CATEGORY	Coverage Indicator	Step Order	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS	PA Required	Comments	Criteria
** PLEASE NOTE: All cost effective generics applicable to DEL are considered PREFERRED Drugs. "BASIC" Covered Drugs are bolded with the Coverage Indicator of "MC / DEL".*									
General Criteria for all PDL categories - For more information or help using the PDL, providers may call 1-888-445-0497; members should call 1-866-796-2463. To access PDL and PA materials via the internet: www.mainecarepdl.org									
A: Preferred Drugs - Unless otherwise specified, preferred drugs are available without prior authorization. Step order may apply for preferred drugs in some drug categories as indicated on the PDL. (See item "D" below for explanation of step order.)									
B: Requests for Non-preferred Drugs - Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.									
C: Adequate Drug Trials - 1. The minimum trial period for each preferred and step order drug is two weeks, unless otherwise stated within specific PDL drug categories; trials with less than a two week duration will be reviewed on a case-by-case basis; 2. A trial will not be considered valid if preferred or non-preferred products were readily available (by override, individual purchase, samples, etc.); 3. Certain drug trials, such as with controlled substances, may require evidence that the preferred drugs were actually tried (example: with random pill counts and with random urine drug tests, using the methods of GC/MS with no lower threshold); 4. Adequate trials require documentation of attempts to titrate dose of preferred agents toward desired clinical response. 5. Adequate trials include prevention/treatment of common adverse effects associated with preferred agents (example: antinausea, antipruritics, etc.)									
D: Step Order - When numbers appear in the "step order" column, it means drugs in this category must be used in the order specified, with the lower numbers having preference over the higher numbers. Chart notes should be provided to confirm drug trials that do not appear in the member's MaineCare drug profile.									
E. The Department will institute strategies to ensure cost effectiveness through the use of an enhanced Drug Benefit Preferred brand drugs will no longer be preferred in any PDL drug category where preferred generic drugs are also available. It is expected that preferred generics will be used prior to any preferred brands. This will be operated as a form of step care. Preferred brands in these categories will require prior authorization for these high utilization / high cost members.									
F: Brand Name Medication Requests - (Must be submitted on the Brand Name PA request form)- According to MaineCare Benefits Manual Chapter II (80.07-5), when medically necessary covered brand-name drugs have an A-rated generic equivalent available, the most cost effective medically necessary version will be approved and reimbursed, since the brand-name and A-rated generic drugs have been determined by the FDA to be chemically and therapeutically equivalent. The Bureau does not make determinations as to whether or not a generic drug is clinically inferior or inequivalent to its brand version. This is the proper role of the FDA. Physicians should submit their reports of generic inequivalence directly to the FDA via the MEDWATCH.									
G: PA requests for non- FDA Approved Indications - Decisions will be made on a case-by-case basis until the DUR committee is able to review the evidence and make a recommendation. Interim approvals and DUR recommendations for approval of a drug for a non- FDA approved indication will require a minimum of two published, peer reviewed, non contradicted, double-blind, placebo-controlled randomized clinical studies establishing both safety and efficacy.									
H: Dose Consolidation Requirements - Some drugs may also be affected by dose consolidation requirements. Please see Dose Consolidation List and/or Splitting Tables provided in the PDL.									
I. Trials from Multiple Drug Classes - Trial/failure/intolerance to preferred agents from multiple classes within the same category or other catagories of drugs may be required prior to the approval of non-preferred agents (e.g., Cymbalta, Zofran, Elidel and others).									
J. Drug-specific PA Forms - Drug-specific PA forms contain medical necessity documentation requirements and/or criteria that may not be repeated in the PDL. Drug-specific PA forms may be obtained on the web at *www.mainecarepdl.org* .									
K. PA Exemptions for Prescribers- According to MaineCare Benefits Manual Chapter II (80.07-4), providers may receive a three (3) month exemption from prior authorization requirement for certain categories of drugs when they demonstrate high compliance with the Department's PDL. The Department will notify providers in writing which drug categories are included and what dates apply to the exemption. If a provider loses his/ her exemption, members who previously were not required to obtain a PA while the prescriber was exempt will be required to do so, and criteria for approval of that medication will need to be met.									
L: Drug-Drug Interactions (DDI) - The DUR Committee has implemented new drug-drug interation edits requiring prior authorization. Several drug-drug combinations and PDL drug catagories are affected by new PA requirements. These will be indicated in the PDL with DDI notation. Please see the DDI document provided in the PDL.									
ASSORTED ANTIBIOTICS									
BETA-LACTAMS / CLAVULANATE COMBO'S	MC/DEL		AMOXICILLIN	MC/DEL		AMOXIL 500MG TABS		1. Amoxil 500mg tabs are non-preferred. All other Amoxil products are preferred. 2.Principen 250 mg is available without PA. 3. Chewable 125mg & 250mg and Solution 125mg/5ml and 250mg/5ml available without PA. 4. Use preferred generic amoxicillin/clavulanate potassium alternatives. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **DDI:** Ampicillin will now be non-preferred and require prior authorization if it is currently being used in combination with either Prevacid, Protonix, Prilosec, or any currently non preferred PPI.
	MC/DEL		AMOXICILLIN/POTASSIUM CLA CHEW	MC/DEL		AUGMENTIN ES-600 SUSR			
	MC/DEL		AMOXICILLIN/POTASSIUM CLA SUSR	MC/DEL		AUGMENTIN[3]			
	MC/DEL		AMOXICILLIN/POTASSIUM CLA TABS	MC/DEL		AUGMENTIN XR TB12[4]			
	MC/DEL		AMOXIL[1]	MC		PRINCIPEN CAPS[2]			
	MC/DEL		AMPICILLIN	MC		PRINCIPEN SUSR			
	MC		BEEPEN						
	MC		BICILLIN L-A SUSP						
	MC/DEL		DICLOXACILLIN SODIUM CAPS						
	MC		DYNAPEN SUSR						
	MC		GEOCILLIN TABS						
	MC		OXACILLIN SODIUM SOLR						
	MC/DEL		PENICILLIN V POTASSIUM						
	MC		TICAR SOLR						
	MC		TIMENTIN SOLR						
	MC		TRIMOX						
	MC		UNASYN SOLR						
	MC		VEETIDS						
	MC/DEL		ZOSYN						
CEPHALOSPORINS	MC/DEL		CEFADROXIL HEMIHYDRATE	MC		CECLOR[1]		1. Both brand and generic are clinically non-preferred. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **DDI:** Vantin will now be non-preferred and require prior authorization if it is currently being used in combination with either Prevacid, Protonix, Prilosec, or any currently non preferred PPI.
	MC/DEL		CEFAZOLIN SODIUM SOLR	MC		CEDAX			
	MC/DEL		CEFDINIR	MC/DEL		CEFACLOR[1]			
	MC/DEL		CEFPODOXIME SUSP	MC/DEL		CEFADROXIL MONOHYDRATE TABS			
	MC/DEL		CEFPODOXIME 100MG	MC/DEL		CEFTIN			
	MC/DEL		CEFPODOXIME 200MG	MC		CEFZIL			
	MC/DEL		CEFPROZIL	MC/DEL		DURICEF TABS			
	MC		CEFTAZIDIME 6MG	MC/DEL		FORTAZ			
	MC/DEL		CEFTIN SUSP	MC/DEL		FORTAZ SOLN			
	MC/DEL		CEFTRIAXONE	MC		KEFLEX CAPS			
	MC/DEL		CEFUROXIME AXETIL TABS	MC		OMNICEF			
	MC/DEL		CEPHALEXIN MONOHYDRATE	MC/DEL		ROCEPHIN			
	MC/DEL		DURICEF SUSR	MC/DEL		SUPRAX			
	MC/DEL		FORTAZ SOLR	MC		TAZICEF SOLR			
	MC		KEFZOL SOLR	MC/DEL		TAZIDIME SOLN			
	MC		MAXIPIME SOLR	MC/DEL		VANTIN 200MG			

	MC	TAZICEF 6GM					
	MC/DEL	TAZIDIME					
	MC/DEL	VANTIN 100MG					
	MC/DEL	VANTIN SUSP					
MACROLIDES / ERYTHROMYCIN'S	MC	BIAXIN XL[1]	MC/DEL		AZITHROMYCIN POWDER	1. 7- Day supply per month without PA.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **DDI:** Preferred erythromycin will now be non-preferred and require prior authorization if it is currently being used in combination with either Enablex 15mg or Vesicare 10mg. Any non preferred formulation of erythromycin will require prior authorization and the member's drug profile will also be monitored for concurrent use with either Enablex 15mg or Vesicare 10mg. **DDI:** Preferred clarithromycin formulations (clarithromycin tablets and Biaxin XL tablets) will now be non-preferred and require prior authorization if they are currently being used in combination with either Enablex 15mg or Vesicare 10mg. Any non preferred formulation of clarithromycin will require prior authorization and the member's drug profile will also be monitored for concurrent use with either Enablex 15mg or Vesicare 10mg.
	MC/DEL	AZITHROMYCIN TABS	MC		BIAXIN		
	MC/DEL	AZITHROMYCIN SUSP	MC/DEL		CLARITHROMYCIN SUSP		
	MC/DEL	CLARITHROMYCIN TABS	MC/DEL		DYNABAC D5-PAK TBEC		
	MC	E.E.S.	MC		ERYPED CHEW		
	MC	E-MYCIN TBEC	MC		PCE TBEC		
	MC	ERYPED 200 SUSR	MC/DEL		ZITHROMAX TABS	Use PA Form# 20420	
	MC	ERYPED 400 SUSR	MC/DEL		ZITHROMAX 1GM PAK		
	MC	ERY-TAB TBEC	MC/DEL		ZITHROMAX TRI-PAK		
	MC	ERYTHROCIN STEARATE TABS	MC/DEL		ZITHROMAX SUSP		
	MC/DEL	ERYTHROMYCIN	MC/DEL		ZMAX		
TETRACYCLINES	MC/DEL	DOXYCYCLINE HYCLATE	MC		DECLOMYCIN TABS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL	MINOCYCLINE HCL CAPS	MC/DEL		DORYX CPEP		
	MC	SUMYCIN	MC/DEL		DOXYCYCLINE MONO CAPS		
	MC/DEL	TETRACYCLINE HCL CAPS	MC/DEL		DYNACIN CAPS		
	MC/DEL	VIBRAMYCIN SYRP	MC		MONODOX CAPS		
			MC		ORACEA		
			MC/DEL		PERIOSTAT		
			MC/DEL		SOLODYN ER		
FLUOROQUINOLONES	MC	AVELOX SOLN	MC		CIPRO	1. QL 3/script/month Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **DDI:** All preferred fluoroquinolones will require clinical PA for patients over 60 that are currently on immunosuppressants or steroid therapy.
	MC	AVELOX TABS	MC		CIPRO XR[1]		
	MC	AVELOX ABC PACK TABS	MC		FLOXIN TABS		
	MC/DEL	CIPROFLOXACIN	MC		FACTIVE		
	MC/DEL	LEVAQUIN TABS	MC/DEL		LEVAQUIN TABS SOLN/INJ		
	MC/DEL	OFLOXACIN	MC		NOROXIN TABS		
			MC		PROQUIN XR		
			MC		TEQUIN		
AMINO GLYCOSIDES	MC	GENTAMICIN					Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL	NEOMYCIN SULFATE TABS					
	MC	TOBI NEBU					
	MC/DEL	TOBRAMYCIN SULFATE SOLN					
ANTI-MYCOBACTERIALS / ANTI-TUBERCULOSIS	MC/DEL	ETHAMBUTOL HCL TABS	MC		RIMACTANE CAPS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL	MYAMBUTOL TABS					
	MC/DEL	MYCOBUTIN CAPS					
	MC/DEL	RIFAMPIN					
ANTIMALARIAL AGENTS	MC/DEL	**CHLOROQUINE PHOSPHATE TABS**	MC		ARALEN TABS	Use PA Form# 20420 1. Ingredients available as preferred without PA.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL	**DARAPRIM TABS**	MC		ISONARIF[1]		
	MC/DEL	**HYDROXYCHLOROQUINE TABS**	MC/DEL		MALARONE TABS		
	MC/DEL	**LARIAM TABS**	MC/DEL		**PLAQUENIL TABS**		
	MC/DEL	**MEFLOQUINE HCL TABS**	MC		QUALAQUIN		
	MC	QUINACRINE HCL POWD					
	MC/DEL	**QUININE SULFATE**					
ANTHELMINTICS	MC/DEL	ALBENZA TABS	MC		VERMOX CHEW	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC	BILTRICIDE TABS					
	MC/DEL	MEBENDAZOLE CHEW					
	MC/DEL	STROMECTOL TABS					
ANTIBIOTICS - MISC.	MC	AZACTAM SOLR	MC		COLY-MYCIN-M SOLR	1. Need to fail other anti-protozoals 2. 375mg caps and 750mg tabs are non-preferred. Please use available preferred strengths(250mg & 500mg tabs) to obtain required dose without PA. 3. Please use multiple 5gm which are preferred to obtain dose without PA. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. 1. For macrolide resistant infections when quinolones inappropriate **DDI:** Ketek is non-preferred but with any prior authorization requests, the member's drug profile will also be monitored for concurrent use with either Enablex 15mg or Vesicare 10mg.
	MC	COLISTIMETHATE SODIUM SOLR	MC/DEL		FLAGYL CAPS		
	MC	FUROXONE TABS	MC/DEL		FLAGYL TABS		
	MC/DEL	METRONIDAZOLE[2]	MC/DEL		FLAGYL ER TBCR		
	MC	PENTAMIDINE ISETHIONATE SOLR	MC/DEL		KETEK		
	MC	PRIMSOL SOLN	MC/DEL		LORABID		
	MC/DEL	TRIMETHOPRIM TABS	MC/DEL		METRONIDAZOLE 375MG CAPS[2]		
	MC	VANCOCIN HCL	MC/DEL		METRONIDAZOLE 750MG TABS[2]		
	MC/DEL	VANCOMYCIN 5GM INJ.	MC		NEBUPENT SOLR		
			MC/DEL		PROLOPRIM TABS		
			MC		TINDAMAX[1]		
			MC/DEL		VANCOMYCIN 10GM INJ.[3]		
			MC		XIFAXAN		
CARBAPENEMS			MC		INVANZ SOLR	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
			MC		MERREM SOLR		
			MC/DEL		PRIMAXIN		
LINCOSAMIDES /	MC/DEL	CLEOCIN SOLN	MC/DEL		CLEOCIN CAPS	1. Use multiple 150's for	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is

OXAZOLIDINONES / LEPROSTATICS	MC/DEL		CLEOCIN SUSR	MC/DEL		CLINDAMYCIN HCL 300CAPS[1]	Clindamycin instead of 300's.	offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. For Zyvox, please see the criteria listed in the Zyvox PA form.
	MC/DEL		CLINDAMYCIN HCL 150CAPS	MC/DEL		ZYVOX SUSR	Zyvox: use PA Form # 30820	
	MC		DAPSONE TABS	MC/DEL		ZYVOX TABS	Others: use PA Form # 20420	
ANTI INFECTIVE COMBO'S - MISC.	MC/DEL		ERYTHROMYCIN/SULF SUSR	MC		BACTRIM DS TABS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		SEPTRA/DS TABS					
	MC/DEL		SULFAMETHOXAZOLE/TRIMETH					
	MC/DEL		TRIMETHOPRIM/SULFAMETHOXA					
ANTIPROTOZOALS				MC		ALINIA[1]	1. Alina is preferred for children less than 12 years of age. Use PA Form# 20420	
ANTI - FUNGALS								
ANTIFUNGALS - ASSORTED	MC		ANCOBON CAPS	MC/DEL	5	LAMISIL TABS[4]	1. QL--1/every 7-day period (150mg only). 2. Sporanox QL 300cc/month with PA. See quantity limit table. 3. Sporanox QL 30/month with PA. See quantity limit table. Non-preferred products must be used in specified step order. Continue to use Anti-Fungal PA form for non-preferred products. 4. Quantity limit of one tablet daily. Please see dosage consolidation list. 5. Approved if immuno suppressed/ HIV or if the member has failed a 7 day trial of a preferred antifungal therapy. 6. Eraxis will be approved if submitting with documentation that it was initiated during a hospitalization and this request is to finish the hospital course. 8. Quantity limits allowing 30 day supply without PA. PA will be required if using > 30 days. 10. For children < 18, quantity limits allows 8 weeks supply without PA. PA will be required if using > than 8 weeks. If 18 and older PA will be required for any quantity. Not approving for Onychomycosis indication. Please use PA form #20420 for Noxafil.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. The other criteria are listed on the Antifungal PA form including the required proof of a non-cosmetic fungal infection. **DDI:** Preferred ketoconazole will now be non-preferred and require prior authorization if it is currently being used in combination with either Enablex 15mg or Vesicare 10mg. **DDI: Any** Griseofulvin will now be non-preferred and require prior authorization if it is currently being used in combination with either Prevacid, Protonix, Prilosec, or any currently non preferred PPI. **DDI:** Sporanox is non-preferred but with any prior authorization requests, the member's drug profile will also be monitored for current use with Enablex 15mg, Vesicare 10mg, Prandin, Prevacid, Protonix, Prilosec, or any currently non preferred PPI, due to a significant drug-drug interaction. **DDI:** Fluconazole (except 150mg strength) will now be non-preferred and require prior authorization if it is currently being used with glimepiride (Amaryl), Enablex 15mg, or Vesicare 10mg. Diflucan is non-preferred but with any prior authorization requests, the member's drug profile will also be monitored for concurrent use with either glimepiride (Amaryl), Enablex 15mg, or Vesicare 10mg.
	MC/DEL		FLUCONAZOLE[1]	MC	6	SPORANOX SOLN[2]		
	MC/DEL		GRIFULVIN V TABS[10]	MC	6	SPORANOX PULSEPAK CAPS[3]		
	MC		GRISEOFULVIN SUSP[10]	MC	7	SPORANOX CAPS[3]		
	MC		GRISEOFULVIN ULTRAMICROSI TABS[10]	MC/DEL	8	ERAXIS INJ[6]		
	MC		GRIS-PEG TABS[10]	MC/DEL	8	DIFLUCAN		
	MC/DEL		KETOCONAZOLE TABS[8]	MC	8	GRIFULVIN SUSP		
	MC/DEL		NYSTATIN	MC	8	NIZORAL TABS		
	MC/DEL		TERBINAFINE TABS[4]	MC/DEL	8	NOXAFIL[5]		
	MC/DEL		VFEND TABS					
ANTI - VIRALS								
ANTIRETROVIRALS	MC/DEL		AGENERASE CAPS	MC/DEL		DIDANOSINE	Fuzeon use PA Form # 10620	Please refer to the criteria listed on the Fuzeon PA form.
	MC/DEL		APTIVUS	MC/DEL		FUZEON[3]		
	MC		ATRIPLA[1]	MC/DEL		INTELENCE[3]		
	MC/DEL		COMBIVIR TABS	MC/DEL		ISENTRESS[3]		
	MC/DEL		CRIXIVAN CAPS	MC/DEL		RETROVIR	1. Quantity limit of one per day 2. Only preferred if Norvir script is in member's profile within the past 30 days of filling Prezista	**DDI:** Reyataz will now be non-preferred and require prior authorization if it is currently being used in combination with either Prevacid, Protonix, Prilosec, or any currently non preferred PPI . **DDI:** Preferred Norvir will now be non-preferred and require prior authorization if it is currently being used in combination with either Enablex 15mg or Vesicare 10mg.
	MC		EMTRIVA	MC/DEL		SELZENTRY[3]		
	MC/DEL		EPIVIR / HBV	MC		ZERIT		
	MC/DEL		EPZICOM					
	MC/DEL		FORTOVASE CAPS					

	MC		HIVID TABS				filling Prezista	
	MC/DEL		INVIRASE CAPS				3. Prescribers with >= 10 ART scripts per quarter and 75% ART PDL compliance will be exempt from PA for these products.	**DDI:** Preferred Crixivan caps will now be non-preferred and require prior authorization if it is currently being used in combination with either Enablex 15mg or Vesicare 10mg.
	MC		KALETRA					
	MC/DEL		LEXIVA					
	MC		NORVIR					
	MC		PREZISTA[2]					
	MC/DEL		RESCRIPTOR TABS					
	MC		REYATAZ					
	MC		STAVUDINE					
	MC		SUSTIVA					
	MC/DEL		TRIZIVIR TABS					
	MC		TRUVADA					
	MC		VIDEX / EC					
	MC/DEL		VIRACEPT TABS					
	MC/DEL		VIRAMUNE TABS					
	MC		VIREAD TABS					
	MC/DEL		ZIAGEN TABS					
	MC/DEL		ZIDOVUDINE					
CYTO-MEGALOVIRUS AGENTS	MC		FOSCARNET SODIUM	MC		CYTOVENE CAPS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		VALCYTE TABS	MC/DEL		FOSCAVIR		
				MC/DEL		GANCICLOVIR		
HERPES AGENTS	MC/DEL		ACYCLOVIR	MC/DEL		FAMVIR TABS	Must fail Acyclovir and Valtrex before non-preferred products.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		VALTREX TABS	MC/DEL		ZOVIRAX	Use PA Form# 20420	
INFLUENZA AGENTS	MC/DEL		AMANTADINE	MC/DEL		FLUMADINE TABS	1. Tamiflu 10 caps or 60cc's per month.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		RELENZA DISKHALER AEPB	MC		FLUMIST[2]	Will be audited for presence of positive influenza tests in patient or family member.	
	MC/DEL		RIMANTADINE HCL TABS				2. For Flumist requests use Form # 10610 Others Use PA Form # 20420	
	MC/DEL		TAMIFLU[1]					
IMMUNE SERUMS								
IMMUNE SERUMS			HYPERRHO INJ					
HEPATITIS AGENTS								
HEPATITIS C AGENTS	MC/DEL		PEGASYS KIT[1]	MC/DEL		COPEGUS TABS	1. Dosing limits apply, please see dosage consolidation list.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		PEGASYS SOLN	MC/DEL		PEG-INTRON KIT[2]	2. Current users are grandfathered.	
	MC/DEL		REBETRON KIT	MC/DEL		REBETOL CAPS	Use PA Form# 20420	
	MC		RIBAVIRIN					
HEPATITIS AGENTS - MISC.				MC		ACTIMMUNE	Use PA Form# 20420	Approved for chronic granulomatous disease, osteopetrosis and idiopathic pulmonary fibrosis.
HEPATITIS B ONLY	MC		HEPSERA TABS	MC		BARACLUDE		
				MC		TYZEKA		
RSV PROPHYLAXIS								
RSV PROPHYLAXIS				MC		SYNAGIS[1]	Use PA Form # 30120 1. MaineCare will approve Synagis PA's for start date of November 23rd for infants who meet the guidelines. PA will be approved for max of 5 doses. Maximum 1 dose/30 days.	Please see the criteria listed on the Synagis PA form.
MS TREATMENTS								
MULTIPLE SCLEROSIS - INTERFERONS	MC		AVONEX KIT[1]	MC/DEL		EXTAVIA	1.Clinical PA is required to establish diagnosis and medical necessity.	Non-Preferred drugs must be tried in step-order and failed due to lack of efficacy or intolerable side effects before lower ranked non-preferred drugs will be approved , unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**BETASERON SOLR**[1]					
	MC		REBIF SOLN[1]					
MULTIPLE SCLEROSIS - NON-INTERFERONS	MC/DEL		**COPAXONE**[2]	MC/DEL	8	TYSABRI[1]	1. Providers must be enrolled in the TOUCH Prescribing program, a restricted distribution	

							program. Clinical PA is required to establish diagnosis and medical necessity. 2. Clinical PA is required to establish diagnosis and medical necessity. Use PA Form # 20430	
ASSORTED NEUROLOGICS								
NEUROLOGICS - MISC.	MC MC/DEL MC		MESTINON ORAP TABS PROSTIGMIN TABS	MC MC/DEL		BOTOX MYOBLOC[1]	1. Myobloc approval will be limited to Cervical Dystonia. Use PA Form #10210	Failed/did not tolerate therapeutic trials fo muscle relaxants, unless contraindicated, including but not limited to baclofen, cyclobenzaprine, orphenadrine, Skelaxin, and tizanidine.
STEROIDS								
GLUCOCORTICOIDS/ MINERALOCORTICOIDS	MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		CELESTONE SUSP CORTEF 5 CORTISONE ACETATE TABS DELTASONE TABS DEPO-MEDROL SUSP DEXAMETHASONE ENTOCORT EC CP24 FLUDROCORTISONE ACETATE TABS HYDROCORTISONE KENALOG METHYLPREDNISOLONE TABS PREDNISOLONE **PREDNISONE** SOLU-CORTEF SOLR SOLU-MEDROL SOLR	MC MC MC/DEL MC/DEL MC MC MC MC MC MC		CORTEF 10 and 20 TABS DECADRON TABS FLORINEF TABS **MEDROL TABS** MEDROL DOSEPAK TABS ORAPRED SOLN PEDIAPRED LIQD PREDNISONE INTENSOL CONC PRELONE SYRP STERAPRED TABS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **DDI:** All preferred steroids will require clinical PA for patients over 60 that are currently on fluoroquinolone therapy.
HORMONE REPLACEMENT THERAPIES								
ANDROGENS / ANABOLICS	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC MC		ANDRODERM PT24 ANDROGEL ANDROID CAPS DANAZOL CAPS DEPO-TESTOSTERONE OIL FLUOXYMESTERONE TABS TESTOSTERONE PROPIONATE TESTRED CAPS WINSTROL TABS	MC MC MC MC/DEL MC/DEL MC/DEL		ANDRO LA 200 OIL DELATESTRYL OIL HALOTESTIN TABS METHITEST TABS OXANDRIN TABS[1] TESTIM	Use PA Form# 20420 **1. Non-preferred effective 12.01.05.** Use the Oxandrin PA Form #20600	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Additionally, laboratory evidence of a testosterone deficiency must be supplied. One of each dosage form should be tried (tablet, injection, and topical)
ESTROGENS - PATCHES / TOPICAL	MC/DEL MC/DEL		**ESTRADERM PTTW**[1] **VIVELLE-DOT PTTW**[1]	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL 8	5 8 8 8 8	**ESTRADIOL PTWK** **ALORA PTTW** **CLIMARA PTWK** **DIVIGEL** **ELESTRIN** **EVAMIST**	1. Both preferred drugs must be tried. 2. Step order drugs must be used in specified step order. Use PA Form# 20420	Approved for failures on multiple oral estrogen agents after 90 day trials or if unable to swallow any oral medication.
ESTROGENS - TABS	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		**CENESTIN TABS** **ESTRADIOL** **ESTROPIPATE TABS** **MENEST TABS** **PREMARIN TABS**	MC/DEL MC/DEL MC MC/DEL MC		ENJUVIA **ESTRACE TABS** ESTRATAB TABS **OGEN TABS** ORTHO-EST TABS	Must fail preferred products before non-preferred products. Use PA Form# 20420	Preferred drugs must be tried for at least 90 days and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ESTROGEN COMBO'S	MC/DEL MC/DEL		**PREMPHASE TABS** **PREMPRO TABS**	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		**ACTIVELLA TABS** **COMBIPATCH PTTW** **FEMHRT 1/5 TABS** **ORTHO-PREFEST TABS** SYNTEST H.S. TABS	Must fail Premphase and Prempro products before non preferred products. Use PA Form# 20420	Preferred drugs must be tried for at least 90 days and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
PROGESTINS	MC/DEL MC/DEL MC		MEDROXYPROGESTERONE ACETA [2] NORETHINDRONE ACETATE TABS[2] PROGESTERONE POWD	MC/DEL MC MC/DEL MC/DEL MC/DEL		AYGESTIN TABS CYCRIN TABS PROMETRIUM 100MG CAPS[1] PROMETRIUM 200MG[1] PROVERA TABS	1. PA approvals will require two 100 mg caps instead of one 200mg. 2. Must fail Medroxyprogesterone and Norethidrone products before non-preferred products. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
CONTRACEPTIVES								
CONTRACEPTIVES - PROGESTIN ONLY	MC		ORTHO MICRONOR TABS	MC/DEL MC/DEL MC/DEL MC/DEL		CAMILA TABS ERRIN JOLIVETTE NORA-BE TABS	If member experienced adverse reactions, consider using Oral Contraceptives from other groups.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.

