CATEGORY	Step Order	PREFERRED DRUGS	Step Order	NON-PREFERRED DRUGS PA Required	Comments

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	Step Order	PREFERRED DRUGS	Step Order	NON-PREFERRED DRUGS PA Required	Comments
BETA-LACTAMS / CLAVULANATE COMBO'S		AMOXICILLIN AMOXICILLIN/POTASSIUM CLA CHEW AMOXICILLIN/POTASSIUM CLA SUSR AMOXICILLIN/POTASSIUM CLA TABS AMPICILLIN BICILLIN L-A SUSP DICLOXACILLIN SODIUM CAPS OXACILLIN SODIUM SOLR PENICILLIN V POTASSIUM TIMENTIN SOLR UNASYN SOLR ZOSYN		AUGMENTIN[1] AUGMENTIN XR TB12[2]	1. Chewable 125mg & 250mg and Solution 125mg/5ml and 250mg/5ml available without PA. 2. Use preferred generic amoxicillin/clavulanate potassium alternatives. Use PA Form# 20420
CEPHALOSPORINS		CEFADROXIL HEMIHYDRATE CEFAZOLIN SODIUM SOLR CEFDINIR CEFEPIME HCI CEFPODOXIME CEFPROZIL CEFTAZIDIME 6MG CEFTIN SUSP CEFTRIAXONE CEFUROXIME AXETIL TABS CEPHALEXIN MONOHYDRATE FORTAZ SOLR TAZICEF 6GM		CEDAX CEFACLOR[1] CEFADROXIL MONOHYDRATE TABS CEFTIN FORTAZ FORTAZ SOLN KEFLEX CAPS OMNICEF ROCEPHIN SUPRAX TAZICEF SOLN TEFLARO	1. Both brand and generic are clinically non-preferred. Use PA Form# 20420
MACROLIDES / ERYTHROMYCIN'S		BIAXIN XL[1] AZITHROMYCIN TABS AZITHROMYCIN SUSP E.E.S. ERYPED 200 SUSR ERYPED 400 SUSR ERY-TAB TBEC ERYTHROCIN STEARATE TABS ERYTHROMYCIN		AZITHROMYCIN POW BIAXIN CLARITHROMYCIN SUSP CLARITHROMYCIN TABS DIFICID PCE TBEC ZITHROMAX TABS ZITHROMAX 1GM PAK ZITHROMAX TRI-PAK ZITHROMAX SUSP ZMAX	1. 7- Day supply per month without PA. Use PA Form# 20420
TETRACYCLINES		DOXYCYCLINE HYCLATE MINOCYCLINE HCL CAPS TETRACYCLINE HCL CAPS VIBRAMYCIN SYRP		DECLOMYCIN TABS DORYX CPEP DOXYCYCLINE MONO CAPS DYNACIN CAPS ORACEA PERIOSTAT SOLODYN ER	Use PA Form# 20420
FLUOROQUINOLONES		CIPROFLOXACIN LEVOFLOXACIN OFLOXACIN		AVELOX SOLN AVELOX TABS AVELOX ABC PACK TABS CIPRO FACTIVE LEVAQUIN TABS[1] LEVAQUIN TABS SOLN/INJ NOROXIN TABS PROQUIN XR	Use PA Form# 20420 1. Dosing limits apply, see Dosage Consolidation List.
AMINO GLYCOSIDES		GENTAMICIN NEOMYCIN SULFATE TABS		TOBI PODHALER[1]	1. Clinical PA to verify appropriate diag

		TOBI NEBU TOBRAMYCIN SULFATE SOLN			Use PA Form# 20420
ANTI-MYCOBACTERIALS / ANTI-TUBERCULOSIS		ETHAMBUTOL HCL TABS MYAMBUTOL TABS MYCOBUTIN CAPS RIFAMPIN			Use PA Form# 20420
ANTIMALARIAL AGENTS		**CHLOROQUINE PHOSPHATE TABS** **DARAPRIM TABS** **HYDROXYCHLOROQUINE TABS** **MEFLOQUINE HCL TABS** **QUININE SULFATE**		ARALEN TABS ISONARIF[1] MALARONE TABS **PLAQUENIL TABS**	Use PA Form# 20420 1. Ingredients available as preferred without PA.
ANTHELMINTICS		ALBENZA TABS BILTRICIDE TABS STROMECTOL TABS			Use PA Form# 20420
ANTIBIOTICS - MISC.		AZACTAM SOLR COLY-MYCIN-M SOLR FUROXONE TABS METRONIDAZOLE[2] PENTAMIDINE ISETHIONATE SOLR PRIMSOL SOLN TRIMETHOPRIM TABS VANCOMYCIN 5GM INJ.		COLISTIMETHATE SODIUM SOLR CAYSTON[4] FLAGYL CAPS FLAGYL TABS FLAGYL ER TBCR KETEK METRONIDAZOLE 375MG CAPS[2] METRONIDAZOLE 750MG TABS[2] NEBUPENT SOLR TINDAMAX[1] VANCOMYCIN 10GM INJ.[3] XIFAXAN	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
CARBAPENEMS				INVANZ SOLR MERREM SOLR PRIMAXIN	Use PA Form# 20420
LINCOSAMIDES / OXAZOLIDINONES / LEPROSTATICS		CLEOCIN SOLN CLEOCIN SUSR CLINDAMYCIN HCL 150CAPS DAPSONE TABS		CLEOCIN CAPS CLINDAMYCIN HCL 300CAPS[1] VIBATIV ZYVOX SUSR ZYVOX TABS	1. Use multiple 150's for Clindamycin instead of 300's. Use PA Form# 30820 for Zyvox & Vibativ Use PA Form# 20420 for all others
ANTI INFECTIVE COMBO'S - MISC.		ERYTHROMYCIN/SULF SUSR SEPTRA/DS TABS SULFAMETHOXAZOLE/TRIMETH TRIMETHOPRIM/SULFAMETHOXA		BACTRIM DS TABS	Use PA Form# 20420
ANTIPROTOZOALS				ALINIA[1]	1. Alina is preferred for children less than 12 years of age. Use PA Form# 20420
		ANTI - FUNGALS			
ANTIFUNGALS - ASSORTED		ANCOBON CAPS FLUCONAZOLE[1] GRIFULVIN V TABS[10] GRISEOFULVIN SUSP[10] GRISEOFULVIN ULTRAMICROSI TABS[10] GRIS-PEG TABS[10] KETOCONAZOLE TABS[8] NYSTATIN TERBINAFINE TABS[4]	5 6 6 7 8 8 8 8 8 8 8	LAMISIL TABS[4] SPORANOX SOLN[2] SPORANOX PULSEPAK CAPS[3] SPORANOX CAPS[3] ERAXIS INJ[6] DIFLUCAN GRIFULVIN SUSP ONMEL NOXAFIL[5] VFEND TABS ITRACONAZOLE	1. QL--1/every 7-day period (150mg only). 2. Sporanox QL 300cc/month with PA. See quantity limit table. 3. Sporanox QL 30/month with PA. See quantity limit table. Non-preferred products must be used in specified step order. Continue to use Anti-Fungal PA form for non-preferred products. 4. Quantity limit of one tablet daily. Please see dosage consolidation list. 5. Approved if immuno suppressed/ HIV or if the member has failed a 7 day trial of a preferred antifungal therapy. 6. Eraxis will be approved if submitting with documentation that it was initiated during a hospitalization and this request is to finish the hospital course. 8. Quantity limits allowing 30 day supply without PA. PA will be required if using > 30 days. 10. For children < 18, quantity limits allows 8 weeks supply without PA. PA will be required if using > than 8 weeks. If 18 and older PA will be required for any quantity. Not approving for Onychomycosis indication. Use PA Form# 10120
		ANTI - VIRALS			
ANTIRETROVIRALS		APTIVUS ATRIPLA[1] COMBIVIR TABS CRIXIVAN CAPS EMTRIVA EPIVIR / HBV EPZICOM INVIRASE CAPS KALETRA LEXIVA NORVIR PREZISTA[2] RESCRIPTOR TABS REYATAZ[1] STAVUDINE SUSTIVA TRIZIVIR TABS TRUVADA VIDEX / EC VIRACEPT TABS VIRAMUNE TABS	8 8 8 8 8 8 8 8 8 9	COMPLERA DIDANOSINE EDURANT FUZEON[3] INTELENCE[3] ISENTRESS[3,4] RETROVIR SELZENTRY[3] ZERIT VIRAMUNE XR	Use PA Form# 10620 for Fuzeon 1. Quantity limit of one per day 2. Only preferred if Norvir script is in member's profile within the past 30 days of filling Prezista 3. Prescribers with >= 10 ART scripts per quarter and 75% ART PDL compliance will be exempt from PA for these products. 4.Isentress Chewable will only be approved if between the age of 2-12 years old

	VIREAD TABS ZIAGEN TABS ZIDOVUDINE			
CYTO-MEGALOVIRUS AGENTS	FOSCARNET SODIUM VALCYTE TABS		FOSCAVIR GANCICLOVIR	Use PA Form# 20420
HERPES AGENTS	ACYCLOVIR VALTREX TABS	8 8 8 9	FAMCICLOVIR[1] ZOVIRAX[1] VALACYCLOVIR[1] FAMVIR TABS[1]	1. Must fail Acyclovir and Valtrex before non-preferred products in step order. Use PA Form# 20420
INFLUENZA AGENTS	AMANTADINE RELENZA DISKHALER AEPB RIMANTADINE HCL TABS TAMIFLU[1]		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
IMMUNE SERUMS				
IMMUNE SERUMS	HYPERRHO INJ			
HEPATITIS AGENTS				
HEPATITIS C AGENTS	INCIVEK[2] VICTRELIS[2] PEGASYS KIT[1] PEGASYS SOLN PEG-INTRON KIT[1] RIBAVIRIN		COPEGUS TABS REBETOL CAPS	1. Dosing limits apply, please see dosage consolidation list. 2. Approvals will require clinical PA to establish genotpye, baseline viral loads and will require periodic SVR's. Must have concurrent peg-a or peg-I and ribavirin therapies. Use PA Form# 20420
HEPATITIS AGENTS - MISC.			ACTIMMUNE	Use PA Form# 20420
HEPATITIS B ONLY	HEPSERA TABS		BARACLUDE TYZEKA	Use PA Form# 20420
RSV PROPHYLAXIS				
RSV PROPHYLAXIS			SYNAGIS[1]	Use PA Form #30120 1. MaineCare will approve Synagis PA's for start date of December 2nd for infants who meet the guidelines. PA will be approved for max of 5 doses. Maximum 1 dose/30 days.
MS TREATMENTS				
MULTIPLE SCLEROSIS - INTERFERONS	AVONEX KIT[1] **BETASERON SOLR[1]** REBIF SOLN[1]		EXTAVIA	1.Clinical PA is required to establish diagnosis and medical necessity. Use PA Form# 20430
MULTIPLE SCLEROSIS - NON-INTERFERONS	**COPAXONE[2]**	6 8 8 8 8	TYSABRI[1] AUBAGIO AMPYRA GILENYA[3] TECFIDERA	1. Providers must be enrolled in the TOUCH Prescribing program, a restricted distribution program. Clinical PA is required to establish diagnosis and medical necessity. 2. Clinical PA is required to establish diagnosis and medical necessity. 3. Dosing limits apply,please see dosing consolidation list. Use PA Form# 20430
ASSORTED NEUROLOGICS				
NEUROLOGICS - MISC.	MESTINON ORAP TABS PROSTIGMIN TABS		BOTOX DYSPORT[1] MYOBLOC[1]	1. Approval will be limited to Cervical dystonia. Use PA Form# 10210
STEROIDS				
GLUCOCORTICOIDS/ MINERALOCORTICOIDS	CELESTONE SUSP CORTEF 5 CORTISONE ACETATE TABS DELTASONE TABS DEPO-MEDROL SUSP DEXAMETHASONE ENTOCORT EC CP24 FLUDROCORTISONE ACETATE TABS HYDROCORTISONE KENALOG METHYLPREDNISOLONE TABS PREDNISOLONE **PREDNISONE** SOLU-CORTEF SOLR SOLU-MEDROL SOLR		BUDESONIDE EC CORTEF 10 and 20 TABS FLORINEF TABS **MEDROL TABS** MEDROL DOSEPAK TABS MILLIPRED ORAPRED SOLN PEDIAPRED LIQD PREDNISONE INTENSOL CONC STERAPRED TABS	Use PA Form# 20420
HORMONE REPLACEMENT THERAPIES				
ANDROGENS / ANABOLICS	ANDRODERM PT24 ANDROGEL ANDROGEL PUMP ANDROID CAPS DANAZOL CAPS DEPO-TESTOSTERONE OIL METHITEST TABS OXANDRIN TABS		ANADROL-50 ANDRO LA 200 OIL ANDROID CAPS AXIRON DELATESTRYL OIL FORTESTA HALOTESTIN TABS **OXANDROLONE** TESTIM TESTOSTERONE CYP TESTRED CAPS	Use PA Form# 20420 Use PA Form# 20600 for Oxandrin requests
ESTROGENS - PATCHES / TOPICAL	**CLIMARA PTWK** **VIVELLE-DOT PTTW[1]**	5 8 8 8 8	**ESTRADIOL PTWK** **ALORA PTTW[2]** **DIVIGEL[2]** **ELESTRIN[2]** **EVAMIST[2]**	1. Both preferred drugs must be tried. 2. Step order drugs must be used in specified step order. Use PA Form# 20420
ESTROGENS - TABS	**CENESTIN TABS** **ESTRADIOL** **ESTROPIPATE TABS** **MENEST TABS** **PREMARIN TABS**		ENJUVIA **ESTRACE TABS** ESTRATAB TABS ORTHO-EST TABS	Must fail preferred products before non-preferred products. Use PA Form# 20420
ESTROGEN COMBO'S	**PREMPHASE TABS**		**ACTIVELLA TABS[1]**	1. Must fail Premphase and Prempro products

		PREMPRO TABS		**COMBIPATCH PTTW**[1] **FEMHRT 1/5 TABS**[1] **ORTHO-PREFEST TABS**[1] SYNTEST H.S. TABS[1]	before non preferred products. Use PA Form# 20420
PROGESTINS		MEDROXYPROGESTERONE ACETA [2] NORETHINDRONE ACETATE TABS[2]		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
CONTRACEPTIVES					
CONTRACEPTIVES - PROGESTIN ONLY		ORTHO MICRONOR TABS		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
CONTRACEPTIVES - INJECTABLE		MEDROXYPROGESTERONE ACETATE 150mg IM		DEPO-PROVERA 150 mg SUSP	Use PA Form# 20420
CONTRACEPTIVE - EMERGENCY	1 2 2	PLAN B ONE STEP[1] ELLA LEVONORGESTREL NEXT CHOICE[1]		PLAN - B	1. Allowed 2 tablets per 30 days without PA Use PA Form# 20420
CONTRACEPTIVES - PATCHES/ VAGINAL PRODUCTS		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.
CONTRACEPTIVES - MONOPHASIC COMBINATION O/C'S		APRI TABS AVIANE TABS BALZIVA CRYSELLE-28 TABS DESOGEN TABS DESOGESTREL/ ETHINYL ESTRADIOL LOW-OGESTREL TABS MODICON TABS MONONESSA NECON 1/50 ORTHO-CEPT-28 TABS ORTHO-CYCLEN-28 TABS ORTHO-NOVUM 1/35-28 TABS OVCON-50 28 TABS PREVIFEM RECLIPSEN SOLIA SPRINTEC 28 TABS YASMIN 28 TABS YAZ SEASONALE ZENCHENT		BEYAZ BREVICON-28 TABS LESSINA-28 TABS LEVORA LOESTRIN TABS LOESTRIN FE TABS LOESTRIN FE 1/20 TABS LOESTRIN 1.5/30-21 TABS LOESTRIN 1/20-21 TABS LO/OVRAL 21 TABS LO/OVRAL 28 TABS MICROGESTIN FE TABS NORDETTE-28 TABS NORINYL NORTREL OCELLA OGESTREL TABS OVCON-35/28 TABS OVRAL PORTIA-28 TABS SAFYRAL ZOVIA	Use PA Form# 20420 If member experienced adverse reactions, consider using Oral Contraceptives from other groups.
CONTRACEPTIVES - BI-PHASIC COMBINATIONS		ORTHO-NOVUM 10/11-28 TABS NORETHINDRONE-ETH ESTRADIOL TAB 0.5-35/1-35 SEASONIQUE LOSEASONIQUE		NECON 10/11-28 TABS KARIVA TABS LOSEASONIQUE MIRCETTE TABS	If member experienced adverse reactions, consider using Oral Contraceptives from other groups. Use PA Form# 20420
CONTRACEPTIVES - TRI-PHASIC COMBINATIONS		ENPRESSE NECON 7/7/7 ORTHO-NOVUM 7/7/7-28 TABS		CYCLESSA TABS ESTROSTEP FE TABS NORTREL 7/7/7	If member experienced adverse reactions, consider using Oral Contraceptives from other groups.

