



BUREAU FOR MEDICAL SERVICES
WEST VIRGINIA MEDICAID

PREFERRED DRUG LIST WITH PRIOR AUTHORIZATION CRITERIA

This is not an all-inclusive list of available covered drugs and includes only managed categories. Refer to cover page for complete list of rules governing this PDL.

EFFECTIVE
01/01/13
Version 2013.1b

- Prior authorization for a non-preferred agent in any category will be given only if there has been a trial of the preferred brand/generic equivalent or preferred formulation of the active ingredient, at a therapeutic dose, that resulted in a partial response with a documented intolerance.
- Prior authorization of a non-preferred isomer, pro-drug, or metabolite will be considered with a trial of a preferred parent drug of the same chemical entity, at a therapeutic dose, that resulted in a partial response with documented intolerance or a previous trial and therapy failure, at a therapeutic dose, with a preferred drug of a different chemical entity indicated to treat the submitted diagnosis. (The required trial may be overridden when documented evidence is provided that the use of these preferred agent(s) would be medically contraindicated.)
- Unless otherwise specified, the listing of a particular brand or generic name includes all legend forms of that drug. OTC drugs are not covered unless specified.
- PA criteria for non-preferred agents apply in addition to general Drug Utilization Review policy that is in effect for the entire pharmacy program, including, but not limited to, appropriate dosing, duplication of therapy, etc.
- The use of pharmaceutical samples will not be considered when evaluating the members' medical condition or prior prescription history for drugs that require prior authorization.
- Acronyms
 - CL - Requires clinical PA. For detailed clinical criteria, please refer to:
<http://www.dhhr.wv.gov/bms/Pharmacy/Pages/PriorAuthorizationCriteria.aspx>
 - NR - New drug has not been reviewed by P & T Committee
 - AP - Non-preferred and selected preferred drugs, where indicated, are subject to auto-PA criteria. See PA criteria column.



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

This is not an all-inclusive list of available covered drugs and includes only managed categories. Refer to cover page for complete list of rules governing this PDL.

**EFFECTIVE
01/01/13
Version 2013.1b**

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA	
ACNE AGENTS (Topical)^{AP}				
ANTI-INFECTIVE				
	AZELEX (azelaic acid) clindamycin gel, lotion, medicated swab, solution erythromycin gel, solution sulfacetamide suspension	ACZONE (dapson) AKNE-MYCIN (erythromycin) CLEOCIN-T (clindamycin) CLINDACIN PAC (clindamycin) CLINDAGEL (clindamycin) clindamycin foam erythromycin medicated swab EVOCLIN (clindamycin) KLARON (sodium sulfacetamide) OVACE/PLUS (sulfacetamide) sulfacetamide cleanser	Thirty (30) day trials each of one preferred retinoid and two unique chemical entities in two other subclasses, including the generic version of a requested non-preferred product, are required before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present. (In cases of pregnancy, a trial of retinoids will not be required.)	
RETINOIDS				
	RETIN A MICRO (tretinoin) TAZORAC (tazarotene)	adapalene ATRALIN (tretinoin) AVITA (tretinoin) DIFFERIN (adapalene) RETIN-A (tretinoin) tretinoin cream, gel		PA required after 17 years of age for tretinoin products.
KERATOLYTICS				
	benzoyl peroxide cleanser OTC, 10% cream OTC, gel Rx & OTC, lotion OTC, 5% & 10% wash OTC TL 4.25% BPO MX (benzoyl peroxide)	BENZEFOAM (benzoyl peroxide) BENZEFOAM ULTRA (benzoyl peroxide) BENZEPRO (benzoyl peroxide) ^{NR} benzoyl peroxide cloths, medicated pads benzoyl peroxide/aloe OTC benzoyl peroxide/urea BPO (benzoyl peroxide) 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) SE-BPO (benzoyl peroxide) SULPHO-LAC (sulfur)	Acne kits are non-preferred.	



**BUREAU FOR MEDICAL SERVICES
WEST VIRGINIA MEDICAID**

PREFERRED DRUG LIST WITH PRIOR AUTHORIZATION CRITERIA

This is not an all-inclusive list of available covered drugs and includes only managed categories. Refer to cover page for complete list of rules governing this PDL.

**EFFECTIVE
01/01/13
Version 2013.1b**

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
COMBINATION AGENTS			
	erythromycin/benzoyl peroxide sulfacetamide solution sulfacetamide/sulfur wash/cleanser	10-1 (sulfacetamide/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/ erythromycin) EPIDUO (adapalene/benzoyl peroxide) GARIMIDE (sulfacetamide/sulfur) INOVA 4/1, 5/2 (benzoyl peroxide/salicylic acid) NUOX (benzoyl peroxide/sulfur) PRASCION (sulfacetamide sodium/sulfur) SE 10-5 SS (sulfacetamide/sulfur) SSS 10-4 (sulfacetamide /sulfur) sulfacetamide sodium/sulfur cloths, lotion, pads, suspension sulfacetamide sodium/sulfur/ urea SUMADAN (sulfacetamide/sulfur) SUMAXIN/TS (sulfacetamide sodium/sulfur) VELTIN (clindamycin/tretinoin) ZIANA (clindamycin/tretinoin)	<p>Thirty (30) day trials each of one preferred retinoid and two unique chemical entities in two other subclasses, including the generic version of a requested non-preferred product, are required before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present. (In cases of pregnancy, a trial of retinoids will not be required.)</p> <p>In addition, thirty (30) day trials of combinations of the corresponding preferred single agents available are required before non-preferred combination agents will be authorized.</p>
ALZHEIMER'S AGENTS^{AP}			
CHOLINESTERASE INHIBITORS			
	donepezil	ARICEPT (donepezil) ARICEPT 23mg (donepezil) ARICEPT ODT(donepezil) COGNEX (tacrine) donepezil ODT EXELON CAPSULE (rivastigmine) EXELON PATCH (rivastigmine)	<p>A thirty (30) day trial of a preferred agent is required before a non-preferred agent in this class will be authorized unless one of the exceptions on the PA form is present.</p>



BUREAU FOR MEDICAL SERVICES
WEST VIRGINIA MEDICAID

PREFERRED DRUG LIST WITH PRIOR AUTHORIZATION CRITERIA

This is not an all-inclusive list of available covered drugs and includes only managed categories. Refer to cover page for complete list of rules governing this PDL.

EFFECTIVE
01/01/13
Version 2013.1b

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		galantamine galantamine ER RAZADYNE (galantamine) RAZADYNE ER (galantamine) rivastigmine	<p>Aricept 23mg tablets will be approved when there is a diagnosis of moderate-to-severe Alzheimer's Disease, a trial of donepezil 10mg daily for at least three (3) months, and donepezil 20mg daily for an additional one (1) month.</p> <p>Aricept and donepezil ODT will be approved only when the oral dosage form is not appropriate for the patient.</p>
NMDA RECEPTOR ANTAGONIST			
	NAMENDA (memantine)		
ANALGESICS, NARCOTIC - SHORT ACTING (Non-parenteral)^{AP}			
	APAP/codeine ASA/codeine butalbital/APAP/caffeine/codeine codeine hydrocodone/APAP hydrocodone/ibuprofen hydromorphone tablets morphine oxycodone oxycodone/APAP pentazocine/APAP pentazocine/naloxone ROXICET (oxycodone/acetaminophen) tramadol tramadol/APAP	ABSTRAL (fentanyl) ACTIQ (fentanyl) butalbital/ASA/caffeine/codeine butorphanol COMBUNOX (oxycodone/ibuprofen) DEMEROL (meperidine) dihydrocodeine/ APAP/caffeine DILAUDID (hydromorphone) fentanyl FENTORA (fentanyl) FIORICET W/ CODEINE (butalbital/APAP/caffeine/codeine) FIORINAL W/ CODEINE (butalbital/ASA/caffeine/codeine) hydromorphone liquid hydromorphone suppositories LAZANDA (fentanyl) levorphanol LORCET (hydrocodone/APAP) LORTAB (hydrocodone/APAP) MAGNACET (oxycodone/APAP) meperidine NUCYNTA (tapentadol) OPANA (oxymorphone) ONSOLIS (fentanyl) oxycodone/ASA	<p>Six (6) day trials of at least four (4) chemically distinct preferred agents (based on narcotic ingredient only), including the generic formulation of a requested non-preferred product, are required before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present.</p> <p>Fentanyl lozenges and Onsolis will only be approved for a diagnosis of cancer and as an adjunct to a long-acting agent. Neither will be approved for monotherapy.</p> <p>Limits: Unless the patient has escalating cancer pain or another diagnosis supporting increased quantities of short-acting opioids, all short acting solid forms of the narcotic analgesics are limited to 120 tablets per 30 days for the purpose of maximizing the use of longer acting medications to prevent unnecessary breakthrough</p>



BUREAU FOR MEDICAL SERVICES
WEST VIRGINIA MEDICAID

PREFERRED DRUG LIST WITH PRIOR AUTHORIZATION CRITERIA

This is not an all-inclusive list of available covered drugs and includes only managed categories. Refer to cover page for complete list of rules governing this PDL.

EFFECTIVE
01/01/13
Version 2013.1b

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		oxycodone/ibuprofen OXECTA (oxycodone) OXYFAST (oxycodone) OXYIR (oxycodone) PANLOR (dihydrocodeine/ APAP/caffeine) PERCOCET (oxycodone/APAP) PERCODAN (oxycodone/ASA) PRIMLEV (oxycodone/APAP) ROXANOL (morphine) RYBIX ODT (tramadol) SUBSYS (fentanyl) ^{NR} 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) ZAMICET (hydrocodone/APAP) ZYDONE (hydrocodone/acetaminophen) XOLOX (oxycodone/APAP)	pain in chronic pain therapy.
ANALGESICS, NARCOTIC - LONG ACTING (Non-parenteral)^{AP}			
	fentanyl transdermal methadone methadone soluble tablet morphine ER tablets	AVINZA (morphine) BUTRANS (buprenorphine) CONZIP ER (tramadol) DOLOPHINE (methadone) DURAGESIC (fentanyl) EXALGO ER (hydromorphone) EMBEDA (morphine/naltrexone) KADIAN (morphine) morphine ER capsules MS CONTIN (morphine) NUCYNTA ER (tapentadol) OPANA ER (oxymorphone) ORAMORPH SR (morphine) oxycodone ER OXYCONTIN (oxycodone) oxymorphone ER RYZOLT 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. Butrans will be approved if the following criteria are met: 1. Diagnosis of moderate to severe chronic pain requiring continuous around-the-clock analgesia and



BUREAU FOR MEDICAL SERVICES
WEST VIRGINIA MEDICAID

PREFERRED DRUG LIST WITH PRIOR AUTHORIZATION CRITERIA

This is not an all-inclusive list of available covered drugs and includes only managed categories. Refer to cover page for complete list of rules governing this PDL.

EFFECTIVE
01/01/13
Version 2013.1b

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		tramadol ER ULTRAM ER (tramadol)	<ol style="list-style-type: none"> 2. Patient cannot take oral medications and has a diagnosis of chronic pain and 3. Needs analgesic medication for an extended period of time and 4. Has had a previous trial** of a non-opioid analgesic medication and 5. Previous trial of one opioid medication** and 6. Current total daily opioid dose is ≤ 80 mg morphine equivalents daily or dose of transdermal fentanyl is ≤ 12.5 mcg/hr and 7. Patient is not currently being treated with buprenorphine. <p>**Requirement is waived for patients who cannot swallow</p> <p><i>Dose optimization is required for achieving equivalent doses of Kadian 80mg and 200mg. AP does not apply.</i></p> <p>Exception: Oxycodone ER will be authorized if a diagnosis of cancer is submitted without a trial of the preferred agents.</p>
ANALGESICS (Topical)^{AP}			
	lidocaine lidocaine/prilocaine xylocaine	EMLA (lidocaine/prilocaine) FLECTOR PATCH (diclofenac) LIDAMANTLE (lidocaine) LIDAMANTLE HC (lidocaine/hydrocortisone) LMX 4 (lidocaine) PENNSAID (diclofenac) SYNERA (lidocaine/tetracaine) VOLTAREN GEL (diclofenac)	<p>Ten (10) day trials of each of the preferred topical anesthetics (lidocaine, lidocaine/prilocaine, and xylocaine) are required before a non-preferred topical anesthetic will be approved unless one of the exceptions on the PA form is present.</p> <p>Lidoderm patches will be approved for a diagnosis of post-herpetic neuralgia.</p>



**BUREAU FOR MEDICAL SERVICES
WEST VIRGINIA MEDICAID**

PREFERRED DRUG LIST WITH PRIOR AUTHORIZATION CRITERIA

This is not an all-inclusive list of available covered drugs and includes only managed categories. Refer to cover page for complete list of rules governing this PDL.

