- 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.

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

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ACNE AGENTS (Topical)[AP]			
	ANTI-INFECTIVE		
	AZELEX (azelaic acid) clindamycin gel, lotion, medicated swab, solution erythromycin gel, solution sulfacetamide suspension	ACZONE (dapsone) AKNE-MYCIN (erythromycin) CLEOCIN-T (clindamycin) CLINDACIN PAC (clindamycin) CLINDAGEL (clindamycin) clindamycin foam erythromycin medicated swab EVOCLIN (clindamycin) KLARON (sulfacetamide) OVACE/PLUS (sulfacetamide) sulfacetamide cleanser	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. (In cases of pregnancy, a trial of retinoids will not be required.)
	RETINOIDS		
	TAZORAC (tazarotene) tretinoin cream, gel	adapalene ATRALIN (tretinoin) AVITA (tretinoin) DIFFERIN (adapalene) RETIN-A (tretinoin) RETIN A MICRO (tretinoin) tretinoin gel micro[NR]	PA required for members eighteen (18) years of age or older for tretinoin products.
	KERATOLYTICS		
	benzoyl peroxide cleanser Rx & OTC, 10% cream OTC, gel Rx & OTC, lotion OTC, wash OTC	BENZEFOAM (benzoyl peroxide) BENZEFOAM ULTRA (benzoyl peroxide) BENZEPRO (benzoyl peroxide) benzoyl peroxide cloths, medicated pads, microspheres cleanser BP 10-1 (benzoyl peroxide) DELOS (benzoyl peroxide) DESQUAM-X (benzoyl peroxide) LAVOCLEN (benzoyl peroxide) PACNEX/HP/LP (benzoyl peroxide) PANOXYL-4, -8 OTC (benzoyl peroxide) PERSA-GEL OTC (benzoyl peroxide) SASTID (sulfur) SULPHO-LAC (sulfur)	Acne kits are non-preferred.
	COMBINATION AGENTS		

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

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			members up to forty-five (45) years of age if there is no diagnosis of Alzheimer's disease. Aricept 23mg tablets will be approved when there is a diagnosis of moderate-to-severe Alzheimer's Disease, a trial of donepezil 10mg daily for at least three (3) months, and donepezil 20mg daily for an additional one (1) month.
	NMDA RECEPTOR ANTAGONIST		
	NAMENDA (memantine)	NAMENDA XR (memantine)[NR]	
ANALGESICS, NARCOTIC - SHORT ACTING (Non-parenteral)[AP]			
	APAP/codeine butalbital/APAP/caffeine/codeine codeine hydrocodone/APAP hydrocodone/ibuprofen hydromorphone tablets morphine oxycodone oxycodone/APAP oxycodone/ASA pentazocine/APAP pentazocine/naloxone ROXICET SOLUTION (oxycodone/ acetaminophen) ROXICODONE TABLETS (oxycodone) tramadol tramadol/APAP	ABSTRAL (fentanyl) ACTIQ (fentanyl) butalbital/ASA/caffeine/codeine butorphanol CAPITAL W/CODEINE (APAP/codeine) DEMEROL (meperidine) dihydrocodeine/ APAP/caffeine DILAUDID (hydromorphone) fentanyl FENTORA (fentanyl) FIORICET W/ CODEINE (butalbital/APAP/caffeine/codeine) FIORINAL W/ CODEINE (butalbital/ASA/caffeine/codeine) hydromorphone liquid hydromorphone suppositories LAZANDA (fentanyl) levorphanol LORCET (hydrocodone/APAP) LORTAB (hydrocodone/APAP) MAXIDONE ((hydrocodone/APAP) MAGNACET (oxycodone/APAP) Meperidine NORCO (hydrocodone/APAP) NUCYNTA (tapentadol) ONSOLIS (fentanyl) OPANA (oxymorphone)	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. Fentanyl lozenges and Onsolis will only be approved for a diagnosis of cancer and as an adjunct to a long-acting agent. Neither will be approved for monotherapy. **Limits:** Unless the patient has escalating cancer pain or another diagnosis supporting increased quantities of short-acting opioids, all short acting solid forms of the narcotic analgesics are limited to 120 tablets per thirty (30) days for the purpose of maximizing the use of longer acting medications to prevent unnecessary breakthrough pain in chronic pain therapy.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		OXECTA (oxycodone) oxycodone/ASA oxycodone/ibuprofen OXYIR (oxycodone) oxymorphone PERCOCET (oxycodone/APAP) PERCODAN (oxycodone/ASA) PRIMLEV (oxycodone/APAP) REPREXAIN (hydrocodone/ibuprofen) RYBIX ODT (tramadol) SUBSYS (fentanyl) SYNALGOS-DC (dihydrocodeine/ASA/ caffeine) TREZIX (dihydrocodeine/ APAP/caffeine) TYLENOL W/CODEINE (APAP/codeine) TYLOX (oxycodone/APAP) ULTRACET (tramadol/APAP) ULTRAM (tramadol) VICODIN (hydrocodone/APAP) VICOPROFEN (hydrocodone/ibuprofen) VOPAC (codeine/acetaminophen) XODOL (hydrocodone/acetaminophen) XOLOX (oxycodone/APAP) ZAMICET (hydrocodone/APAP) ZYDONE (hydrocodone/acetaminophen)	Immediate-release tramadol is limited to 240 tablets per thirty (30) days.
ANALGESICS, NARCOTIC - LONG ACTING (Non-parenteral)[AP]			
	fentanyl transdermal methadone morphine ER tablets	AVINZA (morphine) BUTRANS (buprenorphine) CONZIP ER (tramadol) DOLOPHINE (methadone) DURAGESIC (fentanyl) EXALGO ER (hydromorphone) EMBEDA (morphine/naltrexone) KADIAN (morphine) morphine ER capsules MS CONTIN (morphine) NUCYNTA ER (tapentadol) OPANA ER (oxymorphone) ORAMORPH SR (morphine) oxycodone ER OXYCONTIN (oxycodone) oxymorphone ER	Six (6) day trials each of two (2) preferred unique long acting chemical entities are required before a non-preferred agent will be approved unless one (1) of the exceptions on the PDL form is present. The generic form of the requested non-preferred agent, if available, must be tried before the non-preferred agent will be approved. Butrans will be approved if the following criteria are met: 1. Diagnosis of moderate to severe chronic pain requiring

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		RYZOLT ER (tramadol) tramadol ER ULTRAM ER (tramadol)	continuous around-the-clock analgesia **and** 2. Patient cannot take oral medications and has a diagnosis of chronic pain **and** 3. Needs analgesic medication for an extended period of time **and** 4. Has had a previous trial** of a non-opioid analgesic medication **and** 5. Previous trial of one (1) opioid medication** **and** 6. Current total daily opioid dose is ≤ 80mg morphine equivalents daily or dose of transdermal fentanyl is ≤ 12.5mcg/hr **and** 7. Patient is not currently being treated with buprenorphine. **Requirement is waived for patients who cannot swallow **Exception:** Oxycodone ER and oxymorphone ER will be authorized without a trial of the preferred agents if a diagnosis of cancer is submitted.
ANALGESICS (Topical)[AP]			
	lidocaine lidocaine/prilocaine xylocaine	EMLA (lidocaine/prilocaine) FLECTOR PATCH (diclofenac) LIDAMANTLE (lidocaine) LIDAMANTLE HC (lidocaine/hydrocortisone) LIDORX (lidocaine)[NR] PENNSAID (diclofenac) SYNERA (lidocaine/tetracaine) VOLTAREN GEL (diclofenac)	Ten (10) day trials of each of the preferred topical anesthetics (lidocaine, lidocaine/prilocaine, and xylocaine) are required before a non-preferred topical anesthetic will be approved unless one (1) of the exceptions on the PA form is present. Thirty (30) day trials of each of the preferred oral NSAIDS and capsaicin are required before Voltaren Gel will be approved unless one (1) of the exceptions on

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			the PA form is present. Flector patches will be approved only for a diagnosis of acute strain, sprain or injury after a five (5) day trial of one (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.
ANDROGENIC AGENTS			
	ANDRODERM (testosterone) ANDROGEL (testosterone)	AXIRON (testosterone) FORTESTA (testosterone) TESTIM (testosterone)	The non-preferred agents will be approved only if one (1) of the exceptions on the PA form is present.
ANGIOTENSIN MODULATORS[AP]			
	ACE INHIBITORS		
	benazepril captopril enalapril fosinopril lisinopril quinapril ramipril	ACCUPRIL (quinapril) ACEON (perindopril) ALTACE (ramipril) LOTENSIN (benazepril) MAVIK (trandolapril) moexipril perindopril PRINIVIL (lisinopril) trandolapril UNIVASC (moexipril) VASOTEC (enalapril) ZESTRIL (lisinopril)	Fourteen (14) day trials of each of the preferred agents in the corresponding group, with the exception of the Direct Renin Inhibitors, are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.
	ACE INHIBITOR COMBINATION DRUGS		
	benazepril/amlodipine benazepril/HCTZ captopril/HCTZ enalapril/HCTZ fosinopril/HCTZ lisinopril/HCTZ quinapril/HCTZ	ACCURETIC (quinapril/HCTZ) CAPOZIDE (captopril/HCTZ) LOTENSIN HCT (benazepril/HCTZ) LOTREL (benazepril/amlodipine) moexipril/HCTZ PRINZIDE (lisinopril/HCTZ) TARKA (trandolapril/verapamil)	

