MAINECARE PREFERRED DRUG LIST (with criteria)*

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***As of February 2011**	

Due to formatting page numbers may be off

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						
	MC/DEL		PENICILLIN V POTASSIUM				Use PA Form# 20420		
	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	2. Dosing limits apply, please see Dosage Consolidation List	Suprex will be preferred with dosing limits of one tablet per 7days for prevention and treatment of STI gonorrhoea.	
	MC/DEL		CEFPODOXIME	MC/DEL		FORTAZ			

	MC/DEL		CEFPROZIL	MC/DEL		FORTAZ SOLN	Consolidation List.	
	MC		CEFTAZIDIME 6MG	MC		KEFLEX CAPS		
	MC/DEL		CEFTIN SUSP	MC		OMNICEF		
	MC/DEL		CEFTRIAXONE	MC/DEL		ROCEPHIN		
	MC/DEL		CEFUROXIME AXETIL TABS	MC		TAZICEF SOLR		**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/DEL		TEFLARO		
	MC		FORTAZ SOLR					
	MC/DEL		SUPRAX[2]					
	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.
	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		**DDI:** Preferred erythromycin will now be non-preferred and require prior authorization if it is currently being used in combination with either Carbamazepine, Enablex 15mg or Vesicare 10mg. Any non preferred formulation of erythromycin will require prior authorization and the member's drug profile will also be monitored for concurrent use with either Carbamazepine, Enablex 15mg or Vesicare 10mg.
	MC		ERYPED 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		**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		ZITHROMAX SUSP		
				MC/DEL		ZMAX		
TETRACYCLINES	MC/DEL		DOXYCYCLINE MONOHYDRATE 100mg & 50mg 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		DOXYCYCLINE MONOHYDRATE 150mg & 75mg CAPS		
	MC/DEL		VIBRAMYCIN SYRP	MC/DEL		DYNACIN CAPS		
				MC		ORACEA		
				MC/DEL		PERIOSTAT		
				MC/DEL		SOLODYN ER		
FLUOROQUINOLONES	MC/DEL		CIPROFLOXACIN	MC		AVELOX SOLN		Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		LEVOFLOXACIN	MC		AVELOX TABS	Use PA Form# 20420	
	MC/DEL		OFLOXACIN	MC		AVELOX ABC PACK TABS	1. Dosing limits apply, see Dosage Consolidation List.	**DDI:** Preferred ofloxacin will now be non-preferred and require prior authorization if they are currently being used in combination with amiodarone.
				MC		CIPRO		**DDI:** Preferred levofloxacin will now be non-preferred and require prior authorization if they are currently being used in combination with amiodarone.
				MC		FACTIVE		**DDI:** Preferred Avelox will now be non-preferred and require prior authorization if they are currently being used in combination with amiodarone.
				MC		LEVAQUIN TABS SOLN/INJ		**DDI:** All preferred fluoroquinolones will require clinical PA for patients over 60 that are currently on immunosuppressants or steroid therapy.
				MC		LEVAQUIN TABS[1]		
				MC		NOROXIN TABS		
				MC		PROQUIN XR		**DDI:** Factive is non-preferred but with any prior authorization requests, the member's drug profile will also be monitored for concurrent use with amiodarone.
AMINO GLYCOSIDES	MC		GENTAMICIN	MC/DEL		TOBI PODHALER[1]	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		NEOMYCIN SULFATE TABS				1. Clinial PA to verify appropriate diag	
	MC		TOBI NEBU					TOBI Podhaler is limited to patients with significant impairment from using nebulized version of medication
	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.
	MC/DEL		MYAMBUTOL TABS					
	MC/DEL		MYCOBUTIN CAPS					
	MC/DEL		RIFAMPIN					**DDI:** Preferred rifampin will be non-preferred and require prior authorization if it is currently being used in combination with either Pradaxa or Latuda.
ANTIMALARIAL AGENTS	MC/DEL		**CHLOROQUINE PHOSPHATE TABS**	MC		ARALEN TABS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered

	MC/DEL		**DARAPRIM TABS**	MC		ISONARIF[1]		on the Prior Authorization form, such as the presence of a 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		**HYDROXYCHLOROQUINE TABS**	MC/DEL		MALARONE TABS	1. Ingredients available as preferred without PA.	
	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.	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		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.	
	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:** 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	8	NOXAFIL[5]		
				MC/DEL	8	VFEND TABS		**DDI:** Sporanox is non-preferred but with any prior authorization requests, the member's drug profile will also be monitored for current use with Enablex 15mg, Vesicare 10mg, Prandin, Prevacid, pantoprazole, Prilosec, or any currently non preferred PPI, due to a significant drug-drug interaction.
							4. Quantity limit of one tablet daily. Please see dosage consolidation list.	**DDI:** Vfend is non-preferred but with any prior authorization requests, the member's drug profile will also be monitored for concurrent use with Warfarin.
							5. Approved if immuno suppressed/ HIV or if the member has failed a 7 day trial of a preferred antifungal therapy.	**DDI:** Fluconazole (except 150mg strength) will now be non-preferred and require prior authorization if it is currently being used with glimepiride (Amaryl), Enablex 15mg, or Vesicare 10mg. Diflucan is non-preferred but with any prior authorization requests, the member's drug profile will also be monitored for concurrent use with either glimepiride (Amaryl), Enablex 15mg, or Vesicare 10mg.
								DDI: Fluconazole will require prior authorization if being used in combination with Plavix or Warfarin.
							6. Eraxis will be approved if submitting with documentation that it was initiated during a hospitalization and this request is to finish the hospital course.	
							7. Quantity limits allowing 30 day supply without PA. PA will be required if using > 30 days.	**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.
							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	
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]		
	MC/DEL		CRIXIVAN CAPS	MC/DEL	8	INTELENCE[3]	Use PA Form# 10620 for Fuzeon	
	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	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	
	MC/DEL		EPZICOM	MC	8	STRIBILD		**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		INVIRASE CAPS	MC	8	TIVICAY[5,6]	within the past 30 days of filling Prezista	
	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]				4.Isentress Chewable will only be approved if between the age of 2-12 years old	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		STAVUDINE					
	MC		SUSTIVA					
	MC/DEL		TRIZIVIR TABS					
	MC		TRUVADA					
	MC		VIDEX EC				5. Clinical PA is required to establish diagnosis, verification of age for appropriate indication and medical necessity.	
	MC/DEL		VIRACEPT 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		VIRAMUNE TABS					
	MC		VIREAD TABS					
	MC/DEL		ZIAGEN TABS					
	MC/DEL		ZIDOVUDINE				6. Dosing limits apply, please see dosing consolidation list.	
CYTO-MEGALOVIRUS AGENTS	MC		FOSCARNET SODIUM	MC/DEL		FOSCAVIR	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		VALCYTE TABS	MC/DEL		GANCICLOVIR		
HERPES AGENTS	MC/DEL		ACYCLOVIR	MC/DEL	8	FAMCICLOVIR[1]	1. Must fail Acyclovir and Valacyclovir before non-preferred products in step order.	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		VALACYCLOVIR HCL	MC/DEL	8	ZOVIRAX[1]		
				MC/DEL	8	VALTREX TABS[1]		
				MC/DEL	9	FAMVIR TABS[1]	Use PA Form# 20420	
INFLUENZA AGENTS	MC/DEL		AMANTADINE	MC		FLUMADINE TABS	1. Tamiflu 10 caps or 60cc's per month. Will be audited for presence of positive influenza tests in patient or family member.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		RELENZA DISKHALER AEPB	MC		FLUMIST		
	MC/DEL		RIMANTADINE HCL TABS				Use PA Form# 10610 for Flumist requests	
	MC/DEL		TAMIFLU[1]				Use PA Form# 20420 for all others	
IMMUNE SERUMS								

IMMUNE SERUMS	MC		HYPERRHO INJ					
HEPATITIS AGENTS								
HEPATITIS C AGENTS	MC MC MC/DEL MC/DEL MC/DEL MC MC MC MC/DEL		INCIVEK[2] OLYSIO[3] PEGASYS KIT[1] PEGASYS SOLN PEG-INTRON KIT[1] RIBAVIRIN RIBAPAK SOVALDI[3] VICTRELIS[2]	MC/DEL MC/DEL		COPEGUS TABS REBETOL CAPS	1. Dosing limits apply, please see dosage consolidation list. 2. Approvals will require clinical PA to establish genotype, baseline viral loads and will require periodic SVR's. Must have concurrent peg-a or peg-I and ribavirin therapies. 3. Approvals will require clinical PA. Please see the Sovaldi PA form for criteria Use PA Form # 10700 for Sovaldi request 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. 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). **DDI:** Olysio 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).
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 December 8th 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 20MG[2] GILENYA[2,3]	MC MC MC	6 8 8	TYSABRI[1] AUBAGIO AMPYRA	1. Providers must be enrolled in the TOUCH Prescribing program, a restricted distribution	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	8	COPAXONE 40MG	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	**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.
				MC	8	TECFIDERA		
ASSORTED NEUROLOGICS								
NEUROLOGICS - MISC.	MC/DEL		ORAP TABS	MC		BOTOX[2]	1. Approval will be limited to Cervical dystonia. 2. Please see botulinum PA form for additional criteria 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. **Migraine:** Consideration for Botox approvals will only be made after failures of required trials of the following preferred medications: tricyclic or venlafaxine,beta blocker,valproic acid ,topiramate 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		PROSTIGMIN TABS	MC		DYSPORT[1]		
	MC		PYRIDOSTIGMINE	MC		MESTINON		
				MC		MYOBLOC[1]		
STEROIDS								
GLUCOCORTICOIDS/ MINERALOCORTICOIDS	MC		CELESTONE SUSP	MC/DEL		BUDESONIDE EC	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **DDI:** All preferred steroids will require clinical PA for patients over 60 that are currently on fluoroquinolone therapy.
	MC/DEL		CORTEF 5	MC		CORTEF 10 and 20 TABS		
	MC/DEL		CORTISONE ACETATE TABS	MC/DEL		FLORINEF TABS		
	MC/DEL		DELTASONE TABS	MC/DEL		**MEDROL TABS**		
	MC/DEL		DEPO-MEDROL SUSP	MC		MEDROL DOSEPAK TABS		
	MC/DEL		DEXAMETHASONE	MC		MILLIPRED		
	MC/DEL		ENTOCORT EC CP24	MC		ORAPRED SOLN		
	MC/DEL		FLUDROCORTISONE ACETATE TABS	MC		PEDIAPRED LIQD		
	MC/DEL		HYDROCORTISONE	MC		PREDNISONE INTENSOL CONC		
	MC		KENALOG	MC		STERAPRED TABS		
	MC/DEL		METHYLPREDNISOLONE TABS					
	MC/DEL		PREDNISOLONE					
	MC/DEL		**PREDNISONE**					
	MC/DEL		SOLU-CORTEF SOLR					
	MC/DEL		SOLU-MEDROL SOLR					
HORMONE REPLACEMENT THERAPIES								
ANDROGENS / ANABOLICS	MC/DEL		ANDRODERM PT24	MC		ANADROL-50	Use PA Form# 20420 Use PA Form# 20600 for Oxa	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Additionally, laboratory evidence of a testosterone deficiency must be supplied. One of each dosage form should be tried (tablet, injection, and topical)
	MC/DEL		ANDROGEL	MC		ANDRO LA 200 OIL		
	MC/DEL		ANDROGEL PUMP	MC		ANDROID CAPS		
	MC/DEL		DANAZOL CAPS	MC		AXIRON		
	MC/DEL		DEPO-TESTOSTERONE OIL	MC		DELATESTRYL OIL		
	MC/DEL		METHITEST TABS	MC		FORTESTA		
	MC/DEL		OXANDRIN TABS	MC		HALOTESTIN TABS		
	MC		TESTIM	MC/DEL		**OXANDROLONE**		
				MC/DEL		TESTOSTERONE CYP		
				MC		TESTRED CAPS		

ESTROGENS - PATCHES / TOPICAL	MC/DEL MC/DEL		**VIVELLE-DOT PTTW**[1] **CLIMARA PTWK**	MC/DEL MC/DEL MC/DEL MC/DEL MC	5 8 8 8 8	**ESTRADIOL PTWK** **ALORA PTTW**[2] **DIVIGEL**[2] **ELESTRIN**[2] **EVAMIST**[2]	1. Both preferred drugs must be tried. 2. Step order drugs must be used in specified step order. Use PA Form# 20420	Approved for failures on multiple oral estrogen agents after 90 day trials or if unable to swallow any oral medication.
ESTROGENS - TABS	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		**CENESTIN TABS** **ESTRADIOL** **ESTROPIPATE TABS** **MENEST TABS** **PREMARIN TABS**	MC/DEL MC/DEL MC MC		ENJUVIA **ESTRACE TABS** ESTRATAB TABS ORTHO-EST TABS	Must fail preferred products before non-preferred products. Use PA Form# 20420	Preferred drugs must be tried for at least 90 days and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ESTROGEN COMBO'S	MC/DEL MC/DEL		**PREMPHASE TABS** **PREMPRO TABS**	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		**ACTIVELLA TABS**[1] **COMBIPATCH PTTW**[1] **FEMHRT 1/5 TABS**[1] **ORTHO-PREFEST TABS**[1] SYNTEST H.S. TABS[1]	1. Must fail Premphase and Prempro products before non preferred products. Use PA Form# 20420	Preferred drugs must be tried for at least 90 days and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
PROGESTINS	MC/DEL MC/DEL		MEDROXYPROGESTERONE ACETA [2] NORETHINDRONE ACETATE TABS[2]	MC/DEL MC MC MC MC/DEL MC/DEL MC/DEL		AYGESTIN TABS CYCRIN TABS MAKENA PROGESTERONE POWD PROMETRIUM 100MG CAPS[1] PROMETRIUM 200MG[1] PROVERA TABS	1. PA approvals will require two 100 mg caps instead of one 200mg. 2. Must fail Medroxyprogesterone and Norethidrone products before non-preferred products. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
CONTRACEPTIVES								
CONTRACEPTIVES - PROGESTIN ONLY	MC/DEL MC/DEL		NOR-QD TABS NORETHINDRONE ACETATE 0.35 TABS	MC/DEL MC/DEL MC/DEL MC/DEL MC	7 7 7 7 8	CAMILA TABS ERRIN JOLIVETTE NORA-BE TABS ORTHO MICRONOR 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. If member experienced adverse reactions, consider using Oral Contraceptives from other groups. **DDI:** Preferred Oral Contraceptives will now be non-preferred and require prior authorization if it is currently being used in combination with Tracleer.
CONTRACEPTIVES - INJECTABLE	MC/DEL		MEDROXYPROGESTERONE ACETATE 150mg IM	MC/DEL		DEPO-PROVERA 150 mg SUSP	Use PA Form# 20420	The preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
CONTRACEPTIVE - EMERGENCY	MC/DEL MC/DEL MC MC/DEL	1 2 2 2	PLAN B ONE STEP[1] ELLA LEVONORGESTREL NEXT CHOICE[1]	MC/DEL		PLAN B	1. Allowed 2 tablets per 30 days without PA Use PA Form# 20420	
CONTRACEPTIVES - PATCHES/ VAGINAL PRODUCTS	MC MC		NUVARING RING[3] ORTHO EVRA PTWK[1,2,4]				Use PA Form# 20420 1.No PA required for users less than 21 years of age. 2. The FDA has issued a public health warning of the potentials for increased exposure to estrogen with Ortho Eva use, possibly up to 60% estrogen exposoure.	Approved if adequate clinical reason given why patient unable to comply with other preferred agents including long acting injectable.

