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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): 802-879-5651

E-mail: diane_neal@medmetricshp.com

DVHA Medical Staff:

Medical Director

Dr. Michael Farber, (o) 802-879-5955;

(f) 802-879-5962

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.

Michelle Sirois (o): 802-879-5940

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E-mail: michelle_sirois@medmetricshp.com

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E-mail: Stacey.Baker@ahs.state.vt.us

MHP Account Manager:

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

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E-mail: nancy_miner@medmetricshp.com

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Director of Pharmacy Services

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(f): 802-879-5651

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Note: This document is designed to be a quick reference. For complete details of specific clinical criteria, required step therapy and limitations, please refer to the Clinical Criteria Manual.

Acne Drugs: Oral
Length of Authorization: 1 year

NO PA REQUIRED

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

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

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
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
Vibramycin® (doxycycline calcium) syrup
Vibratab®* (doxycycline hyclate) 100 mg tab
All other brands

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
All other brands

All brands

All brands

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Acne Drugs: Topical Anti-Infectives

Length of Authorization: 1 year

NO PA REQUIRED

BENZOYL PEROXIDE PRODUCTS

BENZOYL PEROXIDE †
2.5%, 4%, 5%, 8%, 10% G,
2.5%, 4%, 5%, 7%, 8%, 10% W;
3.5%, 5.5%, 8.5% C;
3%, 4%, 5%, 6%, 8%, 9% 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
Benzoyl peroxide® 10% L
Brevoxyl® 4%, 8% W; 4%, 8% 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
Pacnex HP/LP 4.25%, 7% P
Triaz® 3%, 6%, 9% G; 3%, 6%, 9% P
Zaclir®* 8% L
All other brands

Cleocin-T®* (clindamycin 2% G)
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)
Avar-E LS® (sulfacetamide/sulfur C)
Avar LS® (sulfacetamide/sulfur W)
Plexion®/ Sumaxin TS® (sulfacetamide/sulfur S)
Rosac®* (sulfacetamide/sulfur W)
Rosula®* (sulfacetamide/sulfur W)
Sulfacet-R®* (sodium sulfacetamide/sulfur L)
All other brands

Zoderm® (urea/benzoyl peroxide) cream, gel

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

AVITA® (tretinoin)

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

C=cream, G=gel

PA REQUIRED

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

adapalene† (compare to Differin®) 0.1% C, G

Differin® (adapalene) 0.1% C, G; L 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

Alpha₁-Proteinase Inhibitors

Length of Authorization: 6 months

NO PA REQUIRED

PA REQUIRED

Aralast NP®

Glassia®

Prolastin®

Prolastin-C®

Zemaira®

Maximum days supply per fill for all drugs is 14 days

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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)

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 §

donepezil† (compare to Aricept®) tablet (QL = 1 tablet/day)

galantamine† tablet § (compare to Razadyne®) Tablet

galantamine ER† capsule § (compare to Razadyne ER®)

Razadyne® (galantamine) Tablet

Razadyne ER® (galantamine) Capsule

rivastigmine† (compare to Exelon®) capsule

(QL = 2 capsules/day)

Aricept® ODT (donepezil)

(QL = 1 tablet/day)

donepezil ODT† (compare to Aricept® ODT)

(QL = 1 tablet/day)

galantamine† (compare to Razadyne®) Oral Solution

Razadyne® (galantamine) Oral Solution

Analgesics: COX-2 Inhibitors

Length of Authorization: 1 year

Quantity limits apply

NO PA REQUIRED

PA REQUIRED

Celebrex® (celecoxib) (QL = 2 capsules/day)

Analgesics: Miscellaneous: Transdermal Patch

Length of Authorization: 6 months

Quantity limits apply

NO PA REQUIRED

PA REQUIRED

Note: Please refer to "Analgesics: Long Acting Narcotics" for Duragesic® and fentanyl patch

Please refer to "Analgesics: NSAIDs" for Flector® patch

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

Qutenza® Patch (capsaicin 8 %) (QL = 4 patches/90 days)

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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)
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®)
ENDOCET® (oxycodone w/ acetaminophen)
ENDODAN® (oxycodone w/ aspirin)
HYDROCODONE† (plain, w/acetaminophen, or w/ibuprofen)
(some exceptions apply)
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®)
ROXICET® (oxycodone w/ acetaminophen)
ROXICODONE INTENSOL® (oxycodone w/ acetaminophen)
ROXICODONE® (oxycodone HCL)
TRAMADOL† (compare to Ultram®) (Qty Limit = 8 tablets/day)
TRAMADOL/APAP† (compare to Ultracet®)
(Qty Limit = 8 tablets/day)

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/hydrocodone (compare to Xodol®) (QL=13 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®* (acetaminophen w/hydrocodone)
Butorphanol Nasal Spray† (Qty Limit = 2 bottles/month)
Capital® w/codeine* (acetaminophen w/codeine)
Cocet®/Cocet Plus® (acetaminophen w/codeine) (QL 30/650 or 60/650 = 6 tablets/day)
Combunox®* (oxycodone w/ ibuprofen)
Dazidox®* (oxycodone)
Demerol® (meperidine)
Dilaudid®*(hydromorphone)
Dilaudid-5®(hydromorphone) oral solution
fentanyl citrate transmucosal† (compare to Actiq®)
Fentora® (fentanyl citrate buccal tablets)
Fioricet® w/codeine*(butalbital/acetaminophen/caffeine/codeine)
Ibudone®* (hydrocodone w/ ibuprofen)
Liquicet® (hydrocodone w/ acetaminophen)
Lorcet®* (also HD, PLUS) (hydrocodone w/ acetaminophen)
Lortab®*(hydrocodone w/ acetaminophen)
Magnacet® (oxycodone w/ acetaminophen)
Maxidone®*(hydrocodone w/ acetaminophen)
Meperidine† (Qty > 30 tabs or 5 day supply)
Norco®*(hydrocodone w/ acetaminophen)
Nucynta® (tapentadol)
Onsolis®(fentanyl buccal soluble film)
Opana® (oxymorphone)
Oxycodone† (plain) capsules
Oxyfast®*(oxycodone)
OxyIR®*(oxycodone)
Oxymorphone† (compare to Opana®)
Panlor DC® (acetaminophen/caffeine/dihydrocodeine)
Pentazocine w/acetaminophen†
Pentazocine w/naloxone†
Percocet®*(oxycodone w/ acetaminophen)
Percodan®* (oxycodone w/aspirin)
Reprexain®* (hydrocodone w/ ibuprofen)
Roxanol®*(morphine sulfate)
Rybix® ODT (tramadol ODT) (Qty Limit = 8 tablets/day)
Ryzolt® (tramadol SR) (Qty Limit = 1 tablet/day)
Synalgos DC®*(dihydrocodeine compound)
Talwin®* (pentazocine) and branded combinations
continued on next page

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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

PA REQUIRED

continued from previous page

Tramadol ER† (compare to Ultram ER®) (*Qty Limit = 1 tablet/day*)

Trelix® (acetaminophen/caffeine/dihydrocodeine)

Tylenol® #3*, #4* (acetaminophen w/codeine)

Tylox®* (oxycodone w/ acetaminophen)

Ultracet® (tramadol w/ acetaminophen) (*Qty Limit = 8 tablets/day*)

Ultram®* (tramadol) (*Qty Limit = 8 tablets/day*)

Ultram ER® (tramadol SR) (*Qty Limit = 1 tablet/day*)

Vicodin®* (hydrocodone w/acetaminophen)

Vicoprofen®* (hydrocodone w/ ibuprofen)

Xodol® (hydrocodone w/acetaminophen)

Xolox® (oxycodone w/ acetaminophen)

Zamicet®* (hydrocodone w/ acetaminophen)

Zydone®* (hydrocodone w/acetaminophen)

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 DVHA web-site.

NO PA REQUIRED

PA REQUIRED

TRANSDERMAL

DURAGESIC® (fentanyl) 12 mcg/hr, 25 mcg/hr, 50 mcg/hr,

(*QL=15 patches/30 days*)

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

ORAL

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

MORPHINE SULFATE SR 12 hr† (compare to MS Contin®)

(*QL=90 tablets/strength/30 days*)

Butrans (buprenorphine) Transdermal System

(*QL = 2 patches/14 days*) (*Maximum 14 day fill*)

Fentanyl Patch† (compare to Duragesic®) 12 mcg/hr, 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*)

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

Dolophine®* (methadone)

Embeda® (morphine sulfate/naltrexone) Capsules (*QL=2 capsules/day*)

Exalgo® (hydromorphone XR) tablet (*QL= 30 tablets/30 days (8 mg tabs), 90
tablets/30 days (12 mg tabs), 120 tablets/30 days (16 mg tabs)*)

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

MS Contin®* (morphine sulfate SR 12 hr) (*QL=90 tablets/strength/30 days*)

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

Oramorph SR®* (morphine sulfate SR 12 hr) (*QL=90 tablets/strength/30 days*)

OxyContin® (oxycodone ER) (*QL= 90 tablets/strength/30 days*)

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Analgesics: NSAIDs

Length of Authorization: 1 year

Quantity limits apply

NO PA REQUIRED

ORAL

SINGLE AGENT

DICLOFENAC POTASSIUM† (compare to Cataflam®)
DICLOFENAC SODIUM† (compare to Voltaren®)
DIFLUNISAL† (formerly Dolobid®)
ETODOLAC† (formerly Lodine®)
FENOPROFEN† (compare to Nalfon®)
FLURBIPROFEN† (compare to Ansaid®)
IBUPROFEN† (compare to Motrin®)
INDOMETHACIN† (formerly Indocin®, Indocin SR®)
KETOPROFEN†
KETOPROFEN ER†
KETOROLAC† (formerly Toradol®)
(QL = 20 doses/5 day supply every 90 days)
MECLOFENAMATE SODIUM† (formerly Meclomen®)
MELOXICAM† tabs (compare to Mobic®)
NABUMETONE† (formerly Relafen®)
NAPROXEN† (compare to Naprosyn®)
NAPROXEN ENTERIC COATED† (compare to EC-Naprosyn®)
NAPROXEN SODIUM† (compare to Anaprox®, Anaprox DS®, Naprelan®)
OXAPROZIN† (compare to Daypro®)
PIROXICAM† (compare to Feldene®)
SULINDAC† (compare to Clinoril®)
TOLMETIN SODIUM† (formerly Tolectin®)

INJECTABLE

KETOROLAC † Injection (formerly Toradol®) (QL = 1 dose per fill)

TRANSDERMAL

NSAID/ANTI-ULCER

Note: Please refer to "Dermatologicals: Actinic Keratosis Therapy" for Solaraze®

PA REQUIRED

Anaprox®* (naproxen sodium)
Anaprox DS®* (naproxen sodium)
Ansaid®* (flurbiprofen)
Cambia® (diclofenac potassium) packet for oral solution
(QL = 9 packets/month)
Cataflam®* (diclofenac potassium)
Clinoril®* (sulindac)
Daypro®* (oxaprozin)
EC-Naprosyn®* (naproxen sodium enteric coated)
Feldene®* (piroxicam)
Indocin®* (indomethacin) suspension
Indocin SR®* (indomethacin) capsules
mefenamic acid† capsules (compare to Ponstel®)
meloxicam suspension
Mobic® (meloxicam) suspension
Mobic®* (meloxicam) tablets
Motrin®* (ibuprofen)
Nalfon®* (fenoprofen)
Naprelan®* (naproxen sodium)
Naprosyn®* (naproxen sodium)
Ponstel® (mefenamic acid)
Voltaren®* (diclofenac sodium)
Voltaren XR®* (diclofenac sodium SR)
Zipsor® (diclofenac potassium)

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

Arthrotec® (diclofenac sodium w/misoprostol)
Vomovo® (naproxen/esomeprazole)
(QL = 2 tablets/day)

Anemia: Hematopoietic/Erythropoietic Agents

Length of Authorization: 3 months initially, 6 months subsequent request

PREFERRED AFTER CLINICAL CRITERIA ARE MET

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

PA REQUIRED

Epogen® (epoetin alpha)

PDL Key:

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Ankylosing Spondylitis: Injectables

****Self-injectables (Enbrel[®], Humira[®] and Simponi[®]) must be obtained through Specialty Pharmacy Provider, ICORE****

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

Drug-specific PA fax form available on DVHA website.

PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

ENBREL[®] (etanercept)
Qty Limit = 4 syringes/28 days(50 mg), 8 syringes/28 days (25 mg)

HUMIRA[®] (adalimumab)
Qty Limit = 2 syringes/28 days

NON-PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

Remicade[®] (infliximab)
Simponi[®] (golimumab) *Qty Limit = 1 syringe/28 days*

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

alprazolam ODT † (compare to Niravam[®])
Alprazolam Intensol[®] (alprazolam concentrate)
Ativan^{®*} (lorazepam)
Diazepam Intensol[®] (diazepam concentrate)
Klonopin^{®*} (clonazepam)
Klonopin Wafers^{®*} (clonazepam ODT)
Librium^{®*} (chlordiazepoxide)
Lorazepam Intensol[®] (lorazepam concentrate)
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*)

FONDAPARINUX† (compare to Arixtra[®])

PA REQUIRED

Coumadin^{®*} (warfarin)
Pradaxa[®] (dabigatran etexilate)
(*Quantity Limit = 2 capsules/day*)

n/a

Enoxaparin † (compare to Lovenox[®])
(*QL = 2 syringes/day calculated in ml volume*)
Innohep[®] (tinzaparin)

Arixtra^{®*} (fondaparinux)

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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

ORAL

CARBAMAZEPINE† (compare to Tegretol®)
CARBAMAZEPINE extended release † (compare to Tegretol XR®)
CARBATROL® (carbamazepine)
CELONTIN® (methsuxamide)
CLONAZEPAM† (compare to Klonopin®)
CLONAZEPAM ODT† (compare to Klonopin Wafers®)
DEPAKOTE SPRINKLES® (divalproex sodium caps)
DILANTIN® (phenytoin)
DIVALPROEX SODIUM † (compare to Depakote®)
DIVALPROEX SODIUM ER† (compare to Depakote ER®)
EPITOL† (carbamazepine)
ETHOSUXAMIDE† (compare to Zarontin®)
GABAPENTIN† 100 mg, 300 mg, 400 mg capsules, 600 mg, 800 mg tablets, 250 mg/5 ml oral solution (compare to Neurontin®)
GABITRIL® (tiagabine)
LAMOTRIGINE† chew tabs (compare to Lamictal® chew tabs)
LAMOTRIGINE† tabs (compare to Lamictal® tabs)
LEVETIRACETAM† tabs (compare to Keppra® tabs)
LEVETIRACETAM† oral soln (compare to Keppra® oral soln)
OXCARBAZEPINE† tablets (compare to Trileptal®)
PEGANONE® (ethotoin)
PHENYTEK® (phenytoin)
PHENYTOIN† (compare to Dilantin®)
PHENYTOIN EX† cap (compare to Phenytek®)
PRIMIDONE† (compare to Mysoline®)
TEGRETOL XR® (carbamazepine) 100 mg ONLY
TOPIRAMATE† tabs (compare to Topamax® tabs)
TOPIRAMATE† sprinkle caps (compare to Topamax® Sprinkles)
TRILEPTAL® oral suspension (oxcarbazepine)
VALPROIC ACID† (compare to Depakene®)
ZONISIMIDE† (compare to Zonegran®)

RECTAL

DIASSTAT® (diazepam rectal gel)

PA REQUIRED

Banzel® (rufinamide)
QL = 8 tabs/day (400 mg) and 16 tabs/day (200 mg)
Depakene®* (valproic acid)
Depakote®* (divalproex sodium)
Depakote ER®* (divalproex sodium)
divalproex sodium capsules † (compare to Depakote Sprinkles®)
Felbatol® (felbamate)
Keppra®* (levetiracetam) tablets, oral solution
Keppra XR® (levetiracetam extended release)
Klonopin®* (clonazepam)
Klonopin Wafers®* (clonazepam ODT)
Lamictal®* tabs (lamotrigine tabs)
Lamictal®* chew tabs (lamotrigine chew tabs)
Lamictal ODT® (lamotrigine orally disintegrating tablets)
Lamictal XR® tablets (lamotrigine extended release)
Lyrica® (pregabalin) § (*Quantity Limit = 3 capsules/day*)
Mysoline®* (primidone)
Neurontin®* (gabapentin) capsules, tablets and oral solution
Oxcarbazepine † oral suspension (compare to Trileptal®)
Sabril® (vigabatrin)
Stavzor® (valproic acid delayed release)
Tegretol®* (carbamazepine)
Tegretol XR® (carbamazepine) (200 and 400 mg strengths)
Topamax®* (topiramate) tablets
Topamax®* (topiramate) Sprinkle Capsules
Trileptal®* tablets (oxcarbazepine)
Vimpat® (lacosamide) tablets, oral solution
Zarontin®* (ethosuxamide)
Zonegran®* (zonisamide)

Diazepam rectal gel

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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
BUDEPRION XL/BUPROPION XL[†] (compare to Wellbutrin XL[®])
FDA maximum recommended dose = 450 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

PA REQUIRED

Aplenzin[®] (bupropion hydrobromide) ER tablets
Quantity Limit = 1 tablet/day
Oleptro[®] (trazodone) ER tablets
Quantity Limit = 2 tablets/day (150 mg) or 1 tablet/day (300 mg)
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
Wellbutrin XL^{®*} (bupropion XL)
FDA maximum recommended dose = 450 mg/day

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[®] § (duloxetine)
FDA maximum recommended dose = 60 mg/day
Effexor[®] (venlafaxine IR)
FDA maximum recommended dose = 225 mg/day
Effexor XR[®] § (venlafaxine XR) capsule
FDA maximum recommended dose = 225 mg/day,
Quantity limit = 1 capsule/day (37.5 mg & 75 mg)
Pristiq[®] § (desvenlafaxine)
FDA maximum recommended dose = 400 mg/day,
Quantity limit = 1 tablet/day (50 mg tablet only)
Venlafaxine ER^{®†} tablet
FDA maximum recommended dose = 225 mg/day,
Quantity limit = 1 tablet/day (37.5 mg & 75 mg)
Venlafaxine ER^{†§} tablet
FDA maximum recommended dose = 225 mg/day,
Quantity limit = 1 tablet/day (37.5 mg & 75 mg)
Venlafaxine ER[†] capsule (compare to Effexor XR[®])
FDA maximum recommended dose = 225 mg/day,
Quantity limit = 1 capsule/day (37.5 mg & 75 mg)
venlafaxine IR ^{†§} (compare to Effexor[®])
FDA maximum recommended dose = 225 mg/day

PDL Key:

[†] Generic product

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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

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

PA REQUIRED

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

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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/PERPHEN† (previously Etrafon®, Triavil®)
AMOXAPINE† (previously Asendis®)
CHLORDIAZEPOXIDE/AMITRIPTYLINE †5mg/12.5mg (compare to Limbitrol®)
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)
Chlordiazepoxide/Amitriptyline 10 mg/25 mg (formerly Limbitrol DS®)
Limbitrol®* (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

PHENELZINE SULFATE (compare to Nardil®)
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)
Nardil®* (phenylzine)
FDA maximum recommended dose = 90 mg/day
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® (metformin ER)
Glucophage®* (metformin)
Glucophage XR®* (metformin XR)
Glucovance®* (glyburide/metformin)
Glumetza® (metformin ER)
Metaglip®* (glipizide/metformin)

Anti-diabetics: Peptide Hormones

Length of Authorization: 1 year

Quantity limits apply

PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

BYETTA® (exenatide) § (Quantity Limit = 1 pen/30 days)
SYMLIN® (pramlintide) § No Quantity Limit

PA REQUIRED

Victoza® (liraglutide) (Quantity Limit=3 pens/30 days)

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Anti-diabetics: Insulins
Length of Authorization: lifetime

NO PA REQUIRED

RAPID-ACTING INJECTABLE

NOVOLOG® (Aspart)

SHORT-ACTING INJECTABLE

HUMULIN R® (Regular)
 NOVOLIN R® (Regular)

INTERMEDIATE-ACTING INJECTABLE

HUMULIN N® (NPH)
 NOVOLIN N® (NPH)

LONG-ACTING ANALOGS INJECTABLE

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

MIXED INSULINS INJECTABLE

HUMULIN 70/30® (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)

ReliOn R® (Regular)

ReliOn N® (NPH)

ReliOn 70/30® (NPH/Regular)

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

NO PA REQUIRED

Single Agent

STARLIX® (nateglinide)

Combination

PA REQUIRED

Nateglinide† (compare to Starlix®)
 Prandin® (repaglinide)

Prandimet® (repaglinide/metformin)

Anti-diabetic: Sulfonylureas 2nd 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®* (glimepiride)
 Diabeta®* (glyburide)
 Glucotrol®** (glipizide)
 Glucotrol XL®** (glipizide ER)
 Glynase® PresTab®** (glyburide micronized)
 Micronase®** (glyburide)

PDL Key:

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Anti-diabetic: Thiazolidinediones & Combinations

Length of Authorization: 1 year

Quantity limits apply

PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

SINGLE AGENT

ACTOS[®] (pioglitazone) §

COMBINATION

ACTOPLUS MET[®] (metformin/pioglitazone) §

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

NON-PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

Avandia[®] (rosiglitazone)

Actoplus Met XR (pioglitazone/metformin ER)

Avandamet[®] (metformin/rosiglitazone maleate)

Avandaryl[®] (glimepiride/rosiglitazone maleate)

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

Length of Authorization: 1 year

Quantity limits apply

PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

SINGLE AGENT

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

ONGLYZA[®] (saxagliptin) § (*Quantity limit=1 tablet/day*)

COMBINATION

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

KOMBIGLYZE XR[®] (saxagliptin/metformin ER) §
(*Quantity limit=1 tab/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/28 days)

*EMEND[®] (aprepitant) 80 mg (2 caps/28 days)

*EMEND[®] (aprepitant) 125 mg (1 cap/28 days)

*EMEND[®] (aprepitant) Tri-fold Pack (1 pack/28 days)

ONDANSETRON† Injection (vial and premix)

ONDANSETRON† tablet 4 mg (12 tabs/28 days), 8 mg (6 tabs/28 days)

ONDANSETRON† ODT 4 mg (12 tabs/28 days), 8 mg (6 tabs/28 days)

* *To be prescribed by oncology practitioners ONLY*

PA REQUIRED

Aloxi[®] (palonosetron, injectable) (2 vials/28 days)

Anzemet[®] (dolansetron) 50 mg (4 tabs/28 days)

Anzemet[®] (dolansetron) 100 mg (2 tabs/28 days)

*Emend[®] (fosapreptiant) 115 mg Injection (Qty Limit = 1 vial/28 days)

Granisetron† (compare to Kytril[®]) 1 mg (6 tabs/28 days)

Granisetron† (compare to Kytril[®]) Injectable

Granisetron† (compare to Kytril[®]) Oral Solution

Kytril[®] (granisetron) 1 mg (6 tabs/28 days)

Kytril[®] (granisetron) Injectable

Ondansetron† (generic) 24 mg (1 tab/28 days)

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

Sancuso[®] 3.1 mg/24 hrs Transdermal Patch (granisetron) (Qty Limit = 1 patch/28 days)

Zofran[®]* (ondansetron) Injection

Zofran[®]* (ondansetron) Oral Tablets and ODT 4 mg (12 tabs/28 days),
8 mg (6 tabs/28 days)

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

Zuplenz[®] (ondansetron) Oral Soluble Film

(*Quantity Limit = 12 films/28 days (4 mg), 6 films/28 days (8 mg)*)

PDL Key:

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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

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Antihyperkinesia: ADHD, ADD, Narcolepsy

Length of Authorization: Duration of Need for Mental Health Indications, 1 Year for Other Indications
CNS Stimulants (all forms short- & long-acting): PA'd for beneficiaries < 3 yrs

Quantity limits apply

NO PA REQUIRED

SHORT/INTERMEDIATE ACTING METHYLPHENIDATE PREPS

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

LONG-ACTING METHYLPHENIDATE PREPS

Oral

CONCERTA[®] (methylphenidate SA OSM
IR/ER 22:78%)
FOCALIN[®] XR (dexamethylphenidate SR 24 HR
IR/ER, 50:50%)

Transdermal

DAYTRANA[®] (methylphenidate patch) (*QL = 1
patch/day*)

SHORT/INTERMEDIATE AMPHETAMINE PREPS

AMPHETAMINE/DETRORAMPHETAMINE †
(compare to Adderall[®])
DEXTRORAMPHETAMINE † (previously
Dexedrine[®])
DEXTRORAMPHETAMINE SR † (compare to
Dexedrine CR[®])
DEXTROSTAT † (dextroamphetamine)

LONG-ACTING AMPHETAMINE PREPS

VYVANSE[®] (lisdexamfetamine) (*QL = 1
capsule/day*)

NON-STIMULANT PREPS

PA REQUIRED

Dexamethylphenidate † (compare to Focalin[®])
Focalin[®] (dexamethylphenidate)
Ritalin[®]* (methylphenidate)
Ritalin SR[®]* (methylphenidate SR)

Metadate CD[®] (methylphenidate CR, IR/ER, 30:70%)
Methylphenidate SA OSM IR/ER, 22:78% † (compare to Concerta[®])
Ritalin LA[®] (methylphenidate SR 24 HR, IR/ER, 50:50%)

Adderall[®]* (amphetamine/dextroamphetamine)
Desoxyn[®] (methamphetamine)
Dexedrine CR[®]* (dextroamphetamine SR)
Methamphetamine † (compare to Desoxyn[®])

Adderall XR[®] (amphetamine/dextroamphetamine SR 24 HR, IR/ER,
50:50%)
(current users grandfathered)
Amphetamine/dextroamphetamine SR 24 HR, IR/ER, 50:50% † (compare
to Adderall XR[®])

Intuniv[®] (guanfacine extended release) Tablet
Qty limit = 1 tablet/day

Kapvay[®] (clonidine extended release) Tablet
Qty limit = 4 tablets/day

Nuvigil[®] (armodafinil)
*Qty limit: 50 mg = 2 tablets/day
150 mg/250 mg = 1 tablet/day*

Provigil[®] (modafinil) (**not approvable for ADHD in children age ≤12**).
*Qty limit: 100 mg = 1.5 tablets/day
200 mg = 2 tablets/day
Maximum Daily Dose = 400 mg (Max days supply = 30 days)*

Strattera[®] (atomoxetine)
FDA maximum recommended dose = 100 mg/day

Xyrem[®] (sodium oxybate)

PDL Key:

† Generic product

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Anti-hypertensives: ACE Inhibitors

Length of Authorization: 1 year

NO PA REQUIRED

BENZAEPRI[†] (compare to Lotensin[®])
CAPTOPRI[†] (previously Capoten[®])
ENALAPRI[†] (compare to Vasotec[®])
FOSINOPRI[†] (previously Monopril[®])
LISINOPRI[†] (compare to Zestril[®], Prinivil[®])
MOEXIPRI[†] (compare to Univas[®])
QUINAPRI[†] (compare to Accupril[®])
RAMIPRI[†] (compare to Altace[®])
TRANDOLAPRI[†] (compare to Mavik[®])

PA REQUIRED

Accupril^{®*} (quinapril)
Aceon[®] (perindopril)
Altace^{®*} (ramipril)
Lotensin^{®*} (benazepril)
Mavik^{®*} (trandolapril)
perindopril[†] (compare to Aceon[®])
Prinivil^{®*} (lisinopril)
Univas^{®*} (moexipril)
Vasotec^{®*} (enalapril)
Zestril^{®*} (lisinopril)

Anti-hypertensives: ACE Inhibitor with Hydrochlorothiazide

Length of Authorization: 1 year

NO PA REQUIRED

BENZAEPRI/HYDROCHLOROTHIAZIDE[†] (compare to Lotensin HCT[®])
ENALAPRI/HYDROCHLOROTHIAZIDE[†] (compare to Vaseretic[®])
FOSINOPRI/HYDROCHLOROTHIAZIDE[†] (previously Monopril HCT[®])
LISINOPRI/HYDROCHLOROTHIAZIDE[†] (compare to Zestoretic[®], Prinzipide[®])
MOEXIPRI/HYDROCHLOROTHIAZIDE[†] (compare to Uniretic[®])
QUINAPRI/HYDROCHLOROTHIAZIDE[†] (compare to Accuretic[®])

