CATEGORY	Coverage Indicator	Step Order	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required	Comments	Criteria

**** PLEASE NOTE: All cost effective generics applicable to DEL are considered PREFERRED Drugs. "BASIC" Covered Drugs are bolded with the Coverage Indicator of "MC / DEL".***

General Criteria for all PDL categories- For more information or help using the PDL, providers may call 1-888-445-0497; members should call 1-866-796-2463. To access PDL and PA materials via the internet: www.mainecarepdl.org

A: Preferred Drugs- Unless otherwise specified, preferred drugs are available without prior authorization. Step order may apply for preferred drugs in some drug categories as indicated on the PDL. (See item "D" below for explanation of step order.)

B: Requests for Non-preferred Drugs- Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.

C: Adequate Drug Trials- 1. The minimum trial period for each preferred and step order drug is two weeks, unless otherwise stated within specific PDL drug categories; trials with less than a two week duration will be reviewed on a case-by-case basis; 2. A trial will not be considered valid if preferred or non-preferred products were readily available (by override, individual purchase, samples, etc.); 3. Certain drug trials, such as with controlled substances, may require evidence that the preferred drugs were actually tried (example: with random pill counts and with random urine drug tests, using the methods of GC/MS with no lower threshold); 4. Adequate trials require documentation of attempts to titrate dose of preferred agents toward desired clinical response. 5. Adequate trials include prevention/treatment of common adverse effects associated with preferred agents (example: antinausea, antipruritics, etc.)

D: Step Order- When numbers appear in the "step order" column, it means drugs in this category must be used in the order specified, with the lower numbers having preference over the higher numbers. Chart notes should be provided to confirm drug trials that do not appear in the member's MaineCare drug profile.

E. The Department will institute strategies to ensure cost effectiveness through the use of an enhanced Drug Benefit Preferred brand drugs will no longer be preferred in any PDL drug category where preferred generic drugs are also available. It is expected that preferred generics will be used prior to any preferred brands. This will be operated as a form of step care. Preferred brands in these categories will require prior authorization for these high utilization / high cost members.

F: Brand Name Medication Requests- (Must be submitted on the Brand Name PA request form)- According to MaineCare Benefits Manual Chapter II (80.07-5), when medically necessary covered brand-name drugs have an A-rated generic equivalent available, the most cost effective medically necessary version will be approved and reimbursed, since the brand-name and A-rated generic drugs have been determined by the FDA to be chemically and therapeutically equivalent. The Bureau does not make determinations as to whether or not a generic drug is clinically inferior or inequivalent to its brand version. This is the proper role of the FDA. Physicians should submit their reports of generic inequivalence directly to the FDA via the MEDWATCH.

G: PA requests for non- FDA Approved Indications- Decisions will be made on a case-by-case basis until the DUR committee is able to review the evidence and make a recommendation. Interim approvals and DUR recommendations for approval of a drug for a non- FDA approved indication will require a minimum of two published, peer reviewed, non contradicted, double- blind, placebo-controlled randomized clinical studies establishing both safety and efficacy.

H: Dose Consolidation Requirements- Some drugs may also be affected by dose consolidation requirements. Please see Dose Consolidation List and/or Splitting Tables provided in the PDL.

I. Trials from Multiple Drug Classes - Trial/failure/intolerance to preferred agents from multiple classes within the same category or other catagories of drugs may be required prior to the approval of non-preferred agents (e.g., Cymbalta, Zofran, Elidel and others).

J. Drug-specific PA Forms- Drug-specific PA forms contain medical necessity documentation requirements and/or criteria that may not be repeated in the PDL. Drug-specific PA forms may be obtained on the web at *www.mainecarepdl.org* .

K. PA Exemptions for Prescribers- According to MaineCare Benefits Manual Chapter II (80.07-4), providers may receive a three (3) month exemption from prior authorization requirement for certain categories of drugs when they demonstrate high compliance with the Department's PDL. The Department will notify providers in writing which drug categories are included and what dates apply to the exemption. If a provider loses his/ her exemption, members who previously were not required to obtain a PA while the prescriber was exempt will be required to do so, and criteria for approval of that medication will need to be met.

L: Drug-Drug Interactions (DDI)- The DUR Committee has implemented new drug-drug interation edits requiring prior authorization. Several drug-drug combinations and PDL drug catagories are affected by new PA requirements. These will be indicated in the PDL with DDI notation. Please see the DDI document provided in the PDL.

ASSORTED ANTIBIOTICS

CATEGORY	Coverage Indicator	Step Order	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required	Comments	Criteria
BETA-LACTAMS / CLAVULANATE COMBO'S	MC/DEL		AMOXICILLIN	MC/DEL		AUGMENTIN[3]	3. Chewable 125mg & 250mg and Solution 125mg/5ml and 250mg/5ml available without PA.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		AMOXICILLIN/POTASSIUM CLA CHEW	MC/DEL		AUGMENTIN XR TB12[4]		
	MC/DEL		AMOXICILLIN/POTASSIUM CLA SUSR					
	MC/DEL		AMOXICILLIN/POTASSIUM CLA TABS					
	MC/DEL		AMPICILLIN					
	MC		BICILLIN L-A SUSP				4. Use preferred generic amoxicillin/clavulanate potassium alternatives.	**DDI:** Ampicillin will now be non-preferred and require prior authorization if it is currently being used in combination with either Prevacid, pantoprazole, Prilosec, or any currently non preferred PPI.
	MC/DEL		DICLOXACILLIN SODIUM CAPS					
	MC		OXACILLIN SODIUM SOLR					
	MC/DEL		PENICILLIN V POTASSIUM				Use PA Form# 20420	
	MC		TIMENTIN SOLR					
	MC		UNASYN SOLR					
	MC/DEL		ZOSYN					
CEPHALOSPORINS	MC/DEL		CEFADROXIL HEMIHYDRATE	MC		CEDAX	1. Both brand and generic are clinically non-preferred.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		CEFAZOLIN SODIUM SOLR	MC/DEL		CEFACLOR[1]		
	MC/DEL		CEFDINIR	MC/DEL		CEFADROXIL MONOHYDRATE TABS		
	MC/DEL		CEFEPIME	MC/DEL		CEFTIN	2. Dosing limits apply, please see Dosage Consolidation List.	
	MC/DEL		CEFPODOXIME	MC/DEL		FORTAZ		Suprex will be preferred with dosing limits of one tablet per 7days for prevention and treatment of STI gonorrhoea.
	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/DEL	AZITHROMYCIN TABS	MC/DEL	AZITHROMYCIN POW	1. 7- Day supply per month without PA.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL	AZITHROMYCIN SUSP	MC/DEL	CLARITHROMYCIN SUSP		
	MC	E.E.S.	MC/DEL	CLARITHROMYCIN TABS		
	MC	ERYPED 200 SUSR	MC	DIFICID		
	MC	ERYPED 400 SUSR	MC	PCE TBEC		**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	ERY-TAB TBEC	MC/DEL	ZITHROMAX TABS		
	MC	ERYTHROCIN STEARATE TABS	MC/DEL	ZITHROMAX 1GM PAK	Use PA Form# 20420	
	MC/DEL	ERYTHROMYCIN	MC/DEL	ZITHROMAX TRI-PAK		
			MC/DEL	ZITHROMAX SUSP		**DDI:** Preferred clarithromycin formulations (clarithromycin 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	ZMAX		
TETRACYCLINES	MC/DEL	DOXYCYCLINE MONOHYDRATE 100mg & 50mg CAPS	MC	DECLOMYCIN TABS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL	MINOCYCLINE HCL CAPS	MC/DEL	DORYX CPEP		
	MC/DEL	TETRACYCLINE HCL CAPS	MC/DEL	DOXYCYCLINE HYCLATE		
			MC/DEL	DOXYCYCLINE MONOHYDRATE 150mg & 75mg CAPS		
	MC/DEL	VIBRAMYCIN SYRP	MC/DEL	DYNACIN CAPS		
			MC	ORACEA		
			MC/DEL	PERIOSTAT		
			MC/DEL	SOLODYN ER		
FLUOROQUINOLONES	MC/DEL	CIPROFLOXACIN	MC	AVELOX SOLN		Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL	LEVOFLOXACIN	MC	AVELOX TABS	Use PA Form# 20420	
	MC/DEL	OFLOXACIN	MC	AVELOX ABC PACK TABS	1. Dosing limits apply, see Dosage Consolidation List.	
			MC	CIPRO		**DDI:** Preferred ofloxacin will now be non-preferred and require prior authorization if they are currently being used in combination with amiodarone.
			MC	FACTIVE		**DDI:** Preferred levofloxacin will now be non-preferred and require prior authorization if they are currently being used in combination with amiodarone.
			MC	LEVAQUIN TABS SOLN/INJ		**DDI:** Preferred Avelox will now be non-preferred and require prior authorization if they are currently being used in combination with amiodarone.
			MC	LEVAQUIN TABS[1]		**DDI:** All preferred fluoroquinolones will require clinical PA for patients over 60 that are currently on immunosuppressants or steroid therapy.
			MC	NOROXIN TABS		
			MC	PROQUIN XR		**DDI:** Factive is non-preferred but with any prior authorization requests, the member's drug profile will also be monitored for concurrent use with amiodarone.
AMINO GLYCOSIDES	MC	GENTAMICIN	MC	BETHKIS[1]	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC	KITABIS PAK	MC/DEL	TOBI PODHALER[1]	1. Clinial PA to verify appropriate diag	
	MC/DEL	NEOMYCIN SULFATE TABS	MC	TOBI NEBU[2]		
			MC/DEL	TOBRAMYCIN SULFATE SOLN[2]	2. See criteria section	TOBI Podhaler is limited to patients with significant impairment from using nebulized version of medication
						Current users of Tobi Nebu and Tobramycin Soln will be allowed a grace period until 10/1/15 to transition to preferred Kitabis.
ANTI-MYCOBACTERIALS / ANTI-TUBERCULOSIS	MC/DEL	ETHAMBUTOL HCL TABS			Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL	MYAMBUTOL TABS				
	MC/DEL	MYCOBUTIN CAPS				
	MC/DEL	RIFAMPIN				**DDI:** Preferred rifampin will be non-preferred and require prior authorization if it is currently being used in combination with either Pradaxa or Latuda.
ANTIMALARIAL AGENTS	MC/DEL	**CHLOROQUINE PHOSPHATE TABS**	MC	ARALEN TABS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL	**DARAPRIM TABS**	MC	ISONARIF[1]		
	MC/DEL	**HYDROXYCHLOROQUINE TABS**	MC/DEL	MALARONE TABS	1. Ingredients available as preferred without PA.	
	MC/DEL	**MEFLOQUINE HCL TABS**	MC/DEL	**PLAQUENIL TABS**		
	MC/DEL	**QUININE SULFATE**				
ANTHELMINTICS	MC/DEL	ALBENZA TABS			Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC	BILTRICIDE TABS				
	MC/DEL	STROMECTOL TABS				
ANTIBIOTICS - MISC.	MC	AZACTAM SOLR	MC	COLISTIMETHATE SODIUM SOLR	1. 375mg caps and 750mg tabs are non-preferred. Please use available	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC	COLY-MYCIN-M SOLR	MC	CAYSTON[3]		

	MC MC MC/DEL MC MC MC/DEL MC/DEL		COLISTIMETHATE SODIUM SOLR FUROXONE TABS METRONIDAZOLE[1] PENTAMIDINE ISETHIONATE SOLR PRIMSOL SOLN TRIMETHOPRIM TABS VANCOMYCIN 5GM INJ.	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC MC MC/DEL MC		FLAGYL CAPS FLAGYL TABS FLAGYL ER TBCR KETEK METRONIDAZOLE 375MG CAPS[1] METRONIDAZOLE 750MG TABS[1] NEBUPENT SOLR TINDAMAX VANCOMYCIN 10GM INJ.[2] XIFAXAN	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 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.
CARBAPENEMS				MC MC MC/DEL		INVANZ SOLR MERREM SOLR PRIMAXIN	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
LINCOSAMIDES / OXAZOLIDINONES / LEPROSTATICS	MC/DEL MC/DEL MC/DEL MC		CLEOCIN SOLN CLEOCIN SUSR CLINDAMYCIN HCL 150CAPS DAPSONE TABS	MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL		CLEOCIN CAPS CLINDAMYCIN HCL 300CAPS[1] SIVEXTRO VIBATIV ZYVOX SUSR ZYVOX TABS	1. Use multiple 150's for Clindamycin instead of 300's. Use PA Form# 30820 for Zyvox & Vibativ Use PA Form# 20420 for all others	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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.
ANTI INFECTIVE COMBO'S - MISC.	MC/DEL MC/DEL MC/DEL MC/DEL		ERYTHROMYCIN/SULF SUSR SEPTRA/DS TABS SULFAMETHOXAZOLE/TRIMETH TRIMETHOPRIM/SULFAMETHOXA	MC		BACTRIM DS TABS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
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 MC/DEL MC/DEL MC MC MC MC/DEL MC/DEL MC/DEL MC/DEL		ANCOBON CAPS FLUCONAZOLE[1] GRIFULVIN V TABS[8] GRISEOFULVIN SUSP[8] GRISEOFULVIN ULTRAMICROSI TABS[8] GRIS-PEG TABS[8] KETOCONAZOLE TABS[7] NYSTATIN TERBINAFINE TABS[4] **VORICONAZOLE TABS**	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL	6 6 8 8 8 8 8 8 8 8 8 8	LAMISIL TABS[4] ITRACONAZOLE CRESEMBA[9] SPORANOX SOLN[2] SPORANOX PULSEPAK CAPS[3] SPORANOX CAPS[3] DIFLUCAN ERAXIS INJ[6] GRIFULVIN SUSP ONMEL NOXAFIL[5] VFEND TABS	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.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. The other criteria are listed on the Antifungal PA form including the required proof of a non-cosmetic fungal infection. **DDI:** 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. **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.

Class	Status		Preferred Agents	Status	Criteria	Non-Preferred Agents	PA Criteria	Comments
							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. 9. For patients ≥ 18years of age Use PA Form# 10120	**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	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 5. Clinical PA is required to establish diagnosis, verification of age for appropriate indication and medical necessity. 6. Dosing limits apply.	Please refer to the criteria listed on the Fuzeon PA form. **DDI:** Reyataz will now be non-preferred and require prior authorization if it is currently being used in combination with either Prevacid, pantoprazole, Prilosec, or any currently non preferred PPI . **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. **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. 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. 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 DDI: Nevirapine, oxcarbazepine, phenytion, phenobarbital, carbamazepine, and St. John;s wort will be non-preferred and require prior authorization if it is currently being used in combination with Tivicay. DDI:Aatazanavir or darunavir and the following drugs are contraindicated (due to potential for serious and/or life-threatening events or loss of therapeutic effect): alfuzosin,
	MC		ATRIPLA[1]	MC/DEL	8	DIDANOSINE		
	MC/DEL		COMBIVIR TABS	MC/DEL	8	EVOTAZ		
	MC/DEL		CRIXIVAN CAPS	MC/DEL	8	FUZEON[3]		
	MC/DEL		EDURANT	MC/DEL	8	INTELENCE[3]		
	MC		EMTRIVA	MC/DEL	8	ISENTRESS[3,4]		
	MC/DEL		EPIVIR / HBV	MC/DEL	8	PREZCOBIX		
	MC/DEL		EPZICOM	MC	8	RETROVIR		
	MC/DEL		INVIRASE CAPS	MC/DEL	8	SELZENTRY[3]		
	MC		KALETRA	MC	8	STRIBILD		
	MC/DEL		LEXIVA	MC	8	TIVICAY[5,6]		
	MC		NORVIR	MC	8	TRIUMEQ[5,7]		
	MC		PREZISTA[2]	MC	8	TYBOST[8]		
	MC/DEL		RESCRIPTOR TABS	MC	8	ZERIT		
	MC		REYATAZ[1]	MC	8	VITEKTA		
	MC		STAVUDINE	MC/DEL	9	VIRAMUNE XR		
	MC		SUSTIVA					
	MC/DEL		TRIZIVIR TABS					
	MC		TRUVADA					
	MC		VIDEX EC					
	MC/DEL		VIRACEPT TABS					
	MC/DEL		VIRAMUNE TABS					
	MC		VIREAD TABS					
	MC/DEL		ZIAGEN TABS					
	MC/DEL		ZIDOVUDINE					

Therapeutic Class			Preferred Agents			Non-Preferred Agents	Criteria	Notes
							6. Dosing limits apply, please see dosing consolidation list. 7. Request will require use of the individual components Tivicay and Epzicom. 8. Diagnosis and verify prior trials and failures or intolerance of preferred treatments is required	DDI: atazanavir or darunavir and the following drugs are contraindicated (due to potential for serious and/or life-threatening events or loss of therapeutic effect): alfuzosin, dronedarone, rifampin, irinotecan, dihydroergotamine, ergotamine, methylergonovine, cisapride, St. John's wort, lovastatin, simvastatin, pimozide, nevirapine, sildenafil (when given as Revatio® for treatment of PAH), indinavir, triazolam, or PO midazolam will be non-preferred and require prior authorization if it is currently being used in combination with Tybost. Evotaz is only available if unable to tolerate or have failed Reyataz and Norvir Prezcobix is only available if unable to tolerate or have failed Prezista and Norvir
CYTO-MEGALOVIRUS AGENTS	MC MC		FOSCARNET SODIUM VALCYTE TABS	MC/DEL MC/DEL		FOSCAVIR GANCICLOVIR	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
HERPES AGENTS	MC/DEL MC/DEL		ACYCLOVIR VALACYCLOVIR HCL	MC/DEL MC MC/DEL MC/DEL MC/DEL	8 8 8 8 9	FAMCICLOVIR[1] SITAVIG ZOVIRAX[1] VALTREX TABS[1] FAMVIR TABS[1]	1. Must fail Acyclovir and Valacyclovir before non-preferred products in step order. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
INFLUENZA AGENTS	MC/DEL MC MC/DEL MC/DEL		AMANTADINE RELENZA DISKHALER AEPB RIMANTADINE HCL TABS TAMIFLU[1]	MC MC		FLUMADINE TABS FLUMIST	1. Tamiflu 10 caps or 60cc's per month. Will be audited for presence of positive influenza tests in patient or family member. Use PA Form# 10610 for Flumist requests Use PA Form# 20420 for all others	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
IMMUNE SERUMS								
IMMUNE SERUMS	MC		HYPERRHO INJ					
HEPATITIS AGENTS								
HEPATITIS C AGENTS	MC MC MC/DEL MC/DEL MC/DEL MC MC MC MC MC		HARVONI[2] OLYSIO[2] PEGASYS KIT[1] PEGASYS SOLN PEG-INTRON KIT[1] RIBAVIRIN RIBAPAK SOVALDI[2] TECHNIVIE[2] VIEKIRA PAK[2]	MC/DEL MC/DEL MC/DEL		COPEGUS TABS DAKLINZA REBETOL CAPS	1. Dosing limits apply, please see dosage consolidation list. 2. Approvals will require clinical PA. Please see the Hepatitis PA form for criteria Use PA Form# 10700	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **DDI:** Olysio will require a prior authorization if it is currently being used in combination with drugs known to be significant CYP3A4 inhibitors (ketoconazole, itraconazole, clarithromycin, indinavir, nefazodone, nelfinavir, ritonavir, atazanavir, saquinavir and telithromycin).

