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

CATEGORY	Coverage Indicator	Step Order	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required	Comments	Criteria
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]		
	MC/DEL		AMOXICILLIN/POTASSIUM CLA TABS	MC		PRINCIPEN CAPS[2]		
	MC/DEL		AMOXIL[1]	MC		PRINCIPEN SUSR	2.Principen 250 mg is available without PA.	
	MC/DEL		AMPICILLIN					**DDI:** Ampicillin will now be non-preferred and require prior authorization if it is currently being used in combination with either Prevacid, pantoprazole, Prilosec, or any currently non preferred PPI.
	MC		BEEPEN				3. Chewable 125mg & 250mg and Solution 125mg/5ml and 250mg/5ml available without PA.	
	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	MAXIPIME		
	MC/DEL	CEFTRIAXONE	MC	OMNICEF		
	MC/DEL	CEFUROXIME AXETIL TABS	MC/DEL	ROCEPHIN		
	MC/DEL	CEPHALEXIN MONOHYDRATE	MC/DEL	SUPRAX		
	MC/DEL	FORTAZ SOLR	MC	TAZICEF SOLR		
	MC	KEFZOL SOLR	MC/DEL	TEFLARO		
	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, pantoprazole, Prilosec, or any currently non preferred PPI.
	MC/DEL	VANTIN 100MG				
	MC/DEL	VANTIN SUSP				
MACROLIDES / ERYTHROMYCIN'S	MC	BIAXIN XL[1]	MC/DEL	AZITHROMYCIN POW	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.
	MC/DEL	AZITHROMYCIN TABS	MC	BIAXIN		
	MC/DEL	AZITHROMYCIN SUSP	MC/DEL	CLARITHROMYCIN SUSP		
	MC	E.E.S.	MC/DEL	CLARITHROMYCIN TABS		
	MC	E-MYCIN TBEC	MC	ERYPED CHEW		**DDI:** Preferred erythromycin will now be non-preferred and require prior authorization if it is currently being used in combination with either Carbamazepine, 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 Carbamazepine, Enablex 15mg or Vesicare 10mg.
	MC	ERYPED 200 SUSR	MC	PCE TBEC		
	MC	ERYPED 400 SUSR	MC/DEL	ZITHROMAX TABS	Use PA Form# 20420	
	MC	ERY-TAB TBEC	MC/DEL	ZITHROMAX 1GM PAK		
	MC	ERYTHROCIN STEARATE TABS	MC/DEL	ZITHROMAX TRI-PAK		**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 Carbamazepine, 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 Carbamazepine, Onglyza 5mg, Enablex 15mg or Vesicare 10mg.
	MC/DEL	ERYTHROMYCIN	MC/DEL	ZITHROMAX SUSP		
			MC/DEL	ZMAX		
TETRACYCLINES	MC/DEL	DOXYCYCLINE HYCLATE	MC	DECLOMYCIN TABS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL	MINOCYCLINE HCL CAPS	MC/DEL	DORYX CPEP		
	MC/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/DEL	CIPROFLOXACIN	MC	AVELOX SOLN		Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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	LEVOFLOXACIN	MC	AVELOX TABS	Use PA Form# 20420	
	MC/DEL	OFLOXACIN	MC	AVELOX ABC PACK TABS	1. Dosing limits apply, see Dosage Consolidation List.	
			MC	CIPRO		**DDI:** Preferred ofloxacin will now be non-preferred and require prior authorization if they are currently being used in combination with amiodarone.
			MC	FACTIVE		**DDI:** Preferred levofloxacin will now be non-preferred and require prior authorization if they are currently being used in combination with amiodarone.
			MC/DEL	LEVAQUIN TABS SOLN/INJ		**DDI:** Preferred Avelox will now be non-preferred and require prior authorization if they are currently being used in combination with amiodarone.
			MC/DEL	LEVAQUIN TABS[1]		**DDI:** All preferred fluoroquinolones will require clinical PA for patients over 60 that are currently on immunosuppressants or steroid therapy.
			MC	NOROXIN TABS		
			MC	PROQUIN XR		**DDI:** Factive is non-preferred but with any prior authorization requests, the member's drug profile will also be monitored for concurrent use with amiodarone.
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			Use PA Form# 20420	
	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				**DDI:** Preferred rifampin will be non-preferred and require prior authorization if it is currently being used in combination with either Pradaxa or Latuda.
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		COLISTIMETHATE SODIUM 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 or carbamazepine.
	MC		COLY-MYCIN-M SOLR	MC		CAYSTON[4]		
	MC		COLISTIMETHATE SODIUM SOLR	MC/DEL		FLAGYL CAPS		
	MC		FUROXONE TABS	MC/DEL		FLAGYL TABS		
	MC/DEL		METRONIDAZOLE[2]	MC/DEL		FLAGYL ER TBCR		
	MC		PENTAMIDINE ISETHIONATE SOLR	MC/DEL		KETEK		
	MC		PRIMSOL SOLN	MC/DEL		METRONIDAZOLE 375MG CAPS[2]		
	MC/DEL		TRIMETHOPRIM TABS	MC/DEL		METRONIDAZOLE 750MG TABS[2]		
	MC/DEL		VANCOMYCIN 5GM INJ.	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 drug and the preferred drug(s) exists.
				MC		MERREM SOLR		
				MC/DEL		PRIMAXIN		
LINCOSAMIDES / OXAZOLIDINONES / LEPROSTATICS	MC/DEL		CLEOCIN SOLN	MC/DEL		CLEOCIN CAPS	1. Use multiple 150's for Clindamycin instead of 300'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. For Zyvox or Vibativ, please see the criteria listed in the Antibacterial Antibiotics PA form.
	MC/DEL		CLEOCIN SUSR	MC/DEL		CLINDAMYCIN HCL 300CAPS[1]		
	MC/DEL		CLINDAMYCIN HCL 150CAPS	MC/DEL		VIBATIV		
	MC		DAPSONE TABS	MC/DEL		ZYVOX SUSR	Use PA Form# 30820 for Zyvox & Vibativ	
				MC/DEL		ZYVOX TABS	Use PA Form# 20420 for **all others**	
ANTI INFECTIVE COMBO'S - MISC.	MC/DEL		ERYTHROMYCIN/SULF SUSR	MC		BACTRIM DS TABS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		SEPTRA/DS TABS					
	MC/DEL		SULFAMETHOXAZOLE/TRIMETH					
	MC/DEL		TRIMETHOPRIM/SULFAMETHOXA					
ANTIPROTOZOALS				MC		ALINIA[1]	1. Alina is preferred for children less than 12 years of age. Use PA Form# 20420	
ANTI - FUNGALS								
ANTIFUNGALS - ASSORTED	MC		ANCOBON CAPS	MC/DEL	5	LAMISIL TABS[4]	1. QL--1/every 7-day period (150mg only). 2. Sporanox QL 300cc/month with PA. See quantity limit table. 3. Sporanox QL 30/month with PA. See quantity limit table. Non-preferred products must be used in specified step order. Continue to use Anti-Fungal PA form for non-preferred products.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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, Vesicare 10mg or Latuda. **DDI:** Any Griseofulvin will now be non-preferred and require prior authorization if it is currently being used in combination with either Prevacid, pantoprazole, Prilosec, or any currently non preferred PPI.
	MC/DEL		FLUCONAZOLE[1]	MC/DEL	6	SPORANOX SOLN[2]		
	MC/DEL		GRIFULVIN V TABS[10]	MC/DEL	6	SPORANOX PULSEPAK CAPS[3]		
	MC		GRISEOFULVIN SUSP[10]	MC/DEL	7	SPORANOX CAPS[3]		
	MC		GRISEOFULVIN ULTRAMICROSI TABS[10]	MC/DEL	8	ERAXIS INJ[6]		
	MC		GRIS-PEG TABS[10]	MC/DEL	8	DIFLUCAN		
	MC/DEL		KETOCONAZOLE TABS[8]	MC	8	GRIFULVIN SUSP		
	MC/DEL		NYSTATIN	MC/DEL	8	NOXAFIL[5]		
	MC/DEL		TERBINAFINE TABS[4]	MC/DEL	8	VFEND TABS		
				MC/DEL	8	ITRACONAZOLE		

								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, pantoprazole, Prilosec, or any currently non preferred PPI, due to a significant drug-drug interaction.
							4. Quantity limit of one tablet daily. Please see dosage consolidation list.	**DDI:** Vfend is non-preferred but with any prior authorization requests, the member's drug profile will also be monitored for concurrent use with Warfarin.
							5. Approved if immuno suppressed/ HIV or if the member has failed a 7 day trial of a preferred antifungal therapy.	**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 or Warfarin.
							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.	**DDI:** Ketoconazole will require prior authorization if being used in combination with Plavix.
							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.	
							Use PA Form# 10120	
ANTI - VIRALS								
ANTIRETROVIRALS	MC/DEL		APTIVUS	MC	8	COMPLERA	Use PA Form# 10620 for **Fuzeon**	Please refer to the criteria listed on the Fuzeon PA form.
	MC		ATRIPLA[1]	MC/DEL	8	DIDANOSINE		
	MC/DEL		COMBIVIR TABS	MC/DEL	8	EDURANT		
	MC/DEL		CRIXIVAN CAPS	MC/DEL	8	FUZEON[3]		
	MC		EMTRIVA	MC/DEL	8	INTELENCE[3]	1. Quantity limit of one per day	**DDI:** Reyataz will now be non-preferred and require prior authorization if it is currently being used in combination with either Prevacid, pantoprazole, Prilosec, or any currently non preferred PPI .
	MC/DEL		EPIVIR / HBV	MC/DEL	8	ISENTRESS[3]		
	MC/DEL		EPZICOM	MC/DEL	8	RETROVIR	2. Only preferred if Norvir script is in member's profile within the past 30 days of filling Prezista	
	MC/DEL		INVIRASE CAPS	MC/DEL	8	SELZENTRY[3]		**DDI:** Preferred Norvir will now be non-preferred and require prior authorization if it is currently being used in combination with either Enablex 15mg or Vesicare 10mg.
	MC		KALETRA	MC	8	ZERIT		
	MC/DEL		LEXIVA	MC/DEL	9	VIRAMUNE XR		
	MC		NORVIR				3. Prescribers with >= 10 ART scripts per quarter and 75% ART PDL compliance will be exempt from PA for these products.	**DDI:** Preferred Crixivan caps will now be non-preferred and require prior authorization if it is currently being used in combination with either Enablex 15mg or Vesicare 10mg.
	MC		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 MC/DEL		ZIAGEN TABS ZIDOVUDINE					
CYTO-MEGALOVIRUS AGENTS	MC MC		FOSCARNET SODIUM VALCYTE TABS	MC/DEL MC/DEL		FOSCAVIR GANCICLOVIR	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.
HERPES AGENTS	MC/DEL MC/DEL		ACYCLOVIR VALTREX TABS	MC/DEL MC/DEL MC/DEL MC/DEL	8 8 8 9	FAMVIR TABS[1] ZOVIRAX[1] VALACYCLOVIR[1] FAMCICLOVIR[1]	1. Must fail Acyclovir and Valtrex before non-preferred products in step order. 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.
INFLUENZA AGENTS	MC/DEL MC MC/DEL MC/DEL		AMANTADINE RELENZA DISKHALER AEPB RIMANTADINE HCL TABS TAMIFLU[1]	MC/DEL MC		FLUMADINE TABS FLUMIST	1. Tamiflu 10 caps or 60cc's per month. Will be audited for presence of positive influenza tests in patient or family member. Use PA Form# 10610 for **Flumist** requests Use PA Form# 20420 for **all others**	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.
IMMUNE SERUMS								
IMMUNE SERUMS	MC		HYPERRHO INJ					
HEPATITIS AGENTS								
HEPATITIS C AGENTS	MC MC/DEL MC/DEL MC/DEL MC/DEL MC		INCIVEK[2] VICTRELIS[2] PEGASYS KIT[1] PEGASYS SOLN PEG-INTRON KIT[1] RIBAVIRIN	MC/DEL MC/DEL		COPEGUS TABS REBETOL CAPS	1. Dosing limits apply, please see dosage consolidation list. 2. Approvals will require clinical PA to establish genotype, baseline viral loads and will require periodic SVR's. Must have concurrent peg-a or peg-I and ribavirin therapies. 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.
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 MC		BARACLUDE TYZEKA	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.
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 MC/DEL MC		AVONEX KIT[1] **BETASERON SOLR[1]** REBIF SOLN[1]	MC/DEL		EXTAVIA	1.Clinical PA is required to establish diagnosis and medical necessity. Use PA Form# 20430	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.
MULTIPLE SCLEROSIS - NON-	MC/DEL		**COPAXONE[2]**	MC/DEL	6	TYSABRI[1]	1. Providers must be	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