							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 preferred drug(s) exists.
	MC/DEL		AVIANE TABS	MC/DEL		BREVICON-28 TABS	If member experienced adverse reactions, consider using Oral Contraceptives from other groups.	
	MC/DEL		BALZIVA	MC/DEL		LESSINA-28 TABS		
	MC/DEL		CRYSELLE-28 TABS	MC/DEL		LEVORA		
	MC		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		ZENCHENT	MC/DEL		SAFYRAL		
				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 MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		HUMULIN INJ 70/30 HUMULIN R U-100 LANTUS SOLN LEVEMIR **NOVOLIN** **NOVOLOG** **NOVOLOG MIX**	MC MC		HUMULIN R INJ U-500 RELION		
DIABETIC - PENFILLS	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		LANTUS SOLOSTAR[1] LEVEMIR FLEXPEN[1] **NOVOLIN PENFILL**[1] **NOVOLIN 70/30**[1] NOVOLOG MIX PENFILL[1] **NOVOLOG PENFILL SOLN**[1] NOVOLOG MIX FLEXPEN[1] NOVOLOG FLEXPEN[1]	MC MC MC MC		APIDRA OPTICLIK PEN HUMALOG KWIK INJ 100/ML HUMALOG MIX INJ 75/25 KWP HUMALOG MIX INJ 50/50 KWP	1. Clinical PA will be required to establish significant visual or neurological impairment. Use PA Form# 20420	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.
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[1,2] **JANUMET XR**[1,2] **JENTADUETO**[1]	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. 2. 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		ONE TOUCH LANCETS DELICA LANCETS				Use PA Form# 20420	

	MC MC MC		UNILET LANCETS UNISTIK LANCING DEVICE AUTOLOT LANCING DEVICE					
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/DEL MC		CYCLOSET **FARXIGA** **INVOKANA**[1] SYMLIN	Use PA Form# 30150 for Symlin 1.Dosing limits apply please refer to Dose Consolidation List Use PA Form #20420 for all others	Please see the criteria listed in the Symlin PA form. **Invokana** will be considered for patients who are unable to tolerate any preferred medicaitons from other diabetic classes.
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 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 MC MC MC MC MC		FREESTYLE[1] FREESTYLE LITE[1] FREESTYLE INSULINX[1] ONE TOUCH DELICA[1] ONE TOUCH ULTRA[1] PRECISION XTRA[1]	MC MC MC MC MC MC		ACCUCHECK ASCENSIA ASSURE EXACTECH PRODIGY CONTOUR BREEZE Z	1. Only 50 ct & 100 ct package size. Use PA Form# 20420	Effective October 25th 2007, approvals for all non preferred meters/ test strips will require medical necessity documenting clinically significant features that are not available on any of the preferred meters.
INCRETIN MIMETIC				MC MC MC/DEL MC/DEL	8 8 8 9	BYDUREON[1] BYETTA[1] **NESINA** VICTOZA[1]	1. If patient is not responding to oral agents (single or multiple) please look to insulin therapy. Dosing limits apply. Please refer to Dose Consolidation List. Use PA Form# 10230	
DIABETIC - ORAL SULFONYLUREAS	MC/DEL MC/DEL MC/DEL MC/DEL		**CHLORPROPAMIDE TABS** GLIMEPIRIDE **GLIPIZIDE TABS** **GLIPIZIDE ER TABS**	MC/DEL MC/DEL MC MC/DEL		**AMARYL TABS** **DIABETA TABS** **GLUCOTROL TABS** **GLUCOTROL XL TBCR**	Use PA Form# 20420 1. Pa required for members ≥65. Glyburide has a greater risk of severe prolonged hypoglycemia in older	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.

	MC/DEL MC/DEL MC/DEL MC/DEL		**GLYBURIDE MICRONIZED TABS** **GLYBURIDE TABS**[1] **TOLAZAMIDE TABS** **TOLBUTAMIDE TABS**	MC/DEL MC/DEL		**GLYNASE TABS** **MICRONASE TABS**	hypoglycemia in older adults.	**DDI:** Glimepiride will now be non-preferred and require prior authorization if it is currently being used with either fluconazole (except 150mg strength) or fluvoxamine. Amaryl is non-preferred but with any prior authorization requests, the member's drug profile will also be monitored for concurrent use with either fluconazole or fluvoxamine.
DIABETIC -ORAL BIGUANIDES	MC/DEL MC/DEL		**METFORMIN HCL TABS** METFORMIN ER	MC MC MC MC/DEL		GLUCOPHAGE TABS GLUCOPHAGE XR TB24 FORTAMET METFORMIN ER OSMOTIC	Use PA Form# 20420	Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
DIABETIC - THIAZOL / BIGUANIDE COMBO				MC/DEL MC/DEL MC/DEL MC/DEL		ACTOPLUS MET[1] ACTOPLUS MET XR AVANDARYL[1] **AVANDAMET TABS**[1]	Use PA Form# 20420 1. Requires use of Actos, Metformin, or other preferred anti-diabetics.	**DDI:** Actos, Avandia, or any combination product with Actos or Avandia will now be non-preferred and require prior authorization if it is currently being used with gemfibrozil.
DIABETIC - / THIAZOL	MC/DEL		**PIOGLITAZONE HCL**[1]	MC/DEL MC/DEL		**ACTOS TABS**[3] **AVANDIA TABS**[2]	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 Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **DDI:** Actos, Avandia, or any combination product with Actos or Avandia will now be non-preferred and require prior authorization if it is currently being used with gemfibrozil.
DIABETIC - ALPHAGLUCOSIDASE	MC/DEL		**GLYSET TABS**	MC		**PRECOSE TABS**	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
DIABETIC - SULFONYLUREA / BIGUANIDE	MC/DEL		GLYBURIDE/METFORMIN	MC MC MC/DEL		**GLUCOVANCE TABS**[1] METAGLIP TABS[1] DUETACT[2]	1. Use individual ingredients. 2. Use Actos 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 MC		GLUCAGON DIAGNOSTIC KIT GLUCAGEN DIAGNOSTIC KIT	Use PA Form# 20420	

THYROID								
THYROID HORMONES	MC/DEL		**ARMOUR THYROID TABS**	MC		LEVOTHYROXINE SODIUM SOLR	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**CYTOMEL TABS**	MC/DEL		LIOTHYRONINE		
	MC/DEL		**LEVOTHROID TABS**	MC		SYNTHROID TABS		
	MC/DEL		**LEVOTHYROXINE SODIUM TABS**					
	MC/DEL		**LEVOXYL TABS**					
	MC/DEL		**THYROID TABS**					
	MC/DEL		**THYROLAR**					
	MC/DEL		**UNITHROID TABS**					
ANTITHYROID THERAPIES	MC/DEL		**METHIMAZOLE TABS**	MC/DEL		**TAPAZOLE TABS**	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**PROPYLTHIOURACIL TABS**					
OSTEOPOROSIS / BONE AGENTS								
OSTEOPOROSIS	MC/DEL		ALENDRONATE	MC/DEL		**ACTONEL TABS**	Use PA Form# 20420 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
	MC/DEL		**MIACALCIN SOLN**[2]	MC		AREDIA SOLR		
				MC		BINOSTO		
				MC/DEL		BONIVA INJECTION KIT		
				MC/DEL		BONIVA TABS[2,4]		
				MC/DEL		CALCITONIN NS		
				MC/DEL		**DIDRONEL TABS**		
				MC		EVISTA TABS[1]		
				MC		FORTEO		
				MC/DEL		FORTICAL		
				MC/DEL		**FOSAMAX TABS AND PLUS D**[3]		
				MC		PROLIA		
				MC		XGEVA		
				MC/DEL		ZOMETA		
CALCIMIMETIC AGENTS								
CALCIMIMETIC AGENTS				MC		SENSIPAR	Use PA Form# 30115	Baseline PTH, Ca, and phosphorous levels are required and initial approvals will be limited to 3 months. Subsequent approvals will require additional levels being done to assess changes. Will not approve if baseline Ca is less than 8.4.
GROWTH HORMONE								
GROWTH HORMONE	MC/DEL		GENOTROPIN[1]	MC	8	HUMATROPE 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		NORDITROPIN SOLN[1]	MC	8	INCRELEX		
				MC/DEL	8	NUTROPIN AQ NUSPIN[2]		
				MC/DEL	8	NUTROPIN		
				MC	8	OMNITROPE		
				MC	8	SAIZEN SOLR		
				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.	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/DEL	6	**DESMOPRESSIN SPRAY**[1]		
				MC	8	DESMOPRESSIN ACETATE SOLN[1]		
				MC/DEL	8	STIMATE SOLN[1,2]		

							2. Patients with a diagnosis of hemophilia or Von Willebrands disease will be exempt from prior authorization. Use PA Form# 20420	
ANTISPASMODICS	**MC/DEL** **MC**		**OXYBUTYNIN** URISPAS TABS	**MC/DEL** **MC/DEL** **MC** **MC/DEL**	8 8 8 9	**DETROL TABS** **DITROPAN** **SANCTURA** TROSPIUM	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.
ANTISPASMODICS - LONG ACTING	**MC/DEL** **MC/DEL** **MC**		**OXYBUTYNIN ER TABS** TOVIAZ VESICARE[1]	**MC** **MC/DEL** **MC/DEL** **MC/DEL** **MC/DEL** **MC/DEL** **MC**	8 8 8 8 8 9 9	**DITROPAN XL TBCR** ENABLEX[1,3] **MYRBETRIQ** **OXYTROL** **TOLTERODINE TAB** DETROL LA CP[2] SANCTURA XR[2]	Use PA Form# 20420 1. See Criteria Section. 2. Product is considered line extension of the original product due to Healthcare Reform (HCR). MaineCare will consider these medications non-preferred and a step 9 because of the impact under the Federal Rebate Program in conjunction with HCR. 3. Use a preferred long acting antispasmodic.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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.
CHOLINERGIC	**MC/DEL** **MC/DEL**		**URECHOLINE** **BETHANECHOL**				Use PA Form# 20420	
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** **MC/DEL** **MC/DEL**		**DIGITEK TABS** **DIGOXIN** **LANOXIN**				Use PA Form# 20420	
ANTIANGINALS--Isosorbide Di-nitrate/ Mono-Nitrates	**MC/DEL** **MC/DEL**		**ISOSORBIDE MONONITRATE TABS** **ISOSORBIDE MONONITRATE ER**	**MC** **MC** **MC** **MC/DEL** **MC/DEL** **MC/DEL** **MC/DEL** **MC/DEL** **MC/DEL** **MC**		DILATRATE SR CPCR ISORDIL TABS ISORDIL TITRADOSE TABS ISOSORBIDE DINITRATE SUBL **ISOSORBIDE DINITRATE TABS** ISOSORBIDE DINITRATE CR TBCR **ISOSORBIDE DINITRATE ER TBCR** ISOSORBIDE DINITRATE TD TBCR **IMDUR TB24** ISMO TABS MONOKET TABS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
NITRO - OINTMENT/CAP/CR	**MC/DEL** **MC/DEL** **MC** **MC**		**NITROBID OINT** **NITROGLYCERIN CPCR** NITROL OINT NITRO-TIME CPCR				Use PA Form# 20420	
NITRO - PATCHES	**MC/DEL** **MC/DEL**	1 1	**NITROGLYCERIN PT24**[1] **NITREK PT24**[1]	**MC** **MC/DEL**		NITRODISC PT24 **NITRO-DUR PT24**	1. At least 2 step 1's and step 3 of the preferred products must be used in	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.

	MC/DEL MC	1 3	**NITRO-DUR PT 24 0.8MG**[1] MINITRAN PT24[1]				products must be used in specified order or PA will be required. Use PA Form# 20420	preferred drug(s) exists.
NITRO - SUBLINGUAL/ SPRAY	MC/DEL MC/DEL		**NITROSTAT SUBL** **NITROTAB SUBL**	MC/DEL MC MC		**NITROQUICK SUBL** **NITROLINGUAL SOLN** NITROLINGUAL TABS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
BETA BLOCKERS - NON SELECTIVE	MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		**CARVEDILOL** LEVATOL TABS **NADOLOL TABS** **PINDOLOL TABS** **PROPRANOLOL HCL SOLN**[1] **PROPRANOLOL HCL TABS**[1] **PROPRANOLOL LA CAPS** SOTALOL AF SOTALOL HCL TABS **TIMOLOL MALEATE TABS**	MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL MC MC MC/DEL MC		**BETAPACE TABS** **BETAPACE AF TABS** **COREG CR**[3] **COREG TABS** **CORGARD TABS** **INDERAL TABS** INDERAL LA CPCR INNOPRAN XL **PROPRANOLOL HCL 60MG TABS**[2] RANEXA	1. Recommend using BID since its effects do not last 24 hours. 2. Please use other strengths in combination to obtain this dose. 3. Dosing limits still apply. Please see dose consolidation list Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
BETA BLOCKERS - CARDIO SELECTIVE	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		**ACEBUTOLOL HCL CAPS** **ATENOLOL TABS**[1] **BETAXOLOL HCL TABS** **BISOPROLOL FUMARATE TABS** **METOPROLOL TARTRATE TABS**[1] **METOPROLOL ER** **TOPROL XL TB24**	MC/DEL MC MC/DEL MC MC/DEL MC/DEL		BYSTOLIC KERLONE TABS **LOPRESSOR TABS** SECTRAL CAPS **TENORMIN TABS** **ZEBETA TABS**	1. Recommend using Atenolol (and metoprolol) BID since its effects do not last 24 hours. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
BETA BLOCKERS - ALPHA / BETA	MC/DEL		**LABETALOL HCL TABS**	MC		TRANDATE TABS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
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/DEL	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/DEL	6	**TAZTIA**[1]		
	MC/DEL		**DILTIAZEM HCL XR CP24**	MC	8	CARDIZEM TABS[1]		
	MC/DEL		**DILTIAZEM CD 300MG CP24**	MC	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 1. Established users will be grandfathered	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
				MC		DYNACIRC CR TBCR[1]		
				MC		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		NICARDIPINE HCL CAPS		
	MC/DEL		**AFEDITAB CR**	MC/DEL		**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/DEL		**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/DEL		**VERAPAMIL HCL SR CP24**		
				MC/DEL		**VERAPAMIL HCL TABS**		
				MC/DEL		**VERELAN CP24**		
				MC/DEL		**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/DEL		**RYTHMOL SR**		
	MC/DEL		**QUINIDINE SULFATE**	MC/DEL		**RYTHMOL**		
ACE INHIBITORS	MC/DEL		**BENAZEPRIL HCL**	MC	5	MAVIK TABS	1. Non-preferred products must be used in specified order.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs (in step-order) will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Non-preferred products are subject to step-order requirements unless clinical circumstances warrant exception.
	MC/DEL		**CAPTOPRIL TABS**	MC/DEL	5	**ACCUPRIL TABS**		
	MC/DEL		**ENALAPRIL MALEATE TABS**	MC/DEL	8	**ACEON TABS**[1]		

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

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/DEL**		**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		DIURIL		
	MC/DEL		INDAPAMIDE TABS	MC/DEL		DYAZIDE CAPS		
	MC/DEL		METHAZOLAMIDE TABS	MC		ENDURON TABS		
	MC/DEL		METHYCLOTHIAZIDE TABS	MC/DEL		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/DEL		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/DEL		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		FENOFIBRATE	MC/DEL		FIBRICOR		
	MC/DEL		GEMFIBROZIL TABS	MC		LIPOFEN		
	MC/DEL		NIASPAN	MC/DEL		LOFIBRA		
	MC		TRILIPIX	MC		TRICOR		
				MC		TRIGLIDE		
CHOLESTEROL - HGM COA + ABSORB INHIBITORS MORE POTENT DRUGS/COMBINATIONS	MC/DEL		ATORVASTATIN	MC/DEL		LIPITOR	1. Dosing limits apply, please see dosage consolidation list. 2. Current users grandfathered. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **DDI:** Lipitor (doses greater than 20mg/day) will now be non-preferred and require prior authorization if they are currently being used in combination cyclosporine. **DDI:** Lipitor (doses greater than 20mg/day) will now be non-preferred and require prior authorization if it is currently being used in combination with Amiodarone. **DDI:** All preferred statins will now be non-preferred and require prior authorization if it is currently being used in combination with Gemfibrozil.
	MC/DEL		CRESTOR	MC		LIPTRUZET		
	MC/DEL		SIMVASTATIN[1]	MC/DEL		ZOCOR		
			VYTORIN	MC/DEL		SIMVASTATIN 80MG[1,2]		
	MC							
CHOLESTEROL - HGM COA + ABSORB INHIBITORS LESS POTENT DRUGS/COMBINATIONS	MC/DEL		LESCOL CAPS	MC	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. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Zetia will be approved for patients unable to tolerate all other therapies or unable to achieve cholesterol goal with maximally tolerated dose of most potent statins. **DDI:** Lescol will now be non-preferred and require prior authorization if it is currently being used in combination with diclofenac. **DDI:** Lovastatin (doses greater than 40mg/day) will now be non-preferred and require prior authorization if it is currently being used in combination with Amiodarone. **DDI:** Lovastatin (doses greater than 20mg per day) will now be non-preferred and require prior authorization if it is currently being used in combination cyclosporine. **DDI:** All preferred statins will now be non-preferred and require prior authorization if it is currently being used in combination with Gemfibrozil.
	MC/DEL		LESCOL XL TB24	MC	8	LIVALO		
	MC/DEL		LOVASTATIN TABS[2]	MC/DEL	8	MEVACOR TABS		
	MC/DEL		PRAVASTATIN[2]	MC/DEL	8	PRAVACHOL TABS		
				MC/DEL	8	PRAVIGARD		
				MC	8	ZETIA TABS[1]		
CHOLESTEROL - HGM COA + ABSORB INHIBITORS STATIN/ NIACIN COMBO	MC		SIMCOR	MC		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
				MC		KYNAMRO[1]		

