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

PA-Prior Authorization **REVISED 4/7/03**

DRUG CLASS	PREFERRED	NON-PREFERRED	CRITERIA
PROTON PUMP INHIBITORS *Effective 10/1/02* *Implement 1/7/03*	lansoprazole (Prevacid)** rabeprazole (AcipHex)**	esomeprazole (Nexium) omeprazole (Prilosec) pantoprazole (Protonix)	***PA Criteria: Both of the preferred drugs must be tried before a non-preferred agent will be approved, unless one of the exceptions on the PA form is present.***
MINIMALLY SEDATING ANTIHISTAMINES AND COMBINATIONS *Effective 10/1/02* *Implement 1/7/03*	desloratadine (Clarinex) loratadine (Claritin) loratadine/pseudoephedrine (Claritin-D 12 hour, Claritin-D 24 hour)	cetirizine (Zyrtec) cetirizine/pseudoephedrine (Zyrtec-D) fexofenadine (Allegra) fexofenadine/pseudoephedrine (Allegra-D)	***PA Criteria: Both Claritin (or a decongestant combination) and Clarinex must be tried before a non-preferred agent will be authorized, unless one of the exceptions on the PA form is present for each agent.***
LEUKOTRIENE RECEPTOR AGONISTS *Effective 10/1/02* *Implement 1/7/03*	montelukast (Singulair)	zafirlukast (Accolate) zileuton (Zyflo)	***PA Criteria: The preferred agent must be tried before the non-preferred agents will be approved, unless one of the exceptions on the PA form is present.***
BETA AGONISTS (INHALED & PERORAL) *Effective 10/1/02* *Implement 1/7/03*	albuterol/ipratropium MDI (Combivent) albuterol HFA MDI (Proventil HFA) albuterol syrup, tablets, CFC MDI, inhalation solution # metaproterenol syrup, tablets, inhalation solution # pirbuterol MDI (Maxair, Maxair Autohaler) salmeterol (Serevent, Serevent Diskus) terbutaline # levalbuterol inhalation solution (Xopenex)	albuterol/ipratropium inhalation solution (Duoneb) albuterol HFA MDI (Ventolin HFA) albuterol inhalation solution (Accuneb) albuterol SR tablets (Volmax) formoteral MDI (Foradil) metaproterenol MDI (Alupent)	***PA Criteria: The preferred agents must be tried before non-preferred agents will be authorized, unless one of the exceptions on the PA form is present.***

DRUG CLASS	PREFERRED	NON-PREFERRED	CRITERIA
HISTAMINE 2 ANTAGONISTS *Effective 10/1/02* *Implement 1/7/03*	cimetidine (Tagamet)# famotidine (Pepcid)# nizatidine (Axid)# ranitidine (Zantac)# ranitidine syrup (Zantac)	famotidine orally disintegrating (Pepcid RPD) famotidine suspension (Pepcid) ranitidine 150mg (Zantac EFFERdose)	***PA Criteria: 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.***
ANTIMIGRAINE (TRIPTANS) *Effective 10/1/02* *Implement 1/7/03*	almotriptan (Axert) sumatriptan (Imitrex) all forms	frovatriptan (Frova) naratriptan (Amerge) rizatriptan (Maxalt) zolmitriptan (Zomig) eletriptan (Relpax)<>	***PA Criteria: All of the preferred agents must be tried before a non-preferred agent will be approved, unless one of the exceptions on the PA form is present. (Quantity limits still apply in this category)***
ANTIINCONTINENCE AGENTS *Effective 10/1/02* *Implement 1/7/03*	flavoxate (Urispas) oxybutynin (Ditropan)# tolterodine (Detrol) tolterodine LA (Detrol LA)	oxybutynin XL (Ditropan XL)	***PA Criteria: All of the preferred agents in this category must be tried before a non-preferred agent will be authorized, unless one of the exceptions on the PA form is present.***
GLUCOCORTICOIDS, INHALED *Effective 10/1/02* *Implement 1/7/03*	beclomethasone CFC (Vanceril) flunisolide (Aerobid, Aerobid M) fluticasone (Flovent, Flovent Rotadisk) fluticasone/salmeterol (Advair)	beclomethasone HFA (QVAR) budesonide (Pulmicort Turbuhaler) budesonide (Pulmicort Respules)*** triamcinolone (Azmacort)	***PA Criteria: All of the preferred agents (in one dosage form) must be tried before a non-preferred agent will be authorized, unless one of the exceptions on the PA form is present.***
LIPOTROPICS, OTHER *Effective 10/1/02* *Implement 1/7/03*	cholestyramine (Questran)# cholestyramine light (Questran Light)# colestipol (Colestid) gemfibrozil (Lopid)# niacin ER (Niaspan) fenofibrate (Tricor)	colesevelam (WelChol) niacin ER/lovastatin (Advicor) ezetimibe (Zetia)***(Implement 2/5/03)***	***PA Criteria: The preferred agents must be tried before a non-preferred agent will be authorized, unless one of the exceptions on the PA form is present. Zetia, as monotherapy, will only be approved for patients who cannot take statins or other available agents. Zetia and Welchol will be approved for add-on therapy only after an insufficient response to the maximum tolerable dose of a statin for 12 weeks of therapy and failure of a binding agent.***

