

CATEGORY	Step Order	PREFERRED DRUGS	Step Order	NON-PREFERRED DRUGS	PA Required	Comments	Criteria
<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 non-preferred products were readily available (by override, individual purchase, samples, etc.); 3. Certain drug trials, such as with preferred narcotics, may require evidence that the preferred drugs were actually tried (example: with urine drug tests); 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.							

**ASSORTED ANTIBIOTICS**

BETA-LACTAMS / CLAVULANATE COMBO'S		AMOXICILLIN AMOXIL <sup>1</sup> AMPICILLIN AMOXICILLIN/POTASSIUM CLA CHEW AMOXICILLIN/POTASSIUM CLA SUSR AMOXICILLIN/POTASSIUM CLA TABS AUGMENTIN ES-600 SUSR AUGMENTIN XR TB12 BEEPEN BICILLIN L-A SUSP DICLOXACILLIN SODIUM CAPS DYNAPEN SUSR GEOCILLIN TABS OXACILLIN SODIUM SOLR PENICILLIN V POTASSIUM TICAR SOLR TIMENTIN SOLR TRIMOX UNASYN SOLR VEETIDS ZOSYN		AMOXIL 500MG TABS 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. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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		CEFADROXIL HEMIHYDRATE CEFAZOLIN SODIUM SOLR CEFTIN SUSP CEFUROXIME AXETIL TABS CEFZIL CEPHALEXIN MONOHYDRATE DURICEF SUSR FORTAZ SOLR KEFZOL SOLR MAXIPIPE SOLR OMNICEF ROCEPHIN VANTIN		CECLOR <sup>1</sup> CEDAX 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. Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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		BIAXIN XL <sup>1</sup> AZITHROMYCIN TABS CLARITHROMYCIN E.E.S. E-MYCIN TBEC ERYPED 200 SUSR ERYPED 400 SUSR ERY-TAB TBEC		BIAXIN DYNABAC D5-PAK TBEC ERYPED CHEW PCE TBEC ZITHROMAX TABS		1. 7-Day supply per month w/o PA	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.

		ERYTHROCIN STEARATE TABS ERYTHROMYCIN ZITHROMAX SUSP ZMAX			Use PA Form # 20420		
TETRACYCLINES		DOXYCYCLINE HYCLATE MINOCYCLINE HCL CAPS SUMYCIN TETRACYCLINE HCL CAPS VIBRAMYCIN SYRP		DECLOMYCIN TABS DORYX CPEP DOXYCYCLINE MONO CAPS DYNACIN CAPS MONODOX CAPS PERIOSTAT	Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.	
FLUOROQUINOLONES		AVELOX ABC PACK TABS AVELOX SOLN AVELOX TABS CIPROFLOXACIN CIPRO XR <sup>1</sup>		CIPRO FLOXIN TABS LEVAQUIN NOROXIN TABS TEQUIN	1. QL 3/script/month Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.	
AMINO GLYCOSIDES		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		ETHAMBUTOL HCL TABS MYAMBUTOL TABS MYCOBUTIN CAPS RIFAMPIN		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		CHLOROQUINE PHOSPHATE TABS DARAPRIM TABS HYDROXYCHLOROQUINE TABS LARIAM TABS MALARONE TABS MEFLOQUINE HCL TABS QUINACRINE HCL POWD QUININE SULFATE		ARALEN TABS PLAQUENIL 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.	
ANTHELMINTICS		ALBENZA TABS BILTRICIDE TABS MEBENDAZOLE CHEW STROMECTOL TABS		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.		AZACTAM SOLR COLISTIMETHATE SODIUM SOLR FUROXONE TABS METRONIDAZOLE <sup>2</sup> PENTAMIDINE ISETHIONATE SOLR PRIMSOL SOLN TRIMETHOPRIM TABS VANCOCIN HCL VANCOMYCIN HCL		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				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		CLEOCIN SOLN CLEOCIN SUSR CLINDAMYCIN HCL 150CAPS DAPSONE TABS		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.		ERYTHROMYCIN/SULF SUSR SEPTRA/DS TABS SULFAMETHOXAZOLE/TRIMETH TRIMETHOPRIM/SULFAMETHOXA		ALINA* BACTRIM DS TABS	* Alina is preferred for children less than 12 years of age.  Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.	
<b>ANTI - FUNGALS</b>							
ANTIFUNGALS - ASSORTED		ANCOBON CAPS FLUCONAZOLE <sup>1</sup> GRIFULVIN GRISEOFULVIN ULTRAMICROSI TABS GRIS-PEG TABS KETOCONAZOLE TABS NYSTATIN	5 5 5 6 8 8	LAMISIL TABS SPORANOX SOLN <sup>2</sup> SPORANOX PULSEPAK CAPS <sup>3</sup> SPORANOX CAPS <sup>3</sup> DIFLUCAN <sup>1</sup> 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 step	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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.	

		VFEND TABS			order. Continue to use Anti-Fungal PA form for non-preferred products. Use PA Form # 10120	
<b>ANTI - VIRALS</b>						
ANTIRETROVIRALS		AGENERASE CAPS APTIVUS COMBIVIR TABS CRIVAN CAPS EMTRIVA EPIVIR / HBV EPZICOM FORTOVASE CAPS HIVID TABS INVIRASE CAPS KALETRA LEXIVA NORVIR RESCRIPTOR TABS RETROVIR REYATAZ SUSTIVA TRIZIVIR TABS TRUVADA VIDEX / EC VIRACEPT TABS VIRAMUNE TABS VIREAD TABS ZERIT ZIAGEN TABS		DIDANOSINE FUZEON	Fuzeon use PA Form # 10620  Turvada use PA form #20420	Please refer to the criteria listed on the Fuzeon PA form.
CYTO-MEGALOVIRUS AGENTS		GANCICLOVIR VALCYTE TABS		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.
<b>HEPATITIS AGENTS</b>						
HEPATITIS C AGENTS		PEG-INTRON KIT REBETRON KIT REBETOL CAPS	8 8 8 8	COPEGUS TABS PEGASYS KIT PEGASYS SOLN RIBAVIRIN CAPS	Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
HEPATITIS AGENTS - MISC.				ACTIMMUNE	Use PA Form # 20420	Approved for chronic granulomatous disease, osteopetrosis and idiopathic pulmonary fibrosis.
HEPATITIS B ONLY		HEPSERA TABS				
HERPES AGENTS		ACYCLOVIR VALTREX TABS		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		AMANTADINE RELENZA DISKHALER AEPB RIMANTADINE HCL TABS TAMIFLU <sup>1</sup>		FLUMADINE TABS FLUMIST <sup>2</sup>	1. Tamiflu 10 caps or 60cc's per month. 2. Flumist Use Form # 10610. Others Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
<b>RSV PROPHYLAXIS</b>						
RSV PROPHYLAXIS				RESPIGAM SYNAGIS	Use PA Form # 30120	Please see the criteria listed on the Synagis PA form.
<b>MS TREATMENTS</b>						
MULTIPLE SCLEROSIS AGENTS			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.
<b>ASSORTED NEUROLOGICS</b>						
NEUROLOGICS - MISC.		MESTINON ORAP TABS PROSTIGMIN TABS		BOTOX MYOBLOC <sup>1</sup>	1. Myobloc approval will be limited to Cervical Dystonia. Use PA Form #10210	Failed/did not tolerate therapeutic trials to muscle relaxants, unless contraindicated, including but not limited to baclofen, cyclobenzaprine, orphenadrine, Skelaxin, and tizanidine.
<b>STEROIDS</b>						
GLUCOCORTICOIDSI MINERALOCORTICOIDSI		CELESTONE SUSP CORTEF 5 CORTISONE ACETATE TABS DELTASONE TABS DEPO-MEDROL SUSP DEXAMETHASONE		CORTEF 10 and 20 TABS DECADRON TABS FLORINEF TABS MEDROL TABS MEDROL DOSEPAK TABS PEDIAPRED LIQD	Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.

		ENTOCORT EC CP24 FLUDROCORTISONE ACETATE TABS HYDROCORTISONE KENALOG METHYLPREDNISOLONE TABS ORAPRED SOLN PREDNISOLONE PREDNISON SOLU-CORTEF SOLR SOLU-MEDROL SOLR		PREDNISON INTENSOL CONC PRELONE SYRP STERAPRED TABS	
<b>HORMONE REPLACEMENT THERAPIES</b>					
ANDROGENS / ANABOLICS		ANDROID CAPS ANDRODERM PT24 DANAZOL CAPS DEPO-TESTOSTERONE OIL FLUOXYMESTERONE TABS OXANDRIN TABS TESTODERM TESTOSTERONE PROPIONATE TESTRED CAPS WINSTROL TABS		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		ESTRADERM PTTW VIVELLE PTTW	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		CENESTIN TABS DELESTROGEN OIL ESTRADIOL ESTROPIPATE TABS MENEST TABS PREMARIN TABS		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		PREMPHASE TABS PREMPRO TABS		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		MEDROXYPROGESTERONE ACETA <sup>2</sup> NORETHINDRONE ACETATE TABS <sup>2</sup> PROGESTERONE POWD		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		ORTHO MICRONOR TABS		CAMILA TABS NORA-BE TABS NOR-OD 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		DEPO-PROVERA SUSP		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		PLAN - B <sup>1</sup>			1. Allowed 4 tablets per 30 days without PA
CONTRACEPTIVES - PATCHES/ VAGINAL PRODUCTS		ORTHO EVRA PTWK <sup>1,2</sup>		NUVARING RING	1. No PA required for users less than 21 years of age. 2. The FDA has issued a public health warning of the potentials for increased exposure to estrogen with Ortho Eva use, possibly up to 60% estrogen exposure. Use PA Form # 20420 Approved if adequate clinical reason given why patient unable to comply with other preferred agents including long acting injectable.
CONTRACEPTIVES -		ALESSE-28 TABS		APRI TABS	Loestrin FE and FE 1/20 are

MONOPHASIC COMBINATION O/C'S	DEMULEN 1/35-28 TABS DEMULEN 1/50-28 TABS DESOGEN TABS LEVLEN-28 TABS LO/OVRAL 21 TABS LO/OVRAL 28 TABS MODICON TABS ORTHO-CEPT-28 TABS ORTHO-CYCLEN-28 TABS ORTHO-NOVUM 1/35-28 TABS ORTHO-NOVUM 1/50-28 TABS OVCON-35/28 TABS OVCON-50 28 TABS	AVIANE TABS BREVICON-28 TABS CRYSELLE-28 TABS DEMULEN 1/35-21 TABS KARIVA TABS LESSINA-28 TABS LEVLITE-28 TABS LEVORA LOESTRIN TABS LOESTRIN FE TABS LOESTRIN FE 1/20 TABS LOESTRIN 1.5/30-21 TABS LOESTRIN 1/20-21 TABS LOW-OGESTREL TABS MICROGESTIN FE TABS MIRCETTE TABS NECON NORDETTE-28 TABS NORINYL NORTREL MONONESSA OGESTREL TABS OVRAL PORTIA-28 TABS SPRINTEC 28 TABS YASMIN 28 TABS ZOVIA	grandfathered for established users. If member experienced adverse reactions, consider using Oral Contraceptives from other groups.  Use PA Form # 20420	on the Prior Authorization form, such as the presence of 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 - BI-PHASIC COMBINATIONS	ORTHO-NOVUM 10/11-28 TABS	NECON 10/11-28 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 - TRI-PHASIC COMBINATIONS	ORTHO TRI-CYCLEN TABS ORTHO-NOVUM 7/7/7-28 TABS TRI-LEVLEN TABS TRIPHASIL 28 TABS	CYCLESSA TABS ENPRESSE ESTROSTEP FE TABS ORTHO TRI-CYCLEN LO TABS TRI-NORINYL 28 TABS TRIVORA-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.
<b>DIABETES THERAPIES</b>				
DIABETIC - INSULIN	ILETIN LANTUS SOLN NOVOLIN NOVOLOG RELION VELOSULIN BR SOLN	HUMALOG HUMULIN	Use PA Form # 30140	Approved if patient has had an allergic reaction to preferred products or for pediatric patients requiring insulin doses with diluent.
DIABETIC - PENFILLS		5 NOVOLIN PENFILL 5 NOVOLOG PENFILL SOLN 5 NOVOLOG MIX PENFILL 8 HUMALOG MIX 75/25 PEN SUSP 8 HUMALOG PEN SOLN 8 HUMULIN PEN	PA's will be granted for significant visual or neurological impairment. Products must be used in specified step order. Use PA Form # 20420	Approved for significant visual or neurologic impairment affecting hand dexterity and for school age children requiring at school doses.
DIABETIC - OTHER		SYMLIN		
INCRETIN MIMETIC		BYETTA		One prefilled pen per month. There are 60 doses per each pen and each pen is a 30 day supply.
DIABETIC - ORAL SULFONYLUREAS	CHLORPROPAMIDE TABS GLIMEPIRIDE GLIPIZIDE TABS GLIPIZIDE ER TABS GLYBURIDE TABS GLYBURIDE MICRONIZED TABS TOLAZAMIDE TABS TOLBUTAMIDE TABS	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	METFORMIN HCL TABS METFORMIN ER 500MG	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 drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.