PA REQUIRED

Accuretic^{®*} (quinapril/HCTZ)
Lotensin HCT^{®*} (benazepril/HCTZ)
Prinzipide^{®*} (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/BENZAEPRI[†] (compare to Lotrel[®])

PA REQUIRED

Lotrel^{®*} amlodipine/(benazepril)
Tarka[®] (trandolapril/verapamil)
trandolapril/verapamil[†] (compare to Tarka[®])

Anti-hypertensives: Angiotensin Receptor Blockers (ARBs)

Length of Authorization: 3 years

PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

AVAPRO[®] (irbesartan) §
BENICAR[®] (olmesartan) §
DIOVAN[®] (valsartan) §
LOSARTAN[†] (compare to Cozaar[®]) §
MICARDIS[®] (telmisartan) §

NON-PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

Atacand[®] (candesartan) §
Cozaar[®] (losartan)
Edarbi[®] (azilsartan) Tablet
(Qty Limit = 1 tablet/day)
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) §
LOSARTAN/HYDROCHLOROTHIAZIDE[†] (compare to Hyzaar[®]) §
MICARDIS HCT[®] (telmisartan/hydrochlorothiazide) §

NON-PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

Atacand HCT[®] (candesartan/hydrochlorothiazide) §
Hyzaar[®] (losartan/hydrochlorothiazide)
Teveten HCT[®] (eprosartan/hydrochlorothiazide) §

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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

Twynsta[®] (amlodipine/telmisartan)
(QL = 1 tablet/day)

Anti-hypertensives: Angiotensin Receptor Blocker/Renin Inhibitor Combination

Length of Authorization: 3 years

Quantity limits apply

PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

NON-PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

Valturna[®] (aliskiren/valsartan)
(Qty Limit = 1 tablet/day)

Anti-hypertensives: Angiotensin Receptor Blocker/Calcium Channel Blocker/HCTZ Combo

Length of Authorization: 3 years

Quantity limits apply

PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

EXFORGE HCT[®] (amlodipine/valsartan/hydrochlorothiazide) §
(Quantity Limit = 1 tablet/day)

NON-PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

Tribenzor[®] (amlodipine/olmesartan/hydrochlorothiazide)
(QL = 1 tablet/day)

Anti-hypertensives: Beta Blockers

Length of Authorization: 3 years

Quantity limits apply

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/CHLOROTHALIDONE † (compare to Tenoretic[®])
BISOPROLOL/HYDROCHLOROTHIAZIDE† (compare to Ziac[®])
METOPROLOL/HYDROCHLOROTHIAZIDE† (compare to Lopressor HCT[®])
NADOLOL/BENDROFLUMETHIAZIDE† (compare to Corzide[®])

PA REQUIRED

Betapace^{®*} (sotalol)
Betapace AF^{®*} (sotalol)
Bystolic[®] (nebivolol) (QL = 1 tablet/day for 2.5 mg, 5 mg and 10 mg
tablet strengths, 2 tablets/day for 20 mg tab)
Coreg^{®*} (carvedilol)
Coreg CR[®] (carvedilol CR) (QL = 1 tablet/day)
Corgard^{®*} (nadolol)
Inderal^{®*} (propranolol)
Inderal LA^{®*} (propranolol ER)
Innopran XL[®] (propranolol SR)
Kerlone^{®*} (betaxolol)
Levadol[®] (penbutolol)
Lopressor^{®*} (metoprolol)
Sectral^{®*} (acebutolol)
Tenormin^{®*} (atenolol)
Toprol XL^{®*} (metoprolol succinate XL)
Trandate^{®*} (labetalol)
Zebeta^{®*} (bisoprolol)

Corzide^{®*} (nadolol/bendroflumethiazide)
Lopressor HCT^{®*} (metoprolol/HCTZ)
Propranolol/HCTZ† (formerly Inderide[®])
Tenoretic^{®*} (atenolol/chlorthalidone)
Ziac^{®*} (bisoprolol/HCTZ)

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Anti-hypertensives: Calcium Channel Blockers

Length of Authorization: 3 years

Quantity limits apply

NO PA REQUIRED

SINGLE AGENT

Dihydropyridines

AFEDITAB[®] CR † (nifedipine SR, compare to Adalat[®] CC)
AMLODIPINE † (compare to Norvasc[®])
FELODIPINE ER † (previously Plendil[®])
NICARDIPINE † (formerly Cardene[®])
NIFEDIAC[®] CC † (nifedipine SR, compare to Adalat[®] CC)
NIFEDICAL[®] XL † (nifedipine SR osmotic, compare to Procardia[®] XL)
NIFEDIPINE IR † (compare to Procardia[®])
NIFEDIPINE SR osmotic † (compare to Procardia[®] XL)
NIFEDIPINE SR † (compare to Adalat[®] CC)
NIMODIPINE † (compare to Nimotop[®])

Miscellaneous

CARTIA[®] XT † (diltiazem SR, compare to Cardizem[®] CD)
DILT-CD[®] † (diltiazem SR, compare to Cardizem[®] CD)
DILT-XR[®] † (diltiazem SR, compare to Dilacor[®] XR)
DILTIAZEM † (compare to Cardizem[®])
DILTIAZEM ER † (formerly Cardizem[®] SR)
DILTIAZEM ER † (compare to Tiazac[®])
DILTIAZEM SR † (compare to Cardizem[®] CD)
DILTIAZEM SR † (compare to Dilacor[®] XR)
TAZTIA[®] XT † (diltiazem ER, 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[®])
VERAPAMIL SR † 100 mg, 200 mg, 300mg (compare to Verelan PM[®])

CALCIUM CHANNEL BLOCKER/OTHER COMBINATION

(preferred after clinical criteria are met)

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

PA REQUIRED

Adalat[®] CC* (nifedipine SR)
Cardene[®] SR (nicardipine SR) (no AB rated generic)
Dynacirc[®] CR (isradipine CR) (no AB rated generic)
Isradipine (formerly Dynacirc[®])
Nimotop[®]* (nimodipine)
Nisoldipine ER † (compare to Sular[®])
Norvasc[®]* (amlodipine)
Procardia[®]* (nifedipine IR)
Procardia XL[®]* (nifedipine SR osmotic)
Sular[®] (nisoldipine)

Calan[®]* (verapamil)
Calan[®] SR* (verapamil CR)
Cardizem[®]* (diltiazem)
Cardizem[®] CD* (diltiazem SR)
Cardizem[®] LA (diltiazem SR)
Covera-HS[®] (verapamil SR) (no AB rated generic)
Diltiazem ER †/Matzin LA † (compare to Cardizem[®] LA)
Dilacor[®] XR* (diltiazem SR)
Isoptin[®] SR* (verapamil CR)
Tiazac[®]* (diltiazem ER)
Verelan[®]* (verapamil SR 120 mg, 180 mg, 240 mg and 360 mg)
Verelan[®] PM* (100 mg, 200 mg and 300 mg)

Tribenzor[®] (amlodipine/olmesartan/hydrochlorothiazide)
(QL = 1 tablet/day)
Twynsta[®] (amlodipine/telmisartan)
(QL = 1 tablet/day)

Caduet[®] (amlodipine/atorvastatin)

Anti-hypertensives: Renin Inhibitor

Length of Authorization: 3 years

Quantity limits apply

NO PA REQUIRED

PA REQUIRED

SINGLE AGENT

Tekturna[®] (aliskiren) (Quantity Limit = 1 tablet/day)

COMBINATION

Amturnide[®] (aliskiren/amlodipine/hydrochlorothiazide) (Qty Limit = 1 tab/day)

Tekamlo[®] (aliskiren/amlodipine) (Qty Limit = 1 tablet/day)

Tekturna HCT[®] (aliskiren/hydrochlorothiazide) (Quantity Limit = 1 tablet/day)

Valturna[®] (aliskiren/valsartan) (Qty Limit = 1 tablet/day)

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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®* (cefadroxil)
Keflex®* (cephalexin)

Anti-infectives: Cephalosporins – 2nd Generation

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

NO PA REQUIRED

TABLETS/CAPSULES

CEFACLOR CAPSULE†
CEFACLOR ER TABLET†
CEFPROZIL† (compare to Cefzil®) TABLETS
CEFUROXIME † (compare to Ceftin®) TABLETS

SUSPENSION

CEFACLOR SUSPENSION†
CEFPROZIL† (compare to Cefzil®) SUSPENSION
CEFUROXIME† (compare to Ceftin®) SUSPENSION

IV drugs are not managed at this time

PA REQUIRED

Ceftin®* (cefuroxime) tablets
Cefzil®* (cefprozil) tablets
Lorabid® (loracarbef) capsule

Ceftin®* (cefuroxime) suspension
Cefzil®* (cefprozil) suspension
Lorabid® (loracarbef) suspension

Anti-infectives: Cephalosporins – 3rd Generation

Length of Authorization: for date of service, no refills

NO PA REQUIRED

CAPSULES/TABLETS

CEFDINIR† (compare to Omnicef®) CAPSULE
CEFPODOXIME PROXETIL† (compare to Vantin®) TABS
OMNICEF® (cefdinir) CAPSULE
SUPRAX® (cefixime) TABLET

SUSPENSION

CEFDINIR† (compare to Omnicef®) SUSPENSION
OMNICEF® (cefdinir) SUSPENSION
SUPRAX® (cefixime) SUSPENSION

IV drugs are not managed at this time

PA REQUIRED

Cedax® (ceftibuten) capsule
Cefditoren† (compare to Spectracef®) tablet
Spectracef® (cefditoren) tablet
Vantin®* (cefepodoxime) tablet

Cedax® (ceftibuten) Suspension
Cefepodoxime proxetil† (formerly Vantin®) suspension

Anti-infectives: Ketolides

Length of Authorization: for date of service, no refills

NO PA REQUIRED

PA REQUIRED

Ketek® (telithromycin)

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Anti-infectives: Macrolides

Length of Authorization: Date of service, only; no refills for generic and brand azithromycin packets .Up to 6 months. Refills permissible with extended duration PAs (others).

Quantity limits apply

NO PA REQUIRED

AZITHROMYCIN† tabs, liquid (≤5 day supply) (compare to Zithromax®)
(Maximum 10 days therapy/30 days)

CLARITHROMYCIN† (compare to Biaxin/Biaxin XL)

E.E.S®† (erythromycin ethylsuccinate)

ERY-TAB® (erythromycin base, delayed release)

ERYTHROCIN† (erythromycin stearate)

ERYTHROMYCIN BASE†

ERYTHROMYCIN ETHYLSUCCINATE† (compare to E.E.S.®)

ERYTHROMYCIN W/ SULFASOXAZOLE† (compare to Pediazole®)

IV drugs are not managed at this time

PA REQUIRED

azithromycin† tablets and liquid (if > 5 day supply)
(compare to Zithromax®)

(Maximum 10 days therapy/30 days)

Azithromycin† packet (compare to Zithromax®)

(QL = 2 grams/fill)

Biaxin®* (clarithromycin)

Biaxin XL® (clarithromycin SR)

Clarithromycin SR† (compare to Biaxin® XL)

Dynabac® (dirithromycin)

Eryped® (erythromycin ethylsuccinate)

PCE Dispertab® (erythromycin base)

Pediazole®* (erythromycin-sulfisoxazole)

Zithromax®* (azithromycin) tablets and liquid

QL = 5 days supply/RX, maximum 10 days therapy/30 days

Zithromax® (azithromycin) packet

(QL=2 grams/fill)

Zmax® Suspension (azithromycin extended release for oral suspension)

QL = 5 days supply/RX, maximum 10 days therapy/30 days

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)

Zyvox® (linezolid) suspension

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

Amoxicillin/clavulanate† (compare to Augmentin XR®) tablets

Augmentin®* (amoxicillin/clavulanate) chewable tablets, tablets, suspension

Augmentin ES®* (amoxicillin/clavulanate) suspension

Augmentin XR® (amoxicillin/clavulanate) tablets

Moxatag® (amoxicillin extended release) tablet

QL = 1 tablet/day

* 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) tabs, sol

OFLOXACIN†

IV drugs are not managed at this time

PA REQUIRED

Avelox® (moxifloxacin HCL)

Avelox ABC PACK® (moxifloxacin HCL)

Cipro®* (ciprofloxacin)

Cipro XR® (ciprofloxacin)

ciprofloxacin ER† (compare to Cipro XR®)

Factive® (gemifloxacin)

levofloxacin † (compare to Levaquin®) tabs, sol

Noroxin® (norfloxacin)

ProQuin XR® (ciprofloxacin)

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Anti-infectives: Antivirals: Influenza Vaccines

Length of Authorization: up to 6 weeks

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

NO PA REQUIRED

SEASONAL Influenza Vaccine Injection

(Trivalent Inactivated Vaccine)

(includes H1N1 for 2011-2012)

AFLURIA[®] 2011- 2012 Injection
AGRIFLU[®] 2011- 2012 Injection
FLUARIX[®] 2011- 2012 Injection
FLULAVAL[®] 2011- 2012 Injection
FLUVIRIN[®] 2011- 2012 Injection
FLUZONE[®] 2011 - 2012 Injection

SEASONAL Influenza Nasal Vaccine

(Live Attenuated Influenza Vaccine)

(includes H1N1 for 2011-2012)

PA REQUIRED

FluMist[®] Nasal

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

SUMATRIPTAN[†] (compare to Imitrex[®])
*Quantity Limit = 18 tablets/month (25 mg),
9 tablets/month (50 mg, 100 mg),*

After Sumatriptan Trial

NARATRIPTAN[†] (compare to Amerge[®])
(Quantity Limit = 9 tablets/month)

After Sumatriptan and Naratriptan Trials

MAXALT-MLT[®] (rizatriptan ODT)
Quantity Limit = 12 tablets/month

NASAL SPRAY

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

INJECTABLE

IMITREX[®] (sumatriptan)
Quantity Limit = 4 injections/month (4 or 6 mg injection)

Combination Product (Oral)

PA REQUIRED, Quantity Limits Apply

Amerge[®] (naratriptan) 1 mg, 2.5 mg
Quantity Limit = 9 tablets/month
Axert[®] (almotriptan)
Quantity Limit = 6 tablets/month
Frova[®] (frovatriptan) 2.5 mg
Quantity Limit = 9 tablets/month
Imitrex[®] (sumatriptan)
Quantity Limit = 18 tablets/month (25 mg), 9 tablets/month (50 mg, 100 mg),
Maxalt[®] (rizatriptan) 5 mg, 10 mg tablet
Quantity Limit = 12 tablets/month
Relpax[®] (eletriptan) 20 mg, 40 mg
Quantity Limit = 12 tablets/month
Zomig[®] (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[†] (compare to Imitrex[®])
*Quantity Limit = 12 units/month (5 mg nasal spray),
6 units/month (20 mg nasal spray)*
Zomig[®] (zolmitriptan)
Quantity Limit = 12 units/month (5 mg nasal spray)

sumatriptan (compare to Imitrex[®])
Quantity Limit = 4 injections/month (4 or 6 mg injection)

Treximet[®] (sumatriptan/naproxen)
Quantity Limit = 9 tablets/month

Anti-obesity

Effective 10/12/2011, anti-obesity agents (weight loss agents) are no longer a covered benefit for all Vermont Pharmacy Programs. This change is resultant from Drug Utilization Review (DUR) Board concerns regarding safety and efficacy of these agents.

