

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

**REVISED 10/27/06  
Implementation Date: 10/02/06  
Originally Posted 9/15/06**

**Version III of III**

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
<b>ACE INHIBITORS</b>  <i>Implement 10/2/06</i>	<b>ACE INHIBITORS</b>		Four of the preferred agents must be tried for at least 30 days each before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present.
	ACEON (perindopril) ALTACE (ramipril) benazepril captopril enalapril lisinopril MAVIK (trandolapril)	ACCUPRIL (quinapril) CAPOTEN (captopril) fosinopril LOTENSIN (benazepril) MONOPRIL (fosinopril) PRINIVIL (lisinopril) quinapril UNIVASC (moexepiril) VASOTEC (enalapril) ZESTRIL (lisinopril)	
<b>ACE INHIBITOR/DIURETIC COMBINATIONS</b>	<b>ACE INHIBITOR/DIURETIC COMBINATIONS</b>		
	benazepril/HCTZ captopril/HCTZ enalapril/HCTZ lisinopril/HCTZ	ACCURETIC (quinapril/HCTZ) CAPOZIDE (captopril/HCTZ) fosinopril/HCTZ LOTENSIN HCT (benazepril/HCTZ) MONOPRIL HCT (fosinopril/HCTZ) PRINZIDE (lisinopril/HCTZ) quinapril/HCTZ UNIRETIC (moexepiril/HCTZ) VASERETIC (enalapril/HCTZ) ZESTORETIC (lisinopril/HCTZ)	
<b>ACE INHIBITOR/CALCIUM CHANNEL BLOCKER COMBINATIONS</b>  <i>Effective 4/1/06</i>	LOTREL (benazepril/amlodipine) TARKA (trandolapril/verapamil)	LEXXEL (enalapril/felodipine)	Each of the preferred agents must be tried for at least two weeks each before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present.  Patients starting therapy in this class must show a documented allergy to the preferred agents before a non-preferred agent will be authorized.
<b>ACNE AGENTS, TOPICAL</b>  <i>Effective 4/1/06</i>	<b>ANTIBIOTICS</b>		A trial of 30 days of one of the preferred agents in each category will be required before a non-preferred agent will be authorized. (In cases of pregnancy, a trial of retinoids will not be required.)  PA required after 17 years of age for tretinoin products.
	AKNE-MYCIN (erythromycin) clindamycin erythromycin	CLINDAGEL (clindamycin) EVOCLIN (clindamycin)	
<b>RETINOIDS</b>	<b>RETINOIDS</b>		
	RETIN-A MICRO (tretinoin) <sup>CL</sup> TAZORAC (tazarotene) Tretinoin <sup>CL</sup>	DIFFERIN (adapalene)	

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	<b>OTHERS</b>		
	AZELEX (azelaic acid) BENZACLIN (benzoyl peroxide/clindamycin) benzoyl peroxide DUAC (benzoyl peroxide/clindamycin) erythromycin/benzoyl peroxide NUOX (benzoyl peroxide/sulfur)	BENZAMYCIN PAK (benzoyl peroxide/erythromycin) BREVOXYL (benzoyl peroxide) CLINAC BPO (benzoyl peroxide) KLARON (sodium sulfacetamide) ZAFLIR (benzoyl peroxide) TRIAZ (benzoyl peroxide) SULFOXYL (benzoyl peroxide/sulfur) ZODERM (benzoyl peroxide)	
<b>ALZHEIMER'S AGENTS</b>	<b>CHOLINESTERASE INHIBITORS</b>		A trial of a preferred agent will be required before a non-preferred agent in this class will be authorized. Current prescriptions for Razadyne and Razadyne ER will be grandfathered..
<i>Implement 10/2/06</i>	ARICEPT (donepezil) EXELON (rivastigmine)	COGNEX (tacrine) RAZADYNE (galantamine) RAZADYNE ER (galantamine)	
	<b>NMDA RECEPTOR ANTAGONIST</b>		
	NAMENDA (memantine)		

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Version III of III

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<b>ANALGESICS, NARCOTIC</b> (Non-parenteral)  <i>Effective 4/1/06</i>	<b>SHORT ACTING</b>		<p>Three of the preferred agents must be tried for at least 72 hours before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present. (The three agents tried must include at least one of the long-acting agents when requesting a PA for a non-preferred long acting agent.) <b>Exception: Oxycodone ER will be authorized if a diagnosis of cancer is submitted without a trial of the preferred agents.</b></p> <p>Actiq will only be approved as an adjunct to a long-acting agent. Actiq for monotherapy will not be approved.</p> <p>Limits: Quantities exceeding 240 tablets per 30 days (8 tablets/day) for agents containing 500 mg of acetaminophen will require a prior authorization and review by the Medical Director.</p>
	acetaminophen/codeine	ACTIQ (fentanyl)	
	aspirin/codeine	butalbital/APAP/caffeine/codeine	
	codeine	butalbital/ASA/caffeine/codeine	
	hydrocodone/APAP	COMBUNOX (oxycodone/ibuprofen)	
	hydrocodone/ibuprofen	DARVOCET (propoxyphene/APAP)	
	hydromorphone	DARVON (propoxyphene)	
	levorphanol	DEMEROL (meperidine)	
	methadone	DILAUDID (hydromorphone)	
	morphine	FIORICET W/ CODEINE (butalbital/APAP/caffeine/codeine)	
	oxycodone	FIORINAL W/ CODEINE (butalbital/ASA/caffeine/codeine)	
	oxycodone/APAP	LORCET, LORTAB (hydrocodone/APAP)	
	oxycodone/aspirin	meperidine	
	pentazocine/APAP	MSIR (morphine)	
	pentazocine/naloxone	OXYFAST, OXYIR (oxycodone)	
	propoxyphene/APAP	PANLOR (dihydrocodeine/APAP/caffeine)	
	tramadol	PERCOCET (oxycodone/APAP)	
tramadol/APAP	PERCODAN (oxycodone/aspirin)		
	propoxyphene		
	propoxyphene/ASA/caffeine		
	TALACEN (pentazocine/APAP)		
	TALWIN NX (pentazocine/naloxone)		
	TYLENOL W/CODEINE (APAP/codeine)		
	ULTRACET (tramadol/APAP)		
	ULTRAM (tramadol)		
	VICODIN (hydrocodone/APAP)		
	VICOPROFEN (hydrocodone/ibuprofen)		

