

Phone Numbers for Vermont 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.

MHP Program Rep-Vermont:

Assistance with any issues related to the PBM program.

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Acne Drugs: Oral
Length of Authorization: 1 year

NO PA REQUIRED

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

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

MINOCYCLINE† 50 mg, 75 mg, 100 mg

TETRACYCLINE† 250 mg, 500 mg cap
SUMYCIN† 250 mg, 500 mg cap

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

PA REQUIRED

All brands:
Adoxa®* (doxycycline monohydrate) 50 mg, 100 mg tab
Doryx®* (doxycycline hyclate) 75 mg, 100 mg cap
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

E.E.S.®* (erythromycin ethylsuccinate)
Eryc®* (erythromycin base, delayed release)
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
Solodyn® (minocycline) 45 mg, 90 mg, 135 mg tabs
All other brands

Sumycin® (tetracycline) 250 mg, 500 mg tab
Sumycin® (tetracycline) 125 mg/5ml syrup
All other brands

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

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)

Acne Drugs: Topical Anti-Infectives

Length of Authorization: 1 year

NO PA REQUIRED

BENZOYL PEROXIDE PRODUCTS

BENZOYL PEROXIDE 2.5%, 5%, 10% *G, L, W*; 10% *C*; 3%, 5%, 6%, 8%, 9%, 10% *L*; 3%, 6%, 9% *P* †

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* †

OTHER

PA REQUIRED

Benzac AC® 2.5%, 5%, 10% *G, W*
Benzashave® 5%, 10% *C*
Brevoxyl® 4%, 8% *W*; 4% *G*; 4%, 8% *L*
Clinac BPO® 7% *G*
Desquam-E/X® 2.5%, 5%, 10% *G*; 5%, 10% *W*
Inova 4% *P*
Panoxyl/AQ 2.5%, 5%, 10% *G*; 5%, 10% *B*
Triaz® 3%, 6%, 9% *G*; 3%, 6%, 9% *P*
Zaclir® 4%, 8% *L*
All other brands

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

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

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

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

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

Azelex® (azelaic acid 20% *C*)
All other brands any topical acne anti-infective medication

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

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Acne Drugs: Topical - Retinoids

Length of Authorization: 1 year

NO PA REQUIRED

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

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

C=cream, G=gel

PA REQUIRED

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

Differin® (adapalene) 0.1% C, 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/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 and Fentora® Buccal

Length of Authorization: 3 months

NO PA REQUIRED

PA REQUIRED

Actiq® (fentanyl lozenge on a stick: 200 mcg, 400 mcg, 600 mcg, 800 mcg, 1200 mcg, 1600 mcg)

Fentora® (fentanyl citrate buccal tablets)

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Analgesics: COX-2 Inhibitors

Length of Authorization: 1 year

NO PA REQUIRED

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

PA REQUIRED

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

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

PA REQUIRED

Acetaminophen w/ codeine: *all branded products*
Acetaminophen w/ hydrocodone: *all branded products*
Acetaminophen w/ oxycodone: *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^{®*}
Liquicet^{®*} (hydrocodone w/acetaminophen)
Lorcet^{®*} (also HD, PLUS)
Lortab^{®*}
Magnacet[®]
Maxidone[®]
Meperidine (*Qty > 30 tabs or 5 day supply*)
Nalbuphine
Norco^{®*}
Nubain^{®*}
Numorphan[®]
Opana[®]
Oxyfast^{®*}
OxyIR^{®*}
Panlor DC^{®*}
Pentazocine and Naloxone
Percocet^{®*}
Percodan^{®*}
Propoxyphene: *all branded products**
Roxanol^{®*}
Stadol[®] (*authorization limited to 2 units/month*)
Synalgos DC^{®*}
Talacen^{®*}
continued on next page

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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

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*)

Fentanyl Patch[†] (compare to Duragesic) 12.5 mcg/hr (*QL=15 patches/30 days*)

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

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

Opana ER[®] (*QL=60 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
Quantity limits apply

NO PA REQUIRED

PA REQUIRED

Stadol® (butorphanol) Nasal Solution: all forms brand & generic
(QL = 2 units/month)

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

NO PA REQUIRED

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

PA REQUIRED

Epogen® (epoetin alpha)

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

Therapy-specific PA fax form available on OVHA website.

PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

ENBREL® (etanercept)
 HUMIRA® (adalimumab)

NON-PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

Remicade® (infliximab)

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Anti-anxiety: Anxiolytics

Length of Authorization: 1 year

NO PA REQUIRED

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®

Anticoagulants

Length of Authorization: 6 months

Quantity limits apply

NO PA REQUIRED

WARFARIN (compare to Coumadin®)

HEPARIN

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

PA REQUIRED

Coumadin® (warfarin)

n/a

Fragmin® (dalteparin)
Innohep® (tinzaparin)

Anticonvulsants

Length of Authorization: lifetime

NO PA REQUIRED

CARBAMAZEPINE† (compare to Tegretol®)
CARBATROL® (carbamazepine)
CELONTIN® (methsuxamide)
DEPAKOTE® (divalproex sodium)
DEPAKOTE ER® (divalproex sodium)
DIASTAT® (diazepam rectal gel)
DILANTIN® (phenytoin)
EPITOL† (carbamazepine)
ETHOSUXAMIDE† (compare to Zaronin®)
FELBATOL® (felbamate)
GABAPENTIN† (compare to Neurontin®)
GABITRIL® (tiagabine)
KEPPRA® (levetiracetam)
LAMICTAL® tabs (lamotrigine tabs)
LAMICTAL® chew tabs (lamotrigine chew tabs)
NEURONTIN® oral solution (gabapentin)
PEGANONE® (ethotoin)
PHENYTEK® (phenytoin)
PHENYTOIN† (compare to Dilantin®)
PRIMIDONE† (compare to Mysoline®)
TEGRETOL XR® (carbamazepine)
TOPAMAX® (topiramate)
TRILEPTAL® (oxcarbazepine)
VALPROIC ACID† (compare to Depakene®)
ZONISIMIDE† (compare to Zonegran®)

PA REQUIRED

Depakene®* (valproic acid)
Gabarone® (gabapentin)
lamotrigine† chew tabs (compare to Lamictal® chew tabs)
Lyrica® (pregabalin) § (*Quantity Limit = 3 capsules/day*)
Mysoline®* (primidone)
Neurontin®* (gabapentin)
Tegretol®* (carbamazepine)
Zaronin®* (ethosuxamide)
Zonegran®* (zonisamide)

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Anti-depressants: Novel
Length of Authorization: Duration of Need
Quantity limits apply
Suggested daily dosage limits

NO PA REQUIRED

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

PA REQUIRED

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

Anti-depressants: SSRIs
Length of Authorization: Duration of Need
Quantity limits apply
Suggested daily dosage limits

NO PA REQUIRED

CITALOPRAM† (compare to Celexa®) *suggested max dose = 75 mg/day*
 FLUOXETINE† (compare to Prozac®) *suggested max dose = 100 mg/day*
 FLUVOXAMINE† (compare to Luvox®) *suggested max dose = 300 mg/day*
 PAROXETINE HCL† (compare to Paxil®) *suggested max dose = 75 mg/day*
 SERTRALINE† (compare to Zoloft®) *suggested max dose = 250 mg/day, QL = 1.5 tabs/day (25 mg & 50 mg tabs)*

PA REQUIRED

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

Anti-depressants: Tricyclics
Length of Authorization: Duration of Need
Suggested daily dosage limits

NO PA REQUIRED

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

PA REQUIRED

Anafranil®*
 Aventyl®*
 Elavil®*
 Limbitrol®*
 Limbitrol DS®
 Norpramin®*
 Pamelor®*
 Sinequan®*
 Surmontil®*
 Tofranil®*

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Anti-depressants: MAO Inhibitors
Length of Authorization: Duration of Need
 Quantity limits apply
 Suggested daily dosage limits

NO PA REQUIRED

NARDIL® (phenylzine) *suggested max dose = 110 mg/day*
 TRANYLCPROMINE† (compare to Parnate®) *suggested max dose = 120 mg/day*

PA REQUIRED

EMSAM® (selegiline) (*QL = 1 patch/day*)
 Marplan® (isocarboxazid)
 Parnate®*

Anti-diabetics: Alpha-Glucosidase Inhibitors
Length of Authorization: n/a

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®)
 RIOMET® (metformin oral solution)