INTERFERONS				MC	8	AMPYRA	enrolled in the TOUCH Prescribing program, a restricted distribution program. Clinical PA is required to establish diagnosis and medical necessity.	exception is offered on the Prior Authorization form, such as the presence of 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	GILENYA[3]	2. Clinical PA is required to establish diagnosis and medical necessity.	
							3. Dosing limits apply, please see dosage consolidation list.	
							Use PA Form# 20430	
ASSORTED NEUROLOGICS								
NEUROLOGICS - MISC.	MC		MESTINON	MC		BOTOX	1. Approval will be limited to Cervical dystonia.	Failed/did not tolerate therapeutic trials fo muscle relaxants, unless contraindicated, including but not limited to baclofen, cyclobenzaprine, orphenadrine, Skelaxin, and tizanidine.
	MC/DEL		ORAP TABS			DYSPORT[1]		
	MC		PROSTIGMIN TABS	MC/DEL		MYOBLOC[1]	Use PA Form# 10210	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.
STEROIDS								
GLUCOCORTICOIDS/ MINERALOCORTICOIDS	MC		CELESTONE SUSP	MC/DEL		BUDESONIDE EC	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		CORTEF 5	MC		CORTEF 10 and 20 TABS		
	MC/DEL		CORTISONE ACETATE TABS	MC/DEL		FLORINEF TABS		
	MC/DEL		DELTASONE TABS	MC/DEL		**MEDROL TABS**		
	MC/DEL		DEPO-MEDROL SUSP	MC		MEDROL DOSEPAK TABS		
	MC/DEL		DEXAMETHASONE	MC		ORAPRED SOLN		
	MC/DEL		ENTOCORT EC CP24	MC		PEDIAPRED LIQD		
	MC/DEL		FLUDROCORTISONE ACETATE TABS	MC		PREDNISONE INTENSOL CONC		
	MC/DEL		HYDROCORTISONE	MC		STERAPRED TABS		
	MC		KENALOG					**DDI:** All preferred steroids will require clinical PA for patients over 60 that are currently on fluoroquinolone therapy.
	MC/DEL		METHYLPREDNISOLONE TABS					
	MC/DEL		PREDNISOLONE					
	MC/DEL		**PREDNISONE**					
	MC/DEL		SOLU-CORTEF SOLR					
	MC/DEL		SOLU-MEDROL SOLR					
HORMONE REPLACEMENT THERAPIES								
ANDROGENS / ANABOLICS	MC/DEL		ANDRODERM PT24	MC		ANDRO LA 200 OIL	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. Additionally, laboratory evidence of a testosterone deficiency must be supplied. One of each dosage form should be tried (tablet, injection, and topical)
	MC/DEL		ANDROGEL	MC		AXIRON		
	MC/DEL		ANDROGEL PUMP	MC		DELATESTRYL OIL		
	MC/DEL		ANDROID CAPS	MC		FORTESTA	Use PA Form# 20600 for **Oxandrin** requests	
	MC/DEL		DANAZOL CAPS	MC		HALOTESTIN TABS		
	MC/DEL		DEPO-TESTOSTERONE OIL	MC/DEL		METHITEST TABS		
	MC/DEL		TESTOSTERONE PROPIONATE	MC/DEL		OXANDRIN TABS		
	MC		TESTRED CAPS	MC/DEL		TESTIM		
ESTROGENS - PATCHES / TOPICAL	MC/DEL		**ESTRADERM PTTW[1]**	MC/DEL	5	**ESTRADIOL PTWK**	1. Both preferred drugs must be tried.	Approved for failures on multiple oral estrogen agents after 90 day trials or if unable to swallow any oral medication.
	MC/DEL		**VIVELLE-DOT PTTW[1]**	MC/DEL	8	**ALORA PTTW[2]**	2. Step order drugs must be used in specified step order.	
	MC/DEL		**CLIMARA PTWK**	MC/DEL	8	**DIVIGEL[2]**		
				MC/DEL	8	**ELESTRIN[2]**		
				MC	8	**EVAMIST[2]**	Use PA Form# 20420	
ESTROGENS - TABS	MC/DEL		**CENESTIN TABS**	MC/DEL		ENJUVIA	Must fail preferred products before non-preferred products.	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.
	MC/DEL		**ESTRADIOL**	MC/DEL		**ESTRACE TABS**		
	MC/DEL		**ESTROPIPATE TABS**	MC		ESTRATAB TABS		
	MC/DEL		**MENEST TABS**	MC		ORTHO-EST TABS		
	MC/DEL		**PREMARIN TABS**				Use PA Form# 20420	

ESTROGEN COMBO'S	MC/DEL MC/DEL		PREMPHASE TABS PREMPRO TABS	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		ACTIVELLA TABS[1] COMBIPATCH PTTW[1] FEMHRT 1/5 TABS[1] ORTHO-PREFEST TABS[1] SYNTEST H.S. TABS[1]	1. 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		MEDROXYPROGESTERONE ACETA [2] NORETHINDRONE ACETATE TABS[2]	MC/DEL MC MC MC MC/DEL MC/DEL MC/DEL		AYGESTIN TABS CYCRIN TABS MAKENA PROGESTERONE POWD PROMETRIUM 100MG CAPS[1] PROMETRIUM 200MG[1] PROVERA TABS	1. PA approvals will require two 100 mg caps instead of one 200mg. 2. Must fail Medroxyprogesterone and Norethidrone products before non-preferred products. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
CONTRACEPTIVES								
CONTRACEPTIVES - PROGESTIN ONLY	MC		ORTHO MICRONOR TABS	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		CAMILA TABS ERRIN JOLIVETTE NORA-BE TABS NOR-QD 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. If member experienced adverse reactions, consider using Oral Contraceptives from other groups. **DDI:** Preferred Oral Contraceptives will now be non-preferred and require prior authorization if it is currently being used in combination with Tracleer.
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 MC/DEL MC MC/DEL	1 2 2 2	PLAN B ONE STEP[1] ELLA LEVONORGESTREL NEXT CHOICE[1]	MC/DEL		PLAN B	1. Allowed 4 tablets per 30 days without PA Use PA Form# 20420	
CONTRACEPTIVES - PATCHES/ VAGINAL PRODUCTS	MC/DEL MC		NUVARING RING[3] ORTHO EVRA PTWK[1,2,4]				Use PA Form# 20420 1.No PA required for users less than 21 years of age. 2. The FDA has issued a public health warning of the potentials for increased exposure to estrogen with Ortho Eva use, possibly up to 60% estrogen exposoure. 3. Quantity limit allowing 1 every 28 days with out PA. 4. Dose limits apply allowing 3 patches per 28 days supply. Please refer to Dose Consolidation Chart.	Approved if adequate clinical reason given why patient unable to comply with other preferred agents including long acting injectable.
CONTRACEPTIVES - MONOPHASIC COMBINATION O/C'S	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC		APRI TABS AVIANE TABS BALZIVA CRYSELLE-28 TABS DESOGEN TABS DESOGESTREL/ ETHINYL ESTRADIOL LOW-OGESTREL TABS MODICON TABS	MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL		BEYAZ BREVICON-28 TABS LESSINA-28 TABS LEVORA LOESTRIN TABS LOESTRIN FE TABS LOESTRIN FE 1/20 TABS LOESTRIN 1.5/30-21 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. If member experienced adverse reactions, consider using Oral Contraceptives from other groups.

	MC/DEL		MONONESSA	MC/DEL		LOESTRIN 1/20-21 TABS		
	MC/DEL		NECON 1/50	MC		LO/OVRAL 21 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		ORTHO-CEPT-28 TABS	MC/DEL		LO/OVRAL 28 TABS		
	MC		ORTHO-CYCLEN-28 TABS	MC/DEL		MICROGESTIN FE TABS		
	MC		ORTHO-NOVUM 1/35-28 TABS	MC/DEL		NORDETTE-28 TABS		
	MC/DEL		OVCON-50 28 TABS	MC/DEL		NORINYL		
	MC/DEL		PREVIFEM	MC/DEL		NORTREL		
	MC/DEL		RECLIPSEN	MC/DEL		OCELLA		
	MC/DEL		SOLIA	MC/DEL		OGESTREL TABS		
	MC/DEL		SPRINTEC 28 TABS	MC/DEL		OVCON-35/28 TABS		
	MC/DEL		YASMIN 28 TABS	MC/DEL		OVRAL		
	MC/DEL		YAZ	MC/DEL		PORTIA-28 TABS		
	MC/DEL		SEASONALE	MC/DEL		SAFYRAL		
	MC/DEL		ZENCHENT	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.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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		NORETHINDRONE-ETH ESTRADIOL TAB 0.5-35/1-35	MC/DEL		KARIVA TABS		
	MC/DEL		SEASONIQUE	MC/DEL		LOSEASONIQUE		If member experienced adverse reactions, consider using Oral Contraceptives from other groups.
				MC/DEL		MIRCETTE TABS		**DDI:** Preferred Oral Contraceptives will now be non-preferred and require prior authorization if it is currently being used in combination with Tracleer.
							Use PA Form# 20420	
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.
	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-NORINYL 28 TABS	MC		ORTHO TRI-CYCLEN TABS		
	MC/DEL		TRI-PREVIFEM	MC		ORTHO TRI-CYCLEN LO TABS		
	MC/DEL		TRIPHASIL 28 TABS					If member experienced adverse reactions, consider using Oral Contraceptives from other groups.
	MC/DEL		TRI-SPRINTEC					**DDI:** Preferred Oral Contraceptives will now be non-preferred and require prior authorization if it is currently being used in combination with Tracleer.
	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/DEL		LEVEMIR		
	MC/DEL		LANTUS SOLN	MC		RELION		
	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.	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		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]**					
	MC/DEL		NOVOLOG MIX FLEXPEN[1]				Use PA Form# 20420	
	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	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		ONGLYZA[1]					
	MC/DEL		TRADJENTA[1]					

							the members drug profile. Dosing limits apply. Please refer to Dose consolidation list. Use PA Form# 20420	**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).
DIABETIC - DPP- 4 ENZYME INHIBITOR-COMBO	MC/DEL MC		JANUMET[1] KOMBIGLYZE				1. Preferred if therapeutic doses of metformin are seen in members drug profile for at least 60 days within the past 18 months or if phosphate binder is currently seen in the members drug profile. Dosing limits apply. Please refer to Dose consolidation list. Use PA Form# 20420	
DIABETIC - LANCET-LANCET DEVICE	MC MC MC MC MC MC		ONE TOUCH LANCETS DELICA LANCETS FREESTYLE LANCETS UNILET LANCETS UNISTIK LANCING DEVICE AUTOLOT LANCING DEVICE				Use PA Form# 20420	
DIABETIC - SYRINGES-NEEDLES	MC/DEL MC MC MC		BD MICRO-FINE BD ULTRA-FINE BD ULTRA-FINE PEN NEEDLES UNIFINE PEN NEEDLES				Use PA Form# 20420	
DIABETIC - OTHER				MC/DEL MC		CYCLOSET SYMLIN	Use PA Form# 301501	Please see the criteria listed in the Symlin PA form.
DIABETIC MONITOR	MC MC MC MC MC MC MC MC		FREESTYLE LITE SYSTEM KIT FREESTYLE FLASH SYSTEM KIT FREESTYLE FREEDOM SYSTEM KIT FREESTYLE FREEDOM LITE KIT ONE TOUCH ULTRA 2 KIT ONE TOUCH ULTRA MINI KIT ONE TOUCH ULTRA SMART KIT PRECISION XTRA METER	MC MC MC MC MC		ACCUCHECK ASCENSIA ASSURE EXACTECH PRODIGY	Use PA Form# 20420	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.
DIABETIC TEST STRIPS	MC MC MC MC MC MC MC MC		FREESTYLE[1] FREESTYLE LITE[1] ONE TOUCH BASIC[1] ONE TOUCH SURESTEP[1] ONE TOUCH FAST TAKE[1] ONE TOUCH ULTRA[1] PRECISION XTRA[1] PRECISION XTRA BETA KETONE 10 CT	MC MC MC MC MC		ACCUCHECK ASCENSIA ASSURE EXACTECH PRODIGY	1. Only 50 ct & 100 ct package size. Use PA Form# 20420	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.
INCRETIN MIMETIC				MC	8	BYETTA[1]	1. If patient is not responding	

				MC/DEL	9	VICTOZA[1]	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 MC/DEL		ACTOPLUS MET[1] ACTOPLUS MET XR 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[1] METAGLIP TABS[1] DUETACT[2]	1. Use individual ingredients. 2. Use Actos 15mgs with generic glimepiride. Use PA Form# 20420	Approved for patients failing to achieve good diabetic control with maximal doses of individual components.
DIABETIC - MEGLITINIDES	MC/DEL		**STARLIX TABS**	MC/DEL MC		**PRANDIN TABS** NATEGLINIDE	Use PA Form# 20420	Preferred drugs from other diabetic sub-categories must be tried and failed due to lack of inadequate diabetic control or intolerable side effects before non-preferred drug will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **DDI**: Prandin is non-preferred but with any prior authorization requests, the member's drug profile will also be monitored for current use with both Sporanox and gemfibrozil, due to a significant drug-drug interaction.
GLUCOSE ELEVATING AGENTS								
GLUCOSE ELEVATING AGENTS	MC/DEL		GLUCAGEN INJ. HYPOKIT	MC/DEL		GLUCAGON DIAGNOSTIC KIT	Use PA Form# 20420	

				MC/DEL		GLUCAGEN DIAGNOSTIC KIT		
THYROID								
THYROID HORMONES	MC/DEL		**ARMOUR THYROID TABS**	MC		LEVOTHYROXINE SODIUM SOLR	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**CYTOMEL TABS**	MC/DEL		LIOTHYRONINE		
	MC/DEL		**LEVOTHROID TABS**	MC		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 / BONE AGENTS								
OSTEOPOROSIS	MC/DEL		ALENDRONATE	MC/DEL		**ACTONEL 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		**FOSAMAX SOLN[2]**	MC		AREDIA SOLR	1. Approval only requires failure of Alendronate or Boniva.	
	MC/DEL		**MIACALCIN SOLN[2]**	MC/DEL		BONIVA INJECTION KIT		
				MC/DEL		BONIVA TABS[2,4]		
				MC/DEL		CALCITONIN NS	2. Quantity limits apply, please see dosage consolidation list.	
				MC/DEL		**DIDRONEL TABS**		
				MC		EVISTA TABS[1]		
				MC		FORTEO	3. Please use Alendronate and Vitamin D.	
				MC/DEL		FORTICAL		
				MC/DEL		**FOSAMAX TABS AND PLUS D[3]**	4. Please use other preferred agents.	
				MC		PROLIA		
				MC		XGEVA		
				MC/DEL		ZOMETA		
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	HUMATROPE SOLR[2]	Use PA Form# 10710	See Growth Hormone PA form for criteria. Step-order will still apply unless clinical contraindication supplied.
	MC/DEL		NUTROPIN AQ NUSPIN[1]	MC	5	INCRELEX[2]	1.Clinical PA is required to establish diagnosis and medical necessity.	
	MC/DEL		NORDITROPIN CARTRIDGE SOLN[1]	MC/DEL	8	NUTROPIN		
				MC	8	OMNITROPE		
				MC	8	SAIZEN SOLR[2]	2. Products must be used in specified step order. All step 5's must be tried prior to moving to step 8's.	
				MC/DEL	8	TEV-TROPIN		
SOMATOSTATIC AGENTS	MC/DEL		OCTREOTIDE INJ	MC/DEL		SANDOSTATIN	Use PA Form# 10710	
						SOMATULINE		
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	1. Products must be used in specified step order. Nocturnal enuresis patients will be encouraged to periodically attempt stopping	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).
				MC/DEL	6	DDAVP SOLN[1]		
				MC	6	DESMOPRESSIN SPRAY[1]		
				MC/DEL	8	DESMOPRESSIN ACETATE SOLN[1]		

