

<p>Acne Medications:</p> <ul style="list-style-type: none"> Oral.....3 Topical-Anti-infectives.....4 Topical-Retinoids.....5 Topical-Rosacea.....5 <p>Alzheimer’s Medications:</p> <ul style="list-style-type: none"> Cholinesterase Inhibitors/NMDA Receptor Antagonists.....5 <p>Analgesics:</p> <ul style="list-style-type: none"> COX-2 Inhibitors.....6 Local Anesthetics: Transdermal Patch.....6 Narcotics-Short Acting.....6-7 Narcotics-Long Acting.....7 NSAIDS.....8 <p>Anemia Medications:</p> <ul style="list-style-type: none"> Hematopoietic/Erythropoietic Agents.....8 <p>Ankylosing Spondylitis Injectables.....8</p> <p>Anti-anxiety: Anxiolytics.....9</p> <p>Anticoagulants.....9</p> <p>Anticonvulsants.....10</p> <p>Anti-depressants:</p> <ul style="list-style-type: none"> Miscellaneous.....11 SNRIs.....11 SSRIs.....12 Tricyclics.....12 MAO Inhibitors.....13 <p>Anti-diabetics:</p> <ul style="list-style-type: none"> Alpha Glucosidase Inhibitors.....13 Biguanides & Combinations.....13 Peptide Hormones.....13 Insulin.....14 Oral-Meglitinides.....14 Sulfonylureas 2nd Generation.....14 Thiazolidinediones & Combinations.....15 Dipeptidyl Peptidase Inhibitors.....15 <p>Anti-emetics:</p> <ul style="list-style-type: none"> NK1/5HT3 Antagonists.....15 Other.....15 <p>Anti-hyperkinesia and Anti-Narcolepsy:</p> <ul style="list-style-type: none"> Short/Intermediate-Acting MPH.....16 Long-Acting MPH.....16 Short/Intermed-Acting Amphetamines.....16 Long-Acting Amphetamines.....16 Non-Stimulants Products.....16 Xyrem.....16 <p>Anti-hypertensives:</p> <ul style="list-style-type: none"> ACE Inhibitors.....17 ACEI with Hydrochlorothiazide.....17 ACE Inhibitors with CCBs.....17 Angiotensin Receptor Blockers.....17 ARBs/Hydrochlorothiazide Combos.....17 ARBs/CCB Combos.....18 ARBs/CCB/HCTZ Combos.....18 Beta-Blockers.....18 Calcium Channel Blockers.....19 Renin Inhibitors.....19 <p>Anti-infectives:</p> <ul style="list-style-type: none"> Cephalosporins: 1st Generation.....20 Cephalosporins: 2nd Generation.....20 	<ul style="list-style-type: none"> Cephalosporins: 3rd Generation.....20 Ketolides.....20 Macrolides.....21 Oxazolidinones.....21 Penicillins (Oral).....21 Quinolones.....21 Antifungal: Allylamines.....22 Antifungal: Azoles.....22 Antifungal: Topical: Onychomycosis.....22 Anti-virals: Herpes (Oral).....22 Influenza Medications.....22 Influenza Vaccines.....23 Miscellaneous.....23 Topical Antibiotics.....23 <p>Anti-migraine: Triptans.....24</p> <p>Anti-obesity.....24</p> <p>Anti-psychotic:</p> <ul style="list-style-type: none"> Atypicals & Combinations.....25 Typicals.....26 <p>Botulinum Toxins.....26</p> <p>BPH:</p> <ul style="list-style-type: none"> Alpha Blockers.....26 Androgen Hormone Inhibitors.....26 <p>Cardiac Glycosides.....26</p> <p>Chemical Dependency.....27</p> <p>Constipation: Chronic, IBS-C or Opioid Induced.....27</p> <p>Contraceptives: Vaginal Ring.....27</p> <p>Coronary Vasodilators/Antianginals:</p> <ul style="list-style-type: none"> Oral.....28 Topical.....28 <p>Cough and Cold Preparations.....28</p> <p>Cystic Fibrosis Medications.....28</p> <p>Dermatological Agents:</p> <ul style="list-style-type: none"> Genital Wart Therapy.....28 Scabicides and Pediculicides.....29 <p>Desmopressin: Intranasal/Oral.....29</p> <p>Diabetic Testing Supplies.....29</p> <p>Estrogens: Vaginal.....30</p> <p>Fibromyalgia Agents.....30</p> <p>Gastrointestinals:</p> <ul style="list-style-type: none"> Crohn’s Disease Injectables.....30 H2-blockers.....30 Inflammatory Bowel (Oral/Rectal).....30 Proton Pump Inhibitors.....31 Ulcerative Colitis Injectables.....31 <p>Glucocorticoids: Topical.....32</p> <p>Gout Agents: Xanthine Oxidase Inhibitors33</p> <p>Growth Stimulating Agents.....33</p> <p>Hemophilia Factors.....33</p> <p>Hepatitis C Agents.....33</p> <p>Immunomodulators: Topical.....34</p> <p>Lipotropics:</p> <ul style="list-style-type: none"> Bile Acid Sequestrants.....34 Fibric Acid Derivatives.....34 Niacin Derivatives.....34 	<ul style="list-style-type: none"> Statins.....34 Miscellaneous/Combinations.....35 <p>Miscellaneous</p> <ul style="list-style-type: none"> Arcalyst® (CAPS Injectable).....35 Cinryze® (Human C1 Inhibitor).....35 Elaprase® (Hunter’s Syndrome Inject.).....35 Soliris® (Paroxysmal Nocturnal Hemoglobinuria Injectable).....35 Somatuline® (Acromegaly Injectable).....35 Xenazine® (Huntington’s Disease).....36 <p>Mood Stabilizers.....36</p> <p>Multiple Sclerosis: Injectables.....36</p> <p>Nutritionals, enteral.....36</p> <p>Oncology: Oral.....36</p> <p>Ophthalmics:</p> <ul style="list-style-type: none"> Antihistamines.....37 Corticosteroids: Topical.....37 Glaucoma Agents/Miotics.....38 Mast Cell Stabilizers.....38 NSAIDS.....39 Quinolone Anti-infectives.....39 <p>Ossification Enhancers.....39</p> <p>Otic: Anti-infectives.....40</p> <p>Pancreatic Enzyme Products.....40</p> <p>Parkinson’s Treatments:</p> <ul style="list-style-type: none"> Dopamine Agonists.....41 <p>Phosphodiesterase-5 Inhibitors.....41</p> <p>Platelet Inhibitors.....41</p> <p>Psoriasis Injectables.....42</p> <p>Psoriasis Non-biologics.....42</p> <p>Pulmonary:</p> <ul style="list-style-type: none"> Anticholinergics, Inhaled.....42 Antihistamines -Intranasal.....43 Antihistamines -1st Generation.....43 Antihistamines - 2nd Generation.....43 Persistent Asthma: Xolair®.....44 Beta-adrenergic Agents.....44 Inhaled Glucocorticoids.....45 Nasal Glucocorticoids.....45 Systemic Glucocorticoids.....46 Leukotriene Modifiers.....46 RSV Prevention: Synagis®.....46 <p>Renal Disease: Phosphate Binders.....46</p> <p>Rheumatoid, Juvenile Idiopathic and Psoriatic Arthritis: Immunomodulators46</p> <p>Saliva Stimulants.....46</p> <p>Sedative/Hypnotics.....47</p> <p>Skeletal Muscle Relaxants: Oral.....47</p> <p>Smoking Cessation Therapies.....48</p> <p>Testosterone: Topical.....48</p> <p>Thrombopoietin Receptor Agonists.....48</p> <p>Urinary Antispasmodics.....49</p> <p>Vaginal: Anti-infectives.....49</p> <p>Vitamins: Prenatal Multivitamins.....49</p>
--	--	---

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

OVHA 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.

