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

	MC/DEL	FORTAZ SOLR	MC/DEL	TEFLARO		
	MC	TAZICEF 6GM			Use PA Form# 20420	
MACROLIDES / ERYTHROMYCIN'S	MC	BIAXIN XL[1]	MC/DEL	AZITHROMYCIN POW	1. 7- Day supply per month without PA.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **DDI:** Preferred erythromycin will now be non-preferred and require prior authorization if it is currently being used in combination with either Carbamazepine, Enablex 15mg or Vesicare 10mg. Any non preferred formulation of erythromycin will require prior authorization and the member's drug profile will also be monitored for concurrent use with either Carbamazepine, Enablex 15mg or Vesicare 10mg. **DDI:** Preferred clarithromycin formulations (clarithromycin tablets and Biaxin XL tablets) will now be non-preferred and require prior authorization if they are currently being used in combination with either Carbamazepine, Onglyza 5mg, Enablex 15mg or Vesicare 10mg. Any non preferred formulation of clarithromycin will require prior authorization and the member's drug profile will also be monitored for concurrent use with either Carbamazepine, Onglyza 5mg, Enablex 15mg or Vesicare 10mg.
	MC/DEL	AZITHROMYCIN TABS	MC	BIAXIN		
	MC/DEL	AZITHROMYCIN SUSP	MC/DEL	CLARITHROMYCIN SUSP		
	MC	E.E.S.	MC/DEL	CLARITHROMYCIN TABS		
	MC	ERYPED 200 SUSR	MC	DIFICID		
	MC	ERYPED 400 SUSR	MC	PCE TBEC		
	MC	ERY-TAB TBEC	MC/DEL	ZITHROMAX TABS	Use PA Form# 20420	
	MC	ERYTHROCIN STEARATE TABS	MC/DEL	ZITHROMAX 1GM PAK		
	MC/DEL	ERYTHROMYCIN	MC/DEL	ZITHROMAX TRI-PAK		
			MC/DEL	ZITHROMAX SUSP		
			MC/DEL	ZMAX		
TETRACYCLINES	MC/DEL	DOXYCYCLINE MONOHYDRATE CAPS	MC	DECLOMYCIN TABS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL	MINOCYCLINE HCL CAPS	MC/DEL	DORYX CPEP		
	MC/DEL	TETRACYCLINE HCL CAPS	MC/DEL	DOXYCYCLINE HYCLATE		
	MC/DEL	VIBRAMYCIN SYRP	MC/DEL	DYNACIN CAPS		
			MC	ORACEA		
			MC/DEL	PERIOSTAT		
			MC/DEL	SOLODYN ER		
FLUOROQUINOLONES	MC/DEL	CIPROFLOXACIN	MC	AVELOX SOLN		Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **DDI:** Preferred ofloxacin will now be non-preferred and require prior authorization if they are currently being used in combination with amiodarone. **DDI:** Preferred levofloxacin will now be non-preferred and require prior authorization if they are currently being used in combination with amiodarone. **DDI:** Preferred Avelox will now be non-preferred and require prior authorization if they are currently being used in combination with amiodarone. **DDI:** All preferred fluoroquinolones will require clinical PA for patients over 60 that are currently on immunosuppressants or steroid therapy. **DDI:** Factive is non-preferred but with any prior authorization requests, the member's drug profile will also be monitored for concurrent use with amiodarone.
	MC/DEL	LEVOFLOXACIN	MC	AVELOX TABS	Use PA Form# 20420 1. Dosing limits apply, see Dosage Consolidation List.	
	MC/DEL	OFLOXACIN	MC	AVELOX ABC PACK TABS		
			MC	CIPRO		
			MC	FACTIVE		
			MC/DEL	LEVAQUIN TABS SOLN/INJ		
			MC/DEL	LEVAQUIN TABS[1]		
			MC	NOROXIN TABS		
			MC	PROQUIN XR		
AMINO GLYCOSIDES	MC	GENTAMICIN	MC/DEL	TOBI PODHALER[1]	Use PA Form# 20420 1. Clinial PA to verify appropriate diag	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. TOBI Podhaler is limited to patients with significant impairment from using nebulized version of medication
	MC/DEL	NEOMYCIN SULFATE TABS				
	MC	TOBI NEBU				
	MC/DEL	TOBRAMYCIN SULFATE SOLN				
ANTI-MYCOBACTERIALS / ANTI-TUBERCULOSIS	MC/DEL	ETHAMBUTOL HCL TABS			Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **DDI:** Preferred rifampin will be non-preferred and require prior authorization if it is currently being used in combination with either Pradaxa or Latuda.
	MC/DEL	MYAMBUTOL TABS				
	MC/DEL	MYCOBUTIN CAPS				
	MC/DEL	RIFAMPIN				
ANTIMALARIAL AGENTS	MC/DEL	**CHLOROQUINE PHOSPHATE TABS**	MC	ARALEN TABS	Use PA Form# 20420 1. Ingredients available as preferred without PA.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL	**DARAPRIM TABS**	MC	ISONARIF[1]		
	MC/DEL	**HYDROXYCHLOROQUINE TABS**	MC/DEL	MALARONE TABS		
	MC/DEL	**MEFLOQUINE HCL TABS**	MC/DEL	**PLAQUENIL TABS**		
	MC/DEL	**QUININE SULFATE**				
ANTHELMINTICS	MC/DEL	ALBENZA TABS			Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC	BILTRICIDE TABS				
	MC/DEL	STROMECTOL TABS				
ANTIBIOTICS - MISC.	MC	AZACTAM SOLR	MC	COLISTIMETHATE SODIUM SOLR	1. 375mg caps and 750mg tabs are non-preferred. Please use available preferred strengths(250mg & 500mg tabs) to obtain required dose without PA.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. 1. For macrolide resistant infections when quinolones inappropriate **DDI:** Ketek is non-preferred but with any prior authorization requests, the member's drug profile will also be monitored for concurrent use with either Enablex 15mg or Vesicare 10mg or carbamazepine.
	MC	COLY-MYCIN-M SOLR	MC	CAYSTON[3]		
	MC	COLISTIMETHATE SODIUM SOLR	MC/DEL	FLAGYL CAPS		
	MC	FUROXONE TABS	MC/DEL	FLAGYL TABS		
	MC/DEL	METRONIDAZOLE[1]	MC/DEL	FLAGYL ER TBCR		
	MC	PENTAMIDINE ISETHIONATE SOLR	MC/DEL	KETEK		
	MC	PRIMSOL SOLN	MC/DEL	METRONIDAZOLE 375MG CAPS[1]		

	MC		TINDAMAX	MC/DEL		METRONIDAZOLE 750MG TABS[1]		
	MC/DEL		TRIMETHOPRIM TABS	MC		NEBUPENT SOLR	2. Please use multiple 5gm which are preferred to obtain dose without PA.	Cayston is only indicated to improve respiratory symptoms in CF patients with Pseudomonas aeruginosa. Dosing limits, as should be given TID X28 days (followed by 28 days OFF Cayston therapy). A bronshodilator should be used before administration of Cayston.
	MC/DEL		VANCOMYCIN 5GM INJ.	MC/DEL		VANCOMYCIN 10GM INJ.[2]		
				MC		XIFAXAN	3. 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				MC		INVANZ SOLR	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
				MC		MERREM SOLR		
				MC/DEL		PRIMAXIN		
LINCOSAMIDES / OXAZOLIDINONES / LEPROSTATICS	MC/DEL		CLEOCIN SOLN	MC/DEL		CLEOCIN CAPS	1. Use multiple 150's for Clindamycin instead of 300's.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. For Zyvox or Vibativ, please see the criteria listed in the Antibacterial Antibiotics PA form.
	MC/DEL		CLEOCIN SUSR	MC/DEL		CLINDAMYCIN HCL 300CAPS[1]		
	MC/DEL		CLINDAMYCIN HCL 150CAPS	MC/DEL		VIBATIV		
	MC		DAPSONE TABS	MC/DEL		ZYVOX SUSR	Use PA Form# 30820 for Zyvox & Vibativ	
				MC/DEL		ZYVOX TABS	Use PA Form# 20420 for all others	
ANTI INFECTIVE COMBO'S - MISC.	MC/DEL		ERYTHROMYCIN/SULF SUSR	MC		BACTRIM DS TABS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		SEPTRA/DS TABS					
	MC/DEL		SULFAMETHOXAZOLE/TRIMETH					
	MC/DEL		TRIMETHOPRIM/SULFAMETHOXA					
ANTIPROTOZOALS				MC		ALINIA[1]	1. Alina is preferred for children less than 12 years of age.	
							Use PA Form# 20420	
ANTI - FUNGALS								
ANTIFUNGALS - ASSORTED	MC		ANCOBON CAPS	MC/DEL	6	LAMISIL TABS[4]	1. QL--1/every 7-day period (150mg only).	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. The other criteria are listed on the Antifungal PA form including the required proof of a non-cosmetic fungal infection.
	MC/DEL		FLUCONAZOLE[1]	MC/DEL	6	ITRACONAZOLE		
	MC/DEL		GRIFULVIN V TABS[8]	MC/DEL	8	SPORANOX SOLN[2]	2. Sporanox QL 300cc/month with PA. See quantity limit table.	
	MC		GRISEOFULVIN SUSP[8]	MC/DEL	8	SPORANOX PULSEPAK CAPS[3]		
	MC		GRISEOFULVIN ULTRAMICROSI TABS[8]	MC/DEL	8	SPORANOX CAPS[3]		
	MC		GRIS-PEG TABS[8]	MC/DEL	8	DIFLUCAN	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.	**DDI:** Any Griseofulvin will now be non-preferred and require prior authorization if it is currently being used in combination with either Prevacid, pantoprazole, Prilosec, or any currently non preferred PPI.
	MC/DEL		KETOCONAZOLE TABS[7]	MC/DEL	8	ERAXIS INJ[6]		
	MC/DEL		NYSTATIN	MC	8	GRIFULVIN SUSP		
	MC/DEL		TERBINAFINE TABS[4]	MC/DEL	8	ONMEL		**DDI:** Sporanox is non-preferred but with any prior authorization requests, the member's drug profile will also be monitored for current use with Enablex 15mg, Vesicare 10mg, Prandin, Prevacid, pantoprazole, Prilosec, or any currently non preferred PPI, due to a significant drug-drug interaction.
				MC/DEL	8	NOXAFIL[5]		
				MC/DEL	8	VFEND TABS	4. Quantity limit of one tablet daily. Please see dosage consolidation list.	**DDI:** Vfend is non-preferred but with any prior authorization requests, the member's drug profile will also be monitored for concurrent use with Warfarin.
							5. Approved if immuno suppressed/ HIV or if the member has failed a 7 day trial of a preferred antifungal therapy.	**DDI:** Fluconazole (except 150mg strength) will now be non-preferred and require prior authorization if it is currently being used with glimepiride (Amaryl), Enablex 15mg, or Vesicare 10mg. Diflucan is non-preferred but with any prior authorization requests, the member's drug profile will also be monitored for concurrent use with either glimepiride (Amaryl), Enablex 15mg, or Vesicare 10mg.

							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. 7. Quantity limits allowing 30 day supply without PA. PA will be required if using > 30 days. 8. 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	**DDI:** Fluconazole will require prior authorization if being used in combination with Plavix or Warfarin. **DDI:** Ketoconazole will now be non-preferred and require prior authorization if they are currently being used in combination with any of the following medications: Prevacid, Pantoprazole, Plavix, Onglyza, Enablex 15mg, Vesicare 10mg, Latuda, Cometriq, Tafinlar or Omeprazole.
ANTI - VIRALS								
ANTIRETROVIRALS	MC/DEL		APTIVUS	MC	8	COMPLERA		Please refer to the criteria listed on the Fuzeon PA form.
	MC		ATRIPLA[1]	MC/DEL	8	DIDANOSINE		
	MC/DEL		COMBIVIR TABS	MC/DEL	8	FUZEON[3]	Use PA Form# 10620 for Fuzeon	
	MC/DEL		CRIXIVAN CAPS	MC/DEL	8	INTELENCE[3]		
	MC/DEL		EDURANT	MC/DEL	8	ISENTRESS[3,4]	1. Quantity limit of one per day	**DDI:** Reyataz will now be non-preferred and require prior authorization if it is currently being used in combination with either Prevacid, pantoprazole, Prilosec, or any currently non preferred PPI .
	MC		EMTRIVA	MC/DEL	8	RETROVIR		
	MC/DEL		EPIVIR / HBV	MC/DEL	8	SELZENTRY[3]	2. Only preferred if Norvir script is in member's profile within the past 30 days of filling Prezista	**DDI:** Preferred Norvir will now be non-preferred and require prior authorization if it is currently being used in combination with either Enablex 15mg or Vesicare 10mg.
	MC/DEL		EPZICOM	MC	8	STRIBILD		
	MC/DEL		INVIRASE CAPS	MC	8	TIVICAY[5,6]		
	MC		KALETRA	MC	8	ZERIT		
	MC/DEL		LEXIVA	MC/DEL	9	VIRAMUNE XR	3. Prescribers with >= 10 ART scripts per quarter and 75% ART PDL compliance will be exempt from PA for these products.	**DDI:** Preferred Crixivan caps will now be non-preferred and require prior authorization if it is currently being used in combination with either Enablex 15mg or Vesicare 10mg.
	MC		NORVIR					
	MC		PREZISTA[2]					EDURANT® treated subjects with HIV-1 RNA greater than 100,000 copies/mL at the start of therapy experienced virologic failure (HIV-1 RNA greater than or equal to 50 copies/mL) compared to EDURANT® treated subjects with HIV-1 RNA less than or equal to 100,000 copies/mL. Regardless of HIV-1 RNA at the start of therapy, more EDURANT® treated subjects with CD4+ cell count less than 200 cells/mm3 experienced virologic failure compared to EDURANT® treated subjects with CD4+ cell count greater than or equal to 200 cells/mm3.
	MC/DEL		RESCRIPTOR TABS					
	MC		REYATAZ[1]					
	MC		STAVUDINE					
	MC		SUSTIVA				4.Isentress Chewable will only be approved if between the age of 2-12 years old	
	MC/DEL		TRIZIVIR TABS					
	MC		TRUVADA					Stribild needs specific indication(only indicated for HIV-1 infection in adults who are antiretroviral treatment-naïve), as there is a boxed warning that this is not indicated for Hep B and has not been studied in those co-infected with HIV-1 and HBV. Should not be co-administered with other antiretroviral medications used for HIV1 infections, as this is a complete regimen
	MC		VIDEX EC					
	MC/DEL		VIRACEPT TABS				5. Clinical PA is required to establish diagnosis, verification of age for appropriate indication and medical necessity.	
	MC/DEL		VIRAMUNE TABS					
	MC		VIREAD TABS					DDI: Nevirapine, oxcarbazepine, phenytion, phenobarbital, carbamazepine, and St. John;s wort will be non-preferred and require prior authorization if it is currently being used in combination with Tivicay.
	MC/DEL		ZIAGEN TABS					
	MC/DEL		ZIDOVUDINE				6. Dosing limits apply, please see dosing consolidation list.	

CYTO-MEGALOVIRUS AGENTS	MC MC		FOSCARNET SODIUM VALCYTE TABS	MC/DEL MC/DEL		FOSCAVIR GANCICLOVIR	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
HERPES AGENTS	MC/DEL MC/DEL		ACYCLOVIR VALACYCLOVIR HCL[1]	MC/DEL MC/DEL MC/DEL MC/DEL	8 8 8 9	FAMCICLOVIR[1] ZOVIRAX[1] VALTREX TABS[1] FAMVIR TABS[1]	1. Must fail Acyclovir and Valacyclovir before non-preferred products in step order. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
INFLUENZA AGENTS	MC/DEL MC MC/DEL MC/DEL		AMANTADINE RELENZA DISKHALER AEPB RIMANTADINE HCL TABS TAMIFLU[1]	MC/DEL MC		FLUMADINE TABS FLUMIST	1. Tamiflu 10 caps or 60cc's per month. Will be audited for presence of positive influenza tests in patient or family member. Use PA Form# 10610 for Flumist requests Use PA Form# 20420 for all others	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
IMMUNE SERUMS								
IMMUNE SERUMS	MC		HYPERRHO INJ					
HEPATITIS AGENTS								
HEPATITIS C AGENTS	MC MC/DEL MC/DEL MC/DEL MC/DEL MC MC		INCIVEK[2] VICTRELIS[2] PEGASYS KIT[1] PEGASYS SOLN PEG-INTRON KIT[1] RIBAVIRIN RIBAPAK	MC/DEL MC/DEL		COPEGUS TABS REBETOL CAPS	1. Dosing limits apply, please see dosage consolidation list. 2. Approvals will require clinical PA to establish genotype, baseline viral loads and will require periodic SVR's. Must have Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Victrelis will now have an additional drug-drug interaction warning. FDA notified healthcare professionals that the Victrelis drug label has been revised to state that co-administration of Victrelis (boceprevir), a hepatitis C virus (HCV) protease inhibitor, along with certain ritonavir-boosted human immunodeficiency virus (HIV) protease inhibitors, is not recommended. The findings of a drug-drug interaction study and clinical trial showed that co-administration increased of the possibility of reducing the effectiveness of the medicines, permitting the amount of HCV or HIV virus in the blood to increase. Ritonavir-boosted HIV protease inhibitors include ritonavir-boosted Reyataz (atazanavir), ritonavir-boosted Prezista (darunavir), and Kaletra (lopinavir/ritonavir).
HEPATITIS AGENTS - MISC.				MC		ACTIMMUNE	Use PA Form# 20420	Approved for chronic granulomatous disease, osteopetrosis and idiopathic pulmonary fibrosis.
HEPATITIS B ONLY	MC		HEPSERA TABS	MC MC		BARACLUDE TYZEKA	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Baraclude is indicated for treatment of chronic Hep B virus (HBV) in adults with: evidence of active viral replication AND either evidence of persistent elevation in serum aminotransferases (ALT or AST) or histologically active disease, Patient is 16 years of age or older. Boxed warning: Use not recommended for those co-infected with HIV and HBV who are not also receiving highly active antiretroviral therapy (HAART).
RSV PROPHYLAXIS								
RSV PROPHYLAXIS				MC		SYNAGIS[1]	Use PA Form# 30120 1. MaineCare will approve Synagis PA's for start date of November 23rd for infants who meet the guidelines. PA will be approved for max of 5 doses. Maximum 1 dose/30 days.	Please see the criteria listed on the Synagis PA form.

MS TREATMENTS								
MULTIPLE SCLEROSIS - INTERFERONS	MC MC/DEL MC		AVONEX KIT[1] **BETASERON SOLR**[1] REBIF SOLN[1]	MC/DEL		EXTAVIA	1.Clinical PA is required to establish diagnosis and medical necessity. Use PA Form# 20430	Non-Preferred drugs must be tried in step-order and failed due to lack of efficacy or intolerable side effects before lower ranked non-preferred drugs will be approved , unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
MULTIPLE SCLEROSIS - NON-INTERFERONS	MC MC/DEL		**COPAXONE**[2] GILENYA[2,3]	MC/DEL MC MC MC	6 8 8 8	TYSABRI[1] AUBAGIO AMPYRA 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 dosage consolidation list. Use PA Form# 20430	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **Aubagio** is non-preferred and is for adults with relapsing forms of MS. No concurrent use of leflunomide . Within 6 months of initiation of Aubagio, lab testing to look at (transaminase, bilirubin, CBC, TB) as boxed warning exists regarding hepatoxicity.
ASSORTED NEUROLOGICS								
NEUROLOGICS - MISC.	MC MC/DEL MC		MESTINON ORAP TABS PROSTIGMIN TABS	MC MC/DEL		BOTOX DYSPORT[1] MYOBLOC[1]	1. Approval will be limited to Cervical dystonia. Use PA Form# 10210	Failed/did not tolerate therapeutic trials fo muscle relaxants, unless contraindicated, including but not limited to baclofen, cyclobenzaprine, orphenadrine, Skelaxin, and tizanidine. Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
STEROIDS								
GLUCOCORTICOIDS/ MINERALOCORTICOIDS	MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		CELESTONE SUSP CORTEF 5 CORTISONE ACETATE TABS DELTASONE TABS DEPO-MEDROL SUSP DEXAMETHASONE ENTOCORT EC CP24 FLUDROCORTISONE ACETATE TABS HYDROCORTISONE KENALOG METHYLPREDNISOLONE TABS PREDNISOLONE **PREDNISONE** SOLU-CORTEF SOLR SOLU-MEDROL SOLR	MC/DEL MC MC/DEL MC/DEL MC MC MC MC MC MC		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	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **DDI:** All preferred steroids will require clinical PA for patients over 60 that are currently on fluoroquinolone therapy.
HORMONE REPLACEMENT THERAPIES								
ANDROGENS / ANABOLICS	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		ANDRODERM PT24 ANDROGEL ANDROGEL PUMP DANAZOL CAPS DEPO-TESTOSTERONE OIL METHITEST TABS OXANDRIN TABS TESTIM	MC MC MC/DEL MC MC MC MC MC/DEL MC/DEL MC		ANADROL-50 ANDRO LA 200 OIL ANDROID CAPS AXIRON DELATESTRYL OIL FORTESTA HALOTESTIN TABS **OXANDROLONE** TESTOSTERONE CYP TESTRED CAPS	Use PA Form# 20420 Use PA Form# 20600 for Ox	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Additionally, laboratory evidence of a testosterone deficiency must be supplied. One of each dosage form should be tried (tablet, injection, and topical)
ESTROGENS - PATCHES / TOPICAL	MC/DEL MC/DEL		**VIVELLE-DOT PTTW**[1] **CLIMARA PTWK**	MC/DEL MC/DEL MC/DEL	5 8 8	**ESTRADIOL PTWK** **ALORA PTTW**[2] **DIVIGEL**[2]	1. Both preferred drugs must be tried. 2. Step order drugs must be	Approved for failures on multiple oral estrogen agents after 90 day trials or if unable to swallow any oral medication.

				MC/DEL	8	**ELESTRIN**[2]	used in specified step order.	
				MC	8	**EVAMIST**[2]	Use PA Form# 20420	
ESTROGENS - TABS	MC/DEL		**CENESTIN TABS**	MC/DEL		ENJUVIA	Must fail preferred products before non-preferred products.	Preferred drugs must be tried for at least 90 days and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**ESTRADIOL**	MC/DEL		**ESTRACE TABS**		
	MC/DEL		**ESTROPIPATE TABS**	MC		ESTRATAB TABS		
	MC/DEL		**MENEST TABS**	MC		ORTHO-EST TABS		
	MC/DEL		**PREMARIN TABS**				Use PA Form# 20420	
ESTROGEN COMBO'S	MC/DEL		**PREMPHASE TABS**	MC/DEL		**ACTIVELLA TABS**[1]	1. Must fail Premphase and Prempro products before non preferred products.	Preferred drugs must be tried for at least 90 days and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**PREMPRO TABS**	MC/DEL		**COMBIPATCH PTTW**[1]		
				MC/DEL		**FEMHRT 1/5 TABS**[1]	Use PA Form# 20420	
				MC/DEL		**ORTHO-PREFEST TABS**[1]		
				MC/DEL		SYNTEST H.S. TABS[1]		
PROGESTINS	MC/DEL		MEDROXYPROGESTERONE ACETA [2]	MC/DEL		AYGESTIN TABS	1. PA approvals will require two 100 mg caps instead of one 200mg.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		NORETHINDRONE ACETATE TABS[2]	MC		CYCRIN TABS		
				MC		MAKENA	2. Must fail Medroxyprogesterone and Norethidrone products before non-preferred products.	
				MC		PROGESTERONE POWD		
				MC/DEL		PROMETRIUM 100MG CAPS[1]		
				MC/DEL		PROMETRIUM 200MG[1]		
				MC/DEL		PROVERA TABS	Use PA Form# 20420	
CONTRACEPTIVES								
CONTRACEPTIVES - PROGESTIN ONLY	MC		LYZA	MC/DEL	7	CAMILA TABS		Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. If member experienced adverse reactions, consider using Oral Contraceptives from other groups. **DDI:** Preferred Oral Contraceptives will now be non-preferred and require prior authorization if it is currently being used in combination with Tracleer.
				MC/DEL	7	ERRIN		
				MC/DEL	7	JOLIVETTE		
				MC/DEL	7	NORA-BE TABS		
				MC/DEL	7	NOR-QD TABS		
				MC	8	ORTHO MICRONOR TABS	Use PA Form# 20420	
CONTRACEPTIVES - INJECTABLE	MC/DEL		MEDROXYPROGESTERONE ACETATE 150mg IM	MC/DEL		DEPO-PROVERA 150 mg SUSP	Use PA Form# 20420	The preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
CONTRACEPTIVE - EMERGENCY	MC/DEL	1	PLAN B ONE STEP[1]	MC/DEL		PLAN B	1. Allowed 2 tablets per 30 days without PA	
	MC/DEL	2	ELLA					
	MC	2	LEVONORGESTREL					
	MC/DEL	2	NEXT CHOICE[1]				Use PA Form# 20420	
CONTRACEPTIVES - PATCHES/ VAGINAL PRODUCTS	MC/DEL		NUVARING RING[3]				Use PA Form# 20420	Approved if adequate clinical reason given why patient unable to comply with other preferred agents including long acting injectable.
	MC		ORTHO EVRA PTWK[1,2,4]				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	MC/DEL		APRI TABS	MC/DEL		BEYAZ	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the
	MC/DEL		AVIANE TABS	MC/DEL		BREVICON-28 TABS	If member experienced	

