CATEGORY	Coverage Indicator	Step Order	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS	PA Required	Comments	Criteria
** PLEASE NOTE: All cost effective generics applicable to DEL are considered PREFERRED Drugs. "BASIC" Covered Drugs are bolded with the Coverage Indicator of "MC / DEL".*									
General Criteria for all PDL categories- For more information or help using the PDL, providers may call 1-888-445-0497; members should call 1-866-796-2463. To access PDL and PA materials via the internet: www.mainecarepdl.org									
A: Preferred Drugs- Unless otherwise specified, preferred drugs are available without prior authorization. Step order may apply for preferred drugs in some drug categories as indicated on the PDL. (See item "D" below for explanation of step order.)									
B: Requests for Non-preferred Drugs- Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.									
C: Adequate Drug Trials- 1. The minimum trial period for each preferred and step order drug is two weeks, unless otherwise stated within specific PDL drug categories; trials with less than a two week duration will be reviewed on a case-by-case basis; 2. A trial will not be considered valid if preferred or non-preferred products were readily available (by override, individual purchase, samples, etc.); 3. Certain drug trials, such as with controlled substances, may require evidence that the preferred drugs were actually tried (example: with random pill counts and with random urine drug tests, using the methods of GC/MS with no lower threshold); 4. Adequate trials require documentation of attempts to titrate dose of preferred agents toward desired clinical response. 5. Adequate trials include prevention/treatment of common adverse effects associated with preferred agents (example: antinausea, antipruritics, etc.)									
D: Step Order- When numbers appear in the "step order" column, it means drugs in this category must be used in the order specified, with the lower numbers having preference over the higher numbers. Chart notes should be provided to confirm drug trials that do not appear in the member's MaineCare drug profile.									
E. The Department will institute strategies to ensure cost effectiveness through the use of an enhanced Drug Benefit Preferred brand drugs will no longer be preferred in any PDL drug category where preferred generic drugs are also available. It is expected that preferred generics will be used prior to any preferred brands. This will be operated as a form of step care. Preferred brands in these categories will require prior authorization for these high utilization / high cost members.									
F: Brand Name Medication Requests- (Must be submitted on the Brand Name PA request form)- According to MaineCare Benefits Manual Chapter II (80.07-5), when medically necessary covered brand-name drugs have an A-rated generic equivalent available, the most cost effective medically necessary version will be approved and reimbursed, since the brand-name and A-rated generic drugs have been determined by the FDA to be chemically and therapeutically equivalent. The Bureau does not make determinations as to whether or not a generic drug is clinically inferior or inequivalent to its brand version. This is the proper role of the FDA. Physicians should submit their reports of generic inequivalence directly to the FDA via the MEDWATCH.									
G: PA requests for non- FDA Approved Indications- Decisions will be made on a case-by-case basis until the DUR committee is able to review the evidence and make a recommendation. Interim approvals and DUR recommendations for approval of a drug for a non- FDA approved indication will require a minimum of two published, peer reviewed, non contradicted, double- blind, placebo-controlled randomized clinical studies establishing both safety and efficacy.									
H: Dose Consolidation Requirements- Some drugs may also be affected by dose consolidation requirements. Please see Dose Consolidation List and/or Splitting Tables provided in the PDL.									
I. Trials from Multiple Drug Classes - Trial/failure/intolerance to preferred agents from multiple classes within the same category or other catagories of drugs may be required prior to the approval of non-preferred agents (e.g., Cymbalta, Zofran, Elidel and others).									
J. Drug-specific PA Forms- Drug-specific PA forms contain medical necessity documentation requirements and/or criteria that may not be repeated in the PDL. Drug-specific PA forms may be obtained on the web at *www.mainecarepdl.org* .									
K. PA Exemptions for Prescribers- According to MaineCare Benefits Manual Chapter II (80.07-4), providers may receive a three (3) month exemption from prior authorization requirement for certain categories of drugs when they demonstrate high compliance with the Department's PDL. The Department will notify providers in writing which drug categories are included and what dates apply to the exemption. If a provider loses his/ her exemption, members who previously were not required to obtain a PA while the prescriber was exempt will be required to do so, and criteria for approval of that medication will need to be met.									
L: Drug-Drug Interactions (DDI)- The DUR Committee has implemented new drug-drug interation edits requiring prior authorization. Several drug-drug combinations and PDL drug catagories are affected by new PA requirements. These will be indicated in the PDL with DDI notation. Please see the DDI document provided in the PDL.									
ASSORTED ANTIBIOTICS									
BETA-LACTAMS / CLAVULANATE COMBO'S	MC/DEL		AMOXICILLIN	MC/DEL		AUGMENTIN[3]	3. Chewable 125mg & 250mg and Solution 125mg/5ml and 250mg/5ml available without PA.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.	
	MC/DEL		AMOXICILLIN/POTASSIUM CLA CHEW	MC/DEL		AUGMENTIN XR TB12[4]			
	MC/DEL		AMOXICILLIN/POTASSIUM CLA SUSR				4. Use preferred generic amoxicillin/clavulanate potassium alternatives.	**DDI:** Ampicillin will now be non-preferred and require prior authorization if it is currently being used in combination with either Prevacid, pantoprazole, Prilosec, or any currently non preferred PPI.	
	MC/DEL		AMOXICILLIN/POTASSIUM CLA TABS				Use PA Form# 20420		
	MC/DEL		AMPICILLIN						
	MC		BICILLIN L-A SUSP						
	MC/DEL		DICLOXACILLIN SODIUM CAPS						
	MC		OXACILLIN SODIUM SOLR						
	MC/DEL		PENICILLIN V POTASSIUM						
	MC		TIMENTIN SOLR						
	MC		UNASYN SOLR						
	MC/DEL		ZOSYN						
CEPHALOSPORINS	MC/DEL		CEFADROXIL HEMIHYDRATE	MC		CEDAX	1. Both brand and generic are clinically non-preferred.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.	
	MC/DEL		CEFAZOLIN SODIUM SOLR	MC/DEL		CEFACLOR[1]			
	MC/DEL		CEFDINIR	MC/DEL		CEFADROXIL MONOHYDRATE TABS			
	MC/DEL		CEFEPIME	MC/DEL		CEFTIN	2. Dosing limits apply, please see Dosage Consolidation List.	Suprex will be preferred with dosing limits of one tablet per 7days for prevention and treatment of STI gonorrhoea.	
	MC/DEL		CEFPODOXIME	MC/DEL		FORTAZ			
	MC/DEL		CEFPROZIL	MC/DEL		FORTAZ SOLN			
	MC		CEFTAZIDIME 6MG	MC		KEFLEX CAPS			
	MC/DEL		CEFTIN SUSP	MC		OMNICEF			
	MC/DEL		CEFTRIAXONE	MC/DEL		ROCEPHIN			
	MC/DEL		CEFUROXIME AXETIL TABS	MC		TAZICEF SOLR		**DDI:** Vantin will now be non-preferred and require prior authorization if it is currently being used in combination with either Prevacid, pantoprazole, Prilosec, or any currently non preferred PPI.	
	MC/DEL		CEPHALEXIN MONOHYDRATE	MC/DEL		TEFLARO			
	MC		FORTAZ SOLR						

	MC/DEL		SUPRAX[2]					
	MC		TAZICEF 6GM				Use PA Form# 20420	
MACROLIDES / ERYTHROMYCIN'S	MC/DEL		AZITHROMYCIN TABS	MC/DEL		AZITHROMYCIN POW	1. 7- Day supply per month without PA.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		AZITHROMYCIN SUSP	MC/DEL		CLARITHROMYCIN SUSP		
	MC		E.E.S.	MC/DEL		CLARITHROMYCIN TABS		
	MC		ERYPED 200 SUSR	MC		DIFICID		
	MC		ERYPED 400 SUSR	MC		PCE TBEC		**DDI:** Preferred erythromycin will now be non-preferred and require prior authorization if it is currently being used in combination with either Carbamazepine, Enablex 15mg or Vesicare 10mg. Any non preferred formulation of erythromycin will require prior authorization and the member's drug profile will also be monitored for concurrent use with either Carbamazepine, Enablex 15mg or Vesicare 10mg.
	MC		ERY-TAB TBEC	MC/DEL		ZITHROMAX TABS		
	MC		ERYTHROCIN STEARATE TABS	MC/DEL		ZITHROMAX 1GM PAK	Use PA Form# 20420	
	MC/DEL		ERYTHROMYCIN	MC/DEL		ZITHROMAX TRI-PAK		
				MC/DEL		ZITHROMAX SUSP		**DDI:** Preferred clarithromycin formulations (clarithromycin tablets) will now be non-preferred and require prior authorization if they are currently being used in combination with either Carbamazepine, Onglyza 5mg, Enablex 15mg or Vesicare 10mg. Any non preferred formulation of clarithromycin will require prior authorization and the member's drug profile will also be monitored for concurrent use with either Carbamazepine, Onglyza 5mg, Enablex 15mg or Vesicare 10mg.
				MC/DEL		ZMAX		
TETRACYCLINES	MC/DEL		DOXYCYCLINE MONOHYDRATE 100mg & 50mg CAPS	MC		DECLOMYCIN TABS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		MINOCYCLINE HCL CAPS	MC/DEL		DORYX CPEP		
	MC/DEL		TETRACYCLINE HCL CAPS	MC/DEL		DOXYCYCLINE HYCLATE		
				MC/DEL		DOXYCYCLINE MONOHYDRATE 150mg & 75mg CAPS		
	MC/DEL		VIBRAMYCIN SYRP	MC/DEL		DYNACIN CAPS		
				MC		ORACEA		
				MC/DEL		PERIOSTAT		
				MC/DEL		SOLODYN ER		
FLUOROQUINOLONES	MC/DEL		CIPROFLOXACIN	MC		AVELOX SOLN		Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		LEVOFLOXACIN	MC		AVELOX TABS	Use PA Form# 20420	
	MC/DEL		OFLOXACIN	MC		AVELOX ABC PACK TABS	1. Dosing limits apply, see Dosage Consolidation List.	**DDI:** Preferred ofloxacin will now be non-preferred and require prior authorization if they are currently being used in combination with amiodarone.
				MC		CIPRO		**DDI:** Preferred levofloxacin will now be non-preferred and require prior authorization if they are currently being used in combination with amiodarone.
				MC		FACTIVE		**DDI:** Preferred Avelox will now be non-preferred and require prior authorization if they are currently being used in combination with amiodarone.
				MC		LEVAQUIN TABS SOLN/INJ		**DDI:** All preferred fluoroquinolones will require clinical PA for patients over 60 that are currently on immunosuppressants or steroid therapy.
				MC		LEVAQUIN TABS[1]		
				MC		NOROXIN TABS		
				MC		PROQUIN XR		**DDI:** Factive is non-preferred but with any prior authorization requests, the member's drug profile will also be monitored for concurrent use with amiodarone.
AMINO GLYCOSIDES	MC		GENTAMICIN	MC		BETHKIS[1]	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		KITABIS PAK	MC/DEL		TOBI PODHALER[1]	1. Clinial PA to verify appropriate diag	
	MC/DEL		NEOMYCIN SULFATE TABS	MC		TOBI NEBU[2]	2. See criteria section	TOBI Podhaler is limited to patients with significant impairment from using nebulized version of medication
				MC/DEL		TOBRAMYCIN SULFATE SOLN[2]		Current users of Tobi Nebu and Tobramycin Soln will be allowed a grace period until 10/1/15 to transition to preferred Kitabis.
ANTI-MYCOBACTERIALS / ANTI-TUBERCULOSIS	MC/DEL		ETHAMBUTOL HCL TABS				Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		MYAMBUTOL TABS					
	MC/DEL		MYCOBUTIN CAPS					
	MC/DEL		RIFAMPIN					**DDI:** Preferred rifampin will be non-preferred and require prior authorization if it is currently being used in combination with either Pradaxa or Latuda.
ANTIMALARIAL AGENTS	MC/DEL		**CHLOROQUINE PHOSPHATE TABS**	MC		ARALEN TABS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**DARAPRIM TABS**	MC/DEL		**HYDROXYCHLOROQUINE TABS**		
	MC/DEL		**MEFLOQUINE HCL TABS**	MC		ISONARIF[1]	1. Ingredients available as preferred without PA.	
	MC/DEL		**PLAQUENIL TABS**	MC/DEL		MALARONE TABS		
	MC/DEL		**QUININE SULFATE**					
ANTHELMINTICS	MC/DEL		ALBENZA TABS				Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		BILTRICIDE TABS					
	MC/DEL		STROMECTOL TABS					
ANTIBIOTICS - MISC.	MC		AZACTAM SOLR	MC		COLISTIMETHATE SODIUM SOLR	1. 375mg caps and 750mg tabs are non-preferred. Please use available preferred strengths/250mg	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		COLY-MYCIN-M SOLR	MC		CAYSTON[3]		
	MC		COLISTIMETHATE SODIUM SOLR	MC/DEL		FLAGYL CAPS		

	MC		FUROXONE TABS	MC/DEL		FLAGYL TABS	preferred strengths(250mg & 500mg tabs) to obtain required dose without PA.	1. For macrolide resistant infections when quinolones inappropriate
	MC/DEL		METRONIDAZOLE[1]	MC/DEL		FLAGYL ER TBCR		
	MC		PENTAMIDINE ISETHIONATE SOLR	MC/DEL		KETEK		**DDI:** Ketek is non-preferred but with any prior authorization requests, the member's drug profile will also be monitored for concurrent use with either Enablex 15mg or Vesicare 10mg or carbamazepine.
	MC		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	2. Please use multiple 5gm which are preferred to obtain dose without PA.	Cayston is only indicated to improve respiratory symptoms in CF patients with Pseudomonas aeruginosa. Dosing limits, as should be given TID X28 days (followed by 28 days OFF Cayston therapy). A bronshodilator should be used before administration of Cayston.
				MC		TINDAMAX		
				MC/DEL		VANCOMYCIN 10GM INJ.[2]		
				MC		XIFAXAN	3. Clinical PA is required to establish CF diagnosis and medical necessity. Prior trail and failure of preferred Tobi before approval will be granted.	
							Use PA Form# 20420	
CARBAPENEMS				MC		INVANZ SOLR	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
				MC		MERREM SOLR		
				MC/DEL		PRIMAXIN		
LINCOSAMIDES / OXAZOLIDINONES / LEPROSTATICS	MC/DEL		CLEOCIN SOLN	MC/DEL		CLEOCIN CAPS	1. Use multiple 150's for Clindamycin instead of 300's.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. For Zyvox or Vibativ, please see the criteria listed in the Antibacterial Antibiotics PA form.
	MC/DEL		CLEOCIN SUSR	MC/DEL		CLINDAMYCIN HCL 300CAPS[1]		
	MC/DEL		CLINDAMYCIN HCL 150CAPS	MC		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	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		SEPTRA/DS TABS					
	MC/DEL		SULFAMETHOXAZOLE/TRIMETH					
	MC/DEL		TRIMETHOPRIM/SULFAMETHOXA					
ANTIPROTOZOALS				MC		ALINIA[1]	1. Alina is preferred for children less than 12 years of age.	
							Use PA Form# 20420	
ANTI - FUNGALS								
ANTIFUNGALS - ASSORTED	MC		ANCOBON CAPS	MC/DEL	6	LAMISIL TABS[4]	1. QL--1/every 7-day period (150mg only).	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. The other criteria are listed on the Antifungal PA form including the required proof of a non-cosmetic fungal infection.
	MC/DEL		FLUCONAZOLE[1]	MC/DEL	6	ITRACONAZOLE		
	MC/DEL		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]		**DDI:** Any Griseofulvin will now be non-preferred and require prior authorization if it is currently being used in combination with either Prevacid, pantoprazole, Prilosec, or any currently non preferred PPI.
				MC/DEL	8	SPORANOX CAPS[3]		
				MC/DEL	8	DIFLUCAN		
				MC/DEL	8	ERAXIS INJ[6]		**DDI:** Sporanox is non-preferred but with any prior authorization requests, the member's drug profile will also be monitored for current use with Enablex 15mg, Vesicare 10mg, Prandin, Prevacid, pantoprazole, Prilosec, or any currently non preferred PPI, due to a significant drug-drug interaction.
				MC	8	GRIFULVIN SUSP	4. Quantity limit of one tablet daily. Please see dosage consolidation list.	**DDI:** Vfend is non-preferred but with any prior authorization requests, the member's drug profile will also be monitored for concurrent use with Warfarin.

							5. Approved if immuno suppressed/ HIV or if the member has failed a 7 day trial of a preferred antifungal therapy.	**DDI:** Fluconazole (except 150mg strength) will now be non-preferred and require prior authorization if it is currently being used with glimepiride (Amaryl), Enablex 15mg, or Vesicare 10mg. Diflucan is non-preferred but with any prior authorization requests, the member's drug profile will also be monitored for concurrent use with either glimepiride (Amaryl), Enablex 15mg, or Vesicare 10mg.
				MC/DEL	8	ONMEL		
				MC/DEL	8	NOXAFIL[5]	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.	**DDI:** Fluconazole will require prior authorization if being used in combination with Plavix or Warfarin.
				MC/DEL	8	VFEND TABS		
							7. Quantity limits allowing 30 day supply without PA. PA will be required if using > 30 days.	**DDI:** Ketoconazole will now be non-preferred and require prior authorization if they are currently being used in combination with any of the following medications: Prevacid, Pantoprazole, Plavix, Onglyza, Enablex 15mg, Vesicare 10mg, Latuda, Cometriq, Tafinlar or Omeprazole.
							8. For children < 18, quantity limits allows 8 weeks supply without PA. PA will be required if using > than 8 weeks. If 18 and older PA will be required for any quantity. Not approving for Onychomycosis indication.	
							9. For patients ≥ 18years of age	
							Use PA Form# 10120	
ANTI - VIRALS								
ANTIRETROVIRALS	MC/DEL		APTIVUS	MC/DEL	8	COMBIVIR TABS	Use PA Form# 10620 for Fuzeon	Please refer to the criteria listed on the Fuzeon PA form.
	MC		ATRIPLA[1]	MC	8	COMPLERA		
	MC/DEL		CRIXIVAN CAPS	MC/DEL	8	DIDANOSINE	Use PA Form# 20420 for all others	
	MC/DEL		EDURANT	MC/DEL	8	EVOTAZ		
	MC		EMTRIVA	MC/DEL	8	FUZEON[3]	1. Quantity limit of one per day	**DDI:** Reyataz will now be non-preferred and require prior authorization if it is currently being used in combination with either Prevacid, pantoprazole, Prilosec, or any currently non preferred PPI .
	MC/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		GENVOYA[9]	MC/DEL	8	PREZCOBIX		**DDI:** Preferred Norvir will now be non-preferred and require prior authorization if it is currently being used in combination with either Enablex 15mg or Vesicare 10mg.
	MC/DEL		INVIRASE CAPS	MC	8	RETROVIR		
	MC		KALETRA	MC/DEL	8	SELZENTRY[3]		
	MC/DEL		LEXIVA	MC	8	STRIBILD	3. Prescribers with >= 10 ART scripts per quarter and 75% ART PDL compliance will be exempt from PA for these products.	**DDI:** Preferred Crixivan caps will now be non-preferred and require prior authorization if it is currently being used in combination with either Enablex 15mg or Vesicare 10mg.
	MC		NORVIR	MC	8	TIVICAY[5,6]		
	MC		PREZISTA[2]	MC	8	TRIUMEQ[5,7]		
	MC/DEL		RESCRIPTOR TABS	MC	8	TYBOST[8]		EDURANT® treated subjects with HIV-1 RNA greater than 100,000 copies/mL at the start of therapy experienced virologic failure (HIV-1 RNA greater than or equal to 50 copies/mL) compared to EDURANT® treated subjects with HIV-1 RNA less than or equal to 100,000 copies/mL. Regardless of HIV-1 RNA at the start of therapy, more EDURANT® treated subjects with CD4+ cell count less than 200 cells/mm3 experienced virologic failure compared to EDURANT® treated subjects with CD4+ cell count greater than or equal to 200 cells/mm3.
	MC		REYATAZ[1]	MC	8	ZERIT		
	MC		STAVUDINE	MC	8	VITEKTA		
	MC		SUSTIVA	MC/DEL	9	VIRAMUNE XR	4.Isentress Chewable will only be approved if between the age of 2-12 years old	
	MC/DEL		TRIZIVIR TABS					Stribild needs specific indication(only indicated for HIV-1 infection in adults who are antiretroviral treatment-naïve), as there is a boxed warning that this is not indicated for Hep B and has not been studied in those co-infected with HIV-1 and HBV. Should not be co-administered with other antiretroviral medications used for HIV1 infections, as this is a complete regimen
	MC		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.	
	MC/DEL		VIRAMUNE TABS					DDI: Nevirapine, oxcarbazepine, phenytion, phenobarbital, carbamazepine, and St. John;s wort will be non-preferred and require prior authorization if it is currently being used in combination with Tivicay.
	MC		VIREAD TABS					
	MC/DEL		ZIAGEN TABS					
	MC/DEL		ZIDOVUDINE					
							6. Dosing limits apply.	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

							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 9. Preferred for the treatment of HIV-1 infection in adults and pediatric patients ≥ 12 years of age	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 Genvoya is available to those for whom there is a clinical need for the improved renal safety profile provided by tenofovir alafenamide that cannot be met with other more cost-effective combination regimens and also to document that the patient is either treatment naïve or virologically-suppressed (HIV-1 RNA < 50 copies/ml) on a stable antiretroviral regimen for at least 6 months with no history of treatment failure and no known substitutions associated with resistance to the individual components of Genvoya.
CYTO-MEGALOVIRUS AGENTS	MC MC		FOSCARNET SODIUM VALCYTE TABS	MC/DEL MC/DEL		FOSCAVIR GANCICLOVIR	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
HERPES AGENTS	MC/DEL MC/DEL		ACYCLOVIR VALACYCLOVIR HCL	MC/DEL MC MC/DEL MC/DEL MC/DEL	8 8 8 8 9	FAMCICLOVIR[1] SITAVIG ZOVIRAX[1] VALTREX TABS[1] FAMVIR TABS[1]	1. Must fail Acyclovir and Valacyclovir before non-preferred products in step order. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
INFLUENZA AGENTS	MC/DEL MC MC/DEL MC/DEL		AMANTADINE RELENZA DISKHALER AEPB RIMANTADINE HCL TABS TAMIFLU[1]	MC MC		FLUMADINE TABS FLUMIST	1. Tamiflu 10 caps or 60cc's per month. Will be audited for presence of positive influenza tests in patient or family member. Use PA Form# 10610 for Flumist requests Use PA Form# 20420 for all others	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
IMMUNE SERUMS								
IMMUNE SERUMS	MC		HYPERRHO INJ					
HEPATITIS AGENTS								
HEPATITIS C AGENTS	MC MC MC/DEL MC/DEL MC/DEL MC MC MC MC MC/DEL		HARVONI[2] OLYSIO[2] PEGASYS KIT[1] PEGASYS SOLN PEG-INTRON KIT[1] RIBAVIRIN SOVALDI[2] TECHNIVIE[2] VIEKIRA PAK[2] **RIBASPHERE**	MC/DEL MC/DEL MC/DEL MC		COPEGUS TABS DAKLINZA REBETOL CAPS RIBAPAK	1. Dosing limits apply, please see dosage consolidation list. 2. Approvals will require clinical PA. Please see the Hepatitis PA form for criteria Use PA Form# 10700	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **DDI:** Olysio will require a prior authorization if it is currently being used in combination with drugs known to be significant CYP3A4 inhibitors (ketoconazole, itraconazole, clarithromycin, indinavir, nefazodone, nelfinavir, ritonavir, atazanavir, saquinavir and telithromycin).

