THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ACNE AGENTS (Topical)[AP]			
	ANTI-INFECTIVE		
	AKNE-MYCIN (erythromycin) AZELEX (azelaic acid) clindamycin erythromycin sodium sulfacetamide	ACZONE (dapsone) CLEOCIN-T (clindamycin) EVOCLIN (clindamycin) KLARON (sodium sulfacetamide)	Thirty (30) day trials each of one preferred retinoid and two unique chemical entities in two other subclasses, including the generic version of a requested non-preferred product, are required before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present. (In cases of pregnancy, a trial of retinoids will not be required.)
	RETINOIDS		
	RETIN A liquid & Micro (tretinoin) TAZORAC (tazarotene) tretinoin cream, gel	adapalene AVITA (tretinoin) DIFFERIN (adapalene) RETIN-A cream, gel (tretinoin)	PA required after 17 years of age for tretinoin products.
	KERATOLYTICS (Benzoyl Peroxides)		
	benzoyl peroxide ETHEXDERM (benzoyl peroxide) OSCION (benzoyl peroxide)	BENZAC WASH (benzoyl peroxide) BREVOXYL (benzoyl peroxide) DESQUAM (benzoyl peroxide) LAVOCLEN (benzoyl peroxide) TRIAZ (benzoyl peroxide)	Acne kits are non-preferred.
	COMBINATION AGENTS		
	benzoyl peroxide/urea erythromycin/benzoyl peroxide sulfacetamide sodium/sulfur wash/cleanser	ACANYA (clindamycin phosphate/benzoyl peroxide) BENZACLIN GEL (benzoyl peroxide/ clindamycin) BENZAMYCIN PAK (benzoyl peroxide/ erythromycin) benzoyl peroxide/clindamycin gel	

Unless otherwise specified, the listing of a particular brand or generic name includes all legend forms of that drug. OTC are not covered unless specified.
PA criteria for non-preferred agents apply in addition to general Drug Utilization Review policy that is in effect for the entire pharmacy program, including, but not limited to, appropriate dosing, duplication of therapy, etc.
CL – Requires Clinical PA. For detailed clinical criteria, please refer to: http://www.wvdhhr.org/bms/sPharmacy/Drugs/bms_drugs_main.asp .
NR – New drug has not been reviewed by P & T Committee
AP – Non-preferred drugs and selected preferred drugs, where indicated, are subject to auto-PA criteria. See PA Criteria column.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		CLENIA (sulfacetamide sodium/sulfur) DUAC CS (benzoyl peroxide/ clindamycin) EPIDUO (adapalene/benzoyl peroxide) INOVA 4/1 (benzoyl peroxide/salicylic acid) NUOX (benzoyl peroxide/sulfur) PLEXION (sulfacetamide sodium/sulfur) PRASCION (sulfacetamide sodium/sulfur) ROSAC (sulfacetamide sodium/avobenzone/sulfur) ROSADERM (sulfacetamide sodium/sulfur) ROSANIL (sulfacetamide sodium/sulfur) ROSULA (sulfacetamide sodium/sulfur/ urea) sulfacetamide sodium/sulfur lotion, gel, pad SULFOXYL (benzoyl peroxide/sulfur) SULFATOL (sulfacetamide sodium/sulfur/urea) ZIANA (clindamycin/tretinoin)	
ALZHEIMER'S AGENTS[AP]			
	CHOLINESTERASE INHIBITORS		A thirty (30) day trial of a preferred agent is required before a non-preferred agent in this class will be authorized unless one of the exceptions on the PA form is present.
	ARICEPT (donepezil) ARICEPT ODT(donepezil) EXELON (rivastigmine)	COGNEX (tacrine) galantamine galantamine ER RAZADYNE (galantamine) RAZADYNE ER (galantamine)	
	NMDA RECEPTOR ANTAGONIST		
	NAMENDA (memantine)		
ANALGESICS, NARCOTIC - SHORT ACTING (Non-parenteral)[AP]			
	APAP/codeine ASA/codeine codeine dihydrocodeine/ APAP/caffeine hydrocodone/APAP	ACTIQ (fentanyl) butalbital/APAP/caffeine/codeine butalbital/ASA/caffeine/codeine butorphanol COMBUNOX (oxycodone/ibuprofen)	Six (6) day trials of at least four (4) chemically distinct preferred agents (based on narcotic ingredient only), including the generic formulation of a requested non-preferred product,

Unless otherwise specified, the listing of a particular brand or generic name includes all legend forms of that drug. OTC are not covered unless specified.
PA criteria for non-preferred agents apply in addition to general Drug Utilization Review policy that is in effect for the entire pharmacy program, including, but not limited to, appropriate dosing, duplication of therapy, etc.
[CL] – Requires Clinical PA. For detailed clinical criteria, please refer to: http://www.wvdhhr.org/bms/sPharmacy/Drugs/bms_drugs_main.asp .
[NR] – New drug has not been reviewed by P & T Committee
[AP] – Non-preferred drugs and selected preferred drugs, where indicated, are subject to auto-PA criteria. See PA Criteria column.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	hydrocodone/ibuprofen hydromorphone levorphanol morphine oxycodone oxycodone/APAP oxycodone/ASA pentazocine/APAP pentazocine/naloxone propoxyphene/APAP ROXICET (oxycodone/acetaminophen) tramadol tramadol/APAP	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 (hydrocodone/APAP) LORTAB (hydrocodone/APAP) MAGNACET (oxycodone/APAP) meperidine NUCYNTA (tapentadol) OPANA (oxymorphone) ONSOLIS (fentanyl) oxycodone/ibuprofen OXYFAST (oxycodone) OXYIR (oxycodone) PANLOR (dihydrocodeine/ APAP/caffeine) PERCOCET (oxycodone/APAP) PERCODAN (oxycodone/ASA) propoxyphene ROXANOL (morphine) RYBIX ODT (tramadol)[NR] TALACEN (pentazocine/APAP) TALWIN NX (pentazocine/naloxone) TYLENOL W/CODEINE (APAP/codeine) ULTRACET (tramadol/APAP) ULTRAM (tramadol) VICODIN (hydrocodone/APAP) VICOPROFEN (hydrocodone/ibuprofen) VOPAC (codeine/acetaminophen) XODOL (hydrocodone/acetaminophen) ZAMICET (hydrocodone/APAP) ZYDONE (hydrocodone/acetaminophen) XOLOX (oxycodone/APAP)	are required before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present. Fentanyl lozenges and Onsolis will only be approved for a diagnosis of cancer and as an adjunct to a long-acting agent. Neither will be approved for monotherapy. **Limits:** Unless the patient has escalating cancer pain or another diagnosis supporting increased quantities of short-acting opioids, all short acting solid forms of the narcotic analgesics are limited to 120 tablets per 30 days for the purpose of maximizing the use of longer acting medications to prevent unnecessary breakthrough pain in chronic pain therapy.

Unless otherwise specified, the listing of a particular brand or generic name includes all legend forms of that drug. OTC are not covered unless specified.
PA criteria for non-preferred agents apply in addition to general Drug Utilization Review policy that is in effect for the entire pharmacy program, including, but not limited to, appropriate dosing, duplication of therapy, etc.
[CL] – Requires Clinical PA. For detailed clinical criteria, please refer to: http://www.wvdhhr.org/bms/sPharmacy/Drugs/bms_drugs_main.asp .
[NR] – New drug has not been reviewed by P & T Committee
[AP] – Non-preferred drugs and selected preferred drugs, where indicated, are subject to auto-PA criteria. See PA Criteria column.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ANALGESICS, NARCOTIC - LONG ACTING (Non-parenteral)[AP]			
	fentanyl transdermal KADIAN (morphine) 10mg, 20mg, 30mg, 50mg, 60mg, 100mg methadone morphine ER OPANA ER (oxymorphone)	AVINZA (morphine) DOLOPHINE (methadone) DURAGESIC (fentanyl) EXALGO ER (hydromorphone)[NR] EMBEDA (morphine/naltrexone) KADIAN (morphine) 80mg, 200mg MS CONTIN (morphine) ORAMORPH SR (morphine) oxycodone ER OXYCONTIN (oxycodone) RYZOLT ER (tramadol) tramadol ER ULTRAM ER (tramadol)	Six (6) day trials each of two preferred unique chemical entities are required before a non-preferred agent will be approved unless one of the exceptions on the PDL form is present. The generic form of the requested non-preferred agent, if available, must be tried before the non-preferred agent will be approved. *Dose optimization is required for achieving equivalent doses of Kadian 80mg and 200mg. AP does not apply.* **Exception:** Oxycodone ER will be authorized if a diagnosis of cancer is submitted without a trial of the preferred agents.
ANALGESICS (Topical)[AP]			
	capsaicin lidocaine lidocaine/prilocaine xylocaine	EMLA (lidocaine/prilocaine) FLECTOR PATCH (diclofenac) LIDODERM PATCH (lidocaine) LIDAMANTLE (lidocaine) LIDAMANTLE HC (lidocaine/hydrocortisone) LMX 4 (lidocaine) PENNSAID (diclofenac)[NR] SYNERA (lidocaine/tetracaine) VOLTAREN GEL (diclofenac) ZOSTRIX (capsaicin)	Ten (10) day trials of each of the preferred topical anesthetics (lidocaine, lidocaine/prilocaine, and xylocaine) are required before a non-preferred topical anesthetic will be approved unless one of the exceptions on the PA form is present. Lidoderm patches will be approved for a diagnosis of post-herpetic neuralgia. Thirty (30) day trials of each of the preferred oral NSAIDS and

Unless otherwise specified, the listing of a particular brand or generic name includes all legend forms of that drug. OTC are not covered unless specified.
PA criteria for non-preferred agents apply in addition to general Drug Utilization Review policy that is in effect for the entire pharmacy program, including, but not limited to, appropriate dosing, duplication of therapy, etc.
[CL] – Requires Clinical PA. For detailed clinical criteria, please refer to: http://www.wvdhhr.org/bms/sPharmacy/Drugs/bms_drugs_main.asp .
[NR] – New drug has not been reviewed by P & T Committee
[AP] – Non-preferred drugs and selected preferred drugs, where indicated, are subject to auto-PA criteria. See PA Criteria column.

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

Unless otherwise specified, the listing of a particular brand or generic name includes all legend forms of that drug. OTC are not covered unless specified.
PA criteria for non-preferred agents apply in addition to general Drug Utilization Review policy that is in effect for the entire pharmacy program, including, but not limited to, appropriate dosing, duplication of therapy, etc.
[CL] – Requires Clinical PA. For detailed clinical criteria, please refer to: http://www.wvdhhr.org/bms/sPharmacy/Drugs/bms_drugs_main.asp .
[NR] – New drug has not been reviewed by P & T Committee
[AP] – Non-preferred drugs and selected preferred drugs, where indicated, are subject to auto-PA criteria. See PA Criteria column.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	ACE INHIBITOR COMBINATION DRUGS		
	benazepril/amlodipine benazepril/HCTZ captopril/HCTZ enalapril/HCTZ fosinopril/HCTZ lisinopril/HCTZ quinapril/HCTZ	ACCURETIC (quinapril/HCTZ) CAPOZIDE (captopril/HCTZ) LEXXEL (enalapril/felodipine) LOTENSIN HCT (benazepril/HCTZ) LOTREL (benazepril/amlodipine) moexipril/HCTZ MONOPRIL HCT (fosinopril/HCTZ) PRINZIDE (lisinopril/HCTZ) TARKA (trandolapril/verapamil) trandolapril/verapamil UNIRETIC (moexipril/HCTZ) VASERETIC (enalapril/HCTZ) ZESTORETIC (lisinopril/HCTZ)	
	ANGIOTENSIN II RECEPTOR BLOCKERS (ARBs)		
	AVAPRO (irbesartan) BENICAR (olmesartan) COZAAR (losartan) 25mg DIOVAN (valsartan) MICARDIS (telmisartan)	ATACAND (candesartan) COZAAR (losartan) 50mg, 100mg losartan TEVETEN (eprosartan)	
	ARB COMBINATIONS		
	AVALIDE (irbesartan/HCTZ) AZOR (olmesartan/amlodipine) BENICAR-HCT (olmesartan/HCTZ) DIOVAN-HCT (valsartan/HCTZ) EXFORGE (valsartan/amlodipine) EXFORGE HCT (valsartan/amlodipine/HCTZ) HYZAAR (losartan/HCTZ) MICARDIS-HCT (telmisartan/HCTZ)	ATACAND-HCT (candesartan/HCTZ) losartan/HCTZ TEVETEN-HCT (eprosartan/HCTZ) TWYNSTA (telmisartan/amlodipine)	
	DIRECT RENIN INHIBITORS		
	TEKTURNA (aliskiren)[AP] TEKTURNA HCT (aliskiren/HCTZ) [AP] VALTURNA (aliskiren/valsartan) [AP]		A thirty (30) day trial of one preferred ACE, ARB, or combination agent, at the maximum tolerable dose, is required before Tekturna or Valturna will be approved.

