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 th Prior Authorization form, such as the presence of a 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				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		BICILLIN L-A SUSP						
	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 th Prior Authorization form, such as the presence of a 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			
	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 th Prior Authorization form, such as the presence of a 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 th Prior Authorization form, such as the presence of a 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	Use PA Form# 20420 1. Dosing limits apply, see Dosage Consolidation List.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on th Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **DDI:** Preferred ofloxacin will now be non-preferred and require prior authorization if they are currently being used in combination with amiodarone. **DDI:** Preferred levofloxacin will now be non-preferred and require prior authorization if they are currently being used in combination with amiodarone. **DDI:** Preferred Avelox will now be non-preferred and require prior authorization if they are currently being used in combination with amiodarone. **DDI:** All preferred fluoroquinolones will require clinical PA for patients over 60 that are currently on immunosuppressants or steroid therapy. **DDI:** Factive is non-preferred but with any prior authorization requests, the member's drug profile will also be monitored for concurrent use with amiodarone.
	MC/DEL		LEVOFLOXACIN	MC		AVELOX TABS		
	MC/DEL		OFLOXACIN	MC		AVELOX ABC PACK TABS		
				MC		CIPRO		
				MC		FACTIVE		
				MC		LEVAQUIN TABS SOLN/INJ		
				MC		LEVAQUIN TABS[1]		
				MC		NOROXIN TABS		
				MC		PROQUIN XR		
AMINO GLYCOSIDES	MC		GENTAMICIN	**MC**		BETHKIS[2]	Use PA Form# 20420 1. Clinial PA to verify appropriate diag	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on th Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. TOBI Podhaler is limited to patients with significant impairment from using nebulized version of medication
	MC/DEL		NEOMYCIN SULFATE TABS	MC/DEL		TOBI PODHALER[1]		
	MC		TOBI NEBU					
	MC/DEL		TOBRAMYCIN SULFATE SOLN					
ANTI-MYCOBACTERIALS / ANTI-TUBERCULOSIS	MC/DEL		ETHAMBUTOL HCL TABS				Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on th Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **DDI:** Preferred rifampin will be non-preferred and require prior authorization if it is currently being used in combination with either Pradaxa or Latud
	MC/DEL		MYAMBUTOL TABS					
	MC/DEL		MYCOBUTIN CAPS					
	MC/DEL		RIFAMPIN					
ANTIMALARIAL AGENTS	MC/DEL		**CHLOROQUINE PHOSPHATE TABS**	MC		ARALEN TABS	Use PA Form# 20420 1. Ingredients available as preferred without PA.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on th Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**DARAPRIM TABS**	MC		ISONARIF[1]		
	MC/DEL		**HYDROXYCHLOROQUINE TABS**	MC/DEL		MALARONE TABS		
	MC/DEL		**MEFLOQUINE HCL TABS**	MC/DEL		**PLAQUENIL TABS**		
	MC/DEL		**QUININE SULFATE**					
ANTHELMINTICS	MC/DEL		ALBENZA TABS				Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on th Prior Authorization form, such as the presence of a 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. 2. Please use multiple 5gm which are preferred to obtain dose without PA. 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	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on th Prior Authorization form, such as the presence of 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. 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		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/DEL		TRIMETHOPRIM TABS	MC/DEL		METRONIDAZOLE 750MG TABS[1]		
	MC/DEL		VANCOMYCIN 5GM INJ.	MC		NEBUPENT SOLR		
				MC		TINDAMAX		
				MC/DEL		VANCOMYCIN 10GM INJ.[2]		
				MC		XIFAXAN		
CARBAPENEMS				MC		INVANZ SOLR	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on th Prior Authorization form, such as the presence of a 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. Use PA Form# 30820 for Zyvox & Vibativ 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, unless an acceptable clinical exception is offered on th Prior Authorization form, such as the presence of 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		SIVEXTRO		
	MC		DAPSONE TABS	MC/DEL		VIBATIV		
				MC/DEL		ZYVOX SUSR		
				MC/DEL		ZYVOX TABS		
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 th

	MC/DEL		SEPTRA/DS TABS					Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferre
	MC/DEL		SULFAMETHOXAZOLE/TRIMETH					drug(s) exists.
	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). 2. Sporanox QL 300cc/month with PA. See quantity limit table. 3. Sporanox QL 30/month with PA. See quantity limit table. Non-preferred products must be used in specified step order. Continue to use Anti-Fungal PA form for non-preferred products. 4. Quantity limit of one tablet daily. Please see dosage consolidation list. 5. Approved if immuno suppressed/ HIV or if the member has failed a 7 day trial of a preferred antifungal therapy. 6. Eraxis will be approved if submitting with documentation that it was initiated during a hospitalization and this request is to finish the hospital course. 7. Quantity limits allowing 30 day supply without PA. PA will be required if using > 30 days. 8. For children < 18, quantity limits allows 8 weeks supply without PA. PA will be required if using > than 8 weeks. If 18 and older PA will be required for any quantity. Not approving for Onychomycosis indication. Use PA Form# 10120	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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]		
	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		
	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.
								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.
								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.
								DDI: Ketoconazole will now be non-preferred and require prior authorization if they are currently being used in combination with any of the following medications: Prevacid, Pantoprazole, Plavix, Onglyza, Enablex 15mg, Vesicare 10mg, Latuda, Cometriq, Tafinlar or Omeprazole.
ANTI - VIRALS								
ANTIRETROVIRALS	MC/DEL		APTIVUS	MC	8	COMPLERA		Please refer to the criteria listed on the Fuzeon PA form.
	MC		ATRIPLA[1]	MC/DEL	8	DIDANOSINE		
	MC/DEL		COMBIVIR TABS	MC/DEL	8	FUZEON[3]	Use PA Form# 10620 for Fuzeon 1. Quantity limit of one per day 2. Only preferred if Norvir script is in member's profile within the past 30 days of filling Prezista 3. Prescribers with >= 10 ART scripts per quarter and 75% ART PDL compliance will be exempt from PA for these products. 4.Isentress Chewable will only be approved if between the age of 2-12 years old	
	MC/DEL		CRIXIVAN CAPS	MC/DEL	8	INTELENCE[3]		
	MC/DEL		EDURANT	MC/DEL	8	ISENTRESS[3,4]		**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 preferre PPI .
	MC		EMTRIVA	MC	8	RETROVIR		
	MC/DEL		EPIVIR / HBV	MC/DEL	8	SELZENTRY[3]		
	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]		
	MC		KALETRA	MC	8	TRIUMEQ[5,7]		**DDI:** Preferred Crixivan caps will now be non-preferred and require prior authorization if it is currently being used in combination with either Enablex 15mg or Vesicare 10mg.
	MC/DEL		LEXIVA	MC	8	ZERIT		
	MC		NORVIR	MC/DEL	9	VIRAMUNE XR		
	MC		PREZISTA[2]					EDURANT® treated subjects with HIV-1 RNA greater than 100,000 copies/mL at the start of therapy experienced virologic failure (HIV-1 RNA greater than or equal to 50 copies/mL) compared to EDURANT® treated subjects with HIV-1 RNA less than or equal to 100,000 copies/mL. Regardless of HIV-1 RNA at the start of therapy, more EDURANT® treated subjects with CD4+ cell count less than 200 cells/mm3 experienced virologic failure compared to EDURANT® treated subjects with CD4+ cell count greater than or equal to 200 cells/mm3.
	MC/DEL		RESCRIPTOR TABS					
	MC		REYATAZ[1]					
	MC		STAVUDINE					
	MC		SUSTIVA					
	MC/DEL		TRIZIVIR TABS					
	MC		TRUVADA					Stribild needs specific indication(only indicated for HIV-1 infection in adults who are antiretroviral treatment-naïve), as there is a boxed warning that this is not indicated for Hep B and has not been studied in those co-infected with HIV-1 and HBV. Should not be co-administered with other antiretroviral medications used for HIV1 infections, as this is a complete regimen
	MC		VIDEX EC					

	MC/DEL		VIRACEPT TABS					5. Clinical PA is required to establish diagnosis, verification of age for appropriate indication and medical necessity. 6. Dosing limits apply, please see dosing consolidation list. 7. Request will require use of the individual components Tivicay and Epzicom.	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 combinatic with Tivicay.
	MC/DEL		VIRAMUNE TABS						
	MC		VIREAD TABS						
	MC/DEL		ZIAGEN TABS						
	MC/DEL		ZIDOVUDINE						
CYTO-MEGALOVIRUS AGENTS	MC		FOSCARNET SODIUM	MC/DEL		FOSCAVIR	Use PA Form# 20420		Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on tl Prior Authorization form, such as the presence of a 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. Use PA Form# 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 offered on the Prior Authorization form, such as the presence of a 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	8	SITAVIG			
				MC/DEL	8	ZOVIRAX[1]			
				MC/DEL	8	VALTREX TABS[1]			
				MC/DEL	9	FAMVIR TABS[1]			
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. Use PA Form# 10610 for Flumist requests Use PA Form# 20420 for all others		Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception offered on the Prior Authorization form, such as the presence of a 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						
	MC/DEL		TAMIFLU[1]						
IMMUNE SERUMS									
IMMUNE SERUMS	MC		HYPERRHO INJ						
HEPATITIS AGENTS									
HEPATITIS C AGENTS	MC		INCIVEK[2]	MC/DEL		COPEGUS TABS	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-l 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 offered on the Prior Authorization form, such as the presence of 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).
	MC		OLYSIO[3]	MC/DEL		REBETOL CAPS			
	MC/DEL		PEGASYS KIT[1]						
	MC/DEL		PEGASYS SOLN						
	MC/DEL		PEG-INTRON KIT[1]						
	MC		RIBAVIRIN						
	MC		RIBAPAK						
	MC		SOVALDI[3]						
	MC/DEL		VICTRELIS[2]						
HEPATITIS AGENTS - MISC.				MC		ACTIMMUNE	Use PA Form# 20420		Approved for chronic granulomatous disease, osteopetrosis and idiopathic pulmonary fibrosis.
HEPATITIS B ONLY	MC		HEPSERA TABS	MC		BARACLUDE	Use PA Form# 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 offered on the Prior Authorization form, such as the presence of 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)
				MC		TYZEKA			

								Highly active antiretroviral therapy (HAART)
RSV PROPHYLAXIS								
RSV PROPHYLAXIS				MC		SYNAGIS[1]	Use PA Form# 30120 1. MaineCare will approve Synagis PA's for start date of November 23rd for infants who meet the guidelines. PA will be approved for max of 5 doses. Maximum 1 dose/30 days.	Please see the criteria listed on the Synagis PA form.
MS TREATMENTS								
MULTIPLE SCLEROSIS - INTERFERONS	MC		AVONEX KIT[1]	MC/DEL		**BETASERON SOLR**	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.
	MC/DEL		EXTAVIA[1]					
	MC		REBIF SOLN[1]					
MULTIPLE SCLEROSIS - NON-INTERFERONS	MC		AMPYRA	MC	6	TYSABRI[1]	1. Providers must be enrolled in the TOUCH Prescribing program, a restricted distribution program. Clinical PA is required to establish diagnosis and medical necessity. 2. Clinical PA is required to establish diagnosis and medical necessity. 3. Dosing limits apply, please see dosage consolidation list. Use PA Form# 20430	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **Aubagio** is non-preferred and is for adults with relapsing forms of MS. No concurrent use of leflunomide . Within 6 months of initiation of Aubagio, lab testing to look at (transaminase, bilirubin, CBC, TB) as boxed warning exists regarding hepatoxicity.
	MC		COPAXONE 20MG[2]	MC	8	AUBAGIO		
	MC/DEL		GILENYA[2,3]	MC	8	COPAXONE 40MG		
				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 offered on the Prior Authorization form, such as the presence of a 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 th Prior Authorization form, such as the presence of 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		DEXPAK	MC		ORAPRED SOLN		
	MC/DEL		ENTOCORT EC CP24	MC		PEDIAPRED LIQD		
	MC/DEL		FLUDROCORTISONE ACETATE TABS	MC		PREDNISONE INTENSOL CONC		
	MC/DEL		HYDROCORTISONE	MC		STERAPRED TABS		
	MC		KENALOG					
	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 th Prior Authorization form, such as the presence of 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/DEL		**OXANDROLONE**		
				MC		TESTIM		
				MC/DEL		TESTOSTERONE CYP		
				MC		TESTRED CAPS		

