VERMONT	*Preferred Drug List (PDL) and Drugs Requiring Prior Authorization (PA)*	*09/19/08*

Acne Medications:
- Oral ... 3
- Topical-Anti-infectives ... 4
- Topical-Retinoids ... 5
- Topical-Rosacea ... 5

Alzheimer's Medications:
- Cholinesterase Inhibitors/NMDA Receptor Antagonists ... 5

Analgesics:
- COX-2 Inhibitors ... 6
- Local Anesthetics: Transdermal Patch ... 6
- Narcotics-Short Acting ... 6-7
- Narcotics-Long Acting ... 7
- NSAIDS ... 8

Anemia Medications:
- Hematopoietic/Erythropoietic Agents ... 8

Ankylosing Spondylitis Injectables ... 8

Anti-anxiety: Anxiolytics ... 9

Anticoagulants ... 9

Anticonvulsants ... 10

Anti-depressants:
- Novel ... 10
- SSRIs ... 11
- Tricyclics ... 11
- MAO Inhibitors ... 11

Anti-diabetics:
- Alpha Glucosidase Inhibitors ... 11
- Biguanides & Combinations ... 12
- Peptide Hormones ... 12
- Insulin ... 12
- Oral-Meglitinides ... 12
- Sulfonylureas 2nd Generation ... 13
- Thiazolidinediones & Combinations ... 13
- Dipeptidyl Peptidase Inhibitors ... 13

Anti-emetics:
- NK1/5HT3 Antagonists ... 13
- Other ... 14

Anti-hyperkinesis and Anti-Narcolepsy:
- Short/Intermediate-Acting MPH ... 14
- Long-Acting MPH ... 14
- Short/Intermed-Acting Amphetamines ... 14
- Long-Acting Amphetamines ... 14
- Non-Stimulants Products ... 14
- Xyrem ... 14

Anti-hypertensives:
- ACE Inhibitors ... 15
- ACEI with Hydrochlorothiazide ... 15
- ACE Inhibitors with CCBs ... 15
- Angiotensin Receptor Blockers ... 15
- ARBs/Hydrochlorothiazide Combos ... 15
- ARBs/CCB Combos ... 16
- Beta-Blockers ... 16
- Calcium Channel Blockers ... 17
- Renin Inhibitors ... 17

Anti-infectives:
- Cephalosporins: 1st Generation ... 17
- Cephalosporins: 2nd Generation ... 18
- Cephalosporins: 3rd Generation ... 18
- Ketolides ... 18
- Macrolides ... 18
- Oxazolidinones ... 19
- Penicillins (Oral) ... 19
- Quinolones ... 19
- Antifungal: Allylamines ... 19
- Antifungal: Azoles ... 19
- Antifungal: Topical: Onychomycosis 20
- Anti-virals: Herpes (Oral) ... 20
- Influenza Medications ... 20
- Influenza Vaccines ... 20
- Miscellaneous ... 20
- Topical Antibiotics ... 20

Anti-migraine: Triptans ... 21

Anti-obesity ... 21

Anti-psychotic:
- Atypicals & Combinations ... 22
- Typicals ... 23

Botulinum Toxins ... 23

BPH:
- Alpha Blockers ... 23
- Androgen Hormone Inhibitors ... 23

Cardiac Glycosides ... 23

Chemical Dependency ... 24

Constipation: Chronic ... 24

Contraceptives: Vaginal Ring ... 24

Coronary Vasodilators/Antianginals:
- Oral ... 24
- Topical ... 25

Cough and Cold Preparations ... 25

Dermatological Agents:
- Genital Wart Therapy ... 25
- Scabicides and Pediculicides ... 25

Desmopressin:Intranasal ... 25

Diabetic Testing Supplies ... 26

Gastrointestinals:
- Crohn's Disease Injectables ... 26
- H2-blockers ... 26
- Inflammatory Bowel (Oral/Rectal) ... 27
- Proton Pump Inhibitors ... 27
- Ulcerative Colitis Injectables ... 27

Glucocorticoids: Topical ... 28

Growth Stimulating Agents ... 29

Hepatitis C Agents ... 29

Immunomodulators: Topical ... 29

Lipotropics:
- Bile Acid Sequestrants ... 29
- Fibric Acid Derivatives ... 30
- Niacin Derivatives ... 30
- Statins ... 30
- Miscellaneous/Combinations ... 30

Miscellaneous
- Elaprase® (Hunter's Syndrome Injectable) ... 31
- Soliris® (Paroxysmal Nocturnal Hemoglobinuria Injectable) ... 31
- Somatuline® (Acromegaly Injectable) 31

Mood Stabilizers ... 31

Multiple Sclerosis: Injectables ... 31

Nutritionals, enteral ... 31

Ophthalmics:
- Antihistamines ... 32
- Glaucoma Agents/Miotics ... 32
- Mast Cell Stabilizers ... 32
- NSAIDS ... 33
- Quinolone Anti-infectives ... 33

Ossification Enhancers ... 33

Otic: Anti-infectives ... 33

Parkinson's Treatments:
- Dopamine Agonists ... 34

Phosphodiesterase-5 Inhibitors ... 34

Platelet Inhibitors ... 34

Psoriasis Injectables ... 35

Psoriasis Non-biologics ... 35

Pulmonary:
- Anticholinergics, Inhaled ... 35
- Antihistamines -Intranasal ... 35
- Antihistamines -1st Generation ... 36
- Antihistamines - 2nd Generation ... 36
- Persistent Asthma: Xolair® ... 36
- Beta-adrenergic Agents ... 37
- Inhaled Glucocorticoids ... 38
- Nasal Glucocorticoids ... 38
- Systemic Glucocorticoids ... 38
- Leukotriene Modifiers ... 38
- RSV Prevention: Synagis® ... 39

Renal Disease: Phosphate Binders ... 39

Rheumatoid and Psoriatic Arthritis:
- Immunomodulators ... 39

Saliva Stimulants ... 39

Sedative/Hypnotics ... 39

Skeletal Muscle Relaxants ... 40

Smoking Cessation Therapies ... 40

Urinary Antispasmodics ... 41

Vaginal: Anti-infectives ... 41

Vitamins: Prenatal Multivitamins ... 41

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.

MedMetrics Health Partners (MHP)
PHARMACY Call Center:

Tel: 1-800-918-7545
Available for assistance with claims processing

MHP Clinical Staff:
Diane Neal, RPh (o): 802-879-5605
(f): 802-879-5919
E-mail: diane_neal@medmetricshp.com

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

MHP Account Manager:
Nancy Hogue, Pharm.D., (o): 802-879-5604
(f): 802-879-5919
E-mail: nancy_hogue@medmetricshp.com

OVHA Medical Staff:
Associate Medical Director
Erin Cody, M.D., (o) 802-879-5920;
(f) 802-879-5963

OVHA Pharmacy Unit Staff:
Stacey Baker, (o) 802-879-5912;
(f) 802-879-5919
E-mail: Stacey.Baker@ahs.state.vt.us

Acne Drugs: Oral

Length of Authorization: 1 year

NO PA REQUIRED	PA REQUIRED
DOXYCYCLINE† 20 mg, 50 mg, 75 mg, 100 mg tab, cap	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
ERY-TAB® (erythromycin base, delayed release) ERYTHROCIN† (erythromycin stearate) ERYTHROMYCIN BASE† ERYTHROMYCIN ESTOLATE† ERYTHROMYCIN ETHYLSUCCINATE† (compare to E.E.S.®, Eryped®) ERYTHROMYCIN STEARATE†	E.E.S.®* (erythromycin ethylsuccinate) Eryc®* (erythromycin base, delayed release) Eryped® (erythromycin ethylsuccinate) PCE Dispertab® (erythromycin base) All other brands
MINOCYCLINE† 50 mg, 75 mg, 100 mg	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
TETRACYCLINE† 250 mg, 500 mg cap SUMYCIN† 250 mg, 500 mg cap	Sumycin® (tetracycline) 250 mg, 500 mg tab Sumycin® (tetracycline) 125 mg/5ml syrup All other brands
ISOTRETINOIN† 10 mg, 20 mg, 40 mg cap (SOTRET, CLARAVIS, AMNESTEEM)	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	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* †	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
CLINDAMYCIN PRODUCTS	
CLINDAMYCIN 1% *S, G, L, P* †	Cleocin-T®* (clindamycin 2% G) Evoclin® (clindamycin 2% F) Clindagel® (clindamycin 1% G) All other brands
ERYTHROMYCIN PRODUCTS	
ERYTHROMYCIN 2% *S, G, P* †	Akne-Mycin® (erythromycin 2% O) Erygel®* (erythromycin 2% G) All other brands
SODIUM SULFACETAMIDE PRODUCTS	
SODIUM SULFACETAMIDE 10% *L*†	Klaron®* (sodium sulfacetamide 10% L) All other brands
COMBINATION PRODUCTS	
ERYTHROMYCIN / BENZOYL PEROXIDE†	Benzaclin®, DUAC® (clindamycin/benzoyl peroxide) Benzamycin®* (erythromycin/benzoyl peroxide) Sulfoxyl (erythromycin/benzoyl peroxide) Z-Clinz® (clindamycin/benzoyl peroxide kit) All other brands
SODIUM SULFACETAMIDE / SULFUR *L*† SODIUM SULFACETAMIDE / SULFUR *W* †	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
OTHER	
	Azelex® (azelaic acid 20% *C*) All other brands any topical acne anti-infective medication

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

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Acne Drugs: Topical – Retinoids

