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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:**

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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

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

#### **OVHA Pharmacy Administration:**

*Director of Pharmacy Benefit Programs*

Cynthia D. LaWare, (o) 802-879-5611;

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E-mail: [cynthia.laware@ahs.state.vt.us](mailto:cynthia.laware@ahs.state.vt.us)

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

**NO PA REQUIRED**

DOXYCYCLINE† 20 mg, 50 mg, 75 mg, 100 mg, 25 mg/5 ml  
tab, cap, susp

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

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)  
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

All 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® (clindamycin/benzoyl peroxide)  
DUAC® (clindamycin/benzoyl peroxide) gel, kit  
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*)  
Aczone® (dapsone 5% *G*)  
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*

**Quantity limits apply**

### 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 §

galantamine† tablet (compare to Razadyne®) Tablet

galantamine ER† capsule (compare to Razadyne ER®)

Razadyne® (galantamine) Tablet §

Razadyne ER® (galantamine) Capsule §

Razadyne® (galantamine) Oral Solution §

### **PDL Key:**

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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>  
Ibudone<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  
continued on next page

### PDL Key:

† Generic product

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*continued from previous page*

Norco<sup>®\*</sup>  
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\*  
Reprexain<sup>®\*</sup>  
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**

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

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

#### **ORAL**

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

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

### **PA REQUIRED**

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

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

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

Fentanyl Patch<sup>†</sup> (compare to Duragesic<sup>®</sup>) 75 mcg/hr, 100 mcg/hr, (*QL=30 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<sup>†</sup> (*QL=90 tablets/strength/30 days*)

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

### **PDL Key:**

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## 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† tabs (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  
meloxicam†susp (compare to Mobic®)  
Mobic®\*  
Motrin®\*  
Nalfon®\*

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

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

## Anemia: Hematopoietic/Erythropoietic Agents

Length of Authorization: 1 year

### NO PA REQUIRED

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

### PA REQUIRED

Epogen® (epoetin alpha)

## Ankylosing Spondylitis: Injectables

\*\*Effective 02/16/09, Self-injectables (Enbrel® and Humira®) must be obtained through Specialty Pharmacy Provider, ICORE\*\*

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

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

## Anti-anxiety: Anxiolytics

Length of Authorization: 1 year

### NO PA REQUIRED

#### Benzodiazepine

ALPRAZOLAM† (compare to Xanax®)  
ALPRAZOLAM ER†, ALPRAZOLAM XR® (compare to Xanax XR®)  
CHLORDIAZEPOXIDE† (compare to Librium®)  
CLONAZEPAM† (compare to Klonopin®)  
CLONAZEPAM ODT† (compare to Klonopin Wafers®)  
CLORAZEPATE† tabs (compare to Tranxene T®)  
DIAZEPAM† (compare to Valium®)  
LORAZEPAM† (compare to Ativan®)  
OXAZEPAM† (compare to Serax®)

#### Non-Benzodiazepine

BUSPIRONE† (compare to Buspar®)  
HYDROXYZINE HYDROCHLORIDE† (previously Atarax®)  
HYDROXYZINE PAMOATE† (compare to Vistaril®)  
MEPROBAMATE† (previously Miltown®)

### PA REQUIRED

Ativan®\* (lorazepam)  
Klonopin®\* (clonazepam)  
Klonopin Wafers®\* (clonazepam ODT)  
Librium®\* (chlordiazepoxide)  
Niravam® (alprazolam ODT)  
Serax®\* (oxazepam)  
Tranxene T®\* (clorazepate tablets)  
Tranxene-SD® (clorazepate SR 24 hr tab)  
Valium®\* (diazepam)  
Xanax®\* (alprazolam)  
Xanax XR®\* (alprazolam XR)

Buspar®\* (buspirone)  
Vistaril®\* (hydroxyzine pamoate)

## 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® (fondaparinux)

### 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**  
**Quantity limits apply**

### 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 Zarontin®)  
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)  
divalproex sodium † (compare to Depakote®)  
Gabarone®\* (gabapentin)  
Klonopin®\*  
Klonopin Wafers®\*  
lamotrigine† chew tabs (compare to Lamictal® chew tabs)  
lamotrigine† tabs (compare to Lamictal® tabs)  
levetiracetam† oral solution (compare to Keppra® oral solution)  
levetiracetam† tabs (compare to Keppra® tabs)  
Lyrica® (pregabalin) § (*Quantity Limit = 3 capsules/day*)  
Mysoline®\* (primidone)  
Neurontin®\* (gabapentin)  
oxcarbazepine † (compare to Trileptal®)  
Tegretol®\* (carbamazepine)  
Zarontin®\* (ethosuxamide)  
Zonegran®\* (zonisamide)

## Anti-depressants: Miscellaneous

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

### NO PA REQUIRED

BUDEPRION® SR/BUPROPION SR† (compare to Wellbutrin SR®)  
*FDA maximum recommended dose = 400 mg/day*  
BUPROPION† (compare to Wellbutrin®)  
*FDA maximum recommended dose = 450 mg/day*  
MAPROTILINE† (previously Ludiomil®)  
*FDA maximum recommended dose = 225 mg/day*  
MIRTAZAPINE† (compare to Remeron®)  
*FDA maximum recommended dose = 45 mg/day*  
MIRTAZAPINE RDT† (compare to Remeron Sol-Tab®)  
*FDA maximum recommended dose = 45 mg/day*  
NEFAZADONE† (previously Serzone®)  
*FDA maximum recommended dose = 600 mg/day*  
TRAZODONE HCL† (previously Desyrel®)  
*FDA maximum recommended dose = 600 mg/day*  
WELLBUTRIN XL® (bupropion XL)  
*FDA maximum recommended dose = 450 mg/day*

### PA REQUIRED

Budeprion XR/bupropion XL† (compare to Wellbutrin XL®)  
*FDA maximum recommended dose = 450 mg/day*  
Remeron®\* (mirtazapine)  
*FDA maximum recommended dose = 45 mg/day*  
Remeron Sol Tab®\* (mirtazapine RDT)  
*FDA maximum recommended dose = 45 mg/day*  
Wellbutrin®\* (bupropion)  
*FDA maximum recommended dose = 450 mg/day*  
Wellbutrin SR®\* (bupropion SR)  
*FDA maximum recommended dose = 400mg/day*

### PDL Key:

† Generic product

\* Indicates a generic equivalent is available without PA

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## Anti-depressants: SNRIs

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

Quantity limits apply

### NO PA REQUIRED

### PA REQUIRED

Cymbalta<sup>®</sup> § (duloxetine)  
*FDA maximum recommended dose = 60 mg/day*  
Effexor<sup>®</sup> (venlafaxine IR)  
*FDA maximum recommended dose = 225 mg/day*  
Effexor XR<sup>®</sup> § (venlafaxine XR)  
*FDA maximum recommended dose = 225 mg/day,*  
*Quantity limit = 1 capsule/day (37.5 mg & 75 mg)*  
Pristiq<sup>®</sup> § (desvenlafaxine)  
*FDA maximum recommended dose = 400 mg/day,*  
*Quantity limit = 1 tablet/day (50 mg tablet only)*  
venlafaxine IR †§ (compare to Effexor<sup>®</sup>)  
*FDA maximum recommended dose = 225 mg/day*  
Venlafaxine ER<sup>®</sup> § tablet  
*FDA maximum recommended dose = 225 mg/day,*  
*Quantity limit = 1 tablet/day (37.5 mg & 75 mg)*

## Anti-depressants: SSRIs

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

Quantity limits apply

### NO PA REQUIRED

### PA REQUIRED

CITALOPRAM† (compare to Celexa<sup>®</sup>)  
*FDA maximum recommended dose = 40 mg/day*  
FLUOXETINE† (compare to Prozac<sup>®</sup>)  
*FDA maximum recommended dose = 80 mg/day*  
FLUVOXAMINE† (previously Luvox<sup>®</sup>)  
*FDA maximum recommended dose = 300 mg/day*  
PAROXETINE tablet† (compare to Paxil<sup>®</sup>)  
*FDA maximum recommended dose = 60 mg/day*  
SERTRALINE† (compare to Zoloft<sup>®</sup>)  
*FDA maximum recommended dose = 200 mg/day,*  
*Quantity limit = 1.5 tabs/day (25 mg & 50 mg tabs)*

