| THERAPEUTIC DRUG CLASS | PREFERRED AGENTS | NON-PREFERRED AGENTS | PA CRITERIA |
|---|---|---|---|
| **ACNE AGENTS, TOPICAL[AP]** | | | |
| | **ANTI-INFECTIVE** | | |
| | AKNE-MYCIN (erythromycin)<br>AZELEX (azelaic acid)<br>clindamycin<br>erythromycin<br>sodium sulfacetamide | ACZONE (dapsone)<br>CLEOCIN-T (clindamycin)<br>EVOCLIN (clindamycin)<br>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)<br>TAZORAC (tazarotene)<br>tretinoin cream, gel | AVITA<br>DIFFERIN (adapalene)<br>RETIN-A cream, gel (tretinoin) | PA required after 17 years of age for tretinoin products. |
| | **KERATOLYTICS (Benzoyl Peroxides)** | | |
| | benzoyl peroxide<br>ETHEXDERM (benzoyl peroxide)<br>OSCION (benzoyl peroxide) | BENZAC WASH (benzoyl peroxide)<br>BREVOXYL (benzoyl peroxide)<br>DESQUAM (benzoyl peroxide)<br>LAVOCLEN (benzoyl peroxide)<br>TRIAZ (benzoyl peroxide) | Acne kits are non-preferred. |
| | **COMBINATION AGENTS** | | |
| | benzoyl peroxide/urea<br>erythromycin/benzoyl peroxide<br>sulfacetamide sodium/sulfur wash/cleanser | ACANYA (clindamycin phosphate/benzoyl peroxide)<br>BENZACLIN GEL (benzoyl peroxide/ clindamycin)<br>BENZAMYCIN PAK (benzoyl peroxide/ erythromycin)<br>benzoyl peroxide/clindamycin gel<br>CLENIA (sulfacetamide sodium/sulfur) | |

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| THERAPEUTIC DRUG CLASS | PREFERRED AGENTS | NON-PREFERRED AGENTS | PA CRITERIA |
|---|---|---|---|
| | | DUAC CS (benzoyl peroxide/ clindamycin)<br>EPIDUO (adapalene/benzoyl peroxide)<br>INOVA 4/1 (benzoyl peroxide/salicylic acid)<br>NUOX (benzoyl peroxide/sulfur)<br>PLEXION (sulfacetamide sodium/sulfur)<br>PRASCION (sulfacetamide sodium/sulfur)<br>ROSAC (sulfacetamide sodium/avobenzone/sulfur)<br>ROSADERM (sulfacetamide sodium/sulfur)<br>ROSANIL (sulfacetamide sodium/sulfur)<br>ROSULA (sulfacetamide sodium/sulfur/ urea)<br>sulfacetamide sodium/sulfur lotion, gel, pad<br>SULFOXYL (benzoyl peroxide/sulfur)<br>SULFATOL (sulfacetamide sodium/sulfur/urea)<br>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)<br>ARICEPT ODT(donepezil)<br>EXELON (rivastigmine) | COGNEX (tacrine)<br>galantamine<br>galantamine ER<br>RAZADYNE (galantamine)<br>RAZADYNE ER (galantamine) | |
| | **NMDA RECEPTOR ANTAGONIST** | | |
| | NAMENDA (memantine) | | |
| **ANALGESICS, NARCOTIC -SHORT ACTING (Non-parenteral)[AP]** | | | |
| | APAP/codeine<br>ASA/codeine<br>codeine<br>dihydrocodeine/ APAP/caffeine<br>hydrocodone/APAP | ACTIQ (fentanyl)<br>butalbital/APAP/caffeine/codeine<br>butalbital/ASA/caffeine/codeine<br>butorphanol<br>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, are |

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|---|---|---|---|
| | hydrocodone/ibuprofen<br>hydromorphone<br>levorphanol<br>morphine<br>oxycodone<br>oxycodone/APAP<br>oxycodone/ASA<br>pentazocine/APAP<br>pentazocine/naloxone<br>propoxyphene/APAP<br>ROXICET (oxycodone/acetaminophen)<br>tramadol<br>tramadol/APAP | DARVOCET (propoxyphene/APAP)<br>DARVON (propoxyphene)<br>DEMEROL (meperidine)<br>DILAUDID (hydromorphone)<br>fentanyl<br>FENTORA (fentanyl)<br>FIORICET W/ CODEINE (butalbital/APAP/caffeine/codeine)<br>FIORINAL W/ CODEINE (butalbital/ASA/caffeine/codeine)<br>LORCET (hydrocodone/APAP)<br>LORTAB (hydrocodone/APAP)<br>meperidine<br>NUCYNTA (tapentadol)<br>OPANA (oxymorphone)<br>ONSOLIS (fentanyl)<br>oxycodone/ibuprofen<br>OXYFAST (oxycodone)<br>OXYIR (oxycodone)<br>PANLOR (dihydrocodeine/ APAP/caffeine)<br>PERCOCET (oxycodone/APAP)<br>PERCODAN (oxycodone/ASA)<br>propoxyphene<br>ROXANOL (morphine)<br>TALACEN (pentazocine/APAP)<br>TALWIN NX (pentazocine/naloxone)<br>TYLENOL W/CODEINE (APAP/codeine)<br>ULTRACET (tramadol/APAP)<br>ULTRAM (tramadol)<br>VICODIN (hydrocodone/APAP)<br>VICOPROFEN (hydrocodone/ibuprofen)<br>VOPAC (codeine/acetaminophen)<br>XODOL (hydrocodone/acetaminophen)<br>ZAMICET (hydrocodone/APAP)<br>ZYDONE (hydrocodone/acetaminophen)<br>XOLOX (oxycodone/APAP) | required before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present.<br><br>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.*<br><br>**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. |

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|---|---|---|---|
| **ANALGESICS, NARCOTIC - LONG ACTING (Non-parenteral)[AP]** | | | |
| | fentanyl transdermal<br>KADIAN (morphine) 10mg, 20mg, 30mg, 50mg, 60mg, 100mg<br>methadone<br>morphine ER<br>OPANA ER (oxymorphone) | AVINZA (morphine)<br>DOLOPHINE (methadone)<br>DURAGESIC (fentanyl)<br>EMBEDA (morphine/naltrexone)<br>KADIAN (morphine) 80mg, 200mg<br>MS CONTIN (morphine)<br>ORAMORPH SR (morphine)<br>oxycodone ER<br>OXYCONTIN (oxycodone)<br>RYZOLT ER (tramadol)<br>tramadol ER<br>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.*<br><br>**Exception:** Oxycodone ER will be authorized if a diagnosis of cancer is submitted without a trial of the preferred agents. |
| **ANALGESICS, TOPICAL[AP]** | | | |
| | capsaicin<br>lidocaine<br>lidocaine/prilocaine<br>xylocaine | EMLA (lidocaine/prilocaine)<br>FLECTOR PATCH (diclofenac)<br>LIDODERM PATCH (lidocaine)<br>LIDAMANTLE (lidocaine)<br>LIDAMANTLE HC (lidocaine/hydrocortisone)<br>LMX 4 (lidocaine)<br>SYNERA (lidocaine/tetracaine)<br>VOLTAREN GEL (diclofenac)<br>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.<br><br>Lidoderm patches will be approved for a diagnosis of post-herpetic neuralgia.<br><br>Thirty (30) day trials of each of the preferred oral NSAIDS and capsaicin are required before *Voltaren Gel will be approved unless one of the exceptions on the PA form is present. |

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|---|---|---|---|
| | | | 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 forms is present. |
| **ANDROGENIC AGENTS** | | | |
| | ANDRODERM (testosterone)<br>ANDROGEL (testosterone) | TESTIM (testosterone) | The non-preferred agents will be approved only if one of the exceptions on the PA form is present. |
| **ANGIOTENSIN MODULATORS[AP]** | | | |
| | **ACE INHIBITORS** | | |
| | benazepril<br>captopril<br>enalapril<br>fosinopril<br>lisinopril<br>quinapril<br>ramipril | ACCUPRIL (quinapril)<br>ACEON (perindopril)<br>ALTACE (ramipril)<br>CAPOTEN (captopril)<br>LOTENSIN (benazepril)<br>MAVIK (trandolapril)<br>moexipril<br>MONOPRIL (fosinopril)<br>perindopril<br>PRINIVIL (lisinopril)<br>trandolapril<br>UNIVASC (moexipril)<br>VASOTEC (enalapril)<br>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. |

