THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ANALGESICS, NARCOTIC LONG ACTING (Non-parenteral)[AP]			
	fentanyl transdermal morphine ER tablets	AVINZA (morphine) BUTRANS* (buprenorphine) CONZIP ER (tramadol) DOLOPHINE (methadone) DURAGESIC (fentanyl) EXALGO ER (hydromorphone) EMBEDA (morphine/naltrexone) hydromorphone ER KADIAN (morphine) methadone tablet, solution and concentrate** methadone solutabs morphine ER capsules (generic for Avinza) morphine ER capsules (generic for Kadian) MS CONTIN (morphine) NUCYNTA ER (tapentadol) OPANA ER (oxymorphone) oxycodone ER** OXYCONTIN (oxycodone) oxymorphone ER** RYZOLT ER (tramadol) tramadol ER ULTRAM ER (tramadol) XARTEMIS XR (oxycodone/ acetaminophen) ZOHYDRO ER (hydrocodone)	Six (6) day trials each of the preferred unique long acting chemical entities are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PDL form is present. A six (6) day trial of the generic form of the requested non-preferred agent, if available, is required before the non-preferred agent will be authorized. *Butrans will be authorized if the following criteria are met: 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 (1) opioid medication* **and** 6. Current total daily opioid dose is less than or equal to (≤) 80mg morphine equivalents daily or dose of transdermal fentanyl is less than or equal to (≤) 12.5mcg/hr **and** 7. Patient is not currently being treated with buprenorphine. *Requirement is waived for patients who cannot swallow **Exception: Methadone, oxycodone ER and oxymorphone

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			ER will be authorized without a trial of the preferred agents if a diagnosis of cancer is submitted.
ANDROGENIC AGENTS			
	ANDRODERM (testosterone) ANDROGEL (testosterone) TESTIM (testosterone)	AXIRON (testosterone) FORTESTA (testosterone) testosterone gel	The non-preferred agents will be authorized only if one (1) of the exceptions on the PA form is present.
ANGIOTENSIN MODULATORS[AP]			
	ANGIOTENSIN II RECEPTOR BLOCKERS (ARBs)		
	BENICAR (olmesartan) DIOVAN (valsartan) irbesartan losartan MICARDIS (telmisartan)	ATACAND (candesartan) AVAPRO (irbesartan) candesartan COZAAR (losartan) EDARBI (azilsartan) eprosartan telmisartan TEVETEN (eprosartan) valsartan	
	ARB COMBINATIONS		
	AZOR (olmesartan/amlodipine) BENICAR-HCT (olmesartan/HCTZ) EXFORGE (valsartan/amlodipine) EXFORGE HCT (valsartan/amlodipine/HCTZ) irbesartan/HCTZ losartan/HCTZ MICARDIS-HCT (telmisartan/HCTZ) valsartan/HCTZ	ATACAND-HCT (candesartan/HCTZ) AVALIDE (irbesartan/HCTZ) candesartan/HCTZ DIOVAN-HCT (valsartan/HCTZ) EDARBYCLOR (azilsartan/chlorthalidone) HYZAAR (losartan/HCTZ) telmisartan/amlodipine telmisartan HCTZ TEVETEN-HCT (eprosartan/HCTZ) TRIBENZOR (olmesartan/amlodipine/HCTZ) TWYNSTA (telmisartan/amlodipine)	
ANTI-ALLERGENS, ORAL			
		GRASTEK (timothy grass pollen allergen extract) RAGWITEK (short ragweed pollen allergen extract)	See specific PA criteria located at: http://www.dhhr.wv.gov/bms/Pharmacy/Pages/pac.aspx
ANTIPARASITICS, TOPICAL[AP]			
	NATROBA (spinosad) permethrin 1% lotion (OTC) pyrethrins-piperonyl butoxide OTC SKLICE (ivermectin) ULESFIA (benzyl alcohol)	EURAX (crotamiton) LICE EGG REMOVER OTC (benzalkonium chloride) lindane malathion	Trials of the preferred agents (which are age and weight appropriate) are required before non-preferred agents will be authorized unless one (1) of the

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		OVIDE (malathion) permethrin 5% cream spinosad	exceptions on the PA form is present.