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	<b>LONG-ACTING</b>		
	DURAGESIC (fentanyl) KADIAN (morphine) morphine SR	AVINZA (morphine) fentanyl MS CONTIN (morphine) ORAMORPH SR (morphine) oxycodone ER OXYCONTIN (oxycodone)	
<b>ANDROGENIC AGENTS</b> <i>Implement 10/2/06</i>	ANDRODERM (testosterone) ANDROGEL (testosterone)	TESTIM (testosterone)	The non-preferred agents will be approved only if one of the exceptions on the PA form is present.
<b>ANGIOTENSIN II RECEPTOR BLOCKERS (ARBs)</b>  <i>Effective 4/1/06</i>	<b>ANGIOTENSIN RECEPTOR BLOCKERS</b>		Each of the preferred agents in the corresponding group must be tried for at least two weeks each before a non-preferred agent in that group will be authorized unless one of the exceptions on the PA form is present.
	AVAPRO (irbesartan) BENICAR (olmesartan) COZAAR (losartan) DIOVAN (valsartan) MICARDIS (telmisartan)	ATACAND (candesartan) TEVETEN (eprosartan)	
	<b>ARB/DIURETIC COMBINATIONS</b>		
	AVALIDE (irbesartan/HCTZ) BENICAR-HCT (olmesartan/HCTZ) DIOVAN-HCT (valsartan/HCTZ) HYZAAR (losartan/HCTZ) MICARDIS-HCT (telmisartan/HCTZ)	ATACAND-HCT (candesartan/HCTZ) TEVETEN-HCT (eprosartan/HCTZ)	
<b>ANTICOAGULANTS, INJECTABLE<sup>CL</sup></b>  <i>Effective 4/1/06</i>	ARIXTRA (fondaparinux) LOVENOX (enoxaparin)	FRAGMIN (dalteparin) INNOHEP (tinzaparin)	A trial of each of the preferred agents will be required before a non-preferred agent will be approved unless one of the exceptions on the PA form is present.

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Version III of III

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<b>ANTICONVULSANTS</b>  <i>Effective 4/1/06</i>	<b>BARBITURATES</b>		Treatment naive patients must have a trial of a preferred agent before a non-preferred agent in its corresponding class will be authorized. Patients stabilized on non-preferred agents will receive authorization to continue these drugs. Additions to that therapy will require a trial of preferred agent in its respective class unless one of the exceptions on the PA form is present.
	mephobarbital phenobarbital primidone	MEBARAL (mephobarbital) MYSOLINE (primidone)	
	<b>HYDANTOINS</b>		
	PEGANONE (ethotoin) Phenytoin	DILANTIN (phenytoin) PHENYTEK (phenytoin)	
	<b>SUCCINIMIDES</b>		
	CELONTIN (methsuximide) Ethosuximide	ZARONTIN (ethosuximide)	
	<b>BENZODIAZEPINES</b>		
	clonazepam DIASTAT (diazepam rectal) diazepam	KLONOPIN (clonazepam)	
	<b>ADJUVANTS</b>		
	carbamazepine DEPAKOTE (divalproex) DEPAKOTE ER (divalproex) EQUETRO (carbamazepine) FELBATOL (felbamate) gabapentin GABITRIL (tiagabine) KEPPRA (levetiracetam) LAMICTAL (lamotrigine) LYRICA (pregabalin) TOPAMAX (topiramate) TRILEPTAL (oxcarbazepine) valproic acid zonisamide	CARBATROL (carbamazepine) DEPAKENE (valproic acid) NEURONTIN (gabapentin) TEGRETOL (carbamazepine) TEGRETOL XR (carbamazepine) ZONEGRAN (zonisamide)	