HEPATITIS AGENTS - MISC.				MC		ACTIMMUNE	Use PA Form# 20420	Approved for chronic granulomatous disease, osteopetrosis and idiopathic pulmonary fibrosis.
HEPATITIS B ONLY	MC		HEPSERA TABS	MC MC		BARACLUDE TYZEKA	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Baraclude is indicated for treatment of chronic Hep B virus (HBV) in adults with: evidence of active viral replication AND either evidence of persistent elevation in serum aminotransferases (ALT or AST) or histologically active disease, Patient is 16 years of age or older. Boxed warning: Use not recommended for those co-infected with HIV and HBV who are not also receiving highly active antiretroviral therapy (HAART).
RSV PROPHYLAXIS								
RSV PROPHYLAXIS				MC		SYNAGIS[1]	Use PA Form# 30120 1. MaineCare will approve Synagis PA's for start date of November 23rd for infants who meet the guidelines. PA will be approved for max of 5 doses. Maximum 1 dose/30 days.	Please see the criteria listed on the Synagis PA form.
MS TREATMENTS								
MULTIPLE SCLEROSIS - INTERFERONS	MC MC/DEL MC		AVONEX KIT[1] EXTAVIA[1] REBIF SOLN[1]	MC/DEL MC		**BETASERON SOLR** PLEGRIDY[1]	1.Clinical PA is required to establish diagnosis and medical necessity. Use PA Form# 20430	Non-Preferred drugs must be tried in step-order and failed due to lack of efficacy or intolerable side effects before lower ranked non-preferred drugs will be approved , unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
MULTIPLE SCLEROSIS - NON-INTERFERONS	MC MC/DEL		COPAXONE 20MG[2] GILENYA[2,3]	MC MC MC MC MC/DEL MC	6 8 8 8 8 8	TYSABRI[1] AMPYRA AUBAGIO COPAXONE 40MG **GLATOPA** TECFIDERA	1. Providers must be enrolled in the TOUCH Prescribing program, a restricted distribution program. Clinical PA is required to establish diagnosis and medical necessity. 2. Clinical PA is required to establish diagnosis and medical necessity. 3. Dosing limits apply, please see dosage consolidation list. Use PA Form# 20430	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **Aubagio** is non-preferred and is for adults with relapsing forms of MS. No concurrent use of leflunomide . Within 6 months of initiation of Aubagio, lab testing to look at (transaminase, bilirubin, CBC, TB) as boxed warning exists regarding hepatoxicity.
ASSORTED NEUROLOGICS								
NEUROLOGICS - MISC.	MC/DEL MC MC		ORAP TABS PROSTIGMIN TABS PYRIDOSTIGMINE	MC MC MC MC		BOTOX[2] DYSPORT[1] MESTINON MYOBLOC[1]	1. Approval will be limited to Cervical dystonia. 2. Please see botulinum PA form for additional criteria Use PA Form# 10210	Failed/did not tolerate therapeutic trials fo muscle relaxants, unless contraindicated, including but not limited to baclofen, cyclobenzaprine, orphenadrine, Skelaxin, and tizanidine. **Migraine:** Consideration for Botox approvals will only be made after failures of required trials of the following preferred medications: tricyclic or venlafaxine,beta blocker,valproic acid ,topiramate Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
STEROIDS								
GLUCOCORTICOIDS/ MINERALOCORTICOIDS	MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		CELESTONE SUSP CORTEF 5 CORTISONE ACETATE TABS DELTASONE TABS DEPO-MEDROL SUSP DEXAMETHASONE	MC/DEL MC MC/DEL MC/DEL MC MC		BUDESONIDE EC CORTEF 10 and 20 TABS FLORINEF TABS **MEDROL TABS** MEDROL DOSEPAK TABS MILLIPRED	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.

	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					**DDI:** All preferred steroids will require clinical PA for patients over 60 that are currently on fluoroquinolone therapy.
	MC/DEL		METHYLPREDNISOLONE TABS					
	MC/DEL		PREDNISOLONE					
	MC/DEL		**PREDNISONE**					
	MC/DEL		SOLU-CORTEF SOLR					
	MC/DEL		SOLU-MEDROL SOLR					
			HORMONE REPLACEMENT THERAPIES					
ANDROGENS / ANABOLICS	MC/DEL		ANDRODERM PT24	MC		ANADROL-50	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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		HALOTESTIN TABS		
				MC		NATESTO		
				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		MAKENA[3]	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. 3. Clinical PA required for indication to reduce the risk of preterm birth in women with a singleton pregnancy who have a history of singleton spontaneous preterm birth. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a 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		MEDROXYPROGESTERONE ACETA [2]	MC		CYCRIN TABS		
	MC/DEL		NORETHINDRONE ACETATE TABS[2]	MC		PROGESTERONE POWD		
	MC		17-ALPH HYDROXYPROGESTERONE[3]	MC/DEL		PROMETRIUM 100MG CAPS[1]		
				MC/DEL		PROMETRIUM 200MG[1]		
				MC/DEL		PROVERA TABS		
			CONTRACEPTIVES					

Category	Status	#	Preferred Drugs	Status	#	Non-Preferred Drugs	PA Criteria	Notes
CONTRACEPTIVES - PROGESTIN ONLY	MC/DEL		NOR-QD TABS	MC/DEL	7	CAMILA TABS		Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		NORETHINDRONE ACETATE 0.35 TABS	MC/DEL	7	ERRIN		
				MC/DEL	7	JOLIVETTE		
				MC/DEL	7	NORA-BE TABS		If member experienced adverse reactions, consider using Oral Contraceptives from other groups.
				MC	8	ORTHO MICRONOR TABS	Use PA Form# 20420	**DDI:** Preferred Oral Contraceptives will now be non-preferred and require prior authorization if it is currently being used in combination with Tracleer.
CONTRACEPTIVES - INJECTABLE	MC/DEL		MEDROXYPROGESTERONE ACETATE 150mg IM	MC/DEL		DEPO-PROVERA 150 mg SUSP	Use PA Form# 20420	The preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
CONTRACEPTIVE - EMERGENCY	MC/DEL	1	PLAN B ONE STEP[1]	MC/DEL		PLAN B	1. Allowed 2 tablets per 30 days without PA	
	MC/DEL	2	ELLA					
	MC	2	LEVONORGESTREL					
	MC/DEL	2	NEXT CHOICE[1]				Use PA Form# 20420	
CONTRACEPTIVES - PATCHES/ VAGINAL PRODUCTS	MC		NUVARING RING[1]	MC/DEL		**XULANE[2]**	Use PA Form# 20420 1. Quantity limit allowing 1 every 28 days with out PA. 2. Dose limits apply allowing 3 patches per 28 days supply.	Approved if adequate clinical reason given why patient unable to comply with other preferred agents including long acting injectable.
CONTRACEPTIVES - MONOPHASIC COMBINATION O/C'S	MC/DEL		APRI TABS	MC/DEL		BEYAZ	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		AVIANE TABS	MC/DEL		BREVICON-28 TABS	If member experienced adverse reactions, consider using Oral Contraceptives from other groups.	
	MC/DEL		BALZIVA	MC/DEL		LESSINA-28 TABS		
	MC/DEL		CRYSELLE-28 TABS	MC/DEL		LEVORA		
	MC		DESOGEN TABS	MC		LOESTRIN TABS		
			DESOGESTREL/ ETHINYL ESTRADIOL	MC/DEL		LOESTRIN FE TABS		If member experienced adverse reactions, consider using Oral Contraceptives from other groups.
	MC/DEL		LOW-OGESTREL TABS	MC/DEL		LOESTRIN FE 1/20 TABS		
	MC		MODICON TABS	MC/DEL		LOESTRIN 1.5/30-21 TABS		
	MC/DEL		MONONESSA	MC/DEL		LOESTRIN 1/20-21 TABS		
	MC/DEL		NECON 1/50	MC		LO/OVRAL 21 TABS		**DDI:** Preferred Oral Contraceptives will now be non-preferred and require prior authorization if it is currently being used in combination with Tracleer.
	MC		ORTHO-CEPT-28 TABS	MC/DEL		LO/OVRAL 28 TABS		
	MC		ORTHO-CYCLEN-28 TABS	MC/DEL		MICROGESTIN FE TABS		
	MC		ORTHO-NOVUM 1/35-28 TABS	MC/DEL		NORDETTE-28 TABS		
	MC/DEL		OVCON-50 28 TABS	MC/DEL		NORINYL		
	MC/DEL		PREVIFEM	MC/DEL		NORTREL		
	MC/DEL		RECLIPSEN	MC/DEL		OCELLA		
	MC/DEL		SOLIA	MC/DEL		OGESTREL TABS		
	MC/DEL		SPRINTEC 28 TABS	MC/DEL		OVCON-35/28 TABS		
	MC/DEL		YASMIN 28 TABS	MC/DEL		OVRAL		
	MC/DEL		YAZ	MC/DEL		PORTIA-28 TABS		
	MC/DEL		ZENCHENT	MC/DEL		SAFYRAL		
				MC/DEL		ZOVIA		
CONTRACEPTIVES - BI-PHASIC COMBINATIONS	MC		ORTHO-NOVUM 10/11-28 TABS	MC/DEL		NECON 10/11-28 TABS	If member experienced adverse reactions, consider using Oral Contraceptives from other groups.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		NORETHINDRONE-ETH ESTRADIOL TAB 0.5-35/1-35	MC/DEL		KARIVA TABS		
	MC/DEL		SEASONIQUE	MC/DEL		LOSEASONIQUE		If member experienced adverse reactions, consider using Oral Contraceptives from other groups.
				MC/DEL		MIRCETTE TABS	Use PA Form# 20420	**DDI:** Preferred Oral Contraceptives will now be non-preferred and require prior authorization if it is currently being used in combination with Tracleer.
CONTRACEPTIVES - TRI-PHASIC COMBINATIONS	MC/DEL		ENPRESSE	MC/DEL		CYCLESSA TABS	If member experienced adverse reactions, consider using Oral Contraceptives from other groups.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		NECON 7/7/7	MC/DEL		ESTROSTEP FE TABS		
	MC		ORTHO-NOVUM 7/7/7-28 TABS	MC/DEL		NORTREL 7/7/7		
	MC/DEL		TRI-NORINYL 28 TABS	MC		ORTHO TRI-CYCLEN TABS		
	MC/DEL		TRI-PREVIFEM	MC		ORTHO TRI-CYCLEN LO TABS		
	MC/DEL		TRIPHASIL 28 TABS					If member experienced adverse reactions, consider using Oral Contraceptives from other groups.

	MC/DEL		TRI-SPRINTEC					**DDI:** Preferred Oral Contraceptives will now be non-preferred and require prior authorization if it is currently being used in combination with Tracleer.
	MC		TRINESSA					
	MC/DEL		TRIVORA-28 TABS				Use PA Form# 20420	
CONTRACEPTIVES - MULTI-PHASIC COMBINATIONS				MC		NATAZIA	Use PA Form# 20420	
DIABETES THERAPIES								
DIABETIC - INSULIN	MC		HUMALOG INJ 100/ML	MC/DEL		APIDRA	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		HUMALOG MIX 75/25	MC/DEL		**AFREZZA[1]**		
	MC		HUMULIN N INJ U-100	MC		HUMALOG MIX 50/50	1. Not to be as a monotherapy. Obtain lab values of pulmonary function and recent smoking history	
	MC		HUMULIN INJ 70/30	MC		HUMULIN INJ 50/50		
	MC		HUMULIN R U-100	MC		HUMULIN R INJ U-500		
	MC/DEL		LANTUS SOLN	MC/DEL		**NOVOLIN**		
	MC/DEL		LEVEMIR	MC/DEL		**NOVOLOG**		
				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 is offered on the Prior Authorization form, such as the presence of a 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		**TOUJEO**		
	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[2]**	1. Preferred if therapeutic doses of metformin are seen in members drug profile for at least 60 days within the past 18 months or if phosphate binder is currently seen in the members drug profile. 2. Dosing limits apply. Please refer to Dose consolidation list. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **DDI:** Onglyza 5mg will require a prior authorization if it is currently being used in combination with drugs known to be significant CYP3A4 inhibitors (ketoconazole, itraconazole, clarithromycin, indinavir, nefazodone, nelfinavir, ritonavir, atazanavir, saquinavir and telithromycin).
	MC/DEL		TRADJENTA[2]					
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. 2. Dosing limits apply. Please refer to Dose consolidation list. Use PA Form# 20420	
	MC/DEL		**JANUMET XR[1,2]**	MC		KOMBIGLYZE XR		
	MC/DEL		**JENTADUETO[1]**	MC/DEL		**OSENI**		
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	**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.

							2. Dosing limits apply please refer to Dose Consolidation List	
DIABETIC - LANCET-LANCET DEVICE	MC MC MC MC MC		ONE TOUCH LANCETS DELICA LANCETS UNILET LANCETS UNISTIK LANCING DEVICE AUTOLOT LANCING DEVICE				Use PA Form# 20420	
DIABETIC - SYRINGES-NEEDLES	MC/DEL MC MC MC		BD MICRO-FINE BD ULTRA-FINE BD ULTRA-FINE PEN NEEDLES UNIFINE PEN NEEDLES				Use PA Form# 20420	
DIABETIC - OTHER				MC/DEL MC		CYCLOSET SYMLIN	Use PA Form# 30150 for Symlin Use PA Form #20420 for all others	Please see the criteria listed in the Symlin PA form.
SGLT 2 INHIBITORS				MC/DEL MC/DEL MC/DEL		**FARXIGA** **INVOKANA**[1] **JARDIANCE**	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.
SGLT 2 INHIBITOR COMBINATIONS				MC/DEL MC/DEL MC/DEL		**GLYXAMBI** **INVOKAMET** **XIGDOU XR**[1]	1. Diagnosis required 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. Glyxambi /Xigduo XR- Verify prior trials and failures or intolerance of preferred treatments from other diabetic categories
DIABETIC MONITOR	MC MC MC MC MC MC MC		FREESTYLE INSULINX FREESTYLE LITE SYSTEM KIT FREESTYLE FREEDOM LITE KIT ONE TOUCH ULTRA 2 KIT ONE TOUCH ULTRA MINI KIT ONE TOUCH ULTRA SMART KIT PRECISION XTRA METER	MC MC MC MC MC MC		ACCUCHECK ASCENSIA ASSURE CONTOUR BREEZE Z EXACTECH PRODIGY	Use PA Form# 20420	Effective October 25th 2007, approvals for all non preferred meters/ test strips will require medical necessity documenting clinically significant features that are not available on any of the preferred meters.
DIABETIC TEST STRIPS	MC MC MC MC MC MC		FREESTYLE[1] FREESTYLE LITE[1] FREESTYLE INSULINX[1] ONE TOUCH DELICA[1] ONE TOUCH ULTRA[1] PRECISION XTRA[1]	MC MC MC MC MC MC		ACCUCHECK ASCENSIA ASSURE EXACTECH PRODIGY CONTOUR BREEZE Z	1. Only 50 ct & 100 ct package size. Use PA Form# 20420	Effective October 25th 2007, approvals for all non preferred meters/ test strips will require medical necessity documenting clinically significant features that are not available on any of the preferred meters.
INCRETIN MIMETIC				MC MC	8 8	BYDUREON[1] BYETTA[1]	1. If patient is not responding to oral agents (single or multiple) please	Trulicity- Verify prior trials and failures or intolerance of preferred treatments from other diabetic categories and that is not being used as first-line treatment

Therapeutic Class			Preferred Drugs			Non-Preferred Drugs	Criteria	Notes
				MC/DEL MC/DEL MC MC/DEL	8 8 8 9	**NESINA** **TANZEUM** TRULICITY[2] VICTOZA[1]	(single or multiple) please look to insulin therapy. Dosing limits apply. Please refer to Dose Consolidation List. 2. Diagnosis required Use PA Form# 10230	
DIABETIC - ORAL SULFONYLUREAS	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		**CHLORPROPAMIDE TABS** GLIMEPIRIDE **GLIPIZIDE TABS** **GLIPIZIDE ER TABS** **GLYBURIDE MICRONIZED TABS** **GLYBURIDE TABS[1]** **TOLAZAMIDE TABS** **TOLBUTAMIDE TABS**	MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL		**AMARYL TABS** **DIABETA TABS** **GLUCOTROL TABS** **GLUCOTROL XL TBCR** **GLYNASE TABS** **MICRONASE TABS**	Use PA Form# 20420 1. Pa required for members ≥65. Glyburide has a greater risk of severe prolonged hypoglycemia in older adults.	Preferred drugs must be tried for at least 3 months at full therapeutic doses and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **DDI:** All sulfonylureas (except glyburide) will now be non-preferred and require prior authorization if it is currently being used with either ranitidine or cimetidine. **DDI:** Glimepiride will now be non-preferred and require prior authorization if it is currently being used with either fluconazole (except 150mg strength) or fluvoxamine. Amaryl is non-preferred but with any prior authorization requests, the member's drug profile will also be monitored for concurrent use with either fluconazole or fluvoxamine.
DIABETIC -ORAL BIGUANIDES	MC/DEL MC/DEL		**METFORMIN HCL TABS** METFORMIN ER	MC MC MC MC/DEL		GLUCOPHAGE TABS GLUCOPHAGE XR TB24 FORTAMET METFORMIN ER OSMOTIC	Use PA Form# 20420	Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
DIABETIC - THIAZOL / BIGUANIDE COMBO				MC/DEL MC/DEL MC/DEL MC/DEL		ACTOPLUS MET[1] ACTOPLUS MET XR AVANDARYL[1] **AVANDAMET TABS[1]**	Use PA Form# 20420 1. Requires use of Actos, Metformin, or other preferred anti-diabetics.	**DDI:** Actos, Avandia, or any combination product with Actos or Avandia will now be non-preferred and require prior authorization if it is currently being used with gemfibrozil.
DIABETIC - / THIAZOL	MC/DEL		**PIOGLITAZONE HCL[1]**	MC/DEL MC/DEL		**ACTOS TABS[3]** **AVANDIA TABS[2]**	1. Pioglitazone HCL is non-preferred as monotherapy. Pioglitazone HCL is preferred if therapeutic doses of metformin, sulfonylurea or insulin are seen in members drug profile for at least 60 days within the past 18 months. 2. Current users of Avandia who have tried Actos will be able to continue use of Avandia. 3. Dosing limits apply please refer to Dose Consolidation List Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **DDI:** Actos, Avandia, or any combination product with Actos or Avandia will now be non-preferred and require prior authorization if it is currently being used with gemfibrozil.
DIABETIC - ALPHAGLUCOSIDASE	MC/DEL		**GLYSET TABS**	MC		**PRECOSE TABS**	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
DIABETIC - SULFONYLUREA / BIGUANIDE	MC/DEL		GLYBURIDE/METFORMIN	MC MC MC/DEL		**GLUCOVANCE TABS[1]** METAGLIP TABS[1] DUETACT[2]	1. Use individual ingredients. 2. Use Actos with generic glimepiride. Use PA Form# 20420	Approved for patients failing to achieve good diabetic control with maximal doses of individual components.
DIABETIC - MEGLITINIDES	MC/DEL		**STARLIX TABS**	MC/DEL MC		**PRANDIN TABS** **NATEGLINIDE**	Use PA Form# 20420	Preferred drugs from other diabetic sub-categories must be tried and failed due to lack of inadequate diabetic control or intolerable side effects before non-preferred drug will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.

								DDI: Prandin is non-preferred but with any prior authorization requests, the member's drug profile will also be monitored for current use with both Sporanox and gemfibrozil, due to a significant drug-drug interaction.
GLUCOSE ELEVATING AGENTS								
GLUCOSE ELEVATING AGENTS	MC/DEL		GLUCAGEN INJ. HYPOKIT	MC		GLUCAGON DIAGNOSTIC KIT	Use PA Form# 20420	
				MC		GLUCAGEN DIAGNOSTIC KIT		
THYROID								
THYROID HORMONES	MC/DEL		**ARMOUR THYROID TABS**	MC		LEVOTHYROXINE SODIUM SOLR	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**CYTOMEL TABS**	MC/DEL		LIOTHYRONINE		
	MC/DEL		**LEVOTHROID TABS**	MC		SYNTHROID TABS		
	MC/DEL		**LEVOTHYROXINE SODIUM TABS**					
	MC/DEL		**LEVOXYL TABS**					
	MC/DEL		**THYROID TABS**					
	MC/DEL		**THYROLAR**					
	MC/DEL		**UNITHROID TABS**					
ANTITHYROID THERAPIES	MC/DEL		**METHIMAZOLE TABS**	MC/DEL		**TAPAZOLE TABS**	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**PROPYLTHIOURACIL TABS**					
OSTEOPOROSIS / BONE AGENTS								
OSTEOPOROSIS	MC/DEL		ALENDRONATE	MC/DEL		**ACTONEL TABS**	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**MIACALCIN SOLN**[2]	MC		AREDIA SOLR	1. Approval only requires failure of Alendronate.	
				MC		BINOSTO		
				MC/DEL		BONIVA INJECTION KIT		
				MC/DEL		BONIVA TABS[2,4]	2. Quantity limits apply, please see dosage consolidation list.	
				MC/DEL		CALCITONIN NS		
				MC/DEL		**DUAVEE**		
				MC/DEL		**DIDRONEL TABS**	3. Please use Alendronate and Vitamin D.	
				MC		EVISTA TABS[1]		
				MC		FORTEO		
				MC/DEL		FORTICAL	4. Please use other preferred agents.	
				MC/DEL		**FOSAMAX TABS AND PLUS D**[3]		**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 30 days to minimize the risk of liver injury.
URINARY INCONTINENCE								
VASOPRESSINS			DESMOPRESSIN TABS	MC/DEL MC/DEL MC/DEL MC MC/DEL	5 6 6 8 8	DDAVP TABS DDAVP SOLN[1] **DESMOPRESSIN SPRAY[1]** DESMOPRESSIN ACETATE SOLN[1] STIMATE SOLN[1,2]	1. Products must be used in specified step order. Nocturnal enuresis patients will be encouraged to periodically attempt stopping DDAVP.	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).

							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 the Prior Authorization form, such as the presence of 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 the Prior Authorization form, such as the presence of 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, 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	
CARDIAC - SINUS NODE INHIBITORS	MC		CORLANOR					In patients with stable, symptomatic chronic heart failure with left ventricular ejection fraction ≤35%, who are in sinus rhythm with resting heart rate ≥70 beats per minute (bpm) and either are on maximally tolerated doses of beta-blockers or have a contraindication to beta-blocker use
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 the Prior Authorization form, such as the presence of 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 24 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.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.