ANTIPSORIATICS, TOPICAL			
	calcipotriene ointment TACLONEX (calcipotriene/ betamethasone) TAZORAC (tazarotene)	calcipotriene cream calcipotriene solution calcipotriene/betamethasone ointment CALCITRENE (calcipotriene) calcitriol DOVONEX (calcipotriene) SORILUX (calcipotriene) VECTICAL (calcitriol)	Thirty (30) day trials of two (2) preferred unique chemical entities are required before non-preferred agents will be authorized unless one (1) of the exceptions on the PA form is present.
ANTIPSYCHOTICS, ATYPICAL			
	SINGLE INGREDIENT		
	ABILIFY (aripiprazole)[AP] * ABILIFY MAINTENA (aripiprazole)**[CL] clozapine FANAPT (iloperidone) [AP] INVEGA SUSTENNA (paliperidone)**[CL] LATUDA (lurasidone) [AP] olanzapine quetiapine*** AP for the 25mg Tablet Only RISPERDAL CONSTA (risperidone) ** [CL] risperidone SAPHRIS (asenapine)[AP] ziprasidone	ADASUVE (loxapine) clozapine ODT CLOZARIL (clozapine) FANAPT TITRATION PACK (iloperidone) FAZACLO (clozapine) GEODON (ziprasidone) GEODON IM (ziprasidone) INVEGA (paliperidone) olanzapine IM** RISPERDAL (risperidone) SEROQUEL (quetiapine) SEROQUEL XR (quetiapine) VERSACLOZ (clozapine) ZYPREXA (olanzapine) ZYPREXA IM (olanzapine)** ZYPREXA RELPREVV (olanzapine)	A fourteen (14) day trial of a preferred generic agent is required before a Preferred Brand will be authorized. All antipsychotic agents require prior authorization for children up to six (6) years of age. Non-preferred agents will be authorized if the following criteria have been met: 1. A fourteen (14) day trial of a preferred generic agent **and** 2. Two (2) fourteen (14) day trials of additional preferred products unless one (1) of the exceptions on the PA form is present. Upon discharge, a hospitalized patient stabilized on a non-preferred agent may receive authorization to continue this drug for labeled indications and at FDA recommended dosages. * Abilify will be prior authorized via electronic PA for MDD if the

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			following criteria are met: 1. The patient is eighteen (18) years of age or older **and** 2. Diagnosis of Major Depressive Disorder (MDD) **and** 3. Prescribed as adjunctive therapy with buproprion, an SSRI agent or an SNRI agent **and** 4. The daily dose does not exceed 15mg **All injectable antipsychotic products require clinical prior authorization and will be approved on a case-by-case basis. ***Quetiapine 25mg will be authorized: 1. For a diagnosis of schizophrenia **or** 2. For a diagnosis of bipolar disorder **or** 3. When prescribed concurrently with other strengths of Seroquel in order to achieve therapeutic treatment levels. ***Quetiapine 25mg will not be authorized for use as a sedative hypnotic.
	ATYPICAL ANTIPSYCHOTIC/SSRI COMBINATIONS		
		olanzapine/fluoxetine SYMBYAX (olanzapine/fluoxetine)	
BETA BLOCKERS[AP]			
	BETA BLOCKERS		
	acebutolol atenolol betaxolol bisoprolol metoprolol metoprolol ER nadolol	BETAPACE (sotalol) BYSTOLIC (nebivolol) CORGARD (nadolol) INDERAL LA (propranolol) INDERAL XL (propranolol) INNOPRAN XL (propranolol) KERLONE (betaxolol)	Fourteen (14) day trials each of three (3) chemically distinct preferred agents, including the generic formulation of a requested non-preferred product, are required before a non-preferred agent will be authorized unless one (1) of the

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	pindolol propranolol propranolol ER sotalol timolol	LEVATOL (penbutolol) LOPRESSOR (metoprolol) SECTRAL (acebutolol) TENORMIN (atenolol) TOPROL XL (metoprolol) ZEBETA (bisoprolol)	exceptions on the PA form is present.