	TRI-NORINYL 28 TABS TRI-PREVIFEM TRIPHASIL 28 TABS TRI-SPRINTEC TRINESSA TRIVORA-28 TABS	ORTHO TRI-CYCLEN TABS ORTHO TRI-CYCLEN LO TABS	Use PA Form# 20420
CONTRACEPTIVES - MULTI-PHASIC COMBINATIONS		NATAZIA	Use PA Form# 20420
DIABETES THERAPIES			
DIABETIC - INSULIN	HUMALOG INJ 100/ML HUMALOG MIX 75/25 HUMULIN N INJ U-100 HUMULIN INJ 70/30 HUMULIN R U-100 LANTUS SOLN **NOVOLIN** **NOVOLOG** **NOVOLOG MIX**	APIDRA HUMALOG MIX 50/50 HUMULIN INJ 50/50 HUMULIN R INJ U-500 LEVEMIR RELION	Use PA Form# 20420
DIABETIC - PENFILLS	LANTUS OPTICLIK PEN [1] LANTUS SOLOSTAR[1] **LEVEMIR FLEXPEN [1]** **NOVOLIN PENFILL[1]** **NOVOLIN 70/30[1]** NOVOLOG MIX PENFILL[1] **NOVOLOG PENFILL SOLN[1]** NOVOLOG MIX FLEXPEN[1] NOVOLOG FLEXPEN[1]	APIDRA OPTICLIK PEN HUMALOG KWIK INJ 100/ML HUMALOG MIX INJ 75/25 KWP HUMALOG MIX INJ 50/50 KWP	1. Clinical PA will be required to establish significant visual or neurological impairment. Use PA Form# 20420
DIABETIC - DPP- 4 ENZYME INHIBITOR	JANUVIA[1,2] ONGLYZA[1,2] TRADJENTA[1,2]		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. 2. Dosing limits apply. Please refer to Dose consolidation list. Use PA Form# 20420
DIABETIC - DPP- 4 ENZYME INHIBITOR-COMBO	JANUMET[1] KOMBIGLYZE	**JANUMET XR** **JENTADUETO** **KAZANO** **OSENI**	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.
DPP- 4 ENZYME INHIBITOR/ HMG- COS REDUCTASE INHIBITOR	JUVISYNC[1,2]		1. Please refer to criteria section of PDL 2. Dosing limits apply. Please refer to Dose consolidation list. Use PA Form# 20420
DIABETIC - LANCET-LANCET DEVICE	ONE TOUCH LANCETS DELICA LANCETS UNILET LANCETS UNISTIK LANCING DEVICE AUTOLOT LANCING DEVICE		Use PA Form# 20420
DIABETIC - SYRINGES-NEEDLES	BD MICRO-FINE BD ULTRA-FINE BD ULTRA-FINE PEN NEEDLES UNIFINE PEN NEEDLES		Use PA Form# 20420
DIABETIC - OTHER		CYCLOSET	Use PA Form# 301501
		INVOKANA[1]	1.Dosing limits apply please refer to Dose

DIABETIC MONITOR		FREESTYLE INSULINX FREESTYLE LITE SYSTEM KIT FREESTYLE FLASH SYSTEM KIT FREESTYLE FREEDOM SYSTEM KIT FREESTYLE FREEDOM LITE KIT ONE TOUCH ULTRA 2 KIT ONE TOUCH ULTRA MINI KIT ONE TOUCH ULTRA SMART KIT PRECISION XTRA METER		ACCUCHECK ASCENSIA ASSURE CONTOUR BREEZE Z EXACTECH PRODIGY	Use PA Form# 20420
DIABETIC TEST STRIPS		FREESTYLE[1] FREESTYLE LITE[1] FREESTYLE INSULINX[1] ONE TOUCH BASIC[1] ONE TOUCH SURESTEP[1] ONE TOUCH FAST TAKE[1] ONE TOUCH ULTRA[1] PRECISION XTRA[1] PRECISION XTRA BETA KETONE 10 CT		ACCUCHECK ASCENSIA ASSURE EXACTECH PRODIGY CONTOUR BREEZE Z	1. Only 50 ct & 100 ct package size. Use PA Form# 20420
INCRETIN MIMETIC			8 8 8 9	BYDUREON[1] BYETTA[1] NESINA VICTOZA[1]	1. If patient is not responding to oral agents (single or multiple) please look to insulin therapy. Dosing limits apply. Please refer to Dose Consolidation List. Use PA Form# 10230
DIABETIC - ORAL SULFONYLUREAS		**CHLORPROPAMIDE TABS** GLIMEPIRIDE **GLIPIZIDE TABS** **GLIPIZIDE ER TABS** **GLYBURIDE TABS** **GLYBURIDE MICRONIZED TABS** **TOLAZAMIDE TABS** **TOLBUTAMIDE TABS**		**AMARYL TABS** **DIABETA TABS** GLUCOTROL TABS **GLUCOTROL XL TBCR** **GLYNASE TABS** **MICRONASE TABS**	Use PA Form# 20420
DIABETIC -ORAL BIGUANIDES		**METFORMIN HCL TABS** METFORMIN ER		GLUCOPHAGE TABS GLUCOPHAGE XR TB24 FORTAMET METFORMIN ER OSMOTIC	Use PA Form# 20420
DIABETIC - THIAZOL / BIGUANIDE COMBO				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.
DIABETIC - / THIAZOL		**ACTOS TABS[1,3]**		**AVANDIA TABS[3]**	1. Actos is non-preferred as monotherapy. Actos is preferred if therapeutic doses of metformin, sulfonylurea or insulin are seen in members drug profile for at least 60 days within the past 18 months. 2. Actos 30mg or 45mg - please use multiple 15mg tabs. 3. Current users of Avandia who have tried Actos will be able to continue use of Avandia. Use PA Form# 20420
DIABETIC - ALPHAGLUCOSIDASE		**GLYSET TABS**		PRECOSE TABS	Use PA Form# 20420
DIABETIC - SULFONYLUREA / BIGUANIDE		GLYBURIDE/METFORMIN		GLUCOVANCE TABS[1] METAGLIP TABS[1] DUETACT[2]	1. Use individual ingredients. 2. Use Actos 15mgs with generic glimepiride. Use PA Form# 20420
DIABETIC - MEGLITINIDES		**STARLIX TABS**		**PRANDIN TABS** NATEGLINIDE	Use PA Form# 20420
GLUCOSE ELEVATING AGENTS					
GLUCOSE ELEVATING AGENTS		GLUCAGEN INJ. HYPOKIT		GLUCAGON DIAGNOSTIC KIT GLUCAGEN DIAGNOSTIC KIT	Use PA Form# 20420
THYROID					
THYROID HORMONES		**ARMOUR THYROID TABS** **CYTOMEL TABS** **LEVOTHROID TABS** **LEVOTHYROXINE SODIUM TABS** **LEVOXYL TABS** **THYROID TABS** **THYROLAR** **UNITHROID TABS**		LEVOTHYROXINE SODIUM SOLR LIOTHYRONINE SYNTHROID TABS	Use PA Form# 20420
ANTITHYROID THERAPIES		**METHIMAZOLE TABS** **PROPYLTHIOURACIL TABS**		**TAPAZOLE TABS**	Use PA Form# 20420
OSTEOPOROSIS/BONE AGENTS					
OSTEOPOROSIS		ALENDRONATE **MIACALCIN SOLN[2]**		**ACTONEL TABS** AREDIA SOLR BINOSTO BONIVA INJECTION KIT BONIVA TABS[2,4] CALCITONIN NS **DIDRONEL TABS** EVISTA TABS[1] FORTEO FORTICAL **FOSAMAX TABS AND PLUS D[3]** PROLIA XGEVA ZOMETA	Use PA Form# 20420 1. Approval only requires failure of Alendronate. 2. Quantity limits apply, please see dosage consolidation list. 3. Please use Alendronate and Vitamin D. 4. Please use other preferred agents.
CALCIMIMETIC AGENTS					
CALCIMIMETIC AGENTS				SENSIPAR	Use PA Form# 30115
GROWTH HORMONE					
GROWTH HORMONE		GENOTROPIN[1] HUMATROPE SOLR NORDITROPIN SOLN[1]	8 8 8 8 8	INCRELEX NUTROPIN AQ NUSPIN[2] NUTROPIN[1] OMNITROPE SAIZEN SOLR	Use PA Form# 10710 1.Clinical PA is required to establish diagnosis and medical necessity. 2.Established users will be grandfathered.

			8	TEV-TROPIN	
SOMATOSTATIC AGENTS		OCTREOTIDE INJ		SANDOSTATIN SOMATULINE	Use PA Form# 10710
GROWTH HORMONE ANTAGONISTS					
GH ANTAGONISTS				SOMAVERT	Use PA Form# 10710
VASOPRESSIN RECEPTOR ANTAGONIST					
VASOPRESSIN RECEPTOR ANTAGONIST				SAMSCA[1]	Use PA Form# 20420 1. See Criteria Section.
URINARY INCONTINENCE					
VASOPRESSINS		DESMOPRESSIN TABS	5 6 6 8 8	DDAVP TABS DDAVP SOLN[1] DESMOPRESSIN SPRAY[1] DESMOPRESSIN ACETATE SOLN[1] STIMATE SOLN[1,2]	1. Products must be used in specified step order. Nocturnal enuresis patients will be encouraged to periodically attempt stopping DDAVP. 2. Patients with a diagnosis of hemophilia or Von Willebrands disease will be exempt from prior authorization. Use PA Form# 20420
ANTISPASMODICS		**OXYBUTYNIN** URISPAS TABS		**DETROL TABS** **DITROPAN** **SANCTURA** TROSPIUM	Use PA Form# 20420
ANTISPASMODICS - LONG ACTING		**OXYBUTYNIN ER TABS** TOVIAZ VESICARE[1]	8 8 8 8 8 8 9 9	DITROPAN XL TBCR ENABLEX[1,3] **MYBETRIQ** **OXYTROL** **TOLTERODINE TAB** TROSPIUM DETROL LA CP[2] SANCTURA XR[2]	Use PA Form# 20420 1. See Criteria Section. 2. Product is considered line extension of the original product due to Healthcare Reform (HCR). MaineCare will consider these medications non-preferred and a step 9 because of the impact under the Federal Rebate Program in conjunction with HCR. 3. Use a preferred long acting antispasmodic.
CHOLINERGIC		**URECHOLINE** **BETHANECHOL**			Use PA Form# 20420
METABOLIC MODIFIER					
HERED. TYROSINEMIA				ORFADIN	Use PA Form# 20420
ANTIHYPERTENSIVES / CARDIAC					
CARDIAC GLYCOSIDES		**DIGITEK TABS** **DIGOXIN** **LANOXIN**			Use PA Form# 20420
ANTIANGINALS--Isosorbide Di-nitrate/ Mono-Nitrates		**ISOSORBIDE MONONITRATE TABS** **ISOSORBIDE MONONITRATE ER**		DILATRATE SR CPCR ISORDIL TABS **ISORDIL TITRADOSE TABS** ISOSORBIDE DINITRATE SUBL **ISOSORBIDE DINITRATE TABS** ISOSORBIDE DINITRATE CR TBCR **ISOSORBIDE DINITRATE ER TBCR** ISOSORBIDE DINITRATE TD TBCR **IMDUR TB24** ISMO TABS MONOKET TABS	Use PA Form# 20420
NITRO - OINTMENT/CAP/CR		NITROBID OINT **NITROGLYCERIN CPCR** NITROL OINT NITRO-TIME CPCR			Use PA Form# 20420
NITRO - PATCHES	1 1 1 3	**NITROGLYCERIN PT24**[1] **NITREK PT24**[1] **NITRO-DUR PT 24 0.8MG**[1] **MINITRAN PT24**[1]		NITRODISC PT24 **NITRO-DUR 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 required. Use PA Form# 20420
NITRO - SUBLINGUAL/ SPRAY		NITROLINGUAL TABS **NITROSTAT SUBL** **NITROTAB SUBL**		**NITROQUICK SUBL** NITROLINGUAL SOLN	Use PA Form# 20420
BETA BLOCKERS - NON SELECTIVE		CARVEDILOL LEVATOL TABS **NADOLOL TABS** **PINDOLOL TABS** **PROPRANOLOL HCL SOLN**[1] **PROPRANOLOL HCL TABS**[1] **PROPRANOLOL LA CAPS** SOTALOL AF SOTALOL HCL TABS **TIMOLOL MALEATE TABS**		**BETAPACE TABS** **BETAPACE AF TABS** **COREG CR**[3] **COREG TABS** **CORGARD TABS** **INDERAL TABS** **INDERAL LA CPCR** INNOPRAN XL **PROPRANOLOL HCL 60MG TABS**[2] 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
BETA BLOCKERS - CARDIO SELECTIVE		**ACEBUTOLOL HCL CAPS** **ATENOLOL TABS**[1] BETAXOLOL HCL TABS **BISOPROLOL FUMARATE TABS** **METOPROLOL TARTRATE TABS**[1] **METOPROLOL ER** **TOPROL XL TB24**		BYSTOLIC KERLONE TABS **LOPRESSOR TABS** SECTRAL CAPS **TENORMIN TABS** **ZEBETA TABS**	1. Recommend using Atenolol (and metoprolol) BID since its effects do not last 24 hours. Use PA Form# 20420
BETA BLOCKERS - ALPHA / BETA		**LABETALOL HCL TABS**		TRANDATE TABS	Use PA Form# 20420
BETA BLOCKERS & DURECTIC COMBOS				**DUTOPROL**	Use PA Form# 20420
CALCIUM CHANNEL BLOCKERS- Amlodipines, Bepridil, Diltiazems, Felodipines, Isradipines, Nifedipines, Nisoldipine, and Verapamils		AMLODIPINE[1]		**NORVASC TABS**[1]	1. Dosing limits apply, please see dose consolidation list. Use PA Form# 20420
	1 1 1 1	DILTIA XT CP24 **DILTIAZEM HCL ER CP24** **DILTIAZEM HCL XR CP24** **DILTIAZEM CD 300MG CP24**	5 6 8 8	DILACOR XR CP24[1] TAZTIA[1] **CARDIZEM TABS**[1] **CARDIZEM CD CP24**[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.

