

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

	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 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 VALTREX TABS	MC/DEL MC/DEL				FAMVIR TABS ZOVIRAX	Must fail Acyclovir and Valtrex before non-preferred products. Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
INFLUENZA AGENTS	MC/DEL MC MC/DEL MC/DEL		AMANTADINE RELENZA DISKHALER AEPB RIMANTADINE HCL TABS TAMIFLU ¹	MC/DEL MC 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				BOTOX MYOBL0C 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.

	MC/DEL		ENTOCORT EC CP24	MC		PREDNISON 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		PREDNISON					
	MC/DEL		SOLU-CORTEF SOLR					
	MC/DEL		SOLU-MEDROL SOLR					

HORMONE REPLACEMENT THERAPIES

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

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.

	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, Blaxin, 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 CP/CR	Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered

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	BETAPACE TABS BETAPACE AF TABS CORCARD TABS INDERAL TABS INNOPRAN XL PROPRANOLOL HCL LA CPR	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, Bepiridil, 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.	

	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 MAVIK TABS 5 ACCUPRIL TABS 8 ACEON TABS 8 ALTACE CAPS 8 CAPOTEN TABS 8 FOSINOPRIL SODIUM 8 LOTENSIN TABS 8 MOEXIPRIL 8 PRINIVIL TABS 8 UNIVASC 8 VASOTEC TABS 8 ZESTRIL TABS	Non-preferred products must be used in specified order. Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs (in step-order) will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Non-preferred products are subject to step-order requirements unless clinical circumstances warrant exception.
ANGIOTENSIN RECEPTOR BLOCKER	MC MC/DEL MC/DEL MC/DEL MC/DEL MC		AVAPRO TABS BENICAR TABS COZAAR TABS DIOVAN MICARDIS TABS TEVETEN TABS	MC/DEL	ATACAND TABS	Preferred products only available without PA if patient on diabetic therapy or prior ACE therapy. Use PA Form # 20420	The initial criteria to use any ARB is that the member must have failed ACE inhibitors (such as due to coughing) in the past or must currently be actively treated for diabetes and Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
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	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 COMBO'S	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		BENAZEPRIL HCL/HYDROCHLOR CAPTOPRIL/HYDROCHLOROTHIA ENALAPRIL MALEATE/HCTZ TABS LISINAPRIL-HCTZ TABS UNIRETIC TABS	MC/DEL MC MC/DEL MC MC/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 COMBO'S	MC/DEL MC/DEL MC/DEL		ATENOLOL/CHLORTHALIDONE BISOPROLOL FUMARATE/HCTZ PROPRANOLOL/HCTZ	MC MC/DEL MC/DEL MC MC MC/DEL	CORZIDE TABS INDERIDE 40/25 TABS LOPRESSOR HCT TABS TENORETIC TIMOLIDE 10/25 TABS ZIAC TABS	Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ARB'S AND DIURETICS	MC MC/DEL MC/DEL MC/DEL MC/DEL MC		AVALIDE TABS BENICAR HCT DIOVAN HCT TABS HYZAAR TABS MICARDIS HCT TABS TEVETEN HCT TABS	MC/DEL	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/DEL MC		ACETAZOLAMIDE TABS AMILORIDE HCL BUMETANIDE CHLOROTHIAZIDE TABS CHLORTHALIDONE TABS EDECRIN TABS	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL	ALDACTAZIDE TABS ALDACTONE TABS BUMEX TABS DEMADEX TABS DIAMOX DIURIL	1. Multiples of Spironolactone 25 mg are cheaper than 50 mg strength. Inspa will be approved for severe breast tenderness and male gynecomastia.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.