				MC/DEL		NOR-QD TABS		
				MC/DEL		OVRETTE 28 TABS	Use PA Form# 20420	
CONTRACEPTIVES - INJECTABLE	MC/DEL		MEDROXYPROGESTERONE ACETATE 150mg IM	MC/DEL MC/DEL		DEPO-PROVERA 150 mg SUSP LUNELLE SUSP	Use PA Form# 20420	The preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
CONTRACEPTIVE - EMERGENCY	MC/DEL		NEXT CHOICE[1]	MC/DEL		PLAN - B	1. Allowed 4 tablets per 30 days without PA Use PA Form# 20420	
CONTRACEPTIVES - PATCHES/ VAGINAL PRODUCTS	MC/DEL MC		NUVARING RING[3] ORTHO EVRA PTWK[1,2,4]				1.No PA required for users less than 21 years of age. 2. The FDA has issued a public health warning of the potentials for increased exposure to estrogen with Ortho Eva use, possibly up to 60% estrogen exposoure. 3. Quantity limit allowing 1 every 28 days with out PA. 4. Dose limits apply allowing 3 patches per 28 days supply. Please refer to Dose Consolidation Chart.	Approved if adequate clinical reason given why patient unable to comply with other preferred agents including long acting injectable.
CONTRACEPTIVES - MONOPHASIC COMBINATION O/C'S	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC MC MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		APRI TABS BALZIVA CRYSELLE-28 TABS DESOGEN TABS DESOGESTREL/ ETHINYL ESTRADIOL LOW-OGESTREL TABS MODICON TABS MONONESSA ORTHO-CEPT-28 TABS ORTHO-CYCLEN-28 TABS ORTHO-NOVUM 1/35-28 TABS ORTHO-NOVUM 1/50-28 TABS OVCON-50 28 TABS PREVIFEM RECLIPSEN SOLIA SPRINTEC 28 TABS YASMIN 28 TABS ZENCHENT SEASONIQUE LOSEASONIQUE	MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		AVIANE TABS BREVICON-28 TABS DEMULEN 1/35-21 TABS KARIVA TABS LESSINA-28 TABS LEVORA LOESTRIN TABS LOESTRIN FE TABS LOESTRIN FE 1/20 TABS LOESTRIN 1.5/30-21 TABS LOESTRIN 1/20-21 TABS LO/OVRAL 21 TABS LO/OVRAL 28 TABS MICROGESTIN FE TABS MIRCETTE TABS NECON NORDETTE-28 TABS NORINYL NORTREL OCELLA OGESTREL TABS OVCON-35/28 TABS OVRAL PORTIA-28 TABS SEASONALE YAZ ZOVIA	Use PA Form# 20420 If member experienced adverse reactions, consider using Oral Contraceptives from other groups.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
CONTRACEPTIVES - BI-PHASIC COMBINATIONS	MC		ORTHO-NOVUM 10/11-28 TABS NORETHINDRONE-ETH ESTRADIOL TAB 0.5-35/1-35	MC/DEL		NECON 10/11-28 TABS	If member experienced adverse reactions, consider using Oral Contraceptives from other groups. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
CONTRACEPTIVES - TRI-PHASIC COMBINATIONS	MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL MC		ENPRESSE NECON 7/7/7 ORTHO-NOVUM 7/7/7-28 TABS TRI-PREVIFEM TRIPHASIL 28 TABS TRI-SPRINTEC TRINESSA	MC/DEL MC/DEL MC/DEL MC MC MC/DEL		CYCLESSA TABS ESTROSTEP FE TABS NORTREL 7/7/7 ORTHO TRI-CYCLEN TABS ORTHO TRI-CYCLEN LO TABS TRI-NORINYL 28 TABS	If member experienced adverse reactions, consider using Oral Contraceptives from other groups. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.

	MC/DEL		TRIVORA-28 TABS					
DIABETES THERAPIES								
DIABETIC - INSULIN	MC		HUMALOG INJ 100/ML	MC/DEL		APIDRA	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		HUMALOG MIX 75/25	MC		HUMALOG MIX 50/50		
	MC		HUMULIN N INJ U-100	MC		HUMULIN INJ 50/50		
	MC		HUMULIN INJ 70/30	MC		HUMULIN R INJ U-500		
	MC		HUMULIN R U-100	MC		RELION		
	MC/DEL		LANTUS SOLN					
	MC/DEL		LEVEMIR					
	MC/DEL		**NOVOLIN**					
	MC/DEL		**NOVOLOG**					
	MC/DEL		**NOVOLOG MIX**					
DIABETIC - PENFILLS	MC/DEL		LANTUS OPTICLIK PEN [1]	MC		APIDRA OPTICLIK PEN	1. Clinical PA will be required to establish significant visual or neurological impairment.	
	MC/DEL		LANTUS SOLOSTAR[1]					
	MC/DEL		**LEVEMIR FLEXPEN** [1]	MC		HUMALOG KWIK INJ 100/ML		
	MC/DEL		**NOVOLIN PENFILL**[1]	MC		HUMALOG MIX INJ 75/25 KWP		
	MC/DEL		**NOVOLIN 70/30**[1]	MC		HUMALOG MIX INJ 50/50 KWP		
	MC/DEL		NOVOLOG MIX PENFILL[1]	MC		HUMALOG PEN SOLN		
	MC/DEL		**NOVOLOG PENFILL SOLN**[1]	MC		HUMULIN PEN	Use PA Form# 20420	
	MC/DEL		NOVOLOG MIX FLEXPEN[1]	MC		HUMULIN N PN INJ U-100		
	MC/DEL		NOVOLOG FLEXPEN[1]	MC		HUMULIN PEN INJ 70/30		
DIABETIC - DPP- 4 ENZYME INHIBITOR	MC/DEL		JANUVIA[1]				1. Preferred if therapeutic doses of metformin are seen in members drug profile for at least 60 days within the past 18 months or if phosphate binder is currently seen in the members drug profile. Dosing limits apply. Please refer to Dose consolidation list.	
	MC		ONGLYZA[1]					
DIABETIC - DPP- 4 ENZYME INHIBITOR-COMBO	MC/DEL		JANUMET[1]				1. Preferred if therapeutic doses of metformin are seen in members drug profile for at least 60 days within the past 18 months or if phosphate binder is currently seen in the members drug profile. Dosing limits apply. Please refer to Dose consolidation list.	
DIABETIC - LANCET-LANCET DEVICE			ONE TOUCH LANCETS				Use PA Form# 20420	
			FREESTYLE LANCETS					
			UNILET LANCETS					
			UNISTIK LANCING DEVICE					
			AUTOLOT LANCING DEVICE					
DIABETIC - SYRINGES-NEEDLES			BD MICRO-FINE				Use PA Form# 20420	
			BD ULTRA-FINE					
			BD ULTRA-FINE PEN NEEDLES					
			UNIFINE PEN NEEDLES					
DIABETIC - OTHER				MC/DEL		CYCLOSET	Use PA Form #301501	Please see the criteria listed in the Symlin PA form.
				MC		SYMLIN		
DIABETIC MONITOR	MC		FREESTYLE LITE SYSTEM KIT	MC		ACCUCHECK	Effective October 25th 2007, approvals for all non preferred meters/ test strips will require medical necessity documenting clinically significant features that are not available on any of the preferred meters.	
	MC		FREESTYLE FLASH SYSTEM KIT	MC		ASCENSIA		
	MC		FREESTYLE FREEDOM SYSTEM KIT	MC		ASSURE		
	MC		FREESTYLE FREEDOM LITE KIT	MC		EXACTECH		
	MC		ONE TOUCH ULTRA 2 KIT	MC		PRODIGY		
	MC		ONE TOUCH ULTRA MINI KIT					
	MC		ONE TOUCH ULTRA SMART KIT					
	MC		PRECISION XTRA METER				Use PA Form# 20420	
DIABETIC TEST STRIPS	MC		FREESTYLE[1]	MC		ACCUCHECK	Effective October 25th 2007, approvals for all non preferred meters/ test strips	
	MC		FREESTYLE LITE[1]	MC		ASCENSIA		

	MC MC MC MC MC MC		ONE TOUCH BASIC[1] ONE TOUCH SURESTEP[1] ONE TOUCH FAST TAKE[1] ONE TOUCH ULTRA[1] PRECISION XTRA[1] PRECISION XTRA BETA KETONE 10 CT	MC MC MC		ASSURE EXACTECH PRODIGY	preferred meters/ test strips will require medical necessity documenting clinically significant features that are not available on any of the preferred meters. 1. Only 50 ct & 100 ct package size. Use PA Form# 20420	
INCRETIN MIMETIC				MC		BYETTA[1]	1. If patient is not responding to oral agents (single or multiple) please look to insulin therapy. Dosing limits apply. Please refer to Dose Consolidation List. Use PA Form# 10230	
DIABETIC - ORAL SULFONYLUREAS	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		**CHLORPROPAMIDE TABS** GLIMEPIRIDE **GLIPIZIDE TABS** **GLIPIZIDE ER TABS** **GLYBURIDE TABS** **GLYBURIDE MICRONIZED TABS** **TOLAZAMIDE TABS** **TOLBUTAMIDE TABS**	MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL		**AMARYL TABS** **DIABETA TABS** GLUCOTROL TABS **GLUCOTROL XL TBCR** **GLYNASE TABS** **MICRONASE TABS**	Use PA Form# 20420	Preferred drugs must be tried for at least 3 months at full therapeutic doses and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **DDI:** All sulfonylureas (except glyburide) will now be non-preferred and require prior authorization if it is currently being used with either ranitidine or cimetidine. **DDI:** Glimepiride will now be non-preferred and require prior authorization if it is currently being used with either fluconazole (except 150mg strength) or fluvoxamine. Amaryl is non-preferred but with any prior authorization requests, the member's drug profile will also be monitored for concurrent use with either fluconazole or fluvoxamine.
DIABETIC -ORAL BIGUANIDES	MC/DEL MC/DEL		**METFORMIN HCL TABS** METFORMIN ER	MC MC MC/DEL		GLUCOPHAGE TABS GLUCOPHAGE XR TB24 FORTAMET	Use PA Form# 20420	Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
DIABETIC - THIAZOL / BIGUANIDE COMBO				MC/DEL MC/DEL MC/DEL		ACTOPLUS MET[1] AVANDARYL[1] **AVANDAMET TABS**[1]	Use PA Form# 20420 1. Requires use of Actos, Metformin, or other preferred anti-diabetics.	**DDI:** Actos, Avandia, or any combination product with Actos or Avandia will now be non-preferred and require prior authorization if it is currently being used with gemfibrozil.
DIABETIC - / THIAZOL	MC/DEL		**ACTOS 15MG TABS**[1]	MC/DEL MC/DEL		**ACTOS 30MG AND 45MG TABS**[2] **AVANDIA TABS**[3]	1. Actos is non-preferred as monotherapy. Actos is preferred if therapeutic doses of metformin, sulfonylurea or insulin are seen in members drug profile for at least 60 days within the past 18 months. 2. Actos 30mg or 45mg - please use multiple 15mg tabs. 3. Current users of Avandia who have tried Actos will be able to continue use of Avandia. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **DDI:** Actos, Avandia, or any combination product with Actos or Avandia will now be non-preferred and require prior authorization if it is currently being used with gemfibrozil.
DIABETIC - ALPHAGLUCOSIDASE	MC/DEL		**GLYSET TABS**	MC		PRECOSE TABS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
DIABETIC - SULFONYLUREA / BIGUANIDE	MC/DEL		GLYBURIDE/METFORMIN	MC MC MC/DEL		GLUCOVANCE TABS METAGLIP TABS DUETACT[1]	Use individual ingredients. 1. Use Actos 15mgs with generic glimepiride. Use PA Form# 20420	Approved for patients failing to achieve good diabetic control with maximal doses of individual components.
DIABETIC - MEGLITINIDES	MC/DEL		**STARLIX TABS**	MC/DEL MC		**PRANDIN TABS** NATEGLINIDE	Use PA Form# 20420	Preferred drugs from other diabetic sub-categories must be tried and failed due to lack of inadequate diabetic control or intolerable side effects before non-preferred drug will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.

								DDI: Prandin is non-preferred but with any prior authorization requests, the member's drug profile will also be monitored for current use with both Sporanox and gemfibrozil, due to a significant drug-drug interaction.
GLUCOSE ELEVATING AGENTS								
GLUCOSE ELEVATING AGENTS	MC/DEL		GLUCAGEN INJ. HYPOKIT	MC/DEL		GLUCAGON DIAGNOSTIC KIT	Use PA Form# 20420	
	MC/DEL			MC/DEL		GLUCAGEN DIAGNOSTIC KIT		
THYROID								
THYROID HORMONES	MC/DEL		**ARMOUR THYROID TABS**	MC		LEVOTHYROXINE SODIUM SOLR	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**CYTOMEL TABS**	MC/DEL		LIOTHYRONINE		
	MC/DEL		**LEVOTHROID TABS**	MC/DEL		SYNTHROID TABS		
	MC/DEL		**LEVOTHYROXINE SODIUM TABS**					
	MC/DEL		**LEVOXYL TABS**					
	MC/DEL		**THYROID TABS**					
	MC/DEL		**THYROLAR**					
	MC/DEL		**UNITHROID TABS**					
ANTITHYROID THERAPIES	MC/DEL		**METHIMAZOLE TABS**	MC/DEL		**TAPAZOLE TABS**	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**PROPYLTHIOURACIL TABS**					
OSTEOPOROSIS								
OSTEOPOROSIS	MC/DEL		ALENDRONATE	MC/DEL		**ACTONEL TABS**	Use PA Form# 20420 1. Approval only requires failure of Alendronate or Boniva. 2. Quantity limits apply, please see dosage consolidation list. 3. Please use Alendronate and Vitamin D.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		BONIVA TABS[2]	MC/DEL		BONIVA INJECTION KIT		
	MC/DEL		**FOSAMAX SOLN[2]**	MC		AREDIA SOLR		
	MC/DEL		**MIACALCIN SOLN[2]**	MC/DEL		**DIDRONEL TABS**		
				MC		EVISTA TABS[1]		
				MC		FORTEO		
				MC/DEL		FORTICAL		
				MC/DEL		**FOSAMAX TABS AND PLUS D[3]**		
CALCIMIMETIC AGENTS								
CALCIMIMETIC AGENTS				MC		SENSIPAR	Use PA Form # 30115	Baseline PTH, Ca, and phosphorous levels are required and initial approvals will be limited to 3 months. Subsequent approvals will require additional levels being done to assess changes. Will not approve if baseline Ca is less than 8.4.
GROWTH HORMONE								
GROWTH HORMONE	MC/DEL		GENOTROPIN[1]	MC/DEL	5	NORDITROPIN CARTRIDGE SOLN	Use PA Form # 10710 1.Clinical PA is required to establish diagnosis and medical necessity. 2. Products must be used in specified step order. All step 5's must be tried prior to moving to step 8's.	See Growth Hormone PA form for criteria. Step-order will still apply unless clinical contraindication supplied.
	MC/DEL		NUTROPIN[1]	MC/DEL	5	TEV-TROPIN		
	MC/DEL		NUTROPIN AQ[1]	MC	8	HUMATROPE SOLR[2]		
	MC		OMNITROPE[1]	MC	8	INCRELEX[2]		
				MC	8	IPLEX[2]		
				MC	8	SAIZEN SOLR[2]		
SOMATOSTATIC AGENTS	MC/DEL		SANDOSTATIN			SOMATULINE	Use PA Form # 10710	
GROWTH HORMONE ANTAGONISTS								
GH ANTAGONISTS				MC		SOMAVERT	Use PA Form # 10710	Approved for acromegaly patients failing surgery/radiation/drug therapy including bromocriptine and sandostatin.
VASOPRESSIN RECEPTOR ANTAGONIST								
VASOPRESSIN RECEPTOR ANTAGONIST				MC/DEL		SAMSCA	Use PA Form# 20420	
URINARY INCONTINENCE								
VASOPRESSINS			DESMOPRESSIN TABS	MC/DEL	5	DDAVP TABS	Products must be used in specified step order. Nocturnal enuresis patients will be encouraged to periodically attempt stopping DDAVP. Use PA Form# 20420	Approved for central diabetes insipidus and for nocturnal enuresis. For nocturnal enuresis- must be over 6 years old, must fail an adequate trial of alarm training (higher success rate, lower relapse rate) and must periodically attempt weaning (at 6 month intervals). * Patients with a diagnosis of hemophilia or Von Willebrands disease will be exempt from prior authorization.
				MC/DEL	6	DDAVP SOLN		
				MC	6	DESMOPRESSIN SPRAY		
				MC/DEL	8	DESMOPRESSIN ACETATE SOLN		
				MC/DEL	8	STIMATE SOLN*		
ANTISPASMODICS	MC/DEL		**OXYBUTYNIN**	MC/DEL		**CYSTOSPAZ TABS**	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		URISPAS TABS	MC/DEL		**DETROL TABS**		
				MC/DEL		**DITROPAN**		
ANTISPASMODICS - LONG ACTING	MC/DEL		**DETROL LA CP24**	MC		DITROPAN XL TBCR	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		ENABLEX[1]	MC/DEL		**OXYTROL**		
	MC		SANCTURA					

	MC		SANCTURA XR					1. Vesicare 5mg and Enablex 7.5mg maximum doses if given with drugs known to be significant CYP3A4 inhibitors.(Ketoconazole, Sporanox, Erythromycin, Biaxin, Nefazodone, Nelfinavir, and Ritonavir) **DDI:** Enablex 15mg and Vesicare 10mg will now be non-preferred and require prior authorization if they are currently being used in combination with any of the following medications: clarithromycin, erythromycin, Ketek, Crixivan, Norvir, ketoconazole, fluconazole, Sporanox. nefazodone, or diltiazem.
	MC/DEL		TOVIAZ					
	MC		VESICARE[1]					
CHOLINERGIC	MC/DEL		**URECHOLINE**					
METABOLIC MODIFIER								
HERED. TYROSINEMIA				MC		ORFADIN	Use PA Form# 20420	Approved for Type 1 hereditary tyrosinemia patients. Must include laboratory evidence of dx at first PA.
ANTIHYPERTENSIVES / CARDIAC								
CARDIAC GLYCOSIDES	MC/DEL		**DIGITEK TABS**					
	MC/DEL		**DIGOXIN**					
	MC/DEL		**LANOXICAPS**					
	MC/DEL		**LANOXIN**					
ANTIANGINALS--Isosorbide Di-nitrate/ Mono-Nitrates	MC/DEL		**ISOSORBIDE MONONITRATE TABS**	MC		DILATRATE SR CPCR	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**ISOSORBIDE MONONITRATE ER**	MC		ISORDIL TABS		
				MC/DEL		**ISORDIL TITRADOSE TABS**		
				MC		ISOSORBIDE DINITRATE SUBL		
				MC/DEL		**ISOSORBIDE DINITRATE TABS**		
				MC/DEL		ISOSORBIDE DINITRATE CR TBCR		
				MC/DEL		**ISOSORBIDE DINITRATE ER TBCR**		
				MC/DEL		ISOSORBIDE DINITRATE TD TBCR		
				MC/DEL		**IMDUR TB24**		
				MC/DEL		ISMO TABS		
				MC		MONOKET TABS		
NITRO - OINTMENT/CAP/CR	MC		NITROBID OINT					
	MC/DEL		**NITROGLYCERIN CPCR**					
	MC		NITROL OINT					
	MC		NITRO-TIME CPCR					
NITRO - PATCHES	MC/DEL	1	**NITROGLYCERIN PT24**	MC		NITRODISC PT24	At least 2 step 1's and step 3 of the preferred products must be used in specified order or PA will be required. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL	1	**NITREK PT24**	MC/DEL		**NITRO-DUR PT24**		
	MC/DEL	1	**NITRO-DUR PT 24 0.8MG**					
	MC/DEL	3	**MINITRAN PT24**					
NITRO - SUBLINGUAL/ SPRAY	MC		NITROLINGUAL AERS	MC		NITROLINGUAL SOLN	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**NITROSTAT SUBL**	MC/DEL		**NITROQUICK SUBL**		
	MC/DEL		**NITROTAB SUBL**					
BETA BLOCKERS - NON SELECTIVE	MC		CARVEDILOL	MC/DEL		**BETAPACE TABS**	1. Recommend using BID since its effects do not last 24 hours. 2. Please use other strengths in combination to obtain this dose. 3. Dosing limits still apply. Please see dose consolidation list Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		LEVATOL TABS	MC		**BETAPACE AF TABS**		
	MC/DEL		**NADOLOL TABS**	MC/DEL		**COREG CR[3]**		
	MC/DEL		**PINDOLOL TABS**	MC/DEL		**COREG TABS**		
	MC/DEL		**PROPRANOLOL HCL SOLN[1]**	MC/DEL		**CORGARD TABS**		
	MC/DEL		**PROPRANOLOL HCL TABS[1]**	MC/DEL		**INDERAL TABS**		
	MC/DEL		**PROPRANOLOL LA CAPS**	MC/DEL		**INDERAL LA CPCR**		
	MC/DEL		SOTALOL HCL TABS	MC		INNOPRAN XL		
	MC/DEL		**TIMOLOL MALEATE TABS**	MC/DEL		**PROPRANOLOL HCL 60MG TABS[2]**		
				MC		RANEXA		
BETA BLOCKERS - CARDIO SELECTIVE	MC/DEL		**ACEBUTOLOL HCL CAPS**	MC/DEL		BYSTOLIC	1. Recommend using Atenolol (and metoprolol) BID since its effects do not last 24 hours. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**ATENOLOL TABS[1]**	MC		KERLONE TABS		
	MC		BETAXOLOL HCL TABS	MC/DEL		**LOPRESSOR TABS**		
	MC/DEL		**BISOPROLOL FUMARATE TABS**	MC/DEL		METOPROLOL ER		
	MC/DEL		**METOPROLOL TARTRATE TABS[1]**	MC		SECTRAL CAPS		
	MC/DEL		**TOPROL XL TB24**	MC/DEL		**TENORMIN TABS**		
				MC/DEL		**ZEBETA TABS**		
BETA BLOCKERS - ALPHA / BETA	MC/DEL		**LABETALOL HCL TABS**	MC		TRANDATE TABS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
CALCIUM CHANNEL BLOCKERS--Amlodipines, Bepridil, Diltiazems, Felodipines, Isradipines, Nifedipines, Nisoldipine, and Verapamils	MC/DEL		AMLODIPINE[1]	MC/DEL		**NORVASC TABS[1]**	1. Dosing limits apply, please see dose consolidation list.	
	MC	1	DILTIA XT CP24	MC	5	DILACOR XR CP24	Products must be used in specified order or PA will be required. Just write "Diltiazem 24-hour"and the pharmacy will use a preferred long acting diltiazem that does not require PA. Use PA Form# 20420	Preferred drugs must be tried and failed (in step-order) due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **DDI:** All preferred diltiazems will now be non-preferred and require prior authorization if they are currently being used in combination with either Enablex 15mg or Vesicare 10mg. All non-preferred diltiazems require prior authorization, but with any prior authorization request, the member's drug profile will also be monitored for current use with Enablex 15mg or Vesicare 10mg.
	MC/DEL	1	**DILTIAZEM HCL ER CP24**	MC	6	TAZTIA		
	MC/DEL	1	**DILTIAZEM HCL XR CP24**	MC/DEL	7	**TIAZAC CP24**		
	MC/DEL	1	**DILTIAZEM CD 300MG CP24**	MC/DEL	8	**CARDIZEM TABS**		
	MC/DEL	1	**DILTIAZEM CD 360MG CP24**	MC/DEL	8	**CARDIZEM CD CP24**		
	MC	4	CARTIA XT CP24	MC	8	CARDIZEM LA TB24		
	MC/DEL	4	**DILTIAZEM CD CP24**	MC	8	CARDIZEM SR CP12		
	MC/DEL	4	**DILTIAZEM HCL ER CP24**	MC/DEL	8	**DILTIAZEM HCL TABS**		
	MC/DEL	4	**DILTIAZEM XR CP24**	MC/DEL	8	**DILTIAZEM HCL ER CP12**		

