



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

This is not an all-inclusive list of available covered drugs and includes only managed categories. Refer to cover page for complete list of rules governing this PDL.

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- 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.



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|--|---|---|---|
| <b>ACNE AGENTS, TOPICAL<sup>AP</sup></b> |   |   |   |
| <b>ANTI-INFECTIVE</b>                    |   |   |   |
|  | clindamycin gel, lotion, medicated swab, solution<br>erythromycin gel, solution       | ACZONE (dapson)<br>AKNE-MYCIN (erythromycin)<br>AZELEX (azelaic acid)<br>CLEOCIN-T (clindamycin)<br>CLINDACIN PAC (clindamycin)<br>CLINDAGEL (clindamycin)<br>clindamycin foam<br>erythromycin medicated swab<br>EVOCLIN (clindamycin)<br>FABIOR (tazarotene)<br>KLARON (sulfacetamide)<br>OVACE/PLUS (sulfacetamide)<br>sodium sulfacetamide 10% cleansing gel<br>sulfacetamide cleanser<br>sulfacetamide cleanser ER<br>sulfacetamide shampoo<br>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 a requested non-preferred product, are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.<br>In cases of pregnancy, a trial of retinoids will <i>not</i> be required.<br>For Members 18 years of age or older, a trial of retinoids will <i>not</i> be required. |
| <b>RETINOIDS</b>                         |   |   |   |
|  | RETIN-A (tretinoin)<br>TAZORAC (tazarotene)   | adapalene<br>ATRALIN (tretinoin)<br>AVITA (tretinoin)<br>DIFFERIN (adapalene)<br>RETIN-A MICRO (tretinoin)<br>tretinoin cream, gel<br>tretinoin gel micro<br>TRETIN-X (tretinoin)   | PA required for members eighteen (18) years of age or older for Retinoids sub-class.  |
| <b>KERATOLYTICS</b>                      |   |   |   |
|  | benzoyl peroxide cleanser Rx & OTC, 10% cream OTC, gel Rx & OTC, lotion OTC, wash OTC | BENZEFOAM (benzoyl peroxide)<br>BENZEFOAM ULTRA (benzoyl peroxide)<br>BENZEPRO (benzoyl peroxide)<br>benzoyl peroxide cloths, medicated pads, microspheres cleanser<br>BP 10-1 (benzoyl peroxide)<br>BP WASH 7% LIQUID<br>DELOS (benzoyl peroxide)<br>DESQUAM-X (benzoyl peroxide)<br>LAVOCLLEN (benzoyl peroxide)<br>PACNEX/HP/LP (benzoyl peroxide)<br>PANOXYL-4, -8 OTC (benzoyl peroxide)<br>PERSA-GEL OTC (benzoyl peroxide)   | Acne kits are non-preferred.  |



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|  |                               | SASTID (sulfur)<br>SULPHO-LAC (sulfur)  |  |
| <b>COMBINATION AGENTS</b>              |                               |   |  |
|  | erythromycin/benzoyl peroxide | ACANYA (clindamycin phosphate/benzoyl peroxide)<br>AVAR/-E/LS (sulfur/sulfacetamide)<br>BENZAACLIN GEL (benzoyl peroxide/clindamycin)<br>BENZAMYCIN PAK (benzoyl peroxide/erythromycin)<br>benzoyl peroxide/clindamycin gel<br>benzoyl peroxide/urea<br>CERISA (sulfacetamide sodium/sulfur)<br>CLARIFOAM EF (sulfacetamide/sulfur)<br>CLENIA (sulfacetamide sodium/sulfur)<br>DUAC (benzoyl peroxide/clindamycin)<br>EPIDUO (adapalene/benzoyl peroxide)*<br>INOVA 4/1, 5/2 (benzoyl peroxide/salicylic acid)<br>NUOX (benzoyl peroxide/sulfur)<br>PRASCION (sulfacetamide sodium/sulfur)<br>SE 10-5 SS (sulfacetamide/sulfur)<br>SSS 10-4 (sulfacetamide /sulfur)<br>SSS 10-5 foam (sulfacetamide /sulfur)<br>sulfacetamide sodium/sulfur cloths, lotion, pads, suspension<br>sulfacetamide/sulfur wash/cleanser<br>sulfacetamide/sulfur wash kit<br>sulfacetamide sodium/sulfur/ urea<br>SUMADAN (sulfacetamide/sulfur)<br>SUMAXIN/TS (sulfacetamide sodium/sulfur)<br>VELTIN (clindamycin/tretinoin)*<br>ZIANA (clindamycin/tretinoin)* | <p>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 a requested non-preferred product, are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.</p> <p>In cases of pregnancy, a trial of retinoids will <i>not</i> be required.</p> <p>For Members 18 years of age or older, a trial of retinoids will <i>not</i> be required.</p> <p>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.</p> <p>*PA required for combination agents with Retinoid products for members eighteen (18) years of age or older.</p> |
| <b>ALZHEIMER'S AGENTS<sup>AP</sup></b> |                               |   |  |
| <b>CHOLINESTERASE INHIBITORS</b>       |                               |   |  |
|  | donepezil 5 and 10 mg         | ARICEPT (donepezil)*<br>donepezil 23 mg<br>EXELON CAPSULE (rivastigmine)<br>EXELON PATCH (rivastigmine)<br>galantamine<br>galantamine ER<br>RAZADYNE (galantamine)  | <p>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.</p> <p>Prior authorization is required for</p>   |



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|   |   | RAZADYNE ER (galantamine)<br>rivastigmine   | members up to forty-five (45) years of age if there is no diagnosis of Alzheimer's disease.<br><br>*Aricept 23mg tablets will be authorized if the following criteria are met:<br>1. There is a diagnosis of moderate-to-severe Alzheimer's Disease and<br>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.  |
| <b>NMDA RECEPTOR ANTAGONIST</b>   |   |   |   |
|   | NAMENDA (memantine)                         | NAMENDA XR (memantine)  |   |
| <b>ANALGESICS, NARCOTIC - LONG ACTING (Non-parenteral)<sup>AP</sup></b> |   |   |   |
|   | fentanyl transdermal<br>morphine ER tablets | AVINZA (morphine)<br>BUTRANS* (buprenorphine)<br>CONZIP ER (tramadol)<br>DOLOPHINE (methadone)<br>DURAGESIC (fentanyl)<br>EXALGO ER (hydromorphone)<br>EMBEDA (morphine/naltrexone)<br>KADIAN (morphine)<br>methadone tablet, solution and concentrate**<br>methadone solutabs<br>morphine ER capsules<br>MS CONTIN (morphine)<br>NUCYNTA ER (tapentadol)<br>OPANA ER (oxymorphone)<br>oxycodone ER**<br>OXYCONTIN (oxycodone)<br>oxymorphone ER**<br>RYZOLT ER (tramadol)<br>tramadol ER<br>ULTRAM ER (tramadol) | 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.<br><br>*Butrans will be authorized if the following criteria are met:<br>1. Diagnosis of moderate to severe chronic pain requiring continuous around-the-clock analgesia <b>and</b><br>2. Patient cannot take oral medications and has a diagnosis of chronic pain <b>and</b><br>3. Needs analgesic medication for an extended period of time <b>and</b><br>4. Has had a previous trial of a |



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|  |  |   | <p>non-opioid analgesic medication* <b>and</b></p> <ol style="list-style-type: none"> <li>Previous trial of one (1) opioid medication* <b>and</b></li> <li>Current total daily opioid dose is less than or equal to (<math>\leq</math>) 80mg morphine equivalents daily or dose of transdermal fentanyl is less than or equal to (<math>\leq</math>) 12.5mcg/hr <b>and</b></li> <li>Patient is not currently being treated with buprenorphine.</li> </ol> <p>*Requirement is waived for patients who cannot swallow</p> <p>**<b>Exception:</b> Methadone, oxycodone ER and oxymorphone ER will be authorized without a trial of the preferred agents if a diagnosis of cancer is submitted.</p> |
| <b>ANALGESICS, NARCOTIC - SHORT ACTING (Non-parenteral)<sup>AP</sup></b> |  |   |   |
|  | APAP/codeine<br>butalbital/APAP/caffeine/codeine<br>codeine<br>hydrocodone/APAP<br>hydrocodone/ibuprofen<br>hydromorphone tablets<br>morphine<br>oxycodone<br>oxycodone/APAP<br>oxycodone/ASA<br>pentazocine/naloxone<br>ROXICET SOLUTION (oxycodone/<br>acetaminophen)<br>ROXICODONE TABLETS (oxycodone)<br>tramadol<br>tramadol/APAP | ABSTRAL (fentanyl)<br>ACTIQ (fentanyl)<br>butalbital/ASA/caffeine/codeine<br>butorphanol<br>CAPITAL W/CODEINE (APAP/codeine)<br>DEMEROL (meperidine)<br>dihydrocodeine/ APAP/caffeine<br>dihydrocodeine/ASA/caffeine<br>DILAUDID (hydromorphone)<br>fentanyl<br>FENTORA (fentanyl)<br>FIORICET W/ CODEINE<br>(butalbital/APAP/caffeine/codeine)<br>FIORINAL W/ CODEINE<br>(butalbital/ASA/caffeine/codeine)<br>hydromorphone liquid<br>hydromorphone suppositories<br>IBUDONE (hydrocodone/ibuprofen)<br>LAZANDA (fentanyl)<br>levorphanol<br>LORCET (hydrocodone/APAP) | <p>Six (6) day trials of at least four (4) chemically distinct preferred agents (based on narcotic ingredient only), including the generic formulation of a requested non-preferred product, are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.</p> <p>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.</p> <p><b>Limits:</b> Unless the patient has escalating cancer pain or another diagnosis supporting increased quantities of short-acting opioids, all short acting solid forms of the</p>    |



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|  |  | LORTAB (hydrocodone/APAP)<br>MAXIDONE ((hydrocodone/APAP)<br>MAGNACET (oxycodone/APAP)<br>meperidine<br>NORCO (hydrocodone/APAP)<br>NUCYNTA (tapentadol)<br>ONSOLIS (fentanyl)<br>OPANA (oxymorphone)<br>OXECTA (oxycodone)<br>oxycodone/ASA<br>oxycodone/ibuprofen<br>OXYIR (oxycodone)<br>oxymorphone<br>pentazocine/APAP<br>PERCOCET (oxycodone/APAP)<br>PERCODAN (oxycodone/ASA)<br>PRIMLEV (oxycodone/APAP)<br>REPRESXAIN (hydrocodone/ibuprofen)<br>RYBIX ODT (tramadol)<br>SUBSYS (fentanyl)<br>SYNALGOS-DC (dihydrocodeine/ASA/<br>caffeine)<br>TREZIX (dihydrocodeine/ APAP/caffeine)<br>TYLENOL W/CODEINE (APAP/codeine)<br>TYLOX (oxycodone/APAP)<br>ULTRACET (tramadol/APAP)<br>ULTRAM (tramadol)<br>VICODIN (hydrocodone/APAP)<br>VICOPROFEN (hydrocodone/ibuprofen)<br>VOPAC (codeine/acetaminophen)<br>XODOL (hydrocodone/acetaminophen)<br>XOLOX (oxycodone/APAP)<br>ZAMICET (hydrocodone/APAP)<br>ZYDONE (hydrocodone/acetaminophen) | 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. |
| <b>ANDROGENIC AGENTS</b>                 |  |   |   |
|  | ANDRODERM (testosterone)<br>ANDROGEL (testosterone)<br>TESTIM (testosterone) | AXIRON (testosterone)<br>FORTESTA (testosterone)  | The non-preferred agents will be authorized only if one (1) of the exceptions on the PA form is present.  |
| <b>ANESTHETICS, TOPICAL<sup>AP</sup></b> |  |   |   |



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|  | lidocaine<br>lidocaine/prilocaine<br>xylocaine   | EMLA (lidocaine/prilocaine)<br>LIDAMANTLE (lidocaine)<br>LIDAMANTLE HC (lidocaine/hydrocortisone)<br>lidocaine/hydrocortisone<br>SYNERA (lidocaine/tetracaine)   | Ten (10) day trials of each of the preferred topical anesthetics (lidocaine, lidocaine/prilocaine, and xylocaine) are required before a non-preferred topical anesthetic will be authorized unless one (1) of the exceptions on the PA form is present           |
| <b>ANGIOTENSIN MODULATORS<sup>AP</sup></b>     |  |  |  |
| <b>ACE INHIBITORS</b>                          |  |  |  |
|  | benazepril<br>captopril<br>enalapril<br>fosinopril<br>lisinopril<br>quinapril<br>ramipril  | ACCUPRIL (quinapril)<br>ACEON (perindopril)<br>ALTACE (ramipril)<br>EPANED (enalapril)<br>LOTENSIN (benazepril)<br>MAVIK (trandolapril)<br>moexipril<br>perindopril<br>PRINIVIL (lisinopril)<br>trandolapril<br>UNIVASC (moexipril)<br>VASOTEC (enalapril)<br>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. |
| <b>ACE INHIBITOR COMBINATION DRUGS</b>         |  |  |  |
|  | benazepril/amlodipine<br>benazepril/HCTZ<br>captopril/HCTZ<br>enalapril/HCTZ<br>fosinopril/HCTZ<br>lisinopril/HCTZ<br>quinapril/HCTZ | ACCURETIC (quinapril/HCTZ)<br>CAPOZIDE (captopril/HCTZ)<br>LOTENSIN HCT (benazepril/HCTZ)<br>LOTREL (benazepril/amlodipine)<br>moexipril/HCTZ<br>PRINZIDE (lisinopril/HCTZ)<br>TARKA (trandolapril/verapamil)<br>trandolapril/verapamil<br>UNIRETIC (moexipril/HCTZ)<br>VASERETIC (enalapril/HCTZ)<br>ZESTORETIC (lisinopril/HCTZ) |  |
| <b>ANGIOTENSIN II RECEPTOR BLOCKERS (ARBs)</b> |  |  |  |
|  | BENICAR (olmesartan)<br>DIOVAN (valsartan)<br>irbesartan<br>losartan<br>MICARDIS (telmisartan)                                       | ATACAND (candesartan)<br>AVAPRO (irbesartan)<br>candesartan<br>COZAAR (losartan)<br>EDARBI (azilsartan)<br>eprosartan  |  |



