BUREAU FOR MEDICAL SERVICES
WEST VIRGINIA MEDICAID

PREFERRED DRUG LIST WITH PRIOR AUTHORIZATION CRITERIA

REVISED 11/22/05
Implementation Date: 10/3/05
Originally Posted 8/31/05

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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ACE INHIBITORS *Implement 10/3/05*	**ACE INHIBITORS**		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.
	ALTACE (ramipril) benazepril captopril enalapril lisinopril MAVIK (trandolapril) UNIVASC (moexepril)	ACEON (perindopril) ACCUPRIL (quinapril) CAPOTEN (captopril) fosinopril LOTENSIN (benazepril) MONOPRIL (fosinopril) PRINIVIL (lisinopril) quinapril VASOTEC (enalapril) ZESTRIL (lisinopril)	
	ACE INHIBITOR/DIURETIC COMBINATIONS		
	benazepril/HCTZ captopril/HCTZ enalapril/HCTZ lisinopril/HCTZ UNIRETIC (moexepril/HCTZ)	ACCURETIC (quinapril/HCTZ) CAPOZIDE (captopril/HCTZ) fosinopril/HCTZ LOTENSIN HCT (benazepril/HCTZ) MONOPRIL HCT (fosinopril/HCTZ) PRINZIDE (lisinopril/HCTZ) quinapril/HCTZ VASERETIC (enalapril/HCTZ) ZESTORETIC (lisinopril/HCTZ)	
ACE INHIBITOR/CALCIUM CHANNEL BLOCKER COMBINATIONS *Effective 7/1/05*	LOTREL (benazepril/amlodipine) TARKA (trandolapril/verapamil)	LEXXEL (enalapril/felodipine)	Each of the preferred agents must be tried for at least two weeks each before a non-preferred agent in that group will be authorized unless one of the exceptions on the PA form is present. **Patients starting therapy in this class must show a documented allergy to the preferred agents before a non-preferred agent will be authorized.**
ALZHEIMER'S AGENTS *Implement 10/3/05*	**CHOLINESTERASE INHIBITORS**		
	ARICEPT (donepezil) EXELON (rivastigmine) RAZADYNE (galantamine) RAZADYNE ER (galantamine)	COGNEX (tacrine)	
	NMDA RECEPTOR ANTAGONIST		
	NAMENDA (memantine)		

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ANALGESICS, NARCOTIC (Non-parenteral) *Effective 7/1/05*	**SHORT ACTING** acetaminophen/codeine aspirin/codeine codeine hydrocodone/APAP hydrocodone/ibuprofen hydromorphone levorphanol methadone morphine oxycodone oxycodone/APAP oxycodone/aspirin pentazocine/APAP pentazocine/naloxone propoxyphene/APAP tramadol tramadol/APAP	ACTIQ (fentanyl) ANEXSIA (hydrocodone/APAP) BALACET (propoxyphene/APAP) BANCAP HC (hydrocodone/APAP) butalbital/APAP/caffeine/codeine butalbital/ASA/caffeine/codeine COMBUNOX (oxycodone/ibuprofen)[NR] DARVOCET (propoxyphene/APAP) DARVON (propoxyphene) DARVON N (propoxyphene) DEMEROL (meperidine) DILAUDID (hydromorphone) FIORICET W/ CODEINE (butalbital/APAP/caffeine/codeine) FIORINAL W/ CODEINE (butalbital/ASA/caffeine/codeine) LORCET, LORTAB (hydrocodone/APAP) MAXIDONE (hydrocodone/APAP) meperidine MSIR (morphine) NORCO (hydrocodone/APAP) OXYFAST, OXYIR (oxycodone) PANLOR (dihydrocodeine/APAP/caffeine) PERCOCET (oxycodone/APAP) PERCODAN (oxycodone/aspirin) PERCOLONE (oxycodone) PHRENILIN W/ CAFFEINE AND CODEINE (butalbital/ASA/caffeine/codeine) propoxyphene propoxyphene/ASA/caffeine propoxyphene napsylate REPREXAIN (hydrocodone/ibuprofen) SYNALGOS-DC (dihydrocodeine/ASA/caffeine) TALACEN (pentazocine/APAP) TALWIN NX (pentazocine/naloxone)	Three of the preferred agents must be tried for at least 72 hours before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present. (The three agents tried must include at least one of the long-acting agents when requesting a PA for a non-preferred long acting agent.) Actiq will only be approved as an adjunct to a long-acting agent. Actiq for monotherapy will not be approved. Limits: Quantities exceeding 240 tablets per 30 days (8 tablets/day) for agents containing 500 mg of acetaminophen will require a prior authorization

