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## *Phone Numbers for Vermont Medicaid PBM Program*

### **MedMetrics Health Partners (MHP)**

#### **PRESCRIBER Call Center:**

#### **PA Requests**

Tel: 1-800-918-7549; Fax: 1-866-767-2649

Note: Fax requests are responded to within 24 hrs.

For urgent requests, please call MHP directly.

#### **MHP Clinical Staff:**

Diane Neal, RPh (o): 802-879-5605

(f): 802-879-5919

E-mail: [diane\\_neal@medmetricshp.com](mailto:diane_neal@medmetricshp.com)

#### **OVHA Medical Staff:**

*Associate Medical Director*

Erin Cody, M.D., (o) 802-879-5920;

(f) 802-879-5963

### **MedMetrics Health Partners (MHP)**

#### **PHARMACY Call Center:**

Tel: 1-800-918-7545

Available for assistance with claims processing

#### **MHP Program Rep-Vermont:**

*Assistance with any issues related to the PBM program.*

Nancy Miner, CPhT, (o) 802-879-5638

(f): 802-879-5919

E-mail: [nancy\\_miner@medmetricshp.com](mailto:nancy_miner@medmetricshp.com)

#### **OVHA Pharmacy Unit Staff:**

Stacey Baker, (o) 802-879-5912;

(f) 802-879-5919

E-mail: [Stacey.Baker@ahs.state.vt.us](mailto:Stacey.Baker@ahs.state.vt.us)

#### **MHP Account Manager:**

Nancy Hogue, Pharm.D., (o): 802-879-5604

(f): 802-879-5919

E-mail: [nancy\\_hogue@medmetricshp.com](mailto:nancy_hogue@medmetricshp.com)

**Acne Drugs: Oral**  
**Length of Authorization: 1 year**

**NO PA REQUIRED**

DOXYCYCLINE† 20 mg, 50 mg, 75 mg, 100 mg tab, cap

ERY-TAB® (erythromycin base, delayed release)  
ERYTHROCIN† (erythromycin stearate)  
ERYTHROMYCIN BASE†  
ERYTHROMYCIN ESTOLATE†  
ERYTHROMYCIN ETHYLSUCCINATE† (compare to E.E.S.®,  
Eryped®)  
ERYTHROMYCIN STEARATE†

MINOCYCLINE† 50 mg, 75 mg, 100 mg

TETRACYCLINE† 250 mg, 500 mg cap  
SUMYCIN† 250 mg, 500 mg cap

ISOTRETINOIN† 10 mg, 20 mg, 40 mg cap (SOTRET,  
CLARAVIS, AMNESTEEM)

**PA REQUIRED**

Adoxa®\* (doxycycline monohydrate) 50 mg, 75 mg tab, 100 mg tab, 150 mg  
tab  
Adoxa Pak®\* (doxycycline monohydrate) 1/75 mg, 1/100 mg, 1/150 mg,  
2/100 mg  
Doryx®\* (doxycycline hyclate) 75 mg, 100 mg cap  
doxycycline monohydrate pak† (compare to Adoxa Pak®) 1/75 mg, 1/100 mg,  
1/150 mg, 2/100 mg  
Monodox®\* (doxycycline monohydrate) 50 mg, 100 mg cap  
Oracea® (doxycycline monohydrate) 40 mg cap  
Periostat®\* (doxycycline hyclate) 20 mg, 100 mg tab  
Vibramycin®\* (doxycycline hyclate) 50 mg, 100 mg cap  
Vibramycin® (doxycycline hyclate) suspension  
Vibratab®\* (doxycycline hyclate) 100 mg tab  
All other brands

E.E.S.®\* (erythromycin ethylsuccinate)  
Eryc®\* (erythromycin base, delayed release)  
Eryped® (erythromycin ethylsuccinate)  
PCE Dispertab® (erythromycin base)  
All other brands

Minocin®\* (minocycline) 50 mg, 75 mg, 100 mg cap  
Dynacin®\* (minocycline) 50 mg, 75 mg, 100 mg cap/tab  
Solodyn® (minocycline) 45 mg, 90 mg, 135 mg tabs  
All other brands

Sumycin® (tetracycline) 250 mg, 500 mg tab  
Sumycin® (tetracycline) 125 mg/5ml syrup  
All other brands

Accutane®\* (isotretinoin) 10 mg, 20 mg, 40 mg caps  
All other brands

**PDL Key:**

† Generic product

\* Indicates a generic equivalent is available without PA

§ Indicates drug is managed via automated Step Therapy (prerequisite drug therapy  
automatically screened for upon claims processing)

## Acne Drugs: Topical Anti-Infectives

Length of Authorization: 1 year

### NO PA REQUIRED

#### BENZOYL PEROXIDE PRODUCTS

BENZOYL PEROXIDE 2.5%, 5%, 10% *G, L, W*; 10% *C*; 3%, 5%, 6%, 8%, 9%, 10% *L*; 3%, 6%, 9% *P* †

#### CLINDAMYCIN PRODUCTS

CLINDAMYCIN 1% *S, G, L, P* †

#### ERYTHROMYCIN PRODUCTS

ERYTHROMYCIN 2% *S, G, P* †

#### SODIUM SULFACETAMIDE PRODUCTS

SODIUM SULFACETAMIDE 10% *L* †

#### COMBINATION PRODUCTS

ERYTHROMYCIN / BENZOYL PEROXIDE †

SODIUM SULFACETAMIDE / SULFUR *L* †

SODIUM SULFACETAMIDE / SULFUR *W* †

#### OTHER

### PA REQUIRED

Benzac AC® 2.5%, 5%, 10% *G, W*  
Benzashave® 5%, 10% *C*  
Brevoxyl® 4%, 8% *W*; 4% *G*; 4%, 8% *L*  
Clinac BPO® 7% *G*  
Desquam-E/X® 2.5%, 5%, 10% *G*; 5%, 10% *W*  
Inova 4% *P*  
Panoxyl/AQ 2.5%, 5%, 10% *G*; 5%, 10% *B*  
Triaz® 3%, 6%, 9% *G*; 3%, 6%, 9% *P*  
Zaclir® 4%, 8% *L*  
All other brands

Cleocin-T®\* (clindamycin 2% *G*)  
Evoclin® (clindamycin 2% *F*)  
Clindagel® (clindamycin 1% *G*)  
All other brands

Akne-Mycin® (erythromycin 2% *O*)  
Erygel®\* (erythromycin 2% *G*)  
All other brands

Klaron®\* (sodium sulfacetamide 10% *L*)  
All other brands

Benzaclin®, DUAC® (clindamycin/benzoyl peroxide)  
Benzamycin®\* (erythromycin/benzoyl peroxide)  
Sulfoxyl (erythromycin/benzoyl peroxide)  
Z-Clinz® (clindamycin/benzoyl peroxide kit)  
All other brands

Avar® (sodium sulfacetamide/sulfur *G*)  
Plexion® (sulfacetamide/sulfur *S*)  
Rosac®\* (sulfacetamide/sulfur *W*)  
Rosula®\* (sulfacetamide/sulfur *W*)  
Sulfacet-R®\* (sodium sulfacetamide/sulfur *L*)  
Plexion® (sulfacetamide/sulfur *S*)  
All other brands

Azelex® (azelaic acid 20% *C*)  
All other brands any topical acne anti-infective medication

*C=cream, E=emulsion, F=foam, G=gel, L=lotion, O=ointment, P=pads, S=solution, W=wash, B=bar*

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## Acne Drugs: Topical – Retinoids

*Length of Authorization: 1 year*

### NO PA REQUIRED

TRETINOIN† (*specific criteria required for ages <10 or >34*) 0.025%, 0.05%, 0.1% C; 0.01%, 0.025% G

TAZORAC® (tazarotene) 0.05%, 0.1% C, G

*C=cream, G=gel*

### PA REQUIRED

All brand tretinoin products (Atralin® 0.05% G, Avita®\*, Retin-A®\*, Retin-A Micro® 0.1%, 0.04%, Tretin-X® etc.)

Differin® (adapalene) 0.1% C, G; 0.3% G

Avage® (tazarotene) ♣

Renova® (tretinoin) ♣

Solage® (tretinoin/mequinol) ♣

Tri-Luma® (tretinoin/hydroquinone/fluocinolone) ♣

♣ *Not indicated for acne. Coverage of topical retinoid products will not be approved for cosmetic use (wrinkles, age spots, etc.).*

## Acne Drugs: Topical – Rosacea

*Length of Authorization: 1 year*

### NO PA REQUIRED

METRONIDAZOLE† 0.75% C, G, L

*C=cream, G=gel, L=lotion*

### PA REQUIRED

All brand metronidazole products (MetroCream®\* 0.75% C, Metrogel®\* 0.75% G, Metrogel® 1% G, MetroLotion®\* 0.75% L, Noritate® 1% C, Rozex® 0.75% G etc.)

Finacea® (azelaic acid) 15% G

## Alzheimer's Medications: Cholinesterase Inhibitors/NMDA Receptor Antagonists

*Length of Authorization: 1 year*

### NO PA REQUIRED

#### CHOLINESTERASE INHIBITORS

ARICEPT® (donepezil) Tablet (QL = 1 tablet/day)

EXELON® (rivastigmine) Capsule (QL = 2 capsules/day)

ARICEPT® ODT (donepezil) (QL = 1 tablet/day)

EXELON® (rivastigmine) Oral Solution

EXELON® (rivastigmine transdermal) Patch (QL = 1 patch/day)

#### NMDA RECEPTOR ANTAGONIST

NAMENDA® (memantine) Tablet

NAMENDA® (memantine) Oral Solution

### PA REQUIRED

Cognex® (tacrine) Capsule §

Razadyne® (galantamine) Tablet §

Razadyne ER® (galantamine) Capsule §

Razadyne® (galantamine) Oral Solution §

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## Analgesics: COX-2 Inhibitors

Length of Authorization: 1 year

Quantity limits apply

### NO PA REQUIRED

CELEBREX<sup>®</sup> (celecoxib) (age ≥ 60 yrs) (QL = 2 capsules/day)

### PA REQUIRED

Celebrex<sup>®</sup> (age < 60 yrs) (QL = 2 capsules/day)

## Analgesics: Local Anesthetics: Transdermal Patch

Length of Authorization: 6 months

Quantity limits apply

### NO PA REQUIRED

### PA REQUIRED

Lidoderm<sup>®</sup> Patch (lidocaine 5 %) (QL = 3 patches/day)

## Analgesics: Narcotics-Short Acting

Length of Authorization: 3 months, subsequent approval up to 6 months

Acetaminophen Containing Products: Maximum daily dose 4 grams APAP/Day

Quantity limits apply

### NO PA REQUIRED

ACETAMINOPHEN W/CODEINE† (compare to Tylenol<sup>®</sup> w/codeine)  
ACETAMINOPHEN W/HYDROCODONE† (compare to Vicodin<sup>®</sup>,  
Lorcet<sup>®</sup>, Maxidone<sup>®</sup>, Norco<sup>®</sup>, Zydone<sup>®</sup>)  
(QL 5/500 = 8 tablets/day, 10/500 = 8 tablets/day,  
7.5/750 = 5 tablets/day)  
ACETAMINOPHEN W/OXYCODONE† (compare to Percocet<sup>®</sup>)  
(QL 10/650 = 6 tablets/day)  
ACETAMINOPHEN W/PROPOXYPHENE† (compare to Darvocet-N<sup>®</sup>)  
(QL 100/650 = 6 tablets/day)  
ASPIRIN W/CODEINE†  
ASPIRIN W/OXYCODONE† (compare to Percodan<sup>®</sup>)  
BUTALBITAL COMP. W/CODEINE† (compare to Fiorinal<sup>®</sup> w/codeine)  
CODEINE SULFATE†  
DIHYDROCODEINE COMPOUND† (compare to Synalgos-DC<sup>®</sup>)  
HYDROCODONE† (plain, w/acetaminophen, or w/ibuprofen)  
HYDROMORPHONE† (compare to Dilaudid<sup>®</sup>)  
MEPERIDINE† (compare to Demerol<sup>®</sup>) (30 tabs or 5 day supply)  
MORPHINE SULFATE†  
MORPHINE SULFATE† (compare to Roxanol<sup>®</sup>)  
OXYCODONE† (plain, w/acetaminophen or w/ibuprofen)  
PENTAZOCINE† (compare to Talwin<sup>®</sup>)  
PROPOXYPHENE† (compare to Darvon<sup>®</sup>)  
PROPOXYPHENE COMPOUND.† (compare to Darvon Compound<sup>®</sup>)  
PROPOXYPHENE N W/ ACETAMINOPHEN†  
ROXICET<sup>®</sup> (oxycodone w/ acetaminophen)  
ROXICODONE INTENSOL<sup>®</sup> (oxycodone w/ acetaminophen)  
ROXICODONE<sup>®</sup> (oxycodone HCL)  
TRAMADOL† (compare to Ultram<sup>®</sup>)  
TRAMADOL/APAP† (compare to Ultracet<sup>®</sup>)

### PA REQUIRED

Acetaminophen w/ codeine: all branded products  
Acetaminophen w/ hydrocodone: all branded products  
(QL 5/500 = 8 tablets/day, 10/500 = 8 tablets/day, 7.5/750 = 5 tablets/day)  
Acetaminophen w/ oxycodone: all branded products  
(QL 10/650 = 6 tablets/day)  
Actiq<sup>®</sup> (fentanyl lozenge on a stick: 200 mcg, 400 mcg, 600 mcg, 800 mcg,  
1200 mcg, 1600 mcg)  
Anexsia<sup>®\*</sup>  
Bancap HC<sup>®</sup>  
Butorphanol Nasal Spray (QL = 2 units/month)  
Capital<sup>®</sup> w/Codeine\*  
Combunox<sup>®\*</sup> (oxycodone w/ibuprofen)  
Darvocet-N<sup>®\*</sup> (QL 100/650 = 6 tablets/day)  
Darvon Compound<sup>®\*</sup>  
Darvon<sup>®\*</sup> / Darvon-N<sup>®\*</sup>  
Dazidox<sup>®\*</sup> (oxycodone)  
Demerol\*  
Dilaudid<sup>®\*</sup>  
Endocet<sup>®</sup>  
Endodan<sup>®</sup>  
fentanyl citrate† transmucosal (compare to Actiq<sup>®</sup>)  
Fentora<sup>®</sup> (fentanyl citrate buccal tablets)  
Fioricet w/codeine<sup>®\*</sup>  
Liquicet<sup>®\*</sup> (hydrocodone w/acetaminophen)  
Lorcet<sup>®\*</sup> (also HD, PLUS)  
Lortab<sup>®\*</sup>  
Magnacet<sup>®</sup>  
Maxidone<sup>®</sup>  
Meperidine (Qty > 30 tabs or 5 day supply)  
Nalbuphine  
Norco<sup>®\*</sup>  
*continued on next page*

