

CATEGORY	Step Order	PREFERRED DRUGS	Step Order	NON-PREFERRED DRUGS Required	PA	Comments
<p>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.mainearepdl.org</p>						
<p>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.)</p>						
<p>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.</p>						
<p>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.)</p>						
<p>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.</p>						
<p>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.</p>						
<p>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.</p>						
<p>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.</p>						
<p>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.</p>						
<p>I. Trials from Multiple Drug Classes: Trial/failure/intolerance to preferred agents from multiple classes within the same category or other categories of drugs may be required prior to the approval of non-preferred agents (e.g., Cymbalta, Zofran, Elidel and others).</p>						
<p>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.mainearepdl.org.</p>						
<p>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.</p>						
<p>L: Drug-Drug Interactions (DDI): The DUR Committee has implemented new drug-drug interaction edits requiring prior authorization. Several drug-drug combinations and PDL drug categories 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.</p>						

ASSORTED ANTIBIOTICS

BETA-LACTAMS / CLAVULANATE COMBO'S		AMOXICILLIN AMOXICILLIN/POTASSIUM CLA CHEW AMOXICILLIN/POTASSIUM CLA SUSR AMOXICILLIN/POTASSIUM CLA TABS AMOXIL ¹ AMPICILLIN BEEPEN BICILLIN L-A SUSP DICLOXACILLIN SODIUM CAPS DYNAPEN SUSR GEOCILLIN TABS OXACILLIN SODIUM SOLR PENICILLIN V POTASSIUM TICAR SOLR TIMENTIN SOLR TRIMOX UNASYN SOLR VEETIDS ZOSYN		AMOXIL 500MG TABS AUGMENTIN ³ AUGMENTIN XR TB12 ⁴ PRINCIPEN CAPS ² PRINCIPEN SUSR		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
CEPHALOSPORINS		CEFADROXIL HEMIHYDRATE CEFAZOLIN SODIUM SOLR CEFDINIR		CECLOR ¹ CEDAX CEFACLOR ¹		1. Both brand and generic are clinically non-preferred.

	CEFEPIME HCl CEFPODOXIME CEFPROZIL CEFTAZIDIME 6MG CEFTIN SUSP CEFTRIAZONE CEFUROXIME AXETIL TABS CEPHALEXIN MONOHYDRATE DURICEF SUSR FORTAZ SOLR KEFZOL SOLR MAXIPIME SOLR TAZICEF 6GM TAZIDIME VANTIN 100MG VANTIN SUSP	CEFADROXIL MONOHYDRATE TABS CEFTIN DURICEF TABS FORTAZ FORTAZ SOLN KEFLEX CAPS OMNICEF ROCEPHIN SUPRAX TAZICEF SOLR TAZIDIME SOLN MAXIPIME	Use PA Form# 20420
MACROLIDES / ERYTHROMYCIN'S	BIAVIN XL ¹ AZITHROMYCIN TABS AZITHROMYCIN SUSP CLARITHROMYCIN TABS E.E.S. E-MYCIN TBEC ERYPED 200 SUSR ERYPED 400 SUSR ERY-TAB TBEC ERYTHROCIN STEARATE TABS ERYTHROMYCIN	AZITHROMYCIN POWDER BIAVIN CLARITHROMYCIN SUSP DYNABAC D5-PAK TBEC ERYPED CHEW PCE TBEC ZITHROMAX TABS ZITHROMAX 1GM PAK ZITHROMAX TRI-PAK ZITHROMAX SUSP ZMAX	1. 7- Day supply per month without PA. Use PA Form# 20420
TETRACYCLINES	DOXYCYCLINE HYCLATE MINOCYCLINE HCL CAPS SUMYCIN TETRACYCLINE HCL CAPS VIBRAMYCIN SYRP	DECLOMYCIN TABS DORYX CPEP DOXYCYCLINE MONO CAPS DYNACIN CAPS MONODOX CAPS ORACEA PERIOSTAT SOLODYN ER	Use PA Form# 20420
FLUOROQUINOLONES	AVELOX SOLN AVELOX TABS AVELOX ABC PACK TABS CIPROFLOXACIN LEVAQUIN TABS OFLOXACIN	CIPRO FLOXIN TABS FACTIVE LEVAQUIN TABS SOLN/INJ NOROXIN TABS PROQUIN XR TEQUIN	Use PA Form# 20420
AMINO GLYCOSIDES	GENTAMICIN NEOMYCIN SULFATE TABS TOBI NEBU TOBRAMYCIN SULFATE SOLN		
ANTI-MYCOBACTERIALS / ANTI-TUBERCULOSIS	ETHAMBUTOL HCL TABS MYAMBUTOL TABS MYCOBUTIN CAPS RIFAMPIN	RIMACTANE CAPS	Use PA Form# 20420
ANTIMALARIAL AGENTS	CHLOROQUINE PHOSPHATE TABS DARAPRIM TABS HYDROXYCHLOROQUINE TABS LARIAM TABS MEFLOQUINE HCL TABS QUINACRINE HCL POWD QUININE SULFATE	ARALEN TABS ISONARIF ¹ MALARONE TABS PLAQUENIL TABS QUALAQUIN	Use PA Form# 20420 1. Ingredients available as preferred without PA.
ANTHELMINTICS	ALBENZA TABS BILTRICIDE TABS MEBENDAZOLE CHEW STROMECTOL TABS	VERMOX CHEW	Use PA Form# 20420
ANTIBIOTICS - MISC.	AZACTAM SOLR COLISTIMETHATE SODIUM SOLR FUROXONE TABS METRONIDAZOLE ² PENTAMIDINE ISETHIONATE SOLR	COLY-MYCIN-M SOLR CAYSTON ⁴ FLAGYL CAPS FLAGYL TABS FLAGYL ER TBCR	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

	PRIMSOL SOLN TRIMETHOPRIM TABS VANCOCIN HCL VANCOMYCIN 5GM INJ.		KETEK LORABID METRONIDAZOLE 375MG CAPS ² METRONIDAZOLE 750MG TABS ² NEBUPENT SOLR PROLOPRIM TABS TINDAMAX ¹ VANCOMYCIN 10GM INJ. ³ XIFAXAN	required dose without PA. 3. Please use multiple 5gm which are preferred to obtain dose without PA. 4. Clinical PA is required to establish CF diagnosis and medical necessity. Prior trial and failure of preferred Tobi before approval will be granted. Use PA Form# 20420
CARBAPENEMS			INVANZ SOLR MERREM SOLR PRIMAXIN	Use PA Form# 20420
LINCOSAMIDES / OXAZOLIDINONES / LEPROSTATICS	CLEOCIN SOLN CLEOCIN SUSR CLINDAMYCIN HCL 150CAPS DAPSONE TABS		CLEOCIN CAPS CLINDAMYCIN HCL 300CAPS ¹ ZYVOX SUSR ZYVOX TABS	1. Use multiple 150's for Clindamycin instead of 300's. Zyvox: use PA Form # 30820 Others: use PA Form # 20420
ANTI INFECTIVE COMBO'S - MISC.	ERYTHROMYCIN/SULF SUSR SEPTRA/DS TABS SULFAMETHOXAZOLE/TRIMETH TRIMETHOPRIM/SULFAMETHOXA		BACTRIM DS TABS	Use PA Form# 20420
ANTIPROTOZOALS			ALINIA ¹	1. Alina is preferred for children less than 12 years of age. Use PA Form# 20420
ANTI - FUNGALS				
ANTIFUNGALS - ASSORTED	ANCOBON CAPS FLUCONAZOLE ¹ GRIFULVIN V TABS ¹⁰ GRISEOFULVIN SUSP ¹⁰ GRISEOFULVIN ULTRAMICROSI TABS ¹⁰ GRIS-PEG TABS ¹⁰ KETOCONAZOLE TABS ⁵ NYSTATIN TERBINAFINE TABS ⁴	5 6 6 7 8 8 8 8 8 8 8	LAMISIL TABS ⁴ SPORANOX SOLN ² SPORANOX PULSEPAK CAPS ³ SPORANOX CAPS ³ ERAXIS INJ ⁶ DIFLUCAN GRIFULVIN SUSP NIZORAL TABS NOXAFIL ⁵ VFEND TABS ITRACONAZOLE	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.
ANTI - VIRALS				
ANTIRETROVIRALS	AGENERASE CAPS APTIVUS ATRIPLA ¹ COMBIVIR TABS CRIXIVAN CAPS EMTRIVA EPIVIR / HBV EPZICOM FORTOVASE CAPS HIVID TABS INVIRASE CAPS		DIDANOSINE FUZEON ³ INTELENCE ³ ISENTRESS ³ RETROVIR SELZENTRY ³ ZERIT	Fuzeon use PA Form # 10620 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 3. Prescribers with >= 10 ART scripts per ...

		KALETRA LEXIVA NORVIR PREZISTA ² RESCRIPTOR TABS REYATAZ STAVUDINE SUSTIVA TRIZIVIR TABS TRUVADA VIDEX / EC VIRACEPT TABS VIRAMUNE TABS VIREAD TABS ZIAGEN TABS ZIDOVUDINE			quarter and 75% ART PDL compliance will be exempt from PA for these products.
CYTO-MEGALOVIRUS AGENTS		FOSCARNET SODIUM VALCYTE TABS		FOSCAVIR GANCICLOVIR	Use PA Form# 20420
HERPES AGENTS		ACYCLOVIR VALTREX TABS	8 8 8 9	FAMVIR TABS ZOVIRAX VALACYCLOVIR FAMCICLOVIR	Must fail Acyclovir and Valtrex before non-preferred products. Use PA Form# 20420
INFLUENZA AGENTS		AMANTADINE RELENZA DISKHALER AEPB RIMANTADINE HCL TABS TAMIFLU ¹		FLUMADINE TABS FLUMIST ²	1. Tamiflu 10 caps or 60cc's per month. Will be audited for presence of positive influenza tests in patient or family member. 2. For Flumist requests: use Form # 10610 Others Use PA Form # 20420
IMMUNE SERUMS					
IMMUNE SERUMS		HYPERRHO INJ			
HEPATITIS AGENTS					
HEPATITIS C AGENTS		PEGASYS KIT ¹ PEGASYS SOLN REBETRON KIT RIBAVIRIN		COPEGUS TABS PEG-INTRON KIT ² REBETOL CAPS	1. Dosing limits apply, please see dosage consolidation list. 2. Current users are grandfathered. Use PA Form# 20420
HEPATITIS AGENTS - MISC.				ACTIMMUNE	Use PA Form# 20420
HEPATITIS B ONLY		HEPSERA TABS		BARACLUDE TYZEKA	
RSV PROPHYLAXIS					
RSV PROPHYLAXIS				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.
MS TREATMENTS					
MULTIPLE SCLEROSIS - INTERFERONS		AVONEX KIT ¹ BETASERON SOLR ¹ REBIF SOLN ¹		EXTAVIA	1. Clinical PA is required to establish diagnosis and medical necessity.
MULTIPLE SCLEROSIS - NON-INTERFERONS		COPAXONE ²		TYSABRI ¹ AMPYRA GILENYA	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.		MESTINON ORAP TABS		BOTOX DYSPORT ¹	1. Approval will be limited to Cervical dystonia.