PA REQUIRED

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

Anti-diabetics: Peptide Hormones
Length of Authorization: 1 year
 Quantity limits apply

PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

Byetta® (exenatide) § (*Quantity Limit = 1 pen/30 days*)

PA REQUIRED

Symlin® (pramlintide) *No Quantity Limit*

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Anti-diabetics: Insulins
Length of Authorization: lifetime

NO PA REQUIRED

RAPID-ACTING INJECTABLE

NOVOLOG[®] (Aspart)

SHORT-ACTING INJECTABLE

NOVOLIN R[®] (Regular)

RELION R[®] (Regular)

INTERMEDIATE-ACTING INJECTABLE

NOVOLIN N[®] (NPH)

RELION N[®] (NPH)

LONG-ACTING ANALOGS INJECTABLE

LANTUS[®] (insulin glargine)

LEVEMIR[®] (insulin detemir)

MIXED INSULINS INJECTABLE

HUMULIN 50/50[®] (NPH/Regular)

NOVOLIN 70/30[®] (NPH/Regular)

RELION 70/30[®] (NPH/Regular)

NOVOLOG MIX 70/30[®] (Protamine/Aspart)

HUMALOG MIX 50/50[®] (Protamine/Lispro)

HUMALOG MIX 75/25[®] (Protamine/Lispro)

INHALED

PA REQUIRED

Apidra[®] (insulin glulisine)

Humalog[®] (insulin lispro)

Humulin R[®] (Regular)

Humulin N[®] (NPH)

Humulin 70/30[®] (NPH/Regular)

Exubera[®] (insulin human [rDNA] Inhalation Powder)

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^{®**}

PDL Key:

[†] Generic product

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Anti-diabetic: Thiazolidinediones & Combinations

Length of Authorization: 1 year

NO PA REQUIRED

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

PA REQUIRED

Duetact® (pioglitazone/glimepiride)

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

Length of Authorization: 1 year

Quantity limits apply

NO PA REQUIRED

PA REQUIRED

Januvia® (sitagliptin) § (*Quantity Limit = 1 tablet/day*)
Janumet® (sitagliptin/metformin) § (*Quantity Limit = 2 tablets/day*)

Anti-emetics: NK1/5HT3 Antagonists

*Length of Authorization: 6 months 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)
ONDANSETRON† Injection (vial and premix)
ZOFRAN® (ondansetron) 24 mg (1 tab), 8 mg (6 tabs), 4 mg (12 tabs)
ZOFRAN (ondansetron) ODT® 4 mg (12 tabs), 8 mg (6 tabs)
ZOFRAN® (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 oral forms – quantity limits apply
Zofran** Injection

Anti-emetics: Other

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

Quantity limits apply

NO PA REQUIRED

PA REQUIRED

Marinol® (dronabinol) (*Quantity Limit = 30 days supply for AIDS anorexia or quantity required for one chemotherapy treatment course*)

Cesamet® (nabilone) (*Quantity Limit = quantity required for one chemotherapy treatment course*)

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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

Quantity limits apply

NO PA REQUIRED

SHORT/INTERMEDIATE ACTING METHYLPHENIDATE PREPS

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

PA REQUIRED

Focalin® (dexamethylphenidate)
Ritalin®*
Ritalin SR®*

LONG-ACTING METHYLPHENIDATE PREPS

FOCALIN® XR (dexamethylphenidate 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) (QL = 1 patch/day)

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 = 100 mg/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®*
Aceaon® (perindopril)
Altace® (ramipril)
Capoten®*
Lotensin®*
Mavik® (trandolapril)
Monopril®*
Prinivil®*
trandolapril† (compare to Mavik®)
Univasc® (moexipril)
Vasotec®*
Zestril®*

Anti-hypertensives: ACE Inhibitor with Hydrochlorothiazide

Length of Authorization: 1 year

NO PA REQUIRED

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

PA REQUIRED

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

PDL Key:

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Anti-hypertensives: ACE Inhibitor w/Calcium Channel Blocker

Length of Authorization: 1 year

NO PA REQUIRED

LOTREL[®] (benazepril/amlodipine)
TARKA[®] (trandolopril/verapamil)

PA REQUIRED

Lexxel[®] (enalapril/felodipine)
benazepril/amlodipine † (compare to Lotrel[®])