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† Generic product

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Nubain<sup>®</sup>\*  
Numorphan<sup>®</sup>  
Opana<sup>®</sup>  
Oxyfast<sup>®</sup>\*  
OxyIR<sup>®</sup>\*  
Panlor DC<sup>®</sup>  
Pentazocine and Naloxone  
Percocet<sup>®</sup>\*  
Percodan<sup>®</sup>\*  
Propoxyphene: *all branded products\**  
Roxanol<sup>®</sup>\*  
Synalgos DC<sup>®</sup>\*  
Talacen<sup>®</sup>\*  
Talwin<sup>®</sup>\* and brand combinations/ Talwin NX<sup>®</sup>\*  
Trezix<sup>®</sup>  
Tylenol<sup>®</sup> #3\*  
Tylenol<sup>®</sup> #4\*  
Tylox<sup>®</sup>\*  
Ultracet<sup>®</sup>  
Ultram<sup>®</sup>\*  
Ultram ER<sup>®</sup>  
Vicodin<sup>®</sup>\*  
Vicoprofen<sup>®</sup>\*  
Wygesic<sup>®</sup>\*  
Xodol<sup>®</sup>  
Zydone<sup>®</sup>\*

## **Analgesics: Narcotics-Long Acting**

*Length of Authorization: initial approval 3 months, subsequent approval up to 6 months*

**Quantity limits apply**

*Therapy Specific PA fax form for Long Acting Narcotics available on OVHA web-site.*

### **NO PA REQUIRED**

#### **TRANSDERMAL**

FENTANYL PATCH† (compare to Duragesic<sup>®</sup>) 25 mcg/hr, 50 mcg/hr,  
(*QL=15 patches/30 days*)

FENTANYL PATCH† (compare to Duragesic<sup>®</sup>) 75 mcg/hr, 100 mcg/hr,  
(*QL=30 patches/30 days*)

#### **ORAL**

METHADONE† (compare to Dolophine<sup>®</sup>) 5 mg, 10 mg

MORPHINE SULFATE ER† (compare to MS Contin<sup>®</sup>)  
(*QL=90 tablets/strength/30 days*)

### **PA REQUIRED**

Duragesic-12<sup>®</sup> 12.5 mcg/hr (*QL=15 patches/30 days*)

Duragesic<sup>®</sup>\* 25 mcg/hr, 50 mcg/hr, (*QL=15 patches/30 days*)

Duragesic<sup>®</sup>\* 75 mcg/hr, 100 mcg/hr (*QL= 30 patches/30 days*)

Fentanyl Patch† (compare to Duragesic<sup>®</sup>) 12.5 mcg/hr (*QL=15 patches/30 days*)

Avinza<sup>®</sup> (morphine sulfate XR) (*QL= 30 capsules/strength/30 days*)

Dolophine<sup>®</sup>\* (methadone)

Kadian<sup>®</sup> (morphine sulfate XR) (*QL= 60 capsules/strength/30 days*)

Methadone 40 mg Dispersible Tablets §

MS Contin<sup>®</sup>\* (morphine sulfate ER) (*QL=90 tablets/strength/30 days*)

Opana ER<sup>®</sup> (oxymorphone ER) (*QL=60 tablets/strength/30 days*)

Oramorph SR<sup>®</sup>\* (morphine sulfate ER) (*QL=90 tablets/strength/30 days*)

Oxycodone ER† (*QL=90 tablets/strength/30 days*)

OxyContin<sup>®</sup> (*QL= 90 tablets/strength/30 days*)

### **PDL Key:**

† Generic product

\* Indicates a generic equivalent is available without PA

§ Indicates drug is managed via automated Step Therapy (prerequisite drug therapy automatically screened for upon claims processing)

## Analgesics: NSAIDs

Length of Authorization: 1 year

Quantity limits apply

### NO PA REQUIRED

#### ORAL

DICLOFENAC POTASSIUM† (compare to Cataflam®)  
DICLOFENAC SODIUM† (compare to Voltaren®)  
DIFLUNISAL† (compare to Dolobid®)  
ETODOLAC†  
FENOPROFEN† (compare to Nalfon®)  
FLURBIPROFEN† (compare to Ansaid®)  
IBUPROFEN† (compare to Motrin®)  
INDOMETHACIN† (compare to Indocin®)  
KETOPROFEN†  
KETOPROFEN ER†  
MECLOFENAMATE SODIUM† (compare to Meclomen®)  
MELOXICAM† (compare to Mobic®)  
NABUMETONE†  
NAPROXEN† (compare to Naprosyn®)  
NAPROXEN SODIUM† (compare to Anaprox®, Naprelan®)  
OXAPROZIN† (compare to Daypro®)  
PIROXICAM† (compare to Feldene®)  
SULINDAC† (compare to Clinoril®)  
TOLMETIN SODIUM†

#### INJECTABLE

KETOROLAC † Injection (QL = 1 dose per fill)

#### TRANSDERMAL

### PA REQUIRED

Anaprox®\*  
Anaprox DS®\*  
Ansaid®\*  
Arthrotec®  
Cataflam®\*  
Clinoril®\*  
Daypro®\*  
Dolobid®\*  
EC-Naprosyn®\*  
Feldene®\*  
Indocin®\*  
Indocin SR®  
Ketorolac† *QL = 20 doses post PA approval*  
Mefanamic acid† (compare to Ponstel®)  
Mobic®\*  
Motrin®\*  
Nalfon®\*

Naprelan®\*  
Naprosyn®\*  
Ponstel®  
Voltaren®\*  
Voltaren XR®\*

Flector® (diclofenac) Patch (QL = 2 patches/day)

## Anemia: Hematopoietic/Erythropoietic Agents

Length of Authorization: 1 year

### NO PA REQUIRED

ARANESP® (darbepoetin alfa)  
PROCRT® (epoetin alpha)

### PA REQUIRED

Epogen® (epoetin alpha)

## Ankylosing Spondylitis: Injectables

Length of Authorization: Initial PA 3 months; 12 months thereafter

Therapy-specific PA fax form available on OVHA website.

### PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

ENBREL® (etanercept)  
HUMIRA® (adalimumab)

### NON-PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

Remicade® (infliximab)

### PDL Key:

† Generic product

\* Indicates a generic equivalent is available without PA

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## Anti-anxiety: Anxiolytics

*Length of Authorization: 1 year*

### NO PA REQUIRED

ALPRAZOLAM† (compare to Xanax®)  
ALPRAZOLAM XR† (compare to Xanax XR®)  
BUSPIRONE† (compare to Buspar®)  
CHLORDIAZEPOXIDE† (compare to Librium®)  
CLONAZEPAM† (compare to Klonopin®)  
CLONAZEPAM ODT† (compare to Klonopin Wafers®)  
CLORAZEPATE† (compare to Tranxene®)  
DIAZEPAM† (compare to Valium®)  
LORAZEPAM† (compare to Ativan®)  
MEPROBAMATE†  
OXAZEPAM† (compare to Serax®)

### PA REQUIRED

Ativan®\*  
Buspar®\*  
Klonopin®\*  
Klonopin Wafers®  
Librium®\*  
Niravam® (alprazolam ODT)  
Serax®\*  
Tranxene®\* (all brand forms)  
Valium®\*  
Xanax®\*  
Xanax XR®

## Anticoagulants

*Length of Authorization: 6 months*

**Quantity limits apply**

### NO PA REQUIRED

WARFARIN† (compare to Coumadin®)  
  
HEPARIN†  
  
FRAGMIN® (dalteparin)  
LOVENOX® (enoxaparin) (QL = 2 syringes/day calculated in ml volume)  
ARIXTRA® (fondiparinux)

### PA REQUIRED

Coumadin®\* (warfarin)  
  
n/a  
  
Innohep® (tinzaparin)

### PDL Key:

† Generic product

\* Indicates a generic equivalent is available without PA

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## Anticonvulsants

**Length of Authorization: Lifetime for Seizure Disorders, Duration of Need for Mental Health Indications, 1 Year for Other Indications**

### NO PA REQUIRED

CARBAMAZEPINE† (compare to Tegretol®)  
CARBATROL® (carbamazepine)  
CELONTIN® (methsuxamide)  
CLONAZEPAM† (compare to Klonopin®)  
CLONAZEPAM ODT† (compare to Klonopin Wafers®)  
DEPAKOTE® (divalproex sodium)  
DEPAKOTE ER® (divalproex sodium)  
DIASTAT® (diazepam rectal gel)  
DILANTIN® (phenytoin)  
EPITOL† (carbamazepine)  
ETHOSUXAMIDE† (compare to Zaronitin®)  
FELBATOL® (felbamate)  
GABAPENTIN† (compare to Neurontin®)  
GABITRIL® (tiagabine)  
KEPPRA® (levetiracetam)  
LAMICTAL® tabs (lamotrigine tabs)  
LAMICTAL® chew tabs (lamotrigine chew tabs)  
NEURONTIN® oral solution (gabapentin)  
PEGANONE® (ethotoin)  
PHENYTEK® (phenytoin)  
PHENYTOIN† (compare to Dilantin®)  
PRIMIDONE† (compare to Mysoline®)  
TEGRETOL XR® (carbamazepine)  
TOPAMAX® (topiramate)  
TRILEPTAL® (oxcarbazepine)  
VALPROIC ACID† (compare to Depakene®)  
ZONISIMIDE† (compare to Zonegran®)

### PA REQUIRED

Depakene®\* (valproic acid)  
Gabarone®\* (gabapentin)  
Klonopin®\*  
Klonopin Wafers®\*  
lamotrigine† chew tabs (compare to Lamictal® chew tabs)  
lamotrigine† tabs (compare to Lamictal® tabs)  
Lyrica® (pregabalin) § (*Quantity Limit = 3 capsules/day*)  
Mysoline®\* (primidone)  
Neurontin®\* (gabapentin)  
oxcarbazepine † (compare to Trileptal®)  
Tegretol®\* (carbamazepine)  
Zaronitin®\* (ethosuxamide)  
Zonegran®\* (zonisamide)

## Anti-depressants: Novel

**Length of Authorization: Duration of Need for Mental Health Indications, 1 Year for Other Indications**

**Quantity limits apply**

**Suggested daily dosage limits**

### NO PA REQUIRED

BUDEPRION®/BUPROPION SR† (compare to Wellbutrin SR®)  
*suggested max dose = 400 mg/day*  
BUPROPION† (compare to Wellbutrin®)  
MAPROTILINE† (compare to Ludiomil®)  
MIRTAZAPINE† (compare to Remeron®) *suggested max dose = 90 mg/day*  
MIRTAZAPINE RDT† (compare to Remeron Sol-Tab®) *suggested max dose = 90 mg/day*  
NEFAZADONE† (compare to Serzone®) *suggested max dose = 750 mg/day*  
TRAZODONE HCL† (compare to Desyrel®) *suggested max dose = 750 mg/day*  
WELLBUTRIN XL®

### PA REQUIRED

Budeprion XR/bupropion XL† (compare to Wellbutrin XL®)  
Cymbalta®  
Desyrel®\* *suggested max dose = 750 mg/day*  
Effexor®  
Effexor XR® § *suggested max dose = 450 mg/day, QL = 1 cap/day (37.5 mg & 75 mg caps)*  
Remeron®\* *suggested max dose = 90 mg/day*  
Remeron Sol Tab®\* *suggested max dose = 90 mg/day*  
venlafaxine IR §  
Wellbutrin®\*  
Wellbutrin SR®\* *suggested max dose = 400 mg/day*

### PDL Key:

† Generic product

\* Indicates a generic equivalent is available without PA

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## Anti-depressants: SSRIs

*Length of Authorization: Duration of Need for Mental Health Indications, 1 Year for Other Indications*

Quantity limits apply

Suggested daily dosage limits

### NO PA REQUIRED

CITALOPRAM† (compare to Celexa®) *suggested max dose = 75 mg/day*  
FLUOXETINE† (compare to Prozac®) *suggested max dose = 100 mg/day*  
FLUVOXAMINE† (compare to Luvox®) *suggested max dose = 300 mg/day*  
PAROXETINE tablet† (compare to Paxil®) *suggested max dose = 75 mg/day*  
SERTRALINE† (compare to Zoloft®) *suggested max dose = 250 mg/day, QL = 1.5 tabs/day (25 mg & 50 mg tabs)*

### PA REQUIRED

Celexa®\* *suggested max dose = 75 mg/day*  
Lexapro® *suggested max dose = 25 mg/day, QL = 1.5 tabs/day (5 mg & 10 mg tabs)*  
Luvox®\* *suggested max dose = 300 mg/day*  
paroxetine suspension† (compare to Paxil® susp) *suggested max dose = 75 mg/day*  
paroxetine† CR (compare to Paxil CR®) *suggested max dose = 75 mg/day*  
Paxil®\* *suggested max dose = 75 mg/day*  
Paxil CR® *suggested max dose = 75 mg/day*  
Pexeva® *suggested max dose = 75 mg/day*  
Prozac®\* *suggested max dose = 100 mg/day*  
Prozac Weekly® *suggested max weekly dose = 540 mg*  
Sarafem® *suggested max dose = 100 mg/day*  
Selfemra®  
Zoloft® *suggested max dose = 250 mg/day, QL = 1.5 tabs/day (25 mg & 50 mg tabs)*

## Anti-depressants: Tricyclics

*Length of Authorization: Duration of Need for Mental Health Indications, 1 Year for Other Indications*

Suggested daily dosage limits

### NO PA REQUIRED

AMITRIPTYLINE† (compare to Elavil®) *suggested max dose = 375 mg/day*  
AMITRIPTYLINE/CHLORDIAZ.† (compare to Limbitrol®)  
AMITRIPTYLINE/PERPHEN† (compare to Etrafon®, Triavil®)  
AMOXAPINE† (compare to Asendin®)  
CLOMIPRAMINE† (compare to Anafranil®)  
DESIPRAMINE† (compare to Norpramin®)  
DOXEPIN† (compare to Sinequan®)  
IMIPRAMINE† (compare to Tofranil®) *suggested max dose = 250 mg/day*  
NORTRIPTYLINE† (compare to Aventyl®, Pamelor®)  
TOFRANIL PM® (imipramine pamoate)  
TRIMIPRAMINE† (compare to Surmontil®)  
VIVACTIL® (protriptyline)