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		trandolapril/verapamil UNIRETIC (moexipril/HCTZ) VASERETIC (enalapril/HCTZ) ZESTORETIC (lisinopril/HCTZ)	
	ANGIOTENSIN II RECEPTOR BLOCKERS (ARBs)		
	BENICAR (olmesartan) DIOVAN (valsartan) irbesartan losartan MICARDIS (telmisartan)	ATACAND (candesartan) AVAPRO (irbesartan) candesartan^{NR} COZAAR (losartan) EDARBI (azilsartan) eprosartan TEVETEN (eprosartan)	
	ARB COMBINATIONS		
	BENICAR-HCT (olmesartan/HCTZ) DIOVAN-HCT (valsartan/HCTZ) EXFORGE (valsartan/amlodipine) EXFORGE HCT (valsartan/amlodipine/HCTZ) irbesartan/HCTZ losartan/HCTZ MICARDIS-HCT (telmisartan/HCTZ)	ATACAND-HCT (candesartan/HCTZ) AVALIDE (irbesartan/HCTZ) AZOR (olmesartan/amlodipine) candesartan/HCTZ EDARBYCLOR (azilsartan/chlorthalidone) HYZAAR (losartan/HCTZ) TEVETEN-HCT (eprosartan/HCTZ) TRIBENZOR (olmesartan/amlodipine/HCTZ) TWYNSTA (telmisartan/amlodipine) valsartan/HCTZ	
	DIRECT RENIN INHIBITORS		
		AMTURNIDE (aliskiren/amlodipine/HCTZ) TEKAMLO (aliskiren/amlodipine) TEKTURNA (aliskiren) TEKTURNA HCT (aliskiren/HCTZ) VALTURNA (aliskiren/valsartan)	A thirty (30) day trial of one (1) preferred ACE, ARB, or combination agents, at the maximum tolerable dose, is required before Tekturna will be approved. Tekturna HCT, Valturna, Tekamlo or Amturnide will be approved if the criteria for Tekturna are met and the patient also needs the other agents in the combination.
ANTIBIOTICS, GI			
	metronidazole tablet NEO-FRADIN (neomycin) neomycin	ALINIA (nitazoxanide) DIFICID (fidaxomicin) FLAGYL (metronidazole)	A fourteen (14) day trial of a corresponding generic preferred agent is required before a non-

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	TINDAMAX (tinidazole)	FLAGYL ER (metronidazole ER) metronidazole capsule paromomycin[NR] tinidazole VANCOCIN (vancomycin) vancomycin XIFAXAN (rifaximin)	preferred brand agent will be approved. Dificid will be approved if: 1. There is a diagnosis of severe *C. difficile* infection **and** 2. There is no response to prior treatment with vancomycin for ten (10) to fourteen (14) days. Xifaxan 200mg will be approved for traveler's diarrhea if 1) there is a diagnosis of *E. coli* diarrhea, 2) patient is from twelve (12) up to eighteen (18) years of age, or is eighteen (18) years of age or older and has failed a ten (10) day trial of ciprofloxacin. Xifaxan 550mg will be approved for hepatic encephalopathy if: 1. There is a diagnosis of hepatic encephalopathy **and** 2. Patient is eighteen (18) years of age or older, **and** 3. Patient has a history of and current treatment with lactulose. Vancocin will be approved after a fourteen (14) day trial of metronidazole for *C. difficile* infections of mild to moderate severity unless one (1) of the exceptions on the PA form is present. Vancocin will be approved for severe *C. difficile* infections with no previous trial of metronidazole.
ANTIBIOTICS, INHALED			

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	TOBI (tobramycin)	CAYSTON (aztreonam) TOBI PODHALER[NR]	A twenty-eight (28) day trial of the preferred agent is required before the non-preferred agent will be approved unless one (1) of the exceptions on the PA form is present.
ANTICOAGULANTS			
	INJECTABLE[CL]		
	FRAGMIN (dalteparin) LOVENOX (enoxaparin)	ARIXTRA (fondaparinux) enoxaparin fondaparinux INNOHEP (tinzaparin)	Trials of each of the preferred agents will be required before a non-preferred agent will be approved unless one (1) of the exceptions on the PA form is present.
	ORAL		
	COUMADIN (warfarin) PRADAXA (dabigatran)[AP] warfarin XARELTO (rivaroxaban)[AP]	ELIQUIS (apixaban)[NR]	Pradaxa will be approved for the diagnosis of non-valvular atrial fibrillation. Xarelto will be approved for the following diagnoses: 1. Non-valvular atrial fibrillation **or** 2. Deep vein thrombosis (DVT), pulmonary embolism (PE), and reduction in risk of recurrence of DVT and PE **or** 3. DVT prophylaxis if treatment is limited to thirty-five (35) days for hip replacement surgeries or twelve (12) days for knee replacement surgeries.
ANTICONVULSANTS			
	ADJUVANTS		
	carbamazepine carbamazepine ER carbamazepine XR CARBATROL (carbamazepine) DEPAKOTE SPRINKLE (divalproex) divalproex divalproex ER	BANZEL(rufinamide) DEPAKENE (valproic acid) DEPAKOTE (divalproex) DEPAKOTE ER (divalproex) divalproex sprinkle EQUETRO (carbamazepine) FANATREX SUSPENSION (gabapentin)	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

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	EPITOL (carbamazepine) FELBATOL (felbamate) GABITRIL (tiagabine) lamotrigine levetiracetam oxcarbazepine tablets TEGRETOL XR (carbamazepine) topiramate TRILEPTAL SUSPENSION (oxcarbazepine) valproic acid zonisamide	felbamate KEPPRA (levetiracetam) KEPPRA XR (levetiracetam) LAMICTAL (lamotrigine) LAMICTAL CHEWABLE (lamotrigine) LAMICTAL ODT (lamotrigine) LAMICTAL XR (lamotrigine) lamotrigine dose pack lamotrigine ER levetiracetam ER ONFI (clobazam) oxcarbazepine suspension OXTELLAR XR (oxcarbazepine) POTIGA (ezogabine) SABRIL (vigabatrin) STAVZOR (valproic acid) TEGRETOL (carbamazepine) tiagabine TOPAMAX (topiramate) TRILEPTAL TABLETS (oxcarbazepine) VIMPAT (lacosamide) ZONEGRAN (zonisamide)	exceptions on the PA form is present. A thirty (30) day trial of one (1) of the preferred agents in the corresponding group is required for patients with a diagnosis other than seizure disorders unless one (1) of the exceptions on the PA form is present. Non-preferred anticonvulsants will be approved for patients on established therapies with a diagnosis of seizure disorders with no trials of preferred agents required. In situations where AB-rated generic equivalent products are available, “Brand Medically Necessary” must be hand-written by the prescriber on the prescription in order for the brand name product to be reimbursed. Requests for Onfi will be authorized if the following criteria are met: 1. Adjunctive therapy for Lennox-Gastaut **or** 2. Generalized tonic, atonic or myoclonic seizures **and** 3. Previous failure of at least two (2) non-benzodiazepine anticonvulsants and previous failure of clonazepam. (For continuation, prescriber must include information regarding improved response/effectiveness with this medication)

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	BARBITURATES[AP]		
	phenobarbital primidone	MEBARAL (mephobarbital) MYSOLINE (primidone)	
	BENZODIAZEPINES[AP]		
	clonazepam DIASTAT (diazepam rectal) diazepam tablets	clonazepam ODT diazepam rectal gel KLONOPIN (clonazepam)	
	HYDANTOINS[AP]		
	DILANTIN 30mg (phenytoin) PEGANONE (ethotoin) phenytoin capsules, chewable tablets, suspension	DILANTIN (phenytoin) DILANTIN INFATABS (phenytoin) PHENYTEK (phenytoin)	
	SUCCINIMIDES		
	CELONTIN (methsuximide) ethosuximide syrup ZARONTIN (ethosuximide) capsules	ethosuximide capsules ZARONTIN (ethosuximide) syrup	
ANTIDEPRESSANTS, OTHER			
	MAOIs[AP]		
	PARNATE (tranylcypromine) phenelzine	MARPLAN (isocarboxazid) NARDIL (phenelzine) tranylcypromine	A thirty (30) day trial of a preferred agent is required before a non-preferred agent will be approved. Patients stabilized on non-preferred agents will be grandfathered.
	SNRIS[AP]		
	venlafaxine ER capsules	desvenlafaxine ER[NH] EFFEXOR XR (venlafaxine) PRISTIQ (desvenlafaxine) venlafaxine IR VENLAFAXINE ER TABLETS (venlafaxine)	A six (6) week trial each of a preferred agent and an SSRI is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.
	SECOND GENERATION NON-SSRI, OTHER[AP]		
	bupropion IR bupropion SR bupropion XL mirtazapine	APLENZIN (bupropion hbr) EMSAM (selegiline) FORFIVO XL (bupropion) nefazodone	

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	trazodone	OLEPTRO ER (trazodone) REMERON (mirtazapine) WELLBUTRIN (bupropion) WELLBUTRIN SR (bupropion) WELLBUTRIN XL (bupropion) VIIBRYD (vilazodone hcl)	
	SELECTED TCAs		
	imipramine hcl	imipramine pamoate TOFRANIL (imipramine hcl) TOFRANIL PM (imipramine pamoate)	A twelve (12) week trial of imipramine hcl is required before a non-preferred TCA will be authorized.
ANTIDEPRESSANTS, SSRIs[AP]			
	citalopram escitalopram tablets fluoxetine capsules, solution fluvoxamine paroxetine sertraline	CELEXA (citalopram) escitalopram solution fluvoxamine ER[NR] fluoxetine tablets LEXAPRO (escitalopram) LUVOX CR (fluvoxamine) PAXIL (paroxetine) PAXIL CR (paroxetine) paroxetine ER PEXEVA (paroxetine) PROZAC (fluoxetine) SARAFEM (fluoxetine) ZOLOFT (sertraline)	Thirty (30) day trials each of two (2) of the preferred agents are required before a non-preferred agent will be approved unless one (1) of the exceptions on the PA form is present. Upon hospital discharge, patients admitted with a primary mental health diagnosis and have been stabilized on a non-preferred SSRI will receive an authorization to continue that drug.
ANTIEMETICS[AP]			
	5HT3 RECEPTOR BLOCKERS		
	ondansetron ODT, solution, tablets	ANZEMET (dolasetron) granisetron GRANISOL (granisetron) ondansetron vials SANCUSO (granisetron) ZOFRAN (ondansetron) ZUPLENZ (ondansetron)	A three (3) day trial of a preferred agent is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. PA is required for ondansetron when limits are exceeded.
	CANNABINOIDS		
		CESAMET (nabilone) dronabinol MARINOL (dronabinol)	Cesamet will be authorized only for the treatment of nausea and vomiting associated with cancer

