MAINECARE PREFERRED DRUG LIST (with criteria)*

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***As of February 2011**	

Due to formatting page numbers may be off

*PLEASE NOTE: For a search box hit Ctrl F

CATEGORY	Coverage Indicator	Step Order	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS	PA Required	Comments	Criteria

*** PLEASE NOTE: All cost effective generics applicable to DEL are considered PREFERRED Drugs. "BASIC" Covered Drugs are bolded with the Coverage Indicator of "MC / DEL".**

General Criteria for all PDL categories- For more information or help using the PDL, providers may call 1-888-445-0497; members should call 1-866-796-2463. To access PDL and PA materials via the internet: www.mainecarepdl.org

A: Preferred Drugs- Unless otherwise specified, preferred drugs are available without prior authorization. Step order may apply for preferred drugs in some drug categories as indicated on the PDL. (See item "D" below for explanation of step order.)

B: Requests for Non-preferred Drugs- Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.

C: Adequate Drug Trials- 1. The minimum trial period for each preferred and step order drug is two weeks, unless otherwise stated within specific PDL drug categories; trials with less than a two week duration will be reviewed on a case-by-case basis; 2. A trial will not be considered valid if preferred or non-preferred products were readily available (by override, individual purchase, samples, etc.); 3. Certain drug trials, such as with controlled substances, may require evidence that the preferred drugs were actually tried (example: with random pill counts and with random urine drug tests, using the methods of GC/MS with no lower threshold); 4. Adequate trials require documentation of attempts to titrate dose of preferred agents toward desired clinical response. 5. Adequate trials include prevention/treatment of common adverse effects associated with preferred agents (example: antinausea, antipruritics, etc.)

D: Step Order- When numbers appear in the "step order" column, it means drugs in this category must be used in the order specified, with the lower numbers having preference over the higher numbers. Chart notes should be provided to confirm drug trials that do not appear in the member's MaineCare drug profile.

E. The Department will institute strategies to ensure cost effectiveness through the use of an enhanced Drug Benefit Preferred brand drugs will no longer be preferred in any PDL drug category where preferred generic drugs are also available. It is expected that preferred generics will be used prior to any preferred brands. This will be operated as a form of step care. Preferred brands in these categories will require prior authorization for these high utilization / high cost members.

F: Brand Name Medication Requests- (Must be submitted on the Brand Name PA request form)- According to MaineCare Benefits Manual Chapter II (80.07-5), when medically necessary covered brand-name drugs have an A-rated generic equivalent available, the most cost effective medically necessary version will be approved and reimbursed, since the brand-name and A-rated generic drugs have been determined by the FDA to be chemically and therapeutically equivalent. The Bureau does not make determinations as to whether or not a generic drug is clinically inferior or inequivalent to its brand version. This is the proper role of the FDA. Physicians should submit their reports of generic inequivalence directly to the FDA via the MEDWATCH.

G: PA requests for non- FDA Approved Indications- Decisions will be made on a case-by-case basis until the DUR committee is able to review the evidence and make a recommendation. Interim approvals and DUR recommendations for approval of a drug for a non- FDA approved indication will require a minimum of two published, peer reviewed, non contradicted, double- blind, placebo-controlled randomized clinical studies establishing both safety and efficacy.

H: Dose Consolidation Requirements- Some drugs may also be affected by dose consolidation requirements. Please see Dose Consolidation List and/or Splitting Tables provided in the PDL.

I. Trials from Multiple Drug Classes - Trial/failure/intolerance to preferred agents from multiple classes within the same category or other catagories of drugs may be required prior to the approval of non-preferred agents (e.g., Cymbalta, Zofran, Elidel and others).

J. Drug-specific PA Forms- Drug-specific PA forms contain medical necessity documentation requirements and/or criteria that may not be repeated in the PDL. Drug-specific PA forms may be obtained on the web at ***www.mainecarepdl.org*** .

K. PA Exemptions for Prescribers- According to MaineCare Benefits Manual Chapter II (80.07-4), providers may receive a three (3) month exemption from prior authorization requirement for certain categories of drugs when they demonstrate high compliance with the Department's PDL. The Department will notify providers in writing which drug categories are included and what dates apply to the exemption. If a provider loses his/ her exemption, members who previously were not required to obtain a PA while the prescriber was exempt will be required to do so, and criteria for approval of that medication will need to be met.

L: Drug-Drug Interactions (DDI)- The DUR Committee has implemented new drug-drug interation edits requiring prior authorization. Several drug-drug combinations and PDL drug catagories are affected by new PA requirements. These will be indicated in the PDL with DDI notation. Please see the DDI document provided in the PDL.

ASSORTED ANTIBIOTICS									
BETA-LACTAMS / CLAVULANATE COMBO'S	MC/DEL		AMOXICILLIN	MC/DEL		AUGMENTIN[3]		3. Chewable 125mg & 250mg and Solution 125mg/5ml and 250mg/5ml available without PA.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		AMOXICILLIN/POTASSIUM CLA CHEW	MC/DEL		AUGMENTIN XR TB12[4]			
	MC/DEL		AMOXICILLIN/POTASSIUM CLA SUSR						
	MC/DEL		AMOXICILLIN/POTASSIUM CLA TABS						
	MC/DEL		AMPICILLIN						**DDI:** Ampicillin will now be non-preferred and require prior authorization if it is currently being used in combination with either Prevacid, pantoprazole, Prilosec, or any currently non preferred PPI.
	MC		BICILLIN L-A SUSP					4. Use preferred generic amoxicillin/clavulanate potassium alternatives.	
	MC/DEL		DICLOXACILLIN SODIUM CAPS						
	MC		OXACILLIN SODIUM SOLR					Use PA Form# 20420	
	MC/DEL		PENICILLIN V POTASSIUM						
	MC		TIMENTIN SOLR						
	MC		UNASYN SOLR						
	MC/DEL		ZOSYN						
CEPHALOSPORINS	MC/DEL		CEFADROXIL HEMIHYDRATE	MC		CEDAX		1. Both brand and generic are clinically non-preferred.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		CEFAZOLIN SODIUM SOLR	MC/DEL		CEFACLOR[1]			
	MC/DEL		CEFDINIR	MC/DEL		CEFADROXIL MONOHYDRATE TABS			
	MC/DEL		CEFEPIME	MC/DEL		CEFTIN		2. Dosing limits apply, please see Dosage Consolidation List.	
	MC/DEL		CEFPODOXIME	MC/DEL		FORTAZ			Suprex will be preferred with dosing limits of one tablet per 7days for prevention and treatment of STI gonorrhoea.
	MC/DEL		CEFPROZIL	MC/DEL		FORTAZ SOLN			
	MC		CEFTAZIDIME 6MG	MC		KEFLEX CAPS			
	MC/DEL		CEFTIN SUSP	MC		OMNICEF			
	MC/DEL		CEFTRIAXONE	MC/DEL		ROCEPHIN			
	MC/DEL		CEFUROXIME AXETIL TABS	MC/DEL		SUPRAX[2]			**DDI:** Vantin will now be non-preferred and require prior authorization if it is currently being used in combination with either Prevacid, pantoprazole, Prilosec, or any currently non

	MC/DEL		CEPHALEXIN MONOHYDRATE	MC		TAZICEF SOLR		preferred PPI.
	MC		FORTAZ SOLR	MC/DEL		TEFLARO		
	MC/DEL		SUPRAX CHEWABLE					
	MC		TAZICEF 6GM				Use PA Form# 20420	
MACROLIDES / ERYTHROMYCIN'S	MC/DEL		AZITHROMYCIN TABS	MC/DEL		AZITHROMYCIN POW	1. 7- Day supply per month without PA.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **DDI:** Preferred erythromycin will now be non-preferred and require prior authorization if it is currently being used in combination with either Carbamazepine, Enablex 15mg or Vesicare 10mg. Any non preferred formulation of erythromycin will require prior authorization and the member's drug profile will also be monitored for concurrent use with either Carbamazepine, Enablex 15mg or Vesicare 10mg. **DDI:** Preferred clarithromycin formulations (clarithromycin tablets) will now be non-preferred and require prior authorization if they are currently being used in combination with either Carbamazepine, Onglyza 5mg, Enablex 15mg or Vesicare 10mg. Any non preferred formulation of clarithromycin will require prior authorization and the member's drug profile will also be monitored for concurrent use with either Carbamazepine, Onglyza 5mg, Enablex 15mg or Vesicare 10mg. Zinplava® will be non-preferred and require clinical prior authorization to verify it is prescribed or consulted by GI or ID specialist, diagnosis, and concurrent use of an antibacterial agent as well as limiting its use to those who have recurrent C. diff disease that has recurred despite use of guideline recommended vancomycin taper or for whom this would be contraindicated.
	MC/DEL		AZITHROMYCIN SUSP	MC/DEL		CLARITHROMYCIN SUSP		
	MC		E.E.S.	MC/DEL		CLARITHROMYCIN TABS		
	MC		ERYPED 200 SUSR	MC		DIFICID		
	MC		ERYPED 400 SUSR	MC		PCE TBEC		
	MC		ERY-TAB TBEC	MC/DEL		ZITHROMAX TABS		
	MC		ERYTHROCIN STEARATE TABS	MC/DEL		ZITHROMAX 1GM PAK	Use PA Form# 20420	
	MC/DEL		ERYTHROMYCIN	MC/DEL		ZITHROMAX TRI-PAK		
				MC/DEL		ZITHROMAX SUSP		
				MC/DEL		ZMAX		
				MC/DEL		ZINPLAVA		
TETRACYCLINES	MC/DEL		DOXYCYCLINE MONOHYDRATE 100mg & 50mg CAPS	MC		DECLOMYCIN TABS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		MINOCYCLINE HCL CAPS	MC/DEL		DORYX CPEP		
	MC/DEL		TETRACYCLINE HCL CAPS	MC/DEL		DOXYCYCLINE HYCLATE		
	MC/DEL		VIBRAMYCIN SYRP	MC/DEL		DOXYCYCLINE MONOHYDRATE 150mg & 75mg CAPS		
				MC/DEL		DYNACIN CAPS		
				MC		ORACEA		
				MC/DEL		PERIOSTAT		
				MC/DEL		SOLODYN ER		
FLUOROQUINOLONES	MC/DEL		CIPROFLOXACIN	MC		AVELOX SOLN		Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **DDI:** Preferred ofloxacin will now be non-preferred and require prior authorization if they are currently being used in combination with amiodarone. **DDI:** Preferred levofloxacin will now be non-preferred and require prior authorization if they are currently being used in combination with amiodarone. **DDI:** Preferred Avelox will now be non-preferred and require prior authorization if they are currently being used in combination with amiodarone. **DDI:** All preferred fluoroquinolones will require clinical PA for patients over 60 that are currently on immunosuppressants or steroid therapy. **DDI:** Factive is non-preferred but with any prior authorization requests, the member's drug profile will also be monitored for concurrent use with amiodarone.
	MC/DEL		LEVOFLOXACIN	MC		AVELOX TABS	Use PA Form# 20420	
	MC/DEL		OFLOXACIN	MC		AVELOX ABC PACK TABS	1. Dosing limits apply, see Dosage Consolidation List.	
				MC		CIPRO		
				MC		FACTIVE		
				MC		LEVAQUIN TABS SOLN/INJ		
				MC		LEVAQUIN TABS[1]		
				MC		NOROXIN TABS		
				MC		PROQUIN XR		
AMINO GLYCOSIDES	MC		GENTAMICIN	MC		BETHKIS[1]	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. TOBI Podhaler is limited to patients with significant impairment from using nebulized version of medication Current users of Tobi Nebu and Tobramycin Soln will be allowed a grace period until 10/1/15 to transition to preferred Kitabis.
	MC		KITABIS PAK	MC/DEL		TOBI PODHALER[1]	1. Clinial PA to verify appropriate diag	
	MC/DEL		NEOMYCIN SULFATE TABS	MC		TOBI NEBU[2]	2. See criteria section	
				MC/DEL		TOBRAMYCIN SULFATE SOLN[2]		
ANTI-MYCOBACTERIALS / ANTI-TUBERCULOSIS	MC/DEL		ETHAMBUTOL HCL TABS				Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **DDI:** Preferred rifampin will be non-preferred and require prior authorization if it is currently being used in combination with either Pradaxa or Latuda.
	MC/DEL		MYAMBUTOL TABS					
	MC/DEL		MYCOBUTIN CAPS					
	MC/DEL		RIFAMPIN					
ANTIMALARIAL AGENTS	MC/DEL		**CHLOROQUINE PHOSPHATE TABS**	MC		ARALEN TABS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**DARAPRIM TABS**	MC/DEL		**HYDROXYCHLOROQUINE TABS**		
	MC/DEL		**MEFLOQUINE HCL TABS**	MC		ISONARIF[1]	1. Ingredients available as preferred without PA.	
	MC/DEL		**PLAQUENIL TABS**	MC/DEL		MALARONE TABS		
	MC/DEL		**QUININE SULFATE**					
ANTHELMINTICS	MC/DEL		ALBENZA TABS	MC		EMVERM	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered

	MC		BILTRICIDE TABS					on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		STROMECTOL TABS					
ANTIBIOTICS - MISC.	MC		AZACTAM SOLR	MC		COLISTIMETHATE SODIUM SOLR	1. 375mg caps and 750mg tabs are non-preferred. Please use available preferred strengths(250mg & 500mg tabs) to obtain required dose without PA.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		COLY-MYCIN-M SOLR	MC		CAYSTON[3]		
	MC		COLISTIMETHATE SODIUM SOLR	MC/DEL		FLAGYL CAPS		1. For macrolide resistant infections when quinolones inappropriate
	MC		FUROXONE TABS	MC/DEL		FLAGYL TABS		
	MC/DEL		METRONIDAZOLE[1]	MC/DEL		FLAGYL ER TBCR		**DDI:** Ketek is non-preferred but with any prior authorization requests, the member's drug profile will also be monitored for concurrent use with either Enablex 15mg or Vesicare 10mg or carbamazepine.
	MC		PENTAMIDINE ISETHIONATE SOLR	MC/DEL		KETEK		
	MC		PRIMSOL SOLN	MC/DEL		METRONIDAZOLE 375MG CAPS[1]		
	MC/DEL		TRIMETHOPRIM TABS	MC/DEL		METRONIDAZOLE 750MG TABS[1]		
	MC/DEL		VANCOMYCIN 5GM INJ.	MC		NEBUPENT SOLR	2. Please use multiple 5gm which are preferred to obtain dose without PA.	Cayston is only indicated to improve respiratory symptoms in CF patients with Pseudomonas aeruginosa. Dosing limits, as should be given TID X28 days (followed by 28 days OFF Cayston therapy). A bronshodilator should be used before administration of Cayston.
	MC/DEL		VANCOMYCIN CAPS	MC		TINDAMAX		
				MC/DEL		VANCOMYCIN 10GM INJ.[2]		
				MC		XIFAXAN	3. Clinical PA is required to establish CF diagnosis and medical necessity. Prior trail and failure of preferred Tobi before approval will be granted.	
							Use PA Form# 20420	
CARBAPENEMS				MC		INVANZ SOLR	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
				MC		MERREM SOLR		
				MC/DEL		PRIMAXIN		
LINCOSAMIDES / OXAZOLIDINONES / LEPROSTATICS	MC/DEL		CLEOCIN SOLN	MC/DEL	8	CLEOCIN CAPS	1. Use multiple 150's for Clindamycin instead of 300's.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. For Zyvox or Vibativ, please see the criteria listed in the Antibacterial Antibiotics PA form.
	MC/DEL		CLEOCIN SUSR	MC/DEL	8	CLINDAMYCIN HCL 300CAPS[1]		
	MC/DEL		CLINDAMYCIN HCL 150CAPS	MC	8	SIVEXTRO		
	MC		DAPSONE TABS	MC/DEL	8	VIBATIV	Use PA Form# 30820 for Zyvox & Vibativ	
				MC/DEL	8	**LINEZOLID TABS**		
				MC/DEL	9	ZYVOX SUSR		
				MC/DEL	9	ZYVOX TABS	Use PA Form# 20420 for all others	
ANTI INFECTIVE COMBO'S - MISC.	MC/DEL		ERYTHROMYCIN/SULF SUSR	MC		BACTRIM DS TABS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		SEPTRA/DS TABS					
	MC/DEL		SULFAMETHOXAZOLE/TRIMETH					
	MC/DEL		TRIMETHOPRIM/SULFAMETHOXA					
ANTIPROTOZOALS				MC		ALINIA[1]	1. Alina is preferred for children less than 12 years of age. Use PA Form# 20420	
ANTI - FUNGALS								
ANTIFUNGALS - ASSORTED	MC		ANCOBON CAPS	MC/DEL	6	LAMISIL TABS[4]	1. QL--1/every 7-day period (150mg only).	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. The other criteria are listed on the Antifungal PA form including the required proof of a non-cosmetic fungal infection.
	MC/DEL		FLUCONAZOLE[1]	MC/DEL	6	ITRACONAZOLE		
	MC/DEL		KETOCONAZOLE TABS[7]	MC/DEL	8	CRESEMBA[9]	2. Sporanox QL 300cc/month with PA. See quantity limit table.	
	MC/DEL		NYSTATIN	MC/DEL	8	GRIFULVIN V TABS		
	MC/DEL		TERBINAFINE TABS[4]	MC	8	GRISEOFULVIN SUSP		
	MC/DEL		**VORICONAZOLE TABS**	MC	8	GRISEOFULVIN ULTRAMICROSI TABS	3. Sporanox QL 30/month with PA. See quantity limit table. Non-preferred products must be used in specified step order. Continue to use Anti-Fungal PA form for non-preferred products.	
				MC	8	GRIS-PEG TABS		
				MC/DEL	8	SPORANOX SOLN[2]		
				MC/DEL	8	SPORANOX PULSEPAK CAPS[3]		**DDI:** Any Griseofulvin will now be non-preferred and require prior authorization if it is currently being used in combination with either Prevacid, pantoprazole, Prilosec, or any currently non preferred PPI.
				MC/DEL	8	SPORANOX CAPS[3]		
				MC/DEL	8	DIFLUCAN		
				MC/DEL	8	ERAXIS INJ[6]		**DDI:** Sporanox is non-preferred but with any prior authorization requests, the member's drug profile will also be monitored for current use with Enablex 15mg, Vesicare 10mg, Prandin, Prevacid, pantoprazole, Prilosec, or any currently non preferred PPI, due to a significant drug-drug interaction.

				MC	8	GRIFULVIN SUSP	4. Quantity limit of one tablet daily. Please see dosage consolidation list.	**DDI:** Vfend is non-preferred but with any prior authorization requests, the member's drug profile will also be monitored for concurrent use with Warfarin.
							5. Approved if immuno suppressed/ HIV or if the member has failed a 7 day trial of a preferred antifungal therapy.	**DDI:** Fluconazole (except 150mg strength) will now be non-preferred and require prior authorization if it is currently being used with glimepiride (Amaryl), Enablex 15mg, or Vesicare 10mg. Diflucan is non-preferred but with any prior authorization requests, the member's drug profile will also be monitored for concurrent use with either glimepiride (Amaryl), Enablex 15mg, or Vesicare 10mg.
				MC/DEL	8	ONMEL		
				MC/DEL	8	NOXAFIL[5]		**DDI:** Fluconazole will require prior authorization if being used in combination with Plavix or Warfarin.
							6. Eraxis will be approved if submitting with documentation that it was initiated during a hospitalization and this request is to finish the hospital course.	
				MC/DEL	8	VFEND TABS	7. Quantity limits allowing 30 day supply without PA. PA will be required if using > 30 days.	
							8. For children < 18, quantity limits allows 8 weeks supply without PA. PA will be required if using > than 8 weeks. If 18 and older PA will be required for any quantity. Not approving for Onychomycosis indication.	**DDI:** Ketoconazole will now be non-preferred and require prior authorization if they are currently being used in combination with any of the following medications: Prevacid, Pantoprazole, Plavix, Onglyza, Enablex 15mg, Vesicare 10mg, Latuda, Cometriq, Tafinlar or Omeprazole.
							9. For patients ≥ 18years of age	
							Use PA Form# 10120	
ANTI - VIRALS								
ANTIRETROVIRALS	MC		ATRIPLA[1]	MC/DEL	8	APTIVUS		
	MC		DESCOVY[1]	MC/DEL	8	COMBIVIR TABS	Use PA Form# 10620 for Fuzeon	Please refer to the criteria listed on the Fuzeon PA form.
	MC/DEL		EDURANT[1]	MC	8	COMPLERA[1]		
	MC		EMTRIVA[1]	MC/DEL	8	CRIXIVAN CAPS	Use PA Form# 20420 for all others	
	MC/DEL		EPIVIR	MC/DEL	8	DIDANOSINE		
	MC/DEL		EPZICOM[1]	MC/DEL	8	FUZEON[3]	1. Quantity limit of one per day	**DDI:** Reyataz requires prior authorization if it is currently being used in combination with either Prevacid, pantoprazole, Prilosec, or any currently non preferred PPI .
	MC/DEL		EVOTAZ[1]	MC/DEL	8	INTELENCE[3]		
	MC		GENVOYA[1,5]	MC/DEL	8	INVIRASE CAPS	2. Only preferred if Norvir script is in member's profile within the past 30 days of filling Prezista	
	MC/DEL		ISENTRESS[3]	MC/DEL	8	LEXIVA		**DDI:** Norvir requires prior authorization if it is currently being used in combination with either Enablex 15mg or Vesicare 10mg.
	MC		KALETRA	MC/DEL	8	NEVIRAPINE		
	MC/DEL		**LAMIVUDINE/ZIDOVUDINE**	MC	8	ODEFSEY[1]		
	MC		NORVIR	MC/DEL	8	PREZCOBIX[1]	3.Isentress Chewable will only be approved if between the age of 2-12 years old	**DDI:** Preferred Crixivan caps requires prior authorization if it is currently being used in combination with either Enablex 15mg or Vesicare 10mg.
	MC		PREZISTA[2]	MC/DEL	8	RESCRIPTOR TABS		
	MC		REYATAZ[1]	MC	8	RETROVIR		DDI: The concomitant use of the following drugs with **Descovy®** is not recommended: tipranavir/ritonavir, St. John's wort, and the antimycobacterials rifabutin, rifampin, or rifapentine.
	MC		SUSTIVA[1]	MC/DEL	8	SELZENTRY		
	MC		TIVICAY[6]	MC	8	STAVUDINE	4. Request will require use of the individual components Tivicay and Epzicom.	
	MC		TRUVADA[1]	MC	8	STRIBILD[1]		DDI: Administration with the following drugs: the anticonvulsants carbamazepine, oxcarbazepine, phenobarbital, and phenytoin; the antimycobacterials rifampin and rifapentine; proton pump inhibitors such as dexlansoprazole, esomeprazole, lansoprazole, omeprazole, pantoprazole, rabeprazole; systemic dexamethasone (more than a single dose); and St. John's wort with **Odefsey** is contraindicated.
	MC		VIREAD TABS[1]	MC	8	TRIUMEQ[1,4]		
	MC/DEL		ZIAGEN TABS	MC/DEL	8	TRIZIVIR TABS		
	MC/DEL		**ZIDOVUDINE**	MC	8	TYBOST	5. Clinical PA required.	Stribild: PA required; must provider rationale as to why the member's medical need cannot be met with preferred agents, particularly Genvoya or combinations of preferred and agents AND must be antiretroviral treatment-naïve or virologically controlled on current therapy (HIV-1RNA < copies/ml) AND be HBV negative AND not be combined with other anti-retroviral agents.
				MC	8	VIDEX EC		
				MC/DEL	8	VIRACEPT TABS		
				MC	8	VITEKTA		
				MC	8	ZERIT		DDI: Tivicay will require prior authorization is used with nevirapine, oxcarbazepine, phenytion, phenobarbital, carbamazepine, and St. John's wort.
				MC/DEL	8	VIRAMUNE TABS		
				MC/DEL	9	VIRAMUNE XR		
								DDI:Aatazanavir or darunavir and the following drugs are contraindicated (due to potential for serious and/or life-threatening events or loss of therapeutic effect): alfuzosin, dronedarone, rifampin, irinotecan, dihydroergotamine, ergotamine, methylergonovine, cisapride, St. John's wort, lovastatin, simvastatin, pimozide, nevirapine, sildenafil (when given as

								Revatio® for treatment of PAH), indinavir, triazolam, or PO midazolam will be non-preferred and require prior authorization if it is currently being used in combination with Tybost. Prezcobix is only available if unable to tolerate of have failed Prezista and Norvir
CYTO-MEGALOVIRUS AGENTS	MC MC		FOSCARNET SODIUM VALCYTE TABS	MC/DEL MC/DEL		FOSCAVIR GANCICLOVIR	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
HERPES AGENTS	MC/DEL MC/DEL		ACYCLOVIR VALACYCLOVIR HCL	MC/DEL MC MC/DEL MC/DEL MC/DEL	8 8 8 8 9	FAMCICLOVIR[1] SITAVIG ZOVIRAX[1] VALTREX TABS[1] FAMVIR TABS[1]	1. Must fail Acyclovir and Valacyclovir before non-preferred products in step order. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
INFLUENZA AGENTS	MC/DEL MC MC/DEL MC/DEL		AMANTADINE RELENZA DISKHALER AEPB RIMANTADINE HCL TABS TAMIFLU[1]	MC MC		FLUMADINE TABS FLUMIST	1. Tamiflu 10 caps or 60cc's per month. Will be audited for presence of positive influenza tests in patient or family member. Use PA Form# 10610 for Flumist requests Use PA Form# 20420 for all others	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
IMMUNE SERUMS								
IMMUNE SERUMS	MC		HYPERRHO INJ					
HEPATITIS AGENTS								
HEPATITIS C AGENTS	MC MC MC MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL		EPCLUSA[2] MAVYRET[2] OLYSIO[2] PEGASYS KIT[1] PEGASYS SOLN PEG-INTRON KIT[1] RIBAVIRIN **RIBASPHERE** ZEPATIER[2]	MC/DEL MC/DEL MC MC/DEL MC MC MC MC MC MC		COPEGUS TABS DAKLINZA HARVONI[2] REBETOL CAPS RIBAPAK SOVALDI[2] TECHNIVIE[2] VIEKIRA PAK[2] VIEKIRA XR[2] VOSEVI	1. Dosing limits apply, please see dosage consolidation list. 2. Approvals will require clinical PA. Please see the Hepatitis PA form for criteria Use PA Form #10700	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **DDI:** Olysio will require a prior authorization if it is currently being used in combination with drugs known to be significant CYP3A4 inhibitors (ketoconazole, itraconazole, clarithromycin, indinavir, nefazodone, nelfinavir, ritonavir, atazanavir, saquinavir and telithromycin).
HEPATITIS AGENTS - MISC.				MC		ACTIMMUNE	Use PA Form# 20420	Approved for chronic granulomatous disease, osteopetrosis and idiopathic pulmonary fibrosis.
HEPATITIS B ONLY	MC MC		HEPSERA TABS TENOFOVIR	MC MC MC		BARACLUDE TYZEKA VEMLIDY	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Baraclude is indicated for treatment of chronic Hep B virus (HBV) in adults with: evidence of active viral replication AND either evidence of persistent elevation in serum aminotransferases (ALT or AST) or histologically active disease, Patient is 16 years of age or older. Boxed warning: Use not recommended for those co-infected with HIV and HBV who are not also receiving highly active antiretroviral therapy (HAART). Vemlidy® remain non-preferred and require prior authorization and be available to those who have evidence of bone loss or renal insufficiency or who are unable to tolerate or who

								have failed on preferred medications.
RSV PROPHYLAXIS								
RSV PROPHYLAXIS				MC		SYNAGIS[1]	Use PA Form# 30120 1. MaineCare will approve Synagis PA's for start date of November 23rd for infants who meet the guidelines. PA will be approved for max of 5 doses. Maximum 1 dose/30 days.	Please see the criteria listed on the Synagis PA form.
MS TREATMENTS								
MULTIPLE SCLEROSIS - INTERFERONS	MC MC/DEL MC		AVONEX KIT[1] **BETASERON SOLR**[1] REBIF SOLN[1]	MC MC/DEL		PLEGRIDY[1] EXTAVIA	1.Clinical PA is required to establish diagnosis and medical necessity. Use PA Form# 20430	Non-Preferred drugs must be tried in step-order and failed due to lack of efficacy or intolerable side effects before lower ranked non-preferred drugs will be approved , unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
MULTIPLE SCLEROSIS - NON-INTERFERONS	MC MC/DEL MC		COPAXONE 20MG[2] GILENYA[2,3] AUBAGIO	MC MC MC MC/DEL MC MC	6 8 8 8 8 8	TYSABRI[1] AMPYRA COPAXONE 40MG **GLATOPA** OCREVUS[2] TECFIDERA	1. Providers must be enrolled in the TOUCH Prescribing program, a restricted distribution program. Clinical PA is required to establish diagnosis and medical necessity. 2. Clinical PA is required to establish diagnosis and medical necessity. 3. Dosing limits apply, please see dosage consolidation list. Use PA Form# 20430	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **Aubagio** is preferred and is for adults with relapsing forms of MS. No concurrent use of leflunomide . Within 6 months of initiation of Aubagio, lab testing to look at (transaminase, bilirubin, CBC, TB) as boxed warning exists regarding hepatoxicity.
MULTIPLE SCLEROSIS - MISC				MC		ZINBRYTA[1]	1. The safety and efficacy of use in children under the age of 17 years have not been established.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists
ASSORTED NEUROLOGICS								
NEUROLOGICS - MISC.	MC/DEL MC MC		ORAP TABS PROSTIGMIN TABS PYRIDOSTIGMINE	MC MC MC MC MC/DEL		BOTOX[2] DYSPORT MESTINON MYOBLOC[1] XEOMIN[2]	1. Approval will be limited to Cervical dystonia. 2. Please see botulinum PA form for additional criteria	Failed/did not tolerate therapeutic trials fo muscle relaxants, unless contraindicated, including but not limited to baclofen, cyclobenzaprine, orphenadrine, Skelaxin, and tizanidine. **Migraine:** Consideration for Botox approvals will only be made after failures of required trials of the following preferred medications: tricyclic or venlafaxine,beta blocker,valproic acid ,topiramate Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between

							Use PA Form# 10210	another drug and the preferred drug(s) exists.
NEUROLOGICS- SMA				MC		SPINRAZA[1]	1. Clinical PA is required to establish diagnosis and medical necessity Use PA Form# 20420	Spinraza: The diagnosis is spinal muscular atrophy (SMA) type 1, 2, or 3 (results of genetic testing must be submitted) AND The patient has at least 2 copies of the SMN2 gene AND The prescriber is a neurologist, pulmonologist, or other physician with expertise in treating SMA AND The need for invasive or noninvasive ventilation (if applicable) does not exceed more than 6 hours per 24-hour period AND Baseline motor ability has been established using one of the following exams: Hammersmith Infant Neurological Exam (HINE) Hammersmith Functional Motor Scale Expanded (HFMSE) Upper Limb Module Test (non-ambulatory) Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP INTEND) AND Prior to starting therapy, and prior to each dose, the following laboratory tests will be conducted: Platelet count, prothrombin time (PT), activated partial thromboplastin time (aPTT), and Note: Initial approval will be granted for 4 loading doses (the first 3 loading doses should be administered at 14-day intervals; the 4th loading dose should be administered 30 days after the 3rd dose). Renewal may be granted for up to 12 months with a maximum of 3 doses approved per year (12mg (5ml) every 4 months). For therapy continuation, clinical documentation must be submitted documenting improvement or maintenance of motor ability OR slower progression of disease than would otherwise be expected.
NEUROLOGICS- ALS				MC		RADICAVA[1]	1. Clinical PA for indication required Use PA Form# 20420	
MOVEMENT DISORDERS				MC MC MC		AUSTEDO[1] INGREZZA[1] TETRABENAZINE XENAZINE	1. Clinical PA required for appropriate diagnosis Use PA Form# 20420 Use PA Form# 20710 for Xenazine	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. DDI: Avoid concomitant use of Ingrezza® with MAO inhibitors (e.g. isocarboxazid, phenelzine, or selegiline). Concomitant use with strong CYP3A4 inducers (e.g. rifampin, carbamazepine, phenytoin, St. John's wort) is not recommended
MUSCULAR DYSTROPHY AGENTS				MC MC		EMFLAZA[2] EXONDYS 51[1]	1. Clinical prior authorization to verify diagnosis and use of stable dose of corticosteroid for at least 6 months. 2. For the treatment of Duchenne muscular dystrophy (DMD) in patients 5 years of age and older and a documented intolerance of oral corticosteroid. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
STEROIDS								
GLUCOCORTICOIDS/ MINERALOCORTICOIDS	MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL		BUDESONIDE EC CELESTONE SUSP CORTEF 5 CORTISONE ACETATE TABS DELTASONE TABS DEPO-MEDROL SUSP	MC MC/DEL MC/DEL MC/DEL MC MC		CORTEF 10 and 20 TABS ENTOCORT EC CP24 FLORINEF TABS **MEDROL TABS** MEDROL DOSEPAK TABS MILLIPRED	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.