		PROSTIGMIN TABS		MYOBLOC ¹	Use PA Form #10210
STERIODS					
GLUCOCORTICOIDS/ MINERALOCORTICOIDS		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		CORTEF 10 and 20 TABS FLORINEF TABS MEDROL TABS MEDROL DOSEPAK TABS ORAPRED SOLN PEDIAPRED LIQD PREDNISONE INTENSOL CONC PRELONE SYRP STERAPRED TABS	Use PA Form# 20420
HORMONE REPLACEMENT THERAPIES					
ANDROGENS / ANABOLICS		ANDRODERM PT24 ANDROGEL ANDROID CAPS DANAZOL CAPS DEPO-TESTOSTERONE OIL FLUOXYMESTERONE TABS TESTOSTERONE PROPIONATE TESTRED CAPS		ANDRO LA 200 OIL ANDROGEL PUMP DELATESTRYL OIL HALOTESTIN TABS METHITEST TABS OXANDRIN TABS TESTIM	Use PA Form# 20420 Use the Oxandrin PA Form #20600
ESTROGENS - PATCHES / TOPICAL		ESTRADERM PTTW ¹ VIVELLE-DOT PTTW ¹	5 8 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
ESTROGENS - TABS		CENESTIN TABS ESTRADIOL ESTROPIPATE TABS MENEST TABS PREMARIN TABS		ENJUWIA ESTRACE TABS ESTRATAB TABS ORTHO-EST TABS	Must fail preferred products before non-preferred products. Use PA Form# 20420
ESTROGEN COMBO'S		PREMPHASE TABS PREMPRO TABS		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
PROGESTINS		MEDROXYPROGESTERONE ACETA ² NORETHINDRONE ACETATE TABS ² PROGESTERONE POWD		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
CONTRACEPTIVES					
CONTRACEPTIVES - PROGESTIN ONLY		ORTHO MICRONOR TABS		CAMILA TABS ERRIN JOLIVETTE NORA-BE TABS NOR-QD TABS OVRETTE 28 TABS	If member experienced adverse reactions, consider using Oral Contraceptives from other groups. Use PA Form# 20420
CONTRACEPTIVES - INJECTABLE		MEDROXYPROGESTERONE ACETATE 150mg IM		DEPO-PROVERA 150 mg SUSP LUNELLE SUSP	Use PA Form# 20420
CONTRACEPTIVE - EMERGENCY		NEXT CHOICE ¹		PLAN - B	1. Allowed 4 tablets per 30 days without PA Use PA Form# 20420
CONTRACEPTIVES - PATCHES/ ORAL PRODUCTS		NUVARING RING ³			1.No PA required for users less than 21 years

VAGINAL PRODUCTS		ORTHO EVRA PTWK ^{1,2,4}		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 exposure. 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.	
CONTRACEPTIVES - MONOPHASIC COMBINATION O/C'S		APRI TABS BALZIVA CRYSSELLE-28 TABS DESOGEN TABS DESOGESTREL/ ETHINYL ESTRADIOL LOW-OGESTREL TABS MODICON TABS MONONESSA NECON 1/50 ORTHO-CEPT-28 TABS ORTHO-CYCLEN-28 TABS ORTHO-NOVUM 1/35-28 TABS OVCON-50 28 TABS PREVIFEM RECLIPSEN SOLIA SPRINTEC 28 TABS YASMIN 28 TABS ZENCHENT SEASONIQUE LOSEASONIQUE		AVIANE TABS BREVICON-28 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 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.
CONTRACEPTIVES - BI-PHASIC COMBINATIONS		ORTHO-NOVUM 10/11-28 TABS NORETHINDRONE-ETH ESTRADIOL TAB 0.5-35/135		NECON 10/11-28 TABS If member experienced adverse reactions, consider using Oral Contraceptives from other groups. Use PA Form# 20420	
CONTRACEPTIVES - TRI-PHASIC COMBINATIONS		ENPRESSE NECON 7/7/7 ORTHO-NOVUM 7/7/7-28 TABS TRI-PREVIFEM TRIPHASIL 28 TABS TRI-SPRINTEC TRINESSA TRIVORA-28 TABS		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	
DIABETES THERAPIES					
DIABETIC - INSULIN		HUMALOG INJ 100/ML HUMALOG MIX 75/25 HUMULIN N INJ U-100 HUMULIN INJ 70/30 HUMULIN R U-100 LANTUS SOLN LEVEMIR NOVOLIN NOVOLOG NOVOLOG MIX		APIDRA HUMALOG MIX 50/50 HUMULIN INJ 50/50 HUMULIN R INJ U-500 RELION Use PA Form# 20420	
DIABETIC - PENFILLS		LANTUS OPTICLIK PEN ¹ LANTUS SOLOSTAR ¹ LEVEMIR FLEXPEN ¹ NOVOLIN PENFILL ¹ NOVOLIN 70/30 ¹ NOVOLOG MIX PENFILL ¹ NOVOLOG PENFILL SOLN ¹		APIDRA OPTICLIK PEN HUMALOG KWIK INJ 100/ML HUMALOG MIX INJ 75/25 KWP HUMALOG MIX INJ 50/50 KWP HUMALOG PEN SOLN HUMULIN PEN HUMULIN N PN INJ U-100 1. Clinical PA will be required to establish significant visual or neurological impairment. Use PA Form# 20420	

		NOVOLOG MIX FLEXPEN ¹ NOVOLOG FLEXPEN ¹		HUMULIN PEN INJ 70/30	
DIABETIC - DPP- 4 ENZYME INHIBITOR		JANUVIA ¹ ONGLYZA ¹ KOMBIGLYZE			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 - DPP- 4 ENZYME INHIBITOR-COMBO		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 FREESTYLE LANCETS UNILET LANCETS UNISTIK LANCING DEVICE AUTOLOT LANCING DEVICE			Use PA Form# 20420
DIABETIC - SYRINGES-NEEDLES		BD MICRO-FINE BD ULTRA-FINE BD ULTRA-FINE PEN NEEDLES UNIFINE PEN NEEDLES			Use PA Form# 20420
DIABETIC - OTHER				CYCLOSET SYMLIN	Use PA Form #301501
DIABETIC MONITOR		FREESTYLE LITE SYSTEM KIT FREESTYLE FLASH SYSTEM KIT FREESTYLE FREEDOM SYSTEM KIT FREESTYLE FREEDOM LITE KIT ONE TOUCH ULTRA 2 KIT ONE TOUCH ULTRA MINI KIT ONE TOUCH ULTRA SMART KIT PRECISION XTRA METER		ACCUCHECK ASCENSIA ASSURE EXACTECH PRODIGY	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. Use PA Form# 20420
DIABETIC TEST STRIPS		FREESTYLE ¹ FREESTYLE LITE ¹ 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		ACCUCHECK ASCENSIA ASSURE EXACTECH PRODIGY	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. 1. Only 50 ct & 100 ct package size. Use PA Form# 20420
INCRETIN MIMETIC				BYETTA ¹ VICTOZA	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		CHLORPROPAMIDE TABS GLIMEPIRIDE GLIPIZIDE TABS GLIPIZIDE ER TABS GLYBURIDE TABS GLYBURIDE MICRONIZED TABS TOLAZAMIDE TABS TOLBUTAMIDE TABS		AMARYL TABS DIABETA TABS GLUCOTROL TABS GLUCOTROL XL TBCR GLYNASE TABS MICRONASE TABS	Use PA Form# 20420
DIABETIC -ORAL BIGUANIDES		METFORMIN HCL TABS METFORMIN ER		GLUCOPHAGE TABS GLUCOPHAGE XR TB24 FORTAMET	Use PA Form# 20420

DIABETIC - THIAZOL / BIGUANIDE COMBO				ACTOPLUS MET ¹ AVANDARYL ¹ AVANDAMET TABS ¹	Use PA Form# 20420 1. Requires use of Actos, Metformin, or other preferred anti-diabetics.
DIABETIC - / THIAZOL		ACTOS 15MG TABS ¹		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
DIABETIC - ALPHA-GLUCOSIDASE		GLYSET TABS		PRECOSE TABS	Use PA Form# 20420
DIABETIC - SULFONYLUREA / BIGUANIDE		GLYBURIDE/METFORMIN		GLUCOVANCE TABS METAGLIP TABS DUETACT ¹	Use individual ingredients. 1. Use Actos 15mgs with generic glimepiride. Use PA Form# 20420
DIABETIC - MEGLITINIDES		STARLIX TABS		PRANDIN TABS NATEGLINIDE	Use PA Form# 20420
GLUCOSE ELEVATING AGENTS					
GLUCOSE ELEVATING AGENTS		GLUCAGEN INJ. HYPOKIT		GLUCAGON DIAGNOSTIC KIT GLUCAGEN DIAGNOSTIC KIT	Use PA Form# 20420
THYROID					
THYROID HORMONES		ARMOUR THYROID TABS CYTOMEL TABS LEVOTHROID TABS LEVOTHYROXINE SODIUM TABS LEVOXYL TABS THYROID TABS THYROLAR UNITHROID TABS		LEVOTHYROXINE SODIUM SOLR LIOTHYRONINE SYNTHROID TABS	Use PA Form# 20420
ANTITHYROID THERAPIES		METHIMAZOLE TABS PROPYLTHIOURACIL TABS		TAPAZOLE TABS	Use PA Form# 20420
OSTEOPOROSIS					
OSTEOPOROSIS		ALENDRONATE FOSAMAX SOLN ² MIACALCIN SOLN ²		ACTONEL TABS BONIVA INJECTION KIT BONIVA TABS ^{2,4} ARELIA SOLR DIDRONEL TABS EVISTA TABS ¹ FORTEO FORTICAL FOSAMAX TABS AND PLUS D ³	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. 4. Please use other preferred agents.
CALCIMIMETIC AGENTS					
CALCIMIMETIC AGENTS				SENSIPAR	Use PA Form # 30115
GROWTH HORMONE					
GROWTH HORMONE		GENOTROPIN ¹ NUTROPIN ¹ NUTROPIN AQ ¹ NORDITROPIN CARTRIDGE SOLN ¹	5 5 8 8	OMNITROPE TEV-TROPIN HUMATROPE SOLR ² INCRELEX ² SAIZEN SOLR ²	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.
SOMATOSTATIC AGENTS		OCTREOTIDE INJ		SANDOSTATIN SOMATULINE	Use PA Form # 10710

GROWTH HORMONE ANTAGONISTS

GH ANTAGONISTS				SOMAVERT	Use PA Form # 10710
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VASOPRESSIN RECEPTOR ANTAGONIST

VASOPRESSIN RECEPTOR ANTAGONIST				SAMSCA	Use PA Form# 20420
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URINARY INCONTINENCE

VASOPRESSINS		DESMOPRESSIN TABS	5 6 6 8 8	DDAVP TABS DDAVP SOLN DESMOPRESSIN SPRAY DESMOPRESSIN ACETATE SOLN STIMATE SOLN*	Products must be used in specified step order. Nocturnal enuresis patients will be encouraged to periodically attempt stopping DDAVP. Use PA Form# 20420
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ANTISPASMODICS		OXYBUTYNIN URISPAS TABS		CYSTOSPAZ TABS DETROL TABS DITROPAN	Use PA Form# 20420
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ANTISPASMODICS - LONG ACTING		SANCTURA TOVIAZ VESICARE ¹	8 8 8 9 9	ENABLEX ^{1,3} DITROPAN XL TBCR OXYTROL DETROL LA CP ² SANCTURA XR ²	2. Product is considered line extension of the original product due to Healthcare Reform (HCR). MaineCare will consider these medications non-preferred and a step 9 because of the impact under the Federal Rebate Program in conjunction with HCR. 3. Use a preferred long acting antispasmodic.
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CHOLINERGIC		BETHANECHOL 25MG & 50MG		URECHOLINE	
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METABOLIC MODIFIER

HERED. TYROSINEMIA				ORFADIN	Use PA Form# 20420
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ANTIHYPERTENSIVES / CARDIAC

