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Phone Numbers for Medicaid PBM Program

MedMetrics Health Partners (MHP)

Clinical 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.

OVHA Medical Staff:

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(f) 802-879-5963

MHP Program Rep-Vermont:

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E-mail: nancy_miner@medmetricshp.com

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Alzheimer's Medications: Cholinesterase/Glutamate Inhibitors

Length of Authorization: 1 year

NO PA REQUIRED

ARICEPT® (donepezil)
NAMENDA® (memantine)

PA REQUIRED

Cognex® (tacrine) §
Exelon® (rivastigmine) §
Razadyne/Razadyne® CR (galantamine) §

Analgesics: Actiq® Transmucosal

Length of Authorization: 3 months

NO PA REQUIRED

PA REQUIRED

Fentanyl lozenge on a stick: 200 mcg, 400 mcg, 600 mcg, 800 mcg, 1200 mcg, 1600 mcg

Analgesics: Buprenorphine

Length of Authorization: 1 year

Special training and DEA number required for prescriber

Therapy specific PA fax form is available on OVHA website.

NO PA REQUIRED

PA REQUIRED

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

Analgesics: COX-2 Inhibitors

Length of Authorization: 1 year

NO PA REQUIRED

CELEBREX® (celecoxib) (age > 60 yrs)

PA REQUIRED

Celebrex® (age ≤ 60 yrs)

Analgesics: Narcotics-Short Acting

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

Quantity limits apply

NO PA REQUIRED

ACETAMINOPHEN W/CODEINE† (compare to Tylenol® w/codeine)
ACETAMINOPHEN W/HYDROCODONE† (compare to Vicodin®, Lorcet®, Maxidone®, Norco®, Zydone®)
ACETAMINOPHEN W/OXYCODONE† (compare to Percocet®)
ACETAMINOPHEN W/PROPOXYPHENE† (compare to Darvocet®)
ASPIRIN W/CODEINE†
ASPIRIN W/OXYCODONE† (compare to Percodan®)
BUTALBITAL COMP. W/CODEINE† (compare to Fiorinal® w/codeine)
CODEINE SULFATE†
DIHYDROCODEINE COMPOUND† (compare to Synalgos-DC®)
HYDROCODONE† (plain, w/acetaminophen, or w/ibuprofen)
HYDROMORPHONE† (compare to Dilaudid®)
MEPERIDINE† (compare to Demerol®) (30 tabs or 5 day supply)
MORPHINE SULFATE†
MORPHINE SULFATE† (compare to Roxanol®)
OXYCODONE† (plain, w/acetaminophen or w/ibuprofen)
PENTAZOCINE† (compare to Talwin®)
PROPOXYPHENE† (compare to Darvon®)
PROPOXYPHENE COMPOUND.† (compare to Darvon Compound®)
PROPOXYPHENE N W/ ACETAMINOPHEN†
ROXICET® (oxycodone w/ acetaminophen)

continued on next page

PA REQUIRED

Acetaminophen w/ codeine: *all branded products*
Acetaminophen w/ hydrocodone: *all branded products*
Anexsia®*
Bancap HC®
Butorphanol NS (authorization limited to 2 units/month)
Capital® w/Codeine*
Combunox®
Darvocet-N®*
Darvon Compound®*
Darvon®*
Darvon-N®*
Demerol*
Dilaudid®*
Endocet®
Endodan®
Fioricet w/codeine®*
Lorcet®* (also HD, PLUS)
Lortab®*
continued on next page

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ROXICODONE INTENSOL® (oxycodone w/ acetaminophen)
ROXICODONE® (oxycodone HCL)
TRAMADOL† (compare to Ultram®)

continued from previous page

Maxidone®
Meperidine (Qty > 30 tabs or 5 day supply)
Nalbuphine
Norco®*
Nubain®*
Numorphan®
Oxyfast®*
OxyIR®*
Panlor DC®*
Pentazocine and Naloxone
Percocet®*
Percodan®*
Propoxyphene: *all branded products**
Roxanol®*
Stadol® (authorization limited to 2 units/month)
Synalgos DC®*
Talacen®*
Talwin®* and brand combinations
Talwin NX®*
Tylenol® #3*
Tylenol® #4*
Tylox®*
Ultracet®
Ultram®*
Ultram ER®
Vicodin®*
Vicoprofen®*
Wygesic®*
Xodol®
Zydone®*

Analgesics: Narcotics-Long Acting

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

Monthly quantity limits apply

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

NO PA REQUIRED

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

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

METHADONE†

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

PA REQUIRED

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

Dolophine®*

Duragesic-12® 12.5 mcg/hr (QL=15 patches/30 days)

Duragesic®* 25 mcg/hr, 50 mcg/hr, (QL=15 patches/30 days)

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

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

MS Contin®* (QL=90 tablets/strength/30 days)

Oramorph SR®* (QL=90 tablets/strength/30 days)

Oxycodone ER†(QL=90 tablets/strength/30 days)

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

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Analgesics: NSAIDs

Length of Authorization: 1 year

Quantity limits apply

NO PA REQUIRED

DICLOFENAC POTASSIUM† (compare to Cataflam®)
DICLOFENAC SODIUM† (compare to Voltaren®)
DIFLUNISAL† (compare to Dolobid®)
ETODOLAC† (compare to Lodine®)
FENOPROFEN† (compare to Nalfon®)
FLURBIPROFEN† (compare to Ansaid®)
IBUPROFEN† (compare to Motrin®)
INDOMETHACIN† (compare to Indocin®)
KETOPROFEN† (compare to Orudis®)
KETOPROFEN ER† (compare to Oruvail®)
MECLOFENAMATE SODIUM† (compare to Meclomen®)
NABUMETONE† (compare to Relafen®)
NAPROXEN† (compare to Naprosyn®)
NAPROXEN SODIUM† (compare to Anaprox®, Naprelan®)
OXAPROZIN† (compare to Daypro®)
PIROXICAM† (compare to Feldene®)
SULINDAC† (compare to Clinoril®)
TOLMETIN SODIUM† (compare to Tolectin®)

PA REQUIRED

Anaprox®*
Anaprox DS®*
Ansaid®*
Arthrotec®
Cataflam®*
Clinoril®*
Daypro®*
Dolobid®*
EC-Naprosyn®*
Feldene®*
Indocin®*
Indocin SR®
Ketorolac† QL = 20 doses post PA approval
Lodine®*
Lodine XL®*
meloxicam
Mobic®
Motrin®*
Nalfon®*
Naprelan®*
Naprosyn®*
Orudis®*
Oruvail®*
Ponstel®
Relafen®*
Tolectin®*
Toradol® QL = 20 doses post PA approval
Voltaren®*
Voltaren XR®*

Analgesics: Stadol (butorphanol) Nasal Spray

Length of Authorization: 1 year

NO PA REQUIRED

PA REQUIRED

Stadol® (butorphanol) Nasal Solution: all forms brand & generic

Anemia: Hematopoietic/Erythropoietic Agents

Length of Authorization: 1 year

NO PA REQUIRED

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

PA REQUIRED

Epogen® (epoetin alpha)

