



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.

EFFECTIVE
6/11/12
Version 2012.5e

- 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/PriorAuthorizationCriteria.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.



**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.

**EFFECTIVE
6/11/12
Version 2012.5e**

| THERAPEUTIC DRUG CLASS | PREFERRED AGENTS | NON-PREFERRED AGENTS | PA CRITERIA |
|---|---|--|--|
| ACNE AGENTS (Topical)^{AP} | | | |
| ANTI-INFECTIVE | | | |
| | AKNE-MYCIN (erythromycin) AZELEX (azelaic acid) clindamycin erythromycin sodium sulfacetamide | ACZONE (dapson) CLEOCIN-T (clindamycin) EVOCLIN (clindamycin) KLARON (sodium sulfacetamide) | Thirty (30) day trials each of one preferred retinoid and two unique chemical entities in two other subclasses, including the generic version of a requested non-preferred product, are required before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present. (In cases of pregnancy, a trial of retinoids will not be required.) |
| RETINOIDS | | | |
| | RETIN A liquid & Micro (tretinoin) TAZORAC (tazarotene) tretinoin cream, gel | adapalene AVITA (tretinoin) DIFFERIN (adapalene) RETIN-A cream, gel (tretinoin) TRETIN-X (tretinoin) | PA required after 17 years of age for tretinoin products. |
| KERATOLYTICS (Benzoyl Peroxides) | | | |
| | benzoyl peroxide ETHEXDERM (benzoyl peroxide) OSCION (benzoyl peroxide) | BENZAC WASH (benzoyl peroxide) BENZEFOAM (benzoyl peroxide) BENZEFOAM ULTRA (benzoyl peroxide) BREVOXYL (benzoyl peroxide) DESQUAM (benzoyl peroxide) LAVOCLEN (benzoyl peroxide) TRIAZ (benzoyl peroxide) | Acne kits are non-preferred. |
| COMBINATION AGENTS | | | |
| | benzoyl peroxide/urea erythromycin/benzoyl peroxide sulfacetamide sodium/sulfur wash/cleanser | ACANYA (clindamycin phosphate/benzoyl peroxide) AVAR (sulfur/sulfacetamide) BENZACLIN GEL (benzoyl peroxide/clindamycin) BENZAMYCIN PAK (benzoyl peroxide/erythromycin) benzoyl peroxide/clindamycin gel | Thirty (30) day trials each of one preferred retinoid and two unique chemical entities in two other subclasses, including the generic version of a requested non-preferred product, are required before a non-preferred agent will be authorized unless one of the exceptions on the PA form is |



**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.

**EFFECTIVE
6/11/12
Version 2012.5e**

| THERAPEUTIC DRUG CLASS | PREFERRED AGENTS | NON-PREFERRED AGENTS | PA CRITERIA |
|--|------------------|---|---|
| | | CLENIA (sulfacetamide sodium/sulfur) DUAC CS (benzoyl peroxide/ clindamycin) EPIDUO (adapalene/benzoyl peroxide) INOVA 4/1 (benzoyl peroxide/salicylic acid) NUOX (benzoyl peroxide/sulfur) PLEXION (sulfacetamide sodium/sulfur) PRASCION (sulfacetamide sodium/sulfur) ROSADERM (sulfacetamide sodium/sulfur) ROSANIL (sulfacetamide sodium/sulfur) ROSULA (sulfacetamide sodium/sulfur/ urea) sulfacetamide sodium/sulfur lotion, gel, pad sulfacetamide sodium/sulfur/ urea SULFOXYL (benzoyl peroxide/sulfur) SULFATOL (sulfacetamide sodium/sulfur/urea) VELTIN (clindamycin/tretinoin) ZENCIA WASH (sulfacetamide sodium/sulfur) ZIANA (clindamycin/tretinoin) | <p>present. (In cases of pregnancy, a trial of retinoids will not 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> |
| ALZHEIMER'S AGENTS^{AP} | | | |
| CHOLINESTERASE INHIBITORS | | | |
| | donepezil | ARICEPT (donepezil) ARICEPT 23mg (donepezil) ARICEPT ODT(donepezil) COGNEX (tacrine) donepezil ODT EXELON CAPSULE (rivastigmine) EXELON PATCH (rivastigmine) galantamine galantamine ER RAZADYNE (galantamine) RAZADYNE ER (galantamine) rivastigmine | <p>A thirty (30) day trial of a preferred agent is required before a non-preferred agent in this class will be authorized unless one of the exceptions on the PA form is present.</p> <p>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.</p> <p>Aricept and donepezil ODT will be approved only when the oral dosage form is not appropriate for the patient.</p> |



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.

EFFECTIVE
6/11/12
Version 2012.5e

| THERAPEUTIC DRUG CLASS | PREFERRED AGENTS | NON-PREFERRED AGENTS | PA CRITERIA |
|--|--|--|--|
| | | | Members currently utilizing Exelon patches as of 1/1/2012 may continue. |
| NMDA RECEPTOR ANTAGONIST | | | |
| | NAMENDA (memantine) | | |
| ANALGESICS, NARCOTIC - SHORT ACTING (Non-parenteral)^{AP} | | | |
| | APAP/codeine ASA/codeine codeine dihydrocodeine/ APAP/caffeine hydrocodone/APAP hydrocodone/ibuprofen hydromorphone tablets levorphanol morphine oxycodone oxycodone/APAP oxycodone/ASA pentazocine/APAP pentazocine/naloxone ROXICET (oxycodone/acetaminophen) tramadol tramadol/APAP | ABSTRAL (fentanyl) ACTIQ (fentanyl) butalbital/APAP/caffeine/codeine butalbital/ASA/caffeine/codeine butorphanol COMBUNOX (oxycodone/ibuprofen) DEMEROL (meperidine) DILAUDID (hydromorphone) fentanyl FENTORA (fentanyl) FIORICET W/ CODEINE (butalbital/APAP/caffeine/codeine) FIORINAL W/ CODEINE (butalbital/ASA/caffeine/codeine) hydromorphone liquid LAZANDA (fentanyl) LORCET (hydrocodone/APAP) LORTAB (hydrocodone/APAP) MAGNACET (oxycodone/APAP) meperidine NUCYNTA (tapentadol) OPANA (oxymorphone) ONSOLIS (fentanyl) oxycodone/ibuprofen OXECTA (oxycodone) OXYFAST (oxycodone) OXYIR (oxycodone) PANLOR (dihydrocodeine/ APAP/caffeine) PERCOCET (oxycodone/APAP) PERCODAN (oxycodone/ASA) PRIMLEV (oxycodone/APAP) ROXANOL (morphine) RYBIX ODT (tramadol) TALACEN (pentazocine/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 of the exceptions on the PA form is present.</p> <p>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.</p> <p>Limits: Unless the patient has escalating cancer pain or another diagnosis supporting increased quantities of short-acting opioids, all short acting solid forms of the narcotic analgesics are limited to 120 tablets per 30 days for the purpose of maximizing the use of longer acting medications to prevent unnecessary breakthrough pain in chronic pain therapy.</p> |



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.

EFFECTIVE
6/11/12
Version 2012.5e

| THERAPEUTIC DRUG CLASS | PREFERRED AGENTS | NON-PREFERRED AGENTS | PA CRITERIA |
|---|---|--|---|
| | | TALWIN NX (pentazocine/naloxone) TREZIX (dihydrocodeine/ APAP/caffeine) ^{NR} TYLENOL W/CODEINE (APAP/codeine) ULTRACET (tramadol/APAP) ULTRAM (tramadol) VICODIN (hydrocodone/APAP) VICOPROFEN (hydrocodone/ibuprofen) VOPAC (codeine/acetaminophen) XODOL (hydrocodone/acetaminophen) ZAMICET (hydrocodone/APAP) ZYDONE (hydrocodone/acetaminophen) XOLOX (oxycodone/APAP) | |
| ANALGESICS, NARCOTIC - LONG ACTING (Non-parenteral)^{AP} | | | |
| | fentanyl transdermal KADIAN (morphine) 10mg, 20mg, 30mg, 50mg, 60mg, 100mg methadone morphine ER tablets OPANA ER (oxymorphone) | AVINZA (morphine) BUTRANS (buprenorphine) CONZIP ER (tramadol) DOLOPHINE (methadone) DURAGESIC (fentanyl) EXALGO ER (hydromorphone) EMBEDA (morphine/naltrexone) KADIAN (morphine) 80mg, 200mg morphine ER capsules MS CONTIN (morphine) NUCYNTA ER (tapentadol) ORAMORPH SR (morphine) oxycodone ER OXYCONTIN (oxycodone) oxymorphone ER RYZOLT ER (tramadol) tramadol ER ULTRAM ER (tramadol) | <p>Six (6) day trials each of two preferred unique long acting chemical entities are required before a non-preferred agent will be approved unless one 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.</p> <p>Butrans will be approved if the following criteria are met:</p> <ol style="list-style-type: none"> 1. Diagnosis of moderate to severe chronic pain requiring continuous around-the-clock analgesia and 2. Patient cannot take oral medications and has a diagnosis of chronic pain and 3. Needs analgesic medication for an extended period of time and 4. Has had a previous trial** of a non-opioid analgesic medication and 5. Previous trial of one opioid medication** and 6. Current total daily opioid dose is ≤ 80 mg morphine equivalents |



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.

