

CATEGORY	Coverage Indicator	Step Order	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS Required	PA	Comments	Criteria
* PLEASE NOTE: All 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.mainearepdl.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: 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.									
F: 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.									
G: 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.									
H: Trials from Multiple Drug Classes - Trial/failure/intolerance to preferred agents from multiple classes within the same category or other categories 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.mainearepdl.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.									
ASSORTED ANTIBIOTICS									
BETA-LACTAMS / CLAVULANATE COMBO'S	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC MC MC/DEL MC MC MC MC/DEL MC MC MC MC MC MC/DEL		AMOXICILLIN AMOXIL' AMPICILLIN AMOXICILLIN/POTASSIUM CLA CHEW AMOXICILLIN/POTASSIUM CLA SUSR AMOXICILLIN/POTASSIUM CLA TABS AUGMENTIN ES-600 SUSR AUGMENTIN XR TB12 BEEPEN BICILLIN L-A SUSP DICLOXACILLIN SODIUM CAPS DYNAPEN SUSR GEOCILLIN TABS OXACILLIN SODIUM SOLR PENICILLIN V POTASSIUM TICAR SOLR TIMENTIN SOLR TRIMOX UNASYN SOLR VEETIDS ZOSYN	MC/DEL MC/DEL MC MC		AMOXIL 500MG TABS AUGMENTIN' PRINCIPEN CAPS' PRINCIPEN SUSR		1. Amoxil 500mg tabs are non-preferred. All other Amoxil products are preferred. 2.Principen 250 mg is available without PA. 3. Chewable 125mg & 250mg and Solution 125mg/5ml and 250mg/5ml 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.
CEPHALOSPORINS	MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL MC MC MC MC/DEL MC/DEL MC/DEL		CEFADROXIL HEMIHYDRATE CEFZOLIN SODIUM SOLR CEFTIN SUSP CEFUROXIME AXETIL TABS CEFZIL CEPHALEXIN MONOHYDRATE DURICEF SUSR FORTAZ SOLR KEFZOL SOLR MAXIPIME SOLR OMNICEF ROCEPHIN SUPRAX VANTIN	MC MC MC/DEL MC/DEL MC/DEL MC/DEL MC MC MC MC/DEL MC/DEL		CECLOR' CEDAX CEFACTOR' CEFADROXIL MONOHYDRATE TABS CEFTIN DURICEF TABS FORTAZ SOLN KEFLEX CAPS TAZICEF SOLR		1. Both brand and generic are clinically 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.
MACROLIDES / ERYTHROMYCIN'S	MC MC/DEL MC/DEL MC MC MC MC		BIAXIN XL' AZITHROMYCIN TABS CLARITHROMYCIN E.E.S E-MYCIN TBEC ERYPED 200 SUSR ERYPED 400 SUSR	MC MC/DEL MC MC MC/DEL		BIAXIN DYNABAC D5-PAK TBEC ERYPED CHEW PCE TBEC ZITHROMAX TABS		1. 7. Day supply per month w/o 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 MC MC/DEL MC/DEL MC/DEL	ERY-TAB TBEC ERYTHROCIN STEARATE TABS ERYTHROMYCIN ZITHROMAX SUSP ZMAX				Use PA Form # 20420	
TETRACYCLINES	MC/DEL MC/DEL MC MC/DEL MC/DEL	DOXYCYCLINE HYCLATE MINOCYCLINE HCL CAPS SUMYCIN TETRACYCLINE HCL CAPS VIBRAMYCIN SYRP	MC MC/DEL MC/DEL MC MC/DEL		DECLOMYCIN TABS DORYX CPEP DOXYCYCLINE MONO CAPS DYNACIN CAPS MONODOX CAPS PERIOSTAT	Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
FLUOROQUINOLONES	MC MC MC MC/DEL MC	AVELOX ABC PACK TABS AVELOX SOLN AVELOX TABS CIPROFLOXACIN CIPRO XR ¹	MC MC MC MC/DEL MC		CIPRO FLOXIN TABS LEVAQUIN NOROXIN TABS TEQUIN	1. QL 3/script/month Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
AMINO GLYCOSIDES	MC MC/DEL MC MC/DEL	GENTAMICIN NEOMYCIN SULFATE TABS TOBI NEBU TOBRAMYCIN SULFATE 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.
ANTI-MYCObACTERIALS / ANTI-TUBERCULOSIS	MC/DEL MC/DEL MC/DEL MC/DEL	ETHAMBUTOL HCL TABS MYAMBUTOL TABS MYCOBUTIN CAPS RIFAMPIN	MC		RIMACTANE 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.
ANTIMALARIAL AGENTS	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL	CHLOROQUINE PHOSPHATE TABS DARAPRIM TABS HYDROXYCHLOROQUINE TABS LARIAM TABS MALARONE TABS MEFLOQUINE HCL TABS QUINACRINE HCL POWD QUININE SULFATE	MC MC/DEL MC		ARALEN TABS PLAQUENIL TABS ISONARIF ¹	Use PA Form # 20420 1. Ingredients available as preferred without PA.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANTHELMINTICS	MC/DEL MC MC/DEL MC/DEL	ALBENZA TABS BILTRICIDE TABS MEBENDAZOLE CHEW STROMECTOL TABS	MC		VERMOX CHEW	Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANTIBIOTICS - MISC.	MC MC MC MC/DEL MC MC MC/DEL MC MC/DEL	AZACTAM SOLR COLISTIMETHATE SODIUM SOLR FUROXONE TABS METRONIDAZOLE ² PENTAMIDINE ISETHIONATE SOLR PRIMSOL SOLN TRIMETHOPRIM TABS VANCOCIN HCL VANCOMYCIN HCL	MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC MC		COLY-MYCIN-M SOLR FLAGYL CAPS FLAGYL TABS FLAGYL ER TBCR KETEK LORABID METRONIDAZOLE 375MG CAPS ² METRONIDAZOLE 750MG TABS ² NEBUPENT SOLR PROLOPRIM TABS TINDAMAX ¹ XIFAXAN	1. Need to fail other anti-protozoals 2. 375mg caps and 750mg tabs are non-preferred. Please use available preferred strengths(250mg & 500mg tabs) to obtain required dose 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. 1. For macrolide resistant infections when quinolones inappropriate
CARBAPENEMS			MC MC MC/DEL		INVANZ SOLR MERRER SOLR PRIMAXIN		Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
LINCOSAMIDES / OXAZOLIDINONES / LEPROSTATICS	MC/DEL MC/DEL MC/DEL MC	CLEOCIN SOLN CLEOCIN SUSR CLINDAMYCIN HCL 150CAPS DAPSONE TABS	MC/DEL MC/DEL MC/DEL MC/DEL		CLEOCIN CAPS CLINDAMYCIN HCL 300CAPS ¹ ZYVOX SUSR ZYVOX TABS	1. Use multiple 150's for Clindamycin instead of 300's. Zyvox: use PA Form # 30820 Others: use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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, please see the criteria listed in the Zyvox PA form.
ANTI INFECTIVE COMBO'S - MISC.	MC/DEL MC/DEL MC/DEL MC/DEL	ERYTHROMYCIN/SULF SUSR SEPTRA/DS TABS SULFAMETHOXAZOLE/TRIMETH TRIMETHOPRIM/SULFAMETHOXA	MC MC		ALINIA* BACTRIM DS TABS	* Alina is preferred for children less than 12 years of age. Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANTI - FUNGALS							
ANTIFUNGALS - ASSORTED	MC MC/DEL MC MC MC MC/DEL MC/DEL	ANCOBON CAPS FLUCONAZOLE ¹ GRIFULVIN GRISEOFULVIN ULTRAMICROSI TABS GRIS-PEG TABS KETOCONAZOLE TABS NYSTATIN	MC/DEL MC MC MC MC/DEL MC	5 5 5 6 8 8	LAMISIL TABS SPORANOX SOLN ² SPORANOX PULSEPAK CAPS ³ SPORANOX CAPS ³ DIFLUCAN NIZORAL TABS	1. QL--1/every 7-day period (150mg only). 2. Sporanox QL 300cc/month with PA. See quantity limit table. 3. Sporanox QL 30/month with PA. See quantity limit table. Non-preferred products must be used in specified	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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		VFEND TABS				step order. Continue to use Anti-Fungal PA form for non-preferred products. Use PA Form # 10120	
ANTI - VIRALS								
ANTIRETROVIRALS	MC/DEL MC/DEL MC MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL MC MC/DEL MC MC/DEL MC MC/DEL MC MC/DEL MC/DEL MC MC/DEL MC MC/DEL MC MC MC/DEL		AGENERASE CAPS APTIVUS ATRIPLA ¹ COMBIVIR TABS CRIXIVAN CAPS EMTRIVA EPIVIR / HBV EPZICOM FORTOVASE CAPS HIVID TABS INVIRASE CAPS KALETRA LEXIVA NORVIR PREZISTA ² RESCRIPTOR TABS RETROVIR REYATAZ SUSTIVA TRIZIVIR TABS TRUVADA VIDEX / EC VIRACEPT TABS VIRAMUNE TABS VIREAD TABS ZERIT ZIAGEN TABS	MC/DEL MC/DEL		DIDANOSINE FUZEON	Fuzeon use PA Form # 10620	Please refer to the criteria listed on the Fuzeon PA form.
							1. Quantity limit of one per day 2. Only preferred if Norvir script is in member's profile within the past 30 days of filling Prezista	
CYTO-MEGALOVIRUS AGENTS	MC/DEL MC		GANCICLOVIR VALCYTE TABS	MC		CYTOVENE 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.
IMMUNE SERUMS								
IMMUNE SERUMS			HYPERRHO INJ					
HEPATITIS AGENTS								
HEPATITIS C AGENTS	MC/DEL MC/DEL MC/DEL		PEG-INTRON KIT REBETRON KIT REBETOL CAPS	MC/DEL MC/DEL MC	8 8 8 8	COPEGUS TABS PEGASYS KIT PEGASYS SOLN RIBAVIRIN 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 (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.
HEPATITIS AGENTS - MISC.				MC		ACTIMMUNE	Use PA Form # 20420	Approved for chronic granulomatous disease, osteopetrosis and idiopathic pulmonary fibrosis.
HEPATITIS B ONLY	MC		HEPSERA TABS	MC		BARACLUDE		
HERPES AGENTS	MC/DEL MC/DEL		ACYCLOVIR VALTREX TABS	MC/DEL MC/DEL		FAMVIR TABS ZOVIRAX	Must fail Acyclovir and Valtrex before non-preferred products. Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (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/DEL MC		FLUMADINE TABS FLUMIST ²	1. Tamiflu 10 caps or 60cc's per month. 2. Flumist Use Form # 10610. Others Use PA Form # 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.
RSV PROPHYLAXIS								
RSV PROPHYLAXIS				MC MC		RESPIGAM SYNAGIS	Use PA Form # 30120	Please see the criteria listed on the Synagis PA form.
MS TREATMENTS								
MULTIPLE SCLEROSIS AGENTS				MC MC/DEL MC MC/DEL	5 5 5 6	AVONEX KIT BETASERON SOLR REBIF SOLN COPAXONE	Established users grandfathered. Must follow specified step order. 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.
ASSORTED NEUROLOGICS								
NEUROLOGICS - MISC.	MC MC/DEL MC		MESTINON ORAP TABS PROSTIGMIN TABS	MC MC/DEL		BOTOX MYOBLOC ¹	1. Myobloc approval will be limited to Cervical Dystonia. Use PA Form #10210	Failed/did not tolerate therapeutic trials for muscle relaxants, unless contraindicated, including but not limited to baclofen, cyclobenzaprine, orphenadrine, Skelaxin, and tizanidine.
STEROIDS								
GLUCOCORTICOIDS/ MINERALOCORTICOIDS	MC MC/DEL MC/DEL MC/DEL		CELESTONE SUSP CORTEF 5 CORTISONE ACETATE TABS DELTASONE TABS	MC MC MC/DEL MC/DEL		CORTEF 10 and 20 TABS DECADRON TABS FLORINEF TABS MEDROL 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		DEPO-MEDROL SUSP	MC		MEDROL DOSEPAK TABS		
	MC/DEL		DEXAMETHASONE	MC		PEDIAPRED LIQD		
	MC/DEL		ENTOCORT EC CP24	MC		PREDNISONE INTENSOL CONC		
	MC/DEL		FLUDROCORTISONE ACETATE TABS	MC		PRELONE SYRP		
	MC/DEL		HYDROCORTISONE	MC		STERAPRED TABS		
	MC		KENALOG					
	MC/DEL		METHYLPREDNISOLONE TABS					
	MC		ORAPRED SOLN					
	MC/DEL		PREDNISOLONE					
	MC/DEL		PREDNISONE					
	MC/DEL		SOLU-CORTEF SOLR					
	MC/DEL		SOLU-MEDROL SOLR					
HORMONE REPLACEMENT THERAPIES								
ANDROGENS / ANABOLICS	MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC MC		ANDRODERM PT24 ANDROID CAPS DANAZOL CAPS DEPO-TESTOSTERONE OIL FLUOXYMESTERONE TABS TESTODERM TESTOSTERONE PROPIONATE TESTRED CAPS WINSTROL TABS	MC MC/DEL MC MC MC/DEL MC/DEL		ANDRO LA 200 OIL ANDROGEL PACK DELATESTRYL OIL HALOTESTIN TABS METHITEST TABS OXANDRIN TABS ¹	Use PA Form # 20420 1. Non-preferred effective 12.01.05. Use the Oxandrin PA Form #20600	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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)
ESTROGENS - PATCHES	MC/DEL MC/DEL		ESTRADERM PTTW VIVELLE PTTW	MC/DEL MC/DEL MC/DEL MC MC/DEL	5 8 8 8 8	ESTRADIOL PTTW ALORA PTTW CLIMARA PTTW ESCLIM PTTW VIVELLE-DOT PTTW	All patches are non-preferred products (require PA). Products must be used in specified step order. Use PA Form # 20420	Approved for failures on multiple oral estrogen agents after 90 day trials or if unable to swallow any oral medication.
ESTROGENS - TABS	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		CENESTIN TABS DELESTROGEN OIL ESTRADIOL ESTROPIPATE TABS MENEST TABS PREMARIN TABS	MC/DEL MC MC/DEL MC		ESTRACE TABS ESTRATAB TABS OGEN TABS ORTHO-EST TABS	Must fail preferred products before non-preferred products. Use PA Form # 20420	Preferred drugs must be tried for at least 90 days and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ESTROGEN COMBO'S	MC/DEL MC/DEL		PREMPHASE TABS PREMPRO TABS	MC/DEL MC/DEL MC/DEL MC/DEL		ACTIVELLA TABS COMBIPATCH PTTW FEMHRT 1/5 TABS ORTHO-PREFEST TABS SYNTEST H.S. TABS	Must fail Premphase and Prempro products before non preferred products. Use PA Form # 20420	Preferred drugs must be tried for at least 90 days and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
PROGESTINS	MC/DEL MC/DEL MC		MEDROXYPROGESTERONE ACETA ² NORETHINDRONE ACETATE TABS ¹ PROGESTERONE POWD	MC/DEL MC MC/DEL MC/DEL		AYGESTIN TABS CYCRIN TABS PROMETRIUM 100MG CAPS ¹ PROMETRIUM 200MG ¹ PROVERA TABS	1. PA approvals will require two 100 mg caps instead of one 200mg. 2. Must fail Medroxyprogesterone and Norethidrone products before non-preferred products. Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
CONTRACEPTIVES								
CONTRACEPTIVES - PROGESTIN ONLY	MC		ORTHO MICRONOR TABS	MC/DEL MC/DEL MC/DEL		CAMILA TABS NORA-BE TABS NOR-QD TABS OVRETTE 28 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.
CONTRACEPTIVES - INJECTABLE	MC/DEL		DEPO-PROVERA SUSP	MC/DEL MC/DEL		LUNELLE SUSP MEDROXYPROGESTERONE ACETATE IM	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		PLAN - B ¹				1. Allowed 4 tablets per 30 days without PA	
CONTRACEPTIVES - PATCHES/ VAGINAL PRODUCTS	MC		ORTHO EVRA PTTW ²	MC/DEL		NUVARING RING	1.No PA required for users less than 21 years of age. 2. The FDA has issued a public health warning of the potentials for increased exposure to estrogen with Ortho Eva use, possibly up to 60% estrogen exposure Use PA Form # 20420	Approved if adequate clinical reason given why patient unable to comply with other preferred agents including long acting injectable.
CONTRACEPTIVES - MONOPHASIC COMBINATION	MC/DEL MC/DEL		ALESSE-28 TABS DESOGEN TABS	MC/DEL MC/DEL		APRI TABS AVIANE TABS	Loestrin FE and FE 1/20 are grandfathered for established use. If member	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a 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	AVANDAMET TABS			upcoming DUR meeting.		
DIABETIC - / THIAZOL	MC/DEL MC/DEL MC/DEL	AVANDIA TABS ³ ACTOS 15MG TABS ¹ ACTOS 45MG TABS ¹	MC/DEL		ACTOS 30MG TABS ²	1. Actos and Avandia preferred without PA if patient on insulin or sulfonylurea or metformin. Avandia non-preferred as monotherapy. 2. Actos 30mg - use two 15mg instead. Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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 - ALPHAGLUCOSIDASE	MC/DEL	GLYSET TABS	MC		PRECOSE TABS	Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
DIABETIC - SULFONYLUREA / BIGUANIDE	MC/DEL	GLYBURIDE/METFORMIN	MC MC		GLUCOVANCE TABS METAGLIP TABS	Use individual ingredients. Use PA Form # 20420	Approved for patients failing to achieve good diabetic control with maximal doses of individual components.
DIABETIC - MEGLITINIDES	MC/DEL	STARLIX TABS	MC/DEL		PRANDIN TABS	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.
THYROID							
THYROID HORMONES	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		LEVOTHYROXINE SODIUM SOLR SYNTHROID TABS 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.
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							
OSTEOPOROSIS	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL	ACTONEL TABS FOSAMAX SOLN ² FOSAMAX TABS ³ FOSAMAX PLUS D ² MIACALCIN SOLN ²	MC MC/DEL MC/DEL MC MC		AREDIA SOLR BONIVA DIDRONEL TABS EVISta TABS ¹ FORTEO	1. Approval only requires failure of Fosamax or Actonel. Use PA Form # 20420 2. Quantity Limits Apply	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
CALCIMIMETIC AGENTS							
CALCIMIMETIC AGENTS			MC		SENSIPAR	Use PA Form # 30115	Baseline PTH, Ca, and phosphorus 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 MC/DEL MC MC/DEL MC	5 5 6 8 8 8	GENOTROPIN TEV-TROPIN NUTROPIN HUMATROPE SOLR NORDITROPIN CARTRIDGE SOLN SAIZEN SOLR	Products must be used in specified step order. Use PA Form # 10710	See Growth Hormone PA form for criteria. Step-order will still apply unless clinical contraindication supplied.
SOMATOSTATIC AGENTS	MC/DEL	SANDOSTATIN					
GROWTH HORMONE ANTAGONISTS							
GH ANTAGONISTS			MC		SOMAVERT	Use PA Form # 10710	Approved for acromegaly patients failing surgery/radiation/drug therapy including bromocriptine and sandostatatin.
URINARY INCONTINENCE							
VASOPRESSINS		DESMOPRESSIN TABS	MC/DEL MC/DEL MC MC/DEL MC/DEL	5 6 6 8 8	DDAVP TABS DDAVP SOLN DESMOPRESSIN SPRAY DESMOPRESSIN ACETATE SOLN STIMATE SOLN*	Products must be used in specified step order. Nocturnal enuresis patients will be encouraged to periodically attempt stopping DDAVP. 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). * Patients with a diagnosis of hemophilia or Von Willebrands disease will be exempt from prior authorization.
ANTISPASMODICS	MC/DEL MC	OXYBUTYNIN URISPAS TABS	MC/DEL MC/DEL MC/DEL		CYSTOSPAZ TABS DETROL TABS DITROPAN	Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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 MC/DEL MC	DETROL LA CP24 DITROPAN XL TBCR ENABLEX ¹ VESICARE ¹	MC/DEL MC MC		OXYTROL SANCTURA	Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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, Biaxin, Nefazodone, Nelfinavir, and Ritonavir)
CHOLINERGIC	MC/DEL	URECHOLINE					
METABOLIC MODIFIER							
HERED. TYROSINEMIA			MC		ORFADIN	Use PA Form # 20420	Approved for Type 1 hereditary tyrosinemia patients. Must include laboratory evidence of dx at first PA.
ANTIHYPERTENSIVES / CARDIAC							
CARDIAC GLYCOSIDES	MC/DEL MC/DEL MC/DEL	DIGITEK TABS DIGOXIN LANOXICAPS					

