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## *Phone Numbers for Vermont Medicaid PBM Program*

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

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

#### **PA Requests**

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

Note: Fax requests are responded to within 24 hrs.

For urgent requests, please call MHP directly.

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

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

(f): 802-879-5651

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

### **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.*

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

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(f): 802-879-5651

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##### *Medical Director*

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##### *Director of Pharmacy Services*

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

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

**NO PA REQUIRED**

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

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

MINOCYCLINE† 50 mg, 75 mg, 100 mg

TETRACYCLINE† 250 mg, 500 mg cap

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

**PA REQUIRED**

Adoxa®\* (doxycycline monohydrate) 50 mg, 75 mg tab, 100 mg tab, 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)  
Clindagel® (clindamycin 1% G)  
All other brands

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

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

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

Avar® (sodium sulfacetamide/sulfur G)  
Avar-E LS® (sulfacetamide/sulfur C)  
Avar LS® (sulfacetamide/sulfur W)  
Plexion® (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

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## Acne Drugs: Topical – Retinoids

Length of Authorization: 1 year

### NO PA REQUIRED

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

AVITA® (tretinoin)

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

C=cream, G=gel

### PA REQUIRED

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

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

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

Avage® (tazarotene) ♣

Renova® (tretinoin) ♣

Solage® (tretinoin/mequinol) ♣

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

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

## Acne Drugs: Topical – Rosacea

Length of Authorization: 1 year

### NO PA REQUIRED

METRONIDAZOLE† 0.75% C, G, L

C=cream, G=gel, L=lotion

### PA REQUIRED

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

Finacea® (azelaic acid) 15% G

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

Length of Authorization: 1 year

Quantity limits apply

### NO PA REQUIRED

#### CHOLINESTERASE INHIBITORS

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

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

EXELON® (rivastigmine) Oral Solution

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

#### NMDA RECEPTOR ANTAGONIST

NAMENDA® (memantine) Tablet

NAMENDA® (memantine) Oral Solution

### PA REQUIRED

Cognex® (tacrine) Capsule §

galantamine† tablet § (compare to Razadyne®) Tablet

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

Razadyne® (galantamine) Tablet

Razadyne ER® (galantamine) Capsule

rivastigmine† (compare to Exelon®) capsule

(QL = 2 capsules/day)

Aricept® ODT (donepezil)

(QL = 1 tablet/day)

galantamine† (compare to Razadyne®) Oral Solution

Razadyne® (galantamine) Oral Solution

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## Analgesics: COX-2 Inhibitors

Length of Authorization: 1 year

Quantity limits apply

### NO PA REQUIRED

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

### PA REQUIRED

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

## Analgesics: Narcotics-Short Acting

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

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

Quantity limits apply

### NO PA REQUIRED

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

### PA REQUIRED

Acetaminophen w/codeine: all branded products  
Acetaminophen w/hydrocodone: all branded products  
(QL 5/500 = 8 tablets/day, 10/500 = 8 tablets/day, 7.5/750 = 5 tablets/day)  
Acetaminophen w/oxycodone: all branded products  
(QL 10/650 = 6 tablets/day)  
Actiq<sup>®</sup> (fentanyl lozenge on a stick: 200 mcg, 400 mcg, 600 mcg, 800 mcg,  
1200 mcg, 1600 mcg)  
Anexsia<sup>®</sup>\* (acetaminophen w/hydrocodone)  
Butorphanol Nasal Spray† (Qty Limit = 2 bottles/month)  
Capital<sup>®</sup> w/codeine\* (acetaminophen w/codeine)  
Cocet<sup>®</sup> /Cocet Plus<sup>®</sup> (acetaminophen w/codeine) (QL 30/650 or 60/650 = 6  
tablets/day)  
Combunox<sup>®</sup>\* (oxycodone w/ ibuprofen)  
Darvocet-N<sup>®</sup>\* (propoxyphene-n w/acetaminophen) (QL 100/650 = 6  
tablets/day)  
Darvon Compound<sup>®</sup>\* (propoxyphene compound)  
Darvon<sup>®</sup>\* / Darvon-N<sup>®</sup>\* (propoxyphene)  
Dazidox<sup>®</sup>\* (oxycodone)  
Demerol<sup>®</sup> (meperidine)  
Dilaudid<sup>®</sup>\* (hydromorphone)  
Dilaudid-5<sup>®</sup> (hydromorphone) oral solution  
fentanyl citrate transmucosal† (compare to Actiq<sup>®</sup>)  
Fentora<sup>®</sup> (fentanyl citrate buccal tablets)  
Fioricet<sup>®</sup> w/codeine\* (butalbital/acetaminophen/caffeine/codeine)  
Ibudone<sup>®</sup>\* (hydrocodone w/ ibuprofen)  
Liquicet<sup>®</sup> (hydrocodone w/ acetaminophen)  
Lorcet<sup>®</sup>\* (also HD, PLUS) (hydrocodone w/ acetaminophen)  
Lortab<sup>®</sup>\* (hydrocodone w/ acetaminophen)  
Magnacet<sup>®</sup> (oxycodone w/ acetaminophen)  
Maxidone<sup>®</sup>\* (hydrocodone w/ acetaminophen)  
Meperidine† (Qty > 30 tabs or 5 day supply)  
Nalbuphine† continued on next page

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Norco<sup>®</sup>\*(hydrocodone w/ acetaminophen)  
Nubain<sup>®</sup>\*(nalbuphine)  
Nucynta<sup>®</sup> (tapentadol)  
Onsolis<sup>®</sup>(fentanyl buccal soluble film)  
Opana<sup>®</sup> (oxymorphone)  
Oxyfast<sup>®</sup>\*(oxycodone)  
OxyIR<sup>®</sup>\*(oxycodone)  
Panlor DC<sup>®</sup> (acetaminophen/caffeine/dihydrocodeine)  
Pentazocine w/acetaminophen†  
Pentazocine w/naloxone†  
Percocet<sup>®</sup>\*(oxycodone w/ acetaminophen)  
Percodan<sup>®</sup>\* (oxycodone w/aspirin)  
Propoxyphene: *all branded products\**  
Reprexain<sup>®</sup>\* (hydrocodone w/ ibuprofen)  
Roxanol<sup>®</sup>\*(morphine sulfate)  
Ryzolt<sup>®</sup> (tramadol SR)  
Synalgos DC<sup>®</sup>\*(dihydrocodeine compound)  
Talwin<sup>®</sup>\* (pentazocine) and branded combinations  
Tramadol ER† (compare to Ultram ER<sup>®</sup>) (*Qty Limit = 1 tablet/day*)  
Trezix<sup>®</sup> (acetaminophen/caffeine/dihydrocodeine)  
Tylenol<sup>®</sup> #3\*,#4\*(acetaminophen w/codeine)  
Tylox<sup>®</sup>\*(oxycodone w/ acetaminophen)  
Ultracet<sup>®</sup> (tramadol w/ acetaminophen)  
Ultram<sup>®</sup>\*/Ultram ER<sup>®</sup> (tramadol/tramadol SR) ) (*Qty Limit for ER tab = 1 tablet/day*)  
Vicodin<sup>®</sup>\*(hydrocodone w/acetaminophen)  
Vicoprofen<sup>®</sup>\*(hydrocodone w/ ibuprofen)  
Xodol<sup>®</sup> (hydrocodone w/acetaminophen)  
Xolox<sup>®</sup> (oxycodone w/ acetaminophen)  
Zamiset<sup>®</sup>\* (hydrocodone w/ acetaminophen)  
Zydone<sup>®</sup>\*(hydrocodone w/acetaminophen)

## Analgesics: Narcotics-Long Acting

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

Quantity limits apply

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

### NO PA REQUIRED

#### TRANSDERMAL

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

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

#### ORAL

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

MORPHINE SULFATE SR 12 hr† (compare to MS Contin<sup>®</sup>)  
(*QL=90 tablets/strength/30 days*)

### PA REQUIRED

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

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

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

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

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

Dolophine<sup>®</sup>\* (methadone)

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

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

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

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

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

Oxycodone ER† (compare to OxyContin<sup>®</sup>) (*QL=90 tablets/strength/30 days*)

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

#### INJECTABLE

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

#### TRANSDERMAL

### PA REQUIRED

Anaprox®\* (naproxen sodium)  
Anaprox DS®\* (naproxen sodium)  
Ansaid®\* (flurbiprofen)  
Arthrotec® (diclofenac sodium w/misoprostol)  
Cataflam®\* (diclofenac potassium)  
Clinoril®\* (sulindac)  
Daypro®\* (oxaprozin)  
EC-Naprosyn®\* (naproxen sodium enteric coated)  
Feldene®\* (piroxicam)  
Indocin®\* (indomethacin) suspension  
Indocin SR®\* (indomethacin) capsules  
meloxicam†susp (compare to Mobic®)  
Mobic®\* (meloxicam)  
Motrin®\* (ibuprofen)  
Nalfon®\* (fenoprofen)  
Naprelan®\* (naproxen sodium)  
Naprosyn®\* (naproxen sodium)  
Ponstel® (mefenamic acid)  
Voltaren®\* (diclofenac sodium)  
Voltaren XR®\* (diclofenac sodium SR)  
Zipsor® (diclofenac potassium)

Flector® (diclofenac) Patch  
(QL = 2 patches/day)  
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®, Humira® and Simponi®) must be obtained through Specialty Pharmacy Provider, ICORE\*\*

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

Drug-specific PA fax form available on DVHA website.

### PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

ENBREL® (etanercept)  
HUMIRA® (adalimumab)

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

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

### PDL Key:

† Generic product

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**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

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## Anticonvulsants

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

Quantity limits apply

### NO PA REQUIRED

#### ORAL

CARBAMAZEPINE† (compare to Tegretol®)  
CARBAMAZEPINE extended release † (compare to Tegretol XR®)  
CARBATROL® (carbamazepine)  
CELONTIN® (methsuxamide)  
CLONAZEPAM† (compare to Klonopin®)  
CLONAZEPAM ODT† (compare to Klonopin Wafers®)  
DEPAKOTE SPRINKLES® (divalproex sodium caps)  
DILANTIN® (phenytoin)  
DIVALPROEX SODIUM † (compare to Depakote®)  
DIVALPROEX SODIUM ER† (compare to Depakote ER®)  
EPITOL† (carbamazepine)  
ETHOSUXAMIDE† (compare to Zarontin®)  
GABAPENTIN† 100 mg, 300 mg, 400 mg capsules, 600 mg, 800 mg tablets (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® (ethoin)  
PHENYTEK® (phenytoin)  
PHENYTOIN† (compare to Dilantin®)  
PHENYTOIN EX† cap (compare to Phenytek®)  
PRIMIDONE† (compare to Mysoline®)  
TEGRETOL XR® (carbamazepine) 100 mg ONLY  
TOPIRAMATE† tabs (compare to Topamax® tabs)  
TOPIRAMATE† sprinkle caps (compare to Topamax® Sprinkles)  
TRILEPTAL® oral suspension (oxcarbazepine)  
VALPROIC ACID† (compare to Depakene®)  
ZONISIMIDE† (compare to Zonegran®)

#### RECTAL

DIASSTAT® (diazepam rectal gel)

### PA REQUIRED

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

Diazepam† rectal gel (compare to Diastat®)

### PDL Key:

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## Anti-depressants: Miscellaneous

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

Quantity limits apply

### NO PA REQUIRED

BUDEPRION<sup>®</sup> SR/BUPROPION SR† (compare to Wellbutrin SR<sup>®</sup>)

*FDA maximum recommended dose = 400 mg/day*

BUPROPION† (compare to Wellbutrin<sup>®</sup>)

*FDA maximum recommended dose = 450 mg/day*

MAPROTILINE† (previously Ludiomil<sup>®</sup>)

*FDA maximum recommended dose = 225 mg/day*

MIRTAZAPINE† (compare to Remeron<sup>®</sup>)

*FDA maximum recommended dose = 45 mg/day*

MIRTAZAPINE RDT† (compare to Remeron Sol-Tab<sup>®</sup>)

*FDA maximum recommended dose = 45 mg/day*

NEFAZADONE† (previously Serzone<sup>®</sup>)

*FDA maximum recommended dose = 600 mg/day*

TRAZODONE HCL† (previously Desyrel<sup>®</sup>)

*FDA maximum recommended dose = 600 mg/day*

WELLBUTRIN XL<sup>®</sup> (bupropion XL)

*FDA maximum recommended dose = 450 mg/day*

### PA REQUIRED

Aplenzin<sup>®</sup> (bupropion hydrobromide) ER tablets

*Quantity Limit = 1 tablet/day*

Budeprion XL/bupropion XL† (compare to Wellbutrin XL<sup>®</sup>)

*FDA maximum recommended dose = 450 mg/day*

Remeron<sup>®</sup>\* (mirtazapine)

*FDA maximum recommended dose = 45 mg/day*

Remeron Sol Tab<sup>®</sup>\* (mirtazapine RDT)

*FDA maximum recommended dose = 45 mg/day*

Wellbutrin<sup>®</sup>\* (bupropion)

*FDA maximum recommended dose = 450 mg/day*

Wellbutrin SR<sup>®</sup>\* (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<sup>®</sup> § (duloxetine)

*FDA maximum recommended dose = 60 mg/day*

Effexor<sup>®</sup> (venlafaxine IR)

*FDA maximum recommended dose = 225 mg/day*

Effexor XR<sup>®</sup> § (venlafaxine XR) capsule

*FDA maximum recommended dose = 225 mg/day,*

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

Pristiq<sup>®</sup> § (desvenlafaxine)

*FDA maximum recommended dose = 400 mg/day,*

*Quantity limit = 1 tablet/day (50 mg tablet only)*

Venlafaxine ER† tablet

*FDA maximum recommended dose = 225 mg/day,*

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

Venlafaxine ER†§ tablet

*FDA maximum recommended dose = 225 mg/day,*

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

Venlafaxine ER† capsule (compare to Effexor XR<sup>®</sup>)

*FDA maximum recommended dose = 225 mg/day,*

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

venlafaxine IR †§ (compare to Effexor<sup>®</sup>)

*FDA maximum recommended dose = 225 mg/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-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*  
fluoxetine† 90 mg (compare to Prozac Weekly®)  
*FDA maximum recommended dose = 90 mg/week*  
Lexapro® (escitalopram)  
*FDA maximum recommended dose = 20 mg/day,*  
*Quantity limit = 1.5 tabs/day (5 mg & 10 mg tabs)*  
Luvox CR® (fluvoxamine CR)  
*FDA maximum recommended dose = 300 mg/day,*  
*Quantity limit = 2 capsules/day*  
paroxetine suspension† (compare to Paxil® susp)  
*FDA maximum recommended dose = 60 mg/day*  
Paroxetine CR† (compare to Paxil CR®)  
*FDA maximum recommended dose = 75 mg/day*  
Paxil®\* (paroxetine)  
*FDA maximum recommended dose = 60 mg/day*  
Paxil 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 Limbitrol®)  
CLOMIPRAMINE† (compare to Anafranil®)  
DESIPRAMINE† (compare to Norpramin®)  
DOXEPIN† (previously Sinequan®)  
IMIPRAMINE† (compare to Tofranil®)  
*FDA maximum recommended dose = 300 mg/day*  
IMIPRAMINE PAMOATE† (compare to Tofranil PM®)  
NORTRIPTYLINE† (previously Aventyl®, compare to Pamelor®)  
PROTRIPTYLINE† (compare to Vivactil®)  
TRIMIPRAMINE (compare to Surmontil®)

### PA REQUIRED

Anafranil®\* (clomipramine)  
Chlordiazepoxide/Amitriptyline † 10 mg/25 mg (compare to Limbitrol DS®)  
Limbitrol®\* (amitriptyline/chlordiazepoxide)  
Limbitrol DS® (amitriptyline/chlordiazepoxide)  
Norpramin®\* (desipramine)  
Pamelor®\* (nortriptyline)  
Surmontil®\* (trimipramine)  
Tofranil®\* (imipramine)  
*FDA maximum recommended dose = 300 mg/day*  
Tofranil PM®\* (imipramine pamoate)  
Vivactil®\* (protriptyline)

### 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<sup>®</sup> (phenylzine)

*FDA maximum recommended dose = 90 mg/day*

TRANLYCYPROMINE (compare to Parnate<sup>®</sup>)

*FDA maximum recommended dose = 60 mg/day*

### PA REQUIRED

EMSAM<sup>®</sup> (selegiline) (*QL = 1 patch/day*)

Marplan<sup>®</sup> (isocarboxazid)

Parnate<sup>®\*</sup> (tranlycypromine)

*FDA maximum recommended dose = 60 mg/day*

## Anti-diabetics: Alpha-Glucosidase Inhibitors

*Length of Authorization: 1 year*

### NO PA REQUIRED

ACARBOSE<sup>†</sup> (compare to Precose<sup>®</sup>)

GLYSET<sup>®</sup> (miglitol)

### PA REQUIRED

Precose<sup>®\*</sup> (acarbose)

## Anti-diabetic: Biguanides & Combinations

*Length of Authorization: 1 year*

### NO PA REQUIRED

GLIPIZIDE/METFORMIN<sup>†</sup> (compare to Metaglip<sup>®</sup>)

GLYBURIDE/METFORMIN<sup>†</sup> (compare to Glucovance<sup>®</sup>)

METFORMIN<sup>†</sup> (compare to Glucophage<sup>®</sup>)

METFORMIN XR<sup>†</sup> (compare to Glucophage XR<sup>®</sup>)

RIOMET<sup>®</sup> (metformin oral solution)

### PA REQUIRED

Fortamet<sup>®</sup> (metformin ER)

Glucophage<sup>®\*</sup> (metformin)

Glucophage XR<sup>®\*</sup> (metformin XR)

Glucovance<sup>®\*</sup> (glyburide/metformin)

Glumetza<sup>®</sup> (metformin ER)

Metaglip<sup>®\*</sup> (glipizide/metformin)

## Anti-diabetics: Peptide Hormones

*Length of Authorization: 1 year*

Quantity limits apply

### PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

BYETTA<sup>®</sup> (exenatide) § (*Quantity Limit = 1 pen/30 days*)

SYMLIN<sup>®</sup> (pramlintide) § *No Quantity Limit*

### 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)

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

**NO PA REQUIRED**

**RAPID-ACTING INJECTABLE**

NOVOLOG® (Aspart)

**SHORT-ACTING INJECTABLE**

HUMULIN R® (Regular)

NOVOLIN R® (Regular)

**INTERMEDIATE-ACTING INJECTABLE**

HUMULIN N® (NPH)

NOVOLIN N® (NPH)

**LONG-ACTING ANALOGS INJECTABLE**

LANTUS® (insulin glargine)

LEVEMIR® (insulin detemir)

**MIXED INSULINS INJECTABLE**

HUMULIN 70/30® (NPH/Regular)

NOVOLIN 70/30® (NPH/Regular)

NOVOLOG MIX 70/30® (Protamine/Aspart)

HUMALOG MIX 50/50® (Protamine/Lispro)

HUMALOG MIX 75/25® (Protamine/Lispro)

**PA REQUIRED**

Apidra® (insulin glulisine)

Humalog® (insulin lispro)

ReliOn R® (Regular)

ReliOn N® (NPH)

ReliOn 70/30® (NPH/Regular)

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

**NO PA REQUIRED**

**Single Agent**

STARLIX® (nateglinide)

**Combination**

**PA REQUIRED**

Nateglinide† (compare to Starlix®)

Prandin® (replaglinide)

Prandimet® (replaglinide/metformin)

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

**NO PA REQUIRED**

GLIMEPIRIDE† (compare to Amaryl®)

GLIPIZIDE† (compare to Glucotrol®)

GLIPIZIDE ER† (compare to Glucotrol XL®)

GLYBURIDE† (compare to Diabeta®, Micronase®)

GLYBURIDE MICRONIZED† (compare to Glynase® PresTab®)

**PA REQUIRED**

Amaryl®\* (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<sup>®</sup> (pioglitazone) §