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|  |   | TEVETEN (eprosartan)  |   |
| <b>ARB COMBINATIONS</b>                |   |   |   |
|  | BENICAR-HCT (olmesartan/HCTZ)<br>EXFORGE (valsartan/amlodipine)<br>EXFORGE HCT (valsartan/amlodipine/HCTZ)<br>irbesartan/HCTZ<br>losartan/HCTZ<br>MICARDIS-HCT (telmisartan/HCTZ)<br>valsartan/HCTZ | ATACAND-HCT (candesartan/HCTZ)<br>AVALIDE (irbesartan/HCTZ)<br>AZOR (olmesartan/amlodipine)<br>candesartan/HCTZ<br>DIOVAN-HCT (valsartan/HCTZ)<br>EDARBYCLOR (azilsartan/chlorthalidone)<br>HYZAAR (losartan/HCTZ)<br>TEVETEN-HCT (eprosartan/HCTZ)<br>TRIBENZOR (olmesartan/amlodipine/HCTZ)<br>TWYNSTA (telmisartan/amlodipine) |   |
| <b>DIRECT RENIN INHIBITORS</b>         |   |   |   |
|  |   | AMTURNIDE (aliskiren/amlodipine/HCTZ)<br>TEKAMLO (aliskiren/amlodipine)<br>TEKTURNA (aliskiren)<br>TEKTURNA HCT (aliskiren/HCTZ)<br>VALTURNA (aliskiren/valsartan)  | A thirty (30) day trial of one (1) preferred ACE, ARB, or combination agents, at the maximum tolerable dose, is required before Tekturna will be authorized unless one (1) of the exceptions on the PA form is present.<br><br>Tekturna HCT, Valturna, Tekamlo or Amturnide will be authorized if the criteria for Tekturna are met and the patient also needs the other agents in the combination. |
| <b>ANTIANGINAL &amp; ANTI-ISCHEMIC</b> |   |   |   |
|  |   | RANEXA (ranolazine) <sup>AP</sup>   | 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.   |
| <b>ANTIBIOTICS, GI</b>                 |   |   |   |
|  | metronidazole tablet<br>neomycin<br>TINDAMAX (tinidazole)   | ALINIA (nitazoxanide)<br>DIFICID (fidaxomicin)*<br>FLAGYL (metronidazole)   | A fourteen (14) day trial of a corresponding generic preferred agent is required before a non-  |



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|                        |                  | FLAGYL ER (metronidazole ER)<br>metronidazole capsule<br>paromomycin<br>tinidazole<br>VANCOCIN (vancomycin)**<br>vancomycin<br>XIFAXAN (rifaximin)*** | <p>preferred brand agent will be authorized unless one (1) of the exceptions on the PA form is present.</p> <p>*Dificid will be authorized if:</p> <ol style="list-style-type: none"> <li>1. There is a diagnosis of severe <i>C. difficile</i> infection <b>and</b></li> <li>2. There is no response to prior treatment with vancomycin for ten (10) to fourteen (14) days.</li> </ol> <p>**Vancocin (brand) will be authorized after a fourteen (14) day trial of metronidazole for <i>C. difficile</i> infections of mild to moderate severity unless one (1) of the exceptions on the PA form is present.</p> <p>**Vancocin (brand) will be authorized for severe <i>C. difficile</i> infections with no previous trial of metronidazole.</p> <p>***Xifaxan 200mg will be authorized for traveler's diarrhea if</p> <ol style="list-style-type: none"> <li>1. There is a diagnosis of <i>E. coli</i> diarrhea <b>and</b></li> <li>2. Patient is from twelve (12) up to eighteen (18) years of age, or is eighteen (18) years of age or older <b>and</b></li> <li>3. Has failed a ten (10) day trial of ciprofloxacin.</li> </ol> <p>***Xifaxan 550mg will be authorized for hepatic encephalopathy if:</p> <ol style="list-style-type: none"> <li>1. There is a diagnosis of hepatic encephalopathy <b>and</b></li> <li>2. Patient is eighteen (18) years of age or older, <b>and</b></li> <li>3. Patient has a history of and current treatment with lactulose.</li> </ol> |



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| <b>ANTIBIOTICS, INHALED</b>    |  |   |   |
|                                | TOBI (tobramycin)  | BETHKIS (tobramycin)<br>CAYSTON (aztreonam)<br>TOBI PODHALER<br>tobramycin  | 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.                                   |
| <b>ANTIBIOTICS, TOPICAL</b>    |  |   |   |
|                                | bacitracin<br>gentamicin sulfate<br>mupirocin ointment   | ALTABAX (retapamulin)<br>BACTROBAN (mupirocin)<br>CENTANY (mupirocin)<br>CORTISPORIN<br>(bacitracin/neomycin/polymyxin/HC)<br>mupirocin cream<br>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. |
| <b>ANTIBIOTICS, VAGINAL</b>    |  |   |   |
|                                | clindamycin cream<br>METROGEL (metronidazole)  | AVC (sulfanilamide)<br>CLEOCIN CREAM (clindamycin)<br>CLEOCIN OVULE (clindamycin)<br>CLINDESSE (clindamycin)<br>metronidazole<br>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.                                     |
| <b>ANTICOAGULANTS</b>          |  |   |   |
| <b>INJECTABLE<sup>CL</sup></b> |  |   |   |
|                                | FRAGMIN (dalteparin)<br>LOVENOX (enoxaparin)   | ARIXTRA (fondaparinux)<br>enoxaparin<br>fondaparinux<br>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.   |
| <b>ORAL</b>                    |  |   |   |
|                                | COUMADIN (warfarin)<br>ELIQUIS (apixaban) <sup>AP</sup><br>PRADAXA (dabigatran) <sup>AP</sup><br>warfarin<br>XARELTO (rivaroxaban) <sup>AP</sup> |   | Eliquis will be authorized for the diagnosis of non-valvular atrial fibrillation.<br><br>Pradaxa will be authorized for the diagnosis of non-valvular atrial fibrillation.  |



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|                        |  |   | <p>Xarelto will be authorized for the following diagnoses:</p> <ol style="list-style-type: none"> <li>1. Non-valvular atrial fibrillation <b>or</b></li> <li>2. Deep vein thrombosis (DVT), pulmonary embolism (PE), and reduction in risk of recurrence of DVT and PE <b>or</b></li> <li>3. DVT prophylaxis if treatment is limited to thirty-five (35) days for hip replacement surgeries or twelve (12) days for knee replacement surgeries.</li> </ol>  |
| <b>ANTICONVULSANTS</b> |  |   |   |
|                        | <b>ADJUVANTS</b>   |   |   |
|                        | carbamazepine<br>carbamazepine ER<br>carbamazepine XR<br>CARBATROL (carbamazepine)<br>DEPAKOTE SPRINKLE (divalproex)<br>divalproex<br>divalproex ER<br>EPITOL (carbamazepine)<br>FELBATOL (felbamate)<br>GABITRIL (tiagabine)<br>lamotrigine<br>levetiracetam<br>oxcarbazepine tablets<br>TEGRETOL XR (carbamazepine)<br>topiramate<br>TRILEPTAL SUSPENSION (oxcarbazepine)<br>valproic acid<br>VIMPAT(lacosamide) <sup>AP*</sup><br>zonisamidec | BANZEL(rufinamide)<br>DEPAKENE (valproic acid)<br>DEPAKOTE (divalproex)<br>DEPAKOTE ER (divalproex)<br>divalproex sprinkle<br>EQUETRO (carbamazepine)<br>FANATREX SUSPENSION (gabapentin)<br>felbamate<br>KEPBRA (levetiracetam)<br>KEPBRA XR (levetiracetam)<br>LAMICTAL (lamotrigine)<br>LAMICTAL CHEWABLE (lamotrigine)<br>LAMICTAL ODT (lamotrigine)<br>LAMICTAL XR (lamotrigine)<br>lamotrigine dose pack<br>lamotrigine ER<br>levetiracetam ER<br>ONFI (clobazam) **<br>ONFI SUSPENSION (clobazam) **<br>oxcarbazepine suspension<br>OXTELLAR XR (oxcarbazepine)<br>POTIGA (ezogabine)<br>SABRIL (vigabatrin)<br>STAVZOR (valproic acid)<br>TEGRETOL (carbamazepine)<br>tiagabine<br>TOPAMAX (topiramate) | <p>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.</p> <p>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.</p> <p>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</p> |



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|                               |  | TRILEPTAL TABLETS (oxcarbazepine)<br>TROKENDI XR (topiramate)<br>ZONEGRAN (zonisamide)      | the prescriber on the prescription in order for the brand name product to be reimbursed.<br><br>*Vimpat will be approved as adjunctive therapy for members 17 years of age or older with a diagnosis of partial-onset seizure disorder.<br><br>**Onfi will be authorized if the following criteria are met:<br>1. Adjunctive therapy for Lennox-Gastaut <b>or</b><br>2. Generalized tonic, atonic or myoclonic seizures <b>and</b><br>3. Previous failure of at least two (2) non-benzodiazepine anticonvulsants and previous failure of clonazepam.<br>(For continuation, prescriber must include information regarding improved response/effectiveness with this medication) |
|                               | <b>BARBITURATES<sup>AP</sup></b>   |   |  |
|                               | phenobarbital<br>primidone   | MEBARAL (mephobarbital)<br>MYSOLINE (primidone)   |  |
|                               | <b>BENZODIAZEPINES<sup>AP</sup></b>  |   |  |
|                               | clonazepam<br>DIASTAT (diazepam rectal)<br>diazepam tablets  | clonazepam ODT<br>diazepam rectal gel<br>KLONOPIN (clonazepam)<br>VALIUM TABLETS (diazepam) |  |
|                               | <b>HYDANTOINS<sup>AP</sup></b>   |   |  |
|                               | DILANTIN 30mg (phenytoin)<br>PEGANONE (ethotoin)<br>phenytoin capsules, chewable tablets, suspension | DILANTIN (phenytoin)<br>DILANTIN INFATABS (phenytoin)<br>PHENYTEK (phenytoin)               |  |
|                               | <b>SUCCINIMIDES</b>  |   |  |
|                               | CELONTIN (methsuximide)<br>ethosuximide syrup<br>ZARONTIN (ethosuximide) capsules                    | ethosuximide capsules<br>ZARONTIN (ethosuximide) syrup                                      |  |
| <b>ANTIDEPRESSANTS, OTHER</b> |  |   |  |



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| <b>MAOIs<sup>AP</sup></b>                             |  |  |   |
|   |  | MARPLAN (isocarboxazid)<br>NARDIL (phenelzine)<br>PARNATE (tranylcypromine)<br>phenelzine<br>tranylcypromine   | Patients stabilized on MAOI agents will be grandfathered.   |
| <b>SNRIS<sup>AP</sup></b>                             |  |  |   |
|   | venlafaxine ER capsules  | desvenlafaxine ER<br>EFFEXOR XR (venlafaxine)<br>FETZIMA (levomilnacipran)<br>KHEDEZLA (desvenlafaxine)<br>PRISTIQ (desvenlafaxine)<br>venlafaxine IR<br>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.   |
| <b>SECOND GENERATION NON-SSRI, OTHER<sup>AP</sup></b> |  |  |   |
|   | bupropion IR<br>bupropion SR<br>bupropion XL<br>mirtazapine<br>trazodone                                       | APLENZIN (bupropion hbr)<br>BRINTELLIX (vortioxetine)<br>EMSAM (selegiline)<br>FORFIVO XL (bupropion)<br>nefazodone<br>OLEPTRO ER (trazodone)<br>REMERON (mirtazapine)<br>WELLBUTRIN (bupropion)<br>WELLBUTRIN SR (bupropion)<br>WELLBUTRIN XL (bupropion)<br>VIIBRYD (vilazodone hcl) |   |
| <b>SELECTED TCAs</b>                                  |  |  |   |
|   | imipramine hcl   | imipramine pamoate<br>TOFRANIL (imipramine hcl)<br>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.                        |
| <b>ANTIDEPRESSANTS, SSRIs<sup>AP</sup></b>            |  |  |   |
|   | citalopram<br>escitalopram tablets<br>fluoxetine capsules, solution<br>fluvoxamine<br>paroxetine<br>sertraline | BRISDELLE (paroxetine)<br>CELEXA (citalopram)<br>escitalopram solution<br>fluvoxamine ER<br>fluoxetine tablets<br>LEXAPRO (escitalopram)<br>LUVOX CR (fluvoxamine)   | 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. |