				MC/DEL		**PLENDIL TB24**	Use PA Form# 20420	Other Preferred calcium channel blockers must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
				MC		DYNACIRC CAPS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
				MC		DYNACIRC CR TBCR[1]	1. Established users will be grandfathered	
				MC/DEL		CARDENE CAPS	Use PA Form# 20420	Other Preferred calcium channel blockers must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
				MC/DEL		**CARDENE SR CPCR**		
				MC/DEL		**NICARDIPINE HCL CAPS**		
	MC/DEL		**AFEDITAB CR**	MC		ADALAT CC TBCR	Established users of Adalat CC are grandfathered.	Preferred drug must be tried and failed in step order due to lack of efficacy or intolerable side effects before non-preferred drugs in step order will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**NIFEDIAC CC**	MC/DEL		**NIFEDIPINE CAPS**		
	MC/DEL		**NIFEDICAL XL TBCR**	MC		PROCARDIA CAPS		
	MC/DEL		**NIFEDIPINE TBCR**	MC/DEL		**PROCARDIA XL TBCR**	Use PA Form# 20420	
	MC/DEL		**NIFEDIPINE ER TBCR**					
				MC		SULAR TB24	Established users of 10MG and 20MG strengths are grandfathered.	
	MC/DEL	1	**VERAPAMIL HCL CR TBCR**	MC/DEL		**CALAN TABS**	Products must be used in specified order or PA will be required. Just write "Verapamil 24-hour" and the pharmacy will use a preferred long acting generic that does not require PA.	Preferred drugs must be tried and failed (in step-order) due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL	1	**VERAPAMIL HCL ER TBCR**	MC/DEL		**CALAN SR TBCR**		
	MC/DEL	1	**VERAPAMIL HCL SR TBCR**	MC/DEL		**COVERA-HS TBCR**		
				MC		ISOPTIN-SR		
				MC/DEL		VERAPAMIL HCL ER CP24		
				MC		VERAPAMIL HCL SR CP24		
				MC		VERAPAMIL HCL TABS		
				MC		VERELAN CP24		
				MC		VERELAN PM CP24	Use PA Form# 20420	
ANTIARRHYTHMICS	MC/DEL		**AMIODARONE**	MC/DEL		**CORDARONE**	1. Prescription must be written by Cardiologist.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**FLECAINIDE**	MC/DEL		**DISOPYRAMIDE**		
	MC/DEL		**MEXILETINE**	MC/DEL		**MEXITIL**		
	MC/DEL		MULTAQ	MC/DEL		**PACERONE**		
	MC/DEL		**NORPACE**	MC		QUINIDEX		
	MC/DEL		**PROCAINAMIDE**	MC/DEL		TAMBOCOR	Use PA Form# 20420	**DDI:** Amiodarone will now be non-preferred and require prior authorization if it is currently being used in combination with either Lovastatin (doses greater than 40mg/day) or Lipitor (doses greater than 20mg/day).
	MC/DEL		**PROCANBID CR**	MC/DEL		TIKOSYN[1]		
	MC/DEL		**PROPAFENONE**					
	MC		QUINAGLUTE					**DDI:** Multaq will be preferred unless the following medications are seen in the member's drug profile within the last 35 days for brand name medications or 90 days for generic medications: Erythromycin, Amiodarone and other antiarrhythmics, TCA's, Phenothiazine, Ketoconazole, Itraconazole, Voriconazole, Cyclosporine, Telithromycin, Clarithromycin, Nefazodone, Ritonavir.
	MC/DEL		**QUINIDINE GLUCONATE**					
	MC/DEL		**QUINIDINE SULFATE**					
	MC		RYTHMOL					
ACE INHIBITORS	MC/DEL		**BENAZEPRIL HCL**	MC	5	MAVIK TABS	Non-preferred products must be used in specified order.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs (in step-order) will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Non-preferred products are subject to step-order requirements unless clinical circumstances warrant exception.
	MC/DEL		**CAPTOPRIL TABS**	MC/DEL	5	**ACCUPRIL TABS**		
	MC/DEL		**ENALAPRIL MALEATE TABS**	MC/DEL	8	**ACEON TABS**		
	MC/DEL		**FOSINOPRIL SODIUM**	MC/DEL	8	**ALTACE CAPS**	Use PA Form# 20420	
	MC/DEL		**LISINOPRIL TABS**	MC	8	CAPOTEN TABS		
	MC/DEL		**RAMIPRIL**	MC/DEL	8	**LOTENSIN TABS**		
	MC/DEL		**QUINAPRIL**	MC/DEL	8	**MOEXIPRIL**		
				MC	8	**MONOPRIL HCT TABS**		
				MC/DEL	8	**PRINIVIL TABS**		
				MC/DEL	8	**UNIVASC**		
				MC	8	VASOTEC TABS		
				MC/DEL	8	**ZESTRIL TABS**		
ANGIOTENSIN RECEPTOR BLOCKER	MC		AVAPRO	MC/DEL		**ATACAND TABS**	Use PA Form# 20420	The initial criteria to use any ARB is that the member must have failed ACE inhibitors (such as due to coughing) in the past or must currently be actively treated for diabetes and Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**BENICAR TABS**	MC/DEL		**COZAAR 50MG & 100MG**[1]	Preferred products only available without PA if patient on diabetic therapy or prior ACE therapy.	
	MC/DEL		**COZAAR TABS 25MG**[2]	MC		TEVETEN TABS		
	MC/DEL		**DIOVAN**				1. Please use multiple preferred 25mg tabs.	
	MC/DEL		**MICARDIS TABS**				2.Dosing limits apply. Please see dose consolidation list.	
DIRECT RENIN INHIBITOR				MC/DEL		TEKTURNA[1]	1. Must show failure of single and combination therapy from all preferred antihypertensive categories	
							Use PA Form# 20420	
ANTIHYPERTENSIVES -	MC/DEL		**CATAPRES-TTS**	MC/DEL		**CATAPRES TABS**	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is

CENTRAL	MC/DEL		CLONIDINE HCL TABS	MC		GUANABENZ ACETATE TABS		offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		GUANFACINE HCL TABS	MC		ISMELIN TABS		
	MC/DEL		HYDRALAZINE HCL TABS	MC		MINIPRESS CAPS		
	MC		HYLOREL TABS	MC/DEL		TENEX TABS		
	MC/DEL		METHYLDOPA TABS					
	MC/DEL		MINOXIDIL TABS					
	MC/DEL		PRAZOSIN HCL CAPS					
	MC/DEL		RESERPINE TABS					
ACE INHIBITORS AND CA CHANNEL BLOCKERS				MC/DEL		LEXXEL TBCR	Use individual preferred generic medications.	
				MC/DEL		LOTREL CAPS		
				MC		TARKA TBCR	Use PA Form# 20420	
ACE AND THIAZIDE COMBO'S	MC/DEL		BENAZEPRIL HCL/HYDROCHLOR	MC/DEL		ACCURETIC TABS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		CAPTOPRIL/HYDROCHLOROTHIA	MC		CAPOZIDE TABS		
	MC/DEL		ENALAPRIL MALEATE/HCTZ TABS	MC/DEL		LOTENSIN HCT TABS		
	MC/DEL		LISINOPRIL-HCTZ TABS	MC		MONOPRIL HCT TABS		
				MC/DEL		PRINZIDE TABS		
				MC/DEL		UNIRETIC TABS		
				MC		VASERETIC TABS		
				MC/DEL		ZESTORETIC TABS		
BETA BLOCKERS AND DIURETIC COMBO'S	MC/DEL		ATENOLOL/CHLORTHALIDONE	MC		CORZIDE TABS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		BISOPROLOL FUMARATE/HCTZ	MC/DEL		INDERIDE 40/25 TABS		
	MC/DEL		PROPRANOLOL/HCTZ	MC/DEL		LOPRESSOR HCT TABS		
				MC		TENORETIC		
				MC		TIMOLIDE 10/25 TABS		
				MC/DEL		ZIAC TABS		
ARB'S AND CA CHANNEL BLOCKERS	MC/DEL		AZOR					
	MC/DEL		EXFORGE					
	MC/DEL		EXFORGE HCT					
ARB'S AND DIURETICS	MC		AVALIDE TABS	MC/DEL		ATACAND HCT TABS	Preferred products only available without PA if patient on diabetic therapy or prior ACE therapy.	Same initial criteria as the ARB class and Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		BENICAR HCT	MC		TEVETEN HCT TABS		
	MC/DEL		DIOVAN HCT TABS					
	MC/DEL		HYZAAR TABS					
	MC/DEL		MICARDIS HCT TABS				Use PA Form# 20420	
ARB'S AND DIRECT RENIN INHIBITOR COMBINATION				MC/DEL		VALTURNA	Use PA Form# 20420	
DIURETICS	MC/DEL		ACETAZOLAMIDE TABS	MC/DEL		ALDACTAZIDE TABS	1. Multiples of Spironolactone 25 mg are cheaper than 50 mg strength. Inspra will be approved for severe breast tenderness and male gynecomastia.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		BUMETANIDE	MC/DEL		ALDACTONE TABS		
	MC/DEL		CHLOROTHIAZIDE TABS	MC		AMILORIDE HCL		
	MC/DEL		CHLORTHALIDONE TABS	MC/DEL		BUMEX TABS		
	MC		EDECRIN TABS	MC/DEL		DEMADEX TABS		
	MC/DEL		FUROSEMIDE	MC/DEL		DIAMOX		
	MC/DEL		HYDROCHLOROTHIAZIDE	MC/DEL		DIURIL		
	MC/DEL		INDAPAMIDE TABS	MC/DEL		DYAZIDE CAPS		
	MC/DEL		METHAZOLAMIDE TABS	MC		ENDURON TABS	Use PA Form# 20420	
	MC/DEL		METHYCLOTHIAZIDE TABS	MC		INSPRA		
	MC/DEL		SPIRONOLACTONE 25MG TABS	MC/DEL		LASIX TABS		
	MC/DEL		SPIRONOLACTONE/HYDRO	MC		LOZOL TABS		
	MC/DEL		TORSEMIDE TABS	MC/DEL		MAXZIDE		
	MC/DEL		TRIAMTERENE/HCTZ	MC		MICROZIDE CAPS		
	MC		ZAROXOLYN TABS	MC/DEL		MIDAMOR TABS		
				MC		MODURETIC 5-50 TABS		
				MC		NAQUA TABS		
				MC		NATURETIN TABS		
				MC/DEL		SPIRONOLACTONE 50MG[1]		
CCB / LIPID	MC/DEL		CADUET					
LIPID DRUGS								
CHOLESTEROL - BILE SEQUESTRANTS	MC/DEL		CHOLESTYRAMINE	MC/DEL		PREVALITE	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		COLESTID	MC		QUESTRAN		
				MC/DEL		WELCHOL TABS		
CHOLESTEROL - FIBRIC ACID DERIVATIVES	MC/DEL		GEMFIBROZIL TABS	MC		ANTARA	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **DDI:** Gemfibrozil will now be non-preferred and require prior authorization if it is currently being used with any of the following medications: Prandin, Actos, Avandia, any Avandia/Actos combination product, or any HMG-COA Reductase Inhibitors (statins).
	MC/DEL		NIASPAN	MC		LOPID		
	MC		TRICOR	MC		LOFIBRA		
	MC		TRILIPIX	MC/DEL		FENOFIBRATE		
				MC		TRIGLIDE		
CHOLESTEROL - HGM COA + ABSORB INHIBITORS MORE POTENT DRUGS/COMBINATIONS	MC/DEL		LIPITOR	MC/DEL		CRESTOR	1. Dosing limits apply, please see dosage consolidation list.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		SIMVASTATIN[1]	MC		VYTORIN		
				MC/DEL		ZOCOR		

							Use PA Form# 20420	**DDI:** Lipitor (doses greater than 20mg/day) will now be non-preferred and require prior authorization if they are currently being used in combination cyclosporine. **DDI:** Lipitor (doses greater than 20mg/day) will now be non-preferred and require prior authorization if it is currently being used in combination with Amiodarone. **DDI:** All preferred statins will now be non-preferred and require prior authorization if it is currently being used in combination with Gemfibrozil.
CHOLESTEROL - HGM COA + ABSORB INHIBITORS LESS POTENT DRUGS/COMBINATIONS	MC/DEL MC/DEL MC/DEL MC/DEL		**LESCOL CAPS** LESCOL XL TB 24 LOVASTATIN TABS[2] PRAVASTATIN[2]	MC/DEL MC MC/DEL MC MC/DEL MC		ALTOPREV TB 24 LIVALO MEVACOR TABS PRAVACHOL TABS PRAVIGARD ZETIA TABS[1,]	1. Zetia available w/out PA as addition to Lipitor 80mg. Zetia will also be approved with a PA as add on for patients at maximally tolerated doses of statins. 2. Dosing limits apply, please see dosage consolidation list. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Zetia will be approved for patients unable to tolerate all other therapies or unable to achieve cholesterol goal with maximally tolerated dose of most potent statins. **DDI:** Lescol will now be non-preferred and require prior authorization if it is currently being used in combination with diclofenac. **DDI:** Lovastatin (doses greater than 40mg/day) will now be non-preferred and require prior authorization if it is currently being used in combination with Amiodarone. **DDI:** Lovastatin (doses greater than 20mg per day) will now be non-preferred and require prior authorization if it is currently being used in combination cyclosporine. **DDI:** All preferred statins will now be non-preferred and require prior authorization if it is currently being used in combination with Gemfibrozil.
CHOLESTEROL - HGM COA + ABSORB INHIBITORS STATIN/ NIACIN COMBO	MC/DEL MC/DEL		**SIMCOR** **ADVICOR TBCR**					
PULMONARY ANTI-HYPERTENSIVES								
PULMONARY ANTI-HYPERTENSIVES	MC/DEL MC MC/DEL		REVATIO[1] VENTAVIS[2] EPOPROSTENOL INJ[5]	MC/DEL MC		FLOLAN REMODULIN[3]	3. There will be dosing limits of one 20ml multidose vial/ 30 days supply without pa. 4. Viagra would be approved after a diagnosis of pulmonary hypertension is confirmed. 5. PA is required to establish and conferm who group 1 diagnosis of primary PAH (Primary Pulmonary Hypertension) and NYHA functional class 3 & 4 Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interation between another drug and the preferred drug(s) exists. 1. Revatio approvals will require WHO Group 1 diagnosis of primary PAH (Primary Pulmonary Hypertension) and NYHA functional class 2,3, or 4. 2. Ventavis approvals will require WHO Group 1 diagnosis of primary PAH (Primary Pulmonary Hypertension) and NYHA functional class 3 or 4.
ERA / ENDOTHELIN RECEPTOR ANTAGONIST	MC MC		TRACLEER LETAIRIS[1, 2]				1. Providers must be registered with LEAP Prescribing program, a restricted distribution program. 2. Clinical PA is required to establish diagnosis and medical necessity.	Tracleer approvals will require WHO Group 1 diagnosis of primary PAH (Primary Pulmonary Hypertension) and NYHA functional class 3 or 4. Letairis approvals will require WHO Group 1 diagnosis of primary PAH (Primary Pulmonary Hypertension) and functional class 2 or 3 symptoms.
IMPOTENCE AGENTS								
IMPOTENCE AGENTS							As of January 1, 2006, per CMS (federal govt.), impotence agents are no longer covered.	
ANTI-EMETOGENICS								
ANTIEMETIC - ANTICHOLINERGIC / DOPAMINERGIC	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC		MECLIZINE HCL TABS PHENERGAN SUPP PHENERGAN FORTIS SYRP PROMETHAZINE SUPP PROMETHAZINE TRANSDERM-SCOP PT72	MC MC/DEL MC/DEL MC/DEL MC/DEL MC		ANTIVERT TABS PHENERGAN SOLN PHENERGAN TABS PROMETHAZINE 50MG SUPP PROMETHEGAN SUPP TORECAN TABS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANTIEMETIC - 5-HT3 RECEPTOR ANTAGONISTS/ SUBSTANCE P NEUROKININ	MC/DEL MC MC MC		MARINOL CAPS ONDANSETRON TABS*[2] ONDANSETRON ODT TBDP*[2] ONDANSETRON INJ*	MC/DEL MC MC MC	5 8 8 8	GRANISETRON ALOXI ANZEMET TABS CESAMET[1]	*See quantity limit table. 1. Approvals will require diagnosis of chemo-induced nausea/vomiting and failed trials of all	Preferred drugs and step therapy must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. * Ondansetron limits still apply as listed on the Ondansetron PA form for covered indications including chemotherapy, radiotherapy, post operative nausea & vomiting and hyperemesis gravidarum. Other medical indications will be approved or denied on a case by case basis. Hyperemesis and other medical indications approved are still subject to failure of multiple preferred antiemesis drugs.

				MC	8	EMEND[3]	preferred anti-emetics, including 5-HT3 class (Ondansetron) and Marinol.	
				MC/DEL	8	KYTRIL		
				MC	8	SANCUSO		
				MC/DEL	8	ZOFRAN ODT TBDP*		
				MC/DEL	8	ZOFRAN TABS*	2. Ondansetron will be preferred with CA diag and dosing limits still apply.	
				MC/DEL	8	ZOFRAN INJ*	3. Clinical PA is required for members on highly emetic anti-neoplastic agents.	
							Ondansetron: use PA Form # 20610 Others: use PA Form # 20420	
NON-SEDATING ANTIHISTAMINES / DECONGESTANTS								
ANTIHISTIMINES - NON-SEDATING	MC MC/DEL MC MC MC/DEL MC/DEL		ALAVERT TABS CETIRIZINE TABS CLARITIN (OTC) CLARITIN SYRP (OTC) LORATADINE TAVIST ND (OTC)	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL	5 5 5 5 5 8 8 8 8	CLARINEX TABS[1] CLARINEX SYR[1,2] FEXOFENADINE[1] ZYRTEC[1] ZYRTEC SYR[1,2] ALLEGRA[3] CLARITIN[3] LORATADINE ODT[4] XYZAL[3]	1. Must fail preferred drugs, OTC loratidine and cetirizine before moving to non-preferred step order drugs. 2. Clarinex and Zyrtec syrup <6 yr w/o PA. 3. Must fail all step 5 drugs (Clarinex, Fexofenadine and Zyrtec) before moving to next step product. 4. All OTC versions of loratadine ODT are now non-preferred. Pseudoephedrine is available with prescription. Use PA Form # 20530	Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. No combination product with decongestant will be approved since pseudoephedrine available without PA.
ANTIHISTIMINES - OTHER	MC/DEL MC/DEL MC/DEL		CLEMASTINE CHLORPHENIRAMINE DIPHENHYDRAMINE					
ALLERGY / ASTHMA THERAPIES								
ANTIASTHMATIC - ANTICHOLINERGICS - INHALER	MC/DEL MC MC/DEL		**ATROVENT AERS** **ATROVENT HFA** SPIRIVA[1,2]				1. Quantity limit of 1 inhalation daily (1 capsule for inhalation daily) Spiriva will require PA if Combivent or Atrovent inhaler/nebulizer solution is in member's current drug profile. 2. We ask physicians to write "asthma" on the prescription whenever Sprivia is primarily being used for that condition.	
ANTIASTHMATIC - ANTICHOLINERGICS - NEBULIZER	MC/DEL		**IPRATROPIUM BROMIDE SOLN**	MC		ATROVENT SOLN	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANTIASTHMATIC - ANTIINFLAMMATORY AGENTS	MC/DEL MC/DEL MC/DEL		CROMOLYN SODIUM NEBU INTAL AERS TILADE AERS	MC/DEL		XOLAIR[1]	1. Need max inhaled steroids and written by pulmonary or allergy specialist Use PA Form# 20420	Xolair approval will require suboptimal response to maximal doses of inhaled steroid as evidenced by asthmatic ER/Hospital admissions and Allergy/Pulmonary specialist management.
ANTIASTHMATIC - NASAL STEROIDS	MC MC/DEL		FLUTICASONE SPR NASONEX SUSP	MC/DEL MC/DEL MC MC/DEL MC/DEL MC	5 5 5 8 8 8	BECONASE AQ INHA[1] NASACORT AQ AERS[1] NASAREL SOLN[1] FLONASE SUSP[2] FLUNISOLIDE SOLN[2] NASACORT AERS[2]	Use PA Form# 20420 Dosing limits apply to whole category, please see dosage consolidation list. 1. All preferred drugs must be tried before moving to	Preferred drugs and step therapy must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.