	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC	FUROSEMIDE HYDROCHLOROTHIAZIDE INDAPAMIDE TABS METHAZOLAMIDE TABS METHYLOTHIAZIDE TABS SPIRONOLACTONE 25MG TABS SPIRONOLACTONE/HYDRO TORSEMIDE TABS TRIAMTERENE/HCTZ ZAROXOLYN TABS	MC/DEL MC MC MC/DEL MC MC/DEL MC MC MC MC/DEL	DYAZIDE CAPS ENDURON TABS INSPRA LASIX TABS LOZOL TABS MAXZIDE MICROZIDE CAPS MIDAMOR TABS MODURETIC 5-50 TABS NAQUA TABS NATURETIN TABS SPIRONOLACTONE 50MG ¹	Use PA Form # 20420	
CCB / LIPID	MC/DEL	CADUET				
LIPID DRUGS						
CHOLESTEROL - BILE SEQUESTRANTS	MC/DEL MC/DEL	CHOLESTYRAMINE COLESTID	MC/DEL MC MC/DEL	PREVALITE QUESTRAN WELCHOL TABS	Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
CHOLESTEROL - FIBRIC ACID DERIVATIVES	MC/DEL MC MC/DEL MC	GEMFIBROZIL TABX TRIGLIDE NIASPAN TRICOR	MC MC MC MC	ANTARA LIPID 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/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 MC/DEL MC MC MC/DEL	MEVACOR TABS PRAVACHOL TABS PRAVIGARD	1. Zetia available w/OPA as addition to Zocor 80mg. Lipitor 80mg, or Crestor 40mg. Zetia will also be approved with a PA as add on for patients at maximally tolerated doses of statins. Zocor patients trying to use Zetia must use Vytorin instead. Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Zetia will be approved for patients unable to tolerate all other therapies or unable to achieve cholesterol goal with maximally tolerated dose of most potent statins.
PULMONARY ANTI-HYPERTENSIVES						
PULMONARY ANTI-HYPERTENSIVES	MC/DEL MC	REVATIO ¹ VENTAVIS ²	MC/DEL MC	FLOLAN TRACLEER	Use PA Form # 20420	Flofan and Tracleer will be approved after the dx of pulmonary hypertension is confirmed. 1. Revatio approvals will require WHO Group 1 diagnosis of primary PAH (Primary Pulmonary Hypertension) and NYHA functional class 2,3, or 4. 2. Ventavis approvals will require WHO Group 1 diagnosis of primary PAH (Primary Pulmonary Hypertension) and NYHA functional class 3 or 4.
IMPOTENCE AGENTS						
IMPOTENCE AGENTS				9 CAVERJECT 9 CIALIS 9 EDEX 9 LEVITRA 9 MUSE 9 VIAGRA 9 YOHEMBINE 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) ¹	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL	5 CLARINEX TABS ² 5 CLARINEX SYR ³ 5 ZYRTEC ³ 8 ALLEGRA 8 CLARITIN ²	1. Preferred drugs are OTC loratadines. 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	Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. No combination

				9	FEXOFENADINE	Ultramex 140s and Zyrtec products before moving to next step product without PA Pseudoephedrine is available with prescription. Use PA Form # 20530	product with decongestant will be approved since pseudoephedrine available without PA.
ALLERGY / ASTHMA THERAPIES							
ANTIASTHMATIC - ANTICHOLINERGICS - INHALER	MC/DEL MC		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 ³ NASONEX SUSP ³ BECONASE AERS BECONASE AQ INHA NASAREL SOLN	MC/DEL MC MC/DEL MC 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 ² 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 ³	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 MC		AEROBID AERS ASMANEX AZMACORT AERS BECLOVENT AERS FLOVENT PULMICORT SUSP ³ QVAR AERS VANCERIL AERS	MC/DEL MC/DEL MC MC MC/DEL MC MC	AEROBID-M AERS PULMICORT TURBUHALER AEP ² VANCERIL DOUBLE STRENGTH AERS	1. No PA for Pulmicort susp under 8 years old 2. No PA for Pulmicort turbobaler if under 14 yr. Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANTIASTHMATIC - 5-Lipoxygenase Inhibitors				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.