**EFFECTIVE
01/01/13
Version 2013.1b**

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			<p>Thirty (30) day trials of each of the preferred oral NSAIDs and capsaicin are required before Voltaren Gel will be approved unless one of the exceptions on the PA form is present.</p> <p>Flector patches will be approved only for a diagnosis of acute strain, sprain or injury after a five (5) day trial of one of the preferred oral NSAIDs and for a maximum duration of 14 days unless one of the exceptions on the PA form is present.</p>
ANDROGENIC AGENTS			
	ANDRODERM (testosterone) ANDROGEL (testosterone)	AXIRON (testosterone) FORTESTA (testosterone) TESTIM (testosterone)	The non-preferred agents will be approved only if one of the exceptions on the PA form is present.
ANGIOTENSIN MODULATORS^{AP}			
ACE INHIBITORS			
	benazepril captopril enalapril fosinopril lisinopril quinapril ramipril	ACCUPRIL (quinapril) ACEON (perindopril) ALTACE (ramipril) CAPOTEN (captopril) LOTENSIN (benazepril) MAVIK (trandolapril) moexipril MONOPRIL (fosinopril) perindopril PRINIVIL (lisinopril) trandolapril UNIVASC (moexipril) VASOTEC (enalapril) ZESTRIL (lisinopril)	Fourteen (14) day trials of each of the preferred agents in the corresponding group, with the exception of the Direct Renin Inhibitors, are required before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present.



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

This is not an all-inclusive list of available covered drugs and includes only managed categories. Refer to cover page for complete list of rules governing this PDL.

**EFFECTIVE
01/01/13
Version 2013.1b**

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
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)			
	BENICAR (olmesartan) DIOVAN (valsartan) irbesartan losartan MICARDIS (telmisartan)	ATACAND (candesartan) AVAPRO (irbesartan) COZAAR (losartan) EDARBI (azilsartan) eprosartan TEVETEN (eprosartan)	
ARB COMBINATIONS			
	BENICAR-HCT (olmesartan/HCTZ) DIOVAN-HCT (valsartan/HCTZ) EXFORGE (valsartan/amlodipine) EXFORGE HCT (valsartan/amlodipine/HCTZ) irbesartan/HCTZ losartan/HCTZ MICARDIS-HCT (telmisartan/HCTZ)	ATACAND-HCT (candesartan/HCTZ) AVALIDE (irbesartan/HCTZ) AZOR (olmesartan/amlodipine) EDARBYCLOR (azilsartan/chlorthalidone) HYZAAR (losartan/HCTZ) TEVETEN-HCT (eprosartan/HCTZ) TRIBENZOR (olmesartan/amlodipine/HCTZ) TWYNSTA (telmisartan/amlodipine)	
DIRECT RENIN INHIBITORS			
		AMTURNIDE (aliskiren/amlodipine/HCTZ) TEKAMLO (aliskiren/amlodipine) TEKTURNA (aliskiren) TEKTURNA HCT (aliskiren/HCTZ) VALTURNA (aliskiren/valsartan)	<p>A thirty (30) day trial of one preferred ACE, ARB, or combination agents, at the maximum tolerable dose, is required before Tekturna will be approved.</p> <p>Tekturna HCT, Valturna, Tekamlo or Amturnide will be approved if the criteria for Tekturna are met and the patient also needs the other agents</p>



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

This is not an all-inclusive list of available covered drugs and includes only managed categories. Refer to cover page for complete list of rules governing this PDL.

**EFFECTIVE
01/01/13
Version 2013.1b**

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			in the combination.
ANTIBIOTICS, GI	NEO-FRADIN (neomycin) neomycin metronidazole tablet TINDAMAX (tinidazole)	ALINIA (nitazoxanide) DIFICID (fidaxomicin) FLAGYL (metronidazole) FLAGYL ER (metronidazole ER) metronidazole capsule VANCOCIN (vancomycin) vancomycin XIFAXIN (rifaximin)	<p>A fourteen (14) day trial of a corresponding generic preferred agent is required before a non-preferred brand agent will be approved.</p> <p>Dificid will be approved if 1) there is a diagnosis of severe <i>C. difficile</i> infection and 2) there is no response to prior treatment with vancomycin for 10-14 days.</p> <p>Xifaxin 200 mg will be approved for traveller's diarrhea if 1) there is a diagnosis of <i>E. coli</i> diarrhea, 2) patient is between 12 and 18 years old or is 18 years or older and has failed a ten (10) day trial of ciprofloxacin.</p> <p>Xifaxin 550 mg will be approved for hepatic encephalopathy if 1) there is a diagnosis of hepatic encephalopathy, 2) patient is 18 years or older, and 3) patient has a history of and current treatment with lactulose.</p> <p>Vancocin will be approved after a fourteen (14) day trial of metronidazole for <i>C. difficile</i> infections of mild to moderate severity unless one of the exceptions on the PA form is present.</p> <p>Vancocin will be approved for severe <i>C. difficile</i> infections with no previous trial of metronidazole.</p>



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

This is not an all-inclusive list of available covered drugs and includes only managed categories. Refer to cover page for complete list of rules governing this PDL.

**EFFECTIVE
01/01/13
Version 2013.1b**

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ANTIBIOTICS, INHALED			
	TOBI (tobramycin)	CAYSTON (aztreonam)	A 28-day trial of the preferred agent is required before the non-preferred agent will be approved unless one of the exceptions on the PA form is present.
ANTICOAGULANTS^{CL}			
INJECTABLE			
	FRAGMIN (dalteparin) LOVENOX (enoxaparin)	ARIXTRA (fondaparinux) enoxaparin fondaparinux INNOHEP (tinzaparin)	Trials 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.
ORAL			
	PRADAXA (dabigatran) ^{AP} warfarin XARELTO (rivaroxaban) ^{AP}		Pradaxa will be approved for the diagnosis of non-valvular atrial fibrillation. Xarelto will be approved for the diagnosis of non-valvular atrial fibrillation. Xarelto will be approved for DVT prophylaxis if treatment is limited to 35 days for hip replacement surgeries or 12 days for knee replacement surgeries.
ANTICONVULSANTS			
ADJUVANTS			
	carbamazepine carbamazepine XR CARBATROL (carbamazepine) DEPAKOTE SPRINKLE (divalproex) divalproex EC divalproex ER divalproex DR EPITOL (carbamazepine) FELBATOL (felbamate)	BANZEL(rufinamide) DEPAKENE (valproic acid) DEPAKOTE (divalproex) DEPAKOTE ER (divalproex) divalproex sprinkle EQUETRO (carbamazepine) FANATREX SUSPENSION (gabapentin) ^{NR} felbamate GRALISE (gabapentin)	A fourteen (14) day trial of one of the preferred agents in the corresponding group is required for treatment naive patients with a diagnosis of a seizure disorder before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present.



BUREAU FOR MEDICAL SERVICES
WEST VIRGINIA MEDICAID

PREFERRED DRUG LIST WITH PRIOR AUTHORIZATION CRITERIA

This is not an all-inclusive list of available covered drugs and includes only managed categories. Refer to cover page for complete list of rules governing this PDL.

EFFECTIVE
01/01/13
Version 2013.1b

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	gabapentin GABITRIL (tiagabine) levetiracetam lamotrigine lamotrigine chewable oxcarbazepine tablets topiramate TEGRETOL XR (carbamazepine) TRILEPTAL SUSPENSION (oxcarbazepine) valproic acid zonisamide	HORIZANT (gabapentin) KEPPRA (levetiracetam) KEPPRA XR (levetiracetam) LAMICTAL (lamotrigine) LAMICTAL CHEWABLE (lamotrigine) LAMICTAL ODT (lamotrigine) LAMICTAL XR (lamotrigine) levetiracetam ER NEURONTIN (gabapentin) ONFI (clobazam) POTIGA (ezogabine) SABRIL (vigabatrin) STAVZOR (valproic acid) TEGRETOL (carbamazepine) TOPAMAX (topiramate) TRILEPTAL TABLETS (oxcarbazepine) VIMPAT (lacosamide) ZONEGRAN (zonisamide)	<p>A thirty (30) day trial of one of the preferred agents in the corresponding group is required for patients with a diagnosis other than seizure disorders unless one of the exceptions on the PA form is present.</p> <p>Non-preferred anticonvulsants will be approved for patients on established therapies with a diagnosis of seizure disorders with no trials of preferred agents required. In situations where AB-rated generic equivalent products are available, "Brand Medically Necessary" must be hand-written by the prescriber on the prescription in order for the brand name product to be reimbursed.</p> <p>Requests for Gralise will be authorized if the following criteria are met:</p> <ol style="list-style-type: none"> 1. Diagnosis of post herpetic neuralgia 2. Trial of a tricyclic antidepressant for a least thirty days 3. Trial of gabapentin immediate release formulation (positive response without adequate duration) 4. Request is for once daily dosing with 1800 mg. maximum daily dosage.
BARBITURATES^{AP}			
	mephobarbital phenobarbital primidone	MEBARAL (mephobarbital) MYSOLINE (primidone)	<p>Requests for Onfi will be authorized if the following criteria are met:</p> <ol style="list-style-type: none"> 1. Adjunctive therapy for Lennox-Gastaut OR 2. Generalized tonic, atonic or myoclonic seizures AND 3. Previous failure of at least two



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

This is not an all-inclusive list of available covered drugs and includes only managed categories. Refer to cover page for complete list of rules governing this PDL.

**EFFECTIVE
01/01/13
Version 2013.1b**

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			non-benzodiazepine anticonvulsants and previous failure of clonazepam. (For continuation, prescriber must include information regarding improved response/effectiveness with this medication)
	BENZODIAZEPINES^{AP}		
	clonazepam DIASTAT (diazepam rectal) diazepam tablets	clonazepam ODT diazepam rectal gel KLONOPIN (clonazepam)	
	HYDANTOINS^{AP}		
	DILANTIN INFATABS (phenytoin) PEGANONE (ethotoin) phenytoin	CEREBYX (fosphenytoin) DILANTIN (phenytoin) PHENYTEK (phenytoin)	
	SUCCINIMIDES		
	CELONTIN (methsuximide) ethosuximide syrup ZARONTIN (ethosuximide) capsules	ethosuximide capsules ZARONTIN (ethosuximide) syrup	
ANTIDEPRESSANTS, OTHER			
	MAOIs^{AP}		
	PARNATE (tranylcypromine) phenelzine	MARPLAN (isocarboxazid) NARDIL (phenelzine) tranylcypromine	
	SNRIS^{AP}		
	CYMBALTA (duloxetine) venlafaxine ER capsules	EFFEXOR (venlafaxine) EFFEXOR XR (venlafaxine) PRISTIQ (desvenlafaxine) venlafaxine VENLAFAXINE ER Tablets (venlafaxine)	A six (6) week trial each of a preferred agent and an SSRI is required before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present.
	SECOND GENERATION NON-SSRI, OTHER^{AP}		
	bupropion IR bupropion SR bupropion XL	APLENZIN (bupropion hbr) DESYREL (trazodone) EMSAM (selegiline)	* Savella will be approved for a diagnosis of fibromyalgia or a previous thirty (30) day trial of a



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

This is not an all-inclusive list of available covered drugs and includes only managed categories. Refer to cover page for complete list of rules governing this PDL.

