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

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

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.mainecarepd

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 ex

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 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 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/M 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 b

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 a 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-ra 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

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 recommend 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.,

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.mai

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 the 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 t

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 requiremen

ASSORTED ANTIBIOTICS

BETA-LACTAMS / CLAVULANATE COMBO'S	MC/DEL		AMOXICILLIN	MC/DEL		AUGMENTIN[3]		3. Chewable 125mg & 250mg and Solution 125mg/5ml and 250mg/5ml available without PA.
	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.
	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. 2. Dosing limits apply, please see Dosage Consolidation List.
	MC/DEL		CEFAZOLIN SODIUM SOLR	MC/DEL		CEFACLOR[1]	
	MC/DEL		CEFDINIR	MC/DEL		CEFADROXIL MONOHYDRATE TABS	
	MC/DEL		CEFEPIME	MC/DEL		CEFTIN	
	MC/DEL		CEFPODOXIME	MC/DEL		FORTAZ	
	MC/DEL		CEFPROZIL	MC/DEL		FORTAZ SOLN	
	MC		CEFTAZIDIME 6MG	MC		KEFLEX CAPS	
	MC/DEL		CEFTIN SUSP	MC		OMNICEF	
	MC/DEL		CEFTRIAXONE	MC/DEL		ROCEPHIN	
	MC/DEL		CEFUROXIME AXETIL TABS	MC		TAZICEF SOLR	
	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.
	MC/DEL		AZITHROMYCIN SUSP	MC/DEL		CLARITHROMYCIN SUSP	
	MC		E.E.S.	MC/DEL		CLARITHROMYCIN TABS	
	MC		ERYPED 200 SUSR	MC		DIFICID	
	MC		ERYPED 400 SUSR	MC		PCE TBEC	
	MC		ERY-TAB TBEC	MC/DEL		ZITHROMAX TABS	
	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	
				MC/DEL		ZMAX	
TETRACYCLINES	MC/DEL		DOXYCYCLINE MONOHYDRATE 100mg & 50mg CAPS	MC		DECLOMYCIN TABS	Use PA Form# 20420
	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	
	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	
				MC		FACTIVE	
				MC		LEVAQUIN TABS SOLN/INJ	

				MC		LEVAQUIN TABS[1]	
				MC		NOROXIN TABS	
				MC		PROQUIN XR	
AMINO GLYCOSIDES	MC		GENTAMICIN	MC		BETHKIS[1]	Use PA Form# 20420 1. Clinial PA to verify appropriate diag 2. See criteria section
	MC		KITABIS PAK	MC/DEL		TOBI PODHALER[1]	
	MC/DEL		NEOMYCIN SULFATE TABS	MC		TOBI NEBU[2]	
				MC/DEL		TOBRAMYCIN SULFATE SOLN[2]	
ANTI-MYCOBACTERIALS / ANTI-TUBERCULOSIS	MC/DEL		ETHAMBUTOL HCL TABS				Use PA Form# 20420
	MC/DEL		MYAMBUTOL TABS				
	MC/DEL		MYCOBUTIN CAPS				
	MC/DEL		RIFAMPIN				
ANTIMALARIAL AGENTS	MC/DEL		**CHLOROQUINE PHOSPHATE TABS**	MC		ARALEN TABS	Use PA Form# 20420 1. Ingredients available as preferred without PA.
	MC/DEL		**DARAPRIM TABS**	MC		ISONARIF[1]	
	MC/DEL		**HYDROXYCHLOROQUINE TABS**	MC/DEL		MALARONE TABS	
	MC/DEL		**MEFLOQUINE HCL TABS**	MC/DEL		**PLAQUENIL TABS**	
	MC/DEL		**QUININE SULFATE**				
ANTHELMINTICS	MC/DEL		ALBENZA TABS				Use PA Form# 20420
	MC		BILTRICIDE TABS				
	MC/DEL		STROMECTOL TABS				
ANTIBIOTICS - MISC.	MC		AZACTAM SOLR	MC		COLISTIMETHATE SODIUM SOLR	1. 375mg caps and 750mg tabs are non-preferred. Please use available preferred strengths(250mg & 500mg tabs) to obtain required dose without PA. 2. Please use multiple 5gm which are preferred to obtain dose without PA. 3. Clinical PA is required to establish CF diagnosis and medical necessity. Prior trail and failure of preferred Tobi before approval will be granted.
	MC		COLY-MYCIN-M SOLR	MC		CAYSTON[3]	
	MC		COLISTIMETHATE SODIUM SOLR	MC/DEL		FLAGYL CAPS	
	MC		FUROXONE TABS	MC/DEL		FLAGYL TABS	
	MC/DEL		METRONIDAZOLE[1]	MC/DEL		FLAGYL ER TBCR	
	MC		PENTAMIDINE ISETHIONATE SOLR	MC/DEL		KETEK	
	MC		PRIMSOL SOLN	MC/DEL		METRONIDAZOLE 375MG CAPS[1]	
	MC/DEL		TRIMETHOPRIM TABS	MC/DEL		METRONIDAZOLE 750MG TABS[1]	
	MC/DEL		VANCOMYCIN 5GM INJ.	MC		NEBUPENT SOLR	
				MC		TINDAMAX	
				MC/DEL		VANCOMYCIN 10GM INJ.[2]	
				MC		XIFAXAN	

							Use PA Form# 20420
CARBAPENEMS				MC		INVANZ SOLR	Use PA Form# 20420
				MC		MERREM SOLR	
				MC/DEL		PRIMAXIN	
LINCOSAMIDES / OXAZOLIDINONES / LEPROSTATICS	MC/DEL		CLEOCIN SOLN	MC/DEL		CLEOCIN CAPS	1. Use multiple 150's for Clindamycin instead of 300's.
	MC/DEL		CLEOCIN SUSR	MC/DEL		CLINDAMYCIN HCL 300CAPS[1]	
	MC/DEL		CLINDAMYCIN HCL 150CAPS	MC		SIVEXTRO	
	MC		DAPSONE TABS	MC/DEL		VIBATIV	
				MC/DEL		ZYVOX SUSR	Use PA Form# 30820 for Zyvox & Vibativ
				MC/DEL		ZYVOX TABS	Use PA Form# 20420 for all others
ANTI INFECTIVE COMBO'S - MISC.	MC/DEL		ERYTHROMYCIN/SULF SUSR	MC		BACTRIM DS TABS	Use PA Form# 20420
	MC/DEL		SEPTRA/DS TABS				
	MC/DEL		SULFAMETHOXAZOLE/TRIMETH				
	MC/DEL		TRIMETHOPRIM/SULFAMETHOXA				
ANTIPROTOZOALS				MC		ALINIA[1]	1. Alina is preferred for children less than 12 years of age.
							Use PA Form# 20420
ANTI - FUNGALS							
ANTIFUNGALS - ASSORTED	MC		ANCOBON CAPS	MC/DEL	6	LAMISIL TABS[4]	1. QL--1/every 7-day period (150mg only).
	MC/DEL		FLUCONAZOLE[1]	MC/DEL	6	ITRACONAZOLE	
	MC/DEL		KETOCONAZOLE TABS[7]	MC/DEL	8	CRESEMBA[9]	2. Sporanox QL 300cc/month with PA. See quantity limit table.
	MC/DEL		NYSTATIN	MC/DEL	8	GRIFULVIN V TABS	
	MC/DEL		TERBINAFINE TABS[4]	MC	8	GRISEOFULVIN SUSP	
	MC/DEL		**VORICONAZOLE TABS**	MC	8	GRISEOFULVIN ULTRAMICROSI TABS	3. Sporanox QL 30/month with PA. See quantity limit table. Non-preferred products must be used in specified step order. Continue to use Anti-Fungal PA form for non-preferred products.
				MC	8	GRIS-PEG TABS	
				MC/DEL	8	SPORANOX SOLN[2]	
				MC/DEL	8	SPORANOX PULSEPAK CAPS[3]	
				MC/DEL	8	SPORANOX CAPS[3]	
				MC/DEL	8	DIFLUCAN	
				MC/DEL	8	ERAXIS INJ[6]	4. Quantity limit of one tablet daily. Please see dosage consolidation list.
				MC	8	GRIFULVIN SUSP	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.
				MC/DEL	8	ONMEL	
				MC/DEL	8	NOXAFIL[5]	
							7. Quantity limits allowing 30 day supply without PA. PA will be required if using > 30 days.
				MC/DEL	8	VFEND TABS	
							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
ANTI - VIRALS							
ANTIRETROVIRALS	MC/DEL		APTIVUS	MC/DEL	8	COMBIVIR TABS	
	MC		ATRIPLA[1]	MC	8	COMPLERA	
	MC/DEL		CRIXIVAN CAPS	MC/DEL	8	DIDANOSINE	
	MC/DEL		EDURANT	MC/DEL	8	EVOTAZ	Use PA Form# 10620 for Fuzeon
	MC		EMTRIVA	MC/DEL	8	FUZEON[3]	1. Quantity limit of one per day
	MC/DEL		EPIVIR / HBV	MC/DEL	8	INTELENCE[3]	
	MC/DEL		EPZICOM	MC/DEL	8	ISENTRESS[3,4]	2. Only preferred if Norvir script is in member's profile within the past 30 days of filling Prezista
	MC/DEL		INVIRASE CAPS	MC/DEL	8	PREZCOBIX	
	MC		KALETRA	MC	8	RETROVIR	
	MC/DEL		LEXIVA	MC/DEL	8	SELZENTRY[3]	
	MC		NORVIR	MC	8	STRIBILD	3. Prescribers with >= 10 ART scripts per quarter and 75% ART PDL compliance will be exempt from PA for these products.
	MC		PREZISTA[2]	MC	8	TIVICAY[5,6]	
	MC/DEL		RESCRIPTOR TABS	MC	8	TRIUMEQ[5,7]	
	MC		REYATAZ[1]	MC	8	TYBOST[8]	
	MC		STAVUDINE	MC	8	ZERIT	
	MC		SUSTIVA	MC	8	VITEKTA	
	MC/DEL		TRIZIVIR TABS	MC/DEL	9	VIRAMUNE XR	4.Isentress Chewable will only be approved if between the age of 2-12 years old
	MC		TRUVADA				
	MC		VIDEX EC				

	MC/DEL		VIRACEPT TABS				5. Clinical PA is required to establish diagnosis, verification of age for appropriate indication and medical necessity. 6. Dosing limits apply, please see dosing consolidation list. 7. Request will require use of the individual components Tivicay and Epzicom. 8. Diagnosis and verify prior trials and failures or intolerance of preferred treatments is required
	MC/DEL		VIRAMUNE TABS				
	MC		VIREAD TABS				
	MC/DEL		ZIAGEN TABS				
	MC/DEL		ZIDOVUDINE				
CYTO-MEGALOVIRUS AGENTS	MC		FOSCARNET SODIUM	MC/DEL		FOSCAVIR	Use PA Form# 20420
	MC		VALCYTE TABS	MC/DEL		GANCICLOVIR	
HERPES AGENTS	MC/DEL		ACYCLOVIR	MC/DEL	8	FAMCICLOVIR[1]	1. Must fail Acyclovir and Valacyclovir before non-preferred products in step order. Use PA Form# 20420
	MC/DEL		VALACYCLOVIR HCL	MC	8	SITAVIG	
				MC/DEL	8	ZOVIRAX[1]	
				MC/DEL	8	VALTREX TABS[1]	
				MC/DEL	9	FAMVIR TABS[1]	
INFLUENZA AGENTS	MC/DEL		AMANTADINE	MC		FLUMADINE TABS	1. Tamiflu 10 caps or 60cc's per month. Will be audited for presence of positive influenza tests in patient or family member. Use PA Form# 10610 for Flumist requests Use PA Form# 20420 for all others
	MC		RELENZA DISKHALER AEPB	MC		FLUMIST	
	MC/DEL		RIMANTADINE HCL TABS				
	MC/DEL		TAMIFLU[1]				
IMMUNE SERUMS							
IMMUNE SERUMS	MC		HYPERRHO INJ				

HEPATITIS AGENTS							
HEPATITIS C AGENTS	MC		HARVONI[2]	MC/DEL		COPEGUS TABS	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
	MC		OLYSIO[2]	MC/DEL		DAKLINZA	
	MC/DEL		PEGASYS KIT[1]	MC/DEL		REBETOL CAPS	
	MC/DEL		PEGASYS SOLN	MC		RIBAPAK	
	MC/DEL		PEG-INTRON KIT[1]				
	MC		RIBAVIRIN				
	MC		SOVALDI[2]				
	MC		TECHNIVIE[2]				
	MC		VIEKIRA PAK[2]				
	MC/DEL		**RIBASPHERE**				
HEPATITIS AGENTS - MISC.				MC		ACTIMMUNE	Use PA Form# 20420
HEPATITIS B ONLY	MC		HEPSERA TABS	MC		BARACLUDE	Use PA Form# 20420
				MC		TYZEKA	
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.
MS TREATMENTS							
MULTIPLE SCLEROSIS - INTERFERONS	MC		AVONEX KIT[1]	MC		PLEGRIDY[1]	1.Clinical PA is required to establish diagnosis and medical necessity.
	MC/DEL		**BETASERON SOLR**[1]	MC/DEL		EXTAVIA	
	MC		REBIF SOLN[1]				

							Use PA Form# 20430
MULTIPLE SCLEROSIS - NON-INTERFERONS	MC		COPAXONE 20MG[2]	MC	6	TYSABRI[1]	1. Providers must be enrolled in the TOUCH Prescribing program, a restricted distribution program. Clinical PA is required to establish diagnosis and medical necessity. 2. Clinical PA is required to establish diagnosis and medical necessity. 3. Dosing limits apply, please see dosage consolidation list. Use PA Form# 20430
	MC/DEL		GILENYA[2,3]	MC	8	AMPYRA	
	MC		AUBAGIO	MC	8	COPAXONE 40MG	
				MC/DEL	8	**GLATOPA**	
				MC	8	TECFIDERA	
ASSORTED NEUROLOGICS							
NEUROLOGICS - MISC.	MC/DEL		ORAP TABS	MC		BOTOX[2]	1. Approval will be limited to Cervical dystonia. 2. Please see botulinum PA form for additional criteria Use PA Form# 10210
	MC		PROSTIGMIN TABS	MC		DYSPORT[1]	
	MC		PYRIDOSTIGMINE	MC		MESTINON	
				MC		MYOBLOC[1]	
STEROIDS							
GLUCOCORTICOIDS/ MINERALOCORTICOIDS	MC		CELESTONE SUSP	MC/DEL		BUDESONIDE EC	Use PA Form# 20420
	MC/DEL		CORTEF 5	MC		CORTEF 10 and 20 TABS	
	MC/DEL		CORTISONE ACETATE TABS	MC/DEL		FLORINEF TABS	
	MC/DEL		DELTASONE TABS	MC/DEL		**MEDROL TABS**	
	MC/DEL		DEPO-MEDROL SUSP	MC		MEDROL DOSEPAK TABS	
	MC/DEL		DEXAMETHASONE	MC		MILLIPRED	
	MC		DEXPAK	MC		ORAPRED SOLN	
	MC/DEL		ENTOCORT EC CP24	MC		PEDIAPRED LIQD	
	MC/DEL		FLUDROCORTISONE ACETATE TABS	MC		PREDNISONE INTENSOL CONC	
	MC/DEL		HYDROCORTISONE	MC		STERAPRED TABS	
	MC		KENALOG				
	MC/DEL		METHYLPREDNISOLONE TABS				
	MC/DEL		PREDNISOLONE				
	MC/DEL		**PREDNISONE**				
	MC/DEL		SOLU-CORTEF SOLR				
	MC/DEL		SOLU-MEDROL SOLR				

HORMONE REPLACEMENT THERAPIES

ANDROGENS / ANABOLICS	MC/DEL		ANDRODERM PT24	MC		ANADROL-50	Use PA Form# 20420
	MC/DEL		DANAZOL CAPS	MC		ANDRO LA 200 OIL	
	MC/DEL		DEPO-TESTOSTERONE OIL	MC/DEL		ANDROGEL	
	MC/DEL		METHITEST TABS	MC/DEL		ANDROGEL PUMP	
				MC		ANDROID CAPS	
				MC		AXIRON	
				MC		DELATESTRYL OIL	
				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
	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
	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
	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
	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	

							preterm birth. Use PA Form# 20420
CONTRACEPTIVES							
CONTRACEPTIVES - PROGESTIN ONLY	**MC/DEL** **MC/DEL**		NOR-QD TABS NORETHINDRONE ACETATE 0.35 TABS	**MC/DEL** **MC/DEL** **MC/DEL** **MC/DEL** **MC**	7 7 7 7 8	CAMILA TABS ERRIN JOLIVETTE NORA-BE TABS ORTHO MICRONOR TABS	Use PA Form# 20420
CONTRACEPTIVES - INJECTABLE	**MC/DEL**		MEDROXYPROGESTERONE ACETATE 150mg IM	**MC/DEL**		DEPO-PROVERA 150 mg SUSP	Use PA Form# 20420
CONTRACEPTIVE - EMERGENCY	**MC/DEL** **MC/DEL** **MC** **MC/DEL**	1 2 2 2	PLAN B ONE STEP[1] ELLA LEVONORGESTREL NEXT CHOICE[1]	**MC/DEL**		PLAN B	1. Allowed 2 tablets per 30 days without PA Use PA Form# 20420
CONTRACEPTIVES - PATCHES/ VAGINAL PRODUCTS	**MC**		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.
CONTRACEPTIVES - MONOPHASIC COMBINATION O/C'S	**MC/DEL** **MC/DEL** **MC/DEL** **MC/DEL** **MC** **MC/DEL** **MC** **MC/DEL** **MC/DEL** **MC** **MC** **MC** **MC/DEL** **MC/DEL** **MC/DEL**		APRI TABS AVIANE TABS BALZIVA CRYSELLE-28 TABS DESOGEN TABS DESOGESTREL/ ETHINYL ESTRADIOL LOW-OGESTREL TABS MODICON TABS MONONESSA NECON 1/50 ORTHO-CEPT-28 TABS ORTHO-CYCLEN-28 TABS ORTHO-NOVUM 1/35-28 TABS OVCON-50 28 TABS PREVIFEM RECLIPSEN	**MC/DEL** **MC/DEL** **MC/DEL** **MC/DEL** **MC** **MC/DEL** **MC/DEL** **MC/DEL** **MC/DEL** **MC** **MC/DEL** **MC/DEL** **MC/DEL** **MC/DEL** **MC/DEL** **MC/DEL**		BEYAZ BREVICON-28 TABS LESSINA-28 TABS LEVORA LOESTRIN TABS LOESTRIN FE TABS LOESTRIN FE 1/20 TABS LOESTRIN 1.5/30-21 TABS LOESTRIN 1/20-21 TABS LO/OVRAL 21 TABS LO/OVRAL 28 TABS MICROGESTIN FE TABS NORDETTE-28 TABS NORINYL NORTREL OCELLA	Use PA Form# 20420 If member experienced adverse reactions, consider using Oral Contraceptives from other groups.