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| THERAPEUTIC DRUG CLASS | PREFERRED AGENTS | NON-PREFERRED AGENTS | PA CRITERIA |
|---|---|---|---|
| | **ACE INHIBITOR COMBINATION DRUGS** | | |
| | benazepril/amlodipine<br>benazepril/HCTZ<br>captopril/HCTZ<br>enalapril/HCTZ<br>fosinopril/HCTZ<br>lisinopril/HCTZ<br>quinapril/HCTZ | ACCURETIC (quinapril/HCTZ)<br>CAPOZIDE (captopril/HCTZ)<br>LEXXEL (enalapril/felodipine)<br>LOTENSIN HCT (benazepril/HCTZ)<br>LOTREL (benazepril/amlodipine)<br>moexipril/HCTZ<br>MONOPRIL HCT (fosinopril/HCTZ)<br>PRINZIDE (lisinopril/HCTZ)<br>TARKA (trandolapril/verapamil)<br>UNIRETIC (moexipril/HCTZ)<br>VASERETIC (enalapril/HCTZ)<br>ZESTORETIC (lisinopril/HCTZ) | |
| | **ANGIOTENSIN II RECEPTOR BLOCKERS (ARBs)** | | |
| | AVAPRO (irbesartan)<br>BENICAR (olmesartan)<br>COZAAR (losartan) 25mg<br>DIOVAN (valsartan)<br>MICARDIS (telmisartan) | ATACAND (candesartan)<br>COZAAR (losartan) 50mg, 100mg<br>TEVETEN (eprosartan) | |
| | **ARB COMBINATIONS** | | |
| | AVALIDE (irbesartan/HCTZ)<br>AZOR (olmesartan/amlodipine)<br>BENICAR-HCT (olmesartan/HCTZ)<br>DIOVAN-HCT (valsartan/HCTZ)<br>EXFORGE (valsartan/amlodipine)<br>EXFORGE HCT (valsartan/amlodipine/HCTZ)<br>HYZAAR (losartan/HCTZ)<br>MICARDIS-HCT (telmisartan/HCTZ) | ATACAND-HCT (candesartan/HCTZ)<br>TEVETEN-HCT (eprosartan/HCTZ)<br>TWYNSTA (telmisartan/amlodipine)[NR] | |

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|---|---|---|---|
| | **DIRECT RENIN INHIBITORS** | | |
| | TEKTURNA (aliskiren)[AP]<br>TEKTURNA HCT (aliskiren/HCTZ) [AP]<br>VALTURNA (aliskiren/valsartan) | | A thirty (30) day trial of one of a preferred ACE, ARB, or combination agents, at the maximum tolerable dose, is required before Tekturna will be approved.<br><br>Valturna will be authorized for patients who have met the criteria for Tekturna and who are also being prescribed valsartan |
| **ANTICOAGULANTS, INJECTABLE[CL]** | | | |
| | ARIXTRA (fondaparinux)<br>FRAGMIN (dalteparin)<br>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<br>CARBATROL (carbamazepine)<br>DEPAKOTE SPRINKLE (divalproex)<br>divalproex EC<br>divalproex ER<br>divalproex DR<br>EPITOL (carbamazepine)<br>FELBATOL (felbamate)<br>gabapentin<br>GABITRIL (tiagabine)<br>KEPPRA XR (levetiracetam)[AP]<br>levetiracetam<br>lamotrigine<br>lamotrigine chewable<br>LYRICA (pregabalin)<br>oxcarbazepine tablets | BANZEL(rufinamide)<br>carbamazepine XR<br>DEPAKENE (valproic acid)<br>DEPAKOTE (divalproex)<br>DEPAKOTE ER (divalproex)<br>EQUETRO (carbamazepine)<br>KEPPRA (levetiracetam)<br>LAMICTAL (lamotrigine)<br>LAMICTAL CHEWABLE (lamotrigine)<br>LAMICTAL ODT (lamotrigine)<br>LAMICTAL XR (lamotrigine)<br>NEURONTIN (gabapentin)<br>SABRIL (vigabatrin)<br>STAVZOR (valproic acid)<br>TEGRETOL (carbamazepine)<br>TEGRETOL XR (carbamazepine) | 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.<br><br>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.<br><br>Non-preferred anticonvulsants will be |

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|---|---|---|---|
| | topiramate<br>TRILEPTAL SUSPENSION (oxcarbazepine)<br>valproic acid<br>zonisamide | TOPAMAX (topiramate)<br>TRILEPTAL TABLETS (oxcarbazepine)<br>VIMPAT (lacosamide)<br>ZONEGRAN (zonisamide) | approved for patients on established therapies with a diagnosis of seizure disorders with no trials of preferred agents required. In situations where AB-rated generic equivalent products are available, "Brand Medically Necessary" must be hand-written by the prescriber on the prescription in order for the brand name product to be reimbursed. |
| | **BARBITURATES[AP]** | | |
| | mephobarbital<br>phenobarbital<br>primidone | MEBARAL (mephobarbital)<br>MYSOLINE (primidone) | |
| | **BENZODIAZEPINES[AP]** | | |
| | clonazepam<br>DIASTAT (diazepam rectal)<br>diazepam | KLONOPIN (clonazepam) | |
| | **HYDANTOINS[AP]** | | |
| | DILANTIN INFATABS (phenytoin)<br>PEGANONE (ethotoin)<br>phenytoin | CEREBYX (fosphenytoin)<br>DILANTIN (phenytoin)<br>PHENYTEK (phenytoin) | |
| | **SUCCINIMIDES** | | |
| | CELONTIN (methsuximide)<br>ethosuximide<br>ZARONTIN (ethosuximide) | | |

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|---|---|---|---|
| **ANTIDEPRESSANTS, OTHER** | | | |
| | **SNRIS[AP]** | | |
| | CYMBALTA (duloxetine)<br>VENLAFAXINE ER (venlafaxine) | EFFEXOR (venlafaxine)<br>EFFEXOR XR (venlafaxine)<br>PRISTIQ (desvenlafaxine)<br>venlafaxine | A six (6) week trial each of a preferred agent and an SSRI is required before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present. |
| | **SECOND GENERATION NON-SSRI, OTHER[AP]** | | |
| | bupropion SR<br>bupropion XL<br>mirtazapine<br>SAVELLA (milnacipran)[AP*]<br>trazodone | APLENZIN (bupropion hbr)<br>bupropion IR<br>DESYREL (trazodone)<br>EMSAM (selegiline)<br>REMERON (mirtazapine)<br>nefazodone<br>WELLBUTRIN (bupropion)<br>WELLBUTRIN SR (bupropion)<br>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<br>TOFRANIL (imipramine hcl)<br>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<br>fluoxetine<br>fluvoxamine<br>LEXAPRO (escitalopram)<br>paroxetine<br>sertraline | CELEXA (citalopram)<br>LUVOX (fluvoxamine)<br>LUVOX CR (fluvoxamine)<br>PAXIL (paroxetine)<br>PAXIL CR (paroxetine)<br>paroxetine ER<br>PEXEVA (paroxetine)<br>PROZAC (fluoxetine)<br>RAPIFLUX (fluoxetine)<br>SARAFEM (fluoxetine)<br>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. |

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|---|---|---|---|
| **ANTIEMETICS**[AP] | | | |
| | **5HT3 RECEPTOR BLOCKERS** | | 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.<br><br>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.<br>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. |
| | ondansetron<br>ondansetron ODT | ANZEMET (dolasetron)<br>KYTRIL (granisetron)<br>granisetron<br>SANCUSO (granisetron)<br>ZOFRAN (ondansetron)<br>ZOFRAN ODT (ondansetron) | |
| | **CANNABINOIDS** | | |
| | | CESAMET (nabilone)<br>MARINOL (dronabinol) | |
| | **SUBSTANCE P ANTAGONISTS** | | |
| | EMEND (aprepitant) | | |