				MC/DEL	8	STIMATE SOLN[1,2]	DDAVP. 2. Patients with a diagnosis of hemophilia or Von Willebrands disease will be exempt from prior authorization. Use PA Form# 20420	
ANTISPASMODICS	MC/DEL		**OXYBUTYNIN**	MC/DEL	8	**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	8	**DITROPAN**		
				MC	8	**SANCTURA**		
				MC/DEL	9	TROSPIUM		
ANTISPASMODICS - LONG ACTING	MC/DEL		**OXYBUTYNIN ER TABS**	MC/DEL	8	ENABLEX[1,3]	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		TOVIAZ	MC	8	DITROPAN XL TBCR	1. See Criteria Section.	
	MC		VESICARE[1]	MC/DEL	8	**OXYTROL**	2. Product is considered line extension of the original product due to Healthcare Reform (HCR). MaineCare will consider these medications non-preferred and a step 9 because of the impact under the Federal Rebate Program in conjunction with HCR.	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/DEL	9	DETROL LA CP[2]		**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.
				MC	9	SANCTURA XR[2]	3. Use a preferred long acting antispasmodic.	
CHOLINERGIC	MC/DEL		**URECHOLINE**				Use PA Form# 20420	
	MC/DEL		**BETHANECHOL**					
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**				Use PA Form# 20420	
	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				Use PA Form# 20420	
	MC/DEL		**NITROGLYCERIN CPCR**					
	MC		NITROL OINT					
	MC		NITRO-TIME CPCR					
NITRO - PATCHES	MC/DEL	1	**NITROGLYCERIN PT24[1]**	MC		NITRODISC PT24	1. At least 2 step 1's and step 3 of the preferred products must be used in specified order or PA will be	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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[1]**	MC/DEL		**NITRO-DUR PT24**		
	MC/DEL	1	**NITRO-DUR PT 24 0.8MG[1]**					

	MC/DEL	3	**MINITRAN PT24[1]**				specified order or PA will be required. Use PA Form# 20420	
NITRO - SUBLINGUAL/ SPRAY	MC/DEL MC/DEL		**NITROSTAT SUBL** **NITROTAB SUBL**	MC/DEL MC MC		**NITROQUICK SUBL** NITROLINGUAL SOLN NITROLINGUAL 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 - NON SELECTIVE	MC MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		CARVEDILOL LEVATOL TABS **NADOLOL TABS** **PINDOLOL TABS** **PROPRANOLOL HCL SOLN[1]** **PROPRANOLOL HCL TABS[1]** **PROPRANOLOL LA CAPS** SOTALOL HCL TABS **TIMOLOL MALEATE TABS**	MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL MC		**BETAPACE TABS** **BETAPACE AF TABS** **COREG CR[3]** **COREG TABS** **CORGARD TABS** **INDERAL TABS** **INDERAL LA CPCR** INNOPRAN XL **PROPRANOLOL HCL 60MG TABS[2]** SOTALOL AF RANEXA	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.
BETA BLOCKERS - CARDIO SELECTIVE	MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL		**ACEBUTOLOL HCL CAPS** **ATENOLOL TABS[1]** BETAXOLOL HCL TABS **BISOPROLOL FUMARATE TABS** **METOPROLOL TARTRATE TABS[1]** **METOPROLOL ER**	MC/DEL MC MC/DEL MC MC/DEL MC/DEL MC/DEL		BYSTOLIC KERLONE TABS **LOPRESSOR TABS** SECTRAL CAPS **TENORMIN TABS** **TOPROL XL TB24** **ZEBETA TABS**	1. Recommend using Atenolol (and metoprolol) BID since its effects do not last 24 hours. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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 - 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. Use PA Form# 20420	
	MC MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL		DILTIA XT CP24 **DILTIAZEM HCL ER CP24** **DILTIAZEM HCL XR CP24** **DILTIAZEM CD 300MG CP24** **DILTIAZEM CD 360MG CP24** CARTIA XT CP24[1] **DILTIAZEM CD CP24[1]** **DILTIAZEM HCL ER CP24[1]** **DILTIAZEM XR CP24[1]** **TIAZAC CP24[1]**	MC MC MC/DEL MC/DEL MC MC MC/DEL MC/DEL MC/DEL	5 6 8 8 8 8 8 8 8	DILACOR XR CP24[1] TAZTIA[1] **CARDIZEM TABS[1]** **CARDIZEM CD CP24[1]** CARDIZEM LA TB24[1] CARDIZEM SR CP12[1] **DILTIAZEM HCL TABS[1]** **DILTIAZEM HCL ER CP12[1]** **DILTIAZEM HCL ER CP12[1]**	1. Products must be used in specified order or PA will be required. Just write "Diltiazem 24-hour"and the pharmacy will use a preferred long acting diltiazem that does not require PA. Use PA Form# 20420	Preferred drugs must be tried and failed (in step-order) due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **DDI:** All preferred diltiazems will now be non-preferred and require prior authorization if they are currently being used in combination with either Enablex 15mg or Vesicare 10mg. All non-preferred diltiazems require prior authorization, but with any prior authorization request, the member's drug profile will also be monitored for current use with Enablex 15mg or Vesicare 10mg.
				MC/DEL MC/DEL		**PLENDIL TB24** **FELODIPINE**	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 MC		DYNACIRC CAPS DYNACIRC CR TBCR[1]	Use PA Form# 20420 1. Established users will be grandfathered	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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 MC/DEL		**CARDENE SR CPCR** **NICARDIPINE HCL CAPS**	Use PA Form# 20420	Other Preferred calcium channel blockers must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		**AFEDITAB CR** **NIFEDIAC CC** **NIFEDICAL XL TBCR** **NIFEDIPINE TBCR** **NIFEDIPINE ER TBCR**	MC MC/DEL MC MC/DEL		ADALAT CC TBCR[1] **NIFEDIPINE CAPS** PROCARDIA CAPS **PROCARDIA XL TBCR**	1. Established users of Adalat CC are grandfathered. Use PA Form# 20420	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		SULAR TB24	1. Established users of 10MG and 20MG strengths are grandfathered. Use PA Form# 20420	
				MC		SULAR CR[1]		
	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. Use PA Form# 20420	Preferred drugs must be tried and failed (in step-order) due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between anothe 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		
ANTIARRHYTHMICS	MC/DEL		**AMIODARONE**	MC/DEL		**CORDARONE**	1. Prescription must be written by Cardiologist. 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:** 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) or Levofloxacin or Gemifloxacin, or Moxifloxacin, or Ofloxacin. **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		**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]		
	MC/DEL		**PROPAFENONE**	MC		RYTHMOL SR		
	MC		QUINAGLUTE	MC		RYTHMOL		
	MC/DEL		**QUINIDINE GLUCONATE**					
	MC/DEL		**QUINIDINE SULFATE**					
ACE INHIBITORS	MC/DEL		**BENAZEPRIL HCL**	MC	5	MAVIK TABS	1. Non-preferred products must be used in specified order. 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 anothe 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[1]**		
	MC/DEL		**FOSINOPRIL SODIUM**	MC/DEL	8	**ALTACE CAPS[1]**		
	MC/DEL		**LISINOPRIL TABS**	MC/DEL	8	**LOTENSIN TABS[1]**		
	MC/DEL		**RAMIPRIL**	MC/DEL	8	**MOEXIPRIL[1]**		
	MC/DEL		**QUINAPRIL**	MC	8	**MONOPRIL HCT TABS[1]**		
				MC/DEL	8	**PRINIVIL TABS[1]**		
				MC/DEL	8	**UNIVASC[1]**		
				MC	8	VASOTEC TABS[1]		
				MC/DEL	8	**ZESTRIL TABS[1]**		
ANGIOTENSIN RECEPTOR BLOCKER	MC		AVAPRO[1]	MC/DEL	8	**ATACAND TABS**	Use PA Form# 20420 1. Preferred products only available without PA if patient on diabetic therapy or prior ACE therapy. 2. Use preferred active ingredients which are available without PA.	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[1]**	MC/DEL	8	**COZAAR**		
	MC/DEL		**DIOVAN[1]**	MC/DEL	8	EDARBI		
	MC/DEL		LOSARTAN[1]	MC	8	TEVETEN TABS		
	MC/DEL		**MICARDIS TABS[1]**	MC/DEL	8	TRIBENZOR[2]		
DIRECT RENIN INHIBITOR				MC/DEL		AMTURNIDE	1. Must show failure of single and combination therapy from all preferred antihypertensive categories. Use PA Form# 20420	
				MC/DEL		TEKTURNA[1]		
				MC/DEL		TEKAMLO		
ANTIHYPERTENSIVES - CENTRAL	MC/DEL		**CATAPRES-TTS**	MC/DEL		**CATAPRES TABS**	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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		**CLONIDINE HCL TABS**	MC/DEL		CLONIDINE TTS		
	MC/DEL		**GUANFACINE HCL TABS**	MC		GUANABENZ ACETATE TABS		
	MC/DEL		**HYDRALAZINE HCL TABS**	MC		ISMELIN TABS		
	MC		HYLOREL TABS	MC		MINIPRESS CAPS		
	MC/DEL		**METHYLDOPA TABS**	MC		**NEXICLON**		
	MC/DEL		**MINOXIDIL TABS**	MC/DEL		**TENEX TABS**		

	MC/DEL		PRAZOSIN HCL CAPS					
	MC/DEL		RESERPINE TABS					
ACE INHIBITORS AND CA CHANNEL BLOCKERS				MC/DEL	8	LOTREL CAPS	Use individual preferred generic medications.	
				MC	8	TARKA TBCR		
				MC/DEL	9	AMLODIPINE/BENAZEPRIL	Use PA Form# 20420	
ACE AND THIAZIDE COMBO'S	MC/DEL		BENAZEPRIL HCL/HYDROCHLOR	MC/DEL		ACCURETIC TABS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		CAPTOPRIL/HYDROCHLOROTHIA	MC		MONOPRIL HCT TABS		
	MC/DEL		ENALAPRIL MALEATE/HCTZ TABS	MC/DEL		PRINZIDE TABS		
	MC/DEL		LISINOPRIL-HCTZ TABS	MC/DEL		UNIRETIC TABS		
	MC/DEL		LOTENSIN HCT TABS	MC		VASERETIC TABS		
				MC/DEL		ZESTORETIC TABS		
BETA BLOCKERS AND DIURETIC COMBO'S	MC/DEL		ATENOLOL/CHLORTHALIDONE	MC		CORZIDE TABS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		BISOPROLOL FUMARATE/HCTZ	MC/DEL		LOPRESSOR HCT TABS		
	MC/DEL		PROPRANOLOL/HCTZ	MC		TENORETIC		
				MC		TIMOLIDE 10/25 TABS		
				MC/DEL		ZIAC TABS		
ARB'S AND CA CHANNEL BLOCKERS	MC/DEL		EXFORGE[1]	MC/DEL		AZOR	1. Preferred products only available without PA if patient on diabetic therapy or prior ACE therapy.	
	MC/DEL		EXFORGE HCT[1]	MC/DEL		TWYNSTA	Use PA Form# 20420	
ARB'S AND DIURETICS	MC		AVALIDE TABS[1]	MC/DEL		ATACAND HCT TABS	1. Preferred products only available without PA if patient on diabetic therapy or prior ACE therapy.	Same initial criteria as the ARB class and Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		BENICAR HCT[1]	MC/DEL		HYZAAR TABS		
	MC/DEL		DIOVAN HCT TABS[1]	MC		TEVETEN HCT TABS		
	MC/DEL		LOSARTAN HCT[1]					
	MC/DEL		MICARDIS HCT TABS[1]				Use PA Form# 20420	
ARB'S AND DIRECT RENIN INHIBITOR COMBINATION	MC/DEL		VALTURNA				Use PA Form# 20420	
DIURETICS	MC/DEL		ACETAZOLAMIDE TABS	MC/DEL		ALDACTAZIDE TABS	1. Multiples of Spironolactone 25 mg are cheaper than 50 mg strength. Inspra will be approved for severe breast tenderness and male gynecomastia.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		BUMETANIDE	MC/DEL		ALDACTONE TABS		
	MC/DEL		CHLOROTHIAZIDE TABS	MC		AMILORIDE HCL		
	MC/DEL		CHLORTHALIDONE TABS	MC/DEL		BUMEX TABS		
	MC		EDECRIN TABS	MC/DEL		DEMADEX TABS		
	MC/DEL		FUROSEMIDE	MC/DEL		DIAMOX		
	MC/DEL		HYDROCHLOROTHIAZIDE	MC/DEL		DIURIL		
	MC/DEL		INDAPAMIDE TABS	MC/DEL		DYAZIDE CAPS		
	MC/DEL		METHAZOLAMIDE TABS	MC		ENDURON TABS		
	MC/DEL		METHYCLOTHIAZIDE TABS	MC		INSPRA		
	MC/DEL		SPIRONOLACTONE 25MG TABS	MC/DEL		LASIX TABS	Use PA Form# 20420	
	MC/DEL		SPIRONOLACTONE/HYDRO	MC/DEL		MAXZIDE		
	MC/DEL		TORSEMIDE TABS	MC		MICROZIDE CAPS		
	MC/DEL		TRIAMTERENE/HCTZ	MC/DEL		MIDAMOR TABS		
	MC		ZAROXOLYN TABS	MC		NAQUA TABS		
				MC/DEL		SPIRONOLACTONE 50MG[1]		
CCB / LIPID				MC/DEL		CADUET		
LIPID DRUGS								
CHOLESTEROL - BILE SEQUESTRANTS	MC/DEL		CHOLESTYRAMINE	MC/DEL		COLESTID	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		COLESTIPOL HCI	MC/DEL		PREVALITE		
				MC		QUESTRAN		
				MC/DEL		WELCHOL TABS		
CHOLESTEROL - FIBRIC ACID DERIVATIVES	MC/DEL		GEMFIBROZIL TABS	MC		ANTARA	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		NIASPAN	MC		LOPID		
	MC		TRICOR	MC		FIBRICOR		

	MC		TRILIPIX	MC MC MC/DEL MC		LIPOFEN LOFIBRA FENOFIBRATE TRIGLIDE		**DDI:** Fenofibrate is non-preferred but with any prior authorization requests, the member's drug profile will also be monitored for concurrent use with Warfarin. **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, any HMG-COA Reductase Inhibitors (statins), or Warfarin.
CHOLESTEROL - HGM COA + ABSORB INHIBITORS MORE POTENT DRUGS/COMBINATIONS	MC/DEL MC/DEL		**LIPITOR** **SIMVASTATIN[1]**	MC/DEL MC MC/DEL MC/DEL		**CRESTOR** **VYTORIN[2]** **ZOCOR** **SIMVASTATIN 80MG[1,3]**	1. Dosing limits apply, please see dosage consolidation list. 2. Only available if component ingredients are unavailable. 3. Current users 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, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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:** 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 TB24 LOVASTATIN TABS[2] PRAVASTATIN[2]	MC/DEL MC MC/DEL MC MC/DEL MC	8 8 8 8 8 8	ALTOPREV TB24 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		**SIMCOR**	MC/DEL		**ADVICOR TBCR**	Use PA Form# 20420	
PULMONARY ANTI-HYPERTENSIVES								
PULMONARY ANTI-HYPERTENSIVES	MC MC MC/DEL		ADCIRCA[1] VENTAVIS[2] EPOPROSTENOL INJ[4]	MC/DEL MC MC/DEL		FLOLAN REMODULIN[3] REVATIO[1,]	1. See Criteria Section. 2. See Criteria Section. 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 significat potential drug interation between another drug and the preferred drug(s) exists. 1. Adcirca approvals will require WHO Group 1 diagnosis of primary PAH (Primary Pulmonary Hypertension) and NYHA functional class 2 or 3. 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.	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.

