

CATEGORY	Coverage Indicator	Step Order	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS Required	PA	Comments	Criteria
<b>* PLEASE NOTE: All Generics applicable to DEL are considered PREFERRED Drugs. "BASIC" Covered Drugs are bolded with the Coverage Indicator of "MC / DEL".</b>									
<b>General Criteria for all PDL categories-</b> 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: <a href="http://www.mainearepdl.org">www.mainearepdl.org</a>									
<b>A: Preferred Drugs-</b> 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>B: Requests for Non-preferred Drugs-</b> Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.									
<b>C: Adequate Drug Trials-</b> 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.)									
<b>D: Step Order-</b> 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.									
<b>E: Brand Name Medication Requests-</b> (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.									
<b>F: PA requests for non- FDA Approved Indications-</b> 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.									
<b>G: Dose Consolidation Requirements-</b> Some drugs may also be affected by dose consolidation requirements. Please see Dose Consolidation List and/or Splitting Tables provided in the PDL.									
<b>H: Trials from Multiple Drug Classes -</b> 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).									
<b>J: Drug-specific PA Forms-</b> 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 <a href="http://www.mainearepdl.org">www.mainearepdl.org</a> .									
<b>K: PA Exemptions for Prescribers-</b> 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.									
<b>ASSORTED ANTIBIOTICS</b>									
BETA-LACTAMS / CLAVULANATE COMBO'S	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC MC MC/DEL MC MC MC/DEL MC MC MC MC MC MC/DEL		AMOXICILLIN AMOXICILLIN/POTASSIUM CLA CHEW AMOXICILLIN/POTASSIUM CLA SUSR AMOXICILLIN/POTASSIUM CLA TABS AMOXIL <sup>1</sup> AMPICILLIN 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/DEL MC MC MC/DEL MC MC MC/DEL MC MC MC MC MC MC MC/DEL		AMOXIL 500MG TABS AUGMENTIN ES-600 SUSR AUGMENTIN <sup>3</sup> PRINCIPEN CAPS <sup>2</sup> 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 <b>Use PA Form# 20420</b>	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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 MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL MC MC MC MC/DEL MC/DEL MC/DEL		CEDAX CEFADROXIL HEMIHYDRATE CEFAZOLIN SODIUM SOLR CEFTIN SUSP CEFUROXIME AXETIL TABS CEFZIL CEPHALEXIN MONOHYDRATE DURICEF SUSR FORTAZ SOLR KEFZOL SOLR MAXIPIME SOLR OMNICEF ROCEPHIN SUPRAX VANTIN	MC MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC MC MC/DEL MC/DEL MC MC/DEL MC/DEL		CECLOR <sup>1</sup> CEFACTOR <sup>1</sup> CEFADROXIL MONOHYDRATE TABS CEFTIN DURICEF TABS FORTAZ SOLN KEFLEX CAPS TAZICEF SOLR		1. Both brand and generic are clinically non-preferred. <b>Use PA Form # 20420</b>	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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 <sup>1</sup> AZITHROMYCIN TABS CLARITHROMYCIN E.E.S. E-MYCIN TBEC ERYPED 200 SUSR ERYPED 400 SUSR	MC MC/DEL MC MC MC/DEL		BIAXIN DYNABAC DS-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 MC/DEL		DELOMYCIN TABS DORYX CPEP DOXYCYCLINE MONO CAPS DYNACIN CAPS MONODOX CAPS ORACA PERIOSTAT SOLODYN ER	Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
FLUOROQUINOLONES	MC MC MC MC/DEL MC	AVELOX SOLN AVELOX TABS AVELOX ABC PACK TABS CIPRO XR <sup>1</sup> CIPROFLOXACIN PROQUIN XR	MC MC MC MC/DEL MC MC		CIPRO FLOXIN TABS LEVAQUIN NOROXIN TABS TEQUIN FACTIVE	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 <sup>1</sup>	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 <sup>2</sup> 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 <sup>2</sup> METRONIDAZOLE 750MG TABS <sup>2</sup> NEBUPENT SOLR PROLOPRIM TABS TINDAMAX <sup>1</sup> 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 MERREM 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 <sup>1</sup> 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	* Alinia 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.
<b>ANTI - FUNGALS</b>							
ANTIFUNGALS - ASSORTED	MC MC/DEL MC MC MC MC/DEL MC/DEL	ANCOBON CAPS FLUCONAZOLE <sup>1</sup> GRIFULVIN GRISEOFULVIN ULTRAMICROSI TABS GRIS-PEG TABS KETOCONAZOLE TABS NYSTATIN	MC/DEL MC MC MC MC/DEL MC	5 6 6 7 8 8	LAMISIL TABS <sup>1</sup> SPORANOX SOLN <sup>2</sup> SPORANOX PULSEPAK CAPS <sup>3</sup> SPORANOX CAPS <sup>3</sup> 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.
						4. Quantity limit of one tablet daily. 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 MC/DEL MC MC/DEL MC MC MC/DEL MC MC MC/DEL	AGENERASE CAPS APTIVUS ATRIPLA <sup>1</sup> COMBIVIR TABS CRIXIVAN CAPS EMTRIVA EPIVIR / HBV EPZICOM FORTOVASE CAPS HIVID TABS INVIRASE CAPS KALETRA LEXIVA NORVIR PREZISTA <sup>2</sup> 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  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	Please refer to the criteria listed on the Fuzeon PA form.
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					
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HEPATITIS AGENTS

HEPATITIS C AGENTS	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL	PEGASYS KIT PEGASYS SOLN PEG-INTRON KIT REBETOL CAPS REBETRON KIT	MC/DEL MC	8 8	COPEGUS TABS 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 <sup>1</sup>	MC/DEL MC		FLUMADINE TABS  FLUMIST <sup>2</sup>	1. Tamiflu 10 caps or 60cc's per month. Will be audited for presence of positive influenza tests in patient or family member. 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.
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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.
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ASSORTED NEUROLOGICS

NEUROLOGICS - MISC.	MC MC/DEL MC	MESTINON ORAP TABS PROSTIGMIN TABS	MC MC/DEL	BOTOX MYOBLOC <sup>1</sup>	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.	
<b>STEROIDS</b>							
GLUCOCORTICOIDS/ MINERALOCORTICOIDS	MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC MC/DEL MC/DEL MC/DEL	CELESTONE SUSP CORTEF 5 CORTISONE ACETATE TABS DELTASONE TABS DEPO-MEDROL SUSP DEXAMETHASONE ENTOCORT EC CP24 FLUDROCORTISONE ACETATE TABS HYDROCORTISONE KENALOG METHYLPREDNISOLONE TABS ORAPRED SOLN PREDNISOLONE PREDNISONE SOLU-CORTEF SOLR SOLU-MEDROL SOLR	MC MC MC/DEL MC/DEL MC MC MC MC MC MC MC MC MC MC	CORTEF 10 and 20 TABS DECADRON TABS FLORINEF TABS MEDROL TABS MEDROL DOSEPAK TABS PEDIAPRED LIQD PREDNISONE INTENSOL CONC PRELONE SYRP STERAPRED 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.	
<b>HORMONE REPLACEMENT THERAPIES</b>							
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/DEL MC/DEL MC/DEL	ANDRO LA 200 OIL ANDROGEL PACK DELATESTRYL OIL HALOTESTIN TABS METHITEST TABS OXANDRIN TABS <sup>1</sup>	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 MC/DEL	5 8 8 8 8	ESTRADIOL PTWK ALORA PTTW CLIMARA PTWK 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 <sup>2</sup> NORETHINDRONE ACETATE TABS <sup>2</sup> PROGESTERONE POWD	MC/DEL MC MC/DEL MC/DEL		AYGESTIN TABS CYCRIN TABS PROMETRIUM 100MG CAPS <sup>1</sup> PROMETRIUM 200MG <sup>1</sup> 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.
<b>CONTRACEPTIVES</b>							
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 <sup>1</sup>				1. Allowed 4 tablets per 30 days without PA	
CONTRACEPTIVES - PATCHES/ VAGINAL PRODUCTS	MC/DEL	NUVARING RING <sup>2</sup>				1.No PA required for users	Approved if adequate clinical reason given why patient unable to comply with other preferred agents including long acting injectable.