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

	MC/DEL		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					**DDI:** All preferred steroids will require clinical PA for patients over 60 that are currently on fluoroquinolone therapy.
	MC/DEL		METHYLPREDNISOLONE TABS					
	MC/DEL		PREDNISOLONE					
	MC/DEL		**PREDNISONE**					
	MC/DEL		SOLU-CORTEF SOLR					
	MC/DEL		SOLU-MEDROL SOLR					
HORMONE REPLACEMENT THERAPIES								
ANDROGENS / ANABOLICS	MC/DEL		ANDRODERM PT24	MC		ANADROL-50	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Additionally, laboratory evidence of a testosterone deficiency must be supplied. One of each dosage form should be tried (tablet, injection, and topical)
	MC/DEL		ANDROGEL 1%	MC		ANDRO LA 200 OIL		
	MC/DEL		DANAZOL CAPS	MC/DEL		ANDROGEL 1.62%		
	MC/DEL		DEPO-TESTOSTERONE OIL	MC/DEL		ANDROGEL PUMP		
	MC/DEL		METHITEST TABS	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.	Approved for failures on multiple oral estrogen agents after 90 day trials or if unable to swallow any oral medication.
	MC/DEL		**CLIMARA PTWK**	MC/DEL	8	**ALORA PTTW**[2]	2. Step order drugs must be used in specified step order.	
				MC/DEL	8	**DIVIGEL**[2]		
				MC/DEL	8	**ELESTRIN**[2]		
				MC	8	**EVAMIST**[2]	Use PA Form# 20420	
ESTROGENS - TABS	MC/DEL		**CENESTIN TABS**	MC/DEL		ENJUVIA	Must fail preferred products before non-preferred products.	Preferred drugs must be tried for at least 90 days and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**ESTRADIOL**	MC/DEL		**ESTRACE TABS**		
	MC/DEL		**ESTROPIPATE TABS**	MC		ESTRATAB TABS		
	MC/DEL		**MENEST TABS**	MC		ORTHO-EST TABS		
	MC/DEL		**PREMARIN TABS**				Use PA Form# 20420	
ESTROGEN COMBO'S	MC/DEL		**PREMPHASE TABS**	MC/DEL		**ACTIVELLA TABS**[1]	1. Must fail Premphase and Prempro products before non preferred products.	Preferred drugs must be tried for at least 90 days and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**PREMPRO TABS**	MC/DEL		**COMBIPATCH PTTW**[1]		
				MC/DEL		**FEMHRT 1/5 TABS**[1]		
				MC/DEL		**ORTHO-PREFEST TABS**[1]	Use PA Form# 20420	
				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.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		MEDROXYPROGESTERONE ACETA [2]	MC		CYCRIN TABS		
	MC/DEL		NORETHINDRONE ACETATE TABS[2]	MC		PROGESTERONE POWD	2. Must fail Medroxyprogesterone and Norethidrone products before non-preferred products.	
	MC		17-ALPH HYDROXYPROGESTERONE[3]	MC/DEL		PROMETRIUM 100MG CAPS[1]		
				MC/DEL		PROMETRIUM 200MG[1]	3. Clinical PA required for indication to reduce the risk of preterm birth in women with a singleton pregnancy who have a history of singleton spontaneous preterm birth.	
				MC/DEL		PROVERA TABS		

							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	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. If member experienced adverse reactions, consider using Oral Contraceptives from other groups. **DDI:** Preferred Oral Contraceptives will now be non-preferred and require prior authorization if it is currently being used in combination with Tracleer.
CONTRACEPTIVES - INJECTABLE	MC/DEL		MEDROXYPROGESTERONE ACETATE 150mg IM	MC/DEL		DEPO-PROVERA 150 mg SUSP	Use PA Form# 20420	The preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
CONTRACEPTIVE - EMERGENCY	MC/DEL MC/DEL MC MC/DEL	1 2 2 2	PLAN B ONE STEP[1] ELLA LEVONORGESTREL NEXT CHOICE[1]	MC/DEL		PLAN B	1. Allowed 2 tablets per 30 days without PA Use PA Form# 20420	
CONTRACEPTIVES - PATCHES/ VAGINAL PRODUCTS	MC		NUVARING RING[1]	MC/DEL		**XULANE**[2]	Use PA Form# 20420 1. Quantity limit allowing 1 every 28 days with out PA. 2. Dose limits apply allowing 3 patches per 28 days supply.	Approved if adequate clinical reason given why patient unable to comply with other preferred agents including long acting injectable.
CONTRACEPTIVES - MONOPHASIC COMBINATION O/C'S	MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC MC/DEL MC/DEL MC MC MC MC/DEL MC/DEL MC/DEL MC/DEL 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 SOLIA SPRINTEC 28 TABS YASMIN 28 TABS YAZ ZENCHENT	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 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 OGESTREL TABS OVCON-35/28 TABS OVRAL PORTIA-28 TABS SAFYRAL ZOVIA	Use PA Form# 20420 If member experienced adverse reactions, consider using Oral Contraceptives from other groups.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. If member experienced adverse reactions, consider using Oral Contraceptives from other groups. **DDI:** Preferred Oral Contraceptives will now be non-preferred and require prior authorization if it is currently being used in combination with Tracleer.
CONTRACEPTIVES - BI-PHASIC COMBINATIONS	MC MC MC/DEL		ORTHO-NOVUM 10/11-28 TABS NORETHINDRONE-ETH ESTRADIOL TAB 0.5-35/1-35 SEASONIQUE	MC/DEL MC/DEL MC/DEL MC/DEL		NECON 10/11-28 TABS KARIVA TABS LOSEASONIQUE MIRCETTE TABS	If member experienced adverse reactions, consider using Oral Contraceptives from other groups. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. If member experienced adverse reactions, consider using Oral Contraceptives from other groups. **DDI:** Preferred Oral Contraceptives will now be non-preferred and require prior authorization if it is currently being used in combination with Tracleer.
CONTRACEPTIVES - TRI-PHASIC COMBINATIONS	MC/DEL MC/DEL MC		ENPRESSE NECON 7/7/7 ORTHO-NOVUM 7/7/7-28 TABS	MC/DEL MC/DEL MC/DEL		CYCLESSA TABS ESTROSTEP FE TABS NORTREL 7/7/7	If member experienced adverse reactions, consider using Oral Contraceptives from other groups.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.

	MC/DEL		TRI-NORINYL 28 TABS	MC		ORTHO TRI-CYCLEN TABS	[illegible] other groups.	
	MC/DEL		TRI-PREVIFEM	MC		ORTHO TRI-CYCLEN LO TABS		
	MC/DEL		TRIPHASIL 28 TABS					If member experienced adverse reactions, consider using Oral Contraceptives from other groups.
	MC/DEL		TRI-SPRINTEC					**DDI:** Preferred Oral Contraceptives will now be non-preferred and require prior authorization if it is currently being used in combination with Tracleer.
	MC		TRINESSA					
	MC/DEL		TRIVORA-28 TABS				Use PA Form# 20420	
CONTRACEPTIVES - MULTI-PHASIC COMBINATIONS				MC		NATAZIA	Use PA Form# 20420	
DIABETES THERAPIES								
DIABETIC - INSULIN	MC		HUMALOG INJ 100/ML	MC/DEL		APIDRA	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		HUMALOG MIX 75/25	MC/DEL		**AFREZZA**[1]		
	MC		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.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		LEVEMIR FLEXPEN[1]	MC		HUMALOG KWIK INJ 100/ML		
	MC/DEL		**NOVOLIN PENFILL**[1]	MC		HUMALOG MIX INJ 75/25 KWP		
	MC/DEL		**NOVOLIN 70/30**[1]	MC		HUMALOG MIX INJ 50/50 KWP		
	MC/DEL		NOVOLOG MIX PENFILL[1]	MC/DEL		**TOUJEO**		
	MC/DEL		**NOVOLOG PENFILL SOLN**[1]	MC/DEL		**TRESIBA**		
	MC/DEL		NOVOLOG MIX FLEXPEN[1]					
	MC/DEL		NOVOLOG FLEXPEN[1]				Use PA Form# 20420	
DIABETIC - DPP- 4 ENZYME INHIBITOR	MC/DEL		JANUVIA[1,2]	MC/DEL		**ONGLYZA**[2]	1. Preferred if therapeutic doses of metformin are seen in members drug profile for at least 60 days within the past 18 months or if phosphate binder is currently seen in the members drug profile.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		TRADJENTA[2]					**DDI:** Onglyza 5mg will require a prior authorization if it is currently being used in combination with drugs known to be significant CYP3A4 inhibitors (ketoconazole, itraconazole, clarithromycin, indinavir, nefazodone, nelfinavir, ritonavir, atazanavir, saquinavir and telithromycin).
							2. Dosing limits apply. Please refer to Dose consolidation list.	
							Use PA Form# 20420	
DIABETIC - DPP- 4 ENZYME INHIBITOR-COMBO	MC/DEL		JANUMET[1,2]	MC/DEL		**KAZANO**	1. Preferred if therapeutic doses of metformin are seen in members drug profile for at least 60 days within the past 18 months or if phosphate binder is currently seen in the members drug profile.	
	MC/DEL		**JANUMET XR**[1,2]	MC		KOMBIGLYZE XR		
	MC/DEL		**JENTADUETO**[1]	MC/DEL		**OSENI**		
							2. Dosing limits apply. Please refer to Dose consolidation list.	
							Use PA Form# 20420	
DPP- 4 ENZYME INHIBITOR/ HMG-COS REDUCTASE INHIBITOR	MC/DEL		JUVISYNC[1,2]				Use PA Form# 20420	**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).

							1. Please refer to criteria section of PDL 2. Dosing limits apply please refer to Dose Consolidation List	Juvisync will remain preferred until product is eventually discontinued later in 2014.
DIABETIC - LANCET-LANCET DEVICE	**MC** **MC** **MC** **MC** **MC**		ONE TOUCH LANCETS DELICA LANCETS UNILET LANCETS UNISTIK LANCING DEVICE AUTOLOT LANCING DEVICE				Use PA Form# 20420	
DIABETIC - SYRINGES-NEEDLES	**MC/DEL** **MC** **MC** **MC**		BD MICRO-FINE BD ULTRA-FINE BD ULTRA-FINE PEN NEEDLES UNIFINE PEN NEEDLES				Use PA Form# 20420	
DIABETIC - OTHER				**MC/DEL** **MC**		CYCLOSET SYMLIN	Use PA Form# 30150 for Symlin Use PA Form #20420 for all others	Please see the criteria listed in the Symlin PA form.
SGLT 2 INHIBITORS	**MC/DEL**		**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	**Invokana** will be considered for patients who are unable to tolerate any preferred medicaitons from other diabetic classes.
SGLT 2 INHIBITOR COMBINATIONS				**MC/DEL** **MC/DEL** **MC/DEL** **MC/DEL**		**GLYXAMBI** **INVOKAMET** **SYNJARDY** **XIGDOU XR**[1]	1. Diagnosis required Use PA Form# 20420	Preferred drugs must be tried for at least 3 months at full therapeutic doses and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Glyxambi /Xigduo XR- Verify prior trials and failures or intolerance of preferred treatments from other diabetic categories
DIABETIC MONITOR	**MC** **MC** **MC** **MC** **MC** **MC** **MC**		FREESTYLE INSULINX FREESTYLE LITE SYSTEM KIT FREESTYLE FREEDOM LITE KIT ONE TOUCH ULTRA 2 KIT ONE TOUCH ULTRA MINI KIT ONE TOUCH ULTRA SMART KIT PRECISION XTRA METER	**MC** **MC** **MC** **MC** **MC** **MC**		ACCUCHECK ASCENSIA ASSURE CONTOUR BREEZE Z EXACTECH PRODIGY	Use PA Form# 20420	Effective October 25th 2007, approvals for all non preferred meters/ test strips will require medical necessity documenting clinically significant features that are not available on any of the preferred meters.
DIABETIC TEST STRIPS	**MC** **MC** **MC** **MC** **MC** **MC**		FREESTYLE[1] FREESTYLE LITE[1] FREESTYLE INSULINX[1] ONE TOUCH DELICA[1] ONE TOUCH ULTRA[1] PRECISION XTRA[1]	**MC** **MC** **MC** **MC** **MC** **MC**		ACCUCHECK ASCENSIA ASSURE EXACTECH PRODIGY CONTOUR BREEZE Z	1. Only 50 ct & 100 ct package size. Use PA Form# 20420	Effective October 25th 2007, approvals for all non preferred meters/ test strips will require medical necessity documenting clinically significant features that are not available on any of the preferred meters.

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

BIGUANIDE				MC MC/DEL		METAGLIP TABS[1] DUETACT[2]	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	Preferred drugs from other diabetic sub-categories must be tried and failed due to lack of inadequate diabetic control or intolerable side effects before non-preferred drug will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **DDI**: Prandin is non-preferred but with any prior authorization requests, the member's drug profile will also be monitored for current use with both Sporanox and gemfibrozil, due to a significant drug-drug interaction.
GLUCOSE ELEVATING AGENTS								
GLUCOSE ELEVATING AGENTS	MC/DEL		GLUCAGEN INJ. HYPOKIT	MC MC		GLUCAGON DIAGNOSTIC KIT GLUCAGEN DIAGNOSTIC KIT	Use PA Form# 20420	
THYROID								
THYROID HORMONES	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		**ARMOUR THYROID TABS** **CYTOMEL TABS** **LEVOTHROID TABS** **LEVOTHYROXINE SODIUM TABS** **LEVOXYL TABS** **THYROID TABS** **THYROLAR** **UNITHROID TABS**	MC MC/DEL MC		LEVOTHYROXINE SODIUM SOLR LIOTHYRONINE SYNTHROID TABS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANTITHYROID THERAPIES	MC/DEL MC/DEL		**METHIMAZOLE TABS** **PROPYLTHIOURACIL TABS**	MC/DEL		**TAPAZOLE TABS**	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
OSTEOPOROSIS / BONE AGENTS								
OSTEOPOROSIS	MC/DEL MC/DEL		ALENDRONATE **MIACALCIN SOLN[2]**	MC/DEL MC MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC MC MC/DEL MC/DEL MC MC MC MC/DEL		**ACTONEL TABS** AREDIA SOLR BINOSTO BONIVA INJECTION KIT BONIVA TABS[2,4] CALCITONIN NS **DUAVEE** **DIDRONEL TABS** EVISTA TABS[1] FORTEO FORTICAL **FOSAMAX TABS AND PLUS D[3]** STRENSIQ[5] PROLIA XGEVA ZOMETA	Use PA Form# 20420 1. Approval only requires failure of Alendronate. 2. Quantity limits apply, please see dosage consolidation list. 3. Please use Alendronate and Vitamin D. 4. Please use other preferred agents. 5. Obtain baseline ophthalmology exams and renal ultrasounds and then periodically during treatment	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **Binosto** use preferred generic alendronate tablets
CALCIMIMETIC AGENTS								
CALCIMIMETIC AGENTS				MC		SENSIPAR	Use PA Form# 30115	Baseline PTH, Ca, and phosphorous levels are required and initial approvals will be limited to 3 months. Subsequent approvals will require additional levels being done to assess changes. Will not approve if baseline Ca is less than 8.4.
GROWTH HORMONE								
GROWTH HORMONE	MC/DEL MC/DEL		GENOTROPIN[1] NORDITROPIN SOLN[1]	MC MC MC/DEL MC MC MC/DEL MC/DEL	8 8 8 8 8 8 8	HUMATROPE SOLR INCRELEX NUTROPIN OMNITROPE SAIZEN SOLR TEV-TROPIN NUTROPIN AQ	Use PA Form# 10710 1.Clinical PA is required to establish diagnosis and medical necessity.	See Growth Hormone PA form for criteria. Step-order will still apply unless clinical contraindication supplied.

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

CARDIAC GLYCOSIDES	MC/DEL		**DIGITEK TABS**				Use PA Form# 20420	
	MC/DEL		**DIGOXIN**					
	MC/DEL		**LANOXIN**					
CARDIAC - SINUS NODE INHIBITORS	MC		CORLANOR					In patients with stable, symptomatic chronic heart failure with left ventricular ejection fraction ≤35%, who are in sinus rhythm with resting heart rate ≥70 beats per minute (bpm) and either are on maximally tolerated doses of beta-blockers or have a contraindication to beta-blocker use
ANTIANGINALS--Isosorbide Di-nitrate/ Mono-Nitrates	MC/DEL		**ISOSORBIDE MONONITRATE TABS**	MC		DILATRATE SR CPCR	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**ISOSORBIDE MONONITRATE ER**	MC		ISORDIL TABS		
				MC		ISORDIL TITRADOSE TABS		
				MC		ISOSORBIDE DINITRATE SUBL		
				MC/DEL		**ISOSORBIDE DINITRATE TABS**		
				MC/DEL		ISOSORBIDE DINITRATE CR TBCR		
				MC/DEL		**ISOSORBIDE DINITRATE ER TBCR**		
				MC/DEL		ISOSORBIDE DINITRATE TD TBCR		
				MC/DEL		**IMDUR TB24**		
				MC/DEL		ISMO TABS		
				MC		MONOKET TABS		
NITRO - OINTMENT/CAP/CR	MC/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	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL	1	**NITREK PT24**[1]	MC/DEL		**NITRO-DUR PT24**		
	MC/DEL	1	**NITRO-DUR PT 24 0.8MG**[1]					
	MC	3	MINITRAN PT24[1]					
NITRO - SUBLINGUAL/ SPRAY	MC/DEL		**NITROSTAT SUBL**	MC/DEL		**NITROQUICK SUBL**	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**NITROTAB SUBL**	MC		**NITROLINGUAL SOLN**		
				MC		NITROLINGUAL TABS		
BETA BLOCKERS - NON SELECTIVE	MC/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	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	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	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**ATENOLOL TABS**[1]	MC		KERLONE TABS		
	MC/DEL		**BETAXOLOL HCL TABS**	MC/DEL		**LOPRESSOR TABS**		
	MC/DEL		**BISOPROLOL FUMARATE TABS**	MC		SECTRAL CAPS		
	MC/DEL		**METOPROLOL TARTRATE TABS**[1]	MC/DEL		**TENORMIN TABS**		
	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	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
BETA BLOCKERS & DURECTIC COMBOS				MC/DEL		**DUTOPROL**	Use PA Form# 20420	

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

	MC/DEL		RAMIPRIL	MC/DEL	8	MOEXIPRIL HCL[1]		
	MC/DEL		QUINAPRIL HCL	MC	8	MONOPRIL HCT TABS[1]		
				MC/DEL	8	PRINIVIL TABS[1]		
				MC/DEL	8	UNIVASC[1]		
				MC	8	VASOTEC TABS[1]		
				MC/DEL	8	ZESTRIL TABS[1]		
ANGIOTENSIN RECEPTOR BLOCKER	MC/DEL		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.	The initial criteria to use any ARB is that the member must have failed ACE inhibitors (such as due to coughing) in the past or must currently be actively treated for diabetes and Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		DIOVAN[1]	MC/DEL	8	AVAPRO		
	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	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		CLONIDINE HCL TABS	MC/DEL		CLONIDINE TTS		
	MC/DEL		GUANFACINE HCL TABS	MC		GUANABENZ ACETATE TABS		
	MC/DEL		HYDRALAZINE HCL TABS	MC		ISMELIN TABS		
	MC		HYLOREL TABS	MC/DEL		MINIPRESS CAPS		
	MC/DEL		METHYLDOPA TABS	MC		NEXICLON		
	MC/DEL		MINOXIDIL TABS	MC/DEL		TENEX TABS		
	MC/DEL		PRAZOSIN HCL CAPS					
	MC/DEL		RESERPINE TABS					
ACE INHIBITORS AND CA CHANNEL BLOCKERS				MC/DEL	8	AMLODIPINE/BENAZEPRIL	Use individual preferred generic medications. Use PA Form# 20420	
				MC	8	TARKA TBCR		
				MC/DEL	9	AMLODIPINE/BENAZEPRIL		
				MC/DEL	9	LOTREL CAPS		
ACE AND THIAZIDE COMBO'S	MC/DEL		BENAZEPRIL HCL/HYDROCHLOR	MC/DEL		ACCURETIC TABS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		CAPTOPRIL/HYDROCHLOROTHIA	MC		MONOPRIL HCT TABS		
	MC/DEL		ENALAPRIL MALEATE/HCTZ TABS	MC/DEL		PRINZIDE TABS		
	MC/DEL		LISINOPRIL-HCTZ TABS	MC/DEL		UNIRETIC TABS		
	MC/DEL		LOTENSIN HCT TABS	MC		VASERETIC TABS		
				MC/DEL		ZESTORETIC TABS		
BETA BLOCKERS AND DIURETIC COMBO'S	MC/DEL		ATENOLOL/CHLORTHALIDONE	MC/DEL		CORZIDE TABS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		BISOPROLOL FUMARATE/HCTZ	MC/DEL		LOPRESSOR HCT TABS		
	MC/DEL		PROPRANOLOL/HCTZ	MC		TENORETIC		
				MC		TIMOLIDE 10/25 TABS		
				MC/DEL		ZIAC TABS		
ARB'S AND CA CHANNEL BLOCKERS	MC/DEL		AZOR	MC/DEL		TWYNSTA	1. Preferred products only available without PA if patient on diabetic therapy or prior ACE therapy. Use PA Form# 20420	
	MC/DEL		EXFORGE[1]					
	MC/DEL		EXFORGE HCT[1]					
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. Use PA Form# 20420	Same initial criteria as the ARB class and Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	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		