### PA REQUIRED

Anafranil®\*  
Aventyl®\*  
Elavil®\*  
Limbitrol®\*  
Limbitrol DS®  
Norpramin®\*  
Pamelor®\*  
Sinequan®\*  
Surmontil®\*  
Tofranil®\*

## Anti-depressants: MAO Inhibitors

*Length of Authorization: Duration of Need for Mental Health Indications*

Quantity limits apply

Suggested daily dosage limits

### NO PA REQUIRED

NARDIL® (phenylzine) *suggested max dose = 110 mg/day*  
TRANLYCPROMINE† (compare to Parnate®) *suggested max dose = 120 mg/day*

### PA REQUIRED

EMSAM® (selegiline) (QL = 1 patch/day)  
Marplan® (isocarboxazid)  
Parnate®\*

### PDL Key:

† Generic product

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## Anti-diabetics: Alpha-Glucosidase Inhibitors

*Length of Authorization: 1 year*

### NO PA REQUIRED

ACARBOSE† (compare to Precose®)  
GLYSET® (miglitol)

### PA REQUIRED

PRECOSE®\* (acarbose)

## Anti-diabetic: Biguanides & Combinations

*Length of Authorization: 1 year*

### NO PA REQUIRED

GLIPIZIDE/METFORMIN† (compare to Metaglip®)  
GLYBURIDE/METFORMIN† (compare to Glucovance®)  
METFORMIN† (compare to Glucophage®)  
METFORMIN XR† (compare to Glucophage XR®)  
RIOMET® (metformin oral solution)

### PA REQUIRED

Fortamet®  
Glucophage®\*  
Glucophage XR®\*  
Glucovance®\*  
Glumetza®  
Metaglip®\*

## Anti-diabetics: Peptide Hormones

*Length of Authorization: 1 year*

**Quantity limits apply**

### PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

Byetta® (exenatide) § (*Quantity Limit = 1 pen/30 days*)

### PA REQUIRED

Symlin® (pramlintide) *No Quantity Limit*

### PDL Key:

† Generic product

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**Anti-diabetics: Insulins**  
*Length of Authorization: lifetime*

**NO PA REQUIRED**

**RAPID-ACTING INJECTABLE**

NOVOLOG® (Aspart)

**SHORT-ACTING INJECTABLE**

NOVOLIN R® (Regular)

**INTERMEDIATE-ACTING INJECTABLE**

NOVOLIN N® (NPH)

**LONG-ACTING ANALOGS INJECTABLE**

LANTUS® (insulin glargine)  
 LEVEMIR® (insulin detemir)

**MIXED INSULINS INJECTABLE**

HUMULIN 50/50® (NPH/Regular)  
 NOVOLIN 70/30® (NPH/Regular)

NOVOLOG MIX 70/30® (Protamine/Aspart)

HUMALOG MIX 50/50® (Protamine/Lispro)  
 HUMALOG MIX 75/25® (Protamine/Lispro)

**PA REQUIRED**

Apidra® (insulin glulisine)  
 Humalog® (insulin lispro)

Humulin R® (Regular)  
 ReliOn R® (Regular)

Humulin N® (NPH)  
 ReliOn N® (NPH)

Humulin 70/30® (NPH/Regular)  
 ReliOn 70/30® (NPH/Regular)

**Anti-diabetic: Oral Meglitinides**  
*Length of Authorization: 1 year*

**NO PA REQUIRED**

STARLIX® (nateglinide)

**PA REQUIRED**

Prandin® (replaglinide)

**Anti-diabetic: Sulfonylureas 2<sup>nd</sup> Generation**  
*Length of Authorization: 1 year*

**NO PA REQUIRED**

GLIMEPIRIDE† (compare to Amaryl®)  
 GLIPIZIDE† (compare to Glucotrol®)  
 GLIPIZIDE ER† (compare to Glucotrol XL®)  
 GLYBURIDE† (compare to Diabeta®, Micronase®)  
 GLYBURIDE MICRONIZED† (compare to Glynase® PresTab®)

**PA REQUIRED**

Amaryl®\*  
 Diabeta®\*  
 Glucotrol®\*  
 Glucotrol XL®\*  
 Glynase® PresTab®\*  
 Micronase®\*

**PDL Key:**

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## Anti-diabetic: Thiazolidinediones & Combinations

*Length of Authorization: 1 year*

**Quantity limits apply**

### PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

#### SINGLE AGENT

ACTOS® (pioglitazone) §

AVANDIA® (rosiglitazone) §

#### COMBINATION

ACTOPLUS MET® (metformin/pioglitazone) §

AVANDAMET® (metformin/rosiglitazone maleate) §

AVANDARYL® (glimepiride/rosiglitazone maleate) §

DUETACT® (pioglitazone/glimepiride) § (*Quantity Limit = 1 tablet/day*)

### NON-PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

## Anti-diabetic: Dipeptidyl Peptidase (DPP-4) Inhibitors

*Length of Authorization: 1 year*

**Quantity limits apply**

### PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

JANUVIA® (sitagliptin) § (*Quantity Limit = 1 tablet/day*)

JANUMET® (sitagliptin/metformin) § (*Quantity Limit = 2 tablets/day*)

### NON-PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

## Anti-emetics: NK1/5HT3 Antagonists

*Length of Authorization: 6 months for chemotherapy or radiotherapy;*

*1 time for prevention of post-op nausea/vomiting: see clinical criteria.*

**Monthly quantity limits apply, PA required to exceed.**

### NO PA REQUIRED

EMEND® (aprepitant) 40 mg (1 cap/30 days)

\*EMEND® (aprepitant) 80 mg (2 caps/30 days)

\*EMEND® (aprepitant) 125 mg (1 cap/30 days)

\*EMEND® (aprepitant) Tri-fold Pack (1 pack/30 days)

ONDANSETRON† Injection (vial and premix)

ONDANSETRON† tablet 4 mg (12 tabs/month), 8 mg (6 tabs/month)

ONDANSETRON† ODT 4 mg (12 tabs/month), 8 mg (6 tabs/month)

\* *To be prescribed by oncology practitioners ONLY*

### PA REQUIRED

Aloxi® (palonosetron, injectable) (2 vials/month)

Anzemet® (dolansetron) 50 mg (4 tabs/month)

Anzemet® (dolansetron) 100 mg (2 tabs/month)

Granisetron† (compare to Kytril®) 1 mg (6 tabs/month)

Granisetron† (compare to Kytril®) Injectable

Granisetron† (compare to Kytril®) Oral Solution

Kytril® (granisetron) 1 mg (6 tabs/month)

Kytril® (granisetron) Injectable

Ondansetron† (generic) 24 mg (1 tab/month)

Ondansetron† (generic) Oral Solution 4 mg/5 ml

Zofran®\* (ondansetron) Injection

Zofran®\* (ondansetron) Oral Tablets and ODT 4 mg (12 tabs/month),  
8 mg (6 tabs/month)

Zofran® (ondansetron) Oral Solution 4 mg/5 ml

## Anti-emetics: Other

*Length of Authorization: Initial approval 3 months, subsequent approval up to 6 months*

**Quantity limits apply**

### NO PA REQUIRED

### PA REQUIRED

Dronabinol† (compare to Marinol®) (*Quantity Limit = 30 days supply for AIDS anorexia or quantity required for one chemotherapy treatment course*)

Marinol® (dronabinol) (*Quantity Limit = 30 days supply for AIDS anorexia or quantity required for one chemotherapy treatment course*)

Cesamet® (nabilone) (*Quantity Limit = quantity required for one chemotherapy treatment course*)

### PDL Key:

† Generic product

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## Antihyperkinesia: ADHD, ADD, Narcolepsy

Length of Authorization: Duration of Need for Mental Health Indications, 1 Year for Other Indications

CNS Stimulants (all forms short- & long-acting): PA'd for beneficiaries < 3 yrs

Quantity limits apply

### NO PA REQUIRED

#### SHORT/INTERMEDIATE ACTING METHYLPHENIDATE PREPS

METADATE ER® (compare to Ritalin® SR)  
METHYLIN® (compare to Ritalin®)  
METHYLIN® ER (compare to Ritalin® SR)  
METHYLPHENIDATE† (compare to Ritalin®)  
METHYLPHENIDATE SR† (compare to Ritalin® SR)

#### LONG-ACTING METHYLPHENIDATE PREPS

FOCALIN® XR (dexamethylphenidate IR/ER, 50:50%)  
CONCERTA® (methylphenidate IR/ER 22:78%)  
DAYTRANA® (methylphenidate patch) (QL = 1 patch/day)

#### SHORT/INTERMEDIATE AMPHETAMINE PREPS

AMPHETAMINE salt combination† (compare to Adderall®)  
DEXTROAMPHETAMINE†  
DEXTROAMPHETAMINE CR† (compare to Dexedrine CR®)  
DEXTROSTAT†

#### LONG-ACTING AMPHETAMINE PREPS

ADDERALL XR® (dextroamphetamine IR/ER, 50:50%)  
VYVANSE® (lisdexamfetamine) (QL = 1 capsule/day)

#### NON-STIMULANT PREPS

### PA REQUIRED

Dexamethylphenidate (compare to Focalin®)  
Focalin® (dexamethylphenidate)  
Ritalin®\*  
Ritalin SR®\*

Metadate CD® (methylphenidate, IR/ER, 30:70%)  
Ritalin LA® (methylphenidate, IR/ER, 50:50%)

Adderall®\*  
Desoxyn® (methamphetamine)  
Dexedrine®\* (CR)

Provigil® (modafinil) (not approvable for ADHD in children age ≤ 12)  
Strattera® (atomoxetine) max dose = 100 mg/day

Xyrem® (sodium oxybate)

## Anti-hypertensives: ACE Inhibitors

Length of Authorization: 1 year

### NO PA REQUIRED

BENAZEPRIL† (compare to Lotensin®)  
CAPTOPRIL† (compare to Capoten®)  
ENALAPRIL† (compare to Vasotec®)  
FOSINOPRIL† (compare to Monopril®)  
LISINOPRIL† (compare to Zestril®, Prinivil®)  
MOEXIPRIL† (compare to Univasce®)  
QUINAPRIL† (compare to Accupril®)

### PA REQUIRED

Accupril®\*  
Aceon® (perindopril)  
Altace® (ramipril)  
Capoten®\*  
Lotensin®\*  
Mavik® (trandolapril)  
Monopril®\*  
Prinivil®\*  
ramipril† (compare to Altace®)  
trandolapril† (compare to Mavik®)  
Univasce®\* (moexipril)  
Vasotec®\*  
Zestril®\*

### PDL Key:

† Generic product

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**Anti-hypertensives: ACE Inhibitor with Hydrochlorothiazide***Length of Authorization: 1 year***NO PA REQUIRED**

BENAZEPRIL/HYDROCHLOROTHIAZIDE† (compare to Lotensin HCT®)  
 CAPTOPRIL/HYDROCHLOROTHIAZIDE† (compare to Capozide®)  
 ENALAPRIL/HYDROCHLOROTHIAZIDE† (compare to Vasoretic®)  
 FOSINOPRIL/HYDROCHLOROTHIAZIDE† (compare to Monopril HCT®)  
 LISINOPRIL/HYDROCHLOROTHIAZIDE† (compare to Zestoretic®, Prinzide®)  
 QUINAPRIL/HYDROCHLOROTHIAZIDE† (compare to Accuretic®)

**PA REQUIRED**

Accuretic®\*  
 Capozide®\*  
 Lotensin HCT®\*  
 moexipril/hydrochlorothiazide† (compare to Uniretic®)  
 Monopril HCT®\*  
 Prinzide®\*  
 Uniretic® (moexipril/hydrochlorothiazide)  
 Vasoretic®\*  
 Zestoretic®\*

**Anti-hypertensives: ACE Inhibitor w/Calcium Channel Blocker***Length of Authorization: 1 year***NO PA REQUIRED**

BENAZEPRIL/AMLODIPINE † (compare to Lotrel®)

**PA REQUIRED**

Lexxel® (enalapril/felodipine)  
 Lotrel® (benazepril/amlodipine)  
 Tarka® (trandolopril/verapamil)

**Anti-hypertensives: Angiotensin Receptor Blockers (ARBs)***Length of Authorization: lifetime***PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET**

AVAPRO® (irbesartan) §  
 BENICAR® (olmesartan) §  
 COZAAR® (losartan) §  
 DIOVAN® (valsartan) §  
 MICARDIS® (telmisartan) §

**NON-PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET**

Atacand® (candesartan) §  
 Teveten® (eprosartan) §

**Anti-hypertensives: Angiotensin Receptor Blocker/Hydrochlorothiazide Combinations***Length of Authorization: lifetime***PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET**

AVALIDE® (irbesartan/hydrochlorothiazide) §  
 BENICAR HCT® (olmesartan/hydrochlorothiazide) §  
 DIOVAN HCT® (valsartan/hydrochlorothiazide) §  
 HYZAAR® (losartan/hydrochlorothiazide) §  
 MICARDIS HCT® (telmisartan/hydrochlorothiazide) §

**NON-PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET**

Atacand HCT® (candesartan/hydrochlorothiazide) §  
 Teveten HCT® (eprosartan/hydrochlorothiazide) §

**Anti-hypertensives: Angiotensin Receptor Blocker/Calcium Channel Blocker Combinations***Length of Authorization: lifetime***Quantity limits apply****PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET**

EXFORGE® (valsartan/amlodipine) § (*Quantity Limit = 1 tablet/day*)

**NON-PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET**

Azor® (olmesartan/amlodipine) (*Quantity Limit = 1 tablet/day*)

**PDL Key:**† **Generic product**\* **Indicates a generic equivalent is available without PA**§ **Indicates drug is managed via automated Step Therapy (prerequisite drug therapy automatically screened for upon claims processing)**

## Anti-hypertensives: Beta Blockers

Length of Authorization: 5 years

### NO PA REQUIRED

#### SINGLE AGENT

ACEBUTOLOL† (compare to Sectral®)  
ATENOLOL† (compare to Tenormin®)  
BETAXOLOL† (compare to Kerlone®)  
BISOPROLOL FUMARATE† (compare to Zebeta®)  
CARVEDILOL† (compare to Coreg®)  
LABETALOL† (compare to Normodyne®, Trandate®)  
METOPROLOL† (compare to Lopressor®)  
METOPROLOL XL† (compare to Toprol XL®)  
NADOLOL† (compare to Corgard®)  
PINDOLOL† (compare to Viskin®)  
PROPRANOLOL† (compare to Inderal®)  
SOTALOL† (compare to Betapace®, Betapace AF®)  
TIMOLOL† (compare to Blocadren®)