INCRETIN MIMETIC	MC		BYETTA <sup>1</sup>			1. Will not need PA if two of the following three are seen in members drug profile: sulfonylurea, metformin and Actos/ Avandia or any combo product with Actos/ Avandia. If insulin or Actos/ Avandia or any combo product with Actos/ Avandia are in members current (with past 30 days) drug profile PA will be required. Use PA Form # 10230	Please see the criteria listed in the Byetta PA form. One pre-filled pen per month. There are 60 doses per each pen and each pen is a 30 day supply.
DIABETIC - ORAL SULFONYLUREAS	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		CHLORPROPAMIDE TABS GLIMEPIRIDE GLIPIZIDE TABS GLIPIZIDE ER TABS GLYBURIDE TABS GLYBURIDE MICRONIZED TABS TOLAZAMIDE TABS TOLBUTAMIDE TABS	MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL		AMARYL TABS DIABETA TABS GLUCOTROL TABS GLUCOTROL XL TBCR GLYNASE TABS MICRONASE TABS	Use PA Form # 20420 Preferred drugs must be tried for at least 3 months at full therapeutic doses and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
DIABETIC - ORAL BIGUANIDES	MC/DEL MC/DEL		METFORMIN HCL TABS METFORMIN ER 500MG	MC MC MC/DEL MC/DEL		GLUCOPHAGE TABS GLUCOPHAGE XR TB24 FORTAMET METFORMIN ER 750MG	Metformin ER 750mg tabs are non preferred. Metformin ER 500mg are 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.
DIABETIC - THIAZOL / BIGUANIDE COMBO	MC/DEL MC/DEL MC/DEL		ACTOPLUS MET AVANDARYL AVANDAMET TABS				
DIABETIC - / THIAZOL	MC/DEL MC/DEL MC/DEL		AVANDIA TABS <sup>1</sup> ACTOS 15MG TABS <sup>1</sup> ACTOS 45MG TABS <sup>1</sup>	MC/DEL		ACTOS 30MG TABS <sup>2</sup>	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/DEL MC		GLUCOVANCE TABS DUETACT 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.
<b>THYROID</b>							
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 MC		LEVOTHYROXINE SODIUM SOLR SYNTHROID TABS <sup>1</sup>	Use Pa Form # 20420 Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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.
<b>OSTEOPOROSIS</b>							
OSTEOPOROSIS	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		BONIVA FOSAMAX SOLN <sup>2</sup> FOSAMAX TABS <sup>2</sup> FOSAMAX PLUS D <sup>2</sup> MIACALCIN SOLN <sup>2</sup>	MC/DEL MC MC/DEL MC MC MC/DEL		ACTIONEL TABS AREIDIA SOLR DIDRONEL TABS EVISTA TABS <sup>1</sup> FORTEO FORTICAL	1. Approval only requires failure of Fosamax or Boniva. 2. Quantity Limits Apply Use PA Form # 20420 Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
<b>CALCIMIMETIC AGENTS</b>							
CALCIMIMETIC AGENTS				MC		SENSIPAR	Use PA Form # 30115 Baseline PTH, Ca, and phosphorous levels are required and initial approvals will be limited to 3 months. Subsequent approvals will require additional levels being done to assess changes. Will not approve if baseline Ca is less than 8.4.
<b>GROWTH HORMONE</b>							
GROWTH HORMONE				MC/DEL MC/DEL	5 5	GENOTROPIN NUTROPIN	Products must be used in specified step order. All step 1c must be tried prior to See Growth Hormone PA form for criteria. Step-order will still apply unless clinical contraindication supplied.

			MC/DEL	5	TEV-TROPIN		PS must be tried prior to moving to step 8's.	
			MC	8	HUMATROPE SOLR		Use PA Form # 10710	
			MC	8	INCRELEX			
			MC/DEL	8	NORDITROPIN CARTRIDGE SOLN			
			MC	8	SAIZEN SOLR			
SOMATOSTATIC AGENTS	MC/DEL		SANDOSTATIN					
<b>GROWTH HORMONE ANTAGONISTS</b>								
GH ANTAGONISTS			MC		SOMAVERT		Use PA Form # 10710	Approved for acromegaly patients failing surgery/radiation/drug therapy including bromocriptine and sandostatin.
<b>URINARY INCONTINENCE</b>								
VASOPRESSINS			DESMOPRESSIN TABS	MC/DEL	5	DDAVP TABS	Products must be used in specified step order.	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 wearing (at 6 month intervals).
				MC/DEL	6	DDAVP SOLN	Nocturnal enuresis patients will be encouraged to periodically attempt stopping DDAVP. Use Pa Form # 20420	* Patients with a diagnosis of hemophilia or Von Willebrands disease will be exempt from prior authorization.
				MC	6	DESMOPRESSIN SPRAY		
				MC/DEL	8	DESMOPRESSIN ACETATE SOLN		
				MC/DEL	8	STIMATE SOLN*		
ANTISPASMODICS	MC/DEL		OXYBUTYNIN	MC/DEL		CYSTOSPAZ 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		URISPAS TABS	MC/DEL		DETROL TABS		
				MC/DEL		DITROPAN		
ANTISPASMODICS - LONG ACTING	MC/DEL		DETROL LA CP24	MC		DITROPAN XL TBCR	Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		ENABLEX <sup>1</sup>	MC/DEL		OXYTROL		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)
	MC		SANCTURA					
	MC		VESICARE <sup>1</sup>					
CHOLINERGIC	MC/DEL		URECHOLINE					
<b>METABOLIC MODIFIER</b>								
HERED. TYROSINEMIA				MC		ORFADIN	Use PA Form # 20420	Approved for Type 1 hereditary tyrosinemia patients. Must include laboratory evidence of dx at first PA.
<b>ANTIHYPERTENSIVES / CARDIAC</b>								
CARDIAC GLYCOSIDES	MC/DEL		DIGITEK TABS					
	MC/DEL		DIGOXIN					
	MC/DEL		LANOXICAPS					
	MC/DEL		LANOXIN					
ANTIANGINALS--Isosorbide Dinitrate/ Mono-Nitrates	MC/DEL		ISOSORBIDE MONONITRATE TABS	MC		DILATRATE SR CPCR	Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		ISOSORBIDE MONONITRATE ER	MC		ISORDIL TABS		
				MC/DEL		ISORDIL TITRADOSE TABS		
				MC		ISOSORBIDE DINITRATE SUBL		
				MC/DEL		ISOSORBIDE DINITRATE TABS		
				MC/DEL		ISOSORBIDE DINITRATE CR TBCR		
				MC/DEL		ISOSORBIDE DINITRATE ER TBCR		
				MC/DEL		ISOSORBIDE DINITRATE TD TBCR		
				MC/DEL		IMDUR TB24		
				MC/DEL		ISMO TABS		
				MC		MONOKET TABS		
NITRO - OINTMENT/CAP/CR	MC		NITROBID OINT					
	MC/DEL		NITROGLYCERIN CPCR					
	MC		NITROL OINT					
	MC		NITRO-TIME CPCR					
NITRO - PATCHES	MC/DEL	1	NITROGLYCERIN PT24	MC		NITRODISC 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.
	MC/DEL	1	NITREK PT24	MC/DEL		NITRO-DUR PT24		
	MC/DEL	1	NITRO-DUR PT 24 0.8MG					
	MC/DEL	3	MINITRAN PT24					
NITRO - SUBLINGUAL/ SPRAY	MC		NITROLINGUAL AERS	MC		NITROLINGUAL SOLN	Use Pa Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		NITROSTAT SUBL	MC/DEL		NITROQUICK SUBL		
	MC/DEL		NITROTAB SUBL					
BETA BLOCKERS - NON SELECTIVE	MC/DEL		COREG TABS	MC/DEL		BETAPACE TABS	1. Recommend using BID since its effects do not last 24 hours.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		INDERAL LA CPCR	MC		BETAPACE AF TABS		
	MC		LEVATOL TABS	MC/DEL		CORGARD TABS		
	MC/DEL		NADOLOL TABS	MC/DEL		INDERAL TABS		
	MC/DEL		PINDOLOL TABS	MC		INNOPRAN XL		
	MC/DEL		PROPRANOLOL HCL SOLN <sup>1</sup>	MC/DEL		PROPRANOLOL HCL LA CPCR		
	MC/DEL		PROPRANOLOL HCL TABS <sup>1</sup>	MC		RANEXA	Use PA Form # 20420	
	MC/DEL		SOTALOL HCL TABS					
	MC/DEL		TIMOLOL MALEATE TABS					
BETA BLOCKERS - CARDIO SELECTIVE	MC/DEL		ACEBUTOLOL HCL CAPS	MC		KERLONE TABS	1. Recommend using Atenolol (and metoprolol) BID since its effects do not last 24 hours. Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		ATENOLOL TABS <sup>1</sup>	MC/DEL		LOPRESSOR TABS		
	MC		BETAXOLOL HCL TABS	MC		SECTRAL CAPS		
	MC/DEL		BISOPROLOL FUMARATE TABS	MC/DEL		TENORMIN TABS		
	MC/DEL		METOPROLOL TARTRATE TABS <sup>1</sup>	MC/DEL		ZEBETA TABS		
	MC/DEL		TOPROL XL TB24					