	MC/DEL		DOXAZOSIN MESYLATE TABS	MC/DEL	8	CARDURA TABS	be used in specified order.	exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Approval of a non-preferred 5-alpha reductase inhibitor requires objective clinical evidence of a very enlarged prostate rather than just the presence of obstructive urinary outflow symptoms along with adequate trial of preferred Proscar.
	MC/DEL		PROSCAR TABS	MC	8	HYTRIN CAPS	Use PA Form #20420	
	MC/DEL		TERAZOSIN HCL CAPS	MC/DEL	8	UROXATRAL		
ANXIOLYTICS								
ANXIOLYTICS - BENZODIAZEPINES	MC/DEL		ALPRAZOLAM TABS	MC/DEL		ATIVAN	Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		CHLORDIAZEPOXIDE HCL CAPS	MC/DEL		NIRAVAM		
	MC/DEL		CLORAZEPATE DIPOTASSIUM TABS	MC/DEL		SERAX		
	MC/DEL		DIAZEPAM	MC/DEL		TRANXENE		
	MC/DEL		LORAZEPAM	MC/DEL		XANAX TABS		
	MC/DEL		OXAZEPAM CAPS	MC/DEL				
ANXIOLYTICS - LONG ACTING	MC/DEL		XANAX XR ¹				1. Xanax XR will be available if the long acting benzo clonazepam fails. Use PA Form # 20420	
ANXIOLYTICS - MISC.	MC/DEL		BUSPIRONE HCL TABS	MC		ATARAX TABS	Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		HYDROXYZINE HCL SOLN	MC		BUSPAR TABS		
	MC		HYDROXYZINE HCL SYRP	MC		DROPERIDOL SOLN		
	MC/DEL		HYDROXYZINE PAMOATE CAPS	MC/DEL		HYDROXYZINE HCL TABS		
				MC/DEL		HYDROXYZINE PAM 100MG CAPS		
				MC		INAPSINE SOLN		
				MC/DEL		MEPROBAMATE TABS		
				MC/DEL		VISTARIL		
ANTI-DEPRESSANTS								
ANTIDEPRESSANTS - MAO INHIBITORS	MC/DEL		NARDIL TABS					
	MC/DEL		PARNATE TABS					
ANTIDEPRESSANTS - SELECTED SSRI's	MC/DEL		BUPROPION HCL TABS	MC	5	CYMBALTA ⁴	Non-preferred products must be used in specified step order. 1. Use Fluoxetine 20 mg in multiples. 2. See Zoloft splitting table. Zoloft requires splitting of 50mg and/or 100mg scored tabs to avoid PA. 3. Strong caution with pediatric population. 4. Established users are grandfathered. 5. See Celexal/Citalopram and Lexapro splitting tables. 6. Max daily dose allowed is 60mg, only 1 per day allowed for all strengths. Use PA Form # 20420	Preferred drugs must be tried for at least 4 weeks each and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. At least one preferred SSRI and one preferred non-SSRI drugs must be tried. Venlafaxine is non-preferred for any anxiety diagnosis and may be approved after trials of one SSRI and one non-SSRI (e.g. any anxiolytic or a tricyclic at any dose). Preferred Fluoxetine will be the only preferred antidepressant for members who are less than 18 years of age. Exceptions to the rule are as follows: 1. If the member (<18) is already an established user for any of the preferred or non-preferred drugs under the Antidepressant category on the PDL, then they can continue to get that drug. 2. If the member (<18) has a prescription for an antidepressant that is on the PREFERRED side of the PDL and has had a 30 day supply of Fluoxetine at least 30 days before the date they are getting it filled, the claim will pay. If they do not have the trial of Fluoxetine in their profile, the claim will reject for PA required. 3. If the member (<18) has a prescription for a medication that is on the NON-PREFERRED side of the PDL regardless of having Fluoxetine in their profile, the prescription will need a PA. 4. Use of a preferred antidepressant for anxiety will require pa to establish anxiety diagnosis. 5. Use of bupropion or Wellbutrin for ADHD diagnosis must show prior trial/failure with methylphenidate and amphetamine <u>Special Kid < 18yo Criteria for New Starters:</u> Must have had fluoxetine trial for at least 30 days before accessing other preferred antidepressants without PA. Cymbalta- Second line therapy for Diabetic Peripheral Neuropathy and Post Herpetic Neuralgia after trial of a preferred TCA (tri-cyclic anti-depressant) and one of the following preferred medications: a preferred anti-convulsant, capsaicin, tramadol, or other narcotic. Combination therapy of non-preferred medications for Diabetic Peripheral Neuropathy and Post Herpetic Neuralgia will not be approved.
	MC/DEL		BUPROPION SR	MC/DEL	8	CELEXA		
	MC/DEL		CITALOPRAM ⁶	MC	8	DESYREL TABS		
	MC/DEL		FLUOXETINE HCL CAPS	MC/DEL	6	EFFEXOR TABS		
	MC/DEL		FLUOXETINE HCL LIQD	MC/DEL	6	EFFEXOR XR CP24 ³		
	MC/DEL		FLUOXETINE HCL TABS	MC/DEL	8	FLUOXETINE 40 mg ¹		
	MC/DEL		FLUVOXAMINE MALEATE TABS	MC	8	LUVOX TABS		
	MC/DEL		LEXAPRO TABS ⁵	MC	8	MAPROTIline HCL TABS		
	MC/DEL		MIRTAZAPINE	MC/DEL	8	MIRTAZAPINE ODT		
	MC/DEL		PAROXETINE ³	MC/DEL	8	PAXIL ³		
	MC		PAXIL CR ³	MC	8	PROZAC		
	MC		SERZONE TABS	MC	8	PROZAC CAPS		
	MC/DEL		TRAZODONE HCL TABS	MC	8	PROZAC WEEKLY CPDR		
	MC/DEL		WELLBUTRIN XL	MC/DEL	8	REMERON TABS		
	MC/DEL		ZOLOFT ²	MC/DEL	9	REMERON SOLTAB TBDP		
				MC/DEL	8	SARAFEM CAPS		
				MC/DEL	8	TRAZODONE HCL 300MG TABS		
				MC/DEL	8	WELLBUTRIN TABS		
				MC/DEL	8	WELLBUTRIN SR TBCR		
ANTIDEPRESSANTS - TRI-CYCLICS	MC/DEL		AMITRIPTYLINE HCL TABS	MC/DEL		AMOXAPINE TABS	PA required for new starters if over 65 years old. Users over 65 years old are 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		AVENTYL SOLN	MC/DEL		ANAFRANIL CAPS		
	MC/DEL		CLOMIPRAMINE HCL CAPS	MC/DEL		ELAVIL TABS		
	MC/DEL		DESIPRAMINE HCL TABS	MC/DEL		NORPRAMIN TABS		
	MC/DEL		DOXEPIH HCL	MC/DEL		PAMELOR	Use PA Form # 20420 or 102220	
	MC/DEL		IMIPRAMINE HCL TABS	MC/DEL		SINEQUAN		
	MC/DEL		NORTRIPTYLINE HCL	MC		TOFRANIL		
	MC		PROTRIPTYLINE HCL TABS	MC		VIVACTIL TABS		
	MC		SURMONTIL CAPS					
SEDATIVE / HYPNOTICS								
SEDATIVE/HYPNOTICS - BARBITURATE	MC		BUTISOL SODIUM TABS	MC		LUMINAL SOLN	PA required for new users of preferred products if over 65 years old. Use PA Form # 30110	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		CHLORAL HYDRATE SYRP	MC		SECONAL CAPS		
	MC		MEBARAL TABS	MC/DEL		SOMNOTE CAPS		
	MC/DEL		PHENOBARBITAL					
SEDATIVE/HYPNOTICS - BENZODIAZEPINES	MC/DEL		DORAL TABS	MC		DALMANE	Previous quantity limits still 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. Benzodiazepines do cause dependence with continued use and usage should be limited to 7-10 days at a time. Chronic intermittent use (2-3 Days per week max) is the standard of care
	MC/DEL		ESTAZOLAM TABS	MC		HALCION TABS		
	MC/DEL		FLURAZEPAM HCL CAPS	MC		MIDAZOLAM HCL SYRP	Use PA Form # 30110	
	MC/DEL		TEMAZEPAM CAPS	MC		PROSOM TABS		
	MC/DEL		TRIAZOLAM TABS	MC/DEL		RESTORIL CAPS		
SEDATIVE/HYPNOTICS - Non-Benzodiazepines	MC/DEL		LUNESTA ¹	MC/DEL	7	AMBIEN	Must fail all preferred products before non-preferred	Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Ambien and Sonata do cause dependence with continued use and as with benzodiazepines, usage should be limited to 7-10 days at a time. Chronic intermittent use (2-3 days per week max) is the standard of care. Please see Sedative/Hypnotic PA form.
	MC/DEL		MIRTAZAPINE	MC/DEL	8	SONATA CAPS		
	MC		TRAZODONE	MC/DEL	8	ROZEREM	1. Quantity Limit of 12 per 34 days. Use PA Form # 30110	
				MC/DEL	9	AMBIEN CR		