				MC/DEL		VOGELXO		
ESTROGENS - PATCHES / TOPICAL	MC/DEL		VIVELLE-DOT PTTW[1]	MC/DEL	5	ESTRADIOL PTWK	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.
	MC/DEL		CLIMARA PTWK	MC/DEL	8	ALORA PTTW[2]		
				MC/DEL	8	DIVIGEL[2]		
				MC/DEL	8	ELESTRIN[2]		
				MC	8	EVAMIST[2]		
ESTROGENS - TABS	MC/DEL		CENESTIN TABS	MC/DEL		ENJUVIA	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.
	MC/DEL		ESTRADIOL	MC/DEL		ESTRACE TABS		
	MC/DEL		ESTROPIPATE TABS	MC		ESTRATAB TABS		
	MC/DEL		MENEST TABS	MC		ORTHO-EST TABS		
	MC/DEL		PREMARIN TABS					
ESTROGEN COMBO'S	MC/DEL		PREMPHASE TABS	MC/DEL		ACTIVELLA 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.
	MC/DEL		PREMPRO TABS	MC/DEL		COMBIPATCH PTTW[1]		
				MC/DEL		FEMHRT 1/5 TABS[1]		
				MC/DEL		ORTHO-PREFEST TABS[1]		
				MC/DEL		SYNTEST H.S. TABS[1]		
PROGESTINS	MC/DEL		MEDROXYPROGESTERONE ACETA [2]	MC/DEL		AYGESTIN TABS	1. PA approvals will require two 100 mg caps instead of one 200mg. 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 tl Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		NORETHINDRONE ACETATE TABS[2]	MC		CYCRIN TABS		
				MC		MAKENA		
				MC		PROGESTERONE POWD		
				MC/DEL		PROMETRIUM 100MG CAPS[1]		
				MC/DEL		PROMETRIUM 200MG[1]		
				MC/DEL		PROVERA TABS		
CONTRACEPTIVES								
CONTRACEPTIVES - PROGESTIN ONLY	MC/DEL		NOR-QD TABS	MC/DEL	7	CAMILA 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 tl Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. If member experienced adverse reactions, consider using Oral Contraceptives from other groups. **DDI:** Preferred Oral Contraceptives will now be non-preferred and require prior authorization if it is currently being used in combination with Tracleer.
	MC/DEL		NORETHINDRONE ACETATE 0.35 TABS	MC/DEL	7	ERRIN		
				MC/DEL	7	JOLIVETTE		
				MC/DEL	7	NORA-BE TABS		
				MC	8	ORTHO MICRONOR TABS		
CONTRACEPTIVES - INJECTABLE	MC/DEL		MEDROXYPROGESTERONE ACETATE 150mg IM	MC/DEL		DEPO-PROVERA 150 mg SUSP	Use PA Form# 20420	The preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
CONTRACEPTIVE - EMERGENCY	MC/DEL	1	PLAN B ONE STEP[1]	MC/DEL		PLAN B	1. Allowed 2 tablets per 30 days without PA Use PA Form# 20420	
	MC/DEL	2	ELLA					
	MC	2	LEVONORGESTREL					
	MC/DEL	2	NEXT CHOICE[1]					
CONTRACEPTIVES - PATCHES/ VAGINAL PRODUCTS	MC		NUVARING RING[3]				Use PA Form# 20420 1.No PA required for users less than 21 years of age. 2. The FDA has issued a public health warning of the potentials for increased exposure to estrogen with Ortho Eva use, possibly up to 60% estrogen exposoure. 3. Quantity limit allowing 1 every 28 days with out PA. 4. Dose limits apply allowing 3 patches per 28 days supply. Please refer to Dose Consolidation Chart.	Approved if adequate clinical reason given why patient unable to comply with other preferred agents including long acting injectable.
	MC		ORTHO EVRA PTWK[1,2,4]					
CONTRACEPTIVES - MONOPHASIC COMBINATION O/C'S	MC/DEL		APRI TABS	MC/DEL		BEYAZ	Use PA Form# 20420 If member experienced adverse reactions, consider using Oral Contraceptives from other groups.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on tl Prior Authorization form, such as the presence of 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 Traclee
	MC/DEL		AVIANE TABS	MC/DEL		BREVICON-28 TABS		
	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		
	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		
	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 th Prior Authorization form, such as the presence of a 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 th Prior Authorization form, such as the presence of a 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 th Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferre drug(s) exists.
	MC		HUMALOG MIX 75/25	MC		HUMALOG MIX 50/50		
	MC		HUMULIN N INJ U-100	MC		HUMULIN INJ 50/50		
	MC		HUMULIN INJ 70/30	MC		HUMULIN R INJ U-500		
	MC		HUMULIN R U-100	MC/DEL		**NOVOLIN**		
	MC/DEL		LANTUS SOLN	MC/DEL		**NOVOLOG**		
	MC/DEL		LEVEMIR	MC/DEL		**NOVOLOG MIX**		
				MC		RELION		
DIABETIC - PENFILLS	MC/DEL		LANTUS SOLOSTAR[1]	MC		APIDRA OPTICLIK PEN	1. Clinical PA will be required to establish significant visual or neurological impairment.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		LEVEMIR FLEXPEN[1]	MC		HUMALOG KWIK INJ 100/ML		
	MC/DEL		**NOVOLIN PENFILL**[1]	MC		HUMALOG MIX INJ 75/25 KWP		
	MC/DEL		**NOVOLIN 70/30**[1]	MC		HUMALOG MIX INJ 50/50 KWP		
	MC/DEL		NOVOLOG MIX PENFILL[1]					
	MC/DEL		**NOVOLOG PENFILL SOLN**[1]					
	MC/DEL		NOVOLOG MIX FLEXPEN[1]					
	MC/DEL		NOVOLOG FLEXPEN[1]				Use PA Form# 20420	
DIABETIC - DPP- 4 ENZYME INHIBITOR	MC/DEL		JANUVIA[1,2]	MC/DEL		**ONGLYZA**[1,2]	1. Preferred if therapeutic doses of metformin are seen in members drug profile for at least 60 days within the past 18 months or if phosphate binder is currently seen in the members drug profile.	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 offered on the Prior Authorization form, such as the presence of a 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		TRADJENTA[2]					**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).
							2. Dosing limits apply. Please refer to Dose consolidation list.	
							Use PA Form# 20420	
DIABETIC - DPP- 4 ENZYME INHIBITOR-COMBO	MC/DEL		JANUMET[1,2]	MC/DEL		**KAZANO**	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.	
	MC/DEL		**JANUMET XR**[1,2]	MC		KOMBIGLYZE XR		
	MC/DEL		**JENTADUETO**[1]	MC/DEL		**OSENI**		
							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		ONE TOUCH LANCETS				Use PA Form# 20420	
	MC		DELICA LANCETS					
	MC		UNILET LANCETS					
	MC		UNISTIK LANCING DEVICE					
	MC		AUTOLOT LANCING DEVICE					
DIABETIC - SYRINGES-NEEDLES	MC/DEL		BD MICRO-FINE				Use PA Form# 20420	
	MC		BD ULTRA-FINE					
	MC		BD ULTRA-FINE PEN NEEDLES					
	MC		UNIFINE PEN NEEDLES					
DIABETIC - OTHER				MC/DEL		CYCLOSET	Use PA Form# 30150 for Symlin Use PA Form #20420 for all others	Please see the criteria listed in the Symlin PA form.
				MC		SYMLIN		
SGLT 2 INHIBITORS				MC/DEL		**FARXIGA**	1.Dosing limits apply please refer to Dose Consolidation List Use PA Form# 20420	**Invokana** will be considered for patients who are unable to tolerate any preferred medicaitons from other diabetic classes.
				MC/DEL		**INVOKANA**[1]		
				MC/DEL		**JARDIANCE**		
SGLT 2 INHIBITOR COMBINATIONS				MC/DEL		**INVOKAMET**	Use PA Form# 20420	Preferred drugs must be tried for at least 3 months at full therapeutic doses and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
DIABETIC MONITOR	MC		FREESTYLE INSULINX	MC		ACCUCHECK	Use PA Form# 20420	Effective October 25th 2007, approvals for all non preferred meters/ test strips will require medical necessity documenting clinically significant features that are not available on any of the preferred meters.
	MC		FREESTYLE LITE SYSTEM KIT	MC		ASCENSIA		
	MC		FREESTYLE FREEDOM LITE KIT	MC		ASSURE		
	MC		ONE TOUCH ULTRA 2 KIT	MC		CONTOUR BREEZE Z		
	MC		ONE TOUCH ULTRA MINI KIT	MC		EXACTECH		
	MC		ONE TOUCH ULTRA SMART KIT	MC		PRODIGY		
	MC		PRECISION XTRA METER					
DIABETIC TEST STRIPS	MC		FREESTYLE[1]	MC		ACCUCHECK	1. Only 50 ct & 100 ct package size. Use PA Form# 20420	Effective October 25th 2007, approvals for all non preferred meters/ test strips will require medical necessity documenting clinically significant features that are not available on any of the preferred meters.
	MC		FREESTYLE LITE[1]	MC		ASCENSIA		
	MC		FREESTYLE INSULINX[1]	MC		ASSURE		
	MC		ONE TOUCH DELICA[1]	MC		EXACTECH		
	MC		ONE TOUCH ULTRA[1]	MC		PRODIGY		
	MC		PRECISION XTRA[1]	MC		CONTOUR BREEZE Z		
INCRETIN MIMETIC				MC	8	BYDUREON[1]	1. If patient is not responding to oral agents (single or multiple) please look to insulin therapy. Dosing limits apply. Please refer to Dose Consolidation List. Use PA Form# 10230	
				MC	8	BYETTA[1]		
				MC/DEL	8	**NESINA**		
				MC/DEL	8	**TANZEUM**		
				MC/DEL	9	VICTOZA[1]		
DIABETIC - ORAL SULFONYLUREAS	MC/DEL		**CHLORPROPAMIDE TABS**	MC/DEL		**AMARYL TABS**	Use PA Form# 20420 1. Pa required for members ≥65. Glyburide has a greater risk of severe prolonged hypoglycemia in older adults.	Preferred drugs must be tried for at least 3 months at full therapeutic doses and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **DDI:** All sulfonylureas (except glyburide) will now be non-preferred and require prior authorization if it is currently being used with either ranitidine or cimetidine.
	MC/DEL		GLIMEPIRIDE	MC/DEL		**DIABETA TABS**		
	MC/DEL		**GLIPIZIDE TABS**	MC		**GLUCOTROL TABS**		
	MC/DEL		**GLIPIZIDE ER TABS**	MC/DEL		**GLUCOTROL XL TBCR**		
	MC/DEL		**GLYBURIDE MICRONIZED TABS**	MC/DEL		**GLYNASE TABS**		

	MC/DEL MC/DEL MC/DEL		**GLYBURIDE TABS**[1] **TOLAZAMIDE TABS** **TOLBUTAMIDE TABS**	MC/DEL		**MICRONASE TABS**		**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 th Prior Authorization form, such as the presence of 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 th Prior Authorization form, such as the presence of 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 MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		**ARMOUR THYROID TABS** **CYTOMEL TABS** **LEVOTHROID TABS** **LEVOTHYROXINE SODIUM TABS** **LEVOXYL TABS** **THYROID TABS** **THYROLAR** **UNITHROID TABS**	MC MC/DEL MC		LEVOTHYROXINE SODIUM SOLR LIOTHYRONINE SYNTHROID TABS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on th Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANTITHYROID THERAPIES	MC/DEL MC/DEL		**METHIMAZOLE TABS** **PROPYLTHIOURACIL TABS**	MC/DEL		**TAPAZOLE TABS**	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on th Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
OSTEOPOROSIS / BONE AGENTS								
OSTEOPOROSIS	MC/DEL MC/DEL		ALENDRONATE **MIACALCIN SOLN**[2]	MC/DEL MC MC MC/DEL MC/DEL MC/DEL MC/DEL MC MC		**ACTONEL TABS** AREDIA SOLR BINOSTO BONIVA INJECTION KIT BONIVA TABS[2,4] CALCITONIN NS **DIDRONEL TABS** EVISTA TABS[1] FORTEO	Use PA Form# 20420 1. Approval only requires failure of Alendronate. 2. Quantity limits apply, please see dosage consolidation list. 3. Please use Alendronate	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on th Prior Authorization form, such as the presence of a 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		and Vitamin D.		
				MC/DEL		FORTICAL **FOSAMAX TABS AND PLUS D**[3]	4. Please use other preferred agents.	**Binosto** use preferred generic alendronate tablets
				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		NORDITROPIN SOLN[1]	MC/DEL	8	GENOTROPIN	Use PA Form# 10710	See Growth Hormone PA form for criteria. Step-order will still apply unless clinical contraindication supplied.
	MC/DEL		NUTROPIN AQ [1]	MC	8	HUMATROPE SOLR	1.Clinical PA is required to establish diagnosis and medical necessity.	
				MC	8	INCRELEX		
				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 3 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/DEL	8 8 9	**DETROL TABS** **DITROPAN** 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 th Prior Authorization form, such as the presence of 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	8 8 8 8 8 9	**DITROPAN XL TBCR** ENABLEX[1,3] **MYRBETRIQ** **OXYTROL** **TOLTERODINE TAB** DETROL LA CP[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 th Prior Authorization form, such as the presence of 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 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 th Prior Authorization form, such as the presence of 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 MC/DEL MC	1 1 1 3	**NITROGLYCERIN PT24**[1] **NITREK PT24**[1] **NITRO-DUR PT 0.8MG**[1] MINITRAN 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 specified order or PA will be required. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on th Prior Authorization form, such as the presence of 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 - 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 th Prior Authorization form, such as the presence of 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 MC/DEL MC/DEL MC/DEL		**CARVEDILOL** LEVATOL TABS **NADOLOL TABS** **PINDOLOL TABS** **PROPRANOLOL HCL SOLN**[1] **PROPRANOLOL HCL TABS**[1] **PROPRANOLOL LA CAPS** RANEXA SOTALOL AF SOTALOL HCL TABS **TIMOLOL MALEATE TABS**	MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC MC MC/DEL		**BETAPACE TABS** **BETAPACE AF TABS** **COREG CR**[3] **COREG TABS** **CORGARD TABS** **INDERAL TABS** INDERAL LA CPCR INNOPRAN XL **PROPRANOLOL HCL 60MG TABS**[2]	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 th Prior Authorization form, such as the presence of 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		**ACEBUTOLOL HCL CAPS**	MC/DEL		BYSTOLIC	1. Recommend using	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on th

	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		**ATENOLOL TABS**[1] **BETAXOLOL HCL TABS** **BISOPROLOL FUMARATE TABS** **METOPROLOL TARTRATE TABS**[1] **METOPROLOL ER** **TOPROL XL TB24**	MC MC/DEL MC MC/DEL MC/DEL		KERLONE TABS **LOPRESSOR TABS** SECTRAL CAPS **TENORMIN TABS** **ZEBETA TABS**	Atenolol (and metoprolol) BID since its effects do not last 24 hours. Use PA Form# 20420	Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferre 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 th Prior Authorization form, such as the presence of 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 tl Prior Authorization form, such as the presence of a 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 tl Prior Authorization form, such as the presence of 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. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs (in step-order) will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Non-preferred products are subject to step-order requirements unless clinical circumstances warrant exception.
	MC/DEL		**CAPTOPRIL TABS**	MC/DEL	5	**ACCUPRIL TABS**		
	MC/DEL		**ENALAPRIL MALEATE TABS**	MC/DEL	8	**ACEON TABS**[1]		
	MC/DEL		**FOSINOPRIL SODIUM**	MC/DEL	8	**ALTACE CAPS**[1]		
	MC/DEL		**LISINOPRIL TABS**	MC/DEL	8	**LOTENSIN TABS**[1]		
	MC/DEL		**RAMIPRIL**	MC/DEL	8	**MOEXIPRIL HCL**[1]		
	MC/DEL		**QUINAPRIL HCL**	MC	8	**MONOPRIL HCT TABS**[1]		
				MC/DEL	8	**PRINIVIL TABS**[1]		
				MC/DEL	8	**UNIVASC**[1]		
				MC	8	VASOTEC TABS[1]		
				MC/DEL	8	**ZESTRIL TABS**[1]		