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

(f): 802-879-5651

E-mail: nancy_miner@medmetricshp.com

OVHA Pharmacy Unit Staff:

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

(f) 802-879-5651

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

MHP Account Manager:

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

(f): 802-879-5651

E-mail: nancy_hogue@medmetricshp.com

OVHA Pharmacy Administration:

Director of Pharmacy Benefit Programs

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

(f) 802-879-5651

E-mail: cynthia.laware@ahs.state.vt.us

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®)
ERYTHROMYCIN STEARATE†

MINOCYCLINE† 50 mg, 75 mg, 100 mg

TETRACYCLINE† 250 mg, 500 mg cap

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

PA REQUIRED

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

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

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

PDL Key:

† Generic product

* Indicates a generic equivalent is available without PA

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

Acne Drugs: Topical Anti-Infectives

Length of Authorization: 1 year

NO PA REQUIRED

BENZOYL PEROXIDE PRODUCTS

BENZOYL PEROXIDE †
2.5%, 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%, 10% L;
3%, 6%, 9% P

CLINDAMYCIN PRODUCTS

CLINDAMYCIN 1% S, G, L, P †

ERYTHROMYCIN PRODUCTS

ERYTHROMYCIN 2% S, G, P †

SODIUM SULFACETAMIDE PRODUCTS

SODIUM SULFACETAMIDE 10% L †

COMBINATION PRODUCTS

ERYTHROMYCIN / BENZOYL PEROXIDE †

SODIUM SULFACETAMIDE / SULFUR L †

SODIUM SULFACETAMIDE / SULFUR W †

OTHER

PA REQUIRED

Benzac AC® 2.5%, 5%, 10% G, W
Benzashave® 5%, 10% C
Brevoxyl® 4%, 8% W; 4%, 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
Triaz® 3%, 6%, 9% G; 3%, 6%, 9% P
Zaclir®* 4%, 8% L
All other brands

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

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

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

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

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

Azelex® (azelaic acid 20% C)
Aczone® (dapsone 5% G)
All other brands any topical acne anti-infective medication

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

PDL Key:

† Generic product

* Indicates a generic equivalent is available without PA

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

Acne Drugs: Topical – Retinoids

Length of Authorization: 1 year

NO PA REQUIRED

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

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

C=cream, G=gel

PA REQUIRED

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

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

Epiduo® (adapalene/benzoyl peroxide) 0.1%/2.5% G

Avage® (tazarotene) ♣

Renova® (tretinoin) ♣

Solage® (tretinoin/mequinol) ♣

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

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

Acne Drugs: Topical – Rosacea

Length of Authorization: 1 year

NO PA REQUIRED

METRONIDAZOLE† 0.75% C, G, L

C=cream, G=gel, L=lotion

PA REQUIRED

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

Finacea® (azelaic acid) 15% G

Alzheimer's Medications: Cholinesterase Inhibitors/NMDA Receptor Antagonists

Length of Authorization: 1 year

Quantity limits apply

NO PA REQUIRED

CHOLINESTERASE INHIBITORS

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

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

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

EXELON® (rivastigmine) Oral Solution

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

NMDA RECEPTOR ANTAGONIST

NAMENDA® (memantine) Tablet

NAMENDA® (memantine) Oral Solution

PA REQUIRED

Cognex® (tacrine) Capsule §

galantamine† tablet § (compare to Razadyne®) Tablet

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

Razadyne® (galantamine) Tablet

Razadyne ER® (galantamine) Capsule

galantamine† (compare to Razadyne®) Oral Solution

Razadyne® (galantamine) Oral Solution

PDL Key:

† Generic product

* Indicates a generic equivalent is available without PA

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

Analgesics: COX-2 Inhibitors

Length of Authorization: 1 year

Quantity limits apply

NO PA REQUIRED

CELEBREX[®] (celecoxib) (age ≥ 60 yrs) (QL = 2 capsules/day)

PA REQUIRED

Celebrex[®] (celecoxib) (age < 60 yrs) (QL = 2 capsules/day)

Analgesics: Local Anesthetics: Transdermal Patch

Length of Authorization: 6 months

Quantity limits apply

NO PA REQUIRED

PA REQUIRED

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

Analgesics: Narcotics-Short Acting

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

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

Quantity limits apply

NO PA REQUIRED

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

PA REQUIRED

Acetaminophen w/codeine: all branded products
Acetaminophen w/hydrocodone: all branded products
(QL 5/500 = 8 tablets/day, 10/500 = 8 tablets/day, 7.5/750 = 5 tablets/day)
Acetaminophen w/oxycodone: all branded products
(QL 10/650 = 6 tablets/day)
Actiq[®] (fentanyl lozenge on a stick: 200 mcg, 400 mcg, 600 mcg, 800 mcg,
1200 mcg, 1600 mcg)
Anexsia^{®*} (acetaminophen w/hydrocodone)
Butorphanol Nasal Spray† (Qty Limit = 2 bottles/month)
Capital[®] w/codeine* (acetaminophen w/codeine)
Cocet[®] (acetaminophen w/codeine) (QL 30/650 = 6 tablets/day)
Combunox^{®*} (oxycodone w/ ibuprofen)
Darvocet-N^{®*} (propoxyphene-n w/acetaminophen) (QL 100/650 = 6
tablets/day)
Darvon Compound^{®*}(propoxyphene compound)
Darvon^{®*}/ Darvon-N^{®*} (propoxyphene)
Dazidox^{®*} (oxycodone)
Demerol[®] (meperidine)
Dilaudid^{®*}(hydromorphone)
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)
Nalbuphine†
Norco^{®*}(hydrocodone w/ acetaminophen)
continued on next page

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)

continued from previous page

Nubain®*(nalbuphine)
Nucynta® (tapentadol)
Opana® (oxymorphone)
Oxyfast®*(oxycodone)
OxyIR®*(oxycodone)
Panlor DC® (acetaminophen/caffeine/dihydrocodeine)
Pentazocine and Naloxone†
Percocet®*(oxycodone w/ acetaminophen)
Percodan®* (oxycodone w/aspirin)
Propoxyphene: *all branded products**
Reprexain®* (hydrocodone w/ ibuprofen)
Roxanol®*(morphine sulfate)
Ryzolt® (tramadol SR)
Synalgos DC®*(dihydrocodeine compound)
Talacen®*(pentazocine w/acetaminophen)
Talwin®* (pentazocine) and branded combinations
Talwin NX®* (pentazocine w/naloxone)
Trezix® (acetaminophen/caffeine/dihydrocodeine)
Tylenol® #3*,#4*(acetaminophen w/codeine)
Tylox®*(oxycodone w/ acetaminophen)
Ultracet® (tramadol w/ acetaminophen)
Ultram®*/Ultram ER® (tramadol/tramadol SR)
Vicodin®*(hydrocodone w/acetaminophen)
Vicoprofen®*(hydrocodone w/ ibuprofen)
Xodol® (hydrocodone w/acetaminophen)
Xolox® (oxycodone w/ acetaminophen)
Zamiset®* (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 OVHA web-site.

NO PA REQUIRED

TRANSDERMAL

DURAGESIC® (fentanyl) 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)

PA REQUIRED

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

Avinza® (morphine sulfate XR) (QL= 30 capsules/strength/30 days)
Dolophine®* (methadone)
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)
Oxycodone ER† (compare to OxyContin®) (QL=90 tablets/strength/30 days)
OxyContin® (oxycodone ER) (QL= 90 tablets/strength/30 days)

PDL Key:

† Generic product

* Indicates a generic equivalent is available without PA

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

Analgesics: NSAIDs

Length of Authorization: 1 year

Quantity limits apply

NO PA REQUIRED

ORAL

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

INJECTABLE

KETOROLAC † Injection (QL = 1 dose per fill)

TRANSDERMAL

PA REQUIRED

Anaprox®*
Anaprox DS®*
Ansaid®*
Arthrotec®
Cataflam®*
Clinoril®**
Daypro®**
Dolobid®*
EC-Naprosyn®*
Feldene®**
Indocin®*
Indocin SR®
meloxicam†susp (compare to Mobic®)
Mobic®*
Motrin®*
Nalfon®*
Naprelan®**
Naprosyn®*
Ponstel®
Voltaren®*
Voltaren XR®*

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

Anemia: Hematopoietic/Erythropoietic Agents

Length of Authorization: 1 year

NO PA REQUIRED

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

PA REQUIRED

Epogen® (epoetin alpha)

Ankylosing Spondylitis: Injectables

Self-injectables (Enbrel® 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 OVHA website.

PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

ENBREL® (etanercept)
HUMIRA® (adalimumab)

NON-PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

Remicade® (infliximab)
Simponi® (golimumab) Qty Limit = 1 syringe/month

PDL Key:

† Generic product

* Indicates a generic equivalent is available without PA

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

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

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

Anticoagulants

Length of Authorization: 6 months

Quantity limits apply

NO PA REQUIRED

WARFARIN† (compare to Coumadin®)

HEPARIN†

FRAGMIN® (dalteparin)
LOVENOX® (enoxaparin) (QL = 2 syringes/day calculated in ml volume)
ARIXTRA® (fondaparinux)

PA REQUIRED

Coumadin®* (warfarin)

n/a

Innohep® (tinzaparin)

PDL Key:

† Generic product

* Indicates a generic equivalent is available without PA

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

Anticonvulsants

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

NO PA REQUIRED

CARBAMAZEPINE† (compare to Tegretol®)
CARBATROL® (carbamazepine)
CELONTIN® (methsuxamide)
CLONAZEPAM† (compare to Klonopin®)
CLONAZEPAM ODT† (compare to Klonopin Wafers®)
DEPAKOTE ER® (divalproex sodium)
DEPAKOTE SPRINKLES® (divalproex sodium caps)
DIASTAT® (diazepam rectal gel)
DILANTIN® (phenytoin)
DIVALPROEX SODIUM † (compare to Depakote®)
EPITOL† (carbamazepine)
ETHOSUXAMIDE† (compare to Zarontin®)
FELBATOL® (felbamate)
GABAPENTIN† 100 mg, 300 mg, 400 mg capsules, 600 mg, 800 mg tablets (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)
NEURONTIN® oral solution (gabapentin)
OXCARBAZEPINE† tablets (compare to Trileptal®)
PEGANONE® (ethotoin)
PHENYTEK® (phenytoin)
PHENYTOIN† (compare to Dilantin®)
PRIMIDONE† (compare to Mysoline®)
TEGRETOL XR® (carbamazepine)
TOPAMAX® (topiramate) Sprinkle Capsules
TOPIRAMATE† tabs (compare to Topamax® tabs)
TRILEPTAL® oral suspension (oxcarbazepine)
VALPROIC ACID† (compare to Depakene®)
ZONISIMIDE† (compare to Zonegran®)

PA REQUIRED

Banzel® (rufinamide)
QL = 8 tabs/day (400 mg) and 16 tabs/day (200 mg)
Carbamazepine extended release † (compare to Tegretol XR®)
Depakene®* (valproic acid)
Depakote®* (divalproex sodium)
divalproex sodium ER † (compare to Depakote ER®)
divalproex sodium capsules † (compare to Depakote Sprinkles®)
Gabapentin† 100mg, 400 mg tablets
Gabarone® (gabapentin) tablets
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)
Lyrica® (pregabalin) § (*Quantity Limit = 3 capsules/day*)
Mysoline®* (primidone)
Neurontin®* (gabapentin) tablets and capsules
Stavzor® (valproic acid delayed release)
Tegretol®* (carbamazepine)
Topamax®* (topiramate) tablets
Topiramate† sprinkle caps (compare to Topamax® Sprinkles)
Trileptal®* tablets (oxcarbazepine)
Zarontin®* (ethosuxamide)
Zonegran®* (zonisamide)

PDL Key:

† Generic product

* Indicates a generic equivalent is available without PA

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

Anti-depressants: Miscellaneous

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

Quantity limits apply

NO PA REQUIRED

BUDEPRION[®] SR/BUPROPION SR† (compare to Wellbutrin SR[®])

FDA maximum recommended dose = 400 mg/day

BUPROPION† (compare to Wellbutrin[®])

FDA maximum recommended dose = 450 mg/day

MAPROTILINE† (previously Ludiomil[®])

FDA maximum recommended dose = 225 mg/day

MIRTAZAPINE† (compare to Remeron[®])

FDA maximum recommended dose = 45 mg/day

MIRTAZAPINE RDT† (compare to Remeron Sol-Tab[®])

FDA maximum recommended dose = 45 mg/day

NEFAZADONE† (previously Serzone[®])

FDA maximum recommended dose = 600 mg/day

TRAZODONE HCL† (previously Desyrel[®])

FDA maximum recommended dose = 600 mg/day

WELLBUTRIN XL[®] (bupropion XL)

FDA maximum recommended dose = 450 mg/day

PA REQUIRED

Aplenzin[®] (bupropion hydrobromide) ER tablets

Quantity Limit = 1 tablet/day

Budeprion XL/bupropion XL† (compare to Wellbutrin XL[®])

FDA maximum recommended dose = 450 mg/day

Remeron[®]* (mirtazapine)

FDA maximum recommended dose = 45 mg/day

Remeron Sol Tab[®]* (mirtazapine RDT)

FDA maximum recommended dose = 45 mg/day

Wellbutrin[®]* (bupropion)

FDA maximum recommended dose = 450 mg/day

Wellbutrin SR[®]* (bupropion SR)

FDA maximum recommended dose = 400mg/day

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)

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 IR †§ (compare to Effexor[®])

FDA maximum recommended dose = 225 mg/day

Venlafaxine ER[®]§ tablet

FDA maximum recommended dose = 225 mg/day,

Quantity limit = 1 tablet/day (37.5 mg & 75 mg)

PDL Key:

† Generic product

* Indicates a generic equivalent is available without PA

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

Anti-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† (pmd) (compare to Selfemra®)
FDA maximum recommended dose = 80 mg/day
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 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)
FDA maximum recommended dose = 80 mg/day
Selfemra® (fluoxetine)
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)

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 Asendin®)
CHLORDIAZEPOXIDE/AMITRIPTYLINE †5mg/12.5mg (compare to
Lorbitrol®)
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 (compare to Lorbitrol DS®)
Lorbitrol®* (amitriptyline/chlordiazepoxide)
Lorbitrol DS® (amitriptyline/chlordiazepoxide)
Norpramin®* (desipramine)
Pamelor®* (nortriptyline)
Surmontil®* (trimipramine)
Tofranil®* (imipramine)
FDA maximum recommended dose = 300 mg/day
Tofranil PM®* (imipramine pamoate)
Vivactil®* (protriptyline)

PDL Key:

† Generic product

* Indicates a generic equivalent is available without PA

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

Anti-depressants: MAO Inhibitors

Length of Authorization: Duration of Need for Mental Health Indications

Quantity limits apply

NO PA REQUIRED

NARDIL[®] (phenylzine)

FDA maximum recommended dose = 90 mg/day

TRANLYCYPROMINE (compare to Parnate[®])

FDA maximum recommended dose = 60 mg/day

PA REQUIRED

EMSAM[®] (selegiline) (*QL = 1 patch/day*)

Marplan[®] (isocarboxazid)

Parnate^{®*} (tranlycypromine)

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

Symlin[®] (pramlintide) § *No Quantity Limit*

PA REQUIRED

Byetta[®] (exenatide) (*Quantity Limit = 1 pen/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)

Anti-diabetics: Insulins
Length of Authorization: lifetime

NO PA REQUIRED

RAPID-ACTING INJECTABLE

NOVOLOG® (Aspart)

SHORT-ACTING INJECTABLE

NOVOLIN R® (Regular)

INTERMEDIATE-ACTING INJECTABLE

NOVOLIN N® (NPH)

LONG-ACTING ANALOGS INJECTABLE

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

MIXED INSULINS INJECTABLE

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

NOVOLOG MIX 70/30® (Protamine/Aspart)

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

PA REQUIRED

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

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

Humulin N® (NPH)
 ReliOn N® (NPH)

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

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

NO PA REQUIRED

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:

† Generic product

* Indicates a generic equivalent is available without PA

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

Anti-diabetic: Thiazolidinediones & Combinations

Length of Authorization: 1 year

Quantity limits apply

PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

SINGLE AGENT

ACTOS® (pioglitazone) §

AVANDIA® (rosiglitazone) §

COMBINATION

ACTOPLUS MET® (metformin/pioglitazone) §

AVANDAMET® (metformin/rosiglitazone maleate) §

AVANDARYL® (glimepiride/rosiglitazone maleate) §

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

NON-PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

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

Length of Authorization: 1 year

Quantity limits apply

PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

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

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

NON-PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

Anti-emetics: NK1/5HT3 Antagonists

Length of Authorization: 6 months for chemotherapy or radiotherapy;

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

Monthly quantity limits apply, PA required to exceed.