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|                                 |                                    | PAXIL (paroxetine)<br>PAXIL CR (paroxetine)<br>paroxetine ER<br>PEXEVA (paroxetine)<br>PROZAC (fluoxetine)<br>SARAFEM (fluoxetine)<br>ZOLOFT (sertraline)     | 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.   |
| <b>ANTIEMETICS<sup>AP</sup></b> |                                    |   |   |
| <b>5HT3 RECEPTOR BLOCKERS</b>   |                                    |   |   |
|                                 | ondansetron ODT, solution, tablets | ANZEMET (dolasetron)<br>granisetron<br>GRANISOL (granisetron)<br>ondansetron vials<br>SANCUSO (granisetron)<br>ZOFRAN (ondansetron)<br>ZUPLLENZ (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.   |
| <b>CANNABINOIDS</b>             |                                    |   |   |
|                                 |                                    | CESAMET (nabilone)<br>dronabinol<br>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.<br><br>Marinol will be authorized only for: <ol style="list-style-type: none"> <li>1. The treatment of anorexia associated with weight loss in patients with AIDS or cancer and unresponsive to megestrol</li> <li><b>or</b></li> <li>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.</li> </ol> |



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|                                |   |  | *Marinol will be preferred over its generic formulation, dronabinol.  |
| <b>SUBSTANCE P ANTAGONISTS</b> |   |  |   |
|                                | EMEND (aprepitant)  |  |   |
| <b>ANTIFUNGALS, ORAL</b>       |   |  |   |
|                                | clotrimazole<br>fluconazole*<br>nystatin<br>terbinafine <sup>CL</sup> | ANCOBON (flucytosine)<br>DIFLUCAN (fluconazole)<br>flucytosine<br>GRIFULVIN V TABLET (griseofulvin)<br>griseofulvin<br>GRIS-PEG (griseofulvin)<br>itraconazole<br>ketoconazole**<br>LAMISIL (terbinafine)<br>MYCELEX (clotrimazole)<br>MYCOSTATIN Tablets (nystatin)<br>NIZORAL (ketoconazole)<br>NOXAFIL SUSPENSION (posaconazole)<br>ONMEL (itraconazole)<br>ORAVIG (miconazole)<br>SPORANOX (itraconazole)<br>VFEND (voriconazole)<br>voriconazole suspension<br>voriconazole tablets | <p>Non-preferred agents will be authorized only if one (1) of the exceptions on the PA form is present.</p> <p>*PA is required when limits are exceeded.</p> <p>PA is not required for griseofulvin suspension for children up to six (6) years of age for the treatment of tinea capitis.</p> <p>**Ketoconazole will be authorized if the following criteria are met:</p> <ol style="list-style-type: none"> <li>1. Diagnosis of one of the following fungal infections: blastomycosis, coccidioidomycosis, histoplasmosis, chromomycosis, or paracoccidioidomycosis <b>and</b></li> <li>2. Documented failure or intolerance of all other diagnosis-appropriate antifungal therapies, i.e. itraconazole, fluconazole, flucytosine, etc <b>and</b></li> <li>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</li> </ol> |



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|  |   |  | <p>treatment <b>and</b></p> <p>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 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.) <b>and</b></p> <p>5. Assessment of all concomitant medications for potential adverse drug interactions with ketoconazole.</p> <p>Ketoconazole will not be authorized for treatment for fungal infections of the skin and nails</p> |
| <b>ANTIFUNGALS, TOPICAL<sup>AP</sup></b> |   |  |   |
| <b>ANTIFUNGALS</b>                       |   |  |   |
|  | econazole<br>ketoconazole cream, shampoo<br>MENTAX (butenafine)<br>miconazole (OTC)<br>nystatin | CICLODAN (ciclopirox)<br>ciclopirox<br>ERTACZO (sertaconazole)<br>EXELDERM (sulconazole)<br>EXTINA (ketoconazole)<br>ketoconazole foam<br>KETODAN (ketoconazole)<br>LOPROX (ciclopirox)<br>MYCOSTATIN (nystatin)<br>NAFTIN CREAM (naftifine)<br>NAFTIN GEL (naftifine)<br>NIZORAL (ketoconazole)<br>OXISTAT (oxiconazole)*<br>PEDIPIROX-4 (ciclopirox)<br>PENLAC (ciclopirox)<br>VUSION (miconazole/petrolatum/zinc oxide)<br>XOLEGEL (ketoconazole) | <p>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.</p> <p>*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.</p>  |
| <b>ANTIFUNGAL/STEROID COMBINATIONS</b>   |   |  |   |



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|  | clotrimazole/betamethasone<br>nystatin/triamcinolone     | KETOCON PLUS<br>(ketoconazole/hydrocortisone)<br>LOTRISONE (clotrimazole/betamethasone)  |   |
| <b>ANTIHISTAMINES, MINIMALLY SEDATING<sup>AP</sup></b> |  |  |   |
| <b>ANTIHISTAMINES</b>                                  |  |  |   |
|  | cetirizine tablets, solution<br>loratadine               | ALLEGRA (fexofenadine)<br>cetirizine chewable tablets<br>cetirizine capsules<br>CLARINEX (desloratadine)<br>CLARITIN (loratadine)<br>desloratadine<br>desloratadine ODT<br>fexofenadine<br>levocetirizine<br>XYZAL (levocetirizine)<br>ZYRTEC (cetirizine)   | Thirty (30) day trials of at least two (2) chemically distinct preferred agents (in the age appropriate form), including the generic formulation of a requested non-preferred product, are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. |
| <b>ANTIHISTAMINE/DECONGESTANT COMBINATIONS</b>         |  |  |   |
|  | cetirizine/pseudoephedrine<br>loratadine/pseudoephedrine | ALLEGRA-D (fexofenadine/ pseudoephedrine)<br>CLARINEX-D (desloratadine/<br>pseudoephedrine)<br>CLARITIN-D (loratadine/pseudoephedrine)<br>fexofenadine/ pseudoephedrine<br>SEMPREX-D (acrivastine/ pseudoephedrine)<br>ZYRTEC-D (cetirizine/pseudoephedrine) |   |
| <b>ANTIHYPERTENSIVES, SYMPATHOLYTICS</b>               |  |  |   |
|  | CATAPRES-TTS (clonidine)<br>clonidine tablets            | clonidine patch<br>NEXICLON XR (clonidine)<br>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.   |
| <b>ANTIHYPERTENSIVES, SYMPATHOLYTICS</b>               |  |  |   |
| <b>ANTIMITOTICS</b>                                    |  |  |   |
|  |  | 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  |



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|   |   |   | <p>exceptions on the PA form is present.</p> <p>*In the case of acute gouty attacks, a ten (10) day supply (twenty (20) tablets) of Colcrys will be authorized per ninety 90 days.</p>  |
|   | <b>ANTIMITOTIC-URICOSURIC COMBINATION</b>   |   |   |
|   | colchicine/probenecid   |   |   |
|   | <b>URICOSURIC</b>   |   |   |
|   | probenecid  |   |   |
|   | <b>XANTHINE OXIDASE INHIBITORS</b>  |   |   |
|   | allopurinol   | ULORIC (febuxostat)<br>ZYLOPRIM (allopurinol)   |   |
| <b>ANTIMIGRAINE AGENTS, OTHER<sup>AP</sup></b>    |   |   |   |
|   |   | CAMBIA (diclofenac)   | Three (3) day trials of each unique chemical entity of the preferred agents are required before Cambia will be authorized unless (1) of the exceptions on the PA form is present.   |
| <b>ANTIMIGRAINE AGENTS, TRIPTANS<sup>AP</sup></b> |   |   |   |
|   | <b>TRIPTANS</b>   |   |   |
|   | IMITREX NASAL SPRAY (sumatriptan)<br>IMITREX INJECTION (sumatriptan) <sup>CL</sup><br>naratriptan<br>rizatriptan<br>sumatriptan tablets | AMERGE (naratriptan)<br>AXERT (almotriptan)<br>FROVA (frovatriptan)<br>IMITREX tablets (sumatriptan)<br>MAXALT (rizatriptan)<br>MAXALT MLT (rizatriptan)<br>RELPAK (eletriptan)<br>rizatriptan ODT<br>sumatriptan nasal spray/injection*<br>SUMAVEL (sumatriptan)<br>zolmitriptan<br>zolmitriptan ODT<br>ZOMIG (zolmitriptan)<br>ZOMIG ZMT (zolmitriptan) | <p>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.</p> <p>Three (3) day trials of each preferred agent will be required before Imitrex injection is authorized.</p> <p>*AP does not apply to nasal spray or injectable sumatriptan.</p> |
|   | <b>TRIPTAN COMBINATIONS</b>   |   |   |



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|   |  | TREXIMET (sumatriptan/naproxen sodium)  |   |  |
| <b>ANTIPARASITICS, TOPICAL<sup>AP</sup></b> |  |   |   |  |
|   | permethrin (OTC)<br>pyrethrins-piperonyl butoxide OTC<br>SKLICE (ivermectin)<br>ULESFIA (benzyl alcohol)                 | EURAX (crotamiton)<br>LICE EGG REMOVER OTC (benzalkonium chloride)<br>lindane<br>malathion<br>NATROBA (spinosad)<br>OVIDE (malathion)<br>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. |  |
| <b>ANTIPARKINSON'S AGENTS</b>               |  |   |   |  |
| <b>ANTICHOLINERGICS</b>                     |  |   |   |  |
|   | benztropine<br>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.   |  |
| <b>COMT INHIBITORS</b>                      |  |   |   |  |
|   |  | COMTAN (entacapone)<br>entacapone<br>TASMAR (tolcapone)   |   |  |
| <b>DOPAMINE AGONISTS</b>                    |  |   |   |  |
|   | pramipexole<br>ropinirole  | MIRAPEX (pramipexole)<br>MIRAPEX ER (pramipexole)<br>NEUPRO (rotigotine)<br>REQUIP (ropinirole)<br>REQUIP XL (ropinirole)<br>ropinirole ER  | Mirapex, Mirapex ER, Requip, and Requip XL will be authorized for a diagnosis of Parkinsonism with no trials of preferred agents required.  |  |
| <b>OTHER ANTIPARKINSON'S AGENTS</b>         |  |   |   |  |
|   | amantadine <sup>AP</sup><br>bromocriptine<br>carbidopa/levodopa<br>selegiline<br>STALEVO (levodopa/carbidopa/entacapone) | AZILECT (rasagiline)<br>ELDEPRYL (selegiline)<br>levodopa/carbidopa ODT<br>levodopa/carbidopa/entacapone<br>LODOSYN (carbidopa)<br>PARCOPA (levodopa/carbidopa)<br>PARLODEL (bromocriptine)<br>SINEMET (levodopa/carbidopa)<br>ZELAPAR (selegiline) | Amantadine will be authorized only for a diagnosis of Parkinsonism.   |  |



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|---------------------------------|---|---|---|
| <b>ANTIPSORIATICS, TOPICAL</b>  |   |   |   |
|                                 | DOVONEX (calcipotriene)<br>TACLONEX (calcipotriene/ betamethasone)<br>TAZORAC (tazarotene)  | calcipotriene cream<br>calcipotriene solution, ointment<br>CALCITRENE (calcipotriene)<br>calcitriol<br>SORILUX (calcipotriene)<br>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.  |
| <b>ANTIPSYCHOTICS, ATYPICAL</b> |   |   |   |
|                                 | <b>SINGLE INGREDIENT</b>  |   |   |
|                                 | ABILIFY (aripiprazole) <sup>AP</sup> *<br>ABILIFY MAINTENA (aripiprazole) <sup>**CL</sup><br>clozapine<br>FANAPT (iloperidone) <sup>AP</sup><br>INVEGA SUSTENNA (paliperidone) <sup>**CL</sup><br>LATUDA (lurasidone) <sup>AP</sup><br>olanzapine<br>quetiapine <sup>***</sup> AP for the 25mg Tablet Only<br>risperidone<br>SAPHRIS (asenapine) <sup>AP</sup><br>ziprasidone | clozapine ODT<br>CLOZARIL (clozapine)<br>FANAPT TITRATION PACK (iloperidone)<br>FAZACLO (clozapine)<br>GEODON (ziprasidone)<br>GEODON IM (ziprasidone)<br>INVEGA (paliperidone)<br>olanzapine IM <sup>**</sup><br>RISPERDAL (risperidone)<br>RISPERDAL CONSTA (risperidone) <sup>**</sup><br>SEROQUEL (quetiapine)<br>SEROQUEL XR (quetiapine)<br>VERSACLOZ (clozapine)<br>ZYPREXA (olanzapine)<br>ZYPREXA IM (olanzapine) <sup>**</sup><br>ZYPREXA RELPREVV (olanzapine) | <p>A fourteen (14) day trial of a preferred generic agent is required before a Preferred Brand will be authorized.</p> <p>All antipsychotic agents require prior authorization for children up to six (6) years of age.</p> <p>Non-preferred agents will be authorized for treatment naïve patients if the following criteria have been met:</p> <ol style="list-style-type: none"> <li>1. A fourteen (14) day trial of a preferred generic agent <b>and</b></li> <li>2. Two (2) fourteen (14) day trials of additional preferred products unless one (1) of the exceptions on the PA form is present.</li> </ol> <p>Upon discharge, a hospitalized patient stabilized on a non-preferred agent may receive authorization to continue this drug for labeled indications and at recommended dosages.</p> <p>* Abilify will be prior authorized via electronic PA for MDD if the following criteria are met:</p> <ol style="list-style-type: none"> <li>1. The patient is eighteen (18) years of age or older <b>and</b></li> </ol> |