							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. Use PA Form# 20420	
IMPOTENCE AGENTS								
IMPOTENCE AGENTS							As of January 1, 2006, per CMS (federal govt.), impotence agents are no longer covered.	As of January 1, 2006, per CMS (federal govt.), impotence agents are no longer covered.
ANTI-EMETOGENICS								
ANTIEMETIC - ANTICHOLINERGIC / DOPAMINERGIC	MC/DEL		MECLIZINE HCL TABS	MC		ANTIVERT 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		PROMETHAZINE SUPP	MC/DEL		PHENERGAN SOLN		
	MC/DEL		PROMETHAZINE	MC/DEL		PROMETHAZINE 50MG SUPP		
	MC		TRANSDERM-SCOP PT72	MC/DEL		PROMETHEGAN SUPP		
				MC		TORECAN TABS		
ANTIEMETIC - 5-HT3 RECEPTOR ANTAGONISTS/ SUBSTANCE P NEUROKININ	MC/DEL		MARINOL CAPS	MC/DEL	5	GRANISETRON	1. Approvals will require diagnosis of chemo-induced nausea/vomiting and failed trials of all preferred anti-emetics, including 5-HT3 class (Ondansetron) and Marinol. 2. Ondansetron will be preferred with CA diag and dosing limits still apply. 3. Clinical PA is required for members on highly emetic anti-neoplastic agents. 4. Dosing limits apply, please see Dosage Consolidation List Use PA Form# 20610 for **Ondansetron** requests Use PA Form# 20420 for **all others**	Preferred drugs and step therapy must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. * Ondansetron limits still apply as listed on the Ondansetron PA form for covered indications including chemotherapy, radiotherapy, post operative nausea & vomiting and hyperemesis gravidarum. Other medical indications will be approved or denied on a case by case basis. Hyperemesis and other medical indications approved are still subject to failure of multiple preferred antiemesis drugs.
	MC		ONDANSETRON TABS[2,4]	MC	8	ALOXI		
	MC		ONDANSETRON ODT TBDP[2,4]	MC	8	ANZEMET TABS		
	MC		ONDANSETRON INJ[2,4]	MC	8	CESAMET[1]		
				MC	8	EMEND[3]		
				MC/DEL	8	KYTRIL		
				MC	8	SANCUSO		
				MC/DEL	8	ZOFRAN ODT TBDP[4]		
				MC/DEL	8	ZOFRAN TABS[4]		
				MC/DEL	8	ZOFRAN INJ[4]		
				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.	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 MC/DEL		LORATADINE TAVIST ND (OTC)	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL	5 8 8 8 8	ZYRTEC SYR[1,2] ALLEGRA[3] CLARITIN[3] LORATADINE ODT[4] XYZAL[3]	2. Clarinex and Zyrtec syrp <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	Pseudoephedrine is available with prescription.
ANTIHISTIMINES - OTHER	MC/DEL MC/DEL MC/DEL		CLEMASTINE CHLORPHENIRAMINE DIPHENHYDRAMINE				Use PA Form# 20530	
			ALLERGY / ASTHMA THERAPIES					
ANTIASTHMATIC - ANTICHOLINERGICS - INHALER	MC/DEL		SPIRIVA[1,2]				Use PA Form# 20420 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 - PHOSPHODIESTERASE 4 INHIBITORS				MC/DEL		DALIRESP	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 - 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 MC/DEL		FLUTICASONE SPR[3] NASONEX SUSP[3]	MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC MC/DEL MC MC MC/DEL MC/DEL	5 5 8 8 8 8 8 8 8 8 8 9	BECONASE AQ INHA[1,3] NASACORT AQ AERS[1,3] FLONASE SUSP[2,3] FLUNISOLIDE SOLN[2,3] NASACORT AERS[2,3] OMNARIS SPR[3] RHINOCORT AERO[2,3] RHINOCORT AQUA SUSP[2,3] TRI-NASAL SOLN[2,3] VANCENASE POCKETHALER AERS[2,3] VERAMYST[2,3] TRIAMCINOLONE NS	Use PA Form# 20420 1. All preferred drugs must be tried before moving to non preferred steps. 2. All step 5 medications need to be tried before moving to step 8's. 3. Dosing limits apply to whole category, please see dosage consolidation list.	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.
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.

	MC/DEL		NASALCROM	MC	7	IPRATROPIUM NASAL SOL[1]	1. Ipratropium will be approved if submitted with documentation supporting use of CPAP machine.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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		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.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**MAXAIR**	MC/DEL		**ALBUTEROL AER**		
	MC/DEL		**METAPROTERENOL**	MC/DEL		**ALBUTEROL HFA**		
	MC		**PROAIR HFA[3]**	MC/DEL		**ALBUTEROL 0.63mg/3ml**		
	MC/DEL		**PROVENTIL HFA**	MC/DEL		**ARCAPTA**		
	MC/DEL		**SEREVENT**	MC/DEL		**BRETHINE**	2. Quantity Limit: 12 cc/day.	
	MC/DEL		**TERBUTALINE SULFATE TABS**	MC/DEL		**FORADIL AEROLIZER CAPS**		
	MC/DEL		**VENTOLIN HFA AERS[3]**	MC/DEL		**VENTOLIN AERS**	3. Dosing limits apply, please see dosage consolidation list.	
				MC		VOLMAX TBCR		
				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[1,2]**				1. We ask physicians to write "asthma" on the prescription whenever Advair is primarily being used for that condition.	
	MC/DEL		DULERA					
	MC/DEL		SYMBICORT[2]				2. Dosing limits apply, please see dosage consolidation list.	
							Use PA Form# 20420	
ANTIASTHMATIC - ADRENERGIC ANTICHOLINERGIC	MC/DEL		**ALBUTEROL/IPRATROPIUM NEB. SOLN**	MC/DEL		DUONEB SOLN[1]	1. Please use preferred individual ingredients Albuterol and Ipratropium.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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]**				2. We ask physicians to write "asthma" on the prescription whenever Combivent is primarily being used for that condition.	
							Use PA Form# 20420	
ANTIASTHMATIC - XANTHINES	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[4]	MC/DEL	5	**AEROBID AERS[2,4]**	1. No PA for Pulmicort susp if under 8 years old.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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[4]**	MC	5	BECLOVENT AERS[2,4]		
	MC/DEL		**FLOVENT HFA[4]**	MC	5	VANCERIL AERS[2,4]		
	MC/DEL		**PULMICORT SUSP[1,4]**	MC/DEL	8	**AEROBID-M AERS[3,4]**		
	MC		QVAR AERS[4]	MC/DEL	8	ALVESCO[4]	2. All preferreds must be tried before moving to non preferred steps.	
				MC	8	VANCERIL DOUBLE STRENGTH AERS[3,4]		
				MC/DEL	8	**PULMICORT FLEXHALER[4]**	3. All step 5 medications need to be tried before	

							moving to step 8's. 4. Dosing limits apply to whole category, please see dosage consolidation list. 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 MC MC MC	8 8 9 9	ARALAST ZEMAIRA GLASSIA PROLASTIN SUSR	Use PA Form# 20420	Prolastin and Azemaira will be approved for members with A1AT deficiency and clinically demonstrable panacinar emphysema.
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	MC/DEL MC/DEL MC/DEL MC MC		DEXTRO-GUAIF SYRP[1] GUAIFENESIN SYRP[1] PSEUDOEPHEDRINE[1] ROBITUSSIN DM SYRP[1] ROBITUSSIN SUGAR FREE SYRP[1]				1. 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.
DIGESTIVE AIDS / ASSORTED GI								
GI - ANTIPERISTALTIC AGENTS	MC/DEL MC/DEL MC/DEL MC/DEL MC		DIPHENOXYLATE DIPHENOXYLATE/ATROPINE LOPERAMIDE HCL CAPS/LIQ OPIUM TINCTURE TINC PAREGORIC TINC	MC/DEL MC MC/DEL		LOFENE TABS LONOX TABS MOTOFEN 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.
GI - ANTI-DIARRHEAL/ ANTACID - MISC.	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		ATROPINE SULFATE SOLN BENTYL SYRP BISMATROL BISMUTH SUBSALICYLATE CALCIUM CARBONATE (ANTACID) CHEW DICYCLOMINE HCL GLYCOPYRROLATE TABS HAPONAL TABS HYOSCYAMINE CAPS & TABS HYOSCYAMINE SULFATE KAOPECTATE MAGNESIUM OXIDE TABS MAG-OX 400 TABS PAMINE TABS PROPANTHELINE BROMIDE TABS SAL-TROPINE TABS SODIUM BICARBONATE TABS TUMS	MC MC/DEL MC MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL MC MC		BELLADONNA ALKALOIDS & OP BENTYL TABS CUVPOSA GLYCOPYRROLATE INJ HYOSCYAMINE SL LEVBID TB12 LEVSIN ELIX LEVSIN TABS LEVSIN/SL SUBL NULEV TBDP ROBINUL INJ ROBINUL 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**. Preferred products that used to require diag codes still require diag codes unless indicated otherwise.
GI - H2-ANTAGONISTS	MC/DEL MC/DEL		CIMETIDINE FAMOTIDINE	MC MC		AXID CAPS AXID AR 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

	MC/DEL MC/DEL MC		RANITIDINE RANITIDINE SYRP ACID REDUCER TABS	MC/DEL MC/DEL MC MC/DEL MC/DEL		NIZATIDINE CAPS PEPCID PEPCID AC ZANTAC SYRP ZANTAC TABS		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.
GI - PROTON PUMP INHIBITOR	MC/DEL MC/DEL MC/DEL		DEXILANT (KAPIDEX)[2] OMEPRAZOLE 20MG[2] PANTOPRAZOLE	MC MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC	6 7 8 8 8 8 8 8 8 8 8 9	PRILOSEC OTC[4] ACIPHEX TBEC[4] PREVACID CPDR[4,5] PREVACID SOLUTABS[1] NEXIUM CPDR[4] PRILOSEC CPDR PROTONIX INJ PROTONIX[2] OMEPRAZOLE 10MG[2] OMEPRAZOLE-SODIUM BICARBONATE CAPS LANSOPRAZOLE OMEPRAZOLE 40MG[3]	1. Prevacid Solutabs available without PA for children less than 9 years old. 2. Dosing limits apply, please see dosage consolidation list. 3. Please use multiple 20mg Capsules to obtain required dose. 4. All preferreds and step therapy must be tried and failed. 5.Established users prior to 10/1/09 may continue to obtain Prevacid until 12/31/09. Use PA Form# 20720	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 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. Patients may be required to step down from a PPI to a histamine H2-receptor antagonist during the 12 months or on an annual clinical review if PPI therapy is continued. **DDI:** Omeprazole will require prior authorization if being used in combination with Plavix. **DDI:** Prevacid, Omeprazole and pantoprazole 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	Use PA Form# 20420	
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[1] GASTROCROM CONC GENERLAC SYRP[1] LACTULOSE SYRP[1] METOCLOPRAMIDE HCL SIMETHICONE	MC/DEL MC MC/DEL MC/DEL		AMITIZA[2] CEPHULAC SYRP INFANTS GAS RELIEF SUSP REGLAN TABS	1. Diag codes no longer necessary for preferred products. Lactulose has 60cc/day QL Use PA Form# 20420 2. 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		ASACOL TBEC 400 APRISO AZULFIDINE TABS	MC/DEL MC/DEL MC/DEL		ASACOL 800MG HD AZULFIDINE EN-TABS TBEC BALSALAZIDE	Use PA Form# 20420 1. Current users	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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	CANASA SUPP	MC/DEL	LIALDA TABS[1]	grandfathered.	
	MC	COLAZAL CAPS	MC/DEL	PENTASA 500MG[2]	2. Use multiple Pentasa 250mg.	
	MC	DIPENTUM CAPS	MC	SFROWASA		
	MC/DEL	PENTASA CPCR 250MG				
	MC/DEL	ROWASA ENEM				
	MC/DEL	**SULFAZINE EC TBEC**				
	MC/DEL	**SULFASALAZINE TABS**				
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			
GI - MISC.	MC/DEL	BISAC-EVAC SUPP	MC/DEL	ACTIGALL CAPS	1. Must show evidence of trials of preferred agents that do not require PA, such as OTC senna, docusate, mineral oil and prescription lactulose. 2. Quantity Limit: 255 g/90-day without PA for greater than 18 years old. If under 18 years of age, allowed 17gms daily 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. **As listed in MaineCare Policy, certain drugs require specific diagnoses for approval.**
	MC/DEL	BISACODYL	MC	BENEFIBER		
	MC	BISCOLAX SUPP	MC/DEL	CARAFATE		
	MC	CINOBAC CAPS	MC/DEL	CLEARLAX POW		
	MC/DEL	CITRATE OF MAGNESIA SOLN	MC/DEL	COLACE CAPS		
	MC/DEL	CITRUCEL	MC/DEL	COLYTE		
	MC/DEL	DIOCTO SYRP	MC	DIOCTO-C SYRP		
	MC	DOCUSATE CALCIUM CAPS	MC	DOC SOD /CAS CAP		
	MC/DEL	DOCUSATE SODIUM	MC	DOC-Q-LAX CAPS		
	MC/DEL	FIBER LAXATIVE TABS	MC/DEL	DOCUSATE SODIUM/CAS CAPS		Preferred products that used to require diag codes still require diag codes unless indicated otherwise.
	MC	FLEET	MC/DEL	DOK PLUS	Use PA Form# 20420	
	MC/DEL	GENFIBER POWD	MC/DEL	DULCOLAX SUPP		
	MC/DEL	GLYCERIN	MC	FIBER CON TABS		
	MC	HIPREX TABS	MC/DEL	FIBER-LAX TABS		
	MC/DEL	KRISTALOSE PACK	MC	GOLYTELY SOLR		
	MC	MAALOX	MC	MALTSUPEX		
	MC	METAMUCIL	MC	MIRALAX PACK (OTC versions)		
	MC/DEL	MILK OF MAGNESIA SUSP	MC	MIRALAX POWD (OTC versions)		
	MC	MINERAL OIL OIL	MC	PEG 3350 POWDER[2]		
	MC	NULYTELY SOLR	MC	PEG-ELECTROLYTES SOLR		
	MC/DEL	SENNA	MC/DEL	SENEXON TABS		
	MC/DEL	SENOKOT GRAN	MC/DEL	SENOKOT TABS		
	MC/DEL	SENOKOT SYRP	MC	SENOKOT S TABS		
	MC/DEL	SENOKOT CHILDRENS SYRP	MC	STOOL SOFTENER PLUS CAPS		
	MC	SENOKOT XTRA TABS	MC/DEL	UNI-CENNA TABS		
	MC/DEL	SORBITOL	MC	UNI-EASE PLUS CAPS		
	MC/DEL	STOOL SOFTENER CAPS	MC	V-R NATURAL SENNA LAXATIV TABS		
	MC/DEL	SUCRALFATE TABS	MC	URSO 250		
	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.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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	Use PA Form# 20420	
	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/DEL	NITROFURANTOIN MACR SUSP		
	MC/DEL	PHENAZOPYRIDINE HCL TABS	MC	POTASSIUM CITRATE/CITRIC SOLN		
	MC/DEL	PHENAZOPYRIDINE PLUS	MC/DEL	PYRIDIUM PLUS TABS		
	MC/DEL	PROSED/DS TABS	MC	PYRIDIUM TABS		
	MC	TRICITRATES SYRP	MC/DEL	RENACIDIN SOLN		