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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

RISPERIDONE† (compare to Risperdal®)

FDA maximum recommended dose = 16 mg/day

SEROQUEL® (quetiapine) > 50 mg/day

SEROQUEL® (quetiapine) ≤ 50 mg/day (children < 18 years old)

FDA maximum recommended dose = 800 mg/day

ORAL SOLUTIONS

RISPERIDONE† (compare to Risperdal®) 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

Continued next page

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

Fanapt® (iloperidone)

FDA maximum recommended dose = 24 mg/day

Quantity limit = 2 tablets/day

Invega® (paliperidone)

FDA maximum recommended dose = 12 mg/day

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

Latuda® (lurasidone)

FDA maximum recommended dose = 80 mg/day

Quantity limit = 1 tablet/day

Risperdal®* (risperidone)

FDA maximum recommended dose = 16 mg/day

Saphris® (asenapine) sublingual tablet

FDA maximum recommended dose = 20 mg/day

Seroquel® (quetiapine) ≤ 50 mg/day (adults ≥ 18 years old)

Seroquel XR® (quetiapine XR)

FDA maximum recommended dose = 800 mg/day

Quantity Limit = 1 tab/day (150 mg and 200 mg tablet strengths), 2 tabs/day (50 mg strength)

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

Risperdal® (risperidone) oral solution

FDA maximum recommended dose = 16 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

Invega Sustenna® (paliperidone palmitate)

FDA maximum recommended dose = 234 mg/month

Risperdal® Consta (risperidone microspheres)

FDA maximum recommended dose = 50 mg/14 days

Zyprexa Relprevv® (olanzapine pamoate)

FDA maximum recommended dose = 600 mg/month

Quantity limit = 1 vial/28 days (405 mg) or 2 vials/month (210 or 300 mg)

Continued next page

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ORALLY DISINTEGRATING TABLETS

Abilify® Discmelt (aripiprazole)
FDA maximum recommended dose = 30 mg/day,
Quantity limit = 2 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
 Risperidone† ODT (compare to Risperdal® M-Tab)
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)

COMBINATION PRODUCTS

Anti-psychotic: Typicals
Length of Authorization: Duration of Need for Mental Health Indications

NO PA REQUIRED

ORAL TABLETS/CAPSULES

CHLORPROMAZINE† (formerly Thorazine®)
 FLUPHENAZINE† (formerly Prolixin®)
 HALOPERIDOL† (compare to Haldol®)
 LOXAPINE† (compare to Loxitane®)
 MOBAN® (molindone)
 NAVANE® (thiothixene) (20 mg ONLY)
 PERPHENAZINE† (formerly Trilafon®)
 THIORIDAZINE† (formerly Mellaril®)
 THIOTHIXENE† (compare to Navane®)
 TRIFLUOPERAZINE† (formerly Stelazine®)

LONG ACTING INJECTABLE PRODUCTS

FLUPHENAZINE DECANOATE† (formerly Prolixin® decanoate)
 HALOPERIDOL DECANOATE † (compare to Haldol® decanoate)

PA REQUIRED

Haldol®* (haloperidol)
 Loxitane®* (loxapine)
 Navane®* (thiothixene) 2 mg, 5 mg, 10 mg

Haldol® decanoate* (haloperidol decanoate)

PDL Key:

† Generic product

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Bone Resorption Inhibitors

Length of Authorization: 3 years

Quantity limits apply

Therapy-specific PA fax form for Injectables available on DVHA website.

NO PA REQUIRED

ORAL BISPHOSPHONATES

TABLETS/CAPSULES

ALENDRONATE† (compare to Fosamax®)

ORAL SOLUTION

INJECTABLE BISPHOSPHONATES

INJECTABLE RANKL INHIBITOR

CALCITONIN NASAL SPRAY

MIACALCIN® (calcitonin)

PARATHYROID HORMONE INJECTION

PA REQUIRED

Actonel® (risedronate)

Actonel® w/calcium (risedronate/calcium)

Altuvia (risedronate) Delayed Release Tablet

(Quantity Limit = 4 tablets/28 days)

Boniva® (ibandronate) (Quantity Limit = 150 mg tablet/1 tablet per 28 days)

Didronel® (etidronate)

Etidronate† (compare to Didronel®)

Fosamax®* (alendronate)

Fosamax Plus D® (alendronate/vitamin D)

Skelid® (tiludronate)

Fosamax® (alendronate) 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)

Prolia® Injection (denosumab) (QL=60 mg/6 months (two doses)/year)

Calcitonin† Nasal Spray (compare to Miacalcin®)

Fortical®† (calcitonin)

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

Botulinum Toxins

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

No approvals for Cosmetic Use

NO PA REQUIRED

PA REQUIRED

BOTOX® (onabotulinumtoxinA)

Myobloc® (rimabotulinumtoxinB)

Available after a BOTOX® trial for select indications:

Dysport® (abobotulinumtoxinA)

Xeomin® (incobotulinumtoxinA)

PDL Key:

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BPH Agents

Length of Authorization: 1 year

Quantity limits apply

Coverage of androgen hormone inhibitors will not be approved for cosmetic use in men or women (male-pattern baldness/alopecia or hirsutism). (This includes Propecia® (finasteride) whose only FDA approved indication is for treatment of male pattern hair loss.)

NO PA REQUIRED

ALPHA BLOCKERS

DOXAZOSIN† (compare to Cardura®)

TAMSULOSIN† (compare to Flomax®)

Quantity Limit = 2 capsules/day

TERAZOSIN† (previously Hytrin®)

ANDROGEN HORMONE INHIBITORS

FINASTERIDE† (compare to Proscar®) (*QL = 1 tablet/day*)

COMBINATION PRODUCT

PA REQUIRED

Cardura®* (doxazosin)

Cardura XL® (doxazosin)

Quantity Limit = 1 tablet/day

Flomax®* (tamsulosin)

Quantity Limit = 2 capsules/day

Rapaflo® (silodosin) *Quantity Limit = 1 capsule/day*

Uroxatral® (alfuzosin)

Quantity Limit = 1 tablet/day

Avodart® (dutasteride) (*QL = 1 capsule/day*)

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

Proscar®* (finasteride) (*QL = 1 tablet/day*)

Jalyn® (dutasteride/tamsulosin) (*QL = 1 capsule/day*)

Cardiac Glycosides

Length of Authorization: n/a

NO PA REQUIRED

DIGOXIN†

DIGOXIN† Oral Solution

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 DVHA website.

NO PA REQUIRED

ALCOHOL DEPENDENCY

CAMPRAL® (acamprosate)
DISULFIRAM† 250 mg, 500 mg tab (compare to Antabuse®)
NALTREXONE oral † (compare to Revia®)

OPIATE DEPENDENCY

NALTREXONE oral † (compare to Revia®)

Preferred Agent after Clinical Criteria are Met

SUBOXONE® sublingual FILM (buprenorphine/nalaxone)
QL = 3 films per day (all strengths)
(Maximum Daily Dose = 24 mg/day (if currently prescribed 24 mg Suboxone SL tablet)
(Maximum daily Dose = 16 mg/day (new Suboxone users))

Maximum days supply for Suboxone is 14 days

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

PA REQUIRED

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

buprenorphine† sublingual TABLET (compare to Subutex®)
QL = 3 tablets per day (2 mg strength) or 2 tablets/day (8 mg strength)
(Maximum Daily Dose = 16 mg/day)

Revia®* (naltrexone oral)

Suboxone® sublingual TABLET (buprenorphine/nalaxone)
QL = 3 tablets per day (all strengths)
(Maximum Daily Dose = 24 mg/day (current users of this dose)
(Maximum daily Dose = 16 mg/day (new users))

Subutex® sublingual Tablet (buprenorphine)
QL = 3 tablets per day (2 mg strength) or 2 tablets/day (8 mg strength)
(Maximum Daily Dose = 16 mg/day)

Maximum days supply for Suboxone/Subutex/buprenorphine is 14 days

For Prevention of Relapse to Opioid Dependency

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

Constipation: Chronic, IBS-C or Opioid Induced

Length of Authorization: Amitiza – Initial PA of 3 months, and 12 months thereafter; Relistor – 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® (methylnaltrexone)

PDL Key:

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Contraceptives: Vaginal Ring

Length of Authorization: n/a

NO PA REQUIRED

NUVARING[®] (etonogestrel/ethinyl estradiol vaginal ring)

PA REQUIRED

Coronary Vasodilators/Antianginals: Oral

Length of Authorization: 3 years

Quantity limits apply

NO PA REQUIRED

ISOSORBIDE DINITRATE† tablet (compare to Isordil[®])
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[®]
NITROGLYCERIN SPRAY LINGUAL† (compare to Nitroglycerin Pump Spray[®])
NITROMIST[®] Lingual Spray
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)
Isosorbide dinitrate SL 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)*)

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)

Corticosteroids: Oral

Length of Authorization: 1 year

NO PA REQUIRED

BUDESONIDE 24HR (compare to Entocort EC[®])
CORTISONE ACETATE†
DEXAMETHASONE†
DEXPAK[®] tabs (dexamethasone taper pack)
ENTOCORT EC[®]* (budesonide 24 hr cap)
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[®]* (hydrocortisone)
Flo-Pred[®] (prednisolone) oral suspension
Medrol[®]* (methylprednisolone)
Millipred[®] (prednisolone) oral solution
Orapred[®] oral solution (age ≥ 12 yrs)
Orapred[®] ODT (age ≥ 12 yrs)
Pediapred[®]*
Prelone[®]*
Veripred[®] 20 oral solution (prednisolone sodium phosphate)

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

Hydrocodone/chlorpheniramine (compare to Tussionex[®]) (*QL = 60 ml/RX*)
Tussionex[®] (hydrocodone/chlorpheniramine) (*QL = 60 ml/RX*)
TussiCaps[®] (hydrocodone/chlorpheniramine) (*QL = 12 capsules/RX*)
All other brands

PDL Key:

† Generic product

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Cryopyrin-Associated Periodic Syndromes (CAPS) Injectables

Length of Authorization: 1 year

Quantity limits apply

PREFERRED AFTER CLINICAL CRITERIA ARE MET

Ilaris[®] (canakinumab) (*QL=1 vial/56 days*)

PA REQUIRED

Arcalyst[®] (rilonacept) (*QL = 2 vials for loading dose, then 1 vial per week*)

Cystic Fibrosis Inhalation Medications

****Pulmozyme[®] and TOBI[®] must be obtained through Specialty Pharmacy Provider, ICORE****

Therapy specific Order form is available on DVHA website.

NO PA REQUIRED for Cystic Fibrosis Diagnosis

TOBI[®] (tobramycin) inhalation solution
(*Quantity Limit = 56 vials/56 days; maximum days supply = 56 days*)
(*2 vials/day for 28 days, then 28 days off*)

PA REQUIRED

Cayston[®] (aztreonam) inhalation solution
(*Quantity Limit = 84 vials/56 days; maximum days supply = 56 days*)
(*3 vials/day for 28 days, then 28 days off*)

Pulmozyme[®] (dornase alfa) inhalation solution
(*Quantity Limit =60/30 days; maximum days supply=30 days*)

Dermatological Agents: Actinic Keratosis Therapy

Length of Authorization: 16 weeks

Quantity limits apply

NO PA REQUIRED

ALDARA[®] (imiquimod) 5 % Cream
FLUOROURACIL[†] (compare to Efudex[®]) 5% cream, 5%, 2% solution
CARAC[®] (fluorouracil) 0.5% cream
FLUOROPLEX[®] (fluorouracil) 1% cream

PA REQUIRED

Efudex^{®*} (fluorouracil) 5% cream, solution
Imiquimod[†] (compare to Aldara[®]) 5 % cream
Solaraze[®] (diclofenac sodium) 3 % Gel
Qty Limit = 1 tube/30 days
Zyclara (imiquimod) 3.75 % Cream
Qty Limit = 56 packets/6 weeks

PDL Key:

[†] Generic product

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Dermatological Agents: Antibiotics: Topical
Length of Authorization: for date of service, no refills
Quantity limits apply

NO PA REQUIRED

Single Agent

BACITRACIN†

GENTAMICIN† Cream or Ointment

MUPIROCIN OINTMENT† (compare to Bactroban®)

Combination Products

BACITRACIN-POLYMYXIN†

NEOMYCIN-BACITRACIN-POLYMYXIN†

Note: Bactroban® Nasal Ointment is not included in this managed category.