Length of Authorization: 1 year

NO PA REQUIRED

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

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

C=cream, G=gel

PA REQUIRED

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

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

Avage® (tazarotene) ♣

Renova® (tretinoin) ♣

Solage® (tretinoin/mequinol) ♣

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

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

Acne Drugs: Topical – Rosacea

Length of Authorization: 1 year

NO PA REQUIRED

METRONIDAZOLE† 0.75% *C, G, L*

C=cream, G=gel, L=lotion

PA REQUIRED

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

Finacea® (azelaic acid) 15% *G*

Alzheimer's Medications: Cholinesterase Inhibitors/NMDA Receptor Antagonists

Length of Authorization: 1 year

NO PA REQUIRED

CHOLINESTERASE INHIBITORS

ARICEPT® (donepezil) Tablet (QL = 1 tablet/day)
EXELON® (rivastigmine) Capsule (QL = 2 capsules/day)

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

EXELON® (rivastigmine) Oral Solution

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

NMDA RECEPTOR ANTAGONIST

NAMENDA® (memantine) Tablet

NAMENDA® (memantine) Oral Solution

PA REQUIRED

Cognex® (tacrine) Capsule §
Razadyne® (galantamine) Tablet §
Razadyne ER® (galantamine) Capsule §

Razadyne® (galantamine) Oral Solution §

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Analgesics: COX-2 Inhibitors
Length of Authorization: 1 year
Quantity limits apply

NO PA REQUIRED	PA REQUIRED
CELEBREX® (celecoxib) (age ≥ 60 yrs) *(QL = 2 capsules/day)*	Celebrex® (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® 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® w/codeine)
ACETAMINOPHEN W/HYDROCODONE† (compare to Vicodin®, Lorcet®, Maxidone®, Norco®, Zydone®)
(QL 5/500 = 8 tablets/day, 10/500 = 8 tablets/day, 7.5/750 = 5 tablets/day)
ACETAMINOPHEN W/OXYCODONE† (compare to Percocet®)
(QL 10/650 = 6 tablets/day)
ACETAMINOPHEN W/PROPOXYPHENE† (compare to Darvocet-N®)
(QL 100/650 = 6 tablets/day)
ASPIRIN W/CODEINE†
ASPIRIN W/OXYCODONE† (compare to Percodan®)
BUTALBITAL COMP. W/CODEINE† (compare to Fiorinal® w/codeine)
CODEINE SULFATE†
DIHYDROCODEINE COMPOUND† (compare to Synalgos-DC®)
HYDROCODONE† (plain, w/acetaminophen, or w/ibuprofen)
HYDROMORPHONE† (compare to Dilaudid®)
MEPERIDINE† (compare to Demerol®) (30 tabs or 5 day supply)
MORPHINE SULFATE†
MORPHINE SULFATE† (compare to Roxanol®)
OXYCODONE† (plain, w/acetaminophen or w/ibuprofen)
PENTAZOCINE† (compare to Talwin®)
PROPOXYPHENE† (compare to Darvon®)
PROPOXYPHENE COMPOUND.† (compare to Darvon Compound ®)
PROPOXYPHENE N W/ ACETAMINOPHEN†
ROXICET® (oxycodone w/ acetaminophen)
ROXICODONE INTENSOL® (oxycodone w/ acetaminophen)
ROXICODONE® (oxycodone HCL)
TRAMADOL† (compare to Ultram®)
TRAMADOL/APAP† (compare to Ultracet®)

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

PDL Key:
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continued from previous page

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

Analgesics: Narcotics-Long Acting

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

Quantity limits apply

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

NO PA REQUIRED

TRANSDERMAL

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

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

ORAL

METHADONE† (compare to Dolophine®) 5 mg, 10 mg

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

PA REQUIRED

Duragesic-12® 12.5 mcg/hr *(QL=15 patches/30 days)*
Duragesic®* 25 mcg/hr, 50 mcg/hr, *(QL=15 patches/30 days)*
Duragesic®* 75 mcg/hr, 100 mcg/hr *(QL= 30 patches/30 days)*
Fentanyl Patch† (compare to Duragesic®) 12.5 mcg/hr *(QL=15 patches/30 days)*

Avinza® (morphine sulfate XR) *(QL= 30 capsules/strength/30 days)*
Dolophine®* (methadone)
Kadian® (morphine sulfate XR) *(QL= 60 capsules/strength/30 days)*
Methadone 40 mg Dispersible Tablets §
MS Contin®* (morphine sulfate ER) (QL=90 tablets/strength/30 days)
Opana ER® (oxymorphone ER) (QL=60 tablets/strength/30 days)
Oramorph SR®* (morphine sulfate ER) (QL=90 tablets/strength/30 days)
Oxycodone ER† *(QL=90 tablets/strength/30 days)*
OxyContin® *(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*
Mefanamic acid† (compare to Ponstel®)
meloxicam†susp (compare to Mobic®)
Mobic®*
Motrin®*
Nalfon®*
Naprelan®*
Naprosyn®*
Ponstel®
Voltaren®*
Voltaren XR® *

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

Anemia: Hematopoietic/Erythropoietic Agents
Length of Authorization: 1 year

NO PA REQUIRED

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

PA REQUIRED

Epogen® (epoetin alpha)

Ankylosing Spondylitis: Injectables
Length of Authorization: Initial PA 3 months; 12 months thereafter

Therapy-specific PA fax form available on OVHA website.

PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

ENBREL® (etanercept)
HUMIRA® (adalimumab)

NON-PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

Remicade® (infliximab)

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Anti-anxiety: Anxiolytics
Length of Authorization: 1 year

NO PA REQUIRED	PA REQUIRED
ALPRAZOLAM† (compare to Xanax®)	Ativan®*
ALPRAZOLAM XR† (compare to Xanax XR®)	Buspar®*
BUSPIRONE† (compare to Buspar®)	Klonopin®*
CHLORDIAZEPOXIDE† (compare to Librium®)	Klonopin Wafers®
CLONAZEPAM† (compare to Klonopin®)	Librium®*
CLONAZEPAM ODT† (compare to Klonopin Wafers®)	Niravam® (alprazolam ODT)
CLORAZEPATE† (compare to Tranxene®)	Serax®*
DIAZEPAM† (compare to Valium®)	Tranxene®* (all brand forms)
LORAZEPAM† (compare to Ativan®)	Valium®*
MEPROBAMATE†	Xanax®*
OXAZEPAM† (compare to Serax®)	Xanax XR®

Anticoagulants
Length of Authorization: 6 months
Quantity limits apply

NO PA REQUIRED	PA REQUIRED
WARFARIN† (compare to Coumadin®)	Coumadin®* (warfarin)
HEPARIN†	n/a
FRAGMIN® (dalteparin) LOVENOX® (enoxaparin) *(QL = 2 syringes/day calculated in ml volume)* ARIXTRA® (fondiparinux)	Innohep® (tinzaparin)

PDL Key:

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Anticonvulsants

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

NO PA REQUIRED

CARBAMAZEPINE† (compare to Tegretol®)
CARBATROL® (carbamazepine)
CELONTIN® (methsuxamide)
CLONAZEPAM† (compare to Klonopin®)
CLONAZEPAM ODT† (compare to Klonopin Wafers®)
DEPAKOTE® (divalproex sodium)
DEPAKOTE ER® (divalproex sodium)
DIASTAT® (diazepam rectal gel)
DILANTIN® (phenytoin)
EPITOL† (carbamazepine)
ETHOSUXAMIDE† (compare to 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)
Lyrica® (pregabalin) § *(Quantity Limit = 3 capsules/day)*
Mysoline®* (primidone)
Neurontin®* (gabapentin)
oxcarbazepine † (compate to Trileptal®)
Tegretol®* (carbamazepine)
Zarontin®* (ethosuxamide)
Zonegran®* (zonisamide)

Anti-depressants: Novel

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

Quantity limits apply

NO PA REQUIRED

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

PA REQUIRED

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

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Anti-depressants: SSRIs

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

Quantity limits apply

NO PA REQUIRED	PA REQUIRED
CITALOPRAM† (compare to Celexa®) *suggested max dose = 75 mg/day* FLUOXETINE† (compare to Prozac®) *suggested max dose = 100 mg/day* FLUVOXAMINE† (compare to Luvox®) *suggested max dose = 300 mg/day* PAROXETINE tablet† (compare to Paxil®) *suggested max dose = 75 mg/day* SERTRALINE† (compare to Zoloft®) *suggested max dose = 250 mg/day, QL = 1.5 tabs/day (25 mg & 50 mg tabs)*	Celexa®* *suggested max dose = 75 mg/day* Lexapro® *suggested max dose = 25 mg/day, QL = 1.5 tabs/day (5 mg & 10 mg tabs)* Luvox®* *suggested max dose = 300 mg/day* paroxetine suspension† (compare to Paxil® susp) *suggested max dose = 75 mg/day* paroxetine† CR (compare to Paxil CR®) *suggested max dose = 75 mg/day* Paxil®* *suggested max dose = 75 mg/day* Paxil CR® *suggested max dose = 75 mg/day* Pexeva® *suggested max dose = 75 mg/day* Prozac®* *suggested max dose = 100 mg/day* Prozac Weekly® *suggested max weekly dose = 540 mg* Sarafem® *suggested max dose = 100 mg/day* Selfemra® Zoloft® *suggested max dose = 250 mg/day , QL = 1.5 tabs/day (25 mg & 50 mg tabs)*