	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.
	MC		NORETHINDRONE-ETH ESTRADIOL TAB 0.5-35/1-35	MC/DEL		KARIVA TABS	
	MC/DEL		SEASONIQUE	MC/DEL		LOSEASONIQUE	
				MC/DEL		MIRCETTE TABS	
							Use PA Form# 20420
CONTRACEPTIVES - TRI-PHASIC COMBINATIONS	MC/DEL		ENPRESSE	MC/DEL		CYCLESSA TABS	If member experienced adverse reactions, consider using Oral Contraceptives from other groups.
	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				
	MC/DEL		TRI-SPRINTEC				
	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
	MC		HUMALOG MIX 75/25	MC/DEL		**AFREZZA**[1]	
	MC		HUMALOG 50/50 VIAL	MC		HUMALOG MIX PEN 50/50	
	MC		HUMULIN N INJ U-100	MC		HUMULIN INJ 50/50	
	MC		HUMULIN INJ 70/30	MC		HUMULIN R INJ U-500	1. Not to be as a monotherapy. Obtain lab values of pulmonary function and recent smoking history
	MC		HUMULIN R U-100	MC/DEL		**NOVOLIN**	
	MC/DEL		LANTUS SOLN	MC/DEL		**NOVOLOG**	
	MC/DEL		LEVEMIR	MC/DEL		**NOVOLOG MIX**	
				MC		RELION	
DIABETIC - PENFILLS	MC/DEL		LANTUS SOLOSTAR[1]	MC		APIDRA OPTICLIK PEN	1. Clinical PA will be required to establish significant visual or neurological impairment.
	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 MC/DEL		JANUVIA[1,2] TRADJENTA[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
DIABETIC - DPP- 4 ENZYME INHIBITOR-COMBO	MC/DEL MC/DEL MC/DEL		JANUMET[1,2] **JANUMET XR[1,2]** **JENTADUETO[1]**	MC/DEL MC MC/DEL		**KAZANO** KOMBIGLYZE XR **OSENI**	1. Preferred if therapeutic doses of metformin are seen in members drug profile for at least 60 days within the past 18 months or if phosphate binder is currently seen in the members drug profile. 2. Dosing limits apply. Please refer to Dose consolidation list. Use PA Form# 20420
DPP- 4 ENZYME INHIBITOR/ HMG-COS REDUCTASE INHIBITOR	MC/DEL		JUVISYNC[1,2]				Use PA Form# 20420 1. Please refer to criteria section of PDL 2. Dosing limits apply please refer to Dose Consolidation List
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
SGLT 2 INHIBITORS	**MC/DEL**		**FARXIGA**[2]	**MC/DEL** **MC/DEL**		**INVOKANA**[1] **JARDIANCE**	1.Dosing limits apply please refer to Dose Consolidation List 2. Preferred if therapeutic doses of metformin are seen in members drug profile for at least 60 days within the past 18 months Use PA Form# 20420
SGLT 2 INHIBITOR COMBINATIONS				**MC/DEL** **MC/DEL** **MC/DEL** **MC/DEL**		**GLYXAMBI** **INVOKAMET** **SYNJARDY** **XIGDOU XR**[1]	1. Diagnosis required Use PA Form# 20420
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
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

INCRETIN MIMETIC	MC MC/DEL		BYDUREON **TANZEUM**	MC MC/DEL MC MC/DEL	8 8 8 9	BYETTA[1] **NESINA** TRULICITY[2] VICTOZA[1]	1. If patient is not responding to oral agents (single or multiple) please look to insulin therapy. Dosing limits apply. Please refer to Dose Consolidation List. 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.
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
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.
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
DIABETIC - ALPHAGLUCOSIDASE	**MC/DEL**		**GLYSET TABS**	**MC**		**PRECOSE TABS**	Use PA Form# 20420
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
DIABETIC - MEGLITINIDES	**MC/DEL**		**STARLIX TABS**	**MC/DEL** **MC**		**PRANDIN TABS** **NATEGLINIDE**	Use PA Form# 20420
GLUCOSE ELEVATING AGENTS							
GLUCOSE ELEVATING AGENTS	**MC/DEL**		GLUCAGEN INJ. HYPOKIT	**MC** **MC**		GLUCAGON DIAGNOSTIC KIT GLUCAGEN DIAGNOSTIC KIT	Use PA Form# 20420
THYROID							
THYROID HORMONES	**MC/DEL** **MC/DEL** **MC/DEL** **MC/DEL** **MC/DEL** **MC/DEL** **MC/DEL** **MC/DEL**		**ARMOUR THYROID TABS** **CYTOMEL TABS** **LEVOTHROID TABS** **LEVOTHYROXINE SODIUM TABS** **LEVOXYL TABS** **THYROID TABS** **THYROLAR** **UNITHROID TABS**	**MC** **MC/DEL** **MC**		LEVOTHYROXINE SODIUM SOLR LIOTHYRONINE SYNTHROID TABS	Use PA Form# 20420
ANTITHYROID THERAPIES	**MC/DEL** **MC/DEL**		**METHIMAZOLE TABS** **PROPYLTHIOURACIL TABS**	**MC/DEL**		**TAPAZOLE TABS**	Use PA Form# 20420
OSTEOPOROSIS / BONE AGENTS							
OSTEOPOROSIS	**MC/DEL** **MC/DEL**		ALENDRONATE **MIACALCIN SOLN**[2]	**MC/DEL** **MC** **MC** **MC/DEL** **MC/DEL** **MC/DEL** **MC/DEL** **MC/DEL** **MC**		**ACTONEL TABS** AREDIA SOLR BINOSTO BONIVA INJECTION KIT BONIVA TABS[2,4] CALCITONIN NS **DUAVEE** **DIDRONEL TABS** EVISTA TABS[1]	Use PA Form# 20420 1. Approval only requires failure of Alendronate. 2. Quantity limits apply, please see dosage consolidation list. 3. Please use Alendronate and Vitamin D.

				MC		FORTEO	
				MC/DEL		FORTICAL	4. Please use other preferred agents.
				MC/DEL		**FOSAMAX TABS AND PLUS D**[3]	
				MC		PROLIA	
				MC		XGEVA	
				MC/DEL		ZOMETA	
CALCIMIMETIC AGENTS							
CALCIMIMETIC AGENTS				MC		SENSIPAR	Use PA Form# 30115
GROWTH HORMONE							
GROWTH HORMONE	MC/DEL		GENOTROPIN[1]	MC	8	HUMATROPE SOLR	Use PA Form# 10710
	MC/DEL		NORDITROPIN SOLN[1]	MC	8	INCRELEX	1.Clinical PA is required to establish diagnosis and medical necessity.
				MC/DEL	8	NUTROPIN	
				MC	8	OMNITROPE	
				MC	8	SAIZEN SOLR	
				MC/DEL	8	TEV-TROPIN	
				MC/DEL	8	NUTROPIN AQ	
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
VASOPRESSIN RECEPTOR ANTAGONIST							
VASOPRESSIN RECEPTOR ANTAGONIST				MC/DEL		SAMSCA	Use PA Form# 20420
URINARY INCONTINENCE							
VASOPRESSINS			DESMOPRESSIN TABS	MC/DEL	5	DDAVP TABS	1. Products must be used in specified step order. Nocturnal enuresis patients will be encouraged to periodically attempt stopping DDAVP.
				MC/DEL	6	DDAVP SOLN[1]	
				MC/DEL	6	**DESMOPRESSIN SPRAY**[1]	
				MC	8	DESMOPRESSIN ACETATE SOLN[1]	
				MC/DEL	8	STIMATE SOLN[1,2]	

							2. Patients with a diagnosis of hemophilia or Von Willebrands disease will be exempt from prior authorization. Use PA Form# 20420
ANTISPASMODICS	**MC/DEL** **MC**		**OXYBUTYNIN** URISPAS TABS	**MC/DEL** **MC/DEL** **MC/DEL**	8 8 9	**DETROL TABS** **DITROPAN** TROSPIUM	Use PA Form# 20420
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.
CHOLINERGIC	**MC/DEL** **MC/DEL**		**URECHOLINE** **BETHANECHOL**				Use PA Form# 20420
METABOLIC MODIFIER							
HERED. TYROSINEMIA				**MC**		ORFADIN	Use PA Form# 20420
ANTIHYPERTENSIVES / CARDIAC							
CARDIAC GLYCOSIDES	**MC/DEL** **MC/DEL** **MC/DEL**		**DIGITEK TABS** **DIGOXIN** **LANOXIN**				Use PA Form# 20420
CARDIAC - SINUS NODE INHIBITORS	**MC**		CORLANOR				
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**		DILATRATE SR CPCR ISORDIL TABS ISORDIL TITRADOSE TABS ISOSORBIDE DINITRATE SUBL **ISOSORBIDE DINITRATE TABS** ISOSORBIDE DINITRATE CR TBCR **ISOSORBIDE DINITRATE ER TBCR**	Use PA Form# 20420

				MC/DEL		ISOSORBIDE DINITRATE TD TBCR	
				MC/DEL		**IMDUR TB24**	
				MC/DEL		ISMO TABS	
				MC		MONOKET TABS	
NITRO - OINTMENT/CAP/CR	MC/DEL		**NITROBID OINT**				Use PA Form# 20420
	MC/DEL		**NITROGLYCERIN CPCR**				
	MC		NITROL OINT				
	MC		NITRO-TIME CPCR				
NITRO - PATCHES	MC/DEL	1	**NITROGLYCERIN PT24**[1]	MC		NITRODISC PT24	1. At least 2 step 1's and step 3 of the preferred products must be used in specified order or PA will be required. Use PA Form# 20420
	MC/DEL	1	**NITREK PT24**[1]	MC/DEL		**NITRO-DUR PT24**	
	MC/DEL	1	**NITRO-DUR PT 24 0.8MG**[1]				
	MC	3	MINITRAN PT24[1]				
NITRO - SUBLINGUAL/ SPRAY	MC/DEL		**NITROSTAT SUBL**	MC/DEL		**NITROQUICK SUBL**	Use PA Form# 20420
	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. 2. Please use other strengths in combination to obtain this dose. 3. Dosing limits still apply. Please see dose consolidation list Use PA Form# 20420
	MC		INNOPRAN XL	MC		**BETAPACE AF TABS**	
	MC		LEVATOL TABS	MC/DEL		**COREG CR**[3]	
	MC/DEL		**NADOLOL TABS**	MC/DEL		**COREG TABS**	
	MC/DEL		**PINDOLOL TABS**	MC/DEL		**CORGARD TABS**	
	MC/DEL		**PROPRANOLOL HCL SOLN**[1]	MC/DEL		**INDERAL TABS**	
	MC/DEL		**PROPRANOLOL HCL TABS**[1]	MC		INDERAL LA CPCR	
	MC/DEL		**PROPRANOLOL HCL 60MG TABS**				
	MC/DEL		**PROPRANOLOL LA CAPS**				
	MC		RANEXA				
	MC/DEL		SOTALOL AF				
	MC/DEL		SOTALOL HCL TABS				
	MC/DEL		**TIMOLOL MALEATE TABS**				
BETA BLOCKERS - CARDIO SELECTIVE	MC/DEL		**ACEBUTOLOL HCL CAPS**	MC/DEL		BYSTOLIC	1. Recommend using Atenolol (and metoprolol) BID since its effects do not last 24 hours. Use PA Form# 20420
	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**	
	MC/DEL		**METOPROLOL ER**	MC/DEL		**TOPROL XL TB24**	
				MC/DEL		**ZEBETA TABS**	
BETA BLOCKERS - ALPHA / BETA	MC/DEL		**LABETALOL HCL TABS**	MC		TRANDATE TABS	Use PA Form# 20420
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
	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
				MC/DEL		**FELODIPINE**	
				MC		DYNACIRC CAPS	Use PA Form# 20420
				MC		DYNACIRC CR TBCR[1]	1. Established users will be grandfathered
				MC		CARDENE SR CPCR	Use PA Form# 20420
				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
	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
	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.
	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	Use PA Form# 20420
	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
	MC/DEL		CAPTOPRIL TABS	MC/DEL	5	ACCUPRIL TABS	
	MC/DEL		ENALAPRIL MALEATE TABS	MC/DEL	8	ACEON TABS[1]	
	MC/DEL		FOSINOPRIL SODIUM	MC/DEL	8	ALTACE CAPS[1]	
	MC/DEL		LISINOPRIL TABS	MC/DEL	8	LOTENSIN TABS[1]	
	MC/DEL		RAMIPRIL	MC/DEL	8	MOEXIPRIL HCL[1]	
	MC/DEL		QUINAPRIL HCL	MC	8	MONOPRIL HCT TABS[1]	
				MC/DEL	8	PRINIVIL TABS[1]	
				MC/DEL	8	UNIVASC[1]	
				MC	8	VASOTEC TABS[1]	
				MC/DEL	8	ZESTRIL TABS[1]	
ANGIOTENSIN RECEPTOR BLOCKER	MC/DEL		BENICAR TABS[1]	MC/DEL	8	ATACAND TABS	Use PA Form# 20420 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.
	MC/DEL		DIOVAN[1]	MC/DEL	8	AVAPRO	
	MC/DEL		IRBESARTAN[1]	MC/DEL	8	COZAAR	
	MC/DEL		LOSARTAN[1]	MC/DEL	8	EDARBI	
	MC/DEL		MICARDIS TABS[1]	MC	8	TEVETEN TABS	
				MC/DEL	8	TRIBENZOR[2]	
DIRECT RENIN INHIBITOR				MC/DEL		AMTURNIDE	1. Must show failure of single and combination therapy from all preferred antihypertensive categories. Use PA Form# 20420
				MC/DEL		TEKTURNA[1]	
				MC/DEL		TEKAMLO	
ANTIHYPERTENSIVES - CENTRAL	MC/DEL		CATAPRES-TTS	MC/DEL		CATAPRES TABS	Use PA Form# 20420
	MC/DEL		CLONIDINE HCL TABS	MC/DEL		CLONIDINE TTS	
	MC/DEL		GUANFACINE HCL TABS	MC		GUANABENZ ACETATE TABS	
	MC/DEL		HYDRALAZINE HCL TABS	MC		ISMELIN TABS	
	MC		HYLOREL TABS	MC/DEL		MINIPRESS CAPS	
	MC/DEL		METHYLDOPA TABS	MC		NEXICLON	
	MC/DEL		MINOXIDIL TABS	MC/DEL		TENEX TABS	
	MC/DEL		PRAZOSIN HCL CAPS				
	MC/DEL		RESERPINE TABS				
ACE INHIBITORS AND CA CHANNEL BLOCKERS				MC/DEL	8	AMLODIPINE/BENAZEPRIL	Use individual preferred generic medications.
				MC	8	TARKA TBCR	
				MC/DEL	9	AMLODIPINE/BENAZEPRIL	

				MC/DEL	9	LOTREL CAPS	Use PA Form# 20420
ACE AND THIAZIDE COMBO'S	MC/DEL		BENAZEPRIL HCL/HYDROCHLOR	MC/DEL		ACCURETIC TABS	Use PA Form# 20420
	MC/DEL		CAPTOPRIL/HYDROCHLOROTHIA	MC		MONOPRIL HCT TABS	
	MC/DEL		ENALAPRIL MALEATE/HCTZ TABS	MC/DEL		PRINZIDE TABS	
	MC/DEL		LISINOPRIL-HCTZ TABS	MC/DEL		UNIRETIC TABS	
	MC/DEL		LOTENSIN HCT TABS	MC		VASERETIC TABS	
				MC/DEL		ZESTORETIC TABS	
BETA BLOCKERS AND DIURETIC COMBO'S	MC/DEL		ATENOLOL/CHLORTHALIDONE	MC/DEL		CORZIDE TABS	Use PA Form# 20420
	MC/DEL		BISOPROLOL FUMARATE/HCTZ	MC/DEL		LOPRESSOR HCT TABS	
	MC/DEL		PROPRANOLOL/HCTZ	MC		TENORETIC	
				MC		TIMOLIDE 10/25 TABS	
				MC/DEL		ZIAC TABS	
ARB'S AND CA CHANNEL BLOCKERS	MC/DEL		AZOR	MC/DEL		TWYNSTA	1. Preferred products only available without PA if patient on diabetic therapy or prior ACE therapy.
	MC/DEL		EXFORGE[1]				
	MC/DEL		EXFORGE HCT[1]				Use PA Form# 20420
ARB'S AND DIURETICS	MC/DEL		BENICAR HCT[1]	MC/DEL	7	IRBESARTAN HYDROCHLOROTHIAZIDE	1. Preferred products only available without PA if patient on diabetic therapy or prior ACE therapy.
	MC/DEL		LOSARTAN HCT[1]	MC/DEL	8	ATACAND HCT TABS	
	MC/DEL		MICARDIS HCT TABS[1]	MC	8	AVALIDE TABS[1]	
	MC/DEL		VALSARTAN-HYDROCHLOROTHIAZIDE[1]	MC/DEL	8	DIOVAN HCT TABS[1]	
				MC/DEL	8	HYZAAR TABS	
				MC	8	TEVETEN HCT TABS	Use PA Form# 20420
ANGIOTENSIN MODULATORS-ARB COMBINATION				MC/DEL		EDARBYCLOR	
				MC		ENTRESTO	Use PA Form# 20420
ARB'S AND DIRECT RENIN INHIBITOR COMBINATION				MC/DEL		VALTURNA	Use PA Form# 20420
DIURETICS	MC/DEL		ACETAZOLAMIDE TABS	MC/DEL		ALDACTAZIDE TABS	1. Multiples of Spironolactone 25 mg are cheaper than 50 mg strength. Inspra will be approved for severe breast tenderness and male gynecomastia.
	MC/DEL		BUMETANIDE	MC/DEL		ALDACTONE TABS	
	MC/DEL		CHLOROTHIAZIDE TABS	MC/DEL		AMILORIDE HCL	
	MC/DEL		CHLORTHALIDONE TABS	MC/DEL		BUMEX TABS	
	MC		EDECRIN TABS	MC/DEL		DEMADEX TABS	
	MC/DEL		EDECRIN TABS	MC/DEL		DIAMOX	
	MC/DEL		HYDROCHLOROTHIAZIDE	MC		DIURIL	
	MC/DEL		INDAPAMIDE TABS	MC/DEL		DYAZIDE CAPS	
	MC/DEL		METHAZOLAMIDE TABS	MC		ENDURON TABS	
	MC/DEL		METHYCLOTHIAZIDE TABS	MC/DEL		INSPRA	
	MC/DEL		SPIRONOLACTONE 25MG TABS	MC/DEL		LASIX TABS	Use PA Form# 20420
	MC/DEL		SPIRONOLACTONE/HYDRO	MC/DEL		MAXZIDE	
	MC/DEL		TORSEMIDE TABS	MC/DEL		MICROZIDE CAPS	
	MC/DEL		TRIAMTERENE/HCTZ	MC/DEL		MIDAMOR TABS	
	MC		ZAROXOLYN TABS	MC		NAQUA TABS	