EFFECTIVE
6/11/12
Version 2012.5e

| THERAPEUTIC DRUG CLASS | PREFERRED AGENTS | NON-PREFERRED AGENTS | PA CRITERIA |
|--|---|--|---|
| | | | <p>daily or dose of transdermal fentanyl is \leq 12.5 mcg/hr and 7. Patient is not currently being treated with buprenorphine.</p> <p>**Requirement is waived for patients who cannot swallow</p> <p><i>Dose optimization is required for achieving equivalent doses of Kadian 80mg and 200mg. AP does not apply.</i></p> <p>Exception: Oxycodone ER will be authorized if a diagnosis of cancer is submitted without a trial of the preferred agents.</p> |
| ANALGESICS (Topical)^{AP} | | | |
| | <p>capsaicin lidocaine lidocaine/prilocaine xylocaine</p> | <p>EMLA (lidocaine/prilocaine) FLECTOR PATCH (diclofenac) LIDODERM PATCH (lidocaine) LIDAMANTLE (lidocaine) LIDAMANTLE HC (lidocaine/hydrocortisone) LMX 4 (lidocaine) PENNSAID (diclofenac) SYNERA (lidocaine/tetracaine) VOLTAREN GEL (diclofenac) ZOSTRIX (capsaicin)</p> | <p>Ten (10) day trials of each of the preferred topical anesthetics (lidocaine, lidocaine/prilocaine, and xylocaine) are required before a non-preferred topical anesthetic will be approved unless one of the exceptions on the PA form is present.</p> <p>Lidoderm patches will be approved for a diagnosis of post-herpetic neuralgia.</p> <p>Thirty (30) day trials of each of the preferred oral NSAIDS and capsaicin are required before Voltaren Gel will be approved unless one of the exceptions on the PA form is present.</p> <p>Flector patches will be approved only for a diagnosis of acute strain, sprain or injury after a five (5) day trial of one of the preferred oral</p> |



**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.

**EFFECTIVE
6/11/12
Version 2012.5e**

| THERAPEUTIC DRUG CLASS | PREFERRED AGENTS | NON-PREFERRED AGENTS | PA CRITERIA |
|--|--|---|--|
| | | | NSAIDs and for a maximum duration of 14 days unless one 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 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) CAPOTEN (captopril) LOTENSIN (benazepril) MAVIK (trandolapril) moexipril MONOPRIL (fosinopril) 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 of the exceptions on the PA form is present. |
| ACE INHIBITOR COMBINATION DRUGS | | | |
| | benazepril/amlodipine benazepril/HCTZ captopril/HCTZ enalapril/HCTZ fosinopril/HCTZ lisinopril/HCTZ quinapril/HCTZ | ACCURETIC (quinapril/HCTZ) CAPOZIDE (captopril/HCTZ) LEXXEL (enalapril/felodipine) LOTENSIN HCT (benazepril/HCTZ) LOTREL (benazepril/amlodipine) moexipril/HCTZ PRINZIDE (lisinopril/HCTZ) TARKA (trandolapril/verapamil) trandolapril/verapamil UNIRETIC (moexipril/HCTZ) VASERETIC (enalapril/HCTZ) ZESTORETIC (lisinopril/HCTZ) | |



**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.

**EFFECTIVE
6/11/12
Version 2012.5e**

| THERAPEUTIC DRUG CLASS | PREFERRED AGENTS | NON-PREFERRED AGENTS | PA CRITERIA |
|--|--|--|--|
| ANGIOTENSIN II RECEPTOR BLOCKERS (ARBs) | | | |
| | AVAPRO (irbesartan) BENICAR (olmesartan) DIOVAN (valsartan) losartan MICARDIS (telmisartan) | ATACAND (candesartan) COZAAR (losartan) EDARBI (azilsartan) eprosartan irbesartan TEVETEN (eprosartan) | |
| ARB COMBINATIONS | | | |
| | AVALIDE (irbesartan/HCTZ) BENICAR-HCT (olmesartan/HCTZ) DIOVAN-HCT (valsartan/HCTZ) EXFORGE (valsartan/amlodipine) EXFORGE HCT (valsartan/amlodipine/HCTZ) losartan/HCTZ MICARDIS-HCT (telmisartan/HCTZ) | ATACAND-HCT (candesartan/HCTZ) AZOR (olmesartan/amlodipine) EDARBYCLOR (azilsartan/chlorthalidone) ^{NR} HYZAAR (losartan/HCTZ) irbesartan/HCTZ TEVETEN-HCT (eprosartan/HCTZ) TRIBENZOR (olmesartan/amlodipine/HCTZ) TWYNSTA (telmisartan/amlodipine) | |
| DIRECT RENIN INHIBITORS | | | |
| | AMTURNIDE (aliskiren/amlodipine/HCTZ) ^{AP} TEKAMLO (aliskiren/amlodipine) ^{AP} TEKTURNA (aliskiren) ^{AP} TEKTURNA HCT (aliskiren/HCTZ) ^{AP} VALTURNA (aliskiren/valsartan) ^{AP} | | A thirty (30) day trial of one 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 | | | |
| | ALINIA (nitazoxanide) NEO-FRADIN (neomycin) neomycin metronidazole tablet TINDAMAX (tinidazole) | DIFICID (fidaxomicin) FLAGYL (metronidazole) FLAGYL ER (metronidazole ER) metronidazole capsule VANCOCIN (vancomycin) vancomycin XIFAXIN (rifaximin) | A fourteen (14) day trial of a corresponding generic preferred agent is required before a non-preferred brand agent will be approved. Dificid will be approved if 1) there is a diagnosis of severe <i>C. difficile</i> |



**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.

**EFFECTIVE
6/11/12
Version 2012.5e**

| THERAPEUTIC DRUG CLASS | PREFERRED AGENTS | NON-PREFERRED AGENTS | PA CRITERIA |
|------------------------------------|--|----------------------------|---|
| | | | <p>infection and 2) there is no response to prior treatment with vancomycin for 10-14 days.</p> <p>Xifaxin 200 mg will be approved for traveller's diarrhea if 1) there is a diagnosis of <i>E. coli</i> diarrhea, 2) patient is between 12 and 18 years old or is 18 years or older and has failed a ten (10) day trial of ciprofloxacin.</p> <p>Xifaxin 550 mg will be approved for hepatic encephalopathy if 1) there is a diagnosis of hepatic encephalopathy, 2) patient is 18 years or older, and 3) patient has a history of and current treatment with lactulose.</p> <p>Vancocin will be approved after a fourteen (14) day trial of metronidazole for <i>C. difficile</i> infections of mild to moderate severity unless one of the exceptions on the PA form is present.</p> <p>Vancocin will be approved for severe <i>C. difficile</i> infections with no previous trial of metronidazole.</p> |
| ANTIBIOTICS, INHALED | | | |
| | TOBI (tobramycin) | CAYSTON (aztreonam) | A 28-day trial of the preferred agent is required before the non-preferred agent will be approved unless one of the exceptions on the PA form is present. |
| ANTICOAGULANTS^{CL} | | | |
| INJECTABLE | | | |
| | ARIXTRA (fondaparinux) FRAGMIN (dalteparin) | enoxaparin fondaparinux | Trials of each of the preferred agents will be required before a |



**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.

**EFFECTIVE
6/11/12
Version 2012.5e**

| THERAPEUTIC DRUG CLASS | PREFERRED AGENTS | NON-PREFERRED AGENTS | PA CRITERIA |
|------------------------|--|---|---|
| | LOVENOX (enoxaparin) | INNOHEP (tinzaparin) | non-preferred agent will be approved unless one of the exceptions on the PA form is present. |
| ORAL | | | |
| | PRADAXA (dabigatran) ^{AP} warfarin XARELTO (rivaroxaban) ^{AP} | | <p>Pradaxa will be approved for the diagnosis of non-valvular atrial fibrillation.</p> <p>Xarelto will be approved for the diagnosis of non-valvular atrial fibrillation.</p> <p>Xarelto will be approved for DVT prophylaxis if treatment is limited to 35 days for hip replacement surgeries or 12 days for knee replacement surgeries.</p> |
| ANTICONVULSANTS | | | |
| ADJUVANTS | | | |
| | carbamazepine CARBATROL (carbamazepine) DEPAKOTE SPRINKLE (divalproex) divalproex EC divalproex ER divalproex DR EPITOL (carbamazepine) FELBATOL (felbamate) gabapentin GABITRIL (tiagabine) levetiracetam lamotrigine lamotrigine chewable LYRICA (pregabalin) oxcarbazepine tablets topiramate TRILEPTAL SUSPENSION (oxcarbazepine) valproic acid zonisamide | BANZEL(rufinamide) carbamazepine XR DEPAKENE (valproic acid) DEPAKOTE (divalproex) DEPAKOTE ER (divalproex) EQUETRO (carbamazepine) FANATREX SUSPENSION (gabapentin) ^{NR} felbamate GRALISE (gabapentin) HORIZANT (gabapentin) KEPBRA (levetiracetam) KEPBRA XR (levetiracetam) LAMICTAL (lamotrigine) LAMICTAL CHEWABLE (lamotrigine) LAMICTAL ODT (lamotrigine) LAMICTAL XR (lamotrigine) levetiracetam ER NEURONTIN (gabapentin) ONFI (clobazam) ^{NR} POTIGA (ezogabine) ^{NR} SABRIL (vigabatrin) | <p>A fourteen (14) day trial of one of the preferred agents in the corresponding group is required for treatment naive patients with a diagnosis of a seizure disorder before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present.</p> <p>A thirty (30) day trial of one of the preferred agents in the corresponding group is required for patients with a diagnosis other than seizure disorders unless one of the exceptions on the PA form is present.</p> <p>Non-preferred anticonvulsants will be approved for patients on established therapies with a</p> |



**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.

**EFFECTIVE
6/11/12
Version 2012.5e**

| THERAPEUTIC DRUG CLASS | PREFERRED AGENTS | NON-PREFERRED AGENTS | PA CRITERIA |
|------------------------|--|---|--|
| | | STAVZOR (valproic acid) TEGRETOL (carbamazepine) TEGRETOL XR (carbamazepine) TOPAMAX (topiramate) TRILEPTAL TABLETS (oxcarbazepine) VIMPAT (lacosamide) ZONEGRAN (zonisamide) | <p>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.</p> <p>Requests for Gralise will be authorized if the following criteria are met:</p> <ol style="list-style-type: none"> 1. Diagnosis of post herpetic neuralgia 2. Trial of a tricyclic antidepressant for a least thirty days 3. Trial of gabapentin immediate release formulation (positive response without adequate duration) 4. Request is for once daily dosing with 1800 mg. maximum daily dosage. |
| | BARBITURATES^{AP} | | |
| | mephobarbital phenobarbital primidone | MEBARAL (mephobarbital) MYSOLINE (primidone) | |
| | BENZODIAZEPINES^{AP} | | |
| | clonazepam DIASTAT (diazepam rectal) diazepam tablets | diazepam rectal gel KLONOPIN (clonazepam) | |
| | HYDANTOINS^{AP} | | |
| | DILANTIN INFATABS (phenytoin) PEGANONE (ethotoin) phenytoin | CEREBYX (fosphenytoin) DILANTIN (phenytoin) PHENYTEK (phenytoin) | |
| | SUCCINIMIDES | | |
| | CELONTIN (methsuximide) ethosuximide ZARONTIN (ethosuximide) | | |



**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.

**EFFECTIVE
6/11/12
Version 2012.5e**

| THERAPEUTIC DRUG CLASS | PREFERRED AGENTS | NON-PREFERRED AGENTS | PA CRITERIA |
|--|--|--|---|
| ANTIDEPRESSANTS, OTHER | | | |
| | SNRIS^{AP} | | |
| | CYMBALTA (duloxetine) venlafaxine ER capsules | EFFEXOR (venlafaxine) EFFEXOR XR (venlafaxine) PRISTIQ (desvenlafaxine) venlafaxine 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 of the exceptions on the PA form is present. |
| | SECOND GENERATION NON-SSRI, OTHER^{AP} | | |
| | bupropion SR bupropion XL mirtazapine SAVELLA (milnacipran) ^{AP*} trazodone | APLENZIN (bupropion hbr) bupropion IR DESYREL (trazodone) EMSAM (selegiline) nefazodone OLEPTRO ER (trazodone) REMERON (mirtazapine) WELLBUTRIN (bupropion) WELLBUTRIN SR (bupropion) WELLBUTRIN XL (bupropion) VIIBRYD (vilazodone hcl) | * Savella will be approved for a diagnosis of fibromyalgia or a previous thirty (30) day trial of a drug that infers fibromyalgia: gabapentin, Cymbalta, Lyrica, amitriptyline or nortriptyline. |
| | 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 fluoxetine fluvoxamine LEXAPRO (escitalopram) paroxetine sertraline | CELEXA (citalopram) escitalopram LUVOX (fluvoxamine) LUVOX CR (fluvoxamine) PAXIL (paroxetine) PAXIL CR (paroxetine) paroxetine ER PEXEVA (paroxetine) PROZAC (fluoxetine) RAPIFLUX (fluoxetine) SARAFEM (fluoxetine) ZOLOFT (sertraline) | Thirty (30) day trials each of two (2) of the preferred agents are required before a non-preferred agent will be approved unless one of the exceptions on the PA form is present. Upon hospital discharge, patients admitted with a primary mental health diagnosis and have been stabilized on a non-preferred SSRI will receive an authorization to continue that drug. |



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.