BETA BLOCKERS - ALPHA / BETA	MC/DEL		LABELALOL 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		NORVASC TABS					
	MC	1	CARDIZEM LA TB24	MC	5	DILACOR XR CP24	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	1	DILTIA XT CP24	MC	6	TAZTIA		
	MC/DEL	1	DILTIAZEM HCL ER CP24	MC/DEL	7	TIAZAC CP24		
	MC/DEL	1	DILTIAZEM HCL XR CP24	MC/DEL	8	CARDIZEM TABS		
	MC/DEL	1	DILTIAZEM CD 300MG CP24	MC/DEL	8	CARDIZEM CD CP24		
	MC/DEL	1	DILTIAZEM CD 360MG CP24	MC	8	CARDIZEM SR CP12		
	MC	4	CARTIA XT CP24	MC/DEL	8	DILTIAZEM HCL TABS		
	MC/DEL	4	DILTIAZEM CD CP24	MC/DEL	8	DILTIAZEM HCL ER CP12		
	MC/DEL	4	DILTIAZEM HCL ER CP24					
	MC/DEL	4	DILTIAZEM XR CP24					
				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		DYNACIRC CAPS	Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
				MC		DYNACIRC CR TBCR <sup>1</sup>	1. Established users will be grandfathered	
				MC/DEL		CARDENE 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		CARDENE SR CPCR		
				MC/DEL		NICARDIPINE HCL CAPS		
	MC/DEL		AFEDITAB CR	MC		ADALAT CC TBCR	Established users of Adalat CC are grandfathered.	Preferred drug must be tried and failed in step order due to lack of efficacy or intolerable side effects before non-preferred drugs in step order will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		NIFEDIAC CC	MC/DEL		NIFEDIPINE CAPS		
	MC/DEL		NIFEDICAL XL TBCR	MC		PROCARDIA CAPS		
	MC/DEL		NIFEDIPINE TBCR	MC/DEL		PROCARDIA XL TBCR		
	MC/DEL		NIFEDIPINE CAPS					
	MC/DEL		NIFEDIPINE ER TBCR					
	MC		SULAR TB24				Use PA Form # 20420	
	MC/DEL	1	VERAPAMIL HCL CR TBCR	MC/DEL		CALAN TABS	Products must be used in specified order or PA will be required. Just write "Verapamil 24-hour" and the pharmacy will use a preferred long acting generic that does not require PA. Use PA Form # 20420	Preferred drugs must be tried and failed (in step-order) due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL	1	VERAPAMIL HCL ER TBCR	MC/DEL		CALAN SR TBCR		
	MC/DEL	1	VERAPAMIL HCL SR TBCR	MC/DEL		COVERA-HS TBCR		
	MC	1	VERELAN PM CP24	MC		ISOPTIN-SR		
				MC/DEL		VERAPAMIL HCL ER CP24		
				MC		VERAPAMIL HCL SR CP24		
				MC		VERAPAMIL HCL TABS		
				MC		VERELAN CP24		
ANTIARRHYTHMICS	MC/DEL		AMIODARONE	MC/DEL		CORDARONE	1. Prescription must be written by Cardiologist. Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		MEXILETINE	MC/DEL		DISOPYRAMIDE		
	MC/DEL		NORPACE	MC/DEL		FLECAINIDE		
	MC/DEL		PROCAINAMIDE	MC/DEL		MEXITIL		
	MC/DEL		PROCANBID CR	MC/DEL		PACERONE		
	MC/DEL		PROPAFENONE	MC		QUINIDEX		
	MC		QUINAGLUTE	MC/DEL		TIKOSYN <sup>1</sup>		
	MC/DEL		QUINIDINE GLUCONATE					
	MC/DEL		QUINIDINE SULFATE					
	MC		RYTHMOL					
	MC/DEL		TAMBOCOR					
ACE INHIBITORS	MC/DEL		BENAZEPRIL HCL	MC	5	MAVIK 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.
	MC/DEL		CAPTOPRIL TABS	MC/DEL	5	ACCUPRIL TABS		
	MC/DEL		ENALAPRIL MALEATE TABS	MC/DEL	8	ACEON TABS		
	MC/DEL		FOSINOPRIL SODIUM	MC/DEL	8	ALTACE CAPS		
	MC/DEL		LISINAPRIL TABS	MC	8	CAPOTEN TABS		
				MC/DEL	8	LOTENSIN TABS		
				MC/DEL	8	MOEXIPRIL		
				MC	8	MONOPRIL HCT TABS		
				MC/DEL	8	PRINIVIL TABS		
				MC/DEL	8	UNIVASC		
				MC	8	VASOTEC TABS		
				MC/DEL	8	ZESTRIL TABS		
ANGIOTENSIN RECEPTOR BLOCKER	MC		AVAPRO	MC/DEL		ATACAND TABS	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.
	MC/DEL		BENICAR TABS	MC		TEVETEN TABS		
	MC/DEL		COZAAR TABS					
	MC/DEL		DIOVAN					
	MC/DEL		MICARDIS TABS					
ANTIHYPERTENSIVES - CENTRAL	MC/DEL		CATAPRES-TTS	MC/DEL		CATAPRES TABS	Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		CLONIDINE HCL TABS	MC		GUANABENZ ACETATE TABS		
	MC/DEL		GUANFACINE HCL TABS	MC		ISMELIN TABS		
	MC/DEL		HYDRALAZINE HCL TABS	MC		MINIPRESS CAPS		

	MC MC/DEL MC/DEL MC/DEL MC/DEL		HYLOREL TABS METHYLDOPA TABS MINOXIDIL TABS PRAZOSIN HCL CAPS RESERPINE TABS	MC/DEL		TENEX TABS		
ACE INHIBITORS AND CA CHANNEL BLOCKERS	MC/DEL MC		LOTREL CAPS TARKA TBCR	MC/DEL		LEXCEL 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		BENAZEPRIL HCL/HYDROCHLOR CAPTOPRIL/HYDROCHLOROTHIA ENALAPRIL MALEATE/HCTZ TABS LISINAPRIL-HCTZ TABS UNIRETIC TABS	MC/DEL MC MC/DEL MC MC/DEL MC		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/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		AVALIDE TABS BENICAR HCT DIOVAN HCT TABS HYZAAR TABS MICARDIS HCT TABS	MC/DEL MC		ATACAND HCT TABS TEVETEN HCT TABS	Use PA Form # 20420	Preferred products only available without PA if patient on diabetic therapy or prior ACE therapy. Same initial criteria as the ARB class and Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
DIURETICS	MC/DEL MC MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC		ACETAZOLAMIDE TABS AMILORIDE HCL BUMETANIDE CHLOROTHIAZIDE TABS CHLORTHALIDONE TABS EDECIN TABS FUROSEMIDE HYDROCHLOROTHIAZIDE INDAPAMIDE TABS METHAZOLAMIDE TABS METHYLOTHIAZIDE TABS SPIRONOLACTONE 25MG TABS SPIRONOLACTONE/HYDRO TORSEMIDE TABS TRIAMTERENE/HCTZ ZAROXOLYN TABS	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC MC MC/DEL MC MC/DEL MC MC/DEL MC MC/DEL MC MC MC/DEL		ALDACTAZIDE TABS ALDACTONE TABS BUMEX TABS DEMADEX TABS DIAMOX DIURIL DYAZIDE CAPS ENDURON TABS INSPIRA LASIX TABS LOZOL TABS MAXZIDE MICROZIDE CAPS MIDAMOR TABS MODURETIC 5-50 TABS NAQUA TABS NATURETIN TABS SPIRONOLACTONE 50MG <sup>1</sup>	Use PA Form # 20420	1. Multiples of Spironolactone 25 mg are cheaper than 50 mg strength. Inspira 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.
CCB / LIPID	MC/DEL		CADUET					
<b>LIPID DRUGS</b>								
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/DEL		ANTARA LOPID LOFIBRA FENOFIBRATE	Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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 MORE POTENT DRUGS/COMBINATIONS	MC/DEL MC/DEL MC/DEL MC		CRESTOR LIPITOR SIMVASTIN <sup>1</sup> VYTORN	MC/DEL		ZOCOR <sup>2</sup>	Use PA Form # 20420	Zocor/simvastatin patients trying to use Zetia must use Vytorin instead. 1. Preferred starting 01.01.2007. 2. Non preferred starting 01.01.2007. Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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 LESS POTENT DRUGS/COMBINATIONS	MC/DEL MC/DEL MC/DEL MC/DEL		ADVICOR TBCR LESCOL CAPS LESCOL XL TB 24 LOVASTIN TABS PRAVASTATIN	MC/DEL MC/DEL MC MC/DEL		ALTOPREV TB 24 MEVACOR TABS PRAVACHOL TABS PRAVIGARD	Use PA Form # 20420	1. Zetia available w/OPA as addition to Lipitor 80mg, or Crestor 40mg. Zetia will also be approved with a PA as add on for patients at maximally tolerated doses of statins. Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Zetia will be approved for patients unable to tolerate all other therapies or unable to achieve cholesterol goal with maximally tolerated dose of most potent statins.