ANTI-PSYCHOTICS

ANTIPSYCHOTICS - ATYPICALS	MC MC/DEL MC/DEL MC/DEL MC MC	RISPERDAL GÉODON SEROQUEL TABS ABILIFY TABS ZYPREXA TABS ZYPREXA ZYDIS TBDP	MC MC	8 8	RISPERDAL CONSA RISPERDAL M TAB	1. If prescribing 2 or more antipsychotics, PA will be required for both drugs, except if one is Clozapine. See Multiple Antipsychotic PA form #20440 2. All atypicals have dosing limitations and maximum daily doses. Please refer to dose consolidation table for any potential dosing limits. Maximum daily doses are as follows: Abilify- 30mg daily max Risperdal- 8mg daily max Seroquel- 800mg daily max Zyprexa- 30mg daily max Use PA form #10420 for requests exceeding these maximum daily doses.	Preferred drugs subject to step order must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Atypicals will be approved, subject to step-order, for patients with FDA-approved indications and for specific conditions supported by at least two published peer-reviewed double-blinded, placebo-controlled randomized trials that are not contradicted by other studies of similar quality and as long as all first line preferred therapies have been tried and failed at full therapeutic doses for adequate durations (at least two weeks). * Abilify: doses above 15mg were not shown to be more effective than doses in the 10-15mg range .4. Seroquel 25mg is available without PA if the following conditions are met: a.) Either 65 years of age or older or less than 18 years of age, b.) dosage is for 3 or more per day, c.) Seroquel 25mg is in the profile within the last 45 days.
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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.
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ANTIPSYCHOTICS - TYPICAL	MC/DEL MC/DEL MC/DEL MC MC/DEL MC MC MC/DEL MC/DEL MC MC/DEL MC/DEL MC MC/DEL MC/DEL MC MC/DEL 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/DEL MC MC/DEL MC MC/DEL MC 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.
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LITHIUM