Anti-anxiety: Anxiolytics

Length of Authorization: 1 year

NO PA REQUIRED

ALPRAZOLAM† (compare to Xanax®)
BUSPIRONE† (compare to BuSpar®)
CHLORDIAZEPOXIDE† (compare to Librium®)
CLONAZEPAM† (compare to Klonopin®)
CLORAZEPATE† (compare to Tranxene®)
DIAZEPAM† (compare to Valium®)
LORAZEPAM† (compare to Ativan®)
MEPROBAMATE† (compare to Equanil®, Miltown®)
OXAZEPAM† (compare to Serax®)

PA REQUIRED

Ativan®*
BuSpar®*
Equanil®*
Klonopin®*
Klonopin Wafers®
Librium®*
Miltown®*
Niravam®
Serax®*
Tranxene®* (all brand forms)
Valium®*
Xanax®*
Xanax XR®

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Anti-depressants: Novel
Length of Authorization: 1 year
Daily dosage limits apply

NO PA REQUIRED

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

PA REQUIRED

Bupropion XL[†] (compare to Wellbutrin XL[®])
 Cymbalta[®]
 Desyrel^{®*} *max dose = 750 mg/day*
 Effexor[®]
 Effexor XR[®] *max dose = 450 mg/day,*
QL = 1 cap/day (37.5 mg & 75 mg caps)
 Remeron^{®*} *max dose = 90 mg/day*
 Remeron Sol Tab^{®*} *max dose = 90 mg/day*
 venlafaxine IR
 Wellbutrin^{®*}
 Wellbutrin SR^{®*} *max dose = 400 mg/day*

Anti-depressants: SSRIs
Length of Authorization: 1 year
Daily Dosage limits apply

NO PA REQUIRED

CITALOPRAM[†] (compare to Celexa[®]) *max dose = 75 mg/day*
 FLUOXETINE[†] (compare to Prozac[®]) *max dose = 100 mg/day*
 FLUVOXAMINE[†] (compare to Luvox[®]) *max dose = 300 mg/day*
 PAROXETINE HCL[†] (compare to Paxil[®]) *max dose = 75 mg/day*

PA REQUIRED

Celexa^{®*} *max dose = 75 mg/day*
 Lexapro[®] *max dose = 25 mg/day,*
QL = 1.5 tabs/day (5 mg & 10 mg tabs)
 Luvox^{®*} *max dose = 300 mg/day*
 Paxil^{®*} *max dose = 75 mg/day*
 Paxil CR[®] *max dose = 75 mg/day*
 Pexeva[®] *max dose = 75 mg/day*
 Prozac^{®*} *max dose = 100 mg/day*
 Prozac Weekly[®] *max weekly dose = 540 mg*
 Sarafem[®] *max dose = 100 mg/day*
 sertraline *max dose = 250 mg/day,*
QL = 1.5 tabs/day (25 mg & 50 mg tabs)
 Zoloft[®] *max dose = 250 mg/day,*
QL = 1.5 tabs/day (25 mg & 50 mg tabs)

Anti-depressants: Tricyclics
Length of Authorization: 1 year

NO PA REQUIRED

AMITRIPTYLINE[†] (compare to Elavil[®]) *max dose = 375mg/day*
 AMITRIPTYLINE/CHLORDIAZ.[†] (compare to Limbitrol[®])
 AMITRIPTYLINE/PERPHEN[†] (compare to Etrafon[®], Triavil[®])
 AMOXAPINE[†] (compare to Asendin[®])
 CLOMIPRAMINE[†] (compare to Anafranil[®])
 DESIPRAMINE[†] (compare to Norpramin[®])
 DOXEPIN[†] (compare to Sinequan[®])
 IMIPRAMINE[†] (compare to Tofranil[®]) *max dose = 250mg/day*
 NORTRIPTYLINE[†] (compare to Aventyl[®], Pamelor[®])
 TOFRANIL PM[®] (imipramine pamoate)
 TRIMIPRAMINE[†] (compare to Surmontil[®])
 VIVACTIL[®] (protriptyline)

PA REQUIRED

Anafranil^{®*}
 Aventyl^{®*}
 Elavil^{®*}
 Limbitrol^{®*}
 Limbitrol DS[®]
 Norpramin^{®*}
 Pamelor^{®*}
 Sinequan^{®*}
 Surmontil^{®*}
 Tofranil^{®*}

Anti-depressants: MAO Inhibitors
Length of Authorization: 1 year

NO PA REQUIRED

NARDIL[®] (phenylzine) *max dose = 110mg/day*
 TRANLYCYPROMINE[†] (compare to Parnate[®]) *max dose = 120mg/day*

PA REQUIRED

EMSAM[®] (selegiline) (*QL = 1 patch/day*)
 Marplan[®] (isocarboxazid)
 Parnate^{®*}

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Anti-diabetics: Alpha-Glucosidase Inhibitors

NO PA REQUIRED

GLYSET® (miglitol)
PRECOSE® (acarbose)

PA REQUIRED

Anti-diabetic: Biguanides & Combinations

Length of Authorization: 1 year

NO PA REQUIRED

GLIPIZIDE/METFORMIN† (compare to Metaglip®)
GLYBURIDE/METFORMIN† (compare to Glucovance®)
METFORMIN† (compare to Glucophage®)
METFORMIN XR† (compare to Glucophage XR®)

PA REQUIRED

Fortamet®
Glucophage®*
Glucophage XR®*
Glucovance®*
Glumetza®
Metaglip®*

Anti-diabetics: Peptide Hormones

Monthly quantity limits apply

NO PA REQUIRED

Byetta® (exenatide) *Quantity Limit = 1 pen/30 days*
(After clinical criteria are met)

PA REQUIRED

Symlin® (pramlintide) *No Quantity Limit*

Anti-diabetics: Insulins

Length of Authorization: lifetime

NO PA REQUIRED

TRADITIONAL

Available in vial, pre-filled and pen-fill dosage forms
HUMULIN 50/50® (NPH/Regular)
LENTE/REGULAR/NPH ILETIN II®
NOVOLIN R® (Regular)
NOVOLIN N® (NPH)
NOVOLOG MIX 70/30® (Protamine/Aspart)
RELION 70/30® (NPH/Regular)
RELION N® (NPH)
RELION R® (Regular)

SHORT-ACTING ANALOGS

HUMALOG MIX 75/25® (Protamine/Lispro)
NOVOLOG® (Aspart)
NOVOLIN 70/30® (NPH/Regular)

LONG-ACTING ANALOGS

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

PA REQUIRED

Humulin R® (Regular)
Humulin N® (NPH)

Apidra® (insulin glulisine)
Humulin 70/30® (NPH/Regular)
Humalog® (insulin lispro)

Levemir® pen (insulin detemir)

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Anti-diabetic: Oral Meglitinides

Length of Authorization: 1 year

NO PA REQUIRED

STARLIX® (nateglinide)

PA REQUIRED

Prandin® (replaglinide)

Anti-diabetic: Sulfonylureas 2nd Generation

Length of Authorization: 1 year

NO PA REQUIRED

GLIMEPIRIDE† (compare to Amaryl®)
GLIPIZIDE† (compare to Glucotrol®)
GLIPIZIDE ER† (compare to Glucotrol XL®)
GLYBURIDE† (compare to Diabeta®, Micronase®)
GLYBURIDE MICRONIZED† (compare to Glynase® PresTab®)

PA REQUIRED

Amaryl®*
Diabeta®*
Glucotrol®*
Glucotrol XL®*
Glynase® PresTab®*
Micronase®*

Anti-diabetic: Thiazolidinediones & Combinations

NO PA REQUIRED

ACTOPLUS MET® (metformin/pioglitazone)
ACTOS® (pioglitazone)
AVANDAMET® (metformin/rosiglitazone maleate)
AVANDARYL® (glimepiride/rosiglitazone maleate)
AVANDIA® (rosiglitazone)

PA REQUIRED

Anti-emetics: NK1/5HT3 Antagonists

Length of Authorization: 6 months of chemotherapy or radiotherapy;

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

Monthly quantity limits apply, PA required to exceed.