DIABETIC - THIAZOL / BIGUANIDE COMBO		ACTOPLUS MET AVANDAMET TABS			
DIABETIC - / THIAZOL		AVANDIA TABS <sup>1</sup> ACTOS 15MG TABS <sup>1</sup> ACTOS 45MG TABS <sup>1</sup>		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
DIABETIC - ALPHAGLUCOSIDASE		GLYSET TABS		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		GLYBURIDE/METFORMIN		GLUCOVANCE TABS METAGLIP TABS	Use individual ingredients. Use PA Form # 20420 Approved for patients failing to achieve good diabetic control with maximal doses of individual components.
DIABETIC - MEGLITINIDES		STARLIX TABS		BRANDIN 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		ARMOUR THYROID TABS CYTOMEL TABS LEVOTHROID TABS LEVOTHYROXINE SODIUM TABS LEVOXYL TABS THYROID TABS THYROLAR UNITHROID TABS		LEVOHYROXINE 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		METHIMAZOLE TABS PROPYLTHIOURACIL TABS		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		ACTONEL TABS FOSAMAX SOLN FOSAMAX TABS FOSAMAX PLUS D MIACALCIN SOLN		AREDIA SOLR BONIVA DIDRONEL TABS EVISTA TABS <sup>1</sup> FORTEO	1. Approval only requires failure of Fosamax or Actonel Use PA Form # 20420 Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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				SENSIPAR	Use PA Form # 30115 Baseline PTH, Ca, and phosphorus levels are required and initial approvals will be limited to 3 months. Subsequent approvals will require additional levels being done to assess changes. Will not approve if baseline Ca is less than 8.4.
<b>GROWTH HORMONE</b>					
GROWTH HORMONE			5 5 6 8 8 8	GENOTROPIN TEV-TROPIN NUTROPIN HUMATROPE SOLR NORDITROPIN CARTRIDGE SOLN SAIZEN SOLR	Products must be used in specified step order. Use PA Form # 10710 See Growth Hormone PA form for criteria. Step-order will still apply unless clinical contraindication supplied.
SOMATOSTATIC AGENTS		SANDOSTATIN			
<b>GROWTH HORMONE ANTAGONISTS</b>					
GH ANTAGONISTS				SOMAVERT	Use PA Form # 10710 Approved for acromegaly patients failing surgery/radiation/drug therapy including bromocriptine and sandostatatin.
<b>URINARY INCONTINENCE</b>					
VASOPRESSINS			5 6 6 8 8	DDAVP TABS DDAVP SOLN DESMOPRESSIN SPRAY DESMOPRESSIN ACETATE SOLN STIMATE SOLN*	Products must be used in specified step order. Nocturnal enuresis patients will be encouraged to periodically attempt stopping DDAVP. Use Pa Form # 20420 Approved for central diabetes insipidus and for nocturnal enuresis. For nocturnal enuresis- must be over 6 years old, must fail an adequate trial of alarm training (higher success rate, lower relapse rate) and must periodically attempt weaning (at 6 month intervals). * Patients with a diagnosis of hemophilia or Von Willebrands disease will be exempt from prior authorization.
ANTISPASMODICS		OXYBUTYNIIN URISPAS TABS		CYSTOSPASZ TABS DETROL TABS DITROPAN	Use PA Form # 20420 Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANTISPASMODICS - LONG ACTING		DETROL LA CP24 DITROPAN XL TBCR ENABLEX <sup>1</sup> VESICARE <sup>1</sup>		OXYTROL SANCTURA	Use PA Form # 20420 Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.  1. Vesicare 5mg and Enablex 7.5mg maximum doses if given with drugs known to be significant CYP3A4 inhibitors. (Ketoconazole, Sporanox, Erythromycin, Biaxin, Nefazodone, Nelfinavir, and Ritonavir)
CHOLINERGIC		URECHOLINE			
<b>METABOLIC MODIFIER</b>					
HERED. TYROSINEMIA				ORFADIN	Use PA Form # 20420 Approved for Type 1 hereditary tyrosinemia patients. Must include laboratory evidence of dx at first PA.

ANTIHYPERTENSIVES / CARDIAC

CARDIAC GLYCOSIDES		DIGITEK TABS DIGOXIN LANOXICAPS LANOXIN			
ANTIANGINALS--Isosorbide Dinitrate/ Mono-Nitrates		ISOSORBIDE MONONITRATE TABS ISOSORBIDE MONONITRATE ER	DILATRATE SR CPCR ISORDIL TABS ISORDIL TITRADOSE TABS ISOSORBIDE DINITRATE SUBL ISOSORBIDE DINITRATE TABS ISOSORBIDE DINITRATE CR TBCR ISOSORBIDE DINITRATE ER TBCR ISOSORBIDE DINITRATE TD TBCR IMDUR TB24 SMO TABS MONOKET TABS	Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
NITRO - OINTMENT/CAP/CR		NITROBID OINT NITROGLYCERIN CPCR NITROL OINT NITRO-TIME CPCR			
NITRO - PATCHES	1 1 1 3	NITROGLYCERIN PT24 NITREK PT24 NITRO-DUR PT 24 0.8MG MINITRAN PT24	NITRODISC PT24 NITRO-DUR PT24	At least 2 step 1's and step 3 of the preferred products must be used in specified order or PA will be required. Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
NITRO - SUBLINGUAL / SPRAY		NITROLINGUAL AERS NITROSTAT SUBL NITROTAB SUBL	NITROLINGUAL SOLN NITROQUICK SUBL	Use Pa Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
BETA BLOCKERS - NON SELECTIVE		COREG TABS INDERAL LA CPCR LEVATOL TABS NADOLOL TABS PINDOLOL TABS PROPRANOLOL HCL SOLN <sup>1</sup> PROPRANOLOL HCL TABS <sup>1</sup> SOTALOLOL HCL TABS TIMOLOL MALEATE TABS	BETAPACE TABS BETAPACE AF TABS CORGARD TABS INDERAL TABS INNOPRAN XL PROPRANOLOL HCL LA CPCR	1. Recommend using BID since its effects do not last 24 hours.  Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
BETA BLOCKERS - CARDIO SELECTIVE		ACEBUTOLOL HCL CAPS ATENOLOL TABS <sup>1</sup> BETAXOLOL HCL TABS BISOPROLOL FUMARATE TABS METOPROLOL TARTRATE TABS <sup>1</sup> TOPROL XL TB24	KERLONE TABS LOPRESSOR TABS SECTRAL CAPS TENORMIN TABS ZEBETA 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.
BETA BLOCKERS - ALPHA / BETA		LABELTALOL HCL TABS	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	1 1 1 1 1 1 4 4 4	NORVASC TABS CARDIZEM LA TB24 DILTIA XT CP24 DILTIAZEM HCL ER CP24 DILTIAZEM HCL XR CP24 DILTIAZEM CD 300MG CP24 DILTIAZEM CD 360MG CP24 CARTIA XT CP24 DILTIAZEM CD CP24 DILTIAZEM HCL ER CP24 DILTIAZEM XR CP24	5 DILACOR XR CP24 6 TAZTIA 7 TIAZAC CP24 8 CARDIZEM TABS 8 CARDIZEM CD CP24 8 CARDIZEM SR CP12 8 DILTIAZEM HCL TABS 8 DILTIAZEM HCL ER CP12	Products must be used in specified order or PA will be required. Just write "Cardizem LA" or "Diltiazem 24-hour" and the pharmacy will use a preferred long acting diltiazem that does not require PA. Use PA Form # 20420	Preferred drugs must be tried and failed (in step-order) due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
			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.
			DYNACIRC CAPS DYNACIRC CR TBCR <sup>1</sup>	Use PA Form # 20420 1. Established users will be grandfathered	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
			CARDENE CAPS CARDENE SR CPCR NICARDIPINE HCL CAPS	Use PA Form # 20420	Other Preferred calcium channel blockers must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
		NIFEDIPINE TBCR NIFEDIPINE ER TBCR	ADALAT CC TBCR NIFEDIPINE CAPS	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.

		NIFEDICAL XL TBCR		PROCARDIA CAPS PROCARDIA XL TBCR	Use PA Form # 20420	between another drug and the preferred drug(s) exists.
		SULAR TB24				
	1	VERAPAMIL HCL CR TBCR		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.
	1	VERAPAMIL HCL ER TBCR		CALAN SR TBCR		
	1	VERAPAMIL HCL SR TBCR		COVERA-HS TBCR		
	1	VERELAN PM CP24		ISOPTIN-SR VERAPAMIL HCL ER CP24 VERAPAMIL HCL SR CP24 VERAPAMIL HCL TABS VERELAN CP24		
ANTIARRHYTHMICS		AMIODARONE MEXILETINE NORPACE PROCAINAMIDE PROCANBID CR QUINAGLUTE QUINIDINE GLUCONATE QUINIDINE SULFATE RYTHMOL TAMBOCOR		PACERONE CORDARONE DISOPYRAMIDE PROPafenone FLECAINIDE MEXITIL QUINIDEX TIKOSYN <sup>1</sup>	1. Prescription must be written by Cardiologist. Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ACE INHIBITORS		CAPTOPRIL TABS BENAZEPRIL HCL ENALAPRIL MALEATE TABS LISINOPRIL TABS MONOPRIL TABS	5 5 8 8 8 8 8 8 8 8 8 8	MAVIK TABS ACCUPRIL TABS ACEON TABS ALTACE CAPS CAPOTEN TABS FOSINOPRIL SODIUM LOTENSIN TABS MOEXIPRIL PRINIVIL TABS UNIVASC VASOTEC TABS ZESTRIL TABS	Non-preferred products must be used in specified order. Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs (in step-order) will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Non-preferred products are subject to step-order requirements unless clinical circumstances warrant exception.
ANGIOTENSIN RECEPTOR BLOCKER		AVAPRO TABS BENICAR TABS COZAAR TABS DIOVAN MICARDIS TABS TEVETEN TABS		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.
ANTIHYPERTENSIVES - CENTRAL		CATAPRES-TTS CLONIDINE HCL TABS GUANFACINE HCL TABS HYDRALAZINE HCL TABS HYLOREL TABS METHYLDOPA TABS MINOXIDIL TABS PRAZOSIN HCL CAPS RESERPINE TABS		CATAPRES TABS GUANABENZ ACETATE TABS SMELIN TABS MINIPRESS CAPS TENEX TABS	Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ACE INHIBITORS AND CA CHANNEL BLOCKERS		LOTREL CAPS TARKA TBCR		LEXXEL 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		BENAZEPRIL HCL/HYDROCHLOR CAPTOPRIL/HYDROCHLOROTHIA ENALAPRIL MALEATE/HCTZ TABS LISINOPRIL-HCTZ TABS UNIRETIC TABS		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		ATENOLOL/CHLORTHALIDONE BISOPROLOL FUMARATE/HCTZ PROPRANOLOL/HCTZ		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		AVALIDE TABS BENICAR HCT DIOVAN HCT TABS HYZAAR TABS		ATACAND HCT TABS	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.