							Use PA Form# 20420	
NITRO - SUBLINGUAL/ SPRAY	MC/DEL		NITROSTAT SUBL	MC/DEL		NITROQUICK SUBL	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		NITROTAB SUBL	MC		NITROLINGUAL SOLN		
				MC		NITROLINGUAL TABS		
BETA BLOCKERS - NON SELECTIVE	MC/DEL		CARVEDILOL	MC/DEL		BETAPACE TABS	1. Recommend using BID since its effects do not last 24 hours.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		LEVATOL TABS	MC		BETAPACE AF TABS		
	MC/DEL		NADOLOL TABS	MC/DEL		COREG CR[3]	2. Please use other strengths in combination to obtain this dose.	
	MC/DEL		PINDOLOL TABS	MC/DEL		COREG TABS		
	MC/DEL		PROPRANOLOL HCL SOLN[1]	MC/DEL		CORGARD TABS		
	MC/DEL		PROPRANOLOL HCL TABS[1]	MC/DEL		INDERAL TABS		
	MC/DEL		PROPRANOLOL LA CAPS	MC		INDERAL LA CPCR		
	MC		RANEXA	MC		INNOPRAN XL	3. Dosing limits still apply. Please see dose consolidation list	
	MC/DEL		SOTALOL AF	MC/DEL		PROPRANOLOL HCL 60MG TABS[2]		
	MC/DEL		SOTALOL HCL TABS					
	MC/DEL		TIMOLOL MALEATE TABS				Use PA Form# 20420	
BETA BLOCKERS - CARDIO SELECTIVE	MC/DEL		ACEBUTOLOL HCL CAPS	MC/DEL		BYSTOLIC	1. Recommend using Atenolol (and metoprolol) BID since its effects do not last 24 hours.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		ATENOLOL TABS[1]	MC		KERLONE TABS		
	MC/DEL		BETAXOLOL HCL TABS	MC/DEL		LOPRESSOR TABS		
	MC/DEL		BISOPROLOL FUMARATE TABS	MC		SECTRAL CAPS		
	MC/DEL		METOPROLOL TARTRATE TABS[1]	MC/DEL		TENORMIN TABS	Use PA Form# 20420	
	MC/DEL		METOPROLOL ER	MC/DEL		ZEBETA TABS		
	MC/DEL		TOPROL XL TB24					
BETA BLOCKERS - ALPHA / BETA	MC/DEL		LABETALOL HCL TABS	MC		TRANDATE TABS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
BETA BLOCKERS & DURECTIC COMBOS				MC/DEL		DUTOPROL	Use PA Form# 20420	
CALCIUM CHANNEL BLOCKERS-- Amlodipines, Bepridil, Diltiazems, Felodipines, Isradipines, Nifedipines, Nisoldipine, and Verapamils	MC/DEL		AMLODIPINE[1]	MC/DEL		NORVASC TABS[1]	1. Dosing limits apply, please see dose consolidation list. Use PA Form# 20420	

	MC		DILTIA XT CP24	MC/DEL	5	DILACOR XR CP24[1]	1. Products must be used in specified order or PA will be required. Just write "Diltiazem 24-hour"and the pharmacy will use a preferred long acting diltiazem that does not require PA. Use PA Form# 20420	Preferred drugs must be tried and failed (in step-order) due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. DDI: All preferred diltiazems will now be non-preferred and require prior authorization if they are currently being used in combination with either Enablex 15mg or Vesicare 10mg. All non-preferred diltiazems require prior authorization, but with any prior authorization request, the member's drug profile will also be monitored for current use with Enablex 15mg or Vesicare 10mg.
	MC/DEL		DILTIAZEM HCL ER CP24	MC/DEL	6	TAZTIA[1]		
	MC/DEL		DILTIAZEM HCL XR CP24	MC	8	CARDIZEM TABS[1]		
	MC/DEL		DILTIAZEM CD 300MG CP24	MC	8	CARDIZEM CD CP24[1]		
	MC/DEL		DILTIAZEM CD 360MG CP24	MC	8	CARDIZEM LA TB24[1]		
	MC		CARTIA XT CP24[1]	MC	8	CARDIZEM SR CP12[1]		
	MC/DEL		DILTIAZEM CD CP24[1]	MC/DEL	8	DILTIAZEM HCL TABS[1]		
	MC/DEL		DILTIAZEM HCL ER CP24[1]	MC/DEL	8	DILTIAZEM HCL ER CP12[1]		
	MC/DEL		DILTIAZEM XR CP24[1]	MC/DEL	8	DILTIAZEM HCL ER CP12[1]		
	MC/DEL		TIAZAC CP24[1]					
				MC/DEL		PLENDIL TB24	Use PA Form# 20420	Other Preferred calcium channel blockers must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
				MC/DEL		FELODIPINE		
				MC		DYNACIRC CAPS	Use PA Form# 20420 1. Established users will be grandfathered	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
				MC		DYNACIRC CR TBCR[1]		
				MC		CARDENE SR CPCR	Use PA Form# 20420	Other Preferred calcium channel blockers must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
				MC		NICARDIPINE HCL CAPS		
	MC/DEL		AFEDITAB CR	MC/DEL		ADALAT CC TBCR[1]	1. Established users of Adalat CC are grandfathered. Use PA Form# 20420	Preferred drug must be tried and failed in step order due to lack of efficacy or intolerable side effects before non-preferred drugs in step order will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		NIFEDIAC CC	MC/DEL		NIFEDIPINE CAPS		
	MC/DEL		NIFEDICAL XL TBCR	MC/DEL		PROCARDIA CAPS		
	MC/DEL		NIFEDIPINE TBCR	MC/DEL		PROCARDIA XL TBCR		
	MC/DEL		NIFEDIPINE ER TBCR					
				MC		SULAR TB24	1. Established users of 10MG and 20MG strengths are grandfathered. Use PA Form# 20420	
				MC		SULAR CR[1]		
	MC/DEL	1	VERAPAMIL HCL CR TBCR	MC/DEL		CALAN TABS	Products must be used in specified order or PA will be required. Just write "Verapamil 24-hour" and the pharmacy will use a preferred long acting generic that does not require PA. Use PA Form# 20420	Preferred drugs must be tried and failed (in step-order) due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL	1	VERAPAMIL HCL ER TBCR	MC/DEL		CALAN SR TBCR		
	MC/DEL	1	VERAPAMIL HCL SR TBCR	MC/DEL		COVERA-HS TBCR		
				MC		ISOPTIN-SR		
				MC/DEL		VERAPAMIL HCL ER CP24		
				MC/DEL		VERAPAMIL HCL SR CP24		
				MC/DEL		VERAPAMIL HCL TABS		
				MC/DEL		VERELAN CP24		
				MC/DEL		VERELAN PM CP24		
ANTIARRHYTHMICS	MC/DEL		AMIODARONE HCL	MC/DEL		CORDARONE	1. Prescription must be written by Cardiologist. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. DDI: Amiodarone will now be non-preferred and require prior authorization if it is currently being used in combination with either Lovastatin (doses greater than 40mg/day) or Lipitor (doses greater than 20mg/day) or Levofloxacin or Gemifloxacin, or Moxifloxacin, or Ofloxacin. DDI: Multaq will be preferred unless the following medications are seen in the member's drug profile within the last 35 days for brand name medications or 90 days for generic medications: Erythromycin, Amiodarone and other antiarrhythmics, TCA's, Phenothiazine, Ketoconazole, Itraconazole, Voriconazole, Cyclosporine, Telithromycin, Clarithromycin, Nefazodone, Ritonavir.
	MC/DEL		FLECAINIDE	MC/DEL		DISOPYRAMIDE		
	MC/DEL		MEXILETINE HCL	MC/DEL		MULTAQ		
	MC/DEL		NORPACE	MC/DEL		PACERONE		
	MC/DEL		PROCAINAMIDE	MC		QUINIDEX		
	MC/DEL		PROPAFENONE	MC/DEL		TAMBOCOR		
	MC		QUINAGLUTE	MC/DEL		TIKOSYN[1]		
	MC/DEL		QUINIDINE GLUCONATE	MC/DEL		RYTHMOL SR		
	MC/DEL		QUINIDINE SULFATE	MC/DEL		RYTHMOL		
ACE INHIBITORS	MC/DEL		BENAZEPRIL HCL	MC	5	MAVIK TABS	1. Non-preferred products must be used in specified order. 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 MC/DEL MC/DEL MC/DEL MC/DEL		BENICAR TABS[1] DIOVAN[1] IRBESARTAN[1] LOSARTAN[1] MICARDIS TABS[1]	MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL	8 8 8 8 8 8	ATACAND TABS AVAPRO COZAAR EDARBI TEVETEN TABS TRIBENZOR[2]	Use PA Form# 20420 1. Preferred products only available without PA if patient on diabetic therapy or prior ACE therapy. 2. Use preferred active ingredients which are available without PA.	The initial criteria to use any ARB is that the member must have failed ACE inhibitors (such as due to coughing) in the past or must currently be actively treated for diabetes and Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
DIRECT RENIN INHIBITOR				MC/DEL MC/DEL MC/DEL		AMTURNIDE TEKTURNA[1] TEKAMLO	1. Must show failure of single and combination therapy from all preferred antihypertensive categories. Use PA Form# 20420	
ANTIHYPERTENSIVES - CENTRAL	MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL		CATAPRES-TTS CLONIDINE HCL TABS GUANFACINE HCL TABS HYDRALAZINE HCL TABS HYLOREL TABS METHYLDOPA TABS MINOXIDIL TABS PRAZOSIN HCL CAPS RESERPINE TABS	MC/DEL MC/DEL MC MC MC/DEL MC MC/DEL		CATAPRES TABS CLONIDINE TTS GUANABENZ ACETATE TABS ISMELIN TABS MINIPRESS CAPS NEXICLON TENEX TABS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ACE INHIBITORS AND CA CHANNEL BLOCKERS				MC/DEL MC MC/DEL MC/DEL	8 8 9 9	AMLODIPINE/BENAZEPRIL TARKA TBCR AMLODIPINE/BENAZEPRIL LOTREL CAPS	Use individual preferred generic medications. Use PA Form# 20420	
ACE AND THIAZIDE COMBO'S	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		BENAZEPRIL HCL/HYDROCHLOR CAPTOPRIL/HYDROCHLOROTHIA ENALAPRIL MALEATE/HCTZ TABS LISINOPRIL-HCTZ TABS LOTENSIN HCT TABS	MC/DEL MC MC/DEL MC/DEL MC MC/DEL		ACCURETIC TABS MONOPRIL HCT TABS PRINZIDE TABS UNIRETIC TABS VASERETIC TABS ZESTORETIC TABS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
BETA BLOCKERS AND DIURETIC COMBO'S	MC/DEL MC/DEL MC/DEL		ATENOLOL/CHLORTHALIDONE BISOPROLOL FUMARATE/HCTZ PROPRANOLOL/HCTZ	MC/DEL MC/DEL MC MC MC/DEL		CORZIDE TABS LOPRESSOR HCT TABS TENORETIC TIMOLIDE 10/25 TABS ZIAC TABS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ARB'S AND CA CHANNEL BLOCKERS	MC/DEL MC/DEL MC/DEL		AZOR EXFORGE[1] EXFORGE HCT[1]	MC/DEL		TWYNSTA	1. Preferred products only available without PA if patient on diabetic therapy or prior ACE therapy. Use PA Form# 20420	
ARB'S AND DIURETICS	MC/DEL MC/DEL MC/DEL MC/DEL		BENICAR HCT[1] LOSARTAN HCT[1] MICARDIS HCT TABS[1] VALSARTAN-HYDROCHLOROTHIAZIDE[1]	MC/DEL MC/DEL MC MC/DEL MC/DEL MC	7 8 8 8 8 8	IRBESARTAN HYDROCHLOROTHIAZIDE ATACAND HCT TABS AVALIDE TABS[1] DIOVAN HCT TABS[1] HYZAAR TABS TEVETEN HCT TABS	1. Preferred products only available without PA if patient on diabetic therapy or prior ACE therapy. Use PA Form# 20420	Same initial criteria as the ARB class and Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANGIOTENSIN MODULATORS-ARB COMBINATION				MC/DEL MC		EDARBYCLOR ENTRESTO	Use PA Form# 20420	
ARB'S AND DIRECT RENIN INHIBITOR COMBINATION				MC/DEL		VALTURNA	Use PA Form# 20420	
DIURETICS	MC/DEL MC/DEL		ACETAZOLAMIDE TABS BUMETANIDE	MC/DEL MC/DEL		ALDACTAZIDE TABS ALDACTONE TABS	1. Multiples of Spironolactone 25 mg are	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the

	MC/DEL	**CHLOROTHIAZIDE TABS**	MC/DEL	**AMILORIDE HCL**	cheaper than 50 mg strength. Inspra will be approved for severe breast tenderness and male gynecomastia.	preferred drug(s) exists.
	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 the Prior Authorization form, such as the presence of 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 the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**COLESTIPOL HCl**	MC/DEL		**PREVALITE**		
				MC		**QUESTRAN**		
				MC/DEL		WELCHOL TABS		
CHOLESTEROL - FIBRIC ACID DERIVATIVES	MC		ANTARA	MC/DEL		**LOPID**	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		FENOFIBRATE	MC/DEL		**FIBRICOR**		
	MC/DEL		**GEMFIBROZIL TABS**	MC		LIPOFEN		
	MC/DEL		NIASPAN	MC/DEL		**LOFIBRA**		**DDI:** Fenofibrate is preferred but will require a prior authorization requests if used concurrent with Warfarin.
	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 the Prior Authorization form, such as the presence of a 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**		
			VYTORIN	MC/DEL		**SIMVASTATIN 80MG**[1,2]	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.
	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 the Prior Authorization form, such as the presence of 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 the Prior Authorization form, such as the presence of a 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 inhbitors.

							Use PA Form#10500	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.
PULMONARY ANTI-HYPERTENSIVES								
PULMONARY ANTI-HYPERTENSIVES	**MC/DEL** **MC** **MC**		SILDENAFIL[4] EPOPROSTENOL INJ[6] VENTAVIS[2]	**MC** **MC/DEL** **MC/DEL** **MC** **MC** **MC** **MC/DEL**		ADCIRCA[1] **ADEMPAS**[6,7] FLOLAN[6] OPSUMIT[7,8] ORENITRAM REMODULIN[6] REVATIO[3]	1. See Criteria Section. 2. See Criteria Section. 3. See Criteria Section. 4. See Criteria Section. 5. There will be dosing limits of one 20ml multidose vial/ 30 days supply without pa. 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	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significat potential drug interation between another drug and the preferred drug(s) exists. 1. Adcirca approvals will require WHO Group 1 diagnosis of primary PAH (Primary Pulmonary Hypertension) and NYHA functional class 2 or 3. 2. Ventavis approvals will require WHO Group 1 diagnosis of primary PAH (Primary Pulmonary Hypertension) and NYHA functional class 3 or 4. 3. Revatio approvals will require WHO Group 1 diagnosis of primary PAH (Primary Pulmonary Hypertension) and NYHA functional class 2 or 3. 3. Revatio approvals will require WHO Group 1 diagnosis of primary PAH (Primary Pulmonary Hypertension) and NYHA functional class 2 or 3. 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 the Prior Authorization form, such as the presence of 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 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 8	GRANISETRON AKYNZEO[1] 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 Use PA Form# 20420 for all others	Preferred drugs and step therapy must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. * Ondansetron limits still apply as listed on the Ondansetron PA form for covered indications including chemotherapy, radiotherapy, post operative nausea & vomiting and hyperemesis gravidarum. Other medical indications will be approved or denied on a case by case basis. Hyperemesis and other medical indications approved are still subject to failure of multiple preferred antiemesis drugs. Akynzeo- Concomitant use should be avoided in patients who are chronically using a strong CYP3A inducer such as rifampin.
NON-SEDATING ANTIHISTAMINES / DECONGESTANTS								
ANTIHISTIMINES - NON-SEDATING	MC MC/DEL MC MC MC/DEL MC		ALAVERT TABS CETIRIZINE TABS CLARITIN (OTC) CLARITIN SYRP (OTC) LORATADINE TAVIST ND (OTC)	MC MC MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL	5 5 5 5 5 8 8 8 8 8 9	CLARINEX TABS[1,5] CLARINEX SYR[1,2] FEXOFENADINE[1] ZYRTEC[1] ZYRTEC SYR[1,2] ALLEGRA[3] CLARITIN[3] DESLORATADIN LORATADINE ODT[4] LEVOCETIRIZINE[4] XYZAL[3]	1. Must fail preferred drugs, OTC loratidine and cetirizine before moving to non-preferred step order drugs. 2. Clarinex and Zyrtec syrp <6 yr w/o PA. 3. Must fail all step 5 drugs (Clarinex, Fexofenadine and Zyrtec) before moving to next step product. 4. All OTC versions of loratadine ODT are now non-preferred. 5. Pa's for Clarinex RediTabs will only be approved if between the ages of 6-11 years old. Use PA Form# 20530	Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. No combination product with decongestant will be approved since pseudoephedrine available without PA. Pseudoephedrine is available with prescription.
ANTIHISTIMINES - OTHER	MC/DEL MC/DEL		CLEMASTINE CHLORPHENIRAMINE				Use PA Form# 20530	

	MC/DEL		DIPHENHYDRAMINE					
ALLERGY / ASTHMA THERAPIES								
ANAPHYLACTIC DEVICES	MC/DEL MC/DEL		**AUVI- Q** **EPIPEN**	MC		TWINJECT		
ALLERGEN IMMUNOTHERAPY				MC/DEL MC/DEL MC		GRASTEK[1] RAGWITEK[1] ORALAIR[1]	Use PA Form# 20420 1. See criteria section	Prescriber must provide the testing to show that the patient is allergic to the components in the prescribed therapy and must provide a clinically valid rationale why single agent sublingual therapy is being chosen over subcutaneous therapy Treatment must start 12 weeks before expected onset of pollen season and only after confirmed by positive skin test or in vitro testing for pollen-specific IgE antibodies for short ragweed pollen (Ragwitek), timothy grass or cross-reactive grass pollens (Grastek), or any of the 5 grass species contained in Oralair Have an auto-injectable epinephrine on-hand **Grastek :** Patient age ≥5 years and ≤65 years **Ragwitek:** Patient age ≥18 years and ≤65 years **Oralair:** Patient age ≥10 years and ≤65 years
ANTIASTHMATIC - ANTICHOLINERGICS - INHALER	MC/DEL		SPIRIVA HANDIHALER[1,2]	MC/DEL MC/DEL MC/DEL		**SPIRIVA RESPIMAT** **TUDORZA** **INCRUSE ELLIPTA[3]**	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 Spiriva is primarily being used for that condition. 3. Quantity limit of 1 inhalation daily	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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 - PHOSPHODIESTERASE 4 INHIBITORS				MC/DEL		DALIRESP	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANTIASTHMATIC - ANTICHOLINERGICS - NEBULIZER	MC/DEL		**IPRATROPIUM BROMIDE SOLN**	MC		ATROVENT SOLN	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANTIASTHMATIC - ANTIINFLAMMATORY AGENTS	MC/DEL		CROMOLYN SODIUM NEBU	MC/DEL		XOLAIR[1]	1. Need max inhaled steroids and written by pulmonary or allergy specialist Use PA Form# 20420	Xolair approval will require suboptimal response to maximal doses of inhaled steroid as evidenced by asthmatic ER/Hospital admissions and Allergy/Pulmonary specialist management.
ANTIASTHMATIC - NASAL STEROIDS	MC/DEL MC/DEL MC/DEL		**FLUTICASONE SPR[3]** NASONEX SUSP[3] OMNARIS SPR[3]	MC/DEL MC/DEL MC/DEL MC/DEL MC MC	5 8 8 8 8 8	BECONASE AQ INHA[1,3] DYMISTA FLONASE SUSP[2,3] FLUNISOLIDE SOLN[1,3] QNASL RHINOCORT AERO[2,3]	Use PA Form# 20420 1. All preferred drugs must be tried before moving to non preferred steps.	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 MC MC MC/DEL MC/DEL MC/DEL	8 8 8 8 8 9	RHINOCORT AQUA SUSP[2,3] TRI-NASAL SOLN[2,3] VANCENASE POCKETHALER AERS[2,3] VERAMYST[2,3] ZETONNA TRIAMCINOLONE NS	2. All step 5 medications need to be tried before moving to step 8's. 3. Dosing limits apply to whole category, please see dosage consolidation list.	
ANTIASTHMATIC - NASAL MISC.	MC/DEL		CROMOLYN NASAL 4%	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 MC/DEL MC/DEL MC/DEL MC MC MC MC		**ACCUNEB NEBU** **ALBUTEROL AER** **ALBUTEROL HFA** **ALBUTEROL 0.63mg/3ml** **ARCAPTA[3]** **BRETHINE** **FORADIL AEROLIZER CAPS** **PROAIR HFA[3]** PROAIR RESPICLICK **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 the Prior Authorization form, such as the presence of 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 MC/DEL		**ANORO ELLIPTA** **COMBIVENT RESPIMAT** DUONEB SOLN[1] **STIOLTO**	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		**AMINOPHYLLINE TABS** THEOCHRON TB12 THEOLAIR-SR TB12 **THEOPHYLLINE CR TB12** THEOPHYLLINE ELIX THEOPHYLLINE SOLN **THEOPHYLLINE ER CP12**	MC/DEL MC MC/DEL		**THEO-24 CP24** THEOLAIR TABS **UNIPHYL TBCR**	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.