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<b>ANTIDEPRESSANTS, OTHER</b> (second generation, non-SSRI)  <i>Effective 4/1/06</i>	CYMBALTA (duloxetine) EFFEXOR XR (venlafaxine) mirtazapine trazodone WELLBUTRIN XL (bupropion)	bupropion IR bupropion SR DESYREL (trazodone) EFFEXOR (venlafaxine) nefazodone REMERON (mirtazapine) SERZONE (nefazodone) WELLBUTRIN (bupropion) WELLBUTRIN SR (bupropion)	A non-preferred agent will only be authorized if there has been a six-week trial of an SSRI and a preferred agent in this class unless one of the exceptions on the PA form is present.
<b>ANTIDEPRESSANTS, SSRIs</b>  <i>Implement 10/2/06</i>	citalopram fluoxetine fluvoxamine LEXAPRO (escitalopram) paroxetine PAXIL CR (paroxetine) PEXEVA (paroxetine) ZOLOFT (sertraline)	CELEXA (citalopram) PAXIL (paroxetine) PROZAC (fluoxetine) RAPIFLUX (fluoxetine) SARAFEM (fluoxetine) sertraline	None of the non-preferred dosage forms will be authorized unless there is documentation showing that the preferred dosage forms of the corresponding agents are inappropriate for the patient.
<b>ANTIEMETICS, ORAL</b>  <i>Implement 10/2/06</i>	<b>5HT3 RECEPTOR BLOCKERS</b>		A trial of Zofran is required before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present. Quantity limits apply for this class* Zofran*-14 tablets per 21 days; in cases of hyperemesis during pregnancy, increased quantities may be authorized.  EMEND*-12 tablets per 28 days
	ZOFRAN (ondansetron) ZOFRAN ODT (ondansetron) EMEND (aprepitant)	ANZEMET (dolasetron) KYTRIL (granisetron)	

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<b>ANTIFUNGALS, ORAL</b>  <i>Implement 10/2/06</i>	clotrimazole fluconazole ketoconazole <sup>CL</sup> LAMISIL (terbinafine) <sup>CL</sup> MYCOSTATIN Pastilles (nystatin) nystatin	ANCOBON (flucytosine) DIFLUCAN (fluconazole) GRIFULVIN V (griseofulvin) griseofulvin GRIS-PEG (griseofulvin) itraconazole MYCELEX (clotrimazole) MYCOSTATIN Tablets (nystatin) NIZORAL (ketoconazole) SPORANOX (itraconazole) VFEND (voriconazole)	Non-preferred agents will be approved only if one of the exceptions on the PA form is present.  PA is required when limits are exceeded.  PA is not required for Grifulvin-V Suspension for children up to 6 years of age for the treatment of tinea capitis
<b>ANTIFUNGALS, TOPICAL</b>  <i>Implement 10/2/06</i>	<b>ANTIFUNGALS</b>		Three of the preferred agents must be tried for at least two weeks each before one of the non-preferred agents will be authorized unless one of the exceptions on the PA form is present.
	econazole EXELDERM (sulconazole) ketoconazole NAFTIN (naftifine) nystatin	ciclopirox ERTACZO (sertaconazole) LOPROX (ciclopirox) MENTAX (butenafine) MYCOSTATIN (nystatin) NIZORAL (ketoconazole) OXISTAT (oxiconazole) PENLAC (ciclopirox) SPECTAZOLE (econazole) VUSION (miconazole/petrolatum/zinc oxide)	
	<b>ANTIFUNGAL/STEROID COMBINATIONS</b>		
	clotrimazole/betamethasone nystatin/triamcinolone	LOTRISONE (clotrimazole/betamethasone) MYCOLOG (nystatin/triamcinolone)	

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<b>ANTIHISTAMINES, MINIMALLY SEDATING</b>  <i>Effective 4/1/06</i>	<b>ANTIHISTAMINES</b>		A preferred agent, in the age appropriate dosage form, must be tried before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present.
	ALAVERT (loratadine) CLARINEX Syrup (desloratadine) loratadine TAVIST-ND (loratadine)	ALLEGRA (fexofenadine) CLARINEX Tablets (desloratadine) CLARITIN (loratadine) fexofenadine ZYRTEC (cetirizine)	
	<b>ANTIHISTAMINE/DECONGESTANT COMBINATIONS</b>		
loratadine/pseudoephedrine	ALAVERT-D (loratadine/pseudoephedrine) ALLEGRA-D (fexofenadine/pseudoephedrine) CLARINEX-D (desloratadine/pseudoephedrine) CLARITIN-D (loratadine/pseudoephedrine) ZYRTEC-D (cetirizine/pseudoephedrine)		
<b>ANTIMIGRAINE AGENTS, TRIPTANS</b>  <i>Effective 4/1/06</i>	AXERT (almotriptan) IMITREX (sumatriptan) MAXALT (rizatriptan) RELPAX (eletriptan)	AMERGE (naratriptan) FROVA (frovatriptan) ZOMIG (zolmitriptan)	All of the preferred agents must be tried 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.

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<b>ANTIPARKINSON'S AGENTS</b> (Oral)  <i>Implement 10/2/06</i>	<b>ANTICHOLINERGICS</b>		Patients starting therapy on drugs in this class must show a documented allergy to all of the preferred agents before a non-preferred agent will be authorized.
	benztropine KEMADRIN (procyclidine) trihexyphenidyl	COGENTIN (benztropine)	
	<b>COMT INHIBITORS</b>		
	COMTAN (entacapone)	TASMAR (tolcapone)	
	<b>DOPAMINE AGONISTS</b>		
	MIRAPEX (pramipexole) REQUIP (ropinirole)	pergolide PERMAX (pergolide)	
<b>OTHER ANTIPARKINSON'S AGENTS</b>			
carbidopa/ levodopa selegiline STALEVO (levodopa/carbidopa/entacapone)	AZILECT (rasagiline) <sup>NR</sup> ELDEPRYL (selegiline) EMSAM (selegiline) <sup>NR</sup> PARCOPA (levodopa/carbidopa) SINEMET (levodopa/carbidopa)		
<b>ANTIPSYCHOTICS, ATYPICAL</b> (Oral)  <i>Implement 10/2/06</i>	<b>ORAL</b>		Upon discharge, hospitalized patients stabilized on non-preferred agents will receive authorization to continue these drugs.  New patients for this class of drugs will be required to try a preferred agent for two weeks unless one of the exceptions on the PA form is present.
	clozapine FAZACLO (clozapine) GEODON (ziprasidone) RISPERDAL (risperidone) SEROQUEL (quetiapine)	ABILIFY (aripiprazole) CLOZARIL (clozapine) ZYPREXA (olanzapine)	
	<b>ATYPICAL ANTIPSYCHOTIC/SSRI COMBINATIONS</b>		
		SYMBYAX (olanzapine/fluoxetine)	
<b>ANTIVIRALS</b> (Oral)  <i>Implement 10/2/06</i>	acyclovir amantadine ganciclovir VALCYTE (valganciclovir) VALTREX (valacyclovir)	CYTOVENE (ganciclovir) FAMVIR (famciclovir) FLUMADINE (rimantadine) rimantadine RELENZA (zanamivir) SYMMETREL (amantadine) TAMIFLU (oseltamivir) ZOVIRAX (acyclovir)	All of the appropriate preferred agents with the applicable indication must be tried before the non-preferred agents will be authorized unless one of the exceptions on the PA form is present.