				MC/DEL		SPIRONOLACTONE 50MG[1]	
CCB / LIPID				MC/DEL		CADUET	
NEUROGENIC ORTHOSTATIC HYPOTENSION							
NEUROGENIC ORTHOSTATIC HYPOTENSION				MC		NORTHERA	Use PA Form# 20420
LIPID DRUGS							
CHOLESTEROL - BILE SEQUESTRANTS	MC/DEL		CHOLESTYRAMINE	MC/DEL		COLESTID	Use PA Form# 20420
	MC/DEL		COLESTIPOL HCl	MC/DEL		PREVALITE	
				MC		QUESTRAN	
				MC/DEL		WELCHOL TABS	
CHOLESTEROL - FIBRIC ACID DERIVATIVES	MC/DEL		FENOFIBRATE	MC		ANTARA	Use PA Form# 20420
	MC/DEL		GEMFIBROZIL TABS	MC/DEL		LOPID	
	MC/DEL		NIASPAN	MC/DEL		FENOFIBRATE 120mg	
	MC		TRILIPIX	MC/DEL		FIBRICOR	
				MC		LIPOFEN	
				MC/DEL		LOFIBRA	
				MC		TRICOR	
				MC		TRIGLIDE	
CHOLESTEROL - HGM COA + ABSORB INHIBITORS MORE POTENT DRUGS/COMBINATIONS	MC/DEL		ATORVASTATIN	MC/DEL		LIPITOR	1. Dosing limits apply, please see dosage consolidation list. 2. Current users grandfathered. Use PA Form# 20420
	MC/DEL		CRESTOR	MC		LIPTRUZET	
	MC/DEL		SIMVASTATIN[1]	MC/DEL		ZOCOR	
			VYTORIN	MC/DEL		SIMVASTATIN 80MG[1,2]	
	MC						
CHOLESTEROL - HGM COA + ABSORB INHIBITORS LESS POTENT DRUGS/COMBINATIONS	MC/DEL		LESCOL CAPS	MC	8	ALTOPREV TB24	2. Dosing limits apply, please see dosage consolidation list. Use PA Form# 20420
	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		ZETIA TABS	MC/DEL	8	PRAVIGARD	
CHOLESTEROL - HGM COA + ABSORB INHIBITORS STATIN/ NIACIN COMBO	MC		SIMCOR	MC		ADVICOR TBCR	Use PA Form# 20420

FAMILIAL HYPERCHOLESTEROLEMIA				MC MC		JUXTAPID KYNAMRO[1]	1. Clinical PA required for appropriate diagnosis Use PA Form#10500
PULMONARY ANTI-HYPERTENSIVES							
PULMONARY ANTI-HYPERTENSIVES	MC/DEL MC MC MC		SILDENAFIL[4] EPOPROSTENOL INJ[6] VENTAVIS[2] ADCIRCA[1]	MC/DEL MC/DEL MC MC MC MC/DEL		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
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
IMPOTENCE AGENTS							
IMPOTENCE AGENTS							As of January 1, 2006, per CMS (federal govt.), impotence agents are no longer covered.
ANTI-EMETOGENICS							
ANTIEMETIC - ANTICHOLINERGIC / DOPAMINERGIC	MC/DEL		MECLIZINE HCL TABS	MC		ANTIVERT TABS	Use PA Form# 20420
	MC		PROMETHAZINE SUPP	MC		PHENERGAN SOLN	
	MC/DEL		PROMETHAZINE	MC		PROMETHAZINE 50MG SUPP	
	MC		TRANSDERM-SCOP PT72	MC		PROMETHEGAN SUPP	
				MC		TORECAN TABS	
ANTIEMETIC - 5-HT3 RECEPTOR ANTAGONISTS/ SUBSTANCE P NEUROKININ	MC/DEL		**DRONABINOL CAPS**	MC/DEL	5	GRANISETRON	1. Approvals will require diagnosis of chemo-induced nausea/vomiting and failed trials of all preferred anti-emetics, including 5-HT3 class (Ondansetron) and Marinol.
	MC/DEL		**ONDANSETRON TABS**[2,4]	MC	8	AKYNZEO[1]	
	MC/DEL		**ONDANSETRON ODT TBDP**[2,4]	MC	8	ALOXI	
	MC/DEL		**ONDANSETRON INJ**[2,4]	MC	8	ANZEMET TABS	
				MC	8	CESAMET[1]	
				MC	8	DICLEGIS	
				MC	8	EMEND[3]	
				MC/DEL	8	KYTRIL	
				MC/DEL	8	MARINOL CAPS	
				MC	8	SANCUSO	2. Ondansetron will be preferred with CA diag and dosing limits still apply.
				MC/DEL	8	ZOFRAN ODT TBDP[4]	
				MC/DEL	8	ZOFRAN TABS[4]	
				MC/DEL	8	ZOFRAN INJ[4]	
				MC	8	ZUPLENZ	3. Clinical PA is required for members on highly emetic anti-neoplastic agents. 4. Dosing limits apply, please see Dosage Consolidation List

							Use PA Form# 20610 for Ondansetron requests Use PA Form# 20420 for all others
NON-SEDATING ANTIHISTAMINES / DECONGESTANTS							
ANTIHISTIMINES - NON-SEDATING	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
ANTIHISTIMINES - OTHER	MC/DEL MC/DEL MC/DEL		CLEMASTINE CHLORPHENIRAMINE DIPHENHYDRAMINE				Use PA Form# 20530
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

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
ANTIASTHMATIC - PHOSPHODIESTERASE 4 INHIBITORS				MC/DEL		DALIRESP	Use PA Form# 20420
ANTIASTHMATIC - ANTICHOLINERGICS - NEBULIZER	MC/DEL		**IPRATROPIUM BROMIDE SOLN**	MC		ATROVENT SOLN	Use PA Form# 20420
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
ANTIASTHMATIC - NASAL STEROIDS	MC/DEL MC/DEL MC/DEL		**FLUTICASONE SPR**[3] OMNARIS SPR[3] ZETONNA[3]	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC	5 8 8 8 8	BECONASE AQ INHA[1,3] DYMISTA FLONASE SUSP[2,3] FLUNISOLIDE SOLN[1,3] NASONEX SUSP QNASL	Use PA Form# 20420 1. All preferred drugs must be tried before moving to non preferred steps.

				MC	8	RHINOCORT AERO[2,3]	
				MC/DEL	8	RHINOCORT AQUA SUSP[2,3]	2. All step 5 medications need to be tried before moving to step 8's.
				MC	8	TRI-NASAL SOLN[2,3]	
				MC	8	VANCENASE POCKETHALER AERS[2,3]	3. Dosing limits apply to whole category, please see dosage consolidation list.
				MC/DEL	8	VERAMYST[2,3]	
				MC/DEL	9	TRIAMCINOLONE NS	
ANTIASTHMATIC - NASAL MISC.	MC/DEL		CROMOLYN NASAL 4%	MC	7	ATROVENT NASAL SOL	Use PA Form# 20420
				MC/DEL	7	ASTELIN	1. Ipratropium will be approved if submitted with documentation supporting use of CPAP machine.
				MC	7	IPRATROPIUM NASAL SOL[1]	
				MC/DEL	8	ASTEPRO[2]	
				MC/DEL	8	PATANASE	2. Utilize Multiple preferred, as well as step therapy Astelin.
ANTIASTHMATIC - BETA - ADRENERGICS	MC/DEL		**ALBUTEROL NEB**	MC/DEL		**ACCUNEB NEBU**	1. Xopenex users w/ prior asthma hospitalization due to albuterol nebulizer failure will be grandfathered.
	MC/DEL		**FORADIL AEROLIZER CAPS**	MC/DEL		**ALBUTEROL AER**	
	MC/DEL		**METAPROTERENOL**	MC/DEL		**ALBUTEROL HFA**	
	MC/DEL		**PROVENTIL HFA**	MC/DEL		**ALBUTEROL 0.63mg/3ml**	
	MC/DEL		**SEREVENT**	MC/DEL		**ARCAPTA[3]**	
	MC/DEL		**TERBUTALINE SULFATE TABS**	MC/DEL		**BRETHINE**	2. Quantity Limit: 12 cc/day.
				MC		**PROAIR HFA[3]**	
				MC		PROAIR RESPICLICK	3. Dosing limits apply, please see dosage consolidation list.
				MC/DEL		**STRIVERDI**	
				MC/DEL		**VENTOLIN AERS**	
				MC/DEL		**VENTOLIN HFA AERS[3]**	
				MC		VOLMAX TBCR	
				MC		VOSPIRE ER TB12	
				MC		**XOPENEX HFA[3]**	
				MC		**XOPENEX NEBU[1,2]**	Use PA Form# 20420
ANTIASTHMATIC - ADRENERGIC COMBINATIONS	MC/DEL		**ADVAIR HFA[1,2]**	MC/DEL		**BREO ELLIPTA[2,3]**	1. We ask physicians to write "asthma" on the prescription whenever Advair is primarily being used for that condition.
	MC/DEL		DULERA	MC/DEL		**ADVAIR DISKUS[2,3]**	
	MC/DEL		SYMBICORT[2]				2. Dosing limits apply, please see dosage consolidation list.
							3. Clinical PA required for appropriate diagnosis
							Use PA Form# 20420

ANTIASTHMATIC - ADRENERGIC ANTICHOLINERGIC	MC/DEL		**ALBUTEROL/IPRATROPIUM NEB. SOLN**	MC/DEL		**ANORO ELLIPTA**	1. Please use preferred individual ingredients Albuterol and Ipratropium. Use PA Form# 20420
				MC/DEL		**COMBIVENT RESPIMAT**	
				MC/DEL		DUONEB SOLN[1]	
				MC/DEL		**STIOLTO**	
ANTIASTHMATIC - XANTHINES	MC/DEL		**AMINOPHYLLINE TABS**	MC/DEL		**THEO-24 CP24**	Use PA Form# 20420
	MC/DEL		THEOCHRON TB12	MC		THEOLAIR TABS	
	MC/DEL		THEOLAIR-SR TB12	MC/DEL		**UNIPHYL TBCR**	
	MC/DEL		**THEOPHYLLINE CR TB12**				
	MC		THEOPHYLLINE ELIX				
	MC/DEL		THEOPHYLLINE SOLN				
	MC/DEL		**THEOPHYLLINE ER CP12**				
	MC/DEL		**THEOPHYLLINE ER TB12**				
ANTIASTHMATIC - STEROID INHALANTS	MC/DEL		ASMANEX[4,5]	MC/DEL	5	**AEROBID AERS[2,4]**	1. No PA for Pulmicort susp if under 8 years old. 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
	MC/DEL		**FLOVENT DISKUS[4]**	MC	5	BECLOVENT AERS[2,4]	
	MC/DEL		**FLOVENT HFA[4]**	MC	5	VANCERIL AERS[2,4]	
	MC/DEL		**PULMICORT FLEXHALER**	MC/DEL	8	**AEROBID-M AERS[3,4]**	
	MC/DEL		**PULMICORT SUSP[1,4]**	MC/DEL	8	ALVESCO[4]	
	MC		QVAR AERS[4]	MC/DEL	8	**ARNUITY ELLIPTA[6]**	
	MC		AEROSPAN	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
ANTIASTHMATIC - LEUKOTRIENE RECEPTOR ANTAGONISTS	MC/DEL		**MONTELUKAST SODIUM TAB**	MC/DEL	7	MONTELUKAST GRANULE[1]	Use PA Form# 20420

	MC/DEL		MONTELUKAST SODIUM CHEW TAB	MC/DEL MC/DEL	8 8	**ACCOLATE TABS** **SINGULAIR**[2]	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.
ANTIASTHMATIC - ALPHA-PROTEINASE INHIBITOR				MC MC/DEL MC MC	8 8 8 8	ARALAST **ZEMAIRA** GLASSIA PROLASTIN SUSR	Use PA Form# 20420
ANTIASTHMATIC - HYDRO-LYTIC ENZYMES				MC/DEL		PULMOZYME SOLN	Use PA Form# 20420
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 MC		ORKAMBI KALYDECO	Use PA Form# 20420
IDIOPATHIC PULMONARY FIBROSIS				MC MC/DEL		ESBRIET[1] **OFEV**[1]	1. Diagnosis required Use PA Form# 20420
COUGH/COLD							
COUGH/COLD	MC/DEL MC/DEL MC/DEL MC MC		DEXTRO-GUAIF SYRP[1] GUAIFENESIN SYRP[1] PSEUDOEPHEDRINE[1] ROBITUSSIN DM SYRP[1] ROBITUSSIN SUGAR FREE SYRP[1]				1. All of cough cold preparations are not covered except these preferred products. Use PA Form# 20420
DIGESTIVE AIDS / ASSORTED GI							

GI - ANTIPERISTALTIC AGENTS	MC/DEL		DIPHENOXYLATE	MC/DEL		LOFENE TABS	Use PA Form# 20420
	MC/DEL		DIPHENOXYLATE/ATROPINE	MC		LONOX TABS	
	MC/DEL		LOPERAMIDE HCL CAPS/LIQ	MC		MOTOFEN TABS	
	MC/DEL		OPIUM TINCTURE TINC				
	MC		PAREGORIC TINC				
GI - ANTI-DIARRHEAL/ ANTACID - MISC.	MC		**ATROPINE SULFATE SOLN**	MC/DEL		**BELLADONNA ALKALOIDS & OP**	Use PA Form# 20420 1.Dosing limits apply please refer to Dose Consolidation List
	MC/DEL		BENTYL SYRP	MC/DEL		BENTYL TABS	
	MC/DEL		BISMATROL	MC		CUVPOSA	
	MC/DEL		BISMUTH SUBSALICYLATE	MC		ED-SPAZ	
	MC/DEL		CALCIUM CARBONATE (ANTACID) CHEW	MC		FULYZAQ[1]	
	MC/DEL		DICYCLOMINE HCL	MC/DEL		GLYCOPYRROLATE INJ	
	MC/DEL		GLYCOPYRROLATE TABS	MC/DEL		HYOSCYAMINE SL	
	MC		HAPONAL TABS	MC/DEL		LEVBID TB12	
	MC/DEL		HYOSCYAMINE CAPS & TABS	MC		LEVSIN ELIX	
	MC/DEL		HYOSCYAMINE SULFATE	MC		LEVSIN TABS	
	MC/DEL		KAOPECTATE	MC		LEVSIN/SL SUBL	
	MC/DEL		MAGNESIUM OXIDE TABS	MC		NULEV TBDP	
	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	
GI - H2-ANTAGONISTS	MC/DEL		CIMETIDINE	MC		AXID CAPS	Use PA Form# 20420
	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	
				MC/DEL		RANITIDINE 150MG CAPS	
				MC/DEL		ZANTAC SYRP	
				MC/DEL		ZANTAC TABS	
GI - PROTON PUMP INHIBITOR	MC/DEL		OMEPRAZOLE 20MG[2]	MC/DEL	6	NEXIUM CPDR[4]	1. Prevacid Solutabs available without PA for children less than 9 years old. 2. Dosing limits apply, please see dosage consolidation list. 3. Please use multiple 20mg Capsules to obtain required dose.
	MC/DEL		PANTOPRAZOLE	MC	7	PRILOSEC OTC[4]	
				MC	7	ACIPHEX TBEC[4]	
				MC/DEL	8	DEXILANT (KAPIDEX)[2]	
				MC/DEL	8	PREVACID CPDR[4,5]	
				MC/DEL	8	PREVACID SOLUTABS[1]	
				MC/DEL	8	PRILOSEC CPDR	
					8	PROTONIX INJ	
				MC/DEL			

				MC/DEL	8	PROTONIX[2]	
				MC/DEL	8	OMEPRAZOLE 10MG[2]	
				MC	8	OMEPRAZOLE-SODIUM BICARBONATE CAPS	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
				MC/DEL	8	LANSOPRAZOLE	
				MC	9	OMEPRAZOLE 40MG[3]	
GI - ULCER ANTI-INFECTIVE				MC		HELIDAC	Use PA Form# 20420
				MC		PREVPAC	
				MC		PYLERA	
GI - PROSTAGLANDINS	MC		MISOPROSTOL TABS	MC/DEL		CYTOTEC TABS	Use PA Form# 20420
GI - DIGESTIVE ENZYMES	MC/DEL		CREON[1]	MC/DEL		LACTRASE CAPS	Use PA Form# 20420 1. Clinical PA is required to establish CF diagnosis and medical necessity. In all cases except cystic fibrosis patients, objective evidence of pancreatic insufficiency (fat malabsorption test etc...) must be supplied.
	MC/DEL		LACTASE CHEW	MC		PANCREAZE	
	MC/DEL		LACTASE TAB	MC/DEL		PERTZYE	
	MC		ZENPEP[1]	MC/DEL		ULTRESA	
				MC/DEL		VIOKACE	
GI - ANTI - FLATULENTS / GI STIMULANTS	MC		CALULOSE SYRP	MC/DEL		AMITIZA[2]	1. Diag codes no longer necessary for preferred products. Lactulose has 60cc/day QL Use PA Form# 20420 2. Prior failed trials of multiple other preferred GI agents must occur first, Such as OTC senna, docusate, lactulose, polyethylene glycol.
	MC/DEL		CONSTULOSE SYRP	MC		CEPHULAC SYRP	
	MC/DEL		ENULOSE SYRP[1]	MC/DEL		INFANTS GAS RELIEF SUSP	
	MC		GASTROCROM CONC	MC/DEL		REGLAN TABS	
	MC/DEL		GENERLAC SYRP[1]				
	MC/DEL		LACTULOSE SYRP[1]				
	MC/DEL		METOCLOPRAMIDE HCL				
	MC/DEL		SIMETHICONE				
GI - INFLAMMATORY BOWEL AGENTS	MC		APRISO	MC/DEL		ASACOL 800MG HD	Use PA Form# 20420
	MC		AZULFIDINE TABS	MC/DEL		AZULFIDINE EN-TABS TBEC	
	MC/DEL		BALSALAZIDE	MC/DEL		DELZICOL	1. Current users