#### BETA-BLOCKER/DIURETIC COMBINATION

ATENOLOL/CHLORTHALIDONE † (compare to Tenoretic®)  
BISOPROLOL/HYDROCHLOROTHIAZIDE† (compare to Ziac®)  
METOPROLOL/HYDROCHLOROTHIAZIDE† (compare to Lopressor HCT®)  
PROPRANOLOL/HYDROCHLOROTHIAZIDE† (compare to Inderide®)

### PA REQUIRED

Betapace®\*  
Betapace AF®\*  
Blocadren®\*  
Cartrol®  
Coreg®  
Coreg CR®  
Corgard®  
Inderal®\* (all products)  
Inderal LA®  
Innopran XL®

Kerlone®\*  
Levitol® (penbutolol)  
Lopressor®\* (all products)  
propranolol ER† (compare to Inderal LA®)  
Sectral®\*  
Tenormin®\*  
Timolide®  
Toprol XL®\* (metoprolol succinate)  
Trandate®\*  
Zebeta®\*

Corzide®  
Inderide®\*  
Lopressor HCT®\*  
Nadolol/bendroflumethiazide† (compare to Corzide®)

Tenoretic®\*  
Ziac®\*

## Anti-hypertensives: Calcium Channel Blockers

Length of Authorization: 5 years

Quantity limits apply

### NO PA REQUIRED

AMLODIPINE† (compare to Norvasc®)  
CARTIA XT® (diltiazem HCL)  
DILTIA XT® (diltiazem HCL)  
DILTIAZEM† (compare to Cardizem®)  
DILTIAZEM ER† (compare to Cardizem® SR)  
DILTIAZEM CD† (compare to Cardizem® CD)  
DILTIAZEM XR† (compare to Dilacor® XR)  
FELODIPINE† (compare to Plendil®)  
NICARDIPINE† (compare to Cardene®)  
NIFEDIAC® CC (compare to Adalat CC®)  
NIFEDICAL XL† (compare to Procardia® XL)  
NIFEDIPINE IR† (compare to Procardia®)  
NIFEDIPINE ER† (compare to Procardia® XL)  
NIMODIPINE† (compare to Nimotop®)  
TAZTIA XT® (compare to Tiazac®)  
VERAPAMIL† (compare to Calan®)  
VERAPAMIL CR† (compare to Calan SR®, Isoptin SR®)  
VERAPAMIL SR† 120 mg, 180 mg 240 mg and 360 mg (compare to Verelan®)

EXFORGE® (valsartan/amlodipine) § (*Quantity Limit = 1 tablet/day*)

### PA REQUIRED

Adalat® CC\*  
Calan®\*  
Calan® SR\*  
Cardene®\*  
Cardene® SR (no AB rated generic)  
Cardizem®\*, Cardizem® CD\*  
Cardizem® LA (no AB rated generic)  
Covera-HS® (no AB rated generic)  
Dilacor® XR\*  
Dynacirc CR® (no AB rated generic)  
Isoptin® SR\*  
isradipine†  
Nimotop®\* (nimodipine)  
Norvasc®\* (amlodipine)  
Plendil®\*  
Procardia®\*  
Procardia® XL\*  
Sular® (nisoldipine)  
Tiazac®\*  
verapamil SR †100 mg, 200 mg, 300mg (compare to Verelan PM®)  
Verelan®\*  
Verelan PM®

Azor® (olmesartan/amlodipine) (*Quantity Limit = 1 tablet/day*)  
Caduet® (amlodipine/atorvastatin)

### PDL Key:

† Generic product

\* Indicates a generic equivalent is available without PA

§ Indicates drug is managed via automated Step Therapy (prerequisite drug therapy automatically screened for upon claims processing)

## Anti-hypertensives: Renin Inhibitor

*Length of Authorization: lifetime*

**Quantity limits apply**

### PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

#### SINGLE AGENT

TEKTURNA<sup>®</sup> (aliskiren) § (*Quantity Limit = 1 tablet/day*)

#### COMBINATION

TEKTURNA HCT<sup>®</sup> (aliskiren/hydrochlorothiazide) § (*Quantity Limit = 1 tablet/day*)

### NON-PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

## Anti-infectives: Cephalosporins – 1<sup>st</sup> Generation

*Length of Authorization: for date of service, no refills*

### NO PA REQUIRED

CEFADROXIL† (compare to Duricef<sup>®</sup>)

CEPHALEXIN† (compare to Keflex<sup>®</sup>)

IV drugs are not managed at this time

### PA REQUIRED

Duricef<sup>®\*</sup>

Keflex<sup>®\*</sup>

## Anti-infectives: Cephalosporins – 2<sup>nd</sup> Generation

*Length of Authorization: for date of service, only: no refills*

### NO PA REQUIRED

#### TABLETS

CEFACLOR CAPSULE†

CEFACLOR ER TABLET†

CEFPROZIL TABLET† (compare to Cefzil<sup>®</sup>)

CEFUROXIME TABLET† (compare to Cefitin<sup>®</sup>)

#### SUSPENSION

CEFACLOR SUSPENSION†

CEFPROZIL SUSPENSION† (compare to Cefzil<sup>®</sup>)

CEFTIN<sup>®</sup> (cefuroxime) SUSPENSION

IV drugs are not managed at this time

### PA REQUIRED

Cefitin<sup>®\*</sup> tablet

Cefzil<sup>®</sup> tablet

Lorabid<sup>®</sup> (loracarbef) capsule

Cefuroxime† Suspension (compare to Cefitin<sup>®</sup>)

Cefzil<sup>®</sup> suspension

Lorabid<sup>®</sup> (loracarbef) suspension

## Anti-infectives: Cephalosporins – 3<sup>rd</sup> Generation

*Length of Authorization: for date of service, no refills*

### NO PA REQUIRED

#### CAPSULES/TABLETS

CEFPODOXIME PROXETIL TABS† (compare to Vantin<sup>®</sup>)

OMNICEF<sup>®</sup> CAPSULE (cefdinir)

#### SUSPENSION

OMNICEF<sup>®</sup> SUSPENSION(cefdinir)

SUPRAX<sup>®</sup> SUSPENSION (cefixime)

IV drugs are not managed at this time

### PA REQUIRED

Cedax<sup>®</sup> capsule (ceftibuten)

cefdinir capsule†

Spectracef<sup>®</sup> tablet (cefditoren)

Vantin<sup>®\*</sup> tablet (cefpodoxime)

Cedax<sup>®</sup> suspension (ceftibuten)

cefdinir suspension †

cefpodoxime proxetil† (compare to Vantin<sup>®</sup>) suspension

Vantin<sup>®</sup> suspension (cefpodoxime)

## Anti-infectives: Ketolides

*Length of Authorization: for date of service, no refills*

### NO PA REQUIRED

### PA REQUIRED

Ketek<sup>®</sup> (telithromycin)

### PDL Key:

† Generic product

\* Indicates a generic equivalent is available without PA

§ Indicates drug is managed via automated Step Therapy (prerequisite drug therapy automatically screened for upon claims processing)

## Anti-infectives: Macrolides

*Length of Authorization: for date of service, no refills*

### NO PA REQUIRED

AZITHROMYCIN† tablets (≤5 day supply) (compare to Zithromax®)  
AZITHROMYCIN† liquid (≤ 5 day supply) (compare to Zithromax®)

CLARITHROMYCIN† (compare to Biaxin/Biaxin XL)

ERY-TAB® (erythromycin base, delayed release)  
ERYTHROCIN† (erythromycin stearate)  
ERYTHROMYCIN BASE†  
ERYTHROMYCIN ESTOLATE†  
ERYTHROMYCIN ETHYLSUCCINATE† (compare to E.E.S.®, Eryped®)  
ERYTHROMYCIN STEARATE†  
ERYTHROMYCIN W/ SULFASOXAZOLE† (compare to Pediazole®)  
IV drugs are not managed at this time

### PA REQUIRED

azithromycin† tablets and liquid (if > 5 day supply)  
Biaxin®\*  
Biaxin XL®  
Dynabac® (dirithromycin)  
E.E.S.®\*  
Eryc®\* (erythromycin base, delayed release)  
Eryped® (erythromycin ethylsuccinate)  
PCE Dispertab® (erythromycin base)  
Pediazole®\* (erythromycin-sulfisoxazole)  
Zithromax® tablets and liquid  
Zmax® (azithromycin extended release oral suspension)

## Anti-infectives: Oxazolidinones

*Length of Authorization: 28 days, no refills*

*Quantity Limits Apply*

### NO PA REQUIRED

IV form of this medication not managed at this time

### PA REQUIRED

Zyvox® (linezolid) (QL = 56 tablets per 28 days)

## Anti-infectives: Penicillins (Oral)

*Length of Authorization: for date of service, no refills*

### NO PA REQUIRED

AMOXICILLIN† (compare to Amoxil®, Trimox®, DisperMox™)  
AMOXICILLIN/CLAVULANATE† (compare to Augmentin®)  
AMPICILLIN† (compare to Principen®)  
DICLOXACILLIN†  
PENICILLIN VK† (compare to Veetids®)

### PA REQUIRED

Augmentin®\*\*  
Augmentin ES®\*\*  
Augmentin XR®

\* PA will be granted for 125 mg/5 mL strength for patients < 12 weeks of age

## Anti-infectives: Quinolones

*Length of Authorization: for date of service, no refills*

### NO PA REQUIRED

CIPROFLOXACIN† (compare to Cipro®)  
CIPRO® OS (ciprofloxacin oral solution) 100 mg/ml  
LEVAQUIN® (levofloxacin)  
OFLOXACIN†

IV drugs are not managed at this time

### PA REQUIRED

Avelox® (moxifloxacin HCL)  
Avelox ABC PACK® (moxifloxacin HCL)  
Cipro®\*  
Cipro XR®  
ciprofloxacin ER†  
Factive® (gemifloxacin)  
Noroxin® (norfloxacin)  
ProQuin XR® (ciprofloxacin)

### PDL Key:

† Generic product

\* Indicates a generic equivalent is available without PA

§ Indicates drug is managed via automated Step Therapy (prerequisite drug therapy automatically screened for upon claims processing)



**Anti-infectives: Miscellaneous***Length of Authorization: 1 year***NO PA REQUIRED****PA REQUIRED**

Quaaloon® (quinine sulfate)

**Anti-infectives: Topical Antibiotics***Length of Authorization: for date of service, no refills***Quantity limits apply****NO PA REQUIRED**

BACITRACIN†  
 GENTAMICIN†  
 BACITRACIN-POLYMXIN†  
 NEOMYCIN-BACITRACIN-POLYMXIN†  
 CORTISPORIN®  
 BACTROBAN® OINTMENT  
 MUPIROCIN OINTMENT (compare to Bactroban®)

**PA REQUIRED**

Altabax® (retapamulin) (*Quantity Limit = 1 tube*)  
 Bactroban® CREAM

**Anti-migraine: Triptans***Length of Authorization: 6 months***Monthly quantity limits apply, PA required to exceed.****NO PA REQUIRED, Quantity Limits Apply**

AXERT® (almotriptan) 6.25 mg, 12.5 mg (*QL = 6 tabs/month*)  
 IMITREX® (sumatriptan) Injection 6 mg (*QL = 4 injections/month*)  
 IMITREX® NS (sumatriptan) 20 mg (*QL = 6 units/month*)  
 IMITREX® NS (sumatriptan) 5 mg (*QL = 12 units/month*)  
 IMITREX® (sumatriptan) 25 mg (*QL = 18 tabs/month*)  
 IMITREX® (sumatriptan) 50 mg, 100 mg (*QL = 9 tabs/month*)  
 MAXALT-MLT® (rizatriptan ODT) 5 mg, 10 mg (*QL = 12 tabs/month*)  
 MAXALT® (rizatriptan) 5 mg, 10 mg (*QL = 12 tabs/month*)

**PA REQUIRED, Quantity Limits Apply**

Amerge® (naratriptan) 1 mg, 2.5 mg (*QL = 9 tabs/month*)  
 Frova® (frovatriptan) 2.5 mg (*QL = 9 tabs/month*)  
 Relpax® (eletriptan) 20 mg, 40 mg (*QL = 12 tabs/month*)  
 Zomig® (zolmitriptan) ZMT 2.5 mg (*QL = 12 tabs/month*),  
 5 mg (*QL = 6 tabs/month*)  
 Zomig® 2.5 mg (*QL = 12 tabs/month*)  
 Zomig® 5 mg (*QL = 6 tabs/month*)  
 Zomig® Nasal Spray (*QL = 12 units/month*)

**Anti-obesity***Length of Authorization: 6 months for initial approval, may renew for additional 6 months if patient has met target goals.***Quantity limits apply***Therapy specific PA fax form available on OVHA website.***NO PA REQUIRED****PA REQUIRED**

Alli® (orlistat OTC) *QL = 3 capsules/day*  
 benzphetamine† (all forms brand & generic)  
 diethylpropion† (all forms brand & generic)  
 Meridia® (sibutramine)  
 phentermine† (all forms brand & generic)  
 phendimetrazine† (all forms brand & generic)  
 Xenical® (orlistat)

**PDL Key:**

† Generic product

\* Indicates a generic equivalent is available without PA

§ Indicates drug is managed via automated Step Therapy (prerequisite drug therapy automatically screened for upon claims processing)

## Anti-psychotic: Atypical & Combinations

*Length of Authorization: Duration of Need*

Quantity limits apply

Suggested daily dosage limits

### NO PA REQUIRED

CLOZAPINE† (compare to Clozaril®) *suggested max dose = 1125 mg/day*

GEODON® (ziprasidone) *suggested max dose = 200 mg/day*

RISPERDAL® (risperidone) *suggested max dose = 10 mg/day*

SEROQUEL® (quetiapine) *suggested max dose = 1000 mg/day*

RISPERDAL® (risperidone) oral solution *suggested max dose = 10 mg/day*

GEODON IM® (ziprasidone Injectable)

### PA REQUIRED

Abilify® (aripiprazole) *suggested max dose = 40 mg/day, QL = 1.5 tabs/day (5 mg, 10 mg & 15 mg tabs)*

