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.	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		AMOXICILLIN/POTASSIUM CLA CHEW	MC/DEL		AUGMENTIN[3]			
	MC/DEL		AMOXICILLIN/POTASSIUM CLA SUSR	MC/DEL		AUGMENTIN XR TB12[4]		2.Principen 250 mg is available without PA.	**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 TABS	MC		PRINCIPEN CAPS[2]			
	MC/DEL		AMOXIL[1]	MC		PRINCIPEN SUSR		3. Chewable 125mg & 250mg and Solution 125mg/5ml and 250mg/5ml available without PA.	
	MC/DEL		AMPICILLIN						
	MC		BEEPEN						
	MC		BICILLIN L-A SUSP						
	MC/DEL		DICLOXACILLIN SODIUM CAPS						
	MC		DYNAPEN SUSR						
	MC		OXACILLIN SODIUM SOLR						
	MC/DEL		PENICILLIN V POTASSIUM					4. Use preferred generic amoxicillin/clavulanate potassium alternatives.	
	MC		TICAR SOLR						
	MC		TIMENTIN SOLR						
	MC		TRIMOX					Use PA Form# 20420	
	MC		UNASYN SOLR						
	MC		VEETIDS						
	MC/DEL		ZOSYN						
CEPHALOSPORINS	MC/DEL		CEFADROXIL HEMIHYDRATE	MC		CEDAX		1. Both brand and generic are clinically 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		CEFAZOLIN SODIUM SOLR	MC/DEL		CEFACLOR[1]			
	MC/DEL		CEFDINIR	MC/DEL		CEFADROXIL MONOHYDRATE TABS			
	MC/DEL		CEFEPIME HCl	MC/DEL		CEFTIN			
	MC/DEL		CEFPODOXIME	MC/DEL		FORTAZ			
	MC/DEL		CEFPROZIL	MC/DEL		FORTAZ SOLN			
	MC		CEFTAZIDIME 6MG	MC		KEFLEX CAPS			
	MC/DEL		CEFTIN SUSP	MC		OMNICEF			
	MC/DEL		CEFTRIAXONE	MC/DEL		ROCEPHIN			
	MC/DEL		CEFUROXIME AXETIL TABS	MC/DEL		SUPRAX			
	MC/DEL		CEPHALEXIN MONOHYDRATE	MC		TAZICEF SOLR			
	MC/DEL		FORTAZ SOLR	MC/DEL		TAZIDIME SOLN			
	MC		KEFZOL SOLR	MC		MAXIPIME			
	MC		MAXIPIME SOLR					Use PA Form# 20420	
	MC		TAZICEF 6GM						**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		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 Onglyza 5mg, 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 Onglyza 5mg, Enablex 15mg or Vesicare 10mg.
	MC/DEL		AZITHROMYCIN TABS	MC		BIAXIN		
	MC/DEL		AZITHROMYCIN SUSP	MC/DEL		CLARITHROMYCIN SUSP		
	MC/DEL		CLARITHROMYCIN TABS	MC		ERYPED CHEW		
	MC		E.E.S.	MC		PCE TBEC		
	MC		E-MYCIN TBEC	MC/DEL		ZITHROMAX TABS		
	MC		ERYPED 200 SUSR	MC/DEL		ZITHROMAX 1GM PAK	Use PA Form# 20420	
	MC		ERYPED 400 SUSR	MC/DEL		ZITHROMAX TRI-PAK		
	MC		ERY-TAB TBEC	MC/DEL		ZITHROMAX SUSP		
	MC		ERYTHROCIN STEARATE TABS	MC/DEL		ZMAX		
	MC/DEL		ERYTHROMYCIN					
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/DEL		TETRACYCLINE HCL CAPS	MC/DEL		DOXYCYCLINE MONO CAPS		
	MC/DEL		VIBRAMYCIN SYRP	MC/DEL		DYNACIN CAPS		
				MC		ORACEA		
				MC/DEL		PERIOSTAT		
				MC/DEL		SOLODYN ER		
FLUOROQUINOLONES	MC		AVELOX SOLN	MC		CIPRO		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		FACTIVE	Use PA Form# 20420	
	MC		AVELOX ABC PACK TABS	MC/DEL		LEVAQUIN TABS SOLN/INJ	1. Dosing limits apply, see Dosage Consolidation List.	
	MC/DEL		CIPROFLOXACIN	MC		NOROXIN TABS		
	MC/DEL		LEVAQUIN TABS[1]	MC		PROQUIN XR		
	MC/DEL		OFLOXACIN					
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	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	1. Ingredients available as preferred without PA.	
	MC/DEL		**LARIAM TABS**	MC/DEL		**PLAQUENIL TABS**		
	MC/DEL		**MEFLOQUINE HCL TABS**					
	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. 4. Clinical PA is required to establish CF diagnosis and medical necessity. Prior trail and failure of preferred Tobi before approval will be granted. 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		CAYSTON[4]		
	MC		FUROXONE TABS	MC/DEL		FLAGYL CAPS		
	MC/DEL		METRONIDAZOLE[2]	MC/DEL		FLAGYL TABS		
	MC		PENTAMIDINE ISETHIONATE SOLR	MC/DEL		FLAGYL ER TBCR		
	MC		PRIMSOL SOLN	MC/DEL		KETEK		
	MC/DEL		TRIMETHOPRIM TABS	MC/DEL		METRONIDAZOLE 375MG CAPS[2]		
	MC/DEL		VANCOMYCIN 5GM INJ.	MC/DEL		METRONIDAZOLE 750MG TABS[2]		
				MC		NEBUPENT SOLR		
				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
				MC		MERREM SOLR		

				MC/DEL		PRIMAXIN		drug and the preferred drug(s) exists.
LINCOSAMIDES / OXAZOLIDINONES / LEPROSTATICS	MC/DEL MC/DEL MC/DEL MC		CLEOCIN SOLN CLEOCIN SUSR CLINDAMYCIN HCL 150CAPS DAPSONE TABS	MC/DEL MC/DEL MC/DEL MC/DEL		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	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. For Zyvox, please see the criteria listed in the Zyvox PA form.
ANTI INFECTIVE COMBO'S - MISC.	MC/DEL MC/DEL MC/DEL MC/DEL		ERYTHROMYCIN/SULF SUSR SEPTRA/DS TABS SULFAMETHOXAZOLE/TRIMETH TRIMETHOPRIM/SULFAMETHOXA	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.
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 MC/DEL MC/DEL MC MC MC MC/DEL MC/DEL MC/DEL		ANCOBON CAPS FLUCONAZOLE[1] GRIFULVIN V TABS[10] GRISEOFULVIN SUSP[10] GRISEOFULVIN ULTRAMICROSI TABS[10] GRIS-PEG TABS[10] KETOCONAZOLE TABS[8] NYSTATIN TERBINAFINE TABS[4]	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL	5 6 6 7 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 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.	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. **DDI:** Fluconazole will require prior authorization if being used in combination with Plavix. **DDI:** Ketoconazole will require prior authorization if being used in combination with Plavix.
ANTI - VIRALS								
ANTIRETROVIRALS	MC/DEL MC MC/DEL MC/DEL MC		APTIVUS ATRIPLA[1] COMBIVIR TABS CRIXIVAN CAPS EMTRIVA	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		DIDANOSINE FUZEON[3] INTELENCE[3] ISENTRESS[3] RETROVIR	Fuzeon use PA Form # 10620 1. Quantity limit of one per	Please refer to the criteria listed on the Fuzeon PA form. **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

	MC/DEL		EPIVIR / HBV	MC/DEL		SELZENTRY[3]	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 quarter and 75% ART PDL compliance will be exempt from PA for these products.	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. **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/DEL		EPZICOM	MC		ZERIT		
	MC/DEL		INVIRASE CAPS					
	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/DEL		FOSCAVIR	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		GANCICLOVIR		
HERPES AGENTS	MC/DEL		ACYCLOVIR	MC/DEL	8	FAMVIR TABS	Must fail Acyclovir and Valtrex 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 (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	8	ZOVIRAX		
				MC/DEL	8	VALACYCLOVIR		
				MC/DEL	9	FAMCICLOVIR		
INFLUENZA AGENTS	MC/DEL		AMANTADINE	MC/DEL		FLUMADINE TABS	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	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]		
	MC/DEL		RIMANTADINE HCL TABS					
	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. 2. Current users are grandfathered. 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 (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]		
	MC		RIBAVIRIN	MC/DEL		REBETOL CAPS		
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		TYSABRI[1]	1. Providers must be enrolled in the TOUCH Prescribing program, a restricted distribution	
				MC		AMPYRA		
				MC/DEL		GILENYA		

							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 DYSPORT[1] MYOBLOC[1]	1. 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/DEL MC/DEL MC MC MC MC MC		CORTEF 10 and 20 TABS FLORINEF TABS **MEDROL TABS** MEDROL DOSEPAK TABS ORAPRED SOLN PEDIAPRED LIQD PREDNISONE INTENSOL CONC 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		ANDRODERM PT24 ANDROGEL ANDROID CAPS DANAZOL CAPS DEPO-TESTOSTERONE OIL TESTOSTERONE PROPIONATE TESTRED CAPS	MC MC/DEL MC MC MC/DEL MC/DEL MC/DEL		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	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	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	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		ENJUVIA **ESTRACE TABS** ESTRATAB 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 -	MC		ORTHO MICRONOR TABS	MC/DEL		CAMILA TABS	If member experienced	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