	MC/DEL		LANOXIN				
ANTIANGINALS--Isosorbide Dinitrate/ Mono-Nitrates	MC/DEL MC/DEL		ISOSORBIDE MONONITRATE TABS ISOSORBIDE MONONITRATE ER	MC MC MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC		DILATRATE SR CPCR ISORDIL TABS ISORDIL TITRADOSE TABS ISOSORBIDE DINITRATE SUBL ISOSORBIDE DINITRATE TABS ISOSORBIDE DINITRATE CR TBCR ISOSORBIDE DINITRATE ER TBCR ISOSORBIDE DINITRATE TD TBCR IMDUR TB24 ISMO TABS MONOKET TABS	Use PA Form # 20420 Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
NITRO - OINTMENT/CAP/CR	MC MC/DEL MC MC		NITROBID OINT NITROGLYCERIN CPCR NITROL OINT NITRO-TIME CPCR				
NITRO - PATCHES	MC/DEL MC/DEL MC/DEL MC/DEL	1 1 1 3	NITROGLYCERIN PT24 NITREK PT24 NITRO-DUR PT 24 0.8MG MINITRAN PT24	MC MC/DEL		NITRODISC PT24 NITRO-DUR PT24	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.
NITRO - SUBLINGUAL/ SPRAY	MC MC/DEL MC/DEL		NITROLINGUAL AERS NITROSTAT SUBL NITROTAB SUBL	MC MC/DEL		NITROLINGUAL SOLN 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.
BETA BLOCKERS - NON SELECTIVE	MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		COREG TABS INDERAL LA CPCR LEVATOL TABS NADOLOL TABS PINDOLOL TABS PROPRANOLOL HCL SOLN ¹ PROPRANOLOL HCL TABS ¹ SOTALOL HCL TABS TIMOLOL MALEATE TABS	MC/DEL MC MC/DEL MC/DEL MC MC/DEL MC		BETAPACE TABS BETAPACE AF TABS CORCARD TABS INDERAL TABS INNOPRAN XL PROPRANOLOL HCL LA CPCR RANEXA	1. Recommend using BID since its effects do not last 24 hours. Use PA Form # 20420 Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
BETA BLOCKERS - CARDIO SELECTIVE	MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL		ACEBUTOLOL HCL CAPS ATENOLOL TABS ¹ BETAXOLOL HCL TABS BISOPROLOL FUMARATE TABS METOPROLOL TARTRATE TABS ¹ TOPROL XL TB24	MC MC/DEL MC MC/DEL MC/DEL		KERLONE TABS LOPRESSOR TABS SECTRAL CAPS TENORMIN TABS ZEBETA TABS	1. Recommend using Atenolo (and metoprolol) BID since its effects do not last 24 hours. Use PA Form # 20420 Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
BETA BLOCKERS - ALPHA / BETA	MC/DEL		LABETALOL HCL TABS	MC		TRANDATE TABS	Use PA Form # 20420 Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
CALCIUM CHANNEL BLOCKERS--Amlodipines, Bepridil, Diltiazems, Felodipines, Isradipines, Nifedipines, Nisoldipine, and Verapamils	MC/DEL MC MC MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL	1 1 1 1 1 1 4 4 4 4	NORVASC TABS CARDIZEM LA TB24 DILTIA XT CP24 DILTIAZEM HCL ER CP24 DILTIAZEM HCL XR CP24 DILTIAZEM CD 300MG CP24 DILTIAZEM CD 360MG CP24 CARTIA XT CP24 DILTIAZEM CD CP24 DILTIAZEM HCL ER CP24 DILTIAZEM XR CP24	MC MC MC/DEL MC/DEL MC MC MC/DEL MC/DEL		DILACOR XR CP24 TAZTIA TIAZAC CP24 CARDIZEM TABS CARDIZEM CD CP24 CARDIZEM SR CP12 DILTIAZEM HCL TABS DILTIAZEM HCL ER CP12	Products must be used in specified order or PA will be required. Just write "Cardizem LA" or "Diltiazem 24-hour" and the pharmacy will use a preferred long acting diltiazem that does not require PA. Use PA Form # 20420 Preferred drugs must be tried and failed (in step-order) due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
				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 MC		DYNACIRC CAPS DYNACIRC CR TBCR ¹	Use PA Form # 20420 1. Established users will be grandfathered Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
				MC/DEL MC/DEL MC/DEL		CARDENE CAPS CARDENE SR CPCR NICARDIPINE HCL CAPS	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 MC/DEL MC/DEL MC/DEL MC/DEL MC		AFEDITAB CR NIFEDIAC CC NIFEDICAL XL TBCR NIFEDIPINE TBCR NIFEDIPINE CAPS NIFEDIPINE ER TBCR SULAR TB24	MC MC/DEL MC MC/DEL MC/DEL MC/DEL		ADALAT CC TBCR NIFEDIPINE CAPS PROCARDIA CAPS PROCARDIA XL TBCR	Established users of Adalat CC are grandfathered. Use PA Form # 20420 Preferred drug must be tried and failed in step order due to lack of efficacy or intolerable side effects before non-preferred drugs in step order will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL	1	VERAPAMIL HCL CR TBCR	MC/DEL		CALAN TABS	Products must be used in 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