	MC/DEL		BALZIVA	MC/DEL		LESSINA-28 TABS	adverse reactions, consider using Oral Contraceptives from other groups.	preferred drug(s) exists.
	MC/DEL		CRYSELLE-28 TABS	MC/DEL		LEVORA		
	MC/DEL		DESOGEN TABS	MC		LOESTRIN TABS		
			DESOGESTREL/ ETHINYL ESTRADIOL	MC/DEL		LOESTRIN FE TABS		If member experienced adverse reactions, consider using Oral Contraceptives from other groups.
	MC/DEL		LOW-OGESTREL TABS	MC/DEL		LOESTRIN FE 1/20 TABS		
	MC		MODICON TABS	MC/DEL		LOESTRIN 1.5/30-21 TABS		
	MC/DEL		MONONESSA	MC/DEL		LOESTRIN 1/20-21 TABS		
	MC/DEL		NECON 1/50	MC		LO/OVRAL 21 TABS		**DDI:** Preferred Oral Contraceptives will now be non-preferred and require prior authorization if it is currently being used in combination with Tracleer.
	MC		ORTHO-CEPT-28 TABS	MC/DEL		LO/OVRAL 28 TABS		
	MC		ORTHO-CYCLEN-28 TABS	MC/DEL		MICROGESTIN FE TABS		
	MC		ORTHO-NOVUM 1/35-28 TABS	MC/DEL		NORDETTE-28 TABS		
	MC/DEL		OVCON-50 28 TABS	MC/DEL		NORINYL		
	MC/DEL		PREVIFEM	MC/DEL		NORTREL		
	MC/DEL		RECLIPSEN	MC/DEL		OCELLA		
	MC/DEL		SOLIA	MC/DEL		OGESTREL TABS		
	MC/DEL		SPRINTEC 28 TABS	MC/DEL		OVCON-35/28 TABS		
	MC/DEL		YASMIN 28 TABS	MC/DEL		OVRAL		
	MC/DEL		YAZ	MC/DEL		PORTIA-28 TABS		
	MC/DEL		SEASONALE	MC/DEL		SAFYRAL		
	MC/DEL		ZENCHENT	MC/DEL		ZOVIA		
CONTRACEPTIVES - BI-PHASIC COMBINATIONS	MC		ORTHO-NOVUM 10/11-28 TABS	MC/DEL		NECON 10/11-28 TABS	If member experienced adverse reactions, consider using Oral Contraceptives from other groups.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		NORETHINDRONE-ETH ESTRADIOL TAB 0.5-35/1-35	MC/DEL		KARIVA TABS		
	MC/DEL		SEASONIQUE	MC/DEL		LOSEASONIQUE		If member experienced adverse reactions, consider using Oral Contraceptives from other groups.
				MC/DEL		MIRCETTE TABS		**DDI:** Preferred Oral Contraceptives will now be non-preferred and require prior authorization if it is currently being used in combination with Tracleer.
							Use PA Form# 20420	
CONTRACEPTIVES - TRI-PHASIC COMBINATIONS	MC/DEL		ENPRESSE	MC/DEL		CYCLESSA TABS	If member experienced adverse reactions, consider using Oral Contraceptives from other groups.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		NECON 7/7/7	MC/DEL		ESTROSTEP FE TABS		
	MC		ORTHO-NOVUM 7/7/7-28 TABS	MC/DEL		NORTREL 7/7/7		
	MC/DEL		TRI-NORINYL 28 TABS	MC		ORTHO TRI-CYCLEN TABS		
	MC/DEL		TRI-PREVIFEM	MC		ORTHO TRI-CYCLEN LO TABS		
	MC/DEL		TRIPHASIL 28 TABS					If member experienced adverse reactions, consider using Oral Contraceptives from other groups.
	MC/DEL		TRI-SPRINTEC					**DDI:** Preferred Oral Contraceptives will now be non-preferred and require prior authorization if it is currently being used in combination with Tracleer.
	MC		TRINESSA					
	MC/DEL		TRIVORA-28 TABS				Use PA Form# 20420	
CONTRACEPTIVES - MULTI-PHASIC COMBINATIONS				MC		NATAZIA	Use PA Form# 20420	
DIABETES THERAPIES								
DIABETIC - INSULIN	MC		HUMALOG INJ 100/ML	MC/DEL		APIDRA	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		HUMALOG MIX 75/25	MC		HUMALOG MIX 50/50		
	MC		HUMULIN N INJ U-100	MC		HUMULIN INJ 50/50		
	MC		HUMULIN INJ 70/30	MC		HUMULIN R INJ U-500		
	MC		HUMULIN R U-100	MC		RELION		
	MC/DEL		LANTUS SOLN					
	MC/DEL		LEVEMIR					
	MC/DEL		**NOVOLIN**					
	MC/DEL		**NOVOLOG**					
	MC/DEL		**NOVOLOG MIX**					
DIABETIC - PENFILLS	MC/DEL		LANTUS SOLOSTAR[1]	MC		APIDRA OPTICLIK PEN	1. Clinical PA will be required to establish significant visual or neurological impairment.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		LEVEMIR FLEXPEN[1]	MC		HUMALOG KWIK INJ 100/ML		
	MC/DEL		**NOVOLIN PENFILL**[1]	MC		HUMALOG MIX INJ 75/25 KWP		
	MC/DEL		**NOVOLIN 70/30**[1]	MC		HUMALOG MIX INJ 50/50 KWP		
	MC/DEL		NOVOLOG MIX PENFILL[1]					
	MC/DEL		**NOVOLOG PENFILL SOLN**[1]					
	MC/DEL		NOVOLOG MIX FLEXPEN[1]					
	MC/DEL		NOVOLOG FLEXPEN[1]				Use PA Form# 20420	

DIABETIC - DPP- 4 ENZYME INHIBITOR	MC/DEL MC/DEL		JANUVIA[1,2] **ONGLYZA[1,2]**	MC/DEL		TRADJENTA[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	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **DDI:** Onglyza 5mg will require a prior authorization if it is currently being used in combination with drugs known to be significant CYP3A4 inhibitors (ketoconazole, itraconazole, clarithromycin, indinavir, nefazodone, nelfinavir, ritonavir, atazanavir, saquinavir and telithromycin).
DIABETIC - DPP- 4 ENZYME INHIBITOR-COMBO	MC/DEL MC/DEL MC/DEL		JANUMET[1] **JANUMET XR[1]** **JENTADUETO**	MC/DEL MC MC/DEL		**KAZANO** KOMBIGLYZE XR **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. Use PA Form# 20420	
DPP- 4 ENZYME INHIBITOR/ HMG-COS REDUCTASE INHIBITOR	MC/DEL		JUVISYNC[1,2]				Use PA Form# 20420 1. Please refer to criteria section of PDL 2. Dosing limits apply please refer to Dose Consolidation List	**DDI:** Juvisync will require a prior authorization if used in concurrent use with drugs known to be significant CYP3A4 inhibitors (ketoconazole, itraconazole, clarithromycin, indinavir, nefazodone, nelfinavir, ritonavir, atazanavir, saquinavir and telithromycin). Juvisync will remain preferred until product is eventually discontinued later in 2014.
DIABETIC - LANCET-LANCET DEVICE	MC MC MC MC MC		ONE TOUCH LANCETS DELICA LANCETS UNILET LANCETS UNISTIK LANCING DEVICE AUTOLOT LANCING DEVICE				Use PA Form# 20420	
DIABETIC - SYRINGES-NEEDLES	MC/DEL MC MC MC		BD MICRO-FINE BD ULTRA-FINE BD ULTRA-FINE PEN NEEDLES UNIFINE PEN NEEDLES				Use PA Form# 20420	
DIABETIC - OTHER				MC/DEL MC/DEL MC		CYCLOSET **INVOKANA[1]** SYMLIN	Use PA Form# 30150 1.Dosing limits apply please refer to Dose Consolidation List	Please see the criteria listed in the Symlin PA form. **Invokana** will be considered for patients who are unable to tolerate any preferred medicaitons
DIABETIC MONITOR	MC MC MC MC MC MC MC		FREESTYLE INSULINX FREESTYLE LITE SYSTEM KIT FREESTYLE FREEDOM LITE KIT ONE TOUCH ULTRA 2 KIT ONE TOUCH ULTRA MINI KIT ONE TOUCH ULTRA SMART KIT PRECISION XTRA METER	MC MC MC MC MC MC		ACCUCHECK ASCENSIA ASSURE CONTOUR BREEZE Z EXACTECH PRODIGY	Use PA Form# 20420	Effective October 25th 2007, approvals for all non preferred meters/ test strips will require medical necessity documenting clinically significant features that are not available on any of the preferred meters.

DIABETIC TEST STRIPS	MC		FREESTYLE[1]	MC		ACCUCHECK	1. Only 50 ct & 100 ct package size. Use PA Form# 20420	Effective October 25th 2007, approvals for all non preferred meters/ test strips will require medical necessity documenting clinically significant features that are not available on any of the preferred meters.
	MC		FREESTYLE LITE[1]	MC		ASCENSIA		
	MC		FREESTYLE INSULINX[1]	MC		ASSURE		
	MC		ONE TOUCH DELICA[1]	MC		EXACTECH		
	MC		ONE TOUCH ULTRA[1]	MC		PRODIGY		
	MC		PRECISION XTRA[1]	MC		CONTOUR BREEZE Z		
INCRETIN MIMETIC				MC	8	BYDUREON[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	
				MC	8	BYETTA[1]		
				MC/DEL	8	**NESINA**		
				MC/DEL	9	VICTOZA[1]		
DIABETIC - ORAL SULFONYLUREAS	MC/DEL		**CHLORPROPAMIDE TABS**	MC/DEL		**AMARYL TABS**	Use PA Form# 20420 1. Pa required for members ≥65. Glyburide has a greater risk of severe prolonged hypoglycemia in older adults.	Preferred drugs must be tried for at least 3 months at full therapeutic doses and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **DDI:** All sulfonylureas (except glyburide) will now be non-preferred and require prior authorization if it is currently being used with either ranitidine or cimetidine. **DDI:** Glimepiride will now be non-preferred and require prior authorization if it is currently being used with either fluconazole (except 150mg strength) or fluvoxamine. Amaryl is non-preferred but with any prior authorization requests, the member's drug profile will also be monitored for concurrent use with either fluconazole or fluvoxamine.
	MC/DEL		GLIMEPIRIDE	MC/DEL		**DIABETA TABS**		
	MC/DEL		**GLIPIZIDE TABS**	MC		GLUCOTROL TABS		
	MC/DEL		**GLIPIZIDE ER TABS**	MC/DEL		**GLUCOTROL XL TBCR**		
	MC/DEL		**GLYBURIDE MICRONIZED TABS**	MC/DEL		**GLYNASE TABS**		
	MC/DEL		**GLYBURIDE TABS[1]**	MC/DEL		**MICRONASE TABS**		
	MC/DEL		**TOLAZAMIDE TABS**					
	MC/DEL		**TOLBUTAMIDE TABS**					
DIABETIC -ORAL BIGUANIDES	MC/DEL		**METFORMIN HCL TABS**	MC		GLUCOPHAGE TABS	Use PA Form# 20420	Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		METFORMIN ER	MC		GLUCOPHAGE XR TB24		
				MC		FORTAMET		
				MC/DEL		METFORMIN ER OSMOTIC		
DIABETIC - THIAZOL / BIGUANIDE COMBO				MC/DEL		ACTOPLUS MET[1]	Use PA Form# 20420 1. Requires use of Actos, Metformin, or other preferred anti-diabetics.	**DDI:** Actos, Avandia, or any combination product with Actos or Avandia will now be non-preferred and require prior authorization if it is currently being used with gemfibrozil.
				MC/DEL		ACTOPLUS MET XR		
				MC/DEL		AVANDARYL[1]		
				MC/DEL		**AVANDAMET TABS[1]**		
DIABETIC - / THIAZOL	MC/DEL		**PIOGLITAZONE HCL[1]**	MC/DEL		**ACTOS TABS[3]**	1. Pioglitazone HCL is non-preferred as monotherapy. Pioglitazone HCL 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. Current users of Avandia who have tried Actos will be able to continue use of Avandia. 3. Dosing limits apply please refer to Dose Consolidation List	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **DDI:** Actos, Avandia, or any combination product with Actos or Avandia will now be non-preferred and require prior authorization if it is currently being used with gemfibrozil.
				MC/DEL		**AVANDIA TABS[2]**		

							Use PA Form# 20420	
DIABETIC - ALPHAGLUCOSIDASE	**MC/DEL**		**GLYSET TABS**	**MC**		PRECOSE TABS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
DIABETIC - SULFONYLUREA / BIGUANIDE	**MC/DEL**		GLYBURIDE/METFORMIN	**MC** **MC** **MC/DEL**		GLUCOVANCE TABS[1] METAGLIP TABS[1] DUETACT[2]	1. Use individual ingredients. 2. Use Actos with generic glimepiride. Use PA Form# 20420	Approved for patients failing to achieve good diabetic control with maximal doses of individual components.
DIABETIC - MEGLITINIDES	**MC/DEL**		**STARLIX TABS**	**MC/DEL** **MC**		**PRANDIN TABS** NATEGLINIDE	Use PA Form# 20420	Preferred drugs from other diabetic sub-categories must be tried and failed due to lack of inadequate diabetic control or intolerable side effects before non-preferred drug will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **DDI**: Prandin is non-preferred but with any prior authorization requests, the member's drug profile will also be monitored for current use with both Sporanox and gemfibrozil, due to a significant drug-drug interaction.
GLUCOSE ELEVATING AGENTS								
GLUCOSE ELEVATING AGENTS	**MC/DEL**		GLUCAGEN INJ. HYPOKIT	**MC/DEL** **MC/DEL**		GLUCAGON DIAGNOSTIC KIT GLUCAGEN DIAGNOSTIC KIT	Use PA Form# 20420	
THYROID								
THYROID HORMONES	**MC/DEL** **MC/DEL** **MC/DEL** **MC/DEL** **MC/DEL** **MC/DEL** **MC/DEL** **MC/DEL**		**ARMOUR THYROID TABS** **CYTOMEL TABS** **LEVOTHROID TABS** **LEVOTHYROXINE SODIUM TABS** **LEVOXYL TABS** **THYROID TABS** **THYROLAR** **UNITHROID TABS**	**MC** **MC/DEL** **MC**		LEVOTHYROXINE SODIUM SOLR LIOTHYRONINE SYNTHROID TABS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANTITHYROID THERAPIES	**MC/DEL** **MC/DEL**		**METHIMAZOLE TABS** **PROPYLTHIOURACIL TABS**	**MC/DEL**		**TAPAZOLE TABS**	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
OSTEOPOROSIS / BONE AGENTS								
OSTEOPOROSIS	**MC/DEL** **MC/DEL**		ALENDRONATE **MIACALCIN SOLN[2]**	**MC/DEL** **MC** **MC** **MC/DEL** **MC/DEL** **MC/DEL** **MC/DEL** **MC** **MC** **MC/DEL** **MC/DEL** **MC** **MC** **MC/DEL**		**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.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **Binosto** use preferred generic alendronate tablets
CALCIMIMETIC AGENTS								
CALCIMIMETIC AGENTS				**MC**		SENSIPAR	Use PA Form# 30115	Baseline PTH, Ca, and phosphorous levels are required and initial approvals will be limited to 3 months. Subsequent approvals will require additional levels being done to assess changes. Will not approve if baseline Ca is less than 8.4.
GROWTH HORMONE								
GROWTH HORMONE	**MC/DEL** **MC/DEL**		GENOTROPIN[1] NORDITROPIN SOLN[1]	**MC** **MC** **MC/DEL** **MC/DEL** **MC** **MC**	8 8 8 8 8 8	HUMATROPE SOLR INCRELEX NUTROPIN AQ NUSPIN[2] NUTROPIN OMNITROPE SAIZEN SOLR	Use PA Form# 10710 1.Clinical PA is required to establish diagnosis and medical necessity. 2.Established users will be grandfathered.	See Growth Hormone PA form for criteria. Step-order will still apply unless clinical contraindication supplied.

				MC/DEL	8	TEV-TROPIN		
SOMATOSTATIC AGENTS				MC/DEL		OCTREOTIDE INJ	Use PA Form# 10710	
				MC/DEL		SANDOSTATIN		
				MC		SOMATULINE		
GROWTH HORMONE ANTAGONISTS								
GH ANTAGONISTS				MC		SOMAVERT	Use PA Form# 10710	Approved for acromegaly patients failing surgery/radiation/drug therapy including bromocriptine and sandostatin.
VASOPRESSIN RECEPTOR ANTAGONIST								
VASOPRESSIN RECEPTOR ANTAGONIST				MC/DEL		SAMSCA	Use PA Form# 20420	**Samsca Drug Warning**- Avoid use in patients with underlying liver disease, including cirrhosis, because the ability to recover from liver injury may be impaired. Limit duration of therapy to 30 days to minimize the risk of liver injury.
URINARY INCONTINENCE								
VASOPRESSINS			DESMOPRESSIN TABS	MC/DEL	5	DDAVP TABS	1. Products must be used in specified step order. Nocturnal enuresis patients will be encouraged to periodically attempt stopping DDAVP. 2. Patients with a diagnosis of hemophilia or Von Willebrands disease will be exempt from prior authorization. Use PA Form# 20420	Approved for central diabetes insipidus and for nocturnal enuresis. For nocturnal enuresis- must be over 6 years old, must fail an adequate trial of alarm training (higher success rate, lower relapse rate) and must periodically attempt weaning (at 6 month intervals).
				MC/DEL	6	DDAVP SOLN[1]		
				MC	6	DESMOPRESSIN SPRAY[1]		
				MC/DEL	8	DESMOPRESSIN ACETATE SOLN[1]		
				MC/DEL	8	STIMATE SOLN[1,2]		
ANTISPASMODICS	MC/DEL		**OXYBUTYNIN**	MC/DEL	8	**DETROL TABS**	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		URISPAS TABS	MC/DEL	8	**DITROPAN**		
				MC	8	**SANCTURA**		
				MC/DEL	9	TROSPIUM		
ANTISPASMODICS - LONG ACTING	MC/DEL		**OXYBUTYNIN ER TABS**	MC	8	DITROPAN XL TBCR	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.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. 1. Vesicare 5mg and Enablex 7.5mg maximum doses if given with drugs known to be significant CYP3A4 inhibitors.(Ketoconazole, Sporanox, Erythromycin, Fluconazole, Biaxin, Nefazodone, Nelfinavir, and Ritonavir) **DDI:** Enablex 15mg and Vesicare 10mg will now be non-preferred and require prior authorization if they are currently being used in combination with any of the following medications: clarithromycin, erythromycin, Ketek, Crixivan, Norvir, ketoconazole, fluconazole (except 150mg strength), Sporanox. nefazodone, or diltiazem.
	MC/DEL		TOVIAZ	MC/DEL	8	ENABLEX[1,3]		
	MC		VESICARE[1]	MC/DEL	8	**MYRBETRIQ**		
				MC/DEL	8	**OXYTROL**		
				MC/DEL	8	**TOLTERODINE TAB**		
				MC/DEL	9	DETROL LA CP[2]		
				MC	9	SANCTURA XR[2]		
CHOLINERGIC	MC/DEL		**URECHOLINE**				Use PA Form# 20420	
	MC/DEL		**BETHANECHOL**					
METABOLIC MODIFIER								

HERED. TYROSINEMIA				MC		ORFADIN	Use PA Form# 20420	Approved for Type 1 hereditary tyrosinemia patients. Must include laboratory evidence of dx at first PA.
ANTIHYPERTENSIVES / CARDIAC								
CARDIAC GLYCOSIDES	MC/DEL		**DIGITEK TABS**				Use PA Form# 20420	
	MC/DEL		**DIGOXIN**					
	MC/DEL		**LANOXIN**					
ANTIANGINALS--Isosorbide Di-nitrate/ Mono-Nitrates	MC/DEL		**ISOSORBIDE MONONITRATE TABS**	MC		DILATRATE SR CPCR	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**ISOSORBIDE MONONITRATE ER**	MC		ISORDIL TABS		
				MC/DEL		**ISORDIL TITRADOSE TABS**		
				MC		ISOSORBIDE DINITRATE SUBL		
				MC/DEL		**ISOSORBIDE DINITRATE TABS**		
				MC/DEL		ISOSORBIDE DINITRATE CR TBCR		
				MC/DEL		**ISOSORBIDE DINITRATE ER TBCR**		
				MC/DEL		ISOSORBIDE DINITRATE TD TBCR		
				MC/DEL		**IMDUR TB24**		
				MC/DEL		ISMO TABS		
				MC		MONOKET TABS		
NITRO - OINTMENT/CAP/CR	MC		NITROBID OINT				Use PA Form# 20420	
	MC/DEL		**NITROGLYCERIN CPCR**					
	MC		NITROL OINT					
	MC		NITRO-TIME CPCR					
NITRO - PATCHES	MC/DEL	1	**NITROGLYCERIN PT24**[1]	MC		NITRODISC PT24	1. At least 2 step 1's and step 3 of the preferred products must be used in specified order or PA will be required. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL	1	**NITREK PT24**[1]	MC/DEL		**NITRO-DUR PT24**		
	MC/DEL	1	**NITRO-DUR PT 24 0.8MG**[1]					
	MC/DEL	3	**MINITRAN PT24**[1]					
NITRO - SUBLINGUAL/ SPRAY	MC/DEL		**NITROSTAT SUBL**	MC/DEL		**NITROQUICK SUBL**	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**NITROTAB SUBL**	MC		NITROLINGUAL SOLN		
				MC		NITROLINGUAL TABS		
BETA BLOCKERS - NON SELECTIVE	MC		CARVEDILOL	MC/DEL		**BETAPACE TABS**	1. Recommend using BID since its effects do not last 24 hours. 2. Please use other strengths in combination to obtain this dose. 3. Dosing limits still apply. Please see dose consolidation list Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		LEVATOL TABS	MC		**BETAPACE AF TABS**		
	MC/DEL		**NADOLOL TABS**	MC/DEL		**COREG CR**[3]		
	MC/DEL		**PINDOLOL TABS**	MC/DEL		**COREG TABS**		
	MC/DEL		**PROPRANOLOL HCL SOLN**[1]	MC/DEL		**CORGARD TABS**		
	MC/DEL		**PROPRANOLOL HCL TABS**[1]	MC/DEL		**INDERAL TABS**		
	MC/DEL		**PROPRANOLOL LA CAPS**	MC/DEL		**INDERAL LA CPCR**		
	MC/DEL		SOTALOL AF	MC		INNOPRAN XL		
	MC/DEL		SOTALOL HCL TABS	MC/DEL		**PROPRANOLOL HCL 60MG TABS**[2]		
	MC/DEL		**TIMOLOL MALEATE TABS**	MC/DEL		SOTALOL AF		
				MC		RANEXA		
BETA BLOCKERS - CARDIO SELECTIVE	MC/DEL		**ACEBUTOLOL HCL CAPS**	MC/DEL		BYSTOLIC	1. Recommend using Atenolol (and metoprolol) BID since its effects do not last 24 hours. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**ATENOLOL TABS**[1]	MC		KERLONE TABS		
	MC		BETAXOLOL HCL TABS	MC/DEL		**LOPRESSOR TABS**		
	MC/DEL		**BISOPROLOL FUMARATE TABS**	MC		SECTRAL CAPS		
	MC/DEL		**METOPROLOL TARTRATE TABS**[1]	MC/DEL		**TENORMIN TABS**		
	MC/DEL		**METOPROLOL ER**	MC/DEL		**ZEBETA TABS**		
	MC/DEL		**TOPROL XL TB24**					
BETA BLOCKERS - ALPHA / BETA	MC/DEL		**LABETALOL HCL TABS**	MC		TRANDATE TABS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
BETA BLOCKERS & DURECTIC COMBOS				MC/DEL		**DUTOPROL**	Use PA Form# 20420	
CALCIUM CHANNEL BLOCKERS--Amlodipines, Bepridil, Diltiazems, Felodipines, Isradipines, Nifedipines, Nisoldipine, and Verapamils	MC/DEL		AMLODIPINE[1]	MC/DEL		**NORVASC TABS**[1]	1. Dosing limits apply, please see dose consolidation list.	