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|---|---|---|---|
| **ANTIFUNGALS, ORAL** | | | |
| | clotrimazole<br>fluconazole*<br>ketoconazole [CL]<br>nystatin<br>terbinafine [CL] | ANCOBON (flucytosine)<br>DIFLUCAN (fluconazole)<br>GRIFULVIN V TABLET (griseofulvin)<br>griseofulvin<br>GRIS-PEG (griseofulvin)<br>itraconazole<br>LAMISIL (terbinafine)<br>MYCELEX (clotrimazole)<br>MYCOSTATIN Tablets (nystatin)<br>NIZORAL (ketoconazole)<br>NOXAFIL (posaconazole)<br>SPORANOX (itraconazole)<br>VFEND (voriconazole) | Non-preferred agents will be approved only if one of the exceptions on the PA form is present.<br><br>*PA is required when limits are exceeded.<br><br>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** | | |
| | econazole<br>ketoconazole<br>MENTAX (butenafine)<br>NAFTIN (naftifine)<br>nystatin | ciclopirox<br>ERTACZO (sertaconazole)<br>EXELDERM (sulconazole)<br>LOPROX (ciclopirox)<br>MYCOSTATIN (nystatin)<br>NIZORAL (ketoconazole)<br>OXISTAT (oxiconazole)<br>PENLAC (ciclopirox)<br>SPECTAZOLE (econazole)<br>VUSION (miconazole/petrolatum/zinc oxide)<br>XOLEGEL (ketoconazole) | Fourteen (14) day trials of two (2) of the preferred agents are required before one of the non-preferred agents will be authorized unless one of the exceptions on the PA form is present. If a non-preferred shampoo is requested, a fourteen (14) day trial of one preferred product (ketoconazole shampoo) is required.) Oxistat cream will be approved for children 12 and under for tinea corporis, tinea cruris, tinea pedis, and tinea (pityriasis) versicolor. |
| | **ANTIFUNGAL/STEROID COMBINATIONS** | | |
| | clotrimazole/betamethasone<br>nystatin/triamcinolone | LOTRISONE (clotrimazole/betamethasone) [AP]<br>MYCOLOG (nystatin/triamcinolone) [AP] | |

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[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 |
|---|---|---|---|
| **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 before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present. |
| | ALAVERT (loratadine)<br>cetirizine<br>loratadine<br>TAVIST-ND (loratadine) | ALLEGRA (fexofenadine)<br>CLARINEX Tablets (desloratadine)<br>CLARINEX REDITABS (desloratadine)<br>CLARINEX Syrup (desloratadine)<br>CLARITIN (loratadine)<br>fexofenadine<br>XYZAL (levocetirizine)<br>ZYRTEC (Rx and OTC) (cetirizine)<br>ZYRTEC SYRUP (cetirizine) | |
| | **ANTIHISTAMINE/DECONGESTANT COMBINATIONS** | | |
| | ALAVERT-D (loratadine/pseudoephedrine)<br>cetirizine/pseudoephedrine<br>loratadine/pseudoephedrine<br>SEMPREX-D (acrivastine/ pseudoephedrine) | ALLEGRA-D (fexofenadine/ pseudoephedrine)<br>CLARINEX-D (desloratadine/ pseudoephedrine)<br>CLARITIN-D (loratadine/pseudoephedrine)<br>ZYRTEC-D (cetirizine/pseudoephedrine) | |
| **ANTIMIGRAINE AGENTS, TRIPTANS[AP]** | | | |
| | **TRIPTANS** | | 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.<br><br>*AP does not apply to nasal spray or injectable sumatriptan. |
| | IMITREX NASAL SPRAY(sumatriptan)<br>IMITREX INJECTION (sumatriptan)[CL]<br>MAXALT MLT (rizatriptan)<br>sumatriptan | AMERGE (naratriptan)<br>AXERT (almotriptan)<br>FROVA (frovatriptan)<br>IMITREX tablets (sumatriptan)<br>MAXALT (rizatriptan)<br>RELPAX (eletriptan)<br>sumatriptan nasal spray/injection*<br>ZOMIG (zolmitriptan) | |
| | **TRIPTAN COMBINATIONS** | | |
| | | TREXIMET (sumatriptan/naproxen sodium) | |

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| THERAPEUTIC DRUG CLASS | PREFERRED AGENTS | NON-PREFERRED AGENTS | PA CRITERIA |
|---|---|---|---|
| **ANTIPARKINSON'S AGENTS (Oral)** | | | |
| | **ANTICHOLINERGICS** | | Patients starting therapy on drugs in this class must show a documented allergy to all of the preferred agents, in the corresponding class, before a non-preferred agent will be authorized. |
| | benztropine<br>KEMADRIN (procyclidine)<br>trihexyphenidyl | COGENTIN (benztropine) | |
| | **COMT INHIBITORS** | | |
| | | COMTAN (entacapone)<br>TASMAR (tolcapone) | |
| | **DOPAMINE AGONISTS** | | Mirapex, Requip, and Requip XL will be approved for a diagnosis of Parkinsonism with no trials of preferred agents required. |
| | ropinirole | MIRAPEX (pramipexole)<br>pramipexole<br>REQUIP (ropinirole)<br>REQUIP XL (ropinirole) | |
| | **OTHER ANTIPARKINSON'S AGENTS** | | |
| | amantadine[AP]<br>bromocriptine<br>carbidopa/levodopa<br>selegiline<br>STALEVO (levodopa/carbidopa/entacapone) | AZILECT (rasagiline)<br>ELDEPRYL (selegiline)<br>levodopa/carbidopa ODT<br>PARCOPA (levodopa/carbidopa)<br>SINEMET (levodopa/carbidopa)<br>SYMMETREL (amantadine)<br>ZELAPAR (selegiline) | |
| **ANTIPSYCHOTICS, ATYPICAL (Oral)** | | | |
| | **ORAL** | | 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, |
| | clozapine<br>GEODON (ziprasidone)<br>INVEGA (paliperidone)<br>RISPERDAL ODT (risperidone)<br>risperidone<br>risperidone solution | ABILIFY (aripiprazole)<br>CLOZARIL (clozapine)<br>FANAPT (iloperidone)[NR]<br>FAZACLO (clozapine)<br>RISPERDAL (risperidone)<br>RISPERDAL SOLUTION (risperidone) | |

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| THERAPEUTIC DRUG CLASS | PREFERRED AGENTS | NON-PREFERRED AGENTS | PA CRITERIA |
|---|---|---|---|
| | SEROQUEL (quetiapine)<br>SEROQUEL XR (quetiapine) | risperidone ODT<br>SAPHRIS (asenapine)<br>ZYPREXA (olanzapine) | a hospitalized patient stabilized on a non-preferred agent may receive authorization to continue this drug for labeled indications and at recommended dosages.<br><br>Claims for Seroquel 25 mg will be approved:<br>1. for a diagnosis of schizophrenia<br>or<br>2. for a diagnosis of bipolar disorder<br>or<br>3. when prescribed concurrently with other strengths of Seroquel in order to achieve therapeutic treatment levels.<br><br>Seroquel 25 mg. will not be approved for use as a sedative hypnotic.<br><br>Abilify will be approved for children between the ages of 6-17 for irritability associated with autism.<br><br>Abilify will be prior authorized for MDD if the following criteria are met:<br>1. The patient is at least 18 years of age.<br>2. Diagnosis of Major Depressive Disorder (MDD),<br>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 |