		MICARDIS HCT TABS TEVETEN HCT TABS			Use PA Form # 20420	
DIURETICS		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		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>	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		CADUET				
<b>LIPID DRUGS</b>						
CHOLESTEROL - BILE SEQUESTRANTS		CHOLESTYRAMINE COLESTID		PREVALITE QUESTRAN WELCHOL TABS	Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
CHOLESTEROL - FIBRIC ACID DERIVATIVES		GEMFIBROZIL TABX TRIGLIDE NIASPAN TRICOR		ANTARA LOPID LOFIBRA	Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
CHOLESTEROL - HGM COA + ABSORB INHIBITORS		ADVICOR TBCR ALTOPREV TB 24 CRESTOR LIPITOR TABS LESCOL CAPS LESCOL XL TB24 LOVASTATIN TABS VYTORIN ZETIA TABS <sup>1</sup> ZOCOR TABS		MEVACOR TABS PRAVACHOL TABS PRAVIGARD	1. Zetia available w/OPA as addition to Zocor 80mg, Lipitor 80mg, or Crestor 40mg. Zetia will also be approved with a PA as add on for patients at maximally tolerated doses of statins. Zocor patients trying to use Zetia must use Vytorin instead. Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Zetia will be approved for patients unable to tolerate all other therapies or unable to achieve cholesterol goal with maximally tolerated dose of most potent statins.
<b>PULMONARY ANTI-HYPERTENSIVES</b>						
PULMONARY ANTI-HYPERTENSIVES				FLOLAN TRACLEER	Use PA Form # 20420	Flolan and Tracleer will be approved after the dx of pulmonary hypertension is confirmed.
<b>IMPOTENCE AGENTS</b>						
IMPOTENCE AGENTS			9 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 - ANTICHOLINERGIC / DOPAMINERGIC		MECLIZINE HCL TABS PHENERGAN SUPP PHENERGAN FORTIS SYRP PROMETHAZINE TRANSDERM-SCOP PT72		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		MARINOL CAPS ZOFRAN SOLN* ZOFRAN TABS* EMEND ZOFRAN ODT TDDP		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>						
ANTIHISTAMINES - NON-SEDATING		ALAVERT TABS <sup>1</sup> CLARITIN ALLERGY (OTC) <sup>1</sup> CLARITIN SYRP (OTC) <sup>2</sup> TAVIST ND (OTC) <sup>1</sup>	5 5 5 8 8	CLARINEX TABS <sup>2</sup> CLARINEX SYR <sup>3</sup> ZYRTEC <sup>2</sup> ALLEGRA CLARITIN <sup>2</sup>	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	Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. No combination

			9	FEFOXENADINE	Clarinet Tabs and Zyrtec products before moving to next step product without PA Pseudoephedrine is available with prescription. Use PA Form # 20530	product with decongestant will be approved since pseudoephedrine available without PA.
<b>ALLERGY / ASTHMA THERAPIES</b>						
ANTIASTHMATIC - ANTICHOLINERGICS - INHALER		ATROVENT AERS ATROVENT HFA		SPIRIVA <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. 1. FEV <sub>1</sub> <= 50% or COPD hospitalization within 6 months due to Atrovent failure.
ANTIASTHMATIC - ANTICHOLINERGICS - NEBULIZER		IPRATROPIUM BROMIDE SOLN		ATROVENT SOLN	Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANTIASTHMATIC - ANTIINFLAMMATORY AGENTS		CROMOLYN SODIUM NEBU INTAL AERS TILADE AERS		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	1 1 4 4 4	FLONASE SUSP <sup>1</sup> NASONEX SUSP <sup>1</sup> BECONASE AERS BECONASE AQ INHA NASAREL SOLN		FLUNISOLIDE SOLN NASACORT AERS NASACORT AQ AERS RHINOCORT AERO RHINOCORT AQUA SUSP TRI-NASAL SOLN VANCENASE POCKETHALER AERS	Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANTIASTHMATIC - NASAL MISC.		NASALCROM		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		ALBUTEROL FORADIL AEROLIZER CAPS MAXAIR METAPROTERENOL SEREVENT TERBUTALINE SULFATE TABS		ACCUNEB NEBU ALUPENT AERP BRETHINE PROVENTIL PROVENTIL HFA AERS VENTOLIN AERS VENTOLIN HFA AERS VOLMAX TBCR VOSPIRE ER TB12 XOPENEX NEBU <sup>1,2</sup>	1. Xopenex users with prior asthma hospitalization due to albuterol nebulizer failure will be grandfathered. 2. Quantity Limit: 12 cc/day.  Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANTIASTHMATIC - ADRENERGIC COMBINATIONS		ADVAIR DISKUS MISC				Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Duoneb components are available separately without PA.
ANTIASTHMATIC - ADRENERGIC ANTICHOLINERGIC		COMBIVENT AERO		DUONEB SOLN <sup>1</sup>	1. Please use preferred individual ingredients Albuterol and Ipratropium. Use PA Form # 20420	
ANTIASTHMATIC - XANTHINES		AMINOPHYLLINE TABS THEOCHRON TB12 THEOLAIR-SR TB12 THEOPHYLLINE ELIX THEOPHYLLINE SOLN THEOPHYLLINE ER CP12 THEOPHYLLINE ER TB12 UNIPHYL TBCR		QUIBRON CAPS QUIBRON-T TABS QUIBRON-TISR 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		AEROBID AERS ASMANEX AZMACORT AERS BECLOVENT AERS FLOVENT PULMICORT SUSP <sup>1</sup> QVAR AERS VANCERIL AERS		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 turbobaler if under 14 yr.  Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANTIASTHMATIC - 5-Lipoxygenase Inhibitors				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		SINGULAIR <sup>1</sup>	ACCOLATE TABS	1. Must be using inhaled steroid, unless less than 14 years old, for script to avoid requiring a PA. Use PA Form # 20420	Singulair will additionally be approved for allergic indications if other cost effective allergy treatments are ineffective, including oral antihistamines and nasal steroids. Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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			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			PULMOZYME SOLN	Use PA Form # 20420	Will be approved for cystic fibrosis patients.
ANTIASTHMATIC - MUCOLYTICS		ACETYLCYSTEINE <sup>1</sup>	MUCOMYST	1. Acetylcysteine is covered with diagnosis of CF. Use PA Form # 20420	
<b>COUGH/COLD</b>					
COUGH/COLD		PSEUDOEPHEDRINE ROBITUSSIN DM SYRP <sup>1</sup> 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		DIPHENOXYLATE DIPHENOXYLATE/ATROPINE IMODIUM A-D TABS LOPERAMIDE HCL CAPS LOPERAMIDE HCL LIQD OPIUM TINCTURE TINC PAREGORIC TINC	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.		ALU-CAP CAPS ANTACID CHEW ATROPINE SULFATE SOLN BENTYL SYRP BISMATROL CALCIUM ANTACID CALCIUM CARBONATE CAL-GEST ANTACID CHEW CHEWABLE ANTACID CHEW DICYCLIMINE 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	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 LEVSIN TABS LEVSIN/SL SUBL NULEV TBDP URO-MAG 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. <b>As listed in MaineCare Policy, certain drugs require specific diagnoses for approval.</b>
GI - H2-ANTAGONISTS		CIMETIDINE FAMOTIDINE RANITIDINE V-R ACID REDUCER TABS	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		PREVACID CPDR OTC PRILOSEC PROTONIX PREVACID ORAL SUSP PREVACID SOLUTABS**	6 ACIPHEX TBEC 7 OMEPRAZOLE CPDR 8 NEXIUM CPDR 8 PRILOSEC CPDR 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-INFECTION		HELIDAC PREVPAC				
GI - PROSTAGLANDINS		MISOPROSTOL TABS		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		LACTAID ULTRA LACTRASE CAPS	5 5 7 7 7 7 7 7 8 8 8 8 8 8 8	ULTRASE CPEP ULTRASE MT LIPRAM PANCREASE PANCRELIPASE PANGESTYME PANOKASE TABS CREON KUTRASE CAPS KU-ZYME CAPS LIPRAM CR PANCREASE MT PANCRECARB MS-8 CPEP VIOKASE	Non-preferred products are a one time PA for life (for CF diagnosis). Non-preferred products must be used in specified step order.  Use PA Form # 20420	Non-Preferred drugs must be tried and failed in step-order due to lack of efficacy or intolerable side effects before other non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. In all cases except cystic fibrosis patients, objective evidence of pancreatic insufficiency (fat malabsorption test etc...) must be supplied.
GI - ANTI - FLATULENTS / GI STIMULANTS		CALULOSE SYRP CONSTULOSE SYRP ENULOSE SYRP GASTROCROM CONC GENERLAC SYRP LACTULOSE SYRP METOCLOPRAMIDE HCL SIMETHICONE		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	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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		ASACOL TBEC AZULFIDINE TABS AZULFIDINE EN-TABS TBEC CANASA SUPP COLAZAL CAPS DIPENTUM CAPS PENTASA CPCR ROWASA ENEM SULFASALAZINE TABS		SULFAZINE EC TBEC	Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
GI - IRRITABLE BOWEL SYNDROME AGENTS				LOTROXEN TABS ZELNORM TABS	Use PA Form # 20420	Zelnorm will be approved for women with IBS and predominant constipation. Lotronex will be approved for females with IBS and predominant diarrhea. Prior failed trials of multiple other preferred GI agents must occur first. IBS dx must be thoroughly documented.
<b>MISCELLANEOUS GI</b>						
<b>**Preferred drugs that used to require diag codes still require diag codes unless indicated otherwise.**</b>						
GI - MISC.		BISAC-EVAC SUPP BISACODYL BISCOLAX SUPP CINOBAC CAPS CITRATE OF MAGNESIA SOLN CITRUCEL D.O.S. CAPS DIOCTO LIOD DIOCTO SYRP DIOCTYN CAPS DOC-Q-LACE CAPS DOCUSATE CALCIUM CAPS DOCUSATE SODIUM DOCUSIL CAPS DOK CAPS FIBER LAXATIVE TABS FLEET GENFIBER POWD GLYCERIN HIPREX TABS KRISTALOSE PACK METAMUCIL MILK OF MAGNESIA SUSP MINERAL OIL OIL MIRALAX PACK <sup>1</sup> MIRALAX POWD <sup>1</sup> SENNA SENOKOT GRAN		ACTIGALL CAPS BENEFIBER CARAFATE COLACE CAPS COLYTE DIOCTO-C SYRP DOC SOD /CAS CAP DOC-Q-LAX CAPS DOCUSATE SODIUM/CAS CAPS DOK PLUS DULCOLAX SUPP FIBER CON TABS FIBER-LAX TABS GOLYTELY SOLR GLYCOLAX <sup>1</sup> MALTSUPEX NULYTELY SOLR PEG 3350/ELECTROLYTES SOLR SENNEXON TABS SENOKOT TABS SENOKOT S TABS STOOL SOFTENER PLUS CAPS UNI-CENNA TABS UNI-EASE PLUS CAPS V-R NATURAL SENNA LAXATIV TABS	1. Quantity Limit: 255 g/90-day without PA for greater than 18 years old. No quantity limit for less than 18 years old.  2. Must show evidence of trials of preferred agents that do not require PA, such as OTC senna, docusate, mineral oil and prescription lactulose.  Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. As listed in MaineCare Policy, certain drugs require specific diagnoses for approval.

