



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

**EFFECTIVE
04/01/2015
Version 2015.2b**

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ACNE AGENTS, TOPICAL^{AP}			
ANTI-INFECTIVE			
	clindamycin gel, lotion, medicated swab, solution erythromycin gel, solution	ACZONE (dapsons) AKNE-MYCIN (erythromycin) AZELEX (azelaic acid) CLEOCIN-T (clindamycin) CLINDACIN PAC (clindamycin) CLINDAGEL (clindamycin) clindamycin foam erythromycin medicated swab EVOCLIN (clindamycin) FABIOR (tazarotene) KLARON (sulfacetamide) OVACE/PLUS (sulfacetamide) sodium sulfacetamide 10% cleansing gel sulfacetamide cleanser sulfacetamide cleanser ER sulfacetamide shampoo sulfacetamide suspension	Thirty (30) day trials each of one (1) preferred retinoid and two (2) unique chemical entities in two (2) other subclasses, including the generic version of a requested non-preferred product, are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. In cases of pregnancy, a trial of retinoids will <i>not</i> be required. For Members 18 years of age or older, a trial of retinoids will <i>not</i> be required.
RETINOIDS			
	RETIN-A (tretinoin) TAZORAC (tazarotene)	adapalene ATRALIN (tretinoin) AVITA (tretinoin) DIFFERIN (adapalene) RETIN-A MICRO (tretinoin) tretinoin cream, gel tretinoin gel micro TRETIN-X (tretinoin)	PA required for members eighteen (18) years of age or older for Retinoids sub-class.
KERATOLYTICS			
	benzoyl peroxide cleanser Rx & OTC, 10% cream OTC, gel Rx & OTC, lotion OTC, wash OTC	BENZEFOAM (benzoyl peroxide) BENZEFOAM ULTRA (benzoyl peroxide) BENZEPRO (benzoyl peroxide) benzoyl peroxide cloths, medicated pads, microspheres cleanser BP 10-1 (benzoyl peroxide) BP WASH 7% LIQUID DELOS (benzoyl peroxide) DESQUAM-X (benzoyl peroxide) LAVOCLEN (benzoyl peroxide) PACNEX/HP/LP (benzoyl peroxide) PANOXYL-4, -8 OTC (benzoyl peroxide) PERSA-GEL OTC (benzoyl peroxide) SASTID (sulfur)	Acne kits are non-preferred.



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

**EFFECTIVE
04/01/2015
Version 2015.2b**

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
COMBINATION AGENTS			
	erythromycin/benzoyl peroxide	SULPHO-LAC (sulfur) ACANYA (clindamycin phosphate/benzoyl peroxide) AVAR/-E/LS (sulfur/sulfacetamide) BENZACLIN GEL (benzoyl peroxide/clindamycin) BENZAMYCIN PAK (benzoyl peroxide/erythromycin) benzoyl peroxide/clindamycin gel benzoyl peroxide/urea CERISA (sulfacetamide sodium/sulfur) CLARIFOAM EF (sulfacetamide/sulfur) CLENIA (sulfacetamide sodium/sulfur) DUAC (benzoyl peroxide/clindamycin) EPIDUO (adapalene/benzoyl peroxide)* INOVA 4/1, 5/2 (benzoyl peroxide/salicylic acid) NEUAC (clindamycin phosphate/benzoyl peroxide) NUOX (benzoyl peroxide/sulfur) PRASCION (sulfacetamide sodium/sulfur) SE 10-5 SS (sulfacetamide/sulfur) SSS 10-4 (sulfacetamide /sulfur) SSS 10-5 foam (sulfacetamide /sulfur) sulfacetamide sodium/sulfur cloths, lotion, pads, suspension sulfacetamide/sulfur wash/cleanser sulfacetamide/sulfur wash kit sulfacetamide sodium/sulfur/ urea SUMADAN/XLT (sulfacetamide/sulfur) SUMAXIN/TS (sulfacetamide sodium/sulfur) VELTIN (clindamycin/tretinoin)* ZIANA (clindamycin/tretinoin)*	<p>Thirty (30) day trials each of one (1) preferred retinoid and two (2) unique chemical entities in two (2) other subclasses, including the generic version of a requested non-preferred product, are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.</p> <p>In cases of pregnancy, a trial of retinoids will <i>not</i> be required.</p> <p>For Members 18 years of age or older, a trial of retinoids will <i>not</i> 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> <p>*PA required for combination agents with Retinoid products for members eighteen (18) years of age or older.</p>
ANDROGENIC AGENTS			
	ANDRODERM (testosterone) ANDROGEL (testosterone) TESTIM (testosterone)	AXIRON (testosterone) FORTESTA (testosterone) testosterone gel VOGELXO (testosterone)	The non-preferred agents will be authorized only if one (1) of the exceptions on the PA form is present.
ANTIBIOTICS, INHALED			
	BETHKIS (tobramycin) tobramycin (Sandoz generic)	CAYSTON (aztreonam) TOBI (tobramycin) TOBI PODHALER tobramycin (all generics except Sandoz)	A twenty-eight (28) day trial of the preferred agent and documentation of therapeutic failure is required before a non-preferred agent will be