	MC		CANASA SUPP	MC		GIAZO	grandfathered.
	MC		COLAZAL CAPS	MC/DEL		LIALDA TABS[1]	
	MC		DIPENTUM CAPS	MC/DEL		PENTASA 500MG[2]	2. Use multiple Pentasa 250mg.
	MC		PENTASA CPCR 250MG	MC		SFROWASA	
	MC/DEL		ROWASA ENEM	MC		UCERIS RECTAL FOAM[3]	
	MC/DEL		**SULFAZINE EC TBEC**	MC		UCERIS TABS[3]	3. Diagnosis required
	MC/DEL		**SULFASALAZINE TABS**				
GI - IRRITABLE BOWEL SYNDROME AGENTS				MC/DEL		LOTRONEX TABS	Use PA Form# 20420
GI- SHORT BOWL SYNDROME				MC		GATTEX	
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.
	MC/DEL		BISACODYL	MC		BENEFIBER	
	MC		BISCOLAX SUPP	MC/DEL		CARAFATE	
	MC		CINOBAC CAPS	MC/DEL		CLEARLAX POW	
	MC/DEL		CITRATE OF MAGNESIA SOLN	MC/DEL		COLACE CAPS	
	MC/DEL		CITRUCEL	MC/DEL		COLYTE	
	MC/DEL		DIOCTO SYRP	MC		DIOCTO-C SYRP	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	
	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. Use PA Form# 20420
	MC		CYTRA-K SOLN	MC/DEL		CYTRA-2 SOLN	
	MC		FURADANTIN SUSP	MC/DEL		ELMIRON CAPS[1]	
	MC		K-PHOS MF TABS	MC/DEL		MACROBID CAPS	
	MC/DEL		METHENAMINE MANDELATE TABS	MC/DEL		MACRODANTIN CAPS	
	MC/DEL		MONUROL PACK	MC/DEL		NITROFURANTOIN MACR SUSP	
	MC/DEL		NEOSPORIN GU IRRIGANT SOLN	MC		POTASSIUM CITRATE/CITRIC SOLN	
	MC/DEL		NITROFURANTOIN MONO CAPS	MC/DEL		PYRIDIUM PLUS TABS	
	MC/DEL		PHENAZOPYRIDINE HCL TABS	MC		PYRIDIUM TABS	
	MC/DEL		PHENAZOPYRIDINE PLUS	MC/DEL		RENACIDIN SOLN	
	MC/DEL		PROSED/DS TABS				
	MC		TRICITRATES SYRP				
	MC/DEL		URELIEF PLUS				
	MC		UREX TABS				
	MC/DEL		URISED TABS				
	MC		UROCIT-K				
	MC/DEL		UROQID #2 TABS				
PHOSPHATE BINDERS							
PHOSPHATE BINDERS	MC/DEL		CALCIUM ACETATE TAB[1]	MC		AURYXIA[1]	Use PA Form# 20420 1. Diag required.
	MC/DEL		CALCIUM ACETATE CAP[1]	MC/DEL		FOSRENOL[1]	
	MC/DEL		ELIPHOS[1]	MC/DEL		RENVELA[1]	
	MC/DEL		MAGNEBIND - 400[1]	MC		VELPHORO[1]	
	MC		PHOSLYRA[1]				
	MC/DEL		RENAGEL[1]				
INTRA-VAGINALS							
VAGINAL - ANTIBACTERIALS	MC/DEL		CLEOCIN CREA	MC/DEL		NUVESSA	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
	MC/DEL		METROGEL VAGINAL GEL[2]	MC/DEL		VANDAZOLE	
	MC/DEL		METRONIDAZOLE VAGINAL GEL[2]				
	MC/DEL		CLEOCIN SUPP[1]				
VAGINAL - ANTI FUNGALS	MC		CLINDESSE CREA	MC		AVC CREA	
	MC/DEL		CLOTRIMAZOLE CREA	MC		CLOTRIMAZOLE 3 DAY CREA	1. Quantity limit: 1/script/2 weeks Use PA Form# 20420
	MC/DEL		GYNE-LOTRIMIN CREA	MC		GYNAZOLE-1 CREA	
	MC		MICONAZOLE CREA	MC		GYNE-LOTRIMIN 3 TABS	

	MC/DEL		MICONAZOLE 3 COMBO PACK KIT[1]	MC/DEL		MICONAZOLE 3 SUPP	
	MC/DEL		MICONAZOLE 7 CREA	MC		TERAZOL 3 CREA	
	MC/DEL		MICONAZOLE NITRATE CREA	MC		TERAZOL 7 CREA	
	MC		NYSTATIN TABS	MC/DEL		TERCONAZOLE 0.8MG	
	MC/DEL		TERCONAZOLE 0.4MG	MC/DEL		TERCONAZOLE SUPP	
	MC		VAGITROL				
	MC		V-R MICONAZOLE-7 CREA				
VAGINAL - CONTRACEPTIVES							Use PA Form# 20420
VAGINAL - ESTROGENS	MC/DEL		**ESTRING RING**	MC/DEL		ESTRACE CREA[1]	1. Must fail all preferred products before non-preferred. Use PA Form# 20420
	MC/DEL		**PREMARIN CREA**	MC/DEL		VAGIFEM TABS[1]	
VAGINAL - OTHER	MC/DEL		ACID JELLY GEL	MC		AMINO ACID CERVICAL CREA	Use PA Form# 20420
	MC		ACI-JEL GEL				
	MC		CERVICAL AMINO ACID CREA				
BPH							
BPH	MC/DEL		**DOXAZOSIN MESYLATE TABS**	MC/DEL	5	**FLOMAX CP24**	1. There will be dosing limits of 1 tab per day with out PA. 2. Prior use of preferred agent prior to any approvals. 3. Use of preferred (tamsulosin and finasteride) and (tamsulosin and non-preferred Avodart). 4. Non-preferred products must be used in specified order. Use PA Form# 20420
	MC/DEL		FINASTERIDE[1]	MC/DEL	8	ALFUZOSIN	
	MC/DEL		TERAZOSIN HCL CAPS	MC/DEL	8	AVODART[2,4]	
	MC/DEL		**TAMSULOSIN HCL**	MC/DEL	8	**CARDURA TABS[4]**	
				MC/DEL	8	JALYN[3,4]	
				MC/DEL	8	PROSCAR TABS[4]	
				MC/DEL	8	RAPAFLO[4]	
				MC/DEL	8	UROXATRAL[4]	
ANXIOLYTICS							
ANXIOLYTICS - BENZODIAZEPINES	MC/DEL		ALPRAZOLAM TABS	MC/DEL	8	ALPRAZOLAM ER	Use PA Form# 20420
	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

	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
ANTIDEPRESSANTS - SELECTED SSRI's	MC/DEL		BUPROPION HCL TABS	MC/DEL	8	APLENZIN[7]	1. Use Fluoxetine 20 mg in multiples.
	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]	
	MC/DEL		FLUOXETINE HCL CAPS	MC/DEL	8	FETZIMA[12]	
	MC/DEL		FLUOXETINE HCL LIQD	MC/DEL	8	FLUOXETINE 40mg AND 60 mg CAPS[1]	
	MC/DEL		FLUVOXAMINE MALEATE TABS	MC/DEL	8	FLUOXETINE 10mg AND 20mg TABS[6]	
	MC/DEL		MIRTAZAPINE	MC	8	FORFIVO XL	
	MC/DEL		NEFAZODONE	MC/DEL	8	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.
	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.
				MC/DEL	8	MIRTAZAPINE ODT	
				MC	8	OLEPTRO	
				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.
				MC/DEL	8	PAXIL CR[3]	
				MC/DEL	8	PRISTIQ	
				MC	8	PROZAC	
				MC	8	PROZAC CAPS	
				MC	8	PROZAC WEEKLY CPDR	6. Use Fluoxetine 10mg tabs in multiples.
				MC/DEL	8	REMERON TABS	
				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	8	SAVELLA[8]	8. Dosing limits allowing 2

				MC/DEL	8	ZOLOFT	tabs/day and a max daily limit of 200mg / day applies. Please see dose consolidation list.
				MC/DEL	8	VENLAFAXINE TABS[9]	9. Dosing limits and max daily dose applies. Limit of 1 per day of 37.5mg, 75mg, will be allowed without pa, along with limits of 2 caps per day of the 150mg strength. Max daily dose allowed is 375mg.
				MC/DEL	8	VENLAFAXINE ER TABS[9]	10. Use venlafaxine ER tabs.
				MC/DEL	9	VIIBRYD	11. Non-preferred products must be used in specified step order.
				MC/DEL	9	FLUOXETINE 90mg TABS[11]	12. Requires previous trials/failure of multiple preferred medications. Dosing limits apply, please see the dose consolidation list. Max daily dose of 80mg if used concomitantly with strong CYP3A4 inhibitor.
							13.Dosing limits apply, please see dose consolidation list.
							Use PA Form# 20420
ANTIDEPRESSANTS - TRI-CYCLICS	MC/DEL		**AMITRIPTYLINE HCL TABS**[1]	MC/DEL		**AMOXAPINE TABS**	1. Users over the age of 65 require a pa.
	MC/DEL		**ANAFRANIL CAPS**[1]	MC/DEL		**CLOMIPRAMINE HCL CAPS**	
	MC/DEL		**DESIPRAMINE HCL TABS**[1]	MC/DEL		**DOXEPIN HCL 150 MG**[2]	
	MC/DEL		**DOXEPIN HCL**[1]	MC/DEL		**NORPRAMIN TABS**	
	MC/DEL		**IMIPRAMINE HCL TABS**[1]	MC/DEL		**PAMELOR**	2. Use multiples of 50mg.
	MC/DEL		**NORTRIPTYLINE HCL**[1]	MC		TOFRANIL	
	MC		PROTRIPTYLINE HCL TABS[1]	MC		VIVACTIL TABS	Use PA Form# 20420
	MC		SURMONTIL CAPS[1]				Use PA Form# 10220 for Brand Name requests
SEDATIVE / HYPNOTICS							

SEDATIVE/HYPNOTICS - BARBITURATE	MC		BUTISOL SODIUM TABS[1]	MC		LUMINAL SOLN	1. PA required for new users of preferred products if over 65 years.
	MC/DEL		CHLORAL HYDRATE SYRP[1]	MC/DEL		SOMNOTE CAPS	
	MC		MEBARAL TABS[1]				
	MC/DEL		PHENOBARBITAL[1]				Use PA Form# 20420
SEDATIVE/HYPNOTICS - BENZODIAZEPINES	MC/DEL		DORAL TABS[1]	MC		HALCION TABS[1]	1. Dosing limits apply, please see dosing consolidation list.
	MC/DEL		ESTAZOLAM TABS[1]	MC		MIDAZOLAM HCL SYRP	
	MC/DEL		FLURAZEPAM HCL CAPS[1]	MC/DEL		RESTORIL CAPS[1]	
	MC/DEL		TEMAZEPAM CAPS 15 & 30MG[1]	MC/DEL		TEMAZEPAM 7.5MG[1]	Use PA Form# 30110
	MC/DEL		TRIAZOLAM TABS[1]				
SEDATIVE/HYPNOTICS - Non-Benzodiazepines	MC/DEL	1	MIRTAZAPINE	MC/DEL	7	AMBIEN[1]	1. Quantity Limt of 12 per 34 days.
	MC	1	TRAZODONE	MC/DEL	7	**ESZOPICLONE**	2. Quantity limits will be allowed up to 30/30, but intermittent therapy is recommended.
	MC/DEL	1	ZOLPIDEM [2]	MC/DEL	7	**ZOLPIDEM ER**	
	MC/DEL	2	ZALEPLON [2,3]	MC/DEL	8	AMBIEN CR[1]	
				MC/DEL	8	BELSOMRA[1]	3. Only zolpidem trial/failure will be required to obtain Zaleplon.
				MCDEL	8	EDLUAR	
				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.
	MC/DEL		**OLANZAPINE**[4]	MC/DEL	8	ABILIFY MAINTENA	
	MC/DEL		RISPERIDONE TAB[4]	MC	8	ARISTADA[7]	
	MC/DEL		RISPERIDONE SOLN[4]	MC	8	FANAPT	
	MC/DEL		QUETIAPINE[4,6]	MC/DEL	8	GEODON	
	MC/DEL		**ZIPRASIDONE**[4]	MC	8	INVEGA	
				MC	8	INVEGA SUSTENNA	
				MC/DEL	8	INVEGA TRINZ INJ	
				MC	8	LATUDA	Use PA form# 20440 for Multiple Antipsychotic requests
				MC	8	REXULTI	
				MC	8	RISPERDAL TAB	
				MC	8	RISPERDAL CONSA [2]	
				MC	8	RISPERDAL M TAB[2]	
				MC	8	RISPERDAL SOLN	
				MC/DEL	8	RISPERIDONE ODT	Use PA form# 10130 for non-preferred single therapy atypical requests

				MC/DEL	8	SAPHRIS	1. Please use multiple 25mg tablets. 2. Established users of single therapy atypicals were grandfathered 3. Abilify requires splitting of tab to avoid PA. Please see Abilify splitting table. 4. Prior Authorization will be required for preferred medications for members under the age of 5. 5. Product is considered line extension of the original product due to Healthcare Reform (HCR). MaineCare will consider these medications non-preferred and a step 9 because of the impact under the Federal Rebate Program in conjunction with HCR. 6. Dosing limits apply: quetiapine 25mg, 50mg and 100mg are available without PA if the daily dosage is less than 1.5 tablets 7. Clinical PA required establishing significant reason why an oral agent can't be used
				MC/DEL	8	SEROQUEL 50MG TABS[1,2]	
				MC	8	ZYPREXA TABS	
				MC	8	ZYPREXA ZYDIS TBDP [2]	
				MC	8	ZYPREXA RELPREVV	
				MC/DEL	8	SEROQUEL TABS	
				MC/DEL	9	SEROQUEL XR[5]	
ANTIPSYCHOTICS - SPECIAL ATYPICALS	MC/DEL		CLOZAPINE TABS	MC/DEL		CLOZARIL TABS	Use PA Form# 20420
				MC		FAZACLO	
ANTIPSYCHOTICS - TYPICAL	MC/DEL		CHLORPROMAZINE HCL	MC/DEL		COMPAZINE	Use PA Form# 20420 If prescribing 2 or more antipsychotics, PA will be required for both drugs, except if one is Clozapine.
	MC/DEL		FLUPHENAZINE DECANOATE	MC/DEL		COMPRO SUPP	
	MC/DEL		FLUPHENAZINE HCL	MC		HALDOL DECANOATE	
	MC		HALDOL	MC/DEL		LOXITANE CAPS	
	MC/DEL		HALOPERIDOL	MC		MELLARIL	
	MC		HALOPERIDOL DECANOATE SOLN	MC/DEL		NAVANE CAPS	

	MC		HALOPERIDOL LACTATE SOLN	MC		PROLIXIN	
	MC/DEL		LOXAPINE SUCCINATE CAPS	MC		STELAZINE TABS	
	MC/DEL		LOXITANE-C CONC				
	MC		MOBAN TABS				
	MC/DEL		PERPHENAZINE				
	MC/DEL		PROCHLORPERAZINE				
	MC		SERENTIL				
	MC/DEL		THIORIDAZINE HCL				
	MC/DEL		THIOTHIXENE				
	MC/DEL		TRIFLUOPERAZINE HCL TABS				
LITHIUM							
LITHIUM	MC/DEL		LITHIUM CARBONATE	MC/DEL		ESKALITH CAPS	Use PA Form# 20420
	MC/DEL		LITHIUM CITRATE SYRP	MC/DEL		ESKALITH CR TBCR	
COMBINATION - PSYCHOTHERAPEUTIC							
PSYCHOTHERPEUTIC COMBINATION	MC/DEL		CHLORDIAZEPOXIDE/AMITRIPT	MC	8	SYMBYAX[1]	1. Only available if component ingredients are unavailable. Use PA Form# 20420
	MC/DEL		PERPHENAZINE/AMITRIPTYLIN				
STIMULANTS							
STIMULANT - AMPHETAMINES -SHORT ACTING	MC/DEL		AMPHETAMINE SALT COMBO[1,4]	MC/DEL		ADDERALL TABS	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
	MC/DEL		DEXTROAMPHET SULF TABS[1,3]	MC		EVEKEO	
	MC/DEL		DEXEDRINE[1,3,4]	MC		PROCENTRA	
STIMULANT - LONG ACTING AMPHETAMINES SALT	MC		VYVANSE[2,3,4]	MC	8	ADDERALL XR CP24[1,3,4]	Use PA Form# 20420
				MC/DEL	9	AMPHETAMINE/DEXTROAMPHET ER	1. As per recent FDA alert, Adderall should not be used in patients with underlying

							in patients with underlying heart defects since they may be at increased risk for sudden death. 2. FDA approval is currently for adults and children 6 or older. Will be available without PA for this age group if within dosing limits. Limit of one capsule daily. Max dose of 70MG daily. 3. Preferred stimulants will be available without PA if diagnosis of ADHD. 4. Dosing limits applly, please see dosing consolidation list.
LONG ACTING AMPHETAMINES	**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**		DEXMETHYLPHENIDATE IR TABS[1] METADATE ER TBCR[1,2] METHYLIN ER TBCR[1,2] METHYLIN TABS[1,2] METHYLIN SOL[1]	**MC/DEL** **MC** **MC/DEL**		FOCALIN IR TABS METHYLIN CHEWABLES RITALIN	1. Preferred stimulants will be available without PA if diagnosis of ADHD. Use PA Form# 20420 2. Dosing limits apply,