								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.
							Use PA Form#10500	
PULMONARY ANTI-HYPERTENSIVES								
PULMONARY ANTI-HYPERTENSIVES	**MC** **MC**		VENTAVIS[2] EPOPROSTENOL INJ[5]	**MC** **MC/DEL** **MC/DEL** **MC** **MC** **MC/DEL**		ADCIRCA[1] **ADEMPAS**[6,7] FLOLAN[5] OPSUMIT[6,7] 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. 6. Requires previous trials/failure of multiple preferred medications. 7. Dosing limits apply, please see the 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 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. 3. Revatio approvals will require WHO Group 1 diagnosis of primary PAH (Primary Pulmonary Hypertension) and NYHA functional class 2 or 3. **DDI:** Opsumit 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). **DDI:** Adempas will require a prior authorization if it is currently being used in combination with drugs known to be PDE inhibitors should be avoided (including dypyridamole, adcira and tadalafil) with adempas
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		MECLIZINE HCL TABS	MC		ANTIVERT TABS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		PROMETHAZINE SUPP	MC		PHENERGAN SOLN		
	MC/DEL		PROMETHAZINE	MC		PROMETHAZINE 50MG SUPP		
	MC		TRANSDERM-SCOP PT72	MC		PROMETHEGAN SUPP		
				MC		TORECAN TABS		
ANTIEMETIC - 5-HT3 RECEPTOR ANTAGONISTS/ SUBSTANCE P NEUROKININ	MC/DEL		MARINOL CAPS	MC/DEL	5	GRANISETRON	1. Approvals will require diagnosis of chemo-induced nausea/vomiting and failed trials of all preferred anti-emetics, including 5-HT3 class (Ondansetron) and Marinol. 2. Ondansetron will be preferred with CA diag and dosing limits still apply. 3. Clinical PA is required for members on highly emetic anti-neoplastic agents. 4. Dosing limits apply, please see Dosage Consolidation List Use PA Form# 20610 for Ondansetron requests Use PA Form# 20420 for all others	Preferred drugs and step therapy must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. * Ondansetron limits still apply as listed on the Ondansetron PA form for covered indications including chemotherapy, radiotherapy, post operative nausea & vomiting and hyperemesis gravidarum. Other medical indications will be approved or denied on a case by case basis. Hyperemesis and other medical indications approved are still subject to failure of multiple preferred antiemesis drugs.
	MC/DEL		**ONDANSETRON TABS[2,4]**	MC	8	ALOXI		
	MC/DEL		**ONDANSETRON ODT TBDP[2,4]**	MC	8	ANZEMET TABS		
	MC/DEL		**ONDANSETRON INJ[2,4]**	MC	8	CESAMET[1]		
				MC	8	EMEND[3]		
				MC/DEL	8	KYTRIL		
				MC	8	SANCUSO		
				MC/DEL	8	ZOFRAN ODT TBDP[4]		
				MC/DEL	8	ZOFRAN TABS[4]		
				MC/DEL	8	ZOFRAN INJ[4]		
				MC	8	ZUPLENZ		
NON-SEDATING ANTIHISTAMINES / DECONGESTANTS								
ANTIHISTIMINES - NON-SEDATING	MC		ALAVERT TABS	MC	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.	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	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		TAVIST ND (OTC)	MC/DEL	8	ALLEGRA[3]		
				MC	8	CLARITIN[3]		
				MC/DEL	8	DESLORATADIN		
				MC/DEL	8	LORATADINE ODT[4]		
				MC/DEL	8	LEVOCETIRIZINE[4]		
				MC/DEL	9	XYZAL[3]		

							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	
ANTIHISTIMINES - OTHER	MC/DEL MC/DEL MC/DEL		CLEMASTINE CHLORPHENIRAMINE DIPHENHYDRAMINE				Use PA Form# 20530	
ALLERGY / ASTHMA THERAPIES								
ANAPHYLACTIC DEVICES	MC/DEL		**EPIPEN**	MC/DEL MC		**AUVI- Q** 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/DEL 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	5 5 8 8 8 8 8 8 8 8 8	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]	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	Preferred drugs and step therapy must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.

				MC/DEL	8	ZETONNA	whole category, please see dosage consolidation list.	
				MC/DEL	9	TRIAMCINOLONE NS		
ANTIASTHMATIC - NASAL MISC.	MC/DEL		CROMOLYN NASAL 4%	MC	7	ATROVENT NASAL SOL	Use PA Form# 20420	Approved if patient fails on nonsedating antihistamines and steroid nasal sprays.
	MC/DEL		OCEAN 0.65%	MC/DEL	7	ASTELIN	1. Ipratropium will be approved if submitted with documentation supporting use of CPAP machine.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		SALINE NASAL SPRAY 0.65%	MC	7	IPRATROPIUM NASAL SOL[1]		
				MC/DEL	8	ASTEPRO[2]		
				MC/DEL	8	PATANASE	2. Utilize Multiple preferred, as well as step therapy Astelin.	
ANTIASTHMATIC - BETA - ADRENERGICS	MC/DEL		**ALBUTEROL NEB**	MC/DEL		**ACCUNEB NEBU**	1. Xopenex users w/ prior asthma hospitalization due to albuterol nebulizer failure will be grandfathered.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**METAPROTERENOL**	MC/DEL		**ALBUTEROL AER**		
	MC/DEL		**PROVENTIL HFA**	MC/DEL		**ALBUTEROL HFA**		
	MC/DEL		**SEREVENT**	MC/DEL		**ALBUTEROL 0.63mg/3ml**		
	MC/DEL		**TERBUTALINE SULFATE TABS**	MC/DEL		**ARCAPTA[3]**		
				MC/DEL		**BRETHINE**	2. Quantity Limit: 12 cc/day.	
				MC/DEL		**FORADIL AEROLIZER CAPS**		
				MC		**PROAIR HFA[3]**	3. Dosing limits apply, please see dosage consolidation list.	
				MC/DEL		**VENTOLIN AERS**		
				MC/DEL		**VENTOLIN HFA AERS[3]**		
				MC		VOLMAX TBCR		
				MC		VOSPIRE ER TB12		
				MC/DEL		**XOPENEX HFA[3]**		
				MC/DEL		**XOPENEX NEBU[1,2]**	Use PA Form# 20420	
ANTIASTHMATIC - ADRENERGIC COMBINATIONS	MC/DEL		**ADVAIR DISKUS/HFA[1,2]**	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.	
	MC/DEL		DULERA					
	MC/DEL		SYMBICORT[2]				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		**ALBUTEROL/IPRATROPIUM NEB. SOLN**	MC/DEL		**ANORO ELLIPTA**	1. Please use preferred individual ingredients Albuterol and Ipratropium.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Duoneb components are available separately without PA.
	MC/DEL		**COMBIVENT AERO[2]**	MC/DEL		**COMBIVENT RESPIMAT**		
				MC/DEL		DUONEB SOLN[1]	2. We ask physicians to write "asthma" on the prescription whenever Combivent is primarily being used for that condition.	
							Use PA Form# 20420	
ANTIASTHMATIC - XANTHINES	MC/DEL		**AMINOPHYLLINE TABS**	MC/DEL		**THEO-24 CP24**	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		THEOCHRON TB12	MC		THEOLAIR TABS		
	MC/DEL		THEOLAIR-SR TB12	MC/DEL		**UNIPHYL TBCR**		

	MC/DEL		**THEOPHYLLINE CR TB12**					
	MC		THEOPHYLLINE ELIX					
	MC/DEL		THEOPHYLLINE SOLN					
	MC/DEL		**THEOPHYLLINE ER CP12**					
	MC/DEL		**THEOPHYLLINE ER TB12**					
ANTIASTHMATIC - STEROID INHALANTS	MC/DEL		ASMANEX[4,5]	MC/DEL	5	**AEROBID AERS[2,4]**	1. No PA for Pulmicort susp if under 8 years old.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**FLOVENT DISKUS[4]**	MC	5	BECLOVENT AERS[2,4]		
	MC/DEL		**FLOVENT HFA[4]**	MC	5	VANCERIL AERS[2,4]		
	MC/DEL		**PULMICORT FLEXHALER**	MC/DEL	8	**AEROBID-M AERS[3,4]**		
	MC/DEL		**PULMICORT SUSP[1,4]**	MC/DEL	8	ALVESCO[4]		
	MC		QVAR AERS[4]	MC	8	VANCERIL DOUBLE STRENGTH AERS[3,4]	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	
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		**MONTELUKAST SODIUM TAB**	MC/DEL		**ACCOLATE TABS**	Use PA Form# 20420	
	MC/DEL		**MONTELUKAST SODIUM CHEW TAB**	MC/DEL		**SINGULAIR[1]**	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/DEL	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.	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]				Use PA Form# 20420	
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		MOTOFEN TABS		
	MC/DEL		OPIUM TINCTURE TINC					
	MC		PAREGORIC TINC					
GI - ANTI-DIARRHEAL/ ANTACID - MISC.	MC		**ATROPINE SULFATE SOLN**	MC/DEL		**BELLADONNA ALKALOIDS & OP**	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **As listed in MaineCare Policy, certain drugs require specific diagnoses for approval** .
	MC/DEL		BENTYL SYRP	MC/DEL		BENTYL TABS	1.Dosing limits apply please refer to Dose Consolidation List	
	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		LEVSIN TABS		
	MC/DEL		HYOSCYAMINE SULFATE	MC		LEVSIN/SL SUBL		Preferred products that used to require diag codes still require diag codes unless indicated otherwise.
	MC/DEL		KAOPECTATE	MC		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/DEL		**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 150MG TABS	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		RANITIDINE 150MG CAPS		
				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]		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.
				MC/DEL	8	PREVACID CPDR[4,5]		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.	
				MC/DEL	8	PRILOSEC CPDR		1. Barrett's esophagus.

				MC/DEL	8	PROTONIX INJ	3. Please use multiple 20mg Capsules to obtain required dose.	2. Erosive esophagitis 3. Hypersecretory conditions (Zollinger-Ellison syndrome, systemic mastocytosis, multiple endocrine adenomas). Recurrent peptic ulcer disease after documentation of previous trials and therapy failure with at least one histamine H2-receptor antagonist at full therapeutic doses and with documentation of either failure of Helicobacter pylori treatment or anegative Helicobacter pylori test result.
				MC/DEL	8	PROTONIX[2]		
				MC/DEL	8	OMEPRAZOLE 10MG[2]		
				MC	8	OMEPRAZOLE-SODIUM BICARBONATE CAPS		
				MC/DEL	8	LANSOPRAZOLE	4. All preferreds and step therapy must be tried and failed.	4. Symptomatic gastroesophageal reflux after documentation of previous trials and therapy failure with at least onehistamine H2-receptor antagonist at full therapeutic doses. Patients may be required to step down from a PPI to a histamine H2-receptor antagonist during the 12 months or on an annual clinical review if PPI therapy is continued. **DDI:** Omeprazole will require prior authorization if being used in combination with Plavix.
				MC	9	OMEPRAZOLE 40MG[3]	5. Established users prior to 10/1/09 may continue to obtain Prevacid until 12/31/09.	**DDI:** Prevacid, Omeprazole and pantoprazole will now be non-preferred and require prior authorization if they are currently being used in combination with any of the following medications: Ampicillin, B-12, Fe salts, Griseofulvin, Sporanox, Ketoconazole, Reyataz, or Vantin. **DDI:** All non-preferred PPIs require prior authorization, but with any prior authorization request, the member's drug profile will also be monitored for current use with ampicillin, B-12, Fe salts, griseofulvin, itraconazole, ketoconazole, Reyataz or Vantin due to a significant drug-drug interaction.
							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		ASACOL 800MG HD	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/DEL		AZULFIDINE EN-TABS TBEC		
	MC/DEL		BALSALAZIDE	MC		GIAZO	1. Current users grandfathered.	
	MC		CANASA SUPP	MC/DEL		LIALDA TABS[1]		
	MC		COLAZAL CAPS	MC/DEL		PENTASA 500MG[2]		
	MC/DEL		DELZICOL	MC		SFROWASA	2. Use multiple Pentasa	

	MC		DIPENTUM CAPS				250mg.	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]	MC		VELPHORO[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/DEL		TERCONAZOLE 0.4MG	MC/DEL		TERCONAZOLE SUPP		
	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

	MC		ACI-JEL GEL					on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	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). 4. 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. 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]		
ANXIOLYTICS								
ANXIOLYTICS - BENZODIAZEPINES	MC/DEL		ALPRAZOLAM TABS	MC/DEL	8	ALPRAZOLAM ER	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		CHLORDIAZEPOXIDE HCL CAPS	MC/DEL	8	ATIVAN		
	MC/DEL		CLORAZEPATE DIPOTASSIUM TABS	MC/DEL	8	NIRAVAM		
	MC/DEL		DIAZEPAM	MC/DEL	8	SERAX		
	MC/DEL		LORAZEPAM	MC/DEL	8	TRANXENE		
	MC/DEL		OXAZEPAM CAPS	MC/DEL	8	XANAX TABS		
				MC/DEL	9	XANAX XR		
ANXIOLYTICS - MISC.	MC/DEL		BUSPIRONE HCL TABS	MC		BUSPAR TABS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		HYDROXYZINE HCL SOLN	MC		DROPERIDOL SOLN		
	MC		HYDROXYZINE HCL SYRP	MC/DEL		HYDROXYZINE HCL TABS		
	MC/DEL		HYDROXYZINE PAMOATE CAPS	MC/DEL		HYDROXYZINE 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	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, cyclobenzaprine and gabapentin prior to approval. Preferred fluoxetine will be the only preferred antidepressant for members who are less than 18 years of age. Exceptions to the rule are as follows: 1. If the member (<18) is already an established user for any of the preferred or non-preferred drugs under the Antidepressant category on the PDL, then they can continue to get that drug. 2. If the member (<18) has a prescription for an antidepressant that is on the PREFERRED side of the PDL and has had a 30 day supply of Fluoxetine at least 30 days before the date
	MC/DEL		BUPROPION SR	MC/DEL	8	BRINTELLIX[13]		
	MC/DEL		BUPROPION XL	MC/DEL	8	CELEXA[4]		
	MC/DEL		CITALOPRAM[4]	MC	8	CYMBALTA[5]		
	MC/DEL		DULOXETINE	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	FETZIMA[12]		
	MC/DEL		FLUOXETINE HCL LIQD	MC/DEL	8	FLUOXETINE 40mg AND 60 mg CAPS[1]		
	MC/DEL		FLUOXETINE HCL 10mg TABS	MC/DEL	8	FLUOXETINE 20mg TABS[6]		
	MC/DEL		FLUVOXAMINE MALEATE TABS	MC	8	FORFIVO XL		
	MC/DEL		MIRTAZAPINE	MC/DEL	8	KHEDEZLA[14]		
	MC/DEL		NEFAZODONE	MC/DEL	8	LEXAPRO TABS[4]		

MC/DEL		PAROXETINE[3]	MC	8	LUVOX TABS	and Lexapro splitting tables.	they are getting it filled, the claim will pay. If they do not have the trial of Fluoxetine in their profile, the claim will reject for PA required.
MC/DEL		SERTRALINE HCL[2]	MC	8	MAPROTILINE HCL TABS		3. If the member (<18) has a prescription for a medication that is on the NON-PREFERRED side of the PDL regardless of having Fluoxetine in their profile, the prescription will need a PA.
MC/DEL		TRAZODONE HCL TABS	MC/DEL	8	MIRTAZAPINE ODT		
MC/DEL		VENLAFAXINE ER CAPS[9]	MC	8	OLEPTRO	5. Max daily dose allowed is 60mg, only 1 capsule per day allowed for all strengths. Combination of multiple strengths require PA.	4. Use of a preferred antidepressant for anxiety will require the diagnosis of anxiety on written prescription and submitted during claim submission.
			MC/DEL	8	PAROXETINE CR[3]		
			MC/DEL	8	PAXIL[3]		**DDI:** Fluvoxamine will now be non-preferred and require prior authorization if it is currently being used with glimepiride (Amaryl).
			MC/DEL	8	PAXIL CR [3]		
			MC/DEL	8	PRISTIQ		**DDI:** Preferred nefazodone will now be non-preferred and require prior authorization if it is currently being used in combination with either Onglyza 5mg, Enablex 15mg or Vesicare 10mg.
			MC	8	PROZAC	6. Use Fluoxetine 10mg tabs in multiples.	**DDI:** Fluoxetine will require prior authorization if being used in combination with Plavix.
			MC	8	PROZAC CAPS		**DDI:** Fluvoxamine will require prior authorization if being used in combination with Plavix.
			MC	8	PROZAC WEEKLY CPDR		
			MC/DEL	8	REMERON TABS	7. Provide clinical documentation as to why a preferred generic alternative cannot be used.	
			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	8. Dosing limits allowing 2 tabs/day and a max daily limit of 200mg / day applies. Please see dose consolidation list.	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.
				8	REMERON SOLTAB TBDP		
			MC/DEL				
			MC/DEL	8	SAVELLA [8]	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	8	ZOLOFT	10. Use venlafaxine ER tabs.	
			MC/DEL	8	VENLAFAXINE TABS[9]	11. Non-preferred products must be used in specified step order.	**SAVELLA: Fibromyalgia diagnosis and trial of a preferred generic amitriptyline, cyclobenzaprine and gabapentin prior to approval.**
			MC/DEL	8	VENLAFAXINE ER TABS[9]		
			MC/DEL	9	VIIBRYD		
			MC/DEL	9	FLUOXETINE 90mg TABS[11]	12. Requires previous trials/failure of multiple preferred medications. Dosing limits apply, please see the dose consolidation list. Max daily dose of 80mg if used concomitantly with strong CYP3A4 inhibitor.	
						13.Dosing limits apply, please see dose consolidation list.	
						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	**ESZOPICLONE**		
	MC/DEL	1	ZOLPIDEM [2]				2. Quantity limits will be allowed up to 30/30, but intermittent therapy is recommended.	
				MC/DEL	7	**ZOLPIDEM ER**		
	MC/DEL	2	ZALEPLON [2,3]	MC/DEL	8	AMBIEN CR[1]		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.
				MCDEL	8	EDLUAR		
				MC/DEL	8	INTERMEZZO		
				MC/DEL	8	LUNESTA[1]		
				MC/DEL	8	SONATA CAPS[1]	3. Only zolpidem trial/failure will be required to obtain Zaleplon.	
				MC/DEL	8	ROZEREM	4. Must fail all preferred products before non-preferred	
				MC/DEL	8	ZOLPIMIST	Use PA Form# 30110	
ANTI-PSYCHOTICS								
ANTIPSYCHOTICS - ATYPICALS	MC		ABILIFY TABS[3,4]	MC/DEL	8	ABILIFY DISC TAB, INJ and SOL [2]	If prescribing 2 or more antipsychotics, PA will be required for both drugs, except if one is Clozapine.This also includes combination of Seroquel with Seroquel XR.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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.
	MC/DEL		**OLANZAPINE**[4]	MC/DEL	8	ABILIFY MAINTENA		
	MC		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]		Prescriptions for quetiapine are limited to a maximum daily dose of 800mg.
				MC	8	RISPERDAL M TAB[2]		
				MC	8	RISPERDAL SOLN	Use PA form# 20440 for Multiple Antipsychotic requests	**DDI:** Abilify, Latuda, 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.
				MC/DEL	8	RISPERIDONE ODT		