LITHIUM	MC/DEL MC/DEL MC/DEL MC/DEL	ESKALITH CAPS ESKALITH CR TBCR LITHIUM CARBONATE LITHIUM CITRATE SYRP					
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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.
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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.
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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.	
LONG ACTING AMPHETAMINES	MC MC		DEXEDRINE CAP CR DEXTRAMPHET SULF CPCR							
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	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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	MC MC/DEL	5 8		METADATE CD CPCR ¹ RITALIN LA	Preferred stimulants will be available without PA if diagnosis of ADHD. Non-preferred products must be used in specified step order. 1. Easily approved for patients needing the sprinkles. Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.	
STIMULANT - STIMULANT LIKE				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	
ANTI-CATALECTIC AGENTS										
PSYCHOTERAPEUTIC AGENTS MISC.				MC/DEL			XYREM SOL	Use PA Form #20710		
WEIGHT LOSS										
WEIGHT LOSS								No longer covered:	Weight loss drugs are not covered as permitted by Federal Medicaid regulations and Maine Medicaid (MaineCare) Policy.	
ALZHEIMER DISEASE										
ALZHEIMER - Cholinomimetics/Others	MC MC/DEL MC/DEL		ARICEPT TABS ¹ EXELON ¹ NAMENDA ¹	MC MC MC	8 8 9		RAZADYNE REMINYL COGNEX CAPS	1. All new users need PA to establish dementia diagnosis and baseline mental status score. Must fail all preferred products before moving to non-preferred. Use PA Form #20420	Revatio approvals will require WHO group 1 diagnosis of primary PAH (primary pulmonary hypertension) and NYHA functional class 2, 3, or 4. Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs (in step-order) will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.	
SMOKING CESSATION										
NICOTINE PATCHES / TABLETS	MC/DEL		NICODERM CO PT24					Bupropion SR 150 mg is available without a prior authorization.	OTC Nicotine products are covered by MaineCare Policy when they have been determined to be cost-effective. Only Nicoderm and the generic nicotine gums have received this designation as preferred. All other nicotine products (OTC & prescription) are non-preferred by MaineCare Policy. Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs (in step-order) will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Another version of Zyban, Bupropion SR (100 and 150mg) is available without PA. There will be a quantity limit of 3 months supply of nicotine products allowed per 12 months.	
NICOTINE REPLACEMENT - OTHER	MC/DEL MC/DEL		NICOTINE POLACRILEX GUM NICORETTE GUM	MC/DEL MC/DEL	5		COMMIT LOZENGES ¹ NICOTROL INHALER	Must fail all preferred products from smoking cessation category (Nicoderm	OTC Nicotine products are covered by MaineCare Policy when they have been determined to be cost-effective. Only Nicoderm and the generic nicotine gums have received this designation as preferred. All other nicotine products (OTC & prescription) are non-preferred by MaineCare Policy. Both preferred Nicotine gum and Nicoderm patch must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs (in step-order) will be approved, unless an acceptable clinical exception is offered on the Prior	

TREATMENTS

max dosing limits of 32mg daily if the following conditions are met: a.) There is not another Suboxone script in member's drug profile within the past 30 days. and b.) There is not more than one narcotic fill in member's drug profile between today's fill of suboxone and a prior suboxone fill within the past 90 days.

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

	MC/DEL	2	PERGOLIDE MESYLATE TABS			USE PA Form # 20420	another drug and the preferred drug(s) exists.
PARKINSONS - DOPAMINERGICS/CARBII/ LEVO	MC/DEL		AMANTADINE HCL	MC/DEL		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.
	MC/DEL		BROMOCRIPTINE MESYLATE	MC			
	MC/DEL		CARBIDOPA/LEVODOPA TABS*	MC/DEL			
	MC/DEL		CARBIDOPA/LEVODOPA ER	MC/DEL			
	MC		LARODOPA TABS	MC			
	MC		LODOSYN TABS	MC			
	MC/DEL		SELEGILINE HCL	MC			
PARKINSONS - COMBO.	MC/DEL		STALEVO				
MUSCLE RELAXANTS							
ALS DRUG	MC/DEL		RILUTEK TABS				
MUSCLE RELAXANTS	MC/DEL		BACLOFEN TABS	MC/DEL	7	ORPHENADRINE CITRATE	Non-preferred drugs will not be approved if members circumventing MaineCare prior authorization requirements by paying (prescribers failed to submit prior authorization prior to cash narcotic scripts being filled by member).
	MC/DEL		CHLORZOXAZONE TABS	MC/DEL	7	TIZANIDINE HCL TABS	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.
	MC/DEL		CYCLOBENZAPRINE HCL TABS	MC/DEL	8	CARISOPRODOL TABS ¹	
	MC		LIORESAL INTRATHECAL KIT	MC/DEL	8	DANTRIUM CAPS	
	MC/DEL		METHOCARBAMOL TABS	MC/DEL	8	FLEXERIL TABS	
				MC	8	LIORESAL TABS	
				MC	8	NORFLEX TBCR	
				MC	8	ROBAXIN-750 TABS	
				MC/DEL	8	ZANAFLEX TABS	Non-preferred products must be used in specified step order. Both step 7's must be tried. Use PA Form # 20420
				MC/DEL	9	SKELAXIN TABS	
				MC/DEL	9	SOMA TABS	
MUSCLE RELAXANT - COMBO.				MC/DEL		CARISOPRODOL/ASPIRIN TABS	Use PA Form # 20420
				MC/DEL		CARISOPRODOL/ASPIRIN/CODE	Individual components are available with PA described in the section above. 1. frequent or persistent early refills of non-controlled drugs; 2. multiple instances of early refill overrides due to reports of misplacement stolen, dropped in toilet or sink, distant travel, etc.
				MC		NORGESIC TABS	
				MC/DEL		ORPHENADRINE COMPOUND	
				MC/DEL		ORPHENADRINE/ASA/CAFF	
				MC		ORPHENGESIC	
VITAMINS							
Preferred products that used to require diag codes still require diag codes unless indicated otherwise.							
VITAMINS	MC/DEL		ASCORBIC ACID TABS	MC		AQUASOL E SOLN	Use PA Form # 20420
	MC		BIOTIN	MC		AQUAVIT-E 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. As listed in MaineCare Policy, certain drugs require specific diagnoses for approval.
	MC		CYANOCOBALAMIN SOLN	MC		DHT SOLN	
	MC		FOLGARD RX 2.2 TABS	MC		NASCOBAL GEL	
	MC/DEL		FOLIC ACID TABS				
	MC		FOLTX TABS				
	MC/DEL		MEPHYTON TABS				
	MC/DEL		NIACIN				
	MC		NIACOR TABS				
	MC/DEL		NICOTINIC ACID SR CPCR				
	MC		PYRIDOXINE HCL TABS				
	MC/DEL		SLO-NIACIN TBCR				
	MC/DEL		THIAMINE HCL SOLN				
	MC/DEL		VITAMIN B-1 TABS				
	MC/DEL		VITAMIN B-12				
	MC		VITAMIN B-6 TABS				
	MC/DEL		VITAMIN C				
	MC/DEL		VITAMIN E CAPS				
	MC/DEL		VITAMIN E/D-ALPHA CAPS				
	MC		VITAMIN K1 SOLN				
	MC		V-R VITAMIN E CAPS				
VITAMIN D's	MC		CALCIFEROL SOLN ¹	MC/DEL		DRISDOL CAPS	1. Diagnosis of dialysis (renal failure) required.
	MC/DEL		CALCITRIOL CAPS ¹	MC		CALCIJEX	Preferred products require dialysis/renal failure diagnosis.
	MC/DEL		DRISDOL SOLN ¹	MC/DEL		HECTOROL (ORAL)	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
	MC/DEL		VITAMIN D ^{1,2}	MC/DEL		HECTOROL (PARENTERAL)	
				MC/DEL		ROCALTRON	
				MC		ZEMPLAR	