Clozaril®\* *suggested max dose = 1125 mg/day*

Invega® (paliperidone) *QL = 1 tab/day (3mg, 9mg), 2 tabs/day (6mg)*

Risperidone† (compare to Risperdal®) *suggested max dose = 10 mg/day*

Seroquel® XR (quetiapine) *QL = 1 tab/day (200 mg tab strength only)*

Zyprexa® (olanzapine) *suggested max dose = 50 mg/day, QL = 1.5 tabs/day (2.5 mg, 5 mg, 7.5 mg, & 10 mg tabs)*

Abilify® (aripiprazole) oral solution *suggested max dose = 40 mg/day*

Abilify® IM (aripiprazole intramuscular injection)

Zyprexa® IM (olanzapine intramuscular injection)

Risperdal Consta® (risperidone microspheres)

Abilify® Discmelt (aripiprazole) *suggested max dose = 40 mg/day, Quantity limit = 1.5 tabs/day (5 mg, 10 mg & 15 mg tabs)*

Fazaclo® (clozapine orally disintegrating tablet) *suggested max dose = 1125 mg/day*

Risperdal M-Tab® (risperidone orally disintegrating tablet) *suggested max dose = 10 mg/day*

Zyprexa Zydis® (olanzapine orally disintegrating tablet) *suggested max dose = 50 mg/day, QL = 1.5 tabs/day (5 mg & 10 mg tabs)*

Symbyax® (olanzapine/fluoxetine)

## Anti-psychotic: Typical

*Length of Authorization: Duration of Need for Mental Health Indications*

### NO PA REQUIRED

CHLORPROMAZINE† (compare to Thorazine®)

FLUPHENAZINE† (compare to Prolixin®, Prolixin®)

HALOPERIDOL† (compare to Haldol®)

LOXAPINE† (compare to Loxitane®)

MOBAN® (molindone)

PERPHENAZINE† (compare to Trilafon®)

THIORIDAZINE† (compare to Mellaril®)

THIOTHIXENE† (compare to Navane®)

TRIFLUOPERAZINE† (compare to Stelazine®)

### PA REQUIRED

Haldol®\*

Loxitane®\*

Mellaril®\*

Navane®\*

Prolixin®\*

Thorazine®\*

Trilafon®\*

## Botulinum toxins

*Length of Authorization: Initial Approval 3 months, Subsequent approval up to 12 months*

### NO PA REQUIRED

### PA REQUIRED

Botox®

Botox® Cosmetic

Myobloc®

### PDL Key:

† Generic product

\* Indicates a generic equivalent is available without PA

§ Indicates drug is managed via automated Step Therapy (prerequisite drug therapy automatically screened for upon claims processing)

**BPH: Alpha Blockers***Length of Authorization: 1 year***NO PA REQUIRED**

DOXAZOSIN† (compare to Cardura®)  
 FLOMAX® (tamsulosin)  
 TERAZOSIN† (compare to Hytrin®)  
 UROXATRAL® (alfuzosin)

**PA REQUIRED**

Cardura®\*, Cardura XL®  
 Hytrin®\*

**BPH: Androgen Hormone Inhibitors***Length of Authorization: 1 year***Quantity limits apply****NO PA REQUIRED**

AVODART® (dutasteride) (*QL = 1 capsule/day*)  
 FINASTERIDE† (compare to Proscar®) (*QL = 1 tablet/day*)  
 PROSCAR® (finasteride) (*QL = 1 tablet/day*)

**PA REQUIRED**

Avodart® (dutasteride) females; males age < 45 (*QL = 1 capsule/day*)  
 finasteride† (compare to Proscar®) females; males age < 45 (*QL = 1 tablet/day*)  
 Proscar® (finasteride) females; males age < 45 (*QL = 1 tablet/day*)

**Cardiac Glycosides***Length of Authorization: n/a***NO PA REQUIRED**

DIGITEK® (digoxin)  
 DIGOXIN†  
 LANOXICAPS® (digoxin)  
 LANOXIN® (digoxin)

**PA REQUIRED****Chemical Dependency: Alcohol and Opiate Dependency***Length of Authorization: Vivitrol – 6 months, no renewal, All Others 1 year**DATA 2000 Waiver (“X” number) required for prescribers of Buprenorphine***Quantity limits apply***Vivitrol and Buprenorphine Therapy specific PA fax forms are available on OVHA website.***NO PA REQUIRED****Alcohol Dependency**

ANTABUSE® (disulfiram)  
 CAMPRAL® (acamprostate)  
 NALTREXONE oral † (compare to Revia®)

**Opiate Dependency**

NALTREXONE oral † (compare to Revia®)

Note: Methadone for opiate dependency can only be prescribed through a Methadone Maintenance Clinic

**PA REQUIRED**

Revia®\* (naltrexone oral)

Vivitrol® (naltrexone for extended-release injectable suspension) (*QL = 1 injection (380 mg) per 30 days*)

Revia®\* (naltrexone oral)

Suboxone® (buprenorphine with naloxone): 2 mg/0.5 mg and 8 mg/2 mg tablet  
 Subutex® (buprenorphine): 2 mg and 8 mg tablets

**Constipation: Chronic or IBS-C***Length of Authorization: 3 months***Quantity limits apply****NO PA REQUIRED****Bulk-Producing Laxatives**

PSYLLIUM†

**Osmotic Laxatives**

LACTULOSE†

POLYETHYLENE GLYCOL 3350 (PEG)† (compare to Miralax®)

**PA REQUIRED**

Amitiza® (lubiprostone) (*Qty Limit = 2 capsules/day*)

**PDL Key:**

† Generic product

\* Indicates a generic equivalent is available without PA

§ Indicates drug is managed via automated Step Therapy (prerequisite drug therapy automatically screened for upon claims processing)

## Contraceptives: Vaginal Ring

*Length of Authorization: n/a*

### NO PA REQUIRED

NUVARING<sup>®</sup> (etonogestrel/ethinyl estradiol vaginal ring)

### PA REQUIRED

## Coronary Vasodilators/Antianginals: Oral

*Length of Authorization: 3 years*

*Quantity limits apply*

### NO PA REQUIRED

ISOSORBIDE DINITRATE† tablet (compare to Isordil<sup>®</sup>)  
ISOSORBIDE DINITRATE† SL tablet  
ISOSORBIDE DINITRATE† ER tablet  
ISOSORBIDE MONONITRATE† tablet (compare to Ismo<sup>®</sup>, Monoket<sup>®</sup>)  
ISOSORBIDE MONONITRATE† ER tablet (compare to Imdur<sup>®</sup>)  
NITROGLYCERIN† SL tablet  
NITROGLYCERIN† ER capsule  
NITROLINGUAL PUMP SPRAY<sup>®</sup>  
NITROGARD<sup>®</sup> BUCCAL  
NITROQUICK<sup>®</sup> (nitroglycerin SL tablet)  
NITROSTAT<sup>®</sup> (nitroglycerin SL tablet)  
NITRO-TIME<sup>®</sup> (nitroglycerin ER capsule)

### PA REQUIRED

Dilatrate-SR<sup>®</sup> (isosorbide dinitrate SR capsule)  
Imdur<sup>®\*</sup> (isosorbide mononitrate ER tablet)  
Ismo<sup>®\*</sup> (isosorbide mononitrate tablet)  
Isordil<sup>®\*</sup> (isosorbide dinitrate tablet)  
Monoket<sup>®\*</sup> (isosorbide mononitrate tablet)  
  
BiDi<sup>®</sup> (isosorbide dinitrate/hydralazine)  
  
Ranexa<sup>®</sup> (ranolazine) (*Quantity Limit = 3 tablets/day (500 mg), 2 tablets/day (1000 mg)*)

## Coronary Vasodilators/Antianginals: Topical

*Length of Authorization: 3 years*

### NO PA REQUIRED

NITREK<sup>®</sup> (nitroglycerin transdermal patch)  
NITRO-BID<sup>®</sup> (nitroglycerin ointment)  
NITROGLYCERIN TRANSDERMAL PATCHES† (compare to Nitro-Dur<sup>®</sup>)

### PA REQUIRED

Nitro-Dur<sup>®\*</sup> (nitroglycerin transdermal patch)

## Cough and Cold Preparations

*Length of Authorization: for date of service, no refills*

*Effective May 1, 2008 PA required for Age < 2 years old for all cough and cold (brand and generic)*

### NO PA REQUIRED

All generics  
MUCINEX<sup>®</sup> (guaifenesin)

### PA REQUIRED

Tussionex<sup>®</sup> (hydrocodone/chlorpheniramine) (*Quantity Limit = 60 ml*)  
All other brands

## Dermatological Agents: Genital Wart Therapy

*Length of Authorization: 1 month*

### NO PA REQUIRED

ALDARA<sup>®</sup> (imiquimod)  
  
PODOFILOX SOLUTION† (compare to Condylox<sup>®</sup>)

### PA REQUIRED

Condylox<sup>®</sup> Gel (podofilox gel)  
Condylox<sup>®\*</sup> solution (podofilox solution)

### PDL Key:

† Generic product

\* Indicates a generic equivalent is available without PA

§ Indicates drug is managed via automated Step Therapy (prerequisite drug therapy automatically screened for upon claims processing)

## Dermatological Agents: Scabicides and Pediculocides

*Length of Authorization: date of service only, no refills*

### NO PA REQUIRED

EURAX<sup>®</sup> (crotamiton) *C, L*  
NIX<sup>®</sup> (permethrin) *CR, G, Sp*  
permethrin† (compare to Elimite<sup>®</sup>) *C*  
permethrin† *L*  
piperonyl butoxide and pyrethrins† *G, S, Sh*  
RID<sup>®</sup> (piperonyl butoxide and pyrethrins) *G, Sh, Sp*

All other brand and generic Scabicides and Pediculocides

*C=cream, CR=crème rinse, G=gel, L=lotion, S=solution, Sh=shampoo, Sp=spray*

### PA REQUIRED

Elimite<sup>®\*</sup> (permethrin 5 %) *C*  
Lindane† *L, Sh*  
Ovide<sup>®</sup> (malathion) *L*

## Desmopressin: Intranasal

*Length of Authorization: 2 years*

### NO PA REQUIRED

### PA REQUIRED

DDAVP<sup>®</sup> (desmopressin) Nasal Solution or Spray 0.01%  
Desmopressin † Nasal Solution or Spray 0.01 % (compare to DDAVP<sup>®</sup>)  
Minirin † (desmopressin) Nasal Spray 0.01%  
Stimate<sup>®</sup> (desmopressin) Nasal Solution 1.5 mg/ml

## Diabetic Testing Supplies

*Length of Authorization: 5 years*

### NO PA REQUIRED

#### DIABETIC MONITORS/METERS

FREESTYLE LITE<sup>®</sup> SYSTEM KIT  
FREESTYLE FLASH<sup>®</sup> SYSTEM KIT  
FREESTYLE FREEDOM<sup>®</sup> SYSTEM KIT  
FREESTYLE FREEDOM LITE<sup>®</sup> SYSTEM KIT  
ONE TOUCH<sup>®</sup> ULTRA 2 KIT  
ONE TOUCH<sup>®</sup> ULTRA MINI KIT  
ONE TOUCH<sup>®</sup> ULTRA SMART KIT  
PRECISION XTRA<sup>®</sup> METER

#### DIABETIC TEST STRIPS

FREESTYLE<sup>®\*</sup>  
FREESTYLE LITE<sup>®\*</sup>  
ONE TOUCH<sup>®</sup> BASIC\*  
ONE TOUCH<sup>®</sup> SURESTEP\*  
ONE TOUCH<sup>®</sup> FAST TAKE\*  
ONE TOUCH<sup>®</sup> ULTRA\*  
PRECISION XTRA<sup>®\*</sup>  
PRECISION XTRA<sup>®</sup> BETA KETONE (10 count)

\* 50 and 100 count package sizes

### PA REQUIRED

Accucheck<sup>®</sup>  
Ascensia<sup>®</sup>  
Assure<sup>®</sup>  
Exactech<sup>®</sup>  
Prodigy<sup>®</sup>

All other brands and store brands

Accucheck<sup>®</sup>  
Ascensia<sup>®</sup>  
Assure<sup>®</sup>  
Exactech<sup>®</sup>  
Prodigy<sup>®</sup>

All other brands and store brands

## Gastrointestinal: Crohn's Disease Injectables

*Length of Authorization: Initial PA 3 months; 12 months thereafter*

*Therapy-specific PA fax form available on OVHA website.*

### PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

HUMIRA<sup>®</sup> (adalimumab)  
REMICADE<sup>®</sup> (infliximab)

### NON-PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

Tysabri<sup>®</sup> (natalizumab)

### PDL Key:

† Generic product

\* Indicates a generic equivalent is available without PA

§ Indicates drug is managed via automated Step Therapy (prerequisite drug therapy automatically screened for upon claims processing)

## Gastrointestinals: H2-blockers

*Length of Authorization: 1 year*

### NO PA REQUIRED

CIMETIDINE† (compare to Tagamet®) tablet  
FAMOTIDINE† (compare to Pepcid®) tablet  
RANITIDINE† (compare to Zantac®) tablet

### SYRUPS AND SPECIAL DOSAGE FORMS

CIMETIDINE † ORAL SOLUTION  
ZANTAC® (ranitidine) SYRUP

### PA REQUIRED

Axid® (nizatidine) capsule §  
nizatidine† (compare to Axid®) capsule §  
Pepcid®\* (famotidine) tablet §  
ranitidine† capsule §  
Tagamet®\* tablet §  
Zantac®\* tablet §

Axid® (nizatidine) Oral Solution §  
Pepcid® Oral Suspension §  
ranitidine† syrup §  
Zantac Effervescent® §

## Gastrointestinals: Inflammatory Bowel Agents (Oral and Rectal Products)

*Length of Authorization: 1 year*

### NO PA REQUIRED

#### Mesalamine Products

ASACOL® (mesalamine tablet delayed-release)  
CANASA® (mesalamine suppository)  
LIALDA® (mesalamine tablet extended-release)  
MESALAMINE ENEMA† (compare to Rowasa®)  
PENTASA® (mesalamine cap CR)

#### Other

BALSALAZIDE† (compare to Colazal®)  
DIPENTUM® (olsalazine)  
SULFASALAZINE† (compare to Azulfidine®)

### PA REQUIRED

Rowasa®\* (mesalamine enema)

Azulfidine®\* (sulfasalazine)  
Colazal®\* (balsalazide)

## Gastrointestinals: Proton Pump Inhibitors

*Length of Authorization: up to 1 year*

Quantity limits apply

♣ No PA required for patients <16 years; Quantity Limits still apply.