	MC/DEL MC/DEL MC	1 1 1	VERAPAMIL HCL ER TBCR VERAPAMIL HCL SR TBCR VERELAN PM CP24	MC/DEL MC/DEL MC MC MC MC	CALAN SR TBCR COVERA-HS TBCR ISOPTIN-SR VERAPAMIL HCL ER CP24 VERAPAMIL HCL SR CP24 VERAPAMIL HCL TABS VERELAN CP24	specified order or PA will be required. Just write "Verapamil 24-hour" and the pharmacy will use a preferred long acting generic that does not require PA. Use PA Form # 20420	exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANTIARRHYTHMICS	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL MC MC/DEL		AMIODARONE MEXILETINE NORPACE PROCAINAMIDE PROCANBID CR PROPAFENONE QUINAGLUTE QUINIDINE GLUCONATE QUINIDINE SULFATE RYTHMOL TAMBOCOR	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL MC MC/DEL	CORDARONE DISOPYRAMIDE FLECAINIDE MEXITIL PACERONE QUINIDEX TIKOSYN ¹	1. Prescription must be written by Cardiologist. Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ACE INHIBITORS	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		BENAZEPRIL HCL CAPTOPRIL TABS ENALAPRIL MALEATE TABS FOSINOPRIL SODIUM LISINAPRIL TABS	MC MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL MC MC/DEL MC MC/DEL MC MC/DEL	5 MAVIK TABS 5 ACCUPRIL TABS 8 ACEON TABS 8 ALTACE CAPS 8 CAPOTEN TABS 8 LOTENSIN TABS 8 MOEXIPRIL 8 MONOPRIL HCT TABS 8 PRINIVIL TABS 8 UNIVASC 8 VASOTEC TABS 8 ZESTRIL TABS	Non-preferred products must be used in specified order. Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs (in step-order) will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Non-preferred products are subject to step-order requirements unless clinical circumstances warrant exception.
ANGIOTENSIN RECEPTOR BLOCKER	MC/DEL MC/DEL MC/DEL MC/DEL MC		BENICAR TABS COZAAR TABS DIOVAN MICARDIS TABS TEVETEN TABS	MC/DEL MC MC MC MC	ATA CAND TABS AVAPRO	Preferred products only available without PA if patient on diabetic therapy or prior ACE therapy. Use PA Form # 20420	The initial criteria to use any ARB is that the member must have failed ACE inhibitors (such as due to coughing) in the past or must currently be actively treated for diabetes and Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANTIHYPERTENSIVES - CENTRAL	MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL		CATAPRES-TTS CLONIDINE HCL TABS GUANFACINE HCL TABS HYDRALAZINE HCL TABS HYLOREL TABS METHYLDOPA TABS MINOXIDIL TABS PRAZOSIN HCL CAPS RESERPINE TABS	MC/DEL MC MC MC MC MC/DEL MC MC/DEL MC/DEL	CATAPRES TABS GUANABENZ ACETATE TABS ISMELIN TABS MINIPRESS CAPS TENEX TABS	Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ACE INHIBITORS AND CA CHANNEL BLOCKERS	MC/DEL MC		LOTREL CAPS TARKA TBCR	MC/DEL MC	LEXSEL TBCR	Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ACE AND THIAZIDE COMBO'S	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		BENAZEPRIL HCL/HYDROCHLOR CAPTOPRIL/HYDROCHLOROTHIA ENALAPRIL MALEATE/HCTZ TABS LISINAPRIL-HCTZ TABS UNIRETIC TABS	MC/DEL MC MC/DEL MC MC MC/DEL	ACCURETIC TABS CAPOZIDE TABS LOTENSIN HCT TABS MONOPRIL HCT TABS PRINZIDE TABS VASERETIC TABS ZESTORETIC TABS	Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
BETA BLOCKERS AND DIURETIC COMBO'S	MC/DEL MC/DEL MC/DEL		ATENOLOL/CHLORTHALIDONE BISOPROLOL FUMARATE/HCTZ PROPRANOLOL/HCTZ	MC MC/DEL MC/DEL MC MC MC/DEL	CORZIDE TABS INDERIDE 40/25 TABS LOPRESSOR HCT TABS TENORETIC TIMOLIDE 10/25 TABS ZIAC TABS	Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ARB'S AND DIURETICS	MC MC/DEL MC/DEL MC/DEL MC/DEL MC		AVALIDE TABS BENICAR HCT DIOVAN HCT TABS HYZAAR TABS MICARDIS HCT TABS TEVETEN HCT TABS	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC	ATA CAND HCT TABS	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.
DIURETICS	MC/DEL MC MC/DEL MC/DEL MC/DEL		ACETAZOLAMIDE TABS AMILORIDE HCL BUMETANIDE CHLOROTHIAZIDE TABS CHLORTHALIDONE TABS	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL	ALDACTAZIDE TABS ALDACTONE TABS BUMEX TABS DEMADEX TABS DIAMOX	1. Multiples of Spironolactone 25 mg are cheaper than 50 mg strength. Inspra will be approved for severe breast tenderness and male gynecomastia.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.

	MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC	EDECIN TABS FUROSEMIDE HYDROCHLOROTHIAZIDE INDAPAMIDE TABS METHAZOLAMIDE TABS METHYLCLOTHIAZIDE TABS SPIRONOLACTONE 25MG TABS SPIRONOLACTONE/HYDRO TORSEMIDE TABS TRIAMTERENE/HCTZ ZAROXOLYN TABS	MC/DEL MC/DEL MC MC MC/DEL MC MC/DEL MC MC MC MC/DEL	DIURIL DYAZIDE CAPS ENDURON TABS INSPRA LASIX TABS LOZOL TABS MAXZIDE MICROZIDE CAPS MIDAMOR TABS MODURETIC 5-50 TABS NAQUA TABS NATURETIN TABS SPIRONOLACTONE 50MG ¹	Use PA Form # 20420	
CCB / LIPID	MC/DEL	CADUET				
LIPID DRUGS						
CHOLESTEROL - BILE SEQUESTRANTS	MC/DEL MC/DEL	CHOLESTYRAMINE COLESTID	MC/DEL MC MC/DEL	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 MC/DEL MC	GEMFIBROZIL TABS TRIGLIDE NIASPAN TRICOR	MC MC MC MC	ANTARA LOPID LOFIBRA	Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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 - HGM COA + ABSORB INHIBITORS	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC MC MC/DEL	ADVICOR TBCR ALTOPREV TB 24 CRESTOR LIPITOR TABS LESCOL CAPS LESCOL XL TB24 LOVASTATIN TABS VYTORIN ZETIA TABS ¹ ZOCOR TABS	MC/DEL MC MC/DEL MC/DEL MC/DEL MC MC MC/DEL	MEVACOR TABS PRAVACHOL TABS PRAVIGARD PRAVASTATIN	1. Zetia available w/OPA as addition to Zocor 80mg, Lipitor 80mg, or Crestor 40mg. Zetia will also be approved with a PA as add on for patients at maximally tolerated doses of statins. Zocor patients trying to use Zetia must use Vytorin instead. Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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.
PULMONARY ANTI-HYPERTENSIVES						
PULMONARY ANTI-HYPERTENSIVES	MC/DEL MC	REVATIO ¹ VENTAVIS ²	MC/DEL MC	FLOLAN TRACLEER	Use PA Form # 20420	Flolan and Tracleer will be approved after the dx of pulmonary hypertension is confirmed. 1. Revatio approvals will require WHO Group 1 diagnosis of primary PAH (Primary Pulmonary Hypertension) and NYHA functional class 2,3, or 4. 2. Ventavis approvals will require WHO Group 1 diagnosis of primary PAH (Primary Pulmonary Hypertension) and NYHA functional class 3 or 4.
IMPOTENCE AGENTS						
IMPOTENCE AGENTS				9 CAVERJECT 9 CIALIS 9 EDEX 9 LEVITRA 9 MUSE 9 VIAGRA 9 YOHIMBINE HCL TABS	As of January 1, 2006, per CMS (federal govt.), impotence agents are no longer covered.	
ANTI-EMETOGENICS						
ANTIEMETIC - ANTICHOLINERGIC / DOPAMINERGIC	MC/DEL MC/DEL MC/DEL MC/DEL MC	MECLIZINE HCL TABS PHENERGAN SUPP PHENERGAN FORTIS SYRP PROMETHAZINE SUPP PROMETHAZINE TRANSDERM-SCOP PT72	MC MC/DEL MC/DEL MC/DEL MC	ANTIVERT TABS PHENERGAN SOLN PHENERGAN TABS PROMETHEGAN SUPP TORECAN TABS	Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANTIEMETIC - 5-HT3 RECEPTOR ANTAGONISTS/ SUBSTANCE P NEUROKININ	MC MC/DEL MC/DEL MC/DEL MC/DEL	EMEND MARINOL CAPS ZOFRAN SOLN* ZOFRAN TABS* ZOFRAN ODT TBPDP*	MC MC MC/DEL	ALOXI ANZEMET TABS KYTRIL	*See quantity limit table. Zofran: use PA Form # 30810 Others: use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. * Zofran limits still apply as listed on the Zofran 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.
NON-SEDATING ANTIHISTAMINES / DECONGESTANTS						
ANTIHISTIMINES - NON-SEDATING	MC MC MC MC/DEL	ALAVERT TABS ¹ CLARITIN ALLERGY (OTC) ¹ CLARITIN SYRP (OTC) ² TAVIST ND (OTC) ¹	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL	5 CLARINEX TABS ² 5 CLARINEX SYR ³ 5 ZYRTEC ³ 8 ALLEGRA 8 CLARITIN ²	1. Preferred drugs are OTC loratidines. 2. Claritin OTC syrup does not require a PA. 3. Clarinex and Zyrtec syrup <6 yr w/o PA. Must fail previous tabs and Zyrtec	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