	MC/DEL		**THEOPHYLLINE ER TB12**					
ANTIASTHMATIC - STEROID INHALANTS	MC/DEL		ASMANEX[4,5]	MC/DEL	5	**AEROBID AERS[2,4]**	1. No PA for Pulmicort susp if under 8 years old. 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. 6. Not approved for children <12 years of age Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**FLOVENT DISKUS[4]**	MC	5	BECLOVENT AERS[2,4]		
	MC/DEL		**FLOVENT HFA[4]**	MC	5	VANCERIL AERS[2,4]		
	MC/DEL		**PULMICORT FLEXHALER**	MC/DEL	8	**AEROBID-M AERS[3,4]**		
	MC/DEL		**PULMICORT SUSP[1,4]**	MC	8	AEROSPAN		
	MC		QVAR AERS[4]	MC/DEL	8	ALVESCO[4]		
				MC/DEL	8	**ARNUITY ELLIPTA[6]**		
				MC/DEL	8	**ASMANEX HFA**		
				MC	8	VANCERIL DOUBLE STRENGTH AERS[3,4]		
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 1.Montelukast Granules will only be approved if between ages of 6months-24 months. 2.Singulair Chewables 4mg from 2years-5years and Singulair Chewables 5mgs from 6years-14years old.	
	MC/DEL		**MONTELUKAST SODIUM CHEW TAB**	MC/DEL	8	**ACCOLATE TABS**		
				MC/DEL	8	**SINGULAIR[2]**		
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	8	GLASSIA		
				MC	8	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 AND COMBINATIONS				MC		ORKAMBI		

AND COMBINATIONS				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
IDIOPATHIC PULMONARY FIBROSIS				MC		ESBRIET[1]	1. Diagnosis required	Ofev- Avoid concomitant use with P-gp and CYPA4 inducers (e.g. carbamazepine, phenytoin, and St. John's wort
				MC/DEL		**OFEV[1]**	Use PA Form# 20420	Esbriet- The concomitant use with strong CYP1A2 inhibitors (e.g. fluvoxamine, enoxacin) is not recommended
COUGH/COLD								
COUGH/COLD	MC/DEL		DEXTRO-GUAIF SYRP[1]				1. All of cough cold preparations are not covered except these preferred products.	All non-preferred products are not covered as permitted by Federal Medicaid regulations and MaineCare Policy.
	MC/DEL		GUAIFENESIN SYRP[1]					
	MC/DEL		PSEUDOEPHEDRINE[1]					
	MC		ROBITUSSIN DM SYRP[1]					
	MC		ROBITUSSIN SUGAR FREE SYRP[1]				Use PA Form# 20420	
DIGESTIVE AIDS / ASSORTED GI								
GI - ANTIPERISTALTIC AGENTS	MC/DEL		DIPHENOXYLATE	MC/DEL		LOFENE TABS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. As listed in MaineCare Policy, certain drugs require specific diagnoses for approval.
	MC/DEL		DIPHENOXYLATE/ATROPINE	MC		LONOX TABS		
	MC/DEL		LOPERAMIDE HCL CAPS/LIQ	MC		MOTOFEN TABS		
	MC/DEL		OPIUM TINCTURE TINC					
	MC		PAREGORIC TINC					
GI - ANTI-DIARRHEAL/ ANTACID - MISC.	MC		**ATROPINE SULFATE SOLN**	MC/DEL		**BELLADONNA ALKALOIDS & OP**	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **As listed in MaineCare Policy, certain drugs require specific diagnoses for approval**.
	MC/DEL		BENTYL SYRP	MC/DEL		BENTYL TABS	1.Dosing limits apply please refer to Dose Consolidation List	
	MC/DEL		BISMATROL	MC		CUVPOSA		
	MC/DEL		BISMUTH SUBSALICYLATE	MC		ED-SPAZ		
	MC/DEL		CALCIUM CARBONATE (ANTACID) CHEW	MC		FULYZAQ[1]		
	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		Preferred products that used to require diag codes still require diag codes unless indicated otherwise.
	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- BILE ACID				MC		CHOLBAM		Indication of bile acid synthesis disorders due to single enzyme defects (SEDs) AND for adjunctive treatment of peroxisomal disorders (PDs)
GI - H2-ANTAGONISTS	MC/DEL		CIMETIDINE	MC		AXID CAPS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		FAMOTIDINE	MC		AXID AR TABS		
	MC/DEL		RANITIDINE 150MG TABS	MC/DEL		NIZATIDINE CAPS		
	MC/DEL		RANITIDINE SYRP	MC/DEL		PEPCID		
	MC		ACID REDUCER TABS	MC		PEPCID AC		**DDI:** Ranitidine and cimetidine will now be non-preferred and require prior authorization if it is currently being used with any sulfonylurea (except for glyburide).
				MC/DEL		RANITIDINE 150MG CAPS		
				MC/DEL		ZANTAC SYRP		
				MC/DEL		ZANTAC TABS		**DDI:** Cimetidine will require prior authorization if being used in combination with Plavix.
GI - PROTON PUMP INHIBITOR	MC/DEL		DEXILANT (KAPIDEX)[2]	MC/DEL	6	NEXIUM CPDR[4]	1. Prevacid Solutabs available without PA for children less than 9 years old.	All preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs (in step-order) will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		OMEPRAZOLE 20MG[2]	MC	7	PRILOSEC OTC[4]		
	MC/DEL		PANTOPRAZOLE	MC	7	ACIPHEX TBEC[4]		

				MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC	8 8 8 8 8 8 8 8 9	PREVACID CPDR[4,5] PREVACID SOLUTABS[1] PRILOSEC CPDR PROTONIX INJ PROTONIX[2] OMEPRAZOLE 10MG[2] OMEPRAZOLE-SODIUM BICARBONATE CAPS LANSOPRAZOLE OMEPRAZOLE 40MG[3]	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	Patients obtaining refills as of 7/10/09 will begin to require prior authorizations if they have been on any PPI longer than 60 days in the past year. The 12-month period is patient specific and begins 12 months before the requested date of prior authorization. Payment for usage beyond these limits will be authorized for cases in which there is a diagnosis of: 1. Barrett's esophagus. 2. Erosive esophagitis 3. Hypersecretory conditions (Zollinger-Ellison syndrome, systemic mastocytosis, multiple endocrine adenomas). Recurrent peptic ulcer disease after documentation of previous trials and therapy failure with at least one histamine H2-receptor antagonist at full therapeutic doses and with documentation of either failure of Helicobacter pylori treatment or anegative Helicobacter pylori test result. 4. Symptomatic gastroesophageal reflux after documentation of previous trials and therapy failure with at least onehistamine H2-receptor antagonist at full therapeutic doses. Patients may be required to step down from a PPI to a histamine H2-receptor antagonist during the 12 months or on an annual clinical review if PPI therapy is continued. **DDI:** Omeprazole will require prior authorization if being used in combination with Plavix. **DDI:** Prevacid, Omeprazole and pantoprazole will now be non-preferred and require prior authorization if they are currently being used in combination with any of the following medications: Ampicillin, B-12, Fe salts, Griseofulvin, Sporanox, Ketoconazole, Reyataz, or Vantin. **DDI:** All non-preferred PPIs require prior authorization, but with any prior authorization request, the member's drug profile will also be monitored for current use with ampicillin, B-12, Fe salts, griseofulvin, itraconazole, ketoconazole, Reyataz or Vantin due to a significant drug-drug interaction.
GI - ULCER ANTI-INFECTIVE				MC MC MC		HELIDAC PREVPAC PYLERA	Use PA Form# 20420	
GI - PROSTAGLANDINS	MC		MISOPROSTOL TABS	MC/DEL		CYTOTEC TABS	Use PA Form# 20420	Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drug will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
GI - DIGESTIVE ENZYMES	MC/DEL MC/DEL MC/DEL MC		CREON[1] LACTASE CHEW LACTASE TAB ZENPEP[1]	MC/DEL MC MC/DEL MC/DEL MC/DEL		LACTRASE CAPS PANCREAZE PERTZYE ULTRESA VIOKACE	Use PA Form# 20420 1. Clinical PA is required to establish CF diagnosis and medical necessity. In all cases except cystic fibrosis patients, objective evidence of pancreatic insufficiency (fat malabsorption test etc...) must be supplied.	Non -Preferred drugs must be tried and failed in step-order due to lack of efficacy or intolerable side effects before other non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
GI - ANTI - FLATULENTS / GI STIMULANTS	MC MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL		CALULOSE SYRP CONSTULOSE SYRP ENULOSE SYRP[1] GASTROCROM CONC GENERLAC SYRP[1] LACTULOSE SYRP[1] METOCLOPRAMIDE HCL SIMETHICONE	MC/DEL MC MC/DEL MC/DEL		AMITIZA[2] CEPHULAC SYRP INFANTS GAS RELIEF SUSP REGLAN TABS	1. Diag codes no longer necessary for preferred products. Lactulose has 60cc/day QL Use PA Form# 20420 2. Prior failed trials of multiple other preferred GI agents must occur first, Such as OTC senna, docusate, lactulose, polyethylene glycol.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **As listed in MaineCare Policy, certain drugs require specific diagnoses for approval.**
GI - INFLAMMATORY BOWEL AGENTS	MC MC MC/DEL MC MC MC MC MC/DEL		APRISO AZULFIDINE TABS BALSALAZIDE CANASA SUPP COLAZAL CAPS DIPENTUM CAPS PENTASA CPCR 250MG ROWASA ENEM	MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL MC MC		ASACOL 800MG HD AZULFIDINE EN-TABS TBEC DELZICOL GIAZO LIALDA TABS[1] PENTASA 500MG[2] SFROWASA UCERIS RECTAL FOAM[3]	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 the Prior Authorization form, such as the presence of 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/DEL	SULFAZINE EC TBEC	MC	UCERIS TABS[3]	3. Diagnosis required	Uceris Rectal Foam or Tab- Concomitant use with CYP3A inhibitors (e.g. ketoconazole, itraconazole, ritonavir, indinavir, saquinavir, erythromycin, cyclosporine, and grapefruit juice) should be avoided. Verify prior trials and failures or intolerance of preferred treatments
	MC/DEL	SULFASALAZINE TABS				
GI - IRRITABLE BOWEL SYNDROME AGENTS			MC/DEL	LOTRONEX TABS	Use PA Form# 20420	Lotronex will be approved for females with IBS and predominant diarrhea. Prior failed trials of multiple preferred GI agents must occur first. IBS dx must be thoroughly documented.
GI- SHORT BOWL SYNDROME			MC	GATTEX		Gattex requires a diagnosis of adult SBS who are dependent on parenteral support. Appropriate colonoscopy and lab assessments 6months prior to starting
MISCELLANEOUS GI						
GI - MISC.	MC/DEL	BISAC-EVAC SUPP	MC/DEL	ACTIGALL CAPS	1. Must show evidence of trials of preferred agents that do not require PA, such as OTC senna, docusate, mineral oil and prescription lactulose.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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		Preferred products that used to require diag codes still require diag codes unless indicated otherwise.
	MC	BISCOLAX SUPP	MC/DEL	CARAFATE		
	MC	CINOBAC CAPS	MC/DEL	CLEARLAX POW		
	MC/DEL	CITRATE OF MAGNESIA SOLN	MC/DEL	COLACE CAPS		
	MC/DEL	CITRUCEL	MC/DEL	COLYTE		
	MC/DEL	DIOCTO SYRP	MC	DIOCTO-C SYRP	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	3.Multiple preferred agents and dietary changes are required.	
	MC	HIPREX TABS	MC/DEL	FIBER-LAX TABS		
	MC/DEL	KRISTALOSE PACK	MC	GOLYTELY SOLR		
	MC	MAALOX	MC/DEL	LINZESS	Use PA Form# 20420	
	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/DEL	MOVANTIK[3]		
	MC/DEL	SENNA	MC	PEG 3350 POWDER[2]		
	MC/DEL	SENOKOT GRAN	MC	PEG-ELECTROLYTES SOLR		
	MC/DEL	SENOKOT SYRP	MC	PREPOPIK PAK		
	MC/DEL	SENOKOT CHILDRENS SYRP	MC/DEL	SENEXON TABS		
	MC	SENOKOT XTRA TABS	MC/DEL	SENOKOT TABS		
	MC/DEL	STOOL SOFTENER CAPS	MC	SENOKOT S TABS		
	MC/DEL	SUCRALFATE TABS	MC/DEL	SORBITOL		
	MC	UNI-EASE CAPS	MC	STOOL SOFTENER PLUS CAPS		
	MC	UNIFIBER POWD	MC/DEL	UNI-CENNA TABS		
	MC	URSO FORTE	MC	UNI-EASE PLUS CAPS		
	MC/DEL	URSODIOL	MC	V-R NATURAL SENNA LAXATIV TABS		
			MC	URSO 250		
MISC. UROLOGICAL						
UROLOGICAL - MISC.	MC	ACETIC ACID 0.25% SOLN	MC	CITRIC ACID/SODIUM CITRAT SOLN	1. Elmiron requires adequate proof of Dx with supportive testing.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC	CYTRA-K SOLN	MC/DEL	CYTRA-2 SOLN		
	MC	FURADANTIN SUSP	MC/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 MC MC/DEL		URISED TABS UROCIT-K UROQID #2 TABS					
PHOSPHATE BINDERS								
PHOSPHATE BINDERS	MC/DEL MC/DEL MC MC/DEL		ELIPHOS[1] MAGNEBIND - 400[1] PHOSLYRA[1] RENAGEL[1]	MC MC/DEL MC/DEL MC/DEL MC		AURYXIA CALCIUM ACETATE FOSRENOL[1] RENVELA[1] VELPHORO[1]	Use PA Form# 20420 1. Diag required.	
INTRA-VAGINALS								
VAGINAL - ANTIBACTERIALS	MC/DEL MC/DEL MC/DEL MC/DEL		CLEOCIN CREA METROGEL VAGINAL GEL[2] METRONIDAZOLE VAGINAL GEL[2] CLEOCIN SUPP[1]	MC/DEL MC/DEL		NUVESSA VANDAZOLE	1. Step order must be followed to avoid PA. Must fail Cleocin Cream and Metronidazole products before moving to next step product without PA. 2. Dosing limits apply, please see Dosage Consolidation List. Use PA Form# 20420	Preferred drugs must be tried and failed in step-order due to lack of efficacy or intolerable side effects before less preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
VAGINAL - ANTI FUNGALS	MC MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL MC MC/DEL MC MC		CLINDESSE CREA CLOTRIMAZOLE CREA GYNE-LOTRIMIN CREA MICONAZOLE CREA MICONAZOLE 3 COMBO PACK KIT[1] MICONAZOLE 7 CREA MICONAZOLE NITRATE CREA NYSTATIN TABS TERCONAZOLE 0.4MG VAGITROL V-R MICONAZOLE-7 CREA	MC MC MC MC MC/DEL MC MC MC/DEL MC/DEL		AVC CREA CLOTRIMAZOLE 3 DAY CREA GYNAZOLE-1 CREA GYNE-LOTRIMIN 3 TABS MICONAZOLE 3 SUPP TERAZOL 3 CREA TERAZOL 7 CREA TERCONAZOLE 0.8MG TERCONAZOLE SUPP	1. Quantity limit: 1/script/2 weeks Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **DDI:** Miconazole will require prior authorization if being used in combination with Warfarin.
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 MC/DEL		**ESTRING RING** **PREMARIN CREA**	MC/DEL MC/DEL		ESTRACE CREA[1] VAGIFEM TABS[1]	1. Must fail all preferred products before non-preferred. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
VAGINAL - OTHER	MC/DEL MC MC		ACID JELLY GEL ACI-JEL GEL CERVICAL AMINO ACID CREA	MC		AMINO ACID CERVICAL CREA	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
BPH								
BPH	MC/DEL MC/DEL MC/DEL MC/DEL		**DOXAZOSIN MESYLATE TABS** FINASTERIDE[1] TERAZOSIN HCL CAPS **TAMSULOSIN HCL**	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL	5 8 8 8 8 8 8 8	**FLOMAX CP24** ALFUZOSIN AVODART[2,4] **CARDURA TABS**[4] JALYN[3,4] PROSCAR TABS[4] RAPAFLO[4] UROXATRAL[4]	1. There will be dosing limits of 1 tab per day with out PA. 2. Prior use of preferred agent prior to any approvals. 3. Use of preferred (tamsulosin and finasteride) and (tamsulosin and non-preferred Avodart).	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.

							4. Non-preferred products must be used in specified order. Use PA Form# 20420	
ANXIOLYTICS								
ANXIOLYTICS - BENZODIAZEPINES	MC/DEL		ALPRAZOLAM TABS	MC/DEL	8	ALPRAZOLAM ER	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		CHLORDIAZEPOXIDE HCL CAPS	MC/DEL	8	ATIVAN		
	MC/DEL		CLORAZEPATE DIPOTASSIUM TABS	MC/DEL	8	NIRAVAM		
	MC/DEL		DIAZEPAM	MC/DEL	8	SERAX		
	MC/DEL		LORAZEPAM	MC/DEL	8	TRANXENE		
	MC/DEL		OXAZEPAM CAPS	MC/DEL	8	XANAX TABS		
				MC/DEL	9	XANAX XR		
ANXIOLYTICS - MISC.	MC/DEL		BUSPIRONE HCL TABS	MC		BUSPAR TABS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		HYDROXYZINE HCL SOLN	MC		DROPERIDOL SOLN		
	MC		HYDROXYZINE HCL SYRP	MC/DEL		HYDROXYZINE HCL TABS		
	MC/DEL		HYDROXYZINE PAMOATE CAPS	MC/DEL		HYDROXYZINE PAMOATE 100MG CAPS		
	MC/DEL		MEPROBAMATE TABS	MC/DEL		VISTARIL		
ANTI-DEPRESSANTS								
ANTIDEPRESSANTS - MAO INHIBITORS	MC/DEL		NARDIL TABS	MC/DEL		**TRANYLCYPROMIINE**	Use PA Form# 20420	
	MC/DEL		PARNATE TABS					
ANTIDEPRESSANTS - MAO INHIBITORS TOPICAL				MC/DEL		EMSAM[1]	1. Dosing limits apply, please refer to Dose consolidation list. Use PA Form# 20420	Preferred drugs (including a preferred SSRI, a non-SSRI, and Venlafaxine ER) must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANTIDEPRESSANTS - SELECTED SSRI's	MC/DEL		BUPROPION HCL TABS	MC/DEL	8	APLENZIN[7]	1. Use Fluoxetine 20 mg in multiples.	Preferred drugs (including failure of at least one preferred SSRI, one SNRI and one non-SSRI/SNRI) must be tried for at least 4 weeks each and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		BUPROPION SR	MC/DEL	8	BRINTELLIX[13]		
	MC/DEL		BUPROPION XL	MC/DEL	8	CELEXA[4]		
	MC/DEL		CITALOPRAM[4]	MC	8	CYMBALTA[5]	2. See Zoloft splitting table. Sertraline requires splitting of scored tabs to avoid PA.	
	MC/DEL		DULOXETINE	MC/DEL	8	EFFEXOR TABS		
	MC/DEL		ESCITALOPRAM[4]	MC/DEL	8	EFFEXOR XR CP24 [3, 10]		Criteria for new starters <18 years of age: Must have had fluoxetine trial for at least 30 days before accessing other preferred antidepressants without PA.
	MC/DEL		FLUOXETINE HCL CAPS	MC/DEL	8	FETZIMA[12]		
	MC/DEL		FLUOXETINE HCL LIQD	MC/DEL	8	FLUOXETINE 40mg AND 60 mg CAPS[1]		**CYMBALTA:** Fibromyalgia diagnosis- prior use and failure of preferred generics (amitriptyline or cyclobenzaprine) and gabapentin prior to approval.
	MC/DEL		FLUVOXAMINE MALEATE TABS	MC/DEL	8	FLUOXETINE 10mg AND 20mg TABS[6]		**SAVELLA:** Fibromyalgia diagnosis and trial of a preferred generic amitriptyline, cyclobenzaprine and gabapentin prior to approval. Exceptions to the rule are as follows.
	MC/DEL		MIRTAZAPINE	MC	8	FORFIVO XL		
	MC/DEL		NEFAZODONE	MC/DEL	8	IRENKA		
	MC/DEL		PAROXETINE[3]	MC/DEL	8	KHEDEZLA[14]		
	MC/DEL		SERTRALINE HCL[2]	MC/DEL	8	LEXAPRO TABS[4]	3. Strong caution with pediatric population.	1. If the member (<18) is already an established user for any of the preferred or non-preferred drugs under the Antidepressant category on the PDL, then they can continue to get that drug.
	MC/DEL		TRAZODONE HCL TABS	MC	8	LUVOX TABS		
	MC/DEL		VENLAFAXINE ER CAPS[9]	MC	8	MAPROTILINE HCL TABS	4. See Celexa/Citalopram and Lexapro splitting tables.	2. If the member (<18) has a prescription for an antidepressant that is on the PREFERRED side of the PDL and has had a 30 day supply of Fluoxetine at least 30 days before the date they are getting it filled, the claim will pay. If they do not have the trial of Fluoxetine in their profile, the claim will reject for PA required.
				MC/DEL	8	MIRTAZAPINE ODT		
				MC	8	OLEPTRO		3. If the member (<18) has a prescription for a medication that is on the NON-PREFERRED side of the PDL regardless of having Fluoxetine in their profile, the prescription will need a PA.
				MC/DEL	8	PAROXETINE CR[3]		
				MC/DEL	8	PAXIL[3]	5. Max daily dose allowed is 60mg, only 1 capsule per day allowed for all strengths. Combination of multiple strengths require PA.	4. Use of a preferred antidepressant for anxiety will require the diagnosis of anxiety on written prescription and submitted during claim submission.
				MC/DEL	8	PAXIL CR [3]		
				MC/DEL	8	PRISTIQ		**DDI:** Fluvoxamine will now be non-preferred and require prior authorization if it is currently being used with glimepiride (Amaryl).
				MC	8	PROZAC		
				MC	8	PROZAC CAPS		**DDI:** Preferred nefazodone will now be non-preferred and require prior authorization if it is currently being used in combination with either Onglyza 5mg, Enablex 15mg or Vesicare 10mg.
				MC	8	PROZAC WEEKLY CPDR	6. Use Fluoxetine 10mg tabs in multiples.	**DDI:** Fluoxetine will require prior authorization if being used in combination with Plavix.
				MC/DEL	8	REMERON TABS		**DDI:** Fluvoxamine will require prior authorization if being used in combination with Plavix.
				MC/DEL	8	SARAFEM CAPS		
				MC/DEL	8	TRAZODONE HCL 300MG TABS	7. Provide clinical documentation as to why a preferred generic alternative cannot be used.	
				MC/DEL	8	WELLBUTRIN TABS		
				MC/DEL	8	WELLBUTRIN SR TBCR		
				MC/DEL	8	WELLBUTRIN XL		
				MC/DEL	8	REMERON SOLTAB TBDP		

				MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL	8 8 8 8 9 9	SAVELLA[8] ZOLOFT VENLAFAXINE TABS[9] VENLAFAXINE ER TABS[9] VIIBRYD FLUOXETINE 90mg TABS[11]	8. Dosing limits allowing 2 tabs/day and a max daily limit of 200mg / day applies. Please see dose consolidation list. 9. Dosing limits and max daily dose applies. Limit of 1 per day of 37.5mg, 75mg, will be allowed without pa, along with limits of 2 caps per day of the 150mg strength. Max daily dose allowed is 375mg. 10. Use venlafaxine ER tabs. 11. Non-preferred products must be used in specified step order. 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	**SAVELLA: Fibromyalgia diagnosis and trial of a preferred generic amitriptyline, cyclobenzaprine, duloxetine and gabapentin prior to approval.**
ANTIDEPRESSANTS - TRI-CYCLICS	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC MC		**AMITRIPTYLINE HCL TABS[1]** **ANAFRANIL CAPS[1]** **DESIPRAMINE HCL TABS[1]** **DOXEPIN HCL[1]** **IMIPRAMINE HCL TABS[1]** **NORTRIPTYLINE HCL[1]** PROTRIPTYLINE HCL TABS[1] SURMONTIL CAPS[1]	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC MC		**AMOXAPINE TABS** **CLOMIPRAMINE HCL CAPS** **DOXEPIN HCL 150 MG[2]** **NORPRAMIN TABS** **PAMELOR** TOFRANIL VIVACTIL TABS	1. Users over the age of 65 require a pa. 2. Use multiples of 50mg. Use PA Form# 20420 Use PA Form# 10220 for Brand Name requests	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
SEDATIVE / HYPNOTICS								
SEDATIVE/HYPNOTICS - BARBITURATE	MC MC/DEL MC MC/DEL		BUTISOL SODIUM TABS[1] CHLORAL HYDRATE SYRP[1] MEBARAL TABS[1] PHENOBARBITAL[1]	MC MC/DEL		LUMINAL SOLN SOMNOTE CAPS	1. PA required for new users of preferred products if over 65 years. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
SEDATIVE/HYPNOTICS - BENZODIAZEPINES	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		DORAL TABS[1] ESTAZOLAM TABS[1] FLURAZEPAM HCL CAPS[1] TEMAZEPAM CAPS 15 & 30MG[1] TRIAZOLAM TABS[1]	MC MC MC/DEL MC/DEL		HALCION TABS[1] MIDAZOLAM HCL SYRP RESTORIL CAPS[1] TEMAZEPAM 7.5MG[1]	1. Dosing limits apply, please see dosing consolidation list. Use PA Form# 30110	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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
SEDATIVE/HYPNOTICS - Non-Benzodiazepines	MC/DEL MC	1 1	MIRTAZAPINE TRAZODONE	MC/DEL MC/DEL	7 7	AMBIEN[1] **ESZOPICLONE**	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/DEL	1	ZOLPIDEM [2]	MC/DEL	7	**ZOLPIDEM ER**	2. Quantity limits will be allowed up to 30/30, but intermittent therapy is recommended.	preferred drug(s) exists.
	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.
				MC/DEL	8	BELSOMRA[1]	3. Only zolpidem trial/failure will be required to obtain Zaleplon.	
				MCDEL	8	EDLUAR		DDI: Belsomra® with strong CYP3A inhibitors (e.g. ketoconazole, itraconazole, posaconazole, clarithromycin, nefazodone, ritonavir, saquinavir, nelfinavir, indinavir, boceprevir, telaprevir, telithromycin, and conivaptan) is not recommended
				MC	8	HETLIOZ		
				MC/DEL	8	INTERMEZZO		
				MC/DEL	8	LUNESTA[1]		
				MC/DEL	8	SONATA CAPS[1]	4. Must fail all preferred products before non-preferred	
				MC/DEL	8	ROZEREM	Use PA Form# 30110	
				MC/DEL	8	ZOLPIMIST		
ANTI-PSYCHOTICS								
ANTIPSYCHOTICS - ATYPICALS	MC		ABILIFY TABS[3,4]	MC/DEL	8	ABILIFY DISC TAB, INJ and SOL[2]	If prescribing 2 or more antipsychotics, PA will be required for both drugs, except if one is Clozapine.This also includes combination of Seroquel with Seroquel XR.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Non preferred atypicals will be approved for patients with FDA-approved indications, and for specific conditions supported by at least two published peer-reviewed double-blinded, placebo-controlled randomized trials that are not contradicted by other studies of similar quality and as long as all first line preferred therapies have been tried and failed at full therapeutic doses for adequate durations (at least two weeks). * Abilify: doses above 15mg were not shown to be more effective than doses in the 10-15mg range.
	MC/DEL		**OLANZAPINE**[4]	MC/DEL	8	ABILIFY MAINTENA		
	MC/DEL		RISPERIDONE TAB[4]	MC	8	FANAPT		
	MC/DEL		RISPERIDONE SOLN[4]	MC/DEL	8	GEODON		
	MC/DEL		QUETIAPINE[4,6]	MC	8	INVEGA		
	MC/DEL		**ZIPRASIDONE**[4]	MC	8	INVEGA SUSTENNA		
				MC/DEL	8	INVEGA TRINZ INJ		
				MC	8	LATUDA		Prescriptions for quetiapine are limited to a maximum daily dose of 800mg.
				MC	8	REXULTI	Use PA form# 20440 for Multiple Antipsychotic requests	
				MC	8	RISPERDAL TAB		**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 CONSA [2]		
				MC	8	RISPERDAL M TAB[2]		**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	8	RISPERDAL SOLN		**• schizophrenia**
				MC/DEL	8	RISPERIDONE ODT		**• bipolar disorder**
				MC/DEL	8	SAPHRIS	Use PA form# 10130 for non preferred single therapy atypical requests	**• agitation related to autism**
				MC/DEL	8	SEROQUEL 50MG TABS[1,2]	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 TABS		If prescribing 2 or more antipsychotics, PA will be required for both drugs, except if one is Clozapine.This also includes combination of Seroquel with Seroquel XR.
				MC	8	ZYPREXA ZYDIS TBDP [2]	2. Established users of single therapy atypicals were grandfathered	
				MC	8	ZYPREXA RELPREVV		
				MC/DEL	8	SEROQUEL TABS	3. Abilify requires splitting of tab to avoid PA. Please see Abilify splitting table.	
				MC/DEL	9	SEROQUEL XR[5]	4. Prior Authorization will be required for preferred medications for members under the age of 5. 5. Product is considered line extension of the original product due to Healthcare Reform (HCR). MaineCare will consider these medications non-preferred and a step 9 because of the impact under the Federal Rebate Program in conjunction with HCR.	

							6. Dosing limits apply: 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 MC		CLOZARIL TABS FAZACLO	Use PA Form# 20420	Preferred generic drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred brand will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Patients previously stabilized on brand name drug will be approved. **DDI:** Clozapine will now be non-preferred and require prior authorization if it is currently being used in combination with carbamazepine. Please use Drug-Drug Interaction PA form #10400.
ANTIPSYCHOTICS - TYPICAL	MC/DEL MC/DEL MC/DEL MC MC/DEL MC MC MC/DEL MC/DEL MC MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL		CHLORPROMAZINE HCL FLUPHENAZINE DECANOATE FLUPHENAZINE HCL HALDOL HALOPERIDOL HALOPERIDOL DECANOATE SOLN HALOPERIDOL LACTATE SOLN LOXAPINE SUCCINATE CAPS LOXITANE-C CONC MOBAN TABS PERPHENAZINE PROCHLORPERAZINE SERENTIL THIORIDAZINE HCL THIOTHIXENE TRIFLUOPERAZINE HCL TABS	MC/DEL MC/DEL MC MC/DEL MC MC/DEL MC MC		COMPAZINE COMPRO SUPP HALDOL DECANOATE LOXITANE CAPS MELLARIL NAVANE CAPS PROLIXIN STELAZINE TABS	Use PA Form# 20420 If prescribing 2 or more antipsychotics, PA will be required for both drugs, except if one is Clozapine.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. If prescribing 2 or more antipsychotics, PA will be required for both drugs, except if one is Clozapine.
LITHIUM								
LITHIUM	MC/DEL MC/DEL		LITHIUM CARBONATE LITHIUM CITRATE SYRP	MC/DEL MC/DEL		ESKALITH CAPS ESKALITH CR TBCR	Use PA Form# 20420	
COMBINATION - PSYCHOTHERAPEUTIC								
PSYCHOTHERPEUTIC COMBINATION	MC/DEL MC/DEL		CHLORDIAZEPOXIDE/AMITRIPT PERPHENAZINE/AMITRIPTYLIN	MC	8	SYMBYAX[1]	1. Only available if component ingredients are unavailable. Use PA Form# 20420	
STIMULANTS								
STIMULANT - AMPHETAMINES -SHORT ACTING	MC/DEL MC/DEL MC/DEL		ADDERALL TABS[1,4] DEXTROAMPHET SULF TABS[1,3] DEXEDRINE[1,3,4]	MC/DEL MC MC		AMPHETAMINE SALT COMBO[1,3] EVEKEO PROCENTRA	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. 4. Max daily dose of 50mg. Use PA Form# 20420	
STIMULANT - LONG ACTING AMPHETAMINES SALT	MC		VYVANSE[2,3,4]	MC MC/DEL	8 9	ADDERALL XR CP24[1,3,4] AMPHETAMINE/DEXTROAMPHET ER	Use PA Form# 20420 1. As per recent FDA alert,	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

							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.	Quillivant is only indicated for use in patients 6 years of age and older. Prior trials of preferred products
LONG ACTING AMPHETAMINES	MC		DEXEDRINE CAP CR[1,2,3]	MC		DEXTROAMPHET SULF CPCR[3]	1. Preferred stimulants will be available without PA if diagnosis of ADHD. 2. As per recent FDA alert, Adderall & Dexedrine should not be used in patients with underlying heart defects since they may be at increased risk for sudden death. 3. Dosing limits applly, please see dosing consolidation list. Use PA Form# 20420	
STIMULANT - METHYLPHENIDATE	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		FOCALIN TABS[1,2] METADATE ER TBCR[1,2] METHYLIN ER TBCR[1,2] METHYLIN TABS[1,2] METHYLIN SOL[1] METHYLPHENIDATE HCL[1,2]	MC MC/DEL		METHYLIN CHEWABLES RITALIN FAZACLO	1. Preferred stimulants will be available without PA if diagnosis of ADHD. Use PA Form# 20420 2. Dosing limits apply, please see dosing consolidation list. Maximum daily doses are as follows: 72mg daily for methylphenidate and 36mg daily for dexmethylphenidate.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Please refer to General Criteria category E.
STIMULANT - METHYLPHENIDATE - LONG ACTING	MC/DEL MC/DEL MC/DEL MC/DEL		DAYTRANA[1,3] FOCALIN XR[1] METHYLPHENIDATE ER TABS RITALIN LA[4]	MC MC MC MC/DEL MC	5 8 8 8 8	METADATE CD CPCR APTENSIO CONCERTA TBCR[2] METHYLPHENIDATE ER CAPS[1,2,4] QUILLIVANT XR	1. Preferred stimulants will be available without PA if diagnosis of ADHD. 2. Non-preferred products must be used in specified step order. 3.FDA approval currently only for ages 6-16. Limit of one patch daily. Max dose of 30MG daily.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.

							4.Dosing limits applly, please see dosing consolidation list. Use PA Form# 20420	
STIMULANT - STIMULANT LIKE	MC/DEL		**GUANFACINE ER**	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]	Use PA Form# 20710 for Xenazine	
				MC		XENAZINE	1.See criteria section	
WEIGHT LOSS								
WEIGHT LOSS							No longer covered: PHENTERMINE, XENICAL,DIDREX, and MERIDIA	Weight loss drugs are not covered as permitted by Federal Medicaid regulations and Maine Medicaid (MaineCare) Policy.
ALZHEIMER DISEASE								
ALZHEIMER - Cholinomimetics/Others	MC/DEL		DONEPEZIL HYDROCHLORIDE TABS[1]	MC	6	ARICEPT TABS[2]	1. PA is required to establish dementia diagnosis and baseline mental status score.	Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs (in step-order) will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		DONEPEZIL HYDROCHLORIDE ODT[1]	MC	6	ARICEPT ODT[2]		
	MC/DEL		EXELON[1]	MC/DEL	7	DONEPEZIL HYDROCHLORIDE TABS 23MG		
	MC/DEL		NAMENDA[1]	MC/DEL	7	**GALANTAMINE CAPS**		
	MC/DEL		NAMENDA XR CAPS[1]	MC/DEL	8	NAMZARIC	2. Must fail all preferred products before moving to non-preferred.	
				MC	8	RAZADYNE[2]		
				MC/DEL	8	RIVASTIGMINE TARTRATE CAPS[2]	Use PA Form# 20420	
				MC	9	COGNEX CAPS[2]		
SMOKING CESSATION								
NICOTINE PATCHES / TABLETS	MC/DEL		CHANTIX[1]	MC/DEL		NICODERM CQ PT24[1]	Use PA Form# 20420	As of July 1, 2014 per MaineCare policy, smoking cessation products will be covered without a copay(including MEDEL). No annual or lifetime limits, must follow FDA approved

	MC/DEL		NICOTINE DIS PT24[1]				1. See criteria section for exemptions	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.
NICOTINE REPLACEMENT - OTHER	MC/DEL		NICOTINE POLACRILEX GUM[1]	MC/DEL MC/DEL MC/DEL MC	8 8 8 8	NICOTROL INHALER[1,2] NICOTROL NASAL SPRAY[1,2] NICORETTE GUM[1,2] NICORETTE LOZENGES	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.
ALCOHOL DETERRENTS								
ALCOHOL DETERRENTS	MC MC MC/DEL		ANTABUSE TABS DISULFIRAM TABS NALTREXONE HCL TABS	MC/DEL		**ACAMPRO[1]**	1. Should only be used in conjunction with formal structured outpatient detoxification program. Use PA Form# 20420	Preferred generic drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
MISCELLANEOUS ANALGESICS								
ANALGESICS - MISC.	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL		ACETAMINOPHEN **ASPIRIN** ASPRIN/ APAP/ CAFF TAB BUTAL/ASA/CAFF BUTALBITAL COMPOUND BUTALBITAL/ACET TABS BUTALBITAL/APAP CAPS BUTALBITAL/APAP/CAFFEINE **CHOLINE MAGNESIUM TRISALI** **DIFLUNISAL TABS** EXCEDRIN **SALSALATE TABS**	MC MC/DEL MC/DEL MC MC MC/DEL MC MC MC MC MC MC		AXOCET CAPS ESGIC-PLUS FIORICET TABS FIORINAL CAPS FIORTAL CAPS FORTABS TABS PHRENILIN TABS PHRENILIN FORTE CAPS TRILISATE LIQD TRILISATE TABS ZEBUTAL CAPS ZORPRIN TBCR	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
LONG ACTING NARCOTICS								
NARCOTICS - LONG ACTING	MC/DEL MC MC/DEL MC/DEL MC/DEL		FENTANYL PATCH[4] KADIAN METHADONE METHADOSE MORPHINE SULFATE ER TB12	MC MC/DEL MC MC/DEL MC MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL	8 8 8 8 8 8 8 8 8 8 8	AVINZA BUTRANS[4] DURAGESIC PT72[4] EMBEDA EXALGO HYSINGLA ER MORPHINE SULFATE SUPP MS CONTIN TB12 OPANA ER ORAMORPH SR TB12 OXYCONTIN TB12[1]	Use PA Form# 20510 Use PA form #10300 for PAs over the opiate limit 1. Oxycontin will be available without PA for patients treated for or dying from cancer or hospice patients. CA (cancer) or HO (hospice) diag code may be used but store must verify since all scripts will be audited and stores will be liable.	Preferred drugs (Fentanyl Patch, Morphine Sulfate ER tab, 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;

				MC	8	XARTEMIS ER		2.Multiple instances of early refill overrides due to reports of misplacement, stolen, dropped in toilet or sink, distant travel, etc.;
				MC	8	ZOHYDRO ER		3.Breaches of narcotic contracts with any provider;
				MC/DEL	9	NUCYNTA ER		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;
				MC/DEL	9	OXYCODONE ER[3,5]	2. Established users are grandfathered. 3. Oxycodone ER allowed only 2 per day for all strengths except 80 mg, where 4 are allowed to 4. Dosing limits apply. Please see dose consolidation list. 5. Non-preferred products must be used in specific order.	5.Failing to take or pass random drug testing; 6.Failing to provide old records regarding prior use of narcotics; 7.Receiving controlled substances from other prescribers that the provider submitting the PA is unaware of 8.Documented history of substance abuse. Substance abuse evaluations may be required for patients with medical records displaying documented substance abuse or potential signs of narcotic misuse and abuse such as chronic early refills, short dosing intervals, frequent dose increases, multiple lost/stolen etc scripts and intolerance or "allergy" to all products but Oxycontin. 9.Circumventing MaineCare prior authorization requirements for narcotics by paying cash for affected narcotics (prescribers failed to submit prior authorization prior to cash narcotic scripts being filled by member). 10.Requests for any Brand name controlled substance, considered by authorities to be highly abused and diverted (Oxycontin, Percocet, Typox, Vicodin, Dilaudid, Ultracet...) with an available AB rated generic equivalent will be denied unless it will be provided in a setting that virtually eliminates the risk of diversion. 11.Allergic reactions to any product within a specific narcotic class will justify and preclude use of any other product in the same class due to the risk of cross-hypersensitivity. Hysingla ER- Concomitant use should be avoided with mixed agonist/antagonist analgesics, partial agonist analgesics, and MAOIs. Verify prior trials and failures or intolerance of preferred treatments
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 medical records displaying potential signs of narcotic misuse and abuse such as chronic early refills, short dosing intervals, frequent dose increases, multiple lost/stolen etc scripts and intolerance or "allergy" to all products but Oxycontin. Allergic reactions to any product within a specific narcotic class will justify and preclude use of any other product in the same class due to the risk of cross-hypersensitivity. **Effective 1/01/2013, MaineCare will implement a 15 day limit for members prescribed opiates for their treatment of pain.** 1. MaineCare members will be allowed over a rolling 12 month period up to a 15 day supply of an opiate without prior authorization 2. Members requiring longer than 15 days will require a PA for continuation of therapy and providers may provide medical necessity 3. Members may be eligible for up to three prior authorizations of up to 14 day supplies of opiates during the 12 month period 4. MaineCare members that are in Hospice care or are being treated for a diagnosis of Cancer, HIV or AIDS will be exempt from these limits 5. Post surgical members may receive prior authorizations for opiates up to 60 days in length if medical necessity is provided by the Surgeon **Please see the Pain Management Policy_Sec. 80 tab for the complete criteria**
MISCELLANEOUS NARCOTICS								
NARCOTICS - MISC.	MC/DEL		ACETAMINOPHEN/CODEINE	MC/DEL	8	ABSTRAL	1. Fentanyl OT loz (Barr) and Capital and codeine suspension products require PA for users over 18 years of age. PA is not required if under 18 years of age.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Please refer to General Criteria category E.
	MC/DEL		ASPIRIN/CODEINE TABS	MC/DEL	8	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	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.	
	MC/DEL		FENTANYL OT LOZ1	MC/DEL	8	HYDROCODONE/IBUPROFEN		**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
	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		**Please see the Pain Management Policy_Sec. 80 for the complete criteria**
	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	3. Only preferred manufacturer's products will be available without prior authorization.	
	MC		ROXIPRIN TABS	MC	8	PHRENILIN W/CAFFEINE/CODE CAPS		
				MC/DEL	8	ROXICET 5/500 TABS		
				MC	8	ROXICODONE TABS		
				MC	8	SYNALGOS-DC CAPS		
				MC	8	TALACEN TABS		
				MC	8	TREZIX		
				MC	8	TYLENOL/CODEINE #3 TABS		
				MC	8	TYLOX CAPS		
				MC	8	XOLOX		
				MC	8	VICODIN		
				MC	8	VICOPROFEN TABS		
				MC	8	ZYDONE TABS		
				MC	9	ACTIQ LPOP		

				MC MC	9 9	CONZIP OPANA	Use PA Form# 20420 Use PA form #10300 for PAs over the opiate limit	
OPIOID DEPENDENCE TREATMENTS	MC		SUBOXONE FILM[2]	MC MC MC/DEL MC		SUBOXONE TABS[3] BUNAVAIL[4] BUPRENORPHINE[1,2] ZUBSOLV[4]	Use PA Form# 10200 for Suboxone Continuation Use PA Form# 10100 for Suboxone Restart 1. Buprenorphine will only be approved for use during pregnancy. 2. See Criteria Section 3. The manufacturer will be disconntinuing the tablets by the end of quarter one 2013.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Suboxone Criteria 1. Effective 1/1/2013, MaineCare will implement a 24 month lifetime limit for members prescribed Suboxone for the treatment of opioid addiction. 2. Prior authorization request will be reviewed for dose titration downward,whether the patient is engaged in recovery oriented support services,periodic urine drug screens, flim counts,factors that threaten stability of recovery or evidence of improvement is social,physical and occupational areas. 3. Members that stop treatment after 24 months and need to restart will require a prior authorization. This prior authorization will assess the patient risk of relapsing or evidence that the patient has relapsed.