Celexa<sup>®</sup>\* (citalopram)  
*FDA maximum recommended dose = 40 mg/day*  
Fluoxetine† (pmdd) (compare to Selfemra<sup>®</sup>)  
*FDA maximum recommended dose = 80 mg/day*  
Lexapro<sup>®</sup> (escitalopram)  
*FDA maximum recommended dose = 20 mg/day,*  
*Quantity limit = 1.5 tabs/day (5 mg & 10 mg tabs)*  
Luvox CR<sup>®</sup> (fluvoxamine CR)  
*FDA maximum recommended dose = 300 mg/day,*  
*Quantity limit = 2 capsules/day*  
paroxetine suspension† (compare to Paxil<sup>®</sup> susp)  
*FDA maximum recommended dose = 60 mg/day*  
Paroxetine CR† (compare to Paxil CR<sup>®</sup>)  
*FDA maximum recommended dose = 75 mg/day*  
Paxil<sup>®</sup>\* (paroxetine)  
*FDA maximum recommended dose = 60 mg/day*  
Paxil CR<sup>®</sup> (paroxetine CR)  
*FDA maximum recommended dose = 75 mg/day*  
Pexeva<sup>®</sup> (paroxetine)  
*FDA maximum recommended dose = 60 mg/day*  
Prozac<sup>®</sup>\* (fluoxetine)  
*FDA maximum recommended dose = 80 mg/day*  
Prozac Weekly<sup>®</sup> (fluoxetine)  
*FDA maximum recommended dose = 90 mg/week*  
Sarafem<sup>®</sup> (fluoxetine)  
*FDA maximum recommended dose = 80 mg/day*  
Selfemra<sup>®</sup> (fluoxetine)  
*FDA maximum recommended dose = 80 mg/day*  
Zoloft<sup>®</sup>\* (sertraline)  
*FDA maximum recommended dose = 200 mg/day,*  
*Quantity limit = 1.5 tabs/day (25 mg & 50 mg tabs)*

### PDL Key:

† Generic product

\* Indicates a generic equivalent is available without PA

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## Anti-depressants: Tricyclics

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

### NO PA REQUIRED

AMITRIPTYLINE† (previously Elavil®)  
*FDA maximum recommended dose = 300 mg/day*  
AMITRIPTYLINE/CHLORDIAZ.† (compare to Limbitrol®, Limbitrol DS®)  
AMITRIPTYLINE/PERPHEN† (previously Etrafon®, Triavil®)  
AMOXAPINE† (previously Asendin®)  
CLOMIPRAMINE† (compare to Anafranil®)  
DESIPRAMINE† (compare to Norpramin®)  
DOXEPIN† (previously Sinequan®)  
IMIPRAMINE† (compare to Tofranil®)  
*FDA maximum recommended dose = 300 mg/day*  
IMIPRAMINE PAMOATE† (compare to Tofranil PM®)  
NORTRIPTYLINE† (previously Aventyl®, compare to Pamelor®)  
PROTRIPTYLINE† (compare to Vivactil®)  
TRIMIPRAMINE (compare to Surmontil®)

### PA REQUIRED

Anafranil®\* (clomipramine)  
Limbitrol®\* (amitriptyline/chlordiazepoxide)  
Limbitrol DS®\* (amitriptyline/chlordiazepoxide)  
Norpramin®\* (desipramine)  
Pamelor®\* (nortriptyline)  
Surmontil®\* (trimipramine)  
Tofranil®\* (imipramine)  
*FDA maximum recommended dose = 300 mg/day*  
Tofranil PM®\* (imipramine pamoate)  
Vivactil®\* (protriptyline)

## Anti-depressants: MAO Inhibitors

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

Quantity limits apply

### NO PA REQUIRED

NARDIL® (phenylzine)  
*FDA maximum recommended dose = 90 mg/day*  
TRANLYCYPROMINE (compare to Parnate®)  
*FDA maximum recommended dose = 60 mg/day*

### PA REQUIRED

EMSAM® (selegiline) (*QL = 1 patch/day*)  
Marplan® (isocarboxazid)  
Parnate®\* (tranylcypromine)  
*FDA maximum recommended dose = 60 mg/day*

## 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

Symlin® (pramlintide) § *No Quantity Limit*

### PA REQUIRED

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

### 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:**

† Generic product

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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)

\*Emend® (fosaprepitant) 115 mg Injection (Qty Limit = 1 vial/30 days)

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*

### NO PA REQUIRED

### PA REQUIRED

Dronabinol† (compare to Marinol®)

Marinol® (dronabinol)

Cesamet® (nabilone)

### PDL Key:

† Generic product

\* Indicates a generic equivalent is available without PA

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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)

### PA REQUIRED

Dexmethylphenidate † (compare to Focalin®)  
Focalin® (dexmethylphenidate)  
Ritalin®\* (methylphenidate)  
Ritalin SR®\* (methylphenidate SR)

#### LONG-ACTING METHYLPHENIDATE PREPS

##### Oral

CONCERTA® (methylphenidate IR/ER 22:78%)  
FOCALIN® XR (dexmethylphenidate IR/ER, 50:50%)

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

##### Transdermal

DAYTRANA® (methylphenidate patch) (QL = 1 patch/day)

#### SHORT/INTERMEDIATE AMPHETAMINE PREPS

AMPHETAMINE salt combo† (compare to Adderall®)  
DEXTROAMPHETAMINE † (previously Dexedrine®)  
DEXTROAMPHETAMINE SR† (compare to Dexedrine CR®)  
DEXTROSTAT † (dextroamphetamine)

Adderall®\* (amphetamine salt combo)  
Desoxyn® (methamphetamine)  
Dexedrine CR®\* (dextroamphetamine SR)

#### LONG-ACTING AMPHETAMINE PREPS

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

#### NON-STIMULANT PREPS

Provigil® (modafinil) (not approvable for ADHD in children age ≤12).

Strattera® (atomoxetine)  
FDA maximum recommended 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 Univas®)  
QUINAPRIL† (compare to Accupril®)  
RAMIPRIL† (compare to Altace®)  
TRANDOLAPRIL† (compare to Mavik®)

### PA REQUIRED

Accupril®\*(quinapril)  
Aceon® (perindopril)  
Altace®\* (ramipril)  
Capoten®\* (captopril)  
Lotensin®\* (benazepril)  
Mavik®\* (trandolapril)  
Monopril®\* (fosinopril)  
Prinivil®\* (lisinopril)  
Univas®\* (moexipril)  
Vasotec®\* (enalapril)  
Zestril®\* (lisinopril)

### PDL Key:

† Generic product

\* Indicates a generic equivalent is available without PA

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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 Vaseretic®)  
FOSINOPRIL/HYDROCHLOROTHIAZIDE† (compare to Monopril HCT®)  
LISINOPRIL/HYDROCHLOROTHIAZIDE† (compare to Zestoretic®, Prinzide®)  
MOEXIPRIL/HYDROCHLOROTHIAZIDE† (compare to Uniretic®)  
QUINAPRIL/HYDROCHLOROTHIAZIDE† (compare to Accuretic®)

### PA REQUIRED

Accuretic®\* (quinapril/HCTZ)  
Capozide®\* (captopril/HCTZ)  
Lotensin HCT®\* (benazepril/HCTZ)  
Monopril HCT®\* (fosinopril/HCTZ)  
Prinzide®\* (lisinopril/HCTZ)  
Uniretic®\* (moexipril/HCTZ)  
Vaseretic®\* (enalapril/HCTZ)  
Zestoretic®\* (lisinopril/HCTZ)

## Anti-hypertensives: ACE Inhibitor w/Calcium Channel Blocker

Length of Authorization: 1 year

### NO PA REQUIRED

AMLODIPINE/BENAZEPRIL † (compare to Lotrel®)

### PA REQUIRED

Lexxel® (enalapril/felodipine)  
Lotrel®\* amlodipine/(benazepril)  
10/40 and 5/40 strengths not available generically – please prescribe individual generic components  
Tarka® (trandolopril/verapamil)