Use PA Form# 20420

	MC		DILTIA XT CP24	MC	5	DILACOR XR 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. Use PA Form# 20420	Preferred drugs must be tried and failed (in step-order) due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **DDI:** All preferred diltiazems will now be non-preferred and require prior authorization if they are currently being used in combination with either Enablex 15mg or Vesicare 10mg. All non-preferred diltiazems require prior authorization, but with any prior authorization request, the member's drug profile will also be monitored for current use with Enablex 15mg or Vesicare 10mg.
	MC/DEL		**DILTIAZEM HCL ER CP24**	MC	6	TAZTIA[1]		
	MC/DEL		**DILTIAZEM HCL XR CP24**	MC/DEL	8	**CARDIZEM TABS**[1]		
	MC/DEL		**DILTIAZEM CD 300MG CP24**	MC/DEL	8	**CARDIZEM CD CP24**[1]		
	MC/DEL		**DILTIAZEM CD 360MG CP24**	MC	8	CARDIZEM LA TB24[1]		
	MC		CARTIA XT CP24[1]	MC	8	CARDIZEM SR CP12[1]		
	MC/DEL		**DILTIAZEM CD CP24**[1]	MC/DEL	8	**DILTIAZEM HCL TABS**[1]		
	MC/DEL		**DILTIAZEM HCL ER CP24**[1]	MC/DEL	8	**DILTIAZEM HCL ER CP12**[1]		
	MC/DEL		**DILTIAZEM XR CP24**[1]	MC/DEL	8	**DILTIAZEM HCL ER CP12**[1]		
	MC/DEL		**TIAZAC CP24**[1]					
				MC/DEL		**PLENDIL TB24**	Use PA Form# 20420	Other Preferred calcium channel blockers must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
				MC/DEL		**FELODIPINE**		
				MC		DYNACIRC CAPS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
				MC		DYNACIRC CR TBCR[1]	1. Established users will be grandfathered	
				MC/DEL		**CARDENE SR CPCR**	Use PA Form# 20420	Other Preferred calcium channel blockers must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
				MC/DEL		**NICARDIPINE HCL CAPS**		
	MC/DEL		**AFEDITAB CR**	MC		ADALAT CC TBCR[1]	1. Established users of Adalat CC are grandfathered. Use PA Form# 20420	Preferred drug must be tried and failed in step order due to lack of efficacy or intolerable side effects before non-preferred drugs in step order will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**NIFEDIAC CC**	MC/DEL		**NIFEDIPINE CAPS**		
	MC/DEL		**NIFEDICAL XL TBCR**	MC		PROCARDIA CAPS		
	MC/DEL		**NIFEDIPINE TBCR**	MC/DEL		**PROCARDIA XL TBCR**		
	MC/DEL		**NIFEDIPINE ER TBCR**					
				MC		SULAR TB24	1. Established users of 10MG and 20MG strengths are grandfathered. Use PA Form# 20420	
				MC		SULAR CR[1]		
	MC/DEL	1	**VERAPAMIL HCL CR TBCR**	MC/DEL		**CALAN TABS**	Products must be used in specified order or PA will be required. Just write "Verapamil 24-hour" and the pharmacy will use a preferred long acting generic that does not require PA. Use PA Form# 20420	Preferred drugs must be tried and failed (in step-order) due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL	1	**VERAPAMIL HCL ER TBCR**	MC/DEL		**CALAN SR TBCR**		
	MC/DEL	1	**VERAPAMIL HCL SR TBCR**	MC/DEL		**COVERA-HS TBCR**		
				MC		ISOPTIN-SR		
				MC/DEL		VERAPAMIL HCL ER CP24		
				MC		VERAPAMIL HCL SR CP24		
				MC		VERAPAMIL HCL TABS		
				MC		VERELAN CP24		
				MC		VERELAN PM CP24		
ANTIARRHYTHMICS	MC/DEL		**AMIODARONE HCL**	MC/DEL		**CORDARONE**	1. Prescription must be written by Cardiologist. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **DDI:** Amiodarone will now be non-preferred and require prior authorization if it is currently being used in combination with either Lovastatin (doses greater than 40mg/day) or Lipitor (doses greater than 20mg/day) or Levofloxacin or Gemifloxacin, or Moxifloxacin, or Ofloxacin. **DDI:** Multaq will be preferred unless the following medications are seen in the member's drug profile within the last 35 days for brand name medications or 90 days for generic medications: Erythromycin, Amiodarone and other antiarrhythmics, TCA's, Phenothiazine, Ketoconazole, Itraconazole, Voriconazole, Cyclosporine, Telithromycin, Clarithromycin, Nefazodone, Ritonavir.
	MC/DEL		**FLECAINIDE**	MC/DEL		**DISOPYRAMIDE**		
	MC/DEL		**MEXILETINE HCL**	MC/DEL		MULTAQ		
	MC/DEL		**NORPACE**	MC/DEL		**PACERONE**		
	MC/DEL		**PROCAINAMIDE**	MC		QUINIDEX		
	MC/DEL		**PROPAFENONE**	MC/DEL		TAMBOCOR		
	MC		QUINAGLUTE	MC/DEL		TIKOSYN[1]		
	MC/DEL		**QUINIDINE GLUCONATE**	MC		RYTHMOL SR		
	MC/DEL		**QUINIDINE SULFATE**	MC		RYTHMOL		
ACE INHIBITORS	MC/DEL		**BENAZEPRIL HCL**	MC	5	MAVIK TABS	1. Non-preferred products must be used in specified order. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs (in step-order) will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Non-preferred products are subject to step-order requirements unless clinical circumstances warrant exception.
	MC/DEL		**CAPTOPRIL TABS**	MC/DEL	5	**ACCUPRIL TABS**		
	MC/DEL		**ENALAPRIL MALEATE TABS**	MC/DEL	8	**ACEON TABS**[1]		
	MC/DEL		**FOSINOPRIL SODIUM**	MC/DEL	8	**ALTACE CAPS**[1]		
	MC/DEL		**LISINOPRIL TABS**	MC/DEL	8	**LOTENSIN TABS**[1]		
	MC/DEL		**RAMIPRIL**	MC/DEL	8	**MOEXIPRIL HCL**[1]		
	MC/DEL		**QUINAPRIL HCL**	MC	8	**MONOPRIL HCT TABS**[1]		
				MC/DEL	8	**PRINIVIL TABS**[1]		
				MC/DEL	8	**UNIVASC**[1]		

				MC	8	VASOTEC TABS[1]		
				MC/DEL	8	**ZESTRIL TABS[1]**		
ANGIOTENSIN RECEPTOR BLOCKER	MC/DEL		**BENICAR TABS[1]**	MC/DEL	8	**ATACAND TABS**	Use PA Form# 20420	The initial criteria to use any ARB is that the member must have failed ACE inhibitors (such as due to coughing) in the past or must currently be actively treated for diabetes and Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**DIOVAN**	MC	8	AVAPRO	1. Preferred products only available without PA if	
	MC/DEL		**IRBESARTAN[1]**	MC/DEL	8	**COZAAR**		

	MC/DEL		LOSARTAN[1]	MC/DEL	8	EDARBI	patient on diabetic therapy or prior ACE therapy.	
	MC/DEL		**MICARDIS TABS[1]**	MC/DEL	8	IRBESARTAN		
				MC	8	TEVETEN TABS		
				MC/DEL	8	TRIBENZOR[2]	2. Use preferred active ingredients which are available without PA.	
DIRECT RENIN INHIBITOR				MC/DEL		AMTURNIDE	1. Must show failure of single and combination therapy from all preferred antihypertensive categories.	
				MC/DEL		TEKTURNA[1]		
				MC/DEL		TEKAMLO	Use PA Form# 20420	
ANTIHYPERTENSIVES - CENTRAL	MC/DEL		**CATAPRES-TTS**	MC/DEL		**CATAPRES TABS**	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**CLONIDINE HCL TABS**	MC/DEL		CLONIDINE TTS		
	MC/DEL		**GUANFACINE HCL TABS**	MC		GUANABENZ ACETATE TABS		
	MC/DEL		**HYDRALAZINE HCL TABS**	MC		ISMELIN TABS		
	MC		HYLOREL TABS	MC		MINIPRESS CAPS		
	MC/DEL		**METHYLDOPA TABS**	MC		**NEXICLON**		
	MC/DEL		**MINOXIDIL TABS**	MC/DEL		**TENEX TABS**		
	MC/DEL		**PRAZOSIN HCL CAPS**					
	MC/DEL		**RESERPINE TABS**					
ACE INHIBITORS AND CA CHANNEL BLOCKERS				MC/DEL	8	**AMLODIPINE/BENAZEPRIL**	Use individual preferred generic medications.	
				MC	8	TARKA TBCR		
				MC/DEL	9	**AMLODIPINE/BENAZEPRIL**		
				MC/DEL	9	**LOTREL CAPS**	Use PA Form# 20420	
ACE AND THIAZIDE COMBO'S	MC/DEL		**BENAZEPRIL HCL/HYDROCHLOR**	MC/DEL		**ACCURETIC TABS**	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**CAPTOPRIL/HYDROCHLOROTHIA**	MC		MONOPRIL HCT TABS		
	MC/DEL		**ENALAPRIL MALEATE/HCTZ TABS**	MC/DEL		**PRINZIDE TABS**		
	MC/DEL		**LISINOPRIL-HCTZ TABS**	MC/DEL		**UNIRETIC TABS**		
	MC/DEL		**LOTENSIN HCT TABS**	MC		VASERETIC TABS		
				MC/DEL		**ZESTORETIC TABS**		
BETA BLOCKERS AND DIURETIC COMBO'S	MC/DEL		**ATENOLOL/CHLORTHALIDONE**	MC		CORZIDE TABS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**BISOPROLOL FUMARATE/HCTZ**	MC/DEL		**LOPRESSOR HCT TABS**		
	MC/DEL		**PROPRANOLOL/HCTZ**	MC		TENORETIC		
				MC		TIMOLIDE 10/25 TABS		
				MC/DEL		**ZIAC TABS**		
ARB'S AND CA CHANNEL BLOCKERS	MC/DEL		**EXFORGE[1]**	MC/DEL		**AZOR**	1. Preferred products only available without PA if patient on diabetic therapy or prior ACE therapy.	
	MC/DEL		**EXFORGE HCT[1]**	MC/DEL		**TWYNSTA**		
							Use PA Form# 20420	
ARB'S AND DIURETICS	MC/DEL		BENICAR HCT[1]	MC/DEL	7	**IRBESARTAN HYDROCHLOROTHIAZIDE**	1. Preferred products only available without PA if patient on diabetic therapy or prior ACE therapy.	Same initial criteria as the ARB class and Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		LOSARTAN HCT[1]	MC/DEL	8	**ATACAND HCT TABS**		
	MC/DEL		MICARDIS HCT TABS[1]	MC	8	**AVALIDE TABS[1]**		
	MC/DEL		**VALSARTAN-HYDROCHLOROTHIAZIDE[1]**	MC/DEL	8	DIOVAN HCT TABS[1]		
				MC/DEL	8	HYZAAR TABS		
				MC	8	TEVETEN HCT TABS	Use PA Form# 20420	
ANGIOTENSIN MODULATORS-ARB COMBINATION				MC/DEL		**EDARBYCLOR**	Use PA Form# 20420	
ARB'S AND DIRECT RENIN INHIBITOR COMBINATION				MC/DEL		**VALTURNA**	Use PA Form# 20420	
DIURETICS	MC/DEL		**ACETAZOLAMIDE TABS**	MC/DEL		**ALDACTAZIDE TABS**	1. Multiples of Spironolactone 25 mg are cheaper than 50 mg strength. Inspra will be approved for severe breast tenderness and male gynecomastia.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**BUMETANIDE**	MC/DEL		**ALDACTONE TABS**		
	MC/DEL		**CHLOROTHIAZIDE TABS**	MC		AMILORIDE HCL		
	MC/DEL		**CHLORTHALIDONE TABS**	MC/DEL		**BUMEX TABS**		
	MC		EDECRIN TABS	MC/DEL		**DEMADEX TABS**		
	MC/DEL		EDECRIN TABS	MC/DEL		**DIAMOX**		

	MC/DEL		HYDROCHLOROTHIAZIDE	MC/DEL		DIURIL		
	MC/DEL		INDAPAMIDE TABS	MC/DEL		DYAZIDE CAPS		
	MC/DEL		METHAZOLAMIDE TABS	MC		ENDURON TABS		
	MC/DEL		METHYCLOTHIAZIDE TABS	MC		INSPRA		
	MC/DEL		SPIRONOLACTONE 25MG TABS	MC/DEL		LASIX TABS	Use PA Form# 20420	
	MC/DEL		SPIRONOLACTONE/HYDRO	MC/DEL		MAXZIDE		
	MC/DEL		TORSEMIDE TABS	MC		MICROZIDE CAPS		
	MC/DEL		TRIAMTERENE/HCTZ	MC/DEL		MIDAMOR TABS		
	MC		ZAROXOLYN TABS	MC		NAQUA TABS		
				MC/DEL		SPIRONOLACTONE 50MG[1]		
CCB / LIPID				MC/DEL		CADUET		
LIPID DRUGS								
CHOLESTEROL - BILE SEQUESTRANTS	MC/DEL		CHOLESTYRAMINE	MC/DEL		COLESTID	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		COLESTIPOL HCl	MC/DEL		PREVALITE		
				MC		QUESTRAN		
				MC/DEL		WELCHOL TABS		
CHOLESTEROL - FIBRIC ACID DERIVATIVES	MC		ANTARA	MC		LOPID	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **DDI:** Fenofibrate is non-preferred but with any prior authorization requests, the member's drug profile will also be monitored for concurrent use with Warfarin. **DDI:** Gemfibrozil will now be non-preferred and require prior authorization if it is currently being used with any of the following medications: Prandin, Actos, Avandia, any Avandia/Actos combination product, any HMG-COA Reductase Inhibitors (statins), or Warfarin.
	MC/DEL		GEMFIBROZIL TABS	MC		FIBRICOR		
	MC/DEL		NIASPAN	MC		LIPOFEN		
	MC		TRICOR	MC		LOFIBRA		
	MC		TRILIPIX	MC/DEL		FENOFIBRATE		
				MC		TRIGLIDE		
CHOLESTEROL - HGM COA + ABSORB INHIBITORS MORE POTENT DRUGS/COMBINATIONS	MC/DEL		ATORVASTATIN	MC/DEL		CRESTOR	1. Dosing limits apply, please see dosage consolidation list. 2. Current users grandfathered.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **DDI:** Lipitor (doses greater than 20mg/day) will now be non-preferred and require prior authorization if they are currently being used in combination cyclosporine. **DDI:** Lipitor (doses greater than 20mg/day) will now be non-preferred and require prior authorization if it is currently being used in combination with Amiodarone. **DDI:** All preferred statins will now be non-preferred and require prior authorization if it is currently being used in combination with Gemfibrozil.
	MC/DEL		SIMVASTATIN[1]	MC/DEL		LIPITOR		
	MC		VYTORIN	MC		LIPTRUZET		
				MC/DEL		ZOCOR		
				MC/DEL		SIMVASTATIN 80MG[1,2]		
							Use PA Form# 20420	
CHOLESTEROL - HGM COA + ABSORB INHIBITORS LESS POTENT DRUGS/COMBINATIONS	MC/DEL		LESCOL CAPS	MC/DEL	8	ALTOPREV TB24	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.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Zetia will be approved for patients unable to tolerate all other therapies or unable to achieve cholesterol goal with maximally tolerated dose of most potent statins. **DDI:** Lescol will now be non-preferred and require prior authorization if it is currently being used in combination with diclofenac. **DDI:** Lovastatin (doses greater than 40mg/day) will now be non-preferred and require prior authorization if it is currently being used in combination with Amiodarone. **DDI:** Lovastatin (doses greater than 20mg per day) will now be non-preferred and require prior authorization if it is currently being used in combination cyclosporine. **DDI:** All preferred statins will now be non-preferred and require prior authorization if it is currently being used in combination with Gemfibrozil.
	MC/DEL		LESCOL XL TB24	MC	8	LIVALO		
	MC/DEL		LOVASTATIN TABS[2]	MC/DEL	8	MEVACOR TABS		
	MC/DEL		PRAVASTATIN[2]	MC	8	PRAVACHOL TABS		
				MC/DEL	8	PRAVIGARD		
				MC	8	ZETIA TABS[1]		
							Use PA Form# 20420	
CHOLESTEROL - HGM COA + ABSORB INHIBITORS STATIN/ NIACIN COMBO	MC/DEL		SIMCOR	MC/DEL		ADVICOR TBCR	Use PA Form# 20420	
FAMILIAL HYPERCHOLESTEROLEMIA				MC		JUXTAPID	1. Clinical PA required for appropriate diagnosis	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists Juxtapid is contraindicated with strong CYP3A4 inhibitors. Juxtapid dosage should not exceed 30mg daily when it is used concomitantly with weak CYP3A4 inhibtors. Kynamro requires an appropriate lab testing prior to starting (ALT<AST), Alkaline phosphatase and total billrubin, monthly liver-related tests for the first year, then every three months.
				MC		KYNAMRO[1]		

							Use PA Form#10500	
PULMONARY ANTI-HYPERTENSIVES								
PULMONARY ANTI-HYPERTENSIVES	MC MC/DEL		VENTAVIS[2] EPOPROSTENOL INJ[5]	MC MC/DEL MC MC/DEL		ADCIRCA[1] FLOLAN[5] REMODULIN[4] REVATIO[3]	1. See Criteria Section. 2. See Criteria Section. 3. See Criteria Section. 4. There will be dosing limits of one 20ml multidose vial/ 30 days supply without pa. 5. PA is required to establish and conform who group 1 diagnosis of primary PAH (Primary Pulmonary Hypertension) and NYHA functional class 3 & 4. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significat potential drug interation between another drug and the preferred drug(s) exists. 1. Adcirca approvals will require WHO Group 1 diagnosis of primary PAH (Primary Pulmonary Hypertension) and NYHA functional class 2 or 3. 2. Ventavis approvals will require WHO Group 1 diagnosis of primary PAH (Primary Pulmonary Hypertension) and NYHA functional class 3 or 4. 3. Revatio approvals will require WHO Group 1 diagnosis of primary PAH (Primary Pulmonary Hypertension) and NYHA functional class 2 or 3.
ERA / ENDOTHELIN RECEPTOR ANTAGONIST	MC MC		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. 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	Tracleer approvals will require WHO Group 1 diagnosis of primary PAH (Primary Pulmonary Hypertension) and NYHA functional class 2 thru 4. **DDI:** Preferred Oral Contraceptives will now be non-preferred and require prior authorization if it is currently being used in combination with Tracleer. Letairis approvals will require WHO Group 1 diagnosis of primary PAH (Primary Pulmonary Hypertension) and functional class 2 or 3 symptoms.
IMPOTENCE AGENTS								
IMPOTENCE AGENTS							As of January 1, 2006, per CMS (federal govt.), impotence agents are no longer covered.	As of January 1, 2006, per CMS (federal govt.), impotence agents are no longer covered.
ANTI-EMETOGENICS								
ANTIEMETIC - ANTICHOLINERGIC / DOPAMINERGIC	MC/DEL MC/DEL MC/DEL MC		MECLIZINE HCL TABS PROMETHAZINE SUPP PROMETHAZINE TRANSDERM-SCOP PT72	MC MC/DEL MC/DEL MC/DEL MC		ANTIVERT TABS PHENERGAN SOLN PROMETHAZINE 50MG SUPP PROMETHEGAN SUPP TORECAN TABS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANTIEMETIC - 5-HT3 RECEPTOR ANTAGONISTS/ SUBSTANCE P NEUROKININ	MC/DEL MC MC MC		MARINOL CAPS ONDANSETRON TABS[2,4] ONDANSETRON ODT TBDP[2,4] ONDANSETRON INJ[2,4]	MC/DEL MC MC MC MC MC/DEL MC MC/DEL	5 8 8 8 8 8 8 8	GRANISETRON ALOXI ANZEMET TABS CESAMET[1] EMEND[3] KYTRIL SANCUSO ZOFRAN ODT TBDP[4]	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.	Preferred drugs and step therapy must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. * Ondansetron limits still apply as listed on the Ondansetron PA form for covered indications including chemotherapy, radiotherapy, post operative nausea & vomiting and hyperemesis gravidarum. Other medical indications will be approved or denied on a case by case basis. Hyperemesis and other medical indications approved are still subject to failure of multiple preferred antiemesis drugs.

				MC/DEL	8	ZOFRAN TABS[4]	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	
				MC/DEL	8	ZOFRAN INJ[4]		
				MC	8	ZUPLENZ		
NON-SEDATING ANTIHISTAMINES / DECONGESTANTS								
ANTIHISTIMINES - NON-SEDATING	MC		ALAVERT TABS	MC/DEL	5	CLARINEX TABS[1,5]	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. 5. Pa's for Clarinex RediTabs will only be approved if between the ages of 6-11 years old. Use PA Form# 20530	Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. No combination product with decongestant will be approved since pseudoephedrine available without PA. Pseudoephedrine is available with prescription.
	MC/DEL		CETIRIZINE TABS	MC/DEL	5	CLARINEX SYR[1,2]		
	MC		CLARITIN (OTC)	MC/DEL	5	FEXOFENADINE[1]		
	MC		CLARITIN SYRP (OTC)	MC/DEL	5	ZYRTEC[1]		
	MC/DEL		LORATADINE	MC/DEL	5	ZYRTEC SYR[1,2]		
	MC/DEL		TAVIST ND (OTC)	MC/DEL	8	ALLEGRA[3]		
				MC/DEL	8	CLARITIN[3]		
				MC/DEL	8	DESLORATADIN		
				MC/DEL	8	LORATADINE ODT[4]		
				MC/DEL	8	LEVOCETIRIZINE[4]		
				MC/DEL	9	XYZAL[3]		
ANTIHISTIMINES - OTHER	MC/DEL		CLEMASTINE				Use PA Form# 20530	
	MC/DEL		CHLORPHENIRAMINE					
	MC/DEL		DIPHENHYDRAMINE					
ALLERGY / ASTHMA THERAPIES								
ANAPHYLACTIC DEVICES	MC/DEL		**EPIPEN**	MC/DEL		**AUVI- Q**		
				MC		TWINJECT		
ANTIASTHMATIC - ANTICHOLINERGICS - INHALER	MC/DEL		SPIRIVA[1,2]	MC/DEL		**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				MC/DEL		DALIRESP	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANTIASTHMATIC - ANTICHOLINERGICS - NEBULIZER	MC/DEL		**IPRATROPIUM BROMIDE SOLN**	MC		ATROVENT SOLN	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANTIASTHMATIC - ANTIINFLAMMATORY AGENTS	MC/DEL		CROMOLYN SODIUM NEBU	MC/DEL		XOLAIR[1]	1. Need max inhaled steroids and written by pulmonary or allergy specialist Use PA Form# 20420	Xolair approval will require suboptimal response to maximal doses of inhaled steroid as evidenced by asthmatic ER/Hospital admissions and Allergy/Pulmonary specialist management.
ANTIASTHMATIC - NASAL STEROIDS	MC MC/DEL MC		FLUTICASONE SPR[3] NASONEX SUSP[3] QNASL	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC MC MC/DEL MC/DEL MC/DEL	5 5 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[1,3] OMNARIS SPR[3] RHINOCORT AERO[2,3] RHINOCORT AQUA SUSP[2,3] TRI-NASAL SOLN[2,3] VANCENASE POCKETHALER AERS[2,3] VERAMYST[2,3] 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.	Preferred drugs and step therapy must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANTIASTHMATIC - NASAL MISC.	MC/DEL MC/DEL MC/DEL		CROMOLYN NASAL 4% OCEAN 0.65% SALINE NASAL SPRAY 0.65%	MC MC/DEL MC MC/DEL MC/DEL	7 7 7 8 8	ATROVENT NASAL SOL ASTELIN IPRATROPIUM NASAL SOL[1] 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.	Approved if patient fails on nonsedating antihistamines and steroid nasal sprays. Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANTIASTHMATIC - BETA - ADRENERGICS	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		**ALBUTEROL NEB** **MAXAIR** **METAPROTERENOL** **PROVENTIL HFA** **SEREVENT** **TERBUTALINE SULFATE TABS**	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL MC MC MC/DEL MC/DEL		**ACCUNEB NEBU** **ALBUTEROL AER** **ALBUTEROL HFA** **ALBUTEROL 0.63mg/3ml** **ARCAPTA[3]** **BRETHINE** **FORADIL AEROLIZER CAPS** **PROAIR HFA[3]** **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	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANTIASTHMATIC - ADRENERGIC COMBINATIONS	MC/DEL MC/DEL MC/DEL		**ADVAIR DISKUS/HFA[1,2]** DULERA SYMBICORT[2]	MC/DEL		**BREO ELLIPTA[2,3]**	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. 3. Clinical PA required for appropriate diagnosis Use PA Form# 20420	
ANTIASTHMATIC - ADRENERGIC ANTICHOLINERGIC	MC/DEL MC/DEL		**ALBUTEROL/IPRATROPIUM NEB. SOLN** **COMBIVENT AERO**[2]	MC/DEL MC/DEL		**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	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Duoneb components are available separately without PA.
ANTIASTHMATIC - XANTHINES	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		**AMINOPHYLLINE TABS** THEOCHRON TB12 THEOLAIR-SR TB12 **THEOPHYLLINE CR TB12** THEOPHYLLINE ELIX THEOPHYLLINE SOLN **THEOPHYLLINE ER CP12** **THEOPHYLLINE ER TB12**	MC/DEL MC MC/DEL		**THEO-24 CP24** THEOLAIR TABS **UNIPHYL TBCR**	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANTIASTHMATIC - STEROID INHALANTS	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC		ASMANEX[4,5] **FLOVENT DISKUS**[4] **FLOVENT HFA**[4] **PULMICORT FLEXHALER** **PULMICORT SUSP**[1,4] QVAR AERS[4]	MC/DEL MC MC MC/DEL MC/DEL MC	5 5 5 8 8 8	**AEROBID AERS**[2,4] BECLOVENT AERS[2,4] VANCERIL AERS[2,4] **AEROBID-M AERS**[3,4] ALVESCO[4] VANCERIL DOUBLE STRENGTH AERS[3,4]	1. No PA for Pulmicort susp if under 8 years old. 2. All preferreds must be tried before moving to non preferred steps. 3. All step 5 medications need to be tried before moving to step 8's. 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	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANTIASTHMATIC - 5-Lipoxygenase Inhibitors				MC		**ZYFLO CR TABS**	Use PA Form# 20420	Other Preferred asthma controller drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANTIASTHMATIC - LEUKOTRIENE RECEPTOR ANTAGONISTS	MC/DEL MC/DEL		**MONTELUKAST SODIUM TAB** **MONTELUKAST SODIUM CHEW TAB**	MC/DEL MC/DEL		**ACCOLATE TABS** **SINGULAIR**[1]	Use PA Form# 20420 1.Singulair Granules will only be approved if between ages of 6months-5years old. Singulair Chewables 4mg from 2years-5years and Singulair Chewables 5mgs from 6years-14years old.	