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			chemotherapy for patients who have failed to respond adequately to three (3) day trials of conventional treatments such as promethazine or ondansetron and are eighteen (18) years of age or older. Marinol will be authorized only for: 1. The treatment of anorexia associated with weight loss in patients with AIDS or cancer and unresponsive to megestrol **or** 2. The prophylaxis of chemotherapy induced nausea and vomiting unresponsive to three (3) day trials of ondansetron or promethazine for patients from eighteen (18) up to sixty-five (65) years of age.
	SUBSTANCE P ANTAGONISTS		
	EMEND (aprepitant)		
ANTIFUNGALS (Oral)			
	clotrimazole fluconazole* ketoconazole nystatin terbinafine CL	ANCOBON (flucytosine) DIFLUCAN (fluconazole) flucytosine GRIFULVIN V TABLET (griseofulvin) griseofulvin GRIS-PEG (griseofulvin) itraconazole LAMISIL (terbinafine) MYCELEX (clotrimazole) MYCOSTATIN Tablets (nystatin) NIZORAL (ketoconazole) NOXAFIL (posaconazole) ONMEL (itraconazole) NR ORAVIG (miconazole) SPORANOX (itraconazole)	Non-preferred agents will be approved only if one (1) of the exceptions on the PA form is present. *PA is required when limits are exceeded. PA is not required for griseofulvin suspension for children up to six (6) years of age for the treatment of tinea capitis.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		VFEND (voriconazole) voriconazole	
ANTIFUNGALS (Topical)[AP]			
	ANTIFUNGALS		
	econazole ketoconazole cream, shampoo MENTAX (butenafine) miconazole (OTC) NAFTIN CREAM (naftifine) nystatin	CICLODAN (ciclopirox) ciclopirox ERTACZO (sertaconazole) EXELDERM (sulconazole) EXTINA (ketoconazole) ketoconazole foam KETODAN (ketoconazole) LOPROX (ciclopirox) MYCOSTATIN (nystatin) NAFTIN GEL (naftifine) NIZORAL (ketoconazole) OXISTAT (oxiconazole) PEDIPIROX-4 (ciclopirox) PENLAC (ciclopirox) VUSION (miconazole/petrolatum/zinc oxide) XOLEGEL (ketoconazole)	Fourteen (14) day trials of two (2) of the preferred agents are required before one (1) of the non-preferred agents will be authorized unless one (1) of the exceptions on the PA form is present. If a non-preferred shampoo is requested, a fourteen (14) day trial of one (1) preferred product (ketoconazole shampoo) is required. Oxistat cream will be approved for children up to thirteen (13) years of age for tinea corporis, tinea cruris, tinea pedis, and tinea (pityriasis) versicolor.
	ANTIFUNGAL/STEROID COMBINATIONS		
	clotrimazole/betamethasone nystatin/triamcinolone	KETOCON PLUS (ketoconazole/hydrocortisone) LOTRISONE (clotrimazole/betamethasone)[AP]	
ANTIHISTAMINES, MINIMALLY SEDATING[AP]			
	ANTIHISTAMINES		
	cetirizine tablets, solution loratadine	ALLEGRA (fexofenadine) cetirizine chewable tablets CLARINEX (desloratadine) CLARITIN (loratadine) desloratadine desloratadine ODT fexofenadine levocetirizine XYZAL (levocetirizine) 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.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	ANTIHISTAMINE/DECONGESTANT COMBINATIONS		
	cetirizine/pseudoephedrine loratadine/pseudoephedrine SEMPREX-D (acrivastine/ pseudoephedrine)	ALLEGRA-D (fexofenadine/ pseudoephedrine) CLARINEX-D (desloratadine/ pseudoephedrine) CLARITIN-D (loratadine/pseudoephedrine) fexofenadine/ pseudoephedrine ZYRTEC-D (cetirizine/pseudoephedrine)	
ANTIMIGRAINE AGENTS, TRIPTANS[AP]			
	TRIPTANS		
	IMITREX NASAL SPRAY (sumatriptan) IMITREX INJECTION (sumatriptan)[CL] naratriptan sumatriptan tablets	AMERGE (naratriptan) AXERT (almotriptan) FROVA (frovatriptan) IMITREX tablets (sumatriptan) MAXALT (rizatriptan) MAXALT MLT (rizatriptan) RELPAX (eletriptan) rizatriptan rizatriptan ODT sumatriptan nasal spray/injection* SUMAVEL (sumatriptan) zolmitriptan[NR] zolmitriptan ODT[NR] ZOMIG (zolmitriptan) ZOMIG ZMT (zolmitriptan)	Three (3) day trials of each unique chemical entity of the preferred agents are required before a non-preferred agent will be approved unless one (1) of the exceptions on the PA form is present. Quantity limits apply for this drug class. Three (3) day trials of each preferred agent will be required for Imitrex injection. *AP does not apply to nasal spray or injectable sumatriptan.
	TRIPTAN COMBINATIONS		
		TREXIMET (sumatriptan/naproxen sodium)	
ANTIPARKINSON'S AGENTS (Oral)			
	ANTICHOLINERGICS		
	benztropine trihexyphenidyl	COGENTIN (benztropine)	Patients starting therapy on drugs in this class must show a documented allergy to all of the preferred agents, in the corresponding class, before a non-preferred agent will be authorized.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	COMT INHIBITORS		
		COMTAN (entacapone) entacapone TASMAR (tolcapone)	
	DOPAMINE AGONISTS		
	pramipexole ropinirole	MIRAPEX (pramipexole) MIRAPEX ER (pramipexole) NEUPRO (rotigotine) REQUIP (ropinirole) REQUIP XL (ropinirole) ropinirole ER	Mirapex, Mirapex ER, Requip, and Requip XL will be approved for a diagnosis of Parkinsonism with no trials of preferred agents required.
	OTHER ANTIPARKINSON'S AGENTS		
	amantadine[AP] bromocriptine carbidopa/levodopa selegiline STALEVO (levodopa/carbidopa/entacapone)	AZILECT (rasagiline) ELDEPRYL (selegiline) levodopa/carbidopa ODT levodopa/carbidopa/entacapone LODOSYN (carbidopa) PARCOPA (levodopa/carbidopa) PARLODEL (bromocriptine) SINEMET (levodopa/carbidopa) ZELAPAR (selegiline)	Amantadine will be approved only for a diagnosis of Parkinsonism.
ANTIPSYCHOTICS, ATYPICAL			
	SINGLE INGREDIENT		Preferred brands require a fourteen (14) day trial of a preferred generic agent before approval.
	clozapine FANAPT (iloperidone) [AP] INVEGA SUSTENNA (paliperidone)* LATUDA (lurasidone) [AP] quetiapine[AP (25mg Tablet Only)] risperidone SAPHRIS (asenapine)[AP] ziprasidone	ABILIFY (aripiprazole) ABILIFY MAINTENA (aripiprazole)[NR] clozapine ODT CLOZARIL (clozapine) FANAPT TITRATION PACK (iloperidone) FAZACLO (clozapine) GEODON (ziprasidone GEODON IM (ziprasidone) INVEGA (paliperidone) olanzapine olanzapine IM* RISPERDAL (risperidone) RISPERDAL CONSTA (risperidone)*	Non-preferred agents will be approved for treatment naïve patients if the following criteria have been met: 1. A fourteen (14) day trial of a preferred generic agent **and** 2. Two (2) fourteen (14) day trials of additional preferred products unless one (1) of the exceptions on the PA form is present.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		SEROQUEL (quetiapine) SEROQUEL XR (quetiapine) ZYPREXA (olanzapine) ZYPREXA IM (olanzapine)* ZYPREXA RELPREVV (olanzapine)	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. Claims for quetiapine 25mg will be approved: 1. For a diagnosis of schizophrenia **or** 2. For a diagnosis of bipolar disorder **or** 3. When prescribed concurrently with other strengths of Seroquel in order to achieve therapeutic treatment levels. Quetiapine 25mg will not be approved for use as a sedative hypnotic. All antipsychotic agents require prior authorization for children up to six (6) years of age. Abilify will be approved for children from six (6) up to seventeen (17) years of age for irritability associated with autism. Abilify will be prior authorized for MDD if the following criteria are met: 1. The patient is eighteen (18) years of age or older **and** 2. Diagnosis of Major Depressive Disorder (MDD) **and** 3. Evidence of trials of appropriate therapeutic duration (thirty (30) days), at the maximum tolerable dose, of at least one (1) agent in two (2) of the following classes:

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			SSRI, SNRI or bupropion in conjunction with Seroquel at doses of 150mg or more **and** 4. Prescribed in conjunction with an SSRI, SNRI, or bupropion **and** 5. The daily dose does not exceed 15mg *All injectable antipsychotic products require clinical prior authorization and will be approved on a case-by-case basis. Patients stabilized on Invega will be grandfathered. 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 with a call to RDTP.
	ATYPICAL ANTIPSYCHOTIC/SSRI COMBINATIONS		
		olanzapine/fluoxetine SYMBYAX (olanzapine/fluoxetine)	
ANTIVIRALS (Oral)			
	ANTI HERPES		
	acyclovir valacyclovir	famciclovir FAMVIR (famciclovir) VALTREX ZOVIRAX (acyclovir)	Five (5) day trials each of the preferred agents are required before the non-preferred agents will be authorized unless one (1) of the exceptions on the PA form is present.
	ANTI-INFLUENZA		
	RELENZA (zanamivir) TAMIFLU (oseltamivir)	amantadine[AP] FLUMADINE (rimantadine) rimantadine	The anti-influenza agents will be approved only for a diagnosis of influenza.
ANTIVIRALS (Topical) [AP]			