Anti-depressants: Tricyclics

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

NO PA REQUIRED	PA REQUIRED
AMITRIPTYLINE† (compare to Elavil®) *suggested max dose = 375 mg/day* AMITRIPTYLINE/CHLORDIAZ.† (compare to Limbitrol®) AMITRIPTYLINE/PERPHEN†.(compare to Etrafon®, Triavil®) AMOXAPINE† (compare to Asendin®) CLOMIPRAMINE† (compare to Anafranil®) DESIPRAMINE† (compare to Norpramin®) DOXEPIN† (compare to Sinequan®) IMIPRAMINE† (compare to Tofranil®) *suggested max dose = 250 mg/day* NORTRIPTYLINE† (compare to Aventyl®, Pamelor®) TOFRANIL PM® (imipramine pamoate) TRIMIPRAMINE† (compare to Surmontil®) VIVACTIL® (protriptyline)	Anafranil®* Aventyl®* Elavil®* Limbitrol®* Limbitrol DS® Norpramin®* Pamelor®* Sinequan®* Surmontil®* Tofranil®*

Anti-depressants: MAO Inhibitors

Length of Authorization: Duration of Need for Mental Health Indications

Quantity limits apply

NO PA REQUIRED	PA REQUIRED
NARDIL® (phenylzine) *suggested max dose = 110 mg/day* TRANYLCYPROMINE† (compare to Parnate®) *suggested max dose = 120 mg/day*	EMSAM® (selegiline) *(QL = 1 patch/day)* Marplan® (isocarboxazid) Parnate®*

Anti-diabetics: Alpha-Glucosidase Inhibitors

Length of Authorization: 1 year

NO PA REQUIRED	PA REQUIRED
ACARBOSE† (compare to Precose®) GLYSET® (miglitol)	PRECOSE®* (acarbose)

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Anti-diabetic: Biguanides & Combinations
Length of Authorization: 1 year

NO PA REQUIRED	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)	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	PA REQUIRED
Byetta® (exenatide) § (*Quantity Limit =1 pen/30 days)*	Symlin® (pramlintide) *No Quantity Limit*

Anti-diabetics: Insulins
Length of Authorization: lifetime

NO PA REQUIRED	PA REQUIRED
<u>RAPID-ACTING INJECTABLE</u>	
NOVOLOG® (Aspart)	Apidra® (insulin glulisine) Humalog® (insulin lispro)
<u>SHORT-ACTING INJECTABLE</u>	
NOVOLIN R® (Regular)	Humulin R® (Regular) ReliOn R® (Regular)
<u>INTERMEDIATE-ACTING INJECTABLE</u>	
NOVOLIN N® (NPH)	Humulin N® (NPH) ReliOn N® (NPH)
<u>LONG-ACTING ANALOGS INJECTABLE</u>	
LANTUS® (insulin glargine) LEVEMIR® (insulin detemir)	
<u>MIXED INSULINS INJECTABLE</u>	
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)	Humulin 70/30® (NPH/Regular) ReliOn 70/30® (NPH/Regular)

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

NO PA REQUIRED	PA REQUIRED
STARLIX® (nateglinide)	Prandin® (replaglinide)

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Anti-diabetic: Sulfonylureas 2nd Generation
Length of Authorization: 1 year

NO PA REQUIRED	PA REQUIRED
GLIMEPIRIDE† (compare to Amaryl®)	Amaryl®*
GLIPIZIDE† (compare to Glucotrol®)	Diabeta®*
GLIPIZIDE ER† (compare to Glucotrol XL®)	Glucotrol®*
GLYBURIDE† (compare to Diabeta®, Micronase®)	Glucotrol XL®*
GLYBURIDE MICRONIZED† (compare to Glynase® PresTab®)	Glynase® PresTab®*
	Micronase®*

Anti-diabetic: Thiazolidinediones & Combinations
Length of Authorization: 1 year
Quantity limits apply

PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET	NON-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)*	

Anti-diabetic: Dipeptidyl Peptidase (DPP-4) Inhibitors
Length of Authorization: 1 year
Quantity limits apply

PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET	NON-PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET
JANUVIA® (sitagliptin) § *(Quantity Limit = 1 tablet/day)*	
JANUMET® (sitagliptin/metformin) § *(Quantity Limit = 2 tablets/day)*	

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	PA REQUIRED
EMEND® (aprepitant) 40 mg (1 cap/30 days)	Aloxi® (palonosetron, injectable) (2 vials/month)
♣EMEND® (aprepitant) 80 mg (2 caps/30 days)	Anzemet® (dolansetron) 50 mg (4 tabs/month)
♣EMEND® (aprepitant) 125 mg (1 cap/30 days)	Anzemet® (dolansetron) 100 mg (2 tabs/month)
♣EMEND® (aprepitant) Tri-fold Pack (1 pack/30 days)	Granisetron† (compare to Kytril®) 1 mg (6 tabs/month)
ONDANSETRON† Injection (vial and premix)	Granisetron† (compare to Kytril®) Injectable
ONDANSETRON†tablet 4 mg (12 tabs/month), 8 mg (6 tabs/month)	Granisetron† (compare to Kytril®) Oral Solution
ONDANSETRON† ODT 4 mg (12 tabs/month), 8 mg (6 tabs/month)	Kytril® (granisetron) 1 mg (6 tabs/month)
	Kytril® (granisetron) Injectable
♣ *To be prescribed by oncology practitioners ONLY*	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

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Anti-emetics: Other

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

Quantity limits apply

NO PA REQUIRED	PA REQUIRED
	Dronabinol† (compare to Marinol®) *(Quantity Limit = 30 days supply for AIDS anorexia or quantity required for one chemotherapy treatment course)*
	Marinol® (dronabinol) *(Quantity Limit = 30 days supply for AIDS anorexia or quantity required for one chemotherapy treatment course)*
	Cesamet® (nabilone) *(Quantity Limit = quantity required for one chemotherapy treatment course)*

Antihyperkinesis: 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	PA REQUIRED
SHORT/INTERMEDIATE ACTING METHYLPHENIDATE PREPS	
METADATE ER® (compare to Ritalin® SR)	Dexmethylphenidate (compare to Focalin®)
METHYLIN® (compare to Ritalin®)	Focalin® (dexmethylphenidate)
METHYLIN® ER (compare to Ritalin® SR)	Ritalin®*
METHYLPHENIDATE† (compare to Ritalin®)	Ritalin SR®*
METHYLPHENIDATE SR† (compare to Ritalin® SR)	
LONG-ACTING METHYLPHENIDATE PREPS	
FOCALIN® XR (dexmethylphenidate IR.ER, 50:50%)	Metadate CD® (methylphenidate, IR/ER, 30:70%)
CONCERTA® (methylphenidate IR/ER 22:78%)	Ritalin LA® (methylphenidate, IR/ER, 50:50%)
DAYTRANA® (methylphenidate patch) *(QL = 1 patch/day)*	
SHORT/INTERMEDIATE AMPHETAMINE PREPS	
AMPHETAMINE salt combination† (compare to Adderall®)	Adderall®*
DEXTROAMPHETAMINE†	Desoxyn® (methamphetamine)
DEXTROAMPHETAMINE CR† (compare to Dexedrine CR®)	Dexedrine®* (CR)
DEXTROSTAT†	
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) *max dose = 100 mg/day*
	Xyrem® (sodium oxybate)

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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 Univasc®)
QUINAPRIL† (compare to Accupril®)

PA REQUIRED

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

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®)
QUINAPRIL/HYDROCHLOROTHIAZIDE† (compare to Accuretic®)

PA REQUIRED

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

Anti-hypertensives: ACE Inhibitor w/Calcium Channel Blocker
Length of Authorization: 1 year

NO PA REQUIRED

BENAZEPRIL/AMLODIPINE † (compare to Lotrel®)

PA REQUIRED

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

Anti-hypertensives: Angiotensin Receptor Blockers (ARBs)
Length of Authorization: lifetime

PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

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

NON-PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

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

Anti-hypertensives: Angiotensin Receptor Blocker/Hydrochlorothiazide Combinations
Length of Authorization: lifetime

PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

AVALIDE® (irbesartan/hydrochlorothiazide) §
BENICAR HCT® (olmesartan/hydrochorothiazide) §
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) §

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Anti-hypertensives: Angiotensin Receptor Blocker/Calcium Channel Blocker Combinations

Length of Authorization: lifetime

Quantity limits apply

PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET	NON-PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET
EXFORGE® (valsartan/amlodipine) § *(Quantity Limit = 1 tablet/day)*	Azor® (olmesartan/amlodipine) *(Quantity Limit = 1 tablet/day)*

Anti-hypertensives: Beta Blockers

Length of Authorization: 5 years

NO PA REQUIRED

<u>SINGLE AGENT</u>

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

<u>BETA-BLOCKER/DIURETIC COMBINATION</u>

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

PA REQUIRED

Betapace®*
Betapace AF®*
Blocadren®*
Cartrol®
Coreg®
Coreg CR®
Corgard®
Inderal®* (all products)
Inderal LA®
Innopran XL®
Kerlone®*
Levatol® (penbutolol)
Lopressor®* (all products)
propranolol ER† (compare to Inderal LA®)
Sectral®*
Tenormin®*
Timolide®
Toprol XL®* (metoprolol succinate)
Trandate®*
Zebeta®*

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

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Anti-hypertensives: Calcium Channel Blockers
Length of Authorization: 5 years
Quantity limits apply

NO PA REQUIRED

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

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

PA REQUIRED

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

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

Anti-hypertensives: Renin Inhibitor
Length of Authorization: lifetime
Quantity limits apply

PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

SINGLE AGENT
TEKTURNA® (aliskiren) § *(Quantity Limit = 1 tablet/day)*

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

NON-PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

Anti-infectives: Cephalosporins – 1st 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®*

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Anti-infectives: Cephalosporins – 2nd Generation
Length of Authorization: for date of service, only: no refills