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		TYLENOL W/CODEINE (APAP/codeine) ULTRACET (tramadol/APAP) ULTRAM (tramadol) VICODIN (hydrocodone/APAP) VICOPROFEN (hydrocodone/ibuprofen) ZYDONE (hydrocodone/APAP)	
	LONG-ACTING		
	DURAGESIC (fentanyl) KADIAN (morphine) morphine SR	AVINZA (morphine) fentanyl patches MS CONTIN (morphine) ORAMORPH SR (morphine) oxycodone ER OXYCONTIN (oxycodone) PALLADONE (hydromorphone ER)	
ANGIOTENSIN II RECEPTOR BLOCKERS (ARBs) *Effective 7/1/05*	**ANGIOTENSIN RECEPTOR BLOCKERS**		Each of the preferred agents in the corresponding group must be tried for at least two weeks each before a non-preferred agent in that group will be authorized, unless one of the exceptions on the PA form is present.
	AVAPRO (irbesartan) COZAAR (losartan) DIOVAN (valsartan) MICARDIS (telmisartan)	ATACAND (candesartan) BENICAR (olmesartan) TEVETEN (eprosartan**)**	
	ARB/DIURETIC COMBINATIONS		
	AVALIDE (irbesartan/HCTZ) DIOVAN-HCT (valsartan/HCTZ) HYZAAR (losartan/HCTZ) MICARDIS-HCT (telmisartan/HCTZ)	ATACAND-HCT (candesartan/HCTZ) BENICAR-HCT (olmesartan/HCTZ) TEVETEN-HCT (eprosartan/HCTZ)	
ANTICOAGULANTS, INJECTABLE[CL] *Effective 7/1/05*	FRAGMIN (dalteparin) LOVENOX (enoxaparin)	ARIXTRA (fondaparinux) INNOHEP (tinzaparin)	A non-preferred agent will only be authorized if one of the exceptions on the PA form is present for each preferred agents.

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ANTIDEPRESSANTS, OTHER (non-SSRI) *Effective 7/1/05*	bupropion SR CYMBALTA (duloxetine) EFFEXOR XR (venlafaxine) mirtazapine trazodone	bupropion IR DESYREL (trazodone) EFFEXOR (venlafaxine) nefazodone REMERON (mirtazapine) SERZONE (nefazodone) WELLBUTRIN (bupropion) WELLBUTRIN SR (bupropion) WELLBUTRIN XL (bupropion)	A non-preferred agent will only be authorized if there has been a six-week trial of a preferred agent in this class unless one of the exceptions on the PA form is present.
ANTIDEPRESSANTS, SSRIs *Implement 10/3/05*	citalopram fluoxetine fluvoxamine LEXAPRO (escitalopram) paroxetine PEXEVA (paroxetine) ZOLOFT (sertraline)	CELEXA (citalopram) PAXIL (paroxetine) PAXIL CR (paroxetine) PROZAC (fluoxetine) RAPIFLUX (fluoxetine) SARAFEM (fluoxetine)	None of the non-preferred dosage forms will be authorized unless there is documentation showing that the preferred dosage forms of the corresponding agents are inappropriate for the patient.
ANTIEMETICS, ORAL	**5HT3 RECEPTOR BLOCKERS**		**A trial of Zofran is required before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present.** **Quantity limits apply for this class*** **Zofran*-14 tablets per 21 days** **EMEND*-12 tablets per 28 days**
	ZOFRAN (ondansetron) ZOFRAN ODT (ondansetron) EMEND (aprepitant)	ANZEMET (dolasetron) KYTRIL (granisetron)	
ANTIFUNGALS, ORAL *Implement 10/3/05*	clotrimazole fluconazole ketoconazole[CL] LAMISIL (terbinafine)[CL] MYCOSTATIN Pastilles (nystatin) nystatin	ANCOBON (flucytosine) DIFLUCAN (fluconazole) GRIFULVIN V (griseofulvin) griseofulvin GRIS-PEG (griseofulvin) itraconazole MYCELEX (clotrimazole) MYCOSTATIN Tablets (nystatin) NIZORAL (ketoconazole) SPORANOX (itraconazole) VFEND (voriconazole)	**Non-preferred agents will be approved only if one of the exceptions on the PA form is present.** **PA is required when limits are exceeded.** **PA is not required for Grifulvin-V Suspension for children up to 16 years of age for the treatment of tinea capitis**