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|---|---------------------------|---|---|
|   |                           |   | 2. Diagnosis of Major Depressive Disorder (MDD) <b>and</b><br>3. Prescribed as adjunctive therapy with bupropion, an SSRI agent or an SNRI agent <b>and</b><br>4. The daily dose does not exceed 15mg<br><br>**All injectable antipsychotic products require clinical prior authorization and will be approved on a case-by-case basis.<br><br>***Quetiapine 25mg will be authorized:<br>1. For a diagnosis of schizophrenia <b>or</b><br>2. For a diagnosis of bipolar disorder <b>or</b><br>3. When prescribed concurrently with other strengths of Seroquel in order to achieve therapeutic treatment levels.<br><br>***Quetiapine 25mg will not be authorized for use as a sedative hypnotic. |
| <b>ATYPICAL ANTIPSYCHOTIC/SSRI COMBINATIONS</b> |                           |   |   |
|   |                           | olanzapine/fluoxetine<br>SYMBYAX (olanzapine/fluoxetine)              |   |
| <b>ANTIVIRALS, ORAL</b>                         |                           |   |   |
| <b>ANTI HERPES</b>                              |                           |   |   |
|   | acyclovir<br>valacyclovir | famciclovir<br>FAMVIR (famciclovir)<br>VALTRES<br>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.   |
| <b>ANTI-INFLUENZA</b>                           |                           |   |   |



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|---|--|---|---|
|   | RELENZA (zanamivir)<br>TAMIFLU (oseltamivir)   | FLUMADINE (rimantadine)<br>rimantadine  | The anti-influenza agents will be authorized only for a diagnosis of influenza.   |
| <b>ANTIVIRALS, TOPICAL<sup>AP</sup></b>           |  |   |   |
|   | ZOVIRAX CREAM (acyclovir)  | ABREVA (docosanol)<br>acyclovir ointment<br>DENA VIR (penciclovir)<br>ZOVIRAX OINTMENT (acyclovir)  | A five (5) day trial of the preferred agent will be required before a non-preferred agent will be approved unless one (1) of the exceptions on the PA form is present.  |
| <b>BETA BLOCKERS<sup>AP</sup></b>                 |  |   |   |
| <b>BETA BLOCKERS</b>                              |  |   |   |
|   | acebutolol<br>atenolol<br>betaxolol<br>bisoprolol<br>metoprolol<br>metoprolol ER<br>nadolol<br>pindolol<br>propranolol<br>propranolol ER<br>sotalol<br>timolol | BETAPACE (sotalol)<br>BYSTOLIC (nebivolol)<br>CORGARD (nadolol)<br>INDERAL LA (propranolol)<br>INNOPRAN XL (propranolol)<br>KERLONE (betaxolol)<br>LEVATOL (penbutolol)<br>LOPRESSOR (metoprolol)<br>SECTRAL (acebutolol)<br>TENORMIN (atenolol)<br>TOPROL XL (metoprolol)<br>ZEBETA (bisoprolol) | Fourteen (14) day trials each of three (3) chemically distinct preferred agents, including the generic formulation of a requested non-preferred product, are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. |
| <b>BETA BLOCKER/DIURETIC COMBINATION DRUGS</b>    |  |   |   |
|   | atenolol/chlorthalidone<br>bisoprolol/HCTZ<br>metoprolol/HCTZ<br>nadolol/bendroflumethiazide<br>propranolol/HCTZ   | CORZIDE (nadolol/bendroflumethiazide)<br>DUTOPROL (metoprolol ER/HCTZ ER)<br>LOPRESSOR HCT (metoprolol/HCTZ)<br>TENORETIC (atenolol/chlorthalidone)<br>ZIAC (bisoprolol/HCTZ)   |   |
| <b>BETA- AND ALPHA-BLOCKERS</b>                   |  |   |   |
|   | carvedilol<br>labetalol  | COREG (carvedilol)<br>COREG CR (carvedilol)<br>TRANDATE (labetalol)   |   |
| <b>BLADDER RELAXANT PREPARATIONS<sup>AP</sup></b> |  |   |   |
|   | oxybutynin IR<br>oxybutynin ER<br>TOVIAZ (fesoterodine)<br>VESICARE (solifenacin)  | DETROL (tolterodine)<br>DETROL LA (tolterodine)<br>DITROPAN XL (oxybutynin)<br>ENABLEX (darifenacin)<br>flavoxate<br>GELNIQUE (oxybutynin)<br>MYRBETRIQ (mirabegron)  | A thirty (30) day trial 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.  |



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|   |   | OXYTROL (oxybutynin)<br>SANCTURA (trospium)<br>SANCTURA XR (trospium)<br>tolterodine<br>trospium<br>trospium ER  |  |
| <b>BONE RESORPTION SUPPRESSION AND RELATED AGENTS</b>       |   |  |  |
| <b>BISPHOSPHONATES</b>                                      |   |  |  |
|   | alendronate tablets                               | ACTONEL (risedronate)<br>ACTONEL WITH CALCIUM (risedronate/<br>calcium)<br>alendronate solution<br>ATELVIA (risedronate)<br>BINOSTO (alendronate)<br>BONIVA (ibandronate)<br>DIDRONEL (etidronate)<br>etidronate<br>FOSAMAX TABLETS (alendronate)<br>FOSAMAX PLUS D (alendronate/vitamin D)<br>ibandronate | 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.   |
| <b>OTHER BONE RESORPTION SUPPRESSION AND RELATED AGENTS</b> |   |  |  |
|   | calcitonin  | EVISTA (raloxifene)<br>FORTEO (teriparatide)<br>FORTICAL (calcitonin)<br>MIACALCIN (calcitonin)  | Evista will be authorized for postmenopausal women with osteoporosis or at high risk for invasive breast cancer.   |
| <b>BPH TREATMENTS</b>                                       |   |  |  |
| <b>5-ALPHA-REDUCTASE (5AR) INHIBITORS</b>                   |   |  |  |
|   | finasteride                                       | AVODART (dutasteride)<br>CIALIS 5 mg (tadalafil)<br>PROSCAR (finasteride)  | Thirty (30) day trials each of at least two (2) chemically distinct preferred agents, including the generic formulation of a requested non-preferred agent, are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. |
| <b>ALPHA BLOCKERS</b>                                       |   |  |  |
|   | alfuzosin<br>doxazosin<br>tamsulosin<br>terazosin | CARDURA (doxazosin)<br>CARDURA XL (doxazosin)<br>FLOMAX (tamsulosin)<br>HYTRIN (terazosin)   |  |



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|   |   | RAPAFLO (silodosin)<br>UROXATRAL (alfuzosin)   |   |
|   | <b>5-ALPHA-REDUCTASE (5AR) INHIBITORS/ALPHA BLOCKER COMBINATION</b> |  |   |
|   |   | JALYN (dutasteride/tamsulosin)   | Thirty (30) day trials of dutasteride and tamsulosin concurrently are required before the non-preferred agent will be authorized.   |
| <b>BRONCHODILATORS, BETA AGONIST<sup>AP</sup></b> |   |  |   |
|   | <b>INHALATION SOLUTION</b>  |  |   |
|   | ACCUNEB (albuterol)*<br>albuterol                                   | BROVANA (arformoterol)<br>levalbuterol<br>metaproterenol<br>PERFOROMIST (formoterol)<br>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.<br><br>*No PA is required for Accuneb for children up to five (5) years of age.      |
|   | <b>INHALERS, LONG-ACTING</b>  |  |   |
|   | FORADIL (formoterol)<br>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.  |
|   | <b>INHALERS, SHORT-ACTING</b>                                       |  |   |
|   | PROAIR HFA (albuterol)<br>PROVENTIL HFA (albuterol)                 | MAXAIR (pirbuterol)<br>VENTOLIN HFA (albuterol)<br>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. |
|   | <b>ORAL</b>   |  |   |
|   | albuterol IR, ER<br>terbutaline                                     | metaproterenol<br>VOSPIRE ER (albuterol)   |   |



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| <b>CALCIUM CHANNEL BLOCKERS<sup>AP</sup></b>                              |  |   |  |
| <b>LONG-ACTING</b>  |  |   |  |
|   | amlodipine<br>diltiazem ER<br>felodipine ER<br>nifedipine ER<br>verapamil ER | ADALAT CC (nifedipine)<br>CALAN SR (verapamil)<br>CARDENE SR (nicardipine)<br>CARDIZEM CD, LA (diltiazem)<br>COVERA-HS (verapamil)<br>diltiazem LA<br>DYNACIRC CR (isradipine)<br>ISOPTIN SR (verapamil)<br>MATZIM LA (diltiazem)<br>nisoldipine<br>NORVASC (amlodipine)<br>PLENDIL (felodipine)<br>PROCARDIA XL (nifedipine)<br>SULAR (nisoldipine)<br>TIAZAC (diltiazem)<br>verapamil ER PM<br>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. |
| <b>SHORT-ACTING</b>   |  |   |  |
|   | diltiazem<br>verapamil   | CALAN (verapamil)<br>CARDIZEM (diltiazem)<br>isradipine<br>nicardipine<br>nifedipine<br>nimodipine<br>NIMOTOP (nimodipine)<br>NYMALIZE SOLUTION (nimodipine)<br>PROCARDIA (nifedipine)  |  |
| <b>CEPHALOSPORINS AND RELATED ANTIBIOTICS<sup>AP</sup></b>                |  |   |  |
| <b>BETA LACTAMS AND BETA LACTAM/BETA-LACTAMASE INHIBITOR COMBINATIONS</b> |  |   |  |
|   | amoxicillin/clavulanate IR   | amoxicillin/clavulanate ER<br>AUGMENTIN (amoxicillin/clavulanate)<br>AUGMENTIN XR (amoxicillin/clavulanate)<br>MOXATAG (amoxicillin)  | 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.                 |
| <b>CEPHALOSPORINS</b>   |  |   |  |
|   | cefaclor<br>cefadroxil capsule, tablet<br>cefdinir<br>cefuroxime tablet      | CEDAX (ceftibuten)<br>cefaclor ER tablet<br>cefadroxil suspension<br>cefditoren   |  |



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|---|--|---|---|
|   | cephalexin capsule, suspension   | cefpodoxime<br>cefprozil<br>ceftibuten capsule, suspension<br>CEFTIN (cefuroxime)<br>cefuroxime suspension<br>cephalexin tablet<br>KEFLEX (cephalexin)<br>OMNICEF (cefdinir)<br>RANICLOR (cefaclor)<br>SPECTRACEF (cefditoren)<br>SUPRAX (cefixime) |   |
| <b>COLONY STIMULATING FACTORS</b>                             |  |   |   |
|   | LEUKINE (sargramostim)<br>NEUPOGEN (filgrastim)                        | NEULASTA (filgrastim)   | 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.  |
| <b>COPD AGENTS</b>  |  |   |   |
| <b>ANTICHOLINERGIC<sup>AP</sup></b>                           |  |   |   |
|   | ATROVENT HFA (ipratropium)<br>ipratropium<br>SPIRIVA (tiotropium)      | TUDORZA (aclidinium)  | A thirty (30) day trial of tiotropium is required before a non-preferred agent will be authorized.  |
| <b>ANTICHOLINERGIC-BETA AGONIST COMBINATIONS<sup>AP</sup></b> |  |   |   |
|   | albuterol/ipratropium<br>COMBIVENT RESPIMAT<br>(albuterol/ipratropium) | DUONEB (albuterol/ipratropium)  | Thirty (30) day trials 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.  |
| <b>PDE4 INHIBITOR</b>   |  |   |   |
|   |  | DALIRESP (roflumilast)  | Daliresp will be authorized if the following criteria are met: <ol style="list-style-type: none"> <li>1. Patient is forty (40) years of age or older <b>and</b></li> <li>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 <b>and</b></li> </ol> |



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|--|---|---|--|
|  |   |   | <ol style="list-style-type: none"> <li>3. Concurrent therapy with an inhaled corticosteroid and long-acting bronchodilator and evidence of compliance <b>and</b></li> <li>4. No evidence of moderate to severe liver impairment (Child-Pugh Class B or C) <b>and</b></li> <li>5. No concurrent use with strong cytochrome P450 inducers (rifampicin, phenobarbital, carbamazepine or phenytoin).</li> </ol>  |
| <b>CYTOKINE &amp; CAM ANTAGONISTS<sup>CL</sup></b> |   |   |  |
| <b>ANTI-TNFs</b>                                   |   |   | <p>Ninety day trials of two of the preferred anti-TNF agents are required before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present.</p> <p>*Xeljanz (tofacitinib) will be authorized after a thirty (30) day trial of one (1) of the preferred agents if the following criteria are met:</p> <ol style="list-style-type: none"> <li>1. Diagnosis of moderately or severely active rheumatoid arthritis <b>and</b></li> <li>2. Negative tuberculin skin test before initiation of therapy <b>and</b></li> <li>3. Intolerance to or an inadequate response to a sixty (60) day trial of methotrexate <b>and</b></li> <li>4. The patient is eighteen (18) years of age or older <b>and</b></li> <li>5. There are no plans to use tofacitinib in combination with biologic DMARDS or potent immunosuppressants (e.g. azathioprine or cyclosporine) <b>and</b></li> <li>6. The dose is limited to two (2) tablets daily.</li> </ol> |
|  | ENBREL (etanercept)<br>HUMIRA (adalimumab)<br>SIMPONI (golimumab) | CIMZIA (certolizumab pegol)   |  |
| <b>OTHERS</b>                                      |   |   |  |
|  |   | ACTEMRA syringe (tocilizumab)<br>KINERET (anakinra)<br>ORENCIA syringe (abatacept)<br>STELARA syringe (ustekinumab)<br>XELJANZ (tofacitinib)* |  |