		SENOKOT SYRP SENOKOT CHILDRENS SYRP SENOKOT XTRA TABS SORBITOL STOOL SOFTENER CAPS SUCRALFATE TABS UNI-EASE CAPS UNIFIBER POWD <b>URSO FORTE</b> URSODIOL			
<b>MISC. UROLOGICAL</b>					
UROLOGICAL - MISC.		ACETIC ACID 0.25% SOLN BICITRA SOLN CYTRA-K SOLN FURADANTIN SUSP K-PHOS MF TABS MACRODANTIN CAPS METHENAMINE MANDELATE TABS MONUROL PACK NEOSPORIN GU IRRIGANT SOLN PHENAZOPYRIDINE HCL TABS POLYCITRA SYRP POLYCITRA-K SOLN POLYCITRA-LC SOLN PROSED/DS TABS PYRIDIUM PLUS TABS <b>RENACIDIN SOLN</b> TRICITRATES SYRP UREX TABS URISED TABS UROCIT-K UROOID #2 TABS	CITRIC ACID/SODIUM CITRAT SOLN CYTRA-2 SOLN ELMIRON CAPS <sup>1</sup> MACROBID CAPS MANDELAMINE TABS NITROFURANTOIN MACR CAPS POLYCITRA-K CRYSTALS PACK POTASSIUM CITRATE/CITRIC SOLN PYRIDIUM TABS	1. Elmiron requires adequate proof of Dx with supportive testing.  <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.
<b>PHOSPHATE BINDERS</b>					
PHOSPHATE BINDERS		PHOSLO MEGNEBIND - 400	FOSRENOL <b>RENAGEL<sup>1,2</sup></b>	1. Renagel will be approved for hypercalcemia, digoxin users, and in cases where maximum phoslo doses are insufficient. 2. Will be verifying patient compliance. Labs must be provided. Please refer to the Phosphate Binders PA form. <b>Use PA Form #20530</b>	Renagel will be approved in patients with hypercalcemia, on concurrent digoxin or insufficient response with Phos-lo (Renagel to be add-on therapy).
<b>INTRA-VAGINALS</b>					
VAGINAL - ANTIBACTERIALS	1 1 3	CLEOCIN CREA METROGEL VAGINAL GEL CLEOCIN SUPP		Step order must be followed to avoid PA. Must fail Cleocin and Metrogel products before moving to next step product without PA.	Preferred drugs must be tried and failed in step-order due to lack of efficacy or intolerable side effects before less preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
VAGINAL - ANTI FUNGALS		CLOTRIMAZOLE CREA GYNE-LOTTRIMIN 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 VAGITROL V-R MICONAZOLE-7 CREA	AVC CREAM CLOTRIMAZOLE 3 DAY CREA GYNAZOLE-1 CREA GYNE-LOTTRIMIN 3 TABS MICONAZOLE 3 SUPP MONISTAT 3 SUPP TERAZOL 3 CREA TERAZOL 3 SUPP TERAZOL 7 CREA	1. Quantity limit: 1/scrip/2 weeks  <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.
VAGINAL - CONTRACEPTIVES		GYNOL II EXTRA STRENGTH GEL	DELFEN FOAM	<b>Use PA Form # 20420</b>	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		ESTRING RING PREMARIN CREA	ESTRACE CREA VAGIFEM TABS	Must fail all preferred products before non-preferred	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.

				USE PA Form # 20420	preferred drug(s) exists.
VAGINAL - OTHER		ACID JELLY GEL ACI-JEL GEL CERVICAL AMINO ACID CREA		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		AVODART DOXAZOSIN MESYLATE TABS PROSCAR TABS TERAZOSIN HCL CAPS	5 8 8 8	FLOMAX CP24 CARDURA TABS 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		ALPRAZOLAM TABS CHLORDIAZEPOXIDE HCL CAPS CLORAZEPATE DIPOTASSIUM TABS DIAZEPAM LORAZEPAM OXAZEPAM CAPS		ATIVAN 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		XANAX XR <sup>1</sup>			1. Xanax XR will be available if the long acting benzo clonazepam fails. Use PA Form # 20420
ANXIOLYTICS - MISC.		BUSPIRONE HCL TABS HYDROXYZINE HCL SOLN HYDROXYZINE HCL SYRP HYDROXYZINE PAMOATE CAPS		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		NARDIL TABS PARNATE TABS			
ANTIDEPRESSANTS - SELECTED SSRI'S		BUPROPION HCL TABS BUPROPION SR CITALOPRAM <sup>6</sup> FLUOXETINE HCL CAPS  FLUOXETINE HCL LIOD FLUOXETINE HCL TABS FLUVOXAMINE MALEATE TABS LEXAPRO TABS <sup>5</sup> MIRTAZAPINE PAROXETINE <sup>3</sup> PAXIL CR <sup>3</sup> SERZONE TABS TRAZODONE HCL TABS WELLBUTRIN XL ZOLOFT <sup>7</sup>	5 6 6 8  8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 9	CYMBALTA <sup>9</sup> EFFEXOR TABS EFFEXOR XR CP24 <sup>3</sup> CELEXA  DESYREL TABS FLUOXETINE 40 mg <sup>1</sup> LUVOX TABS MAPROTILINE HCL TABS PAXIL <sup>3</sup> PROZAC PROZAC CAPS PROZAC WEEKLY CPDR REMERON TABS SARAFEM CAPS TRAZODONE HCL 300MG TABS WELLBUTRIN TABS WELLBUTRIN SR TBCR REMERON SOLTAB TBDP	Non-preferred products must be used in specified step order. 1. Use Fluoxetine 20 mg in multiples. 2. See Zoloft splitting table. Zoloft requires splitting of 50mg and/or 100mg scored tabs to avoid PA. 3. Strong caution with pediatric population. 4. Established users are grandfathered. 5. See Celexa/Citalopram and Lexapro splitting tables. 6. Max daily dose allowed is 60mg, only 1 per day allowed for all strengths. Use PA Form # 20420  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 clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. At least one preferred SSRI and one preferred non-SSRI drugs must be tried. Venlafaxine is non-preferred for any anxiety diagnosis and may be approved after trials of one SSRI and one non-SSRI (e.g. any anxiolytic or a tricyclic at any dose).  Preferred Fluoxetine will be the only preferred antidepressant for members who are less than 18 years of age. Exceptions to the rule are as follows: 1. If the member (<18) is already an established user for any of the preferred or non-preferred drugs under the Antidepressant category on the PDL, then they can continue to get that drug. 2. If the member (<18) has a prescription for an antidepressant that is on the PREFERRED side of the PDL and has had a 30 day supply of Fluoxetine at least 30 days before the date they are getting it filled, the claim will pay. If they do not have the trial of Fluoxetine in their profile, the claim will reject for PA required. 3. If the member (<18) has a prescription for a medication that is on the NON-PREFERRED side of the PDL regardless of having Fluoxetine in their profile, the prescription will need a PA.  4. Use of a preferred antidepressant for anxiety will require pa to establish anxiety diagnosis.  <u>Special Kid &lt; 18yo Criteria for New Starters:</u> Must have had fluoxetine trial for at least 30 days before accessing other preferred antidepressants without PA.  Cymbalta- Second line therapy for Diabetic Peripheral Neuropathy and Post Herpetic Neuralgia after trial of a preferred TCA (tri-cyclic anti-depressant) and one of the following preferred medications: a preferred anti-convulsant, capsaicin, tramadol, or other narcotic. Combination therapy of non-preferred medications for Diabetic Peripheral Neuropathy and Post Herpetic Neuralgia will not be approved.
ANTIDEPRESSANTS - TRI-CYCLICS	*	AMITRIPTYLINE HCL TABS AVENTYL SOLN CLOMIPRAMINE HCL CAPS DESIPRAMINE HCL TABS DOXEPIN HCL IMIPRAMINE HCL TABS NORTRIPTYLINE HCL PROTRIPTYLINE HCL TABS SURMONTIL CAPS		AMOXAPINE TABS ANAFRANIL CAPS ELAVIL TABS NORPRAMIN TABS PAMELOR SINEQUAN TOFRANIL VIVACTIL TABS  PA required for new starters if over 65 years old. Users over 65 years old are grandfathered.  Use PA Form # 20420 or 102220	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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>SEDATIVE / HYPNOTICS</b>					
SEDATIVE/HYPNOTICS - BARBITURATE		BUTISOL SODIUM TABS CHLORAL HYDRATE SYRP MEBARAL TABS PHENOBARBITAL		LUMINAL SOLN SECONAL CAPS SOMNOTE CAPS  PA required for new users of preferred products if over 65 years old. Use PA Form # 30110	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
SEDATIVE/HYPNOTICS - BENZODIAZEPINES		DORAL TABS ESTAZOLAM TABS FLURAZEPAM HCL CAPS		DALMANE HALCION TABS MIDAZOLAM HCL SYRP  Previous quantity limits still apply. Use PA Form # 30110	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Benzodiazepines do cause dependence with continued use and usage should be limited to 7-10 days at a time. Chronic intermittent use (2-3 Days per week max) is the standard of care

		TEMAZEPAM CAPS TRIAZOLAM TABS		PROSOM TABS RESTORIL CAPS		
SEDATIVE/HYPNOTICS - Non-Benzodiazepines		LUNESTA <sup>1</sup> MIRTAZAPINE TRAZODONE	7 8 8 9	AMBIEN SONATA CAPS ROZEREM AMBIEN CR	Must fail all preferred products before non-preferred 1. Quantity Limit of 12 per 34 days. Use PA Form # 30110	Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Ambien and Sonata do cause dependence with continued use and as with benzodiazepines, usage should be limited to 7-10 days at a time. Chronic intermittent use (2-3 days per week max) is the standard of care. Please see Sedative/Hypnotic PA form.
<b>ANTI-PSYCHOTICS</b>						
ANTI-PSYCHOTICS - ATYPICALS		RISPERDAL GEODON <sup>1</sup> SEROQUEL TABS <sup>4</sup> ABILIFY TABS <sup>2</sup> ZYPREXA TABS <sup>3</sup> ZYPREXA ZYDIS TBDP	5 8 8	ABILIFY TABS <sup>2</sup> RISPERDAL M TAB RISPERDAL CONSA	1. Geodon has dose consolidation edit of 2 per day. 2. Abilify 1/day. 3. Zyprexa: maximal recommended dose showing efficacy is 20mg. Use PA Form # 20420	Preferred drugs subject to step order must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Atypicals will be approved, subject to step-order, for patients with FDA-approved indications and for specific conditions supported by at least two published peer-reviewed double-blinded, placebo-controlled randomized trials that are not contradicted by other studies of similar quality and as long as all first line preferred therapies have been tried and failed at full therapeutic doses for adequate durations (at least two weeks). * Abilify: doses above 15mg were not shown to be more effective than doses in the 10-15mg range. 4. Seroquel 25mg is available without PA if the following conditions are met: a.) Either 65 years of age or older or less than 18 years of age, b.) dosage is for 3 or more per day, c.) Seroquel 25mg is in the profile within the last 45 days.
ANTI-PSYCHOTICS - SPECIAL ATYPICALS		CLOZAPINE TABS		CLOZARIL TABS FAZACLO	Use PA Form # 20420	Preferred generic drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred brand will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Patients previously stabilized on brand name drug will be approved.
ANTI-PSYCHOTICS - TYPICAL		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		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		ESKALITH CAPS ESKALITH CR TBCR LITHIUM CARBONATE LITHIUM CITRATE SYRP				
<b>COMBINATION - PSYCHOTHERAPEUTIC</b>						
PSYCHOTHERAPEUTIC COMBINATION		CHLORDIAZEPOXIDE/AMITRIPT PERPHENAZINE/AMITRIPTYLIN	8	SYMBYAX	Use PA Form # 20420	Use individual components, which are currently available without a PA.
<b>STIMULANTS</b>						
STIMULANT - AMPHETAMINES - SHORT ACTING		ADDERALL TABS AMPHETAMINE SALT COMBO DEXEDRINE DEXTROAMPHET SULF TABS DEXTROSTAT TABS			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.	
STIMULANT - LONG ACTING AMPHETAMINES SALT		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.	
LONG ACTING AMPHETAMINES		DEXEDRINE CAP CR DEXTROAMPHET SULF CPCR				
STIMULANT - METHYLDAMPHATE		FOCALIN TABS		METHYLIN CHEWABLES	Preferred stimulants will be available without PA if diagnosis of ADHD As per recent FDA alert. Methylphenidate should not be used in patients with underlying heart defects since they may be at increased risk for sudden death.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered

METHYLPHENIDATE		METADATE ER TBCR METHYLIN ER TBCR METHYLIN TABS METHYLIN SOL METHYLPHENIDATE HCL		RITALIN	available without PA if diagnosis of ADHD.  Use PA Form # 20420	on the Prior Authorization form, such as the presence of 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		CONCERTA TBCR FOCALIN XR	5 8	METADATE CD CPCR <sup>1</sup> RITALIN LA	Preferred stimulants will be available without PA if diagnosis of ADHD. Non-preferred products must be used in specified step order. 1. Easily approved for patients needing the sprinkles. Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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			7 8 8 8 8 8 9	STRATTERA <sup>1,2</sup> CAFCIT SOLN CYLERT CHEW CYLERT TABS DESOXYN TABS PROVIGIL TABS PEMOLINE	1. Required failure of both an amphetamine and methylphenidate (unless history of substance abuse). 2. Strattera allowed only 1 per day for all strengths except 40mg, where 2 are allowed to achieve 80mg or 100mg daily. 3. Non-preferred products must be used in specified step order. Provigil: use PA Form # 20710; Others: use Pa Form # 20420	Provigil requests require diagnosis of Narcolepsy or Obstructive Sleep Apnea. Please refer to detailed criteria on Provigil PA form. Previous failures of methylphenidate and amphetamine is also required.
<b>ANTI-CATAPLECTIC AGENTS</b>						
PSYCHOTHERAPEUTIC AGENTS - MISC.				XYREM SOL	Use PA Form #20710	
<b>WEIGHT LOSS</b>						
WEIGHT LOSS					No longer covered.	Weight loss drugs are not covered as permitted by Federal Medicaid regulations and Maine Medicaid (MaineCare) Policy.
<b>ALZHEIMER DISEASE</b>						
ALZHEIMER - Cholinomimetics/Others		ARICEPT TABS <sup>1</sup> EXELON <sup>1</sup> NAMENDA <sup>1</sup>	8 8 9	RAZADYNE REMINYL COGNEX CAPS	1. All new users need PA to establish dementia diagnosis and baseline mental status score. Must fail all preferred products before moving to non-preferred. Use PA Form #20420	Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs (in step-order) will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
<b>SMOKING CESSATION</b>						
NICOTINE PATCHES / TABLETS		NICODERM CQ PT24			Bupropion SR 150 mg is available without a prior authorization.	OTC Nicotine products are covered by MaineCare Policy when they have been determined to be cost-effective. Only Nicoderm and the generic nicotine gums have received this designation. All other nicotine products (OTC & prescription) are non-covered by MaineCare Policy and as allowed by Federal Medicaid law. Another version of Zyban, Bupropion SR (100 and 150mg) is available without PA.
NICOTINE REPLACEMENT - OTHER		NICOTINE POLACRILEX GUM NICORETTE GUM		COMMIT LOZENGES <sup>1</sup>	1. Will be available to patients unable to tolerate preferred products. Use PA Form # 20420	OTC Nicotine products are covered by MaineCare Policy when they have been determined to be cost-effective. Only Nicoderm and the generic nicotine gums have received this designation. All other nicotine products (OTC & prescription) are non-covered by MaineCare Policy and as allowed by Federal Medicaid law.
<b>ALCOHOL DETERRENTS</b>						
ALCOHOL DETERRENTS		DISULFIRAM TABS ANTABUSE TABS NALTREXONE HCL TABS CAMPRAL <sup>1</sup>			1. Should only be used in conjunction with formal structured outpatient detoxification program.	Preferred generic drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
<b>MISCELLANEOUS ANALGESICS</b>						
ANALGESICS - MISC.		ACEPHEN SUPP ACETAMIN TAB 325MG ACETAMINOPHEN ASPIRIN ASPIRIN EC ASPIR-LOW TBEC BUFFERED ASPIRIN TABS BUTAL/ASA/CAFF BUTALBITAL COMPOUND BUTALBITAL/ACET TABS BUTALBITAL/APAP CAPS		ASPIR-81 TBEC AXOCET CAPS DOLOBID TABS EASPRIN TBEC EQUAGESIC TABS ESGIC-PLUS EXCEDRIN TAB ASA FRE FIORICET TABS FIORINAL CAPS FIORTAL CAPS FORTABS 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.

	BUTALBITAL/APAP/CAFFEINE CHILDRENS ASPIRIN CHEW CHILDRENS PAIN RELIEVER CHOLINE MAGNESIUM TRISALI DIFLUNISAL TABS ECOTRIN FEVERALL SUPP GENAPAP GENEBS TABS HEADACHE FORMULA ADDED TABS INFANTAIRE SOLN INFANTS APAP SOLN INFANTS PAIN RELIEVER SUSP MAPAP PAIN RELIEVER Q-NOL TABS SALSALATE TABS TACTINAL EXTRA STRENGTH TABS TYLENOL V-R CHILDRENS ASPIRIN CHEW V-R NON-ASPIRIN TABS		PHRENILIN TABS PHRENILIN FORTE CAPS TRILISATE LIQD TRILISATE TABS ZEBUTAL CAPS ZORPRIN TBCR		
<b>LONG ACTING NARCOTICS</b>					
NARCOTICS - LONG ACTING	AVINZA METHADONE METHADOSE MORPHINE SULFATE ER TB12 <sup>3</sup> OXYCODONE ER <sup>2</sup>	7 8 8 8 8	DURAGESIC PT72 <sup>1</sup> DRAMORPH SR TB12 MORPHINE SULFATE SUPP MS CONTIN TB12 KADIAN CP 24 <sup>2</sup> OXYCONTIN TB12 <sup>1</sup>	Non-preferred products must be used in specific order. 1. Duragesic, Oxycotin and Palladone will be available without PA for patients treated for or dying from cancer or hospice patients. CA (cancer) or HO (hospice) diag code may be used but store must verify since all scripts will be audited and stores will be liable. 2. Established users are grandfathered. 3. Effective 2.16.2006 only the Endo brand will be available without PA (labeler 60951) Use PA Form # 20510	Preferred drugs (Avinza or morphine sulfate ER tab, Methadone or Methadose, & oxycodone ER) & step order drugs must be tried for at least 2 weeks each & failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug & the preferred drug(s) exists. Adequate trials include prevention/treatment of common adverse effects associated w/ narcotics (antinausea, antipruritics, etc.) as well as adequate equianalgesic dosing when converting from one narcotic to another. Also, adequate documentation of attempts to titrate dose of preferred agents to achieve adequate pain relief & desired clinical response must be provided. Member's drug regimen for additions &/or discontinuations of medications that may affect absorption &/or metabolism of preferred agents must be monitored. Approvals will not be granted if patient had access to either non-preferred products or high doses of short acting narcotics during the trial period. Non-preferred drugs will not be approved for patients showing evidence of 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 requirements for narcotics by paying cash for affected narcotics (prescribers failed to submit prior authorization prior to cash narcotic scripts being filled by member). 10. Requests for any Brand name substance, considered by authorities to be highly abused and diverted (Oxycotin, Percocet, Tylox, Vicodin, Dilaudid, Ultracet...) with an available AB rated generic equivalent will be denied unless it will be provided in a setting that virtually eliminates the risk of diversion. 11. Allergic reactions to any product within a specific narcotic class will justify and preclude use of any other product in the same class due to the risk of cross-hypersensitivity.
NARCOTICS - SELECTED	TRAMADOL HCL TABS		BUPRENEX SOLN BUTORPHANOL NALBUPHINE HCL SOLN NUBAIN SOLN STADOL NS SOLN ULTRACET TABS  ULTRAM TABS	Use PA Form # 20420	Preferred drugs from this and other narcotic classes must be tried for at least 2 weeks each and failed due to lack of efficacy or intolerable side effects before non-preferred drugs from this class will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Approvals will not be granted if patient had access to either non-preferred products or high doses of short acting narcotics during the trial period. Substance abuse evaluations may be required for patients with medical records displaying potential signs of narcotic misuse and abuse such as chronic early refills, short dosing intervals, frequent dose increases, multiple lost/stolen etc scripts and intolerance or "allergy" to all products but desired product. Allergic reactions to any product within a specific narcotic class will justify and preclude use of any other product in the same class due to the risk of cross-hypersensitivity.  Non-preferred drugs will not be approved for patients showing evidence of usage patterns consistent with controlled substance 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; 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. In substance abuse evaluations may be required for patients with medical records displaying potential signs of narcotic misuse and abuse such as chronic early refills, short dosing intervals, frequent dose increases, multiple lost/stolen etc scripts and intolerance or "allergy" to all products but Oxycotin. Allergic reactions to any product within a specific narcotic class will justify and preclude use of any other product in the same class due to the risk of cross-hypersensitivity.
<b>MISCELLANEOUS NARCOTICS</b>					
NARCOTICS - MISC.	ACETAMINOPHEN/CODEINE ACTIO LPQD <sup>1</sup> ASPIRIN/CODEINE TABS BUTAL/ASA/CAFF/COD CAPS BUTALBITAL/ASPIRIN/CAFFEI CAPS CAPITAL AND CODEINE SUSP <sup>1</sup> CAPITAL/CODEINE SUSP <sup>1</sup> CODEINE PHOSPHATE SOLN CODEINE SULFATE TABS ENDOCET TABS <sup>2</sup> ENDODAN TABS FENTANYL CITRATE SOLN		ANEXSIA TABS ASCMP/CODEINE CAPS BUTALBITAL/APAP/CAFFEINE/ CAPS DARVOCET-N DARVON DEMEROL DILAUID DILAUID-HP SOLN FIORICET/CODEINE CAPS FIORINAL/CODEINE #3 CAPS FIORTAL/CODEINE CAPS HYDROCODONE/IBUPROFEN	1. ACTIO lollypop and Capital and codeine suspension products require PA for users over 18 years of age. 2. oxycodone/acet 10/650 is 8 times more expensive. Use twice as many of oxycod/acet 5/325 instead. You can mix and match preferred strengths of oxycodone and oxycodone/acet to minimize acet. dose similar to certain non-preferred drugs. 3. Effective 2.16.2006 only the Endo brand will be available	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Please refer to General Criteria category E.