NO PA REQUIRED	PA REQUIRED
TABLETS	
CEFACLOR CAPSULE†	Ceftin®* tablet
CEFACLOR ER TABLET†	Cefzil® tablet
CEFPROZIL TABLET† (compare to Cefzil®)	Lorabid® (loracarbef) capsule
CEFUROXIME TABLET† (compare to Ceftin®)	
SUSPENSION	
CEFACLOR SUSPENSION†	Cefuroxime† Suspension (compare to Ceftin®)
CEFPROZIL SUSPENSION† (compare to Cefzil®)	Cefzil® suspension
CEFTIN® (cefuroxime) SUSPENSION	Lorabid® (loracarbef) suspension
IV drugs are not managed at this time	

Anti-infectives: Cephalosporins – 3rd Generation
Length of Authorization: for date of service, no refills

NO PA REQUIRED	PA REQUIRED
CAPSULES/TABLETS	Cedax® capsule (ceftibuten)
CEFPODOXIME PROXETIL TABS† (compare to Vantin®)	cefdinir capsule†
OMNICEF® CAPSULE (cefdinir)	Spectracef® tablet (cefditoren)
	Vantin®* tablet (cefpodoxime)
SUSPENSION	
OMNICEF® SUSPENSION(cefdinir)	Cedax® suspension (ceftibuten)
SUPRAX® SUSPENSION (cefixime)	cefdinir suspension †
	cefpodoxime proxetil† (compare to Vantin®) suspension
IV drugs are not managed at this time	Vantin® suspension (cefpodoxime)

Anti-infectives: Ketolides
Length of Authorization: for date of service, no refills

NO PA REQUIRED	PA REQUIRED
	Ketek® (telithromycin)

Anti-infectives: Macrolides
Length of Authorization: for date of service, no refills

NO PA REQUIRED	PA REQUIRED
AZITHROMYCIN† tablets (≤5 day supply) (compare to Zithromax®)	azithromycin† tablets and liquid (if > 5 day supply)
AZITHROMYCIN† liquid (≤ 5 day supply) (compare to Zithromax®)	Biaxin®*
	Biaxin XL®
CLARITHROMYCIN† (compare to Biaxin/Biaxin XL)	Dynabac® (dirithromycin)
	E.E.S.®*
ERY-TAB® (erythromycin base, delayed release)	Eryc®* (erythromycin base, delayed release)
ERYTHROCIN† (erythromycin stearate)	Eryped® (erythromycin ethylsuccinate)
ERYTHROMYCIN BASE†	PCE Dispertab® (erythromycin base)
ERYTHROMYCIN ESTOLATE†	Pediazole®* (erythromycin-sulfisoxazole)
ERYTHROMYCIN ETHYLSUCCINATE† (compare to E.E.S.®, Eryped®)	Zithromax® tablets and liquid
ERYTHROMYCIN STEARATE†	Zmax® (azithromycin extended release oral suspension)
ERYTHROMYCIN W/ SULFASOXAZOLE† (compare to Pediazole®)	
IV drugs are not managed at this time	

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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)

Anti-infectives: Antifungal: Allylamines
Length of Authorization: Up to 3 months
Quantity limits apply

NO PA REQUIRED

PA REQUIRED

terbinafine† tabs (compare to Lamisil®) *QL = 30 tablets/month*
Lamisil® tablets (terbinafine HCL) *QL = 30 tablets/month*

Anti-infectives: Antifungal: Azoles
Length of Authorization: Up to 3 months

NO PA REQUIRED

FLUCONAZOLE† (compare to Diflucan®)
KETOCONAZOLE† (compare to Nizoral®)

IV drugs are not managed at this time.

PA REQUIRED

Itraconazole† (compare to Sporanox®)
Sporanox® (itraconazole)
Vfend® (voriconazole)
Diflucan®* (fluconazole)
Nizoral®* (ketoconazole)
Noxafil® (posaconazole)

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: Antifungal: Topical: Onychomycosis

Length of Authorization: 1 year

Monthly quantity limits apply

NO PA REQUIRED

PA REQUIRED

Cicloprirox † 8 % solution (compare to Penlac® Nail Lacquer) *QL =6.6 ml/90 days*
Penlac® Nail Lacquer (ciclopirox 8 % solution) *QL = 6.6 ml/90 days*

Anti-infectives: Anti-virals: Herpes (Oral)

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

NO PA REQUIRED

ACYCLOVIR† (compare to Zovirax®)
VALTREX® (valacyclovir)

PA REQUIRED

Famciclovir † (compare to Famvir®)
Famvir® (famciclovir) §
Zovirax®* §

Anti-infectives: Influenza Medications

Length of Authorization: for duration of prescription, up to 3 months.

Quantity limits apply

NO PA REQUIRED (During Flu Season Nov 1st – March 31st)

RELENZA® (zanamivir) *QL= 20 blisters / 30 days*
TAMIFLU® (oseltamivir) *QL=10 capsules/30 days(45 mg & 75 mg caps)*
20 capsules / 30 days (30 mg caps)
75 ml /30 days (suspension)

PA REQUIRED

amantadine† PA for quantity ≤ *10 days supply (Not CDC recommended for use in influenza)*
Flumadine® (rimantidine) *(Not CDC recommended for use in influenza)*
rimantadine† *(Not CDC recommended for use in influenza)*
Symmetrel® (amantadine) *(Not CDC recommended for influenza)*

Anti-infectives: Influenza Vaccines

Length of Authorization: for date of service only

NO PA REQUIRED

AFLURIA® Injection
FLUARIX® Injection
FLUZONE® Injection
FLUVIRIN® Injection

PA REQUIRED

FluMist® Nasal

Anti-infectives: Miscellaneous

Length of Authorization: 1 year

NO PA REQUIRED

PA REQUIRED

Qualaquin® (quinine sulfate)

Anti-infectives: Topical Antibiotics

Length of Authorization: for date of service, no refills

Quantity limits apply

NO PA REQUIRED

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

PA REQUIRED

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

PDL Key:

† Generic product
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Anti-migraine: Triptans

Length of Authorization: 6 months

Monthly quantity limits apply, PA required to exceed.

NO PA REQUIRED, Quantity Limits Apply

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

PA REQUIRED, Quantity Limits Apply

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

Anti-obesity

Length of Authorization: 6 months for initial approval, may renew for additional 6 months if patient has met target goals.

Quantity limits apply

Therapy specific PA fax form available on OVHA website.

NO PA REQUIRED

PA REQUIRED

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

PDL Key:

† Generic product
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Anti-psychotic: Atypical & Combinations
Length of Authorization: Duration of Need
Quantity limits apply

NO PA REQUIRED	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*	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)*
ORAL SOLUTIONS RISPERDAL® (risperidone) oral solution *FDA maximum recommended dose = 16 mg/day*	Abilify® (aripiprazole) oral solution *FDA maximum recommended dose = 25 mg/day*
SHORT-ACTING INJECTABLE PRODUCTS GEODON® IM (ziprasidone intramuscular injection) *FDA maximum recommended dose = 40 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*
LONG-ACTING INJECTABLE PRODUCTS	Risperdal® Consta (risperdone microspheres) *FDA maximum recommended dose = 50 mg/14 days*
ORALLY DISINTEGRATING TABLETS	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)*
COMBINATION PRODUCTS	Symbyax® (olanzapine/fluoxetine) *FDA maximum recommended dose = 18 mg/75 mg (perday)*

PDL Key:
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Anti-psychotic: Typicals

Length of Authorization: Duration of Need for Mental Health Indications

NO PA REQUIRED	PA REQUIRED
CHLORPROMAZINE† (compare to Thorazine®)	Haldol®*
FLUPHENAZINE† (compare to Prolixin®, Prolixin®)	Loxitane®*
HALOPERIDOL† (compare to Haldol®)	Mellaril®*
LOXAPINE† (compare to Loxitane®)	Navane®*
MOBAN® (molindone)	Prolixin®*
PERPHENAZINE† (compare to Trilafon®)	Thorazine®*
THIORIDAZINE† (compare to Mellaril®)	Trilafon®*
THIOTHIXENE† (compare to Navane®)	
TRIFLUOPERAZINE† (compare to Stelazine®)	

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	PA REQUIRED
DOXAZOSIN† (compare to Cardura®)	Cardura®*, Cardura XL®
FLOMAX® (tamsulosin)	Hytrin®*
TERAZOSIN† (compare to Hytrin®)	
UROXATRAL® (alfuzosin)	

BPH: Androgen Hormone Inhibitors

Length of Authorization: 1 year

Quantity limits apply

NO PA REQUIRED	PA REQUIRED
AVODART® (dutasteride) *(QL = 1 capsule/day)*	Avodart® (dutasteride) females; males age < 45 *(QL = 1 capsule/day)*
FINASTERIDE† (compare to Proscar®) *(QL = 1 tablet/day)*	finasteride† (compare to Proscar®) females; males age < 45 *(QL = 1 tablet/day)*
PROSCAR® (finasteride) *(QL = 1 tablet/day)*	Proscar® (finasteride) females; males age < 45 *(QL = 1 tablet/day)*

Cardiac Glycosides

Length of Authorization: n/a

NO PA REQUIRED	PA REQUIRED
DIGITEK® (digoxin)	
DIGOXIN†	
LANOXICAPS® (digoxin)	
LANOXIN® (digoxin)	

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	PA REQUIRED
Alcohol Dependency	
ANTABUSE® (disulfiram) CAMPRAL® (acamprosate) NALTREXONE oral † (compare to Revia®)	Revia®* (naltrexone oral) Vivitrol® (naltexone for extended-release injectable suspension) *(QL = 1 injection (380 mg) per 30 days)*
Opiate Dependency	
NALTREXONE oral † (compare to Revia®) Note: Methadone for opiate dependency can only be prescribed through a Methadone Maintenance Clinic	Revia®* (naltrexone oral) Suboxone® (buprenorphine with naloxone): 2 mg/0.5 mg and 8 mg/2 mg tablet Subutex® (buprenorphine): 2 mg and 8 mg tablets