NO PA REQUIRED

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

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

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

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

ONDANSETRON† Injection (vial and premix)

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

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

* *To be prescribed by oncology practitioners ONLY*

PA REQUIRED

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

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

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

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

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

Granisetron† (compare to Kytril®) Injectable

Granisetron† (compare to Kytril®) Oral Solution

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

Kytril® (granisetron) Injectable

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

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

Sancuso® 3.1 mg/24 hrs Transdermal Patch (granisetron) (Qty Limit = 1 patch/month)

Zofran®* (ondansetron) Injection

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

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

Anti-emetics: Other

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

NO PA REQUIRED

PA REQUIRED

Dronabinol† (compare to Marinol®)

Marinol® (dronabinol)

Cesamet® (nabilone)

PDL Key:

† Generic product

* Indicates a generic equivalent is available without PA

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

Antihyperkinesia: ADHD, ADD, Narcolepsy

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

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

Quantity limits apply

NO PA REQUIRED

SHORT/INTERMEDIATE ACTING METHYLPHENIDATE PREPS

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

PA REQUIRED

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

LONG-ACTING METHYLPHENIDATE PREPS

Oral

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

Metadate CD[®] (methylphenidate CR, IR/ER, 30:70%)
Ritalin LA[®] (methylphenidate SR 24 HR, IR/ER, 50:50%)

Transdermal

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

SHORT/INTERMEDIATE AMPHETAMINE PREPS

AMPHETAMINE/DETRIOAMPHETAMINE † (compare to Adderall[®])
DETRIOAMPHETAMINE † (previously Dexedrine[®])
DETRIOAMPHETAMINE SR † (compare to Dexedrine CR[®])
DETRIOSTAT † (dextroamphetamine)

Adderall[®]* (amphetamine/dextroamphetamine)
Desoxyn[®] (methamphetamine)
Dexedrine CR[®]* (dextroamphetamine SR)

LONG-ACTING AMPHETAMINE PREPS

ADDERALL XR[®] (amphetamine/dextroamphetamine SR 24 HR, IR/ER, 50:50%)
VYVANSE[®] (lisdexamfetamine) (QL = 1 capsule/day)

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

NON-STIMULANT PREPS

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

Strattera[®] (atomoxetine)

FDA maximum recommended dose = 100 mg/day

Xyrem[®] (sodium oxybate)

PDL Key:

† Generic product

* Indicates a generic equivalent is available without PA

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

Anti-hypertensives: ACE Inhibitors

Length of Authorization: 1 year

NO PA REQUIRED

BENAZEPRIL† (compare to Lotensin®)
CAPTOPRIL† (compare to Capoten®)
ENALAPRIL† (compare to Vasotec®)
FOSINOPRIL† (compare to Monopril®)
LISINOPRIL† (compare to Zestril®, Prinivil®)
MOEXIPRIL† (compare to Univas®)
QUINAPRIL† (compare to Accupril®)
RAMIPRIL† (compare to Altace®)
TRANDOLAPRIL† (compare to Mavik®)

PA REQUIRED

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

Anti-hypertensives: ACE Inhibitor with Hydrochlorothiazide

Length of Authorization: 1 year

NO PA REQUIRED

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

PA REQUIRED

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

Anti-hypertensives: ACE Inhibitor w/Calcium Channel Blocker

Length of Authorization: 1 year

NO PA REQUIRED

AMLODIPINE/BENAZEPRIL † (compare to Lotrel®)

PA REQUIRED

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

Anti-hypertensives: Angiotensin Receptor Blockers (ARBs)

Length of Authorization: 3 years

PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

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

NON-PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

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

Anti-hypertensives: Angiotensin Receptor Blocker/Hydrochlorothiazide Combinations

Length of Authorization: 3 years

PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

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

NON-PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

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

PDL Key:

† Generic product

* Indicates a generic equivalent is available without PA

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

Anti-hypertensives: 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

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

Anti-hypertensives: Beta Blockers

Length of Authorization: 3 years

NO PA REQUIRED

SINGLE AGENT

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

BETA-BLOCKER/DIURETIC COMBINATION

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

PA REQUIRED

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

PDL Key:

† Generic product

* Indicates a generic equivalent is available without PA

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

Anti-hypertensives: 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 † (compare to Plendil[®])
ISRADIPINE † (formerly Dynacirc[®])
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)
DILTIA[®] XT † (diltiazem SR, compare to Dilacor[®] XR)
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)
Nimotop[®]* (nimodipine)
Norvasc[®]* (amlodipine)
Plendil[®]* (felodipine)
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) (no AB rated generic)
Covera-HS[®] (verapamil SR) (no AB rated generic)
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)

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

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

PDL Key:

† Generic product

* Indicates a generic equivalent is available without PA

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

Anti-infectives: Cephalosporins – 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

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

SUSPENSION

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

IV drugs are not managed at this time

PA REQUIRED

Cedax® (ceftibuten) capsule
Cefdinir† (compare to Omnicef®) capsule
Spectracef® (cefditoren) tablet
Vantin®* (cefpodoxime) tablet

Cedax® (ceftibuten) Suspension
Cefdinir† (compare to Omnicef®) suspension
Cefpodoxime proxetil† (compare to Vantin®) suspension
Vantin® (cefpodoxime) suspension

Anti-infectives: Ketolides

Length of Authorization: for date of service, no refills

NO PA REQUIRED

PA REQUIRED

Ketek® (telithromycin)

PDL Key:

† Generic product

* Indicates a generic equivalent is available without PA

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

Anti-infectives: Macrolides

Length of Authorization: for date of service, no refills

NO PA REQUIRED

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

CLARITHROMYCIN† (compare to Biaxin/Biaxin XL)

E.E.S®† (erythromycin ethylsuccinate)
ERY-TAB® (erythromycin base, delayed release)
ERYTHROCIN† (erythromycin stearate)
ERYTHROMYCIN BASE†
ERYTHROMYCIN ETHYLSUCCINATE† (compare to E.E.S.®)
ERYTHROMYCIN STEARATE†
ERYTHROMYCIN W/ SULFASOXAZOLE† (compare to Pediazole®)

IV drugs are not managed at this time

PA REQUIRED

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

Biaxin®* (clarithromycin)
Biaxin XL® (clarithromycin XL)
Dynabac® (dirithromycin)

Eryped® (erythromycin ethylsuccinate)
PCE Dispertab® (erythromycin base)
Pediazole®* (erythromycin-sulfisoxazole)

Zithromax®* (azithromycin) tablets and liquid
Zmax® Suspension (azithromycin extended release for oral suspension)

Anti-infectives: Oxazolidinones

Length of Authorization: 28 days, no refills

Quantity Limits Apply

NO PA REQUIRED

IV form of this medication not managed at this time

PA REQUIRED

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

Anti-infectives: Penicillins (Oral)

Length of Authorization: for date of service, no refills

NO PA REQUIRED

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

PA REQUIRED

Augmentin®* (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)
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)
Noroxin® (norfloxacin)
ProQuin XR® (ciprofloxacin)

PDL Key:

† Generic product

* Indicates a generic equivalent is available without PA

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

Anti-infectives: Influenza Vaccines

Length of Authorization: for date of service only

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

AFLURIA[®] 2009- 2010 Injection
FLUARIX[®] 2009- 2010 Injection
FLULAVAL[®] 2009- 2010 Injection
FLUVIRIN[®] 2009- 2010 Injection
FLUZONE[®] 2009- 2010 Injection