				9	FEXOFENADINE	Claritin tablets and Zyrtec products before moving to next step product without PA. Pseudoephedrine is available with prescription. Use PA Form # 20530	product with decongestant will be approved since pseudoephedrine available without PA.
ALLERGY / ASTHMA THERAPIES							
ANTIASTHMATIC - ANTICHOLINERGICS - INHALER	MC/DEL MC MC				ATROVENT AERS ATROVENT HFA SPIRIVA ¹	Use PA Form # 20420 1. Quantity limit of 1 inhalation daily (1 capsule for inhalation daily)	
ANTIASTHMATIC - ANTICHOLINERGICS - NEBULIZER	MC/DEL			MC	IPRATROPIUM BROMIDE SOLN	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 MC/DEL MC/DEL			MC/DEL	CROMOLYN SODIUM NEBU INTAL AERS TILADE AERS	XOLAIR ¹	1. Need max inhaled steroids and written by pulmonary or allergy specialist. Use PA Form # 20420 Xolair approval will require suboptimal response to maximal doses of inhaled steroid as evidenced by asthmatic ER/Hospital admissions and Allergy/Pulmonary specialist management.
ANTIASTHMATIC - NASAL STEROIDS	MC/DEL MC/DEL MC MC/DEL MC	1 1 4 4 4		MC/DEL MC MC/DEL MC MC/DEL MC MC	FLONASE SUSP ¹ NASONEX SUSP ¹ BECONASE AERS BECONASE AQ INHA NASAREL SOLN	FLUNISOLIDE SOLN NASACORT AERS NASACORT AQ AERS RHINOCORT AERO RHINOCORT AQUA SUSP TRI-NASAL SOLN VANCENASE POCKETHALER AERS	Use PA Form # 20420 Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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 - NASAL MISC.	MC/DEL			MC MC MC/DEL	NASALCROM	ATROVENT NASAL SOL IPRATROPIUM NASAL SOL ¹ ASTELIN	1. Ipratropium will be approved if submitted with documentation supporting use of CPAP machine. Use PA Form # 20420 Approved if patient fails on non-sedating antihistamines and steroid nasal sprays. Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANTIASTHMATIC - BETA - ADRENERGICS	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL			MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC MC MC/DEL	ALBUTEROL NEB FORADIL AEROLIZER CAPS MAXAIR METAPROTERENOL SEREVENT TERBUTALINE SULFATE TABS XOPENEX HFA	ACCUNE ¹ NEBU ALBUTEROL AER ² ALBUTEROL HFA ALUPENT AERP BRETHINE PROVENTIL PROVENTIL HFA AERS VENTOLIN AERS VENTOLIN HFA AERS VOLMAX TBCR VOSPIRE ER TB12 XOPENEX NEBU ²	1. Xopenex users w/ prior asthma hospitalization due to albuterol nebulizer failure will be grandfathered. 2. Quantity Limit: 12 cc/day. 3. Established users of albuterol prior to 05/01/2006 will have until 06/30/2006 to transition over to preferred Xopenex HFA. Use PA Form # 20420 Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANTIASTHMATIC - ADRENERGIC COMBINATIONS	MC/DEL				ADVAIR DISKUS MISC		Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Duoneb components are available separately without PA.
ANTIASTHMATIC - ADRENERGIC ANTICHOLINERGIC	MC/DEL			MC/DEL	COMBIVENT AERO	DUONEB SOLN ¹	1. Please use preferred individual ingredients Albuterol and Ipratropium. Use PA Form # 20420
ANTIASTHMATIC - XANTHINES	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL			MC MC MC MC/DEL MC MC/DEL MC	AMINOPHYLLINE TABS THEOCHRON TB12 THEOLAIR-SR TB12 THEOPHYLLINE ELIX THEOPHYLLINE SOLN THEOPHYLLINE ER CP12 THEOPHYLLINE ER TB12 UNIPHYL TBCR	QUIBRON CAPS QUIBRON-T TABS QUIBRON-T/SR TB12 THEO-24 CP24 THEOLAIR TABS THEOPHYLLINE CR TB12 T-PHYL TB12	Use PA Form 20420 Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANTIASTHMATIC - STEROID INHALANTS	MC/DEL MC/DEL MC/DEL MC MC/DEL MC MC			MC/DEL MC/DEL MC	AEROBID AERS ASMANEX AZMACORT AERS BECLOVENT AERS FLOVENT HFA PULMICORT SUSP ¹ QVAR AERS VANCERIL AERS	AEROBID-M AERS PULMICORT TURBUHALER AEP ² VANCERIL DOUBLE STRENGTH AERS	1. No PA for Pulmicort susp if under 8 years old 2. No PA for Pulmicort turbobaler if under 14 yr. Use PA Form # 20420 Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.

				MC	8	ZEGERID		
GI - ULCER ANTI-INFECTIVE	MC MC		HELIDAC PREVPAC					
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 MC/DEL		LACTAID ULTRA LACTRASE CAPS	MC MC MC/DEL MC MC/DEL MC/DEL MC MC/DEL MC MC/DEL MC MC/DEL MC MC/DEL MC	5 5 7 7 7 7 7 8 8 8 8 8 8 8 8 8	ULTRASE CPEP ULTRASE MT LIPRAM PANCREASE PANCRELIPASE PANGESTYME PANOKASE TABS CREON KUTRASE CAPS KU-ZYME CAPS LIPRAM CR PANCREASE MT PANCRECARB MS-8 CPEP VIOKASE	Non-preferred products are a one time PA for life (for CF diagnosis). Non-preferred products must be used in specified step order. 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. In all cases except cystic fibrosis patients, objective evidence 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 GASTROCROM CONC GENERLAC SYRP LACTULOSE SYRP METOCLOPRAMIDE HCL SIMETHICONE	MC/DEL MC MC MC/DEL MC/DEL MC/DEL MC/DEL		AMITIZA ¹ CEPHULAC SYRP GAS-X CHEW INFANTS GAS RELIEF SUSP REGLAN TABS	Diag codes no longer necessary for preferred products. Lactulose has 60cc/day QL Use PA Form # 20420 1. 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/DEL MC MC/DEL MC MC MC/DEL MC/DEL MC/DEL		ASACOL TBEC AZULFIDINE TABS AZULFIDINE EN-TABS TBEC CANASA SUPP COLAZAL CAPS DIPENTUM CAPS PENTASA CPCR ROWASA ENEM SULFASALAZINE TABS	MC/DEL MC MC/DEL MC MC MC/DEL MC/DEL		SULFAZINE EC TBEC	Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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 - IRRITABLE BOWEL SYNDROME AGENTS				MC/DEL MC/DEL		LOTROXEN TABS ZELNORM TABS	Use PA Form # 20420	Zelnorm will be approved for members under the age of 65 for chronic idiopathic constipation and for females with IBS and predominant constipation. 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.
MISCELLANEOUS GI								
Preferred drugs that used to require diag codes still require diag codes unless indicated otherwise.								
GI - MISC.	MC/DEL MC/DEL MC MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC MC/DEL MC/DEL MC/DEL MC MC/DEL MC MC/DEL MC/DEL MC MC/DEL MC MC/DEL MC/DEL MC MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL		BISAC-EVAC SUPP BISACODYL BISCOLAX SUPP CINOBAC CAPS CITRATE OF MAGNESIA SOLN CITRUCEL D.O.S. CAPS DIOCTO LIQD DIOCTO SYRP DIOCTYN CAPS DOC-Q-LACE CAPS DOCUSATE CALCIUM CAPS DOCUSATE SODIUM DOCUSIL CAPS DOK CAPS FIBER LAXATIVE TABS FLEET GENFIBER POWD GLYCERIN GLYCOLAX ¹ HIPREX TABS KRISTULOSE PACK METAMUCIL MILK OF MAGNESIA SUSP MINERAL OIL OIL SENNA SENOKOT GRAN SENOKOT SYRP	MC/DEL MC MC/DEL MC/DEL MC/DEL MC MC MC/DEL MC/DEL MC/DEL MC MC/DEL MC MC MC/DEL MC MC/DEL MC MC/DEL MC/DEL MC MC/DEL MC/DEL MC MC/DEL MC/DEL MC MC/DEL MC/DEL MC MC/DEL MC/DEL		ACTIGALL CAPS BENEFIBER CARAFATE 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 MALTSUPEX MIRALAX PACK MIRALAX POWD NULYTELY SOLR PEG 3350/ELECTROLYTES SOLR SENXON TABS SENOKOT TABS SENOKOT S TABS STOOL SOFTENER PLUS CAPS UNI-CENNA TABS UNI-EASE PLUS CAPS V-R NATURAL SENNA LAXATIV TABS	1. 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. 2. Must show evidence of trials of preferred agents that do not require PA, such as OTC senna, docusate, mineral oil and prescription lactulose. Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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		SENOKOT CHILDRENS SYRP				
	MC		SENOKOT XTRA TABS				
	MC/DEL		SORBITOL				
	MC/DEL		STOOL SOFTENER CAPS				
	MC/DEL		SUCRALFATE TABS				
	MC		UNI-EASE CAPS				
	MC		UNIFIBER POWD				
	MC		URSO FORTE				
	MC/DEL		URSODIOL				

MISC. UROLOGICAL

UROLOGICAL - MISC.	MC MC/DEL MC MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC MC MC/DEL MC/DEL MC/DEL MC MC MC/DEL MC MC MC/DEL MC MC/DEL		ACETIC ACID 0.25% SOLN BICITRA SOLN CYTRA-K SOLN FURADANTIN SUSP K-PHOS MF TABS MACRODANTIN CAPS METHENAMINE MANDELATE TABS MONUROL PACK NEOSPORIN GU IRRIGANT SOLN PHENAZOPYRIDINE HCL TABS POLYCITRA SYRP POLYCITRA-K SOLN POLYCITRA-LC SOLN PROSED/DS TABS PYRIDUM PLUS TABS RENACIDIN SOLN TRICITRATES SYRP UREX TABS URISED TABS UROCID-K UROQID #2 TABS	MC MC/DEL MC MC/DEL MC/DEL MC MC MC MC/DEL MC/DEL MC MC MC/DEL MC MC MC/DEL MC MC MC/DEL MC MC/DEL		CITRIC ACID/SODIUM CITRAT SOLN CYTRA-2 SOLN ELMIRON CAPS ¹ MACROBID CAPS MANDELAMINE TABS NITROFURANTOIN MACR CAPS POLYCITRA-K CRYSTALS PACK POTASSIUM CITRATE/CITRIC SOLN PYRIDUM TABS	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.
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PHOSPHATE BINDERS

PHOSPHATE BINDERS	MC MC/DEL		PHOSLO MEGNEBIND - 400	MC/DEL MC/DEL		FOSRENOL RENAGEL ^{1,2}	1. Renegel will be approved for hypercalcemia, digoxin users, and in cases where maximum phoslo doses are insufficient. 2. Will be verifying patient compliance. Labs must be provided. Please refer to the Phosphate Binders PA form. Use PA Form #20530	Renegel will be approved in patients with hypercalcemia, on concurrent digoxin or insufficient response with Phos-lo (Renegel to be add-on therapy).
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INTRA-VAGINALS

VAGINAL - ANTIBACTERIALS	MC/DEL MC/DEL MC/DEL	1 1 3	CLEOCIN CREA METROGEL VAGINAL GEL CLEOCIN SUPP				Step order must be followed to avoid PA. Must fail Cleocin and Metrogel products before moving to next step product without PA.	Preferred drugs must be tried and failed in step-order due to lack of efficacy or intolerable side effects before less preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
VAGINAL - ANTI FUNGALS	MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL MC MC MC MC MC/DEL MC MC		CLOTRIMAZOLE CREA GYNE-LOTRIMIN CREA MICONAZOLE CREA MICONAZOLE 3 COMBO PACK KIT ¹ MICONAZOLE 7 CREA MICONAZOLE NITRATE CREA MONISTAT 1 OINT MONISTAT 3 CREA MONISTAT 7 NYSTATIN TABS TERCONAZOLE 0.4MG VAGITROL V-R MICONAZOLE-7 CREA	MC MC MC MC/DEL MC MC MC MC MC MC/DEL		AVC CREAM CLOTRIMAZOLE 3 DAY CREA GYNAZOLE-1 CREA GYNE-LOTRIMIN 3 TABS MICONAZOLE 3 SUPP MONISTAT 3 SUPP TERAZOL 3 CREA TERAZOL 3 SUPP TERAZOL 7 CREA TERCONAZOLE 0.8MG	1. Quantity limit: 1script/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.
VAGINAL - CONTRACEPTIVES	MC		GYNOL II EXTRA STRENGTH GEL	MC		DELLEN FOAM	Use PA Form # 20420	Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drug will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
VAGINAL - ESTROGENS	MC/DEL MC/DEL		ESTRING RING PREMARIN CREA	MC/DEL MC/DEL		ESTRACE CREA VAGIFEM TABS	Must fail all preferred products before non-preferred. Use PA Form #	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.