Unless otherwise specified, the listing of a particular brand or generic name includes all legend forms of that drug. OTC are not covered unless specified.
PA criteria for non-preferred agents apply in addition to general Drug Utilization Review policy that is in effect for the entire pharmacy program, including, but not limited to, appropriate dosing, duplication of therapy, etc.
[CL] – Requires Clinical PA. For detailed clinical criteria, please refer to: http://www.wvdhhr.org/bms/sPharmacy/Drugs/bms_drugs_main.asp .
[NR] – New drug has not been reviewed by P & T Committee
[AP] – Non-preferred drugs and selected preferred drugs, where indicated, are subject to auto-PA criteria. See PA Criteria column.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ANTICOAGULANTS (Injectable)[CL]			
	ARIXTRA (fondaparinux) FRAGMIN (dalteparin) LOVENOX (enoxaparin)	INNOHEP (tinzaparin)	Trials of each of the preferred agents will be required before a non-preferred agent will be approved unless one of the exceptions on the PA form is present.
ANTICONVULSANTS			
	ADJUVANTS		
	carbamazepine CARBATROL (carbamazepine) DEPAKOTE SPRINKLE (divalproex) divalproex EC divalproex ER divalproex DR EPITOL (carbamazepine) FELBATOL (felbamate) gabapentin GABITRIL (tiagabine) KEPPRA XR (levetiracetam) levetiracetam lamotrigine lamotrigine chewable LYRICA (pregabalin) oxcarbazepine tablets topiramate TRILEPTAL SUSPENSION (oxcarbazepine) valproic acid zonisamide	BANZEL(rufinamide) carbamazepine XR DEPAKENE (valproic acid) DEPAKOTE (divalproex) DEPAKOTE ER (divalproex) EQUETRO (carbamazepine) KEPPRA (levetiracetam) LAMICTAL (lamotrigine) LAMICTAL CHEWABLE (lamotrigine) LAMICTAL ODT (lamotrigine) LAMICTAL XR (lamotrigine) NEURONTIN (gabapentin) SABRIL (vigabatrin) STAVZOR (valproic acid) TEGRETOL (carbamazepine) TEGRETOL XR (carbamazepine) TOPAMAX (topiramate) TRILEPTAL TABLETS (oxcarbazepine) VIMPAT (lacosamide) ZONEGRAN (zonisamide)	A fourteen (14) day trial of one of the preferred agents in the corresponding group is required for treatment naïve patients with a diagnosis of a seizure disorder before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present. A thirty (30) day trial of one of the preferred agents in the corresponding group is required for patients with a diagnosis other than seizure disorders unless one of the exceptions on the PA form is present. Non-preferred anticonvulsants will be approved for patients on established therapies with a diagnosis of seizure disorders with no trials of preferred agents required. In situations where AB-rated generic equivalent products are available, “Brand Medically Necessary” must be hand-written by

Unless otherwise specified, the listing of a particular brand or generic name includes all legend forms of that drug. OTC are not covered unless specified.
PA criteria for non-preferred agents apply in addition to general Drug Utilization Review policy that is in effect for the entire pharmacy program, including, but not limited to, appropriate dosing, duplication of therapy, etc.
[CL] – Requires Clinical PA. For detailed clinical criteria, please refer to: http://www.wvdhhr.org/bms/sPharmacy/Drugs/bms_drugs_main.asp .
[NR] – New drug has not been reviewed by P & T Committee
[AP] – Non-preferred drugs and selected preferred drugs, where indicated, are subject to auto-PA criteria. See PA Criteria column.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			the prescriber on the prescription in order for the brand name product to be reimbursed.
	BARBITURATES[AP]		
	mephobarbital phenobarbital primidone	MEBARAL (mephobarbital) MYSOLINE (primidone)	
	BENZODIAZEPINES[AP]		
	clonazepam DIASTAT (diazepam rectal) diazepam	KLONOPIN (clonazepam)	
	HYDANTOINS[AP]		
	DILANTIN INFATABS (phenytoin) PEGANONE (ethotoin) phenytoin	CEREBYX (fosphenytoin) DILANTIN (phenytoin) PHENYTEK (phenytoin)	
	SUCCINIMIDES		
	CELONTIN (methsuximide) ethosuximide ZARONTIN (ethosuximide)		
ANTIDEPRESSANTS, OTHER			
	SNRIS[AP]		
	CYMBALTA (duloxetine) VENLAFAXINE ER (venlafaxine)	EFFEXOR (venlafaxine) EFFEXOR XR (venlafaxine) PRISTIQ (desvenlafaxine) venlafaxine	A six (6) week trial each of a preferred agent and an SSRI is required before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present.

Unless otherwise specified, the listing of a particular brand or generic name includes all legend forms of that drug. OTC are not covered unless specified.
PA criteria for non-preferred agents apply in addition to general Drug Utilization Review policy that is in effect for the entire pharmacy program, including, but not limited to, appropriate dosing, duplication of therapy, etc.
[CL] – Requires Clinical PA. For detailed clinical criteria, please refer to: http://www.wvdhhr.org/bms/sPharmacy/Drugs/bms_drugs_main.asp .
[NR] – New drug has not been reviewed by P & T Committee
[AP] – Non-preferred drugs and selected preferred drugs, where indicated, are subject to auto-PA criteria. See PA Criteria column.

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

Unless otherwise specified, the listing of a particular brand or generic name includes all legend forms of that drug. OTC are not covered unless specified.
PA criteria for non-preferred agents apply in addition to general Drug Utilization Review policy that is in effect for the entire pharmacy program, including, but not limited to, appropriate dosing, duplication of therapy, etc.
[CL] – Requires Clinical PA. For detailed clinical criteria, please refer to: http://www.wvdhhr.org/bms/sPharmacy/Drugs/bms_drugs_main.asp .
[NR] – New drug has not been reviewed by P & T Committee
[AP] – Non-preferred drugs and selected preferred drugs, where indicated, are subject to auto-PA criteria. See PA Criteria column.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	CANNABINOIDS		
		CESAMET (nabilone) dronabinol MARINOL (dronabinol)	Cesamet will be authorized only for the treatment of nausea and vomiting associated with cancer chemotherapy for patients who have failed to respond adequately to 3-day trials of conventional treatments such as promethazine or ondansetron and are over 18 years of age. Marinol will be authorized only for the treatment of anorexia associated with weight loss in patients with AIDS or cancer and unresponsive to megestrol; or for the prophylaxis of chemotherapy induced nausea and vomiting unresponsive to 3-day trials of ondansetron or promethazine for patients between the ages of 18 and 65.
	SUBSTANCE P ANTAGONISTS		
	EMEND (aprepitant)		
ANTIFUNGALS (Oral)			
	clotrimazole fluconazole* ketoconazole CL nystatin terbinafine CL	ANCOBON (flucytosine) DIFLUCAN (fluconazole) GRIFULVIN V TABLET (griseofulvin) griseofulvin GRIS-PEG (griseofulvin) itraconazole LAMISIL (terbinafine) MYCELEX (clotrimazole)	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.

Unless otherwise specified, the listing of a particular brand or generic name includes all legend forms of that drug. OTC are not covered unless specified.
PA criteria for non-preferred agents apply in addition to general Drug Utilization Review policy that is in effect for the entire pharmacy program, including, but not limited to, appropriate dosing, duplication of therapy, etc.
CL – Requires Clinical PA. For detailed clinical criteria, please refer to: http://www.wvdhhr.org/bms/sPharmacy/Drugs/bms_drugs_main.asp .
NR – New drug has not been reviewed by P & T Committee
AP – Non-preferred drugs and selected preferred drugs, where indicated, are subject to auto-PA criteria. See PA Criteria column.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		MYCOSTATIN Tablets (nystatin) NIZORAL (ketoconazole) NOXAFIL (posaconazole) ORAVIG BUCCAL (miconazole)[NR] SPORANOX (itraconazole) VFEND (voriconazole)	PA is not required for griseofulvin suspension for children up to 6 years of age for the treatment of tinea capitis.
ANTIFUNGALS (Topical)[AP]			
	ANTIFUNGALS		Fourteen (14) day trials of two (2) of the preferred agents are required before one of the non-preferred agents will be authorized unless one of the exceptions on the PA form is present. If a non-preferred shampoo is requested, a fourteen (14) day trial of one preferred product (ketoconazole shampoo) is required. Oxistat cream will be approved for children 12 and under for tinea corporis, tinea cruris, tinea pedis, and tinea (pityriasis) versicolor.
	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/STEROID COMBINATIONS		
	clotrimazole/betamethasone nystatin/triamcinolone	LOTRISONE (clotrimazole/betamethasone)[AP] MYCOLOG (nystatin/triamcinolone)[AP]	
ANTIHISTAMINES, MINIMALLY SEDATING[AP]			
	ANTIHISTAMINES		Thirty (30) day trials of at least two (2) chemically distinct preferred agents (in the age appropriate form), including the generic formulation of a requested non-preferred product, are required
	ALAVERT (loratadine) cetirizine loratadine TAVIST-ND (loratadine)	ALLEGRA (fexofenadine) CLARINEX Tablets (desloratadine) CLARINEX REDITABS (desloratadine) CLARINEX Syrup (desloratadine) CLARITIN (loratadine) fexofenadine	

Unless otherwise specified, the listing of a particular brand or generic name includes all legend forms of that drug. OTC are not covered unless specified.
PA criteria for non-preferred agents apply in addition to general Drug Utilization Review policy that is in effect for the entire pharmacy program, including, but not limited to, appropriate dosing, duplication of therapy, etc.
[CL] – Requires Clinical PA. For detailed clinical criteria, please refer to: http://www.wvdhhr.org/bms/sPharmacy/Drugs/bms_drugs_main.asp .
[NR] – New drug has not been reviewed by P & T Committee
[AP] – Non-preferred drugs and selected preferred drugs, where indicated, are subject to auto-PA criteria. See PA Criteria column.

