmacy/Pages/pac.aspx Vivitrol PA criteria is available at http://www.dhhr.wv.gov/bms/Pharmacy/Pages/pac.aspx *Buprenorphine/naloxone tablets will only be approved with a documented intolerance of or allergy to Suboxone strips.
OTIC ANTIBIOTICS[AP]			
	CIPRODEX (ciprofloxacin/dexamethasone)* COLY-MYCIN S (colistin/hydrocortisone/ neomycin/thonzonium bromide) CORTISPORIN SOLUTION (neomycin/polymyxin/HC) neomycin/polymyxin/HC solution/suspension ofloxacin	ciprofloxacin CIPRO HC (ciprofloxacin/hydrocortisone) CETRAXAL 0.2% SOLUTION (ciprofloxacin) CORTISPORIN-TC (colistin/hydrocortisone/ neomycin) FLOXIN (ofloxacin)	Five (5) day trials of each of the preferred agents are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. *Ciprodex is limited to patients up to nine (9) years of age. Age exceptions will be handled on a case-by-case basis.
PAH AGENTS – ENDOTHELIN RECEPTOR ANTAGONISTS[CL]			
	LETAIRIS (ambrisentan) TRACLEER (bosentan)	OPSUMIT (macitentan)	A thirty (30) day trial of a preferred agent is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. Letairis and Tracleer will be authorized for a diagnosis of pulmonary arterial hypertension (PAH).
PAH AGENTS – GUANYLATE CYCLASE STIMULATOR[CL]			
		ADEMPAS (riociguat)	A thirty (30) day trial of a preferred PAH agent is required before a non-preferred agent will be authorized unless one (1) of the exceptions on

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			the PA form is present.
PAH AGENTS – PDE5s[CL]			
	sildenafil	ADCIRCA (tadalafil) REVATIO IV (sildenafil) REVATIO TABLETS (sildenafil)	A thirty (30) day trial of the preferred agent is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. Patients stabilized on non-preferred agents will be grandfathered.
PAH AGENTS – PROSTACYCLINS[CL]			
	epoprostenol VENTAVIS (iloprost)*	FLOLAN (epoprostenol) ORENITRAM ER (treprostinil) REMODULIN (treprostinil sodium) TYVASO (treprostinil) VELETRI (epoprostenol)	A thirty (30) day trial of a preferred agent, including the preferred generic form of the non-preferred agent, is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present, *Ventavis will only be authorized for the treatment of pulmonary artery hypertension (WHO Group 1) in patients with NYHA Class III or IV symptoms.
PANCREATIC ENZYMES[AP]			
	CREON PANCRELIPASE 5000 ZENPEP	PANCREAZE PERTZYE ULTRESA VIOKACE	A thirty (30) day trial of a preferred agent is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. Non-preferred agents will be authorized for members with cystic fibrosis.
PHOSPHATE BINDERS[AP]			
	calcium acetate MAGNEBIND RX (calcium carbonate, folic acid, magnesium carbonate) PHOSLYRA (calcium acetate) RENAGEL (sevelamer)	AURYXIA (ferric citrate) ELIPHOS (calcium acetate) FOSRENOL (lanthanum) PHOSLO (calcium acetate) RENVELA (sevelamer carbonate) sevelamer carbonate	Thirty (30) day trials of at least two (2) preferred agents are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		VELPHORO (sucroferric oxyhydroxide)	
PLATELET AGGREGATION INHIBITORS			
	AGGRENOX (dipyridamole/ASA) BRILINTA (ticagrelor) clopidogrel EFFIENT (prasugrel)	dipyridamole PERSANTINE (dipyridamole) PLAVIX (clopidogrel) TICLID (ticlopidine) ticlopidine ZONTIVITY (vorapaxar)	A thirty (30) day trial of a preferred agent is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.
PROGESTINS FOR CACHEXIA			
	megestrol	MEGACE (megestrol) MEGACE ES (megestrol)	A thirty (30) day trial of the preferred agent is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.