BONE RESORPTION SUPPRESSION AND RELATED AGENTS			
	BISPHOSPHONATES		
	alendronate tablets	ACTONEL (risedronate) ACTONEL WITH CALCIUM (risedronate/ calcium) alendronate solution ATELVIA (risedronate) BINOSTO (alendronate) BONIVA (ibandronate) DIDRONEL (etidronate) etidronate FOSAMAX TABLETS (alendronate) FOSAMAX PLUS D (alendronate/vitamin D) Ibandronate risedronate	A thirty (30) day trial of the preferred agent is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.
COPD AGENTS			
	ANTICHOLINERGIC[AP]		
	ATROVENT HFA (ipratropium) ipratropium SPIRIVA (tiotropium)	TUDORZA (aclidinium)	A thirty (30) day trial of tiotropium is required before a non-preferred agent will be authorized.
	ANTICHOLINERGIC-BETA AGONIST COMBINATIONS[AP]		
	albuterol/ipratropium COMBIVENT RESPIMAT (albuterol/ipratropium)	ANORO ELLIPTA (umeclidinium/vilanterol)* DUONEB (albuterol/ipratropium)	A thirty (30) day trial of a preferred agent is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. *See specific PA criteria for Anoro Ellipta located at: http://www.dhhr.wv.gov/bms/Pharmacy/Pages/pac.aspx
	PDE4 INHIBITOR		
		DALIRESP (roflumilast)	Daliresp will be authorized if the following criteria are met: 1. Patient is forty (40) years of age or older **and**

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			2. Diagnosis of severe chronic obstructive pulmonary disease (COPD) associated with chronic bronchitis and multiple exacerbations requiring systemic glucocorticoids in the preceding six (6) months **and** **3.** Concurrent therapy with an inhaled corticosteroid and long-acting bronchodilator and evidence of compliance **and** **4.** No evidence of moderate to severe liver impairment (Child-Pugh Class B or C) **and** 5. No concurrent use with strong cytochrome P450 inducers (rifampicin, phenobarbital, carbamazepine or phenytoin).
CYTOKINE & CAM ANTAGONISTS[CL]			
ANTI-TNFs			Ninety day trials of two of the preferred anti-TNF agents are required before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present. *See indication-specific PA criteria located at: http://www.dhhr.wv.gov/bms/Pharmacy/Pages/pac.aspx
	ENBREL (etanercept)* HUMIRA (adalimumab)*	CIMZIA (certolizumab pegol) SIMPONI (golimumab)	
OTHERS			
		ACTEMRA syringe (tocilizumab) KINERET (anakinra) ORENCIA syringe (abatacept) OTEZLA (apremilast)* STELARA syringe (ustekinumab) XELJANZ (tofacitinib)**	
FLUOROQUINOLONES (Oral)[AP]			
	CIPRO SUSPENSION (ciprofloxacin) ciprofloxacin levofloxacin tablet	AVELOX (moxifloxacin) CIPRO TABLETS (ciprofloxacin) CIPRO XR (ciprofloxacin) ciprofloxacin ER ciprofloxacin suspension FACTIVE (gemifloxacin) LEVAQUIN (levofloxacin) levofloxacin solution moxifloxacin NOROXIN (norfloxacin)	A five (5) day trial of a preferred agent is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		ofloxacin	
GLUCOCORTICOIDS, INHALED[AP]			
	GLUCOCORTICOIDS		
	ASMANEX (mometasone) PULMICORT RESPULES (budesonide)* QVAR (beclomethasone)	AEROSPAN (flunisolide) ALVESCO (ciclesonide) budesonide FLOVENT HFA (fluticasone) FLOVENT Diskus (fluticasone) PULMICORT FLEXHALER (budesonide)	Thirty (30) day trials of each of the preferred agents are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. *Pulmicort Respules are preferred for children up to nine (9) years of age. A prior authorization will be required for children nine (9) years of age or older, and for individuals unable to use an MDI. Brand Pulmicort Respules are preferred over the generic formulation.
	GLUCOCORTICOID/BRONCHODILATOR COMBINATIONS		
	ADVAIR (fluticasone/salmeterol) ADVAIR HFA (fluticasone/salmeterol) DULERA (mometasone/formoterol) SYMBICORT(budesonide/formoterol)	BREO ELLIPTA (fluticasone/vilanerol)	Thirty (30) day trials of each of the preferred agents are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. For a diagnosis of COPD, thirty (30) day trials of each of the preferred agents in this category indicated for COPD are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.