	MC		ZETIA TABS <sup>1</sup>					Use PA Form #20420	
<b>PULMONARY ANTI-HYPERTENSIVES</b>									
PULMONARY ANTI-HYPERTENSIVES	MC/DEL MC		REVATIO <sup>1</sup> VENTAVIS <sup>2</sup>	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.
<b>IMPOTENCE AGENTS</b>									
IMPOTENCE AGENTS					9 9 9 9 9 9	CAVERJECT CIALIS EDEX LEVITRA MUSE VIAGRA YOHIMBINE HCL TABS		As of January 1, 2006, per CMS (federal govt.), impotence agents are no longer covered.	
<b>ANTI-EMETOGENICS</b>									
ANTIEMETIC - ANTIHOLINERGIC / 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 TBDP*	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.
<b>NON-SEDATING ANTIHISTAMINES / DECONGESTANTS</b>									
ANTIISTIMINES - NON-SEDATING	MC MC MC MC/DEL		ALAVERT TABS <sup>1</sup> CLARITIN ALLERGY (OTC) <sup>1</sup> CLARITIN SYRP (OTC) <sup>2</sup> TAVIST ND (OTC) <sup>1</sup>	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL	5 5 5 5 8 8 9	CLARINEX TABS <sup>2</sup> CLARINEX SYR <sup>3</sup> ZYRTEC <sup>3</sup> ZYRTEC SYR <sup>3</sup> ALLEGRA CLARITIN <sup>2</sup> FEXOFENADINE		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 Clarinex Tabs and Zyrtec products before moving to next step product without PA Pseudoephedrine is available with prescription. Use PA Form # 20530	Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. No combination product with decongestant will be approved since pseudoephedrine available without PA.
<b>ALLERGY / ASTHMA THERAPIES</b>									
ANTIASTHMATIC - ANTIHOLINERGICS - INHALER	MC/DEL MC MC		ATROVENT AERS ATROVENT HFA SPIRIVA <sup>1</sup>					Use PA Form # 20420 1. Quantity limit of 1 inhalation daily (1 capsule for inhalation daily)	
ANTIASTHMATIC - ANTIHOLINERGICS - NEBULIZER	MC/DEL		IPRATROPIUM BROMIDE SOLN	MC		ATROVENT SOLN		Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANTIASTHMATIC - ANTIINFLAMMATORY AGENTS	MC/DEL MC/DEL MC/DEL		CROMOLYN SODIUM NEBU INTAL AERS TILADE AERS	MC/DEL		XOLAIR <sup>1</sup>		1. Need max inhaled steroids and written by pulmonary or allergy specialist. Use PA Form # 20420	Xolair approval will require suboptimal response to maximal doses of inhaled steroid as evidenced by asthmatic ER/Hospital admissions and Allergy/Pulmonary specialist management.
ANTIASTHMATIC - NASAL STEROIDS	MC/DEL MC/DEL MC/DEL MC/DEL MC	1 1 1 4 4	FLONASE SUSP <sup>1</sup> NASACORT AQ AERS <sup>1</sup> NASONEX SUSP <sup>1</sup> BECONASE AQ INHA NASAREL SOLN	MC/DEL MC MC MC/DEL MC MC		FLUNISOLIDE SOLN NASACORT AERS RHINOCORT AERO RHINOCORT AQUA SUSP TRI-NASAL SOLN VANCENASE POKKETHALER AERS		Use PA Form # 20420 1. All step 1 drugs must be tried.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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		NASALCROM	MC MC MC/DEL		ATROVENT NASAL SOL IPRATROPIUM NASAL SOL <sup>1</sup> 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		ALBUTEROL NEB MAXAIR METAPROTERENOL SEREVENT	MC/DEL MC/DEL MC/DEL MC/DEL		ACCUNEB NEBU ALBUTEROL AER ALBUTEROL HFA ALUPENT AERP		1. Xopenex users w/ prior asthma hospitalization due to albuterol nebulizer failure will be grandfathered. 2. Quantity Limit: 12 cc/day.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a 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		TERBUTALINE SULFATE TABS XOPENEX HFA	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC MC MC/DEL	BRETHINE FORADIL AEROLIZER CAPS PROVENTIL PROVENTIL HFA AERS VENTOLIN AERS VENTOLIN HFA AERS VOLMAX TBCR VOSPIRE ER TB12 XOPENEX NEBU <sup>2</sup>	Use PA Form # 20420	
ANTIASTHMATIC - ADRENERGIC COMBINATIONS	MC/DEL		ADVAIR DISKUS/HFA				Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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		COMBIVENT AERO	MC/DEL		DUONEB SOLN <sup>1</sup>	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		AMINOPHYLLINE TABS THEOCHRON TB12 THEOLAIR-TB12 THEOLAIR-SR TB12 THEOPHYLLINE ELIX THEOPHYLLINE SOLN THEOPHYLLINE ER CP12 THEOPHYLLINE ER TB12 UNIPHYL TBCR	MC MC MC MC/DEL MC MC/DEL MC	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/DEL MC		AEROBID AERS ASMANEX AZMACORT AERS BECLOVENT AERS FLOVENT HFA PULMICORT SUSP <sup>1</sup> QVAR AERS VANCERIL AERS	MC/DEL MC/DEL MC MC MC/DEL MC MC	AEROBID-M AERS PULMICORT TURBUHALER AEPB <sup>2</sup> VANCERIL DOUBLE STRENGTH AERS	1. No PA for Pulmicort susp under 8 years old 2. No PA for Pulmicort turbuhaler 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.
ANTIASTHMATIC - 5-Lipoxygenase Inhibitors				MC	ZYFLO TABS	Use PA Form # 20420	Other Preferred asthma controller drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANTIASTHMATIC - LEUKOTRIENE RECEPTOR ANTAGONISTS	MC/DEL		SINGULAR <sup>1</sup>	MC/DEL	ACCOLATE TABS	1. To determine Singulair use for asthma vs non-asthma use, an asthma diag is required on the prescription or history of inhaled steroid use. Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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 - ALPHA-PROTEINASE INHIBITOR				MC MC	PROLASTIN SUSR ZEMAIRA	Use PA Form # 20420	Prolastin and Azemaira will be approved for members with A1AT deficiency and clinically demonstrable panacinar emphysema.
ANTIASTHMATIC - HYDROLYTIC ENZYMES				MC/DEL	PULMOZYME SOLN	Use PA Form # 20420	Will be approved for cystic fibrosis patients.
ANTIASTHMATIC - MUCOLYTICS	MC/DEL		ACETYLCYSTEINE <sup>1</sup>	MC	MUCOMYST	1. Acetylcysteine is covered with diagnosis of CF Use PA Form # 20420	
<b>COUGH/COLD</b>							
COUGH/COLD	MC/DEL MC MC		PSEUDOEPHEDRINE ROBITUSSIN DM SYRP ROBITUSSIN SUGAR FREE SYRP		All others are a non-covered service (this includes antihistamines-decongestive combinations).	All of cough cold preparations are not covered except these preferred products.	All non-preferred products are not covered as permitted by Federal Medicaid regulations and MaineCare Policy.
<b>DIGESTIVE AIDS / ASSORTED GI</b>							
<b>**Preferred drugs that used to require diag codes still require diag codes unless indicated otherwise.**</b>							
GI - ANTIPERISTALTIC AGENTS	MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL MC		DIPHENOXYLATE DIPHENOXYLATE/ATROPINE IMODIUM A-D TABS LOPERAMIDE HCL CAPS LOPERAMIDE HCL LIQD OPIUM TINCTURE TINC PAREGORIC TINC	MC/DEL MC/DEL MC MC/DEL MC	ANTI-DIARRHEAL TABS LOFENE TABS LONOX TABS MOTOFEN TABS SB ANTI-DIARRHEA TABS	Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. As listed in MaineCare Policy, certain drugs require specific diagnoses for approval.
GI - ANTI-DIARRHEAL/ANTACID - MISC.	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		ALU-CAP <sup>1</sup> CAPS ANTACID CHEW ATROPINE SULFATE SOLN BENTYL SYRP BISMATROL CALCIUM ANTACID CALCIUM CARBONATE CAL-GEST ANTACID CHEW	MC/DEL MC MC MC MC/DEL MC MC/DEL MC	ANTACID EXTRA STRENGTH CHEW B & O 15-A SUPPRETTE SUPP B & O 16-A SUPPRETTE SUPP BELLADONNA ALKALOIDS & OP BENTYL TABS CHILDRENS MYLANTA CHEW LEVBID TB12 LEVSIN ELIX	Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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 MC/DEL MC MC MC/DEL MC MC/DEL MC MC MC MC/DEL MC MC MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL MC MC/DEL	CHEWABLE ANTACID CHEW DICYCLOMINE HCL GAVISCON SUSP HAPONAL TABS HYOSCYAMINE SULFATE IMODIUM ADVANCED CHEW KAOPECTATE K-PEC LIQD K-PEK SUSP MAALOX MAGNESIUM OXIDE TABS MAG-OX 400 TABS MAG-OXIDE TABS PAMINE TABS PINK BISMUTH PROPANTHELINE BROMIDE TABS ROBINUL SAL-TROPINE TABS SCOPOLAMINE HYDROBROMIDE SODIUM BICARBONATE TABS TUMS V-R STOMACH RELIEF SUSP X-STR CHEW ANTACID CHEW	MC/DEL MC/DEL MC/DEL MC	LEVSIN TABS LEVSIN/SL SUBL NULEV TBDP URO-MAG CAPS		
GI - H2-ANTAGONISTS	MC/DEL MC/DEL MC/DEL MC	CIMETIDINE FAMOTIDINE RANITIDINE V-R ACID REDUCER TABS	MC MC MC/DEL MC/DEL MC MC/DEL MC/DEL	AXID CAPS AXID AR TABS NIZATIDINE CAPS PEPCID PEPCID AC TAGAMET TABS ZANTAC <sup>1</sup>	1. Zantac syrup available without PA to users less than 6 years old. Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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 - PROTON PUMP INHIBITOR	MC MC MC MC/DEL	OTC PRILOSEC PREVACID CPDR PREVACID ORAL SUSP PROTONIX	MC MC/DEL MC MC/DEL MC/DEL MC/DEL MC	6 OMEPRAZOLE CPDR 7 ACIPHEX TBEC 8 PREVACID SOLUTABS** 8 NEXIUM CPDR 8 PRILOSEC CPDR 8 PROTONIX INJ 8 ZEGERID	**Prevacid Solutabs available without PA for children less than 9 years old and Long Term Care Residents. 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 (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.
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 MC/DEL MC MC/DEL MC MC/DEL MC MC/DEL MC MC/DEL MC MC/DEL	5 ULTRASE CPEP 5 ULTRASE MT 5 VIOKASE 7 LIPRAM 7 PANCREASE 7 PANCRELIPASE 7 PANGESTYME 7 PANOKASE TABS 8 CREON 8 KUTRASE CAPS 8 KU-ZYME CAPS 8 LIPRAM CR 8 PANCREASE MT 8 PANCRECARB MS-8 CPEP	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 <sup>1</sup> 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	ASACOL TBEC AZULFIDINE TABS AZULFIDINE EN-TABS TBEC COLAZAL CAPS DIPENTUM CAPS	MC MC/DEL	CANASA SUPP 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.

