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

(f) 802-879-5919

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

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

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

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

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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; 0.3% G

Avage® (tazarotene) ♣

Renova® (tretinoin) ♣

Solage® (tretinoin/mequinol) ♣

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

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

Acne Drugs: Topical - Rosacea

Length of Authorization: 1 year

NO PA REQUIRED

METRONIDAZOLE† 0.75% C, G, L

C=cream, G=gel, L=lotion

PA REQUIRED

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

Finacea® (azelaic acid) 15% G

Alzheimer's Medications: Cholinesterase Inhibitors/NMDA Receptor Antagonists

Length of Authorization: 1 year

NO PA REQUIRED

ARICEPT® (donepezil)

NAMENDA® (memantine)

PA REQUIRED

Cognex® (tacrine) §

Exelon® (rivastigmine) §

Razadyne/Razadyne® ER (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)

transmucosal fentanyl citrate† (compare to Actiq®)

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

PA REQUIRED

Acetaminophen w/ codeine: *all branded products*
Acetaminophen w/ hydrocodone: *all branded products*
(QL 5/500 = 8 tablets/day, 10/500 = 8 tablets/day, 7.5/750 = 5 tablets/day)
Acetaminophen w/ oxycodone: *all branded products*
(QL 10/650 = 6 tablets/day)
Anexsia^{®*}
Bancap HC[®]
Butorphanol Nasal Spray (QL= 2 units/month)
Capital[®] w/Codeine*
Combunox[®]
Darvocet-N^{®*} (QL 100/650 = 6 tablets/day)
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^{®*}
Synalgos DC^{®*}
continued on next page

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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

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† (compare to Dolophine) 5 mg, 10 mg

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)

Methadone 40 mg Dispersible Tablets §

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†
FENOPROFEN† (compare to Nalfon®)
FLURBIPROFEN† (compare to Ansaid®)
IBUPROFEN† (compare to Motrin®)
INDOMETHACIN† (compare to Indocin®)
KETOPROFEN†
KETOPROFEN ER†
MECLOFENAMATE SODIUM† (compare to Meclomen®)
NABUMETONE†
NAPROXEN† (compare to Naprosyn®)
NAPROXEN SODIUM† (compare to Anaprox®, Naprelan®)
OXAPROZIN† (compare to Daypro®)
PIROXICAM† (compare to Feldene®)
SULINDAC† (compare to Clinoril®)
TOLMETIN SODIUM†

PA REQUIRED

Anaprox®*
Anaprox DS®*
Ansaid®*
Arthrotec®
Cataflam®*
Clinoril®*
Daypro®*
Dolobid®*
EC-Naprosyn®*
Feldene®*
Indocin®*
Indocin SR®
Ketorolac† *QL = 20 doses post PA approval*
Meloxicam† (compare to Mobic®)
Mefanamic acid† (compare to Ponstel®)
Mobic®
Motrin®*
Nalfon®*

Naprelan®*
Naprosyn®*
Ponstel®
Voltaren®*
Voltaren XR®*

Anemia: Hematopoietic/Erythropoietic Agents

Length of Authorization: 1 year

NO PA REQUIRED

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

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)

Anti-anxiety: Anxiolytics

Length of Authorization: 1 year

NO PA REQUIRED

ALPRAZOLAM† (compare to Xanax®)
ALPRAZOLAM XR† (compare to Xanax XR®)
BUSPIRONE† (compare to Buspar®)
CHLORDIAZEPOXIDE† (compare to Librium®)
CLONAZEPAM† (compare to Klonopin®)
CLONAZEPAM ODT† (compare to Klonopin Wafers®)
CLORAZEPATE† (compare to Tranxene®)
DIAZEPAM† (compare to Valium®)
LORAZEPAM† (compare to Ativan®)
MEPROBAMATE†
OXAZEPAM† (compare to Serax®)

PA REQUIRED

Ativan®*
Buspar®*
Klonopin®*
Klonopin Wafers®
Librium®*
Niravam® (alprazolam ODT)
Serax®*
Tranxene®* (all brand forms)
Valium®*
Xanax®*
Xanax XR®

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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 for Seizure Disorders, Duration of Need for Mental Health Indications, 1 Year for Other Indications