HEPATITIS B TREATMENTS			
	EPIVIR HBV (lamivudine) TYZEKA (telbivudine)	adefovir BARACLUDE (entecavir) HEPSERA (adefovir) lamivudine HBV	A thirty (30) day trial of the preferred agent is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
HYPERPARATHYROID AGENTS[AP]			
	HECTOROL (doxercalciferol) paricalcitol	doxercalciferol capsule doxercalciferol injection SENSIPAR (cinacalcet) ZEMPLAR (paricalcitol)	A thirty (30) day trial of a preferred agent will be required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.
HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS			
	INJECTABLE [AP]		
	BYETTA (exenatide)* VICTOZA (liraglutide)*	BYDUREON (exenatide)** SYMLIN (pramlintide) ***	A thirty (30) day trial of one (1) preferred agent with a chemical entity distinct from the requested non-preferred agent will be required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. All agents (preferred and non-preferred) require a previous history of a thirty (30) day trial of metformin. For concurrent insulin use, all agents will be approved in six (6) month intervals. (Concurrent bolus insulin is contraindicated and will not be authorized.) For re-authorizations, documentation that HgBA1C levels have decreased by at least 1% or are maintained at ≤8% is required. HgBA1C levels submitted must be for the most recent thirty (30) day period. ** Bydureon will not be authorized with insulin therapy of any kind. ***Symlin will be authorized with a history of bolus insulin utilization in the past ninety (90) days with no gaps in insulin therapy greater than thirty (30) days.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	ORAL [AP]		
	JANUMET (sitagliptin/metformin) JANUVIA (sitagliptin) JENTADUETO (linagliptin/metformin) TRADJENTA (linagliptin)	JANUMET XR (sitagliptin/metformin)* KAZANO (alogliptin/metformin) KOMBIGLYZE XR (saxagliptin/metformin) * NESINA (alogliptin) ONGLYZA (saxagliptin) OSENI (alogliptin/pioglitazone)	Thirty (30) day trials of each chemically distinct preferred agent are required before a non-preferred agent will be approved. All agents (preferred and non-preferred) require a previous history of a thirty (30) day trial of metformin. For concurrent insulin use, all agents will be approved in six (6) month intervals. For re-authorizations, documentation that HgBA1C levels have decreased by at least 1% or are maintained at ≤8% is required. HgBA1C levels submitted must be for the most recent thirty (30) day period. *Janumet XR and Kombiglyze XR will be authorized after thirty (30) day trials of the preferred combination agents.
IMMUNE GLOBULINS, IV[CL]			
	BIVIGAM (human immunoglobulin gamma) CARIMUNE NF NANOFILTERED (human immunoglobulin gamma) CYTOGAM (human cytomegalovirus immune globulin) FLEBOGAMMA DIF (human immunoglobulin gamma) GAMASTAN S-D VIAL (human immunoglobulin gamma) GAMMAGARD LIQUID (human immunoglobulin gamma) GAMMAGARD S-D (human immunoglobulin gamma) GAMUNEX-C (human immunoglobulin gamma) GAMMAPLEX (human immunoglobulin gamma) HEPAGAM B (hepatitis b immune globulin	GAMMAKED (human immunoglobulin gamma) PRIVIGEN (human immunoglobulin gamma)	Immune globulin agents will be authorized according to FDA approved indications. A trial of a preferred agent is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	(human)) HIZENTRA (human immunoglobulin gamma) OCTAGAM (human immunoglobulin gamma) VARIZIG (varicella zoster immune globulin (human))		
IMMUNOMODULATORS, TOPICAL & GENITAL WARTS AGENTS			
	ALDARA (imiquimod) CONDYLOX GEL (podofilox)	CONDYLOX SOLUTION (podofilox) imiquimod podofilox VEREGEN (sinecatechins) ZYCLARA (imiquimod)*	A thirty (30) day trial of both preferred agents is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. *Zyclara will be authorized for a diagnosis of actinic keratosis.