	MC/DEL	PENTASA CPCR				
	MC/DEL	ROWASA ENEM				
	MC/DEL	SULFASALAZINE TABS				
GI - IRRITABLE BOWEL SYNDROME AGENTS			MC/DEL	LOTRONEX 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.
			MC/DEL	ZELNORM TABS		
<b>MISCELLANEOUS GI</b>						
<b>**Preferred drugs that used to require diag codes still require diag codes unless indicated otherwise.**</b>						
GI - MISC.	MC/DEL	BISAC-EVAC SUPP	MC/DEL	ACTIGALL CAPS	1. Quantity Limit: 255 g/90-day without PA for greater than 18 years old. No quantity limit for less than 18 years old. If under 18 years of age, allowed 17gms daily 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. <b>As listed in MaineCare Policy, certain drugs require specific diagnoses for approval.</b>
	MC/DEL	BISACODYL	MC	BENEFIBER		
	MC	BISACOLAX SUPP	MC/DEL	CARAFATE		
	MC	CINOBAC CAPS	MC/DEL	COLACE CAPS		
	MC/DEL	CITRATE OF MAGNESIA SOLN	MC/DEL	COLYTE		
	MC/DEL	CITRUCEL	MC	DIOCTO-C SYRP		
	MC/DEL	D.O.S. CAPS	MC	DOC SOD /CAS CAP		
	MC/DEL	DIOCTO LIQD	MC	DOC-Q-LAX CAPS		
	MC/DEL	DIOCTO SYRP	MC/DEL	DOCUSATE SODIUM/CAS CAPS		
	MC/DEL	DIOCTYN CAPS	MC/DEL	DOK PLUS	2. Must show evidence of trials of preferred agents that do not require PA, such as OTC senna, docusate, mineral oil and prescription lactulose.	
	MC/DEL	DOC-Q-LACE CAPS	MC/DEL	DULCOLAX SUPP		
	MC	DOCUSATE CALCIUM CAPS	MC	FIBER CON TABS		
	MC/DEL	DOCUSATE SODIUM	MC/DEL	FIBER-LAX TABS		
	MC	DOCUSIL CAPS	MC	GOLYTELY SOLR		
	MC/DEL	DOK CAPS	MC	MALTSUPEX		
	MC/DEL	FIBER LAXATIVE TABS	MC	MIRALAX PACK		
	MC	FLEET	MC	MIRALAX POWD		
	MC/DEL	GENFIBER POWD	MC/DEL	NULYTELY SOLR		
	MC/DEL	GLYCERIN	MC	PEG 3350/ELECTROLYTES SOLR	Use PA Form # 20420	
	MC/DEL	GLYCOLAX <sup>1</sup>	MC/DEL	SENEXON TABS		
	MC	HIPREX TABS	MC/DEL	SENOKOT TABS		
	MC/DEL	KRISTALOSE PACK	MC	SENOKOT S TABS		
	MC	METAMUCIL	MC	STOOL SOFTENER PLUS CAPS		
	MC/DEL	MILK OF MAGNESIA SUSP	MC/DEL	UNI-CENNA TABS		
	MC	MINERAL OIL OIL	MC	UNI-EASE PLUS CAPS		
	MC/DEL	SENNA	MC	V-R NATURAL SENNA LAXATIV TABS		
	MC/DEL	SENOKOT GRAN	MC	URSO 250		
	MC/DEL	SENOKOT SYRP				
	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				
<b>MISC. UROLOGICAL</b>						
UROLOGICAL - MISC.	MC	ACETIC ACID 0.25% SOLN	MC	CITRIC ACID/SODIUM CITRAT SOLN	1. Elmiron requires adequate proof of Dx with supportive testing.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL	BICITRA SOLN	MC/DEL	CYTRA-2 SOLN		
	MC	CYTRA-K SOLN	MC	ELMIRON CAPS <sup>1</sup>	Use PA Form #20420	
	MC	FURADANTIN SUSP	MC/DEL	MACROBID CAPS		
	MC	K-PHOS MF TABS	MC/DEL	MANDELAMINE TABS		
	MC/DEL	MACRODANTIN CAPS	MC/DEL	NITROFURANTOIN MACR CAPS		
	MC/DEL	METHENAMINE MANDELATE TABS	MC	POLYCITRA-K CRYSTALS PACK		
	MC/DEL	MONUROL PACK	MC	POTASSIUM CITRATE/CITRIC SOLN		
	MC/DEL	NEOSPORIN GU IRRIGANT SOLN	MC	PYRIDIUM TABS		
	MC/DEL	PHENAZOPYRIDINE HCL TABS	MC/DEL	RENACIDIN SOLN		
	MC	POLYCITRA SYRP				
	MC	POLYCITRA-K SOLN				
	MC/DEL	POLYCITRA-LC SOLN				
	MC/DEL	PROSED/DS TABS				
	MC/DEL	PYRIDIUM PLUS TABS				
	MC	TRICITRATES SYRP				
	MC	UREX TABS				
	MC/DEL	URISED TABS				
	MC	UROCID-K				
	MC/DEL	UROQID #2 TABS				
<b>PHOSPHATE BINDERS</b>						
PHOSPHATE BINDERS	MC	PHOSLO <sup>3</sup>	MC/DEL	RENAGEL <sup>1,2</sup>	1. Renagel will be approved for hypercalcemia, digoxin levels, and in cases where	Renagel will be approved in patients with hypercalcemia, on concurrent digoxin or insufficient response with Phos-lo (Renagel to be add-on therapy).
	MC/DEL	MEGNEBIND - 400 <sup>3</sup>				