## Anti-hypertensives: Angiotensin Receptor Blockers (ARBs)

Length of Authorization: 3 years

### 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: 3 years

### 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: 3 years

Quantity limits apply

### PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

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

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

### 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: 3 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 Trandate®)  
METOPROLOL† (compare to Lopressor®)  
METOPROLOL XL† (compare to Toprol XL®)  
NADOLOL† (compare to Corgard®)  
PINDOLOL† (compare to Visken®)  
PROPRANOLOL† (compare to Inderal®)  
PROPRANOLOL ER† (compare to Inderal LA®)  
SOTALOL† (compare to Betapace®, Betapace AF®)  
TIMOLOL† (formerly Blocadren®)

#### BETA-BLOCKER/DIURETIC COMBINATION

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

### PA REQUIRED

Betapace®* (sotalol)	Kerlone®* (betaxolol)
Betapace AF®* (sotalol)	Levatal® (penbutolol )
Bystolic® (nebivolol) ( <i>QL = 1 tablet/day for 2.5 mg and 5 mg tablet strengths</i> )	Lopressor®* (metoprolol)
Coreg®* (carvedilol)	Sectral®* (acebutolol)
Coreg CR® (carvedilol CR) ( <i>QL = 1 tablet/day</i> )	Tenormin®* (atenolol)
Corgard®* (nadolol)	Toprol XL®* (metoprolol succinate XL)
Inderal®* (propranolol)	Trandate®* (labetalol)
Inderal LA®* (propranolol ER)	Zebeta®* (bisoprolol)
Innopran XL® (propranolol SR)	
Corzide®* (nadolol/bendroflumethiazide)	Tenoretic®* (atenolol/chlorthalidone)
Inderide®* (propranolol/HCTZ)	Timolide® (timolol/HCTZ)
Lopressor HCT®* (metoprolol/HCTZ)	Ziac®* (bisoprolol/HCTZ)

### PDL Key:

† Generic product

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## Anti-hypertensives: Calcium Channel Blockers

Length of Authorization: 3 years

Quantity limits apply

### NO PA REQUIRED

#### SINGLE AGENT

##### **Dihydropyridines**

AFEDITAB<sup>®</sup> CR † (nifedipine SR, compare to Adalat<sup>®</sup> CC)  
AMLODIPINE † (compare to Norvasc<sup>®</sup>)  
FELODIPINE † (compare to Plendil<sup>®</sup>)  
ISRADIPINE † (formerly Dynacirc<sup>®</sup>)  
NICARDIPINE † (formerly Cardene<sup>®</sup>)  
NIFEDIAC<sup>®</sup> CC † (nifedipine SR, compare to Adalat<sup>®</sup> CC)  
NIFEDICAL<sup>®</sup> XL † (nifedipine SR osmotic, compare to Procardia<sup>®</sup> XL)  
NIFEDIPINE IR † (compare to Procardia<sup>®</sup>)  
NIFEDIPINE SR osmotic † (compare to Procardia<sup>®</sup> XL)  
NIFEDIPINE SR † (compare to Adalat<sup>®</sup> CC)  
NIMODIPINE † (compare to Nimotop<sup>®</sup>)

##### **Miscellaneous**

CARTIA<sup>®</sup> XT † (diltiazem SR, compare to Cardizem<sup>®</sup> CD)  
DILT-CD<sup>®</sup> † (diltiazem SR, compare to Cardizem<sup>®</sup> CD)  
DILTIA<sup>®</sup> XT † (diltiazem SR, compare to Dilacor<sup>®</sup> XR)  
DILT-XR<sup>®</sup> † (diltiazem SR, compare to Dilacor<sup>®</sup> XR)  
DILTIAZEM† (compare to Cardizem<sup>®</sup>)  
DILTIAZEM ER† (formerly Cardizem<sup>®</sup> SR)  
DILTIAZEM ER† (compare to Tiazac<sup>®</sup>)  
DILTIAZEM SR † (compare to Cardizem<sup>®</sup> CD)  
DILTIAZEM SR † (compare to Dilacor<sup>®</sup> XR)  
TAZTIA<sup>®</sup> XT † (diltiazem ER, compare to Tiazac<sup>®</sup>)  
VERAPAMIL† (compare to Calan<sup>®</sup>)  
VERAPAMIL CR† (compare to Calan SR<sup>®</sup>, Isoptin<sup>®</sup> SR)  
VERAPAMIL SR† 120 mg, 180 mg 240 mg and 360 mg (compare to Verelan<sup>®</sup>)  
VERAPAMIL SR† 100 mg, 200 mg, 300mg (compare to Verelan PM<sup>®</sup>)

#### CALCIUM CHANNEL BLOCKER/OTHER COMBINATION

(preferred after clinical criteria are met)

AZOR<sup>®</sup> (olmesartan/amlodipine) § (*Quantity Limit = 1 tablet/day*)  
EXFORGE<sup>®</sup> (valsartan/amlodipine) § (*Quantity Limit = 1 tablet/day*)

### PA REQUIRED

Adalat<sup>®</sup> CC\* (nifedipine SR)  
Cardene<sup>®</sup> SR (nicardipine SR) (no AB rated generic)  
Dynacirc<sup>®</sup> CR (isradipine CR) (no AB rated generic)  
Nimotop<sup>®</sup>\* (nimodipine)  
Norvasc<sup>®</sup>\* (amlodipine)  
Plendil<sup>®</sup>\* (felodipine)  
Procardia<sup>®</sup>\* (nifedipine IR)  
Procardia XL<sup>®</sup>\* (nifedipine SR osmotic)  
Sular<sup>®</sup> (nisoldipine)

Calan<sup>®</sup>\* (verapamil)  
Calan<sup>®</sup> SR\* (verapamil CR)  
Cardizem<sup>®</sup>\* (diltiazem)  
Cardizem<sup>®</sup> CD\* (diltiazem SR)  
Cardizem<sup>®</sup> LA (diltiazem SR) (no AB rated generic)  
Covera-HS<sup>®</sup> (verapamil SR) (no AB rated generic)  
Dilacor<sup>®</sup> XR\* (diltiazem SR)  
Isoptin<sup>®</sup> SR\* (verapamil CR)  
Tiazac<sup>®</sup>\* (diltiazem ER)  
Verelan<sup>®</sup>\* (verapamil SR 120 mg, 180 mg, 240 mg and 360 mg)  
Verelan<sup>®</sup> PM\* (100 mg, 200 mg and 300 mg)

Caduet<sup>®</sup> (amlodipine/atorvastatin)

## Anti-hypertensives: Renin Inhibitor

Length of Authorization: 3 years

Quantity limits apply

### NO PA REQUIRED

### PA REQUIRED

#### SINGLE AGENT

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

#### COMBINATION

TEKTURNA HCT<sup>®</sup> (aliskiren/hydrochlorothiazide) (*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-infectives: Cephalosporins – 1<sup>st</sup> Generation

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

### NO PA REQUIRED

CEFADROXIL† (compare to Duricef®)  
CEPHALEXIN† (compare to Keflex®)

IV drugs are not managed at this time

### PA REQUIRED

Duricef®\*  
Keflex®\*

## 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®)  
CEFUROXIME TABLET† (compare to Ceftin®)

#### SUSPENSION

CEFACLOR SUSPENSION†  
CEFPROZIL SUSPENSION† (compare to Cefzil®)  
CEFTIN® (cefuroxime) SUSPENSION

IV drugs are not managed at this time

### PA REQUIRED

Ceftin®\* tablet  
Cefzil® tablet  
Lorabid® (loracarbef) capsule

Cefuroxime† Suspension (compare to Ceftin®)  
Cefzil® suspension  
Lorabid® (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®)  
OMNICEF® CAPSULE (cefdinir)  
SUPRAX® TABLET (cefixime)

#### SUSPENSION

OMNICEF® SUSPENSION (cefdinir)  
SUPRAX® SUSPENSION (cefixime)

IV drugs are not managed at this time

### PA REQUIRED

Cedax® capsule (ceftibuten)  
cefдинир capsule†  
Spectracef® tablet (cefditoren)  
Vantin®\* tablet (cefepodoxime)

Cedax® suspension (ceftibuten)  
cefдинир suspension †  
cefepodoxime proxetil† (compare to Vantin®) suspension  
Vantin® suspension (cefepodoxime)