				MC/DEL	8	OMNARIS SPR	non preferred steps.		
				MC	8	RHINOCORT AERO[2]			
				MC/DEL	8	RHINOCORT AQUA SUSP[2]	2. All step 5 medications need to be tried before moving to step 8's.		
				MC	8	TRI-NASAL SOLN[2]			
				MC	8	VANCENASE POCKETHALER AERS[2]			
				MC/DEL	8	VERAMYST[2]			
ANTIASTHMATIC - NASAL MISC.	MC/DEL		CROMOLYN NASAL 4%	MC	7	ATROVENT NASAL SOL	Use PA Form# 20420	Approved if patient fails on nonsedating antihistamines and steroid nasal sprays. Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.	
	MC/DEL		NASALCROM	MC	7	IPRATROPIUM NASAL SOL[1]	1. Ipratropium will be approved if submitted with documentation supporting use of CPAP machine.		
	MC/DEL		OCEAN 0.65%	MC/DEL	7	ASTELIN			
	MC/DEL		SALINE NASAL SPRAY 0.65%	MC/DEL	8	ASTEPRO[2]	2. Utilize Multiple preferred, as well as step therapy Astelin.		
ANTIASTHMATIC - BETA - ADRENERGICS	MC/DEL		**ALBUTEROL NEB**	MC/DEL		**ACCUNEB NEBU**	1. Xopenex users w/ prior asthma hospitalization due to albuterol nebulizer failure will be grandfathered. 2. Quantity Limit: 12 cc/day. 3. Dosing limits apply, please see dosage consolidation list. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.	
	MC/DEL		**MAXAIR**	MC/DEL		**ALBUTEROL AER**			
	MC/DEL		**METAPROTERENOL**	MC/DEL		**ALBUTEROL HFA**			
	MC		**PROAIR HFA[3]**	MC/DEL		**ALBUTEROL 0.63mg/3ml**			
	MC/DEL		**PROVENTIL HFA AERS[3]**	MC/DEL		**ALUPENT AERP**			
	MC/DEL		**SEREVENT**	MC/DEL		**BRETHINE**			
	MC/DEL		**TERBUTALINE SULFATE TABS**	MC/DEL		**FORADIL AEROLIZER CAPS**			
	MC/DEL		**VENTOLIN HFA AERS[3]**	MC/DEL		**PROVENTIL**			
				MC/DEL		**VENTOLIN AERS**			
				MC		VOLMAX TBCR			
				MC		VOSPIRE ER TB12			
				MC/DEL		**XOPENEX HFA[3]**			
				MC/DEL		**XOPENEX NEBU[1,2]**			
ANTIASTHMATIC - ADRENERGIC COMBINATIONS	MC/DEL		**ADVAIR DISKUS/HFA[1]**				We ask physicians to write "asthma" on the prescription whenever Advair is primarily being used for that condition. 1. Dosing limits apply, please see dosage consolidation list. Use PA Form# 20420		
	MC/DEL		SYMBICORT[1]						
ANTIASTHMATIC - ADRENERGIC ANTICHOLINERGIC	MC/DEL		**ALBUTEROL/IPRATROPIUM NEB. SOLN**	MC/DEL		DUONEB SOLN[1]	1. Please use preferred individual ingredients Albuterol and Ipratropium. 2. We ask physicians to write "asthma" on the prescription whenever Combivent is primarily being used for that condition. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Duoneb components are available separately without PA.	
	MC/DEL		**COMBIVENT AERO[2]**						
ANTIASTHMATIC - XANTHINES	MC/DEL		**AMINOPHYLLINE TABS**	MC		QUIBRON CAPS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.	
	MC/DEL		THEOCHRON TB12	MC		QUIBRON-T TABS			
	MC/DEL		THEOLAIR-SR TB12	MC		QUIBRON-T/SR TB12			
	MC/DEL		**THEOPHYLLINE CR TB12**	MC/DEL		**THEO-24 CP24**			
	MC/DEL		THEOPHYLLINE ELIX	MC		THEOLAIR TABS			
	MC/DEL		THEOPHYLLINE SOLN	MC/DEL		**UNIPHYL TBCR**			
	MC/DEL		**THEOPHYLLINE ER CP12**						
	MC/DEL		**THEOPHYLLINE ER TB12**						
ANTIASTHMATIC - STEROID INHALANTS	MC/DEL		ASMANEX	MC/DEL	5	**AEROBID AERS[2]**	Dosing limits apply to whole category, please see dosage consolidation list. 1. No PA for Pulmicort susp if under 8 years old. 2. All preferreds must be tried before moving to non preferred steps. 3. All step 5 medications need to be tried before moving to step 8's. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.	
	MC/DEL		**AZMACORT AERS**	MC	5	BECLOVENT AERS[2]			
	MC/DEL		**FLOVENT DISKUS**	MC	5	VANCERIL AERS[2]			
	MC/DEL		**FLOVENT HFA**	MC/DEL	8	**AEROBID-M AERS[3]**			
	MC/DEL		**PULMICORT SUSP[1]**	MC/DEL	8	ALVESCO			
	MC		QVAR AERS	MC	8	VANCERIL DOUBLE STRENGTH AERS[3]			
				MC/DEL	8	**PULMICORT FLEXHALER**			

ANTIASTHMATIC - 5-Lipoxygenase Inhibitors				MC		ZYFLO CR TABS	Use PA Form# 20420	Other Preferred asthma controller drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANTIASTHMATIC - LEUKOTRIENE RECEPTOR ANTAGONISTS	MC/DEL		SINGULAIR[1]	MC/DEL		ACCOLATE TABS	1. We ask physicians to write "asthma" on the prescription whenever Singulair is primarily being used for that condition. **Use PA Form # 20420**	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANTIASTHMATIC - ALPHA-PROTEINASE INHIBITOR				MC		PROLASTIN SUSR	Use PA Form# 20420	Prolastin and Azemaira will be approved for members with A1AT deficiency and clinically demonstrable panacinar emphysema.
				MC		ZEMAIRA		
ANTIASTHMATIC - HYDRO-LYTIC ENZYMES				MC/DEL		PULMOZYME SOLN	Use PA Form# 20420	Will be approved for cystic fibrosis patients.
ANTIASTHMATIC - MUCOLYTICS	MC/DEL		ACETYLCYSTEINE[1]	MC		MUCOMYST	1. Acetylcysteine is covered with diagnosis of CF. Use PA Form# 20420	
COUGH/COLD								
COUGH/COLD			DEXTRO-GUAIF SYRP			All others are a non-covered service (this includes antihistamines-decongestive combinations).	All of cough cold preparations are not covered except these preferred products. Use PA Form# 20420	All non-preferred products are not covered as permitted by Federal Medicaid regulations and MaineCare Policy.
	MC/DEL		GUAIFENESIN SYRP					
	MC/DEL		PSEUDOEPHEDRINE					
	MC		ROBITUSSIN DM SYRP					
	MC		ROBITUSSIN SUGAR FREE SYRP					
DIGESTIVE AIDS / ASSORTED GI								
****Preferred drugs that used to require diag codes still require diag codes unless indicated otherwise.****								
GI - ANTIPERISTALTIC	MC/DEL		DIPHENOXYLATE	MC/DEL		LOFENE TABS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved,
	MC/DEL		DIPHENOXYLATE/ATROPINE	MC		LONOX TABS		unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage
	MC/DEL		LOPERAMIDE HCL CAPS/LIQ	MC/DEL		MOTOFEN TABS		of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		OPIUM TINCTURE TINC					As listed in MaineCare Policy, certain drugs require specific diagnoses for approval.
	MC		PAREGORIC TINC					
GI - ANTI-DIARRHEAL/ ANTACID - MISC.	MC/DEL		ATROPINE SULFATE SOLN	MC		B & O 15-A SUPPRETTE SUPP	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **As listed in MaineCare Policy, certain drugs require specific diagnoses for approval** .
	MC/DEL		BENTYL SYRP	MC		B & O 16-A SUPPRETTE SUPP		
	MC/DEL		BISMATROL	MC		BELLADONNA ALKALOIDS & OP		
	MC/DEL		BISMUTH SUBSALICYLATE	MC/DEL		BENTYL TABS		
	MC/DEL		CALCIUM CARBONATE (ANTACID) CHEW	MC/DEL		GLYCOPYRROLATE INJ		
	MC/DEL		DICYCLOMINE HCL	MC/DEL		HYOSCYAMINE SL		
	MC/DEL		GLYCOPYRROLATE TABS	MC/DEL		LEVBID TB12		
	MC		HAPONAL TABS	MC		LEVSIN ELIX		
	MC/DEL		HYOSCYAMINE CAPS & TABS	MC/DEL		LEVSIN TABS		
	MC/DEL		HYOSCYAMINE SULFATE	MC/DEL		LEVSIN/SL SUBL		
	MC/DEL		KAOPECTATE	MC/DEL		NULEV TBDP		
	MC/DEL		MAGNESIUM OXIDE TABS	MC		ROBINUL INJ		
	MC		MAG-OX 400 TABS	MC		ROBINUL TABS		
	MC/DEL		PAMINE TABS					
	MC/DEL		PROPANTHELINE BROMIDE TABS					
	MC/DEL		SAL-TROPINE TABS					
	MC		SCOPOLAMINE HYDROBROMIDE					
	MC/DEL		SODIUM BICARBONATE TABS					
	MC/DEL		TUMS					
GI - H2-ANTAGONISTS	MC/DEL		CIMETIDINE	MC		AXID CAPS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **DDI:** Ranitidine and cimetidine will now be non-preferred and require prior authorization if it is currently being used with any sulfonylurea (except for glyburide).
	MC/DEL		FAMOTIDINE	MC		AXID AR TABS		
	MC/DEL		RANITIDINE	MC/DEL		NIZATIDINE CAPS		
	MC/DEL		RANITIDINE SYRUP	MC/DEL		PEPCID		
	MC		ACID REDUCER TABS	MC		PEPCID AC		
				MC/DEL		TAGAMET TABS		
				MC/DEL		ZANTAC SYRUP		
				MC/DEL		ZANTAC TABS		
GI - PROTON PUMP INHIBITOR	MC/DEL		KAPIDEX[2]	MC	6	PRILOSEC OTC[4]	1. Prevacid Solutabs available without PA for children less than 9 years old. 2. Dosing limits apply, please see dosage consolidation list. 3. Please use multiple 20mg Capsules to obtain required dose.	All preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs (in step-order) will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Patients obtaining refills as of 7/10/09 will begin to require prior authorizations if they have been on any PPI longer than 60 days in the past year. The 12-month period is patient specific and begins 12 months before the requested date of prior authorization. Payment for usage beyond these limits will be authorized for cases in which there is a diagnosis of: 1. Barrett's esophagus. 2. Erosive esophagitis 3. Hypersecretory conditions (Zollinger-Ellison syndrome, systemic mastocytosis, multiple endocrine adenomas). Recurrent peptic ulcer disease after documentation of previous trials and therapy failure with at least one histamine H2-receptor antagonist at full therapeutic doses and with documentation of either failure of Helicobacter pylori
	MC/DEL		OMEPRAZOLE 10MG/20MG[2]	MC	7	ACIPHEX TBEC[4]		
	MC/DEL		PROTONIX[2]	MC/DEL	8	PREVACID CPDR[4,5]		
				MC/DEL	8	PREVACID SOLUTABS[1]		
				MC/DEL	8	NEXIUM CPDR[4]		
				MC/DEL	8	PRILOSEC CPDR		
				MC/DEL	8	PROTONIX INJ		
				MC	9	OMEPRAZOLE 40MG[3]		

							required dose. 4. All preferreds and step therapy must be tried and failed. 5.Established users prior to 10/1/09 may continue to obtain Prevacid until 12/31/09. Use PA Form # 20720	treatment or anegative Helicobacter pylori test result. 4. Symptomatic gastroesophageal reflux after documentation of previous trials and therapy failure with at least onehistamine H2-receptor antagonist at full therapeutic doses. **DDI:** Prevacid, Omeprazole and Protonix will now be non-preferred and require prior authorization if they are currently being used in combination with any of the following medications: Ampicillin, B-12, Fe salts, Griseofulvin, Sporanox, Ketoconazole, Reyataz, or Vantin. **DDI:** All non-preferred PPIs require prior authorization, but with any prior authorization request, the member's drug profile will also be monitored for current use with ampicillin, B-12, Fe salts, griseofulvin, itraconazole, ketoconazole, Reyataz or Vantin due to a significant drug-drug interaction.
GI - ULCER ANTI-INFECTIVE				MC MC		HELIDAC PREVPAC		
GI - PROSTAGLANDINS	MC		MISOPROSTOL TABS	MC/DEL		CYTOTEC TABS	Use PA Form# 20420	Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drug will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
GI - DIGESTIVE ENZYMES	MC/DEL MC/DEL MC/DEL MC MC MC		CREON LACTASE CHEW LACTASE TAB ULTRASE CPEP ULTRASE MT VIOKASE	MC/DEL MC/DEL MC/DEL MC MC/DEL MC MC MC/DEL MC/DEL MC/DEL MC		LACTRASE CAPS LIPRAM LIPRAM CR KUTRASE CAPS KU-ZYME CAPS PANCREASE PANCREASE MT PANCRECARB MS-8 CPEP PANCRELIPASE PANGESTYME PANOKASE TABS	Use PA Form# 20420	Non -Preferred drugs must be tried and failed in step-order due to lack of efficacy or intolerable side effects before other non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. In all cases except cystic fibrosis patients, objective evidence of pancreatic insufficiency (fat malabsorption test etc...) must be supplied.
GI - ANTI - FLATULENTS / GI STIMULANTS	MC MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL		CALULOSE SYRP CONSTULOSE SYRP ENULOSE SYRP GASTROCROM CONC GENERLAC SYRP LACTULOSE SYRP METOCLOPRAMIDE HCL SIMETHICONE	MC/DEL MC MC/DEL MC/DEL		AMITIZA[1] CEPHULAC SYRP INFANTS GAS RELIEF SUSP REGLAN TABS	Diag codes no longer necessary for preferred products. Lactulose has 60cc/day QL Use PA Form# 20420 1. Prior failed trials of multiple other preferred GI agents must occur first, Such as OTC senna, docusate, lactulose, polyethylene glycol.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **As listed in MaineCare Policy, certain drugs require specific diagnoses for approval.**
GI - INFLAMMATORY BOWEL AGENTS	MC/DEL MC MC MC MC MC/DEL MC/DEL MC/DEL MC/DEL		ASACOL TBEC APRISO AZULFIDINE TABS CANASA SUPP COLAZAL CAPS DIPENTUM CAPS PENTASA CPCR 250MG ROWASA ENEM **SULFAZINE EC TBEC** **SULFASALAZINE TABS**	MC/DEL MC/DEL MC/DEL MC/DEL		ASACOL 800MG HD AZULFIDINE EN-TABS TBEC PENTASA 500MG[2] LIALDA TABS[1]	Use PA Form# 20420 1. Current users grandfathered. 2. Use multiple Pentasa 250mg.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
GI - IRRITABLE BOWEL SYNDROME AGENTS				MC/DEL		LOTRONEX TABS	Use PA Form# 20420	Lotronex will be approved for females with IBS and predominant diarrhea. Prior failed trials of multiple preferred GI agents must occur first. IBS dx must be thoroughly documented.
MISCELLANEOUS GI								
****Preferred drugs that used to require diag codes still require diag codes unless indicated otherwise.****								
GI - MISC.	MC/DEL MC/DEL MC MC MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL MC MC/DEL MC MC MC/DEL MC		BISAC-EVAC SUPP BISACODYL BISCOLAX SUPP CINOBAC CAPS CITRATE OF MAGNESIA SOLN CITRUCEL DIOCTO SYRP DOCUSATE CALCIUM CAPS DOCUSATE SODIUM FIBER LAXATIVE TABS FLEET GENFIBER POWD GLYCERIN HIPREX TABS KRISTALOSE PACK MAALOX	MC/DEL MC MC/DEL MC/DEL MC/DEL MC MC MC MC/DEL MC/DEL MC/DEL MC MC/DEL MC MC MC		ACTIGALL CAPS BENEFIBER CARAFATE COLACE CAPS COLYTE DIOCTO-C SYRP DOC SOD /CAS CAP DOC-Q-LAX CAPS DOCUSATE SODIUM/CAS CAPS DOK PLUS DULCOLAX SUPP FIBER CON TABS FIBER-LAX TABS GOLYTELY SOLR MALTSUPEX MIRALAX PACK (OTC versions)	1. Must show evidence of trials of preferred agents that do not require PA, such as OTC senna, docusate, mineral oil and prescription lactulose. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **As listed in MaineCare Policy, certain drugs require specific diagnoses for approval.**

	MC		METAMUCIL	MC		MIRALAX POWD (OTC versions)		
	MC/DEL		MILK OF MAGNESIA SUSP	MC		PEG 3350/ELECTROLYTES SOLR		
	MC		MINERAL OIL OIL	MC/DEL		SENEXON TABS		
	MC/DEL		NULYTELY SOLR	MC/DEL		SENOKOT TABS		
	MC/DEL		SENNA	MC		SENOKOT S TABS		
	MC/DEL		SENOKOT GRAN	MC		STOOL SOFTENER PLUS CAPS		
	MC/DEL		SENOKOT SYRP	MC/DEL		UNI-CENNA TABS		
	MC/DEL		SENOKOT CHILDRENS SYRP	MC		UNI-EASE PLUS CAPS		
	MC		SENOKOT XTRA TABS	MC		V-R NATURAL SENNA LAXATIV TABS		
	MC/DEL		SORBITOL	MC		URSO 250		
	MC/DEL		STOOL SOFTENER CAPS					
	MC/DEL		SUCRALFATE TABS					
	MC		UNI-EASE CAPS					
	MC		UNIFIBER POWD					
	MC		URSO FORTE					
	MC/DEL		URSODIOL					
MISC. UROLOGICAL									
UROLOGICAL - MISC.	MC		ACETIC ACID 0.25% SOLN	MC		CITRIC ACID/SODIUM CITRAT SOLN	1. Elmiron requires adequate proof of Dx with supportive testing. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		CYTRA-K SOLN	MC/DEL		CYTRA-2 SOLN		
	MC		FURADANTIN SUSP	MC		ELMIRON CAPS[1]		
	MC		K-PHOS MF TABS	MC/DEL		MACROBID CAPS		
	MC/DEL		METHENAMINE MANDELATE TABS	MC/DEL		MANDELAMINE TABS		
	MC/DEL		MONUROL PACK	MC/DEL		MACRODANTIN CAPS		
	MC/DEL		NEOSPORIN GU IRRIGANT SOLN	MC		POTASSIUM CITRATE/CITRIC SOLN		
	MC/DEL		NITROFURANTOIN MACR CAPS	MC/DEL		PYRIDIUM PLUS TABS		
	MC/DEL		PHENAZOPYRIDINE HCL TABS	MC		PYRIDIUM TABS		
	MC/DEL		PHENAZOPYRIDINE PLUS	MC/DEL		RENACIDIN SOLN		
	MC/DEL		PROSED/DS TABS					
	MC		TRICITRATES SYRP					
	MC/DEL		URELIEF PLUS					
	MC		UREX TABS					
	MC/DEL		URISED TABS					
	MC		UROCIT-K					
	MC/DEL		UROQID #2 TABS					
PHOSPHATE BINDERS									
PHOSPHATE BINDERS	MC		PHOSLO[1]	MC/DEL		RENVELA[2]	Use PA Form# 20420 1. Diag required. 2. Must fail Phoslo, Renagel & Fosrenol before non-preferred products.	
	MC/DEL		MAGNEBIND - 400[1]					
	MC/DEL		RENAGEL[1]					
	MC/DEL		FOSRENOL[1]					
INTRA-VAGINALS									
VAGINAL - ANTIBACTERIALS	MC/DEL	1	CLEOCIN CREA	MC/DEL		METROGEL VAGINAL GEL[2]	1. Step order must be followed to avoid PA. Must fail Cleocin Cream and Metronidazole products before moving to next step product without PA. 2. Dosing limits apply, please see Dosage Consolidation List. Use PA Form# 20420	Preferred drugs must be tried and failed in step-order due to lack of efficacy or intolerable side effects before less preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL	1	METRONIDAZOLE VAGINAL GEL[2]	MC/DEL		VANDAZOLE		
	MC/DEL	3	CLEOCIN SUPP[1]					
VAGINAL - ANTI FUNGALS	MC/DEL		CLOTRIMAZOLE CREA	MC		AVC CREAM	1. Quantity limit: 1/script/2 weeks Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		GYNE-LOTRIMIN CREA	MC		CLOTRIMAZOLE 3 DAY CREA		
	MC		MICONAZOLE CREA	MC		GYNAZOLE-1 CREA		
	MC/DEL		MICONAZOLE 3 COMBO PACK KIT[1]	MC		GYNE-LOTRIMIN 3 TABS		
	MC/DEL		MICONAZOLE 7 CREA	MC/DEL		MICONAZOLE 3 SUPP		
	MC/DEL		MICONAZOLE NITRATE CREA	MC		TERAZOL 3 CREA		
	MC		NYSTATIN TABS	MC		TERAZOL 7 CREA		
	MC		TERAZOL 3 SUPP	MC/DEL		TERCONAZOLE 0.8MG		
	MC/DEL		TERCONAZOLE 0.4MG	MC/DEL		TERCONAZOLE SUPP		
	MC		VAGITROL					
	MC		V-R MICONAZOLE-7 CREA					
VAGINAL - CONTRACEPTIVES	MC		GYNOL II EXTRA STRENGTH GEL	MC		DELFEN FOAM	Use PA Form# 20420	Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drug will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
VAGINAL - ESTROGENS	MC/DEL		**ESTRING RING**	MC/DEL		ESTRACE CREA	Must fail all preferred	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is

	MC/DEL		**PREMARIN CREA**	MC/DEL		VAGIFEM TABS	products before non-preferred. Use PA Form# 20420	offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
VAGINAL - OTHER	MC/DEL MC MC		ACID JELLY GEL ACI-JEL GEL CERVICAL AMINO ACID CREA	MC		AMINO ACID CERVICAL CREA	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
BPH								
BPH	MC/DEL MC/DEL MC/DEL MC/DEL		AVODART **DOXAZOSIN MESYLATE TABS** FINASTERIDE[1] TERAZOSIN HCL CAPS	MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL	5 8 8 8 8 8	**FLOMAX CP24** **CARDURA TABS** HYTRIN CAPS PROSCAR TABS RAPAFLO UROXATRAL	Non-preferred products must be used in specified order. 1. There will be dosing limits of 1 tab per day with out PA. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs (in step-order) will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Approval of a non-preferred 5-alpha reductase inhibitor requires objective clinical evidence of a very enlarged prostate rather than just the presence of obstructive urinary outflow symptoms along with adequate trial of preferred Proscar.
ANXIOLYTICS								
ANXIOLYTICS - BENZODIAZEPINES	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		ALPRAZOLAM TABS CHLORDIAZEPOXIDE HCL CAPS CLORAZEPATE DIPOTASSIUM TABS DIAZEPAM LORAZEPAM OXAZEPAM CAPS	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		ALPRAZOLAM ER ATIVAN NIRAVAM SERAX TRANXENE XANAX TABS XANAX XR	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANXIOLYTICS - MISC.	MC/DEL MC MC MC/DEL MC/DEL		BUSPIRONE HCL TABS HYDROXYZINE HCL SOLN HYDROXYZINE HCL SYRP HYDROXYZINE PAMOATE CAPS MEPROBAMATE TABS	MC MC MC MC/DEL MC/DEL MC MC/DEL		ATARAX TABS BUSPAR TABS DROPERIDOL SOLN HYDROXYZINE HCL TABS HYDROXYZINE PAM 100MG CAPS INAPSINE SOLN VISTARIL	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANTI-DEPRESSANTS								
ANTIDEPRESSANTS - MAO INHIBITORS	MC/DEL MC/DEL		NARDIL TABS PARNATE TABS					
ANTIDEPRESSANTS - MAO INHIBITORS TOPICAL				MC/DEL		EMSAM[1]	1. Dosing limits apply, please refer to Dose consolidation list. Use PA Form# 20420	Preferred drugs (including a preferred SSRI, a non-SSRI, and either Cymbalta or Effexor) must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANTIDEPRESSANTS - SELECTED SSRI's	MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		BUPROPION HCL TABS BUPROPION SR BUPROPION XL CITALOPRAM[4] CYMBALTA[5] FLUOXETINE HCL CAPS FLUOXETINE HCL LIQD FLUVOXAMINE MALEATE TABS LEXAPRO TABS[4] MIRTAZAPINE NEFAZODONE PAROXETINE[3] SERTRALINE[2] TRAZODONE HCL TABS VENLAFAXINE ER TABS[9]	MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL MC MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC MC MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		APLENZIN[7] CELEXA DESYREL TABS EFFEXOR TABS EFFEXOR XR CP24 [3] FLUOXETINE 40 mg CAPS[1] FLUOXETINE 20mg TABS[6] LUVOX TABS MAPROTILINE HCL TABS MIRTAZAPINE ODT PAROXETINE CR[3] PAXIL[3] PAXIL CR [3] PRISTIQ PROZAC PROZAC CAPS PROZAC WEEKLY CPDR REMERON TABS SARAFEM CAPS TRAZODONE HCL 300MG TABS WELLBUTRIN TABS WELLBUTRIN SR TBCR WELLBUTRIN XL REMERON SOLTAB TBDP SAVELLA [8] ZOLOFT	Non-preferred products must be used in specified step order. 1. Use Fluoxetine 20 mg in multiples. 2. See Zoloft splitting table. Sertraline requires splitting of scored tabs to avoid PA. 3. Strong caution with pediatric population. 4. See Celexa/Citalopram and Lexapro splitting tables. 5. Max daily dose allowed is 60mg, only 1 capsule per day allowed for all strengths. Combination of multiple strengths require PA. 6. Use Fluoxetine 10mg tabs or capsules in multiples.	Preferred drugs (including failure of at least one preferred SSRI, one SNRI and one non-SSRI/SNRI) must be tried for at least 4 weeks each and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Preferred Fluoxetine will be the only preferred antidepressant for members who are less than 18 years of age. Exceptions to the rule are as follows: 1. If the member (<18) is already an established user for any of the preferred or non-preferred drugs under the Antidepressant category on the PDL, then they can continue to get that drug. 2. If the member (<18) has a prescription for an antidepressant that is on the PREFERRED side of the PDL and has had a 30 day supply of Fluoxetine at least 30 days before the date they are getting it filled, the claim will pay. If they do not have the trial of Fluoxetine in their profile, the claim will reject for PA required. 3. If the member (<18) has a prescription for a medication that is on the NON-PREFERRED side of the PDL regardless of having Fluoxetine in their profile, the prescription will need a PA. 4. Use of a preferred antidepressant for anxiety will require pa to establish anxiety diagnosis. 5. Use of bupropion or Wellbutrin for ADHD diagnosis must show prior trial/failure with methylphenidate and amphetamine Criteria for new starters <18 years of age. Must have had fluoxetine trial for at least 30 days before accessing other preferred antidepressants without PA. **DDI:** Fluvoxamine will now be non-preferred and require prior authorization if it is currently being used with glimepiride (Amaryl). **DDI:** Preferred nefazodone will now be non-preferred and require prior authorization if it is currently being used in combination with either Enablex 15mg or Vesicare 10mg.