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		ABREVA (docosanol) acyclovir ointment[NR] DENAVIR (penciclovir) ZOVIRAX (acyclovir)	Non-preferred agents will be approved for their FDA indication(s).
ATOPIC DERMATITIS			
	ELIDEL (pimecrolimus)[AP]	PROTOPIC (tacrolimus)	A thirty (30) day trial of a preferred medium or high potency topical corticosteroid is required before coverage of Elidel will be 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.
BETA BLOCKERS (Oral) & MISCELLANEOUS ANTIANGINALS (Oral)[AP]			
	BETA BLOCKERS		
	acebutolol atenolol betaxolol bisoprolol metoprolol metoprolol ER nadolol pindolol propranolol propranolol ER sotalol timolol	BETAPACE (sotalol) BYSTOLIC (nebivolol) CORGARD (nadolol) INDERAL LA (propranolol) INNOPRAN XL (propranolol) KERLONE (betaxolol) LEVATOL (penbutolol) LOPRESSOR (metoprolol) SECTRAL (acebutolol) TENORMIN (atenolol) TOPROL XL (metoprolol) ZEBETA (bisoprolol)	Fourteen (14) day trials each of three (3) chemically distinct preferred agents, including the generic formulation of a requested non-preferred product, are required before one (1) of the non-preferred agents will be approved unless one (1) of the exceptions on the PA form is present.
	BETA BLOCKER/DIURETIC COMBINATION DRUGS		
	atenolol/chlorthalidone bisoprolol/HCTZ metoprolol/HCTZ nadolol/bendroflumethiazide propranolol/HCTZ	CORZIDE (nadolol/bendroflumethiazide) DUTOPROL (metoprolol ER/HCTZ ER) LOPRESSOR HCT (metoprolol/HCTZ) TENORETIC (atenolol/chlorthalidone) ZIAC (bisoprolol/HCTZ)	
	BETA- AND ALPHA-BLOCKERS		
	carvedilol labetalol	COREG (carvedilol) COREG CR (carvedilol) TRANDATE (labetalol)	

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	ANTIANGINALS		
		RANEXA (ranolazine)[AP]	Ranexa will be approved for patients with angina who are also taking a calcium channel blocker, a beta blocker, or a nitrite as single agents or a combination agent containing one (1) of these ingredients.
BLADDER RELAXANT PREPARATIONS[AP]			
	oxybutynin IR oxybutynin ER TOVIAZ (fesoterodine) VESICARE (solifenacin)	DETROL (tolterodine) DETROL LA (tolterodine) DITROPAN XL (oxybutynin) ENABLEX (darifenacin) flavoxate GELNIQUE (oxybutynin) MYRBETRIQ (mirabegron) OXYTROL (oxybutynin) SANCTURA (trospium) SANCTURA XR (trospium) tolterodine trospium trospium ER	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.
BONE RESORPTION SUPPRESSION AND RELATED AGENTS			
	BISPHOSPHONATES		
	alendronate tablets	ACTONEL (risedronate) ACTONEL WITH CALCIUM (risedronate/ calcium) alendronate solution[NR] ATELVIA (risedronate) BINOSTO (alendronate) BONIVA (ibandronate) DIDRONEL (etidronate) etidronate FOSAMAX TABLETS (alendronate) FOSAMAX PLUS D (alendronate/vitamin D) ibandronate	A thirty (30) day trial of the preferred agent is required before a non-preferred agent will be approved.
	OTHER BONE RESORPTION SUPPRESSION AND RELATED AGENTS		
	calcitonin	EVISTA (raloxifene) FORTEO (teriparatide) FORTICAL (calcitonin)	Evista will be approved for postmenopausal women with osteoporosis or at high risk for

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		MIACALCIN (calcitonin)	invasive breast cancer.
BPH AGENTS			
	5-ALPHA-REDUCTASE (5AR) INHIBITORS		
	finasteride	AVODART (dutasteride) CIALIS 5 mg (tadalafil) PROSCAR (finasteride)	Thirty (30) day trials each of at least two (2) chemically distinct preferred agents, including the generic formulation of 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.
	ALPHA BLOCKERS		
	doxazosin tamsulosin terazosin	alfuzosin CARDURA (doxazosin) CARDURA XL (doxazosin) FLOMAX (tamsulosin) HYTRIN (terazosin) RAPAFLO (silodosin) UROXATRAL (alfuzosin)	
	5-ALPHA-REDUCTASE (5AR) INHIBITORS/ALPHA BLOCKER COMBINATION		
		JALYN (dutasteride/tamsulosin)	Thirty (30) day trials of dutasteride and tamsulosin concurrently are required before the non-preferred agent will be approved.
BRONCHODILATORS & RESPIRATORY DRUGS			
	ANTICHOLINERGIC[AP]		
	ATROVENT HFA (ipratropium) ipratropium SPIRIVA (tiotropium)	TUDORZA (aclidinium)	A thirty (30) day trial of tiotropium is required before a non-preferred agent will be approved.
	ANTICHOLINERGIC-BETA AGONIST COMBINATIONS[AP]		
	COMBIVENT CFC (albuterol/ipratropium COMBIVENT RESPIMAT (albuterol/ipratropium)	albuterol/ipratropium DUONEB (albuterol/ipratropium)	For severely compromised patients, albuterol/ipratropium will be approved if the combined volume of albuterol and ipratropium nebules is

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			inhibitory.
	PDE4 INHIBITOR		
		DALIRESP (roflumilast)	Daliresp will be approved when the following criteria are met: 1. Patient is forty (40) years of age or older **and** 2. Diagnosis of severe chronic obstructive pulmonary disease (COPD) associated with chronic bronchitis and multiple exacerbations requiring systemic glucocorticoids in the preceding six (6) months **and** **3.** Concurrent therapy with an inhaled corticosteroid and long-acting bronchodilator and evidence of compliance **and** **4.** No evidence of moderate to severe liver impairment (Child-Pugh Class B or C) **and** 5. No concurrent use with strong cytochrome P450 inducers (rifampicin, phenobarbital, carbamazepine or phenytoin).
	INHALATION SOLUTION[AP]		
	ACCUNEB (albuterol)** albuterol	BROVANA (arformoterol) levalbuterol metaproterenol PERFOROMIST (formoterol) XOPENEX (levalbuterol)	Thirty (30) day trials each of the chemically distinct preferred agents in their corresponding groups are required before a non-preferred agent in that group will be authorized unless one (1) of the exceptions on the PA form is present. **No PA is required for Accuneb for children up to five (5) years of age.
	INHALERS, LONG-ACTING[AP]		
	FORADIL (formoterol) SEREVENT (salmeterol)	ARCAPTA (indacaterol maleate)	Thirty (30) day trials each of the preferred agents are required

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.
	INHALERS, SHORT-ACTING[AP]		
	PROAIR HFA (albuterol) PROVENTIL HFA (albuterol)	MAXAIR (pirbuterol) VENTOLIN HFA (albuterol) XOPENEX HFA (levalbuterol)	Xopenex Inhalation Solution will be approved for twelve (12) months for a diagnosis of asthma or COPD for patients on concurrent asthma controller therapy (either oral or inhaled) with documentation of failure on a trial of albuterol or documented intolerance of albuterol, or for concurrent diagnosis of heart disease.
	ORAL[AP]		
	albuterol IR, ER terbutaline	metaproterenol VOSPIRE ER (albuterol)	
CALCIUM CHANNEL BLOCKERS[AP]			
	LONG-ACTING		
	amlodipine diltiazem ER felodipine ER nifedipine ER verapamil ER	ADALAT CC (nifedipine) CALAN SR (verapamil) CARDENE SR (nicardipine) CARDIZEM CD, LA (diltiazem) COVERA-HS (verapamil) DILACOR XR (diltiazem) diltiazem LA DYNACIRC CR (isradipine) ISOPTIN SR (verapamil) MATZIM LA (diltiazem) nisoldipine NORVASC (amlodipine) PLENDIL (felodipine) PROCARDIA XL (nifedipine) SULAR (nisoldipine) TIAZAC (diltiazem) verapamil ER PM VERELAN/VERELAN PM (verapamil)	Fourteen (14) day trials each of the preferred agents are required before a non-preferred agent will be approved unless one (1) of the exceptions on the PA form is present.

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

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			exceptions on the PA form is present.
CYTOKINE & CAM ANTAGONISTS[CL]			
	ENBREL (etanercept) HUMIRA (adalimumab)	CIMZIA (certolizumab pegol) KINERET (anakinra) ORENCIA (abatacept) SIMPONI (golimumab) STELARA (ustekinumab) XELJANZ (tofacitinib)*	Thirty (30) day trials of each of the preferred agents are required before a non-preferred agent will be approved. * Xeljanz (tofacitinib) will be approved after a thirty (30) day trial of one (1) of the preferred agents if each of the following criteria are met: 1. Diagnosis of moderately or severely active rheumatoid arthritis **and** 2. Negative tuberculin skin test before initiation of therapy **and** 3. Intolerance to or an inadequate response to a sixty (60) day trial of methotrexate **and** 4. The patient is eighteen (18) years of age or older **and** 5. There are no plans to use tolfactinib in combination with biologic DMARDS or potent immunosuppressants (e.g. azathioprine or cyclosporine) **and** 6. The dose is limited to two (2) tablets daily. See additional criteria for treatment of psoriasis or psoriatic arthritis at http://www.dhhr.wv.gov/bms/Pharmacy/Pages/pac.aspx
ERYTHROPOIESIS STIMULATING PROTEINS[CL]			
	PROCRIT (rHuEPO)	ARANESP (darbepoetin) EPOGEN (rHuEPO)	A thirty (30) day trial of the preferred agent is required before a non-preferred agent will be approved.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			No evidence of untreated GI bleeding, hemolysis, or Vitamin B-12, iron or folate deficiency. Prior authorization will be given for the erythropoesis agents if the following criteria are met: 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 considered on an individual basis after medical documentation is reviewed. (Lab oratory values must be dated within six (6) weeks of request.) **and** 2. Transferrin saturation ≥ 20%, ferritin levels ≥100 mg/ml, or on concurrent therapeutic iron therapy. (Laboratory values must be dated within three (3) weeks of request. For re-authorization, transferrin saturation or ferritin levels are not required if the patient has been responsive to the erythropoietin agent **and** 3. For HIV-infected patients, endogenous serum erythropoietin level must be ≤ 500mU/ml to initiate therapy **and** 4. No evidence of untreated GI bleeding, hemolysis, or Vitamin B-12, iron or folate deficiency.
FLUOROQUINOLONES (Oral)[AP]			
	CIPRO SUSPENSION (ciprofloxacin) ciprofloxacin	AVELOX (moxifloxacin) CIPRO TABLETS (ciprofloxacin)	A five (5) day trial of one (1) of the preferred agents is required before