**EFFECTIVE
01/01/13
Version 2013.1b**

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	mirtazapine SAVELLA (milnacipran) ^{AP*} trazodone	nefazodone OLEPTRO ER (trazodone) REMERON (mirtazapine) WELLBUTRIN (bupropion) WELLBUTRIN SR (bupropion) WELLBUTRIN XL (bupropion) VIIBRYD (vilazodone hcl)	drug that infers fibromyalgia: gabapentin, Cymbalta, Lyrica, amitriptyline or nortriptyline.
SELECTED TCAs			
	imipramine hcl	imipramine pamoate TOFRANIL (imipramine hcl) TOFRANIL PM (imipramine pamoate)	A twelve (12) week trial of imipramine hcl is required before a non-preferred TCA will be authorized.
ANTIDEPRESSANTS, SSRIs^{AP}			
	citalopram escitalopram tablet fluoxetine fluvoxamine paroxetine sertraline	CELEXA (citalopram) escitalopram solution LEXAPRO (escitalopram) LUVOX (fluvoxamine) LUVOX CR (fluvoxamine) PAXIL (paroxetine) PAXIL CR (paroxetine) paroxetine ER PEXEVA (paroxetine) PROZAC (fluoxetine) RAPIFLUX (fluoxetine) SARAFEM (fluoxetine) ZOLOFT (sertraline)	Thirty (30) day trials each of two (2) of the preferred agents are required before a non-preferred agent will be approved unless one of the exceptions on the PA form is present. Upon hospital discharge, patients admitted with a primary mental health diagnosis and have been stabilized on a non-preferred SSRI will receive an authorization to continue that drug.
ANTIEMETICS^{AP}			
5HT3 RECEPTOR BLOCKERS			
	ondansetron tablets and vial ondansetron ODT	ANZEMET (dolasetron) KYTRIL (granisetron) granisetron GRANISOL (granisetron) ondansetron solution SANCUSO (granisetron) ZOFTRAN (ondansetron) ZOFTRAN ODT (ondansetron) ZUPLLENZ (ondansetron)	A 3-day trial of a preferred agent is required before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present. PA is required for ondansetron when limits are exceeded.



BUREAU FOR MEDICAL SERVICES
WEST VIRGINIA MEDICAID

PREFERRED DRUG LIST WITH PRIOR AUTHORIZATION CRITERIA

This is not an all-inclusive list of available covered drugs and includes only managed categories. Refer to cover page for complete list of rules governing this PDL.

EFFECTIVE
01/01/13
Version 2013.1b

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
CANNABINOIDS			
		CESAMET (nabilone) dronabinol MARINOL (dronabinol)	<p>Cesamet will be authorized only for the treatment of nausea and vomiting associated with cancer chemotherapy for patients who have failed to respond adequately to 3-day trials of conventional treatments such as promethazine or ondansetron and are over 18 years of age.</p> <p>Marinol will be authorized only for the treatment of anorexia associated with weight loss in patients with AIDS or cancer and unresponsive to megestrol; or for the prophylaxis of chemotherapy induced nausea and vomiting unresponsive to 3-day trials of ondansetron or promethazine for patients between the ages of 18 and 65.</p>
SUBSTANCE P ANTAGONISTS			
	EMEND (aprepitant)		
ANTIFUNGALS (Oral)			
	clotrimazole fluconazole* ketoconazole cream, shampoo ^{CL} nystatin terbinafine ^{CL}	ANCOBON (flucytosine) DIFLUCAN (fluconazole) flucytosine GRIFULVIN V TABLET (griseofulvin) griseofulvin GRIS-PEG (griseofulvin) itraconazole ketoconazole foam LAMISIL (terbinafine) MYCELEX (clotrimazole) MYCOSTATIN Tablets (nystatin) NIZORAL (ketoconazole) NOXAFIL (posaconazole) ORAVIG BUCCAL (miconazole) SPORANOX (itraconazole)	<p>Non-preferred agents will be approved only if one of the exceptions on the PA form is present.</p> <p>*PA is required when limits are exceeded.</p> <p>PA is not required for griseofulvin suspension for children up to 6 years of age for the treatment of tinea capitis.</p>



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

This is not an all-inclusive list of available covered drugs and includes only managed categories. Refer to cover page for complete list of rules governing this PDL.

**EFFECTIVE
01/01/13
Version 2013.1b**

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		VFEND (voriconazole) voriconazole	
ANTIFUNGALS (Topical)^{AP}			
ANTIFUNGALS			
	econazole ketoconazole MENTAX (butenafine) nystatin	CICLODAN (ciclopirox) ^{NR} ciclopirox ERTACZO (sertaconazole) EXELDERM (sulconazole) KETODAN (ketoconazole) ^{NR} LOPROX (ciclopirox) MYCOSTATIN (nystatin) NAFTIN (naftifine) NIZORAL (ketoconazole) OXISTAT (oxiconazole) PEDIPIROX-4 (ciclopirox) ^{NR} PENLAC (ciclopirox) SPECTAZOLE (econazole) VUSION (miconazole/petrolatum/zinc oxide) XOLEGEL (ketoconazole)	Fourteen (14) day trials of two (2) of the preferred agents are required before one of the non-preferred agents will be authorized unless one of the exceptions on the PA form is present. If a non-preferred shampoo is requested, a fourteen (14) day trial of one preferred product (ketoconazole shampoo) is required. Oxistat cream will be approved for children 12 and under for tinea corporis, tinea cruris, tinea pedis, and tinea (pityriasis) versicolor.
ANTIFUNGAL/STEROID COMBINATIONS			
	clotrimazole/betamethasone nystatin/triamcinolone	KETOCON PLUS (ketoconazole/hydrocortisone) LOTRISONE (clotrimazole/betamethasone) ^{AP} MYCOLOG (nystatin/triamcinolone) ^{AP}	
ANTI-HISTAMINES, MINIMALLY SEDATING^{AP}			
ANTI-HISTAMINES			
	ALAVERT (loratadine) cetirizine tablets, solution loratadine TAVIST-ND (loratadine)	ALLEGRA (fexofenadine) cetirizine chewable tablets CLARINEX Tablets (desloratadine) CLARINEX REDITABS (desloratadine) CLARINEX Syrup (desloratadine) CLARITIN (loratadine) desloratadine fexofenadine (Rx and OTC) levocetirizine XYZAL (levocetirizine) ZYRTEC (Rx and OTC) (cetirizine)	Thirty (30) day trials of at least two (2) chemically distinct preferred agents (in the age appropriate form), including the generic formulation of a requested non-preferred product, are required before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present.



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

This is not an all-inclusive list of available covered drugs and includes only managed categories. Refer to cover page for complete list of rules governing this PDL.

**EFFECTIVE
01/01/13
Version 2013.1b**

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		ZYRTEC SYRUP (cetirizine)	
ANTIHISTAMINE/DECONGESTANT COMBINATIONS			
	ALAVERT-D (loratadine/pseudoephedrine) cetirizine/pseudoephedrine loratadine/pseudoephedrine SEMPREX-D (acrivastine/ pseudoephedrine)	ALLEGRA-D (fexofenadine/ pseudoephedrine) CLARINEX-D (desloratadine/ pseudoephedrine) CLARITIN-D (loratadine/pseudoephedrine) fexofenadine/ pseudoephedrine (Rx and OTC) ZYRTEC-D (cetirizine/pseudoephedrine)	
ANTIMIGRAINE AGENTS, TRIPTANS^{AP}			
TRIPTANS			
	IMITREX NASAL SPRAY(sumatriptan) IMITREX INJECTION (sumatriptan) ^{CL} naratriptan sumatriptan	AMERGE (naratriptan) AXERT (almotriptan) FROVA (frovatriptan) IMITREX tablets (sumatriptan) MAXALT (rizatriptan) MAXALT MLT (rizatriptan) RELPAK (eletriptan) sumatriptan nasal spray/injection* ZOMIG (zolmitriptan)	Three (3) day trials of each unique chemical entity of the preferred agents are required before a non-preferred agent will be approved unless one of the exceptions on the PA form is present. Quantity limits apply for this drug class. *AP does not apply to nasal spray or injectable sumatriptan.
TRIPTAN COMBINATIONS			
		TREXIMET (sumatriptan/naproxen sodium)	
ANTIPARKINSON'S AGENTS (Oral)			
ANTICHOLINERGICS			
	benztropine trihexyphenidyl	COGENTIN (benztropine)	Patients starting therapy on drugs in this class must show a documented allergy to all of the preferred agents, in the corresponding class, before a non-preferred agent will be authorized.



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

This is not an all-inclusive list of available covered drugs and includes only managed categories. Refer to cover page for complete list of rules governing this PDL.

**EFFECTIVE
01/01/13
Version 2013.1b**

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
COMT INHIBITORS			
		COMTAN (entacapone) TASMAR (tolcapone)	
DOPAMINE AGONISTS			
	pramipexole ropinirole	MIRAPEX (pramipexole) MIRAPEX ER (pramipexole) NEUPRO (rotigotine) ^{NR} REQUIP (ropinirole) REQUIP XL (ropinirole) ropinirole XL	Mirapex, Mirapex ER, Requip, and Requip XL will be approved for a diagnosis of Parkinsonism with no trials of preferred agents required.
OTHER ANTIPARKINSON'S AGENTS			
	amantadine ^{AP} bromocriptine carbidopa/levodopa selegiline STALEVO (levodopa/carbidopa/entacapone)	AZILECT (rasagiline) ELDEPRYL (selegiline) levodopa/carbidopa ODT levodopa/carbidopa/entacapone LODOSYN (carbidopa) PARCOPA (levodopa/carbidopa) SINEMET (levodopa/carbidopa) ZELAPAR (selegiline)	Amantadine will be approved only for a diagnosis of Parkinsonism.
ANTIPSYCHOTICS, ATYPICAL			
SINGLE INGREDIENT			
	clozapine FANAPT (iloperidone) INVEGA SUSTENNA (paliperidone)* LATUDA (lurasidone) quetiapine ^{AP} (25mg Tablet Only) risperidone risperidone ODT risperidone solution SAPHRIS (asenapine) ziprasidone	ABILIFY (aripiprazole) ABILIFY (aripiprazole) IM clozapine ODT CLOZARIL (clozapine) FAZACLO (clozapine) GEODON (ziprasidone) GEODON IM (ziprasidone) INVEGA (paliperidone) olanzapine olanzapine IM* RISPERDAL (risperidone) RISPERDAL CONSTA (risperidone)* RISPERDAL ODT (risperidone) RISPERDAL SOLUTION (risperidone) SEROQUEL (quetiapine) 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



BUREAU FOR MEDICAL SERVICES
WEST VIRGINIA MEDICAID

PREFERRED DRUG LIST WITH PRIOR AUTHORIZATION CRITERIA

This is not an all-inclusive list of available covered drugs and includes only managed categories. Refer to cover page for complete list of rules governing this PDL.

EFFECTIVE
01/01/13
Version 2013.1b

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

DRAFT



**BUREAU FOR MEDICAL SERVICES
WEST VIRGINIA MEDICAID**

PREFERRED DRUG LIST WITH PRIOR AUTHORIZATION CRITERIA

This is not an all-inclusive list of available covered drugs and includes only managed categories. Refer to cover page for complete list of rules governing this PDL.

**EFFECTIVE
01/01/13
Version 2013.1b**

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ATYPICAL ANTIPSYCHOTIC/SSRI COMBINATIONS			
		olanzapine/fluoxetine SYMBYAX (olanzapine/fluoxetine)	
ANTIVIRALS (Oral)			
ANTI HERPES			
	acyclovir VALTREX (valacyclovir)	famciclovir FAMVIR (famciclovir) valacyclovir ZOVIRAX (acyclovir)	Five (5) day trials each of the preferred agents are required before the non-preferred agents will be authorized unless one of the exceptions on the PA form is present.
ANTI-INFLUENZA			
	RELENZA (zanamivir) TAMIFLU (oseltamivir)	FLUMADINE (rimantadine) rimantadine amantadine ^{AP}	The anti-influenza agents will be approved only for a diagnosis of influenza.
ANTIVIRALS (Topical)^{AP}			
	ABREVA (docosanol)	DENAVIR (penciclovir) ZOVIRAX (acyclovir)	Five day trials of each of the preferred agents are required before the non-preferred agent will be approved.
ATOPIC DERMATITIS			
	ELIDEL (pimecrolimus) ^{AP}	PROTOPIC (tacrolimus)	A thirty (30) day trial of a preferred medium or high potency topical corticosteroid is required before coverage of Elidel will be considered; additionally, a thirty (30) day trial of Elidel is required before Protopic will be considered, unless one of the exceptions on the PA form is present.
BETA BLOCKERS (Oral) & MISCELLANEOUS ANTIANGINALS (Oral)^{AP}			
BETA BLOCKERS			
	acebutolol atenolol betaxolol bisoprolol metoprolol metoprolol ER	BETAPACE (sotalol) BLOCADREN (timolol) BYSTOLIC (nebivolol) CARTROL (carteolol) CORGARD (nadolol) INDERAL LA (propranolol)	Fourteen (14) day trials each of three (3) chemically distinct preferred agents, including the generic formulation of a requested non-preferred product, are required before one of the non-preferred



**BUREAU FOR MEDICAL SERVICES
WEST VIRGINIA MEDICAID**

PREFERRED DRUG LIST WITH PRIOR AUTHORIZATION CRITERIA

This is not an all-inclusive list of available covered drugs and includes only managed categories. Refer to cover page for complete list of rules governing this PDL.