	MC/DEL		METHYLPHENIDATE HCL[1,2]				please see dosing consolidation list. Maximum daily doses are as follows: 72mg daily for methylphenidate and 36mg daily for dexmethylphenidate.
STIMULANT - METHYLPHENIDATE - LONG ACTING	MC/DEL		DAYTRANA[1,3]	MC	5	METADATE CD CPCR	1. Preferred stimulants will be available without PA if diagnosis of ADHD. 2. Non-preferred products must be used in specified step order. 3.FDA approval currently only for ages 6-16. Limit of one patch daily. Max dose of 30MG daily. 4.Dosing limits applly, please see dosing consolidation list. Use PA Form# 20420
	MC/DEL		FOCALIN XR[1]	MC	8	APTENSIO	
	MC/DEL		METHYLPHENIDATE ER TABS	MC	8	CONCERTA TBCR[2]	
	MC/DEL		RITALIN LA[4]	MC/DEL	8	METHYLPHENIDATE ER CAPS[1,2,4]	
				MC	8	QUILLIVANT XR	
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.
	MC		KAPVAY	MC	7	STRATTERA[1, 2]	
				MC	8	CAFCIT SOLN[3]	
				MC/DEL	8	INTUNIV	
				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 Use PA Form# 20710 for Xenazine 1.See criteria section
				MC		XYREM SOL[1]	
				MC		XENAZINE	
WEIGHT LOSS							
WEIGHT LOSS							No longer covered: PHENTERMINE, XENICAL,DIDREX, and MERIDIA
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. 2. Must fail all preferred products before moving to non-preferred. Use PA Form# 20420
	MC/DEL		DONEPEZIL HYDROCHLORIDE ODT[1]	MC	6	ARICEPT ODT[2]	
	MC/DEL		EXELON DIS[1]	MC/DEL	7	DONEPEZIL HYDROCHLORIDE TABS 23MG	
	MC/DEL		**GALANTAMINE CAPS[1]**	MC/DEL	8	EXELON CAP	
	MC/DEL		**GALANTAMINE TAB[1]**	MC/DEL	8	NAMZARIC	
	MC/DEL		NAMENDA[1]	MC	8	RAZADYNE[2]	
	MC/DEL		NAMENDA XR CAPS[1]	MC	9	COGNEX CAPS[2]	
	MC/DEL		RIVASTIGMINE TARTRATE CAPS[1]				
SMOKING CESSATION							
NICOTINE PATCHES / TABLETS	MC/DEL		CHANTIX[1]	MC/DEL		NICODERM CQ PT24[1]	Use PA Form# 20420 1. See criteria section for exemptions
	MC/DEL		NICOTINE DIS PT24[1]				
NICOTINE REPLACEMENT - OTHER	MC/DEL		NICOTINE POLACRILEX GUM[1]	MC/DEL	8	NICOTROL INHALER[1,2]	Use PA Form# 20420 1. See criteria section for exemptions 2. Must use non-preferred
				MC/DEL	8	NICOTROL NASAL SPRAY[1,2]	
				MC/DEL	8	NICORETTE GUM[1,2]	
				MC	8	NICORETTE LOZENGES	

							products in specified step order.
ALCOHOL DETERRENTS							
ALCOHOL DETERRENTS	MC		ANTABUSE TABS	MC/DEL		**ACAMPRO**[1]	1. Should only be used in conjunction with formal structured outpatient detoxification program. Use PA Form# 20420
	MC		DISULFIRAM TABS				
	MC/DEL		NALTREXONE HCL TABS				
MISCELLANEOUS ANALGESICS							
ANALGESICS - MISC.	MC/DEL		ACETAMINOPHEN	MC		AXOCET CAPS	Use PA Form# 20420
	MC/DEL		**ASPIRIN**	MC/DEL		ESGIC-PLUS	
	MC/DEL		ASPRIN/ APAP/ CAFF TAB	MC/DEL		FIORICET TABS	
	MC/DEL		BUTAL/ASA/CAFF	MC		FIORINAL CAPS	
	MC/DEL		BUTALBITAL COMPOUND	MC		FIORTAL CAPS	
	MC/DEL		BUTALBITAL/ACET TABS	MC/DEL		FORTABS TABS	
	MC/DEL		BUTALBITAL/APAP CAPS	MC		PHRENILIN TABS	
	MC/DEL		BUTALBITAL/APAP/CAFFEINE	MC		PHRENILIN FORTE CAPS	
	MC/DEL		**CHOLINE MAGNESIUM TRISALI**	MC		TRILISATE LIQD	
	MC/DEL		**DIFLUNISAL TABS**	MC		TRILISATE TABS	
	MC		EXCEDRIN	MC		ZEBUTAL CAPS	
	MC/DEL		**SALSALATE TABS**	MC		ZORPRIN TBCR	
LONG ACTING NARCOTICS							
NARCOTICS - LONG ACTING	MC/DEL		EMBEDA	MC	8	AVINZA	Use PA Form# 20510 Use PA form #10300 for PAs over the opiate limit 1. Oxycontin will be available without PA for patients treated for or dying from cancer or hospice patients. CA (cancer) or HO (hospice) diag code may be used but store must verify since all scripts will be audited and stores will be liable.
	MC/DEL		FENTANYL PATCH[4]	MC	8	DURAGESIC PT72[4]	
	MC		KADIAN	MC	8	EXALGO	
	MC/DEL		METHADONE	MC/DEL	8	HYSINGLA ER	
	MC/DEL		METHADOSE	MC/DEL	8	MORPHINE SULFATE SUPP	
	MC/DEL		MORPHINE SULFATE ER TB12	MC/DEL	8	MS CONTIN TB12	
	MC/DEL		BUTRANS[4]	MC	8	OPANA ER	
				MC/DEL	8	ORAMORPH SR TB12	
				MC/DEL	8	OXYCONTIN TB12[1]	
				MC	8	XARTEMIS ER	
				MC	8	ZOHYDRO ER	
				MC/DEL	9	NUCYNTA ER	
				MC/DEL	9	OXYCODONE ER[3,5]	

							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.
NARCOTICS - SELECTED	**MC/DEL**		TRAMADOL HCL TABS	**MC/DEL**	7	RYZOLT	Use PA Form# 20420
				MC	8	BUPRENEX SOLN	Use PA form #10300 for PAs over the opiate limit 1. Only available if component ingredients are unavailable.
				MC/DEL	8	BUTORPHANOL	
				MC	8	NALBUPHINE HCL SOLN	
				MC	8	STADOL NS SOLN	
				MC	8	TRAMADOL ER	
				MC	8	ULTRACET TABS[1]	
				MC	8	ULTRAM TABS	
				MC	9	ULTRAM ER	

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.
	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	
	MC/DEL		HYDROCODONE/ACETAMINOPHEN	MC	8	IBUDONE	
	MC/DEL		HYDROMORPHONE HCL[3]	MC/DEL	8	LORCET	
	MC		LORTAB ELX	MC	8	LORTAB	
	MC/DEL		MEPERIDINE HCL	MC	8	MAXIDONE TABS	
	MC/DEL		OXYCODONE	MC/DEL	8	NORCO TABS	
	MC/DEL		OXYCODONE/ACETAMINOPHEN[2,3]	MC/DEL	8	NUCYNTA	
	MC/DEL		PENTAZOCINE/NALOXONE TABS	MC/DEL	8	ONSOLIS	
	MC		PROPOXYPHENE CMPND-65 CAPS	MC/DEL	8	OXECTA	
	MC		PROPOXYPHENE COMPOUND CAPS	MC/DEL	8	OXYCODONE/APAP 10/650	
	MC/DEL		PROPOXYPHENE HCL CAPS	MC/DEL	8	OXYCODONE/APAP 7.5/500	
	MC/DEL		PROPOXYPHENE/ACET TABS	MC/DEL	8	PENTAZOCINE/ACET TABS	
	MC/DEL		PROPOXYPHENE-N/ACET TABS	MC	8	PERCOCET TABS	
	MC/DEL		ROXICET	MC	8	PERCOCET TABS	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	9	CONZIP	Use PA Form# 20420
				MC	9	OPANA	Use PA form #10300 for PAs over the opiate limit
OPIOID DEPENDENCE TREATMENTS	**MC**		SUBOXONE FILM[2]	MC		SUBOXONE TABS[3]	Use PA Form# 10200 for Suboxone Continuation Use PA Form# 10100 for Suboxone Restart
				MC		BUNAVAIL[4]	
				MC/DEL		BUPRENORPHINE[1,2]	1. Buprenorphine will only be approved for use during pregnancy.
				MC		ZUBSOLV[4]	2. See Criteria Section
							3. The manufacturer will be disconntinuing the tablets by the end of quarter one 2013.
							4. 24month lifetime limit for treatment of opioid addiction

NARCOTIC ANTAGONISTS							
NARCOTIC - ANTAGONISTS	MC/DEL		NALTREXONE HCL TABS	MC		EVZIO	Use PA Form# 20420 Use PA form# 30400 for Vivitrol requests
				MC		NALOXONE INJ	
				MC/DEL		REVIA TABS[1]	1. Will only be approved for side effects experienced with generic that are not described in the literature as occurring with the brand version.
				MC/DEL		VIVITROL INJ[2]	2. Please see the criteria listed on the Vivitrrol PA form. Any narcotics attempting to be filled during Vivitrol approval will require prior authorization.
COX 2 / NSAIDS							
COX 2 INHIBITORS - SELECTIVE / HIGHLY SELECTIVE	MC/DEL		CELEBREX CAPS [4,5,6]	MC/DEL		**MOBIC[6]**	Use PA Form# 10310 1. Meloxicam has dosing limits allowing one tablet daily of all strengths without PA.
	MC/DEL		KETOROLAC TROMETHAMINE [2,3,6]	MC/DEL		MOBIC SUSP[6]	
	MC/DEL		NABUMETONE TABS[6]	MC/DEL		**RELAFEN TABS[6]**	
	MC/DEL		MELOXICAM[1,6]				2. Ketorolac Tromethamine is indicated for the short term (up to 5 days) managment of moderately severe acute pain that requires analgesic at the opiod level in adults. Not indicated for minor of chronic pain conditions. 3. Ketorolac has dosing limits allowing 24 tablets for a 5 day supply every 30 days.

							4. Dosing limits will be set at a maximum of 200mg twice daily for PA requests. 5. Users 60 years of age or older will not require PA. If under 60 years of age, Celebrex will require PA. 6. The FDA has issued a Public Health Advisory warning of the potential for increased cardiovascular risk & GI bleeding with NSAID use.
NSAIDS	**MC/DEL**		**CHILDRENS IBUPROFEN**	**MC**		ADVIL TABS	The FDA has issued a Public Health Advisory warning of the potential for increased cardiovascular risk & GI bleeding with NSAID use. Use PA Form# 20420
	MC/DEL		**DICLOFENAC POTASSIUM TABS**	**MC**		ANAPROX TABS	
	MC/DEL		**DICLOFENAC SODIUM**	**MC**		ANAPROX DS TABS	
	MC/DEL		**ETODOLAC**	**MC**		CAMBIA	
	MC/DEL		**FENOPROFEN CALCIUM TABS**	**MC/DEL**		**CATAFLAM TABS**	
	MC/DEL		**FLURBIPROFEN TABS**	**MC**		CHILDRENS ADVIL SUSP	
	MC/DEL		**IBUPROFEN**	**MC**		CHILD'S IBUPROFEN SUSP	
	MC/DEL		**INDOMETHACIN**	**MC/DEL**		CHILDREN'S MOTRIN SUSP	
	MC/DEL		**KETOPROFEN**	**MC/DEL**		**CLINORIL TABS**	
	MC/DEL		**MECLOFENAMATE SODIUM CAPS**	**MC/DEL**		**DAYPRO TABS**	
	MC/DEL		NAPROSYN SUSP	**MC/DEL**		**EC-NAPROSYN TBEC**	
	MC/DEL		NAPROXEN SUSP	**MC/DEL**		**ETODOLAC ER 600MG**	
	MC/DEL		**NAPROXEN TABS**	**MC**		FELDENE CAPS	
	MC/DEL		**NAPROXEN SODIUM TABS**	**MC/DEL**		IBU-200	
	MC/DEL		**OXAPROZIN TABS**	**MC**		INDOCIN	
	MC/DEL		**SULINDAC TABS**	**MC/DEL**		**LODINE**	
	MC/DEL		**TOLMETIN SODIUM**	**MC/DEL**		**MOTRIN**	
				MC		NALFON CAPS	
				MC/DEL		NAPRELAN TBCR	
				MC/DEL		NAPROSYN TABS	
				MC/DEL		**NAPROXEN DR TBEC**	
				MC/DEL		**NAPROXEN SODIUM TBCR**	
				MC		PENNSAID	
				MC/DEL		**PIROXICAM CAPS**	
				MC		PONSTEL CAPS	
				MC		SB IBUPROFEN TABS	
				MC		SPRIX	
				MC		TOLECTIN	
				MC/DEL		VOLTAREN	

				MC		V-R IBUPROFEN TABS	
				MC		ZORVOLEX	
NSAID - PPI				MC		PREVACID NAPRA-PAC	1. Use a preferred NSAID and PPI separately. Use PA Form# 20420
				MC/DEL		VIMOVO[1]	
RHEUMATOID ARTHRITIS							
RHEUMATOID ARTHRITIS	MC/DEL	1	**AZATHIOPRINE**	MC/DEL		**ARAVA**	Use PA Form# 20900
	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	
	MC/DEL	1	METHOTREXATE	MC/DEL		ENTYVIO	
	MC/DEL	1	**SULFASALAZINE TABS**	MC/DEL		**ILARIS**[2,5,6]	
	MC	2	**ENBREL**[1,4]	MC		**KINERET SOLN**	2. Dosing limits apply. Please see dose consolidation list.
	MC	2	**HUMIRA**[1,2,4]	MC		ORENCIA	
				MC		RASUVO[7]	
				MC		**REMICADE**	3. Preferred dosage form allowed without PA after trial of step 1 prodcuts is multi-dose vial, with dosing limits allowing 8 injections per 28 days without pa.
				MC		SIMPONI	4. Established users will be grandfathered for Enbrel and Humira.
				MC/DEL		**XELJANZ**	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
MISCELLANEOUS ARTHRITIS							
ARTHRITIS - MISC.	MC		RIDAURA CAPS	MC/DEL		**ARTHROTEC**[1]	1. The individual components of Arthrotec are available without PA. Use PA Form# 20420
	MC		MYOCHRYSINE SOLN				
LUPUS-SLE							
LUPUS-SLE				MC		BENLYSTA	Use PA Form# 20420
MIGRAINE THERAPIES							
MIGRAINE - ERGOTAMINE DERIVATIVES	MC		MIGRANAL SOLN	MC/DEL		D.H.E. 45 SOLN	Use PA Form# 10110

	MC		SANSERT TABS				
MIGRAINE - CARBOXYLIC ACID DERIVATIVES	MC		DIVALPROEX ER TB24	MC		DEPAKOTE ER TB24	Use PA Form# 10110
MIGRAINE - SELECTIVE SEROTONIN AGONISTS (5HT)--Tabs	MC/DEL 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		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
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) transdermal				MC		ZECUITY PATCH[1,2]	Use PA Form# 10110 1. Dosing limits apply. Please see dose consolidation list. 2. Clinical PA required to establish significant contraindication to other preferred and non-preferred agents.
MIGRAINE - SELECTIVE SEROTONIN AGONISTS (5HT)--Combinations				MC/DEL		TREXIMET[1,2]	Use PA Form# 10110 1. Dosing limits apply. Please see dose consolidation list. 2. Use preferred Sumatriptan and Naproxen separately. Treximet only available if component ingredients of sumatriptan and naproxen are unavailable.
MIGRAINE - MISC.	MC/DEL MC/DEL		CAFERGOT TABS SPASTRIN TABS	MC/DEL MC MC/DEL		MIGRAZONE CAPS BELCOMP-PB SUPP MIGERGOT SUP	Use PA Form# 10110

GOUT

GOUT	MC/DEL		**ALLOPURINOL TABS**	MC		COLCRYS	Use PA Form# 20420	
	MC/DEL		**PROBENECID TABS**	MC/DEL		ULORIC[1]	1. Failure of therapeutic (300mg) dose of Allopurinol (failure define as not being able to get uric acid levels below 6mg/dl) or severe renal disease.	
	MC/DEL		**PROBENECID/COLCHICINE TABS**	MC		ZYLOPRIM TABS		

MISC.

ANESTHETICS - MISC.	MC		BUPIVACAINE HCL SOLN	MC		SENSORCAINE-MPF SOLN	Use PA Form# 30130	
	MC		LIDOCAINE HCL SOLN	MC/DEL		SYNVISC INJ		
	MC		MARCAINE SOLN	MC		XYLOCAINE SOLN		
VACCINES	MC/DEL		GARDASIL VACCINES				Use PA Form# 20420	

ANTI-CONVULSANTS

ANTICONVULSANTS	MC/DEL		CARBAMAZEPINE	MC	8	APTIOM	Use PA Form# 20420	
	MC/DEL		CARBATROL CP12	MC	8	BANZEL		
	MC/DEL		CELONTIN CAPS	MC	8	DEPAKENE	All non-preferred meds must be used in specified order	
	MC/DEL		CLONAZEPAM TABS	MC	8	DEPAKOTE		
	MC		DEPAKOTE SPRINKLES CPSP	MC	8	DEPAKOTE ER		
	MC/DEL		DIASTAT[1]	MC/DEL	8	DIAZEPAM GEL	1. Quantity limit. 5/month	
	MC/DEL		DILANTIN	MC/DEL	8	DIVALPROEX SODIUM SPRINKLE CAPS	2. Dosing limits apply, please see dose consolidation list.	
	MC/DEL		DIVALPROEX SODIUM	MC/DEL	8	EQUETRO		
	MC/DEL		EPITOL TABS	MC/DEL	8	GABITRIL TABS		
	MC/DEL		ETHOSUXIMIDE SYRP	MC/DEL	8	HORIZANT	3. Dosing limits apply per strength as well as a maximum daily dose of 600mg. Please see dose consolidation list.	
	MC/DEL		FELBATOL	MC/DEL	8	GABAPENTIN 600mg & 800mg		
	MC		FYCOMPA[2]	MC	8	GRALISE		
	MC/DEL		GABAPENTIN[2] 300mg & 400mg	MC/DEL	8	KEPPRA TABS		
	MC/DEL		LAMOTRIGINE[2]	MC/DEL	8	KEPPRA SOLN		
	MC/DEL		LEVETIRACETAM SOLN/TABS	MC/DEL	8	KLONOPIN TABS		
	MC/DEL		OXCARBAZEPINE	MC/DEL	8	LAMICTAL		
	MC/DEL		PHENYTEK CAPS	MC/DEL	8	**LEVETIRACETAM INJ**	4. Adjunctive therapy 17 and older.	
	MC/DEL		PHENYTOIN	MC/DEL	8	**LEVETIRACETAM ER TABS**		
	MC/DEL		PRIMIDONE TABS	MC/DEL	8	LYRICA[3]	5. Current users as of 7/30/10 for seizures will be grandfathered.	
	MC/DEL		TEGRETOL	MC/DEL	8	MYSOLINE TABS		
	MC/DEL		TOPIRAMATE	MC	8	ONFI		
	MC/DEL		TOPIRAMATE SPRINKLE CAPS[2]	MC	8	OXTELLAR XR[7]		
	MC/DEL		TRILEPTAL SUSP	MC/DEL	8	POTIGA		
	MC/DEL		VALPROIC ACID				6. Product is considered line extension of the original product due to Healthcare Reform (HCR). MaineCare will consider these	
	MC/DEL		VALPROIC ACID					
	MC/DEL		VIMPAT[4]	MC	8	SABRIL		
	MC/DEL		ZONISAMIDE	MC	8	TOPAMAX		