ANGIOTENSIN MODULATORS-ARB COMBINATION				MC/DEL MC		**EDARBYCLOR** ENTRESTO	Use PA Form# 20420	
ARB'S AND DIRECT RENIN INHIBITOR COMBINATION				MC/DEL		**VALTURNA**	Use PA Form# 20420	
DIURETICS	MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC		**ACETAZOLAMIDE TABS** **BUMETANIDE** **CHLOROTHIAZIDE TABS** **CHLORTHALIDONE TABS** EDECRIN TABS EDECRIN TABS **HYDROCHLOROTHIAZIDE** **INDAPAMIDE TABS** **METHAZOLAMIDE TABS** **METHYCLOTHIAZIDE TABS** **SPIRONOLACTONE 25MG TABS** **SPIRONOLACTONE/HYDRO** **TORSEMIDE TABS** **TRIAMTERENE/HCTZ** ZAROXOLYN TABS	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL		**ALDACTAZIDE TABS** **ALDACTONE TABS** **AMILORIDE HCL** **BUMEX TABS** **DEMADEX TABS** **DIAMOX** DIURIL **DYAZIDE CAPS** ENDURON TABS **INSPRA** **LASIX TABS** **MAXZIDE** **MICROZIDE CAPS** **MIDAMOR TABS** NAQUA TABS **SPIRONOLACTONE 50MG**[1]	1. Multiples of Spironolactone 25 mg are cheaper than 50 mg strength. Inspra will be approved for severe breast tenderness and male gynecomastia. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
CCB / LIPID				MC/DEL		**CADUET**		
NEUROGENIC ORTHOSTATIC HYPOTENSION								
NEUROGENIC ORTHOSTATIC HYPOTENSION				MC		**NORTHERA**	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
LIPID DRUGS								
CHOLESTEROL - BILE SEQUESTRANTS	MC/DEL MC/DEL		**CHOLESTYRAMINE** **COLESTIPOL HCl**	MC/DEL MC/DEL MC MC/DEL		**COLESTID** **PREVALITE** **QUESTRAN** WELCHOL TABS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
CHOLESTEROL - FIBRIC ACID DERIVATIVES	MC/DEL MC/DEL MC/DEL MC		FENOFIBRATE **GEMFIBROZIL TABS** NIASPAN TRILIPIX	MC MC/DEL MC/DEL MC/DEL MC MC/DEL MC MC		ANTARA **LOPID** FENOFIBRATE 120mg **FIBRICOR** LIPOFEN **LOFIBRA** TRICOR TRIGLIDE	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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.
CHOLESTEROL - HGM COA + ABSORB INHIBITORS MORE POTENT DRUGS/COMBINATIONS	MC/DEL MC/DEL MC/DEL MC		**ATORVASTATIN** **CRESTOR** **SIMVASTATIN**[1] **VYTORIN**	MC/DEL MC MC/DEL MC/DEL		**LIPITOR** LIPTRUZET **ZOCOR** **SIMVASTATIN 80MG**[1,2]	1. Dosing limits apply, please see dosage consolidation list. 2. Current users grandfathered. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **DDI:** Lipitor (doses greater than 20mg/day) will now be non-preferred and require prior authorization if they are currently being used in combination cyclosporine. **DDI:** Lipitor (doses greater than 20mg/day) will now be non-preferred and require prior authorization if it is currently being used in combination with Amiodarone. **DDI:** All preferred statins will now be non-preferred and require prior authorization if it is currently being used in combination with Gemfibrozil.
CHOLESTEROL - HGM COA + ABSORB INHIBITORS LESS POTENT DRUGS/COMBINATIONS	MC/DEL MC/DEL MC/DEL MC/DEL MC		**LESCOL CAPS** LESCOL XL TB24 LOVASTATIN TABS[2] PRAVASTATIN[2] ZETIA TABS	MC MC MC/DEL MC/DEL MC/DEL	8 8 8 8 8	ALTOPREV TB24 LIVALO MEVACOR TABS **PRAVACHOL TABS** PRAVIGARD	2. Dosing limits apply, please see dosage consolidation list.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Zetia will be approved for patients unable to tolerate all other therapies or unable to achieve cholesterol goal with maximally tolerated dose of most potent statins. **DDI:** Lescol will now be non-preferred and require prior authorization if it is currently being used in combination with diclofenac. **DDI:** Lovastatin (doses greater than 40mg/day) will now be non-preferred and require prior authorization if it is currently being used in combination with Amiodarone.

							Use PA Form# 20420	**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.
CHOLESTEROL - HGM COA + ABSORB INHIBITORS STATIN/ NIACIN COMBO	MC		SIMCOR	MC		ADVICOR TBCR	Use PA Form# 20420	
FAMILIAL HYPERCHOLESTEROLEMIA				MC MC MC/DEL MC		JUXTAPID KYNAMRO[1] **PRALUENT[1,2,3]** REPATHA[1,2,3]	1. Clinical PA required for appropriate diagnosis 2. Quantity limits apply for HeFH/ASCVD 1 injection per 14 days for HoFH 3 injectors per 30 days 3. Documented adherence to lipid lowering medications and abstinence from tobacco for previous 90 days For Repatha and Praluent please use PA form #10800 Use PA Form#10500	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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. Praluent and Repatha initial approvals will be limited to 8 weeks (for HeFH or ASCVD) or 3 months (for HoFH). Baseline and follow up lipid profiles are required and subsequent approvals will require additional levels being done to assess changes. Will not approve if LDL-C is not at goal after a period of : 1. 24 weeks for Praluent or Repatha for treatment of HeFH/ASCVD 2. 3 months of Repatha for treatment of HoFH)
PULMONARY ANTI-HYPERTENSIVES								
PULMONARY ANTI-HYPERTENSIVES	MC/DEL MC MC MC		SILDENAFIL* EPOPROSTENOL INJ[6] VENTAVIS[2] ADCIRCA[1]	MC/DEL MC/DEL MC MC MC MC/DEL MC		ADEMPAS[6,7] FLOLAN[6] OPSUMIT[7,8] ORENITRAM REMODULIN[6] REVATIO[3] UPTRAVI	1. See Criteria Section. 2. See Criteria Section. 3. See Criteria Section. 4. See Criteria Section. 5. There will be dosing limits of one 20ml multidose vial/ 30 days supply without pa. 6. PA is required to establish and conform who group 1 diagnosis of primary PAH (Primary Pulmonary Hypertension) and NYHA functional class 3 & 4. 7. Requires previous trials/failure of multiple preferred medications. 8. Dosing limits apply, please see the dose consolidation list. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significat potential drug interation between another drug and the preferred drug(s) exists. 1. Adcirca approvals will require WHO Group 1 diagnosis of primary PAH (Primary Pulmonary Hypertension) and NYHA functional class 2 or 3. 2. Ventavis approvals will require WHO Group 1 diagnosis of primary PAH (Primary Pulmonary Hypertension) and NYHA functional class 3 or 4. 3. Revatio approvals will require WHO Group 1 diagnosis of primary PAH (Primary Pulmonary Hypertension) and NYHA functional class 2 or 3. 3. Revatio approvals will require WHO Group 1 diagnosis of primary PAH (Primary Pulmonary Hypertension) and NYHA functional class 2 or 3. 4. Sildenafil will be preferred with clinical PA for treatment of pulmonary arterial hypotenion (WHO Group 1) in adults to improve exercise ability and delay clinical worsening. **DDI:** Opsumit will require a prior authorization if it is currently being used in combination with drugs known to be significant CYP3A4 inhibitors (ketoconazole, itraconazole, clarithromycin, indinavir, nefazodone, nelfinavir, ritonavir, atazanavir, saquinavir and telithromycin). **DDI:** Adempas will require a prior authorization if it is currently being used in combination with drugs known to be PDE inhibitors should be avoided (including dypyridamole, adcira and tadalafil) with adempas DDI: Uptravi will require a prior authorization if it is currently being used in combination with strong inhibitors of CYP2C8 (gemfibrozil)
ERA / ENDOTHELIN RECEPTOR ANTAGONIST	MC MC		LETAIRIS[1,2] TRACLEER[3,4]				1. Providers must be registered with LEAP Prescribing program, a	Tracleer approvals will require WHO Group 1 diagnosis of primary PAH (Primary Pulmonary Hypertension) and NYHA functional class 2 thru 4.

							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	**DDI:** Preferred Oral Contraceptives will now be non-preferred and require prior authorization if it is currently being used in combination with Tracleer. Letairis approvals will require WHO Group 1 diagnosis of primary PAH (Primary Pulmonary Hypertension) and functional class 2 or 3 symptoms.
IMPOTENCE AGENTS								
IMPOTENCE AGENTS							As of January 1, 2006, per CMS (federal govt.), impotence agents are no longer covered.	As of January 1, 2006, per CMS (federal govt.), impotence agents are no longer covered.
ANTI-EMETOGENICS								
ANTIEMETIC - ANTICHOLINERGIC / DOPAMINERGIC	MC/DEL		MECLIZINE HCL TABS	MC		ANTIVERT TABS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		PROMETHAZINE SUPP	MC		PHENERGAN SOLN		
	MC/DEL		PROMETHAZINE	MC		PROMETHAZINE 50MG SUPP		
	MC		TRANSDERM-SCOP PT72	MC		PROMETHEGAN SUPP		
				MC		TORECAN TABS		
ANTIEMETIC - 5-HT3 RECEPTOR ANTAGONISTS/ SUBSTANCE P NEUROKININ	MC/DEL		**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. 2. Ondansetron will be preferred with CA diag and dosing limits still apply. 3. Clinical PA is required for members on highly emetic anti-neoplastic agents. 4. Dosing limits apply, please see Dosage Consolidation List Use PA Form# 20610 for Ondansetron requests Use PA Form# 20420 for all others	Preferred drugs and step therapy must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. * Ondansetron limits still apply as listed on the Ondansetron PA form for covered indications including chemotherapy, radiotherapy, post operative nausea & vomiting and hyperemesis gravidarum. Other medical indications will be approved or denied on a case by case basis. Hyperemesis and other medical indications approved are still subject to failure of multiple preferred antiemesis drugs. Akynzeo- Concomitant use should be avoided in patients who are chronically using a strong CYP3A inducer such as rifampin. Varubi – Available to the few who are unable to tolerate or who have failed on preferred medications
	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		
				MC	8	VARUBI		
				MC/DEL	8	ZOFRAN ODT TBDP[4]		
				MC/DEL	8	ZOFRAN TABS[4]		
				MC/DEL	8	ZOFRAN INJ[4]		
				MC	8	ZUPLENZ		
NON-SEDATING ANTIHISTAMINES / DECONGESTANTS								

ANTIHISTIMINES - NON-SEDATING	MC MC/DEL MC MC MC/DEL MC		ALAVERT TABS CETIRIZINE TABS CLARITIN (OTC) CLARITIN SYRP (OTC) LORATADINE TAVIST ND (OTC)	MC MC MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL	5 5 5 5 5 8 8 8 8 8 9	CLARINEX TABS[1,5] CLARINEX SYR[1,2] FEXOFENADINE[1] ZYRTEC[1] ZYRTEC SYR[1,2] ALLEGRA[3] CLARITIN[3] DESLORATADIN LORATADINE ODT[4] LEVOCETIRIZINE[4] XYZAL[3]	1. Must fail preferred drugs, OTC loratidine and cetirizine before moving to non-preferred step order drugs. 2. Clarinex and Zyrtec syrp <6 yr w/o PA. 3. Must fail all step 5 drugs (Clarinex, Fexofenadine and Zyrtec) before moving to next step product. 4. All OTC versions of loratadine ODT are now non-preferred. 5. Pa's for Clarinex RediTabs will only be approved if between the ages of 6-11 years old. Use PA Form# 20530	Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. No combination product with decongestant will be approved since pseudoephedrine available without PA. Pseudoephedrine is available with prescription.
ANTIHISTIMINES - OTHER	MC/DEL MC/DEL 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	Prescriber must provide the testing to show that the patient is allergic to the components in the prescribed therapy and must provide a clinically valid rationale why single agent sublingual therapy is being chosen over subcutaneous therapy Treatment must start 12 weeks before expected onset of pollen season and only after confirmed by positive skin test or in vitro testing for pollen-specific IgE antibodies for short ragweed pollen (Ragwitek), timothy grass or cross-reactive grass pollens (Grastek), or any of the 5 grass species contained in Oralair Have an auto-injectable epinephrine on-hand **Grastek :** Patient age ≥5 years and ≤65 years **Ragwitek:** Patient age ≥18 years and ≤65 years **Oralair:** Patient age ≥10 years and ≤65 years
ANTIASTHMATIC - ANTICHOLINERGICS - INHALER	MC/DEL		SPIRIVA HANDIHALER[1,2]	MC/DEL MC/DEL MC/DEL		**SPIRIVA RESPIMAT** **TUDORZA** **INCRUSE ELLIPTA**[3]	Use PA Form# 20420 1. Quantity limit of 1 inhalation daily (1 capsule for inhalation daily) Spiriva will require PA if Combivent or Atrovent nebulizer solution is in member's current drug profile.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.

							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	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANTIASTHMATIC - ANTICHOLINERGICS - NEBULIZER	MC/DEL		**IPRATROPIUM BROMIDE SOLN**	MC		ATROVENT SOLN	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANTIASTHMATIC - ANTIINFLAMMATORY AGENTS	MC/DEL		CROMOLYN SODIUM NEBU	MC/DEL		**NUCALA**[2]	1. Need max inhaled steroids and written by pulmonary or allergy specialist 2. For patients with severe asthma aged 12 years or older Use PA Form# 20420	Nucala & Xolair approval will require suboptimal response to maximal doses of inhaled steroid as evidenced by asthmatic ER/Hospital admissions and Allergy/Pulmonary specialist management.
				MC/DEL		XOLAIR[1]		
ANTIASTHMATIC - NASAL STEROIDS	MC/DEL		**FLUTICASONE SPR**[3]	MC/DEL	5	BECONASE AQ INHA[1,3]	Use PA Form# 20420 1. All preferred drugs must be tried before moving to non preferred steps. 2. All step 5 medications need to be tried before moving to step 8's. 3. Dosing limits apply to whole category, please see dosage consolidation list.	Preferred drugs and step therapy must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		OMNARIS SPR[3]	MC/DEL	8	DYMISTA		
	MC/DEL		ZETONNA[3]	MC/DEL	8	FLONASE SUSP[2,3]		
				MC/DEL	8	FLUNISOLIDE SOLN[1,3]		
				MC/DEL	8	NASONEX SUSP		
				MC	8	QNASL		
				MC	8	RHINOCORT AERO[2,3]		
				MC/DEL	8	RHINOCORT AQUA SUSP[2,3]		
				MC	8	TRI-NASAL SOLN[2,3]		
				MC	8	VANCENASE POCKETHALER AERS[2,3]		
				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 1. Ipratropium will be approved if submitted with documentation supporting use of CPAP machine. 2. Utilize Multiple preferred, as well as step therapy Astelin.	Approved if patient fails on nonsedating antihistamines and steroid nasal sprays. Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
				MC/DEL	7	ASTELIN		
				MC	7	IPRATROPIUM NASAL SOL[1]		
				MC/DEL	8	ASTEPRO[2]		
				MC/DEL	8	PATANASE		
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. 2. Quantity Limit: 12 cc/day. 3. Dosing limits apply, please see dosage consolidation list.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**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**		
				MC		**PROAIR HFA**[3]		
				MC		PROAIR RESPICLICK		
				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.	**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.
	MC/DEL		DULERA	MC/DEL		**ADVAIR DISKUS**[2,3]	2. Dosing limits apply, please see dosage consolidation list.	
	MC/DEL		SYMBICORT[2]				3. Clinical PA required for appropriate diagnosis	
							Use PA Form# 20420	
ANTIASTHMATIC - ADRENERGIC ANTICHOLINERGIC	MC/DEL		**ALBUTEROL/IPRATROPIUM NEB. SOLN**	MC/DEL		**ANORO ELLIPTA**	1. Please use preferred individual ingredients Albuterol and Ipratropium.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Duoneb components are available separately without PA.
				MC/DEL		**COMBIVENT RESPIMAT**		
				MC/DEL		DUONEB SOLN[1]		
				MC/DEL		**STIOLTO**		
							Use PA Form# 20420	
ANTIASTHMATIC - XANTHINES	MC/DEL		**AMINOPHYLLINE TABS**	MC/DEL		**THEO-24 CP24**	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		THEOCHRON TB12	MC		THEOLAIR TABS		
	MC/DEL		THEOLAIR-SR TB12	MC/DEL		**UNIPHYL TBCR**		
	MC/DEL		**THEOPHYLLINE CR TB12**					
	MC		THEOPHYLLINE ELIX					
	MC/DEL		THEOPHYLLINE SOLN					
	MC/DEL		**THEOPHYLLINE ER CP12**					
	MC/DEL		**THEOPHYLLINE ER TB12**					
ANTIASTHMATIC - STEROID INHALANTS	MC/DEL		ASMANEX[4,5]	MC/DEL	5	**AEROBID AERS**[2,4]	1. No PA for Pulmicort susp if under 8 years old.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**FLOVENT DISKUS**[4]	MC	5	BECLOVENT AERS[2,4]		
	MC/DEL		**FLOVENT HFA**[4]	MC	5	VANCERIL AERS[2,4]		
	MC/DEL		**PULMICORT FLEXHALER**	MC/DEL	8	**AEROBID-M AERS**[3,4]		
	MC/DEL		**PULMICORT SUSP**[1,4]	MC/DEL	8	ALVESCO[4]		
	MC		QVAR AERS[4]	MC/DEL	8	**ARNUITY ELLIPTA**[6]	2. All preferreds must be tried before moving to non preferred steps.	
	MC		AEROSPAN	MC/DEL	8	**ASMANEX HFA**	3. All step 5 medications need to be tried before moving to step 8's.	
				MC	8	VANCERIL DOUBLE STRENGTH AERS[3,4]	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	
ANTIASTHMATIC - 5-Lipoxygenase Inhibitors				MC		**ZYFLO CR TABS**	Use PA Form# 20420	Other Preferred asthma controller drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.

ANTIASTHMATIC - LEUKOTRIENE RECEPTOR ANTAGONISTS	MC/DEL		**MONTELUKAST SODIUM TAB**	MC/DEL	7	MONTELUKAST GRANULE[1]	Use PA Form# 20420	
	MC/DEL		**MONTELUKAST SODIUM CHEW TAB**	MC/DEL	8	**ACCOLATE TABS**	1.Montelukast Granules will only be approved if between ages of 6months-24 months.	
				MC/DEL	8	**SINGULAIR[2]**	2.Singulair Chewables 4mg from 2years-5years and Singulair Chewables 5mgs from 6years-14years old.	
ANTIASTHMATIC - ALPHA-PROTEINASE INHIBITOR				MC	8	ARALAST	Use PA Form# 20420	Prolastin and Azemaira will be approved for members with A1AT deficiency and clinically demonstrable panacinar emphysema.
				MC/DEL	8	**ZEMAIRA**		
				MC	8	GLASSIA		
				MC	8	PROLASTIN SUSR		
ANTIASTHMATIC - HYDRO-LYTIC ENZYMES				MC/DEL		PULMOZYME SOLN	Use PA Form# 20420	Will be approved for cystic fibrosis patients.
ANTIASTHMATIC - MUCOLYTICS	MC/DEL		ACETYLCYSTEINE[1]	MC		MUCOMYST	1. Acetylcysteine is covered with diagnosis of CF.	
							Use PA Form# 20420	
ANTIASTHMATIC-CFTR POTENTIATOR AND COMBINATIONS				MC		ORKAMBI		
				MC		KALYDECO	Use PA Form# 20420	Kalydeco wil be considered for patients 6 years of age or older; and has a diagnosis of cystic fibrosis with a G551D mutation in the CFTR gene as detected by an FDA-cleared CF mutation test; and prescriber is a CF specialist or pulminologist; and patient does not have one of the following infections: Burkholderia cenocepacia, dolosa or mycobacterium abcessus
IDIOPATHIC PULMONARY FIBROSIS				MC		ESBRIET[1]	1. Diagnosis required	
				MC/DEL		**OFEV[1]**		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
							Use PA Form# 20420	
COUGH/COLD								
COUGH/COLD	MC/DEL		DEXTRO-GUAIF SYRP[1]				1. All of cough cold preparations are not covered except these preferred products.	All non-preferred products are not covered as permitted by Federal Medicaid regulations and MaineCare Policy.
	MC/DEL		GUAIFENESIN SYRP[1]					
	MC/DEL		PSEUDOEPHEDRINE[1]					
	MC		ROBITUSSIN DM SYRP[1]					
	MC		ROBITUSSIN SUGAR FREE SYRP[1]				Use PA Form# 20420	
DIGESTIVE AIDS / ASSORTED GI								
GI - ANTIPERISTALTIC AGENTS	MC/DEL		DIPHENOXYLATE	MC/DEL		LOFENE TABS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. As listed in MaineCare Policy, certain drugs require specific diagnoses for approval.
	MC/DEL		DIPHENOXYLATE/ATROPINE	MC		LONOX TABS		
	MC/DEL		LOPERAMIDE HCL CAPS/LIQ	MC		MOTOFEN TABS		
	MC/DEL		OPIUM TINCTURE TINC					
	MC		PAREGORIC TINC					
GI - ANTI-DIARRHEAL/ ANTACID - MISC.	MC		**ATROPINE SULFATE SOLN**	MC/DEL		**BELLADONNA ALKALOIDS & OP**	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **As listed in MaineCare Policy, certain drugs require specific diagnoses for approval**.
	MC/DEL		BENTYL SYRP	MC/DEL		BENTYL TABS	1.Dosing limits apply please refer to Dose Consolidation List	
	MC/DEL		BISMATROL	MC		CUVPOSA		
	MC/DEL		BISMUTH SUBSALICYLATE	MC		ED-SPAZ		
	MC/DEL		CALCIUM CARBONATE (ANTACID) CHEW	MC		FULYZAQ[1]		
	MC/DEL		DICYCLOMINE HCL	MC/DEL		GLYCOPYRROLATE INJ		