	MC/DEL		DEXAMETHASONE	MC		ORAPRED SOLN		
	MC		DEXPAK	MC		PEDIAPRED LIQD		
	MC/DEL		FLUDROCORTISONE ACETATE TABS	MC		PREDNISONE INTENSOL CONC		
	MC/DEL		HYDROCORTISONE	MC		STERAPRED TABS		
	MC		KENALOG					
	MC/DEL		METHYLPREDNISOLONE TABS					**DDI:** All preferred steroids will require clinical PA for patients over 60 that are currently on fluoroquinolone therapy.
	MC/DEL		PREDNISOLONE					
	MC/DEL		**PREDNISONE**					
	MC/DEL		SOLU-CORTEF SOLR					
	MC/DEL		SOLU-MEDROL SOLR					
HORMONE REPLACEMENT THERAPIES								
ANDROGENS / ANABOLICS	MC/DEL		ANDRODERM PT24	MC		ANADROL-50	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Additionally, laboratory evidence of a testosterone deficiency must be supplied. One of each dosage form should be tried (tablet, injection, and topical)
	MC/DEL		ANDROGEL 1%	MC		ANDRO LA 200 OIL		
	MC/DEL		ANDROGEL PUMP 1.62%	MC/DEL		ANDROGEL PACKETS 1.62%		
	MC/DEL		DANAZOL CAPS	MC		ANDROID CAPS		
	MC/DEL		METHITEST TABS	MC		AXIRON		
	MC/DEL		TESTOSTERONE CYP	MC		DELATESTRYL OIL		
				MC/DEL		DEPO-TESTOSTERONE OIL		
				MC		FORTESTA		
				MC		HALOTESTIN TABS		
				MC		NATESTO		
				MC/DEL		**OXANDROLONE**		
				MC		TESTIM		
				MC		TESTRED CAPS		
				MC/DEL		VOGELXO		
ESTROGENS - PATCHES / TOPICAL	MC/DEL		**VIVELLE-DOT PTTW**	MC/DEL	5	**ESTRADIOL PTWK**	1. Step order drugs must be used in specified step order.	Approved for failures on multiple oral estrogen agents after 90 day trials or if unable to swallow any oral medication.
	MC/DEL		**CLIMARA PTWK**	MC/DEL	8	**ALORA PTTW**[1]		
				MC/DEL	8	**DIVIGEL**[1]		
				MC/DEL	8	**ELESTRIN**[1]		
				MC	8	**EVAMIST**[1]		
							Use PA Form# 20420	
ESTROGENS - TABS	MC/DEL		**CENESTIN TABS**	MC/DEL		ENJUVIA	Must fail preferred products before non-preferred products.	Preferred drugs must be tried for at least 90 days and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**ESTRADIOL**	MC/DEL		**ESTRACE TABS**		
	MC/DEL		**ESTROPIPATE TABS**	MC		ESTRATAB TABS		
	MC/DEL		**MENEST TABS**	MC		ORTHO-EST TABS		
	MC/DEL		**PREMARIN TABS**					
							Use PA Form# 20420	
ESTROGEN COMBO'S	MC/DEL		**PREMPHASE TABS**	MC/DEL		**ACTIVELLA TABS**[1]	1. Must fail Premphase and Prempro products before non preferred products.	Preferred drugs must be tried for at least 90 days and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**PREMPRO TABS**	MC/DEL		**COMBIPATCH PTTW**[1]		
				MC/DEL		**FEMHRT 1/5 TABS**[1]		
				MC/DEL		**ORTHO-PREFEST TABS**[1]	Use PA Form# 20420	
				MC/DEL		SYNTEST H.S. TABS[1]		
PROGESTINS	MC		MAKENA[3]	MC/DEL		AYGESTIN TABS	1. PA approvals will require two 100 mg caps instead of one 200mg.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		MEDROXYPROGESTERONE ACETA [2]	MC		CYCRIN TABS		
	MC/DEL		NORETHINDRONE ACETATE TABS[2]	MC		PROGESTERONE POWD	2. Must fail Medroxyprogesterone and Norethidrone products before non-preferred products.	
	MC		17-ALPH HYDROXYPROGESTERONE[3]	MC/DEL		PROMETRIUM 100MG CAPS[1]		
				MC/DEL		PROMETRIUM 200MG[1]		
				MC/DEL		PROVERA TABS	3. Clinical PA required for indication to reduce the risk of preterm birth in women with a singleton pregnancy who have a history of singleton spontaneous preterm birth.	

							Use PA Form# 20420	
CONTRACEPTIVES								
CONTRACEPTIVES - PROGESTIN ONLY	MC/DEL MC/DEL		NOR-QD TABS NORETHINDRONE ACETATE 0.35 TABS	MC/DEL MC/DEL MC/DEL MC/DEL MC	7 7 7 7 8	CAMILA TABS ERRIN JOLIVETTE NORA-BE TABS ORTHO MICRONOR TABS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. If member experienced adverse reactions, consider using Oral Contraceptives from other groups. **DDI:** Preferred Oral Contraceptives will now be non-preferred and require prior authorization if it is currently being used in combination with Tracleer.
CONTRACEPTIVES - INJECTABLE	MC/DEL		MEDROXYPROGESTERONE ACETATE 150mg IM	MC/DEL		DEPO-PROVERA 150 mg SUSP	Use PA Form# 20420	The preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
CONTRACEPTIVE - EMERGENCY	MC/DEL MC/DEL MC MC/DEL	1 2 2 2	PLAN B ONE STEP[1] ELLA LEVONORGESTREL NEXT CHOICE[1]	MC/DEL		PLAN B	1. Allowed 2 tablets per 30 days without PA Use PA Form# 20420	
CONTRACEPTIVES - PATCHES/ VAGINAL PRODUCTS	MC		NUVARING RING[1]	MC/DEL		**XULANE**[2]	Use PA Form# 20420 1. Quantity limit allowing 1 every 28 days with out PA. 2. Dose limits apply allowing 3 patches per 28 days supply.	Approved if adequate clinical reason given why patient unable to comply with other preferred agents including long acting injectable.
CONTRACEPTIVES - MONOPHASIC COMBINATION O/C'S	MC/DEL MC/DEL MC/DEL MC/DEL MC MC MC/DEL MC MC/DEL MC/DEL MC MC MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		APRI TABS AVIANE TABS BALZIVA CRYSELLE-28 TABS DESOGEN TABS DESOGESTREL/ ETHINYL ESTRADIOL LOW-OGESTREL TABS MODICON TABS MONONESSA NECON 1/50 ORTHO-CEPT-28 TABS ORTHO-CYCLEN-28 TABS ORTHO-NOVUM 1/35-28 TABS OVCON-50 28 TABS PREVIFEM RECLIPSEN SOLIA SPRINTEC 28 TABS YASMIN 28 TABS YAZ ZENCHENT	MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		BEYAZ BREVICON-28 TABS LESSINA-28 TABS LEVORA LOESTRIN TABS LOESTRIN FE TABS LOESTRIN FE 1/20 TABS LOESTRIN 1.5/30-21 TABS LOESTRIN 1/20-21 TABS LO/OVRAL 21 TABS LO/OVRAL 28 TABS MICROGESTIN FE TABS NORDETTE-28 TABS NORINYL NORTREL OCELLA OGESTREL TABS OVCON-35/28 TABS OVRAL PORTIA-28 TABS SAFYRAL ZOVIA	Use PA Form# 20420 If member experienced adverse reactions, consider using Oral Contraceptives from other groups.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. If member experienced adverse reactions, consider using Oral Contraceptives from other groups. **DDI:** Preferred Oral Contraceptives will now be non-preferred and require prior authorization if it is currently being used in combination with Tracleer.
CONTRACEPTIVES - BI-PHASIC COMBINATIONS	MC MC MC/DEL		ORTHO-NOVUM 10/11-28 TABS NORETHINDRONE-ETH ESTRADIOL TAB 0.5-35/1-35 SEASONIQUE	MC/DEL MC/DEL MC/DEL MC/DEL		NECON 10/11-28 TABS KARIVA TABS LOSEASONIQUE MIRCETTE TABS	If member experienced adverse reactions, consider using Oral Contraceptives from other groups. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. If member experienced adverse reactions, consider using Oral Contraceptives from other groups. **DDI:** Preferred Oral Contraceptives will now be non-preferred and require prior authorization if it is currently being used in combination with Tracleer.
CONTRACEPTIVES - TRI-PHASIC COMBINATIONS	MC/DEL MC/DEL MC MC/DEL MC/DEL		ENPRESSE NECON 7/7/7 ORTHO-NOVUM 7/7/7-28 TABS TRI-NORINYL 28 TABS TRI-PREVIFEM	MC/DEL MC/DEL MC/DEL MC MC		CYCLESSA TABS ESTROSTEP FE TABS NORTREL 7/7/7 ORTHO TRI-CYCLEN TABS ORTHO TRI-CYCLEN LO TABS	If member experienced adverse reactions, consider using Oral Contraceptives from other groups.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.

	MC/DEL		TRIPHASIL 28 TABS					If member experienced adverse reactions, consider using Oral Contraceptives from other groups.
	MC/DEL		TRI-SPRINTEC					**DDI:** Preferred Oral Contraceptives will now be non-preferred and require prior authorization if it is currently being used in combination with Tracleer.
	MC		TRINESSA					
	MC/DEL		TRIVORA-28 TABS				Use PA Form# 20420	
CONTRACEPTIVES - MULTI-PHASIC COMBINATIONS				MC		NATAZIA	Use PA Form# 20420	
DIABETES THERAPIES								
DIABETIC - INSULIN	MC		HUMALOG INJ 100/ML	MC/DEL		APIDRA	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		HUMALOG MIX 75/25	MC/DEL		**AFREZZA**[1]	1. Not to be as a monotherapy. Obtain lab values of pulmonary function and recent smoking history	
	MC		HUMALOG 50/50 VIAL	MC		BASAGLAR		
	MC		HUMULIN N INJ U-100	MC		HUMALOG MIX PEN 50/50		
	MC		HUMULIN INJ 70/30	MC		HUMULIN INJ 50/50		
	MC		HUMULIN R U-100	MC/DEL		**NOVOLIN**		
	MC		HUMULIN R INJ U-500	MC/DEL		**NOVOLOG**		
	MC/DEL		LANTUS SOLN	MC/DEL		**NOVOLOG MIX**		
	MC/DEL		LEVEMIR	MC		RELION		
DIABETIC - PENFILLS	MC/DEL		LANTUS SOLOSTAR	MC		APIDRA OPTICLIK PEN	1. Clinical PA will be required to establish significant visual or neurological impairment.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		LEVEMIR FLEXTOUCH	MC		HUMALOG KWIK INJ 100/ML		
	MC/DEL		**NOVOLIN PENFILL**[1]	MC		HUMALOG MIX INJ 75/25 KWP		
	MC/DEL		**NOVOLIN 70/30**[1]	MC		HUMALOG MIX INJ 50/50 KWP		
	MC/DEL		NOVOLOG MIX PENFILL[1]	MC/DEL		**TOUJEO**		
	MC/DEL		**NOVOLOG PENFILL SOLN**[1]	MC/DEL		**TRESIBA**		
	MC/DEL		NOVOLOG MIX FLEXPEN[1]					
	MC/DEL		NOVOLOG FLEXPEN[1]				Use PA Form# 20420	
DIABETIC - DPP- 4 ENZYME INHIBITOR	MC/DEL		JANUVIA[1,2]	MC/DEL		**ONGLYZA**[2]	1. Preferred if therapeutic doses of metformin are seen in members drug profile for at least 60 days within the past 18 months or if phosphate binder is currently seen in the members drug profile.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		TRADJENTA[2]					**DDI:** Onglyza 5mg will require a prior authorization if it is currently being used in combination with drugs known to be significant CYP3A4 inhibitors (ketoconazole, itraconazole, clarithromycin, indinavir, nefazodone, nelfinavir, ritonavir, atazanavir, saquinavir and telithromycin).
							2. Dosing limits apply. Please refer to Dose consolidation list.	
							Use PA Form# 20420	
DIABETIC - DPP- 4 ENZYME INHIBITOR-COMBO	MC/DEL		JANUMET[1,2]	MC/DEL		**JENTADUETO XR**	1. Preferred if therapeutic doses of metformin are seen in members drug profile for at least 60 days within the past 18 months or if phosphate binder is currently seen in the members drug profile.	
	MC/DEL		**JANUMET XR**[1,2]	MC/DEL		**KAZANO**		
	MC/DEL		**JENTADUETO**[1]	MC		KOMBIGLYZE XR		
				MC/DEL		**OSENI**		
							2. Dosing limits apply. Please refer to Dose consolidation list.	
							Use PA Form# 20420	
DPP- 4 ENZYME INHIBITOR/ HMG-COS REDUCTASE INHIBITOR	MC/DEL		JUVISYNC[1,2]				Use PA Form# 20420	**DDI:** Juvisync will require a prior authorization if used in concurrent use with drugs known to be significant CYP3A4 inhibitors (ketoconazole, itraconazole, clarithromycin, indinavir, nefazodone, nelfinavir, ritonavir, atazanavir, saquinavir and telithromycin).
							1. Please refer to criteria section of PDL	Juvisync will remain preferred until product is eventually discontinued later in 2014.

							2. Dosing limits apply please refer to Dose Consolidation List	
DIABETIC - LANCET-LANCET DEVICE	**MC** **MC** **MC** **MC** **MC**		ONE TOUCH LANCETS DELICA LANCETS UNILET LANCETS UNISTIK LANCING DEVICE AUTOLOT LANCING DEVICE				Use PA Form# 20420	
DIABETIC - SYRINGES-NEEDLES	**MC/DEL** **MC** **MC** **MC**		BD MICRO-FINE BD ULTRA-FINE BD ULTRA-FINE PEN NEEDLES UNIFINE PEN NEEDLES				Use PA Form# 20420	
DIABETIC - OTHER				**MC/DEL** **MC**		CYCLOSET SYMLIN	Use PA Form# 30150 for Symlin Use PA Form #20420 for all others	Please see the criteria listed in the Symlin PA form.
SGLT 2 INHIBITORS	**MC/DEL**		**FARXIGA**[2]	**MC/DEL** **MC/DEL**		**INVOKANA**[1] **JARDIANCE**	1.Dosing limits apply please refer to Dose Consolidation List 2. Preferred if therapeutic doses of metformin are seen in members drug profile for at least 60 days within the past 18 months Use PA Form# 20420	**Invokana** will be considered for patients who are unable to tolerate any preferred medicaitons from other diabetic classes.
SGLT 2 INHIBITOR COMBINATIONS				**MC/DEL** **MC/DEL** **MC/DEL** **MC/DEL** **MC/DEL** **MC/DEL**		**GLYXAMBI** **INVOKAMET** **INVOKAMET XR** **SYNJARDY** **SYNJARDY ER** **XIGDOU XR**[1]	1. Diagnosis required Use PA Form# 20420	Preferred drugs must be tried for at least 3 months at full therapeutic doses and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Glyxambi /Xigduo XR- Verify prior trials and failures or intolerance of preferred treatments from other diabetic categories Synjardy® XR is not recommended for patients with type 1 DM or for the treatment of diabetic ketoacidosis.
DIABETIC MONITOR	**MC** **MC** **MC** **MC** **MC** **MC** **MC**		FREESTYLE INSULINX FREESTYLE LITE SYSTEM KIT FREESTYLE FREEDOM LITE KIT ONE TOUCH ULTRA 2 KIT ONE TOUCH ULTRA MINI KIT ONE TOUCH ULTRA SMART KIT PRECISION XTRA METER	**MC** **MC** **MC** **MC** **MC** **MC**		ACCUCHECK ASCENSIA ASSURE CONTOUR BREEZE Z EXACTECH PRODIGY	Use PA Form# 20420	Effective October 25th 2007, approvals for all non preferred meters/ test strips will require medical necessity documenting clinically significant features that are not available on any of the preferred meters.
DIABETIC TEST STRIPS	**MC** **MC** **MC** **MC** **MC** **MC**		FREESTYLE[1] FREESTYLE LITE[1] FREESTYLE INSULINX[1] ONE TOUCH DELICA[1] ONE TOUCH ULTRA[1] PRECISION XTRA[1]	**MC** **MC** **MC** **MC** **MC** **MC**		ACCUCHECK ASCENSIA ASSURE EXACTECH PRODIGY CONTOUR BREEZE Z	1. Only 50 ct & 100 ct package size. Use PA Form# 20420	Effective October 25th 2007, approvals for all non preferred meters/ test strips will require medical necessity documenting clinically significant features that are not available on any of the preferred meters.

INCRETIN MIMETIC	**MC** **MC** **MC/DEL**		BYDUREON BYETTA VICTOZA	**MC/DEL** **MC/DEL** **MC/DEL** **MC** **MC/DEL** **MC/DEL**	8 8 8 8 8 8	**ADLYXIN** **NESINA** **TANZEUM** TRULICITY[2] **SOLIQUA** **XULTOPHY**	1. If patient is not responding to oral agents (single or multiple) please look to insulin therapy. Dosing limits apply. Please refer to Dose Consolidation List. 2. Diagnosis required Use PA Form# 10230	At least two preferred drugs in this category must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Soliqua must try both insulin and a preferred incretin mimetic and have a medical necessity for use that is not based on convenience or simply due to the fact that one injection is needed instead of two. Trulicity- Verify prior trials and failures or intolerance of preferred treatments from other diabetic categories and that is not being used as first-line treatment
DIABETIC - ORAL SULFONYLUREAS	**MC/DEL** **MC/DEL** **MC/DEL** **MC/DEL** **MC/DEL** **MC/DEL** **MC/DEL** **MC/DEL**		**CHLORPROPAMIDE TABS** GLIMEPIRIDE **GLIPIZIDE TABS** **GLIPIZIDE ER TABS** **GLYBURIDE MICRONIZED TABS** **GLYBURIDE TABS**[1] **TOLAZAMIDE TABS** **TOLBUTAMIDE TABS**	**MC/DEL** **MC/DEL** **MC** **MC/DEL** **MC/DEL** **MC/DEL**		**AMARYL TABS** **DIABETA TABS** **GLUCOTROL TABS** **GLUCOTROL XL TBCR** **GLYNASE TABS** **MICRONASE TABS**	Use PA Form# 20420 1. Pa required for members ≥65. Glyburide has a greater risk of severe prolonged hypoglycemia in older adults.	Preferred drugs must be tried for at least 3 months at full therapeutic doses and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **DDI:** All sulfonylureas (except glyburide) will now be non-preferred and require prior authorization if it is currently being used with either ranitidine or cimetidine. **DDI:** Glimepiride will now be non-preferred and require prior authorization if it is currently being used with either fluconazole (except 150mg strength) or fluvoxamine. Amaryl is non-preferred but with any prior authorization requests, the member's drug profile will also be monitored for concurrent use with either fluconazole or fluvoxamine.
DIABETIC -ORAL BIGUANIDES	**MC/DEL** **MC/DEL**		**METFORMIN HCL TABS** METFORMIN ER	**MC** **MC** **MC** **MC/DEL**		GLUCOPHAGE TABS GLUCOPHAGE XR TB24 FORTAMET METFORMIN ER OSMOTIC	Use PA Form# 20420	Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
DIABETIC - THIAZOL / BIGUANIDE COMBO				**MC/DEL** **MC/DEL** **MC/DEL** **MC/DEL**		ACTOPLUS MET[1] ACTOPLUS MET XR AVANDARYL[1] **AVANDAMET TABS**[1]	Use PA Form# 20420 1. Requires use of Actos, Metformin, or other preferred anti-diabetics.	**DDI:** Actos, Avandia, or any combination product with Actos or Avandia will now be non-preferred and require prior authorization if it is currently being used with gemfibrozil.
DIABETIC - / THIAZOL	**MC/DEL**		**PIOGLITAZONE HCL**[1]	**MC/DEL** **MC/DEL**		**ACTOS TABS**[3] **AVANDIA TABS**[2]	1. Pioglitazone HCL is non-preferred as monotherapy. Pioglitazone HCL is preferred if therapeutic doses of metformin, sulfonylurea or insulin are seen in members drug profile for at least 60 days within the past 18 months. 2. Current users of Avandia who have tried Actos will be able to continue use of Avandia. 3. Dosing limits apply please refer to Dose Consolidation List Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **DDI:** Actos, Avandia, or any combination product with Actos or Avandia will now be non-preferred and require prior authorization if it is currently being used with gemfibrozil.
DIABETIC - ALPHAGLUCOSIDASE	**MC/DEL**		**GLYSET TABS**	**MC**		**PRECOSE TABS**	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.

DIABETIC - SULFONYLUREA / BIGUANIDE	MC/DEL		GLYBURIDE/METFORMIN	MC		**GLUCOVANCE TABS**[1]	1. Use individual ingredients.	Approved for patients failing to achieve good diabetic control with maximal doses of individual components.
				MC		METAGLIP TABS[1]	2. Use Actos with generic glimepiride.	
				MC/DEL		DUETACT[2]	Use PA Form# 20420	
DIABETIC - MEGLITINIDES	MC		**NATEGLINIDE**	MC/DEL		**PRANDIN TABS**	Use PA Form# 20420	Preferred drugs from other diabetic sub-categories must be tried and failed due to lack of inadequate diabetic control or intolerable side effects before non-preferred drug will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **DDI**: Prandin is non-preferred but with any prior authorization requests, the member's drug profile will also be monitored for current use with both Sporanox and gemfibrozil, due to a significant drug-drug interaction.
				MC/DEL		**STARLIX TABS**		
GLUCOSE ELEVATING AGENTS								
GLUCOSE ELEVATING AGENTS	MC/DEL		GLUCAGEN INJ. HYPOKIT[1]	MC		GLUCAGON DIAGNOSTIC KIT	Use PA Form# 20420	
				MC		GLUCAGEN DIAGNOSTIC KIT	1. Dosing limits apply, please see dose consolidation list.	
THYROID								
THYROID HORMONES	MC/DEL		**ARMOUR THYROID TABS**	MC		LEVOTHYROXINE SODIUM SOLR	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**CYTOMEL TABS**	MC/DEL		LIOTHYRONINE		
	MC/DEL		**LEVOTHROID TABS**	MC		SYNTHROID TABS		
	MC/DEL		**LEVOTHYROXINE SODIUM TABS**					
	MC/DEL		**LEVOXYL TABS**					
	MC/DEL		**THYROID TABS**					
	MC/DEL		**THYROLAR**					
	MC/DEL		**UNITHROID TABS**					
ANTITHYROID THERAPIES	MC/DEL		**METHIMAZOLE TABS**	MC/DEL		**TAPAZOLE TABS**	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**PROPYLTHIOURACIL TABS**					
OSTEOPOROSIS / BONE AGENTS								
OSTEOPOROSIS	MC/DEL		ALENDRONATE	MC/DEL		**ACTONEL TABS**	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **Binosto** use preferred generic alendronate tablets
	MC/DEL		**MIACALCIN SOLN**[2]	MC		AREDIA SOLR	1. Approval only requires failure of Alendronate.	
				MC		BINOSTO		
				MC/DEL		BONIVA INJECTION KIT	2. Quantity limits apply, please see dosage consolidation list.	
				MC/DEL		BONIVA TABS[2,4]		
				MC/DEL		CALCITONIN NS		
				MC/DEL		**DUAVEE**	3. Please use Alendronate and Vitamin D.	
				MC/DEL		**DIDRONEL TABS**		
				MC		EVISTA TABS[1]		
				MC		FORTEO	4. Please use other preferred agents.	
				MC/DEL		FORTICAL		
				MC/DEL		**FOSAMAX TABS AND PLUS D**[3]	5. Obtain baseline ophthalmology exams and renal ultrasounds and then periodically during treatment	
				MC		PROLIA		
				MC		STRENSIQ[5]		
				MC		TYMLOS		
				MC		XGEVA		
				MC/DEL		ZOMETA		
CALCIMIMETIC AGENTS								
CALCIMIMETIC AGENTS				MC		SENSIPAR	Use PA Form# 30115	Baseline PTH, Ca, and phosphorous levels are required and initial approvals will be limited to 3 months. Subsequent approvals will require additional levels being done to assess changes. Will not approve if baseline Ca is less than 8.4.
GROWTH HORMONE								
GROWTH HORMONE	MC/DEL		GENOTROPIN[1]	MC	8	HUMATROPE SOLR	Use PA Form# 10710	See Growth Hormone PA form for criteria. Step-order will still apply unless clinical contraindication supplied.
	MC/DEL		NORDITROPIN SOLN[1]	MC	8	INCRELEX	1.Clinical PA is required to establish diagnosis and medical necessity.	
				MC/DEL	8	NUTROPIN		
				MC	8	OMNITROPE		
				MC	8	SAIZEN SOLR		
				MC/DEL	8	TEV-TROPIN		
				MC/DEL	8	NUTROPIN AQ		

SOMATOSTATIC AGENTS				MC/DEL		OCTREOTIDE INJ	Use PA Form# 10710	
				MC/DEL		SANDOSTATIN		
				MC		SOMATULINE		
GROWTH HORMONE ANTAGONISTS								
GH ANTAGONISTS				MC		SOMAVERT	Use PA Form# 10710	Approved for acromegaly patients failing surgery/radiation/drug therapy including bromocriptine and sandostatin.
VASOPRESSIN RECEPTOR ANTAGONIST								
VASOPRESSIN RECEPTOR ANTAGONIST				MC/DEL		SAMSCA	Use PA Form# 20420	**Samsca Drug Warning**- Avoid use in patients with underlying liver disease, including cirrhosis, because the ability to recover from liver injury may be impaired. Limit duration of therapy to 30 days to minimize the risk of liver injury.
URINARY INCONTINENCE								
VASOPRESSINS			DESMOPRESSIN TABS	MC/DEL	5	DDAVP TABS	1. Products must be used in specified step order. Nocturnal enuresis patients will be encouraged to periodically attempt stopping DDAVP. 2. Patients with a diagnosis of hemophilia or Von Willebrands disease will be exempt from prior authorization. Use PA Form# 20420	Approved for central diabetes insipidus and for nocturnal enuresis. For nocturnal enuresis- must be over 6 years old, must fail an adequate trial of alarm training (higher success rate, lower relapse rate) and must periodically attempt weaning (at 6 month intervals).
				MC/DEL	6	DDAVP SOLN[1]		
				MC/DEL	6	**DESMOPRESSIN SPRAY**[1]		
				MC	8	DESMOPRESSIN ACETATE SOLN[1]		
				MC/DEL	8	STIMATE SOLN[1,2]		
ANTISPASMODICS	MC/DEL		**OXYBUTYNIN**	MC/DEL	8	**DETROL TABS**	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		URISPAS TABS	MC/DEL	8	**DITROPAN**		
				MC/DEL	9	TROSPIUM		
ANTISPASMODICS - LONG ACTING	MC/DEL		**OXYBUTYNIN ER TABS**	MC	8	**DITROPAN XL TBCR**	Use PA Form# 20420 1. See Criteria Section. 2. Product is considered line extension of the original product due to Healthcare Reform (HCR). MaineCare will consider these medications non-preferred and a step 9 because of the impact under the Federal Rebate Program in conjunction with HCR. 3. Use a preferred long acting antispasmodic.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. 1. Vesicare 5mg and Enablex 7.5mg maximum doses if given with drugs known to be significant CYP3A4 inhibitors.(Ketoconazole, Sporanox, Erythromycin, Fluconazole, Nefazodone, Nelfinavir, and Ritonavir) **DDI:** Enablex 15mg and Vesicare 10mg will now be non-preferred and require prior authorization if they are currently being used in combination with any of the following medications: clarithromycin, erythromycin, Ketek, Crixivan, Norvir, ketoconazole, fluconazole (except 150mg strength), Sporanox. nefazodone, or diltiazem.
	MC/DEL		TOVIAZ	MC/DEL	8	ENABLEX[1,3]		
				MC/DEL	8	**MYRBETRIQ**		
				MC/DEL	8	**OXYTROL**		
				MC/DEL	8	**TOLTERODINE TAB**		
				MC	8	VESICARE[1]		
				MC/DEL	9	DETROL LA CP[2]		
CHOLINERGIC	MC/DEL		**URECHOLINE**				Use PA Form# 20420	
	MC/DEL		**BETHANECHOL**					
METABOLIC MODIFIER								
HERED. TYROSINEMIA				MC		ORFADIN	Use PA Form# 20420	Approved for Type 1 hereditary tyrosinemia patients. Must include laboratory evidence of dx at first PA.
ANTIHYPERTENSIVES / CARDIAC								
CARDIAC GLYCOSIDES	MC/DEL		**DIGITEK TABS**				Use PA Form# 20420	