	1	**DILTIAZEM CD 360MG CP24**	8	CARDIZEM LA TB24[1]	
	4	CARTIA XT CP24[1]	8	CARDIZEM SR CP12[1]	
	4	**DILTIAZEM CD CP24[1]**	8	**DILTIAZEM HCL TABS[1]**	
	4	**DILTIAZEM HCL ER CP24[1]**	8	**DILTIAZEM HCL ER CP12[1]**	
	4	**DILTIAZEM XR CP24[1]**			Use PA Form# 20420
		TIAZAC CP24[1]			
				PLENDIL TB24	Use PA Form# 20420
				FELODIPINE	
				DYNACIRC CAPS	Use PA Form# 20420
				DYNACIRC CR TBCR[1]	1. Established users will be grandfathered
				CARDENE SR CPCR	Use PA Form# 20420
				NICARDIPINE HCL CAPS	
		AFEDITAB CR		ADALAT CC TBCR[1]	1. Established users of Adalat CC are grandfathered.
		NIFEDIAC CC		**NIFEDIPINE CAPS**	
		NIFEDICAL XL TBCR		PROCARDIA CAPS	
		NIFEDIPINE TBCR		**PROCARDIA XL TBCR**	Use PA Form# 20420
		NIFEDIPINE ER TBCR			
				SULAR TB24	1. Established users of 10MG and 20MG strengths are grandfathered.
				SULAR CR[1]	Use PA Form# 20420
	1	**VERAPAMIL HCL CR TBCR**		**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.
	1	**VERAPAMIL HCL ER TBCR**		**CALAN SR TBCR**	
	1	**VERAPAMIL HCL SR TBCR**		**COVERA-HS TBCR**	
				ISOPTIN-SR	
				VERAPAMIL HCL ER CP24	
				VERAPAMIL HCL SR CP24	
				VERAPAMIL HCL TABS	
				VERELAN CP24	
				VERELAN PM CP24	Use PA Form# 20420
ANTIARRHYTHMICS		**AMIODARONE**		**CORDARONE**	1. Prescription must be written by Cardiologist.
		FLECAINIDE		**DISOPYRAMIDE**	
		MEXILETINE		MULTAQ	
		MULTAQ		**PACERONE**	
		NORPACE		QUINIDEX	
		PROCAINAMIDE		TAMBOCOR	Use PA Form# 20420
		PROPAFENONE		TIKOSYN[1]	
		QUINAGLUTE		RYTHMOL SR	
		QUINIDINE GLUCONATE		RYTHMOL	
		QUINIDINE SULFATE			
ACE INHIBITORS		**BENAZEPRIL HCL**	5	MAVIK TABS	1. Non-preferred products must be used in specified order.
		CAPTOPRIL TABS	5	**ACCUPRIL TABS**	
		ENALAPRIL MALEATE TABS	8	**ACEON TABS[1]**	
		FOSINOPRIL SODIUM	8	**ALTACE CAPS[1]**	Use PA Form# 20420
		LISINOPRIL TABS	8	**LOTENSIN TABS[1]**	
		RAMIPRIL	8	**MOEXIPRIL[1]**	
		QUINAPRIL	8	**MONOPRIL HCT TABS[1]**	
			8	**PRINIVIL TABS[1]**	
			8	**UNIVASC[1]**	
			8	VASOTEC TABS[1]	
			8	**ZESTRIL TABS[1]**	
ANGIOTENSIN RECEPTOR BLOCKER		AVAPRO[1]	8	**ATACAND TABS**	Use PA Form# 20420
		BENICAR TABS[1]	8	**COZAAR**	1. Preferred products only available without PA if patient on diabetic therapy or prior ACE therapy.
		DIOVAN[1]	8	EDARBI	
		LOSARTAN[1]	8	IRBESARTAN	
		MICARDIS TABS[1]	8	TEVETEN TABS	
			8	TRIBENZOR[2]	2. Use preferred active ingredients which are available without PA.
DIRECT RENIN INHIBITOR				AMTURNIDE	1. Must show failure of single and combination therapy from all preferred antihypertensive categories.
				TEKTURNA[1]	
				TEKAMLO	Use PA Form# 20420
ANTIHYPERTENSIVES - CENTRAL		**CATAPRES-TTS**		**CATAPRES TABS**	Use PA Form# 20420
		CLONIDINE HCL TABS		CLONIDINE TTS	
		GUANFACINE HCL TABS		GUANABENZ ACETATE TABS	
		HYDRALAZINE HCL TABS		ISMELIN TABS	
		HYLOREL TABS		MINIPRESS CAPS	
		METHYLDOPA TABS		**NEXICLON**	
		MINOXIDIL TABS		**TENEX TABS**	
		PRAZOSIN HCL CAPS			
		RESERPINE TABS			
ACE INHIBITORS AND CA CHANNEL BLOCKERS			8	**LOTREL CAPS**	Use individual preferred generic medications.
			8	TARKA TBCR	
			9	**AMLODIPINE/BENAZEPRIL**	Use PA Form# 20420
ACE AND THIAZIDE COMBO'S		**BENAZEPRIL HCL/HYDROCHLOR**		**ACCURETIC TABS**	Use PA Form# 20420
		CAPTOPRIL/HYDROCHLOROTHIA		MONOPRIL HCT TABS	
		ENALAPRIL MALEATE/HCTZ TABS		**PRINZIDE TABS**	
		LISINOPRIL-HCTZ TABS		**UNIRETIC TABS**	
		LOTENSIN HCT TABS		VASERETIC TABS	
				ZESTORETIC TABS	
BETA BLOCKERS AND DIURETIC COMBO'S		**ATENOLOL/CHLORTHALIDONE**		CORZIDE TABS	Use PA Form# 20420
		BISOPROLOL FUMARATE/HCTZ		**LOPRESSOR HCT TABS**	
		PROPRANOLOL/HCTZ		TENORETIC	
				TIMOLIDE 10/25 TABS	
				ZIAC TABS	
ARB'S AND CA CHANNEL BLOCKERS		**EXFORGE[1]**		**AZOR**	1. Preferred products only available without PA if patient on diabetic therapy or prior ACE therapy.
		EXFORGE HCT[1]		**TWYNSTA**	Use PA Form# 20420
ARB'S AND DIURETICS		**AVALIDE TABS[1]**		**ATACAND HCT TABS**	1. Preferred products only available without PA if patient on diabetic therapy or prior ACE therapy.
		BENICAR HCT[1]		HYZAAR TABS	
		DIOVAN HCT TABS[1]		TEVETEN HCT TABS	
		LOSARTAN HCT[1]			
		MICARDIS HCT TABS[1]			Use PA Form# 20420

ANGIOTENSIN MODULATORS-ARB COMBINATION				EDARBYCLOR	Use PA Form# 20420
ARB'S AND DIRECT RENIN INHIBITOR COMBINATION				VALTURNA	Use PA Form# 20420
DIURETICS		ACETAZOLAMIDE TABS BUMETANIDE CHLOROTHIAZIDE TABS CHLORTHALIDONE TABS EDECRIN TABS FUROSEMIDE HYDROCHLOROTHIAZIDE INDAPAMIDE TABS METHAZOLAMIDE TABS METHYCLOTHIAZIDE TABS SPIRONOLACTONE 25MG TABS SPIRONOLACTONE/HYDRO TORSEMIDE TABS TRIAMTERENE/HCTZ ZAROXOLYN TABS		ALDACTAZIDE TABS ALDACTONE TABS AMILORIDE HCL BUMEX TABS DEMADEX TABS DIAMOX DIURIL DYAZIDE CAPS ENDURON TABS INSPRA LASIX TABS MAXZIDE MICROZIDE CAPS MIDAMOR TABS NAQUA TABS SPIRONOLACTONE 50MG[1]	1. Multiples of Spironolactone 25 mg are cheaper than 50 mg strength. Inspra will be approved for severe breast tenderness and male gynecomastia. Use PA Form# 20420
CCB / LIPID				CADUET	
LIPID DRUGS					
CHOLESTEROL - BILE SEQUESTRANTS		CHOLESTYRAMINE COLESTIPOL HCl		COLESTID PREVALITE QUESTRAN WELCHOL TABS	Use PA Form# 20420
CHOLESTEROL - FIBRIC ACID DERIVATIVES		ANTARA GEMFIBROZIL TABS NIASPAN TRICOR TRILIPIX		ANTARA LOPID FIBRICOR LIPOFEN LOFIBRA FENOFIBRATE TRIGLIDE	Use PA Form# 20420
CHOLESTEROL - HGM COA + ABSORB INHIBITORS MORE POTENT DRUGS/COMBINATIONS		ATORVASTATIN SIMVASTATIN[1] VYTORIN		CRESTOR LIPITOR ZOCOR SIMVASTATIN 80MG[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
CHOLESTEROL - HGM COA + ABSORB INHIBITORS LESS POTENT DRUGS/COMBINATIONS		LESCOL CAPS LESCOL XL TB24 LOVASTATIN TABS[2] PRAVASTATIN[2]	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
CHOLESTEROL - HGM COA + ABSORB INHIBITORS STATIN/ NIACIN COMBO		SIMCOR		ADVICOR TBCR	Use PA Form# 20420
FAMILIAL HYPERCHOLESTEROLEMIA				JUXTAPID KYNAMRO[1]	1. Clinical PA required for appropriate diagnosis
PULMONARY ANTI-HYPERTENSIVES					
PULMONARY ANTI-HYPERTENSIVES		ADCIRCA[1] VENTAVIS[2] EPOPROSTENOL INJ[4]		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
ERA / ENDOTHELIN RECEPTOR ANTAGONIST		LETAIRIS[1,2]		TRACLEER[3,4]	1. Providers must be registered with LEAP Prescribing program, a restricted distribution program. 2. Clinical PA is required to establish diagnosis and medical necessity. 3. 1. Prior trial of Letaris, WHO Group 1 diagnosis of PAH (Primary Pulmonary Hypertension) and NYHA functional class of 3. 4. For members with NYHA functional class of 4, Tracleer approval will be allowed with confirmation of diagnosis and functional class. Use PA Form# 20420
IMPOTENCE AGENTS					
IMPOTENCE AGENTS					As of January 1, 2006, per CMS (federal govt.), impotence agents are no longer covered.
ANTI-EMETOGENICS					
ANTIEMETIC - ANTICHOLINERGIC / DOPAMINERGIC		MECLIZINE HCL TABS PROMETHAZINE SUPP PROMETHAZINE TRANSDERM-SCOP PT72		ANTIVERT TABS PHENERGAN SOLN PROMETHAZINE 50MG SUPP PROMETHEGAN SUPP TORECAN TABS	Use PA Form# 20420
ANTIEMETIC - 5-HT3 RECEPTOR ANTAGONISTS/ SUBSTANCE P NEUROKININ		MARINOL CAPS ONDANSETRON TABS[2,4] ONDANSETRON ODT TBDP[2,4] ONDANSETRON INJ[2,4]	5 8 8 8 8 8	GRANISETRON ALOXI ANZEMET TABS CESAMET[1] EMEND[3] KYTRIL	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.

			8 8 8 8 8	SANCUSO ZOFRAN ODT TBDP[4] ZOFRAN TABS[4] ZOFRAN INJ[4] ZUPLENZ	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
NON-SEDATING ANTIHISTAMINES / DECONGESTANTS					
ANTIHISTIMINES - NON-SEDATING		ALAVERT TABS CETIRIZINE TABS CLARITIN (OTC) CLARITIN SYRP (OTC) LORATADINE TAVIST ND (OTC)	5 5 5 5 5 8 8 8 8 8 9	CLARINEX TABS[1,5] CLARINEX SYR[1,2] FEXOFENADINE[1] ZYRTEC[1] ZYRTEC SYR[1,2] ALLEGRA[3] CLARITIN[3] DELORATADIN LORATADINE ODT[4] LEVOCETIRIZINE XYZAL[3]	1. Must fail preferred drugs, OTC loratidine and cetirizine before moving to non-preferred step order drugs. 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. 5. Pa's for Clarinex RediTabs will only be approved if between the ages of 6-11 years old. Use PA Form# 20530
ANTIHISTIMINES - OTHER		CLEMASTINE CHLORPHENIRAMINE DIPHENHYDRAMINE			Use PA Form# 20530
ALLERGY / ASTHMA THERAPIES					
ANAPHYLACTIC DEVICES		**AUVI- Q** **EPIPEN**			
ANTIASTHMATIC - ANTICHOLINERGICS - INHALER		SPIRIVA[1,2]		**TUDORZA**	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				DALIRESP	Use PA Form# 20420
ANTIASTHMATIC - ANTICHOLINERGICS - NEBULIZER		**IPRATROPIUM BROMIDE SOLN**		ATROVENT SOLN	Use PA Form# 20420
ANTIASTHMATIC - ANTIINFLAMMATORY AGENTS		CROMOLYN SODIUM NEBU		XOLAIR[1]	1. Need max inhaled steroids and written by pulmonary or allergy specialist. Use PA Form# 20420
ANTIASTHMATIC - NASAL STEROIDS		FLUTICASONE SPR[3] NASONEX SUSP[3]	5 5 8 8 8 8 8 8 8 8 8 8 8 8 9	BECONASE AQ INHA[1,3] NASACORT AQ AERS[1,3] DYMISTA 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] QNASL VANCENASE POCKETHALER AERS[2,3] VERAMYST[2,3] ZETONNA 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.
ANTIASTHMATIC - NASAL MISC.		CROMOLYN NASAL 4% OCEAN 0.65% SALINE NASAL SPRAY 0.65%	7 7 7 8 8	ATROVENT NASAL SOL IPRATROPIUM NASAL SOL[1] ASTELIN ASTEPRO[2] PATANASE	Use PA Form# 20420 1. Ipratropium will be approved if submitted with documentation supporting use of CPAP machine. 2. Utilize Multiple preferred, as well as step therapy Astelin.
ANTIASTHMATIC - BETA - ADRENERGICS		**ALBUTEROL NEB** **MAXAIR** **METAPROTERENOL** **PROAIR HFA[3]** **PROVENTIL HFA** **SEREVENT** **TERBUTALINE SULFATE TABS**		**ACCUNEB NEBU** **ALBUTEROL AER** **ALBUTEROL HFA** **ALBUTEROL 0.63mg/3ml** **ARCAPTA[3]** **BRETHINE** **FORADIL AEROLIZER CAPS** **VENTOLIN AERS** **VENTOLIN HFA AERS[3]** VOLMAX TBCR VOSPIRE ER TB12 **XOPENEX HFA[3]** **XOPENEX NEBU[1,2]**	1. Xopenex users w/ prior asthma hospitalization due to albuterol nebulizer failure will be grandfathered. 2. Quantity Limit: 12 cc/day. 3. Dosing limits apply, please see dosage consolidation list. Use PA Form# 20420
ANTIASTHMATIC - ADRENERGIC COMBINATIONS		**ADVAIR DISKUS/HFA[1,2]** DULERA SYMBICORT[2]			1. We ask physicians to write "asthma" on the prescription whenever Advair is primarily being used for that condition. 2. Dosing limits apply, please see dosage consolidation list. Use PA Form# 20420
ANTIASTHMATIC - ADRENERGIC ANTICHOLINERGIC		**ALBUTEROL/IPRATROPIUM NEB. SOLN** **COMBIVENT AERO[2]**		**COMBIVENT RESPIMAT** DUONEB SOLN[1]	1. Please use preferred individual ingredients Albuterol and Ipratropium.