NO PA REQUIRED

EMEND® (aprepitant) 40 mg (1 cap)
*EMEND® (aprepitant) 80 mg (2 caps)
*EMEND® (aprepitant) 125 mg (1 cap)
*EMEND® (aprepitant) Tri-fold Pack (1 pack)
ZOFTRAN® (ondansetron) 24 mg (1 tab), 8 mg (6 tabs), 4 mg (12 tabs)
ZOFTRAN (ondansetron) ODT® 4 mg (12 tabs), 8 mg (6 tabs)
ZOFTRAN® (ondansetron) Solution 4 mg/5 ml

* Limited to oncologist prescribing only

PA REQUIRED

Aloxi® (palonosetron, injectable) (2 vials)
Anzemet® (dolansetron) 50 mg (4 tabs)
Anzemet® (dolansetron) 100 mg (2 tabs)
Kytril® (granisetron) 1 mg (6 tabs)
Kytril® (granisetron) Injectable
Ondansetron (generic) – all forms – quantity limits apply

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Antihyperkinesia: ADHD, ADD, Narcolepsy

Length of Authorization: up to 1 year

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

NO PA REQUIRED

SHORT/INTERMEDIATE ACTING METHYLPHENIDATE PREPS

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

PA REQUIRED

Focalin[®] (dexmethylphenidate)
Ritalin^{®*}
Ritalin SR^{®*}

LONG-ACTING METHYLPHENIDATE PREPS

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

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

SHORT/INTERMEDIATE AMPHETAMINE PREPS

AMPHETAMINE salt combination[†] (compare to Adderall[®])
DEXTROAMPHETAMINE[†] (compare to Dexedrine[®])
DEXTROAMPHETAMINE SA[†] (compare to Dexedrine SA[®])
DEXTROSTAT[†] (compare to Dexedrine[®])

Adderall^{®*}
Desoxyn[®] (methamphetamine)
Dexedrine^{®*}
Dexedrine SA^{®*}

LONG-ACTING AMPHETAMINE PREPS

ADDERALL XR[®] (dextroamphetamine IR/ER, 50:50%)

NON-STIMULANT PREPS

Provigil[®] (modafinil) (not approvable for ADHD in children age ≤ 12)
Strattera[®] (atomoxetine) max dose = 100mg/day

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[®])
QUINAPRIL[†] (compare to Accupril[®])

PA REQUIRED

Accupril^{®*}
Aceon[®] (perindopril)
Altace[®] (ramipril)
Capoten^{®*}
Lotensin^{®*}
Mavik[®] (trandolopril)
Monopril^{®*}
Prinivil^{®*}
Univasc[®] (moexipril)
Vasotec^{®*}
Zestril^{®*}

Anti-hypertensives: ACE Inhibitor with Hydrochlorothiazide

Length of Authorization: 1 year

NO PA REQUIRED

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

PA REQUIRED

Accuretic^{®*}
Capozide^{®*}
Lotensin HCT^{®*}
Monopril HCT^{®*}
Prinzide^{®*}
Uniretic[®] (moexipril/hydrochlorothiazide)
Vaseretic^{®*}
Zestoretic^{®*}

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Anti-hypertensives: Calcium Channel Blockers

Length of Authorization: 5 years

NO PA REQUIRED

CARTIA XT[®] (diltiazem HCL)
DILTIA XT[®] (diltiazem HCL)
DILTIAZEM[†] (compare to Cardizem[®])
DILTIAZEM ER[†] (compare to Cardizem[®] SR)
DILTIAZEM CD[†] (compare to Cardizem[®] CD)
DILTIAZEM XR[†] (compare to Dilacor[®] XR)
FELODIPINE[†] (compare to Plendil[®])
NICARDIPINE[†] (compare to Cardene[®])
NIFEDIAC[®] CC (compare to Adalat CC[®])
NIFEDICAL XL[†] (compare to Procardia[®] XL)
NIFEDIPINE IR[†] (compare to Procardia[®])
NIFEDIPINE ER[†] (compare to Procardia[®] XL)
NIMOTOP[®] (nimodipine)
NORVASC[®] (amlodipine)
SULAR[®] (nisoldipine)
TAZTIA XT[®] (compare to Tiazac[®])
VERAPAMIL[†] (compare to Calan[®], Isoptin[®])
VERAPAMIL SR[†] (compare to Calan SR[®], Isoptin SR[®])
VERAPAMIL ER[†] (compare to Covera-HS[®], Verelan[®])

PA REQUIRED

Adalat[®] CC*
Caduet[®] (amlodipine/atorvastatin)
Calan[®]*
Calan[®] SR*
Cardene[®]*
Cardene[®] SR*
Cardizem[®]*, all: CD, LA, SR
Covera-HS[®]*
Dilacor[®] XR*
Dynacirc[®]
Dynacirc CR[®]
Isoptin[®]*
Isoptin[®] SR*
Plendil[®]*
Procardia[®]
Procardia[®] XL*
Tiazac[®]*
Vascol[®]
Verelan[®]*
Verelan PM[®]

Anti-infectives: Cephalosporins – 1st Generation

Length of Authorization: for date of service, no refills

NO PA REQUIRED

CEFADROXIL[†] (compare to Duricef[®], Ultracet[®])
CEPHALEXIN[†] (compare to Keflex[®])

PA REQUIRED

cephradine[†] (compare to Velosef[®])
Duricef[®]*
Keflex[®]*
Velosef[®]

Anti-infectives: Cephalosporins – 2nd Generation

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

NO PA REQUIRED

CEFACLOR[†] (compare to Ceclor)
CEFACLOR ER[†] (compare to Ceclor CD[®])
CEFACLOR SUSPENSION[†] (age ≤ 10 yrs)
CEFPROZIL SUSPENSION[†] (age ≤ 12 yrs)
CEFPROZIL[†] (compare to Cefzil[®]) tablets
CEFTIN (cefuroxime) SUSPENSION (age ≤ 12 yrs)
CEFUROXIME[†] (compare to Cefitin[®]) tablets