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|---|---|--|---|
|   |   |  | See additional criteria for treatment of psoriasis or psoriatic arthritis at <a href="http://www.dhhr.wv.gov/bms/Pharmacy/Pages/pac.aspx">http://www.dhhr.wv.gov/bms/Pharmacy/Pages/pac.aspx</a>  |
| <b>EPINEPHRINE, SELF-INJECTED</b>                       |   |  |   |
|   | EPIPEN (epinephrine)<br>EPIPEN JR (epinephrine) | ADRENALIN (epinephrine)<br>AUVI-Q (epinephrine)<br>epinephrine | 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.  |
| <b>ERYTHROPOIESIS STIMULATING PROTEINS<sup>CL</sup></b> |   |  |   |
|   | PROCRIT (rHuEPO)                                | ARANESP (darbepoetin)<br>EPOGEN (rHuEPO)                       | <p>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.</p> <p>Erythropoiesis agents will be authorized if the following criteria are met:</p> <ol style="list-style-type: none"> <li>1. Hemoglobin or Hematocrit less than 10/30 respectively. For renewal, hemoglobin or hematocrit levels greater than 12/36 will require dosage reduction or discontinuation. Exceptions will be considered on an individual basis after medical documentation is reviewed. (Laboratory values must be dated within six (6) weeks of request.) <b>and</b></li> <li>2. Transferrin saturation <math>\geq</math> 20%, ferritin levels <math>\geq</math> 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</li> </ol> |



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|--|--|--|---|
|  |  |  | erythropoietin agent <b>and</b><br>3. For HIV-infected patients, endogenous serum erythropoietin level must be $\leq$ 500mU/ml to initiate therapy <b>and</b><br>4. No evidence of untreated GI bleeding, hemolysis, or Vitamin B-12, iron or folate deficiency.  |
| <b>FLUOROQUINOLONES (Oral)<sup>AP</sup></b>  |  |  |   |
|  | CIPRO SUSPENSION (ciprofloxacin)<br>ciprofloxacin<br>levofloxacin tablet   | AVELOX (moxifloxacin)<br>CIPRO TABLETS (ciprofloxacin)<br>CIPRO XR (ciprofloxacin)<br>ciprofloxacin ER<br>FACTIVE (gemifloxacin)<br>LEVAQUIN (levofloxacin)<br>levofloxacin solution<br>NOROXIN (norfloxacin)<br>ofloxacin | A five (5) 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.   |
| <b>GLUCOCORTICOIDS, INHALED<sup>AP</sup></b> |  |  |   |
| <b>GLUCOCORTICOIDS</b>                       |  |  |   |
|  | ASMANEX (mometasone)<br>FLOVENT HFA (fluticasone)<br>FLOVENT Diskus (fluticasone)<br>PULMICORT FLEXHALER (budesonide)<br>PULMICORT RESPULES (budesonide)*<br>QVAR (beclomethasone) | ALVESCO (ciclesonide)<br>budesonide  | 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.<br><br>* Pulmicort Respules do not require a prior authorization for children up to nine (9) years of age or for individuals unable to use an MDI. When children who have been stabilized on Pulmicort Respules reach age 9, prescriptions for the Pulmicort inhaler will be authorized for them.<br><br>*For children up to nine (9) years of age, and for those who meet the PA requirements, brand Pulmicort is preferred over the generic. |



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|---|--|--|--|
| <b>GLUCOCORTICOID/BRONCHODILATOR COMBINATIONS</b> |  |  |  |
|   | ADVAIR (fluticasone/salmeterol)<br>ADVAIR HFA (fluticasone/salmeterol)<br>DULERA (mometasone/formoterol)<br>SYMBICORT(budesonide/formoterol)                 | BREO ELLIPTA (fluticasone/vilanerol)   | <p>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.</p> <p>For a diagnosis of COPD, thirty (30) days trials 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.</p> |
| <b>GROWTH HORMONE<sup>CL</sup></b>                |  |  |  |
|   | GENOTROPIN (somatropin)<br>NORDITROPIN (somatropin)  | HUMATROPE (somatropin)<br>INCRELEX (mecasermin)<br>NUTROPIN (somatropin)<br>NUTROPIN AQ<br>NUTROPIN AQ PENS (somatropin)<br>OMNITROPE (somatropin)<br>SAIZEN (somatropin)<br>SEROSTIM (somatropin)<br>TEV-TROPIN (somatropin)<br>ZORBTIVE (somatropin)     | <p>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.</p> <p>Patients already on a non-preferred agent will receive authorization to continue therapy on that agent for the duration of the existing PA.</p>   |
| <b>H. PYLORI TREATMENT</b>                        |  |  |  |
|   | Please use individual components:<br>preferred PPI (omeprazole or pantoprazole)<br>amoxicillin<br>tetracycline<br>metronidazole<br>clarithromycin<br>bismuth | HELIDAC (bismuth/metronidazole/tetracycline)<br>lansoprazole/amoxicillin/clarithromycin<br>OMECLAMOX-PAK<br>(omeprazole/amoxicillin/clarithromycin)<br>PREVPAC<br>(lansoprazole/amoxicillin/clarithromycin)<br>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.  |
| <b>HEPATITIS B TREATMENTS</b>                     |  |  |  |
|   | EPIVIR HBV (lamivudine)  | adefovir<br>BARACLUDE (entecavir)<br>HEPSERA (adefovir)  | A thirty (30) day trial of the preferred agent is required before a non-preferred agent will be authorized   |



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|   |  | TYZEKA (telbivudine)  | unless one (1) of the exceptions on the PA form is present.   |
| <b>HEPATITIS C TREATMENTS<sup>CL</sup></b>        |  |   |   |
|   | INCIVEK (telaprevir) <sup>*</sup><br>PEGASYS (pegylated interferon)<br>PEG-INTRON (pegylated interferon)<br>ribavirin<br>VICTRELIS (boceprevir) <sup>*</sup> | COPEGUS (ribavirin)<br>INFERGEN (consensus interferon)<br>REBETOL (ribavirin)<br>RIBAPAK (ribavirin)<br>RIBASPHERE 400mg, 600mg (ribavirin) | For patients starting therapy in this class, a trail of the preferred agent of a dosage form is required before a non-preferred agent of that dosage form will be authorized.<br><br><sup>*</sup> See additional criteria for Incivek and Victrelis at <a href="http://www.dhhr.wv.gov/bms/Pharmacy/Pages/pac.aspx">http://www.dhhr.wv.gov/bms/Pharmacy/Pages/pac.aspx</a>  |
| <b>HYPERPARATHYROID AGENTS<sup>AP</sup></b>       |  |   |   |
|   | HECTOROL (doxercalciferol)<br>ZEMPLAR (paricalcitol)   | paricalcitol<br>SENSIPAR (cinacalcet)   | 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.   |
| <b>HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS</b> |  |   |   |
| <b>INJECTABLE</b>                                 |  |   |   |
|   | BYETTA (exenatide) <sup>AP*</sup><br>VICTOZA (liraglutide) <sup>AP*</sup>  | BYDUREON (exenatide)<br>SYMLIN (pramlintide) <sup>**</sup>  | 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.<br><br><sup>*</sup> Byetta and Victoza will be authorized for six (6) month intervals if the following criteria are met:<br>1. Diagnosis of Type 2 Diabetes <b>and</b><br>2. Previous history of a thirty (30) day trial of metformin, unless contraindicated <b>and</b><br>3. No history of pancreatitis <b>and</b> |



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|                           |  |  | <p>4. For concurrent therapy with insulin, treatment with a bolus insulin is contraindicated. Approvals will be given for 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.</p> <p>**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.</p>  |
| <b>ORAL <sup>AP</sup></b> |  |  |  |
|                           | <p>JANUMET (sitagliptin/metformin) <sup>AP</sup><br/>           JANUVIA (sitagliptin) <sup>AP</sup><br/>           JUVISYNC (sitagliptin/simvastatin) <sup>AP</sup><br/>           TRADJENTA (linagliptin) <sup>AP</sup></p> | <p>JANUMET XR (sitagliptin/metformin)*<br/>           JENTADUETO (linagliptin/metformin)<br/>           KAZANO (alogliptin/metformin)<br/>           KOMBIGLYZE XR (saxagliptin/metformin) *<br/>           NESINA (alogliptin)<br/>           ONGLYZA (saxagliptin) **<br/>           OSENI (alogliptin/pioglitazone)</p> | <p>Thirty (30) day trials of each chemically distinct preferred agent are required before a non-preferred agent will be approved.</p> <p>Janumet, Januvia, Juvisync and Tradjenta will be subject to the following edits:</p> <ol style="list-style-type: none"> <li>1. Previous history of a thirty (30) day trial of metformin <b>and</b></li> <li>2. Janumet, Januvia, Juvisync and Tradjenta will be authorized for concurrent use with insulin for six (6) month intervals. For re-authorization, HgBA1C levels must be less than or equal (≤) to eight percent (8%). HgBA1C levels submitted must be for the most recent thirty (30) day period.</li> </ol> <p>*Jentadueto and Janumet XR will</p> |



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|  |  |   | <p>be authorized after thirty (30) day trials of the preferred combination agent.</p> <p>**Patients stabilized on Onglyza will be grandfathered through 3/31/2014.</p>   |
| <b>HYPOGLYCEMICS, INSULIN AND RELATED AGENTS</b> |  |   |  |
|  | <p>HUMALOG (insulin lispro)<br/>HUMALOG MIX VIALS (insulin lispro/lispro protamine)<br/>HUMULIN VIALS (insulin)<br/>LANTUS (insulin glargine)<br/>LEVEMIR (insulin detemir)<br/>NOVOLIN (insulin)<br/>NOVOLOG (insulin aspart)<br/>NOVOLOG MIX (insulin aspart/aspart protamine)</p> | <p>APIDRA (insulin glulisine)<sup>AP</sup><br/>HUMALOG PEN/KWIKPEN (insulin lispro)<br/>HUMALOG MIX PENS (insulin lispro/lispro protamine)<br/>HUMULIN PENS (insulin)</p> | <p>Apidra will be authorized if the following criteria are met:</p> <ol style="list-style-type: none"> <li>1. Patient is four (4) years of age or older; <b>and</b></li> <li>2. Patient is currently on a regimen including a longer acting or basal insulin, <b>and</b></li> <li>3. Patient has had a trial of a similar preferred agent, Novolog or Humalog, with documentation that the desired results were not achieved.</li> </ol> <p>Humulin pens and Humalog Mix pens will be authorized only for patients who cannot utilize vials due to impaired vision or dexterity.</p> |
| <b>HYPOGLYCEMICS, MEGLITINIDES</b>               |  |   |  |
|  | <b>MEGLITINIDES</b>  |   | <p>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.</p>   |
| <p>nateglinide<br/>PRANDIN (repaglinide)</p>     | <p>repaglinide<br/>STARLIX (nateglinide)</p>   |   |  |
|  | <b>MEGLITINIDE COMBINATIONS</b>  |   |  |
|  | <p>PRANDIMET (repaglinide/metformin)</p>   |   |  |
| <b>HYPOGLYCEMICS, MISCELLANEOUS</b>              |  |   |  |
|  | <p>WELCHOL (colesevelam)<sup>AP</sup></p>  |   | <p>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).</p>  |



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| <b>HYPOGLYCEMICS, SGLT2</b>              |   |   |  |
|  |   | INVOKANA (canagliflozin)  | Invokana will be authorized for six (6) months if the following criteria are met: <ol style="list-style-type: none"> <li>1. Diagnosis of Type 2 Diabetes <b>and</b></li> <li>2. Thirty (30) day trial of metformin or metformin combination within the past six (6) months <b>and</b></li> <li>3. HgBA1C levels are equal or less than (<math>\leq</math>) 9% <b>and</b></li> <li>4. Glomerular filtration rate is greater than or equal to (<math>\geq</math>) 45 ml/min/1.73m<sup>2</sup> <b>and</b></li> <li>5. Prior authorizations will be issued at six (6) month intervals if HgBA1C levels are less than or equal to (<math>\leq</math>) 8%</li> </ol> HgBA1C levels submitted must be for the most recent thirty (30) day period. |
| <b>HYPOGLYCEMICS, TZD<sup>AP</sup></b>   |   |   |  |
|  | <b>THIAZOLIDINEDIONES</b><br><br>pioglitazone   | ACTOS (pioglitazone)<br>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.   |
|  |   | <b>TZD COMBINATIONS</b><br><br>ACTOPLUS MET (pioglitazone/ metformin)<br>ACTOPLUS MET XR (pioglitazone/ metformin)<br>AVANDAMET (rosiglitazone/metformin)<br>AVANDARYL (rosiglitazone/glimepiride)<br>DUETACT (pioglitazone/glimepiride)<br>pioglitazone/glimepiride<br>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.  |
| <b>IMMUNE GLOBULINS, IV<sup>CL</sup></b> |   |   |  |
|  | BIVIGAM (human immunoglobulin gamma)<br>CARIMUNE NF NANOFILTERED (human immunoglobulin gamma) | GAMMAKED (human immunoglobulin gamma)<br>GAMMAPLEX (human immunoglobulin gamma)   | Immune globulin agents will be authorized according to FDA approved indications.   |



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|   | CYTOGAM (human cytomegalovirus immune globulin)<br>FLEBOGAMMA DIF (human immunoglobulin gamma)<br>GAMASTAN S-D VIAL (human immunoglobulin gamma)<br>GAMMAGARD LIQUID (human immunoglobulin gamma)<br>GAMMAGARD S-D (human immunoglobulin gamma)<br>GAMUNEX-C (human immunoglobulin gamma)<br>HEPAGAM B (hepatitis b immune globulin (human))<br>HIZENTRA (human immunoglobulin gamma)<br>OCTAGAM (human immunoglobulin gamma)<br>VARIZIG (varicella zoster immune globulin (human)) | PRIVIGEN (human immunoglobulin gamma)                                     | 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.   |
| <b>IMMUNOMODULATORS, ATOPIC DERMATITIS <sup>AP</sup></b>    |   |   |  |
|   | ELIDEL (pimecrolimus) <sup>AP</sup>   | PROTOPIC (tacrolimus)   | A thirty (30) day trial of a preferred medium or high potency topical corticosteroid is required before coverage of Elidel will be 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. |
| <b>IMMUNOMODULATORS, TOPICAL &amp; GENITAL WARTS AGENTS</b> |   |   |  |
|   | ALDARA (imiquimod)<br>CONDYLOX (podofilox)  | imiquimod<br>podofilox<br>VEREGEN (sinecatechins)<br>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.<br><br>*Zyclara will be authorized for a diagnosis of actinic keratosis.  |
| <b>IMMUNOSUPPRESSIVES, ORAL</b>                             |   |   |  |
|   | azathioprine<br>cyclosporine  | ASTAGRAF XL (tacrolimus)<br>AZASAN (azathioprine)                         | A fourteen (14) day trial of a preferred agent is required before a  |