					2. We ask physicians to write "asthma" on the prescription whenever Combivent is primarily being used for that condition.
					Use PA Form# 20420
ANTIASTHMATIC - XANTHINES		**AMINOPHYLLINE TABS**		**THEO-24 CP24**	Use PA Form# 20420
		THEOCHRON TB12		THEOLAIR TABS	
		THEOLAIR-SR TB12		**UNIPHYL TBCR**	
		THEOPHYLLINE CR TB12			
		THEOPHYLLINE ELIX			
		THEOPHYLLINE SOLN			
		THEOPHYLLINE ER CP12			
		THEOPHYLLINE ER TB12			
ANTIASTHMATIC - STEROID INHALANTS		ASMANEX[4,5]	5	**AEROBID AERS[2,4]**	1. No PA for Pulmicort susp if under 8 years old.
		FLOVENT DISKUS[4]	5	BECLOVENT AERS[2,4]	
		FLOVENT HFA[4]	5	VANCERIL AERS[2,4]	
		PULMICORT FLEXHALER	8	**AEROBID-M AERS[3,4]**	
		PULMICORT SUSP[1,4]	8	ALVESCO[4]	2. All preferreds must be tried before moving to non preferred steps.
		QVAR AERS[4]	8	VANCERIL DOUBLE STRENGTH AERS[3,4]	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.
					5. Asmanex 110mcg will be limited to member between the ages of 4-11years old.
					Use PA Form# 20420
ANTIASTHMATIC - 5-Lipoxygenase Inhibitors				**ZYFLO CR TABS**	Use PA Form# 20420
ANTIASTHMATIC - LEUKOTRIENE RECEPTOR ANTAGONISTS		**MONTELUKAST SODIUM TAB**		**ACCOLATE TABS**	Use PA Form# 20420
		MONTELUKAST SODIUM CHEW TAB		**SINGULAIR[1]**	1.Singulair Granules will only be approved if between ages of 6months-5years old. Singulair Chewables 4mg from 2years-5years and Singulair Cheables 5mgs from 6years-14years old.
ANTIASTHMATIC - ALPHA-PROTEINASE INHIBITOR			8	ARALAST	Use PA Form# 20420
			8	ZEMAIRA	
			9	GLASSIA	
			9	PROLASTIN SUSR	
ANTIASTHMATIC - HYDRO-LYTIC ENZYMES				PULMOZYME SOLN	Use PA Form# 20420
ANTIASTHMATIC - MUCOLYTICS		ACETYLCYSTEINE[1]		MUCOMYST	1. Acetylcysteine is covered with diagnosis of CF.
					Use PA Form# 20420
ANTIASTHMATIC-CFTR POTENTIATOR				KALYDECO	Use PA Form# 20420
COUGH/COLD					
COUGH/COLD		DEXTRO-GUAIF SYRP[1]			1. All of cough cold preparations are not covered except these preferred products.
		GUAIFENESIN SYRP[1]			
		PSEUDOEPHEDRINE[1]			
		ROBITUSSIN DM SYRP[1]			
		ROBITUSSIN SUGAR FREE SYRP[1]			Use PA Form# 20420
DIGESTIVE AIDS / ASSORTED GI					
GI - ANTIPERISTALTIC AGENTS		DIPHENOXYLATE		LOFENE TABS	Use PA Form# 20420
		DIPHENOXYLATE/ATROPINE		LONOX TABS	
		LOPERAMIDE HCL CAPS/LIQ		MOTOFEN TABS	
		OPIUM TINCTURE TINC			
		PAREGORIC TINC			
GI - ANTI-DIARRHEAL/ ANTACID - MISC.		ATROPINE SULFATE SOLN		BELLADONNA ALKALOIDS & OP	Use PA Form# 20420
		BENTYL SYRP		BENTYL TABS	1.Dosing limits apply please refer to Dose Consolidation List
		BISMATROL		CUVPOSA	
		BISMUTH SUBSALICYLATE		FULYZAQ[1]	
		CALCIUM CARBONATE (ANTACID) CHEW		GLYCOPYRROLATE INJ	
		DICYCLOMINE HCL		HYOSCYAMINE SL	
		GLYCOPYRROLATE TABS		LEVBID TB12	
		HAPONAL TABS		LEVSIN ELIX	
		HYOSCYAMINE CAPS & TABS		LEVSIN TABS	
		HYOSCYAMINE SULFATE		LEVSIN/SL SUBL	
		KAOPECTATE		NULEV TBDP	
		MAGNESIUM OXIDE TABS		ROBINUL INJ	
		MAG-OX 400 TABS		ROBINUL TABS	
		PAMINE TABS			
		PROPANTHELINE BROMIDE TABS			
		SAL-TROPINE TABS			
		SCOPOLAMINE HYDROBROMIDE			
		SODIUM BICARBONATE TABS			
		TUMS			
GI - H2-ANTAGONISTS		CIMETIDINE		AXID CAPS	Use PA Form# 20420
		FAMOTIDINE		AXID AR TABS	
		RANITIDINE		NIZATIDINE CAPS	
		RANITIDINE SYRP		PEPCID	
		ACID REDUCER TABS		PEPCID AC	
				ZANTAC SYRP	
				ZANTAC TABS	
GI - PROTON PUMP INHIBITOR		DEXILANT (KAPIDEX)[2]	6	PRILOSEC OTC[4]	1. Prevacid Solutabs available without PA for children less than 9 years old.
		OMEPRAZOLE 20MG[2]	7	ACIPHEX TBEC[4]	
		PANTOPRAZOLE	8	PREVACID CPDR[4,5]	
			8	PREVACID SOLUTABS[1]	
			8	NEXIUM CPDR[4]	2. Dosing limits apply, please see dosage consolidation list.
			8	PRILOSEC CPDR	
			8	PROTONIX INJ	
			8	PROTONIX[2]	3. Please use multiple 20mg Capsules to obtain required dose.
			8	OMEPRAZOLE 10MG[2]	
			8	OMEPRAZOLE-SODIUM BICARBONATE CAPS	

			8 9	LANSOPRAZOLE OMEPRAZOLE 40MG[3]	4. All preferreds and step therapy must be tried and failed. 5.Established users prior to 10/1/09 may continue to obtain Prevacid until 12/31/09. Use PA Form# 20720
GI - ULCER ANTI-INFECTIVE				HELIDAC PREVPAC PYLERA	Use PA Form# 20420
GI - PROSTAGLANDINS		MISOPROSTOL TABS		CYTOTEC TABS	Use PA Form# 20420
GI - DIGESTIVE ENZYMES		CREON[1] LACTASE CHEW LACTASE TAB ZENPEP[1]		LACTRASE CAPS PANCREASE PERTZYE	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.
GI - ANTI - FLATULENTS / GI STIMULANTS		CALULOSE SYRP CONSTULOSE SYRP ENULOSE SYRP[1] GASTROCROM CONC GENERLAC SYRP[1] LACTULOSE SYRP[1] METOCLOPRAMIDE HCL SIMETHICONE		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.
GI - INFLAMMATORY BOWEL AGENTS		ASACOL TBEC 400 APRISO AZULFIDINE TABS BALSALAZIDE CANASA SUPP COLAZAL CAPS DELZICOL DIPENTUM CAPS PENTASA CPCR 250MG ROWASA ENEM **SULFAZINE EC TBEC** **SULFASALAZINE TABS**		ASACOL 800MG HD AZULFIDINE EN-TABS TBEC GIAZO LIALDA TABS[1] PENTASA 500MG[2] SFROWASA	Use PA Form# 20420 1. Current users grandfathered. 2. Use multiple Pentasa 250mg.
GI - IRRITABLE BOWEL SYNDROME AGENTS				LOTRONEX TABS	Use PA Form# 20420
GI- SHORT BOWL SYNDROME				GATTEX	
MISCELLANEOUS GI					
GI - MISC.		BISAC-EVAC SUPP BISACODYL BISCOLAX SUPP CINOBAC CAPS CITRATE OF MAGNESIA SOLN CITRUCEL DIOCTO SYRP DOCUSATE CALCIUM CAPS DOCUSATE SODIUM FIBER LAXATIVE TABS FLEET GENFIBER POWD GLYCERIN HIPREX TABS KRISTALOSE PACK MAALOX METAMUCIL MILK OF MAGNESIA SUSP MINERAL OIL OIL NULYTELY SOLR SENNA SENOKOT GRAN SENOKOT SYRP SENOKOT CHILDRENS SYRP SENOKOT XTRA TABS SORBITOL STOOL SOFTENER CAPS SUCRALFATE TABS UNI-EASE CAPS UNIFIBER POWD URSO FORTE URSODIOL		ACTIGALL CAPS BENEFIBER CARAFATE CLEARLAX POW COLACE CAPS COLYTE DIOCTO-C SYRP DOC SOD /CAS CAP DOC-Q-LAX CAPS DOCUSATE SODIUM/CAS CAPS DOK PLUS DULCOLAX SUPP FIBER CON TABS FIBER-LAX TABS GOLYTELY SOLR LINZESS MALTSUPEX MIRALAX PACK (OTC versions) MIRALAX POWD (OTC versions) PEG 3350/ELECTROLYTES SOLR SENEXON TABS SENOKOT TABS SENOKOT S TABS STOOL SOFTENER PLUS CAPS UNI-CENNA TABS UNI-EASE PLUS CAPS V-R NATURAL SENNA LAXATIV TABS URSO 250	1. Must show evidence of trials of preferred agents that do not require PA, such as OTC senna, docusate, mineral oil and prescription lactulose. Use PA Form# 20420
MISC. UROLOGICAL					
UROLOGICAL - MISC.		ACETIC ACID 0.25% SOLN CYTRA-K SOLN FURADANTIN SUSP K-PHOS MF TABS METHENAMINE MANDELATE TABS MONUROL PACK NEOSPORIN GU IRRIGANT SOLN NITROFURANTOIN MONO CAPS PHENAZOPYRIDINE HCL TABS PHENAZOPYRIDINE PLUS PROSED/DS TABS TRICITRATES SYRP URELIEF PLUS UREX TABS URISED TABS UROCIT-K UROQID #2 TABS		CITRIC ACID/SODIUM CITRAT SOLN CYTRA-2 SOLN ELMIRON CAPS[1] FURADANTIN SUSP MACROBID CAPS MACRODANTIN CAPS NITROFURANTOIN MACR SUSP POTASSIUM CITRATE/CITRIC SOLN PYRIDIUM PLUS TABS PYRIDIUM TABS RENACIDIN SOLN	1. Elmiron requires adequate proof of Dx with supportive testing. Use PA Form# 20420
PHOSPHATE BINDERS					
PHOSPHATE BINDERS		ELIPHOS[1] MAGNEBIND - 400[1]		CALCIUM ACETATE FOSRENOL[1]	Use PA Form# 20420 1. Diag required.

		PHOSLYRA[1] RENAGEL[1]		RENVELA	
INTRA-VAGINALS					
VAGINAL - ANTIBACTERIALS		CLEOCIN CREA METROGEL VAGINAL GEL[2] METRONIDAZOLE VAGINAL GEL[2] CLEOCIN SUPP[1]		VANDAZOLE	1. Step order must be followed to avoid PA. Must fail Cleocin Cream and Metronidazole products before moving to next step product without PA. 2. Dosing limits apply, please see Dosage Consolidation List. Use PA Form# 20420
VAGINAL - ANTI FUNGALS		CLOTRIMAZOLE CREA GYNE-LOTRIMIN CREA MICONAZOLE CREA MICONAZOLE 3 COMBO PACK KIT[1] MICONAZOLE 7 CREA MICONAZOLE NITRATE CREA NYSTATIN TABS TERAZOL 3 SUPP TERCONAZOLE 0.4MG VAGITROL V-R MICONAZOLE-7 CREA		AVC CREA CLOTRIMAZOLE 3 DAY CREA GYNAZOLE-1 CREA GYNE-LOTRIMIN 3 TABS MICONAZOLE 3 SUPP TERAZOL 3 CREA TERAZOL 7 CREA TERCONAZOLE 0.8MG TERCONAZOLE SUPP	1. Quantity limit: 1/script/2 weeks Use PA Form# 20420
VAGINAL - CONTRACEPTIVES		GYNOL II EXTRA STRENGTH GEL		DELFEN FOAM	Use PA Form# 20420
VAGINAL - ESTROGENS		**ESTRING RING** **PREMARIN CREA**		ESTRACE CREA[1] VAGIFEM TABS[1]	1. Must fail all preferred products before non-preferred. Use PA Form# 20420
VAGINAL - OTHER		ACID JELLY GEL ACI-JEL GEL CERVICAL AMINO ACID CREA		AMINO ACID CERVICAL CREA	Use PA Form# 20420
BPH					
BPH		**DOXAZOSIN MESYLATE TABS** FINASTERIDE[1] TERAZOSIN HCL CAPS **TAMSULOSIN**	5 8 8 8 8 8 8 8	**FLOMAX CP24** ALFUZOSIN AVODART[2,4] **CARDURA TABS[4]** JALYN[3,4] PROSCAR TABS[4] RAPAFLO[4] UROXATRAL[4]	1. There will be dosing limits of 1 tab per day with out PA. 2. Prior use of preferred agent prior to any approvals. 3. Use of preferred (tamsulosin and finasteride) and (tamsulosin and non-preferred Avodart). 4. Non-preferred products must be used in specified order. Use PA Form# 20420
ANXIOLYTICS					
ANXIOLYTICS - BENZODIAZEPINES		ALPRAZOLAM TABS CHLORDIAZEPOXIDE HCL CAPS CLORAZEPATE DIPOTASSIUM TABS DIAZEPAM LORAZEPAM OXAZEPAM CAPS	8 8 8 8 8 8 9	ATIVAN NIRAVAM SERAX TRANXENE XANAX TABS XANAX XR ALPRAZOLAM ER	Use PA Form# 20420
ANXIOLYTICS - MISC.		BUSPIRONE HCL TABS HYDROXYZINE HCL SOLN HYDROXYZINE HCL SYRP HYDROXYZINE PAMOATE CAPS MEPROBAMATE TABS		BUSPAR TABS DROPERIDOL SOLN HYDROXYZINE HCL TABS HYDROXYZINE PAM 100MG CAPS VISTARIL	Use PA Form# 20420
ANTI-DEPRESSANTS					
ANTIDEPRESSANTS - MAO INHIBITORS		NARDIL TABS PARNATE TABS			Use PA Form# 20420
ANTIDEPRESSANTS - MAO INHIBITORS TOPICAL				EMSAM[1]	1. Dosing limits apply, please refer to Dose consolidation list. Use PA Form# 20420
ANTIDEPRESSANTS - SELECTED SSRI's		BUPROPION HCL TABS BUPROPION SR BUPROPION XL CITALOPRAM[4] ESCITALOPRAM[4] FLUOXETINE HCL CAPS FLUOXETINE HCL LIQD FLUOXETINE HCL 10mg TABS FLUVOXAMINE MALEATE TABS MIRTAZAPINE NEFAZODONE PAROXETINE[3] SERTRALINE[2] TRAZODONE HCL TABS VENLAFAXINE ER CAPS[9]	8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 9	APLENZIN[7] CELEXA[4] CYMBALTA[5, 11] EFFEXOR TABS EFFEXOR XR CP24 [3, 10] FLUOXETINE 40 mg AND 60mg CAPS[1] FLUOXETINE 20mg TABS[6] FORFIVO XL LEXAPRO TABS[4] LUVOX TABS MAPROTILINE HCL TABS MIRTAZAPINE ODT OLEPTRO PAROXETINE CR[3] PAXIL[3] PAXIL CR [3] PRISTIQ PROZAC PROZAC CAPS PROZAC WEEKLY CPDR REMERON TABS SARAFEM CAPS TRAZODONE HCL 300MG TABS WELLBUTRIN TABS WELLBUTRIN SR TBCR WELLBUTRIN XL REMERON SOLTAB TBDP SAVELLA [8] ZOLOFT VENLAFAXINE TABS[9] VENLAFAXINE ER TABS[9] VIBRYD FLUOXETINE 90mg TABS[12]	1. Use Fluoxetine 20 mg in multiples. 2. See Zoloft splitting table. Sertraline requires splitting of scored tabs to avoid PA. 3. Strong caution with pediatric population. 4. See Celexa/Citalopram and Lexapro splitting tables. 5. Max daily dose allowed is 60mg, only 1 capsule per day allowed for all strengths. Combination of multiple strengths require PA. 6. Use Fluoxetine 10mg tabs or capsules in multiples. 7. Provide clinical documentation as to why a preferred generic alternative cannot be used. 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
ANTIDEPRESSANTS - TRI-CYCLICS		**AMITRIPTYLINE HCL TABS**[1] **CLOMIPRAMINE HCL CAPS**[1] **DESIPRAMINE HCL TABS**[1] **DOXEPIN HCL**[1] **IMIPRAMINE HCL TABS**[1] **NORTRIPTYLINE HCL**[1] PROTRIPTYLINE HCL TABS[1] SURMONTIL CAPS[1]		**AMOXAPINE TABS** **ANAFRANIL CAPS** **DOXEPIN HCL 150 MG**[2] **NORPRAMIN TABS** **PAMELOR** TOFRANIL VIVACTIL 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
SEDATIVE / HYPNOTICS					
SEDATIVE/HYPNOTICS - BARBITURATE		BUTISOL SODIUM TABS[1] CHLORAL HYDRATE SYRP[1] MEBARAL TABS[1] PHENOBARBITAL[1]		LUMINAL SOLN SOMNOTE CAPS	1. PA required for new users of preferred products if over 65 years. Use PA Form# 20420
SEDATIVE/HYPNOTICS - BENZODIAZEPINES		DORAL TABS[1] ESTAZOLAM TABS[1] FLURAZEPAM HCL CAPS[1] TEMAZEPAM CAPS 15 & 30MG[1] TRIAZOLAM TABS[1]		HALCION TABS[1] MIDAZOLAM HCL SYRP RESTORIL CAPS[1] TEMAZEPAM 7.5MG[1]	1. Dosing limits apply, please see dosing consolidation list. Use PA Form# 30110
SEDATIVE/HYPNOTICS - Non-Benzodiazepines	1 1 1 2	MIRTAZAPINE TRAZODONE ZOLPIDEM[2] ZALEPLON[2,3]	7 7 8 8 8 8 8 8 8	AMBIEN[1] **ZOLPIDEM ER** AMBIEN CR[1] EDLUAR INTERMEZZO LUNESTA[1] SONATA CAPS[1] ROZEREM ZOLPIMIST	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 Use PA Form# 30110
ANTI-PSYCHOTICS					
ANTIPSYCHOTICS - ATYPICALS		ABILIFY TABS[3,4] **OLANZAPINE**[4] RISPERIDONE TAB[4] RISPERIDONE SOLN[4] QUETIAPINE[4,7] **ZIPRASIDONE**[4]	8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 9	ABILIFY DISC TAB, INJ and SOL[2] ABILIFY MAINTENA FANAPT GEODON INVEGA INVEGA SUSTENNA LATUDA[6] RISPERDAL TAB RISPERDAL CONSA[2] RISPERDAL M TAB[2] RISPERDAL SOLN RISPERIDONE ODT SAPHRIS SEROQUEL 50MG TABS[1,2] ZYPREXA TABS ZYPREXA ZYDIS TBDP[2] ZYPREXA RELPREVV SEROQUEL TABS SEROQUEL XR[5]	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, please see dosing consolidation list. 7. Dosing limits apply: quetiapine 25mg, 50mg and 100mg are available without PA if daily doasage is less than 1.5 tablets
ANTIPSYCHOTICS - SPECIAL ATYPICALS		CLOZAPINE TABS		CLOZARIL TABS FAZACLO	Use PA Form# 20420
ANTIPSYCHOTICS - TYPICAL		CHLORPROMAZINE HCL FLUPHENAZINE DECANOATE FLUPHENAZINE HCL HALDOL HALOPERIDOL HALOPERIDOL DECANOATE SOLN HALOPERIDOL LACTATE SOLN LOXAPINE SUCCINATE CAPS LOXITANE-C CONC MOBAN TABS PERPHENAZINE PROCHLORPERAZINE SERENTIL THIORIDAZINE HCL THIOTHIXENE TRIFLUOPERAZINE HCL TABS		COMPAZINE COMPRO SUPP HALDOL DECANOATE LOXITANE CAPS MELLARIL NAVANE CAPS PROLIXIN STELAZINE TABS	Use PA Form# 20420 If prescribing 2 or more antipsychotics, PA will be required for both drugs, except if one is Clozapine.
LITHIUM					
LITHIUM		LITHIUM CARBONATE LITHIUM CITRATE SYRP		ESKALITH CAPS ESKALITH CR TBCR	Use PA Form# 20420
COMBINATION - PSYCHOTHERAPEUTIC					
PSYCHOTHERPEUTIC COMBINATION		CHLORDIAZEPOXIDE/AMITRIPT PERPHENAZINE/AMITRIPTYLIN	8	SYMBYAX[1]	1. Only available if component ingredients are unavailable.

