THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ACNE AGENTS, TOPICAL	**ANTIBIOTICS**		A trial of at least 30 days each with at least one preferred retinoid and two unique chemical entities in each of the other two subclasses, including the generic version of a requested non-preferred product, will be 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.) PA is required after 17 years of age for tretinoin products.
	AKNE-MYCIN (erythromycin) clindamycin erythromycin	CLEOCIN-T (clindamycin) CLINDAGEL (clindamycin) CLINDAREACH (clindamycin) EVOCLIN (clindamycin)	
	RETINOIDS		
	RETIN A (tretinoin) CL RETIN-A MICRO (tretinoin) CL TAZORAC (tazarotene) tretinoin CL	DIFFERIN (adapalene)	
	OTHERS		
	AZELEX (azelaic acid) BENZAC WASH (benzoyl peroxide) BENZASHAVE (benzoyl peroxide) benzoyl peroxide benzoyl peroxide/urea DUAC (benzoyl peroxide/ clindamycin) erythromycin/benzoyl peroxide sodium sulfacetamide	BENZACLIN GEL (benzoyl peroxide/clindamycin) BENZAGEL (benzoyl peroxide) BENZAMYCIN PAK (benzoyl peroxide/erythromycin) BENZIQ (benzoyl peroxide) BREVOXYL (benzoyl peroxide) CLINAC BPO (benzoyl peroxide) DESQUAM-X (benzoyl peroxide) INOVA (benzoyl peroxide) INOVA 4/1 (benzoyl peroxide/salicyclic acid) KLARON (sodium sulfacetamide) LAVOCLEN (benzoyl peroxide) NEOBENZ MICRO (benzoyl peroxide) NUOX (benzoyl peroxide/sulfur) PLEXION (sulfacetamide sodium/sulfur) sulfacetamide sodium/sulfur in urea vehicle sulfacetamide sodium/sulfur w/sunscreens SULFOXYL (benzoyl peroxide/sulfur) TRIAZ (benzoyl peroxide) ZACLIR (benzoyl peroxide) ZIANA (clindaymcyin/tretinoin) ZODERM (benzoyl peroxide)	

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.
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
ALZHEIMER'S AGENTS	**CHOLINESTERASE INHIBITORS**		A trial of a preferred agent will be required before a non-preferred agent In this class will be authorized.
	ARICEPT (donepezil) ARICEPT ODT(donepezil) EXELON (rivastigmine)	COGNEX (tacrine) RAZADYNE (galantamine) RAZADYNE ER (galantamine)	
	NMDA RECEPTOR ANTAGONIST		
	NAMENDA (memantine)		
ANALGESICS, NARCOTIC - SHORT ACTING (Non-parenteral)	APAP/codeine ASA/codeine codeine dihydrocodeine/ APAP/caffeine hydrocodone/APAP hydrocodone/ibuprofen hydromorphone levorphanol morphine oxycodone oxycodone/APAP oxycodone/ASA pentazocine/APAP pentazocine/naloxone propoxyphene/APAP ROXICET (oxycodone/acetaminophen) tramadol tramadol/APAP VOPAC (codeine/acetaminophen)	ACTIQ (fentanyl) butalbital/APAP/caffeine/codeine butalbital/ASA/caffeine/codeine butorphanol COMBUNOX (oxycodone/ibuprofen) DARVOCET (propoxyphene/APAP) DARVON (propoxyphene) DEMEROL (meperidine) DILAUDID (hydromorphone) fentanyl FENTORA (fentanyl) FIORICET W/ CODEINE (butalbital/APAP/caffeine/codeine) FIORINAL W/ CODEINE (butalbital/ASA/caffeine/codeine) LORCET, LORTAB (hydrocodone/APAP) LYNOX (oxycodone/APAP) meperidine OPANA (oxymorphone) OXYFAST, OXYIR (oxycodone) PANLOR (dihydrocodeine/ APAP/caffeine) PERCOCET (oxycodone/APAP) PERCODAN (oxycodone/ASA) propoxyphene ROXANOL (morphine) TALACEN (pentazocine/APAP) TALWIN NX (pentazocine/naloxone) TYLENOL W/CODEINE (APAP/codeine) ULTRACET (tramadol/APAP) ULTRAM (tramadol) VICODIN (hydrocodone/APAP) VICOPROFEN (hydrocodone/ibuprofen) XODOL (hydrocone/acetaminophen) ZYDONE (hydrocodone/acetaminophen)	A trial of at least four (4) chemically distinct (based on narcotic ingredient only) preferred agents, including the generic formulation of a requested non-preferred product, must be tried before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present. Fentanyl lozenges will only be approved as an adjunct to a long-acting agent. Fentanyl lozenges will not be approved for monotherapy. Limits: Quantities exceeding 240 tablets per 30 days (8 tablets/day) for agents containing 500 mg of acetaminophen will require a prior authorization.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ANALGESICS, NARCOTIC - LONG ACTING (Non-parenteral)	fentanyl KADIAN (morphine) methadone morphine ER	AVINZA (morphine) DURAGESIC (fentanyl) MS CONTIN (morphine) OPANA ER (oxymorphone) ORAMORPH SR (morphine) oxycodone ER OXYCONTIN (oxycodone) ULTRAM ER (tramadol)	A total of four (4) preferred narcotic analgesics, **including at least one long-acting agent**, must be tried for at least six (6) days before a non-preferred agent will be authorized unless one of the exceptions on the PA 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. Exception: Oxycodone ER will be authorized if a diagnosis of cancer is submitted without a trial of the preferred agents.
ANDROGENIC AGENTS	ANDRODERM (testosterone) ANDROGEL (testosterone)	TESTIM (testosterone)	The non-preferred agents will be approved only if one of the exceptions on the PA form is present.
ANGIOTENSIN MODULATORS	ACE INHIBITORS		Each of the preferred agents in the corresponding group and the generic formulation of the requested non-preferred agent, with the exception of Direct Renin Inhibitors, 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.
	ALTACE (ramipril) benazepril captopril enalapril fosinopril lisinopril quinapril	ACCUPRIL (quinapril) ACEON (perindopril) CAPOTEN (captopril) LOTENSIN (benazepril) MAVIK (trandolapril) moexipril MONOPRIL (fosinopril) PRINIVIL (lisinopril) ramipril trandolapril UNIVASC (moexipril) VASOTEC (enalapril) ZESTRIL (lisinopril)	
	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) moexepril/HCTZ MONOPRIL HCT (fosinopril/HCTZ) PRINZIDE (lisinopril/HCTZ) TARKA (trandolapril/verapamil) UNIRETIC (moexepril/HCTZ) VASERETIC (enalapril/HCTZ) ZESTORETIC (lisinopril/HCTZ)	