PROTON PUMP INHIBITORS[AP]			
	omeprazole (Rx) pantoprazole PREVACID SOLUTABS (lansoprazole)*	ACIPHEX (rabeprazole) ACIPHEX SPRINKLE (rabeprazole) DEXILANT (dexlansoprazole) esomeprazole strontium lansoprazole Rx NEXIUM (esomeprazole) omeprazole/sodium bicarbonate (Rx) PREVACID CAPSULES (lansoprazole) PRILOSEC Rx (omeprazole) PROTONIX (pantoprazole) rabeprazole ZEGERID Rx (omeprazole/sodium bicarbonate)	Sixty (60) day trials of each of omeprazole (Rx) and pantoprazole at the maximum recommended dose**, inclusive of a concurrent thirty (30) day trial at the maximum dose of an H_2 antagonist** are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present *Prior authorization is required for Prevacid Solutabs for members eight (8) years of age or older. **Maximum doses can be found at: http://www.dhhr.wv.gov/bms/Pharmacy/Pages/pac.aspx
SEDATIVE HYPNOTICS[AP]			
	BENZODIAZEPINES		
	temazepam 15, 30 mg	DALMANE (flurazepam) DORAL (quazepam) estazolam flurazepam HALCION (triazolam)	Fourteen (14) day trials of the preferred agents in both categories are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		quazepam RESTORIL (temazepam) temazepam 7.5, 22.5 mg triazolam	is present.
	OTHERS		
	zolpidem 5, 10 mg	AMBIEN (zolpidem) AMBIEN CR (zolpidem) chloral hydrate EDLUAR (zolpidem) eszopiclone INTERMEZZO (zolpidem) LUNESTA (eszopiclone) ROZEREM (ramelteon) SILENOR (doxepin) SOMNOTE (chloral hydrate) SONATA (zaleplon) zaleplon zolpidem ER 6.25, 12.5 mg ZOLPIMIST (zolpidem)	Strengths of zolpidem that are non-preferred (6.25 and 12.5mg) must be created by combining or splitting the preferred doses (5 and 10mg) of zolpidem, if appropriate. For treatment naïve female patients, zolpiderm and zolpidem ER maximum dosages will be limited to 5 mg and 6.25 mg respectively per day.
SKELETAL MUSCLE RELAXANTS[AP]			
	ACUTE MUSCULOSKELETAL RELAXANT AGENTS		
	chlorzoxazone cyclobenzaprine IR 5, 10 mg methocarbamol	AMRIX (cyclobenzaprine) carisoprodol carisoprodol/ASA carisoprodol/ASA/codeine cyclobenzaprine ER cyclobenzaprine IR 7.5 mg FEXMID (cyclobenzaprine) FLEXERIL (cyclobenzaprine) LORZONE (chlorzoxazone) metaxalone orphenadrine orphenadrine/ASA/caffeine orphenadrine ER PARAFON FORTE (chlorzoxazone) ROBAXIN (methocarbamol) SKELAXIN (metaxalone) SOMA (carisoprodol)	Thirty (30) day trials of each of the preferred acute musculoskeletal relaxants are required before a non-preferred acute musculoskeletal agent will be authorized, with the exception of carisoprodol. Thirty (30) day trials of each of the preferred acute musculoskeletal relaxants and Skelaxin are required before carisoprodol will be authorized.
	MUSCULOSKELETAL RELAXANT AGENTS USED FOR SPASTICITY		
	baclofen tizanidine tablets	DANTRIUM (dantrolene) dantrolene tizanidine capsules	Thirty (30) day trials of both preferred skeletal muscle relaxants associated with the treatment of

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		ZANAFLEX (tizanidine)	spasticity are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.