NO PA REQUIRED

CARBAMAZEPINE† (compare to Tegretol®)

CARBATROL® (carbamazepine)

CELONTIN® (methsuxamide)

CLONAZEPAM† (compare to Klonopin®)

CLONAZEPAM ODT† (compare to Klonopin Wafers®)

DEPAKOTE® (divalproex sodium)

DEPAKOTE ER® (divalproex sodium)

DIASAT® (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)

Klonopin®*

Klonopin Wafers®*

lamotrigine† chew tabs (compare to Lamictal® chew tabs)

Lyrica® (pregabalin) § (*Quantity Limit = 3 capsules/day*)

Mysoline®* (primidone)

Neurontin®* (gabapentin)

oxcarbazepine † (compare to Trileptal®)

Tegretol®* (carbamazepine)

Zaronin®* (ethosuxamide)

Zonegran®* (zonisamide)

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Anti-depressants: Novel

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

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

Budeprion XR/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 for Mental Health Indications, 1 Year for Other Indications

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 tablet[†] (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*
paroxetine suspension[†] (compare to Paxil[®] susp) *suggested max dose = 75 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)*

PDL Key:

† Generic product

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Anti-depressants: Tricyclics

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

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®*

Anti-depressants: MAO Inhibitors

Length of Authorization: Duration of Need for Mental Health Indications

Quantity limits apply

Suggested daily dosage limits

NO PA REQUIRED

NARDIL® (phenylzine) *suggested max dose = 110 mg/day*
TRANLYCYPROMINE† (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:

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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 for chemotherapy or radiotherapy;
1 time for prevention of post-op nausea/vomiting: see clinical criteria.*

Monthly quantity limits apply, PA required to exceed.

NO PA REQUIRED

EMEND® (aprepitant) 40 mg (1 cap/30 days)
*EMEND® (aprepitant) 80 mg (2 caps/30 days)
*EMEND® (aprepitant) 125 mg (1 cap/30 days)
*EMEND® (aprepitant) Tri-fold Pack (1 pack/30 days)
ONDANSETRON† Injection (vial and premix)
ONDANSETRON† tablet 4 mg (12 tabs/month), 8 mg (6 tabs/month)
ONDANSETRON† ODT 4 mg (12 tabs/month), 8 mg (6 tabs/month)

* *To be prescribed by oncology practitioners ONLY*

PA REQUIRED

Aloxi® (palonosetron, injectable) (2 vials/month)
Anzemet® (dolansetron) 50 mg (4 tabs/month)
Anzemet® (dolansetron) 100 mg (2 tabs/month)
Kytril® (granisetron) 1 mg (6 tabs/month)
Kytril® (granisetron) Injectable
Ondansetron† (generic) 24 mg (1 tab/month)
Ondansetron† (generic) Oral Solution 4 mg/5 ml
Zofran®** (ondansetron) Injection
Zofran®** (ondansetron) Oral Tablets and ODT 4 mg (12 tabs/month),
8 mg (6 tabs/month)
Zofran® (ondansetron) 24 mg (1 tab/month)
Zofran® (ondansetron) Oral Solution 4 mg/5 ml

Anti-emetics: Other

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

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*)

PDL Key:

† Generic product

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automatically screened for upon claims processing)

Antihyperkinesia: ADHD, ADD, Narcolepsy

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

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

Quantity limits apply

NO PA REQUIRED

SHORT/INTERMEDIATE ACTING METHYLPHENIDATE PREPS

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

LONG-ACTING METHYLPHENIDATE PREPS

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

SHORT/INTERMEDIATE AMPHETAMINE PREPS

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

LONG-ACTING AMPHETAMINE PREPS

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

NON-STIMULANT PREPS

PA REQUIRED

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

Metadate CD[®] (methylphenidate, IR/ER, 30:70%)
Ritalin LA[®] (methylphenidate, IR/ER, 50:50%)
Daytrana[®] (methylphenidate patch) (*QL = 1 patch/day*)

Adderall[®]*
Desoxyn[®] (methamphetamine)
Dexedrine[®]* (CR)

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

Xyrem[®] (sodium oxybate)

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[®] (trandolapril)
Monopril[®]*

Prinivil[®]*
trandolapril† (compare to Mavik[®])
Univasc[®] (moexipril)
Vasotec[®]*
Zestril[®]*