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.
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
	ANGIOTENSIN II RECEPTOR BLOCKERS (ARBs)		
	AVAPRO (irbesartan) BENICAR (olmesartan) COZAAR (losartan) DIOVAN (valsartan) MICARDIS (telmisartan)	ATACAND (candesartan) TEVETEN (eprosartan)	
	ARB COMBINATIONS		
	AVALIDE (irbesartan/HCTZ) BENICAR-HCT (olmesartan/HCTZ) DIOVAN-HCT (valsartan/HCTZ) EXFORGE (valsartan/amlodipine**)** HYZAAR (losartan/HCTZ) MICARDIS-HCT (telmisartan/HCTZ)	ATACAND-HCT (candesartan/HCTZ) AZOR **(olmesartan/amlodipine)** TEVETEN-HCT (eprosartan/HCTZ)	
	DIRECT RENIN INHIBITORS		
		TEKTURNA (aliskerin)	A thirty-day trial of one of the preferred ACE, ARB, or combination agents, at the maximum tolerable dose, is required before Tekturna will be approved.
ANTICOAGULANTS, INJECTABLE [CL]	ARIXTRA (fondaparinux) FRAGMIN (dalteparin) LOVENOX (enoxaparin)	INNOHEP (tinzaparin)	A trial 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.

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.
[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
ANTICONVULSANTS	**ADJUVANTS**		Treatment naive patients must have a trial of a preferred agent before a non-preferred agent in its corresponding class will be authorized. Additions to that therapy will require a trial of preferred agent in its respective class unless one of the exceptions on the PA form is present.
	carbamazepine CARBATROL (carbamazepine) DEPAKOTE (divalproex) DEPAKOTE ER (divalproex) DEPAKOTE SPRINKLE (divalproex) FELBATOL (felbamate) gabapentin GABITRIL (tiagabine) KEPPRA (levetiracetam) LAMICTAL (lamotrigine) LYRICA (pregabalin) TOPAMAX (topiramate) TRILEPTAL (oxcarbazepine) valproic acid zonisamide	DEPAKENE (valproic acid) EQUETRO (carbamazepine) lamotrigine NEURONTIN (gabapentin) oxcarbazepine TEGRETOL (carbamazepine) TEGRETOL XR (carbamazepine) ZONEGRAN (zonisamide)	
	BARBITURATES		
	mephobarbital phenobarbital primidone	MEBARAL (mephobarbital) MYSOLINE (primidone)	
	BENZODIAZEPINES		
	clonazepam DIASTAT (diazepam rectal) diazepam	KLONOPIN (clonazepam)	
	HYDANTOINS		
	DILANTIN INFATABS (phenytoin) PEGANONE (ethotoin) phenytoin	CEREBYX (fosphenytoin) DILANTIN (phenytoin) EPITOL (phenytoin) PHENYTEK (phenytoin)	
	SUCCINIMIDES		
	CELONTIN (methsuximide) ethosuximide	ZARONTIN (ethosuximide)	