ANTIASTHMATIC - ALPHA-PROTEINASE INHIBITOR				MC	8	ARALAST	Use PA Form# 20420	Prolastin and Azemaira will be approved for members with A1AT deficiency and clinically demonstrable panacinar emphysema.
				MC	8	ZEMAIRA		
				MC	9	GLASSIA		
				MC	9	PROLASTIN SUSR		
ANTIASTHMATIC - HYDRO-LYTIC ENZYMES				MC/DEL		PULMOZYME SOLN	Use PA Form# 20420	Will be approved for cystic fibrosis patients.
ANTIASTHMATIC - MUCOLYTICS	MC/DEL		ACETYLCYSTEINE[1]	MC		MUCOMYST	1. Acetylcysteine is covered with diagnosis of CF. Use PA Form# 20420	
ANTIASTHMATIC-CFTR POTENTIATOR	MC					KALYDECO	Use PA Form# 20420	Kalydeco wil be considered for patients 6 years of age or older; and has a diagnosis of cystic fibrosis with a G551D mutation in the CFTR gene as detected by an FDA-cleared CF mutation test; and prescriber is a CF specialist or pulminologist; and patient does not have one of the following infections: Burkholderia cenocepacia, dolosa or mycobacterium abcessus
COUGH/COLD								
COUGH/COLD	MC/DEL		DEXTRO-GUAIF SYRP[1]				1. All of cough cold preparations are not covered except these preferred products. Use PA Form# 20420	All non-preferred products are not covered as permitted by Federal Medicaid regulations and MaineCare Policy.
	MC/DEL		GUAIFENESIN SYRP[1]					
	MC/DEL		PSEUDOEPHEDRINE[1]					
	MC		ROBITUSSIN DM SYRP[1]					
	MC		ROBITUSSIN SUGAR FREE SYRP[1]					
DIGESTIVE AIDS / ASSORTED GI								
GI - ANTIPERISTALTIC AGENTS	MC/DEL		DIPHENOXYLATE	MC/DEL		LOFENE TABS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. As listed in MaineCare Policy, certain drugs require specific diagnoses for approval.
	MC/DEL		DIPHENOXYLATE/ATROPINE	MC		LONOX TABS		
	MC/DEL		LOPERAMIDE HCL CAPS/LIQ	MC/DEL		MOTOFEN TABS		
	MC/DEL		OPIUM TINCTURE TINC					
	MC		PAREGORIC TINC					
GI - ANTI-DIARRHEAL/ ANTACID - MISC.	MC/DEL		ATROPINE SULFATE SOLN	MC		BELLADONNA ALKALOIDS & OP	Use PA Form# 20420 1.Dosing limits apply please refer to Dose Consolidation List	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **As listed in MaineCare Policy, certain drugs require specific diagnoses for approval**.
	MC/DEL		BENTYL SYRP	MC/DEL		BENTYL TABS		
	MC/DEL		BISMATROL	MC		CUVPOSA		
	MC/DEL		BISMUTH SUBSALICYLATE	MC		FULYZAQ[1]		
	MC/DEL		CALCIUM CARBONATE (ANTACID) CHEW	MC/DEL		GLYCOPYRROLATE INJ		
	MC/DEL		DICYCLOMINE HCL	MC/DEL		HYOSCYAMINE SL		
	MC/DEL		GLYCOPYRROLATE TABS	MC/DEL		LEVBID TB12		
	MC		HAPONAL TABS	MC		LEVSIN ELIX		
	MC/DEL		HYOSCYAMINE CAPS & TABS	MC/DEL		LEVSIN TABS		
	MC/DEL		HYOSCYAMINE SULFATE	MC/DEL		LEVSIN/SL SUBL		Preferred products that used to require diag codes still require diag codes unless indicated otherwise.
	MC/DEL		KAOPECTATE	MC/DEL		NULEV TBDP		
	MC/DEL		MAGNESIUM OXIDE TABS	MC		ROBINUL INJ		**Fulyzaq** requires a diagnosis of non-infectious diarrhea in patients with HIV/AIDS on anti-retroviral therapy, prior trials of preferred, more cost effective anti-diarrheals.
	MC		MAG-OX 400 TABS	MC		ROBINUL TABS		
	MC/DEL		PAMINE TABS					
	MC/DEL		PROPANTHELINE BROMIDE TABS					
	MC/DEL		SAL-TROPINE TABS					
	MC/DEL		SODIUM BICARBONATE TABS					
	MC/DEL		TUMS					
GI - H2-ANTAGONISTS	MC/DEL		CIMETIDINE	MC		AXID CAPS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		FAMOTIDINE	MC		AXID AR TABS		
	MC/DEL		RANITIDINE	MC/DEL		NIZATIDINE CAPS		
	MC/DEL		RANITIDINE SYRP	MC/DEL		PEPCID		
	MC		ACID REDUCER TABS	MC		PEPCID AC		**DDI:** Ranitidine and cimetidine will now be non-preferred and require prior authorization if it is currently being used with any sulfonylurea (except for glyburide).
				MC/DEL		ZANTAC SYRP		
				MC/DEL		ZANTAC TABS		**DDI:** Cimetidine will require prior authorization if being used in combination with Plavix.
GI - PROTON PUMP INHIBITOR	MC/DEL		DEXILANT (KAPIDEX)[2]	MC/DEL	6	NEXIUM CPDR[4]	1. Prevacid Solutabs available without PA for children less than 9 years old.	All preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs (in step-order) will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		OMEPRAZOLE 20MG[2]	MC	7	PRILOSEC OTC[4]		
	MC/DEL		PANTOPRAZOLE	MC	7	ACIPHEX TBEC[4]		

				MC/DEL	8	PREVACID CPDR[4,5]		Patients obtaining refills as of 7/10/09 will begin to require prior authorizations if they have been on any PPI longer than 60 days in the past year. The 12-month period is patient specific and begins 12 months before the requested date of prior authorization. Payment for usage beyond these limits will be authorized for cases in which there is a diagnosis of:
				MC/DEL	8	PREVACID SOLUTABS[1]	2. Dosing limits apply, please see dosage consolidation list.	1. Barrett's esophagus.
				MC/DEL	8	PRILOSEC CPDR		2. Erosive esophagitis
				MC/DEL	8	PROTONIX INJ	3. Please use multiple 20mg Capsules to obtain required dose.	3. Hypersecretory conditions (Zollinger-Ellison syndrome, systemic mastocytosis, multiple endocrine adenomas). Recurrent peptic ulcer disease after documentation of previous trials and therapy failure with at least one histamine H2-receptor antagonist at full therapeutic doses and with documentation of either failure of Helicobacter pylori treatment or anegative Helicobacter pylori test result.
				MC/DEL				
					8	PROTONIX[2]		
				MC/DEL	8	OMEPRAZOLE 10MG[2]		
				MC	8	OMEPRAZOLE-SODIUM BICARBONATE CAPS		4. Symptomatic gastroesophageal reflux after documentation of previous trials and therapy failure with at least onehistamine H2-receptor antagonist at full therapeutic doses. Patients may be required to step down from a PPI to a histamine H2-receptor antagonist during the 12 months or on an annual clinical review if PPI therapy is continued.
				MC/DEL	8	LANSOPRAZOLE	4. All preferreds and step therapy must be tried and failed.	**DDI:** Omeprazole will require prior authorization if being used in combination with Plavix.
				MC	9	OMEPRAZOLE 40MG[3]		**DDI:** Prevacid, Omeprazole and pantoprazole will now be non-preferred and require prior authorization if they are currently being used in combination with any of the following medications: Ampicillin, B-12, Fe salts, Griseofulvin, Sporanox, Ketoconazole, Reyataz, or Vantin.
							5. Established users prior to 10/1/09 may continue to obtain Prevacid until 12/31/09.	**DDI:** All non-preferred PPIs require prior authorization, but with any prior authorization request, the member's drug profile will also be monitored for current use with ampicillin, B-12, Fe salts, griseofulvin, itraconazole, ketoconazole, Reyataz or Vantin due to a significant drug-drug interaction.
							Use PA Form# 20720	
GI - ULCER ANTI-INFECTIVE				MC		HELIDAC	Use PA Form# 20420	
				MC		PREVPAC		
				MC		PYLERA		
GI - PROSTAGLANDINS	MC		MISOPROSTOL TABS	MC/DEL		CYTOTEC TABS	Use PA Form# 20420	Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drug will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
GI - DIGESTIVE ENZYMES	MC/DEL		CREON[1]	MC/DEL		LACTRASE CAPS	Use PA Form# 20420	Non -Preferred drugs must be tried and failed in step-order due to lack of efficacy or intolerable side effects before other non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		LACTASE CHEW	MC		PANCREAZE	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.	
	MC/DEL		LACTASE TAB	MC/DEL		PERTZYE		
	MC		ZENPEP[1]	MC/DEL		ULTRESA		
				MC/DEL		VIOKACE		
GI - ANTI - FLATULENTS / GI STIMULANTS	MC		CALULOSE SYRP	MC/DEL		AMITIZA[2]	1. Diag codes no longer necessary for preferred products. Lactulose has 60cc/day QL	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **As listed in MaineCare Policy, certain drugs require specific diagnoses for approval.**
	MC/DEL		CONSTULOSE SYRP	MC		CEPHULAC SYRP		
	MC/DEL		ENULOSE SYRP[1]	MC/DEL		INFANTS GAS RELIEF SUSP	Use PA Form# 20420	
	MC		GASTROCROM CONC	MC/DEL		REGLAN TABS	2. Prior failed trials of multiple other preferred GI agents must occur first, Such as OTC senna, docusate, lactulose, polyethylene glycol.	
	MC/DEL		GENERLAC SYRP[1]					
	MC/DEL		LACTULOSE SYRP[1]					
	MC/DEL		METOCLOPRAMIDE HCL					
	MC/DEL		SIMETHICONE					
GI - INFLAMMATORY BOWEL AGENTS	MC		APRISO	MC/DEL		AZULFIDINE EN-TABS TBEC	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		AZULFIDINE TABS	MC		GIAZO		
	MC/DEL		BALSALAZIDE	MC/DEL		LIALDA TABS[1]	1. Current users grandfathered.	
	MC		CANASA SUPP	MC/DEL		PENTASA 500MG[2]		
	MC		COLAZAL CAPS	MC		SFROWASA		
	MC/DEL		DELZICOL				2. Use multiple Pentasa 250mg.	
	MC		DIPENTUM CAPS					Giazo is only indicated for males, as the safety.efficacy for use in females has not been established.Prior trials of preferred products.
	MC		PENTASA CPCR 250MG					

	MC/DEL		ROWASA ENEM					
	MC/DEL		**SULFAZINE EC TBEC**					
	MC/DEL		**SULFASALAZINE TABS**					
GI - IRRITABLE BOWEL SYNDROME AGENTS				MC/DEL		LOTRONEX TABS	Use PA Form# 20420	Lotronex will be approved for females with IBS and predominant diarrhea. Prior failed trials of multiple preferred GI agents must occur first. IBS dx must be thoroughly documented.
GI- SHORT BOWL SYNDROME				MC		GATTEX		Gattex requires a diagnosis of adult SBS who are dependent on parenteral support. Appropriate colonoscopy and lab assessments 6months prior to starting
MISCELLANEOUS GI								
GI - MISC.	MC/DEL		BISAC-EVAC SUPP	MC/DEL		ACTIGALL CAPS	1. Must show evidence of trials of preferred agents that do not require PA, such as OTC senna, docusate, mineral oil and prescription lactulose. 2. Quantity Limit: 255 g/90-day without PA for greater than 18 years old. If under 18 years of age, allowed 17gms daily without PA. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **As listed in MaineCare Policy, certain drugs require specific diagnoses for approval.** Preferred products that used to require diag codes still require diag codes unless indicated otherwise. **Linzess** is non-preferred and is for adults as treatment of IBS-Constipation AND treatment of chronic idiopathic constipation in adults. Prior trials of preferred agents for constipation and IBS-constipation.
	MC/DEL		BISACODYL	MC		BENEFIBER		
	MC		BISCOLAX SUPP	MC/DEL		CARAFATE		
	MC		CINOBAC CAPS	MC/DEL		CLEARLAX POW		
	MC/DEL		CITRATE OF MAGNESIA SOLN	MC/DEL		COLACE CAPS		
	MC/DEL		CITRUCEL	MC/DEL		COLYTE		
	MC/DEL		DIOCTO SYRP	MC		DIOCTO-C SYRP		
	MC		DOCUSATE CALCIUM CAPS	MC		DOC SOD /CAS CAP		
	MC/DEL		DOCUSATE SODIUM	MC		DOC-Q-LAX CAPS		
	MC/DEL		FIBER LAXATIVE TABS	MC/DEL		DOCUSATE SODIUM/CAS CAPS		
	MC		FLEET	MC/DEL		DOK PLUS		
	MC/DEL		GENFIBER POWD	MC/DEL		DULCOLAX SUPP		
	MC/DEL		GLYCERIN	MC		FIBER CON TABS		
	MC		HIPREX TABS	MC/DEL		FIBER-LAX TABS		
	MC/DEL		KRISTALOSE PACK	MC		GOLYTELY SOLR		
	MC		MAALOX	MC/DEL		LINZESS		
	MC		METAMUCIL	MC		MALTSUPEX		
	MC/DEL		MILK OF MAGNESIA SUSP	MC		MIRALAX PACK (OTC versions)		
	MC		MINERAL OIL OIL	MC		MIRALAX POWD (OTC versions)		
	MC		NULYTELY SOLR	MC		PEG 3350 POWDER[2]		
	MC/DEL		SENNA	MC		PEG-ELECTROLYTES SOLR		
	MC/DEL		SENOKOT GRAN	MC/DEL		SENEXON TABS		
	MC/DEL		SENOKOT SYRP	MC/DEL		SENOKOT TABS		
	MC/DEL		SENOKOT CHILDRENS SYRP	MC		SENOKOT S TABS		
	MC		SENOKOT XTRA TABS	MC		STOOL SOFTENER PLUS CAPS		
	MC/DEL		SORBITOL	MC/DEL		UNI-CENNA TABS		
	MC/DEL		STOOL SOFTENER CAPS	MC		UNI-EASE PLUS CAPS		
	MC/DEL		SUCRALFATE TABS	MC		V-R NATURAL SENNA LAXATIV TABS		
	MC		UNI-EASE CAPS	MC		URSO 250		
	MC		UNIFIBER POWD					
	MC		URSO FORTE					
	MC/DEL		URSODIOL					
MISC. UROLOGICAL								
UROLOGICAL - MISC.	MC		ACETIC ACID 0.25% SOLN	MC		CITRIC ACID/SODIUM CITRAT SOLN	1. Elmiron requires adequate proof of Dx with supportive testing. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		CYTRA-K SOLN	MC/DEL		CYTRA-2 SOLN		
	MC		FURADANTIN SUSP	MC/DEL		ELMIRON CAPS[1]		
	MC		K-PHOS MF TABS	MC/DEL		MACROBID CAPS		
	MC/DEL		METHENAMINE MANDELATE TABS	MC/DEL		MACRODANTIN CAPS		
	MC/DEL		MONUROL PACK	MC/DEL		NITROFURANTOIN MACR SUSP		
	MC/DEL		NEOSPORIN GU IRRIGANT SOLN	MC		POTASSIUM CITRATE/CITRIC SOLN		
	MC/DEL		NITROFURANTOIN MONO CAPS	MC/DEL		PYRIDIUM PLUS TABS		
	MC/DEL		PHENAZOPYRIDINE HCL TABS	MC		PYRIDIUM TABS		
	MC/DEL		PHENAZOPYRIDINE PLUS	MC/DEL		RENACIDIN SOLN		
	MC/DEL		PROSED/DS TABS					
	MC		TRICITRATES SYRP					
	MC/DEL		URELIEF PLUS					
	MC		UREX TABS					

	MC/DEL		URISED TABS					
	MC		UROCIT-K					
	MC/DEL		UROQID #2 TABS					
PHOSPHATE BINDERS								
PHOSPHATE BINDERS	MC/DEL		ELIPHOS[1]	MC/DEL		CALCIUM ACETATE	Use PA Form# 20420 1. Diag required.	
	MC/DEL		MAGNEBIND - 400[1]	MC/DEL		FOSRENOL[1]		
	MC		PHOSLYRA[1]	MC/DEL		RENVELA[1]		
	MC/DEL		RENAGEL[1]					
INTRA-VAGINALS								
VAGINAL - ANTIBACTERIALS	MC/DEL		CLEOCIN CREA	MC/DEL		VANDAZOLE	1. Step order must be followed to avoid PA. Must fail Cleocin Cream and Metronidazole products before moving to next step product without PA. 2. Dosing limits apply, please see Dosage Consolidation List. Use PA Form# 20420	Preferred drugs must be tried and failed in step-order due to lack of efficacy or intolerable side effects before less preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		METROGEL VAGINAL GEL[2]					
	MC/DEL		METRONIDAZOLE VAGINAL GEL[2]					
	MC/DEL		CLEOCIN SUPP[1]					
VAGINAL - ANTI FUNGALS	MC		CLINDESSE CREA	MC		AVC CREA	1. Quantity limit: 1/script/2 weeks Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **DDI:** Miconazole will require prior authorization if being used in combination with Warfarin.
	MC/DEL		CLOTRIMAZOLE CREA	MC		CLOTRIMAZOLE 3 DAY CREA		
	MC/DEL		GYNE-LOTRIMIN CREA	MC		GYNAZOLE-1 CREA		
	MC		MICONAZOLE CREA	MC		GYNE-LOTRIMIN 3 TABS		
	MC/DEL		MICONAZOLE 3 COMBO PACK KIT[1]	MC/DEL		MICONAZOLE 3 SUPP		
	MC/DEL		MICONAZOLE 7 CREA	MC		TERAZOL 3 CREA		
	MC/DEL		MICONAZOLE NITRATE CREA	MC		TERAZOL 7 CREA		
	MC		NYSTATIN TABS	MC/DEL		TERCONAZOLE 0.8MG		
	MC		TERAZOL 3 SUPP	MC/DEL		TERCONAZOLE SUPP		
	MC/DEL		TERCONAZOLE 0.4MG					
	MC		VAGITROL					
	MC		V-R MICONAZOLE-7 CREA					
VAGINAL - CONTRACEPTIVES							Use PA Form# 20420	Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drug will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
VAGINAL - ESTROGENS	MC/DEL		**ESTRING RING**	MC/DEL		ESTRACE CREA[1]	1. Must fail all preferred products before non-preferred. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**PREMARIN CREA**	MC/DEL		VAGIFEM TABS[1]		
VAGINAL - OTHER	MC/DEL		ACID JELLY GEL	MC		AMINO ACID CERVICAL CREA	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		ACI-JEL GEL					
	MC		CERVICAL AMINO ACID CREA					
BPH								
BPH	MC/DEL		**DOXAZOSIN MESYLATE TABS**	MC/DEL	5	**FLOMAX CP24**	1. There will be dosing limits of 1 tab per day with out PA. 2. Prior use of preferred agent prior to any approvals. 3. Use of preferred (tamsulosin and finasteride) and (tamsulosin and non-preferred Avodart).	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs (in step-order) will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Approval of a non-preferred 5-alpha reductase inhibitor requires objective clinical evidence of a very enlarged prostate rather than just the presence of obstructive urinary outflow symptoms along with adequate trial of preferred Proscar.
	MC/DEL		FINASTERIDE[1]	MC/DEL	8	ALFUZOSIN		
	MC/DEL		TERAZOSIN HCL CAPS	MC/DEL	8	AVODART[2,4]		
	MC/DEL		**TAMSULOSIN HCL**	MC/DEL	8	**CARDURA TABS[4]**		
				MC/DEL	8	JALYN[3,4]		
				MC/DEL	8	PROSCAR TABS[4]		
				MC/DEL	8	RAPAFLO[4]		
				MC/DEL	8	UROXATRAL[4]		

							4. Non-preferred products must be used in specified order. Use PA Form# 20420	
ANXIOLYTICS								
ANXIOLYTICS - BENZODIAZEPINES	MC/DEL		ALPRAZOLAM TABS	MC/DEL	8	ATIVAN	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		CHLORDIAZEPOXIDE HCL CAPS	MC/DEL	8	NIRAVAM		
	MC/DEL		CLORAZEPATE DIPOTASSIUM TABS	MC/DEL	8	SERAX		
	MC/DEL		DIAZEPAM	MC/DEL	8	TRANXENE		
	MC/DEL		LORAZEPAM	MC/DEL	8	XANAX TABS		
	MC/DEL		OXAZEPAM CAPS	MC/DEL	8	XANAX XR		
				MC/DEL	9	ALPRAZOLAM ER		
ANXIOLYTICS - MISC.	MC/DEL		BUSPIRONE HCL TABS	MC		BUSPAR TABS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		HYDROXYZINE HCL SOLN	MC		DROPERIDOL SOLN		
	MC		HYDROXYZINE HCL SYRP	MC/DEL		HYDROXYZINE HCL TABS		
	MC/DEL		HYDROXYZINE PAMOATE CAPS	MC/DEL		HYDROXYZINE PAMOATE 100MG CAPS		
	MC/DEL		MEPROBAMATE TABS	MC/DEL		VISTARIL		
ANTI-DEPRESSANTS								
ANTIDEPRESSANTS - MAO INHIBITORS	MC/DEL		NARDIL TABS	MC/DEL		**TRANYLCYPROMIINE**	Use PA Form# 20420	
	MC/DEL		PARNATE TABS					
ANTIDEPRESSANTS - MAO INHIBITORS TOPICAL				MC/DEL		EMSAM[1]	1. Dosing limits apply, please refer to Dose consolidation list. Use PA Form# 20420	Preferred drugs (including a preferred SSRI, a non-SSRI, and Venlafaxine ER) must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANTIDEPRESSANTS - SELECTED SSRI's	MC/DEL		BUPROPION HCL TABS	MC/DEL	8	APLENZIN[7]	1. Use Fluoxetine 20 mg in multiples. 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 in multiples. 7. Provide clinical documentation as to why a preferred generic alternative cannot be used. 8. Dosing limits allowing 2	Preferred drugs (including failure of at least one preferred SSRI, one SNRI and one non-SSRI/SNRI) must be tried for at least 4 weeks each and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **CYMBALTA:** Fibromyalgia diagnosis- prior use and failure of preferred generics (amitriptyline or cyclobenzaprine) and gabapentin prior to approval. **SAVELLA:** Fibromyalgia diagnosis and trial of a preferred generic (amitriptyline or cyclobenzaprine, and gabapentin) and Cymbalta prior to approval. Exceptions to the rule are as follows: 1. If the member (<18) is already an established user for any of the preferred or non-preferred drugs under the Antidepressant category on the PDL, then they can continue to get that drug. 2. If the member (<18) has a prescription for an antidepressant that is on the PREFERRED side of the PDL and has had a 30 day supply of Fluoxetine at least 30 days before the date they are getting it filled, the claim will pay. If they do not have the trial of Fluoxetine in their profile, the claim will reject for PA required. 3. If the member (<18) has a prescription for a medication that is on the NON-PREFERRED side of the PDL regardless of having Fluoxetine in their profile, the prescription will need a PA. 4. Use of a preferred antidepressant for anxiety will require the diagnosis of anxiety on written prescription and submitted during claim submission. **DDI:** Fluvoxamine will now be non-preferred and require prior authorization if it is currently being used with glimepiride (Amaryl). **DDI:** Preferred nefazodone will now be non-preferred and require prior authorization if it is currently being used in combination with either Onglyza 5mg, Enablex 15mg or Vesicare 10mg. **DDI:** Fluoxetine will require prior authorization if being used in combination with Plavix. **DDI:** Fluvoxamine will require prior authorization if being used in combination with Plavix. Criteria for new starters <18 years of age: Must have had fluoxetine trial for at least 30 days before accessing other preferred antidepressants without PA.
	MC/DEL		BUPROPION SR	MC/DEL	8	CELEXA[4]		
	MC/DEL		BUPROPION XL	MC	8	CYMBALTA[5, 11]		
	MC/DEL		CITALOPRAM[4]	MC/DEL	8	EFFEXOR TABS		
	MC/DEL		ESCITALOPRAM[4]	MC/DEL	8	EFFEXOR XR CP24 [3, 10]		
	MC/DEL		FLUOXETINE HCL CAPS	MC/DEL	8	FLUOXETINE 40mg AND 60 mg CAPS[1]		
	MC/DEL		FLUOXETINE HCL LIQD	MC/DEL	8	FLUOXETINE 20mg TABS[6]		
	MC/DEL		FLUOXETINE HCL 10mg TABS	MC	8	FORFIVO XL		
	MC/DEL		FLUVOXAMINE MALEATE TABS	MC/DEL	8	LEXAPRO TABS[4]		
	MC/DEL		MIRTAZAPINE	MC	8	LUVOX TABS		
	MC/DEL		NEFAZODONE	MC	8	MAPROTILINE HCL TABS		
	MC/DEL		PAROXETINE[3]	MC/DEL	8	MIRTAZAPINE ODT		
	MC/DEL		SERTRALINE HCL[2]	MC	8	OLEPTRO		
	MC/DEL		TRAZODONE HCL TABS	MC/DEL	8	PAROXETINE CR[3]		
	MC/DEL		VENLAFAXINE ER CAPS[9]	MC/DEL	8	PAXIL[3]		
				MC/DEL	8	PAXIL CR [3]		
				MC/DEL	8	PRISTIQ		
				MC	8	PROZAC		
				MC	8	PROZAC CAPS		
				MC	8	PROZAC WEEKLY CPDR		
				MC/DEL	8	REMERON TABS		
				MC/DEL	8	SARAFEM CAPS		
				MC/DEL	8	TRAZODONE HCL 300MG TABS		
				MC/DEL	8	WELLBUTRIN TABS		
				MC/DEL	8	WELLBUTRIN SR TBCR		
				MC/DEL	8	WELLBUTRIN XL		
				MC/DEL	8	REMERON SOLTAB TBDP		
				MC/DEL	8	SAVELLA [8]		
				MC/DEL	8	ZOLOFT		

				MC/DEL	8	VENLAFAXINE TABS[9]	tabs/day and a max daily limit of 200mg / day applies. Please see dose consolidation list.	
				MC/DEL	8	VENLAFAXINE ER TABS[9]	9. Dosing limits and max daily dose applies. Limit of 1 per day of 37.5mg, 75mg, will be allowed without pa, along with limits of 2 tabs per day of the 150mg strength. Max daily dose allowed is 375mg.	
				MC/DEL	9	VIIBRYD	10. Use venlafaxine ER tabs.	
				MC/DEL		FLUOXETINE 90mg TABS[12]	11. Established users are grandfathered.	
							12. Non-preferred products must be used in specified step order.	
							Use PA Form# 20420	
ANTIDEPRESSANTS - TRI-CYCLICS	MC/DEL		**AMITRIPTYLINE HCL TABS[1]**	MC/DEL		**AMOXAPINE TABS**	1. Users over the age of 65 require a pa.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**ANAFRANIL CAPS[1]**	MC/DEL		**CLOMIPRAMINE HCL CAPS**		
	MC/DEL		**DESIPRAMINE HCL TABS[1]**	MC/DEL		**DOXEPIN HCL 150 MG[2]**		
	MC/DEL		**DOXEPIN HCL[1]**	MC/DEL		**NORPRAMIN TABS**		
	MC/DEL		**IMIPRAMINE HCL TABS[1]**	MC/DEL		**PAMELOR**	2. Use multiples of 50mg.	
	MC/DEL		**NORTRIPTYLINE HCL[1]**	MC		TOFRANIL		
	MC		PROTRIPTYLINE HCL TABS[1]	MC		VIVACTIL TABS	Use PA Form# 20420	
	MC		SURMONTIL CAPS[1]				Use PA Form# 10220 for Brand Name requests	
SEDATIVE / HYPNOTICS								
SEDATIVE/HYPNOTICS - BARBITURATE	MC		BUTISOL SODIUM TABS[1]	MC		LUMINAL SOLN	1. PA required for new users of preferred products if over 65 years.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		CHLORAL HYDRATE SYRP[1]	MC/DEL		SOMNOTE CAPS		
	MC		MEBARAL TABS[1]					
	MC/DEL		PHENOBARBITAL[1]				Use PA Form# 20420	
SEDATIVE/HYPNOTICS - BENZODIAZEPINES	MC/DEL		DORAL TABS[1]	MC		HALCION TABS[1]	1. Dosing limits apply, please see dosing consolidation list.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Benzodiazepines do cause dependence with continued use and usage should be limited to 7-10 days at a time. Chronic intermittent use (2-3 Days per week max) is the standard of care
	MC/DEL		ESTAZOLAM TABS[1]	MC		MIDAZOLAM HCL SYRP		
	MC/DEL		FLURAZEPAM HCL CAPS[1]	MC/DEL		RESTORIL CAPS[1]		
	MC/DEL		TEMAZEPAM CAPS 15 & 30MG[1]	MC/DEL		TEMAZEPAM 7.5MG[1]	Use PA Form# 30110	
	MC/DEL		TRIAZOLAM TABS[1]					
SEDATIVE/HYPNOTICS - Non-Benzodiazepines	MC/DEL	1	MIRTAZAPINE	MC/DEL	7	AMBIEN[1]	1. Quantity Limt of 12 per 34 days.	Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC	1	TRAZODONE	MC/DEL	7	**ZOLPIDEM ER**		
	MC/DEL	1	ZOLPIDEM [2]	MC/DEL	8	AMBIEN CR[1]	2. Quantity limits will be allowed up to 30/30, but intermittent therapy is recommended.	
	MC/DEL	2	ZALEPLON [2,3]	MCDEL	8	EDLUAR		Ambien, Ambien CR, Lunesta, Sonata, Zaleplon and Zolpidem may cause dependence with continued use and as with benzodiazepines, usage should be limited to 7-10 days at a time. Chronic intermittent use (2-3 days per week max) is the standard of care. Please refer to Sedative/Hypnotic PA form.
				MC/DEL	8	INTERMEZZO		
				MC/DEL	8	LUNESTA[1]		
				MC/DEL	8	SONATA CAPS[1]		
				MC/DEL	8	ROZEREM	3. Only zolpidem trial/failure will be required to obtain Zaleplon.	