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<b>ATOPIC DERMATITIS</b>  <i>Implement 10/2/06</i>	ELIDEL (pimecrolimus) PROTOPIC (tacrolimus)		
<b>BETA BLOCKERS</b> (Oral)  <i>Effective 4/1/06</i>	<b>BETA BLOCKERS</b>		If one of the exceptions on the PA form is present or if the physician feels that the patient cannot be stabilized with any of the preferred agents, one of the non-preferred agents will be approved.
	acebutolol atenolol INDERAL LA (propranolol) metoprolol nadolol pindolol propranolol sotalol timolol TOPROL XL (metoprolol)	BETAPACE (sotalol) betaxolol bisoprolol BLOCADREN (timolol) CARTROL (carteolol) CORGARD (nadolol) INNOPRAN XL (propranolol) KERLONE (betaxolol) LEVATOL (penbutolol) LOPRESSOR (metoprolol) SECTRAL (acebutolol) TENORMIN (atenolol) ZEBETA (bisoprolol)	
	<b>BETA- AND ALPHA- BLOCKERS</b>		
	COREG (carvedilol) labetalol	NORMODYNE (labetalol) TRANDATE (labetalol)	
<b>BLADDER RELAXANT PREPARATIONS</b>  <i>Effective 4/1/06</i>	DITROPAN XL (oxybutynin) ENABLEX (darifenacin) oxybutynin OXYTROL (oxybutynin) SANCTURA (trospium) VESICARE (solifenacin)	DETROL (tolterodine) DETROL LA (tolterodine) DITROPAN (oxybutynin)	All of the preferred agents in the class must be tried before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present.

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<b>BONE RESORPTION SUPPRESSION AND RELATED AGENTS</b>  <i>Implement 10/2/06</i>	<b>BISPHOSPHONATES</b>		One of the preferred agents must be tried for at least one month before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present.  For severely compromised patients, albuterol/ipratropium will be approved if the combined volume of albuterol and ipratropium nebulas is inhibitory.
	FOSAMAX (alendronate) FOSAMAX PLUS D (alendronate/vitamin D)	ACTONEL (risedronate) ACTONEL WITH CALCIUM (risedronate/calcium) BONIVA (ibandronate) DIDRONEL (etidronate)	
	<b>OTHER BONE RESORPTION SUPPRESSION AND RELATED AGENTS</b>		
<b>BPH AGENTS</b>  <i>Effective 4/1/06</i>	<b>ALPHA BLOCKERS</b>		One of 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.
	doxazosin FLOMAX (tamsulosin) trazosin UROXATRAL (alfuzosin)	CARDURA (doxazosin) CARDURA XL (doxazosin) <sup>NR</sup> HYTRIN (terazosin)	
	<b>5-ALPHA-REDUCTASE (5AR) INHIBITORS</b>		
	AVODART (dutasteride)	PROSCAR (finasteride)	
<b>BRONCHODILATORS, ANTICHOLINERGIC</b>  <i>Implement 10/2/06</i>	<b>ANTICHOLINERGIC</b>		The preferred agents in the class must be tried before the non-preferred agent will be authorized unless one of the exceptions on the PA form is present.  For severely compromised patients, DUONEB will be approved if the combined volume of albuterol and ipratropium nebulas is inhibitory.
	ATROVENT HFA (ipratropium) ipratropium SPIRIVA (tiotropium)	ATROVENT Inhalation Solution (ipratropium)	
	<b>ANTICHOLINERGIC-BETA AGONIST COMBINATIONS</b>		
	COMBIVENT (albuterol/ipratropium)	DUONEB (albuterol/ipratropium)	