PA REQUIRED

Ceclor[®]*
Ceclor CD[®]*
cefaclor suspension[†] (age > 10 yrs)
cefprozil suspension[†] (age > 12 years)
Cefitin[®]* tablets (all ages)
Cefitin[®] suspension (age > 12 yrs)
Cefzil[®]
Lorabid[®] (loracarbef)

Anti-infectives: Cephalosporins – 3rd Generation

Length of Authorization: for date of service, no refills

NO PA REQUIRED

CEDAX[®] (ceftibuten)
CEFPODOXIME PROXETIL[†] (compare to Vantin[®])
OMNICEF[®] (cefдинир)
SUPRAX[®] (cefіxime)

PA REQUIRED

cefдинир[†]
Spectracef[®] (cefditoren)
Vantin[®]*

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: Ketolides*Length of Authorization: for date of service, no refills***NO PA REQUIRED****PA REQUIRED**

Ketek® (telithromycin)

Anti-infectives: Macrolides*Length of Authorization: for date of service, no refills***NO PA REQUIRED**

AZITHROMYCIN† tablets (<= 5 day supply) (compare to Zithromax®)
 AZITHROMYCIN† liquid (<= 5 day supply) (compare to Zithromax®)
 CLARITHROMYCIN† (compare to Biaxin/Biaxin XL)
 ERY-TAB® (erythromycin)
 ERYTHROMYCIN BASE†
 ERYTHROMYCIN ESTOLATE†
 ERYTHROMYCIN ETHYLSUCCINATE† (compare to E.E.S.®, Eryped®)
 ERYTHROMYCIN STEARATE† (compare to Erythrocin®)
 ERYTHRO W/ SULFASOXAZOLE† (compare to Pediazole®, Eryzole®)

PA REQUIRED

azithromycin† tablets and liquid (if > 5 day supply)
 Biaxin®*
 Biaxin XL®
 Dynabac® (dirithromycin)
 E.E.S.®**
 E.E.S. 400®
 E-Mycin® (erythromycin base)
 Eryc® (erythromycin base, delayed release)
 Erythrocin®*
 Eryped®* (erythromycin ethylsuccinate)
 Pediazole®*
 Zithromax® tablets and liquid
 Zmax® (azithromycin extended release oral suspension)

Anti-infectives: Oxazolidinones*Length of Authorization: for date of service, no refills***NO PA REQUIRED****PA REQUIRED**

Zyvox® (linezolid)

Anti-infectives: Penicillins (Oral)*Length of Authorization: for date of service, no refills***NO PA REQUIRED**

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

PA REQUIRED

Augmentin®**
 Augmentin ES®*
 Augmentin XR®

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

Anti-infectives: Quinolones*Length of Authorization: for date of service, no refills***Monthly quantity limits apply****NO PA REQUIRED**

CIPROFLOXACIN† (compare to Cipro®) 100 mg (6), 250 mg (28),
 500 mg (28), 750 mg (28) tabs
 CIPRO® OS (ciprofloxacin) 100 mg/ml
 LEVAQUIN® (levofloxacin) 250 mg (10), 500 mg (14), 750 mg (14)
 OFLOXACIN† (compare to Floxin®) 200 mg (14), 300 mg (14),
 400 mg (28) tabs

PA REQUIRED

Avelox® (moxifloxacin HCL) 400 mg (10 tabs)
 Avelox ABC PACK® (moxifloxacin HCL)
 Cipro®* 100 mg (6), 250 mg (28), 500 mg (28), 750 mg (28) tabs
 Cipro XR® (7 days)
 Factive® (gemifloxacin) 320 mg (14 tabs)
 Floxin®* 200mg (14), 300 mg (14), 400 mg (28) tabs
 Noroxin® (norfloxacin) 400mg (20 tabs)
 ProQuin XR® (ciprofloxacin) 500 mg (3 tabs)
 Tequin® (gatifloxacin) 200 mg (3 tabs), 400 mg (10 tabs)

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: Onychomycosis Agents*Length of Authorization: 1 year, see clinical criteria.***Monthly quantity limits apply****PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET**LAMISIL[®] tablets (terbinafine HCL) *QL = 30 tabs/month*PENLAC[®] Nail Lacquer (ciclopirox) *QL = 6.6 ml/90 days***NON-PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET**Sporanox[®] (itraconazole) *QL = 28 caps/month (brand & generic)***Anti-infectives: Anti-virals: Herpes***Length of Authorization: for duration of prescription, up to 6 months.***NO PA REQUIRED**ACYCLOVIR[†] (compare to Zovirax[®])VALTREX[®] (valacyclovir)**PA REQUIRED**Famvir[®] (famciclovir) §Zovirax^{®*} §**Anti-infectives: Influenza Medications***Length of Authorization: for duration of prescription, up to 3 months.***Quantity limits apply****NO PA REQUIRED**RELENZA[®] (zanamivir) *QL= 20 blisters / 30 days*TAMIFLU[®] (oseltamivir) *QL=10 capsules or 75 ml /30 days***PA REQUIRED**amantadine[†] PA for quantity ≤ 10 days supply (Not CDC recommended for use in influenza)Flumadine^{®*} (rimantidine) (Not CDC recommended for use in influenza)rimantadine[†] (Not CDC recommended for use in influenza)Symmetrel^{®*} (amantadine) (Not CDC recommended for influenza)**Anti-infectives: Influenza Vaccines***Length of Authorization: for date of service only***NO PA REQUIRED**FLUARIX[®] InjectionFLUZONE[®] InjectionFLUVIRIN[®] Injection**PA REQUIRED**FluMist[®] Nasal**Anti-infectives: Topical Antibiotics***Length of Authorization: N/A***NO PA REQUIRED**BACITRACIN[†]GENTAMICIN[†]BACITRACIN-POLYMXIN[†]NEOMYCIN-BACITRACIN-POLYMXIN[†]CORTISPORIN[®]BACTROBAN[®] (all forms)MUPIROCIN OINTMENT (compare to Bactroban[®])**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-migraine: Triptans

Length of Authorization: 6 months

Monthly quantity limits apply, PA required to exceed.

NO PA REQUIRED, Quantity Limits Apply

AXERT[®] (almotriptan) 6.25 mg, 12.5 mg (QL = 6 tabs)
IMITREX[®] (sumatriptan) Injection 6 mg (QL = 4 inf.)
IMITREX[®] NS (sumatriptan) 20 mg (QL = 6 units)
IMITREX[®] NS (sumatriptan) 5 mg (QL = 12 units)
IMITREX[®] (sumatriptan) 25 mg (QL = 18 tabs)
IMITREX[®] (sumatriptan) 50 mg, 100 mg (QL = 9 tabs)
MAXALT-MLT[®] (rizatriptan) 5 mg, 10 mg (QL = 12 tabs)
MAXALT[®] (rizatriptan) 5 mg, 10 mg (QL = 12 tabs)

PA REQUIRED, Quantity Limits Apply

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

Anti-narcolepsy/cataplexy: Xyrem[®]

Length of Authorization: 1 year

Therapy specific clinical criteria are available on the OVHA website.

NO PA REQUIRED

PA REQUIRED

Xyrem[®] (sodium oxybate)

Anti-obesity

Length of Authorization: 6 months for initial approval,

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

Therapy specific PA fax form available on OVHA website.