AVANDIA<sup>®</sup> (rosiglitazone) §

#### COMBINATION

ACTOPLUS MET<sup>®</sup> (metformin/pioglitazone) §

AVANDAMET<sup>®</sup> (metformin/rosiglitazone maleate) §

AVANDARYL<sup>®</sup> (glimepiride/rosiglitazone maleate) §

DUETACT<sup>®</sup> (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

#### SINGLE AGENT

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

ONGLYZA<sup>®</sup> (saxagliptin) § (*Quantity limit=1 tablet/day*)

#### COMBINATION

JANUMET<sup>®</sup> (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<sup>®</sup> (aprepitant) 40 mg (1 cap/28 days)

\*EMEND<sup>®</sup> (aprepitant) 80 mg (2 caps/28 days)

\*EMEND<sup>®</sup> (aprepitant) 125 mg (1 cap/28 days)

\*EMEND<sup>®</sup> (aprepitant) Tri-fold Pack (1 pack/28 days)

ONDANSETRON† Injection (vial and premix)

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

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

\* *To be prescribed by oncology practitioners ONLY*

### PA REQUIRED

Aloxi<sup>®</sup> (palonosetron, injectable) (2 vials/28 days)

Anzemet<sup>®</sup> (dolansetron) 50 mg (4 tabs/28 days)

Anzemet<sup>®</sup> (dolansetron) 100 mg (2 tabs/28 days)

\*Emend<sup>®</sup> (fosaprepitant) 115 mg Injection (Qty Limit = 1 vial/28 days)

Granisetron† (compare to Kytril<sup>®</sup>) 1 mg (6 tabs/28 days)

Granisetron† (compare to Kytril<sup>®</sup>) Injectable

Granisetron† (compare to Kytril<sup>®</sup>) Oral Solution

Kytril<sup>®</sup> (granisetron) 1 mg (6 tabs/28 days)

Kytril<sup>®</sup> (granisetron) Injectable

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

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

Sancuso<sup>®</sup> 3.1 mg/24 hrs Transdermal Patch (granisetron) (Qty Limit = 1 patch/28 days)

Zofran<sup>®</sup>\* (ondansetron) Injection

Zofran<sup>®</sup>\* (ondansetron) Oral Tablets and ODT 4 mg (12 tabs/28 days), 8 mg (6 tabs/28 days)

Zofran<sup>®</sup> (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<sup>®</sup>)

Marinol<sup>®</sup> (dronabinol)

Cesamet<sup>®</sup> (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<sup>®</sup> (compare to Ritalin<sup>®</sup> SR)  
METHYLIN<sup>®</sup> (compare to Ritalin<sup>®</sup>)  
METHYLIN<sup>®</sup> ER (compare to Ritalin<sup>®</sup> SR)  
METHYLPHENIDATE † (compare to Ritalin<sup>®</sup>)  
METHYLPHENIDATE SR † (compare to Ritalin<sup>®</sup> SR)

### PA REQUIRED

Dexmethylphenidate † (compare to Focalin<sup>®</sup>)  
Focalin<sup>®</sup> (dexmethylphenidate)  
Ritalin<sup>®</sup>\* (methylphenidate)  
Ritalin SR<sup>®</sup>\* (methylphenidate SR)

#### LONG-ACTING METHYLPHENIDATE PREPS

##### Oral

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

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

##### Transdermal

DAYTRANA<sup>®</sup> (methylphenidate patch) (QL = 1 patch/day)

#### SHORT/INTERMEDIATE AMPHETAMINE PREPS

AMPHETAMINE/DETRIOAMPHETAMINE † (compare to Adderall<sup>®</sup>)  
DETRIOAMPHETAMINE † (previously Dexedrine<sup>®</sup>)  
DETRIOAMPHETAMINE SR † (compare to Dexedrine CR<sup>®</sup>)  
DETRIOSTAT † (dextroamphetamine)

Adderall<sup>®</sup>\* (amphetamine/dextroamphetamine)  
Desoxyn<sup>®</sup> (methamphetamine)  
Dexedrine CR<sup>®</sup>\* (dextroamphetamine SR)  
Methamphetamine † (compare to Desoxyn<sup>®</sup>)

#### LONG-ACTING AMPHETAMINE PREPS

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

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

#### NON-STIMULANT PREPS

Intuniv<sup>®</sup> (guanfacine extended release) Tablet  
Qty limit = 1 tablet/day

Nuvigil<sup>®</sup> (armodafinil)  
Qty limit: 50 mg = 2 tablets/day  
150 mg/250 mg = 1 tablet/day

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

Strattera<sup>®</sup> (atomoxetine)  
FDA maximum recommended dose = 100 mg/day

Xyrem<sup>®</sup> (sodium oxybate)

### PDL Key:

† Generic product

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## Anti-hypertensives: ACE Inhibitors

*Length of Authorization: 1 year*

### NO PA REQUIRED

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

### PA REQUIRED

Accupril®\* (quinapril)  
Aceon® (perindopril)  
Altace®\* (ramipril)  
Capoten®\* (captopril)  
Lotensin®\* (benazepril)  
Mavik®\* (trandolapril)  
Monopril®\* (fosinopril)  
perindopril† (compare to Aceon®)  
Prinivil®\* (lisinopril)  
Univasc®\* (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)  
trandolapril/verapamil† (compare to Tarka®)

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

*Length of Authorization: 3 years*

### PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

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

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

Atacand® (candesartan) §  
Losartan† (compare to Cozaar®)  
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) §  
Losartan/hydrochlorothiazide † (compare to Hyzaar®)  
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<sup>®</sup> (olmesartan/amlodipine) § (Quantity Limit = 1 tablet/day)  
EXFORGE<sup>®</sup> (valsartan/amlodipine) § (Quantity Limit = 1 tablet/day)

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

Twynsta<sup>®</sup> (amlodipine/telmisartan)  
(QL = 1 tablet/day)

## Anti-hypertensives: Angiotensin Receptor Blocker/Renin Inhibitor Combination

Length of Authorization: 3 years

Quantity limits apply

### PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

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

Valturna<sup>®</sup> (aliskiren/valsartan)  
(Qty Limit = 1 tablet/day)

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

Length of Authorization: 3 years

Quantity limits apply

### PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

EXFORGE HCT<sup>®</sup> (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

Quantity limits apply

### NO PA REQUIRED

#### SINGLE AGENT

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

#### BETA-BLOCKER/DIURETIC COMBINATION

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

### PA REQUIRED

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

Corzide<sup>®\*</sup> Tenoretic<sup>®\*</sup> (atenolol/chlorthalidone)  
(nadolol/bendroflumethiazide) Timolide<sup>®</sup> (timolol/HCTZ)  
Inderide<sup>®\*</sup> Ziac<sup>®\*</sup> (bisoprolol/HCTZ)  
(propranolol/HCTZ)  
Lopressor HCT<sup>®\*</sup>  
(metoprolol/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<sup>®</sup> CR † (nifedipine SR, compare to Adalat<sup>®</sup> CC)  
AMLODIPINE † (compare to Norvasc<sup>®</sup>)  
FELODIPINE † (compare to Plendil<sup>®</sup>)  
ISRADIPINE † (formerly Dynacirc<sup>®</sup>)  
NICARDIPINE † (formerly Cardene<sup>®</sup>)  
NIFEDIAC<sup>®</sup> CC † (nifedipine SR, compare to Adalat<sup>®</sup> CC)  
NIFEDICAL<sup>®</sup> XL † (nifedipine SR osmotic, compare to Procardia<sup>®</sup> XL)  
NIFEDIPINE IR † (compare to Procardia<sup>®</sup>)  
NIFEDIPINE SR osmotic † (compare to Procardia<sup>®</sup> XL)  
NIFEDIPINE SR † (compare to Adalat<sup>®</sup> CC )  
NIMODIPINE † (compare to Nimotop<sup>®</sup>)

##### **Miscellaneous**

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

#### CALCIUM CHANNEL BLOCKER/OTHER COMBINATION

(preferred after clinical criteria are met)

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

### PA REQUIRED

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

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

Twynsta<sup>®</sup> (amlodipine/telmisartan)  
(QL = 1 tablet/day)

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

## Anti-hypertensives: Renin Inhibitor

Length of Authorization: 3 years

Quantity limits apply

### NO PA REQUIRED

### PA REQUIRED

#### SINGLE AGENT

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

#### COMBINATION

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

Valturna<sup>®</sup> (aliskiren/valsartan)  
(Qty Limit = 1 tablet/day)

### PDL Key:

† Generic product

\* Indicates a generic equivalent is available without PA

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

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

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

### NO PA REQUIRED

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

IV drugs are not managed at this time

### PA REQUIRED

Duricef®\* (cefadroxil)  
Keflex®\* (cephalexin)

## Anti-infectives: Cephalosporins – 2<sup>nd</sup> 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 – 3<sup>rd</sup> Generation

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

### NO PA REQUIRED

#### CAPSULES/TABLETS

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

#### SUSPENSION

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

IV drugs are not managed at this time

### PA REQUIRED

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

Cedax® (ceftibuten) 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 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

Amoxicillin/clavulanate† (compare to Augmentin XR®) tablets  
Augmentin®\* (amoxicillin/clavulanate) chewable tablets, tablets, suspension  
Augmentin ES®\* (amoxicillin/clavulanate) suspension  
Augmentin XR® (amoxicillin/clavulanate) tablets  
Moxatag® (amoxicillin extended release) tablet  
QL = 1 tablet/day

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

## Anti-infectives: Quinolones

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

### NO PA REQUIRED

CIPROFLOXACIN† (compare to Cipro®)  
CIPRO® OS (ciprofloxacin oral solution) 100 mg/ml  
LEVAQUIN® (levofloxacin)  
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: Antivirals: 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<sup>®</sup> 2009- 2010 Injection  
FLUARIX<sup>®</sup> 2009- 2010 Injection  
FLULAVAL<sup>®</sup> 2009- 2010 Injection  
FLUVIRIN<sup>®</sup> 2009- 2010 Injection  
FLUZONE<sup>®</sup> 2009- 2010 Injection

#### SEASONAL Influenza Nasal Vaccine

#### 2009 H1N1 (formerly Swine Flu) Vaccine Injection

#### 2009 H1N1 (formerly Swine Flu) Nasal Vaccine

### PA REQUIRED

FluMist<sup>®</sup> 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-migraine: Triptans

*Length of Authorization: 6 months*

Monthly quantity limits apply, PA required to exceed.