							4. 24month lifetime limit for treatment of opioid addiction	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** **MC** **MC/DEL** **MC/DEL**		EVZIO NALOXONE INJ REVIA TABS[1] VIVITROL INJ[2]	Use PA Form# 20420 Use PA form# 30400 for Vivitrol requests 1. Will only be approved for side effects experienced with generic that are not described in the literature as occurring with the brand version. 2. Please see the criteria listed on the Vivitrrol PA form. Any narcotics attempting to be filled during Vivitrol approval will require prior authorization.	Please see the criteria listed on the Vivitrrol PA form.
COX 2 / NSAIDS								
COX 2 INHIBITORS - SELECTIVE / HIGHLY SELECTIVE	**MC/DEL** **MC/DEL** **MC/DEL** **MC/DEL**		CELEBREX CAPS [4,5,6] KETOROLAC TROMETHAMINE [2,3,6] NABUMETONE TABS[6] MELOXICAM[1,6]	**MC/DEL** **MC/DEL** **MC/DEL**		**MOBIC[6]** MOBIC SUSP[6] **RELAFEN TABS[6]**	Use PA Form# 10310 1. Meloxicam has dosing limits allowing one tablet daily of all strengths without PA. 2. Ketorolac Tromethamine is indicated for the short term (up to 5 days) managment of moderately severe acute pain that requires analgesic at the opiod level in adults. Not indicated for minor of chronic pain conditions.	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.

							3. Ketorolac has dosing limits allowing 24 tablets for a 5 day supply every 30 days. 4. Dosing limits will be set at a maximum of 200mg twice daily for PA requests. 5. Users 60 years of age or older will not require PA. If under 60 years of age, Celebrex will require PA. 6. The FDA has issued a Public Health Advisory warning of the potential for increased cardiovascular risk & GI bleeding with NSAID use.	
NSAIDS	MC/DEL		**CHILDRENS IBUPROFEN**	MC		ADVIL TABS	The FDA has issued a Public Health Advisory warning of the potential for increased cardiovascular risk & GI bleeding with NSAID use.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Approvals will be granted for other requests based on failure of at least one generic NSAID from at least 3 different NSAID classes as described in the COX-II PA form.
	MC/DEL		**DICLOFENAC POTASSIUM TABS**	MC		ANAPROX TABS		
	MC/DEL		**DICLOFENAC SODIUM**	MC		ANAPROX DS TABS		
	MC/DEL		**ETODOLAC**	MC		CAMBIA		
	MC/DEL		**FENOPROFEN CALCIUM TABS**	MC/DEL		**CATAFLAM TABS**		
	MC/DEL		**FLURBIPROFEN TABS**	MC		CHILDRENS ADVIL SUSP		
	MC/DEL		**IBUPROFEN**	MC		CHILD'S IBUPROFEN SUSP		
	MC/DEL		**INDOMETHACIN**	MC/DEL		CHILDREN'S MOTRIN SUSP	Use PA Form# 20420	
	MC/DEL		**KETOPROFEN**	MC/DEL		**CLINORIL TABS**		
	MC/DEL		**MECLOFENAMATE SODIUM CAPS**	MC/DEL		**DAYPRO TABS**		
	MC/DEL		NAPROSYN SUSP	MC/DEL		**EC-NAPROSYN TBEC**		**DDI:** Diclofenac will now be non-preferred and require prior authorization if it is currently being used in combination with lescol.
	MC/DEL		NAPROXEN SUSP	MC/DEL		**ETODOLAC ER 600MG**		
	MC/DEL		**NAPROXEN TABS**	MC		FELDENE CAPS		The FDA has issued a Public Health Advisory warning of the potential for increased cardiovascular risk & GI bleeding with NSAID use.
	MC/DEL		**NAPROXEN SODIUM TABS**	MC/DEL		IBU-200		
	MC/DEL		**OXAPROZIN TABS**	MC		INDOCIN		
	MC/DEL		**SULINDAC TABS**	MC/DEL		**LODINE**		
	MC/DEL		**TOLMETIN SODIUM**	MC/DEL		**MOTRIN**		
				MC		NALFON CAPS		
				MC/DEL		NAPRELAN TBCR		
				MC/DEL		NAPROSYN TABS		
				MC/DEL		**NAPROXEN DR TBEC**		
				MC/DEL		**NAPROXEN SODIUM TBCR**		
				MC		PENNSAID		
				MC/DEL		**PIROXICAM CAPS**		
				MC		PONSTEL CAPS		
				MC		SB IBUPROFEN TABS		
				MC		SPRIX		
				MC		TOLECTIN		
				MC/DEL		VOLTAREN		
				MC		V-R IBUPROFEN TABS		
				MC		ZORVOLEX		
NSAID - PPI				MC		PREVACID NAPRA-PAC	1. Use a preferred NSAID and PPI separately. Use PA Form# 20420	
				MC/DEL		VIMOVO[1]		
			RHEUMATOID ARTHRITIS					
RHEUMATOID ARTHRITIS	MC/DEL	1	**AZATHIOPRINE**	MC/DEL		**ARAVA**	Use PA Form# 20900	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

	MC/DEL MC/DEL MC MC	1 1 2 2	METHOTREXATE **SULFASALAZINE TABS** **ENBREL**[1,4] **HUMIRA**[1,2,4]	MC/DEL MC/DEL MC MC MC MC MC MC/DEL		ENTYVIO **ILARIS**[2,5,6] **KINERET SOLN** ORENCIA RASUVO[7] **REMICADE** SIMPONI **XELJANZ**	Humira without PA. 2. Dosing limits apply. Please see dose consolidation list. 3. Preferred dosage form allowed without PA after trial of step 1 prodcuts is multi-dose vial, with dosing limits allowing 8 injections per 28 days without pa. 4. Established users will be grandfathered for Enbrel and Humira. 5.Clinical PA is required to establish diagnosis and medical necessity. 6. Verification of age for appropriate indication. 7. Treatment failure or intolerance to other forms of preferred methotrexate	pa. Use of greater than 8 injections per month will require PA. **Xeljanz** is limited to adults with moderately to severely active RA who have had an inadequate response or intolerance to methotrexate. Should not be used concomitantly with biologic DMARDs or potent Immunosuppressants. Therapy should not be started in those with lymphocyte count <500cells/mm^3, an ANC <1000cells/mm^3, or have a hemoglobin <9g/dl.
MISCELLANEOUS ARTHRITIS								
ARTHRITIS - MISC.	MC MC		RIDAURA CAPS MYOCHRYSINE SOLN	MC/DEL		**ARTHROTEC**[1]	1. The individual components of Arthrotec are available without PA. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. The individual components of Arthrotec are available without PA.
LUPUS-SLE								
LUPUS-SLE				MC		BENLYSTA	Use PA Form# 20420	
MIGRAINE THERAPIES								
MIGRAINE - ERGOTAMINE DERIVATIVES	MC MC		MIGRANAL SOLN SANSERT TABS	MC/DEL		D.H.E. 45 SOLN	Use PA Form# 10110	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
MIGRAINE - CARBOXYLIC ACID DERIVATIVES	MC		DIVALPROEX ER TB24	MC		DEPAKOTE ER TB24	Use PA Form# 10110	
MIGRAINE - SELECTIVE SEROTONIN AGONISTS (5HT)--Tabs	MC/DEL MC/DEL MC/DEL MC/DEL	1 1 1 2	RELPAX[1] **RIZATRIPTAN TABS** SUMATRIPTAN TABS[1] NARATRIPTAN HCl TABS[1]	MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		AMERGE TABS[1,2] AXERT TABS[1,2] FROVA TABS[1,2] IMITREX TABS[1,2] MAXALT[1,2,3] MAXALT MLT1,2,3 **RIZATRIPTAN ODT** ZOMIG TABS[1,2] ZOMIG NASAL SPARY[1,2] ZOMIG ZMT TBDP[1,2]	1. All drugs in this category have dosing limits. Please refer to dose consolidation table. 2. Must fail all preferred products before non-preferred. 3.Established users will be grandfathered Use PA Form# 10110	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Quantity limit exceptions will require ongoing therapy with therapeutic doses of highly effective prophylactic medication as listed on the Triptan PA form.
MIGRAINE - SELECTIVE SEROTONIN AGONISTS (5HT)--Injectables	MC/DEL MC/DEL MC/DEL MC/DEL		IMITREX KIT IMITREX SOLN IMITREX STATDOSE PEN KIT IMITREX STATDOSE REFILL KIT	MC/DEL		SUMATRIPTAN SOLN	Use PA Form# 10110	
MIGRAINE - SELECTIVE SEROTONIN AGONISTS (5HT)--Combination				MC/DEL		TREXIMET[1,2]	Use PA Form# 10110	

AGONISTS (5HT)--Combinations							1. Dosing limits apply. Please see dose consolidation list. 2. Use preferred Sumatriptan and Naproxen separately. Treximet only available if component ingredients of sumatriptan and naproxen are unavailable.	
MIGRAINE - MISC.	MC/DEL		CAFERGOT TABS	MC/DEL		MIGRAZONE CAPS	Use PA Form# 10110	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		SPASTRIN TABS	MC		BELCOMP-PB SUPP		
				MC/DEL		MIGERGOT SUP		
GOUT								
GOUT	MC/DEL		**ALLOPURINOL TABS**	MC		COLCRYS	Use PA Form# 20420 1. Failure of therapeutic (300mg) dose of Allopurinol (failure define as not being able to get uric acid levels below 6mg/dl) or severe renal disease.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**PROBENECID TABS**	MC/DEL		ULORIC[1]		
	MC/DEL		**PROBENECID/COLCHICINE TABS**	MC		ZYLOPRIM TABS		
MISC.								
ANESTHETICS - MISC.	MC		BUPIVACAINE HCL SOLN	MC		SENSORCAINE-MPF SOLN	Use PA Form# 30130	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		LIDOCAINE HCL SOLN	MC/DEL		SYNVISC INJ		
	MC		MARCAINE SOLN	MC		XYLOCAINE SOLN		
VACCINES	MC/DEL		GARDASIL VACCINES				Use PA Form# 20420	Under the Maine Immunization Program Gardasil is covered under the Vaccine for Children Program for ages 9-18. Gardasil will be preferred by MaineCare for ages 19-26. Children who are 18 years old or younger are eligible for this vaccine through the Maine Immunization Program. Please contact 1-800-867-4775 or 207-287-3746 for assistance.
ANTI-CONVULSANTS								
ANTICONVULSANTS	MC/DEL		CARBAMAZEPINE	MC	8	APTIOM	Use PA Form# 20420 All non-preferred meds must be used in specified order 1. Quantity limit. 5/month 2. Dosing limits apply, please see dose consolidation list. 3. Dosing limits apply per strength as well as a maximum daily dose of 600mg. Please see dose consolidation list. 4. Adjunctive therapy 17 and older. 5. Current users as of 7/30/10 for seizures will be grandfathered. 6. Product is considered line extension of the original product due to Healthcare Reform (HCR). MaineCare	One time PA is required to determine seizure diagnosis for any non-preferred anticonvulsant. Other approvals will be for patients with a variety of drug-specific FDA-approved indications and for specific conditions supported by at least two published peer-reviewed double-blinded, placebo-controlled randomized trials that are not contradicted by other studies of similar quality after recommendation by the DUR Committee and as long as all first line therapies have been tried and failed at full therapeutic doses for adequate durations (at least two weeks). *** SEE CHART AT END OF DOCUMENT Topamax and Neurontin - Second line therapy for migraine prophalaxis after trial of at least three preferred preventive medications from Group 1 listed on page 2 of the Acute Migraine PA form. Lyrica- Second line therapy for Diabetic Peripheral Neuropathy and Post Herpetic Neuralgia. With Fibromyalgia diagnosis, Lyrica will not require PA if previous 4 week trials of the following three are seen in drug profile at full therapeutic doses: TCA or cyclobenzaprine, gabapentin, and savella. All non-preferred meds must be used in specified order. **DDI:** Any Carbamazepine formulation will now be non-preferred and require prior authorization if any of the following drugs are currently being used in combination with carbamazepine: Abilify, clarithomycin, clozapine, erythromycin, Latuda, Seroquel, telithromycin or Zyprexa.
	MC/DEL		CARBATROL CP12	MC	8	BANZEL		
	MC/DEL		CELONTIN CAPS	MC	8	DEPAKENE		
	MC/DEL		CLONAZEPAM TABS	MC	8	DEPAKOTE		
	MC		DEPAKOTE SPRINKLES CPSP	MC	8	DEPAKOTE ER		
	MC/DEL		DIASTAT[1]	MC/DEL	8	DIAZEPAM GEL		
	MC/DEL		DILANTIN	MC/DEL	8	DIVALPROEX SODIUM SPRINKLE CAPS		
	MC/DEL		DIVALPROEX SODIUM	MC/DEL	8	EQUETRO		
	MC/DEL		EPITOL TABS	MC	8	FYCOMPA[2,9]		
	MC/DEL		ETHOSUXIMIDE SYRP	MC/DEL	8	GABITRIL TABS		
	MC/DEL		FELBATOL	MC/DEL	8	HORIZANT		
	MC/DEL		GABAPENTIN[2] 300mg & 400mg	MC/DEL	8	GABAPENTIN 600mg & 800mg		
	MC/DEL		LAMOTRIGINE[2]	MC	8	GRALISE		
	MC/DEL		LEVETIRACETAM SOLN/TABS	MC/DEL	8	KEPPRA TABS		
	MC/DEL		OXCARBAZEPINE	MC/DEL	8	KEPPRA SOLN		
	MC/DEL		PHENYTEK CAPS	MC/DEL	8	KLONOPIN TABS		
	MC/DEL		PHENYTOIN	MC/DEL	8	LAMICTAL		
	MC/DEL		PRIMIDONE TABS	MC/DEL	8	**LEVETIRACETAM INJ**		
	MC/DEL		TEGRETOL	MC/DEL	8	**LEVETIRACETAM ER TABS**		
	MC/DEL		TOPIRAMATE	MC/DEL	8	LYRICA[3]		
	MC/DEL		TOPIRAMATE SPRINKLE CAPS[2]	MC/DEL	8	MYSOLINE TABS		
	MC/DEL		TRILEPTAL SUSP	MC	8	ONFI		
	MC/DEL		VALPROIC ACID	MC	8	OXTELLAR XR[7]		
	MC/DEL		VALPROIC ACID	MC/DEL	8	POTIGA		
	MC/DEL		VIMPAT[4]	MC	8	SABRIL		

	MC/DEL		ZONISAMIDE	MC	8	TOPAMAX	will consider these medications non-preferred and a step 9 because of the impact under the Federal Rebate Program in conjunction with HCR.	Please use Drug-Drug Interaction PA form #10400 for this combination.
				MC	8	TOPAMAX SPRINKLE CAPS[2]		
				MC	8	TROKENDI[2,8]		
				MC/DEL	8	TRILEPTAL		ONFI will require a clinical PA to confirm LGS diagnosis
				MC/DEL	8	ZARONTIN SYRP		
				MC/DEL	9	KEPPRA XR [5,6]		
				MC/DEL	9	NEURONTIN		
				MC/DEL	9	TEGRETOL-XR TB12 [5,6]		
				MC/DEL	9	ZONEGRAN CAPS	7. Max dose 2400mg	
				MC/DEL	9	LAMICTAL XR	8. Clinical PA required for appropriate diagnosis	
							9. Requires previous trials/failure of medications.	
						BIPOLAR DISORDER: STEP ORDER		
					M ~ A		SEE ANTICONVULSANT INDICATION CHART AT THE END OF THIS DOCUMENT M= Monotherapy A= Adjunctive 9= No Evidence The step orders show the relative strength of evidence for use in bi-polar and will guide prior authorization determinations. Step 4 drugs-no PA required.	
					4 ~ 4	LAMICTAL		
					4 ~ 4	LITHIUM		
					4 ~ 4	CARBAMAZEPINE		
					4 ~ 4	VALPROATE		
					4 ~ 4	ATYPICAL ANTIPSYCHOTICS EXC. CLOZAPINE		
					5 ~ 5	TRILEPTAL		
					9 ~ 6	TOPAMAX		
					9 ~ 7	KEPPRA TABS		
					9 ~ 8	GABITRIL TABS		
					9 ~ 9	NEURONTIN		
					9 ~ 9	ZONEGRAN CAPS		
						PEDIATRIC BIPOLAR1 DISORDER: STEP ORDER		
					M ~ A	(6-18 YEARS WITH OR WITHOUT PSYCHOSIS)		
					4 ~ 4	LITHIUM		
					4 ~ 4	CARBAMAZEPINE	Two-step 1 preferred drugs must be tried before Trileptal. The step orders show the relative strength of evidence for use in bi-polar and will guide prior authorization determinations. Step 4 drugs-no PA required.	
					4 ~ 4	VALPROATE		
					4 ~ 4	ATYPICAL ANTIPSYCHOTICS EXC.CLOZAPINE		
					4 ~ 4	LAMICTAL		
					5 ~ 5	TRILEPTA		
ANTI-PARKINSON DRUGS								
PARKINSONS - ANTICHOLINERGICS	MC/DEL		BENZTROPINE MESYLATE TABS				Use PA Form# 20420	
	MC		COGENTIN SOLN					
	MC/DEL		**TRIHEXYPHENIDYL**					
PARKINSONS - COMT INHIBITORS	MC/DEL		**COMTAN TABS**	MC/DEL		**TASMAR TABS**	Use PA Form# 20420	Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
PARKINSONS - SELECTED DOPAMIN AGONISTS	MC/DEL		**PRAMIPEXOLE**	MC/DEL	5	**MIRAPEX TABS[1]**	Use PA Form# 20420 1. As of 12/08 users of Mirapex will be grandfathered if diagnosis is Parkinsons.	Preferred drug must be tried and failed in step-order due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**ROPINIROLE**	MC/DEL	8	**REQUIP TABS**		
				MC/DEL	8	**REQUIP XL TABS**		
				MC/DEL	8	**MIRAPEX ER**		
				MC/DEL	8	**NEUPRO PATCH**		
PARKINSONS - DOPAMINERGICS/CARBII/ LEVO	MC/DEL		**AMANTADINE HCL**	MC/DEL		**APOKYN[3]**	1. Approvals will require concurrent therapy with levodopa and failed trials of	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a 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 TABS**	MC		AZILECT[2]		