PROGESTIN ONLY				MC/DEL		ERRIN	adverse reactions, consider using Oral Contraceptives from other groups.	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		JOLIVETTE		
				MC/DEL		NORA-BE TABS		**DDI:** Preferred Oral Contraceptives will now be non-preferred and require prior authorization if it is currently being used in combination with Tracleer.
				MC/DEL		NOR-QD TABS		
							Use PA Form# 20420	
CONTRACEPTIVES - INJECTABLE	MC/DEL		MEDROXYPROGESTERONE ACETATE 150mg IM	MC/DEL		DEPO-PROVERA 150 mg 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		NUVARING RING[3]				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.
	MC		ORTHO EVRA PTWK[1,2,4]					
CONTRACEPTIVES - MONOPHASIC COMBINATION O/C'S	MC/DEL		APRI TABS	MC/DEL		AVIANE TABS	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. **DDI:** Preferred Oral Contraceptives will now be non-preferred and require prior authorization if it is currently being used in combination with Tracleer.
	MC/DEL		BALZIVA	MC/DEL		BEYAZ		
	MC/DEL		CRYSELLE-28 TABS	MC/DEL		BREVICON-28 TABS		
	MC/DEL		DESOGEN TABS	MC/DEL		LESSINA-28 TABS		
			DESOGESTREL/ ETHINYL ESTRADIOL	MC/DEL		LEVORA		
	MC/DEL		LOW-OGESTREL TABS	MC		LOESTRIN TABS		
	MC		MODICON TABS	MC/DEL		LOESTRIN FE TABS		
	MC/DEL		MONONESSA	MC/DEL		LOESTRIN FE 1/20 TABS		
	MC/DEL		NECON 1/50	MC/DEL		LOESTRIN 1.5/30-21 TABS		
	MC		ORTHO-CEPT-28 TABS	MC/DEL		LOESTRIN 1/20-21 TABS		
	MC		ORTHO-CYCLEN-28 TABS	MC		LO/OVRAL 21 TABS		
	MC		ORTHO-NOVUM 1/35-28 TABS	MC/DEL		LO/OVRAL 28 TABS		
	MC/DEL		OVCON-50 28 TABS	MC/DEL		MICROGESTIN FE TABS		
	MC/DEL		PREVIFEM	MC/DEL		NORDETTE-28 TABS		
	MC/DEL		RECLIPSEN	MC/DEL		NORINYL		
	MC/DEL		SOLIA	MC/DEL		NORTREL		
	MC/DEL		SPRINTEC 28 TABS	MC/DEL		OCELLA		
	MC/DEL		YASMIN 28 TABS	MC/DEL		OGESTREL TABS		
	MC/DEL		ZENCHENT	MC/DEL		OVCON-35/28 TABS		
				MC/DEL		OVRAL		
				MC/DEL		PORTIA-28 TABS		
				MC/DEL		SEASONALE		
				MC/DEL		YAZ		
				MC/DEL		ZOVIA		
CONTRACEPTIVES - BI-PHASIC COMBINATIONS	MC		ORTHO-NOVUM 10/11-28 TABS	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. **DDI:** Preferred Oral Contraceptives will now be non-preferred and require prior authorization if it is currently being used in combination with Tracleer.
			NORETHINDRONE-ETH ESTRADIOL TAB 0.5-35/1-35	MC/DEL		KARIVA TABS		
	MC/DEL		SEASONIQUE	MC/DEL		MIRCETTE TABS		
	MC/DEL		LOSEASONIQUE					
CONTRACEPTIVES - TRI-PHASIC COMBINATIONS	MC/DEL		ENPRESSE	MC/DEL		CYCLESSA 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. **DDI:** Preferred Oral Contraceptives will now be non-preferred and require prior authorization if it is currently being used in combination with Tracleer.
	MC/DEL		NECON 7/7/7	MC/DEL		ESTROSTEP FE TABS		
	MC		ORTHO-NOVUM 7/7/7-28 TABS	MC/DEL		NORTREL 7/7/7		
	MC/DEL		TRI-PREVIFEM	MC		ORTHO TRI-CYCLEN TABS		
	MC/DEL		TRIPHASIL 28 TABS	MC		ORTHO TRI-CYCLEN LO TABS		
	MC/DEL		TRI-SPRINTEC	MC/DEL		TRI-NORINYL 28 TABS		
	MC		TRINESSA					

	MC/DEL		TRIVORA-28 TABS				Use PA Form# 20420	
CONTRACEPTIVES - MULTI-PHASIC COMBINATIONS				MC		NATAZIA		
							Use PA Form# 20420	
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		HUMALOG KWIK INJ 100/ML		
	MC/DEL		**LEVEMIR FLEXPEN** [1]	MC		HUMALOG MIX INJ 75/25 KWP		
	MC/DEL		**NOVOLIN PENFILL**[1]	MC		HUMALOG MIX INJ 50/50 KWP		
	MC/DEL		**NOVOLIN 70/30**[1]					
	MC/DEL		NOVOLOG MIX PENFILL[1]					
	MC/DEL		**NOVOLOG PENFILL SOLN**[1]				Use PA Form# 20420	
	MC/DEL		NOVOLOG MIX FLEXPEN[1]					
	MC/DEL		NOVOLOG FLEXPEN[1]					
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.	**DDI:** Onglyza 5mg will require a prior authorization if it is currently being used in combination with drugs known to be significant CYP3A4 inhibitors (ketoconazole, itraconazole, clarithromycin, indinavir, nefazodone, nelfinavir, ritonavir, atazanavir, saquinavir and telithromycin).
	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.	
	MC		KOMBIGLYZE					
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. Use PA Form# 20420	
	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					
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 MC/DEL		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	MC/DEL 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 MC/DEL		GLUCAGON DIAGNOSTIC KIT GLUCAGEN DIAGNOSTIC KIT	Use PA Form# 20420	

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. 4. Please use other preferred agents.	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		**FOSAMAX SOLN**[2]	MC/DEL		BONIVA INJECTION KIT		
	MC/DEL		**MIACALCIN SOLN**[2]	MC/DEL		BONIVA TABS[2, 4]		
				MC		AREDIA SOLR		
				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	5	OMNITROPE	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/DEL		NORDITROPIN CARTRIDGE SOLN[1]	MC	8	INCRELEX[2]		
				MC	8	SAIZEN SOLR[2]		
SOMATOSTATIC AGENTS	MC/DEL		OCTREOTIDE INJ	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		**DETROL 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		**DITROPAN**		
ANTISPASMODICS - LONG ACTING	MC/DEL		**OXYBUTYNIN ER TABS**	MC/DEL	8	ENABLEX[1, 3]	Use PA Form# 20420 2. Product is considered line extension of the original product due to Healthcare Reform (HCR).	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. Vesicare 5mg and Enablex 7.5mg maximum doses if given with drugs known to be significant CYP3A4 inhibitors.(Ketoconazole, Sporanox, Erythromycin, Fluconazole, Biaxin, Nefazodone, Nelfinavir, and Ritonavir)
	MC		SANCTURA	MC	8	DITROPAN XL TBCR		
	MC/DEL		TOVIAZ	MC/DEL	8	**OXYTROL**		
	MC		VESICARE[1]	MC/DEL	9	DETROL LA CP[2]		
				MC	9	SANCTURA XR[2]		

							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.	**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 (except 150mg strength), Sporanox. nefazodone, or diltiazem.
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		**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 SOLN	MC/DEL		**NITROQUICK SUBL**	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		**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/DEL		SOTALOL AF		
				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		SECTRAL CAPS		
	MC/DEL		**METOPROLOL TARTRATE TABS**[1]	MC/DEL		**TENORMIN TABS**		
	MC/DEL		**METOPROLOL ER**	MC/DEL		**TOPROL XL TB24**		
				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 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	**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	preferred long acting diltiazem that does not require PA.	**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	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	Use PA Form# 20420	
				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/DEL		FELODIPINE		
				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 SR CPCR	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		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		SULAR CR		
	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		PACERONE		
	MC/DEL		MULTAQ	MC		QUINIDEX		
	MC/DEL		NORPACE	MC/DEL		TAMBOCOR		
	MC/DEL		PROCAINAMIDE	MC/DEL		TIKOSYN[1]	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		PROPAFENONE	MC		RYTHMOL SR		
	MC		QUINAGLUTE	MC		RYTHMOL		**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					
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/DEL	8	LOTENSIN TABS		
	MC/DEL		RAMIPRIL	MC/DEL	8	MOEXIPRIL		
	MC/DEL		QUINAPRIL	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	8	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	8	COZAAR	Preferred products only available without PA if patient on diabetic therapy or prior ACE therapy.	
	MC/DEL		DIOVAN	MC	8	TEVETEN TABS		
	MC/DEL		LOSARTAN	MC/DEL	8	TRIBENZOR[1]		
	MC/DEL		MICARDIS TABS				1. Use preferred active ingredients which are available without PA.	
DIRECT RENIN INHIBITOR				MC/DEL		TEKTURNA[1]	1. Must show failure of single and combination therapy from all preferred antihypertensive categories	
				MC/DEL		TEKAMLO	Use PA Form# 20420	