				MC/DEL	8	SAPHRIS		**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:
				MC/DEL	8	SEROQUEL 50MG TABS[1,2]		• **schizophrenia**
				MC	8	ZYPREXA TABS		• **bipolar disorder**
				MC	8	ZYPREXA ZYDIS TBDP [2]	Use PA form# 10130 for non-preferred single therapy atypical requests	• **agitation related to autism**
				MC	8	ZYPREXA RELPREVV	1. Please use multiple 25mg tablets.	• **severe behavioral dyscontrol with risk of imminent need for emergency services such as the emergency room, crisis services, or an inpatient psychiatric facility.**
				MC/DEL	8	SEROQUEL TABS		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	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. **DDI:** Clozapine will now be non-preferred and require prior authorization if it is currently being used in combination with carbamazepine. Please use Drug-Drug Interaction PA form #10400.
				MC		FAZACLO		
ANTIPSYCHOTICS - TYPICAL	MC/DEL		CHLORPROMAZINE HCL	MC/DEL		COMPAZINE	Use PA Form# 20420 If prescribing 2 or more antipsychotics, PA will be required for both drugs, except if one is Clozapine.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. If prescribing 2 or more antipsychotics, PA will be required for both drugs, except if one is Clozapine.
	MC/DEL		FLUPHENAZINE DECANOATE	MC/DEL		COMPRO SUPP		
	MC/DEL		FLUPHENAZINE HCL	MC		HALDOL DECANOATE		
	MC		HALDOL	MC/DEL		LOXITANE CAPS		
	MC/DEL		HALOPERIDOL	MC		MELLARIL		
	MC		HALOPERIDOL DECANOATE SOLN	MC/DEL		NAVANE CAPS		
	MC		HALOPERIDOL LACTATE SOLN	MC		PROLIXIN		
	MC/DEL		LOXAPINE SUCCINATE CAPS	MC		STELAZINE TABS		
	MC/DEL		LOXITANE-C CONC					

	MC		MOBAN TABS					
	MC/DEL		PERPHENAZINE					
	MC/DEL		PROCHLORPERAZINE					
	MC		SERENTIL					
	MC/DEL		THIORIDAZINE HCL					
	MC/DEL		THIOTHIXENE					
	MC/DEL		TRIFLUOPERAZINE HCL TABS					
LITHIUM								
LITHIUM	MC/DEL		LITHIUM CARBONATE	MC/DEL		ESKALITH CAPS	Use PA Form# 20420	
	MC/DEL		LITHIUM CITRATE SYRP	MC/DEL		ESKALITH CR TBCR		
COMBINATION - PSYCHOTHERAPEUTIC								
PSYCHOTHERPEUTIC COMBINATION	MC/DEL		CHLORDIAZEPOXIDE/AMITRIPT	MC	8	SYMBYAX[1]	1. Only available if component ingredients are unavailable. Use PA Form# 20420	
	MC/DEL		PERPHENAZINE/AMITRIPTYLIN					
STIMULANTS								
STIMULANT - AMPHETAMINES -SHORT ACTING	MC/DEL		ADDERALL TABS[1]	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. 2. FDA approval is currently for adults and children 6 or older. Will be available without PA for this age group if within dosing limits. Limit of one capsule daily. Max dose of 70MG daily. 3. Preferred stimulants will be available without PA if diagnosis of ADHD.	Adderall XR- Current users as of 12/31/11 without prior use of Vyvanse will be required to transition to the preferred vyvanse product. Other members 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		

							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 FAZACLO	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[4]	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/DEL MC MC MC/DEL MC MC/DEL MC/DEL	7 7 8 8 8 8 9	MODAFINIL TABS STRATTERA[1,2] CAFCIT SOLN[3] INTUNIV KAPVAY PROVIGIL TABS[3] NUVIGIL[3]	1. Failure of both an amphetamine and methylphenidate is required for consideration for approval of Strattera, unless history of substance abuse without current use of abusable medication(s). Additionally, for patients <17	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	9	DESOXYN TABS[3]	years of age, a trial of quanfacine in required before approval of Strattera.	
				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	DONEPEZIL HYDROCHLORIDE TABS 23MG		
	MC/DEL		NAMENDA[1]	MC/DEL	7	**GALANTAMINE CAPS**		
				MC	8	RAZADYNE[2]	2. Must fail all preferred products before moving to non-preferred.	
				MC/DEL	8	RIVASTIGMINE TARTRATE CAPS[2]		
				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 July 1, 2014 per MaineCare policy, smoking cessation products will be covered without a copay(including MEDEL). No annual or lifetime limits, must follow FDA approved indications and therapy guidelines.
	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. **Note:** MaineCare policy, smoking cessation product were "not covered" except for during pregnancy between 9/1/12 and 1/1/14, between 1/1/2014 and 7/1/14 smoking cessation products were covered with limitations 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.
NICOTINE REPLACEMENT - OTHER	MC/DEL		NICOTINE POLACRILEX GUM[1]	MC/DEL	8	NICOTROL INHALER[1,2]	Use PA Form# 20420 1. See criteria section for exemptions 2. Must use non-preferred products in specified step order.	As of July 1, 2014 per MaineCare policy, smoking cessation products will be covered without a copay(including MEDEL). No annual or lifetime limits, must follow FDA approved indications and therapy guidelines. 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. **Note:** MaineCare policy, smoking cessation product were "not covered" except for during pregnancy between 9/1/12 and 1/1/14, between 1/1/2014 and 7/1/14 smoking cessation products were covered with limitations 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.
				MC/DEL	8	NICOTROL NASAL SPRAY[1,2]		
				MC/DEL	8	NICORETTE GUM[1,2]		
				MC	8	NICORETTE LOZENGES		
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	8	AVINZA	Use PA Form# 20510 Use PA form #10300 for PAs over the opiate limit 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.	Preferred drugs (Fentanyl Patch, Morphine Sulfate ER tab, Opana ER 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;
	MC/DEL		METHADONE	MC/DEL	8	BUTRANS[4]		
	MC/DEL		METHADOSE	MC	8	DURAGESIC PT72[4]		
	MC/DEL		MORPHINE SULFATE ER TB12	MC/DEL	8	EMBEDA		
	MC		OPANA ER	MC	8	EXALGO		
				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	8	ZOHYDRO ER		

				MC/DEL	9	NUCYNTA ER		2.Multiple instances of early refill overrides due to reports of misplacement, stolen, dropped in toilet or sink, distant travel, etc.;
				MC/DEL	9	OXYCODONE ER[3,5]		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;
							2. Established users are grandfathered.	5.Failing to take or pass random drug testing;
							3. Oxycodone ER allowed only 2 per day for all strengths except 80 mg, where 4 are allowed to	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
							4. Dosing limits apply. Please see dose consolidation list.	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.
							5. Non-preferred products must be used in specific order.	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 Use PA form #10300 for PAs over the opiate limit	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.
				MC	8	BUPRENEX SOLN	1. Only available if component ingredients are unavailable.	
				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		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**

MISCELLANEOUS NARCOTICS								
NARCOTICS - MISC.	MC/DEL		ACETAMINOPHEN/CODEINE	MC/DEL	8	ABSTRAL	1. Fentanyl OT loz (Barr) and Capital and codeine suspension products require PA for users over 18 years of age. PA is not required if under 18 years of age. 2. Oxycodone/acet 10/650 is 8 times more expensive. Use twice as many of oxycod/acet 5/325 instead. You can mix andmatch preferred strengths of oxycodone and oxycodone/acet to minimize acet. dose similar to certain non-preferred drugs. 3. Only preferred manufacturer's products will be available without prior authorization. Use PA Form# 20420 Use PA form #10300 for PAs over the opiate limit	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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 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		ASPIRIN/CODEINE TABS	MC/DEL	8	ASCOMP/CODEINE CAPS		
	MC/DEL		BUTAL/ASA/CAFF/COD CAPS	MC/DEL	8	BUTALBITAL/APAP/CAFFEINE/ CAPS		
	MC		BUTALBITAL/ASPIRIN/CAFFEI CAPS	MC	8	DEMEROL		
	MC		CAPITAL AND CODEINE SUSP[1]	MC/DEL	8	DILAUDID		
	MC		CAPITAL/CODEINE SUSP[1]	MC	8	DILAUDID-HP SOLN		
	MC/DEL		CODEINE PHOSPHATE SOLN	MC	8	FENTANYL CITRATE SOLN		
	MC/DEL		CODEINE SULFATE TABS	MC/DEL	8	FENTORA		
	MC/DEL		ENDOCET TABS[3]	MC/DEL	8	FIORICET/CODEINE CAPS		
	MC/DEL		ENDODAN TABS	MC	8	FIORINAL/CODEINE #3 CAPS		
	MC/DEL		FENTANYL OT LOZ[1]	MC	8	FIORTAL/CODEINE CAPS		
	MC/DEL		HYDROCODONE BITARTRATE/AP TABS	MC/DEL	8	HYDROCODONE/IBUPROFEN		
	MC/DEL		HYDROCODONE/ACETAMINOPHEN	MC	8	IBUDONE		
	MC/DEL		HYDROMORPHONE HCL[3]	MC/DEL	8	LORCET		
	MC/DEL		MEPERIDINE HCL	MC	8	LORTAB		
	MC/DEL		OXYCODONE 5MG	MC	8	MAXIDONE TABS		
	MC/DEL		OXYCODONE 15MG	MC/DEL	8	NORCO TABS		
	MC/DEL		OXYCODONE 30MG	MC/DEL	8	NUCYNTA		
	MC/DEL		OXYCODONE/ACETAMINOPHEN[2,3]	MC/DEL	8	ONSOLIS		
	MC/DEL		PENTAZOCINE/NALOXONE TABS	MC/DEL	8	OXECTA		
	MC		PROPOXYPHENE CMPND-65 CAPS	MC/DEL	8	OXYCODONE 10MG		
	MC		PROPOXYPHENE COMPOUND CAPS	MC/DEL	8	OXYCODONE 20MG		
	MC/DEL		PROPOXYPHENE HCL CAPS	MC/DEL	8	OXYCODONE/APAP 10/650		
	MC/DEL		PROPOXYPHENE/ACET TABS	MC/DEL	8	OXYCODONE/APAP 7.5/500		
	MC/DEL		PROPOXYPHENE-N/ACET TABS	MC/DEL	8	PENTAZOCINE/ACET TABS		
	MC/DEL		ROXICET	MC	8	PERCOCET TABS		
	MC		ROXIPRIN TABS	MC	8	PERCOCET TABS		
				MC	8	PHRENILIN W/CAFFEINE/CODE CAPS		
				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		
					9	ACTIQ LPOP		
				MC				
				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	
							1. Buprenorphine will only be approved for use during pregnancy.	
				MC		ZUBSOLV	2. See Criteria Section	Suboxone Criteria
							3. The manufacturer will be disconntinuing the tablets by the end of quarter one 2013.	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]	Use PA Form# 20420	Please see the criteria listed on the Vivitrrol PA form.
				MC/DEL		VIVITROL INJ[2]	Use PA form# 30400 for Vivitrol requests	
							1. Will only be approved for side effects experienced with generic that are not described in the literature as occurring with the brand version.	

							2. Please see the criteria listed on the Vivitrrol PA form. Any narcotics attempting to be filled during Vivitrol approval will require prior authorization.	
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. 6. The FDA has issued a Public Health Advisory warning of the potential for increased cardiovascular risk & GI bleeding with NSAID use.	Approved without PA for patients 60 years old or over. Patients under 60 can use a preferred proton pump inhibitor with any preferred generic NSAID to achieve similar reductions in GI bleeding risk to that seen with the COX-II agents. Approvals for Celebrex will be granted for other requests based on failure of at least one generic NSAID from at least 2 different NSAID classes as described in the COX-II PA form. High risk GI bleeding patients must fail on adequate trials of safer agents (non-NSAID/Cox-2) for GI tract, such as acetaminophen.
NSAIDS	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		**CHILDRENS IBUPROFEN** **DICLOFENAC POTASSIUM TABS** **DICLOFENAC SODIUM** **ETODOLAC** **FENOPROFEN CALCIUM TABS** **FLURBIPROFEN TABS** **IBUPROFEN** **INDOMETHACIN**	MC MC MC MC MC/DEL MC MC MC/DEL		ADVIL TABS ANAPROX TABS ANAPROX DS TABS CAMBIA **CATAFLAM TABS** CHILDRENS ADVIL SUSP CHILD'S IBUPROFEN SUSP CHILDREN'S MOTRIN SUSP	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.

	MC/DEL		**KETOPROFEN**	MC/DEL		**CLINORIL TABS**		
	MC/DEL		**MECLOFENAMATE SODIUM CAPS**	MC/DEL		**DAYPRO TABS**		
	MC/DEL		NAPROSYN SUSP	MC/DEL		**EC-NAPROSYN TBEC**		**DDI:** Diclofenac will now be non-preferred and require prior authorization if it is currently being used in combination with lescol.
	MC/DEL		NAPROXEN SUSP	MC/DEL		**ETODOLAC ER 600MG**		
	MC/DEL		**NAPROXEN TABS**	MC		FELDENE CAPS		The FDA has issued a Public Health Advisory warning of the potential for increased cardiovascular risk & GI bleeding with NSAID use.
	MC/DEL		**NAPROXEN SODIUM TABS**	MC/DEL		IBU-200		
	MC/DEL		**OXAPROZIN TABS**	MC		INDOCIN		
	MC/DEL		**SULINDAC TABS**	MC/DEL		**LODINE**		
	MC/DEL		**TOLMETIN SODIUM**	MC/DEL		**MOTRIN**		
				MC		NALFON CAPS		
				MC/DEL		NAPRELAN TBCR		
				MC/DEL		NAPROSYN TABS		
				MC/DEL		**NAPROXEN DR TBEC**		
				MC/DEL		**NAPROXEN SODIUM TBCR**		
				MC		PENNSAID		
				MC/DEL		**PIROXICAM CAPS**		
				MC		PONSTEL CAPS		
				MC		SB IBUPROFEN TABS		
				MC		SPRIX		
				MC		TOLECTIN		
				MC/DEL		VOLTAREN		
				MC		V-R IBUPROFEN TABS		
				MC		ZORVOLEX		
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. 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.	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**		

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 MC/DEL	1 1 1 2	RELPAX[1] **RIZATRIPTAN** SUMATRIPTAN TABS[1] NARATRIPTAN HCl TABS[1]	MC/DEL MC 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 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 MC/DEL MC/DEL		**ALLOPURINOL TABS** **PROBENECID TABS** **PROBENECID/COLCHICINE TABS**	MC MC/DEL MC		COLCRYS ULORIC[1] ZYLOPRIM TABS	Use PA Form# 20420 1. Failure of therapeutic (300mg) dose of Allopurinol (failure define as not being	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.