NO PA REQUIRED

PA REQUIRED

Didrex[®] (benzphetamine)
Diethylpropion (all forms brand & generic)
Meridia[®] (sibutramine)
Phentermine (all forms brand & generic)
Phendimetrazine (all forms brand & generic)
Xenical[®] (orlistat)

Anti-psychotic: Atypical & Combinations

Length of Authorization: duration of need or lifetime

Daily dosage limits apply

NO PA REQUIRED

CLOZAPINE[†] (compare to Clozaril[®]) - max dose = 1125 mg/day
GEODON[®] (ziprasidone) max dose = 200 mg/day
GEODON IM[®] (ziprasidone Injectable)
RISPERDAL[®] (risperidone) - max dose = 10 mg/day
SEROQUEL[®] (quetiapine) - max dose = 1000 mg/day

PA REQUIRED

Abilify[®] (aripiprazole) all forms, max dose = 40 mg/day,
QL = 1.5 tabs/day (5 mg, 10 mg & 15 mg tabs)
Clozaril[®]* max dose = 1125 mg/day
Fazaclo[®] (clozapine ODT) max dose = 1125 mg/day
Risperdal Consta[®] (risperidone microspheres)
Risperdal Tab Raptis[®] (risperidone rapid dissolve tab) max dose = 10 mg/day
Symbyax[®] (olanzapine/fluoxetine)
Zyprexa[®] (olanzapine) max dose = 50 mg/day,
QL = 1.5 tabs/day (2.5 mg, 5 mg, 7.5 mg, & 10 mg tabs)
Zyprexa IM[®] (olanzapine injectable)
Zyprexa Zydis[®] (olanzapine rapid dissolve tab) max dose = 50 mg/day,
QL = 1.5 tabs/day (5 mg & 10 mg tabs)

PDL Key:

† Generic product

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Anti-psychotic: Typical

Length of Authorization: duration of need or lifetime.

NO PA REQUIRED

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

PA REQUIRED

Haldol®*
Loxitane®*
Mellaril®*
Navane®*
Prolixin®*
Thorazine®*
Trilafon®*

BPH: Alpha Blockers

Length of Authorization: 1 year

NO PA REQUIRED

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

PA REQUIRED

Cardura®*, Cardura XL®
Hytrin®*

BPH: Androgen Hormone Inhibitors

Length of Authorization: lifetime

NO PA REQUIRED

AVODART® (dutasteride)
FINASTERIDE† (compare to Proscar®)
PROSCAR® (finasteride)

PA REQUIRED

AVODART® (dutasteride) females; males age < 45
FINASTERIDE† (compare to Proscar®) females; males age < 45
PROSCAR® (finasteride) females; males age < 45

Cardiac Glycosides:

Length of Authorization: N/A

NO PA REQUIRED

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

PA REQUIRED

Constipation: Chronic

Length of Authorization: 3 months

NO PA REQUIRED

Bulk-Producing Laxatives
PSYLLIUM†
Osmotic Laxatives
LACTULOSE†
POLYETHYLENE GLYCOL 3350 (PEG)†

PA REQUIRED

Zelnorm® (tegaserod)
Amitiza® (lubiprostone)

Cough and Cold Preparations

Length of Authorization: for date of service, no refills

Effective June 1, 2006

NO PA REQUIRED

All generics
MUCINEX® (guaifenesin)

PA REQUIRED

All brands

PDL Key:

† Generic product

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Coronary Vasodilators/Antianginals: Oral

Length of Authorization: 3 years

NO PA REQUIRED

ISOSORBIDE DINITRATE† (compare to Isordil®)
ISOSORBIDE MONONITRATE† (compare to Imdur®, Ismo®,
Monoket®)
NITROGLYCERIN
NITROLINGUAL SPRAY
NITROQUICK®
NITROSTAT®
NITRO-TIME®

PA REQUIRED

BiDi®
Dilatrate-SR®
Imdur®*
Ismo®*
Isordil®*
Monoket®*
Ranexa® (ranolazine) (QL = 4 tabs/day)

Coronary Vasodilators/Antianginals: Topical

Length of Authorization: 3 years

NO PA REQUIRED

NITREK®
NITRO PASTE†
NITROGLYCERIN PATCHES† (compare to Minitran®, Nitro-Dur®)

PA REQUIRED

Minitran®*
Nitro-Bid®*
Nitro-Dur®*

Gastrointestinals: H2-blockers

Length of Authorization: 1 year

NO PA REQUIRED

CIMETIDINE† (compare to Tagamet®)
FAMOTIDINE† (compare to Pepcid®)
RANITIDINE† (compare to Zantac®)
ZANTAC® (ranitidine) SYRUP

PA REQUIRED

Axid® §
nizatadine §
Pepcid®* §
Tagamet®* §
Zantac®/Zantac Effervescent® §

Gastrointestinals: Proton Pump Inhibitors

Length of Authorization: per diagnosis, see clinical criteria

Daily dosage limits apply

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

♣ No PA required for patients < 7 years; Quantity Limits still apply.

NO PA REQUIRED FOR ONCE DAILY DOSES

PREVACID® (lansoprazole) capsules (*Quantity Limit=1 capsule/day*)
PREVACID® (lansoprazole) packets (*Quantity Limit=1 packet/day*)
PRILOSEC OTC® (omeprazole) *No Quantity Limit*
PROTONIX® (pantoprazole) *Qty Limit=1 tab/day*

H. Pylori eradication
PREVPAC® (lansoprazole w/ H.pylori anti-bacterials) *No Quantity Limit*

PA REQUIRED

Aciphex® (rabeprazole) § *Qty Limit=1 tablet/day*
Nexium® (esomeprazole) § *Qty Limit=1 capsule/day*
omeprazole generic* § *Qty Limit=1 capsule/day*
Prevacid Solutabs®♣ *Qty Limit=1 tablet/day*
Prilosec® (brand) § *Qty Limit=1 capsule/day*
Zegerid®* (omeprazole powder for suspension) § *Qty Limit=1 powder
packet/day*
Zegerid® (omeprazole capsules) § *Qty Limit=1 capsule/day*

PDL Key:

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Glucocorticoids: Topical

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

NO PA REQUIRED

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

PA REQUIRED

Low Potency

Aclovate®*
Cortaid®*
Desowen®*
Hytone®*
Synalar®* (all products)
Tridesilon®*

Medium Potency

BECLOMETHASONE DIPROPIONATE† (compare to Diprosone®,
Maxivate®)
BETAMETHASONE VALERATE† (compare to Valisone®)
DESOXIMETASONE 0.05%† (compare to Topicort®)
FLUOCINOLONE 0.025%† (compare to Synalar®)
FLUTICASONE PROPRIONATE† (compare to Cutivate®)
HYDROCORTISONE BUTYRATE† (compare to Locoid®)
HYDROCORTISONE VALERATE† (compare to Westcort®)
MOMETASONE FUROATE† (compare to Elocon®)
TRIAMCINOLONE ACET.† (compare to Aristocort®)