**EFFECTIVE
01/01/13
Version 2013.1b**

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	nadolol pindolol propranolol propranolol ER sotalol timolol	INNOPRAN XL (propranolol) KERLONE (betaxolol) LEVATOL (penbutolol) LOPRESSOR (metoprolol) SECTRAL (acebutolol) TENORMIN (atenolol) TOPROL XL (metoprolol) ZEBETA (bisoprolol)	agents will be approved unless one 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) INDERIDE (propranolol/HCTZ) LOPRESSOR HCT (metoprolol/HCTZ) TENORETIC (atenolol/chlorthalidone) ZIAC (bisoprolol/HCTZ)	
BETA- AND ALPHA-BLOCKERS			
	carvedilol labetalol	COREG (carvedilol) COREG CR (carvedilol) TRANDATE (labetalol)	
ANTIANGINALS			
		RANEXA (ranolazine) ^{AP}	Ranexa will be approved for patients with angina who are also taking a calcium channel blocker, a beta blocker, or a nitrite as single agents or a combination agent containing one of these ingredients.
BLADDER RELAXANT PREPARATIONS^{AP}			
	oxybutynin oxybutynin ER TOVIAZ (fesoterodine) VESICARE (solifenacin)	ENABLEX (darifenacin) DETROL (tolterodine) DETROL LA (tolterodine) DITROPAN (oxybutynin) DITROPAN XL (oxybutynin) flavoxate GELNIQUE (oxybutynin) OXYTROL (oxybutynin) SANCTURA (trospium) SANCTURA XR (trospium) tolterodine trospium	A thirty (30) day trial each of the chemically distinct preferred agents is required before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present.



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

This is not an all-inclusive list of available covered drugs and includes only managed categories. Refer to cover page for complete list of rules governing this PDL.

**EFFECTIVE
01/01/13
Version 2013.1b**

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



**BUREAU FOR MEDICAL SERVICES
WEST VIRGINIA MEDICAID**

PREFERRED DRUG LIST WITH PRIOR AUTHORIZATION CRITERIA

This is not an all-inclusive list of available covered drugs and includes only managed categories. Refer to cover page for complete list of rules governing this PDL.

**EFFECTIVE
01/01/13
Version 2013.1b**

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
5-ALPHA-REDUCTASE (5AR) INHIBITORS/ALPHA BLOCKER COMBINATION			
		JALYN (dutasteride/tamsulosin)	Thirty (30) day trials of dutasteride and tamsulosin concurrently are required before the non-preferred agent will be approved.
BRONCHODILATORS & RESPIRATORY DRUGS			
ANTICHOLINERGIC^{AP}			
	ATROVENT HFA (ipratropium) ipratropium SPIRIVA (tiotropium)		Thirty (30) day trials each of the preferred agents in the corresponding group are required before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present.
ANTICHOLINERGIC-BETA AGONIST COMBINATIONS^{AP}			
	COMBIVENT (albuterol/ipratropium)	albuterol/ipratropium COMBIVENT RESPIMAT (albuterol/ipratropium) ^{NR} DUONEB (albuterol/ipratropium)	For severely compromised patients, albuterol/ipratropium will be approved if the combined volume of albuterol and ipratropium nebulas is inhibitory.
PDE4 INHIBITOR			
		DALIRESP (roflumilast)	Daliresp will be approved when the following criteria are met: 1. Patient is ≥ forty (40) years of age and 2. Diagnosis of severe chronic obstructive pulmonary disease (COPD) associated with chronic bronchitis and multiple exacerbations requiring systemic glucocorticoids in the preceding six (6) months and 3. Concurrent therapy with an inhaled corticosteroid and long-acting bronchodilator and evidence of compliance and 4. No evidence of moderate to severe liver impairment (Child-Pugh Class B or C) and 5. No concurrent use with strong



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

This is not an all-inclusive list of available covered drugs and includes only managed categories. Refer to cover page for complete list of rules governing this PDL.

**EFFECTIVE
01/01/13
Version 2013.1b**

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			cytochrome P450 inhibitors (rimampicin, phenobarbital, carbamazepine or phenytoin).
	INHALATION SOLUTION^{AP}		
	albuterol 2.5mg/0.5mL	ACCUNEB (albuterol)** albuterol 0.63mg & 1.25mg/3mL ^{AP} BROVANA (arformoterol) levalbuterol metaproterenol PERFOROMIST (formoterol) XOPENEX (levalbuterol)	Thirty (30) day trials each of the chemically distinct preferred agents in their corresponding groups are required before a non-preferred agent in that group will be authorized unless one of the exceptions on the PA form is present. **No PA is required for ACCUNEB for children up to 5 years of age.
	INHALERS, LONG-ACTING^{AP}		
	FORADIL (formoterol) SEREVENT (salmeterol)	ARCAPTA (indacaterol maleate)	Thirty (30) day trials each of the preferred agents are required before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present.
	INHALERS, SHORT-ACTING^{AP}		
	PROAIR HFA (albuterol) PROVENTIL HFA (albuterol)	MAXAIR (pirbuterol) XOPENEX HFA (levalbuterol) VENTOLIN HFA (albuterol)	Xopenex Inhalation Solution will be approved for 12 months for a diagnosis of asthma or COPD for patients on concurrent asthma controller therapy (either oral or inhaled) with documentation of failure on a trial of albuterol or documented intolerance of albuterol, or for concurrent diagnosis of heart disease.
	ORAL^{AP}		
	albuterol terbutaline	metaproterenol VOSPIRE ER (albuterol)	



BUREAU FOR MEDICAL SERVICES
WEST VIRGINIA MEDICAID

PREFERRED DRUG LIST WITH PRIOR AUTHORIZATION CRITERIA

This is not an all-inclusive list of available covered drugs and includes only managed categories. Refer to cover page for complete list of rules governing this PDL.

EFFECTIVE
01/01/13
Version 2013.1b

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
CALCIUM CHANNEL BLOCKERS^{AP}			
LONG-ACTING			
	amlodipine diltiazem XR, XT felodipine ER nifedipine ER verapamil ER	ADALAT CC (nifedipine) CALAN SR (verapamil) CARDENE SR (nicardipine) CARDIZEM CD, LA, SR (diltiazem) COVERA-HS (verapamil) DILACOR XR (diltiazem) diltiazem LA DYNACIRC CR (isradipine) ISOPTIN SR (verapamil) MATZIM LA (diltiazem) nisoldipine NORVASC (amlodipine) PLENDIL (felodipine) PROCARDIA XL (nifedipine) SULAR (nisoldipine) TIAZAC (diltiazem) verapamil ER PM VERELAN/VERELAN PM (verapamil)	Fourteen (14) day trials each of the preferred agents are required before a non-preferred agent will be approved unless one of the exceptions on the PA form is present.
SHORT-ACTING			
	diltiazem verapamil	CALAN (verapamil) CARDENE (nicardipine) CARDIZEM (diltiazem) DYNACIRC (isradipine) isradipine nicardipine nimodipine nifedipine NIMOTOP (nimodipine) PROCARDIA (nifedipine)	
CEPHALOSPORINS AND RELATED ANTIBIOTICS (Oral)^{AP}			
BETA LACTAMS AND BETA LACTAM/BETA-LACTAMASE INHIBITOR COMBINATIONS			
	amoxicillin/clavulanate	amoxicillin/clavulanate ER AUGMENTIN (amoxicillin/clavulanate) AUGMENTIN XR (amoxicillin/clavulanate) MOXATAG (amoxicillin)	A five (5) day trial of the preferred agent is required before a non-preferred agent is authorized unless one of the exceptions on the PA form is present.



BUREAU FOR MEDICAL SERVICES
WEST VIRGINIA MEDICAID

PREFERRED DRUG LIST WITH PRIOR AUTHORIZATION CRITERIA

This is not an all-inclusive list of available covered drugs and includes only managed categories. Refer to cover page for complete list of rules governing this PDL.

EFFECTIVE
01/01/13
Version 2013.1b

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
CEPHALOSPORINS			
	cefaclor cefadroxil capsule cefdinir cefprozil cefuroxime cephalexin capsule	CECLOR (cefaclor) CEDAX (ceftibuten) cefaclor ER cefadroxil suspension cefditoren cefpodoxime CEFTIN (cefuroxime) CEFZIL (cefprozil) cephalixin tablet DURICEF (cefadroxil) KEFLEX (cephalexin) OMNICEF (cefdinir) PANIXINE (cephalexin) RANICLOR (cefaclor) SPECTRACEF (cefditoren) SUPRAX (cefixime) VANTIN (cefpodoxime)	
COLONY STIMULATING FACTORS			
	LEUKINE (sargramostim) NEUPOGEN (filgrastim)	NEULASTA (filgrastim)	A thirty (30) day trial of one of the preferred agents is required before the non-preferred agent will be authorized unless one of the exceptions on the PA form is present.
COUGH & COLD/1st GENERATION ANTIHISTAMINES			
ANTIHISTAMINES, 1ST GENERATION			
	chlorpheniramine clemastine diphenhydramine		See posted list of covered NDCs.
ANTITUSSIVE-ANTIHISTAMINE COMBINATIONS			
	dextromethorphan HBR/promethazine		See posted list of covered NDCs.
ANTIHISTAMINE-ANTITUSSIVE-DECONGESTANT COMBINATIONS			
	brompheniramine/dextromethorphan HBR/pseudoephedrine chlorpheniramine/dextromethorphan/		See posted list of covered NDCs.



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

This is not an all-inclusive list of available covered drugs and includes only managed categories. Refer to cover page for complete list of rules governing this PDL.

**EFFECTIVE
01/01/13
Version 2013.1b**

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	pseudoephedrine		
	ANTITUSSIVE-NON-NARCOTIC		
		DELSYM (dextromethorphan polistirex)	See posted list of covered NDCs.
	DECONGESTANTS		
	phenylephrine pseudoephedrine		See posted list of covered NDCs.
	ANTITUSSIVES/EXPECTORANTS		
	guaifenesin guaifenesin/dextromethorphan		See posted list of covered NDCs.
	DECONGESTANT-ANTIHISTAMINE-ANTICHOLINERGIC COMBINATIONS		
	pseudoephedrine/chlorpheniramine/ scopolamine syrup		See posted list of covered NDCs.
	DECONGESTANT-ANTIHISTAMINE COMBINATIONS		
	phenylephrine HCL/chlorpheniramine maleate syrup/drops phenylephrine HCL/promethazine syrup		See posted list of covered NDCs.
CYTOKINE & CAM ANTAGONISTS^{CL}			
	ENBREL (etanercept) HUMIRA (adalimumab)	CIMZIA (certolizumab/pegol) KINERET (anakinra) ORENCIA (abatacept) SUBCUTANEOUS SIMPONI (golimumab)	Thirty (30) day trials of each of the preferred agents are required before a non-preferred agent will be approved. See additional criteria for treatment of psoriasis or psoriatic arthritis at http://www.dhr.wv.gov/bms/Pharmacy/Pages/pac.aspx
ERYTHROPOIESIS STIMULATING PROTEINS^{CL}			
	PROCRIT (rHuEPO)	ARANESP (darbepoetin) EPOGEN (rHuEPO)	A thirty (30) day trial of the preferred agent is required before a non-preferred agent will be approved. No evidence of untreated GI



BUREAU FOR MEDICAL SERVICES
WEST VIRGINIA MEDICAID

PREFERRED DRUG LIST WITH PRIOR AUTHORIZATION CRITERIA

This is not an all-inclusive list of available covered drugs and includes only managed categories. Refer to cover page for complete list of rules governing this PDL.