							failure define as not being able to get uric acid levels below 6mg/dl) or severe renal disease.	
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		
VACCINES	MC/DEL		GARDASIL VACCINES				Use PA Form# 20420	Under the Maine Immunization Program Gardasil is covered under the Vaccine for Children Program for ages 9-18. Gardasil will be preferred by MaineCare for ages 19-26. Children who are 18 years old or younger are eligible for this vaccine through the Maine Immunization Program. Please contact 1-800-867-4775 or 207-287-3746 for assistance.
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,	
	MC/DEL		DILANTIN	MC/DEL	8	EQUETRO	please see dose	
	MC/DEL		DIVALPROEX SODIUM	MC	8	FYCOMPA[4,9]	consolidation list.	*** SEE CHART AT END OF DOCUMENT
	MC/DEL		EPITOL TABS	MC/DEL	8	GABITRIL TABS	3. Dosing limits apply per	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	HORIZANT	strength as well as a	
	MC/DEL		FELBATOL	MC/DEL	8	GABAPENTIN 600mg & 800mg	maximum daily dose of	
	MC/DEL		GABAPENTIN[2] 300mg & 400mg	MC	8	GRALISE	600mg. Please see dose	
	MC/DEL		LAMOTRIGINE[2]	MC/DEL	8	KEPPRA TABS	consolidation list.	
	MC/DEL		LEVETIRACETAM SOLN/TABS	MC/DEL	8	KEPPRA SOLN		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	KLONOPIN TABS	4. Adjunctive therapy 17 and	
	MC/DEL		OXCARBAZEPINE	MC/DEL	8	LAMICTAL	older.	
	MC/DEL		PHENYTEK CAPS	MC/DEL	8	**LEVETIRACETAM INJ**	5. Current users as of	All non-preferred meds must be used in specified order.
	MC/DEL		PHENYTOIN	MC/DEL	8	**LEVETIRACETAM ER TABS**	7/30/10 for seizures will be	
	MC/DEL		TEGRETOL	MC/DEL	8	LYRICA[3]	grandfathered.	
	MC/DEL		TOPIRAMATE	MC	8	ONFI		
	MC/DEL		TOPIRAMATE SPRINKLE CAPS[2]	MC	8	OXTELLAR XR[7]		**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, Latuda, Seroquel, telithromycin or Zyprexa.
	MC/DEL		TRILEPTAL SUSP	MC/DEL	8	POTIGA	6. Product is considered line	
	MC/DEL		VALPROIC ACID	MC/DEL	8	PRIMIDONE TABS	extension of the original	
	MC/DEL		VALPROIC ACID	MC	8	SABRIL	product due to Healthcare	
	MC/DEL		ZONISAMIDE	MC	8	TOPAMAX	Reform (HCR). MaineCare will consider these	Please use Drug-Drug Interaction PA form #10400 for this combination.
				MC	8	TOPAMAX SPRINKLE CAPS[2]	medications non-preferred	
				MC	8	TROKENDI[2,8]	and a step 9 because of the	
				MC/DEL	8	TRILEPTAL	impact under the Federal	ONFI will require a clinical PA to confirm LGS diagnosis
				MC/DEL	8	VIMPAT[4]	Rebate Program in	
				MC/DEL	8	ZARONTIN SYRP	conjunction with HCR.	
				MC/DEL	9	KEPPRA XR[5,6]		
				MC/DEL	9	NEURONTIN		
				MC/DEL	9	TEGRETOL-XR TB12[5,6]	7. Max dose 2400mg	
				MC/DEL	9	ZONEGRAN CAPS	8. Clinical PA required for	
				MC/DEL	9	LAMICTAL XR	appropriate diagnosis	

							9. Requires previous trials/failure of medications.	
						BIPOLAR DISORDER: STEP ORDER		
					M ~ A		SEE ANTICONVULSANT INDICATION CHART AT THE END OF THIS DOCUMENT M= Monotherapy A= Adjunctive 9= No Evidence The step orders show the relative strength of evidence for use in bi-polar and will guide prior authorization determinations. Step 4 drugs-no PA required.	
					4 ~ 4	LAMICTAL		
					4 ~ 4	LITHIUM		
					4 ~ 4	CARBAMAZEPINE		
					4 ~ 4	VALPROATE		
					4 ~ 4	ATYPICAL ANTIPSYCHOTICS EXC. CLOZAPINE		
					5 ~ 5	TRILEPTAL		
					9 ~ 6	TOPAMAX		
					9 ~ 7	KEPPRA TABS		
					9 ~ 8	GABITRIL TABS		
					9 ~ 9	NEURONTIN		
					9 ~ 9	ZONEGRAN CAPS		
						PEDIATRIC BIPOLAR1 DISORDER: STEP ORDER		
					M ~ A	(6-18 YEARS WITH OR WITHOUT PSYCHOSIS)		
					4 ~ 4	LITHIUM		
					4 ~ 4	CARBAMAZEPINE	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.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a 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/DEL		**BROMOCRYPTINE**		
	MC/DEL		**CARBIDOPA/LEVODOPA ER**	MC		ELDEPRYL CAPS		
	MC		LARODOPA TABS	MC		LODOSYN TABS		
	MC/DEL		**PARLODEL CAPS**	MC/DEL		**PARLODEL TABS**		
	MC/DEL		**SELEGILINE CAPS HCL**	MC/DEL		**SELEGILINE TABS HCL**		
				MC		SINEMET TABS		

				MC		SINEMET TBCR		
				MC		ZELAPAR[1]	3. Only preferred manufacturer's products will be available without prior authorization. Use PA Form# 20420	
PARKINSONS - COMBO.				MC/DEL		STALEVO[1]	Use PA Form# 20420	
				MC		CARBIDOPA/LEVODOPA/ENTACA[1]	1.Clinical PA is required to establish diagnosis and medical necessity.	
MUSCLE RELAXANTS								
ALS DRUG	MC/DEL		**RILUZOLE**	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 approved, unless an…… acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Elderly patients, over 65, will require written notice of the increased sedative risks and impaired driving.Prior Authorization will not be given for:1. frequent or persistent early refills of controlled drugs; 2. multiple instances of early refill overrides due to reports of misplacement, stolen, dropped in toilet or sink, distant travel, etc.
	MC/DEL		**CHLORZOXAZONE TABS**	MC/DEL	7	**ORPHENADRINE CITRATE**		
	MC/DEL		**CYCLOBENZAPRINE HCL TABS**	MC/DEL	8	**CARISOPRODOL 350MG 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		**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	8	**ZANAFLEX TABS**		
				MC/DEL	9	**CARISOPRODOL 250MG TABS**		
				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					Preferred products that used to require diag codes still require diag codes unless indicated otherwise.
	MC		PYRIDOXINE HCL TABS					
	MC/DEL		SLO-NIACIN TBCR					
	MC/DEL		THIAMINE HCL SOLN					
	MC/DEL		VITAMIN B-1 TABS					
	MC/DEL		VITAMIN B-12					
	MC		VITAMIN B-6 TABS					
	MC/DEL		VITAMIN C					
	MC/DEL		VITAMIN E CAPS					

	MC/DEL		VITAMIN E/D-ALPHA CAPS					
	MC		VITAMIN K1 SOLN					
	MC		V-R VITAMIN E CAPS					
VITAMIN D's	MC/DEL		**CALCITRIOL CAPS**[1]	MC/DEL		**DRISDOL CAPS**	1. Diagnosis of dialysis (renal failure) required. Use PA Form# 20420	Preferred products require dialysis/renal failure diagnosis. 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/DEL		**VITAMIN D**	MC		CALCIJEX		
	MC		ZEMPLAR TABS	MC/DEL		HECTOROL (ORAL)		
				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. Please refer to OTC 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. As listed in MaineCare Policy, certain drugs require specific diagnoses for approval. Please refer to OTC list. Preferred products that used to require diag codes still require diag codes unless indicated otherwise.
	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		
	MC		CENTRUM-LUTEIN TABS	MC		CENTRUM PERFORMANCE TABS		
	MC		CEROVITE ADVANCED FO TABS	MC		CITRANATAL		
	MC/DEL		CHEWABLE MULTIVIT/FL CHEW	MC		DALYVITE LIQD		
	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 Please refer to OTC list.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. As listed in MaineCare Policy, certain drugs require specific diagnoses for approval. **DDI:** Fe salts will now be non-preferred and require prior authorization if it is currently being used in combination with either Prevacid, pantoprazole, Prilosec, or any currently non preferred PPI. Please refer to OTC list. Preferred products that used to require diag codes still require diag codes unless indicated otherwise.
	MC		CALCI-MIX CAPSULE CAPS	MC		CALCET TABS		
	MC		CALCIQUID SYRP	MC/DEL		**CALCIUM 600-D TABS**		
	MC		CALCITRATE/VITAMIN D TABS	MC		CALCIUM/VITAMIN D TABS		
	MC/DEL		CALCIUM	MC		CALTRATE 600 PLUS/VIT D TABS		
	MC/DEL		CALCIUM CARBONATE	MC		CALTRATE PLUS TABS		
	MC/DEL		CALCIUM CITRATE TABS	MC		CHROMAGEN		
	MC/DEL		CALCIUM GLUCONATE TABS	MC		CITRACAL PLUS TABS		
	MC/DEL		CALCIUM LACTATE TABS	MC		CONTRIN CAPS		
	MC		CALCIUM/MAGNESIUM TABS	MC		FEOGEN FORTE CAPS		
	MC/DEL		**CALCIUM/VITAMIN D TABS**	MC		FEROCON CAPS		
	MC		CALTRATE 600 TABS	MC/DEL		FERREX 150 CAPS		
	MC/DEL		CHEWABLE CALCIUM CHEW	MC		FERRO-SEQUELS TBCR		
	MC		CITRACAL TABS	MC		FE-TINIC CAPS		
	MC		CITRACAL + D TABS	MC		FE-TINIC 150 FORTE CAPS		
	MC		CITRUS CALCIUM TABS	MC/DEL		FLUOR-A-DAY SOLN		
	MC		CITRUS CALCIUM 1500 + D TABS	MC/DEL		K-DUR TBCR		
	MC		EFFERVESCENT POTASSIUM TBEF	MC		KLOR-CON PACK		
	MC/DEL		FEOSTAT CHEW	MC		K-LYTE		
	MC		FERATAB TABS	MC/DEL		K-PHOS TABS NEUTRAL		
	MC/DEL		FER-GEN-SOL SOLN	MC		K-TABS TBCR		
	MC		FER-IRON SOLN	MC		K-VESCENT PACK		
	MC		FERRONATE TABS	MC		MICRO-K 10 MEG CPCR		
	MC/DEL		FERROUS SULFATE	MC		NU-IRON 150 CAPS		
	MC/DEL		FLUOR-A-DAY CHEW	MC/DEL		**OYSTER SHELL CALCIUM/VITA TABS**		
	MC		FLUORIDE CHEW	MC/DEL		POLY-IRON 150 CAPS		
	MC		FLUORIDE SODIUM CHEW	MC/DEL		POLYSACCHARIDE IRON CAPS		
	MC		FLUORITAB CHEW	MC/DEL		POTASSIUM BICARB/CHLORIDE		
	MC		HEMOCYTE TABS	MC/DEL		POTASSIUM CHLORIDE 10MEQ CAPS		
	MC		HM CALCIUM TABS	MC/DEL		POTASSIUM CHLORIDE 8MEQ CAPS		
	MC		K+ POTASSIUM PACK	MC/DEL		SLOW FE TBCR		
	MC		KAON ELIX	MC		TUMS 500 CHEW		

	MC		KAON-CL-10 TBCR	MC		VIACTIV CHEW		
	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.** Medical foods are not to be authorized solely for the purpose of enhancing nutrient intake or managing body weight if the participant is able to eat conventional foods adequately. Medical foods may be approved if the member has a medical condition which precludes or restricts the use of conventional foods and necessitates the use of a formula. Concurrent Stimulant therapy is not an acceptable medical reason/condition for use of medical foods for enhancing nutrient intake or managing body weight.
	MC		P.T.E. -5 SOLN[1]	MC		CASEC POWD[1]		
	MC/DEL		SEA-OMEGA CAPS[1]	MC		CHOICE DM LIQD[1]		
				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 1. Clinical PA is required to establish medical necessity and that appropriate lab monitoring is being done.	Non-Preferred drugs must be tried and failed in step-order, due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Please see the EPO PA form for other approval and renewal criteria.
				MC	8	ARANESP SOLN		
				MC/DEL	8	OMONTYS		
GRANULOCYTE CSF								
GRANULOCYTE CSF				MC	8	LEUKINE	1. Must be used in specified step order. 2.10 day supply/month may be used without a PA. Use PA Form# 20520	See approval criteria detailed on Neupogen PA form.
				MC	8	NEUPOGEN SOLN[2]		
				MC	9	NEULASTA[1]		
ANTICOAGULANTS / PLATELET AGENTS								
ANTICOAGULANTS	MC		ARIXTRA SOLN[1]	MC/DEL		ELIQUIS	1. Arixtra, Fragmin and Lovenox therapy durations greater than 7 days require PA. 2. Use other strengths available to obtain desired dose. 3. Please refer to Pradaxa PA form for criteria. 4.Established users will be grandfathered, new starters must use preferred product Coumadin. Use PA form# 20725 for Pradaxa requests Use PA form# 20420 for other requests	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Exceeding days supply limits for LMWH class requires PA. **DDI:** Warfarin will require prior authorization if being used in combination with fluconazole, miconazole, or voriconazole. **DDI:** Warfarin will require prior authorization if being used in conjunction with Gemfibrozil or Fenofibrate. Current Warfarin Sodium Tab
	MC		COUMADIN TABS	MC/DEL		ENOXAPARIN		
	MC/DEL		FRAGMIN INJ[1]	MC/DEL		FONDAPARINUX		
	MC		HEPARIN SODIUM/NACL 0.9% SOLN	MC		IPRIVASK		
	MC		HEP-LOCK SOLN	MC/DEL		JANTOVEN		
	MC/DEL		**INNOHEP**	MC/DEL		LOVENOX 300[2]		
	MC/DEL		**LOVENOX SOLN[1]**	MC/DEL		PRADAXA[3]		
	MC		HEPARIN LOCK SOLN	MC/DEL		**WARFARIN SODIUM TABS[4]**		
	MC/DEL		HEPARIN LOCK FLUSH SOLN	MC/DEL		XARELTO		
	MC/DEL		HEPARIN SODIUM SOLN					
	MC/DEL		HEPARIN SODIUM LOCK FLUSH SOLN					
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	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				volume dosing in patients with poor venous access.	
	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	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a 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		**DIPYRIDAMOLE TABS**	MC	8	EFFIENT[1]		
	MC/DEL		**CLOPIDOGREL 75MG**	MC/DEL	8	PERSANTINE TABS	Use PA form# 20420 for other requests	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.
				MC/DEL	8	BRILINTA[1,2]	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.	**DDI:** Plavix will require prior authorization if being used in combination with omeprazole, esomeprazole, cimetidine, fluconazole, ketoconazole, intelence, fluoxetine, ticlopidine, and fluvoxamine.
				MC/DEL	8	PLAVIX TABS[1]		**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.
							2. Dosing limits apply, please see dose consolidation list.	
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		MAXITROL OPTH OINT 0.1%	MC		NEO/POLY/BAC/HC OINT		
	MC		PRED MILD SUSP	MC/DEL		NEOM/POLY/DEX OPTH OINT 0.1%		
	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	

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

				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.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a 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]		

							Use PA Form# 20420	
TOPICAL - ANTISEBORRHEICS	MC/DEL		SELENIUM SULFIDE SHAM	MC		CARMOL SCALP TREATMENT KIT	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
				MC		ZNP BAR		
TOPICAL - ANTIVIRALS				MC/DEL		DENAVIR CREA[1, 3]	1. Must fail oral treatment with Acyclovir or Valacyclovir. 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		GRANUL-DERM AERS	MC		CARMOL 40 CREA	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Ziox, Panafil and Papain products have been removed from the PDL due to FDA safety concerns regarding drugs containing Papain.
	MC/DEL		GRANULEX AERS	MC		SALEX CREA		
	MC		TBC AERS	MC		SALEX LOTN		
	MC		SANTYL OINT					
TOPICAL - GENITAL WARTS	MC/DEL		IMIQUIMOD[2]	MC/DEL	5	PODOFILOX SOLN	Use PA Form# 20420 1. Non-preferred products must be used in specified order. 2. Dosing limits still apply. Please see dose consolidation list.	
				MC/DEL	8	ALDARA		
				MC/DEL	8	CONDYLOX[1]		
				MC	8	PICATO		
				MC	8	VEREGEN[1]		
				MC	8	ZYCLARA[1]		
TOPICAL - IMMUNOMODULATORS				MC/DEL	8	ELIDEL CREA[1]	Use PA Form# 20420 1. Non-preferred products must be used in specified order. 2. The FDA has issued a Public Health Advisory for both Elidel and Protopic concerning the potential cancer risk associated with their use. Use for children less than 2 years of age is not recommended.	Preferred corticosteroids from other classes must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Approvals will be made for small amounts of non-preferred products for the treatment of very steroid-sensitive areas in conjunction with topical steroids for the treatment of atopic dermatitis.
				MC	9	PROTOPIC OINT[1,2]		