Aristocort®*
Cloderm® (clocortolone)
Cordran®* (all products)
Cutivate®*
Dermatop®
Diprosone®*
Elocon®* (all products)
Kenalog® (all products)
Locoid®
Luxiq Foam®
Synalar®* (all products)
Topicort®* (all products)
Westcort®* (all products)

High Potency

AMCINONIDE† (compare to Cyclocort®)
AUGM. BETHAMETH. CREAM† (compare to Diprolene®)
BETAMETHASONE DIPROP.† (compare to Diprosone®)
DESOXIMETASONE 0.25%† (compare to Topicort®)
DIFLORASONE DIAC.† (compare to Maxiflor®, Psorcon®)
FLUOCINOLONE 0.2%† (compare to Synalar®)
FLUOCINONIDE† (compare to Lidex®)

Cyclocort®*
Diprolene®* (all products)
Diprosone®*
Halog®* (all products)
Lidex®* (all products)
Maxiflor®*
Synalar®* (all products)
Topicort®* (all products)

Very High Potency

AUGM. BETHAMETH. OINT.† (compare to Diprolene®)
CLOBETASOL PROPIONATE† (compare to Temovate®)
DIFLORASONE DIAC. EMOLL† (compare to Psorcon®)
HALOBETASOL PROPRIONATE† (compare to Ultravate®)

Cormax®
Diprolene®* (all products)
Embeline E®*
Psorcon®*
Temovate®* (all products)
Ultravate®* (all products)

Growth Stimulating Agents

Length of Authorization: up to 6 months; short bowel syndrome = 4 weeks.

Agents available after clinical criteria are met.

Therapy specific PA form is available on OVHA website.

PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

NUTROPIN®
NUTROPIN® AQ
NUTROPIN® Depot
TEV-TROPIN®

INCRELEX® (mecasermin)

NON-PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

Genotropin®
Humatrope®
Norditropin®
Saizen®
Serostim®
Zorbtive® (with special criteria)

PDL Key:

† Generic product

* Indicates a generic equivalent is available without PA

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Hepatitis C Agents

Length of Authorization: 6 months

Therapy specific PA form is available at OVHA website.

PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

RIBAVIRIN

RIBAVIRIN†

INTERFERON

PEGASYS® (peg-interferon alpha 2-a)

PEGASYS CONV. PAK® (peg-interferon alfa-2a)

NON-PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

RIBAVIRIN

Copegus®

Ribasphere®

Rebetol®

INTERFERON

Infergen® (interferon alphacon-1)

Peg-Intron® (peg-interferon alpha-2b)

COMBINATION

Rebetron® (Rebetol/Intron-A)

Immunomodulators: Topical

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

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

NO PA REQUIRED

ELIDEL® (pimecrolimus) §

PROTOPIC® (tacrolimus) §

PA REQUIRED

Elidel® (age < 2 yrs)

Protopic® (age < 2 yrs)

Lipotropics: Bile Acid Sequestrants

Length of Authorization: lifetime

NO PA REQUIRED

CHOLESTYRAMINE† powder (compare to Questran®)

CHOLESTYRAMINE LIGHT† powder (compare to Questran Light®)

PREVALITE† powder (cholestyramine light)

COLESTIPOL† tablets, granules (compare to Colestid®)

PA REQUIRED

Questran® powder (cholestyramine)

Questran Light® powder (cholestyramine light)

Colestid® tablets, granules (colestipol)

Welchol® (colesevelam)

Lipotropics: Fibric Acid Derivatives

Length of Authorization: 1 year

NO PA REQUIRED

GEMFIBROZIL† (compare to Lopid®)

♦TRICOR® (fenofibrate) §

♦TRIGLIDE® (fenofibrate) §

♦PA required if patient not on concurrent statin

PA REQUIRED

Antara® (fenofibrate micronized) §

fenofibrate †

Lofibra® (fenofibrate micronized) §

Lopid®* (gemfibrozil) §

Lipotropics: Niacin Derivatives

Length of Authorization: N/A

NO PA REQUIRED

NIACIN†

NIASPAN® (niacin)

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)

Lipotropics: Statins

Length of Authorization: 1 year

NO PA REQUIRED

LESCOL[®] (fluvastatin)
LESCOL[®] XL (fluvastatin XL)
LOVASTATIN[†] (compare to Mevacor[®])
PRAVASTATIN[†] (compare to Pravachol[®])

CRESTOR[®] (rosuvastatin calcium)
SIMVASTATIN^{†**}

PA REQUIRED

Low/Medium Potency Statins

Altoprev[®] (lovastatin) §
Mevacor^{®**} §
Pravachol^{®*} (pravastatin) §

High Potency Statins

Lipitor[®] (atorvastatin) §
Zocor^{®**} (simvastatin)

Lipotropics: Miscellaneous/Combinations

Length of Authorization: 1 year

NO PA REQUIRED

ZETIA^{®**} (ezetimibe)
VYTORIN[®] (ezetimibe/simvastatin)

** If recipient is on Zetia[®] and simvastatin concurrently, change to Vytorin[®] is required.

ADVICOR[®] (lovastatin/niacin)

PA REQUIRED

Miscellaneous

Omacor[®] (omega-3-acid ethyl esters)

Cholesterol Absorption Inhibitors/Combinations

Other Statin Combinations

Caduet[®] (atorvastatin/amlodipine) §
Pravigard PAC[®] (pravastatin/aspirin) §

Mood Stabilizers

Daily dosage limits apply

PREFERRED

1st-LINE

DEPAKOTE (valproate)
DEPAKOTE ER (valproate ER)
LAMICTAL (lamotrigine) *max dose = 600 mg/day*
LITHIUM CARBONATE[†] (compare to Eskalith[®])
LITHIUM CARBONATE SR[†] (compare to Eskalith CR[®])
VALPROIC ACID[†] (compare to Depakene[®])

2nd-LINE

CARBAMAZEPINE[†] (compare to Tegretol[®])
CARBATROL (carbamazepine)
EQUETRO (carbamazepine)
TEGRETOL XR (carbamazepine XR)

NON-PREFERRED

Depakene^{®*}
Eskalith^{®*}
Eskalith CR^{®**}
Lithobid^{®**}

Gabapentin (brand & generic)
Tegretol^{®**}
Topamax^{®**}
Trileptal^{®**} *max dose = 2400 mg/day*

Multiple Sclerosis: Injectables

Length of Authorization: 5 years

NO PA REQUIRED

BETASERON[®] (interferon B-1b)
COPAXONE[®] (glatiramer acetate)
REBIF[®] (interferon B-1a)

PA REQUIRED

Avonex[®] (interferon B-1a)

PDL Key:

[†] Generic product

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

Nutritionals, enteral*Length of Authorization: 6 months**Therapy specific PA fax form available on OVHA website.***NO PA REQUIRED****PA REQUIRED**

PA applies to oral (swallowed) liquid nutrition: Contact MedMetrics.
 For enteral nutrition requiring DME equipment and supplies call OVHA
 Clinical staff for authorization.