EFFECTIVE
01/01/13
Version 2013.1b

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			<p>bleeding, hemolysis, or Vitamin B-12, iron or folate deficiency.</p> <p>Prior authorization will be given for the erythropoiesis agents if the following criteria are met:</p> <ol style="list-style-type: none"> 1. Hemoglobin or Hematocrit less than 10/30 respectively. For renewal, hemoglobin or hematocrit levels greater than 12/36 will require dosage reduction or discontinuation. Exceptions will be considered on an individual basis after medical documentation is reviewed. (Laboratory values must be dated within six (6) weeks of request.) 2. Transferrin saturation \geq 20%, ferritin levels \geq100 mg/ml, or on concurrent therapeutic iron therapy. (Laboratory values must be dated within three (3) weeks of request. For re-authorization, transferrin saturation or ferritin levels are not required if the patient has been responsive to the erythropoietin agent. 3. For HIV-infected patients, endogenous serum erythropoietin level must be \leq 500mU/ml to initiate therapy. 4. No evidence of untreated GI bleeding, hemolysis, or Vitamin B-12, iron or folate deficiency.
FLUOROQUINOLONES (Oral)^{AP}			
	<p>CIPRO (ciprofloxacin) Suspension ciprofloxacin levofloxacin tablet</p>	<p>AVELOX (moxifloxacin) CIPRO (ciprofloxacin) Tablets CIPRO XR (ciprofloxacin) ciprofloxacin ER</p>	<p>A five (5) day trial of one of the preferred agents is required before a non-preferred agent will be approved unless one of the</p>



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

This is not an all-inclusive list of available covered drugs and includes only managed categories. Refer to cover page for complete list of rules governing this PDL.

**EFFECTIVE
01/01/13
Version 2013.1b**

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		FACTIVE (gemifloxacin) FLOXIN (ofloxacin) LEVAQUIN (levofloxacin) levofloxacin solution NOROXIN (norfloxacin) ofloxacin PROQUIN XR (ciprofloxacin)	exceptions on the PA form is present.
GENITAL WARTS AGENTS			
	ALDARA (imiquimod)	CONDYLOX (podofilox) imiquimod podofilox VEREGEN (sinecatechins) ZYCLARA (imiquimod)	A thirty (30) day trial of the preferred agent is required before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present. Zyclara will be approved for a diagnosis of actinic keratosis.
GLUCOCORTICOIDS (Inhaled)^{AP}			
GLUCOCORTICOIDS			
	ASMANEX (mometasone) FLOVENT HFA (fluticasone) FLOVENT Diskus (fluticasone) QVAR (beclomethasone) PULMICORT FLEXHALER (budesonide)	ALVESCO (ciclesonide) budesonide PULMICORT RESPULES (budesonide)*	Thirty (30) day trials each of the preferred agents are required before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present. Pulmicort Respules do not require a prior authorization for children through 8 years of age or for individuals unable to use an MDI. When children who have been stabilized on Pulmicort Respules reach age 9, prescriptions for the Pulmicort inhaler will be authorized for them. *For children less than 9 years of age, and for those who meet the PA requirements, brand Pulmicort is preferred over the generic.



BUREAU FOR MEDICAL SERVICES
WEST VIRGINIA MEDICAID

PREFERRED DRUG LIST WITH PRIOR AUTHORIZATION CRITERIA

This is not an all-inclusive list of available covered drugs and includes only managed categories. Refer to cover page for complete list of rules governing this PDL.

EFFECTIVE
01/01/13
Version 2013.1b

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
GLUCOCORTICOID/BRONCHODILATOR COMBINATIONS			
	ADVAIR (fluticasone/salmeterol) ADVAIR HFA (fluticasone/salmeterol) DULERA (mometasone/formoterol) SYMBICORT(budesonide/formoterol)		
GLUCOCORTICOIDS (Topical)			
VERY HIGH & HIGH POTENCY			
	betamethasone dipropionate cream betamethasone valerate ointment clobetasol propionate cream/gel/ointment/solution clobetasol propionate/emollient fluocinonide fluocinonide/emollient halobetasol propionate triamcinolone acetonide 0.5%	amcinonide APEXICON (diflorasone diacetate) APEXICON E (diflorasone diacetate) betamethasone dipropionate gel betamethasone dipropionate ointment betamethasone dipropionate/propylene glycol clobetasol propionate foam, lotion, shampoo CLOBEX (clobetasol propionate) CORMAX (clobetasol propionate) desoximetasone cream/gel/ointment diflorasone diacetate diflorasone diacetate/emollient DIPROLENE (betamethasone dipropionate/propylene glycol) DIPROLENE AF (betamethasone dipropionate/propylene glycol) DIPROSONE (betamethasone dipropionate) halcinonide HALAC (halobetasol propionate) HALOG (halcinonide) HALONATE (halobetasol propionate) KENALOG 0.5% (triamcinolone acetonide) LIDEX (fluocinonide) LIDEX-E (fluocinonide) LUXIQ (betamethasone valerate) OLUX (clobetasol propionate) OLUX-E (clobetasol propionate/emollient) PSORCON (diflorasone diacetate) TEMOVATE (clobetasol propionate) TEMOVATE-E (clobetasol propionate/emollient) TOPICORT (desoximetasone) ULTRAVATE (halobetasol propionate) ULTRAVATE PAC cream	Five (5) day trials of one (1) form of each preferred unique active ingredient in the corresponding potency group are required before a non-preferred agent will be approved.



BUREAU FOR MEDICAL SERVICES
WEST VIRGINIA MEDICAID

PREFERRED DRUG LIST WITH PRIOR AUTHORIZATION CRITERIA

This is not an all-inclusive list of available covered drugs and includes only managed categories. Refer to cover page for complete list of rules governing this PDL.

EFFECTIVE
01/01/13
Version 2013.1b

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		ULTRAVATE X (halobetasol propionate / lactic acid) ^{NR} VANOS (fluocinonide)	
MEDIUM POTENCY			
	betamethasone dipropionate lotion betamethasone valerate cream betamethasone valerate lotion desoximetasone 0.05% cream fluocinonide acetamide 0.025% fluticasone propionate hydrocortisone butyrate ointment, solution hydrocortisone valerate mometasone furoate triamcinolone acetamide 0.025% and 0.1% cream	ARISTOCORT (triamcinolone) BETA-VAL (betamethasone valerate) CLODERM (clocortolone pivalate) CORDRAN/CORDRAN SP (flurandrenolide) CUTIVATE (fluticasone propionate) DERMATOP (prednicarbate) ELOCON (mometasone furoate) hydrocortisone butyrate cream hydrocortisone butyrate/emollient KENALOG 0.1% (triamcinolone acetamide) LOCOID (hydrocortisone butyrate) LOCOID LIPOCREAM (hydrocortisone butyrate/emollient) prednicarbate TOPICORT LP (desoximetasone) triamcinolone acetamide 0.025% and 0.1% lotion TRIDERM (triamcinolone acetamide) WESTCORT (hydrocortisone valerate)	
LOW POTENCY			
	desonide cream, ointment hydrocortisone 0.5%, 1%, 2.5% hydrocortisone acetate 0.5%, 1% (Rx & OTC) hydrocortisone-aloe cream (OTC) hydrocortisone-aloe ointment (OTC) NEOSPORIN (OTC) (hydrocortisone) hydrocortisone 1% solution (OTC) hydrocortisone/mineral oil/petrolatum ointment	ACLOVATE (alclometasone dipropionate) alclometasone dipropionate AQUA GLYCOLIC HC (hydrocortisone) ^{NR} CAPEX (fluocinonide acetamide) DERMA-SMOOTH FS (fluocinonide acetamide) DESONATE (desonide) desonide lotion DESOWEN (desonide) fluocinonide acetamide hydrocortisone acetate/urea hydrocortisone lotion LOKARA (desonide) PANDEL (hydrocortisone probutate) pediaderm HC	



**BUREAU FOR MEDICAL SERVICES
WEST VIRGINIA MEDICAID**

PREFERRED DRUG LIST WITH PRIOR AUTHORIZATION CRITERIA

This is not an all-inclusive list of available covered drugs and includes only managed categories. Refer to cover page for complete list of rules governing this PDL.

**EFFECTIVE
01/01/13
Version 2013.1b**

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		pediaderm TA SYNALAR (fluocinolone) VERDESO (desonide)	
GROWTH HORMONE^{CL}			
	GENOTROPIN (somatropin) NORDITROPIN NORDIFLEX (somatropin) NORDITROPIN FLEXPPO (somatropin) NUTROPIN AQ NUSPIN (somatropin)	HUMATROPE (somatropin) INCRELEX (mecasermin) NUTROPIN (somatropin) NUTROPIN AQ (somatropin) OMNITROPE (somatropin) SAIZEN (somatropin) SEROSTIM (somatropin) TEV-TROPIN (somatropin) ZORBTIVE (somatropin)	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. Patients already on a non-preferred agent will receive authorization to continue therapy on that agent for the duration of the existing PA.
H. PYLORI COMBINATION TREATMENTS			
	Please use individual components: preferred PPI (Dexilant, omeprazole or pantoprazole) amoxicillin tetracycline metronidazole clarithromycin bismuth	HELIDAC (bismuth/metronidazole/tetracycline) OMECLAMOX-PAK (omeprazole/amoxicillin/clarithromycin) PREVPAC (lansoprazole/amoxicillin/clarithromycin) PYLERA (bismuth/metronidazole/tetracycline)	A trial of all the individual preferred components (with Dexilant, omeprazole or pantoprazole) at the recommended dosages, frequencies and duration is required before the brand name combination packages will be approved unless one of the exceptions on the PA form is present.
HEPATITIS B TREATMENTS			
	EPIVIR HBV (lamivudine) HEPSERA (adefovir) TYZEKA (telbivudine)	BARACLUDE (entecavir)	A thirty (30) day trial of one of the preferred agents is required before the non-preferred agent will be authorized unless one of the exceptions on the PA form is present.
HEPATITIS C TREATMENTS^{CL}			
	INCIVEK (telaprevir) ^{CL} PEGASYS (pegylated interferon) PEG-INTRON (pegylated interferon) ribavirin VICTRELIS (boceprevir) ^{CL}	COPEGUS (ribavirin) INFERGEN (consensus interferon) REBETOL (ribavirin) RIBAPAK DOSEPACK (ribavirin) RIBASPHERE (ribavirin)	Patients starting therapy in this class must try the preferred agent of a dosage form before a non-preferred agent of that dosage form will be authorized.



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

This is not an all-inclusive list of available covered drugs and includes only managed categories. Refer to cover page for complete list of rules governing this PDL.

EFFECTIVE 01/01/13 Version 2013.1b

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			See additional criteria for Incivek and Victrelis at http://www.dhhr.wv.gov/bms/Pharmacy/Pages/pac.aspx
HYPERURICEMIA AND GOUT AGENTS			
ANTIMITOTICS			
		COLCRYS (colchicine)*	A thirty (30) day trial of one of the preferred agents for the prevention of gouty arthritis attacks (colchicine/probenecid, probenecid, or allopurinol) is required before a non-preferred agent will be approved unless one of the exceptions on the PA form is present. *In the case of acute gouty attacks, a 10-day supply (20 tablets) of Colcrys will be approved per 90 days.
ANTIMITOTIC-URICOSURIC COMBINATION			
	colchicine/probenecid		
URICOSURIC			
	probenecid		
XANTHINE OXIDASE INHIBITORS			
	allopurinol	ULORIC (febuxostat) ZYLOPRIM (allopurinol)	
HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS			
INJECTABLE			
		BYDUREON (exenatide) BYETTA (exenatide) SYMLIN (pramlintide) VICTOZA (liraglutide)	Byetta, Bydureon and Victoza will be authorized for six-month intervals if each of the following criteria are met: 1. Diagnosis of Type 2 Diabetes



BUREAU FOR MEDICAL SERVICES
WEST VIRGINIA MEDICAID

PREFERRED DRUG LIST WITH PRIOR AUTHORIZATION CRITERIA

This is not an all-inclusive list of available covered drugs and includes only managed categories. Refer to cover page for complete list of rules governing this PDL.

