

| CATEGORY | Coverage Indicator | Step Order | PREFERRED DRUGS | Coverage Indicator | Step Order | NON-PREFERRED DRUGS Required | PA | Comments | Criteria |
|--|--|------------|---|--|------------|--|----|--|--|
| * PLEASE NOTE: All Generics applicable to DEL are considered PREFERRED Drugs. "BASIC" Covered Drugs are bolded with the Coverage Indicator of "MC / DEL". | | | | | | | | | |
| General Criteria for all PDL categories: For more information or help using the PDL, providers may call 1-888-445-0497; members should call 1-866-796-2463. To access PDL and PA materials via the internet: www.mainearepdl.org | | | | | | | | | |
| A: Preferred Drugs: Unless otherwise specified, preferred drugs are available without prior authorization. Step order may apply for preferred drugs in some drug categories as indicated on the PDL. (See item "D" below for explanation of step order.) | | | | | | | | | |
| B: Requests for Non-preferred Drugs: Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. | | | | | | | | | |
| C: Adequate Drug Trials: 1. The minimum trial period for each preferred and step order drug is two weeks, unless otherwise stated within specific PDL drug categories; trials with less than a two week duration will be reviewed on a case-by-case basis; 2. A trial will not be considered valid if 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.) | | | | | | | | | |
| D: Step Order: When numbers appear in the "step order" column, it means drugs in this category must be used in the order specified, with the lower numbers having preference over the higher numbers. Chart notes should be provided to confirm drug trials that do not appear in the member's MaineCare drug profile. | | | | | | | | | |
| E: Brand Name Medication Requests: (Must be submitted on the Brand Name PA request form) According to MaineCare Benefits Manual Chapter II (80.07-5), when medically necessary covered brand-name drugs have an A-rated generic equivalent available, the most cost effective medically necessary version will be approved and reimbursed, since the brand-name and A-rated generic drugs have been determined by the FDA to be chemically and therapeutically equivalent. The Bureau does not make determinations as to whether or not a generic drug is clinically inferior or inequivalent to its brand version. This is the proper role of the FDA. Physicians should submit their reports of generic inequivalence directly to the FDA via the MEDWATCH. | | | | | | | | | |
| F: PA requests for non- FDA Approved Indications: Decisions will be made on a case-by-case basis until the DUR committee is able to review the evidence and make a recommendation. Interim approvals and DUR recommendations for approval of a drug for a non- FDA approved indication will require a minimum of two published, peer reviewed, non contradicted, double- blind, placebo-controlled randomized clinical studies establishing both safety and efficacy. | | | | | | | | | |
| G: Dose Consolidation Requirements: Some drugs may also be affected by dose consolidation requirements. Please see Dose Consolidation List and/or Splitting Tables provided in the PDL. | | | | | | | | | |
| H: Trials from Multiple Drug Classes: Trial/failure/intolerance to preferred agents from multiple classes within the same category or other categories of drugs may be required prior to the approval of non-preferred agents (e.g., Cymbalta, Zofran, Elidel and others). | | | | | | | | | |
| J: Drug-specific PA Forms: Drug-specific PA forms contain medical necessity documentation requirements and/or criteria that may not be repeated in the PDL. Drug-specific PA forms may be obtained on the web at www.mainearepdl.org . | | | | | | | | | |
| K: PA Exemptions for Prescribers: According to MaineCare Benefits Manual Chapter II (80.07-4), providers may receive a three (3) month exemption from prior authorization requirement for certain categories of drugs when they demonstrate high compliance with the Department's PDL. The Department will notify providers in writing which drug categories are included and what dates apply to the exemption. If a provider loses his/ her exemption, members who previously were not required to obtain a PA while the prescriber was exempt will be required to do so, and criteria for approval of that medication will need to be met. | | | | | | | | | |
| ASSORTED ANTIBIOTICS | | | | | | | | | |
| BETA-LACTAMS / CLAVULANATE COMBO'S | MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC MC MC/DEL MC MC MC MC/DEL MC MC MC MC MC MC/DEL | | AMOXICILLIN AMOXIL ¹ AMPICILLIN AMOXICILLIN/POTASSIUM CLA CHEW AMOXICILLIN/POTASSIUM CLA SUSR AMOXICILLIN/POTASSIUM CLA TABS AUGMENTIN ES-600 SUSR AUGMENTIN XR TB12 BEEPEN BICILLIN L-A SUSP DICLOXACILLIN SODIUM CAPS DYNAPEN SUSR GEOCILLIN TABS OXACILLIN SODIUM SOLR PENICILLIN V POTASSIUM TICAR SOLR TIMENTIN SOLR TRIMOX UNASYN SOLR VEETIDS ZOSYN | MC/DEL MC/DEL MC MC MC/DEL MC MC MC/DEL MC MC MC MC MC MC MC MC MC MC MC MC/DEL | | AMOXIL 500MG TABS AUGMENTIN ² PRINCIPEN CAPS ² PRINCIPEN SUSR | | 1. Amoxil 500mg tabs are non-preferred. All other Amoxil products are preferred. 2. Principen 250 mg is available without PA. 3. Chewable 125mg & 250mg and Solution 125mg/5ml and 250mg/5ml available without PA Use PA Form# 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| CEPHALOSPORINS | MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL MC MC MC MC/DEL MC/DEL MC/DEL | | CEFADROXIL HEMIHYDRATE CEFZOLIN SODIUM SOLR CEFTIN SUSP CEFURXIME AXETIL TABS CEFZIL CEPHALEXIN MONOHYDRATE DURICEF SUSR FORTAZ SOLR KEFZOL SOLR MAXIPIME SOLR OMNICEF ROCEPHIN SUPRAX VANTIN | MC MC MC/DEL MC/DEL MC/DEL MC/DEL MC MC MC MC/DEL MC/DEL MC/DEL | | CECLOR ¹ CEDAX CEFACTOR ¹ CEFADROXIL MONOHYDRATE TABS CEFTIN DURICEF TABS FORTAZ SOLN KEFLEX CAPS TAZICEF SOLR | | 1. Both brand and generic are clinically non-preferred. Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| MACROLIDES / ERYTHROMYCIN'S | MC MC/DEL MC/DEL MC MC MC MC | | BIAXIN XL ¹ AZITHROMYCIN TABS CLARITHROMYCIN E.E.S E-MYCIN TBEC ERYPED 200 SUSR ERYPED 400 SUSR | MC MC/DEL MC MC MC MC/DEL | | BIAXIN DYNABAC D5-PAK TBEC ERYPED CHEW PCE TBEC ZITHROMAX TABS | | 1. 7 Day supply per month w/o PA | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |

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| | MC MC MC/DEL MC/DEL MC/DEL | ERY-TAB TBEC ERYTHROCIN STEARATE TABS ERYTHROMYCIN ZITHROMAX SUSP ZMAX | | | | Use PA Form # 20420 | |
| TETRACYCLINES | MC/DEL MC/DEL MC MC/DEL MC/DEL | DOXYCYCLINE HYCLATE MINOCYCLINE HCL CAPS SUMYCIN TETRACYCLINE HCL CAPS VIBRAMYCIN SYRP | MC MC/DEL MC/DEL MC MC/DEL | | DECLOMYCIN TABS DORYX CPEP DOXYCYCLINE MONO CAPS DYNACIN CAPS MONODOX CAPS PERIOSTAT | Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| FLUOROQUINOLONES | MC MC MC MC/DEL MC | AVELOX ABC PACK TABS AVELOX SOLN AVELOX TABS CIPROFLOXACIN CIPRO XR ² | MC MC MC MC/DEL MC | | CIPRO FLOXIN TABS LEVAQUIN NOROXIN TABS TEQUIN | 1. QL 3/script/month Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| AMINO GLYCOSIDES | MC MC/DEL MC MC/DEL | GENTAMICIN NEOMYCIN SULFATE TABS TOBI NEBU TOBRAMYCIN SULFATE SOLN | | | | | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| ANTI-MYCObACTERIALS / ANTI-TUBERCULOSIS | MC/DEL MC/DEL MC/DEL MC/DEL | ETHAMBUTOL HCL TABS MYAMBUTOL TABS MYCOBUTIN CAPS RIFAMPIN | MC | | RIMACTANE CAPS | Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| ANTIMALARIAL AGENTS | MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL | CHLOROQUINE PHOSPHATE TABS DARAPRIM TABS HYDROXYCHLOROQUINE TABS LARIAM TABS MALARONE TABS MEFLOQUINE HCL TABS QUINACRINE HCL POWD QUININE SULFATE | MC MC/DEL MC | | ARALEN TABS PLAQUENIL TABS ISONARIF ² | Use PA Form # 20420 1. Ingredients available as preferred without PA. | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| ANTHELMINTICS | MC/DEL MC MC/DEL MC/DEL | ALBENZA TABS BILTRICIDE TABS MEBENDAZOLE CHEW STROMECTOL TABS | MC | | VERMOX CHEW | Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| ANTIBIOTICS - MISC. | MC MC MC MC/DEL MC MC MC/DEL MC MC/DEL | AZACTAM SOLR COLISTIMETHATE SODIUM SOLR FUROXONE TABS METRONIDAZOLE ² PENTAMIDINE ISETHIONATE SOLR PRIMSOL SOLN TRIMETHOPRIM TABS VANCOCIN HCL VANCOMYCIN HCL | MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC MC | | COLY-MYCIN-M SOLR FLAGYL CAPS FLAGYL TABS FLAGYL ER TBCR KETEK LORABID METRONIDAZOLE 375MG CAPS ² METRONIDAZOLE 750MG TABS ² NEBUPENT SOLR PROLOPRIM TABS TINDAMAX ¹ XIFAXAN | 1. Need to fail other anti-protozoals 2. 375mg caps and 750mg tabs are non-preferred. Please use available preferred strengths(250mg & 500mg tabs) to obtain required dose without PA. Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. 1. For macrolide resistant infections when quinolones inappropriate |
| CARBAPENEMS | | | MC MC MC/DEL | | INVANZ SOLR MERREM SOLR PRIMAXIN | | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| LINCOSAMIDES / OXAZOLIDINONES / LEPROSTATICS | MC/DEL MC/DEL MC/DEL MC | CLEOCIN SOLN CLEOCIN SUSR CLINDAMYCIN HCL 150CAPS DAPSONE TABS | MC/DEL MC/DEL MC/DEL MC/DEL | | CLEOCIN CAPS CLINDAMYCIN HCL 300CAPS ¹ ZYVOX SUSR ZYVOX TABS | 1. Use multiple 150's for Clindamycin instead of 300's. Zyvox: use PA Form # 30820 Others: use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. For Zyvox, please see the criteria listed in the Zyvox PA form. |
| ANTI INFECTIVE COMBO'S - MISC. | MC/DEL MC/DEL MC/DEL MC/DEL | ERYTHROMYCIN/SULF SUSR SEPTRA/DS TABS SULFAMETHOXAZOLE/TRIMETH TRIMETHOPRIM/SULFAMETHOXA | MC MC | | ALINIA* BACTRIM DS TABS | * Alina is preferred for children less than 12 years of age. Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| ANTI - FUNGALS | | | | | | | |
| ANTIFUNGALS - ASSORTED | MC MC/DEL MC MC MC MC/DEL MC/DEL | ANCOBON CAPS FLUCONAZOLE ¹ GRIFULVIN GRISEOFULVIN ULTRAMICROSI TABS GRIS-PEG TABS KETOCONAZOLE TABS NYSTATIN | MC/DEL MC MC MC MC/DEL MC | 5 5 5 6 8 8 | LAMISIL TABS SPORANOX SOLN ² SPORANOX PULSEPAK CAPS ² SPORANOX CAPS ² DIFLUCAN ¹ NIZORAL TABS | 1. QL--1/every 7-day period (150mg only). 2. Sporanox QL 300cc/month with PA. See quantity limit table. 3. Sporanox QL 30/month with PA. See quantity limit table. Non-preferred products must be used in specified | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. The other criteria are listed on the Antifungal PA form including the required proof of a non-cosmetic fungal infection. |