SEASONAL Influenza Nasal Vaccine

2009 H1N1 (formerly Swine Flu) Vaccine Injection

2009 H1N1 (formerly Swine Flu) Nasal Vaccine

PA REQUIRED

FluMist[®] Nasal

Influenza A H1N1 Vaccine Injection (provided free of charge by VT Dept of Health through clinics or prescriber office)

Influenza A H1N1 Spray Vaccine (provided free of charge by VT Dept of Health through clinics or prescriber office)

Anti-infectives: Miscellaneous

Length of Authorization: 1 year

NO PA REQUIRED

PA REQUIRED

Quaaliquin[®] (quinine sulfate)

Anti-infectives: Topical Antibiotics

Length of Authorization: for date of service, no refills

Quantity limits apply

NO PA REQUIRED

BACITRACIN†
GENTAMICIN†
BACITRACIN-POLYMXIN†
NEOMYCIN-BACITRACIN-POLYMXIN†
CORTISPORIN[®]
BACTROBAN[®] OINTMENT
MUPIROICIN OINTMENT (compare to Bactroban[®])

PA REQUIRED

Altanax[®] (retapamulin) (*Quantity Limit = 1 tube*)
Bactroban[®] CREAM (mupirocin)

PDL Key:

† Generic product

* Indicates a generic equivalent is available without PA

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

Anti-migraine: Triptans

Length of Authorization: 6 months

Monthly quantity limits apply, PA required to exceed.

NO PA REQUIRED, Quantity Limits Apply

Single Agent

ORAL

AXERT[®] (almotriptan) 6.25 mg, 12.5 mg

Quantity Limit = 6 tablets/month

MAXALT[®] (rizatriptan) tablet or MAXALT-MLT[®] (rizatriptan ODT)

5 mg, 10 mg

Quantity Limit = 12 tablets/month

SUMATRIPTAN[†] (compare to Imitrex[®])

Quantity Limit = 18 tablets/month (25 mg),

9 tablets/month (50 mg, 100 mg),

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

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),

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

Length of Authorization: 6 months for initial approval,

Select medications may renew for additional 6 months if patient has met target goals.

Quantity limits apply

Therapy specific PA fax form available on OVHA website.

NO PA REQUIRED

PA REQUIRED

Alli[®] (orlistat OTC) QL = 3 capsules/day

benzphetamine[†] (all forms brand & generic)

diethylpropion[†] (all forms brand & generic)

Meridia[®] (sibutramine)

phentermine[†] (all forms brand & generic)

phendimetrazine[†] (all forms brand & generic)

Xenical[®] (orlistat)

PDL Key:

† Generic product

* Indicates a generic equivalent is available without PA

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

Anti-psychotic: Atypical & Combinations

Length of Authorization: Duration of Need

Quantity limits apply

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)

FDA maximum recommended dose = 800 mg/day

ORAL SOLUTIONS

RISPERDAL® (risperidone) oral solution

FDA maximum recommended dose = 16 mg/day

SHORT-ACTING INJECTABLE PRODUCTS

GEODON® IM (ziprasidone intramuscular injection)

FDA maximum recommended dose = 40 mg/day

LONG-ACTING INJECTABLE PRODUCTS

ORALLY DISINTEGRATING TABLETS

COMBINATION PRODUCTS

PA REQUIRED

Abilify® (aripiprazole)

FDA maximum recommended dose = 30 mg/day,

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

Clozaril®* (clozapine)

FDA maximum recommended dose = 900 mg/day

Invega® (paliperidone)

FDA maximum recommended dose = 12 mg/day

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

Risperdal®* (risperidone)

FDA maximum recommended dose = 16 mg/day

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

Risperidone† (compare to Risperdal®) 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

Risperdal® Consta (risperidone microspheres)

FDA maximum recommended dose = 50 mg/14 days

Abilify® Discmelt (aripiprazole)

FDA maximum recommended dose = 30 mg/day,

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

FazaClo® (clozapine orally disintegrating tablets)

FDA maximum recommended dose = 900 mg/day

Risperdal® M-Tab (risperidone orally disintegrating tablets)

FDA maximum recommended dose = 16 mg/day

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)

PDL Key:

† Generic product

* Indicates a generic equivalent is available without PA

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

Anti-psychotic: Typical

Length of Authorization: Duration of Need for Mental Health Indications

NO PA REQUIRED

CHLORPROMAZINE† (compare to Thorazine®)
FLUPHENAZINE† (compare to Prolixin®, Prolixin®)
HALOPERIDOL† (compare to Haldol®)
LOXAPINE† (compare to Loxitane®)
MOBAN® (molindone)
PERPHENAZINE† (compare to Trilafon®)
THIORIDAZINE† (compare to Mellaril®)
THIOTHIXENE† (compare to Navane®)
TRIFLUOPERAZINE† (compare to Stelazine®)

PA REQUIRED

Haldol®* (haloperidol)
Loxitane®* (loxapine)
Mellaril®* (thioridazine)
Navane®* (thiothixene)
Prolixin®* (fluphenazine)
Thorazine®* (chlorpromazine)
Trilafon®* (perphenazine)

Botulinum toxins

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

NO PA REQUIRED

PA REQUIRED

BOTOX® (onabotulinumtoxinA)
Myobloc® (rimabotulinumtoxinB)

BPH: Alpha Blockers

Length of Authorization: 1 year

NO PA REQUIRED

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

PA REQUIRED

Cardura®* (doxazosin)
Cardura XL® (doxazosin)
Hytrin®* (terazosin)
Rapaflo® (silodosin) *Quantity Limit = 1 capsule/day*

BPH: Androgen Hormone Inhibitors

Length of Authorization: 1 year

Quantity limits apply

Coverage of androgen hormone inhibitors will not be approved for cosmetic use (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

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

PA REQUIRED

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

Cardiac Glycosides

Length of Authorization: n/a

NO PA REQUIRED

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

PA REQUIRED

PDL Key:

† Generic product

* 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)

Chemical Dependency: Alcohol and Opiate Dependency

Length of Authorization: Vivitrol – 6 months, no renewal, All Others 1 year
DATA 2000 Waiver (“X” number) required for prescribers of Buprenorphine
Quantity limits apply

Vivitrol and Buprenorphine Therapy specific PA fax forms are available on OVHA website.

NO PA REQUIRED

Alcohol Dependency

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

Opiate Dependency

NALTREXONE oral † (compare to Revia®)

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

PA REQUIRED

Revia®* (naltrexone oral)

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

Revia®* (naltrexone oral)

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

Quantity Limit = 3 tablets/day

Subutex® (buprenorphine): 2 mg and 8 mg tablets

Quantity Limit = 3 tablets/day

Constipation: Chronic, IBS-C or Opioid Induced

Length of Authorization: 3 months

Quantity limits apply

NO PA REQUIRED

Bulk-Producing Laxatives

PSYLLIUM†

Osmotic Laxatives

LACTULOSE†

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

Stimulant Laxative

BISACODYL†

SENNA†

Stool Softener

DOCUSATE†

PA REQUIRED

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

Relistor® (methylnatrexone)

Contraceptives: Vaginal Ring

Length of Authorization: n/a

NO PA REQUIRED

NUVARING® (etonogestrel/ethinyl estradiol vaginal ring)

PA REQUIRED

PDL Key:

† Generic product

* Indicates a generic equivalent is available without PA

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

Coronary Vasodilators/Antianginals: Oral

Length of Authorization: 3 years

Quantity limits apply

NO PA REQUIRED

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

PA REQUIRED

Dilatrate-SR® (isosorbide dinitrate SR capsule)
Imdur®* (isosorbide mononitrate ER tablet)
Ismo®* (isosorbide mononitrate tablet)
Isordil®* (isosorbide dinitrate tablet)
Monoket®* (isosorbide mononitrate tablet)

BiDi® (isosorbide dinitrate/hydralazine)

Ranexa® (ranolazine) (*Quantity Limit = 3 tablets/day (500 mg), 2 tablets/day (1000 mg))*)

Coronary Vasodilators/Antianginals: Topical

Length of Authorization: 3 years

NO PA REQUIRED

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

PA REQUIRED

Nitro-Dur®* (nitroglycerin transdermal patch)

Cough and Cold Preparations

Length of Authorization: for date of service, no refills

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

NO PA REQUIRED

All generics
MUCINEX® (guaifenesin)

PA REQUIRED

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

Cystic Fibrosis Medications

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

Therapy specific Order form is available on OVHA website.