	MC/DEL		**DIGOXIN**					
	MC/DEL		**LANOXIN**					
CARDIAC - SINUS NODE INHIBITORS	MC		CORLANOR					In patients with stable, symptomatic chronic heart failure with left ventricular ejection fraction ≤35%, who are in sinus rhythm with resting heart rate ≥70 beats per minute (bpm) and either are on maximally tolerated doses of beta-blockers or have a contraindication to beta-blocker use
ANTIANGINALS--Isosorbide Di-nitrate/ Mono-Nitrates	MC/DEL		**ISOSORBIDE MONONITRATE TABS**	MC		DILATRATE SR CPCR	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**ISOSORBIDE MONONITRATE ER**	MC		ISORDIL TABS		
				MC		ISORDIL TITRADOSE TABS		
				MC		ISOSORBIDE DINITRATE SUBL		
				MC/DEL		**ISOSORBIDE DINITRATE TABS**		
				MC/DEL		ISOSORBIDE DINITRATE CR TBCR		
				MC/DEL		**ISOSORBIDE DINITRATE ER TBCR**		
				MC/DEL		ISOSORBIDE DINITRATE TD TBCR		
				MC/DEL		**IMDUR TB24**		
				MC/DEL		ISMO TABS		
				MC		MONOKET TABS		
NITRO - OINTMENT/CAP/CR	MC/DEL		**NITROBID OINT**				Use PA Form# 20420	
	MC/DEL		**NITROGLYCERIN CPCR**					
	MC		NITROL OINT					
	MC		NITRO-TIME CPCR					
NITRO - PATCHES	MC/DEL	1	**NITROGLYCERIN PT24**[1]	MC		NITRODISC PT24	1. At least 2 step 1's and step 3 of the preferred products must be used in specified order or PA will be required. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL	1	**NITREK PT24**[1]	MC/DEL		**NITRO-DUR PT24**		
	MC/DEL	1	**NITRO-DUR PT 24 0.8MG**[1]					
	MC	3	MINITRAN PT24[1]					
NITRO - SUBLINGUAL/ SPRAY	MC/DEL		**NITROSTAT SUBL**	MC/DEL		**NITROQUICK SUBL**	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**NITROTAB SUBL**	MC		**NITROLINGUAL SOLN**		
				MC		NITROLINGUAL TABS		
BETA BLOCKERS - NON SELECTIVE	MC/DEL		**CARVEDILOL**	MC/DEL		**BETAPACE TABS**	1. Recommend using BID since its effects do not last 24 hours. 2. Please use other strengths in combination to obtain this dose. 3. Dosing limits still apply. Please see dose consolidation list Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		INNOPRAN XL	MC		**BETAPACE AF TABS**		
	MC		LEVATOL TABS	MC/DEL		**COREG CR**[3]		
	MC/DEL		**NADOLOL TABS**	MC/DEL		**COREG TABS**		
	MC/DEL		**PINDOLOL TABS**	MC/DEL		**CORGARD TABS**		
	MC/DEL		**PROPRANOLOL HCL SOLN**[1]	MC/DEL		**INDERAL TABS**		
	MC/DEL		**PROPRANOLOL HCL TABS**[1]	MC		INDERAL LA CPCR		
	MC/DEL		**PROPRANOLOL HCL 60MG TABS**					
	MC/DEL		**PROPRANOLOL LA CAPS**					
	MC		RANEXA					
	MC/DEL		SOTALOL AF					
	MC/DEL		SOTALOL HCL TABS					
	MC/DEL		**TIMOLOL MALEATE TABS**					
BETA BLOCKERS - CARDIO SELECTIVE	MC/DEL		**ACEBUTOLOL HCL CAPS**	MC/DEL		BYSTOLIC	1. Recommend using Atenolol (and metoprolol) BID since its effects do not last 24 hours. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**ATENOLOL TABS**[1]	MC		KERLONE TABS		
	MC/DEL		**BETAXOLOL HCL TABS**	MC/DEL		**LOPRESSOR TABS**		
	MC/DEL		**BISOPROLOL FUMARATE TABS**	MC		SECTRAL CAPS		
	MC/DEL		**METOPROLOL TARTRATE TABS**[1]	MC/DEL		**TENORMIN TABS**		
	MC/DEL		**METOPROLOL ER**	MC/DEL		**TOPROL XL TB24**		
				MC/DEL		**ZEBETA TABS**		
BETA BLOCKERS - ALPHA / BETA	MC/DEL		**LABETALOL HCL TABS**	MC		TRANDATE TABS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
BETA BLOCKERS & DURECTIC COMBOS				MC/DEL		**DUTOPROL**	Use PA Form# 20420	
CALCIUM CHANNEL BLOCKERS--Amlodipines, Bepridil, Diltiazems, Felodipines, Isradipines, Nifedipines, Nisoldipine, and Verapamils	MC/DEL		AMLODIPINE[1]	MC/DEL		**NORVASC TABS**[1]	1. Dosing limits apply, please see dose consolidation list. Use PA Form# 20420	
	MC		DILTIA XT CP24	MC/DEL	5	**DILACOR XR CP24**[1]	1. Products must be used in specified order or PA will be required. Just write	Preferred drugs must be tried and failed (in step-order) due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**DILTIAZEM HCL ER CP24**	MC/DEL	6	**TAZTIA**[1]		

	MC/DEL		DILTIAZEM HCL XR CP24	MC	8	CARDIZEM TABS[1]	required. Just write "Diltiazem 24-hour"and the pharmacy will use a preferred long acting diltiazem that does not require PA. Use PA Form# 20420	another drug and the preferred drug(s) exists. **DDI:** All preferred diltiazems will now be non-preferred and require prior authorization if they are currently being used in combination with either Enablex 15mg or Vesicare 10mg. All non-preferred diltiazems require prior authorization, but with any prior authorization request, the member's drug profile will also be monitored for current use with Enablex 15mg or Vesicare 10mg.
	MC/DEL		DILTIAZEM CD 300MG CP24	MC	8	CARDIZEM CD CP24[1]		
	MC/DEL		DILTIAZEM CD 360MG CP24	MC	8	CARDIZEM LA TB24[1]		
	MC		CARTIA XT CP24[1]	MC	8	CARDIZEM SR CP12[1]		
	MC/DEL		DILTIAZEM CD CP24[1]	MC/DEL	8	DILTIAZEM HCL TABS[1]		
	MC/DEL		DILTIAZEM HCL ER CP24[1]	MC/DEL	8	DILTIAZEM HCL ER CP12[1]		
	MC/DEL		DILTIAZEM XR CP24[1]	MC/DEL	8	DILTIAZEM HCL ER CP12[1]		
	MC/DEL		TIAZAC CP24[1]					
				MC/DEL		PLENDIL TB24	Use PA Form# 20420	Other Preferred calcium channel blockers must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
				MC/DEL		FELODIPINE		
				MC		DYNACIRC CAPS	Use PA Form# 20420 1. Established users will be grandfathered	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
				MC		DYNACIRC CR TBCR[1]		
				MC		CARDENE SR CPCR	Use PA Form# 20420	Other Preferred calcium channel blockers must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
				MC		NICARDIPINE HCL CAPS		
	MC/DEL		AFEDITAB CR	MC/DEL		ADALAT CC TBCR[1]	1. Established users of Adalat CC are grandfathered. Use PA Form# 20420	Preferred drug must be tried and failed in step order due to lack of efficacy or intolerable side effects before non-preferred drugs in step order will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		NIFEDIAC CC	MC/DEL		NIFEDIPINE CAPS		
	MC/DEL		NIFEDICAL XL TBCR	MC/DEL		PROCARDIA CAPS		
	MC/DEL		NIFEDIPINE TBCR	MC/DEL		PROCARDIA XL TBCR		
	MC/DEL		NIFEDIPINE ER TBCR					
				MC		SULAR TB24	1. Established users of 10MG and 20MG strengths are grandfathered. Use PA Form# 20420	
				MC		SULAR CR[1]		
	MC/DEL	1	VERAPAMIL HCL CR TBCR	MC/DEL		CALAN TABS	Products must be used in specified order or PA will be required. Just write "Verapamil 24-hour" and the pharmacy will use a preferred long acting generic that does not require PA. Use PA Form# 20420	Preferred drugs must be tried and failed (in step-order) due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL	1	VERAPAMIL HCL ER TBCR	MC/DEL		CALAN SR TBCR		
	MC/DEL	1	VERAPAMIL HCL SR TBCR	MC/DEL		COVERA-HS TBCR		
				MC		ISOPTIN-SR		
				MC/DEL		VERAPAMIL HCL ER CP24		
				MC/DEL		VERAPAMIL HCL SR CP24		
				MC/DEL		VERAPAMIL HCL TABS		
				MC/DEL		VERELAN CP24		
				MC/DEL		VERELAN PM CP24		
ANTIARRHYTHMICS	MC/DEL		AMIODARONE HCL	MC/DEL		CORDARONE	1. Prescription must be written by Cardiologist. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **DDI:** Amiodarone will now be non-preferred and require prior authorization if it is currently being used in combination with either Lovastatin (doses greater than 40mg/day) or Lipitor (doses greater than 20mg/day) or Levofloxacin or Gemifloxacin, or Moxifloxacin, or Ofloxacin. **DDI:** Multaq will be preferred unless the following medications are seen in the member's drug profile within the last 35 days for brand name medications or 90 days for generic medications: Erythromycin, Amiodarone and other antiarrhythmics, TCA's, Phenothiazine, Ketoconazole, Itraconazole, Voriconazole, Cyclosporine, Telithromycin, Clarithromycin, Nefazodone, Ritonavir.
	MC/DEL		FLECAINIDE	MC/DEL		DISOPYRAMIDE		
	MC/DEL		MEXILETINE HCL	MC/DEL		MULTAQ		
	MC/DEL		NORPACE	MC/DEL		PACERONE		
	MC/DEL		PROCAINAMIDE	MC		QUINIDEX		
	MC/DEL		PROPAFENONE	MC/DEL		TAMBOCOR		
	MC		QUINAGLUTE	MC/DEL		TIKOSYN[1]		
	MC/DEL		QUINIDINE GLUCONATE	MC/DEL		RYTHMOL SR		
	MC/DEL		QUINIDINE SULFATE	MC/DEL		RYTHMOL		
ACE INHIBITORS	MC/DEL		BENAZEPRIL HCL	MC	5	MAVIK TABS	1. Non-preferred products must be used in specified order. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs (in step-order) will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Non-preferred products are subject to step-order requirements unless clinical circumstances warrant exception.
	MC/DEL		CAPTOPRIL TABS	MC/DEL	5	ACCUPRIL TABS		
	MC/DEL		ENALAPRIL MALEATE TABS	MC/DEL	8	ACEON TABS[1]		
	MC/DEL		FOSINOPRIL SODIUM	MC/DEL	8	ALTACE CAPS[1]		
	MC/DEL		LISINOPRIL TABS	MC	8	EPANED		
	MC/DEL		RAMIPRIL	MC/DEL	8	LOTENSIN TABS[1]		
	MC/DEL		QUINAPRIL HCL	MC/DEL	8	MOEXIPRIL HCL[1]		
				MC	8	MONOPRIL HCT TABS[1]		
				MC/DEL	8	PRINIVIL TABS[1]		
				MC	8	QBRELIS		
				MC/DEL	8	UNIVASC[1]		
				MC	8	VASOTEC TABS[1]		

				MC/DEL	8	**ZESTRIL TABS**[1]		
ANGIOTENSIN RECEPTOR BLOCKER	MC/DEL MC/DEL MC/DEL MC/DEL		**BENICAR TABS**[1] **IRBESARTAN**[1] LOSARTAN[1] **MICARDIS TABS**[1]	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL	8 8 8 8 8 8 8	**ATACAND TABS** **AVAPRO** **COZAAR** **DIOVAN** EDARBI TEVETEN TABS TRIBENZOR[2]	Use PA Form# 20420 1. Preferred products only available without PA if patient on diabetic therapy or prior ACE therapy. 2. Use preferred active ingredients which are available without PA.	The initial criteria to use any ARB is that the member must have failed ACE inhibitors (such as due to coughing) in the past or must currently be actively treated for diabetes and Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
DIRECT RENIN INHIBITOR				MC/DEL MC/DEL MC/DEL		AMTURNIDE TEKTURNA[1] TEKAMLO	1. Must show failure of single and combination therapy from all preferred antihypertensive categories. Use PA Form# 20420	
ANTIHYPERTENSIVES - CENTRAL	MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL		**CATAPRES-TTS** **CLONIDINE HCL TABS** **GUANFACINE HCL TABS** **HYDRALAZINE HCL TABS** HYLOREL TABS **METHYLDOPA TABS** **MINOXIDIL TABS** **PRAZOSIN HCL CAPS** **RESERPINE TABS**	MC/DEL MC/DEL MC MC MC/DEL MC MC/DEL		**CATAPRES TABS** CLONIDINE TTS GUANABENZ ACETATE TABS ISMELIN TABS **MINIPRESS CAPS** **NEXICLON** **TENEX TABS**	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ACE INHIBITORS AND CA CHANNEL BLOCKERS				MC/DEL MC MC MC/DEL MC/DEL	8 8 8 9 9	**AMLODIPINE/BENAZEPRIL** PRESTALIA[1] TARKA TBCR **AMLODIPINE/BENAZEPRIL** **LOTREL CAPS**	1. Prestalia will only be approved for patients ≥ 18 years of age. Use individual preferred generic medications. Use PA Form# 20420	
ACE AND THIAZIDE COMBO'S	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		**BENAZEPRIL HCL/HYDROCHLOR** **CAPTOPRIL/HYDROCHLOROTHIA** **ENALAPRIL MALEATE/HCTZ TABS** **LISINOPRIL-HCTZ TABS** **LOTENSIN HCT TABS**	MC/DEL MC MC/DEL MC/DEL MC MC/DEL		**ACCURETIC TABS** MONOPRIL HCT TABS **PRINZIDE TABS** **UNIRETIC TABS** VASERETIC TABS **ZESTORETIC TABS**	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
BETA BLOCKERS AND DIURETIC COMBO'S	MC/DEL MC/DEL MC/DEL		**ATENOLOL/CHLORTHALIDONE** **BISOPROLOL FUMARATE/HCTZ** **PROPRANOLOL/HCTZ**	MC/DEL MC/DEL MC MC MC/DEL		**CORZIDE TABS** **LOPRESSOR HCT TABS** TENORETIC TIMOLIDE 10/25 TABS **ZIAC TABS**	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ARB'S AND CA CHANNEL BLOCKERS	MC/DEL MC/DEL MC/DEL		**AMLODIPINE/VALSARTAN** **AZOR** **EXFORGE HCT**[1]	MC MC/DEL MC/DEL		BYVALSON **TWYNSTA** **EXFORGE**	1. Preferred products only available without PA if patient on diabetic therapy or prior ACE therapy. Use PA Form# 20420	DDI: Byvalson will be non-preferred and require a prior authorization if it is currently being used in combination with drugs known to be significant CYP2D6 inhibitors (e.g. quinidine, propafenone, fluoxetine, paroxetine).
ARB'S AND DIURETICS	MC/DEL MC/DEL MC/DEL MC/DEL		BENICAR HCT[1] LOSARTAN HCT[1] MICARDIS HCT TABS[1] **VALSARTAN-HYDROCHLOROTHIAZIDE**[1]	MC/DEL MC/DEL MC MC/DEL MC/DEL MC	7 8 8 8 8 8	**IRBESARTAN HYDROCHLOROTHIAZIDE** **ATACAND HCT TABS** **AVALIDE TABS**[1] DIOVAN HCT TABS[1] HYZAAR TABS TEVETEN HCT TABS	1. Preferred products only available without PA if patient on diabetic therapy or prior ACE therapy. Use PA Form# 20420	Same initial criteria as the ARB class and Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANGIOTENSIN MODULATORS-ARB COMBINATION	MC		ENTRESTO	MC/DEL		**EDARBYCLOR**	Use PA Form# 20420	
ARB'S AND DIRECT RENIN INHIBITOR COMBINATION				MC/DEL		**VALTURNA**	Use PA Form# 20420	
DIURETICS	MC/DEL MC/DEL MC/DEL MC/DEL		**ACETAZOLAMIDE TABS** **BUMETANIDE** **CHLOROTHIAZIDE TABS** **CHLORTHALIDONE TABS**	MC/DEL MC/DEL MC/DEL MC/DEL		**ALDACTAZIDE TABS** **ALDACTONE TABS** **AMILORIDE HCL** **BUMEX TABS**	1. Multiples of Spironolactone 25 mg are cheaper than 50 mg strength. Inspra will be approved for severe breast	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.

	MC		EDECRIN TABS	MC/DEL		**DEMADEX TABS**	tenderness and male gynecomastia.	
	MC/DEL		EDECRIN TABS	MC/DEL		**DIAMOX**		
	MC/DEL		**HYDROCHLOROTHIAZIDE**	MC		DIURIL		
	MC/DEL		**INDAPAMIDE TABS**	MC/DEL		**DYAZIDE CAPS**		
	MC/DEL		**METHAZOLAMIDE TABS**	MC		ENDURON TABS		
	MC/DEL		**METHYCLOTHIAZIDE TABS**	MC/DEL		**INSPRA**		DDI: The concomitant use of Keveyis® with high dose aspirin is contraindicated.
	MC/DEL		**SPIRONOLACTONE 25MG TABS**	MC/DEL		**KEVEYIS**		
	MC/DEL		**SPIRONOLACTONE/HYDRO**	MC/DEL		**LASIX TABS**		
	MC/DEL		**TORSEMIDE TABS**	MC/DEL		**MAXZIDE**		
	MC/DEL		**TRIAMTERENE/HCTZ**	MC/DEL		**MICROZIDE CAPS**		
	MC		ZAROXOLYN TABS	MC/DEL		**MIDAMOR TABS**		
				MC		NAQUA TABS	Use PA Form# 20420	
				MC/DEL		**SPIRONOLACTONE 50MG**[1]		
CCB / LIPID				MC/DEL		**CADUET**		
NEUROGENIC ORTHOSTATIC HYPOTENSION								
NEUROGENIC ORTHOSTATIC HYPOTENSION				MC		**NORTHERA**	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
LIPID DRUGS								
CHOLESTEROL - BILE SEQUESTRANTS	MC/DEL		**CHOLESTYRAMINE**	MC/DEL		**COLESTID**	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**COLESTIPOL HCl**	MC/DEL		**PREVALITE**		
				MC		**QUESTRAN**		
				MC/DEL		WELCHOL TABS		
CHOLESTEROL - FIBRIC ACID DERIVATIVES	MC/DEL		FENOFIBRATE	MC		ANTARA	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **DDI:** Fenofibrate is preferred but will require a prior authorization requests if used concurrent with Warfarin. **DDI:** Gemfibrozil will now be non-preferred and require prior authorization if it is currently being used with any of the following medications: Prandin, Actos, Avandia, any Avandia/Actos combination product, any HMG-COA Reductase Inhibitors (statins), or Warfarin.
	MC/DEL		**GEMFIBROZIL TABS**	MC/DEL		**LOPID**		
	MC/DEL		NIASPAN	MC/DEL		FENOFIBRATE 120mg		
				MC/DEL		**FIBRICOR**		
				MC		LIPOFEN		
				MC/DEL		**LOFIBRA**		
				MC		TRICOR		
				MC		TRIGLIDE		
				MC		TRILIPIX		
CHOLESTEROL - HGM COA + ABSORB INHIBITORS MORE POTENT DRUGS/COMBINATIONS	MC/DEL		**ATORVASTATIN**	MC/DEL		**LIPITOR**	1. Dosing limits apply, please see dosage consolidation list. 2. Current users grandfathered. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **DDI:** Lipitor (doses greater than 20mg/day) will now be non-preferred and require prior authorization if they are currently being used in combination cyclosporine. **DDI:** Lipitor (doses greater than 20mg/day) will now be non-preferred and require prior authorization if it is currently being used in combination with Amiodarone. **DDI:** All preferred statins will now be non-preferred and require prior authorization if it is currently being used in combination with Gemfibrozil.
	MC/DEL		**CRESTOR**	MC		LIPTRUZET		
	MC/DEL		**SIMVASTATIN**[1]	MC/DEL		**ZOCOR**		
	MC		**VYTORIN**	MC/DEL		**SIMVASTATIN 80MG**[1,2]		
CHOLESTEROL - HGM COA + ABSORB INHIBITORS LESS POTENT DRUGS/COMBINATIONS	MC/DEL		LESCOL XL TB24	MC	8	ALTOPREV TB24	2. Dosing limits apply, please see dosage consolidation list. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Zetia will be approved for patients unable to tolerate all other therapies or unable to achieve cholesterol goal with maximally tolerated dose of most potent statins. **DDI:** Lescol will now be non-preferred and require prior authorization if it is currently being used in combination with diclofenac. **DDI:** Lovastatin (doses greater than 40mg/day) will now be non-preferred and require prior authorization if it is currently being used in combination with Amiodarone. **DDI:** Lovastatin (doses greater than 20mg per day) will now be non-preferred and require prior authorization if it is currently being used in combination cyclosporine. **DDI:** All preferred statins will now be non-preferred and require prior authorization if it is currently being used in combination with Gemfibrozil.
	MC/DEL		LOVASTATIN TABS[2]	MC	8	LIVALO		
	MC/DEL		PRAVASTATIN[2]	MC/DEL	8	MEVACOR TABS		
	MC		ZETIA TABS	MC/DEL	8	**PRAVACHOL TABS**		
				MC/DEL	8	PRAVIGARD		
CHOLESTEROL - HGM COA + ABSORB INHIBITORS STATIN/ NIACIN COMBO	MC		SIMCOR	MC		ADVICOR TBCR	Use PA Form# 20420	
FAMILIAL HYPERCHOLESTEROLEMIA				MC		JUXTAPID	1. Clinical PA required for appropriate diagnosis 2. Quantity limits apply for HeFH/ASCVD 1 injection per 14 days for HoFH 3 injections per 30 days	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists Juxtapid is contraindicated with strong CYP3A4 inhibitors. Juxtapid dosage should not exceed 30mg daily when it is used concomitantly with weak CYP3A4 inhibtors.
				MC		KYNAMRO[1]		
				MC/DEL		**PRALUENT**[1,2,3]		
				MC		REPATHA[1,2,3]		

							3. Documented adherence to lipid lowering medications and abstinence from tobacco for previous 90 days For Repatha and Praluent please use PA form #10800 Use PA Form#10500	Kynamro requires an appropriate lab testing prior to starting (ALT<AST), Alkaline phosphatase and total billrubin, monthly liver-related tests for the first year, then every three months. Praluent and Repatha initial approvals will be limited to 8 weeks (for HeFH or ASCVD) or 3 months (for HoFH). Baseline and follow up lipid profiles are required and subsequent approvals will require additional levels being done to assess changes. Will not approve if LDL-C is not at goal after a period of : 1. 24 weeks for Praluent or Repatha for treatment of HeFH/ASCVD 2. 3 months of Repatha for treatment of HoFH)
PULMONARY ANTI-HYPERTENSIVES								
PULMONARY ANTI-HYPERTENSIVES	MC		EPOPROSTENOL INJ[6]	MC		ADCIRCA[1]	1. See Criteria Section. 2. See Criteria Section. 3. See Criteria Section. 4. See Criteria Section. 5. There will be dosing limits of one 20ml multidose vial/ 30 days supply without pa. 6. PA is required to establish and conform who group 1 diagnosis of primary PAH (Primary Pulmonary Hypertension) and NYHA functional class 3 & 4. 7. Requires previous trials/failure of multiple preferred medications. 8. Dosing limits apply, please see the dose consolidation list. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significat potential drug interation between another drug and the preferred drug(s) exists. 1. Adcirca approvals will require WHO Group 1 diagnosis of primary PAH (Primary Pulmonary Hypertension) and NYHA functional class 2 or 3. 2. Ventavis approvals will require WHO Group 1 diagnosis of primary PAH (Primary Pulmonary Hypertension) and NYHA functional class 3 or 4. 3. Revatio approvals will require WHO Group 1 diagnosis of primary PAH (Primary Pulmonary Hypertension) and NYHA functional class 2 or 3. 3. Revatio approvals will require WHO Group 1 diagnosis of primary PAH (Primary Pulmonary Hypertension) and NYHA functional class 2 or 3. 4. Sildenafil will be preferred with clinical PA for treatment of pulmonary arterial hypotenion (WHO Group 1) in adults to improve exercise ability and delay clinical worsening. **DDI:** Opsumit will require a prior authorization if it is currently being used in combination with drugs known to be significant CYP3A4 inhibitors (ketoconazole, itraconazole, clarithromycin, indinavir, nefazodone, nelfinavir, ritonavir, atazanavir, saquinavir and telithromycin). **DDI:** Adempas will require a prior authorization if it is currently being used in combination with drugs known to be PDE inhibitors should be avoided (including dypyridamole, adcira and tadalafil) with adempas DDI: Uptravi will require a prior authorization if it is currently being used in combination with strong inhibitors of CYP2C8 (gemfibrozil)
	MC		ORENITRAM	MC/DEL		ADEMPAS[6,7]		
	MC/DEL		SILDENAFIL[4]	MC/DEL		FLOLAN[6]		
	MC		VENTAVIS[2]	MC		OPSUMIT[7,8]		
				MC		REMODULIN[6]		
				MC/DEL		REVATIO[3]		
				MC		TYVASO		
				MC		UPTRAVI		
				MC		VELVETRI		
ERA / ENDOTHELIN RECEPTOR ANTAGONIST	MC		LETAIRIS[1,2]				1. Providers must be registered with LEAP Prescribing program, a restricted distribution program. 2. Clinical PA is required to establish diagnosis and medical necessity. 3. Prior trial of Letaris, WHO Group 1 diagnosis of PAH (Primary Pulmonary Hypertension) and NYHA functional class of 3. 4. For members with NYHA functional class of 4, Tracleer approval will be allowed with confirmation of diagnosis and functional class. Use PA Form# 20420	Tracleer approvals will require WHO Group 1 diagnosis of primary PAH (Primary Pulmonary Hypertension) and NYHA functional class 2 thru 4. **DDI:** Preferred Oral Contraceptives will now be non-preferred and require prior authorization if it is currently being used in combination with Tracleer. Letairis approvals will require WHO Group 1 diagnosis of primary PAH (Primary Pulmonary Hypertension) and functional class 2 or 3 symptoms.
	MC		TRACLEER[3,4]					

IMPOTENCE AGENTS								
IMPOTENCE AGENTS							As of January 1, 2006, per CMS (federal govt.), impotence agents are no longer covered.	As of January 1, 2006, per CMS (federal govt.), impotence agents are no longer covered.
ANTI-EMETOGENICS								
ANTIEMETIC - ANTICHOLINERGIC / DOPAMINERGIC	MC/DEL		MECLIZINE HCL TABS	MC		ANTIVERT TABS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		PROMETHAZINE SUPP	MC		PHENERGAN SOLN		
	MC/DEL		PROMETHAZINE	MC		PROMETHAZINE 50MG SUPP		
	MC		TRANSDERM-SCOP PT72	MC		PROMETHEGAN SUPP		
				MC		TORECAN TABS		
ANTIEMETIC - 5-HT3 RECEPTOR ANTAGONISTS/ SUBSTANCE P NEUROKININ	MC/DEL		**DRONABINOL CAPS**	MC/DEL	5	GRANISETRON	1. Approvals will require diagnosis of chemo-induced nausea/vomiting and failed trials of all preferred anti-emetics, including 5-HT3 class (Ondansetron) and Marinol.	Preferred drugs and step therapy must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. * Ondansetron limits still apply as listed on the Ondansetron PA form for covered indications including chemotherapy, radiotherapy, post operative nausea & vomiting and hyperemesis gravidarum. Other medical indications will be approved or denied on a case by case basis. Hyperemesis and other medical indications approved are still subject to failure of multiple preferred antiemesis drugs.
	MC/DEL		**ONDANSETRON TABS[2,4]**	MC	8	AKYNZEO[1]		
	MC/DEL		**ONDANSETRON ODT TBDP[2,4]**	MC	8	ALOXI		Akynzeo- Concomitant use should be avoided in patients who are chronically using a strong CYP3A inducer such as rifampin.
	MC/DEL		**ONDANSETRON INJ[2,4]**	MC	8	ANZEMET TABS		
				MC	8	CESAMET[1]		
				MC	8	DICLEGIS		
				MC	8	EMEND[3]		
				MC/DEL	8	KYTRIL		
				MC/DEL	8	MARINOL CAPS		Varubi – Available to the few who are unable to tolerate or who have failed on preferred medications
				MC	8	SANCUSO	2. Ondansetron will be preferred with CA diag and dosing limits still apply.	
				MC	8	SUSTOL		
				MC	8	SYNDROS		
				MC	8	VARUBI		
				MC/DEL	8	ZOFRAN ODT TBDP[4]	3. Clinical PA is required for members on highly emetic anti-neoplastic agents.	
				MC/DEL	8	ZOFRAN TABS[4]	4. Dosing limits apply, please see Dosage Consolidation List	
				MC/DEL	8	ZOFRAN INJ[4]	Use PA Form# 20610 for Ondansetron requests	
				MC	8	ZUPLENZ		
							Use PA Form# 20420 for all others	
NON-SEDATING ANTIHISTAMINES / DECONGESTANTS								
ANTIHISTIMINES - NON-SEDATING	MC		ALAVERT TABS	MC	5	CLARINEX TABS[1,5]	1. Must fail preferred drugs, OTC loratidine and cetirizine before moving to non-preferred step order drugs.	Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. No combination product with decongestant will be approved since pseudoephedrine available without PA.
	MC/DEL		CETIRIZINE TABS	MC	5	CLARINEX SYR[1,2]		
	MC		CLARITIN (OTC)	MC/DEL	5	FEXOFENADINE[1]		
	MC		CLARITIN SYRP (OTC)	MC/DEL	5	ZYRTEC[1]		
	MC/DEL		LORATADINE	MC/DEL	5	ZYRTEC SYR[1,2]		
	MC		TAVIST ND (OTC)	MC/DEL	8	ALLEGRA[3]	2. Clarinex and Zyrtec syrp <6 yr w/o PA.	Pseudoephedrine is available with prescription.
				MC	8	CLARITIN[3]		
				MC/DEL	8	DESLORATADIN	3. Must fail all step 5 drugs (Clarinex, Fexofenadine and Zyrtec) before moving to next step product.	
				MC/DEL	8	LORATADINE ODT[4]		
				MC/DEL	8	LEVOCETIRIZINE[4]		
				MC/DEL	9	XYZAL[3]		
							4. All OTC versions of loratadine ODT are now non-preferred.	
							5. Pa's for Clarinex RediTabs will only be approved if between the ages of 6-11 years old.	
							Use PA Form# 20530	
ANTIHISTIMINES - OTHER	MC/DEL		CLEMASTINE				Use PA Form# 20530	

	MC/DEL		CHLORPHENIRAMINE					
	MC/DEL		DIPHENHYDRAMINE					
ALLERGY / ASTHMA THERAPIES								
ANAPHYLACTIC DEVICES	MC/DEL		**EPINEPHRINE**	MC		TWINJECT		
	MC/DEL		**EPIPEN**					
	MC/DEL		**EPIPEN JR**					
ALLERGEN IMMUNOTHERAPY				MC/DEL		GRASTEK[1]	Use PA Form# 20420 1. See criteria section	Prescriber must provide the testing to show that the patient is allergic to the components in the prescribed therapy and must provide a clinically valid rationale why single agent sublingual therapy is being chosen over subcutaneous therapy Treatment must start 12 weeks before expected onset of pollen season and only after confirmed by positive skin test or in vitro testing for pollen-specific IgE antibodies for short ragweed pollen (Ragwitek), timothy grass or cross-reactive grass pollens (Grastek), or any of the 5 grass species contained in Oralair Have an auto-injectable epinephrine on-hand **Grastek :** Patient age ≥5 years and ≤65 years **Ragwitek:** Patient age ≥18 years and ≤65 years **Oralair:** Patient age ≥10 years and ≤65 years
				MC/DEL		RAGWITEK[1]		
				MC		ORALAIR[1]		
ANTIASTHMATIC - ANTICHOLINERGICS - INHALER	MC/DEL		SPIRIVA HANDIHALER[1,2]	MC		SEEBRI NEOHALER	Use PA Form# 20420 1. Quantity limit of 1 inhalation daily (1 capsule for inhalation daily) Spiriva will require PA if Combivent or Atrovent nebulizer solution is in member's current drug profile. 2. We ask physicians to write "asthma" on the prescription whenever Spiriva is primarily being used for that condition. 3. Quantity limit of 1 inhalation daily	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
				MC/DEL		**SPIRIVA RESPIMAT**		
				MC/DEL		**TUDORZA**		
				MC/DEL		**INCRUSE ELLIPTA[3]**		
ANTIASTHMATIC - PHOSPHODIESTERASE 4 INHIBITORS				MC/DEL		DALIRESP	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANTIASTHMATIC - ANTICHOLINERGICS - NEBULIZER	MC/DEL		**IPRATROPIUM BROMIDE SOLN**	MC		ATROVENT SOLN	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANTIASTHMATIC - ANTIINFLAMMATORY AGENTS	MC/DEL		CROMOLYN SODIUM NEBU	MC		CINQAIR[3]	1. Need max inhaled steroids and written by pulmonary or allergy specialist 2. For patients with severe asthma aged 12 years or older 3. For patients ≥ 18 years of age Use PA Form# 20420	Nucala & Xolair approval will require suboptimal response to maximal doses of inhaled steroid as evidenced by asthmatic ER/Hospital admissions and Allergy/Pulmonary specialist management. Cinqair approval will require inadequate response to guideline based therapy including max inhaled steroid eosinophilic phenotype eosinophilia > 400/mcl.
				MC/DEL		**NUCALA[2]**		
				MC/DEL		XOLAIR[1]		
ANTIASTHMATIC - NASAL STEROIDS	MC/DEL		**FLUTICASONE SPR[3]**	MC/DEL	5	BECONASE AQ INHA[1,3]	Use PA Form# 20420 1. All preferred drugs must be tried before moving to non preferred steps.	Preferred drugs and step therapy must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		OMNARIS SPR[3]	MC/DEL	8	DYMISTA		
	MC/DEL		ZETONNA[3]	MC/DEL	8	FLONASE SUSP[2,3]		
				MC/DEL	8	FLUNISOLIDE SOLN[1,3]		
				MC/DEL	8	NASONEX SUSP		
				MC	8	QNASL		