				MC/DEL	8	ZOLPIMIST	4. Must fail all preferred products before non-preferred Use PA Form# 30110	
ANTI-PSYCHOTICS								
ANTIPSYCHOTICS - ATYPICALS	MC		ABILIFY TABS[3,4]	MC/DEL	8	ABILIFY DISC TAB, INJ and SOL[2]	If prescribing 2 or more antipsychotics, PA will be required for both drugs, except if one is Clozapine.This also includes combination of Seroquel with Seroquel XR.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Non preferred atypicals will be approved for patients with FDA-approved indications, and for specific conditions supported by at least two published peer-reviewed double-blinded, placebo-controlled randomized trials that are not contradicted by other studies of similar quality and as long as all first line preferred therapies have been tried and failed at full therapeutic doses for adequate durations (at least two weeks). * Abilify: doses above 15mg were not shown to be more effective than doses in the 10-15mg range. Prescriptions for quetiapine are limited to a maximum daily dose of 800mg. **DDI:** Abilify, Quetiapine, and Zyprexa will now be non-preferred and require prior authorization if they are currently being used in combination with carbamazepine. Please use Drug-Drug Interaction PA form #10400. **Atypicals:** Prior Authorization will be required for preferred medication to assure indication is in accordance with FDA approved or literature supported evidence-based best practices. The approved indications are: • **schizophrenia** • **bipolar disorder** • **agitation related to autism** • **severe behavioral dyscontrol with risk of imminent need for emergency services such as the emergency room, crisis services, or an inpatient psychiatric facility.** If prescribing 2 or more antipsychotics, PA will be required for both drugs, except if one is Clozapine.This also includes combination of Seroquel with Seroquel XR.
	MC/DEL		**OLANZAPINE**[4]	MC/DEL	8	ABILIFY MAINTENA		
	MC/DEL		LATUDA[6]	MC	8	FANAPT		
	MC/DEL		RISPERIDONE TAB[4]	MC/DEL	8	GEODON		
	MC/DEL		RISPERIDONE SOLN[4]	MC	8	INVEGA		
	MC/DEL		QUETIAPINE[4,7]	MC	8	INVEGA SUSTENNA		
	MC/DEL		**ZIPRASIDONE**[4]	MC	8	RISPERDAL TAB		
				MC	8	RISPERDAL CONSA [2]		
				MC	8	RISPERDAL M TAB[2]		
				MC	8	RISPERDAL SOLN	Use PA form# 20440 for Multiple Antipsychotic requests	
				MC/DEL	8	RISPERIDONE ODT		
				MC/DEL	8	SAPHRIS		
				MC/DEL	8	SEROQUEL 50MG TABS[1,2]		
				MC	8	ZYPREXA TABS		
				MC	8	ZYPREXA ZYDIS TBDP [2]	Use PA form# 10130 for non-preferred single therapy atypical requests	
				MC	8	ZYPREXA RELPREVV	1. Please use multiple 25mg tablets.	
				MC/DEL	8	SEROQUEL TABS		
				MC/DEL	9	SEROQUEL XR[5]	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. Latuda requires splitting of tab to avoid PA.	
							7. Dosing limits apply: quetiapine 25mg, 50mg and 100mg are available without PA if the daily dosage is less than 1.5 tablets	
ANTIPSYCHOTICS - SPECIAL ATYPICALS	MC/DEL		CLOZAPINE TABS	MC/DEL		CLOZARIL TABS	Use PA Form# 20420	Preferred generic drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred brand will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Patients previously stabilized on brand name drug will be approved.
				MC		FAZACLO		

								DDI: Clozapine will now be non-preferred and require prior authorization if it is currently being used in combination with carbamazepine. Please use Drug-Drug Interaction PA form #10400.
ANTIPSYCHOTICS - TYPICAL	MC/DEL		CHLORPROMAZINE HCL	MC/DEL		COMPAZINE	Use PA Form# 20420 If prescribing 2 or more antipsychotics, PA will be required for both drugs, except if one is Clozapine.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. If prescribing 2 or more antipsychotics, PA will be required for both drugs, except if one is Clozapine.
	MC/DEL		FLUPHENAZINE DECANOATE	MC/DEL		COMPRO SUPP		
	MC/DEL		FLUPHENAZINE HCL	MC		HALDOL DECANOATE		
	MC		HALDOL	MC/DEL		LOXITANE CAPS		
	MC/DEL		HALOPERIDOL	MC		MELLARIL		
	MC		HALOPERIDOL DECANOATE SOLN	MC/DEL		NAVANE CAPS		
	MC		HALOPERIDOL LACTATE SOLN	MC		PROLIXIN		
	MC/DEL		LOXAPINE SUCCINATE CAPS	MC		STELAZINE TABS		
	MC/DEL		LOXITANE-C CONC					
	MC		MOBAN TABS					
	MC/DEL		PERPHENAZINE					
	MC/DEL		PROCHLORPERAZINE					
	MC		SERENTIL					
	MC/DEL		THIORIDAZINE HCL					
	MC/DEL		THIOTHIXENE					
	MC/DEL		TRIFLUOPERAZINE HCL TABS					
LITHIUM								
LITHIUM	MC/DEL		LITHIUM CARBONATE	MC/DEL		ESKALITH CAPS	Use PA Form# 20420	
	MC/DEL		LITHIUM CITRATE SYRP	MC/DEL		ESKALITH CR TBCR		
COMBINATION - PSYCHOTHERAPEUTIC								
PSYCHOTHERPEUTIC COMBINATION	MC/DEL		CHLORDIAZEPOXIDE/AMITRIPT	MC	8	SYMBYAX[1]	1. Only available if component ingredients are unavailable. Use PA Form# 20420	
	MC/DEL		PERPHENAZINE/AMITRIPTYLIN					
STIMULANTS								
STIMULANT - AMPHETAMINES -SHORT ACTING	MC/DEL		ADDERALL TABS[1]	MC/DEL		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	
	MC/DEL		DEXTROAMPHET SULF TABS[1,3]	MC		PROCENTRA		
	MC/DEL		DEXEDRINE[1,3]					
STIMULANT - LONG ACTING AMPHETAMINES SALT	MC		VYVANSE[2,3,4]	MC	8	ADDERALL XR CP24[1,3,4]	Use PA Form# 20420 1. As per recent FDA alert, Adderall should not be used in patients with underlying heart defects since they may be at increased risk for sudden death.	Adderall XR- Current users as of 12/31/11 without prior use of Vyvanse will be required to transition to the preferred vyvanse product. Other members will required PA Quillivant is only indicated for use in patients 6 years of age and older. Prior trials of preferred products
				MC/DEL	9	AMPHETAMINE/DEXTROAMPHET ER		

							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	**MC**		DEXEDRINE CAP CR[1,2,3]	**MC**		DEXTROAMPHET SULF CPCR[3]	1. Preferred stimulants will be available without PA if diagnosis of ADHD. 2. As per recent FDA alert, Adderall & Dexedrine should not be used in patients with underlying heart defects since they may be at increased risk for sudden death. 3. Dosing limits applly, please see dosing consolidation list. Use PA Form# 20420	
STIMULANT - METHYLPHENIDATE	**MC/DEL** **MC/DEL** **MC/DEL** **MC/DEL** **MC/DEL** **MC/DEL**		FOCALIN TABS[1,2] METADATE ER TBCR[1,2] METHYLIN ER TBCR[1,2] METHYLIN TABS[1,2] METHYLIN SOL[1] METHYLPHENIDATE HCL[1,2]	**MC** **MC/DEL**		METHYLIN CHEWABLES RITALIN	1. Preferred stimulants will be available without PA if diagnosis of ADHD. Use PA Form# 20420 2. Dosing limits apply, please see dosing consolidation list. Maximum daily doses are as follows: 72mg daily for methylphenidate and 36mg daily for dexmethylphenidate.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Please refer to General Criteria category E.
STIMULANT - METHYLPHENIDATE - LONG ACTING	**MC/DEL** **MC/DEL** **MC/DEL** **MC/DEL**		DAYTRANA[1,3] FOCALIN XR[1] METHYLPHENIDATE ER TABS RITALIN LA	**MC** **MC** **MC/DEL** **MC**	5 8 8 8	METADATE CD CPCR CONCERTA TBCR[2] METHYLPHENIDATE ER CAPS[1,2,4] QUILLIVANT XR	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	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
STIMULANT - STIMULANT LIKE				**MC** **MC** **MC/DEL**	7 8 8	STRATTERA[1,2] CAFCIT SOLN[3] INTUNIV	1. Failure of both an amphetamine and methylphenidate is required for consideration for	Provigil requests require diagnosis of Narcolepsy, ADHD, or Obstructive Sleep Apnea. Previous failures of methylphenidate and amphetamine is required for Narcolepsy and ADHD diagnosis, with additional Strattera trial needed with ADHD diagnosis. Please refer to detailed criteria on Provigil PA form

				MC	8	KAPVAY	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.	
				MC/DEL	8	PROVIGIL TABS[3]		
				MC/DEL	9	NUVIGIL[3]		
				MC	9	DESOXYN TABS[3]		
				MC	9	DESOXYN CR[3]		
							2. Strattera currently has dosing limitations allowing one tablet per day for all strengths if obtain approval. Max daily dose of Strattera is 100mg. Please see dosing consolidation list.	
							3. Non-preferred products must be used in specified	
							4. Please use generic Guanfacine.	
							Use PA Form# 20710 for Provigil, Nuvigil and Xyrem	
							Use PA Form# 20420 for all others	
ANTI-CATAPLECTIC AGENTS								
PSYCHOTHERAPEUTIC AGENTS - MISC.				MC		NUEDEXTA	Use PA Form# 20710 for Xyrem	FDA reminded healthcare professionals and patients that the combined use of Xyrem (sodium oxybate) with alcohol or central nervous system (CNS) depressant drugs can markedly impair consciousness and may lead to severe breathing problems (respiratory depression
				MC		XYREM SOL[1]	Use PA Form# 20710 for Xenazine	
				MC		XENAZINE	1.See criteria section	
WEIGHT LOSS								
WEIGHT LOSS							No longer covered: PHENTERMINE, XENICAL,DIDREX, and MERIDIA	Weight loss drugs are not covered as permitted by Federal Medicaid regulations and Maine Medicaid (MaineCare) Policy.
ALZHEIMER DISEASE								
ALZHEIMER - Cholinomimetics/Others	MC/DEL		DONEPEZIL HYDROCHLORIDE TABS[1]	MC	6	ARICEPT TABS[2]	1. PA is required to establish dementia diagnosis and baseline mental status score.	Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs (in step-order) will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		DONEPEZIL HYDROCHLORIDE ODT[1]	MC	6	ARICEPT ODT[2]		
	MC/DEL		EXELON[1]	MC/DEL	7	**GALANTAMINE CAPS**		
	MC/DEL		NAMENDA[1]	MC	8	RAZADYNE[2]		
				MC/DEL	8	RIVASTIGMINE TARTRATE CAPS[2]	2. Must fail all preferred products before moving to non-preferred.	
				MC	9	COGNEX CAPS[2]		
							Use PA Form# 20420	
SMOKING CESSATION								
NICOTINE PATCHES / TABLETS	MC/DEL		CHANTIX[1]	MC/DEL		NICODERM CQ PT24[1]	Use PA Form# 20420	As of January 1, 2014 per MaineCare policy, smoking cessation products are covered with limitations.
	MC/DEL		NICOTINE DIS PT24[1]				1. See criteria section for exemptions	Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs (in step-order) will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
								Between 9/1/12 and 1/1/14 per MaineCare policy, smoking cessation products were "not covered" except for use during pregnancy.
								Patients may qualify for the medication through The Maine Tobacco Helpline. Patients are encouraged to call The Maine Tobacco helpline at 1-800-207-1230.

								There will be a quantity limit of 3 months supply of nicotine products allowed per 12 months Prior Authorization approvals for preferred products exceeding 3 month supply may be granted **only** for use during pregnancy.
NICOTINE REPLACEMENT - OTHER	MC/DEL		NICOTINE POLACRILEX GUM[1]	MC/DEL	5	COMMIT LOZENGES[1,2]	Use PA Form# 20420 1. See criteria section for exemptions 2. Must use non-preferred products in specified step order.	As of January 1, 2014 per MaineCare policy, smoking cessation products are covered with limitations. Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs (in step-order) will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Between 9/1/12 and 1/1/14 per MaineCare policy, smoking cessation products were "not covered" except for use during pregnancy. Patients may qualify for the medication through The Maine Tobacco Helpline. Patients are encouraged to call The Maine Tobacco helpline at 1-800-207-1230. There will be a quantity limit of 3 months supply of nicotine products allowed per 12 months Prior Authorization approvals for preferred products exceeding 3 month supply may be granted **only** for use during pregnancy.
				MC/DEL	8	NICOTROL INHALER[1,2]		
				MC/DEL	8	NICOTROL NASAL SPRAY[1,2]		
				MC/DEL	8	NICORETTE GUM[1,2]		
ALCOHOL DETERRENTS								
ALCOHOL DETERRENTS	MC		ANTABUSE TABS				1. Should only be used in conjunction with formal structured outpatient detoxification program. Use PA Form# 20420	Preferred generic drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		CAMPRAL[1]					
	MC		DISULFIRAM TABS					
	MC/DEL		NALTREXONE HCL TABS					
MISCELLANEOUS ANALGESICS								
ANALGESICS - MISC.	MC/DEL		ACETAMINOPHEN	MC		AXOCET CAPS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**ASPIRIN**	MC/DEL		ESGIC-PLUS		
	MC/DEL		ASPRIN/ APAP/ CAFF TAB	MC/DEL		FIORICET TABS		
	MC/DEL		BUTAL/ASA/CAFF	MC		FIORINAL CAPS		
	MC/DEL		BUTALBITAL COMPOUND	MC		FIORTAL CAPS		
	MC/DEL		BUTALBITAL/ACET TABS	MC/DEL		FORTABS TABS		
	MC/DEL		BUTALBITAL/APAP CAPS	MC		PHRENILIN TABS		
	MC/DEL		BUTALBITAL/APAP/CAFFEINE	MC		PHRENILIN FORTE CAPS		
	MC/DEL		**CHOLINE MAGNESIUM TRISALI**	MC		TRILISATE LIQD		
	MC/DEL		**DIFLUNISAL TABS**	MC		TRILISATE TABS		
	MC		EXCEDRIN	MC		ZEBUTAL CAPS		
	MC/DEL		**SALSALATE TABS**	MC		ZORPRIN TBCR		
LONG ACTING NARCOTICS								
NARCOTICS - LONG ACTING	MC/DEL		FENTANYL PATCH[4]	MC/DEL	8	ABSTRAL	Use PA Form# 20510 1. Oxycontin will be available without PA for patients treated for or dying from cancer or hospice patients. CA (cancer) or HO (hospice) diag code may be used but store must verify since all scripts will be audited and stores will be liable. 2. Established users are grandfathered. 3. Oxycodone ER allowed only 2 per day for all strengths except 80 mg, where 4 are allowed to	Preferred drugs (Avinza or morphine sulfate ER tab, Duragesic, Methadone or Methadose) must be tried for at least 2 weeks each & failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug & the preferred drug(s) exists. Adequate trials include prevention/treatment of common adverse effects associated w/ narcotics (antinausea, antipruritics, etc.) as well as adequate equianalgesic dosing when converting from one narcotic to another.Also, adequate documentation of attempts to titrate dose of preferred agents to achieve adequate pain relief & desired clinical response must be provided. Member's drug regimen for additions &/or discontinuations of medications that may affect absorption &/or metabolism of preferred agents must be monitored. Approvals will not be granted if patient had access to either non-preferred products or high doses of short acting narcotics during the trial period. Non-preferred drugs will not be approved for patients showing evidence of usage patterns consistent w/ controlled substance abuse such as: 1.Frequent or persistent early refills of controlled drugs; 2.Multiple instances of early refill overrides due to reports of misplacement, stolen, dropped in toilet or sink, distant travel, etc.; 3.Breaches of narcotic contracts with any provider; 4.Failure to comply with patient responsibilities in attached opioid documentation (see PA form) including but not limited to failing to submit to and pass pill counts; 5.Failing to take or pass random drug testing; 6.Failing to provide old records regarding prior use of narcotics; 7.Receiving controlled substances from other prescribers that the provider submitting the PA is unaware of
	MC/DEL		METHADONE	MC	8	AVINZA		
	MC/DEL		METHADOSE	MC/DEL	8	BUTRANS[4]		
	MC/DEL		MORPHINE SULFATE ER TB12	MC	8	DURAGESIC PT72[4]		
	MC		OPANA ER	MC/DEL	8	EMBEDA		
				MC	8	EXALGO		
				MC	8	IBUDONE		
				MC	8	KADIAN		
				MC/DEL	8	MORPHINE SULFATE SUPP		
				MC/DEL	8	MS CONTIN TB12		
				MC/DEL	8	ORAMORPH SR TB12		
				MC/DEL	8	OXYCONTIN TB12[1]		
				MC/DEL	9	NUCYNTA ER		
				MC/DEL	9	OXYCODONE ER[3,5]		

							4. Dosing limits apply. Please see dose consolidation list. 5. Non-preferred products must be used in specific order.	8.Documented history of substance abuse. Substance abuse evaluations may be required for patients with medical records displaying documented substance abuse or potential signs of narcotic misuse and abuse such as chronic early refills, short dosing intervals, frequent dose increases, multiple lost/stolen etc scripts and intolerance or "allergy" to all products but Oxycontin. 9.Circumventing MaineCare prior authorization requirements for narcotics by paying cash for affected narcotics (prescribers failed to submit prior authorization prior to cash narcotic scripts being filled by member). 10.Requests for any Brand name controlled substance, considered by authorities to be highly abused and diverted (Oxycontin, Percocet, Typox, Vicodin, Dilaudid, Ultracet...) with an available AB rated generic equivalent will be denied unless it will be provided in a setting that virtually eliminates the risk of diversion. 11.Allergic reactions to any product within a specific narcotic class will justify and preclude use of any other product in the same class due to the risk of cross-hypersensitivity.
NARCOTICS - SELECTED	MC/DEL		TRAMADOL HCL TABS	MC/DEL	7	RYZOLT	Use PA Form# 20420 1. Only available if component ingredients are unavailable.	Preferred drugs from this and other narcotic classes must be tried for at least 2 weeks each and failed due to lack of efficacy or intolerable side effects before non-preferred drugs from this class will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Approvals will not be granted if patient had access to either non-preferred products or high doses of short acting narcotics during the trial period. Substance abuse evaluations may be required for patients with medical records displaying potential signs of narcotic misuse and abuse such as chronic early refills, short dosing intervals, frequent dose increases, multiple lost/stolen etc scripts and intolerance or "allergy" to all products but desired product. Allergic reactions to any product within a specific narcotic class will justify and preclude use of any other product in the same class due to the risk of cross-hypersensitivity. Non-preferred drugs will not be approved for patients showing evidence of usage patterns consistent with controlled substance abouse such as: 1.frequent or persistant early refills of controlled drugs; 2.multiple instances of early refill overrides due to reports of misplacement, stolen, dropped in toilet or sink, distant travel; 3.breaches of narcotic contracts with any provider; 4.failure to comply with patient responsibilities in attached opiod documentaion (see PA form) including but not limited to failing to submit to and pass pill counts; 5.failing to take or pass random drug testing; 6.failing to provide old recoreds regarding prior use of narcotics; 7.receiving controlled substances from other prescribers that the provider submitting the PA is unaware of. in Substance abuse evaluations may be required for patients with medical records displaying potential signs of narcotic misuse and abuse such as chronic early refills, short dosing intervals, frequent dose increases, multiple lost/stolen etc scripts and intolerance or "allergy" to all products but Oxycontin. Allergic reactions to any product within a specific narcotic class will justify and preclude use of any other product in the same class due to the risk of cross-hypersensitivity. **Effective 1/01/2013, MaineCare will implement a 15 day limit for members prescribed opiates for their treatment of pain.** 1. MaineCare members will be allowed over a rolling 12 month period up to a 15 day supply of an opiate without prior authorization 2. Members requiring longer than 15 days will require a PA for continuation of therapy and providers may provide medical necessity 3. Members may be eligible for up to three prior authorizations of up to 14 day supplies of opiates during the 12 month period 4. MaineCare members that are in Hospice care or are being treated for a diagnosis of Cancer, HIV or AIDS will be exempt from these limits 5. Post surgical members may receive prior authorizations for opiates up to 60 days in length if medical necessity is provided by the Surgeon **Please see the Pain Management Policy_Sec. 80 tab for the complete criteria**
				MC	8	BUPRENEX SOLN		
				MC/DEL	8	BUTORPHANOL		
				MC	8	NALBUPHINE HCL SOLN		
				MC	8	STADOL NS SOLN		
				MC	8	TRAMADOL ER		
				MC	8	ULTRACET TABS[1]		
				MC	8	ULTRAM TABS		
				MC	9	ULTRAM ER		
MISCELLANEOUS NARCOTICS								
NARCOTICS - MISC.	MC/DEL		ACETAMINOPHEN/CODEINE	MC/DEL	8	ASCOMP/CODEINE CAPS	1. Fentanyl OT loz (Barr) and Capital and codeine suspension products require PA for users over 18 years of age. PA is not required if under 18 years of age. 2. Oxycodone/acet 10/650 is 8 times more expensive. Use twice as many of oxycod/acet 5/325 instead.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Please refer to General Criteria category E. **Effective 1/01/2013, MaineCare will implement a 15 day limit for members prescribed opiates for their treatment of pain.** 1. MaineCare members will be allowed over a rolling 12 month period up to a 15 day supply of an opiate without prior authorization
	MC/DEL		ASPIRIN/CODEINE TABS	MC/DEL	8	BUTALBITAL/APAP/CAFFEINE/ CAPS		
	MC/DEL		BUTAL/ASA/CAFF/COD CAPS	MC	8	DEMEROL		
	MC		BUTALBITAL/ASPIRIN/CAFFEI CAPS	MC/DEL	8	DILAUDID		
	MC		CAPITAL AND CODEINE SUSP[1]	MC	8	DILAUDID-HP SOLN		
	MC		CAPITAL/CODEINE SUSP[1]	MC	8	FENTANYL CITRATE SOLN		
	MC/DEL		CODEINE PHOSPHATE SOLN	MC/DEL	8	FENTORA		
	MC/DEL		CODEINE SULFATE TABS	MC/DEL	8	FIORICET/CODEINE CAPS		
	MC/DEL		ENDOCET TABS[3]	MC	8	FIORINAL/CODEINE #3 CAPS		
	MC/DEL		ENDODAN TABS	MC	8	FIORTAL/CODEINE CAPS		
	MC/DEL		FENTANYL OT LOZ[1]	MC/DEL	8	HYDROCODONE/IBUPROFEN		
	MC/DEL		HYDROCODONE BITARTRATE/AP TABS	MC/DEL	8	LORCET		