## Anti-infectives: Ketolides

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

### NO PA REQUIRED

### PA REQUIRED

Ketek® (telithromycin)

### PDL Key:

† Generic product

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## 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.®\*  
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

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## Anti-infectives: Influenza Vaccines

*Length of Authorization: for date of service only*

Note: Influenza Nasal Vaccine provided free of charge and without PA by Vermont Department of Health for ages 2 – 18 years

### NO PA REQUIRED

AFLURIA<sup>®</sup> Injection  
FLUARIX<sup>®</sup> Injection  
FLUZONE<sup>®</sup> Injection  
FLUVIRIN<sup>®</sup> Injection

### PA REQUIRED

FluMist<sup>®</sup> Nasal

## Anti-infectives: Miscellaneous

*Length of Authorization: 1 year*

### NO PA REQUIRED

### PA REQUIRED

Quaalain<sup>®</sup> (quinine sulfate)

## Anti-infectives: Topical Antibiotics

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

Quantity limits apply

### NO PA REQUIRED

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

### PA REQUIRED

Altabax<sup>®</sup> (retapamulin) (*Quantity Limit = 1 tube*)  
Bactroban<sup>®</sup> CREAM

## Anti-migraine: Triptans

*Length of Authorization: 6 months*

Monthly quantity limits apply, PA required to exceed.

### NO PA REQUIRED, Quantity Limits Apply

#### Single Agent

#### ORAL

AXERT<sup>®</sup> (almotriptan) 6.25 mg, 12.5 mg  
*Quantity Limit = 6 tablets/month*  
IMITREX<sup>®</sup> (sumatriptan)  
*Quantity Limit = 18 tablets/month (25 mg),  
9 tablets/month (50 mg, 100 mg),*  
MAXALT<sup>®</sup> (rizatriptan) tablet or MAXALT-MLT<sup>®</sup> (rizatriptan ODT)  
5 mg, 10 mg  
*Quantity Limit = 12 tablets/month*

#### NASAL SPRAY

IMITREX<sup>®</sup> (sumatriptan)  
*Quantity Limit = 12 units/month (5 mg nasal spray),  
6 units/month (20 mg nasal spray)*

#### INJECTABLE

IMITREX<sup>®</sup> (sumatriptan)  
*Quantity Limit = 4 injections/month (4 or 6 mg injection)*

#### Combination Product (Oral)

### PA REQUIRED, Quantity Limits Apply

Amerge<sup>®</sup> (naratriptan) 1 mg, 2.5 mg  
*Quantity Limit = 9 tablets/month*  
Frova<sup>®</sup> (frovatriptan) 2.5 mg  
*Quantity Limit = 9 tablets/month*  
Relpax<sup>®</sup> (eletriptan) 20 mg, 40 mg  
*Quantity Limit = 12 tablets/month*  
Sumatriptan<sup>†</sup> (compare to Imitrex<sup>®</sup>)  
*Quantity Limit = 18 tablets/month (25 mg), 9 tablets/month (50 mg, 100 mg),*  
Zomig<sup>®</sup> (zolmitriptan)  
*Quantity Limit = 12 tablets/month (2.5 mg tablets or orally disintegrating  
tablets), 6 tablets/month (5 mg tablets or orally disintegrating tablets)*  
  
Sumatriptan<sup>†</sup> (compare to Imitrex<sup>®</sup>)  
*Quantity Limit = 12 units/month (5 mg nasal spray),  
6 units/month (20 mg nasal spray)*  
Zomig<sup>®</sup> (zolmitriptan)  
*Quantity Limit = 12 units/month (5 mg nasal spray)*  
  
sumatriptan (compare to Imitrex<sup>®</sup>)  
*Quantity Limit = 4 injections/month (4 or 6 mg injection)*  
  
Treximet<sup>®</sup> (sumatriptan/naproxen)  
*Quantity Limit = 9 tablets/month*

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

### NO PA REQUIRED

#### TABLETS/CAPSULES

CLOZAPINE† (compare to Clozaril®)

*FDA maximum recommended dose = 900 mg/day*

GEODON® (ziprasidone)

*FDA maximum recommended dose = 160 mg/day*

RISPERDAL® (risperidone)

*FDA maximum recommended dose = 16 mg/day*

SEROQUEL® (quetiapine)

*FDA maximum recommended dose = 800 mg/day*

#### ORAL SOLUTIONS

RISPERDAL® (risperidone) oral solution

*FDA maximum recommended dose = 16 mg/day*

#### SHORT-ACTING INJECTABLE PRODUCTS

GEODON® IM (ziprasidone intramuscular injection)

*FDA maximum recommended dose = 40 mg/day*

#### LONG-ACTING INJECTABLE PRODUCTS

#### ORALLY DISINTEGRATING TABLETS

#### COMBINATION PRODUCTS

### PA REQUIRED

Abilify® (aripiprazole)

*FDA maximum recommended dose = 30 mg/day,*

*Quantity limit = 1.5 tabs/day (5 mg, 10 mg & 15 mg tabs)*

Clozaril®\* (clozapine)

*FDA maximum recommended dose = 900 mg/day*

Invega® (paliperidone)

*FDA maximum recommended dose = 12 mg/day*

*Quantity limit = 1 tab/day (3mg, 9mg), 2 tabs/day (6mg)*

Risperidone† (compare to Risperdal®)

*FDA maximum recommended dose = 16 mg/day*

Seroquel XR® (quetiapine XR)

*FDA maximum recommended dose = 800 mg/day*

*Quantity Limit = 1 tab/day (200 mg tablet strength only)*

Zyprexa® (olanzapine)

*FDA maximum recommended dose = 20 mg/day,*

*Quantity limit = 1.5 tabs/day (2.5 mg, 5 mg, 7.5 mg & 10 mg tabs)*

Abilify® (aripiprazole) oral solution

*FDA maximum recommended dose = 25 mg/day*

Abilify® IM (aripiprazole intramuscular injection)

*FDA maximum recommended dose = 30 mg/day*

Zyprexa® IM (olanzapine intramuscular injection)

*FDA maximum recommended dose = 30 mg/day*

Risperdal® Consta (risperidone microspheres)

*FDA maximum recommended dose = 50 mg/14 days*

Abilify® Discmelt (aripiprazole)

*FDA maximum recommended dose = 30 mg/day,*

*Quantity limit = 1.5 tabs/day (10 mg & 15 mg tabs)*

FazaClo® (clozapine orally disintegrating tablets)

*FDA maximum recommended dose = 900 mg/day*

Risperdal® M-Tab (risperidone orally disintegrating tablets)

*FDA maximum recommended dose = 16 mg/day*

Zyprexa Zydis® (olanzapine orally disintegrating tablets)

*FDA maximum recommended dose = 20 mg/day,*

*Quantity limit = 1.5 tabs/day (5 mg & 10 mg tabs)*

Symbyax® (olanzapine/fluoxetine)

*FDA maximum recommended dose = 18 mg/75 mg (perday)*

### PDL Key:

† Generic product

\* Indicates a generic equivalent is available without PA

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## Anti-psychotic: Typicals

*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®

## 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

### PDL Key:

† Generic product

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**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® (acamprosate)  
 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, IBS-C or Opioid Induced**

*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®)

**Stimulant Laxative**

BISACODYL†  
 SENNA†

**Stool Softener**

DOCUSATE†

**PA REQUIRED**

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

Relistor® (methylnatrexone)

**Contraceptives: Vaginal Ring**

*Length of Authorization: n/a*

**NO PA REQUIRED**

NUVARING® (etonogestrel/ethinyl estradiol vaginal ring)

**PA REQUIRED****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)

## Coronary Vasodilators/Antianginals: Oral

*Length of Authorization: 3 years*

**Quantity limits apply**

### NO PA REQUIRED

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

### PA REQUIRED

Dilatrate-SR® (isosorbide dinitrate SR capsule)  
Imdur®\* (isosorbide mononitrate ER tablet)  
Ismo®\* (isosorbide mononitrate tablet)  
Isordil®\* (isosorbide dinitrate tablet)  
Monoket®\* (isosorbide mononitrate tablet)  
  
BiDi® (isosorbide dinitrate/hydralazine)  
  
Ranexa® (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® (nitroglycerin transdermal patch)  
NITRO-BID® (nitroglycerin ointment)  
NITROGLYCERIN TRANSDERMAL PATCHES† (compare to Nitro-Dur®)