IMMUNOSUPPRESSIVES, ORAL			
	Azathioprine cyclosporine cyclosporine, modified mycophenolate mofetil PROGRAF (tacrolimus) RAPAMUNE (sirolimus) sirolimus	ASTAGRAF XL (tacrolimus) AZASAN (azathioprine) CELLCEPT (mycophenolate mofetil) IMURAN (azathioprine) MYFORTIC (mycophenolic acid) mycophenolic acid NEORAL (cyclosporine, modified) SANDIMMUNE (cyclosporine) tacrolimus ZORTRESS (everolimus)	A fourteen (14) day trial of a preferred agent is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.
INTRANASAL RHINITIS AGENTS[AP]			
	ANTICHOLINERGICS		
	Ipratropium	ATROVENT(ipratropium)	Thirty (30) day trials each of one (1) of the nasal anti-cholinergic, one (1) of the antihistamine, and one (1) of the corticosteroid preferred agents are required before a non-preferred anti-cholinergic will be authorized unless one (1) of the exceptions on the PA form is present.
	ANTIHISTAMINES		
	ASTEPRO (azelastine) PATANASE (olopatadine)	azelastine	Thirty (30) day trials of each preferred intranasal antihistamines and a thirty (30) day trial of one (1) of the preferred intranasal corticosteroids are required before a

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.
	COMBINATIONS		
		DYMISTA (azelastine / fluticasone)	A concurrent thirty (30) day trial of each of the preferred components is required before Dymista will be authorized unless one (1) of the exceptions on the PA form is present.
	CORTICOSTEROIDS		
	fluticasone propionate NASONEX (mometasone)	BECONASE AQ (beclomethasone) budesonide FLONASE (fluticasone propionate) flunisolide NASACORT AQ (triamcinolone) OMNARIS (ciclesonide) QNASL (beclomethasone) RHINOCORT AQUA (budesonide) triamcinolone VERAMYST (fluticasone furoate) ZETONNA (ciclesonide)	Thirty (30) day trials of each preferred agent in the corticosteroid group are required before a non-preferred corticosteroid agent will be authorized unless one (1) of the exceptions on the PA form is present.
IRRITABLE BOWEL SYNDROME			
	AMITIZA (lubiprostone)[CL]* LINZESS (linaclotide) [CL]*	LOTRONEX (alosetron)	Thirty (30) day trial of the preferred agent is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. *See PA criteria located at: http://www.dhhr.wv.gov/bms/Pharmacy/Pages/pac.aspx
LAXATIVES AND CATHARTICS			
	COLYTE GOLYTELY NULYTELY peg 3350	HALFLYTELY-BISACODYL KIT MOVIPREP OSMOPREP PREPOPIK SUPREP	Thirty (30) day trials each of the preferred agents are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
LIPOTROPICS, OTHER (Non-statins)[AP]			
	BILE ACID SEQUESTRANTS		
	cholestyramine colestipol tablets	COLESTID (colestipol) colestipol granules KYNAMRO (mipomersen) QUESTRAN (cholestyramine) WELCHOL (colesevelam)*	A twelve (12) week trial of one (1) of the preferred agents is required before a non-preferred agent in the corresponding category will be authorized. *Welchol will be authorized for add-on therapy for type 2 diabetes when there is a previous history of a thirty (30) day trial of an oral agent (metformin, sulfonylurea or thiazolidinedione (TZD)). See HYPOGLYCEMICS, MISCELLANEOUS.
	CHOLESTEROL ABSORPTION INHIBITORS		
	ZETIA (ezetimibe) [AP]		Zetia will be authorized with prior use of a HMG-CoA reductase inhibitor within the previous six (6) months.
	FATTY ACIDS		
		LOVAZA (omega-3-acid ethyl esters)[AP] omega-3 acid ethyl esters VASCEPA (icosapent ethyl)	Lovaza and Vascepa will be authorized when the patient is intolerant or not responsive to, or not a candidate for, nicotinic acid or fibrate therapy.