TOPICAL - LOCAL ANESTHETICS	MC		AF CAPSICUM OLEORESIN CREA	MC/DEL		EMLA PADS	1. Lidocaine/Prilocaine cream and Ela-Max products require PA for users over 18 years of age.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		CAPSAICIN CREA	MC/DEL		EMLA CREA		
	MC		ELA-MAX[1]	MC		LIDA MANTLE CREA		
	MC/DEL		LIDOCAINE/PRILOCAINE CREA[1]	MC		LIDODERM PTCH		
	MC/DEL		LIDOCAINE GEL	MC		PONTOCAINE SOLN		
				MC		SYNERA	Use PA Form# 20420	
				MC		ZOSTRIX		
TOPICAL - DEPIGMENTING AGENTS				MC	8	ALUSTRA CREA		As per Medicaid Policy, cosmetic drugs are not covered. Non-cosmetic clinical applications will be considered by prior authorization on a case by case basis.
				MC	8	EPIQUIN MICRO		
				MC	8	GLYQUIN CREA		
				MC/DEL	8	HYDROQUINONE CREA	Use PA Form# 20420	
				MC/DEL	8	HYDROQUINONE/SUNSCREENS		
				MC	8	SOLAQUIN FORTE CREA		
				MC	8	TRI-LUMA CREA		
				MC	9	ELDOQUIN		
TOPICAL - SCABICIDES AND PEDICULICIDES	MC/DEL	1	ACTICIN CREA	MC/DEL		LINDANE	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.
	MC	1	ELIMITE CREA	MC		MALATHION		
	MC	1	EURAX	MC		OVIDE LOTN		
	MC	1	LICE KILLING SHAM	MC		SKLICE		
	MC/DEL	1	LICE TREATMENT CREME RINS LIQD	MC		ULESFIA		
	MC/DEL	1	PERMETHRIN LOTN					
	MC	2	NATROBA[1,2]					
TOPICAL - WOUND / DECUBITUS CARE				MC		REGRANEX 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. Regranex will be approved for diabetic patients in good control (hgba1c <8), who are not smoking, with a stage III or IV WOCN AND NPUAP lower extremity diabetic ulcer and with an adequate blood supply (Tcp 02 >30, ABI>0.7 or ASP> 70), and where the underlying cause has been corrected. The wound must be free of infection and have been previously treated with preferred standard therapies for at least 2 months. Maximum approval for 20 weeks. Accuzyme and Ethezyme products have been removed from the PDL due to FDA concerns regarding drugs containing Papain.
				MC/DEL		REGENECARE		
				MC/DEL		RADIAPLEXRX		
TOPICAL - ASTRINGENTS / PROTECTANTS	MC		ALUMINUM CHLORIDE SOLN	MC		LOWILA BAR	Use PA Form# 20420 1. Dosing limits apply, please refer to dosage consolidation list.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		DRYSOL SOLN[1]	MC		MOISTURIN DRY SKIN CREA		
	MC		XERAC AC SOLN	MC		PROSHIELD PLUS SKIN PROTE CREA		
				MC		SURGILUBE GEL		
TOPICAL - ANTISEPTICS / DISINFECTANTS	MC/DEL		PHISOHEX LIQD	MC		BETADINE OINT	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		POVIDONE-IODINE SOLN	MC		FORMALYDE-10 AERS		
				MC		IODOSORB		
				MC		LAZERFORMALYDE SOLUTION SOLN		
MISCELLANEOUS EYE								
OP. - EYE	MC		AK-DILATE SOLN	MC		LENS PLUS REWETTING DROPS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		EYE WASH SOLN	MC/DEL		MURO 128		
	MC		NAPHAZOLINE HCL SOLN	MC		NEO-SYNEPHRINE SOLN		
	MC		PHENYLEPHRINE HCL SOLN					
	MC		PONTOCAINE SOLN					
	MC/DEL		SODIUM CHLORIDE					
MISCELLANEOUS EAR								
EAR	MC/DEL		A/B OTIC SOLN	MC		AERO OTIC HC SOLN	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		ACETASOL SOLN	MC		ANTIBIOTIC EAR SOLN		
	MC/DEL		ACETASOL HC SOLN	MC		ANTIBIOTIC EAR SUSP		
	MC/DEL		ACETIC ACID	MC		AURALGAN SOLN		
	MC/DEL		ACETIC ACID/HYDROCORTISON	MC		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		
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	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.
	MC		HUMIRA[1]					

							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	Enbrel is preferred after a trial of a step 1 product (e.g. azathioprine, methotrexate, etc.); however, dosing limits will also still apply. Dosing limits will allow 8 injections per month without pa. Use of greater than 8 injections per month will require PA. In addition, the preferred Enbrel 25mg product will be the multi-dose vial (NDC- 58406-0425-34). The single-use prefilled syringes are non-preferred.
ALTERNATIVE MEDICINES								
ALTERNATIVE MEDICINES	MC		DIMETHYL SULFOXIDE SOLN	MC/DEL MC		CO-ENZYME Q-10 MELATONIN TABS	Use PA Form# 20420	Will only be approved for specific conditions supported by at least two double-blinded, placebo-controlled randomized trials that are not contradicted by other studies of similar quality.
CHELATING AGENTS								
CHELATING AGENTS	MC/DEL		**CUPRIMINE CAPS**	MC MC/DEL		DEPEN TITRATABS TABS EXJADE[1]	Use PA Form# 20420 1. FDA indication of treatment of chronic iron ovrload due to blood transfustions in membes 2 years of age and older is requried for approval of Exjade.	
ANTILEPROTIC								
ANTILEPROTIC				MC		THALOMID CAPS[1]	1. All PA requests for 150mg dosing will require use of Thalomid 100mg and 50mg capsules. Use PA Form# 20420	Approved for indications of leprosy, treatment-resistant multiple myeloma and AIDS.
ANTINEOPLASTIC AGENTS								
ANTINEOPLASTIC AGENTS - ANTIADNDROGENS	MC/DEL		BICALUTAMIDE	MC/DEL		CASODEX	Use PA Form# 20420	
ANTINEOPLASTIC AGENTS- LHRH ANALOGS	MC		LUPRON DEPOT[1]	MC MC MC/DEL		VANTAS[2] FIRMAGON[2] TRELSTAR	1. Dosing limits apply, please refer to dosage consolidation list. 2. PA required to confirm FDA approved indication. Use PA Form# 20420	
ANTINEOPLASTIC AGENTS - TYROSINE KINASE INHIBITORS				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/DEL MC MC MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC		ARIMIDEX BOSULIF COMETRIQ[3,4,5] ERIVEDGE FOLOTYN GILOTRIF[4,5] 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). **Gilotrif** needs to be prescribed by an oncologist **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 MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL		CYCLOSPORINE MODIFIED GENGRAF CAPS MYCOPHENOLATE MYFORTIC NEORAL PROGRAF CAPS RAPAMUNE SANDIMMUNE	MC/DEL MC/DEL MC/DEL		CELLCEPT CYCLOSPORINE CAPS CYCLOSPORINE SOL. MODIFIED	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		KAYEXALATE POWD				Use PA Form# 20420	

	MC		KIONEX POWD					
	MC/DEL		SODIUM POLYSTYRENE SULFON					
	MC/DEL		SPS SUSP					
	MC/DEL		SPS 30GM/120ML ENEMA SUSP					

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

ANTI-CONVULSANTS INDICATION CHART

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

PEDIATRIC ANTI-CONVULSANTS INDICATION CHART

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

Last update 12/13

PDL DOSAGE CONSOLIDATION LIST

Tabs/Caps/Patches: Quantities in units

Sprays/Inhalers/Nebulizers: Quantities in GM, ML, OR MCG

Injectibles: Quantities in ML

Shaded areas are non-preferred agents - Quantities of these non-preferred agents are available up the limit only with prior authorization

Drug Name	Strength	Limit/Day	Limit/Days
ABILIFY	5MG	0.5	18/35
ABILIFY	10MG	0.5	18/35
ABILIFY	15MG	0.5	18/35
ABILIFY	20MG	0.5	18/35
ABILIFY	30MG	0.5	18/35
ABILIFY SOLUTION	1MG/ML	30ML	1020/34
ACCUPRIL	5MG	1	35/35
ACCUPRIL	10MG	1	35/35
ACCUPRIL	20MG	1	35/35
ACEON	2MG	1	35/35
ACEON	4MG	1	35/35
ACTONEL	5MG	1	35/35
ACTONEL	35MG	1/WK	5/35
ACTOS	All Strengths	1	35/35
ADDERALL XR	All Strengths	1	35/35
ADEMPAS	All Strengths	1	35/35
AEROBID	250MCG	8 INHALATIONS	21/35
AEROBID-M	250MCG	8 INHALATIONS	21/35
ALAVERT-NON DROW	TAB	1	96/96
ALDARA	5%		12/30
ALENDRONATE	All Strengths	1/WK	35/35
ALTABAX	5GM		1 TUBE/30
ALTABAX	15GM		1 TUBE/30
ALTABAX	30GM		1 TUBE/30
ALTACE	1.25MG	1	35/35
ALTACE	2.5MG	1	35/35
ALTACE	5MG	1	35/35
AMARYL	1MG	1	35/35
AMARYL	2MG	1	35/35
AMBIEN	5MG		12/34
AMBIEN	10MG		12/34
AMBIEN CR	6.25MG		12/34
AMBIEN CR	12.5MG		12/34
AMERGE (Step 8)	1MG		12/30
AMERGE (Step 8)	2.5MG	2.5MG	12/30
AMLODIPINE	2.5MG	1.5	53/35 DAYS
AMLODIPINE	5MG	1.5	53/35 DAYS
AMMONIUM LACTATE CREA	12%		1 TUBE/10
AMMONIUM LACTATE LOTN	12%		1TUBE/8
AMPHETAMINE SALT	5,10,15MG	3	105/35
AMPHETAMINE SALT	20MG	2	70/35
AMPHETAMINE SALT	30MG	1	35/35
ANDRODERM	2.5MG	2	60/30
ANDRODERM	5MG	1	30/30
ARAVA	10MG	1	35/35
ARCAPTA	75MCG	1 INHALATION	35/35
ARICEPT	5MG	1	35/35
ARICEPT	10MG	1	35/35
ARIXTRA INJECTION	2.5MG/0.5ML		7/30
ARIXTRA INJECTION	5MG/0.4ML		7/30
ARIXTRA INJECTION	7.5MG/0.6ML		7/30
ARIXTRA INJECTION	10MG/0.8ML		7/30
ASMANEX 30 UNITS	220MCG	1 INHALATION	30U/30
ASMANEX 60 UNITS	220MCG	2 INHALATIONS	60U/30
ASMANEX 120 UNITS	220MCG	4 INHALATIONS	120U/30
ATROVENT HFA	17MCG	12 INHALATIONS	25.8/34
ATROVENT 30ML	0.03%	12 SPRAYS	30/30
ATROVENT 15ML	0.06%	16 SPRAYS	45/30
AVANDIA	2MG	1.5	53/35
AVANDIA	4MG	1	35/35
AVAPRO	75MG	1.5	53/35
AVAPRO	150MG	1	35/35
AXERT (Step 8)	6.25MG		12/30
AXERT (Step 8)	12.5MG		12/30
AZELEX	20%		1 TUBE/18
AZILECT	All Strengths	1	35/35
BACTROBAN CREAM			1 TUBE/30
BECONASE AQ	42MCG	8 INHALATIONS	50/30
BENAZEPRIL	5MG	1	35/35
BENAZEPRIL	10MG	1.5	53/35
BENAZEPRIL	20MG	1	35/35
BENAZEP/HCTZ	5-6.25	1	35/35
BENAZEP/HCTZ	10/12.5	1	35/35
BONIVA	2.5MG	1	35/35
BONIVA	150MG	1/MO	1/30
BOTOX (ADULTS)	100U/ML	1 session/90 days	600U/90
BOTOX (CHILDREN>12)	100U/ML	1 session/90 days	400U/90
BREO ELLIPTA	100/25MCG	1 INHALATIONS	28/28
BRILINTA	All Strengths	2	70/35
BRINTELLIX	All Strengths	1	35/35
BUTRANS		1 patch/WK	4/28
BYETTA	5mcg inj	0.04ML	1.2ML/30
BYETTA	10mcg inj	0.08ML	2.4ML/30
CALAN SR	120MG	1	35/35
CALAN SR	180MG	2	70/35
CALAN SR	240MG	2	70/35
CARDIZEM CD	120MG/24	1	35/35
CARDIZEM CD	180MG/24	1	35/35
CARDIZEM CD	240MG/24	1	35/35
CARDIZEM CD	300MG/24	1	35/35
CARDIZEM CD	360MG/24	1	35/35
CARDIZEM LA	120MG/24	1	35/35
CARDIZEM LA	180MG/24	1	35/35
CARDIZEM LA	240MG/24	1	35/35
CARDIZEM LA	300MG/24	1	35/35
CARDIZEM LA	360MG/24	1	35/35
CARDURA	1MG	1	35/35
CARDURA	2MG	1.5	53/35
CARDURA	4MG	1.5	53/35
CARTIA XT	120MG	1	90/90
CARTIA XT	180MG	1	90/90
CARTIA XT	240MG	1	90/90
CARTIA XT	300MG	1	90/90
CATAPRES-TTS1	0.1 MG/24HR		5/35
CATAPRES- TTS2	0.2 MG/24HR		5/35
CATAPRES- TTS3	0.3 MG/24HR		5/35
CELEBREX	100MG	1	35/35
CELEBREX	200MG	2	70/35
CELEXA	20mg	0.5	17/34
CELEXA	40mg	1	51/34

ATACAND	4MG	1.5	53/35
ATACAND	8MG	1.5	53/35
ATACAND	16MG	1	35/35
ATRIPLA	600MG	1	35/35
Drug Name	**Strength**	**Limit/Day**	**Limit/Days**
COMETRIQ	80MG	1	35/35
COMETRIQ	20MG	3	105/35
CONCERTA	All Strengths	1	35/35
COPAXONE INJ	20MG		1/32
COPAXONE KIT	20MG/ML		1/30
COREG CR	All Strengths	1	34/34
CRESTOR	5MG	1	35/35
CRESTOR	10MG	1	35/35
CRESTOR	20MG	1	35/35
CRESTOR	40MG	1	35/35
CYMBALTA	All Strengths	1	35/35
DALMANE	15MG		10/30
DALMANE	30MG		10/30
DAYPRO	600MG	2	70/35
DAYTRANA	10mg/9hr (27.5mg)	1	34/34
DAYTRANA	15mg/9hr (41.3mg)	1	34/34
DAYTRANA	20mg/9hr (55.0mg)	1	34/34
DAYTRANA	30mg/9hr (82.5mg)	1	34/34
DDAVP	5ML		15/34
DENAVIR CREAM			2gm/30
DEPO-PROVERA	150MG/ML		1/90
DEPO-PROVERA	400MG/ML		2.5/90
DEPO-TESTOSTERONE	200MG/ML		20/90
DESMOPRESSIN	0.1MG	12	420/35
DESMOPRESSIN	0.2MG	6	210/35
DESONIDE	0.05%		2 TUBES/30
DESOWEN	0.05%		2 TUBES/30
DETROL LA	2MG	1	35/35
DEXEDRINE	All Strengths	3	90/30
DEXILANT	All Strengths	1	35/35
DEXTROAMPHETAMINE	All Strengths	3	90/30
DIFLUCAN	150MG		1/7
DILACOR XR	240MG/24	1	35/35
DILACOR XR	120MG/24	1	35/35
DILACOR XR	180MG/24	1	35/35
DILTIA - XT	120MG/24	1	90/90
DILTIA - XT	180MG	1	90/90
DILTIA - XT	240MG/24	1	90/90
DILTIAZEM CAP ER	120MG	1	90/90
DILTIAZEM CAP XR	120MG	1	90/90
DILTIAZEM CAP	120MG/24	1	90/90
DILTIAZEM CAP	180MG/24	1	90/90
DILTIAZEM CAP ER	240MG	1	90/90
DILTIAZEM CAP XR	240MG	1	90/90
DILTIAZEM XR CAP	240MG/24	1	90/90
DILTIAZEM CAP	240MG/24	1	90/90
DILTIAZEM CAP	300MG/24	1	90/90
DILTIAZEM CAP	360MG/24	1	90/90
DIOVAN	80MG	1	35/35
DIOVAN - HCT	80 - 12.5	1	35/35
DITROPAN XL	5MG	1	35/35
DITROPAN XL	10MG	2	70/35
DORAL	7.5MG		10/30
DORAL	15MG		10/30
DOXAZOSIN	1MG	1	90/90