DRUG CLASS	PREFERRED	NON-PREFERRED	CRITERIA
BETA-ADRENERGIC RECEPTOR BLOCKING AGENTS *Effective 10/1/02* *Implement 1/7/03*	acebutolol (Sectral)# atenolol (Tenormin)# betaxolol (Kerlone)# bisoprolol (Zebeta)# carvedilol (Coreg) labetalol (Normodyne, Trandate)# metoprolol (Lopressor)# metoprolol XL (Toprol XL) nadolol (Corgard)# pindolol (Visken)# propranolol (Inderal)# propranolol LA (Inderal LA) sotalol (Betapace)# timolol (Blocadren)#	carteolol (Cartrol) penbutolol (Levatol) sotalol (Betapace AF)	***PA Criteria: If one of the exceptions on the PA form is present or if the physician feels that the patient cannot be stabilized with any of the preferred agents, one of the non-preferred agents will be approved.***
CORTICOSTEROIDS, NASAL *Effective 10/1/02* *Implement 1/7/03*	flunisolide (Nasalide)# fluticasone (Flonase) mometasone (Nasonex)	flunisolide (Nasarel) beclomethasone (Beconase, Vancenase) beclomethasone AQ (Beconase AQ, Vancenase AQ) budesonide (Rhinocort) budesonide aqua (Rhinocort Aqua) triamcinolone (Nasacort) triamcinolone AQ (Nasacort AQ)	***PA Criteria: All of the preferred agents must be tried before a non-preferred agent will be authorized, unless one of the exceptions on the PA form is present.***
CALCIUM CHANNEL BLOCKERS *Effective 10/1/02* *Implement 2/5/03*	diltiazem (Cardizem)# diltiazem SR (Cardizem SR, Cardizem CD, Dilacor XR)# felodipine (Plendil) isradipine (Dynacirc) isradipine SR (Dynacirc CR) nicardipine (Cardene)# nifedipine SR (Adalat CC, Procardia XL)# nimodipine (Nimotop) nisoldipine (Sular) verapamil (Calan, Isoptin)# verapamil ER (Verelan PM) verapamil SR (Calan SR, Isoptin SR)#	amlodipine (Norvasc) bepridil (Vascor) nicardipine SR (Cardene SR) nifedipine (Adalat, Procardia) generic and brand verapamil ER (Covera-HS) verapamil SR (Verelan) diltiazem SR (Tiazac)	***PA Criteria: If one of the preferred agents on the list has already been tried or if one of the exceptions on the PA form is present, a non-preferred agent will be authorized.***