Ophthalmics: Antihistamines*Length of Authorization: 1 year***NO PA REQUIRED**

ELESTAT[®] (epinastine)
 PATANOL[®] (olopatadine)

PA REQUIRED

Emadine[®] (emedastine)
 ketotifen†
 Optivar[®] (azelastine)
 Zaditor[®] (ketotifen)

Ophthalmics: Glaucoma Agents/Miotics*Length of Authorization: lifetime***NO PA REQUIRED****PA REQUIRED****ALPHA-2 ADRENERGIC**

ALPHAGAN[®] P (brimonidine tartrate)
 BRIMONIDINE TARTARATE† (compare to Alphagan[®])

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

BETA BLOCKER

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

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

PROSTAGLANDIN INHIBITORS

Note: Coverage of a 'preferred' PI agent is contingent upon a 1st-line trial of any other preferred beta-blocker, a-2 adrenergic or CAI agent. Coverage of a 'non-preferred' PI agent is contingent upon a similar first-line trial as well as a failed trial of both preferred PI products.

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

Xalatan[®] (latanoprost)

CARBONIC ANHYDRASE INHIBITOR

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

Azopt[®] (brinzolamide)

MISCELLANEOUS

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

Carbastat[®]
 Miochol-E[®]
 Miostat[®]
 Pilocar[®]*
 Propine[®]*

Ophthalmics: Mast Cell Stabilizers*Length of Authorization: 6 months***NO PA REQUIRED****PA REQUIRED**

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

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

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

Ophthalmics: Quinolone Anti-infectives

Length of Authorization: for date of service, no refills

NO PA REQUIRED

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

PA REQUIRED

Ciloxan®*
Ocuflox®*
Quixin® (levofloxacin)
Vigamox® (moxifloxacin)
Zymar® (gatifloxacin)

Ossification Enhancers

Length of Authorization: lifetime

Monthly quantity limits apply

NO PA REQUIRED

BONIVA® (ibandronate) 150 mg *Quantity Limit = 1 tab/28 days*
BONIVA® (ibandronate) 2.5 mg *No quantity limits*
FOSAMAX® (alendronate)
FOSAMAX PLUS D® (alendronate/vitamin D)

MIACALCIN® (calcitonin)

PA REQUIRED

Actonel® (risedronate)
Actonel® w/calcium (risedronate/calcium)
Didronel® (etidronate)
Skelid® (tiludronate)
Fortical® (calcitonin)

Parkinson's: Non-Ergot Dopamine Receptor Agonist

Length of Authorization: 1 year

NO PA REQUIRED

DOPAMINE PRECURSOR

CARBIDOPA/LEVODOPA† (compare to Sinemet®)
PARCOPA® (carbidopa/levodopa ODT)

DOPAMINE AGONISTS

BROMOCRIPTINE† (compare to Parlodel®)
MIRAPEX® (pramipexole)
PERGOLIDE† (compare to Permax®)
REQUIP® (ropinirole)

COMT INHIBITORS

TASMAR® (tolcapone)
COMTAN® (entacapone)

MAO-B INHIBITORS

SELEGILINE† (compare to Eldepryl®)

OTHER

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

PA REQUIRED

Sinemet® - all forms* (brand)
Sinemet CR®

Parlodel® (bromocriptine)
Permax® (pergolide)

Eldepryl® (selegiline)

Symmetrel® (amantadine)

PDL Key:

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Phosphodiesterase-5 (PDE-5) Inhibitors

Length of Authorization: 1 year

Daily dosage limits apply

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

PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

NON-PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

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

Platelet Inhibitors

Length of Authorization: 3 years

NO PA REQUIRED

ASPIRIN[†]
CILOSTAZOL[†] (compare to Pletal[®])
CLOPIDOGREL[†] (compare to Plavix[®])
DIPYRIDAMOLE[†] (compare to Persantine[®])
PLAVIX[®] (clopidogrel bisulfate)
TICLOPIDINE[†] (compare to Ticlid[®])

PA REQUIRED

Aggrenox[®] (dipyridamole/ASA)
Persantine^{®*}
Pletal^{®*}
Ticlid^{®*}

Psoriasis Injectables

Length of Authorization: initially for 3 months, and 6 months thereafter.

Monthly quantity limits apply

Therapy-specific PA fax form available on OVHA website.

PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

ENBREL[®] (etanercept) *QL = 50 mg x8/month x 3 months, then 50 mg dose/week*
RAPTIVA[®] (efalizumab) *QL = 4 doses/month*

NON-PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

Amevive[®] *QL = 4 doses/month*
Remicade[®] (infliximab)

Psoriasis: Non-Biologics

Length of Authorization: 1 year

NO PA REQUIRED

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

PA REQUIRED

Oral

Topical

DOVONEX[®] (calcipotriene cream/ointment)
PSORIATEC[®], DRITHO-SCALP[®] (anthralin cream)
TAZORAC[®] (tazarotene cream)

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

PDL Key:

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Pulmonary: Anticholinergics, Inhaled

NO PA REQUIRED

ATROVENT® (ipratropium)
ATROVENT HFA® (ipratropium)
COMBIVENT® (ipratropium/albuterol)
DUONEB® (ipratropium/albuterol)
SPIRIVA® (tiotropium)

PA REQUIRED

Pulmonary: Antihistamines-2nd Gen.

Length of Authorization: 1 year

NO PA REQUIRED

FEXOFENADINE (after 15-day loratadine trial and failure w/in last 30 days)
LORATADINE (OTC) all forms †
LORATADINE/D (OTC) †
ZYRTEC® (cetirizine) SYRUP (age <12 yrs)
‡ *other OTC products are not covered.*

PA REQUIRED

Allegra® (fexofenadine)
Allegra-D® § (12 HR & 24 HR)
Clarinet® (desloratadine) §
Clarinet-D® § (12 HR & 24 HR)
Clarinet® Syrup §
Clarinet Reditabs® §
Zyrtec® (cetirizine) §
Zyrtec-D® §
Zyrtec® Chewable Tablets §
Zyrtec® Syrup § (age ≥ 12 years)
*All other branded
Antihistamine/decongestant
combinations*

Pulmonary: Persistent Asthma

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

Therapy specific clinical criteria are available on the OVHA website.

NO PA REQUIRED

PA REQUIRED

Xolair® (omalizumab)

PDL Key:

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Pulmonary: Beta-adrenergic Agents

Length of Authorization: 5 years

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

NO PA REQUIRED

METERED-DOSE INHALERS (SHORT-ACTING)

XOPENEX HFA[®] (levalbuterol)

METERED-DOSE INHALERS (LONG-ACTING)

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

NEBULIZER SOLUTIONS

ACCUNEB[®]
ALBUTEROL NEBS[†]
METAPROTERENOL[†] (compare to Alupent[®])
XOPENEX[®] neb solution (levalbuterol HCL) (age ≤ 12 yrs)

TABLETS/SYRUP (SHORT-ACTING)

TERBUTALINE[†] tablets (compare to Brethine[®])
ALBUTEROL tablets/syrup
METAPROTERENOL tablets/syrup

TABLETS (LONG-ACTING)

ALBUTEROL ER tablets

PA REQUIRED

♣albuterol MDI[†]
Alupent[®] (metaproterenol)
Maxair[™] Autohaler (pirbuterol)
♣Proair[®] (albuterol)
♣Proventil HFA[®] (albuterol)
♣Ventolin HFA[®] (albuterol)