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

Unless otherwise specified, the listing of a particular brand or generic name includes all legend forms of that drug. OTC are not covered unless specified.
PA criteria for non-preferred agents apply in addition to general Drug Utilization Review policy that is in effect for the entire pharmacy program, including, but not limited to, appropriate dosing, duplication of therapy, etc.
[CL] – Requires Clinical PA. For detailed clinical criteria, please refer to: http://www.wvdhhr.org/bms/sPharmacy/Drugs/bms_drugs_main.asp .
[NR] – New drug has not been reviewed by P & T Committee
[AP] – Non-preferred drugs and selected preferred drugs, where indicated, are subject to auto-PA criteria. See PA Criteria column.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	COMT INHIBITORS		
		COMTAN (entacapone) TASMAR (tolcapone)	
	DOPAMINE AGONISTS		
	ropinirole	MIRAPEX (pramipexole) MIRAPEX ER (pramipexole) pramipexole REQUIP (ropinirole) REQUIP XL (ropinirole)	Mirapex, Mirapex ER, Requip, and Requip XL will be approved for a diagnosis of Parkinsonism with no trials of preferred agents required.
	OTHER ANTIPARKINSON'S AGENTS		
	amantadine[AP] bromocriptine carbidopa/levodopa selegiline STALEVO (levodopa/carbidopa/entacapone)	AZILECT (rasagiline) ELDEPRYL (selegiline) levodopa/carbidopa ODT PARCOPA (levodopa/carbidopa) SINEMET (levodopa/carbidopa) SYMMETREL (amantadine) ZELAPAR (selegiline)	Amantadine will be approved only for a diagnosis of Parkinsonism.
ANTIPSYCHOTICS, ATYPICAL (Oral)			
	ORAL		
	clozapine GEODON (ziprasidone) INVEGA (paliperidone) risperidone risperidone ODT risperidone solution SEROQUEL (quetiapine) SEROQUEL XR (quetiapine)	ABILIFY (aripiprazole) CLOZARIL (clozapine) FANAPT (iloperidone)[NR] FAZACLO (clozapine) RISPERDAL (risperidone) RISPERDAL ODT (risperidone) RISPERDAL SOLUTION (risperidone) SAPHRIS (asenapine) ZYPREXA (olanzapine)	A fourteen (14) day trial of a preferred agent is required for treatment naïve patients before a non-preferred agent will be approved unless one of the exceptions on the PA form is present. Upon discharge, a hospitalized patient stabilized on a non-preferred agent may receive authorization to continue this drug for labeled indications and at recommended dosages. Claims for Seroquel 25 mg will be approved:

Unless otherwise specified, the listing of a particular brand or generic name includes all legend forms of that drug. OTC are not covered unless specified.
PA criteria for non-preferred agents apply in addition to general Drug Utilization Review policy that is in effect for the entire pharmacy program, including, but not limited to, appropriate dosing, duplication of therapy, etc.
[CL] – Requires Clinical PA. For detailed clinical criteria, please refer to: http://www.wvdhhr.org/bms/sPharmacy/Drugs/bms_drugs_main.asp .
[NR] – New drug has not been reviewed by P & T Committee
[AP] – Non-preferred drugs and selected preferred drugs, where indicated, are subject to auto-PA criteria. See PA Criteria column.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			1. for a diagnosis of schizophrenia or 2. for a diagnosis of bipolar disorder or 3. when prescribed concurrently with other strengths of Seroquel in order to achieve therapeutic treatment levels. Seroquel 25 mg. will not be approved for use as a sedative hypnotic. Abilify will be approved for children between the ages of 6-17 for irritability associated with autism. Abilify will be prior authorized for MDD if the following criteria are met: 1. The patient is at least 18 years of age. 2. Diagnosis of Major Depressive Disorder (MDD), 3. Evidence of trials of appropriate therapeutic duration (30 days), at the maximum tolerable dose, of at least one agent in two of the following classes: SSRI, SNRI or bupropion in conjunction with Seroquel XR or Seroquel at doses of 150 mg* or more 4. Prescribed in conjunction with an SSRI, SNRI, or bupropion 5. The daily dose does not exceed 15 mg.

Unless otherwise specified, the listing of a particular brand or generic name includes all legend forms of that drug. OTC are not covered unless specified.
PA criteria for non-preferred agents apply in addition to general Drug Utilization Review policy that is in effect for the entire pharmacy program, including, but not limited to, appropriate dosing, duplication of therapy, etc.
CL – Requires Clinical PA. For detailed clinical criteria, please refer to: http://www.wvdhhr.org/bms/sPharmacy/Drugs/bms_drugs_main.asp .
NR – New drug has not been reviewed by P & T Committee
AP – Non-preferred drugs and selected preferred drugs, where indicated, are subject to auto-PA criteria. See PA Criteria column.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			*The FDA indicated dosage for Seroquel XR as an add-on for Major Depressive Disorder is 150-300 mg.
	ATYPICAL ANTIPSYCHOTIC/SSRI COMBINATIONS		
		SYMBYAX (olanzapine/fluoxetine)	
ANTIVIRALS (Oral)			
	ANTI HERPES		
	acyclovir VALTREX (valacyclovir)	famciclovir FAMVIR (famciclovir) valacyclovir ZOVIRAX (acyclovir)	Five (5) day trials each of the preferred agents are required before the non-preferred agents will be authorized unless one of the exceptions on the PA form is present.
	ANTI INFLUENZA		
	RELENZA (zanamivir) TAMIFLU (oseltamivir)	FLUMADINE (rimantadine) rimantadine SYMMETREL (amantadine) amantadine[AP]	The anti influenza agents will be approved only for a diagnosis of influenza.
ANTIVIRALS (Topical) [AP]			
	ABREVA (docosanol) DENAVIR (penciclovir)	ZOVIRAX (acyclovir)	Five day trials of each of the preferred agents are required before the non-preferred agent will be approved.
ATOPIC DERMATITIS			
	ELIDEL (pimecrolimus) PROTOPIC (tacrolimus)		

Unless otherwise specified, the listing of a particular brand or generic name includes all legend forms of that drug. OTC are not covered unless specified.
PA criteria for non-preferred agents apply in addition to general Drug Utilization Review policy that is in effect for the entire pharmacy program, including, but not limited to, appropriate dosing, duplication of therapy, etc.
[CL] – Requires Clinical PA. For detailed clinical criteria, please refer to: http://www.wvdhhr.org/bms/sPharmacy/Drugs/bms_drugs_main.asp .
[NR] – New drug has not been reviewed by P & T Committee
[AP] – Non-preferred drugs and selected preferred drugs, where indicated, are subject to auto-PA criteria. See PA Criteria column.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
BETA BLOCKERS (Oral) & MISCELLANEOUS ANTIANGINALS (Oral)[AP]			
	BETA BLOCKERS		
	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)	Fourteen (14) day trials each of three (3) chemically distinct preferred agents, including the generic formulation of a requested non-preferred product, are required before one of the non-preferred agents will be approved unless one of the exceptions on the PA form is present.
	BETA BLOCKER/DIURETIC COMBINATION DRUGS		
	atenolol/chlorthalidone bisoprolol/HCTZ metoprolol/HCTZ nadolol/bendroflumethiazide propranolol/HCTZ	CORZIDE (nadolol/bendroflumethiazide) INDERIDE (propranolol/HCTZ) LOPRESSOR HCT (metoprolol/HCTZ) TENORETIC (atenolol/chlorthalidone) ZIAC (bisoprolol/HCTZ)	
	BETA- AND ALPHA-BLOCKERS		
	carvedilol labetalol	COREG (carvedilol) COREG CR (carvedilol) TRANDATE (labetalol)	
	ANTIANGINALS		
	RANEXA (ranolazine)[AP]		Ranexa will be approved for patients with angina who are also taking a calcium channel blocker, a beta blocker, or a nitrite as single agents or a combination agent containing one of these ingredients.

Unless otherwise specified, the listing of a particular brand or generic name includes all legend forms of that drug. OTC are not covered unless specified.
PA criteria for non-preferred agents apply in addition to general Drug Utilization Review policy that is in effect for the entire pharmacy program, including, but not limited to, appropriate dosing, duplication of therapy, etc.
[CL] – Requires Clinical PA. For detailed clinical criteria, please refer to: http://www.wvdhhr.org/bms/sPharmacy/Drugs/bms_drugs_main.asp .
[NR] – New drug has not been reviewed by P & T Committee
[AP] – Non-preferred drugs and selected preferred drugs, where indicated, are subject to auto-PA criteria. See PA Criteria column.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
BLADDER RELAXANT PREPARATIONS[AP]			
	DETROL LA (tolterodine) ENABLEX (darifenacin) oxybutynin oxybutynin ER SANCTURA (trospium) SANCTURA XR (trospium) VESICARE (solifenacin)	DETROL (tolterodine) DITROPAN (oxybutynin) DITROPAN XL (oxybutynin) GELNIQUE (oxybutynin) OXYTROL (oxybutynin) TOVIAZ (fesoterodine)	A thirty (30) day trial each of the chemically distinct preferred agents is required before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present.
BONE RESORPTION SUPPRESSION AND RELATED AGENTS			
	BISPHOSPHONATES		
	alendronate FOSAMAX SOLUTION (alendronate)	ACTONEL (risedronate) ACTONEL WITH CALCIUM (risedronate/ calcium) BONIVA (ibandronate) DIDRONEL (etidronate) FOSAMAX TABLETS (alendronate) FOSAMAX PLUS D (alendronate/vitamin D)	A 30-day trial of the preferred agent is required before a non-preferred agent will be approved.
	OTHER BONE RESORPTION SUPPRESSION AND RELATED AGENTS		
	MIACALCIN (calcitonin)	calcitonin EVISTA (raloxifene) FORTEO (teriparatide) FORTICAL (calcitonin)	Evista will be approved for postmenopausal women with osteoporosis or at high risk for invasive breast cancer.
BPH AGENTS[AP]			
	5-ALPHA-REDUCTASE (5AR) INHIBITORS		
	AVODART (dutasteride) finasteride	PROSCAR (finasteride)	Thirty (30) day trials each of at least two (2) chemically distinct preferred agents, including the generic formulation of a requested non-preferred agent, are required before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present.

Unless otherwise specified, the listing of a particular brand or generic name includes all legend forms of that drug. OTC are not covered unless specified.
PA criteria for non-preferred agents apply in addition to general Drug Utilization Review policy that is in effect for the entire pharmacy program, including, but not limited to, appropriate dosing, duplication of therapy, etc.
[CL] – Requires Clinical PA. For detailed clinical criteria, please refer to: http://www.wvdhhr.org/bms/sPharmacy/Drugs/bms_drugs_main.asp .
[NR] – New drug has not been reviewed by P & T Committee
[AP] – Non-preferred drugs and selected preferred drugs, where indicated, are subject to auto-PA criteria. See PA Criteria column.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	ALPHA BLOCKERS		
	doxazosin tamsulosin terazosin UROXATRAL (alfuzosin)	CARDURA (doxazosin) CARDURA XL (doxazosin) FLOMAX (tamsulosin) HYTRIN (terazosin) RAPAFLO (silodosin)	
BRONCHODILATORS, ANTICHOLINERGIC			
	ANTICHOLINERGIC		
	ATROVENT HFA (ipratropium) ipratropium SPIRIVA (tiotropium)		Thirty (30) day trials each of the preferred agents in the corresponding group are required before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present.
	ANTICHOLINERGIC-BETA AGONIST COMBINATIONS		
	COMBIVENT (albuterol/ipratropium)	albuterol/ipratropium DUONEB (albuterol/ipratropium)	For severely compromised patients, albuterol/ipratropium will be approved if the combined volume of albuterol and ipratropium nebules is inhibitory.
BRONCHODILATORS, BETA AGONIST[AP]			
	INHALATION SOLUTION		
	albuterol 2.5mg/0.5mL	ACCUNEB (albuterol)** albuterol 0.63mg & 1.25mg/3mL[AP] BROVANA (arformoterol) levalbuterol metaproterenol PERFOROMIST (formoterol) PROVENTIL (albuterol) XOPENEX (levalbuterol)	Thirty (30) day trials each of the chemically distinct preferred agents in their corresponding groups are required before a non-preferred agent in that group will be authorized unless one of the exceptions on the PA form is present. **No PA is required for ACCUNEB for children up to 5 years of age.