	MC/DEL		HYDROCODONE/ACETAMINOPHEN	MC	8	LORTAB	You can mix andmatch preferred strengths of oxycodone and oxycodone/acet to minimize acet. dose similar to certain non-preferred drugs.	2. Members requiring longer than 15 days will require a PA for continuation of therapy and providers may provide medical necessity 3. Members may be eligible for up to three prior authorizations of up to 14 day supplies of opiates during the 12 month period 4. MaineCare members that are in Hospice care or are being treated for a diagnosis of Cancer, HIV or AIDS will be exempt from these limits 5. Post surgical members may receive prior authorizations for opiates up to 60 days in length if medical necessity is provided by the Surgeon **Please see the Pain Management Policy_Sec. 80 for the complete criteria**
	MC/DEL		HYDROMORPHONE HCL[3]	MC	8	MAXIDONE TABS		
	MC/DEL		MEPERIDINE HCL	MC/DEL	8	NORCO TABS		
	MC/DEL		OXYCODONE 5MG	MC/DEL	8	NUCYNTA		
	MC/DEL		OXYCODONE 15MG	MC/DEL	8	ONSOLIS		
	MC/DEL		OXYCODONE 30MG	MC/DEL	8	OXECTA		
	MC/DEL		OXYCODONE/ACETAMINOPHEN[2,3]	MC/DEL	8	OXYCODONE 10MG		
	MC/DEL		PENTAZOCINE/NALOXONE TABS	MC/DEL	8	OXYCODONE 20MG		
	MC		PROPOXYPHENE CMPND-65 CAPS	MC/DEL	8	OXYCODONE/APAP 10/650		
	MC		PROPOXYPHENE COMPOUND CAPS	MC/DEL	8	OXYCODONE/APAP 7.5/500		
	MC/DEL		PROPOXYPHENE HCL CAPS	MC/DEL	8	PENTAZOCINE/ACET TABS	3. Only preferred manufacturer's products will be available without prior authorization.	
	MC/DEL		PROPOXYPHENE/ACET TABS	MC	8	PERCOCET TABS		
	MC/DEL		PROPOXYPHENE-N/ACET TABS	MC	8	PERCOCET TABS		
	MC/DEL		ROXICET	MC	8	PHRENILIN W/CAFFEINE/CODE CAPS		
	MC		ROXIPRIN TABS	MC/DEL	8	ROXICET 5/500 TABS		
				MC	8	ROXICODONE TABS		
				MC	8	SYNALGOS-DC CAPS		
				MC	8	TALACEN TABS		
				MC	8	TREZIX		
				MC	8	TYLENOL/CODEINE #3 TABS		
				MC	8	TYLOX CAPS		
				MC	8	XOLOX		
				MC	8	VICODIN		
				MC	8	VICOPROFEN TABS		
				MC	8	ZYDONE TABS	Use PA Form# 20420	
				MC	9	ACTIQ LPOP		
				MC	9	CONZIP		
				MC	9	OPANA		
OPIOID DEPENDENCE TREATMENTS	MC		SUBOXONE FILM[2]	MC		SUBOXONE TABS[3]	Use PA Form# 10200 for Suboxone Continuation	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
				MC/DEL		BUPRENORPHINE[1,2]	Use PA Form# 10100 for Suboxone Restart	
				MC		ZUBSOLV	1. Buprenorphine will only be approved for use during pregnancy. 2. See Criteria Section 3. The manufacturer will be disconntinuing the tablets by the end of quarter one 2013.	Suboxone Criteria 1. Effective 1/1/2013, MaineCare will implement a 24 month lifetime limit for members prescribed Suboxone for the treatment of opioid addiction. 2. Prior authorization request will be reviewed for dose titration downward,whether the patient is engaged in recovery oriented support services,periodic urine drug screens, flim counts,factors that threaten stability of recovery or evidence of improvement is social,physical and occupational areas. 3. Members that stop treatment after 24 months and need to restart will require a prior authorization. This prior authorization will assess the patient risk of relapsing or evidence that the patient has relapsed. Members will continue to be required to follow the criteria listed below: 1-Induction period for new starts max of 60 days 2-Max dose of 32 mg for induction 3-Max dose of 16 mg for maintenance 4-There is not more than one narcotic fill in member's drug profile between today's fill of suboxone and a prior suboxone fill within the past 90 days. 5- Prescribers limited to those with X-DEA 6- Should be evidence provided of monthly monitoring including random pill counts urine drug tests and prescription monitoring program reports. 7-Suboxone tablets will be available upon demonstrated allergy to the preferred product. Allergy may be established by 1) formal allergy testing by a board certified allergist or 2) demonstration of hives after skin exposure for 24 hours to the Suboxone Film. (The product may be applied to the skin using a band-aid and member can be assessed after 24 hours to ascertain the presence of hives by the prescriber).

NARCOTIC ANTAGONISTS								
NARCOTIC - ANTAGONISTS	MC/DEL		NALTREXONE HCL TABS	MC/DEL		REVIA TABS[1] 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 Vivitrrol PA form. Any narcotics attempting to be filled during Vivitrol approval will require prior authorization.	Please see the criteria listed on the Vivitrrol PA form.
COX 2 / NSAIDS								
COX 2 INHIBITORS - SELECTIVE / HIGHLY SELECTIVE	MC/DEL MC/DEL MC/DEL MC/DEL		CELEBREX CAPS [4,5,6] KETOROLAC TROMETHAMINE [2,3,6] NABUMETONE TABS[6] MELOXICAM[1,6]	MC/DEL MC/DEL MC/DEL		**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.	Approved without PA for patients 60 years old or over. Patients under 60 can use a preferred proton pump inhibitor with any preferred generic NSAID to achieve similar reductions in GI bleeding risk to that seen with the COX-II agents. Approvals for Celebrex will be granted for other requests based on failure of at least one generic NSAID from at least 2 different NSAID classes as described in the COX-II PA form. High risk GI bleeding patients must fail on adequate trials of safer agents (non-NSAID/Cox-2) for GI tract, such as acetaminophen.

							6. The FDA has issued a Public Health Advisory warning of the potential for increased cardiovascular risk & GI bleeding with NSAID use.	
NSAIDS	MC/DEL		**CHILDRENS IBUPROFEN**	MC		ADVIL TABS	The FDA has issued a Public Health Advisory warning of the potential for increased cardiovascular risk & GI bleeding with NSAID use. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Approvals will be granted for other requests based on failure of at least one generic NSAID from at least 3 different NSAID classes as described in the COX-II PA form. **DDI:** Diclofenac will now be non-preferred and require prior authorization if it is currently being used in combination with lescol. The FDA has issued a Public Health Advisory warning of the potential for increased cardiovascular risk & GI bleeding with NSAID use.
	MC/DEL		**DICLOFENAC POTASSIUM TABS**	MC		ANAPROX TABS		
	MC/DEL		**DICLOFENAC SODIUM**	MC		ANAPROX DS TABS		
	MC/DEL		**ETODOLAC**	MC		CAMBIA		
	MC/DEL		**FENOPROFEN CALCIUM TABS**	MC/DEL		**CATAFLAM TABS**		
	MC/DEL		**FLURBIPROFEN TABS**	MC		CHILDRENS ADVIL SUSP		
	MC/DEL		**IBUPROFEN**	MC		CHILD'S IBUPROFEN SUSP		
	MC/DEL		**INDOMETHACIN**	MC/DEL		CHILDREN'S MOTRIN SUSP		
	MC/DEL		**KETOPROFEN**	MC/DEL		**CLINORIL TABS**		
	MC/DEL		**MECLOFENAMATE SODIUM CAPS**	MC/DEL		**DAYPRO TABS**		
	MC/DEL		NAPROSYN SUSP	MC/DEL		**EC-NAPROSYN TBEC**		
	MC/DEL		NAPROXEN SUSP	MC/DEL		**ETODOLAC ER 600MG**		
	MC/DEL		**NAPROXEN TABS**	MC		FELDENE CAPS		
	MC/DEL		**NAPROXEN SODIUM TABS**	MC/DEL		IBU-200		
	MC/DEL		**OXAPROZIN TABS**	MC		INDOCIN		
	MC/DEL		**SULINDAC TABS**	MC/DEL		**LODINE**		
	MC/DEL		**TOLMETIN SODIUM**	MC/DEL		**MOTRIN**		
				MC		NALFON CAPS		
				MC/DEL		NAPRELAN TBCR		
				MC/DEL		NAPROSYN TABS		
				MC/DEL		**NAPROXEN DR TBEC**		
				MC/DEL		**NAPROXEN SODIUM TBCR**		
				MC		PENNSAID		
				MC/DEL		**PIROXICAM CAPS**		
				MC		PONSTEL CAPS		
				MC		SB IBUPROFEN TABS		
				MC		SPRIX		
				MC		TOLECTIN		
				MC/DEL		VOLTAREN		
				MC		V-R IBUPROFEN TABS		
NSAID - PPI				MC		PREVACID NAPRA-PAC	1. Use a preferred NSAID and PPI separately. Use PA Form# 20420	
				MC/DEL		VIMOVO[1]		
RHEUMATOID ARTHRITIS								
RHEUMATOID ARTHRITIS	MC/DEL	1	**AZATHIOPRINE**	MC/DEL		**ARAVA**	Use PA Form# 20900 1. Only one step 1 drug is required to obtain Enbrel, Cimzia or Humira without PA. 2. Dosing limits apply. Please see dose consolidation list. 3. 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.	See criteria as listed on Rheumatoid Arthritis PA form. Enbrel is preferred after a trial of a step 1 product (e.g. azathioprine, methotrexate, etc.); however, dosing limits will also still apply. Dosing limits will allow 8 injections per month without pa. Use of greater than 8 injections per month will require PA. **Xeljanz** is limited to adults with moderately to severely active RA who have had an inadequate response or intolerance to methotrexate. Should not be used concomitantly with biologic DMARDs or potent Immunosuppressants. Therapy should not be started in those with lymphocyte count <500cells/mm^3, an ANC <1000cells/mm^3, or have a hemoglobin <9g/dl.
	MC/DEL	1	**HYDROXYCHLOROQUINE**	MC/DEL		ACTEMRA		
	MC/DEL	1	LEFLUNOMIDE	MC/DEL		**ILARIS**[2,5,6]		
	MC/DEL	1	METHOTREXATE	MC		**KINERET SOLN**		
	MC/DEL	1	**SULFASALAZINE TABS**	MC		ORENCIA		
	MC/DEL	2	CIMZIA[1]	MC		**REMICADE**		
	MC	2	**ENBREL**[1,4]	MC		SIMPONI		
	MC	2	**HUMIRA**[1,2,4]	MC/DEL		**XELJANZ**		

							4. Established users will be grandfathered for Enbrel and Humira. 5.Clinical PA is required to establish diagnosis and medical necessity. 6. Verification of age for appropriate indication.	
MISCELLANEOUS ARTHRITIS								
ARTHRITIS - MISC.	MC MC		RIDAURA CAPS MYOCHRYSINE SOLN	MC/DEL		**ARTHROTEC**[1]	1. The individual components of Arthrotec are available without PA. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. The individual components of Arthrotec are available without PA.
LUPUS-SLE								
LUPUS-SLE				MC		BENLYSTA	Use PA Form# 20420	
MIGRAINE THERAPIES								
MIGRAINE - ERGOTAMINE DERIVATIVES	MC MC		MIGRANAL SOLN SANSERT TABS	MC/DEL		D.H.E. 45 SOLN	Use PA Form# 10110	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
MIGRAINE - CARBOXYLIC ACID DERIVATIVES	MC		DIVALPROEX ER TB24	MC		DEPAKOTE ER TB24	Use PA Form# 10110	
MIGRAINE - SELECTIVE SEROTONIN AGONISTS (5HT)--Tabs	MC/DEL MC/DEL MC/DEL		NARATRIPTAN HCl TABS[1] RELPAX[1] SUMATRIPTAN TABS[1]	MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		AMERGE TABS[1,2] AXERT TABS[1,2] FROVA TABS[1,2] IMITREX TABS[1,2] MAXALT[1,2,3] MAXALT MLT1,2,3 **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	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Quantity limit exceptions will require ongoing therapy with therapeutic doses of highly effective prophylactic medication as listed on the Triptan PA form.
MIGRAINE - SELECTIVE SEROTONIN AGONISTS (5HT)--Injectables	MC/DEL MC/DEL MC/DEL MC/DEL		IMITREX KIT IMITREX SOLN IMITREX STATDOSE PEN KIT IMITREX STATDOSE REFILL KIT	MC/DEL		SUMATRIPTAN SOLN	Use PA Form# 10110	
MIGRAINE - SELECTIVE SEROTONIN AGONISTS (5HT)--Combinations				MC/DEL		TREXIMET[1,2]	Use PA Form# 10110 1. Dosing limits apply. Please see dose consolidation list. 2. Use preferred Sumatriptan and Naproxen separately. Treximet only available if component ingredients of sumatriptan and naproxen are unavailable.	
MIGRAINE - MISC.	MC/DEL MC/DEL		CAFERGOT TABS SPASTRIN TABS	MC/DEL MC MC/DEL		MIGRAZONE CAPS BELCOMP-PB SUPP MIGERGOT SUP	Use PA Form# 10110	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
GOUT								
GOUT	MC/DEL		**ALLOPURINOL TABS**	MC		COLCRYS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered

	MC/DEL		PROBENECID TABS	MC/DEL		ULORIC[1]	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.	on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		PROBENECID/COLCHICINE TABS	MC		ZYLOPRIM TABS		
MISC.								
ANESTHETICS - MISC.	MC		BUPIVACAINE HCL SOLN	MC		SENSORCAINE-MPF SOLN	Use PA Form# 30130	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		LIDOCAINE HCL SOLN	MC/DEL		SYNVISC INJ		
	MC		MARCAINE SOLN	MC		XYLOCAINE SOLN		
ANTI-CONVULSANTS								
ANTICONVULSANTS	MC/DEL		CARBAMAZEPINE	MC	8	BANZEL	Use PA Form# 20420	One time PA is required to determine seizure diagnosis for any non-preferred anticonvulsant. Other approvals will be for patients with a variety of drug-specific FDA-approved indications and for specific conditions supported by at least two published peer-reviewed double-blinded, placebo-controlled randomized trials that are not contradicted by other studies of similar quality after recommendation by the DUR Committee and as long as all first line therapies have been tried and failed at full therapeutic doses for adequate durations (at least two weeks).
	MC/DEL		CARBATROL CP12	MC	8	DEPAKENE	All non-preferred meds must be used in specified order	
	MC/DEL		CELONTIN CAPS	MC	8	DEPAKOTE		
	MC/DEL		CLONAZEPAM TABS	MC	8	DEPAKOTE ER		
	MC		DEPAKOTE SPRINKLES CPSP	MC/DEL	8	DIAZEPAM GEL	1. Quantity limit. 5/month	
	MC/DEL		DIASTAT[1]	MC/DEL	8	DIVALPROEX SODIUM SPRINKLE CAPS	2. Dosing limits apply, please see dose consolidation list.	
	MC/DEL		DILANTIN	MC/DEL	8	EQUETRO		
	MC/DEL		DIVALPROEX SODIUM	MC/DEL	8	GABITRIL TABS		*** SEE CHART AT END OF DOCUMENT
	MC/DEL		EPITOL TABS	MC/DEL	8	HORIZANT	3. Dosing limits apply per strength as well as a maximum daily dose of 600mg. Please see dose consolidation list.	Topamax and Neurontin - Second line therapy for migraine prophalaxis after trial of at least three preferred preventive medications from Group 1 listed on page 2 of the Acute Migraine PA form.
	MC/DEL		ETHOSUXIMIDE SYRP	MC/DEL	8	GABAPENTIN 600mg & 800mg		
	MC/DEL		FELBATOL	MC	8	GRALISE		
	MC/DEL		GABAPENTIN[z] 300mg & 400mg	MC/DEL	8	KEPPRA TABS		
	MC/DEL		LAMOTRIGINE[2]	MC/DEL	8	KEPPRA SOLN		
	MC/DEL		LEVETIRACETAM SOLN/TABS	MC/DEL	8	KLONOPIN TABS		Lyrica- Second line therapy for Diabetic Peripheral Neuropathy and Post Herpetic Neuralgia. With Fibromyalgia diagnosis, Lyrica will not require PA if previous 4 week trials of the following three are seen in drug profile at full therapeutic doses: TCA or cyclobenzaprine, gabapentin, and savella.
	MC/DEL		MYSOLINE TABS	MC/DEL	8	LAMICTAL	4. Adjunctive therapy 17 and older.	
	MC/DEL		OXCARBAZEPINE	MC/DEL	8	**LEVETIRACETAM INJ**		
	MC/DEL		PHENYTEK CAPS	MC/DEL	8	**LEVETIRACETAM ER TABS**	5. Current users as of 7/30/10 for seizures will be grandfathered.	All non-preferred meds must be used in specified order.
	MC/DEL		PHENYTOIN	MC/DEL	8	LYRICA[3]		
	MC/DEL		TEGRETOL	MC	8	ONFI		
	MC/DEL		TOPIRAMATE	MC	8	OXTELLAR XR[f]		
	MC/DEL		TOPIRAMATE SPRINKLE CAPS[2]	MC/DEL	8	POTIGA		**DDI:** Any Carbamazepine formulation will now be non-preferred and require prior authorization if any of the following drugs are currently being used in combination with carbamazepine: Abilify, clarithomycin, clozapine, erythromycin, Seroquel, telithromycin or Zyprexa.
	MC/DEL		TRILEPTAL SUSP	MC/DEL	8	PRIMIDONE TABS	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.	
	MC/DEL		VALPROIC ACID	MC	8	SABRIL		
	MC/DEL		VALPROIC ACID	MC	8	TOPAMAX		
	MC/DEL		ZONISAMIDE	MC	8	TOPAMAX SPRINKLE CAPS[2]		Please use Drug-Drug Interaction PA form #10400 for this combination.
				MC	8	TROKENDI[2,8]		
				MC/DEL	8	TRILEPTAL		
				MC/DEL	8	VIMPAT[4]		ONFI will require a clinical PA to confirm LGS diagnosis
				MC/DEL	8	ZARONTIN SYRP		
				MC/DEL	9	KEPPRA XR[5,6]		
				MC/DEL	9	NEURONTIN		
				MC/DEL	9	TEGRETOL-XR TB12[5,6]		
				MC/DEL	9	ZONEGRAN CAPS	7. Max dose 2400mg	
				MC/DEL	9	LAMICTAL XR	8. Clinical PA required for appropriate diagnosis	
						BIPOLAR DISORDER: STEP ORDER		
					M ~ A		SEE ANTICONVULSANT INDICATION CHART AT THE END OF THIS DOCUMENT M= Monotherapy	
					4 ~ 4	LAMICTAL		
					4 ~ 4	LITHIUM		
					4 ~ 4	CARBAMAZEPINE		

					4 ~ 4	VALPROATE	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	ATYPICAL ANTIPSYCHOTICS EXC. CLOZAPINE		
					5 ~ 5	TRILEPTAL		
					9 ~ 6	TOPAMAX		
					9 ~ 7	KEPPRA TABS		
					9 ~ 8	GABITRIL TABS		
					9 ~ 9	NEURONTIN		
					9 ~ 9	ZONEGRAN CAPS		
						PEDIATRIC BIPOLAR1 DISORDER: STEP ORDER		
					M ~ A	(6-18 YEARS WITH OR WITHOUT PSYCHOSIS)		
					4 ~ 4	LITHIUM		
					4 ~ 4	CARBAMAZEPINE	Two-step 1 preferred drugs must be tried before Trileptal. The step orders show the relative strength of evidence for use in bi-polar and will guide prior authorization determinations. Step 4 drugs-no PA required.	
					4 ~ 4	VALPROATE		
					4 ~ 4	ATYPICAL ANTIPSYCHOTICS EXC.CLOZAPINE		
					4 ~ 4	LAMICTAL		
					5 ~ 5	TRILEPTA		
ANTI-PARKINSON DRUGS								
PARKINSONS - ANTICHOLINERGICS	MC/DEL		BENZTROPINE MESYLATE TABS				Use PA Form# 20420	
	MC		COGENTIN SOLN					
	MC/DEL		**TRIHEXYPHENIDYL**					
PARKINSONS - COMT INHIBITORS	MC/DEL		**COMTAN TABS**	MC/DEL		**TASMAR TABS**	Use PA Form# 20420	Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
PARKINSONS - SELECTED DOPAMIN AGONISTS	MC/DEL		**PRAMIPEXOLE**	MC/DEL	5	**MIRAPEX TABS**[1]	Use PA Form# 20420 1. As of 12/08 users of Mirapex will be grandfathered if diagnosis is Parkinsons.	Preferred drug must be tried and failed in step-order due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**ROPINIROLE**	MC/DEL	8	**REQUIP TABS**		
				MC/DEL	8	**REQUIP XL TABS**		
				MC/DEL	8	**MIRAPEX ER**		
				MC/DEL	8	**NEUPRO PATCH**		
PARKINSONS - DOPAMINERGICS/CARBII/ LEVO	MC/DEL		**AMANTADINE HCL**	MC/DEL		**APOKYN**[3]	1. Approvals will require concurrent therapy with Levodopa and failed trials of Selegiline, Comtan, and Stalevo. 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	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**BROMOCRIPTINE MESYLATE**	MC		AZILECT[2]		
	MC/DEL		**CARBIDOPA/LEVODOPA TABS**[3]	MC		ELDEPRYL CAPS		
	MC/DEL		**CARBIDOPA/LEVODOPA ER**	MC		LODOSYN TABS		
	MC		LARODOPA TABS	MC/DEL		**PARLODEL CAPS**		
	MC/DEL		**SELEGILINE HCL**	MC/DEL		**PARLODEL TABS**		
				MC		SINEMET TABS		
				MC		SINEMET TBCR		
				MC		ZELAPAR[1]		
PARKINSONS - COMBO.				MC/DEL		STALEVO[1]	Use PA Form# 20420 1.Clinical PA is required to establish diagnosis and medical necessity.	
				MC		CARBIDOPA/LEVODOPA/ENTACA[1]		
MUSCLE RELAXANTS								
ALS DRUG	MC/DEL		**RILUTEK TABS**				Use PA Form# 20420	
MUSCLE RELAXANTS	MC/DEL		**BACLOFEN TABS**	MC/DEL	6	**SKELAXIN TAB**		At least 4 preferred drugs (including tizanidine) must be tried for at least 2 weeks and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be

	MC/DEL		**CHLORZOXAZONE TABS**	MC/DEL	7	**ORPHENADRINE CITRATE**		approved, unless an…… acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Elderly patients, over 65, will require written notice of the increased sedative risks and impaired driving.Prior Authorization will not be given for:1. frequent or persistent early refills of controlled drugs; 2. multiple instances of early refill overrides due to reports of misplacement, stolen, dropped in toilet or sink, distant travel, etc.
	MC/DEL		**CYCLOBENZAPRINE HCL TABS**	MC/DEL	8	**CARISOPRODOL TABS**		
	MC		LIORESAL INTRATHECAL KIT	MC/DEL	8	AMRIX		
	MC/DEL		**METHOCARBAMOL TABS**	MC/DEL	8	DANTRIUM CAPS		
	MC/DEL		**TIZANIDINE HCL TABS**	MC	8	LIORESAL TABS		
				MC	8	LORZONE		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).
				MC/DEL	8	**METAXALONE**		
				MC	8	NORFLEX TBCR		Non-preferred products must be used in specified step order.
				MC	8	ROBAXIN-750 TABS		
				MC	8	VECUROMIUM INJ		
				MC/DEL	8	**ZANAFLEX TABS**		**Lorzone** is non preferred and requires at least 4 preferred drugs (including tizanidine) and step care therapy (orphenadrine), as well as reasons for why chlorzoxazone is not acceptable.
				MC/DEL	9	**SOMA TABS**	Use PA Form# 20420	
MUSCLE RELAXANT - COMBO.				MC/DEL		CARISOPRODOL/ASPIRIN TABS	Use PA Form# 20420	Individual components are available with PA described in the section above.1. frequent or persistent early refills of non-controlled drugs; 2. multiple instances of early refill overrides due to reports of misplacement stolen, dropped in toilet or sink, distant travel, etc.
				MC/DEL		CARISOPRODOL/ASPIRIN/CODE		
				MC		NORGESIC TABS		
				MC/DEL		ORPHENADRINE COMPOUND		
				MC/DEL		ORPHENADRINE/ASA/CAFF		
				MC		ORPHENGESIC		
VITAMINS								
VITAMINS	MC/DEL		ASCORBIC ACID TABS	MC		AQUASOL E SOLN	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **As listed in MaineCare Policy, certain drugs require specific diagnoses for approval.**
	MC		BIOTIN	MC		AQUAVIT-E SOLN	Please refer to OTC list.	
	MC		CYANOCOBALAMIN SOLN	MC		DHT SOLN		
	MC/DEL		FOLIC ACID TABS	MC		NASCOBAL GEL		
	MC/DEL		MEPHYTON TABS					Please refer to OTC list.
	MC/DEL		NIACIN					**DDI:** B-12 will now be non-preferred and require prior authorization if it is currently being used in combination with either Prevacid, pantoprazole, Prilosec, or any currently non preferred PPI.
	MC		NIACOR TABS					
	MC/DEL		NICOTINIC ACID SR CPCR					
	MC		PYRIDOXINE HCL TABS					Preferred products that used to require diag codes still require diag codes unless indicated otherwise.
	MC/DEL		SLO-NIACIN TBCR					
	MC/DEL		THIAMINE HCL SOLN					
	MC/DEL		VITAMIN B-1 TABS					
	MC/DEL		VITAMIN B-12					
	MC		VITAMIN B-6 TABS					
	MC/DEL		VITAMIN C					
	MC/DEL		VITAMIN E CAPS					
	MC/DEL		VITAMIN E/D-ALPHA CAPS					
	MC		VITAMIN K1 SOLN					
	MC		V-R VITAMIN E CAPS					
VITAMIN D's	MC/DEL		**CALCITRIOL CAPS**[1]	MC/DEL		**DRISDOL CAPS**	1. Diagnosis of dialysis (renal failure) required.	Preferred products require dialysis/renal failure diagnosis.
	MC/DEL		**VITAMIN D**	MC		CALCIJEX		Non-preferred products require: Secondary hyperparathyroidism in patients with Chronic Kidney Disease on dialysis., iPTH>400 pg/ml, Phosophorous ,6.5mg/dl, corrected calcium <12.2mg/dl, corrected calcium x phosphorous products <70mg^2/dl^2
	MC		ZEMPLAR TABS	MC/DEL		HECTOROL (ORAL)	Use PA Form# 20420	
				MC/DEL		HECTOROL (PARENTERAL)		
				MC/DEL		**ROCALTROL**		
				MC		ZEMPLAR INJ		
MISC MULTI-VITAMINS								
VITAMINS - MISC.	MC		CENTRUM LIQD	MC		ADEKS	1. Diag codes are no longer required on prenatal vitamins.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. As listed in MaineCare Policy, certain drugs require specific diagnoses for approval.
	MC		CENTRUM TABS	MC/DEL		ADVANCED NATALCARE TABS		
	MC		CENTRUM JR/IRON CHEW	MC		AQUADEKS		
	MC		CENTRUM SILVER TABS	MC		CENTRUM JR/EXTRA C CHEW	Please refer to OTC list.	
	MC		CENTRUM-LUTEIN TABS	MC		CENTRUM PERFORMANCE TABS		Please refer to OTC list.
	MC		CEROVITE ADVANCED FO TABS	MC		CITRANATAL	Use PA Form# 20420	
	MC/DEL		CHEWABLE MULTIVIT/FL CHEW	MC		DALYVITE LIQD		Preferred products that used to require diag codes still require diag codes unless indicated otherwise.
	MC		COD LIVER OIL CAPS	MC		EMBREX 600 MISC		
	MC		COMPLETE SENIOR TABS	MC		IBERET		