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.
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
ANTIDEPRESSANTS, OTHER (second generation, non-SSRI)	bupropion SR CYMBALTA (duloxetine) EFFEXOR XR (venlafaxine) mirtazapine trazodone	bupropion IR bupropion XL DESYREL (trazodone) EFFEXOR (venlafaxine) EMSAM (selegiline) nefazodone REMERON (mirtazapine) venlafaxine 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 an SSRI and a preferred agent in this class unless one of the exceptions on the PA form is present.
ANTIDEPRESSANTS, SSRIs	citalopram fluoxetine fluvoxamine paroxetine sertraline	CELEXA (citalopram) LEXAPRO (escitalopram) PAXIL (paroxetine) PAXIL CR (paroxetine) PEXEVA (paroxetine) PROZAC (fluoxetine) RAPIFLUX (fluoxetine) SARAFEM (fluoxetine) ZOLOFT (sertraline)	A trial of two of the preferred agents will be required, for at least 30 days, 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 authorization to continue that drug.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ANTIEMETICS, ORAL	**5HT3 RECEPTOR BLOCKERS**		A 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. PA is required when limits are exceeded.
	ondansetron ZOFRAN (ondansetron) ZOFRAN ODT (ondansetron)	ANZEMET (dolasetron) KYTRIL (granisetron) ondansetron ODT	
	CANNABINOIDS		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 conventional treatments such as promethazine or ondansetron and are over 18 years of age. Marinol will be authorized only for the treatment of anorexia associated with weight loss in patients with AIDS or cancer and unresponsive to megestrol, the prophylaxis of chemotherapy induced nausea and vomiting unresponsive to ondansetron or promethazine and for patients between the ages of 18 and 65 years of age.
		CESAMET (nabilone) MARINOL (dronabinol)	
	SUBSTANCE P ANTAGONISTS		PA is required when limits are exceeded.
	EMEND (aprepitant)		
ANTIFUNGALS, ORAL	clotrimazole fluconazole* ketoconazole [CL] nystatin terbinafine [CL]	ANCOBON (flucytosine) DIFLUCAN (fluconazole) GRIFULVIN V (griseofulvin) griseofulvin GRIS-PEG (griseofulvin) itraconazole LAMISIL (terbinafine) MYCELEX (clotrimazole) MYCOSTATIN Tablets (nystatin) NIZORAL (ketoconazole) NOXAFIL (posaconazole) 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 6 years of age for the treatment of tinea capitis.

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.
[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
ANTIFUNGALS, TOPICAL	**ANTIFUNGALS**		Two 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.
	econazole ketoconazole MENTAX (butenafine) NAFTIN (naftifine) nystatin	ciclopirox ERTACZO (sertaconazole) EXELDERM (sulconazole) LOPROX (ciclopirox) MYCOSTATIN (nystatin) NIZORAL (ketoconazole) OXISTAT (oxiconazole) PENLAC (ciclopirox) SPECTAZOLE (econazole) VUSION (miconazole/petrolatum/zinc oxide) XOLEGEL (ketoconazole)	
	ANTIFUNGAL/STEROIDCOMBINATIONS		
	clotrimazole/betamethasone nystatin/triamcinolone	LOTRISONE (clotrimazole/betamethasone) MYCOLOG (nystatin/triamcinolone)	
ANTIHISTAMINES, MINIMALLY SEDATING	**ANTIHISTAMINES**		A preferred agent (in the age appropriate dosage form), including the generic formulation of a requested non-preferred agent, must be tried before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present.
	ALAVERT (loratadine) cetirizine (OTC) loratadine TAVIST-ND (loratadine)	ALLEGRA (fexofenadine) CLARINEX Tablets (desloratadine) CLARINEX REDITABS (desloratadine) CLARINEX Syrup (desloratadine) CLARITIN (loratadine) fexofenadine XYZAL (levocetirizine) ZYRTEC (Rx and OTC) (cetirizine) ZYRTEC SYRUP (Rx and OTC) (cetirizine)	
	ANTIHISTAMINE/DECONGESTANT COMBINATIONS		
	ALAVERT-D (loratadine/pseudoephedrine) cetirizine /pseudoephedrine (OTC) loratadine/pseudoephedrine SEMPREX-D (acrivastine/ pseudoephedrine)	ALLEGRA-D (fexofenadine/pseudoephedrine) CLARINEX-D (desloratadine/pseudoephedrine) CLARITIN-D (loratadine/pseudoephedrine) ZYRTEC-D (Rx and OTC) (cetirizine/pseudoephedrine)	