	MC/DEL		FOSRENOL <sup>3</sup>				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.	
							3. Requires diag to be preferred Use PA Form #20530	
<b>INTRA-VAGINALS</b>								
VAGINAL - ANTIBACTERIALS	MC/DEL MC/DEL MC/DEL	1 1 3	CLEOCIN CREA METROGEL VAGINAL GEL CLEOCIN SUPP	MC/DEL		VANZAZOLE	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		CLOTTRIMAZOLE CREA GYNE-LOTRIMIN CREA MICONAZOLE CREA MICONAZOLE 3 COMBO PACK KIT <sup>1</sup> 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 MC/DEL MC MC MC MC MC/DEL		AVC CREAM CLOTTRIMAZOLE 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: 1/script/2 weeks Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
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 # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
VAGINAL - OTHER	MC/DEL MC MC		ACID JELLY GEL ACI-JEL GEL CERVICAL AMINO ACID CREA	MC		AMINO ACID CERVICAL CREA	Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
<b>BPH</b>								
BPH	MC/DEL MC/DEL MC/DEL MC/DEL		AVODART DOXAZOSIN MESYLATE TABS PROSCAR TABS TERAZOSIN HCL CAPS	MC/DEL MC/DEL MC/DEL MC MC/DEL	5 8 8 8 8	FLOMAX CP24 CARDURA TABS FINASTERIDE HYTRIN CAPS UROXATRAL	Non-preferred products must be used in specified order. Use PA Form #20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs (in step-order) will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Approval of a non-preferred 5-alpha reductase inhibitor requires objective clinical evidence of a very enlarged prostate rather than just the presence of obstructive urinary outflow symptoms along with adequate trial of preferred Proscar.
<b>ANXIOLYTICS</b>								
ANXIOLYTICS - BENZODIAZEPINES	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		ALPRAZOLAM TABS CHLORDIAZEPOXIDE HCL CAPS CLORAZEPATE DIPOTASSIUM TABS DIAZEPAM LORAZEPAM OXAZEPAM CAPS	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		ATIVAN NIRAVAM SERAX TRANXENE XANAX 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.
ANXIOLYTICS - LONG ACTING	MC/DEL		XANAX XR <sup>2</sup>	MC/DEL		ALPRAZOLAM ER	1. Xanax XR will be available if the long acting benzo clonazepam fails. Use PA Form # 20420	
ANXIOLYTICS - MISC.	MC/DEL MC MC MC/DEL		BUSPIRONE HCL TABS HYDROXYZINE HCL SOLN HYDROXYZINE HCL SYRP HYDROXYZINE PAMOATE CAPS	MC MC MC MC/DEL MC MC/DEL		ATARAX TABS BUSPAR TABS DROPERIDOL SOLN HYDROXYZINE HCL TABS HYDROXYZINE PAM 100MG CAPS INAPSINE SOLN MEPROBAMATE TABS VISTARIL	Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
<b>ANTI-DEPRESSANTS</b>								
ANTIDEPRESSANTS - MAO INHIBITORS	MC/DEL MC/DEL		NARDIL TABS PARNATE TABS					
ANTIDEPRESSANTS -	MC/DEL		BUPROPION HCL TABS	MC	5	CYMBALTA <sup>4</sup>	Non-preferred products must	Preferred drugs must be tried for at least 4 weeks each and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable



ATYPICALS			MC		FAZACLO		offered on the Prior Authorization form, such as the presence of 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/DEL MC MC MC/DEL MC/DEL MC MC/DEL MC/DEL MC MC/DEL MC/DEL MC MC/DEL	CHLORPROMAZINE HCL FLUPHENAZINE DECANOATE FLUPHENAZINE HCL HALDOL HALOPERIDOL HALOPERIDOL DECANOATE SOLN HALOPERIDOL LACTATE SOLN LOXAPINE SUCCINATE CAPS LOXITANE-C CONC MOBAN TABS PERPHENAZINE PROCHLORPERAZINE SERENTIL THIORIDAZINE HCL THIOTHIXENE THORAZINE SUPP TRIFLUOPERAZINE HCL TABS	MC/DEL MC/DEL MC MC/DEL MC/DEL MC MC MC MC MC/DEL MC/DEL MC MC MC/DEL MC/DEL MC MC/DEL		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.
<b>LITHIUM</b>							
LITHIUM	MC/DEL MC/DEL	LITHIUM CARBONATE LITHIUM CITRATE SYRP	MC/DEL MC/DEL		ESKALITH CAPS ESKALITH CR TBCR		
<b>COMBINATION - PSYCHOTHERAPEUTIC</b>							
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.
<b>STIMULANTS</b>							
STIMULANT - AMPHETAMINES SHORT ACTING	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL	ADDERALL TABS AMPHETAMINE SALT COMBO DEXTRAMPHET SULF TABS DEXEDRINE DEXTROSTAT TABS					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 - 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	DEXEDRINE CAP CR					Preferred stimulants will be

	MC		DEXTRAMPHET SULF CPCR				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.  <b>Use PA Form # 20420</b> 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/DEL MC		CONCERTA TBCR DAYTRANA <sup>2</sup> FOCALIN XR <sup>1</sup>	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 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.  2. FDA approval currently only for ages 6-16. Will be available without PA for this age group. Limit of one patch daily. Max dose of 30MG daily. <b>Use PA Form # 20420</b>	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
STIMULANT - STIMULANT LIKE				MC MC MC/DEL MC MC	7 8 8 9 9	STRATTERA <sup>1,2</sup> 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. <b>Provigil: use PA Form # 20710; Others: use Pa Form # 20420</b>	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
ANTI-CATALECTIC AGENTS								



	MC	TACTINAL EXTRA STRENGTH TABS				
	MC	TYLENOL				
	MC	V-R CHILDRENS ASPIRIN CHEW				
	MC	V-R NON-ASPIRIN TABS				
<b>LONG ACTING NARCOTICS</b>						
<b>NARCOTICS - LONG ACTING</b>	MC	AVINZA	MC	7	DURAGESIC PT72 <sup>1</sup>	<p>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 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</p> <p>Preferred drugs (Avinza or morphine sulfate ER tab, Methadone or Methadose, &amp; oxycodone ER) &amp; step order drugs must be tried for at least 2 weeks each &amp; failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug &amp; 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 &amp; desired clinical response must be provided. Member's drug regimen for additions &amp;/or discontinuations of medications that may affect absorption &amp;/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 "allergy" to all products but Oxycotin. 9. Circumventing MaineCare prior authorization</p>
	MC/DEL	METHADONE	MC/DEL	8	ORAMORPH SR TB12	
	MC/DEL	METHADOSE	MC/DEL	8	MORPHINE SULFATE SUPP	
	MC/DEL	MORPHINE SULFATE ER TB12 <sup>3,5</sup>	MC/DEL	8	MS CONTIN TB12	
	MC/DEL	OXYCODONE ER <sup>3,4</sup>	MC/DEL	9	KADIAN CP 24 <sup>2</sup> 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. Should be evidence provided of monthly monitoring including random pill counts urine drug tests and prescription monitoring program reports.

on the Prior Authorization form, such as the presence of 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.