DRUG CLASS	PREFERRED	NON-PREFERRED	CRITERIA
HMG-CoA REDUCTASE INHIBITORS *Effective 10/1/02* *Implement 2/5/03*	fluvastatin (Lescol) fluvastatin XL (Lescol XL) lovastatin (Mevacor)# lovastatin ER (Altocor) simvastatin (Zocor)	atorvastatin (Lipitor) pravastatin (Pravachol)	***PA Criteria: One of the preferred agents must be tried before a non-preferred agent will be authorized, unless one of the exceptions on the PA form is present.***
NARCOTIC ANALGESICS *Effective 12/1/02* *Implement 2/5/03*	all generics acetaminophen/caffeine/dihydrocodeine bitartrate (Panlor) fentanyl transdermal (Duragesic) hydrocodone/acetaminophen (Maxidone) morphine sulfate ER (Kadian) morphine sulfate ER (Avinza) oxycodone (Roxicodone) tablets oxycodone/acetaminophen (Roxicet) tramadol/acetaminophen (Ultracet)†	aspirin/caffeine/dihydrocodeine bitartrate (Synalgos-DC) fentanyl citrate (Actiq) hydrocodone bitartrate/ibuprofen (Vicoprofen) oxycodone (Roxicodone Intensol) oxycodone CR (OxyContin) propoxyphene napsylate (Darvon-N)	***PA Criteria: Three of the preferred agents must be tried, for at least 72 hours, before a non-preferred agent will be authorized, unless one of the exceptions on the PA form is present.***
NSAIDS *Effective 12/1/02* *Implement 2/5/03*	all generics rofecoxib (Vioxx)** valdecoxib (Bextra)**	celecoxib (Celebrex) diclofenac/misoprostol (Arthrotec) meloxicam (Mobic) meclofenamic acid (Ponstel)	***PA Criteria: A two-week trial of Vioxx and Bextra is required before Celebrex will be authorized, unless one of the exceptions on the PA form is present.***
HYPOGLYCEMICS, BIGUANIDES *Effective 12/1/02* *Implement 2/5/03*	glipizide/metformin (Metaglip) ***(Effective 2/1/03)*** rosiglitazone/metformin (Avandamet) ***(Effective 2/1/03)*** metformin (Glucophage)# metformin XR (Glucophage XR) metformin/glyburide (Glucovance)		
HYPOGLYCEMICS, INSULINS *Effective 12/1/02* *Implement 2/5/03*	human insulin (Novolin, Novolog) human insulin (Relion) insulin glargine (Lantus)	human insulin (Humulin, Humalog) all insulin pens and devices	***PA Criteria: Lilly products will be available for pediatric patients requiring diluted doses. Non-preferred insulins will only be authorized with documented proof of an allergic reaction to the preferred insulins.***

DRUG CLASS	PREFERRED	NON-PREFERRED	CRITERIA
HYPOGLYCEMICS, POST-PRANDIAL *Effective 12/1/02* *Implement 2/5/03*	nateglinide (Starlix) repaglinide (Prandin)		
HYPOGLYCEMICS, SULFONYLUREAS *Effective 12/1/02* *Implement 2/5/03*	glimepiride (Amaryl) glipizide (Glucotrol)# glyburide (Micronase, DiaBeta)# glyburide extended release (Glynase)#	glipizide XL (Glucotrol XL) acetohexamide (Dymelor and generics) chlorpropamide (Diabinese and generics) tolazamide (Tolinase and generics) tolbutamide (Orinase and generics)	***PA Criteria: A two-month trial of the maximum dose of glimepiride, glipizide, and glyburide is required before an authorization will be given for a non-preferred product. Requests for acetohexamide, tolazamide, tolbutamide, and chlorpropamide must be reviewed by the BMS Medical Director.***
HYPOGLYCEMICS, THIAZOLIDINEDIONES *Effective 12/1/02* *Implement 2/5/03*	rosiglitazone (Avandia) pioglitazone (Actos)		
MACROLIDES *Effective 12/1/02* *Implement 2/5/03*	azithromycin (Zithromax) clarithromycin (Biaxin) clarithromycin (Biaxin XL) erythromycin# (excluding erythromycin estolate)	dirithromycin (Dynabac) troleandomycin (Tao) erythromycin estolate cinoxacin (Cinobac)	***PA Criteria: No non-preferred agents will be authorized unless one of the exceptions on the PA form is present for all of the preferred agents.***
BONE RESORPTION SUPPRESSION AGENTS *Effective 12/1/02* *Implement 2/5/03*	alendronate (Fosamax) calcitonin-salmon (Miacalcin) etidronate (Didronel) risedronate (Actonel) raloxifene (Evista) ***(Effective 2/1/03)***		
ANGIOTENSIN II RECEPTOR BLOCKERS *Effective 12/1/02* *Implement 2/5/03*	eprosartan (Teveten) losartan (Cozaar) losartan/HCTZ (Hyzaar) olmesartan (Benicar) telmisartan (Micardis) telmisartan/HCTZ (Micardis HCT) valsartan (Diovan) valsartan/HCTZ (Diovan HCT)	candesartan (Atacand) candesartan/HCTZ (Atacand HCT) irbesartan (Avapro) irbesartan/HCTZ (Avalide)	***PA Criteria: Five of the agents must be tried, for at least two weeks each, before one of the non-preferred agents will be authorized. Exceptions to this criteria are those listed on the PA form.***