	MC	DAILY MULTI VIT/IRON	MC	MATERNA TABS			
	MC/DEL	DIALYVITE 1MG	MC	MAXARON			
	MC/DEL	DIALYVITE 800MG	MC	MULTIRET FOLIC -500 TBCR			
	MC	FERRALET 90	MC/DEL	NATAFORT TABS			
	MC/DEL	FULL SPECTRUM B	MC/DEL	NATALCARE CFE 60 TABS[1]			
	MC	M.V.I.-12 INJ	MC/DEL	NATALCARE GLOSS TABS[1]			
	MC	MULTI-VIT/FLUORIDE	MC	NATALCARE PIC TABS[1]			
	MC/DEL	NATALCARE RX TABS	MC	NATALCARE PIC FORTE TABS[1]			
	MC/DEL	NEPHRONEX	MC/DEL	NATALCARE PLUS TABS[1]			
	MC/DEL	O-CAL PRENATAL	MC	NATALCARE THREE TABS[1]			
	MC/DEL	ONE DAILY TABS	MC/DEL	NATACHEW CHEW			
	MC/DEL	ONE-DAILY MULTIVITAMINS	MC	NATALFIRST TABS			
	MC/DEL	ONE-TABLET-DAILY	MC	NATATAB RX TABS			
	MC/DEL	POLY-VIT/IRON/FLUORID SOLN	MC/DEL	NEPHPLEX RX TABS			
	MC/DEL	POLY-VITAMIN/FLUORIDE SOLN	MC/DEL	NEPHROCAPS CAPS			
	MC/DEL	POLY-VITAMINS/IRON SOLN	MC/DEL	NEPHRO-VITE TABS			
	MC/DEL	PRENATAL TABS[1]	MC	NESTABS RX TABS			
	MC/DEL	PRENATAL FORMULA 3 TABS[1]	MC/DEL	NIFEREX			
	MC/DEL	PRENATAL PLUS TABS[1]	MC/DEL	OCUVITE TABS			
	MC/DEL	PRENATAL PLUS NF TABS[1]	MC	POLY-VI-FLOR SOLN			
	MC	PRENATAL PLUS/27MG IRON[1]	MC	POLY-VI-SOL SOLN			
	MC	PRENATAL PLUS/IRON TABS[1]	MC	POLY-VI-SOL/IRON SOLN			
	MC/DEL	PRENATAL RX/BETA-CAROTENE[1]	MC	POLY-VITAMIN DROPS SOLN			
	MC/DEL	RENAL CAPS	MC	PRECARE			
	MC/DEL	RENAPHRO CAPS	MC	PREFERA OB			
	MC	STRESS TAB NF TABS	MC	PREMESIS RX TABS			
	MC	THERAPEUTIC-M TABS	MC	PRENATABS CBF TABS[1]			
	MC	THERAVITE LIQD	MC	PRENATAL CARE TABS[1]			
	MC/DEL	TRI-VITAMIN/FLUORIDE SOLN	MC	PRENATAL MR 90 TBCR[1]			
	MC	VITA CON FORTE CAPS	MC/DEL	PRENATAL MTR/SELENIUM TABS[1]			
	MC	VITAMIN B COMPLEX CAPS	MC	PRENATAL OPTIMA ADVANCE TABS[1]			
	MC	VITAPLEX PLUS TABS	MC	PRENATAL PC 40 TABS[1]			
			MC/DEL	PRENATAL RX TABS[1]			
			MC	PRENATE[1]			
			MC	PRENATE ELITE[1]			
			MC	PRIMACARE MISC			
			MC	PROTEGRA CAPS			
			MC	STUARTNATAL PLUS 3 TABS[1]			
			MC	TRI-VI-SOL SOLN			
			MC	TRI-VI-SOL/IRON SOLN			
			MC/DEL	ULTRA NATALCARE TABS			
			MC	ULTRA-NATAL TABS[1]			
			MC	VICON FORTE CAPS			
			MC	VINATAL FORTE TABS[1]			
			MC	VINATE[1]			
			MC/DEL	VINATE ADVANCED TABS[1]			
MISCELLANEOUS MINERALS							
MINERALS	MC	CALCARB	MC	ANEMAGEN	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. As listed in MaineCare Policy, certain drugs require specific diagnoses for approval.	
	MC	CALCI-MIX CAPSULE CAPS	MC	CALCET TABS	Please refer to OTC list.		
	MC	CALCIQUID SYRP	MC/DEL	**CALCIUM 600-D TABS**			
	MC	CALCITRATE/VITAMIN D TABS	MC	CALCIUM/VITAMIN D TABS			
	MC/DEL	CALCIUM	MC	CALTRATE 600 PLUS/VIT D TABS			
	MC/DEL	CALCIUM CARBONATE	MC	CALTRATE PLUS TABS		**DDI:** Fe salts will now be non-preferred and require prior authorization if it is currently being used in combination with either Prevacid, pantoprazole, Prilosec, or any currently non preferred PPI.	
	MC/DEL	CALCIUM CITRATE TABS	MC	CHROMAGEN			
	MC/DEL	CALCIUM GLUCONATE TABS	MC	CITRACAL PLUS TABS			
	MC/DEL	CALCIUM LACTATE TABS	MC	CONTRIN CAPS		Please refer to OTC list.	

MC		CALCIUM/MAGNESIUM TABS	MC		FEOGEN FORTE CAPS		
MC/DEL		**CALCIUM/VITAMIN D TABS**	MC		FEROCON CAPS		Preferred products that used to require diag codes still require diag codes unless indicated otherwise.
MC		CALTRATE 600 TABS	MC/DEL		FERREX 150 CAPS		
MC/DEL		CHEWABLE CALCIUM CHEW	MC		FERRO-SEQUELS TBCR		
MC		CITRACAL TABS	MC		FE-TINIC CAPS		
MC		CITRACAL + D TABS	MC		FE-TINIC 150 FORTE CAPS		
MC		CITRUS CALCIUM TABS	MC/DEL		FLUOR-A-DAY SOLN		
MC		CITRUS CALCIUM 1500 + D TABS	MC/DEL		K-DUR TBCR		
MC		MC/DEL	MC		KLOR-CON PACK		
MC		EFFERVESCENT POTASSIUM TBEF	MC		K-LYTE		
MC/DEL		FEOSTAT CHEW	MC/DEL		K-PHOS TABS NEUTRAL		
MC		FERATAB TABS	MC		K-TABS TBCR		
MC/DEL		FER-GEN-SOL SOLN	MC		K-VESCENT PACK		
MC		FER-IRON SOLN	MC		MICRO-K 10 MEG CPCR		
MC		FERRONATE TABS	MC		NU-IRON 150 CAPS		
MC/DEL		FERROUS SULFATE	MC/DEL		**OYSTER SHELL CALCIUM/VITA TABS**		
MC/DEL		FLUOR-A-DAY CHEW	MC/DEL		POLY-IRON 150 CAPS		
MC		FLUORIDE CHEW	MC/DEL		POLYSACCHARIDE IRON CAPS		
MC		FLUORIDE SODIUM CHEW	MC/DEL		POTASSIUM BICARB/CHLORIDE		
MC		FLUORITAB CHEW	MC/DEL		POTASSIUM CHLORIDE 10MEQ CAPS		
MC		HEMOCYTE TABS	MC/DEL		POTASSIUM CHLORIDE 8MEQ CAPS		
MC		HM CALCIUM TABS	MC/DEL		SLOW FE TBCR		
MC		K+ POTASSIUM PACK	MC		TUMS 500 CHEW		
MC		KAON ELIX	MC		VIACTIV CHEW		
MC		KAON-CL-10 TBCR					
MC		KCL 0.075%/D5W/NACL 0.2% SOLN					
MC		K-EFFERVESCENT TBEF					
MC		KLOR-CON					
MC		KLOTRIX TBCR					
MC/DEL		K-PHOS TABS					
MC/DEL		K-VESCENT TBEF					
MC/DEL		LURIDE CHEW					
MC/DEL		MAGNESIUM GLUCONATE TABS					
MC/DEL		MAGNESIUM SULFATE SOLN					
MC		MAGTABS					
MC		MICRO-K 8 MEG					
MC/DEL		OS-CAL TABS					
MC/DEL		**OS-CAL 500 + D TABS**					
MC/DEL		**OYSCO**					
MC/DEL		OYST-CAL TABS					
MC/DEL		**OYST-CAL D TABS**					
MC/DEL		**OYST-CAL/VITAMIN D TABS**					
MC/DEL		OYSTER CALCIUM TABS					
MC/DEL		OYSTER SHELL					
MC		PHARMA FLUR					
MC/DEL		PHOSPHA 250 NEUTRAL TABS					
MC		POTASSIUM BICARBONATE TBEF					
MC/DEL		POTASSIUM CHLORIDE 8MEQ					
MC		POTASSIUM EFFERVESCENT					
MC/DEL		SELENIUM TABS					
MC		SLOW-MAG TBCR					
MC/DEL		SODIUM FLUORIDE					
MC/DEL		SSKI SOLN					
MC		V-R CALCIUM					
MC		V-R OYSTER SHELL CALCIUM					
MC		ZINC SULFATE CAPS					

MISC. ELECTROLYTES/NUTRITIONALS								
ELECTROLYTES/ NUTRITIONALS	MC		INTRALIPID EMUL[1]	MC		BOOST[1]	1. This list of nutritionals is incomplete. All nutritionals still require a PA except for the miscellaneous products listed as preferred. SGA form required for nutritionals unless member has a G/I tube.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **As listed in MaineCare Policy, certain drugs require specific diagnoses for approval.**
	MC		P.T.E. -5 SOLN[1]	MC		CASEC POWD[1]		
	MC/DEL		SEA-OMEGA CAPS[1]	MC		CHOICE DM LIQD[1]		Medical foods are not to be authorized solely for the purpose of enhancing nutrient intake or managing body weight if the participant is able to eat conventional foods adequately. Medical foods may be approved if the member has a medical condition which precludes or restricts the use of conventional foods and necessitates the use of a formula. Concurrent Stimulant therapy is not an acceptable medical reason/condition for use of medical foods for enhancing nutrient intake or managing body weight.
				MC		DELIVER 2.0 LIQD[1]		
				MC		ENFAMIL[1]		
				MC		ENSURE[1]		
				MC		GLUCERNA[1]		
				MC		ISOCAL LIQD[1]		
				MC		KINDERCAL TF LIQD[1]		
				MC		KINDERCAL TF/FIBER LIQD[1]	2. Formerly known as Omacor.	For children under the age of 5, MaineCare will not provide milk- or soy-based standard infant formulas. Regular formulas may be sought through your nearest WIC office. MaineCare will continue to cover medical food for all participants in MaineCare when medical necessity is met.
				MC/DEL		L-CARNITINE CAPS[1]		
				MC		LIPISORB LIQD[1]		
				MC		LOVAZA[1,2]	Use PA Form# 20420 & SGA Form	
				MC		MODULEN IBD POWD[1]		Vascepa requires adjunct therapy for specific indication to reduce TG in those with severe hypertriglyceridemia (500mg per deciliter or more). Proper indication per lab values is required before approval
				MC		NUTRAMIGEN POWD[1]		
				MC/DEL		NUTREN[1]		
				MC		NUTRITIONAL SUPPLEMENT LIQD[1]		
				MC		NUTRIVENT 1.5 LIQD[1]		
				MC/DEL		PEPTAMEN[1]		
				MC		PHENYLADE[1]		
				MC		PHENYL-FREE[1]		
				MC		PKU 3 POWD[1]		
				MC		PREGESTIMIL POWD[1]		
				MC/DEL		PROBALANCE LIQD[1]		
				MC		PROSOBEE[1]		
				MC		SCANDISHAKE PACK[1]		
				MC		VASCEPA		
ERYTHROPOEITINS								
ERYTHROPOEITINS	MC		PROCRIT SOLN[1]	MC	6	EPOGEN SOLN	Use PA Form# 10520	Non-Preferred drugs must be tried and failed in step-order, due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Please see the EPO PA form for other approval and renewal criteria.
				MC	8	ARANESP SOLN	1. Clinical PA is required to establish medical necessity and that appropriate lab monitoring is being done.	
				MC/DEL	8	OMONTYS		
GRANULOCYTE CSF								
GRANULOCYTE CSF				MC	8	LEUKINE	1. Must be used in specified step order.	See approval criteria detailed on Neupogen PA form.
				MC	8	NEUPOGEN SOLN[2]	2.10 day supply/month may be used without a PA.	
				MC	9	NEULASTA[1]	Use PA Form# 20520	
ANTICOAGULANTS / PLATELET AGENTS								
ANTICOAGULANTS	MC		ARIXTRA SOLN[1]	MC/DEL		ELIQUIS	1. Arixtra, Fragmin and Lovenox therapy durations greater than 7 days require PA.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Exceeding days supply limits for LMWH class requires PA.
	MC		COUMADIN TABS	MC/DEL		ENOXAPARIN		
	MC/DEL		FRAGMIN INJ[1]	MC/DEL		FONDAPARINUX		
	MC		HEPARIN SODIUM/NACL 0.9% SOLN	MC		IPRIVASK		**DDI:** Warfarin will require prior authorization if being used in combination with fluconazole, miconazole, or voriconazole.
	MC		HEP-LOCK SOLN	MC/DEL		JANTOVEN		
	MC/DEL		**INNOHEP**	MC/DEL		LOVENOX 300[2]	2. Use other strengths available to obtain desired dose.	
	MC/DEL		**LOVENOX SOLN[1]**	MC/DEL		PRADAXA[3]		**DDI:** Warfarin will require prior authorization if being used in conjunction with Gemfibrozil or Fenofibrate.
	MC		HEPARIN LOCK SOLN	MC/DEL		**WARFARIN SODIUM TABS[4]**		
	MC/DEL		HEPARIN LOCK FLUSH SOLN	MC/DEL			3. Please refer to Pradaxa PA form for criteria.	Current Warfarin Sodium Tab
						XARELTO		

	MC/DEL		HEPARIN SODIUM SOLN				4.Established users will be grandfathered, new starters must use preferred product Coumadin.	
	MC/DEL		HEPARIN SODIUM LOCK FLUSH SOLN				Use PA form# 20725 for Pradaxa requests Use PA form# 20420 for other requests	
ANTIHEMOPHILIC AGENTS	MC		ALPHANATE	MC		ADVATE[1,2]	1. Only if other products unavailable. 2. Advate may be available with PA in cases of large volume dosing in patients with poor venous access.	Non-preferred will only be approved if other preferred products are unavailable.
	MC		ALPHANINE SD	MC		KOATE-DVI		
	MC/DEL		BENEFIX SOLR					
	MC/DEL		HELIXATE FS KIT					
	MC		HEMOFIL - M					
	MC		HUMATE-P SOLR					
	MC		KOGENATE FS					
	MC		KONYNE - 80					
	MC		MONARC - M					
	MC		MONOCLATE - P				Use PA Form# 20420	
	MC		MONONINE					
	MC		NOVOSEVEN SOLR					
	MC/DEL		PROFILNINE					
	MC		RECOMBINATE SOLR					
	MC		REFACTO					
	MC		WILATE INJ					
PLATELET AGGREGATION INHIBITORS	MC/DEL		ASPIRIN	MC/DEL	7	TICLOPIDINE HCL TABS	Use PA Form# 20715 for Plavix,Effent & 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.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. A special PA may be obtained at the pharmacy for members scheduled for "stent" placement or have had placement if in the last 12months. Please indicate on prescription date of stent placement. **DDI:** Plavix will require prior authorization if being used in combination with omeprazole, esomeprazole, cimetidine, fluconazole, ketoconazole, intelence, fluoxetine, ticlopidine, and fluvoxamine. **DDI:** exists for using maintenance ASA dose >100mg, as it reduces the effectiveness of Brilinta Brilianta- Concomitant use with strong CYP3A4 inhibitors should be avoided (including ketoconazole, itraconazole, atazanavir, and telithromycin). Doses of simvastatin and lovastatin >40mg should be avoided.
	MC/DEL		**DIPYRIDAMOLE TABS**	MC	8	EFFIENT[1]		
	MC/DEL		**CLOPIDOGREL 75MG**	MC/DEL	8	PERSANTINE TABS		
				MC/DEL	8	BRILINTA[1,2]		
				MC/DEL	8	PLAVIX TABS[1]		
PLATELET AGGR. INHIBITORS / COMBO'S - MISC.	MC/DEL		**AGGRENOX**	MC/DEL		**AGRYLIN CAPS**	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**CILOSTAZOL**	MC/DEL		**ANAGRELIDE CAPS**		
	MC/DEL		PENTOXIFYLLINE ER TBCR	MC/DEL		**PLETAL TABS**		
				MC		TRENTAL TBCR		
HEMATOLOGICALS								
MONOCLONAL ANTIBODY				MC		SOLIRIS	Use PA Form# 20420	A diagnosis of Paroxysmal nocturnal hemoglobinuria (PNH) using the HAM test or flow cytometry is required. In addition, the patient must show evidence of having received a meningitis vaccine at least 2 weeks prior to the start of therapy.
BRADYKININ B2 RECEPTOR ANTAGONIST				MC		FIRAZYR	Use PA Form# 20420	
HEMATOLOGICAL AGENTS-THROMBOPOIETIN RECEPTOR AGONISTS				MC/DEL	7	PROMACTA	Use PA Form# 20420	Clinical PA required. Must see prior trial with insufficient response to corticosteroids and immunoglobulins.
				MC	8	NPLATE		
HEMOSTATIC								

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

	MC/DEL		FLAREX SUSP	MC		EFLONE SUSP		
	MC/DEL		FLUOROMETHOLONE SUSP	MC		FLUOR-OP SUSP		
	MC		FML S.O.P. OINT	MC/DEL		LOTEMAX SUSP		
	MC/DEL		NEOM/POLIN/DEX	MC		MAXITROL		
	MC		PRED MILD SUSP	MC		NEO/POLY/BAC/HC OINT		
	MC/DEL		PREDNISOLONE	MC/DEL		OZURDEX		
	MC/DEL		TOBRADEX	MC		PRED FORTE SUSP		
				MC		PRED-G SUSP		
				MC		PRED-G S.O.P. OINT		
				MC/DEL		SULFACET SOD/PRED SOLN		
				MC/DEL		TOBRADEX ST		
				MC/DEL		TOBRAMYCIN SUSP DEXAMETHASONE		
				MC		VASOCIDIN SOLN		
				MC/DEL		VEXOL SUSP		
OP. - PROSTAGLANDINS	MC/DEL		**LATANOPROST SOL 0.005%**	MC/DEL	7	XALATAN SOLN[1]	1. All preferreds must be tried. 2. Dosing limits apply, please see dosing consolidation list. 3. Clinical PA is required to establish diagnosis and medical necessity. Use PA Form# 20420	Preferred drugs must be tried and failed, in step-order, due to lack of efficacy (failure to reach target IOP reduction) or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**TRAVATAN-Z**	MC	8	LUMIGAN SOLN[1]		
				MC	8	RESCULA[1,2,3]		
				MC/DEL	8	**TRAVATAN SOLN**		
				MC/DEL	8	**ZIOPTAN**		
OP. - CYCLOPLEGICS	MC		AK-PENTOLATE SOLN	MC/DEL		CYCLOGYL SOLN	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		ATROPINE SULFATE	MC		ISOPTO ATROPINE SOLN		
	MC/DEL		CYCLOPENTOLATE HCL SOLN	MC/DEL		ISOPTO HOMATROPINE SOLN		
	MC/DEL		ISOPTO HYOSCINE SOLN	MC		MUROCOLL-2 SOLN		
OP. - MIOTICS - DIRECT ACTING	MC/DEL		**ISOPTO CARBACHOL SOLN**				Use PA Form# 20420	
	MC		ISOPTO CARPINE SOLN					
	MC		PILOCAR SOLN					
	MC/DEL		**PILOCARPINE HCL SOLN**					
	MC/DEL		**PILOPINE HS GEL**					
OP. - ADRENERGIC AGENTS	MC/DEL		**DIPIVEFRIN HCL SOLN**	MC		PROPINE SOLN	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		EPIFRIN SOLN					
OP. - SELECTIVE ALPHA ADRENERGIC AGONISTS	MC		ALPHAGAN P 0.15% SOLN	MC		ALPHAGAN SOLN	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		SIMBRINZA	MC		ALPHAGAN P 0.1% SOLN		
				MC/DEL		BRIMONIDINE 0.2%		
				MC/DEL		**IOPIDINE SOLN**		
OP. - ANTI-ALLERGICS	MC/DEL		PATADAY SOLN	MC	8	ALOCRIL SOLN	Use PA Form# 20420	All preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		PATANOL SOLN	MC/DEL	8	ALOMIDE SOLN		
				MC	8	BEPREVE		
				MC	8	ELESTAT		
				MC/DEL	8	EMADINE SOLN		
				MC	8	LASTACAFT		
				MC/DEL	8	OPTIVAR		
				MC	8	OPTICROM SOLN		
				MC/DEL	8	ZADITOR SOLN		
				MC/DEL	9	EPINASTINE		
OP. ANTI-ALLERGICS- MASTCELL STABILIZER CLASS				MC/DEL		ALAMAST SOLN	Use PA Form# 20420	
OP. - CARBONIC ANHYDRASE INHIBITORS/COMBO	MC/DEL		**AZOPT SUSP**	MC/DEL		**COSOPT SOLN PF**	Use PA Form# 20420	
	MC		COMBIGAN	MC/DEL		**TRUSOPT SOLN**		
	MC/DEL		DORZOLAMIDE					
	MC/DEL		DORZOLAMIDE/TIMOLOL					
OP. - NSAID'S	MC		FLURBIPROFEN SODIUM SOLN	MC	8	ACULAR LS[1]	1. Must fail all preferred	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered

	MC/DEL		DICLOFENAC OPTH 0.1%	MC	8	ACULAR SOLN[1]	products before non-preferred.	on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		KETOROLAC OPTH 0.4%	MC/DEL	8	ILEVRO		
	MC/DEL		KETOROLAC OPTH 0.5%	MC/DEL	8	PROLENSA		
				MC/DEL	8	NEVANAC[1]		
				MC	8	OCUFEN SOLN[1]		
				MC	8	XIBROM[1]		
				MC	8	VOLTAREN SOLN[1]		
				MC	8	ACUVAIL[1]		
				MC/DEL	9	BROMFENAC	Use PA Form# 20420	
OP. - OF INTEREST	MC/DEL		ENUCLENE SOLN	MC		BOTOX SOLR	1. Must have kerato conjuctivitus sicca and failed other dry eye therapies.	Must fail adequate trials of multi agents from artificial tears and lubricant category.
				MC		RESTASIS[1]		
							Use PA Form# 20420	
DERMATOLOGICAL								
TOPICAL - ORAL	MC		AMNESTEEM[1]				1. Users 24 or under, PA will not be required.	
	MC		CLARAVIS[1]					
	MC		SOTRET[1]				Use PA Form# 20420	
TOPICAL - ACNE PREPARATIONS	MC		AZELEX CREA[4]	MC		ACZONE	1. Users 24 or under, PA will not be required.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		BENZOYL PEROXIDE	MC		ALTINAC CREA		
	MC/DEL		CLINDAMYCIN PHOSPHATE [2]	MC		AVITA CREA	2. Dosing limits allowing one package per month. Please refer to Dose Consolidation List.	
	MC		ERYDERM SOLN	MC		BENZAC		
	MC/DEL		ERYTHROMYCIN GEL	MC/DEL		BENZACLIN GEL[3]		
	MC/DEL		ERYTHROMYCIN PADS	MC/DEL		BENZAGEL-10 GEL		
	MC/DEL		ERYTHROMYCIN SOLN	MC/DEL		BENZAMYCIN GEL	3. Only available if component ingredients are unavailable.	
	MC		ISOTRETINOIN	MC/DEL		BENZAMYCINPAK PACK		
	MC		METRONIDAZOLE CREA[2]	MC		BENZEFOAM		
	MC		METRONIDAZOLE GEL[2]	MC		BREVOXYL		
	MC		METRONIDAZOLE LOTN[2]	MC/DEL		CLEOCIN-T[2]		
	MC/DEL		SODIUM SULFACET/SULF LOTN	MC		CLINAC BPO GEL		
				MC		CLINDAGEL GEL	4. Dosing limits apply, please see dosing consolidation list.	
	MC		TAZORAC					
	MC/DEL		TRETINOIN GEL[1]	MC		CLINDETS SWAB	Use PA Form# 10220 for Brand Name requests	
	MC		TRETINOIN CREA[1,2]	MC		DESQUAM-E GEL		
				MC		DESQUAM-X		
				MC		DIFFERIN 0.3% GEL	Use PA Form# 20420 for all other requests	
				MC		DIFFERIN		
				MC		DUAC GEL		
				MC		EMGEL GEL		
				MC		EPIDUO		
				MC		ERYCETTE PADS		
				MC/DEL		EVOCLIN		
				MC		FINEVIN CREA		
				MC/DEL		KLARON LOTN		
				MC		METROCREAM CREA[2]		
				MC		METROGEL GEL[2]		
				MC		METROLOTION LOTN[2]		
				MC		NEOBENZ MICRO		
				MC/DEL		NORITATE CREA		
				MC		RETIN-A GEL[2]		
				MC		RETIN-A CREA[2]		
				MC		RETIN-A MICRO GEL		
				MC/DEL		TRIAZ		
				MC		VELTIN		
				MC		ZENCIA WASH		
				MC		ZETACET		