ANTICHOLINERGICS	MC/DEL MC MC/DEL MC/DEL		BENZTROPINE MESYLATE TABS COGENTIN SOLN KEMADRIN TABS TRIHEXYPHENIDYL					
PARKINSONS - COMT INHIBITORS	MC/DEL		COMTAN TABS	MC/DEL		TASMAR TABS	Use PA Form # 20420	Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
PARKINSONS - SELECTED DOPAMIN AGONISTS	MC/DEL 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 - DOPAMINERGICS/CARBI/ LEVCO	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					
<b>MUSCLE RELAXANTS</b>								
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 MC MC MC MC/DEL MC/DEL MC/DEL	7 8 8 8 8 8 8 8 9 9	ORPHENADRINE CITRATE CARISOPRODOL TABS* 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.
<b>VITAMINS</b>								
<b>**Preferred products that used to require diag codes still require diag codes unless indicated otherwise.**</b>								
VITAMINS	MC/DEL MC MC 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		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 MC MC MC MC MC MC MC MC MC MC MC MC MC MC MC MC MC MC		AQUASOL E SOLN AQUAVIT-E SOLN DHT SOLN NASCOCAL 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* CALCITRIOL CAPS* DRISDOL SOLN* VITAMIN D <sup>12</sup>	MC/DEL MC MC/DEL MC/DEL MC/DEL		DRISDOL CAPS CALCIJEX 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 <sup>2</sup> /dl <sup>2</sup>

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 required on prenatal vitamins.	Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. As listed in MaineCare Policy, certain drugs require specific diagnoses for approval.	
MC	CENTRUM TABS	MC/DEL	ADVANCED NATALCARE TABS				
MC	CENTRUM JR/IRON CHEW	MC	CENTRUM JR/EXTRA C CHEW				
MC	CENTRUM SILVER TABS	MC	CENTRUM PERFORMANCE TABS				
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	PRENATE ELITE				
		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 on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. As listed in MaineCare Policy, certain drugs require specific diagnoses for approval.	
MC	CALCI-MIX CAPSULE CAPS	MC	CALCET TABS				
MC	CALCIQUID SYRP	MC/DEL	<b>CALCIUM 600-D TABS</b>				
MC	CALCITRATE/VITAMIN D TABS	MC	CALCIUM/VITAMIN D TABS				
MC/DEL	CALCIUM	MC	CALTRATE 600 PLUS/VIT D TABS				
MC/DEL	CALCIUM CARBONATE	MC	CALTRATE PLUS TABS				
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	FEOPEN FORTE CAPS				
MC/DEL	<b>CALCIUM/VITAMIN D TABS</b>	MC	FEROCOON 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	OYSO		
MC/DEL	OYST-CAL TABS		
MC/DEL	OYST-CAL D TABS		
MC/DEL	OYST-CAL/VITAMIN D TABS		
MC/DEL	OYSTER CALCIUM TABS		
MC/DEL	OYSTER SHELL		
MC	PHARMA FLUR		
MC/DEL	PHOSPHA 250 NEUTRAL TABS		
MC	POTASSIUM BICARBONATE TBEF		
MC/DEL	POTASSIUM CHLORIDE		
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 GI tube.  Use PA Form # 20420 & SGA 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. 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			
<b>ERYTHROPOIETINS</b>									
ERYTHROPOIETINS				MC	5	PROCRIT SOLN <sup>1</sup>	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		
<b>GRANULOCYTE CSF</b>									
GRANULOCYTE CSF				MC	8	LEUKINE	Must be used in specified	See approval criteria detailed on Neupogen PA form.	
				MC	8	NEUPOGEN SOLN <sup>1</sup>	step order. 1. 10 day		
				MC	9	NEULASTA	supply/month may be used		
							without a PA. Use PA Form #		
							20520		
<b>ANTICOAGULANTS / PLATELET AGENTS</b>									
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 <sup>1</sup>	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 <sup>1</sup>						
	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 <sup>1,2</sup>	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 <sup>1</sup>	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 CP12 <sup>1</sup>	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		CILOSTAZOL	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		
<b>HEMOSTATIC</b>									
HEMOSTATIC	MC/DEL		AMICAR						
	MC		AMINOCAPROIC ACID						
<b>OPHTHALMICS</b>									
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 MC MC/DEL MC MC/DEL MC/DEL MC MC MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL		BACITRACIN OINT BACITRACIN/NEOMYCIN/POLYM BACITRACIN/POLYMYXIN B OINT CHLOROPTIC SOLN ERYTHROMYCIN OINT GENTAMICIN SULFATE NEOMYCIN/POLYMYXIN/GRAMIC NEOSPORIN SOLN POLYSPORIN SODIUM SULFACETAMIDE SOLN SULFACETAMIDE SODIUM TERRAMYCIN OINT TOBRAMYCIN SULFATE SOLN TRIMETHOPRIM SULFATE/POLY VIROPTIC SOLN	MC MC MC MC/DEL MC MC MC/DEL MC/DEL	AK-SULF OINT AK-TOB SOLN BLEPH-10 SOLN GENTAK ILOTYCIN OINT NEOMYCIN/BACI/POLYM OINT NEOSPORIN OINT OCUSULF-10 SOLN OCUTRICIN SOLN TERAK OINT TOBREX OINT TRIFLURIDINE SOLN		on the Prior Authorization form, such as the presence of 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. - QUINOLONES	MC/DEL MC/DEL MC MC/DEL	1 1 1 2	CILOXAN OINT CILOXAN SOLN OCUFLOX SOLN QUIXIN SOLN			Step order must be followed to avoid PA. Must fail Ocuflox and a Cioxan product before moving to next step product without PA. Use PA Form # 20420	Preferred drugs must be tried in step-order and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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.QUINOLONES-4TH GENERATION	MC/DEL MC		VIGAMOX ZYMAR				
OP. - ARTIFICIAL TEARS AND LUBRICANTS	MC MC/DEL MC/DEL MC MC MC/DEL MC MC MC MC MC MC MC MC MC		AKWA TEARS OINT ARTIFICIAL TEARS OINT ARTIFICIAL TEARS SOLN CELLUVISC SOLN EYE LUBRICANT OINT GENTEAL LIQUITEARNS SOLN MAJOR TEARS SOLN PURALUBE OINT PURALUBE TEARS SOLN REFRESH SOLN OP REFRESH PLUS SOLN REFRESH PM OINT	MC MC/DEL MC MC MC/DEL MC MC MC MC MC MC MC MC/DEL MC/DEL MC MC/DEL MC MC	AKWA TEARS SOLN ARTIFICIAL TEARS SOLN OP BION TEARS SOLN DRY EYES OINT DURATEARS OINT HYPO TEARS ISOPTO TEARS SOLN LACRI-LUBE LUBRIFRESH P.M. OINT MURINE SOLN MUROCEL SOLN NATURE'S TEARS SOLN REFRESH SOLN REFRESH TEARS SOLN SYSTANE TEARGEN SOLN TEARISOL SOLN TEARS NATURALE TEARS PURE SOLN TEARS RENEWED OINT THERATEARS SOLN V-R ARTIFICIAL TEARS 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. - BETA - BLOCKERS	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		BETOPTIC-S SUSP CARTEOLOL HCL SOLN LEVOBUNOLOL HCL SOLN METIPRANOLOL SOLN TIMOLOL MALEATE SOLG (GEL) TIMOLOL MALEATE SOLN	MC MC/DEL MC/DEL MC MC/DEL MC MC/DEL	BETAGAN SOLN BETAXOLOL HCL SOLN BETIMOL SOLN ISTALOL OCUPRESS SOLN OPTIPRANOLOL SOLN TIMOPTIC SOLN TIMOPTIC-XE SOLG	Use Pa Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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-INFLAMMATORY / STEROIDS OPHTH.	MC MC/DEL MC MC/DEL MC/DEL MC/DEL MC MC MC MC MC MC/DEL MC/DEL MC MC MC/DEL MC/DEL		AK-SPORE HC OINT ALREX SUSP BLEPHAMIDE SUSP CORTISPORIN SUSP DEXAMETH SOD PHOS SOLN FLAREX SUSP FLUOROMETHOLONE SUSP FML LIQUIFILM SUSP FML S.O.P. OINT FML-S LIQUIFILM SUSP INFLAMASE SOLN LOTEMAX SUSP NEOMIPOLIN/DEX PRED FORTE SUSP PRED MILD SUSP PREDNISOLONE TOBRADEX	MC MC MC MC MC MC MC MC MC MC MC MC/DEL MC MC/DEL MC MC/DEL	AK-TROL SUSP BACI/POLY/NEOMY/HC OINT BLEPHAMIDE S.O.P. OINT ECONOPRED EFLONE SUSP FLUOR-OP SUSP MAXITROL NEOI/POLY/BACI/HC OINT PRED-G SUSP PRED-G S.O.P. OINT SULFACET SOD/PRED SOLN VASOCIDIN SOLN VEXOL SUSP	Use Pa Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
OP. - PROSTAGLANDINS	MC		LUMIGAN SOLN	MC/DEL	RESCULA SOLN	All preferreds must be tried.	Preferred drugs must be tried and failed, in step-order, due to lack of efficacy (failure to reach target IOP reduction) or intolerable side effects before non-preferred drugs will be