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

**EFFECTIVE
04/01/2015
Version 2015.2b**

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			authorized unless one (1) of the exceptions on the PA form is present.
ANTICONVULSANTS			
	ADJUVANTS		
	carbamazepine carbamazepine ER carbamazepine XR CARBATROL (carbamazepine) DEPAKOTE SPRINKLE (divalproex) divalproex divalproex ER EPITOL (carbamazepine) FELBATOL (felbamate) GABITRIL (tiagabine) lamotrigine levetiracetam oxcarbazepine tablets TEGRETOL XR (carbamazepine) topiramate TRILEPTAL SUSPENSION (oxcarbazepine) valproic acid VIMPAT (lacosamide) ^{AP*} zonisamide	APTIOM (eslicarbazepine) BANZEL (rufinamide) DEPAKENE (valproic acid) DEPAKOTE (divalproex) DEPAKOTE ER (divalproex) divalproex sprinkle EQUETRO (carbamazepine) FANATREX SUSPENSION (gabapentin) felbamate FYCOMPA (perampanel) KEPPRA (levetiracetam) KEPPRA XR (levetiracetam) LAMICTAL (lamotrigine) LAMICTAL CHEWABLE (lamotrigine) LAMICTAL ODT (lamotrigine) LAMICTAL XR (lamotrigine) lamotrigine dose pack lamotrigine ER levetiracetam ER ONFI (clobazam) ** ONFI SUSPENSION (clobazam) ** oxcarbazepine suspension OXTELLAR XR (oxcarbazepine) POTIGA (ezogabine) QUDEXY XR (topiramate ER) SABRIL (vigabatrin) STAVZOR (valproic acid) TEGRETOL (carbamazepine) tiagabine TOPAMAX (topiramate) topiramate ER TRILEPTAL TABLETS (oxcarbazepine) TROKENDI XR (topiramate) ZONEGRAN (zonisamide)	<p>A fourteen (14) day trial of one (1) of the preferred agents in the corresponding group is required for treatment naïve patients with a diagnosis of a seizure disorder before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.</p> <p>A thirty (30) day trial of one (1) of the preferred agents in the corresponding group is required for patients with a diagnosis other than seizure disorders unless one (1) of the exceptions on the PA form is present.</p> <p>Non-preferred anticonvulsants will be authorized for patients on established therapies with a diagnosis of seizure disorders with no trials of preferred agents required. In situations where AB-rated generic equivalent products are available, "Brand Medically Necessary" must be hand-written by the prescriber on the prescription in order for the brand name product to be reimbursed.</p> <p>*Vimpat will be approved as monotherapy or adjunctive therapy for members 17 years of age or older with a diagnosis of partial-onset seizure disorder.</p> <p>**Onfi will be authorized if the following criteria are met:</p>