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| | MC/DEL | | VFEND TABS | | | | | | step order. Continue to use Anti-Fungal PA form for non-preferred products. Use PA Form # 10120 | | |
| ANTI - VIRALS | | | | | | | | | | | |
| ANTIRETROVIRALS | MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL MC MC/DEL MC MC/DEL MC MC/DEL MC MC/DEL MC MC MC/DEL MC MC/DEL MC MC MC/DEL | | AGENERASE CAPS APTIVUS COMBIVIR TABS CRIXIVAN 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 | MC/DEL MC/DEL | | | | | 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 | MC/DEL MC | | GANCICLOVIR VALCYTE TABS | MC | | | | CYTOVENE CAPS | Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. | |
| IMMUNE SERUMS | | | | | | | | | | | |
| IMMUNE SERUMS | | | HYPERRHO INJ | | | | | | | | |
| HEPATITIS AGENTS | | | | | | | | | | | |
| HEPATITIS C AGENTS | MC/DEL MC/DEL MC/DEL | | PEG-INTRON KIT REBETRON KIT REBETOL CAPS | MC/DEL MC/DEL MC/DEL MC | 8 8 8 8 | | | COPEGUS TABS PEGASYS KIT PEGASYS SOLN RIBAVIRIN CAPS | Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. | |
| HEPATITIS AGENTS - MISC. | | | | MC | | | | ACTIMMUNE | Use PA Form # 20420 | Approved for chronic granulomatous disease, osteopetrosis and idiopathic pulmonary fibrosis. | |
| HEPATITIS B ONLY | MC | | HEPSERA TABS | MC | | | | BARACLUDE | | | |
| HERPES AGENTS | MC/DEL MC/DEL | | ACYCLOVIR VALTRES TABS | MC/DEL MC/DEL | | | | FAMVIR TABS ZOVIRAX | Must fail Acyclovir and Valtrex before non-preferred products. Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. | |
| INFLUENZA AGENTS | MC/DEL MC MC/DEL MC/DEL | | AMANTADINE RELENZA DISKHALER AEPB RIMANTADINE HCL TABS TAMIFLU ¹ | MC/DEL MC MC MC | | | | FLUMADINE TABS FLUMIST ² | 1. Tamiflu 10 caps or 60cc's per month. 2. Flumist Use PA Form # 10610. Others Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. | |
| RSV PROPHYLAXIS | | | | | | | | | | | |
| RSV PROPHYLAXIS | | | | MC MC | | | | RESPIGAM SYNAGIS | Use PA Form # 30120 | Please see the criteria listed on the Synagis PA form. | |
| MS TREATMENTS | | | | | | | | | | | |
| MULTIPLE SCLEROSIS AGENTS | | | | MC MC/DEL MC MC/DEL | 5 5 5 6 | | | AVONEX KIT BETASERON SOLR REBIF SOLN COPAXONE | Established users grandfathered. Must follow specified step order. Use PA Form # 20430 | Non-Preferred drugs must be tried in step-order and failed due to lack of efficacy or intolerable side effects before lower ranked non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. | |
| ASSORTED NEUROLOGICS | | | | | | | | | | | |
| NEUROLOGICS - MISC. | MC MC/DEL MC | | MESTINON ORAP TABS PROSTIGMIN TABS | MC MC/DEL MC | | | | BOTOX MYOBLOC ¹ | 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. | |
| STEROIDS | | | | | | | | | | | |
| GLUCOCORTICOID/ MINERALOCORTICOID | MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL | | CELESTONE SUSP CORTEF 5 CORTISONE ACETATE TABS DELTASONE TABS DEPO-MEDROL SUSP DEXAMETHASONE | MC MC MC/DEL MC/DEL MC MC | | | | 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. | |

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| | MC/DEL | | ENTOCORT EC CP24 | MC | | PREDNISONE INTENSOL CONC | | |
| | MC/DEL | | FLUDROCORTISONE ACETATE TABS | MC | | PRELONE SYRP | | |
| | MC/DEL | | HYDROCORTISONE | MC | | STERAPRED TABS | | |
| | MC | | KENALOG | | | | | |
| | MC/DEL | | METHYLPREDNISOLONE TABS | | | | | |
| | MC | | ORAPRED SOLN | | | | | |
| | MC/DEL | | PREDNISOLONE | | | | | |
| | MC/DEL | | PREDNISONE | | | | | |
| | MC/DEL | | SOLU-CORTEF SOLR | | | | | |
| | MC/DEL | | SOLU-MEDROL SOLR | | | | | |

HORMONE REPLACEMENT THERAPIES

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|-----------------------|--|--|--|--|-----------------------|--|--|--|
| ANDROGENS / ANABOLICS | MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC MC | | ANDRODERM PT24 ANDROID CAPS DANAZOL CAPS DEPO-TESTOSTERONE OIL FLUOXYMESTERONE TABS TESTODERM TESTOSTERONE PROPIONATE TESTRED CAPS WINSTROL TABS | MC MC/DEL MC MC MC/DEL MC/DEL | | ANDRO LA 200 OIL ANDROGEL PACK DELATESTYL OIL HALOTESTIN TABS METHITEST TABS OXANDRIN TABS ¹ | Use PA Form # 20420 1. Non-preferred effective 12.01.05. Use the Oxandrin PA Form #20600 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Additionally, laboratory evidence of a testosterone deficiency must be supplied. One of each dosage form should be tried (tablet, injection, and topical) |
| ESTROGENS - PATCHES | MC/DEL MC/DEL | | ESTRADERM PTTW VIVELLE PTTW | MC/DEL MC/DEL MC/DEL MC MC/DEL | 5 8 8 8 8 | ESTRADIOL PTWK ALORA PTTW CLIMARA PTWK ESCLIM PTTW VIVELLE-DOT PTTW | All patches are non-preferred products (require PA). Products must be used in specified step order. Use PA Form # 20420 | Approved for failures on multiple oral estrogen agents after 90 day trials or if unable to swallow any oral medication. |
| ESTROGENS - TABS | MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL | | CENESTIN TABS DELESTROGEN OIL ESTRADIOL ESTROPIPATE TABS MENEST TABS PREMARIN TABS | MC/DEL MC MC/DEL MC | | ESTRACE TABS ESTRATAB TABS OGEN TABS ORTHO-EST TABS | Must fail preferred products before non-preferred products. Use PA Form # 20420 | Preferred drugs must be tried for at least 90 days and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| ESTROGEN COMBO'S | MC/DEL MC/DEL | | PREMPHASE TABS PREMPRO TABS | MC/DEL MC/DEL MC/DEL MC/DEL | | ACTIVELLA TABS COMBIPATCH PTTW FEMHRT 1/5 TABS ORTHO-PREFEST TABS SYNTEST H.S. TABS | Must fail Premphase and Prempro products before non-preferred products. Use PA Form # 20420 | Preferred drugs must be tried for at least 90 days and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| PROGESTINS | MC/DEL MC/DEL MC | | MEDROXYPROGESTERONE ACETA ² NORETHINDRONE ACETATE TABS ¹ PROGESTERONE POWD | MC/DEL MC MC/DEL MC/DEL MC/DEL | | AYGESTIN TABS CYCRIN TABS PROMETRIUM 100MG CAPS ¹ PROMETRIUM 200MG ¹ PROVERA TABS | 1. PA approvals will require two 100 mg caps instead of one 200mg. 2. Must fail Medroxyprogesterone and Norethidrone products before non-preferred products. Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |

CONTRACEPTIVES

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|---|--------------------------------------|--|--|--------------------------------------|--|---|---|---|
| CONTRACEPTIVES - PROGESTIN ONLY | MC | | ORTHO MICRONOR TABS | MC/DEL MC/DEL MC/DEL MC/DEL | | 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 | MC/DEL | | DEPO-PROVERA SUSP | MC/DEL MC/DEL | | LUNELLE SUSP MEDROXYPROGESTERONE ACETATE IM | Use PA Form # 20420 | The preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| CONTRACEPTIVE - EMERGENCY | MC/DEL | | PLAN - B ¹ | | | | 1. Allowed 4 tablets per 30 days without PA | |
| CONTRACEPTIVES - PATCHES/ VAGINAL PRODUCTS | MC | | ORTHO EVRA PTWK ^{1,2} | MC/DEL | | NUVARING RING | 1.No PA required for users less than 21 years of age. 2. The FDA has issued a public health warning of the potentials for increased exposure to estrogen with Ortho Eva use, possibly up to 60% estrogen exposure Use PA Form # 20420 | Approved if adequate clinical reason given why patient unable to comply with other preferred agents including long acting injectable. |
| CONTRACEPTIVES - MONOPHASIC COMBINATION OIC'S | MC/DEL MC/DEL MC/DEL MC/DEL | | ALESSE-28 TABS DEMULEN 1/35-28 TABS DEMULEN 1/50-28 TABS DESOGEN TABS | MC/DEL MC/DEL MC/DEL MC/DEL | | APRI TABS AVIANE TABS BREVICON-28 TABS CRYSSELLE-28 TABS | Loestrin FE and FE 1/20 are grandfathered for established users. If member experienced adverse reactions, consider using Oral | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |

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| | MC/DEL MC/DEL | | ACTOS 15MG TABS ¹ ACTOS 45MG TABS ¹ | | | | 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 | on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| DIABETIC - ALPHAGLUCOSIDASE | MC/DEL | | GLYSET TABS | MC | | PRECOSE TABS | Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| DIABETIC - SULFONYLUREA / BIGUANIDE | MC/DEL | | GLYBURIDE/METFORMIN | MC MC | | GLUCOVANCE TABS METAGLIP TABS | Use individual ingredients. Use PA Form # 20420 | Approved for patients failing to achieve good diabetic control with maximal doses of individual components. |
| DIABETIC - MEGLITINIDES | MC/DEL | | STARLIX TABS | MC/DEL | | PRANDIN TABS | Use PA Form # 20420 | Preferred drugs from other diabetic sub-categories must be tried and failed due to lack of inadequate diabetic control or intolerable side effects before non-preferred drug will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| THYROID | | | | | | | | |
| THYROID HORMONES | MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL | | ARMOUR THYROID TABS CYTOMEL TABS LEVOTHROID TABS LEVOTHYROXINE SODIUM TABS LEVOXYL TABS THYROID TABS THYROLAR UNITHROID TABS | MC MC | | LEVOTHYROXINE SODIUM SOLR SYNTHROID TABS ¹ | Use Pa Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| ANTITHYROID THERAPIES | MC/DEL MC/DEL | | METHIMAZOLE TABS PROPYLTHIOURACIL TABS | MC/DEL | | TAPAZOLE TABS | Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| OSTEOPOROSIS | | | | | | | | |
| OSTEOPOROSIS | MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL | | ACTONEL TABS FOSAMAX SOLN ² FOSAMAX TABS ² FOSAMAX PLUS D ² MIACALCIN SOLN | MC MC/DEL MC/DEL MC MC | | AREDIA SOLR BONIVA DIDRONEL TABS EVISTA TABS ¹ FORTEO | 1. Approval only requires failure of Fosamax or Actonel. Use PA Form # 20420 2. Quantity Limits Apply | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| CALCIMIMETIC AGENTS | | | | | | | | |
| CALCIMIMETIC AGENTS | | | | MC | | SENSIPAR | Use PA Form # 30115 | Baseline PTH, Ca, and phosphorous levels are required and initial approvals will be limited to 3 months. Subsequent approvals will require additional levels being done to assess changes. Will not approve if baseline Ca is less than 8.4. |
| GROWTH HORMONE | | | | | | | | |
| GROWTH HORMONE | | | | MC/DEL MC/DEL MC/DEL MC MC/DEL MC | 5 5 6 8 8 8 | GENOTROPIN TEV-TROPIN NUTROPIN HUMATROPE SOLR NORDITROPIN CARTRIDGE SOLN SAIZEN SOLR | Products must be used in specified step order. Use PA Form # 10710 | See Growth Hormone PA form for criteria. Step-order will still apply unless clinical contraindication supplied. |
| SOMATOSTATIC AGENTS | MC/DEL | | SANDOSTATIN | | | | | |
| GROWTH HORMONE ANTAGONISTS | | | | | | | | |
| GH ANTAGONISTS | | | | MC | | SOMAVERT | Use PA Form # 10710 | Approved for acromegaly patients failing surgery/radiation/drug therapy including bromocriptine and sandostatatin. |
| URINARY INCONTINENCE | | | | | | | | |
| VASOPRESSINS | | | DESMOPRESSIN TABS | MC/DEL MC/DEL MC MC/DEL MC/DEL | 5 6 6 8 8 | DDAVP TABS DDAVP SOLN DESMOPRESSIN SPRAY DESMOPRESSIN ACETATE SOLN STIMATE SOLN* | Products must be used in specified step order. Nocturnal enuresis patients will be encouraged to periodically attempt stopping DDAVP. Use Pa Form # 20420 | Approved for central diabetes insipidus and for nocturnal enuresis. For nocturnal enuresis- must be over 6 years old, must fail an adequate trial of alarm training (higher success rate, lower relapse rate) and must periodically attempt weaning (at 6 month intervals). * Patients with a diagnosis of hemophilia or Von Willebrands disease will be exempt from prior authorization. |
| ANTISPASMODICS | MC/DEL MC | | OXYBUTYNIN URISPAS TABS | MC/DEL MC/DEL MC/DEL | | CYSTOSPAZ TABS DETROL TABS DITROPAN | Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| ANTISPASMODICS - LONG ACTING | MC/DEL MC MC/DEL MC | | DETROL LA CP24 DITROPAN XL TBCR ENABLEX ¹ VESICARE ¹ | MC/DEL MC | | 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 Rilonavir) |
| CHOLINERGIC | MC/DEL | | URECHOLINE | | | | | |
| METABOLIC MODIFIER | | | | | | | | |
| HERED. TYROSINEMIA | | | | MC | | ORFADIN | Use PA Form # 20420 | Approved for Type 1 hereditary tyrosinemia patients. Must include laboratory evidence of dx at first PA. |
| ANTIHYPERTENSIVES / CARDIAC | | | | | | | | |
| CARDIAC GLYCOSIDES | MC/DEL MC/DEL MC/DEL MC/DEL | | DIGITEK TABS DIGOXIN LANOXICAPS LANOXIN | | | | | |
| ANTIANGINALS--Isosorbide Di- | MC/DEL | | ISOSORBIDE MONONITRATE TABS | MC | | DILATRATE SR CPCR | Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered |

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| Nitrate/ Mono-Nitrates | MC/DEL | | ISOSORBIDE MONONITRATE ER | MC MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC | ISORDIL TABS ISORDIL TITRADOSE TABS ISOSORBIDE DINITRATE SUBL ISOSORBIDE DINITRATE TABS ISOSORBIDE DINITRATE CR TBCR ISOSORBIDE DINITRATE ER TBCR ISOSORBIDE DINITRATE TD TBCR IMDUR TB24 ISMO TABS MONOKET TABS | | on the Prior Authorization form, such as the presence of 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/PCR | MC MC/DEL MC MC | | NITROBID OINT NITROGLYCERIN CPR NITROL OINT NITRO-TIME CPR | | | | | |
| NITRO - PATCHES | MC/DEL MC/DEL MC/DEL MC/DEL | 1 1 1 3 | NITROGLYCERIN PT24 NITREK PT24 NITRO-DUR PT 24 0.8MG MINITRAN PT24 | MC MC/DEL | NITRODISC PT24 NITRO-DUR PT24 | At least 2 step 1's and step 3 of the preferred products must be used in specified order or PA will be required. Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. | |
| NITRO - SUBLINGUAL SPRAY | MC MC/DEL MC/DEL | | NITROLINGUAL AERS NITROSTAT SUBL NITROTAB SUBL | MC MC/DEL | NITROLINGUAL SOLN NITROQUICK SUBL | Use Pa Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. | |
| BETA BLOCKERS - NON SELECTIVE | MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL | | COREG TABS INDERAL LA CPR LEVATOL TABS NADOLOL TABS PINDOLOL TABS PROPRANOLOL HCL SOLN ¹ PROPRANOLOL HCL TABS ¹ SOTALOL HCL TABS TIMOLOL MALEATE TABS | MC/DEL MC MC/DEL MC/DEL MC MC/DEL MC | BETAPACE TABS BETAPACE AF TABS CORCARD TABS INDERAL TABS INNOPRAN XL PROPRANOLOL HCL LA CPR RANEXA | 1. Recommend using BID since its effects do not last 24 hours. Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. | |
| BETA BLOCKERS - CARDIO SELECTIVE | MC/DEL MC/DEL MC MC/DEL MC/DEL | | ACEBUTOLOL HCL CAPS ATENOLOL TABS ¹ BETAXOLOL HCL TABS BISOPROLOL FUMARATE TABS METOPROLOL TARTRATE TABS ¹ TOPROL XL TB24 | MC MC/DEL MC MC/DEL MC/DEL | KERLONE TABS LOPRESSOR TABS SECTRAL CAPS TENORMIN TABS ZEBETA TABS | 1. Recommend using 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 | MC/DEL | | LABETALOL HCL TABS | MC | TRANDATE TABS | Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. | |
| CALCIUM CHANNEL BLOCKERS- Amlodipines, Bepidil, Diltiazems, Felodipines, Isradipines, Nifedipines, Nisoldipine, and Verapamils | MC/DEL MC MC MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL | 1 1 1 1 1 1 4 4 4 4 | NORVASC TABS CARDIZEM LA TB24 DILTIA XT CP24 DILTIAZEM HCL ER CP24 DILTIAZEM HCL XR CP24 DILTIAZEM CD 300MG CP24 DILTIAZEM CD 360MG CP24 CARTIA XT CP24 DILTIAZEM CD CP24 DILTIAZEM HCL ER CP24 DILTIAZEM XR CP24 | MC MC MC/DEL MC/DEL MC MC/DEL MC/DEL | 5 6 7 8 8 8 8 8 8 | DILACOR XR CP24 TAZTIA TIAZAC CP24 CARDIZEM TABS CARDIZEM CD CP24 CARDIZEM SR CP12 DILTIAZEM HCL TABS DILTIAZEM HCL ER CP12 | Products must be used in specified order or PA will be required. Just write "Cardizem LA" or "Diltiazem 24-hour" and the pharmacy will use a preferred long acting diltiazem that does not require PA. Use PA Form # 20420 | Preferred drugs must be tried and failed (in step-order) due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| | | | | MC/DEL | PLENDIL TB24 | Use PA Form # 20420 | Other Preferred calcium channel blockers must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. | |
| | | | | MC MC | DYNACIRC CAPS DYNACIRC CR TBCR ¹ | Use PA Form # 20420 1. Established users will be grandfathered | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. | |
| | | | | MC/DEL MC/DEL MC/DEL | CARDENE CAPS CARDENE SR CPR NICARDIPINE HCL CAPS | Use PA Form # 20420 | Other Preferred calcium channel blockers must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. | |
| | MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL | | AFEDITAB CR NIFEDIAC CC NIFEDICAL XL TBCR NIFEDIPINE TBCR NIFEDIPINE CAPS NIFEDIPINE ER TBCR | MC MC/DEL MC | ADALAT CC TBCR NIFEDIPINE CAPS PROCARDIA 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. | |
| | MC | | SULAR TB24 | | PROCARDIA XL TBCR | Use PA Form # 20420 | | |
| | MC/DEL MC/DEL MC/DEL | 1 1 1 | VERAPAMIL HCL CR TBCR VERAPAMIL HCL ER TBCR VERAPAMIL HCL SR TBCR | MC/DEL MC/DEL MC/DEL | CALAN TABS CALAN SR TBCR COVERA-HS TBCR | Products must be used in specified order or PA will be required. Just write "Verapamil 24-hour" and the | 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. | |