PDL Key:

† Generic product

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Anti-hypertensives: ACE Inhibitor with Hydrochlorothiazide*Length of Authorization: 1 year***NO PA REQUIRED**

BENZAEPRI/ HYDROCHLOROTHIAZIDE † (compare to Lotensin HCT[®])
 CAPTOPRIL/ HYDROCHLOROTHIAZIDE † (compare to Capozide[®])
 ENALAPRIL/ HYDROCHLOROTHIAZIDE † (compare to Vasertic[®])
 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 † (compare to Uniretic[®])
 Monopril HCT^{®*}
 Prinzide^{®*}
 Uniretic[®] (moexipril/hydrochlorothiazide)
 Vasertic^{®*}
 Zestoretic^{®*}

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) §

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Anti-hypertensives: Beta Blockers

Length of Authorization: 5 years

NO PA REQUIRED

SINGLE AGENT

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

BETA-BLOCKER/DIURETIC COMBINATION

ATENOLOL/CHLORTHALIDONE † (compare to Tenoretic®)
BISOPROLOL/HYDROCHLOROTHIAZIDE† (compare to Ziac®)
METOPROLOL/HYDROCHLOROTHIAZIDE† (compare to Lopressor HCT®)
PROPRANOLOL/HYDROCHLOROTHIAZIDE† (compare to Inderide®)

PA REQUIRED

Betapace®*
Betapace AF®*
Blocadren®*
Cartrol®
Coreg®
Coreg CR®
Corgard®
Inderal®* (all products)
Inderal LA®
Innopran XL®

Kerlone®*
Levatal® (penbutolol)
Lopressor®* (all products)
propranolol ER† (compare to Inderal LA®)
Sectral®*
Tenormin®*
Timolide®
Toprol XL®* (metoprolol succinate)
Trandate®*
Zebeta®*

Corzide®
Inderide®*
Lopressor HCT®*
Nadolol/bendroflumethiazide† (compare to Corzide®)

Tenoretic®*
Ziac®*

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®)
VERAPAMIL CR† (compare to Calan SR®, Isoptin SR®)
VERAPAMIL SR† 120 mg, 180 mg 240 mg and 360 mg (compare to Verelan®)

PA REQUIRED

Adalat® CC*
amlodipine† (compare to Norvasc®)
Calan®*
Calan® SR*
Cardene®*
Cardene® SR (no AB rated generic)
Cardizem®*, Cardizem® CD*
Cardizem® LA (no AB rated generic)
Covera-HS® (no AB rated generic)
Dilacor® XR*
Dynacirc CR® (no AB rated generic)
Isoptin® SR*
isradipine†
nimodipine† (compare to Nimotop®)
Plendil®*
Procardia®*
Procardia® XL*
Tiazac®*
verapamil SR †100 mg, 200 mg, 300mg (compare to Verelan PM®)
Verelan®*
Verelan PM®

Caduet® (amlodipine/atorvastatin)

PDL Key:

† Generic product

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Anti-hypertensives: Renin Inhibitor

Length of Authorization: lifetime

PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

TEKTURNA® (aliskiren) §

NON-PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

Anti-infectives: Cephalosporins – 1st Generation

Length of Authorization: for date of service, no refills

NO PA REQUIRED

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

IV drugs are not managed at this time

PA REQUIRED

Duricef®*
Keflex®*

Anti-infectives: Cephalosporins – 2nd Generation

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

NO PA REQUIRED

TABLETS

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

SUSPENSION

CEFACLOR SUSPENSION†
CEFPROZIL SUSPENSION† (compare to Cefzil®)
CEFTIN® (cefuroxime) SUSPENSION

IV drugs are not managed at this time

PA REQUIRED

Ceftin®* tablets
Cefzil® tablets
Lorabid® (loracarbef)

Cefzil® suspension

Anti-infectives: Cephalosporins – 3rd Generation

Length of Authorization: for date of service, no refills

NO PA REQUIRED

CAPSULES/TABLETS

CEDAX® CAPSULE (ceftibuten)
CEFPODOXIME PROXETIL TABS† (compare to Vantin®)
OMNICEF® CAPSULE(cefdinir)