### NO PA REQUIRED, Quantity Limits Apply

#### Single Agent

##### ORAL

AXERT<sup>®</sup> (almotriptan) 6.25 mg, 12.5 mg  
*Quantity Limit = 6 tablets/month*  
SUMATRIPTAN† (compare to Imitrex<sup>®</sup>)  
*Quantity Limit = 18 tablets/month (25 mg),  
9 tablets/month (50 mg, 100 mg),*

##### NASAL SPRAY

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

##### INJECTABLE

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

#### Combination Product (Oral)

### PA REQUIRED, Quantity Limits Apply

Amerge<sup>®</sup> (naratriptan) 1 mg, 2.5 mg  
*Quantity Limit = 9 tablets/month*  
Frova<sup>®</sup> (frovatriptan) 2.5 mg  
*Quantity Limit = 9 tablets/month*  
Imitrex<sup>®</sup> (sumatriptan)  
*Quantity Limit = 18 tablets/month (25 mg), 9 tablets/month (50 mg, 100 mg),*  
Maxalt<sup>®</sup> (rizatriptan) 5 mg, 10 mg tablet  
*Quantity Limit = 12 tablets/month*  
Maxalt-MLT<sup>®</sup> (rizatriptan ODT) 5 mg, 10 mg  
*Quantity Limit = 12 tablets/month*  
naratriptan† (compare to Amerge<sup>®</sup>)  
*Quantity Limit = 9 tablets/month*  
Relpax<sup>®</sup> (eletriptan) 20 mg, 40 mg  
*Quantity Limit = 12 tablets/month*  
Zomig<sup>®</sup> (zolmitriptan)  
*Quantity Limit = 12 tablets/month (2.5 mg tablets or orally disintegrating  
tablets), 6 tablets/month (5 mg tablets or orally disintegrating tablets)*

Sumatriptan† (compare to Imitrex<sup>®</sup>)  
*Quantity Limit = 12 units/month (5 mg nasal spray),  
6 units/month (20 mg nasal spray)*  
Zomig<sup>®</sup> (zolmitriptan)  
*Quantity Limit = 12 units/month (5 mg nasal spray)*

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

Treximet<sup>®</sup> (sumatriptan/naproxen)  
*Quantity Limit = 9 tablets/month*

### PDL Key:

† Generic product

\* Indicates a generic equivalent is available without PA

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

## Anti-obesity

*Length of Authorization: 6 months for initial approval,*

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

Quantity limits apply

*Therapy specific PA fax form available on DVHA website.*

### NO PA REQUIRED

### PA REQUIRED

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

### PDL Key:

† Generic product

\* Indicates a generic equivalent is available without PA

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

## Anti-psychotic: Atypical & Combinations

*Length of Authorization: Duration of Need*

Quantity limits apply

### NO PA REQUIRED

#### TABLETS/CAPSULES

CLOZAPINE† (compare to Clozaril®)

*FDA maximum recommended dose = 900 mg/day*

GEODON® (ziprasidone)

*FDA maximum recommended dose = 160 mg/day*

RISPERIDONE† (compare to Risperdal®)

*FDA maximum recommended dose = 16 mg/day*

SEROQUEL® (quetiapine)

*FDA maximum recommended dose = 800 mg/day*

#### ORAL SOLUTIONS

RISPERIDONE† (compare to Risperdal®) oral solution

*FDA maximum recommended dose = 16 mg/day*

#### SHORT-ACTING INJECTABLE PRODUCTS

GEODON® IM (ziprasidone intramuscular injection)

*FDA maximum recommended dose = 40 mg/day*

#### LONG-ACTING INJECTABLE PRODUCTS

#### 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*

Fanapt® (iloperidone)

*FDA maximum recommended dose = 24 mg/day*

*Quantity limit = 2 tablets/day*

Invega® (paliperidone)

*FDA maximum recommended dose = 12 mg/day*

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

Risperdal®\* (risperidone)

*FDA maximum recommended dose = 16 mg/day*

Saphris® (asenapine) sublingual tablet

*FDA maximum recommended dose = 20 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*

Risperdal® (risperidone) oral solution

*FDA maximum recommended dose = 16 mg/day*

Abilify® IM (aripiprazole intramuscular injection)

*FDA maximum recommended dose = 30 mg/day*

Zyprexa® IM (olanzapine intramuscular injection)

*FDA maximum recommended dose = 30 mg/day*

Invega Sustenna® (paliperidone palmitate)

*FDA maximum recommended dose = 234 mg/month*

Risperdal® Consta (risperidone microspheres)

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

Abilify® Discmelt (aripiprazole)

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

*Quantity limit = 2 tabs/day (10 mg & 15 mg tabs)*

FazaClo® (clozapine orally disintegrating tablets)

*FDA maximum recommended dose = 900 mg/day*

Risperdal® M-Tab (risperidone orally disintegrating tablets)

*FDA maximum recommended dose = 16 mg/day*

Risperidone† ODT (compare to Risperdal® M-Tab)

*FDA maximum recommended dose = 16 mg/day*

Zyprexa Zydis® (olanzapine orally disintegrating tablets)

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

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

Symbyax® (olanzapine/fluoxetine)

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

### 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: Typicals

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

### NO PA REQUIRED

#### ORAL TABLETS/CAPSULES

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

#### LONG ACTING INJECTABLE PRODUCTS

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

### PA REQUIRED

Haldol®\* (haloperidol)  
Loxitane®\* (loxapine)  
Navane®\* (thiothixene)

Haldol® decanoate\* (haloperidol decanoate)

## Botulinum Toxins

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

*No approvals for Cosmetic Use*

### NO PA REQUIRED

### PA REQUIRED

BOTOX® (onabotulinumtoxinA)  
Myobloc® (rimabotulinumtoxinB)

**Available after a BOTOX® trial for select indications:**  
Dysport® (abobotulinumtoxinA)

## BPH: Alpha Blockers

*Length of Authorization: 1 year*

### NO PA REQUIRED

DOXAZOSIN† (compare to Cardura®)  
FLOMAX® (tamsulosin)  
*Quantity Limit = 2 capsules/day*  
TERAZOSIN† (compare to Hytrin®)  
UROXATRAL® (alfuzosin)  
*Quantity Limit = 1 tablet/day*

### PA REQUIRED

Cardura®\* (doxazosin)  
Cardura XL® (doxazosin)  
*Quantity Limit = 1 tablet/day*  
Hytrin®\* (terazosin)  
Rapaflo® (silodosin) *Quantity Limit = 1 capsule/day*  
Tamsulosin† (compare to Flomax®)  
*Quantity Limit = 2 capsules/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*)

### 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)

## Cardiac Glycosides

Length of Authorization: n/a

### NO PA REQUIRED

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

### PA REQUIRED

## Chemical Dependency: Alcohol and Opiate Dependency

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

Vivitrol and Buprenorphine Therapy specific PA fax forms are available on DVHA 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)

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

Revia®\* (naltrexone oral)

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

QL = 3 tablets per day (all strengths)

(Maximum Daily Dose = 24 mg/day)

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

QL = 3 tablets per day (2 mg strength) or 2 tablets/day (8 mg strength)

(Maximum Daily Dose = 16 mg/day)

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

## Constipation: Chronic, IBS-C or Opioid Induced

Length of Authorization: Amitiza – Initial PA of 3 months, and 12 months thereafter; Relistor – 3 months  
Quantity limits apply

### NO PA REQUIRED

#### Bulk-Producing Laxatives

PSYLLIUM†

#### Osmotic Laxatives

LACTULOSE†

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

#### Stimulant Laxative

BISACODYL†

SENNA†

#### Stool Softener

DOCUSATE†

### PA REQUIRED

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

Relistor® (methylnaltrexone)

### PDL Key:

† Generic product

\* Indicates a generic equivalent is available without PA

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## Contraceptives: Vaginal Ring

*Length of Authorization: n/a*

### NO PA REQUIRED

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

### PA REQUIRED

## Coronary Vasodilators/Antianginals: Oral

*Length of Authorization: 3 years*

*Quantity limits apply*

### NO PA REQUIRED

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

### PA REQUIRED

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

## Coronary Vasodilators/Antianginals: Topical

*Length of Authorization: 3 years*

### NO PA REQUIRED

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

### PA REQUIRED

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

## Corticosteroids: Oral

*Length of Authorization: 1 year*

### NO PA REQUIRED

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

### PA REQUIRED

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

## Cough and Cold Preparations

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

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

### NO PA REQUIRED

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

### PA REQUIRED

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

## Cryopyrin-Associated Periodic Syndromes (CAPS) Injectables

*Length of Authorization: 1 year*

Quantity limits apply

### PREFERRED AFTER CLINICAL CRITERIA ARE MET

Ilaris<sup>®</sup> (canakinumab) (*QL=1 vial/56 days*)

### PA REQUIRED

Arcalyst<sup>®</sup> (rilonacept) (*QL = 2 vials for loading dose, then 1 vial per week*)

## Cystic Fibrosis Inhalation Medications

**\*\*Pulmozyme<sup>®</sup> and TOBI<sup>®</sup> must be obtained through Specialty Pharmacy Provider, ICORE\*\***

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

### NO PA REQUIRED for Cystic Fibrosis Diagnosis

TOBI<sup>®</sup> (tobramycin) inhalation solution  
(*Quantity Limit = 84 vials/56 days; maximum days supply = 56 days*)

### PA REQUIRED

Cayston<sup>®</sup> (aztreonam) inhalation solution  
(*Quantity Limit = 84 vials/56 days; maximum days supply = 56 days*)

Pulmozyme<sup>®</sup> (dornase alfa) inhalation solution  
(*Quantity Limit =60/30 days; maximum days supply=30 days*)

## Dermatological Agents: Antibiotics: Topical

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

Quantity limits apply

### NO PA REQUIRED

#### Single Agent

BACITRACIN†  
GENTAMICIN† Cream or Ointment  
MUPIROICIN OINTMENT† (compare to Bactroban<sup>®</sup>)

#### Combination Products

BACITRACIN-POLYMYXIN†  
NEOMYCIN-BACITRACIN-POLYMYXIN†

Note: Bactroban<sup>®</sup> Nasal Ointment is not included in this managed category.