				MC	8	TOPAMAX SPRINKLE CAPS[2]	medications non-preferred and a step 9 because of the impact under the Federal Rebate Program in conjunction with HCR.
				MC	8	TROKENDI[2,8]	
				MC/DEL	8	TRILEPTAL	
				MC/DEL	8	ZARONTIN SYRP	
				MC/DEL	9	KEPPRA XR [5,6]	
				MC/DEL	9	NEURONTIN	
				MC/DEL	9	TEGRETOL-XR TB12 [5,6]	
				MC/DEL	9	ZONEGRAN CAPS	7. Max dose 2400mg
				MC/DEL	9	LAMICTAL XR	8. Clinical PA required for appropriate diagnosis
						BIPOLAR DISORDER: STEP ORDER	
					M ~ A		SEE ANTICONVULSANT INDICATION CHART AT THE END OF THIS DOCUMENT M= Monotherapy 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
PARKINSONS - SELECTED DOPAMIN AGONISTS	MC/DEL		PRAMIPEXOLE	MC/DEL	5	MIRAPEX TABS[1]	Use PA Form# 20420
	MC/DEL		ROPINIROLE	MC/DEL	8	REQUIP TABS	1. As of 12/08 users of Mirapex will be grandfathered if diagnosis is Parkinsons.
				MC/DEL	8	REQUIP XL TABS	
				MC/DEL	8	MIRAPEX ER	
				MC/DEL	8	NEUPRO PATCH	
PARKINSONS - DOPAMINERGICS/CARBII/ LEVO	MC/DEL		AMANTADINE HCL	MC/DEL		APOKYN[3]	1. Approvals will require concurrent therapy with Levodopa and failed trials of Selegiline, Comtan, and Stalevo.
	MC/DEL		BROMOCRIPTINE MESYLATE TABS	MC		AZILECT[2]	
	MC/DEL		CARBIDOPA/LEVODOPA TABS[3]	MC/DEL		BROMOCRIPTINE MESYLATE CAPS	
	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	
	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	
				MC/DEL	8	METAXALONE	
				MC	8	NORFLEX TBCR	
				MC	8	ROBAXIN-750 TABS	
				MC	8	VECUROMIUM INJ	
				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
				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.
VITAMINS							
VITAMINS	MC/DEL		ASCORBIC ACID TABS	MC		AQUASOL E SOLN	Use PA Form# 20420
	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	
	MC		FERIVAFA CAP				Click here for the OTC List
	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				
	MC/DEL		NIACIN				
	MC		NIACOR TABS				
	MC/DEL		NICOTINIC ACID SR CPCR				
	MC		PYRIDOXINE HCL TABS				
	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. Use PA Form# 20420
	MC/DEL		**VITAMIN D**	MC		CALCIJEX	
	MC		ZEMPLAR TABS	MC/DEL		HECTOROL (ORAL)	
				MC/DEL		HECTOROL (PARENTERAL)	
				MC/DEL		**ROCALTROL**	
				MC		ZEMPLAR INJ	
MISC MULTI-VITAMINS							
VITAMINS - MISC.	MC		CENTRUM LIQD	MC		ADEKS	1. Diag codes are no longer required on prenatal vitamins. **Please refer to OTC list.** Use PA Form# 20420 Click here for the OTC List
	MC		CENTRUM TABS	MC/DEL		ADVANCED NATALCARE TABS	
	MC		CENTRUM JR/IRON CHEW	MC		AQUADEKS	
	MC		CENTRUM SILVER TABS	MC		CENTRUM JR/EXTRA C CHEW	
	MC		CENTRUM-LUTEIN TABS	MC		CENTRUM PERFORMANCE TABS	
	MC		CEROVITE ADVANCED FO TABS	MC		CITRANATAL	
	MC/DEL		CHEWABLE MULTIVIT/FL CHEW	MC		DALYVITE LIQD	
	MC		COD LIVER OIL CAPS	MC		EMBREX 600 MISC	
	MC		COMPLETE SENIOR TABS	MC		IBERET	
	MC		DAILY MULTI VIT/IRON	MC		MATERNA TABS	
	MC/DEL		DIALYVITE 1MG	MC		MAXARON	
	MC/DEL		DIALYVITE 800MG	MC		MULTIRET FOLIC -500 TBCR	
	MC		FERRALET 90	MC/DEL		NATAFORT TABS	
	MC/DEL		FULL SPECTRUM B	MC/DEL		NATALCARE CFE 60 TABS[1]	
	MC		M.V.I.-12 INJ	MC/DEL		NATALCARE GLOSS TABS[1]	
	MC		MULTI-VIT/FLUORIDE	MC		NATALCARE PIC TABS[1]	
	MC/DEL		NATALCARE RX TABS	MC		NATALCARE PIC FORTE TABS[1]	
	MC/DEL		NEPHRONEX	MC/DEL		NATALCARE PLUS TABS[1]	
	MC/DEL		O-CAL PRENATAL	MC		NATALCARE THREE TABS[1]	
	MC/DEL		ONE DAILY TABS	MC/DEL		NATACHEW CHEW	
	MC/DEL		ONE-DAILY MULTIVITAMINS	MC		NATALFIRST TABS	
	MC/DEL		ONE-TABLET-DAILY	MC		NATATAB RX TABS	
	MC/DEL		POLY-VIT/IRON/FLUORID SOLN	MC/DEL		NEPHPLEX RX TABS	
	MC/DEL		POLY-VITAMIN/FLUORIDE SOLN	MC/DEL		NEPHROCAPS CAPS	
	MC/DEL		POLY-VITAMINS/IRON SOLN	MC/DEL		NEPHRO-VITE TABS	
	MC/DEL		PRENATAL TABS[1]	MC		NESTABS RX TABS	
	MC/DEL		PRENATAL FORMULA 3 TABS[1]	MC/DEL		NIFEREX	
	MC/DEL		PRENATAL PLUS TABS[1]	MC/DEL		OCUVITE TABS	
	MC/DEL		PRENATAL PLUS NF TABS[1]	MC		POLY-VI-FLOR SOLN	
	MC		PRENATAL PLUS/27MG IRON[1]	MC		POLY-VI-SOL SOLN	
	MC		PRENATAL PLUS/IRON TABS[1]	MC		POLY-VI-SOL/IRON SOLN	
	MC/DEL		PRENATAL RX/BETA-CAROTENE[1]	MC		POLY-VITAMIN DROPS SOLN	

	MC/DEL		RENAL CAPS	MC		PRECARE	
	MC/DEL		RENAPHRO CAPS	MC		PREFERA OB	
	MC		STRESS TAB NF TABS	MC		PREMESIS RX TABS	
	MC		THERAPEUTIC-M TABS	MC		PRENATABS CBF TABS[1]	
	MC		THERAVITE LIQD	MC		PRENATAL CARE TABS[1]	
	MC/DEL		TRI-VITAMIN/FLUORIDE SOLN	MC		PRENATAL MR 90 TBCR[1]	
	MC		VITA CON FORTE CAPS	MC/DEL		PRENATAL MTR/SELENIUM TABS[1]	
	MC		VITAMIN B COMPLEX CAPS	MC		PRENATAL OPTIMA ADVANCE TABS[1]	
	MC		VITAPLEX PLUS TABS	MC		PRENATAL PC 40 TABS[1]	
				MC/DEL		PRENATAL RX TABS[1]	
				MC		PRENATE[1]	
				MC		PRENATE ELITE[1]	
				MC		PRIMACARE MISC	
				MC		PROTEGRA CAPS	
				MC		STUARTNATAL PLUS 3 TABS[1]	
				MC		TRI-VI-SOL SOLN	
				MC		TRI-VI-SOL/IRON SOLN	
				MC/DEL		ULTRA NATALCARE TABS	
				MC		ULTRA-NATAL TABS[1]	
				MC		VICON FORTE CAPS	
				MC		VINATAL FORTE TABS[1]	
				MC		VINATE[1]	
				MC/DEL		VINATE ADVANCED TABS[1]	
MISCELLANEOUS MINERALS							
MINERALS	MC		CALCARB	MC		ANEMAGEN	Use PA Form# 20420
	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	
	MC/DEL		CALCIUM CITRATE TABS	MC		CHROMAGEN	
	MC/DEL		CALCIUM GLUCONATE TABS	MC		CITRACAL PLUS TABS	
	MC/DEL		CALCIUM LACTATE TABS	MC		CONTRIN CAPS	
	MC		CALCIUM/MAGNESIUM TABS	MC		FEOGEN FORTE CAPS	
	MC/DEL		**CALCIUM/VITAMIN D TABS**	MC		FEROCON CAPS	
	MC		CALTRATE 600 TABS	MC/DEL		FERREX 150 CAPS	
	MC/DEL		CHEWABLE CALCIUM CHEW	MC		FERRO-SEQUELS TBCR	
	MC		CITRACAL TABS	MC		FE-TINIC CAPS	
	MC		CITRACAL + D TABS	MC		FE-TINIC 150 FORTE CAPS	
	MC		CITRUS CALCIUM TABS	MC/DEL		FLUOR-A-DAY SOLN	
	MC		CITRUS CALCIUM 1500 + D TABS	MC/DEL		K-DUR TBCR	
	MC		EFFERVESCENT POTASSIUM TBEF	MC		KLOR-CON PACK	

MC/DEL	FEOSTAT CHEW
MC	FERATAB TABS
MC/DEL	FER-GEN-SOL SOLN
MC	FER-IRON SOLN
MC	FERRONATE TABS
MC/DEL	FERROUS SULFATE
MC/DEL	FLUOR-A-DAY CHEW
MC	FLUORIDE CHEW
MC	FLUORIDE SODIUM CHEW
MC	FLUORITAB CHEW
MC	HEMOCYTE TABS
MC	HM CALCIUM TABS
MC	K+ POTASSIUM PACK
MC	KAON ELIX
MC	KAON-CL-10 TBCR
MC	KCL 0.075%/D5W/NACL 0.2% SOLN
MC	K-EFFERVESCENT TBEF
MC	KLOR-CON
MC	KLOTRIX TBCR
MC/DEL	K-PHOS TABS
MC/DEL	K-VESCENT TBEF
MC/DEL	LURIDE CHEW
MC/DEL	MAGNESIUM GLUCONATE TABS
MC/DEL	MAGNESIUM SULFATE SOLN
MC	MAGTABS
MC	MICRO-K 8 MEG
MC/DEL	OS-CAL TABS
MC/DEL	**OS-CAL 500 + D TABS**
MC/DEL	**OYSCO**
MC/DEL	OYST-CAL TABS
MC/DEL	**OYST-CAL D TABS**
MC/DEL	**OYST-CAL/VITAMIN D TABS**
MC/DEL	OYSTER CALCIUM TABS
MC/DEL	OYSTER SHELL
MC	PHARMA FLUR
MC/DEL	PHOSPHA 250 NEUTRAL TABS
MC	POTASSIUM BICARBONATE TBEF
MC/DEL	POTASSIUM CHLORIDE 8MEQ
MC	POTASSIUM EFFERVESCENT
MC/DEL	SELENIUM TABS
MC	SLOW-MAG TBCR
MC/DEL	SODIUM FLUORIDE
MC/DEL	SSKI SOLN
MC	K-LYTE
MC/DEL	K-PHOS TABS NEUTRAL
MC	K-TABS TBCR
MC	K-VESCENT PACK
MC	MICRO-K 10 MEG CPCR
MC	NU-IRON 150 CAPS
MC/DEL	**OYSTER SHELL CALCIUM/VITA TABS**
MC/DEL	POLY-IRON 150 CAPS
MC/DEL	POLYSACCHARIDE IRON CAPS
MC/DEL	POTASSIUM BICARB/CHLORIDE
MC/DEL	POTASSIUM CHLORIDE 10MEQ CAPS
MC/DEL	POTASSIUM CHLORIDE 8MEQ CAPS
MC/DEL	SLOW FE TBCR
MC	TUMS 500 CHEW
MC	VIACTIV CHEW

	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.
	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.
				MC/DEL		L-CARNITINE CAPS[1]	
				MC		LIPISORB LIQD[1]	
				MC		LOVAZA[1,2]	Use PA Form# 20420 & SGA Form
				MC		MODULEN IBD POWD[1]	
				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
				MC	8	ARANESP SOLN	1. Clinical PA is required to establish medical necessity and that appropriate lab monitoring is being done.
				MC/DEL	8	MIRCERA[1]	
				MC/DEL	8	OMONTYS	
GRANULOCYTE CSF							
GRANULOCYTE CSF				MC	8	LEUKINE	1. Must be used in specified step order.
				MC	8	NEUPOGEN SOLN[2]	
				MC	9	NEULASTA[1]	2.10 day supply/month may

				MC/DEL		ZARXIO	be used without a PA. Use PA Form# 20520
GAUCHER DISEASE							
GAUCHER DISEASE				MC		CERDELGA	Use PA Form# 20420
ANTICOAGULANTS / PLATELET AGENTS							
ANTICOAGULANTS	MC		ARIXTRA SOLN[1]	MC/DEL		**LOVENOX SOLN**	1. Arixtra, Fragmin and Enoxaparin therapy durations greater than 7 days require PA.
	MC/DEL		ENOXAPARIN[1]	MC/DEL		FONDAPARINUX	
	MC/DEL		ELIQUIS	MC		IPRIVASK	
	MC		COUMADIN TABS	MC/DEL		JANTOVEN	
	MC/DEL		FRAGMIN INJ[1]	MC/DEL		LOVENOX 300[2]	
	MC		HEPARIN SODIUM/NACL 0.9% SOLN	MC/DEL		**WARFARIN SODIUM TABS3**	
	MC		HEP-LOCK SOLN	MC/DEL		SAVAYSAS[4]	
	MC/DEL		**INNOHEP**				2. Use other strengths available to obtain desired dose.
	MC		HEPARIN LOCK SOLN				
	MC/DEL		HEPARIN LOCK FLUSH SOLN				3.Established users will be grandfathered, new starters must use preferred product Coumadin.
	MC/DEL		HEPARIN SODIUM SOLN				
	MC/DEL		PRADAXA				
	MC/DEL		XARELTO				
	MC/DEL		HEPARIN SODIUM LOCK FLUSH SOLN				4. 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.
	MC		ALPHANINE SD	MC		KOATE-DVI	
	MC/DEL		BENEFIX SOLR				2. Advate may be available with PA in cases of large volume dosing in patients with poor venous access.
	MC/DEL		HELIXATE FS KIT				
	MC		HEMOFIL - M				
	MC		HUMATE-P SOLR				
	MC		KOGENATE FS				
	MC		KONYNE - 80				
	MC		MONARC - M				
	MC		MONOCLATE - P				Use PA Form# 20420
	MC		MONONINE				

	MC		NOVOSEVEN SOLR				
	MC/DEL		PROFILNINE				
	MC		RECOMBINATE SOLR				
	MC		REFACTO				
	MC		WILATE INJ				
PLATELET AGGREGATION INHIBITORS	MC/DEL		ASPIRIN	MC/DEL	7	TICLOPIDINE HCL TABS	Use PA Form# 20715 for Plavix,Effent & Brilinta 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.
	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
	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
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
				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
	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		CILOXAN SOLN	Use PA Form# 20420
	MC/DEL		CIPROFLOXACIN SOL 0.3%	MC		OCUFLOX SOLN	
	MC/DEL		BESIVANCE				
	MC/DEL		OFLOXACIN				
	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.
	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

	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
	MC/DEL		ALREX SUSP	MC		BAC/POLY/NEOMY/HC OINT	
	MC		BLEPHAMIDE SUSP	MC		BLEPHAMIDE S.O.P. OINT	
	MC/DEL		DEXAMETH SOD PHOS SOLN	MC		BROMDAY	
	MC/DEL		FLAREX SUSP	MC		EFLONE SUSP	
	MC/DEL		FLUOROMETHOLONE SUSP	MC		FLUOR-OP SUSP	
	MC		FML S.O.P. OINT	MC/DEL		LOTEMAX SUSP	
	MC		MAXITROL OPTH OINT 0.1%	MC		NEO/POLY/BAC/HC OINT	
	MC		PRED MILD SUSP	MC/DEL		NEOM/POLY/DEX OPTH OINT 0.1%	
	MC/DEL		PREDNISOLONE	MC/DEL		OZURDEX	
	MC/DEL		TOBRADEX OINT	MC		PRED FORTE SUSP	
	MC/DEL		TOBRADEX ST	MC		PRED-G SUSP	
	MC/DEL		**LOTEMAX GEL**	MC		PRED-G S.O.P. OINT	
	MC/DEL		**LOTEMAX OINT**	MC/DEL		SULFACET SOD/PRED SOLN	
				MC/DEL		TOBRADEX SUSP	
				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
	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
	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
	MC		EPIFRIN SOLN				
OP. - SELECTIVE ALPHA ADRENERGIC AGONISTS	MC		ALPHAGAN P 0.15% SOLN	MC		ALPHAGAN SOLN	Use PA Form# 20420
	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
	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.
	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. Use PA Form# 20420
				MC		RESTASIS[1]	
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. 2. Dosing limits allowing one package per month. Please refer to Dose Consolidation List. 3. Only available if component ingredients are unavailable. 4. Dosing limits apply, please see dosing consolidation list. 5. Not approved for use in children <12 years of age Use PA Form# 10220 for Brand Name requests Use PA Form# 20420 for all other requests
	MC		BENZOYL PEROXIDE	MC		ACZONE	
	MC/DEL		CLINDAMYCIN PHOSPHATE [2]	MC		ALTINAC CREA	
	MC		ERYDERM SOLN	MC		AVITA CREA	
	MC/DEL		ERYTHROMYCIN GEL	MC		BENZAC	
	MC/DEL		ERYTHROMYCIN PADS	MC/DEL		BENZACLIN GEL[3]	
	MC/DEL		ERYTHROMYCIN SOLN	MC/DEL		BENZAGEL-10 GEL	
	MC		ISOTRETINOIN	MC/DEL		BENZAMYCIN GEL	
	MC		METRONIDAZOLE CREA[2]	MC/DEL		BENZAMYCINPAK PACK	
	MC		METRONIDAZOLE GEL[2]	MC		BENZEFOAM	
	MC		METRONIDAZOLE LOTN[2]	MC		BREVOXYL	
	MC/DEL		SODIUM SULFACET/SULF LOTN	MC/DEL		CLEOCIN-T[2]	
	MC		TAZORAC	MC		CLINAC BPO GEL	
	MC/DEL		TRETINOIN GEL[1]	MC		CLINDAGEL GEL	
	MC		TRETINOIN CREA[1,2]	MC		CLINDETS SWAB	
				MC		DESQUAM-E GEL	
				MC		DESQUAM-X	
				MC		DIFFERIN 0.3% GEL	
				MC		DIFFERIN	
				MC		DUAC GEL	
				MC		EMGEL GEL	
				MC		EPIDUO	
				MC		ERYCETTE PADS	
				MC/DEL		EVOCLIN	
				MC		FINEVIN CREA	
				MC/DEL		KLARON LOTN	
				MC		METROCREAM CREA[2]	
				MC		METROGEL GEL[2]	
				MC		METROLOTION LOTN[2]	
				MC		NEOBENZ MICRO	
				MC/DEL		NORITATE CREA	
				MC		ONEXTON[5]	
				MC		RETIN-A GEL[2]	
				MC		RETIN-A CREA[2]	
				MC		RETIN-A MICRO GEL	
				MC		SOOLANTRA[4]	
				MC/DEL		TRIAZ	
				MC		VELTIN	
				MC		ZENCIA WASH	
				MC		ZETACET	
				MC/DEL		ZIANA	
TOPICAL - ANTIBIOTIC	MC		BACIT/NEOMYCIN/POLYM OINT	MC/DEL		ALTABAX [1]	1. Dosing limits apply,