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| | MC | 1 | VERELAN PM CP24 | MC MC/DEL MC MC MC | | ISOPTIN-SR VERAPAMIL HCL ER CP24 VERAPAMIL HCL SR CP24 VERAPAMIL HCL TABS VERELAN CP24 | pharmacy will use a preferred long acting generic that does not require PA. Use PA Form # 20420 | |
| ANTIARRHYTHMICS | MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL MC MC/DEL | | AMIODARONE MEXILETINE NORPACE PROCAINAMIDE PROCANBID CR PROPAPENONE QUINAGLUTE QUINIDINE GLUCONATE QUINIDINE SULFATE RYTHMOL TAMBOCOR | MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL MC MC/DEL | | CORDARONE DISOPYRAMIDE FLECAINIDE MEXITIL PACERONE QUINIDEX TIKOSYN ¹ | 1. Prescription must be written by Cardiologist. Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| ACE INHIBITORS | MC/DEL MC/DEL MC/DEL MC/DEL MC | | CAPTAPRIL TABS BENAZEPRIL HCL ENALAPRIL MALEATE TABS LISINAPRIL TABS MONOPRIL TABS | MC MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL | 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 | MC/DEL MC/DEL MC/DEL MC/DEL MC | | BENICAR TABS COZAAR TABS DIOVAN MICARDIS TABS TEVETEN TABS | MC/DEL MC MC/DEL MC/DEL MC | | ATACAND TABS AVAPRO | Preferred products only available without PA if patient on diabetic therapy or prior ACE therapy. Use PA Form # 20420 | The initial criteria to use any ARB is that the member must have failed ACE inhibitors (such as due to coughing) in the past or must currently be actively treated for diabetes and Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| ANTIHYPERTENSIVES - CENTRAL | MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL | | CATAPRES-TTS CLONIDINE HCL TABS GUANFACINE HCL TABS HYDRALAZINE HCL TABS HYLOREL TABS METHYLDOPA TABS MINOXIDIL TABS PRAZOSIN HCL CAPS RESERPINE TABS | MC/DEL MC MC MC MC/DEL MC MC/DEL MC/DEL MC/DEL | | CATAPRES TABS GUANABENZ ACETATE TABS ISMELIN TABS MINIPRESS CAPS TENEX TABS | Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| ACE INHIBITORS AND CA CHANNEL BLOCKERS | MC/DEL MC | | LOTREL CAPS TARKA TBCR | MC/DEL | | LEXCEL TBCR | Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| ACE AND THIAZIDE COMBOS | MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL | | BENAZEPRIL HCL/HYDROCHLOR CAPTOPRIL/HYDROCHLOROTHIA ENALAPRIL MALEATE/HCTZ TABS LISINAPRIL-HCTZ TABS UNIRETIC TABS | MC/DEL MC MC/DEL MC MC/DEL MC MC/DEL | | ACCURETIC TABS CAPOZIDE TABS LOTENSIN HCT TABS MONOPRIL HCT TABS PRINZIDE TABS VASERETIC TABS ZESTORETIC TABS | Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| BETA BLOCKERS AND DIURETIC COMBOS | MC/DEL MC/DEL MC/DEL | | ATENOLOL/CHLORTHALIDONE BISOPROLOL FUMARATE/HCTZ PROPRANOLOL/HCTZ | MC MC/DEL MC/DEL MC MC MC/DEL | | CORZIDE TABS INDERIDE 40/25 TABS LOPRESSOR HCT TABS TENORETIC TIMOLIDE 10/25 TABS ZIAC TABS | Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| ARB'S AND DIURETICS | MC MC/DEL MC/DEL MC/DEL MC/DEL MC | | AVALIDE TABS BENICAR HCT DIOVAN HCT TABS HYZAAR TABS MICARDIS HCT TABS TEVETEN HCT TABS | MC/DEL | | ATACAND HCT TABS | Preferred products only available without PA if patient on diabetic therapy or prior ACE therapy. Use PA Form # 20420 | Same initial criteria as the ARB class and Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| DIURETICS | MC/DEL MC MC/DEL MC/DEL MC/DEL MC MC/DEL | | ACETAZOLAMIDE TABS AMILORIDE HCL BUMETANIDE CHLOROTHIAZIDE TABS CHLORTHALIDONE TABS EDECIN TABS FUROSEMIDE | MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL | | ALDACTAZIDE TABS ALDACTONE TABS BUMEX TABS DEMADEX TABS DIAMOX DIURIL DYAZIDE CAPS | 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. |

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|---|--|--|--|--|---------------------------------|--|--|---|--|
| | MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC | | HYDROCHLOROTHIAZIDE INDAPAMIDE TABS METHAZOLAMIDE TABS METHYLOTHIAZIDE TABS SPIRONOLACTONE 25MG TABS SPIRONOLACTONE/HYDRO TORSEMIDE TABS TRIAMTERENE/HCTZ ZAROXOLYN TABS | MC MC MC/DEL MC MC/DEL MC MC MC MC/DEL | | ENDURON TABS INSPRA LASIX TABS LOZOL TABS MAXZIDE MICROZIDE CAPS MIDAMOR TABS MODURETIC 5-50 TABS NAQUA TABS NATURETIN TABS SPIRONOLACTONE 50MG ¹ | Use PA Form # 20420 | | |
| CCB / LIPID | MC/DEL | | CADUET | | | | | | |
| LIPID DRUGS | | | | | | | | | |
| CHOLESTEROL - BILE SEQUESTRANTS | MC/DEL MC/DEL | | CHOLESTYRAMINE COLESTID | MC/DEL MC MC/DEL | | PREVALITE QUESTRAN WELCHOL TABS | Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. | |
| CHOLESTEROL - FIBRIC ACID DERIVATIVES | MC/DEL MC MC/DEL MC | | GEMFIBROZIL TABX TRIGLIDE NIASPAN TRICOR | MC MC MC | | ANTARA LOPID LOFIBRA | Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. | |
| CHOLESTEROL - HGM COA + ABSORB INHIBITORS | MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC MC MC/DEL | | ADVICOR TBCR ALTOPREV TB 24 CRESTOR LIPITOR TABS LESCOL CAPS LESCOL XL TB24 LOVASTATIN TABS VYTORIN ZETIA TABS ¹ ZOCOR TABS | MC/DEL MC MC/DEL MC/DEL | | MEVACOR TABS PRAVACHOL TABS PRAVIGARD PRAVASTATIN | 1. Zetia available w/OPA as addition to Zocor 80mg, Lipitor 80mg, or Crestor 40mg. Zetia will also be approved with a PA as add on for patients at maximally tolerated doses of statins. Zocor patients trying to use Zetia must use Vytorin instead. Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Zetia will be approved for patients unable to tolerate all other therapies or unable to achieve cholesterol goal with maximally tolerated dose of most potent statins. | |
| PULMONARY ANTI-HYPERTENSIVES | | | | | | | | | |
| PULMONARY ANTI-HYPERTENSIVES | MC/DEL MC | | REVATIO ¹ VENTAVIS ² | MC/DEL MC | | FLOLAN TRACLEER | Use PA Form # 20420 | Flolan and Tracleer will be approved after the dx of pulmonary hypertension is confirmed. 1. Revatio approvals will require WHO Group 1 diagnosis of primary PAH (Primary Pulmonary Hypertension) and NYHA functional class 2,3, or 4. 2. Ventavis approvals will require WHO Group 1 diagnosis of primary PAH (Primary Pulmonary Hypertension) and NYHA functional class 3 or 4. | |
| IMPOTENCE AGENTS | | | | | | | | | |
| IMPOTENCE AGENTS | | | | | 9 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. | | |
| ANTI-EMETOGENICS | | | | | | | | | |
| ANTIEMETIC - ANTICHOLINERGIC / DOPAMINERGIC | MC/DEL MC/DEL MC/DEL MC/DEL MC | | MECLIZINE HCL TABS PHENERGAN SUPP PHENERGAN FORTIS SYRP PROMETHAZINE SUPP PROMETHAZINE TRANSDERM-SCOP PT72 | MC MC/DEL MC/DEL MC/DEL MC | | ANTIVERT TABS PHENERGAN SOLN PHENERGAN TABS PROMETHEGAN SUPP TORECAN TABS | Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. | |
| ANTIEMETIC - 5-HT3 RECEPTOR ANTAGONISTS/ SUBSTANCE P NEUROKININ | MC MC/DEL MC/DEL MC/DEL MC/DEL | | EMEND MARINOL CAPS ZOFRAN SOLN* ZOFRAN TABS* ZOFRAN ODT TBDP* | MC MC MC/DEL | | ALOXI ANZEMET TABS KYTRIL | *See quantity limit table. Zofran: use PA Form # 30810 Others: use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. * Zofran limits still apply as listed on the Zofran PA form for covered indications including chemotherapy, radiotherapy, post operative nausea & vomiting and hyperemesis gravidarum. Other medical indications will be approved or denied on a case by case basis. Hyperemesis and other medical indications approved are still subject to failure of multiple preferred antiemesis drugs. | |
| NON-SEDATING ANTIHISTAMINES / DECONGESTANTS | | | | | | | | | |
| ANTIHISTAMINES - NON-SEDATING | MC MC MC MC/DEL | | ALAVERT TABS ¹ CLARITIN ALLERGY (OTC) ¹ CLARITIN SYRP (OTC) ² TAVIST ND (OTC) ³ | MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL | 5 5 5 8 8 9 | CLARINEX TABS ² CLARINEX SYR ² ZYRTEC ³ ALLEGRA CLARITIN ² FEXOFENADINE | 1. Preferred drugs are OTC loratidines. 2. Claritin OTC syrup does not require a PA. 3. Clarinex and Zyrtec syrup <6 yr w/o PA. Must fail Clarinex Tabs and Zyrtec products before moving to next step product without PA Pseudoephedrine is available with prescription. Use PA Form # 20530 | Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. No combination product with decongestant will be approved since pseudoephedrine available without PA. | |