Unless otherwise specified, the listing of a particular brand or generic name includes all legend forms of that drug. OTC are not covered unless specified.
PA criteria for non-preferred agents apply in addition to general Drug Utilization Review policy that is in effect for the entire pharmacy program, including, but not limited to, appropriate dosing, duplication of therapy, etc.
[CL] – Requires Clinical PA. For detailed clinical criteria, please refer to: http://www.wvdhhr.org/bms/sPharmacy/Drugs/bms_drugs_main.asp .
[NR] – New drug has not been reviewed by P & T Committee
[AP] – Non-preferred drugs and selected preferred drugs, where indicated, are subject to auto-PA criteria. See PA Criteria column.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	INHALERS, LONG-ACTING		
	FORADIL (formoterol) SEREVENT (salmeterol)		
	INHALERS, SHORT-ACTING		
	MAXAIR (pirbuterol) PROAIR HFA (albuterol) PROVENTIL HFA (albuterol) VENTOLIN HFA (albuterol)	ALUPENT (metaproterenol) PROVENTIL (albuterol) XOPENEX HFA (levalbuterol)	Xopenex Inhalation Solution will be approved for 12 months for a diagnosis of asthma or COPD for patients on concurrent asthma controller therapy (either oral or inhaled) with documentation of failure on a trial of albuterol or documented intolerance of albuterol, or for concurrent diagnosis of heart disease.
	ORAL		
	albuterol terbutaline	BRETHINE (terbutaline) metaproterenol VOSPIRE ER (albuterol)	
CALCIUM CHANNEL BLOCKERS[AP]			
	LONG-ACTING		
	amlodipine diltiazem XR, XT felodipine ER nifedipine ER nisoldipine verapamil ER	ADALAT CC (nifedipine) CALAN SR (verapamil) CARDENE SR (nicardipine) CARDIZEM CD, LA, SR (diltiazem) COVERA-HS (verapamil) DILACOR XR (diltiazem) DYNACIRC CR (isradipine) ISOPTIN SR (verapamil) NORVASC (amlodipine) PLENDIL (felodipine) PROCARDIA XL (nifedipine) SULAR (nisoldipine) TIAZAC (diltiazem) VERELAN/VERELAN PM (verapamil)	Fourteen (14) day trials each of the preferred agents are required before a non-preferred agent will be approved unless one of the exceptions on the PA form is present.

Unless otherwise specified, the listing of a particular brand or generic name includes all legend forms of that drug. OTC are not covered unless specified.
PA criteria for non-preferred agents apply in addition to general Drug Utilization Review policy that is in effect for the entire pharmacy program, including, but not limited to, appropriate dosing, duplication of therapy, etc.
[CL] – Requires Clinical PA. For detailed clinical criteria, please refer to: http://www.wvdhhr.org/bms/sPharmacy/Drugs/bms_drugs_main.asp .
[NR] – New drug has not been reviewed by P & T Committee
[AP] – Non-preferred drugs and selected preferred drugs, where indicated, are subject to auto-PA criteria. See PA Criteria column.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	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)[AP]			
	BETA LACTAMS AND BETA LACTAM/BETA-LACTAMASE INHIBITOR COMBINATIONS		A five (5) day trial of the preferred agent is required before a non-preferred agent is authorized unless one of the exceptions on the PA form is present.
	amoxicillin/clavulanate	amoxicillin/clavulanate ER AUGMENTIN XR (amoxicillin/clavulanate) MOXATAG (amoxicillin)	
	CEPHALOSPORINS		
	cefaclor cefadroxil cefdinir cefditoren cefpodoxime cefprozil cefuroxime cephalexin SPECTRACEF (cefditoren)	CECLOR (cefaclor) CEDAX (ceftibuten) CEFTIN (cefuroxime) CEFZIL (cefprozil) DURICEF (cefadroxil) KEFLEX (cephalexin) OMNICEF (cefdinir) PANIXINE (cephalexin) RANICLOR (cefaclor) SUPRAX (cefixime) VANTIN (cefpodoxime)	

Unless otherwise specified, the listing of a particular brand or generic name includes all legend forms of that drug. OTC are not covered unless specified.
PA criteria for non-preferred agents apply in addition to general Drug Utilization Review policy that is in effect for the entire pharmacy program, including, but not limited to, appropriate dosing, duplication of therapy, etc.
CL – Requires Clinical PA. For detailed clinical criteria, please refer to: http://www.wvdhhr.org/bms/sPharmacy/Drugs/bms_drugs_main.asp .
NR – New drug has not been reviewed by P & T Committee
AP – Non-preferred drugs and selected preferred drugs, where indicated, are subject to auto-PA criteria. See PA Criteria column.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
COUGH & COLD/1ST GENERATION ANTIHISTAMINES			
	ANTIHISTAMINES, 1ST GENERATION		See posted list of covered NDCs.
	chlorpheniramine clemastine cyproheptadine diphenhydramine promethazine	brompheniramine maleate brompheniramine tannate BROVEX (brompheniramine tannate) carbinoxamine maleate LODRANE (brompheniramine maleate and tannate) LOHIST (brompheniramine maleate) PALGIC (carbinoxamine maleate) TANACOF (brompheniramine tannate) TANAHIST-PD (chorpheniramine tannate)	
	ANTITUSSIVE-ANTIHISTAMINE COMBINATIONS		
	codeine/promethazine dextromethorphan HBR/promethazine		
	ANTIHISTAMINE-ANTITUSSIVE-DECONGESTANT COMBINATIONS		
	brompheniramine/dextromethorphan HBR/pseudoephedrine chlorpheniramine/dextromethorphan/ pseudoephedrine promethazine/codeine/phenylephrine		
	ANTITUSSIVE-DECONGESTANT COMBINATIONS		
		MUCINEX-D (guaifenesin/pseudoephedrine)	
	DECONGESTANTS		
	phenylephrine pseudoephedrine	NASOP (phenylephrine)	

Unless otherwise specified, the listing of a particular brand or generic name includes all legend forms of that drug. OTC are not covered unless specified.
PA criteria for non-preferred agents apply in addition to general Drug Utilization Review policy that is in effect for the entire pharmacy program, including, but not limited to, appropriate dosing, duplication of therapy, etc.
CL – Requires Clinical PA. For detailed clinical criteria, please refer to: http://www.wvdhhr.org/bms/sPharmacy/Drugs/bms_drugs_main.asp .
NR – New drug has not been reviewed by P & T Committee
AP – Non-preferred drugs and selected preferred drugs, where indicated, are subject to auto-PA criteria. See PA Criteria column.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	ANTITUSSIVES/EXPECTORANTS		See posted list of covered NDCs.
	benzonatate guaifenesin guaifenesin/dextromethorphan	MUCINEX (guaifenesin) MUCINEX-DM (guaifenesin/dextromethorphan) TESSALON (benzonatate)	
	DECONGESTANT-ANTIHISTAMINE-ANTICHOLINERGIC COMBINATIONS		
	phenylephrine/chlorpheniramine/ scopolamine syrup & chewable	DURAHIST (pseudoephedrine/chlorpheniramine/ methscopolamine) EXTENDRYL CHW /JR TAB (phenylephrine/chlorpheniramine/ scopolamine) EXTENDRYL SOL (phenylephrine/dexchlorpheniramine/ methscopolamine) NOHIST-PLUS (phenylephrine/ chlorpheniramine/methscopolamine) phenylephrine/chlorpheniramine/ methscopolamine pseudoephedrine/chlorpheniramine/ methscopolamine phenylephrine/dexchlorpheniramine/ methscopolamine RE-DRYLEX JR (phenylephrine/ chlorpheniramine/scopolamine) RE-DRYLEX SYRUP (phenylephrine/dexchlorpheniramine/ methscopolamine) SCOPOHIST (pseudoephedrine/ chlorpheniramine/methscopolamine)	

Unless otherwise specified, the listing of a particular brand or generic name includes all legend forms of that drug. OTC are not covered unless specified.
PA criteria for non-preferred agents apply in addition to general Drug Utilization Review policy that is in effect for the entire pharmacy program, including, but not limited to, appropriate dosing, duplication of therapy, etc.
CL – Requires Clinical PA. For detailed clinical criteria, please refer to: http://www.wvdhhr.org/bms/sPharmacy/Drugs/bms_drugs_main.asp .
NR – New drug has not been reviewed by P & T Committee
AP – Non-preferred drugs and selected preferred drugs, where indicated, are subject to auto-PA criteria. See PA Criteria column.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	DECONGESTANT-ANTIHISTAMINE COMBINATIONS		
	phenylephrine HCL/chlorpheniramine maleate syrup/drops phenylephrine HCL/phenyltoloxamine/ chlorpheniramine liquid phenylephrine HCL/promethazine syrup phenylephrine HCL/pyrilamine maleate/chlorpheniramine liquid	BROVEX-D (phenylephrine/ brompheniramine) CHLOR-TAN SUSP (phenylephrine tannate/pyrilamine tannate/ chlorpheniramine) DURATUSS DA (pseudoephedrine/chlorpheniramine) DYTAN-D CHW/SUSP (phenylephrine tannate/diphenhydramine tannate) LODRANE 12D/24D//D (pseudoephedrine/brompheniramine) LOHIST 12D/PD (pseudoephedrine/brompheniramine) LOHIST-D (pseudoephedrine/chlorpheniramine) NALEX-A LIQUID/SUSPENSION (phenylephrine/phenyltoloxamine/ chlorpheniramine) phenylephrine/brompheniramine phenylephrine tannate/chlorpheniramine tannate phenylephrine tannate/diphenhydramine tannate phenylephrine tannate/pyrilamine tannate/chlorpheniramine suspension POLY HIST FORTE/PD (phenylephrine/ pyrilamine/chlorpheniramine) pseudoephedrine/brompheniramine pseudoephedrine/chlorpheniramine RONDEC (phenylephrine/chlorpheniramine) RU-HIST FORTE (phenylephrine/pyrilamine/ chlorpheniramine)	See posted list of covered NDCs.

Unless otherwise specified, the listing of a particular brand or generic name includes all legend forms of that drug. OTC are not covered unless specified.
PA criteria for non-preferred agents apply in addition to general Drug Utilization Review policy that is in effect for the entire pharmacy program, including, but not limited to, appropriate dosing, duplication of therapy, etc.
CL – Requires Clinical PA. For detailed clinical criteria, please refer to: http://www.wvdhhr.org/bms/sPharmacy/Drugs/bms_drugs_main.asp .
NR – New drug has not been reviewed by P & T Committee
AP – Non-preferred drugs and selected preferred drugs, where indicated, are subject to auto-PA criteria. See PA Criteria column.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		RYNATAN (phenylephrine/chlorpheniramine) SUDAL 12 (pseudoephedrine/chlorpheniramine) TANNATE PED SUSP (phenylephrine/chlorpheniramine)	
	NARCOTIC ANTITUSSIVE-EXPECTORANT COMBINATION		
	guaifenesin/codeine		Guaifenesin/codeine will only be approved for children ≤ 12 years old.
CYTOKINE & CAM ANTAGONISTS[CL]			
	CIMZIA (certolizumab/pegol) ENBREL (etanercept) HUMIRA (adalimumab) KINERET (anakinra)	SIMPONI (golimumab)	Thirty day trials of each of the preferred agents are required before a non-preferred agent will be approved.
ERYTHROPOIESIS STIMULATING PROTEINS[CL]			
	PROCRIT (rHuEPO)	ARANESP (darbepoetin) EPOGEN (rHuEPO)	A thirty (30) day trial of the preferred agent is required before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present.
FLUOROQUINOLONES (Oral)[AP]			
	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)	A five (5) day trial of one of the preferred agents is required before a non-preferred agent will be approved unless one of the exceptions on the PA form is present.
GENITAL WARTS AGENTS			
	ALDARA (imiquimod)	CONDYLOX (podofilox) imiquimod podofilox VEREGEN (sinecatechins)	A thirty (30) day trial of the preferred agent is required before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present.