### PA REQUIRED

Nitro-Dur®\* (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® (guaifenesin)

### PA REQUIRED

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

## Dermatological Agents: Genital Wart Therapy

*Length of Authorization: Up to 16 weeks*

**Quantity limits apply**

### NO PA REQUIRED

ALDARA® (imiquimod)  
  
PODOFILOX SOLUTION† (compare to Condylox®)

### PA REQUIRED

Condylox® Gel (podofilox gel)  
Condylox®\* solution (podofilox solution)  
  
Veregan® (sinecatechins ointment)  
(*Quantity limit = 15 grams (1 tube)/per 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)

## 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

### 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)

## Estrogens: Vaginal

*Length of Authorization: n/a*

### NO PA REQUIRED

#### Estradiol

ESTRACE VAGINAL<sup>®</sup> Cream  
ESTRING<sup>®</sup> Vaginal Ring  
VAGIFEM<sup>®</sup> Vaginal Tablets

#### Conjugated Estrogens

PREMARIN VAGINAL<sup>®</sup> Cream

#### Estradiol Acetate

FEMRING<sup>®</sup> Vaginal Ring

### PA REQUIRED

## Gastrointestinal: Crohn's Disease Injectables

**\*\*Effective 02/16/09, Self-injectable (Humira<sup>®</sup>) must be obtained through Specialty Pharmacy Provider, ICORE\*\***

***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

CIMZIA<sup>®</sup> (certolizumab pegol)  
HUMIRA<sup>®</sup> (adalimumab)  
REMICADE<sup>®</sup> (infliximab)

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

Tysabri<sup>®</sup> (natalizumab)

## Gastrointestinals: H2-blockers

*Length of Authorization: 1 year*

### NO PA REQUIRED

CIMETIDINE<sup>†</sup> (compare to Tagamet<sup>®</sup>) tablet  
FAMOTIDINE<sup>†</sup> (compare to Pepcid<sup>®</sup>) tablet  
RANITIDINE<sup>†</sup> (compare to Zantac<sup>®</sup>) tablet

#### SYRUPS AND SPECIAL DOSAGE FORMS

CIMETIDINE † ORAL SOLUTION  
ZANTAC<sup>®</sup> (ranitidine) SYRUP

### PA REQUIRED

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

Axid<sup>®</sup> (nizatidine) Oral Solution §  
Pepcid<sup>®</sup> Oral Suspension §  
ranitidine<sup>†</sup> syrup §  
Zantac Effervescent<sup>®</sup> §

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

*Length of Authorization: 1 year*

### NO PA REQUIRED

#### Mesalamine Products

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

#### Other

BALSALAZIDE<sup>†</sup> (compare to Colazal<sup>®</sup>)  
DIPENTUM<sup>®</sup> (olsalazine)  
SULFASALAZINE<sup>†</sup> (compare to Azulfidine<sup>®</sup>)

### PA REQUIRED

Rowasa<sup>®</sup>\* (mesalamine enema)

Azulfidine<sup>®</sup>\* (sulfasalazine)  
Colazal<sup>®</sup>\* (balsalazide)

### 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: 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

#### ORAL CAPULES/TABLETS

PREVACID® (lansoprazole) capsules (*Quantity limit=1 cap/day*)

PRILOSEC OTC® 20mg (omeprazole magnesium) tablets

(*No Quantity limit applies*)

PROTONIX® (pantoprazole) tablets (*Quantity limit=1 tab/day*)

#### SUSPENSION & SPECIAL DOSAGE FORMS

PREVACID® (lansoprazole) packets (*Quantity limit=1 packet/day*)

PREVACID SOLUTABS®\* (lansoprazole) (*Quantity limit=1 tab/day*)

#### COMBINATION (H.Pylori eradication)

Prevpac® (lansoprazole w/ H.pylori anti-bacterials) (*No Quantity limit applies*)

### PA REQUIRED

Aciphex® (rabeprazole) tablets § (*Quantity limit=1 tab/day*)

Nexium® (esomeprazole) capsules § (*Quantity limit=1 cap/day*)

omeprazole †\* generic RX capsules § (*Quantity limit=1 cap/day*)

omeprazole †\* generic OTC tablets § (*Quantity limit=1 tab/day*)

pantoprazole † generic tablets (*Quantity limit=1 tab/day*)

Prilosec® (brand) capsules § (*Quantity limit=1 cap/day*)

Zegerid® (omeprazole) capsules § (*Quantity limit=1 cap/day*)

Nexium® (esomeprazole) powder for suspension §

(*Quantity limit=1 packet/day*)

Protonix® (pantoprazole) packet (*Quantity limit=1 packet/day*)

Zegerid®\* (omeprazole) powder for suspension §

(*Quantity limit=1 packet/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

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## Glucocorticoids: Topical

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

### NO PA REQUIRED

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

### PA REQUIRED

#### Low Potency

Aclovate®\*  
Capex® Shampoo (fluocinolone)  
Desonate® gel (desonide)  
DesOwen®\*  
Hytone®\*  
Nucort® 2 % Lotion (hydrocortisone acetate)  
Verdeso® (desonide foam)  
All other brands

#### Medium Potency

BECLOMETHASONE DIPROPIONATE† (compare to Alphatrex®)  
BETAMETHASONE VALERATE† (compare to Beta-Val®)  
DESOXIMETASONE 0.05%† (compare to Topicort®)  
FLUOCINOLONE 0.025%† (formerly 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®)

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®  
Topicort® 0.05 %\* (all products)  
Westcort®\* (all products)  
All other brands

#### High Potency

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

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

#### Very High Potency

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

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

### PDL Key:

† Generic product

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## 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.*

**\*\*Must be obtained through Specialty Pharmacy Provider, ICORE\*\***

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

### PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

NORDITROPIN®  
NUTROPIN®/NUTROPIN® AQ

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

Genotropin®  
Humatrope®  
Omnitrope®  
Saizen®  
Tev-Tropin®

#### Specialized Indications – See Specific Criteria

Increlex® (mecasermin)  
Serostim®  
Zorbtive®

## Hemophilia Factors

**\*\*Must be obtained through Specialty Pharmacy Provider, ICORE\*\***

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

### NO PA REQUIRED

All Factors

### PA REQUIRED

None

## Hepatitis C Agents

*Length of Authorization: 6 months*

*Quantity limits apply*

**\*\*Must be obtained through Specialty Pharmacy Provider, ICORE\*\***

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

### PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

#### RIBAVIRIN

Tablets/Capsules

RIBAVIRIN† 200 mg tablets or capsules

#### Oral Solution

#### INTERFERON

PEGASYS® (peg-interferon alpha 2-a) (QL = 4 vials/28 days)

PEGASYS CONVENIENCE PACK® (peg-interferon alfa-2a) (QL = 1 kit/28 days)

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

#### RIBAVIRIN

Copegus®\* (ribavirin 200 mg tablet)

Ribapak® 400 mg/600 mg Dose Pack (ribavirin)

Rebetol®\*\* (ribavirin 200 mg capsule)

All other strengths/brands of ribavirin tablets/capsules

Rebetol® (ribavirin 40 mg/ml) oral solution

#### INTERFERON

Infergen® (interferon alphacon-1)

Peg-Intron® (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® (pimecrolimus) §  
PROTOPIC® (tacrolimus) §

### PA REQUIRED

Elidel® (age < 2 yrs)  
Protopic® (age < 2 yrs)

### PDL Key:

† Generic product

\* Indicates a generic equivalent is available without PA

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## Lipotropics: Bile Acid Sequestrants

*Length of Authorization: lifetime*

### NO PA REQUIRED

CHOLESTYRAMINE† powder (compare to Questran®)  
CHOLESTYRAMINE LIGHT† powder (compare to Questran Light®)  
PREVALITE† powder (cholestyramine light)

COLESTIPOL† tablets, granules (compare to Colestid®)

### PA REQUIRED

Questran® powder (cholestyramine)  
Questran Light® powder (cholestyramine light)

Colestid®\* tablets, granules (colestipol)  
Welchol® (colesevelam)