EFFECTIVE
6/11/12
Version 2012.5e

| THERAPEUTIC DRUG CLASS | PREFERRED AGENTS | NON-PREFERRED AGENTS | PA CRITERIA |
|---------------------------------|--|---|---|
| ANTIEMETICS^{AP} | | | |
| 5HT3 RECEPTOR BLOCKERS | | | |
| | ondansetron ondansetron ODT | ANZEMET (dolasetron) KYTRIL (granisetron) granisetron GRANISOL (granisetron) SANCUSO (granisetron) ZOFTRAN (ondansetron) ZOFTRAN ODT (ondansetron) ZUPLENZ (ondansetron) | A 3-day trial of a preferred agent is required before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present. PA is required for ondansetron when limits are exceeded. |
| CANNABINOIDS | | | |
| | | CESAMET (nabilone) dronabinol MARINOL (dronabinol) | Cesamet will be authorized only for the treatment of nausea and vomiting associated with cancer chemotherapy for patients who have failed to respond adequately to 3-day trials of conventional treatments such as promethazine or ondansetron and are over 18 years of age. Marinol will be authorized only for the treatment of anorexia associated with weight loss in patients with AIDS or cancer and unresponsive to megestrol; or for the prophylaxis of chemotherapy induced nausea and vomiting unresponsive to 3-day trials of ondansetron or promethazine for patients between the ages of 18 and 65. |
| SUBSTANCE P ANTAGONISTS | | | |
| | EMEND (aprepitant) | | |
| ANTIFUNGALS (Oral) | | | |
| | clotrimazole fluconazole* ketoconazole ^{CL} nystatin | ANCOBON (flucytosine) DIFLUCAN (fluconazole) flucytosine GRIFULVIN V TABLET (griseofulvin) | Non-preferred agents will be approved only if one of the exceptions on the PA form is |



**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.

**EFFECTIVE
6/11/12
Version 2012.5e**

| THERAPEUTIC DRUG CLASS | PREFERRED AGENTS | NON-PREFERRED AGENTS | PA CRITERIA |
|---|--|--|--|
| | terbinafine ^{CL} | griseofulvin GRIS-PEG (griseofulvin) itraconazole LAMISIL (terbinafine) MYCELEX (clotrimazole) MYCOSTATIN Tablets (nystatin) NIZORAL (ketoconazole) NOXAFIL (posaconazole) ORAVIG BUCCAL (miconazole) SPORANOX (itraconazole) VFEND (voriconazole) voriconazole | present. *PA is required when limits are exceeded. PA is not required for griseofulvin suspension for children up to 6 years of age for the treatment of tinea capitis. |
| ANTIFUNGALS (Topical)^{AP} | | | |
| ANTIFUNGALS | | | |
| | econazole ketoconazole MENTAX (butenafine) NAFTIN (naftifine) nystatin | ciclopirox ERTACZO (sertaconazole) EXELDERM (sulconazole) LOPROX (ciclopirox) MYCOSTATIN (nystatin) NIZORAL (ketoconazole) OXISTAT (oxiconazole) PEDIPIROX-4 (ciclopirox) ^{NR} PENLAC (ciclopirox) SPECTAZOLE (econazole) VUSION (miconazole/petrolatum/zinc oxide) XOLEGEL (ketoconazole) | Fourteen (14) day trials of two (2) of the preferred agents are required before one of the non-preferred agents will be authorized unless one of the exceptions on the PA form is present. If a non-preferred shampoo is requested, a fourteen (14) day trial of one preferred product (ketoconazole shampoo) is required. Oxistat cream will be approved for children 12 and under for tinea corporis, tinea cruris, tinea pedis, and tinea (pityriasis) versicolor. |
| ANTIFUNGAL/STEROID COMBINATIONS | | | |
| | clotrimazole/betamethasone nystatin/triamcinolone | KETOCON PLUS (ketoconazole/hydrocortisone) LOTRISONE (clotrimazole/betamethasone) ^{AP} MYCOLOG (nystatin/triamcinolone) ^{AP} | |
| ANTI-HISTAMINES, MINIMALLY SEDATING^{AP} | | | |
| ANTI-HISTAMINES | | | |
| | ALAVERT (loratadine) cetirizine loratadine TAVIST-ND (loratadine) | ALLEGRA (fexofenadine) CLARINEX Tablets (desloratadine) CLARINEX REDITABS (desloratadine) CLARINEX Syrup (desloratadine) CLARITIN (loratadine) | 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- |



**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.

**EFFECTIVE
6/11/12
Version 2012.5e**

| THERAPEUTIC DRUG CLASS | PREFERRED AGENTS | NON-PREFERRED AGENTS | PA CRITERIA |
|---|--|--|---|
| | | fexofenadine (Rx and OTC) levocetirizine XYZAL (levocetirizine) ZYRTEC (Rx and OTC) (cetirizine) ZYRTEC SYRUP (cetirizine) | preferred product, are required before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present. |
| ANTIHISTAMINE/DECONGESTANT COMBINATIONS | | | |
| | ALAVERT-D (loratadine/pseudoephedrine) cetirizine/pseudoephedrine loratadine/pseudoephedrine SEMPREX-D (acrivastine/ pseudoephedrine) | ALLEGRA-D (fexofenadine/ pseudoephedrine) CLARINEX-D (desloratadine/ pseudoephedrine) CLARITIN-D (loratadine/pseudoephedrine) fexofenadine/ pseudoephedrine (Rx and OTC) ZYRTEC-D (cetirizine/pseudoephedrine) | |
| ANTIMIGRAINE AGENTS, TRIPTANS^{AP} | | | |
| TRIPTANS | | | |
| | IMITREX NASAL SPRAY(sumatriptan) IMITREX INJECTION (sumatriptan) ^{CL} naratriptan sumatriptan | AMERGE (naratriptan) AXERT (almotriptan) FROVA (frovatriptan) IMITREX tablets (sumatriptan) MAXALT (rizatriptan) MAXALT MLT (rizatriptan) RELPAX (eletriptan) sumatriptan nasal spray/injection * ZOMIG (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 of the exceptions on the PA form is present. Quantity limits apply for this drug class. *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- |



**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.

**EFFECTIVE
6/11/12
Version 2012.5e**

| THERAPEUTIC DRUG CLASS | PREFERRED AGENTS | NON-PREFERRED AGENTS | PA CRITERIA |
|---------------------------------|--|---|--|
| | | | preferred agent will be authorized. |
| | COMT INHIBITORS | | |
| | | COMTAN (entacapone) TASMAR (tolcapone) | |
| | DOPAMINE AGONISTS | | |
| | pramipexole ropinirole | MIRAPEX (pramipexole) MIRAPEX ER (pramipexole) REQUIP (ropinirole) REQUIP XL (ropinirole) ropinirole XL | 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) SINEMET (levodopa/carbidopa) ZELAPAR (selegiline) | Amantadine will be approved only for a diagnosis of Parkinsonism. |
| ANTIPSYCHOTICS, ATYPICAL | | | |
| | SINGLE INGREDIENT | | |
| | clozapine GEODON (ziprasidone) INVEGA (paliperidone) INVEGA SUSTENNA (paliperidone)* risperidone risperidone ODT risperidone solution quetiapine ^{AP} (25mg Tablet Only) | ABILIFY (aripiprazole) CLOZARIL (clozapine) FANAPT (iloperidone) FAZACLO (clozapine) LATUDA (lurasidone) olanzapine olanzapine IM* RISPERDAL (risperidone) RISPERDAL CONSTA (risperidone)* RISPERDAL ODT (risperidone) RISPERDAL SOLUTION (risperidone) SAPHRIS (asenapine) SEROQUEL (quetiapine) SEROQUEL XR (quetiapine) ziprasidone ZYPREXA (olanzapine) ZYPREXA INTRAMUSCULAR (olanzapine)* | A fourteen (14) day trial of a preferred agent is required for treatment naïve patients before a non-preferred agent will be approved unless one of the exceptions on the PA form is present. Upon discharge, a hospitalized patient stabilized on a non-preferred agent may receive authorization to continue this drug for labeled indications and at recommended dosages. Claims for Seroquel 25 mg will be approved: 1. for a diagnosis of schizophrenia or |



**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.

**EFFECTIVE
6/11/12
Version 2012.5e**

| THERAPEUTIC DRUG CLASS | PREFERRED AGENTS | NON-PREFERRED AGENTS | PA CRITERIA |
|------------------------|------------------|----------------------|---|
| | | | <p>2. for a diagnosis of bipolar disorder</p> <p align="center">or</p> <p>3. when prescribed concurrently with other strengths of Seroquel in order to achieve therapeutic treatment levels.</p> <p>Seroquel 25 mg. will not be approved for use as a sedative hypnotic.</p> <p>All antipsychotic agents require prior authorization for children up to six (6) years of age.</p> <p>Abilify will be approved for children between the ages of 6-17 for irritability associated with autism. Abilify will be prior authorized for MDD if the following criteria are met:</p> <ol style="list-style-type: none"> 1. The patient is at least 18 years of age. 2. Diagnosis of Major Depressive Disorder (MDD), 3. Evidence of trials of appropriate therapeutic duration (30 days), at the maximum tolerable dose, of at least one agent in two of the following classes: SSRI, SNRI or bupropion in conjunction with Seroquel at doses of 150 mg or more 4. Prescribed in conjunction with an SSRI, SNRI, or bupropion 5. The daily dose does not exceed 15 mg. <p>*All injectable antipsychotic products require clinical prior authorization.</p> |