♣ coverage grandfathered for current users

Foradil[®] (formoterol)

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

Brethine^{®*} (terbutaline)

Vospire ER[®] (albuterol)

Pulmonary: Inhaled Glucocorticoids/Glucocorticoid Combinations

Length of Authorization: 5 years

NO PA REQUIRED

ADVAIR[®] (fluticasone/salmeterol)
ADVAIR[®] HFA (fluticasone/salmeterol)
ASMANEX[®] (mometasone furoate)
AZMACORT[®] (triamcinolone acetonide)
FLOVENT[®] HFA (fluticasone propionate)
PULMICORT RESPULES[®] (budesonide) (age ≤ 12 yrs)
QVAR[®] (beclomethasone)

PA REQUIRED

AeroBid[®] (flunisolide) §
AeroBid-M[®] §
Pulmicort (budesonide) Respules[®] (age > 12 yrs)
Pulmicort Turbuhaler[®] §

PDL Key:

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Pulmonary: Nasal Glucocorticoids

Length of Authorization: 5 years

NO PA REQUIRED

FLONASE[®] (fluticasone propionate)
FLUNISOLIDE† (compare to Nasalide[®])
NASACORT AQ[®] (triamcinolone AQ)
NASONEX[®] (mometasone)

PA REQUIRED

Beconase AQ[®] (beclomethasone AQ) Nasarel[®] (flunisolide)
Fluticasone† (compare to Flonase[®]) Rhinocort AQ[®] (budesonide AQ)
Nasacort HFA[®] (triamcinolone HFA)

Pulmonary: Systemic Glucocorticoids

Length of Authorization: 1 year

NO PA REQUIRED

CORTISONE ACETATE†
DEXAMETHASONE† (compare to Decadron[®])
HYDROCORTISONE†
METHYLPREDNISOLONE† (compare to Medrol[®])
ORAPRED[®] (prednisolone sod phosphate) (age < 12 yrs)
PREDNISOLONE† tabs / liquid (compare to Prelone[®])
PREDNISONE† (compare to Deltasone)

PA REQUIRED

Aristocort^{®*} Orapred[®] (age ≥ 12 yrs)
Celestone^{®*} Pediapred^{®*}
Cortef[®] Prelone^{®*}
Decadron^{®*} Any dose packaging (i.e.: Dosepak)
Deltasone^{®*}
Kenalog^{®*}
Medrol^{®*}

Pulmonary: Leukotriene Modifiers

NO PA REQUIRED

ACCOLATE[®] (zafirlukast)
SINGULAIR[®] (montelukast sodium)

PA REQUIRED

ZyFlo[®] (zileuton)

Pulmonary: RSV Prevention

Length of Authorization: 1 season, 6 doses (October 1-April 15)

NO PA REQUIRED

PA REQUIRED: Therapy specific PA fax form is available on the OVHA website
SYNAGIS[®] (palivizumab)

Renal Disease: Phosphate Binders

NO PA REQUIRED

FOSRENOL[®] (lanthanum carbonate)
PHOS LO[®] (calcium acetate)
RENAGEL[®] (sevelamer)

PA REQUIRED

Retinoids: Topical

Length of Authorization: 6 months maximum

NO PA REQUIRED (age > 10 and age < 34)

AVAGE CREAM[®] (tazarotene)
AVITA[®] (tretinoin)
DIFFERIN[®] (adapalene)
RENOVA[®] (tretinoin)
RETIN-A[®] (tretinoin)
SOLAGÉ[®] (mequinol-tretinoin)
TAZORAC[®] (tazarotene)
TRETINOIN † (compare to Retin-A)

PA REQUIRED (age < 10 or age > 34)

Avage Cream[®]
Avita[®]
Differin[®]
Renova[®]
Retin-A[®]
Solagé[®]
Tazorac[®]

PDL Key:

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Rheumatoid Arthritis: Immunomodulators

Length of Authorization: initial 3 months, re-evaluate every 12 months

Monthly quantity limits apply

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

PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

HUMIRA® (adalimumab) QL = 2 syringes/month
ENBREL® (etanercept) QL = 8 doses/month

NON-PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

Kineret® QL = 28 syringes/month

Sedative/Hypnotics

Length of Authorization: 1 year

NO PA REQUIRED

CHLORAL HYDRATE† syrup, suppository
ESTAZOLAM† (compare to Prosom®)
FLURAZEPAM† (compare to Dalmane®)
TEMAZEPAM† (compare to Restoril®)

LUNESTA® (eszopiclone) (Quantity Limit = 1 tab/day)

PA REQUIRED

Benzodiazepine

Dalmane®*
Doral® (quazepam)
Prosom®*
Restoril®*
Somnote®
Triazolam and Halcion®

Non-benzodiazepine

Ambien® / Ambien CR® (zolpidem) (Quantity Limit = 1 tab/day)
Rozerem® (ramelteon) (Quantity Limit = 1 tab/day)
Sonata® (zaleplon)

Skeletal Muscle Relaxants

Length of Authorization: 1 year

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

NO PA REQUIRED

CHLORZOXAZONE† (compare to Parafon Forte DSC®)
CYCLOBENZAPRINE† (compare to Flexeril®)
METHOCARBAMOL† (compare to Robaxin®)
METHOCARBAMOL, ASA† (compare to Robaxisal®)
ORPHENADRINE CITRATE† (compare to Norflex®)
ORPHENADRINE, ASA, CAFFEINE† (compare to Norgesic®, Norgesic Forte®)

ASA = aspirin

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

PA REQUIRED

Musculoskeletal Agents

carisoprodol †
carisoprodol, ASA†
carisoprodol, ASA, codeine †
Flexeril®*
Norflex®*
Norgesic®*
Norgesic Forte®*
Parafon Forte DSC®*
Robaxin®*
Robaxisal®*
Skelaxin®
Soma®
Soma Compound®
Soma Compound with Codeine®

Antispasticity Agents

Dantrium®*
Lioresal®*
Zanaflex®*

PDL Key:

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Urinary Antispasmodics

Length of Authorization: 1 year

NO PA REQUIRED*

SHORT-ACTING AGENTS

OXYBUTYNIN† (compare to Ditropan®)

LONG-ACTING AGENTS

DITROPAN XL® (oxybutynin XL)

ENABLEX® (darifenacin)

VESICARE® (solifenacin)

>NOTE:

- *Patients under the age of 65 must fail an adequate trial of generic oxybutynin before approval will be granted for either Ditropan XL®, Vesicare® or Enablex®.*
- *A therapeutic failure on at least two preferred products is required before a PA will be approved on any non-preferred medication, regardless of patient age.*

*Recipients < 21 years of age are exempt from all PA Requirements.
(Exception: An adequate trial of Ditropan XL will be required before approval of oxybutynin XL will be granted)*

PA REQUIRED

Ditropan®*

Detrol® (tolterodine)

Detrol LA® (tolterodine LA)

Oxybutynin XL†

Oxytrol® (oxybutynin transdermal)

Sanctura® (trospium)

Urispas® (flavoxate)

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