PA REQUIRED

Altabax® (retapamulin) *QL = 1 tube*

Bactroban® (mupirocin) Cream or Ointment

Cortisporin® Cream (neomycin-polymyxin-hydrocortisone)

Cortisporin® Ointment(bacitracin-neomycin-polymyxin-hydrocortisone)

Neosporin® (neomycin-bacitracin-polymyxin)

Polysporin®* (bacitracin-polymixin)

All other branded products

Dermatological Agents: Antifungals: Onychomycosis
Length of Authorization: 1 year
Monthly quantity limits apply

NO PA REQUIRED

PA REQUIRED

Ciclopirox † 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*

PDL Key:

† Generic product

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Dermatological Agents: Antifungals: Topical

Length of Authorization: Up to 3 months

Quantity limits apply

NO PA REQUIRED

Single Agent

CICLOPIROX † (compare to Loprox[®]) 0.77% C, Sus, G; 1% Sh

CLOTRIMAZOLE † (formerly Lotrimin[®])

1% C, S

ECONAZOLE † (formerly Spectazole[®]) 1% C

KETOCONAZOLE † (compare to Kuric[®], Nizoral[®]) 2% C, 2% Sh

MICONAZOLE † all generic/OTC products

NYSTATIN † O, C, P (compare to Mycostatin[®], Nystop[®], Pedi-Dri[®], Nyamyc[®])

TOLNAFTATE † (compare to Tinactin[®]) 1% C, P, Sp, S

Combination Products

CLOTRIMAZOLE W/BETAMETHASONE † (compare to Lotrisone[®])
C, L

NYSTATIN W/TRIAMCINOLONE † (formerly Mycolog II[®]) C, O

C=cream, F=foam, G=gel, L=lotion, P=powder, S=solution,
Sh=shampoo, Sp=spray, Sus=suspension

PA REQUIRED

Ertaczo[®] (sertaconazole) 2% C

Exelderm[®] (sulconazole) 1% C, S

Extina[®] (ketoconazole) 2% F

Kuric[®]* (ketoconazole) 2% C

Lamisil RX/OTC[®] (terbinafine) 1% C, S, Sp, G

Loprox[®]* (ciclopirox) 0.77% C, S, G; 1% Sh

Lotrimin AF[®]* OTC (clotrimazole) 1% C, S, L

Mentax[®]/ Lotrimin Ultra[®] OTC (butenafine) 1% C

Mycostatin[®]* (nystatin) C, P

Naftin[®] (naftifine) 1% C, G

Nizoral[®]* (ketoconazole) 2% Sh

Nizoral A-D[®] OTC (ketoconazole) 1% Sh

Nystop[®], Pedi-Dri[®], Nyamyc[®]* (nystatin) P

Oxistat[®] (oxiconazole) 1% C, L

Tinactin[®]/Tinactin AT OTC* (tolnaftate) 1% C, P, Sp, S

Xolegel[®] (ketoconazole) 2% G

All other branded products

Lotrisone[®]* (clotrimazole w/betamethasone) C, L

Vusion[®] (miconazole w/zinc oxide) O

(QL=50 g/30 days)

All other branded products

Note: Please refer to "Dermatological: Antifungals: Onychomycosis" for ciclopirox solution and Penlac[®] Nail Lacquer

Dermatological Agents: Antivirals: Topical

Length of Authorization: 6 months

NO PA REQUIRED

ABREVA OTC (docosanol) 10% C

C=cream, O=ointment

PA REQUIRED

Denavir[®] (penciclovir) 1% C

Zovirax[®] (acyclovir) 5% C, O

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Dermatological Agents: Corticosteroids

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

NO PA REQUIRED

ALCLOMETASONE 0.05% C, O† (compare to Aclovate®)
DESONIDE† 0.05% C, L, O (compare to DesOwen®)
FLUOCINOLONE 0.01% C, S† (formerly Synalar®)
HYDROCORTISONE†
0.5%, 1%, 2.5% C; 1%, 2.5% L, 0.5%, 1%, 2.5% O
HYDROCORTISONE ACETATE† 1% C; 1% O (all generics)

BETAMETHASONE DIPROPIONATE† 0.05% L (formerly Diprosome®)
BETAMETHASONE VALERATE† 0.1% C, L (compare to Beta-Val®)
DESOXIMETASONE† 0.05% C (compare to Topicort®)
FLUOCINOLONE† 0.025% C, O (formerly Synalar®)
FLUTICASONE † 0.05% C; 0.005% O (compare to Cutivate®)
HYDROCORTISONE BUTYRATE† 0.1% C, O, S (compare to Locoid®)
HYDROCORTISONE VALERATE† 0.2% C, O (compare to Westcort®)
MOMETASONE FUROATE† 0.1% C, L, O (compare to Elocon®)
TRIAMCINOLONE ACETONIDE† 0.025%, 0.1% C, L, O (compare to Aristocort®; formerly Kenalog®)

AMCINONIDE† (formerly Cyclocort®)
AUGMENTED BETAMETHASONE† 0.05% C (compare to Diprolene® AF)
BETAMETHASONE VALERATE† 0.1% O (formerly Beta-Val®)
DESOXIMETASONE† 0.05% G; 0.25% C, O (compare to Topicort®)
FLUOCINONIDE† 0.05% C, G, O, S (compare to Lidex®)
TRIAMCINOLONE ACETONIDE† 0.5% C, O (formerly Aristocort®)

AUGMENTED BETAMETHASONE† 0.05% L, O (compare to Diprolene®)
AUGMENTED BETAMETHASONE † 0.05% G (compare to Alphatrex®)
CLOBETASOL PROPIONATE† (compare to Temovate®/Cormax®)
CLOBETASOL PROPIONATE† 0.05% F (compare to Olux®)
DIFLORASONE DIACETATE† 0.05% O (compare to Psorcon E/Apexicon®)
HALOBETASOL PROPIONATE† (compare to Ultravate®)

PA REQUIRED

Low Potency

Aclovate®* (alclometasone) 0.05% C, O
Balneol® (hydrocortisone) 0.25% L
Capex® (fluocinolone) 0.01% shampoo
Desonate® (desonide) 0.05% G
DesOwen®* (desonide) 0.05% C, L, O
Hytone®* (hydrocortisone) 1%, 2.5% C
Nucort 2% lotion (hydrocortisone acetate)
Verdeso® (desonide) 0.05% F
All other brands

Medium Potency

Aristocort®* (triamcinolone) 0.1% C
Beta-Val®* (betamethasone valerate) 0.1% C, L
Cloderm® (clocortolone) 0.1% C
Cordran® (all products)
Cutivate®*(fluticasone) 0.05% C; 0.005% O
Cutivate®(fluticasone) 0.05% L
Dermatop® (prednicarbate) 0.1% C, O
Elocon®* (all products)
Locoid®* (hydrocortisone butyrate) 0.1% C, O, S
Locoid® (hydrocortisone butyrate) 0.1% L
Luxiq® (betamethasone valerate) F
prednicarbate† (compare to Dermatop®) 0.1% C, O
Topicort®* (desoximetasone) 0.05% C
Trianex®* (triamcinolone) 0.05% O
Westcort®* (hydrocortisone valerate) all products
All other brands

High Potency

Apexicon E® (diflorasone) 0.05% C
Diflorasone diacetate† 0.05% C (compare to Apexicon E®)
Diprolene® AF* (augmented betamethasone) 0.05% C
Halog® (halcinonide) all products
Lidex®* (fluocinonide) 0.05% C
Topicort®* (desoximetasone) 0.05% G; 0.25% C, O
All other brands

Very High Potency

Alphatrex®* (augmented betamethasone) 0.05% G
Apexicon®* (diflorasone) 0.05% O
Clobex® (clobetasol propionate) 0.05% L, shampoo, spray
Cormax®* (clobetasol propionate) 0.05% C, O, S
Diprolene®* (augmented betamethasone) 0.05% L, O
Olux®*/Olux E® (clobetasol propionate) 0.05% F
Psorcon-E®* (diflorasone diacetate) 0.05% C
Temovate®* (clobetasol propionate) 0.05% C, G, O, S
Vanos® (fluocinonide) 0.1% C
Ultravate®* (halobetasol propionate) 0.05% C, O
All other brands

C=cream, F=foam, G=gel, L=lotion, O=ointment, S=solution

PDL Key:

† Generic product

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Dermatological Agents: Genital Wart Therapy

Length of Authorization: Up to 16 weeks

Quantity limits apply

NO PA REQUIRED

ALDARA[®] (imiquimod 5%)

PODOFILOX SOLUTION[†] (compare to Condylox[®])

PA REQUIRED

Imiquimod[†] 5 % (compare to Aldara[®]) cream

Condylox[®] Gel (podofilox gel)
Condylox^{®*} solution (podofilox solution)

Veregan[®] (sinecatechins ointment)
(Quantity limit = 15 grams (1 tube)/per 30 days)

Zyclara[®] (imiquimod 3.75%) Cream
(Quantity limit = 56 packets)/per 8 weeks)

Dermatological Agents: Immunomodulators

****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)

Dermatological Agents: Scabicides and Pediculocides

Length of Authorization: date of service only, no refills

NO 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 Pediculocides

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

PA REQUIRED

Elimite^{®*} (permethrin 5 %) C

Lindane[†] L, Sh

Malathion [†]L (compare to Ovide[®])

Ovide[®] (malathion) L

Ulesfia[®] (benzoyl alcohol 5%) L

Desmopressin: Intranasal/Oral

Length of Authorization: 2 years

NO PA REQUIRED

Intranasal

Oral

DESMOPRESSIN[†]

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

DDAVP^{®*} (desmopressin) tablets

PDL Key:

[†] Generic product

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Diabetic Testing Supplies

Length of Authorization: 5 years

NO PA REQUIRED

DIABETIC MONITORS/METERS

FREESTYLE LITE[®] SYSTEM KIT
FREESTYLE FLASH[®] SYSTEM KIT
FREESTYLE FREEDOM[®] SYSTEM KIT
FREESTYLE FREEDOM LITE[®] SYSTEM KIT
ONE TOUCH[®] ULTRA 2 KIT
ONE TOUCH[®] ULTRA MINI KIT
ONE TOUCH[®] ULTRA SMART KIT
PRECISION XTRA[®] METER

DIABETIC TEST STRIPS

FREESTYLE^{®*}
FREESTYLE LITE^{®*}
ONE TOUCH[®] BASIC*
ONE TOUCH[®] SURESTEP*
ONE TOUCH[®] FAST TAKE*
ONE TOUCH[®] UL[®]TRA*
PRECISION XTRA^{®*}
PRECISION XTRA[®] BETA KETONE (10 count)
* 50 and 100 count package sizes

PA REQUIRED

Accucheck[®]
Ascensia[®]
Assure[®]
Exactech[®]
Prodigy[®]

All other brands and store brands

Accucheck[®]
Ascensia[®]
Assure[®]
Exactech[®]
Prodigy[®]

All other brands and store brands

Estrogens: Vaginal

Length of Authorization: n/a

NO PA REQUIRED

Estradiol

ESTRACE VAGINAL[®] Cream
ESTRING[®] Vaginal Ring
VAGIFEM[®] Vaginal Tablets

Conjugated Estrogens

PREMARIN VAGINAL[®] Cream

Estradiol Acetate

FEMRING[®] Vaginal Ring

PA REQUIRED

Fibromyalgia Agents

Length of Authorization: 1 year

Quantity limits apply

NO PA REQUIRED

PA REQUIRED

Savella[®] (milnacipran) tablet, titration pack
Quantity Limit = 2 tablets/day

Gastrointestinal: Crohn's Disease Injectables

****Self-injectable (Cimzia[®] and Humira[®]) must be obtained through Specialty Pharmacy Provider, ICORE****

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

Drug-specific PA fax form available on DVHA website.

PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

HUMIRA[®] (adalimumab)

Quantity limit = 6 syringes/28 days for the first month (Crohn's starter kit); 2 syringes/28 days subsequently

REMICADE[®] (infliximab)

NON-PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

Cimzia[®] (certolizumab pegol)

Quantity limit = 1 kit/28 days (starter X 1, then regular)

Tysabri[®] (natalizumab)

PDL Key:

† Generic product

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Gastrointestinals: H2-blockers

Length of Authorization: 1 year

NO PA REQUIRED

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

SYRUPS AND SPECIAL DOSAGE FORMS

CIMETIDINE † ORAL SOLUTION
RANITIDINE† syrup (compare to Zantac®)

PA REQUIRED

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

Axid® (nizatidine) Oral Solution §
famotidine† (compare to Pepcid®) oral suspension §
Nizatidine †Oral Solution (compare to Axid®)
Pepcid® (famotidine) Oral Suspension §
Zantac (ranitidine)Effervescent® §
Zantac®* (ranitidine) Syrup§

Gastrointestinals: Inflammatory Bowel Agents (Oral and Rectal Products)

Length of Authorization: 1 year

NO PA REQUIRED

MESALAMINE PRODUCTS

Oral

APRISO® (mesalamine capsule extended-release)
ASACOL® (mesalamine tablet delayed-release)
LIALDA® (mesalamine tablet extended-release)
PENTASA® (mesalamine cap CR)

Rectal

CANASA® (mesalamine suppository)
MESALAMINE ENEMA† (compare to Rowasa®)

OTHER

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

PA REQUIRED

Asacol HD® (mesalamine tablet delayed release)

Rowasa®* (mesalamine enema)
Sfrowasa® (mesalamine enema sulfite free)

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

Gastrointestinals: Prokinetic Agents

Length of Authorization: up to 3 months

Quantity limits apply

NO PA REQUIRED

Tablets

METOCLOPRAMIDE† tabs (compare to Reglan®)

Oral Solution

METOCLOPRAMIDE† (formerly Reglan®) oral solution

Orally Disintegrating Tablets

PA REQUIRED

Reglan®* (metoclopramide)

Metozolv ODT® (metoclopramide) (QL= 4 tabs/day)

PDL Key:

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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

KAPIDEX[®] /DEXILANT[®] (dexlansoprazole) capsules (*Quantity limit=1 cap/day*)

OMEPRAZOLE† 20 mg or 40 mg RX capsule (compare to Prilosec[®]) (*Quantity limit = 1 capsule/day*)

PANTOPRAZOLE† tablets (compare to Protonix[®]) (*Quantity limit=1 tab/day*)

SUSPENSION & SPECIAL DOSAGE FORMS

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*)

lansoprazole generic RX (compare to Prevacid[®]) capsules (*Quantity limit = 1 cap/day*)

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

omeprazole^{†*} generic 10 mg RX capsules § (compare to Prilosec[®]) (*Quantity limit=1 cap/day*)

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

omeprazole magnesium† generic OTC 20 mg capsules§ (*Quantity limit=1 cap/day*)

Omeprazole/sodium bicarb capsules RX (compare to Zegerid[®])§ (*Quantity limit=1 cap/day*)

Prevacid[®] RX (lansoprazole) capsules § (*Quantity limit=1 cap/day*)

Prevacid[®] 24 hr OTC (lansoprazole) capsules (*Quantity limit=1 cap/day*)

Prilosec OTC[®] 20mg (omeprazole magnesium) tablets (*Quantity limit = 1 tablet/day*)

Prilosec^{®*} RX (brand) (omeprazole) capsules § (*Quantity limit=1 cap/day*)

Protonix^{®**} (pantoprazole) tablets (*Quantity limit=1 tab/day*)

lansoprazole ODT† generic RX (compare to Prevacid[®] Solutabs) (*Quantity limit=1 tab/day*)

Nexium[®] (esomeprazole) powder for suspension § (*Quantity limit=1 packet/day*)

Prilosec (omeprazole magnesium) packet (*Quantity limit=2 packets/day*)

Protonix[®] (pantoprazole) packet (*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 DVHA website.