## Lipotropics: Fibric Acid Derivatives

*Length of Authorization: 3 months initially, then 1 year if response shown*

### NO PA REQUIRED

GEMFIBROZIL† (compare to Lopid®) 600 mg  
♦TRICOR® (fenofibrate) § 48 mg, 145 mg

♦ *PA required if patient not on concurrent statin*

### PA REQUIRED

Antara® (fenofibrate micronized) § 43 mg, 130 mg  
fenofibrate† § 54 mg  
fenofibrate micronized† § 67 mg, 134 mg, 200 mg  
Fenoglide® (fenofibrate) § 40 mg, 120 mg  
Lipofen® (fenofibrate) § 50 mg, 150 mg  
Lofibra® (fenofibrate micronized) Capsules § 67mg, 134 mg, 200 mg  
Lofibra® (fenofibrate) Tablets § 54 mg, 160 mg  
Lopid®\* (gemfibrozil) § 600 mg  
Triglide® (fenofibrate) § 50 mg, 160 mg

## Lipotropics: Niacin Derivatives

*Length of Authorization: n/a*

### NO PA REQUIRED

NIACIN†  
NIASPAN® (niacin)  
NIASPAN® ER (niacin)

### PA REQUIRED

## Lipotropics: Statins

*Length of Authorization: 1 year*

**Quantity limits apply**

### NO PA REQUIRED

LOVASTATIN† (compare to Mevacor®) (*QL = 1 tablet/day (10 & 20 mg), 2 tabs/day (40 mg)*)  
PRAVASTATIN† (compare to Pravachol®) (*QL = 1 tablet/day (10 & 20 mg), 2 tabs/day (40 mg)*)

SIMVASTATIN† (compare to Zocor) (*QL = 1 tablet/day*)

### AFTER GENERIC SIMVASTATIN TRIAL

CRESTOR® (rosuvastatin calcium) §  
(*QL = 1 tablet/day*)

### PA REQUIRED

#### Low/Medium Potency Statins

Altoprev® (aka: Altocor®) (lovastatin) (*QL = 1 tablet/day*)  
Lescol® (fluvastatin) (*QL = 1 tablet/day*)  
Lescol® XL (fluvastatin XL) (*QL = 1 tablet/day*)  
Mevacor®\* (lovastatin) (*QL = 1 tab/day (10 & 20 mg), 2 tabs/day (40 mg)*)  
Pravachol®\* (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® (atorvastatin) (*QL = 1 tablet/day*)  
Zocor®\* (◻imvastatin) (*QL = 1 tablet/day*)

### PDL Key:

† Generic product

\* Indicates a generic equivalent is available without PA

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**Lipotropics: Miscellaneous/Combinations***Length of Authorization: 1 year**Quantity limits apply*

NO PA REQUIRED

PA REQUIRED

MiscellaneousLovaza<sup>®</sup> (omega-3-acid ethyl esters)Cholesterol Absorption Inhibitors/CombinationsZETIA<sup>®</sup> (ezetimibe) § (AFTER CLINICAL CRITERIA ARE MET)  
(Qty Limit = 1 tablet/day)Vytorin<sup>®</sup> (ezetimibe/simvastatin) (QL = 1 tablet/day)Other Statin CombinationsADVICOR<sup>®</sup> (lovastatin/niacin) (Qty Limit = 1 tablet/day)  
SIMCOR<sup>®</sup> (simvastatin/extended release niacin) (Qty Limit = 1  
tablet/day)Caduet<sup>®</sup> (atorvastatin/amlodipine) (Qty Limit = 1 tablet/day)**Miscellaneous: Arcalyst<sup>®</sup> (CAPS Injectable)***Length of Authorization: 1 year**Quantity limits apply*

NO PA REQUIRED

PA REQUIRED

Arcalyst<sup>®</sup> (rilonacept) (QL = 2 vials for loading dose, then 1 vial per week)**Miscellaneous: Elaprase<sup>®</sup> (Hunter's Syndrome Injectable)***Length of Authorization: 1 year**Quantity limits apply***\*\*Must be obtained through Specialty Pharmacy Provider, ICORE\*\***

NO PA REQUIRED

PA REQUIRED

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

NO PA REQUIRED

PA REQUIRED

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

NO PA REQUIRED

PA REQUIRED

Somatuline<sup>®</sup> 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

LITHIUM CARBONATE† (formerly Eskalith<sup>®</sup>)  
LITHIUM CARBONATE SR† (compare to Lithobid<sup>®</sup>, formerly  
Eskalith CR<sup>®</sup>)  
LITHIUM CITRATE SYRUP†Equetro<sup>®</sup> (carbamazepine SR)  
Lithobid<sup>®</sup>\*\* (lithium carbonate 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)

## Multiple Sclerosis: Injectables

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

Quantity limits apply

**\*\*Self-injectables (Avonex<sup>®</sup>, Betaseron<sup>®</sup>, Rebif<sup>®</sup> and Copaxone<sup>®</sup>) must be obtained through Specialty Pharmacy Provider, ICORE\*\***

### NO PA REQUIRED

#### Interferons

AVONEX<sup>®</sup> (interferon B-1a)

BETASERON<sup>®</sup> (interferon B-1b)

REBIF<sup>®</sup> (interferon B-1a)

#### Other

COPAXONE<sup>®</sup> (glatiramer acetate) (QL = 1 kit/30 days)

### PA REQUIRED

Tysabri<sup>®</sup> (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)

## Ophthalmics: Antihistamines

*Length of Authorization: 1 year*

Quantity limits apply

### NO PA REQUIRED

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

#### After trial of ketotifen 0.025 %

OPTIVAR<sup>®</sup>§ (azelastine) (Quantity Limit = 1 bottle/month)

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

### PA REQUIRED

Elestat<sup>®</sup> (epinastine) (Quantity Limit = 1 bottle/month)

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

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

### PDL Key:

<sup>†</sup> 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)

## Ophthalmics: Glaucoma Agents/Miotics

*Length of Authorization: lifetime*

### NO PA REQUIRED

#### ALPHA-2 ADRENERGIC

##### Single Agent

ALPHAGAN<sup>®</sup> P (brimonidine tartrate)  
BRIMONIDINE TARTARATE† (compare to Alphagan<sup>®</sup>)

##### Combination

COMBIGAN<sup>®</sup> (brimonidine tartrate/timolol maleate)

#### BETA BLOCKER

BETAXOLOL HCl† (compare to Betoptic<sup>®</sup>)  
BETOPTIC S<sup>®</sup> (betaxolol suspension)  
CARTEOLOL HCl† (compare to Ocupress<sup>®</sup>)  
LEVOBUNOLOL HCl† (compare to AKBeta<sup>®</sup>, Betagan<sup>®</sup>)  
METIPRANOLOL† (compare to Optipranolol<sup>®</sup>)  
TIMOLOL MALEATE† (compare to Istalol<sup>®</sup>, Timoptic<sup>®</sup>)

#### 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<sup>®</sup> (bimatoprost) §  
TRAVATAN<sup>®</sup>/TRAVATAN Z<sup>®</sup> (travoprost) §

#### CARBONIC ANHYDRASE INHIBITOR

##### Single Agent

DORZOLAMIDE 2 % (compare to Trusopt<sup>®</sup>)

##### Combination

DORZOLAMIDE w/TIMOLOL (compare to Cosopt<sup>®</sup>)

#### MISCELLANEOUS

DIPIVEFRIN HCl† (compare to AKPro<sup>®</sup>, Propine<sup>®</sup>)  
EPINEPHRINE† (compare to Epifrin<sup>®</sup>, Glaucon<sup>®\*</sup>)  
ISOPTO<sup>®</sup> CARBACHOL (carbachol)  
ISOPTO<sup>®</sup> CARPINE (pilocarpine)  
PILOCARPINE HCl† (compare to Pilocar<sup>®</sup>)  
PILOPINE<sup>®</sup> (pilocarpine)  
PHOSPHOLINE IODIDE<sup>®</sup> (echothiophate)

### PA REQUIRED

Iopidine<sup>®</sup> (apraclonidine) - *no PA required for pts <=10yrs*

Betagan<sup>®\*</sup>  
Betimol<sup>®\*</sup>  
Istalol<sup>®\*</sup>  
Optipranolol<sup>®\*</sup>  
Timoptic<sup>®\*</sup>  
Timoptic XE<sup>®\*</sup>