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	levofloxacin tablet	CIPRO XR (ciprofloxacin) ciprofloxacin ER FACTIVE (gemifloxacin) FLOXIN (ofloxacin) LEVAQUIN (levofloxacin) levofloxacin solution NOROXIN (norfloxacin) ofloxacin PROQUIN XR (ciprofloxacin)	a non-preferred agent will be approved unless one (1) of the exceptions on the PA form is present.
GENITAL WARTS AGENTS			
	ALDARA (imiquimod)	CONDYLOX (podofilox) imiquimod podofilox VEREGEN (sinecatechins) ZYCLARA (imiquimod)	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. Zyclara will be approved for a diagnosis of actinic keratosis.
GLUCOCORTICOIDS (Inhaled)[AP]			
	GLUCOCORTICOIDS		
	ASMANEX (mometasone) FLOVENT HFA (fluticasone) FLOVENT Diskus (fluticasone) PULMICORT FLEXHALER (budesonide) PULMICORT RESPULES (budesonide)* QVAR (beclomethasone)	ALVESCO (ciclesonide) 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. 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. *For children up to nine (9) years of age, and for those who meet the PA

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			requirements, brand Pulmicort is preferred over the generic.
	GLUCOCORTICOID/BRONCHODILATOR COMBINATIONS		
	ADVAIR (fluticasone/salmeterol) ADVAIR HFA (fluticasone/salmeterol) DULERA (mometasone/formoterol) SYMBICORT(budesonide/formoterol)		
GLUCOCORTICOIDS (Topical)			
	VERY HIGH & HIGH POTENCY		
	betamethasone dipropionate cream, lotion betamethasone valerate cream clobetasol propionate cream/gel/ointment/solution clobetasol emollient fluocinonide cream, gel, solution fluocinonide/emollient halobetasol propionate triamcinolone acetonide cream, ointment	amcinonide APEXICON (diflorasone diacetate) APEXICON E (diflorasone diacetate) betamethasone dipropionate gel, lotion, ointment betamethasone valerate lotion, ointment, clobetasol lotion, shampoo clobetasol propionate foam CLOBEX (clobetasol propionate) CORMAX (clobetasol propionate) desoximetasone cream/gel/ointment diflorasone diacetate DIPROLENE (betamethasone dipropionate/propylene glycol) DIPROLENE AF (betamethasone dipropionate/propylene glycol) DIPROSONE (betamethasone dipropionate) fluocinonide ointment halcinonide HALAC (halobetasol propionate) HALOG (halcinonide) HALONATE (halobetasol propionate) KENALOG (triamcinolone acetonide) LIDEX (fluocinonide) LIDEX-E (fluocinonide) OLUX (clobetasol propionate) OLUX-E (clobetasol propionate/emollient) PSORCON (diflorasone diacetate) TEMOVATE (clobetasol propionate) TEMOVATE-E (clobetasol propionate/emollient) TOPICORT CREAM, GEL, OINTMENT	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 approved.

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

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	hydrocortisone-aloe cream OTC hydrocortisone-aloe ointment OTC	desonide lotion DESOWEN (desonide) hydrocortisone/mineral oil/petrolatum hydrocortisone acetate/urea hydrocortisone lotion hydrocortisone/aloe gel LOKARA (desonide) PEDIADERM HC (hydrocortisone) PEDIADERM TA (hydrocortisone) SCALPICIN OTC (hydrocortisone) SYNALAR (fluocinolone) TEXACORT (hydrocortisone) VERDESO (desonide)	
GROWTH HORMONE[CL]			
	GENOTROPIN (somatropin) NORDITROPIN (somatropin) NUTROPIN AQ PENS (somatropin)	HUMATROPE (somatropin) INCRELEX (mecasermin) NUTROPIN (somatropin) NUTROPIN AQ VIALS (somatropin) OMNITROPE (somatropin) SAIZEN (somatropin) SEROSTIM (somatropin) TEV-TROPIN (somatropin) ZORBTIVE (somatropin)	The preferred agents must be tried before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. Patients already on a non-preferred agent will receive authorization to continue therapy on that agent for the duration of the existing PA.
***H. PYLORI* COMBINATION TREATMENTS**			
	Please use individual components: preferred PPI (Dexilant, omeprazole or pantoprazole) amoxicillin tetracycline metronidazole clarithromycin bismuth	HELIDAC (bismuth/metronidazole/tetracycline) OMECLAMOX-PAK (omeprazole/amoxicillin/clarithromycin) PREVPAC (lansoprazole/amoxicillin/clarithromycin) PYLERA (bismuth/metronidazole/tetracycline)	A trial of all the individual preferred components (with Dexilant, omeprazole or pantoprazole) at the recommended dosages, frequencies and duration is required before the brand name combination packages will be approved unless one (1) of the exceptions on the PA form is present.
HEPATITIS B TREATMENTS			
	EPIVIR HBV (lamivudine) HEPSERA (adefovir) TYZEKA (telbivudine)	BARACLUDE (entecavir)	A thirty (30) day trial of one (1) of the preferred agents is required before the non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
HEPATITIS C TREATMENTS[CL]			
	INCIVEK (telaprevir)[CL] PEGASYS (pegylated interferon) PEG-INTRON (pegylated interferon) ribavirin VICTRELIS (boceprevir)[CL]	COPEGUS (ribavirin) INFERGEN (consensus interferon) REBETOL (ribavirin) RIBAPAK (ribavirin) RIBASPHERE 400mg, 600mg (ribavirin)	Patients starting therapy in this class must try the preferred agent of a dosage form before a non-preferred agent of that dosage form will be authorized. See additional criteria for Incivek and Victrelis at http://www.dhhr.wv.gov/bms/Pharmacy/Pages/pac.aspx
HYPERURICEMIA AND GOUT AGENTS			
	ANTIMITOTICS		
		COLCRYS (colchicine)*	A thirty (30) day trial of one (1) of the preferred agents for the prevention of gouty arthritis attacks (colchicine/probenecid, probenecid, or allopurinol) is required before a non-preferred agent will be approved unless one (1) of the exceptions on the PA form is present. *In the case of acute gouty attacks, a ten (10) day supply (twenty (20) tablets) of Colcrys will be approved per ninety 90 days.
	ANTIMITOTIC-URICOSURIC COMBINATION		
	colchicine/probenecid		
	URICOSURIC		
	probenecid		
	XANTHINE OXIDASE INHIBITORS		
	allopurinol	ULORIC (febuxostat) ZYLOPRIM (allopurinol)	

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS			
	INJECTABLE		
		BYDUREON (exenatide) BYETTA (exenatide) SYMLIN (pramlintide) VICTOZA (liraglutide)	Byetta, Bydureon and Victoza will be authorized for six (6) month intervals if each of the following criteria are met: 1. Diagnosis of Type 2 Diabetes **and** 2. Previous history of a thirty (30) day trial of metformin, unless contraindicated **and** 3. No history of pancreatitis **and** 4. For concurrent therapy with insulin, treatment with a bolus insulin is contraindicated. Approval will be given for six (6) month intervals. For re-authorizations, HgBA1C levels must have decreased by at least 1% until levels are ≤8%. HgBA1C levels within ninety (90) days of start date and at the six (6) month interval must be submitted. Further authorizations will be issued for six (6) month intervals. Laboratory work submitted must be for the most recent thirty (30) day period. Symlin will be approved with a history of bolus insulin utilization in the past ninety (90) days with no gaps in insulin therapy greater than thirty (30) days.
	ORAL[AP]		
	JANUMET (sitagliptin/metformin) JANUVIA (sitagliptin) JUVISYNC (sitagliptin/simvastatin) KOMBIGLYZE XR (saxagliptin/metformin) ONGLYZA (saxagliptin) TRADJENTA (linagliptin)	JANUMET XR (sitagliptin/metformin) JENTADUETO (linagliptin/metformin) KAZANO (alogliptin/metformin)[NR] NESINA (alogliptin)[NR] OSENI (alogliptin/pioglitazone)[NR]	Januvia/Janumet/Juvisync, Onglyza/Kombiglyze XR and Tradjenta will be subject to the following edits: 1. Previous history of a thirty (30)

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			day trial of metformin. 2. Januvia / Janumet / Juvisync, Onglyza/Kombiglyze XR and Tradjenta will be approved 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%). Current laboratory values must be submitted. Jentadueto and Janumet XR will be approved after thirty (30) day trials of the preferred combination agents, Janumet and Kombiglyze XR.
	SGLT2		
		INVOKANA (canagliflozin)[NR]	
HYPOGLYCEMICS, INSULINS			
	HUMALOG (insulin lispro) HUMALOG PEN/KWIKPEN (insulin lispro) HUMALOG MIX VIALS (insulin lispro/lispro protamine) HUMULIN VIALS (insulin) LANTUS (insulin glargine) LEVEMIR (insulin detemir) NOVOLIN (insulin) NOVOLOG (insulin aspart) NOVOLOG MIX (insulin aspart/aspart protamine)	APIDRA (insulin glulisine)[AP] HUMALOG MIX PENS (insulin lispro/lispro protamine) HUMULIN PENS (insulin)	To receive Apidra, patients must meet the following criteria: 1. Be four (4) years of age or older; 2. Be currently on a regimen including a longer-acting or basal insulin. 3. Had a trial of a similar preferred agent, Novolog or Humalog, with documentation that the desired results were not achieved. Humulin pens and Humalog Mix pens will be approved only for patients who cannot utilize vials due to impaired vision or dexterity.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
HYPOGLYCEMICS, MEGLITINIDES			
	MEGLITINIDES		
	PRANDIN (repaglinide) STARLIX (nateglinide)	nateglinide	A thirty (30) day trial of a preferred agent is required before a non-preferred agent will be authorized, unless one (1) of the exceptions on the PA form is present.
	MEGLITINIDE COMBINATIONS		
		PRANDIMET (repaglinide/metformin)	
HYPOGLYCEMICS, MISCELLANEOUS			
	WELCHOL (colesevelam)[AP]		Welchol will be approved for add-on therapy for type 2 diabetes when there is a previous history of a thirty (30) day trial of an oral agent (sulfonylurea, thiazolidinedione (TZD) or metformin).
HYPOGLYCEMICS, TZDS[AP]			
	THIAZOLIDINEDIONES		
	pioglitazone	ACTOS (pioglitazone) AVANDIA (rosiglitazone)	Treatment naïve patients require a two (2) week trial of Actos before Avandia will be authorized, unless one (1) of the exceptions on the PA form is present.
	TZD COMBINATIONS		
		ACTOPLUS MET (pioglitazone/ metformin) ACTOPLUS MET XR (pioglitazone/ metformin) AVANDAMET (rosiglitazone/metformin)[AP] AVANDARYL (rosiglitazone/glimepiride)[AP] DUETACT (pioglitazone/glimepiride) pioglitazone/glimepiride pioglitazone/ metformin	Patients are required to use the components of Actoplus Met and Duetact separately. Exceptions will be handled on a case-by-case basis.
IMMUNOSUPPRESSIVES			
	azathioprine cyclosporine cyclosporine, modified mycophenolate mofetil	AZASAN (azathioprine) CELLCEPT (mycophenolate mofetil) IMURAN (azathioprine) MYFORTIC (mycophenolic acid)	A fourteen (14) day trial of a preferred agent is required before a non-preferred agent will be authorized unless one (1) of the