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ANTIFUNGALS, TOPICAL *Implement 10/3/05*	**ANTIFUNGALS**		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.
	ciclopirox (cream, suspension) econazole EXELDERM (sulconazole) ketoconazole LOPROX Gel, Shampoo (ciclopirox) nystatin	ERTACZO (sertaconazole) LOPROX Cream, TS (ciclopirox) MENTAX (butenafine) MYCOSTATIN (nystatin) NAFTIN (naftifine) NIZORAL (ketoconazole) OXISTAT (oxiconazole) PENLAC (ciclopirox) SPECTAZOLE (econazole)	
	ANTIFUNGAL/STEROID COMBINATIONS		
	clotrimazole/betamethasone nystatin/triamcinolone	LOTRISONE (clotrimazole/betamethasone) MYCOLOG (nystatin/triamcinolone)	
ANTIHISTAMINES, MINIMALLY SEDATING *Effective 7/1/05*	**ANTIHISTAMINES**		A preferred agent must be tried before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present.
	loratadine CLARINEX Syrup (desloratadine) ALAVERT (loratadine) TAVIST-ND (loratadine)	ALLEGRA (fexofenadine) CLARINEX tablets (desloratadine) CLARITIN (loratadine) ZYRTEC (cetirizine)	
	ANTIHISTAMINE/DECONGESTANT COMBINATIONS		
	ALAVERT D (loratadine/psuedoephedrine) loratadine/pseudoephedrine	ALLEGRA-D (fexofenadine/pseudoephedrine) CLARITIN-D (loratadine/pseudoephedrine) ZYRTEC-D (cetirizine/pseudoephedrine)	
ANTIMIGRAINE AGENTS, TRIPTANS *Effective 7/1/05*	AXERT (almotriptan) IMITREX Injection (sumatriptan) MAXALT (rizatriptan) ZOMIG (zolmitriptan)	AMERGE (naratriptan) FROVA (frovatriptan) IMITREX Nasal (sumatriptan) IMITREX Tablets (sumatriptan) RELPAX (eletriptan)	Two of the oral agents must be tried before a non-preferred agent will be approved, unless one of the exceptions on the PA form is present. Quantity limits apply for this drug class.
ANTIPARKINSON'S AGENTS (Oral) *Implement 10/3/05*	**ANTICHOLINERGICS**		Patients starting therapy on drugs in this class must show a documented allergy to all of the preferred agents before a non-preferred agent will be authorized.
	benztropine KEMADRIN (procyclidine) trihexyphenidyl	COGENTIN (benztropine)	
	COMT INHIBITORS		
	COMTAN (entacapone)	TASMAR (tolcapone)	

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	DOPAMINE AGONISTS		
	MIRAPEX (pramipexole) REQUIP (ropinirole)	pergolide PERMAX (pergolide)	
	OTHER ANTIPARKINSON'S AGENTS		
	carbidopa/ levodopa selegiline STALEVO (levodopa/carbidopa/entacapone)	ELDEPRYL (selegiline) PARCOPA (levodopa/carbidopa) SINEMET (levodopa/carbidopa)	
ANTIPSYCHOTICS, ATYPICAL (Oral) *Implement 10/3/05*	**ORAL**		Upon discharge, hospitalized patients stabilized on non-preferred agents will receive authorization to continue these drugs. New patients for this class of drugs will be required to try a preferred agent for two weeks unless one of the exceptions on the PA form is present.
	clozapine FAZACLO (clozapine) GEODON (ziprasidone) RISPERDAL (risperidone) SEROQUEL (quetiapine)	ABILIFY (aripiprazole) CLOZARIL (clozapine) ZYPREXA (olanzapine)	
	INJECTABLE		
		GEODON (ziprasidone)[CL] RISPERDAL CONSTA (risperidone)[CL] ZYPREXA (olanzapine)[CL]	
	ATYPICAL ANTIPSYCHOTIC/SSRI COMBINATIONS		
		SYMBYAX (olanzapine/fluoxetine)	
ANTIVIRALS (Oral) *Implement 10/3/05*	acyclovir amantadine rimantadine VALCYTE (valganciclovir) VALTREX (valacyclovir)	CYTOVENE (ganciclovir) FAMVIR (famciclovir) FLUMADINE (rimantadine) ganciclovir RELENZA (zanamivir) SYMMETREL (amantadine) TAMIFLU (oseltamivir) ZOVIRAX (acyclovir)	All of the appropriate preferred agents with the applicable indication must be tried before the non-preferred agents will be authorized unless one of the exceptions on the PA form is present.
ATOPIC DERMATITIS *Implement 10/3/05*	ELIDEL (pimecrolimus) PROTOPIC (tacrolimus)		
BETA BLOCKERS (Oral) *Effective 7/1/05*	**BETA BLOCKERS**		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.
	atenolol INDERAL LA (propranolol) INNOPRAN XL (propranolol) metoprolol	acebutolol BETAPACE (sotalol) betaxolol bisoprolol	