					Use PA Form# 20420
STIMULANTS					
STIMULANT - AMPHETAMINES - SHORT ACTING		ADDERALL TABS[1] DEXTROAMPHET SULF TABS[1,3] DEXEDRINE[1,3] PROCENTRA		AMPHETAMINE SALT COMBO[1,3]	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
STIMULANT - LONG ACTING AMPHETAMINES SALT		VYVANSE[2,3,4]	8 8 9	ADDERALL XR CP24[1,3,4] QUILLIVANT XR AMPHETAMINE/DEXTROAMPHET ER	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. 4. Dosing limits applly, please see dosing consolidation list.
LONG ACTING AMPHETAMINES		DEXEDRINE CAP CR[1,2,3]		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		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]		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.
STIMULANT - METHYLPHENIDATE - LONG ACTING		DAYTRANA[1,4] FOCALIN XR[1] RITALIN LA	5 8 8	METADATE CD CPCR CONCERTA TBCR METHYLPHENIDATE ER CAPS[1,2,4]	1. Preferred stimulants will be available without PA if diagnosis of ADHD. 2. Non-preferred products must be used in specified step order. 3. FDA approval currently only for ages 6-16. Limit of one patch daily. Max dose of 30MG daily. 4.Dosing limits applly, please see dosing consolidation list. Use PA Form# 20420
STIMULANT - STIMULANT LIKE			7 8 8 8 8 9 9 9	STRATTERA[1, 2] CAFCIT SOLN[3] INTUNIV 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). Additionally, for patients >17 years of age, a trial of quanfacine in required before approval of Strattera. 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 step order. 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.				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
ALZHEIMER DISEASE					
ALZHEIMER - Cholinomimetics/Others		DONEPEZIL HYDROCHLORIDE TABS[1] DONEPEZIL HYDROCHLORIDE ODT[1] EXELON[1] NAMENDA[1]	6 6 8 8 9	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
SMOKING CESSATION					
NICOTINE PATCHES / TABLETS		CHANTIX[1,2,3] NICOTINE DIS PT24[2,3]		NICODERM CQ PT24[3]	Use PA Form# 20420 1. Products are preferred only for use during pregnancy 2. As of September 1, 2012 per MaineCare policy, smoking cessation products are no longer covered except for use during pregnancy. 3. See criteria section for exemptions
NICOTINE REPLACEMENT - OTHER		NICOTINE POLACRILEX GUM[2]	5 8	COMMIT LOZENGES[1,3,4] NICOTROL INHALER[3,4]	Use PA Form# 20420 1. Products are preferred only for use during

			8	NICOTROL NASAL SPRAY[3,4]	pregnancy
				NICORETTE GUM	2. As of September 1, 2012 per MaineCare policy, smoking cessation products are no longer covered except for use during pregnancy.
					3. See criteria section for exemptions
					4. Must use non-preferred products in specified step order.
ALCOHOL DETERRENTS					
ALCOHOL DETERRENTS		ANTABUSE TABS			1. Should only be used in conjunction with formal structured outpatient detoxification program.
		CAMPRAL[1]			
		DISULFIRAM TABS			
		NALTREXONE HCL TABS			Use PA Form# 20420
MISCELLANEOUS ANALGESICS					
ANALGESICS - MISC.		ACETAMINOPHEN		AXOCET CAPS	Use PA Form# 20420
		ASPIRIN		ESGIC-PLUS	
		ASPRIN/ APAP/ CAFF TAB		FIORICET TABS	
		BUTAL/ASA/CAFF		FIORINAL CAPS	
		BUTALBITAL COMPOUND		FIORTAL CAPS	
		BUTALBITAL/ACET TABS		FORTABS TABS	
		BUTALBITAL/APAP CAPS		PHRENILIN TABS	
		BUTALBITAL/APAP/CAFFEINE		PHRENILIN FORTE CAPS	
		CHOLINE MAGNESIUM TRISALI		TRILISATE LIQD	
		DIFLUNISAL TABS		TRILISATE TABS	
		EXCEDRIN		ZEBUTAL CAPS	
		SALSALATE TABS		ZORPRIN TBCR	
LONG ACTING NARCOTICS					
NARCOTICS - LONG ACTING		FENTANYL PATCH[5]	8	ABSTRAL	Use PA Form# 20510
		METHADONE	8	AVINZA	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.
		METHADOSE	8	BUTRANS[5]	
		MORPHINE SULFATE ER TB12	8	DURAGESIC PT72[5]	
		OPANA ER	8	EMBEDA	
			8	EXALGO	
			8	KADIAN	
			8	MORPHINE SULFATE SUPP	
			8	MS CONTIN TB12	
			8	ORAMORPH SR TB12	
			8	OXYCONTIN TB12[1,4]	
			9	NUCYNTA	
			9	OXYCODONE ER[3,7]	2. Established users are grandfathered.
					3. Oxycodone ER allowed only 2 per day for all strengths except 80 mg, where 4 are allowed to achieve max total daily dose of 320mg.
					4. Oxycontin 15mg, 30mg & 60mg are new strengths. Any PA request for the new strengths will be required to use combinations of strengths that have previously been available (including 10mg, 20mg, 40mg, & 80mg tablets) to obtain requested dose.
					5. Dosing limits apply. Please see dose consolidation list.
					6. Kadian 10mg, 80mg & 200mg are non-preferred.
					7. Non-preferred products must be used in specific order.
NARCOTICS - SELECTED		TRAMADOL HCL TABS	7	RYZOLT	Use PA Form# 20420
			8	BUPRENEX SOLN	1. Only available if component ingredients are unavailable.
			8	BUTORPHANOL	
			8	NALBUPHINE HCL SOLN	
			8	STADOL NS SOLN	
			8	TRAMADOL ER	
			8	ULTRACET TABS[1]	
			8	ULTRAM TABS	
			8	ULTRAM ER	
MISCELLANEOUS NARCOTICS					
NARCOTICS - MISC.		ACETAMINOPHEN/CODEINE	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.
		ASPIRIN/CODEINE TABS	8	BUTALBITAL/APAP/CAFFEINE/ CAPS	
		BUTAL/ASA/CAFF/COD CAPS	8	DEMEROL	
		BUTALBITAL/ASPIRIN/CAFFEI CAPS	8	DILAUDID	
		CAPITAL AND CODEINE SUSP[1]	8	DILAUDID-HP SOLN	
		CAPITAL/CODEINE SUSP[1]	8	FENTANYL CITRATE SOLN	
		CODEINE PHOSPHATE SOLN	8	FENTORA	
		CODEINE SULFATE TABS	8	FIORICET/CODEINE CAPS	
		ENDOCET TABS[3]	8	FIORINAL/CODEINE #3 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 non-preferred drugs.
		ENDODAN TABS	8	FIORTAL/CODEINE CAPS	
		FENTANYL OT LOZ[1]	8	HYDROCODONE/IBUPROFEN	
		HYDROCODONE BITARTRATE/AP TABS	8	LORCET	
		HYDROCODONE/ACETAMINOPHEN	8	LORTAB	
		HYDROMORPHONE HCL[3]	8	MAXIDONE TABS	
		MEPERIDINE HCL	8	NORCO TABS	
		OXYCODONE 5MG	8	ONSOLIS	
		OXYCODONE 15MG	8	OXECTA	
		OXYCODONE 30MG	8	OXYCODONE 10MG	
		OXYCODONE/ACETAMINOPHEN[2,3]	8	OXYCODONE 20MG	
		PENTAZOCINE/NALOXONE TABS	8	OXYCODONE/APAP 10/650	
		PROPOXYPHENE CMPND-65 CAPS	8	OXYCODONE/APAP 7.5/500	3. Only preferred manufacturer's products will be available without prior authorization.
		PROPOXYPHENE COMPOUND CAPS	8	PENTAZOCINE/ACET TABS	
		PROPOXYPHENE HCL CAPS	8	PERCOCET TABS	
		PROPOXYPHENE/ACET TABS	8	PERCOCET TABS	
		PROPOXYPHENE-N/ACET TABS	8	PHRENILIN W/CAFFEINE/CODE CAPS	
		ROXICET	8	ROXICET 5/500 TABS	
		ROXIPRIN TABS	8	ROXICODONE TABS	
			8	SYNALGOS-DC CAPS	
			8	TALACEN TABS	
			8	TREZIX	