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 TBEP	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%/DSW/NACL 0.2% SOLN		
MC	K-EFFERVESCENT TBEP		
MC	KLOR-CON		
MC	KLOTRIX TBCR		
MC/DEL	K-PHOS TABS		
MC/DEL	K-VESCENT TBEP		
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 TBEP		
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 ¹²	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 MC/DEL MC MC/DEL MC/DEL MC/DEL MC MC MC/DEL MC/DEL MC MC/DEL MC/DEL		BACITRACIN/NEOMYCIN/POLYM BACITRACIN/POLYMYXIN B OINT CHLOROPTIC SOLN ERYTHROMYCIN OINT GENTAMICIN SULFATE NEOMYCIN/POLYMYXIN/GRAMIC NEOSPORIN SOLN POLYSPORIN SODIUM SULFACETAMIDE SOLN SULFACETAMIDE SODIUM TERRAMYCIN OINT TOBRAMYCIN SULFATE SOLN TRIMETHOPRIM SULFATE/POLY VIROPTIC SOLN	MC MC MC MC/DEL MC MC MC MC/DEL MC/DEL	AK-TOB SOLN BLEPH-10 SOLN GENTAK ILOTYCIN OINT NEOMYCIN/BACI/POLYM OINT NEOSPORIN OINT OCUSULF-10 SOLN OCUTRICIN SOLN TERAK OINT TOBREX OINT TRIFLURIDINE SOLN		preferred drug(s) exists.	
OP. - QUINOLONES	MC/DEL MC/DEL MC MC/DEL	1 1 1 2	CIOXAN OINT CIOXAN SOLN OCUFLOX SOLN QUIXIN SOLN				Step order must be followed to avoid PA. Must fail Ocuflox and a Cioxan product before moving to next step product without PA. Use PA Form # 20420	Preferred drugs must be tried in step-order and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
OP. QUINOLONES - 4TH GENERATION	MC/DEL		VIGAMOX	MC	ZYMAR			
OP. - ARTIFICIAL TEARS AND LUBRICANTS	MC MC/DEL MC/DEL MC MC MC/DEL MC MC MC MC MC MC MC MC MC MC		AKWA TEARS OINT ARTIFICIAL TEARS OINT ARTIFICIAL TEARS SOLN CELLUVISC SOLN EYE LUBRICANT OINT GENTEAL LIQUITEARS SOLN MAJOR TEARS SOLN PURALUBE OINT PURALUBE TEARS SOLN REFRESH SOLN OP REFRESH PLUS SOLN REFRESH PM OINT	MC MC/DEL MC MC MC MC/DEL MC MC MC MC MC MC MC/DEL MC/DEL MC MC MC MC/DEL MC MC MC MC/DEL MC	AKWA TEARS SOLN ARTIFICIAL TEARS SOLN OP BION TEARS SOLN DRY EYES OINT DURATEARS OINT HYPO TEARS ISOPTO TEARS SOLN LACRI-LUBE LUBRIFRESH P.M. OINT MURINE SOLN MUROCEL SOLN NATURE'S TEARS SOLN REFRESH SOLN REFRESH TEARS SOLN SYSTANE TEARGEN SOLN TEARISOL SOLN TEARS NATURALE TEARS PURE SOLN TEARS RENEWED OINT THERATEARS SOLN V-R ARTIFICIAL TEARS SOLN	Use Pa Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.	
OP. - BETA - BLOCKERS	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		BETIMOL SOLN BETOPTIC-S SUSP CARTEOLOL HCL SOLN LEVUBUNOLOL HCL SOLN METIPRANOLOL SOLN TIMOLOL MALEATE SOLN TIMOLOL MALEATE SOLG (GEL)	MC MC/DEL MC/DEL MC MC/DEL MC/DEL	BETAGAN SOLN BETAXOLOL HCL SOLN ISTALOL OCUPRESS SOLN OPTIPRANOLOL SOLN TIMOPTIC SOLN TIMOPTIC-XE SOLG	Use Pa Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.	
OP. - ANTI-INFLAMMATORY / STEROIDS OPHTH.	MC MC/DEL MC MC/DEL MC/DEL MC/DEL MC MC MC MC MC MC MC/DEL MC/DEL MC MC MC/DEL MC/DEL		AK-SPORE HC OINT ALREX SUSP BLEPHAMIDE SUSP CORTISPORIN SUSP DEXAMETH SOD PHOS SOLN FLAREX SUSP FLUOROMETHOLONE SUSP FML LIQUIFILM SUSP FML S.O.P. OINT FML-S LIQUIFILM SUSP INFLAMASE SOLN LOTEMAX SUSP NEOM/POLIN/DEX PRED FORTE SUSP PRED MILD SUSP PREDNISOLONE TOBRADEX	MC MC MC MC MC MC MC MC MC MC MC/DEL MC MC/DEL	AK-TROL SUSP BACI/POLY/NEOMY/HC OINT BLEPHAMIDE S.O.P. OINT ECONOPRED EFLONE SUSP FLUOR-OP SUSP MAXITROL NEO/POLY/BAC/HC OINT PRED-G SUSP PRED-G S.O.P. OINT SULFACET SODI/PRED SOLN VASOCIDIN SOLN VEXOL SUSP	Use Pa Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.	
OP. - PROSTAGLANDINS	MC/DEL MC/DEL	1 1	XALATAN SOLN TRAVATAN SOLN	MC/DEL	RESCULA SOLN	Established users grandfathered. Preferred products must be used.	Preferred drugs must be tried and failed, in step-order, due to lack of efficacy (failure to reach target IOP reduction) or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.	