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	nadolol propranolol sotalol timolol TOPROL XL (metoprolol)	BLOCADREN (timolol) CARTROL (carteolol) CORGARD (nadolol) KERLONE (betaxolol) LEVATOL (penbutolol) LOPRESSOR (metoprolol) pindolol SECTRAL (acebutolol) TENORMIN (atenolol) ZEBETA (bisoprolol)	
	BETA- AND ALPHA- BLOCKERS		
	COREG (carvedilol) labetalol	NORMODYNE (labetalol) TRANDATE (labetalol)	
BLADDER RELAXANT PREPARATIONS *Effective 7/1/05*	DITROPAN XL (oxybutynin) ENABLEX (darifenacin) oxybutynin OXYTROL (oxybutynin)	DETROL (tolterodine) DETROL LA (tolterodine) DITROPAN (oxybutynin) SANCTURA (trospium) VESICARE (solifenacin)	Two chemical entities in the class must be tried before a non-preferred agent will be authorized, unless one of the exceptions on the PA form is present.
BONE RESORPTION SUPPRESSION AND RELATED AGENTS *Implement 10/3/05*	**BISPHOSPHONATES**		One of the preferred agents must be tried for at least one month before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present. Forteo will be approved for patients with a history of osteoporotic fractures or if one of the exceptions on the PA form is present.
	ACTONEL (risedronate) ACTONEL WITH CALCIUM (risedronate/calcium) FOSAMAX (alendronate) FOSAMAX PLUS D (alendronate/vitamin D)	BONIVA (ibandronate) DIDRONEL (etidronate)	
	OTHER BONE RESORPTION SUPPRESSION AND RELATED AGENTS		
	EVISTA (raloxifene) MIACALCIN (calcitonin)	FORTEO (teriparatide) FORTICAL (calcitonin)[NR]	
BPH AGENTS *Effective 7/1/05*	**ALPHA BLOCKERS**		One of the preferred agents must be tried before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present.
	doxazosin FLOMAX (tamsulosin) terazosin UROXATRAL (alfuzosin)	CARDURA (doxazosin) HYTRIN (terazosin)	
	5-ALPHA-REDUCTASE (5AR) INHIBITORS		
	PROSCAR (finasteride)	AVODART (dutasteride)	

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BRONCHODILATORS, ANTICHOLINERGIC *Implement 10/3/05*	**ANTICHOLINERGIC**		**The preferred agents in the class must be tried before the non-preferred agent will be authorized unless one of the exceptions on the PA form is present.** **For severely compromised patients, DUONEB will be approved if the combined volume of albuterol and ipratropium nebules is inhibitory.**
	ATROVENT Inhaler (ipratropium) ATROVENT HFA (ipratropium) ipratropium SPIRIVA (tiotropium)	ATROVENT Inhalation Solution (ipratropium)	
	ANTICHOLINERGIC-BETA AGONIST COMBINATIONS		
	COMBIVENT (albuterol/ipratropium)	**DUONEB (albuterol/ipratropium)**	
BRONCHODILATORS, BETA AGONIST *Implement* 10/3/05	**INHALERS, SHORT-ACTING**		**All of the preferred agents in a group must be tried before a non-preferred agent in that group will be authorized unless one of the exceptions on the PA form is present.** **Xopenex Inhalatiion Solutiion will be approved for 12 months for a diagnosis of asthma for patients on concurrent controller therapy (either oral of inhaled) with documentation of failure on a trial of albuterol or documented intolerance of albuterol.** **Xopenex will be approved for patients with documented cardiac conditions** ****No PA is required for ACCUNEB for children up to 5 years of age.**
	albuterol MAXAIR (pirbuterol)	ALUPENT (metaproterenol) PROVENTIL (albuterol) PROVENTIL HFA (albuterol) VENTOLIN HFA (albuterol)	
	INHALERS, LONG-ACTING		
	SEREVENT (salmeterol)	FORADIL (formoterol)	
	INHALATION SOLUTION		
	albuterol	**ACCUNEB (albuterol)**** **metaproterenol** **PROVENTIL (albuterol)** **XOPENEX (levalbuterol**)	
	ORAL		
	albuterol terbutaline	BRETHINE (terbutaline) metaproterenol VOSPIRE ER (albuterol)	
CALCIUM CHANNEL BLOCKERS (Oral) *Effective 7/1/05*	**SHORT-ACTING**		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. Nimodipine will be approved with the appropriate diagnosis.
	diltiazem verapamil	ADALAT (nifedipine) CALAN (verapamil) CARDENE (nicardipine) CARDIZEM (diltiazem) DYNACIRC (isradipine) nicardipine nifedipine NIMOTOP (nimodipine) PROCARDIA (nifedipine)	

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	LONG-ACTING		
	CARDIZEM LA (diltiazem) diltiazem DYNACIRC CR (isradipine) felodipine nifedipine SULAR (nisoldipine) verapamil VERELAN PM (verapamil)	ADALAT CC (nifedipine) CALAN SR (verapamil) CARDENE SR (nicardipine) CARDIZEM CD (diltiazem) CARDIZEM SR (diltiazem) COVERA-HS (verapamil) DILACOR XR (diltiazem) ISOPTIN SR (verapamil) NORVASC (amlodipine) PLENDIL (felodipine) PROCARDIA XL (nifedipine) TIAZAC (diltiazem) VERELAN (verapamil)	
CEPHALOSPORINS AND RELATED ANTIBIOTICS (Oral) *Implement 10/3/05*	**BETA LACTAM/BETA-LACTAMASE INHIBITOR COMBINATIONS**		The preferred agents must be tried before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present.
	amoxicillin/clavulanate amoxicillin 600 mg/clavulanate 42.9 mg	AUGMENTIN (amoxicillin/clavulanate) AUGMENTIN ES-600 (amoxicillin/clavulanate) AUGMENTIN XR (amoxicillin/clavulanate)	
	CEPHALOSPORINS		
	CEDAX (ceftibuten) cefaclor cefadroxil cefuroxime CEFZIL (cefprozil) cephalexin cephradine OMNICEF (cefdinir) SPECTRACEF (cefditoren) SUPRAX (cefixime)	CECLOR (cefaclor) cefpodoxime CEFTIN (cefuroxime) DURICEF (cefadroxil) KEFLEX (cephalexin) LORABID (loracarbef) PANIXINE (cephalexin) RANICLOR (cefaclor) VANTIN (cefpodoxime) VELOSEF (cephradine)	