	MC/DEL		**CARBIDOPA/LEVODOPA TABS**[3]	MC/DEL		**BROMOCRIPTINE MESYLATE CAPS**	Levodopa and failed trials of Selegiline, Comtan, and Stalevo.	preferred drug(s) exists.
	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		RYTARY		
				MC/DEL		**SELEGILINE TABS HCL**		
				MC		SINEMET TABS		
				MC		SINEMET TBCR	3. Only preferred manufacturer's products will be available without prior authorization.	
				MC		ZELAPAR[1]	Use PA Form# 20420	
PARKINSONS - COMBO.				MC/DEL		STALEVO[1]	Use PA Form# 20420	
				MC		CARBIDOPA/LEVODOPA/ENTACA[1]	1.Clinical PA is required to establish diagnosis and medical necessity.	
MUSCLE RELAXANTS								
ALS DRUG	MC/DEL		**RILUZOLE**	MC/DEL		**RILUTEK TABS**	Use PA Form# 20420	
MUSCLE RELAXANTS	MC/DEL		**BACLOFEN TABS**	MC/DEL	6	**SKELAXIN TAB**		At least 4 preferred drugs (including tizanidine) must be tried for at least 2 weeks and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an…… acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Elderly patients, over 65, will require written notice of the increased sedative risks and impaired driving.Prior Authorization will not be given for:1. frequent or persistent early refills of controlled drugs; 2. multiple instances of early refill overrides due to reports of misplacement, stolen, dropped in toilet or sink, distant travel, etc.
	MC/DEL		**CHLORZOXAZONE TABS**	MC/DEL	7	**ORPHENADRINE CITRATE**		
	MC/DEL		**CYCLOBENZAPRINE HCL TABS**	MC/DEL	8	**CARISOPRODOL 350MG TABS**		
	MC		LIORESAL INTRATHECAL KIT	MC/DEL	8	AMRIX		
	MC/DEL		**METHOCARBAMOL TABS**	MC/DEL	8	DANTRIUM CAPS		
	MC/DEL		**TIZANIDINE HCL TABS**	MC	8	LIORESAL TABS		
				MC	8	LORZONE		Non-preferred drugs will not be approved if members circumventing MaineCare prior authorization requirements by paying (prescribers failed to submit prior authorization prior to cash narcotic scripts being filled by member).
				MC/DEL	8	**METAXALONE**		
				MC	8	NORFLEX TBCR		Non-preferred products must be used in specified step order.
				MC	8	ROBAXIN-750 TABS		
				MC	8	VECUROMIUM INJ		**Lorzone** is non preferred and requires at least 4 preferred drugs (including tizanidine) and step care therapy (orphenadrine), as well as reasons for why chlorzoxazone is not acceptable.
				MC/DEL	8	**ZANAFLEX TABS**		
				MC/DEL	9	**CARISOPRODOL 250MG TABS**		
				MC/DEL	9	**SOMA TABS**	Use PA Form# 20420	
MUSCLE RELAXANT - COMBO.				MC/DEL		CARISOPRODOL/ASPIRIN TABS	Use PA Form# 20420	Individual components are available with PA described in the section above.1. frequent or persistent early refills of non-controlled drugs; 2. multiple instances of early refill overrides due to reports of misplacement stolen, dropped in toilet or sink, distant travel, etc.
				MC/DEL		CARISOPRODOL/ASPIRIN/CODE		
				MC		NORGESIC TABS		
				MC/DEL		ORPHENADRINE COMPOUND		
				MC/DEL		ORPHENADRINE/ASA/CAFF		
				MC		ORPHENGESIC		
PARATHYROID HORMONE								
PARATHYOID HORMONE				MC		NATPARA[1]	1. Recommended only for those who cannot be well-controlled on calcium supplements and active forms of vitamin D alone.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
VITAMINS								
VITAMINS	MC/DEL		ASCORBIC ACID TABS	MC		AQUASOL E SOLN	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **As listed in MaineCare Policy, certain drugs require specific diagnoses for approval.**
	MC		BIOTIN	MC		AQUAVIT-E SOLN	**Please refer to OTC list for covered products.**	
	MC		CYANOCOBALAMIN SOLN	MC		DHT SOLN		
	MC		FERIVA CAP	MC		NASCOBAL GEL		
			FERIVAFA CAP				Click here for the OTC List	
	MC							
	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 for covered products.**
	MC/DEL	NIACIN				**DDI:** B-12 will now be non-preferred and require prior authorization if it is currently being used in combination with either Prevacid, pantoprazole, Prilosec, or any currently non preferred PPI.
	MC	NIACOR TABS				
	MC/DEL	NICOTINIC ACID SR CPCR				
	MC	PYRIDOXINE HCL TABS				Preferred products that used to require diag codes still require diag codes unless indicated otherwise.
	MC/DEL	SLO-NIACIN TBCR				
	MC	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.	Preferred products require dialysis/renal failure diagnosis.
	MC/DEL	**VITAMIN D**	MC	CALCIJEX		Non-preferred products require: Secondary hyperparathyroidism in patients with Chronic Kidney Disease on dialysis., iPTH>400 pg/ml, Phosophorous ,6.5mg/dl, corrected calcium <12.2mg/dl, corrected calcium x phosphorous products <$70mg^2/dl^2$
	MC	ZEMPLAR TABS	MC/DEL	HECTOROL (ORAL)	Use PA Form# 20420	
			MC/DEL	HECTOROL (PARENTERAL)		
			MC/DEL	**ROCALTROL**		
			MC	ZEMPLAR INJ		
MISC MULTI-VITAMINS						
VITAMINS - MISC.	MC	CENTRUM LIQD	MC	ADEKS	1. Diag codes are no longer required on prenatal vitamins.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. As listed in MaineCare Policy, certain drugs require specific diagnoses for approval.
	MC	CENTRUM TABS	MC/DEL	ADVANCED NATALCARE TABS		
	MC	CENTRUM JR/IRON CHEW	MC	AQUADEKS		
	MC	CENTRUM SILVER TABS	MC	CENTRUM JR/EXTRA C CHEW	**Please refer to OTC list.**	
	MC	CENTRUM-LUTEIN TABS	MC	CENTRUM PERFORMANCE TABS		**Please refer to OTC list.**
	MC	CEROVITE ADVANCED FO TABS	MC	CITRANATAL	Use PA Form# 20420	
	MC/DEL	CHEWABLE MULTIVIT/FL CHEW	MC	DALYVITE LIQD		Preferred products that used to require diag codes still require diag codes unless indicated otherwise.
	MC	COD LIVER OIL CAPS	MC	EMBREX 600 MISC		
	MC	COMPLETE SENIOR TABS	MC	IBERET	Click here for the OTC List	
	MC	DAILY MULTI VIT/IRON	MC	MATERNA TABS		
	MC/DEL	DIALYVITE 1MG	MC	MAXARON		
	MC/DEL	DIALYVITE 800MG	MC	MULTIRET FOLIC -500 TBCR		
	MC	FERRALET 90	MC/DEL	NATAFORT TABS		
	MC/DEL	FULL SPECTRUM B	MC/DEL	NATALCARE CFE 60 TABS[1]		
	MC	M.V.I.-12 INJ	MC/DEL	NATALCARE GLOSS TABS[1]		
	MC	MULTI-VIT/FLUORIDE	MC	NATALCARE PIC TABS[1]		
	MC/DEL	NATALCARE RX TABS	MC	NATALCARE PIC FORTE TABS[1]		
	MC/DEL	NEPHRONEX	MC/DEL	NATALCARE PLUS TABS[1]		
	MC/DEL	O-CAL PRENATAL	MC	NATALCARE THREE TABS[1]		
	MC/DEL	ONE DAILY TABS	MC/DEL	NATACHEW CHEW		
	MC/DEL	ONE-DAILY MULTIVITAMINS	MC	NATALFIRST TABS		
	MC/DEL	ONE-TABLET-DAILY	MC	NATATAB RX TABS		
	MC/DEL	POLY-VIT/IRON/FLUORID SOLN	MC/DEL	NEPHPLEX RX TABS		
	MC/DEL	POLY-VITAMIN/FLUORIDE SOLN	MC/DEL	NEPHROCAPS CAPS		
	MC/DEL	POLY-VITAMINS/IRON SOLN	MC/DEL	NEPHRO-VITE TABS		

	MC/DEL	PRENATAL TABS[1]	MC	NESTABS RX TABS		
	MC/DEL	PRENATAL FORMULA 3 TABS[1]	MC/DEL	NIFEREX		
	MC/DEL	PRENATAL PLUS TABS[1]	MC/DEL	OCUVITE TABS		
	MC/DEL	PRENATAL PLUS NF TABS[1]	MC	POLY-VI-FLOR SOLN		
	MC	PRENATAL PLUS/27MG IRON[1]	MC	POLY-VI-SOL SOLN		
	MC	PRENATAL PLUS/IRON TABS[1]	MC	POLY-VI-SOL/IRON SOLN		
	MC/DEL	PRENATAL RX/BETA-CAROTENE[1]	MC	POLY-VITAMIN DROPS SOLN		
	MC/DEL	RENAL CAPS	MC	PRECARE		
	MC/DEL	RENAPHRO CAPS	MC	PREFERA OB		
	MC	STRESS TAB NF TABS	MC	PREMESIS RX TABS		
	MC	THERAPEUTIC-M TABS	MC	PRENATABS CBF TABS[1]		
	MC	THERAVITE LIQD	MC	PRENATAL CARE TABS[1]		
	MC/DEL	TRI-VITAMIN/FLUORIDE SOLN	MC	PRENATAL MR 90 TBCR[1]		
	MC	VITA CON FORTE CAPS	MC/DEL	PRENATAL MTR/SELENIUM TABS[1]		
	MC	VITAMIN B COMPLEX CAPS	MC	PRENATAL OPTIMA ADVANCE TABS[1]		
	MC	VITAPLEX PLUS TABS	MC	PRENATAL PC 40 TABS[1]		
			MC/DEL	PRENATAL RX TABS[1]		
			MC	PRENATE[1]		
			MC	PRENATE ELITE[1]		
			MC	PRIMACARE MISC		
			MC	PROTEGRA CAPS		
			MC	STUARTNATAL PLUS 3 TABS[1]		
			MC	TRI-VI-SOL SOLN		
			MC	TRI-VI-SOL/IRON SOLN		
			MC/DEL	ULTRA NATALCARE TABS		
			MC	ULTRA-NATAL TABS[1]		
			MC	VICON FORTE CAPS		
			MC	VINATAL FORTE TABS[1]		
			MC	VINATE[1]		
			MC/DEL	VINATE ADVANCED TABS[1]		
MISCELLANEOUS MINERALS						
MINERALS	MC	CALCARB	MC	ANEMAGEN	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. As listed in MaineCare Policy, certain drugs require specific diagnoses for approval.
	MC	CALCI-MIX CAPSULE CAPS	MC	CALCET TABS	**Please refer to OTC list.**	
	MC	CALCIQUID SYRP	MC/DEL	**CALCIUM 600-D TABS**		
	MC	CALCITRATE/VITAMIN D TABS	MC	CALCIUM/VITAMIN D TABS	Click here for the OTC List	
	MC/DEL	CALCIUM	MC	CALTRATE 600 PLUS/VIT D TABS		
	MC/DEL	CALCIUM CARBONATE	MC	CALTRATE PLUS TABS		**DDI:** Fe salts will now be non-preferred and require prior authorization if it is currently being used in combination with either Prevacid, pantoprazole, Prilosec, or any currently non preferred PPI.
	MC/DEL	CALCIUM CITRATE TABS	MC	CHROMAGEN		
	MC/DEL	CALCIUM GLUCONATE TABS	MC	CITRACAL PLUS TABS		
	MC/DEL	CALCIUM LACTATE TABS	MC	CONTRIN CAPS		**Please refer to OTC list.**
	MC	CALCIUM/MAGNESIUM TABS	MC	FEOGEN FORTE CAPS		
	MC/DEL	**CALCIUM/VITAMIN D TABS**	MC	FEROCON CAPS		Preferred products that used to require diag codes still require diag codes unless indicated otherwise.
	MC	CALTRATE 600 TABS	MC/DEL	FERREX 150 CAPS		
	MC/DEL	CHEWABLE CALCIUM CHEW	MC	FERRO-SEQUELS TBCR		
	MC	CITRACAL TABS	MC	FE-TINIC CAPS		
	MC	CITRACAL + D TABS	MC	FE-TINIC 150 FORTE CAPS		
	MC	CITRUS CALCIUM TABS	MC/DEL	FLUOR-A-DAY SOLN		
	MC	CITRUS CALCIUM 1500 + D TABS	MC/DEL	K-DUR TBCR		
	MC	EFFERVESCENT POTASSIUM TBEF	MC	KLOR-CON PACK		
	MC/DEL	FEOSTAT CHEW	MC	K-LYTE		
	MC	FERATAB TABS	MC/DEL	K-PHOS TABS NEUTRAL		
	MC/DEL	FER-GEN-SOL SOLN	MC	K-TABS TBCR		
	MC	FER-IRON SOLN	MC	K-VESCENT PACK		
	MC	FERRONATE TABS	MC	MICRO-K 10 MEG CPCR		

	MC/DEL	FERROUS SULFATE	MC	NU-IRON 150 CAPS		
	MC/DEL	FLUOR-A-DAY CHEW	MC/DEL	**OYSTER SHELL CALCIUM/VITA TABS**		
	MC	FLUORIDE CHEW	MC/DEL	POLY-IRON 150 CAPS		
	MC	FLUORIDE SODIUM CHEW	MC/DEL	POLYSACCHARIDE IRON CAPS		
	MC	FLUORITAB CHEW	MC/DEL	POTASSIUM BICARB/CHLORIDE		
	MC	HEMOCYTE TABS	MC/DEL	POTASSIUM CHLORIDE 10MEQ CAPS		
	MC	HM CALCIUM TABS	MC/DEL	POTASSIUM CHLORIDE 8MEQ CAPS		
	MC	K+ POTASSIUM PACK	MC/DEL	SLOW FE TBCR		
	MC	KAON ELIX	MC	TUMS 500 CHEW		
	MC	KAON-CL-10 TBCR	MC	VIACTIV CHEW		
	MC	KCL 0.075%/D5W/NACL 0.2% SOLN				
	MC	K-EFFERVESCENT TBEF				
	MC	KLOR-CON				
	MC	KLOTRIX TBCR				
	MC/DEL	K-PHOS TABS				
	MC/DEL	K-VESCENT TBEF				
	MC/DEL	LURIDE CHEW				
	MC/DEL	MAGNESIUM GLUCONATE TABS				
	MC/DEL	MAGNESIUM SULFATE SOLN				
	MC	MAGTABS				
	MC	MICRO-K 8 MEG				
	MC/DEL	OS-CAL TABS				
	MC/DEL	**OS-CAL 500 + D TABS**				
	MC/DEL	**OYSCO**				
	MC/DEL	OYST-CAL TABS				
	MC/DEL	**OYST-CAL D TABS**				
	MC/DEL	**OYST-CAL/VITAMIN D TABS**				
	MC/DEL	OYSTER CALCIUM TABS				
	MC/DEL	OYSTER SHELL				
	MC	PHARMA FLUR				
	MC/DEL	PHOSPHA 250 NEUTRAL TABS				
	MC	POTASSIUM BICARBONATE TBEF				
	MC/DEL	POTASSIUM CHLORIDE 8MEQ				
	MC	POTASSIUM EFFERVESCENT				
	MC/DEL	SELENIUM TABS				
	MC	SLOW-MAG TBCR				
	MC/DEL	SODIUM FLUORIDE				
	MC/DEL	SSKI SOLN				
	MC	V-R CALCIUM				
	MC	V-R OYSTER SHELL CALCIUM				
	MC	ZINC SULFATE CAPS				
MISC. ELECTROLYTES/NUTRITIONALS						
ELECTROLYTES/ NUTRITIONALS	MC	INTRALIPID EMUL[1]	MC	BOOST[1]	1. This list of nutritionals is incomplete. All nutritionals still require a PA except for the miscellaneous products listed as preferred. SGA form required for nutritionals unless member has a G/I tube.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **As listed in MaineCare Policy, certain drugs require specific diagnoses for approval.** Medical foods are not to be authorized solely for the purpose of enhancing nutrient intake or managing body weight if the participant is able to eat conventional foods adequately. Medical foods may be approved if the member has a medical condition which precludes or restricts the use of conventional foods and necessitates the use of a formula. Concurrent Stimulant therapy is not an acceptable medical reason/condition for use of medical foods for enhancing nutrient intake or managing body weight.
	MC	P.T.E. -5 SOLN[1]	MC	CASEC POWD[1]		
	MC/DEL	SEA-OMEGA CAPS[1]	MC	CHOICE DM LIQD[1]		
			MC	DELIVER 2.0 LIQD[1]		
			MC	ENFAMIL[1]		
			MC	ENSURE[1]		
			MC	GLUCERNA[1]		
			MC	ISOCAL LIQD[1]		
			MC	KINDERCAL TF LIQD[1]		
			MC	KINDERCAL TF/FIBER LIQD[1]	2. Formerly known as Omacor.	For children under the age of 5, MaineCare will not provide milk- or soy-based standard infant formulas. Regular formulas may be sought through your nearest WIC office. MaineCare will continue to cover medical food for all participants in MaineCare when medical necessity is met.
			MC/DEL	L-CARNITINE CAPS[1]		
			MC	LIPISORB LIQD[1]		
			MC	LOVAZA[1,2]	Use PA Form# 20420	

				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	MC		PROCRIT SOLN[1]	MC	6	EPOGEN SOLN	Use PA Form# 10520 1. Clinical PA is required to establish medical necessity and that appropriate lab monitoring is being done.	Non-Preferred drugs must be tried and failed in step-order, due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Please see the EPO PA form for other approval and renewal criteria.
				MC	8	ARANESP SOLN		
				MC/DEL	8	MIRCERA[1]		
				MC/DEL	8	OMONTYS		
GRANULOCYTE CSF								
GRANULOCYTE CSF				MC	8	LEUKINE	1. Must be used in specified step order. 2.10 day supply/month may be used without a PA. Use PA Form# 20520	See approval criteria detailed on Neupogen PA form.
				MC	8	NEUPOGEN SOLN[2]		
				MC	9	NEULASTA[1]		
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 the Prior Authorization form, such as the presence of 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 the Prior Authorization form, such as the presence of 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]**		
	MC/DEL		HEPARIN LOCK FLUSH SOLN	MC/DEL		SAVAYSAS[5]		**DDI:** Rifampin will require prior authorization if being used in combination with Savaysa
	MC/DEL		HEPARIN SODIUM SOLN	MC/DEL		XARELTO	3. Please refer to Pradaxa PA form for criteria.	
	MC/DEL		HEPARIN SODIUM LOCK FLUSH SOLN				4.Established users will be grandfathered, new starters must use preferred product Coumadin. 5. Diagnosis required	

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

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

	MC/DEL		FLUOROMETHOLONE SUSP	MC		FLUOR-OP SUSP		
	MC		FML S.O.P. OINT	MC/DEL		**LOTEMAX 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		NEOM/POLY/DEX OPTH OINT 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 establish diagnosis and medical necessity. Use PA Form# 20420	Preferred drugs must be tried and failed, in step-order, due to lack of efficacy (failure to reach target IOP reduction) or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**TRAVATAN-Z**	MC	8	LUMIGAN SOLN[1]		
				MC	8	RESCULA[1,2,3]		
				MC/DEL	8	**TRAVATAN SOLN**		
				MC/DEL	8	**TRAVOPROST**		
				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 the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		ATROPINE SULFATE	MC		ISOPTO ATROPINE SOLN		
	MC/DEL		CYCLOPENTOLATE HCL SOLN	MC/DEL		ISOPTO HOMATROPINE SOLN		
	MC/DEL		ISOPTO HYOSCINE SOLN	MC		MUROCOLL-2 SOLN		
OP. - MIOTICS - DIRECT ACTING	MC/DEL		**ISOPTO CARBACHOL SOLN**				Use PA Form# 20420	
	MC		ISOPTO CARPINE SOLN					
	MC		PILOCAR SOLN					
	MC/DEL		**PILOCARPINE HCL SOLN**					
	MC/DEL		**PILOPINE HS GEL**					
OP. - ADRENERGIC AGENTS	MC/DEL		**DIPIVEFRIN HCL SOLN**	MC		PROPINE SOLN	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		EPIFRIN SOLN					
OP. - SELECTIVE ALPHA ADRENERGIC AGONISTS	MC		ALPHAGAN P 0.15% SOLN	MC		ALPHAGAN SOLN	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		SIMBRINZA	MC		ALPHAGAN P 0.1% SOLN		
				MC/DEL		BRIMONIDINE 0.2%		
				MC/DEL		**IOPIDINE SOLN**		
OP. - ANTI-ALLERGICS	MC/DEL		PATADAY SOLN	MC	8	ALOCRIL SOLN	Use PA Form# 20420	All preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		PATANOL SOLN	MC/DEL	8	ALOMIDE SOLN		
				MC	8	BEPREVE		
				MC	8	ELESTAT		
				MC/DEL	8	EMADINE SOLN		
				MC	8	LASTACAFT		
				MC/DEL	8	OPTIVAR		
				MC	8	OPTICROM SOLN		
				MC/DEL	8	PAZEO		
				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.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a 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	Use PA Form# 20420	
OP. - OF INTEREST	MC/DEL		ENUCLENE SOLN	MC		BOTOX SOLR	1. Must have kerato conjuctivitus sicca and failed other dry eye therapies.	Must fail adequate trials of multi agents from artificial tears and lubricant category.
				MC		RESTASIS[1]	Use PA Form# 20420	
DERMATOLOGICAL								
TOPICAL - ORAL	MC		AMNESTEEM[1]				1. Users 24 or under, PA will not be required.	
	MC		CLARAVIS[1]					
	MC		SOTRET[1]				Use PA Form# 20420	
TOPICAL - ACNE PREPARATIONS	MC		AZELEX CREA[4]	MC/DEL		ADAPALENE 0.3% GEL	1. Users 24 or under, PA will not be required.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		BENZOYL PEROXIDE	MC		ACZONE		
	MC/DEL		CLINDAMYCIN PHOSPHATE[2]	MC		ALTINAC CREA	2. Dosing limits allowing one package per month. Please refer to Dose Consolidation List.	
	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	3. Only available if component ingredients are unavailable.	
	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	4. Dosing limits apply, please see dosing consolidation list.	
	MC/DEL		TRETINOIN GEL[1]	MC		CLINDAGEL GEL		
	MC		TRETINOIN CREA[1,2]	MC		CLINDETS SWAB		
				MC		DESQUAM-E GEL		
				MC		DESQUAM-X	5. Not approved for use in children <12 years of age	
				MC		DIFFERIN 0.3% GEL		
				MC		DIFFERIN		
				MC		DUAC GEL		
				MC		EMGEL GEL	Use PA Form# 10220 for Brand Name requests	
				MC		EPIDUO	Use PA Form# 20420 for all other requests	
				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		ONEXTON[5]		
				MC		RETIN-A GEL[2]		
				MC		RETIN-A CREA[2]		
				MC		RETIN-A MICRO GEL		
				MC		SOOLANTRA[4]		
				MC/DEL		TRIAZ		