	MC	1	LUMIGAN SOLN			products must be used in specified step order or PA required. Use PA Form # 20420	significant potential drug interaction between another drug and the preferred drug(s) exists.
OP. - CYCLOPLEGICS	MC MC/DEL MC/DEL MC/DEL		AK-PENTOLATE SOLN ATROPINE SULFATE CYCLOPENTOLATE HCL SOLN ISOPTO HYOSCINE SOLN	MC/DEL MC MC/DEL MC		Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
OP. - MIOTICS - DIRECT ACTING	MC/DEL MC MC MC/DEL MC/DEL		ISOPTO CARBACHOL SOLN ISOPTO CARPINE SOLN PILOCAR SOLN PILOCARPINE HCL SOLN PILOPINE HS GEL				
OP. - ADRENERGIC AGENTS	MC/DEL MC		DIPIVEFRIN HCL SOLN EPIFRIN SOLN	MC		Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
OP. - SELECTIVE ALPHA ADRENERGIC AGONISTS	MC MC		ALPHAGAN SOLN ALPHAGAN P SOLN	MC/DEL		Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
OP. - ANTI-ALLERGICS	MC MC/DEL		ELESTAT PATANOL SOLN	MC MC/DEL MC/DEL MC MC/DEL		Use PA Form # 20420	All preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
OP. ANTI-ALLERGICS-MASTCELL STABILIZER CLASS	MC/DEL		ALAMAST SOLN				
OP. - CARBONIC ANHYDRASE INHIBITORS/COMBO	MC/DEL MC/DEL MC/DEL		AZOPT SUSP COSOPT SOLN TRUSOPT SOLN				
OP. - NSAID'S	MC MC MC MC		ACULAR LS ACULAR SOLN FLURBIPROFEN SODIUM SOLN VOLTAREN SOLN	MC		Must fail all preferred products before non-preferred. Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
OP. - OF INTEREST	MC/DEL		ENUCLENE SOLN	MC MC		1. Must have kerato conjunctivitis sicca and failed other dry eye therapies. Use PA Form #20420	Must fail adequate trials of multi agents from artificial tears and lubricant category.
DERMATOLOGICAL							
TOPICAL - ACNE PREPARATIONS	MC/DEL MC MC MC MC/DEL MC MC MC/DEL MC MC MC MC/DEL MC MC MC MC/DEL		ACCUTANE CAPS AKNE-MYCIN OINT AZELEX CREA BENZOYL PEROXIDE CLEOCIN-T DIFFERIN ERYDERM SOLN ERYTHROMYCIN GEL ERYTHROMYCIN PADS ERYTHROMYCIN SOLN METROCREAM CREA METROGEL GEL METROLOTION LOTN PLEXION RETIN-A CREA ² RETIN-A GEL ² RETIN-A LIOD ² SODIUM SULFACET/SULF LOTN	MC MC MC MC/DEL MC/DEL MC/DEL MC MC MC MC MC/DEL MC MC MC MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		2. For these Retin-A products, over 24 yr. need PA. Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
TOPICAL - ANTIBIOTIC	MC MC/DEL MC/DEL MC/DEL		BACIT/NEOMYCIN/POLYM OINT BACITRACIN OINT BACTROBAN ¹ CENTANY OINT 2% ¹	MC MC/DEL MC/DEL		1. Quantity limit of 30 g per month. Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.