CARDIAC GLYCOSIDES		DIGITEK TABS DIGOXIN LANOXICAPS LANOXIN			
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ANTIANGINALS--Isosorbide Dinitrate/ Mono-Nitrates		ISOSORBIDE MONONITRATE TABS ISOSORBIDE MONONITRATE ER		DILATRATE SR CPCR ISORDIL TABS ISORDIL TITRADOSE TABS ISOSORBIDE DINITRATE SUBL ISOSORBIDE DINITRATE TABS ISOSORBIDE DINITRATE CR TBCR ISOSORBIDE DINITRATE ER TBCR ISOSORBIDE DINITRATE TD TBCR IMDUR TB24 ISMO TABS MONOKET TABS	Use PA Form# 20420
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NITRO - OINTMENT/CAP/CR		NITROBID OINT NITROGLYCERIN CPCR NITROL OINT NITRO-TIME CPCR			
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NITRO - PATCHES	1 1 1 3	NITROGLYCERIN PT24 NITREK PT24 NITRO-DUR PT 24 0.8MG MINITRAN PT24		NITRODISC PT24 NITRO-DUR 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
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NITRO - SUBLINGUAL/ SPRAY		NITROLINGUAL SOLN NITROSTAT SUBL NITROTAB SUBL		NITROQUICK SUBL	Use PA Form# 20420
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BETA BLOCKERS - NON SELECTIVE		CARVEDILOL LEVATOL TABS NADOLOL TABS PINDOLOL TABS PROPRANOLOL HCL SOLN ¹ PROPRANOLOL HCL TABS ¹ PROPRANOLOL LA CAPS		BETAPACE TABS BETAPACE AF TABS COREG CR ³ COREG TABS CORGARD TABS INDERAL TABS INDERAL LA CPCR	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
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		SOTALOL HCL TABS TIMOLOL MALEATE TABS		INNOPRAN XL PROPRANOLOL HCL 60MG TABS ² RANEXA	consolidation list Use PA Form# 20420
BETA BLOCKERS - CARDIO SELECTIVE		ACEBUTOLOL HCL CAPS ATENOLOL TABS ¹ BETAXOLOL HCL TABS BISOPROLOL FUMARATE TABS METOPROLOL TARTRATE TABS ¹ METOPROLOL ER		BYSTOLIC KERLONE TABS LOPRESSOR TABS SECTRAL CAPS TENORMIN TABS TOPROL XL TB24 ZEBETA TABS	1. Recommend using Atenolol (and metoprolol) BID since its effects do not last 24 hours. Use PA Form# 20420
BETA BLOCKERS - ALPHA / BETA		LABETALOL HCL TABS		TRANDATE TABS	Use PA Form# 20420
CALCIUM CHANNEL BLOCKERS--Amlodipines, Bepridil, Diltiazems, Felodipines, Isradipines, Nifedipines, Nisoldipine, and Verapamils		AMLODIPINE ¹		NORVASC TABS ¹	1. Dosing limits apply, please see dose consolidation list.
	1	DILTIA XT CP24	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
	1	DILTIAZEM HCL ER CP24	6	TAZTIA	
	1	DILTIAZEM HCL XR CP24	7	TIAZAC CP24	
	1	DILTIAZEM CD 300MG CP24	8	CARDIZEM TABS	
	1	DILTIAZEM CD 360MG CP24	8	CARDIZEM CD CP24	
	4	CARTIA XT CP24	8	CARDIZEM LA TB24	
	4	DILTIAZEM CD CP24	8	CARDIZEM SR CP12	
	4	DILTIAZEM HCL ER CP24	8	DILTIAZEM HCL TABS	
	4	DILTIAZEM XR CP24	8	DILTIAZEM HCL ER CP12	
			PLENDIL TB24 FELODIPINE	Use PA Form# 20420	
			DYNACIRC CAPS DYNACIRC CR TBCR ¹	Use PA Form# 20420 1. Established users will be grandfathered	
			CARDENE SR CPCR NICARDIPINE HCL CAPS	Use PA Form# 20420	
		AFEDITAB CR NIFEDIAC CC NIFEDICAL XL TBCR NIFEDIPINE TBCR NIFEDIPINE ER TBCR		ADALAT CC TBCR NIFEDIPINE CAPS PROCARDIA CAPS PROCARDIA XL TBCR	Established users of Adalat CC are grandfathered. Use PA Form# 20420
			SULAR TB24 SULAR CR	Established users of 10MG and 20MG strengths are grandfathered.	
	1 1 1	VERAPAMIL HCL CR TBCR VERAPAMIL HCL ER TBCR VERAPAMIL HCL SR TBCR		CALAN TABS CALAN SR TBCR COVERA-HS TBCR ISOPTIN-SR VERAPAMIL HCL ER CP24 VERAPAMIL HCL SR CP24 VERAPAMIL HCL TABS VERELAN CP24 VERELAN PM CP24	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. Use PA Form# 20420
ANTIARRHYTHMICS		AMIODARONE FLECAINIDE MEXILETINE MULTAQ NORPACE PROCAINAMIDE PROPafenONE QUINAGLUTE QUINIDINE GLUCONATE QUINIDINE SULFATE		CORDARONE DISOPYRAMIDE PACERONE QUINIDEX TAMBOCOR TIKOSYN ¹ RYTHMOL SR RYTHMOL	1. Prescription must be written by Cardiologist. Use PA Form# 20420
ACE INHIBITORS		BENAZEPRIL HCL CAPTOPRIL TABS ENALAPRIL MALEATE TABS FOSINOPRIL SODIUM LISINOPRIL TABS RAMIPRIL QUINAPRIL	5 5 8 8 8 8 8 8	MAVIK TABS ACCUPRIL TABS ACEON TABS ALTACE CAPS CAPOTEN TABS LOTENSIN TABS MOEXIPRIL MONOPRIL HCT TABS PRINIVIL TABS	Non-preferred products must be used in specified order. Use PA Form# 20420

			8	UNIVASC	
			8	VASOTEC TABS	
			8	ZESTRIL TABS	
ANGIOTENSIN RECEPTOR BLOCKER	AVAPRO BENICAR TABS COZAAR TABS 25MG ² DIOVAN LOSARTAN MICARDIS TABS		8	ATACAND TABS	Use PA Form# 20420
			8	COZAAR 50MG & 100MG ¹	Preferred products only available without PA if patient on diabetic therapy or prior ACE therapy.
			8	TEVETEN TABS	
			8	TRIBENZOR ²	1. Please use multiple preferred 25mg tabs. 2. Dosing limits apply. Please see dose consolidation list. 3. Use preferred active ingredients which are available without PA.
DIRECT RENIN INHIBITOR				TEKTURN ¹	1. Must show failure of single and combination therapy from all preferred antihypertensive categories. Use PA Form# 20420
ANTIHYPERTENSIVES - CENTRAL	CATAPRES-TTS CLONIDINE HCL TABS GUANFACINE HCL TABS HYDRALAZINE HCL TABS HYLOREL TABS METHYLDOPA TABS MINOXIDIL TABS PRAZOSIN HCL CAPS RESERPINE TABS			CATAPRES TABS CLONIDINE TTS GUANABENZ ACETATE TABS ISMELIN TABS MINIPRESS CAPS TENEX TABS	Use PA Form# 20420
ACE INHIBITORS AND CA CHANNEL BLOCKERS			8	LEXCEL TBCR	Use individual preferred generic medications.
			8	LOTREL CAPS	
			8	TARKA TBCR	
			9	AMLODIPINE/BENAZEPRIL	Use PA Form# 20420
ACE AND THIAZIDE COMBO'S	BENAZEPRIL HCL/HYDROCHLOR CAPTOPRIL/HYDROCHLOROTHIA ENALAPRIL MALEATE/HCTZ TABS LISINOPRIL-HCTZ TABS LOTENSIN HCT TABS			ACCURETIC TABS CAPOZIDE TABS MONOPRIL HCT TABS PRINZIDE TABS UNIRETIC TABS VASERETIC TABS ZESTORETIC TABS	Use PA Form# 20420
BETA BLOCKERS AND DIURETIC COMBO'S	ATENOLOL/CHLORTHALIDONE BISOPROLOL FUMARATE/HCTZ PROPRANOLOL/HCTZ			CORZIDE TABS INDERIDE 40/25 TABS LOPRESSOR HCT TABS TENORETIC TIMOLIDE 10/25 TABS ZIAC TABS	Use PA Form# 20420
ARB'S AND CA CHANNEL BLOCKERS	AZOR EXFORGE EXFORGE HCT			TWYNSTA	Preferred products only available without PA if patient on diabetic therapy or prior ACE therapy.
ARB'S AND DIURETICS	AVALIDE TABS BENICAR HCT DIOVAN HCT TABS LOSARTAN HCT MICARDIS HCT TABS			ATACAND HCT TABS HYZAAR TABS TEVETEN HCT TABS	Preferred products only available without PA if patient on diabetic therapy or prior ACE therapy. Use PA Form# 20420
ARB'S AND DIRECT RENIN INHIBITOR COMBINATION				VALTURN ¹	Use PA Form# 20420
DIURETICS	ACETAZOLAMIDE TABS BUMETANIDE CHLOROTHIAZIDE TABS CHLORTHALIDONE TABS EDECIN TABS FUROSEMIDE HYDROCHLOROTHIAZIDE INDAPAMIDE TABS METHAZOLAMIDE TABS			ALDACTAZIDE TABS ALDACTONE TABS AMILORIDE HCL BUMEX TABS DEMADEX TABS DIAMOX DIURIL DYAZIDE CAPS ENDURON TABS	1. Multiples of Spironolactone 25 mg are cheaper than 50 mg strength. Inspra will be approved for severe breast tenderness and male gynecomastia.

		METHYCLOTHIAZIDE TABS SPIRONOLACTONE 25MG TABS SPIRONOLACTONE/HYDRO TORSEMIDE TABS TRIAMTERENE/HCTZ ZAROXOLYN TABS		INSPIRA LASIX TABS LOZOL TABS MAXZIDE MICROZIDE CAPS MIDAMOR TABS MODURETIC 5-50 TABS NAQUA TABS NATURETIN TABS SPIRONOLACTONE 50MG ¹	Use PA Form# 20420
CCB / LIPID		CADUET			
LIPID DRUGS					
CHOLESTEROL - BILE SEQUESTRANTS		CHOLESTYRAMINE COLESTIPOL HCl		COLESTID PREVALITE QUESTRAN WELCHOL TABS	Use PA Form# 20420
CHOLESTEROL - FIBRIC ACID DERIVATIVES		GEMFIBROZIL TABS NIASPAN TRICOR TRILIPIX		ANTARA LOPID FIBRICOR LIPOFEN LOFIBRA FENOFIBRATE TRIGLIDE	Use PA Form# 20420
CHOLESTEROL - HGM COA + ABSORB INHIBITORS MORE POTENT DRUGS/COMBINATIONS		LIPITOR SIMVASTATIN ¹		CRESTOR VYTORIN ² ZOCOR	1. Dosing limits apply, please see dosage consolidation list. 2. Only available if component ingredients are unavailable. Use PA Form# 20420
CHOLESTEROL - HGM COA + ABSORB INHIBITORS LESS POTENT DRUGS/COMBINATIONS		LESCOL CAPS LESCOL XL TB 24 LOVASTATIN TABS ² PRAVASTATIN ²	8 8 8 8 8 8	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
CHOLESTEROL - HGM COA + ABSORB INHIBITORS STATIN/ NIACIN COMBO		SIMCOR ADVICOR TBCR			
PULMONARY ANTI-HYPERTENSIVES					
PULMONARY ANTI-HYPERTENSIVES		REVATIO VENTAVIS EPOPROSTENOL INJ ⁴		ADCIRCA FLOLAN REMODULIN ³	3. There will be dosing limits of one 20ml multidose vial/ 30 days supply without pa. 4. PA is required to establish and confirm who group 1 diagnosis of primary PAH (Primary Pulmonary Hypertension) and NYHA functional class 3 & 4. Use PA Form# 20420
ERA / ENDOTHELIN RECEPTOR ANTAGONIST		LETAIRIS ^{1,2}		TRACLEER ^{3,4}	1. Providers must be registered with LEAP Prescribing program, a restricted distribution program. 2. Clinical PA is required to establish diagnosis and medical necessity. 3. 1. Prior trial of Letaris, WHO Group 1 diagnosis of PAH (Primary Pulmonary Hypertension) and NYHA functional class of 3. 4. For members with NYHA functional class of 4, Tracleer approval will be allowed with confirmation of diagnosis and functional class.

IMPOTENCE AGENTS

IMPOTENCE AGENTS				As of January 1, 2006, per CMS (federal govt.), impotence agents are no longer covered.
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ANTI-EMETOGENICS

ANTIEMETIC - ANTICHOLINERGIC / DOPAMINERGIC	MECLIZINE HCL TABS PHENERGAN SUPP PHENERGAN FORTIS SYRP PROMETHAZINE SUPP PROMETHAZINE TRANSDERM-SCOP PT72		ANTIVERT TABS PHENERGAN SOLN PHENERGAN TABS PROMETHAZINE 50MG SUPP PROMETHEGAN SUPP TORECAN TABS	Use PA Form# 20420
ANTIEMETIC - 5-HT3 RECEPTOR ANTAGONISTS/ SUBSTANCE P NEUROKININ	MARINOL CAPS ONDANSETRON TABS* ² ONDANSETRON ODT TBDP* ² ONDANSETRON INJ*	5 8 8 8 8 8 8 8 8 8	GRANISETRON ALOXI ANZEMET TABS CESAMET ¹ EMEND ³ KYTRIL SANCUSO ZOFTRAN ODT TBDP* ZOFTRAN TABS* ZOFTRAN INJ*	*See quantity limit table. 1. Approvals will require diagnosis of chemo-induced nausea/vomiting and failed trials of all preferred anti-emetics, including 5-HT3 class (Ondansetron) and Marinol. 2. Ondansetron will be preferred with CA diag and dosing limits still apply. 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

ANTI-HISTAMINES - NON- SEDATING	ALAVERT TABS CETIRIZINE TABS CLARITIN (OTC) CLARITIN SYRP (OTC) LORATADINE TAVIST ND (OTC)	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 loratidine ODT are now non-preferred. Pseudoephedrine is available with prescription. Use PA Form # 20530
ANTI-HISTAMINES - OTHER	CLEMASTINE CHLORPHENIRAMINE DIPHENHYDRAMINE			

ALLERGY / ASTHMA THERAPIES

ANTI-ASTHMATIC - ANTICHOLINERGICS - INHALER	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 Spiriva is primarily being used for that condition.
ANTI-ASTHMATIC - ANTICHOLINERGICS - NEBULIZER	IPRATROPIUM BROMIDE SOLN		ATROVENT SOLN	Use PA Form# 20420
ANTI-ASTHMATIC - ANTI-INFLAMMATORY AGENTS	CROMOLYN SODIUM NEBU INTAL AERS TILADE AERS		XOLAIR ¹	1. Need max inhaled steroids and written by pulmonary or allergy specialist. Use PA Form# 20420
ANTI-ASTHMATIC - NASAL STEROIDS	FLUTICASON E SPR NASONEX SUSP	5 5 8 8	BECONASE AQ INHA ¹ NASACORT AQ AERS ¹ FLONASE SUSP ² FLUNISOLIDE SOLN ²	Use PA Form# 20420 Dosing limits apply to whole category, please see dosage consolidation list. 1. All preferred drugs must be tried before