			8	TYLENOL/CODEINE #3 TABS	
			8	TYLOX CAPS	
			8	XOLOX	Use PA Form# 20420
			8	VICODIN	
			8	VICOPROFEN TABS	
			8	ZYDONE TABS	
			9	ACTIQ LPOP	
			9	CONZIP	
			9	OPANA	
OPIOID DEPENDENCE TREATMENTS		SUBOXONE FILM[2]		SUBOXONE TABS BUPRENORPHINE[1]	Use PA Form# 10200 for Suboxone Continuation Use PA Form# 10100 for Suboxone for Suboxone Restart 1. Buprenophine will only be approved for use during pregnancy. 2. See Criteria Section
			NARCOTIC ANTAGONISTS		
NARCOTIC - ANTAGONISTS		NALTREXONE HCL TABS		REVIA TABS[1] VIVITROL INJ[2]	Use PA Form# 20420 Use PA form# 30400 for Vivitrol requests 1. Will only be approved for side effects experienced with generic that are not described in the literature as occurring with the brand version. 2. Please see the criteria listed on the Vivitrol PA form. Any narcotics attempting to be filled during Vivitrol approval will require prior authorization.
			COX 2 / NSAIDS		
COX 2 INHIBITORS - SELECTIVE / HIGHLY SELECTIVE		CELEBREX CAPS [4,5,6] KETOROLAC TROMETHAMINE [2,3,6] NABUMETONE TABS[6] MELOXICAM[1,6]		**MOBIC[6]** MOBIC SUSP[6] **RELAFEN TABS[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 twice 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.
NSAIDS		**CHILDRENS IBUPROFEN** **DICLOFENAC POTASSIUM TABS** **DICLOFENAC SODIUM** **ETODOLAC** **FENOPROFEN CALCIUM TABS** **FLURBIPROFEN TABS** **IBUPROFEN** **INDOMETHACIN** **KETOPROFEN** **MECLOFENAMATE SODIUM CAPS** NAPROSYN SUSP NAPROXEN SUSP **NAPROXEN TABS** **NAPROXEN SODIUM TABS** **OXAPROZIN TABS** **SULINDAC TABS** **TOLMETIN SODIUM**		ADVIL TABS ANAPROX TABS ANAPROX DS TABS CAMBIA **CATAFLAM TABS** CHILDRENS ADVIL SUSP CHILD'S IBUPROFEN SUSP CHILDREN'S MOTRIN SUSP **CLINORIL TABS** **DAYPRO TABS** **EC-NAPROSYN TBEC** **ETODOLAC ER 600MG** FELDENE CAPS IBU-200 INDOCIN **LODINE** **MOTRIN** NALFON CAPS NAPRELAN TBCR NAPROSYN TABS **NAPROXEN DR TBEC** **NAPROXEN SODIUM TBCR** PENNSAID **PIROXICAM CAPS** PONSTEL CAPS SB IBUPROFEN TABS SPRIX TOLECTIN VOLTAREN V-R IBUPROFEN TABS	The FDA has issued a Public Health Advisory warning of the potential for increased cardiovascular risk & GI bleeding with NSAID use. Use PA Form# 20420
NSAID - PPI				PREVACID NAPRA-PAC VIMOVO[1]	1. Use a preferred NSAID and PPI separately. Use PA Form# 20420
			RHEUMATOID ARTHRITIS		
RHEUMATOID ARTHRITIS	1	**AZATHIOPRINE**		**ARAVA**	Use PA Form# 20900
	1	**HYDROXYCHLOROQUINE**		ACTEMRA	1. Only one step 1 drug is required to obtain Enbrel or Humira without PA.
	1	LEFLUNOMIDE		CIMZIA	
	1	METHOTREXATE		**KINERET SOLN**	
	1	**SULFASALAZINE TABS**		ORENCIA	
	2	**ENBREL [1,4]**		**REMICADE**	2. Dosing limits apply. Please see dose consolidation list.
	2	**HUMIRA[1,2]**		**SIMPONI**	
				XELJANZ	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.		RIDAURA CAPS MYOCHRYSINE SOLN		**ARTHROTEC[1]**	1. The individual components of Arthrotec are available without PA. Use PA Form# 20420
LUPUS-SLE					
LUPUS-SLE				BENLYSTA	Use PA Form# 20420
MIGRAINE THERAPIES					
MIGRAINE - ERGOTAMINE DERIVATIVES		MIGRANAL SOLN SANSERT TABS		D.H.E. 45 SOLN	Use PA Form# 10110
MIGRAINE - CARBOXYLIC ACID DERIVATIVES		DIVALPROEX ER TB24		DEPAKOTE ER TB24	Use PA Form# 10110
MIGRAINE - SELECTIVE SEROTONIN AGONISTS (5HT)--Tabs		NARATRIPTAN HCI TABS[1] RELPAX[1] SUMATRIPTAN TABS[1]		AMERGE TABS[1,2] AXERT TABS[1,2] FROVA TABS[1,2] IMITREX TABS[1,2] MAXALT MLT[1,2,3] MAXALT[1,2,3] **RIZATRIPTAN** ZOMIG TABS[1,2] ZOMIG NASAL SPARY[1,2] ZOMIG ZMT TBDP[1,2]	1. All drugs in this category have dosing limits. Please refer to dose consolidation table. 2. Must fail all preferred products before non-preferred. 3. Established users will be grandfathered Use PA Form# 10110
MIGRAINE - SELECTIVE SEROTONIN AGONISTS (5HT)--Injectables		IMITREX KIT IMITREX SOLN IMITREX STATDOSE PEN KIT IMITREX STATDOSE REFILL KIT		SUMATRIPTAN SOLN	Use PA Form# 10110
MIGRAINE - SELECTIVE SEROTONIN AGONISTS (5HT)--Combinations				TREXIMET[1,2]	Use PA Form# 10110 1. Dosing limits apply. Please see dose consolidation list. 2. Use preferred Sumatriptan and Naproxen separately. Treximet only available if component ingredients of sumatriptan and naproxen are unavailable.
MIGRAINE - MISC.		CAFERGOT TABS SPASTRIN TABS		MIGRAZONE CAPS BELCOMP-PB SUPP MIGERGOT SUP	Use PA Form# 10110
GOUT					
GOUT		**ALLOPURINOL TABS** **COLCHICINE TABS** **PROBENECID TABS** **PROBENECID/COLCHICINE TABS**		COLCRYS ULORIC[1] ZYLOPRIM TABS	Use PA Form# 20420 1. Failure of therapeutic (300mg) dose of Allopurinol (failure define as not being able to get uric acid levels below 6mg/dl) or severe renal disease.
MISC.					
ANESTHETICS - MISC.		BUPIVACAINE HCL SOLN LIDOCAINE HCL SOLN MARCAINE SOLN		SENSORCAINE-MPF SOLN SYNVISC INJ XYLOCAINE SOLN	Use PA Form# 30130
ANTI-CONVULSANTS					
ANTICONVULSANTS		CARBAMAZEPINE	8	BANZEL	Use PA Form# 20420
		CARBATROL CP12	8	DEPAKENE	All non-preferred meds must be used in specified order
		CELONTIN CAPS	8	DEPAKOTE	
		CLONAZEPAM TABS	8	DEPAKOTE ER	
		DEPAKOTE SPRINKLES CPSP	8	DIAZEPAM GEL	1. Quantity limit. 5/month
		DIASTAT[1]	8	DIVALPROEX SODIUM SPRINKLE CAPS	2. Dosing limits apply, please see dose consolidation list.
		DILANTIN	8	EQUETRO	
		DIVALPROEX SODIUM	8	HORIZANT	
		EPITOL TABS	8	GRALISE	3. Dosing limits apply per strength as well as a maximum daily dose of 600mg. Please see dose consolidation list.
		ETHOSUXIMIDE SYRP	8	GABITRIL TABS	
		FELBATOL	8	KEPPRA TABS	
		GABAPENTIN[2]	8	KEPPRA SOLN	4. Adjunctive therapy 17 and older.
		LAMOTRIGINE[2]	8	KLONOPIN TABS	5. Current users as of 7/30/10 for seizures will be grandfathered.
		LEVETIRACETAM SOLN/TABS	8	LAMICTAL	
		MYSOLINE TABS	8	LYRICA[3]	6. Product is considered line extension of the original product due to Healthcare Reform (HCR). MaineCare will consider these medications non-preferred and a step 9 because of the impact under the Federal Rebate Program in conjunction with HCR.
		OXCARBAZEPINE	8	ONFI	
		PHENYTEK CAPS	8	OXTELLAR XR[7]	
		PHENYTOIN	8	POTIGA	
		TEGRETOL	8	PRIMIDONE TABS	
		TOPIRAMATE	8	SABRIL	
		TOPIRAMATE SPRINKLE CAPS[2]	8	TOPAMAX	7. Max dose 2400mg
		TRILEPTAL SUSP	8	TOPAMAX SPRINKLE CAPS[2]	
		VALPROIC ACID	8	TRILEPTAL	
		ZARONTIN CAPS	8	VIMPAT[4]	
		ZONISAMIDE	8	ZARONTIN SYRP	
			9	KEPPRA XR[5,6]	
			9	NEURONTIN	
			9	TEGRETOL-XR TB12[5,6]	
			9	ZONEGRAN CAPS	
			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)	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.
			4 ~ 4	LITHIUM	
			4 ~ 4	CARBAMAZEPINE	

Class		Preferred Drugs	Step	Non-Preferred Drugs	Criteria
			4 ~ 4 4 ~ 4 4 ~ 4 5 ~ 5	VALPROATE ATYPICAL ANTIPSYCHOTICS EXC.CLOZAPINE LAMICTAL TRILEPTA	Step 4 drugs-no PA required.
ANTI-PARKINSON DRUGS					
PARKINSONS - ANTICHOLINERGICS		BENZTROPINE MESYLATE TABS COGENTIN SOLN **TRIHEXYPHENIDYL**			Use PA Form# 20420
PARKINSONS - COMT INHIBITORS		**COMTAN TABS**		**TASMAR TABS**	Use PA Form# 20420
PARKINSONS - SELECTED DOPAMIN AGONISTS		**PRAMIPEXOLE** **ROPINIROLE**	5 8 8 8 8	**MIRAPEX TABS**[1] **REQUIP TABS** **REQUIP XL TABS** **MIRAPEX ER** **NEUPRO PATCH**	Use PA Form# 20420 1. As of 12/08 users of Mirapex will be grandfathered if diagnosis is Parkinsons.
PARKINSONS - DOPAMINERGICS/CARBII/ LEVO		**AMANTADINE HCL** **BROMOCRIPTINE MESYLATE** **CARBIDOPA/LEVODOPA TABS**[3] **CARBIDOPA/LEVODOPA ER** LARODOPA TABS **SELEGILINE HCL**		**APOKYN**[3] AZILECT[2] ELDEPRYL CAPS LODOSYN TABS **PARLODEL CAPS** **PARLODEL TABS** SINEMET TABS SINEMET TBCR ZELAPAR[1]	1. Approvals will require concurrent therapy with Levodopa and failed trials of Selegiline, Comtan, and Stalevo. 2. Approvals will require trials of Carbidopa/Levodopa, Selegiline, Comtan, and Stalevo. 3. Only preferred manufacturer's products will be available without prior authorization. Use PA Form# 20420
PARKINSONS - COMBO.				CARBIDOPA/LEVODOPA/ENTACA[1] STALEVO[1]	Use PA Form# 20420 1.Clinical PA is required to establish diagnosis and medical necessity.
MUSCLE RELAXANTS					
ALS DRUG		**RILUTEK TABS**			Use PA Form# 20420
MUSCLE RELAXANTS		**BACLOFEN TABS** **CHLORZOXAZONE TABS** **CYCLOBENZAPRINE HCL TABS** LIORESAL INTRATHECAL KIT **METHOCARBAMOL TABS** **TIZANIDINE HCL TABS**	6 7 8 8 8 8 8 8 8 8 8 8 9 9 9	**SKELAXIN TAB** **ORPHENADRINE CITRATE** AMRIX **CARISOPRODOL TABS** DANTRIUM CAPS LIORESAL TABS LORZONE **METAXALONE** NORFLEX TBCR ROBAXIN-750 TABS VECUROMIUM INJ **ZANAFLEX TABS** CYCLOBENZOPRINE ER **SKELAXIN TABX** **SOMA TABS**	Non-preferred drugs will not be approved if members circumventing MaineCare prior authorization requirements by paying (prescribers failed to submit prior authorization prior to cash narcotic scripts being filled by member). Non-preferred products must be used in specified step order. Use PA Form# 20420
MUSCLE RELAXANT - COMBO.				CARISOPRODOL/ASPIRIN TABS CARISOPRODOL/ASPIRIN/CODE NORGESIC TABS ORPHENADRINE COMPOUND ORPHENADRINE/ASA/CAFF ORPHENGESIC	Use PA Form# 20420
VITAMINS					
VITAMINS		ASCORBIC ACID TABS BIOTIN CYANOCOBALAMIN SOLN FOLIC ACID TABS MEPHYTON TABS NIACIN NIACOR TABS NICOTINIC ACID SR CPCR PYRIDOXINE HCL TABS SLO-NIACIN TBCR THIAMINE HCL SOLN VITAMIN B-1 TABS VITAMIN B-12 VITAMIN B-6 TABS VITAMIN C VITAMIN E CAPS VITAMIN E/D-ALPHA CAPS VITAMIN K1 SOLN V-R VITAMIN E CAPS		AQUASOL E SOLN AQUAVIT-E SOLN DHT SOLN NASCOBAL GEL	Use PA Form# 20420 Please refer to OTC list.
VITAMIN D's		**CALCITRIOL CAPS**[1] **VITAMIN D** ZEMPLAR TABS		**DRISDOL CAPS** CALCIJEX HECTOROL (ORAL) HECTOROL (PARENTERAL) **ROCALTROL** ZEMPLAR INJ	1. Diagnosis of dialysis (renal failure) required. Use PA Form# 20420
MISC MULTI-VITAMINS					
VITAMINS - MISC.		CENTRUM LIQD CENTRUM TABS CENTRUM JR/IRON CHEW CENTRUM SILVER TABS CENTRUM-LUTEIN TABS CEROVITE ADVANCED FO TABS CHEWABLE MULTIVIT/FL CHEW COD LIVER OIL CAPS COMPLETE SENIOR TABS DAILY MULTI VIT/IRON DIALYVITE 1MG DIALYVITE 800MG FULL SPECTRUM B M.V.I.-12 INJ MULTI-VIT/FLUORIDE NATALCARE RX TABS		ADEKS ADVANCED NATALCARE TABS AQUADEKS CENTRUM JR/EXTRA C CHEW CENTRUM PERFORMANCE TABS CITRANATAL DALYVITE LIQD EMBREX 600 MISC FERRALET 90 IBERET MATERNA TABS MULTIRET FOLIC -500 TBCR NATAFORT TABS NATALCARE CFE 60 TABS[1] NATALCARE GLOSS TABS[1] NATALCARE PIC TABS[1]	1. Diag codes are no longer required on prenatal vitamins. Please refer to OTC list. Use PA Form# 20420

Class	Preferred	Non-Preferred	Criteria
	NEPHRONEX	NATALCARE PIC FORTE TABS[1]	
	O-CAL PRENATAL	NATALCARE PLUS TABS[1]	
	ONE DAILY TABS	NATALCARE THREE TABS[1]	
	ONE-DAILY MULTIVITAMINS	NATACHEW CHEW	
	ONE-TABLET-DAILY	NATALFIRST TABS	
	POLY-VIT/IRON/FLUORID SOLN	NATATAB RX TABS	
	POLY-VITAMIN/FLUORIDE SOLN	NEPHPLEX RX TABS	
	POLY-VITAMINS/IRON SOLN	NEPHROCAPS CAPS	
	PRENATAL 19 CHEW[1]	NEPHRO-VITE TABS	
	PRENATAL TABS[1]	NESTABS RX TABS	
	PRENATAL FORMULA 3 TABS[1]	NIFEREX	
	PRENATAL PLUS TABS[1]	OCUVITE TABS	
	PRENATAL PLUS NF TABS[1]	POLY-VI-FLOR SOLN	
	PRENATAL PLUS/27MG IRON[1]	POLY-VI-SOL SOLN	
	PRENATAL PLUS/IRON TABS[1]	POLY-VI-SOL/IRON SOLN	
	PRENATAL RX/BETA-CAROTENE[1]	POLY-VITAMIN DROPS SOLN	
	RENA-VITE RX TABS	PRECARE	
	RENAL CAPS	PREFERA OB	
	RENAPHRO CAPS	PREMESIS RX TABS	
	STRESS TAB NF TABS	PRENATABS CBF TABS[1]	
	THERAPEUTIC-M TABS	PRENATAL CARE TABS[1]	
	THERAVITE LIQD	PRENATAL MR 90 TBCR[1]	
	TRI-VITAMIN/FLUORIDE SOLN	PRENATAL MTR/SELENIUM TABS[1]	
	VITA CON FORTE CAPS	PRENATAL OPTIMA ADVANCE TABS[1]	
	VITAMIN B COMPLEX CAPS	PRENATAL PC 40 TABS[1]	
	VITAPLEX PLUS TABS	PRENATAL RX TABS[1]	
		PRENATE[1]	
		PRENATE ELITE[1]	
		PRIMACARE MISC	
		PROTEGRA CAPS	
		STUARTNATAL PLUS 3 TABS[1]	
		TRI-VI-SOL SOLN	
		TRI-VI-SOL/IRON SOLN	
		ULTRA NATALCARE TABS	
		ULTRA-NATAL TABS[1]	
		VICON FORTE CAPS	
		VINATAL FORTE TABS[1]	
		VINATE[1]	
		VINATE ADVANCED TABS[1]	
MISCELLANEOUS MINERALS			
MINERALS	CALCARB	ANEMAGEN	Use PA Form# 20420
	CALCI-MIX CAPSULE CAPS	CALCET TABS	Please refer to OTC list.
	CALCIQUID SYRP	**CALCIUM 600-D TABS**	
	CALCITRATE/VITAMIN D TABS	CALCIUM/VITAMIN D TABS	
	CALCIUM	CALTRATE 600 PLUS/VIT D TABS	
	CALCIUM CARBONATE	CALTRATE PLUS TABS	
	CALCIUM CITRATE TABS	CHROMAGEN	
	CALCIUM GLUCONATE TABS	CITRACAL PLUS TABS	
	CALCIUM LACTATE TABS	CONTRIN CAPS	
	CALCIUM/MAGNESIUM TABS	FEOGEN FORTE CAPS	
	CALCIUM/VITAMIN D TABS	FEROCON CAPS	
	CALTRATE 600 TABS	FERREX 150 CAPS	
	CHEWABLE CALCIUM CHEW	FERRO-SEQUELS TBCR	
	CITRACAL TABS	FE-TINIC CAPS	
	CITRACAL + D TABS	FE-TINIC 150 FORTE CAPS	
	CITRUS CALCIUM TABS	FLUOR-A-DAY SOLN	
	CITRUS CALCIUM 1500 + D TABS	K-DUR TBCR	
	MC/DEL	KLOR-CON PACK	
	EFFERVESCENT POTASSIUM TBEF	K-LYTE	
	FEOSTAT CHEW	K-PHOS TABS NEUTRAL	
	FERATAB TABS	K-TABS TBCR	
	FER-GEN-SOL SOLN	K-VESCENT PACK	
	FER-IN-SOL SOLN	MICRO-K 10 MEG CPCR	
	FER-IRON SOLN	NU-IRON 150 CAPS	
	FERRONATE TABS	**OYSTER SHELL CALCIUM/VITA TABS**	
	FERROUS SULFATE	POLY-IRON 150 CAPS	
	FLUOR-A-DAY CHEW	POLYSACCHARIDE IRON CAPS	
	FLUORIDE CHEW	POTASSIUM BICARB/CHLORIDE	
	FLUORIDE SODIUM CHEW	POTASSIUM CHLORIDE 10MEQ CAPS	
	FLUORITAB CHEW	POTASSIUM CHLORIDE 8MEQ CAPS	
	HEMOCYTE TABS	SLOW FE TBCR	
	HM CALCIUM TABS	TUMS 500 CHEW	
	K+ POTASSIUM PACK	VIACTIV CHEW	
	KAON ELIX		
	KAON-CL-10 TBCR		
	KCL 0.075%/D5W/NACL 0.2% SOLN		
	K-EFFERVESCENT TBEF		
	KLOR-CON		
	KLOTRIX TBCR		
	K-PHOS TABS		
	K-VESCENT TBEF		
	LURIDE CHEW		
	MAGNESIUM GLUCONATE TABS		
	MAGNESIUM SULFATE SOLN		
	MAGTABS		
	MICRO-K 8 MEG		
	OS-CAL TABS		
	OS-CAL 500 + D TABS		
	OYSCO		
	OYST-CAL TABS		
	OYST-CAL D TABS		
	OYST-CAL/VITAMIN D TABS		
	OYSTER CALCIUM TABS		
	OYSTER SHELL		
	PHARMA FLUR		
	PHOSPHA 250 NEUTRAL TABS		
	POTASSIUM BICARBONATE TBEF		
	POTASSIUM CHLORIDE 8MEQ		