	FIBRIC ACID DERIVATIVES		
	fenofibrate 54mg & 160mg fenofibrate micronized 67mg, 134mg & 200mg gemfibrozil	ANTARA (fenofibrate) FENOGLIDE (fenofibrate) FIBRICOR (fenofibric acid) fenofibrate 43mg, 130mg fenofibrate 50mg, 150mg fenofibrate nanocrystallized 48mg, 145mg fenofibric acid LIPOFEN (fenofibrate) LOFIBRA (fenofibrate) LOPID (gemfibrozil) TRICOR (fenofibrate nanocrystallized) TRIGLIDE (fenofibrate) TRILIPIX (fenofibric acid)	
	NIACIN		

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	niacin NIACOR (niacin) NIASPAN (niacin) SLO-NIACIN (niacin)	niacin ER	
LIPOTROPICS, STATINS[AP]			
	STATINS		
	atorvastatin CRESTOR (rosuvastatin) lovastatin pravastatin simvastatin[CL]*	ALTOPREV (lovastatin) fluvastatin LESCOL (fluvastatin) LESCOL XL (fluvastatin) LIPITOR (atorvastatin) LIVALO (pitavastatin) MEVACOR (lovastatin) PRAVACHOL (pravastatin) ZOCOR (simvastatin)*	Twelve (12) week trials each of two (2) of the preferred statins, including the generic formulation of a requested non-preferred agent, are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. *Zocor/simvastatin 80mg tablets will require a clinical PA
	STATIN COMBINATIONS		
		ADVICOR (lovastatin/niacin) amlodipine/atorvastatin CADUET (atorvastatin/amlodipine) LIPTRUZET (atorvastatin/ezetimibe) SIMCOR (simvastatin/niacin ER) VYTORIN (simvastatin/ezetimibe)*	Thirty (30) day concurrent trials of the appropriate single agents are required before a non-preferred Statin combination will be authorized. *Vytorin will be authorized only after an insufficient response to the maximum tolerable dose of atorvastatin after twelve (12) weeks, unless one (1) of the exceptions on the PA form is present. Vytorin 80/10mg tablets will require a clinical PA
MACROLIDES/KETOLIDES			
	KETOLIDES		
		KETEK (telithromycin)	Requests for telithromycin will be authorized if there is documentation of the use of any antibiotic within the past twenty-eight (28) days.
	MACROLIDES		

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	azithromycin BIAXIN XL (clarithromycin) clarithromycin erythromycin base	BIAXIN (clarithromycin) clarithromycin ER E.E.S. (erythromycin ethylsuccinate) E-MYCIN (erythromycin) ERYC (erythromycin) ERYPED (erythromycin ethylsuccinate) ERY-TAB (erythromycin) ERYTHROCIN (erythromycin stearate) erythromycin estolate PCE (erythromycin) ZITHROMAX (azithromycin) ZMAX (azithromycin)	Five (5) day trials each of the preferred agents are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.
MULTIPLE SCLEROSIS AGENTS[AP]			
	INTERFERONS		
	AVONEX (interferon beta-1a)[AP] AVONEX PEN (interferon beta-1a)[AP] EXTAVIA (interferon beta-1b)[AP]	BETASERON KIT (interferon beta-1b)[AP] REBIF (interferon beta-1a)[AP] REBIF REBIDOSE (interferon beta-1a)[AP]	A diagnosis of multiple sclerosis and a thirty (30) day trial of a preferred agent in the corresponding class (interferon or non-interferon) will be required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.