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	RAPAMUNE (sirolimus) tacrolimus	NEORAL (cyclosporine, modified) PROGRAF (tacrolimus) SANDIMMUNE (cyclosporine) ZORTRESS (everolimus)	exceptions on the PA form is present (non-preferred agents will be grandfathered for patients currently on these therapies).
IMPETIGO AGENTS (Topical)			
	bacitracin gentamicin sulfate mupirocin ointment	ALTABAX (retapamulin) BACTROBAN (mupirocin) CENTANY (mupirocin) CORTISPORIN (bacitracin/neomycin/ polymyxin/HC) mupirocin cream NR 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.
INTRANASAL RHINITIS AGENTS AP			
	ANTICHOLINERGICS		
	ipratropium	ATROVENT(ipratropium)	Thirty (30) day trials of the preferred nasal anti-cholinergic, an antihistamine, and corticosteroid groups are required before a non-preferred anti-cholinergic will be approved unless one (1) of the exceptions on the PA form is present.
	ANTIHISTAMINES		
	ASTELIN (azelastine) PATANASE (olopatadine)	ASTEPRO (azelastine) 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 the non-preferred agent will be approved unless one (1) of the exceptions on the PA form is present.
	COMBINATIONS		
		DYMISTA (azelastine / fluticasone)	
	CORTICOSTEROIDS		

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	fluticasone propionate NASACORT AQ (triamcinolone) NASONEX (mometasone)	BECONASE AQ (beclomethasone) FLONASE (fluticasone propionate) flunisolide OMNARIS (ciclesonide) QNASL (beclomethasone) RHINOCORT AQUA (budesonide) triamcinolone VERAMYST (fluticasone furoate) ZETONNA (ciclesonide)	Thirty (30) day trials of each preferred agent in the corticosteroid group are required before a non-preferred corticosteroid agent will be authorized unless one (1) of the exceptions on the PA form is present.
LEUKOTRIENE MODIFIERS			
	ACCOLATE (zafirlukast) montelukast	SINGULAIR (montelukast) zafirlukast ZYFLO (zileuton)	Thirty (30) day trials each of the preferred agents are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.
LIPOTROPICS, OTHER (Non-statins)[AP]			
	BILE ACID SEQUESTRANTS		
	cholestyramine colestipol tablets	COLESTID (colestipol) colestipol granules KYNAMRO (mipomersen) [NR] QUESTRAN (cholestyramine) WELCHOL (colesevelam)	A twelve (12) week trial of one (1) of the preferred agents is required before a non-preferred agent in the corresponding category will be authorized. Welchol will be approved 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). See HYPOGLYCEMICS, MISCELLANEOUS.
	CHOLESTEROL ABSORPTION INHIBITORS		
	ZETIA (ezetimibe) [AP]		Zetia will be approved with prior use of a HMG-CoA reductase inhibitor within the previous six (6) months.
	FATTY ACIDS		

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		LOVAZA (omega-3-acid ethyl esters)[AP] VASCEPA (icosapent ethyl)[NR]	Lovaza will be approved when the patient is intolerant or not responsive to, or not a candidate for nicotinic acid or fibrate therapy.
	FIBRIC ACID DERIVATIVES		
	fenofibrate 54mg & 160mg fenofibrate micronized 67mg, 134mg & 200mg gemfibrozil TRICOR (fenofibrate nanocrystallized) TRILIPIX (fenofibric acid)	ANTARA (fenofibrate) FENOGLIDE (fenofibrate) FIBRICOR (fenofibric acid) fenofibrate 43mg, 130mg[NR] fenofibrate nanocrystallized 48mg, 145mg fenofibric acid LIPOFEN (fenofibrate) LOFIBRA (fenofibrate) LOPID (gemfibrozil) TRIGLIDE (fenofibrate)	
	NIACIN		
	niacin NIACOR (niacin) NIASPAN (niacin) SLO-NIACIN (niacin)		
LIPOTROPICS, STATINS[AP]			
	STATINS		
	atorvastatin LESCOL (fluvastatin) LESCOL XL (fluvastatin) lovastatin pravastatin simvastatin[CL*]	ALTOPREV (lovastatin) CRESTOR (rosuvastatin) fluvastatin LIPITOR (atorvastatin) LIVALO (pitavastatin) MEVACOR (lovastatin) PRAVACHOL (pravastatin) ZOCOR (simvastatin)*	Twelve (12) week trials each of two (2) of the preferred statins, including the generic formulation of a requested non-preferred agent, are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. *Zocor/simvastatin 80mg tablets will require a clinical PA
	STATIN COMBINATIONS		
	ADVICOR (lovastatin/niacin) amlodipine / atorvastatin SIMCOR (simvastatin/niacin ER)	CADUET (atorvastatin/amlodipine) LIPTRUZET (atorvastatin/ezetimibe)[NR] VYTORIN (simvastatin/ ezetimibe)*	Vytorin will be approved only after an insufficient response to the maximum tolerable dose of atorvastatin after twelve (12)

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			weeks, unless one (1) of the exceptions on the PA form is present. *Vytorin 80/10mg tablets will require a clinical PA
MACROLIDES/KETOLIDES (Oral)			
	KETOLIDES		
		KETEK (telithromycin)	Requests for telithromycin will be authorized if there is documentation of the use of any antibiotic within the past twenty-eight (28) days.
	MACROLIDES		
	azithromycin clarithromycin erythromycin base	BIAXIN (clarithromycin) BIAXIN XL (clarithromycin) clarithromycin ER E.E.S. (erythromycin ethylsuccinate) E-MYCIN (erythromycin) ERYC (erythromycin) ERYPED (erythromycin ethylsuccinate) ERY-TAB (erythromycin) ERYTHROCIN (erythromycin stearate) erythromycin estolate PCE (erythromycin) ZITHROMAX (azithromycin) ZMAX (azithromycin)	Five (5) day trials each of the preferred agents are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.
MULTIPLE SCLEROSIS AGENTS[CL, AP]			
	INTERFERONS		
	AVONEX (interferon beta-1a) AVONEX PEN (interferon beta-1a) BETASERON (interferon beta-1b) REBIF (interferon beta-1a) REBIF REBIDOSE (interferon beta-1a)	EXTAVIA (interferon beta-1b)	A thirty (30) day trial of a preferred agent will be required before a non-preferred agent will be approved.
	NON-INTERFERONS		
	COPAXONE (glatiramer)	AMPYRA (dalfampridine)* GILENYA (fingolimod) ** AUBAGIO (teriflunomide)***	A thirty (30) day trial of the preferred agent will be required before a non-preferred agent will be

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		TECFIDERA (dimethyl fumarate)[NR]	approved. *Amypra will be prior authorized if the following conditions are met: 1. Diagnosis of multiple sclerosis **and** 2. No history of seizures **and** 3. No evidence of moderate or severe renal impairment **and** 4. Initial prescription will be approved for thirty (30) days only. ** Gilenya: PA Criteria 1. A diagnosis of a relapsing form of multiple sclerosis **and** 2. Medication is prescribed by a neurologist **and** 3. History of a thirty (30) day trial of one (1) of the preferred agents for multiple sclerosis unless one (1) *of* the exceptions on the PA form is present **and** 4. Dosage is limited to one (1) tablet per day. (AP does not apply.) *** Aubagio will be authorized if each of the following criteria are met: 1. Diagnosis of relapsing multiple sclerosis **and** 2. Trial of the preferred first-line agent in each class (interferon and non-interferon) for thirty (30) days each **and** 3. Measurement of transaminase and bilirubin levels within the (6) months before initiation of

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			therapy and ALT levels at least monthly for six (6) months after initiation of therapy **and** 4. Complete blood cell count (CBC) within six (6) months before initiation of therapy **and** 5. Female patients must have a negative pregnancy test before initiation of therapy and be established on a reliable method of contraception if appropriate **and** 6. Patient is from eighteen (18) up to sixty-five (65) years of age **and** 7. Negative tuberculin skin test before initiation of therapy
MUSCLE RELAXANTS (Oral)[AP]			
	ACUTE MUSCULOSKELETAL RELAXANT AGENTS		
	chlorzoxazone cyclobenzaprine IR 5, 10 mg methocarbamol	AMRIX (cyclobenzaprine) carisoprodol carisoprodol/ASA carisoprodol/ASA/codeine cyclobenzaprine ER cyclobenzaprine IR 7.5 mg FEXMID (cyclobenzaprine) FLEXERIL (cyclobenzaprine) LORZONE (chlorzoxazone) metaxalone orphenadrine orphenadrine/ASA/caffeine PARAFON FORTE (chlorzoxazone) ROBAXIN (methocarbamol) SKELAXIN (metaxalone) SOMA (carisoprodol)	Thirty (30) day trials of the preferred acute musculoskeletal relaxants are required before a non-preferred acute musculoskeletal agent will be approved, with the exception of carisoprodol. Thirty (30) day trials of the preferred acute musculoskeletal relaxants and Skelaxin are required before carisoprodol will be approved.
	MUSCULOSKELETAL RELAXANT AGENTS USED FOR SPASTICITY		

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	baclofen tizanidine tablets	DANTRIUM (dantrolene) dantrolene tizanidine capsules ZANAFLEX (tizanidine)	Thirty (30) day trials of the preferred skeletal muscle relaxants associated with the treatment of spasticity (are required before non-preferred agents will be approved unless one (1) of the exceptions on the PA form is present.
NEUROPATHIC PAIN			
	capsaicin OTC CYMBALTA (duloxetine) gabapentin LYRICA (pregabalin)[AP] SAVELLA (milnacipran)*[AP]	GRALISE (gabapentin) HORIZANT (gabapentin) LIDODERM (lidocaine)[AP] NEURONTIN (gabapentin) QUTENZA (capsaicin) ZOSTRIX OTC (capsaicin)	Lyrica will be approved for: 1. Diagnosis of seizure disorders or neuropathic pain associated with a spinal cord injury **or** 2. Diagnosis of fibromyalgia, postherpetic neuralgia, or diabetic neuropathy AND a history of a trial of 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.) Lidoderm patches will be approved for a diagnosis of post-herpetic neuralgia. * Savella will be approved for a diagnosis of fibromyalgia or a previous thirty (30) day trial of a