	MC/DEL		GLYCOPYRROLATE TABS	MC/DEL		HYOSCYAMINE SL		
	MC		HAPONAL TABS	MC/DEL		LEVBID TB12		
	MC/DEL		HYOSCYAMINE CAPS & TABS	MC		LEVSIN ELIX		
	MC/DEL		HYOSCYAMINE SULFATE	MC		LEVSIN TABS		Preferred products that used to require diag codes still require diag codes unless indicated otherwise.
	MC/DEL		KAOPECTATE	MC		LEVSIN/SL SUBL		
	MC/DEL		MAGNESIUM OXIDE TABS	MC		NULEV TBDP		**Fulyzaq** requires a diagnosis of non-infectious diarrhea in patients with HIV/AIDS on anti-retroviral therapy, prior trials of preferred, more cost effective anti-diarrheals.
	MC/DEL		**MAG-OX 400 TABS**	MC		ROBINUL INJ		
	MC/DEL		PAMINE TABS	MC		ROBINUL TABS		
	MC/DEL		PROPANTHELINE BROMIDE TABS					
	MC/DEL		SAL-TROPINE TABS					
	MC/DEL		SODIUM BICARBONATE TABS					
	MC/DEL		TUMS					
GI- BILE ACID				MC		CHOLBAM		Indication of bile acid synthesis disorders due to single enzyme defects (SEDs) AND for adjunctive treatment of peroxisomal disorders (PDs)
GI - H2-ANTAGONISTS	MC/DEL		CIMETIDINE	MC		AXID CAPS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		FAMOTIDINE	MC		AXID AR TABS		
	MC/DEL		RANITIDINE 150MG TABS	MC/DEL		NIZATIDINE CAPS		
	MC/DEL		RANITIDINE SYRP	MC/DEL		PEPCID		
	MC		ACID REDUCER TABS	MC		PEPCID AC		**DDI:** Ranitidine and cimetidine will now be non-preferred and require prior authorization if it is currently being used with any sulfonylurea (except for glyburide).
				MC/DEL		RANITIDINE 150MG CAPS		
				MC/DEL		ZANTAC SYRP		
				MC/DEL		ZANTAC TABS		**DDI:** Cimetidine will require prior authorization if being used in combination with Plavix.
GI - PROTON PUMP INHIBITOR	MC/DEL		OMEPRAZOLE 20MG[2]	MC/DEL	6	NEXIUM CPDR[4]	1. Prevacid Solutabs available without PA for children less than 9 years old.	All preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs (in step-order) will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		PANTOPRAZOLE	MC	7	PRILOSEC OTC[4]		
				MC	7	ACIPHEX TBEC[4]		Patients obtaining refills as of 7/10/09 will begin to require prior authorizations if they have been on any PPI longer than 60 days in the past year.
				MC/DEL	8	DEXILANT (KAPIDEX)[2]		The 12-month period is patient specific and begins 12 months before the requested date of prior authorization. Payment for usage beyond these limits will be authorized for cases in which there is a diagnosis of:
				MC/DEL	8	PREVACID CPDR[4,5]	2. Dosing limits apply, please see dosage consolidation list.	
				MC/DEL	8	PREVACID SOLUTABS[1]		1. Barrett's esophagus.
				MC/DEL	8	PRILOSEC CPDR	3. Please use multiple 20mg Capsules to obtain required dose.	2. Erosive esophagitis
					8	PROTONIX INJ		3. Hypersecretory conditions (Zollinger-Ellison syndrome, systemic mastocytosis, multiple endocrine adenomas). Recurrent peptic ulcer disease after documentation of previous trials and therapy failure with at least one histamine H2-receptor antagonist at full therapeutic doses and with documentation of either failure of Helicobacter pylori treatment or anegative Helicobacter pylori test result.
				MC/DEL				
				MC/DEL	8	PROTONIX[2]		
				MC/DEL	8	OMEPRAZOLE 10MG[2]		4. Symptomatic gastroesophageal reflux after documentation of previous trials and therapy failure with at least onehistamine H2-receptor antagonist at full therapeutic doses. Patients may be required to step down from a PPI to a histamine H2-receptor antagonist during the 12 months or on an annual clinical review if PPI therapy is continued.
				MC	8	OMEPRAZOLE-SODIUM BICARBONATE CAPS	4. All preferreds and step therapy must be tried and failed.	**DDI:** Omeprazole will require prior authorization if being used in combination with Plavix.
				MC/DEL	8	LANSOPRAZOLE		**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.
				MC	9	OMEPRAZOLE 40MG[3]	5. Established users prior to 10/1/09 may continue to obtain Prevacid until 12/31/09.	**DDI:** All non-preferred PPIs require prior authorization, but with any prior authorization request, the member's drug profile will also be monitored for current use with ampicillin, B-12, Fe salts, griseofulvin, itraconazole, ketoconazole, Reyataz or Vantin due to a significant drug-drug interaction.
							Use PA Form# 20720	
GI - ULCER ANTI-INFECTIVE				MC		HELIDAC	Use PA Form# 20420	
				MC		PREVPAC		
				MC		PYLERA		
GI - PROSTAGLANDINS	MC		MISOPROSTOL TABS	MC/DEL		CYTOTEC TABS	Use PA Form# 20420	Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drug will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
GI - DIGESTIVE ENZYMES	MC/DEL		CREON[1]	MC/DEL		LACTRASE CAPS	Use PA Form# 20420	Non -Preferred drugs must be tried and failed in step-order due to lack of efficacy or intolerable side effects before other non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		LACTASE CHEW	MC		PANCREAZE	1. Clinical PA is required to establish CF diagnosis and medical necessity. In all cases except cystic fibrosis patients, objective evidence	
	MC/DEL		LACTASE TAB	MC/DEL		PERTZYE		
	MC		ZENPEP[1]	MC/DEL		ULTRESA		
				MC/DEL		VIOKACE		

							of pancreatic insufficiency (fat malabsorption test etc...) must be supplied.	
GI - ANTI - FLATULENTS / GI STIMULANTS	MC MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL		CALULOSE SYRP CONSTULOSE SYRP ENULOSE SYRP[1] GASTROCROM CONC GENERLAC SYRP[1] LACTULOSE SYRP[1] METOCLOPRAMIDE HCL SIMETHICONE	MC/DEL MC MC/DEL MC/DEL		AMITIZA[2] CEPHULAC SYRP INFANTS GAS RELIEF SUSP REGLAN TABS	1. Diag codes no longer necessary for preferred products. Lactulose has 60cc/day QL Use PA Form# 20420 2. Prior failed trials of multiple other preferred GI agents must occur first, Such as OTC senna, docusate, lactulose, polyethylene glycol.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **As listed in MaineCare Policy, certain drugs require specific diagnoses for approval.**
GI - INFLAMMATORY BOWEL AGENTS	MC MC MC/DEL MC MC MC MC MC/DEL MC/DEL MC/DEL		APRISO AZULFIDINE TABS BALSALAZIDE CANASA SUPP COLAZAL CAPS DIPENTUM CAPS PENTASA CPCR 250MG ROWASA ENEM **SULFAZINE EC TBEC** **SULFASALAZINE TABS**	MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL MC MC MC		ASACOL 800MG HD AZULFIDINE EN-TABS TBEC DELZICOL GIAZO LIALDA TABS[1] PENTASA 500MG[2] SFROWASA UCERIS RECTAL FOAM[3] UCERIS TABS[3]	Use PA Form# 20420 1. Current users grandfathered. 2. Use multiple Pentasa 250mg. 3. Diagnosis required	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. 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
GI - IRRITABLE BOWEL SYNDROME AGENTS				MC/DEL		LOTRONEX TABS	Use PA Form# 20420	Lotronex will be approved for females with IBS and predominant diarrhea. Prior failed trials of multiple preferred GI agents must occur first. IBS dx must be thoroughly documented.
GI- SHORT BOWL SYNDROME				MC		GATTEX		Gattex requires a diagnosis of adult SBS who are dependent on parenteral support. Appropriate colonoscopy and lab assessments 6months prior to starting
MISCELLANEOUS GI								
GI - MISC.	MC/DEL MC/DEL MC MC MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL MC MC/DEL MC MC MC/DEL MC MC MC/DEL MC/DEL		BISAC-EVAC SUPP BISACODYL BISCOLAX SUPP CINOBAC CAPS CITRATE OF MAGNESIA SOLN CITRUCEL DIOCTO SYRP DOCUSATE CALCIUM CAPS DOCUSATE SODIUM FIBER LAXATIVE TABS FLEET GENFIBER POWD GLYCERIN HIPREX TABS KRISTALOSE PACK MAALOX METAMUCIL MILK OF MAGNESIA SUSP MINERAL OIL OIL NULYTELY SOLR SENNA SENOKOT GRAN	MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL MC MC MC MC/DEL MC/DEL MC/DEL MC MC/DEL MC MC/DEL MC MC MC MC/DEL MC MC		ACTIGALL CAPS BENEFIBER CARAFATE CLEARLAX POW COLACE CAPS COLYTE DIOCTO-C SYRP DOC SOD /CAS CAP DOC-Q-LAX CAPS DOCUSATE SODIUM/CAS CAPS DOK PLUS DULCOLAX SUPP FIBER CON TABS FIBER-LAX TABS GOLYTELY SOLR LINZESS MALTSUPEX MIRALAX PACK (OTC versions) MIRALAX POWD (OTC versions) MOVANTIK[3] PEG 3350 POWDER[2] PEG-ELECTROLYTES SOLR	1. Must show evidence of trials of preferred agents that do not require PA, such as OTC senna, docusate, mineral oil and prescription lactulose. 2. Quantity Limit: 255 g/90-day without PA for greater than 18 years old. If under 18 years of age, allowed 17gms daily without PA. 3.Multiple preferred agents and dietary changes are required. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **As listed in MaineCare Policy, certain drugs require specific diagnoses for approval.** Preferred products that used to require diag codes still require diag codes unless indicated otherwise. **Linzess** is non-preferred and is for adults as treatment of IBS-Constipation AND treatment of chronic idiopathic constipation in adults. Prior trials of preferred agents for constipation and IBS-constipation.

	MC/DEL		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	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		CYTRA-K SOLN	MC/DEL		CYTRA-2 SOLN		
	MC		FURADANTIN SUSP	MC/DEL		ELMIRON CAPS[1]		
	MC		K-PHOS MF TABS	MC/DEL		MACROBID CAPS		
	MC/DEL		METHENAMINE MANDELATE TABS	MC/DEL		MACRODANTIN CAPS		
	MC/DEL		MONUROL PACK	MC/DEL		NITROFURANTOIN MACR SUSP		
	MC/DEL		NEOSPORIN GU IRRIGANT SOLN	MC		POTASSIUM CITRATE/CITRIC SOLN		
	MC/DEL		NITROFURANTOIN MONO CAPS	MC/DEL		PYRIDIUM PLUS TABS		
	MC/DEL		PHENAZOPYRIDINE HCL TABS	MC		PYRIDIUM TABS		
	MC/DEL		PHENAZOPYRIDINE PLUS	MC/DEL		RENACIDIN SOLN		
	MC/DEL		PROSED/DS TABS					
	MC		TRICITRATES SYRP					
	MC/DEL		URELIEF PLUS					
	MC		UREX TABS					
	MC/DEL		URISED TABS					
	MC		UROCIT-K					
	MC/DEL		UROQID #2 TABS					
PHOSPHATE BINDERS								
PHOSPHATE BINDERS	MC/DEL		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	Preferred drugs must be tried and failed in step-order due to lack of efficacy or intolerable side effects before less preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		METROGEL VAGINAL GEL[2]	MC/DEL		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	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **DDI:** Miconazole will require prior authorization if being used in combination with Warfarin.
	MC/DEL		GYNE-LOTRIMIN CREA	MC		GYNAZOLE-1 CREA		
	MC		MICONAZOLE CREA	MC		GYNE-LOTRIMIN 3 TABS		
	MC/DEL		MICONAZOLE 3 COMBO PACK KIT[1]	MC/DEL		MICONAZOLE 3 SUPP		
	MC/DEL		MICONAZOLE 7 CREA	MC		TERAZOL 3 CREA		
	MC/DEL		MICONAZOLE NITRATE CREA	MC		TERAZOL 7 CREA		
	MC		NYSTATIN TABS	MC/DEL		TERCONAZOLE 0.8MG		
	MC/DEL		TERCONAZOLE 0.4MG	MC/DEL		TERCONAZOLE SUPP		

	MC		VAGITROL					
	MC		V-R MICONAZOLE-7 CREA					
VAGINAL - CONTRACEPTIVES							Use PA Form# 20420	Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drug will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
VAGINAL - ESTROGENS	MC/DEL		**ESTRING RING**	MC/DEL		ESTRACE CREA[1]	1. Must fail all preferred products before non-preferred. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**PREMARIN CREA**	MC/DEL		VAGIFEM TABS[1]		
VAGINAL - OTHER	MC/DEL		ACID JELLY GEL	MC		AMINO ACID CERVICAL CREA	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		ACI-JEL GEL					
	MC		CERVICAL AMINO ACID CREA					
BPH								
BPH	MC/DEL		**DOXAZOSIN MESYLATE TABS**	MC/DEL	5	**FLOMAX CP24**	1. There will be dosing limits of 1 tab per day with out PA. 2. Prior use of preferred agent prior to any approvals. 3. Use of preferred (tamsulosin and finasteride) and (tamsulosin and non-preferred Avodart). 4. Non-preferred products must be used in specified order. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs (in step-order) will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Approval of a non-preferred 5-alpha reductase inhibitor requires objective clinical evidence of a very enlarged prostate rather than just the presence of obstructive urinary outflow symptoms along with adequate trial of preferred Proscar.
	MC/DEL		FINASTERIDE[1]	MC/DEL	8	ALFUZOSIN		
	MC/DEL		TERAZOSIN HCL CAPS	MC/DEL	8	AVODART[2,4]		
	MC/DEL		**TAMSULOSIN HCL**	MC/DEL	8	**CARDURA TABS[4]**		
				MC/DEL	8	JALYN[3,4]		
				MC/DEL	8	PROSCAR TABS[4]		
				MC/DEL	8	RAPAFLO[4]		
				MC/DEL	8	UROXATRAL[4]		
ANXIOLYTICS								
ANXIOLYTICS - BENZODIAZEPINES	MC/DEL		ALPRAZOLAM TABS	MC/DEL	8	ALPRAZOLAM ER	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		CHLORDIAZEPOXIDE HCL CAPS	MC/DEL	8	ATIVAN		
	MC/DEL		CLORAZEPATE DIPOTASSIUM TABS	MC/DEL	8	NIRAVAM		
	MC/DEL		DIAZEPAM	MC/DEL	8	SERAX		
	MC/DEL		LORAZEPAM	MC/DEL	8	TRANXENE		
	MC/DEL		OXAZEPAM CAPS	MC/DEL	8	XANAX TABS		
				MC/DEL	9	XANAX XR		
ANXIOLYTICS - MISC.	MC/DEL		BUSPIRONE HCL TABS	MC		BUSPAR TABS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		HYDROXYZINE HCL SOLN	MC		DROPERIDOL SOLN		
	MC		HYDROXYZINE HCL SYRP	MC/DEL		HYDROXYZINE HCL TABS		
	MC/DEL		HYDROXYZINE PAMOATE CAPS	MC/DEL		HYDROXYZINE PAMOATE 100MG CAPS		
	MC/DEL		MEPROBAMATE TABS	MC/DEL		VISTARIL		
ANTI-DEPRESSANTS								
ANTIDEPRESSANTS - MAO INHIBITORS	MC/DEL		NARDIL TABS	MC/DEL		**TRANYLCYPROMIINE**	Use PA Form# 20420	
	MC/DEL		PARNATE TABS					
ANTIDEPRESSANTS - MAO INHIBITORS TOPICAL				MC/DEL		EMSAM[1]	1. Dosing limits apply, please refer to Dose consolidation list. Use PA Form# 20420	Preferred drugs (including a preferred SSRI, a non-SSRI, and Venlafaxine ER) must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANTIDEPRESSANTS - SELECTED SSRI's	MC/DEL		BUPROPION HCL TABS	MC/DEL	8	APLENZIN[7]	1. Use Fluoxetine 20 mg in multiples. 2. See Zoloft splitting table. Sertraline requires splitting of scored tabs to avoid PA.	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.
	MC/DEL		BUPROPION SR	MC/DEL	8	BRINTELLIX[13]		
	MC/DEL		BUPROPION XL	MC/DEL	8	CELEXA[4]		
	MC/DEL		CITALOPRAM[4]	MC	8	CYMBALTA[5]		
	MC/DEL		DULOXETINE	MC/DEL	8	EFFEXOR TABS		
	MC/DEL		ESCITALOPRAM[4]	MC/DEL	8	EFFEXOR XR CP24 [3, 10]		
	MC/DEL		FLUOXETINE HCL CAPS	MC/DEL	8	FETZIMA[12]		

	MC/DEL		FLUOXETINE HCL LIQD	MC/DEL	8	FLUOXETINE 40mg AND 60 mg CAPS[1]			**CYMBALTA:** Fibromyalgia diagnosis- prior use and failure of preferred generics (amitriptyline or cyclobenzaprine) and gabapentin prior to approval.
	MC/DEL		FLUVOXAMINE MALEATE TABS	MC/DEL	8	FLUOXETINE 10mg AND 20mg TABS[6]			**SAVELLA:** Fibromyalgia diagnosis and trial of a preferred generic amitriptyline, cyclobenzaprine and gabapentin prior to approval.
	MC/DEL		MIRTAZAPINE	MC	8	FORFIVO XL			Exceptions to the rule are as follows:
	MC/DEL		NEFAZODONE	MC/DEL	8	IRENKA			
	MC/DEL		PAROXETINE[3]	MC/DEL	8	KHEDEZLA[14]			
	MC/DEL		SERTRALINE HCL[2]	MC/DEL	8	LEXAPRO TABS[4]	3. Strong caution with pediatric population.		1. If the member (<18) is already an established user for any of the preferred or non-preferred drugs under the Antidepressant category on the PDL, then they can continue to get that drug.
	MC/DEL		TRAZODONE HCL TABS	MC	8	LUVOX TABS			
	MC/DEL		VENLAFAXINE ER CAPS[9]	MC	8	MAPROTILINE HCL TABS	4. See Celexa/Citalopram and Lexapro splitting tables.		2. If the member (<18) has a prescription for an antidepressant that is on the PREFERRED side of the PDL and has had a 30 day supply of Fluoxetine at least 30 days before the date they are getting it filled, the claim will pay. If they do not have the trial of Fluoxetine in their profile, the claim will reject for PA required.
				MC/DEL	8	MIRTAZAPINE ODT			
				MC	8	OLEPTRO			3. If the member (<18) has a prescription for a medication that is on the NON-PREFERRED side of the PDL regardless of having Fluoxetine in their profile, the prescription will need a PA.
				MC/DEL	8	PAROXETINE CR[3]			
				MC/DEL	8	PAXIL[3]	5. Max daily dose allowed is 60mg, only 1 capsule per day allowed for all strengths. Combination of multiple strengths require PA.		4. Use of a preferred antidepressant for anxiety will require the diagnosis of anxiety on written prescription and submitted during claim submission.
				MC/DEL	8	PAXIL CR[3]			
				MC/DEL	8	PRISTIQ			**DDI:** Fluvoxamine will now be non-preferred and require prior authorization if it is currently being used with glimepiride (Amaryl).
				MC	8	PROZAC			
				MC	8	PROZAC CAPS			**DDI:** Preferred nefazodone will now be non-preferred and require prior authorization if it is currently being used in combination with either Onglyza 5mg, Enablex 15mg or Vesicare 10mg.
				MC	8	PROZAC WEEKLY CPDR	6. Use Fluoxetine 10mg tabs in multiples.		**DDI:** Fluoxetine will require prior authorization if being used in combination with Plavix.
				MC/DEL	8	REMERON TABS			**DDI:** Fluvoxamine will require prior authorization if being used in combination with Plavix.
				MC/DEL	8	SARAFEM CAPS			
				MC/DEL	8	TRAZODONE HCL 300MG TABS	7. Provide clinical documentation as to why a preferred generic alternative cannot be used.		
				MC/DEL	8	WELLBUTRIN TABS			
				MC/DEL	8	WELLBUTRIN SR TBCR			
				MC/DEL	8	WELLBUTRIN XL			
				MC/DEL	8	REMERON SOLTAB TBDP			
				MC/DEL	8	SAVELLA[8]	8. Dosing limits allowing 2 tabs/day and a max daily limit of 200mg / day applies. Please see dose consolidation list.		
				MC/DEL	8	ZOLOFT			
				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.		**SAVELLA: Fibromyalgia diagnosis and trial of a preferred generic amitriptyline, cyclobenzaprine, duloxetine and gabapentin prior to approval.**
				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 MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC MC		**AMITRIPTYLINE HCL TABS**[1] **ANAFRANIL CAPS**[1] **DESIPRAMINE HCL TABS**[1] **DOXEPIN HCL**[1] **IMIPRAMINE HCL TABS**[1] **NORTRIPTYLINE HCL**[1] PROTRIPTYLINE HCL TABS[1] SURMONTIL CAPS[1]	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC MC		**AMOXAPINE TABS** **CLOMIPRAMINE HCL CAPS** **DOXEPIN HCL 150 MG**[2] **NORPRAMIN TABS** **PAMELOR** TOFRANIL VIVACTIL TABS	1. Users over the age of 65 require a pa. 2. Use multiples of 50mg. Use PA Form# 20420 Use PA Form# 10220 for Brand Name requests	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
SEDATIVE / HYPNOTICS								
SEDATIVE/HYPNOTICS - BARBITURATE	MC MC/DEL MC MC/DEL		BUTISOL SODIUM TABS[1] CHLORAL HYDRATE SYRP[1] MEBARAL TABS[1] PHENOBARBITAL[1]	MC MC/DEL		LUMINAL SOLN SOMNOTE CAPS	1. PA required for new users of preferred products if over 65 years. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
SEDATIVE/HYPNOTICS - BENZODIAZEPINES	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		DORAL TABS[1] ESTAZOLAM TABS[1] FLURAZEPAM HCL CAPS[1] TEMAZEPAM CAPS 15 & 30MG[1] TRIAZOLAM TABS[1]	MC MC MC/DEL MC/DEL		HALCION TABS[1] MIDAZOLAM HCL SYRP RESTORIL CAPS[1] TEMAZEPAM 7.5MG[1]	1. Dosing limits apply, please see dosing consolidation list. Use PA Form# 30110	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Benzodiazepines do cause dependence with continued use and usage should be limited to 7-10 days at a time. Chronic intermittent use (2-3 Days per week max) is the standard of care
SEDATIVE/HYPNOTICS - Non-Benzodiazepines	MC/DEL MC MC/DEL MC/DEL	1 1 1 2	MIRTAZAPINE TRAZODONE ZOLPIDEM [2] ZALEPLON [2,3]	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MCDEL MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL	7 7 7 8 8 8 8 8 8 8 8 8	AMBIEN[1] **ESZOPICLONE** **ZOLPIDEM ER** AMBIEN CR[1] BELSOMRA[1] EDLUAR HETLIOZ INTERMEZZO LUNESTA[1] SONATA CAPS[1] ROZEREM ZOLPIMIST	1. Quantity Limt of 12 per 34 days. 2. Quantity limits will be allowed up to 30/30, but intermittent therapy is recommended. 3. Only zolpidem trial/failure will be required to obtain Zaleplon. 4. Must fail all preferred products before non-preferred Use PA Form# 30110	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
ANTI-PSYCHOTICS								
ANTIPSYCHOTICS - ATYPICALS	MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		ABILIFY TABS[3,4] **OLANZAPINE**[4] RISPERIDONE TAB[4] RISPERIDONE SOLN[4] QUETIAPINE[4,6] **ZIPRASIDONE**[4]	MC/DEL MC/DEL MC MC MC/DEL MC MC MC/DEL MC MC MC MC MC MC MC/DEL	8 8 8 8 8 8 8 8 8 8 8 8 8 8 8	ABILIFY DISC TAB, INJ and SOL[2] ABILIFY MAINTENA ARISTADA[7] FANAPT GEODON INVEGA INVEGA SUSTENNA INVEGA TRINZ INJ LATUDA REXULTI RISPERDAL TAB RISPERDAL CONSA [2] RISPERDAL M TAB[2] RISPERDAL SOLN RISPERIDONE ODT	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. Use PA form# 20440 for Multiple Antipsychotic requests Use PA form# 10130 for non-preferred single therapy atypical requests	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. 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**

