BUREAU FOR MEDICAL SERVICES-Attachment B
WEST VIRGINIA MEDICAID
PREFERRED DRUG LIST WITH PRIOR AUTHORIZATION CRITERIA
This is not an all-inclusive list of available covered drugs and includes only managed categories. Refer to cover page for complete list of rules governing this PDL.

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ANALGESICS, NARCOTIC - SHORT ACTING (Non-parenteral)[AP]			
	APAP/codeine ASA/codeine codeine dihydrocodeine/ APAP/caffeine hydrocodone/APAP hydrocodone/ibuprofen hydromorphone 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) LORCET (hydrocodone/APAP) LORTAB (hydrocodone/APAP) MAGNACET (oxycodone/APAP) meperidine NUCYNTA (tapentadol) OPANA (oxymorphone) ONSOLIS (fentanyl) oxycodone/ibuprofen OXYFAST (oxycodone) OXYIR (oxycodone) PANLOR (dihydrocodeine/ APAP/caffeine) PERCOCET (oxycodone/APAP) PERCODAN (oxycodone/ASA) ROXANOL (morphine) RYBIX ODT (tramadol) TALACEN (pentazocine/APAP) 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) XOLOX (oxycodone/APAP)[NR] ZAMICET (hydrocodone/APAP) ZYDONE (hydrocodone/acetaminophen)	Six (6) day trials of at least four (4) chemically distinct preferred agents (based on narcotic ingredient only), including the generic formulation of a requested non-preferred product, are required before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present. Fentanyl lozenges and Onsolis will only be approved for a diagnosis of cancer and as an adjunct to a long-acting agent. Neither will be approved for monotherapy. **Limits:** Unless the patient has escalating cancer pain or another diagnosis supporting increased quantities of short-acting opioids, all short acting solid forms of the narcotic analgesics are limited to 120 tablets per 30 days for the purpose of maximizing the use of longer acting medications to prevent unnecessary breakthrough pain in chronic pain therapy.

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		XOLOX (oxycodone/APAP)	
ANALGESICS, NARCOTIC - LONG ACTING (Non-parenteral)[AP]			
	fentanyl transdermal KADIAN (morphine) 10mg, 20mg, 30mg, 50mg, 60mg, 100mg methadone morphine ER OPANA ER (oxymorphone)	AVINZA (morphine) BUTRANS (buprenorphine) DOLOPHINE (methadone) DURAGESIC (fentanyl) EXALGO ER (hydromorphone) EMBEDA (morphine/naltrexone) KADIAN (morphine) 80mg, 200mg MS CONTIN (morphine) ORAMORPH SR (morphine) oxycodone ER OXYCONTIN (oxycodone) RYZOLT ER (tramadol) tramadol ER ULTRAM ER (tramadol)	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. *Dose optimization is required for achieving equivalent doses of Kadian 80mg and 200mg. AP does not apply.* **Exception:** Oxycodone ER will be authorized if a diagnosis of cancer is submitted without a trial of the preferred agents.
ANDROGENIC AGENTS			
	ANDRODERM (testosterone) ANDROGEL (testosterone)	AXIRON (testosterone)[NR] FORTESTA (testosterone) TESTIM (testosterone)	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	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.

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		PRINIVIL (lisinopril) trandolapril UNIVASC (moexipril) VASOTEC (enalapril) ZESTRIL (lisinopril)	
	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)	
	ANGIOTENSIN II RECEPTOR BLOCKERS (ARBs)		
	AVAPRO (irbesartan) BENICAR (olmesartan) DIOVAN (valsartan) losartan MICARDIS (telmisartan)	ATACAND (candesartan) COZAAR (losartan) EDARBI (azilsartan)[NR] TEVETEN (eprosartan)	
	ARB COMBINATIONS		
	AVALIDE (irbesartan/HCTZ) AZOR (olmesartan/amlodipine) 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) HYZAAR (losartan/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]		A thirty (30) day trial of one preferred ACE, ARB, or combination agents, at the maximum tolerable dose, is

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	VALTURNA (aliskiren/valsartan) AP		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.
ANTIPSYCHOTICS, ATYPICAL			
	SINGLE INGREDIENT		
	clozapine GEODON (ziprasidone) INVEGA (paliperidone) INVEGA SUSTENNA (paliperidone)* risperidone risperidone ODT risperidone solution SEROQUEL (quetiapine) AP (25mg Tablet Only)	ABILIFY (aripiprazole) CLOZARIL (clozapine) FANAPT (iloperidone) FAZACLO (clozapine) LATUDA (lurasidone) RISPERDAL (risperidone) RISPERDAL CONSTA (risperidone)* RISPERDAL ODT (risperidone) RISPERDAL SOLUTION (risperidone) SAPHRIS (asenapine) SEROQUEL XR (quetiapine) 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 2. for a diagnosis of bipolar disorder or 3. when prescribed concurrently with other strengths of Seroquel in order to achieve therapeutic treatment levels. Seroquel 25 mg. will not be approved for use as a sedative hypnotic. Abilify will be approved for children between the ages of 6-17 for