♠ No PA required for patients < 12 years; Quantity Limits still apply.

### NO PA REQUIRED FOR ONCE DAILY DOSES

PREVACID® (lansoprazole) capsules (*Quantity Limit=1 capsule/day*)  
PREVACID® (lansoprazole) packets (*Quantity Limit=1 packet/day*)  
PRILOSEC OTC® (omeprazole magnesium ) *No Quantity Limit*  
PROTONIX® (pantoprazole) (*Quantity Limit=1 tablet/day*)

#### H.Pylori eradication

PREVPAC® (lansoprazole w/ H.pylori anti-bacterials) *No Quantity Limit*

### PA REQUIRED

Aciphex® (rabeprazole) § *Qty Limit=1 tablet/day*  
Nexium® (esomeprazole) capsules § *Qty Limit=1 capsule/day*  
Nexium® (esomeprazole) powder for suspension § (*Qty limit=1 packet/day*)  
omeprazole† generic♣ RX capsules § *Qty Limit=1 capsule/day*  
omeprazole† generic♣ OTC tablets § *Qty Limit=1 tablet/day*  
pantoprazole† generic♣ tablets *Qty Limit=1 tablet/day*  
Prevacid Solutabs®♠ *Qty Limit=1 tablet/day*  
Prilosec® (brand) § *Qty Limit=1 capsule/day*  
Zegerid®♠ (omeprazole powder for suspension) § *Qty Limit=1 powder packet/day*  
Zegerid® (omeprazole capsules) § *Qty Limit=1 capsule/day*

## Gastrointestinal: Ulcerative Colitis Injectables

*Length of Authorization: Initial PA 3 months; 12 months thereafter*

*Therapy-specific PA fax form available on OVHA website.*

### NO PA REQUIRED

### PA REQUIRED

Remicade® (infliximab)

### PDL Key:

† Generic product

\* Indicates a generic equivalent is available without PA

§ Indicates drug is managed via automated Step Therapy (prerequisite drug therapy automatically screened for upon claims processing)

## Glucocorticoids: Topical

*Length of Authorization: duration of prescription, up to 6 months.*

### NO PA REQUIRED

ALCLOMETASONE† (compare to Aclovate®)  
DESONIDE† (compare to Tridesilon®)  
FLUOCINOLONE 0.01%† (compare to Synalar®)  
HYDROCORTISONE ACETATE† (all generics)

BECLOMETHASONE DIPROPIONATE† (compare to Alphatrex®)  
BETAMETHASONE VALERATE† (compare to Beta-Val®)  
DESOXIMETASONE 0.05%† (compare to Topicort®)  
FLUOCINOLONE 0.025%† (compare to Synalar®)  
FLUTICASONE TOPICAL† (compare to Cutivate®)  
HYDROCORTISONE BUTYRATE† (compare to Locoid®)  
HYDROCORTISONE VALERATE† (compare to Westcort®)  
MOMETASONE FUROATE† (compare to Elocon®)  
TRIAMCINOLONE ACETONIDE† (compare to Aristocort®)

AMCINONIDE† (compare to Cyclocort®)  
AUGMENTED BETHAMETHASONE CREAM† (compare to Diprolene® AF)  
DESOXIMETASONE 0.25%† (compare to Topicort®)  
DIFLORASONE DIACETATE† (compare to Apexicon®, Maxiflor®, Psorcon-E®)  
FLUOCINOLONE 0.2%† (compare to Synalar®)  
FLUOCINONIDE† (compare to Lidex®)

AUGMENTED BETHAMETHASONE OINTMENT† (compare to Diprolene®)  
CLOBETASOL PROPIONATE† (compare to Temovate®)  
CLOBETASOL PROPIONATE† FOAM (compare to Olux®)  
DIFLORASONE DIACETATE EMOLL† (compare to Psorcon®)  
HALOBETASOL PROPIONATE† (compare to Ultravate®)

### PA REQUIRED

#### Low Potency

Aclovate®\*  
Cortaid®\*  
Desonate® gel (desonide)  
DesOwen®\*  
Hytone®\*  
Synalar® 0.01%\* (all products)  
Tridesilon®\*  
Verdeso® (desonide foam)  
All other brands

#### Medium Potency

Alphatrex®\*  
Aristocort®\* (all products)  
Beta-Val®\*  
Cloderm® (clocortolone)  
Cordran®\* (all products)  
Cutivate®\*  
Dermatop®  
Elocon®\* (all products)  
Kenalog® (all products)  
Locoid®  
Luxiq®  
prednicarbate† (compare to Dermatop®)  
Pandel®  
Synalar® 0.025%\* (all products)  
Topicort® 0.05%\* (all products)  
Westcort®\* (all products)  
All other brands

#### High Potency

Apexicon®\*  
Cyclocort®\*  
Diprolene® AF\* (all products)  
Halog®\* (all products)  
Lidex®\* (all products)  
Maxiflor®\*  
Synalar® 0.2%\* (all products)  
Topicort® 0.25%\* (all products)  
Vanos®  
All other brands

#### Very High Potency

Clobex®  
Cormax®  
Diprolene®\* (all products)  
Embeline E®\*  
Olux®/Olux E®  
Psorcon®\*  
Temovate®\* (all products)  
Ultravate®\* (all products)  
All other brands

### PDL Key:

† Generic product

\* Indicates a generic equivalent is available without PA

§ Indicates drug is managed via automated Step Therapy (prerequisite drug therapy automatically screened for upon claims processing)

## Growth Stimulating Agents

*Length of Authorization: 6 months initially, then up to 1 year; short bowel syndrome = 4 weeks.  
Agents available after clinical criteria are met.*

*Therapy specific PA form is available on OVHA website.*

### PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

NORDITROPIN<sup>®</sup>  
NUTROPIN<sup>®</sup>  
NUTROPIN<sup>®</sup> AQ

OMNITROPE<sup>®</sup>

INCRELEX<sup>®</sup> (mecasermin)

### NON-PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

Genotropin<sup>®</sup>  
Humatrope<sup>®</sup>  
Saizen<sup>®</sup>  
Serostim<sup>®</sup>  
Tev-Tropin<sup>®</sup>

Zorbtive<sup>®</sup> (with special criteria)

## Hepatitis C Agents

*Length of Authorization: 6 months  
Quantity limits apply*

*Therapy specific PA form is available on OVHA website.*

### PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

**RIBAVIRIN**  
RIBAVIRIN<sup>†</sup>

### **INTERFERON**

PEGASYS<sup>®</sup> (peg-interferon alpha 2-a) (QL = 4 vials/28 days)  
PEGASYS CONVENIENCE PACK<sup>®</sup> (peg-interferon alfa-2a) (QL = 1 kit/28 days)

### NON-PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

### **RIBAVIRIN**

Copegus<sup>®</sup>  
Ribasphere<sup>®</sup>  
Rebetol<sup>®</sup>

### **INTERFERON**

Infergen<sup>®</sup> (interferon alphacon-1)  
Peg-Intron<sup>®</sup> (peg-interferon alpha-2b)

## Immunomodulators: Topical

**\*\*Caution not approved for use in children under 2 years old\*\***

*Effective 11/1/06: PA required for Elidel / Protopic for children < 2 years. Quantity Limit = 30 gm / fill, 90 gm / 6 mos. Step Therapy required (previous trial of topical steroid for patients ≥ 2 yrs). Protopic ointment concentration limited to 0.03% for age < 16 years old.*

### NO PA REQUIRED

ELIDEL<sup>®</sup> (pimecrolimus) §  
PROTOPIC<sup>®</sup> (tacrolimus) §

### PA REQUIRED

Elidel<sup>®</sup> (age < 2 yrs)  
Protopic<sup>®</sup> (age < 2 yrs)

## Lipotropics: Bile Acid Sequestrants

*Length of Authorization: lifetime*

### NO PA REQUIRED

CHOLESTYRAMINE<sup>†</sup> powder (compare to Questran<sup>®</sup>)  
CHOLESTYRAMINE LIGHT<sup>†</sup> powder (compare to Questran Light<sup>®</sup>)  
PREVALITE<sup>†</sup> powder (cholestyramine light)

COLESTIPOL<sup>†</sup> tablets, granules (compare to Colestid<sup>®</sup>)

### PA REQUIRED

Questran<sup>®</sup> powder (cholestyramine)  
Questran Light<sup>®</sup> powder (cholestyramine light)

Colestid<sup>®</sup> tablets, granules (colestipol)  
Welchol<sup>®</sup> (colesevelam)

### PDL Key:

<sup>†</sup> Generic product

\* Indicates a generic equivalent is available without PA

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## Lipotropics: Fibric Acid Derivatives

Length of Authorization: 1 year

### NO PA REQUIRED

GEMFIBROZIL<sup>†</sup> (compare to Lopid<sup>®</sup>)

◆TRICOR<sup>®</sup> (fenofibrate) §

◆PA required if patient not on concurrent statin

### PA REQUIRED

Antara<sup>®</sup> (fenofibrate micronized) §

fenofibrate<sup>†</sup> §

fenofibrate micronized<sup>†</sup> §

Lipofen<sup>®</sup> (fenofibrate) §

Lofibra<sup>®</sup> (fenofibrate micronized) Capsules §

Lofibra<sup>®</sup> (fenofibrate) Tablets §

Lopid<sup>®\*</sup> (gemfibrozil) §

Triglide<sup>®</sup> (fenofibrate) §

## Lipotropics: Niacin Derivatives

Length of Authorization: n/a

### NO PA REQUIRED

NIACIN<sup>†</sup>

NIASPAN<sup>®</sup> (niacin)

NIASPAN<sup>®</sup> ER (niacin)

### PA REQUIRED

## Lipotropics: Statins

Length of Authorization: 1 year

Quantity limits apply

### NO PA REQUIRED

LOVASTATIN<sup>†</sup> (compare to Mevacor<sup>®</sup>) (QL = 1 tablet/day (10 & 20 mg), 2 tabs/day (40 mg))

PRAVASTATIN<sup>†</sup> (compare to Pravachol<sup>®</sup>) (QL = 1 tablet/day (10 & 20 mg), 2 tabs/day (40 mg))

SIMVASTATIN<sup>†</sup> (compare to Zocor) (QL = 1 tablet/day)

**AFTER GENERIC SIMVASTATIN TRIAL**

CRESTOR<sup>®</sup> (rosuvastatin calcium) §

(QL = 1 tablet/day)

### PA REQUIRED

#### Low/Medium Potency Statins

Altoprev<sup>®</sup> (aka: Altocor<sup>®</sup>) (lovastatin) (QL = 1 tablet/day)

Lescol<sup>®</sup> (fluvastatin) (QL = 1 tablet/day)

Lescol<sup>®</sup> XL (fluvastatin XL) (QL = 1 tablet/day)

Mevacor<sup>®\*</sup> (lovastatin) (QL = 1 tab/day (10 & 20 mg), 2 tabs/day (40 mg))

Pravachol<sup>®\*</sup> (pravastatin) (QL = 1 tab/day (10 & 20 mg), 2 tabs/day (40 mg))

Pravastatin † 80 mg Tablet (use 40 mg tablets)

#### High Potency Statins

Lipitor<sup>®</sup> (atorvastatin) (QL = 1 tablet/day)

Zocor<sup>®\*</sup> (simvastatin) (QL = 1 tablet/day)

## Lipotropics: Miscellaneous/Combinations

Length of Authorization: 1 year

Quantity limits apply

### NO PA REQUIRED

ZETIA<sup>®</sup> (ezetimibe) § (AFTER CLINICAL CRITERIA ARE MET)  
(Qty Limit = 1 tablet/day)

ADVICOR<sup>®</sup> (lovastatin/niacin) (Qty Limit = 1 tablet/day)  
SIMCOR<sup>®</sup> (simvastatin/extended release niacin) (Qty Limit = 1 tablet/day)

### PA REQUIRED

#### Miscellaneous

Lovaza<sup>®</sup> (omega-3-acid ethyl esters)

#### Cholesterol Absorption Inhibitors/Combinations

Vytorin<sup>®</sup> (ezetimibe/simvastatin) (QL = 1 tablet/day)

#### Other Statin Combinations

Caduet<sup>®</sup> (atorvastatin/amlodipine) (Qty Limit = 1 tablet/day)

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**Miscellaneous: Elaprase® (Hunter's Syndrome Injectable)***Length of Authorization: 1 year*

Quantity limits apply

NO PA REQUIRED

PA REQUIRED

Elaprase® (idursulfase) (*QL = calculated dose/week*)**Miscellaneous: Soliris® (Paroxysmal Nocturnal Hemoglobinuria Injectable)***Length of Authorization: Initial 3 months, Subsequent 1 year*

Quantity limits apply

NO PA REQUIRED

PA REQUIRED

Soliris® (eculizumab) (*Quantity Limit = 20 vials total/3 months initially; 6 vials/month subsequently*)**Miscellaneous: Somatuline® (Acromegaly Injectable)***Length of Authorization: Initial 3 months, Subsequent 1 year*

Quantity limits apply

NO PA REQUIRED

PA REQUIRED

Somatuline® Depot Injection (lanreotide) (*Quantity Limit = 0.2 ml/28 days (60 mg syringe), 0.3 ml/28 days (90 mg syringe) and 0.5 ml/28 days (120 mg syringe)*)**Mood Stabilizers (see also Anticonvulsants)***Length of Authorization: duration of need*

NO PA REQUIRED

PA REQUIRED

EQUETRO® (carbamazepine)  
 LITHIUM CARBONATE† (compare to Eskalith®)  
 LITHIUM CARBONATE SR† (compare to Eskalith CR®, Lithobid®)  
 LITHIUM CITRATE SYRUP†

Eskalith CR®\* (lithium carbonate SR)  
 Lithobid®\* (lithium carbonate SR)

**Multiple Sclerosis: Injectables***Length of Authorization: Initial PA 3 months; 12 months thereafter*

Quantity limits apply

NO PA REQUIRED

PA REQUIRED

Interferons

AVONEX® (interferon B-1a)  
 BETASERON® (interferon B-1b)  
 REBIF® (interferon B-1a)

OtherCOPAXONE® (glatiramer acetate) (*QL = 1 kit/30 days*)

Tysabri® (natalizumab)

**Nutritionals, liquid oral supplements***Length of Authorization: 6 months**Therapy specific PA fax form available on OVHA website.*

NO PA REQUIRED

PA REQUIRED

PA applies to oral (swallowed) liquid nutrition: Contact MedMetrics.