	MC/DEL MC MC/DEL	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	ACTICIN CREA ELIMITE CREA EURAX LICE KILLING SHAM LICE TREATMENT CREME RINS LIOD NIX CREME RINSE LIOD PERMETHRIN LOTN	MC/DEL MC		LINDANE OVIDE LOTN	Use PA Form # 20420 Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
TOPICAL - WOUND / DECUBITUS CARE	MC MC MC/DEL	ACCUZYME OINT ACCUZYME SPRAY ETHEZYME	MC		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 (HgbA1c <8), who are not smoking, with a stage III or IV WOCN AND NPUAP lower extremity diabetic ulcer and with an adequate blood supply (TcP 02 >30, ABI >0.7 or ASP > 70), and where the underlying cause has been corrected. The wound must be free of infection and have been previously treated with preferred standard therapies for at least 2 months. Maximum approval for 20 weeks.
TOPICAL - ASTRINGENTS / PROTECTANTS	MC MC MC	ALUMINUM CHLORIDE SOLN DRYSOL SOLN XERAC AC SOLN	MC MC MC MC		LOWILA BAR MOISTURIN DRY SKIN CREA PROSHIELD PLUS SKIN PROTE CREA SURGILLUBE GEL	Use PA Form # 20420 Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
TOPICAL - ANTISEPTICS /	MC	HIBICLENS LIOD	MC		BETADINE 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.

DISINFECTANTS		MC/DEL MC/DEL	PHISOHEX LIQD POVIDONE-IODINE SOLN	MC MC MC	FORMALDE-10 AERS IODOSORB LAZERFORMALYDE SOLUTION SOLN		unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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 MC MC/DEL	LENS PLUS REWETTING DROPS MURO 128 NEO-SYNEPHRINE SOLN	Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
MISCELLANEOUS EAR							
EAR		MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL MC MC/DEL MC MC/DEL MC MC/DEL MC MC/DEL MC/DEL	A/B OTIC SOLN ACETASOL SOLN ACETASOL HC SOLN ACETIC ACID ACETIC ACID/HYDROCORTISON ALLERGEN SOLN ANTIPYRINE/BENZOCAINE SOLN AURODEX SOLN AUROGUARD SOLN AUROTO OTIC SOLN CERUMENEX SOLN CIPRODEX CORTISPORIN SOLN CORTOMYCIN EAR DROPS SOLN EAR DROPS RX SOLN EAR WAX REMOVAL DROPS EAR-GESIC SOLN FLOXIN OTIC SOLN NEOMYCIN/POLYMYXINH OTICAINE OTIC SOLN	MC MC MC MC MC/DEL MC MC MC/DEL MC/DEL MC MC MC/DEL MC MC MC/DEL MC MC/DEL MC MC/DEL	AERO OTIC HC SOLN ANTIBIOTIC EAR SOLN ANTIBIOTIC EAR SUSP AURALGAN SOLN CIPRO HC SUSP COLY-MYCIN-S SUSP CORTISPORIN SUSP CORTISPORIN-TC SUSP DEBROX SOLN DOMEBORO SOLN PEDIOTIC SUSP VOSOL-HC SOLN ZOTANE HC SOLN ZOTO-HC SOLN	Use PA Form # 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
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	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 MC MC	ARTHXS CAPS CO-ENZYME Q-10 DEHYDROEPIANDOSTERONE DHEA TABS	Use PA Form # 20420	Will only be approved for specific conditions supported by at least two double-blinded, placebo-controlled randomized trials that are not contradicted by other studies of similar quality.

MC
MC/DEL
MC
MC

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	
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ANTILEPTIC

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

ANTINEOPLASTIC AGENTS - ANTIANDROGENS	MC/DEL	CASODEX				
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CANCER

CANCER	MC MC/DEL MC MC/DEL	ALIMTA AVASTIN ERBITUX VIDAZA				
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IMMUNOSUPPRESSANTS

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

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

K REMOVING RESINS	MC/DEL MC MC/DEL MC/DEL MC/DEL	KAYEXALATE POWD KIONEX POWD SODIUM POLYSTYRENE SULFON SPS SUSP SPS 30GM/120ML ENEMA SUSP			Use PA Form # 20420	
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New drugs are initially non-preferred until reviewed by the DUR Committee and the State. According to State policy, any drug requiring specific diagnosis still requires the specific diagnosis unless otherwise noted within this document.

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