SUSPENSION

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

IV drugs are not managed at this time

PA REQUIRED

cefdinir capsule†
Spectracef® tablet (cefditoren)
Vantin®* tablet (cefpodoxime)

cefdinir suspension †
cefpodoxime proxetil† (compare to Vantin®) suspension
Vantin® suspension (cefpodoxime)

Anti-infectives: Ketolides

Length of Authorization: for date of service, no refills

NO PA REQUIRED

PA REQUIRED

Ketek® (telithromycin)

PDL Key:

† Generic product

* Indicates a generic equivalent is available without PA

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

Anti-infectives: Macrolides

Length of Authorization: for date of service, no refills

NO PA REQUIRED

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

CLARITHROMYCIN† (compare to Biaxin/Biaxin XL)

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)
PCE Dispertab® (erythromycin base)
Pediazole®* (erythromycin-sulfisoxazole)
Zithromax® tablets and liquid
Zmax® (azithromycin extended release oral suspension)

Anti-infectives: Oxazolidinones

Length of Authorization: 28 days, no refills

Quantity Limits Apply

NO PA REQUIRED

IV form of this medication not managed at this time

PA REQUIRED

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

Anti-infectives: Penicillins (Oral)

Length of Authorization: for date of service, no refills

NO PA REQUIRED

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

PA REQUIRED

Augmentin®**
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

NO PA REQUIRED

CIPROFLOXACIN† (compare to Cipro®)
CIPRO® OS (ciprofloxacin oral solution) 100 mg/ml
LEVAQUIN® (levofloxacin)
OFLOXACIN†

IV drugs are not managed at this time

PA REQUIRED

Avelox® (moxifloxacin HCL)
Avelox ABC PACK® (moxifloxacin HCL)
Cipro®*
Cipro XR®
ciprofloxacin ER†
Factive® (gemifloxacin)
Noroxin® (norfloxacin)
ProQuin XR® (ciprofloxacin)

PDL Key:

† Generic product

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Anti-infectives: Onychomycosis Agents

Length of Authorization: 1 year, see clinical criteria.

Monthly quantity limits apply

PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

CICLOPIROX† Nail Lacquer (compare to Penlac®) *QL = 6.6 ml/90 days*
TERBINAFINE† tabs (compare to Lamisil®) *QL = 30 tablets/month*

NON-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*
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

Famciclovir † (compare to Famvir®)
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 (During Flu Season Nov 1st – March 31st)

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® Injection
FLUZONE® Injection
FLUVIRIN® Injection

PA REQUIRED

FluMist® Nasal

Anti-infectives: Miscellaneous

Length of Authorization: 1 year

NO PA REQUIRED

PA REQUIRED

Quaaliquin® (quinine sulfate)

PDL Key:

† Generic product

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Anti-infectives: Topical Antibiotics

Length of Authorization: for date of service, no refills

Quantity limits apply

NO PA REQUIRED

BACITRACIN†
GENTAMICIN†
BACITRACIN-POLYMXIN†
NEOMYCIN-BACITRACIN-POLYMXIN†
CORTISPORIN®
BACTROBAN® (all forms)
MUIPIROCIN OINTMENT (compare to Bactroban®)

PA REQUIRED

Altabax® (retapamulin) (*Quantity Limit = 1 tube*)

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/month*)
IMITREX® (sumatriptan) Injection 6 mg (*QL = 4 injections/month*)
IMITREX® NS (sumatriptan) 20 mg (*QL = 6 units/month*)
IMITREX® NS (sumatriptan) 5 mg (*QL = 12 units/month*)
IMITREX® (sumatriptan) 25 mg (*QL = 18 tabs/month*)
IMITREX® (sumatriptan) 50 mg, 100 mg (*QL = 9 tabs/month*)
MAXALT-MLT® (rizatriptan ODT) 5 mg, 10 mg (*QL = 12 tabs/month*)
MAXALT® (rizatriptan) 5 mg, 10 mg (*QL = 12 tabs/month*)

PA REQUIRED, Quantity Limits Apply

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

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)

PDL Key:

† Generic product

* Indicates a generic equivalent is available without PA

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

Anti-psychotic: Atypical & Combinations

Length of Authorization: Duration of Need

Quantity limits apply

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)*

Fazaclo® (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)