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| THERAPEUTIC DRUG CLASS | PREFERRED AGENTS | NON-PREFERRED AGENTS | PA CRITERIA |
|---|---|---|---|
| | | | doses of 150 mg* or more<br>4. Prescribed in conjunction with an SSRI, SNRI, or bupropion<br>5. The daily dose does not exceed 15 mg.<br><br>*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<br>VALTREX (valacyclovir) | famciclovir<br>FAMVIR (famciclovir)<br>valacyclovir<br>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)<br>TAMIFLU (oseltamivir) | FLUMADINE (rimantadine)<br>rimantadine<br>SYMMETREL (amantadine)<br>amantadine[AP] | The anti influenza agents will be approved only for a diagnosis of influenza. |
| **ATOPIC DERMATITIS** | | | |
| | ELIDEL (pimecrolimus)<br>PROTOPIC (tacrolimus) | | |

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| THERAPEUTIC DRUG CLASS | PREFERRED AGENTS | NON-PREFERRED AGENTS | PA CRITERIA |
|---|---|---|---|
| **BETA BLOCKERS (Oral) & Miscellaneous Antianginals (Oral)[AP]** | | | |
| | **BETA BLOCKERS** | | |
| | acebutolol<br>atenolol<br>betaxolol<br>bisoprolol<br>metoprolol<br>metoprolol ER<br>nadolol<br>pindolol<br>propranolol<br>propranolol ER<br>sotalol<br>timolol<br>TOPROL XL (metoprolol) | BETAPACE (sotalol)<br>BLOCADREN (timolol)<br>BYSTOLIC (nebivolol)<br>CARTROL (carteolol)<br>CORGARD (nadolol)<br>INDERAL LA (propranolol)<br>INNOPRAN XL (propranolol)<br>KERLONE (betaxolol)<br>LEVATOL (penbutolol)<br>LOPRESSOR (metoprolol)<br>SECTRAL (acebutolol)<br>TENORMIN (atenolol)<br>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<br>bisoprolol/HCTZ<br>metoprolol/HCTZ<br>nadolol/bendroflumethiazide<br>propranolol/HCTZ | CORZIDE (nadolol/bendroflumethiazide)<br>INDERIDE (propranolol/HCTZ)<br>LOPRESSOR HCT (metoprolol/HCTZ)<br>TENORETIC (atenolol/chlorthalidone)<br>ZIAC (bisoprolol/HCTZ) | |
| | **BETA- AND ALPHA-BLOCKERS** | | |
| | carvedilol<br>labetalol | COREG (carvedilol)<br>COREG CR (carvedilol)<br>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. |

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| THERAPEUTIC DRUG CLASS | PREFERRED AGENTS | NON-PREFERRED AGENTS | PA CRITERIA |
|---|---|---|---|
| **BLADDER RELAXANT PREPARATIONS[AP]** | | | |
| | DETROL LA (tolterodine)<br>ENABLEX (darifenacin)<br>oxybutynin<br>oxybutynin ER<br>SANCTURA (trospium)<br>SANCTURA XR (trospium)<br>VESICARE (solifenacin) | DETROL (tolterodine)<br>DITROPAN (oxybutynin)<br>DITROPAN XL (oxybutynin)<br>GELNIQUE (oxybutynin)<br>OXYTROL (oxybutynin)<br>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 | ACTONEL (risedronate)<br>ACTONEL WITH CALCIUM (risedronate/ calcium)<br>BONIVA (ibandronate)<br>DIDRONEL (etidronate)<br>FOSAMAX (alendronate)<br>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<br>EVISTA (raloxifene)<br>FORTEO (teriparatide)<br>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)<br>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. |

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| THERAPEUTIC DRUG CLASS | PREFERRED AGENTS | NON-PREFERRED AGENTS | PA CRITERIA |
|---|---|---|---|
| | **ALPHA BLOCKERS** | | |
| | doxazosin<br>FLOMAX (tamsulosin)<br>terazosin<br>UROXATRAL (alfuzosin) | CARDURA (doxazosin)<br>CARDURA XL (doxazosin)<br>HYTRIN (terazosin)<br>RAPAFLO (silodosin) | |
| **BRONCHODILATORS, ANTICHOLINERGIC** | | | |
| | **ANTICHOLINERGIC** | | |
| | ATROVENT HFA (ipratropium)<br>ipratropium<br>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<br>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)**<br>albuterol 0.63mg & 1.25mg/3mL[AP]<br>BROVANA (arformoterol)<br>levalbuterol<br>metaproterenol<br>PERFOROMIST (formoterol)<br>PROVENTIL (albuterol)<br>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.<br><br>**No PA is required for ACCUNEB for children up to 5 years of age. |
| | **INHALERS, LONG-ACTING** | | |
| | FORADIL (formoterol)<br>SEREVENT (salmeterol) | | |

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| THERAPEUTIC DRUG CLASS | PREFERRED AGENTS | NON-PREFERRED AGENTS | PA CRITERIA |
|---|---|---|---|
| | **INHALERS, SHORT-ACTING** | | |
| | MAXAIR (pirbuterol)<br>PROAIR HFA (albuterol)<br>PROVENTIL HFA (albuterol)<br>VENTOLIN HFA (albuterol) | ALUPENT (metaproterenol)<br>PROVENTIL (albuterol)<br>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<br>terbutaline | BRETHINE (terbutaline)<br>metaproterenol<br>VOSPIRE ER (albuterol) | |
| **CALCIUM CHANNEL BLOCKERS[AP]** | | | |
| | **LONG-ACTING** | | |
| | amlodipine<br>diltiazem XR, XT<br>felodipine ER<br>nifedipine ER<br>nisoldipine<br>verapamil ER | ADALAT CC (nifedipine)<br>CALAN SR (verapamil)<br>CARDENE SR (nicardipine)<br>CARDIZEM CD, LA, SR (diltiazem)<br>COVERA-HS (verapamil)<br>DILACOR XR (diltiazem)<br>DYNACIRC CR (isradipine)<br>ISOPTIN SR (verapamil)<br>NORVASC (amlodipine)<br>PLENDIL (felodipine)<br>PROCARDIA XL (nifedipine)<br>SULAR (nisoldipine)<br>TIAZAC (diltiazem)<br>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. |

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| THERAPEUTIC DRUG CLASS | PREFERRED AGENTS | NON-PREFERRED AGENTS | PA CRITERIA |
|---|---|---|---|
| | **SHORT-ACTING** | | |
| | diltiazem<br>verapamil | ADALAT (nifedipine)<br>CALAN (verapamil)<br>CARDENE (nicardipine)<br>CARDIZEM (diltiazem)<br>DYNACIRC (isradipine)<br>isradipine<br>nicardipine<br>nimodipine<br>nifedipine<br>NIMOTOP (nimodipine)<br>PROCARDIA (nifedipine) | |
| **CEPHALOSPORINS AND RELATED ANTIBIOTICS (Oral)[AP]** | | | |
| | **BETA LACTAMS AND BETA LACTAM/BETA-LACTAMASE INHIBITOR COMBINATIONS** | | |
| | amoxicillin/clavulanate | AUGMENTIN XR (amoxicillin/clavulanate)<br>MOXATAG (amoxicillin) | Five (5) day trials each of the preferred agents required before a non-preferred agent is authorized unless one of the exceptions on the PA form is present. |
| | **CEPHALOSPORINS** | | |
| | cefaclor<br>cefadroxil<br>cefdinir<br>cefditoren<br>cefpodoxime<br>cefprozil<br>cefuroxime<br>cephalexin<br>SPECTRACEF (cefditoren) | CECLOR (cefaclor)<br>CEDAX (ceftibuten)<br>CEFTIN (cefuroxime)<br>CEFZIL (cefprozil)<br>DURICEF (cefadroxil)<br>KEFLEX (cephalexin)<br>OMNICEF (cefdinir)<br>PANIXINE (cephalexin)<br>RANICLOR (cefaclor)<br>SUPRAX (cefixime)<br>VANTIN (cefpodoxime) | |