				MC	8	RHINOCORT AERO[2,3]	2. All step 5 medications need to be tried before moving to step 8's. 3. Dosing limits apply to whole category, please see dosage consolidation list.	
				MC/DEL	8	RHINOCORT AQUA SUSP[2,3]		
				MC	8	TRI-NASAL SOLN[2,3]		
				MC	8	VANCENASE POCKETHALER AERS[2,3]		
				MC/DEL	8	VERAMYST[2,3]		
				MC/DEL	9	TRIAMCINOLONE NS		
ANTIASTHMATIC - NASAL MISC.	MC/DEL		CROMOLYN NASAL 4%	MC	7	ATROVENT NASAL SOL	Use PA Form# 20420 1. Ipratropium will be approved if submitted with documentation supporting use of CPAP machine. 2. Utilize Multiple preferred, as well as step therapy Azelastine.	Approved if patient fails on nonsedating antihistamines and steroid nasal sprays. Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
				MC/DEL	7	AZELASTINE		
				MC	7	IPRATROPIUM NASAL SOL[1]		
				MC/DEL	8	ASTEPRO[2]		
				MC/DEL	8	PATANASE		
ANTIASTHMATIC - BETA - ADRENERGICS	MC/DEL		**ALBUTEROL NEB**	MC/DEL		**ACCUNEB NEBU**	1. Xopenex users w/ prior asthma hospitalization due to albuterol nebulizer failure will be grandfathered. 2. Quantity Limit: 12 cc/day. 3. Dosing limits apply, please see dosage consolidation list. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**FORADIL AEROLIZER CAPS**	MC/DEL		**ALBUTEROL AER**		
	MC/DEL		**METAPROTERENOL**	MC/DEL		**ALBUTEROL HFA**		
	MC/DEL		**PROVENTIL HFA**	MC/DEL		**ALBUTEROL 0.63mg/3ml**		
	MC/DEL		**SEREVENT**	MC/DEL		**ARCAPTA[3]**		
	MC/DEL		**TERBUTALINE SULFATE TABS**	MC/DEL		**BRETHINE**		
				MC		**PROAIR HFA[3]**		
				MC		PROAIR RESPICLICK		
				MC/DEL		**STRIVERDI**		
				MC/DEL		**VENTOLIN AERS**		
				MC/DEL		**VENTOLIN HFA AERS[3]**		
				MC		VOLMAX TBCR		
				MC		VOSPIRE ER TB12		
				MC		**XOPENEX HFA[3]**		
				MC		**XOPENEX NEBU[1,2]**		
ANTIASTHMATIC - ADRENERGIC	MC/DEL		**ADVAIR HFA[1,2]**	MC/DEL		**BREO ELLIPTA[2,3]**	1. We ask physicians to write "asthma" on the prescription whenever Advair is primarily being used for that condition. 2. Dosing limits apply, please see dosage consolidation list. 3. Clinical PA required for appropriate diagnosis 4. For patients ≥ 12 years and older. Use PA Form# 20420	**ADVAIR DISKUS**- Patients currently using Advair Diskus® will have a 90 day grace period to transition to Advair HFA® or another preferred product on the PDL such as Dulera® or Symbicort® Advair Diskus will be approved for patients with asthma or COPD who: have difficulty using MDIs due to lack of hand-breath coordination AND/OR have a history or develop thrush with MDI formulations of inhaled corticosteroids AND/OR are 4-11 years old. AirDuo® Respiclick be non-preferred and require prior authorization and be available to those who are unable to tolerate or who have failed on preferred medications DDI: Avoid concomitant use of strong CYP3A4 inhibitors (e.g. ritonavir, atazanavir, clarithromycin, indinavir, itraconazole, nefazodone, nelfinavir, saquinavir, ketoconazole, telithromycin) with **AirDuo® Respiclick** is not recommended due to increased systemic corticosteroid and increased cardiovascular adverse effects DDI: Avoid concomitant use of **Utibron** with other anticholinergic-containing drugs, due to an increased risk of anticholinergic adverse events. **Utibron®** should be used with extreme caution in patients being treated with MAO inhibitors, TCAs, or other drugs known to prolong the QTc interval.
	MC/DEL		DULERA	MC/DEL		**ADVAIR DISKUS[2,3]**		
	MC/DEL		SYMBICORT[2]	MC		AIRDUO[4]		
				MC		UTIBRON[2]		
ANTIASTHMATIC - ADRENERGIC ANTICHOLINERGIC	MC/DEL		**ALBUTEROL/IPRATROPIUM NEB. SOLN**	MC/DEL		**ANORO ELLIPTA**	1. Please use preferred individual ingredients Albuterol and Ipratropium.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Duoneb components are available separately without PA.
	MC/DEL		**BEVESPI AEROSPHERE[2,3]**	MC/DEL		**COMBIVENT RESPIMAT**		
				MC/DEL		DUONEB SOLN[1]		

				MC/DEL		**STIOLTO**	2. Dosing limits apply, please see dosing consolidation list. 3. The safety and efficacy of use in children under the age of 18 years have not been established. Use PA Form# 20420	DDI: Avoid concomitant use of Bevespi with other anticholinergic-containing drugs, due to an increased risk of anticholinergic adverse events. Bevespi® should be used with extreme caution in patients being treated with MAO inhibitors, TCAs, or other drugs known to prolong the QTc interval. Bevespi should be used with extreme caution in patients being treated with MAO inhibitors, TCAs, or other drugs known to prolong the QTc interval.
ANTIASTHMATIC - XANTHINES	MC/DEL		**AMINOPHYLLINE TABS**	MC/DEL		**THEO-24 CP24**	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		THEOCHRON TB12	MC		THEOLAIR TABS		
	MC/DEL		THEOLAIR-SR TB12	MC/DEL		**UNIPHYL TBCR**		
	MC/DEL		**THEOPHYLLINE CR TB12**					
	MC		THEOPHYLLINE ELIX					
	MC/DEL		THEOPHYLLINE SOLN					
	MC/DEL		**THEOPHYLLINE ER CP12**					
	MC/DEL		**THEOPHYLLINE ER TB12**					
ANTIASTHMATIC - STEROID INHALANTS	MC/DEL		**FLOVENT HFA**[4]	MC/DEL	5	**AEROBID AERS**[2,4]	1. No PA for Pulmicort susp if under 8 years old. 2. All preferreds must be tried before moving to non preferred steps. 3. All step 5 medications need to be tried before moving to step 8's. 4. Dosing limits apply to whole category, please see dosage consolidation list. 5. Asmanex 110mcg will be limited to member between the ages of 4-11years old. 6. Not approved for children <12 years of age Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**PULMICORT FLEXHALER**	MC	5	BECLOVENT AERS[2,4]		
	MC/DEL		**PULMICORT SUSP**[1,4]	MC	5	VANCERIL AERS[2,4]		
	MC		QVAR AERS[4]	MC/DEL	8	**AEROBID-M AERS**[3,4]		
				MC	8	AEROSPAN		
				MC/DEL	8	ALVESCO[4]		
				MC/DEL	8	**ARNUITY ELLIPTA**[6]		
				MC/DEL	8	ASMANEX[4,5]		
				MC/DEL	8	**ASMANEX HFA**		
				MC/DEL	8	**FLOVENT DISKUS**[4]		
				MC	8	VANCERIL DOUBLE STRENGTH AERS[3,4]		
ANTIASTHMATIC - 5-Lipoxygenase Inhibitors				MC		**ZYFLO CR TABS**	Use PA Form# 20420	Other Preferred asthma controller drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANTIASTHMATIC - LEUKOTRIENE RECEPTOR ANTAGONISTS	MC/DEL		**MONTELUKAST SODIUM TAB**	MC/DEL	7	MONTELUKAST GRANULE[1]	Use PA Form# 20420 1.Montelukast Granules will only be approved if between ages of 6months-24 months. 2.Singulair Chewables 4mg from 2years-5years and Singulair Chewables 5mgs from 6years-14years old.	
	MC/DEL		**MONTELUKAST SODIUM CHEW TAB**	MC/DEL	8	**ACCOLATE TABS**		
				MC/DEL	8	**SINGULAIR**[2]		

ANTIASTHMATIC - ALPHA-PROTEINASE INHIBITOR				MC	8	ARALAST	Use PA Form# 20420	Prolastin and Azemaira will be approved for members with A1AT deficiency and clinically demonstrable panacinar emphysema.
				MC/DEL	8	**ZEMAIRA**		
				MC	8	GLASSIA		
				MC	8	PROLASTIN SUSR		
ANTIASTHMATIC - HYDRO-LYTIC ENZYMES				MC/DEL		PULMOZYME SOLN	Use PA Form# 20420	Will be approved for cystic fibrosis patients.
ANTIASTHMATIC - MUCOLYTICS	MC/DEL		ACETYLCYSTEINE[1]	MC		MUCOMYST	1. Acetylcysteine is covered with diagnosis of CF. Use PA Form# 20420	
ANTIASTHMATIC-CFTR POTENTIATOR AND COMBINATIONS				MC		ORKAMBI		
				MC		KALYDECO	Use PA Form# 20420	Kalydeco will be considered for patients 6 years of age or older; and has a diagnosis of cystic fibrosis with a G551D mutation in the CFTR gene as detected by an FDA-cleared CF mutation test; and prescriber is a CF specialist or pulminologist; and patient does not have one of the following infections: Burkholderia cenocepacia, dolosa or mycobacterium abcessus
IDIOPATHIC PULMONARY FIBROSIS				MC		ESBRIET[1]	1. Diagnosis required Use PA Form# 20420	Ofev- Avoid concomitant use with P-gp and CYPA4 inducers (e.g. carbamazepine, phenytoin, and St. John's wort Esbriet- The concomitant use with strong CYP1A2 inhibitors (e.g. fluvoxamine, enoxacin) is not recommended
				MC/DEL		**OFEV[1]**		
COUGH/COLD								
COUGH/COLD	MC/DEL		DEXTRO-GUAIF SYRP[1]				1. All of cough cold preparations are not covered except these preferred products. Use PA Form# 20420	All non-preferred products are not covered as permitted by Federal Medicaid regulations and MaineCare Policy.
	MC/DEL		GUAIFENESIN SYRP[1]					
	MC/DEL		PSEUDOEPHEDRINE[1]					
	MC		ROBITUSSIN DM SYRP[1]					
	MC		ROBITUSSIN SUGAR FREE SYRP[1]					
DIGESTIVE AIDS / ASSORTED GI								
GI - ANTIPERISTALTIC AGENTS	MC/DEL		DIPHENOXYLATE	MC/DEL		LOFENE TABS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. As listed in MaineCare Policy, certain drugs require specific diagnoses for approval.
	MC/DEL		DIPHENOXYLATE/ATROPINE	MC		LONOX TABS		
	MC/DEL		LOPERAMIDE HCL CAPS/LIQ	MC		MOTOFEN TABS		
	MC/DEL		OPIUM TINCTURE TINC					
	MC		PAREGORIC TINC					
GI - ANTI-DIARRHEAL/ ANTACID - MISC.	MC		**ATROPINE SULFATE SOLN**	MC/DEL		**BELLADONNA ALKALOIDS & OP**	Use PA Form# 20420 1.Dosing limits apply please refer to Dose Consolidation List	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **As listed in MaineCare Policy, certain drugs require specific diagnoses for approval**. Preferred products that used to require diag codes still require diag codes unless indicated otherwise. **Fulyzaq** requires a diagnosis of non-infectious diarrhea in patients with HIV/AIDS on anti-retroviral therapy, prior trials of preferred, more cost effective anti-diarrheals.
	MC/DEL		BENTYL SYRP	MC/DEL		BENTYL TABS		
	MC/DEL		BISMATROL	MC		CUVPOSA		
	MC/DEL		BISMUTH SUBSALICYLATE	MC		ED-SPAZ		
	MC/DEL		CALCIUM CARBONATE (ANTACID) CHEW	MC		MYTESI[1]		
	MC/DEL		DICYCLOMINE HCL	MC/DEL		GLYCOPYRROLATE INJ		
	MC/DEL		GLYCOPYRROLATE TABS	MC		LEVSIN TABS		
	MC/DEL		HYOSCYAMINE CAPS & TABS	MC		LEVSIN/SL SUBL		
	MC/DEL		HYOSCYAMINE SULFATE	MC		NULEV TBDP		
	MC/DEL		KAOPECTATE	MC		OSCIMIN		
	MC/DEL		MAGNESIUM OXIDE TABS	MC		ROBINUL INJ		
	MC/DEL		**MAG-OX 400 TABS**	MC		ROBINUL TABS		
	MC/DEL		PAMINE TABS					
	MC/DEL		PROPANTHELINE BROMIDE TABS					
	MC/DEL		SODIUM BICARBONATE TABS					
	MC/DEL		TUMS					
GI- BILE ACID				MC		CHOLBAM		Indication of bile acid synthesis disorders due to single enzyme defects (SEDs) AND for adjunctive treatment of peroxisomal disorders (PDs)
GI - H2-ANTAGONISTS	MC/DEL		CIMETIDINE	MC		AXID CAPS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered

	MC/DEL		FAMOTIDINE	MC		AXID AR TABS		on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		RANITIDINE 150MG TABS	MC/DEL		NIZATIDINE CAPS		
	MC/DEL		RANITIDINE SYRP	MC/DEL		PEPCID		
	MC		ACID REDUCER TABS	MC		PEPCID AC		**DDI:** Ranitidine and cimetidine will now be non-preferred and require prior authorization if it is currently being used with any sulfonylurea (except for glyburide).
				MC/DEL		RANITIDINE 150MG CAPS		
				MC/DEL		ZANTAC SYRP		
				MC/DEL		ZANTAC TABS		**DDI:** Cimetidine will require prior authorization if being used in combination with Plavix.
GI - PROTON PUMP INHIBITOR	MC/DEL		OMEPRAZOLE 20MG[2]	MC/DEL	6	NEXIUM CPDR[4]	1. Prevacid Solutabs available without PA for children less than 9 years old. 2. Dosing limits apply, please see dosage consolidation list. 3. Please use multiple 20mg Capsules to obtain required dose. 4. All preferreds and step therapy must be tried and failed. 5. Established users prior to 10/1/09 may continue to obtain Prevacid until 12/31/09. Use PA Form# 20720	All preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs (in step-order) will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Patients obtaining refills as of 7/10/09 will begin to require prior authorizations if they have been on any PPI longer than 60 days in the past year. The 12-month period is patient specific and begins 12 months before the requested date of prior authorization. Payment for usage beyond these limits will be authorized for cases in which there is a diagnosis of: 1. Barrett's esophagus. 2. Erosive esophagitis 3. Hypersecretory conditions (Zollinger-Ellison syndrome, systemic mastocytosis, multiple endocrine adenomas). Recurrent peptic ulcer disease after documentation of previous trials and therapy failure with at least one histamine H2-receptor antagonist at full therapeutic doses and with documentation of either failure of Helicobacter pylori treatment or anegative Helicobacter pylori test result. 4. Symptomatic gastroesophageal reflux after documentation of previous trials and therapy failure with at least onehistamine H2-receptor antagonist at full therapeutic doses. Patients may be required to step down from a PPI to a histamine H2-receptor antagonist during the 12 months or on an annual clinical review if PPI therapy is continued. **DDI:** Omeprazole will require prior authorization if being used in combination with Plavix. **DDI:** Prevacid, Omeprazole and pantoprazole will now be non-preferred and require prior authorization if they are currently being used in combination with any of the following medications: Ampicillin, B-12, Fe salts, Griseofulvin, Sporanox, Ketoconazole, Reyataz, or Vantin. **DDI:** All non-preferred PPIs require prior authorization, but with any prior authorization request, the member's drug profile will also be monitored for current use with ampicillin, B-12, Fe salts, griseofulvin, itraconazole, ketoconazole, Reyataz or Vantin due to a significant drug-drug interaction.
	MC/DEL		PANTOPRAZOLE	MC	7	PRILOSEC OTC[4]		
				MC	7	ACIPHEX TBEC[4]		
				MC/DEL	8	DEXILANT (KAPIDEX)[2]		
				MC/DEL	8	PREVACID CPDR[4,5]		
				MC/DEL	8	PREVACID SOLUTABS[1]		
				MC/DEL	8	PRILOSEC CPDR		
					8	PROTONIX INJ		
				MC/DEL				
				MC/DEL	8	PROTONIX[2]		
				MC/DEL	8	OMEPRAZOLE 10MG[2]		
				MC	8	OMEPRAZOLE-SODIUM BICARBONATE CAPS		
				MC/DEL	8	LANSOPRAZOLE		
				MC	9	OMEPRAZOLE 40MG[3]		
GI - ULCER ANTI-INFECTIVE				MC		HELIDAC	Use PA Form# 20420	
				MC		PREVPAC		
				MC		PYLERA		
GI - PROSTAGLANDINS	MC		MISOPROSTOL TABS	MC/DEL		CYTOTEC TABS	Use PA Form# 20420	Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drug will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
GI - DIGESTIVE ENZYMES	MC/DEL		CREON[1]	MC/DEL		LACTRASE CAPS	Use PA Form# 20420 1. Clinical PA is required to establish CF diagnosis and medical necessity. In all cases except cystic fibrosis patients, objective evidence of pancreatic insufficiency (fat malabsorption test etc...) must be supplied.	Non -Preferred drugs must be tried and failed in step-order due to lack of efficacy or intolerable side effects before other non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		LACTASE CHEW	MC		PANCREAZE		
	MC/DEL		LACTASE TAB	MC/DEL		PERTZYE		
	MC		ZENPEP[1]	MC/DEL		ULTRESA		
				MC/DEL		VIOKACE		
GI - ANTI - FLATULENTS / GI STIMULANTS	MC/DEL		AMITIZA	MC		CEPHULAC SYRP	1. Diag codes no longer necessary for preferred products. Lactulose has 60cc/day QL Use PA Form# 20420 2. Prior failed trials of multiple other preferred GI agents must occur first, Such as OTC senna	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **As listed in MaineCare Policy, certain drugs require specific diagnoses for approval.**
	MC		CALULOSE SYRP	MC/DEL		INFANTS GAS RELIEF SUSP		
	MC/DEL		CONSTULOSE SYRP	MC/DEL		REGLAN TABS		
	MC/DEL		ENULOSE SYRP[1]					
	MC		GASTROCROM CONC					
	MC/DEL		GENERLAC SYRP[1]					
	MC/DEL		LACTULOSE SYRP[1]					
	MC/DEL		METOCLOPRAMIDE HCL					

	MC/DEL		SIMETHICONE				docusate, lactulose, polyethylene glycol.	
GI - INFLAMMATORY BOWEL AGENTS	MC		APRISO	MC/DEL		ASACOL 800MG HD	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		AZULFIDINE TABS	MC/DEL		AZULFIDINE EN-TABS TBEC		
	MC/DEL		BALSALAZIDE	MC		COLAZAL CAPS	1. Current users grandfathered.	
	MC		CANASA SUPP	MC/DEL		DELZICOL		
	MC/DEL		**SULFAZINE EC TBEC**	MC		DIPENTUM CAPS		
	MC/DEL		**SULFASALAZINE TABS**	MC		GIAZO	2. Use multiple Pentasa 250mg.	Giazo is only indicated for males, as the safety.efficacy for use in females has not been established.Prior trials of preferred products.
				MC/DEL		LIALDA TABS[1]		
				MC/DEL		PENTASA 500MG[2]		
				MC		PENTASA CPCR 250MG	3. Diagnosis required	Uceris Rectal Foam or Tab- Concomitant use with CYP3A inhibitors (e.g. ketoconazole, itraconazole, ritonavir, indinavir, saquinavir, erythromycin, cyclosporine, and grapefruit juice) should be avoided. Verify prior trials and failures or intolerance of preferred treatments
				MC/DEL		ROWASA ENEM		
				MC		SFROWASA		
				MC		UCERIS RECTAL FOAM[3]		
				MC		UCERIS TABS[3]		
GI - IRRITABLE BOWEL SYNDROME AGENTS				MC/DEL		LOTRONEX TABS	Use PA Form# 20420	Lotronex will be approved for females with IBS and predominant diarrhea. Prior failed trials of multiple preferred GI agents must occur first. IBS dx must be thoroughly documented.
				MC		VIBERZI		Viberzi: It is recommended to discontinue treatment in patients who develop severe constipation for more than 4 days. Prior failed trials of multiple preferred GI agents must occur first. IBS dx must be thoroughly documented.
GI- SHORT BOWL SYNDROME				MC		GATTEX		Gattex requires a diagnosis of adult SBS who are dependent on parenteral support. Appropriate colonoscopy and lab assessments 6months prior to starting
MISCELLANEOUS GI								
GI - MISC.	MC/DEL		BISAC-EVAC SUPP	MC/DEL		ACTIGALL CAPS	1. Must show evidence of trials of preferred agents that do not require PA, such as OTC senna, docusate, mineral oil and prescription lactulose.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **As listed in MaineCare Policy, certain drugs require specific diagnoses for approval.**
	MC/DEL		BISACODYL	MC		BENEFIBER		
	MC		BISCOLAX SUPP	MC/DEL		CARAFATE		Preferred products that used to require diag codes still require diag codes unless indicated otherwise.
	MC		CINOBAC CAPS	MC/DEL		CLEARLAX POW		
	MC/DEL		CITRATE OF MAGNESIA SOLN	MC/DEL		COLACE CAPS		
	MC/DEL		CITRUCEL	MC/DEL		COLYTE		
	MC/DEL		DIOCTO SYRP	MC		DIOCTO-C SYRP	2. Quantity Limit: 255 g/90-day without PA for greater than 18 years old. If under 18 years of age, allowed 17gms daily without PA.	
	MC		DOCUSATE CALCIUM CAPS	MC		DOC SOD /CAS CAP		**Linzess** is non-preferred and is for adults as treatment of IBS-Constipation AND treatment of chronic idiopathic constipation in adults. Prior trials of preferred agents for constipation and IBS-constipation.
	MC/DEL		DOCUSATE SODIUM	MC		DOC-Q-LAX CAPS		
	MC/DEL		FIBER LAXATIVE TABS	MC/DEL		DOCUSATE SODIUM/CAS CAPS		
	MC		FLEET	MC/DEL		DOK PLUS		
	MC/DEL		GENFIBER POWD	MC/DEL		DULCOLAX SUPP		Trulance is contraindicated in pediatric patients less than 6 years of age, and use should be avoided in pediatric patients 6 years to less than 18 years of age.
	MC/DEL		GLYCERIN	MC		FIBER CON TABS		
	MC		HIPREX TABS	MC/DEL		FIBER-LAX TABS	3.Multiple preferred agents and dietary changes are required.	
	MC/DEL		KRISTALOSE PACK	MC		GOLYTELY SOLR		
	MC/DEL		LINZESS	MC		MALTSUPEX	4. PA required to confirm FDA approved indication.	
	MC		MAALOX	MC		MIRALAX PACK (OTC versions)		
	MC		METAMUCIL	MC		MIRALAX POWD (OTC versions)	5. For the treatment of chronic idiopathic constipation (CIC	
	MC/DEL		MILK OF MAGNESIA SUSP	MC/DEL		MOVANTIK[3]		
	MC		MINERAL OIL OIL	MC		OCALIVA[4]		
	MC		NULYTELY SOLR	MC		PEG 3350 POWDER[2]	6. For the treatment of carcinoid syndrome diarrhea in combination with somatostatin analog (SSA) therapy in adults inadequately controlled by SSA therapy	
	MC/DEL		SENNA	MC		PEG-ELECTROLYTES SOLR		
	MC/DEL		SENOKOT GRAN	MC		PREPOPIK PAK		
	MC/DEL		SENOKOT SYRP	MC		RELISTOR TABS		
	MC/DEL		SENOKOT CHILDRENS SYRP	MC/DEL		SENEXON TABS		
	MC		SENOKOT XTRA TABS	MC/DEL		SENOKOT TABS		
	MC/DEL		STOOL SOFTENER CAPS	MC		SENOKOT S TABS		
	MC/DEL		SUCRALFATE TABS	MC/DEL		SORBITOL		

	MC		UNI-EASE CAPS	MC		STOOL SOFTENER PLUS CAPS		
	MC		UNIFIBER POWD	MC		TRULANCE[5]		
	MC		URSO FORTE	MC/DEL		UNI-CENNA TABS		
	MC/DEL		URSODIOL	MC		UNI-EASE PLUS CAPS		
				MC		V-R NATURAL SENNA LAXATIV TABS		
				MC		URSO 250	Use PA Form# 20420	
				MC		XERMELO[6]		
MISC. UROLOGICAL								
UROLOGICAL - MISC.	MC		ACETIC ACID 0.25% SOLN	MC		CITRIC ACID/SODIUM CITRAT SOLN	1. Elmiron requires adequate proof of Dx with supportive testing. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		CYTRA-K SOLN	MC/DEL		CYTRA-2 SOLN		
	MC		FURADANTIN SUSP	MC/DEL		ELMIRON CAPS[1]		
	MC		K-PHOS MF TABS	MC/DEL		MACROBID CAPS		
	MC/DEL		METHENAMINE MANDELATE TABS	MC/DEL		MACRODANTIN CAPS		
	MC/DEL		MONUROL PACK	MC/DEL		NITROFURANTOIN MACR SUSP		
	MC/DEL		NEOSPORIN GU IRRIGANT SOLN	MC		POTASSIUM CITRATE/CITRIC SOLN		
	MC/DEL		NITROFURANTOIN MONO CAPS	MC/DEL		PYRIDIUM PLUS TABS		
	MC/DEL		PHENAZOPYRIDINE HCL TABS	MC		PYRIDIUM TABS		
	MC/DEL		PHENAZOPYRIDINE PLUS	MC/DEL		RENACIDIN SOLN		
	MC/DEL		PROSED/DS TABS					
	MC		TRICITRATES SYRP					
	MC/DEL		URELIEF PLUS					
	MC		UREX TABS					
	MC/DEL		URISED TABS					
	MC		UROCIT-K					
	MC/DEL		UROQID #2 TABS					
PHOSPHATE BINDERS								
PHOSPHATE BINDERS	MC/DEL		CALCIUM ACETATE CAP[1]	MC		AURYXIA[1]	Use PA Form# 20420	
	MC/DEL		MAGNEBIND - 400[1]	MC/DEL		CALCIUM ACETATE TAB[1]	1. Diag required.	
	MC		PHOSLYRA[1]	MC/DEL		ELIPHOS[1]		
	MC/DEL		RENAGEL[1]	MC/DEL		FOSRENOL[1]		
				MC/DEL		RENVELA[1]		
				MC		VELPHORO[1]		
INTRA-VAGINALS								
VAGINAL - ANTIBACTERIALS	MC/DEL		METRONIDAZOLE VAGINAL GEL[2]	MC/DEL		CLEOCIN CREA	1. Step order must be followed to avoid PA. Must fail Cleocin Cream and Metronidazole products before moving to next step product without PA. 2. Dosing limits apply, please see Dosage Consolidation List. Use PA Form# 20420	Preferred drugs must be tried and failed in step-order due to lack of efficacy or intolerable side effects before less preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		CLEOCIN SUPP[1]	MC/DEL		NUVESSA		
				MC/DEL		METROGEL VAGINAL GEL[2]		
				MC/DEL		VANDAZOLE		
VAGINAL - ANTI FUNGALS	MC/DEL		CLOTRIMAZOLE CREA	MC		AVC CREA	1. Quantity limit: 1/script/2 weeks Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **DDI:** Miconazole will require prior authorization if being used in combination with Warfarin.
	MC		CLINDESSE CREA	MC		CLOTRIMAZOLE 3 DAY CREA		
	MC/DEL		GYNE-LOTRIMIN CREA	MC		GYNAZOLE-1 CREA		
	MC		MICONAZOLE CREA	MC		GYNE-LOTRIMIN 3 TABS		
	MC/DEL		MICONAZOLE 3 COMBO PACK KIT[1]	MC/DEL		MICONAZOLE 3 SUPP		
	MC/DEL		MICONAZOLE 7 CREA	MC		TERAZOL 3 CREA		
	MC/DEL		MICONAZOLE NITRATE CREA	MC		TERAZOL 7 CREA		
	MC		NYSTATIN TABS	MC/DEL		TERCONAZOLE 0.8MG		
	MC/DEL		TERCONAZOLE 0.4MG	MC/DEL		TERCONAZOLE SUPP		
	MC		VAGITROL					
	MC		V-R MICONAZOLE-7 CREA					