	MC/DEL		BACITRACIN OINT	MC/DEL		BACTROBAN OINT.	please see dosing consolidation list.
	MC/DEL		BACTROBAN CREA[1]	MC/DEL		TRIPLE ANTIBIOTIC OINT	
	MC/DEL		BACTROBAN NASAL OINT				
	MC/DEL		CENTANY OINT 2%[1]				Use PA Form# 20420
	MC/DEL		GENTAMICIN SULFATE				
	MC/DEL		MUPIROCIN[1]				
TOPICAL - ANTIFUNGALS	MC/DEL		BETAMETHASONE CLOTRIMAZOLE LOT	MC/DEL	8	BETAMETHASONE CLOTRIMAZOLE CREA	
	MC		CICLOPIROX 0.77 CREA	MC/DEL	8	CICLOPIROX SOLN	Use PA Form# 10120
	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	
	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	
	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
TOPICAL - ANTIPSORIATICS	MC/DEL		SORIATANE CAPS	MC		OXSORALEN ULTRA CAPS[1]	1. Must fail all preferred products before non-preferred.
	MC		TAZORAC	MC		PSORIATEC CREA[1]	
				MC/DEL		SORIATANE CK KIT[1]	2. Individual ingredients are available as preferred witout PA.
				MC/DEL		TACLONEX[1,2]	
				MC		VECTICAL[1]	Use PA Form# 20420
TOPICAL - ANTISEBORRHEICS	MC/DEL		SELENIUM SULFIDE SHAM	MC		CARMOL SCALP TREATMENT KIT	Use PA Form# 20420
				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]	

						valacyclovir. 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
	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
	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.
	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
TOPICAL - STEROID COMBINATIONS	MC		DERMA-SMOOTHE/FS ATOPIC P KIT	MC		CARMOL-HC CREA	Use PA Form# 20420
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.
	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
				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.
				MC	9	PROTOPIC OINT[1,2]	

							2. The FDA has issued a Public Health Advisory for both Elidel and Protopic concerning the potential cancer risk associated with their use. Use for children less than 2 years of age is not recommended.
TOPICAL - LOCAL ANESTHETICS	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.
	MC/DEL		CAPSAICIN CREA	MC/DEL		EMLA CREA	
	MC		ELA-MAX[1]	MC		LIDA MANTLE CREA	
	MC/DEL		LIDOCAINE/PRILOCAINE CREA[1]	MC		LIDODERM PTCH	
	MC/DEL		LIDOCAINE GEL	MC		PONTOCAINE SOLN	
				MC		SYNERA	Use PA Form# 20420
				MC		ZOSTRIX	
TOPICAL - DEPIGMENTING AGENTS				MC	8	ALUSTRA CREA	
				MC	8	EPIQUIN MICRO	
				MC	8	GLYQUIN CREA	
				MC/DEL	8	HYDROQUINONE CREA	Use PA Form# 20420
				MC/DEL	8	HYDROQUINONE/SUNSCREENS	
				MC	8	SOLAQUIN FORTE CREA	
				MC	8	TRI-LUMA CREA	
				MC	9	ELDOQUIN	
TOPICAL - SCABICIDES AND PEDICULICIDES	MC/DEL	1	ACTICIN CREA	MC		ELIMITE CREA	Use PA Form# 20420
	MC	1	LICE KILLING SHAM	MC		EURAX	1. Dosing limits apply, please refer to dosage consolidation list.
	MC/DEL	1	LICE TREATMENT CREME RINS LIQD	MC/DEL		LINDANE	
	MC/DEL	1	PERMETHRIN LOTN	MC		MALATHION	
	MC	2	NATROBA[1,2]			OVIDE LOTN	2. Will require two applications of permethrin.
				MC			
				MC		SKLICE	
				MC		ULESFIA	
TOPICAL - WOUND / DECUBITUS CARE				MC		REGRANEX GEL	Use PA Form# 20420
				MC/DEL		REGENECARE	
				MC/DEL		RADIAPLEXRX	
TOPICAL - ASTRINGENTS / PROTECTANTS	MC		XERAC AC SOLN	MC		LOWILA BAR	Use PA Form# 20420
				MC		MOISTURIN DRY SKIN CREA	1. Dosing limits apply, please refer to dosage consolidation list.
				MC		PROSHIELD PLUS SKIN PROTE CREA	
				MC		SURGILUBE GEL	
TOPICAL - ANTISEPTICS / DISINFECTANTS	MC/DEL		PHISOHEX LIQD	MC		BETADINE OINT	Use PA Form# 20420
	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
	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		ANTIBIOTIC EAR SOLN	Use PA Form# 20420
	MC		ACETASOL SOLN	MC		ANTIBIOTIC EAR SUSP	
	MC/DEL		ACETASOL HC SOLN	MC		COLY-MYCIN-S SUSP	
	MC/DEL		ACETIC ACID	MC/DEL		CORTISPORIN-TC SUSP	
	MC/DEL		ACETIC ACID/HYDROCORTISON	MC/DEL		DEBROX SOLN	
	MC/DEL		ALLERGEN SOLN	MC		DERMOTIC	
	MC		CARBAMIDE PEROXIDE 6.5% OTIC SOLN.	MC/DEL		OFLOXACIN 0.3% OTIC	
	MC/DEL		CIPRODEX				
	MC/DEL		CIPRO HC SUSP				
	MC		CORTISPORIN SOLN				
	MC/DEL		CORTOMYCIN				
	MC		EAR DROPS SOLN				
	MC		EAR DROPS RX SOLN				
	MC/DEL		EAR WAX REMOVAL DROPS				
	MC/DEL		NEOMYCIN/POLYMYXIN/HC				
MOUTH ANTISEPTICS							
MOUTH ANTI-INFECTIVES	MC		NILSTAT SUSP	MC		MYCELEX TROC	Use PA Form# 20420
	MC/DEL		NYSTATIN SUSP	MC		ORAVIG	
MOUTH ANTISEPTICS	MC/DEL		CHLORHEXIDINE GLUCONATE	MC		APHTHASOL PSTE[1]	Use PA Form# 20420 1. Must fail all preferred products before non-preferred.
	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
	MC/DEL		GEL-KAM CONC	MC/DEL		DENTAGEL GEL	
	MC/DEL		GEL-KAM GEL 0.4%	MC/DEL		PHOS-FLUR GEL	

	MC/DEL		PHOS FLUR SOLN	MC		THERA-FLUR-N GEL	
	MC/DEL		SF 5000 PLUS CREA				
	MC/DEL		SF GEL				
	MC		STANNOUS FLUORIDE ORAL RI CONC				
ARTIFICIAL SALIVA/STIMULANTS							
ARTIFICIAL SALIVA/STIMULANTS	MC		SALIVA SUBSTITUTE SOLN	MC		EVOXAC CAPS	Use PA Form# 20420
				MC		RADIACARE SOLR	
				MC		SALAGEN TABS	
MISCELLANEOUS ANORECTAL							
ANORECTAL - MISC.	MC/DEL		COLOCORT ENEM	MC/DEL		ANUSOL-HC CREA	Use PA Form# 20420
	MC		CORTENEMA ENEM	MC/DEL		CORTIFOAM FOAM	
	MC		ELA-MAX 5 CREA	MC/DEL		PROCTOFOAM HC FOAM	
	MC/DEL		HYDROCORTISONE ENEM	MC/DEL		PROCTO-KIT CREA 2.5%	
	MC/DEL		PROCTOSOL HC CREA	MC		RECTIV OINT	
	MC/DEL		PROCTOZONE-HC CREA				
T-CELL ACTIVATION INHIBITOR							
PSORIASIS BIOLOGICALS	MC		**COSENTYX**[3]	MC		OTEZLA	1. Will not require a PA if at least one systemic drug such as methotrexate, cyclosporine, methoxsalen or acitretin is in members drug profile. Please refer to dose consolidation list. 2. Preferred dosage form allowed without PA after trial of step 1 prodcuts is multi-dose vial, with dosing limits allowing 8 injections per 28 days without pa. 3. Will be preferred for the indication of plaque psoriasis only after trail and failure of Humira. Use PA Form# 20910
	MC		ENBREL[1,2]	MC		STELARA	
	MC		HUMIRA[1]				

ALTERNATIVE MEDICINES							
ALTERNATIVE MEDICINES	MC		DIMETHYL SULFOXIDE SOLN	MC/DEL		CO-ENZYME Q-10	Use PA Form# 20420
				MC		MELATONIN TABS	
CHELATING AGENTS							
CHELATING AGENTS	MC/DEL		**CUPRIMINE CAPS**	MC		DEPEN TITRATABS TABS	Use PA Form# 20420
				MC/DEL		EXJADE[1]	1. FDA indication of treatment of chronic iron ovrload due to blood transfustions in membes 2 years of age and older is requried for approval of Exjade.
ANTILEPROTIC							
ANTILEPROTIC				MC		THALOMID CAPS[1]	1. All PA requests for 150mg dosing will require use of Thalomid 100mg and 50mg capsules. Use PA Form# 20420
ANTINEOPLASTIC AGENTS							
ANTINEOPLASTIC AGENTS - ANTIADNDROGENS	MC/DEL		BICALUTAMIDE	MC/DEL		CASODEX	Use PA Form# 20420
ANTINEOPLASTIC AGENTS- LHRH ANALOGS	MC		LUPRON DEPOT[1]	MC		VANTAS[2]	1. Dosing limits apply, please refer to dosage consolidation list. 2. PA required to confirm FDA approved indication. Use PA Form# 20420
				MC		FIRMAGON[2]	
				MC/DEL		TRELSTAR	
ANTINEOPLASTIC AGENTS - TYROSINE KINASE INHIBITORS				MC		SPRYCEL[1]	Use PA Form# 20420 1. Verification of diagnosis is required. 2. PA required to confirm FDA approved indication and to monitor for potential drug-drug interactions.
				MC/DEL		TYKERB[2]	
				MC		GLEEVEC[1]	
ANTINEOPLASTICS-MISCELLANEOUS	MC		AMIFOSTINE	MC		DOCEFREZ	Use PA Form# 20420
	MC/DEL		MERCAPTOPURINE	MC/DEL		ETHYOL	
				MC		LEUPROLIDE	
				MC/DEL		**OXALIPLATIN**	
				MC/DEL		PURINETHOL	
				MC/DEL		ZOLINZA	
ANTINEOPLASTICS- MONOCLONAL				MC/DEL		HERCEPTIN[1]	1. PA required to confirm

ANTIBODIES							FDA approved indication. Use PA Form# 20420
CANCER							
CANCER	MC		ALIMTA	MC/DEL		ARIMIDEX	1. PA required to confirm FDA approved indication
	MC/DEL		ANASTROZOLE TABS	MC/DEL		BOSULIF	
	MC/DEL		AVASTIN	MC		COMETRIQ[3,4,5]	
	MC		ERBITUX	MC/DEL		ERIVEDGE	2. Avoid CYP3AY drug drug interaction.
	MC/DEL		LETROZOLE	MC		FARYDAK	
	MC		MEGACE ES	MC		FOLOTYN	
	MC/DEL		VIDAZA	MC/DEL		GILOTRIF[4,5]	3. Clinical PA required for appropriate diagnosis
				MC/DEL		IBRANCE	
				MC		ICLUSIG[3]	
				MC/DEL		INLYTA	
				MC		JAKAFI	4. Re-approval will require documentation of response without disease progression and tolerance to treatment
				MC/DEL		KEYTRUDA[7]	
				MC		LENVIMA	
				MC		LYNPARZA[7]	
				MC		NEXAVAR[1]	
				MC/DEL		MEKINIST[3,4]	5. Dosing limits apply, please see dosage consolidation list.
				MC		ODOMZO[1,2,5]	
				MC		POMALYST	
				MC/DEL		STIVARGA	6. Max daily dose of 300mg.
				MC/DEL		SUTENT[1,2]	
				MC/DEL		SYLATRON	
				MC/DEL		TAFINLAR[3,4,5,6]	7. PA required to confirm FDA approved indication
				MC/DEL		FEMARA	Use PA Form# 20420
				MC/DEL		YERVOY	
				MC/DEL		XALKORI	
				MC/DEL		XTANDI	
				MC/DEL		ZELBORAF	
				MC		ZYDELIG	
				MC/DEL		ZYKADIA	
				MC		ZYTIGA	
IMMUNOSUPPRESSANTS							
IMMUNOSUPPRESSANTS	MC/DEL		CYCLOSPORINE MODIFIED	MC/DEL		CELLCEPT	
	MC		GENGRAF CAPS	MC/DEL		CYCLOSPORINE CAPS	
	MC/DEL		MYCOPHENOLATE	MC/DEL		CYCLOSPORINE SOL. MODIFIED	
	MC/DEL		MYFORTIC				
	MC/DEL		NEORAL				Use PA Form# 20420

	MC		PROGRAF CAPS				
	MC/DEL		RAPAMUNE				
	MC/DEL		SANDIMMUNE				
PURINE ANALOG							
PURINE ANALOG	MC		AZASAN TABS	MC/DEL		**IMURAN TABS**	Use PA Form# 20420
	MC/DEL		**AZATHIOPRINE TABS**				
K REMOVING RESINS							
K REMOVING RESINS	MC/DEL		KAYEXALATE POWD				Use PA Form# 20420
	MC		KIONEX POWD				
	MC/DEL		SODIUM POLYSTYRENE SULFON				
	MC/DEL		SPS SUSP				
	MC/DEL		SPS 30GM/120ML ENEMA SUSP				

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

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

Criteria
of "MC / DEL".
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lanation of step order.)
the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another
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, S with no lower threshold); 4. Adequate trials require documentation of attempts to titrate dose of preferred agents toward desired clinical response. 5. Adequate trials
provided to confirm drug trials that do not appear in the member's MaineCare drug profile.
e 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
ed generic equivalent available, the most cost effective medically necessary version will be approved and reimbursed, since the brand-name and A-rated generic drugs ne proper role of the FDA. Physicians should submit their reports of generic inequivalence directly to the FDA via the MEDWATCH.
ations 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-
Cymbalta, Zofran, Elidel and others).
***necarepdl.org* .**
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 be met.
s. These will be indicated in the PDL with DDI notation. Please see the DDI document provided in the PDL.

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

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

Suprex will be preferred with dosing limits of one tablet per 7days for prevention and treatment of STI gonorrhoea.

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.

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

DDI: Preferred erythromycin will now be non-preferred and require prior authorization if it is currently being used in combination with either Carbamazepine, Enablex 15mg or Vesicare 10mg. Any non preferred formulation of erythromycin will require prior authorization and the member's drug profile will also be monitored for concurrent use with either Carbamazepine, Enablex 15mg or Vesicare 10mg.

DDI: Preferred clarithromycin formulations (clarithromycin tablets) 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.

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

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

DDI: Preferred ofloxacin will now be non-preferred and require prior authorization if they are currently being used in combination with amiodarone.

DDI: Preferred levofloxacin will now be non-preferred and require prior authorization if they are currently being used in combination with amiodarone.

DDI: Preferred Avelox will now be non-preferred and require prior authorization if they are currently being used in combination with amiodarone.

DDI: All preferred fluoroquinolones will require clinical PA for patients over 60 that are currently on immunosuppressants or steroid therapy.

DDI: Factive is non-preferred but with any prior authorization requests, the member's drug profile will also be monitored for concurrent use with amiodarone.

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

TOBI Podhaler is limited to patients with significant impairment from using nebulized version of medication

Current users of Tobi Nebu and Tobramycin Soln will be allowed a grace period until 10/1/15 to transition to preferred Kitabis.

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

DDI: Preferred rifampin will be non-preferred and require prior authorization if it is currently being used in combination with either Pradaxa or Latuda.

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

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

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

1. For macrolide resistant infections when quinolones inappropriate

DDI: Ketek is non-preferred but with any prior authorization requests, the member's drug profile will also be monitored for concurrent use with either Enablex 15mg or Vesicare 10mg or carbamazepine.

Cayston is only indicated to improve respiratory symptoms in CF patients with Pseudomonas aeruginosa. Dosing limits, as should be given TID X28 days (followed by 28 days OFF Cayston therapy). A bronshodilator should be used before administration of Cayston.

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

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

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

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

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.

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, 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

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

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.

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.

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).

Approved for chronic granulomatous disease, osteopetrosis and idiopathic pulmonary fibrosis.

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).

Please see the criteria listed on the Synagis PA form.

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.

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 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.

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.

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

DDI: All preferred steroids will require clinical PA for patients over 60 that are currently on fluoroquinolone therapy.

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

Approved for failures on multiple oral estrogen agents after 90 day trials or if unable to swallow any oral medication.

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.

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.

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

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

If member experienced adverse reactions, consider using Oral Contraceptives from other groups.

DDI: Preferred Oral Contraceptives will now be non-preferred and require prior authorization if it is currently being used in combination with Tracleer.

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.

Approved if adequate clinical reason given why patient unable to comply with other preferred agents including long acting injectable.

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

If member experienced adverse reactions, consider using Oral Contraceptives from other groups.

DDI: Preferred Oral Contraceptives will now be non-preferred and require prior authorization if it is currently being used in combination with Tracleer.

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

If member experienced adverse reactions, consider using Oral Contraceptives from other groups.

DDI: Preferred Oral Contraceptives will now be non-preferred and require prior authorization if it is currently being used in combination with Tracleer.

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

If member experienced adverse reactions, consider using Oral Contraceptives from other groups.

DDI: Preferred Oral Contraceptives will now be non-preferred and require prior authorization if it is currently being used in combination with Tracleer.

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

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.

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).

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.

Please see the criteria listed in the Symlin PA form.

Invokana will be considered for patients who are unable to tolerate any preferred medicaitons from other diabetic classes.

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

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.

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.

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

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.

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.

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.

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

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

Approved for patients failing to achieve good diabetic control with maximal doses of individual components.

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.

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

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

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

Binosto use preferred generic alendronate tablets

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.

See Growth Hormone PA form for criteria. Step-order will still apply unless clinical contraindication supplied.

Approved for acromegaly patients failing surgery/radiation/drug therapy including bromocriptine and sandostatin.

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.

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).

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

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

Approved for Type 1 hereditary tyrosinemia patients. Must include laboratory evidence of dx at first PA.

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

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

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

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

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

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

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

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.

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.

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

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.

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.

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.

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

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.

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.

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.

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

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

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

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.