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|  | cyclosporine, modified<br>mycophenolate mofetil<br>PROGRAF (tacrolimus)<br>RAPAMUNE (sirolimus) | CELLCEPT (mycophenolate mofetil)<br>IMURAN (azathioprine)<br>MYFORTIC (mycophenolic acid)<br>NEORAL (cyclosporine, modified)<br>SANDIMMUNE (cyclosporine)<br>tacrolimus<br>ZORTRESS (everolimus) | non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.   |
| <b>INTERMITTENT CLAUDICATION<sup>AP</sup></b>  |   |  |  |
|  | cilostazol<br>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.  |
| <b>INTRANASAL RHINITIS AGENTS<sup>AP</sup></b> |   |  |  |
| <b>ANTICHOLINERGICS</b>                        |   |  |  |
|  | 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 unless one (1) of the exceptions on the PA form is present. |
| <b>ANTIHISTAMINES</b>                          |   |  |  |
|  | ASTELIN (azelastine)<br>PATANASE (olopatadine)  | ASTEPRO (azelastine)<br>azelastine   | Thirty (30) day trials of both 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.             |
| <b>COMBINATIONS</b>                            |   |  |  |
|  |   | 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.   |



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| <b>CORTICOSTEROIDS</b>                               |  |  |   |
|  | fluticasone propionate<br>NASONEX (mometasone) | BECONASE AQ (beclomethasone)<br>FLONASE (fluticasone propionate)<br>flunisolide<br>NASACORT AQ (triamcinolone)<br>OMNARIS (ciclesonide)<br>QNASL (beclomethasone)<br>RHINOCORT AQUA (budesonide)<br>triamcinolone<br>VERAMYST (fluticasone furoate)<br>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.  |
| <b>LEUKOTRIENE MODIFIERS</b>                         |  |  |   |
|  | ACCOLATE (zafirlukast)<br>montelukast          | SINGULAIR (montelukast)<br>zafirlukast<br>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.  |
| <b>LIPOTROPICS, OTHER (Non-statins)<sup>AP</sup></b> |  |  |   |
| <b>BILE ACID SEQUESTRANTS</b>                        |  |  |   |
|  | cholestyramine<br>colestipol tablets           | COLESTID (colestipol)<br>colestipol granules<br>KYNAMRO (mipomersen)<br>QUESTRAN (cholestyramine)<br>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.<br><br>*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 thiazolidinedione (TZD)). See HYPOGLYCEMICS, MISCELLANEOUS. |
| <b>CHOLESTEROL ABSORPTION INHIBITORS</b>             |  |  |   |
|  | ZETIA (ezetimibe) <sup>AP</sup>                |  | Zetia will be authorized with prior use of a HMG-CoA reductase inhibitor within the previous six (6) months.  |
| <b>FATTY ACIDS</b>                                   |  |  |   |



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|  |  | LOVAZA (omega-3-acid ethyl esters) <sup>AP</sup><br>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.  |
|  | <b>FIBRIC ACID DERIVATIVES</b>   |  |  |
|  | fenofibrate 54mg & 160mg<br>fenofibrate micronized 67mg, 134mg & 200mg<br>gemfibrozil<br>TRICOR (fenofibrate nanocrystallized)<br>TRILIPIX (fenofibric acid) | ANTARA (fenofibrate)<br>FENOGLIDE (fenofibrate)<br>FIBRICOR (fenofibric acid)<br>fenofibrate 43mg, 130mg<br>fenofibrate nanocrystallized 48mg, 145mg<br>fenofibric acid<br>LIPOFEN (fenofibrate)<br>LOFIBRA (fenofibrate)<br>LOPID (gemfibrozil)<br>TRIGLIDE (fenofibrate) |  |
|  | <b>NIACIN</b>  |  |  |
|  | niacin<br>NIACOR (niacin)<br>NIASPAN (niacin)<br>SLO-NIACIN (niacin)   | niacin ER  |  |
| <b>LIPOTROPICS, STATINS<sup>AP</sup></b> |  |  |  |
|  | <b>STATINS</b>   |  | 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 is present.<br><br>*Zocor/simvastatin 80mg tablets will require a clinical PA |
|  | atorvastatin<br>LESCOL (fluvastatin)<br>LESCOL XL (fluvastatin)<br>lovastatin<br>pravastatin<br>simvastatin <sup>CL*</sup>                                   | ALTOPREV (lovastatin)<br>CRESTOR (rosuvastatin)<br>fluvastatin<br>LIPITOR (atorvastatin)<br>LIVALO (pitavastatin)<br>MEVACOR (lovastatin)<br>PRAVACHOL (pravastatin)<br>ZOCOR (simvastatin) <sup>*</sup>   |  |
|  | <b>STATIN COMBINATIONS</b>   |  |  |
|  | ADVICOR (lovastatin/niacin)<br>amlodipine/atorvastatin<br>SIMCOR (simvastatin/niacin ER)   | CADUET (atorvastatin/amlodipine)<br>LIPTRUZET (atorvastatin/ezetimibe)<br>VYTORIN (simvastatin/ezetimibe)  | 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.  |



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|   |   |   | Vytorin 80/10mg tablets will require a clinical PA   |
| <b>MACROLIDES/KETOLIDES</b>                   |   |   |  |
| <b>KETOLIDES</b>                              |   |   |  |
|   |   | 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.   |
| <b>MACROLIDES</b>                             |   |   |  |
|   | azithromycin<br>clarithromycin<br>erythromycin base   | BIAXIN (clarithromycin)<br>BIAXIN XL (clarithromycin)<br>clarithromycin ER<br>E.E.S. (erythromycin ethylsuccinate)<br>E-MYCIN (erythromycin)<br>ERYC (erythromycin)<br>ERYPED (erythromycin ethylsuccinate)<br>ERY-TAB (erythromycin)<br>ERYTHROCIN (erythromycin stearate)<br>erythromycin estolate<br>PCE (erythromycin)<br>ZITHROMAX (azithromycin)<br>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.  |
| <b>MULTIPLE SCLEROSIS AGENTS<sup>AP</sup></b> |   |   |  |
| <b>INTERFERONS</b>                            |   |   |  |
|   | AVONEX (interferon beta-1a) <sup>AP</sup><br>AVONEX PEN (interferon beta-1a) <sup>AP</sup><br>BETASERON KIT (interferon beta-1b) <sup>AP</sup><br>REBIF (interferon beta-1a) <sup>AP</sup><br>REBIF REBIDOSE (interferon beta-1a) <sup>AP</sup> | EXTAVIA (interferon beta-1b)  | A diagnosis of multiple sclerosis and 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.            |
| <b>NON-INTERFERONS</b>                        |   |   |  |
|   | COPAXONE (glatiramer) <sup>AP</sup>   | AMPYRA (dalfampridine) <sup>CL*</sup><br>AUBAGIO (teriflunomide) <sup>CL**</sup><br>GILENYA (fingolimod) <sup>CL***</sup><br>TECFIDERA (dimethyl fumarate) <sup>CL****</sup>  | *Amypra will be authorized if the following criteria are met:<br>1. Diagnosis of multiple sclerosis <b>and</b><br>2. No history of seizures <b>and</b><br>3. No evidence of moderate or severe renal impairment <b>and</b> |



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|------------------------|------------------|----------------------|---|
|                        |                  |                      | <p>4. Initial prescription will be authorized for thirty (30) days only.</p> <p>**Aubagio will be authorized if the following criteria are met:</p> <ol style="list-style-type: none"> <li>1. Diagnosis of relapsing multiple sclerosis <b>and</b></li> <li>2. Trial of the preferred first-line agent in each class (interferon and non-interferon) for thirty (30) days each <b>and</b></li> <li>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 <b>and</b></li> <li>4. Complete blood cell count (CBC) within six (6) months before initiation of therapy <b>and</b></li> <li>5. Female patients must have a negative pregnancy test before initiation of therapy and be established on a reliable method of contraception if appropriate <b>and</b></li> <li>6. Patient is from eighteen (18) up to sixty-five (65) years of age <b>and</b></li> <li>7. Negative tuberculin skin test before initiation of therapy</li> </ol> <p>***Gilenya will be authorized if the following criteria are met: A diagnosis of a relapsing form of multiple sclerosis <b>and</b></p> <ol style="list-style-type: none"> <li>1. Medication is prescribed by a neurologist <b>and</b></li> <li>2. History of a thirty (30) day trial of one (1) of the preferred agents for multiple sclerosis unless one (1) of the</li> </ol> |



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|-------------------------|---|---|--|
|                         |   |   | <p>exceptions on the PA form is present <b>and</b></p> <ol style="list-style-type: none"> <li>3. Dosage is limited to one (1) tablet per day.<br/>(AP does not apply.)</li> </ol> <p>****Tecfidera will be authorized if the following criteria are met:</p> <ol style="list-style-type: none"> <li>1. Diagnosis of relapsing multiple sclerosis <b>and</b></li> <li>2. Trial of one first line injectable agent, such as interferon <math>\beta</math>-1a, interferon <math>\beta</math>-1b or glatiramer <b>and</b></li> <li>3. Complete blood count (CBC) within six (6) months of initiation of therapy and six months after initiation <b>and</b></li> <li>4. Complete blood count (CBC) annually during therapy</li> </ol> |
| <b>NEUROPATHIC PAIN</b> |   |   |  |
|                         | capsaicin OTC<br>CYMBALTA (duloxetine)<br>gabapentin capsules, solution | duloxetine<br>gabapentin tablets<br>GRALISE (gabapentin)*<br>HORIZANT (gabapentin)<br>lidocaine patch<br>LIDODERM (lidocaine)**<br>LYRICA CAPSULE (pregabalin)***<br>LYRICA SOLUTION (pregabalin)***<br>NEURONTIN (gabapentin)<br>QUTENZA (capsaicin)<br>SAVELLA (milnacipran)****<br>ZOSTRIX OTC (capsaicin) | <p>A trial of the preferred agent(s) in the corresponding dosage (oral or topical) form will be required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.</p> <p>*Gralise will be authorized if the following criteria are met:</p> <ol style="list-style-type: none"> <li>1. Diagnosis of post herpetic neuralgia <b>and</b></li> <li>2. Trial of a tricyclic antidepressant for a least thirty (30) days <b>and</b></li> <li>3. Trial of gabapentin immediate release formulation (positive response without adequate duration) <b>and</b></li> <li>4. Request is for once daily dosing with 1800mg. maximum</li> </ol>   |



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|----------------------------|---|---|---|
|                            |   |   | <p>daily dosage.</p> <p>**Lidoderm patches will be authorized for a diagnosis of post-herpetic neuralgia.</p> <p>***Lyrica will be authorized if the following criteria are met:</p> <ol style="list-style-type: none"> <li>1. Diagnosis of seizure disorders or neuropathic pain associated with a spinal cord injury <b>or</b></li> <li>2. Diagnosis of fibromyalgia, postherpetic neuralgia, or diabetic neuropathy AND a history of a trial of 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 be adjusted based on the degree of impairment.)</li> </ol> <p>****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.</p> |
| <b>NSAIDS<sup>AP</sup></b> |   |   |   |
| <b>NON-SELECTIVE</b>       |   |   |   |
|                            | diclofenac (IR, SR)<br>etodolac IR<br>flurbiprofen<br>ibuprofen (Rx and OTC)<br>INDOCIN SUSPENSION (indomethacin)<br>indomethacin | ANAPROX (naproxen)<br>ANSAID (flurbiprofen)<br>CATAFLAM (diclofenac)<br>CLINORIL (sulindac)<br>DAYPRO (oxaprozin)<br>diflunisal | 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.   |



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|---|---|---|---|
|   | ketoprofen<br>ketorolac<br>nabumetone<br>naproxen (Rx and OTC)<br>piroxicam<br>sulindac | DUEXIS (famotidine/ibuprofen)<br>etodolac SR<br>FELDENE (piroxicam)<br>fenoprofen<br>INDOCIN SUPPOSITORIES (indomethacin)<br>indomethacin ER<br>ketoprofen ER<br>meclofenamate<br>mefenamic acid<br>MOTRIN (ibuprofen)<br>NALFON (fenoprofen)<br>NAPRELAN (naproxen)<br>NAPROSYN (naproxen)<br>oxaprozin<br>PONSTEL (meclofenamate)<br>SPRIX (ketorolac)<br>tolmetin<br>VOLTAREN (diclofenac)<br>ZIPSOR (diclofenac potassium)<br>ZORVOLEX (diclofenac) |   |
| <b>NSAID/GI PROTECTANT COMBINATIONS</b> |   |   |   |
|   |   | ARTHROTEC (diclofenac/misoprostol)<br>diclofenac/misoprostol<br>VIMOVO (naproxen/esomeprazole)  |   |
| <b>COX-II SELECTIVE</b>                 |   |   |   |
|   | meloxicam   | CELEBREX (celecoxib)<br>MOBIC (meloxicam)   | COX-II Inhibitor agents will be authorized if the following criteria are met:<br><br>Patient has a history or risk of a serious GI complication <b>or</b><br>Agent is requested for treatment of a chronic condition <b>and</b><br>1. Patient is 70 years of age or older, <b>or</b><br>2. Patient is currently on anticoagulation therapy. |
| <b>TOPICAL<sup>AP</sup></b>             |   |   |   |
|   |   | FLECTOR PATCH (diclofenac)<br>PENNSAID (diclofenac)<br>VOLTAREN GEL (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   |