							7. Provide clinical documentation as to why a preferred generic alternative cannot be used. 8. Dosing limits allowing 2 tabs/day and a max daily limit of 200mg / day applies. Please see dose consolidation list. 9. Dosing limits and max daily dose applies. Limit of 1 tab per day of 37.5mg, 75mg, and 225mg will be allowed without pa, along with limits of 2 tabs per day of the 150mg strength. Max daily dose allowed is 375mg. Use PA Form# 20420	
ANTIDEPRESSANTS - TRI-CYCLICS	MC/DEL	*	**AMITRIPTYLINE HCL TABS**	MC/DEL		**AMOXAPINE TABS**	*Users over the age of 65 require a pa. Use PA Form# 20420 or 10220	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC	*	AVENTYL SOLN	MC/DEL		**ANAFRANIL CAPS**		
	MC/DEL	*	**CLOMIPRAMINE HCL CAPS**	MC/DEL		**ELAVIL TABS**		
	MC/DEL	*	**DESIPRAMINE HCL TABS**	MC/DEL		**NORPRAMIN TABS**		
	MC/DEL	*	**DOXEPIN HCL**	MC/DEL		**PAMELOR**		
	MC/DEL	*	**IMIPRAMINE HCL TABS**	MC/DEL		**SINEQUAN**		
	MC/DEL		**NORTRIPTYLINE HCL**	MC		TOFRANIL		
	MC	*	PROTRIPTYLINE HCL TABS	MC		VIVACTIL TABS		
	MC	*	SURMONTIL CAPS					
SEDATIVE / HYPNOTICS								
SEDATIVE/HYPNOTICS - BARBITURATE	MC		BUTISOL SODIUM TABS	MC		LUMINAL SOLN	PA required for new users of preferred products if over 65 years. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		CHLORAL HYDRATE SYRP	MC/DEL		SOMNOTE CAPS		
	MC		MEBARAL TABS					
	MC/DEL		PHENOBARBITAL					
SEDATIVE/HYPNOTICS - BENZODIAZEPINES	MC/DEL		DORAL TABS	MC		DALMANE	Previous quantity limits still apply. Use PA Form # 30110	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Benzodiazepines do cause dependence with continued use and usage should be limited to 7-10 days at a time. Chronic intermittent use (2-3 Days per week max) is the standard of care
	MC/DEL		ESTAZOLAM TABS	MC		HALCION TABS		
	MC/DEL		FLURAZEPAM HCL CAPS	MC		MIDAZOLAM HCL SYRP		
	MC/DEL		TEMAZEPAM CAPS 15 & 30MG	MC/DEL		RESTORIL CAPS		
	MC/DEL		TRIAZOLAM TABS	MC/DEL		TEMAZEPAM 7.5MG		
SEDATIVE/HYPNOTICS - Non-Benzodiazepines	MC/DEL	1	MIRTAZAPINE	MC/DEL	7	AMBIEN[1]	Must fail all preferred products before non-preferred 1. Quantity Limt of 12 per 34 days. 2. Quantity limits will be allowed up to 30/30, but intermittent therapy is recommended. 3. Only zolpidem trial/failure will be required to obtain Zaleplon. Use PA Form # 30110	Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **Ambien, Ambien CR, Lunesta, Sonata, Zaleplon and Zolpidem may cause dependence with continued use and as with benzodiazepines, usage should be limited to 7-10 days at a time. Chronic intermittent use (2-3 days per week max) is the standard of care. Please refer to Sedative/Hypnotic PA form.**
	MC	1	TRAZODONE	MC/DEL	8	AMBIEN CR[1]		
	MC/DEL	1	ZOLPIDEM [2]	MCDEL	8	EDLUAR		
	MC/DEL	2	ZALEPLON [2,3]	MC/DEL	8	LUNESTA[1]		
				MC/DEL	8	SONATA CAPS[1]		
				MC/DEL	8	ROZEREM		
ANTI-PSYCHOTICS								
ANTIPSYCHOTICS - ATYPICALS	MC/DEL		ABILIFY TABS[3]	MC/DEL		ABILIFY DISC TAB, INJ and SOL[2]	If prescribing 2 or more antipsychotics, PA will be required for both drugs, except if one is Clozapine. This also includes combination of Seroquel with Seroquel XR. See Multiple Antipsychotic PA form #20440.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Non preferred atypicals will be approved for patients with FDA-approved indications, and for specific conditions supported by at least two published peer-reviewed double-blinded, placebo-controlled randomized trials that are not contradicted by other studies of similar quality and as long as all first line preferred therapies have been tried and failed at full therapeutic doses for adequate durations (at least two weeks). * Abilify: doses above 15mg were not shown to be more effective than doses in the 10-15mg range. **Seroquel 25mg** is preferred and available without PA if the following conditions are met: a.) Either 65 years of age or older or less than 18 years of age, b.) dosage is for 3 or more per day, c.) Seroquel 25mg is in the profile within the last 45 days OR if any of the following doses are being used in combination with any daily dose of Seroquel 25mg: a.) at least 1.5 Seroquel 100mg tabs, b.) Seroquel 200mg tabs, c.) Seroquel 300mg tabs, d.) Seroquel 400mg tabs OR if dose is beting titrated up. **Seroquel 100mg** is preferred and available without pa if the daily dosage is 1.5 tablets or more per day OR if any of the following doses are being used in combination with any daily dose of Seroquel 100mg: a.) at least 3- Seroquel 25mg tabs, b.) Seroquel 200mg tabs, c.) Seroquel 300mg tabs, d.) Seroquel 400mg tabs.
	MC/DEL		GEODON	MC		FANAPT		
	MC/DEL		RISPERIDONE TAB	MC		INVEGA		
	MC/DEL		RISPERIDONE SOLN	MC		INVEGA SUSTENNA		
	MC/DEL		SEROQUEL TABS	MC		RISPERDAL TAB		
	MC/DEL		SEROQUEL XR	MC		RISPERDAL CONSA[2]		
	MC		ZYPREXA TABS	MC		RISPERDAL M TAB[2]		
				MC		RISPERDAL SOLN		
				MC/DEL		SAPHRIS	Please use Miscellaneous PA form # 20420 for non-	

				MC/DEL		SEROQUEL 50MG TABS[1,2]	preferred single therapy atypical requests.	**Seroquel 50mg** tablets are non-preferred and multiple Seroquel 25mg tablets should be used.
				MC		ZYPREXA ZYDIS TBDP [2]	1. Please use multiple 25mg tablets. 2. Established users of single therapy atypicals were grandfathered. 3. Abilify requires splitting of tab to avoid PA. Please see Abilify splitting table.	**DDI:** Abilify, Seroquel, and Zyprexa will now be non-preferred and require prior authorization if they are currently being used in combination with carbamazepine. Please use Drug-Drug Interaction PA form #10400.
ANTIPSYCHOTICS - SPECIAL ATYPICALS	MC/DEL		CLOZAPINE TABS	MC/DEL MC		CLOZARIL TABS FAZACLO	Use PA Form# 20420	Preferred generic drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred brand will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Patients previously stabilized on brand name drug will be approved. **DDI:** Clozapine will now be non-preferred and require prior authorization if it is currently being used in combination with carbamazepine. Please use Drug-Drug Interaction PA form #10400.
ANTIPSYCHOTICS - TYPICAL	MC/DEL MC/DEL MC/DEL MC MC/DEL MC MC MC/DEL MC/DEL MC MC/DEL MC/DEL MC MC/DEL MC/DEL MC MC/DEL		CHLORPROMAZINE HCL FLUPHENAZINE DECANOATE FLUPHENAZINE HCL HALDOL HALOPERIDOL HALOPERIDOL DECANOATE SOLN HALOPERIDOL LACTATE SOLN LOXAPINE SUCCINATE CAPS LOXITANE-C CONC MOBAN TABS PERPHENAZINE PROCHLORPERAZINE SERENTIL THIORIDAZINE HCL THIOTHIXENE THORAZINE SUPP TRIFLUOPERAZINE HCL TABS	MC/DEL MC/DEL MC MC/DEL MC MC/DEL MC MC MC MC		COMPAZINE COMPRO SUPP HALDOL DECANOATE LOXITANE CAPS MELLARIL NAVANE CAPS PROLIXIN STELAZINE TABS THORAZINE	Use PA Form# 20420 If prescribing 2 or more antipsychotics, PA will be required for both drugs, except if one is Clozapine. See Multiple Antipsychotic PA form #20440. For PA requests for non preferred single user antipsychotic medications, please use miscellaneous PA form #20420.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
LITHIUM								
LITHIUM	MC/DEL MC/DEL		LITHIUM CARBONATE LITHIUM CITRATE SYRP	MC/DEL MC/DEL		ESKALITH CAPS ESKALITH CR TBCR	Use PA Form# 20420	
COMBINATION - PSYCHOTHERAPEUTIC								
PSYCHOTHERPEUTIC COMBINATION	MC/DEL MC/DEL		CHLORDIAZEPOXIDE/AMITRIPT PERPHENAZINE/AMITRIPTYLIN	MC	8	SYMBYAX[4]	Please use individual preferred medications. Use PA Form# 20420	
STIMULANTS								
STIMULANT - AMPHETAMINES SHORT ACTING	MC/DEL MC/DEL MC/DEL MC/DEL		ADDERALL TABS AMPHETAMINE SALT COMBO DEXTROAMPHET SULF TABS DEXEDRINE				Preferred stimulants will be available without PA if diagnosis of ADHD.As per recent FDA alert, Adderal & Dexedrinel should not be	

	MC/DEL		DEXTROSTAT TABS				used in patients with underlying heart defects since they may be at increased risk for sudden death. Stimulants have dosing limitations per strength and maximum daily doses. Please refer to dose consolidation table for any potential dosing limits per strength. Maximum daily doses are as follows: 50mg daily.	
STIMULANT - LONG ACTING AMPHETAMINES SALT	MC/DEL MC		ADDERALL XR CP24[1] VYVANSE[2]				**Preferred stimulants will be available without PA if diagnosis of ADHD. Stimulants have dosing limitations per strength and maximum daily doses. Please refer to dose consolidation table for any potential dosing limits per strength.** 1. As per recent FDA alert, Adderall should not be used in patients with underlying heart defects since they may be at increased risk for sudden death. 2. FDA approval is currently for adults and children 6 or older. Will be available without PA for this age group if within dosing limits. Limit of one capsule daily. Max dose of 70MG daily.	
LONG ACTING AMPHETAMINES	MC		DEXEDRINE CAP CR	MC		DEXTROAMPHET SULF CPCR	Preferred stimulants will be available without PA if diagnosis of ADHD. As per recent FDA alert, Adderall & Dexedrine should not be used in patients with underlying heart defects since they may be at increased risk for sudden death. Stimulants have dosing limitations per strength and maximum daily doses. Please refer to dose consolidation table for any potential dosing limits per strength. Maximum daily doses are as follows: 50mg daily.	
STIMULANT - METHYLPHENIDATE	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		FOCALIN TABS METADATE ER TBCR METHYLIN ER TBCR METHYLIN TABS METHYLIN SOL	MC MC/DEL		METHYLIN CHEWABLES RITALIN	Preferred stimulants will be available without PA if diagnosis of ADHD. Use PA Form# 20420 Stimulants have dosing	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Please refer to General Criteria category E.

	MC/DEL		METHYLPHENIDATE HCL				limitations per strength and maximum daily doses. Please refer to dose consolidation table for any potential dosing limits per strength. Maximum daily doses are as follows: 72mg daily for methylphenidate and 36mg daily for dexmethylphenidate.	
STIMULANT - METHYLPHENIDATE - LONG ACTING	MC MC		CONCERTA TBCR FOCALIN XR[1]	MC MC/DEL MC/DEL	5 8 8	METADATE CD CPCR DAYTRANA[2] RITALIN LA	Preferred stimulants will be available without PA if diagnosis of ADHD. Non-preferred products must be used in specified step order. Stimulants also have dosing limitations per strength and maximum daily doses. Please refer to dose consolidation table for any potential dosing limits per strength. 1. Available to those members needing sprinkles with diagnosis of ADHD. 2. FDA approval currently only for ages 6-16. Limit of one patch daily. Max dose of 30MG daily. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
STIMULANT - STIMULANT LIKE				MC MC MC/DEL MC/DEL MC MC	7 8 8 8 9 9	STRATTERA[1,2] CAFCIT SOLN INTUNIV[4] PROVIGIL TABS DESOXYN TABS DESOXYN CR	1. Failure of both an amphetamine and methylphenidate is required for consideration for approval of Strattera, unless history of substance abuse without current use of abusable medication(s) 2. Strattera currently has dosing limitations allowing one tablet per day for all strengths if obtain approval. Max daily dose of Strattera is 100mg. Please refer to PDL dosage consolidation chart. 3. Non-preferred products must be used in specified step order. 4. Please use generic Guanfacine. Provigil: use PA Form # 20710; Use PA Form# 20420	Provigil requests require diagnosis of Narcolepsy, ADHD, or Obstructive Sleep Apnea. Previous failures of methylphenidate and amphetamine is required for Narcolepsy and ADHD diagnosis, with additional Strattera trial needed with ADHD diagnosis. Please refer to detailed criteria on Provigil PA form
ANTI-CATAPLECTIC AGENTS								
PSYCHOTHERAPEUTIC AGENTS - MISC.				MC/DEL MC		XYREM SOL XENAZINE	Use PA Form # 20710	
WEIGHT LOSS								
WEIGHT LOSS							No longer covered: PHENTERMINE, XENICAL,DIDREX, and MERIDIA	Weight loss drugs are not covered as permitted by Federal Medicaid regulations and Maine Medicaid (MaineCare) Policy.
ALZHEIMER DISEASE								
ALZHEIMER - Cholinomimetics/Others	MC MC/DEL		ARICEPT TABS[1] NAMENDA[1]	MC MC	8 8	RAZADYNE[2] REMINYL[2]	1. PA is required to establish dementia diagnosis and baseline	Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs (in step-order) will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.

				MC/DEL	8	EXELON[2]	diagnosis and baseline mental status score. 2. Must fail all preferred products before moving to non-preferred.	between another drug and the preferred drug(s) exists.
				MC	9	COGNEX CAPS[2]	Use PA Form# 20420	
SMOKING CESSATION								
NICOTINE PATCHES / TABLETS	MC/DEL		CHANTIX[1, 2]				Bupropion SR 150 mg is available without a prior authorization.	OTC Nicotine products are covered by MaineCare Policy when they have been determined to be cost-effective. Only Nicoderm and the generic nicotine gums have received this designation as preferred. All other nicotine products (OTC & prescription) are non-preferred by MaineCare Policy. Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs (in step-order) will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Another version of Zyban, Bupropion SR (100 and 150mg) is available without PA. There will be a quantity limit of 3 months supply of nicotine products allowed per 12 months.
	MC/DEL		NICODERM CQ PT24[2]				1. Chantix is preferred without PA for up to 6 months of **continuous** use once per lifetime.	
	MC/DEL		NICOTINE DIS PT24[2]				2. Preferred nicotine replacement therapy and Chantix will become non-preferred and will require PA if they are being used in combination together.	
NICOTINE REPLACEMENT - OTHER	MC/DEL		NICOTINE POLACRILEX GUM[2]	MC/DEL	5	COMMIT LOZENGES[1]	Use PA Form# 20420	OTC Nicotine products are covered by MaineCare Policy when they have been determined to be cost-effective. Only Nicoderm and the generic nicotine gums have received this designation as preferred. All other nicotine products (OTC & prescription) are non-preferred by MaineCare Policy. Both preferred Nicotine gum and Nicoderm patch must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs (in step-order) will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. There will be a quantity limit of 3 months supply of nicotine products allowed per 12 months.
	MC/DEL		NICORETTE GUM[2]	MC/DEL	8	NICOTROL INHALER	Must fail all preferred products from smoking cessation category (Nicoderm patch and nicotine gum) before moving to non-preferred. Must use Non-preferred products in specified step order. 1. Will be available to patients unable to tolerate preferred products.	
				MC/DEL	8	NICOTROL NASAL SPRAY	2. Preferred nicotine replacement therapy and Chantix will become non-preferred and will require PA if they are being used in combination together.	
ALCOHOL DETERRENTS								
ALCOHOL DETERRENTS	MC		ANTABUSE TABS				1. Should only be used in conjunction with formal structured outpatient detoxification program.	Preferred generic drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		CAMPRAL[1]					
	MC		DISULFIRAM TABS					
	MC/DEL		NALTREXONE HCL TABS					
MISCELLANEOUS ANALGESICS								
ANALGESICS - MISC.	MC/DEL		ACETAMINOPHEN	MC		AXOCET CAPS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**ASPIRIN**	MC		DOLOBID TABS		
	MC/DEL		ASPRIN/ APAP/ CAFF TAB	MC		EQUAGESIC TABS		
	MC/DEL		BUTAL/ASA/CAFF	MC/DEL		ESGIC-PLUS		
	MC/DEL		BUTALBITAL COMPOUND	MC/DEL		FIORICET TABS		
	MC/DEL		BUTALBITAL/ACET TABS	MC		FIORINAL CAPS		
	MC/DEL		BUTALBITAL/APAP CAPS	MC		FIORTAL CAPS		
	MC/DEL		BUTALBITAL/APAP/CAFFEINE	MC/DEL		FORTABS TABS		
	MC/DEL		**CHOLINE MAGNESIUM TRISALI**	MC		PHRENILIN TABS		
	MC/DEL		**DIFLUNISAL TABS**	MC		PHRENILIN FORTE CAPS		
	MC		EXCEDRIN	MC		TRILISATE LIQD		
	MC/DEL		**SALSALATE TABS**	MC		TRILISATE TABS		
				MC		ZEBUTAL CAPS		
				MC		ZORPRIN TBCR		
LONG ACTING NARCOTICS								
NARCOTICS - LONG ACTING	MC		AVINZA	MC	8	DURAGESIC PT72[6]	Use PA Form # 20510	Preferred drugs (Avinza or morphine sulfate ER tab, Duragesic, Methadone or Methadose) must be tried for at least 2 weeks each & failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug & the preferred drug(s) exists. Adequate trials include prevention/treatment of common adverse effects associated w/ narcotics (antinausea, antipruritics, etc.) as well as adequate equianalgesic dosing when converting from one narcotic to another.Also, adequate documentation of attempts to titrate dose of preferred agents to achieve adequate pain relief & desired clinical response must be provided. Member's drug regimen for additions &/or discontinuations of medications that may affect absorption &/or metabolism of preferred agents must be monitored. Approvals will not be granted if patient had access to either non-preferred products or high doses of short acting narcotics during the trial period. Non-preferred drugs will not be approved for patients s
	MC/DEL		FENTANYL PATCH[6]	MC/DEL	8	EMBEDA	Non-preferred products must be used in specific order.	
	MC		KADIAN[7]	MC/DEL	8	MORPHINE SULFATE SUPP		
	MC/DEL		METHADONE	MC/DEL	8	MS CONTIN TB12		
	MC/DEL		METHADOSE	MC/DEL	8	ORAMORPH SR TB12		
	MC/DEL		MORPHINE SULFATE ER TB12[3,4]	MC/DEL	8	OXYCONTIN TB12[1,5]	1. Oxycontin will be available without PA for patients treated for or dying from cancer or hospice patients. CA (cancer) or	
				MC/DEL	9	OXYCODONE ER[3]		
				MC	9	OPANA		

				MC	9	OPANA ER	HO (hospice) diag code may be used but store must verify since all scripts will be audited and stores will be liable. 2. Established users are grandfathered. 3. Oxycodone ER allowed only 2 per day for all strengths except 80 mg, where 4 are allowed to achieve max total daily dose of 320mg. 4. Endo products preferred but not exclusive. 5. Oxycontin 15mg, 30mg & 60mg are new strengths. Any PA request for the new strengths will be required to use combinations of strengths that have previously been available (including 10mg, 20mg, 40mg, & 80mg tablets) to obtain requested dose. 6. Dosing limits apply. Please see dose consolidation list. 7. Kadian 80mg & 200mg are non-preferred.	substance abuse such as: 1. Frequent or persistent early refills of controlled drugs; 2. Multiple instances of early refill overrides due to reports of misplacement, stolen, dropped in toilet or sink, distant travel, etc.;3. Breaches of narcotic contracts with any provider; 4. Failure to comply with patient responsibilities in attached opioid documentation (see PA form) including but not limited to failing to submit to and pass pill counts; 5. Failing to take or pass random drug testing; 6. Failing to provide old records regarding prior use of narcotics; 7. Receiving controlled substances from other prescribers that the provider submitting the PA is unaware of 8. Documented history of substance abuse. Substance abuse evaluations may be required for patients with medical records displaying documented substance abuse or potential signs of narcotic misuse and abuse such as chronic early refills, short dosing intervals, frequent dose increases, multiple lost/stolen etc scripts and intolerance or "allergy" to all products but Oxycontin. 9. Circumventing MaineCare prior authorization requirements for narcotics by paying cash for affected narcotics (prescribers failed to submit prior authorization prior to cash narcotic scripts being filled by membe substance, considered by authorities to be highly abused and diverted (Oxycontin, Percocet, Typox, Vicodin, Dilaudid, Ultracet...) with an available AB rated generic equivalent will be denied unless it will be provided in a setting that virtually eliminates the risk of diversion. 11. Allergic reactions to any product within a specific narcotic class will justify and preclude use of any other product in the same class due to the risk of cross-hypersensitivity.
NARCOTICS - SELECTED	**MC/DEL**		TRAMADOL HCL TABS	**MC**	8	BUPRENEX SOLN	Use PA Form# 20420	Preferred drugs from this and other narcotic classes must be tried for at least 2 weeks each and failed due to lack of efficacy or intolerable side effects before non-preferred drugs from this class will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Approvals will not be granted if patient had access to either non-preferred products or high doses of short acting narcotics during the trial period. Substance abuse evaluations may be required for patients with medical records displaying potential signs of narcotic misuse and abuse such as chronic early refills, short dosing intervals, frequent dose increases, multiple lost/stolen etc scripts and intolerance or "allergy" to all products but desired product. Allergic reactions to any product within a specific narcotic class will justify and preclude use of any other product in the same class due to the risk of cross-hypersensitivity. Non-preferred drugs will not be approved for patients showing evidence of usage patterns consistent with controlled substance abouse such as: 1. frequent or persistant early refills of controlled drugs; 2. multiple instances of early refill overrides due to reports of misplacement, stolen, dropped in toilet or sink, distant travel; 3. breaches of narcotic contracts with any provider; 4. failure to comply with patient responsibilities in attached opiod documentaion (see PA form) including but not limited to failing to submit to and pass pill counts; 5. failing to take or pass random drug testing; 6. failing to provide old recoreds regarding prior use of narcotics; 7. receiving controlled substances from other prescribers that the provider submitting the PA is unaware of. in Substance abuse evaluations may be required for patients with medical records displaying potential signs of narcotic misuse and abuse such as chronic early refills, short dosing intervals, frequent dose increases, multiple lost/stolen etc scripts and intolerance or "allergy" to all products but Oxycontin. Allergic reactions to any product within a specific narcotic class will justify and preclude use of any other product in the same class due to the risk of cross-hypersensi
				MC/DEL	8	BUTORPHANOL		
				MC	8	NALBUPHINE HCL SOLN		
				MC	8	NUBAIN SOLN		
				MC	8	STADOL NS SOLN		
				MC	8	ULTRACET TABS		
				MC	8	ULTRAM TABS		
				MC	8	ULTRAM ER		
				MC/DEL	9	RYZOLT		
MISCELLANEOUS NARCOTICS								
NARCOTICS - MISC.	**MC/DEL**		ACETAMINOPHEN/CODEINE	**MC**	8	ANEXSIA TABS	1. Fentanyl OT loz (Barr) and Capital and codeine suspension products require PA for users over 18 years of age. PA is not required if under 18 years of age. 2. Oxycodone/acet 10/650 is 8 times more expensive. Use twice as many of oxycod/acet 5/325 instead. You can mix andmatch preferred strengths of oxycodone and oxycodone/acet to minimize acet. dose similar to certain non-preferred drugs. 3. Only preferred	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Please refer to General Criteria category E.
	MC/DEL		ASPIRIN/CODEINE TABS	**MC/DEL**	8	ASCOMP/CODEINE CAPS		
	MC/DEL		BUTAL/ASA/CAFF/COD CAPS	**MC/DEL**	8	BUTALBITAL/APAP/CAFFEINE/ CAPS		
	MC		BUTALBITAL/ASPIRIN/CAFFEI CAPS	**MC**	8	DARVOCET-N		
	MC		CAPITAL AND CODEINE SUSP[1]	**MC**	8	DARVON		
	MC		CAPITAL/CODEINE SUSP[1]	**MC**	8	DEMEROL		
	MC/DEL		CODEINE PHOSPHATE SOLN	**MC/DEL**	8	DILAUDID		
	MC/DEL		CODEINE SULFATE TABS	**MC**	8	DILAUDID-HP SOLN		
	MC/DEL		ENDOCET TABS[3]	**MC**	8	FENTANYL CITRATE SOLN		
	MC/DEL		ENDODAN TABS	**MC/DEL**	8	FENTORA		
	MC/DEL		FENTANYL OT LOZ[1]	**MC/DEL**	8	FIORICET/CODEINE CAPS		
	MC/DEL		HYDROCODONE BITARTRATE/AP TABS	**MC**	8	FIORINAL/CODEINE #3 CAPS		
	MC/DEL		HYDROCODONE/ACETAMINOPHEN	**MC**	8	FIORTAL/CODEINE CAPS		
	MC/DEL		HYDROMORPHONE HCL[3]	**MC/DEL**	8	HYDROCODONE/IBUPROFEN		
	MC/DEL		MEPERIDINE HCL	**MC/DEL**	8	LORCET		
	MC/DEL		OXYCODONE 5MG	**MC**	8	LORTAB		