DRUG CLASS	PREFERRED	NON-PREFERRED	CRITERIA
ANTIFUNGALS, TOPICAL *Effective 12/1/02* *Implement 2/5/03*	clotrimazole/betamethasone (Lotrisone)# ketoconazole (Nizoral)# naftifine (Naftin) nystatin (Mycostatin)# nystatin/triamcinolone (Mycolog)# sulconazole (Exelderm) ciclopirox (Loprox)	butenafine (Mentax) ciclopirox (Penlac) econazole (Spectazole) oxiconazole (Oxistat) terbinafine (Lamisil)	***PA Criteria: Three of the preferred agents must be tried for at least two weeks each before one of the non-preferred agents will be authorized, unless one of the exceptions on the PA form is present.***
ANTIFUNGALS, ORAL *Effective 12/1/02* *Implement 2/5/03*	clotrimazole (Mycelex Troche) fluconazole (Diflucan) ***(Quantity limits still apply)***† ketoconazole (Nizoral)#** nystatin# terbinafine (Lamisil)**	flucytosine (Ancobon) itraconazole (Sporanox) griseofulvin (brand & generic)	***PA Criteria: Non-preferred agents will be authorized only if one of the exceptions on the PA form is present for the appropriate preferred agent's use.***
ACE INHIBITOR/CALCIUM CHANNEL BLOCKER, COMBINATIONS *Effective 12/1/02* *Implement 2/5/03*	amlodipine/benazepril (Lotrel) verapamil SR/trandolapril (Tarka)	felodipine/enalapril (Lexxel)	***PA Criteria: A thirty day trial of both of the preferred agents is required before a non-preferred agent will be authorized.***
ESTROGEN AGENTS, ORAL AND TRANSDERMAL *Effective 12/1/02* *Implement 2/5/03*	Transdermal patch (All brands, Vivelle, Vivelle DOT, Esclim, Alora, Climara, Estraderm and generics) conjugated estrogens (Premarin) esterified estrogens (Menest) estradiol (Estrace)# estropipate (Ortho-Est, Ogen)#	synthetic conjugated estrogens (Cenestin)	***PA Criteria: The preferred agents must be tried, for at least 90 days, before a non-preferred agent will be authorized, unless one of the exceptions on the PA form is present.***
ESTROGEN AGENTS, COMBINATION *Effective 12/1/02* *Implement 2/5/03*	17β-estradiol/norethindrone acetate (Activella) 17β-estradiol/norethindrone acetate (Combipatch) 17β-estradiol/norgestimate (Ortho-Prefast) conjugated estrogens/ edroxyprogesterone acetate (Premphase)	conjugated estrogens/ medroxyprogesterone acetate (Prempro) esterified estrogens/ ethyltestosterone (Estratest, HS) ethinyl estradiol/norethindrone acetate Femhrt)	***PA Criteria: A trial of each of the preferred agents, for at least 90 days, is required before a non-preferred agent will be authorized. Requests for Estratest will be handled on a case-by-case basis.***