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

Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **DDI:** Fenofibrate is preferred but will require a prior authorization requests if used concurrent with Warfarin. **DDI:** Gemfibrozil will now be non-preferred and require prior authorization if it is currently being used with any of the following medications: Prandin, Actos, Avandia, any Avandia/Actos combination product, any HMG-COA Reductase Inhibitors (statins), or Warfarin.
Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **DDI:** Lipitor (doses greater than 20mg/day) will now be non-preferred and require prior authorization if they are currently being used in combination cyclosporine. **DDI:** Lipitor (doses greater than 20mg/day) will now be non-preferred and require prior authorization if it is currently being used in combination with Amiodarone. **DDI:** All preferred statins will now be non-preferred and require prior authorization if it is currently being used in combination with Gemfibrozil.
Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Zetia will be approved for patients unable to tolerate all other therapies or unable to achieve cholesterol goal with maximally tolerated dose of most potent statins. **DDI:** Lescol will now be non-preferred and require prior authorization if it is currently being used in combination with diclofenac. **DDI:** Lovastatin (doses greater than 40mg/day) will now be non-preferred and require prior authorization if it is currently being used in combination with Amiodarone. **DDI:** Lovastatin (doses greater than 20mg per day) will now be non-preferred and require prior authorization if it is currently being used in combination cyclosporine. **DDI:** All preferred statins will now be non-preferred and require prior authorization if it is currently being used in combination with Gemfibrozil.

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

Juxtapid is contraindicated with strong CYP3A4 inhibitors. Juxtapid dosage should not exceed 30mg daily when it is used concomitantly with weak CYP3A4 inhibtors.

Kynamro requires an appropriate lab testing prior to starting (ALT<AST), Alkaline phosphatase and total billrubin, monthly liver-related tests for the first year, then every three months.

Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical 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

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.

As of January 1, 2006, per CMS (federal govt.), impotence agents are no longer covered.

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

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.

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.

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

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

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

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

Xolair approval will require suboptimal response to maximal doses of inhaled steroid as evidenced by asthmatic ER/Hospital admissions and Allergy/Pulmonary specialist management.

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.

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.

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

ADVAIR DISKUS- Patients currently using Advair Diskus® will have a 90 day grace period to transition to Advair HFA® or another preferred product on the PDL such as Dulera® or Symbicort® Advair Diskus will be approved for patients with asthma or COPD who: have difficulty using MDIs due to lack of hand-breath coordination AND/OR have a history or develop thrush with MDI formulations of inhaled corticosteroids AND/OR are 4-11 years old.

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

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

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.

Prolastin and Azemaira will be approved for members with A1AT deficiency and clinically demonstrable panacinar emphysema.

Will be approved for cystic fibrosis patients.

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

Ofev- Avoid concomitant use with P-gp and CYPA4 inducers (e.g. carbamazepine, phenytoin, and St. John's wort

Esbriet- The concomitant use with strong CYP1A2 inhibitors (e.g. fluvoxamine, enoxacin) is not recommended

All non-preferred products are not covered as permitted by Federal Medicaid regulations and MaineCare Policy.

Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. As listed in MaineCare Policy, certain drugs require specific diagnoses for approval.

Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **As listed in MaineCare Policy, certain drugs require specific diagnoses for approval** .

Preferred products that used to require diag codes still require diag codes unless indicated otherwise.

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.

Indication of bile acid synthesis disorders due to single enzyme defects (SEDs) AND for adjunctive treatment of peroxisomal disorders (PDs)

Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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: Ranitidine and cimetidine will now be non-preferred and require prior authorization if it is currently being used with any sulfonylurea (except for glyburide).

DDI: Cimetidine will require prior authorization if being used in combination with Plavix.

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.

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.

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.

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.

Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **As listed in MaineCare Policy, certain drugs require specific diagnoses for approval.**

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

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

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.

Gattex requires a diagnosis of adult SBS who are dependent on parenteral support. Appropriate colonoscopy and lab assessments 6months prior to starting

Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **As listed in MaineCare Policy, certain drugs require specific diagnoses for approval.**

Preferred products that used to require diag codes still require diag codes unless indicated otherwise.

Linzess is non-preferred and is for adults as treatment of IBS-Constipation AND treatment of chronic idiopathic constipation in adults. Prior trials of preferred agents for constipation and IBS-constipation.

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

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.

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

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.

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

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

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.

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

Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered

on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.

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.

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.

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.

CYMBALTA: Fibromyalgia diagnosis- prior use and failure of preferred generics (amitriptyline or cyclobenzaprine) and gabapentin prior to approval.

SAVELLA: Fibromyalgia diagnosis and trial of a preferred generic amitriptyline, cyclobenzaprine and gabapentin prior to approval.

Exceptions to the rule are as follows:

1. If the member (<18) is already an established user for any of the preferred or non-preferred drugs under the Antidepressant category on the PDL, then they can continue to get that drug.
2. If the member (<18) has a prescription for an antidepressant that is on the PREFERRED side of the PDL and has had a 30 day supply of Fluoxetine at least 30 days before the date they are getting it filled, the claim will pay. If they do not have the trial of Fluoxetine in their profile, the claim will reject for PA required.
3. If the member (<18) has a prescription for a medication that is on the NON-PREFERRED side of the PDL regardless of having Fluoxetine in their profile, the prescription will need a PA.
4. Use of a preferred antidepressant for anxiety will require the diagnosis of anxiety on written prescription and submitted during claim submission.

DDI: Fluvoxamine will now be non-preferred and require prior authorization if it is currently being used with glimepiride (Amaryl).

DDI: Preferred nefazodone will now be non-preferred and require prior authorization if it is currently being used in combination with either Onglyza 5mg, Enablex 15mg or Vesicare 10mg.

DDI: Fluoxetine will require prior authorization if being used in combination with Plavix.

DDI: Fluvoxamine will require prior authorization if being used in combination with Plavix.

SAVELLA: Fibromyalgia diagnosis and trial of a preferred generic amitriptyline, cyclobenzaprine, duloxetine and gabapentin prior to approval.

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

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

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

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.

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.

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

Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Non preferred atypicals will be approved for patients with FDA-approved indications, and for specific conditions supported by at least two published peer-reviewed double-blinded, placebo-controlled randomized trials that are not contradicted by other studies of similar quality and as long as all first line preferred therapies have been tried and failed at full therapeutic doses for adequate durations (at least two weeks). * Abilify: doses above 15mg were not shown to be more effective than doses in the 10-15mg range.

Prescriptions for quetiapine are limited to a maximum daily dose of 800mg.

DDI: Abilify, 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.

Atypicals: Prior Authorization will be required for preferred medication to assure indication is in accordance with FDA approved or literature supported evidence-based best practices. The approved indications are:

- **schizophrenia**
- **bipolar disorder**
- **agitation related to autism**

• severe behavioral dyscontrol with risk of imminent need for emergency services such as the emergency room, crisis services, or an inpatient psychiatric facility.

If prescribing 2 or more antipsychotics, PA will be required for both drugs, except if one is Clozapine.This also includes combination of Seroquel with Seroquel XR.

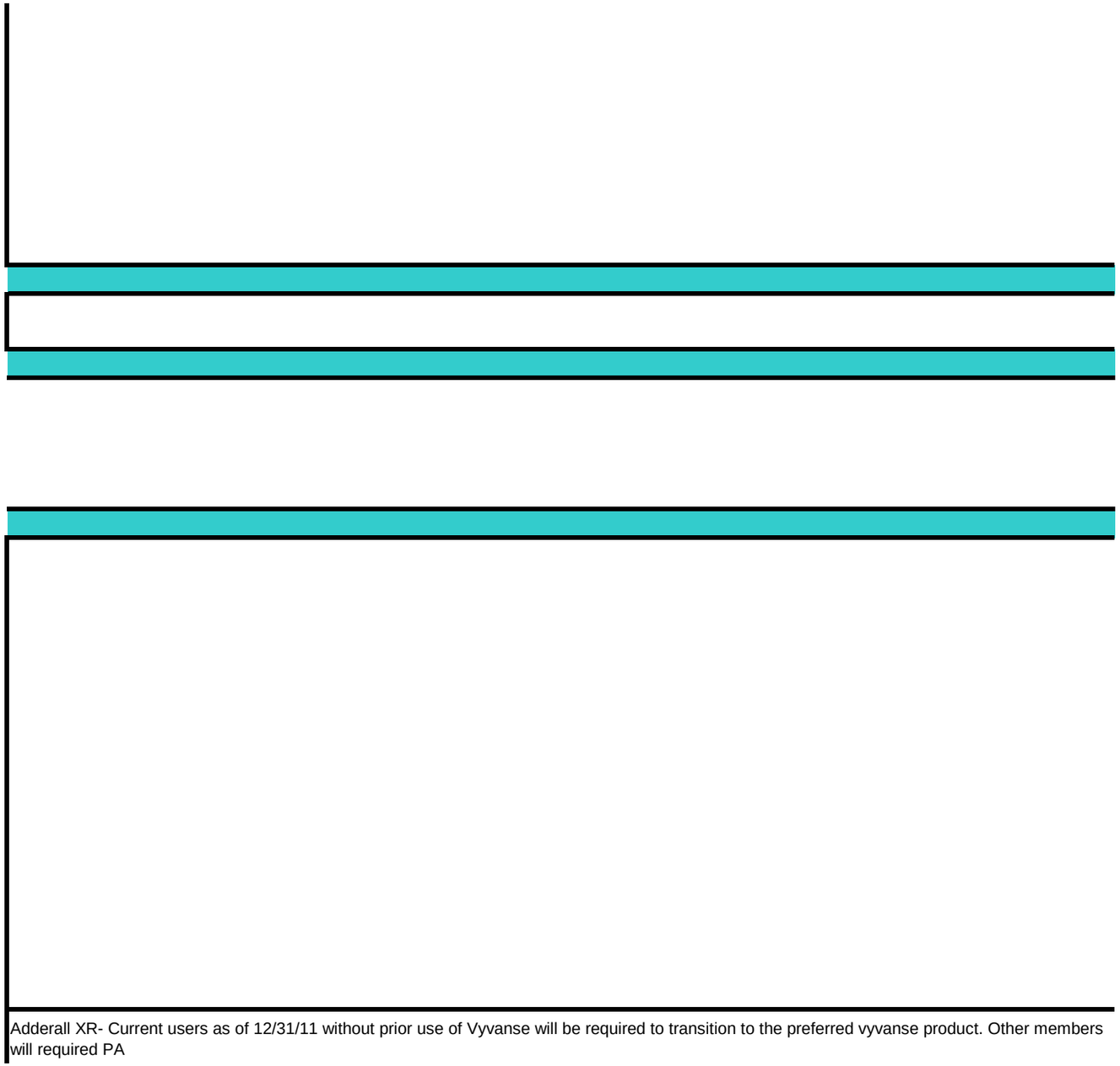
Aristada- establish tolerability to Abilify/oral aripiprazole

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.

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



Adderall XR- Current users as of 12/31/11 without prior use of Vyvanse will be required to transition to the preferred vyvanse product. Other members will required PA

Quillivant is only indicated for use in patients 6 years of age and older. Prior trials of preferred products

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

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

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

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

Weight loss drugs are not covered as permitted by Federal Medicaid regulations and Maine Medicaid (MaineCare) Policy.

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.

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.

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.

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.

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

Preferred drugs (Fentanyl Patch, Morphine Sulfate ER tab, Kadian Methadone or Methadose) must be tried for at least 2 weeks each & failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug & the preferred drug(s) exists. Adequate trials include prevention/treatment of common adverse effects associated w/ narcotics (antinausea, antipruritics, etc.) as well as adequate equianalgesic dosing when converting from one narcotic to another.Also, adequate documentation of attempts to titrate dose of preferred agents to achieve adequate pain relief & desired clinical response must be provided. Member’s drug regimen for additions &/or discontinuations of medications that may affect absorption &/or metabolism of preferred agents must be monitored. Approvals will not be granted if patient had access to either non-preferred products or high doses of short acting narcotics during the trial period. Non-preferred drugs will not be approved for patients showing evidence of usage patterns consistent w/ controlled substance abuse such as:

1.Frequent or persistent early refills of controlled drugs;

2.Multiple instances of early refill overrides due to reports of misplacement, stolen, dropped in toilet or sink, distant travel, etc.;

3.Breaches of narcotic contracts with any provider;

4.Failure to comply with patient responsibilities in attached opioid documentation (see PA form) including but not limited to failing to submit to and pass pill counts;
5.Failing to take or pass random drug testing;

6.Failing to provide old records regarding prior use of narcotics;

7.Receiving controlled substances from other prescribers that the provider submitting the PA is unaware of

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

Preferred drugs from this and other narcotic classes must be tried for at least 2 weeks each and failed due to lack of efficacy or intolerable side effects before non-preferred drugs from this class will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Approvals will not be granted if patient had access to either non-preferred products or high doses of short acting narcotics during the trial period. Substance abuse evaluations may be required for patients with medical records displaying potential signs of narcotic misuse and abuse such as chronic early refills, short dosing intervals, frequent dose increases, multiple lost/stolen etc scripts and intolerance or "allergy" to all products but desired product. Allergic reactions to any product within a specific narcotic class will justify and preclude use of any other product in the same class due to the risk of cross-hypersensitivity.

Non-preferred drugs will not be approved for patients showing evidence of usage patterns consistent with controlled substance abouse such as:

1.frequent or persistant early refills of controlled drugs;

2.multiple instances of early refill overrides due to reports of misplacement, stolen, dropped in toilet or sink, distant travel;

3.breaches of narcotic contracts with any provider;

4.failure to comply with patient responsibilities in attached opiod documentaion (see PA form) including but not limited to failing to submit to and pass pill counts;

5.failing to take or pass random drug testing;

6.failing to provide old recoreds regarding prior use of narcotics;

7.receiving controlled substances from other prescribers that the provider submitting the PA is unaware of. in Substance abuse evaluations may be required for patients with medical records displaying potential signs of narcotic misuse and abuse such as chronic early refills, short dosing intervals, frequent dose increases, multiple lost/stolen etc scripts and intolerance or "allergy" to all products but Oxycontin. Allergic reactions to any product within a specific narcotic class will justify and preclude use of any other product in the same class due to the risk of cross-hypersensitivity.

Effective 1/01/2013, MaineCare will implement a 15 day limit for members prescribed opiates for their treatment of pain.

1. MaineCare members will be allowed over a rolling 12 month period up to a 15 day supply of an opiate without prior authorization
2. Members requiring longer than 15 days will require a PA for continuation of therapy and providers may provide medical necessity
3. Members may be eligible for up to three prior authorizations of up to 14 day supplies of opiates during the 12 month period
4. MaineCare members that are in Hospice care or are being treated for a diagnosis of Cancer, HIV or AIDS will be exempt from these limits
5. Post surgical members may receive prior authorizations for opiates up to 60 days in length if medical necessity is provided by the Surgeon

Please see the Pain Management Policy_Sec. 80 tab for the complete criteria

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

Effective 1/01/2013, MaineCare will implement a 15 day limit for members prescribed opiates for their treatment of pain.

1. MaineCare members will be allowed over a rolling 12 month period up to a 15 day supply of an opiate without prior authorization
2. Members requiring longer than 15 days will require a PA for continuation of therapy and providers may provide medical necessity
3. Members may be eligible for up to three prior authorizations of up to 14 day supplies of opiates during the 12 month period
4. MaineCare members that are in Hospice care or are being treated for a diagnosis of Cancer, HIV or AIDS will be exempt from these limits
5. Post surgical members may receive prior authorizations for opiates up to 60 days in length if medical necessity is provided by the Surgeon

Please see the Pain Management Policy_Sec. 80 for the complete criteria

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

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).

Please see the criteria listed on the Vivitrrol PA form.

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.

Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
Approvals will be granted for other requests based on failure of at least one generic NSAID from at least 3 different NSAID classes as described in the COX-II PA form.

DDI: Diclofenac will now be non-preferred and require prior authorization if it is currently being used in combination with Iescol.

The FDA has issued a Public Health Advisory warning of the potential for increased cardiovascular risk & GI bleeding with NSAID use.

See criteria as listed on Rheumatoid Arthritis PA form.

Enbrel is preferred after a trial of a step 1 product (e.g. azathioprine, methotrexate, etc.); however, dosing limits will also still apply. Dosing limits will allow 8 injections per month without pa. Use of greater than 8 injections per month will require PA.

Xeljanz is limited to adults with moderately to severely active RA who have had an inadequate response or intolerance to methotrexate. Should not be used concomitantly with biologic DMARDs or potent Immunosuppressants. Therapy should not be started in those with lymphocyte count <500cells/mm^3, an ANC <1000cells/mm^3, or have a hemoglobin <9g/dl.

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

Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered

on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.

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

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

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

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

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.

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.

Please use Drug-Drug Interaction PA form #10400 for this combination.

ONFI will require a clinical PA to confirm LGS diagnosis

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.

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.

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

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.

Non-preferred drugs will not be approved if members circumventing MaineCare prior authorization requirements by paying (prescribers failed to submit prior authorization prior to cash narcotic scripts being filled by member).

Non-preferred products must be used in specified step order.

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.

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.

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

Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **As listed in MaineCare Policy, certain drugs require specific diagnoses for approval.**

Please refer to OTC list for covered products.

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.

Preferred products that used to require diag codes still require diag codes unless indicated otherwise.

Preferred products require dialysis/renal failure diagnosis.

Non-preferred products require: Secondary hyperparathyroidism in patients with Chronic Kidney Disease on dialysis., iPTH>400 pg/ml, Phosophorous ,6.5mg/dl, corrected calcium <12.2mg/dl, corrected calcium x phosphorous products <70mg^2/dl^2

Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. As listed in MaineCare Policy, certain drugs require specific diagnoses for approval.

Please refer to OTC list.

Preferred products that used to require diag codes still require diag codes unless indicated otherwise.

Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. As listed in MaineCare Policy, certain drugs require specific diagnoses for approval.

DDI: Fe salts will now be non-preferred and require prior authorization if it is currently being used in combination with either Prevacid, pantoprazole, Prilosec, or any currently non preferred PPI.

Please refer to OTC list.

Preferred products that used to require diag codes still require diag codes unless indicated otherwise.

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

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.

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

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.

See approval criteria detailed on Neupogen PA form.

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

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

DDI: Warfarin will require prior authorization if being used in combination with fluconazole, miconazole, or voriconazole.

DDI: Warfarin will require prior authorization if being used in conjunction with Gemfibrozil or Fenofibrate.

DDI: Rifampin will require prior authorization if being used in combination with Savaysa

Non-preferred will only be approved if other preferred products are unavailable.

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

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

Clinical PA required. Must see prior trial with insufficient response to corticosteroids and immunoglobulins.

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

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

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

Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered

on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.

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

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.

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

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

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

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.

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

Must fail adequate trials of multi agents from artificial tears and lubricant category.

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

Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered

on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.

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

DDI: Ketoconazole will now be non-preferred and require prior authorization if they are currently being used in combination with any of the following medications: Prevacid, pantoprazole, Onglyza or Omeprazole.

Kerydin- Verify prior trials and failures or intolerance of preferred treatments, including both topical and oral agents

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

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

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

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.

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

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

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.

Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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 per Medicaid Policy, cosmetic drugs are not covered. Non-cosmetic clinical applications will be considered by prior authorization on a case by case basis.

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

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

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

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

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

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

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.

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.

Approved for indications of leprosy, treatment-resistant multiple myeloma and AIDS.

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

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

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

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

erwise noted within this document.