CITALOPRAM	10MG	0.5	45/90
CITALOPRAM	20MG	0.5	45/90
CITALOPRAM	40MG	1	90/90
CLARINEX	REDI TAB	1	35/35
CLEOCIN-T		1 PACKAGE	1/30
CLINDAMYCIN PHOSPHATE		1 PACKAGE	1/30
COMBIVENT	103-18MCG	12 INHALATIONS	30/35
Drug Name	**Strength**	**Limit/Day**	**Limit/Days**
EFFEXOR XR	37.5MG	1	35/35
EFFEXOR XR	75MG	1	35/35
EMSAM	All Strengths	1	34/34
ENALAPRIL	2.5	1	90/90
ENALAPRIL	5MG	1.5	135/90
ENALAPRIL	10MG	1.5	135/90
ENALAPR/HCTZ	5-12.5	1	90/90
ENBREL	25MG/ML		8/28
ESTAZOLAM	1MG		10/30
ESTAZOLAM	2MG		10/30
ESTRING MIS	2MG		1/90
FELODIPINE	2.5MG	1	90/90
FELODIPINE	5MG	1.5	135/90
FENTANYL	25MCG/HR		11/33
FENTANYL	50MCG/HR		11/33
FENTANYL	75MCG/HR		11/33
FENTANYL	100MCG/HR		22/33
FETZIMA	All Strengths	1	35/35
FINASTERIDE	5MG	1	90/90
FLONASE	50MCG	4 SPRAYS	32/34
FLOVENT HFA 44MCG	44MCG	4 INHALATIONS	10.6/30
FLOVENT HFA 110MCG	110MCG	4 INHALATIONS	12/30
FLOVENT HFA 220MCG	220MCG	8 INHALATIONS	24/30
FLUCONAZOLE	150MG		1/7
FLUNISOLIDE SOLN	0.025%	16 SPRAYS	75/30
FLUOXETINE TAB	20MG	4	140/35
FLURAZEPAM	15MG		10/30
FLURAZEPAM	30MG		10/30
FLUTICASONE SPR		4 SPRAYS	32/34
FLUVOXAMINE	25MG	1	90/90
FLUVOXAMINE	50MG	1	90/90
FOCALIN	All Strengths	3	105/35
FOCALIN XR	All Strengths	1	35/35
FORFIVO XL	All Strengths	1	35/35
FOSAMAX	5MG	1	35/35
FOSAMAX	10MG	1	35/35
FOSAMAX	70MG	1/WK	5/35
FOSAMAX	40MG	2/WK	10/35
FOSINOPRIL	10MG	1.5	135/90
FOSINOPRIL	20MG	2	180/90
FRAGMIN INJ	10000U/ML	2ML	14/7
FRAGMIN INJ	2500U/.2ML	0.4ML	2.80/7
FRAGMIN INJ	25000U/ML	0.8ML	5.6/7
FRAGMIN INJ	5000U/.2ML	0.4ML	2.80/7
FRAGMIN INJ	7500U/.3ML	0.6ML	4.2/7
FROVA TAB (Step 8)	2.5MG		12/30
FULYZAQ	125MG	2	70/35
FUZEON	KIT	1	1/30
FYCOMPA	All Strengths	1	35/35
GABAPENTIN	300MG	9	720/90
GABAPENTIN	400MG	9	720/90
GEODON	20MG	2	70/35

DOXAZOSIN	2MG	1.5	135/90
DOXAZOSIN	4MG	1.5	135/90
DRYSOL SOL	20%		1 BOTTLE/30DAYS
DURAGESIC PATCHES	12.5MCG/HR		11/33
DURAGESIC PATCHES	25MCG/HR		11/33
DURAGESIC PATCHES	50MCG/HR		11/33
DURAGESIC PATCHES	75MCG/HR		11/33
DURAGESIC PATCHES	100MCG/HR		22/33
EDEX	All Strengths		1/30
Drug Name	**Strength**	**Limit/Day**	**Limit/Days**
ILARIS			2/28
HALCION	0.125MG		10/35
HALCION	0.25		10/35
HUMIRA	40mg/0.8ml		4/28
HYTRIN	1MG	1	35/35
HYTRIN	5MG	1	35/35
HYZAAR	50-12.5	1	35/35
IMDUR	30MG	1.5	53/35
IMDUR	60MG	1.5	53/35
IMITREX (step 8)	25MG		12/30
IMITREX (step 8)	50MG		12/30
IMITREX (step 8)	100MG		12/30
IMITREX INJ	4MG/.5ML		6 boxes/30
IMITREX INJ	6MG/.5ML		6 boxes/30
IMITREX KIT	6MG/.5ML		6/30
IMITREX SPR	5MG		12/30
IMITREX SPR	20MG		12/30
INTAL	800MCG	8 INHALATIONS	28.4/34
INVOKANA	All Strengths	1	35/35
IPRATROPIUM 30ML	0.03%	12 SPRAYS	90/90
IPRATROPIUM 15ML	0.06%	16 SPRAYS	135/90
ISOPTIN SR	180MG	2	70/35
ISOPTIN SR	240MG	2	70/35
ISOSORBIDE MONO	30MG	1.5	135/90
ISOSORBIDE MONO	60 MG	1.5	135/90
JANUMET	All Strengths	2	70/35
JANUVIA	All Strengths	1	35/35
JUVISYNC	All Strengths	1	35/35
KETOPROFEN	100MG	2	180/90
KETOPROFEN	200MG	1	90/90
KETOROLAC	10MG	4.8	24/30
KHEDEZLA	All Strengths	1	35/35
LAC-HYDRIN CREAM	12%		1TUBE/30
LAMICTAL	25MG	6	210/35
LAMICTAL	25MG CHW	6	210/35
LAMICTAL	100MG	2	70/35
LAMISIL	250MG	1	35/35
LAMOTRIGINE	25MG	6	540/90
LAMOTRIGINE	100MG	2	180/90
LATUDA	80MG	1	30/30
LEFLUNOMIDE	10MG	1	90/90
LESCOL	20MG	1	35/35
LEVAQUIN	250MG	1	35/35
LEXAPRO	5MG	0.5	15/30
LEXAPRO	10MG	0.5	15/30
LEXAPRO	20MG	1	35/35
LIPITOR	10MG	1	35/35
LIPITOR	20MG	1	35/35
LIPITOR	40MG	1.5	53/35

GEODON	40MG	2	70/35
GEODON	60MG	2	70/35
GEODON	80MG	2	70/35
GEODON	INJ	2	70/35
GILENYA	0.5MG	1	30/30
GILOTRIF	All Strengths	1	35/35
GLIMEPIRIDE	1MG	1	90/90
GLIMEPIRIDE	2MG	1	90/90
GLUCOSE TES STRP		12	420/35
GLYCOLAX*	255GM		255GM/90

*** Available for once daily dosing to members under the age of 18 years**

Drug Name	**Strength**	**Limit/Day**	**Limit/Days**
LATUDA	All Strengths	0.5	18/35
LUNESTA	2MG		12/34
LUNESTA	3MG		12/34
LUPRON DEPOT INJ	11.25MG	KIT	1/90
LUPRON DEPOT INJ	22.5	KIT	1/90
LUPRON DEPOT INJ	30MG		1/90
LUPRON DEPOT INJ	30MG	KIT	1/90
LYRICA	25,50,75MG	3	102/35
LYRICA	100,150,200MG	3	102/35
LYRICA	225,300MG	2	70/35
MAVIK	1MG	1	35/35
MAVIK	2MG	1	35/35
MAXAIR AUTO	200MCG	12 INHALATIONS	14/30
MAXALT (step 8)	5MG		12/30
MAXALT (step 8)	10MG		12/30
MAXALT MLT (step 1)	10MG		12/30
MEDROXYPR AC	150MG/ML		1/90
MELOXICAM	7.5MG	1	35/35
MELOXICAM	15MG	1	35/35
METADATE ER	10,20MG	3	90/30
METFORMIN ER	500MG	4	360/90
METHYLIN	All Strengths	3	90/30
METHYLPHENIDATE ER	36mg	2	180/90
METHYLPHENIDATE	All Strengths	3	90/30
METROCREAM		1 PACKAGE	1/30
METROGEL		1 PACKAGE	1/30
METROLOTION		1 PACKAGE	1/30
METRONIDAZOLE CREAM		1 PACKAGE	1/30
METRONIDAZOLE GEL		1 PACKAGE	1/30
METRONIDAZOLE LOTION		1 PACKAGE	1/30
MEVACOR	10MG	1.5	53/35
MEVACOR	20MG	1.5	53/35
MIACALCIN		3.75ml	1 bottle/34
MICARDIS	40MG	1.5	53/35
MIRALAX	255G	8.5G	1 bottle/30
MIRALAX	17G/PACKET	0.5 packet	15 packets/30
MIRTAZAPINE	15mg	1.5	53/35
MOBIC	7.5 MG	1	35/35
MOBIC	15MG	1	35/35
MOEXIPRIL	7.5	1.5	135/90
MONOPRIL	10MG	1.5	53/35
MONOPRIL	20MG	2	70/35
MUPIROCIN			1 TUBE/30
NABUMETONE	500MG	2	180/90
NABUMETONE	750MG	2	180/90
NARATRIPTAN			12/30
NASACORT AERS	55 MCG	4 SPRAYS	9.3/25

LISINOP/HCTZ	10/12.5MG	1	90/90
LOTENSIN	5MG	1	35/35
LOTENSIN	10MG	1.5	35/35
LOTENSIN	20MG	1	53/35
LOTENSIN - HCT	5 - 6.25	1	35/35
LOTENSIN - HCT	10 - 12.5	1	35/35
LOVASTATIN	10MG	1.5	135/90
LOVASTATIN	20MG	1.5	135/90
LOVENOX INJ	30MG/.3ML	0.6	14 injections/7
LOVENOX INJ	40MG/.4ML	0.8	14 injections/7
LOVENOX INJ	60MG/.6ML	1.2	14 injections/7
LOVENOX INJ	80MG/.8ML	1.6	14 injections/7
LOVENOX INJ	100MG/ML	2	14 injections/7
LOVENOX INJ	120MG/.8ML	1.6	14 injections/7
LOVENOX INJ	150MG/ML	2	14 injections/7
LUNESTA	1MG		12/34
Drug Name	**Strength**	**Limit/Day**	**Limit/Days**
NIFEDIPINE ER	90MG	1	90/90
NIFEDIPINE ER,CR	30MG	1	90/90
NORVASC	2.5MG	1.5	53/35 DAYS
NORVASC	5MG	1.5	53/35 DAYS
NUVARING		1/MO	1/28
OMEPRAZOLE	10MG	1	30/30
OMEPRAZOLE	20MG	2	120/60
ONDANSETRON*	4MG	3	90/30
ONDANSETRON*	8MG	1.5	45/30
ONDANSETRON*	24MG	0.5	15/30
ONDANSETRON INJ*			
ONGLYZA	All Strengths	1	35/35
OPSUMIT	All Strengths	1	35/35
ORTHO-EVRA			3/28
ORUVAIL	100MG	2	70/35
ORUVAIL	200MG	1	35/35
OXAPROZIN	600MG	2	180/90
OXYCODONE ER	10,20,40MG	2	70/35
OXYCODONE ER	80MG	4	140/35
OXYCONTIN**	10,20,40MG	2	70/35
OXYCONTIN**	80MG	4	140/35
PAROXETINE	10MG	1.5	135/90
PAROXETINE	20MG	1	90/90
PAXIL	10MG	1.5	53/35
PAXIL	20MG	1	35/35
PEGASYS KIT		KIT	1/28
PLAN B			2/15 or 4/30
PLENDIL	2.5MG	1	35/35
PLENDIL	5MG	1.5	53/35
PRAVACHOL	10MG	1	35/35
PRAVACHOL	20MG	1	35/35
PRAVACHOL	40MG	1	35/35
PRAVACHOL	80MG	1	35/35
PRAVASTATIN	10MG	1	35/35
PRAVASTATIN	20MG	1	35/35
PRAVASTATIN	40MG	2	180/90
PRAVASTATIN	80MG	1	35/35
PREVPAC MIS	500MG-30MG		14/30
PRILOSEC OTC	20MG	2	168/84
PRINIVIL	2.5MG	1	35/35
PRINIVIL	5MG	1	35/35
PRINIVIL	10MG	1.5	53/35
PRINIVIL	20MG	1.5	53/35

NASACORT AQ	55MCG	4 SPRAYS	17/30
NASONEX	50MCG	4 SPRAYS	17/30
NATROBA		120ML	1 bottle/30
NEUPOGEN INJ	300MCG/ML		10/30
NEUPOGEN INJ	480MCG/1.6		16/30
NEUPOGEN INJ	300MCG/.5ML		5/30
NEUPOGEN INJ	480MCG/.8ML		8/30
NEURONTIN	300MG	3	105/35
NEURONTIN	600MG	3	105/35
NEXIUM	20MG	1	35/35
NEXIUM	40MG	2	70/35
NIFEDIPINE CR	90MG	1	90/90
NIFEDIPINE ER	60MG	1	90/90
NIFEDIPINE ER	30MG	1	90/90
NIFEDIPINE ER	60MG	1	90/90
Drug Name	**Strength**	**Limit/Day**	**Limit/Days**
RELPAX	All Strengths		12/30
REMODULIN	All Strengths		1 MDV/30
RESTORIL	7.5MG		10/30
RESTORIL	15MG		10/30
RESTORIL	30MG		10/30
RETIN-A		1 TUBE	1 TUBE/30
REVLIMID	All Strengths	1	35/35
RHINOCORT AQ	32MCG	8 SPRAYS	18/30
REFRESH PLUS		15 ML	1 bottle/30
REFRESH PLUS		30 ML	2 bottles/30
REFRESH TEARS		15 ML	1 bottle/30
REFRESH TEARS		30 ML	2 bottles/30
RESCULA			2 bottles/35
REYATAZ	All Strengths	1	35/35
RISPERDAL	0.5MG	1.5	53/35
RISPERDAL	0.25MG	1.5	53/35
RISPERDAL	1MG	1.5	53/35
RISPERDAL	2MG	1.5	53/35
RISPERDAL	3MG	2	70/35
RISPERDAL	4MG	2	70/35
RISPERDAL INJ	25MG		2/28
RISPERDAL INJ	37.5		2/28
RISPERDAL INJ	50MG		2/28
RISPERDAL M-TAB	0.5MG	1.5	53/35
RISPERDAL M-TAB	1MG	1.5	53/35
RISPERDAL M-TAB	2MG	4	140/35
RISPERDAL SOL.	1MG/ML	8ML	280/35
RISPERIDONE	0.5MG	1.5	53/35
RISPERIDONE	0.25MG	1.5	53/35
RISPERIDONE	1MG	1.5	53/35
RISPERIDONE	2MG	1.5	53/35
RISPERIDONE	3MG	2	70/35
RISPERIDONE	4MG	2	70/35
RISPERIDONE SOL.	1MG/ML	8ML	280/35
RITALIN LA	All Strengths	1	35/35
SAVELLA	All Strengths	2	70/35
SEREVENT DISKUS	50MCG	2 INHALATIONS	60/30
SEROQUEL	100MG		45/30
SEROQUEL XR	150MG	1	35/35
SEROQUEL XR	200MG	1	35/35
SEROQUEL XR	300MG	2	70/35
SEROQUEL XR	400MG	2	70/35
SERTRALINE	25MG	0.5	18/35
SERTRALINE	50MG	0.5	18/35

PRINZIDE	10-12.5	1	35/35
PROAIR HFA	90mcg	12 INHALATIONS	17/34
PROTONIX	20MG	2	70/35
PROTONIX	40MG	2	70/35
PROZAC	10MG	1.5	53/35
PULMICORT	200MCG	8 INHALATIONS	1/25
PULMICORT FLEX	All Strengths	8 Inhalations	2/30
QUETIAPINE	25MG	1.5	135/90
QUETIAPINE	50MG	1.5	135/90
QUETIAPINE	100MG	1.5	135/90
QUINAPRIL	5MG	1	90/90
QUINAPRIL	10MG	1	90/90
QUINAPRIL	20MG	1	90/90
QVAR AERS	All Strengths	8 Inhalations	14.6/25
RANITIDINE SYRUP***	15MG/ML	20ML	700ML/35
RELAFEN	500MG	2	70/35
RELAFEN	750MG	2	70/35
REMERON	15MG	1.5	53/35
Drug Name	**Strength**	**Limit/Day**	**Limit/Days**
SULAR	10MG	1.5	53/35
SULAR	20MG	1	35/35
SUMATRIPTAN (step 1)	All Strengths		12/30
SYMBICORT	All Strengths	4 Inhalations	10.2/30
SYNVISC INJ	8MG/ML		2/30
SYRINGES		10	1000/100
TAFINLAR	50MG	6	210/35
TAFINLAR	75MG	4	140/35
TAMIFLU CAPS	75MG		10/30
TAZTIA XT CAP	120MG/24	1	90/90
TAZTIA XT CAP	180MG/24	1	90/90
TAZTIA XT CAP	240MG/24	1	90/90
TAZTIA XT CAP	300MG/24	1	90/90
TAZTIA XT CAP	360MG/24	1	90/90
TEMAZEPAM	7.5MG		10/30
TEMAZEPAM	15MG		10/30
TEMAZEPAM	30MG		10/30
TEQUIN	200MG	1	35/35
TERAZOSIN	1MG	1	90/90
TERAZOSIN	5MG	1	90/90
TERBINAFINE	250MG	1	35/35
TEST STRIPS	Blood Glucose	12	420/35
TIAZAC	120MG/24	1	35/35
TIAZAC	180MG/24	1	35/35
TIAZAC	240MG/24	1	35/35
TIAZAC	300MG/24	1	35/35
TIAZAC	360MG/24	1	35/35
TIAZAC	420MG/24	1	35/35
TILADE	1.75MG	8 INHALATIONS	48.6/35
TOPAMAX SPRINKLES	All Strengths	400MG	35/35
TOPIRAMATE SPRINKLES	All Strengths	400MG	35/35
TOPROL XL	25MG	1.5	53/35
TOPROL XL	50MG	1.5	53/35
TRADJENTA	All Strengths	1	35/35
TRAMADOL	50MG	8	720/90
TRAMADOL/ APAP	37.5/325MG	8	720/90
TRETINOIN		1 TUBE	1 TUBE/30
TREXIMET	85/500	2.5	12/30
TRIAZOLAM	0.125MG		10/30
TRIAZOLAM	0.25MG		10/30
TROKENDI XR	25MG	1	35/35
TROKENDI XR	50MG	1	35/35