DRUG CLASS	PREFERRED	NON-PREFERRED	CRITERIA
SKELETAL MUSCLE RELAXANTS *Effective 1/1/03* *Implement 3/5/03*	baclofen# carisoprodol# carisoprodol compound# carisoprodol compound with codeine# chlorzoxazone# cyclobenzaprine# methocarbamol# methocarbamol with ASA# orphenadrine# orphenadrine/ASA/caffeine# tizanidine#	dantrolene (Dantrium) metaxolone (Skelaxin)	***PA Criteria: All of the preferred agents must be tried, for a minimum of 14 days, before a non-preferred agent will be authorized, unless one of the exceptions on the PA form is present. Patients with chronic spasticity will be exempted from these trials.***
QUINOLONES *Effective 1/1/03* *Implement 3/5/03*	ciprofloxacin (Cipro) moxifloxacin (Avelox)	cinoxacin (Cinobac) gatifloxacin (Tequin) levofloxacin (Levaquin) lomefloxacin (Maxaquin) norfloxacin (Noroxin) ofloxacin (Floxin) ciprofloxacin extended-release (Cipro XL)<>	***PA Criteria: 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.***
SELECTED INTRAOCULAR PRESSURE REDUCERS *Effective 1/1/03* *Implement 3/5/03*	brimonidine (Alphagan P) brinzolamide (Azopt) dipivefrin# dorzolamide (Trusopt) dorzolamide/timolol (Cosopt) epinephrine # epinephryl borate# pilocarpine# pilocarpine/epinephrine#		
PROSTAGLANDIN INHIBITORS, OPHTHALMIC *Effective 1/1/03* *Implement 3/5/03*	bimatoprost (Lumigan) 2.5 ml latanoprost (Xalatan) travoprost (Travatan)	bimatoprost (Lumigan) 5 ml unoprostone (Rescula)	***PA Criteria: Authorization for a non-preferred agent will only be given if there is an allergy to the preferred agents.***
BENIGN PROSTATIC HYPERPLASIA (BPH)/MICTURITION AGENTS *Effective 1/1/03* *Implement 3/5/03*	doxazosin (Cardura)# finasteride (Proscar) tamsulosin (Flomax) terazosin (Hytrin)#	dutasteride (Avodart)<>	***PA Criteria: The preferred agents must be tried before the non-preferred agent will be approved, unless one of the exceptions on the PA form is present.***

DRUG CLASS	PREFERRED	NON-PREFERRED	CRITERIA
ATOPIC DERMATITIS IMMUNE MODULATORS *Effective 1/1/03* *Implement 3/5/03*	pimecrolimus (Elidel)	tacrolimus (Protopic)	***PA Criteria: The preferred agent must be tried, for at least 30 days, before a non-preferred agent will be authorized.***
AMINOSALICYLATES/ ULCERATIVE COLITIS AGENTS *Effective 1/1/03* *Implement 3/5/03*	balsalazide (Colazal) mesalamine (Asacol) mesalamine (Rowasa) olsalazine (Dipentum) sulfasalazine# sulfasalazine EC#	mesalamine (Pentasa)	***PA Criteria: 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.***
ANTIEMETIC/ ANTIVERTIGO AGENTS *Effective 1/1/03* *Implement 3/5/03*	**ANTIEMETIC** hydroxyzine# metoclopramide# ondansetron (Zofran) ***(Quantity limits still apply)*** ondansetron (Zofran) ODT ***(Quantity limits still apply)*** prochlorperazine# promethazine# **ANTIVERTIGO** meclizine# scopolamine, oral (Scopace) scopolamine, transdermal (Transderm Scop)	**ANTIEMETIC** dolasetron (Anzemet) dronabinol (Marinol) granisetron (Kytril) thiethylperazine maleate (Torecan)	***PA Criteria: A trial of the preferred agents (with corresponding routes of administration and for appropriate diagnoses) is required before non-preferred agents will be approved, unless one of the exceptions on the PA form is present. For chemotherapy or radiation-induced nausea, a trial of Zofran is adequate for approval of the 5 HT-3 agents.***
ACE INHIBITORS *Effective 1/1/03* *Implement 3/5/03*	benazepril (Lotensin) benazepril/HCTZ (Lotensin HCT) captopril (Capoten)# captopril/HCTZ (Capozide)# enalapril (Vasotec)# enalapril/HCTZ (Vasoretic)# fosinopril (Monopril) fosinopril/HCTZ (Monopril HCT) lisinopril (Prinivil/Zestril)# lisinopril/HCTZ (Prinzide/Zestoretic) moexipril (Univasc) moexipril/HCTZ (Uniretic) quinapril (Accupril) quinapril/HCTZ (Accuretic) trandolapril (Mavik)	perindopril (Aceon) ramipril (Altace)	***PA Criteria: Four of the preferred agents must be tried, for at least 30 days each, before a non-preferred agent will be authorized, unless one of the exceptions on the PA form is present.***