	MC/DEL		URELIEF PLUS					
	MC		UREX TABS					
	MC/DEL		URISED TABS					
	MC		UROCIT-K					
	MC/DEL		UROQID #2 TABS					
PHOSPHATE BINDERS								
PHOSPHATE BINDERS	MC/DEL		ELIPHOS[1]	MC/DEL		CALCIUM ACETATE	Use PA Form# 20420	
	MC/DEL		MAGNEBIND - 400[1]	MC		PHOSLYRA	1. Diag required.	
	MC/DEL		RENAGEL[1]					
	MC/DEL		FOSRENOL[1]					
	MC/DEL		RENVELA[1]					
INTRA-VAGINALS								
VAGINAL - ANTIBACTERIALS	MC/DEL		CLEOCIN CREA	MC/DEL		VANDAZOLE	1. Step order must be followed to avoid PA. Must fail Cleocin Cream and Metronidazole products before moving to next step product without PA. 2. Dosing limits apply, please see Dosage Consolidation List. Use PA Form# 20420	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		METROGEL VAGINAL GEL[2]	MC/DEL		METRONIDAZOLE VAGINAL GEL[2]		
	MC/DEL		CLEOCIN SUPP[1]					
VAGINAL - ANTI FUNGALS	MC/DEL		CLOTRIMAZOLE CREA	MC		AVC CREA	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. **DDI:** Miconazole will require prior authorization if being used in combination with Warfarin.
	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[1]	1. 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[1]		
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**	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 [illegible]	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	ALFUZOSIN		
	MC/DEL		TERAZOSIN HCL CAPS	MC/DEL	8	AVODART[2,4]		
	MC/DEL		**TAMSULOSIN**	MC/DEL	8	**CARDURA TABS[4]**		
				MC/DEL	8	JALYN[3,4]		
				MC/DEL	8	PROSCAR TABS[4]		
				MC/DEL	8	RAPAFLO[4]		

				MC/DEL	8	UROXATRAL[4]	(tamsulosin and finasteride) and (tamsulosin and non-preferred Avodart). 4. Non-preferred products must be used in specified order. Use PA Form# 20420	
ANXIOLYTICS								
ANXIOLYTICS - BENZODIAZEPINES	MC/DEL		ALPRAZOLAM TABS	MC/DEL	8	ATIVAN	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	8	NIRAVAM		
	MC/DEL		CLORAZEPATE DIPOTASSIUM TABS	MC/DEL	8	SERAX		
	MC/DEL		DIAZEPAM	MC/DEL	8	TRANXENE		
	MC/DEL		LORAZEPAM	MC/DEL	8	XANAX TABS		
	MC/DEL		OXAZEPAM CAPS	MC/DEL	8	XANAX XR		
				MC/DEL	9	ALPRAZOLAM ER		
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				Use PA Form# 20420	
	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]	1. Use Fluoxetine 20 mg in multiples.	Preferred drugs (including failure of at least one preferred SSRI, one SNRI and one non-SSRI/SNRI) must be tried for at least 4 weeks each and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		BUPROPION SR	MC/DEL	8	CELEXA[4]		
	MC/DEL		BUPROPION XL	MC	8	CYMBALTA[5, 11]		
	MC/DEL		CITALOPRAM[4]	MC/DEL	8	EFFEXOR TABS	2. See Zoloft splitting table. Sertraline requires splitting of scored tabs to avoid PA.	
	MC/DEL		FLUOXETINE HCL CAPS	MC/DEL	8	EFFEXOR XR CP24[3, 10]		
	MC/DEL		FLUOXETINE HCL LIQD	MC/DEL	8	FLUOXETINE 40mg AND 60 mg CAPS[1]		**CYMBALTA:** Fibromyalgia diagnosis- prior use and failure of preferred generics (amitriptyline or cyclobenzaprine) and gabapentin prior to approval.
	MC/DEL		FLUOXETINE HCL 10mg TABS	MC/DEL	8	FLUOXETINE 20mg TABS[6]		**SAVELLA:** Fibromyalgia diagnosis and trial of a preferred generic (amitriptyline or cyclobenzaprine, and gabapentin) and Cymbalta prior to approval.
	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	3. Strong caution with pediatric population.	
	MC/DEL		NEFAZODONE	MC	8	OLEPTRO		Preferred Fluoxetine will be the only preferred antidepressant for members who are less than 18 years of age.
	MC/DEL		PAROXETINE[3]	MC/DEL	8	PAROXETINE CR[3]	4. See Celexa/Citalopram and Lexapro splitting tables.	Exceptions to the rule are as follows:
	MC/DEL		SERTRALINE[2]	MC/DEL	8	PAXIL[3]		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
	MC/DEL		TRAZODONE HCL TABS	MC/DEL	8	PAXIL CR[3]		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.
	MC/DEL		VENLAFAXINE ER CAPS[9]	MC/DEL	8	PRISTIQ		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.
				MC	8	PROZAC	5. Max daily dose allowed is 60mg, only 1 capsule per day allowed for all strengths. Combination of multiple strengths require PA.	4. Use of a preferred antidepressant for anxiety will require the diagnosis of anxiety on written prescription and submitted during claim submission.
				MC	8	PROZAC CAPS		
				MC	8	PROZAC WEEKLY CPDR		**DDI:** Fluvoxamine will now be non-preferred and require prior authorization if it is currently being used with glimepiride (Amaryl).
				MC/DEL	8	REMERON TABS		
				MC/DEL	8	SARAFEM CAPS		**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.
				MC/DEL	8	TRAZODONE HCL 300MG TABS	6. Use Fluoxetine 10mg tabs or capsules in multiples.	**DDI:** Fluoxetine will require prior authorization if being used in combination with Plavix.
				MC/DEL	8	WELLBUTRIN TABS		**DDI:** Fluvoxamine will require prior authorization if being used in combination with Plavix.
				MC/DEL	8	WELLBUTRIN SR TBCR		
				MC/DEL	8	WELLBUTRIN XL	7. Provide clinical documentation as to why a preferred generic alternative cannot be used.	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	8	REMERON SOLTAB TBDP		
				MC/DEL	8	SAVELLA[8]		
				MC/DEL	8	ZOLOFT		

				MC/DEL	8	VENLAFAXINE TABS[9]	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. 12. Non-preferred products must be used in specified step order. Use PA Form# 20420	
				MC/DEL	8	VENLAFAXINE ER TABS[9]		
				MC/DEL	8	VIIBRYD		
				MC/DEL	9	FLUOXETINE 90mg TABS[12]		
ANTIDEPRESSANTS - TRI-CYCLICS	MC/DEL		**AMITRIPTYLINE HCL TABS[1]**	MC/DEL		**AMOXAPINE TABS**	1. Users over the age of 65 require a pa. 2. Use multiples of 50mg. Use PA Form# 20420 Use PA Form# 10220 for **Brand Name requests**	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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[1]**	MC/DEL		**ANAFRANIL CAPS**		
	MC/DEL		**DESIPRAMINE HCL TABS[1]**	MC/DEL		**DOXEPIN HCL 150 MG[2]**		
	MC/DEL		**DOXEPIN HCL[1]**	MC/DEL		**NORPRAMIN TABS**		
	MC/DEL		**IMIPRAMINE HCL TABS[1]**	MC/DEL		**PAMELOR**		
	MC/DEL		**NORTRIPTYLINE HCL[1]**	MC		TOFRANIL		
	MC		PROTRIPTYLINE HCL TABS[1]	MC		VIVACTIL TABS		
	MC		SURMONTIL CAPS[1]					
SEDATIVE / HYPNOTICS								
SEDATIVE/HYPNOTICS - BARBITURATE	MC		BUTISOL SODIUM TABS[1]	MC		LUMINAL SOLN	1. 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[1]	MC/DEL		SOMNOTE CAPS		
	MC		MEBARAL TABS[1]					
	MC/DEL		PHENOBARBITAL[1]					
SEDATIVE/HYPNOTICS - BENZODIAZEPINES	MC/DEL		DORAL TABS[1]	MC		HALCION TABS[1]	1. Dosing limits apply, please see dosing consolidation list. 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[1]	MC		MIDAZOLAM HCL SYRP		
	MC/DEL		FLURAZEPAM HCL CAPS[1]	MC/DEL		RESTORIL CAPS[1]		
	MC/DEL		TEMAZEPAM CAPS 15 & 30MG[1]	MC/DEL		TEMAZEPAM 7.5MG[1]		
	MC/DEL		TRIAZOLAM TABS[1]					
SEDATIVE/HYPNOTICS - Non-Benzodiazepines	MC/DEL	1	MIRTAZAPINE	MC/DEL	7	AMBIEN[1]	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. 4. Must fail all preferred products before non-preferred	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		
				MC/DEL	8	ZOLPIMIST		

							Use PA Form# 30110	
ANTI-PSYCHOTICS								
ANTIPSYCHOTICS - ATYPICALS	MC		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. Use PA form# 20440 for **Multiple Antipsychotic requests** Use PA form# 10130 for **non-preferred single therapy atypical requests** 1. Please use multiple 25mg tablets. 2. Established users of single therapy atypicals were grandfathered. 3. Abilify requires splitting of tab to avoid PA. Please see Abilify splitting table. 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. 6. Dosing limits apply to 80mg, 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. 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 ORif 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. **Seroquel 50mg** tablets are non-preferred and multiple Seroquel 25mg tablets should be used. **DDI:** Abilify, Seroquel, and Zyprexa will now be non-preferred and require prior authorization if they are currently being used in combination with carbamazepine. **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. 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.
	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/DEL	8	LATUDA[6]		
	MC		ZYPREXA TABS[4]	MC	8	RISPERDAL TAB		
				MC	8	RISPERDAL CONSA[2]		
				MC	8	RISPERDAL M TAB[2]		
				MC	8	RISPERDAL SOLN		
				MC/DEL	8	RISPERIDONE ODT		
				MC/DEL	8	SAPHRIS		
				MC/DEL	8	SEROQUEL 50MG TABS[1,2]		
				MC	8	ZYPREXA ZYDIS TBDP[2]		
				MC	8	ZYPREXA RELPREVV		
				MC/DEL	9	SEROQUEL XR[5]		
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.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. If prescribing 2 or more antipsychotics, PA will be required for both drugs, except if one is Clozapine.
	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[1]				1. Preferred stimulants will be available without PA if diagnosis of ADHD. 2. As per recent FDA alert, Adderal & Dexedrinel should not be used in patients with underlying heart defects since they may be at increased risk for sudden death. 3. Dosing limits apply, please see dosing consolidation list. Use PA Form# 20420	
	MC/DEL		AMPHETAMINE SALT COMBO[1,3]					
	MC/DEL		DEXTROAMPHET SULF TABS[1,3]					
	MC/DEL		DEXEDRINE[1,3]					
	MC/DEL		DEXTROSTAT TABS[1]					
STIMULANT - LONG ACTING AMPHETAMINES SALT	MC		VYVANSE[2,3,4]	MC/DEL	8	ADDERALL XR CP24[1,3,4]	Use PA Form# 20420 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. 3. Preferred stimulants will be available without PA if diagnosis of ADHD.	Adderall XR- Current users as of 12/31/11 without prior use of Vyvanse will be required to transition to the preferred vyvanse product. Other members wi required PA
				MC/DEL	9	AMPHETAMINE/DEXTROAMPHET ER		

							4. Dosing limits applly, please see dosing consolidation list.	
LONG ACTING AMPHETAMINES	**MC**		DEXEDRINE CAP CR[1,2,3]	**MC**		DEXTROAMPHET SULF CPCR[3]	1. Preferred stimulants will be available without PA if diagnosis of ADHD. 2. 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. 3. Dosing limits applly, please see dosing consolidation list. Use PA Form# 20420	
STIMULANT - METHYLPHENIDATE	**MC/DEL** **MC/DEL** **MC/DEL** **MC/DEL** **MC/DEL** **MC/DEL**		FOCALIN TABS[1,2] METADATE ER TBCR[1,2] METHYLIN ER TBCR[1,2] METHYLIN TABS[1,2] METHYLIN SOL[1] METHYLPHENIDATE HCL[1,2]	**MC** **MC/DEL**		METHYLIN CHEWABLES RITALIN	1. Preferred stimulants will be available without PA if diagnosis of ADHD. Use PA Form# 20420 2. Dosing limits apply, please see dosing consolidation list. Maximum daily doses are as follows: 72mg daily for methylphenidate and 36mg daily for dexmethylphenidate.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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.
STIMULANT - METHYLPHENIDATE - LONG ACTING	**MC/DEL** **MC** **MC/DEL**		DAYTRANA[1,4] FOCALIN XR[1] METHYLPHENIDATE ER[1]	**MC** MC **MC/DEL**	5 8 8	METADATE CD CPCR[3] CONCERTA TBCR RITALIN LA[2]	1. Preferred stimulants will be available without PA if diagnosis of ADHD. 2. Non-preferred products must be used in specified step order. 3. Dosing limits apply, please see doseage consolidation list. 4. 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/DEL**		INTUNIV	**MC** **MC** **MC** **MC/DEL** **MC/DEL** **MC** **MC**	7 8 8 8 9 9 9	STRATTERA[1,2] CAFCIT SOLN[3] 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).	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

							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 see dosing consolidation list. 3. Non-preferred products must be used in specified 4. Please use generic Guanfacine. Use PA Form# 20710 for **Provigil, Nuvigil and Xyrem** Use PA Form# 20420 for **all others**	
ANTI-CATAPLECTIC AGENTS								
PSYCHOTHERAPEUTIC AGENTS - MISC.				MC MC MC		NUEDEXTA XYREM SOL XENAZINE	Use PA Form# 20710 for **Xyrem** Use PA Form# 20710 for **Xenazine**	
WEIGHT LOSS								
WEIGHT LOSS							No longer covered: PHENTERMINE, XENICAL,DIDREX, and MERIDIA	Weight loss drugs are not covered as permitted by Federal Medicaid regulations and Maine Medicaid (MaineCare) Policy.
ALZHEIMER DISEASE								
ALZHEIMER - Cholinomimetics/Others	MC/DEL MC/DEL MC/DEL		DONEPEZIL HYDROCHLORIDE TABS[1] DONEPEZIL HYDROCHLORIDE ODT[1] NAMENDA[1]	MC/DEL MC MC MC MC/DEL MC	5 5 5 8 8 9	EXELON[2] ARICEPT TABS[2] ARICEPT ODT[2] RAZADYNE[2] RIVASTIGMINE TARTRATE CAPS[2] COGNEX CAPS[2]	1. PA is required to establish dementia diagnosis and baseline mental status score. 2. Must fail all preferred products before moving to non-preferred. Use PA Form# 20420	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.
SMOKING CESSATION								
NICOTINE PATCHES / TABLETS	MC/DEL MC/DEL		CHANTIX[1,2,3] NICOTINE DIS PT24[2,3]	MC/DEL		NICODERM CQ PT24	Use PA Form# 20420 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. 3. Bupropion SR 150 mg is available without a prior authorization.	OTC Nicotine products are covered by MaineCare Policy when they have been determined to be cost-effective. Only Nicoderm and the generic nicotine gums have received this designation as preferred. All other nicotine products (OTC & prescription) are non-preferred by MaineCare Policy. Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs (in step-order) will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Another version of Zyban, Bupropion SR (100 and 150mg) is available without PA. There will be a quantity limit of 3 months supply of nicotine products allowed per 12 months.
NICOTINE REPLACEMENT - OTHER	MC/DEL		NICOTINE POLACRILEX GUM[2]	MC/DEL MC/DEL MC/DEL	5 8 8	COMMIT LOZENGES[1,3,4] NICOTROL INHALER[3,4] NICOTROL NASAL SPRAY[3,4]	Use PA Form# 20420 1. Will be available to patients unable to tolerate preferred products.	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.