### PA REQUIRED

Altabax<sup>®</sup> (retapamulin) *QL = 1 tube*  
Bactroban<sup>®</sup> (mupirocin) Cream or Ointment

Cortisporin<sup>®</sup> Cream (neomycin-polymyxin-hydrocortisone)  
Cortisporin<sup>®</sup> Ointment(bacitracin-neomycin-polymyxin-hydrocortisone)  
Neosporin<sup>®</sup> (neomycin-bacitracin-polymyxin)  
Polysporin<sup>®</sup> (bacitracin-polymixin)

#### **All other branded products**

## Dermatological Agents: Antifungals: Onychomycosis

*Length of Authorization: 1 year*

Monthly quantity limits apply

### NO PA REQUIRED

### PA REQUIRED

Ciclopirox † 8 % solution (compare to Penlac<sup>®</sup> Nail Lacquer)  
*QL =6.6 ml/90 days*  
Penlac<sup>®</sup> Nail Lacquer (ciclopirox 8 % solution) *QL = 6.6 ml/90 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: Antifungals: Topical

Length of Authorization: Up to 3 months

Quantity limits apply

### NO PA REQUIRED

#### Single Agent

CICLOPIROX † (compare to Loprox<sup>®</sup>) 0.77% C, Sus, G; 1% Sh

CLOTRIMAZOLE † (formerly Lotrimin<sup>®</sup>)

1% C, S

ECONAZOLE † (formerly Spectazole<sup>®</sup>) 1% C

KETOCONAZOLE † (compare to Kuric<sup>®</sup>, Nizoral<sup>®</sup>) 2% C, 2% Sh

MICONAZOLE † all generic/OTC products

NYSTATIN † O, C, P (compare to Mycostatin<sup>®</sup>, Nystop<sup>®</sup>, Pedi-Dri<sup>®</sup>, Nyamyc<sup>®</sup>)

TOLNAFTATE † (compare to Tinactin<sup>®</sup>) 1% C, P, Sp, S

#### Combination Products

CLOTRIMAZOLE W/BETAMETHASONE † (compare to Lotrisone<sup>®</sup>)  
C, L

NYSTATIN W/TRIAMCINOLONE † (formerly Mycolog II<sup>®</sup>) C, O

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

### PA REQUIRED

Ertaczo<sup>®</sup> (sertaconazole) 2% C

Exelderm<sup>®</sup> (sulconazole) 1% C, S

Extina<sup>®</sup> (ketoconazole) 2% F

Kuric<sup>®</sup>\* (ketoconazole) 2% C

Lamisil RX/OTC<sup>®</sup> (terbinafine) 1% C, S, Sp, G

Loprox<sup>®</sup>\* (ciclopirox) 0.77% C, S, G; 1% Sh

Lotrimin AF<sup>®</sup>\* OTC (clotrimazole) 1% C, S, L

Mentax<sup>®</sup>/ Lotrimin Ultra<sup>®</sup> OTC (butenafine) 1% C

Mycostatin<sup>®</sup>\* (nystatin) C, P

Naftin<sup>®</sup> (naftifine) 1% C, G

Nizoral<sup>®</sup>\* (ketoconazole) 2% Sh

Nizoral A-D<sup>®</sup> OTC (ketoconazole) 1% Sh

Nystop<sup>®</sup>, Pedi-Dri<sup>®</sup>, Nyamyc<sup>®</sup>\* (nystatin) P

Oxistat<sup>®</sup> (oxiconazole) 1% C, L

Tinactin<sup>®</sup>/Tinactin AT OTC\* (tolnaftate) 1% C, P, Sp, S

Xolegel<sup>®</sup> (ketoconazole) 2% G

#### All other branded products

Lotrisone<sup>®</sup>\* (clotrimazole w/betamethasone) C, L

Vusion<sup>®</sup> (miconazole w/zinc oxide) O

(QL=50 g/30 days)

#### All other branded products

**Note:** Please refer to "Dermatological: Antifungals: Onychomycosis" for ciclopirox solution and Penlac<sup>®</sup> Nail Lacquer

## Dermatological Agents: Antivirals: Topical

Length of Authorization: 6 months

### NO PA REQUIRED

ABREVA OTC (docosanol) 10% C

C=cream, O=ointment

### PA REQUIRED

Denavir<sup>®</sup> (penciclovir) 1% C

Zovirax<sup>®</sup> (acyclovir) 5% C, O

### 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: Corticosteroids

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

### NO PA REQUIRED

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

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

AMCINONIDE† (formerly Cyclocort®)  
AUGMENTED BETAMETHASONE† 0.05% C (compare to Diprolene® AF)  
BETAMETHASONE VALERATE† 0.1% O (formerly Beta-Val®)  
DESOXIMETASONE† 0.05% G; 0.25% C, O (compare to Topicort®)  
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®\* (desoximetason) 0.05% C  
Westcort®\* (hydrocortisone valerate) all products  
**All other brands**

#### High Potency

Apexicon E®/Psorcon E®\* (diflorason) 0.05% C  
Diprolene® AF\* (augmented betamethasone) 0.05% C  
Halog® (halcinonide) all products  
Lidex®\* (fluocinonide) 0.05% C  
Topicort®\* (desoximetason) 0.05% G; 0.25% C, O  
**All other brands**

#### Verv High Potency

Alphatrex®\* (augmented betamethasone) 0.05% G  
Apexicon®\* (diflorason) 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®\* (diflorason 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)

## Dermatological Agents: Genital Wart Therapy

Length of Authorization: Up to 16 weeks

Quantity limits apply

### NO PA REQUIRED

ALDARA<sup>®</sup> (imiquimod)

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

### PA REQUIRED

Imiquimod<sup>†</sup> (compare to Aldara<sup>®</sup>) cream

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

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

## Dermatological Agents: Immunomodulators

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

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

### NO PA REQUIRED

ELIDEL<sup>®</sup> (pimecrolimus) §

PROTOPIC<sup>®</sup> (tacrolimus) §

### PA REQUIRED

Elidel<sup>®</sup> (age < 2 yrs)

Protopic<sup>®</sup> (age < 2 yrs)

## Dermatological Agents: Scabicides and Pediculocides

Length of Authorization: date of service only, no refills

### NO PA REQUIRED

EURAX<sup>®</sup> (crotamiton) C, L

NIX<sup>®</sup> (permethrin) CR, G, Sp

PERMETHRIN<sup>†</sup> (compare to Elimite<sup>®</sup>) C

PERMETHRIN<sup>†</sup> L

PIPERONYL BUTOXIDE AND PYRETHRINS<sup>†</sup> G, S, Sh

RID<sup>®</sup> (piperonyl butoxide and pyrethrins) G, Sh, Sp

All other brand and generic Scabicides and Pediculocides

### PA REQUIRED

Elimite<sup>®\*</sup> (permethrin 5 %) C

Lindane<sup>†</sup> L, Sh

Malathion <sup>†</sup>L (compare to Ovide<sup>®</sup>)

Ovide<sup>®</sup> (malathion) L

Ulesfia<sup>®</sup> (benzoyl alcohol 5%) L

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

## Desmopressin: Intranasal/Oral

Length of Authorization: 2 years

### NO PA REQUIRED

#### Intranasal

#### Oral

DESMOPRESSIN<sup>†</sup>

### PA REQUIRED

DDAVP<sup>®</sup> (desmopressin) Nasal Solution or Spray 0.01%

Desmopressin <sup>†</sup> Nasal Solution or Spray 0.01 % (compare to DDAVP<sup>®</sup>)

Minirin <sup>†</sup> (desmopressin) Nasal Spray 0.01%

Stimate<sup>®</sup> (desmopressin) Nasal Solution 1.5 mg/ml

DDAVP<sup>®\*</sup> (desmopressin) tablets

### PDL Key:

<sup>†</sup> Generic product

\* Indicates a generic equivalent is available without PA

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

## Diabetic Testing Supplies

*Length of Authorization: 5 years*

### NO PA REQUIRED

#### DIABETIC MONITORS/METERS

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

#### DIABETIC TEST STRIPS

FREESTYLE<sup>®\*</sup>  
FREESTYLE LITE<sup>®\*</sup>  
ONE TOUCH<sup>®</sup> BASIC\*  
ONE TOUCH<sup>®</sup> SURESTEP\*  
ONE TOUCH<sup>®</sup> FAST TAKE\*  
ONE TOUCH<sup>®</sup> UL<sup>®</sup>TRA\*  
PRECISION XTRA<sup>®\*</sup>  
PRECISION XTRA<sup>®</sup> BETA KETONE (10 count)  
\* 50 and 100 count package sizes

### PA REQUIRED

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

All other brands and store brands

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

All other brands and store brands

## Estrogens: Vaginal

*Length of Authorization: n/a*

### NO PA REQUIRED

#### Estradiol

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

#### Conjugated Estrogens

PREMARIN VAGINAL<sup>®</sup> Cream

#### Estradiol Acetate

FEMRING<sup>®</sup> Vaginal Ring

### PA REQUIRED

## Fibromyalgia Agents

*Length of Authorization: 1 year*

*Quantity limits apply*

### NO PA REQUIRED

### PA REQUIRED

Savella<sup>®</sup> (milnacipran) tablet, titration pack  
*Quantity Limit = 2 tablets/day*

## Gastrointestinal: Crohn's Disease Injectables

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

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

*Drug-specific PA fax form available on DVHA website.*

### PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

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

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

Tysabri<sup>®</sup> (natalizumab)

### PDL Key:

† Generic product

\* Indicates a generic equivalent is available without PA

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

## Gastrointestinals: H2-blockers

*Length of Authorization: 1 year*

### NO PA REQUIRED

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

### SYRUPS AND SPECIAL DOSAGE FORMS

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

### PA REQUIRED

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

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

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

*Length of Authorization: 1 year*

### NO PA REQUIRED

#### MESALAMINE PRODUCTS

##### Oral

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

##### Rectal

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

##### OTHER

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

### PA REQUIRED

Asacol HD® (mesalamine tablet delayed release)