Unless otherwise specified, the listing of a particular brand or generic name includes all legend forms of that drug. OTC are not covered unless specified.
PA criteria for non-preferred agents apply in addition to general Drug Utilization Review policy that is in effect for the entire pharmacy program, including, but not limited to, appropriate dosing, duplication of therapy, etc.
[CL] – Requires Clinical PA. For detailed clinical criteria, please refer to: http://www.wvdhhr.org/bms/sPharmacy/Drugs/bms_drugs_main.asp .
[NR] – New drug has not been reviewed by P & T Committee
[AP] – Non-preferred drugs and selected preferred drugs, where indicated, are subject to auto-PA criteria. See PA Criteria column.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
GLUCOCORTICOIDS (Inhaled)[AP]			
	GLUCOCORTICOIDS		Thirty (30) day trials each of the preferred agents are required before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present. Pulmicort Respules do not require a prior authorization for children through 8 years of age or for individuals unable to use an MDI. When children who have been stabilized on Pulmicort Respules reach age 9, prescriptions for the Pulmicort inhaler will be authorized for them. *For children less than 9 years of age and for those who meet the PA requirements, brand Pulmicort is preferred over the generic.
	AEROBID (flunisolide) AEROBID-M (flunisolide) ASMANEX (mometasone) AZMACORT (triamcinolone) FLOVENT HFA (fluticasone) FLOVENT Diskus (fluticasone) QVAR (beclomethasone)	ALVESCO (ciclesonide) budesonide PULMICORT (budesonide)*	
	GLUCOCORTICOID/BRONCHODILATOR COMBINATIONS		
	ADVAIR (fluticasone/salmeterol) ADVAIR HFA (fluticasone/salmeterol) SYMBICORT(budesonide/formoterol)		
GLUCOCORTICOIDS (Topical)			
	VERY HIGH & HIGH POTENCY		Five day trials of one form of each preferred unique active ingredient in the corresponding potency group are required before a non-preferred agent will be approved.
	betamethasone dipropionate cream/ointment betamethasone dipropionate/propylene glycol betamethasone valerate ointment clobetasol propionate cream/gel/ointment/solution	amcinonide APEXICON (diflorasone diacetate) APEXICON E (diflorasone diacetate) betamethasone dipropionate gel clobetasol propionate foam	

Unless otherwise specified, the listing of a particular brand or generic name includes all legend forms of that drug. OTC are not covered unless specified.
PA criteria for non-preferred agents apply in addition to general Drug Utilization Review policy that is in effect for the entire pharmacy program, including, but not limited to, appropriate dosing, duplication of therapy, etc.
[CL] – Requires Clinical PA. For detailed clinical criteria, please refer to: http://www.wvdhhr.org/bms/sPharmacy/Drugs/bms_drugs_main.asp .
[NR] – New drug has not been reviewed by P & T Committee
[AP] – Non-preferred drugs and selected preferred drugs, where indicated, are subject to auto-PA criteria. See PA Criteria column.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	clobetasol propionate/emollient desoximetasone cream/gel/ointment fluocinonide halobetasol propionate triamcinolone acetonide 0.5%	CLOBEX (clobetasol propionate) CORMAX (clobetasol propionate) diflorasone diacetate diflorasone diacetate/emollient DIPROLENE (betamethasone dipropionate/propylene glycol) DIPROLENE AF (betamethasone dipropionate/propylene glycol) DIPROSONE (betamethasone dipropionate) fluocinonide/emollient halcinonide HALOG (halcinonide) KENALOG 0.5% (triamcinolone acetonide) LIDEX (fluocinonide) LIDEX-E (fluocinonide) LUXIQ (betamethasone valerate) OLUX (clobetasol propionate) OLUX-E (clobetasol propionate/emollient) PSORCON (diflorasone diacetate) TEMOVATE (clobetasol propionate) TEMOVATE-E (clobetasol propionate/emollient) TOPICORT (desoximetasone) ULTRAVATE (halobetasol propionate) VANOS (fluocinonide)	
	MEDIUM POTENCY		
	betamethasone dipropionate lotion betamethasone valerate cream desoximetasone 0.05%cream fluocinolone acetonide 0.025% fluticasone propionate hydrocortisone valerate mometasone furoate triamcinolone acetonide 0.025% and 0.1%	ARISTOCORT (triamcinolone) betamethasone valerate lotion BETA-VAL (betamethasone valerate) CLODERM (clocortolone pivalate) CORDRAN/CORDRAN SP (flurandrenolide) CUTIVATE (fluticasone propionate) DERMATOP (prednicarbate) ELOCON (mometasone furoate) hydrocortisone butyrate hydrocortisone butyrate/emollient KENALOG 0.1% (triamcinolone acetonide)	

Unless otherwise specified, the listing of a particular brand or generic name includes all legend forms of that drug. OTC are not covered unless specified.
PA criteria for non-preferred agents apply in addition to general Drug Utilization Review policy that is in effect for the entire pharmacy program, including, but not limited to, appropriate dosing, duplication of therapy, etc.
CL – Requires Clinical PA. For detailed clinical criteria, please refer to: http://www.wvdhhr.org/bms/sPharmacy/Drugs/bms_drugs_main.asp .
NR – New drug has not been reviewed by P & T Committee
AP – Non-preferred drugs and selected preferred drugs, where indicated, are subject to auto-PA criteria. See PA Criteria column.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		LOCOID (hydrocortisone butyrate) LOCOID LIPOCREAM (hydrocortisone butyrate/emollient) prednicarbate TOPICORT LP (desoximetasone) TRIDERM (triamcinolone acetonide) WESTCORT (hydrocortisone valerate)	
	LOW POTENCY		
	desonide fluocinolone acetonide 0.01% hydrocortisone 0.5%, 1%, 2.5% hydrocortisone acetate 0.5%, 1% (Rx & OTC)	ACLOVATE (alclometasone dipropionate) alclometasone dipropionate CAPEX (fluocinolone acetonide) DERMA-SMOOTHE FS (fluocinolone acetonide) DESONATE (desonide) DESOWEN (desonide) LOKARA (desonide) PANDEL (hydrocortisone probutate) VERDESO (desonide)	
GROWTH HORMONE[CL]			
	GENOTROPIN (somatropin) NORDITROPIN (somatropin) NUTROPIN (somatropin) NUTROPIN AQ (somatropin)	HUMATROPE (somatropin) INCRELEX (mecasermin) OMNITROPE (somatropin) SAIZEN (somatropin) SEROSTIM (somatropin) TEV-TROPIN (somatropin) ZORBTIVE (somatropin)	The preferred agents must be tried before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present. Patients already on a non-preferred agent will receive authorization to continue therapy on that agent for the duration of the existing PA.
HEPATITIS B TREATMENTS			
	EPIVIR HBV (lamivudine) HEPSERA (adefovir) TYZEKA (telbivudine)	BARACLUDE (entecavir)	A thirty (30) day trial of one of the preferred agents is required before the non-preferred agent will be authorized unless one of the exceptions on the PA form is present.

Unless otherwise specified, the listing of a particular brand or generic name includes all legend forms of that drug. OTC are not covered unless specified.
PA criteria for non-preferred agents apply in addition to general Drug Utilization Review policy that is in effect for the entire pharmacy program, including, but not limited to, appropriate dosing, duplication of therapy, etc.
[CL] – Requires Clinical PA. For detailed clinical criteria, please refer to: http://www.wvdhhr.org/bms/sPharmacy/Drugs/bms_drugs_main.asp .
[NR] – New drug has not been reviewed by P & T Committee
[AP] – Non-preferred drugs and selected preferred drugs, where indicated, are subject to auto-PA criteria. See PA Criteria column.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
HEPATITIS C TREATMENTS[CL]			
	PEGASYS (pegylated interferon) PEG-INTRON (pegylated interferon) ribavirin	COPEGUS (ribavirin) INFERGEN (consensus interferon) REBETOL (ribavirin) RIBAPAK DOSEPACK (ribavirin) RIBASPHERE (ribavirin)	Patients starting therapy in this class must try the preferred agent of a dosage form before a non-preferred agent of that dosage form will be authorized.
HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS			
	Injectable		
		BYETTA (exenatide) SYMLIN (pramlintide) VICTOZA (liraglutide)	Byetta, Symlin, and Victoza will be subject to the following clinical edits: Byetta and Victoza will be approved with a previous history of a thirty (30) day trial of an oral agent (sulfonylurea, thiazolindinedione (TZD) and/ or metformin) and no evidence of concurrent insulin therapy. Symlin- History of insulin utilization in the past 90 days. No gaps in insulin therapy greater than 30 days.
	Oral[AP]		
	JANUMET (sitagliptin/metformin) JANUVIA (sitagliptin) ONGLYZA (saxagliptin)		Januvia/Janumet, and Onglyza will be subject to the following clinical edits: 1. Previous history of a 30-day trial of an oral agent (sulfonylurea, thiazolindinedione (TZD) or metformin) **and** 2. No evidence of concurrent insulin therapy.

Unless otherwise specified, the listing of a particular brand or generic name includes all legend forms of that drug. OTC are not covered unless specified.
PA criteria for non-preferred agents apply in addition to general Drug Utilization Review policy that is in effect for the entire pharmacy program, including, but not limited to, appropriate dosing, duplication of therapy, etc.
[CL] – Requires Clinical PA. For detailed clinical criteria, please refer to: http://www.wvdhhr.org/bms/sPharmacy/Drugs/bms_drugs_main.asp .
[NR] – New drug has not been reviewed by P & T Committee
[AP] – Non-preferred drugs and selected preferred drugs, where indicated, are subject to auto-PA criteria. See PA Criteria column.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
HYPOGLYCEMICS, INSULINS			
	HUMALOG (insulin lispro) vials only HUMALOG MIX (insulin lispro/lispro protamine) vials only HUMULIN (insulin) vials only LANTUS (insulin glargine) all forms LEVEMIR (insulin detemir) all forms NOVOLIN (insulin) all forms NOVOLOG (insulin aspart) all forms NOVOLOG MIX all forms (insulin aspart/aspart protamine)	APIDRA (insulin glulisine)[AP] HUMALOG PEN/KWIKPEN (insulin lispro) HUMALOG MIX PENS (insulin lispro/lispro protamine) HUMULIN PEN (insulin)	To receive Apidra, patients must meet the following criteria: 1. be 4 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 Humalog, with documentation that the desired results were not achieved.
HYPOGLYCEMICS, MEGLITINIDES			
	STARLIX (nateglinide)	nateglinide PRANDIN (repaglinide)[AP] repaglinide[AP]	A thirty (30) day trial of the preferred agent is required before a non-preferred agent will be authorized, unless one of the exceptions on the PA form is present.
HYPOGLYCEMICS, TZDS			
	THIAZOLIDINEDIONES		
	ACTOS 15mg (pioglitazone)	ACTOS 30mg, 45mg (pioglitazone) AVANDIA (rosiglitazone)[AP]	Dose optimization of Actos 15mg tablets is required for achieving equivalent doses of Actos 30mg and 45mg. Treatment naïve patients require a two (2) week trial of Actos15mg before Avandia 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 legend forms of that drug. OTC are not covered unless specified.
PA criteria for non-preferred agents apply in addition to general Drug Utilization Review policy that is in effect for the entire pharmacy program, including, but not limited to, appropriate dosing, duplication of therapy, etc.
[CL] – Requires Clinical PA. For detailed clinical criteria, please refer to: http://www.wvdhhr.org/bms/sPharmacy/Drugs/bms_drugs_main.asp .
[NR] – New drug has not been reviewed by P & T Committee
[AP] – Non-preferred drugs and selected preferred drugs, where indicated, are subject to auto-PA criteria. See PA Criteria column.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	TZD COMBINATIONS		
		ACTOPLUS MET (pioglitazone/ metformin) ACTOPLUS MET XR (pioglitazone/ metformin) AVANDAMET (rosiglitazone/metformin)[AP] AVANDARYL (rosiglitazone/glimepiride)[AP] DUETACT (pioglitazone/glimepiride)	Patients are required to use the components of Actoplus Met and Duetact separately. Exceptions will be handled on a case-by-case basis.
IMPETIGO AGENTS (Topical)			
	bacitracin gentamicin sulfate mupirocin	ALTABAX (retapamulin) BACTROBAN (mupirocin) CORTISPORIN (bacitracin/neomycin/ polymyxin/HC)	Ten (10) day trials of at least one preferred agent, including the generic formulation of a requested non-preferred agent, are required before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present.
INTRANASAL RHINITIS AGENTS[AP]			
	ANTICHOLINERGICS		
	ipratropium	ATROVENT(ipratropium)	Thirty (30) day trials of the preferred nasal anti-cholinergic, an antihistamine, and corticosteroid groups are required before a non-preferred anti-cholinergic will be approved unless one of the exceptions on the PA form is present
	ANTIHISTAMINES		
	ASTELIN (azelastine)	ASTEPRO (azelastine) PATANASE (olopatadine)	Thirty (30) day trials of both preferred intranasal antihistamines and a thirty (30) day trial of one of the preferred intranasal corticosteroids are required before the non-preferred agent will be approved unless one of the exceptions on the PA form is present.