Class	Preferred status		Preferred drugs	Non-preferred status		Non-preferred drugs	Notes	Criteria
				MC		VELTIN		
				MC		ZENCIA WASH		
				MC		ZETACET		
				MC/DEL		ZIANA		
TOPICAL - ANTIBIOTIC	MC		BACIT/NEOMYCIN/POLYM OINT	MC/DEL		ALTABAX [1]	1. Dosing limits apply, please see dosing consolidation list.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		BACITRACIN OINT	MC/DEL		BACTROBAN OINT.		
	MC/DEL		BACTROBAN CREA[1]	MC/DEL		TRIPLE ANTIBIOTIC OINT		
	MC/DEL		BACTROBAN NASAL OINT				Use PA Form# 20420	
	MC/DEL		CENTANY OINT 2% [1]					
	MC/DEL		GENTAMICIN SULFATE					
	MC/DEL		MUPIROCIN[1]					
TOPICAL - ANTIFUNGALS	MC/DEL		BETAMETHASONE CLOTRIMAZOLE LOT	MC/DEL	8	BETAMETHASONE CLOTRIMAZOLE CREA		
	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 the Prior Authorization form, such as the presence of a 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	1. Diagnosis required	
	MC		ECONAZOLE NITRATE CREA	MC/DEL	8	HYDROCORT/IODOQ CREA		
	MC/DEL		KETOCONAZOLE CREA	MC	8	JUBLIA		
	MC/DEL		KETOCONAZOLE SHAM	MC	8	KERYDIN[1]		
	MC/DEL		LOPROX 1.0 CREA	MC/DEL	8	LAMISIL		**DDI:** Ketoconazole will now be non-preferred and require prior authorization if they are currently being used in combination with any of the following medications: Prevacid, pantoprazole, Onglyza or Omeprazole.
	MC/DEL		LOPROX 1.O LOTN	MC/DEL	8	LOPROX 0.77 LOTN		
	MC/DEL		LOPROX GEL	MC/DEL	8	LOPROX 0.77 CREA		
	MC/DEL		LOPROX TS LOTN	MC/DEL	8	LOPROX 0.77 SUSP		Kerydin- Verify prior trials and failures or intolerance of preferred treatments, including both topical and oral agents
	MC/DEL		LOTRISONE CREA	MC/DEL	8	LOPROX SHAMPOO SHAM		
	MC/DEL		MICONAZOLE NITRATE CREA	MC	8	LOTRIMIN		
	MC		MYCO-TRIACET II CREA	MC/DEL	8	LOTRISONE LOT		
	MC/DEL		NYSTATIN	MC	8	LUZU		
	MC/DEL		NYSTATIN/TRIAMCINOLONE CREA	MC/DEL	8	MENTAX CREA		
	MC/DEL		NYSTOP POWD	MC	8	MYCOGEN II CREA		
	MC		PEDI-DRI POWD	MC	8	NAFTIN		
	MC/DEL		TINACTIN	MC	8	NIZORAL SHAM		
	MC		TRI-STATIN II CREA	MC/DEL	8	NYSTATIN/TRIAMCINOLONE OINT		
				MC	8	NYSTAT-RX POWD		
				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 the Prior Authorization form, such as the presence of 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 the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		TAZORAC	MC		PSORIATEC CREA[1]		
				MC/DEL		SORIATANE CK KIT[1]		
				MC/DEL		TACLONEX[1,2]	2. Individual ingredients are available as preferred witout PA.	
				MC		VECTICAL[1]		
							Use PA Form# 20420	
TOPICAL - ANTISEBORRHEICS	MC/DEL		SELENIUM SULFIDE SHAM	MC		CARMOL SCALP TREATMENT KIT	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
				MC		ZNP BAR		
TOPICAL - ANTIVIRALS				MC/DEL		DENAVIR CREA[1, 3]	1. Must fail oral treatment with Acyclovir or 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		EFUDEX	MC/DEL		CARAC CREA	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		FLUOROPLEX CREA	MC/DEL		FLUOROURACIL		
				MC		SOLARAZE GEL		
				MC/DEL		ZYCLARA		
TOPICAL - BURN PRODUCTS	MC		FURACIN CREA	MC/DEL		SILVADENE CREA	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		SILVER SULFADIAZINE CREA					
	MC		SSD AF CREA					
	MC		SSD CREA					
	MC/DEL		THERMAZENE CREA					
TOPICAL - CORTICOSTEROIDS			**LOW POTENCY**	MC/DEL		ACLOVATE	Use PA Form# 20420 1. Dosing limits apply, please see dosing consolidation list.	At least 1 drug from each potency of preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		DESOWEN[1]	MC		AMCINONIDE CREA		
	MC/DEL		HYDROCORTISONE CREA	MC		ANUSOL HC-1 OINT		
	MC		HYDROCORTISONE LOTN	MC/DEL		**CLOBETASOL PROPINATE LOTN**		
	MC		LACTICARE-HC LOTN	MC		CLODERM CREA		
	MC		NUTRACORT LOTN	MC/DEL		CORDRAN		
	MC		TEXACORT SOLN	MC/DEL		CORMAX		
				MC/DEL		CUTIVATE CREA / OINT		
			MEDIUM POTENCY	MC/DEL		CUTIVATE LOTN		
	MC/DEL		DESOXIMETASONE .05%	MC		DERMA-SMOOTHE/FS OIL		
	MC/DEL		ELOCON	MC/DEL		DERMATOP		
	MC/DEL		FLUOCINOLONE ACETONIDE .025-.01%	MC		DESONATE GEL		
	MC		FLUROSYN CREA	MC/DEL		DIPROLENE		
	MC		FLUTICASONE PROPIONATE CREA/OINT	MC		ELOCON OINT		
	MC		HYDROCORTISONE BUTYRATE	MC		HYDROCORTISONE POWD		
	MC		HYDROCORTISONE OINT	MC		KENALOG AERS		
	MC		HYDROCORTISONE VALERATE	MC		LIDA MANTLE HC CREA		
	MC		MOMETASONE FUROATE OINT	MC/DEL		LOCOID		
	MC/DEL		TRIAMCINOLONE ACETONIDE .025-.1%	MC/DEL		LUXIQ FOAM		
				MC/DEL		OLUX FOAM		
			HIGH POTENCY	MC		PANDEL CREA		
	MC/DEL		BETAMETHASONE DIPROPIONATE	MC		PROCTOCORT CREA		
	MC		CLOBEX LOTN	MC/DEL		PSORCON		
	MC/DEL		DESOXIMETASONE .25%	MC/DEL		PSORCON E		
	MC/DEL		DESONIDE[1]	MC/DEL		TEMOVATE		
	MC/DEL		FLUOCINOLONE ACETONIDE .02%	MC		TOPICORT		
	MC/DEL		FLUOCINONIDE	MC		TOPICORT LP CREA		
	MC		HALOG	MC		ULTRAVATE		
	MC		HALOG-E CREA	MC/DEL		VERDESO		
	MC/DEL		TRIAMCINOLONE ACETONIDE .5%	MC		WESTCORT		
			VERY HIGH POTENCY					
	MC/DEL		AUGMENTED BETA DIP					
	MC/DEL		BETAMETHASONE VALERATE					
	MC/DEL		BETA-VAL					
	MC		DIFLORASONE DIACETATE					
	MC		HALOBETASOL					
			MISCELLANEOUS					
	MC		PROCTO-KIT CREA 1%					
TOPICAL - STEROID LOCAL ANESTHETICS				MC		EPIFOAM FOAM	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
TOPICAL - STEROID COMBINATIONS	MC		DERMA-SMOOTHE/FS ATOPIC P KIT	MC		CARMOL-HC CREA	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.

TOPICAL - EMOLLIENTS	MC/DEL		AMMONIUM LACTATE CREA[1]	MC		LAC-HYDRIN CREA[1]	Use PA Form# 20420 1. Dosing limits still apply. Please see dose consolidation list.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		AMMONIUM LACTATE LOTN 12%[1]	MC		LAC-HYDRIN LOTN 12%		
	MC		VITAMIN A & D MEDICATED OINT	MC		MEDERMA GEL		
				MC		MIMYX		
				MC		RENOVA CREA		
TOPICAL - ENZYMES / KERATOLYTICS / UREA	MC		SANTYL OINT	MC		CARMOL 40 CREA	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Ziox, Panafil and Papain products have been removed from the PDL due to FDA safety concerns regarding drugs containing Papain.
				MC		SALEX CREA		
				MC		SALEX LOTN		
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 the Prior Authorization form, such as the presence of a 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 applications of permethrin.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC	1	ELIMITE CREA	MC		MALATHION		
	MC	1	EURAX	MC		OVIDE LOTN		
	MC	1	LICE KILLING SHAM	MC		SKLICE		
	MC/DEL	1	LICE TREATMENT CREME RINS LIQD	MC		ULESFIA		
	MC/DEL	1	PERMETHRIN LOTN					
	MC	2	NATROBA[1,2]					
TOPICAL - WOUND / DECUBITUS CARE				MC		REGRANEX GEL	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered

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

	MC		STANNOUS FLUORIDE ORAL RI CONC					
ARTIFICIAL SALIVA/STIMULANTS								
ARTIFICIAL SALIVA/STIMULANTS	MC		SALIVA SUBSTITUTE SOLN	MC MC MC		EVOXAC CAPS RADIACARE SOLR SALAGEN TABS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
MISCELLANEOUS ANORECTAL								
ANORECTAL - MISC.	MC/DEL MC MC MC/DEL MC/DEL MC/DEL		COLOCORT ENEM CORTENEMA ENEM ELA-MAX 5 CREA HYDROCORTISONE ENEM PROCTOSOL HC CREA PROCTOZONE-HC CREA	MC/DEL MC/DEL MC/DEL MC/DEL MC		ANUSOL-HC CREA CORTIFOAM FOAM PROCTOFOAM HC FOAM PROCTO-KIT CREA 2.5% RECTIV OINT	Use PA Form# 20420	
T-CELL ACTIVATION INHIBITOR								
PSORIASIS BIOLOGICALS	MC MC		ENBREL[1,2] HUMIRA[1]	MC MC MC		COSENTYX OTEZLA STELARA	1. Will not require a PA if at least one systemic drug such as methotrexate, cyclosporine, methoxsalen or acitretin is in members drug profile. Please refer to dose consolidation list. 2. Preferred dosage form allowed without PA after trial of step 1 prodcuts is multi-dose vial, with dosing limits allowing 8 injections per 28 days without pa. Use PA Form# 20910	Approved for severe chronic plaque psoriasis unresponsive to first line therapies. A trial of at least several potent topicals from the following categories: corticosteroids, coal tars, anthralin, calcipotriene and tazorotene, and at least one systemic drug such as methotrexate, cyclosporine, methoxsalen or acitretin and phototherapy/UVA. Enbrel is preferred after a trial of a step 1 product (e.g. azathioprine, methotrexate, etc.); however, dosing limits will also still apply. Dosing limits will allow 8 injections per month without pa. Use of greater than 8 injections per month will require PA. In addition, the preferred Enbrel 25mg product will be the multi-dose vial (NDC- 58406-0425-34). The single-use prefilled syringes are non-preferred.
ALTERNATIVE MEDICINES								
ALTERNATIVE MEDICINES	MC		DIMETHYL SULFOXIDE SOLN	MC/DEL MC		CO-ENZYME Q-10 MELATONIN TABS	Use PA Form# 20420	Will only be approved for specific conditions supported by at least two double-blinded, placebo-controlled randomized trials that are not contradicted by other studies of similar quality.
CHELATING AGENTS								
CHELATING AGENTS	MC/DEL		**CUPRIMINE CAPS**	MC MC/DEL		DEPEN TITRATABS TABS EXJADE[1]	Use PA Form# 20420 1. FDA indication of treatment of chronic iron ovrload due to blood transfustions in membes 2 years of age and older is requried for approval of Exjade.	
ANTILEPROTIC								
ANTILEPROTIC				MC		THALOMID CAPS[1]	1. All PA requests for 150mg dosing will require use of Thalomid 100mg and 50mg capsules. Use PA Form# 20420	Approved for indications of leprosy, treatment-resistant multiple myeloma and AIDS.
ANTINEOPLASTIC AGENTS								

ANTINEOPLASTIC AGENTS - ANTIADNDROGENS	MC/DEL		BICALUTAMIDE	MC/DEL		CASODEX	Use PA Form# 20420	
ANTINEOPLASTIC AGENTS- LHRH ANALOGS	MC		LUPRON DEPOT[1]	MC MC MC/DEL		VANTAS[2] FIRMAGON[2] TRELSTAR	1. Dosing limits apply, please refer to dosage consolidation list. 2. PA required to confirm FDA approved indication. Use PA Form# 20420	
ANTINEOPLASTIC AGENTS - TYROSINE KINASE INHIBITORS				MC MC/DEL MC		SPRYCEL[1] TYKERB[2] GLEEVEC[1]	Use PA Form# 20420 1. Verification of diagnosis is required. 2. PA required to confirm FDA approved indication and to monitor for potential drug-drug interactions.	
ANTINEOPLASTICS-MISCELLANEOUS	MC MC/DEL		AMIFOSTINE MERCAPTOPURINE	MC MC/DEL MC MC/DEL MC/DEL MC/DEL		DOCEFREZ ETHYOL LEUPROLIDE **OXALIPLATIN** PURINETHOL ZOLINZA	Use PA Form# 20420	
ANTINEOPLASTICS- MONOCLONAL ANTIBODIES				MC/DEL		HERCEPTIN[1]	1. PA required to confirm FDA approved indication. Use PA Form# 20420	
CANCER								
CANCER	MC MC/DEL MC/DEL MC MC/DEL MC MC/DEL		ALIMTA ANASTROZOLE TABS AVASTIN ERBITUX LETROZOLE MEGACE ES VIDAZA	MC/DEL MC/DEL MC MC/DEL MC MC MC/DEL MC/DEL MC MC/DEL MC MC/DEL MC MC MC MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL		ARIMIDEX BOSULIF COMETRIQ[3,4,5] ERIVEDGE FARYDAK FOLOTYN GILOTRIF[4,5] IBRANCE ICLUSIG[3] INLYTA JAKAFI KEYTRUDA[7] LENVIMA LYNPARZA[7] NEXAVAR[1] MEKINIST[3,4] POMALYST STIVARGA SUTENT[1,2] SYLATRON TAFINLAR[3,4,5,6] FEMARA YERVOY XALKORI XTANDI ZELBORAF ZYDELIG ZYKADIA	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. 7. PA required to confirm FDA approved indication Use PA Form# 20420	A clinical PA is required for Inlyta to verify diagnosis and failure of one prior systemic therapies **Xalkori** will be considered for patients with a diagnosis of locally advanced or metastatic non-small cell lung cancer (NSCLC) that is anaplastic lymphoma kinase (ALK)-positive as detected by an FDA- approved test (please included a copy of test results; and is prescribed by an oncologist; quantity limit of 60 tablets per 30 days. **Zelboraf** will be considered for patients 18 years of age or older; has a diagnosis of unresectable or metastatic melanoma with BRAF mutation as detected be an FDA-approved test; prescriber is an oncologist with a quantity limit of 240 tablets per 30 days. **Bosulif** requires a clinical PA, requiring diagnosis. Must have resistance or intolerance to prior therapy (such as imatinib [Gleevec®] or a TKI) seen in drug profile, monthly heptic enzyme tests should be preformed for the first three months of treatment , as clinically indicated. **Iclusig** requires prior trail of TKI therapy, appropriate monitoring and has DDI with strong CYP3A4 inducers **Stivarga** is non-preferred and is for the treatment of metastatic colorectal cancer (CRC) who have been previously treated with fluoropyrimidine- oxaliplatin- and irinotecan-based chemotherapy, an anti-VEGF therapy, and if KRAS wild type, an anti-EGFR therapy).The safety and efficacy of use in children under the age of 18 years have not been established. **DDI:** Cometriq, Ibrance and Tafinlar will require a prior authorization if it is currently being used in combination with drugs known to be significant CYP3A4 inhibitors (ketoconazole, itraconazole, clarithromycin, indinavir, nefazodone, nelfinavir, ritonavir, atazanavir, saquinavir and telithromycin). **Gilotrif** needs to be prescribed by an oncologist **Xtandi** is non-preferred and is limited to adults treatment of metastatic castration-resistant prostate cancer, with previous trials of docetaxel. **Pomalyst** has a DDI with strong inhibitors of CYP1A2 and CYP3A4 drugs. Complete blood counts weelky for first 8 weeks, then monthly, patients have at least 2 prior therapies, including lenalidomide and bortezomib,female patients of reproductive potential must have 2 negative pregnancy tests and use 2 forms of contraception and providers must be certified with Pomalyst REMS Program. **DDI:** Strong and moderate CYP3A inhibitors and Strong and moderate CYP3A inducers should be avoided with use of Lynparza

				MC		ZYTIGA		Clinical PA required for Ibrance to verify diagnosis and concomitant use with letrozole Farydak in combination with bortezomib and dexamethasone for the treatment of patients with multiple myeloma (MM) who have received ≥2 prior regimens, including bortezomib and an immunomodulatory agent
IMMUNOSUPPRESSANTS								
IMMUNOSUPPRESSANTS	MC/DEL MC MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL		CYCLOSPORINE MODIFIED GENGRAF CAPS MYCOPHENOLATE MYFORTIC NEORAL PROGRAF CAPS RAPAMUNE SANDIMMUNE	MC/DEL MC/DEL MC/DEL		CELLCEPT CYCLOSPORINE CAPS CYCLOSPORINE SOL. MODIFIED	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **DDI:** Cyclosporine will now be non-preferred and require prior authorization if it is currently being used in combination with either Lipitor (doses greater than 20mg/day), Crestor, or lovastatin (doses greater than 20mg). **DDI:** Cyclosporine will require prior authorization when used with Livalo. **DDI:** All preferred immunosuppressants will require clinical PA for patients over 60 that are currently on fluoroquinolone therapy.
PURINE ANALOG								
PURINE ANALOG	MC MC/DEL		AZASAN TABS **AZATHIOPRINE TABS**	MC/DEL		**IMURAN TABS**	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
K REMOVING RESINS								
K REMOVING RESINS	MC/DEL MC MC/DEL MC/DEL MC/DEL		KAYEXALATE POWD KIONEX POWD SODIUM POLYSTYRENE SULFON SPS SUSP SPS 30GM/120ML ENEMA SUSP				Use PA Form# 20420	

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

ANTI-CONVULSANTS INDICATION CHART

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

PEDIATRIC ANTI-CONVULSANTS INDICATION CHART

	SEIZURES	MONOTHERAPY BIPOLAR	ADJUNCTIVE BIPOLAR
LITHIUM		**1**	**1**
CARBMAZEPINE	**X**	**1**	**1**
VALPROATE	**X**	**1**	**1**

ATYPICAL ANTIPSYCHOTICS EXC. CLOZAPINE	X	1	1
LAMICTAL	X	1	1
TRILEPTAL	X	5	5
CLOZAPINE	X	6	6