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PREFERRED DRUG LIST WITH PRIOR AUTHORIZATION CRITERIA**

**REVISED 10/27/06  
Implementation Date: 10/02/06  
Originally Posted 9/15/06**

Version III of III

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
<b>BRONCHODILATORS, BETA AGONIST</b>  <i>Implement 10/2/06</i>	<b>INHALERS, SHORT-ACTING</b>		<p>All of the preferred agents in a group must be tried before a non-preferred agent in that group will be authorized unless one of the exceptions on the PA form is present.</p> <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 a concurrent diagnosis of heart disease.</p> <p><b>**No PA is required for ACCUNEB for children up to 5 years of age.</b></p>
	albuterol CFA MAXAIR (pirbuterol) XOPENEX HFA (levalbuterol)	albuterol HFA ALUPENT (metaproterenol) PROVENTIL (albuterol) PROVENTIL HFA (albuterol) VENTOLIN HFA (albuterol)	
	<b>INHALERS, LONG-ACTING</b>		
	FORADIL (formoterol)	SEREVENT (salmeterol)	
	<b>INHALATION SOLUTION</b>		
	albuterol	ACCUNEB (albuterol)** metaproterenol PROVENTIL (albuterol) XOPENEX (levalbuterol)	
<b>ORAL</b>			
albuterol terbutaline	BRETHINE (terbutaline) metaproterenol VOSPIRE ER (albuterol)		
<b>CALCIUM CHANNEL BLOCKERS (Oral)</b>  <i>Effective 4/1/06</i>	<b>SHORT-ACTING</b>		<p>One of 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>Nimodipine will be approved with the appropriate diagnosis.</p>
	diltiazem verapamil	ADALAT (nifedipine) CALAN (verapamil) CARDENE (nicardipine) CARDIZEM (diltiazem) DYNACIRC (isradipine) isradipine nicardipine nifedipine NIMOTOP (nimodipine) PROCARDIA (nifedipine)	

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	<b>LONG-ACTING</b>		
	CARDIZEM LA (diltiazem) diltiazem DYNACIRC CR (isradipine) felodipine nifedipine SULAR (nisoldipine) verapamil VERELAN PM (verapamil)	ADALAT CC (nifedipine) CALAN SR (verapamil) CARDENE SR (nicardipine) CARDIZEM CD (diltiazem) CARDIZEM SR (diltiazem) COVERA-HS (verapamil) DILACOR XR (diltiazem) ISOPTIN SR (verapamil) NORVASC (amlodipine) PLENDIL (felodipine) PROCARDIA XL (nifedipine) TIAZAC (diltiazem) VERELAN (verapamil)	
<b>CEPHALOSPORINS AND RELATED ANTIBIOTICS</b> (Oral)  <i>Implement 10/2/06</i>	<b>BETA LACTAM/BETA-LACTAMASE INHIBITOR COMBINATIONS</b>		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.
	amoxicillin/clavulanate AUGMENTIN XR (amoxicillin/clavulanate)	AUGMENTIN (amoxicillin/clavulanate) AUGMENTIN ES-600 (amoxicillin/clavulanate)	
	<b>CEPHALOSPORINS</b>		
	CEDAX (ceftibuten) cefaclor cefadroxil cefprozil cefuroxime cephalexin OMNICEF (cefdinir) SPECTRACEF (cefditoren) SUPRAX (cefixime)	CECLOR (cefaclor) cefpodoxime CEFTIN (cefuroxime) CEFZIL (cefprozil) DURICEF (cefadroxil) KEFLEX (cephalexin) LORABID (loracarbef) PANIXINE (cephalexin) RANICLOR (cefaclor) VANTIN (cefpodoxime)	
<b>CYTOKINE &amp; CAM ANTAGONISTS</b> <sup>CL</sup>  <i>Implement 10/2/06</i>	ENBREL (etanercept) HUMIRA (adalimumab) KINERET (anakinra) RAPTIVA (efalizumab)		

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**Version III of III**

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<b>ERYTHROPOIESIS STIMULATING PROTEINS<sup>CL</sup></b>  <i>Implement 4/1/06</i>	ARANESP (darbepoetin) PROCRIT (rHuEPO)	EPOGEN (rHuEPO)	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.
<b>FLUROQUINOLONES, ORAL</b>  <i>Implement 10/2/06</i>	AVELOX (moxifloxacin) ciprofloxacin CIPRO (ciprofloxacin suspension) FACTIVE (gemifloxacin)	CIPRO (ciprofloxacin) CIPRO XR (ciprofloxacin extended-release) FLOXIN (ofloxacin) LEVAQUIN (levofloxacin) ofloxacin PROQUIN XR (ciprofloxacin extended-release)	One of 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.
<b>GLUCOCORTICOIDS, INHALED</b>  <i>Implement 10/2/06</i>	<b>GLUCOCORTICOIDS</b>		All 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.  Pulmicort Respules do not require a prior authorization for children through 8 years of age or for individuals unable to use an MDI.  Flovent HFA will not require a PA for children through age 6.
	AEROBID (flunisolide) AEROBID-M (flunisolide) ASMANEX (mometasone) AZMACORT (triamcinolone) QVAR (beclomethasone)	FLOVENT HFA (fluticasone) PULMICORT (budesonide)	
	<b>GLUCOCORTICOID/BRONCHODILATOR COMBINATIONS</b>		
	ADVAIR (fluticasone/salmeterol)		
<b>GROWTH HORMONE<sup>CL</sup></b>  <i>Implement 4/1/06</i>	NORDITROPIN (somatropin) NUTROPIN AQ (somatropin) SAIZEN (somatropin) SEROSTIM (somatropin) TEV-TROPIN (somatropin)	GENOTROPIN (somatropin) HUMATROPE (somatropin) NUTROPIN (somatropin)	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.
<b>HEPATITIS C TREATMENTS<sup>CL</sup></b>  <i>Implement 4/1/06</i>	COPEGUS (ribavirin) PEG-INTRON (pegylated interferon) PEGASYS (pegylated interferon) REBETOL (ribavirin)	INFERGEN (consensus interferon) REBETRON (interferon alpha/ribavirin) ribavirin	Patients already on a non-preferred agent will receive authorization to continue therapy on that agent.  Patients starting therapy in this class must try the preferred agents of a dosage form before a non-preferred agent of that dosage form will be authorized.