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

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| THERAPEUTIC DRUG CLASS | PREFERRED AGENTS | NON-PREFERRED AGENTS | PA CRITERIA |
|---|---|---|---|
| | **ANTITUSSIVES/EXPECTORANTS** | | |
| | benzonatate<br>guaifenesin<br>guaifenesin/dextromethorphan | MUCINEX (guaifenesin)<br>MUCINEX-DM (guaifenesin/dextromethorphan)<br>TESSALON (benzonatate) | |
| | **DECONGESTANT-ANTIHISTAMINE-ANTICHOLINERGIC COMBINATIONS** | | |
| | phenylephrine/chlorpheniramine/ scopolamine | DURAHIST (pseudoephedrine/chlorpheniramine/ methscopolamine)<br>EXTENDRYL CHW /JR TAB (phenylephrine/chlorpheniramine/ scopolamine)<br>EXTENDRYL SOL (phenylephrine/dexchlorpheniramine/ methscopolamine)<br>NOHIST-PLUS (phenylephrine/ chlorpheniramine/methscopolamine)<br>phenylephrine/chlorpheniramine/ methscopolamine<br>pseudoephedrine/chlorpheniramine/ methscopolamine<br>phenylephrine/dexchlorpheniramine/ methscopolamine<br>RE-DRYLEX JR (phenylephrine/ chlorpheniramine/scopolamine)<br>RE-DRYLEX SYRUP (phenylephrine/dexchlorpheniramine/ methscopolamine)<br>SCOPOHIST (pseudoephedrine/ chlorpheniramine/methscopolamine) | |

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|---|---|---|---|
| | **DECONGESTANT-ANTIHISTAMINE COMBINATIONS** | | |
| | phenylephrine HCL/chlorpheniramine maleate<br>phenylephrine HCL/phenyltoloxamine/ chlorpheniramine<br>phenylephrine HCL/promethazine<br>phenylephrine HCL/pyrilamine maleate/chlorpheniramine<br>phenylephrine tannate/diphenhydramine tannate<br>phenylephrine tannate/pyrilamine tannate/chlorpheniramine suspension<br>pseudoephedrine/brompheniramine<br>pseudoephedrine/chlorpheniramine | BROVEX-D (phenylephrine/ brompheniramine)<br>CHLOR-TAN SUSP (phenylephrine tannate/pyrilamine tannate/ chlorpheniramine)<br>DURATUSS DA (pseudoephedrine/chlorpheniramine)<br>DYTAN-D CHW/SUSP (phenylephrine tannate/diphenhydramine tannate)<br>LODRANE 12D/24D//D (pseudoephedrine/brompheniramine)<br>LOHIST 12D/PD (pseudoephedrine/brompheniramine)<br>LOHIST-D (pseudoephedrine/chlorpheniramine)<br>NALEX-A LIQUID/SUSPENSION (phenylephrine/phenyltoloxamine/ chlorpheniramine)<br>phenylephrine/brompheniramine<br>phenylephrine tannate/chlorpheniramine tannate<br>POLY HIST FORTE/PD (phenylephrine/ pyrilamine/chlorpheniramine)<br>RONDEC (phenylephrine/chlorpheniramine)<br>RU-HIST FORTE (phenylephrine/pyrilamine/ chlorpheniramine)<br>RYNATAN (phenylephrine/chlorpheniramine)<br>SUDAL 12 (pseudoephedrine/chlorpheniramine)<br>TANNATE PED SUSP (phenylephrine/chlorpheniramine) | See posted list of covered NDCs. |

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|---|---|---|---|
| | **NARCOTIC ANTITUSSIVE-EXPECTORANT COMBINATION** | | |
| | guaifenesin/codeine | | Guaifenesin/codeine will only be approved for children ≤ 12 years old. |
| **CYTOKINE & CAM ANTAGONISTS[CL]** | | | |
| | CIMZIA (certolizumab/pegol)<br>ENBREL (etanercept)<br>HUMIRA (adalimumab)<br>KINERET (anakinra) | ACTEMRA (tocilizumab)[NR]<br>SIMPONI (golimumab)<br>STELARA (ustekinumab)[NR] | 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)<br>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)<br>CIPRO (ciprofloxacin) Suspension<br>ciprofloxacin<br>ciprofloxacin ER<br>LEVAQUIN (levofloxacin) | CIPRO (ciprofloxacin) Tablets<br>CIPRO XR (ciprofloxacin)<br>FACTIVE (gemifloxacin)<br>FLOXIN (ofloxacin)<br>NOROXIN (norfloxacin)<br>ofloxacin<br>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[AP]** | | | |
| | ALDARA (imiquimod) | CONDYLOX (podofilox)<br>podofilox<br>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. |

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| THERAPEUTIC DRUG CLASS | PREFERRED AGENTS | NON-PREFERRED AGENTS | PA CRITERIA |
|---|---|---|---|
| **GLUCOCORTICOIDS, INHALED[AP]** | | | |
| | **GLUCOCORTICOIDS** | | |
| | AEROBID (flunisolide)<br>AEROBID-M (flunisolide)<br>ASMANEX (mometasone)<br>AZMACORT (triamcinolone)<br>FLOVENT HFA (fluticasone)<br>FLOVENT Diskus (fluticasone)<br>QVAR (beclomethasone) | ALVESCO (ciclesonide)<br>budesonide<br>PULMICORT (budesonide)* | Thirty (30) day trials each of the preferred agents are required before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present.<br><br>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.<br><br>*For children less than 9 years of age and for those who meet the PA requirements, brand Pulmicort is preferred over the generic. |
| | **GLUCOCORTICOID/BRONCHODILATOR COMBINATIONS** | | |
| | ADVAIR (fluticasone/salmeterol)<br>ADVAIR HFA (fluticasone/salmeterol)<br>SYMBICORT(budesonide/formoterol) | | |
| **GROWTH HORMONE[CL]** | | | |
| | GENOTROPIN (somatropin)<br>NORDITROPIN (somatropin)<br>NUTROPIN (somatropin)<br>NUTROPIN AQ (somatropin) | HUMATROPE (somatropin)<br>INCRELEX (mecasermin)<br>OMNITROPE (somatropin)<br>SAIZEN (somatropin)<br>SEROSTIM (somatropin)<br>TEV-TROPIN (somatropin)<br>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.<br><br>Patients already on a non-preferred agent will receive authorization to continue therapy on that agent for the duration of the existing PA. |

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| THERAPEUTIC DRUG CLASS | PREFERRED AGENTS | NON-PREFERRED AGENTS | PA CRITERIA |
|---|---|---|---|
| **HEPATITIS B TREATMENTS** | | | |
| | EPIVIR HBV (lamivudine)<br>HEPSERA (adefovir)<br>TYZEKA (telbivudine) | BARACLUDE (entecavir) | A thirty (30) day trial of one of the preferred agents is required before the non-preferred agent will be authorized unless one of the exceptions on the PA form is present. |
| **HEPATITIS C TREATMENTS**[CL] | | | |
| | PEGASYS (pegylated interferon)<br>PEG-INTRON (pegylated interferon)<br>ribavirin | COPEGUS (ribavirin)<br>INFERGEN (consensus interferon)<br>REBETOL (ribavirin)<br>RIBAPAK DOSEPACK (ribavirin)<br>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)<br>SYMLIN (pramlintide)<br>VICTOZA (liraglutide)[NR] | Byetta and Symlin will be subject to the following clinical edits:<br><br>Byetta 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.<br>Symlin- History of insulin utilization in the past 90 days. No gaps in insulin therapy greater than 30 days. |