NO PA REQUIRED

PA REQUIRED

Remicade[®] (infliximab)

Gaucher's Disease Medications

Length of Authorization: initial approval 6 months, subsequent approval 1 year

Quantity limits apply

NO PA REQUIRED

PA REQUIRED

Cerezyme[®] (imiglucerase for injection)

Vpriv[®] (velaglucerase alfa for injection)

Maximum days supply per fill for all drugs is 14 days

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Gout Agents

Length of Authorization: 1 year

Quantity limits apply

NO PA REQUIRED

SINGLE INGREDIENT COLCHICINE

SINGLE INGREDIENT URICOSURIC AGENTS

PROBENECID†

XANTHINE OXIDASE INHIBITORS

ALLOPURINOL† (compare to Zyloprim®)

COMBINATION PRODUCTS

COLCHICINE/PROBENECID†

PEG-URICASE AGENTS

PA REQUIRED

Colcrys® (colchicine) tablet
QL = 3 tablets/day (gout) or 4 tablets/day (FMF)

Uloric® (febuxostat) *QL (40 mg tablets) = 1 tablet/day*
Zyloprim®* (allopurinol)

Krystexxa (pegloticase) Vials for IV Infusion
QL = 2 vials/28 days

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 DVHA website.

PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

NORDITROPIN®

NON-PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

Genotropin®
Humatrope®
Nutropin®/Nutropin® AQ
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 DVHA website.

NO PA REQUIRED

All Factors

PA REQUIRED

None

PDL Key:

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Hepatic Encephalopathy Agents

Length of Authorization: 1 year

Quantity limits apply

NO PA REQUIRED

Osmotic Laxatives

LACTULOSE†

Antibiotics

METRONIDAZOLE† 250 mg Tablets

NEOMYCIN SULFATE† 500 mg Tablets

PA REQUIRED

Xifaxan® (rifaximin) 550 mg Tablets
(Qty limit = 2 tablets/day)

Note: Xifaxan (rifaximin) 200 mg tablets – *Quantity Limit = 9 tablets/RX*
(only FDA approved for traveler's diarrhea indication)

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 DVHA 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-Intron Redipen® (peg-interferon alpha-2b) (QL=4 pens per 28 days)

Peg-Intron Redipen Pak 4® (peg-interferon alpha-2b) (QL=1 kit (4 pens) per 28 days)

Hereditary Angioedema Medications

Length of Authorization: initial approval 6 months, subsequent approval 1 year

Quantity limits apply

NO PA REQUIRED

PA REQUIRED

Beriner® (human C1 inhibitor)

Cinryze® (human C1 inhibitor)

(QL = 16 vials/28 days for prophylaxis; 4 vials per fill for acute attacks)

Kalbitor® (ecallantide)

(QL = 6 vials (2 packs) per fill)

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Lipotropics: Bile Acid Sequestrants

Length of Authorization: 3 years

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: 1 year

NO PA REQUIRED

GEMFIBROZIL† (compare to Lopid®) 600 mg

On statin concurrently or after gemfibrozil trial

TRICOR® (fenofibrate nanocrystallized) § 48 mg, 145 mg
Quantity Limit = 1 tablet/day
TRILIPIX (fenofibric acid) §45 mg, 135 mg delayed release capsule
Quantity Limit = 1 capsule/day

PA REQUIRED

Antara® (fenofibrate micronized) § 43 mg, 130 mg
fenofibrate tablets†(compare to Lofibra® tablets) § 54 mg, 160 mg
fenofibrate micronized capsule†(compare to Lofibra® capsules) § 67 mg, 134 mg, 200 mg
fenofibric acid § 35 mg, 105 mg
Quantity Limit = 1 capsule/day
Fenoglide® (fenofibrate MeltDose) § 40 mg, 120 mg
Fibricor® (fenofibric acid) § 35 mg, 105 mg
Quantity Limit = 1 capsule/day
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: Nicotinic Acid Derivatives

Length of Authorization: n/a

NO PA REQUIRED

NIASPAN® (niacin extended release)

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*)

SIMVASTATIN† (compare to Zocor®)
(*QL = 1 tablet/day of 5 mg, 10 mg, 20 mg and 40 mg*)

**AFTER GENERIC SIMVASTATIN TRIAL
(6 week trial of simvastatin of 40 mg/day)**
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*)

High Potency Statins

Lipitor® (atorvastatin) (*QL = 1 tablet/day*)
Livalo (pitavastatin) (*QL = 1 tablet/day*)
Simvastatin† 80 mg tablets (compare to Zocor®) (*QL = 1 tablet/day*)
Zocor®* (simvastatin) (*QL = 1 tablet/day*)

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Lipotropics: Miscellaneous/Combinations

Length of Authorization: 1 year

Quantity limits apply

NO PA REQUIRED

PA REQUIRED

Miscellaneous

Lovaza[®] (omega-3-acid ethyl esters)

Cholesterol Absorption Inhibitors/Combinations

Vytorin[®] (ezetimibe/simvastatin)

(*QL = 1 tablet/day*)

Zetia[®] (ezetimibe)

(*Qty Limit = 1 tablet/day*)

Other Statin Combinations

SIMCOR[®] (simvastatin/extended release niacin)

(*Qty Limit = 1 tablet/day*)

Advicor[®] (lovastatin/extended release niacin)

(*Qty Limit = 1 tablet/day*)

Caduet[®] (atorvastatin/amlodipine)

(*Qty Limit = 1 tablet/day*)

Miscellaneous: Carbaglu[®]

Length of Authorization: 1 year

Quantity limits apply ****Requires DVHA Medical Director Final Review****

NO PA REQUIRED

PA REQUIRED

Carbaglu[®] dispersible tablets (carglumic acid)

(*Maximum days supply per fill = 14 days*)

Miscellaneous: Elaprase[®] (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[®] (idursulfase) (*QL = calculated dose/week*)

Miscellaneous: Glycopyrrolate

Length of Authorization: 1 year

Quantity limits apply

NO PA REQUIRED

PA REQUIRED

GLYCOPYRROLATE 1 mg, 2 mg tablets (compare to Robinul[®], Robinul Forte[®])

Cuvposa[®] oral solution (glycopyrrolate)*

Maximum days supply per fill is 30 days

Robinul[®] 1 mg tablet (glycopyrrolate)

Robinul[®] Forte 2 mg tablet (glycopyrrolate)

Miscellaneous: Lysteda[®]

Length of Authorization: 1 year

Quantity limits apply

NO PA REQUIRED

PA REQUIRED

Lysteda[®] tablets (tranexamic acid)

Quantity limit = 30 tablets/28 days

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Miscellaneous: Samsca® (for Hyponatremia)*Length of Authorization: Initial 1 month, Subsequent up to 1 year***Quantity limits apply**

NO PA REQUIRED

PA REQUIRED

Samsca® tablets (tolvaptan)

*Quantity limit = 15 mg tablets (1 tablet/day), 30 mg tablets (2 tablets/day)***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/12 weeks initially; 6 vials/28 days 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)*)**Miscellaneous: Xenazine® (for Huntington's Disease with chorea)***Length of Authorization: Initial 1 month, Subsequent up to 1 year***Quantity limits apply**

NO PA REQUIRED

PA REQUIRED

Xenazine® tablets (tetrabenazine) (*Maximum 1 month supply per fill*
Quantity limit = 50 mg/day at initial approval (12.5 mg tablets ONLY), up to 100 mg/day at subsequent approvals (12.5 mg or 25 mg tablets))**Mood Stabilizers (see also Anticonvulsants)***Length of Authorization: duration of need*

NO PA REQUIRED

PA REQUIRED

LITHIUM CARBONATE† (formerly Eskalith®)
LITHIUM CARBONATE SR† (compare to Lithobid®, formerly Eskalith CR®)
LITHIUM CITRATE SYRUP†Equetro® (carbamazepine SR)
Lithobid®* (lithium carbonate SR)**Mucosal Coating Agents***Length of Authorization: 6 months***Quantity limits apply**

NO PA REQUIRED

PA REQUIRED

ALUMINUM HYDROXIDE† (formerly Amphojel®)
GELCLAIR® (povidone sodium hyaluronate glycyrrhetic acid gel)
MYLANTA/DIPHENYDRAMINE/LIDOCAINE VISCOUS (aka "Magic Mouthwash")MuGard® (mucoadhesive oral wound rinse)
(*QL = 4 bottles/month*)

Or other similar single or combination products

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Multiple Sclerosis Medications

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

Quantity limits apply

****Self-injectables (Avonex[®], Betaseron[®], Rebif[®], Extavia[®] and Copaxone[®]) and Gilenya[®] must be obtained through Specialty Pharmacy Provider, ICORE****

NO PA REQUIRED

INJECTABLES

Interferons

AVONEX[®] (interferon B-1a)

BETASERON[®] (interferon B-1b)

REBIF[®] (interferon B-1a)

Other

COPAXONE[®] (glatiramer acetate) (*QL = 1 kit/30 days*)

ORAL

PA REQUIRED

Extavia[®] (interferon beta-1b)

Tysabri[®] (natalizumab)

Ampyra[®] (dalfampridine) tablet

(*QL = 2 tablets/day, maximum 30 day supply per fill*)

Gilenya[®] (fingolimod) capsule

(*QL = 1 capsule/day, maximum 28 day supply per fill*)

Nutritionals, liquid oral supplements

Length of Authorization: 6 months

Therapy specific PA fax form available on DVHA 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

Oncology: Oral (select)

****Select medications must be obtained through Specialty Pharmacy Provider, ICORE****

Therapy specific Order form is available on DVHA website.

NO PA REQUIRED

ALL – see Oncology: Oral order form for details of medication that must be obtained through ICORE, DVHA's specialty pharmacy provider

PA REQUIRED

PDL Key:

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Ophthalmics: Antibiotics

Length of Authorization: Duration of therapy requested

NO PA REQUIRED

QUINOLONES

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

MACROLIDES

ERYTHROMYCIN†
ROMYCIN† (erythromycin)

AMINOGLYCOSIDES

Single Agent

AK-TOB† (tobramycin)
GENOPTIC† (gentamicin)
GENTAK† (gentamicin)
GENTAMICIN†
TOBRAMYCIN † sol (compare to Tobrex®)

Combination

TOBRAMYCIN W/DEXAMETHASONE (compare to Tobradex®)

MISCELLANEOUS

Single Agent

BACITRACIN
SULFACETAMIDE SODIUM (compare to Bleph-10®)

Combination

AK-POLY-BAC† (bacitracin/polymyxin)
BACITRACIN ZINC W/POLYMYXIN B (compare to Polysporin®)
NEOMYCIN/POLYMYXIN W/BACITRACIN (compare to Neosporin®)
NEOMYCIN/POLYMYXIN W/DEXAMETHASONE (compare to Maxitrol®)
NEOMYCIN/POLYMYXIN W/GRAMICIDIN (compare to Neosporin®)
NEOMYCIN/POLYMYXIN W/HYDROCORTISONE
NEOMYCIN/POLYMYXIN/BACITRACIN/ HYDROCORTISONE
POLYMYXIN B W/TRIMETHOPRIM (Polytrim®)
SULFACETAMIDE W/PREDNISOLONE ACETATE (compare to Blephamide®)
SULFACETAMIDE W/PREDNISOLONE SOD PHOSPHATE

PA REQUIRED

Besivance® (besifloxacin)
Ciloxan®*(ciprofloxacin)
Iquix® (levofloxacin 1.5 %) (preservative free)
levofloxacin† 0.5 % (compare to Quixin®)
Moxeza® (moxifloxacin 0.5%) (preservative free)
Ocuflox®*(ofloxacin)
Quixin® (levofloxacin 0.5 %)
Vigamox® (moxifloxacin) (preservative free)
Zymar® (gatifloxacin 0.3%)
Zymaxid® (gatifloxacin 0.5%)

Azasite®(azithromycin)

All other brands

Tobrex® sol* (tobramycin)

Tobrex® gel (tobramycin)

Tobradex®* (tobramycin/dexamethasone)

TobraDex ST® (tobramycin/dexamethasone)

Zylet® (tobramycin/loteprednol)

Pred-G® (gentamicin/prednisolone)

All other brands

Bleph-10®* (sulfacetamide)

All other brands

Blephamide® (sulfacetamide/prednisolone acetate)

Maxitrol®* (neomycin/polymyxin/dexamethasone)

Neosporin®* (neomycin/polymyxin/gramicidin or neomycin/polymyxin/bacitracin)

Poly-pred® (neomycin/polymyxin B/prednisolone acetate)

Polysporin®* (bacitracin/polymyxin B)

Polytrim®* (polymyxin B/trimethoprim)

All other brands

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Ophthalmics: Antihistamines

Length of Authorization: 1 year

Quantity limits apply

NO PA REQUIRED

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

After trial of ketotifen 0.025 %

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

PA REQUIRED

Azelastine † (compare to Optivar®) (QL = 1 bottle/month)
Bepreve® (bepotastine besilate) (QL = 1 bottle/month)
Elestat® (epinastine) (Quantity Limit = 1 bottle/month)
Epinastine† (compare to Elestat®) (QL = 1 bottle/month)
Emadine® (emedastine) (Quantity Limit = 2 bottles/month)
Lastacaft® (alcaftadine) (QL = 1 bottle/month)
Optivar® (azelastine) (QL = 1 bottle/month)
Zaditor® RX (ketotifen 0.025 %) (Quantity Limit = 1 bottle/month)