VAGINAL - CONTRACEPTIVES							Use PA Form# 20420	Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drug will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
VAGINAL - ESTROGENS	MC/DEL		**ESTRING RING**	MC/DEL		ESTRACE CREA[1]	1. Must fail all preferred products before non-preferred. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**PREMARIN CREA**	MC/DEL		VAGIFEM TABS[1]		
VAGINAL - OTHER	MC/DEL		ACID JELLY GEL	MC		AMINO ACID CERVICAL CREA	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		ACI-JEL GEL					
	MC		CERVICAL AMINO ACID CREA					
BPH								
BPH	MC/DEL		**DOXAZOSIN MESYLATE TABS**	MC/DEL	5	**FLOMAX CP24**	1. There will be dosing limits of 1 tab per day with out PA. 2. Prior use of preferred agent prior to any approvals. 3. Use of preferred (tamsulosin and finasteride) and (tamsulosin and non-preferred Avodart). 4. Non-preferred products must be used in specified order. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs (in step-order) will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Approval of a non-preferred 5-alpha reductase inhibitor requires objective clinical evidence of a very enlarged prostate rather than just the presence of obstructive urinary outflow symptoms along with adequate trial of preferred Proscar.
	MC/DEL		FINASTERIDE[1]	MC/DEL	8	ALFUZOSIN		
	MC/DEL		TERAZOSIN HCL CAPS	MC/DEL	8	AVODART[2,4]		
	MC/DEL		**TAMSULOSIN HCL**	MC/DEL	8	**CARDURA TABS[4]**		
				MC/DEL	8	JALYN[3,4]		
				MC/DEL	8	PROSCAR TABS[4]		
				MC/DEL	8	RAPAFLO[4]		
				MC/DEL	8	UROXATRAL[4]		
ANXIOLYTICS								
ANXIOLYTICS - BENZODIAZEPINES	MC/DEL		ALPRAZOLAM TABS	MC/DEL	8	ALPRAZOLAM ER	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		CHLORDIAZEPOXIDE HCL CAPS	MC/DEL	8	ATIVAN		
	MC/DEL		CLORAZEPATE DIPOTASSIUM TABS	MC/DEL	8	NIRAVAM		
	MC/DEL		DIAZEPAM	MC/DEL	8	SERAX		
	MC/DEL		LORAZEPAM	MC/DEL	8	TRANXENE		
	MC/DEL		OXAZEPAM CAPS	MC/DEL	8	XANAX TABS		
				MC/DEL	9	XANAX XR		
ANXIOLYTICS - MISC.	MC/DEL		BUSPIRONE HCL TABS	MC		BUSPAR TABS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		HYDROXYZINE HCL SOLN	MC		DROPERIDOL SOLN		
	MC		HYDROXYZINE HCL SYRP	MC/DEL		HYDROXYZINE HCL TABS		
	MC/DEL		HYDROXYZINE PAMOATE CAPS	MC/DEL		HYDROXYZINE PAMOATE 100MG CAPS		
	MC/DEL		MEPROBAMATE TABS	MC/DEL		VISTARIL		
ANTI-DEPRESSANTS								
ANTIDEPRESSANTS - MAO INHIBITORS	MC/DEL		NARDIL TABS	MC/DEL		**TRANYLCYPROMIINE**	Use PA Form# 20420	
	MC/DEL		PARNATE TABS					
ANTIDEPRESSANTS - MAO INHIBITORS TOPICAL				MC/DEL		EMSAM[1]	1. Dosing limits apply, please refer to Dose consolidation list. Use PA Form# 20420	Preferred drugs (including a preferred SSRI, a non-SSRI, and Venlafaxine ER) must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANTIDEPRESSANTS - SELECTED SSRI's	MC/DEL		BUPROPION HCL TABS	MC/DEL	8	APLENZIN[7]	1. Use Fluoxetine 20 mg in multiples. 2. See Zoloft splitting table. Sertraline requires splitting of scored tabs to avoid PA. 3. Strong caution with pediatric population. 4. See Celexa/ Citalopram splitting tables.	Preferred drugs (including failure of at least one preferred SSRI, one SNRI and one non-SSRI/SNRI) must be tried for at least 4 weeks each and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Criteria for new starters <18 years of age: Must have had fluoxetine trial for at least 30 days before accessing other preferred antidepressants without PA. **CYMBALTA:** Fibromyalgia diagnosis- prior use and failure of preferred generics (amitriptyline or cyclobenzaprine) and gabapentin prior to approval. **SAVELLA:** Fibromyalgia diagnosis and trial of a preferred generic amitriptyline, cyclobenzaprine and gabapentin prior to approval.
	MC/DEL		BUPROPION SR	MC/DEL	8	TRINTELLIX[13]		
	MC/DEL		BUPROPION XL	MC/DEL	8	CELEXA[4]		
	MC/DEL		CITALOPRAM[4]	MC	8	CYMBALTA[5]		
	MC/DEL		DULOXETINE	MC/DEL	8	EFFEXOR TABS		
	MC/DEL		ESCITALOPRAM	MC/DEL	8	EFFEXOR XR CP24 [3, 10]		
	MC/DEL		FLUOXETINE HCL CAPS	MC/DEL	8	FETZIMA[12]		
	MC/DEL		FLUOXETINE HCL LIQD	MC/DEL	8	FLUOXETINE 40mg AND 60 mg CAPS[1]		
	MC/DEL		FLUVOXAMINE MALEATE TABS	MC/DEL	8	FLUOXETINE 10mg AND 20mg TABS[6]		
	MC/DEL		MIRTAZAPINE	MC	8	FORFIVO XL		
	MC/DEL		NEFAZODONE	MC/DEL	8	IRENKA		
	MC/DEL		PAROXETINE[3]	MC/DEL	8	KHEDEZLA		

	MC/DEL		SERTRALINE HCL[2]	MC/DEL	8	LEXAPRO TABS	5. Max daily dose allowed is 60mg, only 1 capsule per day allowed for all strengths. Combination of multiple strengths require PA. 6. Use Fluoxetine 10mg tabs in multiples. 7. Provide clinical documentation as to why a preferred generic alternative cannot be used. 8. Dosing limits allowing 2 tabs/day and a max daily limit of 200mg / day applies. Please see dose consolidation list. 9. Dosing limits and max daily dose applies. Limit of 1 per day of 37.5mg, 75mg, will be allowed without pa, along with limits of 2 caps per day of the 150mg strength. Max daily dose allowed is 375mg. 10. Use venlafaxine ER tabs. 11. Non-preferred products must be used in specified step order. 12. Requires previous trials/failure of multiple preferred medications. Dosing limits apply, please see the dose consolidation list. Max daily dose of 80mg if used concomitantly with strong CYP3A4 inhibitor. 13.Dosing limits apply, please see dose consolidation list. Use PA Form# 20420	Exceptions to the rule are as follows: 1. If the member (<18) is already an established user for any of the preferred or non-preferred drugs under the Antidepressant category on the PDL, then they can continue to get that drug. 2. If the member (<18) has a prescription for an antidepressant that is on the PREFERRED side of the PDL and has had a 30 day supply of Fluoxetine at least 30 days before the date they are getting it filled, the claim will pay. If they do not have the trial of Fluoxetine in their profile, the claim will reject for PA required. 3. If the member (<18) has a prescription for a medication that is on the NON-PREFERRED side of the PDL regardless of having Fluoxetine in their profile, the prescription will need a PA. 4. Use of a preferred antidepressant for anxiety will require the diagnosis of anxiety on written prescription and submitted during claim submission. **DDI:** Fluvoxamine will now be non-preferred and require prior authorization if it is currently being used with glimepiride (Amaryl). **DDI:** Preferred nefazodone will now be non-preferred and require prior authorization if it is currently being used in combination with either Onglyza 5mg, Enablex 15mg or Vesicare 10mg. **DDI:** Fluoxetine will require prior authorization if being used in combination with Plavix. **DDI:** Fluvoxamine will require prior authorization if being used in combination with Plavix. **SAVELLA:** Fibromyalgia diagnosis and trial of a preferred generic amitriptyline, cyclobenzaprine, duloxetine and gabapentin prior to approval.
	MC/DEL		TRAZODONE HCL TABS	MC	8	LUVOX TABS		
	MC/DEL		VENLAFAXINE ER CAPS[9]	MC	8	MAPROTILINE HCL TABS		
				MC/DEL	8	MIRTAZAPINE ODT		
				MC	8	OLEPTRO		
				MC/DEL	8	PAROXETINE CR[3]		
				MC/DEL	8	PAXIL[3]		
				MC/DEL	8	PAXIL CR[3]		
				MC/DEL	8	PRISTIQ		
				MC	8	PROZAC		
				MC	8	PROZAC CAPS		
				MC	8	PROZAC WEEKLY CPDR		
				MC/DEL	8	REMERON TABS		
				MC/DEL	8	SARAFEM CAPS		
				MC/DEL	8	TRAZODONE HCL 300MG TABS		
				MC/DEL	8	WELLBUTRIN TABS		
				MC/DEL	8	WELLBUTRIN SR TBCR		
				MC/DEL	8	WELLBUTRIN XL		
				MC/DEL	8	REMERON SOLTAB TBDP		
				MC/DEL	8	SAVELLA[8]		
				MC/DEL	8	ZOLOFT		
				MC/DEL	8	VENLAFAXINE TABS[9]		
				MC/DEL	8	VENLAFAXINE ER TABS[9]		
				MC/DEL	9	VIIBRYD		
				MC/DEL	9	FLUOXETINE 90mg TABS[11]		
ANTIDEPRESSANTS - TRI-CYCLICS	MC/DEL		**AMITRIPTYLINE HCL TABS[1]**	MC/DEL		**AMOXAPINE TABS**	1. Users over the age of 65 require a pa. 2. Use multiples of 50mg. Use PA Form# 20420 Use PA Form# 10220 for Brand Name requests	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**CLOMIPRAMINE HCL CAPS[1]**	MC/DEL		**ANAFRANIL CAPS**		
	MC/DEL		**DESIPRAMINE HCL TABS[1]**	MC/DEL		**DOXEPIN HCL 150 MG[2]**		
	MC/DEL		**DOXEPIN HCL[1]**	MC/DEL		**NORPRAMIN TABS**		
	MC/DEL		**IMIPRAMINE HCL TABS[1]**	MC/DEL		**PAMELOR**		
	MC/DEL		**NORTRIPTYLINE HCL[1]**	MC		TOFRANIL		
	MC		PROTRIPTYLINE HCL TABS[1]	MC		VIVACTIL TABS		
	MC		SURMONTIL CAPS[1]					
SEDATIVE / HYPNOTICS								
SEDATIVE/HYPNOTICS - BARBITURATE	MC		BUTISOL SODIUM TABS[1]	MC		LUMINAL SOLN	1. PA required for new users	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered

	MC/DEL		CHLORAL HYDRATE SYRP[1]	MC/DEL		SOMNOTE CAPS	of preferred products if over 65 years.	on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		MEBARAL TABS[1]					
	MC/DEL		PHENOBARBITAL[1]				Use PA Form# 20420	
SEDATIVE/HYPNOTICS - BENZODIAZEPINES	MC/DEL		DORAL TABS[1]	MC		HALCION TABS[1]	1. Dosing limits apply, please see dosing consolidation list.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Benzodiazepines do cause dependence with continued use and usage should be limited to 7-10 days at a time. Chronic intermittent use (2-3 Days per week max) is the standard of care
	MC/DEL		ESTAZOLAM TABS[1]	MC		MIDAZOLAM HCL SYRP		
	MC/DEL		FLURAZEPAM HCL CAPS[1]	MC/DEL		RESTORIL CAPS[1]		
	MC/DEL		TEMAZEPAM CAPS 15 & 30MG[1]	MC/DEL		TEMAZEPAM 7.5MG[1]	Use PA Form# 30110	
	MC/DEL		TRIAZOLAM TABS[1]					
SEDATIVE/HYPNOTICS - Non-Benzodiazepines	MC/DEL	1	MIRTAZAPINE	MC/DEL	7	AMBIEN[1]	1. Quantity Limt of 12 per 34 days.	Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC	1	TRAZODONE	MC/DEL	7	**ESZOPICLONE**		
	MC/DEL	1	ZOLPIDEM [2]				2. Quantity limits will be allowed up to 30/30, but intermittent therapy is recommended.	
				MC/DEL	7	**ZOLPIDEM ER**		
	MC/DEL	2	ZALEPLON[2,3]	MC/DEL	8	AMBIEN CR[1]		Ambien, Ambien CR, Lunesta, Sonata, Zaleplon and Zolpidem may cause dependence with continued use and as with benzodiazepines, usage should be limited to 7-10 days at a time. Chronic intermittent use (2-3 days per week max) is the standard of care. Please refer to Sedative/Hypnotic PA form.
				MC/DEL	8	BELSOMRA[1]	3. Only zolpidem trial/failure will be required to obtain Zaleplon.	
				MCDEL	8	EDLUAR		DDI: Belsomra® with strong CYP3A inhibitors (e.g. ketoconazole, itraconazole, posaconazole, clarithromycin, nefazodone, ritonavir, saquinavir, nelfinavir, indinavir, boceprevir, telaprevir, telithromycin, and conivaptan) is not recommended
				MC	8	HETLIOZ		
				MC/DEL	8	INTERMEZZO		
				MC/DEL	8	LUNESTA[1]		
				MC/DEL	8	SONATA CAPS[1]	4. Must fail all preferred products before non-preferred	
				MC/DEL	8	ROZEREM	Use PA Form# 30110	
				MC/DEL	8	ZOLPIMIST		
ANTI-PSYCHOTICS								
ANTIPSYCHOTICS - ATYPICALS	MC/DEL		**ARIPIPRAZOLE**[3,4]	MC/DEL	8	ABILIFY DISC TAB, INJ and SOL[2]	If prescribing 2 or more antipsychotics, PA will be required for both drugs, except if one is Clozapine.This also includes combination of Seroquel with Seroquel XR.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Non preferred atypicals will be approved for patients with FDA-approved indications, and for specific conditions supported by at least two published peer-reviewed double-blinded, placebo-controlled randomized trials that are not contradicted by other studies of similar quality and as long as all first line preferred therapies have been tried and failed at full therapeutic doses for adequate durations (at least two weeks). * Abilify: doses above 15mg were not shown to be more effective than doses in the 10-15mg range.
	MC/DEL		**OLANZAPINE**[4]	MC	8	ABILIFY MAINTENA		
	MC/DEL		RISPERIDONE TAB[4]	MC	8	ABILIFY TABS[3,4]		
	MC/DEL		RISPERIDONE SOLN[4]	MC	8	ARISTADA[7]		
	MC/DEL		SAPHRIS[4]	MC	8	FANAPT		
	MC/DEL		QUETIAPINE[4,6]	MC/DEL	8	GEODON		Prescriptions for quetiapine are limited to a maximum daily dose of 800mg.
	MC/DEL		QUETIAPINE XR[4]	MC	8	INVEGA		
	MC/DEL		**ZIPRASIDONE**[4]	MC	8	INVEGA SUSTENNA		
				MC/DEL	8	INVEGA TRINZ INJ		
				MC	8	NUPLAZID	Use PA form# 20440 for Multiple Antipsychotic requests	**DDI:** Abilify, Latuda, Quetiapine, and Zyprexa will now be non-preferred and require prior authorization if they are currently being used in combination with carbamazepine. Please use Drug-Drug Interaction PA form #10400.
				MC	8	LATUDA[8]		
				MC	8	REXULTI		**Atypicals:** Prior Authorization will be required for preferred medication to assure indication is in accordance with FDA approved or literature supported evidence-based best practices. The approved indications are:
				MC	8	RISPERDAL TAB		• **schizophrenia**
				MC	8	RISPERDAL CONSA [2]		• **bipolar disorder**
				MC	8	RISPERDAL M TAB[2]	Use PA form# 10130 for non preferred single therapy atypical requests	• **agitation related to autism**
				MC	8	RISPERDAL SOLN	1. Please use multiple 25mg tablets.	• **severe behavioral dyscontrol with risk of imminent need for emergency services such as the emergency room, crisis services, or an inpatient psychiatric facility.** If prescribing 2 or more antipsychotics, PA will be required for both drugs, except if one is Clozapine.This also includes combination of Seroquel with Seroquel XR.
				MC/DEL	8	RISPERIDONE ODT		
				MC/DEL	8	SEROQUEL 50MG TABS[1,2]	2. Established users of single therapy atypicals	
				MC	8	VRAYLAR		Aristada- establish tolerability to Abilify/oral aripiprazole
				MC	8	ZYPREXA TABS	3. Aripiprazole and Abilify requires splitting of tab to avoid PA. Please see splitting table	
				MC	8	ZYPREXA ZYDIS TBDP [2]		DDI: It is recommended to reduce the Vraylar® dose if it is used concomitantly with a strong CYP3A inhibitor (such as itraconazole, ketoconazole). The concomitant use of Vraylar® with a CYP3A4 inducer (such as rifampin, carbamazepine) is not recommended.
				MC	8	ZYPREXA RELPREVV		
				MC/DEL	8	SEROQUEL TABS	4. Prior Authorization will be required for preferred medications for members under the age of 5.	DDI: The concomitant use of Nuplazid with other drugs known to prolong the QT interval (e.g. Class IA antiarrhythmics, Class 3 antiarrhythmics, antipsychotics, and antibiotics such as gatifloxacin and moxifloxacin).
				MC/DEL	9	SEROQUEL XR[5]		
							5. Product is considered line extension of the original product due to Healthcare Reform (HCR). MaineCare will consider these medications non-preferred	

							and a step 9 because of the impact under the Federal Rebate Program in conjunction with HCR. 6. Dosing limits apply: quetiapine 25mg, 50mg and 100mg are available without PA if the daily dosage is less than 1.5 tablets 7. Clinical PA required establishing significant reason why an oral agent can't be used 8. Established users are grandfathered.	
ANTIPSYCHOTICS - SPECIAL ATYPICALS	MC/DEL		CLOZAPINE TABS	MC/DEL MC		CLOZARIL TABS FAZACLO	Use PA Form# 20420	Preferred generic drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred brand will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Patients previously stabilized on brand name drug will be approved. **DDI:** Clozapine will now be non-preferred and require prior authorization if it is currently being used in combination with carbamazepine. Please use Drug-Drug Interaction PA form #10400.
ANTIPSYCHOTICS - TYPICAL	MC/DEL MC/DEL MC/DEL MC MC/DEL MC MC MC/DEL MC/DEL MC MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL		CHLORPROMAZINE HCL FLUPHENAZINE DECANOATE FLUPHENAZINE HCL HALDOL HALOPERIDOL HALOPERIDOL DECANOATE SOLN HALOPERIDOL LACTATE SOLN LOXAPINE SUCCINATE CAPS LOXITANE-C CONC MOBAN TABS PERPHENAZINE PROCHLORPERAZINE SERENTIL THIORIDAZINE HCL THIOTHIXENE TRIFLUOPERAZINE HCL TABS	MC/DEL MC/DEL MC MC/DEL MC MC/DEL MC MC		COMPAZINE COMPRO SUPP HALDOL DECANOATE LOXITANE CAPS MELLARIL NAVANE CAPS PROLIXIN STELAZINE TABS	Use PA Form# 20420 If prescribing 2 or more antipsychotics, PA will be required for both drugs, except if one is Clozapine.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. If prescribing 2 or more antipsychotics, PA will be required for both drugs, except if one is Clozapine.
LITHIUM								
LITHIUM	MC/DEL MC/DEL		LITHIUM CARBONATE LITHIUM CITRATE SYRP	MC/DEL MC/DEL		ESKALITH CAPS ESKALITH CR TBCR	Use PA Form# 20420	
COMBINATION - PSYCHOTHERAPEUTIC								
PSYCHOTHERPEUTIC COMBINATION	MC/DEL MC/DEL		CHLORDIAZEPOXIDE/AMITRIPT PERPHENAZINE/AMITRIPTYLIN	MC	8	SYMBYAX[1]	1. Only available if component ingredients are unavailable. Use PA Form# 20420	
STIMULANTS								
STIMULANT - AMPHETAMINES -SHORT ACTING	MC/DEL MC/DEL MC/DEL		AMPHETAMINE SALT COMBO[1,4] DEXTROAMPHET SULF TABS[1,3] DEXEDRINE[1,3,4]	MC/DEL MC MC MC		ADDERALL TABS EVEKEO PROCENTRA ZENZEDI	1. Preferred stimulants will be available without PA if diagnosis of ADHD or Narcolepsy.	

							2. As per recent FDA alert, Adderal & Dexedrinel should not be used in patients with underlying heart defects since they may be at increased risk for sudden death. 3. Dosing limits apply, please see dosing consolidation list. 4. Max daily dose of 50mg. Use PA Form# 20420	
STIMULANT - LONG ACTING AMPHETAMINES SALT	**MC** **MC**		VYVANSE[2,3,4] VYVANSE CHEW2,3,4	**MC** **MC/DEL**	8 9	ADDERALL XR CP24[1,3,4] AMPHETAMINE/DEXTROAMPHET ER	Use PA Form# 20420 1. As per recent FDA alert, Adderall should not be used in patients with underlying heart defects since they may be at increased risk for sudden death. 2. FDA approval is currently for adults and children 6 or older. Will be available without PA for this age group if within dosing limits. Limit of one capsule daily. Max dose of 70MG daily. 3. Preferred stimulants will be available without PA if diagnosis of ADHD. 4. Dosing limits applly, please see dosing consolidation list.	Adderall XR- Current users as of 12/31/11 without prior use of Vyvanse will be required to transition to the preferred vyvanse product. Other members will required PA
LONG ACTING AMPHETAMINES	**MC** **MC/DEL**		DEXTROAMPHET SULF CPSR[1,3] **DEXTROAMPHETAMINE ER**	 **MC** **MC** **MC**		 ADZENYS XR[3] DEXEDRINE CAP SR[2,3] DYANAVEL XR	1. Preferred stimulants will be available without PA if diagnosis of ADHD. 2. As per recent FDA alert, Adderall & Dexedrine should not be used in patients with underlying heart defects since they may be at increased risk for sudden death. 3. Dosing limits applly, please see dosing consolidation list. Use PA Form# 20420	DDI: : The concomitant use of Adzenys® XR is contraindicated with monoamine oxidase inhibitors (MAOIs) or within 14 days after discontinuing MAOI treatment.
STIMULANT - METHYLPHENIDATE	**MC/DEL** **MC/DEL** **MC/DEL** **MC/DEL** **MC/DEL**		DEXMETHYLPHENIDATE IR TABS[1] METADATE ER TBCR[1,2] METHYLIN ER TBCR[1,2] METHYLIN TABS[1,2] METHYLIN SOL[1]	**MC/DEL** **MC** **MC** **MC/DEL**		FOCALIN IR TABS METHYLIN CHEWABLES METHYLPHENIDATE HCL CHEW RITALIN	1. Preferred stimulants will be available without PA if diagnosis of ADHD. Use PA Form# 20420 2. Dosing limits apply,	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Please refer to General Criteria category E.

	MC/DEL						please see dosing consolidation list. Maximum daily doses are as follows: 72mg daily for methylphenidate and 36mg daily for dexmethylphenidate.	
STIMULANT - METHYLPHENIDATE - LONG ACTING	MC		APTENSIO XR[1]	MC	5	METADATE CD CPCR	1. Preferred stimulants will be available without PA if diagnosis of ADHD. 2. Non-preferred products must be used in specified step order. 3.FDA approval currently only for ages 6-16. Limit of one patch daily. Max dose of 30MG daily. 4.Dosing limits applly, please see dosing consolidation list. 5. Quillivant XR and Quillichew ER are only indicated for use in patients 6 years of age and older. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		DAYTRANA[1,3]	MC	8	CONCERTA TBCR[2]		
	MC/DEL		FOCALIN XR[1]	MC/DEL	8	METHYLPHENIDATE ER CAPS[1,2,4]		
	MC/DEL		METHYLPHENIDATE ER TABS[1]	MC/DEL	8	METHYLPHENIDATE ER TABS (MANUFACTURE/NDC 00406)		
	MC		QUILLICHEW ER[5,1]					
	MC		QUILLIVANT XR SUS[1,5]	MC/DEL	8	RITALIN LA[4]		
STIMULANT - STIMULANT LIKE			**ATOMOXETINE HCL (66993 manufacturer/NDC)**	MC/DEL	7	PROVIGIL TABS[3]	1. Failure of both an amphetamine and methylphenidate is required for consideration for approval of Strattera, unless history of substance abuse without current use of abusable medication(s). Additionally, for patients <17 years of age, a trial of quanfacine in required before approval of Strattera. 2. Strattera currently has dosing limitations allowing one tablet per day for all strengths if obtain approval. Max daily dose of Strattera is 100mg. Please see dosing consolidation list. 3. Non-preferred products must be used in specified 4. Please use generic Guanfacine. Use PA Form# 20710 for Provigil, Nuvigil and Xyrem Use PA Form# 20420 for all others	Provigil requests require diagnosis of Narcolepsy, ADHD, or Obstructive Sleep Apnea. Previous failures of methylphenidate and amphetamine is required for Narcolepsy and ADHD diagnosis, with additional Strattera trial needed with ADHD diagnosis. Please refer to detailed criteria on Provigil PA form
	MC/DEL		ARMODAFINIL	MC	7	STRATTERA[1, 2]		
	MC/DEL		**GUANFACINE ER**	MC	8	CAFCIT SOLN[3]		
				MC/DEL	8	INTUNIV		
				MC/DEL	8	MODAFINIL TABS		
				MC	8	KAPVAY		
				MC/DEL	9	NUVIGIL[3]		
				MC	9	DESOXYN TABS[3]		
				MC	9	DESOXYN CR[3]		
ANTI-CATAPLECTIC AGENTS								
PSYCHOTHERAPEUTIC AGENTS - MISC.						AUSTEDO	Use PA Form# 20710 for	FDA reminded healthcare professionals and patients that the combined use of Xyrem (sodium oxybate) with alcohol or central nervous system (CNS) depressant drugs can markedly

				MC		NUEDEXTA	Xyrem	impair consciousness and may lead to severe breathing problems (respiratory depression
				MC		XYREM SOL[1]	Use PA Form# 20710 for Xenazine	
				MC		XENAZINE	1.See criteria section	
WEIGHT LOSS								
WEIGHT LOSS							No longer covered: PHENTERMINE, XENICAL,DIDREX, and MERIDIA	Weight loss drugs are not covered as permitted by Federal Medicaid regulations and Maine Medicaid (MaineCare) Policy.
ALZHEIMER DISEASE								
ALZHEIMER - Cholinomimetics/Others	MC/DEL		DONEPEZIL HYDROCHLORIDE TABS[1]	MC	6	ARICEPT TABS[2]	1. PA is required to establish dementia diagnosis and baseline mental status score.	Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs (in step-order) will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		DONEPEZIL HYDROCHLORIDE ODT[1]	MC	6	ARICEPT ODT[2]		
	MC/DEL		EXELON DIS[1]	MC/DEL	7	DONEPEZIL HYDROCHLORIDE TABS 23MG	2. Must fail all preferred products before moving to non-preferred.	
	MC/DEL		**GALANTAMINE CAPS**[1]	MC/DEL	8	EXELON CAP		
	MC/DEL		**GALANTAMINE TAB**[1]	MC/DEL	8	NAMENDA	Use PA Form# 20420	
				MC/DEL				
	MC/DEL		MEMANTINE[1]		8	NAMENDA XR CAPS		
				MC/DEL	8	NAMZARIC		
				MC	8	RAZADYNE[2]		
				MC	9	COGNEX CAPS[2]		
	MC/DEL		RIVASTIGMINE TARTRATE CAPS[1]					
SMOKING CESSATION								
NICOTINE PATCHES / TABLETS	MC/DEL		CHANTIX TAB[1,2]	MC/DEL		NICODERM CQ PT24[1]	Use PA Form# 20420	As of July 1, 2014 per MaineCare policy, smoking cessation products will be covered without a copay(including MEDEL). No annual or lifetime limits, must follow FDA approved indications and therapy guidelines.
	MC/DEL		NICOTINE DIS PT24[1]				1. See criteria section for exemptions	
							2. The Starter/Titration packs are non-preferred. Please use the tablets.	Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs (in step-order) will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
								Note: MaineCare policy, smoking cessation product were "not covered" except for during pregnancy between 9/1/12 and 1/1/14, between 1/1/2014 and 7/1/14 smoking cessation products were covered with limitations
								Patients may qualify for the medication through The Maine Tobacco Helpline if they do not have MaineCare or MEDEL. Patients are encouraged to call The Maine Tobacco helpline at 1-800-207-1230.
NICOTINE REPLACEMENT - OTHER	MC/DEL		NICOTINE POLACRILEX GUM[1]	MC/DEL	8	NICOTROL INHALER[1,2]	Use PA Form# 20420	As of July 1, 2014 per MaineCare policy, smoking cessation products will be covered without a copay(including MEDEL). No annual or lifetime limits, must follow FDA approved indications and therapy guidelines.
				MC/DEL	8	NICOTROL NASAL SPRAY[1,2]	1. See criteria section for exemptions	
				MC/DEL	8	NICORETTE GUM[1,2]	2. Must use non-preferred products in specified step order.	Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs (in step-order) will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
				MC	8	NICORETTE LOZENGES		**Note:** MaineCare policy, smoking cessation product were "not covered" except for during pregnancy between 9/1/12 and 1/1/14, between 1/1/2014 and 7/1/14 smoking cessation products were covered with limitations
								Patients may qualify for the medication through The Maine Tobacco Helpline if they do not have MaineCare or MEDEL. Patients are encouraged to call The Maine Tobacco helpline at 1-800-207-1230.
ALCOHOL DETERRENTS								
ALCOHOL DETERRENTS	MC		ANTABUSE TABS	MC/DEL		**ACAMPRO**[1]	1. Should only be used in conjunction with formal structured outpatient detoxification program.	Preferred generic drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		DISULFIRAM TABS					
	MC/DEL		NALTREXONE HCL TABS				Use PA Form# 20420	
MISCELLANEOUS ANALGESICS								
ANALGESICS - MISC.	MC/DEL		ACETAMINOPHEN	MC		AXOCET CAPS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the
	MC/DEL		**ASPIRIN**	MC/DEL		ESGIC-PLUS		