Anti-hypertensives: Angiotensin Receptor Blockers (ARBs)

Length of Authorization: lifetime

PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

BENICAR[®] (olmesartan) §
COZAAR[®] (losartan) §
DIOVAN[®] (valsartan) §
MICARDIS[®] (telmisartan) §

NON- PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

Atacand[®] (candesartan) §
Avapro[®] (irbesartan) §
Teveten[®] (eprosartan) §

Anti-hypertensives: Angiotensin Receptor Blockers/Hydrochlorothiazide Combinations

Length of Authorization: lifetime

PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

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) §
Avalide[®] (irbesartan/hydrochlorothiazide) §
Teveten HCT[®] (eprosartan/hydrochlorothiazide) §

Anti-hypertensives: Beta Blockers

Length of Authorization: 5 years

NO PA REQUIRED

ACEBUTOLOL † (compare to Sectral[®])
ATENOLOL † (compare to Tenormin[®])
ATENOLOL/CHLORTHALIDONE † (compare to Tenoretic[®])
BETAXOLOL † (compare to Kerlone[®])
BISOPROLOL FUMARATE † (compare to Zebeta[®])
BISOPROLOL/HYDROCHLOROTHIAZIDE † (compare to Ziac[®])
COREG[®] (carvedilol)
LABETALOL † (compare to Normodyne[®], Trandate[®])
METOPROLOL † (compare to Lopressor[®])
METOPROLOL/HYDROCHLOROTHIAZIDE † (compare to Lopressor HCT[®])
NADOLOL † (compare to Corgard[®])
PINDOLOL † (compare to Viskin[®])
PROPRANOLOL † (compare to Inderal[®])
PROPRANOLOL/HYDROCHLOROTHIAZIDE † (compare to Inderide[®])
SOTALOL † (compare to Betapace[®], Betapace AF[®])
TIMOLOL † (compare to Blocadren[®])

PA REQUIRED

Betapace^{®*}
Betapace AF^{®*}
Blocadren^{®*}
Cartrol[®]
Corgard[®]
Corzide[®]
Inderal^{®*} (all products)
Inderal LA[®]
Inderide^{®*}
Innopran XL[®]
Kerlone^{®*}
LevatoI[®] (penbutolol)
Lopressor^{®*} (all products)
Lopressor HCT^{®*}
propranolol ER † (compare to
Inderal LA[®])

Sectral^{®*}
Tenoretic^{®*}
Tenormin^{®*}
Timolide[®]
Toprol XL[®] (metoprolol succinate)
Trandate^{®*}
Ziac^{®*}
Zebeta^{®*}

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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*
amlodipine[†] (compare to Norvasc[®])
Caduet[®] (amlodipine/atorvastatin)
Calan[®]*
Calan[®] SR*
Cardene[®]*
Cardene[®] SR*
Cardizem[®]*, all: CD, LA, SR
Covera-HS[®]*
Dilacor[®] XR*
Dynacirc[®]
Dynacirc CR[®]
Isoptin[®]*
Isoptin[®] SR*
nimodipine[†] (compare to Nimotop[®])
Plendil[®]*
Procardia[®]
Procardia[®] XL*
Tiazac[®]*
Vasacor[®]
Verelan[®]*
Verelan PM[®]

Anti-infectives: Cephalosporins – 1st Generation

Length of Authorization: for date of service, no refills

NO PA REQUIRED

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

IV drugs are not managed at this time

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

IV drugs are not managed at this time

PA REQUIRED

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

PDL Key:

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Anti-infectives: Cephalosporins – 3rd Generation

Length of Authorization: for date of service, no refills

NO PA REQUIRED

CEDAX[®] (ceftibuten)
CEFPODOXIME PROXETIL TABS† (compare to Vantin[®])
OMNICEF[®] (cefdinir)
SUPRAX[®] (cefixime)

IV drugs are not managed at this time

PA REQUIRED

cefdinir †
cefepodoxime proxetil† (compare to Vantin[®]) suspension
Spectracef[®] (cefditoren)
Vantin^{®*} (cefepodoxime) tabs, suspension