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| THERAPEUTIC DRUG CLASS | PREFERRED AGENTS | NON-PREFERRED AGENTS | PA CRITERIA |
|---|---|---|---|
| | **Oral**[AP] | | |
| | JANUMET (sitagliptin/metformin)<br>JANUVIA (sitagliptin)<br>ONGLYZA (saxagliptin) | | Januvia/Janumet, and Onglyza will be subject to the following clinical edits:<br><br>1. Previous history of a 30-day trial of an oral agent (sulfonylurea, thiazolindinedione (TZD) or metformin)<br>**and**<br>2. No evidence of concurrent insulin therapy. |
| **HYPOGLYCEMICS, INSULINS** | | | |
| | HUMALOG (insulin lispro) vials only<br>HUMALOG MIX (insulin lispro/lispro protamine) vials only<br>HUMULIN (insulin) vials only<br>LANTUS (insulin glargine) all forms<br>LEVEMIR (insulin detemir) all forms<br>NOVOLIN (insulin) all forms<br>NOVOLOG (insulin aspart) all forms<br>NOVOLOG MIX all forms (insulin aspart/aspart protamine) | APIDRA (insulin glulisine)[AP]<br>HUMALOG PEN/KWIKPEN (insulin lispro)<br>HUMALOG MIX PENS (insulin lispro/lispro protamine)<br>HUMULIN PEN (insulin) | To receive Apidra, patients must meet the following criteria:<br><br>1. be 4 years or older;<br>2. be currently on a regimen including a longer-acting or basal insulin.<br>3. have had a trial of a similar preferred agent, Novolog or Humalog, with documentation that the desired results were not achieved.<br><br>Current prescriptions for Humalog Pens and cartridges, Humalog Kwikpens, Humalog Mix Pens, and Humulin Pens will be grandfathered. |
| **HYPOGLYCEMICS, MEGLITINIDES** | | | |
| | STARLIX (nateglinide) | nateglinide<br>PRANDIN (repaglinide)[AP]<br>repaglinid[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. |

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| THERAPEUTIC DRUG CLASS | PREFERRED AGENTS | NON-PREFERRED AGENTS | PA CRITERIA |
|---|---|---|---|
| **HYPOGLYCEMICS, TZDS** | | | |
| | **THIAZOLIDINEDIONES** | | |
| | ACTOS 15mg (pioglitazone) | ACTOS 30mg, 45mg (pioglitazone)<br>AVANDIA (rosiglitazone)[AP] | Dose optimization of Actos 15mg tablets is required for achieving equivalent doses of Actos 30mg and 45mg.<br><br>Prescriptions for Avandia and combination agents containing Avandia will be grandfathered for patients on established therapy with a prior trial of Actos or having a diagnosis of CHF.<br><br>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. |
| | **TZD COMBINATIONS** | | |
| | | ACTOPLUS MET (pioglitazone/ metformin)<br>AVANDAMET (rosiglitazone/metformin)[AP]<br>AVANDARYL (rosiglitazone/glimepiride)[AP]<br>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<br>gentamicin sulfate<br>mupirocin | ALTABAX (retapamulin)<br>BACTROBAN (mupirocin)<br>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. |

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|---|---|---|---|
| **INTRANASAL RHINITIS AGENTS[AP]** | | | |
| | **ANTICHOLINERGICS** | | |
| | | ATROVENT(ipratropium)<br>ipratropium | Thirty (30) day trials of one preferred agent in the antihistamine and corticosteroid groups are required before an anti-cholinergic agent will be approved unless one of the exceptions on the PA form is present. |
| | **ANTIHISTAMINES** | | |
| | ASTELIN (azelastine) | ASTEPRO (azelastine)<br>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. |
| | **CORTICOSTEROIDS** | | |
| | fluticasone propionate<br>NASACORT AQ (triamcinolone)<br>NASONEX (mometasone) | BECONASE AQ (beclomethasone)<br>flunisolide<br>FLONASE (fluticasone propionate)<br>NASALIDE (flunisolide)<br>NASAREL (flunisolide)<br>OMNARIS (ciclesonide)<br>RHINOCORT AQUA (budesonide)<br>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.<br><br>Veramyst will be approved for children under 12 years of age. |
| **LEUKOTRIENE MODIFIERS** | | | |
| | ACCOLATE (zafirlukast)<br>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. |

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| THERAPEUTIC DRUG CLASS | PREFERRED AGENTS | NON-PREFERRED AGENTS | PA CRITERIA |
|---|---|---|---|
| **LIPOTROPICS, OTHER (non-statins)[AP]** | | | |
| | **BILE ACID SEQUESTRANTS** | | 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.<br><br>Zetia, as monotherapy, will only be approved for patients who cannot take statins or other preferred agents. AP does not apply.<br><br>Welchol will be approved for add-on therapy only after an insufficient response to the maximum tolerable dose of a statin after 12 weeks of therapy. |
| | cholestyramine<br>colestipol | COLESTID (colestipol)<br>QUESTRAN (cholestyramine)<br>WELCHOL (colesevelam) | |
| | **CHOLESTEROL ABSORPTION INHIBITORS** | | 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. |
| | | ZETIA (ezetimibe) | |
| | **FATTY ACIDS** | | Lovaza will be approved when the patient is intolerant or not responsive to, or not a candidate for nicotinic acid or fibrate therapy. |
| | LOVAZA (omega-3-acid ethyl esters)[AP] | | |

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| THERAPEUTIC DRUG CLASS | PREFERRED AGENTS | NON-PREFERRED AGENTS | PA CRITERIA |
|---|---|---|---|
| | **FIBRIC ACID DERIVATIVES** | | |
| | fenofibrate<br>gemfibrozil<br>TRICOR (fenofibrate)<br>TRILIPIX (fenofibric acid) | ANTARA (fenofibrate)<br>FENOGLIDE (fenofibrate)<br>FIBRICOR (fenofibric acid)<br>LIPOFEN (fenofibrate)<br>LOFIBRA (fenofibrate)<br>LOPID (gemfibrozil)<br>TRIGLIDE (fenofibrate) | |
| | **NIACIN** | | |
| | niacin<br>NIASPAN (niacin) | NIACELS (niacin)<br>NIACOR (niacin)<br>NIADELAY (niacin)<br>SLO-NIACIN (niacin) | |
| **LIPOTROPICS, STATINS[AP]** | | | |
| | **STATINS** | | |
| | CRESTOR (rosuvastatin)<br>LESCOL (fluvastatin)<br>LESCOL XL (fluvastatin)<br>LIPITOR (atorvastatin)<br>lovastatin<br>pravastatin<br>simvastatin | ALTOPREV (lovastatin)<br>LIVALO (pitavastatin)<br>MEVACOR (lovastatin)<br>PRAVACHOL (pravastatin)<br>ZOCOR (simvastatin) | Twelve (12) week trials each of two (2) of the preferred statins, including the generic formulation of a requested non-preferred agent, are required before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present. |
| | **STATIN COMBINATIONS** | | |
| | ADVICOR (lovastatin/niacin)<br>CADUET (atorvastatin/amlodipine)<br>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. |

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| THERAPEUTIC DRUG CLASS | PREFERRED AGENTS | NON-PREFERRED AGENTS | PA CRITERIA |
|---|---|---|---|
| **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<br>clarithromycin<br>erythromycin | BIAXIN (clarithromycin)<br>BIAXIN XL (clarithromycin)<br>clarithromycin ER<br>E.E.S. (erythromycin ethylsuccinate)<br>E-MYCIN (erythromycin)<br>ERYC (erythromycin)<br>ERYPED (erythromycin ethylsuccinate)<br>ERY-TAB (erythromycin)<br>ERYTHROCIN (erythromycin stearate)<br>erythromycin estolate<br>PCE (erythromycin)<br>ZITHROMAX (azithromycin)<br>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. |
| **MULTIPLE SCLEROSIS AGENTS[CL, AP]** | | | |
| | AVONEX (interferon beta-1a)<br>BETASERON (interferon beta-1b)<br>COPAXONE (glatiramer)<br>REBIF (interferon beta-1a) | AMPYRA ER (dalfampridine)[NR]<br>EXTAVIA (interferon beta-1b)<br>TYSABRI (natalizumab) | A 30-day trial of a preferred agent will be required before a non-preferred agent will be approved.<br><br>Tysabri will only be approved for members who are enrolled in the TOUCH Prescribing Program. AP does not apply. |