	NON-INTERFERONS		
	COPAXONE 20 mg (glatiramer)[AP]	AMPYRA (dalfampridine)[CL]* AUBAGIO (teriflunomide)[CL]** COPAXONE 40 mg (glatiramer) GILENYA (fingolimod)[CL]*** TECFIDERA (dimethyl fumarate)[CL]****	*Amypra will be authorized if the following criteria are met: 1. Diagnosis of multiple sclerosis **and** 2. No history of seizures **and** 3. No evidence of moderate or severe renal impairment **and** 4. A thirty (30) day trial of a preferred agent in the corresponding **and** 5. Initial prescription will be authorized for thirty (30) days only. **Aubagio will be authorized if the following criteria are met: 1. Diagnosis of relapsing multiple sclerosis **and** 2. A thirty (30) day trial of a

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			preferred agent in the corresponding class **and** 3. Measurement of transaminase and bilirubin levels within the (6) months before initiation of therapy and ALT levels at least monthly for six (6) months after initiation of therapy **and** 4. Complete blood cell count (CBC) within six (6) months before initiation of therapy **and** 5. Female patients must have a negative pregnancy test before initiation of therapy and be established on a reliable method of contraception if appropriate **and** 6. Patient is from eighteen (18) up to sixty-five (65) years of age **and** 7. Negative tuberculin skin test before initiation of therapy ***Gilenya will be authorized if the following criteria are met: A diagnosis of a relapsing form of multiple sclerosis **and** 1. Medication is prescribed by a neurologist **and** 2. A thirty (30) day trial of a preferred agent in the corresponding class **and** 3. Dosage is limited to one (1) tablet per day. (AP does not apply.) ****Tecfidera will be authorized if the following criteria are met: 1. Diagnosis of relapsing multiple sclerosis **and** **2.** A thirty (30) day trial of a preferred agent in the corresponding class **and** 3. Complete blood count (CBC)

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			within six (6) months of initiation of therapy and six months after initiation **and** 4. Complete blood count (CBC) annually during therapy
NEUROPATHIC PAIN			
	capsaicin OTC duloxetine gabapentin capsules, solution LIDODERM (lidocaine)**	CYMBALTA (duloxetine) gabapentin tablets GRALISE (gabapentin)* HORIZANT (gabapentin) lidocaine patch LYRICA CAPSULE (pregabalin)*** LYRICA SOLUTION (pregabalin)*** NEURONTIN (gabapentin) QUTENZA (capsaicin) SAVELLA (milnacipran)**** ZOSTRIX OTC (capsaicin)	A trial of a preferred agent in the corresponding dosage form (oral or topical) will be required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. *Gralise will be authorized if the following criteria are met: 1. Diagnosis of post herpetic neuralgia **and** 2. Trial of a tricyclic antidepressant for a least thirty (30) days **and** 3. Trial of gabapentin immediate release formulation (positive response without adequate duration) **and** 4. Request is for once daily dosing with 1800mg. maximum daily dosage. **Lidoderm patches will be authorized for a diagnosis of post-herpetic neuralgia. ***Lyrica will be authorized if the following criteria are met: 1. Diagnosis of seizure disorders or neuropathic pain associated with a spinal cord injury **or** 2. Diagnosis of fibromyalgia, postherpetic neuralgia, or diabetic neuropathy AND a history of a trial of duloxetine at the generally accepted

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			maximum therapeutic dose of 60 mg/day OR gabapentin at a therapeutic dose range between 900mg and 2,400mg per day for thirty (30) days within the previous twenty-four (24) month period or an intolerance due to a potential adverse drug-drug interaction, drug-disease interaction, or intolerable side effect (In cases of renal impairment, doses may be adjusted based on the degree of impairment.) ****Savella will be authorized for a diagnosis of fibromyalgia or a previous thirty (30) day trial of a drug that infers fibromyalgia: duloxetine, gabapentin, amitriptyline or nortriptyline.
NSAIDS[AP]			
	NON-SELECTIVE		
	diclofenac (IR, SR) etodolac IR flurbiprofen ibuprofen (Rx and OTC) INDOCIN SUSPENSION (indomethacin) indomethacin ketoprofen ketorolac nabumetone naproxen (Rx and OTC) piroxicam sulindac	ANAPROX (naproxen) ANSAID (flurbiprofen) CATAFLAM (diclofenac) CLINORIL (sulindac) DAYPRO (oxaprozin) diflunisal DUEXIS (famotidine/ibuprofen) etodolac SR FELDENE (piroxicam) fenoprofen INDOCIN SUPPOSITORIES (indomethacin) indomethacin ER ketoprofen ER meclofenamate mefenamic acid MOTRIN (ibuprofen) NALFON (fenoprofen) NAPRELAN (naproxen) NAPROSYN (naproxen)	Thirty (30) day trials of each of the preferred agents are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		oxaprozin PONSTEL (meclofenamate) SPRIX (ketorolac) tolmetin VOLTAREN (diclofenac) ZIPSOR (diclofenac potassium) ZORVOLEX (diclofenac)	
	NSAID/GI PROTECTANT COMBINATIONS		
		ARTHROTEC (diclofenac/misoprostol) diclofenac/misoprostol VIMOVO (naproxen/esomeprazole)	
	COX-II SELECTIVE		
	meloxicam	CELEBREX (celecoxib) MOBIC (meloxicam)	COX-II Inhibitor agents will be authorized if the following criteria are met: Patient has a history or risk of a serious GI complication **or** Agent is requested for treatment of a chronic condition **and** 1. Patient is 70 years of age or older, **or** 2. Patient is currently on anticoagulation therapy**.**
	TOPICAL		
	VOLTAREN GEL (diclofenac)*[CL]	diclofenac solution FLECTOR PATCH (diclofenac) PENNSAID (diclofenac)	Thirty (30) day trials of each of the preferred oral NSAIDS are required before a topical NSAID gel or solution will be authorized unless one (1) of the exceptions on the PA form is present. Flector patches will be authorized for a diagnosis of acute strain, sprain or injury after a five (5) day trial of one (1) of the preferred oral NSAIDs and for a maximum duration of fourteen (14) days unless one (1) of the exceptions on the PA form is present. *Voltaren Gel will be authorized if the following criteria are met:

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			1. Thirty (30) day trials of two (2) of the preferred oral NSAIDs, **or**. 2. The patient is on anticoagulant therapy **or** 3. The Patient has had a GI bleed or ulcer diagnosed in the last 2 years. Prior authorizations will be limited to 100 grams per month.