				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	**• 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
				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	Preferred generic drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred brand will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Patients previously stabilized on brand name drug will be approved. **DDI:** Clozapine will now be non-preferred and require prior authorization if it is currently being used in combination with carbamazepine. Please use Drug-Drug Interaction PA form #10400.
				MC		FAZACLO		
ANTIPSYCHOTICS - TYPICAL	MC/DEL		CHLORPROMAZINE HCL	MC/DEL		COMPAZINE	Use PA Form# 20420 If prescribing 2 or more antipsychotics, PA will be required for both drugs, except if one is Clozapine.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. If prescribing 2 or more antipsychotics, PA will be required for both drugs, except if one is Clozapine.
	MC/DEL		FLUPHENAZINE DECANOATE	MC/DEL		COMPRO SUPP		
	MC/DEL		FLUPHENAZINE HCL	MC		HALDOL DECANOATE		
	MC		HALDOL	MC/DEL		LOXITANE CAPS		
	MC/DEL		HALOPERIDOL	MC		MELLARIL		
	MC		HALOPERIDOL DECANOATE SOLN	MC/DEL		NAVANE CAPS		
	MC		HALOPERIDOL LACTATE SOLN	MC		PROLIXIN		
	MC/DEL		LOXAPINE SUCCINATE CAPS	MC		STELAZINE TABS		
	MC/DEL		LOXITANE-C CONC					
	MC		MOBAN TABS					
	MC/DEL		PERPHENAZINE					
	MC/DEL		PROCHLORPERAZINE					
	MC		SERENTIL					
	MC/DEL		THIORIDAZINE HCL					
	MC/DEL		THIOTHIXENE					
	MC/DEL		TRIFLUOPERAZINE HCL TABS					
LITHIUM								
LITHIUM	MC/DEL		LITHIUM CARBONATE	MC/DEL		ESKALITH CAPS	Use PA Form# 20420	
	MC/DEL		LITHIUM CITRATE SYRP	MC/DEL		ESKALITH CR TBCR		

COMBINATION - PSYCHOTHERAPEUTIC								
PSYCHOTHERPEUTIC COMBINATION	**MC/DEL** **MC/DEL**		CHLORDIAZEPOXIDE/AMITRIPT PERPHENAZINE/AMITRIPTYLIN	**MC**	8	SYMBYAX[1]	1. Only available if component ingredients are unavailable. Use PA Form# 20420	
STIMULANTS								
STIMULANT - AMPHETAMINES -SHORT ACTING	**MC/DEL** **MC/DEL** **MC/DEL**		AMPHETAMINE SALT COMBO[1,4] DEXTROAMPHET SULF TABS[1,3] DEXEDRINE[1,3,4]	**MC/DEL** **MC** **MC**		ADDERALL TABS EVEKEO PROCENTRA	1. Preferred stimulants will be available without PA if diagnosis of ADHD. 2. As per recent FDA alert, Adderal & Dexedrinel should not be used in patients with underlying heart defects since they may be at increased risk for sudden death. 3. Dosing limits apply, please see dosing consolidation list. 4. Max daily dose of 50mg. Use PA Form# 20420	
STIMULANT - LONG ACTING AMPHETAMINES SALT	**MC**		VYVANSE[2,3,4]	**MC** **MC/DEL**	8 9	ADDERALL XR CP24[1,3,4] AMPHETAMINE/DEXTROAMPHET ER	Use PA Form# 20420 1. As per recent FDA alert, Adderall should not be used in patients with underlying heart defects since they may be at increased risk for sudden death. 2. FDA approval is currently for adults and children 6 or older. Will be available without PA for this age group if within dosing limits. Limit of one capsule daily. Max dose of 70MG daily. 3. Preferred stimulants will be available without PA if diagnosis of ADHD. 4. Dosing limits applly, please see dosing consolidation list.	Adderall XR- Current users as of 12/31/11 without prior use of Vyvanse will be required to transition to the preferred vyvanse product. Other members will required PA Quillivant is only indicated for use in patients 6 years of age and older. Prior trials of preferred products
LONG ACTING AMPHETAMINES	**MC**		DEXEDRINE CAP CR[1,2,3]	**MC**		DEXTROAMPHET SULF CPCR[3]	1. Preferred stimulants will be available without PA if diagnosis of ADHD. 2. As per recent FDA alert, Adderall & Dexedrine should not be used in patients with underlying heart defects since they may be at increased risk for sudden death.	

							3. Dosing limits applly, please see dosing consolidation list. Use PA Form# 20420	
STIMULANT - METHYLPHENIDATE	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		DEXMETHYLPHENIDATE IR TABS[1] METADATE ER TBCR[1,2] METHYLIN ER TBCR[1,2] METHYLIN TABS[1,2] METHYLIN SOL[1] METHYLPHENIDATE HCL[1,2]	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, please see dosing consolidation list. Maximum daily doses are as follows: 72mg daily for methylphenidate and 36mg daily for dexmethylphenidate.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Please refer to General Criteria category E.
STIMULANT - METHYLPHENIDATE - LONG ACTING	MC/DEL MC/DEL MC/DEL MC/DEL		DAYTRANA[1,3] FOCALIN XR[1] METHYLPHENIDATE ER TABS RITALIN LA[4]	MC MC MC MC/DEL MC	5 8 8 8 8	METADATE CD CPCR APTENSIO CONCERTA TBCR[2] METHYLPHENIDATE ER CAPS[1,2,4] QUILLIVANT XR	1. Preferred stimulants will be available without PA if diagnosis of ADHD. 2. Non-preferred products must be used in specified step order. 3.FDA approval currently only for ages 6-16. Limit of one patch daily. Max dose of 30MG daily. 4.Dosing limits applly, please see dosing consolidation list. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
STIMULANT - STIMULANT LIKE	MC/DEL MC		**GUANFACINE ER** KAPVAY	MC/DEL MC MC MC/DEL MC/DEL MC/DEL MC MC	7 7 8 8 8 9 9 9	PROVIGIL TABS[3] STRATTERA[1,2] CAFCIT SOLN[3] INTUNIV MODAFINIL TABS NUVIGIL[3] DESOXYN TABS[3] DESOXYN CR[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. 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.	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

							Use PA Form# 20710 for Provigil, Nuvigil and Xyrem Use PA Form# 20420 for all others	
ANTI-CATAPLECTIC AGENTS								
PSYCHOTHERAPEUTIC AGENTS - MISC.				MC		NUEDEXTA	Use PA Form# 20710 for Xyrem	FDA reminded healthcare professionals and patients that the combined use of Xyrem (sodium oxybate) with alcohol or central nervous system (CNS) depressant drugs can markedly impair consciousness and may lead to severe breathing problems (respiratory depression
				MC		XYREM SOL[1]	Use PA Form# 20710 for Xenazine	
				MC		XENAZINE	1.See criteria section	
WEIGHT LOSS								
WEIGHT LOSS							No longer covered: PHENTERMINE, XENICAL,DIDREX, and MERIDIA	Weight loss drugs are not covered as permitted by Federal Medicaid regulations and Maine Medicaid (MaineCare) Policy.
ALZHEIMER DISEASE								
ALZHEIMER - Cholinomimetics/Others	MC/DEL		DONEPEZIL HYDROCHLORIDE TABS[1]	MC	6	ARICEPT TABS[2]	1. PA is required to establish dementia diagnosis and baseline mental status score. 2. Must fail all preferred products before moving to non-preferred. Use PA Form# 20420	Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs (in step-order) will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		DONEPEZIL HYDROCHLORIDE ODT[1]	MC	6	ARICEPT ODT[2]		
	MC/DEL		EXELON 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 TAB[1,2]	MC/DEL		NICODERM CQ PT24[1]	Use PA Form# 20420 1. See criteria section for exemptions 2. The Starter/Titration packs are non-preferred. Please use the tablets.	As of July 1, 2014 per MaineCare policy, smoking cessation products will be covered without a copay(including MEDEL). No annual or lifetime limits, must follow FDA approved indications and therapy guidelines. Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs (in step-order) will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **Note:** MaineCare policy, smoking cessation product were "not covered" except for during pregnancy between 9/1/12 and 1/1/14, between 1/1/2014 and 7/1/14 smoking cessation products were covered with limitations Patients may qualify for the medication through The Maine Tobacco Helpline. Patients are encouraged to call The Maine Tobacco helpline at 1-800-207-1230.
	MC/DEL		NICOTINE DIS PT24[1]					
NICOTINE REPLACEMENT - OTHER	MC/DEL		NICOTINE POLACRILEX GUM[1]	MC/DEL	8	NICOTROL INHALER[1,2]	Use PA Form# 20420 1. See criteria section for exemptions 2. Must use non-preferred products in specified step order.	As of July 1, 2014 per MaineCare policy, smoking cessation products will be covered without a copay(including MEDEL). No annual or lifetime limits, must follow FDA approved indications and therapy guidelines. Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs (in step-order) will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **Note:** MaineCare policy, smoking cessation product were "not covered" except for during pregnancy between 9/1/12 and 1/1/14, between 1/1/2014 and 7/1/14 smoking cessation products were covered with limitations Patients may qualify for the medication through The Maine Tobacco Helpline. Patients are encouraged to call The Maine Tobacco helpline at 1-800-207-1230.
				MC/DEL	8	NICOTROL NASAL SPRAY[1,2]		
				MC/DEL	8	NICORETTE GUM[1,2]		
				MC	8	NICORETTE LOZENGES		
ALCOHOL DETERRENTS								
ALCOHOL DETERRENTS	MC		ANTABUSE TABS	MC/DEL		**ACAMPRO**[1]	1. Should only be used in conjunction with formal	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
	MC		DISULFIRAM TABS					

	MC/DEL		NALTREXONE HCL TABS				structured outpatient detoxification program. Use PA Form# 20420	and the preferred drug(s) exists.
MISCELLANEOUS ANALGESICS								
ANALGESICS - MISC.	MC/DEL		ACETAMINOPHEN	MC		AXOCET CAPS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**ASPIRIN**	MC/DEL		ESGIC-PLUS		
	MC/DEL		ASPRIN/ APAP/ CAFF TAB	MC/DEL		FIORICET TABS		
	MC/DEL		BUTAL/ASA/CAFF	MC		FIORINAL CAPS		
	MC/DEL		BUTALBITAL COMPOUND	MC		FIORTAL CAPS		
	MC/DEL		BUTALBITAL/ACET TABS	MC/DEL		FORTABS TABS		
	MC/DEL		BUTALBITAL/APAP CAPS	MC		PHRENILIN TABS		
	MC/DEL		BUTALBITAL/APAP/CAFFEINE	MC		PHRENILIN FORTE CAPS		
	MC/DEL		**CHOLINE MAGNESIUM TRISALI**	MC		TRILISATE LIQD		
	MC/DEL		**DIFLUNISAL TABS**	MC		TRILISATE TABS		
	MC		EXCEDRIN	MC		ZEBUTAL CAPS		
	MC/DEL		**SALSALATE TABS**	MC		ZORPRIN TBCR		
LONG ACTING NARCOTICS								
NARCOTICS - LONG ACTING	MC/DEL		EMBEDA	MC	8	AVINZA	Use PA Form# 20510	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
	MC/DEL		FENTANYL PATCH[4]	MC	8	BELBUCA	Use PA form #10300 for PAs over the opiate limit 1. Oxycontin will be available without PA for patients treated for or dying from cancer or hospice patients. CA (cancer) or HO (hospice) diag code may be used but store must verify since all scripts will be audited and stores will be liable. 2. Established users are grandfathered. 3. Oxycodone ER allowed only 2 per day for all strengths except 80 mg, where 4 are allowed to 4. Dosing limits apply. Please see dose consolidation list. 5. Non-preferred products must be used in specific order.	
	MC		KADIAN	MC	8	DURAGESIC PT72[4]		
	MC/DEL		METHADONE	MC	8	EXALGO		
	MC/DEL		METHADOSE	MC/DEL	8	HYSINGLA ER		
	MC/DEL		MORPHINE SULFATE ER TB12	MC/DEL	8	MORPHINE SULFATE SUPP		
	MC/DEL		BUTRANS[4]	MC/DEL	8	MS CONTIN TB12		
				MC	8	OPANA ER		
				MC/DEL	8	ORAMORPH SR TB12		
				MC/DEL	8	OXYCONTIN TB12[1]		
				MC	8	XARTEMIS ER		
				MC	8	ZOHYDRO ER		
				MC/DEL	9	NUCYNTA ER		
				MC/DEL	9	OXYCODONE ER[3,5]		
NARCOTICS - SELECTED	MC/DEL		TRAMADOL HCL TABS	MC/DEL	7	RYZOLT	Use PA Form# 20420 Use PA form #10300 for PAs over the opiate limit 1. Only available if	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
				MC	8	BUPRENEX SOLN		
				MC/DEL	8	BUTORPHANOL		
				MC	8	NALBUPHINE HCL SOLN		

				MC	8	STADOL NS SOLN	component ingredients are unavailable.	desired product. Allergic reactions to any product within a specific narcotic class will justify and preclude use of any other product in the same class due to the risk of cross-hypersensitivity.
				MC	8	TRAMADOL ER		
				MC	8	ULTRACET TABS[1]		
				MC	8	ULTRAM TABS		
				MC	9	ULTRAM ER		
								Non-preferred drugs will not be approved for patients showing evidence of usage patterns consistent with controlled substance abouse such as: 1.frequent or persistant early refills of controlled drugs; 2.multiple instances of early refill overrides due to reports of misplacement, stolen, dropped in toilet or sink, distant travel; 3.breaches of narcotic contracts with any provider; 4.failure to comply with patient responsibilities in attached opiod documentaion (see PA form) including but not limited to failing to submit to and pass pill counts; 5.failing to take or pass random drug testing; 6.failing to provide old recoreds regarding prior use of narcotics; 7.receiving controlled substances from other prescribers that the provider submitting the PA is unaware of. in Substance abuse evaluations may be required for patients with medical records displaying potential signs of narcotic misuse and abuse such as chronic early refills, short dosing intervals, frequent dose increases, multiple lost/stolen etc scripts and intolerance or "allergy" to all products but Oxycontin. Allergic reactions to any product within a specific narcotic class will justify and preclude use of any other product in the same class due to the risk of cross-hypersensitivity. **Effective 1/01/2013, MaineCare will implement a 15 day limit for members prescribed opiates for their treatment of pain.** 1. MaineCare members will be allowed over a rolling 12 month period up to a 15 day supply of an opiate without prior authorization 2. Members requiring longer than 15 days will require a PA for continuation of therapy and providers may provide medical necessity 3. Members may be eligible for up to three prior authorizations of up to 14 day supplies of opiates during the 12 month period 4. MaineCare members that are in Hospice care or are being treated for a diagnosis of Cancer, HIV or AIDS will be exempt from these limits 5. Post surgical members may receive prior authorizations for opiates up to 60 days in length if medical necessity is provided by the Surgeon **Please see the Pain Management Policy_Sec. 80 tab for the complete criteria**
MISCELLANEOUS NARCOTICS								
NARCOTICS - MISC.	MC/DEL		ACETAMINOPHEN/CODEINE	MC/DEL	8	ABSTRAL	1. Fentanyl OT loz (Barr) and Capital and codeine suspension products require PA for users over 18 years of age. PA is not required if under 18 years of age. 2. Oxycodone/acet 10/650 is 8 times more expensive. Use twice as many of oxycod/acet 5/325 instead. You can mix andmatch preferred strengths of oxycodone and oxycodone/acet to minimize acet. dose similar to certain non-preferred drugs. 3. Only preferred	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Please refer to General Criteria category E. **Effective 1/01/2013, MaineCare will implement a 15 day limit for members prescribed opiates for their treatment of pain.** 1. MaineCare members will be allowed over a rolling 12 month period up to a 15 day supply of an opiate without prior authorization 2. Members requiring longer than 15 days will require a PA for continuation of therapy and providers may provide medical necessity 3. Members may be eligible for up to three prior authorizations of up to 14 day supplies of opiates during the 12 month period 4. MaineCare members that are in Hospice care or are being treated for a diagnosis of Cancer, HIV or AIDS will be exempt from these limits 5. Post surgical members may receive prior authorizations for opiates up to 60 days in length if medical necessity is provided by the Surgeon **Please see the Pain Management Policy_Sec. 80 for the complete criteria**
	MC/DEL		ASPIRIN/CODEINE TABS	MC/DEL	8	ASCOMP/CODEINE CAPS		
	MC/DEL		BUTAL/ASA/CAFF/COD CAPS	MC/DEL	8	BUTALBITAL/APAP/CAFFEINE/ CAPS		
	MC		BUTALBITAL/ASPIRIN/CAFFEI CAPS	MC	8	DEMEROL		
	MC		CAPITAL AND CODEINE SUSP[1]	MC/DEL	8	DILAUDID		
	MC		CAPITAL/CODEINE SUSP[1]	MC	8	DILAUDID-HP SOLN		
	MC/DEL		CODEINE PHOSPHATE SOLN	MC	8	FENTANYL CITRATE SOLN		
	MC/DEL		CODEINE SULFATE TABS	MC/DEL	8	FENTORA		
	MC/DEL		ENDOCET TABS[3]	MC/DEL	8	FIORICET/CODEINE CAPS		
	MC/DEL		ENDODAN TABS	MC	8	FIORINAL/CODEINE #3 CAPS		
	MC/DEL		FENTANYL OT LOZ[1]	MC	8	FIORTAL/CODEINE CAPS		
	MC/DEL		FENTANYL OT LOZ1	MC/DEL	8	HYDROCODONE/IBUPROFEN		
	MC/DEL		HYDROCODONE/ACETAMINOPHEN	MC	8	IBUDONE		
	MC/DEL		HYDROMORPHONE HCL[3]	MC/DEL	8	LORCET		
	MC		LORTAB ELX	MC	8	LORTAB		
	MC/DEL		MEPERIDINE HCL	MC	8	MAXIDONE TABS		
	MC/DEL		OXYCODONE	MC/DEL	8	NORCO TABS		
	MC/DEL		OXYCODONE/ACETAMINOPHEN[2,3]	MC/DEL	8	NUCYNTA		
	MC/DEL		PENTAZOCINE/NALOXONE TABS	MC/DEL	8	ONSOLIS		
	MC		PROPOXYPHENE CMPND-65 CAPS	MC/DEL	8	OXECTA		
	MC		PROPOXYPHENE COMPOUND CAPS	MC/DEL	8	OXYCODONE/APAP 10/650		
	MC/DEL		PROPOXYPHENE HCL CAPS	MC/DEL	8	OXYCODONE/APAP 7.5/500		
	MC/DEL		PROPOXYPHENE/ACET TABS	MC/DEL	8	PENTAZOCINE/ACET TABS		
	MC/DEL		PROPOXYPHENE-N/ACET TABS	MC	8	PERCOCET TABS		
	MC/DEL		ROXICET	MC	8	PERCOCET TABS		

	MC		ROXIPRIN TABS	MC	8	PHRENILIN W/CAFFEINE/CODE CAPS	manufacturer's products will be available without prior authorization.	
				MC/DEL	8	ROXICET 5/500 TABS		
				MC	8	ROXICODONE TABS		
				MC	8	SYNALGOS-DC CAPS		
				MC	8	TALACEN TABS		
				MC	8	TREZIX		
				MC	8	TYLENOL/CODEINE #3 TABS		
				MC	8	TYLOX CAPS		
				MC	8	XOLOX		
				MC	8	VICODIN		
				MC	8	VICOPROFEN TABS		
				MC	8	ZYDONE TABS		
				MC	9	ACTIQ LPOP		
				MC	9	CONZIP	Use PA Form# 20420	
				MC	9	OPANA	Use PA form #10300 for PAs over the opiate limit	
OPIOID DEPENDENCE TREATMENTS	MC		SUBOXONE FILM[2]	MC		SUBOXONE TABS[3]	Use PA Form# 10200 for Suboxone Continuation Use PA Form# 10100 for Suboxone Restart	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
				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	Suboxone Criteria
							3. The manufacturer will be disconntinuing the tablets by the end of quarter one 2013.	1. Effective 1/1/2013, MaineCare will implement a 24 month lifetime limit for members prescribed Suboxone for the treatment of opioid addiction.
								2. Prior authorization request will be reviewed for dose titration downward,whether the patient is engaged in recovery oriented support services,periodic urine drug screens, flim counts,factors that threaten stability of recovery or evidence of improvement is social,physical and occupational areas.
								3. Members that stop treatment after 24 months and need to restart will require a prior authorization. This prior authorization will assess the patient risk of relapsing or evidence that the patient has relapsed.
							4. 24month lifetime limit for treatment of opioid addiction	Members will continue to be required to follow the criteria listed below:
								1-Induction period for new starts max of 60 days
								2-Max dose of 32 mg for induction
								3-Max dose of 16 mg for maintenance
								4-There is not more than one narcotic fill in member's drug profile between today's fill of suboxone and a prior suboxone fill within the past 90 days.
								5- Prescribers limited to those with X-DEA
								6- Should be evidence provided of monthly monitoring including random pill counts urine drug tests and prescription monitoring program reports.
								7-Suboxone tablets will be available upon demonstrated allergy to the preferred product. Allergy may be established by 1) formal allergy testing by a board certified allergist or 2) demonstration of hives after skin exposure for 24 hours to the Suboxone Film. (The product may be applied to the skin using a band-aid and member can be assessed after 24 hours to ascertain the presence of hives by the prescriber).
NARCOTIC ANTAGONISTS								