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

**EFFECTIVE
04/01/2015
Version 2015.2b**

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			1. Adjunctive therapy for Lennox-Gastaut or 2. Generalized tonic, atonic or myoclonic seizures and 3. Previous failure of at least two (2) non-benzodiazepine anticonvulsants and previous failure of clonazepam. (For continuation, prescriber must include information regarding improved response/effectiveness with this medication)
	BARBITURATES^{AP}		
	phenobarbital primidone	MEBARAL (mephobarbital) MYSOLINE (primidone)	
	BENZODIAZEPINES^{AP}		
	clonazepam DIASTAT (diazepam rectal) diazepam tablets	clonazepam ODT diazepam rectal gel KLONOPIN (clonazepam) VALIUM TABLETS (diazepam)	
	HYDANTOINS^{AP}		
	DILANTIN 30mg (phenytoin) PEGANONE (ethotoin) phenytoin capsules, chewable tablets, suspension	DILANTIN (phenytoin) DILANTIN INFATABS (phenytoin) PHENYTEK (phenytoin)	
	SUCCINIMIDES		
	CELONTIN (methsuximide) ethosuximide syrup ZARONTIN (ethosuximide) capsules	ethosuximide capsules ZARONTIN (ethosuximide) syrup	
ANTIFUNGALS, TOPICAL^{AP}			
	ANTIFUNGALS		
	econazole ketoconazole cream, shampoo MENTAX (butenafine) miconazole (OTC) nystatin	CICLODAN (ciclopirox) ciclopirox ERTACZO (sertaconazole) EXELDERM (sulconazole) EXTINA (ketoconazole) JUBLIA (efinaconazole) ketoconazole foam KETODAN (ketoconazole) LOPROX (ciclopirox) LUZU (luliconazole) MYCOSTATIN (nystatin) NAFTIN CREAM (naftifine)	Fourteen (14) day trials of two (2) of the preferred agents are required before one (1) of the non-preferred agents will be authorized unless one (1) of the exceptions on the PA form is present. If a non-preferred shampoo is requested, a fourteen (14) day trial of one (1) preferred product (ketoconazole shampoo) is required. *Oxistat cream will be authorized for



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

**EFFECTIVE
04/01/2015
Version 2015.2b**

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		NAFTIN GEL (naftifine) NIZORAL (ketoconazole) OXISTAT (oxiconazole)* PEDIPROX-4 (ciclopirox) PENLAC (ciclopirox) VUSION (miconazole/petrolatum/zinc oxide) XOLEGEL (ketoconazole)	children up to thirteen (13) years of age for tinea corporis, tinea cruris, tinea pedis, and tinea (pityriasis) versicolor.
	ANTIFUNGAL/STEROID COMBINATIONS		
	clotrimazole/betamethasone nystatin/triamcinolone	KETOCON PLUS (ketoconazole/hydrocortisone) LOTRISONE (clotrimazole/betamethasone)	
ANTIVIRALS, ORAL			
	ANTI HERPES		
	acyclovir valacyclovir	famciclovir FAMVIR (famciclovir) SITAVIG (acyclovir) VALTREX ZOVIRAX (acyclovir)	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.
BETA BLOCKERS^{AP}			
	BETA BLOCKERS		
	acebutolol atenolol betaxolol bisoprolol metoprolol metoprolol ER nadolol pindolol propranolol propranolol ER sotalol timolol	BETAPACE (sotalol) BYSTOLIC (nebivolol) CORGARD (nadolol) HEMANGEOL (propranolol) INDERAL LA (propranolol) INDERAL XL (propranolol) INNOPRAN XL (propranolol) KERLONE (betaxolol) LEVATOL (penbutolol) LOPRESSOR (metoprolol) SECTRAL (acebutolol) TENORMIN (atenolol) TOPROL XL (metoprolol) ZEBETA (bisoprolol)	Fourteen (14) day trials each of three (3) chemically distinct preferred agents, including the generic formulation of a requested non-preferred product, are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.
	BETA BLOCKER/DIURETIC COMBINATION DRUGS		
	atenolol/chlorthalidone bisoprolol/HCTZ metoprolol/HCTZ nadolol/bendroflumethiazide propranolol/HCTZ	CORZIDE (nadolol/bendroflumethiazide) DUTOPROL (metoprolol ER/HCTZ ER) LOPRESSOR HCT (metoprolol/HCTZ) TENORETIC (atenolol/chlorthalidone) ZIAC (bisoprolol/HCTZ)	
	BETA- AND ALPHA-BLOCKERS		



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

**EFFECTIVE
04/01/2015
Version 2015.2b**

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	carvedilol labetalol	COREG (carvedilol) COREG CR (carvedilol) TRANDATE (labetalol)	
EPINEPHRINE, SELF-INJECTED			
	AUVI-Q (epinephrine) epinephrine	ADRENALICK (epinephrine) EPIPEN (epinephrine) EPIPEN JR (epinephrine)	A thirty (30) day trial of each preferred agent is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.
HEPATITIS C TREATMENTS^{CL}			
	HARVONI (ledipasvir/sofosbuvir)* PEGASYS (pegylated interferon) PEG-INTRON (pegylated interferon) RIBASPHERE 200mg ribavirin	COPEGUS (ribavirin) INFERGEN (consensus interferon) OLYSIO (simeprevir)* REBETOL (ribavirin) RIBAPAK (ribavirin) RIBASPHERE 400mg, 600mg (ribavirin) ribavirin dose pack SOVALDI (sofosbuvir)* VICTRELIS (boceprevir)*	For patients starting therapy in this class, a trial of the preferred agent of a dosage form is required before a non-preferred agent of that dosage form will be authorized. *Full PA criteria may be found on the BMS Website: http://www.dhr.wv.gov/bms/Pharmacy/Pages/pac.aspx
HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS			
INJECTABLE			
	BYETTA (exenatide) ^{AP} VICTOZA (liraglutide) ^{AP}	BYDUREON (exenatide)* TANZEUM (albiglutide) 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. For re-authorizations, documentation that HgBA1C levels have decreased by at least 1% or are maintained at ≤8% is required. HgBA1C levels