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CYTOKINE & CAM ANTAGONISTS [CL] *Implement 10/3/05*	ENBREL (etanercept) KINERET (anakinra)	**HUMIRA (adalimumab)** **RAPTIVA (efalizumab)**	**For all new therapy, 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 currently on a non-preferred agent will receive an authorization to continue therapy on that agent.**
ERYTHROPOIESIS STIMULATING PROTEINS[CL] *Implement 7/1/05*	ARANESP (darbepoetin) PROCRIT (rHuEPO)	EPOGEN (rHuEPO)	The preferred agents must be tried before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present.
ESTROGEN AGENTS, COMBINATIONS *Implement 7/1/05*	**ORAL**		The preferred agents of a dosage form must be tried for at least 90 days before a non-preferred agent of that dosage form will be authorized unless one of the exceptions on the PA form is present.
	ACTIVELLA (17ß-estradiol/norethindrone acetate) FEMHRT (EE/norethindrone acetate) PREFEST (17ß-estradiol/norgestimate) PREMPHASE (CE/MPA) PREMPRO (CE/MPA)		
	TOPICAL		
	COMBIPATCH (17ß-estradiol/norethindrone acetate)	CLIMARA PRO (estradiol/levonorgestrel)	
FLUROQUINOLONES, ORAL *Implement 10/3/05*	AVELOX (moxifloxacin) ciprofloxacin	**CIPRO (ciprofloxacin)** **CIPRO XR (ciprofloxacin extended-release)** **FACTIVE (gemifloxacin)** **FLOXIN (ofloxacin)** **LEVAQUIN (levofloxacin)** **MAXAQUIN (lomefloxacin)** **NOROXIN (norfloxacin)** **ofloxacin** **TEQUIN (gatifloxacin)**	**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.**
GLUCOCORTICOIDS, INHALED *Implement 10/3/05*	**GLUCOCORTICOIDS**		**All of the preferred agents of a dosage form must be tried before a non-preferred agent of that dosage form will be authorized unless one of the exceptions on the PA form is present.** **Pulmicort Respules do not require a prior authorization for children through 8 years of age or for individuals unable to use an MDI.**
	AEROBID (flunisolide) AEROBID-M (flunisolide) AZMACORT (triamcinolone) FLOVENT (fluticasone) FLOVENT HFA (fluticasone) QVAR (beclomethasone)	**ASMANEX (mometasone)**[NR] **PULMICORT (budesonide)**	
	GLUCOCORTICOID/BRONCHODILATOR COMBINATIONS		
	ADVAIR (fluticasone/salmeterol)		

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GROWTH HORMONE[CL] *Implement 7/1/05*	NORDITROPIN (somatropin) NUTROPIN AQ (somatropin) TEV-TROPIN (somatropin)	GENOTROPIN (somatropin) HUMATROPE (somatropin) NUTROPIN (somatropin) SAIZEN (somatropin) SEROSTIM (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.
HEPATITIS C TREATMENTS[CL] *Implement 7/1/05*	PEG-INTRON (pegylated IFN) REBETOL (ribavirin) ribavirin	**COPEGUS (ribavirin)** **INFERGEN (consensus IFN)** **PEGASYS (pegylated IFN)** **REBETRON (IFNα/ribavirin)** **ribavirin**	**Patients already on a non-preferred agent will receive authorization to continue therapy on that agent.** **Patients starting therapy in this class must try the preferred agent of a dosage form before a non-preferred agent of that dosage form will be authorized, with the exception of the following conditions: (1) Hepatitis B infection, (2) co-infection with Hepatitis C and HIV, and** **(3) Hepatitis C infection with mild cirrhosis.**
HYPOGLYCEMICS, INSULINS AND RELATED AGENTS *Implement 10/3/05*	**INSULIN**		Non-preferred insulins 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.
	LANTUS (insulin glargine) NOVOLIN (insulin) NOVOLOG (insulin aspart) NOVOLOG MIX (insulin aspart/aspart protamine)	HUMALOG (insulin lispro) HUMALOG MIX (insulin lispro/lispro protamine) HUMULIN (insulin)	
	RELATED AGENTS		
	BYETTA (exenatide) SYMLIN (amylin)		
HYPOGLYCEMICS, MEGLITINIDES **Implement 7/1/05**	STARLIX (nateglinide)	PRANDIN (repaglinide)	The preferred agent must be tried before a non-preferred agent will be authorized, unless one of the exceptions on the PA form is present.
HYPOGLYCEMICS, METFORMINS *Implement 10/3/05*	**METFORMIN**		No non-preferred agents will be approved without a 12-week trial of the preferred agents unless one of the exceptions on the PA form is present.
	FORTAMET metformin RIOMET	GLUCOPHAGE	
	METFORMIN-CONTAINING COMBINATIONS		**No non-preferred agents will be approved without a 12-week trial of the individual agents unless one of the exceptions on the PA form is present. (A trial of metformin/glyburide is not necessary for approval of the individual components of a combination**