ANTIHYPERTENSIVES - CENTRAL	MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL		**CATAPRES-TTS** **CLONIDINE HCL TABS** **GUANFACINE HCL TABS** **HYDRALAZINE HCL TABS** HYLOREL TABS **METHYLDOPA TABS** **MINOXIDIL TABS** **PRAZOSIN HCL CAPS** **RESERPINE TABS**	MC/DEL MC/DEL MC MC MC MC/DEL		**CATAPRES TABS** CLONIDINE TTS GUANABENZ ACETATE TABS ISMELIN TABS MINIPRESS CAPS **TENEX 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.
ACE INHIBITORS AND CA CHANNEL BLOCKERS				MC/DEL MC MC/DEL	8 8 9	**LOTREL CAPS** TARKA TBCR **AMLODIPINE/BENAZEPRIL**	Use individual preferred generic medications. Use PA Form# 20420	
ACE AND THIAZIDE COMBO'S	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		**BENAZEPRIL HCL/HYDROCHLOR** **CAPTOPRIL/HYDROCHLOROTHIA** **ENALAPRIL MALEATE/HCTZ TABS** **LISINOPRIL-HCTZ TABS** **LOTENSIN HCT TABS**	MC/DEL MC MC/DEL MC/DEL MC MC/DEL		**ACCURETIC TABS** MONOPRIL HCT TABS **PRINZIDE TABS** **UNIRETIC TABS** VASERETIC TABS **ZESTORETIC 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.
BETA BLOCKERS AND DIURETIC COMBO'S	MC/DEL MC/DEL MC/DEL		**ATENOLOL/CHLORTHALIDONE** **BISOPROLOL FUMARATE/HCTZ** **PROPRANOLOL/HCTZ**	MC MC/DEL MC MC MC/DEL		CORZIDE TABS **LOPRESSOR HCT TABS** TENORETIC TIMOLIDE 10/25 TABS **ZIAC 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.
ARB'S AND CA CHANNEL BLOCKERS	MC/DEL MC/DEL MC/DEL		**AZOR** **EXFORGE** **EXFORGE HCT**	MC/DEL		**TWYNSTA**	Preferred products only available without PA if patient on diabetic therapy or prior ACE therapy.	
ARB'S AND DIURETICS	MC MC/DEL MC/DEL MC/DEL MC/DEL		**AVALIDE TABS** BENICAR HCT DIOVAN HCT TABS LOSARTAN HCT MICARDIS HCT TABS	MC/DEL MC/DEL MC		**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	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.
ARB'S AND DIRECT RENIN INHIBITOR COMBINATION	MC/DEL		**VALTURNA**				Use PA Form# 20420	
DIURETICS	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		**ACETAZOLAMIDE TABS** **BUMETANIDE** **CHLOROTHIAZIDE TABS** **CHLORTHALIDONE TABS** EDECRIN TABS **FUROSEMIDE** **HYDROCHLOROTHIAZIDE** **INDAPAMIDE TABS** **METHAZOLAMIDE TABS** **METHYCLOTHIAZIDE TABS** **SPIRONOLACTONE 25MG TABS** **SPIRONOLACTONE/HYDRO** **TORSEMIDE TABS** **TRIAMTERENE/HCTZ** ZAROXOLYN TABS	MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC MC MC/DEL MC/DEL MC MC/DEL MC MC/DEL		**ALDACTAZIDE TABS** **ALDACTONE TABS** AMILORIDE HCL **BUMEX TABS** **DEMADEX TABS** **DIAMOX** **DIURIL** **DYAZIDE CAPS** ENDURON TABS INSPRA **LASIX TABS** **MAXZIDE** MICROZIDE CAPS **MIDAMOR TABS** NAQUA TABS **SPIRONOLACTONE 50MG**[1]	1. Multiples of Spironolactone 25 mg are cheaper than 50 mg strength. Inspra will be approved for severe breast tenderness and male gynecomastia. 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.
CCB / LIPID	MC/DEL		**CADUET**					
LIPID DRUGS								
CHOLESTEROL - BILE SEQUESTRANTS	MC/DEL MC/DEL		**CHOLESTYRAMINE** **COLESTIPOL HCl**	MC/DEL MC/DEL MC MC/DEL		**COLESTID** **PREVALITE** **QUESTRAN** WELCHOL 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.
CHOLESTEROL - FIBRIC ACID DERIVATIVES	MC/DEL MC/DEL MC MC		**GEMFIBROZIL TABS** NIASPAN TRICOR TRILIPIX	MC MC MC MC MC MC/DEL MC		ANTARA LOPID FIBRICOR LIPOFEN LOFIBRA FENOFIBRATE TRIGLIDE	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).
CHOLESTEROL - HGM COA + ABSORB INHIBITORS MORE POTENT	MC/DEL MC/DEL		**LIPITOR** **SIMVASTATIN**[1]	MC/DEL MC		**CRESTOR** **VYTORIN**[2]	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.

POTENT DRUGS/COMBINATIONS				MC/DEL		**ZOCOR**	consolidation list. 2. Only available if component ingredients are unavailable. Use PA Form# 20420	drug and the preferred drug(s) exists. **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	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	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[4]	MC MC/DEL MC		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 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		LETAIRIS[1, 2]	MC		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.	Tracleer approvals will require WHO Group 1 diagnosis of primary PAH (Primary Pulmonary Hypertension) and NYHA functional class 3 or 4. **DDI:** Preferred Oral Contraceptives will now be non-preferred and require prior authorization if it is currently being used in combination with Tracleer. 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		MECLIZINE HCL TABS PROMETHAZINE SUPP PROMETHAZINE TRANSDERM-SCOP PT72	MC MC/DEL MC/DEL MC/DEL MC		ANTIVERT TABS PHENERGAN SOLN 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		MARINOL CAPS ONDANSETRON TABS* [2] ONDANSETRON ODT TBDP* [2]	MC/DEL MC MC	5 8 8	GRANISETRON ALOXI ANZEMET TABS	*See quantity limit table. 1. Approvals will require diagnosis of chemo-induced nausea/vomiting	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.

	MC		ONDANSETRON INJ*	MC	8	CESAMET[1]	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	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]		
				MC/DEL	8	KYTRIL		
				MC	8	SANCUSO		
				MC/DEL	8	ZOFRAN ODT TBDP*		
				MC/DEL	8	ZOFRAN TABS*		
				MC/DEL	8	ZOFRAN INJ*		
				MC	8	ZUPLENZ		
NON-SEDATING ANTIHISTAMINES / DECONGESTANTS								
ANTIHISTIMINES - NON-SEDATING	MC		ALAVERT TABS	MC/DEL	5	CLARINEX TABS[1]	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.
	MC/DEL		CETIRIZINE TABS	MC/DEL	5	CLARINEX SYR[1,2]		
	MC		CLARITIN (OTC)	MC/DEL	5	FEXOFENADINE[1]		
	MC		CLARITIN SYRP (OTC)	MC/DEL	5	ZYRTEC[1]		
	MC/DEL		LORATADINE	MC/DEL	5	ZYRTEC SYR[1,2]		
	MC/DEL		TAVIST ND (OTC)	MC/DEL	8	ALLEGRA[3]		
				MC/DEL	8	CLARITIN[3]		
				MC/DEL	8	LORATADINE ODT[4]		
				MC/DEL	8	XYZAL[3]		
ANTIHISTIMINES - OTHER	MC/DEL		CLEMASTINE					
	MC/DEL		CHLORPHENIRAMINE					
	MC/DEL		DIPHENHYDRAMINE					
ALLERGY / ASTHMA THERAPIES								
ANTIASTHMATIC - ANTICHOLINERGICS - INHALER	MC/DEL		SPIRIVA[1,2]				1. Quantity limit of 1 inhalation daily (1 capsule for inhalation daily) Spiriva will require PA if Combivent or Atrovent 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		CROMOLYN SODIUM NEBU	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		FLUTICASONE SPR	MC/DEL	5	BECONASE AQ INHA[1]	Use PA Form# 20420 Dosing limits apply to whole category, please see dosage consolidation list. 1. All preferred drugs must	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		NASONEX SUSP	MC/DEL	5	NASACORT AQ AERS[1]		
				MC/DEL	8	FLONASE SUSP[2]		
				MC/DEL	8	FLUNISOLIDE SOLN[2]		

				MC	8	NASACORT AERS[2]	be tried before moving to non preferred steps.	
				MC/DEL	8	OMNARIS SPR		
				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.	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		**SEREVENT**	MC/DEL		**BRETHINE**		
	MC/DEL		**TERBUTALINE SULFATE TABS**	MC/DEL		**FORADIL AEROLIZER CAPS**		
	MC/DEL		**VENTOLIN HFA AERS[3]**	MC/DEL		**VENTOLIN AERS**		
				MC		VOLMAX TBCR	3. Dosing limits apply, please see dosage consolidation list.	
				MC		VOSPIRE ER TB12		
				MC/DEL		**XOPENEX HFA[3]**		
				MC/DEL		**XOPENEX NEBU[1,2]**	Use PA Form# 20420	
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		DULERA					
	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/DEL		**THEO-24 CP24**	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		THEOLAIR TABS		
	MC/DEL		THEOLAIR-SR TB12	MC/DEL		**UNIPHYL TBCR**		
	MC/DEL		**THEOPHYLLINE CR TB12**					
	MC/DEL		THEOPHYLLINE ELIX					
	MC/DEL		THEOPHYLLINE SOLN					
	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.	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		**FLOVENT DISKUS**	MC	5	BECLOVENT AERS[2]		
	MC/DEL		**FLOVENT HFA**	MC	5	VANCERIL AERS[2]		
	MC/DEL		**PULMICORT SUSP[1]**	MC/DEL	8	**AEROBID-M AERS[3]**		
	MC		QVAR AERS	MC/DEL	8	ALVESCO		
				MC	8	VANCERIL DOUBLE STRENGTH AERS[3]		
				MC/DEL	8	**PULMICORT FLEXHALER**		