ANGIOTENSIN RECEPTOR BLOCKER	MC/DEL		**BENICAR TABS**[1]	MC/DEL	8	**ATACAND TABS**	Use PA Form# 20420	The initial criteria to use any ARB is that the member must have failed ACE inhibitors (such as due to coughing) in the past or must currently be actively treated for diabetes and Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**DIOVAN**[1]	MC/DEL	8	**AVAPRO**	1. Preferred products only available without PA if patient on diabetic therapy or prior ACE therapy.	
	MC/DEL		**IRBESARTAN**[1]	MC/DEL	8	**COZAAR**		
	MC/DEL		LOSARTAN[1]	MC/DEL	8	EDARBI		
	MC/DEL		**MICARDIS TABS**[1]	MC	8	TEVETEN TABS		
				MC/DEL	8	TRIBENZOR[2]	2. Use preferred active ingredients which are available without PA.	
DIRECT RENIN INHIBITOR				MC/DEL		AMTURNIDE	1. Must show failure of single and combination therapy from all preferred antihypertensive categories.	
				MC/DEL		TEKTURNA[1]		
				MC/DEL		TEKAMLO		
							Use PA Form# 20420	
ANTIHYPERTENSIVES - CENTRAL	MC/DEL		**CATAPRES-TTS**	MC/DEL		**CATAPRES TABS**	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on th Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**CLONIDINE HCL TABS**	MC/DEL		CLONIDINE TTS		
	MC/DEL		**GUANFACINE HCL TABS**	MC		GUANABENZ ACETATE TABS		
	MC/DEL		**HYDRALAZINE HCL TABS**	MC		ISMELIN TABS		
	MC		HYLOREL TABS	MC/DEL		**MINIPRESS CAPS**		
	MC/DEL		**METHYLDOPA TABS**	MC		**NEXICLON**		
	MC/DEL		**MINOXIDIL TABS**	MC/DEL		**TENEX TABS**		
	MC/DEL		**PRAZOSIN HCL CAPS**					
	MC/DEL		**RESERPINE TABS**					
ACE INHIBITORS AND CA CHANNEL BLOCKERS				MC/DEL	8	**AMLODIPINE/BENAZEPRIL**	Use individual preferred generic medications.	
				MC	8	TARKA TBCR		
				MC/DEL	9	**AMLODIPINE/BENAZEPRIL**		
				MC/DEL	9	**LOTREL CAPS**	Use PA Form# 20420	
ACE AND THIAZIDE COMBO'S	MC/DEL		**BENAZEPRIL HCL/HYDROCHLOR**	MC/DEL		**ACCURETIC TABS**	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on th Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**CAPTOPRIL/HYDROCHLOROTHIA**	MC		MONOPRIL HCT TABS		
	MC/DEL		**ENALAPRIL MALEATE/HCTZ TABS**	MC/DEL		**PRINZIDE TABS**		
	MC/DEL		**LISINOPRIL-HCTZ TABS**	MC/DEL		**UNIRETIC TABS**		
	MC/DEL		**LOTENSIN HCT TABS**	MC		VASERETIC TABS		
				MC/DEL		**ZESTORETIC TABS**		
BETA BLOCKERS AND DIURETIC COMBO'S	MC/DEL		**ATENOLOL/CHLORTHALIDONE**	MC/DEL		**CORZIDE TABS**	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on th Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**BISOPROLOL FUMARATE/HCTZ**	MC/DEL		**LOPRESSOR HCT TABS**		
	MC/DEL		**PROPRANOLOL/HCTZ**	MC		TENORETIC		
				MC		TIMOLIDE 10/25 TABS		
				MC/DEL		**ZIAC TABS**		
ARB'S AND CA CHANNEL BLOCKERS	MC/DEL		**AZOR**	MC/DEL		**TWYNSTA**	1. Preferred products only available without PA if patient on diabetic therapy or prior ACE therapy.	
	MC/DEL		**EXFORGE**[1]					
	MC/DEL		**EXFORGE HCT**[1]				Use PA Form# 20420	
ARB'S AND DIURETICS	MC/DEL		BENICAR HCT[1]	MC/DEL	7	**IRBESARTAN HYDROCHLOROTHIAZIDE**	1. Preferred products only available without PA if patient on diabetic therapy or prior ACE therapy.	Same initial criteria as the ARB class and Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		LOSARTAN HCT[1]	MC/DEL	8	**ATACAND HCT TABS**		
	MC/DEL		MICARDIS HCT TABS[1]	MC	8	**AVALIDE TABS**[1]		
	MC/DEL		**VALSARTAN-HYDROCHLOROTHIAZIDE**[1]	MC/DEL	8	DIOVAN HCT TABS[1]		
				MC/DEL	8	HYZAAR TABS		
				MC	8	TEVETEN HCT TABS	Use PA Form# 20420	
ANGIOTENSIN MODULATORS-ARB COMBINATION				MC/DEL		**EDARBYCLOR**	Use PA Form# 20420	
ARB'S AND DIRECT RENIN INHIBITOR COMBINATION				MC/DEL		**VALTURNA**	Use PA Form# 20420	
DIURETICS	MC/DEL		**ACETAZOLAMIDE TABS**	MC/DEL		**ALDACTAZIDE TABS**	1. Multiples of Spironolactone 25 mg are cheaper than 50 mg strength. Inspra will be approved for severe breast tenderness and male gynecomastia.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on th Prior Authorization form, such as the presence of a 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		
NEUROGENIC ORTHOSTATIC HYPOTENSION								
NEUROGENIC ORTHOSTATIC HYPOTENSION				MC		NORTHERA	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on t Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
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 t Prior Authorization form, such as the presence of a 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 t Prior Authorization form, such as the presence of a 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		FENOFIBRATE	MC/DEL		FIBRICOR		
	MC/DEL		GEMFIBROZIL TABS	MC		LIPOFEN		**DDI:** Fenofibrate is preferred but will require a prior authorization requests if used concurrent with Warfarin.
	MC/DEL		NIASPAN	MC/DEL		LOFIBRA		
	MC		TRILIPIX	MC		TRICOR		
				MC		TRIGLIDE		**DDI:** Gemfibrozil will now be non-preferred and require prior authorization if it is currently being used with any of the following medications: Prandin, Actos, Avandia, any Avandia/Actos combination product, any HMG-COA Reductase Inhibitors (statins), or Warfarin.
CHOLESTEROL - HGM COA + ABSORB INHIBITORS MORE POTENT DRUGS/COMBINATIONS	MC/DEL		ATORVASTATIN	MC/DEL		LIPITOR	1. Dosing limits apply, please see dosage consolidation list.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on t Prior Authorization form, such as the presence of a 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		CRESTOR	MC		LIPTRUZET		
	MC/DEL		SIMVASTATIN[1]	MC/DEL		ZOCOR	2. Current users grandfathered.	**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.
			VYTORIN	MC/DEL		SIMVASTATIN 80MG[1,2]		
	MC							**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.
							Use PA Form# 20420	**DDI:** All preferred statins will now be non-preferred and require prior authorization if it is currently being used in combination with Gemfibrozil.
CHOLESTEROL - HGM COA + ABSORB INHIBITORS LESS POTENT DRUGS/COMBINATIONS	MC/DEL		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.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on t Prior Authorization form, such as the presence of 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.
	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		**DDI:** Lescol will now be non-preferred and require prior authorization if it is currently being used in combination with diclofenac.
				MC	8	ZETIA TABS[1]		**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.
							2. Dosing limits apply, please see dosage consolidation list.	**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.
							Use PA Form# 20420	**DDI:** All preferred statins will now be non-preferred and require prior authorization if it is currently being used in combination with Gemfibrozil.
CHOLESTEROL - HGM COA + ABSORB INHIBITORS STATIN/ NIACIN COMBO	MC		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 t Prior Authorization form, such as the presence of a 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/DEL		SILDENAFIL*	MC		ADCIRCA[1]	1. See Criteria Section.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on t 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.
	MC		EPOPROSTENOL INJ[5]	MC/DEL		ADEMPAS[6,7]	2. See Criteria Section.	
	MC		VENTAVIS[2]	MC/DEL		FLOLAN[6]	3. See Criteria Section.	
				MC		OPSUMIT[7,8]	4. See Criteria Section.	
				MC		ORENITRAM	5. There will be dosing limits of one 20ml multidose vial/ 30 days supply without pa.	
				MC		REMODULIN[6]		
				MC/DEL		REVATIO[3]		

							6. PA is required to establish and conform who group 1 diagnosis of primary PAH (Primary Pulmonary Hypertension) and NYHA functional class 3 & 4. 7. Requires previous trials/failure of multiple preferred medications. 8. Dosing limits apply, please see the dose consolidation list. Use PA Form# 20420	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. 4. Sildenafil will be preferred with clinical PA for treatment of pulmonary arterial hypotenion (WHO Group 1) in adults to improve exercise ability and delay clinical worsening. **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 MC MC/DEL MC		MECLIZINE HCL TABS PROMETHAZINE SUPP PROMETHAZINE TRANSDERM-SCOP PT72	MC MC MC MC MC		ANTIVERT TABS PHENERGAN SOLN PROMETHAZINE 50MG SUPP PROMETHEGAN SUPP TORECAN TABS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on th Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANTIEMETIC - 5-HT3 RECEPTOR ANTAGONISTS/ SUBSTANCE P NEUROKININ	MC/DEL MC/DEL MC/DEL MC/DEL		**DRONABINOL CAPS** **ONDANSETRON TABS[2,4]** **ONDANSETRON ODT TBDP[2,4]** **ONDANSETRON INJ[2,4]**	MC/DEL MC MC MC MC MC MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL MC	5 8 8 8 8 8 8 8 8 8 8 8 8	GRANISETRON ALOXI ANZEMET TABS CESAMET[1] DICLEGIS EMEND[3] KYTRIL MARINOL CAPS SANCUSO ZOFRAN ODT TBDP[4] ZOFRAN TABS[4] ZOFRAN INJ[4] ZUPLENZ	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	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.

							Use PA Form# 20420 for all others	
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.	Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. No combination product with decongestant will be approved since pseudoephedrine available without PA.
	MC/DEL		CETIRIZINE TABS	MC	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]	2. Clarinex and Zyrtec syrp <6 yr w/o PA.	Pseudoephedrine is available with prescription.
				MC	8	CLARITIN[3]		
				MC/DEL	8	DESLORATADIN	3. Must fail all step 5 drugs (Clarinex, Fexofenadine and Zyrtec) before moving to next step product.	
				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		CLEMASTINE				Use PA Form# 20530	
	MC/DEL		CHLORPHENIRAMINE					
	MC/DEL		DIPHENHYDRAMINE					
ALLERGY / ASTHMA THERAPIES								
ANAPHYLACTIC DEVICES	MC/DEL		**AUVI- Q**	MC		TWINJECT		
	MC/DEL		**EPIPEN**					
ALLERGEN IMMUNOTHERAPY				MC/DEL		GRASTEK	Use PA Form# 20420	
				MC/DEL		RAGWITEK		
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 tl Prior Authorization form, such as the presence of 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 tl Prior Authorization form, such as the presence of 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		**FLUTICASONE SPR[3]**	MC/DEL	5	BECONASE AQ INHA[1,3]	Use PA Form# 20420	Preferred drugs and step therapy must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		NASONEX SUSP[3]	MC/DEL	8	DYMISTA		
				MC/DEL	8	FLONASE SUSP[2,3]	1. All preferred drugs must be tried before moving to non preferred steps.	
				MC/DEL	8	FLUNISOLIDE SOLN[1,3]		
				MC/DEL	8	OMNARIS SPR[3]		
				MC	8	QNASL		
				MC	8	RHINOCORT AERO[2,3]		
				MC/DEL	8	RHINOCORT AQUA SUSP[2,3]	2. All step 5 medications need to be tried before moving to step 8's.	
				MC	8	TRI-NASAL SOLN[2,3]		
				MC	8	VANCENASE POCKETHALER AERS[2,3]		
				MC/DEL	8	VERAMYST[2,3]	3. Dosing limits apply to whole category, please see dosage consolidation list.	
				MC/DEL	8	ZETONNA		

				MC/DEL	9	TRIAMCINOLONE NS		
ANTIASTHMATIC - NASAL MISC.	MC/DEL MC/DEL MC/DEL		CROMOLYN NASAL 4% OCEAN 0.65% SALINE NASAL SPRAY 0.65%	MC MC/DEL MC MC/DEL MC/DEL	7 7 7 8 8	ATROVENT NASAL SOL ASTELIN IPRATROPIUM NASAL SOL[1] ASTEPRO[2] PATANASE	Use PA Form# 20420 1. Ipratropium will be approved if submitted with documentation supporting use of CPAP machine. 2. Utilize Multiple preferred, as well as step therapy Astelin.	Approved if patient fails on nonsedating antihistamines and steroid nasal sprays. Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANTIASTHMATIC - BETA - ADRENERGICS	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		**ALBUTEROL NEB** **METAPROTERENOL** **PROVENTIL HFA** **SEREVENT** **TERBUTALINE SULFATE TABS**	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL MC MC MC/DEL MC/DEL		**ACCUNEB NEBU** **ALBUTEROL AER** **ALBUTEROL HFA** **ALBUTEROL 0.63mg/3ml** **ARCAPTA**[3] **BRETHINE** **FORADIL AEROLIZER CAPS** **PROAIR HFA**[3] **STRIVERDI** **VENTOLIN AERS** **VENTOLIN HFA AERS**[3] VOLMAX TBCR VOSPIRE ER TB12 **XOPENEX HFA**[3] **XOPENEX NEBU**[1,2]	1. Xopenex users w/ prior asthma hospitalization due to albuterol nebulizer failure will be grandfathered. 2. Quantity Limit: 12 cc/day. 3. Dosing limits apply, please see dosage consolidation list. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on th Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANTIASTHMATIC - ADRENERGIC COMBINATIONS	MC/DEL MC/DEL MC/DEL		**ADVAIR DISKUS/HFA**[1,2] DULERA SYMBICORT[2]	MC/DEL		**BREO ELLIPTA**[2,3]	1. We ask physicians to write "asthma" on the prescription whenever Advair is primarily being used for that condition. 2. Dosing limits apply, please see dosage consolidation list. 3. Clinical PA required for appropriate diagnosis Use PA Form# 20420	
ANTIASTHMATIC - ADRENERGIC ANTICHOLINERGIC	MC/DEL		**ALBUTEROL/IPRATROPIUM NEB. SOLN**	MC/DEL MC/DEL MC/DEL		**ANORO ELLIPTA** **COMBIVENT RESPIMAT** DUONEB SOLN[1]	1. Please use preferred individual ingredients Albuterol and Ipratropium. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Duoneb components are available separately without PA.
ANTIASTHMATIC - XANTHINES	MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL		**AMINOPHYLLINE TABS** THEOCHRON TB12 THEOLAIR-SR TB12 **THEOPHYLLINE CR TB12** THEOPHYLLINE ELIX THEOPHYLLINE SOLN **THEOPHYLLINE ER CP12** **THEOPHYLLINE ER TB12**	MC/DEL MC MC/DEL		**THEO-24 CP24** THEOLAIR TABS **UNIPHYL TBCR**	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on th Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANTIASTHMATIC - STEROID INHALANTS	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC		ASMANEX[4,5] **FLOVENT DISKUS**[4] **FLOVENT HFA**[4] **PULMICORT FLEXHALER** **PULMICORT SUSP**[1,4] QVAR AERS[4]	MC/DEL MC MC MC/DEL MC MC/DEL MC	5 5 5 8 8 8 8	**AEROBID AERS**[2,4] BECLOVENT AERS[2,4] VANCERIL AERS[2,4] **AEROBID-M AERS**[3,4] AEROSPAN ALVESCO[4] VANCERIL DOUBLE STRENGTH AERS[3,4]	1. No PA for Pulmicort susp if under 8 years old. 2. All preferreds must be tried before moving to non preferred steps. 3. All step 5 medications need to be tried before moving to step 8's. 4. Dosing limits apply to whole category, please see dosage consolidation list. 5. Asmanex 110mcg will be limited to member between the ages of 4-11years old. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on th Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.