	MC/DEL		TRIAZOLAM TABS	MC/DEL		RESTORIL CAPS		
SEDATIVE/HYPNOTICS - Non-Benzodiazepines	MC/DEL MC/DEL MC		LUNESTA ¹ MIRTAZAPINE TRAZODONE	MC/DEL MC/DEL MC/DEL MC/DEL	7 8 8 9	AMBIEN SONATA CAPS ROZEREM AMBIEN CR	Must fail all preferred products before non-preferred 1. Quantity Limit of 12 per 34 days. 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 and Sonata do 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 see Sedative/Hypnotic PA form.
ANTI-PSYCHOTICS								
ANTIPSYCHOTICS - ATYPICALS	MC MC/DEL MC/DEL MC/DEL MC MC		RISPERDAL GEODON SEROQUEL TABS ABILIFY TABS ZYPREXA TABS ZYPREXA ZYDIS TBDP	MC MC	8 8	RISPERDAL CONSA RISPERDAL M TAB	1. If prescribing 2 or more antipsychotics, PA will be required for both drugs, except if one is Clozapine. See Multiple Antipsychotic PA form #20440 2. All atypicals have dosing limitations and maximum daily doses. Please refer to dose consolidation table for any potential dosing limits. Maximum daily doses are as follows: Abilify- 30mg daily max Risperdal- 8mg daily max Seroquel- 800mg daily max Zyprexa- 30mg daily max Use PA form #10420 for requests exceeding these maximum daily doses.	Preferred drugs subject to step order must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Atypicals will be approved, subject to step-order, 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 . 4. Seroquel 25mg is available without PA if the following conditions are met: a.) Either 65 years of age or older or less than 18 years of age, b.) dosage is for 3 or more per day, c.) Seroquel 25mg is in the profile within the last 45 days.
ANTIPSYCHOTICS - SPECIAL ATYPICALS	MC/DEL		CLOZAPINE TABS	MC/DEL MC		CLOZARIL TABS FAZACLO	Use PA Form # 20420	Preferred generic drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred brand will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Patients previously stabilized on brand name drug will be approved.
ANTIPSYCHOTICS - TYPICAL	MC/DEL MC/DEL MC/DEL MC MC MC/DEL MC/DEL MC MC/DEL MC/DEL MC MC/DEL MC MC/DEL MC MC/DEL MC		CHLORPROMAZINE HCL FLUPHENAZINE DECANOATE FLUPHENAZINE HCL HALDOL HALOPERIDOL HALOPERIDOL DECANOATE SOLN HALOPERIDOL LACTATE SOLN LOXAPINE SUCCINATE CAPS LOXITANE-C CONC MOBAN TABS PERPHENAZINE PROCHLORPERAZINE SERENTIL THIORIDAZINE HCL THIOTHIXENE THORAZINE SUPP TRIFLUOPERAZINE HCL TABS	MC/DEL MC/DEL MC MC/DEL MC MC/DEL MC MC MC/DEL MC MC/DEL MC MC/DEL MC MC/DEL MC		COMPAZINE COMPRO SUPP HALDOL DECANOATE LOXITANE CAPS MELLARIL NAVANE CAPS PROLIXIN STELAZINE TABS THORAZINE	Use PA Form # 120420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
LITHIUM								
LITHIUM	MC/DEL MC/DEL MC/DEL MC/DEL		ESKALITH CAPS ESKALITH CR TBCR LITHIUM CARBONATE LITHIUM CITRATE SYRP					
COMBINATION - PSYCHOTHERAPEUTIC								
PSYCHOTHERAPEUTIC COMBINATION	MC/DEL MC/DEL		CHLORDIAZEPOXIDE/AMITRIPT PERPHENAZINE/AMITRIPTYLIN	MC	8	SYMBYAX	Use PA Form # 20420	Use individual components, which are currently available without a PA.
STIMULANTS								
STIMULANT - AMPHETAMINES SHORT ACTING	MC/DEL MC/DEL MC/DEL MC/DEL		ADDERALL TABS AMPHETAMINE SALT COMBO DEXEDRINE DEXTROAMPHET SULF TABS				Preferred stimulants will be available without PA if diagnosis of ADHD As per recent FDA alert, Adderall & Dexedrine should not be	

	MC/DEL		DEXTRSTAT TABS				used in patients with underlying heart defects since they may be at increased risk for sudden death. Stimulants have dosing limitations per strength and maximum daily doses. Please refer to dose consolidation table for any potential dosing limits per strength. Maximum daily doses are as follows: 50mg daily.	
STIMULANT - LONG ACTING AMPHETAMINES SALT	MC/DEL		ADDERALL XR CP24				Preferred stimulants will be available without PA if diagnosis of ADHD. 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. Stimulants have dosing limitations per strength and maximum daily doses. Please refer to dose consolidation table for any potential dosing limits per strength. Maximum daily doses are as follows: 50mg daily.	
LONG ACTING AMPHETAMINES	MC MC		DEXEDRINE CAP CR DEXTRAMPHET SULF CPCR				Preferred stimulants will be available without PA if diagnosis of ADHD. 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. Stimulants have dosing limitations per strength and maximum daily doses. Please refer to dose consolidation table for any potential dosing limits per strength. Maximum daily doses are as follows: 50mg daily.	
STIMULANT - METHYLPHENIDATE	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		FOCALIN TABS METADATE ER TBCR METHYLIN ER TBCR METHYLIN TABS METHYLIN SOL METHYLPHENIDATE HCL	MC MC/DEL		METHYLIN CHEWABLES RITALIN	Preferred stimulants will be available without PA if diagnosis of ADHD. Use PA Form # 20420 Stimulants have dosing limitations per strength and maximum daily doses. Please refer to dose consolidation table for any potential dosing limits per strength. Maximum daily doses are as follows: 72mg daily	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Please refer to General Criteria category E.
STIMULANT - METHYLPHENIDATE - LONG ACTING	MC MC		CONCERTA TBCR FOCALIN XR ¹	MC MC/DEL	5 8	METADATE CD CPCR RITALIN LA	Preferred stimulants will be available without PA if diagnosis of ADHD. Non-preferred products must be	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.

used in specified step order. Stimulants also have dosing limitations per strength and maximum daily doses. Please refer to dose consolidation table for any potential dosing limits per strength. 1. Available to those members needing sprinkles with diagnosis of ADHD. Use PA Form # 20420

STIMULANT - STIMULANT LIKE				MC MC MC/DEL MC MC	7 8 8 9 9	STRATTERA ^{1,2} CAFCIT SOLN PROVIGIL TABS DESOXYN TABS DESOXYN CR	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) 2. Strattera currently has dosing limitations allowing one tablet per day for all strengths if obtain approval. Please refer to PDL dosage consolidation chart. 3. Non-preferred products must be used in specified step order. Provigil: use PA Form # 20710; Others: use Pa Form # 20420	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
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ANTI-CATAPLECTIC AGENTS

PSYCHOTERAPEUTIC AGENTS MISC.				MC/DEL		XYREM SOL	Use PA Form #20710	
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WEIGHT LOSS

WEIGHT LOSS							No longer covered:	Weight loss drugs are not covered as permitted by Federal Medicaid regulations and Maine Medicaid (MaineCare) Policy.
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ALZHEIMER DISEASE

ALZHEIMER - Cholinomimetics/Others	MC MC/DEL MC/DEL		ARICEPT TABS ¹ EXELON ¹ NAMENDA ¹	MC MC MC	8 8 9	RAZADYNE REMINYL COGNEX CAPS	1. All new users need PA to establish dementia diagnosis and baseline mental status score. Must fail all preferred products before moving to non-preferred. Use PA Form #20420	Revatio approvals will require WHO group 1 diagnosis of primary PAH (primary pulmonary hypertension) and NYHA functional class 2, 3, or 4. 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.
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SMOKING CESSATION

NICOTINE PATCHES / TABLETS	MC/DEL		NICODERM CQ PT24				Bupropion SR 150 mg is available without a prior authorization.	OTC Nicotine products are covered by MaineCare Policy when they have been determined to be cost-effective. Only Nicoderm and the generic nicotine gums have received this designation as preferred. All other nicotine products (OTC & prescription) are non-preferred by MaineCare Policy. Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs (in step-order) will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Another version of Zyban, Bupropion SR (100 and 150mg) is available without PA. There will be a quantity limit of 3 months supply of nicotine products allowed per 12 months.
NICOTINE REPLACEMENT - OTHER	MC/DEL MC/DEL		NICOTINE POLACRILEX GUM NICORETTE GUM	MC/DEL MC/DEL MC/DEL	5	COMMIT LOZENGES ¹ NICOTROL INHALER NICOTROL NASAL SPRAY	Must fail all preferred products from smoking cessation category (Nicoderm patch and nicotine gum) before moving to non-preferred. Must use Non-preferred products in specified step order. 1. Will be available to patients unable to tolerate preferred products. Use PA Form # 20420	OTC Nicotine products are covered by MaineCare Policy when they have been determined to be cost-effective. Only Nicoderm and the generic nicotine gums have received this designation as preferred. All other nicotine products (OTC & prescription) are non-preferred by MaineCare Policy. Both preferred Nicotine gum and Nicoderm patch 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. There will be a quantity limit of 3 months supply of nicotine products allowed per 12 months.

ALCOHOL DETERRENTS

ALCOHOL DETERRENTS	MC MC MC/DEL		DISULFIRAM TABS ANTABUSE TABS NALTREXONE HCL TABS				1. Should only be used in conjunction with formal structured outpatient detoxification program	Preferred generic drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
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MC		CAMPRAL ¹			personalization program.	
MISCELLANEOUS ANALGESICS						
ANALGESICS - MISC.	MC	ACEPHEN SUPP	MC	ASPIR-81 TBEC	Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a 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	ACETAMIN TAB 325MG	MC	AXOCET CAPS		
	MC/DEL	ACETAMINOPHEN	MC	DOLOBID TABS		
	MC/DEL	ASPIRIN	MC	EASPRIN TBEC		
	MC/DEL	ASPIRIN EC	MC	EQUAGESIC TABS		
	MC/DEL	ASPIR-LOW TBEC	MC/DEL	ESGIC-PLUS		
	MC/DEL	BUFFERED ASPIRIN TABS	MC	EXCEDRIN TAB ASA FRE		
	MC/DEL	BUTAL/ASA/CAFF	MC/DEL	FIORICET TABS		
	MC/DEL	BUTALBITAL COMPOUND	MC	FIORINAL CAPS		
	MC/DEL	BUTALBITAL/ACET TABS	MC	FIORTAL CAPS		
	MC/DEL	BUTALBITAL/APAP CAPS	MC/DEL	FORTABS TABS		
	MC/DEL	BUTALBITAL/APAP/CAFFEINE	MC	PHRENILIN TABS		
	MC/DEL	CHILDRENS ASPIRIN CHEW	MC	PHRENILIN FORTE CAPS		
	MC/DEL	CHILDRENS PAIN RELIEVER	MC	TRILISATE LIQD		
	MC/DEL	CHOLINE MAGNESIUM TRISALI	MC	TRILISATE TABS		
	MC/DEL	DIFLUNISAL TABS	MC	ZEBUTAL CAPS		
	MC/DEL	ECOTRIN	MC	ZORPRIN TBEC		
	MC/DEL	FEVERALL SUPP				
	MC/DEL	GENAPAP				
	MC/DEL	GENEBS TABS				
	MC	HEADACHE FORMULA ADDED TABS				
	MC	INFANTAIRE SOLN				
	MC	INFANTS APAP SOLN				
	MC	INFANTS PAIN RELIEVER SUSP				
	MC/DEL	MAPAP				
	MC/DEL	PAIN RELIEVER				
	MC/DEL	Q-NOL TABS				
	MC/DEL	SALSALATE TABS				
	MC	TACTINAL EXTRA STRENGTH TABS				
	MC	TYLENOL				
	MC	V-R CHILDRENS ASPIRIN CHEW				
	MC	V-R NON-ASPIRIN TABS				
LONG ACTING NARCOTICS						
NARCOTICS - LONG ACTING	MC	AVINZA	MC	7 DURAGESIC PT72 ²	Non-preferred products must be used in specific order. 1. Duragesic 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	Preferred drugs (Avinza or morphine sulfate ER tab, Methadone or Methadose, & oxycodone ER) & step order drugs 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 (anti-nausea, 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 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 "allorov" to all products but Oxycotin. 9. Circumventing MaineCare prior authorization
	MC/DEL	METHADONE	MC/DEL	8 ORAMORPH SR TB12		
	MC/DEL	METHADOSE	MC/DEL	8 MORPHINE SULFATE SUPP		
	MC/DEL	MORPHINE SULFATE ER TB12 ²	MC/DEL	8 MS CONTIN TB12		
	MC/DEL	OXYCODONE ER ⁴	MC	8 KADIAN CP 24 ²		
			MC/DEL	9 OXYCONTIN TB12		