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

**EFFECTIVE
04/01/2015
Version 2015.2b**

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			<p>submitted must be for the most recent thirty (30) day period. (Concurrent therapy with a bolus insulin is contraindicated.)</p> <p>*Bydureon will not be authorized with insulin therapy of any kind.</p> <p>**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.</p>
ORAL ^{AP}			
	<p>JANUMET (sitagliptin/metformin)^{AP} JANUVIA (sitagliptin)^{AP} JENTADUETO (linagliptin/metformin)^{AP} TRADJENTA (linagliptin)^{AP}</p>	<p>JANUMET XR (sitagliptin/metformin)* KAZANO (alogliptin/metformin) KOMBIGLYZE XR (saxagliptin/metformin) * NESINA (alogliptin) ONGLYZA (saxagliptin) OSENI (alogliptin/pioglitazone)</p>	<p>Thirty (30) day trials of each chemically distinct preferred agent are required before a non-preferred agent will be approved.</p> <p>All agents (preferred and non-preferred) require a previous history of a thirty (30) day trial of metformin.</p> <p>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.</p> <p>*Janumet XR and Kombiglyze XR will be authorized after thirty (30) day trials of the preferred combination agents.</p>
OPIATE DEPENDENCE TREATMENTS			
	<p>SUBOXONE FILM (buprenorphine/naloxone)^{CL} VIVITROL (naltrexone)^{CL} naloxone</p>	<p>EVZIO (naloxone) SUBOXONE TABLETS (buprenorphine/naloxone) buprenorphine/naloxone tablets ZUBSOLV (buprenorphine/naloxone)</p>	<p>Suboxone PA criteria is available at http://www.dhhr.wv.gov/bms/Pharmacy/Pages/pac.aspx</p> <p>Vivitrol PA criteria is available at http://www.dhhr.wv.gov/bms/Pharmacy/Pages/pac.aspx</p>



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

**EFFECTIVE
04/01/2015
Version 2015.2b**

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			acy/Pages/pac.aspx *Buprenorphine/naloxone tablets will only be approved with a documented intolerance of or allergy to Suboxone strips.
PHOSPHATE BINDERS^{AP}			
	calcium acetate MAGNEBIND RX (calcium carbonate, folic acid, magnesium carbonate) PHOSLYRA (calcium acetate) RENAGEL (sevelamer)	AURYXIA (ferric citrate) ELIPHOS (calcium acetate) FOSRENOL (lanthanum) PHOSLO (calcium acetate) RENVELA (sevelamer carbonate) sevelamer carbonate VELPHORO (sucroferric oxyhydroxide)	Thirty (30) day trials of at least two (2) preferred agents are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.
PLATELET AGGREGATION INHIBITORS			
	AGGRENOX (dipyridamole/ASA) BRILINTA (ticagrelor) clopidogrel EFFIENT (prasugrel)	dipyridamole PERSANTINE (dipyridamole) PLAVIX (clopidogrel) TICLID (ticlopidine) ticlopidine ZONTIVITY (vorapaxar)	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.
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) CLODAN (clobetasol propionate) CORMAX (clobetasol propionate) desoximetasone cream/gel/ointment diflorasone diacetate DIPROLENE (betamethasone dipropionate/propylene glycol) DIPROLENE AF (betamethasone dipropionate/propylene glycol) DIPROSONE (betamethasone dipropionate) fluocinonide ointment	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.



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

**EFFECTIVE
04/01/2015
Version 2015.2b**

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		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) LOCOID LIPOCREAM (hydrocortisone butyrate/emollient) LUXIQ (betamethasone valerate) MOMEXIN (mometasone) PANDEL (hydrocortisone probutate) prednicarbate TOPICORT LP (desoximetasone)	



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

**EFFECTIVE
04/01/2015
Version 2015.2b**

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		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-SMOOTHIE 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)	