			8	NASACORT AERS ²	moving to non preferred steps.
			8	OMNARIS SPR	
			8	RHINOCORT AERO ²	
			8	RHINOCORT AQUA SUSP ²	2. All step 5 medications need to be tried before moving to step 8's.
			8	TRI-NASAL SOLN ²	
			8	VANCENASE POCKETHALER AERS ²	
			8	VERAMYST ²	
ANTIASTHMATIC - NASAL MISC.	CROMOLYN NASAL 4% NASALCROM OCEAN 0.65% SALINE NASAL SPRAY 0.65%		7	ATROVENT NASAL SOL	Use PA Form# 20420
			7	IPRATROPIUM NASAL SOL ¹	1. Ipratropium will be approved if submitted with documentation supporting use of CPAP machine.
			7	ASTELIN	2. Utilize Multiple preferred, as well as step therapy Astelin.
			8	ASTEPRO ²	
ANTIASTHMATIC - BETA - ADRENERGICS	ALBUTEROL NEB MAXAIR METAPROTERENOL PROAIR HFA ³ PROVENTIL HFA AERS ³ SEREVENT TERBUTALINE SULFATE TABS VENTOLIN HFA AERS ³			ACCUNEB NEBU ALBUTEROL AER ALBUTEROL HFA ALBUTEROL 0.63mg/3ml ALUPENT AERP BRETHINE FORADIL AEROLIZER CAPS PROVENTIL VENTOLIN AERS VOLMAX TBCR VOSPIRE ER TB12 XOPENEX HFA ³ XOPENEX NEBU ^{1,2}	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
ANTIASTHMATIC - ADRENERGIC COMBINATIONS	ADVAIR DISKUS/HFA ¹ DULERA SYMBICORT 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
ANTIASTHMATIC - ADRENERGIC ANTICHOLINERGIC	ALBUTEROL/IPRATROPIUM NEB. SOLN COMBIVENT AERO ²			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
ANTIASTHMATIC - XANTHINES	AMINOPHYLLINE TABS THEOCHRON TB12 THEOLAIR-SR TB12 THEOPHYLLINE CR TB12 THEOPHYLLINE ELIX THEOPHYLLINE SOLN THEOPHYLLINE ER CP12 THEOPHYLLINE ER TB12			QUIBRON CAPS QUIBRON-T TABS QUIBRON-T/SR TB12 THEO-24 CP24 THEOLAIR TABS UNIPHYL TBCR	Use PA Form# 20420
ANTIASTHMATIC - STEROID INHALANTS	ASMANEX FLOVENT DISKUS FLOVENT HFA PULMICORT SUSP ¹ QVAR AERS		5	AEROBID AERS ²	Dosing limits apply to whole category, please see dosage consolidation list.
			5	BECLOVENT AERS ²	
			5	VANCERIL AERS ²	
			8	AEROBID-M AERS ³	1. No PA for Pulmicort susp if under 8 years old.
			8	ALVESCO	2. All preferreds must be tried before moving to non preferred steps.
			8	VANCERIL DOUBLE STRENGTH AERS ³	3. All step 5 medications need to be tried before moving to step 8's.
			8	PULMICORT FLEXHALER	Use PA Form# 20420
ANTIASTHMATIC - 5-Lipoxygenase Inhibitors				ZYFLO CR TABS	Use PA Form# 20420
ANTIASTHMATIC - LEUKOTRIENE RECEPTOR ANTAGONISTS	SINGULAIR			ACCOLATE TABS	Use PA Form # 20420
ANTIASTHMATIC - ALPHA-1 ADRENERGIC AGONISTS				PROLASTIN SUSR	Use PA Form# 20420

PROTEINASE INHIBITOR				ZEMAIRA	
ANTIASTHMATIC - HYDRO-LYTIC ENZYMES				PULMOZYME SOLN	Use PA Form# 20420
ANTIASTHMATIC - MUCOLYTICS		ACETYLCYSTEINE ¹		MUCOMYST	1. Acetylcysteine is covered with diagnosis of CF. Use PA Form# 20420
COUGH/COLD					
COUGH/COLD		DEXTRO-GUAIF SYRP GUAIFENESIN SYRP PSEUDOEPHEDRINE ROBITUSSIN DM SYRP ROBITUSSIN SUGAR FREE 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
DIGESTIVE AIDS / ASSORTED GI					
Preferred drugs that used to require diag codes still require diag codes unless indicated otherwise.					
GI - ANTIPERISTALTIC AGENTS		DIPHENOXYLATE DIPHENOXYLATE/ATROPINE LOPERAMIDE HCL CAPS/LIQ OPIUM TINCTURE TINC PAREGORIC TINC		LOFENE TABS LONOX TABS MOTOFEN TABS	Use PA Form# 20420
GI - ANTI-DIARRHEAL/ ANTACID - MISC.		ATROPINE SULFATE SOLN BENTYL SYRP BISMATROL BISMUTH SUBSALICYLATE CALCIUM CARBONATE (ANTACID) CHEW DICYCLOMINE HCL GLYCOPYRROLATE TABS HAPONAL TABS HYOSCYAMINE CAPS & TABS HYOSCYAMINE SULFATE KAOPECTATE MAGNESIUM OXIDE TABS MAG-OX 400 TABS PAMINE TABS PROPANTHELINE BROMIDE TABS SAL-TROPINE TABS SCOPOLAMINE HYDROBROMIDE SODIUM BICARBONATE TABS TUMS		B & O 15-A SUPPRETTE SUPP B & O 16-A SUPPRETTE SUPP BELLADONNA ALKALOIDS & OP BENTYL TABS GLYCOPYRROLATE INJ HYOSCYAMINE SL LEVVID TB12 LEVSIN ELIX LEVSIN TABS LEVSIN/SL SUBL NULEV TBDP ROBINUL INJ ROBINUL TABS	Use PA Form# 20420
GI - H2-ANTAGONISTS		CIMETIDINE FAMOTIDINE RANITIDINE RANITIDINE SYRUP ACID REDUCER TABS		AXID CAPS AXID AR TABS NIZATIDINE CAPS PEPCID PEPCID AC TAGAMET TABS ZANTAC SYRUP ZANTAC TABS	Use PA Form# 20420
GI - PROTON PUMP INHIBITOR		DEXILANT (KAPIDEX) ⁴ OMEPRAZOLE 10MG/20MG ² PROTONIX ²	6 7 8 8 8 8 8 8 8 8 9 9	PRILOSEC OTC ⁴ ACIPHEX TBEC ⁴ PREVACID CPDR ^{4,5} PREVACID SOLUTABS ¹ NEXIUM CPDR ⁴ PRILOSEC CPDR PROTONIX INJ OMEPRAZOLE-SODIUM BICARBONATE CAPS LANSOPRAZOLE OMEPRAZOLE 40MG ³ PANTOPRAZOLE	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. 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
GI - ULCER ANTI-INFECTIVE				HELIDAC PREVPAC	
GI - PROSTAGLANDINS		MISOPROSTOL TABS		CYTOTEC TABS	Use PA Form# 20420
GI - DIGESTIVE ENZYMES		CREON ¹ LACTASE CHEW LACTASE TAB ZENPEP ¹		LACTRASE CAPS LIPRAM LIPRAM CR KU-ZYME CAPS	1. Clinical PA is required to establish CF diagnosis and medical necessity. In all cases except cystic fibrosis patients, objective

			PANCREASE PANOKASE TABS TRIPASE	except cystic fibrosis patients, objective evidence of pancreatic insufficiency (fat malabsorption test etc...) must be supplied.
GI - ANTI - FLATULENTS / GI STIMULANTS		CALULOSE SYRP CONSTULOSE SYRP ENULOSE SYRP GASTROCROM CONC GENERLAC SYRP LACTULOSE SYRP METOCLOPRAMIDE HCL SIMETHICONE	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.
GI - INFLAMMATORY BOWEL AGENTS		ASACOL TBEC 400 APRISO AZULFIDINE TABS CANASA SUPP COLAZAL CAPS DIPENTUM CAPS PENTASA CPCR 250MG ROWASA ENEM SULFAZINE EC TBEC SULFASALAZINE TABS	ASACOL 800MG HD AZULFIDINE EN-TABS TBEC BALSALAZIDE LIALDA TABS ¹ PENTASA 500MG ² SFROWASA	Use PA Form# 20420 1. Current users grandfathered. 2. Use multiple Pentasa 250mg.
GI - IRRITABLE BOWEL SYNDROME AGENTS			LOTROXEX TABS	Use PA Form# 20420
MISCELLANEOUS GI				
Preferred drugs that used to require diag codes still require diag codes unless indicated otherwise.				
GI - MISC.		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 METAMUCIL MILK OF MAGNESIA SUSP MINERAL OIL OIL NULYTELY SOLR SENNA SEKOKOT GRAN SEKOKOT SYRP SEKOKOT CHILDRENS SYRP SEKOKOT XTRA TABS SORBITOL STOOL SOFTENER CAPS SUCRALFATE TABS UNI-EASE CAPS UNIFIBER POWD URSO FORTE URSODIOL	ACTIGALL CAPS BENEFIBER CARAFATE CLEARLAX POW 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) MIRALAX POWD (OTC versions) PEG 3350/ELECTROLYTES SOLR SEKONON TABS SEKONOT TABS SEKONOT S TABS STOOL SOFTENER PLUS CAPS UNI-CENNA TABS UNI-EASE PLUS CAPS V-R NATURAL SENNA LAXATIV TABS URSO 250	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
MISC. UROLOGICAL				
UROLOGICAL - MISC.		ACETIC ACID 0.25% SOLN CYTRA-K SOLN FURADANTIN SUSP K-PHOS MF TABS METHENAMINE MANDELATE TABS MONUROL PACK	CITRIC ACID/SODIUM CITRAT SOLN CYTRA-2 SOLN ELMIRON CAPS ¹ MACROBID CAPS MANDELAMINE TABS MACRODANTIN CAPS	1. Elmiron requires adequate proof of Dx with supportive testing. Use PA Form# 20420

		NEOSPORIN GU IRRIGANT SOLN NITROFURANTOIN MACR CAPS PHENAZOPYRIDINE HCL TABS PHENAZOPYRIDINE PLUS PROSED/DS TABS TRICITRATES SYRP URELIEF PLUS UREX TABS URISED TABS UROCIT-K UROQID #2 TABS		POTASSIUM CITRATE/CITRIC SOLN PYRIDIUM PLUS TABS PYRIDIUM TABS RENACIDIN SOLN	
PHOSPHATE BINDERS					
PHOSPHATE BINDERS		PHOSLO ¹ MAGNEBIND - 400 ¹ RENAGEL 400 ¹ FOSRENOL ¹ RENVELA ¹		RENAGEL 800	Use PA Form# 20420 1. Diag required.
INTRA-VAGINALS					
VAGINAL - ANTIBACTERIALS	1 1 3	CLEOCIN CREA METRONIDAZOLE VAGINAL GEL ² CLEOCIN SUPP ¹		METROGEL VAGINAL GEL ² VANDAZOLE	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
VAGINAL - ANTI FUNGALS		CLOTRIMAZOLE CREA GYNE-LOTRIMIN CREA MICONAZOLE CREA MICONAZOLE 3 COMBO PACK KIT ¹ MICONAZOLE 7 CREA MICONAZOLE NITRATE CREA NYSTATIN TABS TERAZOL 3 SUPP TERCONAZOLE 0.4MG VAGITROL V-R MICONAZOLE-7 CREA		AVC CREAM CLOTRIMAZOLE 3 DAY CREA GYNAZOLE-1 CREA GYNE-LOTRIMIN 3 TABS MICONAZOLE 3 SUPP TERAZOL 3 CREA TERAZOL 7 CREA TERCONAZOLE 0.8MG TERCONAZOLE SUPP	1. Quantity limit: 1/script/2 weeks Use PA Form# 20420
VAGINAL - CONTRACEPTIVES		GYNOL II EXTRA STRENGTH GEL		DELLEN FOAM	Use PA Form# 20420
VAGINAL - ESTROGENS		ESTRING RING PREMARIN CREA		ESTRACE CREA VAGIFEM TABS	Must fail all preferred products before non-preferred. Use PA Form# 20420
VAGINAL - OTHER		ACID JELLY GEL ACI-JEL GEL CERVICAL AMINO ACID CREA		AMINO ACID CERVICAL CREA	Use PA Form# 20420
BPH					
BPH		DOXAZOSIN MESYLATE TABS FINASTERIDE ¹ TERAZOSIN HCL CAPS TAMSULOSIN	5 8 8 8 8 8 8	FLOMAX CP24 AVODART ² CARDURA TABS HYTRIN CAPS JALYN ³ 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. 2. Prior use of preferred agent prior to any approvals. 3. Use of preferred (tamsulosin and finasteride) and (tamsulosin and non-preferred Avodart). Use PA Form# 20420
ANXIOLYTICS					
ANXIOLYTICS - BENZODIAZEPINES		ALPRAZOLAM TABS CHLORDIAZEPOXIDE HCL CAPS CLORAZEPATE DIPOTASSIUM TABS DIAZEPAM LORAZEPAM OXAZEPAM CAPS		ALPRAZOLAM ER ATIVAN NIRAVAM SERAX TRANXENE XANAX TABS	Use PA Form# 20420