NO PA REQUIRED

PULMOZYME® (dornase alfa inhalation)
TOBI® (tobramycin solution for inhalation)

PA REQUIRED

Dermatological Agents: Genital Wart Therapy

Length of Authorization: Up to 16 weeks

Quantity limits apply

NO PA REQUIRED

ALDARA® (imiquimod)

PODOFILOX SOLUTION† (compare to Condylox®)

PA REQUIRED

Condylox® Gel (podofilox gel)
Condylox®* solution (podofilox solution)

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

PDL Key:

† Generic product

* Indicates a generic equivalent is available without PA

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

Dermatological Agents: Scabicides and Pediculocides

Length of Authorization: date of service only, no refills

NO PA REQUIRED

EURAX[®] (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*

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

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

PDL Key:

† Generic product

* Indicates a generic equivalent is available without PA

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

Estrogens: Vaginal

Length of Authorization: n/a

NO PA REQUIRED

Estradiol

ESTRACE VAGINAL[®] 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

NO PA REQUIRED

PA REQUIRED

Savella[®] (milnacipran)

Quantity Limit = 2 tablets/day

Gastrointestinal: Crohn's Disease Injectables

****Self-injectable (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 OVHA website.

PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

CIMZIA[®] (certolizumab pegol)

HUMIRA[®] (adalimumab)

REMICADE[®] (infliximab)

NON-PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

Tysabri[®] (natalizumab)

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 §

Pepcid[®] (famotidine) Oral Suspension §

Zantac (ranitidine) Effervescent[®] §

Zantac^{®*} (ranitidine) Syrup §

PDL Key:

[†] Generic product

* Indicates a generic equivalent is available without PA

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

Gastrointestinals: 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[®], Sfrowasa[®])

OTHER

BALSALAZIDE[†] (compare to Colazal[®])

DIPENTUM[®] (olsalazine)

SULFASALAZINE[†] (compare to Azulfidine[®])

PA REQUIRED

Rowasa^{®*} (mesalamine enema)

Sfrowasa^{®*} (mesalamine enema)

Azulfidine^{®*} (sulfasalazine)

Colazal^{®*} (balsalazide)

Gastrointestinals: Proton Pump Inhibitors

Length of Authorization: up to 1 year

Quantity limits apply

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

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

NO PA REQUIRED FOR ONCE DAILY DOSES

ORAL CAPULES/TABLETS

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

PRILOSEC OTC[®] 20mg (omeprazole magnesium) tablets

(*No Quantity limit applies*)

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

SUSPENSION & SPECIAL DOSAGE FORMS

PREVACID 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 RX capsules § (compare to Prilosec[®])

(*Quantity limit=1 cap/day*)

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

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

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

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

Prilosec[®] RX (brand) (omeprazole) capsules § (*Quantity limit=1 cap/day*)

Zegerid[®] (omeprazole/sodium bicarb) capsules § (*Quantity limit=1 cap/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*)

Zegerid^{®*} (omeprazole/sodium bocarb) powder for suspension §

(*Quantity limit=1 packet/day*)

Gastrointestinal: Ulcerative Colitis Injectables

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

Therapy-specific PA fax form available on OVHA website.

NO PA REQUIRED

PA REQUIRED

Remicade[®] (infliximab)

PDL Key:

† Generic product

* Indicates a generic equivalent is available without PA

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

Glucocorticoids: Topical

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

NO PA REQUIRED

ALCLOMETASONE 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®)
DIFLORASONE DIACETATE† 0.05% C
(compare to Apexicon E®/Psorcon E®*)
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
Westcort®* (hydrocortisone valerate) all products
All other brands

High Potency

Apexicon E®/Psorcon E®* (diflorasone) 0.05% C
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

Verv 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

* 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)

Gout Agents: Xanthine Oxidase Inhibitors

Length of Authorization: 1 year

Quantity limits apply

NO PA REQUIRED

ALLOPURINOL† (compare to Zyloprim®)

PA REQUIRED

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

Growth Stimulating Agents

Length of Authorization: 6 months initially, then up to 1 year; short bowel syndrome = 4 weeks.

Agents available after clinical criteria are met.

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

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

PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

NORDITROPIN®
NUTROPIN®/NUTROPIN® AQ

NON-PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

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

Specialized Indications – See Specific Criteria

Increlex® (mecasermin)
Serostim®
Zorbtive®

Hemophilia Factors

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

Therapy specific Order form is available on OVHA website.

NO PA REQUIRED

All Factors

PA REQUIRED

None

Hepatitis C Agents

Length of Authorization: 6 months

Quantity limits apply

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

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

PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

RIBAVIRIN

Tablets/Capsules
RIBAVIRIN† 200 mg tablets or capsules

Oral Solution

INTERFERON

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

NON-PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

RIBAVIRIN

Copegus® (ribavirin 200 mg tablet)
Ribapak® 400 mg/600 mg Dose Pack (ribavirin)
Rebetol® (ribavirin 200 mg capsule)

All other strengths/brands of ribavirin tablets/capsules

Rebetol® (ribavirin 40 mg/ml) oral solution

INTERFERON

Infergen® (interferon alphacon-1)
Peg-Intron® (peg-interferon alpha-2b)

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)

Immunomodulators: Topical

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

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

NO PA REQUIRED

ELIDEL[®] (pimecrolimus) §
PROTOPIC[®] (tacrolimus) §

PA REQUIRED

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

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: 3 months initially, then 1 year if response shown

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

Lipotropics: Niacin Derivatives

Length of Authorization: n/a

NO PA REQUIRED

NIACIN†
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 (10 & 20 mg), 2 tabs/day (40 mg)*)

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

AFTER GENERIC SIMVASTATIN TRIAL

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

PA REQUIRED

Low/Medium Potency Statins

Altoprev[®] (aka: Altacor[®]) (lovastatin) (*QL = 1 tablet/day*)
Lescol[®] (fluvastatin) (*QL = 1 tablet/day*)
Lescol[®] XL (fluvastatin XL) (*QL = 1 tablet/day*)
Mevacor[®]* (lovastatin) (*QL = 1 tab/day (10 & 20 mg), 2 tabs/day (40 mg)*)
Pravachol[®]* (pravastatin) (*QL = 1 tab/day (10 & 20 mg), 2 tabs/day (40 mg)*)
Pravastatin † 80 mg Tablet (use 40 mg tablets)

High Potency Statins

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

PDL Key:

† Generic product

* Indicates a generic equivalent is available without PA

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

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

NO PA REQUIRED

PA REQUIRED

MiscellaneousLovaza[®] (omega-3-acid ethyl esters)Cholesterol Absorption Inhibitors/CombinationsVytorin[®] (ezetimibe/simvastatin)*(QL = 1 tablet/day)*Zetia[®] (ezetimibe)*(Qty Limit = 1 tablet/day)*Other Statin CombinationsADVICOR[®] (lovastatin/extended release niacin)*(Qty Limit = 1 tablet/day)*SIMCOR[®] (simvastatin/extended release niacin)*(Qty Limit = 1 tablet/day)*Caduet[®] (atorvastatin/amlopidine)*(Qty Limit = 1 tablet/day)***Miscellaneous: Arcalyst[®] (CAPS Injectable)***Length of Authorization: 1 year***Quantity limits apply**

NO PA REQUIRED

PA REQUIRED

Arcalyst[®] (rilonacept) *(QL = 2 vials for loading dose, then 1 vial per week)***Miscellaneous: Cinryze[®] (Human C1 Inhibitor) IV Infusion***Length of Authorization: Initial 6 months, Subsequent 1 year***Quantity limits apply**

NO PA REQUIRED

PA REQUIRED

Cinryze[®] (human C1 inhibitor)*(QL = 16 vials/28 days for prophylaxis; 4 vials per fill for acute attacks)***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: Soliris[®] (Paroxysmal Nocturnal Hemoglobinuria Injectable)***Length of Authorization: Initial 3 months, Subsequent 1 year***Quantity limits apply**

NO PA REQUIRED

PA REQUIRED

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

NO PA REQUIRED

PA REQUIRED

Somatuline[®] Depot Injection (lanreotide) *(Quantity Limit = 0.2 ml/28 days (60 mg syringe), 0.3 ml/28 days (90 mg syringe) and 0.5 ml/28 days (120 mg syringe))***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)

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

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

PA REQUIRED

Eqetro® (carbamazepine SR)
Lithobid®* (lithium carbonate SR)

Multiple Sclerosis: Injectables

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

Quantity limits apply

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

NO PA REQUIRED

Interferons

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

Other

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

PA REQUIRED

Tysabri® (natalizumab)

Nutritionals, liquid oral supplements

Length of Authorization: 6 months

Therapy specific PA fax form available on OVHA website.