RHEUMATOID ARTHRITIS						
RHEUMATOID ARTHRITIS	1	AZATHIOPRINE	5	ARAVA	1. No PA for Arava if methotrexate previously tried. Use PA Form # 10510	See criteria as listed on Rheumatoid Arthritis PA form.
	1	HYDROXYCHLOROQUINE	5	ENBREL KIT		
	1	LEFLUNAMIDE	8	HUMIRA		
	1	METHOTREXATE	8	KINERET SOLN		
	1	SULFASALAZINE TABS	8	REMICADE		
MISCELLANEOUS ARTHRITIS						
ARTHRITIS - MISC.		RIDAURA CAPS MYOCHRYSINE SOLN		ARTHROTEC <sup>1</sup>	1. The individual components of Arthrotec are available without PA. Use PA Form # 10110	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. The individual components of Arthrotec are available without PA.
MIGRAINE THERAPIES						
MIGRAINE - ERGOTAMINE DERIVATIVES		MIGRANAL SOLN SANSERT TABS		D.H.E. 45 SOLN	Use PA Form # 10110	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
MIGRAINE - CARBOXYLIC ACID DERIVATIVES		DEPAKOTE ER TB24				
MIGRAINE - SELECTIVE SEROTONIN AGONISTS (5HT)- Tabs	1	IMITREX TABS		FROVA TABS	Use PA Form # 10110	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. Quantity limit exceptions will require ongoing therapy with therapeutic doses of highly effective prophylactic medication as listed on the Triptan PA form.
	1	MAXALT MLT		AXERT TABS		
	1	RELPAK		AMERG TABS		
	1	MAXALT		ZOMIG TABS		
				ZOMIG NASAL SPARY		
				ZOMIG ZMT TBDP		
MIGRAINE - SELECTIVE SEROTONIN AGONISTS (5HT)- Injectables		IMITREX KIT IMITREX SOLN			Use PA Form # 10110	
		IMITREX STATDOSE PEN KIT				
		IMITREX STATDOSE REFILL KIT				
MIGRAINE - MISC.		CAFERGOT SUPP CAFERGOT TABS SPASTRIN TABS		MIGRAZONE CAPS BELCOMP-PB SUPP	Use PA Form # 10110	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
GOUT						
GOUT		ALLOPURINOL TABS COLCHICINE TABS PROBENECID TABS PROBENECID/COLCHICINE TABS SULFINPYRAZONE TABS		ZYLOPRIM 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.
MISC.						
ANESTHETICS - MISC.		BUPIVACAINE HCL SOLN LIDOCAINE HCL SOLN MARCAINE SOLN		SENSORCAINE-MPF SOLN SYNVISC INJ XYLOCAINE SOLN	Use PA Form # 30130	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANTI-CONVULSANTS						
ANTICONSULSANTS		CARBAMAZEPINE	8	DEPAKENE	1. Quantity limit. 5/month	Seizure patients will be approved for any anticonvulsant. Other approvals will be for patients with a variety of drug-specific FDA-approved indications and for specific conditions supported by at least two published peer-reviewed double-blinded, placebo-controlled randomized trials that are not contradicted by other studies of similar quality after recommendation by the DUR Committee and as long as all first line therapies have been tried and failed at full therapeutic doses for adequate durations (at least two weeks).
		CARBATROL CP12	8	GABAPENTIN	2. 200 mg requires a PA.	
		CELONTIN CAPS	8	GABITRIL TABS	Use two 100 mg	
		CLONAZEPAM TABS	8	KEPPRA TABS	instead Pharmaceutical supply issues will delay implementation until further notice.	Topamax and Neurontin - Second line therapy for migraine prophalaxis after trial of at least three preferred preventive medications from Group 1 listed on page 2 of the Acute Migraine PA form.
		DEPAKOTE TBEC	8	KLONOPIN TABS		*** SEE CHART AT END OF DOCUMENT
		DEPAKOTE SPRINKLES CPSP	8	LYRICA		Gabapentin and Lyrica- Second line therapy for Diabetic Peripheral Neuropathy and Post Herpetic Neuralgia after trial of a preferred TCA (tri-cyclic anti-depressant) and one of the following preferred medications: a preferred anti-convulsant, capsaicin, tramadol, or other narcotic. Combination therapy of non-preferred medications for Diabetic Peripheral Neuropathy and Post Herpetic Neuralgia will not be approved.
		DIASTAT <sup>1</sup>	8	PRIMIDONE TABS		
		DILANTIN	8	TOPAMAX		
		EPITOL TABS	8	TRILEPTAL	All non-preferred meds must be used in specified order	
		EQUETRO	8	ZARONTIN SYRP		
		ETHOSUXIMIDE SYRP	8	ZONEGRAN CAPS		
		FELBATOL	9	NEURONTIN	Use PA Form # 20420	
		LAMICTAL				
		MYSOLINE TABS				
		PHENYTEK CAPS	A - B	BIPOLAR DISORDER: STEP ORDER	See review in DUR section of website.	
		PHENYTOIN	4 - 4	LAMICTAL	A= Monotherapy	
		TEGRETOL <sup>2</sup>	5 - 5	TRILEPTAL	B= Adjunctive	
		TEGRETOL-XR TB12	9 - 6	TOPAMAX	9= No Evidence	
		VALPROIC ACID	9 - 7	KEPPRA TABS	The step orders show the relative strength of evidence for use in bi-polar and will guide prior authorization determinations.	
		ZARONTIN CAPS	9 - 8	GABITRIL TABS		
			9 - 9	NEURONTIN		
			9 - 9	ZONEGRAN CAPS		
			A - B	PEDIATRIC BIPOLAR 1 DISORDER: STEP ORDER		
			1 - 1	(6-18 YEARS WITH OR WITHOUT PSYCHOSIS)	Two step 1 preferred drugs must be tried before Trileptal.	
			1 - 1	LITHIUM		
			1 - 1	CARBAMAZEPINE		
			1 - 1	VALPROATE		

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

**ANTI-PARKINSON DRUGS**

PARKINSONS - ANTICHOLINERGICS		AKINETON TABS BENZTROPINE MESYLATE TABS COGENTIN SOLN KEMADRIN TABS TRIHEXYPHENIDYL			
PARKINSONS - COMT INHIBITORS		COMTAN TABS		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	1 1 2	MIRAPEX TABS REQUIP TABS PERGOLIDE MESYLATE TABS		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/CARBIU/LEVO		AMANTADINE HCL BROMOCRIPTINE MESYLATE <b>CARBIDOPA/LEVODOPA TABS*</b> CARBIDOPA/LEVODOPA ER LARODOPA TABS LODOSYN TABS SELEGILINE HCL		APOKYN* ELDEPRYL CAPS PARLODEL CAPS PARLODEL TABS SINEMET TABS SINEMET TBCR SYMMETREL TABS	* Effective 2.16.2006 only the Endo brand will be available without PA (labeler 60951) Use PA Form # 20420 Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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.		STALEVO			

**MUSCLE RELAXANTS**

ALS DRUG		RILUTEK TABS				
MUSCLE RELAXANTS		BACLOFEN TABS CHLORZOXAZONE TABS CYCLOBENZAPRINE HCL TABS LIORESAL INTRATHECAL KIT METHOCARBAMOL TABS	7 7 8 8 8 8 8 8 8 8 9 9	ORPHENADRINE CITRATE TIZANIDINE HCL TABS CARISOPRODOL TABS <sup>1</sup> DANTRIUM CAPS FLEXERIL TABS LIORESAL TABS NORFLEX TBCR ROBAXIN-750 TABS ZANAFLEX TABS SKELAXIN TABS 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. Both step 7's must be tried. 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.				CARISOPRODOL/ASPIRIN TABS CARISOPRODOL/ASPIRIN/CODE NORGESIC TABS ORPHENADRINE COMPOUND ORPHENADRINE/ASA/CAFF ORPHENGESIC	Use PA Form # 20420 Individual components are available with PA described in the section above. 1. frequent or persistent early refills of non-controlled drugs; 2. multiple instances of early refill overrides due to reports of misplacement stolen, dropped in toilet or sink, distant travel, etc.	

**VITAMINS**

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

VITAMINS		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		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.
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		VITAMIN K1 SOLN V-R VITAMIN E CAPS			
VITAMIN D's		CALCIFEROL SOLN <sup>1</sup> CALCITRIOL CAPS <sup>1</sup> DRISDOL SOLN <sup>1</sup> VITAMIN D <sup>1,2</sup>	DRISDOL CAPS CALCJEX HECTOROL (ORAL) HECTOROL (PARENTERAL) ROCALTROL ZEMPLAR	1. Diagnosis of dialysis (renal failure) required. 2. OTC Vitamin D no diagnosis required.	Preferred products require dialysis/renal failure diagnosis. Non-preferred products require: Secondary hyperparathyroidism in patients with Chronic Kidney Disease on dialysis., iPTH>400 pg/ml, Phosphorous .6.5mg/dl, corrected calcium <12.2mg/dl, corrected calcium x phosphorous products <70mg <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.\*\***

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

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

<p>MINERALS</p>	<p>CALCARB CALCI-MIX CAPSULE CAPS CALCIQUID SYRP CALCITRATE/VITAMIN D TABS CALCIUM CALCIUM CARBONATE CALCIUM CITRATE TABS CALCIUM CITRATE TABS CALCIUM GLUCONATE TABS CALCIUM LACTATE TABS CALCIUM/MAGNESIUM TABS CALCIUM/VITAMIN D TABS CALTRATE 600 TABS CHEWABLE CALCIUM CHEW CITRACAL TABS</p>	<p>ANEMAGEN CALCET TABS CALCIUM 600-D TABS CALCIUM/VITAMIN D TABS CALTRATE 600 PLUS/VIT D TABS CALTRATE PLUS TABS CHROMAGEN CITRACAL PLUS TABS CONTRIN CAPS FEOGEN FORTE CAPS FEROCON CAPS FERREX 150 CAPS FERRO-SEQUELS TBCR FE-TINIC CAPS</p>	<p>Use PA Form # 20420</p>	<p>Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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.</p>
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CITRACAL + D TABS  
 CITRUS CALCIUM TABS  
 CITRUS CALCIUM 1500 + D TABS  
 DEXFERRUM SOLN  
 EFFERVESCENT POTASSIUM TBEF  
 FEOSTAT CHEW  
 FERATAB TABS  
 FER-GEN-SOL SOLN  
 FERGON TABS  
 FER-IN-SOL SOLN  
 FER-IRON SOLN  
 FERRONATE TABS  
 FERROUS FUMARATE TABS  
 FERROUS GLUCONATE TABS  
 FERROUS SULFATE  
 FLUOR-A-DAY CHEW  
 FLUORIDE CHEW  
 FLUORIDE SODIUM CHEW  
 FLUORITAB CHEW  
 HEMOCYTE TABS  
 HM CALCIUM TABS  
 K+ POTASSIUM PACK  
 KAON ELIX  
 KAON-CL-10 TBCR  
 KCL 0.075%/D5W/NACL 0.2% SOLN  
 K-EFFERVESCENT TBEF  
 KLOR-CON  
 KLOTRIX TBCR  
 K-PHOS TABS  
 K-VESCENT TBEF  
 LURIDE CHEW  
 MAGNESIUM GLUCONATE TABS  
 MAGNESIUM SULFATE SOLN  
**MAGTABS**  
 MICRO-K CPCR  
 NEUTRA-PHOS  
 OS-CAL TABS  
 OS-CAL 500 + D TABS  
 OYSCO  
 OYST-CAL TABS  
 OYST-CAL D TABS  
 OYST-CAL/VITAMIN D TABS  
 OYSTER CALCIUM TABS  
 OYSTER SHELL  
**PHARMA FLUR**  
 PHOSPHA 250 NEUTRAL TABS  
 POTASSIUM BICARBONATE TBEF  
 POTASSIUM CHLORIDE  
 POTASSIUM EFFERVESCENT  
 SELENIUM TABS  
 SLOW-MAG TBCR  
 SODIUM FLUORIDE  
 SSKI SOLN  
 V-R CALCIUM  
 V-R OYSTER SHELL CALCIUM  
 ZINC SULFATE CAPS

FE-TINIC 150 FORTE CAPS  
 FLUOR-A-DAY SOLN  
 K-DUR TBCR  
 KLOR-CON PACK  
 K-LYTE  
 K-PHOS TABS  
 K-TABS TBCR  
 K-VESCENT PACK  
 NU-IRON 150 CAPS  
 OYSTER SHELL CALCIUM/VITA TABS  
 POLY-IRON 150 CAPS  
 POLYSACCHARIDE IRON CAPS  
 POTASSIUM BICARB/CHLORIDE  
 SLOW FE TBCR  
 TUMS 500 CHEW  
 VIACTIV CHEW

MISC. ELECTROLYTES/NUTRITIONALS

ELECTROLYTES/  
NUTRITIONALS

FISH OIL CAPS  
 INTRALIPID EMUL  
 MCT OIL OIL  
 ORALYTE SOLN  
 P.T.E. -5 SOLN  
 PEDIALYTE SOLN

BOOST  
 CASEC POWD  
 CHOICE DM LIQD  
 DELIVER 2.0 LIQD  
 ENFAMIL  
 ENSURE  
 GLUCERNA  
 ISOCAL LIQD  
 KINDERCAL TF LIQD  
 KINDERCAL TF/FIBER LIQD

This list of nutritionals is incomplete. All nutritionals still require a PA except for the miscellaneous products listed as preferred. SGA form required for nutritionals unless member has a G/I tube.