DRUG CLASS	PREFERRED	NON-PREFERRED	CRITERIA
CEPHALOSPORIN AND RELATED ANTIBIOTICS *Effective 1/1/03* *Implement 3/5/03*	**FIRST GENERATION** cefadroxil (Duricef)# cephalexin (Keflex)# cephradine (Velosef)# **SECOND GENERATION** cefaclor (Ceclor)# cefuroxime axetil (Ceftin)# **THIRD GENERATION** cefdinir (Omnicef) cefditoren pivoxil (Spectracef) cefixime (Suprax) **PENICILLIN/BETA LACTAMASE INHIBITOR** amoxicillin/clavulanate (Augmentin)# amoxicillin/clavulanate (Augmentin ES-600) amoxicillin/clavulanate (Augmentin XR)	**SECOND GENERATION** cefprozil (Cefzil) loracarbef (Lorabid) **THIRD GENERATION** cefpodoxime proxetil (Vantin) ceftibuten (Cedax)	***PA Criteria: Preferred drugs must be tried before non- preferred drugs will be approved, unless one of the exceptions on the PA form is present.***
PLATELET AGGREGATION INHIBITORS *Effective 1/1/03* *Implement 3/5/03*	aspirin#(OTC) aspirin/dipyridamole ER (Aggrenox) clopidogrel (Plavix) dipyridamole (Persantine)# ticlopidine (Ticlid)#		
INTERMITTENT CLAUDICATION MEDICATIONS *Effective 1/1/03* *Implement 3/5/03*	pentoxifylline (Trental)# cilostazol (Pletal)		
SEDATIVES/ HYPNOTICS *Effective 1/1/03* *Implement 3/5/03*	estazolam (ProSom)# temazepam (Restoril)# temazepam (Restoril 7.5mg) zolpidem (Ambien)	quazepam (Doral) zaleplon (Sonata) chloral hydrate flurazepam (Dalmane) triazolam (Halcion)	***PA Criteria: Each of the preferred agents must be tried before non-preferred agents will be authorized. Prior authorization is required for these agents for patients over 65 years of age.***

DRUG CLASS	PREFERRED	NON-PREFERRED	CRITERIA
ANTIDEPRESSANTS, OTHER *Effective 1/1/03* *Implement 3/5/03*	bupropion (Wellbutrin)# bupropion XR (Wellbutrin SR) mirtazapine (Remeron) mirtazapine (Remeron SolTab) trazodone (Desyrel)#	venlafaxine (Effexor) venlafaxine (Effexor XR) nefazodone (Serzone)	***PA Criteria: A non-preferred agent will only be prior authorized if there has been a six-week trial of an SSRI and a preferred agent in this class, unless one of the exceptions on the PA form is present.***
STIMULANTS++ *Effective 1/1/03* *Implement 3/5/03*	desmethylphenidate (Focalin)++ dextroamphetamine#++ methylphenidate#++ methylphenidate ER#++ methylphenidate ER (Concerta)++ methylphenidate ER (Metadate CD)++ methylphenidate ER (Methylin ER)++ mixed salt amphetamines#++ mixed salt amphetamines (Adderall XR)++ pemoline#++	methamphetamine (Desoxyn) modafinil (Provigil) methylphenidate ER (Ritalin LA) atomoxetine (Strattera)<>	***PA Criteria: One of the preferred agents in each group (methylphenidates and amphetamines) must be tried before a non-preferred agent will be authorized. Ritalin LA will only be approved if there is an allergy to all of the preferred long-acting agents on the list.***
Phase IV			
OPHTHALMICS, ALLERGIC CONJUNCTIVITIS *Effective 2/1/03* *Implement 4/9/03*	azelastine hydrochloride (Optivar) cromolyn sodium (Opticrom)# emedastine difumarate (Emadine) ketorolac tromethamine (Acular) ketotifen fumarate (Zaditor) levocabastine (Livostin) loteprednol (Alrex) olopatadine hydrochloride (Patanol)	lodoxamide tromethamine (Alomide) nedocromil sodium (Alocril) pemirolast potassium (Alamast)	***PA Criteria: All of the preferred agents must be tried before non-preferred agents will be authorized, unless one of the exceptions on the PA form is present.***
ANTIVIRALS, GENERAL *Effective 2/1/03* *Implement 4/9/03*	acyclovir (Zovirax)# amantadine (Symmetrel)# ganciclovir (Cytovene) rimantadine (Flumadine)# valacyclovir (Valtrex)	famciclovir (Famvir)* valganciclovir (Valcyte) zanamivir (Relenza) oseltamivir (Tamiflu)	***PA Criteria: All of the appropriate preferred agents must be tried before the non-preferred agents will be prior authorized, unless one of the exceptions on the PA form is present.***