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			irritability associated with autism. Abilify will be prior authorized for MDD if the following criteria are met: 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. *All injectable antipsychotic products require clinical prior authorization.
	ATYPICAL ANTIPSYCHOTIC/SSRI COMBINATIONS		
		SYMBYAX (olanzapine/fluoxetine)	
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. Zyclara will be approved for a diagnosis of actinic keratosis.
***H. PYLORI* COMBINATION TREATMENTS**			
	Please use individual components: preferred PPI (Dexilant or Nexium) amoxicillin tetracycline	HELIDAC (bismuth/metronidazole/tetracycline) PREVPAC (lansoprazole/amoxicillin/clarithromycin)	A trial of all the individual preferred components (with Dexilant or Nexium substituted for lansoprazole) at the recommended dosages,

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	metronidazole clarithromycin bismuth	PYLERA (bismuth/metronidazole/tetracycline)	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.
OPHTHALMICS FOR ALLERGIC CONJUNCTIVITIS			
	ALAWAY (ketotifen) ALREX (loteprednol) cromolyn ketorolac 0.5% OPTIVAR (azelastine) PATADAY (olopatadine) PATANOL (olopatadine) ZADITOR OTC (ketotifen)	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 LASTACAFT (alcaftadine) OPTICROM (cromolyn) AP ZYRTEC ITCHY EYE (ketotifen) AP	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.
PEDICULICIDES/SCABICIDES (Topical)AP			
	OVIDE (malathion) permethrin (Rx and OTC) pyrethrins-piperonyl butoxide	EURAX (crotamiton) lindane 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.
PSORIATIC AGENTS - TOPICAL			
	calcipotriene ointment DOVONEX (calcipotriene) TAZORAC (tazarotene)	calcipotriene solution 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.

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SEDATIVE HYPNOTICS[AP]			
	BENZODIAZEPINES		
	temazepam	DALMANE (flurazepam) DORAL (quazepam) estazolam flurazepam HALCION (triazolam) RESTORIL (temazepam) triazolam	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.
	OTHERS		
	zolpidem	AMBIEN (zolpidem) AMBIEN CR (zolpidem) chloral hydrate EDLUAR SL (zolpidem) LUNESTA (eszopiclone) ROZEREM (ramelteon) SILENOR (doxepin) SOMNOTE (chloral hydrate) SONATA (zaleplon) zaleplon zolpidem tartrate ER ZOLPIMIST SPRAY (zolpidem)	
STIMULANTS AND RELATED AGENTS			
	AMPHETAMINES		
	ADDERALL XR (amphetamine salt combination) amphetamine salt combination dextroamphetamine VYVANSE (lisdexamfetamine)	ADDERALL (amphetamine salt combination) amphetamine salt combination ER DESOXYN (methamphetamine) DEXEDRINE (dextroamphetamine) DEXTROSTAT (dextroamphetamine) methamphetamine PROCENTRA (dextroamphetamine)[NR]	Except for Strattera, PA is required for adults >18 years. One of the preferred agents in each group (amphetamines and non-amphetamines) must be tried for thirty (30) days before a non-preferred agent will be authorized. Thirty (30) day trials of at least three (3) antidepressants are required before amphetamines will be approved for depression. Provigil will only be approved for

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			patients >16 years of age with a diagnosis of narcolepsy.
	NON-AMPHETAMINE		
	CONCERTA (methylphenidate) DAYTRANA (methylphenidate) FOCALIN (dexmethylphenidate) FOCALIN XR (dexmethylphenidate) guanfacine METADATE CD (methylphenidate) methylphenidate methylphenidate ER STRATTERA (atomoxetine)	dexmethylphenidate INTUNIV (guanfacine extended-release) KAPVAY ER (clonidine) METADATE ER (methylphenidate) methylphenidate ER (Generic Concerta) NUVIGIL (armodafinil) pemoline PROVIGIL (modafinil) RITALIN (methylphenidate) RITALIN LA (methylphenidate) RITALIN-SR (methylphenidate)	Strattera will not be approved for concurrent administration with amphetamines or methylphenidates, except for 30 days or less for tapering purposes. Strattera is limited to a maximum of 100mg per day. Intuniv or Kapvay will be approved if the following criteria are met: 1. Fourteen (14) trials of at least one preferred product from the amphetamine and non-amphetamine class **and** 2. Fourteen (14) day trial of Strattera **and** 3. Fourteen (14) day trial of guanfacine (for Intuniv) and 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 guanfacine (for Intuniv) or clonidine (for Kapvay) is required for approval.
	CLONIDINE		

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	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		
	SANDOSTATIN (octreotide)	octreotide	
	EPINEPHRINE		
	TWINJECT (epinephrine) EPIPEN (epinephrine)		
	ORAL CONTRACEPTIVES		
	LO SEASONIQUE (ethinyl estradiol/levonorgestrel) SEASONIQUE (ethinyl estradiol/levonorgestrel) 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)[CL]		Suboxone PA criteria is available at http://www.dhhr.wv.gov/bms/Pharmacy/Drug%20Utilization%20Review/Documents/DRUGS/drugs_Suboxone_Subutex.pdf