Unless otherwise specified, the listing of a particular brand or generic name includes all legend forms of that drug. OTC are not covered unless specified.
PA criteria for non-preferred agents apply in addition to general Drug Utilization Review policy that is in effect for the entire pharmacy program, including, but not limited to, appropriate dosing, duplication of therapy, etc.
[CL] – Requires Clinical PA. For detailed clinical criteria, please refer to: http://www.wvdhhr.org/bms/sPharmacy/Drugs/bms_drugs_main.asp .
[NR] – New drug has not been reviewed by P & T Committee
[AP] – Non-preferred drugs and selected preferred drugs, where indicated, are subject to auto-PA criteria. See PA Criteria column.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	CORTICOSTEROIDS		
	fluticasone propionate NASACORT AQ (triamcinolone) NASONEX (mometasone)	BECONASE AQ (beclomethasone) flunisolide FLONASE (fluticasone propionate) NASALIDE (flunisolide) NASAREL (flunisolide) OMNARIS (ciclesonide) RHINOCORT AQUA (budesonide) VERAMYST (fluticasone furoate)	Thirty (30) day trials of each preferred agent in the corticosteroid group are required before a non-preferred corticosteroid agent will be authorized unless one of the exceptions on the PA form is present. Veramyst will be approved for children under 12 years of age.
LEUKOTRIENE MODIFIERS			
	ACCOLATE (zafirlukast) SINGULAIR (montelukast)	ZYFLO (zileuton)	Thirty (30) day trials each of the preferred agents are required before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present.
LIPOTROPICS, OTHER (Non-statins)[AP]			
	BILE ACID SEQUESTRANTS		
	cholestyramine colestipol	COLESTID (colestipol) QUESTRAN (cholestyramine) WELCHOL (colesevelam)	A twelve (12) week trial of one of the preferred agents is required before a non-preferred agent in the corresponding category will be authorized. Welchol will be approved for add-on therapy only after an insufficient response to the maximum tolerable dose of a statin after 12 weeks of therapy.

Unless otherwise specified, the listing of a particular brand or generic name includes all legend forms of that drug. OTC are not covered unless specified.
PA criteria for non-preferred agents apply in addition to general Drug Utilization Review policy that is in effect for the entire pharmacy program, including, but not limited to, appropriate dosing, duplication of therapy, etc.
[CL] – Requires Clinical PA. For detailed clinical criteria, please refer to: http://www.wvdhhr.org/bms/sPharmacy/Drugs/bms_drugs_main.asp .
[NR] – New drug has not been reviewed by P & T Committee
[AP] – Non-preferred drugs and selected preferred drugs, where indicated, are subject to auto-PA criteria. See PA Criteria column.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	CHOLESTEROL ABSORPTION INHIBITORS		
		ZETIA (ezetimibe)	Zetia, as monotherapy, will only be approved for patients who cannot take statins or other preferred agents. AP does not apply. Zetia will be approved for add-on therapy only after an insufficient response to the maximum tolerable dose of a statin after 12 weeks of therapy. AP does not apply.
	FATTY ACIDS		
	LOVAZA (omega-3-acid ethyl esters)[AP]		Lovaza will be approved when the patient is intolerant or not responsive to, or not a candidate for nicotinic acid or fibrate therapy.
	FIBRIC ACID DERIVATIVES		
	fenofibrate gemfibrozil TRICOR (fenofibrate) TRILIPIX (fenofibric acid)	ANTARA (fenofibrate) FENOGLIDE (fenofibrate) FIBRICOR (fenofibric acid) LIPOFEN (fenofibrate) LOFIBRA (fenofibrate) LOPID (gemfibrozil) TRIGLIDE (fenofibrate)	
	NIACIN		
	niacin NIASPAN (niacin)	NIACELS (niacin) NIACOR (niacin) NIADELAY (niacin) SLO-NIACIN (niacin)	
LIPOTROPICS, STATINS[AP]			
	STATINS		
	CRESTOR (rosuvastatin) LESCOL (fluvastatin) LESCOL XL (fluvastatin)	ALTOPREV (lovastatin) LIVALO (pitavastatin) MEVACOR (lovastatin)	Twelve (12) week trials each of two (2) of the preferred statins, including the generic formulation of a

Unless otherwise specified, the listing of a particular brand or generic name includes all legend forms of that drug. OTC are not covered unless specified.
PA criteria for non-preferred agents apply in addition to general Drug Utilization Review policy that is in effect for the entire pharmacy program, including, but not limited to, appropriate dosing, duplication of therapy, etc.
[CL] – Requires Clinical PA. For detailed clinical criteria, please refer to: http://www.wvdhhr.org/bms/sPharmacy/Drugs/bms_drugs_main.asp .
[NR] – New drug has not been reviewed by P & T Committee
[AP] – Non-preferred drugs and selected preferred drugs, where indicated, are subject to auto-PA criteria. See PA Criteria column.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	LIPITOR (atorvastatin) lovastatin pravastatin simvastatin	PRAVACHOL (pravastatin) ZOCOR (simvastatin)	requested non-preferred agent, are required before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present.
	STATIN COMBINATIONS		
	ADVICOR (lovastatin/niacin) CADUET (atorvastatin/amlodipine) SIMCOR (simvastatin/niacin ER)	VYTORIN (simvastatin/ ezetimibe)	Vytorin will be approved only after an insufficient response to the maximum tolerable dose of Lipitor (atorvastatin) or Crestor (rosuvastatin) after 12 weeks, unless one of the exceptions on the PA form is present.
MACROLIDES/KETOLIDES (Oral)			
	KETOLIDES		
		KETEK (telithromycin)	Requests for telithromycin will be authorized if there is documentation of the use of any antibiotic within the past 28 days.
	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)	Five (5) day trials each of the preferred agents are required before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present.

Unless otherwise specified, the listing of a particular brand or generic name includes all legend forms of that drug. OTC are not covered unless specified.
PA criteria for non-preferred agents apply in addition to general Drug Utilization Review policy that is in effect for the entire pharmacy program, including, but not limited to, appropriate dosing, duplication of therapy, etc.
CL – Requires Clinical PA. For detailed clinical criteria, please refer to: http://www.wvdhhr.org/bms/sPharmacy/Drugs/bms_drugs_main.asp .
NR – New drug has not been reviewed by P & T Committee
AP – Non-preferred drugs and selected preferred drugs, where indicated, are subject to auto-PA criteria. See PA Criteria column.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
MULTIPLE SCLEROSIS AGENTS[CL, AP]			
	AVONEX (interferon beta-1a) BETASERON (interferon beta-1b) COPAXONE (glatiramer) REBIF (interferon beta-1a)	AMPYRA (dalfampridine)[CL]* EXTAVIA (interferon beta-1b) TYSABRI (natalizumab)	A 30-day trial of a preferred agent will be required before a non-preferred agent will be approved. *Ampyra will be prior authorized if the following conditions are met: 1. Diagnosis of multiple sclerosis 2. No history of seizures 3. No evidence of moderate or severe renal impairment 4. Initial prescription will be approved for 30 days only. Tysabri will only be approved for members who are enrolled in the TOUCH Prescribing Program. AP does not apply.
MUSCLE RELAXANTS (Oral)[AP]			
	ACUTE MUSCULOSKELETAL RELAXANT AGENTS		
	chlorzoxazone cyclobenzaprine methocarbamol	AMRIX (cyclobenzaprine) carisoprodol carisoprodol/ASA carisoprodol/ASA/codeine FEXMID (cyclobenzaprine) FLEXERIL (cyclobenzaprine) metaxalone methocarbamol/ASA orphenadrine orphenadrine/ASA/caffeine PARAFON FORTE DSC (chlorzoxazone) ROBAXIN (methocarbamol) SKELAXIN (metaxalone) SOMA (carisoprodol) SOMA COMPOUND (carisoprodol /ASA) SOMA COMP w/ COD (carisoprodol/ASA/ codeine)	Thirty (30) day trials of the preferred acute musculoskeletal relaxants are required before a non-preferred acute musculoskeletal agent will be approved, with the exception of carisoprodol. Thirty (30) day trials of the preferred acute musculoskeletal relaxants and Skelaxin are required before carisoprodol will be approved.

Unless otherwise specified, the listing of a particular brand or generic name includes all legend forms of that drug. OTC are not covered unless specified.
PA criteria for non-preferred agents apply in addition to general Drug Utilization Review policy that is in effect for the entire pharmacy program, including, but not limited to, appropriate dosing, duplication of therapy, etc.
[CL] – Requires Clinical PA. For detailed clinical criteria, please refer to: http://www.wvdhhr.org/bms/sPharmacy/Drugs/bms_drugs_main.asp .
[NR] – New drug has not been reviewed by P & T Committee
[AP] – Non-preferred drugs and selected preferred drugs, where indicated, are subject to auto-PA criteria. See PA Criteria column.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	MUSCULOSKELETAL RELAXANT AGENTS USED FOR SPASTICITY		
	baclofen dantrolene tizanidine	DANTRIUM (dantrolene) ZANAFLEX (tizanidine)	Thirty (30) day trials of the preferred skeletal muscle relaxants associated with the treatment of spasticity (are required before non-preferred agents will be approved unless one of the exceptions on the PA form is present.
NSAIDS[AP]			
	NON-SELECTIVE		
	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) CAMBIA (diclofenac) CATAFLAM (diclofenac) CLINORIL (sulindac) DAYPRO (oxaprozin) FELDENE (piroxicam) INDOCIN (indomethacin) ketoprofen ketoprofen ER LODINE (etodolac) meclofenamate mefenamic acid MOTRIN (ibuprofen) nabumetone NALFON (fenoprofen) NAPRELAN (naproxen) NAPROSYN (naproxen) NUPRIN (ibuprofen) ORUDIS (ketoprofen) PONSTEL (meclofenamate) tolmetin VOLTAREN (diclofenac) ZIPSOR (diclofenac potassium)	Thirty (30) day trials of each of the preferred agents are required before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present.