							Use PA Form# 20420	
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	MC/DEL		ACCOLATE TABS	**Use PA Form # 20420**	
ANTIASTHMATIC - ALPHA-PROTEINASE INHIBITOR				MC		GLASSIA	Use PA Form# 20420	Prolastin and Azemaira will be approved for members with A1AT deficiency and clinically demonstrable panacinar emphysema.
				MC		PROLASTIN SUSR		
				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, 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		DIPHENOXYLATE/ATROPINE	MC		LONOX TABS		
	MC/DEL		LOPERAMIDE HCL CAPS/LIQ	MC/DEL		MOTOFEN TABS		
	MC/DEL		OPIUM TINCTURE TINC					
	MC		PAREGORIC TINC					
GI - ANTI-DIARRHEAL/ ANTACID - MISC.	MC/DEL		ATROPINE SULFATE SOLN	MC		BELLADONNA ALKALOIDS & OP	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/DEL		BENTYL TABS		
	MC/DEL		BISMATROL	MC/DEL		GLYCOPYRROLATE INJ		
	MC/DEL		BISMUTH SUBSALICYLATE	MC/DEL		HYOSCYAMINE SL		
	MC/DEL		CALCIUM CARBONATE (ANTACID) CHEW	MC/DEL		LEVBID TB12		
	MC/DEL		DICYCLOMINE HCL	MC		LEVSIN ELIX		
	MC/DEL		GLYCOPYRROLATE TABS	MC/DEL		LEVSIN TABS		
	MC		HAPONAL TABS	MC/DEL		LEVSIN/SL SUBL		
	MC/DEL		HYOSCYAMINE CAPS & TABS	MC/DEL		NULEV TBDP		
	MC/DEL		HYOSCYAMINE SULFATE	MC		ROBINUL INJ		
	MC/DEL		KAOPECTATE	MC		ROBINUL TABS		
	MC/DEL		MAGNESIUM OXIDE TABS					
	MC		MAG-OX 400 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). **DDI:** Cimetidine will require prior authorization if being used in combination with Plavix.
	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		ZANTAC SYRUP		
				MC/DEL		ZANTAC TABS		
GI - PROTON PUMP INHIBITOR	MC/DEL		DEXILANT (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	8	OMEPRAZOLE-SODIUM BICARBONATE CAPS		
				MC/DEL	8	LANSOPRAZOLE		
				MC	9	OMEPRAZOLE 40MG[3]		

				MC/DEL	9	PANTOPRAZOLE	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:** Omeprazole will require prior authorization if being used in combination with Plavix. **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		CREON[1] LACTASE CHEW LACTASE TAB ZENPEP[1]	MC/DEL MC/DEL MC/DEL MC/DEL MC MC MC		LACTRASE CAPS LIPRAM LIPRAM CR KU-ZYME CAPS PANCREASE PANOKASE TABS TRIPASE	Use PA Form# 20420 1. Clinical PA is required to establish CF diagnosis and medical necessity. In all cases except cystic fibrosis patients, objective evidence of pancreatic insufficiency (fat malabsorption test etc...) must be supplied.	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.
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 MC/DEL MC/DEL MC/DEL MC/DEL		ASACOL TBEC 400 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 MC/DEL MC		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.	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		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	MC/DEL MC MC/DEL 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 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)	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/DEL		MILK OF MAGNESIA SUSP	MC		MIRALAX POWD (OTC versions)		
	MC		MINERAL OIL OIL	MC		PEG 3350/ELECTROLYTES SOLR		
	MC		NULYTELY SOLR	MC/DEL		SENEXON TABS		
	MC/DEL		SENNA	MC/DEL		SENOKOT TABS		
	MC/DEL		SENOKOT GRAN	MC		SENOKOT S TABS		
	MC/DEL		SENOKOT SYRP	MC		STOOL SOFTENER PLUS CAPS		
	MC/DEL		SENOKOT CHILDRENS SYRP	MC/DEL		UNI-CENNA TABS		
	MC		SENOKOT XTRA TABS	MC		UNI-EASE PLUS CAPS		
	MC/DEL		SORBITOL	MC		V-R NATURAL SENNA LAXATIV TABS		
	MC/DEL		STOOL SOFTENER CAPS	MC		URSO 250		
	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		MACRODANTIN CAPS		
	MC/DEL		MONUROL PACK	MC/DEL		NITROFURANTOIN MACR CAPS		
	MC/DEL		NEOSPORIN GU IRRIGANT SOLN	MC		POTASSIUM CITRATE/CITRIC SOLN		
	MC/DEL		PHENAZOPYRIDINE HCL TABS	MC/DEL		PYRIDIUM PLUS TABS		
	MC/DEL		PHENAZOPYRIDINE PLUS	MC		PYRIDIUM TABS		
	MC/DEL		PROSED/DS TABS	MC/DEL		RENACIDIN SOLN		
	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		RENAGEL 800	Use PA Form# 20420 1. Diag required.	
	MC/DEL		MAGNEBIND - 400[1]					
	MC/DEL		RENAGEL 400[1]					
	MC/DEL		FOSRENOL[1]					
	MC/DEL		RENVELA[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 products before 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.
	MC/DEL		**PREMARIN CREA**	MC/DEL		VAGIFEM TABS		

VAGINAL - OTHER	MC/DEL		ACID JELLY GEL	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.
	MC		ACI-JEL GEL					
	MC		CERVICAL AMINO ACID CREA					
BPH								
BPH	MC/DEL		**DOXAZOSIN MESYLATE TABS**	MC/DEL	5	**FLOMAX CP24**	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	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.
	MC/DEL		FINASTERIDE[1]	MC/DEL	8	AVODART[2]		
	MC/DEL		TERAZOSIN HCL CAPS	MC/DEL	8	**CARDURA TABS**		
	MC/DEL		**TAMSULOSIN**	MC/DEL	8	JALYN[3]		
				MC/DEL	8	PROSCAR TABS		
				MC/DEL	8	RAPAFLO		
				MC/DEL	8	UROXATRAL		
ANXIOLYTICS								
ANXIOLYTICS - BENZODIAZEPINES	MC/DEL		ALPRAZOLAM TABS	MC/DEL		ALPRAZOLAM ER	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		CHLORDIAZEPOXIDE HCL CAPS	MC/DEL		ATIVAN		
	MC/DEL		CLORAZEPATE DIPOTASSIUM TABS	MC/DEL		NIRAVAM		
	MC/DEL		DIAZEPAM	MC/DEL		SERAX		
	MC/DEL		LORAZEPAM	MC/DEL		TRANXENE		
	MC/DEL		OXAZEPAM CAPS	MC/DEL		XANAX TABS		
				MC/DEL		XANAX XR		
ANXIOLYTICS - MISC.	MC/DEL		BUSPIRONE HCL TABS	MC		BUSPAR 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		HYDROXYZINE HCL SOLN	MC		DROPERIDOL SOLN		
	MC		HYDROXYZINE HCL SYRP	MC/DEL		HYDROXYZINE HCL TABS		
	MC/DEL		HYDROXYZINE PAMOATE CAPS	MC/DEL		HYDROXYZINE PAM 100MG CAPS		
	MC/DEL		MEPROBAMATE TABS	MC/DEL		VISTARIL		
ANTI-DEPRESSANTS								
ANTIDEPRESSANTS - MAO INHIBITORS	MC/DEL		NARDIL TABS					
	MC/DEL		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 Venlafaxine ER tabs) 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		BUPROPION HCL TABS	MC/DEL	8	APLENZIN[7]	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. 7. Provide clinical documentation as to why a preferred generic alternative cannot be used.	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. **CYMBALTA:** Fibromyalgia diagnosis- prior use and failure of preferred generics (amitriptyline or cyclobenzaprine) and gabapentin prior to approval. **SAVELLA:** Fibromyalgia diagnosis and trial of a preferred generic (amitriptyline or cyclobenzaprine, and gabapentin) and Cymbalta prior to approval. 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. **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 Onglyza 5mg, Enablex 15mg or Vesicare 10mg. **DDI:** Fluoxetine will require prior authorization if being used in combination with Plavix. **DDI:** Fluvoxamine will require prior authorization if being used in combination with Plavix. 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.
	MC/DEL		CITALOPRAM[4]	MC/DEL	8	EFFEXOR TABS		
	MC/DEL		FLUOXETINE HCL CAPS	MC/DEL	8	EFFEXOR XR CP24 [3, 10]		
	MC/DEL		FLUOXETINE HCL LIQD	MC/DEL	8	FLUOXETINE 40 mg CAPS[1]		
	MC/DEL		FLUOXETINE HCL 10mg TABS	MC/DEL	8	FLUOXETINE 20mg TABS[6]		
	MC/DEL		FLUVOXAMINE MALEATE TABS	MC	8	LUVOX TABS		
	MC/DEL		LEXAPRO TABS[4]	MC	8	MAPROTILINE HCL TABS		
	MC/DEL		MIRTAZAPINE	MC/DEL	8	MIRTAZAPINE ODT		
	MC/DEL		NEFAZODONE	MC	8	OLEPTRO		
	MC/DEL		PAROXETINE[3]	MC/DEL	8	PAROXETINE CR[3]		
	MC/DEL		SERTRALINE[2]	MC/DEL	8	PAXIL[3]		
	MC/DEL		TRAZODONE HCL TABS	MC/DEL	8	PAXIL CR[3]		
	MC/DEL		VENLAFAXINE ER TABS[9]	MC/DEL	8	PRISTIQ		
				MC	8	PROZAC		
				MC	8	PROZAC CAPS		
				MC	8	PROZAC WEEKLY CPDR		
				MC/DEL	8	REMERON TABS		
				MC/DEL	8	SARAFEM CAPS		
				MC/DEL	8	TRAZODONE HCL 300MG TABS		
				MC/DEL	8	WELLBUTRIN TABS		
				MC/DEL	8	WELLBUTRIN SR TBCR		
				MC/DEL	8	WELLBUTRIN XL		
				MC/DEL	8	REMERON SOLTAB TBDP		
				MC/DEL	8	SAVELLA[8]		
				MC/DEL	8	ZOLOFT		
				MC/DEL	8	VENLAFAXINE CAPS		