For enteral nutrition (tube feedings), billed via the Medical Benefit, see the following guidelines:  
[http://ovha.vermont.gov/forproviders/copy\\_of\\_GOC13.pdf](http://ovha.vermont.gov/forproviders/copy_of_GOC13.pdf)

**PDL Key:**

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## Ophthalmics: Antihistamines

Length of Authorization: 1 year

### NO PA REQUIRED

KETOTIFEN† 0.025 % (eg. Alaway®, Zaditor® OTC, others)  
(Quantity Limit = 1 bottle/month)

#### After trial of ketotifen 0.025 %

ELESTAT® (epinastine) (Quantity Limit = 1 bottle/month)

PATADAY® (olopatadine 0.2 %)/PATANOL® (olopatadine 0.1%)  
(Quantity Limit = 1 bottle/month)

### PA REQUIRED

Emadine® (emedastine) (Quantity Limit = 2 bottles/month)

Optivar® (azelastine) (Quantity Limit = 1 bottle/month)

Zaditor® RX (ketotifen 0.025 %) (Quantity Limit = 1 bottle/month)

## Ophthalmics: Glaucoma Agents/Miotics

Length of Authorization: lifetime

### NO PA REQUIRED

#### ALPHA-2 ADRENERGIC

##### Single Agent

ALPHAGAN® P (brimonidine tartrate)

BRIMONIDINE TARTARATE† (compare to Alphagan®)

##### Combination

COMBIGAN® (brimonidine tartrate/timolol maleate)

#### BETA BLOCKER

BETAXOLOL HCl† (compare to Betoptic®)

BETOPTIC S® (betaxolol suspension)

CARTEOLOL HCl† (compare to Ocupress®)

LEVOBUNOLOL HCl† (compare to AKBeta®, Betagan®)

METIPRANOLOL†(compare to Optipranolol®)

TIMOLOL MALEATE† (compare to Istalol®, Timoptic®)

### PA REQUIRED

Iopidine® (apraclonidine) - no PA required for pts <=10yrs

Betagan®\*

Betimol®\*

Istalol®\*

Optipranolol®\*

Timoptic®\*

Timoptic XE®\*

#### PROSTAGLANDIN INHIBITORS

Note: Coverage of a 'preferred' PI agent is contingent upon a 1<sup>st</sup>-line trial of any other preferred beta-blocker, a-2 adrenergic or CAI agent. Coverage of a 'non-preferred' PI agent is contingent upon a similar first-line trial as well as a failed trial of both preferred PI products.

LUMIGAN® (bimatoprost) §

TRAVATAN®/TRAVATAN Z® (travoprost) §

Xalatan® (latanoprost)

#### CARBONIC ANHYDRASE INHIBITOR

COSOPT® (dorzolamide w/timolol)

TRUSOPT® (dorzolamide)

Azopt® (brinzolamide)

#### MISCELLANEOUS

DIPIVEFRIN HCL† (compare to AKPro®, Propine®)

EPINEPHRINE† (compare to Epifrin®, Glaucon®\*)

ISOPTO® CARBACHOL (carbachol)

ISOPTO® CARPINE (pilocarpine)

PILOCARPINE HCl† (compare to Pilocar®)

PILOPINE® (pilocarpine)

PHOSPHOLINE IODIDE® (echothiophate)

Miochol-E®

Miostat®

Pilocar®\*

Propine®\*

## Ophthalmics: Mast Cell Stabilizers

Length of Authorization: 6 months

### NO PA REQUIRED

ALAMAST® (pemirolast potassium)

CROMOLYN SODIUM† (compare to CroloM®, Opticrom®)

### PA REQUIRED

Alocril® (nedocromil sodium)

Alomide® (iodoxamide)

CroloM®\*

### PDL Key:

† Generic product

\* Indicates a generic equivalent is available without PA

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## Ophthalmics: Non-Steroidal Anti-inflammatory Drugs (NSAIDs)

*Length of Authorization: 1 year*

### NO PA REQUIRED

ACULAR® (ketorolac 0.5% ophthalmic sol.)  
ACULAR LS® (ketorolac 0.4% ophthalmic sol.)  
ACULAR® PF (ketorolac 0.5% ophthalmic sol.)  
FLURBIPROFEN † 0.03% ophthalmic sol.

### PA REQUIRED

Diclofenac† 0.1% ophthalmic sol (compare to Voltaren®)  
Nevanac® ophthalmic susp. (nepafenac 0.1%)  
Xibrom® ophthalmic sol. (bromfenac 0.09%)  
Ocufen®\* ophthalmic sol. (flurbiprofen 0.03%)  
Voltaren® (diclofenac 0.1% ophthalmic sol.)

## Ophthalmics: Quinolone Anti-infectives

*Length of Authorization: duration of therapy requested*

### NO PA REQUIRED

CIPROFLOXACIN HCl† (compare to Ciloxan®)  
OFLOXACIN† (compare to Ocuflox®)

### PA REQUIRED

Ciloxan®\*  
Iquix® (levofloxacin 1.5%) (preservative free)  
Ocuflox®\*  
Quixin® (levofloxacin 0.5%)  
Vigamox® (moxifloxacin) (preservative free)  
Zymar® (gatifloxacin)

## Ossification Enhancers

*Length of Authorization: lifetime*

*Quantity limits apply*

*Therapy-specific PA fax form for Injectable Bisphosphonates available on OVHA website.*

### NO PA REQUIRED

#### ORAL BISPHOSPHONATES

BONIVA® (ibandronate) 150 mg (*Quantity Limit = 1 tab/28 days*)  
BONIVA® (ibandronate) 2.5 mg *No quantity limits*  
FOSAMAX® (alendronate)  
FOSAMAX PLUS D® (alendronate/vitamin D)

#### INJECTABLE BISPHOSPHONATES

MIACALCIN® (calcitonin)

### PA REQUIRED

Actonel® (risedronate)  
Actonel® w/calcium (risedronate/calcium)  
Alendronate† (compare to Fosamax®)  
Didronel® (etidronate)  
Etidronate† (compare to Didronel®)  
Skelid® (tiludronate)

Boniva® Injection (ibandronate) (*Quantity Limit = 3 mg/3 months (four doses)/year*)  
Reclast® Injection (zoledronic acid) (*Quantity Limit = 5 mg (one dose)/year*)

Fortical® (calcitonin)

Forteo® (teriparatide) (*Quantity Limit = 1 pen (3 ml)/28 days*)

## Otic: Anti-Infectives

*Length of Authorization: 1 year*

### NO PA REQUIRED

CIPRODEX® (ciprofloxacin 0.3%/dexamethasone 0.1%; otic susp.)  
FLOXIN® (ofloxacin 0.3%; otic soln.)  
NEOMYCIN/POLYMYXIN B SULFATE/HYDROCORTISONE †

### PA REQUIRED

Cipro-HC® (ciprofloxacin 0.2%/hydrocortisone 1%; otic susp.)  
Ofloxacin† 0.3 % otic solution  
Coly-Mycin S®/Cortisporin TC®  
(neomycin/colistin/thonzium/hydrocortisone)  
Cortisporin otic®/Pediotic®\* (neomycin/polymyxin B sulfate /hydrocortisone)  
otic solution/sus

### PDL Key:

† Generic product

\* Indicates a generic equivalent is available without PA

§ Indicates drug is managed via automated Step Therapy (prerequisite drug therapy automatically screened for upon claims processing)

## Parkinson's: Non-Ergot Dopamine Receptor Agonist

Length of Authorization: 1 year

Quantity limits apply

### NO PA REQUIRED

#### DOPAMINE PRECURSOR

CARBIDOPA/LEVODOPA† (compare to Sinemet®)  
CARBIDOPA/LEVODOPA† ER (compare to Sinemet® CR)  
PARCOPA® (carbidopa/levodopa ODT)

#### DOPAMINE AGONISTS (ORAL)

BROMOCRIPTINE† (compare to Parlodel®)  
MIRAPEX® (pramipexole)  
ROPINIROLE† (compare to Requip®)

#### DOPAMINE AGONISTS (TOPICAL)

#### COMT INHIBITORS

TASMAR® (tolcapone)  
COMTAN® (entacapone)

#### MAO-B INHIBITORS

SELEGILINE† (compare to Eldepryl®)

#### OTHER

AMANTADINE† (compare to Symmetrel®)  
STALEVO® (carbidopa/levodopa/entacapone)

### PA REQUIRED

Sinemet®\*  
Sinemet CR®\*

Parlodel® (bromocriptine)  
Requip®\* (ropinirole)

Neupro® Patch (rotigotine transdermal) (QL = 1 patch/day)

Eldepryl® (selegiline)  
Azilect® (rasagiline) (QL = 1 mg/day)  
Zelapar® (selegiline ODT) (QL = 2.5 mg/day)

Symmetrel® (amantadine)

## Phosphodiesterase-5 (PDE-5) Inhibitors

Length of Authorization: 1 year

Quantity limits apply

Effective 7/1/06, phosphodiesterase-5 (PDE-5) inhibitors are no longer a covered benefit for all Vermont Pharmacy Programs for the treatment of erectile dysfunction. This change is resultant from changes set into effect January 1, 2006 and as detailed in Section 1903 (i)(21)(K) of the Social Security Act (the Act), precluding Medicaid Federal Funding for outpatient drugs used for the treatment of sexual or erectile dysfunction. Sildenafil will remain available for coverage via prior-authorization for the treatment of Pulmonary Arterial Hypertension.

### PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

### NON-PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

Revatio® (sildenafil) (Quantity Limit = 3 tabs/day)  
Viagra® (sildenafil) (Quantity Limit = 3 tabs/day)

## Platelet Inhibitors

Length of Authorization: 3 years

### NO PA REQUIRED

#### AGGREGATION INHIBITORS

CILOSTAZOL† (compare to Pletal®)  
CLOPIDOGREL† (compare to Plavix®)  
PLAVIX® (clopidogrel bisulfate)  
TICLOPIDINE† (compare to Ticlid®)

#### OTHER

ASPIRIN†  
DIPYRIDAMOLE† (compare to Persantine®)

### PA REQUIRED

Pletal®\*  
Ticlid®\*

Aggrenox® (dipyridamole/ASA)  
Persantine®\*

### PDL Key:

† Generic product

\* Indicates a generic equivalent is available without PA

§ Indicates drug is managed via automated Step Therapy (prerequisite drug therapy automatically screened for upon claims processing)

## Psoriasis Injectables

*Length of Authorization: initial PA of 3 months, 12 months thereafter.*

Quantity limits apply

*Therapy-specific PA fax form available on OVHA website.*

### PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

ENBREL® (etanercept)  
HUMIRA® (adalimumab)  
RAPTIVA® (efalizumab)

### NON-PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

Amevive® (alefacept)  
Remicade® (infliximab)

## Psoriasis: Non-Biologics

*Length of Authorization: 1 year*

Quantity limits apply

### NO PA REQUIRED

CYCLOSPORINE † (all brand and generic)  
METHOTREXATE † (all brand and generic)  
OXSORALEN-ULTRA® (methoxsalen)  
SORIATANE® CK (acitretin)

CALCIPOTRIENE † Solution (compare to Dovonex®)  
DOVONEX® (calcipotriene cream/ointment)  
PSORIATEC®, DRITHO-SCALP® (anthralin cream)  
TAZORAC® (tazarotene cream, gel)

### PA REQUIRED

#### Oral

#### Topical

Dovonex®\* solution (calcipotriene)  
Taclonex® (calcipotriene/betamethasone ointment/scalp suspension)  
(QL for initial fill = 60 grams)

## Pulmonary: Anticholinergics, Inhaled

*Length of Authorization: 1 year*

### NO PA REQUIRED

#### METERED DOSE INHALER (SINGLE AGENT)

ATROVENT HFA® (ipratropium)  
SPIRIVA® (tiotropium)

#### NEBULIZER (SINGLE AGENT)

IPRATROPIUM SOLN FOR INHALATION

#### METERED DOSE INHALER (COMBINATION PRODUCT)

COMBIVENT® (ipratropium/albuterol)

#### NEBULIZER (COMBINATION PRODUCT)

IPRATROPIUM/ALBUTEROL † (compare to Duoneb®)

### PA REQUIRED

Duoneb®\* (ipratropium/albuterol)

## Pulmonary: Antihistamines - Intranasal

*Length of Authorization: 1 year*

### NO PA REQUIRED

### PA REQUIRED

Astelin® (azelastine) Nasal Spray  
*Quantity Limit = 1 bottle (30 ml)/25 days*

### PDL Key:

† Generic product

\* Indicates a generic equivalent is available without PA

§ Indicates drug is managed via automated Step Therapy (prerequisite drug therapy automatically screened for upon claims processing)

## Pulmonary: Antihistamines-1<sup>st</sup> Generation

*Length of Authorization: 1 year*

### NO PA REQUIRED

All generic antihistamines

All generic antihistamine/decongestant combinations

### PA REQUIRED

All brand antihistamines (example: Benadryl®)

All brand antihistamine/decongestant combinations (example: Deconamine SR®, Rynatan®, Ryna-12®)

## Pulmonary: Antihistamines-2<sup>nd</sup> Generation

*Length of Authorization: 1 year*

### NO PA REQUIRED

LORATADINE (OTC) † (compare to Claritin®)

CETIRIZINE † OTC (compare to Zyrtec® OTC)

FEXOFENADINE † (after loratadine OTC and cetirizine OTC trials)

LORATADINE-D (OTC) †

LORATADINE (OTC) † syrup

CETIRIZINE † (OTC) syrup

ZYRTEC® OTC (cetirizine) SYRUP

LORATADINE (OTC) † rapidly disintegrating tablet (RDT)

### PA REQUIRED

Allegra® (fexofenadine)

Clarinex® (desloratadine)

Claritin® (loratadine)

Xyzal® (levocetirizine)

Zyrtec® RX/OTC\* (cetirizine)

Allegra-D® § (12 HR & 24 HR)

Cetirizine-D † SR

Clarinex-D® § (12 HR & 24 HR)

Claritin-D® §

Zyrtec-D® §

Allegra® suspension

Clarinex® Syrup

Claritin Syrup\*\*

Xyzal (levocetirizine) Syrup®

Zyrtec RX Syrup®

Allegra ODT® §

Cetirizine † Chewable Tablets

Clarinex Reditabs® §

Claritin Chewable Tablets® §

Claritin Reditabs®\*§

Zyrtec® Chewable Tablets §

## Pulmonary: Persistent Asthma

*Length of Authorization: 3 months after clinical criteria are met.*

*Therapy specific clinical criteria are available on the OVHA website.*

### NO PA REQUIRED

### PA REQUIRED

Xolair® (omalizumab)