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.
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
ANTIMIGRAINE AGENTS, TRIPTANS	AMERGE (naratriptan) IMITREX (sumatriptan) MAXALT (rizatriptan) RELPAX (eletriptan)	AXERT (almotriptan) FROVA (frovatriptan) ZOMIG (zolmitriptan)	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 apply for this drug class.
ANTIPARKINSON'S AGENTS (Oral)	**ANTICHOLINERGICS**		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.
	benztropine KEMADRIN (procyclidine) trihexyphenidyl	COGENTIN (benztropine)	
	COMT INHIBITORS		
		COMTAN (entacapone) TASMAR (tolcapone)	
	DOPAMINE AGONISTS		
	REQUIP (ropinirole)	MIRAPEX (pramipexole)	
	OTHER ANTIPARKINSON'S AGENTS		
	carbidopa/levodopa selegiline STALEVO (levodopa/carbidopa/entacapone)	AZILECT (rasagiline) ELDEPRYL (selegiline) PARCOPA (levodopa/carbidopa) SINEMET (levodopa/carbidopa) ZELAPAR (selegiline)	
ANTIPSYCHOTICS, ATYPICAL (Oral)	**ORAL**		Treatment naïve 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. Upon discharge, hospitalized patients stabilized on non-preferred agents will receive authorization to continue these drugs for labeled indications and at recommended dosages.
	clozapine GEODON (ziprasidone) INVEGA (paliperidone) RISPERDAL (risperidone) SEROQUEL (quetiapine) SEROQUEL XR (quetiapine)	ABILIFY (aripiprazole) CLOZARIL (clozapine) FAZACLO (clozapine) ZYPREXA (olanzapine)	
	ATYPICAL ANTIPSYCHOTIC/SSRI COMBINATIONS		
		SYMBYAX (olanzapine/fluoxetine)	

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.
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
ANTIVIRALS (Oral)	**ANTI HERPES**		All of the appropriate preferred agents must be tried before the non-preferred agents will be authorized unless one of the exceptions on the PA form is present. All of the appropriate preferred agents must be tried before the non-preferred agents will be authorized unless one of the exceptions on the PA form is present.
	acyclovir VALTREX (valacyclovir)	FAMVIR (famciclovir) ZOVIRAX (acyclovir)	
	ANTI INFLUENZA		
	amantadine	FLUMADINE (rimantadine) RELENZA (zanamivir) rimantadine SYMMETREL (amantadine) TAMIFLU (oseltamivir)	
ATOPIC DERMATITIS	ELIDEL (pimecrolimus) PROTOPIC (tacrolimus)		
BETA BLOCKERS (Oral)	**BETA BLOCKERS**		A trial of each of three chemically distinct preferred agents, including the generic formulation of a requested non-preferred product, is required before one of the non-preferred agents will be approved, unless one of the exceptions on the PA form is present. 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.
	acebutolol atenolol betaxolol bisoprolol metoprolol metoprolol ER nadolol pindolol propranolol propranolol ER sotalol timolol	BETAPACE (sotalol) BLOCADREN (timolol) BYSTOLIC (nebivolol) CARTROL (carteolol) CORGARD (nadolol) INDERAL LA (propranolol) INNOPRAN XL (propranolol) KERLONE (betaxolol) LEVATOL (penbutolol) LOPRESSOR (metoprolol) SECTRAL (acebutolol) TENORMIN (atenolol) TOPROL XL (metoprolol) ZEBETA (bisoprolol)	
	BETA- AND ALPHA-BLOCKERS		
	carvedilol labetalol	**COREG (carvedilol)** COREG CR (carvedilol) TRANDATE (labetalol)	

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.
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
BLADDER RELAXANT PREPARATIONS	ENABLEX (darifenacin) oxybutynin oxybutynin ER OXYTROL (oxybutynin) SANCTURA (trospium) SANCTURA XR (trospium) VESICARE (solifenacin)	DETROL (tolterodine) DETROL LA (tolterodine) DITROPAN (oxybutynin) DITROPAN XL (oxybutynin)	A trial of at least one of each of the chemically distinct preferred agents 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	**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. Evista will be approved for postmenopausal women with osteoporosis or at high risk for invasive breast cancer.
	FOSAMAX (alendronate) FOSAMAX PLUS D (alendronate/vitamin D)	ACTONEL (risedronate) ACTONEL WITH CALCIUM (risedronate/calcium) BONIVA (ibandronate) DIDRONEL (etidronate)	
	OTHER BONE RESORPTION SUPPRESSION AND RELATED AGENTS		
	MIACALCIN (calcitonin)	EVISTA (raloxifene) FORTEO (teriparatide) FORTICAL (calcitonin)	
BPH AGENTS	**5-ALPHA-REDUCTASE (5AR) INHIBITORS**		A trial of at least two (2) chemically distinct preferred agents, including the generic formulation of a requested non-preferred agent, must be tried before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present.
	AVODART (dutasteride)	finasteride PROSCAR (finasteride)	
	ALPHA BLOCKERS		
	doxazosin FLOMAX (tamsulosin) terazosin UROXATRAL (alfuzosin)	CARDURA (doxazosin) CARDURA XL (doxazosin) HYTRIN (terazosin)	
BRONCHODILATORS, ANTICHOLINERGIC	**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, albuterol/ipratropium will be approved if the combined volume of albuterol and ipratropium nebules is inhibitory.
	ATROVENT HFA (ipratropium) ipratropium SPIRIVA (tiotropium)	ATROVENT Inhalation Solution (ipratropium)	
	ANTICHOLINERGIC-BETA AGONIST COMBINATIONS		
	COMBIVENT (albuterol/ipratropium)	albuterol/ipratropium DUONEB (albuterol/ipratropium)	