		POTASSIUM EFFERVESCENT SELENIUM TABS SLOW-MAG TBCR SODIUM FLUORIDE SSKI SOLN V-R CALCIUM V-R OYSTER SHELL CALCIUM ZINC SULFATE CAPS			
MISC. ELECTROLYTES/NUTRITIONALS					
ELECTROLYTES/ NUTRITIONALS		INTRALIPID EMUL[1] P.T.E. -5 SOLN[1] SEA-OMEGA CAPS[1]		BOOST[1] CASEC POWD[1] CHOICE DM LIQD[1] DELIVER 2.0 LIQD[1] ENFAMIL[1] ENSURE[1] GLUCERNA[1] ISOCAL LIQD[1] KINDERCAL TF LIQD[1] KINDERCAL TF/FIBER LIQD[1] L-CARNITINE CAPS[1] LIPISORB LIQD[1] LOVAZA[1,2] MODULEN IBD POWD[1] NUTRAMIGEN POWD[1] NUTREN[1] NUTRITIONAL SUPPLEMENT LIQD[1] NUTRIVENT 1.5 LIQD[1] PEPTAMEN[1] PHENYLADE[1] PHENYL-FREE[1] PKU 3 POWD[1] PREGESTIMIL POWD[1] PROBALANCE LIQD[1] PROSOBEE[1] SCANDISHAKE PACK[1] VASCEPA	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. 2. Formerly known as Omacor. Use PA Form# 20420 & SGA Form
ERYTHROPOEITINS					
ERYTHROPOEITINS		PROCRIT SOLN[1]	6 8 8	EPOGEN SOLN ARANESP SOLN OMONTYS	Use PA Form# 10520 1. Clinical PA is required to establish medical necessity and that appropriate lab monitoring is being done.
GRANULOCYTE CSF					
GRANULOCYTE CSF			8 8 9	LEUKINE NEUPOGEN SOLN[2] NEULASTA[1]	1. Must be used in specified step order. 2.10 day supply/month may be used without a PA. Use PA Form# 20520
ANTICOAGULANTS / PLATELET AGENTS					
ANTICOAGULANTS		ARIXTRA SOLN[1] COUMADIN TABS FRAGMIN INJ[1] HEPARIN SODIUM/NACL 0.9% SOLN HEP-LOCK SOLN **INNOHEP** **LOVENOX SOLN[1]** HEPARIN LOCK SOLN HEPARIN LOCK FLUSH SOLN HEPARIN SODIUM SOLN HEPARIN SODIUM LOCK FLUSH SOLN		ELIQUIS ENOXAPARIN FONDAPARINUX IPRIVASK JANTOVEN LOVENOX 300[2] PRADAXA[3] **WARFARIN SODIUM TABS[4]** XARELTO	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 4.Established users will be grandfathered, new starters must use preferred product Coumadin. Use PA Form# 20420 Use PA form#20725 for Pradaxa requests
ANTIHEMOPHILIC AGENTS		ALPHANATE ALPHANINE SD BENEFIX SOLR HELIXATE FS KIT HEMOFIL - M HUMATE-P SOLR KOATE-DVI KOGENATE FS MONARC - M MONOCLATE - P MONONINE NOVOSEVEN SOLR PROFILNINE RECOMBINATE SOLR		ADVATE[1,2]	1. Only if other products unavailable. 2. Advate may be available with PA in cases of large volume dosing in patients with poor venous access. Use PA Form# 20420
PLATELET AGGREGATION INHIBITORS		ASPIRIN **DIPYRIDAMOLE TABS** **CLOPIDOGREL 75MG**	7 8 8 8 8	TICLOPIDINE HCL TABS BRILINTA[1,2] EFFIENT[2] PERSANTINE TABS PLAVIX TABS[1]	Use PA Form# 20715 for Plavix, Effient & Brilinta 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. 2. Dosing limits apply, please see dose consolidation list
PLATELET AGGR. INHIBITORS / COMBO'S - MISC.		**AGGRENOX** CILOSTAZOL PENTOXIFYLLINE ER TBCR		**AGRYLIN CAPS** **PLETAL TABS** TRENTAL TBCR	Use PA Form# 20420
HEMATOLOGICALS					
MONOCLONAL ANTIBODY				SOLIRIS	Use PA Form# 20420
BRADYKININ B2 RECEPTOR ANTAGONIST				FIRAZYR	Use PA Form# 20420
HEMATOLOGICAL AGENTS-			7	PROMACTA	Use PA Form# 20420

THROMBOPOIETIN RECEPTOR AGONISTS			8	NPLATE	
HEMOSTATIC					
HEMOSTATIC		AMICAR AMINOCAPROIC ACID			Use PA Form# 20420
OPHTHALMICS					
OP. - ANTIBIOTICS		AK-SPORE OINT BACITRACIN OINT BACITRACIN/NEOMYCIN/POLYM BACITRACIN/POLYMYXIN B OINT CHLOROPTIC SOLN ERYTHROMYCIN OINT GENTAMICIN SULFATE NEOMYCIN/POLYMYXIN/GRAMIC NEOSPORIN SOLN POLYSPORIN SODIUM SULFACETAMIDE SOLN SULFACETAMIDE SODIUM TOBRAMYCIN SULFATE SOLN TRIMETHOPRIM SULFATE/POLY VIROPTIC SOLN		AK-POLY-BAC OINT AK-SULF OINT AK-TOB SOLN AZASITE BLEPH-10 SOLN GENTAK ILOTYCIN OINT NEOMYCIN/BACI/POLYM OINT NEOSPORIN OINT OCUSULF-10 SOLN OCUTRICIN SOLN TERAK OINT TOBREX OINT TRIFLURIDINE SOLN	Use PA Form# 20420
OP. - QUINOLONES		CILOXAN OINT CIPROFLOXACIN SOL 0.3% OFLOXACIN QUIXIN SOLN		BESIVANCE CILOXAN SOLN OCUFLOX SOLN	Use PA Form# 20420
OP.QUINOLONES-4TH GENERATION		VIGAMOX MOXEZA		ZYMAXID	Use PA Form# 20420
OP. - ARTIFICIAL TEARS AND LUBRICANTS		AKWA TEARS OINT ARTIFICIAL TEARS OINT ARTIFICIAL TEARS SOLN CELLUVISC SOLN EYE LUBRICANT OINT GENTEAL LIQUITEARS SOLN MAJOR TEARS SOLN PURALUBE OINT PURALUBE TEARS SOLN REFRESH SOLN OP REFRESH PLUS SOLN[1] REFRESH PM OINT		AKWA TEARS SOLN ARTIFICIAL TEARS SOLN OP BION TEARS SOLN DRY EYES OINT DURATEARS OINT HYPO TEARS ISOPTO TEARS SOLN LACRI-LUBE LUBRIFRESH P.M. OINT MURINE SOLN MUROCEL SOLN NATURE'S TEARS SOLN REFRESH SOLN REFRESH TEARS SOLN[1] SYSTANE TEARGEN SOLN TEARISOL SOLN TEARS NATURALE TEARS PURE SOLN TEARS RENEWED OINT THERATEARS SOLN V-R ARTIFICIAL TEARS SOLN	Use PA Form# 20420 1. Dosing limits apply, please see dose consolidation list.
OP. - BETA - BLOCKERS		**BETOPTIC-S SUSP** **CARTEOLOL HCL SOLN** **LEVOBUNOLOL HCL SOLN** METIPRANOLOL SOLN **TIMOLOL MALEATE SOLG (GEL)** **TIMOLOL MALEATE SOLN**		BETAGAN SOLN **BETAXOLOL HCL SOLN** **BETIMOL SOLN** ISTALOL **OCUPRESS SOLN** OPTIPRANOLOL SOLN **TIMOPTIC SOLN** **TIMOPTIC-XE SOLG**	Use PA Form# 20420
OP. - ANTI-INFLAMMATORY / STEROIDS OPHTH.		AK-SPORE HC OINT ALREX SUSP BLEPHAMIDE SUSP DEXAMETH SOD PHOS SOLN FLAREX SUSP FLUOROMETHOLONE SUSP FML S.O.P. OINT NEOM/POLIN/DEX PRED MILD SUSP PREDNISOLONE TOBRADEX		AK-TROL SUSP BAC/POLY/NEOMY/HC OINT BLEPHAMIDE S.O.P. OINT BROMDAY EFLONE SUSP FLUOR-OP SUSP LOTEMAX SUSP MAXITROL NEO/POLY/BAC/HC OINT OZURDEX PRED FORTE SUSP PRED-G SUSP PRED-G S.O.P. OINT SULFACET SOD/PRED SOLN TOBRADEX ST TOBRAMYCIN SUSP DEXAMETHASONE VASOCIDIN SOLN VEXOL SUSP	Use PA Form# 20420
OP. - PROSTAGLANDINS		**LATANOPROST SOL 0.005%[1]** **TRAVATAN-Z**	7 8 **8** **8**	XALATAN SOLN[1] LUMIGAN SOLN[1] **TRAVATAN SOLN** **ZIOPTAN**	1. All preferreds must be tried. Use PA Form# 20420
OP. - CYCLOPLEGICS		AK-PENTOLATE SOLN ATROPINE SULFATE CYCLOPENTOLATE HCL SOLN ISOPTO HYOSCINE SOLN		CYCLOGYL SOLN ISOPTO ATROPINE SOLN ISOPTO HOMATROPINE SOLN MUROCOLL-2 SOLN	Use PA Form# 20420
OP. - MIOTICS - DIRECT ACTING		**ISOPTO CARBACHOL SOLN** ISOPTO CARPINE SOLN PILOCAR SOLN **PILOCARPINE HCL SOLN** **PILOPINE HS GEL**			Use PA Form# 20420
OP. - ADRENERGIC AGENTS		**DIPIVEFRIN HCL SOLN** EPIFRIN SOLN		PROPINE SOLN	Use PA Form# 20420
OP. - SELECTIVE ALPHA ADRENERGIC AGONISTS		ALPHAGAN P 0.15% SOLN		ALPHAGAN SOLN ALPHAGAN P 0.1% SOLN BRIMONIDINE 0.2% **IOPIDINE SOLN**	Use PA Form# 20420
OP. - ANTI-ALLERGICS		PATADAY SOLN PATANOL SOLN	8 8 8 8 8 8	ALOCRIL SOLN ALOMIDE SOLN BEPREVE ELESTAT EMADINE SOLN LASTACAFT	Use PA Form# 20420

			8 8 8 9	OPTIVAR OPTICROM SOLN ZADITOR SOLN EPINASTINE	
OP. ANTI-ALLERGICS-MASTCELL STABILIZER CLASS				ALAMAST SOLN	Use PA Form# 20420
OP. - CARBONIC ANHYDRASE INHIBITORS/COMBO		**AZOPT SUSP** COMBIGAN DORZOLAMIDE DORZOLAMIDE/TIMOLOL		**COSOPT SOLN** **TRUSOPT SOLN**	Use PA Form# 20420
OP. - NSAID'S		FLURBIPROFEN SODIUM SOLN DICLOFENAC OPTH 0.1% KETOROLAC OPTH 0.4% KETOROLAC OPTH 0.5%	8 8 8 8 8 8 8 8 8 9	ACULAR LS[1] ACULAR SOLN[1] ILEVRO OCUFEN SOLN[1] NEVANAC[1] PROLENSA XIBROM[1] VOLTAREN SOLN[1] ACUVAIL[1] BROMFENAC	1. Must fail all preferred products before non-preferred. Use PA Form# 20420
OP. - OF INTEREST		ENUCLENE SOLN		BOTOX SOLR RESTASIS[1]	1. Must have kerato conjuctivitus sicca and failed other dry eye therapies. Use PA Form# 20420
DERMATOLOGICAL					
TOPICAL - ORAL		AMNESTEEM[1] CLARAVIS[1] SOTRET[1]			1. Users 24 or under, PA will not be required. Use PA Form# 20420
TOPICAL - ACNE PREPARATIONS		AZELEX CREA[4] BENZOYL PEROXIDE CLINDAMYCIN PHOSPHATE[2] ERYDERM SOLN ERYTHROMYCIN GEL ERYTHROMYCIN PADS ERYTHROMYCIN SOLN ISOTRETINOIN METRONIDAZOLE CREA[2] METRONIDAZOLE GEL[2] METRONIDAZOLE LOTN[2] SODIUM SULFACET/SULF LOTN TAZORAC TRETINOIN GEL[1] TRETINOIN CREA[1,2]		ACZONE ALTINAC CREA AVITA CREA BENZAC BENZACLIN GEL[3] BENZAGEL-10 GEL BENZAMYCIN GEL BENZAMYCINPAK PACK BENZEFOAM BREVOXYL CLEOCIN-T[2] CLINAC BPO GEL CLINDAGEL GEL CLINDETS SWAB DESQUAM-E GEL DESQUAM-X DIFFERIN 0.3% GEL DIFFERIN DUAC GEL EMGEL GEL EPIDUO ERYCETTE PADS EVOCLIN FINEVIN CREA KLARON LOTN METROCREAM CREA[2] METROGEL GEL[2] METROLOTION LOTN[2] NEOBENZ MICRO NORITATE CREA RETIN-A GEL[2] RETIN-A MICRO GEL RETIN-A CREA[2] TRIAZ VELTIN ZENCIA WASH ZETACET ZIANA	1. Users 24 or under, PA will not be required. 2. Dosing limits allowing one package per month. Please refer to Dose Consolidation List. 3. Only available if component ingredients are unavailable. 4. Dosing limits apply, please see dosing consolidation list Use PA Form# 10220 for Brand Name requests Use PA Form# 20420 for all other requests
TOPICAL - ANTIBIOTIC		BACIT/NEOMYCIN/POLYM OINT BACITRACIN OINT BACTROBAN CREA[1] BACTROBAN NASAL OINT CENTANY OINT 2%[1] GENTAMICIN SULFATE MUPIROCIN[1]		ALTABAX[1] BACTROBAN OINT. TRIPLE ANTIBIOTIC OINT	1. Dosing limits apply, please see dosing consolidation list. Use PA Form# 20420
TOPICAL - ANTIFUNGALS		BETAMETHASONE CLOTRIMAZOLE LOT CICLOPIROX 0.77 CREA CICLOPIROX 0.77 SUSP CLOTRIMAZOLE ECONAZOLE NITRATE CREA KETOCONAZOLE CREA KETOCONAZOLE SHAM LOPROX 1.0 CREA LOPROX 1.O LOTN LOPROX GEL LOPROX TS LOTN LOTRISONE CREA MICONAZOLE NITRATE CREA MYCO-TRIACET II CREA NYSTATIN NYSTATIN/TRIAMCINOLONE NYSTOP POWD PEDI-DRI POWD TINACTIN TRI-STATIN II CREA	8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 9	BETAMETHASONE CLOTRIMAZOLE CREA CICLOPIROX SOLN EXELDERM FUNGIZONE CREA HYDROCORT/IODOQ CREA LAMISIL LOPROX 0.77 LOTN LOPROX 0.77 CREA LOPROX 0.77 SUSP LOPROX SHAMPOO SHAM LOTRIMIN LOTRISONE LOT MENTAX CREA MYCOGEN II CREA NAFTIN NIZORAL SHAM NYSTAT-RX POWD OXISTAT PENLAC NAIL LACQUER SOLN	Use PA Form# 10120
TOPICAL - ANTIPRURITICS		ZONALON CREA		PRUDOXIN CREA	Use PA Form# 20420
TOPICAL - ANTIPSORIATICS		SORIATANE CAPS		OXSORALEN ULTRA CAPS[1]	1. Must fail all preferred products before non-