**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.

**EFFECTIVE
6/11/12
Version 2012.5e**

| THERAPEUTIC DRUG CLASS | PREFERRED AGENTS | NON-PREFERRED AGENTS | PA CRITERIA |
|--|---|--|--|
| ATYPICAL ANTIPSYCHOTIC/SSRI COMBINATIONS | | | |
| | | SYMBYAX (olanzapine/fluoxetine) | |
| ANTIVIRALS (Oral) | | | |
| ANTI HERPES | | | |
| | acyclovir VALTREX (valacyclovir) | famciclovir FAMVIR (famciclovir) valacyclovir ZOVIRAX (acyclovir) | Five (5) day trials each of the preferred agents are required before the non-preferred agents will be authorized unless one of the exceptions on the PA form is present. |
| ANTI-INFLUENZA | | | |
| | RELENZA (zanamivir) TAMIFLU (oseltamivir) | FLUMADINE (rimantadine) rimantadine amantadine ^{AP} | The anti-influenza agents will be approved only for a diagnosis of influenza. |
| ANTIVIRALS (Topical)^{AP} | | | |
| | ABREVA (docosanol) DENA VIR (penciclovir) | ZOVIRAX (acyclovir) | Five day trials of each of the preferred agents are required before the non-preferred agent will be approved. |
| 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 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 | BETAPACE (sotalol) BLOCADREN (timolol) BYSTOLIC (nebivolol) CARTROL (carteolol) CORGARD (nadolol) INDERAL LA (propranolol) INNOPRAN XL (propranolol) | Fourteen (14) day trials each of three (3) chemically distinct preferred agents, including the generic formulation of a requested non-preferred product, are required before one of the non-preferred agents will be approved unless one |



**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.

**EFFECTIVE
6/11/12
Version 2012.5e**

| THERAPEUTIC DRUG CLASS | PREFERRED AGENTS | NON-PREFERRED AGENTS | PA CRITERIA |
|---|--|---|---|
| | pindolol propranolol propranolol ER sotalol timolol | KERLONE (betaxolol) LEVATOL (penbutolol) LOPRESSOR (metoprolol) SECTRAL (acebutolol) TENORMIN (atenolol) TOPROL XL (metoprolol) ZEBETA (bisoprolol) | 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) ^{NR} INDERIDE (propranolol/HCTZ) LOPRESSOR HCT (metoprolol/HCTZ) TENORETIC (atenolol/chlorthalidone) ZIAC (bisoprolol/HCTZ) | |
| BETA- AND ALPHA-BLOCKERS | | | |
| | carvedilol labetalol | COREG (carvedilol) COREG CR (carvedilol) TRANDATE (labetalol) | |
| ANTIANGINALS | | | |
| | | RANEXA (ranolazine) ^{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 of these ingredients. |
| BLADDER RELAXANT PREPARATIONS^{AP} | | | |
| | oxybutynin oxybutynin ER TOVIAZ (fesoterodine) VESICARE (solifenacin) | ENABLEX (darifenacin) DETROL (tolterodine) DETROL LA (tolterodine) DITROPAN (oxybutynin) DITROPAN XL (oxybutynin) GELNIQUE (oxybutynin) OXYTROL (oxybutynin) SANCTURA (trospium) SANCTURA XR (trospium) trospium | A thirty (30) day trial each of the chemically distinct preferred agents is required before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present. |
| BONE RESORPTION SUPPRESSION AND RELATED AGENTS | | | |
| BISPHOSPHONATES | | | |



**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.

**EFFECTIVE
6/11/12
Version 2012.5e**

| THERAPEUTIC DRUG CLASS | PREFERRED AGENTS | NON-PREFERRED AGENTS | PA CRITERIA |
|---|---|---|--|
| | alendronate FOSAMAX SOLUTION (alendronate) | ACTONEL (risedronate) ACTONEL WITH CALCIUM (risedronate/ calcium) ATELVIA (risedronate) BONIVA (ibandronate) DIDRONEL (etidronate) FOSAMAX TABLETS (alendronate) FOSAMAX PLUS D (alendronate/vitamin D) ibandronate ZOMETA (zoledronic acid) | A 30-day trial of the preferred agent is required before a non-preferred agent will be approved. |
| OTHER BONE RESORPTION SUPPRESSION AND RELATED AGENTS | | | |
| | MIACALCIN (calcitonin) | calcitonin EVISTA (raloxifene) FORTEO (teriparatide) FORTICAL (calcitonin) | Evista will be approved for postmenopausal women with osteoporosis or at high risk for invasive breast cancer. |
| BPH AGENTS^{AP} | | | |
| 5-ALPHA-REDUCTASE (5AR) INHIBITORS | | | |
| | AVODART (dutasteride) finasteride | PROSCAR (finasteride) | Thirty (30) day trials each of at least two (2) chemically distinct preferred agents, including the generic formulation of a requested non-preferred agent, are required before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present. |
| 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. |



**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.

**EFFECTIVE
6/11/12
Version 2012.5e**

| THERAPEUTIC DRUG CLASS | PREFERRED AGENTS | NON-PREFERRED AGENTS | PA CRITERIA |
|---|---|---|--|
| BRONCHODILATORS & RESPIRATORY DRUGS | | | |
| ANTICHOLINERGIC^{AP} | | | |
| | ATROVENT HFA (ipratropium) ipratropium SPIRIVA (tiotropium) | | Thirty (30) day trials each of the preferred agents in the corresponding group are required before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present. |
| ANTICHOLINERGIC-BETA AGONIST COMBINATIONS^{AP} | | | |
| | COMBIVENT (albuterol/ipratropium) | albuterol/ipratropium DUONEB (albuterol/ipratropium) | For severely compromised patients, albuterol/ipratropium will be approved if the combined volume of albuterol and ipratropium nebulas is inhibitory. |
| PDE4 INHIBITOR | | | |
| | | DALIRESP (roflumilast) | Daliresp will be approved when the following criteria are met: 1. Patient is ≥ forty (40) years of age 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 inhibitors (rimampicin, phenobarbital, carbamazepine or phenytoin). |



**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.

**EFFECTIVE
6/11/12
Version 2012.5e**

| THERAPEUTIC DRUG CLASS | PREFERRED AGENTS | NON-PREFERRED AGENTS | PA CRITERIA |
|--|--|--|---|
| INHALATION SOLUTION^{AP} | | | |
| | albuterol 2.5mg/0.5mL | ACCUNEB (albuterol)** albuterol 0.63mg & 1.25mg/3mL ^{AP} BROVANA (arformoterol) levalbuterol metaproterenol PERFOROMIST (formoterol) XOPENEX (levalbuterol) | <p>Thirty (30) day trials each of the chemically distinct preferred agents in their corresponding groups are required before a non-preferred agent in that group will be authorized unless one of the exceptions on the PA form is present.</p> <p>**No PA is required for ACCUNEB for children up to 5 years of age.</p> |
| INHALERS, LONG-ACTING^{AP} | | | |
| | FORADIL (formoterol) SEREVENT (salmeterol) | ARCAPTA (indacaterol maleate) | <p>Thirty (30) day trials each of the preferred agents are required before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present.</p> |
| INHALERS, SHORT-ACTING^{AP} | | | |
| | MAXAIR (pirbuterol) PROAIR HFA (albuterol) PROVENTIL HFA (albuterol) VENTOLIN HFA (albuterol) | XOPENEX HFA (levalbuterol) | <p>Xopenex Inhalation Solution will be approved for 12 months for a diagnosis of asthma or COPD for patients on concurrent asthma controller therapy (either oral or inhaled) with documentation of failure on a trial of albuterol or documented intolerance of albuterol, or for concurrent diagnosis of heart disease.</p> |
| ORAL^{AP} | | | |
| | albuterol terbutaline | metaproterenol VOSPIRE ER (albuterol) | |
| CALCIUM CHANNEL BLOCKERS^{AP} | | | |
| LONG-ACTING | | | |
| | amlodipine diltiazem XR, XT felodipine ER nifedipine ER | ADALAT CC (nifedipine) CALAN SR (verapamil) CARDENE SR (nicardipine) CARDIZEM CD, LA, SR (diltiazem) | <p>Fourteen (14) day trials each of the preferred agents are required before a non-preferred agent will be approved unless one of the</p> |



**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.

**EFFECTIVE
6/11/12
Version 2012.5e**

| THERAPEUTIC DRUG CLASS | PREFERRED AGENTS | NON-PREFERRED AGENTS | PA CRITERIA |
|---|---|---|--|
| | nisoldipine verapamil ER | COVERA-HS (verapamil) DILACOR XR (diltiazem) DYNACIRC CR (isradipine) ISOPTIN SR (verapamil) NORVASC (amlodipine) PLENDIL (felodipine) PROCARDIA XL (nifedipine) SULAR (nisoldipine) TIAZAC (diltiazem) VERELAN/VERELAN PM (verapamil) | exceptions on the PA form is present. |
| SHORT-ACTING | | | |
| | diltiazem verapamil | CALAN (verapamil) CARDENE (nicardipine) CARDIZEM (diltiazem) DYNACIRC (isradipine) isradipine nicardipine nimodipine nifedipine NIMOTOP (nimodipine) PROCARDIA (nifedipine) | |
| CEPHALOSPORINS AND RELATED ANTIBIOTICS (Oral)^{AP} | | | |
| BETA LACTAMS AND BETA LACTAM/BETA-LACTAMASE INHIBITOR COMBINATIONS | | | |
| | amoxicillin/clavulanate | 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 of the exceptions on the PA form is present. |
| CEPHALOSPORINS | | | |
| | cefaclor cefadroxil cefдинир cefditoren cefpodoxime cefprozil cefuroxime cephalexin SPECTRACEF (cefditoren) | CECLOR (cefaclor) CEDAX (ceftibuten) CEFTIN (cefuroxime) CEFZIL (cefprozil) DURICEF (cefadroxil) KEFLEX (cephalexin) OMNICEF (cefдинир) PANIXINE (cephalexin) RANICLOR (cefaclor) SUPRAX (cefixime) VANTIN (cefpodoxime) | |