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.
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
BRONCHODILATORS, BETA AGONIST	**INHALATION SOLUTION**		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 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. **No PA is required for ACCUNEB for children up to 5 years of age.
	albuterol	ACCUNEB (albuterol)** BROVANA (arformoterol) [NR] metaproterenol PERFOROMIST (formoterol)[NR] PROVENTIL (albuterol) XOPENEX (levalbuterol)	
	INHALERS, LONG-ACTING		
	FORADIL (formoterol)	SEREVENT (salmeterol)	
	INHALERS, SHORT-ACTING		
	albuterol CFC MAXAIR (pirbuterol) PROAIR HFA (albuterol) PROVENTIL HFA (albuterol) VENTOLIN HFA (albuterol) XOPENEX HFA (levalbuterol)	ALUPENT (metaproterenol) PROVENTIL (albuterol)	
	ORAL		
	albuterol terbutaline	BRETHINE (terbutaline) metaproterenol VOSPIRE ER (albuterol)	

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.
[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
CALCIUM CHANNEL BLOCKERS (Oral)	**LONG-ACTING**		The preferred agents must be tried before a non-preferred agent will be approved.
	amlodipine CARDIZEM LA (diltiazem) diltiazem DYNACIRC CR (isradipine) felodipine ER 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)	
	SHORT-ACTING		
	diltiazem verapamil	ADALAT (nifedipine) CALAN (verapamil) CARDENE (nicardipine) CARDIZEM (diltiazem) DYNACIRC (isradipine) isradipine nicardipine nimodipine nifedipine NIMOTOP (nimodipine) PROCARDIA (nifedipine)	
CEPHALOSPORINS AND RELATED ANTIBIOTICS (Oral)	**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		
	CEPHALOSPORINS		
	cefaclor cefadroxil cefpodoxime cefprozil cefuroxime cephalexin OMNICEF (cefdinir) SPECTRACEF (cefditoren)	CECLOR (cefaclor) CEDAX (ceftibuten) cefdinir CEFTIN (cefuroxime) CEFZIL (cefprozil) DURICEF (cefadroxil) KEFLEX (cephalexin) PANIXINE (cephalexin) RANICLOR (cefaclor) SUPRAX (cefixime) VANTIN (cefpodoxime)	

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.
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
CYTOKINE & CAM ANTAGONISTS [CL]	ENBREL (etanercept) HUMIRA (adalimumab) KINERET (anakinra) RAPTIVA (efalizumab)		
ERYTHROPOIESIS STIMULATING PROTEINS [CL]	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.
FLUOROQUINOLONES, ORAL	AVELOX (moxifloxacin) CIPRO (ciprofloxacin) Suspension ciprofloxacin ciprofloxacin ER LEVAQUIN (levofloxacin)	CIPRO (ciprofloxacin) Tablets CIPRO XR (ciprofloxacin) FACTIVE (gemifloxacin) FLOXIN (ofloxacin) NOROXIN (norfloxacin) ofloxacin PROQUIN XR (ciprofloxacin)	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.
GENITAL WARTS AGENTS	ALDARA (imiquimod)	CONDYLOX (podofilox) podofilox VEREGEN (sinecatechins)	The preferred agent must be tried before a non-preferred agent will be authorized unless on of the exceptions on the PA form is present.
GLUCOCORTICOIDS, INHALED	**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. When children who have been stabilized on Pulmicort Respules reach age 9, prescriptions for the Pulmicort inhaler will be authorized for them.
	AEROBID (flunisolide) AEROBID-M (flunisolide) ASMANEX (mometasone) AZMACORT (triamcinolone) FLOVENT HFA (fluticasone) QVAR (beclomethasone)	PULMICORT (budesonide)	
	GLUCOCORTICOID/BRONCHODILATOR COMBINATIONS		
	ADVAIR (fluticasone/salmeterol) ADVAIR HFA (fluticasone/salmeterol)	SYMBICORT(budesonide/formoterol)	