Constipation: Chronic or IBS-C

Length of Authorization: 3 months
Quantity limits apply

NO PA REQUIRED	PA REQUIRED
Bulk-Producing Laxatives PSYLLIUM† **Osmotic Laxatives** LACTULOSE† POLYETHYLENE GLYCOL 3350 (PEG)† (compare to Miralax®)	Amitiza® (lubiprostone) *(Qty Limit = 2 capsules/day)*

Contraceptives: Vaginal Ring

Length of Authorization: n/a

NO PA REQUIRED	PA REQUIRED
NUVARING® (etonogestrel/ethinyl estradiol vaginal ring)	

Coronary Vasodilators/Antianginals: Oral

Length of Authorization: 3 years
Quantity limits apply

NO PA REQUIRED	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)	Dilatrate-SR® (isosorbide dinitrate SR capsule) Imdur®* (isosorbide mononitrate ER tablet) Ismo®* (isosorbide mononitrate tablet) Isordil®* (isosorbide dinitrate tablet) Monoket®* (isosorbide mononitrate tablet) BiDil® (isosorbide dinitrate/hydralazine) Ranexa® (ranolazine) *(Quantity Limit = 3 tablets/day (500 mg), 2 tablets/day (1000 mg)))*

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Coronary Vasodilators/Antianginals: Topical

Length of Authorization: 3 years

NO PA REQUIRED	PA REQUIRED
NITREK® (nitroglycerin transdermal patch) NITRO-BID® (nitroglycerin ointment) NITROGLYCERIN TRANSDERMAL PATCHES† (compare to Nitro-Dur®)	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	PA REQUIRED
All generics MUCINEX® (guaifenesin)	Tussionex® (hydrocodone/chlorpheniramine) *(Quantity Limit = 60 ml)* All other brands

Dermatological Agents: Genital Wart Therapy

Length of Authorization: 1 month

NO PA REQUIRED	PA REQUIRED
ALDARA® (imiqumod)	
PODOFILOX SOLUTION† (compare to Condylox®)	Condylox® Gel (podofilox gel) Condylox®* solution (podofilox solution)

Dermatological Agents: Scabicides and Pediculocides

Length of Authorization: date of service only, no refills

NO PA REQUIRED	PA REQUIRED
EURAX® (crotamiton) *C, L* NIX® (permethrin) *CR, G, Sp* permethrin† (compare to Elimite®) *C* permethrin† *L* piperonyl butoxide and pyrethrins† *G, S, Sh* RID® (piperonyl butoxide and pyrethrins) *G, Sh, Sp* All other brand and generic Scabicides and Pediculicides	Elimite®* (permethrin 5 %) *C* Lindane† *L, Sh* Ovide® (malathion) *L*

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

Desmopressin: Intranasal

Length of Authorization: 2 years

NO PA REQUIRED	PA REQUIRED
	DDAVP® (desmopressin) Nasal Solution or Spray 0.01% Desmopressin † Nasal Solution or Spray 0.01 % (compare to DDAVP®) Minirin † (desmopressin) Nasal Spray 0.01% Stimate® (desmopressin) Nasal Solution 1.5 mg/ml

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Diabetic Testing Supplies
Length of Authorization: 5 years

NO PA REQUIRED	PA REQUIRED
DIABETIC MONITORS/METERS	Accucheck®
FREESTYLE LITE® SYSTEM KIT	Ascensia®
FREESTYLE FLASH® SYSTEM KIT	Assure®
FREESTYLE FREEDOM® SYSTEM KIT	Exactech®
FREESTYLE FREEDOM LITE® SYSTEM KIT	Prodigy®
ONE TOUCH® ULTRA 2 KIT	
ONE TOUCH® ULTRA MINI KIT	All other brands and store brands
ONE TOUCH® ULTRA SMART KIT	
PRECISION XTRA® METER	
DIABETIC TEST STRIPS	
FREESTYLE®*	Accucheck®
FREESTYLE LITE®*	Ascensia®
ONE TOUCH® BASIC*	Assure®
ONE TOUCH® SURESTEP*	Exactech®
ONE TOUCH® FAST TAKE*	Prodigy®
ONE TOUCH® UL®TRA*	
PRECISION XTRA®*	All other brands and store brands
PRECISION XTRA® BETA KETONE (10 count)	
* 50 and 100 count package sizes	

Gastrointestinal: Crohn's Disease Injectables
Length of Authorization: Initial PA 3 months; 12 months thereafter

Therapy-specific PA fax form available on OVHA website.

PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET	NON-PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET
HUMIRA® (adalimumab)	Tysabri® (natalizumab)
REMICADE® (infliximab)	

Gastrointestinals: H2-blockers
Length of Authorization: 1 year

NO PA REQUIRED	PA REQUIRED
CIMETIDINE† (compare to Tagamet®) tablet	Axid® (nizatidine) capsule §
FAMOTIDINE† (compare to Pepcid®) tablet	nizatidine† (compare to Axid®) capsule §
RANITIDINE† (compare to Zantac®) tablet	Pepcid®* (famotidine) tablet §
	ranitidine† capsule §
	Tagamet®* tablet §
	Zantac®* tablet §
SYRUPS AND SPECIAL DOSAGE FORMS	Axid® (nizatidine) Oral Solution §
CIMETIDINE † ORAL SOLUTION	Pepcid® Oral Suspension §
ZANTAC® (ranitidine) SYRUP	ranitidine† syrup§
	Zantac Effervescent® §

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Gastrointestinals: Inflammatory Bowel Agents (Oral and Rectal Products)
Length of Authorization: 1 year

NO PA REQUIRED	PA REQUIRED
Mesalamine Products	Rowasa®* (mesalamine enema)
ASACOL® (mesalamine tablet delayed-release)	
CANASA® (mesalamine suppository)	
LIALDA® (mesalamine tablet extended-release)	
MESALAMINE ENEMA† (compare to Rowasa®)	
PENTASA® (mesalamine cap CR)	
Other	
BALSALAZIDE† (compare to Colazal®)	Azulfidine®* (sulfasalazine)
DIPENTUM® (olsalazine)	Colazal®* (balsalazide)
SULFASALAZINE† (compare to Azulfidine®)	

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	PA REQUIRED
PREVACID® (lansoprazole) capsules (*Quantity Limit=1 capsule/day)*	Aciphex® (rabeprazole) § *Qty Limit=1 tablet/day*
PREVACID® (lansoprazole) packets (*Quantity Limit=1 packet/day)*	Nexium® (esomeprazole) capsules§ *Qty Limit=1 capsule/day*
PRILOSEC OTC® (omeprazole magnesium) *No Quantity Limit*	Nexium® (esomeprazole) powder for suspension § *(Qty limit=1 packet/day)*
PROTONIX® (pantoprazole) (*Quantity Limit=1 tablet/day)*	omeprazole† generic♣ RX capsules § *Qty Limit=1 capsule/day*
	omeprazole† generic♣ OTC tablets § *Qty Limit=1 tablet/day*
H.Pylori eradication	pantoprazole† generic tablets *Qty Limit=1 tablet/day*
PREVPAC® (lansoprazole w/ H.pylori anti-bacterials) *No Quantity Limit*	Prevacid Solutabs®♠ *Qty Limit=1 tablet/day*
	Prilosec® (brand) § *Qty Limit=1capsule/day*
	Zegerid®♣ (omeprazole powder for suspension) § *Qty Limit=1 powder packet/day*
	Zegerid® (omeprazole capsules) § *Qty Limit=1 capsule/day*

Gastrointestinal: Ulcerative Colitis Injectables
Length of Authorization: Initial PA 3 months; 12 months thereafter

Therapy-specific PA fax form available on OVHA website.

NO PA REQUIRED	PA REQUIRED
	Remicade® (infliximab)

PDL Key:
† Generic product
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Glucocorticoids: Topical

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

Low Potency

NO PA REQUIRED	PA REQUIRED
ALCLOMETASONE† (compare to Aclovate®)	Aclovate®*
DESONIDE† (compare to Tridesilon®)	Cortaid®*
FLUOCINOLONE 0.01%† (compare to Synalar®)	Desonate® gel (desonide)
HYDROCORTISONE ACETATE† (all generics)	DesOwen®*
	Hytone®*
	Synalar® 0.01% * (all products)
	Tridesilon®*
	Verdeso® (desonide foam)
	All other brands

Medium Potency

NO PA REQUIRED	PA REQUIRED
BECLOMETHASONE DIPROPIONATE† (compare to Alphatrex®)	Alphatrex®*
BETAMETHASONE VALERATE† (compare to Beta-Val®)	Aristocort®* (all products)
DESOXIMETASONE 0.05%† (compare to Topicort®)	Beta-Val®*
FLUOCINOLONE 0.025%† (compare to Synalar®)	Cloderm® (clocortolone)
FLUTICASONE TOPICAL† (compare to Cutivate®)	Cordran®* (all products)
HYDROCORTISONE BUTYRATE† (compare to Locoid®)	Cutivate®*
HYDROCORTISONE VALERATE† (compare to Westcort®)	Dermatop®
MOMETASONE FUROATE† (compare to Elocon®)	Elocon®* (all products)
TRIAMCINOLONE ACETONIDE† (compare to Aristocort®)	Kenalog® (all products)
	Locoid®
	Luxiq®
	prednicarbate† (compare to Dermatop®)
	Pandel®
	Synalar®0.025 %* (all products)
	Topicort®0.05 %* (all products)
	Westcort®* (all products)
	All other brands