Anti-psychotic: Typical

Length of Authorization: Duration of Need for Mental Health Indications

NO PA REQUIRED

CHLORPROMAZINE† (compare to Thorazine®)

FLUPHENAZINE† (compare to Prolixin®, Prolixin®)

HALOPERIDOL† (compare to Haldol®)

LOXAPINE† (compare to Loxitane®)

MOBAN® (molindone)

PERPHENAZINE† (compare to Trilafon®)

THIORIDAZINE† (compare to Mellaril®)

THIOTHIXENE† (compare to Navane®)

TRIFLUOPERAZINE† (compare to Stelazine®)

PA REQUIRED

Haldol®**

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®

PDL Key:

† Generic product

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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**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)

PDL Key:

† Generic product

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

PA REQUIRED

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

BiDi® (isosorbide dinitrate/hydralazine)

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

Coronary Vasodilators/Antianginals: Topical

Length of Authorization: 3 years

NO PA REQUIRED

NITREK® (nitroglycerin transdermal patch)
NITROGLYCERIN ONTMENT†
NITROGLYCERIN TRANSDERMAL PATCHES† (compare to
Minitran®, Nitro-Dur®)

PA REQUIRED

Minitran®* (nitroglycerin transdermal patch)
Nitro-Bid®* (nitroglycerin ointment)
Nitro-Dur®* (nitroglycerin transdermal patch)

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

SYRUPS AND SPECIAL DOSAGE FORMS

ZANTAC® (ranitidine) SYRUP

PA REQUIRED

Axid® §
nizatadine †§
Pepcid®* §
Tagamet®* §
Zantac® §

ranitidine† syrup §
Zantac Effervescent® §

PDL Key:

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Gastrointestinals: Proton Pump Inhibitors

Length of Authorization: up to 1 year

Quantity limits apply

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

♠ No PA required for patients < 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:

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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 Alphatrex®)
BETAMETHASONE VALERATE† (compare to Beta-Val®)
DESOXIMETASONE 0.05%† (compare to Topicort®)
FLUOCINOLONE 0.025%† (compare to Synalar®)
FLUTICASONE TOPICAL† (compare to Cutivate®)
HYDROCORTISONE BUTYRATE† (compare to Locoid®)
HYDROCORTISONE VALERATE† (compare to Westcort®)
MOMETASONE FUROATE† (compare to Elocon®)
TRIAMCINOLONE ACETONIDE† (compare to Aristocort®)

AMCINONIDE† (compare to Cyclocort®)
AUGMENTED BETHAMETHASONE CREAM† (compare to Diprolene® AF)
DESOXIMETASONE 0.25%† (compare to Topicort®)
DIFLORASONE DIACETATE† (compare to Apexicon®, Maxiflor®, Psorcon-E®)
FLUOCINOLONE 0.2%† (compare to Synalar®)
FLUOCINONIDE† (compare to Lidex®)

AUGMENTED BETHAMETHASONE OINTMENT† (compare to Diprolene®)
CLOBETASOL PROPIONATE† (compare to Temovate®)
DIFLORASONE DIACETATE EMOLL† (compare to Psorcon®)
HALOBETASOL PROPIONATE† (compare to Ultravate®)

PA REQUIRED

Low Potency

Aclovate®*
Cortaid®*
Desonate® gel (desonide)
DesOwen®*
Hytone®*
Synalar® 0.01%* (all products)
Tridesilon®*
Verdeso® (desonide foam)
All other brands

Medium Potency

Alphatrex®*
Aristocort®* (all products)
Beta-Val®*
Cloderm® (clocortolone)
Cordran®* (all products)
Cutivate®*
Dermatop®
Elocon®* (all products)
Kenalog® (all products)
Locoid®
Luxiq®
prednicarbate† (compare to Dermatop®)
Pandel®
Synalar® 0.025%* (all products)
Topicort® 0.05%* (all products)
Westcort®* (all products)
All other brands

High Potency

Apexicon®*
Cyclocort®*
Diprolene® AF* (all products)
Halog®* (all products)
Lidex®* (all products)
Maxiflor®*
Synalar® 0.2%* (all products)
Topicort® 0.25%* (all products)
Vanos®
All other brands

Very High Potency

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

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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
OMNITROPE[®]
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)