	MC/DEL		OXYCODONE 15MG	MC	8	MAXIDONE TABS	manufacturer's products will be available without prior authorization.	
	MC/DEL		OXYCODONE 30MG	MC/DEL	8	NORCO TABS		
	MC/DEL		OXYCODONE/ACETAMINOPHEN[2,3]	MC/DEL	8	NUCYNTA		
	MC/DEL		PENTAZOCINE/NALOXONE TABS	MC/DEL	8	ONSOLIS		
	MC		PROPOXYPHENE CMPND-65 CAPS	MC/DEL	8	OXYCODONE 10MG		
	MC		PROPOXYPHENE COMPOUND CAPS	MC/DEL	8	OXYCODONE 20MG		
	MC/DEL		PROPOXYPHENE HCL CAPS	MC/DEL	8	OXYCODONE/APAP 10/650		
	MC/DEL		PROPOXYPHENE/ACET TABS	MC/DEL	8	OXYCODONE/APAP 7.5/500		
	MC/DEL		PROPOXYPHENE-N/ACET TABS	MC/DEL	8	PENTAZOCINE/ACET TABS		
	MC/DEL		ROXICET	MC	8	PERCOCET TABS		
	MC		ROXIPRIN TABS	MC	8	PERCOCET TABS		
				MC	8	PHRENILIN W/CAFFEINE/CODE CAPS		
				MC/DEL	8	ROXICET 5/500 TABS		
				MC	8	ROXICODONE TABS		
				MC	8	SYNALGOS-DC CAPS	Use PA Form# 20420	
				MC	8	TALACEN TABS		
				MC/DEL	8	TALWIN NX TABS		
				MC	8	TYLENOL/CODEINE #3 TABS		
				MC	8	TYLOX CAPS		
				MC	8	VICODIN		
				MC	8	VICOPROFEN TABS		
				MC	8	ZYDONE TABS		
				MC	9	ACTIQ LPOP		
OPIOID DEPENDENCE TREATMENTS	MC		SUBOXONE*	MC		SUBUTEX	Use PA Form# 20420 *Suboxone is preferred with max dosing limits of 32mg daily if the following conditions are met: a.) There is not another Suboxone script in member's drug profile within the past 30 days. and b.) There is not more than one narcotic fill in member's drug profile between today's fill of suboxone and a prior suboxone fill within the past 90 days. Should be evidence provided of monthly monitoring including random pill counts urine drug tests and prescription monitoring program reports.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Subutex will onlybe approved for use during pregnancy.
NARCOTIC ANTAGONISTS								
NARCOTIC - ANTAGONISTS	MC/DEL		NALTREXONE HCL TABS	MC/DEL		REVIA TABS[1]	Use PA Form# 20420	1. Will only be approved for side effects experienced with generic that are not described in the literature as occurring with the brand version.
				MC/DEL		VIVITROL INJ[2]	Use PA form #30400 for Vivitrol requests.	2. Please see the criteria listed on the Vivitrol PA form. Any narcotics attempting to be filled during Vivitrol approval will require prior authorization.
COX 2 / NSAIDS								
NSAID - PPI						PREVACID NAPRA-PAC		
COX 2 INHIBITORS - SELECTIVE / HIGHLY SELECTIVE	MC/DEL		CELEBREX CAPS [4, 5]	MC/DEL		**MOBIC**	The FDA has issued a Public Health Advisory warning of the potential for increased cardiovascular risk & GI bleeding with NSAID use. Use PA Form # 10310 1. Meloxicam has dosing limits allowing one tablet daily of all strengths without PA. 2. Ketorolac Tromethamine is indicated for the short term (up to 5 days) managment of moderately sever acute	Approved without PA for patients 60 years old or over. Patients under 60 can use a preferred proton pump inhibitor with any preferred generic NSAID to achieve similar reductions in GI bleeding risk to that seen with the COX-II agents. Approvals for Celebrex will be granted for other requests based on failure of at least one generic NSAID from at least 2 different NSAID classes as described in the COX-II PA form. High risk GI bleeding patients must fail on adequate trials of safer agents (non-NSAID/Cox-2) for GI tract, such as acetaminophen.
	MC/DEL		KETOROLAC TROMETHAMINE [2,3]	MC/DEL		MOBIC SUSP		
	MC/DEL		NABUMETONE TABS	MC/DEL		**RELAFEN TABS**		
	MC/DEL		MELOXICAM [1]	MC/DEL		TORADOL		
				MC/DEL		TORADOL		

							pain that requires analgesic at the opiod level in adults. Not indicated for minor of chronic pain conditions. 3. Ketorolac has dosing limits allowing 24 tablets for a 5 day supply every 30 days. 4. Dosing limits will be set at a maximum of 200mg once daily for PA requests. 5. Users 60 years of age or older will not require PA. If under 60 years of age, Celebrex will require PA.	
NSAIDS	MC/DEL		**CHILDRENS IBUPROFEN**	MC		ADVIL TABS	The FDA has issued a Public Health Advisory warning of the potential for increased cardiovascular risk & GI bleeding with NSAID use. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Approvals will be granted for other requests based on failure of at least one generic NSAID from at least 3 different NSAID classes as described in the COX-II PA form. **DDI:** Diclofenac will now be non-preferred and require prior authorization if it is currently being used in combination with lescol.
	MC/DEL		**DICLOFENAC POTASSIUM TABS**	MC		ANAPROX TABS		
	MC/DEL		**DICLOFENAC SODIUM**	MC		ANAPROX DS TABS		
	MC/DEL		**ETODOLAC**	MC		ANSAID TABS		
	MC/DEL		**FENOPROFEN CALCIUM TABS**	MC		CAMBIA		
	MC/DEL		**FLURBIPROFEN TABS**	MC/DEL		**CATAFLAM TABS**		
	MC/DEL		**IBUPROFEN**	MC		CHILDRENS ADVIL SUSP		
	MC/DEL		**INDOMETHACIN**	MC		CHILD'S IBUPROFEN SUSP		
	MC/DEL		**KETOPROFEN**	MC/DEL		CHILDREN'S MOTRIN SUSP		
	MC/DEL		**MECLOFENAMATE SODIUM CAPS**	MC/DEL		**CLINORIL TABS**		
	MC/DEL		NAPROSYN SUSP	MC/DEL		**DAYPRO TABS**		
	MC/DEL		NAPROXEN SUSP	MC/DEL		**EC-NAPROSYN TBEC**		
	MC/DEL		**NAPROXEN TABS**	MC/DEL		**ETODOLAC ER 600MG**		
	MC/DEL		**NAPROXEN SODIUM TABS**	MC		FELDENE CAPS		
	MC/DEL		**OXAPROZIN TABS**	MC/DEL		IBU-200		
	MC/DEL		**PIROXICAM CAPS**	MC		INDOCIN		
	MC/DEL		**SULINDAC TABS**	MC/DEL		**LODINE**		
	MC/DEL		**TOLMETIN SODIUM**	MC/DEL		**MOTRIN**		
				MC		NALFON CAPS		
				MC/DEL		NAPRELAN TBCR		
				MC/DEL		NAPROSYN TABS		
				MC/DEL		**NAPROXEN DR TBEC**		
				MC/DEL		**NAPROXEN SODIUM TBCR**		
				MC		ORUVAIL CP24		
				MC		PONSTEL CAPS		
				MC		SB IBUPROFEN TABS		
				MC		TOLECTIN		
				MC/DEL		VOLTAREN		
				MC		V-R IBUPROFEN TABS		
RHEUMATOID ARTHRITIS								
RHEUMATOID ARTHRITIS	MC/DEL	1	**AZATHIOPRINE**	MC/DEL	8	**ARAVA**	Use PA Form # 20900. 1. Only one step 1 drug is required to obtain Enbrel, Cimzia or Humira without PA. 2. Dosing limits apply. Please see dose consolidation list. 3. Please use multiples of 25mg. 4. Preferred dosage form allowed without PA after trial of step 1 prodcuts is multi-dose vial, with dosing limits allowing 8 injections per 28 days without pa. Established users will be grandfathered for Enbrel and Humira.	See criteria as listed on Rheumatoid Arthritis PA form. Enbrel 25mg is preferred after a trial of a step 1 product (e.g. azathioprine, methotrexate, etc.); however, dosing limits will also still apply. Dosing limits will allow 8 injections per month without pa. Use of greater than 8 injections per month will require PA. In addition, the preferred Enbrel 25mg product will be the multi-dose vial (NDC- 58406-0425-34). The single-use prefilled syringes are non-preferred.
	MC/DEL	1	**HYDROXYCHLOROQUINE**	MC	8	**KINERET SOLN**		
	MC/DEL	1	LEFLUNOMIDE	MC	8	ORENCIA		
	MC/DEL	1	METHOTREXATE	MC	8	**REMICADE**		
	MC/DEL	1	**SULFASALAZINE TABS**	MC	8	**ENBREL 50MG**[3]		
	MC/DEL	2	CIMZIA[1]					
	MC	2	**ENBREL 25MG INJECTIONS ONLY**[1, 4]					
	MC	2	**HUMIRA**[1, 2]					

MISCELLANEOUS ARTHRITIS								
ARTHRITIS - MISC.	MC MC		RIDAURA CAPS MYOCHRYSINE SOLN	MC/DEL		**ARTHROTEC**[1]	1. The individual components of Arthrotec are available without PA. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. The individual components of Arthrotec are available without PA.
MIGRAINE THERAPIES								
MIGRAINE - ERGOTAMINE DERIVATIVES	MC/DEL MC		MIGRANAL SOLN SANSERT TABS	MC/DEL		D.H.E. 45 SOLN	Use PA Form # 10110	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
MIGRAINE - CARBOXYLIC ACID DERIVATIVES	MC		DIVALPROEX ER TB24	MC		DEPAKOTE ER TB24		
MIGRAINE - SELECTIVE SEROTONIN AGONISTS (5HT)--Tabs	MC/DEL MC/DEL	1 1	MAXALT MLT[1] SUMATRIPTAN TABS[1]	MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		AMERGE TABS[2] AXERT TABS FROVA TABS MAXALT IMITREX TABS[1] RELPAX ZOMIG TABS ZOMIG NASAL SPARY ZOMIG ZMT TBDP	1. All step 1 medications must be tried. All drugs in this category have dosing limits. Please refer to dose consolidation table. Use PA Form # 10110	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Quantity limit exceptions will require ongoing therapy with therapeutic doses of highly effective prophylactic medication as listed on the Triptan PA form.
MIGRAINE - SELECTIVE SEROTONIN AGONISTS (5HT)--Injectables	MC/DEL MC/DEL MC/DEL MC/DEL		IMITREX KIT IMITREX SOLN IMITREX STATDOSE PEN KIT IMITREX STATDOSE REFILL KIT	MC/DEL		SUMATRIPTAN SOLN	Use PA Form # 10110	
MIGRAINE - SELECTIVE SEROTONIN AGONISTS (5HT)--Combinations				MC/DEL		TREXIMET[1, 2]	Use PA Form # 10110 1. Dosing limits apply. Please see dose consolidation list. 2. Use preferred Sumatriptan and Naproxen separately.	
MIGRAINE - MISC.	MC/DEL MC/DEL MC/DEL		CAFERGOT SUPP CAFERGOT TABS SPASTRIN TABS	MC/DEL MC		MIGRAZONE CAPS BELCOMP-PB SUPP	Use PA Form # 10110	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
GOUT								
GOUT	MC/DEL MC/DEL MC/DEL MC/DEL MC		**ALLOPURINOL TABS** **COLCHICINE TABS** **PROBENECID TABS** **PROBENECID/COLCHICINE TABS** SULFINPYRAZONE TABS	MC/DEL MC		ULORIC[1] ZYLOPRIM TABS	Use PA Form# 20420 1. Failure of therapeutic (300mg) dose of Allopurinol (failure define as not being able to get uric acid levels below 6mg/dl) or severe renal disease.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
MISC.								
ANESTHETICS - MISC.	MC MC MC		BUPIVACAINE HCL SOLN LIDOCAINE HCL SOLN MARCAINE SOLN	MC MC/DEL MC		SENSORCAINE-MPF SOLN SYNVISC INJ XYLOCAINE SOLN	Use PA Form # 30130	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANTI-CONVULSANTS								
ANTICONVULSANTS	MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		CARBAMAZEPINE CARBATROL CP12 CELONTIN CAPS CLONAZEPAM TABS DEPAKOTE SPRINKLES CPSP DIASTAT[1] DILANTIN DIVALPROEX SODIUM EPITOL TABS ETHOSUXIMIDE SYRP FELBATOL GABAPENTIN[3] KEPPRA XR LAMOTRIGINE LEVETIRACETAM SOLN/TABS MYSOLINE TABS OXCARBAZEPINE PHENYTEK CAPS	MC MC MC MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC MC MC/DEL MC/DEL MC/DEL	8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8	BANZEL DEPAKENE DEPAKOTE DEPAKOTE ER DIVALPROEX SODIUM SPRINKLE CAPS EQUETRO GABITRIL TABS KEPPRA TABS KEPPRA SOLN KLONOPIN TABS LAMICTAL LYRICA[4] PRIMIDONE TABS SABRIL TOPAMAX TRILEPTAL VIMPAT[5] ZARONTIN SYRP	1. Quantity limit. 5/month Use PA Form# 20420 2. 200 mg requires a PA. Use two 100 mg instead.Pharmaceutical supply issues will delay implementation until further notice. All non-preferred meds must be used in specified order 3. Dosing limits apply, please see dose consolidation list. 4. Dosing limits apply per strength as well as a	One time PA is required to determine seizure diagnosis for any non-preferred anticonvulsant. Other approvals will be for patients with a variety of drug-specific FDA-approved indications and for specific conditions supported by at least two published peer-reviewed double-blinded, placebo-controlled randomized trials that are not contradicted by other studies of similar quality after recommendation by the DUR Committee and as long as all first line therapies have been tried and failed at full therapeutic doses for adequate durations (at least two weeks). *** SEE CHART AT END OF DOCUMENT Topamax and Neurontin - Second line therapy for migraine prophalaxis after trial of at least three preferred preventive medications from Group 1 listed on page 2 of the Acute Migraine PA form. Lyrica- Second line therapy for Diabetic Peripheral Neuropathy and Post Herpetic Neuralgia. With Fibromyalgia diagnosis, Lyrica will not require PA if previous 4 week trials of the following are seen in drug profile at full therapeutic doses: TCA or cyclobenzaprine, gabapentin, and savella.

	MC/DEL		PHENYTOIN	MC/DEL	9	NEURONTIN	maximum daily dose of 600mg. Please see dose consolidation list.	**DDI:** Any Carbamazepine formulation will now be non-preferred and require prior authorization if any of the following drugs are currently being used in combination with carbamazepine: Abilify, clozapine, Seroquel, or Zyprexa. Please use Drug-Drug Interaction PA form #10400 for this combination.
	MC/DEL		TEGRETOL[2]	MC/DEL	9	ZONEGRAN CAPS		
	MC/DEL		TEGRETOL-XR TB12				5. Adjunctive therapy 17 and older.	
	MC/DEL		TOPIRAMATE			**BIPOLAR DISORDER: STEP ORDER**		
	MC/DEL		TRILEPTAL SUSP				SEE ANTICONVULSANT INDICATION CHART AT THE END OF THIS DOCUMENT M= Monotherapy A= Adjunctive 9= No Evidence The step orders show the relative strength of evidence for use in bi-polar and will guide prior authorization determinations. Step 4 drugs-no PA required.	
	MC/DEL		VALPROIC ACID		M ~ A			
	MC/DEL		ZARONTIN CAPS		4 ~ 4	LAMICTAL		
	MC/DEL		ZONISAMIDE		4 ~ 4	LITHIUM		
					4 ~ 4	CARBAMAZEPINE		
					4 ~ 4	VALPROATE		
					4 ~ 4	ATYPICAL ANTIPSYCHOTICS EXC. CLOZAPINE		
					5 ~ 5	TRILEPTAL		
					9 ~ 6	TOPAMAX		
					9 ~ 7	KEPPRA TABS		
					9 ~ 8	GABITRIL TABS		
					9 ~ 9	NEURONTIN		
					9 ~ 9	ZONEGRAN CAPS		
						PEDIATRIC BIPOLAR1 DISORDER: STEP ORDER		
					M ~ A	(6-18 YEARS WITH OR WITHOUT PSYCHOSIS)		
					4 ~ 4	LITHIUM	Two-step 1 preferred drugs must be tried before Trileptal. The step orders show the relative strength of evidence for use in bi-polar and will guide prior authorization determinations. Step 4 drugs-no PA required.	
					4 ~ 4	CARBAMAZEPINE		
					4 ~ 4	VALPROATE		
					4 ~ 4	ATYPICAL ANTIPSYCHOTICS EXC.CLOZAPINE		
					4 ~ 4	LAMICTAL		
					5 ~ 5	TRILEPTA		
ANTI-PARKINSON DRUGS								
PARKINSONS - ANTICHOLINERGICS	MC		AKINETON TABS					
	MC/DEL		BENZTROPINE MESYLATE TABS					
	MC		COGENTIN SOLN					
	MC/DEL		**KEMADRIN TABS**					
	MC/DEL		**TRIHEXYPHENIDYL**					
PARKINSONS - COMT INHIBITORS	MC/DEL		**COMTAN TABS**	MC/DEL		**TASMAR TABS**	Use PA Form# 20420	Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
PARKINSONS - SELECTED DOPAMIN AGONISTS	MC/DEL		**ROPINIROLE**	MC/DEL		**MIRAPEX TABS**[1]	Use PA Form# 20420 1. As of 12/08 users of Mirapex will be grandfathered if diagnosis is Parkinsons.	Preferred drug must be tried and failed in step-order due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
				MC/DEL		**REQUIP TABS**		
				MC/DEL		**REQUIP XL TABS**		
PARKINSONS - DOPAMINERGICS/CARBII/ LEVO	MC/DEL		**AMANTADINE HCL**	MC/DEL		**APOKYN***	* Only preferred manufacturer's products will be available without prior authorization. 1. Approvals will require concurrent therapy with Levodopa and failed trials of Selegiline, Comtan, and Stalevo. 2. Approvals will require trials of Carbidopa/Levodopa, Selegiline, Comtan, and Stalevo. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**BROMOCRIPTINE MESYLATE**	MC		AZILECT[2]		
	MC/DEL		**CARBIDOPA/LEVODOPA TABS***	MC		ELDEPRYL CAPS		
	MC/DEL		**CARBIDOPA/LEVODOPA ER**	MC/DEL		**PARLODEL CAPS**		
	MC		LARODOPA TABS	MC/DEL		**PARLODEL TABS**		
	MC		LODOSYN TABS	MC		SINEMET TABS		
	MC/DEL		**SELEGILINE HCL**	MC		SINEMET TBCR		
				MC		SYMMETREL TABS		
				MC		ZELAPAR[1]		
PARKINSONS - COMBO.	MC/DEL		STALEVO					
MUSCLE RELAXANTS								
ALS DRUG	MC/DEL		**RILUTEK TABS**					
MUSCLE RELAXANTS	MC/DEL		**BACLOFEN TABS**	MC/DEL	7	**ORPHENADRINE CITRATE**	Non-preferred drugs will not be approved if members circumventing MaineCare prior authorization requirements by paying	At least 4 preferred drugs (including tizanidine) must be tried for at least 2 weeks and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an…… acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Elderly patients, over 65, will require written notice of the increased sedative risks and impaired driving.Prior Authorization will not be given for:1. frequent or persistent early refills of controlled drugs; 2. multiple instances of early refill overrides due to reports of misplacement, stolen, dropped in toilet or sink, distant travel, etc.
	MC/DEL		**CHLORZOXAZONE TABS**	MC/DEL	8	**CARISOPRODOL TABS**		
	MC/DEL		**CYCLOBENZAPRINE HCL TABS**	MC/DEL	8	DANTRIUM CAPS		
	MC		LIORESAL INTRATHECAL KIT	MC/DEL	8	**FLEXERIL TABS**		

	MC/DEL		METHOCARBAMOL TABS	MC	8	LIORESAL TABS	requirements by paying (prescribers failed to submit prior authorization prior to cash narcotic scripts being filled by member). Non-preferred products must be used in specified step order.	of misplacement, stolen, dropped in toilet or sink, distant travel, etc.
	MC/DEL		TIZANIDINE HCL TABS	MC	8	NORFLEX TBCR		
				MC	8	ROBAXIN-750 TABS		
				MC/DEL	8	**ZANAFLEX TABS**		
				MC/DEL	9	**SKELAXIN TABX**		
				MC/DEL	9	**SOMA TABS**		
							Use PA Form# 20420	
MUSCLE RELAXANT - COMBO.				MC/DEL		CARISOPRODOL/ASPIRIN TABS	Use PA Form# 20420	Individual components are available with PA described in the section above.1. frequent or persistent early refills of non-controlled drugs; 2. multiple instances of early refill overrides due to reports of misplacement stolen, dropped in toilet or sink, distant trave, etc.
				MC/DEL		CARISOPRODOL/ASPIRIN/CODE		
				MC		NORGESIC TABS		
				MC/DEL		ORPHENADRINE COMPOUND		
				MC/DEL		ORPHENADRINE/ASA/CAFF		
				MC		ORPHENGESIC		
VITAMINS								
****Preferred products that used to require diag codes still require diag codes unless indicated otherwise.****								
VITAMINS	MC/DEL		ASCORBIC ACID TABS	MC		AQUASOL E SOLN	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **As listed in MaineCare Policy, certain drugs require specific diagnoses for approval.**
	MC		BIOTIN	MC		AQUAVIT-E SOLN	1. PA required to confirm diagnosis and prior use of IM Vit B12. Lab results should be submitted.	
	MC		CYANOCOBALAMIN SOLN	MC/DEL		CALOMIST NASAL SPRAY[1]		
	MC		FOLGARD RX 2.2 TABS	MC		DHT SOLN		
	MC/DEL		FOLIC ACID TABS	MC		NASCOBAL GEL		
	MC		FOLTX TABS					**DDI:** B-12 will now be non-preferred and require prior authorization if it is currently being used in combination with either Prevacid, Protonix, Prilosec, or any currently non preferred PPI.
	MC/DEL		MEPHYTON TABS				Please refer to OTC list.	
	MC/DEL		NIACIN					
	MC		NIACOR TABS					
	MC/DEL		NICOTINIC ACID SR CPCR					
	MC		PYRIDOXINE HCL TABS					
	MC/DEL		SLO-NIACIN TBCR					
	MC/DEL		THIAMINE HCL SOLN					
	MC/DEL		VITAMIN B-1 TABS					
	MC/DEL		VITAMIN B-12					
	MC		VITAMIN B-6 TABS					
	MC/DEL		VITAMIN C					
	MC/DEL		VITAMIN E CAPS					
	MC/DEL		VITAMIN E/D-ALPHA CAPS					
	MC		VITAMIN K1 SOLN					
	MC		V-R VITAMIN E CAPS					
VITAMIN D's	MC/DEL		**CALCITRIOL CAPS**[1]	MC/DEL		**DRISDOL CAPS**	1. Diagnosis of dialysis (renal failure) required.	Preferred products require dialysis/renal failure diagnosis.
	MC/DEL		**VITAMIN D**	MC		CALCIJEX		Non-preferred products require: Secondary hyperparathyroidism in patients with Chronic Kidney Disease on dialysis., iPTH>400 pg/ml, Phosophorous ,6.5mg/dl, corrected calcium <12.2mg/dl, corrected calcium x phosphorous products <70mg ^{2}/dl^2
	MC		ZEMPLAR TABS	MC/DEL		HECTOROL (ORAL)	Use PA Form# 20420	
				MC/DEL		HECTOROL (PARENTERAL)		
				MC/DEL		**ROCALTROL**		
				MC		ZEMPLAR INJ		
MISC MULTI-VITAMINS								
****Preferred products that used to require diag codes still require diag codes unless indicated otherwise.****								
VITAMINS - MISC.	MC		CENTRUM LIQD	MC		ADEKS	Diag codes are no longer required on prenatal vitamins.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. As listed in MaineCare Policy, certain drugs require specific diagnoses for approval.
	MC		CENTRUM TABS	MC/DEL		ADVANCED NATALCARE TABS		
	MC		CENTRUM JR/IRON CHEW	MC		AQUADEKS		
	MC		CENTRUM SILVER TABS	MC		CENTRUM JR/EXTRA C CHEW	Please refer to OTC list.	
	MC		CENTRUM-LUTEIN TABS	MC		CENTRUM PERFORMANCE TABS		
	MC		CEROVITE ADVANCED FO TABS	MC		DALYVITE LIQD	Use PA Form# 20420	
	MC/DEL		CHEWABLE MULTIVIT/FL CHEW	MC		EMBREX 600 MISC		
	MC		COD LIVER OIL CAPS	MC		IBERET		
	MC		COMPLETE SENIOR TABS	MC		MATERNA TABS		
	MC		DAILY MULTI VIT/IRON	MC		MULTIRET FOLIC -500 TBCR		
	MC/DEL		DIALYVITE 1MG	MC/DEL		NATAFORT TABS		
	MC/DEL		DIALYVITE 800MG	MC/DEL		NATALCARE CFE 60 TABS		
	MC/DEL		FULL SPECTRUM B	MC/DEL		NATALCARE GLOSS TABS		
	MC		M.V.I.-12 INJ	MC		NATALCARE PIC TABS		
	MC		MULTI-VIT/FLUORIDE	MC		NATALCARE PIC FORTE TABS		
	MC/DEL		NATALCARE RX TABS	MC/DEL		NATALCARE PLUS TABS		
	MC/DEL		NEPHRONEX	MC		NATALCARE THREE TABS		
	MC/DEL		NUTRINATE CHEW	MC/DEL		NATACHEW CHEW		
	MC/DEL		O-CAL PRENATAL	MC		NATALFIRST TABS		
	MC/DEL		ONE DAILY TABS	MC		NATATAB RX TABS		