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
GROWTH HORMONE [CL]	GENOTROPIN (somatropin) NORDITROPIN (somatropin) NUTROPIN (somatropin) NUTROPIN AQ (somatropin) SAIZEN (somatropin) TEV-TROPIN (somatropin)	HUMATROPE (somatropin) INCRELEX (mecasermin) OMNITROPE (somatropin) SEROSTIM (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.
HEPATITIS B TREATMENTS	EPIVIR HBV (lamivudine) HEPSERA (adefovir) TYZEKA (telbivudine)	BARACLUDE (entecavir)	One of the preferred agents must be tried before the non-preferred agent will be authorized unless one of the exceptions on the PA form is present.
HEPATITIS C TREATMENTS [CL]	PEGASYS (pegylated interferon) ribavirin	COPEGUS (ribavirin) INFERGEN (consensus interferon) PEG-INTRON (pegylated interferon) REBETOL (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.
HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS	BYETTA (exenatide) JANUMET (sitagliptin/metformin) JANUVIA (sitagliptin) SYMLIN (amylin)		Byetta and Symlin are both subject to the following step therapy edits: Byetta-Current history of therapy with a sufonlyurea, thiazolindinedione (TZD), and/or metformin. No gaps of therapy greater than 30 days in the past 180 days. Symlin- History of insulin utilization in the past 90 days. No gaps in therapy of greater than 30 days.
HYPOGLYCEMICS, INSULINS	HUMALOG (insulin lispro) HUMALOG MIX (insulin lispro/lispro protamine) HUMULIN (insulin) LANTUS (insulin glargine) LEVEMIR (insulin detemir) NOVOLIN (insulin) NOVOLOG (insulin aspart) NOVOLOG MIX (insulin aspart/aspart protamine)	APIDRA (insulin glulisine) HUMALOG KWIKPEN (insulin lispro) [NR]	To receive Apidra, patients must meet the following criteria: 1. be 18 years or older; 2. be currently on a regimen including a longer-acting or basal insulin. 3. have had a trial of a similar preferred agent, Novolog or Humulin, with documentation that the desired results were not achieved.
HYPOGLYCEMICS, MEGLITINIDES	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.

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.
[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
HYPOGLYCEMICS, TZDS	**THIAZOLIDINEDIONES**		
	ACTOS (pioglitazone) AVANDIA (rosiglitazone)		
	TZD COMBINATIONS		
	ACTOPLUS MET (pioglitazone/metformin) AVANDAMET (rosiglitazone/metformin) AVANDARYL (rosiglitazone/glimepiride) DUETACT (pioglitazone/glimepiride)		
IMPETIGO AGENTS, TOPICAL	ALTABAX (retapamulin) mupirocin bacitracin gentamycin sulfate	BACTROBAN (mupirocin) CORTISPORIN (bacitracin/neomycin/polymyxin/HC)	A trial of one of at least one preferred agent, including the generic formulation of a requested non-preferred agent, must be tried for 10 days before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present.
INTRANASAL RHINITIS AGENTS	**ANTICHOLINERGICS**		All of the preferred agents, in corresponding categories, 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		
	fluticasone propionate NASACORT AQ (triamcinolone) NASONEX (mometasone) VERAMYST (fluticasone furoate)	BECONASE AQ (beclomethasone) flunisolide FLONASE (fluticasone propionate) NASALIDE (flunisolide) NASAREL (flunisolide) RHINOCORT AQUA (budesonide)	
LEUKOTRIENE MODIFIERS	ACCOLATE (zafirlukast) SINGULAIR (montelukast)	ZYFLO (zileuton)	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.

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.
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
LIPOTROPICS, OTHER (non-statins)	**BILE ACID SEQUESTRANTS**		One of the preferred agents must be tried before a non-preferred agent in the corresponding category will be authorized. 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.
	cholestyramine colestipol	COLESTID (colestipol) QUESTRAN (cholestyramine) WELCHOL (colesevalam)	
	CHOLESTEROL ABSORPTION INHIBITORS		
		ZETIA (ezetimibe)	
	FATTY ACIDS		
		OMACOR (omega-3-acid ethyl esters)	
	FIBRIC ACID DERIVATIVES		
	fenofibrate gemfibrozil TRICOR (fenofibrate)	ANTARA (fenofibrate) LOFIBRA (fenofibrate) LOPID (gemfibrozil) TRIGLIDE (fenofibrate)	
	NIACIN		
	niacin NIASPAN (niacin)	NIACELS (niacin) NIADELAY (niacin) SLO-NIACIN (niacin)	
LIPOTROPICS, STATINS	**STATINS**		One of the preferred statins, including the generic formulation of a requested non-preferred agent, must be tried for 12 weeks before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present 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
	CRESTOR (rosuvastatin) LESCOL (fluvastatin) LESCOL XL (fluvastatin) LIPITOR (atorvastatin) lovastatin pravastatin simvastatin	ALTOPREV (lovastatin) MEVACOR (lovastatin) PRAVACHOL (pravastatin) ZOCOR (simvastatin)	
	STATIN COMBINATIONS		