EFFECTIVE
01/01/13
Version 2013.1b

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			<p>2. Previous history of a thirty (30) day trial of metformin 3. No history of pancreatitis 4. For concurrent therapy with insulin, treatment with a basal insulin is required. Approval will be given for six (6)-month intervals. For re-authorization, HgBA1C levels must be less than or equal (\leq) to seven (7). Current laboratory values must be submitted.</p> <p>Symlin will be approved with a history of bolus insulin utilization in the past 90 days with no gaps in insulin therapy greater than 30 days.</p>
ORAL^{AP}			
	<p>JANUMET (sitagliptin/metformin) JANUVIA (sitagliptin) JUVISYNC (sitagliptin/simvastatin) KOMBIGLYZE XR (saxagliptin/metformin) ONGLYZA (saxagliptin) TRADJENTA (linagliptin)</p>	<p>JANUMET XR (sitagliptin/metformin) JENTADUETO (linagliptin/metformin)</p>	<p>Januvia/Janumet/Juvisync, Onglyza/Kombiglyze XR and Tradjenta will be subject to the following edits:</p> <ol style="list-style-type: none"> 1. Previous history of a 30-day trial of metformin, sulfonylurea, or TZD. 2. Januvia / Janumet / Juvisync, Onglyza/Kombiglyze XR/Tradjenta will be approved for concurrent use with insulin for six (6) month intervals. For re-authorization, HgBA1C levels must be less than or equal (\leq) to 7. Current laboratory values must be submitted. <p>Jentajueto and Janumet XR will be approved after thirty (30) day trials of the preferred combination agents, Janumet and Kombiglyze XR.</p>



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

This is not an all-inclusive list of available covered drugs and includes only managed categories. Refer to cover page for complete list of rules governing this PDL.

**EFFECTIVE
01/01/13
Version 2013.1b**

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



**BUREAU FOR MEDICAL SERVICES
WEST VIRGINIA MEDICAID**

PREFERRED DRUG LIST WITH PRIOR AUTHORIZATION CRITERIA

This is not an all-inclusive list of available covered drugs and includes only managed categories. Refer to cover page for complete list of rules governing this PDL.

**EFFECTIVE
01/01/13
Version 2013.1b**

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
TZD COMBINATIONS			
		ACTOPLUS MET (pioglitazone/ metformin) ACTOPLUS MET XR (pioglitazone/ metformin) AVANDAMET (rosiglitazone/metformin) ^{AP} AVANDARYL (rosiglitazone/glimepiride) ^{AP} DUETACT (pioglitazone/glimepiride)	Patients are required to use the components of Actoplus Met and Duetact separately. Exceptions will be handled on a case-by-case basis.
IMMUNOSUPPRESSIVES			
	azathioprine cyclosporine, modified cyclosporine mycophenolate mofetil RAPAMUNE (sirolimus) tacrolimus	AZASAN (azathioprine) CELLCEPT (mycophenolate mofetil) MYFORTIC (mycophenolic acid) NEORAL (cyclosporine, modified) PROGRAF (tacrolimus) SANDIMMUNE (cyclosporine) ZORTRESS (everolimus)	A fourteen (14) 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 (non-preferred agents will be grandfathered for patients currently on these therapies).
IMPETIGO AGENTS (Topical)			
	bacitracin gentamicin sulfate mupirocin	ALTABAX (retapamulin) BACTROBAN (mupirocin) CENTANY (mupirocin) CORTISPORIN (bacitracin/neomycin/ polymyxin/HC)	Ten (10) day trials of at least one preferred agent, including the generic formulation of a requested non-preferred agent, are required before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present.
INTRANASAL RHINITIS AGENTS^{AP}			
ANTICHOLINERGICS			
	ipratropium	ATROVENT(ipratropium)	Thirty (30) day trials of the preferred nasal anti-cholinergic, an antihistamine, and corticosteroid groups are required before a non-preferred anti-cholinergic will be approved unless one of the exceptions on the PA form is present.



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

This is not an all-inclusive list of available covered drugs and includes only managed categories. Refer to cover page for complete list of rules governing this PDL.

**EFFECTIVE
01/01/13
Version 2013.1b**

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA	
ANTIHISTAMINES				
	ASTELIN (azelastine) PATANASE (olopatadine)	ASTEPRO (azelastine) azelastine	Thirty (30) day trials of both preferred intranasal antihistamines and a thirty (30) day trial of one of the preferred intranasal corticosteroids are required before the non-preferred agent will be approved unless one of the exceptions on the PA form is present.	
COMBINATIONS				
		DYMISTA (azelastine / fluticasone)		
CORTICOSTEROIDS				
	fluticasone propionate NASACORT AQ (triamcinolone) NASONEX (mometasone)	BECONASE AQ (beclomethasone) flunisolide FLONASE (fluticasone propionate) NASALIDE (flunisolide) NASAREL (flunisolide) 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 of the exceptions on the PA form is present.	
LEUKOTRIENE MODIFIERS				
	ACCOLATE (zafirlukast) montelukast	SINGULAIR (montelukast) zafirlukast ZYFLO (zileuton)	Thirty (30) day trials each of the preferred agents are required before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present.	
LIPOTROPICS, OTHER (Non-statins)^{AP}				
BILE ACID SEQUESTRANTS				
	cholestyramine colestipol tablets	COLESTID (colestipol) colestipol granules QUESTRAN (cholestyramine) WELCHOL (colesevelam)	A twelve (12) week trial of one of the preferred agents is required before a non-preferred agent in the corresponding category will be authorized. Welchol will be approved for add-on	



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

This is not an all-inclusive list of available covered drugs and includes only managed categories. Refer to cover page for complete list of rules governing this PDL.

**EFFECTIVE
01/01/13
Version 2013.1b**

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			therapy for type 2 diabetes when there is a previous history of a 30-day trial of an oral agent (sulfonylurea, thiazolidinedione (TZD) or metformin). See HYPOGLYCEMICS, MISCELLANEOUS.
	CHOLESTEROL ABSORPTION INHIBITORS		
	ZETIA (ezetimibe)		Zetia, as monotherapy, will only be approved for patients who cannot take statins or other preferred agents. AP does not apply. Zetia will be approved for add-on therapy only after an insufficient response to the maximum tolerable dose of a statin after 12 weeks of therapy. AP does not apply.
		FATTY ACIDS	
		LOVAZA (omega-3-acid ethyl esters) ^{AP}	Lovaza will be approved when the patient is intolerant or not responsive to, or not a candidate for nicotinic acid or fibrate therapy.
	FIBRIC ACID DERIVATIVES		
	fenofibrate 54mg & 160mg fenofibrate micronized 67mg, 134mg & 200mg gemfibrozil TRICOR (fenofibrate nanocrystallized) TRILIPIX (fenofibric acid)	ANTARA (fenofibrate) FENOGLIDE (fenofibrate) FIBRICOR (fenofibric acid) fenofibrate nanocrystallized 145mg LIPOFEN (fenofibrate) LOFIBRA (fenofibrate) LOPID (gemfibrozil) TRIGLIDE (fenofibrate)	
	NIACIN		
	niacin NIACOR (niacin) NIASPAN (niacin) SLO-NIACIN (niacin)	NIACELS (niacin) NIADELAY (niacin)	



BUREAU FOR MEDICAL SERVICES
WEST VIRGINIA MEDICAID

PREFERRED DRUG LIST WITH PRIOR AUTHORIZATION CRITERIA

This is not an all-inclusive list of available covered drugs and includes only managed categories. Refer to cover page for complete list of rules governing this PDL.

EFFECTIVE
01/01/13
Version 2013.1b

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
LIPOTROPICS, STATINS^{AP}			
STATINS			
	atorvastatin LESCOL (fluvastatin) LESCOL XL (fluvastatin) lovastatin pravastatin simvastatin ^{CL*}	ALTOPREV (lovastatin) CRESTOR (rosuvastatin) fluvastatin LIPITOR (atorvastatin) LIVALO (pitavastatin) MEVACOR (lovastatin) PRAVACHOL (pravastatin) ZOCOR (simvastatin)*	<p>Twelve (12) week trials each of two (2) of the preferred statins, including the generic formulation of a requested non-preferred agent, are required before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present.</p> <p>*Zocor/simvastatin 80mg tablets will require a clinical PA</p>
STATIN COMBINATIONS			
	ADVICOR (lovastatin/niacin) amlodipine / atorvastatin SIMCOR (simvastatin/niacin ER)	CADUET (atorvastatin/amlodipine), VYTORIN (simvastatin/ ezetimibe)	<p>Vytorin will be approved only after an insufficient response to the maximum tolerable dose of Lipitor (atorvastatin) or Crestor (rosuvastatin) after 12 weeks, unless one of the exceptions on the PA form is present.</p> <p>*Vytorin 80/10mg tablets will require a clinical PA</p>
MACROLIDES/KETOLIDES (Oral)			
KETOLIDES			
		KETEK (telithromycin)	<p>Requests for telithromycin will be authorized if there is documentation of the use of any antibiotic within the past 28 days.</p>
MACROLIDES			
	azithromycin clarithromycin erythromycin	BIAXIN (clarithromycin) BIAXIN XL (clarithromycin) clarithromycin ER E.E.S. (erythromycin ethylsuccinate) E-MYCIN (erythromycin) ERYC (erythromycin) ERYPED (erythromycin ethylsuccinate)	<p>Five (5) day trials each of the preferred agents are required before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present.</p>



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

This is not an all-inclusive list of available covered drugs and includes only managed categories. Refer to cover page for complete list of rules governing this PDL.

**EFFECTIVE
01/01/13
Version 2013.1b**

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		ERY-TAB (erythromycin) ERYTHROCIN (erythromycin stearate) erythromycin estolate PCE (erythromycin) ZITHROMAX (azithromycin) ZMAX (azithromycin)	
MULTIPLE SCLEROSIS AGENTS^{CL, AP}			
INTERFERONS			
	AVONEX (interferon beta-1a) AVONEX PEN (interferon beta-1a) BETASERON (interferon beta-1b) REBIF (interferon beta-1a)	EXTAVIA (interferon beta-1b)	A 30-day trial of a preferred agent will be required before a non-preferred agent will be approved.
NON-INTERFERONS			
	COPAXONE (glatiramer)	AMPYRA (dalfampridine)* GILENYA (fingolimod)**	A 30-day trial of the preferred agent will be required before a non-preferred agent will be approved. *Amypra will be prior authorized if the following conditions are met: 1. Diagnosis of multiple sclerosis 2. No history of seizures 3. No evidence of moderate or severe renal impairment 4. Initial prescription will be approved for 30 days only. ** Gilenya: PA Criteria 1) A diagnosis of a relapsing form of multiple sclerosis AND 2) Medication is prescribed by a neurologist AND 3) History of a thirty (30) trial of one of the preferred agents for multiple sclerosis unless <i>one of</i> the exceptions on the PA form is present AND 4) Dosage is limited to one tablet per day. (AP does not apply.)



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

This is not an all-inclusive list of available covered drugs and includes only managed categories. Refer to cover page for complete list of rules governing this PDL.

**EFFECTIVE
01/01/13
Version 2013.1b**

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
MUSCLE RELAXANTS (Oral)^{AP}			
ACUTE MUSCULOSKELETAL RELAXANT AGENTS			
	chlorzoxazone cyclobenzaprine methocarbamol	AMRIX (cyclobenzaprine) carisoprodol carisoprodol/ASA carisoprodol/ASA/codeine cyclobenzaprine ER FEXMID (cyclobenzaprine) FLEXERIL (cyclobenzaprine) LORZONE (chlorzoxazone) metaxalone methocarbamol/ASA orphenadrine orphenadrine/ASA/caffeine PARAFON FORTE DSC (chlorzoxazone) ROBAXIN (methocarbamol) SKELAXIN (metaxalone) SOMA (carisoprodol) SOMA COMPOUND (carisoprodol /ASA) SOMA COMP w/ COD (carisoprodol/ASA/ codeine)	<p>Thirty (30) day trials of the preferred acute musculoskeletal relaxants are required before a non-preferred acute musculoskeletal agent will be approved, with the exception of carisoprodol.</p> <p>Thirty (30) day trials of the preferred acute musculoskeletal relaxants and Skelaxin are required before carisoprodol will be approved.</p>
MUSCULOSKELETAL RELAXANT AGENTS USED FOR SPASTICITY			
	baclofen tizanidine tablets	DANTRIUM (dantrolene) dantrolene tizanidine capsules ZANAFLEX (tizanidine)	<p>Thirty (30) day trials of the preferred skeletal muscle relaxants associated with the treatment of spasticity (are required before non-preferred agents will be approved unless one of the exceptions on the PA form is present.</p>
NEUROPATHIC PAIN			
	capsaicin OTC CYMBALTA (duloxetine) gabapentin capsule, solution SAVELLA (milnacipran)	gabapentin tablet GRALISE (gabapentin) HORIZANT (gabapentin) LIDODERM (lidocaine)	<p>Lyrica will be approved for:</p> <p>Diagnosis of seizure disorders or neuropathic pain associated with a</p>



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

This is not an all-inclusive list of available covered drugs and includes only managed categories. Refer to cover page for complete list of rules governing this PDL.