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Version III of III

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<b>HYPOGLYCEMICS, INSULINS AND RELATED AGENTS</b>  <i>Implement 10/2/06</i>	<p align="center"><b>INSULIN</b></p> HUMALOG (insulin lispro) HUMALOG MIX (insulin lispro/lispro protamine) HUMULIN (insulin) LANTUS (insulin glargine) LEVEMIR (insulin detemir) NOVOLIN (insulin) NOVOLOG (insulin aspart) NOVOLOG MIX (insulin aspart/aspart protamine)	APIDRA (insulin glulisine) EXUBERA (insulin) <sup>NR</sup>	PA Criteria for Exubera: Patient must: <ol style="list-style-type: none"> <li>be 18 years or older;</li> <li>have no history of smoking in the past six months;</li> <li>have no history of chronic lung disease in the past two year or presence of acute lower respiratory lung infection;</li> <li>have a base line spirometry to measure FEV1. For renewal, spirometry to measure FEV1 six months after treatment initiation and then annually from second FEV1 measure;</li> <li>have a diagnosis of Type 1 diabetes (stated or inferred) with concomitant use of a longer acting insulin;</li> </ol> <p align="center">OR</p> have a diagnosis of Type II Diabetes (stated or inferred) and maximization of dosage of at least one available oral agent (sulfonylurea, metformin or thiazolidinediones), unless contraindicated; <ol style="list-style-type: none"> <li>Diagnosis of lipodystrophy or needle phobia that prevents self-injection or injection by a caregiver.</li> </ol> PA Criteria for Apidra: Patient must: <ol style="list-style-type: none"> <li>be 18 years or older;</li> <li>be currently on a regimen including a longer-acting or basal insulin.</li> <li>have had a trial of a similar preferred agent, Novolog or Humulin, with documentation that the desired results were not achieved.</li> </ol>
<b>HYPOGLYCEMICS, MEGLITINIDES</b>  <i>Implement 4/1/06</i>	STARLIX (nateglinide)	PRANDIN (repaglinide)	The preferred agent must be tried before a non-preferred agent will be authorized, unless one of the exceptions on the PA form is present.
<b>HYPOGLYCEMICS, METFORMINS</b> <b>Class Retired</b> <i>Implement 10/2/06</i>			

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<b>HYPOGLYCEMICS, TZDS</b>  <i>Implement 4/1/06</i>	<b>THIAZOLIDINEDIONES</b>		A preferred agent must be tried before the non-preferred agent will be authorized unless one of the exceptions on the PA form is present.
	ACTOS (pioglitazone) AVANDIA (rosiglitazone)		
	<b>TZD COMBINATIONS</b>		
	ACTOPLUS MET (pioglitazone/metformin) AVANDAMET (rosiglitazone/metformin)	AVANDARYL (rosiglitazone/glimepiride) <sup>NR</sup>	
<b>INTRANASAL RHINITIS AGENTS</b>  <i>Implement 10/2/06</i>	<b>ANTICHOLINERGICS</b>		All of 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.
		ATROVENT (ipratropium) ipratropium	
	<b>ANTI-HISTAMINES</b>		
	ASTELIN (azelastine)		
	<b>CORTICOSTEROIDS</b>		
	FLONASE (fluticasone) NASACORT AQ (triamcinolone) NASONEX (mometasone)	BECONASE AQ (beclomethasone) flunisolide fluticasone NASALIDE (flunisolide) NASAREL (flunisolide) RHINOCORT AQUA (budesonide)	
<b>LEUKOTRIENE RECEPTOR BLOCKERS</b>  <i>Implement 10/2/06</i>	ACCOLATE (zafirlukast) SINGULAIR (montelukast)	ZYFLO (zileuton)	
<b>LIPOTROPICS, OTHER (non-statins)</b>  <i>Implement 4/1/06</i>	<b>BILE ACID SEQUESTRANTS</b>		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.  Zetia, as monotherapy, will only be approved for patients who cannot take statins or other preferred agents.  Zetia and Welchol 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.  If patients require the addition of Zetia to Zocor to achieve goal, use of the combination product, Vytorin, will be required. If patients are on other statins and require the addition of Zetia, patients will not be required to switch the statin that they have been using.
	cholestyramine COLESTID (colestipol)	QUESTRAN (cholestyramine) WELCHOL (colesevalam)	
	<b>CHOLESTEROL ABSORPTION INHIBITORS</b>		
		ZETIA (ezetimibe)	

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	<b>FATTY ACIDS</b>		
		OMACOR (omega-3-acid ethyl esters)	
	<b>FIBRIC ACID DERIVATIVES</b>		
	fenofibrate gemfibrozil TRICOR (fenofibrate)	ANTARA (fenofibrate) LOFIBRA (fenofibrate) LOPID (gemfibrozil) TRIGLIDE (fenofibrate)	
	<b>NIACIN</b>		
	niacin NIASPAN (niacin)	NIACELS (niacin) NIADELAY (niacin) SLO-NIACIN (niacin)	
<b>LIPOTROPICS, STATINS</b>	<b>STATINS</b>		One of the preferred statins must be tried before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present.
<i>Implement 4/1/06</i>	ALTOPREV (lovastatin) CRESTOR (rosuvastatin) LESCOL (fluvastatin) LESCOL XL (fluvastatin) lovastatin ZOCOR (simvastatin)	LIPITOR (atorvastatin) MEVACOR (lovastatin) PRAVACHOL (pravastatin) pravastatin <sup>NR</sup>	
	<b>STATIN COMBINATIONS</b>		
	ADVICOR (lovastatin/niacin) VYTORIN (ezetimibe/simvastatin)	CADUET (atorvastatin/amlodipine)	