TREATMENTS

max dosing limits of 32mg daily if the following conditions are met: a.) There is not another Suboxone script in member's drug profile within the past 30 days. and b.) 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.

on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Subtext will only be approved for use during pregnancy.

	MC MC/DEL MC/DEL		COGENTIN SOLN KEMADRIN TABS TRIHXYPHENDYL						
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 MC/DEL MC/DEL	1 1 2	MIRAPEX TABS REQUIP TABS PERGOLIDE MESYLATE TABS	MC		PERMAX	Both Mirapex and requip must be used before Pergolide. Use PA Form # 20420	Preferred drug must be tried and failed in step-order due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.	
PARKINSONS - DOPAMINERGIC/CARBI/ LEVO	MC/DEL MC/DEL MC/DEL MC MC MC/DEL		AMANTADINE HCL BROMOCRIPTINE MESYLATE CARBIDOPA/LEVODOPA TABS* CARBIDOPA/LEVODOPA ER LARODOPA TABS LODOSYN TABS SELEGILINE HCL	MC/DEL MC MC/DEL MC/DEL MC MC MC		APOKYN* ELDEPRYL CAPS PARLODEL CAPS PARLODEL TABS SINEMET TABS SINEMET TBCR SYMMETREL TABS	* Only preferred manufacturer's products will be available without prior authorization. Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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 - COMBO.	MC/DEL		STALEVO						
MUSCLE RELAXANTS									
ALS DRUG	MC/DEL		RILUTEK TABS						
MUSCLE RELAXANTS	MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL		BACLOFEN TABS CHLORZOXAZONE TABS CYCLOBENZAPRINE HCL TABS LIORESAL INTRATHECAL KIT METHOCARBAMOL TABS TIZANIDINE HCL TABS	MC/DEL MC/DEL MC/DEL MC/DEL MC MC MC MC/DEL MC/DEL MC/DEL	7 8 8 8 8 8 8 8 9 9	ORPHENADRINE CITRATE CARISOPRODOL TABS ¹ DANTRIUM CAPS FLEXERIL TABS LIORESAL TABS NORFLEX TBCR ROBAXIN-750 TABS ZANAFLEX TABS SKELAXIN TABX SOMA TABS	Non-preferred drugs will not be approved if members circumventing MaineCare prior authorization requirements by paying (prescribers failed to submit prior authorization prior to cash narcotic scripts being filled by member). Non-preferred products must be used in specified step order. Use PA Form # 20420	At least 3 preferred drugs 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.	
MUSCLE RELAXANT - COMBO.				MC/DEL MC/DEL MC MC/DEL MC/DEL MC		CARISOPRODOL/ASPIRIN TABS CARISOPRODOL/ASPIRIN/CODE NORGESIC TABS ORPHENADRINE COMPOUND ORPHENADRINE/ASA/CAFF ORPHENGESIC	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.	
VITAMINS									
Preferred products that used to require diag codes still require diag codes unless indicated otherwise.									
VITAMINS	MC/DEL MC MC MC MC/DEL MC MC/DEL MC/DEL MC MC MC/DEL MC/DEL MC MC/DEL MC/DEL MC MC/DEL MC/DEL MC MC		ASCORBIC ACID TABS BIOTIN CYANOCOBALAMIN SOLN FOLGARD RX 2.2 TABS FOLIC ACID TABS FOLTX TABS MEPHYTON TABS NIACIN NIACOR TABS NICOTINIC ACID SR CPCR PYRIDOXINE HCL TABS SLO-NIACIN TBCR THIAMINE HCL SOLN VITAMIN B-1 TABS VITAMIN B-12 VITAMIN B-6 TABS VITAMIN C VITAMIN E CAPS VITAMIN E/D-ALPHA CAPS VITAMIN K1 SOLN V-R VITAMIN E CAPS	MC MC		AQUASOL E SOLN AQUAVIT-E SOLN DHT SOLN NASCOBAL 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. As listed in MaineCare Policy, certain drugs require specific diagnoses for approval.	
VITAMIN D's	MC MC/DEL MC/DEL MC/DEL		CALCIFEROL SOLN ¹ CALCITRIOL CAPS ¹ DRISDOL SOLN ¹ VITAMIN D ^{1,2}	MC/DEL MC MC/DEL MC/DEL MC/DEL MC		DRISDOL CAPS CALCJEX HECTOROL (ORAL) HECTOROL (PARENTERAL) ROCALTROL ZEMPLAR	1. Diagnosis of dialysis (renal failure) required. 2. OTC Vitamin D no diagnosis required.	Preferred products require dialysis/renal failure diagnosis. Non-preferred products require: Secondary hyperparathyroidism in patients with Chronic Kidney Disease on dialysis, iPTH>400 pg/ml, Phosphorous .6.5mg/dl, corrected calcium <12.2mg/dl, corrected calcium x phosphorous products <70mg ² /dl ²	

MISC MULTI-VITAMINS

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

VITAMINS - MISC.							
MC	CENTRUM LIQD	MC	ADEKS	Diag codes are no longer	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved,		
MC	CENTRUM TABS	MC/DEL	ADVANCED NATALCARE TABS	required on prenatal	unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of		
MC	CENTRUM JR/IRON CHEW	MC	CENTRUM JR/EXTRA C CHEW	vitamins.	the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. As listed in MaineCare		
MC	CENTRUM SILVER TABS	MC	CENTRUM PERFORMANCE TABS	Use PA Form # 20420	Policy, certain drugs require specific diagnoses for approval.		
MC	CENTRUM-LUTEIN TABS	MC	DALYVITE LIQD				
MC	CEROVITE ADVANCED FO TABS	MC	EMBREX 600 MISC				
MC/DEL	CHEWABLE MULTIVIT/FL CHEW	MC	IBERET				
MC	COD LIVER OIL CAPS	MC	MATERNA TABS				
MC	COMPLETE SENIOR TABS	MC	MULTIRET FOLIC-500 TBCR				
MC	DAILY MULTI VIT/IRON	MC/DEL	NATAFORT TABS				
MC/DEL	DIALYVITE 800MG	MC/DEL	NATALCARE CFE 60 TABS				
MC/DEL	FULL SPECTRUM B	MC/DEL	NATALCARE GLOSS TABS				
MC	M.V.I.-12 INJ	MC	NATALCARE PIC TABS				
MC	MULTI-VIT/FLUORIDE	MC	NATALCARE PIC FORTE TABS				
MC/DEL	NATACHEW CHEW	MC/DEL	NATALCARE PLUS TABS				
MC/DEL	NATALCARE RX TABS	MC	NATALCARE THREE TABS				
MC/DEL	O-CAL PRENATAL	MC	NATALFIRST TABS				
MC/DEL	OCUVITE TABS	MC	NATATAB RX TABS				
MC/DEL	ONE DAILY TABS	MC/DEL	NEPHPLEX RX TABS				
MC/DEL	ONE-DAILY MULTIVITAMINS	MC/DEL	NEPHROCAPS CAPS				
MC/DEL	ONE-TABLET-DAILY	MC/DEL	NEPHRO-VITE TABS				
MC/DEL	POLY-VIT/IRON/FLUORID SOLN	MC	NESTABS RX TABS				
MC/DEL	POLY-VITAMIN/FLUORIDE SOLN	MC/DEL	NIFEREX				
MC/DEL	POLY-VITAMINS/IRON SOLN	MC/DEL	NUTRINATE CHEW				
MC/DEL	PRENATAL TABS	MC	POLY-VI-FLOR SOLN				
MC/DEL	PRENATAL FORMULA 3 TABS	MC	POLY-VI-SOL SOLN				
MC/DEL	PRENATAL PLUS TABS	MC	POLY-VI-SOL/IRON SOLN				
MC/DEL	PRENATAL PLUS NF TABS	MC	POLY-VITAMIN DROPS SOLN				
MC	PRENATAL PLUS/27MG IRON	MC	PRECARE				
MC	PRENATAL PLUS/IRON TABS	MC	PREMESIS RX TABS				
MC/DEL	PRENATAL RX/BETA-CAROTENE	MC	PRENATABS CBF TABS				
MC	PROTEGRA CAPS	MC	PRENATAL 19 CHEW				
MC	STRESS TAB NF TABS	MC	PRENATAL CARE TABS				
MC	THERAPEUTIC-M TABS	MC	PRENATAL MR 90 TBCR				
MC	THERAVITE LIQD	MC/DEL	PRENATAL MTR/SELENIUM TABS				
MC/DEL	TRI-VITAMIN/FLUORIDE SOLN	MC	PRENATAL OPTIMA ADVANCE TABS				
MC	VITA CON FORTE CAPS	MC	PRENATAL PC 40 TABS				
MC	VITAMIN B COMPLEX CAPS	MC/DEL	PRENATAL RX TABS				
MC	VITAPLEX PLUS TABS	MC	PRENATE				
		MC	PRIMACARE MISC				
		MC/DEL	RENAL CAPS				
		MC/DEL	RENAPHRO CAPS				
		MC/DEL	RENA-VITE RX TABS				
		MC	STUARTNATAL PLUS 3 TABS				
		MC	TRI-VI-SOL SOLN				
		MC	TRI-VI-SOL/IRON SOLN				
		MC/DEL	ULTRA NATALCARE TABS				
		MC	ULTRA-NATAL TABS				
		MC	VICON FORTE CAPS				
		MC	VINATAL FORTE TABS				
		MC	VINATE				
		MC/DEL	VINATE ADVANCED TABS				

MISCELLANEOUS MINERALS

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

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
MC	CALCI-MIX CAPSULE CAPS	MC	CALCET TABS		on the Prior Authorization form, such as the presence of a condition that prevents usage of the
MC	CALCIQUID SYRP	MC/DEL	CALCIUM 600-D TABS		preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. As listed in MaineCare Policy,
MC	CALCITRATE/VITAMIN D TABS	MC	CALCIUM/VITAMIN D TABS		certain drugs require specific diagnoses for approval.
MC/DEL	CALCIUM	MC	CALTRATE 600 PLUS/VIT D TABS		
MC/DEL	CALCIUM CARBONATE	MC	CALTRATE PLUS TABS		
MC/DEL	CALCIUM CITRATE TABS	MC	CHROMAGEN		
MC/DEL	CALCIUM GLUCONATE TABS	MC	CITRACAL PLUS TABS		
MC/DEL	CALCIUM LACTATE TABS	MC	CONTRIN CAPS		
MC	CALCIUM/MAGNESIUM TABS	MC	FEOGEN FORTE CAPS		
MC/DEL	CALCIUM/VITAMIN D TABS	MC	FEROCON CAPS		
MC	CALTRATE 600 TABS	MC/DEL	FERREX 150 CAPS		
MC/DEL	CHEWABLE CALCIUM CHEW	MC	FERRO-SEQUELS TBCR		
MC	CITRACAL TABS	MC	FE-TINIC CAPS		
MC	CITRACAL + D TABS	MC	FE-TINIC 150 FORTE CAPS		