**EFFECTIVE
01/01/13
Version 2013.1b**

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		<p>LYRICA (pregabalin) NEURONTIN) TABLET, CAPSULE, SOLUTION (gabapentin) QUTENZA (capsaicin) ZOSTRIX OTC (capsaicin)</p>	<p>spinal cord injury OR</p> <p>Diagnosis of fibromyalgia, postherpetic neuralgia, or diabetic neuropathy AND a history of therapeutic failure of gabapentin at the maximum tolerable dose (1800 mg/day) for thirty (30) days 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.)</p>
NSAIDS^{AP}			
NON-SELECTIVE			
	<p>diclofenac fenoprofen flurbiprofen ibuprofen (Rx and OTC) INDOCIN (indomethacin) (suspension only) indomethacin ketorolac naproxen (Rx only) sulindac</p>	<p>ADVIL (ibuprofen) ANAPROX (naproxen) ANSAID (flurbiprofen) CAMBIA (diclofenac) CATAFLAM (diclofenac) CLINORIL (sulindac) DAYPRO (oxaprozin) diflunisal etodolac FELDENE (piroxicam) INDOCIN (indomethacin) indomethacin ER ketoprofen ketoprofen ER LODINE (etodolac) meclofenamate mefenamic acid MOTRIN (ibuprofen) nabumetone NALFON (fenoprofen) NAPRELAN (naproxen) NAPROSYN (naproxen) NUPRIN (ibuprofen) ORUDIS (ketoprofen) oxaprozin piroxicam</p>	<p>Thirty (30) day trials of each of the preferred agents are required before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present.</p>



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

This is not an all-inclusive list of available covered drugs and includes only managed categories. Refer to cover page for complete list of rules governing this PDL.

**EFFECTIVE
01/01/13
Version 2013.1b**

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		PONSTEL (meclofenamate) SPRIX (ketorolac) tolmetin VOLTAREN (diclofenac) ZIPSOR (diclofenac potassium)	
NSAID/GI PROTECTANT COMBINATIONS			
		ARTHROTEC (diclofenac/misoprostol) VIMOVO (naproxen/esomeprazole)	
COX-II SELECTIVE			
	meloxicam	CELEBREX (celecoxib) MOBIC (meloxicam)	Requests for COX-2 Inhibitor agents will be authorized if the following criteria are met: Agent is requested for treatment of a chronic condition, and a. Patient is greater than or equal to 70 years of age, or b. Patient is currently on anticoagulation therapy, or c. Patient has a history or risk of a serious GI complication.
OPHTHALMIC ANTIBIOTICS^{AP}			
	bacitracin/polymyxin ointment ciprofloxacin erythromycin gentamicin drops, ointment ilotycin MOXEZA (moxifloxacin) ofloxacin polymyxin/trimethoprim sulfacetamide solution tobramycin **The American Academy of Ophthalmology guidelines on treating bacterial conjunctivitis recommend as first line treatment options:	AZASITE (azithromycin) bacitracin BESIVANCE (besifloxacin) BLEPH-10 (sulfacetamide) CILOXAN (ciprofloxacin) garamycin drops, ointment levofloxacin NATACYN neomycin/bacitracin/polymyxin neomycin/polymyxin/gramicidin NEOSPORIN (neomycin/polymyxin/gramicidin) OCUFLOX (ofloxacin) POLYTRIM (polymyxin/trimethoprim)	Five (5) day trials of each of the preferred agents are required before non-preferred agents will be authorized unless one of the exceptions on the PA form is present. **A prior authorization is required for the fluoroquinolone agents for patients under 21 years of age unless there has been a trial of a first line treatment option within the past 10 days.



BUREAU FOR MEDICAL SERVICES
WEST VIRGINIA MEDICAID

PREFERRED DRUG LIST WITH PRIOR AUTHORIZATION CRITERIA

This is not an all-inclusive list of available covered drugs and includes only managed categories. Refer to cover page for complete list of rules governing this PDL.

EFFECTIVE
01/01/13
Version 2013.1b

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	<p>erythromycin ointment, sulfacetamide drops, or polymyxin/trimethoprim drops. Alternative treatments include bacitracin ointment, sulfacetamide ointment, polymyxin/bacitracin ointment, fluoroquinolone drops, or azithromycin drops. All generic forms of ophthalmic erythromycin, sulfacetamide, and polymyxin/trimethoprim, polymyxin/bacitracin and bacitracin are preferred.</p>	<p>QUIXIN (levofloxacin) sulfacetamide ointment TOBREX DROPS, OINTMENT (tobramycin) VIGAMOX (moxifloxacin) ZYMAR (gatifloxacin) ZYMAXID (gatifloxacin)</p>	
OPHTHALMIC ANTIBIOTIC/STEROID COMBINATIONS			
	<p>BLEPHAMIDE (prednisolone/sulfacetamide) BLEPHAMIDE S.O.P. (prednisolone/sulfacetamide) MAXITROL OINTMENT (neomycin/polymyxin/dexamethasone) MAXITROL DROPS (neomycin/polymyxin/dexamethasone) TOBRADEX SUSPENSION (tobramycin/dexamethasone) neomycin/polymyxin/dexamethasone neomycin/bacitracin/polymyxin/hydrocortisone sulfacetamide/prednisolone</p>	<p>neomycin/polymyxin/hydrocortisone POLY-PRED (prednisolone/neomycin/polymyxin B) PRED-G (prednisolone/gentamicin) TOBRADEX OINTMENT (tobramycin/dexamethasone) TOBRADEX ST (tobramycin/dexamethasone) tobramycin/dexamethasone suspension ZYLET (loteprednol/tobramycin)</p>	<p>Thirty (30) day trials of each of the preferred agents are required unless one of the exceptions on the PA form is present.</p>
OPHTHALMIC ANTI-INFLAMMATORIES			
	<p>dexamethasone diclofenac fluorometholone flurbiprofen ketorolac 0.4% NEVANAC (nepafenac) prednisolone acetate</p>	<p>ACULAR LS (ketorolac) ACUVAIL 0.45% (ketorolac tromethamine)^{AP} BROMDAY (bromfenac) DUREZOL (difluprednate)^{AP} FLAREX (fluorometholone) FML (fluorometholone) FML FORTE (fluorometholone) LOTEMAX (loteprednol) MAXIDEX (dexamethasone) OMNIPRED (prednisolone) OZURDEX (dexamethasone) PRED FORTE (prednisolone) PRED MILD (prednisolone)</p>	<p>Five (5) day trials of each of the preferred ophthalmic anti-inflammatory agents are required before non-preferred agents will be authorized unless one of the exceptions on the PA form is present.</p>



BUREAU FOR MEDICAL SERVICES
WEST VIRGINIA MEDICAID

PREFERRED DRUG LIST WITH PRIOR AUTHORIZATION CRITERIA

This is not an all-inclusive list of available covered drugs and includes only managed categories. Refer to cover page for complete list of rules governing this PDL.

EFFECTIVE
01/01/13
Version 2013.1b

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA	
		<p>prednisolone sodium phosphate RETISERT (fluocinolone) TRIESENCE (triamcinolone) VEXOL (rimexolone) XIBROM (bromfenac)</p>		
OPHTHALMICS FOR ALLERGIC CONJUNCTIVITIS				
	<p>ALWAY (ketotifen) ALREX (loteprednol) cromolyn ketorolac 0.5% PATADAY (olopatadine) PATANOL (olopatadine) ZADITOR OTC (ketotifen)</p>	<p>ACULAR (ketorolac) ALAMAST (pemirolast)^{AP} ALOCRIL (nedocromil)^{AP} ALOMIDE (lodoxamide)^{AP} azelastine BEPREVE (bepotastine)^{AP} CROLOM (cromolyn)^{AP} DUREZOL (difuprednate)^{NR} ELESTAT (epinastine)^{AP} EMADINE (emedastine)^{AP} epinastine ketotifen LASTACAFT (alcaftadine) OPTICROM (cromolyn)^{AP} OPTIVAR (azelastine) ZYRTEC ITCHY EYE (ketotifen)^{AP}</p>	<p>Thirty (30) day trials of each of three (3) of the preferred agents are required before non-preferred agents will be authorized, unless one of the exceptions on the PA form is present.</p>	
OPHTHALMICS, GLAUCOMA AGENTS				
COMBINATION AGENTS				
	<p>COMBIGAN (brimonidine/timolol) dorzolamide/timolol</p>	<p>COSOPT (dorzolamide/timolol) COSOPT PF (dorzolamide/timolol)</p>	<p>Authorization for a non-preferred agent will only be given if there is an allergy to the preferred agents.</p>	
BETA BLOCKERS				
	<p>BETOPTIC S (betaxolol) carteolol levobunolol metipranolol timolol</p>	<p>BETAGAN (levobunolol) betaxolol BETIMOL (timolol) ISTALOL (timolol) OPTIPRANOLOL (metipranolol) TIMOPTIC (timolol)</p>		
CARBONIC ANHYDRASE INHIBITORS				
	<p>AZOPT (brinzolamide) dorzolamide</p>	<p>TRUSOPT (dorzolamide)</p>		



BUREAU FOR MEDICAL SERVICES
WEST VIRGINIA MEDICAID

PREFERRED DRUG LIST WITH PRIOR AUTHORIZATION CRITERIA

This is not an all-inclusive list of available covered drugs and includes only managed categories. Refer to cover page for complete list of rules governing this PDL.

EFFECTIVE
01/01/13
Version 2013.1b

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
PARASYMPATHOMIMETICS			
	CARBOPTIC (carbachol) ISOPTO CARBACHOL (carbachol) PHOSPHOLINE IODIDE (echothiophate iodide) pilocarpine	ISOPTO CARPINE (pilocarpine) PILOPINE HS (pilocarpine)	
PROSTAGLANDIN ANALOGS			
	latanoprost TRAVATAN-Z (travoprost)	LUMIGAN (bimatoprost) XALATAN (latanoprost) ZIOPTAN (tafluprost)	
SYMPATHOMIMETICS			
	ALPHAGAN P (brimonidine) brimonidine 0.2% dipivefrin	apraclonidine brimonidine 0.15% IOPIDINE (apraclonidine) PROPINE (dipivefrin)	
OTIC ANTIBIOTICS^{AP}			
	CIPRODEX (ciprofloxacin/dexamethasone)* CORTISPORIN SOLUTION (neomycin/polymyxin/HC) neomycin/polymyxin/HC solution/suspension ofloxacin	ciprofloxacin CIPRO HC (ciprofloxacin/hydrocortisone) CETRAXAL 0.2% SOLUTION (ciprofloxacin) COLY-MYCIN S (colistin/hydrocortisone/neomycin/ thonzonium bromide) CORTISPORIN-TC (colistin/hydrocortisone/ neomycin) FLOXIN (ofloxacin)	Five (5) day trials of each of the preferred agents are required before a non-preferred agent will be approved unless one of the exceptions on the PA form is present. *Ciprodex is limited to patients 8 years of age and younger. Age exceptions will be handled on a case-by-case basis.
PANCREATIC ENZYMES^{AP}			
	CREON PANCRELIPASE 5000 ZENPEP	PANCREAZE PERTZYE ^{NR} VIOKACE ^{NR}	A thirty (30) day trial of a preferred agent is required before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present. Non-preferred agents will be approved for members with cystic fibrosis.



BUREAU FOR MEDICAL SERVICES
WEST VIRGINIA MEDICAID

PREFERRED DRUG LIST WITH PRIOR AUTHORIZATION CRITERIA

This is not an all-inclusive list of available covered drugs and includes only managed categories. Refer to cover page for complete list of rules governing this PDL.