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|---|---|--|--|
|   |   |  | <p>one (1) of the exceptions on the PA form is present.</p> <p>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.</p>  |
| <b>OPHTHALMIC ANTIBIOTICS<sup>AP</sup></b>        |   |  |  |
|   | bacitracin/polymyxin ointment<br>ciprofloxacin*<br>erythromycin<br>gentamicin<br>MOXEZA (moxifloxacin)*<br>ofloxacin*<br>polymyxin/trimethoprim<br>sulfacetamide<br>tobramycin<br>VIGAMOX (moxifloxacin)*     | AZASITE (azithromycin)<br>bacitracin<br>BESIVANCE (besifloxacin)<br>BLEPH-10 (sulfacetamide)<br>CILOXAN (ciprofloxacin)<br>GARAMYCIN (gentamicin)<br>gatifloxacin<br>ILOTYCIN (erythromycin)<br>levofloxacin<br>NATACYN (natamycin)<br>neomycin/bacitracin/polymyxin<br>neomycin/polymyxin/gramicidin<br>NEOSPORIN (neomycin/polymyxin/gramicidin)<br>OCUFLOX (ofloxacin)<br>POLYTRIM (polymyxin/trimethoprim)<br>sulfacetamide ointment<br>TOBEX (tobramycin)<br>ZYMAR (gatifloxacin)<br>ZYMAXID (gatifloxacin) | <p>Five (5) 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.</p> <p>The American Academy of Ophthalmology guidelines on treating bacterial conjunctivitis recommend as first line treatment options: erythromycin ointment, sulfacetamide drops, or polymyxin/trimethoprim drops.</p> <p>*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.</p> |
| <b>OPHTHALMIC ANTIBIOTIC/STEROID COMBINATIONS</b> |   |  |  |
|   | BLEPHAMIDE (prednisolone/sulfacetamide)<br>BLEPHAMIDE S.O.P. (prednisolone/sulfacetamide)<br>neomycin/polymyxin/dexamethasone<br>sulfacetamide/prednisolone<br>TOBRADEX SUSPENSION (tobramycin/dexamethasone) | MAXITROL (neomycin/polymyxin/dexamethasone)<br>neomycin/bacitracin/polymyxin/ hydrocortisone<br>neomycin/polymyxin/hydrocortisone<br>PRED-G (prednisolone/gentamicin)<br>TOBRADEX OINTMENT (tobramycin/dexamethasone)<br>TOBRADEX ST (tobramycin/ dexamethasone)   | <p>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.</p>   |



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|---|--|---|---|
|   |  | tobramycin/dexamethasone suspension<br>ZYLET (loteprednol/tobramycin)   |   |
| <b>OPHTHALMICS FOR ALLERGIC CONJUNCTIVITIS<sup>AP</sup></b> |  |   |   |
|   | ALAWAY (ketotifen)<br>ALREX (loteprednol)<br>cromolyn<br>ketotifen<br>PATADAY (olopatadine)<br>ZADITOR OTC (ketotifen)<br>ZYRTEC ITCHY EYE (ketotifen) | ALAMAST (pemirolast)<br>ALOCRIL (nedocromil)<br>ALOMIDE (iodoxamide)<br>azelastine<br>BEPREVE (bepotastine)<br>CROLOM (cromolyn)<br>ELESTAT (epinastine)<br>EMADINE (emedastine)<br>epinastine<br>LASTACRAFT (alcaftadine)<br>OPTICROM (cromolyn)<br>OPTIVAR (azelastine)<br>PATANOL (olopatadine)  | 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. |
| <b>OPHTHALMIC ANTI-INFLAMMATORIES<sup>AP</sup></b>          |  |   |   |
|   | dexamethasone<br>diclofenac<br>fluorometholone<br>flurbiprofen<br>ketorolac<br>prednisolone acetate  | ACULAR (ketorolac)<br>ACULAR LS (ketorolac)<br>ACUVAIL (ketorolac tromethamine)<br>BROMDAY (bromfenac)<br>bromfenac<br>DUREZOL (difluprednate)<br>FLAREX (fluorometholone)<br>FML (fluorometholone)<br>FML FORTE (fluorometholone)<br>FML S.O.P. (fluorometholone)<br>ILEVRO (nepafenac)<br>LOTEMAX DROPS, OINTMENT (loteprednol)<br>LOTEMAX GEL (loteprednol)<br>MAXIDEX (dexamethasone)<br>NEVANAC (nepafenac)<br>OMNIPRED (prednisolone)<br>OZURDEX (dexamethasone)<br>PRED FORTE (prednisolone)<br>PRED MILD (prednisolone)<br>prednisolone sodium phosphate<br>PROLENSA (bromfenac)<br>RETISERT (fluocinolone)<br>TRISENCE (triamcinolone)<br>VEXOL (rimexolone) | 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.                  |



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|--------------------------------------|--|---|--|--|
|                                      |  | XIBROM (bromfenac)  |  |  |
| <b>OPHTHALMICS, GLAUCOMA AGENTS</b>  |  |   |  |  |
| <b>COMBINATION AGENTS</b>            |  |   |  |  |
|                                      | COMBIGAN (brimonidine/timolol)<br>dorzolamide/timolol<br>SIMBRINZA (brinzolamide/brimonidine)  | COSOPT (dorzolamide/timolol)<br>COSOPT PF (dorzolamide/timolol)   | A non-preferred agent will only be authorized if there is an allergy to the preferred agents.  |  |
| <b>BETA BLOCKERS</b>                 |  |   |  |  |
|                                      | BETOPTIC S (betaxolol)<br>carteolol<br>levobunolol<br>metipranolol<br>timolol                  | BETAGAN (levobunolol)<br>betaxolol<br>BETIMOL (timolol)<br>ISTALOL (timolol)<br>OPTIPRANOLOL (metipranolol)<br>TIMOPTIC (timolol) |  |  |
| <b>CARBONIC ANHYDRASE INHIBITORS</b> |  |   |  |  |
|                                      | AZOPT (brinzolamide)<br>dorzolamide  | TRUSOPT (dorzolamide)   |  |  |
| <b>PARASYMPATHOMIMETICS</b>          |  |   |  |  |
|                                      | ISOPTO CARBACHOL (carbachol)<br>PHOSPHOLINE IODIDE (echothiophate iodide)                      | pilocarpine   |  |  |
| <b>PROSTAGLANDIN ANALOGS</b>         |  |   |  |  |
|                                      | latanoprost<br>TRAVATAN-Z (travoprost)   | LUMIGAN (bimatoprost)<br>RESCULA (unoprostone)<br>travoprost<br>XALATAN (latanoprost)<br>ZIOPTAN (tafluprost)                     |  |  |
| <b>SYMPATHOMIMETICS</b>              |  |   |  |  |
|                                      | ALPHAGAN P 0.15% Solution (brimonidine)<br>brimonidine 0.2%                                    | ALPHAGAN P 0.1% Solution (brimonidine)<br>apraclonidine<br>brimonidine 0.15%<br>IOPIDINE (apraclonidine)                          |  |  |
| <b>OPIATE DEPENDENCE TREATMENTS</b>  |  |   |  |  |
|                                      | SUBOXONE FILM<br>(buprenorphine/naloxone) <sup>CL</sup><br>VIVITROL (naltrexone) <sup>CL</sup> | SUBOXONE TABLETS<br>(buprenorphine/naloxone)<br>buprenorphine/naloxone tablets<br>ZUBSOLV (buprenorphine/naloxone)                | As of 9/1/12, West Virginia law requires any practitioner prescribing or dispensing a combination of buprenorphine and naloxone (Suboxone) for opioid addiction shall prescribe or dispense the drug |  |



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|  |   |   | <p>in the form of a sublingual film, unless clinically contraindicated.</p> <p>Suboxone PA criteria is available at <a href="http://www.dhhr.wv.gov/bms/Pharmacy/Pages/pac.aspx">http://www.dhhr.wv.gov/bms/Pharmacy/Pages/pac.aspx</a></p> <p>Vivitrol PA criteria is available at <a href="http://www.dhhr.wv.gov/bms/Pharmacy/Pages/pac.aspx">http://www.dhhr.wv.gov/bms/Pharmacy/Pages/pac.aspx</a></p> |
| <b>OTIC ANTIBIOTICS<sup>AP</sup></b>                             |   |   |   |
|  | CIPRODEX (ciprofloxacin/dexamethasone)*<br>COLY-MYCIN S (colistin/hydrocortisone/neomycin/thonzonium bromide)<br>CORTISPORIN SOLUTION (neomycin/polymyxin/HC)<br>neomycin/polymyxin/HC solution/suspension<br>ofloxacin | ciprofloxacin<br>CIPRO HC (ciprofloxacin/hydrocortisone)<br>CETRAXAL 0.2% SOLUTION (ciprofloxacin)<br>CORTISPORIN-TC (colistin/hydrocortisone/neomycin)<br>FLOXIN (ofloxacin) | <p>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.</p> <p>*Ciprodex is limited to patients up to nine (9) years of age. Age exceptions will be handled on a case-by-case basis.</p>  |
| <b>PAH AGENTS – ENDOTHELIN RECEPTOR ANTAGONISTS<sup>CL</sup></b> |   |   |   |
|  | LETAIRIS (ambrisentan)<br>TRACLEER (bosentan)   | OPSUMIT (macitentan)  | Letairis and Tracleer will be authorized for a diagnosis of pulmonary arterial hypertension (PAH).  |
| <b>PAH AGENTS – GUANYLATE CYCLASE STIMULATOR<sup>CL</sup></b>    |   |   |   |
|  |   | ADEMPAS (riociguat)   | 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.  |
| <b>PAH AGENTS – PDE5s<sup>CL</sup></b>                           |   |   |   |
|  | sildenafil  | ADCIRCA (tadalafil)<br>REVATIO IV (sildenafil)<br>REVATIO TABLETS (sildenafil)  | <p>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.</p> <p>Patients stabilized on non-preferred</p>   |



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|--|---|---|--|
|  |   |   | agents will be grandfathered.  |
| <b>PAH AGENTS – PROSTACYCLINS<sup>CL</sup></b> |   |   |  |
|  | epoprostenol<br>VENTAVIS (iloprost)*  | FLOLAN (epoprostenol)<br>REMODULIN (treprostinil sodium)<br>TYVASO (treprostinil)<br>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,<br><br>*Ventavis will only be authorized for the treatment of pulmonary artery hypertension (WHO Group 1) in patients with NYHA Class III or IV symptoms. |
| <b>PANCREATIC ENZYMES<sup>AP</sup></b>         |   |   |  |
|  | CREON<br>PANCRELIPASE 5000<br>ZENPEP  | PANCREAZE<br>PERTZYE<br>ULTRESA<br>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.<br><br>Non-preferred agents will be authorized for members with cystic fibrosis.  |
| <b>PHOSPHATE BINDERS<sup>AP</sup></b>          |   |   |  |
|  | calcium acetate<br>MAGNEBIND RX (calcium carbonate, folic acid, magnesium carbonate)<br>PHOSLYRA (calcium acetate)<br>RENAGEL (sevelamer) | ELIPHOS (calcium acetate)<br>FOSRENOL (lanthanum)<br>PHOSLO (calcium acetate)<br>REVELA (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.   |
| <b>PLATELET AGGREGATION INHIBITORS</b>         |   |   |  |
|  | AGGRENOX (dipyridamole/ASA)<br>BRILINTA (ticagrelor)<br>clopidogrel   | dipyridamole<br>EFFIENT (prasugrel)<br>PERSANTINE (dipyridamole)<br>PLAVIX (clopidogrel)<br>TICLID (ticlopidine)<br>ticlopidine | 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.   |
| <b>PROGESTINS FOR CACHEXIA</b>                 |   |   |  |



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|--|--|---|---|
|  | megestrol  | MEGACE (megestrol)<br>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.  |
| <b>PROTON PUMP INHIBITORS<sup>AP</sup></b> |  |   |   |
|  | omeprazole (Rx)<br>pantoprazole<br>PREVACID SOLUTABS (lansoprazole)* | ACIPHEX (rabeprazole)<br>ACIPHEX SPRINKLE (rabeprazole)<br>DEXILANT (dexlansoprazole)<br>esomeprazole strontium<br>lansoprazole Rx<br>NEXIUM (esomeprazole)<br>omeprazole/sodium bicarbonate (Rx)<br>PREVACID CAPSULES (lansoprazole)<br>PRILOSEC Rx (omeprazole)<br>PROTONIX (pantoprazole)<br>rabeprazole<br>ZEGERID Rx (omeprazole/sodium bicarbonate) | Sixty (60) day trials of each of the preferred agents, inclusive of a concurrent thirty (30) day trial at the maximum dose of an H <sub>2</sub> antagonist are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present<br><br>*Prior authorization is required for Prevacid Solutabs for members eight (8) years of age or older. |
| <b>SEDATIVE HYPNOTICS<sup>AP</sup></b>     |  |   |   |
| <b>BENZODIAZEPINES</b>                     |  |   |   |
|  | temazepam 15, 30 mg  | DALMANE (flurazepam)<br>DORAL (quazepam)<br>estazolam<br>flurazepam<br>HALCION (triazolam)<br>quazepam<br>RESTORIL (temazepam)<br>temazepam 7.5, 22.5 mg<br>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 is present.  |
| <b>OTHERS</b>                              |  |   |   |
|  | zolpidem 5, 10 mg  | AMBIEN (zolpidem)<br>AMBIEN CR (zolpidem)<br>chloral hydrate<br>EDLUAR (zolpidem)<br>INTERMEZZO (zolpidem)<br>LUNESTA (eszopiclone)<br>ROZEREM (ramelteon)<br>SILENOR (doxepin)<br>SOMNOTE (chloral hydrate)<br>SONATA (zaleplon)<br>zaleplon   | 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.<br><br>For treatment naïve patients, zolpidem and zolpidem ER maximum dosages will be limited to 5 mg and 6.25 mg respectively per day for females.  |