		TAZORAC		PSORIATEC CREA[1] SORIATANE CK KIT[1] TACLONEX[1,2] VECTICAL[1]	preferred. 2. Individual ingredients are available as preferred witout PA. Use PA Form# 20420
TOPICAL - ANTISEBORRHEICS		SELENIUM SULFIDE SHAM		CARMOL SCALP TREATMENT KIT ZNP BAR	Use PA Form# 20420
TOPICAL - ANTIVIRALS				DENAVIR CREA[1,3] ZOVIRAX OINT[1,2]	1. Must fail oral treatment with Acyclovir or Valtrex. 2. Approvals limited to 1 tube per 180 days. 3. Dosing limits apply, please see dosing consolidation list. Use PA Form# 20420
TOPICAL - ANTINEOPLASTICS		EFUDEX FLUOROPLEX CREA		CARAC CREA FLUOROURACIL SOLARAZE GEL ZYCLARA	Use PA Form# 20420
TOPICAL - BURN PRODUCTS		FURACIN CREA SILVER SULFADIAZINE CREA SSD AF CREA SSD CREA THERMAZENE CREA		SILVADENE CREA	Use PA Form# 20420
TOPICAL - CORTICOSTEROIDS		**LOW POTENCY** DESOWEN[1] HYDROCORTISONE CREA HYDROCORTISONE LOTN LACTICARE-HC LOTN NUTRACORT LOTN TEXACORT SOLN **MEDIUM POTENCY** DESOXIMETASONE .05% ELOCON FLUOCINOLONE ACETONIDE .025-.01% FLUROSYN CREA FLUTICASONE PROPIONATE CREA/OINT HYDROCORTISONE BUTYRATE HYDROCORTISONE OINT HYDROCORTISONE VALERATE MOMETASONE FUROATE OINT TRIAMCINOLONE ACETONIDE .025-.1% **HIGH POTENCY** BETAMETHASONE DIPROPIONATE CLOBEX LOTN DESOXIMETASONE .25% DESONIDE[1] FLUOCINOLONE ACETONIDE .02% FLUOCINONIDE HALOG HALOG-E CREA TRIAMCINOLONE ACETONIDE .5% **VERY HIGH POTENCY** AUGMENTED BETA DIP BETAMETHASONE VALERATE BETA-VAL CLOBETASOL PROPIONATE DIFLORASONE DIACETATE HALOBETASOL **MISCELLANEOUS** CAPEX SHAM DERMA-SMOOTHE/FS OIL PROCTO-KIT CREA 1%		ACLOVATE AMCINONIDE CREA ANUSOL HC-1 OINT **CLOBETASOL PROPINATE LOTN** CLODERM CREA CORDRAN CORMAX CUTIVATE CREA / OINT CUTIVATE LOTN DERMA-SMOOTHE/FS OIL DERMATOP DESONATE GEL DIPROLENE ELOCON OINT HYDROCORTISONE POWD KENALOG AERS LIDA MANTLE HC CREA LOCOID LUXIQ FOAM OLUX FOAM PANDEL CREA PROCTOCORT CREA PSORCON PSORCON E TEMOVATE TOPICORT TOPICORT LP CREA ULTRAVATE VERDESO WESTCORT	Use PA Form# 20420 1. Dosing limits apply, please see dosing consolidation list.
TOPICAL - STEROID LOCAL ANESTHETICS				EPIFOAM FOAM	Use PA Form# 20420
TOPICAL - STEROID COMBINATIONS		DERMA-SMOOTHE/FS ATOPIC P KIT		CARMOL-HC CREA	Use PA Form# 20420
TOPICAL - EMOLLIENTS		AMMONIUM LACTATE LOTN 12%[1] LAC-HYDRIN CREA1 UREACIN-20 CREA VITAMIN A & D MEDICATED OINT		AMMONIUM LACTATE CREA[1] LAC-HYDRIN LOTN 12% MEDERMA GEL MIMYX RENOVA CREA	Use PA Form# 20420 1. Dosing limits apply, please see dosing consolidation list.
TOPICAL - ENZYMES / KERATOLYTICS / UREA		GRANUL-DERM AERS GRANULEX AERS TBC AERS SANTYL OINT		CARMOL 40 CREA SALEX CREA SALEX LOTN	Use PA Form# 20420 Ziox, Panafil and Papain products have been removed from the PDL due to FDA safety concerns regarding drugs containing Papain.
TOPICAL - GENITAL WARTS		IMIQUIMOD[2]	5 8 8 8 8 8	PODOFILOX SOLN ALDARA CONDYLOX[1] PICATO[2] VEREGEN[1] ZYCLARA[1]	Use PA Form# 20420 1. Non-preferred products must be used in specified order. 2. Dosing limits still apply. Please see dose consolidation list
TOPICAL - IMMUNOMODULATORS			8 9	ELIDEL CREA[1] PROTOPIC OINT[1,2]	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.
TOPICAL - LOCAL ANESTHETICS		AF CAPSICUM OLEORESIN CREA CAPSAICIN CREA ELA-MAX[1] LIDOCAINE/PRILOCAINE CREA[1] LIDOCAINE GEL		EMLA PADS EMLA CREA LIDA MANTLE CREA LIDODERM PTCH PONTOCAINE SOLN SYNERA	1. Lidocaine/Prilocaine cream and Ela-Max products require PA for users over 18 years of age. Use PA Form# 20420

				ZOSTRIX	
TOPICAL - DEPIGMENTING AGENTS			8 8 8 8 8 8 8 9	ALUSTRA CREA EPIQUIN MICRO GLYQUIN CREA HYDROQUINONE CREA HYDROQUINONE/SUNSCREENS SOLAQUIN FORTE CREA TRI-LUMA CREA ELDOQUIN	Not covered for cosmetic purposes. Use PA Form# 20420
TOPICAL - SCABICIDES AND PEDICULICIDES		ACTICIN CREA ELIMITE CREA EURAX LICE KILLING SHAM LICE TREATMENT CREME RINS LIQD NATROBA[1,2] PERMETHRIN LOTN		LINDANE MALATHION OVIDE LOTN ULESFIA	Use PA Form# 20420 1. Dosing limits apply, please see dosing consolidation list 2. Will require two failed trails of permethrin
TOPICAL - WOUND / DECUBITUS CARE				REGRANEX GEL REGENECARE RADIAPLEXRX	Use PA Form# 20420 Accuzyme and Ethezyme products have been removed from the PDL due to FDA concerns regarding drugs containing Papain.
TOPICAL - ASTRINGENTS / PROTECTANTS		ALUMINUM CHLORIDE SOLN DRYSOL SOLN[1] XERAC AC SOLN		LOWILA BAR MOISTURIN DRY SKIN CREA PROSHIELD PLUS SKIN PROTE CREA SURGILUBE GEL	Use PA Form# 20420 1. Dosing limits still apply. Please see dose consolidation list.
TOPICAL - ANTISEPTICS / DISINFECTANTS		PHISOHEX LIQD POVIDONE-IODINE SOLN		BETADINE OINT FORMALYDE-10 AERS IODOSORB LAZERFORMALYDE SOLUTION SOLN	Use PA Form# 20420
MISCELLANEOUS EYE					
OP. - EYE		AK-DILATE SOLN EYE WASH SOLN NAPHAZOLINE HCL SOLN PHENYLEPHRINE HCL SOLN PONTOCAINE SOLN SODIUM CHLORIDE		LENS PLUS REWETTING DROPS MURO 128 NEO-SYNEPHRINE SOLN	Use PA Form# 20420
MISCELLANEOUS EAR					
EAR		A/B OTIC SOLN ACETASOL SOLN ACETASOL HC SOLN ACETIC ACID ACETIC ACID/HYDROCORTISON ALLERGEN SOLN ANTIPYRINE/BENZOCAINE SOLN AURODEX SOLN AUROGUARD SOLN AUROTO OTIC SOLN CARBAMIDE PEROXIDE 6.5% OTIC SOLN. CIPRODEX CORTISPORIN SOLN CORTOMYCIN EAR DROPS SOLN EAR DROPS RX SOLN EAR WAX REMOVAL DROPS EAR-GESIC SOLN NEOMYCIN/POLYMYXIN/HC OFLOXACIN 0.3% OTIC OTICAINE OTIC SOLN		AERO OTIC HC SOLN ANTIBIOTIC EAR SOLN ANTIBIOTIC EAR SUSP AURALGAN SOLN CETRAXAL CIPRO HC SUSP COLY-MYCIN-S SUSP CORTISPORIN-TC SUSP DERMOTIC DEBROX SOLN PEDIOTIC SUSP VOSOL-HC SOLN ZOTANE HC SOLN ZOTO-HC SOLN	Use PA Form# 20420
MOUTH ANTISEPTICS					
MOUTH ANTI-INFECTIVES		NILSTAT SUSP EAR-GESIC SOLN NYSTATIN SUSP		MYCELEX TROC ORAVIG	Use PA Form# 20420
MOUTH ANTISEPTICS		CHLORHEXIDINE GLUCONATE LIDOCAINE VISCOUS SOLN TRIAMCINOLONE IN ORABASE PSTE TRIAMCINOLONE ORADENT PSTE		APHTHASOL PSTE[1] PERIOGARD SOLN[1] TRIAMCINOLONE ACETONIDE PSTE[1]	Use PA Form# 20420 1. Must fail all preferred products before non-preferred.
DENTAL PRODUCTS					
DENTAL PRODUCTS		ETHEDENT CREA GEL-KAM CONC GEL-KAM GEL 0.4% PHOS FLUR SOLN PREVIDENT GEL PREVIDENT SOLN SF 5000 PLUS CREA SF GEL STANNOUS FLUORIDE ORAL RI CONC		APF GEL GEL DENTAGEL GEL PHOS-FLUR GEL PREVIDENT CREA THERA-FLUR-N GEL	Use PA Form# 20420
ARTIFICIAL SALIVA/STIMULANTS					
ARTIFICIAL SALIVA/STIMULANTS		SALIVA SUBSTITUTE SOLN		EVOXAC CAPS RADIACARE SOLR SALAGEN TABS	Use PA Form# 20420
MISCELLANEOUS ANORECTAL					
ANORECTAL - MISC.		COLOCORT ENEM CORTENEMA ENEM ELA-MAX 5 CREA HYDROCORTISONE ENEM PROCTOZONE-HC CREA PROCTOSOL HC CREA PROCTOCREAM-HC CREA		ANUSOL-HC CREA CORTIFOAM FOAM PROCTOFOAM HC FOAM PROCTO-KIT CREA 2.5% RECTIV OINT	Use PA Form# 20420
T-CELL ACTIVATION INHIBITOR					
PSORIASIS BIOLOGICALS		ENBREL[1] HUMIRA[1]		**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.

					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. Use PA Form# 20910
ALTERNATIVE MEDICINES					
ALTERNATIVE MEDICINES		DIMETHYL SULFOXIDE SOLN		CO-ENZYME Q-10 MELATONIN TABS	Use PA Form# 20420
CHELATING AGENTS					
CHELATING AGENTS		**CUPRIMINE CAPS**		DEPEN TITRATABS TABS EXJADE[1]	Use PA Form# 20420 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				THALOMID CAPS[1]	1. All PA requests for 150mg dosing will require use of Thalomid 100mg and 50mg capsules. Use PA Form# 20420
ANTINEOPLASTIC AGENTS					
ANTINEOPLASTIC AGENTS - ANTIADNDROGENS		BICALUTAMIDE		CASODEX	Use PA Form# 20420
ANTINEOPLASTIC AGENTS-LHRH ANALOGS		LUPRON DEPOT[1]		VANTAS[2] FIRMAGON[2] TRELSTAR	1. Dosing limits apply, please refer to dosage consolidation list. 2. PA required to confirm FDA approved indication. Use PA Form# 20420
ANTINEOPLASTIC AGENTS - TYROSINE KINASE INHIBITORS				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		AMIFOSTINE MERCAPTOPURINE		ETHYOL PURINETHOL ZOLINZA	Use PA Form# 20420
ANTINEOPLASTICS-MONOCLONAL ANTIBODIES				HERCEPTIN[1]	1. PA required to confirm FDA approved indication. Use PA Form# 20420
CANCER					
CANCER		ALIMTA ANASTROZOLE TABS AVASTIN ERBITUX LETROZOLE MEGACE ES VIDAZA		ARIMIDEX BOSULIF ERIVEDGE FOLOTYN ICLUSIG[3] INLYTA JAKAFI NEXAVAR[1] POMALYST STRIVARGA SUTENT[1,2] ZELBORAF SYLATRON FEMARA YERVOY XALKORI XTANDI ZELBORAF ZYTIGA	1. PA required to confirm FDA approved indication 2. Avoid CYP3AY drug drug interaction. 3. Clinical PA required for appropriate diagnosis Use PA Form# 20420
IMMUNOSUPPRESSANTS					
IMMUNOSUPPRESSANTS		CYCLOSPORINE MODIFIED CYCLOSPORINE SOL. MODIFIED GENGRAF CAPS MYCOPHENOLATE MYFORTIC PROGRAF CAPS RAPAMUNE SANDIMMUNE		CELLCEPT CYCLOSPORINE CAPS NEORAL[1,2]	1. Established users will require a one time PA. 2. Established users will require a one time PA Use PA Form# 20420
PURINE ANALOG					
PURINE ANALOG		AZASAN TABS **AZATHIOPRINE TABS**		**IMURAN TABS**	Use PA Form# 20420
K REMOVING RESINS					
K REMOVING RESINS		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**		

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