**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.

**EFFECTIVE
6/11/12
Version 2012.5e**

| THERAPEUTIC DRUG CLASS | PREFERRED AGENTS | NON-PREFERRED AGENTS | PA CRITERIA |
|--|--|-----------------------|--|
| COLONY STIMULATING FACTORS | | | |
| | LEUKINE (sargramostim) NEUPOGEN (filgrastim) | NEULASTA (filgrastim) | A thirty (30) day trial of one of the preferred agents is required before the non-preferred agent will be authorized unless one of the exceptions on the PA form is present. |
| COUGH & COLD/1st GENERATION ANTIHISTAMINES | | | |
| ANTIHISTAMINES, 1ST GENERATION | | | |
| | chlorpheniramine clemastine diphenhydramine | | See posted list of covered NDCs. |
| ANTITUSSIVE-ANTIHISTAMINE COMBINATIONS | | | |
| | dextromethorphan HBR/promethazine | | See posted list of covered NDCs. |
| ANTIHISTAMINE-ANTITUSSIVE-DECONGESTANT COMBINATIONS | | | |
| | brompheniramine/dextromethorphan HBR/pseudoephedrine chlorpheniramine/dextromethorphan/ pseudoephedrine | | See posted list of covered NDCs. |
| ANTITUSSIVE-NON-NARCOTIC | | | |
| | DELSYM (dextromethorphan polistirex) | | See posted list of covered NDCs. |
| DECONGESTANTS | | | |
| | phenylephrine pseudoephedrine | | See posted list of covered NDCs. |
| ANTITUSSIVES/EXPECTORANTS | | | |
| | guaifenesin guaifenesin/dextromethorphan | | See posted list of covered NDCs. |
| DECONGESTANT-ANTIHISTAMINE-ANTICHOLINERGIC COMBINATIONS | | | |



**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.

**EFFECTIVE
6/11/12
Version 2012.5e**

| THERAPEUTIC DRUG CLASS | PREFERRED AGENTS | NON-PREFERRED AGENTS | PA CRITERIA |
|---|---|--|---|
| | pseudoephedrine/chlorpheniramine/ scopolamine syrup | | See posted list of covered NDCs. |
| DECONGESTANT-ANTI HISTAMINE COMBINATIONS | | | |
| | phenylephrine HCL/chlorpheniramine maleate syrup/drops phenylephrine HCL/promethazine syrup | | See posted list of covered NDCs. |
| NARCOTIC ANTITUSSIVE-EXPECTORANT COMBINATION | | | |
| | | | |
| CYTOKINE & CAM ANTAGONISTS^{CL} | | | |
| | ENBREL (etanercept) HUMIRA (adalimumab) | CIMZIA (certolizumab/pegol) KINERET (anakinra) ORENCIA (abatacept) SUBCUTANEOUS SIMPONI (golimumab) | Thirty (30) day trials of each of the preferred agents are required before a non-preferred agent will be approved. 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) OMONTYS (peginesatide) ^{NR} | A thirty (30) day trial of the preferred agent is required before a non-preferred agent will be approved. No evidence of untreated GI bleeding, hemolysis, or Vitamin B-12, iron or folate deficiency. Prior authorization will be given for the erythropoiesis 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 be considered on an individual basis |



**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.

**EFFECTIVE
6/11/12
Version 2012.5e**

| THERAPEUTIC DRUG CLASS | PREFERRED AGENTS | NON-PREFERRED AGENTS | PA CRITERIA |
|---|---|---|--|
| | | | <p>after medical documentation is reviewed. (Laboratory values must be dated within six (6) weeks of request.)</p> <p>2. Transferrin saturation \geq 20%, ferritin levels \geq100 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.</p> <p>3. For HIV-infected patients, endogenous serum erythropoietin level must be \leq 500mU/ml to initiate therapy.</p> <p>4. No evidence of untreated GI bleeding, hemolysis, or Vitamin B-12, iron or folate deficiency.</p> |
| FLUOROQUINOLONES (Oral)^{AP} | | | |
| | CIPRO (ciprofloxacin) Suspension ciprofloxacin ciprofloxacin ER levofloxacin | AVELOX (moxifloxacin) CIPRO (ciprofloxacin) Tablets CIPRO XR (ciprofloxacin) FACTIVE (gemifloxacin) FLOXIN (ofloxacin) LEVAQUIN (levofloxacin) NOROXIN (norfloxacin) ofloxacin PROQUIN XR (ciprofloxacin) | A five (5) day trial of one of the preferred agents is required before a non-preferred agent will be approved unless one of the exceptions on the PA form is present. |
| GENITAL WARTS AGENTS | | | |
| | ALDARA (imiquimod) | CONDYLOX (podofilox) 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 of the exceptions on the PA form is present. |



**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.

**EFFECTIVE
6/11/12
Version 2012.5e**

| THERAPEUTIC DRUG CLASS | PREFERRED AGENTS | NON-PREFERRED AGENTS | PA CRITERIA |
|---|--|---|---|
| | | | Zyclara will be approved for a diagnosis of actinic keratosis. |
| GLUCOCORTICOIDS (Inhaled)^{AP} | | | |
| | GLUCOCORTICOIDS | | |
| | ASMANEX (mometasone) FLOVENT HFA (fluticasone) FLOVENT Diskus (fluticasone) QVAR (beclomethasone) | ALVESCO (ciclesonide) budesonide PULMICORT (budesonide)* | <p>Thirty (30) day trials each of the preferred agents are required before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present.</p> <p>Pulmicort Respules do not require a prior authorization for children through 8 years of age or for individuals unable to use an MDI. When children who have been stabilized on Pulmicort Respules reach age 9, prescriptions for the Pulmicort inhaler will be authorized for them.</p> <p>*For children less than 9 years of age and for those who meet the PA requirements, brand Pulmicort is preferred over the generic.</p> |
| | 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/ointment betamethasone dipropionate/propylene glycol betamethasone valerate ointment clobetasol propionate cream/gel/ointment/solution clobetasol propionate/emollient desoximetasone cream/gel/ointment | amcinonide APEXICON (diflorasone diacetate) APEXICON E (diflorasone diacetate) betamethasone dipropionate gel clobetasol propionate foam, lotion, shampoo CLOBEX (clobetasol propionate) CORMAX (clobetasol propionate) | 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. |



**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.

**EFFECTIVE
6/11/12
Version 2012.5e**

| THERAPEUTIC DRUG CLASS | PREFERRED AGENTS | NON-PREFERRED AGENTS | PA CRITERIA |
|------------------------|---|--|-------------|
| | fluocinonide halobetasol propionate triamcinolone acetonide 0.5% | difflorasone diacetate difflorasone diacetate/emollient DIPROLENE (betamethasone dipropionate/propylene glycol) DIPROLENE AF (betamethasone dipropionate/propylene glycol) DIPROSONE (betamethasone dipropionate) fluocinonide/emollient halcinonide HALOG (halcinonide) KENALOG 0.5% (triamcinolone acetonide) LIDEX (fluocinonide) LIDEX-E (fluocinonide) LUXIQ (betamethasone valerate) OLUX (clobetasol propionate) OLUX-E (clobetasol propionate/emollient) PSORCON (difflorasone diacetate) TEMOVATE (clobetasol propionate) TEMOVATE-E (clobetasol propionate/emollient) TOPICORT (desoximetasone) ULTRAVATE (halobetasol propionate) VANOS (fluocinonide) | |
| MEDIUM POTENCY | | | |
| | betamethasone dipropionate lotion betamethasone valerate cream desoximetasone 0.05% cream flucinolone acetonide 0.025% fluticasone propionate hydrocortisone valerate mometasone furoate triamcinolone acetonide 0.025% and 0.1% | ARISTOCORT (triamcinolone) betamethasone valerate lotion BETA-VAL (betamethasone valerate) CLODERM (clocortolone pivalate) CORDRAN/CORDRAN SP (flurandrenolide) CUTIVATE (fluticasone propionate) DERMATOP (prednicarbate) ELOCON (mometasone furoate) hydrocortisone butyrate hydrocortisone butyrate/emollient KENALOG 0.1% (triamcinolone acetonide) LOCOID (hydrocortisone butyrate) LOCOID LIPOCREAM (hydrocortisone butyrate/emollient) prednicarbate TOPICORT LP (desoximetasone) TRIDERM (triamcinolone acetonide) WESTCORT (hydrocortisone valerate) | |



**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.

**EFFECTIVE
6/11/12
Version 2012.5e**

| THERAPEUTIC DRUG CLASS | PREFERRED AGENTS | NON-PREFERRED AGENTS | PA CRITERIA |
|---|--|---|--|
| LOW POTENCY | | | |
| | desonide fluocinolone acetonide 0.01% hydrocortisone 0.5%, 1%, 2.5% hydrocortisone acetate 0.5%, 1% (Rx & OTC) | ACLOVATE (alclometasone dipropionate) alclometasone dipropionate AQUA GLYCOLIC HC (hydrocortisone) ^{NR} CAPEX (fluocinolone acetonide) DERMA-SMOOTH FS (fluocinolone acetonide) DESONATE (desonide) DESOWEN (desonide) LOKARA (desonide) PANDEL (hydrocortisone probutate) VERDESO (desonide) | |
| GROWTH HORMONE^{CL} | | | |
| | GENOTROPIN (somatropin) NORDITROPIN NORDIFLEX (somatropin) NORDITROPIN FLEXPLO (somatropin) NUTROPIN AQ NUSPIN (somatropin) | HUMATROPE (somatropin) INCRELEX (mecasermin) NUTROPIN (somatropin) NUTROPIN AQ (somatropin) OMNITROPE (somatropin) SAIZEN (somatropin) SEROSTIM (somatropin) TEV-TROPIN (somatropin) ZORBTIVE (somatropin) | <p>The preferred agents must be tried before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present.</p> <p>Patients already on a non-preferred agent will receive authorization to continue therapy on that agent for the duration of the existing PA.</p> |
| 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) ^{NR} 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 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 of the preferred agents is required before the non-preferred agent will be authorized unless one of the exceptions on the PA form is present. |



**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.

**EFFECTIVE
6/11/12
Version 2012.5e**

| 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 DOSEPACK (ribavirin) RIBASPHERE (ribavirin) | <p>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.</p> <p>See additional criteria for Incivek and Victrelis at http://www.dhr.wv.gov/bms/Pharmacy/Pages/pac.aspx</p> |
| HYPERURICEMIA AND GOUT AGENTS | | | |
| ANTIMITOTICS | | | |
| | | COLCRYS (colchicine)* | <p>A thirty (30) day trial of one 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 of the exceptions on the PA form is present.</p> <p>*In the case of acute gouty attacks, a 10-day supply (20 tablets) of Colcrys will be approved per 90 days.</p> |
| ANTIMITOTIC-URICOSURIC COMBINATION | | | |
| | colchicine/probenecid | | |
| URICOSURIC | | | |
| | probenecid | | |
| XANTHINE OXIDASE INHIBITORS | | | |
| | allopurinol | ULORIC (febuxostat) ZYLOPRIM (allopurinol) | |