NARCOTIC - ANTAGONISTS	**MC/DEL**		NALTREXONE HCL TABS	**MC**		EVZIO	Use PA Form# 20420 Use PA form# 30400 for Vivitrol requests	Please see the criteria listed on the Vivitrrol PA form.
				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		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. 2. Ketorolac Tromethamine is indicated for the short term (up to 5 days) managment of moderately severe acute pain that requires analgesic at the opiod level in adults. Not indicated for minor of chronic pain conditions. 3. Ketorolac has dosing limits allowing 24 tablets for a 5 day supply every 30 days. 4. Dosing limits will be set at a maximum of 200mg twice daily for PA requests. 5. Users 60 years of age or older will not require PA. If under 60 years of age, Celebrex will require PA. 6. The FDA has issued a Public Health Advisory warning of the potential for increased cardiovascular risk & GI bleeding with NSAID use.	Approved without PA for patients 60 years old or over. Patients under 60 can use a preferred proton pump inhibitor with any preferred generic NSAID to achieve similar reductions in GI bleeding risk to that seen with the COX-II agents. Approvals for Celebrex will be granted for other requests based on failure of at least one generic NSAID from at least 2 different NSAID classes as described in the COX-II PA form. High risk GI bleeding patients must fail on adequate trials of safer agents (non-NSAID/Cox-2) for GI tract, such as acetaminophen.
	MC/DEL		KETOROLAC TROMETHAMINE [2,3,6]	**MC/DEL**		MOBIC SUSP[6]		
	MC/DEL		NABUMETONE TABS[6]	**MC/DEL**		**RELAFEN TABS[6]**		
	MC/DEL		MELOXICAM[1,6]	**MC/DEL**		**VIVLODEX**		
NSAIDS	**MC/DEL**		**CHILDRENS IBUPROFEN**	**MC**		ADVIL TABS	The FDA has issued a Public Health Advisory warning of the potential for increased cardiovascular risk & GI bleeding with NSAID use.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Approvals will be granted for other requests based on failure of at least one generic NSAID from at least 3 different NSAID classes as described in the COX-II PA form.
	MC/DEL		**DICLOFENAC POTASSIUM TABS**	**MC**		ANAPROX TABS		
	MC/DEL		**DICLOFENAC SODIUM**	**MC**		ANAPROX DS TABS		
	MC/DEL		**ETODOLAC**	**MC**		CAMBIA		
	MC/DEL		**FENOPROFEN CALCIUM TABS**	**MC/DEL**		**CATAFLAM TABS**		

	MC/DEL		**FLURBIPROFEN TABS**	MC		CHILDRENS ADVIL SUSP		
	MC/DEL		**IBUPROFEN**	MC		CHILD'S IBUPROFEN SUSP		
	MC/DEL		**INDOMETHACIN**	MC/DEL		CHILDREN'S MOTRIN SUSP	Use PA Form# 20420	
	MC/DEL		**KETOPROFEN**	MC/DEL		**CLINORIL TABS**		
	MC/DEL		**MECLOFENAMATE SODIUM CAPS**	MC/DEL		**DAYPRO TABS**		
	MC/DEL		NAPROSYN SUSP	MC/DEL		**EC-NAPROSYN TBEC**		**DDI:** Diclofenac will now be non-preferred and require prior authorization if it is currently being used in combination with lescol.
	MC/DEL		NAPROXEN SUSP	MC/DEL		**ETODOLAC ER 600MG**		
	MC/DEL		**NAPROXEN TABS**	MC		FELDENE CAPS		The FDA has issued a Public Health Advisory warning of the potential for increased cardiovascular risk & GI bleeding with NSAID use.
	MC/DEL		**NAPROXEN SODIUM TABS**	MC/DEL		IBU-200		
	MC/DEL		**OXAPROZIN TABS**	MC		INDOCIN		
	MC/DEL		**SULINDAC TABS**	MC/DEL		**LODINE**		
	MC/DEL		**TOLMETIN SODIUM**	MC/DEL		**MOTRIN**		
				MC		NALFON CAPS		
				MC/DEL		NAPRELAN TBCR		
				MC/DEL		NAPROSYN TABS		
				MC/DEL		**NAPROXEN DR TBEC**		
				MC/DEL		**NAPROXEN SODIUM TBCR**		
				MC		PENNSAID		
				MC/DEL		**PIROXICAM CAPS**		
				MC		PONSTEL CAPS		
				MC		SB IBUPROFEN TABS		
				MC		SPRIX		
				MC		TOLECTIN		
				MC/DEL		VOLTAREN		
				MC		V-R IBUPROFEN TABS		
				MC		ZORVOLEX		
NSAID - PPI				MC		PREVACID NAPRA-PAC	1. Use a preferred NSAID and PPI separately.	
				MC/DEL		VIMOVO[1]	Use PA Form# 20420	
RHEUMATOID ARTHRITIS								
RHEUMATOID ARTHRITIS	MC/DEL	1	**AZATHIOPRINE**	MC/DEL		**ARAVA**	Use PA Form# 20900	See criteria as listed on Rheumatoid Arthritis PA form.
	MC/DEL	1	**HYDROXYCHLOROQUINE**	MC/DEL		ACTEMRA	1. Only one step 1 drug is required to obtain Enbrel or Humira without PA.	
	MC/DEL	1	LEFLUNOMIDE	MC/DEL		CIMZIA		Enbrel is preferred after a trial of a step 1 product (e.g. azathioprine, methotrexate, etc.); however, dosing limits will also still apply. Dosing limits will allow 8 injections per month without pa. Use of greater than 8 injections per month will require PA.
	MC/DEL	1	METHOTREXATE	MC/DEL		ENTYVIO		
	MC/DEL	1	**SULFASALAZINE TABS**	MC/DEL		**ILARIS**[2,5,6]		
	MC	2	**ENBREL**[1,4]	MC		**KINERET SOLN**	2. Dosing limits apply. Please see dose consolidation list.	
	MC	2	**HUMIRA**[1,2,4]	MC		ORENCIA		
				MC		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.	**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.
							4. Established users will be grandfathered for Enbrel and Humira.	
				MC		SIMPONI		
				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 MC		RIDAURA CAPS MYOCHRYSINE SOLN	MC/DEL		**ARTHROTEC**[1]	1. The individual components of Arthrotec are available without PA. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. The individual components of Arthrotec are available without PA.
LUPUS-SLE								
LUPUS-SLE				MC		BENLYSTA	Use PA Form# 20420	
MIGRAINE THERAPIES								
MIGRAINE - ERGOTAMINE DERIVATIVES	MC MC		MIGRANAL SOLN SANSERT TABS	MC/DEL		D.H.E. 45 SOLN	Use PA Form# 10110	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
MIGRAINE - CARBOXYLIC ACID DERIVATIVES	MC		DIVALPROEX ER TB24	MC		DEPAKOTE ER TB24	Use PA Form# 10110	
MIGRAINE - SELECTIVE SEROTONIN AGONISTS (5HT)--Tabs	MC/DEL MC/DEL MC/DEL MC/DEL	1 1 1 2	RELPAX[1] **RIZATRIPTAN TABS** SUMATRIPTAN TABS[1] NARATRIPTAN HCl TABS[1]	MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		AMERGE TABS[1,2] AXERT TABS[1,2] FROVA TABS[1,2] IMITREX TABS[1,2] MAXALT[1,2,3] MAXALT MLT1,2,3 **RIZATRIPTAN ODT** ZOMIG TABS[1,2] ZOMIG NASAL SPARY[1,2] ZOMIG ZMT TBDP[1,2]	1. All drugs in this category have dosing limits. Please refer to dose consolidation table. 2. Must fail all preferred products before non-preferred. 3.Established users will be grandfathered Use PA Form# 10110	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Quantity limit exceptions will require ongoing therapy with therapeutic doses of highly effective prophylactic medication as listed on the Triptan PA form.
MIGRAINE - SELECTIVE SEROTONIN AGONISTS (5HT)--Injectables	MC/DEL MC/DEL MC/DEL MC/DEL		IMITREX KIT IMITREX SOLN IMITREX STATDOSE PEN KIT IMITREX STATDOSE REFILL KIT	MC/DEL		SUMATRIPTAN SOLN	Use PA Form# 10110	
Migraine-selective serotonin agonists (5HT) 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	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
GOUT								

GOUT	MC/DEL		**ALLOPURINOL TABS**	MC		COLCRYS	Use PA Form# 20420 1. Failure of therapeutic (300mg) dose of Allopurinol (failure define as not being able to get uric acid levels below 6mg/dl) or severe renal disease.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**PROBENECID TABS**	MC/DEL		ULORIC[1]		
	MC/DEL		**PROBENECID/COLCHICINE TABS**	MC		ZYLOPRIM TABS		
MISC.								
ANESTHETICS - MISC.	MC		BUPIVACAINE HCL SOLN	MC		SENSORCAINE-MPF SOLN	Use PA Form# 30130	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		LIDOCAINE HCL SOLN	MC/DEL		SYNVISC INJ		
	MC		MARCAINE SOLN	MC		XYLOCAINE SOLN		
VACCINES	MC/DEL		GARDASIL VACCINES				Use PA Form# 20420	Under the Maine Immunization Program Gardasil is covered under the Vaccine for Children Program for ages 9-18. Gardasil will be preferred by MaineCare for ages 19-26. Children who are 18 years old or younger are eligible for this vaccine through the Maine Immunization Program. Please contact 1-800-867-4775 or 207-287-3746 for assistance.
ANTI-CONVULSANTS								
ANTICONVULSANTS	MC/DEL		CARBAMAZEPINE	MC	8	APTIOM	Use PA Form# 20420 All non-preferred meds must be used in specified order 1. Quantity limit. 5/month 2. Dosing limits apply, please see dose consolidation list. 3. Dosing limits apply per strength as well as a maximum daily dose of 600mg. Please see dose consolidation list. 4. Adjunctive therapy 17 and older. 5. Current users as of 7/30/10 for seizures will be grandfathered. 6. Product is considered line extension of the original product due to Healthcare Reform (HCR). MaineCare will consider these medications non-preferred and a step 9 because of the impact under the Federal Rebate Program in conjunction with HCR. 7. Max dose 2400mg 8. Clinical PA required for appropriate diagnosis	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
	MC/DEL		CARBATROL CP12	MC	8	BANZEL		
	MC/DEL		CELONTIN CAPS	MC	8	DEPAKENE		
	MC/DEL		CLONAZEPAM TABS	MC	8	DEPAKOTE		
	MC		DEPAKOTE SPRINKLES CPSP	MC	8	DEPAKOTE ER		
	MC/DEL		DIASTAT[1]	MC/DEL	8	DIAZEPAM GEL		
	MC/DEL		DILANTIN	MC/DEL	8	DIVALPROEX SODIUM SPRINKLE CAPS		
	MC/DEL		DIVALPROEX SODIUM	MC/DEL	8	EQUETRO		
	MC/DEL		EPITOL TABS	MC/DEL	8	GABITRIL TABS		
	MC/DEL		ETHOSUXIMIDE SYRP	MC/DEL	8	HORIZANT		
	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**		
	MC/DEL		PHENYTOIN	MC/DEL	8	**LEVETIRACETAM ER TABS**		
	MC/DEL		PRIMIDONE TABS	MC/DEL	8	LYRICA[3]		
	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	MC	8	SABRIL		
	MC/DEL		VALPROIC ACID	MC	8	TOPAMAX		
	MC/DEL		VIMPAT[4]	MC	8	TOPAMAX SPRINKLE CAPS[2]		
	MC/DEL		ZONISAMIDE	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		
				MC/DEL	9	LAMICTAL XR		

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

				MC		CARBIDOPA/LEVODOPA/ENTACA[1]	1.Clinical PA is required to establish diagnosis and medical necessity.	
MUSCLE RELAXANTS								
ALS DRUG	MC/DEL		**RILUZOLE**	MC/DEL		**RILUTEK TABS**	Use PA Form# 20420	
MUSCLE RELAXANTS	MC/DEL		**BACLOFEN TABS**	MC/DEL	6	**SKELAXIN TAB**		At least 4 preferred drugs (including tizanidine) must be tried for at least 2 weeks and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an…… acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Elderly patients, over 65, will require written notice of the increased sedative risks and impaired driving.Prior Authorization will not be given for:1. frequent or persistent early refills of controlled drugs; 2. multiple instances of early refill overrides due to reports of misplacement, stolen, dropped in toilet or sink, distant travel, etc.
	MC/DEL		**CHLORZOXAZONE TABS**	MC/DEL	7	**ORPHENADRINE CITRATE**		
	MC/DEL		**CYCLOBENZAPRINE HCL TABS**	MC/DEL	8	**CARISOPRODOL 350MG TABS**		
	MC		LIORESAL INTRATHECAL KIT	MC/DEL	8	AMRIX		
	MC/DEL		**METHOCARBAMOL TABS**	MC/DEL	8	DANTRIUM CAPS		
	MC/DEL		**TIZANIDINE HCL TABS**	MC	8	LIORESAL TABS		
				MC	8	LORZONE		Non-preferred drugs will not be approved if members circumventing MaineCare prior authorization requirements by paying (prescribers failed to submit prior authorization prior to cash narcotic scripts being filled by member).
				MC/DEL	8	**METAXALONE**		
				MC	8	NORFLEX TBCR		Non-preferred products must be used in specified step order.
				MC	8	ROBAXIN-750 TABS		
				MC	8	VECUROMIUM INJ		
				MC/DEL	8	**ZANAFLEX TABS**		**Lorzone** is non preferred and requires at least 4 preferred drugs (including tizanidine) and step care therapy (orphenadrine), as well as reasons for why chlorzoxazone is not acceptable.
				MC/DEL	9	**CARISOPRODOL 250MG TABS**		
				MC/DEL	9	**SOMA TABS**	Use PA Form# 20420	
MUSCLE RELAXANT - COMBO.				MC/DEL		CARISOPRODOL/ASPIRIN TABS	Use PA Form# 20420	Individual components are available with PA described in the section above.1. frequent or persistent early refills of non-controlled drugs; 2. multiple instances of early refill overrides due to reports of misplacement stolen, dropped in toilet or sink, distant travel, etc.
				MC/DEL		CARISOPRODOL/ASPIRIN/CODE		
				MC		NORGESIC TABS		
				MC/DEL		ORPHENADRINE COMPOUND		
				MC/DEL		ORPHENADRINE/ASA/CAFF		
				MC		ORPHENGESIC		
PARATHYROID HORMONE								
PARATHYOID HORMONE				MC		NATPARA[1]	1. Recommended only for those who cannot be well-controlled on calcium supplements and active forms of vitamin D alone.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
VITAMINS								
VITAMINS	MC/DEL		ASCORBIC ACID TABS	MC		AQUASOL E SOLN	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **As listed in MaineCare Policy, certain drugs require specific diagnoses for approval.**
	MC		BIOTIN	MC		AQUAVIT-E SOLN	**Please refer to OTC list for covered products.**	
	MC		CYANOCOBALAMIN SOLN	MC		DHT SOLN		
	MC		FERIVA CAP	MC		NASCOBAL GEL		
			FERIVAFA CAP				Click here for the OTC List	
	MC							
	MC		FERRALET 90 TAB					
	MC/DEL		FOLIC ACID TABS					
	MC		FUSION PLUS CAP					
	MC		HEMOCYTE PLU CAP					
	MC		INTEGRA CAP					
	MC		INTEGRA PLUS CAP					
	MC		INTEGRA F CAP					**Please refer to OTC list for covered products.**
	MC/DEL		MEPHYTON TABS					**DDI:** B-12 will now be non-preferred and require prior authorization if it is currently being used in combination with either Prevacid, pantoprazole, Prilosec, or any currently non preferred PPI.
	MC/DEL		NIACIN					
	MC		NIACOR TABS					
	MC/DEL		NICOTINIC ACID SR CPCR					Preferred products that used to require diag codes still require diag codes unless indicated otherwise.
	MC		PYRIDOXINE HCL TABS					
	MC/DEL		SLO-NIACIN TBCR					
	MC		TANDEM CAP					
	MC		TANDEM PLUS CAP					

	MC/DEL		THIAMINE HCL SOLN					
	MC/DEL		VITAMIN B-1 TABS					
	MC/DEL		VITAMIN B-12					
	MC		VITAMIN B-6 TABS					
	MC/DEL		VITAMIN C					
	MC/DEL		VITAMIN E CAPS					
	MC/DEL		VITAMIN E/D-ALPHA CAPS					
	MC		VITAMIN K1 SOLN					
	MC		V-R VITAMIN E CAPS					
VITAMIN D's	MC/DEL		**CALCITRIOL CAPS**[1]	MC/DEL		**DRISDOL CAPS**	1. Diagnosis of dialysis (renal failure) required.	Preferred products require dialysis/renal failure diagnosis.
	MC/DEL		**VITAMIN D**	MC		CALCIJEX		Non-preferred products require: Secondary hyperparathyroidism in patients with Chronic Kidney Disease on dialysis., iPTH>400 pg/ml, Phosophorous ,6.5mg/dl, corrected calcium <12.2mg/dl, corrected calcium x phosphorous products <70mg^2/dl^2
	MC		ZEMPLAR TABS	MC/DEL		HECTOROL (ORAL)	Use PA Form# 20420	
				MC/DEL		HECTOROL (PARENTERAL)		
				MC/DEL		**ROCALTROL**		
				MC		ZEMPLAR INJ		
MISC MULTI-VITAMINS								
VITAMINS - MISC.	MC		CENTRUM LIQD	MC		ADEKS	1. Diag codes are no longer required on prenatal vitamins.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. As listed in MaineCare Policy, certain drugs require specific diagnoses for approval.
	MC		CENTRUM TABS	MC/DEL		ADVANCED NATALCARE TABS		
	MC		CENTRUM JR/IRON CHEW	MC		AQUADEKS		
	MC		CENTRUM SILVER TABS	MC		CENTRUM JR/EXTRA C CHEW	**Please refer to OTC list.**	
	MC		CENTRUM-LUTEIN TABS	MC		CENTRUM PERFORMANCE TABS		**Please refer to OTC list.**
	MC		CEROVITE ADVANCED FO TABS	MC		CITRANATAL	Use PA Form# 20420	
	MC/DEL		CHEWABLE MULTIVIT/FL CHEW	MC		DALYVITE LIQD		Preferred products that used to require diag codes still require diag codes unless indicated otherwise.
	MC		COD LIVER OIL CAPS	MC		EMBREX 600 MISC		
	MC		COMPLETE SENIOR TABS	MC		IBERET	Click here for the OTC List	
	MC		DAILY MULTI VIT/IRON	MC		MATERNA TABS		
	MC/DEL		DIALYVITE 1MG	MC		MAXARON		
	MC/DEL		DIALYVITE 800MG	MC		MULTIRET FOLIC -500 TBCR		
	MC		FERRALET 90	MC/DEL		NATAFORT TABS		
	MC/DEL		FULL SPECTRUM B	MC/DEL		NATALCARE CFE 60 TABS[1]		
	MC		M.V.I.-12 INJ	MC/DEL		NATALCARE GLOSS TABS[1]		
	MC		MULTI-VIT/FLUORIDE	MC		NATALCARE PIC TABS[1]		
	MC/DEL		NATALCARE RX TABS	MC		NATALCARE PIC FORTE TABS[1]		
	MC/DEL		NEPHRONEX	MC/DEL		NATALCARE PLUS TABS[1]		
	MC/DEL		O-CAL PRENATAL	MC		NATALCARE THREE TABS[1]		
	MC/DEL		ONE DAILY TABS	MC/DEL		NATACHEW CHEW		
	MC/DEL		ONE-DAILY MULTIVITAMINS	MC		NATALFIRST TABS		
	MC/DEL		ONE-TABLET-DAILY	MC		NATATAB RX TABS		
	MC/DEL		POLY-VIT/IRON/FLUORID SOLN	MC/DEL		NEPHPLEX RX TABS		
	MC/DEL		POLY-VITAMIN/FLUORIDE SOLN	MC/DEL		NEPHROCAPS CAPS		
	MC/DEL		POLY-VITAMINS/IRON SOLN	MC/DEL		NEPHRO-VITE TABS		
	MC/DEL		PRENATAL TABS[1]	MC		NESTABS RX TABS		
	MC/DEL		PRENATAL FORMULA 3 TABS[1]	MC/DEL		NIFEREX		
	MC/DEL		PRENATAL PLUS TABS[1]	MC/DEL		OCUVITE TABS		
	MC/DEL		PRENATAL PLUS NF TABS[1]	MC		POLY-VI-FLOR SOLN		
	MC		PRENATAL PLUS/27MG IRON[1]	MC		POLY-VI-SOL SOLN		
	MC		PRENATAL PLUS/IRON TABS[1]	MC		POLY-VI-SOL/IRON SOLN		
	MC/DEL		PRENATAL RX/BETA-CAROTENE[1]	MC		POLY-VITAMIN DROPS SOLN		
	MC/DEL		RENAL CAPS	MC		PRECARE		
	MC/DEL		RENAPHRO CAPS	MC		PREFERA OB		
	MC		STRESS TAB NF TABS	MC		PREMESIS RX TABS		
	MC		THERAPEUTIC-M TABS	MC		PRENATABS CBF TABS[1]		
	MC		THERAVITE LIQD	MC		PRENATAL CARE TABS[1]		
	MC/DEL		TRI-VITAMIN/FLUORIDE SOLN	MC		PRENATAL MR 90 TBCR[1]		
	MC		VITA CON FORTE CAPS	MC/DEL		PRENATAL MTR/SELENIUM TABS[1]		
	MC		VITAMIN B COMPLEX CAPS	MC		PRENATAL OPTIMA ADVANCE TABS[1]		