ANTIASTHMATIC - 5-Lipoxygenase Inhibitors				MC		**ZYFLO CR TABS**	Use PA Form# 20420	Other Preferred asthma controller drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANTIASTHMATIC - LEUKOTRIENE RECEPTOR ANTAGONISTS	MC/DEL		**MONTELUKAST SODIUM TAB**	MC/DEL	7	MONTELUKAST GRANULE[1]	Use PA Form# 20420	
	MC/DEL		**MONTELUKAST SODIUM CHEW TAB**	MC/DEL	8	**ACCOLATE TABS**	1.Montelukast Granules will only be approved if between ages of 6months-24 months.	
				MC/DEL	8	**SINGULAIR**[2]	2.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. Use PA Form# 20420	All non-preferred products are not covered as permitted by Federal Medicaid regulations and MaineCare Policy.
	MC/DEL		GUAIFENESIN SYRP[1]					
	MC/DEL		PSEUDOEPHEDRINE[1]					
	MC		ROBITUSSIN DM SYRP[1]					
	MC		ROBITUSSIN SUGAR FREE SYRP[1]					
DIGESTIVE AIDS / ASSORTED GI								
GI - ANTIPERISTALTIC AGENTS	MC/DEL		DIPHENOXYLATE	MC/DEL		LOFENE TABS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on th Prior Authorization form, such as the presence of 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 1.Dosing limits apply please refer to Dose Consolidation List	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on th Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **As listed in MaineCare Policy, certain drugs require specific diagnoses for approval**
	MC/DEL		BENTYL SYRP	MC/DEL		BENTYL TABS		
	MC/DEL		BISMATROL	MC		CUVPOSA		
	MC/DEL		BISMUTH SUBSALICYLATE	MC		ED-SPAZ		
	MC/DEL		CALCIUM CARBONATE (ANTACID) CHEW	MC		FULYZAQ[1]		Preferred products that used to require diag codes still require diag codes unless indicated otherwise.
	MC/DEL		DICYCLOMINE HCL	MC/DEL		GLYCOPYRROLATE INJ		
	MC/DEL		GLYCOPYRROLATE TABS	MC/DEL		HYOSCYAMINE SL		
	MC		HAPONAL TABS	MC/DEL		LEVBID TB12		
	MC/DEL		HYOSCYAMINE CAPS & TABS	MC		LEVSIN ELIX		
	MC/DEL		HYOSCYAMINE SULFATE	MC		LEVSIN TABS		
	MC/DEL		KAOPECTATE	MC		LEVSIN/SL SUBL		
	MC/DEL		MAGNESIUM OXIDE TABS	MC		NULEV TBDP		**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 INJ		
	MC/DEL		**PAMINE TABS**	MC		**ROBINUL 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 th Prior Authorization form, such as the presence of a 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)[4]	MC/DEL	6	NEXIUM CPDR[3]	1. Prevacid Solutabs	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

	MC/DEL		OMEPRAZOLE 20MG[2]	MC	7	PRILOSEC OTC[4]	available without PA for children less than 9 years old. 2. Dosing limits apply, please see dosage consolidation list. 3. Please use multiple 20mg Capsules to obtain required dose. 4. All preferreds and step therapy must be tried and failed. 5. Established users prior to 10/1/09 may continue to obtain Prevacid until 12/31/09. Use PA Form# 20720	exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Patients obtaining refills as of 7/10/09 will begin to require prior authorizations if they have been on any PPI longer than 60 days in the past year. The 12-month period is patient specific and begins 12 months before the requested date of prior authorization. Payment for usage beyond these limits will be authorized for cases in which there is a diagnosis of: 1. Barrett's esophagus. 2. Erosive esophagitis 3. Hypersecretory conditions (Zollinger-Ellison syndrome, systemic mastocytosis, multiple endocrine adenomas). Recurrent peptic ulcer disease after documentation of previous trials and therapy failure with at least one histamine H2-receptor antagonist at full therapeutic doses and with documentation of either failure of Helicobacter pylori treatment or anegative Helicobacter pylori test result. 4. Symptomatic gastroesophageal reflux after documentation of previous trials and therapy failure with at least onehistamine H2-receptor antagonist at full therapeutic doses. Patients may be required to step down from a PPI to a histamine H2-receptor antagonist during the 12 months or on an annual clinical review if PPI therapy is continued. **DDI:** Omeprazole will require prior authorization if being used in combination with Plavix. **DDI:** Prevacid, Omeprazole and pantoprazole will now be non-preferred and require prior authorization if they are currently being used in combination with any of the following medications: Ampicillin, B-12, Fe salts, Griseofulvin, Sporanox, Ketoconazole, Reyataz, or Vantin. **DDI:** All non-preferred PPIs require prior authorization, but with any prior authorization request, the member's drug profile will also be monitored for current use with ampicillin, B-12, Fe salts, griseofulvin, itraconazole, ketoconazole, Reyataz or Vantin due to a significant drug-drug interaction.
	MC/DEL		PANTOPRAZOLE	MC	7	ACIPHEX TBEC[4]	
				MC/DEL	8	PREVACID CPDR[4,5]	
				MC/DEL	8	PREVACID SOLUTABS[1]	
				MC/DEL	8	PRILOSEC CPDR	
				MC/DEL	8	PROTONIX INJ	
				MC/DEL			
					8	PROTONIX[2]	
				MC/DEL	8	OMEPRAZOLE 10MG[2]	
				MC	8	OMEPRAZOLE-SODIUM BICARBONATE CAPS	
				MC/DEL	8	LANSOPRAZOLE	
				MC	9	OMEPRAZOLE 40MG[3]	
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 1. Clinical PA is required to establish CF diagnosis and medical necessity. In all cases except cystic fibrosis patients, objective evidence of pancreatic insufficiency (fa malabsorption test etc...) must be supplied. Non -Preferred drugs must be tried and failed in step-order due to lack of efficacy or intolerable side effects before other non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		LACTASE CHEW	MC		PANCREAZE	
	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 Use PA Form# 20420 2. Prior failed trials of multiple other preferred GI agents must occur first, Such as OTC senna, docusate, lactulose, polyethylene glycol Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on th Prior Authorization form, such as the presence of 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	
	MC		GASTROCROM CONC	MC/DEL		REGLAN TABS	
	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 1. Current users grandfathered. 2. Use multiple Pentasa 250mg. Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on th Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Giazo is only indicated for males, as the safety.efficacy for use in females has not been established.Prior trials of preferred products.
	MC		AZULFIDINE TABS	MC/DEL		AZULFIDINE EN-TABS TBEC	
	MC/DEL		BALSALAZIDE	MC/DEL		DELZICOL	
	MC		CANASA SUPP	MC		GIAZO	
	MC		COLAZAL CAPS	MC/DEL		LIALDA TABS[1]	
	MC		DIPENTUM CAPS	MC/DEL		PENTASA 500MG[2]	
	MC		PENTASA CPCR 250MG	MC		SFROWASA	
	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. Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on th Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **As listed in MaineCare Policy, certain drugs require specific diagnoses for approval.**
	MC/DEL		BISACODYL	MC		BENEFIBER	
	MC		BISCOLAX SUPP	MC/DEL		CARAFATE	

	MC		CINOBAC CAPS	MC/DEL		CLEARLAX POW	mineral oil and prescription lactulose.	Preferred products that used to require diag codes still require diag codes unless indicated otherwise.
	MC/DEL		CITRATE OF MAGNESIA SOLN	MC/DEL		COLACE CAPS		
	MC/DEL		CITRUCEL	MC/DEL		COLYTE		
	MC/DEL		DIOCTO SYRP	MC		DIOCTO-C SYRP	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.	
	MC		DOCUSATE CALCIUM CAPS	MC		DOC SOD /CAS CAP		**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		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	Use PA Form# 20420	
	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		PREPOPIK PAK		
	MC/DEL		SENOKOT SYRP	MC/DEL		SENEXON TABS		
	MC/DEL		SENOKOT CHILDRENS SYRP	MC/DEL		SENOKOT TABS		
	MC		SENOKOT XTRA TABS	MC		SENOKOT S TABS		
	MC/DEL		SORBITOL	MC		STOOL SOFTENER PLUS CAPS		
	MC/DEL		STOOL SOFTENER CAPS	MC/DEL		UNI-CENNA TABS		
	MC/DEL		SUCRALFATE TABS	MC		UNI-EASE PLUS CAPS		
	MC		UNI-EASE CAPS	MC		V-R NATURAL SENNA LAXATIV TABS		
	MC		UNIFIBER POWD	MC		URSO 250		
	MC		URSO FORTE					
	MC/DEL		URSODIOL					
MISC. UROLOGICAL								
UROLOGICAL - MISC.	MC		ACETIC ACID 0.25% SOLN	MC		CITRIC ACID/SODIUM CITRAT SOLN	1. Elmiron requires adequate proof of Dx with supportive testing.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on th Prior Authorization form, such as the presence of a 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	Use PA Form# 20420	
	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	
	MC/DEL		MAGNEBIND - 400[1]	MC/DEL		FOSRENOL[1]	1. Diag required.	
	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.	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]				2. Dosing limits apply, please see Dosage Consolidation List.	
	MC/DEL		CLEOCIN SUPP[1]					
							Use PA Form# 20420	
VAGINAL - ANTI FUNGALS	MC		CLINDESSE CREA	MC		AVC CREA		
	MC/DEL		CLOTRIMAZOLE CREA	MC		CLOTRIMAZOLE 3 DAY CREA	1. Quantity limit: 1/script/2 weeks	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on th Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		GYNE-LOTRIMIN CREA	MC		GYNAZOLE-1 CREA		
	MC		MICONAZOLE CREA	MC		GYNE-LOTRIMIN 3 TABS	Use PA Form# 20420	
	MC/DEL		MICONAZOLE 3 COMBO PACK KIT[1]	MC/DEL		MICONAZOLE 3 SUPP		
	MC/DEL		MICONAZOLE 7 CREA	MC		TERAZOL 3 CREA		**DDI:** Miconazole will require prior authorization if being used in combination with Warfarin.

	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.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on th Prior Authorization form, such as the presence of a 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]	Use PA Form# 20420	
VAGINAL - OTHER	MC/DEL		ACID JELLY GEL	MC		AMINO ACID CERVICAL CREA	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on th Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		ACI-JEL GEL					
	MC		CERVICAL AMINO ACID CREA					
BPH								
BPH	MC/DEL		**DOXAZOSIN MESYLATE TABS**	MC/DEL	5	**FLOMAX CP24**	1. There will be dosing limits of 1 tab per day with out PA. 2. Prior use of preferred agent prior to any approvals. 3. Use of preferred (tamsulosin and finasteride) and (tamsulosin and non-preferred Avodart). 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 th Prior Authorization form, such as the presence of a 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 th Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		HYDROXYZINE HCL SOLN	MC		DROPERIDOL SOLN		
	MC		HYDROXYZINE HCL SYRP	MC/DEL		HYDROXYZINE HCL TABS		
	MC/DEL		HYDROXYZINE PAMOATE CAPS	MC/DEL		HYDROXYZINE PAMOATE 100MG CAPS		
	MC/DEL		MEPROBAMATE TABS	MC/DEL		VISTARIL		
ANTI-DEPRESSANTS								
ANTIDEPRESSANTS - MAO INHIBITORS	MC/DEL		NARDIL TABS	MC/DEL		**TRANYLCYPROMIINE**	Use PA Form# 20420	
	MC/DEL		PARNATE TABS					
ANTIDEPRESSANTS - MAO INHIBITORS TOPICAL				MC/DEL		EMSAM[1]	1. Dosing limits apply, please refer to Dose consolidation list. Use PA Form# 20420	Preferred drugs (including a preferred SSRI, a non-SSRI, and Venlafaxine ER) must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANTIDEPRESSANTS - SELECTED SSRI's	MC/DEL		BUPROPION HCL TABS	MC/DEL	8	APLENZIN[7]	1. Use Fluoxetine 20 mg in multiples. 2. See Zoloft splitting table. Sertraline requires splitting of scored tabs to avoid PA. 3. Strong caution with pediatric population. 4. See Celexa/Citalopram and Lexapro splitting tables. 5. Max daily dose allowed is 60mg, only 1 capsule per day allowed for all strengths. Combination of multiple strengths require PA.	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 they are getting it filled, the claim will pay. If they do not have the trial of Fluoxetine in their profile, the claim will reject for PA required. 3. If the member (<18) has a prescription for a medication that is on the NON-PREFERRED side of the PDL regardless of having Fluoxetine in their profile, the prescription will need a PA. 4. Use of a preferred antidepressant for anxiety will require the diagnosis of anxiety on written prescription and submitted during claim submission. **DDI:** Fluvoxamine will now be non-preferred and require prior authorization if it is currently being used with glimepiride (Amaryl).
	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		FLUVOXAMINE MALEATE TABS	MC/DEL	8	FLUOXETINE 10mg AND 20mg TABS[6]		
	MC/DEL		MIRTAZAPINE	MC	8	FORFIVO XL		
	MC/DEL		NEFAZODONE	MC/DEL	8	KHEDEZLA[14]		
	MC/DEL		PAROXETINE[3]	MC/DEL	8	LEXAPRO TABS[4]		
	MC/DEL		SERTRALINE HCL[2]	MC	8	LUVOX TABS		
	MC/DEL		TRAZODONE HCL TABS	MC	8	MAPROTILINE HCL TABS		
	MC/DEL		VENLAFAXINE ER CAPS[9]	MC/DEL	8	MIRTAZAPINE ODT		
				MC	8	OLEPTRO		
				MC/DEL	8	PAROXETINE CR[3]		
				MC/DEL	8	PAXIL[3]		
				MC/DEL	8	PAXIL CR[3]		

				MC/DEL	8	PRISTIQ		
				MC	8	PROZAC	6. Use Fluoxetine 10mg tabs in multiples.	**DDI:** Preferred nefazodone will now be non-preferred and require prior authorization if it is currently being used in combination with either Onglyza 5mg, Enablex 15mg or Vesicare 10mg. **DDI:** Fluoxetine will require prior authorization if being used in combination with Plavix.
				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 limi	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	of 200mg / day applies. Please see dose consolidation list.	
				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 o 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 th Prior Authorization form, such as the presence of a 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 th Prior Authorization form, such as the presence of a 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 th Prior Authorization form, such as the presence of 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	8	HETLIOZ		
				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 th Prior Authorization form, such as the presence of 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/DEL		RISPERIDONE TAB[4]	MC	8	FANAPT		
	MC/DEL		RISPERIDONE SOLN[4]	MC/DEL	8	GEODON		
	MC/DEL		QUETIAPINE[4,7]	MC	8	INVEGA		Prescriptions for quetiapine are limited to a maximum daily dose of 800mg.
	MC/DEL		**ZIPRASIDONE[4]**	MC	8	INVEGA SUSTENNA		
				MC	8	LATUDA		
				MC	8	RISPERDAL TAB		
				MC	8	RISPERDAL CONSA [2]	Use PA form# 20440 for Multiple Antipsychotic requests	
				MC	8	RISPERDAL M TAB[2]		**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	8	RISPERDAL SOLN		
				MC/DEL	8	RISPERIDONE ODT		**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	SAPHRIS		• **schizophrenia**
				MC/DEL	8	SEROQUEL 50MG TABS[1,2]		• **bipolar disorder**
				MC	8	ZYPREXA TABS	Use PA form# 10130 for non-preferred single therapy atypical requests	• **agitation related to autism**
				MC	8	ZYPREXA ZYDIS TBDP [2]	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	8	ZYPREXA RELPREVV		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	8	SEROQUEL TABS	2. Established users of single therapy atypicals were grandfathered	
				MC/DEL	9	SEROQUEL XR[5]	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 offer on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Patients previously stabilized on brand name drug will be approved.
				MC		FAZACLO		**DDI:** Clozapine will now be non-preferred and require prior authorization if it is currently being used in combination with carbamazepine. Please use Drug-Drug Interaction PA form #10400.
ANTIPSYCHOTICS - TYPICAL	MC/DEL		CHLORPROMAZINE HCL	MC/DEL		COMPAZINE	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		FLUPHENAZINE DECANOATE	MC/DEL		COMPRO SUPP	If prescribing 2 or more antipsychotics, PA will be required for both drugs, except if one is Clozapine.	
	MC/DEL		FLUPHENAZINE HCL	MC		HALDOL DECANOATE		
	MC		HALDOL	MC/DEL		LOXITANE CAPS		If prescribing 2 or more antipsychotics, PA will be required for both drugs, except if one is Clozapine.
	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. 4. Dosing limits applly, please see dosing consolidation list.	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		
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		FOCALIN TABS[1,2]	MC		METHYLIN CHEWABLES	1. Preferred stimulants will be available without PA if diagnosis of ADHD	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on th Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Please refer to General Criteria category E
	MC/DEL		METADATE ER TBCR[1,2]	MC/DEL		RITALIN		