NO PA REQUIRED

PA REQUIRED

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

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

Oncology: Oral (select)

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

Therapy specific Order form is available on OVHA website.

NO PA REQUIRED

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

PA REQUIRED

PDL Key:

† Generic product

* Indicates a generic equivalent is available without PA

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

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 %

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

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

PA REQUIRED

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

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

Alex® (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

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: Glaucoma Agents/Miotics

Length of Authorization: lifetime

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 AKBeta[®], 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 any other preferred beta-blocker, a-2 adrenergic or CAI agent. Coverage of a 'non-preferred' PI agent is contingent upon a similar first-line trial as well as a failed trial of both preferred PI products.

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

CARBONIC ANHYDRASE INHIBITOR

Single Agent

DORZOLAMIDE 2 % (compare to Trusopt[®])

Combination

DORZOLAMIDE w/TIMOLOL (compare to Cosopt[®])

MISCELLANEOUS

DIPIVEFRIN HCl† (compare to AKPro[®], Propine[®])
EPINEPHRINE† (compare to Epifrin[®], Glaucon^{®*})
ISOPTO[®] CARBACHOL (carbachol)
ISOPTO[®] CARPINE (pilocarpine)
PILOCARPINE HCl† (compare to Pilocar[®])
PILOPINE[®] (pilocarpine)
PILOPTIC-1/2[®], PILOPTIC-3[®] (pilocarpine)
PHOSPHOLINE IODIDE[®] (echothiophate)
PROPINE[®] (dipivefrin)

PA REQUIRED

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

Betagan^{®*}
Betimol^{®*}
Istalol^{®*}
Optipranolol^{®*}
Timoptic^{®*} (timolol maleate)
Timoptic XE^{®*} (timolol maleate gel)

Xalatan[®] (latanoprost)

Azopt[®] (brinzolamide 1%)
Trusopt^{®*} (dorzolamide 2%)

Cosopt^{®*} (dorzolamide w/timolol)

Miochol-E[®]
Miostat[®]
Pilocar^{®*}

Ophthalmics: Mast Cell Stabilizers

Length of Authorization: 6 months

NO PA REQUIRED

ALAMAST[®] (pemirolast potassium)
CROMOLYN SODIUM† (compare to Crolo[®], Opticrom[®])

PA REQUIRED

Alocril[®] (nedocromil sodium)
Alomide[®] (iodoxamide)
Crolo^{®*}

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: Non-Steroidal Anti-inflammatory Drugs (NSAIDs)

Length of Authorization: 1 year

NO PA REQUIRED

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

PA REQUIRED

Diclofenac † 0.1% ophthalmic sol (compare to Voltaren[®])
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%)

Ophthalmics: Quinolone Anti-infectives

Length of Authorization: duration of therapy requested

NO PA REQUIRED

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

PA REQUIRED

Ciloxan[®]* (ciprofloxacin)
Iquix[®] (levofloxacin 1.5%) (preservative free)
Ocuflox[®]* (ofloxacin)
Quixin[®] (levofloxacin 0.5%)
Vigamox[®] (moxifloxacin) (preservative free)
Zymar[®] (gatifloxacin)

Ossification Enhancers

Length of Authorization: lifetime

Quantity limits apply

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

NO PA REQUIRED

ORAL BISPHOSPHONATES

TABLETS/CAPSULES

ALENDRONATE † (compare to Fosamax[®])
BONIVA[®] (ibandronate) 150 mg (*Quantity Limit = 1 tab/28 days*)

ORAL SOLUTION

INJECTABLE BISPHOSPHONATES

CALCITONIN NASAL SPRAY

FORTICAL[®] (calcitonin)
MIACALCIN[®] (calcitonin)

PARATHYROID HORMONE INJECTION

PA REQUIRED

Actonel[®] (risedronate)
Actonel[®] w/calcium (risedronate/calcium)
Didronel[®] (etidronate)
Etidronate † (compare to Didronel[®])
Fosamax[®] (alendronate)
Fosamax Plus D[®] (alendronate/vitamin D)
Skelid[®] (tiludronate)

Fosamax[®] (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*)

Calcitonin † Nasal Spray (compare to Miacalcin[®])

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

Otic: Anti-Infectives

Length of Authorization: 1 year

NO PA REQUIRED

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

PA REQUIRED

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

Pancreatic Enzyme Products

Length of Authorization: n/a

NO PA REQUIRED

CREON[®] 5 Capsule-DR, EC, microspheres
CREON[®] 10 Capsule-DR, EC, microspheres
CREON[®] 20 Capsule-DR, EC, microspheres
CREON 6,000 (lipase units) DR Capsule
CREON 12,000 (lipase units) DR Capsule
CREON 24,000 (lipase units) DR Capsule
PANGESTYME[®] CN-10 Capsule-DR, EC granules
PANGESTYME[®] CN-20 Capsule-DR, EC granules
PANGESTYME[®] EC Capsule-DR, EC granules
PANGESTYME[®] MT16 Capsule-DR, EC granules
PANGESTYME[®] UL12 Capsule-DR, EC granules
PANGESTYME[®] UL18 Capsule-DR, EC granules
PANGESTYME[®] UL20 Capsule-DR, EC granules
PANCRECARB[®] MS-4 Capsule-DR, EC, microspheres
PANCRECARB[®] MS-8 Capsule-DR, EC, microspheres
PANCRECARB[®] MS-16 Capsule-DR, EC, microspheres
ULTRASE[®] Capsule-EC microspheres
ULTRASE[®] MT12 Capsule-EC minitabets
ULTRASE[®] MT18 Capsule-EC minitabets
ULTRASE[®] MT20 Capsule-EC minitabets
VIOKASE[®] 8 Tablets
VIOKASE[®] 16 Tablets

DR=delayed release, EC=enteric-coated

PA REQUIRED

PDL Key:

† Generic product

* Indicates a generic equivalent is available without PA

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

Parkinson's: Non-Ergot Dopamine Receptor Agonist

Length of Authorization: 1 year

Quantity limits apply

NO PA REQUIRED

DOPAMINE PRECURSOR

CARBIDOPA/LEVODOPA† (compare to Sinemet®)
CARBIDOPA/LEVODOPA† ER (compare to Sinemet® CR)
CARBIDOPA/LEVODOPA† ODT (compare to Parcopa®)

DOPAMINE AGONISTS (ORAL)

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

COMT INHIBITORS

COMTAN® (entacapone)

MAO-B INHIBITORS

SELEGILINE† (compare to Eldepryl®)

OTHER

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

PA REQUIRED

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

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

Symmetrel® (amantadine)

Phosphodiesterase-5 (PDE-5) Inhibitors

Length of Authorization: 1 year

Quantity limits apply

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

PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

NON-PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

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

Platelet Inhibitors

Length of Authorization: 1 year

NO PA REQUIRED

AGGREGATION INHIBITORS

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

OTHER

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

PA REQUIRED

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

Persantine®* (dipyridamole)

PDL Key:

† Generic product

* Indicates a generic equivalent is available without PA

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

Psoriasis Injectables

****Self-injectables (Enbrel[®] and Humira[®]) 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 form available on OVHA website.

PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

ENBREL[®] (etanercept)
HUMIRA[®] (adalimumab)

NON-PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

Amevive[®] (alefacept)
Remicade[®] (infliximab)

Psoriasis: Non-Biologics

Length of Authorization: 1 year

Quantity limits apply

NO PA REQUIRED

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

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

PA REQUIRED

Oral

Topical

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

Pulmonary: Anticholinergics, Inhaled

Length of Authorization: 1 year

NO PA REQUIRED

METERED DOSE INHALER (SINGLE AGENT)

ATROVENT HFA[®] (ipratropium)
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)

PDL Key:

† Generic product

* Indicates a generic equivalent is available without PA

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

Pulmonary: Antihistamines – Intranasal

Length of Authorization: 1 year

Quantity limits apply

NO PA REQUIRED

PA REQUIRED

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

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

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

Pulmonary: Antihistamines-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®)

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

ZYRTEC® OTC (cetirizine) SYRUP

LORATADINE (OTC) † rapidly disintegrating tablet (RDT)

PA REQUIRED

Allegra® (fexofenadine)
Clarinet® (desloratadine)
Claritin® capsule (loratadine)
Claritin® tablet (loratadine)
Xyzal® (levocetirizine)
Zyrtec® RX/OTC* (cetirizine)

Allegra-D® § (12 HR & 24 HR)
Cetirizine-D † SR
Clarinet-D® § (12 HR & 24 HR)
Claritin-D® §
Fexofenadine-PSE † (compare to Allegra-D® 12 hr)
Zyrtec-D® §

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

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

PDL Key:

† Generic product

* Indicates a generic equivalent is available without PA

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

Pulmonary: Persistent Asthma

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

Therapy specific clinical criteria are available on the OVHA website.

Drug-specific PA fax form available on OVHA website.

NO PA REQUIRED

PA REQUIRED

Xolair[®] (omalizumab)

Pulmonary: Beta-adrenergic Agents

Length of Authorization: 1 year

Quantity limits apply

NO PA REQUIRED

PA REQUIRED

METERED-DOSE INHALERS (SHORT-ACTING)

XOPENEX[®] HFA (levalbuterol)

MAXAIR[®] Autohaler (pirbuterol)

Alupent[®] (metaproterenol)

Proair[®] HFA (albuterol)

Proventil[®] HFA (albuterol)

Ventolin[®] HFA (albuterol)

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

METAPROTERENOL † neb solution

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

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)

NEBULIZER SOLUTIONS (LONG-ACTING)

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

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

TABLETS/SYRUP (SHORT-ACTING)

TERBUTALINE † tablets (compare to Brethine[®])

ALBUTEROL † tablets/syrup

METAPROTERENOL † tablets/syrup

Brethine^{®*} (terbutaline)

TABLETS (LONG-ACTING)

ALBUTEROL ER † tablets

Vospire ER^{®*} (albuterol)

PDL Key:

† Generic product

* Indicates a generic equivalent is available without PA

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

Pulmonary: Inhaled Glucocorticoids/Glucocorticoid Combinations

Length of Authorization: 1 year

Quantity limits apply

NO PA REQUIRED

METERED DOSE INHALERS (SINGLE AGENT)

ASMANEX[®] 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))

AZMACORT[®] (triamcinolone acetonide)

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 = 14.6 gm (2 inhalers)/90 days)

QVAR[®] 80 mcg/inh (beclomethasone)

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

METERED DOSE INHALERS (COMBINATION PRODUCT)

ADVAIR[®] DISKUS (fluticasone/salmeterol)

(QL = 3 inhalers/90 days)

ADVAIR[®] HFA (fluticasone/salmeterol)

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

SYMBICORT[®] (budesonide/formoterol)

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

NEBULIZER SOLUTIONS

BUDESONIDE INH SUSPENSION (compare to Pulmicort Respules[®])
(age ≤ 12 yrs)

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[®]) (age > 12 years)

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

Pulmonary: Nasal Glucocorticoids

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

Veramyst[®] (fluticasone furoate)

QL = 10 gm (1 inhaler)/30 days

PDL Key:

† Generic product

* Indicates a generic equivalent is available without PA

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

Pulmonary: Systemic Glucocorticoids

Length of Authorization: 1 year

NO PA REQUIRED

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

PA REQUIRED

Celestone®
Cortef®* (hydrocortisone)
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)

Pulmonary: Leukotriene Modifiers

Length of Authorization: 1 year

NO PA REQUIRED

ACCOLATE® (zafirlukast)
(Quantity Limit = 2 tablets/day)
SINGULAIR® (montelukast sodium)
(Quantity Limit = 1 tablet or packet per day)

PA REQUIRED

ZyFlo® CR (zileuton SR) §
(Quantity Limit = 4 tablets/day)

Pulmonary: RSV Prevention

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 OVHA website

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

Renal Disease: Phosphate Binders

Length of Authorization: 1 year

NO PA REQUIRED

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

PA REQUIRED

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

Rheumatoid, Juvenile & Psoriatic Arthritis: Immunomodulators

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

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

Quantity limits apply

Drug specific PA fax forms available on the OVHA website.

PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

ENBREL® (etanercept)
HUMIRA® (adalimumab)

NON-PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

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

† 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)

Sedative/Hypnotics

Length of Authorization: 1 year

Quantity limits apply

NO PA REQUIRED

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

PA REQUIRED

Benzodiazepine

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

Non-benzodiazepine, Non-barbiturate

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

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

Skeletal Muscle Relaxants

Length of Authorization: 1 year

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

NO PA REQUIRED

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† (compare to Soma®)
Flexmid® (cyclobenzaprine)
Flexeril®* (cyclobenzaprine)
Parafon Forte DSC®* (chlorzoxazone)
Robaxin®* (methocarbamol)
Skelaxin® (metaxalone)
Soma® (carisoprodol)

carisoprodol, ASA† (compare to Soma Compound®)
carisoprodol, ASA, codeine† (compare to Soma Compound with Codeine®)
orphenadrine, ASA, caffeine† (previously Norgesic®, Norgesic Forte®)
Soma Compound® (carisoprodol/ASA)
Soma Compound with Codeine® (carisoprodol/ASA/codeine)

Antispasticity Agents

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

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

PDL Key:

† 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®
NICOTINE LOZENGE†
NICOTROL INHALER®

ORAL THERAPY

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

PA REQUIRED

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

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

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

Testosterone: Topical

Length of Authorization: 1 year

Quantity limits apply

NO PA REQUIRED

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

PA REQUIRED

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

Thrombopoietin Receptor Agonists

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

NO PA REQUIRED

PA REQUIRED

Nplate® (romiplostim)
Promacta® (eltrombopag)

PDL Key:

† Generic product

* Indicates a generic equivalent is available without PA

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

Urinary Antispasmodics

Length of Authorization: 1 year

Quantity limits apply

NO PA REQUIRED*

SHORT-ACTING AGENTS

OXYBUTYNIN† (compare to Ditropan®)

LONG-ACTING AGENTS (after clinical criteria are met)

Twice Daily Oral (Qty Limit = 2 per day)

SANCTURA® (trospium)

Once Daily Oral (Qty Limit = 1 per day)

ENABLEX® (darifenacin)

SANCTURA XR® (trospium)

VESICARE® (solifenacin)

Transdermal

>NOTE:

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

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

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

PA REQUIRED

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

Detrol® (tolterodine)

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

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

Vaginal Anti-Infectives

Length of Authorization: 1 year

NO PA REQUIRED

CLINDAMYCIN

CLINDAMYCIN VAGINAL† (clindamycin vaginal cream 2%)

CLINDAMAX† (clindamycin vaginal cream 2%)

METRONIDAZOLE

METRONIDAZOLE VAGINAL GEL 0.75%†

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

All generics

PA REQUIRED

All brands

PDL Key:

† Generic product

* Indicates a generic equivalent is available without PA

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