Xalatan<sup>®</sup> (latanoprost)

Azopt<sup>®</sup> (brinzolamide 1%)  
Trusopt<sup>®\*</sup> (dorzolamide 2 %)

Cosopt<sup>®\*</sup> (dorzolamide w/timolol)

Miochol-E<sup>®</sup>  
Miostat<sup>®</sup>  
Pilocar<sup>®\*</sup>  
Propine<sup>®\*</sup>

## Ophthalmics: Mast Cell Stabilizers

*Length of Authorization: 6 months*

### NO PA REQUIRED

ALAMAST<sup>®</sup> (pemirolast potassium)  
CROMOLYN SODIUM† (compare to Crolo<sup>®</sup>, Opticrom<sup>®</sup>)

### PA REQUIRED

Alocril<sup>®</sup> (nedocromil sodium)  
Alomide<sup>®</sup> (iodoxamide)  
Crolo<sup>®\*</sup>

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

*Length of Authorization: 1 year*

### NO PA REQUIRED

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

### PA REQUIRED

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

### 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)

## 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®\* (ciprofloxacin)  
Iquix® (levofloxacin 1.5%) (preservative free)  
Ocuflox®\* (ofloxacin)  
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

##### TABLETS/CAPSULES

ALENDRONATE† (compare to Fosamax®)  
BONIVA® (ibandronate) 150 mg (*Quantity Limit = 1 tab/28 days*)  
BONIVA® (ibandronate) 2.5 mg *No quantity limits*

##### ORAL SOLUTION

#### INJECTABLE BISPHOSPHONATES

#### CALCITONIN NASAL SPRAY

FORTICAL® (calcitonin)  
MIACALCIN® (calcitonin)

#### PARATHYROID HORMONE INJECTION

### PA REQUIRED

Actonel® (risedronate)  
Actonel® w/calcium (risedronate/calcium)  
Didronel® (etidronate)  
Etidronate† (compare to Didronel®)  
Fosamax®\* (alendronate)  
Fosamax Plus D® (alendronate/vitamin D)  
Skelid® (tiludronate)  
  
Fosamax® Oral Solution  
  
Boniva® Injection (ibandronate) (*Quantity Limit = 3 mg/3 months (four doses)/year*)  
Reclast® Injection (zoledronic acid) (*Quantity Limit = 5 mg (one dose)/year*)

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)

## Pancreatic Enzyme Products

Length of Authorization: n/a

### NO PA REQUIRED

CREON<sup>®</sup> 5 Capsule-DR, EC, microspheres  
CREON<sup>®</sup> 10 Capsule-DR, EC, microspheres  
CREON<sup>®</sup> 20 Capsule-DR, EC, microspheres  
CREON<sup>®</sup> 5 Minimicrosphere<sup>®</sup> Capsule-DR, EC, minimicrospheres  
CREON<sup>®</sup> 10 Minimicrosphere<sup>®</sup> Capsule-DR, EC, minimicrospheres  
CREON<sup>®</sup> 20 Minimicrosphere<sup>®</sup> Capsule-DR, EC, minimicrospheres  
PANGESTYME<sup>®</sup> CN-10 Capsule-DR, EC granules  
PANGESTYME<sup>®</sup> CN-20 Capsule-DR, EC granules  
PANGESTYME<sup>®</sup> EC Capsule-DR, EC granules  
PANGESTYME<sup>®</sup> MT16 Capsule-DR, EC granules  
PANGESTYME<sup>®</sup> UL12 Capsule-DR, EC granules  
PANGESTYME<sup>®</sup> UL18 Capsule-DR, EC granules  
PANGESTYME<sup>®</sup> UL20 Capsule-DR, EC granules  
PANCRECARB<sup>®</sup> MS-4 Capsule-DR, EC, microspheres  
PANCRECARB<sup>®</sup> MS-8 Capsule-DR, EC, microspheres  
PANCRECARB<sup>®</sup> MS-16 Capsule-DR, EC, microspheres  
ULTRASE<sup>®</sup> Capsule-EC microspheres  
ULTRASE<sup>®</sup> MT12 Capsule-EC minitabets  
ULTRASE<sup>®</sup> MT18 Capsule-EC minitabets  
ULTRASE<sup>®</sup> MT20 Capsule-EC minitabets  
VIOKASE<sup>®</sup> 8 Tablets  
VIOKASE<sup>®</sup> 16 Tablets

DR=delayed release, EC=enteric-coated

### PA REQUIRED

### 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)  
CARBIDOPA/LEVODOPA† ODT (compare to Parcopa®)

#### DOPAMINE AGONISTS (ORAL)

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

#### DOPAMINE AGONISTS (TRANSDERMAL)

#### COMT INHIBITORS

TASMAR® (tolcapone)  
COMTAN® (entacapone)

#### MAO-B INHIBITORS

SELEGILINE† (compare to Eldepryl®)

#### OTHER

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

### PA REQUIRED

Parcopa®\* (carbidopa/levodopa ODT)  
Sinemet®\* (carbidopa/levodopa)  
Sinemet CR®\* (carbidopa/levodopa ER)

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

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

Azilect® (rasagiline) (QL = 1 mg/day)  
Eldepryl® (selegiline)  
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: 1 year

### NO PA REQUIRED

#### AGGREGATION INHIBITORS

CILOSTAZOL† (compare to Pletal®)  
PLAVIX® 75 mg (clopidogrel bisulfate)  
TICLOPIDINE† (compare to Ticlid®)

#### OTHER

AGGRENOX® (dipyridamole/Aspirin)  
ASPIRIN†  
DIPYRIDAMOLE† (compare to Persantine®)

### PA REQUIRED

Plavix® 300 mg (clopidogrel bisulfate)  
Pletal®\* (cilostazol)  
Ticlid®\* (ticlopidine)

Persantine®\* (dipyridamole)

### 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

**\*\*Effective 02/16/09, Self-injectables (Enbrel<sup>®</sup>, Humira<sup>®</sup> and Raptiva<sup>®</sup>) must be obtained through Specialty Pharmacy Provider, ICORE\*\***

**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<sup>®</sup> (etanercept)  
HUMIRA<sup>®</sup> (adalimumab)  
RAPTIVA<sup>®</sup> (efalizumab)

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

Amevive<sup>®</sup> (alefacept)  
Remicade<sup>®</sup> (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<sup>®</sup> (methoxsalen)  
SORIATANE<sup>®</sup> CK (acitretin)

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

### PA REQUIRED

#### Oral

#### Topical

Dovonex<sup>®\*</sup> solution (calcipotriene)  
Taclonex<sup>®</sup> (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<sup>®</sup> (ipratropium)  
SPIRIVA<sup>®</sup> (tiotropium)

#### NEBULIZER (SINGLE AGENT)

IPRATROPIUM SOLN FOR INHALATION

#### METERED DOSE INHALER (COMBINATION PRODUCT)

COMBIVENT<sup>®</sup> (ipratropium/albuterol)

#### NEBULIZER (COMBINATION PRODUCT)

IPRATROPIUM/ALBUTEROL† (compare to Duoneb<sup>®</sup>)

### PA REQUIRED

Duoneb<sup>®\*</sup> (ipratropium/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: Antihistamines – Intranasal

*Length of Authorization: 1 year*

**Quantity limits apply**

### NO PA REQUIRED

### PA REQUIRED

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

Patanase® (olopatadine 0.6%) Nasal Spray  
*Quantity Limit = 1 bottle (31 gm)/30 days*

## 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)  
Clarinetx® (desloratadine)  
Claritin® (loratadine)  
Xyzal® (levocetirizine)  
Zyrtec® RX/OTC\* (cetirizine)

Allegra-D® § (12 HR & 24 HR)  
Cetirizine-D † SR  
Clarinetx-D® § (12 HR & 24 HR)  
Claritin-D® §  
Zyrtec-D® §

Allegra® suspension  
Clarinetx® Syrup  
Claritin Syrup\*\*  
Xyzal (levocetirizine) Syrup®  
Zyrtec RX Syrup®

Allegra ODT® §  
Cetirizine † Chewable Tablets  
Clarinetx Reditabs® §  
Claritin Chewable Tablets® §  
Clarinetx Reditabs®\*§  
Zyrtec® Chewable Tablets §