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.

				L-CARNITINE CAPS LIPISORB LIQD MODULEN IBD POWD NUTRAMIGEN POWD NUTREN NUTRITIONAL SUPPLEMENT LIQD NUTRIVENT 1.5 LIQD PEPTAMEN PHENYL-FREE PKU 3 POWD PREGESTIMIL POWD PROBALANCE LIQD PROSOBEE SCANDISHAKE PACK	SGA Form	
<b>ERYTHROPOEITINS</b>						
ERYTHROPOEITINS			5 6 8	PROCRIT SOLN <sup>1</sup> EPOGEN SOLN ARANESP SOLN	1. All products require PA but Procrit is first choice. Still 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 non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Please see the EPO PA form for other approval and renewal criteria.
<b>GRANULOCYTE CSF</b>						
GRANULOCYTE CSF			8 8 9	LEUKINE NEUPOGEN SOLN <sup>1</sup> NEULASTA	Must be used in specified step order. 1. 10 day supply/month may be used without a PA. Use PA Form # 20520	See approval criteria detailed on Neupogen PA form.
<b>ANTICOAGULANTS / PLATELET AGENTS</b>						
ANTICOAGULANTS		ARIXTRA SOLN FRAGMIN INJ <sup>1</sup> HEPARIN SODIUM/NACL 0.9% SOLN HEP-LOCK SOLN INNOHEP LOVENOX SOLN <sup>1</sup> WARFARIN SODIUM TABS HEPARIN LOCK SOLN HEPARIN LOCK FLUSH SOLN HEPARIN SODIUM SOLN HEPARIN SODIUM LOCK FLUSH SOLN JANTOVEN		COUMADIN TABS IPRIVASC	1. Fragmin and Lovenox therapy durations greater than 7 days require 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. Exceeding days supply limits for LMWH class requires PA.
ANTIHEMOPHILIC AGENTS		ALPHANATE BENEFIX SOLR BIOCLATE HELIKATE FS KIT HEMOPIL - M HUMATE-P SOLR KOGENATE FS KONYNE - 80 MONARC - M MONOCLATE - P MONONINE NOVOSEVEN SOLR PROPLEX -T RECOMBINATE SOLR REFACTO		ADVATE <sup>1,2</sup>	1. Only if other products unavailable.  2. Advate may be available with PA in cases of large volume dosing in patients with poor venous access.  Use PA Form # 20420	Non-preferred will only be approved if other preferred products are unavailable.
PLATELET AGGREGATION INHIBITORS		ASPIRIN DIPYRIDAMOLE TABS PLAVIX TABS <sup>1</sup>	7 8 8	TICLOPIDINE HCL TABS PERSANTINE TABS TICLID TABS	Use PA Form # 20420  1. As of 04.01.2005 Plavix is only available without PA if concurrent aspirin use (on prescription) within 100 days or documented failure or intolerance or other contraindication to aspirin.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
PLATELET AGGR. INHIBITORS/ COMBO'S - MISC.		PENTOXIFYLLINE ER TBCR CILOSTAZOL		AGGRENOX CP12 <sup>1</sup> AGRYLIN CAPS PLETAL TABS TRENENTAL TBCR	1. Aspirin and dipyridamole are available separately 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.
<b>HEMOSTATIC</b>						

HEMOSTATIC		AMICAR			
		AMINOCAPROIC ACID			
<b>OPHTHALMICS</b>					
OP. - ANTIBIOTICS		AK-SPORE OINT 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		AK-POLY-BAC OINT 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	Use PA Form # 20420  Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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	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 Ciloxan 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		VIGAMOX		ZYMAR	
OP. - ARTIFICIAL TEARS AND LUBRICANTS		AKWA TEARS OINT ARTIFICIAL TEARS OINT ARTIFICIAL TEARS SOLN CELLUVISC SOLN EYE LUBRICANT OINT GENTEAL LIQUITEARS SOLN MAJOR TEARS SOLN PURALUBE OINT PURALUBE TEARS SOLN REFRESH SOLN OP REFRESH PLUS SOLN		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 REFRESH-PM OINT <b>SYSTANE</b> 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		BETIMOL SOLN BETOPTIC-S SUSP CARTEOLOL HCL SOLN LEVOBUNOLOL HCL SOLN METIPRANOLOL SOLN TIMOLOL MALEATE SOLN TIMOLOL MALEATE SOLG (GEL)		BETAGAN SOLN BETAXOLOL HCL 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.		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 NEOMPOLIN/DEX		AK-TROL SUSP BAC/POLY/NEOMY/HC OINT BLEPHAMIDE S.O.P. OINT ECONOPRED EFLONE SUSP FLUOR-OP SUSP MAXITROL NEO/POLY/BAC/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.

		PRED FORTE SUSP PRED MILD SUSP PREDNISOLONE TOBRADEX				
OP. - PROSTAGLANDINS	1 1 1	XALATAN SOLN TRAVATAN SOLN LUMIGAN SOLN		RESCULA SOLN	Established users grandfathered. Preferred products must be used in specified step order or PA required. Use PA Form # 20420	Preferred drugs must be tried and failed, in step-order, due to lack of efficacy (failure to reach target IOP reduction) or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
OP. - CYCLOPLEGICS		AK-PENTOLATE SOLN ATROPINE SULFATE CYCLOPENTOLATE HCL SOLN ISOPTO HYOSCINE SOLN		CYCLOGYL SOLN ISOPTO ATROPINE SOLN ISOPTO HOMATROPINE SOLN MUROCOLL-2 SOLN	Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
OP. - MIOTICS - DIRECT ACTING		ISOPTO CARBACHOL SOLN ISOPTO CARPINE SOLN PILOCAR SOLN PILOCARPINE HCL SOLN PILOPINE HS GEL				
OP. - ADRENERGIC AGENTS		DIPIVEFRIN HCL SOLN EPIFRIN SOLN		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		ALPHAGAN SOLN ALPHAGAN P SOLN		IOPIDINE SOLN	Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
OP. - ANTI-ALLERGICS		ELESTAT PATANOL SOLN		ALOCRIL SOLN ALOMIDE SOLN EMADINE SOLN LIVOSTIN SUSP OPTICROM SOLN ZADITOR SOLN	Use PA Form # 20420	All preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
OP. ANTI-ALLERGICS- MASTCELL STABILIZER CLASS		ALAMAST SOLN				
OP. - CARBONIC ANHYDRASE INHIBITORS/COMBO		AZOPT SUSP COSOPT SOLN TRUSOPT SOLN				
OP. - NSAID'S		ACULAR LS ACULAR SOLN FLURBIPROFEN SODIUM SOLN VOLTAREN SOLN		OCUFEN SOLN	Must fail all preferred products before non-preferred. Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
OP. - OF INTEREST		ENUCLENE SOLN		BOTOX SOLR RESTASIS <sup>1</sup>	1. Must have kerato conjunctivitis sicca and failed other dry eye therapies. Use PA Form # 10210	Must fail adequate trials of multi agents from artificial tears and lubricant category.

**DERMATOLOGICAL**

TOPICAL - ACNE PREPARATIONS		ACCUTANE CAPS AKNE-MYCIN OINT AZELEX CREA BENZOYL PEROXIDE CLEOCIN-T DIFFERIN 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		ALTINAC CREA AVITA CREA BENZAC BENZACLIN GEL BENZAGEL-10 GEL BENZAMYCIN GEL BENZAMYCINPAK PACK BREVOXYL CLINAC BPO GEL CLINDAGEL GEL CLINDAMYCIN PHOSPHATE CLINDETS SWAB DESQUAM-E GEL DESQUAM-X DUAC GEL EMGEL GEL ERYCETTE PADS ERYDERM SOLN ERYGEL GEL FINEVIN CREA KLARON LOTN NORITATE CREA	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.
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			RETIN-A MICRO GEL SULFACET-R LOTN TRETINOIN TRIAZ ZETACET		
TOPICAL - ANTIBIOTIC		BACIT/NEOMYCIN/POLYM OINT BACITRACIN OINT BACTROBAN <sup>1</sup> CENTANY OINT 2% <sup>1</sup> GENTAMICIN SULFATE	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.
TOPICAL - ANTIFUNGALS		CLOTRIMAZOLE CLOTRIMAZOLE/BETA CREA KETOCONAZOLE CREA LOPROX .77 CREA LOPROX 1.0 CREAM LOPROX 1.0 LOTN LOPROX GEL LOPROX TS LOTN MICONAZOLE NITRATE CREA MYCO-TRIACT II CREA NIZORAL SHAM NTA OINT NYSTATIN NYSTATIN/TRIAMCINOLONE PEDI-DRI POWD SPECTAZOLE CREA TINACTIN TRI-STATIN II CREA	ECONAZOLE NITRATE CREA EXELDERM FUNGIZONE CREA HYDROCORT/IDOOO CREA LAMISIL LOPROX 0.77 LOTN LOPROX SHAMPOO SHAM LOTRIMIN LOTRISONE MENTAX CREA MONISTAT-DERM CREA MYCOGEN II CREA MYCOLOG-II CREA MYCOSTATIN POWD NAFTIN NIZORAL CREA NYSTAT-RX POWD NYSTOP POWD OXISTAT PENLAC NAIL LACQUER SOLN	Use PA Form # 10120	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
TOPICAL - ANTIPRURITICS		ZONALON CREA	PRUDOXIN CREA	Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
TOPICAL - ANTIPSORIATICS		DOVONEX OXSORALEN ULTRA CAPS TAZORAC	PSORiatec CREA SORIATANE CAPS VANAMIDE	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.
TOPICAL - ANTISEBORRHEICS		CAPITROL SHAM SELENIUM SULFIDE SHAM SELSUN BLUE SHAM	CARMOL SCALP TREATMENT KIT ZNP 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 on the Prior Authorization form, such as the presence of 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 - ANTIVIRALS		DENAVIR CREA ZOVIRAX OINT <sup>1</sup>			1. Zovirax may be used once without PA.
TOPICAL - ANTINEOPLASTICS		EFUDEX FLUOROPLEX CREA SOLARAZE GEL	CARAC CREA	Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
TOPICAL - BURN PRODUCTS		FURACIN CREA SSD CREA THERMAZENE CREA	SILVADENE CREA SILVER SULFADIAZINE CREA SSD AF 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 - CORTICOSTEROIDS		<b>LOW POTENCY</b> DESOWEN HYDROCORTISONE CREA HYDROCORTISONE LOTN LACTICARE-HC LOTN NUTRACORT LOTN TEXACORT SOLN TRIDESILON CREA <b>MEDIUM POTENCY</b> CUTIVATE DESOXIMETASONE .05% ELOCON FLUOCINOLONE ACETONIDE .025-.01% FLUROSYN CREA HYDROCORTISONE BUTYRATE HYDROCORTISONE OINT HYDROCORTISONE VALERATE MOMETASONE FUROATE OINT TRIAMCINOLONE ACETONIDE .025-.1% <b>HIGH POTENCY</b> CYCLOCORT DIPROLENE	ACLOVATE AMCINONIDE CREA ANUSOL HC-1 OINT ARISTOCORT A AUGMENTED BETA DIP OINT CLOBEX CLODERM CREA CORDRAN CORMAX DERMATOP DIFLORASONE DIACETATE ELOCON OINT HYDROCORTISONE POWD KENALOG AERS LIDA MANTLE HC CREA LIDEX LIDEX-E CREA LUXIQ FOAM OLUX FOAM PANDEL CREA PROCTOCORT CREA PSORCON E	Use PA Form # 20420	At least 1 drug from each potency of preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.