	MC/DEL		METHYLIN ER TBCR[1,2]				diagnosis of ADHD. drug(s) exists. Please refer to General Criteria category 2	
	MC/DEL		METHYLIN TABS[1,2]				Use PA Form# 20420	
	MC/DEL		METHYLIN SOL[1]				2. Dosing limits apply, please see dosing consolidation list. Maximum daily doses are as follows: 72mg daily for methylphenidate and 36mg daily for dexmethylphenidate.	
	MC/DEL		METHYLPHENIDATE HCL[1,2]			FAZACLO		
STIMULANT - METHYLPHENIDATE - LONG ACTING	MC/DEL		DAYTRANA[1,3]	MC	5	METADATE CD CPCR	1. Preferred stimulants will be available without PA if diagnosis of ADHD.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on th Prior Authorization form, such as the presence of a 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		FOCALIN XR[1]	MC	8	CONCERTA TBCR[2]		
	MC/DEL		METHYLPHENIDATE ER TABS	MC/DEL	8	METHYLPHENIDATE ER CAPS[1,2,4]	2. Non-preferred products must be used in specified step order.	
	MC/DEL		RITALIN LA[4]	MC	8	QUILLIVANT XR	3.FDA approval currently only for ages 6-16. Limit of one patch daily. Max dose of 30MG daily.	
							4.Dosing limits applly, please see dosing consolidation list.	
							Use PA Form# 20420	
STIMULANT - STIMULANT LIKE				MC/DEL	7	PROVIGIL TABS[3]	1. Failure of both an amphetamine and methylphenidate is required for consideration for approval of Strattera, unless history of substance abuse without current use of abusable medication(s). Additionally, for patients <17 years of age, a trial of quanfacine in required before approval of Strattera.	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	7	STRATTERA[1, 2]		
				MC	8	CAFCIT SOLN[3]		
				MC/DEL	8	INTUNIV		
				MC	8	KAPVAY		
				MC/DEL	8	MODAFINIL TABS		
				MC/DEL	9	NUVIGIL[3]		
				MC	9	DESOXYN TABS[3]		
				MC	9	DESOXYN CR[3]	2. Strattera currently has dosing limitations allowing one tablet per day for all strengths if obtain approval. Max daily dose of Strattera is 100mg. Please see dosing consolidation list.	
							3. Non-preferred products must be used in specified	
							4. Please use generic Guanfacine.	
							Use PA Form# 20710 for Provigil, Nuvigil and Xyrem	
							Use PA Form# 20420 for all others	
ANTI-CATAPLECTIC AGENTS								
PSYCHOTHERAPEUTIC AGENTS - MISC.				MC		NUEDEXTA	Use PA Form# 20710 for Xyrem	FDA reminded healthcare professionals and patients that the combined use of Xyrem (sodium oxybate) with alcohol or central nervous system (CNS) depressant drugs can markedly impair consciousness and may lead to severe breathing problems (respiratory depression
				MC		XYREM SOL[1]		
				MC		XENAZINE	Use PA Form# 20710 for 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/DEL		NAMENDA XR CAPS[1]	MC	8	RAZADYNE[2]	2. Must fail all preferred	

				MC/DEL	8	RIVASTIGMINE TARTRATE CAPS[2]	products before moving to non-preferred.	
				MC	9	COGNEX CAPS[2]	Use PA Form# 20420	
SMOKING CESSATION								
NICOTINE PATCHES / TABLETS	MC/DEL		CHANTIX[1]	MC/DEL		NICODERM CQ PT24[1]	Use PA Form# 20420 1. See criteria section for exemptions	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		NICOTINE DIS PT24[1]					
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.	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 offere on the Prior Authorization form, such as the presence of a 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				Use PA Form# 20420	
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 t Prior Authorization form, such as the presence of a 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. 2. Established users are grandfathered. 3. Oxycodone ER allowed only 2 per day for all strengths except 80 mg, where 4 are allowed to	Preferred drugs (Fentanyl Patch, Morphine Sulfate ER tab, Kadian Methadone or Methadose) must be tried for at least 2 weeks each & failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug & the preferred drug(s) exists. Adequate trials include prevention/treatment of common adverse effects associated w/ narcotics (antinausea, antipruritics, etc.) as well as adequate equianalgesic dosing when converting from one narcotic to another.Also, adequate documentation of attempts to titrate dose of preferred agents to achieve adequate pain relief & desired clinical response must be provided. Member's drug regimen for additions &/or discontinuations of medications that may affect absorption &/or metabolism of preferred agents must be monitored. Approvals will not be granted if patient had access to either non-preferred products or high doses of short acting narcotics during the trial period. Non-preferred drugs will not be approved for patients showing evidence of usage patterns consistent w/ controlled substance abuse such as: 1.Frequent or persistent early refills of controlled drugs; 2.Multiple instances of early refill overrides due to reports of misplacement, stolen, dropped in toilet or sink, distant travel, etc.; 3.Breaches of narcotic contracts with any provider; 4.Failure to comply with patient responsibilities in attached opioid documentation (see PA form) including but not limited to failing to submit to and pass pill counts; 5.Failing to take or pass random drug testing; 6.Failing to provide old records regarding prior use of narcotics; 7.Receiving controlled substances from other prescribers that the provider submitting the PA is unaware of
	MC		KADIAN	MC/DEL	8	BUTRANS[4]		
	MC/DEL		METHADONE	MC	8	DURAGESIC PT72[4]		
	MC/DEL		METHADOSE	MC/DEL	8	EMBEDA		
	MC/DEL		MORPHINE SULFATE ER TB12	MC	8	EXALGO		
				MC/DEL	8	MORPHINE SULFATE SUPP		
				MC/DEL	8	MS CONTIN TB12		
				MC	8	OPANA ER		
				MC/DEL	8	ORAMORPH SR TB12		
				MC/DEL	8	OXYCONTIN TB12[1]		
				MC	8	XARTEMIS ER		
				MC	8	ZOHYDRO ER		
				MC/DEL	9	NUCYNTA ER		
				MC/DEL	9	OXYCODONE ER[3,5]		

							4. Dosing limits apply. Please see dose consolidation list. 5. Non-preferred products must be used in specific order.	8.Documented history of substance abuse. Substance abuse evaluations may be required for patients with medical records displaying documented substance abuse or potential signs of narcotic misuse and abuse such as chronic early refills, short dosing intervals, frequent dose increases, multiple lost/stolen etc scripts and intolerance or "allergy" to all products but Oxycontin. 9.Circumventing MaineCare prior authorization requirements for narcotics by paying cash for affected narcotics (prescribers failed to submit prior authorization prior to cash narcotic scripts being filled by member). 10.Requests for any Brand name controlled substance, considered by authorities to be highly abused and diverted (Oxycontin, Percocet, Typox, Vicodin, Dilaudid, Ultracet...) with an available AB rated generic equivalent will be denied unless it will be provided in a setting that virtually eliminates the risk of diversion. 11.Allergic reactions to any product within a specific narcotic class will justify and preclude use of any other product in the same class due to the risk of cross-hypersensitivity.
NARCOTICS - SELECTED	**MC/DEL**		TRAMADOL HCL TABS	**MC/DEL**	7	RYZOLT	Use PA Form# 20420 Use PA form #10300 for PAs over the opiate limit 1. Only available if component ingredients are unavailable.	Preferred drugs from this and other narcotic classes must be tried for at least 2 weeks each and failed due to lack of efficacy or intolerable side effects before non-preferred drugs from this class will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Approvals will not be granted if patient had access to either non-preferred products or high doses of short acting narcotics during the trial period. Substance abuse evaluations may be required for patients with medical records displaying potential signs of narcotic misuse and abuse such as chronic early refills, short dosing intervals, frequent dose increases, multiple lost/stolen etc scripts and intolerance or "allergy" to all products but desired product. Allergic reactions to any product within a specific narcotic class will justify and preclude use of any other product in the same class due to the risk of cross-hypersensitivity.
				MC	8	BUPRENEX SOLN		
				MC/DEL	8	BUTORPHANOL		
				MC	8	NALBUPHINE HCL SOLN		
				MC	8	STADOL NS SOLN		
				MC	8	TRAMADOL ER		
				MC	8	ULTRACET TABS[1]		
				MC	8	ULTRAM TABS		
				MC	9	ULTRAM ER		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 medic 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	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on tl Prior Authorization form, such as the presence of 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		FENTANYL OT LOZ1	**MC/DEL**	8	HYDROCODONE/IBUPROFEN		
	MC/DEL		HYDROCODONE/ACETAMINOPHEN	**MC**	8	IBUDONE		
	MC/DEL		HYDROMORPHONE HCL[3]	**MC/DEL**	8	LORCET		
	MC		LORTAB ELX	**MC**	8	LORTAB		
	MC/DEL		MEPERIDINE HCL	**MC**	8	MAXIDONE TABS		
	MC/DEL		OXYCODONE	**MC/DEL**	8	NORCO TABS		
	MC/DEL		OXYCODONE/ACETAMINOPHEN[2,3]	**MC/DEL**	8	NUCYNTA		
	MC/DEL		PENTAZOCINE/NALOXONE TABS	**MC/DEL**	8	ONSOLIS		
	MC		PROPOXYPHENE CMPND-65 CAPS	**MC/DEL**	8	OXECTA		
	MC		PROPOXYPHENE COMPOUND CAPS	**MC/DEL**	8	OXYCODONE/APAP 10/650		
	MC/DEL		PROPOXYPHENE HCL CAPS	**MC/DEL**	8	OXYCODONE/APAP 7.5/500		
	MC/DEL		PROPOXYPHENE/ACET TABS	**MC/DEL**	8	PENTAZOCINE/ACET TABS		
	MC/DEL		PROPOXYPHENE-N/ACET TABS	**MC**	8	PERCOCET TABS		
	MC/DEL		ROXICET	**MC**	8	PERCOCET TABS		

	MC		ROXIPRIN TABS	MC	8	PHRENILIN W/CAFFEINE/CODE CAPS	manufacturer's products will be available without prior authorization.	
				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		
				MC	9	ACTIQ LPOP		
				MC	9	CONZIP	Use PA Form# 20420	
				MC	9	OPANA	Use PA form #10300 for PAs over the opiate limit	
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 tl Prior Authorization form, such as the presence of a 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 addictior
								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	
				MC/DEL		VIVITROL INJ[2]	Use PA form# 30400 for Vivitrol requests	Please see the criteria listed on the Vivittrol PA form.
							1. Will only be approved for side effects experienced with generic that are not described in the literature as occurring with the brand version.	

							2. Please see the criteria listed on the Vivitrol PA form. Any narcotics attempting to be filled during Vivitrol approval will require prior authorization.	
COX 2 / NSAIDS								
COX 2 INHIBITORS - SELECTIVE / HIGHLY SELECTIVE	MC/DEL		CELEBREX CAPS [4,5,6]	MC/DEL		**MOBIC**[6]	Use PA Form# 10310 1. Meloxicam has dosing limits allowing one tablet daily of all strengths without PA. 2. Ketorolac Tromethamine is indicated for the short term (up to 5 days) managment of moderately severe acute pain that requires analgesic at the opiod level in adults. Not indicated for minor of chronic pain conditions. 3. Ketorolac has dosing limits allowing 24 tablets for a 5 day supply every 30 days. 4. Dosing limits will be set at a maximum of 200mg 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.
	MC/DEL		KETOROLAC TROMETHAMINE [2,3,6]	MC/DEL		MOBIC SUSP[6]		
	MC/DEL		NABUMETONE TABS[6]	MC/DEL		**RELAFEN TABS**[6]		
	MC/DEL		MELOXICAM[1,6]					
NSAIDS	MC/DEL		**CHILDRENS IBUPROFEN**	MC		ADVIL TABS	The FDA has issued a Public Health Advisory warning of the potential for increased cardiovascular risk & GI bleeding with NSAID use. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on th Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Approvals will be granted for other requests based on failure of at least one generic NSAID from at least 3 different NSAID classes as described in the COX-II PA form. **DDI:** Diclofenac will now be non-preferred and require prior authorization if it is currently being used in combination with lescol. The FDA has issued a Public Health Advisory warning of the potential for increased cardiovascular risk & GI bleeding with NSAID use.
	MC/DEL		**DICLOFENAC POTASSIUM TABS**	MC		ANAPROX TABS		
	MC/DEL		**DICLOFENAC SODIUM**	MC		ANAPROX DS TABS		
	MC/DEL		**ETODOLAC**	MC		CAMBIA		
	MC/DEL		**FENOPROFEN CALCIUM TABS**	MC/DEL		**CATAFLAM TABS**		
	MC/DEL		**FLURBIPROFEN TABS**	MC		CHILDRENS ADVIL SUSP		
	MC/DEL		**IBUPROFEN**	MC		CHILD'S IBUPROFEN SUSP		
	MC/DEL		**INDOMETHACIN**	MC/DEL		CHILDREN'S MOTRIN SUSP		
	MC/DEL		**KETOPROFEN**	MC/DEL		**CLINORIL TABS**		
	MC/DEL		**MECLOFENAMATE SODIUM CAPS**	MC/DEL		**DAYPRO TABS**		
	MC/DEL		NAPROSYN SUSP	MC/DEL		**EC-NAPROSYN TBEC**		
	MC/DEL		NAPROXEN SUSP	MC/DEL		**ETODOLAC ER 600MG**		
	MC/DEL		**NAPROXEN TABS**	MC		FELDENE CAPS		
	MC/DEL		**NAPROXEN SODIUM TABS**	MC/DEL		IBU-200		
	MC/DEL		**OXAPROZIN TABS**	MC		INDOCIN		
	MC/DEL		**SULINDAC TABS**	MC/DEL		**LODINE**		
	MC/DEL		**TOLMETIN SODIUM**	MC/DEL		**MOTRIN**		
				MC		NALFON CAPS		
				MC/DEL		NAPRELAN TBCR		
				MC/DEL		NAPROSYN TABS		
				MC/DEL		**NAPROXEN DR TBEC**		
				MC/DEL		**NAPROXEN SODIUM TBCR**		
				MC		PENNSAID		
				MC/DEL		**PIROXICAM CAPS**		
				MC		PONSTEL CAPS		
				MC		SB IBUPROFEN TABS		
				MC		SPRIX		
				MC		TOLECTIN		
				MC/DEL		VOLTAREN		
				MC		V-R IBUPROFEN TABS		