		THIORIDAZINE HCL THIOTHIXENE THORAZINE SUPP TRIFLUOPERAZINE HCL TABS			
LITHIUM					
LITHIUM		LITHIUM CARBONATE LITHIUM CITRATE SYRP		ESKALITH CAPS ESKALITH CR TBCR	Use PA Form# 20420
COMBINATION - PSYCHOTHERAPEUTIC					
PSYCHOTHERAPEUTIC COMBINATION		CHLORDIAZEPOXIDE/AMITRIPT PERPHENAZINE/AMITRIPTYLIN	8	SYMBYAX ¹	1. Only available if component ingredients are unavailable. Use PA Form# 20420
STIMULANTS					
STIMULANT - AMPHETAMINES - SHORT ACTING		ADDERALL TABS AMPHETAMINE SALT COMBO DEXTROAMPHET SULF TABS DEXEDRINE DEXTROSTAT TABS			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 - LONG ACTING AMPHETAMINES SALT		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		DEXEDRINE CAP CR		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		FOCALIN TABS METADATE ER TBCR METHYLIN ER TBCR METHYLIN TABS METHYLIN SOL METHYLPHENIDATE HCL		METHYLIN CHEWABLES RITALIN	Preferred stimulants will be available without PA if diagnosis of ADHD. Use PA Form# 20420 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: 72mg daily for methylphenidate and 36mg daily for dexmethylphenidate.
STIMULANT - METHYLPHENIDATE - LONG ACTING		CONCERTA TBCR DAYTRANA ¹	5 8	METADATE CD CPCR RITALIN LA	Preferred stimulants will be available without PA if diagnosis of ADHD. Non-preferred products must be used in specified steps.

ACTING		FOCALIN XR			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. FDA approval currently only for ages 6-16. Limit of one patch daily. Max dose of 30MG daily. Use PA Form# 20420
STIMULANT - STIMULANT LIKE			7 8 8 8 8 9 9	STRATTERA ^{1,2} CAFCIT SOLN ³ INTUNIV ^{3,4} PROVIGIL TABS ³ NUVIGIL ³ DESOXYN TABS ³ DESOXYN CR ³	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
ANTI-CATAPLECTIC AGENTS					
PSYCHOTHERAPEUTIC AGENTS - MISC.				XYREM SOL XENAZINE	Use PA Form # 20710
WEIGHT LOSS					
WEIGHT LOSS					No longer covered: PHENTERMINE, XENICAL, DIDREX, and MERIDIA
ALZHEIMER DISEASE					
ALZHEIMER - Cholinomimetics/Others		ARICEPT TABS ¹ ARICEPT ODT NAMENDA ¹	8 8 8 8 9	RAZADYNE ² REMINYL ² EXELON ² RIVASTIGMINE TARTRATE CAPS ² COGNEX CAPS ²	1. PA is required to establish dementia diagnosis and baseline mental status score. 2. Must fail all preferred products before moving to non-preferred. Use PA Form# 20420
SMOKING CESSATION					
NICOTINE PATCHES / TABLETS		CHANTIX ^{1,2} NICODERM CQ PT24 ² NICOTINE DIS PT24 ²			Bupropion SR 150 mg is available without a prior authorization. 1. Chantix is preferred without PA for up to 6 months of continuous use once per lifetime. 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		NICOTINE POLACRILEX GUM ² NICORETTE GUM ²	5 8 8	COMMIT LOZENGES ¹ NICOTROL INHALER NICOTROL NASAL SPRAY	Use PA Form# 20420 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. 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		ANTABUSE TABS			1. Should only be used in conjunction with

	CAMPRAL ¹ DISULFIRAM TABS NALTREXONE HCL TABS			formal structured outpatient detoxification program.
MISCELLANEOUS ANALGESICS				
ANALGESICS - MISC.	ACETAMINOPHEN ASPIRIN ASPRIN/ APAP/ CAFF TAB BUTAL/ASA/CAFF BUTALBITAL COMPOUND BUTALBITAL/ACET TABS BUTALBITAL/APAP CAPS BUTALBITAL/APAP/CAFFEINE CHOLINE MAGNESIUM TRISALI DIFLUNISAL TABS EXCEDRIN SALSALATE TABS		AXOCET CAPS DOLOBID TABS EQUAGESIC TABS ESGIC-PLUS FIORICET TABS FIORINAL CAPS FIORTAL CAPS FORTABS TABS PHRENILIN TABS PHRENILIN FORTE CAPS TRILISATE LIQD TRILISATE TABS ZEBUTAL CAPS ZORPRIN TBCR	Use PA Form# 20420
LONG ACTING NARCOTICS				
NARCOTICS - LONG ACTING	AVINZA FENTANYL PATCH ⁵ KADIAN ⁶ METHADONE METHADOSE MORPHINE SULFATE ER TB12	8 8 8 8 8 8 9 9	DURAGESIC PT72 ⁵ EMBEDA MORPHINE SULFATE SUPP MS CONTIN TB12 ORAMORPH SR TB12 OXYCONTIN TB12 ^{1,4} OXYCODONE ER ³ OPANA ER	Use PA Form # 20510 Non-preferred products must be used in specific order. 1. Oxycontin will be available without PA for patients treated for or dying from cancer or hospice patients. CA (cancer) or 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. 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. 5. Dosing limits apply. Please see dose consolidation list. 6. Kadian 10mg, 80mg & 200mg are non-preferred.
NARCOTICS - SELECTED	TRAMADOL HCL TABS	8 8 8 8 8 8 8 8 9	BUPRENEX SOLN BUTORPHANOL NALBUPHINE HCL SOLN NUBAIN SOLN STADOL NS SOLN ULTRACET TABS ¹ ULTRAM TABS ULTRAM ER RYZOLT	Use PA Form# 20420 1. Only available if component ingredients are unavailable.
MISCELLANEOUS NARCOTICS				
NARCOTICS - MISC.	ACETAMINOPHEN/CODEINE ASPIRIN/CODEINE TABS BUTAL/ASA/CAFF/COD CAPS BUTALBITAL/ASPIRIN/CAFFEI CAPS CAPITAL AND CODEINE SUSP ¹ CAPITAL/CODEINE SUSP ¹ CODEINE PHOSPHATE SOLN CODEINE SULFATE TABS ENDOCET TABS ³	8 8 8 8 8 8 8 8 8	ANEXSIA TABS ASCOMP/CODEINE CAPS BUTALBITAL/APAP/CAFFEINE/ CAPS DARVOCET-N DARVON DEMEROL DILAUDID DILAUDID-HP SOLN FENTANYL CITRATE SOLN	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 oxycodone/acet 5/225 instead. You can mix

					5. Users 60 years of age or older will not require PA. If under 60 years of age, Celebrex will require PA.
NSAIDS		CHILDRENS IBUPROFEN DICLOFENAC POTASSIUM TABS DICLOFENAC SODIUM ETODOLAC FENOPROFEN CALCIUM TABS FLURBIPROFEN TABS IBUPROFEN INDOMETHACIN KETOPROFEN MECLOFENAMATE SODIUM CAPS NAPROSYN SUSP NAPROXEN SUSP NAPROXEN TABS NAPROXEN SODIUM TABS OXAPROZIN TABS SULINDAC TABS TOLMETIN SODIUM		ADVIL TABS ANAPROX TABS ANAPROX DS TABS CAMBIA CATAFLAM TABS CHILDRENS ADVIL SUSP CHILD'S IBUPROFEN SUSP CHILDREN'S MOTRIN SUSP CLINORIL TABS DAYPRO TABS EC-NAPROSYN TBEC ETODOLAC ER 600MG FELDENE CAPS IBU-200 INDOCIN LODINE MOTRIN NALFON CAPS NAPRELAN TBCR NAPROSYN TABS NAPROXEN DR TBEC NAPROXEN SODIUM TBCR ORUVAIL CP24 PENNSAID PIROXICAM CAPS PONSTEL CAPS SB IBUPROFEN TABS TOLECTIN VOLTAREN V-R IBUPROFEN 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
NSAID - PPI				PREVACID NAPRA-PAC VIMOVO ¹	1. Use a preferred NSAID and PPI separately.
RHEUMATOID ARTHRITIS					
RHEUMATOID ARTHRITIS	1 1 1 1 1 2 2 2	AZATHIOPRINE HYDROXYCHLOROQUINE LEFLUNOMIDE METHOTREXATE SULFASALAZINE TABS CIMZIA ¹ ENBREL 25MG INJECTIONS ONLY ^{1,4} HUMIRA ^{1,2}		ARAVA ACTEMRA KINERET SOLN ORENCIA REMICADE ENBREL 50MG ³ SIMPONI	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 products is multi-dose vial, with dosing limits allowing 8 injections per 28 days without pa. Established users will be grandfathered for Enbrel and Humira.
MISCELLANEOUS ARTHRITIS					
ARTHRITIS - MISC.		RIDAURA CAPS MYOCHRYSLINE SOLN		ARTHROTEC ¹	1. The individual components of Arthrotec are available without PA. Use PA Form# 20420
MIGRAINE THERAPIES					
MIGRAINE - ERGOTAMINE DERIVATIVES		MIGRANAL SOLN SANSERT TABS		D.H.E. 45 SOLN	Use PA Form # 10110
MIGRAINE - CARBOXYLIC ACID DERIVATIVES		DIVALPROEX ER TB24		DEPAKOTE ER TB24	
MIGRAINE - SELECTIVE SEROTONIN AGONISTS (5HT)- Tabs		MAXALT MLT NARATRIPTAN HCI TABS SUMATRIPTAN TABS	8 8 8 8	AMERGE TABS AXERT TABS FROVA TABS MAXALT	All drugs in this category have dosing limits. Please refer to dose consolidation table.

			8	IMITREX TABS	
			8	RELPAX	
			8	ZOMIG TABS	
			8	ZOMIG NASAL SPARY	
			8	ZOMIG ZMT TBDP	Use PA Form # 10110
MIGRAINE - SELECTIVE SEROTONIN AGONISTS (5HT)--Injectables		IMITREX KIT IMITREX SOLN IMITREX STATDOSE PEN KIT IMITREX STATDOSE REFILL KIT		SUMATRIPTAN SOLN	Use PA Form # 10110
MIGRAINE - SELECTIVE SEROTONIN AGONISTS (5HT)--Combinations				TREXIMET ^{1,2}	Use PA Form # 10110 1. Dosing limits apply. Please see dose consolidation list. 2. Use preferred Sumatriptan and Naproxen separately. Treximet only available if component ingredients of sumatriptan and naproxen are unavailable.
MIGRAINE - MISC.		CAFERGOT TABS SPASTRIN TABS		MIGRAZONE CAPS BELCOMP-PB SUPP MIGERGOT SUP	Use PA Form # 10110
GOUT					
GOUT		ALLOPURINOL TABS COLCHICINE TABS PROBENECID TABS PROBENECID/COLCHICINE TABS SULFINPYRAZONE TABS		COLCRYS 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.
MISC.					
ANESTHETICS - MISC.		BUPIVACAINE HCL SOLN LIDOCAINE HCL SOLN MARCAINE SOLN		SENSORCAINE-MPF SOLN SYNVISC INJ XYLOCAINE SOLN	Use PA Form # 30130
ANTI-CONVULSANTS					
ANTICNVULSANTS		CARBAMAZEPINE CARBATROL CP12 CELONTIN CAPS CLONAZEPAM TABS DEPAKOTE SPRINKLES CPSP DIASTAT ¹ DILANTIN DIVALPROEX SODIUM EPITOL TABS ETHOSUXIMIDE SYRP FELBATOL GABAPENTIN ³ LAMOTRIGINE ³ LEVETIRACETAM SOLN/TABS MYSOLINE TABS OXCARBAZEPINE PHENYTEK CAPS PHENYTOIN TEGRETOL ² TOPIRAMATE TOPIRAMATE SPRINKLE CAPS ³ TRILEPTAL SUSP VALPROIC ACID ZARONTIN CAPS ZONISAMIDE	8 9 9 9 9	BANZEL DEPAKENE DEPAKOTE DEPAKOTE ER DIAZEPAM GEL DIVALPROEX SODIUM SPRINKLE CAPS EQUETRO GABITRIL TABS KEPPRA TABS KEPPRA SOLN KLONOPIN TABS LAMICTAL LYRICA ⁴ PRIMIDONE TABS SABRIL TOPAMAX TOPAMAX SPRINKLE CAPS ³ TRILEPTAL VIMPAT ⁵ ZARONTIN SYRP KEPPRA XR ^{6,7} NEURONTIN TEGRETOL-XR TB12 ^{6,7} ZONEGRAN CAPS	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 maximum daily dose of 600mg. Please see dose consolidation list. 5. Adjunctive therapy 17 and older. 6. Current users as of 7/30/10 for seizures will be grandfathered. 7. Product is considered line extension of the original product due to Healthcare Reform (HCR). MaineCare will consider these medications non-preferred and a step 9 because of the impact under the Federal Rebate Program in conjunction with HCR.
BIPOLAR DISORDER: STEP ORDER					