### PDL Key:

† Generic product

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## Pulmonary: Beta-adrenergic Agents

**Length of Authorization: 5 years**

Effective 11/1/06: Albuterol Sulfate MDI moves to "PA REQUIRED" (existing users of this product will maintain coverage without prior authorization indefinitely via grandfathering provisions)

### NO PA REQUIRED

#### METERED-DOSE INHALERS (SHORT-ACTING)

XOPENEX<sup>®</sup> HFA (levalbuterol)

#### METERED-DOSE INHALERS (LONG-ACTING)

FORADIL<sup>®</sup> (formoterol) (after criteria for LABA are met)  
SEREVENT<sup>®</sup> DISKUS (salmeterol xinafoate) (after criteria for LABA are met)

#### NEBULIZER SOLUTIONS (SHORT-ACTING)

ACCUNEB<sup>®</sup> (albuterol sulfate solution 0.63 mg/ml and 1.25 mg/ml)  
ALBUTEROL 0.83 mg/ml neb solution †  
METAPROTERENOL † neb solution  
XOPENEX<sup>®</sup> neb solution (levalbuterol HCL) (age ≤ 12 yrs)

#### NEBULIZER SOLUTIONS (LONG-ACTING)

#### TABLETS/SYRUP (SHORT-ACTING)

TERBUTALINE † tablets (compare to Brethine<sup>®</sup>)  
ALBUTEROL † tablets/syrup  
METAPROTERENOL † tablets/syrup

#### TABLETS (LONG-ACTING)

ALBUTEROL ER † tablets

### PA REQUIRED

♣ albuterol MDI †  
Alupent<sup>®</sup> (metaproterenol)  
Maxair<sup>®</sup> Autohaler (pirbuterol)  
♣ Proair<sup>®</sup> (albuterol)  
♣ Proventil<sup>®</sup> HFA (albuterol)  
♣ Ventolin<sup>®</sup> HFA (albuterol)

♣ coverage grandfathered for current users

albuterol sulfate solution † 0.63 mg/ml and 1.25 mg/ml (compare to Accuneb<sup>®</sup>)

Xopenex<sup>®</sup> neb solution (age > 12 yrs)

Brovana<sup>®</sup> (arformoterol) QL = 2 vial/day  
Perforomist<sup>®</sup> (formoterol) QL = 2 vial/day

Brethine<sup>®</sup>\* (terbutaline)

Vospire ER<sup>®</sup>\* (albuterol)

### PDL Key:

† Generic product

\* Indicates a generic equivalent is available without PA

§ Indicates drug is managed via automated Step Therapy (prerequisite drug therapy automatically screened for upon claims processing)

## Pulmonary: Inhaled Glucocorticoids/Glucocorticoid Combinations

Length of Authorization: 5 years

### NO PA REQUIRED

#### METERED DOSE INHALERS (SINGLE AGENT)

ASMANEX<sup>®</sup> 220 mcg/inh (mometasone furoate) ((QL = 0.72 gm (3 inhalers)/90 days))

ASMANEX<sup>®</sup> 110 mcg/inh (mometasone furoate) ((QL = 0.405 gm (3 inhalers)/90 days))

AZMACORT<sup>®</sup> (triamcinolone acetonide)

FLOVENT<sup>®</sup> DISKUS (fluticasone propionate)

FLOVENT<sup>®</sup> HFA (fluticasone propionate) (QL = 36 gm(3 inhalers)/90 days)

PULMICORT Flexhaler<sup>®</sup> (budesonide)

#### METERED DOSE INHALERS (COMBINATION PRODUCT)

ADVAIR<sup>®</sup> DISKUS (fluticasone/salmeterol)

ADVAIR<sup>®</sup> HFA (fluticasone/salmeterol)

SYMBICORT<sup>®</sup> (budesonide/formoterol) (QL = 30.6 gm (3 inhalers)/90 days)

#### NEBULIZER SOLUTIONS

PULMICORT RESPULES<sup>®</sup> (budesonide) (age ≤ 12 yrs)

### PA REQUIRED

AeroBid<sup>®</sup> (flunisolide) §

AeroBid-M<sup>®</sup> §

QVAR<sup>®</sup> (beclomethasone) §

Pulmicort (budesonide) Respules<sup>®</sup> (age > 12 yrs)

## Pulmonary: Nasal Glucocorticoids

Length of Authorization: 5 years

### NO PA REQUIRED

FLUTICASONE Propionate † (compare to Flonase<sup>®</sup>)

FLUNISOLIDE†25 mcg/spray (previously Nasalide<sup>®</sup>)

NASACORT AQ<sup>®</sup> (triamcinolone AQ)

NASONEX<sup>®</sup> (mometasone)

### PA REQUIRED

Beconase AQ<sup>®</sup> (beclomethasone AQ)

Flonase<sup>®</sup>\* (fluticasone propionate)

flunisolide† 29 mcg/spray (compare to Nasarel<sup>®</sup>)

Nasarel<sup>®</sup> (flunisolide)

Rhinocort AQ<sup>®</sup> (budesonide AQ)

Veramyst<sup>®</sup> (fluticasone furoate)

## Pulmonary: Systemic Glucocorticoids

Length of Authorization: 1 year

### NO PA REQUIRED

CORTISONE ACETATE†

DEXAMETHASONE†

HYDROCORTISONE† (compare to Cortef<sup>®</sup>)

METHYLPREDNISOLONE† (compare to Medrol<sup>®</sup>)

ORAPRED<sup>®</sup> oral solution/ODT (prednisolone sod phosphate) (age < 12 yrs)

PREDNISOLONE† tabs / liquid (compare to Pediapred<sup>®</sup>, Prelone<sup>®</sup>)

PREDNISONE†

### PA REQUIRED

Celestone<sup>®</sup>

Cortef<sup>®</sup>\*

Medrol<sup>®</sup>\*

Millipred<sup>®</sup> (prednisolone) oral solution

Orapred<sup>®</sup> oral solution (age ≥ 12 yrs)

Orapred<sup>®</sup> ODT (age ≥ 12 yrs)

Pediapred<sup>®</sup>\*

Prelone<sup>®</sup>\*

## Pulmonary: Leukotriene Modifiers

Length of Authorization: 1 year

### NO PA REQUIRED

ACCOLATE<sup>®</sup> (zafirlukast)

SINGULAIR<sup>®</sup> (montelukast sodium)

### PA REQUIRED

ZyFlo<sup>®</sup> (zileuton) §

ZyFlo<sup>®</sup> CR (zileuton SR) §

### PDL Key:

† Generic product

\* Indicates a generic equivalent is available without PA

§ Indicates drug is managed via automated Step Therapy (prerequisite drug therapy automatically screened for upon claims processing)

## Pulmonary: RSV Prevention

*Length of Authorization: 1 season, 6 doses (November 1-April 30)*

Quantity limits apply

NO PA REQUIRED

PA REQUIRED: Therapy specific PA fax form is available on the OVHA website  
SYNAGIS® (palivizumab)

## Renal Disease: Phosphate Binders

*Length of Authorization: n/a*

NO PA REQUIRED

FOSRENOL® (lanthanum carbonate)  
PHOS LO® (calcium acetate)  
RENAGEL® (sevelamer)

PA REQUIRED

## Rheumatoid, Juvenile & Psoriatic Arthritis: Immunomodulators

*Length of Authorization: Initial PA of 3 months; 12 months thereafter*

Quantity limits apply

*Therapy specific PA fax form is available on the OVHA website.*

PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

ENBREL® (etanercept)  
HUMIRA® (adalimumab)

NON-PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

Kineret® (anakinra)  
Orencia® (abatacept)  
Remicade® (infliximab)

## Saliva Stimulants

*Length of Authorization: 1 year*

NO PA REQUIRED

PILOCARPINE (compare to Salagen®)  
EVOXAC® (cevimeline)

PA REQUIRED

Salagen®\* (pilocarpine)

## Sedative/Hypnotics

*Length of Authorization: 1 year*

Quantity limits apply

NO PA REQUIRED

ESTAZOLAM† (compare to Prosom®)  
FLURAZEPAM† (compare to Dalmane®)  
TEMAZEPAM† (compare to Restoril®)

PA REQUIRED

### Benzodiazepine

Dalmane®\* (flurazepam)  
Doral® (quazepam)  
Halcion® (triazolam)  
Prosom®\* (estazolam)  
Restoril®\* (temazepam)  
triazolam† (compare to Halcion®)

### Non-benzodiazepine

CHLORAL HYDRATE† syrup, suppository  
LUNESTA® (eszopiclone) (*Quantity Limit = 1 tab/day*)  
ZOLPIDEM † (compare to Ambien®)(*Quantity Limit = 1 tab/day*)

Ambien®\* (zolpidem) (*Quantity Limit = 1 tab/day*)  
Ambien CR® (zolpidem) (*Quantity Limit = 1 tab/day*)  
Rozerem® (ramelteon) (*Quantity Limit = 1 tab/day*)  
Somnote® (chloral hydrate capsule)  
Sonata® (zaleplon)  
Zaleplon †

## PDL Key:

† Generic product

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## Skeletal Muscle Relaxants

Length of Authorization: 1 year

Effective 11/1/06: All carisoprodol products (brand and generics) move to "PA REQUIRED"

### NO PA REQUIRED

CHLORZOXAZONE† (compare to Parafon Forte DSC®)  
CYCLOBENZAPRINE† (compare to Flexeril®)  
METHOCARBAMOL† (compare to Robaxin®)  
METHOCARBAMOL, ASA† (compare to Robaxisal®)  
ORPHENADRINE CITRATE† (compare to Norflex®)  
ORPHENADRINE, ASA, CAFFEINE† (compare to Norgesic®, Norgesic Forte®)

ASA = aspirin

### PA REQUIRED

#### Musculoskeletal Agents

Amrix® (cyclobenzaprine extended release)  
carisoprodol †  
carisoprodol, ASA†  
carisoprodol, ASA, codeine †  
Fexmid® (cyclobenzaprine)  
Flexeril®\*  
Norflex®\*  
Norgesic®\*  
Norgesic Forte®\*  
Parafon Forte DSC®\*  
Robaxin®\*  
Robaxisal®\*  
Skelaxin®  
Soma®  
Soma Compound®  
Soma Compound with Codeine®

#### Antispasticity Agents

BACLOFEN† (compare to Lioresal®)  
DANTROLENE† (compare to Dantrium®)  
TIZANIDINE† (compare to Zanaflex®)

Dantrium®\*  
Lioresal®\*  
Zanaflex®\*

## Smoking Cessation Therapies

Length of Authorization: see table

Quantity limits apply (maximum 2 courses per rolling 365 days)

### NO PA REQUIRED

#### NICOTINE REPLACEMENT (maximum duration is 16 weeks (2 x 8 weeks)/365 days)♣

NICODERM CQ PATCH®  
NICORETTE GUM®  
COMMIT LOZENGE®  
NICOTINE LOZENGE†  
NICOTROL INHALER®

#### ORAL THERAPY

BUPROPION SR†  
CHANTIX® (varenicline) (Limited to 18 years and older, Quantity Limit = 2 tabs/day, maximum duration 24 weeks (2 x 12 weeks)/365 days)♣

### PA REQUIRED

nicotine patch OTC†  
nicotine patch RX† (compare to Habitrol®)  
Nicotine System Kit®  
nicotine gum†  
Nicotrol Nasal Spray®

Zyban®\* (bupropion SR)  
(maximum duration 24 weeks (2 x 12 weeks)/365 days)

♣ For approval of therapy beyond the established maximum duration, the prescriber must provide evidence that the patient is engaged in a smoking cessation counseling program.

### PDL Key:

† Generic product

\* Indicates a generic equivalent is available without PA

§ Indicates drug is managed via automated Step Therapy (prerequisite drug therapy automatically screened for upon claims processing)

**Urinary Antispasmodics**  
*Length of Authorization: 1 year*  
**Quantity limits apply**

**NO PA REQUIRED\***

**SHORT-ACTING AGENTS**

OXYBUTYNIN† (compare to Ditropan®)

**LONG-ACTING AGENTS (after clinical criteria are met)**

**Twice Daily Oral (Qty Limit = 2 per day)**

SANCTURA® (trospium)

**Once Daily Oral (Qty Limit = 1 per day)**

ENABLEX® (darifenacin)

OXYBUTYNIN XL† (compare to Ditropan® XL)

SANCTURA XR® (trospium)

VESICARE® (solifenacin)

**Transdermal**

>NOTE:

- *Patients under the age of 65 must fail an adequate trial of generic oxybutinin before approval will be granted for either oxybutynin XL®, Vesicare®, Sanctura®, Sanctura XR® or Enablex®.*
- *A therapeutic failure on at least two long acting preferred products is required before a PA will be approved on any non-preferred long acting medication..*

*Recipients < 21 years of age are exempt from all PA Requirements.*

*(Exception: An adequate trial of oxybutinin/oxybutinin XL will be required before approval of Ditropan®/Ditropan® XL will be granted)*

**PA REQUIRED**

Ditropan®\*  
 Flavoxate † (compare to Urispas®)  
 Urispas® (flavoxate)

Detrol® (tolterodine)

Detrol LA® (tolterodine LA)  
 Ditropan XL® (oxybutynin XL)

Oxytrol® (oxybutinin transdermal) (Qty Limit = 8 patches/28 days)

**Vaginal Anti-Infectives**  
*Length of Authorization: 1 year*

**NO PA REQUIRED**

**CLINDAMYCIN**

CLINDAMYCIN VAGINAL† (clindamycin vaginal cream 2%)

CLINDAMAX† (clindamycin vaginal cream 2%)

**METRONIDAZOLE**

METRONIDAZOLE VAGINAL GEL 0.75%†

VANDAZOLE† (metronidazole vaginal 0.75%)

**PA REQUIRED**

Cleocin®\* (clindamycin vaginal cream 2%)  
 Clindesse® (clindamycin vaginal cream 2%)  
 Cleocin® Vaginal Ovules (clindamycin vaginal suppositories)

Metrogel Vaginal®\* (metronidazole vaginal gel 0.75%)

**Vitamins: Prenatal Multivitamins**  
*Length of Authorization: 1 year*

**NO PA REQUIRED**

All generics

**PA REQUIRED**

All brands

**PDL Key:**

† Generic product

\* Indicates a generic equivalent is available without PA

§ Indicates drug is managed via automated Step Therapy (prerequisite drug therapy automatically screened for upon claims processing)