	MC		VITAPLEX PLUS TABS	MC		PRENATAL PC 40 TABS[1]		
				MC/DEL		PRENATAL RX TABS[1]		
				MC		PRENATE[1]		
				MC		PRENATE ELITE[1]		
				MC		PRIMACARE MISC		
				MC		PROTEGRA CAPS		
				MC		STUARTNATAL PLUS 3 TABS[1]		
				MC		TRI-VI-SOL SOLN		
				MC		TRI-VI-SOL/IRON SOLN		
				MC/DEL		ULTRA NATALCARE TABS		
				MC		ULTRA-NATAL TABS[1]		
				MC		VICON FORTE CAPS		
				MC		VINATAL FORTE TABS[1]		
				MC		VINATE[1]		
				MC/DEL		VINATE ADVANCED TABS[1]		
MISCELLANEOUS MINERALS								
MINERALS	MC		CALCARB	MC		ANEMAGEN	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. As listed in MaineCare Policy, certain drugs require specific diagnoses for approval.
	MC		CALCI-MIX CAPSULE CAPS	MC		CALCET TABS	**Please refer to OTC list.**	
	MC		CALCIQUID SYRP	MC/DEL		**CALCIUM 600-D TABS**		
			CALCITRATE/VITAMIN D TABS	MC		CALCIUM/VITAMIN D TABS	Click here for the OTC List	
	MC							
	MC/DEL		CALCIUM	MC		CALTRATE 600 PLUS/VIT D TABS		
	MC/DEL		CALCIUM CARBONATE	MC		CALTRATE PLUS TABS		**DDI:** Fe salts will now be non-preferred and require prior authorization if it is currently being used in combination with either Prevacid, pantoprazole, Prilosec, or any currently non preferred PPI.
	MC/DEL		CALCIUM CITRATE TABS	MC		CHROMAGEN		
	MC/DEL		CALCIUM GLUCONATE TABS	MC		CITRACAL PLUS TABS		
	MC/DEL		CALCIUM LACTATE TABS	MC		CONTRIN CAPS		**Please refer to OTC list.**
	MC		CALCIUM/MAGNESIUM TABS	MC		FEOGEN FORTE CAPS		
	MC/DEL		**CALCIUM/VITAMIN D TABS**	MC		FEROCON CAPS		Preferred products that used to require diag codes still require diag codes unless indicated otherwise.
	MC		CALTRATE 600 TABS	MC/DEL		FERREX 150 CAPS		
	MC/DEL		CHEWABLE CALCIUM CHEW	MC		FERRO-SEQUELS TBCR		
	MC		CITRACAL TABS	MC		FE-TINIC CAPS		
	MC		CITRACAL + D TABS	MC		FE-TINIC 150 FORTE CAPS		
	MC		CITRUS CALCIUM TABS	MC/DEL		FLUOR-A-DAY SOLN		
	MC		CITRUS CALCIUM 1500 + D TABS	MC		HEMOCYTE TABS		
	MC		EFFERVESCENT POTASSIUM TBEF	MC/DEL		K-DUR TBCR		
	MC/DEL		FEOSTAT CHEW	MC		KLOR-CON PACK		
	MC		FERATAB TABS	MC		K-LYTE		
	MC/DEL		FER-GEN-SOL SOLN	MC/DEL		K-PHOS TABS NEUTRAL		
	MC		FER-IRON SOLN	MC		K-TABS TBCR		
	MC		FERRONATE TABS	MC		K-VESCENT PACK		
	MC/DEL		FERROUS SULFATE	MC		MICRO-K 10 MEG CPCR		
	MC/DEL		FLUOR-A-DAY CHEW	MC		NU-IRON 150 CAPS		
	MC		FLUORIDE CHEW	MC/DEL		**OYSTER SHELL CALCIUM/VITA TABS**		
	MC		FLUORIDE SODIUM CHEW	MC/DEL		POLY-IRON 150 CAPS		
	MC		FLUORITAB CHEW	MC/DEL		POLYSACCHARIDE IRON CAPS		
	MC		HM CALCIUM TABS	MC/DEL		POTASSIUM BICARB/CHLORIDE		
	MC		K+ POTASSIUM PACK	MC/DEL		POTASSIUM CHLORIDE 10MEQ CAPS		
	MC		KAON ELIX	MC/DEL		POTASSIUM CHLORIDE 8MEQ CAPS		
	MC		KAON-CL-10 TBCR	MC/DEL		SLOW FE TBCR		
	MC		KCL 0.075%/D5W/NACL 0.2% SOLN	MC		TUMS 500 CHEW		
	MC		K-EFFERVESCENT TBEF	MC		VIACTIV CHEW		
	MC		KLOR-CON					
	MC		KLOTRIX TBCR					
	MC/DEL		K-PHOS TABS					
	MC/DEL		K-VESCENT TBEF					

	MC/DEL		LURIDE CHEW					
	MC/DEL		MAGNESIUM GLUCONATE TABS					
	MC/DEL		MAGNESIUM SULFATE SOLN					
	MC		MAGTABS					
	MC		MICRO-K 8 MEG					
	MC/DEL		OS-CAL TABS					
	MC/DEL		**OS-CAL 500 + D TABS**					
	MC/DEL		**OYSCO**					
	MC/DEL		OYST-CAL TABS					
	MC/DEL		**OYST-CAL D TABS**					
	MC/DEL		**OYST-CAL/VITAMIN D TABS**					
	MC/DEL		OYSTER CALCIUM TABS					
	MC/DEL		OYSTER SHELL					
	MC		PHARMA FLUR					
	MC/DEL		PHOSPHA 250 NEUTRAL TABS					
	MC		POTASSIUM BICARBONATE TBEF					
	MC/DEL		POTASSIUM CHLORIDE 8MEQ					
	MC		POTASSIUM EFFERVESCENT					
	MC/DEL		SELENIUM TABS					
	MC		SLOW-MAG TBCR					
	MC/DEL		SODIUM FLUORIDE					
	MC/DEL		SSKI SOLN					
	MC		V-R CALCIUM					
	MC		V-R OYSTER SHELL CALCIUM					
	MC		ZINC SULFATE CAPS					
MISC. ELECTROLYTES/NUTRITIONALS								
ELECTROLYTES/ NUTRITIONALS	MC		INTRALIPID EMUL[1]	MC		BOOST[1]	1. This list of nutritionals is incomplete. All nutritionals still require a PA except for the miscellaneous products listed as preferred. SGA form required for nutritionals unless member has a G/I tube.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **As listed in MaineCare Policy, certain drugs require specific diagnoses for approval.** Medical foods are not to be authorized solely for the purpose of enhancing nutrient intake or managing body weight if the participant is able to eat conventional foods adequately. Medical foods may be approved if the member has a medical condition which precludes or restricts the use of conventional foods and necessitates the use of a formula. Concurrent Stimulant therapy is not an acceptable medical reason/condition for use of medical foods for enhancing nutrient intake or managing body weight.
	MC		P.T.E. -5 SOLN[1]	MC		CASEC POWD[1]		
	MC/DEL		SEA-OMEGA CAPS[1]	MC		CHOICE DM LIQD[1]		
				MC		DELIVER 2.0 LIQD[1]		
				MC		ENFAMIL[1]		
				MC		ENSURE[1]		
				MC		GLUCERNA[1]		
				MC		ISOCAL LIQD[1]		
				MC		KINDERCAL TF LIQD[1]		
				MC		KINDERCAL TF/FIBER LIQD[1]	2. Formerly known as Omacor.	For children under the age of 5, MaineCare will not provide milk- or soy-based standard infant formulas. Regular formulas may be sought through your nearest WIC office. MaineCare will continue to cover medical food for all participants in MaineCare when medical necessity is met.
				MC/DEL		L-CARNITINE CAPS[1]		
				MC		LIPISORB LIQD[1]		
				MC		LOVAZA[1,2]	Use PA Form# 20420 & SGA Form	
				MC		MODULEN IBD POWD[1]		Vascepa requires adjunct therapy for specific indication to reduce TG in those with severe hypertriglyceridemia (500mg per deciliter or more). Proper indication per lab values is required before approval
				MC		NUTRAMIGEN POWD[1]		
				MC/DEL		NUTREN[1]		
				MC		NUTRITIONAL SUPPLEMENT LIQD[1]		
				MC		NUTRIVENT 1.5 LIQD[1]		
				MC/DEL		PEPTAMEN[1]		
				MC		PHENYLADE[1]		
				MC		PHENYL-FREE[1]		
				MC		PKU 3 POWD[1]		
				MC		PREGESTIMIL POWD[1]		
				MC/DEL		PROBALANCE LIQD[1]		
				MC		PROSOBEE[1]		
				MC		SCANDISHAKE PACK[1]		
				MC		VASCEPA		
ERYTHROPOEITINS	MC		PROCRIT SOLN[1]	MC	6	EPOGEN SOLN	Use PA Form# 10520	Non-Preferred drugs must be tried and failed in step-order, due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between

				MC	8	ARANESP SOLN	1. Clinical PA is required to establish medical necessity and that appropriate lab monitoring is being done.	exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Please see the EPO PA form for other approval and renewal criteria.
				MC/DEL	8	MIRCERA[1]		
				MC/DEL	8	OMONTYS		
GRANULOCYTE CSF								
GRANULOCYTE CSF				MC	8	LEUKINE	1. Must be used in specified step order. 2.10 day supply/month may be used without a PA. Use PA Form# 20520	See approval criteria detailed on Neupogen PA form.
				MC	8	NEUPOGEN SOLN[2]		
				MC	9	NEULASTA[1]		
				MC/DEL		ZARXIO		
GAUCHER DISEASE								
GAUCHER DISEASE				MC		CERDELGA	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Exceeding days supply limits for LMWH class requires PA.
ANTICOAGULANTS / PLATELET AGENTS								
ANTICOAGULANTS	MC		ARIXTRA SOLN[1]	MC/DEL		**LOVENOX SOLN**	1. Arixtra, Fragmin and Enoxaparin therapy durations greater than 7 days require PA. 2. Use other strengths available to obtain desired dose. 3.Established users will be grandfathered, new starters must use preferred product Coumadin. 4. Diagnosis required Use PA form# 20725 for Pradaxa requests Use PA form# 20420 for other requests	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Exceeding days supply limits for LMWH class requires PA. **DDI:** Warfarin will require prior authorization if being used in combination with fluconazole, miconazole, or voriconazole. **DDI:** Warfarin will require prior authorization if being used in conjunction with Gemfibrozil or Fenofibrate. **DDI:** Rifampin will require prior authorization if being used in combination with Savaysa
	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**					
	MC		HEPARIN LOCK SOLN					
	MC/DEL		HEPARIN LOCK FLUSH SOLN					
	MC/DEL		HEPARIN SODIUM SOLN					
	MC/DEL		PRADAXA					
	MC/DEL		XARELTO					
	MC/DEL		HEPARIN SODIUM LOCK FLUSH SOLN					
ANTIHEMOPHILIC AGENTS	MC		ALPHANATE	MC		ADVATE[1,2]	1. Only if other products unavailable. 2. Advate may be available with PA in cases of large volume dosing in patients with poor venous access. Use PA Form# 20420	Non-preferred will only be approved if other preferred products are unavailable.
	MC		ALPHANINE SD	MC		KOATE-DVI		
	MC/DEL		BENEFIX SOLR					
	MC/DEL		HELIXATE FS KIT					
	MC		HEMOFIL - M					
	MC		HUMATE-P SOLR					
	MC		KOGENATE FS					
	MC		KONYNE - 80					
	MC		MONARC - M					
	MC		MONOCLATE - P					
	MC		MONONINE					
	MC		NOVOSEVEN SOLR					
	MC/DEL		PROFILNINE					
	MC		RECOMBINATE SOLR					
	MC		REFACTO					

	MC		WILATE INJ					
PLATELET AGGREGATION INHIBITORS	MC/DEL		ASPIRIN	MC/DEL	7	TICLOPIDINE HCL TABS	Use PA Form# 20715 for Plavix,Effent & Brilinta Use PA form# 20420 for other requests 1. A special PA may be obtained at the pharmacy for members scheduled for "stent" placement or have had placement if in the last 12months. Please indicate on prescription date of stent placement. 2. Dosing limits apply, please see dose consolidation list.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. A special PA may be obtained at the pharmacy for members scheduled for "stent" placement or have had placement if in the last 12months. Please indicate on prescription date of stent placement. **DDI:** Plavix will require prior authorization if being used in combination with omeprazole, esomeprazole, cimetidine, fluconazole, ketoconazole, intelence, fluoxetine, ticlopidine, and fluvoxamine. **DDI:** exists for using maintenance ASA dose >100mg, as it reduces the effectiveness of Brilinta Brilianta- Concomitant use with strong CYP3A4 inhibitors should be avoided (including ketoconazole, itraconazole, atazanavir, and telithromycin). Doses of simvastatin and lovastatin >40mg should be avoided.
	MC/DEL		**DIPYRIDAMOLE TABS**	MC	8	EFFIENT[1]		
	MC/DEL		**CLOPIDOGREL 75MG**	MC/DEL	8	PERSANTINE TABS		
				MC/DEL	8	BRILINTA[1,2]		
				MC/DEL	8	PLAVIX TABS[1]		
				MC/DEL	8	**ZONTIVITY**		
PLATELET AGGR. INHIBITORS / COMBO'S - MISC.	MC/DEL		**AGGRENOX**	MC/DEL		**AGRYLIN CAPS**	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**CILOSTAZOL**	MC/DEL		**ANAGRELIDE CAPS**		
	MC/DEL		PENTOXIFYLLINE ER TBCR	MC/DEL		**PLETAL TABS**		
				MC		TRENTAL TBCR		
HEMATOLOGICALS								
MONOCLONAL ANTIBODY				MC		SOLIRIS	Use PA Form# 20420	A diagnosis of Paroxysmal nocturnal hemoglobinuria (PNH) using the HAM test or flow cytometry is required. In addition, the patient must show evidence of having received a meningitis vaccine at least 2 weeks prior to the start of therapy.
IMMUNE GLOBULIN INTRAVENOUS (IVIG)	MC		OCTAGAM INJ[1]	MC		GAMMAPLEX INJ	Use PA Form# 20420 1. Clinical PA required	
BRADYKININ B2 RECEPTOR ANTAGONIST				MC		FIRAZYR	Use PA Form# 20420	
HEMATOLOGICAL AGENTS-THROMBOPOIETIN RECEPTOR AGONISTS				MC/DEL	7	PROMACTA	Use PA Form# 20420	Clinical PA required. Must see prior trial with insufficient response to corticosteroids and immunoglobulins.
				MC	8	NPLATE		
HEMOSTATIC								
HEMOSTATIC	MC/DEL		AMICAR				Use PA Form# 20420	
	MC		AMINOCAPROIC ACID					
OPHTHALMICS								
OP. - ANTIBIOTICS	MC		AK-SPORE OINT	MC		AK-POLY-BAC OINT	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		BACITRACIN OINT	MC		AK-SULF OINT		
	MC		BACITRACIN/NEOMYCIN/POLYM	MC		AK-TOB SOLN		
	MC/DEL		BACITRACIN/POLYMYXIN B OINT	MC		AZASITE		
	MC		CHLOROPTIC SOLN	MC		BLEPH-10 SOLN		
	MC/DEL		ERYTHROMYCIN OINT	MC		GENTAK		
	MC/DEL		GENTAMICIN SULFATE	MC		ILOTYCIN OINT		
	MC/DEL		NEOMYCIN/POLYMYXIN/GRAMIC	MC/DEL		NEOMYCIN/BACI/POLYM OINT		
	MC		NEOSPORIN SOLN	MC		NEOSPORIN OINT		
	MC		POLYSPORIN	MC		OCUSULF-10 SOLN		
	MC/DEL		SODIUM SULFACETAMIDE SOLN	MC		OCUTRICIN SOLN		
	MC/DEL		SULFACETAMIDE SODIUM	MC		TERAK OINT		
	MC/DEL		TRIMETHOPRIM SULFATE/POLY	MC/DEL		TOBRAMYCIN SULFATE SOLN		
	MC/DEL		VIROPTIC SOLN	MC/DEL		TOBREX OINT		
				MC/DEL		TRIFLURIDINE SOLN		
OP. - QUINOLONES	MC/DEL		CILOXAN OINT	MC/DEL		CILOXAN SOLN	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		CIPROFLOXACIN SOL 0.3%	MC		OCUFLOX SOLN		

	MC/DEL		BESIVANCE					preferred drug(s) exists.
	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.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		ARTIFICIAL TEARS OINT	MC/DEL		ARTIFICIAL TEARS SOLN OP		
	MC/DEL		ARTIFICIAL TEARS SOLN	MC		BION TEARS SOLN		
	MC		CELLUVISC SOLN	MC		DRY EYES OINT		
	MC		EYE LUBRICANT OINT	MC		DURATEARS OINT		
	MC/DEL		GENTEAL	MC/DEL		HYPO TEARS		
	MC		LIQUITEARS SOLN	MC/DEL		ISOPTO TEARS SOLN		
	MC		MAJOR TEARS SOLN	MC		LACRI-LUBE		
	MC		PURALUBE OINT	MC		LUBRIFRESH P.M. OINT		
	MC		PURALUBE TEARS SOLN	MC		MURINE SOLN		
	MC		REFRESH SOLN OP	MC/DEL		MUROCEL SOLN		
	MC		REFRESH PLUS SOLN[1]	MC/DEL		NATURE'S TEARS SOLN		
	MC		REFRESH PM OINT	MC		REFRESH SOLN		
				MC		REFRESH TEARS SOLN[1]		
				MC		SYSTANE		
				MC		TEARGEN SOLN		
				MC		TEARISOL SOLN		
				MC/DEL		TEARS NATURALE		
				MC/DEL		TEARS PURE SOLN		
				MC		TEARS RENEWED OINT		
				MC/DEL		THERATEARS SOLN		
				MC		V-R ARTIFICIAL TEARS SOLN		
OP. - BETA - BLOCKERS	MC/DEL		**BETOPTIC-S SUSP**	MC		BETAGAN SOLN	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**CARTEOLOL HCL SOLN**	MC/DEL		**BETAXOLOL HCL SOLN**		
	MC/DEL		**LEVOBUNOLOL HCL SOLN**	MC/DEL		**BETIMOL SOLN**		
	MC/DEL		METIPRANOLOL SOLN	MC		ISTALOL		
	MC/DEL		**TIMOLOL MALEATE SOLG (GEL)**	MC/DEL		**OCUPRESS SOLN**		
	MC/DEL		**TIMOLOL MALEATE SOLN**	MC		OPTIPRANOLOL SOLN		
				MC/DEL		**TIMOPTIC SOLN**		
				MC/DEL		**TIMOPTIC-XE SOLG**		
OP. - ANTI-INFLAMMATORY / STEROIDS OPHTH.	MC		AK-SPORE HC OINT	MC		AK-TROL SUSP	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		ALREX SUSP	MC		BAC/POLY/NEOMY/HC OINT		
	MC		BLEPHAMIDE SUSP	MC		BLEPHAMIDE S.O.P. OINT		
	MC/DEL		DEXAMETH SOD PHOS SOLN	MC		BROMDAY		
	MC/DEL		FLAREX SUSP	MC		EFLONE SUSP		
	MC/DEL		FLUOROMETHOLONE SUSP	MC		FLUOR-OP SUSP		
	MC		FML S.O.P. OINT	MC/DEL		LOTEMAX SUSP		
	MC		MAXITROL OPTH OINT 0.1%	MC		NEO/POLY/BAC/HC OINT		
	MC		PRED MILD SUSP	MC/DEL		NEOM/POLY/DEX OPTH OINT 0.1%		
	MC/DEL		PREDNISOLONE	MC/DEL		OZURDEX		
	MC/DEL		TOBRADEX 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.	Preferred drugs must be tried and failed, in step-order, due to lack of efficacy (failure to reach target IOP reduction) or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**TRAVATAN-Z**	MC	8	LUMIGAN SOLN[1]		

				MC	8	RESCULA[1,2,3]	2. Dosing limits apply, please see dosing consolidation list. 3. Clinical PA is required to establish diagnosis and medical necessity. Use PA Form# 20420	significant potential drug interaction between another drug and the preferred drug(s) exists.
				MC/DEL	8	**TRAVATAN SOLN**		
				MC/DEL	8	**TRAVOPROST**		
				MC/DEL	8	XALATAN SOLN[1]		
OP. - CYCLOPLEGICS	MC		AK-PENTOLATE SOLN	MC/DEL		CYCLOGYL SOLN	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		ATROPINE SULFATE	MC		ISOPTO ATROPINE SOLN		
	MC/DEL		CYCLOPENTOLATE HCL SOLN	MC/DEL		ISOPTO HOMATROPINE SOLN		
	MC/DEL		ISOPTO HYOSCINE SOLN	MC		MUROCOLL-2 SOLN		
OP. - MIOTICS - DIRECT ACTING	MC/DEL		**ISOPTO CARBACHOL SOLN**				Use PA Form# 20420	
	MC		ISOPTO CARPINE SOLN					
	MC		PILOCAR SOLN					
	MC/DEL		**PILOCARPINE HCL SOLN**					
	MC/DEL		**PILOPINE HS GEL**					
OP. - ADRENERGIC AGENTS	MC/DEL		**DIPIVEFRIN HCL SOLN**	MC		PROPINE SOLN	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		EPIFRIN SOLN					
OP. - SELECTIVE ALPHA ADRENERGIC AGONISTS	MC		ALPHAGAN P 0.15% SOLN	MC		ALPHAGAN SOLN	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		SIMBRINZA	MC		ALPHAGAN P 0.1% SOLN		
				MC/DEL		BRIMONIDINE 0.2%		
				MC/DEL		**IOPIDINE SOLN**		
OP. - ANTI-ALLERGICS	MC/DEL		PATADAY SOLN	MC	8	ALOCRIL SOLN	Use PA Form# 20420	All preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		PATANOL SOLN	MC/DEL	8	ALOMIDE SOLN		
				MC	8	BEPREVE		
				MC	8	ELESTAT		
				MC/DEL	8	EMADINE SOLN		
				MC	8	LASTACAFT		
				MC/DEL	8	OPTIVAR		
				MC	8	OPTICROM SOLN		
				MC/DEL	8	PAZEO		
				MC/DEL	8	ZADITOR SOLN		
				MC/DEL	9	EPINASTINE		
OP. ANTI-ALLERGICS- MASTCELL STABILIZER CLASS				MC/DEL		ALAMAST SOLN	Use PA Form# 20420	
OP. - CARBONIC ANHYDRASE INHIBITORS/COMBO	MC/DEL		**AZOPT SUSP**	MC/DEL		**COSOPT SOLN PF**	Use PA Form# 20420	
	MC		COMBIGAN	MC/DEL		**TRUSOPT SOLN**		
	MC/DEL		DORZOLAMIDE					
	MC/DEL		DORZOLAMIDE/TIMOLOL					
OP. - NSAID'S	MC		FLURBIPROFEN SODIUM SOLN	MC	8	ACULAR LS[1]	1. Must fail all preferred products before non-preferred. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		DICLOFENAC OPTH 0.1%	MC	8	ACULAR SOLN[1]		
	MC/DEL		KETOROLAC OPTH 0.4%	MC/DEL	8	ILEVRO		
	MC/DEL		KETOROLAC OPTH 0.5%	MC/DEL	8	PROLENSA		
				MC/DEL	8	NEVANAC[1]		
				MC	8	OCUFEN SOLN[1]		
				MC	8	XIBROM[1]		
				MC	8	VOLTAREN SOLN[1]		
				MC	8	ACUVAIL[1]		
				MC/DEL	9	BROMFENAC		
OP. - OF INTEREST	MC/DEL		ENUCLENE SOLN	MC		BOTOX SOLR	1. Must have kerato conjuctivitus sicca and failed other dry eye therapies. Use PA Form# 20420	Must fail adequate trials of multi agents from artificial tears and lubricant category.
				MC		RESTASIS[1]		