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<b>MACROLIDES/KETOLIDES</b> (Oral)  <i>Implement 10/2/06</i>	<b>MACROLIDES</b>		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.
	azithromycin BIAXIN XL (clarithromycin) erythromycin (base, ethylsuccinate, stearate)	BIAXIN (clarithromycin) clarithromycin DYNABAC (dirithromycin) 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 Suspension (azithromycin)	
	<b>KETOLIDES</b>		Requests for telithromycin will be authorized if there is documentation of the use of any antibiotic within the past 28 days.
	KETEK (telithromycin)		
<b>MULTIPLE SCLEROSIS AGENTS<sup>CL</sup></b>  <i>Implement 4/1/06</i>	AVONEX (interferon beta-1a) BETASERON (interferon beta-1b) COPAXONE (glatiramer) REBIF (interferon beta-1a)		

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<b>NSAIDS</b>  <i>Implement 10/2/06</i>	<b>NONSELECTIVE</b>		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.
	diclofenac	ADVIL (ibuprofen)	
	etodolac	ANAPROX (naproxen)	
	fenoprofen	ANSAID (flurbiprofen)	
	flurbiprofen	CATAFLAM (diclofenac)	
	ibuprofen (Rx and OTC)	CLINORIL (sulindac)	
	indomethacin	DAYPRO (oxaprozin)	
	ketoprofen	FELDENE (piroxicam)	
	ketorolac	INDOCIN (indomethacin)	
	naproxen (Rx only)	LODINE (etodolac)	
oxaprozin	meclofenamate		
piroxicam	MOTRIN (ibuprofen)		
PONSTEL (meclofenamate)	nabumetone		
sulindac	NALFON (fenoprofen)		
tolmetin	NAPRELAN (naproxen)		
	NAPROSYN (naproxen)		
	NUPRIN (ibuprofen)		
	ORUDIS (ketoprofen)		
	ORUVAIL (ketoprofen)		
	RELAFEN (nabumetone)		
	TOLECTIN (tolmetin)		
	TORADOL (ketorolac)		
	VOLTAREN (diclofenac)		
	<b>NSAID/GI PROTECTANT COMBINATIONS</b>		
		ARTHROTEC (diclofenac/misoprostol)	
		PREVACID NAPRAPAC (naproxen/lansoprazole)	
	<b>COX-II SELECTIVE<sup>CL</sup></b>		COX-II selective NSAIDs will be approved for patients with a GI Risk Score of $\geq 13$ .
		CELEBREX (celecoxib)	
		meloxicam MOBIC (meloxicam)	

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<b>OPHTHALMIC ANTIBIOTICS</b>  <i>Implement 10/2/06</i>	<b>FLUOROQUINOLONES</b>		All of the preferred agents must be tried before non-preferred agents will be authorized unless one of the exceptions on the PA form is present.
	VIGAMOX (moxifloxacin)	ciprofloxacin CILOXAN (ciprofloxacin) OCUFLOX (ofloxacin) ofloxacin QUIXIN (levofloxacin) ZYMAR (gatifloxacin)	
	<b>OTHER SINGLE AGENTS</b>		
	bacitracin erythromycin gentamicin polymyxin B sulfacetamide tobramycin	BLEPH-10 (sulfacetamide) GENOPTIC (gentamicin) TOBREX (tobramycin)	
<b>COMBINATION AGENTS</b>			
	neomycin/polymyxin/bacitracin neomycin/polymyxin/gramicidin polymyxin/bacitracin polymyxin/trimethoprim	NEOSPORIN (neomycin/polymyxin/bacitracin) NEOSPORIN (neomycin/polymyxin/gramicidin) POLYSPORIN (polymyxin/bacitracin) POLYTRIM (polymyxin/trimethoprim)	
<b>OPHTHALMICS FOR ALLERGIC CONJUNCTIVITIS</b>  <i>Implement 10/2/06</i>	ACULAR (ketorolac) ALREX (loteprednol) cromolyn ELESTAT (epinastine) OPTIVAR (azelastine) PATANOL (olopatadine)	ALOCRIIL (nedocromil) ALAMAST (pemirolast) ALOMIDE (iodoxamide) CROLOM (cromolyn) EMADINE (emedastine) OPTICROM (cromolyn) ZADITOR (ketotifen)	All of the preferred agents must be tried before non-preferred agents will be authorized, unless one of the exceptions on the PA form is present.