				MC/DEL	9	FLUOXETINE 90mg TABS	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. 10. Use venlafaxine ER tabs. 11. Established users are grandfathered. 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. 1. Use multiples of 50mg. 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/DEL	*	**CLOMIPRAMINE HCL CAPS**	MC/DEL		**ANAFRANIL CAPS**		
	MC/DEL	*	**DESIPRAMINE HCL TABS**	MC/DEL		**DOXEPIN HCL 150 MG**[1]		
	MC/DEL	*	**DOXEPIN HCL**	MC/DEL		**NORPRAMIN TABS**		
	MC/DEL	*	**IMIPRAMINE HCL TABS**	MC/DEL		**PAMELOR**		
	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		HALCION TABS	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		MIDAZOLAM HCL SYRP		
	MC/DEL		FLURAZEPAM HCL CAPS	MC/DEL		RESTORIL CAPS		
	MC/DEL		TEMAZEPAM CAPS 15 & 30MG	MC/DEL		TEMAZEPAM 7.5MG		
	MC/DEL		TRIAZOLAM TABS					
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 [3,4]	MC/DEL	8	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[4]	MC	8	FANAPT		
	MC/DEL		RISPERIDONE TAB[4]	MC	8	INVEGA		
	MC/DEL		RISPERIDONE SOLN[4]	MC	8	INVEGA SUSTENNA		
	MC/DEL		SEROQUEL TABS[4]	MC	8	RISPERDAL TAB		
	MC		ZYPREXA TABS[4]	MC	8	RISPERDAL CONSA [2]		
				MC	8	RISPERDAL M TAB[2]		
				MC	8	RISPERDAL SOLN		
				MC/DEL	8	RISPERIDONE ODT	Please use Miscellaneous PA form # 20420 for non-	

				MC/DEL	8	SAPHRIS	preferred single therapy atypical requests.	**Seroquel 50mg** tablets are non-preferred and multiple Seroquel 25mg tablets should be used.
				MC/DEL	8	SEROQUEL 50MG TABS[1,2]	1. Please use multiple 25mg tablets.	
				MC	8	ZYPREXA ZYDIS TBDP [2]		**DDI:** Abilify, Seroquel, and Zyprexa will now be non-preferred and require prior authorization if they are currently being used in combination with carbamazepine.
				MC	8	ZYPREXA RELPREVV		
				MC/DEL	9	SEROQUEL XR[5]	2. Established users of single therapy atypicals were grandfathered.	**Atypicals:** Prior Authorization will be required for preferred medication to assure indication is in accordance with FDA approved or literature supported evidence-based best practices. The approved indications are: • schizophrenia • bipolar disorder • agitation related to autism • severe behavioral dyscontrol with risk of imminent need for emergency services such as the emergency room, crisis services, or an inpatient psychiatric facility.
							3. Abilify requires splitting of tab to avoid PA. Please see Abilify splitting table.	
							4. Prior Authorization will be required for preferred medications for members under the age of 5.	
							5. 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.	
ANTIPSYCHOTICS - SPECIAL ATYPICALS	MC/DEL		CLOZAPINE TABS	MC/DEL		CLOZARIL TABS	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.
				MC		FAZACLO		
ANTIPSYCHOTICS - TYPICAL	MC/DEL		CHLORPROMAZINE HCL	MC/DEL		COMPAZINE	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.
	MC/DEL		FLUPHENAZINE DECANOATE	MC/DEL		COMPRO SUPP		
	MC/DEL		FLUPHENAZINE HCL	MC		HALDOL DECANOATE		
	MC		HALDOL	MC/DEL		LOXITANE CAPS		
	MC/DEL		HALOPERIDOL	MC		MELLARIL		
	MC		HALOPERIDOL DECANOATE SOLN	MC/DEL		NAVANE CAPS		
	MC		HALOPERIDOL LACTATE SOLN	MC		PROLIXIN		
	MC/DEL		LOXAPINE SUCCINATE CAPS	MC		STELAZINE TABS		
	MC/DEL		LOXITANE-C CONC					
	MC		MOBAN TABS					
	MC/DEL		PERPHENAZINE					
	MC/DEL		PROCHLORPERAZINE					
	MC		SERENTIL					
	MC/DEL		THIORIDAZINE HCL					
	MC/DEL		THIOTHIXENE					
	MC/DEL		TRIFLUOPERAZINE HCL TABS					
LITHIUM								
LITHIUM	MC/DEL		LITHIUM CARBONATE	MC/DEL		ESKALITH CAPS	Use PA Form# 20420	
	MC/DEL		LITHIUM CITRATE SYRP	MC/DEL		ESKALITH CR TBCR		
COMBINATION - PSYCHOTHERAPEUTIC								
PSYCHOTHERPEUTIC COMBINATION	MC/DEL		CHLORDIAZEPOXIDE/AMITRIPT	MC	8	SYMBYAX[1]	1. Only available if component ingredients are unavailable. Use PA Form# 20420	
	MC/DEL		PERPHENAZINE/AMITRIPTYLIN					
STIMULANTS								
STIMULANT - AMPHETAMINES SHORT ACTING	MC/DEL		ADDERALL TABS				Preferred stimulants will be available without PA if diagnosis of ADHD.As per recent FDA alert, Adderal & Dexedrinel should not be	
	MC/DEL		AMPHETAMINE SALT COMBO					
	MC/DEL		DEXTROAMPHET SULF TABS					
	MC/DEL		DEXEDRINE					

	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/DEL MC		CONCERTA TBCR DAYTRANA[1] FOCALIN XR	MC MC/DEL	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 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	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 MC/DEL MC/DEL MC MC	7 8 8 8 8 8 9 9	STRATTERA[1, 2] CAFCIT SOLN[3] INTUNIV [3,4] KAPVAY 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	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 MC		XYREM SOL XENAZINE	Use PA Form # 20710	
WEIGHT LOSS								
WEIGHT LOSS							No longer covered: PHENTERMINE, XENICAL,DIREX, 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 MC/DEL		ARICEPT TABS[1] ARICEPT ODT NAMENDA[1]	MC/DEL MC/DEL MC	8 8 8	DONEPEZIL HYDROCHLORIDE TABS & ODT EXELON[2] RAZADYNE[2]	1. PA is required to establish dementia diagnosis and baseline mental status score 2	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	RIVASTIGMINE TARTRATE CAPS[2]	mental status score. 2. Must fail all preferred products before moving to non-preferred. Use PA Form# 20420	
				MC	9	COGNEX CAPS[2]		
SMOKING CESSATION								
NICOTINE PATCHES / TABLETS	MC/DEL		CHANTIX[1, 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.	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]					
	MC/DEL		NICOTINE DIS PT24[2]					
NICOTINE REPLACEMENT - OTHER	MC/DEL		NICOTINE POLACRILEX GUM[2]	MC/DEL	5	COMMIT LOZENGES[1]	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.	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		
				MC/DEL	8	NICOTROL NASAL SPRAY		
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/DEL		ESGIC-PLUS		
	MC/DEL		ASPRIN/ APAP/ CAFF TAB	MC/DEL		FIORICET TABS		
	MC/DEL		BUTAL/ASA/CAFF	MC		FIORINAL CAPS		
	MC/DEL		BUTALBITAL COMPOUND	MC		FIORTAL CAPS		
	MC/DEL		BUTALBITAL/ACET TABS	MC/DEL		FORTABS TABS		
	MC/DEL		BUTALBITAL/APAP CAPS	MC		PHRENILIN TABS		
	MC/DEL		BUTALBITAL/APAP/CAFFEINE	MC		PHRENILIN FORTE CAPS		
	MC/DEL		**CHOLINE MAGNESIUM TRISALI**	MC		TRILISATE LIQD		
	MC/DEL		**DIFLUNISAL TABS**	MC		TRILISATE TABS		
	MC		EXCEDRIN	MC		ZEBUTAL CAPS		
	MC/DEL		**SALSALATE TABS**	MC		ZORPRIN TBCR		
LONG ACTING NARCOTICS								
NARCOTICS - LONG ACTING	MC		AVINZA	MC/DEL	8	ABSTRAL	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	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 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
	MC/DEL		FENTANYL PATCH[5]	MC/DEL	8	BUTRANS		
	MC		KADIAN[6]	MC	8	DURAGESIC PT72[5]		
	MC/DEL		METHADONE	MC/DEL	8	EMBEDA		
	MC/DEL		METHADOSE		8	EXALGO		
	MC/DEL		MORPHINE SULFATE ER TB12	MC/DEL	8	MORPHINE SULFATE SUPP		
				MC/DEL	8	MS CONTIN TB12		
				MC/DEL	8	ORAMORPH SR TB12		
				MC/DEL	8	OXYCONTIN TB12[1,4]		
				MC/DEL	9	OXYCODONE ER[3]		
				MC	9	OPANA ER		

							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; 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 10. Requests for any Brand name controlled 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 1. Only available if component ingredients are unavailable.	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	STADOL NS SOLN		
				MC	8	ULTRACET TABS[1]		
				MC	8	ULTRAM TABS		
				MC	8	ULTRAM ER		
				MC/DEL	9	RYZOLT		
MISCELLANEOUS NARCOTICS								
NARCOTICS - MISC.	**MC/DEL**		ACETAMINOPHEN/CODEINE	**MC/DEL**	8	ASCOMP/CODEINE CAPS	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 manufacturer's products will be available without prior authorization.	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	BUTALBITAL/APAP/CAFFEINE/ CAPS		
	MC/DEL		BUTAL/ASA/CAFF/COD CAPS	**MC**	8	DEMEROL		
	MC		BUTALBITAL/ASPIRIN/CAFFEI CAPS	**MC/DEL**	8	DILAUDID		
	MC		CAPITAL AND CODEINE SUSP[1]	**MC**	8	DILAUDID-HP SOLN		
	MC		CAPITAL/CODEINE SUSP[1]	**MC**	8	FENTANYL CITRATE SOLN		
	MC/DEL		CODEINE PHOSPHATE SOLN	**MC/DEL**	8	FENTORA		
	MC/DEL		CODEINE SULFATE TABS	**MC/DEL**	8	FIORICET/CODEINE CAPS		
	MC/DEL		ENDOCET TABS[3]	**MC**	8	FIORINAL/CODEINE #3 CAPS		
	MC/DEL		ENDODAN TABS	**MC**	8	FIORTAL/CODEINE CAPS		
	MC/DEL		FENTANYL OT LOZ[1]	**MC/DEL**	8	HYDROCODONE/IBUPROFEN		
	MC/DEL		HYDROCODONE BITARTRATE/AP TABS	**MC/DEL**	8	LORCET		
	MC/DEL		HYDROCODONE/ACETAMINOPHEN	**MC**	8	LORTAB		
	MC/DEL		HYDROMORPHONE HCL[3]	**MC**	8	MAXIDONE TABS		
	MC/DEL		MEPERIDINE HCL	**MC/DEL**	8	NORCO TABS		
	MC/DEL		OXYCODONE 5MG	**MC/DEL**	8	NUCYNTA		
	MC/DEL		OXYCODONE 15MG	**MC/DEL**	8	ONSOLIS		
	MC/DEL		OXYCODONE 30MG	**MC**	8	OPANA		
	MC/DEL		OXYCODONE/ACETAMINOPHEN[2,3]	**MC/DEL**	8	OXYCODONE 10MG		
	MC/DEL		PENTAZOCINE/NALOXONE TABS	**MC/DEL**	8	OXYCODONE 20MG		
	MC		PROPOXYPHENE CMPND-65 CAPS	**MC/DEL**	8	OXYCODONE/APAP 10/650		
	MC		PROPOXYPHENE COMPOUND CAPS	**MC/DEL**	8	OXYCODONE/APAP 7.5/500		