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

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

## Gastrointestinals: Prokinetic Agents

*Length of Authorization: up to 3 months*

**Quantity limits apply**

### NO PA REQUIRED

#### **Tablets**

METOCLOPRAMIDE† tabs (compare to Reglan®)

#### **Oral Solution**

METOCLOPRAMIDE† (formerly Reglan®) oral solution

#### **Orally Disintegrating Tablets**

### PA REQUIRED

Reglan®\* (metoclopramide)

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

### PDL Key:

† Generic product

\* Indicates a generic equivalent is available without PA

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## Gastrointestinals: Proton Pump Inhibitors

Length of Authorization: up to 1 year

Quantity limits apply

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

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

### NO PA REQUIRED FOR ONCE DAILY DOSES

#### ORAL CAPULES/TABLETS

KAPIDEX<sup>®</sup> /DEXILANT<sup>®</sup> (dexlansoprazole) capsules (*Quantity limit=1 cap/day*)

PRILOSEC OTC<sup>®</sup> 20mg (omeprazole magnesium) tablets  
(*No Quantity limit applies*)

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

#### SUSPENSION & SPECIAL DOSAGE FORMS

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

#### COMBINATION (H.Pylori eradication)

PREVPAC<sup>®</sup> (lansoprazole w/ H.pylori anti-bacterials) (*No Quantity limit applies*)

### PA REQUIRED

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

lansoprazole generic RX (compare to Prevacid<sup>®</sup>) capsules

(*Quantity limit = 1 cap/day*)

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

omeprazole †\* generic RX capsules § (compare to Prilosec<sup>®</sup>)

(*Quantity limit=1 cap/day*)

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

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

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

Prevacid<sup>®</sup> RX (lansoprazole) capsules § (*Quantity limit=1 cap/day*)

Prevacid<sup>®</sup> 24 hr OTC (lansoprazole) capsules (*Quantity limit=1 cap/day*)

Prilosec<sup>®</sup> RX (brand) (omeprazole) capsules § (*Quantity limit=1 cap/day*)

Nexium<sup>®</sup> (esomeprazole) powder for suspension §

(*Quantity limit=1 packet/day*)

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

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

## Gastrointestinal: Ulcerative Colitis Injectables

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

Therapy-specific PA fax form available on DVHA website.

### NO PA REQUIRED

### PA REQUIRED

Remicade<sup>®</sup> (infliximab)

## Gaucher's Disease Medications

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

Quantity limits apply

### NO PA REQUIRED

### PA REQUIRED

Cerezyme<sup>®</sup> (imiglucerase for injection)

Vpriv<sup>®</sup> (velaglucerase alfa for injection)

\*\*Maximum days supply per fill for all drugs is 14 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)

## 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 DVHA website.*

### PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

NORDITROPIN®  
OMNITROPE®

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

Genotropin®  
Humatrope®  
Nutropin®/Nutropin® AQ  
Saizen®  
Tev-Tropin®

#### Specialized Indications – See Specific Criteria

Increlex® (mecasermin)  
Serostim®  
Zorbtive®

## Hemophilia Factors

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

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

### NO PA REQUIRED

All Factors

### PA REQUIRED

None

### PDL Key:

† 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)

## Hepatitis C Agents

Length of Authorization: 6 months

Quantity limits apply

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

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

### PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

#### RIBAVIRIN

##### Tablets/Capsules

RIBAVIRIN† 200 mg tablets or capsules

##### Oral Solution

#### INTERFERON

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

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

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

#### RIBAVIRIN

Copegus® (ribavirin 200 mg tablet)

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

Rebetol® (ribavirin 200 mg capsule)

All other strengths/brands of ribavirin tablets/capsules

Rebetol® (ribavirin 40 mg/ml) oral solution

#### INTERFERON

Infergen® (interferon alphacon-1)

Peg-Intron® (peg-interferon alpha-2b)

## Hereditary Angioedema Medications

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

Quantity limits apply

### NO PA REQUIRED

### PA REQUIRED

Beriner® (human C1 inhibitor)

Cinryze® (human C1 inhibitor)

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

Kalbitor® (ecallantide)

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

## 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

Fibricor® (fenofibric acid) § 35 mg, 105 mg *Quantity Limit = 1 capsule/day*

Lipofen® (fenofibrate) § 50 mg, 150 mg

Lofibra® (fenofibrate micronized) Capsules § 67mg, 134 mg, 200 mg

Lofibra® (fenofibrate micronized) Tablets § 54 mg, 160 mg

Lopid®\* (gemfibrozil) § 600 mg

Triglide® (fenofibrate micronized) § 50 mg, 160 mg

### PDL Key:

† Generic product

\* Indicates a generic equivalent is available without PA

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## Lipotropics: Nicotinic Acid Derivatives

Length of Authorization: n/a

### NO PA REQUIRED

NIASPAN<sup>®</sup> (niacin extended release)

### PA REQUIRED

## Lipotropics: Statins

Length of Authorization: 1 year

Quantity limits apply

### NO PA REQUIRED

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

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

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

#### AFTER GENERIC SIMVASTATIN TRIAL

CRESTOR<sup>®</sup> (rosuvastatin calcium) §  
(QL = 1 tablet/day)

### PA REQUIRED

#### Low/Medium Potency Statins

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

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

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

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

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

Pravastatin † 80 mg Tablet (use 40 mg tablets)

#### High Potency Statins

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

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

## Lipotropics: Miscellaneous/Combinations

Length of Authorization: 1 year

Quantity limits apply

### NO PA REQUIRED

ADVICOR<sup>®</sup> (lovastatin/extended release niacin)

(Qty Limit = 1 tablet/day)

SIMCOR<sup>®</sup> (simvastatin/extended release niacin)

(Qty Limit = 1 tablet/day)

### PA REQUIRED

#### Miscellaneous

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

#### Cholesterol Absorption Inhibitors/Combinations

Vytorin<sup>®</sup> (ezetimibe/simvastatin)

(QL = 1 tablet/day)

Zetia<sup>®</sup> (ezetimibe)

(Qty Limit = 1 tablet/day)

#### Other Statin Combinations

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

(Qty Limit = 1 tablet/day)

## Miscellaneous: Elaprase<sup>®</sup> (Hunter's Syndrome Injectable)

Length of Authorization: 1 year

Quantity limits apply

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

### NO PA REQUIRED

### PA REQUIRED

Elaprase<sup>®</sup> (idursulfase) (QL = calculated dose/week)

### PDL Key:

† Generic product

\* Indicates a generic equivalent is available without PA

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

NO PA REQUIRED

PA REQUIRED

Samsca® tablets (tolvaptan)  
*Quantity limit = 15 mg tablets (1 tablet/day), 30 mg tablets (2 tablets/day)*

**Miscellaneous: Soliris® (Paroxysmal Nocturnal Hemoglobinuria Injectable)**  
*Length of Authorization: Initial 3 months, Subsequent 1 year*  
Quantity limits apply

NO PA REQUIRED

PA REQUIRED

Soliris® (eculizumab) (*Quantity Limit = 20 vials total/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)*)

**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

Equetro® (carbamazepine SR)  
Lithobid®\* (lithium carbonate SR)

**PDL Key:**

† Generic product

\* Indicates a generic equivalent is available without PA

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

## Multiple Sclerosis Medications

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

Quantity limits apply

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

### NO PA REQUIRED

#### INJECTABLES

##### Interferons

AVONEX<sup>®</sup> (interferon B-1a)

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

REBIF<sup>®</sup> (interferon B-1a)

##### Other

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

#### ORAL

### PA REQUIRED

Extavia<sup>®</sup> (interferon beta-1b)

Tysabri<sup>®</sup> (natalizumab)

Ampyra<sup>®</sup> (dalfampridine) tablet  
(*QL = 2 tablets/day, maximum 30 day supply per fill*)

## Nutritionals, liquid oral supplements

*Length of Authorization: 6 months*

*Therapy specific PA fax form available on DVHA website.*

### NO PA REQUIRED

### PA REQUIRED

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

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

## Oncology: Oral (select)

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

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

### NO PA REQUIRED

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

### PA REQUIRED

### PDL Key:

† 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: Antibiotics

*Length of Authorization: Duration of therapy requested*

### NO PA REQUIRED

#### QUINOLONES

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

#### MACROLIDES

ERYTHROMYCIN†  
ROMYCIN† (erythromycin)

#### AMINOGLYCOSIDES

##### Single Agent

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

##### Combination

TOBRAMYCIN W/DEXAMETHASONE (compare to Tobradex®)

#### MISCELLANEOUS

##### Single Agent

BACITRACIN  
SULFACETAMIDE SODIUM (compare to Bleph-10®)

##### Combination

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

### PA REQUIRED

Besivance® (besifloxacin)  
Ciloxan®\*(ciprofloxacin)  
Iquix® (levofloxacin 1.5 %) (preservative free)  
Ocuflor®\*(ofloxacin)  
Quixin® (levofloxacin 0.5 %)  
Vigamox® (moxifloxacin) (preservative free)  
Zymar® (gatifloxacin)

Azasite®(azithromycin)  
All other brands

Tobrex® sol\* (tobramycin)  
Tobrex® gel (tobramycin)

Tobradex®\* (tobramycin/dexamethasone)  
Zylet® (tobramycin/loteprednol)  
Pred-G® (gentamicin/prednisolone)  
All other brands

Bleph-10®\* (sulfacetamide)  
All other brands

Blephamide® (sulfacetamide/prednisolone acetate)  
Maxitrol®\* (neomycin/polymyxin/dexamethasone)  
Neosporin®\* (neomycin/polymyxin/gramicidin or (neomycin/polymyxin/bacitracin)  
Poly-pred® (neomycin/polymyxin B/prednisolone acetate)  
Polysporin®\* (bacitracin/polymyxin B)  
Polytrim®\* (polymyxin B/trimethoprim)

All other brands

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## Ophthalmics: Antihistamines

*Length of Authorization: 1 year*

**Quantity limits apply**

### NO PA REQUIRED

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

#### After trial of ketotifen 0.025 %

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

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

### PA REQUIRED

Azelastine † (compare to Optivar®) (QL = 1 bottle/month)

Bepreve® (bepotastine besilate) (QL = 1 bottle/month)

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

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

Alrex® (loteprednol) 0.2% S

Durezol® (difluprednate) 0.05% E

FML® (fluorometholone) 0.1% O

FML Forte® (fluorometholone) 0.25% S

FML Liquifilm®/Flarex® (fluorometholone) 0.1% S

Lotemax® (loteprednol) 0.5% S

Pred Forte®/Omnipred® (prednisolone acetate) 1% S

Pred Mild® (prednisolone acetate) 0.12% S

Vexol® (rimexolone) 1% S

All other brands

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## Ophthalmics: Glaucoma Agents/Miotics

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

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

#### CARBONIC ANHYDRASE INHIBITOR

##### Single Agent

DORZOLAMIDE 2 % (compare to Trusopt®)

##### Combination

DORZOLAMIDE w/TIMOLOL (compare to Cosopt®)

#### MISCELLANEOUS

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

### PA REQUIRED

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

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

Xalatan® (latanoprost)

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

Cosopt®\* (dorzolamide w/timolol)

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

## Ophthalmics: Immunomodulators

*Length of Authorization: 1 year*

*Quantity limits apply*

### NO PA REQUIRED

### PA REQUIRED

Restasis® (cyclosporine ophthalmic emulsion) 0.05% (*QL=60 vials per 30 days*).