				MC		ZORVOLEX		
NSAID - PPI				MC		PREVACID NAPRA-PAC	1. Use a preferred NSAID and PPI separately.	
				MC/DEL		VIMOVO[1]	Use PA Form# 20420	
RHEUMATOID ARTHRITIS								
RHEUMATOID ARTHRITIS	MC/DEL	1	AZATHIOPRINE	MC/DEL		ARAVA	Use PA Form# 20900	See criteria as listed on Rheumatoid Arthritis PA form.
	MC/DEL	1	HYDROXYCHLOROQUINE	MC/DEL		ACTEMRA	1. Only one step 1 drug is required to obtain Enbrel or Humira without PA.	
	MC/DEL	1	LEFLUNOMIDE	MC/DEL		CIMZIA		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.
	MC/DEL	1	METHOTREXATE	MC/DEL		ENTYVIO		
	MC/DEL	1	SULFASALAZINE TABS	MC/DEL		ILARIS[2,5,6]		
	MC	2	ENBREL[1,4]	MC		KINERET SOLN	2. Dosing limits apply. Please see dose consolidation list.	
	MC	2	HUMIRA[1,2,4]	MC		ORENCIA		
				MC		REMICADE		
							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.	**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, an ANC <1000cells/mm^3, or have a hemoglobin <9g/dl.
				MC		SIMPONI		
				MC/DEL		XELJANZ	4. Established users will be grandfathered for Enbrel and Humira.	
							5.Clinical PA is required to establish diagnosis and medical necessity.	
							6. Verification of age for appropriate indication.	
MISCELLANEOUS ARTHRITIS								
ARTHRITIS - MISC.	MC		RIDAURA CAPS	MC/DEL		ARTHROTEC[1]	1. The individual components of Arthrotec are available without PA.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on th Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. The individual components of Arthrotec are available without PA.
	MC		MYOCHRYSINE SOLN				Use PA Form# 20420	
LUPUS-SLE								
LUPUS-SLE				MC		BENLYSTA	Use PA Form# 20420	
MIGRAINE THERAPIES								
MIGRAINE - ERGOTAMINE DERIVATIVES	MC		MIGRANAL SOLN	MC/DEL		D.H.E. 45 SOLN	Use PA Form# 10110	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on th Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		SANSERT TABS					
MIGRAINE - CARBOXYLIC ACID DERIVATIVES	MC		DIVALPROEX ER TB24	MC		DEPAKOTE ER TB24	Use PA Form# 10110	
MIGRAINE - SELECTIVE SEROTONIN AGONISTS (5HT)--Tabs	MC/DEL	1	RELPAX[1]	MC/DEL		AMERGE TABS[1,2]	1. All drugs in this category have dosing limits. Please refer to dose consolidation table.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on th Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Quantity limit exceptions will require ongoing therapy with therapeutic doses of highly effective prophylactic medication as listed on the Triptan PA form.
	MC/DEL	1	RIZATRIPTAN TABS	MC		AXERT TABS[1,2]		
	MC/DEL	1	SUMATRIPTAN TABS[1]	MC/DEL		FROVA TABS[1,2]	2. Must fail all preferred products before non-preferred.	
	MC/DEL	2	NARATRIPTAN HCl TABS[1]	MC/DEL		IMITREX TABS[1,2]		
				MC/DEL		MAXALT[1,2,3]		
				MC/DEL		MAXALT MLT1,2,3		
				MC/DEL		RIZATRIPTAN ODT	3.Established users will be grandfathered	
				MC/DEL		ZOMIG TABS[1,2]		
				MC/DEL		ZOMIG NASAL SPARY[1,2]	Use PA Form# 10110	
				MC/DEL		ZOMIG ZMT TBDP[1,2]		
MIGRAINE - SELECTIVE SEROTONIN AGONISTS (5HT)--Injectables	MC/DEL		IMITREX KIT	MC/DEL		SUMATRIPTAN SOLN	Use PA Form# 10110	
	MC/DEL		IMITREX SOLN					
	MC/DEL		IMITREX STATDOSE PEN KIT					
	MC/DEL		IMITREX STATDOSE REFILL KIT					
MIGRAINE - SELECTIVE SEROTONIN AGONISTS (5HT)--Combinations				MC/DEL		TREXIMET[1,2]	Use PA Form# 10110	
							1. Dosing limits apply. Please see dose consolidation list.	
							2. Use preferred Sumatriptan and Naproxen separately. Treximet only available if component ingredients of sumatriptan and naproxen are unavailable.	

MIGRAINE - MISC.	MC/DEL		CAFERGOT TABS	MC/DEL		MIGRAZONE CAPS	Use PA Form# 10110	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on th
	MC/DEL		SPASTRIN TABS	MC		BELCOMP-PB SUPP		Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred
				MC/DEL		MIGERGOT SUP		drug(s) exists.
GOUT								
GOUT	MC/DEL		**ALLOPURINOL TABS**	MC		COLCRYS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on th
	MC/DEL		**PROBENECID TABS**	MC/DEL		ULORIC[1]	1. Failure of therapeutic	Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred
	MC/DEL		**PROBENECID/COLCHICINE TABS**	MC		ZYLOPRIM TABS	(300mg) dose of Allopurinol	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 th
	MC		LIDOCAINE HCL SOLN	MC/DEL		SYNVISC INJ		Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred
	MC		MARCAINE SOLN	MC		XYLOCAINE SOLN		drug(s) exists.
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 a 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	APTIOM	Use PA Form# 20420	
	MC/DEL		CARBATROL CP12	MC	8	BANZEL		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
	MC/DEL		CELONTIN CAPS	MC	8	DEPAKENE	All non-preferred meds must	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
	MC/DEL		CLONAZEPAM TABS	MC	8	DEPAKOTE	be used in specified order	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		DEPAKOTE SPRINKLES CPSP	MC	8	DEPAKOTE ER		
	MC/DEL		DIASTAT[1]	MC/DEL	8	DIAZEPAM GEL	1. Quantity limit. 5/month	
	MC/DEL		DILANTIN	MC/DEL	8	DIVALPROEX SODIUM SPRINKLE CAPS	2. Dosing limits apply, please	
	MC/DEL		DIVALPROEX SODIUM	MC/DEL	8	EQUETRO	see dose consolidation list.	
	MC/DEL		EPITOL TABS	MC	8	FYCOMPA[2,9]		*** SEE CHART AT END OF DOCUMENT
	MC/DEL		ETHOSUXIMIDE SYRP	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
	MC/DEL		FELBATOL	MC/DEL	8	HORIZANT	strength as well as a	form.
	MC/DEL		GABAPENTIN[2] 300mg & 400mg	MC/DEL	8	GABAPENTIN 600mg & 800mg	maximum daily dose of	
	MC/DEL		LAMOTRIGINE[2]	MC	8	GRALISE	600mg. Please see dose	
	MC/DEL		LEVETIRACETAM SOLN/TABS	MC/DEL	8	KEPPRA TABS	consolidation list.	
	MC/DEL		OXCARBAZEPINE	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
	MC/DEL		PHENYTEK CAPS	MC/DEL	8	KLONOPIN TABS	4. Adjunctive therapy 17 and	three are seen in drug profile at full therapeutic doses: TCA or cyclobenzaprine, gabapentin, and savella.
	MC/DEL		PHENYTOIN	MC/DEL	8	LAMICTAL	older.	
	MC/DEL		PRIMIDONE TABS	MC/DEL	8	**LEVETIRACETAM INJ**	5. Current users as of	All non-preferred meds must be used in specified order.
	MC/DEL		TEGRETOL	MC/DEL	8	**LEVETIRACETAM ER TABS**	7/30/10 for seizures will be	
	MC/DEL		TOPIRAMATE	MC/DEL	8	LYRICA[3]	grandfathered.	
	MC/DEL		TOPIRAMATE SPRINKLE CAPS[2]	MC/DEL	8	MYSOLINE TABS		
	MC/DEL		TRILEPTAL SUSP	MC	8	ONFI		**DDI:** Any Carbamazepine formulation will now be non-preferred and require prior authorization if any of the following drugs are currently being used in combination with carbamazepine:
	MC/DEL		VALPROIC ACID	MC	8	OXTELLAR XR[7]	6. Product is considered line	Abilify, clarithomycin, clozapine, erythromycin, Latuda, Seroquel, telithromycin or Zyprexa.
	MC/DEL		VALPROIC ACID	MC/DEL	8	POTIGA	extension of the original	
	MC/DEL		VIMPAT[4]	MC	8	SABRIL	product due to Healthcare	
	MC/DEL		ZONISAMIDE	MC	8	TOPAMAX	Reform (HCR). MaineCare	Please use Drug-Drug Interaction PA form #10400 for this combination.
				MC	8	TOPAMAX SPRINKLE CAPS[2]	will consider these	
				MC	8	TROKENDI[2,8]	medications non-preferred	
				MC/DEL	8	TRILEPTAL	and a step 9 because of the	ONFI will require a clinical PA to confirm LGS diagnosis
				MC/DEL	8	ZARONTIN SYRP	impact under the Federal	
				MC/DEL	9	KEPPRA XR [5,6]	Rebate Program in	
				MC/DEL	9	NEURONTIN	conjunction with HCR.	
				MC/DEL	9	TEGRETOL-XR TB12 [5,6]		
				MC/DEL	9	ZONEGRAN CAPS	7. Max dose 2400mg	
				MC/DEL	9	LAMICTAL XR	8. Clinical PA required for	
							appropriate diagnosis	
							9. Requires previous	
							trials/failure of medications.	
						BIPOLAR DISORDER: STEP ORDER		
					M ~ A		SEE ANTICONVULSANT	
					4 ~ 4	LAMICTAL	INDICATION CHART AT	
					4 ~ 4	LITHIUM	THE END OF THIS	
					4 ~ 4	CARBAMAZEPINE	DOCUMENT	
					4 ~ 4	VALPROATE	M= Monotherapy	
					4 ~ 4	ATYPICAL ANTIPSYCHOTICS EXC. CLOZAPINE	A= Adjunctive	
					5 ~ 5	TRILEPTAL	9= No Evidence	
					9 ~ 6	TOPAMAX	The step orders show the	
					9 ~ 7	KEPPRA TABS	relative strength of evidence	
					9 ~ 8	GABITRIL TABS	for use in bi-polar and will	
					9 ~ 9	NEURONTIN	guide prior authorization	
							determinations.	
							Step 4 drugs-no PA required.	