Ophthalmics: Corticosteroids: Topical

Length of Authorization: up to 3 months

NO PA REQUIRED

DEXAMETHASONE SODIUM PHOSPHATE 0.1% Sol†
FLUOROMETHOLONE 0.1% S†
PREDNISOLONE ACETATE 1% S†

E=emulsion, S=suspension, Sol=solution

PA REQUIRED

Alrex® (loteprednol) 0.2% S
Durezol® (difluprednate) 0.05% E
FML® (fluorometholone) 0.1% O
FML Forte® (fluorometholone) 0.25% S
FML Liquifilm®/Flarex® (fluorometholone) 0.1% S
Lotemax® (loteprednol) 0.5% S
Pred Forte®/Omnipred® (prednisolone acetate) 1% S
Pred Mild® (prednisolone acetate) 0.12% S
Vexol® (rimexolone) 1% S

All other brands

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Ophthalmics: Glaucoma Agents/Miotics

Length of Authorization: 1 year

NO PA REQUIRED

ALPHA-2 ADRENERGIC

Single Agent

ALPHAGAN P® 0.1 %, 0.15 % (brimonidine tartrate)
BRIMONIDINE TARTRATE† 0.2 % (formerly Alphagan®)

Combination

COMBIGAN® (brimonidine tartrate/timolol maleate)

BETA BLOCKER

BETAXOLOL HCL† (compare to Betoptic®)
BETOPTIC S® (betaxolol suspension)
CARTEOLOL HCL† (compare to Ocupress®)
LEVOBUNOLOL HCL† (compare to Betagan®)
METIPRANOLOL† (compare to Optipranolol®)
TIMOLOL MALEATE† (compare to Istalol®, Timoptic®)
TIMOLOL MALEATE †gel (compare to Timotic XE®)

PROSTAGLANDIN INHIBITORS

Note: Coverage of a 'preferred' PI agent is contingent upon a 1st-line trial of at least one preferred beta-blocker. Coverage of a 'non-preferred' PI agent is contingent upon a similar first-line trial as well as a failed trial of both Lumigan and Travatan/Travatan Z.

LUMIGAN® 0.01 %/0.03 % (bimatoprost) §
TRAVATAN®/TRAVATAN Z® (travoprost) §

CARBONIC ANHYDRASE INHIBITOR

Single Agent

DORZOLAMIDE 2 % (compare to Trusopt®)

Combination

DORZOLAMIDE w/TIMOLOL (compare to Cosopt®)

MISCELLANEOUS

DIPIVEFRIN HCL† (compare to Propine®)
ISOPTO® CARBACHOL (carbachol)
ISOPTO® CARPINE (pilocarpine)
PILOCARPINE HCL† (formerly Pilocar®)
PILOPINE® (pilocarpine)
PHOSPHOLINE IODIDE® (echothiophate)
PROPINE® (dipivefrin)

PA REQUIRED

apraclonidine† (compare to Iopidine®) (no PA required for patients ≤ 10 years of age)
brimonidine tartrate 0.15 % † (compare to Alphagan P®)
Iopidine® (apraclonidine) (no PA required for patients ≤ 10 years of age)

Betagan®* (levobunolol)
Betimol® (timolol)
Istalol®* (timolol)
Optipranolol®* (metipranolol)
Timoptic®* (timolol maleate)
Timoptic XE®* (timolol maleate gel)

Latanoprost† (compare to Xalatan®)
Xalatan® (latanoprost)

Azopt® (brinzolamide 1%)
Trusopt®* (dorzolamide 2%)

Cosopt®* (dorzolamide w/timolol)

Miochol-E® (acetylcholine)
Miostat® (carbachol)

Ophthalmics: Immunomodulators

Length of Authorization: 1 year

Quantity limits apply

NO PA REQUIRED

PA REQUIRED

Restasis® (cyclosporine ophthalmic emulsion) 0.05% (QL=60 vials 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)

Ophthalmics: Mast Cell Stabilizers

Length of Authorization: 6 months

NO PA REQUIRED

CROMOLYN SODIUM† (compare to Cromol[®])

PA REQUIRED

Alamast[®] (pemirolast potassium)
Alocril[®] (nedocromil sodium)
Alomide[®] (lodoxamide)
Crolom^{®*} (cromolyn sodium)

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

Length of Authorization: 1 year

NO PA REQUIRED

ACULAR[®] (ketorolac 0.5% ophthalmic sol.)
ACULAR LS[®] (ketorolac 0.4% ophthalmic sol.)

FLURBIPROFEN † 0.03% ophthalmic sol.

PA REQUIRED

Acuvail (ketorolac 0.45 %) Ophthalmic Solution (*Quantity Limit = 30 unit dose packets/15 days*)
Bromfenac † 0.09 % ophthalmic sol (compare to Xibrom[®])
Diclofenac† 0.1% ophthalmic sol (compare to Voltaren[®])
Ketorolac† 0.4 % ophthalmic sol (compare to Acular LS[®])
Ketorolac† 0.5 % ophthalmic sol (compare to Acular[®])
Nevanac[®] ophthalmic susp. (nepafenac 0.1%)
Ocufen^{®*} ophthalmic sol. (flurbiprofen 0.03%)
Voltaren[®] (diclofenac 0.1% ophthalmic sol)
Xibrom[®] ophthalmic sol. (bromfenac 0.09%)

Otic: Anti-Infectives

Length of Authorization: 1 year

NO PA REQUIRED

Anti-infective Single Agent

OFLOXACIN† 0.3% Otic Soln (previously Floxin[®])

Anti-infective/Corticosteroid Combination

CIPRODEX[®] (ciprofloxacin 0.3%/dexamethasone 0.1%) otic suspension

NEOMYCIN/POLYMYXIN B SULFATE/HYDROCORTISONE†
(compare to Cortisporin otic[®])

CORTOMYCIN† (neomycin/polymyxin B sulfate/hydrocortisone) Otic soln, susp

Miscellaneous Agents

ACETIC ACID† Otic soln

ACETIC ACID-ALUMINUM ACETATE† Otic soln

VOSOL[®] (acetic acid 2%) Otic soln

PA REQUIRED

Cetraxal (ciprofloxacin 0.2%) otic solution
(*Quantity limit = 14 unit dose packages/7 days*)

Cipro-HC[®] (ciprofloxacin 0.2%/hydrocortisone 1%) otic suspension

Coly-Mycin S[®]/Cortisporin TC[®] (neomycin/colistin/thonzium/hydrocortisone)

Cortisporin otic^{®*} (neomycin/polymyxin B sulfate /hydrocortisone) otic solution/suspension

Acetasol HC† (acetic acid 2%/hydrocortisone 1% otic soln)

Acetic Acid/Hydrocortisone† Otic Soln

Auralgan[®]/Otic Care[®]/ Otic Edge[®]/PR Otic[®]/Treagan[®] (acetic acid/antipyrine/benzocaine/polycosanol)

TriOxin[®]/ Myoxin (benzocaine/chloroxylenol/hydrocortisone susp)

Vosol HC[®] (acetic acid 2%/hydrocortisone 1% otic soln)

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Over-the-Counter (OTC) Medications

Please refer to the DVHA website for covered OTC categories not already managed on the PDL. Many categories limited to generics ONLY and other categories not covered.

No PA process for non-covered OTCs.

Pancreatic Enzyme Products

Length of Authorization: n/a

NO PA REQUIRED

CREON 3,000 (lipase units) DR Capsule
CREON 6,000 (lipase units) DR Capsule
CREON 12,000 (lipase units) DR Capsule
CREON 24,000 (lipase units) DR Capsule
PANCREAZE® 4,200 (lipase units) DR Capsule
PANCREAZE® 10,500 (lipase units) DR Capsule
PANCREAZE® 16,800 (lipase units) DR Capsule
PANCREAZE® 21,000 (lipase units) DR Capsule
ZENPEP® 5,000 (lipase units) DR Capsule
ZENPEP® 10,000 (lipase units) DR Capsule
ZENPEP® 15,000 (lipase units) DR Capsule
ZENPEP® 20,000 (lipase units) DR Capsule

DR=delayed release

PA REQUIRED

PDL Key:

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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®)
PRAMIPEXOLE † (compare to Mirapex®)
ROPINIROLE† (compare to Requip®)

COMT INHIBITORS

COMTAN® (entacapone)

MAO-B INHIBITORS

SELEGILINE† (compare to Eldepryl®)

OTHER

AMANTADINE† capsules (formerly Symmetrel®)
STALEVO® (carbidopa/levodopa/entacapone)

PA REQUIRED

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

Mirapex®* (pramipexole)
Mirapex ER® (pramipexole ER)
QL = 1 tab/day
Parlodel® (bromocriptine)
Requip®* (ropinirole)
Requip XL® (ropinirole XL)
QL = 1 tab/day (all strengths except 12 mg), QL = 2 tabs/day (12 mg)

Tasmar® (tolcapone)

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

Amantadine† tablets (formerly Symmetrel®)

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

Adcirca® (tadalafil) (*Quantity Limit = 2 tablets/day*)
Revatio® (sildenafil) (*Quantity Limit = 3 tablets/day*)
Revatio® (sildenafil citrate) vial
(*Quantity Limit = 3 vials/day, maximum 14 days supply per fill*)
Viagra® (sildenafil) (*Quantity Limit = 3 tablets/day*)

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Platelet Inhibitors

Length of Authorization: 1 year

NO PA REQUIRED

AGGREGATION INHIBITORS

CILOSTAZOL† (compare to Pletal®)
EFFIENT® (prasugrel) Tablet *QL = 1 tablet/day*
PLAVIX® 75 mg (clopidogrel bisulfate)
TICLOPIDINE† (previously Ticlid®)

OTHER

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

PA REQUIRED

Plavix® 300 mg (clopidogrel bisulfate)
Pletal®* (cilostazol)

Agrylin®* (anagrelide)
Persantine®* (dipyridamole)

Psoriasis Injectables

****Self-injectables (Enbrel® and Humira®) and Stelara® must be obtained through Specialty Pharmacy Provider, ICORE****

Length of Authorization: initial PA of 3 months (Stelara 4 months), 12 months thereafter.

Quantity limits apply

Drug-specific PA fax form available on DVHA website.

PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

ENBREL® (etanercept)
Quantity limit = 8 syringes/28 days for the first 3 months; then 4 syringes/28 days (50 mg) or 8 syringes/28 days (25 mg) subsequently
HUMIRA® (adalimumab)
Quantity limit = 4 syringes/28 days for one month; 2 syringes/28 days subsequently

NON-PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

Amevive® (alefacept)
Remicade® (infliximab)
Stelara® (ustekinumab)
*(Quantity limit = 45 mg (0.5 ml) or 90 mg (1 ml) per dose)
(90 mg dose only permitted if pt weight > 100 kg)*

Psoriasis: Non-Biologics

Length of Authorization: 1 year

Quantity limits apply

NO PA REQUIRED

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

CALCIPOTRIENE† Solution (compare to Dovonex®)
CALCIPOTRIENE® Ointment (formerly Dovonex®)
DOVONEX® (calcipotriene cream)
PSORiatec®, DRITHO-SCALP® (anthralin cream)
TAZORAC® (tazarotene cream, gel)

PA REQUIRED

Oral

Topical

Calcitrene® (calcipotriene) ointment
Dovonex®* solution (calcipotriene)
Taclonex® (calcipotriene/betamethasone ointment/scalp suspension)
(QL for initial fill = 60 grams)
Vectical® Ointment (calcitriol)
(Quantity Limit = 200 g (2 tubes)/week)

PDL Key:

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Pulmonary: Anticholinergics: Inhaled

Length of Authorization: 1 year

NO PA REQUIRED

METERED DOSE INHALER (SINGLE AGENT)

ATROVENT HFA® (ipratropium)

Quantity Limit = 2 inhalers/25 days

SPIRIVA® (tiotropium)

Quantity Limit = 1 capsule/day

NEBULIZER (SINGLE AGENT)

IPRATROPIUM SOLN FOR INHALATION

METERED DOSE INHALER (COMBINATION PRODUCT)

COMBIVENT® (ipratropium/albuterol)

Quantity Limit = 2 inhalers/30 days

NEBULIZER (COMBINATION PRODUCT)

IPRATROPIUM/ALBUTEROL† (compare to Duoneb®)

PA REQUIRED

Duoneb®* (ipratropium/albuterol)

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

Astepro® (azelastine) Nasal Spray

Quantity Limit = 1 bottle (30 ml)/25 days

azelastine (compare to Astelin®) Nasal Spray

Quantity Limit = 1 bottle (30 ml)/25 days

Patanase® (olopatadine 0.6%) Nasal Spray

Quantity Limit = 1 bottle (31 gm)/25 days

Pulmonary: Antihistamines: 1st 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®)

PDL Key:

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Pulmonary: Antihistamines: 2nd 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

LORATADINE (OTC) † rapidly disintegrating tablet (RDT)

PA REQUIRED

Allegra[®] (fexofenadine)

Clarinex[®] (desloratadine)

Claritin[®] capsule (loratadine)

Claritin[®] tablet (loratadine)

Levocetirizine (compare to Xyzal[®])

Xyzal[®] (levocetirizine)

All other brands

Allegra-D[®] § (12 HR & 24 HR)

Cetirizine-D † SR

Clarinex-D[®] § (12 HR & 24 HR)

Claritin-D[®] §

Fexofenadine-PSE † (compare to Allegra-D[®] 12 hr)

All other brands

Allegra[®] suspension

Clarinex[®] Syrup

Claritin Syrup^{®*}

Xyzal (levocetirizine) Syrup[®]

All other brands

Allegra ODT[®] §

Cetirizine † Chewable Tablets

Clarinex Reditabs[®] §

Claritin Chewable Tablets[®] §

Claritin Reditabs^{®*} §

All other brands

PDL Key:

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Pulmonary: Beta-adrenergic Agents

Length of Authorization: 1 year

Quantity limits apply

NO PA REQUIRED

METERED-DOSE INHALERS (SHORT-ACTING)

XOPENEX[®] HFA (levalbuterol)

MAXAIR[®] Autohaler (pirbuterol)

METERED-DOSE INHALERS (LONG-ACTING)

FORADIL[®] (formoterol) *(after criteria for LABA are met)*

Quantity Limit = 60 capsules/month

SEREVENT[®] DISKUS (salmeterol xinafoate) *(after criteria for LABA are met)*

Quantity Limit = 60 blisters/30 days

NEBULIZER SOLUTIONS (SHORT-ACTING)

ALBUTEROL † 0.63 mg/ml and 1.25 mg/ml neb solution (compare to Accuneb[®])

ALBUTEROL † 0.83 mg/ml neb solution

XOPENEX[®] neb solution (levalbuterol HCL) (age ≤ 12 yrs)

NEBULIZER SOLUTIONS (LONG-ACTING)

TABLETS/SYRUP (SHORT-ACTING)

ALBUTEROL † tablets/syrup

METAPROTERENOL † tablets/syrup

TABLETS (LONG-ACTING)

ALBUTEROL ER † tablets

PA REQUIRED

Proair[®] HFA (albuterol)

Proventil[®] HFA (albuterol)

Ventolin[®] HFA (albuterol)

Accuneb[®]* (albuterol sulfate neb solution 0.63 mg/ml and 1.25 mg/ml)

Levalbuterol † neb solution (compare to Xopenex[®]) (all ages)

Xopenex[®] neb solution (age > 12 yrs)

Brovana[®] (arformoterol) *QL = 2 vial/day*

Perforomist[®] (formoterol) *QL = 2 vial/day*

Brethine[®]* (terbutaline)

terbutaline tablets † (compare to Brethine[®])

Vospire ER[®]* (albuterol)

PDL Key:

† Generic product

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Pulmonary: Corticosteroids/Combinations: Inhaled

Length of Authorization: 1 year

Quantity limits apply

NO PA REQUIRED

METERED DOSE INHALERS (SINGLE AGENT)

ASMANEX[®] 220 mcg/inh (mometasone furoate)

((QL = 0.72 gm (3 inhalers)/90 days))

ASMANEX[®] 110 mcg/inh (mometasone furoate)

((QL = 0.405 gm (3 inhalers)/90 days))

FLOVENT[®] DISKUS (fluticasone propionate)

(QL = 3 inhalers/90 days)

FLOVENT[®] HFA (fluticasone propionate)

(QL = 36 gm (3 inhalers)/90 days)

PULMICORT FLEXHALER[®] (budesonide)

(QL = 6 inhalers/90 days)

QVAR[®] 40 mcg/inh (beclomethasone)

(QL = 17.4 gm (2 inhalers)/90 days)

QVAR[®] 80 mcg/inh (beclomethasone)

(QL = 58.4 gm (8 or 6 inhalers)/90 days)

METERED DOSE INHALERS (COMBINATION PRODUCT)

ADV AIR[®] DISKUS (fluticasone/salmeterol)

(QL = 3 inhalers/90 days)

ADV AIR[®] HFA (fluticasone/salmeterol)

(QL = 36 gm (3 inhalers)/90 days)

DULERA[®] (mometasone/formoterol)

(QL = 39 gm (3 inhalers)/90 days)

SYMBICORT[®] (budesonide/formoterol)

(QL = 30.6 gm (3 inhalers)/90 days)

NEBULIZER SOLUTIONS

PULMICORT RESPULES[®] (budesonide) (age ≤ 12 yrs)

PA REQUIRED

Aerobid[®] (flunisolide)

Aerobid M[®] (flunisolide/menthol)

Alvesco[®] (ciclesonide)

(QL = 18.3 gm (3 inhalers)/90 days) (80 mcg/inh)

(QL = 36.6 gm (6 inhalers)/90 days) (160 mcg/inh)

Budesonide Inh Suspension (compare to Pulmicort Respules[®]) (all ages)

Pulmicort Respules[®] (budesonide) (age > 12 years)

Pulmonary: Corticosteroids: Intranasal

Length of Authorization: 1 year

Quantity limits apply

NO PA REQUIRED

FLUTICASONE Propionate[†] (compare to Flonase[®])

QL = 16 gm (1 inhaler)/30 days

NASACORT AQ[®] (triamcinolone)

QL = 16.5 gm (1 inhaler)/30 days

NASONEX[®] (mometasone)

QL = 17 gm (1 inhaler)/30 days

PA REQUIRED

Beconase AQ[®] (beclomethasone)

QL = 50 gm (2 inhalers)/30 days

Flonase^{®*} (fluticasone propionate)

QL = 16 gm (1 inhaler)/30 days

flunisolide † 25 mcg/spray (previously Nasalide[®])

QL = 50 ml (2 inhalers)/30 days

flunisolide † 29 mcg/spray (formerly Nasarel[®])

QL = 50 ml (2 inhalers)/30 days

Omnaris[®] (ciclesonide)

QL = 12.5 gm (1 inhaler)/30 days

Rhinocort Aqua[®] (budesonide)

QL = 8.6 gm (1 inhaler)/30 days

triamcinolone † (compare to Nasacort AQ[®])

QL = 16.5 gm (1 inhaler)/30 days

Veramyst[®] (fluticasone furoate)

QL = 10 gm (1 inhaler)/30 days

PDL Key:

† Generic product

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Pulmonary: Leukotriene Modifiers

Length of Authorization: 1 year

NO PA REQUIRED

Note: Children 5 years old and under not subject to PA criteria for Singulair®.

PA REQUIRED

Accolate® (zafirlukast) §
Quantity Limit = 2 tablets/day
Singulair® (montelukast sodium) §
Quantity Limit = 1 tablet or packet per day
zafirlukast (compare to Accolate®) §
Quantity Limit = 2 tablets/day
Zyflo CR® (zileuton SR)
Quantity Limit = 4 tablets/day

Pulmonary: Synagis®

Length of Authorization: 1 season, up to 5 doses (per clinical criteria) (November 1-March 31)

Quantity limits apply

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

NO PA REQUIRED

PA REQUIRED: Drug specific PA fax form is available on the DVHA website

SYNAGIS® (palivizumab)
Quantity Limit = 1 vial/month (50 mg) or 2 vials/month (100 mg)

Pulmonary: Xolair®

Length of Authorization: 3 months initially, subsequent approvals for 1 year.

Quantity limits apply

Therapy specific clinical criteria are available on the DVHA website.

Drug-specific PA fax form available on DVHA website.

NO PA REQUIRED

PA REQUIRED

Xolair® (omalizumab) 150 mg subcutaneous injection vial
Quantity limit = 6 vials every 28 days

Pulmonary Arterial Hypertension Medications

Length of Authorization: 1 year

Quantity limits apply

NO PA REQUIRED

ENDOTHELIAL RECEPTOR ANTAGONISTS

LETAIRIS® (ambrisentan) Tablet
Quantity Limit = one tablet/day
TRACLEER® (bosentan) Tablet
Quantity Limit = 2 tablets/day

PROSTANOIDS

Injection

EPOPROSTENOL † (compare to Flolan®)
REMODULIN® (treprostinil sodium injection)
VELETRI® (epoprostinil)

Inhalation

TYVASO® (treprostinil inhalation solution)
VENTAVIS® (iloprost inhalation solution)

****Maximum days supply for all drugs is 30 days****

PA REQUIRED

Flolan® (epoprostenol)

PDL Key:

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Renal Disease: Phosphate Binders

Length of Authorization: 1 year

Quantity limits apply

NO PA REQUIRED

CALCIUM ACETATE † (compare to Phos Lo[®]) capsule
ELIPHOS[®] (calcium acetate) tablet
FOSRENOL[®] (lanthanum carbonate)
RENAGEL[®] (sevelamer)

PA REQUIRED

Phos Lo^{®*} (calcium acetate) capsule
Renvela[®] (sevelamer carbonate) Oral Suspension Packet
(*QL = 2 packs/day (0.8 g strength only)*)
Renvela[®] (sevelamer carbonate) tablets

Rheumatoid, Juvenile & Psoriatic Arthritis: Immunomodulators

****Self-injectables (Enbrel[®], Humira[®], Cimzia[®], Kineret[®] and Simponi[®]) must be obtained through Specialty Pharmacy Provider, ICORE****

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

Quantity limits apply

Drug specific PA fax forms available on the DVHA website.

PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

ENBREL[®] (etanercept)
(*Quantity limit = 4 syringes/28 days (50 mg) and 8 syringes/28 days (25 mg)*)
HUMIRA[®] (adalimumab)
(*Quantity limit = 4 syringes/28 days*)

NON-PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

Actemra[®] (tocilizumab)
(*Qty limit = 4 vials/28 days (80 mg vial), 3 vials/28 days (200 mg vial) or 2 vials/28 days (400 mg vial)*)
Cimzia[®] (certolizumab pegol)
(*Quantity limit = 1 kit/28 days (starter X 1, then regular)*)
Kineret[®] (anakinra)
(*Quantity limit = 1 syringe/day*)
Orencia[®] (abatacept)
Remicade[®] (infliximab)
Simponi[®] (golimumab) *Qty Limit = 1 syringe/month*

Saliva Stimulants

Length of Authorization: 1 year

NO PA REQUIRED

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

PA REQUIRED

Salagen^{®*} (pilocarpine)

PDL Key:

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Sedative/Hypnotics

Length of Authorization: 1 year

Quantity limits apply

NO PA REQUIRED

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

PA REQUIRED

Benzodiazepine

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
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)
Edluar[®] (zolpidem) sublingual tablet (Quantity Limit = 1 tab/day)
Lunesta[®] (eszopiclone) (Quantity Limit = 1 tab/day)
Rozerem[®] (ramelteon) (Quantity Limit = 1 tab/day)
Silenor[®] (doxepin) (Quantity limit = 1 tab/day)
Somnote[®] (chloral hydrate capsule)
Sonata[®]* (zaleplon) (Quantity Limit = 1 cap/day (5 mg) or 2 caps/day (10 mg))
Zolpidem CR† (compare to Ambien CR[®]) (Quantity Limit = 1 tab/day)
Zolpimist[®] (zolpidem) Spray (5 mg/spray) (Qty Limit = 1 canister/30 days)

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

Single Agent

CHLORZOXAZONE† (compare to Parafon Forte DSC[®])
CYCLOBENZAPRINE† (compare to Flexeril[®])
METHOCARBAMOL† (compare to Robaxin[®])
ORPHENADRINE CITRATE ER† (previously Norflex[®])

Combination Product

ASA = aspirin

PA REQUIRED

Musculoskeletal Agents

Amrix[®] (cyclobenzaprine sustained-release)
carisoprodol 250 mg
carisoprodol† 350 mg (compare to Soma[®])
cyclobenzaprine ER† (compare to Amrix[®])
cyclobenzaprine 7.5 mg† (compare to Fexmid[®])
Fexmid[®] (cyclobenzaprine)
Flexeril[®]* (cyclobenzaprine)
metaxalone† (compare to Skelaxin[®])
Parafon Forte DSC[®]* (chlorzoxazone)
Robaxin[®]* (methocarbamol)
Skelaxin[®] (metaxalone)
Soma[®] (carisoprodol)

carisoprodol, ASA† (formerly Soma Compound[®])
carisoprodol, ASA, codeine† (formerly Soma Compound with Codeine[®])
orphenadrine, ASA, caffeine† (previously Norgesic[®], Norgesic Forte[®])

Antispasticity Agents

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

Dantrium[®]* (dantrolene)
Zanaflex[®] (tizanidine) capsules
Zanaflex[®]* (tizanidine) 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)

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®
NICORETTE LOZENGE®

ORAL THERAPY

BUPROPION SR† (compare to Zyban®)
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†
nicotine lozenge†
Nicotrol Inhaler®
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

Note: Coverage of testosterone products is limited to males.

NO PA REQUIRED

ANDROGEL® GEL (testosterone 1% gel packets)
*Quantity limit = 2.5 gm packet (1 packet/day)
5 gm packet (2 packets/day)*
ANDROGEL® PUMP (testosterone pump bottles)
*Quantity limit = 1 % (4 bottles/30 days)
1.62% (2 bottles/30 days)*

* Maximum days supply all products is 30 days *

PA REQUIRED

Androderm® Transdermal 2.5 mg, 5 mg (testosterone patch) *Quantity limit = 1 patch/day/strength*
Fortesta® (testosterone 2 % Gel) 60 gm Pump Bottle
Quantity limit = 2 bottles/30 days
Testim® Gel 5 gm (testosterone 1% gel tube)
Quantity limit = 2 tubes/day

* Maximum days supply all products is 30 days *

Thrombopoietin Receptor Agonists

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

NO PA REQUIRED

PA REQUIRED

Nplate® (romiplostim)
Promacta® (eltrombopag)

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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)

Once Daily Oral (Qty Limit = 1 per day)

ENABLEX® (darifenacin)

VESICARE® (solifenacin)

Transdermal/Topical

>NOTE:

- Patients under the age of 65 must fail an adequate trial of generic oxybutynin before approval will be granted for either Vesicare® or Enablex®.
- A therapeutic failure on 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 ORAL PA Requirements. (Exception: An adequate trial of oxybutynin/oxybutynin XL will be required before approval of Ditropan®/Ditropan® XL will be granted)

PA REQUIRED

Ditropan®* (oxybutynin)
Flavoxate † (formerly Urispas®)

Detrol® (tolterodine)
Sanctura® (trospium)
Trospium† (Sanctura®)

Detrol LA® (tolterodine LA)
Ditropan XL® (oxybutynin XL)
oxybutynin XL† (compare to Ditropan® XL)
Sanctura XR® (trospium)
Toviaz® (fesoterodine)

Gelnique® (oxybutynin topical gel)
(Qty limit = 1 sachet/day)
Oxytrol® (oxybutynin 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% †

VANADAZOLE† (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

PRENAPLUS®

PRENATAL PLUS/IRON®

PRENATAL PLUS®

PRENATE PLUS®

PA REQUIRED

All others

PDL Key:

† Generic product

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