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 base, delayed release)
ERYTHROCIN† (erythromycin stearate)
ERYTHROMYCIN BASE†
ERYTHROMYCIN ESTOLATE†
ERYTHROMYCIN ETHYLSUCCINATE† (compare to E.E.S.[®], Eryped[®])
ERYTHROMYCIN STEARATE†
ERYTHROMYCIN W/ SULFASOXAZOLE† (compare to Pediazole[®])

IV drugs are not managed at this time

PA REQUIRED

azithromycin† tablets and liquid (if > 5 day supply)
Biaxin^{®*}
Biaxin XL[®]
Dynabac[®] (dirithromycin)
E.E.S.^{®**}
Eryc^{®*} (erythromycin base, delayed release)
Eryped[®] (erythromycin ethylsuccinate)
Pediazole^{®**} (erythromycin-sulfisoxazole)
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

PDL Key:

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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

IV drugs are not managed at this time

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)
ciprofloxacin ER† 500 mg, 1000 mg (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)

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 tablets/month*
PENLAC® Nail Lacquer (ciclopirox) *QL = 6.6 ml/90 days*

NON-PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

Sporanox® (itraconazole) *QL = 28 capsules/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: Genital Antivirals

Length of Authorization: 1 month

NO PA REQUIRED

ALDARA® (imiquimod)
CONDYLOX® GEL (podofilox gel)
PODOFILOX SOLUTION† (compare to Condylox®)

PA REQUIRED

Condylox®* solution (podofilox solution)

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)

PDL Key:

† Generic product

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automatically screened for upon claims processing)

Anti-infectives: Influenza Vaccines*Length of Authorization: for date of service only***NO PA REQUIRED**

FLUARIX[®] Injection
 FLUZONE[®] Injection
 FLUVIRIN[®] Injection

PA REQUIRED

FluMist[®] Nasal

Anti-infectives: Miscellaneous*Length of Authorization: 1 year***NO PA REQUIRED****PA REQUIRED**

Quaalun[®] (quinine sulfate)

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**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 inj.*)
 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)

PDL Key:

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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

benzphetamine† (all forms brand & generic)
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

Quantity limits apply

Suggested daily dosage limits

NO PA REQUIRED

CLOZAPINE† (compare to Clozaril®) *suggested max dose = 1125 mg/day*

GEODON® (ziprasidone) *suggested max dose = 200 mg/day*

RISPERDAL® (risperidone) *suggested max dose = 10 mg/day*

SEROQUEL® (quetiapine) *suggested max dose = 1000 mg/day*

RISPERDAL® (risperidone) oral solution *suggested max dose=10 mg/day*

GEODON IM® (ziprasidone Injectable)

PA REQUIRED

Abilify® (aripiprazole) *suggested max dose = 40 mg/day, QL = 1.5 tabs/day (5 mg, 10 mg & 15 mg tabs)*

Clozaril®* *suggested max dose = 1125 mg/day*

Invega® (paliperidone) *QL = 1 tab/day (3mg, 9mg), 2 tabs/day (6mg)*

Zyprexa® (olanzapine) *suggested max dose = 50 mg/day, QL = 1.5 tabs/day (2.5 mg, 5 mg, 7.5 mg, & 10 mg tabs)*

Abilify® (aripiprazole) oral solution *suggested max dose = 40 mg/day*

Abilify® IM (aripiprazole intramuscular injection)

Zyprexa® IM (olanzapine intramuscular injection)

Risperdal Consta® (risperidone microspheres)

Abilify Discmelt (aripiprazole) *suggested max dose = 40 mg/day, Quantity limit = 1.5 tabs/day (5 mg, 10 mg & 15 mg tabs)*

Fazaclor® (clozapine orally disintegrating tablet) *suggested max dose = 1125 mg/day*

Risperdal M-Tab® (risperidone orally disintegrating tablet) *suggested max dose = 10 mg/day*

Zyprexa Zydis® (olanzapine orally disintegrating tablet) *suggested max dose = 50 mg/day, QL = 1.5 tabs/day (5 mg & 10 mg tabs)*

Symbyax® (olanzapine/fluoxetine)

PDL Key:

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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®*

Botulinum toxins

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

NO PA REQUIRED

PA REQUIRED

Botox®
Botox® Cosmetic
Myobloc®

BPH: Alpha Blockers

Length of Authorization: 1 year

NO PA REQUIRED

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

PDL Key:

† Generic product

* Indicates a generic equivalent is available without PA

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

Chemical Dependency: Alcohol and Opiate Dependency

Length of Authorization: 1 year

Special training and DEA number required for prescribers of Buprenorphine

Quantity limits apply

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

NO PA REQUIRED

Alcohol Dependency

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

Opiate Dependency

NALTREXONE oral † (compare to Revia[®])

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

PA REQUIRED

Revia^{®*} (naltrexone oral)

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

Revia^{®*} (naltrexone oral)

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

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

Constipation: Chronic

Length of Authorization: 3 months

NO PA REQUIRED

Bulk-Producing Laxatives

PSYLLIUM†

Osmotic Laxatives

LACTULOSE†

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

PA REQUIRED

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

Coronary Vasodilators/Antianginals: Oral

Length of Authorization: 3 years

Quantity limits apply

NO PA REQUIRED

ISOSORBIDE DINITRATE† (compare to Isordil[®])

ISOSORBIDE MONONITRATE† (compare to Imdur[®], Ismo[®], Monoket[®])

NITROGLYCERIN

NITROLINGUAL SPRAY

NITROQUICK[®]

NITROSTAT[®]

NITRO-TIME[®]

PA REQUIRED

BiDil[®]

Dilatrate-SR[®]

Imdur^{®*}

Ismo^{®*}

Isordil^{®*}

Monoket^{®*}

Ranexa[®] (ranolazine) (*Quantity Limit = 4 tablets/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^{®*}

PDL Key:

† Generic product

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Gastrointestinal: Crohn's Disease Injectables

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

Therapy-specific PA fax form available on OVHA website.

PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

HUMIRA® (adalimumab)

NON-PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

Remicade® (infliximab)

Gastrointestinals: H2-blockers

Length of Authorization: 1 year

NO PA REQUIRED

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

PA REQUIRED

Axid® §
nizatadine †§
Pepcid®* §
ranitidine† syrup
Tagamet®* §
Zantac®/Zantac Effervescent® §

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 < 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) (*Quantity Limit=1 tablet/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) capsules § *Qty Limit=1 capsule/day*
Nexium® (esomeprazole) powder for suspension § (*Qty limit=1 packet/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*

Gastrointestinal: Ulcerative Colitis Injectables

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

Therapy-specific PA fax form available on OVHA website.

NO PA REQUIRED

PA REQUIRED

Remicade® (infliximab)

PDL Key:

† Generic product

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Glucocorticoids: Topical

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

NO PA REQUIRED

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

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

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®)

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

PA REQUIRED

Low Potency

Aclovate®*
Cortaid®*
Desonate® gel (desonide)
Desowen®*
Hytone®*
Synalar®* (all products)
Tridesilon®*
All other brands

Medium Potency

Aristocort®*
Cloderm® (clocortolone)
Cordran®* (all products)
Cutivate®*
Dermatop®
Diprosone®*
Elocon®* (all products)
Kenalog® (all products)
Locoid®
Luxiq Foam®
prednicarbate† (compare to Dermatop®)
Synalar®* (all products)
Topicort®* (all products)
Westcort®* (all products)
All other brands

High Potency

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

Very High Potency

Cormax®
Diprolene®* (all products)
Embeline E®*
Olux®/Olux E®
Psorcon®*
Temovate®* (all products)
Ultravate®* (all products)
All other brands

PDL Key:

† Generic product

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Growth Stimulating Agents

Length of Authorization: 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)

Hepatitis C Agents

Length of Authorization: 6 months

Therapy specific PA form is available on OVHA website.

PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

RIBAVIRIN
RIBAVIRIN[†]

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[®]
Ribasphere[®]
Rebetol[®]

INTERFERON

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

COMBINATION

Rebetron[®] (Rebetol/Intron-A)

Hunter's Syndrome Injectables

Length of Authorization: 1 year

Quantity limits apply

NO PA REQUIRED

PA REQUIRED

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

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)

PDL Key:

[†] Generic product

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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

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

Altprev[®] (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 Vytolin[®] is required.