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[CL] - Requires Clinical PA
[NR] – New drug has not been reviewed by P & T Committee

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	metformin/glyburide	**AVANDAMET (metformin/rosiglitazone)** **GLUCOVANCE (metformin/glyburide)** **METAGLIP (metformin/glipizide)**	**agent.)**
HYPOGLYCEMICS, TZDS *Implement 7/1/05*	ACTOS (pioglitazone)	AVANDIA (rosiglitazone)	The preferred agent must be tried before the non-preferred agent will be authorized unless one of the exceptions on the PA form is present.
INTRANASAL RHINITIS AGENTS *Implement 10/3/05*	**ANTICHOLINERGICS**		**All of the preferred agents must be tried before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present.**
		ATROVENT (ipratropium) ipratropium	
	ANTIHISTAMINES		
	ASTELIN (azelastine)		
	CORTICOSTEROIDS		
	FLONASE (fluticasone) NASACORT AQ (triamcinolone) NASONEX (mometasone)	BECONASE AQ (beclomethasone) flunisolide NASALIDE (flunisolide) NASAREL (flunisolide) RHINOCORT AQUA (budesonide)	
LEUKOTRIENE RECEPTOR BLOCKERS *Implement 10/3/05*	ACCOLATE (zafirlukast) SINGULAIR (montelukast)		
LIPOTROPICS, OTHER (non-statins) *Implement 7/1/05*	**BILE ACID SEQUESTRANTS**		The preferred agents must be tried before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present. Zetia, as monotherapy, will only be approved for patients who cannot take statins or other preferred agents. Zetia and Welchol will be approved for add-on therapy only after an insufficient response to the maximum tolerable dose of a statin after 12 weeks of therapy. If patients require the addition of Zetia to Zocor to achieve goal, use of the combination product, Vytorin, will be required. If patients are on
	cholestyramine COLESTID (colestipol)	QUESTRAN (cholestyramine) WELCHOL (colesevalam)	
	CHOLESTEROL ABSORPTION INHIBITORS		
		ZETIA (ezetimibe)	
	FIBRIC ACID DERIVATIVES		

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	gemfibrozil TRICOR (fenofibrate)	ANTARA (fenofibrate) LOFIBRA (fenofibrate) LOPID (gemfibrozil) TRIGLIDE (fenofibrate)[NR]	other statins and require the addition of Zetia, patients will not be required to switch the statin that they have been using.
	NIACIN		
	niacin NIASPAN (niacin)	NIACELS (niacin) NIADELAY (niacin) SLO-NIACIN (niacin)	
LIPOTROPICS, STATINS *Implement 7/1/05*	**STATINS**		One of the preferred statins must be tried before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present.
	ALTOPREV (lovastatin) CRESTOR (rosuvastatin) LESCOL (fluvastatin) LESCOL XL (fluvastatin) ZOCOR (simvastatin)	LIPITOR (atorvastatin) lovastatin MEVACOR (lovastatin) PRAVACHOL (pravastatin)	
	STATIN COMBINATIONS		
	ADVICOR (lovastatin/niacin) VYTORIN (ezetimibe/stimvastatin)	CADUET (atorvastatin/amlodipine) PRAVIGARD PAC (pravastatin/ASA)	
MACROLIDES/KETOLIDES (Oral) *Implement 10/3/05*	**MACROLIDES**		**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.**
	BIAXIN XL (clarithromycin) clarithromycin erythromycin (base, ethylsuccinate, stearate) ZITHROMAX (azithromycin) ZMAX Suspension (azithromycin)	BIAXIN (clarithromycin) DYNABAC (dirithromycin) E.E.S. (erythromycin ethylsuccinate) E-MYCIN (erythromycin) ERYC (erythromycin) ERYPED (erythromycin ethylsuccinate) ERY-TAB (erythromycin) ERYTHROCIN (erythromycin stearate) erythromycin estolate PCE (erythromycin)	
	KETOLIDES		
		KETEK (telithromycin)	**Requests for Ketek will be authorized if there is documentation of the use of any antibiotic within the past 28 days.**