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	ADVICOR (lovastatin/niacin) CADUET (atorvastatin/amlodipine)	**VYTORIN (ezetimibe/simvastatin)**	form is present. **Members on Vytorin 10/80 will be grandfathered on that therapy. Members on all other strengths of Vytorin will be grandfathered until 6/30/08 on that therapy, but their prescriptions will require prior authorization after that period.**
MACROLIDES/KETOLIDES (Oral)	**KETOLIDES**		Requests for telithromycin will be authorized if there is documentation of the use of any antibiotic within the past 28 days.
		KETEK (telithromycin)	
	MACROLIDES		
	azithromycin clarithromycin erythromycin	BIAXIN (clarithromycin) BIAXIN XL (clarithromycin) clarithromycin ER E.E.S. (erythromycin ethylsuccinate) E-MYCIN (erythromycin) ERYC (erythromycin) ERYPED (erythromycin ethylsuccinate) ERY-TAB (erythromycin) ERYTHROCIN (erythromycin stearate) erythromycin estolate PCE (erythromycin) ZITHROMAX (azithromycin) ZMAX (azithromycin)	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.
MULTIPLE SCLEROSIS AGENTS [CL]	AVONEX (interferon beta-1a) BETASERON (interferon beta-1b) COPAXONE (glatiramer) REBIF (interferon beta-1a)	TYSABRI (natalizumab)	A trial of a preferred agent will be required before a trial of a non-preferred agent will be approved. Tysabri will only be approved for members who meet the conditions and are enrolled the TOUCH Prescribing Program.

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.
[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
NSAIDS	**NONSELECTIVE**		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.
	diclofenac etodolac fenoprofen flurbiprofen ibuprofen (Rx and OTC) INDOCIN (indomethacin) (suspension only) indomethacin ketorolac naproxen (Rx only) oxaprozin piroxicam sulindac	ADVIL (ibuprofen) ANAPROX (naproxen) ANSAID (flurbiprofen) CATAFLAM (diclofenac) CLINORIL (sulindac) DAYPRO (oxaprozin) FELDENE (piroxicam) INDOCIN (indomethacin) ketoprofen LODINE (etodolac) meclofenamate mefenamic acid MOTRIN (ibuprofen) nabumetone NALFON (fenoprofen) NAPRELAN (naproxen) NAPROSYN (naproxen) NUPRIN (ibuprofen) ORUDIS (ketoprofen) PONSTEL (meclofenamate) tolmetin VOLTAREN (diclofenac)	
	NSAID/GI PROTECTANT COMBINATIONS		
		ARTHROTEC (diclofenac/misoprostol) PREVACID/NAPRAPAC (naproxen/lansoprazole)	
	COX-II SELECTIVE [CL]		COX-II selective NSAIDs will be approved for

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		CELEBREX (celecoxib) meloxicam MOBIC (meloxicam)	patients with a GI Risk Score of ≥13.
OPHTHALMIC ANTIBIOTICS	ciprofloxacin ofloxacin VIGAMOX (moxifloxacin)	AZASITE (azithromycin) [NR] CILOXAN (ciprofloxacin) OCUFLOX (ofloxacin) QUIXIN (levofloxacin) ZYMAR (gatifloxacin)	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.
OPHTHALMIC NSAIDS	ACULAR LS (ketorolac) ACULAR PF (ketorolac) flurbiprofen NEVANAC (nepafenac) XIBROM (bromfenac)	diclofenac	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.
OPHTHALMICS FOR ALLERGIC CONJUNCTIVITIS	ACULAR (ketorolac) ALAWAY (ketotifen) ALREX (loteprednol) cromolyn ELESTAT (epinastine) OPTIVAR (azelastine) PATADAY (olopatadine) PATANOL (olopatadine) ZADITOR OTC (ketotifen)	ALAMAST (pemirolast) ALOCRIL (nedocromil) ALOMIDE (lodoxamide) CROLOM (cromolyn) EMADINE (emedastine) ketotifen OPTICROM (cromolyn)	Two 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.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
OPHTHALMICS, GLAUCOMA AGENTS	**COMBINATION AGENTS**		Authorization for a non-preferred agent will only be given if there is an allergy to the preferred agents.
	COSOPT (dorzolamide/timolol)		
	BETA BLOCKERS		
	Betaxolol BETIMOL (timolol) BETOPTIC S (betaxolol) carteolol ISTALOL (timolol) levobunolol metipranolol timolol	BETAGAN (levobunolol) OPTIPRANOLOL (metipranolol) TIMOPTIC (timolol)	
	CARBONIC ANHYDRASE INHIBITORS		
	AZOPT (brinzolamide) TRUSOPT (dorzolamide)		
	PARASYMPATHOMIMETICS		
	CARBOPTIC (carbachol) ISOPTO CARBACHOL (carbachol) PHOSPHOLINE IODIDE (echothiophate iodide) pilocarpine	ISOPTO CARPINE (pilocarpine) PILOPINE HS (pilocarpine)	
	PROSTAGLANDIN ANALOGS		
	LUMIGAN (bimatoprost) TRAVATAN (travoprost) TRAVATAN-Z (travaprost)	XALATAN (latanoprost)	
	SYMPATHOMIMETICS		