ADVICOR[®] (lovastatin/niacin)

PA REQUIRED

Miscellaneous

Omacor[®] (omega-3-acid ethyl esters)

Cholesterol Absorption Inhibitors/Combinations

Other Statin Combinations

Caduet[®] (atorvastatin/amlodipine)

Mood Stabilizers (see also Anticonvulsants)

Length of Authorization: duration of need

NO PA REQUIRED

EQUETRO[®] (carbamazepine)
LITHIUM CARBONATE † (compare to Eskalith[®])
LITHIUM CARBONATE SR † (compare to Eskalith CR[®], Lithobid[®])
LITHIUM CITRATE SYRUP †

PA REQUIRED

Eskalith CR[®]* (lithium carbonate SR)
Lithobid[®]* (lithium carbonate SR)

PDL Key:

† Generic product

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Multiple Sclerosis: Injectables

Length of Authorization: 5 years

Quantity limits apply

NO PA REQUIRED

BETASERON[®] (interferon B-1b)
COPAXONE[®] (glatiramer acetate) (QL = 1 kit/30 days)
REBIF[®] (interferon B-1a)

PA REQUIRED

Avonex[®] (interferon B-1a)

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[®]*

PDL Key:

† Generic product

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Ophthalmics: Mast Cell Stabilizers

Length of Authorization: 6 months

NO PA REQUIRED

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

PA REQUIRED

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

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

Length of Authorization: 1 year

NO PA REQUIRED

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

PA REQUIRED

Nevanac[®] ophthalmic susp. (nepafenac 0.1%)
Xibrom[®] ophthalmic sol. (bromfenac 0.09%)
Ocufer^{®*} ophthalmic sol. (flurbiprofen 0.03%)
Voltaren[®] (diclofenac 0.1% ophthalmic sol.)

Ophthalmics: Quinolone Anti-infectives

Length of Authorization: for date of service, no refills

NO PA REQUIRED

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

PA REQUIRED

Ciloxan^{®*}
Ocuflor^{®*}
Quixin[®] (levofloxacin)
Vigamox[®] (moxifloxacin)
Zymar[®] (gatifloxacin)

Ossification Enhancers

Length of Authorization: lifetime

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)

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

Otic: Anti-Infectives

Length of Authorization: 1 year

NO PA REQUIRED

CIPRODEX[®] (ciprofloxacin 0.3%/dexamethasone 0.1%; otic susp.)

FLOXIN[®] (ofloxacin 0.3%; otic soln.)

NEOMYCIN/POLYMYXIN B SULFATE/HYDROCORTISONE †

PA REQUIRED

Cipro-HC[®] (ciprofloxacin 0.2%/hydrocortisone 1%; otic susp.)

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

Cortisporin otic[®]/Pediatic^{®*} (neomycin/polymyxin B sulfate /hydrocortisone)
otic solution/sus

PDL Key:

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Parkinson's: Non-Ergot Dopamine Receptor Agonist

Length of Authorization: 1 year

Quantity limits apply

NO PA REQUIRED

DOPAMINE PRECURSOR

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

DOPAMINE AGONISTS

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

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

Symmetrel® (amantadine)

Phosphodiesterase-5 (PDE-5) Inhibitors

Length of Authorization: 1 year

Quantity limits apply

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

PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

NON-PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

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

Platelet Inhibitors

Length of Authorization: 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®*

PDL Key:

† Generic product

* Indicates a generic equivalent is available without PA

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

Psoriasis Injectables

Length of Authorization: initial PA of 3 months, 12 months thereafter.

Quantity limits apply

Therapy-specific PA fax form available on OVHA website.

PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

ENBREL[®] (etanercept)
RAPTIVA[®] (efalizumab)

NON-PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

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

Psoriasis: Non-Biologics

Length of Authorization: 1 year

Quantity limits apply

NO PA REQUIRED

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

DOVONEX[®] (calcipotriene cream)
PSORiatec[®], DRITHO-SCALP[®] (anthralin cream)
TAZORAC[®] (tazarotene cream)

PA REQUIRED

Oral

Topical

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

Pulmonary: Anticholinergics, Inhaled

Length of Authorization: n/a

NO PA REQUIRED

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

PA REQUIRED

Pulmonary: Antihistamines-1st Generation

Length of Authorization: 1 year

NO PA REQUIRED

All generic antihistamines

All generic antihistamine/decongestant combinations

PA REQUIRED

All brand antihistamines (example: Benadryl[®])

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

PDL Key:

† Generic product

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Pulmonary: Antihistamines-2nd Generation

Length of Authorization: 1 year

NO PA REQUIRED

LORATADINE (OTC) †

FEXOFENADINE § (after 15-day loratadine trial and failure w/in last 30 days)

LORATADINE/D (OTC) †

LORATADINE (OTC) † syrup
ZYRTEC® (cetirizine) SYRUP (age <12 yrs)

LORATADINE (OTC) † chewable tablets

PA REQUIRED

Allegra® (fexofenadine) §
Clarinetx® (desloratadine) §
Claritin® §
Zyrtec® (cetirizine) §

Allegra-D® § (12 HR & 24 HR)
Clarinetx-D® § (12 HR & 24 HR)
Claritin-D® §
Zyrtec-D® §

Allegra® suspension §
Clarinetx® Syrup §
Claritin Syrup®*§
Zyrtec Syrup® (age ≥ 12 yrs) §

Clarinetx Reditabs® §
Claritin Reditabs®*§
Zyrtec® Chewable Tablets §

Pulmonary: Persistent Asthma

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

Therapy specific clinical criteria are available on the OVHA website.

NO PA REQUIRED

PA REQUIRED

Xolair® (omalizumab)

PDL Key:

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

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

QVAR[®] (beclomethasone)

PA REQUIRED

AeroBid[®] (flunisolide) §

AeroBid-M[®] §

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

Pulmicort Flexhaler[®] §

Pulmicort Turbuhaler[®] §

PDL Key:

[†] Generic product

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

Pulmonary: Leukotriene Modifiers

Length of Authorization: 1 year

NO PA REQUIRED

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

PA REQUIRED

ZyFlo[®] (zileuton) §

Pulmonary: RSV Prevention

Length of Authorization: 1 season, 6 doses (November 1-April 30)

Quantity limits apply

NO PA REQUIRED

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

Renal Disease: Phosphate Binders

Length of Authorization: n/a

NO PA REQUIRED

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

PA REQUIRED

Rheumatoid & Psoriatic Arthritis: Immunomodulators

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

Quantity limits apply

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

PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

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

NON-PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

Kineret[®] (anakinra)
Orencia[®] (abatacept)
Remicade[®] (infliximab)

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Saliva Stimulants

Length of Authorization: 1 year

NO PA REQUIRED

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

PA REQUIRED

Salagen^{®*} (pilocarpine)

Sedative/Hypnotics

Length of Authorization: 1 year

Quantity limits apply

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*)
ZOLPIDEM † (compare to Ambien[®])(*Quantity Limit = 1 tab/day*)

PA REQUIRED

Benzodiazepine

Dalmane^{®*}
Doral[®] (quazepam)
Prosom^{®*}
Restoril^{®*}
Somnote[®]
triazolam† and Halcion[®]

Non-benzodiazepine

Ambien^{®*} (zolpidem) (*Quantity Limit = 1 tab/day*)
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 Robaxial[®])
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 †
Fexmid[®] (cyclobenzaprine)
Flexeril^{®*}
Norflex^{®*}
Norgesic^{®*}
Norgesic Forte^{®*}
Parafon Forte DSC^{®*}
Robaxin^{®*}
Robaxial^{®*}
Skelaxin[®]
Soma[®]
Soma Compound[®]
Soma Compound with Codeine[®]

Antispasticity Agents

Dantrium^{®*}
Lioresal^{®*}
Zanaflex^{®*}

PDL Key:

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Smoking Cessation Therapies

Length of Authorization: see table

Quantity limits apply

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.

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)
SANCTURA® (trospium)
VESICARE® (solifenacin)

>NOTE:

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

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

PA REQUIRED

Ditropan®*

Detrol® (tolterodine)
Detrol LA® (tolterodine LA)
oxybutynin XL†
Oxytrol® (oxybutinin transdermal)
Urispas® (flavoxate)

Vaginal Anti-Infectives

Length of Authorization: 1 year

NO PA REQUIRED

CLINDAMYCIN

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

METRONIDAZOLE

METROGEL VAGINAL® (metronidazole vaginal gel 0.75%)

PA REQUIRED

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

metronidazole vaginal gel 0.75%†
Vandazole† (metronidazole vaginal 0.75%)

PDL Key:

† Generic product

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