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MULTIPLE SCLEROSIS AGENTS[CL] *Implement 7/1/05*	AVONEX (interferon beta-1a) BETASERON (interferon beta-1b) REBIF (interferon beta-1a)	COPAXONE (glatiramer)	Patients already on non-preferred agents will receive authorization for those agents for one year. Patients starting therapy in this class will be required to try the preferred agents unless one of the exceptions on the PA form is present.
NSAIDS *Implement 10/3/05*	**NONSELECTIVE**		Non-preferred agents will only be approved after the preferred agents have been tried unless one of the exceptions on the PA form is present. COX II Selectives: Must score a minimum of 13 on the GI Risk Scale.
	diclofenac etodolac fenoprofen flurbiprofen ibuprofen (Rx and OTC) indomethacin ketoprofen ketorolac naproxen (Rx only) oxaprozin piroxicam sulindac tolmetin	ADVIL (ibuprofen) ANAPROX (naproxen) ANSAID (flurbiprofen) CATAFLAM (diclofenac) CLINORIL (sulindac) DAYPRO (oxaprozin) FELDENE (piroxicam) INDOCIN (indomethacin) LODINE (etodolac) meclofenamate MOTRIN (ibuprofen) nabumetone NALFON (fenoprofen) NAPRELAN (naproxen) NAPROSYN (naproxen) NUPRIN (ibuprofen) ORUDIS (ketoprofen) ORUVAIL (ketoprofen) PONSTEL (meclofenamate) RELAFEN (nabumetone) TOLECTIN (tolmetin) TORADOL (ketorolac) VOLTAREN (diclofenac)	
	NSAID/GI PROTECTANT COMBINATIONS		
		ARTHROTEC (diclofenac/misoprostol) PREVACID NAPRAPAC (naproxen/lansoprazole)	
	COX-II SELECTIVE[CL]		
		CELEBREX (celecoxib) MOBIC (meloxicam)	

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OPHTHALMIC ANTIBIOTICS *Implement 10/3/05*	**FLUOROQUINOLONES**		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.
	ciprofloxacin VIGAMOX (moxifloxacin)	CILOXAN (ciprofloxacin) OCUFLOX (ofloxacin) ofloxacin QUIXIN (levofloxacin) ZYMAR (gatifloxacin)	
	OTHER SINGLE AGENTS		
	bacitracin erythromycin gentamicin polymyxin B sulfacetamide tobramycin	BLEPH-10 (sulfacetamide) CETAMIDE (sulfacetamide) CHLOROMYCETIN (chloramphenicol) CHLOROPTIC (chloramphenicol) GARAMYCIN (gentamicin) GENOPTIC (gentamicin) ILOTYCIN (erythromycin) TOBREX (tobramycin)	
	COMBINATION AGENTS		
	neomycin/polymyxin/bacitracin neomycin/polymyxin/gramicidin polymyxin/bacitracin polymyxin/trimethoprim	NEOSPORIN (neomycin/polymyxin/bacitracin) NEOSPORIN (neomycin/polymyxin/gramicidin) POLYSPORIN (polymyxin/bacitracin) POLYTRIM (polymyxin/trimethoprim) TERAK W/ POLYMYXIN (oxytetracycline/polymyxin) TERRAMYCIN W/ POLYMYXIN (oxytetracycline/polymyxin)	
OPHTHALMICS FOR ALLERGIC CONJUNCTIVITIS *Implement 10/3/05*	ACULAR (ketorolac) ALREX (loteprednol) cromolyn ELESTAT (epinastine) PATANOL (olopatadine)	ALOCRIL (nedocromil) ALAMAST (pemirolast) ALOMIDE (lodoxamide) CROLOM (cromolyn) EMADINE (emedastine) LIVOSTIN (levocabastine) OPTICROM (cromolyn) OPTIVAR (azelastine) ZADITOR (ketotifen)	All of the preferred agents must be tried before non-preferred agents will be authorized, unless one of the exceptions on the PA form is present.