	MC/DEL		ASPRIN/ APAP/ CAFF TAB	MC/DEL		FIORICET TABS		preferred drug(s) exists.
	MC/DEL		BUTAL/ASA/CAFF	MC		FIORINAL CAPS		
	MC/DEL		BUTALBITAL COMPOUND	MC		FIORTAL CAPS		
	MC/DEL		BUTALBITAL/ACET TABS	MC/DEL		FORTABS TABS		
	MC/DEL		BUTALBITAL/APAP CAPS	MC		PHRENILIN TABS		
	MC/DEL		BUTALBITAL/APAP/CAFFEINE	MC		PHRENILIN FORTE CAPS		
	MC/DEL		**CHOLINE MAGNESIUM TRISALI**	MC		TRILISATE LIQD		
	MC/DEL		**DIFLUNISAL TABS**	MC		TRILISATE TABS		
	MC		EXCEDRIN	MC		ZEBUTAL CAPS		
	MC/DEL		**SALSALATE TABS**	MC		ZORPRIN TBCR		
LONG ACTING NARCOTICS								
NARCOTICS - LONG ACTING	MC/DEL		EMBEDA	MC	8	ARYMO ER	Use PA Form# 20510 Use PA form #10300 for PAs over the opiate limit 1. Oxycontin will be available without PA for patients treated for or dying from cancer or hospice patients. CA (cancer) or HO (hospice) diag code may be used but store must verify since all scripts will be audited and stores will be liable. 2. Established users are grandfathered. 3. Oxycodone ER allowed only 2 per day for all strengths except 80 mg, where 4 are allowed to 4. Dosing limits apply. Please see dose consolidation list. 5. Non-preferred products must be used in specific order. 6. Methadone will be available without PA for patients treated for or dying from cancer or hospice patients or similar conditions as supported by clinical documentation. CA (cancer) or HO (hospice) diag code may be used but store must verify since all scripts will be audited and stores will be liable.	Preferred drugs (Fentanyl Patch, Morphine Sulfate ER tab, Butrans and Embeda) must be tried for at least 2 weeks each & failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug & the preferred drug(s) exists. Adequate trials include prevention/treatment of common adverse effects associated w/ narcotics (antinausea, antipruritics, etc.) as well as adequate equianalgesic dosing when converting from one narcotic to another.Also, adequate documentation of attempts to titrate dose of preferred agents to achieve adequate pain relief & desired clinical response must be provided. Member's drug regimen for additions &/or discontinuations of medications that may affect absorption &/or metabolism of preferred agents must be monitored. Approvals will not be granted if patient had access to either non-preferred products or high doses of short acting narcotics during the trial period. Non-preferred drugs will not be approved for patients showing evidence of usage patterns consistent w/ controlled substance abuse such as: 1.Frequent or persistent early refills of controlled drugs; 2.Multiple instances of early refill overrides due to reports of misplacement, stolen, dropped in toilet or sink, distant travel, etc.; 3.Breaches of narcotic contracts with any provider; 4.Failure to comply with patient responsibilities in attached opioid documentation (see PA form) including but not limited to failing to submit to and pass pill counts; 5.Failing to take or pass random drug testing; 6.Failing to provide old records regarding prior use of narcotics; 7.Receiving controlled substances from other prescribers that the provider submitting the PA is unaware of 8.Documented history of substance abuse. Substance abuse evaluations may be required for patients with medical records displaying documented substance abuse or potential signs of narcotic misuse and abuse such as chronic early refills, short dosing intervals, frequent dose increases, multiple lost/stolen etc scripts and intolerance or "allergy" to all products but Oxycontin. 9.Circumventing MaineCare prior authorization requirements for narcotics by paying cash for affected narcotics (prescribers failed to submit prior authorization prior to cash narcotic scripts being filled by member). 10.Requests for any Brand name controlled substance, considered by authorities to be highly abused and diverted (Oxycontin, Percocet, Typox, Vicodin, Dilaudid, Ultracet...) with an available AB rated generic equivalent will be denied unless it will be provided in a setting that virtually eliminates the risk of diversion. 11.Allergic reactions to any product within a specific narcotic class will justify and preclude use of any other product in the same class due to the risk of cross-hypersensitivity. Hysingla ER- Concomitant use should be avoided with mixed agonist/antagonist analgesics, partial agonist analgesics, and MAOIs. Verify prior trials and failures or intolerance of preferred treatments Methadone – Established users must have a trial and failure of at least 2preferred drugs for least 2 weeks. Otherwise they will be allowed 180 days to transition to a preferred product.
	MC/DEL		FENTANYL PATCH[4]	MC	8	AVINZA		
	MC/DEL		MORPHINE SULFATE ER TB12	MC	8	BELBUCA		
	MC/DEL		BUTRANS[4]	MC	8	DURAGESIC PT72[4]		
				MC	8	EXALGO		
				MC/DEL	8	HYSINGLA ER		
				MC	8	KADIAN		
				MC/DEL	8	METHADONE		
				MC/DEL	8	METHADOSE		
				MC/DEL	8	MORPHABOND ER		
				MC/DEL	8	MORPHINE SULFATE SUPP		
				MC/DEL	8	MS CONTIN TB12		
				MC	8	OPANA ER		
				MC/DEL	8	ORAMORPH SR TB12		
				MC/DEL	8	OXYCONTIN TB12[1]		
				MC	8	XARTEMIS ER		
				MC	8	XTAMPZA ER		
				MC	8	ZOHYDRO ER		
				MC/DEL	9	NUCYNTA ER		
				MC/DEL	9	OXYCODONE ER[3,5]		
NARCOTICS - SELECTED	MC/DEL		TRAMADOL HCL TABS	MC/DEL	7	RYZOLT	Use PA Form# 20420 Use PA form #10300 for PAs over the opiate limit 1. Only available if component ingredients are unavailable.	Preferred drugs from this and other narcotic classes must be tried for at least 2 weeks each and failed due to lack of efficacy or intolerable side effects before non-preferred drugs from this class will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Approvals will not be granted if patient had access to either non-preferred products or high doses of short acting narcotics during the trial period. Substance abuse evaluations may be required for patients with medical records displaying potential signs of narcotic misuse and abuse such as chronic early refills, short dosing intervals, frequent dose increases, multiple lost/stolen etc scripts and intolerance or "allergy" to all products but desired product. Allergic reactions to any product within a specific narcotic class will justify and preclude use of any other product in the same class due to the risk of cross-hypersensitivity.
				MC	8	BUPRENEX SOLN		
				MC/DEL	8	BUTORPHANOL		
				MC	8	NALBUPHINE HCL SOLN		
				MC	8	STADOL NS SOLN		
				MC	8	TRAMADOL ER		
				MC	8	ULTRACET TABS[1]		
				MC	8	ULTRAM TABS		

				MC	9	ULTRAM ER		Non-preferred drugs will not be approved for patients showing evidence of usage patterns consistent with controlled substance abouse such as: 1.frequent or persistant early refills of controlled drugs; 2.multiple instances of early refill overrides due to reports of misplacement, stolen, dropped in toilet or sink, distant travel; 3.breaches of narcotic contracts with any provider; 4.failure to comply with patient responsibilities in attached opiod documentaion (see PA form) including but not limited to failing to submit to and pass pill counts; 5.failing to take or pass random drug testing; 6.failing to provide old recoreds regarding prior use of narcotics; 7.receiving controlled substances from other prescribers that the provider submitting the PA is unaware of. in Substance abuse evaluations may be required for patients with medical records displaying potential signs of narcotic misuse and abuse such as chronic early refills, short dosing intervals, frequent dose increases, multiple lost/stolen etc scripts and intolerance or "allergy" to all products but Oxycontin. Allergic reactions to any product within a specific narcotic class will justify and preclude use of any other product in the same class due to the risk of cross-hypersensitivity. Beginning January 2017, all current opiate users who are above the maximum combined daily dose of 100 MME must titrate their total daily dose of opioid medications below 300 MME. Also, the maximum daily supply of an opiate prescription for acute pain will be limited to 7-day supplies. The maximum day supply of an opiate prescription for chronic pain will be limited to 30-day supplies. As of July 1, 2017 all users of opioid medications must comply with the maximum combined daily dose of 100 MME. However, for MaineCare members, effective January 1, 2017, opioid prescription(s) for more than a 7-day supply and/or more than 30 MME/ day will require a prior authorization. Please note that MaineCare implemented a 30 MME limit January 1, 2013 that is still effective. Post-surgical members may receive prior authorizations for opiates up to a 60 days in length if medical necessity is provided by the surgical provider. An MME conversion chart is available at www.mainecarepdl.org. Click on “General Pharmacy Info.” **Please see the Pain Management Policy tab for the complete criteria**
MISCELLANEOUS NARCOTICS								
NARCOTICS - MISC.	MC/DEL		ACETAMINOPHEN/CODEINE	MC/DEL	8	ABSTRAL	1. Fentanyl OT loz (Barr) and Capital and codeine suspension products require PA for users over 18 years of age. PA is not required if under 18 years of age. 2. Oxycodone/acet 10/650 is 8 times more expensive. Use twice as many of oxycod/acet 5/325 instead. You can mix andmatch preferred strengths of oxycodone and oxycodone/acet to minimize acet. dose similar to certain non-preferred drugs. 3. Only preferred	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Please refer to General Criteria category E. Beginning January 2017, all current opiate users who are above the maximum combined daily dose of 100 MME must titrate their total daily dose of opioid medications below 300 MME. Also, the maximum daily supply of an opiate prescription for acute pain will be limited to 7-day supplies. The maximum day supply of an opiate prescription for chronic pain will be limited to 30-day supplies. As of July 1, 2017 all users of opioid medications must comply with the maximum combined daily dose of 100 MME. However, for MaineCare members, effective January 1, 2017, opioid prescription(s) for more than a 7-day supply and/or more than 30 MME/ day will require a prior authorization. Please note that MaineCare implemented a 30 MME limit January 1, 2013 that is still effective. Post-surgical members may receive prior authorizations for opiates up to a 60 days in length if medical necessity is provided by the surgical provider. An MME conversion chart is available at www.mainecarepdl.org. Click on “General Pharmacy Info.” **Please see the Pain Management Policy for the complete criteria**
	MC/DEL		ASPIRIN/CODEINE TABS	MC/DEL	8	ASCOMP/CODEINE CAPS		
	MC/DEL		BUTAL/ASA/CAFF/COD CAPS	MC/DEL	8	BUTALBITAL/APAP/CAFFEINE/ CAPS		
	MC		BUTALBITAL/ASPIRIN/CAFFEI CAPS	MC	8	DEMEROL		
	MC		CAPITAL AND CODEINE SUSP[1]	MC/DEL	8	DILAUDID		
	MC		CAPITAL/CODEINE SUSP[1]	MC	8	DILAUDID-HP SOLN		
	MC/DEL		CODEINE PHOSPHATE SOLN	MC	8	FENTANYL CITRATE SOLN		
	MC/DEL		CODEINE SULFATE TABS	MC/DEL	8	FENTORA		
	MC/DEL		ENDOCET TABS[3]	MC/DEL	8	FIORICET/CODEINE CAPS		
	MC/DEL		ENDODAN TABS	MC	8	FIORINAL/CODEINE #3 CAPS		
	MC/DEL		FENTANYL OT LOZ[1]	MC	8	FIORTAL/CODEINE CAPS		
	MC/DEL		FENTANYL OT LOZ1	MC/DEL	8	HYDROCODONE/IBUPROFEN		
	MC/DEL		HYDROCODONE/ACETAMINOPHEN	MC	8	IBUDONE		
	MC/DEL		HYDROMORPHONE HCL[3]	MC/DEL	8	LORCET		
	MC		LORTAB ELX	MC	8	LORTAB		
	MC/DEL		MEPERIDINE HCL	MC	8	MAXIDONE TABS		
	MC/DEL		OXYCODONE	MC/DEL	8	NORCO TABS		
	MC/DEL		OXYCODONE/ACETAMINOPHEN[2,3]	MC/DEL	8	NUCYNTA		
	MC/DEL		PENTAZOCINE/NALOXONE TABS	MC/DEL	8	ONSOLIS		
	MC		PROPOXYPHENE CMPND-65 CAPS	MC/DEL	8	OXECTA		
	MC		PROPOXYPHENE COMPOUND CAPS	MC/DEL	8	OXYCODONE/APAP 10/650		
	MC/DEL		PROPOXYPHENE HCL CAPS	MC/DEL	8	OXYCODONE/APAP 7.5/500		
	MC/DEL		PROPOXYPHENE/ACET TABS	MC/DEL	8	PENTAZOCINE/ACET TABS		
	MC/DEL		PROPOXYPHENE-N/ACET TABS	MC	8	PERCOCET TABS		
	MC/DEL		ROXICET	MC	8	PERCOCET TABS		

	MC		ROXIPRIN TABS	MC	8	PHRENILIN W/CAFFEINE/CODE CAPS	manufacturer's products will be available without prior authorization.	
				MC/DEL	8	ROXICET 5/500 TABS		
				MC	8	ROXICODONE TABS		
				MC	8	SYNALGOS-DC CAPS		
				MC	8	TALACEN TABS		
				MC	8	TREZIX		
				MC	8	TYLENOL/CODEINE #3 TABS		
				MC	8	TYLOX CAPS		
				MC	8	XOLOX		
				MC	8	VICODIN		
				MC	8	VICOPROFEN TABS		
				MC	8	ZYDONE TABS		
				MC	9	ACTIQ LPOP		
				MC	9	CONZIP	Use PA Form# 20420	
				MC	9	OPANA	Use PA form #10300 for PAs over the opiate limit	
OPIOID DEPENDENCE TREATMENTS	MC		SUBOXONE FILM[2]	MC		BUNAVAIL3	Use PA Form# 10200 for Suboxone Continuation Use PA Form# 10100 for Suboxone Restart 1. Buprenorphine will only be approved for use during pregnancy. 2. See Criteria Section 3. 24month lifetime limit for treatment of opioid addiction 4. Both provider and patient need to be registerd as part of the Probuphine REMS program.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Suboxone Criteria 1. Effective 1/1/2013, MaineCare will implement a 24 month lifetime limit for members prescribed Suboxone for the treatment of opioid addiction. 2. Prior authorization request will be reviewed for dose titration downward,whether the patient is engaged in recovery oriented support services,periodic urine drug screens, flim counts,factors that threaten stability of recovery or evidence of improvement is social,physical and occupational areas. 3. Members that stop treatment after 24 months and need to restart will require a prior authorization. This prior authorization will assess the patient risk of relapsing or evidence that the patient has relapsed. Members will continue to be required to follow the criteria listed below: 1-Induction period for new starts max of 60 days 2-Max dose of 32 mg for induction 3-Max dose of 16 mg for maintenance 4-There is not more than one narcotic fill in member's drug profile between today's fill of suboxone and a prior suboxone fill within the past 90 days. 5- Prescribers limited to those with X-DEA 6- Should be evidence provided of monthly monitoring including random pill counts urine drug tests and prescription monitoring program reports. 7-Suboxone tablets will be available upon demonstrated allergy to the preferred product. Allergy may be established by 1) formal allergy testing by a board certified allergist or 2) demonstration of hives after skin exposure for 24 hours to the Suboxone Film. (The product may be applied to the skin using a band-aid and member can be assessed after 24 hours to ascertain the presence of hives by the prescriber).
				MC/DEL		BUPRENORPHINE[1,2]		
				MC		PROBUPHINE[4]		
				MC		ZUBSOLV[3]		
NARCOTIC ANTAGONISTS								
NARCOTIC - ANTAGONISTS	MC/DEL		NALTREXONE HCL TABS	MC		EVZIO	Use PA Form# 20420	
	MC		NARCAN NS[2]					
				MC		NALOXONE INJ		

	MC		VIVITROL INJ	MC/DEL		REVIA TABS[1]	1. Will only be approved for side effects experienced with generic that are not described in the literature as occurring with the brand version. 2. Quantity limits apply 2units/28days	
COX 2 / NSAIDS								
COX 2 INHIBITORS - SELECTIVE / HIGHLY SELECTIVE	MC/DEL MC/DEL MC/DEL MC/DEL		**CELECOXIB**[4,5,6] KETOROLAC TROMETHAMINE [2,3,6] NABUMETONE TABS[6] MELOXICAM[1,6]	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		CELEBREX CAPS[4,5,6] **MOBIC**[6] MOBIC SUSP[6] **RELAFEN TABS**[6] **VIVLODEX**	Use PA Form# 10310 1. Meloxicam has dosing limits allowing one tablet daily of all strengths without PA. 2. Ketorolac Tromethamine is indicated for the short term (up to 5 days) managment of moderately severe acute pain that requires analgesic at the opiod level in adults. Not indicated for minor of chronic pain conditions. 3. Ketorolac has dosing limits allowing 24 tablets for a 5 day supply every 30 days. 4. Dosing limits will be set at a maximum of 200mg twice daily for PA requests. 5. Users 60 years of age or older will not require PA. If under 60 years of age, Celebrex will require PA. 6. The FDA has issued a Public Health Advisory warning of the potential for increased cardiovascular risk & GI bleeding with NSAID use.	Approved without PA for patients 60 years old or over. Patients under 60 can use a preferred proton pump inhibitor with any preferred generic NSAID to achieve similar reductions in GI bleeding risk to that seen with the COX-II agents. Approvals for Celebrex will be granted for other requests based on failure of at least one generic NSAID from at least 2 different NSAID classes as described in the COX-II PA form. High risk GI bleeding patients must fail on adequate trials of safer agents (non-NSAID/Cox-2) for GI tract, such as acetaminophen.
NSAIDS	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		**CHILDRENS IBUPROFEN** **DICLOFENAC POTASSIUM TABS** **DICLOFENAC SODIUM** **ETODOLAC** **FENOPROFEN CALCIUM TABS** **FLURBIPROFEN TABS** **IBUPROFEN** **INDOMETHACIN** **KETOPROFEN** **MECLOFENAMATE SODIUM CAPS** NAPROSYN SUSP	MC MC MC MC MC/DEL MC MC MC/DEL MC/DEL MC/DEL MC/DEL		ADVIL TABS ANAPROX TABS ANAPROX DS TABS CAMBIA **CATAFLAM TABS** CHILDRENS ADVIL SUSP CHILD'S IBUPROFEN SUSP CHILDREN'S MOTRIN SUSP **CLINORIL TABS** **DAYPRO TABS** **EC-NAPROSYN TBEC**	The FDA has issued a Public Health Advisory warning of the potential for increased cardiovascular risk & GI bleeding with NSAID use. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Approvals will be granted for other requests based on failure of at least one generic NSAID from at least 3 different NSAID classes as described in the COX-II PA form. **DDI:** Diclofenac will now be non-preferred and require prior authorization if it is currently being used in combination with lescol.

	MC/DEL		NAPROXEN SUSP	MC/DEL		**ETODOLAC ER 600MG**		
	MC/DEL		**NAPROXEN TABS**	MC		FELDENE CAPS		The FDA has issued a Public Health Advisory warning of the potential for increased cardiovascular risk & GI bleeding with NSAID use.
	MC/DEL		**NAPROXEN SODIUM TABS**	MC/DEL		FLECTOR PATCH		
	MC/DEL		**OXAPROZIN TABS**	MC/DEL		IBU-200		
	MC/DEL		**SULINDAC TABS**	MC		INDOCIN		
	MC/DEL		**TOLMETIN SODIUM**	MC/DEL		**LODINE**		
				MC/DEL		**MOTRIN**		
				MC		NALFON CAPS		
				MC/DEL		NAPRELAN TBCR		
				MC/DEL		NAPROSYN TABS		
				MC/DEL		**NAPROXEN DR TBEC**		
				MC/DEL		**NAPROXEN SODIUM TBCR**		
				MC		PENNSAID		
				MC/DEL		**PIROXICAM CAPS**		
				MC		PONSTEL CAPS		
				MC		SB IBUPROFEN TABS		
				MC		SPRIX		
				MC		TIVORBEX		
				MC		TOLECTIN		
				MC/DEL		VOLTAREN		
				MC		V-R IBUPROFEN TABS		
				MC		ZORVOLEX		
NSAID - PPI				MC		PREVACID NAPRA-PAC	1. Use a preferred NSAID and PPI separately. Use PA Form# 20420	
				MC/DEL		VIMOVO[1]		
RHEUMATOID ARTHRITIS								
RHEUMATOID ARTHRITIS	MC/DEL	1	**AZATHIOPRINE**	MC/DEL		**ARAVA**	Use PA Form# 20900	See criteria as listed on Rheumatoid Arthritis PA form.
	MC/DEL	1	LEFLUNOMIDE	MC/DEL		ACTEMRA	1. Only one step 1 drug is required to obtain Enbrel or Humira without PA.	
	MC/DEL	1	METHOTREXATE	MC/DEL		CIMZIA		Enbrel is preferred after a trial of a step 1 product (e.g. azathioprine, methotrexate, etc.); however, dosing limits will also still apply. Dosing limits will allow 8 injections per month without pa. Use of greater than 8 injections per month will require PA.
	MC/DEL	1	**SULFASALAZINE TABS**	MC/DEL		ENTYVIO		
	MC	2	**ENBREL**[1,4]	MC/DEL		**HYDROXYCHLOROQUINE**		
	MC	2	ENBREL SURECLICK[1,4]	MC/DEL		**ILARIS**[2,5,6]	2. Dosing limits apply. Please see dose consolidation list.	
	MC	2	**HUMIRA**[1,2,4]	MC/DEL		INFLECTRA		
				MC/DEL		**KEVZARA**		
						KINERET SOLN	3. Preferred dosage form allowed without PA after trial of step 1 prodcuts is multi-dose vial, with dosing limits allowing 8 injections per 28 days without pa.	**Xeljanz** is limited to adults with moderately to severely active RA who have had an inadequate response or intolerance to methotrexate. Should not be used concomitantly with biologic DMARDs or potent Immunosuppressants. Therapy should not be started in those with lymphocyte count <500cells/mm^3, an ANC <1000cells/mm^3, or have a hemoglobin <9g/dl.
				MC				
				MC		ORENCIA	4. Established users will be grandfathered for Enbrel and Humira.	
							5.Clinical PA is required to establish diagnosis and medical necessity.	
				MC		RASUVO[7]		
				MC		**REMICADE**	6. Verification of age for appropriate indication.	
				MC		SIMPONI	7. Treatment failure or intolerance to other forms of preferred methotrexate	DDI: The concomitant use of **Xeljanz® XR** with biologic DMARDs or potent immunosuppressants such as azathioprine and cyclosporine are not recommended. The concomitant use of **Xeljanz® XR** with potent CYP3A4 inducers (e.g. rifampin) is not recommended
				MC/DEL		**XELJANZ**		
				MC/DEL		**XELJANZ XR**		
MISCELLANEOUS ARTHRITIS								
ARTHRITIS - MISC.	MC		RIDAURA CAPS	MC/DEL		**ARTHROTEC**[1]	1. The individual	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered

	MC		MYOCHRYSINE SOLN				components of Arthrotec are available without PA. Use PA Form# 20420	on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. The individual components of Arthrotec are available without PA.
LUPUS-SLE								
LUPUS-SLE				MC		BENLYSTA	Use PA Form# 20420	
MIGRAINE THERAPIES								
MIGRAINE - ERGOTAMINE DERIVATIVES	MC MC		MIGRANAL SOLN SANSERT TABS	MC/DEL		D.H.E. 45 SOLN	Use PA Form# 10110	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
MIGRAINE - CARBOXYLIC ACID DERIVATIVES	MC		DIVALPROEX ER TB24	MC		DEPAKOTE ER TB24	Use PA Form# 10110	
MIGRAINE - SELECTIVE SEROTONIN AGONISTS (5HT)--Tabs/Nasal	MC/DEL MC/DEL MC/DEL MC/DEL	1 1 1 2	RELPAX[1] **RIZATRIPTAN TABS** SUMATRIPTAN TABS[1] NARATRIPTAN HCl TABS[1]	MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL		AMERGE TABS[1,2] AXERT TABS[1,2] FROVA TABS[1,2] IMITREX TABS[1,2] MAXALT[1,2,3] MAXALT MLT1,2,3 ONZETRA XSAIL2 **RIZATRIPTAN ODT** ZOMIG TABS[1,2] ZOMIG NASAL SPARY[1,2] ZOMIG ZMT TBDP[1,2]	1. All drugs in this category have dosing limits. Please refer to dose consolidation table. 2. Must fail all preferred products before non-preferred. 3.Established users will be grandfathered Use PA Form# 10110	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Quantity limit exceptions will require ongoing therapy with therapeutic doses of highly effective prophylactic medication as listed on the Triptan PA form.
MIGRAINE - SELECTIVE SEROTONIN AGONISTS (5HT)--Injectables	MC/DEL MC/DEL MC/DEL MC/DEL		IMITREX KIT IMITREX SOLN IMITREX STATDOSE PEN KIT IMITREX STATDOSE REFILL KIT	MC/DEL MC		SUMATRIPTAN SOLN ZEMBRACE[1]	Use PA Form# 10110 1. Dosing limits aply. Please refer to the dose consolidation table.	
MIGRAINE - SELECTIVE SEROTONIN AGONISTS (5HT)--Combinations				MC/DEL		TREXIMET[1,2]	Use PA Form# 10110 1. Dosing limits apply. Please see dose consolidation list. 2. Use preferred Sumatriptan and Naproxen separately. Treximet only available if component ingredients of sumatriptan and naproxen are unavailable.	
MIGRAINE - MISC.	MC/DEL MC/DEL		CAFERGOT TABS SPASTRIN TABS	MC/DEL MC MC/DEL		MIGRAZONE CAPS BELCOMP-PB SUPP MIGERGOT SUP	Use PA Form# 10110	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
GOUT								
GOUT	MC/DEL MC/DEL MC MC/DEL MC/DEL		**ALLOPURINOL TABS** **COLCHICINE CAP** MITIGARE **PROBENECID TABS** **PROBENECID/COLCHICINE TABS**	MC/DEL MC MC/DEL MC/DEL MC		COLCHICINE TAB COLCRYS ULORIC[1] **ZURAMPIC[2]** ZYLOPRIM TABS	Use PA Form# 20420 1. Failure of therapeutic (300mg) dose of Allopurinol (failure define as not being able to get uric acid levels below 6mg/dl) or severe renal disease. 2. Zurampic should be used	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.

							in combination with a xanthine oxidase inhibitor, including allopurinol or febuxostat.	
MISC.								
ANESTHETICS - MISC.	MC		BUPIVACAINE HCL SOLN	MC		SENSORCAINE-MPF SOLN	Use PA Form# 30130	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		LIDOCAINE HCL SOLN	MC/DEL		SYNVISC INJ		
	MC		MARCAINE SOLN	MC		XYLOCAINE SOLN		
VACCINES	MC/DEL		GARDASIL VACCINES				Use PA Form# 20420	Under the Maine Immunization Program Gardasil is covered under the vaccine for Children Program for ages 9-18. Gardasil will be preferred by MaineCare for ages 19-26. Children who are 18 years old or younger are eligible for this vaccine through the Maine Immunization Program. Please contact 1-800-867-4775 or 207-287-3746 for assistance.
ANTI-CONVULSANTS								
ANTICONVULSANTS	MC/DEL		CARBAMAZEPINE	MC	8	APTIOM	Use PA Form# 20420	
	MC/DEL		CARBATROL CP12	MC	8	BANZEL		One time PA is required to determine seizure diagnosis for any non-preferred anticonvulsant. Other approvals will be for patients with a variety of drug-specific FDA-approved indications and for specific conditions supported by at least two published peer-reviewed double-blinded, placebo-controlled randomized trials that are not contradicted by other studies of similar quality after recommendation by the DUR Committee and as long as all first line therapies have been tried and failed at full therapeutic doses for adequate durations (at least two weeks).
	MC/DEL		CELONTIN CAPS	MC/DEL	8	BRIVIACT[9]	All non-preferred meds must be used in specified order	
	MC/DEL		CLONAZEPAM TABS	MC	8	DEPAKENE		
	MC		DEPAKOTE SPRINKLES CPSP	MC	8	DEPAKOTE		
	MC/DEL		DIASTAT[1]	MC	8	DEPAKOTE ER	1. Quantity limit. 5/month	
	MC/DEL		DILANTIN	MC/DEL	8	DIAZEPAM GEL	2. Dosing limits apply, please see dose consolidation list.	
	MC/DEL		DIVALPROEX SODIUM	MC/DEL	8	DIVALPROEX SODIUM SPRINKLE CAPS		*** SEE CHART AT END OF DOCUMENT
	MC/DEL		EPITOL TABS	MC/DEL	8	EQUETRO		
	MC/DEL		ETHOSUXIMIDE SYRP	MC/DEL	8	FELBATOL	3. Dosing limits apply per strength as well as a maximum daily dose of 600mg. Please see dose consolidation list.	Topamax and Neurontin - Second line therapy for migraine prophalaxis after trial of at least three preferred preventive medications from Group 1 listed on page 2 of the Acute Migraine PA form.
	MC		FYCOMPA[2]	MC/DEL	8	GABITRIL TABS		
	MC/DEL		GABAPENTIN[2] 300mg & 400mg	MC/DEL	8	HORIZANT		
	MC/DEL		LAMOTRIGINE[2]	MC/DEL	8	GABAPENTIN 600mg & 800mg		
	MC/DEL		LEVETIRACETAM SOLN/TABS	MC	8	GRALISE		
	MC/DEL		OXCARBAZEPINE	MC/DEL	8	KEPPRA TABS		
	MC/DEL		PHENYTEK CAPS	MC/DEL	8	KEPPRA SOLN		Lyrica- Second line therapy for Diabetic Peripheral Neuropathy and Post Herpetic Neuralgia. With Fibromyalgia diagnosis, Lyrica will not require PA if previous 4 week trials of the following three are seen in drug profile at full therapeutic doses: TCA or cyclobenzaprine, gabapentin, and savella.
	MC/DEL		PHENYTOIN	MC/DEL	8	KLONOPIN TABS	4. Adjunctive therapy 17 and older.	
	MC/DEL		PRIMIDONE TABS	MC/DEL	8	LAMICTAL		
	MC/DEL		TEGRETOL	MC/DEL	8	**LEVETIRACETAM INJ**	5. Current users as of 7/30/10 for seizures will be grandfathered.	All non-preferred meds must be used in specified order.
	MC/DEL		TOPIRAMATE	MC/DEL	8	**LEVETIRACETAM ER TABS**		
	MC/DEL		TOPIRAMATE SPRINKLE IR CAPS[2]	MC/DEL	8	LYRICA[3]		
	MC/DEL		TRILEPTAL SUSP	MC/DEL	8	MYSOLINE TABS		
	MC/DEL		VALPROIC ACID TABS	MC	8	ONFI		**DDI:** Any Carbamazepine formulation will now be non-preferred and require prior authorization if any of the following drugs are currently being used in combination with carbamazepine: Abilify, clarithomycin, clozapine, erythromycin, Latuda, Seroquel, telithromycin or Zyprexa.
	MC/DEL		VALPROIC ACID SOL	MC	8	OXTELLAR XR[7]	6. Product is considered line extension of the original product due to Healthcare Reform (HCR). MaineCare will consider these medications non-preferred and a step 9 because of the impact under the Federal Rebate Program in conjunction with HCR.	
	MC/DEL		VIMPAT[4]	MC/DEL	8	POTIGA		
	MC/DEL		ZONISAMIDE	MC	8	SABRIL		
				MC	8	SPRITAM		Please use Drug-Drug Interaction PA form #10400 for this combination.
				MC	8	TOPAMAX		
				MC	8	TOPAMAX SPRINKLE IR CAPS[2]		
				MC	8	TOPAMAX SPRINKLE ER CAPS[2]		ONFI will require a clinical PA to confirm LGS diagnosis
				MC/DEL	8	TOPIRAMATE SPRINKLE ER CAPS[2]		
				MC	8	TROKENDI[2,8]		
				MC/DEL	8	TRILEPTAL		
				MC/DEL	8	ZARONTIN SYRP		
				MC/DEL	9	KEPPRA XR [5,6]	7. Max dose 2400mg	
					9		8. Clinical PA required for appropriate diagnosis	
				MC/DEL		NEURONTIN		
				MC/DEL	9	TEGRETOL-XR TB12 [5,6]		
				MC/DEL	9	ZONEGRAN CAPS		
				MC/DEL	9	LAMICTAL XR	9. Adjunctive therapy in the treatment of partial-onset seizures in patient's ≥16 years of age with epilepsy.	