	MC/DEL		ONE-DAILY MULTIVITAMINS	MC/DEL		NEPHPLEX RX TABS		
	MC/DEL		ONE-TABLET-DAILY	MC/DEL		NEPHROCAPS CAPS		
	MC/DEL		POLY-VIT/IRON/FLUORID SOLN	MC/DEL		NEPHRO-VITE TABS		
	MC/DEL		POLY-VITAMIN/FLUORIDE SOLN	MC		NESTABS RX TABS		
	MC/DEL		POLY-VITAMINS/IRON SOLN	MC/DEL		NIFEREX		
	MC		PRENATAL 19 CHEW	MC/DEL		OCUVITE TABS		
	MC/DEL		PRENATAL TABS	MC		POLY-VI-FLOR SOLN		
	MC/DEL		PRENATAL FORMULA 3 TABS	MC		POLY-VI-SOL SOLN		
	MC/DEL		PRENATAL PLUS TABS	MC		POLY-VI-SOL/IRON SOLN		
	MC/DEL		PRENATAL PLUS NF TABS	MC		POLY-VITAMIN DROPS SOLN		
	MC		PRENATAL PLUS/27MG IRON	MC		PRECARE		
	MC		PRENATAL PLUS/IRON TABS	MC		PREMESIS RX TABS		
	MC/DEL		PRENATAL RX/BETA-CAROTENE	MC		PRENATABS CBF TABS		
	MC/DEL		RENA-VITE RX TABS	MC		PRENATAL CARE TABS		
	MC/DEL		RENAL CAPS	MC		PRENATAL MR 90 TBCR		
	MC/DEL		RENAPHRO CAPS	MC/DEL		PRENATAL MTR/SELENIUM TABS		
	MC		STRESS TAB NF TABS	MC		PRENATAL OPTIMA ADVANCE TABS		
	MC		THERAPEUTIC-M TABS	MC		PRENATAL PC 40 TABS		
	MC		THERAVITE LIQD	MC/DEL		PRENATAL RX TABS		
	MC/DEL		TRI-VITAMIN/FLUORIDE SOLN	MC		PRENATE		
	MC		VITA CON FORTE CAPS	MC		PRENATE ELITE		
	MC		VITAMIN B COMPLEX CAPS	MC		PRIMACARE MISC		
	MC		VITAPLEX PLUS TABS	MC		PROTEGRA CAPS		
				MC		STUARTNATAL PLUS 3 TABS		
				MC		TRI-VI-SOL SOLN		
				MC		TRI-VI-SOL/IRON SOLN		
				MC/DEL		ULTRA NATALCARE TABS		
				MC		ULTRA-NATAL TABS		
				MC		VICON FORTE CAPS		
				MC		VINATAL FORTE TABS		
				MC		VINATE		
				MC/DEL		VINATE ADVANCED TABS		
MISCELLANEOUS MINERALS								
****Preferred products that used to require diag codes still require diag codes unless indicated otherwise.****								
MINERALS	MC		CALCARB	MC		ANEMAGEN	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. As listed in MaineCare Policy, certain drugs require specific diagnoses for approval. **DDI:** Fe salts will now be non-preferred and require prior authorization if it is currently being used in combination with either Prevacid, Protonix, Prilosec, or any currently non preferred PPI.
	MC		CALCI-MIX CAPSULE CAPS	MC		CALCET TABS	Please refer to OTC list.	
	MC		CALCIQUID SYRP	MC/DEL		**CALCIUM 600-D TABS**		
	MC		CALCITRATE/VITAMIN D TABS	MC		CALCIUM/VITAMIN D TABS		
	MC/DEL		CALCIUM	MC		CALTRATE 600 PLUS/VIT D TABS		
	MC/DEL		CALCIUM CARBONATE	MC		CALTRATE PLUS TABS		
	MC/DEL		CALCIUM CITRATE TABS	MC		CHROMAGEN		
	MC/DEL		CALCIUM GLUCONATE TABS	MC		CITRACAL PLUS TABS		
	MC/DEL		CALCIUM LACTATE TABS	MC		CONTRIN CAPS		
	MC		CALCIUM/MAGNESIUM TABS	MC		FEOGEN FORTE CAPS		
	MC/DEL		**CALCIUM/VITAMIN D TABS**	MC		FEROCON CAPS		
	MC		CALTRATE 600 TABS	MC/DEL		FERREX 150 CAPS		
	MC/DEL		CHEWABLE CALCIUM CHEW	MC		FERRO-SEQUELS TBCR		
	MC		CITRACAL TABS	MC		FE-TINIC CAPS		
	MC		CITRACAL + D TABS	MC		FE-TINIC 150 FORTE CAPS		
	MC		CITRUS CALCIUM TABS	MC/DEL		FLUOR-A-DAY SOLN		
	MC		CITRUS CALCIUM 1500 + D TABS	MC/DEL		K-DUR TBCR		
	MC		MC/DEL	MC		KLOR-CON PACK		
	MC		EFFERVESCENT POTASSIUM TBEF	MC		K-LYTE		
	MC/DEL		FEOSTAT CHEW	MC/DEL		K-PHOS TABS NEUTRAL		
	MC		FERATAB TABS	MC		K-TABS TBCR		
	MC/DEL		FER-GEN-SOL SOLN	MC		K-VESCENT PACK		
	MC		FER-IN-SOL SOLN	MC		MICRO-K 10 MEG CPCR		
	MC		FER-IRON SOLN	MC		NU-IRON 150 CAPS		
	MC		FERRONATE TABS	MC/DEL		**OYSTER SHELL CALCIUM/VITA TABS**		
	MC/DEL		FERROUS SULFATE	MC/DEL		POLY-IRON 150 CAPS		
	MC/DEL		FLUOR-A-DAY CHEW	MC/DEL		POLYSACCHARIDE IRON CAPS		
	MC		FLUORIDE CHEW	MC/DEL		POTASSIUM BICARB/CHLORIDE		
	MC		FLUORIDE SODIUM CHEW	MC/DEL		POTASSIUM CHLORIDE 10MEQ		
	MC		FLUORITAB CHEW	MC/DEL		SLOW FE TBCR		
	MC		HEMOCYTE TABS	MC		TUMS 500 CHEW		
	MC		HM CALCIUM TABS	MC		VIACTIV CHEW		
	MC		K+ POTASSIUM PACK					

	MC		KAON ELIX					
	MC		KAON-CL-10 TBCR					
	MC		KCL 0.075%/D5W/NACL 0.2% SOLN					
	MC		K-EFFERVESCENT TBEF					
	MC		KLOR-CON					
	MC		KLOTRIX TBCR					
	MC/DEL		K-PHOS TABS					
	MC/DEL		K-VESCENT TBEF					
	MC/DEL		LURIDE CHEW					
	MC/DEL		MAGNESIUM GLUCONATE TABS					
	MC/DEL		MAGNESIUM SULFATE SOLN					
	MC		MAGTABS					
	MC		MICRO-K 8 MEG					
	MC/DEL		OS-CAL TABS					
	MC/DEL		**OS-CAL 500 + D TABS**					
	MC/DEL		**OYSCO**					
	MC/DEL		OYST-CAL TABS					
	MC/DEL		**OYST-CAL D TABS**					
	MC/DEL		**OYST-CAL/VITAMIN D TABS**					
	MC/DEL		OYSTER CALCIUM TABS					
	MC/DEL		OYSTER SHELL					
	MC		PHARMA FLUR					
	MC/DEL		PHOSPHA 250 NEUTRAL TABS					
	MC		POTASSIUM BICARBONATE TBEF					
	MC/DEL		POTASSIUM CHLORIDE 8MEQ					
	MC		POTASSIUM EFFERVESCENT					
	MC/DEL		SELENIUM TABS					
	MC		SLOW-MAG TBCR					
	MC/DEL		SODIUM FLUORIDE					
	MC/DEL		SSKI SOLN					
	MC		V-R CALCIUM					
	MC		V-R OYSTER SHELL CALCIUM					
	MC		ZINC SULFATE CAPS					
MISC. ELECTROLYTES/NUTRITIONALS								
ELECTROLYTES/ NUTRITIONALS	MC/DEL		PED ELECTROLYTE SOLN.	MC		BOOST	This list of nutritionals is incomplete. All nutritionals still require a PA except for the miscellaneous products listed as preferred. SGA form required for nutritionals unless member has a G/I tube. 1. Formerly known as Omacor. Use PA Form# 20420 & SGA Form	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **As listed in MaineCare Policy, certain drugs require specific diagnoses for approval.**
	MC/DEL		FISH OIL CAPS	MC		CASEC POWD		
	MC		INTRALIPID EMUL	MC		CHOICE DM LIQD		
	MC		ORALYTE SOLN	MC		DELIVER 2.0 LIQD		
	MC		P.T.E. -5 SOLN	MC		ENFAMIL		
	MC/DEL		SEA-OMEGA CAPS	MC		ENSURE		
				MC		GLUCERNA		
				MC		ISOCAL LIQD		
				MC		KINDERCAL TF LIQD		
				MC		KINDERCAL TF/FIBER LIQD		
				MC/DEL		L-CARNITINE CAPS		
				MC		LIPISORB LIQD		
				MC		LOVAZA[1]		
				MC		MODULEN IBD POWD		
				MC		NUTRAMIGEN POWD		
				MC/DEL		NUTREN		
				MC		NUTRITIONAL SUPPLEMENT LIQD		
				MC		NUTRIVENT 1.5 LIQD		
				MC/DEL		PEPTAMEN		
				MC		PHENYL-FREE		
				MC		PKU 3 POWD		
				MC		PREGESTIMIL POWD		
				MC/DEL		PROBALANCE LIQD		
				MC		PROSOBEE		
				MC		SCANDISHAKE PACK		
ERYTHROPOEITINS								
ERYTHROPOEITINS	MC		PROCRIT SOLN[1]	MC	6	EPOGEN SOLN	Use PA Form# 10520 1. Clinical PA is required to establish medical necessity and that appropriate lab monitoring is being done.	Non-Preferred drugs must be tried and failed in step-order, due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Please see the EPO PA form for other approval and renewal criteria.
				MC	8	ARANESP SOLN		
GRANULOCYTE CSF								

GRANULOCYTE CSF				MC MC MC	8 8 9	LEUKINE NEUPOGEN SOLN[1] NEULASTA	Must be used in specified step order. 1. 10 day supply/month may be used without a PA. Use PA Form # 20520	See approval criteria detailed on Neupogen PA form.
ANTICOAGULANTS / PLATELET AGENTS								
ANTICOAGULANTS	MC MC/DEL MC MC MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL		ARIXTRA SOLN[1] FRAGMIN INJ[1] HEPARIN SODIUM/NACL 0.9% SOLN HEP-LOCK SOLN **INNOHEP** **LOVENOX SOLN[1]** **WARFARIN SODIUM TABS** HEPARIN LOCK SOLN HEPARIN LOCK FLUSH SOLN HEPARIN SODIUM SOLN HEPARIN SODIUM LOCK FLUSH SOLN JANTOVEN	MC MC		COUMADIN TABS IPRIVASK	1. Arixtra, Fragmin and Lovenox therapy durations greater than 7 days require PA. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Exceeding days supply limits for LMWH class requires PA.
ANTIHEMOPHILIC AGENTS	MC MC/DEL MC MC/DEL MC MC MC MC MC MC MC MC/DEL MC MC MC		ALPHANATE ALPHANINE SD BENEFIX SOLR BIOCLATE HELIXATE FS KIT HEMOFIL - M HUMATE-P SOLR KOGENATE FS KONYNE - 80 MONARC - M MONOCLATE - P MONONINE NOVOSEVEN SOLR PROFILNINE PROPLEX -T RECOMBINATE SOLR REFACTO	MC		ADVATE[1,2]	1. Only if other products unavailable. 2. Advate may be available with PA in cases of large volume dosing in patients with poor venous access. Use PA Form# 20420	Non-preferred will only be approved if other preferred products are unavailable.
PLATELET AGGREGATION INHIBITORS	MC/DEL MC/DEL		ASPIRIN **DIPYRIDAMOLE TABS**	MC/DEL MC MC/DEL MC/DEL MC	7 8 8 8 8	TICLOPIDINE HCL TABS EFFIENT PERSANTINE TABS PLAVIX TABS[1, 2] TICLID TABS	Use PA Form # 20715 for Plavix requests. For all other requests please use form # 20420. 1. As of 10.16.08 all new users of Plavix will require prior authorization. 2. A special PA may be obtained at the pharmacy for members scheduled for "stent" placement or have had placement if in the last 12months. Please indicate on prescription date of stent placement.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. A special PA may be obtained at the pharmacy for members scheduled for "stent" placement or have had placement if in the last 12months. Please indicate on prescription date of stent placement.
PLATELET AGGR. INHIBITORS / COMBO'S - MISC.	MC/DEL MC/DEL		PENTOXIFYLLINE ER TBCR CILOSTAZOL	MC/DEL MC/DEL MC/DEL MC/DEL MC		**AGGRENOX CP12[1]** AGGRENOX[2] **AGRYLIN CAPS** **PLETAL TABS** TRENTAL TBCR	1. Asprin and dipyridamole are available separately without PA. **Use PA Form # 20420** 2. Aggrenox will be approved if submitted with documentation supporting that it is being used for non-embolic stroke. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
HEMATOLOGICALS								
MONOCLONAL ANTIBODY				MC		SOLIRIS	Use PA Form# 20420	A diagnosis of Paroxysmal nocturnal hemoglobinuria (PNH) using the HAM test or flow cytometry is required. In addition, the patient must show evidence of having received a meningitis vaccine at least 2 weeks prior to the start of therapy.
HEMATOLOGICAL AGENTS-THROMBOPOIETIN RECEPTOR AGONISTS				MC/DEL MC	7 8	PROMACTA NPLATE	Use PA Form# 20420	Clinical PA required. Must see prior trial with insufficient response to corticosteroids and immunoglobulins.

HEMOSTATIC								
HEMOSTATIC	MC/DEL		AMICAR					
	MC		AMINOCAPROIC ACID					
OPHTHALMICS								
OP. - ANTIBIOTICS	MC		AK-SPORE OINT	MC		AK-POLY-BAC OINT	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		BACITRACIN OINT	MC		AK-SULF OINT		
	MC		BACITRACIN/NEOMYCIN/POLYM	MC		AK-TOB SOLN		
	MC/DEL		BACITRACIN/POLYMYXIN B OINT	MC		AZASITE		
	MC		CHLOROPTIC SOLN	MC		BLEPH-10 SOLN		
	MC/DEL		ERYTHROMYCIN OINT	MC		GENTAK		
	MC/DEL		GENTAMICIN SULFATE	MC		ILOTYCIN OINT		
	MC/DEL		NEOMYCIN/POLYMYXIN/GRAMIC	MC/DEL		NEOMYCIN/BACI/POLYM OINT		
	MC		NEOSPORIN SOLN	MC		NEOSPORIN OINT		
	MC		POLYSPORIN	MC		OCUSULF-10 SOLN		
	MC/DEL		SODIUM SULFACETAMIDE SOLN	MC		OCUTRICIN SOLN		
	MC/DEL		SULFACETAMIDE SODIUM	MC		TERAK OINT		
	MC		TERRAMYCIN OINT	MC/DEL		TOBREX OINT		
	MC/DEL		TOBRAMYCIN SULFATE SOLN	MC/DEL		TRIFLURIDINE SOLN		
	MC/DEL		TRIMETHOPRIM SULFATE/POLY					
	MC/DEL		VIROPTIC SOLN					
OP. - QUINOLONES	MC/DEL		CILOXAN OINT	MC/DEL		BESIVANCE	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		CIPROFLOXACIN SOL 0.3%	MC/DEL		CILOXAN SOLN		
	MC/DEL		OFLOXACIN	MC		OCUFLOX SOLN		
	MC/DEL		QUIXIN SOLN					
OP.QUINOLONES-4TH GENERATION	MC/DEL		VIGAMOX					
	MC		ZYMAR					
OP. - ARTIFICIAL TEARS AND LUBRICANTS	MC		AKWA TEARS OINT	MC		AKWA TEARS SOLN	Use PA Form# 20420 1. Dosing limits apply, please see dose consolidation list.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		ARTIFICIAL TEARS OINT	MC/DEL		ARTIFICIAL TEARS SOLN OP		
	MC/DEL		ARTIFICIAL TEARS SOLN	MC		BION TEARS SOLN		
	MC		CELLUVISC SOLN	MC		DRY EYES OINT		
	MC		EYE LUBRICANT OINT	MC		DURATEARS OINT		
	MC/DEL		GENTEAL	MC/DEL		HYPO TEARS		
	MC		LIQUITEARS SOLN	MC/DEL		ISOPTO TEARS SOLN		
	MC		MAJOR TEARS SOLN	MC		LACRI-LUBE		
	MC		PURALUBE OINT	MC		LUBRIFRESH P.M. OINT		
	MC		PURALUBE TEARS SOLN	MC		MURINE SOLN		
	MC		REFRESH SOLN OP	MC/DEL		MUROCEL SOLN		
	MC		REFRESH PLUS SOLN[1]	MC/DEL		NATURE'S TEARS SOLN		
	MC		REFRESH PM OINT	MC		REFRESH SOLN		
				MC		REFRESH TEARS SOLN[1]		
				MC		SYSTANE		
				MC		TEARGEN SOLN		
				MC		TEARISOL SOLN		
				MC/DEL		TEARS NATURALE		
				MC/DEL		TEARS PURE SOLN		
				MC		TEARS RENEWED OINT		
				MC/DEL		THERATEARS SOLN		
				MC		V-R ARTIFICIAL TEARS SOLN		
OP. - BETA - BLOCKERS	MC/DEL		**BETOPTIC-S SUSP**	MC		BETAGAN SOLN	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**CARTEOLOL HCL SOLN**	MC/DEL		**BETAXOLOL HCL SOLN**		
	MC/DEL		**LEVOBUNOLOL HCL SOLN**	MC/DEL		**BETIMOL SOLN**		
	MC/DEL		METIPRANOLOL SOLN	MC		ISTALOL		
	MC/DEL		**TIMOLOL MALEATE SOLG (GEL)**	MC/DEL		**OCUPRESS SOLN**		
	MC/DEL		**TIMOLOL MALEATE SOLN**	MC		OPTIPRANOLOL SOLN		
				MC/DEL		**TIMOPTIC SOLN**		
				MC/DEL		**TIMOPTIC-XE SOLG**		
OP. - ANTI-INFLAMMATORY / STEROIDS OPHTH.	MC		AK-SPORE HC OINT	MC		AK-TROL SUSP	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		ALREX SUSP	MC		BAC/POLY/NEOMY/HC OINT		
	MC		BLEPHAMIDE SUSP	MC		BLEPHAMIDE S.O.P. OINT		
	MC/DEL		CORTISPORIN SUSP	MC		ECONOPRED		
	MC/DEL		DEXAMETH SOD PHOS SOLN	MC		EFLONE SUSP		
	MC/DEL		FLAREX SUSP	MC		FLUOR-OP SUSP		
	MC/DEL		FLUOROMETHOLONE SUSP	MC		FML LIQUIFILM SUSP		
	MC		FML S.O.P. OINT	MC		MAXITROL		
	MC		FML-S LIQUIFILM SUSP	MC		NEO/POLY/BAC/HC OINT		
	MC		INFLAMASE SOLN	MC		PRED FORTE SUSP		
	MC/DEL		LOTEMAX SUSP	MC		PRED-G SUSP		
	MC/DEL		NEOM/POLIN/DEX	MC		PRED-G S.O.P. OINT		
	MC		PRED MILD SUSP	MC/DEL		SULFACET SOD/PRED SOLN		
	MC/DEL		PREDNISOLONE	MC		VASOCIDIN SOLN		

	MC/DEL		TOBRADEX	MC/DEL		VEXOL SUSP		
OP. - PROSTAGLANDINS	MC		LUMIGAN SOLN	MC/DEL		**RESCULA SOLN**	All preferreds must be tried.	Preferred drugs must be tried and failed, in step-order, due to lack of efficacy (failure to reach target IOP reduction) or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**TRAVATAN SOLN**	MC/DEL		**XALATAN SOLN**	Use PA Form# 20420	
OP. - CYCLOPLEGICS	MC		AK-PENTOLATE SOLN	MC/DEL		CYCLOGYL SOLN	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		ATROPINE SULFATE	MC		ISOPTO ATROPINE SOLN		
	MC/DEL		CYCLOPENTOLATE HCL SOLN	MC/DEL		ISOPTO HOMATROPINE SOLN		
	MC/DEL		ISOPTO HYOSCINE SOLN	MC		MUROCOLL-2 SOLN		
OP. - MIOTICS - DIRECT ACTING	MC/DEL		**ISOPTO CARBACHOL SOLN**					
	MC		ISOPTO CARPINE SOLN					
	MC		PILOCAR SOLN					
	MC/DEL		**PILOCARPINE HCL SOLN**					
	MC/DEL		**PILOPINE HS GEL**					
OP. - ADRENERGIC AGENTS	MC/DEL		**DIPIVEFRIN HCL SOLN**	MC		PROPINE SOLN	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		EPIFRIN SOLN					
OP. - SELECTIVE ALPHA ADRENERGIC AGONISTS	MC		ALPHAGAN SOLN	MC/DEL		**IOPIDINE SOLN**	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		ALPHAGAN P SOLN					
	MC/DEL		BRIMONIDINE 0.2%					
OP. - ANTI-ALLERGICS	MC/DEL		OPTIVAR	MC		ALOCRIL SOLN	Use PA Form# 20420	All preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		PATADAY SOLN	MC/DEL		ALOMIDE SOLN		
	MC/DEL		PATANOL SOLN	MC		BEPREVE		
				MC		ELESTAT		
				MC/DEL		EMADINE SOLN		
				MC/DEL		LIVOSTIN SUSP		
				MC		OPTICROM SOLN		
				MC/DEL		ZADITOR SOLN		
OP. ANTI-ALLERGICS-MASTCELL STABILIZER CLASS				MC/DEL		ALAMAST SOLN	Use PA Form# 20420	
OP. - CARBONIC ANHYDRASE INHIBITORS/COMBO	MC/DEL		**AZOPT SUSP**	MC/DEL		DORZOLAMIDE	Use PA Form# 20420	
	MC/DEL		**COSOPT SOLN**	MC/DEL		DORZOLAMIDE/TIMOLOL		
	MC		COMBIGAN					
	MC/DEL		**TRUSOPT SOLN**					
OP. - NSAID'S	MC		ACULAR LS	MC		OCUFEN SOLN	Must fail all preferred products before non-preferred.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		ACULAR SOLN	MC/DEL		NEVANAC		
	MC		FLURBIPROFEN SODIUM SOLN	MC		XIBROM		
	MC		VOLTAREN SOLN	MC		ACUVAIL	Use PA Form# 20420	
OP. - OF INTEREST	MC/DEL		ENUCLENE SOLN	MC		BOTOX SOLR	1. Must have kerato conjuctivitus sicca and failed other dry eye therapies.	Must fail adequate trials of multi agents from artificial tears and lubricant category.
				MC		RESTASIS[1]	Use PA Form #20420	
DERMATOLOGICAL								
TOPICAL - ACNE PREPARATIONS	MC		AZELEX CREA			AZONE	1. Users 24 or under, PA will not be required.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		BENZOYL PEROXIDE	MC		ALTINAC CREA	2. Dosing limits allowing one package per month. Please refer to Dose Consolidation List.	
	MC/DEL		CLINDAMYCIN PHOSPHATE[2]	MC		AVITA CREA		
	MC		ERYDERM SOLN	MC		BENZAC		
	MC/DEL		ERYTHROMYCIN GEL	MC/DEL		BENZACLIN GEL		
	MC/DEL		ERYTHROMYCIN PADS	MC/DEL		BENZAGEL-10 GEL		
	MC/DEL		ERYTHROMYCIN SOLN	MC/DEL		BENZAMYCIN GEL		
	MC		ISOTRETINOIN	MC/DEL		BENZAMYCINPAK PACK	If requesting any brands	
	MC		METRONIDAZOLE CREAM[2]	MC		BREVOXYL	use PA Form # 10220,	
	MC		METRONIDAZOLE GEL[2]	MC/DEL		CLEOCIN-T[2]	for all others use	
	MC		METRONIDAZOLE LOTN[2]	MC		CLINAC BPO GEL	PA Form # 20420	
	MC/DEL		PLEXION	MC		CLINDAGEL GEL		
	MC		RETIN-A GEL[1,2]	MC		CLINDETS SWAB		
	MC/DEL		SODIUM SULFACET/SULF LOTN	MC		DESQUAM-E GEL		
	MC		TAZORAC GEL	MC		DESQUAM-X		
				MC		DIFFERIN 0.3% GEL		
				MC		DIFFERIN		
				MC		DUAC GEL		
				MC		EMGEL GEL		
				MC		EPIDUO		
				MC		ERYCETTE PADS		
				MC		ERYGEL GEL		
				MC/DEL		EVOCLIN		
				MC		FINEVIN CREA		
				MC/DEL		KLARON LOTN		