	MC/DEL		TRAVATAN SOLN	MC/DEL	XALATAN SOLN	Use PA Form # 20420	approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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. - 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	CYCOGYL 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-ALLERGENICS	MC MC/DEL		ELESTAT PATANOL SOLN	MC MC/DEL 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-ALLERGENICS- 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 MC/DEL	OCUFEN SOLN NEVANAC	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 <sup>1</sup>	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.
<b>DERMATOLOGICAL</b>							
TOPICAL - ACNE PREPARATIONS	MC/DEL MC MC MC/DEL MC MC MC/DEL MC/DEL MC MC MC MC MC/DEL MC MC MC MC MC MC MC/DEL MC MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL MC		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 <sup>2</sup> RETIN-A GEL <sup>2</sup> RETIN-A LIQD <sup>2</sup> SODIUM SULFACET/SULF LOTN	MC MC MC MC/DEL MC/DEL MC MC MC/DEL MC MC MC MC MC MC MC MC MC MC MC MC MC/DEL MC MC/DEL MC MC/DEL MC/DEL MC/DEL MC	ALTINAC CREA AVITA CREA BENZAC BENZAACLIN GEL BENZAGEL-10 GEL BENZAMYCIN GEL BENZAMYCINPAK PACK BREVOXYL CLINAC BPO GEL CLINDAGEL GEL CLINDAMYCIN PHOSPHATE CLINDETS SWAB DESQUAM-E GEL DESQUAM-X DUJAC GEL EMGEL GEL ERYCETTE PADS ERYGEL GEL EVOCLIN FINEVIN CREA KLARON LOTN NEOBENZ MICRO 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 MC/DEL		BACIT/NEOMYCIN/POLYM OINT BACITRACIN OINT BACTROBAN <sup>1</sup> CENTANY OINT 2% <sup>1</sup> GENTAMICIN SULFATE	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 MC/DEL	BETA-VAL CLOBETASOL PROPIONATE ULTRAVATE PSORCON					
	MC MC MC	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 MC MC MC		AMMONIUM LACTATE CREA LACLOTION LOTN LACTINOL LOTN MEDERMA GEL MIMYX 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 MC	GRANUL-DERM AERS GRANULEX AERS PANAFIL OINT PANAFIL SE PAPAIN-UREA-CHLORO OINT TBC AERS XENADERM OINT	MC MC 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 MC	8 9	ELIDEL CREA PROTOPIQ 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 <sup>1</sup> EMLA CREA <sup>1</sup> EMLA/TEGADERM KIT <sup>1</sup> 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 MC/DEL MC/DEL MC MC MC	8 8 8 8 8 8 8 9	ALUSTRA CREA EPIQUIN MICRO GLYQUIN CREA HYDROQUINONE CREA HYDROQUINONE/SUNSCREENS SOLAQUIN FORTE CREA TRI-LUMA CREA ELDOQUIN	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 MC MC MC/DEL MC MC/DEL		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 ACCUZYME SE ETHEZYME	MC MC/DEL MC/DEL		REGREANEX GEL REGENECARE RADIAPLEXRX	Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Regranex will be approved for diabetic patients in good control (HgbA1c <8), who are not smoking, with a stage III or IV WOCN AND NPUAP lower extremity diabetic ulcer and with an adequate blood supply (TcPO2 >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 /	MC	ALUMINUM CHLORIDE SOLN	MC		LOWILA BAR	Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered

PROTECTANTS	MC MC	DRYSOL SOLN XERAC AC SOLN	MC MC MC	MOISTURIN DRY SKIN CREA PROSHIELD PLUS SKIN PROTE CREA SURGILUBE GEL		on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
TOPICAL - ANTISEPTICS / DISINFECTANTS	MC 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.
<b>MISCELLANEOUS EYE</b>						
OP. - EYE	MC 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 MC MC MC/DEL	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.
<b>MISCELLANEOUS EAR</b>						
EAR	MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC MC/DEL MC MC/DEL MC MC/DEL MC MC/DEL 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/DEL MC MC MC/DEL MC/DEL MC MC/DEL MC MC/DEL MC MC/DEL MC MC/DEL MC MC/DEL MC 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.
<b>MOUTH ANTISEPTICS</b>						
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.
<b>DENTAL PRODUCTS</b>						
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	MC/MC MC/DEL MC/DEL MC/DEL MC 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.
<b>ARTIFICIAL SALIVA/STIMULANTS</b>						
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.
<b>MISCELLANEOUS ANORECTAL</b>						
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	
<b>T-CELL ACTIVATION INHIBITOR</b>						
PSORIASIS BIOLOGICALS	MC MC	ENBREL <sup>1</sup> RAPTIVA <sup>1</sup>	MC	AMEVIVE <sup>2</sup>	1. Will not require a PA if at least one systemic drug such as methotrexate	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.

as methotrexate, cyclosporine, methoxsalen or acitretin is in members drug profile. High dose Enbrel will require a PA.  
 2. Trial of both preferred drugs are required. Use PA Form # 20910

**ALTERNATIVE MEDICINES**

ALTERNATIVE MEDICINES	MC		DIMETHYL SULFOXIDE SOLN	MC MC/DEL		ARTHX DS CAPS CO-ENZYME Q-10 DEHYDROEPIANDOSTERONE DHEA TABS FLEXAGEN TABS GLUCOSAMINE/CHONDROITIN HM GINKGO BILOBA TABS MELATONIN TABS	Use PA Form # 20420	Will only be approved for specific conditions supported by at least two double-blinded, placebo-controlled randomized trials that are not contradicted by other studies of similar quality.
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**CHELATING AGENTS**

CHELATING AGENTS	MC/DEL		CUPRIMINE CAPS	MC MC/DEL		DEPEN TITRATABS TABS EXJADE <sup>1</sup>	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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**ANTILEPTIC**

ANTILEPTIC				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 <sup>1</sup> SUTENT <sup>1,2</sup>	1. PA required to confirm FDA approved indication 2. Avoid CYP3A4 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 <sup>1,2</sup>	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 <sup>nd</sup> line)	X(2 <sup>nd</sup> line)				
NEURONTIN	X	X(2 <sup>nd</sup> line)	X (2 <sup>nd</sup> line)	9	9	X (2 <sup>nd</sup> line)	X (2 <sup>nd</sup> line)
TOPAMAX	X			9	6	X (2 <sup>nd</sup> 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