			M - A		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.
			4 ~ 4	LAMICTAL	
			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)	Two-step 1 preferred drugs must be tried before Trileptal.
			4 ~ 4	LITHIUM	The step orders show the relative strength of evidence for use in bi-polar and will guide prior authorization determinations.
			4 ~ 4	CARBAMAZEPINE	Step 4 drugs-no PA required.
			4 ~ 4	VALPROATE	
			4 ~ 4	ATYPICAL ANTIPSYCHOTICS EXC.CLOZAPINE	
			4 ~ 4	LAMICTAL	
			5 ~ 5	TRILEPTA	

ANTI-PARKINSON DRUGS

PARKINSONS - ANTICHOLINERGICS	AKINETON TABS BENZTROPINE MESYLATE TABS COGENTIN SOLN KEMADRIN TABS TRIHEXYPHENIDYL				
PARKINSONS - COMT INHIBITORS	COMTAN TABS			TASMAR TABS	Use PA Form# 20420
PARKINSONS - SELECTED DOPAMIN AGONISTS	PRAMIPEXOLE ROPINIROLE	5 8 8 8		MIRAPEX TABS ¹ REQUIP TABS REQUIP XL TABS MIRAPEX ER	Use PA Form# 20420 1. As of 12/08 users of Mirapex will be grandfathered if diagnosis is Parkinsons.
PARKINSONS - DOPAMINERGICS/CARBII/ LEVO	AMANTADINE HCL BROMOCRIPTINE MESYLATE CARBIDOPA/LEVODOPA TABS* CARBIDOPA/LEVODOPA ER LARODOPA TABS SELEGILINE HCL			APOKYN* AZILECT ² ELDEPRYL CAPS LODOSYN TABS PARLODEL CAPS PARLODEL TABS SINEMET TABS SINEMET TBCR SYMMETREL TABS	* 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
PARKINSONS - COMBO.	STALEVO				

MUSCLE RELAXANTS

ALS DRUG	RILUTEK TABS				
MUSCLE RELAXANTS	BACLOFEN TABS CHLORZOXAZONE TABS CYCLOBENZAPRINE HCL TABS LIORESAL INTRATHECAL KIT METHOCARBAMOL TABS TIZANIDINE HCL TABS	7 8 8 8 8 8		ORPHENADRINE CITRATE CARISOPRODOL TABS DANTRIUM CAPS FLEXERIL TABS LIORESAL TABS NORFLEX TBCR ROBAXIN-750 TABS ZANAFLEX TABS SKELAXIN TABX SOMA TABS	Non-preferred drugs will not be approved if members circumventing MaineCare prior authorization 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. Use PA Form# 20420
MUSCLE RELAXANT - COMBO.				CARISOPRODOL/ASPIRIN TABS CARISOPRODOL/ASPIRIN/CODE NORGESIC TABS	Use PA Form# 20420

ORPHENADRINE COMPOUND
 ORPHENADRINE/ASA/CAFF
 ORPHENGESIC

VITAMINS

****Preferred products that used to require diag codes still require diag codes unless indicated otherwise.****

VITAMINS	ASCORBIC ACID TABS BIOTIN CYANOCOBALAMIN SOLN FOLGARD RX 2.2 TABS FOLIC ACID TABS FOLTX TABS MEPHYTON TABS NIACIN NIACOR TABS NICOTINIC ACID SR CPCR PYRIDOXINE HCL TABS SLO-NIACIN TBCR THIAMINE HCL SOLN VITAMIN B-1 TABS VITAMIN B-12 VITAMIN B-6 TABS VITAMIN C VITAMIN E CAPS VITAMIN E/D-ALPHA CAPS VITAMIN K1 SOLN V-R VITAMIN E CAPS	AQUASOL E SOLN AQUAVIT-E SOLN DHT SOLN NASCOBAL GEL	Use PA Form# 20420 Please refer to OTC list.
VITAMIN D's	CALCITRIOL CAPS ¹ VITAMIN D ZEMPLAR TABS	DRISDOL CAPS CALCIJEX HECTOROL (ORAL) HECTOROL (PARENTERAL) ROCALTROL ZEMPLAR INJ	1. Diagnosis of dialysis (renal failure) required. Use PA Form# 20420

MISC MULTI-VITAMINS

****Preferred products that used to require diag codes still require diag codes unless indicated otherwise.****

VITAMINS - MISC.	CENTRUM LIQD CENTRUM TABS CENTRUM JR/IRON CHEW CENTRUM SILVER TABS CENTRUM-LUTEIN TABS CEROVITE ADVANCED FO TABS CHEWABLE MULTIVIT/FL CHEW COD LIVER OIL CAPS COMPLETE SENIOR TABS DAILY MULTI VIT/IRON DIALYVITE 1MG DIALYVITE 800MG FULL SPECTRUM B M.V.I.-12 INJ MULTI-VIT/FLUORIDE NATALCARE RX TABS NEPHRONEX NUTRINATE CHEW O-CAL PRENATAL ONE DAILY TABS ONE-DAILY MULTIVITAMINS ONE-TABLET-DAILY POLY-VIT/IRON/FLUORID SOLN POLY-VITAMIN/FLUORIDE SOLN POLY-VITAMINS/IRON SOLN PRENATAL 19 CHEW PRENATAL TABS PRENATAL FORMULA 3 TABS PRENATAL PLUS TABS PRENATAL PLUS NF TABS PRENATAL PLUS/27MG IRON	ADEKS ADVANCED NATALCARE TABS AQUADEKS CENTRUM JR/EXTRA C CHEW CENTRUM PERFORMANCE TABS DALYVITE LIQD EMBREX 600 MISC IBERET MATERNA TABS MULTIRET FOLIC -500 TBCR NATAFORT TABS NATALCARE CFE 60 TABS NATALCARE GLOSS TABS NATALCARE PIC TABS NATALCARE PIC FORTE TABS NATALCARE PLUS TABS NATALCARE THREE TABS NATACHEW CHEW NATALFIRST TABS NATATAB RX TABS NEPHPLEX RX TABS NEPHROCAPS CAPS NEPHRO-VITE TABS NESTABS RX TABS NIFEREX OCUVITE TABS POLY-VI-FLOR SOLN POLY-VI-SOL SOLN POLY-VI-SOL/IRON SOLN POLY-VITAMIN DROPS SOLN PRECARE	Diag codes are no longer required on prenatal vitamins. Please refer to OTC list. Use PA Form# 20420
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PRENATAL PLUS/IRON TABS
 PRENATAL RX/BETA-CAROTENE
 RENA-VITE RX TABS
 RENAL CAPS
 RENAPHRO CAPS
 STRESS TAB NF TABS
 THERAPEUTIC-M TABS
 THERAVITE LIQD
 TRI-VITAMIN/FLUORIDE SOLN
 VITA CON FORTE CAPS
 VITAMIN B COMPLEX CAPS
 VITAPLEX PLUS TABS

PREMESIS RX TABS
 PRENATABS CBF TABS
 PRENATAL CARE TABS
 PRENATAL MR 90 TBCR
 PRENATAL MTR/SELENIUM TABS
 PRENATAL OPTIMA ADVANCE TABS
 PRENATAL PC 40 TABS
 PRENATAL RX TABS
 PRENATE
 PRENATE ELITE
 PRIMACARE MISC
 PROTEGRA CAPS
 STUARTNATAL PLUS 3 TABS
 TRI-VI-SOL SOLN
 TRI-VI-SOL/IRON SOLN
 ULTRA NATALCARE TABS
 ULTRA-NATAL TABS
 VICON FORTE CAPS
 VINATAL FORTE TABS
 VINATE
 VINATE ADVANCED TABS

MISCELLANEOUS MINERALS

****Preferred products that used to require diag codes still require diag codes unless indicated otherwise.****

MINERALS

CALCARB
 CALCI-MIX CAPSULE CAPS
 CALCIQUID SYRP
 CALCITRATE/VITAMIN D TABS
 CALCIUM
 CALCIUM CARBONATE
 CALCIUM CITRATE TABS
 CALCIUM GLUCONATE TABS
 CALCIUM LACTATE TABS
 CALCIUM/MAGNESIUM TABS
CALCIUM/VITAMIN D TABS
 CALTRATE 600 TABS
 CHEWABLE CALCIUM CHEW
 CITRACAL TABS
 CITRACAL + D TABS
 CITRUS CALCIUM TABS
 CITRUS CALCIUM 1500 + D TABS
 MC/DEL
 EFFERVESCENT POTASSIUM TBEF
 FEOSTAT CHEW
 FERATAB TABS
 FER-GEN-SOL SOLN
 FER-IN-SOL SOLN
 FER-IRON SOLN
 FERRONATE TABS
 FERROUS SULFATE
 FLUOR-A-DAY CHEW
 FLUORIDE CHEW
 FLUORIDE SODIUM CHEW
 FLUORITAB CHEW
 HEMOCYTE TABS
 HM CALCIUM TABS
 K+ POTASSIUM PACK
 KAON ELIX
 KAON-CL-10 TBCR
 KCL 0.075%/D5W/NACL 0.2% SOLN
 K-EFFERVESCENT TBEF
 KLOR-CON
 KLOTRIX TBCR
 K-PHOS TABS
 K-VESCENT TBEF

ANEMAGEN
 CALCET TABS
CALCIUM 600-D TABS
 CALCIUM/VITAMIN D TABS
 CALTRATE 600 PLUS/VIT D TABS
 CALTRATE PLUS TABS
 CHROMAGEN
 CITRACAL PLUS TABS
 CONTRIN CAPS
 FEOGEN FORTE CAPS
 FEROCON CAPS
 FERREX 150 CAPS
 FERRO-SEQUELS TBCR
 FE-TINIC CAPS
 FE-TINIC 150 FORTE CAPS
 FLUOR-A-DAY SOLN
 K-DUR TBCR
 KLOR-CON PACK
 K-LYTE
 K-PHOS TABS NEUTRAL
 K-TABS TBCR
 K-VESCENT PACK
 MICRO-K 10 MEG CPCR
 NU-IRON 150 CAPS
OYSTER SHELL CALCIUM/VITA TABS
 POLY-IRON 150 CAPS
 POLYSACCHARIDE IRON CAPS
 POTASSIUM BICARB/CHLORIDE
 POTASSIUM CHLORIDE 10MEQ CAPS
 POTASSIUM CHLORIDE 8MEQ CAPS
 SLOW FE TBCR
 TUMS 500 CHEW
 VIACTIV CHEW

[Use PA Form# 20420](#)
 Please refer to OTC list.

LURIDE CHEW
MAGNESIUM GLUCONATE TABS
MAGNESIUM SULFATE SOLN
MAGTABS
MICRO-K 8 MEG
OS-CAL TABS
OS-CAL 500 + D TABS
OYSCO
OYST-CAL TABS
OYST-CAL D TABS
OYST-CAL/VITAMIN D TABS
OYSTER CALCIUM TABS
OYSTER SHELL
PHARMA FLUR
PHOSPHA 250 NEUTRAL TABS
POTASSIUM BICARBONATE TBEF
POTASSIUM CHLORIDE 8MEQ
POTASSIUM EFFERVESCENT
SELENIUM TABS
SLOW-MAG TBCR
SODIUM FLUORIDE
SSKI SOLN
V-R CALCIUM
V-R OYSTER SHELL CALCIUM
ZINC SULFATE CAPS

MISC. ELECTROLYTES/NUTRITIONALS

ELECTROLYTES/ NUTRITIONALS	INTRALIPID EMUL P.T.E. -5 SOLN SEA-OMEGA CAPS		BOOST CASEC POWD CHOICE DM LIQD DELIVER 2.0 LIQD ENFAMIL ENSURE GLUCERNA ISOCAL LIQD KINDERCAL TF LIQD KINDERCAL TF/FIBER LIQD L-CARNITINE CAPS LIPISORB LIQD LOVAZA ¹ MODULEN IBD POWD NUTRAMIGEN POWD NUTREN NUTRITIONAL SUPPLEMENT LIQD NUTRIVENT 1.5 LIQD PEPTAMEN PHENYL-FREE PKU 3 POWD PREGESTIMIL POWD PROBALANCE LIQD PROSOBEE SCANDISHAKE PACK	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
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ERYTHROPOEITINS

ERYTHROPOEITINS	PROCRIT SOLN ¹	6 8	EPOGEN SOLN ARANESP SOLN	Use PA Form# 10520 1. Clinical PA is required to establish medical necessity and that appropriate lab monitoring is being done.
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GRANULOCYTE CSF