STEROIDS, TOPICAL			
	VERY HIGH & HIGH POTENCY		
	betamethasone dipropionate cream, lotion betamethasone valerate cream clobetasol propionate cream/gel/ointment/solution clobetasol emollient fluocinonide cream, gel, solution fluocinonide/emollient halobetasol propionate triamcinolone acetonide cream, ointment	amcinonide APEXICON (diflorasone diacetate) APEXICON E (diflorasone diacetate) betamethasone dipropionate gel, lotion, ointment betamethasone valerate lotion, ointment, clobetasol lotion, shampoo clobetasol propionate foam CLOBEX (clobetasol propionate) CLODAN (clobetasol propionate) CORMAX (clobetasol propionate) desoximetasone cream/gel/ointment diflorasone diacetate DIPROLENE (betamethasone dipropionate/propylene glycol) DIPROLENE AF (betamethasone dipropionate/propylene glycol) DIPROSONE (betamethasone dipropionate) fluocinonide ointment halcinonide HALAC (halobetasol propionate) HALOG (halcinonide) HALONATE (halobetasol propionate) KENALOG (triamcinolone acetonide) LIDEX (fluocinonide) LIDEX-E (fluocinonide) OLUX (clobetasol propionate) OLUX-E (clobetasol propionate/emollient) PSORCON (diflorasone diacetate) TEMOVATE (clobetasol propionate) TEMOVATE-E (clobetasol propionate/emollient) TOPICORT CREAM, GEL, OINTMENT (desoximetasone) TOPICORT SPRAY (desoximetasone) triamcinolone acetonide lotion	Five (5) day trials of one (1) form of each preferred unique active ingredient in the corresponding potency group are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		ULTRAVATE (halobetasol propionate) ULTRAVATE PAC cream ULTRAVATE X (halobetasol propionate / lactic acid) VANOS (fluocinonide)	
	MEDIUM POTENCY		
	fluticasone propionate cream, ointment hydrocortisone butyrate ointment, solution hydrocortisone valerate mometasone furoate triamcinolone acetonide 0.025% and 0.1% cream	ARISTOCORT (triamcinolone) BETA-VAL (betamethasone valerate) betamethasone valerate foam CLODERM (clocortolone pivalate) clocortolone cream CORDRAN/CORDRAN SP (flurandrenolide) CUTIVATE (fluticasone propionate) DERMATOP (prednicarbate) ELOCON (mometasone furoate) fluocinolone acetonide cream, ointment, solution fluticasone propionate lotion hydrocortisone butyrate cream LOCOID (hydrocortisone butyrate) LOCOID LIPOCREAM (hydrocortisone butyrate/emollient) LUXIQ (betamethasone valerate) MOMEXIN (mometasone) PANDEL (hydrocortisone probutate) prednicarbate TOPICORT LP (desoximetasone) TRIDERM (triamcinolone acetonide) WESTCORT (hydrocortisone valerate)	
	LOW POTENCY		
	desonide cream, ointment hydrocortisone acetate (Rx, OTC) hydrocortisone cream (Rx, OTC) hydrocortisone lotion OTC hydrocortisone ointment (Rx, OTC) hydrocortisone solution OTC hydrocortisone-aloe cream OTC hydrocortisone-aloe ointment OTC	ACLOVATE (alclometasone dipropionate) alclometasone dipropionate AQUA GLYCOLIC HC (hydrocortisone) CAPEX (fluocinolone acetonide) DERMA-SMOOTHE FS (fluocinolone acetonide) DESONATE (desonide) desonide lotion DESOWEN (desonide) fluocinolone oil hydrocortisone/mineral oil/petrolatum hydrocortisone acetate/urea hydrocortisone lotion	

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		hydrocortisone/aloe gel LOKARA (desonide) PEDIADERM HC (hydrocortisone) PEDIADERM TA (hydrocortisone) SCALPICIN OTC (hydrocortisone) SYNALAR (fluocinolone) TEXACORT (hydrocortisone) VERDESO (desonide)	
STIMULANTS AND RELATED AGENTS			
	AMPHETAMINES		
	amphetamine salt combination IR dextroamphetamine PROCENTRA solution (dextroamphetamine) VYVANSE (lisdexamfetamine)	ADDERALL XR* (amphetamine salt combination) amphetamine salt combination ER DESOXYN (methamphetamine) DEXEDRINE (dextroamphetamine) dextroamphetamine ER dextroamphetamine solution DEXTROSTAT (dextroamphetamine) methamphetamine ZENZEDI (dextroamphetamine)	A PA is required for adults eighteen (18) years of age or older. A thirty (30) day trial of one of the preferred agents in each group (amphetamines and non-amphetamines) is required before a non-preferred agent will be authorized. In addition, a thirty (30) day trial of a long-acting preferred agent in each class is required before a non-preferred long-acting stimulant will be authorized. Thirty (30) day trials of at least three (3) antidepressants are required before amphetamines will be authorized for depression. *Adderall XR is preferred over its generic equivalents.