					9 ~ 9	ZONEGRAN CAPS		
						PEDIATRIC BIPOLAR1 DISORDER: STEP ORDER		
					M ~ A	(6-18 YEARS WITH OR WITHOUT PSYCHOSIS)		
					4 ~ 4	LITHIUM		
					4 ~ 4	CARBAMAZEPINE		
					4 ~ 4	VALPROATE		
					4 ~ 4	ATYPICAL ANTIPSYCHOTICS EXC.CLOZAPINE	Two-step 1 preferred drugs must be tried before Trileptal. The step orders show the relative strength of evidence for use in bi-polar and will guide prior authorization determinations. Step 4 drugs-no PA required.	
					4 ~ 4	LAMICTAL		
					5 ~ 5	TRILEPTA		
ANTI-PARKINSON DRUGS								
PARKINSONS - ANTICHOLINERGICS	MC/DEL		BENZTROPINE MESYLATE TABS				Use PA Form# 20420	
	MC		COGENTIN SOLN					
	MC/DEL		**TRIHEXYPHENIDYL**					
PARKINSONS - COMT INHIBITORS	MC/DEL		**COMTAN TABS**	MC/DEL		**TASMAR TABS**	Use PA Form# 20420	Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
PARKINSONS - SELECTED DOPAMIN AGONISTS	MC/DEL		**PRAMIPEXOLE**	MC/DEL	5	**MIRAPEX TABS**[1]	Use PA Form# 20420	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**	1. As of 12/08 users of Mirapex will be grandfathered if diagnosis is Parkinsons.	
				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.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on th Prior Authorization form, such as the presence of a 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	2. Approvals will require trials of Carbidopa/Levodopa, Selegiline, Comtan, and Stalevo.	
	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		
				MC/DEL	8	**ZANAFLEX TABS**		**Lorzone** is non preferred and requires at least 4 preferred drugs (including tizanidine) and step care therapy (orphenadrine), as well as reasons for why chlorzoxazone is not acceptable.
				MC/DEL	9	**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 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 th Prior Authorization form, such as the presence of 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		
	MC		CYANOCOBALAMIN SOLN	MC		DHT SOLN		
	MC		FERIVA CAP	MC		NASCOBAL GEL		
	MC		FERIVAFA CAP					
	MC		FERRALET 90 TAB					
	MC/DEL		FOLIC ACID TABS					
	MC		FUSION PLUS CAP					
	MC		HEMOCYTE PLU CAP					
	MC		INTEGRA CAP					
	MC		INTEGRA PLUS CAP					
	MC/DEL		MEPHYTON TABS				Please refer to OTC list.	
	MC/DEL		NIACIN				**DDI:** B-12 will now be non-preferred and require prior authorization if it is currently being used in combination with either Prevacid, pantoprazole, Prilosec, or any currently non preferred PPI.	
	MC		NIACOR TABS					
	MC/DEL		NICOTINIC ACID SR CPCR					
	MC		PYRIDOXINE HCL TABS				Preferred products that used to require diag codes still require diag codes unless indicated otherwise.	
	MC/DEL		SLO-NIACIN TBCR					
			TANDEM CAP					
	MC		TANDEM PLUS CAP					
	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/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 th Prior Authorization form, such as the presence of 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	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on th
	MC		CALCI-MIX CAPSULE CAPS	MC		CALCET TABS	Please refer to OTC list.	Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred
	MC		CALCIQUID SYRP	MC/DEL		**CALCIUM 600-D TABS**		drug(s) exists. As listed in MaineCare Policy, certain drugs require specific diagnoses for approval.
	MC		CALCITRATE/VITAMIN D TABS	MC		CALCIUM/VITAMIN D TABS		
	MC/DEL		CALCIUM	MC		CALTRATE 600 PLUS/VIT D TABS		
	MC/DEL		CALCIUM CARBONATE	MC		CALTRATE PLUS TABS		**DDI:** Fe salts will now be non-preferred and require prior authorization if it is currently being used in combination with either Prevacid, pantoprazole, Prilosec, or any currently non preferred
	MC/DEL		CALCIUM CITRATE TABS	MC		CHROMAGEN		PPI.
	MC/DEL		CALCIUM GLUCONATE TABS	MC		CITRACAL PLUS TABS		
	MC/DEL		CALCIUM LACTATE TABS	MC		CONTRIN CAPS		Please refer to OTC list.
	MC		CALCIUM/MAGNESIUM TABS	MC		FEOGEN FORTE CAPS		
	MC/DEL		**CALCIUM/VITAMIN D TABS**	MC		FEROCON CAPS		Preferred products that used to require diag codes still require diag codes unless indicated otherwise.
	MC		CALTRATE 600 TABS	MC/DEL		FERREX 150 CAPS		
	MC/DEL		CHEWABLE CALCIUM CHEW	MC		FERRO-SEQUELS TBCR		
	MC		CITRACAL TABS	MC		FE-TINIC CAPS		
	MC		CITRACAL + D TABS	MC		FE-TINIC 150 FORTE CAPS		
	MC		CITRUS CALCIUM TABS	MC/DEL		FLUOR-A-DAY SOLN		
	MC		CITRUS CALCIUM 1500 + D TABS	MC/DEL		K-DUR TBCR		
	MC		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 th Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **As listed in MaineCare Policy, certain drugs require specific diagnoses for approval.**
	MC		P.T.E. -5 SOLN[1]	MC		CASEC POWD[1]		
	MC/DEL		SEA-OMEGA CAPS[1]	MC		CHOICE DM LIQD[1]		
				MC		DELIVER 2.0 LIQD[1]		Medical foods are not to be authorized solely for the purpose of enhancing nutrient intake or managing body weight if the participant is able to eat conventional foods adequately. Medical foods may be approved if the member has a medical condition which precludes or restricts the use of conventional foods and necessitates the use of a formula. Concurrent Stimulant therapy is not an acceptable medical reason/condition for use of medical foods for enhancing nutrient intake or managing body weight.
				MC		ENFAMIL[1]		
				MC		ENSURE[1]		
				MC		GLUCERNA[1]		
				MC		ISOCAL LIQD[1]		
				MC		KINDERCAL TF LIQD[1]		
				MC		KINDERCAL TF/FIBER LIQD[1]	2. Formerly known as Omacor.	For children under the age of 5, MaineCare will not provide milk- or soy-based standard infant formulas. Regular formulas may be sought through your nearest WIC office. MaineCare will continue to cover medical food for all participants in MaineCare when medical necessity is met.
				MC/DEL		L-CARNITINE CAPS[1]		
				MC		LIPISORB LIQD[1]		
				MC		LOVAZA[1,2]	Use PA Form# 20420	
				MC		MODULEN IBD POWD[1]	& SGA Form	Vascepa requires adjunct therapy for specific indication to reduce TG in those with severe hypertriglyceridemia (500mg per deciliter or more). Proper indication per lab values is required before approval
				MC		NUTRAMIGEN POWD[1]		
				MC/DEL		NUTREN[1]		
				MC		NUTRITIONAL SUPPLEMENT LIQD[1]		
				MC		NUTRIVENT 1.5 LIQD[1]		
				MC/DEL		PEPTAMEN[1]		
				MC		PHENYLADE[1]		
				MC		PHENYL-FREE[1]		
				MC		PKU 3 POWD[1]		
				MC		PREGESTIMIL POWD[1]		
				MC/DEL		PROBALANCE LIQD[1]		
				MC		PROSOBEE[1]		
				MC		SCANDISHAKE PACK[1]		
				MC		VASCEPA		
ERYTHROPOEITINS								
ERYTHROPOEITINS	MC		PROCRIT SOLN[1]	MC	6	EPOGEN SOLN	Use PA Form# 10520	Non-Preferred drugs must be tried and failed in step-order, due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Please see the EPO PA form for other approval and renewal criteria.
				MC	8	ARANESP SOLN	1. Clinical PA is required to establish medical necessity and that appropriate lab monitoring is being done.	
				MC/DEL	8	OMONTYS		
GRANULOCYTE CSF								
GRANULOCYTE CSF				MC	8	LEUKINE	1. Must be used in specified step order.	See approval criteria detailed on Neupogen PA form.
				MC	8	NEUPOGEN SOLN[2]		
				MC	9	NEULASTA[1]	2.10 day supply/month may be used without a PA.	
							Use PA Form# 20520	
GAUCHER DISEASE								
GAUCHER DISEASE				MC		CERDELGA	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on th Prior Authorization form, such as the presence of 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.
ANTICOAGULANTS / PLATELET AGENTS								
ANTICOAGULANTS	MC		ARIXTRA SOLN[1]	MC/DEL		ELIQUIS	1. Arixtra, Fragmin and Lovenox therapy durations greater than 7 days require PA.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on th Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Exceeding days supply limits for LMWH class requires PA.
	MC		COUMADIN TABS	MC/DEL		ENOXAPARIN		
	MC/DEL		FRAGMIN INJ[1]	MC/DEL		FONDAPARINUX		
	MC		HEPARIN SODIUM/NACL 0.9% SOLN	MC		IPRIVASK		
	MC		HEP-LOCK SOLN	MC/DEL		JANTOVEN		**DDI:** Warfarin will require prior authorization if being used in combination with fluconazole, miconazole, or voriconazole.
	MC/DEL		**INNOHEP**	MC/DEL		LOVENOX 300[2]	2. Use other strengths available to obtain desired dose	
	MC/DEL		**LOVENOX SOLN[1]**	MC/DEL		PRADAXA[3]		**DDI:** Warfarin will require prior authorization if being used in conjunction with Gemfibrozil or Fenofibrate.

	MC		HEPARIN LOCK SOLN	MC/DEL		**WARFARIN SODIUM TABS**[4]	[illegible]	
	MC/DEL		HEPARIN LOCK FLUSH SOLN	MC/DEL		XARELTO	3. Please refer to Pradaxa PA form for criteria.	
	MC/DEL		HEPARIN SODIUM SOLN				4.Established users will be grandfathered, new starters must use preferred product Coumadin.	
	MC/DEL		HEPARIN SODIUM LOCK FLUSH SOLN				Use PA form# 20725 for Pradaxa requests Use PA form# 20420 for other requests	
ANTIHEMOPHILIC AGENTS	MC		ALPHANATE	MC		ADVATE[1,2]	1. Only if other products unavailable.	Non-preferred will only be approved if other preferred products are unavailable.
	MC		ALPHANINE SD	MC		KOATE-DVI		
	MC/DEL		BENEFIX SOLR				2. Advate may be available with PA in cases of large volume dosing in patients with poor venous access.	
	MC/DEL		HELIXATE FS KIT					
	MC		HEMOFIL - M					
	MC		HUMATE-P SOLR					
	MC		KOGENATE FS					
	MC		KONYNE - 80					
	MC		MONARC - M					
	MC		MONOCLATE - P				Use PA Form# 20420	
	MC		MONONINE					
	MC		NOVOSEVEN SOLR					
	MC/DEL		PROFILNINE					
	MC		RECOMBINATE SOLR					
	MC		REFACTO					
	MC		WILATE INJ					
PLATELET AGGREGATION INHIBITORS	MC/DEL		ASPIRIN	MC/DEL	7	TICLOPIDINE HCL TABS	Use PA Form# 20715 for Plavix,Effent & Brilinta	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on th Prior Authorization form, such as the presence of a 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]	Use PA form# 20420 for other requests	
	MC/DEL		**CLOPIDOGREL 75MG**	MC/DEL	8	PERSANTINE TABS	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.	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]		**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
				MC/DEL	8	**ZONTIVITY**	2. Dosing limits apply, please see dose consolidation list.	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.
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 th Prior Authorization form, such as the presence of a 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.
IMMUNE GLOBULIN INTRAVENOUS (IVIG)	MC		GAMMAPLEX INJ[1]				Use PA Form# 20420	
	MC		OCTAGAM INJ[1]				1. Clinical PA required	
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 th Prior Authorization form, such as the presence of a 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 th Prior Authorization form, such as the presence of a 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 th Prior Authorization form, such as the presence of a 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 th Prior Authorization form, such as the presence of a 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 th Prior Authorization form, such as the presence of a 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 GEL**		
	MC		MAXITROL OPTH OINT 0.1%	MC/DEL		**LOTEMAX OINT**		
	MC		PRED MILD SUSP	MC/DEL		LOTEMAX SUSP		
	MC/DEL		PREDNISOLONE	MC		NEO/POLY/BAC/HC OINT		
	MC/DEL		TOBRADEX	MC/DEL		NEOMYCIN/POLYMYXIN/DEXAMETHASONE OPHTHALMIC OINTMENT 0.1%		
				MC/DEL		OZURDEX		
				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	**ZIOPTAN**	1. All preferreds must be tried. 2. Dosing limits apply, please see dosing consolidation list. 3. Clinical PA is required to	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	**TRAVOPROST**	3. Clinical PA is required to establish diagnosis and medical necessity. Use PA Form# 20420	
				MC/DEL	8	XALATAN SOLN[1]		
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 th Prior Authorization form, such as the presence of a 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 th Prior Authorization form, such as the presence of a 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 th Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		SIMBRINZA	MC		ALPHAGAN P 0.1% SOLN		
				MC/DEL		BRIMONIDINE 0.2%		
				MC/DEL		**IOPIDINE SOLN**		
OP. - ANTI-ALLERGICS	MC/DEL		PATADAY SOLN	MC	8	ALOCRIL SOLN	Use PA Form# 20420	All preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		PATANOL SOLN	MC/DEL	8	ALOMIDE SOLN		
				MC	8	BEPREVE		
				MC	8	ELESTAT		
				MC/DEL	8	EMADINE SOLN		
				MC	8	LASTACAFT		
				MC/DEL	8	OPTIVAR		
				MC	8	OPTICROM SOLN		
				MC/DEL	8	ZADITOR SOLN		
				MC/DEL	9	EPINASTINE		
OP. ANTI-ALLERGICS- MASTCELL STABILIZER CLASS				MC/DEL		ALAMAST SOLN	Use PA Form# 20420	
OP. - CARBONIC ANHYDRASE INHIBITORS/COMBO	MC/DEL		**AZOPT SUSP**	MC/DEL		**COSOPT SOLN PF**	Use PA Form# 20420	
	MC		COMBIGAN	MC/DEL		**TRUSOPT SOLN**		
	MC/DEL		DORZOLAMIDE					
	MC/DEL		DORZOLAMIDE/TIMOLOL					
OP. - NSAID'S	MC		FLURBIPROFEN SODIUM SOLN	MC	8	ACULAR LS[1]	1. Must fail all preferred 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 th Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		DICLOFENAC OPTH 0.1%	MC	8	ACULAR SOLN[1]		
	MC/DEL		KETOROLAC OPTH 0.4%	MC/DEL	8	ILEVRO		
	MC/DEL		KETOROLAC OPTH 0.5%	MC/DEL	8	PROLENSA		
				MC/DEL	8	NEVANAC[1]		
				MC	8	OCUFEN SOLN[1]		
				MC	8	XIBROM[1]		
				MC	8	VOLTAREN SOLN[1]		
				MC	8	ACUVAIL[1]		
				MC/DEL	9	BROMFENAC		
OP. - OF INTEREST	MC/DEL		ENUCLENE SOLN	MC		BOTOX SOLR	1. Must have kerato conjuctivitus sicca and failed other dry eye therapies. Use PA Form# 20420	Must fail adequate trials of multi agents from artificial tears and lubricant category.
				MC		RESTASIS[1]		
DERMATOLOGICAL								
TOPICAL - ORAL	MC		AMNESTEEM[1]				1. Users 24 or under, PA will not be required. Use PA Form# 20420	
	MC		CLARAVIS[1]					
	MC		SOTRET[1]					
TOPICAL - ACNE PREPARATIONS	MC		**AZELEX CREA**[4]	MC/DEL		**ADAPALENE 0.3% GEL**	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	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on th Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		BENZOYL PEROXIDE	MC		ACZONE		
	MC/DEL		CLINDAMYCIN PHOSPHATE [2]	MC		ALTINAC CREA		
	MC		ERYDERM SOLN	MC		AVITA CREA		
	MC/DEL		ERYTHROMYCIN GEL	MC		BENZAC		
	MC/DEL		ERYTHROMYCIN PADS	MC/DEL		BENZACLIN GEL[3]		
	MC/DEL		ERYTHROMYCIN SOLN	MC/DEL		BENZAGEL-10 GEL		
	MC		ISOTRETINOIN	MC/DEL		BENZAMYCIN GEL		
	MC		METRONIDAZOLE CREA[2]	MC/DEL		BENZAMYCINPAK PACK		
	MC		METRONIDAZOLE GEL[2]	MC		BENZEFOAM		
	MC		METRONIDAZOLE LOTN[2]	MC		BREVOXYL		
	MC/DEL		SODIUM SULFACET/SULF LOTN	MC/DEL		CLEOCIN-T[2]		
	MC		TAZORAC	MC		CLINAC BPO GEL		
	MC/DEL		TRETINOIN GEL[1]	MC		CLINDAGEL GEL		
	MC		TRETINOIN CREA[1,2]	MC		CLINDETS SWAB		
				MC		DESQUAM-E GEL		

				MC		DESQUAM-X	Brand Name requests	
				MC		DIFFERIN 0.3% GEL		
				MC		DIFFERIN	Use PA Form# 20420 for all other requests	
				MC		DUAC GEL		
				MC		EMGEL GEL		
				MC		EPIDUO		
				MC		ERYCETTE PADS		
				MC/DEL		EVOCLIN		
				MC		FINEVIN CREA		
				MC/DEL		KLARON LOTN		
				MC		METROCREAM CREA[2]		
				MC		METROGEL GEL[2]		
				MC		METROLOTION LOTN[2]		
				MC		NEOBENZ MICRO		
				MC/DEL		NORITATE CREA		
				MC		RETIN-A GEL[2]		
				MC		RETIN-A CREA[2]		
				MC		RETIN-A MICRO GEL		
				MC/DEL		TRIAZ		
				MC		VELTIN		
				MC		ZENCIA WASH		
				MC		ZETACET		
				MC/DEL		ZIANA		
TOPICAL - ANTIBIOTIC	MC		BACIT/NEOMYCIN/POLYM OINT	MC/DEL		ALTABAX[1]	1. Dosing limits apply, please see dosing consolidation list.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on th Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		BACITRACIN OINT	MC/DEL		BACTROBAN OINT.		
	MC/DEL		BACTROBAN CREA[1]	MC/DEL		TRIPLE ANTIBIOTIC OINT		
	MC/DEL		BACTROBAN NASAL OINT					
	MC/DEL		CENTANY OINT 2%[1]				Use PA Form# 20420	
	MC/DEL		GENTAMICIN SULFATE					
	MC/DEL		MUPIROCIN[1]					
TOPICAL - ANTIFUNGALS	MC/DEL		BETAMETHASONE CLOTRIMAZOLE LOT	MC/DEL	8	BETAMETHASONE CLOTRIMAZOLE CREA		
	MC		CICLOPIROX 0.77 CREA	MC/DEL	8	CICLOPIROX SOLN	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 th Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		CICLOPIROX 0.77 SUSP	MC	8	EXELDERM		
	MC/DEL		CLOTRIMAZOLE	MC	8	FUNGIZONE CREA		
	MC		ECONAZOLE NITRATE CREA	MC/DEL	8	HYDROCORT/IODOQ CREA		
	MC/DEL		KETOCONAZOLE CREA	MC	8	JUBLIA		**DDI:** Ketoconazole will now be non-preferred and require prior authorization if they are currently being used in combination with any of the following medications: Prevacid, pantoprazole, Onglyza or Omeprazole.
	MC/DEL		KETOCONAZOLE SHAM	MC/DEL	8	LAMISIL		
	MC/DEL		LOPROX 1.0 CREA	MC/DEL	8	LOPROX 0.77 LOTN		
	MC/DEL		LOPROX 1.O LOTN	MC/DEL	8	LOPROX 0.77 CREA		
	MC/DEL		LOPROX GEL	MC/DEL	8	LOPROX 0.77 SUSP		
	MC/DEL		LOPROX TS LOTN	MC/DEL	8	LOPROX SHAMPOO SHAM		
	MC/DEL		LOTRISONE CREA	MC	8	LOTRIMIN		
	MC/DEL		MICONAZOLE NITRATE CREA	MC/DEL	8	LOTRISONE LOT		
	MC		MYCO-TRIACET II CREA	MC	8	LUZU		
	MC/DEL		NYSTATIN	MC/DEL	8	MENTAX CREA		
	MC/DEL		NYSTATIN/TRIAMCINOLONE	MC	8	MYCOGEN II CREA		
	MC/DEL		NYSTOP POWD	MC	8	NAFTIN		
	MC		PEDI-DRI POWD	MC	8	NIZORAL SHAM		
	MC/DEL		TINACTIN	MC	8	NYSTAT-RX POWD		
	MC		TRI-STATIN II CREA	MC/DEL	8	OXISTAT		
				MC/DEL	9	PENLAC NAIL LACQUER SOLN		
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 th Prior Authorization form, such as the presence of 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.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on th Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferre drug(s) exists.
	MC		TAZORAC	MC		PSORIATEC CREA[1]		
				MC/DEL		SORIATANE CK KIT[1]	2. Individual ingredients are available as preferred witout PA.	
				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 th Prior Authorization form, such as the presence of a 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	
				MC		ZOVIRAX OINT[1,2]		
							2. Approvals limited to 1 tube per 180 days.	