EFFECTIVE
01/01/13
Version 2013.1b

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
PARATHYROID AGENTS^{AP}			
	<p>HECTOROL oral & injection (doxercalciferol) ZEMPLAR (paricalcitol)</p>	<p>SENSIPAR (cinacalcet)</p>	<p>A thirty (30) day trial of a preferred agent will be required before a non-preferred agent will be approved.</p>
PEDICULICIDES/SCABICIDES (Topical)^{AP}			
	<p>permethrin (Rx and OTC) pyrethrins-piperonyl butoxide OTC ULESFIA (benzyl alcohol)</p>	<p>EURAX (crotamiton) lindane LICE EGG REMOVER OTC (benzalkonium chloride) malathion NATROBA (spinosad) OVIDE (malathion) SKLICE (ivermectin)</p>	<p>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.</p>
PHOSPHATE BINDERS^{AP}			
	<p>ELIPHOS (calcium acetate) PHOSLO (calcium acetate) RENAGEL 400 MG (sevelamer)</p>	<p>calcium acetate FOSRENOL (lanthanum) PHOSLYRA (calcium acetate) RENAGEL 800 MG (sevelamer) RENVELA (sevelamer carbonate)</p>	<p>Thirty (30) day trials of at least two preferred agents are required unless one of the exceptions on the PA form is present.</p>
PLATELET AGGREGATION INHIBITORS^{AP}			
	<p>AGGRENOX (dipyridamole/ASA) cilostazol clopidogrel</p>	<p>BRILINTA (ticagrelor) dipyridamole EFFIENT (prasugrel) PERSANTINE (dipyridamole) PLAVIX (clopidogrel) PLETAL (cilostazol) TICLID (ticlopidine) ticlopidine</p>	<p>A thirty (30) day trial of a preferred agent is required before a non-preferred agent will be approved unless one of the exceptions on the PA form is present.</p> <p>Effient will be approved for acute coronary syndrome when it is to be managed by acute or delayed percutaneous coronary intervention (PCI). Three (3) day emergency supplies of Effient are available when necessary.</p>
PROGESTINS FOR CACHEXIA			
	<p>megestrol</p>	<p>MEGACE (megestrol) MEGACE ES (megestrol)</p>	



BUREAU FOR MEDICAL SERVICES
WEST VIRGINIA MEDICAID

PREFERRED DRUG LIST WITH PRIOR AUTHORIZATION CRITERIA

This is not an all-inclusive list of available covered drugs and includes only managed categories. Refer to cover page for complete list of rules governing this PDL.

EFFECTIVE
01/01/13
Version 2013.1b

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
PROTON PUMP INHIBITORS^{AP}			
	DEXILANT (dexlansoprazole) omeprazole pantoprazole	ACIPHEX (rabeprazole) lansoprazole NEXIUM (esomeprazole) NEXIUM PACKETS (esomeprazole) omeprazole/sodium bicarbonate (Rx/OTC) PREVACID capsules (lansoprazole) PREVACID Solu-Tabs (lansoprazole) PRILLOSEC (omeprazole) PROTONIX (pantoprazole) ZEGERID OTC (omeprazole)	<p>Sixty (60) day trials of each of the preferred agents, inclusive of a concurrent thirty (30) day trial at the maximum dose of an H₂ antagonist are required before a non-preferred agent will be approved unless one of the exceptions on the PA form is present</p> <p>Prior authorization is not required for Prevacid Solu-Tabs for patients ≤8 years of age.</p>
PSORIATIC AGENTS - TOPICAL			
	calcipotriene cream, ointment DOVONEX (calcipotriene) TAZORAC (tazarotene)	calcipotriene solution calcitriol SORILUX (calcipotriene) TACLONEX (calcipotriene/betamethasone) VECTICAL (calcitriol)	<p>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.</p>
PULMONARY ANTIHYPERTENSIVES - ENDOTHELIN RECEPTOR ANTAGONISTS^{CL}			
	LETAIRIS (ambrisentan) TRACLEER (bosentan)		<p>Letairis will be approved for the treatment of pulmonary artery hypertension (PAH) World Health Organization (WHO) Group I to improve exercise ability and decrease the rate of clinical deterioration.</p> <p>Tracleer will be approved for the treatment of pulmonary artery hypertension (PAH) (WHO Group I) in patients with World Health Organization (WHO) Class II, III, or IV symptoms to improve exercise capacity and decrease the rate of clinical deterioration AND when there has been a failure with Letairis.</p>



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

This is not an all-inclusive list of available covered drugs and includes only managed categories. Refer to cover page for complete list of rules governing this PDL.

**EFFECTIVE
01/01/13
Version 2013.1b**

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
PULMONARY ANTIHYPERTENSIVES – PDE5s^{CL}			
	ADCIRCA (tadalafil) REVATIO TABLETS (sildenafil)	REVATIO IV (sildenafil)	
PULMONARY ANTIHYPERTENSIVES – PROSTACYCLINS^{CL}			
	epoprostenol VENTAVIS (iloprost)	FLOLAN (epoprostenol) REMODULIN (treprostinil sodium) TYVASO (treprostinil) VELETRI (epoprostenol)	Ventavis will only be approved for the treatment of pulmonary artery hypertension (WHO Group 1) in patients with NYHA Class III or IV symptoms. Remodulin and Tyvaso will be approved only after a 30-day trial of Ventavis unless one of the exceptions on the PA form is present.
SEDATIVE HYPNOTICS^{AP}			
BENZODIAZEPINES			
	temazepam 15 & 30 mg	DALMANE (flurazepam) DORAL (quazepam) estazolam flurazepam HALCION (triazolam) RESTORIL (temazepam) temazepam 7.5 & 22.5 mg 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) INTERMEZZO (zolpidem) LUNESTA (eszopiclone) ROZEREM (ramelteon) SILENOR (doxepin) SOMNOTE (chloral hydrate) SONATA (zaleplon) zaleplon zolpidem tartrate ER ZOLPIMIST SPRAY (zolpidem)	



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

This is not an all-inclusive list of available covered drugs and includes only managed categories. Refer to cover page for complete list of rules governing this PDL.

**EFFECTIVE
01/01/13
Version 2013.1b**

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
STIMULANTS AND RELATED AGENTS			
AMPHETAMINES			
	amphetamine salt combination dextroamphetamine VYVANSE (lisdexamfetamine)	ADDERALL (amphetamine salt combination) ADDERALL XR (amphetamine salt combination) amphetamine salt combination ER DESOXYN (methamphetamine) DEXEDRINE (dextroamphetamine) dextroamphetamine ER DEXTROSTAT (dextroamphetamine) methamphetamine PROCENTRA (dextroamphetamine) ^{NR}	<p>One of the preferred agents in each group (amphetamines and non-amphetamines) must be tried for thirty (30) days before a non-preferred agent will be authorized. In addition, a long-acting preferred agent in each class must be tried for thirty (30) days before a non-preferred long-acting stimulant will be approved.</p> <p>Except for Strattera, PA is required for adults >18 years.</p> <p>Thirty (30) day trials of at least three (3) antidepressants are required before amphetamines will be approved for depression.</p> <p>Provigil will only be approved for patients >16 years of age with a diagnosis of narcolepsy.</p>
NON-AMPHETAMINE			
	DAYTRANA (methylphenidate) FOCALIN (dexmethylphenidate) FOCALIN XR (dexmethylphenidate) guanfacine INTUNIV (guanfacine extended-release) METADATE CD (methylphenidate) methylphenidate methylphenidate ER (Generic Concerta) methylphenidate ER (Generic Ritalin SR, Metadate ER, Methylin ER) STRATTERA (atomoxetine)	dexmethylphenidate CONCERTA (methylphenidate) KAPVAY ER (clonidine) METADATE ER (methylphenidate) methylphenidate solution methylphenidate ER (Generic Ritalin LA) modafinil NUVIGIL (armodafinil) pemoline PROVIGIL (modafinil) RITALIN (methylphenidate) RITALIN LA (methylphenidate) RITALIN-SR (methylphenidate)	<p>Strattera will not be approved for concurrent administration with amphetamines or methylphenidates, except for 30 days or less for tapering purposes. Strattera is limited to a maximum of 100mg per day.</p> <p>Kapvay will be approved if the following criteria are met:</p> <ol style="list-style-type: none"> 1. Fourteen (14) day trials of at least one preferred product from the amphetamine and non-amphetamine class and 2. A fourteen (14) day trial of Strattera and 3. A fourteen (14) day trial of clonidine (for Kapvay) unless



BUREAU FOR MEDICAL SERVICES
WEST VIRGINIA MEDICAID

PREFERRED DRUG LIST WITH PRIOR AUTHORIZATION CRITERIA

This is not an all-inclusive list of available covered drugs and includes only managed categories. Refer to cover page for complete list of rules governing this PDL.

EFFECTIVE
01/01/13
Version 2013.1b

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			<p>one of the exceptions on the PA form is present or</p> <p>4. In cases of a diagnosis of Tourette's syndrome, tics, autism or disorders included in the autism spectrum, only a fourteen (14) day trial of clonidine (for Kapvay) is required for approval.</p>
TETRACYCLINES ^{AP}			
	<p>doxycycline hyclate minocycline capsules tetracycline</p>	<p>ADOXA (doxycycline monohydrate) demeclocycline* DORYX (doxycycline hyclate) doxycycline hyclate delayed release doxycycline monohydrate DYNACIN (minocycline) MINOCIN (minocycline) minocycline SR capsules minocycline tablets MONODOX (doxycycline monohydrate) ORACEA (doxycycline monohydrate) SOLODYN (minocycline) SUMYCIN (tetracycline) VIBRAMYCIN SYRUP (doxycycline calcium) VIBRAMYCIN (doxycycline hyclate) VIBRAMYCIN (doxycycline monohydrate) VIBRA-TABS (doxycycline hyclate)</p>	<p>A ten (10) day trial of each of the preferred agents is required before a non-preferred agent will be approved.</p> <p>*Demeclocycline will be approved for conditions caused by susceptible strains of organisms designated in the product information supplied by the manufacturer. A C&S report must accompany this request.</p> <p>*Demeclocycline will also be approved for SIADH.</p>
ULCERATIVE COLITIS AGENTS ^{AP}			
ORAL			
	<p>APRISO (mesalamine) ASACOL (mesalamine) 400mg balsalazide DIPENTUM (olsalazine) PENTASA (mesalamine) 250mg sulfasalazine</p>	<p>ASACOL HD (mesalamine) 800mg AZULFIDINE (sulfasalazine) COLAZAL (balsalazide) LIALDA (mesalamine) PENTASA (mesalamine) 500mg</p>	<p>Thirty (30) day trials of each of the preferred agents of a dosage form must be tried before a non-preferred agent of that dosage form will be authorized unless one of the exceptions on the PA form is present.</p>



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

This is not an all-inclusive list of available covered drugs and includes only managed categories. Refer to cover page for complete list of rules governing this PDL.

**EFFECTIVE
01/01/13
Version 2013.1b**

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
RECTAL			
	CANASA (mesalamine) mesalamine	SF ROWASA (mesalamine)	
VAGINAL ANTIBACTERIALS			
	clindamycin cream METROGEL (metronidazole)	AVC (sulfanilamide) CLEOCIN CREAM (clindamycin) CLEOCIN OVULE (clindamycin) CLINDESSE (clindamycin) metronidazole VANDAZOLE (metronidazole)	A trial, the duration of the manufacturer's recommendation, of each of the preferred agents is required before a non-preferred agent will be approved unless one of the exceptions on the PA form is present.
MISC BRAND/GENERIC			
CLONIDINE			
	CATAPRES-TTS (clonidine) clonidine tablets	clonidine patch NEXICLON XR (clonidine) CATAPRES TABLETS (clonidine)	A thirty (30) day trial of each preferred unique chemical entity in the corresponding therapeutic category is required before a non-preferred agent will be authorized.
SUBLINGUAL NITROGLYCERIN			
	nitroglycerin sublingual NITROLINGUAL (nitroglycerin) NITROSTAT SUBLINGUAL (nitroglycerin)	NITROMIST (nitroglycerin)	
SUBSTANCE ABUSE TREATMENTS			
	SUBOXONE (buprenorphine) FILM ^{CL}	SUBOXONE (buprenorphine) TABS	Suboxone PA criteria is available at http://www.dhr.wv.gov/bms/Pharmacy/Pages/pac.aspx