DRUG CLASS	PREFERRED	NON-PREFERRED	CRITERIA
NASAL PREPARATIONS, OTHER *Effective 2/1/03* *Implement 4/9/03*		ipratropium nasal 0.03% (Atrovent Nasal Spray) ipratropium nasal 0.06% (Atrovent Nasal Spray) azelastine (Astelin)	***PA Criteria: One of the non-preferred nasal sprays will be approved only if the patient fails on a steroid nasal spray and and a non-sedating antihistamine and is still complaining of rhinorrhea.***
ERYTHROPOIESIS STIMULATING PROTEINS *Effective 2/1/03* *Implement 4/9/03*	rHuEPO (Epogen)** rHuEPO (Procrit)**	darbepoetin (Aranesp)	***PA Criteria: Prior approval for Aranesp will be given only in cases where administration is an issue.***
PHOSPHATE BINDERS *Effective 2/1/03* *Implement 4/9/03*	calcium acetate (PhosLo) magnesium carbonate, calcium carbonate, folic acid (Magnebind 400 Rx)	sevelamer (RenaGel)*	***PA Criteria: A trial of one 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.***
HYPOGLYCEMICS, ALPHA-GLUCOSIDASE INHIBITORS *Effective 2/1/03* *Implement 4/9/03*	miglitol (Glyset)	acarbose (Precose)	***PA Criteria: The preferred agent must be tried before the non-preferred agent will be prior authorized.***
IMMUNOMODULATORY AGENTS FOR MULTIPLE SCLEROSIS *Effective 2/1/03* *Implement 4/9/03*	interferon beta-1a (Rebif)** interferon beta-1b (Betaseron)**	glatiramer (Copaxone) interferon beta-1a (Avonex)	***PA Criteria: Patients starting therapy in this class will be required to try the preferred agents, unless one of the exception criteria on the PA form is present. Patients already on non-preferred agents will receive prior authorization for that agent for one year.***
ANTICOAGULANTS, INJECTABLES *Effective 2/1/03* *Implement 4/9/03*	dalteparin (Fragmin)** fondaparinux (Arixtra)** enoxaparin (Lovenox)**	tinzaparin (Innohep)	***PA Criteria: All of the preferred agents must be tried before approval of the non-preferred agent will be approved, unless one of the exceptions on the PA form is present.***

DRUG CLASS	PREFERRED	NON-PREFERRED	CRITERIA
ANTIDEPRESSANTS, SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIs) *Effective 2/1/03* *Implement 4/9/03*	citalopram (Celexa) fluoxetine (Prozac)# fluvoxamine (Luvox)# paroxetine (Paxil) paroxetine CR (Paxil CR) sertraline (Zoloft)	escitalopram (Lexapro) fluoxetine ER (Prozac Weekly) fluoxetine (Sarafem)	***PA Criteria: None of the non-preferred agents will be authorized unless there is a documented allergic reaction to all of the preferred agents.***
ANTIPSYCHOTICS, ATYPICAL *Effective 2/1/03* *Implement 4/9/03*	clozapine (Clozaril)# quetiapine (Seroquel) risperidone (Risperdal) ziprasidone (Geodon)	aripiprazole (Abilify) olanzapine (Zyprexa) olanzapine (Zyprexa Zydis)	***PA Criteria: Patients already on non-preferred agents will receive authorization to continue these drugs. New patients for this class of therapy will be required to try a preferred agent for 2 weeks, unless one of the exceptions on the PA form is present.***
ALZHEIMER'S AGENTS *Effective 2/1/03* *Implement 4/9/03*	donepezil (Aricept) galantamine (Reminyl) rivastigmine (Exelon)	tacrine (Cognex)	***PA Criteria: Patients already on a non-preferred agent will receive authorization to continue therapy on that agent. Patients starting therapy in this class must show a documented allergy to all of the preferred agents before a non-preferred agent will be prior authorized.***

\# Generic forms only.
* Status pending.
** Prior authorization required.
*** No prior authorization required for children through 8 years of age.
† Prior authorization required after limits exceeded.
++ Prior authorization required for adults > age 18 years.
<> New drug, not yet reviewed.