	MC/DEL		PROPOXYPHENE HCL CAPS	MC/DEL	8	PENTAZOCINE/ACET TABS		
	MC/DEL		PROPOXYPHENE/ACET TABS	MC	8	PERCOCET TABS		
	MC/DEL		PROPOXYPHENE-N/ACET TABS	MC	8	PERCOCET TABS		
	MC/DEL		ROXICET	MC	8	PHRENILIN W/CAFFEINE/CODE CAPS		
	MC		ROXIPRIN TABS	MC/DEL	8	ROXICET 5/500 TABS		
				MC	8	ROXICODONE TABS		
				MC	8	SYNALGOS-DC CAPS		
				MC	8	TALACEN TABS		
				MC	8	TYLENOL/CODEINE #3 TABS		
				MC	8	TYLOX CAPS	Use PA Form# 20420	
				MC	8	VICODIN		
				MC	8	VICOPROFEN TABS		
				MC	8	ZYDONE TABS		
				MC	9	ACTIQ LPOP		
OPIOID DEPENDENCE TREATMENTS	MC		SUBOXONE*	MC		SUBUTEX[1]	Use PA Form# 20420 1. Subutex will only be approved for use during pregnancy. *See Criteria Section	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. Suboxone Criteria 1-Induction period for new starts max of 60 days 2-Max dose of 32 mg for induction 3-Max dose of 16 mg for maintenance 4-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. 5- Prescribers limited to those with X-DEA 6- Should be evidence provided of monthly monitoring including random pill counts urine drug tests and prescription monitoring program reports.
				MC/DEL		BUPRENORPHIN		
NARCOTIC ANTAGONISTS								
NARCOTIC - ANTAGONISTS	MC/DEL		NALTREXONE HCL TABS	MC/DEL		REVIA TABS[1]	Use PA Form# 20420 Use PA form #30400 for Vivitrol requests.	1. Will only be approved for side effects experienced with generic that are not described in the literature as occurring with the brand version. 2. Please see the criteria listed on the Vivitrol PA form. Any narcotics attempting to be filled during Vivitrol approval will require prior authorization.
				MC/DEL		VIVITROL INJ[2]		
COX 2 / NSAIDS								
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 severe acute 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.	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]					
NSAIDS	MC/DEL		**CHILDRENS IBUPROFEN**	MC		ADVIL TABS	The FDA has issued a Public Health Advisory warning of the potential for increased cardiovascular	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 2 different NSAID classes as described in the COX-II PA form.
	MC/DEL		**DICLOFENAC POTASSIUM TABS**	MC		ANAPROX TABS		
	MC/DEL		**DICLOFENAC SODIUM**	MC		ANAPROX DS TABS		

	MC/DEL		**ETODOLAC**	MC		CAMBIA	Increased cardiovascular risk & GI bleeding with NSAID use.	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.
	MC/DEL		**FENOPROFEN CALCIUM TABS**	MC/DEL		**CATAFLAM TABS**		
	MC/DEL		**FLURBIPROFEN TABS**	MC		CHILDRENS ADVIL SUSP		
	MC/DEL		**IBUPROFEN**	MC		CHILD'S IBUPROFEN SUSP		
	MC/DEL		**INDOMETHACIN**	MC/DEL		CHILDREN'S MOTRIN SUSP	Use PA Form# 20420	
	MC/DEL		**KETOPROFEN**	MC/DEL		**CLINORIL TABS**		
	MC/DEL		**MECLOFENAMATE SODIUM CAPS**	MC/DEL		**DAYPRO TABS**		
	MC/DEL		NAPROSYN SUSP	MC/DEL		**EC-NAPROSYN TBEC**		**DDI:** Diclofenac will now be non-preferred and require prior authorization if it is currently being used in combination with lescol.
	MC/DEL		NAPROXEN SUSP	MC/DEL		**ETODOLAC ER 600MG**		
	MC/DEL		**NAPROXEN TABS**	MC		FELDENE CAPS		
	MC/DEL		**NAPROXEN SODIUM TABS**	MC/DEL		IBU-200		
	MC/DEL		**OXAPROZIN TABS**	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		PENNSAID		
				MC/DEL		**PIROXICAM CAPS**		
				MC		PONSTEL CAPS		
				MC		SB IBUPROFEN TABS		
				MC		TOLECTIN		
				MC/DEL		VOLTAREN		
				MC		V-R IBUPROFEN TABS		
NSAID - PPI				MC		PREVACID NAPRA-PAC	1. Use a preferred NSAID and PPI separately.	
				MC/DEL		VIMOVO[1]		
RHEUMATOID ARTHRITIS								
RHEUMATOID ARTHRITIS	MC/DEL	1	**AZATHIOPRINE**	MC/DEL		**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/DEL		ACTEMRA		
	MC/DEL	1	LEFLUNOMIDE	MC		**KINERET SOLN**		
	MC/DEL	1	METHOTREXATE	MC		ORENCIA		
	MC/DEL	1	**SULFASALAZINE TABS**	MC		**REMICADE**		
	MC/DEL	2	CIMZIA[1]	MC		**ENBREL 50MG**[3]		
	MC	2	**ENBREL 25MG INJECTIONS ONLY**[1, 4]	MC		SIMPONI		
	MC	2	**HUMIRA**[1, 2]					
MISCELLANEOUS ARTHRITIS								
ARTHRITIS - MISC.	MC		RIDAURA CAPS	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.
	MC		MYOCHRYSINE SOLN					
MIGRAINE THERAPIES								
MIGRAINE - ERGOTAMINE DERIVATIVES	MC/DEL		MIGRANAL SOLN	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.
	MC		SANSERT TABS					
MIGRAINE - CARBOXYLIC ACID DERIVATIVES	MC		DIVALPROEX ER TB24	MC		DEPAKOTE ER TB24		
MIGRAINE - SELECTIVE SEROTONIN AGONISTS (5HT)--Tabs	MC/DEL		MAXALT MLT	MC/DEL		AMERGE TABS	All drugs in this category have dosing limits. Please refer to dose consolidation table. 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. Quantity limit exceptions will require ongoing therapy with therapeutic doses of highly effective prophylactic medication as listed on the Triptan PA form.
	MC/DEL		NARATRIPTAN HCl TABS	MC		AXERT TABS		
	MC/DEL		SUMATRIPTAN TABS	MC/DEL		FROVA TABS		
				MC/DEL		MAXALT		
				MC/DEL		IMITREX TABS		
				MC/DEL		RELPAX		
				MC/DEL		ZOMIG TABS		
				MC/DEL		ZOMIG NASAL SPARY		

				MC/DEL		ZOMIG ZMT TBDP	Use PA Form # 10110	
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. Treximet only available if component ingredients of sumatriptan and naproxen are unavailable.	
MIGRAINE - MISC.	MC/DEL MC/DEL		CAFERGOT TABS SPASTRIN TABS	MC/DEL MC MC/DEL		MIGRAZONE CAPS BELCOMP-PB SUPP MIGERGOT SUP	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		**ALLOPURINOL TABS** **COLCHICINE TABS** **PROBENECID TABS** **PROBENECID/COLCHICINE TABS**	MC MC/DEL MC		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.	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		CARBAMAZEPINE CARBATROL CP12 CELONTIN CAPS CLONAZEPAM TABS DEPAKOTE SPRINKLES CPSP DIASTAT[1] DILANTIN DIVALPROEX SODIUM EPITOL TABS ETHOSUXIMIDE SYRP FELBATOL GABAPENTIN[2] LAMOTRIGINE[2] LEVETIRACETAM SOLN/TABS MYSOLINE TABS OXCARBAZEPINE PHENYTEK CAPS PHENYTOIN TEGRETOL TOPIRAMATE TOPIRAMATE SPRINKLE CAPS[2] TRILEPTAL SUSP VALPROIC ACID ZARONTIN CAPS ZONISAMIDE	MC MC MC MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL 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	8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 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[3] PRIMIDONE TABS SABRIL TOPAMAX TOPAMAX SPRINKLE CAPS[2] TRILEPTAL VIMPAT[4] ZARONTIN SYRP KEPPRA XR[5,6] NEURONTIN TEGRETOL-XR TB12[5,6] ZONEGRAN CAPS	Use PA Form# 20420 All non-preferred meds must be used in specified order 1. Quantity limit. 5/month 2. Dosing limits apply, please see dose consolidation list. 3. Dosing limits apply per strength as well as a maximum daily dose of 600mg. Please see dose consolidation list. 4. Adjunctive therapy 17 and older. 5. Current users as of 7/30/10 for seizures will be grandfathered. 6. 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.	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. **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.
						BIPOLAR DISORDER: STEP ORDER		
					M ~ A 4 ~ 4	LAMICTAL	SEE ANTICONVULSANT INDICATION CHART AT THE END OF THIS	