MC	CITRUS CALCIUM TABS	MC/DEL	FLUOR-A-DAY SOLN
MC	CITRUS CALCIUM 1500 + D TABS	MC/DEL	K-DUR TBCR
MC	MC/DEL	MC	KLOR-CON PACK
MC	EFFERVESCENT POTASSIUM TBEF	MC	K-LYTE
MC/DEL	FEOSTAT CHEW	MC/DEL	K-PHOS TABS
MC	FERATAB TABS	MC	K-TABS TBCR
MC/DEL	FER-GEN-SOL SOLN	MC	K-VESCENT PACK
MC/DEL	FERGON TABS	MC	NU-IRON 150 CAPS
MC	FER-IN-SOL SOLN	MC/DEL	OYSTER SHELL CALCIUM/VITA TABS
MC	FER-IRON SOLN	MC/DEL	POLY-IRON 150 CAPS
MC	FERRONATE TABS	MC/DEL	POLYSACCHARIDE IRON CAPS
MC	FERROUS FUMARATE TABS	MC/DEL	POTASSIUM BICARB/CHLORIDE
MC/DEL	FERROUS GLUCONATE TABS	MC/DEL	SLOW FE TBCR
MC/DEL	FERROUS SULFATE	MC	TUMS 500 CHEW
MC/DEL	FLUOR-A-DAY CHEW	MC	VIACTIV CHEW
MC	FLUORIDE CHEW		
MC	FLUORIDE SODIUM CHEW		
MC	FLUORITAB CHEW		
MC	HEMOCYTE TABS		
MC	HM CALCIUM TABS		
MC	K+ POTASSIUM PACK		
MC	KAON ELIX		
MC	KAON-CL-10 TBCR		
MC	KCL 0.075%/D5W/NACL 0.2% SOLN		
MC	K-EFFERVESCENT TBEF		
MC	KLOR-CON		
MC	KLOTRIX TBCR		
MC/DEL	K-PHOS TABS		
MC/DEL	K-VESCENT TBEF		
MC/DEL	LURIDE CHEW		
MC/DEL	MAGNESIUM GLUCONATE TABS		
MC/DEL	MAGNESIUM SULFATE SOLN		
MC	MAGTABS		
MC	MICRO-K CPCR		
MC/DEL	NEUTRA-PHOS		
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 260 NEUTRAL TABS		
MC	POTASSIUM BICARBONATE TBEF		
MC/DEL	POTASSIUM CHLORIDE		
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/DEL	FISH OIL CAPS	MC	BOOST	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.
	MC	INTRALIPID EMUL	MC	CASEC POWD		
	MC	MCT OIL OIL	MC	CHOICE DM LIQD		
	MC	ORALYTE SOLN	MC	DELIVER 2.0 LIQD		
	MC	P.T.E. -5 SOLN	MC	ENFAMIL		
	MC	PEDIALYTE SOLN	MC	ENSURE		
			MC	GLUCERNA		
			MC	ISOCAL LIQD		
			MC	KINDERCAL TF LIQD		
			MC	KINDERCAL TF/FIBER LIQD		
			MC/DEL	L-CARNITINE CAPS		
			MC	LIPISORB LIQD		
		MC	MODULEN IBD POWD			
		MC	NUTRAMIGEN POWD			

				MC/DEL		NUTREN			
				MC		NUTRITIONAL SUPPLEMENT LIQD			
				MC		NUTRIVENT 1.5 LIQD			
				MC		OMACOR			
				MC/DEL		PEPTAMEN			
				MC		PHENYL-FREE			
				MC		PKU 3 POWD			
				MC		PREGESTIMIL POWD			
				MC/DEL		PROBALANCE LIQD			
				MC		PROSOBEE			
				MC		SCANDISHAKE PACK			
ERYTHROPOIETINS									
ERYTHROPOIETINS				MC	5	PROCRT SOLN ¹	1. All products require PA	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	
				MC	6	EPOGEN SOLN	but Procrit is first choice. Still	approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents	
				MC	8	ARANESP SOLN	must be used in specified	usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Please see the	
							step order. Use PA Form #	EPO PA form for other approval and renewal criteria.	
							10520		
GRANULOCYTE CSF									
GRANULOCYTE CSF				MC	8	LEUKINE	Must be used in specified	See approval criteria detailed on Neupogen PA form.	
				MC	8	NEUPOGEN SOLN ¹	step order. 1. 10 day		
				MC	9	NEULASTA	supply/month may be used		
							without a PA. Use PA Form #		
							20520		
ANTICOAGULANTS / PLATELET AGENTS									
ANTICOAGULANTS	MC		ARIXTRA SOLN	MC		COUMADIN TABS	1. Fragmin and Lovenox	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered	
	MC/DEL		FRAGMIN INJ ¹	MC		IPRIVAS C	therapy durations greater	on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the	
	MC		HEPARIN SODIUM/NAACL 0.9% SOLN				than 7 days require PA.	preferred drug(s) exists. Exceeding days supply limits for LMWH class requires PA.	
	MC		HEP-LOCK SOLN				Use PA Form # 20420		
	MC/DEL		INNOHEP						
	MC/DEL		LOVENOX SOLN ¹						
	MC/DEL		WARFARIN SODIUM TABS						
	MC		HEPARIN LOCK SOLN						
	MC/DEL		HEPARIN LOCK FLUSH SOLN						
	MC/DEL		HEPARIN SODIUM SOLN						
	MC/DEL		HEPARIN SODIUM LOCK FLUSH SOLN						
	MC/DEL		JANTOVEN						
ANTIHEMOPHILIC AGENTS	MC		ALPHANATE	MC		ADVATE ^{1,2}	1. Only if other products	Non-preferred will only be approved if other preferred products are unavailable.	
	MC/DEL		BENEFIX SOLR				unavailable.		
	MC		BIOCLATE				2. Advate may be available		
	MC/DEL		HELIXATE FS KIT				with PA in cases of large		
	MC		HEMOFIL - M				volume dosing in patients with		
	MC		HUMATE-P SOLR				poor venous access.		
	MC		KOGENATE FS				Use PA Form # 20420		
	MC		KONYNE - 80						
	MC		MONARC - M						
	MC		MONOCLATE - P						
	MC		MONONINE						
	MC/DEL		NOVOSEVEN SOLR						
	MC		PROPLEX-T						
	MC		RECOMBINATE SOLR						
	MC		REFACTO						
PLATELET AGGREGATION INHIBITORS	MC/DEL		ASPIRIN	MC/DEL	7	TICLOPIDINE 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	
	MC/DEL		DIPYRIDAMOLE TABS	MC/DEL	8	PERSANTINE TABS	1. As of 04.01.2005 Plavix is	on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the	
	MC/DEL		PLAVIX TABS ¹	MC	8	TICLID TABS	only available without PA if	preferred drug(s) exists.	
							concurrent aspirin use (on		
							prescription) within 100 days		
							or documented failure or		
							intolerance or other		
							contraindication to aspirin.		
PLATELET AGGR. INHIBITORS COMBO'S - MISC.	MC/DEL		PENTOXIFYLLINE ER TBCR	MC/DEL		AGGRENOX CP1 ²	1. Aspirin and dipyridamole	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered	
	MC/DEL		CLOSTAZOL	MC/DEL		AGRYLIN CAPS	are available separately	on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the	
				MC/DEL		PLETAL TABS	without PA. Use PA Form #	preferred drug(s) exists.	
				MC		TRENTAL TBCR	20420		
HEMOSTATIC									
HEMOSTATIC	MC/DEL		AMICAR						
	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	
	MC		BACITRACIN OINT	MC		AK-SULF OINT		on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the	

	MC	1	LUMIGAN SOLN			products must be used in specified step order or PA required. Use PA Form # 20420	significant potential drug interaction between another drug and the preferred drug(s) exists.
OP. - CYCLOPLEGICS	MC MC/DEL MC/DEL MC/DEL		AK-PENTOLATE SOLN ATROPINE SULFATE CYCLOPENTOLATE HCL SOLN ISOPTO HYOSCINE SOLN	MC/DEL MC MC/DEL MC	CYCLOGYL SOLN ISOPTO ATROPINE SOLN ISOPTO HOMATROPINE SOLN MUROCOLL-2 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.
OP. - MIOTICS - DIRECT ACTING	MC/DEL MC MC MC/DEL MC/DEL		ISOPTO CARBACHOL SOLN ISOPTO CARPINE SOLN PILOCAR SOLN PILOCARPINE HCL SOLN PILOPINE HS GEL				
OP. - ADRENERGIC AGENTS	MC/DEL MC		DIPIVEFRIN HCL SOLN EPIFRIN 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.
OP. - SELECTIVE ALPHA ADRENERGIC AGONISTS	MC MC		ALPHAGAN SOLN ALPHAGAN P SOLN	MC/DEL	IOPIDINE 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.
OP. - ANTI-ALLERGICS	MC MC/DEL		ELESTAT PATANOL SOLN	MC MC/DEL MC/DEL MC MC/DEL	ALOCRIL SOLN ALOMIDE SOLN EMADINE SOLN LIVOSTIN SUSP OPTICROM SOLN ZADITOR 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.
OP. ANTI-ALLERGICS- MASTCELL STABILIZER CLASS	MC/DEL		ALAMAST SOLN				
OP. - CARBONIC ANHYDRASE INHIBITORS/COMBO	MC/DEL MC/DEL MC/DEL		AZOPT SUSP COSOPT SOLN TRUSOPT SOLN				
OP. - NSAID'S	MC MC MC MC		ACULAR LS ACULAR SOLN FLURBIPROFEN SODIUM SOLN VOLTAREN SOLN	MC	OCUFEN SOLN	Must fail all preferred products before non-preferred. Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
OP. - OF INTEREST	MC/DEL		ENUCLENE SOLN	MC MC	BOTOX SOLR RESTASIS ¹	1. Must have kerato conjunctivitis sicca and failed other dry eye therapies. Use PA Form #20420	Must fail adequate trials of multi agents from artificial tears and lubricant category.
DERMATOLOGICAL							
TOPICAL - ACNE PREPARATIONS	MC/DEL MC MC MC/DEL MC MC MC/DEL MC/DEL MC MC MC MC/DEL MC MC MC MC MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		ACCUTANE CAPS AZELEX CREA BENZOYL PEROXIDE CLEOCIN-T DIFFERIN ERYDERM SOLN ERYTHROMYCIN GEL ERYTHROMYCIN PADS ERYTHROMYCIN SOLN METROCREAM CREA METROGEL GEL METROLOTION LOTN PLEXION RETIN-A CREA ² RETIN-A GEL ² RETIN-A LIQD ² SODIUM SULFACET/SULF LOTN	MC MC MC MC/DEL MC/DEL MC/DEL MC MC MC MC/DEL MC MC MC MC MC MC MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL	ALTNAC CREA AVITA CREA BENZAC BENZAFLIN GEL BENZAFLIN-10 GEL BENZAMYCIN GEL BENZAMYCINPAK PACK BREVOXYL CLINAC BPO GEL CLINDAGEL GEL CLINDAMYCIN PHOSPHATE CLINDETS SWAB DESQUAM-E GEL DESQUAM-X DUAC GEL EMGEL GEL ERYCETTE PADS ERYGEL GEL FINEVIN CREA KLARON LOTN NORITATE CREA RETIN-A MICRO GEL SULFACET-R LOTN TRETINOIN TRIAZ ZETACET	2. For these Retin-A products, over 24 yr. need 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.
TOPICAL - ANTIBIOTIC	MC MC/DEL MC/DEL MC/DEL		BACIT/NEOMYCIN/POLYM OINT BACITRACIN OINT BACTROBAN ¹ CENTANY OINT 2% ¹	MC/DEL MC/DEL	CORTISPORIN TRIPLE ANTIBIOTIC OINT	1. Quantity limit of 30 g per month. Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.