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	CARBOPTIC (carbachol) ISOPTO CARBACHOL (carbachol) PHOSPHOLINE IODIDE (echothiophate iodide) pilocarpine	ISOPTO CARPINE (pilocarpine) PILOPINE HS (pilocarpine)	
	<b>SYMPATHOMIMETICS</b>		
	ALPHAGAN P (brimonidine) brimonidine dipivefrin	ALPHAGAN (brimonidine) PROPINE (dipivefrin)	
	<b>BETA BLOCKERS</b>		
	BETIMOL (timolol) BETOPTIC S (betaxolol) betaxolol carteolol levobunolol metipranolol timolol	BETAGAN (levobunolol) ISTALOL (timolol) OPTIPRANOLOL (metipranolol) TIMOPTIC (timolol)	
	<b>CARBONIC ANHYDRASE INHIBITORS</b>		
	AZOPT (brinzolamide) TRUSOPT (dorzolamide)		
	<b>PROSTAGLANDIN ANALOGS</b>		
	LUMIGAN (bimatoprost) TRAVATAN (travoprost)	XALATAN (latanoprost)	
<b>COMBINATION AGENTS</b>			
COSOPT (dorzolamide/timolol)			
<b>OTIC ANTIBIOTIC PREPARATIONS</b>  <i>Effective 4/1/06</i>	CIPRODEX (ciprofloxacin/dexamethasone) COLY-MYCIN S (neomycin/hydrocortisone) FLOXIN (ofloxacin) neomycin/polymyxin/hydrocortisone	CIPRO HC (ciprofloxacin/hydrocortisone) CORTISPORIN (neomycin/polymyxin/hydrocortisone) CORTISPORIN TC (neomycin/hydrocortisone) PEDIOTIC (neomycin/polymyxin/hydrocortisone)	All of the preferred agents must be tried before a non-preferred agent will be approved unless one of the exceptions on the PA form is present.

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<b>PHOSPHATE BINDERS</b>  <i>Implement 4/1/06</i>	FOSRENOL (lanthanum) PHOSLO (calcium acetate) RENAGEL (sevelamer)	MAGNEBIND 400 (magnesium/calcium carbonate)	A trial of the preferred agents will be required before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present.
<b>PLATELET AGGREGATION INHIBITORS</b>  <i>Implement 10/2/06</i>	AGGRENOX (dipyridamole/ASA) PLAVIX (clopidogrel)	dipyridamole PERSANTINE (dipyridamole) TICLID (ticlopidine) ticlopidine	All of the preferred agents must be tried before a non-preferred agent will be approved unless one of the exceptions on the PA form is present.
<b>PROTON PUMP INHIBITORS</b> (Oral)  <i>Implement 4/1/06</i>	NEXIUM (esomeprazole) PREVACID (lansoprazole)	ACIPHEX (rabeprazole) omeprazole PROTONIX (pantoprazole) ZEGERID (omeprazole)	The preferred agents must be tried before a non-preferred agent will be approved unless one of the exceptions on the PA form is present.
<b>SEDATIVE HYPNOTICS</b>  <i>Implement 4/1/06</i>	<b>BENZODIAZEPINES</b>		Each of the preferred agents, in its respective class, must be tried for 10 days before a non-preferred agent in that class will be authorized.
	temazepam	DALMANE (flurazepam) DORAL (quazepam) estazolam flurazepam HALCION (triazolam) PROSOM (estazolam) RESTORIL (temazepam) triazolam	
	<b>OTHERS</b>		
	AMBIEN (zolpidem) LUNESTA (eszopiclone) ROZEREM (ramelteon) SONATA (zaleplon)	AMBIEN CR (zolpidem) AQUA CHLORAL (chloral hydrate) chloral hydrate SOMNOTE (chloral hydrate)	

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

<sup>CL</sup> - Requires Clinical PA

<sup>NR</sup> - New drug has not been reviewed by P & T Committee

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

**REVISED 10/27/06  
Implementation Date: 10/02/06  
Originally Posted 9/15/06**

Version III of III

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
<b>STIMULANTS AND RELATED AGENTS</b>  <i>Implement 10/2/06</i>	<b>AMPHETAMINES</b>		<p>Except for Strattera, PA is required for adults &gt;18 years.</p> <p>One of the preferred agents in each group (amphetamines and non-amphetamines) must be tried before a non-preferred agent will be authorized.</p>
	ADDERALL XR (amphetamine salt combination) amphetamine salt combination dextroamphetamine	ADDERALL (amphetamine salt combination) DESOXYN (methamphetamine) DEXEDRINE (dextroamphetamine) DEXTROSTAT(dextroamphetamine)	
<b>ULCERATIVE COLITIS AGENTS</b>  <i>Implement 4/1/06</i>	<b>NON-AMPHETAMINE</b>		<p>Amphetamines will be authorized for the treatment of depression only after documented failure of multiple antidepressants.</p> <p>Provigil will only be approved for patients &gt;16 years of age with a diagnosis of narcolepsy.</p> <p>Strattera will not be approved for concurrent administration with amphetamines or methylphenidates, except for 30 days or less for tapering purposes. Only two doses of each strength, or two concurrent doses of any strength, and a maximum of one dose of a 60 mg capsule, will be approved in a 34-day period.</p>
	CONCERTA (methylphenidate) FOCALIN (dexmethylphenidate) FOCALIN XR (dexmethylphenidate) METADATE CD (methylphenidate) methylphenidate methylphenidate ER STRATTERA (atomoxetine)	DAYTRANA (methylphenidate) <sup>NR</sup> METADATE ER (methylphenidate) pemoline PROVIGIL (modafanil) RITALIN (methylphenidate) RITALIN LA (methylphenidate) RITALIN-SR (methylphenidate)	
<b>ULCERATIVE COLITIS AGENTS</b>  <i>Implement 4/1/06</i>	<b>ORAL</b>		<p>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.</p>
	ASACOL (mesalamine) DIPENTUM (olsalazine) PENTASA (mesalamine) sulfasalazine	AZULFIDINE (sulfasalazine) COLAZAL (balsalazide)	
	<b>RECTAL</b>		
	CANASA (mesalamine) Mesalamine	ROWASA (mesalamine)	

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