**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.

**EFFECTIVE
6/11/12
Version 2012.5e**

| THERAPEUTIC DRUG CLASS | PREFERRED AGENTS | NON-PREFERRED AGENTS | PA CRITERIA |
|---|---|---|--|
| HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS | | | |
| INJECTABLE | | | |
| | | BYDUREON (exenatide) ^{NR} BYETTA (exenatide) SYMLIN (pramlintide) VICTOZA (liraglutide) | <p>Byetta, Symlin, and Victoza will be subject to the following clinical edits:</p> <p>Byetta and Victoza will be approved with a previous history of a thirty (30) day trial of an oral agent (sulfonylurea, thiazolidinedione (TZD) and/ or metformin) and no evidence of concurrent insulin therapy.</p> <p>Symlin- History of insulin utilization in the past 90 days. No gaps in insulin therapy greater than 30 days.</p> |
| ORAL^{AP} | | | |
| | JANUMET (sitagliptin/metformin) JANUVIA (sitagliptin) JUVISYNC (sitagliptin/simvastatin) KOMBIGLYZE XR (saxagliptin/metformin) ONGLYZA (saxagliptin) TRADJENTA (linagliptin) | JANUMET XR (sitagliptin/metformin) ^{NR} JENTADUETO (linagliptin/metformin) ^{NR} | <p>Januvia/Janumet/Juvisync, Onglyza/Kombiglyze XR and Tradjenta will be subject to the following edits:</p> <ol style="list-style-type: none"> 1. Previous history of a 30-day trial of metformin, sulfonylurea, or TZD. 2. Tradjenta will not be approved for concurrent use with insulin. 3. Januvia / Janumet / Juvisync, Onglyza/Kombiglyze XR 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 7. Current laboratory values must be submitted. |



**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.

**EFFECTIVE
6/11/12
Version 2012.5e**

| THERAPEUTIC DRUG CLASS | PREFERRED AGENTS | NON-PREFERRED AGENTS | PA CRITERIA | |
|-------------------------------------|--|---|---|--|
| HYPOGLYCEMICS, INSULINS | | | | |
| | HUMALOG (insulin lispro) vials HUMALOG PEN/KWIKPEN (insulin lispro) HUMALOG MIX (insulin lispro/lispro protamine) vials only HUMULIN (insulin) vials only LANTUS (insulin glargine) all forms LEVEMIR (insulin detemir) all forms NOVOLIN (insulin) all forms NOVOLOG (insulin aspart) all forms NOVOLOG MIX all forms (insulin aspart/aspart protamine) | APIDRA (insulin glulisine) ^{AP} HUMALOG MIX PENS (insulin lispro/lispro protamine) HUMULIN PEN (insulin) | To receive Apidra, patients must meet the following criteria: <ol style="list-style-type: none"> be 4 years or older; be currently on a regimen including a longer-acting or basal insulin. had a trial of a similar preferred agent, Novolog or Humalog, with documentation that the desired results were not achieved. | |
| HYPOGLYCEMICS, MEGLITINIDES | | | | |
| MEGLITINIDES | | | | |
| | PRANDIN (repaglinide) STARLIX (nateglinide) | nateglinide | A thirty (30) day trial of the preferred agent is required before a non-preferred agent will be authorized, unless one of the exceptions on the PA form is present. | |
| 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 30-day trial of an oral agent (sulfonylurea, thiazolidinedione (TZD) or metformin). | |
| HYPOGLYCEMICS, TZDS | | | | |
| THIAZOLIDINEDIONES | | | | |
| | ACTOS (pioglitazone) | AVANDIA (rosiglitazone) ^{AP} | Treatment naïve patients require a two (2) week trial of Actos before Avandia will be authorized, unless one of the exceptions on the PA | |



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.

EFFECTIVE
6/11/12
Version 2012.5e

| THERAPEUTIC DRUG CLASS | PREFERRED AGENTS | NON-PREFERRED AGENTS | PA CRITERIA |
|--|--|---|--|
| | | | 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) | Patients are required to use the components of Actoplus Met and Duetact separately. Exceptions will be handled on a case-by-case basis. |
| IMPETIGO AGENTS (Topical) | | | |
| | bacitracin gentamicin sulfate mupirocin | ALTABAX (retapamulin) BACTROBAN (mupirocin) CORTISPORIN (bacitracin/neomycin/ polymyxin/Hc) | Ten (10) day trials of at least one preferred agent, including the generic formulation of a requested non-preferred agent, are required before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present. |
| INTRANASAL RHINITIS AGENTS^{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 of the exceptions on the PA form is present. |
| ANTI-HISTAMINES | | | |
| | ASTELIN (azelastine) PATANASE (olopatadine) | ASTEPRO (azelastine) azelastine | Thirty (30) day trials of both preferred intranasal antihistamines and a thirty (30) day trial of one of the preferred intranasal corticosteroids are required before the non-preferred agent will be approved unless one of the exceptions on the PA form is present. |



**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.

**EFFECTIVE
6/11/12
Version 2012.5e**

| THERAPEUTIC DRUG CLASS | PREFERRED AGENTS | NON-PREFERRED AGENTS | PA CRITERIA |
|--|---|---|---|
| CORTICOSTEROIDS | | | |
| | fluticasone propionate NASACORT AQ (triamcinolone) NASONEX (mometasone) | BECONASE AQ (beclomethasone) flunisolide FLONASE (fluticasone propionate) NASALIDE (flunisolide) NASAREL (flunisolide) OMNARIS (ciclesonide) QNASL (beclomethasone) ^{NR} RHINOCORT AQUA (budesonide) triamcinolone VERAMYST (fluticasone furoate) | Thirty (30) day trials of each preferred agent in the corticosteroid group are required before a non-preferred corticosteroid agent will be authorized unless one of the exceptions on the PA form is present. |
| LEUKOTRIENE MODIFIERS | | | |
| | ACCOLATE (zafirlukast) SINGULAIR (montelukast) | zafirlukast ZYFLO (zileuton) | Thirty (30) day trials each of the preferred agents are required before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present. |
| LIPOTROPICS, OTHER (Non-statins)^{AP} | | | |
| BILE ACID SEQUESTRANTS | | | |
| | cholestyramine colestipol | COLESTID (colestipol) QUESTRAN (cholestyramine) WELCHOL (colesevelam) | A twelve (12) week trial of one of the preferred agents is required before a non-preferred agent in the corresponding category will be authorized. Welchol will be approved for add-on therapy for type 2 diabetes when there is a previous history of a 30-day trial of an oral agent (sulfonylurea, thiazolidinedione (TZD) or metformin). See HYPOGLYCEMICS, MISCELLANEOUS. |
| CHOLESTEROL ABSORPTION INHIBITORS | | | |
| | | ZETIA (ezetimibe) | Zetia, as monotherapy, will only be approved for patients who cannot take statins or other preferred agents. AP does not apply. |



**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.

**EFFECTIVE
6/11/12
Version 2012.5e**

| THERAPEUTIC DRUG CLASS | PREFERRED AGENTS | NON-PREFERRED AGENTS | PA CRITERIA |
|--|--|--|--|
| | | | Zetia will be approved for add-on therapy only after an insufficient response to the maximum tolerable dose of a statin after 12 weeks of therapy. AP does not apply. |
| | FATTY ACIDS | | |
| | LOVAZA (omega-3-acid ethyl esters) ^{AP} | | Lovaza will be approved when the patient is intolerant or not responsive to, or not a candidate for nicotinic acid or fibrate therapy. |
| | FIBRIC ACID DERIVATIVES | | |
| | fenofibrate 54mg & 160mg fenofibrate micronized 67mg, 134mg & 200mg gemfibrozil TRICOR (fenofibrate nanocrystallized) TRILIPIX (fenofibric acid) | ANTARA (fenofibrate) FENOGLIDE (fenofibrate) FIBRICOR (fenofibric acid) fenofibrate nanocrystallized 145mg LIPOFEN (fenofibrate) LOFIBRA (fenofibrate) LOPID (gemfibrozil) TRIGLIDE (fenofibrate) | |
| | NIACIN | | |
| | niacin NIASPAN (niacin) | NIACELS (niacin) NIACOR (niacin) NIADELAY (niacin) SLO-NIACIN (niacin) | |
| LIPOTROPICS, STATINS^{AP} | | | |
| | STATINS | | |
| | atorvastatin CRESTOR (rosuvastatin) LESCOL (fluvastatin) LESCOL XL (fluvastatin) lovastatin pravastatin simvastatin ^{CL*} | ALTOPREV (lovastatin) 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 of the exceptions on the PA form is present. *Zocor/simvastatin 80mg tablets will require a clinical PA |



**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.

**EFFECTIVE
6/11/12
Version 2012.5e**

| THERAPEUTIC DRUG CLASS | PREFERRED AGENTS | NON-PREFERRED AGENTS | PA CRITERIA |
|---|---|---|---|
| STATIN COMBINATIONS | | | |
| | ADVICOR (lovastatin/niacin) amlodipine / atorvastatin SIMCOR (simvastatin/niacin ER) | CADUET (atorvastatin/amlodipine) VYTORIN (simvastatin/ ezetimibe)* | Vytorin will be approved only after an insufficient response to the maximum tolerable dose of Lipitor (atorvastatin) or Crestor (rosuvastatin) after 12 weeks, unless one of the exceptions on the PA form is present. *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 28 days. |
| MACROLIDES | | | |
| | azithromycin clarithromycin erythromycin | BIAVIN (clarithromycin) BIAVIN XL (clarithromycin) clarithromycin ER E.E.S. (erythromycin ethylsuccinate) E-MYCIN (erythromycin) ERYC (erythromycin) ERYPED (erythromycin ethylsuccinate) ERY-TAB (erythromycin) ERYTHROCIN (erythromycin stearate) erythromycin estolate PCE (erythromycin) ZITHROMAX (azithromycin) ZMAX (azithromycin) | Five (5) day trials each of the preferred agents are required before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present. |
| MULTIPLE SCLEROSIS AGENTS^{CL, AP} | | | |
| INTERFERONS | | | |
| | AVONEX (interferon beta-1a) BETASERON (interferon beta-1b) REBIF (interferon beta-1a) | AVONEX PEN (interferon beta-1a) EXTAVIA (interferon beta-1b) | A 30-day trial of a preferred agent will be required before a non-preferred agent will be approved. |
| NON-INTERFERONS | | | |