OPHTHALMICS, ANTI-INFLAMMATORIES- IMMUNOMODULATORS			
		RESTASIS (cyclosporine)	See PA criteria located at: http://www.dhhr.wv.gov/bms/Pharmacy/Pages/pac.aspx
PAH AGENTS – PROSTACYCLINS[CL]			
	epoprostenol VENTAVIS (iloprost)*	FLOLAN (epoprostenol) ORENITRAM ER (treprostinil) REMODULIN (treprostinil sodium) TYVASO (treprostinil) VELETRI (epoprostenol)	A thirty (30) day trial of a preferred agent, including the preferred generic form of the non-preferred agent, is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present, *Ventavis will only be authorized for the treatment of pulmonary artery hypertension (WHO Group 1) in patients with NYHA Class III or IV symptoms.
STEROIDS, TOPICAL			
	VERY HIGH & HIGH POTENCY		
	betamethasone dipropionate cream, lotion betamethasone valerate cream clobetasol propionate cream/gel/ointment/solution clobetasol emollient fluocinonide cream, gel, solution fluocinonide/emollient halobetasol propionate triamcinolone acetonide cream, ointment	amcinonide APEXICON (diflorasone diacetate) APEXICON E (diflorasone diacetate) betamethasone dipropionate gel, lotion, ointment betamethasone valerate lotion, ointment, clobetasol lotion, shampoo clobetasol propionate foam CLOBEX (clobetasol propionate) CORMAX (clobetasol propionate) desoximetasone cream/gel/ointment	Five (5) day trials of one (1) form of each preferred unique active ingredient in the corresponding potency group are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.

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

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		LOCOID LIPOCREAM (hydrocortisone butyrate/emollient) LUXIQ (betamethasone valerate) MOMEXIN (mometasone) PANDEL (hydrocortisone probutate) prednicarbate TOPICORT LP (desoximetasone) TRIDERM (triamcinolone acetonide) WESTCORT (hydrocortisone valerate)	
	LOW POTENCY		
	desonide cream, ointment hydrocortisone acetate (Rx, OTC) hydrocortisone cream (Rx, OTC) hydrocortisone lotion OTC hydrocortisone ointment (Rx, OTC) hydrocortisone solution OTC hydrocortisone-aloe cream OTC hydrocortisone-aloe ointment OTC	ACLOVATE (alclometasone dipropionate) alclometasone dipropionate AQUA GLYCOLIC HC (hydrocortisone) CAPEX (fluocinolone acetonide) DERMA-SMOOTHE FS (fluocinolone acetonide) DESONATE (desonide) desonide lotion DESOWEN (desonide) fluocinolone oil hydrocortisone/mineral oil/petrolatum hydrocortisone acetate/urea hydrocortisone lotion hydrocortisone/aloe gel LOKARA (desonide) PEDIADERM HC (hydrocortisone) PEDIADERM TA (hydrocortisone) SCALPICIN OTC (hydrocortisone) SYNALAR (fluocinolone) TEXACORT (hydrocortisone) VERDESO (desonide)	