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|---|---|---|---|
| **MUSCLE RELAXANTS, ORAL[AP]** | | | |
| | **ACUTE MUSCULOSKELETAL RELAXANT AGENTS** | | |
| | chlorzoxazone<br>cyclobenzaprine<br>methocarbamol | AMRIX (cyclobenzaprine)<br>carisoprodol<br>carisoprodol/ASA<br>carisoprodol/ASA/codeine<br>FEXMID (cyclobenzaprine)<br>FLEXERIL (cyclobenzaprine)<br>methocarbamol/ASA<br>orphenadrine<br>orphenadrine/ASA/caffeine<br>PARAFON FORTE DSC (chlorzoxazone)<br>ROBAXIN (methocarbamol)<br>SKELAXIN (metaxalone)<br>SOMA (carisoprodol)<br>SOMA COMPOUND (carisoprodol /ASA)<br>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.<br><br>Thirty (30) day trials of the preferred acute musculoskeletal relaxants and Skelaxin are required before carisoprodol will be approved. |
| | **MUSCULOSKELETAL RELAXANT AGENTS USED FOR SPASTICITY** | | |
| | baclofen<br>dantrolene<br>tizanidine | DANTRIUM (dantrolene)<br>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<br>etodolac<br>fenoprofen<br>flurbiprofen<br>ibuprofen (Rx and OTC)<br>INDOCIN (indomethacin) (suspension only)<br>indomethacin | ADVIL (ibuprofen)<br>ANAPROX (naproxen)<br>ANSAID (flurbiprofen)<br>CAMBIA (diclofenac)<br>CATAFLAM (diclofenac)<br>CLINORIL (sulindac)<br>DAYPRO (oxaprozin) | 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. |

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| THERAPEUTIC DRUG CLASS | PREFERRED AGENTS | NON-PREFERRED AGENTS | PA CRITERIA |
|---|---|---|---|
| | ketorolac<br>naproxen (Rx only)<br>oxaprozin<br>piroxicam<br>sulindac | FELDENE (piroxicam)<br>INDOCIN (indomethacin)<br>ketoprofen<br>ketoprofen ER<br>LODINE (etodolac)<br>meclofenamate<br>mefenamic acid<br>MOTRIN (ibuprofen)<br>nabumetone<br>NALFON (fenoprofen)<br>NAPRELAN (naproxen)<br>NAPROSYN (naproxen)<br>NUPRIN (ibuprofen)<br>ORUDIS (ketoprofen)<br>PONSTEL (meclofenamate)<br>tolmetin<br>VOLTAREN (diclofenac)<br>ZIPSOR (diclofenac potassium) | |
| | **NSAID/GI PROTECTANT COMBINATIONS** | | |
| | | ARTHROTEC (diclofenac/misoprostol)<br>PREVACID/NAPRAPAC (naproxen/ lansoprazole) | |
| | **COX-II SELECTIVE** | | |
| | CELEBREX (celecoxib) [CL]<br>meloxicam | MOBIC (meloxicam) | Celebrex will be approved for patients with a GI Risk Score of ≥13. AP does not apply. |
| **OPHTHALMIC ANTIBIOTICS[AP]** | | | |
| | ciprofloxacin<br>ofloxacin<br>VIGAMOX (moxifloxacin)<br>ZYMAR (gatifloxacin) | AZASITE (azithromycin)<br>BESIVANCE (besifloxacin)<br>CILOXAN (ciprofloxacin)<br>OCUFLOX (ofloxacin)<br>QUIXIN (levofloxacin) | 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. |

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|---|---|---|---|
| **OPHTHALMIC ANTI-INFLAMMATORIES** | | | |
| | ACULAR LS/PF (ketorolac)<br>flurbiprofen<br>NEVANAC (nepafenac)<br>XIBROM (bromfenac) | ACUVAIL 0.45% (ketorolac tromethamine) AP<br>diclofenac AP<br>DUREZOL (difluprednate) AP<br>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. |
| **OPHTHALMICS FOR ALLERGIC CONJUNCTIVITIS** | | | |
| | ACULAR (ketorolac)<br>ALAWAY (ketotifen)<br>ALREX (loteprednol)<br>cromolyn<br>OPTIVAR (azelastine)<br>PATADAY (olopatadine)<br>PATANOL (olopatadine)<br>ZADITOR OTC (ketotifen) | ALAMAST (pemirolast) AP<br>ALOCRIL (nedocromil) AP<br>ALOMIDE (lodoxamide) AP<br>azelastine<br>BEPREVE (bepotastine) AP<br>CROLOM (cromolyn) AP<br>ELESTAT (epinastine) AP<br>EMADINE (emedastine) AP<br>ketorolac 0.5%<br>ketotifen<br>OPTICROM (cromolyn) AP<br>ZYRTEC ITCHY EYE (OTC) (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)<br>COSOPT (dorzolamide/timolol) | dorzolamide/timolol | |
| | **BETA BLOCKERS** | | |
| | betaxolol<br>BETOPTIC S (betaxolol)<br>carteolol<br>levobunolol<br>metipranolol<br>timolol | BETAGAN (levobunolol)<br>BETIMOL (timolol)<br>ISTALOL (timolol)<br>OPTIPRANOLOL (metipranolol)<br>TIMOPTIC (timolol) | |

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| THERAPEUTIC DRUG CLASS | PREFERRED AGENTS | NON-PREFERRED AGENTS | PA CRITERIA |
|---|---|---|---|
| | **CARBONIC ANHYDRASE INHIBITORS** | | |
| | AZOPT (brinzolamide)<br>TRUSOPT (dorzolamide) | dorzolamide | |
| | **PARASYMPATHOMIMETICS** | | |
| | CARBOPTIC (carbachol)<br>ISOPTO CARBACHOL (carbachol)<br>PHOSPHOLINE IODIDE (echothiophate iodide)<br>pilocarpine | ISOPTO CARPINE (pilocarpine)<br>PILOPINE HS (pilocarpine) | |
| | **PROSTAGLANDIN ANALOGS** | | |
| | LUMIGAN (bimatoprost)<br>TRAVATAN (travoprost)<br>TRAVATAN-Z (travoprost) | XALATAN (latanoprost) | |
| | **SYMPATHOMIMETICS** | | |
| | ALPHAGAN P (brimonidine)<br>brimonidine 0.2%<br>dipivefrin | brimonidine 0.15%<br>PROPINE (dipivefrin) | |
| **OTIC FLUOROQUINOLONES[AP]** | | | |
| | CIPRODEX (ciprofloxacin/dexamethasone)<br>ofloxacin | CIPRO HC (ciprofloxacin/hydrocortisone)<br>CETRAXAL 0.2% SOLUTION (ciprofloxacin)<br>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<br>ULTRASE<br>ULTRASE MT<br>VIOKASE | KUZYME<br>LIPRAM<br>PALCAPS<br>PANCREASE<br>PANCRECARB<br>PANCRELIPASE<br>PANGESTYME<br>PANOKASE<br>PLARETASE<br>ZENPEP[NR] | Thirty (30) day trials of each of at least three (3) preferred agents are required before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present.<br><br>Non-preferred agents will be approved for members with cystic fibrosis. |

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| THERAPEUTIC DRUG CLASS | PREFERRED AGENTS | NON-PREFERRED AGENTS | PA CRITERIA |
|---|---|---|---|
| **PARATHYROID AGENTS[AP]** | | | |
| | calcitriol<br>HECTOROL (doxercalciferol)<br>vitamin d 2 (ergocalciferol) (Rx and OTC)*<br>vitamin d 3 (cholecalciferol) (Rx and OTC)*<br>ZEMPLAR (paricalcitol) | DRISDOL (ergocalciferol)<br>ROCALTROL (calcitriol)<br>SENSIPAR (cinacalcet) | A thirty (30) day trial of a preferred agent will be required before a non-preferred agent will be approved.<br><br>*See Covered List |
| **PEDICULICIDES/SCABICIDES, TOPICAL[AP]** | | | |
| | EURAX (crotamiton)<br>OVIDE (malathion)<br>permethrin (Rx and OTC)<br>pyrethrins-piperonyl butoxide | lindane<br>malathion 0.5% lotion<br>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)<br>PHOSLO (calcium acetate)<br>RENAGEL (sevelamer)<br>RENVELA (sevelamer carbonate) | calcium acetate<br>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)<br>cilostazol<br>PLAVIX (clopidogrel) | dipyridamole<br>EFFIENT (prasugrel)<br>PERSANTINE (dipyridamole)<br>PLETAL (cilostazol)<br>TICLID (ticlopidine)<br>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.<br><br>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. |