					4 ~ 4	LITHIUM	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	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/DEL		BENZTROPINE MESYLATE TABS					
	MC		COGENTIN SOLN					
	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		**PRAMIPEXOLE**	MC/DEL	5	**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		**ROPINIROLE**	MC/DEL	8	**REQUIP TABS**		
				MC/DEL	8	**REQUIP XL TABS**		
				MC/DEL	8	**MIRAPEX ER**		
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		LODOSYN TABS		
	MC		LARODOPA TABS	MC/DEL		**PARLODEL CAPS**		
	MC/DEL		**SELEGILINE HCL**	MC/DEL		**PARLODEL TABS**		
				MC		SINEMET TABS		
				MC		SINEMET TBCR		
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 (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	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	8	LIORESAL TABS		
	MC/DEL		**METHOCARBAMOL TABS**	MC	8	NORFLEX TBCR		
	MC/DEL		**TIZANIDINE HCL TABS**	MC	8	ROBAXIN-750 TABS		
				MC/DEL	8	**ZANAFLEX TABS**		
				MC/DEL	9	**SKELAXIN TABX**		
				MC/DEL	9	**SOMA TABS**		

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	Please refer to OTC list.	
	MC		CYANOCOBALAMIN SOLN	MC		DHT SOLN		
	MC		FOLGARD RX 2.2 TABS	MC		NASCOBAL GEL		
	MC/DEL		FOLIC ACID TABS					
	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					
	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	Please refer to OTC list.	
	MC		CENTRUM SILVER TABS	MC		CENTRUM JR/EXTRA C CHEW		
	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		O-CAL PRENATAL	MC/DEL		NATACHEW CHEW		
	MC/DEL		ONE DAILY TABS	MC		NATALFIRST TABS		
	MC/DEL		ONE-DAILY MULTIVITAMINS	MC		NATATAB RX TABS		
	MC/DEL		ONE-TABLET-DAILY	MC/DEL		NEPHPLEX RX TABS		
	MC/DEL		POLY-VIT/IRON/FLUORID SOLN	MC/DEL		NEPHROCAPS CAPS		
	MC/DEL		POLY-VITAMIN/FLUORIDE SOLN	MC/DEL		NEPHRO-VITE TABS		
	MC/DEL		POLY-VITAMINS/IRON SOLN	MC		NESTABS RX TABS		
	MC		PRENATAL 19 CHEW	MC/DEL		NIFEREX		
	MC/DEL		PRENATAL TABS	MC/DEL		OCUVITE TABS		
	MC/DEL		PRENATAL FORMULA 3 TABS	MC		POLY-VI-FLOR SOLN		
	MC/DEL		PRENATAL PLUS TABS	MC		POLY-VI-SOL SOLN		
	MC/DEL		PRENATAL PLUS NF TABS	MC		POLY-VI-SOL/IRON SOLN		
	MC		PRENATAL PLUS/27MG IRON	MC		POLY-VITAMIN DROPS SOLN		
	MC		PRENATAL PLUS/IRON TABS	MC		PRECARE		

	MC/DEL	PRENATAL RX/BETA-CAROTENE	MC	PREMESIS RX TABS			
	MC/DEL	RENA-VITE RX TABS	MC	PRENATABS CBF TABS			
	MC/DEL	RENAL CAPS	MC	PRENATAL CARE TABS			
	MC/DEL	RENAPHRO CAPS	MC	PRENATAL MR 90 TBCR			
	MC	STRESS TAB NF TABS	MC/DEL	PRENATAL MTR/SELENIUM TABS			
	MC	THERAPEUTIC-M TABS	MC	PRENATAL OPTIMA ADVANCE TABS			
	MC	THERAVITE LIQD	MC	PRENATAL PC 40 TABS			
	MC/DEL	TRI-VITAMIN/FLUORIDE SOLN	MC/DEL	PRENATAL RX TABS			
	MC	VITA CON FORTE CAPS	MC	PRENATE			
	MC	VITAMIN B COMPLEX CAPS	MC	PRENATE ELITE			
	MC	VITAPLEX PLUS TABS	MC	PRIMACARE MISC			
			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 Please refer to OTC 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. 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		
	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 CAPS		
	MC	FLUORITAB CHEW	MC/DEL	POTASSIUM CHLORIDE 8MEQ CAPS		
	MC	HEMOCYTE TABS	MC/DEL	SLOW FE TBCR		
	MC	HM CALCIUM TABS	MC	TUMS 500 CHEW		
	MC	K+ POTASSIUM PACK	MC	VIACTIV CHEW		
	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		INTRALIPID EMUL	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.	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.** Medical foods are not to be authorized solely for the purpose of enhancing nutrient intake or managing body weight if the participant is able to eat conventional foods adequately. Medical foods may be approved if the member has a medical condition which precludes or restricts the use of conventional foods and necessitates the use of a formula. Concurrent Stimulant therapy is not an acceptable medical reason/condition for use of medical foods for enhancing nutrient intake or managing body weight.
	MC		P.T.E. -5 SOLN	MC		CASEC POWD		
	MC/DEL		SEA-OMEGA CAPS	MC		CHOICE DM LIQD		
				MC		DELIVER 2.0 LIQD		
				MC		ENFAMIL		
				MC		ENSURE		
				MC		GLUCERNA		
				MC		ISOCAL LIQD		
				MC		KINDERCAL TF LIQD		
				MC		KINDERCAL TF/FIBER LIQD	1. Formerly known as Omacor.	For children under the age of 5, MaineCare will not provide milk- or soy-based standard infant formulas. Regular formulas may be sought through your nearest WIC office. MaineCare will continue to cover medical food for all participants in MaineCare when medical necessity is met.
				MC/DEL		L-CARNITINE CAPS		
				MC		LIPISORB LIQD		
				MC		LOVAZA[1]	Use PA Form# 20420 & SGA Form	
				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	8	LEUKINE	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.
				MC	8	NEUPOGEN SOLN[1]		
				MC	9	NEULASTA		
ANTICOAGULANTS / PLATELET AGENTS								
ANTICOAGULANTS	MC		ARIXTRA SOLN[1]	MC		COUMADIN TABS	1. Arixtra, Fragmin and Lovenox therapy durations greater than 7 days require 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. Exceeding days supply limits for LMWH class requires PA.
	MC/DEL		FRAGMIN INJ[1]	MC		IPRIVASK		
	MC		HEPARIN SODIUM/NACL 0.9% SOLN	MC/DEL		LOVENOX 300[2]		
	MC		HEP-LOCK SOLN	MC/DEL		PRADAXA		
	MC/DEL		**INNOHEP**					

	MC/DEL		**LOVENOX SOLN**[1]				2. Use other strengths available to obtain desired dose. Use PA Form# 20420	
	MC/DEL		**WARFARIN SODIUM TABS**					
	MC		HEPARIN LOCK SOLN					
	MC/DEL		HEPARIN LOCK FLUSH SOLN					
	MC/DEL		HEPARIN SODIUM SOLN					
	MC/DEL		HEPARIN SODIUM LOCK FLUSH SOLN					
	MC/DEL		JANTOVEN					
ANTIHEMOPHILIC AGENTS	MC		ALPHANATE	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.
			ALPHANINE SD					
	MC/DEL		BENEFIX SOLR					
	MC/DEL		HELIXATE FS KIT					
	MC		HEMOFIL - M					
	MC		HUMATE-P SOLR					
	MC		KOGENATE FS					
	MC		KONYNE - 80					
	MC		MONARC - M					
	MC		MONOCLATE - P					
	MC		MONONINE					
	MC		NOVOSEVEN SOLR					
	MC/DEL		PROFILNINE					
	MC		RECOMBINATE SOLR					
	MC		REFACTO					
PLATELET AGGREGATION INHIBITORS	MC/DEL		ASPIRIN	MC/DEL	7	TICLOPIDINE HCL 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.	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. **DDI:** Plavix will require prior authorization if being used in combination with omeprazole, esomeprazole, cimetidine, fluconazole, ketoconazole, intelence, fluoxetine, ticlopidine, and fluvoxamine.
	MC/DEL		**DIPYRIDAMOLE TABS**	MC	8	EFFIENT		
				MC/DEL	8	PERSANTINE TABS		
				MC/DEL	8	PLAVIX TABS[1, 2]		
PLATELET AGGR. INHIBITORS / COMBO'S - MISC.	MC/DEL		**AGGRENOX**	MC/DEL		**AGRYLIN 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		CILOSTAZOL	MC/DEL		**PLETAL TABS**		
	MC/DEL		PENTOXIFYLLINE ER TBCR	MC		TRENTAL TBCR		
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	7	PROMACTA	Use PA Form# 20420	Clinical PA required. Must see prior trial with insufficient response to corticosteroids and immunoglobulins.
				MC	8	NPLATE		
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/DEL		TOBRAMYCIN SULFATE SOLN	MC/DEL		TOBREX OINT		
	MC/DEL		TRIMETHOPRIM SULFATE/POLY	MC/DEL		TRIFLURIDINE SOLN		
	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		DEXAMETH SOD PHOS SOLN	MC		BROMDAY		
	MC/DEL		FLAREX SUSP	MC		EFLONE SUSP		
	MC/DEL		FLUOROMETHOLONE SUSP	MC		FLUOR-OP SUSP		
	MC		FML S.O.P. OINT	MC		MAXITROL		
	MC/DEL		LOTEMAX SUSP	MC		NEO/POLY/BAC/HC OINT		
	MC/DEL		NEOM/POLIN/DEX	MC/DEL		OZURDEX		
	MC		PRED MILD SUSP	MC		PRED FORTE SUSP		
	MC/DEL		PREDNISOLONE	MC		PRED-G SUSP		
	MC/DEL		TOBRADEX	MC		PRED-G S.O.P. OINT		
				MC/DEL		SULFACET SOD/PRED SOLN		
				MC		VASOCIDIN SOLN		
				MC/DEL		VEXOL SUSP		
OP. - PROSTAGLANDINS	MC		LUMIGAN SOLN	MC/DEL		**XALATAN SOLN**	All preferreds must be tried. Use PA Form# 20420	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**					
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/DEL		BRIMONIDINE 0.2%	MC		ALPHAGAN 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		**IOPIDINE SOLN**		
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