GRANULOCYTE CSF		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
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ANTICOAGULANTS / PLATELET AGENTS

ANTICOAGULANTS	ARIXTRA SOLN ¹ FRAGMIN INJ ¹		COUMADIN TABS IPRIVASK	1. Arixtra, Fragmin and Lovenox therapy durations greater than 7 days require PA.
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	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		LOVENOX 300 ²	2. Use other strengths available to obtain desired dose. Use PA Form# 20420
ANTIHEMOPHILIC AGENTS	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		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
PLATELET AGGREGATION INHIBITORS	ASPIRIN DIPYRIDAMOLE TABS	7 8 8 8 8	TICLOPIDINE HCL TABS EFFIENT PERSANTINE TABS PLAVIX TABS ^{1,2} TICLID TABS	Use PA Form # 20715 for Plavix & Effient 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.
PLATELET AGGR. INHIBITORS / COMBO'S - MISC.	AGGRENOX CILOSTAZOL PENTOXIFYLLINE ER TBCR		AGRYLIN CAPS PLETAL TABS TRENAL TBCR	Use PA Form# 20420
HEMATOLOGICALS				
MONOCLONAL ANTIBODY			SOLIRIS	Use PA Form# 20420
HEMATOLOGICAL AGENTS- THROMBOPOIETIN RECEPTOR AGONISTS		7 8	PROMACTA NPLATE	Use PA Form# 20420
HEMOSTATIC				
HEMOSTATIC	AMICAR AMINOCAPROIC ACID			
OPHTHALMICS				
OP. - ANTIBIOTICS	AK-SPORE OINT BACITRACIN OINT BACITRACIN/NEOMYCIN/POLYM BACITRACIN/POLYMYXIN B OINT CHLOROPTIC SOLN ERYTHROMYCIN OINT GENTAMICIN SULFATE NEOMYCIN/POLYMYXIN/GRAMIC NEOSPORIN SOLN POLYSPORIN SODIUM SULFACETAMIDE SOLN		AK-POLY-BAC OINT AK-SULF OINT AK-TOB SOLN AZASITE BLEPH-10 SOLN GENTAK ILOTYCIN OINT NEOMYCIN/BACI/POLYM OINT NEOSPORIN OINT OCUSULF-10 SOLN OCUTRICIN SOLN	Use PA Form# 20420

	SULFACETAMIDE SODIUM TERRAMYCIN OINT TOBRAMYCIN SULFATE SOLN TRIMETHOPRIM SULFATE/POLY VIOPTIC SOLN		TERAK OINT TOBREX OINT TRIFLURIDINE SOLN	
OP. - QUINOLONES	CILOXAN OINT CIPROFLOXACIN SOL 0.3% OFLOXACIN QUIXIN SOLN		BESIVANCE CILOXAN SOLN OCUFLOX SOLN	Use PA Form# 20420
OP. QUINOLONES-4TH GENERATION	VIGAMOX ZYMAR			
OP. - ARTIFICIAL TEARS AND LUBRICANTS	AKWA TEARS OINT ARTIFICIAL TEARS OINT ARTIFICIAL TEARS SOLN CELLUVISC SOLN EYE LUBRICANT OINT GENTEAL LIQUITEARS SOLN MAJOR TEARS SOLN PURALUBE OINT PURALUBE TEARS SOLN REFRESH SOLN OP REFRESH PLUS SOLN ¹ REFRESH PM OINT		AKWA TEARS SOLN ARTIFICIAL TEARS SOLN OP BION TEARS SOLN DRY EYES OINT DURATEARS OINT HYPO TEARS ISOPTO TEARS SOLN LACRI-LUBE LUBRIFRESH P.M. OINT MURINE SOLN MUROCEL SOLN NATURE'S TEARS SOLN REFRESH SOLN REFRESH TEARS SOLN ¹ SYSTANE TEARGEN SOLN TEARISOL SOLN TEARS NATURALE TEARS PURE SOLN TEARS RENEWED OINT THERATEARS SOLN V-R ARTIFICIAL TEARS SOLN	Use PA Form# 20420 1. Dosing limits apply, please see dose consolidation list.
OP. - BETA - BLOCKERS	BETOPTIC-S SUSP CARTEOLOL HCL SOLN LEVOBUNOLOL HCL SOLN METIPRANOLOL SOLN TIMOLOL MALEATE SOLG (GEL) TIMOLOL MALEATE SOLN		BETAGAN SOLN BETAXOLOL HCL SOLN BETIMOL SOLN ISTALOL OCUPRESS SOLN OPTIPRANOLOL SOLN TIMOPTIC SOLN TIMOPTIC-XE SOLG	Use PA Form# 20420
OP. - ANTI-INFLAMMATORY / STEROIDS OPTH.	AK-SPORE HC OINT ALREX SUSP BLEPHAMIDE SUSP CORTISPORIN SUSP DEXAMETH SOD PHOS SOLN FLAREX SUSP FLUOROMETHOLONE SUSP FML S.O.P. OINT FML-S LIQUIFILM SUSP INFLAMASE SOLN LOTEMAX SUSP NEOM/POLIN/DEX PRED MILD SUSP PREDNISOLONE TOBRADEX		AK-TROL SUSP BAC/POLY/NEOMY/HC OINT BLEPHAMIDE S.O.P. OINT ECONOPRED EFLONE SUSP FLUOR-OP SUSP FML LIQUIFILM SUSP MAXITROL NEO/POLY/BAC/HC OINT PRED FORTE SUSP PRED-G SUSP PRED-G S.O.P. OINT SULFACET SOD/PRED SOLN VASOCIDIN SOLN VEXOL SUSP	Use PA Form# 20420
OP. - PROSTAGLANDINS	LUMIGAN SOLN TRAVATAN SOLN		RESCULA SOLN XALATAN SOLN	All preferreds must be tried. Use PA Form# 20420
OP. - CYCLOPLEGICS	AK-PENTOLATE SOLN ATROPINE SULFATE CYCLOPENTOLATE HCL SOLN ISOPTO HYOSCINE SOLN		CYCLOGYL SOLN ISOPTO ATROPINE SOLN ISOPTO HOMATROPINE SOLN MUROCOLL-2 SOLN	Use PA Form# 20420
OP. - MIOTICS - DIRECT ACTING	ISOPTO CARBACHOL SOLN ISOPTO CARPINE SOLN PILOCAR SOLN			

		PILOCARPINE HCL SOLN PILOPINE HS GEL			
OP. - ADRENERGIC AGENTS		DIPIVEFRIN HCL SOLN EPIFRIN SOLN		PROPINE SOLN	Use PA Form# 20420
OP. - SELECTIVE ALPHA ADRENERGIC AGONISTS		ALPHAGAN P SOLN BRIMONIDINE 0.2%		ALPHAGAN SOLN IOPIDINE SOLN	Use PA Form# 20420
OP. - ANTI-ALLERGICS		OPTIVAR PATADAY SOLN PATANOL SOLN		ALOCRIOL SOLN ALOMIDE SOLN BEPREVE ELESTAT EMADINE SOLN LIVOSTIN SUSP OPTICROM SOLN ZADITOR SOLN	Use PA Form# 20420
OP. ANTI-ALLERGICS- MASTCELL STABILIZER CLASS				ALAMAST SOLN	Use PA Form# 20420
OP. - CARBONIC ANHYDRASE INHIBITORS/COMBO		AZOPT SUSP COSOPT SOLN COMBIGAN TRUSOPT SOLN		DORZOLAMIDE DORZOLAMIDE/TIMOLOL	Use PA Form# 20420
OP. - NSAID'S		FLURBIPROFEN SODIUM SOLN DICLOFENAC OPTH 0.1% KETOROLAC OPTH 0.4% KETOROLAC OPTH 0.5%		ACULAR LS ACULAR SOLN OCUFEN SOLN NEVANAC XIBROM VOLTAREN SOLN ACUVAIL	Must fail all preferred products before non-preferred. Use PA Form# 20420
OP. - OF INTEREST		ENUCLENE SOLN		BOTOX SOLR RESTASIS ¹	1. Must have kerato conjunctivitis sicca and failed other dry eye therapies. Use PA Form #20420
DERMATOLOGICAL					
TOPICAL - ACNE PREPARATIONS		AZELEX CREA BENZOYL PEROXIDE CLINDAMYCIN PHOSPHATE ² ERYDERM SOLN ERYTHROMYCIN GEL ERYTHROMYCIN PADS ERYTHROMYCIN SOLN ISOTRETINOIN METRONIDAZOLE CREAM ² METRONIDAZOLE GEL ² METRONIDAZOLE LOTN ² PLEXION RETIN-A GEL ^{1,2} SODIUM SULFACET/SULF LOTN TAZORAC GEL		ACZONE ALTINAC CREA AVITA CREA BENZAC BENZACLIN GEL ³ BENZAGEL-10 GEL BENZAMYCIN GEL BENZAMYCINPAK PACK BREVOXYL CLEOCIN-T ² CLINAC BPO GEL CLINDAGEL GEL CLINDETS SWAB DESQUAM-E GEL DESQUAM-X DIFFERIN 0.3% GEL DIFFERIN DUAC GEL EMGEL GEL EPIDUO ERYCETTE PADS ERYGEL GEL EVOCLIN FINEVIN CREA KLARON LOTN METROCREAM CREAM ² METROGEL GEL ² METROLOTION LOTN ² NEOBENZ MICRO NORITATE CREA RETIN-A MICRO GEL RETIN-A CREAM ²	1. Users 24 or under, PA will not be required. 2. Dosing limits allowing one package per month. Please refer to Dose Consolidation List. 3. Only available if component ingredients are unavailable. If requesting any brands use PA Form # 10220 , for all others use PA Form # 20420

			SULFACET-R LOTN TRETINOIN ^{1,2} TRIAZ ZETACET ZIANA	
TOPICAL - ANTIBIOTIC		BACIT/NEOMYCIN/POLYM OINT BACITRACIN OINT BACTROBAN CREAM BACTROBAN NASAL OINT CENTANY OINT 2% ¹ GENTAMICIN SULFATE MUIPIROCIN ¹	ALTABAX ¹ BACTROBAN OINT. CORTISPORIN TRIPLE ANTIBIOTIC OINT	1. Dosing limits apply, please see dosing consolidation list. Use PA Form# 20420
TOPICAL - ANTIFUNGALS		CICLOPIROX 0.77 CREAM CICLOPIROX 0.77 SUSP CLOTRIMAZOLE CLOTRIMAZOLE/BETA CREAM ECONAZOLE NITRATE CREAM KETOCONAZOLE CREAM LOPROX 1.0 CREAM LOPROX 1.0 LOTN LOPROX GEL LOPROX TS LOTN MICONAZOLE NITRATE CREA MYCO-TRIA CET II CREA NIZORAL SHAM NTA OINT NYSTATIN NYSTATIN/TRIAMCINOLONE NYSTOP POWD PEDI-DRI POWD TINACTIN TRI-STATIN II CREA	EXELDERM FUNGIZONE CREA HYDROCORT/ODOO CREA LAMISIL LOPROX 0.77 LOTN LOPROX 0.77 CREAM LOPROX 0.77 SUSP LOPROX SHAMPOO SHAM LOTRIMIN LOTRISONE MENTAX CREA MYCOGEN II CREA MYCOLOG-II CREA MYCOSTATIN POWD NAFTIN NIZORAL CREA NYSTAT-RX POWD OXISTAT PENLAC NAIL LACQUER SOLN SPECTAZOLE CREAM	Use PA Form # 10120
TOPICAL - ANTIPRURITICS		ZONALON CREA	PRUDOXIN CREA	Use PA Form# 20420
TOPICAL - ANTIPSORIATICS		DOVONEX SORIATANE CAPS TAZORAC	OXSORALEN ULTRA CAPS PSORIATEC CREA SORIATANE CK KIT TACLONEX ¹ VANAMIDE VECTICAL	Must fail all preferred products before non-preferred. 1. Individual ingredients are available as preferred without PA. Use PA Form# 20420
TOPICAL - ANTISEBORRHEICS		SELENIUM SULFIDE SHAM SELSUN BLUE SHAM	CARMOL SCALP TREATMENT KIT ZNP BAR	Use PA Form# 20420
TOPICAL - ANTIVIRALS			DENAVIR CREA ¹ ZOVIRAX OINT ^{1,2}	1. Must fail oral treatment with Acyclovir or Valtrex. 2. Approvals limited to 1 tube per 180 days. Use PA Form# 20420
TOPICAL - ANTINEOPLASTICS		EFUDEX FLUOROPLEX CREA	CARAC CREA FLUOROURACIL SOLARAZE GEL	Use PA Form# 20420
TOPICAL - BURN PRODUCTS		FURACIN CREA SILVER SULFADIAZINE CREA SSD AF CREA SSD CREA THERMAZENE CREA	SILVADENE CREA	Use PA Form# 20420
TOPICAL - CORTICOSTEROIDS		LOW POTENCY DESOWEN HYDROCORTISONE CREA HYDROCORTISONE LOTN LACTICARE-HC LOTN NUTRACORT LOTN TEXACORT SOLN TRIDESILON CREA MEDIUM POTENCY DESOXIMETASONE .05% ELOCON FLUOCINOLONE ACETONIDE .025-.01%	ACLOVATE AMCINONIDE CREA ANUSOL HC-1 OINT ARISTOCORT A CLOBEX CLODERM CREA CORDRAN CORMAX CUTIVATE CREAM / OINT CUTIVATE LOTION DERMATOP DESONATE GEL	Use PA Form# 20420