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)
NIASPAN[®] ER (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

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

Lovaza[®] (omega-3-acid ethyl esters)

Cholesterol Absorption Inhibitors/Combinations

Other Statin Combinations

Caduet[®] (atorvastatin/amlodipine)

Miscellaneous: Elaprase[®] (Hunter's Syndrome Injectable)

Length of Authorization: 1 year

Quantity limits apply

NO PA REQUIRED

PA REQUIRED

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

PDL Key:

† Generic product

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Miscellaneous: Soliris® (Paroxysmal Nocturnal Hemoglobinuria Injectable)*Length of Authorization: Initial 3 months, Subsequent 1 year***Quantity limits apply****NO PA REQUIRED****PA REQUIRED**Soliris® (eculizumab) (*Quantity Limit = 20 vials total/3 months initially; 6 vials/month subsequently*)**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)**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)**PDL Key:**

† Generic product

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Ophthalmics: Glaucoma Agents/Miotics

Length of Authorization: lifetime

NO PA REQUIRED

ALPHA-2 ADRENERGIC

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

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[®])

PROSTAGLANDIN INHIBITORS

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

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

CARBONIC ANHYDRASE INHIBITOR

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

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)

PA REQUIRED

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

Betagan^{®*}
Betimol^{®*}
Istalol^{®*}
Optipranolol^{®*}
Timoptic^{®*}
Timoptic XE^{®*}

Xalatan[®] (latanoprost)

Azopt[®] (brinzolamide)

Miochol-E[®]
Miostat[®]
Pilocar^{®*}
Propine^{®*}

Ophthalmics: Mast Cell Stabilizers

Length of Authorization: 6 months

NO PA REQUIRED

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

PA REQUIRED

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

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%)
Ocufen^{®*} ophthalmic sol. (flurbiprofen 0.03%)
Voltaren[®] (diclofenac 0.1% ophthalmic sol.)

PDL Key:

† Generic product

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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

ORAL BIPHOSPHONATES

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)

INJECTABLE BIPHOSPHONATES

MIACALCIN® (calcitonin)

PA REQUIRED

Actonel® (risedronate)
Actonel® w/calcium (risedronate/calcium)
Didronel® (etidronate)
Etidronate (compare to Didronel®)
Skelid® (tiludronate)

Boniva® Injection (ibandronate) (*Quantity Limit = 3 mg/3 months (four doses)/year*)
Reclast® Injection (zoledronic acid) (*Quantity Limit = 5 mg (one dose)/year*)

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:

† Generic product

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Parkinson's: Non-Ergot Dopamine Receptor Agonist

Length of Authorization: 1 year

Quantity limits apply

NO PA REQUIRED

DOPAMINE PRECURSOR

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

AGGREGATION INHIBITORS

CILOSTAZOL† (compare to Pletal®)
CLOPIDOGREL† (compare to Plavix®)
PLAVIX® (clopidogrel bisulfate)
TICLOPIDINE† (compare to Ticlid®)

OTHER

ASPIRIN†
DIPYRIDAMOLE† (compare to Persantine®)

PA REQUIRED

Pletal®*
Ticlid®*

Aggrenox® (dipyridamole/ASA)
Persantine®*

PDL Key:

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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® CK (acitretin)

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

PA REQUIRED

Oral

Topical

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

Pulmonary: Anticholinergics, Inhaled

Length of Authorization: 1 year

NO PA REQUIRED

METERED DOSE INHALER (SINGLE AGENT)

ATROVENT HFA® (ipratropium)
SPIRIVA® (tiotropium)

NEBULIZER (SINGLE AGENT)

IPRATROPIUM SOLN FOR INHALATION

METERED DOSE INHALER (COMBINATION PRODUCT)

COMBIVENT® (ipratropium/albuterol)

NEBULIZER (COMBINATION PRODUCT)

DUONEB® (ipratropium/albuterol)

PA REQUIRED

Ipratropium/albuterol† (compare to Duoneb®)

Pulmonary: Antihistamines-1st Generation

Length of Authorization: 1 year

NO PA REQUIRED

All generic antihistamines

All generic antihistamine/decongestant combinations

PA REQUIRED

All brand antihistamines (example: Benadryl®)

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

PDL Key:

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Pulmonary: Antihistamines-2nd Generation