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## Ophthalmics: Mast Cell Stabilizers

*Length of Authorization: 6 months*

### NO PA REQUIRED

CROMOLYN SODIUM† (compare to Cromol<sup>®</sup>)

### PA REQUIRED

Alamast<sup>®</sup> (pemirolast potassium)  
Alocril<sup>®</sup> (nedocromil sodium)  
Alomide<sup>®</sup> (Iodoxamide)  
Crolom<sup>®\*</sup> (cromolyn sodium)

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

*Length of Authorization: 1 year*

### NO PA REQUIRED

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

### PA REQUIRED

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

## Ossification Enhancers

*Length of Authorization: lifetime*

*Quantity limits apply*

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

### NO PA REQUIRED

#### ORAL BISPHOSPHONATES

##### TABLETS/CAPSULES

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

##### ORAL SOLUTION

##### INJECTABLE BISPHOSPHONATES

##### CALCITONIN NASAL SPRAY

FORTICAL<sup>®</sup> (calcitonin)  
MIACALCIN<sup>®</sup> (calcitonin)

##### PARATHYROID HORMONE INJECTION

### PA REQUIRED

Actonel<sup>®</sup> (risedronate)  
Actonel<sup>®</sup> w/calcium (risedronate/calcium)  
Didronel<sup>®</sup> (etidronate)  
Etidronate† (compare to Didronel<sup>®</sup>)  
Fosamax<sup>®\*</sup> (alendronate)  
Fosamax Plus D<sup>®</sup> (alendronate/vitamin D)  
Skelid<sup>®</sup> (tiludronate)  
  
Fosamax<sup>®</sup> (alendronate) Oral Solution  
  
Boniva<sup>®</sup> Injection (ibandronate) (*Quantity Limit = 3 mg/3 months (four doses)/year*)  
Reclast<sup>®</sup> Injection (zoledronic acid) (*Quantity Limit = 5 mg (one dose)/year*)  
  
Calcitonin† Nasal Spray (compare to Miacalcin<sup>®</sup>)  
  
Forteo<sup>®</sup> (teriparatide) (*Quantity Limit = 1 pen (3 ml)/28 days*)

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## Otic: Anti-Infectives

Length of Authorization: 1 year

### NO PA REQUIRED

#### Anti-infective Single Agent

OFLOXACIN† 0.3% Otic Soln (compare to Floxin®)

#### Anti-infective/Corticosteroid Combination

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

NEOMYCIN/POLYMYXIN B SULFATE/HYDROCORTISONE†  
(compare to Cortisporin otic®, Pediotic®)

### PA REQUIRED

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

Floxin®\* (ofloxacin 0.3% otic soln.)

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

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

Cortisporin otic®/Pediotic®\* (neomycin/polymyxin B sulfate /hydrocortisone)  
otic solution/suspension

## Pancreatic Enzyme Products

Length of Authorization: n/a

### NO PA REQUIRED

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 minitables  
ULTRASE® MT18 Capsule-EC minitables  
ULTRASE® MT20 Capsule-EC minitables  
VIOKASE® 8 Tablets  
VIOKASE® 16 Tablets

DR=delayed release, EC=enteric-coated

### PA REQUIRED

### PDL Key:

† Generic product

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

Length of Authorization: 1 year

Quantity limits apply

### NO PA REQUIRED

#### DOPAMINE PRECURSOR

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

#### DOPAMINE AGONISTS (ORAL)

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

#### COMT INHIBITORS

COMTAN® (entacapone)

#### MAO-B INHIBITORS

SELEGILINE† (compare to Eldepryl®)

#### OTHER

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

### PA REQUIRED

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

Mirapex ER® (pramipexole ER)  
QL = 1 tab/day  
Parlodel® (bromocriptine)  
Pramipexole † (compare to Mirapex®)  
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)

## Phosphodiesterase-5 (PDE-5) Inhibitors

Length of Authorization: 1 year

Quantity limits apply

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

### PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

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

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

### PDL Key:

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## Platelet Inhibitors

*Length of Authorization: 1 year*

### NO PA REQUIRED

#### AGGREGATION INHIBITORS

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

## Psoriasis Injectables

**\*\*Self-injectables (Enbrel® and Humira®) and Stelara® must be obtained through Specialty Pharmacy Provider, ICORE\*\***  
*Length of Authorization: initial PA of 3 months (Stelara 4 months), 12 months thereafter.*

Quantity limits apply

*Drug-specific PA fax form available on DVHA website.*

### PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

ENBREL® (etanercept)  
HUMIRA® (adalimumab)

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

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

## Psoriasis: Non-Biologics

*Length of Authorization: 1 year*

Quantity limits apply

### NO PA REQUIRED

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

CALCIPOTRIENE† Solution (compare to Dovonex®)  
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)  
Vectical® Ointment (calcitriol)  
*(Quantity Limit = 200 g (2 tubes)/week)*

### PDL Key:

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## Pulmonary: Anticholinergics: Inhaled

Length of Authorization: 1 year

### NO PA REQUIRED

#### METERED DOSE INHALER (SINGLE AGENT)

ATROVENT HFA® (ipratropium)

Quantity Limit = 2 inhalers/25 days

SPIRIVA® (tiotropium)

Quantity Limit = 1 capsule/day

#### NEBULIZER (SINGLE AGENT)

IPRATROPIUM SOLN FOR INHALATION

#### METERED DOSE INHALER (COMBINATION PRODUCT)

COMBIVENT® (ipratropium/albuterol)

Quantity Limit = 2 inhalers/30 days

#### NEBULIZER (COMBINATION PRODUCT)

IPRATROPIUM/ALBUTEROL† (compare to Duoneb®)

### PA REQUIRED

Duoneb®\* (ipratropium/albuterol)

## Pulmonary: Antihistamines: Intranasal

Length of Authorization: 1 year

Quantity limits apply

### NO PA REQUIRED

### PA REQUIRED

Astelin® (azelastine) Nasal Spray

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

Astepro® (azelastine) Nasal Spray

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

azelastine (compare to Astelin®) Nasal Spray

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

Patanase® (olopatadine 0.6%) Nasal Spray

Quantity Limit = 1 bottle (31 gm)/30 days

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

Length of Authorization: 1 year

### NO PA REQUIRED

All generic antihistamines

All generic antihistamine/decongestant combinations

### PA REQUIRED

All brand antihistamines (example: Benadryl®)

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

### PDL Key:

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

*Length of Authorization: 1 year*

### NO PA REQUIRED

LORATADINE (OTC) † (compare to Claritin<sup>®</sup>)  
CETIRIZINE † OTC (compare to Zyrtec<sup>®</sup> OTC)

FEXOFENADINE † (after loratadine OTC and cetirizine OTC trials)

LORATADINE-D (OTC) †

LORATADINE (OTC) † syrup  
CETIRIZINE † (OTC) syrup  
ZYRTEC<sup>®</sup> OTC (cetirizine) SYRUP

LORATADINE (OTC) † rapidly disintegrating tablet (RDT)

### PA REQUIRED

Allegra<sup>®</sup> (fexofenadine)  
Clarinex<sup>®</sup> (desloratadine)  
Claritin<sup>®</sup> capsule (loratadine)  
Claritin<sup>®</sup> tablet (loratadine)  
Xyzal<sup>®</sup> (levocetirizine)  
Zyrtec<sup>®</sup> RX/OTC\* (cetirizine)  
All other brands

Allegra-D<sup>®</sup> § (12 HR & 24 HR)  
Cetirizine-D † SR  
Clarinex-D<sup>®</sup> § (12 HR & 24 HR)  
Claritin-D<sup>®</sup> §  
Fexofenadine-PSE † (compare to Allegra-D<sup>®</sup> 12 hr)  
Zyrtec-D<sup>®</sup> §  
All other brands

Allegra<sup>®</sup> suspension  
Clarinex<sup>®</sup> Syrup  
Claritin Syrup<sup>®\*</sup>  
Xyzal (levocetirizine) Syrup<sup>®</sup>  
Zyrtec RX Syrup<sup>®</sup>  
All other brands

Allegra ODT<sup>®</sup> §  
Cetirizine † Chewable Tablets  
Clarinex Reditabs<sup>®</sup> §  
Claritin Chewable Tablets<sup>®</sup> §  
Claritin Reditabs<sup>®\*</sup> §  
Zyrtec<sup>®</sup> Chewable Tablets §  
All other brands

### PDL Key:

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## Pulmonary: Beta-adrenergic Agents

Length of Authorization: 1 year

Quantity limits apply

### NO PA REQUIRED

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

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

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

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

FORADIL<sup>®</sup> (formoterol) *(after criteria for LABA are met)*

*Quantity Limit = 60 capsules/month*

SEREVENTI<sup>®</sup> 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<sup>®</sup>)

ALBUTEROL † 0.83 mg/ml neb solution

METAPROTERENOL † neb solution

XOPENEX<sup>®</sup> neb solution (levalbuterol HCL) (age ≤ 12 yrs)