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	ALPHAGAN P (brimonidine) brimonidine dipivefrin	ALPHAGAN (brimonidine) PROPINE (dipivefrin)	
OTIC FLUOROQUINOLONES	CIPRODEX (ciprofloxacin/dexamethasone) FLOXIN (ofloxacin)	CIPRO HC (ciprofloxacin/hydrocortisone) ofloxacin	Each 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.
PANCREATIC ENZYMES	PANCRECARB ULTRASE ULTRASE MT VIOKASE	CREON KUZYME LIPRAM PALCAPS PANCREASE PANGESTYME PANOKASE PLARETASE	A trial of at least 3 preferred agents, for at least 30 days each, 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. In all cases except cystic fibrosis, objective evidence of pancreatic insufficiency(fat malabsorption, etc.) must be documented.
PARATHYROID AGENTS	ergocalciferol calcitriol HECTOROL (doxercalciferol) ZEMPLAR (paricalcitol)	DRISDOL (ergocalciferol) ROCALTROL (calcitriol) SENSIPAR (cinacalcet)	A trial of a non-preferred agent will be required, for at least 30 days, before a non-preferred agent will be approved. Presciptions for Sensipar will be grandfathered.
PEDICULICIDES/ SCABICIDES, TOPICAL	EURAX (crotamiton) OVIDE (malathion) permethrins (Rx and OTC) pyrethrins-piperonyl butoxide	lindane	A trial of all three pediculicides (Ovide, permethrins, and pyrethrins-piperonyl butoxide) is required before lindane will be approved unless one of the exceptions on the PA form is present.
PHOSPHATE BINDERS	FOSRENOL (lanthanum) PHOSLO (calcium acetate) RENAGEL (sevelamer)	RENVELA (sevelamer carbonate) [NR]	A trial of at least two preferred agents will be required unless one of the exceptions on the PA form is present.
PLATELET AGGREGATION INHIBITORS	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.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
PROTON PUMP INHIBITORS	NEXIUM (esomeprazole) PREVACID Capsules (lansoprazole)	ACIPHEX (rabeprazole) omeprazole pantoprazole PREVACID Solu-Tabs (lansoprazole) PREVACID Suspension (lansoprazole) PRILOSEC (omeprazole) PROTONIX (pantoprazole) ZEGERID (omeprazole/sodium bicarbonate)	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. Prior authorization is not required for Prevacid Solu-Tabs for patients ≤8 years of age.
SEDATIVE HYPNOTICS	**BENZODIAZEPINES**		The preferred agent must be tried for 14 days before a nonpreferred agent will be authorized unless one of the exceptions on the PA form is present.
	temazepam	DALMANE (flurazepam) DORAL (quazepam) estazolam flurazepam HALCION (triazolam) PROSOM (estazolam) RESTORIL (temazepam) triazolam	
	OTHERS		
	zolpidem	AMBIEN (zolpidem) AMBIEN CR (zolpidem) AQUA CHLORAL (chloral hydrate) chloral hydrate LUNESTA (eszopiclone) ROZEREM (ramelteon) SOMNOTE (chloral hydrate) SONATA (zaleplon)	
STIMULANTS AND RELATED AGENTS	**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.
	ADDERALL XR (amphetamine salt combination) amphetamine salt combination dextroamphetamine VYVANSE (lisdexamphetamine)	ADDERALL (amphetamine salt combination) DESOXYN (methamphetamine) DEXEDRINE (dextroamphetamine) DEXTROSTAT (dextroamphetamine)	

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.
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
	NON-AMPHETAMINE		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. Strattera 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.
	CONCERTA (methylphenidate) DAYTRANA (methylphenidate) FOCALIN (dexmethylphenidate) FOCALIN XR (dexmethylphenidate) METADATE CD (methylphenidate) methylphenidate methylphenidate ER STRATTERA (atomoxetine)	dexmethylphenidate METADATE ER (methylphenidate) pemoline PROVIGIL (modafanil) RITALIN (methylphenidate) RITALIN LA (methylphenidate) RITALIN-SR (methylphenidate)	
ULCERATIVE COLITIS AGENTS	**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.
	ASACOL (mesalamine) COLAZAL (balsalazide) DIPENTUM (olsalazine) PENTASA (mesalamine) sulfasalazine	AZULFIDINE (sulfasalazine) LIALDA (mesalamine)	
	RECTAL		
	CANASA (mesalamine) mesalamine	ROWASA (mesalamine)	