High Potency

NO PA REQUIRED	PA REQUIRED
AMCINONIDE† (compare to Cyclocort®)	Apexicon®*
AUGMENTED BETHAMETHASONE CREAM† (compare to Diprolene® AF)	Cyclocort®*
DESOXIMETASONE 0.25%† (compare to Topicort®)	Diprolene®AF* (all products)
DIFLORASONE DIACETATE† (compare to Apexicon®, Maxiflor®, Psorcon-E®)	Halog®* (all products)
FLUOCINOLONE 0.2%† (compare to Synalar®)	Lidex®* (all products)
FLUOCINONIDE† (compare to Lidex®)	Maxiflor®*
	Synalar®0.2 %* (all products)
	Topicort®0.25 %* (all products)
	Vanos®
	All other brands

Very High Potency

NO PA REQUIRED	PA REQUIRED
AUGMENTED BETHAMETHASONE OINTMENT† (compare to Diprolene®)	Clobex®
CLOBETASOL PROPIONATE† (compare to Temovate®)	Cormax®
CLOBETASOL PROPIONATE† FOAM (compare to Olux®)	Diprolene®* (all products)
DIFLORASONE DIACETATE EMOLL† (compare to Psorcon®)	Embeline E®*
HALOBETASOL PROPRIONATE† (compare to Ultravate®)	Olux®/Olux E®
	Psorcon®*
	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.

Therapy specific PA form is available on OVHA website.

PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET	NON-PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET
NORDITROPIN®	Genotropin®
NUTROPIN®	Humatrope®
NUTROPIN® AQ	Saizen®
	Serostim®
OMNITROPE®	Tev-Tropin®
INCRELEX® (mecasermin)	Zorbtive® (with special criteria)

Hepatitis C Agents

Length of Authorization: 6 months

Quantity limits apply

Therapy specific PA form is available on OVHA website.

PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET	NON-PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET
RIBAVIRIN	**RIBAVIRIN**
RIBAVIRIN†	Copegus®
	Ribasphere®
	Rebetol®
INTERFERON	**INTERFERON**
PEGASYS® (peg-interferon alpha 2-a) (*QL = 4 vials/28 days)*	Infergen® (interferon alphacon-1)
PEGASYS CONVENIENCE PACK® (peg-interferon alfa-2a) (*QL = 1 kit/28 days)*	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	PA REQUIRED
ELIDEL® (pimecrolimus) §	Elidel® (age < 2 yrs)
PROTOPIC® (tacrolimus) §	Protopic® (age < 2 yrs)

Lipotropics: Bile Acid Sequestrants

Length of Authorization: lifetime

NO PA REQUIRED	PA REQUIRED
CHOLESTYRAMINE† powder (compare to Questran®)	Questran®* powder (cholestyramine)
CHOLESTYRAMINE LIGHT† powder (compare to Questran Light®)	Questran Light®* powder (cholestyramine light)
PREVALITE† powder (cholestyramine light)	
	Colestid®* tablets, granules (colestipol)
COLESTIPOL† tablets, granules (compare to Colestid®)	Welchol® (colesevelam)

PDL Key:

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Lipotropics: Fibric Acid Derivatives
Length of Authorization: 1 year

NO PA REQUIRED

GEMFIBROZIL® † (compare to Lopid®)
♦TRICOR® (fenofibrate) §

♦PA required if patient not on concurrent statin

PA REQUIRED

Antara® (fenofibrate micronized) §
fenofibrate† §
fenofibrate micronized† §
Lipofen® (fenofibrate) §
Lofibra® (fenofibrate micronized) Capsules §
Lofibra® (fenofibrate) Tablets §
Lopid®* (gemfibrozil) §
Triglide® (fenofibrate) §

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 / **PA REQUIRED**

Low/Medium Potency Statins

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))*

PA REQUIRED

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

NO PA REQUIRED

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

AFTER GENERIC SIMVASTATIN TRIAL
CRESTOR® (rosuvastatin calcium) §
(QL = 1 tablet/day)

PA REQUIRED

Lipitor® (atorvastatin) *(QL = 1 tablet/day)*
Zocor®* (imvastatin) *(QL = 1 tablet/day)*

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

NO PA REQUIRED / **PA REQUIRED**

Miscellaneous

PA REQUIRED

Lovaza® (omega-3-acid ethyl esters)

Cholesterol Absorption Inhibitors/Combinations

NO PA REQUIRED

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

PA REQUIRED

Vytorin® (ezetimibe/simvastatin) *(QL = 1 tablet/day)*

Other Statin Combinations

NO PA REQUIRED

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

PA REQUIRED

Caduet® (atorvastatin/amlodipine) *(Qty Limit = 1 tablet/day)*

PDL Key:
† Generic product
*** Indicates a generic equivalent is available without PA**
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Miscellaneous: Elaprase® (Hunter's Syndrome Injectable)

Length of Authorization: 1 year

Quantity limits apply

NO PA REQUIRED	PA REQUIRED
	Elaprase® (idursulfase) (*QL = calculated dose/week)*

Miscellaneous: Soliris® (Paroxysmal Nocturnal Hemoglobinuria Injectable)

Length of Authorization: Initial 3 months, Subsequent 1 year

Quantity limits apply

NO PA REQUIRED	PA REQUIRED
	Soliris® (eculizumab) *(Quantity Limit = 20 vials total/3 months initially; 6 vials/month subsequently)*

Miscellaneous: Somatuline® (Acromegaly Injectable)

Length of Authorization: Initial 3 months, Subsequent 1 year

Quantity limits apply

NO PA REQUIRED	PA REQUIRED
	Somatuline® Depot Injection (lanreotide) *(Quantity Limit = 0.2 ml/28 days (60 mg syringe), 0.3 ml/28 days (90 mg syringe) and 0.5 ml/28 days (120 mg syringe))*

Mood Stabilizers (see also Anticonvulsants)

Length of Authorization: duration of need

NO PA REQUIRED	PA REQUIRED
EQUETRO® (carbamazepine)	Eskalith CR®* (lithium carbonate SR)
LITHIUM CARBONATE† (compare to Eskalith®)	Lithobid®* (lithium carbonate SR)
LITHIUM CARBONATE SR† (compare to Eskalith CR®, Lithobid®)	
LITHIUM CITRATE SYRUP†	

Multiple Sclerosis: Injectables

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

Quantity limits apply

NO PA REQUIRED	PA REQUIRED
Interferons	
AVONEX® (interferon *B*-1a)	
BETASERON® (interferon *B*-1b)	
REBIF® (interferon *B*-1a)	
Other	
COPAXONE® (glatiramer acetate) *(QL = 1 kit/30 days)*	Tysabri® (natalizumab)

Nutritionals, liquid oral supplements

Length of Authorization: 6 months

Therapy specific PA fax form available on OVHA website.

NO PA REQUIRED	PA REQUIRED
	PA applies to oral (swallowed) liquid nutrition: Contact MedMetrics. For enteral nutrition (tube feedings), billed via the Medical Benefit, see the following guidelines: http://ovha.vermont.gov/forproviders/copy_of_GOC13.pdf

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Ophthalmics: Antihistamines
Length of Authorization: 1 year

NO PA REQUIRED

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

After trial of ketotifen 0.025 %

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

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

PA REQUIRED

Emadine® (emedastine) *(Quantity Limit = 2 bottles/month)*
Optivar® (azelastine) *(Quantity Limit = 1 bottle/month)*
Zaditor® RX (ketotifen 0.025 %) *(Quantity Limit = 1 bottle/month)*

Ophthalmics: Glaucoma Agents/Miotics
Length of Authorization: lifetime

NO PA REQUIRED | **PA REQUIRED**

ALPHA-2 ADRENERGIC

NO PA REQUIRED

Single Agent
ALPHAGAN® P (brimonidine tartrate)
BRIMONIDINE TARTRATE† (compare to Alphagan®)
Combination
COMBIGAN® (brimonidine tartrate/timolol maleate)

PA REQUIRED

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

BETA BLOCKER

NO PA REQUIRED

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

PA REQUIRED

Betagan®*
Betimol®*
Istalol®*
Optipranolol®*
Timoptic®*
Timoptic XE®*

PROSTAGLANDIN INHIBITORS

Note: Coverage of a 'preferred' PI agent is contingent upon a 1st-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.

NO PA REQUIRED

LUMIGAN® (bimatoprost) §
TRAVATAN®/TRAVATAN Z® (travoprost) §

PA REQUIRED

Xalatan® (latanoprost)

CARBONIC ANHYDRASE INHIBITOR

NO PA REQUIRED

COSOPT® (dorzolamide w/timolol)
TRUSOPT® (dorzolamide)

PA REQUIRED

Azopt® (brinzolamide)

MISCELLANEOUS

NO PA REQUIRED

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

PA REQUIRED

Miochol-E®
Miostat®
Pilocar®*
Propine®*

Ophthalmics: Mast Cell Stabilizers
Length of Authorization: 6 months

NO PA REQUIRED

ALAMAST® (pemirolast potassium)
CROMOLYN SODIUM† (compare to Crolom®, Opticrom®)

PA REQUIRED

Alocril® (nedocromil sodium)
Alomide® (iodoxamide)
Crolom®*

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Ophthalmics: Non-Steroidal Anti-inflammatory Drugs (NSAIDS)
Length of Authorization: 1 year

NO PA REQUIRED	PA REQUIRED
ACULAR® (ketorolac 0.5% ophthalmic sol.)	Diclofenac† 0.1% ophthalmic sol (compare to Voltaren®)
ACULAR LS ® (ketorolac 0.4% ophthalmic sol.)	Nevanac® ophthalmic susp. (nepafenac 0.1%)
ACULAR® PF (ketorolac 0.5% ophthalmic sol.)	Xibrom® ophthalmic sol. (bromfenac 0.09%)
FLURBIPROFEN † 0.03% ophthalmic sol.	Ocufen®* ophthalmic sol. (flurbiprofen 0.03%)
	Voltaren® (diclofenac 0.1% ophthalmic sol.)