#### NEBULIZER SOLUTIONS (LONG-ACTING)

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

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

ALBUTEROL † tablets/syrup

METAPROTERENOL † tablets/syrup

#### TABLETS (LONG-ACTING)

ALBUTEROL ER † tablets

### PA REQUIRED

Alupent<sup>®</sup> (metaproterenol)

Proair<sup>®</sup> HFA (albuterol)

Proventil<sup>®</sup> HFA (albuterol)

Ventolin<sup>®</sup> HFA (albuterol)

Accuneb<sup>®</sup>\* (albuterol sulfate neb solution 0.63 mg/ml and 1.25 mg/ml)

Levalbuterol † neb solution (compare to Xopenex<sup>®</sup>) (all ages)

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

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

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

Brethine<sup>®</sup>\* (terbutaline)

Vospire ER<sup>®</sup>\* (albuterol)

### PDL Key:

† Generic product

\* Indicates a generic equivalent is available without PA

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

## Pulmonary: Corticosteroids/Combinations: Inhaled

Length of Authorization: 1 year

Quantity limits apply

### NO PA REQUIRED

#### METERED DOSE INHALERS (SINGLE AGENT)

ASMANEX<sup>®</sup> 220 mcg/inh (mometasone furoate)

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

ASMANEX<sup>®</sup> 110 mcg/inh (mometasone furoate)

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

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

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

(QL = 3 inhalers/90 days)

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

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

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

(QL = 6 inhalers/90 days)

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

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

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

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

#### METERED DOSE INHALERS (COMBINATION PRODUCT)

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

(QL = 3 inhalers/90 days)

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

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

SYMBICORT<sup>®</sup> (budesonide/formoterol)

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

#### NEBULIZER SOLUTIONS

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

### PA REQUIRED

Aerobid<sup>®</sup> (flunisolide)

Aerobid M<sup>®</sup> (flunisolide/menthol)

Alvesco<sup>®</sup> (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<sup>®</sup>) (all ages)

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

## Pulmonary: Corticosteroids: Intranasal

Length of Authorization: 1 year

Quantity limits apply

### NO PA REQUIRED

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

QL = 16 gm (1 inhaler)/30 days

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

QL = 16.5 gm (1 inhaler)/30 days

NASONEX<sup>®</sup> (mometasone)

QL = 17 gm (1 inhaler)/30 days

### PA REQUIRED

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

QL = 50 gm (2 inhalers)/30 days

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

QL = 16 gm (1 inhaler)/30 days

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

QL = 50 ml (2 inhalers)/30 days

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

QL = 50 ml (2 inhalers)/30 days

Omnaris<sup>®</sup> (ciclesonide)

QL = 12.5 gm (1 inhaler)/30 days

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

QL = 8.6 gm (1 inhaler)/30 days

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

QL = 10 gm (1 inhaler)/30 days

### PDL Key:

† Generic product

\* Indicates a generic equivalent is available without PA

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## 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® (zileuton) §

*(Quantity Limit = 4 tablets/day)*

ZyFlo® CR (zileuton SR) §

*(Quantity Limit = 4 tablets/day)*

## Pulmonary: Synagis®

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

Quantity limits apply

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

### NO PA REQUIRED

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

SYNAGIS® (palivizumab)

*Quantity Limit = 1 vial/month (50 mg) or 2 vials/month (100 mg)*

## Pulmonary: Xolair®

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

Quantity limits apply

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

*Drug-specific PA fax form available on DVHA website.*

### NO PA REQUIRED

### PA REQUIRED

Xolair® (omalizumab) 150 mg subcutaneous injection vial

*Quantity limit = 6 vials every 28 days*

## Pulmonary Arterial Hypertension Medications

*Length of Authorization: 1 year*

Quantity limits apply

### NO PA REQUIRED

#### ENDOTHELIAL RECEPTOR ANTAGONISTS

LETAIRIS® (ambrisentan) Tablet

*Quantity Limit = one tablet/day*

TRACLEER® (bosentan) Tablet

*Quantity Limit = 2 tablets/day*

#### PROSTANOIDS

##### **Injection**

EPOPROSTENOL † ( compare to Flolan®)

REMODULIN® (treprostinil sodium injection)

##### **Inhalation**

TYVASO® (treprostinil inhalation solution)

VENTAVIS® (iloprost inhalation solution)

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

### PA REQUIRED

Flolan®\* (epoprostenol)

### PDL Key:

† Generic product

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## Renal Disease: Phosphate Binders

*Length of Authorization: 1 year*

Quantity limits apply

### NO PA REQUIRED

CALCIUM ACETATE † (compare to Phos Lo<sup>®</sup>)  
FOSRENOL<sup>®</sup> (lanthanum carbonate)  
RENAGEL<sup>®</sup> (sevelamer)

### PA REQUIRED

Phos Lo<sup>®\*</sup> (calcium acetate)  
Renvela<sup>®</sup> (sevelamer carbonate) Oral Suspension Packet  
(*QL = 2 packs/day (0.8 g strength only)*)  
Renvela<sup>®</sup> (sevelamer carbonate) tablets

## Rheumatoid, Juvenile & Psoriatic Arthritis: Immunomodulators

**\*\*Self-injectables (Enbrel<sup>®</sup>, Humira<sup>®</sup>, Kineret<sup>®</sup> and Simponi<sup>®</sup>) must be obtained through Specialty Pharmacy Provider, ICORE\*\***

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

Quantity limits apply

*Drug specific PA fax forms available on the DVHA website.*

### PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

ENBREL<sup>®</sup> (etanercept)  
HUMIRA<sup>®</sup> (adalimumab)

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

Actemra<sup>®</sup> (tocilizumab)  
(*Qty limit = 4 vials/28 days (80 mg vial), 3 vials/28 days (200 mg vial) or 2 vials/28 days (400 mg vial)*)  
Cimzia<sup>®</sup> (certolizumab pegol)  
(*Qty limit = 1 kit/28 days*)  
Kineret<sup>®</sup> (anakinra)  
Orencia<sup>®</sup> (abatacept)  
Remicade<sup>®</sup> (infliximab)  
Simponi<sup>®</sup> (golimumab) *Qty Limit = 1 syringe/month*

## Saliva Stimulants

*Length of Authorization: 1 year*

### NO PA REQUIRED

PILOCARPINE (compare to Salagen<sup>®</sup>)  
EVOXAC<sup>®</sup> (cevimeline)

### PA REQUIRED

Salagen<sup>®\*</sup> (pilocarpine)

## Sedative/Hypnotics

*Length of Authorization: 1 year*

Quantity limits apply

### NO PA REQUIRED

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

### PA REQUIRED

#### Benzodiazepine

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

#### Non-benzodiazepine, Non-barbiturate

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

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

### PDL Key:

† Generic product

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## Skeletal Muscle Relaxants

Length of Authorization: 1 year

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

### NO PA REQUIRED

#### 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

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

### PA REQUIRED

#### Musculoskeletal Agents

Amrix® (cyclobenzaprine sustained-release)  
carisoprodol† (compare to Soma®)  
Flexmid® (cyclobenzaprine)  
Flexeril®\* (cyclobenzaprine)  
metaxalone† (compare to Skelaxin®)  
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

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

## Smoking Cessation Therapies

Length of Authorization: see table

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

### NO PA REQUIRED

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

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

#### ORAL THERAPY

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

### PA REQUIRED

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

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

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

### PDL Key:

† Generic product

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## Testosterone: Topical

*Length of Authorization: 1 year*

Quantity limits apply

### NO PA REQUIRED

ANDROGEL<sup>®</sup> 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<sup>®</sup> Transdermal 2.5 mg, 5 mg (testosterone patch) *Quantity limit = 1 patch/day/strength*  
Testim<sup>®</sup> 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<sup>®</sup> (romiplostim)  
Promacta<sup>®</sup> (eltrombopag)

## Urinary Antispasmodics

*Length of Authorization: 1 year*

Quantity limits apply

### NO PA REQUIRED\*

### PA REQUIRED

#### SHORT-ACTING AGENTS

OXYBUTYNIN<sup>†</sup> (compare to Ditropan<sup>®</sup>)

Ditropan<sup>®</sup>\* (oxybutynin)  
Flavoxate <sup>†</sup> (compare to Urispas<sup>®</sup>)  
Urispas<sup>®</sup> (flavoxate)

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

Twice Daily Oral (Qty Limit = 2 per day)

Detrol<sup>®</sup> (tolterodine) Sanctura<sup>®</sup> (trospium)  
Trospium<sup>†</sup> (Sanctura<sup>®</sup>)

Once Daily Oral (Qty Limit = 1 per day)

ENABLEX<sup>®</sup> (darifenacin)  
VESICARE<sup>®</sup> (solifenacin)

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

#### Transdermal/Topical

Gelnique<sup>®</sup> (oxybutynin topical gel)  
(Qty limit = 1 sachet/day)  
Oxytrol<sup>®</sup> (oxybutynin transdermal) (Qty Limit = 8 patches/28 days)

>NOTE:

- Patients under the age of 65 must fail an adequate trial of generic oxybutynin before approval will be granted for either Vesicare<sup>®</sup>, Sanctura<sup>®</sup>, Sanctura XR<sup>®</sup> or Enablex<sup>®</sup>.
- 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 ORAL PA Requirements. (Exception: An adequate trial of oxybutynin/oxybutynin XL will be required before approval of Ditropan<sup>®</sup>/Ditropan<sup>®</sup> XL will be granted)

### PDL Key:

<sup>†</sup> Generic product

\* Indicates a generic equivalent is available without PA

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## Vaginal Anti-Infectives

*Length of Authorization: 1 year*

### NO PA REQUIRED

#### CLINDAMYCIN

CLINDAMYCIN VAGINAL† (clindamycin vaginal cream 2%)  
CLINDAMAX† (clindamycin vaginal cream 2%)

#### METRONIDAZOLE

METRONIDAZOLE VAGINAL GEL 0.75%†  
VANDAZOLE† (metronidazole vaginal 0.75%)

### PA REQUIRED

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

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

## Vitamins: Prenatal Multivitamins

*Length of Authorization: 1 year*

### NO PA REQUIRED

All generics

### PA REQUIRED

All brands

### PDL Key:

† Generic product

\* Indicates a generic equivalent is available without PA

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