**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.

**EFFECTIVE
6/11/12
Version 2012.5e**

| THERAPEUTIC DRUG CLASS | PREFERRED AGENTS | NON-PREFERRED AGENTS | PA CRITERIA |
|--|---|---|--|
| | COPAXONE (glatiramer) | AMPYRA (dalfampridine)* GILENYA (fingolimod) ** TYSABRI (natalizumab)*** | <p>A 30-day trial of the preferred agent will be required before a non-preferred agent will be approved.</p> <p>*Amypra will be prior authorized if the following conditions are met:</p> <ol style="list-style-type: none"> 1. Diagnosis of multiple sclerosis 2. No history of seizures 3. No evidence of moderate or severe renal impairment 4. Initial prescription will be approved for 30 days only. <p>** Gilenya: PA Criteria</p> <ol style="list-style-type: none"> 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) trial of one of the preferred agents for multiple sclerosis unless <i>one of</i> the exceptions on the PA form is present AND 4) Dosage is limited to one tablet per day. (AP does not apply.) <p>***Tysabri will only be <i>approved</i> for members who are enrolled in the TOUCH Prescribing Program. AP does not apply.</p> |
| MUSCLE RELAXANTS (Oral)^{AP} | | | |
| ACUTE MUSCULOSKELETAL RELAXANT AGENTS | | | |
| | chlorzoxazone cyclobenzaprine methocarbamol | AMRIX (cyclobenzaprine) carisoprodol carisoprodol/ASA carisoprodol/ASA/codeine cyclobenzaprine ER FEXMID (cyclobenzaprine) | 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. |



**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.

**EFFECTIVE
6/11/12
Version 2012.5e**

| THERAPEUTIC DRUG CLASS | PREFERRED AGENTS | NON-PREFERRED AGENTS | PA CRITERIA |
|--|--|---|--|
| | | FLEXERIL (cyclobenzaprine) LORZONE (chlorzoxazone) metaxalone methocarbamol/ASA orphenadrine orphenadrine/ASA/caffeine PARAFON FORTE DSC (chlorzoxazone) ROBAXIN (methocarbamol) SKELAXIN (metaxalone) SOMA (carisoprodol) SOMA COMPOUND (carisoprodol /ASA) SOMA COMP w/ COD (carisoprodol/ASA/ codeine) | Thirty (30) day trials of the preferred acute musculoskeletal relaxants and Skelaxin are required before carisoprodol will be approved. |
| MUSCULOSKELETAL RELAXANT AGENTS USED FOR SPASTICITY | | | |
| | baclofen dantrolene tizanidine tablets | DANTRIUM (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 of the exceptions on the PA form is present. |
| NSAIDS^{AP} | | | |
| NON-SELECTIVE | | | |
| | diclofenac etodolac fenoprofen flurbiprofen ibuprofen (Rx and OTC) INDOCIN (indomethacin) (suspension only) indomethacin ketorolac naproxen (Rx only) oxaprozin sulindac | ADVIL (ibuprofen) ANAPROX (naproxen) ANSAID (flurbiprofen) CAMBIA (diclofenac) CATAFLAM (diclofenac) CLINORIL (sulindac) DAYPRO (oxaprozin) FELDENE (piroxicam) INDOCIN (indomethacin) ketoprofen ketoprofen ER LODINE (etodolac) meclofenamate mefenamic acid MOTRIN (ibuprofen) nabumetone NALFON (fenoprofen) NAPRELAN (naproxen) | Thirty (30) day trials of each of the preferred agents are required before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present. |



**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.

**EFFECTIVE
6/11/12
Version 2012.5e**

| THERAPEUTIC DRUG CLASS | PREFERRED AGENTS | NON-PREFERRED AGENTS | PA CRITERIA |
|---|--|---|---|
| | | NAPROSYN (naproxen) NUPRIN (ibuprofen) ORUDIS (ketoprofen) piroxicam PONSTEL (meclofenamate) SPRIX (ketorolac) tolmetin VOLTAREN (diclofenac) ZIPSOR (diclofenac potassium) | |
| NSAID/GI PROTECTANT COMBINATIONS | | | |
| | | ARTHROTEC (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 a. Patient is greater than or equal to 70 years of age, or b. Patient is currently on anticoagulation therapy, or c. Patient has a history or risk of a serious GI complication. |
| OPHTHALMIC ANTIBIOTICS (FLUOROQUINOLONES & SELECT MACROLIDES)^{AP} | | | |
| | ciprofloxacin MOXEZA (moxifloxacin) ofloxacin VIGAMOX (moxifloxacin) **The American Academy of Ophthalmology guidelines on treating bacterial conjunctivitis | AZASITE (azithromycin) BESIVANCE (besifloxacin) CILOXAN (ciprofloxacin) levofloxacin OCUFLOX (ofloxacin) QUIXIN (levofloxacin) ZYMAXID (gatifloxacin) | Five (5) day trials of each of the preferred agents are required before non-preferred agents will be authorized unless one of the exceptions on the PA form is present. |



**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.

**EFFECTIVE
6/11/12
Version 2012.5e**

| THERAPEUTIC DRUG CLASS | PREFERRED AGENTS | NON-PREFERRED AGENTS | PA CRITERIA |
|--|---|--|---|
| | <p>recommend as first line treatment options: erythromycin ointment, sulfacetamide drops, or polymyxin/trimethoprim drops. Alternative treatments include bacitracin ointment, sulfacetamide ointment, polymyxin/bacitracin ointment, fluoroquinolone drops, or azithromycin drops. All generic forms of ophthalmic erythromycin, sulfacetamide, and polymyxin/trimethoprim, polymyxin/bacitracin and bacitracin are preferred.</p> | | <p>**A prior authorization is required for the fluoroquinolone agents for patients under 21 years of age unless there has been a trial of a first line treatment option within the past 10 days.</p> |
| OPHTHALMIC ANTI-INFLAMMATORIES | | | |
| | <p>flurbiprofen ketorolac 0.4% NEVANAC (nepafenac)</p> | <p>ACULAR LS (ketorolac) ACUVAIL 0.45% (ketorolac tromethamine)^{AP} BROMDAY (bromfenac) diclofenac^{AP} DUREZOL (difluprednate)^{AP} LOTEMAX (loteprednol) VEXOL (rimexolone) XIBROM (bromfenac)</p> | <p>Five (5) day trials of each of the preferred ophthalmic anti-inflammatory agents are required before non-preferred agents will be authorized unless one of the exceptions on the PA form is present.</p> |
| OPHTHALMICS FOR ALLERGIC CONJUNCTIVITIS | | | |
| | <p>ALAWAY (ketotifen) ALREX (loteprednol) cromolyn ketorolac 0.5% PATADAY (olopatadine) PATANOL (olopatadine) ZADITOR OTC (ketotifen)</p> | <p>ACULAR (ketorolac) ALAMAST (pemirolast)^{AP} ALOCRIL (nedocromil)^{AP} ALOMIDE (lodoxamide)^{AP} azelastine BEPREVE (bepotastine)^{AP} CROLOM (cromolyn)^{AP} DUREZOL (difuprednate)^{NR} ELESTAT (epinastine)^{AP} EMADINE (emedastine)^{AP} epinastine ketotifen LASTACRAFT (alcaftadine) OPTICROM (cromolyn)^{AP} OPTIVAR (azelastine) ZYRTEC ITCHY EYE (ketotifen)^{AP}</p> | <p>Thirty (30) day trials of each of three (3) of the preferred agents are required before non-preferred agents will be authorized, unless one of the exceptions on the PA form is present.</p> |
| OPHTHALMICS, GLAUCOMA AGENTS | | | |



**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.

**EFFECTIVE
6/11/12
Version 2012.5e**

| THERAPEUTIC DRUG CLASS | PREFERRED AGENTS | NON-PREFERRED AGENTS | PA CRITERIA |
|---|---|--|--|
| COMBINATION AGENTS | | | |
| | COMBIGAN (brimonidine/timolol) dorzolamide/timolol | COSOPT (dorzolamide/timolol) COSOPT PF (dorzolamide/timolol) ^{NR} | |
| BETA BLOCKERS | | | |
| | betaxolol BETOPTIC S (betaxolol) carteolol levobunolol metipranolol timolol | BETAGAN (levobunolol) BETIMOL (timolol) ISTALOL (timolol) OPTIPRANOLOL (metipranolol) TIMOPTIC (timolol) | |
| CARBONIC ANHYDRASE INHIBITORS | | | |
| | AZOPT (brinzolamide) dorzolamide | TRUSOPT (dorzolamide) | |
| PARASYMPATHOMIMETICS | | | |
| | CARBOPTIC (carbachol) ISOPTO CARBACHOL (carbachol) PHOSPHOLINE IODIDE (echothiophate iodide) pilocarpine | ISOPTO CARPINE (pilocarpine) PILOPINE HS (pilocarpine) | |
| PROSTAGLANDIN ANALOGS | | | |
| | latanoprost LUMIGAN (bimatoprost) TRAVATAN-Z (travoprost) | XALATAN (latanoprost) ZIOPTAN (tafluprost) | |
| SYMPATHOMIMETICS | | | |
| | ALPHAGAN P (brimonidine) brimonidine 0.2% dipivefrin | brimonidine 0.15% PROPINE (dipivefrin) | |
| OTIC FLUOROQUINOLONES^{AP} | | | |
| | CIPRODEX (ciprofloxacin/dexamethasone)* ofloxacin | CIPRO HC (ciprofloxacin/hydrocortisone) CETRAXAL 0.2% SOLUTION (ciprofloxacin) FLOXIN (ofloxacin) | Five (5) day trials of each of the preferred agents are required before a non-preferred agent will be approved unless one of the exceptions on the PA form is present. |



**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.

**EFFECTIVE
6/11/12
Version 2012.5e**

| THERAPEUTIC DRUG CLASS | PREFERRED AGENTS | NON-PREFERRED AGENTS | PA CRITERIA |
|--|---|---|---|
| | | | *Ciprodex is limited to patients 8 years of age and younger. Age exceptions will be handled on a case-by-case basis. |
| PANCREATIC ENZYMES^{AP} | | | |
| | CREON ZENPEP | PANCREAZE PANCRELIPASE 5000 | A thirty (30) day trial of a preferred agent is required before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present. Non-preferred agents will be approved for members with cystic fibrosis. |
| PARATHYROID AGENTS^{AP} | | | |
| | calcitriol HECTOROL (doxercalciferol) vitamin d 2 (ergocalciferol) (Rx and OTC)* vitamin d 3 (cholecalciferol) (Rx and OTC)* ZEMPLAR (paricalcitol) | DRISDOL (ergocalciferol) ROCALTROL (calcitriol) SENSIPAR (cinacalcet) | A thirty (30) day trial of a preferred agent will be required before a non-preferred agent will be approved. *See Covered List |
| PEDICULICIDES/SCABICIDES (Topical)^{AP} | | | |
| | OVIDE (malathion) permethrin (Rx and OTC) pyrethrins-piperonyl butoxide | EURAX (crotamiton) lindane LYCELLE (topical gel) malathion 0.5% lotion NATROBA (spinosad) ULESFIA 5% LOTION (benzyl alcohol) | Trials of the preferred agents (which are age and weight appropriate) are required before non-preferred agents will be approved unless one of the exceptions on the PA form is present. |
| PHOSPHATE BINDERS^{AP} | | | |
| | calcium acetate FOSRENOL (lanthanum) PHOSLO (calcium acetate) RENAGEL (sevelamer) RENVELA (sevelamer carbonate) | ELIPHOS (calcium acetate) PHOSLYRA (calcium acetate) | Thirty (30) day trials of at least two preferred agents are required unless one of the exceptions on the PA form is present. |
| PLATELET AGGREGATION INHIBITORS^{AP} | | | |
| | AGGRENOX (dipyridamole/ASA) cilostazol clopidogrel | BRILINTA (ticagrelor) dipyridamole EFFIENT (prasugrel) | A thirty (30) day trial of a preferred agent is required before a non-preferred agent will be approved |



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.