### 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: 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<sup>®</sup> (omalizumab)

## Pulmonary: Beta-adrenergic Agents

*Length of Authorization: 1 year*

**Quantity limits apply**

### NO PA REQUIRED

### PA REQUIRED

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

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

MAXAIR<sup>®</sup> Autohaler (pirbuterol)

Alupent<sup>®</sup> (metaproterenol)

Proair<sup>®</sup> HFA (albuterol)

Proventil<sup>®</sup> HFA (albuterol)

Ventolin<sup>®</sup> HFA (albuterol)

#### 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)

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)

#### NEBULIZER SOLUTIONS (LONG-ACTING)

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

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

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

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

ALBUTEROL † tablets/syrup

METAPROTERENOL † tablets/syrup

Brethine<sup>®\*</sup> (terbutaline)

#### TABLETS (LONG-ACTING)

ALBUTEROL ER † tablets

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: 1 year

Quantity limits apply

### 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)

(*QL* = 6 inhalers/90 days)

QVAR<sup>®</sup> 40 mcg/inh (beclomethasone)

(*QL* = 14.6 gm (2 inhalers)/90 days)

QVAR<sup>®</sup> 80 mcg/inh (beclomethasone)

(*QL* = 58.4 gm (8 inhalers)/90 days)

#### METERED DOSE INHALERS (COMBINATION PRODUCT)

ADV AIR<sup>®</sup> DISKUS (fluticasone/salmeterol)

ADV AIR<sup>®</sup> HFA (fluticasone/salmeterol)

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

#### NEBULIZER SOLUTIONS

BUDESONIDE INH SUSPENSION (compare to Pulmicort Respules<sup>®</sup>) (age ≤ 12 yrs)

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

### PA REQUIRED

AeroBid<sup>®</sup> (flunisolide) §

AeroBid-M<sup>®</sup> §

Budesonide Inh Suspension (compare to Pulmicort Respules<sup>®</sup>) (age > 12 years)

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

## Pulmonary: Nasal Glucocorticoids

Length of Authorization: 1 year

Quantity limits apply

### NO PA REQUIRED

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

*QL* = 16 gm (1 inhaler)/30 days

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

*QL* = 16.5 gm (1 inhaler)/30 days

NASONEX<sup>®</sup> (mometasone)

*QL* = 17 gm (1 inhaler)/30 days

### PA REQUIRED

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

*QL* = 50 gm (2 inhalers)/30 days

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

*QL* = 16 gm (1 inhaler)/30 days

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

*QL* = 50 ml (2 inhalers)/30 days

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

*QL* = 50 ml (2 inhalers)/30 days

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

*QL* = 50 ml (2 inhalers)/30 days

Omnaris<sup>®</sup> (ciclesonide)

*QL* = 12.5 gm (1 inhaler)/30 days

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

*QL* = 8.6 gm (1 inhaler)/30 days

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

*QL* = 10 gm (1 inhaler)/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)

## Pulmonary: Systemic Glucocorticoids

*Length of Authorization: 1 year*

### NO PA REQUIRED

CORTISONE ACETATE†  
DEXAMETHASONE†  
HYDROCORTISONE† (compare to Cortef®)  
METHYLPREDNISOLONE† (compare to Medrol®)  
ORAPRED® oral solution/ODT (prednisolone sod phosphate) (age < 12 yrs)  
PREDNISOLONE† tabs / liquid (compare to Pediapred®, Prelone®)  
PREDNISONE†

### PA REQUIRED

Celestone®  
Cortef®\*  
Medrol®\*  
Millipred® (prednisolone) oral solution  
Orapred® oral solution (age ≥ 12 yrs)  
Orapred® ODT (age ≥ 12 yrs)  
Pediapred®\*  
Prelone®\*\*  
Veripred® 20 oral solution (prednisolone sodium phosphate)

## Pulmonary: Leukotriene Modifiers

*Length of Authorization: 1 year*

### NO PA REQUIRED

ACCOLATE® (zafirlukast)  
SINGULAIR® (montelukast sodium)

### PA REQUIRED

ZyFlo® (zileuton) §  
ZyFlo® CR (zileuton SR) §

## Pulmonary: RSV Prevention

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

**Quantity limits apply**

**\*\*Must be obtained through Specialty Pharmacy Provider, Wilcox Home Infusion\*\***

### 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: 1 year*

### NO PA REQUIRED

CALCIUM ACETATE † (compare to Phos Lo®)  
FOSRENOL® (lanthanum carbonate)  
RENAGEL® (sevelamer)

### PA REQUIRED

Phos Lo®\* (calcium acetate)  
Renvela® (sevelamer carbonate)

## Rheumatoid, Juvenile & Psoriatic Arthritis: Immunomodulators

**\*\*Effective 02/16/09, Self-injectables (Enbrel®, Humira® and Kineret®) must be obtained through Specialty Pharmacy Provider, ICORE\*\***

*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)

### PDL Key:

† Generic product

\* Indicates a generic equivalent is available without PA

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## Sedative/Hypnotics

Length of Authorization: 1 year

Quantity limits apply

### NO PA REQUIRED

ESTAZOLAM† (compare to Prosom®)  
FLURAZEPAM† (compare to Dalmane®)  
TEMAZEPAM† 15 mg, 30 mg (compare to Restoril®)

### PA REQUIRED

#### Benzodiazepine

Dalmane®\* (flurazepam)  
Doral® (quazepam)  
Halcion® (triazolam)  
Prosom®\* (estazolam)  
Restoril®\* (temazepam)  
temazepam† 7.5 mg, 22.5 mg (compare to Restoril®)  
triazolam† (compare to Halcion®)

#### Non-benzodiazepine, Non-barbiturate

CHLORAL HYDRATE† syrup, suppository  
ZOLPIDEM † (compare to Ambien®)(Quantity Limit = 1 tab/day)  
ZALEPLON † (compare to Sonata®)  
(Quantity Limit = 1 cap/day (5 mg) or 2 caps/day (10 mg))

Ambien®\* (zolpidem) (Quantity Limit = 1 tab/day)  
Ambien CR® (zolpidem) (Quantity Limit = 1 tab/day)  
Lunesta® (eszopiclone) (Quantity Limit = 1 tab/day)  
Rozerem® (ramelteon) (Quantity Limit = 1 tab/day)  
Somnote® (chloral hydrate capsule)  
Sonata®\* (zaleplon) (Quantity Limit = 1 cap/day (5 mg) or 2 caps/day (10 mg))

## 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®)  
ORPHENADRINE CITRATE ER† (previously Norflex®)  
ORPHENADRINE, ASA, CAFFEINE† (previously Norgestic®)

ASA = aspirin

### PA REQUIRED

#### Musculoskeletal Agents

Amrix® (cyclobenzaprine sustained-release)  
carisoprodol† (compare to Soma®)  
carisoprodol, ASA† (compare to Soma Compound®)  
carisoprodol, ASA, codeine† (compare to Soma Compound with Codeine®)  
Fexmid® (cyclobenzaprine)  
Flexeril®\* (cyclobenzaprine)  
Parafon Forte DSC®\* (chlorzoxazone)  
Robaxin®\* (methocarbamol)  
Skelaxin® (metaxalone)  
Soma® (carisoprodol)  
Soma Compound® (carisoprodol/ASA)  
Soma Compound with Codeine® (carisoprodol/ASA/codeine)

#### Antispasticity Agents

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

Dantrium®\* (dantrolene)  
Zanaflex® (tizanidine) capsules  
Zanaflex®\* (tizanidine) tablets

### PDL Key:

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## 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.

## Testosterone: Topical

*Length of Authorization: 1 year*

**Quantity limits apply**

### NO PA REQUIRED

ANDROGEL® GEL  
(testosterone 1% gel packets or pump)  
*Quantity limit = 2.5 gm packet (1 packet/day)  
5 gm packet (2 packets/day)  
Pump (4 bottles/30 days)*

### PA REQUIRED

Androderm® Transdermal 2.5 mg, 5 mg (testosterone patch) *Quantity limit = 1 patch/day/strength*  
Testim® Gel 5 gm (testosterone 1% gel tube)  
*Quantity limit = 2 tubes/day*

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## 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:

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