	MC/DEL MC/DEL MC/DEL MC MC/DEL MC MC MC	BETAMETHASONE VALERATE BETA-VAL CLOBETASOL PROPIONATE ULTRAVATE PSORCON MISCELLANEOUS CAPEX SHAM DERMA-SMOOTHIE/FS OIL PROCTO-KIT CREA					
TOPICAL - STEROID LOCAL ANESTHETICS	MC/DEL MC	PRAMOSONE ZONE-A FORTE LOTN	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-SMOOTHIE/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 MC MC MC MC MC	AMLACTIN CREA CETAPHIL GENTLE CLEANSER LOTN LAC-HYDRIN LACTINOL-E CREA UREACIN-20 CREA VITAMIN A & D MEDICATED OINT	MC/DEL MC/DEL MC/DEL MC MC		AMMONIUM LACTATE CREA LACLOTION LOTN LACTINOL LOTN MEDERMA GEL RENOVA 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 - ENZYMES / KERATOLYTICS / UREA	MC MC/DEL MC MC MC MC	GRANUL-DERM AERS GRANULEX AERS PANAFIL OINT PAPAIN-UREA-CHLORO OINT TBC AERS XENADERM OINT	MC MC MC MC MC		CARMOL 40 CREA SANTYL OINT SALEX CREAM SALEX LOTION ZIOX 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.
TOPICAL - GENITAL WARTS	MC/DEL	ALDARA	MC/DEL MC/DEL	5 8	PODOFILOX SOLN CONDYLOX	Non-preferred products must be used in specified order. Use PA Form # 20420	
TOPICAL - IMMUNOMODULATORS			MC/DEL	8 9	ELIDEL CREA PROTOPIC OINT	Non-preferred products must be used in specified order. 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. Use PA Form # 20420	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 MC/DEL	AF CAPSICUM OLEORESIN CREA CAPSAICIN CREA ELA-MAX ¹ EMLA CREA ¹ EMLA/TEGADERM KIT ¹ XYLOCAINE	MC/DEL MC MC/DEL MC MC MC		EMLA PADS LIDA MANTLE CREA LIDOCAINE HCL LIDODERM PTCH PONTOCAINE SOLN ZOSTRIX	1. Emla 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/DEL MC/DEL MC MC MC	8 8 8 8 8 8 9	ALUSTRA CREA GLYQUIN CREA HYDROQUINONE CREA HYDROQUINONE/SUNSCREENS SOLAQUIN FORTE CREA TRI-LUMA CREA ELDOQUIN	Not covered for cosmetic purposes. 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 MC MC/DEL MC MC/DEL	ACTION CREA ELIMITE CREA EURAX LICE KILLING SHAM LICE TREATMENT CREME RINS LIQD NIX CREME RINSE LIQD PERMETHRIN LOTN	MC/DEL MC		LINDANE OVIDE LOTN	Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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 MC/DEL	ACCUZYME OINT ACCUZYME SPRAY ETHEZYME	MC		REGREANEX GEL	Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Regranex will be approved for diabetic patients in good control (HbA1c <8), who are not smoking, with a stage III or IV WOCN AND NPUAP lower extremity diabetic ulcer and with an adequate blood supply (TTP 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.
TOPICAL - ASTRINGENTS / PROTECTANTS	MC MC MC	ALUMINUM CHLORIDE SOLN DRYSOL SOLN XERAC AC SOLN	MC MC MC		LOWILA BAR MOISTURIN DRY SKIN CREA PROSHIELD PLUS SKIN PROTE 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		SURGILUBE GEL		
TOPICAL - ANTISEPTICS / DISINFECTANTS	MC MC/DEL MC/DEL	HIBICLENS LIQD 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 MC/DEL	AK-DILATE SOLN EYE WASH SOLN NAPHAZOLINE HCL SOLN PHENYLEPHRINE HCL SOLN PONTOCAINE SOLN SODIUM CHLORIDE	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.
MISCELLANEOUS EAR							
EAR	MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC MC/DEL MC MC MC/DEL MC MC MC/DEL MC/DEL MC MC MC/DEL MC/DEL	A/B OTIC SOLN ACETASOL SOLN ACETASOL HC SOLN ACETIC ACID ACETIC ACID/HYDROCORTISON ALLERGEN SOLN ANTIPYRINE/BENZOCAINE SOLN AURODEX SOLN AUROGUARD SOLN AUROTO OTIC SOLN CERUMENEX SOLN CIPRODEX CORTISPORIN SOLN CORTOMYCIN EAR DROPS SOLN EAR DROPS RX SOLN EAR WAX REMOVAL DROPS EAR-GESIC SOLN FLOXIN OTIC SOLN NEOMYCIN/POLYMYXIN/HC OTICAINE OTIC SOLN	MC MC MC MC MC/DEL MC MC MC/DEL MC MC MC/DEL MC MC MC MC MC MC/DEL MC MC MC MC MC/DEL MC/DEL		AERO OTIC HC SOLN ANTIBIOTIC EAR SOLN ANTIBIOTIC EAR SUSP AURALGAN SOLN CIPRO HC SUSP COLY-MYCIN-S SUSP CORTISPORIN SUSP CORTISPORIN-TC SUSP DEBROX SOLN DOMEBORO SOLN PEDIOTIC SUSP VOSOL-HC SOLN ZOTANE HC SOLN ZOTO-HC SOLN	Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
MOUTH ANTISEPTICS							
MOUTH ANTI-INFECTIVES	MC MC MC/DEL	NILSTAT SUSP EAR-GESIC SOLN NYSTATIN SUSP	MC MC MC		MYCELEX TROC MYCOSTATIN LOZG	Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
MOUTH ANTISEPTICS	MC/DEL MC/DEL MC MC	CHLORHEXIDINE GLUCONATE LIDOCAINE VISCOUS SOLN TRIAMCINOLONE IN ORABASE PSTE TRIAMCINOLONE ORADENT PSTE	MC MC MC MC		APHTHASOL PSTE PERIDEX SOLN PERIOGARD SOLN TRIAMCINOLONE ACETONIDE PSTE XYLOCAINE VISCOUS SOLN	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.
DENTAL PRODUCTS							
DENTAL PRODUCTS	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC	ETHEDENT CREA GEL-KAM CONC PHOS FLUR SOLN PREVIDENT PREVIDENT SOLN SF GEL STANNOUS FLUORIDE ORAL RI CONC	MCOMC MC/DEL MC/DEL MC		APF GEL GEL DENTAGEL GEL PHOS-FLUR GEL SF 5000 PLUS CREA THERA-FLUR-N 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.
ARTIFICIAL SALIVA/STIMULANTS							
ARTIFICIAL SALIVA/STIMULANTS	MC MC	EVOXAC CAPS SALIVA SUBSTITUTE SOLN	MC MC		RADIACARE SOLR SALAGEN TABS	Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
MISCELLANEOUS ANORECTAL							
ANORECTAL - MISC.	MC/DEL MC/DEL MC MC MC/DEL MC/DEL	ANALPRAM-HC CREA COLOCORT ENEM CORTENEMA ENEM ELA-MAX 5 CREA HYDROCORTISONE ENEM PROCTOZONE-HC CREA	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		ANUSOL-HC CREA CORTIFOAM FOAM PROCTOCREAM-HC CREA PROCTOFOAM HC FOAM PROCTO-KIT CREA PROCTOSOL HC CREA	Use PA Form # 20420	
T-CELL ACTIVATION INHIBITOR							
PSORIASIS BIOLOGICALS			MC MC MC	5 8 8	ENBREL AMEVIVE RAPTIVA	Use PA Form # 20910	Approved for severe chronic plaque psoriasis unresponsive to first line therapies. A trial of at least several potent topicals from the following categories: corticosteroids, coal tars, anthralin, calcipotriene and tazarotene, and at least one systemic drug such as methotrexate, cyclosporine, methoxsalen or acitretin and phototherapy/UVA. High dose Enbrel will be approved for chronic severe psoriasis only after failure of all traditional therapies listed here and adequate trial of either Amevive or Raptiva.
ALTERNATIVE MEDICINES							
ALTERNATIVE MEDICINES	MC	DIMETHYL SULFOXIDE SOLN	MC MC/DEL		ARTHX DS CAPS CO-ENZYME Q-10	Use PA Form # 20420	Will only be approved for specific conditions supported by at least two double-blinded, placebo-controlled randomized trials that are not contradicted by other studies of similar quality.

MC DEHYDROEPIANDOSTERONE
 MC DHEA TABS
 MC FLEXAGEN TABS
 MC/DEL GLUCOSAMINE/CHONDROITIN
 MC HM GINKGO BILOBA TABS
 MC MELATONIN TABS

CHELATING AGENTS

CHELATING AGENTS	MC/DEL	CUPRIMINE CAPS	MC MC/DEL	DEPEN TITRATABS TABS EXIjade ¹	Use PA Form # 20420	1. FDA indication of treatment of chronic iron overload due to blood transfusions in membes 2 years of age and older is required for approval of Exjade
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ANTILEPROTIC

ANTILEPROTIC			MC	THALOMID CAPS	Use PA Form # 20420	Approved for indications of leprosy, treatment-resistant multiple myeloma and AIDS.
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ANTINEOPLASTIC AGENTS - ANTIADNDROGENS

ANTINEOPLASTIC AGENTS - ANTIADNDROGENS	MC/DEL	CASODEX				
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CANCER

CANCER	MC MC/DEL MC MC/DEL	ALIMTA AVASTIN ERBITUX VIDAZA	MC MC/DEL	NEXAVAR ¹ SUTENT ^{1,2}		1. PA required to confirm FDA approved indication 2. Avoid CYP3AY drug drug interaction
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IMMUNOSUPPRESSANTS

IMMUNOSUPPRESSANTS	MC/DEL MC/DEL MC/DEL MC MC/DEL MC MC/DEL MC/DEL	CELLCEPT CYCLOSPORINE MODIFIED CYCLOSPORINE SOL. MODIFIED GENGRAF CAPS MYFORTIC PROGRAF CAPS RAPAMUNE SANDIMMUNE	MC/DEL MC/DEL	CYCLOSPORINE CAPS NEORAL ^{1,2}		1. Established users will require a one time PA. 2. Established users will require a one time 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.
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PURINE ANALOG

PURINE ANALOG	MC MC/DEL	AZASAN TABS AZATHIOPRINE TABS	MC/DEL	IMURAN TABS	Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
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K REMOVING RESINS

K REMOVING RESINS	MC/DEL MC MC/DEL MC/DEL MC/DEL	KAYEXALATE POWD KIONEX POWD SODIUM POLYSTYRENE SULFON SPS SUSP SPS 30GM/120ML ENEMA SUSP			Use PA Form # 20420	
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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.

ANVULSANTS INDICATION CHART

	SEIZURES	POST HERPETIC NEURALGIA	DIABETIC PERIPHERAL NEUROPATHY	MONOTHERAPY BIPOLAR	ADJUNCTIVE BIPOLAR	MIGRAINE PROPHYLAXIS	RESTLESS LEG SYNDROME
GABITRIL	X			9	8		
KEPPRA	X			9	7		
LAMICTAL	X			4	4		
LYRICA	X	X(2 nd line)	X(2 nd line)				
NEURONTIN	X	X(2 nd line)	X (2 nd line)	9	9	X (2 nd line)	X (2 nd line)
TOPAMAX	X			9	6	X (2 nd line)	
TRILEPTAL	X			5	5		
ZONISAMIDE	X			9	9		

TI-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