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			drug that infers fibromyalgia: gabapentin, Cymbalta, Lyrica, amitriptyline or nortriptyline. Requests for Gralise will be authorized if the following criteria are met: 1. Diagnosis of post herpetic neuralgia **and** 2. Trial of a tricyclic antidepressant for a least thirty (30) days **and** 3. Trial of gabapentin immediate release formulation (positive response without adequate duration) Request is for once daily dosing with 1800mg. maximum daily dosage.
NSAIDS[AP]			
	NON-SELECTIVE		
	diclofenac (IR, SR) etodolac IR flurbiprofen ibuprofen (Rx and OTC) INDOCIN SUSPENSION (indomethacin) indomethacin ketorolac naproxen (Rx and OTC) sulindac	ANAPROX (naproxen) ANSAID (flurbiprofen) CAMBIA (diclofenac) CATAFLAM (diclofenac) CLINORIL (sulindac) DAYPRO (oxaprozin) diflunisal DUEXIS (famotidine/ibuprofen) etodolac SR FELDENE (piroxicam) fenoprofen INDOCIN SUPPOSITORIES (indomethacin) indomethacin ER ketoprofen ketoprofen ER meclofenamate mefenamic acid MOTRIN (ibuprofen) nabumetone NALFON (fenoprofen) NAPRELAN (naproxen) NAPROSYN (naproxen)	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.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		oxaprozin piroxicam PONSTEL (meclofenamate) SPRIX (ketorolac) tolmetin VOLTAREN (diclofenac) ZIPSOR (diclofenac potassium)	
	NSAID/GI PROTECTANT COMBINATIONS		
		ARTHROTEC (diclofenac/misoprostol) diclofenac/misoprostol VIMOVO (naproxen/esomeprazole)	
	COX-II SELECTIVE		
	meloxicam	CELEBREX (celecoxib) MOBIC (meloxicam)	Requests for COX-2 Inhibitor agents will be authorized if the following criteria are met: Agent is requested for treatment of a chronic condition **and** 1. Patient is 70 years of age or older, **or** 2. Patient is currently on anticoagulation therapy, **or** 3. Patient has a history or risk of a serious GI complication.
OPHTHALMIC ANTIBIOTICS[AP]			
	bacitracin/polymyxin ointment ciprofloxacin* erythromycin gentamicin MOXEZA (moxifloxacin)* ofloxacin* polymyxin/trimethoprim sulfacetamide tobramycin VIGAMOX (moxifloxacin)*	AZASITE (azithromycin) bacitracin BESIVANCE (besifloxacin) BLEPH-10 (sulfacetamide) CILOXAN (ciprofloxacin) GARAMYCIN (gentamicin) ILOTYCIN (erythromycin) levofloxacin NATACYN (natamycin) neomycin/bacitracin/polymyxin neomycin/polymyxin/gramicidin NEOSPORIN (neomycin/polymyxin/gramicidin) OCUFLOX (ofloxacin)	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. The American Academy of Ophthalmology guidelines on treating bacterial conjunctivitis recommend as first line treatment options: erythromycin ointment, sulfacetamide drops, or polymyxin/trimethoprim drops.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		POLYTRIM (polymyxin/trimethoprim) QUIXIN (levofloxacin) sulfacetamide ointment TOBREX (tobramycin) ZYMAR (gatifloxacin) ZYMAXID (gatifloxacin)	*A prior authorization is required for the fluoroquinolone agents for patients up to twenty-one (21) years of age unless there has been a trial of a first line treatment option within the past ten (10) days.
OPHTHALMIC ANTIBIOTIC/STEROID COMBINATIONS			
	BLEPHAMIDE (prednisolone/sulfacetamide) BLEPHAMIDE S.O.P. (prednisolone/ sulfacetamide) MAXITROL (neomycin/polymyxin/ dexamethasone) neomycin/bacitracin/polymyxin/ hydrocortisone neomycin/polymyxin/dexamethasone sulfacetamide/prednisolone TOBRADEX SUSPENSION (tobramycin/ dexamethasone)	neomycin/polymyxin/hydrocortisone POLY-PRED (prednisolone/neomycin/ polymyxin B) PRED-G (prednisolone/gentamicin) TOBRADEX OINTMENT (tobramycin/ dexamethasone) TOBRADEX ST (tobramycin/ dexamethasone) tobramycin/dexamethasone suspension ZYLET (loteprednol/tobramycin)	Thirty (30) day trials of each of the preferred agents are required unless one (1) of the exceptions on the PA form is present.
OPHTHALMIC ANTI-INFLAMMATORIES			
	dexamethasone diclofenac fluorometholone flurbiprofen ketorolac NEVANAC (nepafenac) prednisolone acetate	ACULAR (ketorolac) ACULAR LS (ketorolac) ACUVAIL (ketorolac tromethamine) AP BROMDAY (bromfenac) bromfenac DUREZOL (difluprednate) AP FLAREX (fluorometholone) FML (fluorometholone) FML FORTE (fluorometholone) FML S.O.P. (fluorometholone) ILEVRO (nepafenac) NR LOTEMAX DROPS, OINTMENT (loteprednol) LOTEMAX GEL (loteprednol) NR MAXIDEX (dexamethasone) OMNIPRED (prednisolone) OZURDEX (dexamethasone) PRED FORTE (prednisolone PRED MILD (prednisolone prednisolone sodium phosphate	Five (5) day trials of each of the preferred ophthalmic anti-inflammatory agents are required before non-preferred agents will be authorized unless one (1) of the exceptions on the PA form is present.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		PROLENSA (bromfenac) NR RETISERT (fluocinolone) TRIESENCE (triamcinolone) VEXOL (rimexolone) XIBROM (bromfenac)	
OPHTHALMICS FOR ALLERGIC CONJUNCTIVITIS			
	ALAWAY (ketotifen) ALREX (loteprednol) cromolyn ketotifen PATADAY (olopatadine) PATANOL (olopatadine) ZADITOR OTC (ketotifen) ZYRTEC ITCHY EYE (ketotifen)	ALAMAST (pemirolast) AP ALOCRIL (nedocromil) AP ALOMIDE (lodoxamide) AP azelastine BEPREVE (bepotastine) AP CROLOM (cromolyn) AP ELESTAT (epinastine) AP EMADINE (emedastine) AP epinastine LASTACAFT (alcaftadine) OPTICROM (cromolyn) AP OPTIVAR (azelastine)	Thirty (30) day trials of each of three (3) 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.
OPHTHALMICS, GLAUCOMA AGENTS			
	COMBINATION AGENTS		
	COMBIGAN (brimonidine/timolol) dorzolamide/timolol	COSOPT (dorzolamide/timolol) COSOPT PF (dorzolamide/timolol) SIMBRINZA (brinzolamide/brimonidine) NR	Authorization for a non-preferred agent will only be given if there is an allergy to the preferred agents.
	BETA BLOCKERS		
	BETOPTIC S (betaxolol) carteolol levobunolol metipranolol timolol	BETAGAN (levobunolol) betaxolol BETIMOL (timolol) ISTALOL (timolol) OPTIPRANOLOL (metipranolol) TIMOPTIC (timolol)	
	CARBONIC ANHYDRASE INHIBITORS		
	AZOPT (brinzolamide) dorzolamide	TRUSOPT (dorzolamide)	
	PARASYMPATHOMIMETICS		

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	CARBOPTIC (carbachol) ISOPTO CARBACHOL (carbachol) PHOSPHOLINE IODIDE (echothiophate iodide) pilocarpine	ISOPTO CARPINE (pilocarpine) PILOPINE HS (pilocarpine)	
	PROSTAGLANDIN ANALOGS		
	latanoprost TRAVATAN/TRAVATAN-Z (travoprost)	LUMIGAN (bimatoprost) RESCULA (unoprostone)[NR] travoprost[NR] XALATAN (latanoprost) ZIOPTAN (tafluprost)	
	SYMPATHOMIMETICS		
	ALPHAGAN P (brimonidine) brimonidine 0.2% dipivefrin	apraclonidine brimonidine 0.15% IOPIDINE (apraclonidine) PROPINE (dipivefrin)	
OTIC ANTIBIOTICS[AP]			
	CIPRODEX (ciprofloxacin/dexamethasone)* COLY-MYCIN S (colistin/hydrocortisone/ neomycin/thonzonium bromide) CORTISPORIN SOLUTION (neomycin/polymyxin/HC) neomycin/polymyxin/HC solution/suspension ofloxacin	ciprofloxacin CIPRO HC (ciprofloxacin/hydrocortisone) CETRAXAL 0.2% SOLUTION (ciprofloxacin) CORTISPORIN-TC (colistin/hydrocortisone/ neomycin) FLOXIN (ofloxacin)	Five (5) day trials of each of the preferred agents are required before a non-preferred agent will be approved unless one (1) of the exceptions on the PA form is present. *Ciprodex is limited to patients up to nine (9) years of age. Age exceptions will be handled on a case-by-case basis.
PANCREATIC ENZYMES[AP]			
	CREON PANCRELIPASE 5000 ZENPEP	PANCREAZE PERTZYE ULTRESA VIOKACE	A thirty (30) day trial of a preferred agent is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. Non-preferred agents will be approved for members with cystic fibrosis.
PARATHYROID AGENTS[AP]			