Unless otherwise specified, the listing of a particular brand or generic name includes all legend forms of that drug. OTC are not covered unless specified.
PA criteria for non-preferred agents apply in addition to general Drug Utilization Review policy that is in effect for the entire pharmacy program, including, but not limited to, appropriate dosing, duplication of therapy, etc.
[CL] – Requires Clinical PA. For detailed clinical criteria, please refer to: http://www.wvdhhr.org/bms/sPharmacy/Drugs/bms_drugs_main.asp .
[NR] – New drug has not been reviewed by P & T Committee
[AP] – Non-preferred drugs and selected preferred drugs, where indicated, are subject to auto-PA criteria. See PA Criteria column.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	NSAID/GI PROTECTANT COMBINATIONS		
		ARTHROTEC (diclofenac/misoprostol) PREVACID/NAPRAPAC (naproxen/ lansoprazole) VIMOVO (naproxen/esomeprazole)[NR]	
	COX-II SELECTIVE		
	CELEBREX (celecoxib) [CL] meloxicam	MOBIC (meloxicam)	Celebrex will be approved for patients with a GI Risk Score of ≥13. AP does not apply.
OPHTHALMIC ANTIBIOTICS[AP]			
	ciprofloxacin ofloxacin VIGAMOX (moxifloxacin) ZYMAR (gatifloxacin)	AZASITE (azithromycin) BESIVANCE (besifloxacin) CILOXAN (ciprofloxacin) OCUFLOX (ofloxacin) QUIXIN (levofloxacin) ZYMAXID (gatifloxacin)[NR]	Five (5) day trials of each of the preferred agents are required before non-preferred agents will be authorized unless one of the exceptions on the PA form is present. This class is limited to patients age 21 years and over. Age exceptions will be handled on a case-by-case basis.
OPHTHALMIC ANTI-INFLAMMATORIES			
	ACULAR LS/PF (ketorolac) flurbiprofen NEVANAC (nepafenac) XIBROM (bromfenac)	ACUVAIL 0.45% (ketorolac tromethamine) [AP] diclofenac[AP] DUREZOL (difluprednate)[AP] ketorolac 0.4%	Five (5) day trials of each of the preferred ophthalmic anti-inflammatory agents are required before nonpreferred agents 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 legend forms of that drug. OTC are not covered unless specified.
PA criteria for non-preferred agents apply in addition to general Drug Utilization Review policy that is in effect for the entire pharmacy program, including, but not limited to, appropriate dosing, duplication of therapy, etc.
[CL] – Requires Clinical PA. For detailed clinical criteria, please refer to: http://www.wvdhhr.org/bms/sPharmacy/Drugs/bms_drugs_main.asp .
[NR] – New drug has not been reviewed by P & T Committee
[AP] – Non-preferred drugs and selected preferred drugs, where indicated, are subject to auto-PA criteria. See PA Criteria column.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
OPHTHALMICS FOR ALLERGIC CONJUNCTIVITIS			
	ACULAR (ketorolac) ALAWAY (ketotifen) ALREX (loteprednol) cromolyn OPTIVAR (azelastine) PATADAY (olopatadine) PATANOL (olopatadine) ZADITOR OTC (ketotifen)	ALAMAST (pemirolast) AP ALOCRIL (nedocromil) AP ALOMIDE (lodoxamide) AP azelastine BEPREVE (bepotastine) AP CROLOM (cromolyn) AP ELESTAT (epinastine) AP EMADINE (emedastine) AP ketorolac 0.5% ketotifen OPTICROM (cromolyn) AP ZYRTEC ITCHY EYE (ketotifen) AP	Thirty (30) day trials of each of two (2) of the preferred agents are required before non-preferred agents will be authorized, unless one of the exceptions on the PA form is present.
OPHTHALMICS, GLAUCOMA AGENTS			
	COMBINATION AGENTS		Authorization for a non-preferred agent will only be given if there is an allergy to the preferred agents.
	COMBIGAN (brimonidine/timolol) COSOPT (dorzolamide/timolol)	dorzolamide/timolol	
	BETA BLOCKERS		
	betaxolol BETOPTIC S (betaxolol) carteolol levobunolol metipranolol timolol	BETAGAN (levobunolol) BETIMOL (timolol) ISTALOL (timolol) OPTIPRANOLOL (metipranolol) TIMOPTIC (timolol)	
	CARBONIC ANHYDRASE INHIBITORS		
	AZOPT (brinzolamide) TRUSOPT (dorzolamide)	dorzolamide	
	PARASYMPATHOMIMETICS		
	CARBOPTIC (carbachol) ISOPTO CARBACHOL (carbachol) PHOSPHOLINE IODIDE (echothiophate iodide) pilocarpine	ISOPTO CARPINE (pilocarpine) PILOPINE HS (pilocarpine)	

Unless otherwise specified, the listing of a particular brand or generic name includes all legend forms of that drug. OTC are not covered unless specified.
PA criteria for non-preferred agents apply in addition to general Drug Utilization Review policy that is in effect for the entire pharmacy program, including, but not limited to, appropriate dosing, duplication of therapy, etc.
CL – Requires Clinical PA. For detailed clinical criteria, please refer to: http://www.wvdhhr.org/bms/sPharmacy/Drugs/bms_drugs_main.asp .
NR – New drug has not been reviewed by P & T Committee
AP – Non-preferred drugs and selected preferred drugs, where indicated, are subject to auto-PA criteria. See PA Criteria column.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	PROSTAGLANDIN ANALOGS		
	LUMIGAN (bimatoprost) TRAVATAN (travoprost) TRAVATAN-Z (travoprost)	XALATAN (latanoprost)	
	SYMPATHOMIMETICS		
	ALPHAGAN P (brimonidine) brimonidine 0.2% dipivefrin	brimonidine 0.15% PROPINE (dipivefrin)	
OTIC FLUOROQUINOLONES[AP]			
	CIPRODEX (ciprofloxacin/dexamethasone) ofloxacin	CIPRO HC (ciprofloxacin/hydrocortisone) CETRAXAL 0.2% SOLUTION (ciprofloxacin) FLOXIN (ofloxacin)	Five (5) day trials of each of the preferred agents are required before a non-preferred agent will be approved unless one of the exceptions on the PA form is present.
PANCREATIC ENZYMES[AP]			
	CREON	PANCREASE PANCRELIPASE 5000 ZENPEP[NR]	A thirty (30) day trial of the preferred agent is required before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present. Non-preferred agents will be approved for members with cystic fibrosis.
PARATHYROID AGENTS[AP]			
	calcitriol HECTOROL (doxercalciferol) vitamin d 2 (ergocalciferol) (Rx and OTC)* vitamin d 3 (cholecalciferol) (Rx and OTC)* ZEMPLAR (paricalcitol)	DRISDOL (ergocalciferol) ROCALTROL (calcitriol) SENSIPAR (cinacalcet)	A thirty (30) day trial of a preferred agent will be required before a non-preferred agent will be approved. *See Covered List

Unless otherwise specified, the listing of a particular brand or generic name includes all legend forms of that drug. OTC are not covered unless specified.
PA criteria for non-preferred agents apply in addition to general Drug Utilization Review policy that is in effect for the entire pharmacy program, including, but not limited to, appropriate dosing, duplication of therapy, etc.
[CL] – Requires Clinical PA. For detailed clinical criteria, please refer to: http://www.wvdhhr.org/bms/sPharmacy/Drugs/bms_drugs_main.asp .
[NR] – New drug has not been reviewed by P & T Committee
[AP] – Non-preferred drugs and selected preferred drugs, where indicated, are subject to auto-PA criteria. See PA Criteria column.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
PEDICULICIDES/SCABICIDES (Topical)[AP]			
	EURAX (crotamiton) OVIDE (malathion) permethrin (Rx and OTC) pyrethrins-piperonyl butoxide	lindane malathion 0.5% lotion ULESFIA 5% LOTION (benzyl alcohol)	Trials of the preferred agents (which are age and weight appropriate) are required before lindane will be approved unless one of the exceptions on the PA form is present.
PHOSPHATE BINDERS[AP]			
	FOSRENOL (lanthanum) PHOSLO (calcium acetate) RENAGEL (sevelamer) RENVELA (sevelamer carbonate)	calcium acetate ELIPHOS (calcium acetate)	Thirty (30) day trials of at least two preferred agents are required unless one of the exceptions on the PA form is present.
PLATELET AGGREGATION INHIBITORS[AP]			
	AGGRENOX (dipyridamole/ASA) cilostazol PLAVIX (clopidogrel)	dipyridamole EFFIENT (prasugrel) PERSANTINE (dipyridamole) PLETAL (cilostazol) TICLID (ticlopidine) ticlopidine	A thirty (30) day trial of a preferred agent is required before a non-preferred agent will be approved unless one of the exceptions on the PA form is present. Effient will be approved for acute coronary syndrome when it is to be managed by acute or delayed percutaneous coronary intervention (PCI). Three -day emergency supplies of Effient are available when necessary.
PRENATAL VITAMINS			
	prenatal vitamin 27 w/calcium/ferrous fumarate/folic acid prenatal vitamins 28 w/calcium/iron ps complex/folic acid prenatal vitamins/ferrous fumarate/docusate/folic acid	CARENATAL DHA CITRANATAL DHA COMBI RX FOLBECAL DUET/DUET DHA FOLTABS PLUS DHA	See posted list of covered NDCs.

Unless otherwise specified, the listing of a particular brand or generic name includes all legend forms of that drug. OTC are not covered unless specified.
PA criteria for non-preferred agents apply in addition to general Drug Utilization Review policy that is in effect for the entire pharmacy program, including, but not limited to, appropriate dosing, duplication of therapy, etc.
[CL] – Requires Clinical PA. For detailed clinical criteria, please refer to: http://www.wvdhhr.org/bms/sPharmacy/Drugs/bms_drugs_main.asp .
[NR] – New drug has not been reviewed by P & T Committee
[AP] – Non-preferred drugs and selected preferred drugs, where indicated, are subject to auto-PA criteria. See PA Criteria column.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	prenatal vitamins/ferrous fumarate/folic acid prenatal vitamins/ferrous fumarate/folic acid/selenium prenatal vitamins/iron, carbonyl/folic acid prenatal vitamin no. 15/iron, carbonyl/folic acid/docusate sod prenatal vitamin no. 16/iron, carbonyl/folic acid/docusate sod prenatal vitamin no. 17/iron, carbonyl/folic acid/docusate sod prenatal vitamin no. 18/iron, carbonyl/folic acid/docusate sod prenatal vitamin w-o calcium/ferrous fumarate/folic acid prenatal vitamin w-o vit a/fe carbonyl-fe fumarate/fa	NATACHEW NATAFORT NATELLE PLUS W/DHA NEEVO NOVANATAL OB-NATAL ONE OPTINATE PRECARE/PRECARE PREMIER PREMESIS PRENATAL RX PRENATAL RX 1 PRENATAL U prenatal vitamins/ferrous bis-glycinate chelate/folic acid prenatal vitamins/iron, carbonyl/omega-3/FA/fat combo no. 1 prenatal vitamins comb no. 20/iron bisgly/folic acid/DHA prenatal vitamins no. 22/iron, carbonyl/FA/docusate/DHA prenatal vitamins w-CA, FE, FA (<1 mg) prenatal vitamins w-o calcium/iron ps complex/FA prenatal vitamins w-o CA no. 5/ferrous fumarate/folic acid prenatal vitamins CMB w-o CA no. 2 prenatal vitamins w-o calcium no. 9/iron/folic acid PRENATE DHA/PRENATE ELITE PRENAVITE PRENEXA PRIMACARE RENATE/RENATE DHA SELECT-OB TANDEM DHA/TANDEM OB	

Unless otherwise specified, the listing of a particular brand or generic name includes all legend forms of that drug. OTC are not covered unless specified.
PA criteria for non-preferred agents apply in addition to general Drug Utilization Review policy that is in effect for the entire pharmacy program, including, but not limited to, appropriate dosing, duplication of therapy, etc.
CL – Requires Clinical PA. For detailed clinical criteria, please refer to: http://www.wvdhhr.org/bms/sPharmacy/Drugs/bms_drugs_main.asp .
NR – New drug has not been reviewed by P & T Committee
AP – Non-preferred drugs and selected preferred drugs, where indicated, are subject to auto-PA criteria. See PA Criteria column.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
PROTON PUMP INHIBITORS[AP]			
	DEXILANT (dexlansoprazole)* NEXIUM (esomeprazole)	ACIPHEX (rabeprazole) lansoprazole NEXIUM PACKETS (esomeprazole) omeprazole pantoprazole PREVACID capsules (lansoprazole) (Rx and OTC) PREVACID Solu-Tabs (lansoprazole) PRILOSEC (omeprazole) PROTONIX (pantoprazole) ZEGERID OTC (omeprazole)	Sixty (60) day trials of each of the preferred agents, inclusive of a concurrent thirty (30) day trial at the maximum dose of an H_2 antagonist are required 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. *Formerly listed as KAPIDEX
PULMONARY ANTIHYPERTENSIVES[CL]			
	ENDOTHELIN RECEPTOR ANTAGONISTS		
	LETAIRIS (ambrisentan) TRACLEER (bosentan)		Letairis will be approved for the treatment of pulmonary artery hypertension (PAH) World Health Organization (WHO) Group I in patients with Class II or III symptoms to improve exercise capacity and decrease the rate of clinical deterioration. Tracleer will be approved for the treatment of pulmonary artery hypertension (PAH) (WHO Group I) in patients with World Health Organization (WHO) Class II, III, or IV symptoms to improve exercise capacity and decrease the rate of clinical deterioration.