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| THERAPEUTIC DRUG CLASS | PREFERRED AGENTS | NON-PREFERRED AGENTS | PA CRITERIA |
|---|---|---|---|
| **PRENATAL VITAMINS** | | | |
| | prenatal vitamin 27 w/calcium/ferrous fumarate/folic acid<br>prenatal vitamins 28 w/calcium/iron ps complex/folic acid<br>prenatal vitamins/ferrous fumarate/docusate/folic acid<br>prenatal vitamins/ferrous fumarate/folic acid<br>prenatal vitamins/ferrous fumarate/folic acid/selenium<br>prenatal vitamins/iron, carbonyl/folic acid<br>prenatal vitamin no. 15/iron, carbonyl/folic acid/docusate sod<br>prenatal vitamin no. 16/iron, carbonyl/folic acid/docusate sod<br>prenatal vitamin no. 17/iron, carbonyl/folic acid/docusate sod<br>prenatal vitamin no. 18/iron, carbonyl/folic acid/docusate sod<br>prenatal vitamin w-o calcium/ferrous fumarate/folic acid<br>prenatal vitamin w-o vit a/fe carbonyl-fe fumarate/fa | CARENATAL DHA<br>CITRANATAL DHA<br>COMBI RX<br>FOLBECAL<br>DUET/DUET DHA<br>FOLTABS PLUS DHA<br>NATACHEW<br>NATAFORT<br>NATELLE PLUS W/DHA<br>NEEVO<br>NOVANATAL<br>OB-NATAL ONE<br>OPTINATE<br>PRECARE/PRECARE PREMIER<br>PREMESIS<br>PRENATAL RX<br>PRENATAL RX 1<br>PRENATAL U<br>prenatal vitamins/ferrous bis-glycinate chelate/folic acid<br>prenatal vitamins/iron, carbonyl/omega-3/FA/fat combo no. 1<br>prenatal vitamins comb no. 20/iron bisgly/folic acid/DHA<br>prenatal vitamins no. 22/iron, carbonyl/FA/docusate/DHA<br>prenatal vitamins w-CA, FE, FA (<1 mg)<br>prenatal vitamins w-o calcium/iron ps complex/FA<br>prenatal vitamins w-o CA no. 5/ferrous fumarate/folic acid<br>prenatal vitamins CMB w-o CA no. 2<br>prenatal vitamins w-o calcium no. 9/iron/folic acid<br>PRENATE DHA/PRENATE ELITE<br>PRENAVITE<br>PRENEXA | See posted list of covered NDCs. |

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| THERAPEUTIC DRUG CLASS | PREFERRED AGENTS | NON-PREFERRED AGENTS | PA CRITERIA |
|---|---|---|---|
| | | PRIMACARE<br>RENATE/RENATE DHA<br>SELECT-OB<br>TANDEM DHA/TANDEM OB | |
| **PROTON PUMP INHIBITORS[AP]** | | | |
| | DEXILANT/KAPIDEX (dexlansoprazole)<br>NEXIUM (esomeprazole) | ACIPHEX (rabeprazole)<br>lansoprazole<br>NEXIUM PACKETS (esomeprazole)<br>omeprazole<br>pantoprazole<br>PREVACID capsules (lansoprazole) (Rx and OTC)<br>PREVACID Solu-Tabs (lansoprazole)<br>PREVACID Suspension (lansoprazole)<br>PRILOSEC (omeprazole)<br>PROTONIX (pantoprazole)<br>ZANTAC-PPI (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<br><br>Prior authorization is not required for Prevacid Solu-Tabs for patients ≤8 years of age. |
| **PULMONARY ANTIHYPERTENSIVES[CL]** | | | |
| | **ENDOTHELIN RECEPTOR ANTAGONISTS** | | |
| | LETAIRIS (ambrisentan)<br>TRACLEER (bosentan) | | These agents will only be approved for the treatment of pulmonary artery hypertension World Health Organization (WHO) group I.<br><br>Letairis will only be approved for patients with WHO class II or III symptoms after a fourteen (14) day trial of the preferred agent unless one of the exceptions on the PA form is present. |

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| 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. |
| **SEDATIVE HYPNOTICS[AP]** | | | |
| | **BENZODIAZEPINES** | | |
| | temazepam | DALMANE (flurazepam)<br>DORAL (quazepam)<br>estazolam<br>flurazepam<br>HALCION (triazolam)<br>PROSOM (estazolam)<br>RESTORIL (temazepam)<br>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)<br>AMBIEN CR (zolpidem)<br>AQUA CHLORAL (chloral hydrate)<br>chloral hydrate<br>EDLUAR SL (zolpidem)<br>LUNESTA (eszopiclone)<br>ROZEREM (ramelteon)<br>SOMNOTE (chloral hydrate)<br>SONATA (zaleplon)<br>zaleplon | |

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| THERAPEUTIC DRUG CLASS | PREFERRED AGENTS | NON-PREFERRED AGENTS | PA CRITERIA |
|---|---|---|---|
| **STIMULANTS AND RELATED AGENTS** | | | |
| | **AMPHETAMINES** | | |
| | ADDERALL XR (amphetamine salt combination)<br>amphetamine salt combination<br>dextroamphetamine<br>VYVANSE (lisdexamfetamine) | ADDERALL (amphetamine salt combination)<br>amphetamine salt combination ER<br>DESOXYN (methamphetamine)<br>DEXEDRINE (dextroamphetamine)<br>DEXTROSTAT (dextroamphetamine) | Except for Strattera, PA is required for adults >18 years.<br><br>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.<br><br>Thirty (30) day trials of at least three (3) antidepressants are required before amphetamines will be approved for depression.<br>Provigil will only be approved for patients >16 years of age with a diagnosis of narcolepsy.<br>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)<br>FOCALIN (dexmethylphenidate)<br>FOCALIN XR (dexmethylphenidate)<br>METADATE CD (methylphenidate)<br>methylphenidate<br>methylphenidate ER<br>STRATTERA (atomoxetine) | DAYTRANA (methylphenidate)<br>dexmethylphenidate<br>INTUNIV ER (guanfacine)<br>METADATE ER (methylphenidate)<br>NUVIGIL (armodafinil)<br>pemoline<br>PROVIGIL (modafinil)<br>RITALIN (methylphenidate)<br>RITALIN LA (methylphenidate)<br>RITALIN-SR (methylphenidate) | Intuniv ER will be approved only after thirty (30) day trials of at least one product from of all chemically unique entities of preferred stimulants (amphetamines and non amphetamine), as well as Strattera and generic guanfacine unless one of the exceptions on the PA form is present |

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|---|---|---|---|
| **ULCERATIVE COLITIS AGENTS[AP]** | | | |
| | **ORAL** | | 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. |
| | APRISO (mesalamine)<br>ASACOL (mesalamine) 400mg<br>COLAZAL (balsalazide)<br>DIPENTUM (olsalazine)<br>PENTASA (mesalamine) 250mg<br>sulfasalazine | ASACOL HD (mesalamine) 800mg<br>AZULFIDINE (sulfasalazine)<br>balsalazide<br>LIALDA (mesalamine)<br>PENTASA (mesalamine) 500mg | |
| | **RECTAL** | | |
| | CANASA (mesalamine)<br>mesalamine<br>SF ROWASA (mesalamine) | | |
| **MISC BRAND/GENERIC** | | | |
| | CATAPRES-TTS (clonidine)<br>EPIPEN (epinephrine)<br>MEGACE ES (megestrol)<br>megestrol<br>SANDOSTATIN (octreotide)<br>SANTYL (collagenase)<br>TWINJECT (epinephrine)<br>YASMIN (ethinyl estradiol/drospirenone) | clonidine patch<br>MEGACE (megestrol)<br>Ocella (ethinyl estradiol/drospirenone)<br>octreotide<br>YAZ (ethinyl estradiol/drospirenone) | Thirty (30) day trials each of the preferred agents are required before a non-preferred agent will be authorized. |

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