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	HECTOROL (doxercalciferol) ZEMPLAR (paricalcitol)	SENSIPAR (cinacalcet)	A thirty (30) day trial of a preferred agent will be required before a non-preferred agent will be approved.
PEDICULICIDES/SCABICIDES (Topical)[AP]			
	permethrin (RX, OTC) pyrethrins-piperonyl butoxide OTC ULESFIA (benzyl alcohol)	EURAX (crotamiton) LICE EGG REMOVER OTC (benzalkonium chloride) lindane malathion NATROBA (spinosad) OVIDE (malathion) SKLICE (ivermectin) spinosad	Trials of the preferred agents (which are age and weight appropriate) are required before non-preferred agents will be approved unless one (1) of the exceptions on the PA form is present.
PHOSPHATE BINDERS[AP]			
	ELIPHOS (calcium acetate) PHOSLO (calcium acetate) RENAGEL 400 MG (sevelamer) RENAGEL 800 MG (sevelamer)	calcium acetate FOSRENOL (lanthanum) PHOSLYRA (calcium acetate) RENVELA (sevelamer carbonate)	Thirty (30) day trials of at least two (2) preferred agents are required unless one (1) of the exceptions on the PA form is present.
PLATELET AGGREGATION INHIBITORS[AP]			
	AGGRENOX (dipyridamole/ASA) cilostazol clopidogrel	BRILINTA (ticagrelor) dipyridamole EFFIENT (prasugrel) PERSANTINE (dipyridamole) PLAVIX (clopidogrel) PLETAL (cilostazol) TICLID (ticlopidine) ticlopidine	A thirty (30) day trial of a preferred agent is required before a non-preferred agent will be approved unless one (1) of the exceptions on the PA form is present. Effient will be approved for acute coronary syndrome when it is to be managed by acute or delayed percutaneous coronary intervention (PCI). Three (3) day emergency supplies of Effient are available when necessary.
PROGESTINS FOR CACHEXIA			
	megestrol	MEGACE (megestrol) MEGACE ES (megestrol)	
PROTON PUMP INHIBITORS[AP]			

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	DEXILANT (dexlansoprazole) omeprazole (Rx) pantoprazole PREVACID SOLUTABS (lansoprazole)*	ACIPHEX (rabeprazole) lansoprazole Rx NEXIUM (esomeprazole) omeprazole/sodium bicarbonate (Rx) PREVACID CAPSULES (lansoprazole) PRILOSEC Rx (omeprazole) PROTONIX (pantoprazole)	Sixty (60) day trials of each of the preferred agents, inclusive of a concurrent thirty (30) day trial at the maximum dose of an H_2 antagonist are required before a non-preferred agent will be approved unless one (1) of the exceptions on the PA form is present * Prior authorization is required for Prevacid Solutabs for members eight (8) years of age or older.
PSORIATIC AGENTS - TOPICAL			
	calcipotriene solution, ointment CALCITRENE (calcipotriene) DOVONEX (calcipotriene) TAZORAC (tazarotene)	calcipotriene cream calcitriol SORILUX (calcipotriene) TACLONEX (calcipotriene/ betamethasone) VECTICAL (calcitriol)	Thirty (30) day trials of two (2) preferred unique chemical entities are required before non-preferred agents will be approved unless one (1) of the exceptions on the PA form is present.
PULMONARY ANTIHYPERTENSIVES - ENDOTHELIN RECEPTOR ANTAGONISTS[CL]			
	LETAIRIS (ambrisentan) TRACLEER (bosentan)		Letairis and Tracleer will be approved for a diagnosis of pulmonary arterial hypertension (PAH).
PULMONARY ANTIHYPERTENSIVES – PDE5s[CL]			
	ADCIRCA (tadalafil) REVATIO TABLETS (sildenafil)	REVATIO IV (sildenafil) sildenafil	
PULMONARY ANTIHYPERTENSIVES – PROSTACYCLINS[CL]			
	epoprostenol VENTAVIS (iloprost)	FLOLAN (epoprostenol) REMODULIN (treprostinil sodium) TYVASO (treprostinil) VELETRI (epoprostenol)	Ventavis will only be approved for the treatment of pulmonary artery hypertension (WHO Group 1) in patients with NYHA Class III or IV symptoms. Remodulin and Tyvaso will be approved only after a thirty (30) day trial of Ventavis unless one (1) of

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			the exceptions on the PA form is present.
SEDATIVE HYPNOTICS[AP]			
	BENZODIAZEPINES		
	temazepam 15, 30 mg	DALMANE (flurazepam) DORAL (quazepam) estazolam flurazepam HALCION (triazolam) RESTORIL (temazepam) temazepam 7.5, 22.5 mg 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. 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.
	OTHERS		
	zolpidem 5, 10 mg	AMBIEN (zolpidem) AMBIEN CR (zolpidem) chloral hydrate EDLUAR (zolpidem) INTERMEZZO (zolpidem) LUNESTA (eszopiclone) ROZEREM (ramelteon) SILENOR (doxepin) SOMNOTE (chloral hydrate) SONATA (zaleplon) zaleplon zolpidem ER 6.25, 12.5 mg ZOLPIMIST (zolpidem)	
STIMULANTS AND RELATED AGENTS			
	AMPHETAMINES		
	amphetamine salt combination IR dextroamphetamine VYVANSE (lisdexamfetamine)	ADDERALL (amphetamine salt combination) ADDERALL XR (amphetamine salt combination) amphetamine salt combination ER DESOXYN (methamphetamine) DEXEDRINE (dextroamphetamine) dextroamphetamine ER DEXTROSTAT (dextroamphetamine) methamphetamine PROCENTRA (dextroamphetamine)	One of the preferred agents in each group (amphetamines and non-amphetamines) must be tried for thirty (30) days before a non-preferred agent will be authorized. In addition, a long-acting preferred agent in each class must be tried for thirty (30) days before a non-preferred long-acting stimulant will be approved.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			Except for Strattera, PA is required for adults eighteen (18) years of age or older. Thirty (30) day trials of at least three (3) antidepressants are required before amphetamines will be approved for depression. Provigil will only be approved for patients sixteen (16) years of age or older with a diagnosis of narcolepsy.
	NON-AMPHETAMINE		
	DAYTRANA (methylphenidate) FOCALIN (dexmethylphenidate) FOCALIN XR (dexmethylphenidate) guanfacine INTUNIV (guanfacine extended-release) METADATE CD (methylphenidate) METHYLIN CHEWABLE TABLETS, SOLUTION (methylphenidate) methylphenidate methylphenidate ER (generic Concerta, Ritalin SR, Metadate ER, Methylin ER) STRATTERA (atomoxetine)	CONCERTA (methylphenidate) dexmethylphenidate KAPVAY ER (clonidine) METADATE ER (methylphenidate) methylphenidate solution methylphenidate CD methylphenidate ER (generic Ritalin LA) modafinil NUVIGIL (armodafinil) pemoline PROVIGIL (modafinil) QUILLIVANT XR (methylphenidate)[NR] RITALIN (methylphenidate) RITALIN LA (methylphenidate) RITALIN SR (methylphenidate)	Strattera will not be approved 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. Kapvay will be approved if the following criteria are met: 1. Fourteen (14) day trials of at least one (1) preferred product from the amphetamine and non-amphetamine class **and** 2. A fourteen (14) day trial of Strattera **and** 3. A fourteen (14) day trial of clonidine (for Kapvay) unless one (1) of the exceptions on the PA form is present **or** 4. In cases of a diagnosis of Tourette's syndrome, tics, autism or disorders included in the autism spectrum, only a fourteen (14) day trial of clonidine (for Kapvay) is required for approval.

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TETRACYCLINES [AP]			
	doxycycline hyclate capsules, tablets minocycline capsules tetracycline	ADOXA (doxycycline monohydrate) demeclocycline* DORYX (doxycycline hyclate) doxycycline hyclate tablet DR doxycycline monohydrate DYNACIN (minocycline) MINOCIN (minocycline) minocycline ER capsules minocycline tablets MONODOX (doxycycline monohydrate) MORGIDOX KIT (doxycycline) ORACEA (doxycycline monohydrate) SOLODYN (minocycline) VIBRAMYCIN CAPSULES, SUSPENSION, SYRUP (doxycycline)	A ten (10) day trial of each of the preferred agents is required before a non-preferred agent will be approved. *Demeclocycline will be approved for conditions caused by susceptible strains of organisms designated in the product information supplied by the manufacturer. A C&S report must accompany this request. *Demeclocycline will also be approved for SIADH.
ULCERATIVE COLITIS AGENTS [AP]			
	ORAL		
	APRISO (mesalamine) ASACOL (mesalamine) 400mg balsalazide DELZICOL (mesalamine) DIPENTUM (olsalazine) PENTASA (mesalamine) 250mg sulfasalazine	ASACOL HD (mesalamine) AZULFIDINE (sulfasalazine) COLAZAL (balsalazide) GIAZO (balsalazide) [NR] LIALDA (mesalamine) PENTASA (mesalamine) 500mg	Thirty (30) day trials of each of the preferred agents of a dosage form must be tried before a non-preferred agent of that dosage form will be authorized unless one (1) of the exceptions on the PA form is present.
	RECTAL		
	CANASA (mesalamine) mesalamine	mesalamine kit ROWASA (mesalamine) SF ROWASA (mesalamine)	
VAGINAL ANTIBACTERIALS			
	clindamycin cream METROGEL (metronidazole)	AVC (sulfanilamide) CLEOCIN CREAM (clindamycin) CLEOCIN OVULE (clindamycin) CLINDESSE (clindamycin) metronidazole VANDAZOLE (metronidazole)	A trial, the duration of the manufacturer's recommendation, of each of the preferred agents is required before a non-preferred agent will be approved unless one (1) of the exceptions on the PA

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			form is present.
MISC BRAND/GENERIC			
	CLONIDINE		
	CATAPRES-TTS (clonidine) clonidine tablets	clonidine patch NEXICLON XR (clonidine) CATAPRES TABLETS (clonidine)	A thirty (30) day trial of each preferred unique chemical entity in the corresponding therapeutic category is required before a non-preferred agent will be authorized.
	SUBLINGUAL NITROGLYCERIN		
	nitroglycerin sublingual NITROLINGUAL SPRAY (nitroglycerin) NITROSTAT SUBLINGUAL (nitroglycerin)	nitroglycerin spray NITROMIST (nitroglycerin)	
	SUBSTANCE ABUSE TREATMENTS		
	SUBOXONE FILM (buprenorphine/naloxone)[CL]	SUBOXONE TABLETS (buprenorphine/naloxone) buprenorphine/naloxone tablets[NR]	Suboxone PA criteria is available at http://www.dhhr.wv.gov/bms/Pharmacy/Pages/pac.aspx