Unless otherwise specified, the listing of a particular brand or generic name includes all legend forms of that drug. OTC are not covered unless specified.
PA criteria for non-preferred agents apply in addition to general Drug Utilization Review policy that is in effect for the entire pharmacy program, including, but not limited to, appropriate dosing, duplication of therapy, etc.
[CL] – Requires Clinical PA. For detailed clinical criteria, please refer to: http://www.wvdhhr.org/bms/sPharmacy/Drugs/bms_drugs_main.asp .
[NR] – New drug has not been reviewed by P & T Committee
[AP] – Non-preferred drugs and selected preferred drugs, where indicated, are subject to auto-PA criteria. See PA Criteria column.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	PDE5s		
	REVATIO (sildenafil)	ADCIRCA (tadalafil)	A 14-day trial of the preferred agent is required before the non-preferred agent will be approved unless one of the exceptions on the PA form is present.
	PROSTACYCLINS		
	epoprostenol VENTAVIS (iloprost)	FLOLAN (epoprostenol) REMODULIN (treprostinil sodium) TYVASO (treprostinil)	Ventavis will only be approved for the treatment of pulmonary artery hypertension (WHO Group 1) in patients with NYHA Class III or IV symptoms. Remodulin and Tyvaso will be approved only after a 30-day trial of Ventavis unless one of the exceptions on the PA form is present.
SEDATIVE HYPNOTICS[AP]			
	BENZODIAZEPINES		
	temazepam	DALMANE (flurazepam) DORAL (quazepam) estazolam flurazepam HALCION (triazolam) RESTORIL (temazepam) triazolam	Fourteen (14) day trials of the preferred agents in both categories are required before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present.
	OTHERS		
	zolpidem	AMBIEN (zolpidem) AMBIEN CR (zolpidem) chloral hydrate EDLUAR SL (zolpidem) LUNESTA (eszopiclone) ROZEREM (ramelteon)	

Unless otherwise specified, the listing of a particular brand or generic name includes all legend forms of that drug. OTC are not covered unless specified.
PA criteria for non-preferred agents apply in addition to general Drug Utilization Review policy that is in effect for the entire pharmacy program, including, but not limited to, appropriate dosing, duplication of therapy, etc.
[CL] – Requires Clinical PA. For detailed clinical criteria, please refer to: http://www.wvdhhr.org/bms/sPharmacy/Drugs/bms_drugs_main.asp .
[NR] – New drug has not been reviewed by P & T Committee
[AP] – Non-preferred drugs and selected preferred drugs, where indicated, are subject to auto-PA criteria. See PA Criteria column.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		SOMNOTE (chloral hydrate) SONATA (zaleplon) zaleplon	
STIMULANTS AND RELATED AGENTS			
	AMPHETAMINES		
	ADDERALL XR (amphetamine salt combination) amphetamine salt combination dextroamphetamine VYVANSE (lisdexamfetamine)	ADDERALL (amphetamine salt combination) amphetamine salt combination ER DESOXYN (methamphetamine) DEXEDRINE (dextroamphetamine) DEXTROSTAT (dextroamphetamine) methamphetamine	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 for thirty (30) days before a non-preferred agent will be authorized. Thirty (30) day trials of at least three (3) antidepressants are required before amphetamines will be approved for depression. 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 methylphenidates, except for 30 days or less for tapering purposes. Strattera is limited to a maximum of 100mg per day.
	NON-AMPHETAMINE		
	CONCERTA (methylphenidate) FOCALIN (dexmethylphenidate) FOCALIN XR (dexmethylphenidate) METADATE CD (methylphenidate)	DAYTRANA (methylphenidate) dexmethylphenidate INTUNIV (guanfacine) METADATE ER (methylphenidate)	Intuniv will be approved only after thirty (30) day trials of at least one preferred product from each stimulant class (amphetamines and

Unless otherwise specified, the listing of a particular brand or generic name includes all legend forms of that drug. OTC are not covered unless specified.
PA criteria for non-preferred agents apply in addition to general Drug Utilization Review policy that is in effect for the entire pharmacy program, including, but not limited to, appropriate dosing, duplication of therapy, etc.
CL – Requires Clinical PA. For detailed clinical criteria, please refer to: http://www.wvdhhr.org/bms/sPharmacy/Drugs/bms_drugs_main.asp .
NR – New drug has not been reviewed by P & T Committee
AP – Non-preferred drugs and selected preferred drugs, where indicated, are subject to auto-PA criteria. See PA Criteria column.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	methylphenidate methylphenidate ER STRATTERA (atomoxetine)	NUVIGIL (armodafinil) pemoline PROVIGIL (modafinil) RITALIN (methylphenidate) RITALIN LA (methylphenidate) RITALIN-SR (methylphenidate)	non-amphetamines), as well as a trial of Strattera and generic guanfacine unless one of the exceptions on the PA form is present.
TETRACYCLINES [AP]			
	doxycycline hyclate minocycline capsules tetracycline	ADOXA (doxycycline monohydrate) DECLOMYCIN (demeclocycline)* demeclocycline* DORYX (doxycycline hyclate) doxycycline hyclate delayed release doxycycline monohydrate DYNACIN (minocycline) MINOCIN (minocycline) minocycline SR capsules minocycline tablets MONODOX (doxycycline monohydrate) ORACEA (doxycycline monohydrate) SOLODYN (minocycline) SUMYCIN (tetracycline) VIBRAMYCIN SYRUP (doxycycline calcium) VIBRAMYCIN (doxycycline hyclate) VIBRAMYCIN (doxycycline monohydrate) VIBRA-TABS (doxycycline hyclate)	A ten-day trial of each of the preferred agents is required before a non-preferred agent will be approved. Declomycin will be approved for conditions caused by susceptible strains of organisms designated in the product information supplied by the manufacturer. A C&S report must accompany this request. Declomycin will also be approved for SIADH. *For those who meet the PA requirements, brand Declomycin is preferred over the generic.
ULCERATIVE COLITIS AGENTS [AP]			
	ORAL		
	APRISO (mesalamine) ASACOL (mesalamine) 400mg COLAZAL (balsalazide) DIPENTUM (olsalazine) PENTASA (mesalamine) 250mg sulfasalazine	ASACOL HD (mesalamine) 800mg AZULFIDINE (sulfasalazine) balsalazide LIALDA (mesalamine) PENTASA (mesalamine) 500mg	Thirty (30) day trials of each of the preferred agents of a dosage form must be tried before a non-preferred agent of that dosage form will be authorized unless one of the exceptions on the PA form is present.

Unless otherwise specified, the listing of a particular brand or generic name includes all legend forms of that drug. OTC are not covered unless specified.
PA criteria for non-preferred agents apply in addition to general Drug Utilization Review policy that is in effect for the entire pharmacy program, including, but not limited to, appropriate dosing, duplication of therapy, etc.
[CL] – Requires Clinical PA. For detailed clinical criteria, please refer to: http://www.wvdhhr.org/bms/sPharmacy/Drugs/bms_drugs_main.asp .
[NR] – New drug has not been reviewed by P & T Committee
[AP] – Non-preferred drugs and selected preferred drugs, where indicated, are subject to auto-PA criteria. See PA Criteria column.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	RECTAL		
	CANASA (mesalamine) mesalamine SF ROWASA (mesalamine)		
VAGINAL ANTIBACTERIALS			
	clindamycin cream METROGEL (metronidazole)	AVC (sulfanilamide) CLEOCIN CREAM (clindamycin) CLEOCIN OVULE (clindamycin) CLINDESSE (clindamycin) metronidazole VANDAZOLE (metronidazole)	A trial, the duration of the manufacturer's recommendation, of each of the preferred agents is required before a non-preferred agent will be approved unless one of the exceptions on the PA form is present.
MISC BRAND/GENERIC			
	TRANSDERMAL CLONIDINE		Thirty (30) day trials each of the preferred agents, in the corresponding therapeutic category, are required before a non-preferred agent will be authorized.
	CATAPRES-TTS (clonidine)	clonidine patch	
	MEGESTROL		
	MEGACE ES (megestrol) megestrol	MEGACE (megestrol)	
	SUBLINGUAL NITROGLYCERIN		
	nitroglycerin sublingual NITROSTAT SUBLINGUAL (nitroglycerin)	NITROLINGUAL (nitroglycerin) NITROMIST (nitroglycerin)	
	OCTREOTIDE		
	SANDOSTATIN (octreotide)	octreotide	
	COLLAGENASE		
	SANTYL (collagenase)		

Unless otherwise specified, the listing of a particular brand or generic name includes all legend forms of that drug. OTC are not covered unless specified.
PA criteria for non-preferred agents apply in addition to general Drug Utilization Review policy that is in effect for the entire pharmacy program, including, but not limited to, appropriate dosing, duplication of therapy, etc.
CL – Requires Clinical PA. For detailed clinical criteria, please refer to: http://www.wvdhhr.org/bms/sPharmacy/Drugs/bms_drugs_main.asp .
NR – New drug has not been reviewed by P & T Committee
AP – Non-preferred drugs and selected preferred drugs, where indicated, are subject to auto-PA criteria. See PA Criteria column.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	EPINEPHRINE		
	TWINJECT (epinephrine) EPIPEN (epinephrine)		
	ORAL CONTRACEPTIVES		
	YASMIN (ethinyl estradiol/drospirenone)	Gianvi (ethinyl estradiol/drospirenone) Ocella (ethinyl estradiol/drospirenone) YAZ (ethinyl estradiol/drospirenone)	

Unless otherwise specified, the listing of a particular brand or generic name includes all legend forms of that drug. OTC are not covered unless specified.
PA criteria for non-preferred agents apply in addition to general Drug Utilization Review policy that is in effect for the entire pharmacy program, including, but not limited to, appropriate dosing, duplication of therapy, etc.
CL – Requires Clinical PA. For detailed clinical criteria, please refer to: http://www.wvdhhr.org/bms/sPharmacy/Drugs/bms_drugs_main.asp .
NR – New drug has not been reviewed by P & T Committee
AP – Non-preferred drugs and selected preferred drugs, where indicated, are subject to auto-PA criteria. See PA Criteria column.