	FLUROSYN CREA FLUTICASON PROPRIONATE CREAM/OINT HYDROCORTISONE BUTYRATE HYDROCORTISONE OINT HYDROCORTISONE VALERATE MOMETASONE FUROATE OINT TRIAMCINOLONE ACETONIDE .025-.1% HIGH POTENCY CYCLOCORT BETAMETHASONE DIPROPIONATE DESOXIMETASONE .25% DESONIDE FLUOCINOLONE ACETONIDE .02% FLUOCINONIDE HALOG HALOG-E CREA TRIAMCINOLONE ACETONIDE .5% VERY HIGH POTENCY AUGMENTED BETA DIP BETAMETHASONE VALERATE BETA-VAL CLOBETASOL PROPIONATE DIFLORASONE DIACETATE HALOBETASOL MISCELLANEOUS CAPEX SHAM DERMA-SMOOTH/FS OIL PROCTO-KIT CREA 1%		DIPROLENE ELOCON OINT HYDROCORTISONE POWD KENALOG AERS LIDA MANTLE HC CREA LIDEX LIDEX-E CREA LOCOID LUXIQ FOAM OLUX FOAM PANDEL CREA PROCTOCORT CREA PSORCON PSORCON E TEMOVATE TOPICORT TOPICORT LP CREA ULTRAVATE VERDESO WESTCORT	
TOPICAL - STEROID LOCAL ANESTHETICS			EPIFOAM FOAM	Use PA Form# 20420
TOPICAL - STEROID COMBINATIONS	DERMA-SMOOTH/FS ATOPIC P KIT		CARMOL-HC CREA	Use PA Form# 20420
TOPICAL - EMOLLIENTS	AMMONIUM LACTATE LOTION 12% LAC-HYDRIN CREAM UREACIN-20 CREA VITAMIN A & D MEDICATED OINT		AMMONIUM LACTATE CREA LAC-HYDRIN LOTION 12% LACTINOL LOTN MEDERMA GEL MIMYX RENOVA CREA	Use PA Form# 20420
TOPICAL - ENZYMES / KERATOLYTICS / UREA	GRANUL-DERM AERS GRANULEX AERS TBC AERS SANTYL OINT		CARMOL 40 CREA SALEX CREAM SALEX LOTION	Use PA Form# 20420 Ziox, Panafil and Papain products have been removed from the PDL due to FDA safety concerns regarding drugs containing Papain.
TOPICAL - GENITAL WARTS	ALDARA	5 8 8 8	PODOFILOX SOLN CONDYLOX VEREGEN ZYCLARA	Use PA Form# 20420 Non-preferred products must be used in specified order.
TOPICAL - IMMUNOMODULATORS		8 9	ELIDEL CREA PROTOPIC OINT	Use PA Form# 20420 Non-preferred products must be used in specified order. The FDA has issued a Public 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.
TOPICAL - LOCAL ANESTHETICS	AF CAPSICUM OLEORESIN CREA CAPSAICIN CREA ELA-MAX ¹ LIDOCAINE/PRILOCAINE CREA ¹ XYLOCAINE		EMLA PADS EMLA CREA LIDA MANTLE CREA LIDODERM PTCH PONTOCAINE SOLN SYNERA ZOSTRIX	1. Lidocaine/Prilocaine cream and Ela-Max products require PA for users over 18 years of age. Use PA Form# 20420
TOPICAL - DEPIGMENTING AGENTS		8 8	ALUSTRA CREA EPIQUIN MICRO	Not covered for cosmetic purposes.

			8	GLYQUIN CREA	
			8	HYDROQUINONE CREA	Use PA Form# 20420
			8	HYDROQUINONE/SUNSCREENS	
			8	SOLAQUIN FORTE CREA	
			8	TRI-LUMA CREA	
			9	ELDOQUIN	
TOPICAL - SCABICIDES AND PEDICULICIDES		ACTICIN CREA ELIMITE CREA EURAX LICE KILLING SHAM LICE TREATMENT CREME RINS LIQD PERMETHRIN LOTN		LINDANE OVIDE LOTN MALATHION ULESFIA	Use PA Form# 20420
TOPICAL - WOUND / DECUBITUS CARE				REGANEX GEL REGENECARE RADIAPLEXRX	Use PA Form# 20420 Accuzyme and Ethezyme products have been removed from the PDL due to FDA concerns regarding drugs containing Papain.
TOPICAL - ASTRINGENTS / PROTECTANTS		ALUMINUM CHLORIDE SOLN DRYSOL SOLN XERAC AC SOLN		LOWILA BAR MOISTURIN DRY SKIN CREA PROSHIELD PLUS SKIN PROTE CREA SURGILUBE GEL	Use PA Form# 20420
TOPICAL - ANTISEPTICS / DISINFECTANTS		PHISOHEX LIQD POVIDONE-IODINE SOLN		BETADINE OINT FORMALYDE-10 AERS IODOSORB LAZERFORMALYDE SOLUTION SOLN	Use PA Form# 20420
MISCELLANEOUS EYE					
OP. - EYE		AK-DILATE SOLN EYE WASH SOLN NAPHAZOLINE HCL SOLN PHENYLEPHRINE HCL SOLN PONTOCAINE SOLN SODIUM CHLORIDE		LENS PLUS REWETTING DROPS MURO 128 NEO-SYNEPHRINE SOLN	Use PA Form# 20420
MISCELLANEOUS EAR					
EAR		A/B OTIC SOLN ACETASOL SOLN ACETASOL HC SOLN ACETIC ACID ACETIC ACID/HYDROCORTISON ALLERGEN SOLN ANTIPYRINE/BENZOCAINE SOLN AURODEX SOLN AUROGUARD SOLN AUROTO OTIC SOLN CARBAMIDE PEROXIDE 6.5% OTIC SOLN. CIPRODEX CORTISPORIN SOLN CORTOMYCIN EAR DROPS SOLN EAR DROPS RX SOLN EAR WAX REMOVAL DROPS EAR-GESIC SOLN NEOMYCIN/POLYMYXIN/HC OFLOXACIN 0.3% OTIC OTICAINE OTIC SOLN		AERO OTIC HC SOLN ANTIBIOTIC EAR SOLN ANTIBIOTIC EAR SUSP AURALGAN SOLN CIPRO HC SUSP COLY-MYCIN-S SUSP CORTISPORIN SUSP CORTISPORIN-TC SUSP DEBROX SOLN DOMEBORO SOLN FLOXIN OTIC SOLN PEDIOTIC SUSP VOSOL-HC SOLN ZOTANE HC SOLN ZOTO-HC SOLN	Use PA Form# 20420
MOUTH ANTISEPTICS					
MOUTH ANTI-INFECTIVES		NILSTAT SUSP EAR-GESIC SOLN NYSTATIN SUSP		MYCELEX TROC MYCOSTATIN LOZG ORAVIG	Use PA Form# 20420
MOUTH ANTISEPTICS		CHLORHEXIDINE GLUCONATE LIDOCAINE VISCOUS SOLN TRIAMCINOLONE IN ORABASE PSTE TRIAMCINOLONE ORADENT PSTE		APHTHASOL PSTE PERIDEX SOLN PERIOGARD SOLN TRIAMCINOLONE ACETONIDE PSTE	Use PA Form# 20420 Must fail all preferred products before non-preferred.
DENTAL PRODUCTS					
DENTAL PRODUCTS		ETHEDENT CREA GEL-KAM CONC		APF GEL GEL DENTAGEL GEL	Use PA Form# 20420

	GEL-KAM GEL 0.4% PHOS FLUR SOLN PREVIDENT GEL PREVIDENT SOLN SF 5000 PLUS CREA SF GEL STANNOUS FLUORIDE ORAL RI CONC		PHOS-FLUR GEL PREVIDENT CREAM THERA-FLUR-N GEL	
ARTIFICIAL SALIVA/STIMULANTS				
ARTIFICIAL SALIVA/STIMULANTS	SALIVA SUBSTITUTE SOLN		EVOXAC CAPS RADIACARE SOLR SALAGEN TABS	Use PA Form# 20420
MISCELLANEOUS ANORECTAL				
ANORECTAL - MISC.	COLOCORT ENEM CORTENEMA ENEM ELA-MAX 5 CREA HYDROCORTISONE ENEM PROCTOZONE-HC CREA		ANUSOL-HC CREA CORTIFOAM FOAM PROCTOCREAM-HC CREA PROCTOFOAM HC FOAM PROCTO-KIT CREA 2.5% PROCTOSOL HC CREA	Use PA Form# 20420
T-CELL ACTIVATION INHIBITOR				
PSORIASIS BIOLOGICALS	ENBREL 25MG INJECTIONS ONLY ⁴ HUMIRA ¹		AMEVIVE ² ENBREL 50 MG ³ STELARA	<p>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.</p> <p>2. Trial of both preferred drugs are required.</p> <p>3. Use multiple 25mg injections.</p> <p>4. Preferred dosage form allowed without PA after trial of step 1 products is multi-dose vial, with dosing limits allowing 8 injections per 28 days without pa.</p> <p>Use PA Form # 20910</p>
ALTERNATIVE MEDICINES				
ALTERNATIVE MEDICINES	DIMETHYL SULFOXIDE SOLN		CO-ENZYME Q-10 MELATONIN TABS	Use PA Form# 20420
CHELATING AGENTS				
CHELATING AGENTS	CUPRIMINE CAPS		DEPEN TITRATABS TABS EXJADE ¹	Use PA Form# 20420
ANTILEPROTIC				
ANTILEPROTIC			THALOMID CAPS ¹	<p>1. All PA requests for 150mg dosing will require use of Thalomid 100mg and 50mg capsules.</p> <p>Use PA Form# 20420</p>
ANTINEOPLASTIC AGENTS				
ANTINEOPLASTIC AGENTS - ANTIADNDROGENS	BICALUTAMIDE		CASODEX	Use PA Form# 20420
ANTINEOPLASTIC AGENTS- LHRH ANALOGS	LUPRON DEPOT ¹		VANTAS ² FIRMAGON ² TRELSTAR	<p>1. Dosing limits apply, please refer to dosage consolidation list.</p> <p>2. PA required to confirm FDA approved indication.</p> <p>Use PA Form# 20420</p>
ANTINEOPLASTIC AGENTS - TYROSINE KINASE INHIBITORS	GLEEVEC		SPRYCEL ¹ TYKERB ²	<p>Use PA Form# 20420</p> <p>1. Verification of diagnosis and prior trial of at least Gleevec is required.</p> <p>2. PA required to confirm FDA approved indication and to monitor for potential drug-drug interactions.</p>
ANTINEOPLASTICS- MISCELLANEOUS	MERCAPTOPYRINE		ZOLINZA PURINETHOL	Use PA Form# 20420
ANTINEOPLASTICS- MONOCLONAL ANTIBODIES			HERCEPTIN ¹	<p>1. PA required to confirm FDA approved indication.</p> <p>Use PA Form# 20420</p>

CANCER

CANCER	ALIMTA ANASTROZOLE TABS AVASTIN ERBITUX VIDAZA	ARIMIDEX FOLOTYN NEXAVAR ¹ SUTENT ^{1,2}	1. PA required to confirm FDA approved indication 2. Avoid CYP3A4 drug drug interaction. Use PA Form# 20420
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IMMUNOSUPPRESSANTS

IMMUNOSUPPRESSANTS	CYCLOSPORINE MODIFIED CYCLOSPORINE SOL. MODIFIED GENGRAF CAPS MYCOPHENOLATE MYFORTIC PROGRAF CAPS RAPAMUNE SANDIMMUNE	CELLCEPT CYCLOSPORINE CAPS NEORAL ^{1,2}	1. Established users will require a one time PA. 2. Established users will require a one time PA Use PA Form# 20420
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PURINE ANALOG

PURINE ANALOG	AZASAN TABS AZATHIOPRINE TABS	IMURAN TABS	Use PA Form# 20420
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K REMOVING RESINS

K REMOVING RESINS	KAYEXALATE POWD KIONEX POWD SODIUM POLYSTYRENE SULFON SPS SUSP SPS 30GM/120ML ENEMA SUSP		Use PA Form# 20420
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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(2 nd line)	X(2 nd line)				X(2 nd line)
TOPAMAX	X			9	6	X (2 nd 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