				MC		METROCREAM CREAM[2]		
				MC		METROGEL GEL[2]		
				MC		METROLOTION LOTN[2]		
				MC		NEOBENZ MICRO		
				MC/DEL		NORITATE CREA		
				MC		RETIN-A MICRO GEL		
				MC		RETIN-A CREAM[2]		
				MC/DEL		SULFACET-R LOTN		
				MC/DEL		TRETINOIN[1, 2]		
				MC/DEL		TRIAZ		
				MC		ZETACET		
				MC/DEL		ZIANA		
TOPICAL - ANTIBIOTIC	MC		BACIT/NEOMYCIN/POLYM OINT	MC/DEL		ALTABAX [1]	1. Dosing limits apply, please see dosing consolidation list. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		BACITRACIN OINT	MC/DEL		BACTROBAN OINT.		
	MC/DEL		BACTROBAN CREAM	MC/DEL		CORTISPORIN		
	MC/DEL		BACTROBAN NASAL OINT	MC/DEL		TRIPLE ANTIBIOTIC OINT		
	MC/DEL		CENTANY OINT 2%[1]					
	MC/DEL		GENTAMICIN SULFATE					
	MC/DEL		MUPIROCIN[1]					
TOPICAL - ANTIFUNGALS	MC		CICLOPIROX 0.77 CREAM	MC		EXELDERM	Use PA Form # 10120	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **DDI:** Ketoconazole will now be non-preferred and require prior authorization if they are currently being used in combination with any of the following medications: Prevacid, Protonix, or Omeprazole.
	MC		CICLOPIROX 0.77 SUSP	MC		FUNGIZONE CREA		
	MC/DEL		CLOTRIMAZOLE	MC/DEL		HYDROCORT/IODOQ CREA		
	MC/DEL		CLOTRIMAZOLE/BETA CREAM	MC/DEL		LAMISIL		
	MC		ECONAZOLE NITRATE CREAM	MC/DEL		LOPROX 0.77 LOTN		
	MC/DEL		KETOCONAZOLE CREAM	MC/DEL		LOPROX 0.77 CREAM		
	MC/DEL		LOPROX 1.0 CREAM	MC/DEL		LOPROX 0.77 SUSP		
	MC/DEL		LOPROX 1.O LOTN	MC/DEL		LOPROX SHAMPOO SHAM		
	MC/DEL		LOPROX GEL	MC		LOTRIMIN		
	MC/DEL		LOPROX TS LOTN	MC/DEL		LOTRISONE		
	MC/DEL		MICONAZOLE NITRATE CREA	MC/DEL		MENTAX CREA		
	MC		MYCO-TRIACET II CREA	MC		MYCOGEN II CREA		
	MC		NIZORAL SHAM	MC		MYCOLOG-II CREA		
	MC		NTA OINT	MC		MYCOSTATIN POWD		
	MC/DEL		NYSTATIN	MC		NAFTIN		
	MC/DEL		NYSTATIN/TRIAMCINOLONE	MC		NIZORAL CREA		
	MC		PEDI-DRI POWD	MC		NYSTAT-RX POWD		
	MC/DEL		TINACTIN	MC/DEL		NYSTOP POWD		
	MC		TRI-STATIN II CREA	MC/DEL		OXISTAT		
				MC/DEL		PENLAC NAIL LACQUER SOLN		
				MC		SPECTAZOLE CREAM		
TOPICAL - ANTIPRURITICS	MC		ZONALON CREA	MC		PRUDOXIN CREA	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
TOPICAL - ANTIPSORIATICS	MC		DOVONEX	MC		OXSORALEN ULTRA CAPS	Must fail all preferred products before non-preferred. 1. Individual ingredients are available as preferred witout PA. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		SORIATANE CAPS	MC		PSORIATEC CREA		
	MC		TAZORAC	MC/DEL		SORIATANE CK KIT		
				MC/DEL		TACLONEX[1]		
				MC		VANAMIDE		
				MC		VECTICAL		
TOPICAL - ANTISEBORRHEICS	MC		CAPITROL SHAM	MC		CARMOL SCALP TREATMENT KIT	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		SELENIUM SULFIDE SHAM	MC		ZNP BAR		
	MC		SELSUN BLUE SHAM					
TOPICAL - ANTIVIRALS				MC/DEL		DENAVIR CREA[1]	1. Must fail oral treatment with Acyclovir or Valtrex. Use PA Form# 20420	
				MC		ZOVIRAX OINT[1]		
TOPICAL - ANTINEOPLASTICS	MC		EFUDEX	MC/DEL		CARAC CREA	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		FLUOROPLEX CREA	MC/DEL		FLUOROURACIL		
	MC		SOLARAZE GEL					
TOPICAL - BURN PRODUCTS	MC		FURACIN CREA	MC/DEL		SILVADENE CREA	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		SSD CREA	MC/DEL		SILVER SULFADIAZINE CREA		
	MC/DEL		THERMAZENE CREA	MC		SSD AF CREA		
TOPICAL - CORTICOSTEROIDS			**LOW POTENCY**	MC/DEL		ACLOVATE	Use PA Form# 20420	At least 1 drug from each potency of preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		DESOWEN	MC		AMCINONIDE CREA		
	MC/DEL		HYDROCORTISONE CREA	MC		ANUSOL HC-1 OINT		
	MC		HYDROCORTISONE LOTN	MC		ARISTOCORT A		
	MC		LACTICARE-HC LOTN	MC		CLOBEX		

	MC		NUTRACORT LOTN	MC		CLODERM CREA		
	MC		TEXACORT SOLN	MC/DEL		CORDRAN		
	MC		TRIDESILON CREA	MC/DEL		CORMAX		
			MEDIUM POTENCY	MC/DEL		CUTIVATE CREAM / OINT		
	MC/DEL		DESOXIMETASONE .05%	MC/DEL		CUTIVATE LOTION		
	MC/DEL		ELOCON	MC/DEL		DERMATOP		
	MC/DEL		FLUOCINOLONE ACETONIDE .025-.01%			DESONATE GEL		
	MC		FLUROSYN CREA	MC/DEL		DIPROLENE		
	MC		FLUTICASONE PROPIONATE CREAM/OINT	MC		ELOCON OINT		
	MC		HYDROCORTISONE BUTYRATE	MC		HYDROCORTISONE POWD		
	MC		HYDROCORTISONE OINT	MC		KENALOG AERS		
	MC		HYDROCORTISONE VALERATE	MC		LIDA MANTLE HC CREA		
	MC		MOMETASONE FUROATE OINT	MC		LIDEX		
	MC/DEL		TRIAMCINOLONE ACETONIDE .025-.1%	MC		LIDEX-E CREA		
				MC/DEL		LOCOID		
			HIGH POTENCY	MC/DEL		LUXIQ FOAM		
	MC		CYCLOCORT	MC/DEL		OLUX FOAM		
	MC/DEL		BETAMETHASONE DIPROPIONATE	MC		PANDEL CREA		
	MC/DEL		DESOXIMETASONE .25%	MC		PROCTOCORT CREA		
	MC/DEL		DESONIDE	MC/DEL		PSORCON		
	MC/DEL		FLUOCINOLONE ACETONIDE .02%	MC/DEL		PSORCON E		
	MC/DEL		FLUOCINONIDE	MC		SYNALAR OINT		
	MC		HALOG	MC/DEL		TEMOVATE		
	MC		HALOG-E CREA	MC		TOPICORT		
	MC/DEL		TRIAMCINOLONE ACETONIDE .5%	MC		TOPICORT LP CREA		
			VERY HIGH POTENCY	MC		ULTRAVATE		
	MC/DEL		AUGMENTED BETA DIP	MC/DEL		VERDESO		
	MC/DEL		BETAMETHASONE VALERATE	MC		WESTCORT		
	MC/DEL		BETA-VAL					
	MC/DEL		CLOBETASOL PROPIONATE					
	MC		DIFLORASONE DIACETATE					
	MC		HALOBETASOL					
			MISCELLANEOUS					
	MC		CAPEX SHAM					
	MC		DERMA-SMOOTHE/FS OIL					
	MC		PROCTO-KIT CREA 1%					
TOPICAL - STEROID LOCAL ANESTHETICS	MC		ZONE-A FORTE LOTN	MC		EPIFOAM FOAM	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
TOPICAL - STEROID COMBINATIONS	MC		DERMA-SMOOTHE/FS ATOPIC P KIT	MC		CARMOL-HC CREA	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
TOPICAL - EMOLLIENTS	MC		AMMONIUM LACTATE LOTION 12%	MC/DEL		AMMONIUM LACTATE CREA	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		LAC-HYDRIN CREAM	MC		LAC-HYDRIN LOTION 12%		
	MC		LACTINOL-E CREA	MC/DEL		LACTINOL LOTN		
	MC		UREACIN-20 CREA	MC		MEDERMA GEL		
	MC		VITAMIN A & D MEDICATED OINT	MC		MIMYX		
				MC		RENOVA CREA		
TOPICAL - ENZYMES / KERATOLYTICS / UREA	MC		GRANUL-DERM AERS	MC		CARMOL 40 CREA	Use PA Form# 20420 Ziox, Panafil and Papain products have been removed from the PDL due to FDA safety concerns regarding drugs containing Papain.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		GRANULEX AERS	MC		SALEX CREAM		
	MC		TBC AERS	MC		SALEX LOTION		
	MC		SANTYL OINT					
TOPICAL - GENITAL WARTS	MC/DEL		ALDARA	MC/DEL	5	PODOFILOX SOLN	Use PA Form# 20420 Non-preferred products must be used in specified order.	
				MC/DEL	8	CONDYLOX		
				MC	8	VEREGEN		
TOPICAL -				MC/DEL	8	ELIDEL CREA	Use PA Form# 20420	Preferred corticosteroids from other classes must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an

IMMUNOMODULATORS				MC	9	PROTOPIC OINT	Non-preferred products must be used in specified order. The FDA has issued a Publilc Health Advisory for both Elidel and Protopic concerning the potential cancer risk associated with their use. Use for children less than 2 years of age is not recommended.	acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Approvals will be made for small amounts of non-preferred products for the treatment of very steroid-sensitive areas in conjunction with topical steroids for the treatment of atopic dermatitis.
TOPICAL - LOCAL ANESTHETICS	MC		AF CAPSICUM OLEORESIN CREA	MC/DEL		EMLA PADS	1. Lidocaine/Prilocaine cream and Ela-Max products require PA for users over 18 years of age.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		CAPSAICIN CREA	MC/DEL		EMLA CREA		
	MC		ELA-MAX[1]	MC		LIDA MANTLE CREA		
	MC/DEL		LIDOCAINE/PRILOCAINE CREA[1]	MC		LIDODERM PTCH		
	MC/DEL		XYLOCAINE	MC		PONTOCAINE SOLN		
				MC		ZOSTRIX	Use PA Form# 20420	
TOPICAL - DEPIGMENTING AGENTS				MC	8	ALUSTRA CREA	Not covered for cosmetic purposes.	As per Medicaid Policy, cosmetic drugs are not covered. Non-cosmetic clinical applications will be considered by prior authorization on a case by case basis.
				MC	8	EPIQUIN MICRO		
				MC	8	GLYQUIN CREA		
				MC/DEL	8	HYDROQUINONE CREA	Use PA Form# 20420	
				MC/DEL	8	HYDROQUINONE/SUNSCREENS		
				MC	8	SOLAQUIN FORTE CREA		
				MC	8	TRI-LUMA CREA		
				MC	9	ELDOQUIN		
TOPICAL - SCABICIDES AND PEDICULICIDES	MC/DEL		ACTICIN CREA	MC/DEL		LINDANE	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		ELIMITE CREA	MC		OVIDE LOTN		
	MC		EURAX	MC		MALATHION		
	MC		LICE KILLING SHAM	MC		ULESFIA		
	MC/DEL		LICE TREATMENT CREME RINS LIQD					
	MC/DEL		PERMETHRIN LOTN					
TOPICAL - WOUND / DECUBITUS CARE				MC		REGRANEX GEL	Use PA Form# 20420 Accuzyme and Ethezyme products have been removed from the PDL due to FDA concerns regarding drugs containing Papain.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Regranex will be approved for diabetic patients in good control (hgba1c <8), who are not smoking, with a stage III or IV WOCN AND NPUAP lower extremity diabetic ulcer and with an adequate blood supply (Tcp 02 >30, ABI>0.7 or ASP> 70), and where the underlying cause has been corrected. The wound must be free of infection and have been previously treated with preferred standard therapies for at least 2 months. Maximum approval for 20 weeks.
				MC/DEL		REGENECARE		
				MC/DEL		RADIAPLEXRX		
TOPICAL - ASTRINGENTS / PROTECTANTS	MC		ALUMINUM CHLORIDE SOLN	MC		LOWILA BAR	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		DRYSOL SOLN	MC		MOISTURIN DRY SKIN CREA		
	MC		XERAC AC SOLN	MC		PROSHIELD PLUS SKIN PROTE CREA		
						SURGILUBE GEL		
				MC				
TOPICAL - ANTISEPTICS / DISINFECTANTS	MC/DEL		PHISOHEX LIQD	MC		BETADINE OINT	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		POVIDONE-IODINE SOLN	MC		FORMALYDE-10 AERS		
				MC		IODOSORB		
				MC		LAZERFORMALYDE SOLUTION SOLN		
MISCELLANEOUS EYE								
OP. - EYE	MC		AK-DILATE SOLN	MC		LENS PLUS REWETTING DROPS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		EYE WASH SOLN	MC/DEL		MURO 128		
	MC		NAPHAZOLINE HCL SOLN	MC		NEO-SYNEPHRINE SOLN		
	MC		PHENYLEPHRINE HCL SOLN					
	MC		PONTOCAINE SOLN					
	MC/DEL		SODIUM CHLORIDE					
MISCELLANEOUS EAR								
EAR	MC/DEL		A/B OTIC SOLN	MC		AERO OTIC HC SOLN	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		ACETASOL SOLN	MC		ANTIBIOTIC EAR SOLN		
	MC/DEL		ACETASOL HC SOLN	MC		ANTIBIOTIC EAR SUSP		
	MC/DEL		ACETIC ACID	MC		AURALGAN SOLN		
	MC/DEL		ACETIC ACID/HYDROCORTISON	MC/DEL		CIPRO HC SUSP		
	MC/DEL		ALLERGEN SOLN	MC		COLY-MYCIN-S SUSP		
	MC/DEL		ANTIPYRINE/BENZOCAINE SOLN	MC		CORTISPORIN SUSP		
	MC/DEL		AURODEX SOLN	MC/DEL		CORTISPORIN-TC SUSP		
	MC		AUROGUARD SOLN	MC/DEL		DEBROX SOLN		
	MC/DEL		AUROTO OTIC SOLN	MC		DOMEBORO SOLN		
	MC		CARBAMIDE PEROXIDE 6.5% OTIC SOLN.	MC		FLOXIN OTIC SOLN		

	MC/DEL		CIPRODEX	MC/DEL		PEDIOTIC SUSP		
	MC		CORTISPORIN SOLN	MC		VOSOL-HC SOLN		
	MC/DEL		CORTOMYCIN	MC/DEL		ZOTANE HC SOLN		
	MC		EAR DROPS SOLN	MC		ZOTO-HC SOLN		
	MC		EAR DROPS RX SOLN					
	MC/DEL		EAR WAX REMOVAL DROPS					
	MC		EAR-GESIC SOLN					
	MC/DEL		NEOMYCIN/POLYMYXIN/HC					
	MC/DEL		OFLOXACIN 0.3% OTIC					
	MC/DEL		OTICAINE OTIC SOLN					
MOUTH ANTISEPTICS								
MOUTH ANTI-INFECTIVES	MC		NILSTAT SUSP	MC		MYCELEX TROC	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		EAR-GESIC SOLN	MC		MYCOSTATIN LOZG		
	MC/DEL		NYSTATIN SUSP	MC				
MOUTH ANTISEPTICS	MC/DEL		CHLORHEXIDINE GLUCONATE	MC		APHTHASOL PSTE	Use PA Form# 20420 Must fail all preferred products before non-preferred.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		LIDOCAINE VISCOUS SOLN	MC		PERIDEX SOLN		
	MC		TRIAMCINOLONE IN ORABASE PSTE	MC		PERIOGARD SOLN		
	MC		TRIAMCINOLONE ORADENT PSTE	MC		TRIAMCINOLONE ACETONIDE PSTE		
				MC		XYLOCAINE VISCOUS SOLN		
DENTAL PRODUCTS								
DENTAL PRODUCTS	MC/DEL		ETHEDENT CREA	MC0MC		APF GEL GEL	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		GEL-KAM CONC	MC/DEL		DENTAGEL GEL		
	MC/DEL		GEL-KAM GEL 0.4%	MC/DEL		PHOS-FLUR GEL		
	MC/DEL		PHOS FLUR SOLN	MC/DEL		PREVIDENT CREAM		
	MC/DEL		PREVIDENT GEL	MC		THERA-FLUR-N GEL		
	MC/DEL		PREVIDENT SOLN					
	MC/DEL		SF 5000 PLUS CREA					
	MC/DEL		SF GEL					
	MC		STANNOUS FLUORIDE ORAL RI CONC					
ARTIFICIAL SALIVA/STIMULANTS								
ARTIFICIAL SALIVA/STIMULANTS	MC		SALIVA SUBSTITUTE SOLN	MC		EVOXAC CAPS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
				MC		RADIACARE SOLR		
				MC		SALAGEN TABS		
MISCELLANEOUS ANORECTAL								
ANORECTAL - MISC.	MC/DEL		COLOCORT ENEM	MC/DEL		ANUSOL-HC CREA	Use PA Form# 20420	
	MC		CORTENEMA ENEM	MC/DEL		CORTIFOAM FOAM		
	MC		ELA-MAX 5 CREA	MC/DEL		PROCTOCREAM-HC CREA		
	MC/DEL		HYDROCORTISONE ENEM	MC/DEL		PROCTOFOAM HC FOAM		
	MC/DEL		PROCTOZONE-HC CREA	MC/DEL		PROCTO-KIT CREA 2.5%		
				MC/DEL		PROCTOSOL HC CREA		
T-CELL ACTIVATION INHIBITOR								
PSORIASIS BIOLOGICALS	MC		ENBREL 25MG INJECTIONS ONLY[4]	MC		**AMEVIVE**[2]	1. Will not require a PA if at least one systemic drug such as methotrexate, cyclosporine, methoxsalen or acitretin is in members drug profile. Please refer to dose consolidation list.	Approved for severe chronic plaque psoriasis unresponsive to first line therapies. A trial of at least several potent topicals from the following categories: corticosteroids, coal tars, anthralin, calcipotriene and tazorotene, and at least one systemic drug such as methotrexate, cyclosporine, methoxsalen or acitretin and phototherapy/UVA.
	MC		HUMIRA[1]	MC		ENBREL 50 MG[3]		Enbrel 25mg is preferred after a trial of a step 1 product (e.g. azathioprine, methotrexate, etc.); however, dosing limits will also still apply. Dosing limits will allow 8 injections per month without pa. Use of greater than 8 injections per month will require PA. In addition, the preferred Enbrel 25mg product will be the multi-dose vial (NDC- 58406-0425-34). The single-use prefilled syringes are non-preferred.
							2. Trial of both preferred drugs are required. 3. Use multiple 25mg injections. 4. Preferred dosage form allowed without PA after trial of step 1 prodcuts is multi-dose vial, with dosing limits allowing 8 injections per 28 days without pa. Use PA Form # 20910	
ALTERNATIVE MEDICINES								

ALTERNATIVE MEDICINES	MC		DIMETHYL SULFOXIDE SOLN	MC/DEL		CO-ENZYME Q-10	Use PA Form# 20420	Will only be approved for specific conditions supported by at least two double-blinded, placebo-controlled randomized trials that are not contradicted by other studies of similar quality.
						GLUCOSAMINE		
				MC		MELATONIN TABS		
CHELATING AGENTS								
CHELATING AGENTS	MC/DEL		**CUPRIMINE CAPS**	MC		DEPEN TITRATABS TABS	Use PA Form# 20420	1. FDA indication of treatment of chronic iron ovrload due to blood transfustions in membes 2 years of age and older is requried for approval of Exjade
				MC/DEL		EXJADE[1]		
ANTILEPROTIC								
ANTILEPROTIC				MC		THALOMID CAPS[1]	1. All PA requests for 150mg dosing will require use of Thalomid 100mg and 50mg capsules. Use PA Form# 20420	Approved for indications of leprosy, treatment-resistant multiple myeloma and AIDS.
ANTINEOPLASTIC AGENTS								
ANTINEOPLASTIC AGENTS - ANTIADNDROGENS	MC/DEL		BICALUTAMIDE	MC/DEL		CASODEX	Use PA Form# 20420	
ANTINEOPLASTIC AGENTS-LHRH ANALOGS	MC		LUPRON DEPOT[1]			VANTAS[2]	1. Dosing limits apply, please refer to dosage consolidation list. 2. PA required to confirm FDA approved indication. Use PA Form# 20420	
				MC		FIRMAGON[2]		
				MC/DEL		TRELSTAR		
ANTINEOPLASTIC AGENTS - TYROSINE KINASE INHIBITORS	MC		GLEEVEC	MC		SPRYCEL[1]	Use PA Form# 20420 1. Verification of diagnosis and prior trial of at least Gleevec is required. 2. PA required to confirm FDA approved indication and to monitor for potential drug-drug interactions.	
	MC/DEL			MC/DEL		TYKERB[2]		
ANTINEOPLASTICS-MISCELLANEOUS	MC/DEL		MERCAPTOPURINE	MC/DEL		ZOLINZA	Use PA Form# 20420	
				MC/DEL		PURINETHOL		
ANTINEOPLASTICS-MONOCLONAL ANTIBODIES				MC/DEL		HERCEPTIN[1]	1. PA required to confirm FDA approved indication. Use PA Form# 20420	
CANCER								
CANCER	MC		ALIMTA	MC		NEXAVAR[1]	1. PA required to confirm FDA approved indication 2. Avoid CYP3AY drug drug interaction. Use PA Form# 20420	
	MC/DEL		AVASTIN	MC/DEL		SUTENT[1,2]		
	MC		ERBITUX					
			VIDAZA					
	MC/DEL							
IMMUNOSUPPRESSANTS								
IMMUNOSUPPRESSANTS	MC/DEL		CYCLOSPORINE MODIFIED	MC/DEL		CELLCEPT	1. Established users will require a one time PA. 2. Established users will require a one time PA Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **DDI:** Cyclosporine will now be non-preferred and require prior authorization if it is currently being used in combination with either Lipitor (doses greater than 20mg/day), Crestor, or lovastatin (doses greater than 20mg). **DDI:** All preferred immunosuppressants will require clinical PA for patients over 60 that are currently on fluoroquinolone therapy.
	MC/DEL		CYCLOSPORINE SOL. MODIFIED	MC/DEL		CYCLOSPORINE CAPS		
	MC		GENGRAF CAPS	MC/DEL		NEORAL[1,2]		
	MC/DEL		MYCOPHENOLATE					
	MC/DEL		MYFORTIC					
	MC		PROGRAF CAPS					
	MC/DEL		RAPAMUNE					
	MC/DEL		SANDIMMUNE					
PURINE ANALOG								
PURINE ANALOG	MC		AZASAN TABS	MC/DEL		**IMURAN TABS**	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**AZATHIOPRINE TABS**					
K REMOVING RESINS								
K REMOVING RESINS	MC/DEL		KAYEXALATE POWD				Use PA Form# 20420	
	MC		KIONEX POWD					
	MC/DEL		SODIUM POLYSTYRENE SULFON					
	MC/DEL		SPS SUSP					
	MC/DEL		SPS 30GM/120ML ENEMA SUSP					

New drugs are initially non-preferred until reviewed by the DUR Committee and the State. According to State policy, any drug requiring specific diagnosis still requires the specific diagnosis unless otherwise noted within this document.

ANTI-CONVULSANTS INDICATION CHART

	SEIZURES	POST HERPETIC NEURALGIA	DIABETIC PERIPHERAL NEUROPATHY	MONOTHERAPY BIPOLAR	ADJUNCTIVE BIPOLAR	MIGRAINE PROPHYLAXIS	FIBROMYALGIA
GABITRIL	**X**			**9**	**8**		
LAMICTAL	**X**			**4**	**4**		
LYRICA	**X**	**X(2nd line)**	**X(2nd line)**				**X(2nd line)**
TOPAMAX	**X**			**9**	**6**	**X (2nd line)**	
TRILEPTAL	**X**			**5**	**5**		

PEDIATRIC ANTI-CONVULSANTS INDICATION CHART

	SEIZURES	MONOTHERAPY BIPOLAR	ADJUNCTIVE BIPOLAR
LITHIUM		**1**	**1**
CARBMAZEPINE	**X**	**1**	**1**
VALPROATE	**X**	**1**	**1**
ATYPICAL ANTIPSYCHOTICS EXC. CLOZAPINE	**X**	**1**	**1**
LAMICTAL	**X**	**1**	**1**
TRILEPTAL	**X**	**5**	**5**
CLOZAPINE	**X**	**6**	**6**