ALLERGY / ASTHMA THERAPIES

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|--|--|-----------------------|--|--|--|---|---|--|
| ANTIASTHMATIC - ANTICHOLINERGICS - INHALER | MC/DEL MC | | ATROVENT AERS ATROVENT HFA | MC | | SPIRIVA ¹ | Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. 1. FEV ₁ <= 50% or COPD hospitalization within 6 months due to Atrovent failure. |
| ANTIASTHMATIC - ANTICHOLINERGICS - NEBULIZER | MC/DEL | | IPRATROPIUM BROMIDE SOLN | MC | | ATROVENT SOLN | Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| ANTIASTHMATIC - ANTIINFLAMMATORY AGENTS | MC/DEL MC/DEL MC/DEL | | CROMOLYN SODIUM NEBU INTAL AERS TILADE AERS | MC/DEL | | XOLAIR ² | 1. Need max inhaled steroids and written by pulmonary or allergy specialist. Use PA Form # 20420 | Xolair approval will require suboptimal response to maximal doses of inhaled steroid as evidenced by asthmatic ER/Hospital admissions and Allergy/Pulmonary specialist management. |
| ANTIASTHMATIC - NASAL STEROIDS | MC/DEL MC/DEL MC MC/DEL MC | 1 1 4 4 4 | FLONASE SUSP ¹ NASONEX SUSP ¹ BECONASE AERS BECONASE AQ INHA NASAREL SOLN | MC/DEL MC MC/DEL MC MC/DEL MC MC | | FLUNISOLIDE SOLN NASACORT AERS NASACORT AQ AERS RHINOCORT AERO RHINOCORT AQUA SUSP TRI-NASAL SOLN VANCENASE POCKETHALER AERS | Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| ANTIASTHMATIC - NASAL MISC. | MC/DEL | | NASALCROM | MC MC MC/DEL | | ATROVENT NASAL SOL IPRATROPIUM NASAL SOL ¹ ASTELIN | 1. Ipratropium will be approved if submitted with documentation supporting use of CPAP machine. Use PA Form # 20420 | Approved if patient fails on non-sedating antihistamines and steroid nasal sprays. Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| ANTIASTHMATIC - BETA - ADRENERGICS | MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL | | ALBUTEROL NEB FORADIL AEROLIZER CAPS MAXAIR METAPROTERENOL SEREVENT TERBUTALINE SULFATE TABS XOPENEX HFA | MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC MC MC/DEL | | ACCUNE ¹ NEBU ALBUTEROL AER ² ALBUTEROL HFA ALUPENT AERP BRETHINE PROVENTIL PROVENTIL HFA AERS VENTOLIN AERS VENTOLIN HFA AERS VOLMAX TBCR VOSPIRE ER TB12 XOPENEX NEBU ² | 1. Xopenex users w/ prior asthma hospitalization due to albuterol nebulizer failure will be grandfathered. 2. Quantity Limit: 12 cc/day. 3. Established users of albuterol prior to 05/01/2006 will have until 06/30/2006 to transition over to preferred Xopenex HFA. Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| ANTIASTHMATIC - ADRENERGIC COMBINATIONS | MC/DEL | | ADVAIR DISKUS MISC | | | | | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Duoneb components are available separately without PA. |
| ANTIASTHMATIC - ADRENERGIC ANTICHOLINERGIC | MC/DEL | | COMBIVENT AERO | MC/DEL | | DUONEB SOLN ¹ | 1. Please use preferred individual ingredients Albuterol and Ipratropium. Use PA Form # 20420 | |
| ANTIASTHMATIC - XANTHINES | MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL | | AMINOPHYLLINE TABS THEOCHRON TB12 THEOLAIR-SR TB12 THEOPHYLLINE ELIX THEOPHYLLINE SOLN THEOPHYLLINE ER CP12 THEOPHYLLINE ER TB12 UNIPHYL TBCR | MC MC MC MC/DEL MC MC/DEL MC | | QUIBRON CAPS QUIBRON-T TABS QUIBRON-T/SR TB12 THEO-24 CP24 THEOLAIR TABS THEOPHYLLINE CR TB12 T-PHYL TB12 | Use PA Form 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| ANTIASTHMATIC - STEROID INHALANTS | MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL MC MC | | AEROBID AERS ASMANEX AZMACORT AERS BECLOVENT AERS FLOVENT HFA PULMICORT SUSP ¹ QVAR AERS VANCERIL AERS | MC/DEL MC/DEL MC MC MC/DEL MC MC | | AEROBID-M AERS PULMICORT TURBUHALER AEPB ² VANCERIL DOUBLE STRENGTH AERS | 1. No PA for Pulmicort susp if under 8 years old 2. No PA for Pulmicort turbobaler if under 14 yr. Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| ANTIASTHMATIC - 5-Lipoxygenase Inhibitors | | | | MC | | ZYFLO TABS | Use PA Form # 20420 | Other Preferred asthma controller drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| ANTIASTHMATIC - LEUKOTRIENE RECEPTOR ANTAGONISTS | MC/DEL | | SINGULAIR ³ | MC/DEL | | 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 | Singular 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 | | | | MC MC | | PROLASTIN SUSR ZEMAIRA | Use PA Form # 20420 | Prolastin and Azemaira will be approved for members with A1AT deficiency and clinically demonstrable panacinar emphysema. |
| ANTIASTHMATIC - HYDRO-LYTIC ENZYMES | | | | MC/DEL | | PULMOZYME SOLN | Use PA Form # 20420 | Will be approved for cystic fibrosis patients. |

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| | | | MC | 7 | PANOKASE TABS | Use PA Form # 20420 | |
| | | | MC/DEL | 8 | CREON | | |
| | | | MC | 8 | KUTRASE CAPS | | |
| | | | MC/DEL | 8 | KU-ZYME CAPS | | |
| | | | MC/DEL | 8 | LIPRAM CR | | |
| | | | MC | 8 | PANCREASE MT | | |
| | | | MC/DEL | 8 | PANCRECARB MS-8 CPEP | | |
| | | | MC | 8 | VIOKASE | | |
| GI - ANTI - FLATULENTS / GI STIMULANTS | MC MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL | CALULOSE SYRP CONSTULOSE SYRP ENULOSE SYRP GASTROCOM CONC GENERLAC SYRP LACTULOSE SYRP METOCLOPRAMIDE HCL SIMETHICONE | MC/DEL MC MC MC/DEL MC/DEL | | AMITIZA 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 | MC/DEL MC MC/DEL MC MC MC/DEL MC/DEL MC/DEL | ASACOL TBEC AZULFIDINE TABS AZULFIDINE EN-TABS TBEC CANASA SUPP COLAZAL CAPS DIPENTUM CAPS PENTASA CPCR ROWASA ENEM SULFASALAZINE TABS | MC/DEL MC MC/DEL MC MC MC/DEL MC/DEL | | SULFAZINE EC TBEC | Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| GI - IRRITABLE BOWEL SYNDROME AGENTS | | | MC/DEL MC/DEL | | LOTROXEN TABS ZELNORM TABS | Use PA Form # 20420 | Zelnorm will be approved for 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. |
| MISCELLANEOUS GI | | | | | | | |
| **Preferred drugs that used to require diag codes still require diag codes unless indicated otherwise.** | | | | | | | |
| GI - MISC. | MC/DEL MC/DEL MC MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL MC MC/DEL MC/DEL MC MC/DEL MC/DEL MC MC/DEL MC MC/DEL MC/DEL MC MC MC/DEL MC/DEL MC MC MC/DEL MC/DEL MC MC MC/DEL MC/DEL MC MC MC/DEL MC/DEL MC MC MC/DEL MC/DEL | 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 ¹ MIRALAX POWD ¹ SENNA SENOKOT GRAN SENOKOT SYRP SENOKOT CHILDRENS SYRP SENOKOT XTRA TABS SORBITOL STOOL SOFTENER CAPS SUCRALFATE TABS UNI-EASE CAPS UNIFIBER POWD URSO FORTE URSODIOL | MC/DEL MC MC/DEL MC/DEL MC MC MC/DEL MC/DEL MC MC/DEL MC MC/DEL MC/DEL MC MC/DEL MC/DEL MC MC/DEL MC/DEL MC MC MC/DEL MC/DEL MC MC MC/DEL MC/DEL MC MC MC/DEL MC/DEL MC MC MC/DEL MC/DEL MC MC MC/DEL MC/DEL | | ACTIONGALL 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 MALTSUPEX NULYTELY SOLR PEG 3350/ELECTROLYTES SOLR SENXON TABS SENOKOT TABS SENOKOT S TABS STOOL SOFTENER PLUS CAPS UNI-CENNA TABS UNI-EASE PLUS CAPS V-R NATURAL SENNA LAXATIV TABS | 1. Quantity Limit: 255 g/90-day without PA for greater than 18 years old. 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. |
| MISC. UROLOGICAL | | | | | | | |
| UROLOGICAL - MISC. | MC MC/DEL MC MC | ACETIC ACID 0.25% SOLN BICITRA SOLN CYTRA-K SOLN FURADANTIN SUSP | MC MC/DEL MC MC/DEL | | CITRIC ACID/SODIUM CITRAT SOLN CYTRA-2 SOLN ELMIRON CAPS ¹ MACROBID CAPS | 1. Elmiron requires adequate proof of Dx with supportive testing. Use PA Form #20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |

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|-------------------------------|--|-------------|---|--|--|---|---|---|
| | MC MC/DEL MC/DEL MC/DEL MC/DEL MC MC MC/DEL MC/DEL MC/DEL MC/DEL MC MC MC/DEL MC MC/DEL | | K-PHOS MF TABS MACRODANTIN CAPS METHENAMINE MANDELATE TABS MONUROL PACK NEOSPORIN GU IRRIGANT SOLN PHENAZOPYRIDINE HCL TABS POLYCITRA SYRP POLYCITRA-K SOLN POLYCITRA-LC SOLN PROSED/DS TABS PYRIDUM PLUS TABS RENACIDIN SOLN TRICITRATES SYRP UREX TABS URISED TABS UROCIT-K UROID #2 TABS | MC/DEL MC/DEL MC MC MC MC/DEL MC/DEL MC MC MC/DEL MC MC/DEL MC MC/DEL | MANDELAMINE TABS NITROFURANTOIN MACR CAPS POLYCITRA-K CRYSTALS PACK POTASSIUM CITRATE/CITRIC SOLN PYRIDUM TABS | | | |
| PHOSPHATE BINDERS | | | | | | | | |
| PHOSPHATE BINDERS | MC MC/DEL | | PHOSLO MEGNEBIND - 400 | MC/DEL MC/DEL | FOSRENOL RENAGEL ^{1,2} | 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. Use PA Form #20530 | Renagel will be approved in patients with hypercalcemia, on concurrent digoxin or insufficient response with Phos-lo (Renagel to be add-on therapy). | |
| INTRA-VAGINALS | | | | | | | | |
| VAGINAL - ANTIBACTERIALS | MC/DEL MC/DEL MC/DEL | 1 1 3 | CLEOCIN CREA METROGEL VAGINAL GEL CLEOCIN SUPP | | | Step order must be followed to avoid PA. Must fail Cleocin and Metrogel products before moving to next step product without PA. | Preferred drugs must be tried and failed in step-order due to lack of efficacy or intolerable side effects before less preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. | |
| VAGINAL - ANTI FUNGALS | MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL MC MC MC MC MC/DEL MC MC | | CLOTTRIMAZOLE CREA GYNE-LOTTRIMIN CREA MICONAZOLE CREA MICONAZOLE 3 COMBO PACK KIT ¹ MICONAZOLE 7 CREA MICONAZOLE NITRATE CREA MONISTAT 1 OINT MONISTAT 3 CREA MONISTAT 7 NYSTATIN TABS TERCONAZOLE 0.4MG VAGITROL V-R MICONAZOLE-7 CREA | MC MC MC MC MC/DEL MC MC MC MC MC/DEL | AVC CREAM CLOTTRIMAZOLE 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 TERCONAZOLE 0.8MG | 1. Quantity limit: 1/script/2 weeks Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. | |
| VAGINAL - CONTRACEPTIVES | MC | | GYNOL II EXTRA STRENGTH GEL | MC | DELLEN FOAM | Use PA Form # 20420 | Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drug will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. | |
| VAGINAL - ESTROGENS | MC/DEL MC/DEL | | ESTRING RING PREMARIN CREA | MC/DEL MC/DEL | ESTRACE CREA VAGIFEM TABS | Must fail all preferred products before non-preferred. Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. | |
| VAGINAL - OTHER | MC/DEL MC MC | | ACID JELLY GEL ACI-JEL GEL CERVICAL AMINO ACID CREA | MC | AMINO ACID CERVICAL CREA | Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. | |
| BPH | | | | | | | | |
| BPH | MC/DEL MC/DEL MC/DEL MC/DEL | | AVODART DOXAZOSIN MESYLATE TABS PROSCAR TABS TERAZOSIN HCL CAPS | MC/DEL MC/DEL MC MC/DEL | 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. |
| ANXIOLYTICS | | | | | | | | |
| ANXIOLYTICS - BENZODIAZEPINES | MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL | | ALPRAZOLAM TABS CHLORDIAZEPOXIDE HCL CAPS CLORAZEPATE DIPOTASSIUM TABS DIAZEPAM LORAZEPAM | MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL | | ATIVAN NIRAVAM SERAX TRANXENE XANAX TABS | Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |

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| | MC | ZYPREXA ZYDIS TBDP | | | | 2. All atypicals have dosing limitations and maximum daily doses. Please refer to dose consolidation table for any potential dosing limits. Maximum daily doses are as follows: Abilify- 30mg daily max Risperdal- 8mg daily max Seroquel- 800mg daily max Zyprexa- 30mg daily max Use PA form #10420 for requests exceeding these maximum daily doses. | | age, b.) dosage is for 3 or more per day, c.) Seroquel 25mg is in the profile within the last 45 days. |
| ANTIPSYCHOTICS - SPECIAL ATYPICALS | MC/DEL | CLOZAPINE TABS | MC/DEL MC | | CLOZARIL TABS FAZACLO | Use PA Form # 20420 | | Preferred generic drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred brand will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Patients previously stabilized on brand name drug will be approved. |
| ANTIPSYCHOTICS - TYPICAL | MC/DEL MC/DEL MC MC/DEL MC MC MC/DEL MC/DEL MC MC/DEL MC/DEL MC MC/DEL MC/DEL MC MC/DEL MC MC/DEL | CHLORPROMAZINE HCL FLUPHENAZINE DECANOATE FLUPHENAZINE HCL HALDOL HALOPERIDOL HALOPERIDOL DECANOATE SOLN HALOPERIDOL LACTATE SOLN LOXAPINE SUCCINATE CAPS LOXITANE-C CONC MOBAN TABS PERPHENAZINE PROCHLORPERAZINE SERENTIL THIORIDAZINE HCL THIOTHIXENE THORAZINE SUPP TRIFLUOPERAZINE HCL TABS | MC/DEL MC/DEL MC MC/DEL MC MC/DEL MC MC MC MC MC MC MC/DEL MC/DEL MC MC/DEL MC MC/DEL | | COMPAZINE COMPRO SUPP HALDOL DECANOATE LOXITANE CAPS MELLARIL NAVANE CAPS PROLIXIN STELAZINE TABS THORAZINE | Use PA Form # 120420 | | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| LITHIUM | | | | | | | | |
| LITHIUM | MC/DEL MC/DEL MC/DEL MC/DEL | ESKALITH CAPS ESKALITH CR TBCR LITHIUM CARBONATE LITHIUM CITRATE SYRP | | | | | | |
| COMBINATION - PSYCHOTHERAPEUTIC | | | | | | | | |
| PSYCHOTHERAPEUTIC COMBINATION | MC/DEL MC/DEL | CHLORDIAZEPOXIDE/AMITRIPT PERPHENAZINE/AMITRIPTYLIN | MC | 8 | SYMBYAX | Use PA Form # 20420 | | Use individual components, which are currently available without a PA. |
| STIMULANTS | | | | | | | | |
| STIMULANT - AMPHETAMINES SHORT ACTING | MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL | 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. Stimulants have dosing limitations per strength and maximum daily doses. Please refer to dose consolidation table for any potential dosing limits per strength. Maximum daily doses are as follows: 50mg daily. |
| STIMULANT - LONG ACTING AMPHETAMINES SALT | MC/DEL | ADDERALL XR CP24 | | | | | | Preferred stimulants will be available without PA if diagnosis of ADHD. As per |

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|---|--|--|--|--------------------------------|-----------------------|--|---|---|
| | | | | | | | diagnosis of ADHD. As per recent FDA alert, Adderall should not be used in patients with underlying heart defects since they may be at increased risk for sudden death. Stimulants have dosing limitations per strength and maximum daily doses. Please refer to dose consolidation table for any potential dosing limits per strength. Maximum daily doses are as follows: 50mg daily. | |
| LONG ACTING AMPHETAMINES | MC MC | | DEXEDRINE CAP CR DEXTRAMPHET SULF CPCR | | | | Preferred stimulants will be available without PA if diagnosis of ADHD. Stimulants have dosing limitations per strength and maximum daily doses. Please refer to dose consolidation table for any potential dosing limits per strength. Maximum daily doses are as follows: 50mg daily. | |
| STIMULANT - METHYLPHENIDATE | MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL | | FOCALIN TABS METADATE ER TBCR METHYLIN ER TBCR METHYLIN TABS METHYLIN SOL METHYLPHENIDATE HCL | MC MC/DEL | | METHYLIN CHEWABLES RITALIN | Preferred stimulants will be available without PA if diagnosis of ADHD. Use PA Form # 20420 Stimulants have dosing limitations per strength and maximum daily doses. Please refer to dose consolidation table for any potential dosing limits per strength. Maximum daily doses are as follows: 72mg daily | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Please refer to General Criteria category E. |
| STIMULANT - METHYLPHENIDATE - LONG ACTING | MC MC | | CONCERTA TBCR FOCALIN XR ¹ | MC MC/DEL | 5 8 | METADATE CD CPCR RITALIN LA | Preferred stimulants will be available without PA if diagnosis of ADHD. Non-preferred products must be used in specified step order. 1. Available to those members needing sprinkles with diagnosis of ADHD. Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| STIMULANT - STIMULANT LIKE | | | | MC MC MC/DEL MC MC | 7 8 8 9 9 | STRATTERA ^{1,2} CAFCIT SOLN PROVIGIL TABS DESOXYN TABS DESOXYN CR | 1. Failure of both an amphetamine and methylphenidate is required for consideration for approval of Strattera, unless history of substance abuse without current use of abusable medication(s) 2. Strattera currently has dosing limitations allowing one tablet per day for all strengths if obtain approval. Please refer to PDL dosage consolidation chart. 3. Non-preferred products must be used in specified step order. Provigil: use PA Form # 20710; Others: use Pa Form # 20420 | Provigil requests require diagnosis of Narcolepsy, ADHD, or Obstructive Sleep Apnea. Previous failures of methylphenidate and amphetamine is required for Narcolepsy and ADHD diagnosis, with additional Strattera trial needed with ADHD diagnosis. Please refer to detailed criteria on Provigil PA form |

MC

V-R NON-ASPIRIN TABS

LONG ACTING NARCOTICS

| NARCOTICS - LONG ACTING | | MC | V-R NON-ASPIRIN TABS | MC | | | |
|-------------------------|--------|----|---------------------------------------|--------|---|--|--|
| | MC/DEL | | AVINZA | MC/DEL | 7 | DURAGESIC PT72 ¹ | <p>Non-preferred products must be used in specific order. 1. Duragesic will be available without PA for patients treated for or dying from cancer or hospice patients. CA (cancer) or HO (hospice) diagnosis may be used but store must verify since all scripts will be audited and stores will be liable. 2. Established users are grandfathered. 3. Oxycodone ER allowed only 2 per day for all strengths except 80 mg, where 4 are</p> <p>Preferred drugs (Avinza or morphine sulfate ER tab, Methadone or Methadose, & oxycodone ER) & step order drugs must be tried for at least 2 weeks each & failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug & the preferred drug(s) exists. Adequate trials include prevention/treatment of common adverse effects associated w/ narcotics (anti-nausea, anti-pruritics, 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 "allergic" to all products but Oxycotin. 9. Circumventing MaineCare prior authorization</p> |
| | MC/DEL | | METHADONE | MC/DEL | 8 | ORAMORPH SR TB12 | |
| | MC/DEL | | METHADOSE | MC/DEL | 8 | MORPHINE SULFATE SUPP | |
| | MC/DEL | | MORPHINE SULFATE ER TB12 ³ | MC/DEL | 8 | MS CONTIN TB12 | |
| | MC/DEL | | OXYCODONE ER ^{3,4} | MC/DEL | 9 | KADIAN CP 24 ² OXYCONTIN TB12 ¹ | |

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

MISC MULTI-VITAMINS

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

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

MISCELLANEOUS MINERALS

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

| MINERALS | | | | | |
|----------|---------------------------|--------|------------------------------|---------------------|--|
| MC | CALCARB | MC | ANEMAGEN | Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. As listed in MaineCare Policy, certain drugs require specific diagnoses for approval. |
| MC | CALCI-MIX CAPSULE CAPS | MC | CALCET TABS | | |
| MC | CALCIQUID SYRP | MC/DEL | CALCIUM 600-D TABS | | |
| MC | CALCITRATE/VITAMIN D TABS | MC | CALCIUM/VITAMIN D TABS | | |
| MC/DEL | CALCIUM | MC | CALTRATE 600 PLUS/VIT D TABS | | |
| MC/DEL | CALCIUM CARBONATE | MC | CALTRATE PLUS TABS | | |
| MC/DEL | CALCIUM CITRATE TABS | MC | CHROMAGEN | | |
| MC/DEL | CALCIUM GLUCONATE TABS | MC | CITRACAL PLUS TABS | | |
| MC/DEL | CALCIUM LACTATE TABS | MC | CONTRIN CAPS | | |
| MC | CALCIUM/MAGNESIUM TABS | MC | FEOGEN FORTE CAPS | | |
| MC/DEL | CALCIUM/VITAMIN D TABS | MC | FEROCON CAPS | | |
| MC | CALTRATE 600 TABS | MC/DEL | FERREX 150 CAPS | | |
| MC/DEL | CHEWABLE CALCIUM CHEW | MC | FERRO-SEQUELS TBCR | | |
| MC | CITRACAL TABS | MC | FE-TINIC CAPS | | |
| MC | CITRACAL + D TABS | MC | FE-TINIC 150 FORTE CAPS | | |

| | | | |
|--------|-------------------------------|--------|--------------------------------|
| MC | CITRUS CALCIUM TABS | MC/DEL | FLUOR-A-DAY SOLN |
| MC | CITRUS CALCIUM 1500 + D TABS | MC/DEL | K-DUR TBCR |
| MC | MC/DEL | MC | KLOR-CON PACK |
| MC | EFFERVESCENT POTASSIUM TBEF | MC | K-LYTE |
| MC/DEL | FEOSTAT CHEW | MC/DEL | K-PHOS TABS |
| MC | FERATAB TABS | MC | K-TABS TBCR |
| MC/DEL | FER-GEN-SOL SOLN | MC | K-VESCENT PACK |
| MC/DEL | FERGON TABS | MC | NU-IRON 150 CAPS |
| MC | FER-IN-SOL SOLN | MC/DEL | OYSTER SHELL CALCIUM/VITA TABS |
| MC | FER-IRON SOLN | MC/DEL | POLY-IRON 150 CAPS |
| MC | FERRONATE TABS | MC/DEL | POLYSACCHARIDE IRON CAPS |
| MC | FERROUS FUMARATE TABS | MC/DEL | POTASSIUM BICARB/CHLORIDE |
| MC/DEL | FERROUS GLUCONATE TABS | MC/DEL | SLOW FE TBCR |
| MC/DEL | FERROUS SULFATE | MC | TUMS 500 CHEW |
| MC/DEL | FLUOR-A-DAY CHEW | MC | VIACTIV CHEW |
| MC | FLUORIDE CHEW | | |
| MC | FLUORIDE SODIUM CHEW | | |
| MC | FLUORITAB CHEW | | |
| MC | HEMOCYTE TABS | | |
| MC | HM CALCIUM TABS | | |
| MC | K+ POTASSIUM PACK | | |
| MC | KAON ELIX | | |
| MC | KAON-CL-10 TBCR | | |
| MC | KCL 0.075%/D5W/NACL 0.2% SOLN | | |
| MC | K-EFFERVESCENT TBEF | | |
| MC | KLOR-CON | | |
| MC | KLOTRIX TBCR | | |
| MC/DEL | K-PHOS TABS | | |
| MC/DEL | K-VESCENT TBEF | | |
| MC/DEL | LURIDE CHEW | | |
| MC/DEL | MAGNESIUM GLUCONATE TABS | | |
| MC/DEL | MAGNESIUM SULFATE SOLN | | |
| MC | MAGTABS | | |
| MC | MICRO-K CPCR | | |
| MC/DEL | NEUTRA-PHOS | | |
| MC/DEL | OS-CAL TABS | | |
| MC/DEL | OS-CAL 500 + D TABS | | |
| MC/DEL | OYSCO | | |
| MC/DEL | OYST-CAL TABS | | |
| MC/DEL | OYST-CAL D TABS | | |
| MC/DEL | OYST-CAL/VITAMIN D TABS | | |
| MC/DEL | OYSTER CALCIUM TABS | | |
| MC/DEL | OYSTER SHELL | | |
| MC | PHARMA FLUR | | |
| MC/DEL | PHOSPHA 250 NEUTRAL TABS | | |
| MC | POTASSIUM BICARBONATE TBEF | | |
| MC/DEL | POTASSIUM CHLORIDE | | |
| MC | POTASSIUM EFFERVESCENT | | |
| MC/DEL | SELENIUM TABS | | |
| MC | SLOW-MAG TBCR | | |
| MC/DEL | SODIUM FLUORIDE | | |
| MC/DEL | SSKI SOLN | | |
| MC | V-R CALCIUM | | |
| MC | V-R OYSTER SHELL CALCIUM | | |
| MC | ZINC SULFATE CAPS | | |