Ophthalmics: Quinolone Anti-infectives
Length of Authorization: duration of therapy requested

NO PA REQUIRED	PA REQUIRED
CIPROFLOXACIN HCl† (compare to Ciloxan®)	Ciloxan®*
OFLOXACIN† (compare to Ocuflox®)	Iquix ® (levofloxacin 1.5%) (preservative free)
	Ocuflox®*
	Quixin® (levofloxacin 0.5%)
	Vigamox® (moxifloxacin) (preservative free)
	Zymar® (gatifloxacin)

Ossification Enhancers
Length of Authorization: lifetime
Quantity limits apply

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

NO PA REQUIRED	PA REQUIRED
ORAL BISPHOSPHONATES	Actonel® (risedronate)
BONIVA® (ibandronate) 150 mg (*Quantity Limit = 1 tab/28 days)*	Actonel® w/calcium (risedronate/calcium)
BONIVA® (ibandronate) 2.5 mg *No quantity limits*	Alendronate† (compare to Fosamax®)
FOSAMAX® (alendronate)	Didronel® (etidronate)
FOSAMAX PLUS D® (alendronate/vitamin D)	Etidronate† (compare to Didronel®)
	Skelid® (tiludronate)
INJECTABLE BISPHOSPHONATES	
	Boniva® Injection (ibandronate) *(Quantity Limit = 3 mg/3 months (four doses)/year)*
	Reclast® Injection (zoledronic acid) *(Quantity Limit = 5 mg (one dose)/year)*
MIACALCIN® (calcitonin)	Fortical® (calcitonin)
	Forteo® (teriparatide) *(Quantity Limit = 1 pen (3 ml)/28 days)*

Otic: Anti-Infectives
Length of Authorization: 1 year

NO PA REQUIRED	PA REQUIRED
CIPRODEX® (ciprofloxacin 0.3%/dexamethasone 0.1%; otic susp.)	Cipro-HC® (ciprofloxacin 0.2%/hydrocortisone 1%; otic susp.)
FLOXIN® (ofloxacin 0.3%; otic soln.)	Ofloxacin† 0.3 % otic solution
NEOMYCIN/POLYMYXIN B SULFATE/HYDROCORTISONE †	Coly-Mycin S®/Cortisporin TC® (neomycin/colistin/thonzium/hydrocortisone)
	Cortisporin otic®/Pediotic®* (neomycin/polymyxin B sulfate /hydrocortisone) otic solution/sus

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Parkinson's: Non-Ergot Dopamine Receptor Agonist
Length of Authorization: 1 year
Quantity limits apply

NO PA REQUIRED	PA REQUIRED
DOPAMINE PRECURSOR	
CARBIDOPA/LEVODOPA† (compare to Sinemet®) CARBIDOPA/LEVODOPA† ER (compare to Sinemet® CR) PARCOPA® (carbidopa/levodopa ODT)	Sinemet®* Sinemet CR®*
DOPAMINE AGONISTS (ORAL)	
BROMOCRIPTINE† (compare to Parlodel®) MIRAPEX® (pramipexole) ROPINIROLE† (compare to Requip®)	Parlodel® (bromocriptine) Requip®* (ropinirole)
DOPAMINE AGONISTS (TOPICAL)	
	Neupro® Patch (rotigotine transdermal) *(QL = 1 patch/day)*
COMT INHIBITORS	
TASMAR® (tolcapone) COMTAN® (entacapone)	
MAO-B INHIBITORS	
SELEGILINE† (compare to Eldepryl®)	Eldepryl® (selegiline) Azilect® (rasagiline) *(QL = 1 mg/day)* Zelapar® (selegiline ODT) *(QL = 2.5 mg/day)*
OTHER	
AMANTADINE† (compare to Symmetrel®) STALEVO® (carbidopa/levodopa/entacapone)	Symmetrel® (amantadine)

Phosphodiesterase-5 (PDE-5) Inhibitors
Length of Authorization: 1 year
Quantity limits apply

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

PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET	NON-PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET
	Revatio® (sildenafil) (*Quantity Limit = 3 tabs/day)* Viagra® (sildenafil) (*Quantity Limit = 3 tabs/day)*

Platelet Inhibitors
Length of Authorization: 3 years

NO PA REQUIRED	PA REQUIRED
AGGREGATION INHIBITORS CILOSTAZOL† (compare to Pletal®) CLOPIDOGREL† (compare to Plavix®) PLAVIX® (clopidogrel bisulfate) TICLOPIDINE† (compare to Ticlid®)	Pletal®* Ticlid®*
OTHER ASPIRIN† DIPYRIDAMOLE† (compare to Persantine®)	Aggrenox® (dypiridamole/ASA) Persantine®*

PDL Key:
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Psoriasis Injectables
Length of Authorization: initial PA of 3 months, 12 months thereafter.
Quantity limits apply

Therapy-specific PA fax form available on OVHA website.

PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET	NON-PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET
ENBREL® (etanercept) HUMIRA® (adalimumab) RAPTIVA® (efalizumab)	Amevive® (alefacept) Remicade® (infliximab)

Psoriasis: Non-Biologics
Length of Authorization: 1 year
Quantity limits apply

NO PA REQUIRED	PA REQUIRED
Oral	
CYCLOSPORINE † (all brand and generic) METHOTREXATE † (all brand and generic) OXSORALEN-ULTRA® (methoxsalen) SORIATANE® CK (acitretin)	
Topical	
CALCIPOTRIENE† Solution (compare to Dovonex®) DOVONEX® (calcipotriene cream/ointment) PSORIATEC®, DRITHO-SCALP® (anthralin cream) TAZORAC® (tazarotene cream, gel)	Dovonex®* solution (calcipotriene) Taclonex® (calcipotriene/betamethasone ointment/scalp suspension) (QL for initial fill = 60 grams)

Pulmonary: Anticholinergics, Inhaled
Length of Authorization: 1 year

NO PA REQUIRED	PA REQUIRED
METERED DOSE INHALER (SINGLE AGENT) ATROVENT HFA® (ipratropium) SPIRIVA® (tiotropium)	
NEBULIZER (SINGLE AGENT) IPRATROPIUM SOLN FOR INHALATION	
METERED DOSE INHALER (COMBINATION PRODUCT) COMBIVENT® (ipratropium/albuterol)	
NEBULIZER (COMBINATION PRODUCT) IPRATROPIUM/ALBUTEROL† (compare to Duoneb®)	Duoneb®* (ipratropium/albuterol)

Pulmonary: Antihistamines - Intranasal
Length of Authorization: 1 year

NO PA REQUIRED	PA REQUIRED
	Astelin® (azelastine) Nasal Spray *Quantity Limit = 1 bottle (30 ml)/25 days*

PDL Key:
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Pulmonary: Antihistamines-1st Generation

Length of Authorization: 1 year

NO PA REQUIRED	PA REQUIRED
All generic antihistamines	All brand antihistamines (example: Benadryl®)
All generic antihistamine/decongestant combinations	All brand antihistamine/decongestant combinations (example: Deconamine SR®, Rynatan®, Ryna-12®)

Pulmonary: Antihistamines-2nd Generation

Length of Authorization: 1 year

NO PA REQUIRED	PA REQUIRED
LORATADINE (OTC) † (compare to Claritin®) CETIRIZINE† OTC (compare to Zyrtec® OTC) FEXOFENADINE † (after loratadine OTC and certirizine OTC trials)	Allegra® (fexofenadine) Clarinex® (desloratadine) Claritin® (loratadine) Xyzal® (levocetirizine) Zyrtec® RX/OTC* (cetirizine)
LORATADINE-D (OTC) †	Allegra-D® § (12 HR & 24 HR) Cetirizine-D† SR Clarinex-D® § (12 HR & 24 HR) Claritin-D® § Zyrtec-D® §
LORATADINE (OTC) † syrup CETIRIZINE† (OTC) syrup ZYRTEC® OTC (cetirizine) SYRUP	Allegra® suspension Clarinex® Syrup Claritin Syrup®* Xyzal (levocetirizine) Syrup® Zyrtec RX Syrup®
LORATADINE (OTC) † rapidly disintegrating tablet (RDT)	Allegra ODT® § Certirizine † Chewable Tablets Clarinex Reditabs® § Claritin Chewable Tablets® § Claritin Reditabs®*§ Zyrtec® Chewable Tablets §

Pulmonary: Persistent Asthma

Length of Authorization: 3 months after clinical criteria are met.
Therapy specific clinical criteria are available on the OVHA website.