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OPHTHALMICS, GLAUCOMA AGENTS *Implement 10/3/05*	**PARASYMPATHOMIMETICS**		Authorization for a non-preferred agent will only be given if there is an allergy to the preferred agents.
	CARBOPTIC (carbachol) ISOPTO CARBACHOL (carbachol) MIOSTAT (carbachol) PHOSPHOLINE IODIDE (echothiophate iodide) pilocarpine	ISOPTO CARPINE (pilocarpine) PILOCAR (pilocarpine) PILOPINE HS (pilocarpine)	
	SYMPATHOMIMETICS		
	ALPHAGAN P (brimonidine) brimonidine dipivefrin	ALPHAGAN (brimonidine) EPIFRIN (epinephrine) PROPINE (dipivefrin)	
	BETA BLOCKERS		
	BETIMOL (timolol) BETOPTIC S (betaxolol) betaxolol carteolol levobunolol metipranolol timolol	BETAGAN (levobunolol) BETOPTIC (betaxolol) ISTALOL (timolol) OCUPRESS (carteolol) OPTIPRANOLOL (metipranolol) TIMOPTIC (timolol)	
	CARBONIC ANHYDRASE INHIBITORS		
	AZOPT (brinzolamide) TRUSOPT (dorzolamide)		
	PROSTAGLANDIN ANALOGS		
	LUMIGAN (bimatoprost) TRAVATAN (travoprost)	RESCULA (unoprostone) XALATAN (latanoprost)	
	COMBINATION AGENTS		
	COSOPT (dorzolamide/timolol)	E-PILO-1 (pilocarpine/epinephrine)	
OTIC ANTIBIOTIC PREPARATIONS *Effective 7/1/05*	CIPRODEX (ciprofloxacin/dexamethasone) COLY-MYCIN S (neomycin/hydrocortisone) FLOXIN (ofloxacin) neomycin/polymyxin/hydrocortisone	CIPRO HC (ciprofloxacin/hydrocortisone) CORTISPORIN (neomycin/polymyxin/hydrocortisone) CORTISPORIN TC (neomycin/hydrocortisone) PEDIOTIC (neomycin/polymyxin/hydrocortisone)	All of the preferred agents must be tried before a non-preferred agent will be approved unless one of the exceptions on the PA form is present.

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PHOSPHATE BINDERS *Implement 7/1/05*	FOSRENOL (lanthanum) MAGNEBIND 400 (magnesium/calcium carbonate) PHOSLO (calcium acetate) RENAGEL (sevelamer)		
PLATELET AGGREGATION INHIBITORS *Implement 10/3/05*	AGGRENOX (dipyridamole/ASA) PLAVIX (clopidogrel)	dipyridamole PERSANTINE (dipyridamole) TICLID (ticlopidine) ticlopidine	All of the preferred agents must be tried before a non-preferred agent will be approved unless one of the exceptions on the PA form is present.
PROTON PUMP INHIBITORS (Oral) *Implement 7/1/05*	PREVACID (lansoprazole)	ACIPHEX (rabeprazole) NEXIUM (esomeprazole) omeprazole PRILOSEC (omeprazole) PRILOSEC OTC (omeprazole) PROTONIX (pantoprazole) ZEGERID (omeprazole)	The preferred agent must be tried before a non-preferred agent will be approved unless one of the exceptions on the PA form is present. Prevacid given more than once daily does require a prior authorization.
SEDATIVE HYPNOTICS *Implement 7/1/05*	**BENZODIAZEPINES**		
	RESTORIL 7.5 mg (temazepam) temazepam	DALMANE (flurazepam) DORAL (quazepam) estazolam flurazepam HALCION (triazolam) PROSOM (estazolam) RESTORIL 15, 22.5, 30 mg (temazepam) triazolam	
	OTHERS		
	SONATA (zaleplon)	AMBIEN (zolpidem) AQUA CHLORAL (chloral hydrate) chloral hydrate LUNESTA (eszolpiclone) [NR] SOMNOTE (chloral hydrate)	

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STIMULANTS AND RELATED AGENTS *Implement 10/3/05*	**AMPHETAMINES**		Except for Strattera, PA is required for adults >18 years. One of the preferred agents in each group (amphetamines and non-amphetamines) must be tried before a non-preferred agent will be authorized. Amphetamines will be authorized for the treatment of depression only after documented failure of multiple antidepressants. Provigil will only be approved for patients >16 years of age with a diagnosis of narcolepsy. Straterra will not be approved for concurrent administration with amphetamines or methyphenidates, exept for 30 days or less for tapering purposes. Only two doses of each strength, or two concurrent doses of any strength, and a maximum of one dose of a 60 mg capsule, will be approved in a 34-day period.
	ADDERALL XR (amphetamine salt combination) amphetamine salt combination dextroamphetamine	ADDERALL (amphetamine salt combination) DESOXYN (methamphetamine) DEXEDRINE (dextroamphetamine) DEXTROSTAT(dextroamphetamine)	
	NON-AMPHETAMINE		
	CONCERTA (methylphenidate) FOCALIN (dexmethylphenidate) FOCALIN XR (dexmethylphenidate) METADATE CD (methylphenidate) methylphenidate RITALIN LA (methylphenidate) STRATTERA (atomoxetine)	METADATE ER (methylphenidate) pemoline PROVIGIL (modafanil) RITALIN (methylphenidate) RITALIN-SR (methylphenidate)	
ULCERATIVE COLITIS AGENTS *Implement 7/1/05*	**ORAL**		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.
	COLAZAL (balsalazide) PENTASA (mesalamine) sulfasalazine	ASACOL (mesalamine) AZULFIDINE (sulfasalazine) DIPENTUM (olsalazine)	
	RECTAL		
	mesalamine	CANASA (mesalamine) ROWASA (mesalamine)	