MISC. ELECTROLYTES/NUTRITIONALS

| | | | | | | |
|-------------------------------|--------|-----------------|--------|--------------------------------|--|--|
| ELECTROLYTES/ NUTRITIONALS | MC/DEL | FISH OIL CAPS | MC | BOOST | This list of nutritionals is incomplete. All nutritionals still require a PA except for the miscellaneous products listed as preferred. SGA form required for nutritionals unless member has a G/I tube. | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. As listed in MaineCare Policy, certain drugs require specific diagnoses for approval. |
| | MC | INTRALIPID EMUL | MC | CASEC POWD | | |
| | MC | MCT OIL OIL | MC | CHOICE DM LIQD | | |
| | MC | ORALYTE SOLN | MC | DELIVER 2.0 LIQD | | |
| | MC | P.T.E. - 5 SOLN | MC | ENFAMIL | | |
| | MC | PEDIALYTE SOLN | MC | ENSURE | | |
| | | | MC | GLUCERNA | | |
| | | | MC | ISOCAL LIQD | | |
| | | | MC | KINDERCAL TF LIQD | | |
| | | | MC | KINDERCAL TF/FIBER LIQD | | |
| | | | MC/DEL | L-CARNITINE CAPS | | |
| | | | MC | LIPISORB LIQD | | |
| | | | MC | MODULEN IBD POWD | | |
| | | | MC | NUTRAMIGEN POWD | | |
| | | | | Use PA Form # 20420 & SGA Form | | |

| | | | | | | | | |
|--|--|--|--|--------|--|-----------------------------|--|--|
| | | | | MC/DEL | | NUTREN | | |
| | | | | MC | | NUTRITIONAL SUPPLEMENT LIQD | | |
| | | | | MC | | NUTRIVENT 1.5 LIQD | | |
| | | | | MC | | OMACOR | | |
| | | | | MC/DEL | | PEPTAMEN | | |
| | | | | MC | | PHENYL-FREE | | |
| | | | | MC | | PKU 3 POWD | | |
| | | | | MC | | PREGESTIMIL POWD | | |
| | | | | MC/DEL | | PROBALANCE LIQD | | |
| | | | | MC | | PROSOBEE | | |
| | | | | MC | | SCANDISHAKE PACK | | |

ERYTHROPOIETINS

| | | | | | | | | |
|-----------------|--|--|--|----|---|----------------------------|------------------------------------|--|
| ERYTHROPOIETINS | | | | MC | 5 | PROCRIPT SOLN ¹ | 1. All products require PA | Non-Preferred drugs must be tried and failed in step-order, due to lack of efficacy or intolerable side effects before non-preferred drugs will be |
| | | | | MC | 6 | EPOGEN SOLN | but Procrit is first choice. Still | approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents |
| | | | | MC | 8 | ARANESP SOLN | must be used in specified | usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Please see the |
| | | | | | | | step order. Use PA Form # | EPO PA form for other approval and renewal criteria. |
| | | | | | | | 10520 | |

GRANULOCYTE CSF

| | | | | | | | | |
|-----------------|--|--|--|----|---|----------------------------|-----------------------------|---|
| GRANULOCYTE CSF | | | | MC | 8 | LEUKINE | Must be used in specified | See approval criteria detailed on Neupogen PA form. |
| | | | | MC | 8 | NEUPOGEN SOLN ¹ | step order. 1. 10 day | |
| | | | | MC | 9 | NEULASTA | supply/month may be used | |
| | | | | | | | without a PA. Use PA Form # | |
| | | | | | | | 20520 | |

ANTICOAGULANTS / PLATELET AGENTS

| | | | | | | | | |
|----------------|--------|--|--------------------------------|----|--|---------------|---------------------------|--|
| ANTICOAGULANTS | MC | | ARIXTRA SOLN | MC | | COUMADIN TABS | 1. Fragmin and Lovenox | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered |
| | MC/DEL | | FRAGMIN INJ ¹ | MC | | IPRIVAS C | therapy durations greater | on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the |
| | MC | | HEPARIN SODIUM/NACL 0.9% SOLN | | | | than 7 days require PA. | preferred drug(s) exists. Exceeding days supply limits for LMWH class requires PA. |
| | MC | | HEP-LOCK SOLN | | | | Use PA Form # 20420 | |
| | MC/DEL | | INNOHEP | | | | | |
| | MC/DEL | | LOVENOX SOLN ¹ | | | | | |
| | MC/DEL | | WARFARIN SODIUM TABS | | | | | |
| | MC | | HEPARIN LOCK SOLN | | | | | |
| | MC/DEL | | HEPARIN LOCK FLUSH SOLN | | | | | |
| | MC/DEL | | HEPARIN SODIUM SOLN | | | | | |
| | MC/DEL | | HEPARIN SODIUM LOCK FLUSH SOLN | | | | | |
| | MC/DEL | | JANTOVEN | | | | | |

| | | | | | | | | |
|-----------------------|--------|--|------------------|----|--|-----------------------|--------------------------------|--|
| ANTIHEMOPHILIC AGENTS | MC | | ALPHANATE | MC | | ADVATE ^{1,2} | 1. Only if other products | Non-preferred will only be approved if other preferred products are unavailable. |
| | MC/DEL | | BENEFIX SOLR | | | | unavailable. | |
| | MC | | BIOCLATE | | | | 2. Advate may be available | |
| | MC/DEL | | HELIXATE FS KIT | | | | with PA in cases of large | |
| | MC | | HEMOFIL - M | | | | volume dosing in patients with | |
| | MC | | HUMATE-P SOLR | | | | poor venous access. | |
| | MC | | KOGENATE FS | | | | Use PA Form # 20420 | |
| | MC | | KONYNE - 80 | | | | | |
| | MC | | MONARC - M | | | | | |
| | MC | | MONOCLATE - P | | | | | |
| | MC | | MONONINE | | | | | |
| | MC/DEL | | NOVOSEVEN SOLR | | | | | |
| | MC | | PROPLEX - T | | | | | |
| | MC | | RECOMBINATE SOLR | | | | | |
| | MC | | REFACTO | | | | | |

| | | | | | | | | |
|---------------------------------|--------|--|--------------------------|--------|---|----------------------|-------------------------------|--|
| PLATELET AGGREGATION INHIBITORS | MC/DEL | | ASPIRIN | MC/DEL | 7 | TICLOPIDINE HCL TABS | Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered |
| | MC/DEL | | DIPYRIDAMOLE TABS | MC/DEL | 8 | PERSANTINE TABS | 1. As of 04.01.2005 Plavix is | on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the |
| | MC/DEL | | PLAVIX TABS ¹ | MC | 8 | TICLID TABS | only available without PA if | preferred drug(s) exists. |
| | | | | | | | concurrent aspirin use (on | |
| | | | | | | | prescription) within 100 days | |
| | | | | | | | or documented failure or | |
| | | | | | | | intolerance or other | |
| | | | | | | | contraindication to aspirin. | |

| | | | | | | | | |
|---|--------|--|------------------------|--------|--|-----------------------------|-----------------------------|--|
| PLATELET AGGR. INHIBITORS COMBO'S - MISC. | MC/DEL | | PENTOXIFYLLINE ER TBCR | MC/DEL | | AGGRENOX CPT ^{1,2} | 1. Aspirin and dipyridamole | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered |
| | MC/DEL | | CLOSTAZOL | MC/DEL | | AGRYLIN CAPS | are available separately | on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the |
| | | | | MC/DEL | | PLETAL TABS | without PA. Use PA Form # | preferred drug(s) exists. |
| | | | | MC | | TRENTAL TBCR | 20420 | |

HEMOSTATIC

| | | | | | | | | |
|------------|--------|--|-------------------|--|--|--|--|--|
| HEMOSTATIC | MC/DEL | | AMICAR | | | | | |
| | MC | | AMINOCAPROIC ACID | | | | | |