DERMATOLOGICAL								
TOPICAL - ORAL	MC		AMNESTEEM[1]				1. Users 24 or under, PA will not be required. Use PA Form# 20420	
	MC		CLARAVIS[1]					
	MC		SOTRET[1]					
TOPICAL - ACNE PREPARATIONS	MC		AZELEX CREA[4]	MC/DEL		ADAPALENE 0.3% GEL	1. Users 24 or under, PA will not be required. 2. Dosing limits allowing one package per month. Please refer to Dose Consolidation List. 3. Only available if component ingredients are unavailable. 4. Dosing limits apply, please see dosing consolidation list. 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	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		BENZOYL PEROXIDE	MC		ACZONE		
	MC/DEL		CLINDAMYCIN PHOSPHATE[2]	MC		ALTINAC CREA		
	MC		ERYDERM SOLN	MC		AVITA CREA		
	MC/DEL		ERYTHROMYCIN GEL	MC		BENZAC		
	MC/DEL		ERYTHROMYCIN PADS	MC/DEL		BENZACLIN GEL[3]		
	MC/DEL		ERYTHROMYCIN SOLN	MC/DEL		BENZAGEL-10 GEL		
	MC		ISOTRETINOIN	MC/DEL		BENZAMYCIN GEL		
	MC		METRONIDAZOLE CREA[2]	MC/DEL		BENZAMYCINPAK PACK		
	MC		METRONIDAZOLE GEL[2]	MC		BENZEFOAM		
	MC		METRONIDAZOLE LOTN[2]	MC		BREVOXYL		
	MC/DEL		SODIUM SULFACET/SULF LOTN	MC/DEL		CLEOCIN-T[2]		
	MC		TAZORAC	MC		CLINAC BPO GEL		
	MC/DEL		TRETINOIN GEL[1]	MC		CLINDAGEL GEL		
	MC		TRETINOIN CREA[1,2]	MC		CLINDETS SWAB		
				MC		DESQUAM-E GEL		
				MC		DESQUAM-X		
				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, please see dosing consolidation list. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		BACITRACIN OINT	MC/DEL		BACTROBAN OINT.		
	MC/DEL		BACTROBAN CREA[1]	MC/DEL		TRIPLE ANTIBIOTIC OINT		
	MC/DEL		BACTROBAN NASAL OINT					
	MC/DEL		CENTANY OINT 2%[1]					
	MC/DEL		GENTAMICIN SULFATE					
	MC/DEL		MUPIROCIN[1]					
TOPICAL - ANTIFUNGALS	MC/DEL		BETAMETHASONE CLOTRIMAZOLE LOT	MC/DEL	8	BETAMETHASONE CLOTRIMAZOLE CREA		
	MC		CICLOPIROX 0.77 CREA	MC/DEL	8	CICLOPIROX SOLN	Use PA Form# 10120 1. Diagnosis required	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		CICLOPIROX 0.77 SUSP	MC	8	EXELDERM		
	MC/DEL		CLOTRIMAZOLE	MC	8	FUNGIZONE CREA		

	MC		ECONAZOLE NITRATE CREA	MC/DEL	8	HYDROCORT/IODOQ CREA		
	MC/DEL		KETOCONAZOLE CREA	MC	8	JUBLIA		
	MC/DEL		KETOCONAZOLE SHAM	MC	8	KERYDIN[1]		
	MC/DEL		LOPROX 1.0 CREA	MC/DEL	8	LAMISIL		**DDI:** Ketoconazole will now be non-preferred and require prior authorization if they are currently being used in combination with any of the following medications: Prevacid, pantoprazole, Onglyza or Omeprazole.
	MC/DEL		LOPROX 1.O LOTN	MC/DEL	8	LOPROX 0.77 LOTN		
	MC/DEL		LOPROX GEL	MC/DEL	8	LOPROX 0.77 CREA		
	MC/DEL		LOPROX TS LOTN	MC/DEL	8	LOPROX 0.77 SUSP		Kerydin- Verify prior trials and failures or intolerance of preferred treatments, including both topical and oral agents
	MC/DEL		LOTRISONE CREA	MC/DEL	8	LOPROX SHAMPOO SHAM		
	MC/DEL		MICONAZOLE NITRATE CREA	MC	8	LOTRIMIN		
	MC		MYCO-TRIACET II CREA	MC/DEL	8	LOTRISONE LOT		
	MC/DEL		NYSTATIN	MC	8	LUZU		
	MC/DEL		NYSTATIN/TRIAMCINOLONE CREA	MC/DEL	8	MENTAX CREA		
	MC/DEL		NYSTOP POWD	MC	8	MYCOGEN II CREA		
	MC		PEDI-DRI POWD	MC	8	NAFTIN		
	MC/DEL		TINACTIN	MC	8	NIZORAL SHAM		
	MC		TRI-STATIN II CREA	MC/DEL	8	NYSTATIN/TRIAMCINOLONE OINT		
				MC	8	NYSTAT-RX POWD		
				MC/DEL	8	OXISTAT		
				MC/DEL	9	PENLAC NAIL LACQUER SOLN		
TOPICAL - ANTIPRURITICS	MC		ZONALON CREA	MC		PRUDOXIN CREA	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
TOPICAL - ANTIPSORIATICS	MC/DEL		SORIATANE CAPS	MC		OXSORALEN ULTRA CAPS[1]	1. Must fail all preferred products before non-preferred. 2. Individual ingredients are available as preferred witout PA. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		TAZORAC	MC		PSORIATEC CREA[1]		
				MC/DEL		SORIATANE CK KIT[1]		
				MC/DEL		TACLONEX[1,2]		
				MC		VECTICAL[1]		
TOPICAL - ANTISEBORRHEICS	MC/DEL		SELENIUM SULFIDE SHAM	MC		CARMOL SCALP TREATMENT KIT	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
				MC		ZNP BAR		
TOPICAL - ANTIVIRALS				MC/DEL		DENAVIR CREA[1, 3]	1. Must fail oral treatment with Acyclovir or Valacyclovir. 2. Approvals limited to 1 tube per 180 days. 3. Dosing limits apply, please see dosing consolidation list. Use PA Form# 20420	
				MC		ZOVIRAX OINT[1,2]		
TOPICAL - ANTINEOPLASTICS	MC		EFUDEX	MC/DEL		CARAC CREA	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		FLUOROPLEX CREA	MC/DEL		FLUOROURACIL		
				MC		SOLARAZE GEL		
				MC/DEL		ZYCLARA		
TOPICAL - BURN PRODUCTS	MC		FURACIN CREA	MC/DEL		SILVADENE CREA	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		SILVER SULFADIAZINE CREA					
	MC		SSD AF CREA					
	MC		SSD CREA					
	MC/DEL		THERMAZENE CREA					
TOPICAL - CORTICOSTEROIDS			**LOW POTENCY**	MC/DEL		ACLOVATE	Use PA Form# 20420 1. Dosing limits apply, please see dosing consolidation list.	At least 1 drug from each potency of preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		DESOWEN[1]	MC		AMCINONIDE CREA		
	MC/DEL		HYDROCORTISONE CREA	MC		ANUSOL HC-1 OINT		
	MC		HYDROCORTISONE LOTN	MC/DEL		**CLOBETASOL PROPINATE LOTN**		
	MC		LACTICARE-HC LOTN	MC		CLODERM CREA		
	MC		NUTRACORT LOTN	MC/DEL		CORDRAN		
	MC		TEXACORT SOLN	MC/DEL		CORMAX		

				MC/DEL		CUTIVATE CREA / OINT		
			MEDIUM POTENCY	MC/DEL		CUTIVATE LOTN		
	MC/DEL		DESOXIMETASONE .05%	MC		DERMA-SMOOTHE/FS OIL		
	MC/DEL		ELOCON	MC/DEL		DERMATOP		
	MC/DEL		FLUOCINOLONE ACETONIDE .025-.01%	MC		DESONATE GEL		
	MC		FLUROSYN CREA	MC/DEL		DIPROLENE		
	MC		FLUTICASONE PROPIONATE CREA/OINT	MC		ELOCON OINT		
	MC		HYDROCORTISONE BUTYRATE	MC		HYDROCORTISONE POWD		
	MC		HYDROCORTISONE OINT	MC		KENALOG AERS		
	MC		HYDROCORTISONE VALERATE	MC		LIDA MANTLE HC CREA		
	MC		MOMETASONE FUROATE OINT	MC/DEL		LOCOID		
	MC/DEL		TRIAMCINOLONE ACETONIDE .025-.1%	MC/DEL		LUXIQ FOAM		
				MC/DEL		OLUX FOAM		
			HIGH POTENCY	MC		PANDEL CREA		
	MC/DEL		BETAMETHASONE DIPROPIONATE	MC		PROCTOCORT CREA		
	MC		CLOBEX LOTN	MC/DEL		PSORCON		
	MC/DEL		DESOXIMETASONE .25%	MC/DEL		PSORCON E		
	MC/DEL		DESONIDE[1]	MC/DEL		TEMOVATE		
	MC/DEL		FLUOCINOLONE ACETONIDE .02%	MC		TOPICORT		
	MC/DEL		FLUOCINONIDE	MC		TOPICORT LP CREA		
	MC		HALOG	MC		ULTRAVATE		
	MC		HALOG-E CREA	MC/DEL		VERDESO		
	MC/DEL		TRIAMCINOLONE ACETONIDE .5%	MC		WESTCORT		
			VERY HIGH POTENCY					
	MC/DEL		AUGMENTED BETA DIP					
	MC/DEL		BETAMETHASONE VALERATE					
	MC/DEL		BETA-VAL					
	MC		DIFLORASONE DIACETATE					
	MC		HALOBETASOL					
			MISCELLANEOUS					
	MC		PROCTO-KIT CREA 1%					
TOPICAL - STEROID LOCAL ANESTHETICS				MC		EPIFOAM FOAM	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
TOPICAL - STEROID COMBINATIONS	MC		DERMA-SMOOTHE/FS ATOPIC P KIT	MC		CARMOL-HC CREA	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
TOPICAL - EMOLLIENTS	MC/DEL		AMMONIUM LACTATE CREA[1]	MC		LAC-HYDRIN CREA[1]	Use PA Form# 20420 1. Dosing limits still apply. Please see dose consolidation list.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		AMMONIUM LACTATE LOTN 12%[1]	MC		LAC-HYDRIN LOTN 12%		
	MC		VITAMIN A & D MEDICATED OINT	MC		MEDERMA GEL		
				MC		MIMYX		
				MC		RENOVA CREA		
TOPICAL - ENZYMES / KERATOLYTICS / UREA	MC		SANTYL OINT	MC		CARMOL 40 CREA	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Ziox, Panafil and Papain products have been removed from the PDL due to FDA safety concerns regarding drugs containing Papain.
				MC		SALEX CREA		
				MC		SALEX LOTN		
TOPICAL - GENITAL WARTS	MC/DEL		IMIQUIMOD[2]	MC/DEL	5	PODOFILOX SOLN	Use PA Form# 20420 1. Non-preferred products must be used in specified order. 2. Dosing limits still apply. Please see dose	
				MC/DEL	8	ALDARA		
				MC/DEL	8	CONDYLOX[1]		
				MC	8	PICATO		
				MC	8	VEREGEN[1]		

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

	MC		PONTOCAINE SOLN					
	MC/DEL		SODIUM CHLORIDE					
MISCELLANEOUS EAR								
EAR	MC/DEL		A/B OTIC SOLN	MC		ANTIBIOTIC EAR SOLN	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		ACETASOL SOLN	MC		ANTIBIOTIC EAR 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	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		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.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		LIDOCAINE VISCOUS SOLN	MC		PERIOGARD SOLN[1]		
	MC		TRIAMCINOLONE IN ORABASE PSTE	MC		TRIAMCINOLONE ACETONIDE PSTE[1]		
	MC		TRIAMCINOLONE ORADENT PSTE					
DENTAL PRODUCTS								
DENTAL PRODUCTS	MC/DEL		ETHEDENT CREA	MC0MC		APF GEL GEL	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		GEL-KAM CONC	MC/DEL		DENTAGEL GEL		
	MC/DEL		GEL-KAM GEL 0.4%	MC/DEL		PHOS-FLUR GEL		
	MC/DEL		PHOS FLUR SOLN	MC		THERA-FLUR-N GEL		
	MC/DEL		SF 5000 PLUS CREA					
	MC/DEL		SF GEL					
	MC		STANNOUS FLUORIDE ORAL RI CONC					
ARTIFICIAL SALIVA/STIMULANTS								
ARTIFICIAL SALIVA/STIMULANTS	MC		SALIVA SUBSTITUTE SOLN	MC		EVOXAC CAPS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
				MC		RADIACARE SOLR		
				MC		SALAGEN TABS		
MISCELLANEOUS ANORECTAL								
ANORECTAL - MISC.	MC/DEL		COLOCORT ENEM	MC/DEL		ANUSOL-HC CREA	Use PA Form# 20420	
	MC		CORTENEMA ENEM	MC/DEL		CORTIFOAM FOAM		
	MC		ELA-MAX 5 CREA	MC/DEL		PROCTOFOAM HC FOAM		
	MC/DEL		HYDROCORTISONE ENEM	MC/DEL		PROCTO-KIT CREA 2.5%		
	MC/DEL		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	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,

	MC MC		ENBREL[1,2] HUMIRA[1]	MC		STELARA	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	anthralin, calcipotriene and tazorotene, and at least one systemic drug such as methotrexate, cyclosporine, methoxsalen or acitretin and phototherapy/UVA. Enbrel is preferred after a trial of a step 1 product (e.g. azathioprine, methotrexate, etc.); however, dosing limits will also still apply. Dosing limits will allow 8 injections per month without pa. Use of greater than 8 injections per month will require PA. In addition, the preferred Enbrel 25mg product will be the multi-dose vial (NDC- 58406-0425-34). The single-use prefilled syringes are non-preferred.
ALTERNATIVE MEDICINES								
ALTERNATIVE MEDICINES	MC		DIMETHYL SULFOXIDE SOLN	MC/DEL MC		CO-ENZYME Q-10 MELATONIN TABS	Use PA Form# 20420	Will only be approved for specific conditions supported by at least two double-blinded, placebo-controlled randomized trials that are not contradicted by other studies of similar quality.
CHELATING AGENTS								
CHELATING AGENTS	MC/DEL		**CUPRIMINE CAPS**	MC MC/DEL		DEPEN TITRATABS TABS EXJADE[1]	Use PA Form# 20420 1. FDA indication of treatment of chronic iron ovrload due to blood transfustions in membes 2 years of age and older is requried for approval of Exjade.	
ANTILEPROTIC								
ANTILEPROTIC				MC		THALOMID CAPS[1]	1. All PA requests for 150mg dosing will require use of Thalomid 100mg and 50mg capsules. Use PA Form# 20420	Approved for indications of leprosy, treatment-resistant multiple myeloma and AIDS.
ANTINEOPLASTIC AGENTS								
ANTINEOPLASTIC AGENTS - ANTIADNDROGENS	MC/DEL		BICALUTAMIDE	MC/DEL		CASODEX	Use PA Form# 20420	
ANTINEOPLASTIC AGENTS- LHRH ANALOGS	MC		LUPRON DEPOT[1]	MC MC MC/DEL		VANTAS[2] FIRMAGON[2] TRELSTAR	1. Dosing limits apply, please refer to dosage consolidation list. 2. PA required to confirm FDA approved indication. Use PA Form# 20420	
ANTINEOPLASTIC AGENTS - TYROSINE KINASE INHIBITORS				MC MC/DEL MC		SPRYCEL[1] TYKERB[2] GLEEVEC[1]	Use PA Form# 20420 1. Verification of diagnosis is required.	

							2. PA required to confirm FDA approved indication and to monitor for potential drug-drug interactions.	
ANTINEOPLASTICS-MISCELLANEOUS	MC MC/DEL		AMIFOSTINE MERCAPTOPURINE	MC MC/DEL MC MC/DEL MC/DEL MC/DEL		DOCEFREZ ETHYOL LEUPROLIDE **OXALIPLATIN** PURINETHOL ZOLINZA	Use PA Form# 20420	
ANTINEOPLASTICS- MONOCLONAL ANTIBODIES				MC/DEL		HERCEPTIN[1]	1. PA required to confirm FDA approved indication. Use PA Form# 20420	
CANCER								
CANCER	MC MC/DEL MC/DEL MC MC/DEL MC MC/DEL		ALIMTA ANASTROZOLE TABS AVASTIN ERBITUX LETROZOLE MEGACE ES VIDAZA	MC MC/DEL MC/DEL MC MC MC/DEL MC MC/DEL MC/DEL MC MC MC/DEL MC/DEL MC MC MC/DEL MC MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC		ALECENSA ARIMIDEX BOSULIF COMETRIQ[3,4,5] COTELLIC EMPLICITI(IV)[8] ERIVEDGE FARYDAK FOLOTYN GILOTRIF[4,5] IBRANCE ICLUSIG[3] IMLYGIC INLYTA JAKAFI KEYTRUDA[7] LENVIMA LONSURF LYNPARZA[7] NEXAVAR[1] NINLARO(PO) MEKINIST[3,4] ODOMZO[1,2,5] POMALYST STIVARGA SUTENT[1,2] SYLATRON TAFINLAR[3,4,5,6] TAGRISSO FEMARA YERVOY XALKORI XTANDI ZELBORAF ZYDELIG ZYKADIA ZYTIGA	1. PA required to confirm FDA approved indication 2. Avoid CYP3AY drug drug interaction. 3. Clinical PA required for appropriate diagnosis 4. Re-approval will require documentation of response without disease progression and tolerance to treatment 5. Dosing limits apply, please see dosage consolidation list. 6. Max daily dose of 300mg. 7. PA required to confirm FDA approved indication 8. Monitor liver enzymes periodically and stop treatment upon Grade 3 or higher elevation of liver enzymes approved indication Use PA Form# 20420	A clinical PA is required for Inlyta to verify diagnosis and failure of one prior systemic therapies **Xalkori** will be considered for patients with a diagnosis of locally advanced or metastatic non-small cell lung cancer (NSCLC) that is anaplastic lymphoma kinase (ALK)-positive as detected by an FDA- approved test (please included a copy of test results; and is prescribed by an oncologist; quantity limit of 60 tablets per 30 days. **Zelboraf** will be considered for patients 18 years of age or older; has a diagnosis of unresectable or metastatic melanoma with BRAF mutation as detected be an FDA-approved test; prescriber is an oncologist with a quantity limit of 240 tablets per 30 days. **Bosulif** requires a clinical PA, requiring diagnosis. Must have resistance or intolerance to prior therapy (such as imatinib [Gleevec®] or a TKI) seen in drug profile, monthly heptic enzyme tests should be preformed for the first three months of treatment , as clinically indicated. **Iclusig** requires prior trail of TKI therapy, appropriate monitoring and has DDI with strong CYP3A4 inducers **Stivarga** is non-preferred and is for the treatment of metastatic colorectal cancer (CRC) who have been previously treated with fluoropyrimidine- oxaliplatin- and irinotecan-based chemotherapy, an anti-VEGF therapy, and if KRAS wild type, an anti-EGFR therapy).The safety and efficacy of use in children under the age of 18 years have not been established. **DDI:** Cometriq, Ibrance and Tafinlar will require a prior authorization if it is currently being used in combination with drugs known to be significant CYP3A4 inhibitors (ketoconazole, itraconazole, clarithromycin, indinavir, nefazodone, nelfinavir, ritonavir, atazanavir, saquinavir and telithromycin). **Gilotrif** needs to be prescribed by an oncologist **Xtandi** is non-preferred and is limited to adults treatment of metastatic castration-resistant prostate cancer, with previous trials of docetaxel. **Pomalyst** has a DDI with strong inhibitors of CYP1A2 and CYP3A4 drugs. Complete blood counts weelky for first 8 weeks, then monthly, patients have at least 2 prior therapies, including lenalidomide and bortezomib,female patients of reproductive potential must have 2 negative pregnancy tests and use 2 forms of contraception and providers must be certified with Pomalyst REMS Program. **DDI:** Strong and moderate CYP3A inhibitors and Strong and moderate CYP3A inducers should be avoided with use of Lynparza 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 DDI: Strong or moderate CYP3A inhibitors and strong or moderate CYP3A inducers (carbamazepine, efavirenz, phenytoin, rifampin and St. John's Wort) should be avoided with use of Cotellic DDI: Acyclovir/other antiherpetic viral agents may interfere with the effectiveness of Imlygic Ninlaro: prior to starting a new cycle of therapy, it is recommended that: the absolute neutrophil count be ≥ 1,000/ mm3, platelet count be ≥ 75,000/ mm3 and non-hematologic toxicities be recovered to patient's baseline condition or Grade 1 or lower

								Lonsurf: Complete blood cell count should be obtained prior to an on day 15 of each cycle Cycle of Lonsurf should not be started until: absolute neutrophil count (ANC) is ≥ 1500/mm3 or febrile neutropenia is resolved; platelets are >75,00/ mm3; and Grade 3 or 4 non-hematological adverse reactions are resolved to Grade 0 or 1. -Within a treatment cycle, withhold Lonsurf if: ANC <500/ mm3 or febrile neutropenia; platelets <50,000/ mm3; Grade 3 or 4 non-hematological adverse reactions - After Recovery, resume Lonsurf after reducing the dose by 5mg/m2/dose from the previous dose if the following occurs: febrile neutropenia; uncomplicated Grade 4 neutropenia or thrombocytopenia that results in >1 week delay in start of next cycle; or non-hematologic Grade 3 or Grade 4 adverse reaction except for Grade 3 nausea and/or vomiting controlled by antiemetic therapy or Grade 3 diarrhea responsive to antidiarrheal medication DDI: Avoid concomitant use of Tagrisso with strong CYP3A inhibitors, strong CYP3A inducers, drugs that are sensitive substrates of CYP3A, breast cancer resistance protein (BCRP), or CYP1A2 with narrow therapeutic indices.
IMMUNOSUPPRESSANTS								
IMMUNOSUPPRESSANTS	MC/DEL		CYCLOSPORINE MODIFIED	MC/DEL		CELLCEPT		Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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.
	MC		GENGRAF CAPS	MC/DEL		CYCLOSPORINE CAPS		
	MC/DEL		MYCOPHENOLATE	MC/DEL		CYCLOSPORINE SOL. MODIFIED		
	MC/DEL		MYFORTIC	MC		PROGRAF CAPS		
	MC/DEL		NEORAL				Use PA Form# 20420	
	MC/DEL		RAPAMUNE					
	MC/DEL		SANDIMMUNE					
			TACROLIMUS					
PURINE ANALOG								
PURINE ANALOG	MC		AZASAN TABS	MC/DEL		**IMURAN TABS**	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**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 otherwise noted within this document.

ANTI-CONVULSANTS INDICATION CHART

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

PEDIATRIC ANTI-CONVULSANTS INDICATION CHART

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