						BIPOLAR DISORDER: STEP ORDER		
					M ~ A		SEE ANTICONVULSANT INDICATION CHART AT THE END OF THIS DOCUMENT M= Monotherapy A= Adjunctive 9= No Evidence The step orders show the relative strength of evidence for use in bi-polar and will guide prior authorization determinations. Step 4 drugs-no PA required.	
					4 ~ 4	LAMICTAL		
					4 ~ 4	LITHIUM		
					4 ~ 4	CARBAMAZEPINE		
					4 ~ 4	VALPROATE		
					4 ~ 4	ATYPICAL ANTIPSYCHOTICS EXC. CLOZAPINE		
					5 ~ 5	TRILEPTAL		
					9 ~ 6	TOPAMAX		
					9 ~ 7	KEPPRA TABS		
					9 ~ 8	GABITRIL TABS		
					9 ~ 9	NEURONTIN		
					9 ~ 9	ZONEGRAN CAPS		
						PEDIATRIC BIPOLAR1 DISORDER: STEP ORDER		
					M ~ A	(6-18 YEARS WITH OR WITHOUT PSYCHOSIS)		
					4 ~ 4	LITHIUM		
					4 ~ 4	CARBAMAZEPINE	Two-step 1 preferred drugs must be tried before Trileptal. The step orders show the relative strength of evidence for use in bi-polar and will guide prior authorization determinations. Step 4 drugs-no PA required.	
					4 ~ 4	VALPROATE		
					4 ~ 4	ATYPICAL ANTIPSYCHOTICS EXC.CLOZAPINE		
					4 ~ 4	LAMICTAL		
					5 ~ 5	TRILEPTA		
ANTI-PARKINSON DRUGS								
PARKINSONS - ANTICHOLINERGICS	MC/DEL		BENZTROPINE MESYLATE TABS				Use PA Form# 20420	
	MC		COGENTIN SOLN					
	MC/DEL		**TRIHEXYPHENIDYL**					
PARKINSONS - COMT INHIBITORS	MC/DEL		**COMTAN TABS**	MC/DEL		**TASMAR TABS**		Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
							Use PA Form# 20420	
PARKINSONS - SELECTED DOPAMIN AGONISTS	MC/DEL		**PRAMIPEXOLE**	MC/DEL	5	**MIRAPEX TABS**[1]	Use PA Form# 20420 1. As of 12/08 users of Mirapex will be grandfathered if diagnosis is Parkinsons.	Preferred drug must be tried and failed in step-order due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**ROPINIROLE**	MC/DEL	8	**REQUIP TABS**		
				MC/DEL	8	**REQUIP XL TABS**		
				MC/DEL	8	**MIRAPEX ER**		
				MC/DEL	8	**NEUPRO PATCH**		
PARKINSONS- MAOIS				MC		XADAGO		Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
PARKINSONS - DOPAMINERGICS/CARBII/ LEVO	MC/DEL		**AMANTADINE HCL**	MC/DEL		**APOKYN**[3]	1. Approvals will require concurrent therapy with Levodopa and failed trials of Selegiline, Comtan, and Stalevo. 2. Approvals will require trials of Carbidopa/Levodopa, Selegiline, Comtan, and Stalevo.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**BROMOCRIPTINE MESYLATE TABS**	MC		AZILECT[2]		
	MC/DEL		**CARBIDOPA/LEVODOPA TABS**[3]	MC/DEL		**BROMOCRIPTINE MESYLATE CAPS**		
	MC/DEL		**CARBIDOPA/LEVODOPA ER**	MC		ELDEPRYL CAPS		
	MC		LARODOPA TABS	MC		LODOSYN TABS		
	MC/DEL		**PARLODEL CAPS**	MC/DEL		**PARLODEL TABS**		
	MC/DEL		**SELEGILINE CAPS HCL**	MC		RYTARY		
				MC/DEL		**SELEGILINE TABS HCL**		
				MC		SINEMET TABS		

				MC		SINEMET TBCR	3. Only preferred manufacturer's products will be available without prior authorization.	
				MC		ZELAPAR[1]	Use PA Form# 20420	
PARKINSONS - COMBO.				MC/DEL		STALEVO[1]	Use PA Form# 20420	
				MC		CARBIDOPA/LEVODOPA/ENTACA[1]	1.Clinical PA is required to establish diagnosis and medical necessity.	
MUSCLE RELAXANTS								
ALS DRUG	MC/DEL		RILUZOLE	MC/DEL		RILUTEK TABS	Use PA Form# 20420	
MUSCLE RELAXANTS	MC/DEL		BACLOFEN TABS	MC/DEL	7	ORPHENADRINE CITRATE		At least 4 preferred drugs (including tizanidine) must be tried for at least 2 weeks and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an…… acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Elderly patients, over 65, will require written notice of the increased sedative risks and impaired driving.Prior Authorization will not be given for:1. frequent or persistent early refills of controlled drugs; 2. multiple instances of early refill overrides due to reports of misplacement, stolen, dropped in toilet or sink, distant travel, etc.
	MC/DEL		CHLORZOXAZONE TABS	MC/DEL	8	CARISOPRODOL 350MG TABS		
	MC/DEL		CYCLOBENZAPRINE HCL TABS	MC/DEL	8	AMRIX		
	MC		LIORESAL INTRATHECAL KIT	MC/DEL	8	DANTRIUM CAPS		
	MC/DEL		METHOCARBAMOL TABS	MC	8	LIORESAL TABS		
	MC/DEL		TIZANIDINE HCL TABS	MC	8	LORZONE		
				MC/DEL	8	METAXALONE		Non-preferred drugs will not be approved if members circumventing MaineCare prior authorization requirements by paying (prescribers failed to submit prior authorization prior to cash narcotic scripts being filled by member).
				MC	8	NORFLEX TBCR		
				MC	8	ROBAXIN-750 TABS		Non-preferred products must be used in specified step order.
				MC	8	VECUROMIUM INJ		
				MC/DEL	8	ZANAFLEX TABS		
				MC/DEL	9	CARISOPRODOL 250MG TABS		**Lorzone** is non preferred and requires at least 4 preferred drugs (including tizanidine) and step care therapy (orphenadrine), as well as reasons for why chlorzoxazone is not acceptable.
				MC/DEL	9	SKELAXIN TAB		
				MC/DEL	9	SOMA TABS		
							Use PA Form# 20420	
MUSCLE RELAXANT - COMBO.				MC/DEL		CARISOPRODOL/ASPIRIN TABS	Use PA Form# 20420	Individual components are available with PA described in the section above.1. frequent or persistent early refills of non-controlled drugs; 2. multiple instances of early refill overrides due to reports of misplacement stolen, dropped in toilet or sink, distant travel, etc.
				MC/DEL		CARISOPRODOL/ASPIRIN/CODE		
				MC		NORGESIC TABS		
				MC/DEL		ORPHENADRINE COMPOUND		
				MC/DEL		ORPHENADRINE/ASA/CAFF		
				MC		ORPHENGESIC		
PARATHYROID HORMONE								
PARATHYOID HORMONE				MC		NATPARA[1]	1. Recommended only for those who cannot be well-controlled on calcium supplements and active forms of vitamin D alone.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
VITAMINS								
VITAMINS	MC/DEL		ASCORBIC ACID TABS	MC		AQUASOL E SOLN	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **As listed in MaineCare Policy, certain drugs require specific diagnoses for approval.**
	MC		BIOTIN	MC		AQUAVIT-E SOLN	**Please refer to OTC list for covered products.**	
	MC		CYANOCOBALAMIN SOLN			CONCEPT		
	MC		FERIVA CAP	MC		DHT SOLN		
	MC		FERIVAFA CAP	MC		NASCOBAL GEL	Click here for the OTC List	
	MC		FERRALET 90 TAB			VITAFOL		
	MC/DEL		FOLIC ACID TABS					
	MC		FUSION PLUS CAP					
	MC		HEMOCYTE PLU CAP					
	MC		INTEGRA CAP					
	MC		INTEGRA PLUS CAP					
	MC		INTEGRA F CAP					**Please refer to OTC list for covered products.**
	MC/DEL		MEPHYTON TABS					
	MC/DEL		NIACIN					**DDI:** B-12 will now be non-preferred and require prior authorization if it is currently being used in combination with either Prevacid, pantoprazole, Prilosec, or any currently non preferred PPI.
	MC		NIACOR TABS					
	MC/DEL		NICOTINIC ACID SR CPCR					Preferred products that used to require diag codes still require diag codes unless indicated otherwise.

	MC		PYRIDOXINE HCL TABS					
	MC/DEL		SLO-NIACIN TBCR					
	MC		TANDEM CAP					
	MC		TANDEM PLUS CAP					
	MC/DEL		THIAMINE HCL SOLN					
	MC/DEL		VITAMIN B-1 TABS					
	MC/DEL		VITAMIN B-12					
	MC		VITAMIN B-6 TABS					
	MC/DEL		VITAMIN C					
	MC/DEL		VITAMIN E CAPS					
	MC/DEL		VITAMIN E/D-ALPHA CAPS					
	MC		VITAMIN K1 SOLN					
	MC		V-R VITAMIN E CAPS					
VITAMIN D's	MC/DEL		**CALCITRIOL CAPS**[1]	MC		CALCIJEX	1. Diagnosis of dialysis (renal failure) required.	Preferred products require dialysis/renal failure diagnosis.
	MC/DEL		**VITAMIN D**	MC/DEL		**DOXERCALCIF CAP**		
	MC		ZEMPLAR CAPS	MC/DEL		**DOXERCALCIF INJ**	Use PA Form# 20420	
				MC/DEL		**PARICALCITROL CAP**		
				MC/DEL		**PARICALCITROL INJ**		
				MC/DEL		HECTOROL (ORAL)		
				MC/DEL		HECTOROL (PARENTERAL)		Rayaldee requires clinical PA to verify stage 3 or 4 CKD.
				MC		RAYALDEE		
				MC/DEL		**ROCALTROL**		
				MC		ZEMPLAR INJ		
MISC MULTI-VITAMINS								
VITAMINS - MISC.	MC		CENTRUM LIQD	MC		ADEKS	1. Diag codes are no longer required on prenatal vitamins.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. As listed in MaineCare Policy, certain drugs require specific diagnoses for approval.
	MC		CENTRUM TABS	MC/DEL		ADVANCED NATALCARE TABS		
	MC		CENTRUM JR/IRON CHEW	MC		AQUADEKS		
	MC		CENTRUM SILVER TABS	MC		CENTRUM JR/EXTRA C CHEW	**Please refer to OTC list.**	
	MC		CENTRUM-LUTEIN TABS	MC		CENTRUM PERFORMANCE TABS		**Please refer to OTC list.**
	MC		CEROVITE ADVANCED FO TABS	MC		DALYVITE LIQD	Use PA Form# 20420	
	MC/DEL		CHEWABLE MULTIVIT/FL CHEW	MC		EMBREX 600 MISC		Preferred products that used to require diag codes still require diag codes unless indicated otherwise.
	MC		COD LIVER OIL CAPS	MC		IBERET		
	MC		COMPLETE SENIOR TABS	MC		MATERNA TABS	Click here for the OTC List	
	MC		DAILY MULTI VIT/IRON	MC		MAXARON		
	MC/DEL		DIALYVITE 1MG	MC		MULTIRET FOLIC -500 TBCR		
	MC/DEL		DIALYVITE 800MG	MC/DEL		NATAFORT TABS		
	MC		FERRALET 90	MC/DEL		NATALCARE CFE 60 TABS[1]		
	MC/DEL		FULL SPECTRUM B	MC/DEL		NATALCARE GLOSS TABS[1]		
	MC		M.V.I.-12 INJ	MC		NATALCARE PIC TABS[1]		
	MC		MULTI-VIT/FLUORIDE	MC		NATALCARE PIC FORTE TABS[1]		
	MC/DEL		NATALCARE RX TABS	MC/DEL		NATALCARE PLUS TABS[1]		
	MC/DEL		NEPHRONEX	MC		NATALCARE THREE TABS[1]		
	MC/DEL		O-CAL PRENATAL	MC/DEL		NATACHEW CHEW		
	MC/DEL		ONE DAILY TABS	MC		NATALFIRST TABS		
	MC/DEL		ONE-DAILY MULTIVITAMINS	MC		NATATAB RX TABS		
	MC/DEL		ONE-TABLET-DAILY	MC/DEL		NEPHPLEX RX TABS		
	MC/DEL		POLY-VIT/IRON/FLUORID SOLN	MC/DEL		NEPHROCAPS CAPS		
	MC/DEL		POLY-VITAMIN/FLUORIDE SOLN	MC/DEL		NEPHRO-VITE TABS		
	MC/DEL		POLY-VITAMINS/IRON SOLN	MC		NESTABS RX TABS		
	MC/DEL		PRENATAL TABS[1]	MC/DEL		NIFEREX		
	MC/DEL		PRENATAL FORMULA 3 TABS[1]	MC/DEL		OCUVITE TABS		
	MC/DEL		PRENATAL PLUS TABS[1]	MC		POLY-VI-FLOR SOLN		
	MC/DEL		PRENATAL PLUS NF TABS[1]	MC		POLY-VI-SOL SOLN		
	MC		PRENATAL PLUS/27MG IRON[1]	MC		POLY-VI-SOL/IRON SOLN		
	MC		PRENATAL PLUS/IRON TABS[1]	MC		POLY-VITAMIN DROPS SOLN		
	MC/DEL		PRENATAL RX/BETA-CAROTENE[1]	MC		PRECARE		
	MC/DEL		RENAL CAPS	MC		PREFERA OB		
	MC/DEL		RENAPHRO CAPS	MC		PREMESIS RX TABS		

	MC		STRESS TAB NF TABS	MC		PRENATABS CBF TABS[1]		
	MC		THERAPEUTIC-M TABS	MC		PRENATAL CARE TABS[1]		
	MC		THERAVITE LIQD	MC		PRENATAL MR 90 TBCR[1]		
	MC/DEL		TRI-VITAMIN/FLUORIDE SOLN	MC/DEL		PRENATAL MTR/SELENIUM TABS[1]		
	MC		VITA CON FORTE CAPS	MC		PRENATAL OPTIMA ADVANCE TABS[1]		
	MC		VITAMIN B COMPLEX CAPS	MC		PRENATAL PC 40 TABS[1]		
	MC		VITAPLEX PLUS TABS	MC/DEL		PRENATAL RX TABS[1]		
				MC		PRENATE[1]		
				MC		PRENATE ELITE[1]		
				MC		PRIMACARE MISC		
				MC		PROTEGRA CAPS		
				MC		STUARTNATAL PLUS 3 TABS[1]		
				MC		TRI-VI-SOL SOLN		
				MC		TRI-VI-SOL/IRON SOLN		
				MC/DEL		ULTRA NATALCARE TABS		
				MC		ULTRA-NATAL TABS[1]		
				MC		VICON FORTE CAPS		
				MC		VINATAL FORTE TABS[1]		
				MC		VINATE[1]		
				MC/DEL		VINATE ADVANCED TABS[1]		
MISCELLANEOUS MINERALS								
MINERALS	MC		CALCARB	MC		ANEMAGEN	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. As listed in MaineCare Policy, certain drugs require specific diagnoses for approval.
	MC		CALCI-MIX CAPSULE CAPS	MC		CALCET TABS	**Please refer to OTC list.**	
	MC		CALCIQUID SYRP	MC/DEL		**CALCIUM 600-D TABS**		
	MC		CALCITRATE/VITAMIN D TABS	MC		CALCIUM/VITAMIN D TABS	Click here for the OTC List	
	MC/DEL		CALCIUM	MC		CALTRATE 600 PLUS/VIT D TABS		
	MC/DEL		CALCIUM CARBONATE	MC		CALTRATE PLUS TABS		**DDI:** Fe salts will now be non-preferred and require prior authorization if it is currently being used in combination with either Prevacid, pantoprazole, Prilosec, or any currently non preferred PPI.
	MC/DEL		CALCIUM CITRATE TABS	MC		CHROMAGEN		
	MC/DEL		CALCIUM GLUCONATE TABS	MC		CITRACAL PLUS TABS		
	MC/DEL		CALCIUM LACTATE TABS	MC		CONTRIN CAPS		**Please refer to OTC list.**
	MC		CALCIUM/MAGNESIUM TABS	MC		FEOGEN FORTE CAPS		
	MC/DEL		**CALCIUM/VITAMIN D TABS**	MC		FEROCON CAPS		Preferred products that used to require diag codes still require diag codes unless indicated otherwise.
	MC		CALTRATE 600 TABS	MC/DEL		FERREX 150 CAPS		
	MC/DEL		CHEWABLE CALCIUM CHEW	MC		FERRO-SEQUELS TBCR		
	MC		CITRACAL TABS	MC		FE-TINIC CAPS		
	MC		CITRACAL + D TABS	MC		FE-TINIC 150 FORTE CAPS		
	MC		CITRUS CALCIUM TABS	MC/DEL		FLUOR-A-DAY SOLN		
	MC		CITRUS CALCIUM 1500 + D TABS	MC		HEMOCYTE TABS		
	MC		EFFERVESCENT POTASSIUM TBEF	MC/DEL		K-DUR TBCR		
	MC/DEL		FEOSTAT CHEW	MC		KLOR-CON PACK		
	MC		FERATAB TABS	MC		K-LYTE		
	MC/DEL		FER-GEN-SOL SOLN	MC/DEL		K-PHOS TABS NEUTRAL		
	MC		FER-IRON SOLN	MC		K-TABS TBCR		
	MC		FERRONATE TABS	MC		K-VESCENT PACK		
	MC/DEL		FERROUS SULFATE	MC		MICRO-K 10 MEG CPCR		
	MC/DEL		FLUOR-A-DAY CHEW	MC		NU-IRON 150 CAPS		
	MC		FLUORIDE CHEW	MC/DEL		**OYSTER SHELL CALCIUM/VITA TABS**		
	MC		FLUORIDE SODIUM CHEW	MC/DEL		POLY-IRON 150 CAPS		
	MC		FLUORITAB CHEW	MC/DEL		POLYSACCHARIDE IRON CAPS		
	MC		HM CALCIUM TABS	MC/DEL		POTASSIUM BICARB/CHLORIDE		
	MC		K+ POTASSIUM PACK	MC/DEL		POTASSIUM CHLORIDE 10MEQ CAPS		
	MC		KAON ELIX	MC/DEL		POTASSIUM CHLORIDE 8MEQ CAPS		
	MC		KAON-CL-10 TBCR	MC/DEL		SLOW FE TBCR		
	MC		KCL 0.075%/D5W/NACL 0.2% SOLN	MC		TUMS 500 CHEW		
	MC		K-EFFERVESCENT TBEF	MC		VIACTIV CHEW		
	MC		KLOR-CON					
	MC		KLOTRIX TBCR					

	MC/DEL		K-PHOS TABS					
	MC/DEL		K-VESCENT TBEF					
	MC/DEL		LURIDE CHEW					
	MC/DEL		MAGNESIUM GLUCONATE TABS					
	MC/DEL		MAGNESIUM SULFATE SOLN					
	MC		MAGTABS					
	MC		MICRO-K 8 MEG					
	MC/DEL		OS-CAL TABS					
	MC/DEL		**OS-CAL 500 + D TABS**					
	MC/DEL		**OYSCO**					
	MC/DEL		OYST-CAL TABS					
	MC/DEL		**OYST-CAL D TABS**					
	MC/DEL		**OYST-CAL/VITAMIN D TABS**					
	MC/DEL		OYSTER CALCIUM TABS					
	MC/DEL		OYSTER SHELL					
	MC		PHARMA FLUR					
	MC/DEL		PHOSPHA 250 NEUTRAL TABS					
	MC		POTASSIUM BICARBONATE TBEF					
	MC/DEL		POTASSIUM CHLORIDE 8MEQ					
	MC		POTASSIUM EFFERVESCENT					
	MC/DEL		SELENIUM TABS					
	MC		SLOW-MAG TBCR					
	MC/DEL		SODIUM FLUORIDE					
	MC/DEL		SSKI SOLN					
	MC		V-R CALCIUM					
	MC		V-R OYSTER SHELL CALCIUM					
	MC		ZINC SULFATE CAPS					
MISC. ELECTROLYTES/NUTRITIONALS								
ELECTROLYTES/ NUTRITIONALS	MC		INTRALIPID EMUL[1]	MC		BOOST[1]	1. This list of nutritionals is incomplete. All nutritionals still require a PA except for the miscellaneous products listed as preferred. SGA form required for nutritionals unless member has a G/I tube.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **As listed in MaineCare Policy, certain drugs require specific diagnoses for approval.** Medical foods are not to be authorized solely for the purpose of enhancing nutrient intake or managing body weight if the participant is able to eat conventional foods adequately. Medical foods may be approved if the member has a medical condition which precludes or restricts the use of conventional foods and necessitates the use of a formula. Concurrent Stimulant therapy is not an acceptable medical reason/condition for use of medical foods for enhancing nutrient intake or managing body weight.
	MC		P.T.E. -5 SOLN[1]	MC		CASEC POWD[1]		
	MC		SEA-OMEGA CAPS[1]	MC		CHOICE DM LIQD[1]		
				MC		DELIVER 2.0 LIQD[1]		
				MC		ENFAMIL[1]		
				MC		ENSURE[1]		
				MC		GLUCERNA[1]		
				MC		ISOCAL LIQD[1]		
				MC		KINDERCAL TF LIQD[1]		
				MC		KINDERCAL TF/FIBER LIQD[1]	2. Formerly known as Omacor.	For children under the age of 5, MaineCare will not provide milk- or soy-based standard infant formulas. Regular formulas may be sought through your nearest WIC office. MaineCare will continue to cover medical food for all participants in MaineCare when medical necessity is met.
				MC		L-CARNITINE CAPS[1]		
				MC		LIPISORB LIQD[1]		
				MC		LOVAZA[1,2]	Use PA Form# 20420 & SGA Form	
				MC		MODULEN IBD POWD[1]		Vascepa requires adjunct therapy for specific indication to reduce TG in those with severe hypertriglyceridemia (500mg per deciliter or more). Proper indication per lab values is required before approval
				MC		NUTRAMIGEN POWD[1]		
				MC		NUTREN[1]		
				MC		NUTRITIONAL SUPPLEMENT LIQD[1]		
				MC		NUTRIVENT 1.5 LIQD[1]		
				MC		PEPTAMEN[1]		
				MC		PHENYLADE[1]		
				MC		PHENYL-FREE[1]		
				MC		PKU 3 POWD[1]		
				MC		PREGESTIMIL POWD[1]		
				MC		PROBALANCE LIQD[1]		
				MC		PROSOBEE[1]		
				MC		SCANDISHAKE PACK[1]		
				MC		VASCEPA		
ERYTHROPOEITINS	MC		ARANESP SOLN[1]	MC	6	EPOGEN SOLN	Use PA Form# 10520 1. Clinical PA is required to	Non-Preferred drugs must be tried and failed in step-order, due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Please see the EPO PA form for other approval and renewal criteria.
	MC		PROCRIT SOLN[1]	MC/DEL	8	OMONTYS		

							establish medical necessity and that appropriate lab monitoring is being done.	another drug and the preferred drug(s) exists. Please see the LA-CHA form for other approval and renewal criteria.
GRANULOCYTE CSF								
GRANULOCYTE CSF	MC		GRANIX	MC	8	LEUKINE	1. Must be used in specified step order. 2.10 day supply/month may be used without a PA. Use PA Form# 20520	See approval criteria detailed on Neupogen PA form.
				MC	8	NEUPOGEN SOLN[2]		
				MC/DEL	8	ZARXIO		
				MC	9	NEULASTA[1]		
GAUCHER DISEASE								
GAUCHER DISEASE				MC		CERDELGA	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Exceeding days supply limits for LMWH class requires PA.
ANTICOAGULANTS / PLATELET AGENTS								
ANTICOAGULANTS	MC		COUMADIN TABS	MC		ARIXTRA SOLN	1. Fragmin and Enoxaparin therapy durations greater than 7 days require PA. 2. Use other strengths available to obtain desired dose. 3.Established users will be grandfathered, new starters must use preferred product Coumadin. 4. Diagnosis required Use PA form# 20725 for Pradaxa requests Use PA form# 20420 for other requests	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Exceeding days supply limits for LMWH class requires PA. **DDI:** Warfarin will require prior authorization if being used in combination with fluconazole, miconazole, or voriconazole. **DDI:** Warfarin will require prior authorization if being used in conjunction with Gemfibrozil or Fenofibrate. **DDI:** Rifampin will require prior authorization if being used in combination with Savaysa
	MC/DEL		ENOXAPARIN[1]	MC/DEL		**LOVENOX SOLN**		
	MC/DEL		ELIQUIS	MC		IPRIVASK		
	MC/DEL		FONDAPARINUX$_1$	MC/DEL		JANTOVEN		
	MC/DEL		FRAGMIN INJ[1]	MC/DEL		LOVENOX 300[2]		
	MC		HEPARIN SODIUM/NACL 0.9% SOLN	MC/DEL		**WARFARIN SODIUM TABS3**		
	MC		HEP-LOCK SOLN	MC/DEL		SAVAYSAS[4]		
	MC/DEL		**INNOHEP**					
	MC		HEPARIN LOCK SOLN					
	MC/DEL		HEPARIN LOCK FLUSH SOLN					
	MC/DEL		HEPARIN SODIUM SOLN					
	MC/DEL		PRADAXA					
	MC/DEL		XARELTO					
	MC/DEL		HEPARIN SODIUM LOCK FLUSH SOLN					
ANTIHEMOPHILIC AGENTS	MC		ALPHANATE	MC		ADVATE[1,2]	1. Only if other products unavailable. 2. Advate may be available with PA in cases of large volume dosing in patients with poor venous access. Use PA Form# 20420	Non-preferred will only be approved if other preferred products are unavailable.
	MC		ALPHANINE SD	MC/DEL		KOVALTRY		
	MC/DEL		BENEFIX SOLR	MC		RECOMBINATE SOLR		
	MC/DEL		HELIXATE FS KIT					
	MC		HEMOFIL - M					
	MC		HUMATE-P SOLR					
	MC		KOATE-DVI					
	MC		KOGENATE FS					
	MC		KONYNE - 80					
	MC		MONARC - M					
	MC		MONOCLATE - P					
	MC		MONONINE					
	MC/DEL		NOVOEIGHT					
	MC		NOVOSEVEN SOLR					
	MC		NUWIQ					
	MC/DEL		PROFILNINE					
	MC		REFACTO					
	MC		WILATE INJ					

	MC/DEL		XYNTHA					
PLATELET AGGREGATION INHIBITORS	MC/DEL		ASPIRIN	MC/DEL	7	TICLOPIDINE HCL TABS	Use PA Form# 20715 for Plavix,Effent & Brilinta Use PA form# 20420 for other requests 1. A special PA may be obtained at the pharmacy for members scheduled for "stent" placement or have had placement if in the last 12months. Please indicate on prescription date of stent placement. 2. Dosing limits apply, please see dose consolidation list.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. A special PA may be obtained at the pharmacy for members scheduled for "stent" placement or have had placement if in the last 12months. Please indicate on prescription date of stent placement. **DDI:** Plavix will require prior authorization if being used in combination with omeprazole, esomeprazole, cimetidine, fluconazole, ketoconazole, intelence, fluoxetine, ticlopidine, and fluvoxamine. **DDI:** exists for using maintenance ASA dose >100mg, as it reduces the effectiveness of Brilinta Brilianta- Concomitant use with strong CYP3A4 inhibitors should be avoided (including ketoconazole, itraconazole, atazanavir, and telithromycin). Doses of simvastatin and lovastatin >40mg should be avoided.
	MC/DEL		**DIPYRIDAMOLE TABS**	MC	8	DURLAZA		
	MC/DEL		**CLOPIDOGREL 75MG**	MC	8	EFFIENT[1]		
				MC/DEL	8	PERSANTINE TABS		
				MC/DEL	8	BRILINTA[1,2]		
				MC/DEL	8	PLAVIX TABS[1]		
				MC/DEL	8	**ZONTIVITY**		
PLATELET AGGR. INHIBITORS / COMBO'S - MISC.	MC/DEL		**AGGRENOX**	MC/DEL		**AGRYLIN CAPS**	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**CILOSTAZOL**	MC/DEL		**ANAGRELIDE CAPS**		
	MC/DEL		PENTOXIFYLLINE ER TBCR	MC/DEL		**PLETAL TABS**		
				MC		TRENTAL TBCR		
				MC		YOSPRALA		
HEMATOLOGICALS								
MONOCLONAL ANTIBODY				MC		SOLIRIS	Use PA Form# 20420	A diagnosis of Paroxysmal nocturnal hemoglobinuria (PNH) using the HAM test or flow cytometry is required. In addition, the patient must show evidence of having received a meningitis vaccine at least 2 weeks prior to the start of therapy.
IMMUNE GLOBULIN INTRAVENOUS (IVIG)	MC		OCTAGAM INJ[1]	MC		GAMMAPLEX INJ	Use PA Form# 20420 1. Clinical PA required	
BRADYKININ B2 RECEPTOR ANTAGONIST				MC		FIRAZYR	Use PA Form# 20420	
HEMATOLOGICAL AGENTS-THROMBOPOIETIN RECEPTOR AGONISTS				MC/DEL	7	PROMACTA	Use PA Form# 20420	Clinical PA required. Must see prior trial with insufficient response to corticosteroids and immunoglobulins.
				MC	8	NPLATE		
HEMOSTATIC								
HEMOSTATIC	MC/DEL		AMICAR				Use PA Form# 20420	
	MC		AMINOCAPROIC ACID					
OPHTHALMICS								
OP. - ANTIBIOTICS	MC		AK-SPORE OINT	MC		AK-POLY-BAC OINT	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		BACITRACIN OINT	MC		AK-SULF OINT		
	MC		BACITRACIN/NEOMYCIN/POLYM	MC		AK-TOB SOLN		
	MC/DEL		BACITRACIN/POLYMYXIN B OINT	MC		AZASITE		
	MC		CHLOROPTIC SOLN	MC		BLEPH-10 SOLN		
	MC/DEL		ERYTHROMYCIN OINT	MC		GENTAK		
	MC/DEL		GENTAMICIN SULFATE	MC		ILOTYCIN OINT		
	MC/DEL		NEOMYCIN/POLYMYXIN/GRAMIC	MC/DEL		NEOMYCIN/BACI/POLYM OINT		
	MC		NEOSPORIN SOLN	MC		NEOSPORIN OINT		
	MC		POLYSPORIN	MC		OCUSULF-10 SOLN		
	MC/DEL		SODIUM SULFACETAMIDE SOLN	MC		OCUTRICIN SOLN		
	MC/DEL		SULFACETAMIDE SODIUM	MC		TERAK OINT		
	MC/DEL		TRIMETHOPRIM SULFATE/POLY	MC/DEL		TOBRAMYCIN SULFATE SOLN		
	MC/DEL		VIROPTIC SOLN	MC/DEL		TOBREX OINT		
				MC/DEL		TRIFLURIDINE SOLN		
OP. - QUINOLONES	MC/DEL		CILOXAN OINT	MC/DEL		BESIVANCE	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		CIPROFLOXACIN SOL 0.3%	MC/DEL		CILOXAN SOLN		
	MC/DEL		OFLOXACIN	MC		OCUFLOX SOLN		