EFFECTIVE
6/11/12
Version 2012.5e

| THERAPEUTIC DRUG CLASS | PREFERRED AGENTS | NON-PREFERRED AGENTS | PA CRITERIA |
|---|---|---|--|
| | | prenatal vitamins CMB w-o CA no. 2 prenatal vitamins w-o calcium no. 9/iron/folic acid PRENATE DHA/PRENATE ELITE PRENAVITE PRENEXA PRIMACARE RENATE/RENATE DHA SELECT-OB TANDEM DHA/TANDEM OB | |
| PROTON PUMP INHIBITORS^{AP} | | | |
| | DEXILANT (dexlansoprazole) omeprazole pantoprazole | ACIPHEX (rabeprazole) lansoprazole NEXIUM (esomeprazole) NEXIUM PACKETS (esomeprazole) omeprazole/sodium bicarbonate PREVACID capsules (lansoprazole) PREVACID Solu-Tabs (lansoprazole) PRILOSEC (omeprazole) PROTONIX (pantoprazole) ZEGERID OTC (omeprazole) | 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 of the exceptions on the PA form is present Prior authorization is not required for Prevacid Solu-Tabs for patients ≤8 years of age. |
| PSORIATIC AGENTS - TOPICAL | | | |
| | calcipotriene ointment DOVONEX (calcipotriene) TAZORAC (tazarotene) | calcipotriene solution 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 of the exceptions on the PA form is present. |
| PULMONARY ANTIHYPERTENSIVES - ENDOTHELIN RECEPTOR ANTAGONISTS^{CL} | | | |
| | LETAIRIS (ambrisentan) | TRACLEER (bosentan) | Letairis will be approved for the treatment of pulmonary artery hypertension (PAH) World Health Organization (WHO) Group I to improve exercise ability and decrease the rate of clinical deterioration. |



**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.

**EFFECTIVE
6/11/12
Version 2012.5e**

| THERAPEUTIC DRUG CLASS | PREFERRED AGENTS | NON-PREFERRED AGENTS | PA CRITERIA |
|---|---|---|--|
| | | | <p>Tracleer will be approved for the treatment of pulmonary artery hypertension (PAH) (WHO Group I) in patients with World Health Organization (WHO) Class II, III, or IV symptoms to improve exercise capacity and decrease the rate of clinical deterioration AND when there has been a failure with Letairis.</p> |
| PULMONARY ANTIHYPERTENSIVES – PDE5s^{CL} | | | |
| | ADCIRCA (tadalafil) REVATIO (sildenafil) | | |
| PULMONARY ANTIHYPERTENSIVES – PROSTACYCLINS^{CL} | | | |
| | epoprostenol VENTAVIS (iloprost) | FLOLAN (epoprostenol) REMODULIN (treprostinil sodium) TYVASO (treprostinil) | <p>Ventavis will only be approved for the treatment of pulmonary artery hypertension (WHO Group 1) in patients with NYHA Class III or IV symptoms.</p> <p>Remodulin and Tyvaso will be approved only after a 30-day trial of Ventavis unless one of the exceptions on the PA form is present.</p> |
| SEDATIVE HYPNOTICS^{AP} | | | |
| BENZODIAZEPINES | | | |
| | temazepam | DALMANE (flurazepam) DORAL (quazepam) estazolam flurazepam HALCION (triazolam) RESTORIL (temazepam) triazolam | <p>Fourteen (14) day trials of the preferred agents in both categories are required before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present.</p> |
| OTHERS | | | |
| | zolpidem | AMBIEN (zolpidem) AMBIEN CR (zolpidem) | |



**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.

**EFFECTIVE
6/11/12
Version 2012.5e**

| THERAPEUTIC DRUG CLASS | PREFERRED AGENTS | NON-PREFERRED AGENTS | PA CRITERIA |
|--------------------------------------|--|--|--|
| | | chloral hydrate EDLUAR SL (zolpidem) INTERMEZZO (zolpidem) ^{NR} LUNESTA (eszopiclone) ROZEREM (ramelteon) SILENOR (doxepin) SOMNOTE (chloral hydrate) SONATA (zaleplon) zaleplon zolpidem tartrate ER ZOLPIMIST SPRAY (zolpidem) | |
| STIMULANTS AND RELATED AGENTS | | | |
| AMPHETAMINES | | | |
| | amphetamine salt combination dextroamphetamine VYVANSE (lisdexamfetamine) | ADDERALL (amphetamine salt combination) ADDERALL XR (amphetamine salt combination) amphetamine salt combination ER DESOXYN (methamphetamine) DEXEDRINE (dextroamphetamine) DEXTROSTAT (dextroamphetamine) methamphetamine PROCENTRA (dextroamphetamine) ^{NR} | <p>Members currently utilizing Adderall XR as of 1/1/2012 may continue use until 6/30/2012.</p> <p>Except for Strattera, PA is required for adults >18 years.</p> <p>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.</p> <p>Thirty (30) day trials of at least three (3) antidepressants are required before amphetamines will be approved for depression.</p> <p>Provigil will only be approved for patients >16 years of age with a diagnosis of narcolepsy.</p> |
| NON-AMPHETAMINE | | | |
| | CONCERTA (methylphenidate) DAYTRANA (methylphenidate) FOCALIN (dexmethylphenidate) FOCALIN XR (dexmethylphenidate) guanfacine INTUNIV (guanfacine extended-release) | dexmethylphenidate KAPVAY ER (clonidine) METADATE ER (methylphenidate) methylphenidate ER (Generic Concerta) methylphenidate ER (Generic Ritalin LA) modafinil | <p>Strattera will not be approved for concurrent administration with amphetamines or methylphenidates, except for 30 days or less for tapering purposes. Strattera is limited to a maximum of</p> |



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.

EFFECTIVE
6/11/12
Version 2012.5e

| THERAPEUTIC DRUG CLASS | PREFERRED AGENTS | NON-PREFERRED AGENTS | PA CRITERIA |
|---|--|---|--|
| | METADATE CD (methylphenidate) methylphenidate methylphenidate ER (Generic Ritalin SR, Metadate ER, Methylin ER) STRATTERA (atomoxetine) | NUVIGIL (armodafinil) pemoline PROVIGIL (modafinil) RITALIN (methylphenidate) RITALIN LA (methylphenidate) RITALIN-SR (methylphenidate) | 100mg per day. Kapvay will be approved if the following criteria are met: <ol style="list-style-type: none"> 1. Fourteen (14) day trials of at least one 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 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. |
| TETRACYCLINES^{AP} | | | |
| | doxycycline hyclate minocycline capsules tetracycline | ADOXA (doxycycline monohydrate) demeclocycline* DORYX (doxycycline hyclate) doxycycline hyclate delayed release doxycycline monohydrate DYNACIN (minocycline) MINOCIN (minocycline) minocycline SR capsules minocycline tablets MONODOX (doxycycline monohydrate) ORACEA (doxycycline monohydrate) SOLODYN (minocycline) SUMYCIN (tetracycline) VIBRAMYCIN SYRUP (doxycycline calcium) VIBRAMYCIN (doxycycline hyclate) VIBRAMYCIN (doxycycline monohydrate) VIBRA-TABS (doxycycline hyclate) | 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} | | | |



**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.

**EFFECTIVE
6/11/12
Version 2012.5e**

| THERAPEUTIC DRUG CLASS | PREFERRED AGENTS | NON-PREFERRED AGENTS | PA CRITERIA |
|---------------------------------|---|--|---|
| ORAL | | | |
| | APRISO (mesalamine) ASACOL (mesalamine) 400mg COLAZAL (balsalazide) DIPENTUM (olsalazine) PENTASA (mesalamine) 250mg sulfasalazine | ASACOL HD (mesalamine) 800mg AZULFIDINE (sulfasalazine) balsalazide 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 of the exceptions on the PA form is present. |
| RECTAL | | | |
| | CANASA (mesalamine) 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 of the exceptions on the PA 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. |
| MEGESTROL | | | |
| | MEGACE ES (megestrol) megestrol | MEGACE (megestrol) | |
| SUBLINGUAL NITROGLYCERIN | | | |
| | nitroglycerin sublingual NITROSTAT SUBLINGUAL (nitroglycerin) | NITROLINGUAL (nitroglycerin) NITROMIST (nitroglycerin) | |
| OCTREOTIDE | | | |



**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.

**EFFECTIVE
6/11/12
Version 2012.5e**

| THERAPEUTIC DRUG CLASS | PREFERRED AGENTS | NON-PREFERRED AGENTS | PA CRITERIA |
|-----------------------------------|---|---|--|
| | SANDOSTATIN (octreotide) | octreotide | |
| ORAL CONTRACEPTIVES | | | |
| | YASMIN (ethinyl estradiol/drospirenone) | BEYAZ (ethinyl estradiol/drospirenone/levomefolate) Gianvi (ethinyl estradiol/drospirenone) Ocella (ethinyl estradiol/drospirenone) YAZ (ethinyl estradiol/drospirenone) | |
| SUBSTANCE ABUSE TREATMENTS | | | |
| | SUBOXONE (buprenorphine) FILM ^{CL} | SUBOXONE (buprenorphine) TABS | Suboxone PA criteria is available at http://www.dhr.wv.gov/bms/Pharmacy/Pages/pac.aspx |