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|--|--|--|---|
|  |  | zolpidem ER 6.25, 12.5 mg<br>ZOLPIMIST (zolpidem)  |   |
| <b>SKELETAL MUSCLE RELAXANTS<sup>AP</sup></b>              |  |  |   |
| <b>ACUTE MUSCULOSKELETAL RELAXANT AGENTS</b>               |  |  |   |
|  | chlorzoxazone<br>cyclobenzaprine IR 5, 10 mg<br>methocarbamol  | AMRIX (cyclobenzaprine)<br>carisoprodol<br>carisoprodol/ASA<br>carisoprodol/ASA/codeine<br>cyclobenzaprine ER<br>cyclobenzaprine IR 7.5 mg<br>FEXMID (cyclobenzaprine)<br>FLEXERIL (cyclobenzaprine)<br>LORZONE (chlorzoxazone)<br>metaxalone<br>orphenadrine<br>orphenadrine/ASA/caffeine<br>PARAFON FORTE (chlorzoxazone)<br>ROBAXIN (methocarbamol)<br>SKELAXIN (metaxalone)<br>SOMA (carisoprodol) | <p>Thirty (30) day trials of the preferred acute musculoskeletal relaxants are required before a non-preferred acute musculoskeletal agent will be authorized, with the exception of carisoprodol.</p> <p>Thirty (30) day trials of the preferred acute musculoskeletal relaxants and Skelaxin are required before carisoprodol will be authorized.</p> |
| <b>MUSCULOSKELETAL RELAXANT AGENTS USED FOR SPASTICITY</b> |  |  |   |
|  | baclofen<br>tizanidine tablets   | DANTRIUM (dantrolene)<br>dantrolene<br>tizanidine capsules<br>ZANAFLEX (tizanidine)  | Thirty (30) day trials of both preferred skeletal muscle relaxants associated with the treatment of spasticity are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.   |
| <b>STEROIDS, TOPICAL</b>                                   |  |  |   |
| <b>VERY HIGH &amp; HIGH POTENCY</b>                        |  |  |   |
|  | betamethasone dipropionate cream, lotion<br>betamethasone valerate cream<br>clobetasol propionate<br>cream/gel/ointment/solution<br>clobetasol emollient<br>fluocinonide cream, gel, solution<br>fluocinonide/emollient<br>halobetasol propionate<br>triamcinolone acetonide cream, ointment | amcinonide<br>APEXICON (diflorasone diacetate)<br>APEXICON E (diflorasone diacetate)<br>betamethasone dipropionate gel, lotion,<br>ointment<br>betamethasone valerate lotion, ointment,<br>clobetasol lotion, shampoo<br>clobetasol propionate foam<br>CLOBEX (clobetasol propionate)<br>CORMAX (clobetasol propionate)<br>desoximetasone cream/gel/ointment   | 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.  |



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|                        |  | diflorasone diacetate<br>DIPROLENE (betamethasone dipropionate/propylene glycol)<br>DIPROLENE AF (betamethasone dipropionate/propylene glycol)<br>DIPROSONE (betamethasone dipropionate)<br>fluocinonide ointment<br>halcinonide<br>HALAC (halobetasol propionate)<br>HALOG (halcinonide)<br>HALONATE (halobetasol propionate)<br>KENALOG (triamcinolone acetonide)<br>LIDEX (fluocinonide)<br>LIDEX-E (fluocinonide)<br>OLUX (clobetasol propionate)<br>OLUX-E (clobetasol propionate/emollient)<br>PSORCON (diflorasone diacetate)<br>TEMOVATE (clobetasol propionate)<br>TEMOVATE-E (clobetasol propionate/emollient)<br>TOPICORT CREAM, GEL, OINTMENT (desoximetasone)<br>TOPICORT SPRAY (desoximetasone)<br>triamcinolone acetonide lotion<br>ULTRAVATE (halobetasol propionate)<br>ULTRAVATE PAC cream<br>ULTRAVATE X (halobetasol propionate / lactic acid)<br>VANOS (fluocinonide) |             |
| <b>MEDIUM POTENCY</b>  |  |  |             |
|                        | fluticasone propionate cream, ointment<br>hydrocortisone butyrate ointment, solution<br>hydrocortisone valerate<br>mometasone furoate<br>triamcinolone acetonide 0.025% and 0.1% cream | ARISTOCORT (triamcinolone)<br>BETA-VAL (betamethasone valerate)<br>betamethasone valerate foam<br>CLODERM (clocortolone pivalate)<br>CORDRAN/CORDRAN SP (flurandrenolide)<br>CUTIVATE (fluticasone propionate)<br>DERMATOP (prednicarbate)<br>ELOCON (mometasone furoate)<br>fluocinolone acetonide cream, ointment, solution<br>fluticasone propionate lotion<br>hydrocortisone butyrate cream<br>LOCOID (hydrocortisone butyrate)  |             |



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|                                      |  | LOCOID LIPOCREAM (hydrocortisone butyrate/emollient)<br>LUXIQ (betamethasone valerate)<br>MOMEXIN (mometasone)<br>PANDEL (hydrocortisone probutate) prednicarbate<br>TOPICORT LP (desoximetasone)<br>TRIDERM (triamcinolone acetonide)<br>WESTCORT (hydrocortisone valerate)   |   |
| <b>LOW POTENCY</b>                   |  |  |   |
|                                      | desonide cream, ointment<br>fluocinolone oil<br>hydrocortisone acetate (Rx, OTC)<br>hydrocortisone cream (Rx, OTC)<br>hydrocortisone lotion OTC<br>hydrocortisone ointment (Rx, OTC)<br>hydrocortisone solution OTC<br>hydrocortisone-aloe cream OTC<br>hydrocortisone-aloe ointment OTC | ACLOVATE (acclometasone dipropionate)<br>acclometasone dipropionate<br>AQUA GLYCOLIC HC (hydrocortisone)<br>CAPEX (fluocinolone acetonide)<br>DERMA-SMOOTHIE FS (fluocinolone acetonide)<br>DESONATE (desonide)<br>desonide lotion<br>DESOWEN (desonide)<br>hydrocortisone/mineral oil/petrolatum<br>hydrocortisone acetate/urea<br>hydrocortisone lotion<br>hydrocortisone/aloe gel<br>LOKARA (desonide)<br>PEDIADERM HC (hydrocortisone)<br>PEDIADERM TA (hydrocortisone)<br>SCALPICIN OTC (hydrocortisone)<br>SYNALAR (fluocinolone)<br>TEXACORT (hydrocortisone)<br>VERDESO (desonide) |   |
| <b>STIMULANTS AND RELATED AGENTS</b> |  |  |   |
| <b>AMPHETAMINES</b>                  |  |  |   |
|                                      | amphetamine salt combination IR<br>dextroamphetamine<br>PROCENTRA solution (dextroamphetamine)<br>VYVANSE (lisdexamfetamine)   | ADDERALL (amphetamine salt combination)<br>ADDERALL XR* (amphetamine salt combination)<br>amphetamine salt combination ER<br>DESOXYN (methamphetamine)<br>DEXEDRINE (dextroamphetamine)<br>dextroamphetamine ER<br>dextroamphetamine solution<br>DEXTROSTAT (dextroamphetamine)<br>methamphetamine   | A PA is required for adults eighteen (18) years of age or older.<br><br>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 |



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|                        |   | ZENZEDI (dextroamphetamine)  | <p>agent in each class is required before a non-preferred long-acting stimulant will be authorized.</p> <p>Thirty (30) day trials of at least three (3) antidepressants are required before amphetamines will be authorized for depression.</p> <p>*Adderall XR is preferred over its generic equivalents.</p>  |
| <b>NON-AMPHETAMINE</b> |   |  |   |
|                        | clonidine<br>DAYTRANA (methylphenidate)<br>FOCALIN (dexmethylphenidate)<br>FOCALIN XR (dexmethylphenidate)<br>guanfacine<br>METADATE CD (methylphenidate)<br>methylphenidate<br>methylphenidate ER (generic Concerta, Ritalin SR, Metadate ER, Methylin ER)<br>STRATTERA (atomoxetine)* | clonidine ER<br>CONCERTA (methylphenidate)<br>dexmethylphenidate<br>dexmethylphenidate XR<br>INTUNIV (guanfacine extended-release) **<br>KAPVAY (clonidine extended-release)**<br>METHYLIN CHEWABLE TABLETS, SOLUTION (methylphenidate)<br>methylphenidate solution<br>methylphenidate CD<br>methylphenidate ER (generic Ritalin LA)<br>modafinil<br>NUVIGIL (armodafinil)<br>pemoline<br>PROVIGIL (modafinil) ***<br>QUILLIVANT XR (methylphenidate)<br>RITALIN (methylphenidate)<br>RITALIN LA (methylphenidate)<br>RITALIN SR (methylphenidate) | <p>Except for Strattera, PA is required for adults eighteen (18) years of age or older.</p> <p>*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 maximum of 100mg per day.</p> <p>**Intuniv and Kapvay/generic will be authorized if the following criteria are met:</p> <ol style="list-style-type: none"> <li>1. Fourteen (14) day trials of at least one (1) preferred product from the amphetamine and non-amphetamine class <b>and</b></li> <li>2. A fourteen (14) day trial of Strattera <b>and</b></li> <li>3. 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.</li> </ol> <p>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</p> |



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|                                    |   |   | <p>clonidine (for Kapvay) will be required for approval.</p> <p>***Provigil will only be authorized for patients sixteen (16) years of age or older with a diagnosis of narcolepsy.</p> <p>Patients stabilized on non-preferred agents will be grandfathered.</p>  |
| <b>TETRACYCLINES</b> <sup>AP</sup> |   |   |  |
|                                    | <p>doxycycline hyclate capsules, tablets<sup>CL</sup><br/>doxycycline monohydrate tablet<sup>CL</sup><br/>minocycline capsules<br/>tetracycline</p> | <p>ADOXA (doxycycline monohydrate)<sup>CL</sup><br/>demeclocycline*<br/>DORYX (doxycycline hyclate)<sup>CL</sup><br/>doxycycline hyclate tablet DR<sup>CL</sup><br/>doxycycline monohydrate capsule<sup>CL</sup><br/>doxycycline monohydrate suspension<sup>CL</sup><br/>DYNACIN (minocycline)<br/>MINOCIN (minocycline)<br/>minocycline ER capsules<br/>minocycline tablets<br/>MONODOX (doxycycline monohydrate)<sup>CL</sup><br/>MORGIDOX KIT (doxycycline)<sup>CL</sup><br/>ORACEA (doxycycline monohydrate)<sup>CL</sup><br/>SOLODYN (minocycline)<br/>VIBRAMYCIN CAPSULES, SUSPENSION,<br/>SYRUP (doxycycline)<sup>CL</sup></p> | <p>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.</p> <p>*Demeclocycline will be authorized for conditions caused by susceptible strains of organisms designated in the product information supplied by the manufacturer. A C&amp;S report must accompany this request.<br/>*Demeclocycline will also be authorized for SIADH.</p> <p>As per the CDC Health Advisory from 6/12/13 on the nationwide shortage of doxycycline,</p> |



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|   |  |  | doxycycline will only be authorized for any one of the following: <ol style="list-style-type: none"> <li>1. Treatment of Rickettsial infection (or suspected Rickettsial infection) <b>or</b></li> <li>2. Prophylaxis of Lyme Disease <b>or</b></li> <li>3. Treatment of Lyme Disease in patients with known penicillin/cephalosporin allergy <b>or</b></li> <li>4. Prophylaxis and treatment of malaria <b>or</b></li> <li>5. Treatment of STDs in patients with trial and failure, contraindication, drug-drug interaction to alternative therapies.</li> </ol> |  |
| <b>ULCERATIVE COLITIS AGENTS<sup>AP</sup></b> |  |  |   |  |
| <b>ORAL</b>                                   |  |  |   |  |
|   | APRISO (mesalamine)<br>balsalazide<br>DELZICOL (mesalamine)<br>PENTASA (mesalamine) 250mg<br>sulfasalazine | ASACOL HD (mesalamine)<br>AZULFIDINE (sulfasalazine)<br>COLAZAL (balsalazide)<br>DIPENTUM (olsalazine)<br>GIAZO (balsalazide)<br>LIALDA (mesalamine)<br>PENTASA (mesalamine) 500mg | 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.   |  |
| <b>RECTAL</b>                                 |  |  |   |  |
|   | CANASA (mesalamine)<br>mesalamine  | mesalamine kit<br>ROWASA (mesalamine)<br>SF ROWASA (mesalamine)  |   |  |
| <b>VASODILATORS, CORONARY</b>                 |  |  |   |  |
| <b>SUBLINGUAL NITROGLYCERIN</b>               |  |  |   |  |
|   | nitroglycerin sublingual<br>NITROLINGUAL SPRAY (nitroglycerin)<br>NITROSTAT SUBLINGUAL (nitroglycerin)     | nitroglycerin spray<br>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.  |  |