SERTRALINE	100MG	3	105/35
SIMVASTATIN	5MG	1	35/35
SIMVASTATIN	10MG	1.5	53/35
SIMVASTATIN	20MG	1.5	53/35
SIMVASTATIN	40MG	1.5	53/35
SIMVASTATIN	80MG	1	35/35
SINGULAIR	4MG	1	35/35
SINGULAIR	5MG	1	35/35
SINGULAIR	10MG	1	35/35
SONATA	5MG		12/34
SONATA	10MG		12/34
SPIRIVA	HANDIHLR	1 INHALTION	30/30
SPORANOX SOL	10MG/ML	10ML/ML	300cc/30
SPORANOX PULSEPAK	100MG		30/30
SPORANOX	100MG		30/30
STADOL INJ	1MG/ML		9/35
STADOL INJ	2MG/ML		9/35
STRATTERA	All Strengths	1	35/35
SUPRAX	400MG	1	1/7
Drug Name	**Strength**	**Limit/Day**	**Limit/Days**
XOPENEX HFA		12 INHALATIONS	2 INHALERS/34
XOPENEX NEB		12CC	408/34
ZALEPLON	All Strengths		30/30
ZESTORETIC	10-12.5	1	35/35
ZESTRIL	2.5MG	1	35/35
ZESTRIL	5MG	1	35/35
ZESTRIL	10MG	1.5	53/35
ZESTRIL	20MG	1.5	53/35
ZOCOR	5MG	1	35/35
ZOCOR	10MG	1.5	53/35
ZOCOR	20MG	1.5	53/35
ZOCOR	40MG	1.5	53/35
ZOFRAN*	4MG	3	90/30
ZOFRAN*	8MG	1.5	45/30
ZOFRAN*	24MG	0.5	15/30
ZOFRAN*	4MG/5ML	15ML	450/30
ZOLOFT	25MG	0.5	18/35
ZOLOFT	50MG	0.5	18/35
ZOLOFT	100MG	3	105/35
ZOLPIDEM (step 1)	5MG		30/30
ZOLPIDEM (step 1)	10MG		30/30
ZOMIG (Step 8)	5MG		12/30
ZYPREXA	2.5MG	1.5	53/35
ZYPREXA	5MG	1	35/35
ZYPREXA	7.5MG	1	35/35
ZYPREXA	10MG	1	35/35
ZYPREXA	15MG	1	35/35
ZYPREXA	20MG	1	35/35
ZYPREXA ZYDIS	5MG	1	35/35
ZYPREXA ZYDIS	10MG	1	35/35
ZYPREXA ZYDIS	15MG	1	35/35
ZYPREXA ZYDIS	20MG	1	35/35

*Cancer diagnosis with non-daily chemotherapy required

**Available without pa with CA and HO diag.

*** Ranitidine syrup available without PA to users less than 6 years old.

TROKENDI XR	100MG	1	35/35
TROKENDI XR	200MG	2	70/35
ULTRAM	50MG	8	280/35
UNIVASC	7.5MG	1.5	53/35 DAYS
VASERETIC	5-12.5MG	1	35/35
VASOTEC	2.5MG	1	35/35
VASOTEC	5MG	1.5	53/35
VASOTEC	10MG	1.5	53/35
VENLAFAXINE	37.5	1	90/90
VENLAFAXINE	75	1	90/90
VENLAFAXINE	150	2	180/90
VENLAFAXINE	225	1	90/90
VENTOLIN HFA	90MCG	12 INHALATIONS	36/34
VERAPAMIL ER, SR	120MG	1	90/90
VERAPAMIL ER, CR, SR	180MG	2	90/90
VERAPAMIL ER, CR, SR	240MG	2	90/90
VERELAN	180MG	1	35/35
VERELAN SR	120MG	1	35/35
VERELAN SR	180MG	1	35/35
VERELAN SR	240MG	2	70/35
VERAMYST	27.5MCG	4 sprays	10/30
VYVANSE	All Strengths	1	35/35

MDV=Multidose Vial

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CELEXA/CITALOPRAM SPLITTING TABLE

The most cost effective way to utilize Celexa/citalopram

NON PREFERRED: PA NEEDED				DESIRED DOSE	PREFERRED: NO PA Required (splitting tabs)				savings per 30 day supply
10MG	20MG	40MG	COST/DAY	MG/DAY	10MG	20MG	40MG	COST/ DAY	
30			$1.50	10mg		15		$0.75	**$22.50**
	30		$1.50	20mg			15	$0.75	**$22.50**
	45		$3.00	30mg		15	15	$1.50	**$45.00**
		30	$1.50	40mg			30	$1.50	**N/A**

**** Citalopram requires splitting of 20mg and/or 40mg scored tabs to avoid PA. Celexa is non-preferred but still requires splitting with a PA.***

**** At present these represent the most commonly written scripts. The shaded areas require no changes since they do not offer savings opportunities. Celexa is flat priced across all strengths. They are scored and easily split. The unshaded rows on the left side all have less expensive ways of being written involving splitting of the***

**** Max daily dose of Celexa / citalopram is 40mg. Clinical studies of effectiveness did not demonstrate an advantage for the 60mg/day dose over the 40mg/day dose. There is an increased risk of side effects at doses greater than 40mg/day. (Celexa® Package Insert 2005 Forest Laboratories, Inc.)***

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LEXAPRO SPLITTING TABLE

The most cost effective way to utilize Lexapro

NON PREFERRED: PA NEEDED				DESIRED DOSE	PREFERRED: NO PA Required (splitting tabs)				savings per 30 day supply
5MG	10MG	20MG	COST/DAY	MG/DAY	5MG	10MG	20MG	COST/ DAY	
15 tabs				2.5MG	15 tabs				

	15		$0.75	5MG		15		$0.75	N/A
	30		$1.50	10MG			15	$0.75	**$22.50**
	45		$2.25	15MG		15	15	$1.50	**$22.50**
	30		$1.50	20MG			30	$1.50	N/A

**** Lexapro requires splitting of 5mg, 10mg and/or 20mg scored tabs to avoid PA.***

**** At present these represent the most commonly written scripts. The shaded areas require no changes since they do not offer savings opportunities. Lexapro is flat priced across all strengths. They are scored and easily split. The unshaded rows on the left side all have less expensive ways of being written involving splitting of the***

**** Max daily dose of Lexapro is 20mg.***

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ZOLOFT/ SERTRALINE SPLITTING TABLE

The most cost effective way to utilize Zoloft/Sertraline

NON PREFERRED: PA NEEDED				DESIRED DOSE	PREFERRED: NO PA Required (splitting tabs)				savings per 30 day supply
25MG	50MG	100MG	COST/DAY	MG/DAY	25MG	50MG	100MG	COST/ DAY	
15 tabs			$1.00	12.5mg	15 tabs			$1.00	N/A
30			$2.00	25*		15		$1.00	**$30.00**
45			$3.00	37.5	15	15		$2.00	**$30.00**
	30		$2.00	50*			15	$1.00	**$30.00**
	45		$3.00	75		15	15	$2.00	**$30.00**
		30	$2.00	100*			30	$2.00	N/A
30		30	$4.00	125		15	30	$3.00	**$30.00**
	30	30	$4.00	150*			45	$3.00	**$30.00**
30	30	30	$6.00	175		15	45	$4.00	**$60.00**
		60	$4.00	200*			60	$4.00	N/A
30		60	$6.00	225		15	60	$5.00	**$30.00**
	30	60	$6.00	250*			75	$5.00	**$30.00**
30	30	60	$8.00	275		15	75	$6.00	**$60.00**
		90	$6.00	300*			90	$6.00	N/A

** Sertraline requires splitting of scored tabs to avoid PA. Zoloft is non-preferred but still requires splitting with a PA.*

** At present these represent the most commonly written scripts. The shaded areas require no changes since they do not offer savings opportunities. Zoloft is flat priced across all strengths. They are scored and easily split. The unshaded rows on the left side all have less expensive ways of being written involving splitting of the Zoloft scored tabs.*

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ABILIFY SPLITTING TABLE

The most cost effective way to utilize Abilify

NON PREFERRED: PA NEEDED						DESIRED DOSE	PREFERRED: NO PA Required (splitting tabs)					
2MG	5MG	10MG	15MG	20MG	30MG	MG/DAY	2MG	5MG	10MG	15MG	20MG	30MG
30						2.5		15				
	30					5			15			
		30				10					15	
			30			15						15
				30		20						
					30	30						

Opioid Drugs for the Treatment of Pain

Treatment of acute pain

Face to Face Visit

A face-to-face visit between the member and the prescriber must occur within four(4) days before or after the date of the prescription of an opiod drug for the treatment of acute pain. Each authorization will allow for up to fourteen(14) days of coverage.

After the first authorization, further reimbursement may be authorized only after a face-to face visit has occurred in reference to the prescription for opioids

Prior authorization is required after a total of fifteen (15) days of opioids have been prescribed for the treatment of acute pain within a twelve (12)- month period. Three subsequent prior authorized prescriptions of up to fourteen (14) days are allowed within a twelve (12)-month period; each individual fourteen (14)- day prescription requires prior authorization for a cumulative maximum of fifty-seven (57) days.

Opioid drugs prescribed in conjunction with post suregical care are exempt from the requirements stated above.

In order to maintain continuity of care for transition to longer-term treatment, a pain management care plan consisting of a therapeutic treatment option must be developed and prior authorized before exhausting the third (3rd) prior authorization refill. Once authorized another prescriber may continue to prescribe refills under the approved prior authorization, up to the maximum amount identified in the original prior authorization request.

Post Surgical Care

If the provider of the surgical procedure determines that the use of opioid drugs for post-surgical care beyond the first fifteen (15)-day prescription is medically necessary, further reimbursement may be available through prior authorization. A face-to face visit between the member and the prescriber must occur within four(4) days before or after the date of the prescription requiring prior authorization.

Reimbursement for post surgical care is limited to a one-time prior authorization up to a total sixty (60)- day quantity, regardless of the number of prescriptions, outside the context of the treatment for non-acute pain or exceptions decribed below.

Long-acting, extended-release Opioids

Prior authorization, based on the providers determination of medical necessity, is required for long-acting,extended-release Opioid drugs prescribed for acute pain.

Treatment of (long-term) non-acute pain

Reimbursement of opioid drugs beyond the limit for acute pain and post-surgical care is allowed by prior authorization if the MaineCare member participates in one (1) or more therapeutic treatment options.

In order to qualify for reimbursement for opioid drugs of long-term, non-acute pain, the prescribing physician must demonstrate that the member has:

Participated in a pain management care plan (when clinically appropiate); and

Failed to have adequate response to the prescribed pain management care plan; or

Completed the prescribed therapeutic treatment option in accord with the member's plan and show signs of regression;or

Completed at least fifty percent (50%) of the visits specified in the prescribed pain management care plan. After which the prescriber recommends that adequate control of pain will not be obtained under the therapeutic treatment.

Approved prior authorization will not exceed twelve (12) months. After the twelve (12)-month period expires opioid drugs for the treatment of pain will be reimbursed only within the restrictions as listed in the acute pain section 80, unless:

the provider demonstrates that the member qualifies for an exception, listed in section 80, or

the provider has indicated that the member has chronic pain and is still engaged in a pain management care plan, in which instance, the provider must request prior authorization for another period, not to exceed twele (12) months.

Other terms and conditions

Therapeutic Treatment Options:

The Department may grant prior authorization for an opioid drug when participation in all appropriate therapeutic treatmetns is not feasible and opioid treatment is medically nacessary.

Exceptions

The following shall be exempt from the prior authorization requirements stated above:

A MaineCare member who is receiving opioid drugs for symptoms related to HIV,AIDS and cancer and other qualifying diseases and conditions, as set forth on the Department's Preferred Drug List; or

A MaineCare member who is receiving opioid drugs during inpatient treatment in a;
hospital,in a nursing facility or during hospice care

A MaineCare member who is receiving 30 thirty milligrams (30mg) or less of morphine sulfate equivalents on a daily basis; or

A MaineCare member for whom MaineCare reimbursement for opioid drugs for the treatment of addiction is restricted by limits applicable to methadone and buprenophine and na,oxone combination drugs.

MaineCare Sovaldi Clinical Prior Authorization Criteria

25-Mar-14

Prior authorization is required for direct-acting oral antiviral agents against the hepatitis C virus.

1. Patient is ≥ 18 years of age; AND
2. Documentation of HCV active infection verified by positive viral load performed within the last year ar
3. Genotype is verified by lab submitted with initial request; AND
4. Treatment regimen has been prescribed by or based on a documented consult that included a recom
5. Patient is not a pregnant female, not planning to become pregnant during treatment (or within 6 mon
6. Women of childbearing potential and their male partners must agree to use two forms of effective no
7. Documentation that monthly pregnancy tests will be performed during this time; AND
8. Documentation of counseling regarding abstinence from alcohol and education on how to prevent the
9. Patient is not receiving dialysis and has CrCl ≥ 30 ml/min, (lab result documenting renal function mee
10. Must be taken along with required concomitant meds as outlined below. Sovaldi will not be refilled
11. Patient must not be on any of the following medications: carbamazepine, phenytoin, phenobarbital,
12. All Sovaldi dosing is 400 mg once daily
13. Olysio dosing is 150 mg once daily
14. Ribavirin dosing must be weight-based
15. Sovaldi is subject to MaineCare's Initial Script Limit. Once approved, the first two fills will be for 14-c
16. Compliance with all medications on regimen will be followed and must have > 85% compliance for a

gimen-regardless of prior therapy for Genotype 1, 3, 4, 5 or 6 (see below if HIV

Sovaldi X 84 days plus PEG/IFN plus ribavirin (12

- If prior treatment with PEG/IFN plus a protease inhibitor (boceprevir or telaprevir) with null or parti

Genotype 2 Preferred Regimen

Sovaldi + Ribavirin X 84 days (12 weeks)

- If the member is treatment experienced with a prior null or partial response, and cirrhosis is

Alternative Regimens for Selected Patients who are IFN ineligible

Genotype 1 and IFN intolerance

Olysio + Sovaldi +/- Ribavirin X 84 days (12 weeks)

- IFN intolerance must be due to documented life-threatening side effects and specifically will
- Must not have decompensated liver disease (Child-Pugh score B or C (> 6)) as Olysio is no

Genotype 1 and Child-Pugh Score > 6

Sovaldi + Ribavirin X 168 days (24 weeks)

Genotype 3 or 4 and IFN intolerance

Sovaldi + Ribavirin X 168 days (24 weeks)

- IFN intolerance must be due to documented life-threatening side effects and specifically will
- If advanced liver disease is cause of IFN intolerance, must have Child-Pugh score > 6, clas

Genotype 5 or 6 and IFN intolerance

- **no currently recommended alternative regimen**

HIV Co-infection

Genotype 1

Sovaldi X 84 days plus PEG/IFN plus ribavirin (12

- If prior treatment with PEG/IFN plus a protease inhibitor (boceprevir or telaprevir) with null or parti

Genotype 1 with prior PEG/IFN non-response

Olysio + Sovaldi +/- Ribavirin X 84 days (12 weeks)

- Must be on only antiretroviral drugs with which there is not a significant interaction

Other Genotypes

- regimens as per HCV mono infection

Patients with Hepatocellular Carcinoma Awaiting Liver Transplantation

Sovaldi plus ribavirin for up to 48 weeks or until liver transplantation, whichever occurs first

Payment will be considered under the following conditions:

nd must be submitted with request; AND

mmendation for the requested treatment by a gastroenterologist, hepatologist, infectious disease speciali
ths of stopping treatment), or a male with a pregnant female partner; AND
n-hormonal contraception during treatment and for at least 6 months after treatment has concluded; ANI

e transmission of HCV to others AND
eting this criteria within the last 6 months must be submitted with this request)
for those non-compliant with required concomitant medications.
oxcarbazepine, rifabutin, rifampin, rifapentine, St. John's wort or tipranavir.

day supplies, with remaining refills of 28-day supplies to complete the treatment course.
authorization of continued treatment. For continuation of treatment we require some indicator of compliа

/ co-infected)

al response, plan must be to continue PEG/IFN for an additional 12 weeks (24 weeks total)

present and Child-Pugh score < 6, must be co-administered with PEG/IFN

not be approved due to a history of depression alone
t indicated for these patients

not be approved due to a history of depression alone
s B or C

al response, plan should be to continue PEG/IFN for an additional 12 weeks

st or other practitioner specializing in the treatment of hepatitis. Consult must be within the year prior to

D

ance to be submitted - either by lab values (i.e significant log decrease in HepC viral load) or documenta

request and include a recommendation for the requested therapy and be attached; AND

tion from an office visit provider-patient discussion that indicates full patient compliance.