	DESOXIMETASONE .25% DESONIDE FLUOCINOLONE ACETONIDE .02% FLUOCINONIDE HALOG HALOG-E CREA TRIAMCINOLONE ACETONIDE .5% <b>VERY HIGH POTENCY</b> BETAMETHASONE DIPROPIONATE BETAMETHASONE VALERATE BETA-VAL CLOBETASOL PROPIONATE ULTRAVATE PSORCON <b>MISCELLANEOUS</b> CAPEX SHAM DERMA-SMOOTHIE/FS OIL PROCTO-KIT CREA	SYNALAR OINT TEMOVATE TOPICORT TOPICORT LP CREA WESTCORT <b>LOCOID</b>		
TOPICAL - STEROID LOCAL ANESTHETICS	PRAMOSONE ZONE-A FORTE LOTN	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	DERMA-SMOOTHIE/FS ATOPIC P KIT	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	AMLACTIN CREA CETAPHIL GENTLE CLEANSER LOTN LAC-HYDRIN LACTINOL-E CREA UREACIN-20 CREA VITAMIN A & D MEDICATED OINT	AMMONIUM LACTATE CREA LACLOTION LOTN LACTINOL LOTN MEDERMA GEL RENOVA CREA	Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
TOPICAL - ENZYMES / KERATOLYTICS / UREA	GRANUL-DERM AERS GRANULEX AERS PANAFIL OINT PAPAIN-UREA-CHLORO OINT TBC AERS XENADERM OINT	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	ALDARA	5 PODOFILOX SOLN 8 CONDYLOX	Non-preferred products must be used in specified order. Use PA Form # 20420	
TOPICAL - IMMUNOMODULATORS		8 ELIDEL CREA 9 PROTOPIC OINT	Non-preferred products must be used in specified order. The FDA has issued a Public Health Advisory for both Elidel and Protopic concerning the potential cancer risk associated with their use. Use for children less than 2 years of age is not recommended. Use PA Form # 20420	Preferred corticosteroids from other classes must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Approvals will be made for small amounts of non-preferred products for the treatment of very steroid-sensitive areas in conjunction with topical steroids for the treatment of atopic dermatitis.
TOPICAL - LOCAL ANESTHETICS	AF CAPSICUM OLEORESIN CREA CAPSAICIN CREA ELA-MAX <sup>1</sup> EMLA CREA <sup>1</sup> EMLA/TEGADERM KIT <sup>1</sup> XYLOCAINE	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		8 ALUSTRA CREA 8 GLYQUIN CREA 8 HYDROQUINONE CREA 8 HYDROQUINONE/SUNSCREENS 8 SOLAQUIN FORTE CREA 8 TRI-LUMA CREA 9 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	ACTICIN CREA ELIMITE CREA EURAX LICE KILLING SHAM		Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.

		LICE TREATMENT CREME RINS LIOD LINDANE NIX CREME RINSE LIOD OVIDE LOTN PERMETHRIN LOTN			
TOPICAL - WOUND / DECUBITUS CARE		ACCUZYME OINT ACCUZYME SPRAY ETHEZYME		REGRANEX GEL	Use PA Form # 20420 Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Regranex will be approved for diabetic patients in good control (hba1c <8), who are not smoking, with a stage III or IV WOCN AND NPUAP lower extremity diabetic ulcer and with an adequate blood supply (TcP 02 >30, ABI>0.7 or ASP> 70), and where the underlying cause has been corrected. The wound must be free of infection and have been previously treated with preferred standard therapies for at least 2 months. Maximum approval for 20 weeks.
TOPICAL - ASTRINGENTS / PROTECTANTS		ALUMINUM CHLORIDE SOLN DRYSOL SOLN XERAC AC SOLN		LOWILA BAR MOISTURIN DRY SKIN CREA PROSHIELD PLUS SKIN PROTE CREA SURGILUBE 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.
TOPICAL - ANTISEPTICS / DISINFECTANTS		HIBICLENS LIOD PHISOHEX LIOD POVIDONE-IODINE SOLN		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		AK-DILATE SOLN EYE WASH SOLN NAPHAZOLINE HCL SOLN PHENYLEPHRINE HCL SOLN PONTOCAINE SOLN SODIUM CHLORIDE		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		A/B OTIC SOLN ACETASOL 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		ACETASOL HC SOLN 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		NILSTAT SUSP EAR-GESIC SOLN NYSTATIN SUSP		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		CHLORHEXIDINE GLUCONATE LIDOCAINE VISCOUS SOLN TRIAMCINOLONE IN ORABASE PSTE TRIAMCINOLONE ORADENT PSTE		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		ETHEDENT CREA GEL-KAM CONC PHOS-FLUR SOLN PREVIDENT PREVIDENT SOLN SF GEL STANNOUS FLUORIDE ORAL RI CONC		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		EVOXAC CAPS SALIVA SUBSTITUTE SOLN		RADIACARE SOLR SALAGEN TABS	Use PA Form # 20420 Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.

MISCELLANEOUS ANORECTAL

ANORECTAL - MISC.		ANALPRAM-HC CREA COLOCORT ENEM CORTENEMA ENEM ELA-MAX 5 CREA HYDROCORTISONE ENEM PROCTOZONE-HC CREA		ANUSOL-HC CREA CORTIFOAM FOAM PROCTOCREAM-HC CREA PROCTOFOAM HC FOAM PROCTO-KIT CREA PROCTOSOL HC CREA	Use PA Form # 20420	
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T-CELL ACTIVATION INHIBITOR

PSORIASIS BIOLOGICALS			5 8 8	ENBREL AMEVIVE RAPTIVA	Use PA Form # 20910	Approved for severe chronic plaque psoriasis unresponsive to first line therapies. A trial of at least several potent topicals from the following categories: corticosteroids, coal tars, anthralin, calcipotriene and tazarotene, and at least one systemic drug such as methotrexate, cyclosporine, methoxsalen or actretin and phototherapy/UVA. <b>High dose Enbrel will be approved for chronic severe psoriasis only after failure of all traditional therapies listed here and adequate trial of either Amevive or Raptiva.</b>
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ALTERNATIVE MEDICINES

ALTERNATIVE MEDICINES		DIMETHYL SULFOXIDE SOLN		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		CUPRIMINE CAPS		DEPEN TITRATABS TABS	Use PA Form # 20420	
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ANTILEPTIC

ANTILEPTIC				THALOMID CAPS	Use PA Form # 20420	Approved for indications of leprosy, treatment-resistant multiple myeloma and AIDS.
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CANCER

CANCER		ALIMTA AVASTIN ERBITUX VIDAZA				
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IMMUNOSUPPRESSANTS

IMMUNOSUPPRESSANTS		CELLCEPT CYCLOSPORINE MODIFIED CYCLOSPORINE SOL MODIFIED GENGRAF CAPS MYFORTIC PROGRAF CAPS RAPAMUNE SANDIMMUNE		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		AZASAN TABS AZATHIOPRINE TABS		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		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.

**ANTI-CONVULSANTS 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		
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		
ZONEGRAN	X			9	9		
LYRICA	X	X(2 <sup>nd</sup> line)	X(2 <sup>nd</sup> line)				

**PEDIATRIC ANTI-CONVULSANTS INDICATION CHART**

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

## CELEXA/CITALOPRAM SPLITTING TABLE

*The most cost effective way to utilize Celexa/citalopram*

NON PREFERRED: PA NEEDED				DESIRED DOSE	PREFERRED: NO PA Required (splitting tabs)				savings per 30 day supply
10MG	20MG	40MG	COST/DAY	MG/DAY	10MG	20MG	40MG	COST/DAY	
30			\$1.50	10mg		15		\$0.75	\$22.50
	30		\$1.50	20mg			15	\$0.75	\$22.50
	45		\$3.00	30mg		15	15	\$1.50	\$45.00
		30	\$1.50	40mg			30	\$1.50	N/A

\* Celexa / citalopram requires splitting of 20mg and/or 40mg scored tabs to avoid PA.

\* At present these represent the most commonly written scripts. The shaded areas require no changes since they do not offer savings opportunities. Celexa is flat priced across all strengths. They are scored and easily split. The unshaded rows on the left side all have less expensive ways of being written involving splitting of the Celexa scored tabs.

\* Max daily dose of Celexa / citalopram is 40mg. Clinical studies of effectiveness did not demonstrate an advantage for the 60mg/day dose over the 40mg/day dose. There is an increased risk of side effects at doses greater than 40mg/day. (Celexa® Package Insert 2005 Forest Laboratories, Inc.)

## LEXAPRO SPLITTING TABLE

*The most cost effective way to utilize Lexapro*

NON PREFERRED: PA NEEDED				DESIRED DOSE	PREFERRED: NO PA Required (splitting tabs)				savings per 30 day supply
5MG	10MG	20MG	COST/DAY	MG/DAY	5MG	10MG	20MG	COST/DAY	
15 tabs				2.5MG	15 tabs				

	15		\$0.75	5MG		15		\$0.75	N/A
	30		\$1.50	10MG			15	\$0.75	\$22.50
	45		\$2.25	15MG		15	15	\$1.50	\$22.50
	30		\$1.50	20MG			30	\$1.50	N/A

\* Lexapro requires splitting of 5mg, 10mg and/or 20mg scored tabs to avoid PA.

\* At present these represent the most commonly written scripts. The shaded areas require no changes since they do not offer savings opportunities. Lexapro is flat priced across all strengths. They are scored and easily split. The unshaded rows on the left side all have less expensive ways of being written involving splitting of the Lexapro scored tabs.

\* Max daily dose of Lexapro is 20mg.



## ZOLOFT SPLITTING TABLE

*The most cost effective way to utilize Zoloft*

NON PREFERRED: PA NEEDED				DESIRED DOSE	PREFERRED: NO PA Required (splitting tabs)				savings per 30 day supply
25MG	50MG	100MG	COST/DAY	MG/DAY	25MG	50MG	100MG	COST/DAY	
15 tabs			\$1.00	12.5mg	15 tabs			\$1.00	N/A
30			\$2.00	25*		15		\$1.00	\$30.00
45			\$3.00	37.5	15	15		\$2.00	\$30.00
	30		\$2.00	50*			15	\$1.00	\$30.00
	45		\$3.00	75		15	15	\$2.00	\$30.00
		30	\$2.00	100*			30	\$2.00	N/A
30		30	\$4.00	125		15	30	\$3.00	\$30.00
	30	30	\$4.00	150*			45	\$3.00	\$30.00
30	30	30	\$6.00	175		15	45	\$4.00	\$60.00
		60	\$4.00	200*			60	\$4.00	N/A
30		60	\$6.00	225		15	60	\$5.00	\$30.00
	30	60	\$6.00	250*			75	\$5.00	\$30.00
30	30	60	\$8.00	275		15	75	\$6.00	\$60.00

		90	\$6.00	300*			90	\$6.00	N/A
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*\* At present these represent the most commonly written scripts. The shaded areas require no changes since they do not offer savings opportunities. Zoloft is flat priced across all strengths. They are scored and easily split. The unshaded rows on the left side all have less expensive ways of being written involving splitting of the Zoloft scored tabs.*