Length of Authorization: 1 year

NO PA REQUIRED

LORATADINE (OTC) †

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:

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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 (SHORT-ACTING)

ACCUNEB[®] (albuterol sulfate solution 0.63 mg/ml and 1.25 mg/ml)

ALBUTEROL 0.83 mg/ml neb solution †

METAPROTERENOL † neb solution

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

NEBULIZER SOLUTIONS (LONG-ACTING)

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)

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

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

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

Brethine^{®*} (terbutaline)

Vospire ER^{®*} (albuterol)

PDL Key:

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Pulmonary: Inhaled Glucocorticoids/Glucocorticoid Combinations

Length of Authorization: 5 years

NO PA REQUIRED

METERED DOSE INHALERS (SINGLE AGENT)

ASMANEX[®] (mometasone furoate) (*QL* = 0.008 gm/day (1 inhaler (0.24 gm)/30 days))

AZMACORT[®] (triamcinolone acetonide)

FLOVENT[®] DISKUS (fluticasone propionate)

FLOVENT[®] HFA (fluticasone propionate) (*QL* = 36 gm(3 inhalers)/90 days)

QVAR[®] (beclomethasone)

METERED DOSE INHALERS (COMBINATION PRODUCT)

ADVAIR[®] DISKUS (fluticasone/salmeterol)

ADVAIR[®] HFA (fluticasone/salmeterol)

NEBULIZER SOLUTIONS

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

PA REQUIRED

AeroBid[®] (flunisolide) §

AeroBid-M[®] §

Pulmicort Flexhaler[®] §

Pulmicort Turbuhaler[®] §

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

Pulmonary: Nasal Glucocorticoids

Length of Authorization: 5 years

NO PA REQUIRED

FLONASE[®] (fluticasone propionate)

FLUNISOLIDE†25 mcg/spray (compare to Nasalide[®])

NASACORT AQ[®] (triamcinolone AQ)

NASONEX[®] (mometasone)

PA REQUIRED

Beconase AQ[®] (beclomethasone AQ)

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

fluticasone† (compare to Flonase[®])

Nasarel[®] (flunisolide)

Rhinocort AQ[®] (budesonide AQ)

Pulmonary: Systemic Glucocorticoids

Length of Authorization: 1 year

NO PA REQUIRED

CORTISONE ACETATE†

DEXAMETHASONE†

HYDROCORTISONE† (compare to Cortef[®])

METHYLPREDNISOLONE† (compare to Medrol[®])

ORAPRED[®] oral solution/ODT (prednisolone sod phosphate) (age < 12 yrs)

PREDNISOLONE† tabs / liquid (compare to Pediapred[®], Prelone[®])

PREDNISONE†

PA REQUIRED

Celestone[®]

Cortef[®]*

Medrol[®]*

Orapred[®] oral solution (age ≥ 12 yrs)

Orapred[®] ODT (age ≥ 12 yrs)

Pediapred[®]*

Prelone[®]*

Pulmonary: Leukotriene Modifiers

Length of Authorization: 1 year

NO PA REQUIRED

ACCOLATE[®] (zafirlukast)

SINGULAIR[®] (montelukast sodium)

PA REQUIRED

ZyFlo[®] (zileuton) §

ZyFlo[®] CR (zileuton SR) §

PDL Key:

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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)

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[®])

PA REQUIRED

Benzodiazepine

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

Non-benzodiazepine

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

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

PDL Key:

[†] Generic product

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Skeletal Muscle Relaxants

Length of Authorization: 1 year

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

NO PA REQUIRED

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 Norgestic®, Norgestic Forte®)

ASA = aspirin

PA REQUIRED

Musculoskeletal Agents

Amrix® (cyclobenzaprine extended release)
carisoprodol †
carisoprodol, ASA†
carisoprodol, ASA, codeine †
Fexmid® (cyclobenzaprine)
Flexeril®*
Norflex®*
Norgestic®*
Norgestic Forte®*
Parafon Forte DSC®*
Robaxin®*
Robaxisal®*
Skelaxin®
Soma®
Soma Compound®
Soma Compound with Codeine®

Antispasticity Agents

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

Dantrium®*
Lioresal®*
Zanaflex®*

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.

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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)
 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%)

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