OPHTHALMICS

| | | | | | | | | |
|-------------------|----|--|-----------------|----|--|------------------|---------------------|--|
| OP. - ANTIBIOTICS | MC | | AK-SPORE OINT | MC | | AK-POLY-BAC OINT | Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered |
| | MC | | BACITRACIN OINT | MC | | AK-SULF OINT | | on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the |

| | | | | | | | |
|---|--|---|--|---------------------------------|--|---|---|
| | MC/DEL MC/DEL MC/DEL MC MC/DEL | BETAMETHASONE VALERATE BETA-VAL CLOBETASOL PROPIONATE ULTRAVATE PSORCON | | | | | |
| | MC MC MC | MISCELLANEOUS CAPEX SHAM DERMA-SMOOTHIE/FS OIL PROCTO-KIT CREA | | | | | |
| TOPICAL - STEROID LOCAL ANESTHETICS | MC/DEL MC | PRAMOSONE ZONE-A FORTE LOTN | MC | | EPIFOAM FOAM | Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| TOPICAL - STEROID COMBINATIONS | MC | DERMA-SMOOTHIE/FS ATOPIC P KIT | MC | | CARMOL-HC CREA | Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| TOPICAL - EMOLLIENTS | MC/DEL MC MC MC MC MC | AMLACTIN CREA CETAPHIL GENTLE CLEANSER LOTN LAC-HYDRIN LACTINOL-E CREA UREACIN-20 CREA VITAMIN A & D MEDICATED OINT | MC/DEL MC/DEL MC/DEL MC MC | | AMMONIUM LACTATE CREA LACLOTION LOTN LACTINOL LOTN MEDERMA GEL RENOVA CREA | Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| TOPICAL - ENZYMES / KERATOLYTICS / UREA | MC MC/DEL MC MC MC MC | GRANUL-DERM AERS GRANULEX AERS PANAFIL OINT PAPAIN-UREA-CHLORO OINT TBC AERS XENADERM OINT | MC MC MC MC MC | | CARMOL 40 CREA SANTYL OINT SALEX CREAM SALEX LOTION ZIOX OINT | Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| TOPICAL - GENITAL WARTS | MC/DEL | ALDARA | MC/DEL MC/DEL | 5 8 | PODOFILOX SOLN CONDYLOX | Non-preferred products must be used in specified order. Use PA Form # 20420 | |
| TOPICAL - IMMUNOMODULATORS | | | MC/DEL | 8 9 | ELIDEL CREA PROTOPIC OINT | Non-preferred products must be used in specified order. The FDA has issued a Public Health Advisory for both Elidel and Protopic concerning the potential cancer risk associated with their use. Use for children less than 2 years of age is not recommended. Use PA Form # 20420 | Preferred corticosteroids from other classes must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Approvals will be made for small amounts of non-preferred products for the treatment of very steroid-sensitive areas in conjunction with topical steroids for the treatment of atopic dermatitis. |
| TOPICAL - LOCAL ANESTHETICS | MC MC/DEL MC MC/DEL MC/DEL MC/DEL | AF CAPSICUM OLEORESIN CREA CAPSAICIN CREA ELA-MAX ¹ EMLA CREA ¹ EMLA/TEGADERM KIT ¹ XYLOCAINE | MC/DEL MC MC/DEL MC MC MC | | EMLA PADS LIDA MANTLE CREA LIDOCAINE HCL LIDODERM PTCH PONTOCAINE SOLN ZOSTRIX | 1. Emla and Ela-Max products require PA for users over 18 years of age. Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| TOPICAL - DEPIGMENTING AGENTS | | | MC MC MC/DEL MC/DEL MC MC MC | 8 8 8 8 8 8 9 | ALUSTRA CREA GLYQUIN CREA HYDROQUINONE CREA HYDROQUINONE/SUNSCREENS SOLAQUIN FORTE CREA TRI-LUMA CREA ELDOQUIN | Not covered for cosmetic purposes. Use PA Form # 20420 | As per Medicaid Policy, cosmetic drugs are not covered. Non-cosmetic clinical applications will be considered by prior authorization on a case by case basis. |
| TOPICAL - SCABICIDES AND PEDICULICIDES | MC/DEL MC MC MC MC/DEL MC MC/DEL | ACTION CREA ELIMITE CREA EURAX LICE KILLING SHAM LICE TREATMENT CREME RINS LIQD NIX CREME RINSE LIQD PERMETHRIN LOTN | MC/DEL MC | | LINDANE OVIDE LOTN | Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| TOPICAL - WOUND / DECBUTUS CARE | MC MC MC/DEL | ACCUZYME OINT ACCUZYME SPRAY ETHEZYME | MC | | 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 (TcPO2 >30, ABI>0.7 or ASP> 70), and where the underlying cause has been corrected. The wound must be free of infection and have been previously treated with preferred standard therapies for at least 2 months. Maximum approval for 20 weeks. |
| TOPICAL - ASTRINGENTS / PROTECTANTS | MC MC MC | ALUMINUM CHLORIDE SOLN DRYSOL SOLN XERAC AC SOLN | MC MC MC | | LOWILA BAR MOISTURIN DRY SKIN CREA PROSHIELD PLUS SKIN PROTE CREA | Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |

| | | | | | | | |
|---------------------------------------|--|--|--|-------------|---|--|--|
| | | | MC | | SURGILUBE GEL | | |
| TOPICAL - ANTISEPTICS / DISINFECTANTS | MC MC/DEL MC/DEL | HIBICLENS LIQD PHISOHEX LIQD POVIDONE-IODINE SOLN | MC MC MC MC | | BETADINE OINT FORMALYDE-10 AERS IODOSORB LAZERFORMALYDE SOLUTION SOLN | Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| MISCELLANEOUS EYE | | | | | | | |
| OP. - EYE | MC MC MC MC MC/DEL | AK-DILATE SOLN EYE WASH SOLN NAPHAZOLINE HCL SOLN PHENYLEPHRINE HCL SOLN PONTOCAINE SOLN SODIUM CHLORIDE | MC MC/DEL MC | | LENS PLUS REWETTING DROPS MURO 128 NEO-SYNEPHRINE SOLN | Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| MISCELLANEOUS EAR | | | | | | | |
| EAR | MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC MC/DEL MC MC MC/DEL MC MC MC/DEL MC/DEL MC MC MC/DEL MC/DEL | A/B OTIC SOLN ACETASOL SOLN ACETASOL HC SOLN ACETIC ACID ACETIC ACID/HYDROCORTISON ALLERGEN SOLN ANTIPYRINE/BENZOCAINE SOLN AURODEX SOLN AUROGUARD SOLN AUROTO OTIC SOLN CERUMENEX SOLN CIPRODEX CORTISPORIN SOLN CORTOMYCIN EAR DROPS SOLN EAR DROPS RX SOLN EAR WAX REMOVAL DROPS EAR-GESIC SOLN FLOXIN OTIC SOLN NEOMYCIN/POLYMYXINH/C OTICAINE OTIC SOLN | MC MC MC MC MC/DEL MC MC MC/DEL MC MC MC/DEL MC MC MC MC MC MC/DEL MC MC MC MC MC/DEL MC/DEL | | AERO OTIC HC SOLN ANTIBIOTIC EAR SOLN ANTIBIOTIC EAR SUSP AURALGAN SOLN CIPRO HC SUSP COLY-MYCIN-S SUSP CORTISPORIN SUSP CORTISPORIN-TC SUSP DEBROX SOLN DOMEBORO SOLN PEDIOTIC SUSP VOSOL-HC SOLN ZOTANE HC SOLN ZOTO-HC SOLN | Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| MOUTH ANTISEPTICS | | | | | | | |
| MOUTH ANTI-INFECTIVES | MC MC MC/DEL | NILSTAT SUSP EAR-GESIC SOLN NYSTATIN SUSP | MC MC MC | | MYCELEX TROC MYCOSTATIN LOZG | Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| MOUTH ANTISEPTICS | MC/DEL MC/DEL MC MC | CHLORHEXIDINE GLUCONATE LIDOCAINE VISCOUS SOLN TRIAMCINOLONE IN ORABASE PSTE TRIAMCINOLONE ORADENT PSTE | MC MC MC MC | | APHTHASOL PSTE PERIDEX SOLN PERIOGARD SOLN TRIAMCINOLONE ACETONIDE PSTE XYLOCAINE VISCOUS SOLN | Must fail all preferred products before non-preferred. Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| DENTAL PRODUCTS | | | | | | | |
| DENTAL PRODUCTS | MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC | ETHEDENT CREA GEL-KAM CONC PHOS FLUR SOLN PREVIDENT PREVIDENT SOLN SF GEL STANNOUS FLUORIDE ORAL RI CONC | MCOMC MC/DEL MC/DEL MC/DEL MC | | APF GEL GEL DENTAGEL GEL PHOS-FLUR GEL SF 5000 PLUS CREA THERA-FLUR-N GEL | Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| ARTIFICIAL SALIVA/STIMULANTS | | | | | | | |
| ARTIFICIAL SALIVA/STIMULANTS | MC MC | EVOXAC CAPS SALIVA SUBSTITUTE SOLN | MC MC | | RADIACARE SOLR SALAGEN TABS | Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
| MISCELLANEOUS ANORECTAL | | | | | | | |
| ANORECTAL - MISC. | MC/DEL MC/DEL MC MC MC/DEL MC/DEL | ANALPRAM-HC CREA COLOCORT ENEM CORTENEMA ENEM ELA-MAX 5 CREA HYDROCORTISONE ENEM PROCTOZONE-HC CREA | MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL | | ANUSOL-HC CREA CORTIFOAM FOAM PROCTOCREAM-HC CREA PROCTOFOAM HC FOAM PROCTO-KIT CREA PROCTOSOL HC CREA | Use PA Form # 20420 | |
| T-CELL ACTIVATION INHIBITOR | | | | | | | |
| PSORIASIS BIOLOGICALS | | | MC MC MC | 5 8 8 | ENBREL AMEVIVE RAPTIVA | Use PA Form # 20910 | Approved for severe chronic plaque psoriasis unresponsive to first line therapies. A trial of at least several potent topicals from the following categories: corticosteroids, coal tars, anthralin, calcipotriene and tazarotene, and at least one systemic drug such as methotrexate, cyclosporine, methoxsalen or acitretin and phototherapy/UVA. High dose Enbrel will be approved for chronic severe psoriasis only after failure of all traditional therapies listed here and adequate trial of either Amevive or Raptiva. |
| ALTERNATIVE MEDICINES | | | | | | | |
| ALTERNATIVE MEDICINES | MC | DIMETHYL SULFOXIDE SOLN | MC MC/DEL | | ARTHX DS CAPS CO-ENZYME Q-10 | Use PA Form # 20420 | Will only be approved for specific conditions supported by at least two double-blinded, placebo-controlled randomized trials that are not contradicted by other studies of similar quality. |

MC
 MC
 MC
 MC/DEL
 MC
 MC

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

CHELATING AGENTS

| | | | | | | |
|------------------|--------|----------------|----|----------------------|---------------------|--|
| CHELATING AGENTS | MC/DEL | CUPRIMINE CAPS | MC | DEPEN TITRATABS TABS | Use PA Form # 20420 | |
|------------------|--------|----------------|----|----------------------|---------------------|--|

ANTILEPROTIC

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

ANTINEOPLASTIC AGENTS - ANTIANDROGENS

| | | | | | | |
|---------------------------------------|--------|---------|--|--|--|--|
| ANTINEOPLASTIC AGENTS - ANTIANDROGENS | MC/DEL | CASODEX | | | | |
|---------------------------------------|--------|---------|--|--|--|--|

CANCER

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

IMMUNOSUPPRESSANTS

| | | | | | | |
|--------------------|--|---|------------------|--|--|--|
| IMMUNOSUPPRESSANTS | MC/DEL MC/DEL MC/DEL MC MC/DEL MC MC/DEL MC/DEL | CELLCEPT CYCLOSPORINE MODIFIED CYCLOSPORINE SOL. MODIFIED GENGRAF CAPS MYFORTIC PROGRAF CAPS RAPAMUNE SANDIMMUNE | MC/DEL MC/DEL | CYCLOSPORINE CAPS NEORAL ^{1,2} | 1. Established users will require a one time PA. 2. Established users will require a one time PA Use PA Form # 20420 | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. |
|--------------------|--|---|------------------|--|--|--|

PURINE ANALOG

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

K REMOVING RESINS

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

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.

IVULSANTS INDICATION CHART

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

TI-CONVULSANTS INDICATION CHART

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