	MC/DEL		PATADAY SOLN	MC/DEL		ALOMIDE SOLN		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		PATANOL SOLN	MC		BEPREVE		
				MC		ELESTAT		
				MC/DEL		EMADINE SOLN		
				MC		LASTACAFT		
				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		FLURBIPROFEN SODIUM SOLN	MC		ACULAR LS	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		DICLOFENAC OPTH 0.1%	MC		ACULAR SOLN		
	MC/DEL		KETOROLAC OPTH 0.4%	MC		OCUFEN SOLN		
	MC/DEL		KETOROLAC OPTH 0.5%	MC/DEL		NEVANAC		
				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. Use PA Form #20420	Must fail adequate trials of multi agents from artificial tears and lubricant category.
				MC		RESTASIS[1]		
DERMATOLOGICAL								
TOPICAL - ACNE PREPARATIONS	MC		AZELEX CREA	MC		ACZONE	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	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		
	MC/DEL		CLINDAMYCIN PHOSPHATE[2]	MC		AVITA CREA		
	MC		ERYDERM SOLN	MC		BENZAC		
	MC/DEL		ERYTHROMYCIN GEL	MC/DEL		BENZACLIN GEL[3]		
	MC/DEL		ERYTHROMYCIN PADS	MC/DEL		BENZAGEL-10 GEL		
	MC/DEL		ERYTHROMYCIN SOLN	MC/DEL		BENZAMYCIN GEL		
	MC		ISOTRETINOIN	MC/DEL		BENZAMYCINPAK PACK		
	MC		METRONIDAZOLE CREAM[2]	MC		BENZEFOAM		
	MC		METRONIDAZOLE GEL[2]	MC		BREVOXYL		
	MC		METRONIDAZOLE LOTN[2]	MC/DEL		CLEOCIN-T[2]		
	MC/DEL		PLEXION	MC		CLINAC BPO GEL		
	MC		RETIN-A GEL[1,2]	MC		CLINDAGEL GEL		
	MC/DEL		SODIUM SULFACET/SULF LOTN	MC		CLINDETS SWAB		
	MC		TAZORAC GEL	MC		DESQUAM-E GEL		
				MC		DESQUAM-X		
				MC		DIFFERIN 0.3% GEL		
				MC		DIFFERIN		
				MC		DUAC GEL		
				MC		EMGEL GEL		
				MC		EPIDUO		
				MC		ERYCETTE PADS		
				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		TRETINOIN[2]		
				MC/DEL		TRIAZ		
				MC		VELTIN		
				MC		ZENCIA WASH		
				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.	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		TRIPLE ANTIBIOTIC OINT		

	MC/DEL		BACTROBAN NASAL OINT					
	MC/DEL		CENTANY OINT 2%[1]					
	MC/DEL		GENTAMICIN SULFATE					
	MC/DEL		MUPIROCIN[1]				Use PA Form# 20420	
TOPICAL - ANTIFUNGALS	MC		CICLOPIROX 0.77 CREAM	MC		EXELDERM		
	MC		CICLOPIROX 0.77 SUSP	MC		FUNGIZONE CREA	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.
	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		**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, Onglyza or Omeprazole.
	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		NAFTIN		
	MC		NTA OINT	MC		NYSTAT-RX POWD		
	MC/DEL		NYSTATIN	MC/DEL		OXISTAT		
	MC/DEL		NYSTATIN/TRIAMCINOLONE	MC/DEL		PENLAC NAIL LACQUER SOLN		
	MC/DEL		NYSTOP POWD					
	MC		PEDI-DRI POWD					
	MC/DEL		TINACTIN					
	MC		TRI-STATIN II CREA					
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		VECTICAL		
TOPICAL - ANTISEBORRHEICS	MC/DEL		SELENIUM SULFIDE 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		ZNP BAR		
TOPICAL - ANTIVIRALS				MC/DEL		DENAVIR CREA[1]	1. Must fail oral treatment with Acyclovir or Valtrex. 2. Approvals limited to 1 tube per 180 days. Use PA Form# 20420	
				MC		ZOVIRAX OINT[1, 2]		
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/DEL		SILVER SULFADIAZINE CREA					
	MC		SSD AF CREA					
	MC		SSD CREA					
	MC/DEL		THERMAZENE 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		CLOBEX		
	MC		LACTICARE-HC LOTN	MC		CLODERM CREA		
	MC		NUTRACORT LOTN	MC/DEL		CORDRAN		
	MC		TEXACORT SOLN	MC/DEL		CORMAX		
				MC/DEL		CUTIVATE CREAM / OINT		
			MEDIUM POTENCY	MC/DEL		CUTIVATE LOTION		
	MC/DEL		DESOXIMETASONE .05%	MC/DEL		DERMATOP		
	MC/DEL		ELOCON			DESONATE GEL		
	MC/DEL		FLUOCINOLONE ACETONIDE .025-.01%	MC/DEL		DIPROLENE		
	MC		FLUROSYN CREA	MC		ELOCON OINT		
	MC		FLUTICASONE PROPIONATE CREAM/OINT	MC		HYDROCORTISONE POWD		
	MC		HYDROCORTISONE BUTYRATE	MC		KENALOG AERS		
	MC		HYDROCORTISONE OINT	MC		LIDA MANTLE HC CREA		
	MC		HYDROCORTISONE VALERATE	MC/DEL		LOCOID		
	MC		MOMETASONE FUROATE OINT	MC/DEL		LUXIQ FOAM		

	MC/DEL		TRIAMCINOLONE ACETONIDE .025-.1%	MC/DEL		OLUX FOAM		
				MC		PANDEL CREA		
			HIGH POTENCY	MC		PROCTOCORT CREA		
	MC/DEL		BETAMETHASONE DIPROPIONATE	MC/DEL		PSORCON		
	MC/DEL		DESOXIMETASONE .25%	MC/DEL		PSORCON E		
	MC/DEL		DESONIDE	MC/DEL		TEMOVATE		
	MC/DEL		FLUOCINOLONE ACETONIDE .02%	MC		TOPICORT		
	MC/DEL		FLUOCINONIDE	MC		TOPICORT LP CREA		
	MC		HALOG	MC		ULTRAVATE		
	MC		HALOG-E CREA	MC/DEL		VERDESO		
	MC/DEL		TRIAMCINOLONE ACETONIDE .5%	MC		WESTCORT		
			VERY HIGH POTENCY					
	MC/DEL		AUGMENTED BETA DIP					
	MC/DEL		BETAMETHASONE VALERATE					
	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		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		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		
				MC	8	ZYCLARA		
TOPICAL - IMMUNOMODULATORS				MC/DEL	8	ELIDEL CREA	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.	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 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.
				MC	9	PROTOPIC OINT		
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. 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		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		SYNERA		
				MC		ZOSTRIX		
TOPICAL - DEPIGMENTING AGENTS				MC	8	ALUSTRA CREA	Not covered for cosmetic purposes. Use PA Form# 20420	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		
				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		
				MC		SURGILUBE GEL		
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/DEL		CORTISPORIN-TC SUSP		
	MC/DEL		AURODEX SOLN	MC/DEL		DEBROX SOLN		
	MC		AUROGUARD SOLN	MC/DEL		PEDIOTIC SUSP		
	MC/DEL		AUROTO OTIC SOLN	MC		VOSOL-HC SOLN		
	MC		CARBAMIDE PEROXIDE 6.5% OTIC SOLN.	MC/DEL		ZOTANE HC SOLN		
	MC/DEL		CIPRODEX	MC		ZOTO-HC SOLN		
	MC		CORTISPORIN SOLN					
	MC/DEL		CORTOMYCIN					
	MC		EAR DROPS 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		ORAVIG		
	MC/DEL		NYSTATIN SUSP					
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		PERIOGARD SOLN		
	MC		TRIAMCINOLONE IN ORABASE PSTE	MC		TRIAMCINOLONE ACETONIDE PSTE		
	MC		TRIAMCINOLONE ORADENT PSTE					
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. 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	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. 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		HUMIRA[1]	MC		ENBREL 50 MG[3]		
				MC		STELARA		
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.
				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		SPRYCEL[1]	Use PA Form# 20420 1. Verification of diagnosis is required. 2. PA required to confirm FDA approved indication and to monitor for potential drug-drug interactions.	
				MC/DEL		TYKERB[2]		
				MC		GLEEVEC[1]		
ANTINEOPLASTICS-	MC/DEL		MERCAPTOPURINE	MC/DEL		ZOLINZA	Use PA Form# 20420	

MISCELLANEOUS				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/DEL		ARIMIDEX	1. PA required to confirm FDA approved indication 2. Avoid CYP3AY drug drug interaction. Use PA Form# 20420	
	MC/DEL		ANASTROZOLE TABS	MC		FOLOTYN		
	MC/DEL		AVASTIN	MC		NEXAVAR[1]		
	MC		ERBITUX	MC/DEL		SUTENT[1,2]		
	MC/DEL		VIDAZA					
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:** Cyclosporine will require prior authorization when used with Livalo. **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