				MC/DEL		NICORETTE GUM	2. Preferred nicotine replacement therapy and Chantix will become non-preferred and will require PA if they are being used in combination together. 3. Must fail all preferred products from smoking cessation category (Nicoderm patch and nicotine gum) before moving to non-preferred. 4. Must use non-preferred products in specified step order.	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.
ALCOHOL DETERRENTS								
ALCOHOL DETERRENTS	MC		ANTABUSE TABS				1. Should only be used in conjunction with formal structured outpatient detoxification program. Use PA Form# 20420	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 1. Oxycontin will be available without PA for patients treated for or dying from cancer or hospice patients. CA (cancer) or HO (hospice) diag code may be used but store must verify since all scripts will be audited and stores will be liable. 2. Established users are grandfathered. 3. Oxycodone ER allowed only 2 per day for all strengths except 80 mg	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 showing evidence of usage patterns consistent w/ controlled substance abuse such as: 1. Frequent or persistent early refills of controlled drugs; 2. Multiple instances of early refill overrides due to reports of misplacement, stolen, dropped in toilet or sink, distant travel, etc.;3. Breaches of narcotic contracts with any provider; 4. Failure to comply with patient responsibilities in attached opioid documentation (see PA form) including but not limited to failing to submit to and pass pill counts; 5. Failing to take or pass random drug testing; 6. Failing to provide old records regarding prior use of narcotics; 7. Receiving controlled substances from other prescribers that the provider submitting the PA is unaware of 8. Documented history of substance abuse. Substance abuse evaluations may be required for patients with medical records displaying documented substance abuse or potential signs of narcotic misuse and abuse such as chronic early refills, short dosing intervals, frequent dose increases, multiple lost/stolen etc scripts and intolerance or "allergy" to all products but Oxycontin. 9. Circumventing MaineCare prior authorization requirements for narcotics by paying cash for affected narcotics (prescribers failed to submit prior authorization prior to cash narcotic scripts being filled by member). 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.
	MC/DEL		FENTANYL PATCH[5]	MC/DEL	8	BUTRANS[5]		
	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[3,7]		
				MC	9	OPANA ER[7]		

							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. 7. Non-preferred products must be used in specific order.	
NARCOTICS - SELECTED	MC/DEL		TRAMADOL HCL TABS	MC MC/DEL MC MC MC MC MC MC/DEL	8 8 8 8 8 8 9 9	BUPRENEX SOLN BUTORPHANOL NALBUPHINE HCL SOLN STADOL NS SOLN ULTRACET TABS[1] ULTRAM TABS ULTRAM ER RYZOLT	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-hypersensitivity.
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.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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	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	
	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	non-preferred drugs.	
	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	3. Only preferred manufacturer's products will be available without prior authorization.	
	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	TREZIX		
				MC	8	TYLENOL/CODEINE #3 TABS		
				MC	8	TYLOX CAPS		
				MC	8	VICODIN		
				MC	8	VICOPROFEN TABS		
				MC	8	ZYDONE TABS	Use PA Form# 20420	
				MC	9	ACTIQ LPOP		
				MC	9	CONZIP		
				MC/DEL	9	NUCYNTA ER		
OPIOID DEPENDENCE TREATMENTS	MC		SUBOXONE FILM[2]	MC		SUBOXONE 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		BUPRENORPHINE[1]	1. Buprenorphine will only be approved for use during pregnancy. 2. See Criteria Section	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. 7-Suboxone tablets will be available upon demonstrated allergy to the preferred product. Allergy may be established by 1) formal allergy testing by a board certified allergist or 2) demonstration of hives after skin exposure for 24 hours to the Suboxone Film. (The product may be applied to the skin using a band-aid and member can be assessed after 24 hours to ascertain the presence of hives by the prescriber).
NARCOTIC ANTAGONISTS								
NARCOTIC - ANTAGONISTS	MC/DEL		NALTREXONE HCL TABS	MC/DEL		REVIA TABS[1]	Use PA Form# 20420	
				MC/DEL		VIVITROL INJ[2]	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.	Please see the criteria listed on the Vivitrol PA form.

COX 2 / NSAIDS

COX 2 INHIBITORS - SELECTIVE / HIGHLY SELECTIVE	MC/DEL		CELEBREX CAPS [4,5,6]	MC/DEL		**MOBIC[6]**	[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. 6. The FDA has issued a Public Health Advisory warning of the potential for increased cardiovascular risk & GI bleeding with NSAID use.	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 [2,3,6]	MC/DEL		MOBIC SUSP[6]		
	MC/DEL		NABUMETONE TABS[6]	MC/DEL		**RELAFEN TABS[6]**		
	MC/DEL		MELOXICAM[1,6]					
NSAIDS	MC/DEL		**CHILDRENS IBUPROFEN**	MC		ADVIL TABS	The FDA has issued a Public Health Advisory warning of the potential for increased cardiovascular risk & GI bleeding with NSAID use.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Approvals will be granted for other requests based on failure of at least one generic NSAID from at least 3 different NSAID classes as described in the COX-II PA form.
	MC/DEL		**DICLOFENAC POTASSIUM TABS**	MC		ANAPROX TABS		
	MC/DEL		**DICLOFENAC SODIUM**	MC		ANAPROX DS TABS		
	MC/DEL		**ETODOLAC**	MC		CAMBIA		
	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		The FDA has issued a Public Health Advisory warning of the potential for increased cardiovascular risk & GI bleeding with NSAID use.
	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		SPRIX		
				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]	Use PA Form# 20420	
RHEUMATOID ARTHRITIS								
RHEUMATOID ARTHRITIS	MC/DEL	1	**AZATHIOPRINE**	MC/DEL		**ARAVA**	Use PA Form# 20900	See criteria as listed on Rheumatoid Arthritis PA form.
	MC/DEL	1	**HYDROXYCHLOROQUINE**	MC/DEL		ACTEMRA	1. Only one step 1 drug is required to obtain Enbrel or Humira without PA.	Enbrel 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	LEFLUNOMIDE	MC/DEL		CIMZIA		
	MC/DEL	1	METHOTREXATE	MC		**KINERET SOLN**		
	MC/DEL	1	**SULFASALAZINE TABS**	MC		ORENCIA		
	MC	2	**ENBREL**[1,4]	MC		**REMICADE**	2. Dosing limits apply. Please see dose consolidation list.	
	MC	2	**HUMIRA**[1,2,4]	MC		SIMPONI	3. 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.	
							4. Established users will be grandfathered for Enbrel and Humira.	
MISCELLANEOUS ARTHRITIS								
ARTHRITIS - MISC.	MC		RIDAURA CAPS	MC/DEL		**ARTHROTEC**[1]	1. The individual components of Arthrotec are available 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. The individual components of Arthrotec are available without PA.
	MC		MYOCHRYSINE SOLN				Use PA Form# 20420	
LUPUS-SLE								
LUPUS-SLE				MC		BENLYSTA	Use PA Form# 20420	
MIGRAINE THERAPIES								
MIGRAINE - ERGOTAMINE DERIVATIVES	MC		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	Use PA Form# 10110	
MIGRAINE - SELECTIVE SEROTONIN AGONISTS (5HT)--Tabs	MC/DEL		MAXALT MLT[1]	MC/DEL		AMERGE TABS[1,2]	1. All drugs in this category have dosing limits. Please refer to dose consolidation table.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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 HCI TABS[1]	MC		AXERT TABS[1,2]		
	MC/DEL		SUMATRIPTAN TABS[1]	MC/DEL		FROVA TABS[1,2]		
	MC/DEL		MAXALT[1]	MC/DEL		IMITREX TABS[1,2]		
				MC/DEL		RELPAX[1,2]	2. Must fail all preferred products before non-preferred.	
				MC/DEL		ZOMIG TABS[1,2]		
				MC/DEL		ZOMIG NASAL SPARY[1,2]		
				MC/DEL		ZOMIG ZMT TBDP[1,2]	Use PA Form# 10110	

MIGRAINE - SELECTIVE SEROTONIN AGONISTS (5HT)--Injectables	MC/DEL		IMITREX KIT	MC/DEL		SUMATRIPTAN SOLN	Use PA Form# 10110	
	MC/DEL		IMITREX SOLN					
	MC/DEL		IMITREX STATDOSE PEN KIT					
	MC/DEL		IMITREX STATDOSE REFILL KIT					
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		CAFERGOT TABS	MC/DEL		MIGRAZONE CAPS	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/DEL		SPASTRIN TABS	MC		BELCOMP-PB SUPP		
				MC/DEL		MIGERGOT SUP		
GOUT								
GOUT	MC/DEL		**ALLOPURINOL TABS**	MC		COLCRYS	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.
	MC/DEL		**PROBENECID TABS**	MC/DEL		ULORIC[1]		
	MC/DEL		**PROBENECID/COLCHICINE TABS**	MC		ZYLOPRIM TABS		
MISC.								
ANESTHETICS - MISC.	MC		BUPIVACAINE HCL SOLN	MC		SENSORCAINE-MPF 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.
	MC		LIDOCAINE HCL SOLN	MC/DEL		SYNVISC INJ		
	MC		MARCAINE SOLN	MC		XYLOCAINE SOLN		
ANTI-CONVULSANTS								
ANTICONVULSANTS	MC/DEL		CARBAMAZEPINE	MC	8	BANZEL	Use PA Form# 20420	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).
	MC/DEL		CARBATROL CP12	MC	8	DEPAKENE	All non-preferred meds must be used in specified order	
	MC/DEL		CELONTIN CAPS	MC	8	DEPAKOTE		
	MC/DEL		CLONAZEPAM TABS	MC	8	DEPAKOTE ER		
	MC		DEPAKOTE SPRINKLES CPSP	MC/DEL	8	DIAZEPAM GEL	1. Quantity limit. 5/month	
	MC/DEL		DIASTAT[1]	MC/DEL	8	DIVALPROEX SODIUM SPRINKLE CAPS	2. Dosing limits apply, please see dose consolidation list.	
	MC/DEL		DILANTIN	MC/DEL	8	EQUETRO		
	MC/DEL		DIVALPROEX SODIUM	MC/DEL	8	GABITRIL TABS		*** SEE CHART AT END OF DOCUMENT
	MC/DEL		EPITOL TABS	MC/DEL	8	HORIZANT	3. Dosing limits apply per strength as well as a maximum daily dose of 600mg. Please see dose consolidation list.	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.
	MC/DEL		ETHOSUXIMIDE SYRP	MC	8	GRALISE		
	MC/DEL		FELBATOL	MC/DEL	8	KEPPRA TABS		
	MC/DEL		GABAPENTIN[2]	MC/DEL	8	KEPPRA SOLN		
	MC/DEL		LAMOTRIGINE[2]	MC/DEL	8	KLONOPIN TABS		Lyrica- Second line therapy for Diabetic Peripheral Neuropathy and Post Herpetic Neuralgia. With Fibromyalgia diagnosis, Lyrica will not require PAwith Fibromyalgia diagnosis if previous 4 week trials of the following are seen in drug profile at full therapeutic doses: TCA or cyclobenzaprine, gabapentin, and savella.
	MC/DEL		LEVETIRACETAM SOLN/TABS	MC/DEL	8	LAMICTAL	4. Adjunctive therapy 17 and older.	
	MC/DEL		MYSOLINE TABS	MC/DEL	8	LYRICA[3]		
	MC/DEL		OXCARBAZEPINE	MC/DEL	8	PRIMIDONE TABS	5. Current users as of 7/30/10 for seizures will be grandfathered.	
	MC/DEL		PHENYTEK CAPS	MC	8	SABRIL		
	MC/DEL		PHENYTOIN	MC	8	TOPAMAX		
	MC/DEL		TEGRETOL	MC	8	TOPAMAX SPRINKLE CAPS[2]	6. Product is considered line extension of the original product due to Healthcare Reform (HCR). MaineCare	All non-preferred meds must be used in specified order.
	MC/DEL		TOPIRAMATE	MC/DEL	8	TRILEPTAL		
	MC/DEL		TOPIRAMATE SPRINKLE CAPS[2]	MC/DEL	8	VIMPAT[4]		**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:

	MC/DEL		TRILEPTAL SUSP	MC/DEL	8	ZARONTIN SYRP	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.	Abilify, clarithomycin, clozapine, erythromycin, Seroquel, telithromycin or Zyprexa.
	MC/DEL		VALPROIC ACID	MC/DEL	9	KEPPRA XR[5,6]		
	MC/DEL		ZARONTIN CAPS	MC/DEL	9	NEURONTIN		
	MC/DEL		ZONISAMIDE	MC/DEL	9	TEGRETOL-XR TB12[5,6]		Please use Drug-Drug Interaction PA form #10400 for this combination.
				MC/DEL	9	ZONEGRAN CAPS		
				MC/DEL	9	LAMICTAL XR		
						BIPOLAR DISORDER: STEP ORDER		
					M ~ A		SEE ANTICONVULSANT INDICATION CHART AT THE END OF THIS DOCUMENT M= Monotherapy A= Adjunctive 9= No Evidence The step orders show the relative strength of evidence for use in bi-polar and will guide prior authorization determinations. Step 4 drugs-no PA required.	
					4 ~ 4	LAMICTAL		
					4 ~ 4	LITHIUM		
					4 ~ 4	CARBAMAZEPINE		
					4 ~ 4	VALPROATE		
					4 ~ 4	ATYPICAL ANTIPSYCHOTICS EXC. CLOZAPINE		
					5 ~ 5	TRILEPTAL		
					9 ~ 6	TOPAMAX		
					9 ~ 7	KEPPRA TABS		
					9 ~ 8	GABITRIL TABS		
					9 ~ 9	NEURONTIN		
					9 ~ 9	ZONEGRAN CAPS		
						PEDIATRIC BIPOLAR1 DISORDER: STEP ORDER		
					M ~ A	(6-18 YEARS WITH OR WITHOUT PSYCHOSIS)		
					4 ~ 4	LITHIUM		
					4 ~ 4	CARBAMAZEPINE		
					4 ~ 4	VALPROATE		
					4 ~ 4	ATYPICAL ANTIPSYCHOTICS EXC.CLOZAPINE	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	LAMICTAL		
					5 ~ 5	TRILEPTA		
ANTI-PARKINSON DRUGS								
PARKINSONS - ANTICHOLINERGICS	MC/DEL		BENZTROPINE MESYLATE TABS				Use PA Form# 20420	
	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[3]**	1. Approvals will require concurrent therapy with Levodopa and failed trials of Selegiline, Comtan, and Stalevo.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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[3]**	MC		ELDEPRYL CAPS		
	MC/DEL		**CARBIDOPA/LEVODOPA ER**	MC		LODOSYN TABS		
	MC		LARODOPA TABS	MC/DEL		**PARLODEL CAPS**	2. Approvals will require trials of Carbidopa/Levodopa,	
	MC/DEL		**SELEGILINE HCL**	MC/DEL		**PARLODEL TABS**		

Class	Status		Preferred Drugs	Status	Step	Non-Preferred Drugs	PA Form / Notes	Criteria
				MC		SINEMET TABS	Selegiline, Comtan, and Stalevo.	
				MC		SINEMET TBCR		
				MC		ZELAPAR[1]	3. Only preferred manufacturer's products will be available without prior authorization.	
							Use PA Form# 20420	
PARKINSONS - COMBO.	MC/DEL		STALEVO				Use PA Form# 20420	
MUSCLE RELAXANTS								
ALS DRUG	MC/DEL		RILUTEK TABS				Use PA Form# 20420	
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.	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	AMRIX		
	MC		LIORESAL INTRATHECAL KIT	MC/DEL	8	DANTRIUM CAPS		
	MC/DEL		METHOCARBAMOL TABS	MC	8	LIORESAL TABS		
	MC/DEL		TIZANIDINE HCL TABS	MC	8	NORFLEX TBCR		
				MC	8	ROBAXIN-750 TABS		
				MC/DEL	8	ZANAFLEX TABS		
				MC/DEL	9	CYCLOBENZOPRINE ER		
				MC/DEL	9	SKELAXIN TABX		
				MC/DEL	9	SOMA TABS		
							Use PA Form# 20420	
MUSCLE RELAXANT - COMBO.				MC/DEL		CARISOPRODOL/ASPIRIN TABS	Use PA Form# 20420	Individual components are available with PA described in the section above.1. frequent or persistent early refills of non-controlled drugs; 2. multiple instances of early refill overrides due to reports of misplacement stolen, dropped in toilet or sink, distant travel, etc.
				MC/DEL		CARISOPRODOL/ASPIRIN/CODE		
				MC		NORGESIC TABS		
				MC/DEL		ORPHENADRINE COMPOUND		
				MC/DEL		ORPHENADRINE/ASA/CAFF		
				MC		ORPHENGESIC		
VITAMINS								
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					Please refer to OTC list.
	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, pantoprazole, Prilosec, or any currently non preferred PPI.
	MC/DEL		MEPHYTON TABS					
	MC/DEL		NIACIN					
	MC		NIACOR TABS					Preferred products that used to require diag codes still require diag codes unless indicated otherwise.
	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					

Class	Status	Preferred Drugs	Status	Non-Preferred Drugs	Criteria	Notes
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						
VITAMINS - MISC.	MC	CENTRUM LIQD	MC	ADEKS	1. Diag codes are no longer required on prenatal vitamins.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. As listed in MaineCare Policy, certain drugs require specific diagnoses for approval.
	MC	CENTRUM TABS	MC/DEL	ADVANCED NATALCARE TABS		
	MC	CENTRUM JR/IRON CHEW	MC	AQUADEKS		
	MC	CENTRUM SILVER TABS	MC	CENTRUM JR/EXTRA C CHEW	Please refer to OTC list.	
	MC	CENTRUM-LUTEIN TABS	MC	CENTRUM PERFORMANCE TABS		Please refer to OTC list.
	MC	CEROVITE ADVANCED FO TABS	MC	DALYVITE LIQD	Use PA Form# 20420	
	MC/DEL	CHEWABLE MULTIVIT/FL CHEW	MC	EMBREX 600 MISC		Preferred products that used to require diag codes still require diag codes unless indicated otherwise.
	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[1]		
	MC/DEL	FULL SPECTRUM B	MC/DEL	NATALCARE GLOSS TABS[1]		
	MC	M.V.I.-12 INJ	MC	NATALCARE PIC TABS[1]		
	MC	MULTI-VIT/FLUORIDE	MC	NATALCARE PIC FORTE TABS[1]		
	MC/DEL	NATALCARE RX TABS	MC/DEL	NATALCARE PLUS TABS[1]		
	MC/DEL	NEPHRONEX	MC	NATALCARE THREE TABS[1]		
	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[1]	MC/DEL	NIFEREX		
	MC/DEL	PRENATAL TABS[1]	MC/DEL	OCUVITE TABS		
	MC/DEL	PRENATAL FORMULA 3 TABS[1]	MC	POLY-VI-FLOR SOLN		
	MC/DEL	PRENATAL PLUS TABS[1]	MC	POLY-VI-SOL SOLN		
	MC/DEL	PRENATAL PLUS NF TABS[1]	MC	POLY-VI-SOL/IRON SOLN		
	MC	PRENATAL PLUS/27MG IRON[1]	MC	POLY-VITAMIN DROPS SOLN		
	MC	PRENATAL PLUS/IRON TABS[1]	MC	PRECARE		
	MC/DEL	PRENATAL RX/BETA-CAROTENE[1]	MC	PREMESIS RX TABS		
	MC/DEL	RENA-VITE RX TABS	MC	PRENATABS CBF TABS[1]		
	MC/DEL	RENAL CAPS	MC	PRENATAL CARE TABS[1]		
	MC/DEL	RENAPHRO CAPS	MC	PRENATAL MR 90 TBCR[1]		
	MC	STRESS TAB NF TABS	MC/DEL	PRENATAL MTR/SELENIUM TABS[1]		
	MC	THERAPEUTIC-M TABS	MC	PRENATAL OPTIMA ADVANCE TABS[1]		
	MC	THERAVITE LIQD	MC	PRENATAL PC 40 TABS[1]		
	MC/DEL	TRI-VITAMIN/FLUORIDE SOLN	MC/DEL	PRENATAL RX TABS[1]		
	MC	VITA CON FORTE CAPS	MC	PRENATE[1]		
	MC	VITAMIN B COMPLEX CAPS	MC	PRENATE ELITE[1]		
	MC	VITAPLEX PLUS TABS	MC	PRIMACARE MISC		
			MC	PROTEGRA CAPS		
			MC	STUARTNATAL PLUS 3 TABS[1]		
			MC	TRI-VI-SOL SOLN		
			MC	TRI-VI-SOL/IRON SOLN		
			MC/DEL	ULTRA NATALCARE TABS		
			MC	ULTRA-NATAL TABS[1]		
			MC	VICON FORTE CAPS		

				MC		VINATAL FORTE TABS[1]		
				MC		VINATE[1]		
				MC/DEL		VINATE ADVANCED TABS[1]		
MISCELLANEOUS MINERALS								
MINERALS	MC		CALCARB	MC		ANEMAGEN	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. As listed in MaineCare Policy, certain drugs require specific diagnoses for approval.
	MC		CALCI-MIX CAPSULE CAPS	MC		CALCET TABS	Please refer to OTC list.	
	MC		CALCIQUID SYRP	MC/DEL		**CALCIUM 600-D TABS**		
	MC		CALCITRATE/VITAMIN D TABS	MC		CALCIUM/VITAMIN D TABS		
	MC/DEL		CALCIUM	MC		CALTRATE 600 PLUS/VIT D TABS		
	MC/DEL		CALCIUM CARBONATE	MC		CALTRATE PLUS TABS		**DDI:** Fe salts will now be non-preferred and require prior authorization if it is currently being used in combination with either Prevacid, pantoprazole, Prilosec, or any currently non preferred PPI.
	MC/DEL		CALCIUM CITRATE TABS	MC		CHROMAGEN		
	MC/DEL		CALCIUM GLUCONATE TABS	MC		CITRACAL PLUS TABS		
	MC/DEL		CALCIUM LACTATE TABS	MC		CONTRIN CAPS		Please refer to OTC list.
	MC		CALCIUM/MAGNESIUM TABS	MC		FEOGEN FORTE CAPS		
	MC/DEL		**CALCIUM/VITAMIN D TABS**	MC		FEROCON CAPS		Preferred products that used to require diag codes still require diag codes unless indicated otherwise.
	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-IRON SOLN	MC		MICRO-K 10 MEG CPCR		
	MC		FERRONATE TABS	MC		NU-IRON 150 CAPS		
	MC/DEL		FERROUS SULFATE	MC/DEL		**OYSTER SHELL CALCIUM/VITA TABS**		
	MC/DEL		FLUOR-A-DAY CHEW	MC/DEL		POLY-IRON 150 CAPS		
	MC		FLUORIDE CHEW	MC/DEL		POLYSACCHARIDE IRON CAPS		
	MC		FLUORIDE SODIUM CHEW	MC/DEL		POTASSIUM BICARB/CHLORIDE		
	MC		FLUORITAB CHEW	MC/DEL		POTASSIUM CHLORIDE 10MEQ CAPS		
	MC		HEMOCYTE TABS	MC/DEL		POTASSIUM CHLORIDE 8MEQ CAPS		
	MC		HM CALCIUM TABS	MC/DEL		SLOW FE TBCR		
	MC		K+ POTASSIUM PACK	MC		TUMS 500 CHEW		
	MC		KAON ELIX	MC		VIACTIV CHEW		
	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[1]	MC		BOOST[1]	1. 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.**
	MC		P.T.E. -5 SOLN[1]	MC		CASEC POWD[1]		
	MC/DEL		SEA-OMEGA CAPS[1]	MC		CHOICE DM LIQD[1]		
				MC		DELIVER 2.0 LIQD[1]		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		ENFAMIL[1]		
				MC		ENSURE[1]		
				MC		GLUCERNA[1]		
				MC		ISOCAL LIQD[1]		
				MC		KINDERCAL TF LIQD[1]		
				MC		KINDERCAL TF/FIBER LIQD[1]	2. 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[1]		
				MC		LIPISORB LIQD[1]		
				MC		LOVAZA[1,2]	Use PA Form# 20420	
				MC		MODULEN IBD POWD[1]	& SGA Form	
				MC		NUTRAMIGEN POWD[1]		
				MC/DEL		NUTREN[1]		
				MC		NUTRITIONAL SUPPLEMENT LIQD[1]		
				MC		NUTRIVENT 1.5 LIQD[1]		
				MC/DEL		PEPTAMEN[1]		
				MC		PHENYLADE[1]		
				MC		PHENYL-FREE[1]		
				MC		PKU 3 POWD[1]		
				MC		PREGESTIMIL POWD[1]		
				MC/DEL		PROBALANCE LIQD[1]		
				MC		PROSOBEE[1]		
				MC		SCANDISHAKE PACK[1]		
ERYTHROPOEITINS								
ERYTHROPOEITINS	MC		PROCRIT SOLN[1]	MC	6	EPOGEN SOLN	Use PA Form# 10520	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	1. Clinical PA is required to establish medical necessity and that appropriate lab monitoring is being done.	
GRANULOCYTE CSF								
GRANULOCYTE CSF				MC	8	LEUKINE	1. Must be used in specified step order.	See approval criteria detailed on Neupogen PA form.
				MC	8	NEUPOGEN SOLN[2]		
				MC	9	NEULASTA[1]	2.10 day supply/month may	

							be used without a PA. Use PA Form# 20520	
ANTICOAGULANTS / PLATELET AGENTS								
ANTICOAGULANTS	MC		ARIXTRA SOLN[1]	MC		COUMADIN TABS	1. Arixtra, Fragmin and Lovenox therapy durations greater than 7 days require PA. 2. Use other strengths available to obtain desired dose. 3. Please refer to Pradaxa PA form for criteria. Use PA form# 20725 for Pradaxa requests Use PA form# 20420 for **other requests**	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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. **DDI:** Warfarin will require prior authorization if being used in combination with fluconazole, miconazole, or voriconazole. **DDI:** Warfarin will require prior authorization if being used in conjunction with Gemfibrozil or Fenofibrate.
	MC/DEL		FRAGMIN INJ[1]	MC/DEL		ENOXAPARIN		
	MC		HEPARIN SODIUM/NACL 0.9% SOLN	MC/DEL		FONDAPARINUX		
	MC		HEP-LOCK SOLN	MC		IPRIVASK		
	MC/DEL		**INNOHEP**	MC/DEL		LOVENOX 300[2]		
	MC/DEL		**LOVENOX SOLN[1]**	MC/DEL		PRADAXA[3]		
	MC/DEL		**WARFARIN SODIUM TABS**	MC/DEL		XARELTO		
	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** Use PA form# 20420 for **other requests** 1. 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[1]		
				MC/DEL	8	PERSANTINE TABS		
				MC/DEL	8	BRILINTA[1]		
				MC/DEL	8	PLAVIX TABS[1]		
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		**ANAGRELIDE CAPS**		
	MC/DEL		PENTOXIFYLLINE ER TBCR	MC/DEL		**PLETAL TABS**		
				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.