NO PA REQUIRED	PA REQUIRED
	Xolair® (omalizumab)

PDL Key:

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Pulmonary: Beta-adrenergic Agents

Length of Authorization: 5 years

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

NO PA REQUIRED	PA REQUIRED
METERED-DOSE INHALERS (SHORT-ACTING)	
XOPENEX® HFA (levalbuterol)	♣albuterol MDI† Alupent® (metaproterenol) Maxair® Autohaler (pirbuterol) ♣Proair® (albuterol) ♣Proventil® HFA (albuterol) ♣Ventolin® HFA (albuterol) ♣ *coverage grandfathered for current users*
METERED-DOSE INHALERS (LONG-ACTING)	
FORADIL® (formoterol) *(after criteria for LABA are met)* SEREVENT® DISKUS (salmeterol xinafoate) *(after criteria for LABA are met)*	
NEBULIZER SOLUTIONS (SHORT-ACTING)	
ACCUNEB® (albuterol sulfate solution 0.63 mg/ml and 1.25 mg/ml) ALBUTEROL 0.83 mg/ml neb solution † METAPROTERENOL† neb solution XOPENEX® neb solution (levalbuterol HCL) (age ≤ 12 yrs)	albuterol sulfate solution † 0.63 mg/ml and 1.25 mg/ml (compare to Accuneb®) Xopenex® neb solution (age > 12 yrs)
NEBULIZER SOLUTIONS (LONG-ACTING)	
	Brovana® (arformoterol) *QL = 2 vial/day* Perforomist® (formoterol) *QL = 2 vial/day*
TABLETS/SYRUP (SHORT-ACTING)	
TERBUTALINE† tablets (compare to Brethine®) ALBUTEROL † tablets/syrup METAPROTERENOL †tablets/syrup	Brethine®* (terbutaline)
TABLETS (LONG-ACTING)	
ALBUTEROL ER † tablets	Vospire ER®* (albuterol)

PDL Key:

† Generic product

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Pulmonary: Inhaled Glucocorticoids/Glucocorticoid Combinations

Length of Authorization: 5 years

NO PA REQUIRED	PA REQUIRED
METERED DOSE INHALERS (SINGLE AGENT)	
ASMANEX® 220 mcg/inh (mometasone furoate) *((QL =0.72 gm (3 inhalers)/90 days))*	AeroBid® (flunisolide) §
ASMANEX® 110 mcg/inh (mometasone furoate) *((QL =0.405 gm (3 inhalers)/90 days))*	AeroBid-M® §
AZMACORT® (triamcinolone acetonide)	QVAR® (beclomethasone) §
FLOVENT® DISKUS (fluticasone propionate)	
FLOVENT® HFA (fluticasone propionate) *(QL = 36 gm(3 inhalers)/90 days)*	
PULMICORT Flexhaler® (budesonide)	
METERED DOSE INHALERS (COMBINATION PRODUCT)	
ADVAIR® DISKUS (fluticasone/salmeterol)	
ADVAIR® HFA (fluticasone/salmeterol)	
SYMBICORT® (budesonide/formoterol) *(QL = 30.6 gm (3 inhalers)/90 days)*	Pulmicort (budesonide) Respules® (age > 12 yrs)
NEBULIZER SOLUTIONS	
PULMICORT RESPULES® (budesonide) (age ≤ 12 yrs)	

Pulmonary: Nasal Glucocorticoids

Length of Authorization: 5 years

NO PA REQUIRED	PA REQUIRED
FLUTICASONE Propionate † (compare to Flonase®)	Beconase AQ® (beclomethasone AQ)
FLUNISOLIDE†25 mcg/spray (previously Nasalide®)	Flonase®* (fluticasone propionate)
NASACORT AQ® (triamcinolone AQ)	flunisolide† 29 mcg/spray (compare to Nasarel®)
NASONEX® (mometasone)	Nasarel® (flunisolide)
	Rhinocort AQ® (budesonide AQ)
	Veramyst® (fluticasone furoate)

Pulmonary: Systemic Glucocorticoids

Length of Authorization: 1 year

NO PA REQUIRED	PA REQUIRED
CORTISONE ACETATE†	Celestone®
DEXAMETHASONE†	Cortef®*
HYDROCORTISONE† (compare to Cortef®)	Medrol®*
METHYLPREDNISOLONE† (compare to Medrol®)	Millipred® (prednisolone) oral solution
ORAPRED® oral solution/ODT (prednisolone sod phosphate) (age < 12 yrs)	Orapred® oral solution (age ≥ 12 yrs)
PREDNISOLONE† tabs / liquid (compare to Pediapred®, Prelone®)	Orapred® ODT (age ≥ 12 yrs)
PREDNISONE†	Pediapred®*
	Prelone®*

Pulmonary: Leukotriene Modifiers

Length of Authorization: 1 year

NO PA REQUIRED	PA REQUIRED
ACCOLATE® (zafirlukast)	ZyFlo® (zileuton) §
SINGULAIR® (montelukast sodium)	ZyFlo® CR (zileuton SR) §

PDL Key:

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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: n/a

NO PA REQUIRED	PA REQUIRED
FOSRENOL® (lanthanum carbonate) PHOS LO® (calcium acetate) RENAGEL® (sevelamer)	

Rheumatoid, Juvenile & Psoriatic Arthritis: Immunomodulators
Length of Authorization: Initial PA of 3 months; 12 months thereafter
Quantity limits apply

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

PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET	NON-PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET
ENBREL® (etanercept) HUMIRA® (adalimumab)	Kineret® (anakinra) Orencia® (abatacept) Remicade® (infliximab)

Saliva Stimulants
Length of Authorization: 1 year

NO PA REQUIRED	PA REQUIRED
PILOCARPINE (compare to Salagen®) EVOXAC® (cevimeline)	Salagen®* (pilocarpine)

Sedative/Hypnotics
Length of Authorization: 1 year
Quantity limits apply

NO PA REQUIRED	PA REQUIRED
Benzodiazepine	
ESTAZOLAM† (compare to Prosom®) FLURAZEPAM† (compare to Dalmane®) TEMAZEPAM† (compare to Restoril®)	Dalmane®* (flurazepam) Doral® (quazepam) Halcion® (triazolam) Prosom®* (estazolam) Restoril®* (temazepam) triazolam† (compare to Halcion®)
Non-benzodiazepine	
CHLORAL HYDRATE† syrup, suppository LUNESTA® (eszopiclone) *(Quantity Limit = 1 tab/day)* ZOLPIDEM † (compare to Ambien®)*(Quantity Limit = 1 tab/day)*	Ambien®* (zolpidem) *(Quantity Limit = 1 tab/day)* Ambien CR® (zolpidem) *(Quantity Limit = 1 tab/day)* Rozerem® (ramelteon) *(Quantity Limit = 1 tab/day)* Somnote® (chloral hydrate capsule) Sonata® (zaleplon) Zaleplon †

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Skeletal Muscle Relaxants

Length of Authorization: 1 year

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

NO PA REQUIRED	PA REQUIRED
Musculoskeletal Agents	
CHLORZOXAZONE† (compare to Parafon Forte DSC®) CYCLOBENZAPRINE† (compare to Flexeril®) METHOCARBAMOL† (compare to Robaxin®) METHOCARBAMOL, ASA† (compare to Robaxisal®) ORPHENADRINE CITRATE† (compare to Norflex®) ORPHENADRINE, ASA, CAFFEINE† (compare to Norgesic®, Norgesic Forte®) *ASA = aspirin*	Amrix® (cyclobenzaprine extended release) carisoprodol † carisoprodol, ASA† carisoprodol, ASA, codeine † Fexmid® (cyclobenzaprine) Flexeril®* Norflex®* Norgesic®* Norgesic Forte®* Parafon Forte DSC®* Robaxin®* Robaxisal®* Skelaxin® Soma® Soma Compound® Soma Compound with Codeine®
Antispasticity Agents	
BACLOFEN† (compare to Lioresal®) DANTROLENE† (compare to Dantrium®) TIZANIDINE† (compare to Zanaflex®)	Dantrium®* Lioresal®* Zanaflex®*

Smoking Cessation Therapies

Length of Authorization: see table

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

NO PA REQUIRED	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®	nicotine patch OTC† nicotine patch RX† (compare to Habitrol®) Nicotine System Kit® nicotine gum† Nicotrol Nasal Spray®
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)♠	Zyban®* (bupropion SR) (maximum duration 24 weeks (2 x 12 weeks)/365 days)

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

PDL Key:

† Generic product

*** Indicates a generic equivalent is available without PA**

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

Urinary Antispasmodics
Length of Authorization: 1 year
Quantity limits apply

NO PA REQUIRED*	PA REQUIRED
SHORT-ACTING AGENTS	
OXYBUTYNIN† (compare to Ditropan®)	Ditropan®* Flavoxate † (compare to Urispas®) Urispas® (flavoxate)
LONG-ACTING AGENTS (after clinical criteria are met)	
Twice Daily Oral ***(Qty Limit = 2 per day)*** SANCTURA® (trospium)	Detrol® (tolterodine)
Once Daily Oral ***(Qty Limit = 1 per day)*** ENABLEX® (darifenacin) OXYBUTYNIN XL† (compare to Ditropan® XL) SANCTURA XR® (trospium) VESICARE® (solifenacin)	Detrol LA® (tolterodine LA) Ditropan XL® (oxybutynin XL)
Transdermal	Oxytrol® (oxybutinin transdermal) *(Qty Limit = 8 patches/28 days)*

>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)

Vaginal Anti-Infectives
Length of Authorization: 1 year

NO PA REQUIRED	PA REQUIRED
CLINDAMYCIN	
CLINDAMYCIN VAGINAL† (clindamycin vaginal cream 2%) CLINDAMAX† (clindamycin vaginal cream 2%)	Cleocin®* (clindamycin vaginal cream 2%) Clindesse® (clindamycin vaginal cream 2%) Cleocin® Vaginal Ovules (clindamycin vaginal suppositories)
METRONIDAZOLE	
METRONIDAZOLE VAGINAL GEL 0.75%† VANDAZOLE† (metronidazole vaginal 0.75%)	Metrogel Vaginal®* (metronidazole vaginal gel 0.75%)

Vitamins: Prenatal Multivitamins
Length of Authorization: 1 year

NO PA REQUIRED	PA REQUIRED
All generics	All brands

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