				MC/DEL		ZIANA		
TOPICAL - ANTIBIOTIC	MC		BACIT/NEOMYCIN/POLYM OINT	MC/DEL		ALTABAX[1]	1. Dosing limits apply, please see dosing consolidation list. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		BACITRACIN OINT	MC/DEL		BACTROBAN OINT.		
	MC/DEL		BACTROBAN CREA[1]	MC/DEL		TRIPLE ANTIBIOTIC OINT		
	MC/DEL		BACTROBAN NASAL OINT					
	MC/DEL		CENTANY OINT 2%[1]					
	MC/DEL		GENTAMICIN SULFATE					
	MC/DEL		MUPIROCIN[1]					
TOPICAL - ANTIFUNGALS	MC/DEL		BETAMETHASONE CLOTRIMAZOLE LOT	MC/DEL	8	BETAMETHASONE CLOTRIMAZOLE CREA	Use PA Form# 10120	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **DDI:** Ketoconazole will now be non-preferred and require prior authorization if they are currently being used in combination with any of the following medications: Prevacid, pantoprazole, Onglyza or Omeprazole.
	MC		CICLOPIROX 0.77 CREA	MC/DEL	8	CICLOPIROX SOLN		
	MC		CICLOPIROX 0.77 SUSP	MC	8	EXELDERM		
	MC/DEL		CLOTRIMAZOLE	MC	8	FUNGIZONE CREA		
	MC		ECONAZOLE NITRATE CREA	MC/DEL	8	HYDROCORT/IODOQ CREA		
	MC/DEL		KETOCONAZOLE CREA	MC/DEL	8	LAMISIL		
	MC/DEL		KETOCONAZOLE SHAM	MC/DEL	8	LOPROX 0.77 LOTN		
	MC/DEL		LOPROX 1.0 CREA	MC/DEL	8	LOPROX 0.77 CREA		
	MC/DEL		LOPROX 1.O LOTN	MC/DEL	8	LOPROX 0.77 SUSP		
	MC/DEL		LOPROX GEL	MC/DEL	8	LOPROX SHAMPOO SHAM		
	MC/DEL		LOPROX TS LOTN	MC	8	LOTRIMIN		
	MC/DEL		LOTRISONE CREA	MC/DEL	8	LOTRISONE LOT		
	MC/DEL		MICONAZOLE NITRATE CREA	MC/DEL	8	MENTAX CREA		
	MC		MYCO-TRIACET II CREA	MC	8	MYCOGEN II CREA		
	MC/DEL		NYSTATIN	MC	8	NAFTIN		
	MC/DEL		NYSTATIN/TRIAMCINOLONE	MC	8	NIZORAL SHAM		
	MC/DEL		NYSTOP POWD	MC	8	NYSTAT-RX POWD		
	MC		PEDI-DRI POWD	MC/DEL	8	OXISTAT		
	MC/DEL		TINACTIN	MC/DEL	9	PENLAC NAIL LACQUER SOLN		
	MC		TRI-STATIN II CREA					
TOPICAL - ANTIPRURITICS	MC		ZONALON CREA	MC		PRUDOXIN CREA	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
TOPICAL - ANTIPSORIATICS	MC/DEL		SORIATANE CAPS	MC		OXSORALEN ULTRA CAPS[1]	1. Must fail all preferred products before non-preferred. 2. Individual ingredients are available as preferred witout PA. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		TAZORAC	MC		PSORIATEC CREA[1]		
				MC/DEL		SORIATANE CK KIT[1]		
				MC/DEL		TACLONEX[1,2]		
				MC		VECTICAL[1]		
TOPICAL - ANTISEBORRHEICS	MC/DEL		SELENIUM SULFIDE SHAM	MC		CARMOL SCALP TREATMENT KIT	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
				MC		ZNP BAR		
TOPICAL - ANTIVIRALS				MC/DEL		DENAVIR CREA[1, 3]	1. Must fail oral treatment with Acyclovir or Valtrex. 2. Approvals limited to 1 tube per 180 days. 3. Dosing limits apply, please see dosing consolidation list. Use PA Form# 20420	
				MC		ZOVIRAX OINT[1,2]		
TOPICAL - ANTINEOPLASTICS	MC		EFUDEX	MC/DEL		CARAC CREA	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		FLUOROPLEX CREA	MC/DEL		FLUOROURACIL		
				MC		SOLARAZE GEL		
				MC/DEL		ZYCLARA		

TOPICAL - BURN PRODUCTS	MC		FURACIN CREA	MC/DEL		SILVADENE CREA	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		SILVER SULFADIAZINE CREA					
	MC		SSD AF CREA					
	MC		SSD CREA					
	MC/DEL		THERMAZENE CREA					
TOPICAL - CORTICOSTEROIDS			**LOW POTENCY**	MC/DEL		ACLOVATE	Use PA Form# 20420 1. Dosing limits apply, please see dosing consolidation list.	At least 1 drug from each potency of preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		DESOWEN[1]	MC		AMCINONIDE CREA		
	MC/DEL		HYDROCORTISONE CREA	MC		ANUSOL HC-1 OINT		
	MC		HYDROCORTISONE LOTN	MC/DEL		**CLOBETASOL PROPINATE LOTN**		
	MC		LACTICARE-HC LOTN	MC		CLODERM CREA		
	MC		NUTRACORT LOTN	MC/DEL		CORDRAN		
	MC		TEXACORT SOLN	MC/DEL		CORMAX		
				MC/DEL		CUTIVATE CREA / OINT		
			MEDIUM POTENCY	MC/DEL		CUTIVATE LOTN		
	MC/DEL		DESOXIMETASONE .05%	MC		DERMA-SMOOTHE/FS OIL		
	MC/DEL		ELOCON	MC/DEL		DERMATOP		
	MC/DEL		FLUOCINOLONE ACETONIDE .025-.01%	MC		DESONATE GEL		
	MC		FLUROSYN CREA	MC/DEL		DIPROLENE		
	MC		FLUTICASONE PROPIONATE CREA/OINT	MC		ELOCON OINT		
	MC		HYDROCORTISONE BUTYRATE	MC		HYDROCORTISONE POWD		
	MC		HYDROCORTISONE OINT	MC		KENALOG AERS		
	MC		HYDROCORTISONE VALERATE	MC		LIDA MANTLE HC CREA		
	MC		MOMETASONE FUROATE OINT	MC/DEL		LOCOID		
	MC/DEL		TRIAMCINOLONE ACETONIDE .025-.1%	MC/DEL		LUXIQ FOAM		
				MC/DEL		OLUX FOAM		
			HIGH POTENCY	MC		PANDEL CREA		
	MC/DEL		BETAMETHASONE DIPROPIONATE	MC		PROCTOCORT CREA		
	MC		CLOBEX LOTN	MC/DEL		PSORCON		
	MC/DEL		DESOXIMETASONE .25%	MC/DEL		PSORCON E		
	MC/DEL		DESONIDE[1]	MC/DEL		TEMOVATE		
	MC/DEL		FLUOCINOLONE ACETONIDE .02%	MC		TOPICORT		
	MC/DEL		FLUOCINONIDE	MC		TOPICORT LP CREA		
	MC		HALOG	MC		ULTRAVATE		
	MC		HALOG-E CREA	MC/DEL		VERDESO		
	MC/DEL		TRIAMCINOLONE ACETONIDE .5%	MC		WESTCORT		
			VERY HIGH POTENCY					
	MC/DEL		AUGMENTED BETA DIP					
	MC/DEL		BETAMETHASONE VALERATE					
	MC/DEL		BETA-VAL					
	MC		DIFLORASONE DIACETATE					
	MC		HALOBETASOL					
			MISCELLANEOUS					
	MC		CAPEX SHAM					
	MC		PROCTO-KIT CREA 1%					
TOPICAL - STEROID LOCAL ANESTHETICS				MC		EPIFOAM FOAM	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
TOPICAL - STEROID COMBINATIONS	MC		DERMA-SMOOTHE/FS ATOPIC P KIT	MC		CARMOL-HC CREA	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
TOPICAL - EMOLLIENTS	MC/DEL		AMMONIUM LACTATE CREA[1]	MC		LAC-HYDRIN CREA[1]	Use PA Form# 20420 1. Dosing limits still apply. Please see dose consolidation list.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		AMMONIUM LACTATE LOTN 12%[1]	MC		LAC-HYDRIN LOTN 12%		
	MC		UREACIN-20 CREA	MC		MEDERMA GEL		
	MC		VITAMIN A & D MEDICATED OINT	MC		MIMYX		
				MC		RENOVA CREA		

TOPICAL - ENZYMES / KERATOLYTICS / UREA	MC MC/DEL MC MC		GRANUL-DERM AERS GRANULEX AERS TBC AERS SANTYL OINT	MC MC MC		CARMOL 40 CREA SALEX CREA SALEX LOTN	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Ziox, Panafil and Papain products have been removed from the PDL due to FDA safety concerns regarding drugs containing Papain.
TOPICAL - GENITAL WARTS	MC/DEL		IMIQUIMOD[2]	MC/DEL MC/DEL MC/DEL MC MC MC	5 8 8 8 8 8	PODOFILOX SOLN ALDARA CONDYLOX[1] PICATO 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				MC/DEL MC	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.	Preferred corticosteroids from other classes must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Approvals will be made for small amounts of non-preferred products for the treatment of very steroid-sensitive areas in conjunction with topical steroids for the treatment of atopic dermatitis.
TOPICAL - LOCAL ANESTHETICS	MC MC/DEL MC MC/DEL MC/DEL		AF CAPSICUM OLEORESIN CREA CAPSAICIN CREA ELA-MAX[1] LIDOCAINE/PRILOCAINE CREA[1] LIDOCAINE GEL	MC/DEL MC/DEL MC MC MC MC MC		EMLA PADS EMLA CREA LIDA MANTLE CREA LIDODERM PTCH PONTOCAINE SOLN SYNERA ZOSTRIX	1. Lidocaine/Prilocaine cream and Ela-Max products require PA for users over 18 years of age. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
TOPICAL - DEPIGMENTING AGENTS				MC MC MC MC/DEL MC/DEL MC MC MC	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	Use PA Form# 20420	As per Medicaid Policy, cosmetic drugs are not covered. Non-cosmetic clinical applications will be considered by prior authorization on a case by case basis.
TOPICAL - SCABICIDES AND PEDICULICIDES	MC/DEL MC MC MC MC/DEL MC/DEL MC	1 1 1 1 1 1 2	ACTICIN CREA ELIMITE CREA EURAX LICE KILLING SHAM LICE TREATMENT CREME RINS LIQD PERMETHRIN LOTN NATROBA[1,2]	MC/DEL MC MC MC MC		LINDANE MALATHION OVIDE LOTN SKLICE ULESFIA	Use PA Form# 20420 1. Dosing limits apply, please refer to dosage consolidation list. 2. Will require two failed trials of permethrin.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
TOPICAL - WOUND / DECUBITUS CARE				MC MC/DEL MC/DEL		REGRANEX GEL REGENECARE RADIAPLEXRX	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Regranex will be approved for diabetic patients in good control (hgba1c <8), who are not smoking, with a stage III or IV WOCN AND NPUAP lower extremity diabetic ulcer and with an adequate blood supply (Tcp 02 >30, ABI>0.7 or ASP> 70), and where the underlying cause has been corrected. The wound must be free of infection and have been previously treated with preferred standard therapies for at least 2 months. Maximum approval for 20 weeks. Accuzyme and Ethezyme products have been removed from the PDL due to FDA concerns regarding drugs containing Papain.
TOPICAL - ASTRINGENTS / PROTECTANTS	MC MC		ALUMINUM CHLORIDE SOLN DRYSOL SOLN[1]	MC MC		LOWILA BAR MOISTURIN DRY SKIN CREA	Use PA Form# 20420 1. Dosing limits apply,	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.

	MC		XERAC AC SOLN	MC		PROSHIELD PLUS SKIN PROTE CREA	please refer to dosage consolidation list.	preferred drug(s) exists.
				MC		SURGILUBE GEL		
TOPICAL - ANTISEPTICS / DISINFECTANTS	MC/DEL		PHISOHEX LIQD	MC		BETADINE OINT	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		POVIDONE-IODINE SOLN	MC		FORMALYDE-10 AERS		
				MC		IODOSORB		
				MC		LAZERFORMALYDE SOLUTION SOLN		
MISCELLANEOUS EYE								
OP. - EYE	MC		AK-DILATE SOLN	MC		LENS PLUS REWETTING DROPS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		EYE WASH SOLN	MC/DEL		MURO 128		
	MC		NAPHAZOLINE HCL SOLN	MC		NEO-SYNEPHRINE SOLN		
	MC		PHENYLEPHRINE HCL SOLN					
	MC		PONTOCAINE SOLN					
	MC/DEL		SODIUM CHLORIDE					
MISCELLANEOUS EAR								
EAR	MC/DEL		A/B OTIC SOLN	MC		AERO OTIC HC SOLN	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		ACETASOL SOLN	MC		ANTIBIOTIC EAR SOLN		
	MC/DEL		ACETASOL HC SOLN	MC		ANTIBIOTIC EAR SUSP		
	MC/DEL		ACETIC ACID	MC		AURALGAN SOLN		
	MC/DEL		ACETIC ACID/HYDROCORTISON	MC		CETRAXAL		
	MC/DEL		ALLERGEN SOLN	MC/DEL		CIPRO HC SUSP		
	MC/DEL		ANTIPYRINE/BENZOCAINE SOLN	MC		COLY-MYCIN-S SUSP		
	MC/DEL		AURODEX SOLN	MC/DEL		CORTISPORIN-TC SUSP		
	MC		AUROGUARD SOLN	MC/DEL		DEBROX SOLN		
	MC/DEL		AUROTO OTIC SOLN	MC		DERMOTIC		
	MC		CARBAMIDE PEROXIDE 6.5% OTIC SOLN.	MC/DEL		PEDIOTIC SUSP		
	MC/DEL		CIPRODEX	MC		VOSOL-HC SOLN		
	MC		CORTISPORIN SOLN	MC/DEL		ZOTANE HC SOLN		
	MC/DEL		CORTOMYCIN	MC		ZOTO-HC SOLN		
	MC		EAR DROPS SOLN					
	MC		EAR DROPS RX SOLN					
	MC/DEL		EAR WAX REMOVAL DROPS					
	MC		EAR-GESIC SOLN					
	MC/DEL		NEOMYCIN/POLYMYXIN/HC					
	MC/DEL		OFLOXACIN 0.3% OTIC					
	MC/DEL		OTICAINE OTIC SOLN					
MOUTH ANTISEPTICS								
MOUTH ANTI-INFECTIVES	MC		NILSTAT SUSP	MC		MYCELEX TROC	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		EAR-GESIC SOLN	MC		ORAVIG		
	MC/DEL		NYSTATIN SUSP					
MOUTH ANTISEPTICS	MC/DEL		CHLORHEXIDINE GLUCONATE	MC		APHTHASOL PSTE[1]	Use PA Form# 20420 1. Must fail all preferred products before non-preferred.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		LIDOCAINE VISCOUS SOLN	MC		PERIOGARD SOLN[1]		
	MC		TRIAMCINOLONE IN ORABASE PSTE	MC		TRIAMCINOLONE ACETONIDE PSTE[1]		
	MC		TRIAMCINOLONE ORADENT PSTE					
DENTAL PRODUCTS								
DENTAL PRODUCTS	MC/DEL		ETHEDENT CREA	MC0MC		APF GEL GEL	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		GEL-KAM CONC	MC/DEL		DENTAGEL GEL		
	MC/DEL		GEL-KAM GEL 0.4%	MC/DEL		PHOS-FLUR GEL		
	MC/DEL		PHOS FLUR SOLN	MC		THERA-FLUR-N GEL		
	MC/DEL		SF 5000 PLUS CREA					
	MC/DEL		SF GEL					
	MC		STANNOUS FLUORIDE ORAL RI CONC					
ARTIFICIAL SALIVA/STIMULANTS								
ARTIFICIAL SALIVA/STIMULANTS	MC		SALIVA SUBSTITUTE SOLN	MC		EVOXAC CAPS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
				MC		RADIACARE SOLR		

				MC		SALAGEN TABS		preferred drug(s) exists.
MISCELLANEOUS ANORECTAL								
ANORECTAL - MISC.	MC/DEL		COLOCORT ENEM	MC/DEL		ANUSOL-HC CREA	Use PA Form# 20420	
	MC		CORTENEMA ENEM	MC/DEL		CORTIFOAM FOAM		
	MC		ELA-MAX 5 CREA	MC/DEL		PROCTOFOAM HC FOAM		
	MC/DEL		HYDROCORTISONE ENEM	MC/DEL		PROCTO-KIT CREA 2.5%		
	MC/DEL		PROCTOCREAM-HC CREA	MC		RECTIV OINT		
	MC/DEL		PROCTOSOL HC CREA					
	MC/DEL		PROCTOZONE-HC CREA					
T-CELL ACTIVATION INHIBITOR								
PSORIASIS BIOLOGICALS	MC		ENBREL[1,2]	MC		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. Preferred dosage form allowed without PA after trial of step 1 prodcuts is multi-dose vial, with dosing limits allowing 8 injections per 28 days without pa. Use PA Form# 20910	Approved for severe chronic plaque psoriasis unresponsive to first line therapies. A trial of at least several potent topicals from the following categories: corticosteroids, coal tars, anthralin, calcipotriene and tazorotene, and at least one systemic drug such as methotrexate, cyclosporine, methoxsalen or acitretin and phototherapy/UVA. Enbrel is preferred after a trial of a step 1 product (e.g. azathioprine, methotrexate, etc.); however, dosing limits will also still apply. Dosing limits will allow 8 injections per month without pa. Use of greater than 8 injections per month will require PA. In addition, the preferred Enbrel 25mg product will be the multi-dose vial (NDC- 58406-0425-34). The single-use prefilled syringes are non-preferred.
	MC		HUMIRA[1]					
ALTERNATIVE MEDICINES								
ALTERNATIVE MEDICINES	MC		DIMETHYL SULFOXIDE SOLN	MC/DEL		CO-ENZYME Q-10	Use PA Form# 20420	Will only be approved for specific conditions supported by at least two double-blinded, placebo-controlled randomized trials that are not contradicted by other studies of similar quality.
				MC		MELATONIN TABS		
CHELATING AGENTS								
CHELATING AGENTS	MC/DEL		**CUPRIMINE CAPS**	MC		DEPEN TITRATABS TABS	Use PA Form# 20420	
				MC/DEL		EXJADE[1]	1. FDA indication of treatment of chronic iron ovrload due to blood transfustions in membes 2 years of age and older is requried for approval of Exjade.	
ANTILEPROTIC								
ANTILEPROTIC				MC		THALOMID CAPS[1]	1. All PA requests for 150mg dosing will require use of Thalomid 100mg and 50mg capsules. Use PA Form# 20420	Approved for indications of leprosy, treatment-resistant multiple myeloma and AIDS.
ANTINEOPLASTIC AGENTS								
ANTINEOPLASTIC AGENTS - ANTIADNDROGENS	MC/DEL		BICALUTAMIDE	MC/DEL		CASODEX	Use PA Form# 20420	
ANTINEOPLASTIC AGENTS- LHRH ANALOGS	MC		LUPRON DEPOT[1]	MC		VANTAS[2]	1. Dosing limits apply, please refer to dosage consolidation list. 2. PA required to confirm FDA approved indication.	
				MC		FIRMAGON[2]		
				MC/DEL		TRELSTAR		

							Use PA Form# 20420	
ANTINEOPLASTIC AGENTS - TYROSINE KINASE INHIBITORS				MC MC/DEL MC		SPRYCEL[1] TYKERB[2] GLEEVEC[1]	Use PA Form# 20420 1. Verification of diagnosis is required. 2. PA required to confirm FDA approved indication and to monitor for potential drug-drug interactions.	
ANTINEOPLASTICS-MISCELLANEOUS	MC MC/DEL		AMIFOSTINE MERCAPTOPURINE	MC MC/DEL MC MC/DEL MC/DEL MC/DEL		DOCEFREZ ETHYOL LEUPROLIDE **OXALIPLATIN** PURINETHOL ZOLINZA	Use PA Form# 20420	
ANTINEOPLASTICS- MONOCLONAL ANTIBODIES				MC/DEL		HERCEPTIN[1]	1. PA required to confirm FDA approved indication. Use PA Form# 20420	
CANCER								
CANCER	MC MC/DEL MC/DEL MC MC/DEL MC MC/DEL		ALIMTA ANASTROZOLE TABS AVASTIN ERBITUX LETROZOLE MEGACE ES VIDAZA	MC/DEL MC/DEL MC MC/DEL MC MC MC MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC		ARIMIDEX BOSULIF COMETRIQ[3,4,5] ERIVEDGE FOLOTYN JAKAFI ICLUSIG[3] INLYTA NEXAVAR[1] MEKINIST[3,4] POMALYST STIVARGA SUTENT[1,2] SYLATRON TAFINLAR[3,4,5,6] 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 4. Re-approval will require documentation of response without disease progression and tolerance to treatment 5. Dosing limits apply, please see dosage consolidation list. 6. Max daily dose of 300mg. Use PA Form# 20420	A clinical PA is required for Inlyta to verify diagnosis and failure of one prior systemic therapies **Xalkori** will be considered for patients with a diagnosis of locally advanced or metastatic non-small cell lung cancer (NSCLC) that is anaplastic lymphoma kinase (ALK)-positive as detected by an FDA- approved test (please included a copy of test results; and is prescribed by an oncologist; quantity limit of 60 tablets per 30 days. **Zelboraf** will be considered for patients 18 years of age or older; has a diagnosis of unresectable or metastatic melanoma with BRAF mutation as detected be an FDA-approved test; prescriber is an oncologist with a quantity limit of 240 tablets per 30 days. **Bosulif** requires a clinical PA, requiring diagnosis. Must have resistance or intolerance to prior therapy (such as imatinib [Gleevec®] or a TKI) seen in drug profile, monthly heptic enzyme tests should be preformed for the first three months of treatment , as clinically indicated. **Iclusig** requires prior trail of TKI therapy, appropriate monitoring and has DDI with strong CYP3A4 inducers **Stivarga** is non-preferred and is for the treatment of metastatic colorectal cancer (CRC) who have been previously treated with fluoropyrimidine- oxaliplatin- and irinotecan-based chemotherapy, an anti-VEGF therapy, and if KRAS wild type, an anti-EGFR therapy).The safety and efficacy of use in children under the age of 18 years have not been established. DDI Cometriq and Tafinlar will require a prior authorization if it is currently being used in combination with drugs known to be significant CYP3A4 inhibitors (ketoconazole, itraconazole, clarithromycin, indinavir, nefazodone, nelfinavir, ritonavir, atazanavir, saquinavir and telithromycin). **Xtandi** is non-preferred and is limited to adults treatment of metastatic castration-resistant prostate cancer, with previous trials of docetaxel. **Pomalyst** has a DDI with strong inhibitors of CYP1A2 and CYP3A4 drugs. Complete blood counts weelky for first 8 weeks, then monthly, patients have at least 2 prior therapies, including lenalidomide and bortezomib,female patients of reproductive potential must have 2 negative pregnancy tests and use 2 forms of contraception and providers must be certified with Pomalyst REMS Program.
IMMUNOSUPPRESSANTS								
IMMUNOSUPPRESSANTS	MC/DEL MC/DEL MC MC/DEL MC/DEL MC MC/DEL MC/DEL		CYCLOSPORINE MODIFIED CYCLOSPORINE SOL. MODIFIED GENGRAF CAPS MYCOPHENOLATE MYFORTIC PROGRAF CAPS RAPAMUNE SANDIMMUNE	MC/DEL MC/DEL MC/DEL		CELLCEPT CYCLOSPORINE CAPS NEORAL[1]	1. Established users will require a one time PA. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **DDI:** Cyclosporine will now be non-preferred and require prior authorization if it is currently being used in combination with either Lipitor (doses greater than 20mg/day), Crestor, or lovastatin (doses greater than 20mg). **DDI:** Cyclosporine will require prior authorization when used with Livalo. **DDI:** All preferred immunosuppressants will require clinical PA for patients over 60 that are currently on fluoroquinolone therapy.
PURINE ANALOG								
PURINE ANALOG	MC MC/DEL		AZASAN TABS **AZATHIOPRINE TABS**	MC/DEL		**IMURAN TABS**	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
K REMOVING RESINS								

K REMOVING RESINS	MC/DEL MC MC/DEL MC/DEL MC/DEL		KAYEXALATE POWD KIONEX POWD SODIUM POLYSTYRENE SULFON SPS SUSP SPS 30GM/120ML ENEMA SUSP				Use PA Form# 20420	

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

ANTI-CONVULSANTS INDICATION CHART

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

PEDIATRIC ANTI-CONVULSANTS INDICATION CHART

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