BRADYKININ B2 RECEPTOR ANTAGONIST				MC		FIRAZYR	Use PA Form# 20420	
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				Use PA Form# 20420	
	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		ZYMAXID	Use PA Form# 20420	
	MC/DEL		MOXEZA					
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/DEL		LOTEMAX SUSP		
	MC/DEL		NEOM/POLIN/DEX	MC		MAXITROL		
	MC		PRED MILD SUSP	MC		NEO/POLY/BAC/HC OINT		
	MC/DEL		PREDNISOLONE	MC/DEL		OZURDEX		
	MC/DEL		TOBRADEX	MC		PRED FORTE SUSP		
				MC		PRED-G SUSP		
				MC		PRED-G S.O.P. OINT		
				MC/DEL		SULFACET SOD/PRED SOLN		
				MC/DEL		TOBRAMYCIN SUSP DEXAMETHASONE		
				MC		VASOCIDIN SOLN		
				MC/DEL		VEXOL SUSP		
OP. - PROSTAGLANDINS	MC/DEL		**LATANOPROST SOL 0.005%**	MC/DEL	7	XALATAN SOLN[1]	1. All preferreds must be tried.	Preferred drugs must be tried and failed, in step-order, due to lack of efficacy (failure to reach target IOP reduction) or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**TRAVATAN-Z**	MC	8	LUMIGAN SOLN[1]		
				MC/DEL	8	**TRAVATAN SOLN**	Use PA Form# 20420	
OP. - CYCLOPLEGICS	MC		AK-PENTOLATE SOLN	MC/DEL		CYCLOGYL SOLN	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		ATROPINE SULFATE	MC		ISOPTO ATROPINE SOLN		
	MC/DEL		CYCLOPENTOLATE HCL SOLN	MC/DEL		ISOPTO HOMATROPINE SOLN		
	MC/DEL		ISOPTO HYOSCINE SOLN	MC		MUROCOLL-2 SOLN		
OP. - MIOTICS - DIRECT ACTING	MC/DEL		**ISOPTO CARBACHOL SOLN**				Use PA Form# 20420	
	MC		ISOPTO CARPINE SOLN					
	MC		PILOCAR SOLN					
	MC/DEL		**PILOCARPINE HCL SOLN**					
	MC/DEL		**PILOPINE HS GEL**					
OP. - ADRENERGIC AGENTS	MC/DEL		**DIPIVEFRIN HCL SOLN**	MC		PROPINE SOLN	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		EPIFRIN SOLN					
OP. - SELECTIVE ALPHA ADRENERGIC AGONISTS	MC		ALPHAGAN P SOLN	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/DEL		BRIMONIDINE 0.2%		
				MC/DEL		**IOPIDINE SOLN**		
OP. - ANTI-ALLERGICS	MC/DEL		PATADAY SOLN	MC	8	ALOCRIL SOLN	Use PA Form# 20420	All preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		PATANOL SOLN	MC/DEL	8	ALOMIDE SOLN		
				MC	8	BEPREVE		
				MC	8	ELESTAT		
				MC/DEL	8	EMADINE SOLN		
				MC	8	LASTACAFT		
				MC/DEL	8	OPTIVAR		
				MC	8	OPTICROM SOLN		
				MC/DEL	8	ZADITOR SOLN		
				MC/DEL	9	EPINASTINE		
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		**COSOPT SOLN**	Use PA Form# 20420	
	MC		COMBIGAN	MC/DEL		**TRUSOPT SOLN**		
	MC/DEL		DORZOLAMIDE					
	MC/DEL		DORZOLAMIDE/TIMOLOL					

OP. - NSAID'S	MC		FLURBIPROFEN SODIUM SOLN	MC	8	ACULAR LS[1]	1. 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	8	ACULAR SOLN[1]		
	MC/DEL		KETOROLAC OPTH 0.4%	MC	8	OCUFEN SOLN[1]		
	MC/DEL		KETOROLAC OPTH 0.5%	MC/DEL	8	NEVANAC[1]		
				MC	8	XIBROM[1]		
				MC	8	VOLTAREN SOLN[1]		
				MC	8	ACUVAIL[1]		
				MC/DEL	9	BROMFENAC	Use PA Form# 20420	
OP. - OF INTEREST	MC/DEL		ENUCLENE SOLN	MC		BOTOX SOLR	1. Must have kerato conjunctivitus sicca and failed other dry eye therapies.	Must fail adequate trials of multi agents from artificial tears and lubricant category.
				MC		RESTASIS[1]	Use PA Form# 20420	
DERMATOLOGICAL								
TOPICAL - ORAL	MC		AMNESTEEM[1]				1. Users 24 or under, PA will not be required.	
	MC		CLARAVIS[1]					
	MC		SOTRET[1]				Use PA Form# 20420	
TOPICAL - ACNE PREPARATIONS	MC		AZELEX CREA	MC		ACZONE	1. Users 24 or under, PA will not be required.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		BENZOYL PEROXIDE	MC		ALTINAC CREA		
	MC/DEL		CLINDAMYCIN PHOSPHATE[2]	MC		AVITA CREA	2. Dosing limits allowing one package per month. Please refer to Dose Consolidation List.	
	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	3. Only available if component ingredients are unavailable.	
	MC		ISOTRETINOIN	MC/DEL		BENZAMYCINPAK PACK		
	MC		METRONIDAZOLE CREA[2]	MC		BENZEFOAM		
	MC		METRONIDAZOLE GEL[2]	MC		BREVOXYL		
	MC		METRONIDAZOLE LOTN[2]	MC/DEL		CLEOCIN-T[2]		
	MC/DEL		SODIUM SULFACET/SULF LOTN	MC		CLINAC BPO GEL	Use PA Form# 10220 for **Brand Name requests**	
	MC		TAZORAC	MC		CLINDAGEL GEL		
	MC/DEL		TRETINOIN GEL[1]	MC		CLINDETS SWAB		
	MC		TRETINOIN CREA[1,2]	MC		DESQUAM-E GEL	Use PA Form# 20420 for **all other requests**	
				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 CREA[2]		
				MC		METROGEL GEL[2]		
				MC		METROLOTION LOTN[2]		
				MC		NEOBENZ MICRO		
				MC/DEL		NORITATE CREA		
				MC		RETIN-A GEL[2]		
				MC		RETIN-A MICRO GEL		
				MC		RETIN-A CREA[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 CREA[1]	MC/DEL		TRIPLE ANTIBIOTIC OINT		
	MC/DEL		BACTROBAN NASAL OINT					
	MC/DEL		CENTANY OINT 2%[1]				Use PA Form# 20420	
	MC/DEL		GENTAMICIN SULFATE					
	MC/DEL		MUPIROCIN[1]					
TOPICAL - ANTIFUNGALS	MC/DEL		BETAMETHASONE CLOTRIMAZOLE LOT	MC/DEL		BETAMETHASONE CLOTRIMAZOLE CREA		
	MC		CICLOPIROX 0.77 CREA	MC		EXELDERM	Use PA Form# 10120	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		CICLOPIROX 0.77 SUSP	MC		FUNGIZONE CREA		
	MC/DEL		CLOTRIMAZOLE	MC/DEL		HYDROCORT/IODOQ CREA		
	MC		ECONAZOLE NITRATE CREA	MC/DEL		LAMISIL		
	MC/DEL		KETOCONAZOLE CREA	MC/DEL		LOPROX 0.77 LOTN		
	MC/DEL		LOPROX 1.0 CREA	MC/DEL		LOPROX 0.77 CREA		**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, pantoprazole, Onglyza or Omeprazole.
	MC/DEL		LOPROX 1.O LOTN	MC/DEL		LOPROX 0.77 SUSP		
	MC/DEL		LOPROX GEL	MC/DEL		LOPROX SHAMPOO SHAM		
	MC/DEL		LOPROX TS LOTN	MC		LOTRIMIN		
	MC/DEL		LOTRISONE CREA	MC/DEL		LOTRISONE LOT		
	MC/DEL		MICONAZOLE NITRATE CREA	MC/DEL		MENTAX CREA		
	MC		MYCO-TRIACET II CREA	MC		MYCOGEN II CREA		
	MC		NIZORAL SHAM	MC		NAFTIN		
	MC/DEL		NYSTATIN	MC		NYSTAT-RX POWD		
	MC/DEL		NYSTATIN/TRIAMCINOLONE	MC/DEL		OXISTAT		
	MC/DEL		NYSTOP POWD	MC/DEL		PENLAC NAIL LACQUER SOLN		
	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[1]	1. 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		SORIATANE CAPS	MC		PSORIATEC CREA[1]		
	MC		TAZORAC	MC/DEL		SORIATANE CK KIT[1]		
				MC/DEL		TACLONEX[1,2]	2. Individual ingredients are available as preferred witout PA.	
				MC		VECTICAL[1]		
							Use PA Form# 20420	
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, 3]	1. Must fail oral treatment with Acyclovir or Valtrex.	
				MC		ZOVIRAX OINT[1,2]		
							2. Approvals limited to 1 tube per 180 days.	
							3. Dosing limits apply, please see dosing consolidation list.	
							Use PA Form# 20420	
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		
				MC/DEL		ZYCLARA		
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
	MC/DEL		SILVER SULFADIAZINE CREA					

Therapeutic Class	Status	Preferred Drugs	Status	Non-Preferred Drugs	PA Form	Criteria
	MC	SSD AF CREA				drug(s) exists.
	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 CREA / OINT		
		MEDIUM POTENCY	MC/DEL	CUTIVATE LOTN		
	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 CREA/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 LOTN 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 CREA	MC	LAC-HYDRIN LOTN 12%		
	MC	UREACIN-20 CREA	MC	MEDERMA GEL		
	MC	VITAMIN A & D MEDICATED OINT	MC	MIMYX		
			MC	RENOVA CREA		
TOPICAL - ENZYMES /	MC	GRANUL-DERM AERS	MC	CARMOL 40 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

KERATOLYTICS / UREA	MC/DEL		GRANULEX AERS	MC		SALEX CREA	Ziox, Panafil and Papain products have been removed from the PDL due to FDA safety concerns regarding drugs containing Papain.	the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Ziox, Panafil and Papain products have been removed from the PDL due to FDA safety concerns regarding drugs containing Papain.
	MC		TBC AERS	MC		SALEX LOTN		
	MC		SANTYL OINT					
TOPICAL - GENITAL WARTS	MC/DEL		IMIQUIMOD[2]	MC/DEL	5	PODOFILOX SOLN	Use PA Form# 20420 1. Non-preferred products must be used in specified order. 2. Dosing limits still apply. Please see dose consolidation list.	
				MC/DEL	8	ALDARA		
				MC/DEL	8	CONDYLOX[1]		
				MC	8	VEREGEN[1]		
				MC	8	ZYCLARA1		
TOPICAL - IMMUNOMODULATORS				MC/DEL	8	ELIDEL CREA[1]	Use PA Form# 20420 1. Non-preferred products must be used in specified order. 2. 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[1,2]		
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 1. Dosing limits apply, please refer to dosage consolidation list.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		ELIMITE CREA	MC		MALATHION		
	MC		EURAX	MC		NATROBA[1]		
	MC		LICE KILLING SHAM	MC		OVIDE LOTN		
	MC/DEL		LICE TREATMENT CREME RINS LIQD	MC		ULESFIA		
	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 Accuzyme and Ethezyme products have been removed from the PDL due to FDA concerns regarding drugs containing Papain.
				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[1]	Use PA Form# 20420 1. 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[1]		
	MC		TRIAMCINOLONE IN ORABASE PSTE	MC		TRIAMCINOLONE ACETONIDE PSTE[1]		
	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 CREA		
	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 MC MC		EVOXAC CAPS RADIACARE SOLR SALAGEN 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.
MISCELLANEOUS ANORECTAL								
ANORECTAL - MISC.	MC/DEL MC MC MC/DEL MC/DEL		COLOCORT ENEM CORTENEMA ENEM ELA-MAX 5 CREA HYDROCORTISONE ENEM PROCTOZONE-HC CREA	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		ANUSOL-HC CREA CORTIFOAM FOAM PROCTOCREAM-HC CREA PROCTOFOAM HC FOAM PROCTO-KIT CREA 2.5% PROCTOSOL HC CREA	Use PA Form# 20420	
T-CELL ACTIVATION INHIBITOR								
PSORIASIS BIOLOGICALS	MC MC		ENBREL[1,4] HUMIRA[1]	MC MC		**AMEVIVE[2]** STELARA	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. 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 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.
ALTERNATIVE MEDICINES								
ALTERNATIVE MEDICINES	MC		DIMETHYL SULFOXIDE SOLN	MC/DEL MC		CO-ENZYME Q-10 MELATONIN TABS	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.
CHELATING AGENTS								
CHELATING AGENTS	MC/DEL		**CUPRIMINE CAPS**	MC MC/DEL		DEPEN TITRATABS TABS EXJADE[1]	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.	
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]	MC MC		VANTAS[2] FIRMAGON[2]	1. Dosing limits apply, please refer to dosage consolidation list.	

				MC/DEL		TRELSTAR	consolidation list. 2. PA required to confirm FDA approved indication. Use PA Form# 20420	
ANTINEOPLASTIC AGENTS - TYROSINE KINASE INHIBITORS				MC MC/DEL MC		SPRYCEL[1] TYKERB[2] GLEEVEC[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.	
ANTINEOPLASTICS-MISCELLANEOUS	MC MC/DEL		AMIFOSTINE MERCAPTOPURINE	MC/DEL MC/DEL MC/DEL		ETHYOL PURINETHOL ZOLINZA	Use PA Form# 20420	
ANTINEOPLASTICS-MONOCLONAL ANTIBODIES				MC/DEL		HERCEPTIN[1]	1. PA required to confirm FDA approved indication. Use PA Form# 20420	
CANCER								
CANCER	MC MC/DEL MC/DEL MC MC/DEL MC/DEL		ALIMTA ANASTROZOLE TABS AVASTIN ERBITUX LETROZOLE VIDAZA	MC/DEL MC MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC		ARIMIDEX FOLOTYN NEXAVAR[1] SUTENT[1,2] ZELBORAF SYLATRON FEMARA YERVOY ZYTIGA	1. PA required to confirm FDA approved indication 2. Avoid CYP3AY drug drug interaction. Use PA Form# 20420	
IMMUNOSUPPRESSANTS								
IMMUNOSUPPRESSANTS	MC/DEL MC/DEL MC MC/DEL MC/DEL MC MC/DEL MC/DEL		CYCLOSPORINE MODIFIED CYCLOSPORINE SOL. MODIFIED GENGRAF CAPS MYCOPHENOLATE MYFORTIC PROGRAF CAPS RAPAMUNE SANDIMMUNE	MC/DEL MC/DEL MC/DEL		CELLCEPT CYCLOSPORINE CAPS NEORAL[1,2]	1. Established users will require a one time PA. 2. Established users will require a one time PA Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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.
PURINE ANALOG								
PURINE ANALOG	MC MC/DEL		AZASAN TABS **AZATHIOPRINE 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.
K REMOVING RESINS								
K REMOVING RESINS	MC/DEL MC MC/DEL MC/DEL MC/DEL		KAYEXALATE POWD KIONEX POWD SODIUM POLYSTYRENE SULFON SPS SUSP SPS 30GM/120ML ENEMA SUSP				Use PA Form# 20420	

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**