	NON-AMPHETAMINE		
	clonidine DAYTRANA (methylphenidate) FOCALIN (dexmethylphenidate) FOCALIN XR (dexmethylphenidate) guanfacine METADATE CD (methylphenidate) methylphenidate methylphenidate ER (generic Concerta, Ritalin SR, Metadate ER, Methylin ER) STRATTERA (atomoxetine)*	clonidine ER CONCERTA (methylphenidate) dexmethylphenidate dexmethylphenidate XR INTUNIV (guanfacine extended-release) ** KAPVAY (clonidine extended-release)** METHYLIN CHEWABLE TABLETS, SOLUTION (methylphenidate) methylphenidate solution methylphenidate CD	Except for Strattera, PA is required for adults eighteen (18) years of age or older. *Strattera will not be authorized for concurrent administration with amphetamines or methylphenidates, except for thirty (30) days or less for tapering purposes. Strattera is limited to a

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		methylphenidate ER (generic Ritalin LA) modafinil NUVIGIL (armodafinil) pemoline PROVIGIL (modafinil) *** QUILLIVANT XR (methylphenidate) RITALIN (methylphenidate) RITALIN LA (methylphenidate) RITALIN SR (methylphenidate)	maximum of 100mg per day. **Intuniv and Kapvay/generic will be authorized if the following criteria are met: 1. Fourteen (14) day trials of at least one (1) preferred product from the amphetamine and non-amphetamine class **and** 2. A fourteen (14) day trial of clonidine IR (for Kapvay) and guanfacine IR (for Intuniv) unless one (1) of the exceptions on the PA form is present**.** In cases of a diagnosis of Tourette's syndrome, tics, autism or disorders included in the autism spectrum, only a fourteen (14) day trial of clonidine (for Kapvay) will be required for approval. ***Provigil will only be authorized for patients sixteen (16) years of age or older with a diagnosis of narcolepsy. Patients stabilized on non-preferred agents will be grandfathered.
TETRACYCLINES			
	doxycycline hyclate capsules, tablets doxycycline monohydrate 50, 100 mg capsules minocycline capsules tetracycline	ADOXA (doxycycline monohydrate) demeclocycline* DORYX (doxycycline hyclate) doxycycline hyclate tablet DR doxycycline monohydrate 75, 150 mg capsule doxycycline monohydrate tablet doxycycline monohydrate suspension DYNACIN (minocycline) MINOCIN (minocycline) minocycline ER capsules minocycline tablets MONODOX (doxycycline monohydrate)	A ten (10) day trial of each of the preferred agents is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. *Demeclocycline will be authorized for conditions caused by susceptible strains of organisms designated in the product information supplied by the manufacturer. A C&S report

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		MORGIDOX KIT (doxycycline) ORACEA (doxycycline monohydrate) SOLODYN (minocycline) VIBRAMYCIN CAPSULES, SUSPENSION, SYRUP (doxycycline)	must accompany this request. *Demeclocycline will also be authorized for SIADH.
ULCERATIVE COLITIS AGENTS[AP]			
	ORAL		
	APRISO (mesalamine) balsalazide DELZICOL (mesalamine) PENTASA (mesalamine) 250mg sulfasalazine	ASACOL HD (mesalamine) AZULFIDINE (sulfasalazine) COLAZAL (balsalazide) DIPENTUM (olsalazine) GIAZO (balsalazide) LIALDA (mesalamine) PENTASA (mesalamine) 500mg UCERIS (budesonide)	Thirty (30) day trials of each of the preferred dosage form or chemical entity must be tried before the corresponding non-preferred agent of that dosage form or chemical entity will be authorized unless one (1) of the exceptions on the PA form is present.
	RECTAL		
	CANASA (mesalamine) mesalamine	mesalamine kit ROWASA (mesalamine) SF ROWASA (mesalamine)	
VASODILATORS, CORONARY			
	SUBLINGUAL NITROGLYCERIN		
	nitroglycerin sublingual NITROLINGUAL SPRAY (nitroglycerin) NITROSTAT SUBLINGUAL (nitroglycerin)	nitroglycerin spray NITROMIST (nitroglycerin)	A thirty (30) day trial of each preferred dosage form will be required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.