							3. Dosing limits apply, please see dosing consolidation list. Use PA Form# 20420	
TOPICAL - ANTINEOPLASTICS	MC MC		EFUDEX FLUOROPLEX CREA	MC/DEL MC/DEL MC MC/DEL		CARAC CREA FLUOROURACIL SOLARAZE GEL ZYCLARA	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on th Prior Authorization form, such as the presence of 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 - BURN PRODUCTS	MC MC/DEL MC MC MC/DEL		FURACIN CREA SILVER SULFADIAZINE CREA SSD AF CREA SSD CREA THERMAZENE 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.
TOPICAL - CORTICOSTEROIDS	 MC MC/DEL MC MC MC MC/DEL MC/DEL MC/DEL MC MC MC MC MC MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL MC MC MC MC		**LOW POTENCY** DESOWEN[1] HYDROCORTISONE CREA HYDROCORTISONE LOTN LACTICARE-HC LOTN NUTRACORT LOTN TEXACORT SOLN **MEDIUM POTENCY** DESOXIMETASONE .05% ELOCON FLUOCINOLONE ACETONIDE .025-.01% FLUROSYN CREA FLUTICASONE PROPIONATE CREA/OINT HYDROCORTISONE BUTYRATE HYDROCORTISONE OINT HYDROCORTISONE VALERATE MOMETASONE FUROATE OINT TRIAMCINOLONE ACETONIDE .025-.1% **HIGH POTENCY** BETAMETHASONE DIPROPIONATE CLOBEX LOTN DESOXIMETASONE .25% DESONIDE[1] FLUOCINOLONE ACETONIDE .02% FLUOCINONIDE HALOG HALOG-E CREA TRIAMCINOLONE ACETONIDE .5% **VERY HIGH POTENCY** AUGMENTED BETA DIP BETAMETHASONE VALERATE BETA-VAL DIFLORASONE DIACETATE HALOBETASOL **MISCELLANEOUS** CAPEX SHAM PROCTO-KIT CREA 1%	MC/DEL MC MC MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC MC MC MC MC MC/DEL MC/DEL MC/DEL MC MC/DEL MC MC MC MC MC/DEL MC MC/DEL MC/DEL MC MC MC/DEL MC		ACLOVATE AMCINONIDE CREA ANUSOL HC-1 OINT **CLOBETASOL PROPINATE LOTN** CLODERM CREA CORDRAN CORMAX CUTIVATE CREA / OINT CUTIVATE LOTN DERMA-SMOOTHE/FS OIL DERMATOP DESONATE GEL DIPROLENE ELOCON OINT HYDROCORTISONE POWD KENALOG AERS LIDA MANTLE HC CREA LOCOID LUXIQ FOAM OLUX FOAM PANDEL CREA PROCTOCORT CREA PSORCON PSORCON E TEMOVATE TOPICORT TOPICORT LP CREA ULTRAVATE VERDESO WESTCORT	Use PA Form# 20420 1. Dosing limits apply, please see dosing consolidation list.	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.
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 th Prior Authorization form, such as the presence of 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 th Prior Authorization form, such as the presence of 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 MC MC MC		AMMONIUM LACTATE CREA[1] AMMONIUM LACTATE LOTN 12%[1] UREACIN-20 CREA VITAMIN A & D MEDICATED OINT	MC MC MC MC MC		LAC-HYDRIN CREA[1] LAC-HYDRIN LOTN 12% MEDERMA GEL MIMYX RENOVA CREA	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 th Prior Authorization form, such as the presence of 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 - ENZYMES / KERATOLYTICS / UREA	MC MC/DEL MC MC		GRANUL-DERM AERS GRANULEX AERS TBC AERS SANTYL OINT	MC MC MC		CARMOL 40 CREA SALEX CREA SALEX LOTN	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on th Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Ziox, Panafil and Papain products have been removed from the PDL due to FDA safety concerns regarding drugs containing Papain.

TOPICAL - GENITAL WARTS	MC/DEL		IMIQUIMOD[2]	MC/DEL	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. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on th Prior Authorization form, such as the presence of a 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		
				MC		ZOSTRIX		
TOPICAL - DEPIGMENTING AGENTS				MC	8	ALUSTRA CREA	Use PA Form# 20420	As per Medicaid Policy, cosmetic drugs are not covered. Non-cosmetic clinical applications will be considered by prior authorization on a case by case basis.
				MC	8	EPIQUIN MICRO		
				MC	8	GLYQUIN CREA		
				MC/DEL	8	HYDROQUINONE CREA		
				MC/DEL	8	HYDROQUINONE/SUNSCREENS		
				MC	8	SOLAQUIN FORTE CREA		
				MC	8	TRI-LUMA CREA		
				MC	9	ELDOQUIN		
TOPICAL - SCABICIDES AND PEDICULICIDES	MC/DEL	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 th Prior Authorization form, such as the presence of a 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 th Prior Authorization form, such as the presence of 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		XERAC AC 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 th Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
				MC		MOISTURIN DRY SKIN CREA		
				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 th Prior Authorization form, such as the presence of a 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 th Prior Authorization form, such as the presence of a 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 1. Prior Authorization will be required for preferred medications for members over the age of 8.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on th Prior Authorization form, such as the presence of a 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[1]	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 th
	MC		EAR-GESIC SOLN	MC		ORAVIG		Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred
	MC/DEL		NYSTATIN SUSP					drug(s) exists.
MOUTH ANTISEPTICS	MC/DEL		CHLORHEXIDINE GLUCONATE	MC		APHTHASOL PSTE[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 th
	MC/DEL		LIDOCAINE VISCOUS SOLN	MC		PERIOGARD SOLN[1]	1. Must fail all preferred products before non-preferred.	Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred
	MC		TRIAMCINOLONE IN ORABASE PSTE	MC		TRIAMCINOLONE ACETONIDE PSTE[1]		drug(s) exists.
	MC		TRIAMCINOLONE ORADENT PSTE					
DENTAL PRODUCTS								
DENTAL PRODUCTS	MC/DEL		ETHEDENT CREA	MC/MC		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 th
	MC/DEL		GEL-KAM CONC	MC/DEL		DENTAGEL GEL		Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred
	MC/DEL		GEL-KAM GEL 0.4%	MC/DEL		PHOS-FLUR GEL		drug(s) exists.
	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 th
				MC		RADIACARE SOLR		Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred
				MC		SALAGEN TABS		drug(s) exists.
MISCELLANEOUS ANORECTAL								
ANORECTAL - MISC.	MC/DEL		COLOCORT ENEM	MC/DEL		ANUSOL-HC CREA	Use PA Form# 20420	
	MC		CORTENEMA ENEM	MC/DEL		CORTIFOAM FOAM		
	MC		ELA-MAX 5 CREA	MC/DEL		PROCTOFOAM HC FOAM		
	MC/DEL		HYDROCORTISONE ENEM	MC/DEL		PROCTO-KIT CREA 2.5%		
	MC/DEL		PROCTOSOL HC CREA	MC		RECTIV OINT		
	MC/DEL		PROCTOZONE-HC CREA					
T-CELL ACTIVATION INHIBITOR								
PSORIASIS BIOLOGICALS	MC		ENBREL[1,2]	MC		OTEZLA	1. Will not require a PA if at least one systemic drug such as methotrexate, cyclosporine, methoxsalen or acitretin is in members drug profile. Please refer to dose consolidation list. 2. Preferred dosage form allowed without PA after trial of step 1 prodcuts is multi-dose vial, with dosing limits allowing 8 injections per 28 days without pa. Use PA Form# 20910	Approved for severe chronic plaque psoriasis unresponsive to first line therapies. A trial of at least several potent topicals from the following categories: corticosteroids, coal tars, anthralin, calcipotriene and tazorotene, and at least one systemic drug such as methotrexate, cyclosporine, methoxsalen or acitretin and phototherapy/UVA. Enbrel is preferred after a trial of a step 1 product (e.g. azathioprine, methotrexate, etc.); however, dosing limits will also still apply. Dosing limits will allow 8 injections per month without pa. Use of greater than 8 injections per month will require PA. In addition, the preferred Enbrel 25mg product will be the multi-dose vial (NDC- 58406-0425-34). The single-use prefilled syringes are non-preferred.
	MC		HUMIRA[1]	MC		STELARA		
ALTERNATIVE MEDICINES								
ALTERNATIVE MEDICINES	MC		DIMETHYL SULFOXIDE SOLN	MC/DEL		CO-ENZYME Q-10	Use PA Form# 20420	Will only be approved for specific conditions supported by at least two double-blinded, placebo-controlled randomized trials that are not contradicted by other studies of similar quality.
				MC		MELATONIN TABS		
CHELATING AGENTS								
CHELATING AGENTS	MC/DEL		**CUPRIMINE CAPS**	MC		DEPEN TITRATABS TABS	Use PA Form# 20420	

				MC/DEL		EXJADE[1]	1. FDA indication of treatment of chronic iron ovrload due to blood transfustions in membes 2 years of age and older is requried for approval of Exjade.	
ANTILEPROTIC								
ANTILEPROTIC				MC		THALOMID CAPS[1]	1. All PA requests for 150mg dosing will require use of Thalomid 100mg and 50mg capsules. Use PA Form# 20420	Approved for indications of leprosy, treatment-resistant multiple myeloma and AIDS.
ANTINEOPLASTIC AGENTS								
ANTINEOPLASTIC AGENTS - ANTIADNDROGENS	MC/DEL		BICALUTAMIDE	MC/DEL		CASODEX	Use PA Form# 20420	
ANTINEOPLASTIC AGENTS- LHRH ANALOGS	MC		LUPRON DEPOT[1]	MC		VANTAS[2]	1. Dosing limits apply, please refer to dosage consolidation list. 2. PA required to confirm FDA approved indication. Use PA Form# 20420	
				MC		FIRMAGON[2]		
				MC/DEL		TRELSTAR		
ANTINEOPLASTIC AGENTS - TYROSINE KINASE INHIBITORS				MC		SPRYCEL[1]	Use PA Form# 20420	
				MC/DEL		TYKERB[2]	1. Verification of diagnosis is required. 2. PA required to confirm FDA approved indication and to monitor for potential drug-drug interactions.	
				MC		GLEEVEC[1]		
ANTINEOPLASTICS-MISCELLANEOUS	MC		AMIFOSTINE	MC		DOCEFREZ	Use PA Form# 20420	
	MC/DEL		MERCAPTOPURINE	MC/DEL		ETHYOL		
				MC		LEUPROLIDE		
				MC/DEL		**OXALIPLATIN**		
				MC/DEL		PURINETHOL		
				MC/DEL		ZOLINZA		
ANTINEOPLASTICS- MONOCLONAL ANTIBODIES				MC/DEL		HERCEPTIN[1]	1. PA required to confirm FDA approved indication. Use PA Form# 20420	
CANCER								
CANCER	MC		ALIMTA	MC/DEL		ARIMIDEX	1. PA required to confirm FDA approved indication 2. Avoid CYP3AY drug drug interaction. 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.	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, itraconazol 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.
	MC/DEL		AVASTIN	MC		COMETRIQ[3,4,5]		
	MC		ERBITUX	MC/DEL		ERIVEDGE		
	MC/DEL		LETROZOLE	MC		FOLOTYN		
	MC		MEGACE ES	MC/DEL		GILOTRIF[4,5]		
	MC/DEL		VIDAZA	MC		JAKAFI		
				MC		ICLUSIG[3]		
				MC/DEL		INLYTA		
				MC		NEXAVAR[1]		
				MC/DEL		MEKINIST[3,4]		
				MC		POMALYST		
				MC/DEL		STIVARGA		
				MC/DEL		SUTENT[1,2]		
				MC/DEL		**SYLATRON**		
				MC/DEL		TAFINLAR[3,4,5,6]		
				MC/DEL		FEMARA		
				MC/DEL		YERVOY		
				MC/DEL		XALKORI		
				MC/DEL		XTANDI		
				MC/DEL		ZELBORAF	Use PA Form# 20420	
				MC		ZYDELIG		
				MC/DEL		ZYKADIA		
				MC		ZYTIGA		
IMMUNOSUPPRESSANTS								
IMMUNOSUPPRESSANTS	MC/DEL		CYCLOSPORINE MODIFIED	MC/DEL		CELLCEPT		Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on th Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		GENGRAF CAPS	MC/DEL		CYCLOSPORINE CAPS		
	MC/DEL		MYCOPHENOLATE	MC/DEL		CYCLOSPORINE SOL. MODIFIED		
	MC/DEL		MYFORTIC					

	MC/DEL		NEORAL				Use PA Form# 20420	**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).
	MC		PROGRAF CAPS					
	MC/DEL		RAPAMUNE					**DDI:** Cyclosporine will require prior authorization when used with Livalo.
	MC/DEL		SANDIMMUNE					**DDI:** All preferred immunosuppressants will require clinical PA for patients over 60 that are currently on fluoroquinolone therapy
PURINE ANALOG								
PURINE ANALOG	MC		AZASAN TABS	MC/DEL		**IMURAN TABS**	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on th
	MC/DEL		**AZATHIOPRINE TABS**					Prior Authorization form, such as the presence of 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

MAINECARE PREFERRED DRUG LIST (with criteria)*

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***As of February 2011**	

Due to formatting page numbers may be off

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
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
LISINOP/HCTZ	10/12.5MG	1	90/90

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**
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)	5MG		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
NASACORT AQ	55MCG	4 SPRAYS	17/30

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
PRINZIDE	10-12.5	1	35/35

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
SERTRALINE	100MG	3	105/35

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

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	F		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.***

MaineCare
Health Care for Maine People

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.*

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.