	MC/DEL		QUIXIN SOLN					
OP.QUINOLONES-4TH GENERATION	MC/DEL		MOXEZA	MC/DEL		VIGAMOX	Use PA Form# 20420	
				MC		ZYMAXID		
OP. - ARTIFICIAL TEARS AND LUBRICANTS	MC		AKWA TEARS OINT	MC		AKWA TEARS SOLN	Use PA Form# 20420 1. Dosing limits apply, please see dose consolidation list.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		ARTIFICIAL TEARS OINT	MC/DEL		ARTIFICIAL TEARS SOLN OP		
	MC/DEL		ARTIFICIAL TEARS SOLN	MC		BION TEARS SOLN		
	MC		CELLUVISC SOLN	MC		DRY EYES OINT		
	MC		EYE LUBRICANT OINT	MC		DURATEARS OINT		
	MC/DEL		GENTEAL	MC/DEL		HYPO TEARS		
	MC		LIQUITEARS SOLN	MC/DEL		ISOPTO TEARS SOLN		
	MC		MAJOR TEARS SOLN	MC		LACRI-LUBE		
	MC		PURALUBE OINT	MC		LUBRIFRESH P.M. OINT		
	MC		PURALUBE TEARS SOLN	MC		MURINE SOLN		
	MC		REFRESH SOLN OP	MC/DEL		MUROCEL SOLN		
	MC		REFRESH PLUS SOLN[1]	MC/DEL		NATURE'S TEARS SOLN		
	MC		REFRESH PM OINT	MC		REFRESH SOLN		
				MC		REFRESH TEARS SOLN[1]		
				MC		SYSTANE		
				MC		TEARGEN SOLN		
				MC		TEARISOL SOLN		
				MC/DEL		TEARS NATURALE		
				MC/DEL		TEARS PURE SOLN		
				MC		TEARS RENEWED OINT		
				MC/DEL		THERATEARS SOLN		
				MC		V-R ARTIFICIAL TEARS SOLN		
OP. - BETA - BLOCKERS	MC/DEL		**BETOPTIC-S SUSP**	MC		BETAGAN SOLN	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**CARTEOLOL HCL SOLN**	MC/DEL		**BETAXOLOL HCL SOLN**		
	MC/DEL		**LEVOBUNOLOL HCL SOLN**	MC/DEL		**BETIMOL SOLN**		
	MC/DEL		METIPRANOLOL SOLN	MC		ISTALOL		
	MC/DEL		**TIMOLOL MALEATE SOLG (GEL)**	MC/DEL		**OCUPRESS SOLN**		
	MC/DEL		**TIMOLOL MALEATE SOLN**	MC		OPTIPRANOLOL SOLN		
				MC/DEL		**TIMOPTIC SOLN**		
				MC/DEL		**TIMOPTIC-XE SOLG**		
OP. - ANTI-INFLAMMATORY / STEROIDS OPHTH.	MC		AK-SPORE HC OINT	MC		AK-TROL SUSP	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		ALREX SUSP	MC		BAC/POLY/NEOMY/HC OINT		
	MC		BLEPHAMIDE SUSP	MC		BLEPHAMIDE S.O.P. OINT		
	MC/DEL		DEXAMETH SOD PHOS SOLN	MC		BROMDAY		
	MC/DEL		FLAREX SUSP	MC		EFLONE SUSP		
	MC/DEL		FLUOROMETHOLONE SUSP	MC		FLUOR-OP SUSP		
	MC		FML S.O.P. OINT	MC		MAXITROL OPTH OINT 0.1%		
	MC/DEL		NEO/POLY/DEXAMETH OINT	MC		NEO/POLY/BAC/HC OINT		
	MC		NEO/POLY/DEXAMETH SUSP	MC/DEL		NEOM/POLY/DEX OPTH OINT 0.1%		
	MC		PRED MILD SUSP	MC/DEL		OZURDEX		
	MC/DEL		PREDNISOLONE	MC		PRED FORTE SUSP		
	MC/DEL		TOBRADEX OINT	MC		PRED-G SUSP		
	MC/DEL		TOBRADEX SUSP	MC		PRED-G S.O.P. OINT		
	MC/DEL		**LOTEMAX GEL**	MC/DEL		SULFACET SOD/PRED SOLN		
	MC/DEL		**LOTEMAX OINT**	MC/DEL		TOBRADEX ST		
	MC/DEL		LOTEMAX SUSP	MC/DEL		TOBRAMYCIN SUSP DEXAMETHASONE		
	MC		SULFACETAMIDE/PREDNISOLONE	MC		VASOCIDIN SOLN		
	MC/DEL		ZYLET SUSP	MC/DEL		VEXOL SUSP		
OP. - PROSTAGLANDINS	MC/DEL		**LATANOPROST SOL 0.005%**	MC/DEL	7	**ZIOPTAN**	1. All preferreds must be tried. 2. Dosing limits apply, please see dosing consolidation list.	Preferred drugs must be tried and failed, in step-order, due to lack of efficacy (failure to reach target IOP reduction) or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**TRAVATAN-Z**	MC	8	LUMIGAN SOLN[1]		
				MC	8	RESCULA[1,2,3]		
				MC/DEL	8	**TRAVATAN SOLN**		

				MC/DEL	8	**TRAVOPROST**	3. Clinical PA is required to establish diagnosis and medical necessity. Use PA Form# 20420	
				MC/DEL	8	XALATAN SOLN[1]		
OP. - CYCLOPLEGICS	MC		AK-PENTOLATE SOLN	MC/DEL		CYCLOGYL SOLN	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		ATROPINE SULFATE	MC		ISOPTO ATROPINE SOLN		
	MC/DEL		CYCLOPENTOLATE HCL SOLN	MC/DEL		ISOPTO HOMATROPINE SOLN		
	MC/DEL		ISOPTO HYOSCINE SOLN	MC		MUROCOLL-2 SOLN		
OP. - MIOTICS - DIRECT ACTING	MC/DEL		**ISOPTO CARBACHOL SOLN**				Use PA Form# 20420	
	MC		ISOPTO CARPINE SOLN					
	MC		PILOCAR SOLN					
	MC/DEL		**PILOCARPINE HCL SOLN**					
	MC/DEL		**PILOPINE HS GEL**					
OP. - ADRENERGIC AGENTS	MC/DEL		**DIPIVEFRIN HCL SOLN**	MC		PROPINE SOLN	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		EPIFRIN SOLN					
OP. - SELECTIVE ALPHA ADRENERGIC AGONISTS	MC		ALPHAGAN SOLN	MC/DEL		BRIMONIDINE 0.2%	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		ALPHAGAN P 0.1% SOLN	MC/DEL		**IOPIDINE SOLN**		
	MC		ALPHAGAN P 0.15% SOLN					
	MC/DEL		SIMBRINZA					
OP. - ANTI-ALLERGICS	MC/DEL		PAZEO	MC	8	ALOCRIL SOLN	Use PA Form# 20420	All preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
				MC/DEL	8	ALOMIDE SOLN		
				MC	8	BEPREVE		
				MC	8	ELESTAT		
				MC/DEL	8	EMADINE SOLN		
				MC	8	LASTACAFT		
				MC	8	OPTICROM SOLN		
				MC/DEL	8	PATADAY SOLN		
				MC/DEL	8	PATANOL SOLN		
				MC/DEL	8	ZADITOR SOLN		
				MC/DEL	9	EPINASTINE		
OP. ANTI-ALLERGICS- MASTCELL STABILIZER CLASS				MC/DEL		ALAMAST SOLN	Use PA Form# 20420	
OP. - CARBONIC ANHYDRASE INHIBITORS/COMBO	MC/DEL		**AZOPT SUSP**	MC/DEL		**COSOPT SOLN PF**	Use PA Form# 20420	
	MC		COMBIGAN	MC/DEL		**TRUSOPT SOLN**		
	MC/DEL		DORZOLAMIDE					
	MC/DEL		DORZOLAMIDE/TIMOLOL					
OP. - NSAID'S	MC		FLURBIPROFEN SODIUM SOLN	MC	8	ACULAR LS[1]	1. Must fail all preferred products before non-preferred. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		DICLOFENAC OPTH 0.1%	MC	8	ACULAR SOLN[1]		
	MC/DEL		**DUREZOL**	MC	8	BROMSITE[1]		
	MC/DEL		ILEVRO	MC/DEL	8	PROLENSA		
	MC/DEL		KETOROLAC OPTH 0.4%	MC/DEL	8	NEVANAC[1]		
	MC/DEL		KETOROLAC OPTH 0.5%	MC	8	OCUFEN SOLN[1]		
				MC	8	XIBROM[1]		
				MC	8	VOLTAREN SOLN[1]		
				MC	8	ACUVAIL[1]		
				MC/DEL	9	BROMFENAC		
OP. - OF INTEREST	MC/DEL		ENUCLENE SOLN	MC		BOTOX SOLR	1. Must have kerato conjuctivitus sicca and failed other dry eye therapies. Use PA Form# 20420	Must fail adequate trials of multi agents from artificial tears and lubricant category.
				MC		RESTASIS[1]		
				MC		XIIDRA		
DERMATOLOGICAL								
TOPICAL - ORAL	MC		AMNESTEEM[1]				1. Users 24 or under, PA	

	MC		CLARAVIS[1]				will not be required.	
	MC		SOTRET[1]				Use PA Form# 20420	
TOPICAL - ACNE PREPARATIONS	MC		AZELEX CREA[4]	MC/DEL		ADAPALENE 0.3% GEL	1. Users 24 or under, PA will not be required.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		CLINDAMYCIN PHOSPHATE[2]	MC		ACZONE		
	MC		ERYDERM SOLN	MC		ALTINAC CREA	2. Dosing limits allowing one package per month. Please refer to Dose Consolidation List.	
	MC/DEL		ERYTHROMYCIN GEL	MC		AVITA CREA		
	MC/DEL		ERYTHROMYCIN PADS	MC		BENZAC		
	MC/DEL		ERYTHROMYCIN SOLN	MC/DEL		BENZACLIN GEL[3]		
	MC		ISOTRETINOIN	MC/DEL		BENZAGEL-10 GEL	3. Only available if component ingredients are unavailable.	
	MC		METRONIDAZOLE CREA[2]	MC/DEL		BENZAMYCIN GEL		
	MC		METRONIDAZOLE GEL[2]	MC/DEL		BENZAMYCINPAK PACK		
	MC		METRONIDAZOLE LOTN[2]	MC		BENZEFOAM		
	MC/DEL		SODIUM SULFACET/SULF LOTN	MC		BENZOYL PEROXIDE		
	MC		TAZORAC	MC		BREVOXYL		
	MC/DEL		TRETINOIN GEL[1]	MC/DEL		CLEOCIN-T[2]		
	MC		TRETINOIN CREA[1,2]	MC		CLINAC BPO GEL	4. Dosing limits apply, please see dosing consolidation list.	
				MC		CLINDAGEL GEL		
				MC		CLINDETS SWAB		
				MC		DESQUAM-E GEL		
				MC		DESQUAM-X		
				MC		DIFFERIN 0.3% GEL	5. Not approved for use in children <12 years of age	
				MC		DIFFERIN		
				MC		DUAC GEL		
				MC		EMGEL GEL	Use PA Form# 10220 for Brand Name requests	
				MC		EPIDUO		
				MC		ERYCETTE PADS	Use PA Form# 20420 for all other requests	
				MC/DEL		EVOCLIN		
				MC		FINEVIN CREA		
				MC/DEL		KLARON LOTN		
				MC		METROCREAM CREA[2]		
				MC		METROGEL GEL[2]		
				MC		METROLOTION LOTN[2]		
				MC		NEOBENZ MICRO		
				MC/DEL		NORITATE CREA		
				MC		ONEXTON[5]		
				MC		RETIN-A GEL[2]		
				MC		RETIN-A CREA[2]		
				MC		RETIN-A MICRO GEL		
				MC		RHOFADE		
				MC		SOOLANTRA[4]		
				MC/DEL		TRIAZ		
				MC		VELTIN		
				MC		ZENCIA WASH		
				MC		ZETACET		
				MC/DEL		ZIANA		
TOPICAL- ATOPIC DERMATITIS	MC/DEL		ELIDEL CREA	MC/DEL		DUPIXENT[1]	1.Avoid live vaccines if treated with Dupixent	Preferred drugs also indicated for this condition, including topical steroids, cyclosporin AND calcineurin inhibitors must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists
	MC/DEL		PROTOPIC OINT	MC		EUCRISA		
							Use PA Form# 20420	
TOPICAL - ANTIBIOTIC	MC		BACIT/NEOMYCIN/POLYM OINT	MC/DEL		ALTABAX[1]	1. Dosing limits apply, please see dosing consolidation list.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		BACITRACIN OINT	MC/DEL		BACTROBAN OINT.		
	MC/DEL		BACTROBAN CREA[1]	MC/DEL		GENTAMICIN SULFATE		
	MC/DEL		BACTROBAN NASAL OINT	MC/DEL		TRIPLE ANTIBIOTIC OINT		

	MC/DEL		CENTANY OINT 2%[1]				Use PA Form# 20420	
	MC/DEL		MUPIROCIN[1]					
TOPICAL - ANTIFUNGALS	MC/DEL		BETAMETHASONE CLOTRIMAZOLE CREA	MC/DEL	8	CICLOPIROX SOLN		
	MC/DEL		BETAMETHASONE CLOTRIMAZOLE LOT	MC	8	EXELDERM	Use PA Form# 10120	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		CICLOPIROX 0.77 CREA	MC	8	FUNGIZONE CREA		
	MC		CICLOPIROX 0.77 SUSP	MC/DEL	8	HYDROCORT/IODOQ CREA	1. Diagnosis required	
	MC/DEL		CLOTRIMAZOLE	MC	8	JUBLIA		
	MC		ECONAZOLE NITRATE CREA	MC	8	KERYDIN[1]		
	MC/DEL		KETOCONAZOLE CREA	MC/DEL	8	LAMISIL		
	MC/DEL		KETOCONAZOLE SHAM	MC/DEL	8	LOPROX 0.77 LOTN		**DDI:** Ketoconazole will now be non-preferred and require prior authorization if they are currently being used in combination with any of the following medications: Prevacid, pantoprazole, Onglyza or Omeprazole.
	MC/DEL		LOPROX 1.0 CREA	MC/DEL	8	LOPROX 0.77 CREA		
	MC/DEL		LOPROX 1.O LOTN	MC/DEL	8	LOPROX 0.77 SUSP		
	MC/DEL		LOPROX GEL	MC/DEL	8	LOPROX SHAMPOO SHAM		Kerydin- Verify prior trials and failures or intolerance of preferred treatments, including both topical and oral agents
	MC/DEL		LOPROX TS LOTN	MC	8	LOTRIMIN		
	MC/DEL		MICONAZOLE NITRATE CREA	MC/DEL	8	LOTRISONE LOT		
	MC		MYCO-TRIACET II CREA	MC/DEL	8	LOTRISONE CREA		
	MC/DEL		NYSTATIN	MC	8	LUZU		
	MC/DEL		NYSTATIN/TRIAMCINOLONE CREA	MC/DEL	8	MENTAX CREA		
	MC/DEL		NYSTOP POWD	MC	8	MYCOGEN II CREA		
	MC		PEDI-DRI POWD	MC	8	NAFTIN		
	MC/DEL		TINACTIN	MC	8	NIZORAL SHAM		
	MC		TRI-STATIN II CREA	MC/DEL	8	NYSTATIN/TRIAMCINOLONE OINT		
				MC	8	NYSTAT-RX POWD		
				MC/DEL	8	OXISTAT		
				MC/DEL	9	PENLAC NAIL LACQUER SOLN		
TOPICAL - ANTIPRURITICS	MC		ZONALON CREA	MC		PRUDOXIN CREA	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
TOPICAL - ANTIPSORIATICS	MC/DEL		SORIATANE CAPS	MC/DEL	7	TACLONEX[1,2]	1. Must fail all preferred products before non-preferred.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		TAZORAC	MC	8	ENSTILAR		
				MC	8	OXSORALEN ULTRA CAPS[1]	2. Individual ingredients are available as preferred witout PA.	
				MC	8	PSORIATEC CREA[1]		
				MC/DEL	8	SORIATANE CK KIT[1]		
				MC	8	VECTICAL[1]	Use PA Form# 20420	
MISC- ANTIPSORIATICS				MC		TALTZ	Use PA Form# 20420	It is recommended to assess for TB infection prior to starting treatment with Taltz®.
TOPICAL - ANTISEBORRHEICS	MC/DEL		SELENIUM SULFIDE SHAM	MC		CARMOL SCALP TREATMENT KIT	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
				MC		ZNP BAR		
TOPICAL - ANTIVIRALS				MC/DEL		DENAVIR CREA[1, 3]	1. Must fail oral treatment with Acyclovir or Valacyclovir.	
				MC		ZOVIRAX OINT[1,2]	2. Approvals limited to 1 tube per 180 days.	
							3. Dosing limits apply, please see dosing consolidation list.	
							Use PA Form# 20420	
TOPICAL - ANTINEOPLASTICS	MC		EFUDEX	MC/DEL		CARAC CREA	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		FLUOROPLEX CREA	MC/DEL		FLUOROURACIL		
				MC		SOLARAZE GEL		
				MC/DEL		ZYCLARA		
TOPICAL - BURN PRODUCTS	MC		FURACIN CREA	MC/DEL		SILVADENE CREA	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		SILVER SULFADIAZINE CREA					
	MC		SSD AF CREA					
	MC		SSD CREA					
	MC/DEL		THERMAZENE CREA					
TOPICAL - CORTICOSTEROIDS			**LOW POTENCY**			**LOW POTENCY**	Use PA Form# 20420	At least 1 drug from each potency of preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an

	MC		DESOWEN[1]	MC/DEL		ACLOVATE	1. Dosing limits apply, please see dosing consolidation list. 2. Treatment beyond 4 weeks is not recommended.	acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		HYDROCORTISONE CREA	MC		ANUSOL HC-1 OINT		
	MC		HYDROCORTISONE LOTN	MC		DERMA-SMOOTHE/FS OIL		
	MC		LACTICARE-HC LOTN	MC		DESONATE GEL		
	MC		NUTRACORT LOTN	MC/DEL		**FLUOCINOLONE ACETONIDE**		
	MC		TEXACORT SOLN	MC/DEL		**FLUOCINOLONE**		
				MC		HALOG		
			MEDIUM POTENCY	MC		HYDROCORTISONE POWD		
	MC/DEL		DESOXIMETASONE 0.05% CREA/GEL	MC		LIDA MANTLE HC CREA		
	MC/DEL		ELOCON	MC		PROCTOCORT CREA		
	MC/DEL		FLUROSYN CREA	MC/DEL		VERDESO		
	MC		FLUTICASONE PROPIONATE CREA/OINT			**MEDIUM POTENCY**		
	MC		HYDROCORTISONE BUTYRATE	MC		CLODERM CREA		
	MC		HYDROCORTISONE OINT	MC/DEL		CORDRAN		
	MC		HYDROCORTISONE VALERATE	MC/DEL		CUTIVATE CREA / OINT		
	MC		MOMETASONE FUROATE OINT	MC/DEL		CUTIVATE LOTN		
	MC		TRIAMCINOLONE ACETONIDE .025-.1%	MC/DEL		DERMATOP		
	MC/DEL			MC		ELOCON OINT		
				MC		KENALOG AERS		
			HIGH POTENCY	MC/DEL		LOCOID		
	MC		CLOBEX LOTN	MC/DEL		LUXIQ FOAM		
	MC		CLOBEX SHAMPOO 0.05%	MC		PANDEL CREA		
	MC/DEL		DESONIDE[1]	MC		TOPICORT		
	MC/DEL		HALOG-E CREA	MC		TOPICORT LP CREA		
	MC		TRIAMCINOLONE ACETONIDE .5%	MC		WESTCORT		
						HIGH POTENCY		
				MC		AMCINONIDE CREA		
				MC		BETAMETHASONE DIPROPIONATE		
			VERY HIGH POTENCY	MC/DEL		**DESOXIMETASONE 0.25% CREA/OINT**		
	MC/DEL		AUGMENTED BETA DIP			**VERY HIGH POTENCY**		
	MC/DEL		BETAMETHASONE VALERATE	MC/DEL		**CLOBETASOL PROPINATE LOTN**		
	MC/DEL		BETA-VAL	MC/DEL		CLOBETASOL PROPINATE SHAMPOO 0.05%		
	MC		DIFLORASONE DIACETATE	MC/DEL		CORMAX		
	MC		HALOBETASOL	MC/DEL		DIPROLENE		
				MC/DEL		OLUX FOAM		
			MISCELLANEOUS	MC/DEL		PSORCON		
	MC		PROCTO-KIT CREA 1%	MC/DEL		PSORCON E		
				MC		SERNIVO SPRAY[2]		
				MC/DEL		TEMOVATE		
				MC		ULTRAVATE		
TOPICAL - STEROID LOCAL ANESTHETICS				MC		EPIFOAM FOAM	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
TOPICAL - STEROID COMBINATIONS	MC		DERMA-SMOOTHE/FS ATOPIC P KIT	MC		CARMOL-HC CREA	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
TOPICAL - EMOLLIENTS	MC/DEL		AMMONIUM LACTATE CREA[1]	MC		LAC-HYDRIN CREA[1]	Use PA Form# 20420 1. Dosing limits still apply. Please see dose consolidation list.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		AMMONIUM LACTATE LOTN 12%[1]	MC		LAC-HYDRIN LOTN 12%		
	MC		VITAMIN A & D MEDICATED OINT	MC		MEDERMA GEL		
				MC		MIMYX		
				MC		RENOVA CREA		
TOPICAL - ENZYMES / KERATOLYTICS / UREA	MC		SANTYL OINT	MC		CARMOL 40 CREA	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Ziox, Panafil and Papain products have been removed from the PDL due to FDA safety concerns regarding drugs containing Papain.
				MC		SALEX CREA		
				MC		SALEX LOTN		

TOPICAL - GENITAL WARTS	MC/DEL		IMIQUIMOD[2]	MC/DEL	5	PODOFILOX SOLN	Use PA Form# 20420 1. Non-preferred products must be used in specified order. 2. Dosing limits still apply. Please see dose consolidation list.	
				MC/DEL	8	CONDYLOX[1]		
				MC/DEL	8	ALDARA[1]		
				MC	8	PICATO		
				MC	8	VEREGEN[1]		
				MC	8	ZYCLARA[1]		
TOPICAL - LOCAL ANESTHETICS	MC		AF CAPSICUM OLEORESIN CREA	MC/DEL		EMLA PADS	1. Lidocaine/Prilocaine cream and Ela-Max products require PA for users over 18 years of age. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		CAPSAICIN CREA	MC/DEL		EMLA CREA		
	MC		ELA-MAX[1]	MC		LIDA MANTLE CREA		
	MC/DEL		LIDOCAINE/PRILOCAINE CREA[1]	MC		LIDODERM PTCH		
	MC/DEL		LIDOCAINE GEL	MC		PONTOCAINE SOLN		
				MC		SYNERA		
				MC		ZOSTRIX		
TOPICAL - DEPIGMENTING AGENTS				MC	8	ALUSTRA CREA	Use PA Form# 20420	As per Medicaid Policy, cosmetic drugs are not covered. Non-cosmetic clinical applications will be considered by prior authorization on a case by case basis.
				MC	8	EPIQUIN MICRO		
				MC	8	GLYQUIN CREA		
				MC/DEL	8	HYDROQUINONE CREA		
				MC/DEL	8	HYDROQUINONE/SUNSCREENS		
				MC	8	SOLAQUIN FORTE CREA		
				MC	8	TRI-LUMA CREA		
				MC	9	ELDOQUIN		
TOPICAL - SCABICIDES AND PEDICULICIDES	MC/DEL		ACTICIN CREA	MC		ELIMITE CREA	Use PA Form# 20420 1. Dosing limits apply, please refer to dosage consolidation list.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		LICE KILLING SHAM	MC		EURAX		
	MC/DEL		LICE TREATMENT CREME RINS LIQD	MC/DEL		LINDANE		
	MC/DEL		PERMETHRIN LOTN	MC		MALATHION		
	MC		NATROBA[1]	MC		OVIDE LOTN		
				MC		SKLICE		
				MC		ULESFIA		
TOPICAL - WOUND / DECUBITUS CARE				MC		REGRANEX GEL	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Regranex will be approved for diabetic patients in good control (hgba1c <8), who are not smoking, with a stage III or IV WOCN AND NPUAP lower extremity diabetic ulcer and with an adequate blood supply (Tcp 02 >30, ABI>0.7 or ASP> 70), and where the underlying cause has been corrected. The wound must be free of infection and have been previously treated with preferred standard therapies for at least 2 months. Maximum approval for 20 weeks. Accuzyme and Ethezyme products have been removed from the PDL due to FDA concerns regarding drugs containing Papain.
				MC/DEL		REGENECARE		
				MC/DEL		RADIAPLEXRX		
TOPICAL - ASTRINGENTS / PROTECTANTS	MC		XERAC AC SOLN	MC		LOWILA BAR	Use PA Form# 20420 1. Dosing limits apply, please refer to dosage consolidation list.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
				MC		MOISTURIN DRY SKIN CREA		
				MC		PROSHIELD PLUS SKIN PROTE CREA		
				MC		SURGILUBE GEL		
TOPICAL - ANTISEPTICS / DISINFECTANTS	MC/DEL		PHISOHEX LIQD	MC		BETADINE OINT	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		POVIDONE-IODINE SOLN	MC		FORMALYDE-10 AERS		
				MC		IODOSORB		
				MC		LAZERFORMALYDE SOLUTION SOLN		
MISCELLANEOUS EYE								
OP. - EYE	MC		AK-DILATE SOLN	MC		LENS PLUS REWETTING DROPS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		EYE WASH SOLN	MC/DEL		MURO 128		
	MC		NAPHAZOLINE HCL SOLN	MC		NEO-SYNEPHRINE SOLN		
	MC		PHENYLEPHRINE HCL SOLN					
	MC		PONTOCAINE SOLN					
	MC/DEL		SODIUM CHLORIDE					
MISCELLANEOUS EAR								
EAR	MC/DEL		A/B OTIC SOLN	MC		ANTIBIOTIC EAR SOLN	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		ACETASOL SOLN	MC		ANTIBIOTIC EAR SUSP		
	MC/DEL		ACETASOL HC SOLN	MC/DEL		**CIPROFLOXACIN HCL**		
	MC/DEL		ACETIC ACID	MC		COLY-MYCIN-S SUSP		
	MC/DEL		ACETIC ACID/HYDROCORTISON	MC/DEL		CORTISPORIN-TC SUSP		
	MC/DEL		ALLERGEN SOLN	MC/DEL		DEBROX SOLN		
	MC		CARBAMIDE PEROXIDE 6.5% OTIC SOLN.	MC		DERMOTIC		
	MC/DEL		CIPRODEX	MC		FLOXIN		

	MC/DEL		CIPRO HC SUSP	MC/DEL		NEOMYCIN/POLYMYXIN/HC		
	MC		CORTISPORIN SOLN	MC/DEL		OFLOXACIN 0.3% OTIC		
	MC/DEL		CORTOMYCIN	MC		OTIPRIO		
	MC		EAR DROPS SOLN	MC		OTOVEL		
	MC		EAR DROPS RX SOLN					
	MC/DEL		EAR WAX REMOVAL DROPS					
MOUTH ANTISEPTICS								
MOUTH ANTI-INFECTIVES	MC		NILSTAT SUSP	MC		MYCELEX TROC	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		NYSTATIN SUSP	MC		ORAVIG		
MOUTH ANTISEPTICS	MC/DEL		CHLORHEXIDINE GLUCONATE	MC		APHTHASOL PSTE[1]	Use PA Form# 20420 1. Must fail all preferred products before non-preferred.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		LIDOCAINE VISCOUS SOLN	MC		PERIOGARD SOLN[1]		
	MC		TRIAMCINOLONE IN ORABASE PSTE	MC		TRIAMCINOLONE ACETONIDE PSTE[1]		
	MC		TRIAMCINOLONE ORADENT PSTE					
DENTAL PRODUCTS								
DENTAL PRODUCTS	MC/DEL		ETHEDENT CREA	MC0MC		APF GEL GEL	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		GEL-KAM CONC	MC/DEL		DENTAGEL GEL		
	MC/DEL		GEL-KAM GEL 0.4%	MC/DEL		PHOS-FLUR GEL		
	MC/DEL		PHOS FLUR SOLN	MC		THERA-FLUR-N GEL		
	MC/DEL		SF 5000 PLUS CREA					
	MC/DEL		SF GEL					
	MC		STANNOUS FLUORIDE ORAL RI CONC					
ARTIFICIAL SALIVA/STIMULANTS								
ARTIFICIAL SALIVA/STIMULANTS	MC		SALIVA SUBSTITUTE SOLN	MC		EVOXAC CAPS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
				MC		RADIACARE SOLR		
				MC		SALAGEN TABS		
MISCELLANEOUS ANORECTAL								
ANORECTAL - MISC.	MC/DEL		COLOCORT ENEM	MC/DEL		ANUSOL-HC CREA	Use PA Form# 20420	
	MC		CORTENEMA ENEM	MC/DEL		CORTIFOAM FOAM		
	MC		ELA-MAX 5 CREA	MC/DEL		PROCTOFOAM HC FOAM		
	MC/DEL		HYDROCORTISONE ENEM	MC/DEL		PROCTO-KIT CREA 2.5%		
	MC/DEL		PROCTOSOL HC CREA	MC		RECTIV OINT		
	MC/DEL		PROCTOZONE-HC CREA					
T-CELL ACTIVATION INHIBITOR								
PSORIASIS BIOLOGICALS	MC		**COSENTYX**[3]	MC		OTEZLA	1. Will not require a PA if at least one systemic drug such as methotrexate, cyclosporine, methoxsalen or acitretin is in members drug profile. Please refer to dose consolidation list. 2. Preferred dosage form allowed without PA after trial of step 1 prodcuts is multi-dose vial, with dosing limits allowing 8 injections per 28 days without pa.	Approved for severe chronic plaque psoriasis unresponsive to first line therapies. A trial of at least several potent topicals from the following categories: corticosteroids, coal tars, anthralin, calcipotriene and tazorotene, and at least one systemic drug such as methotrexate, cyclosporine, methoxsalen or acitretin and phototherapy/UVA. Enbrel is preferred after a trial of a step 1 product (e.g. azathioprine, methotrexate, etc.); however, dosing limits will also still apply. Dosing limits will allow 8 injections per month without pa. Use of greater than 8 injections per month will require PA. In addition, the preferred Enbrel 25mg product will be the multi-dose vial (NDC- 58406-0425-34). The single-use prefilled syringes are non-preferred.
	MC		ENBREL[1,2]	MC		SILIQ		
	MC		ENBREL SURECLICK[2]	MC		STELARA		
	MC		HUMIRA[1]	MC		TREMFYA		

							3. Will be preferred for the indication of plaque psoriasis only after trail and failure of Humira. Use PA Form# 20910	
ALTERNATIVE MEDICINES								
ALTERNATIVE MEDICINES	MC		DIMETHYL SULFOXIDE SOLN	MC/DEL		CO-ENZYME Q-10	Use PA Form# 20420	Will only be approved for specific conditions supported by at least two double-blinded, placebo-controlled randomized trials that are not contradicted by other studies of similar quality.
				MC		MELATONIN TABS		
CHELATING AGENTS								
CHELATING AGENTS	MC/DEL		**CUPRIMINE CAPS**	MC		DEPEN TITRATABS TABS	Use PA Form# 20420	
				MC/DEL		EXJADE[1]	1. FDA indication of treatment of chronic iron ovrload due to blood transfustions in membes 2 years of age and older is requried for approval of Exjade.	
ANTILEPROTIC								
ANTILEPROTIC				MC		THALOMID CAPS[1]	1. All PA requests for 150mg dosing will require use of Thalomid 100mg and 50mg capsules. Use PA Form# 20420	Approved for indications of leprosy, treatment-resistant multiple myeloma and AIDS.
ANTINEOPLASTIC AGENTS								
ANTINEOPLASTIC AGENTS - ANTIADNDROGENS	MC/DEL		BICALUTAMIDE	MC/DEL		CASODEX	Use PA Form# 20420	
ANTINEOPLASTIC AGENTS- LHRH ANALOGS	MC		LUPRON DEPOT[1]	MC		VANTAS[2]	1. Dosing limits apply, please refer to dosage consolidation list. 2. PA required to confirm FDA approved indication. Use PA Form# 20420	
				MC		FIRMAGON[2]		
				MC/DEL		TRELSTAR		
ANTINEOPLASTIC AGENTS - TYROSINE KINASE INHIBITORS				MC		SPRYCEL[1]	Use PA Form# 20420 1. Verification of diagnosis is required. 2. PA required to confirm FDA approved indication and to monitor for potential drug-drug interactions.	
				MC/DEL		TYKERB[2]		
				MC		GLEEVEC[1]		
ANTINEOPLASTICS-MISCELLANEOUS	MC		AMIFOSTINE	MC		DOCEFREZ	Use PA Form# 20420	
	MC/DEL		MERCAPTOPURINE	MC/DEL		ELOXATIN		
	MC/DEL		**OXALIPLATIN**	MC/DEL		ETHYOL		
				MC		LEUPROLIDE		
				MC/DEL		PURINETHOL		
				MC/DEL		ZOLINZA		
ANTINEOPLASTICS- MONOCLONAL ANTIBODIES				MC/DEL		HERCEPTIN[1]	1. PA required to confirm FDA approved indication. Use PA Form# 20420	
CANCER								
CANCER	MC		ALIMTA	MC		ALECENSA	1. PA required to confirm appropriate diagnosis and testing. 2. Avoid CYP3AY drug drug interaction. 3. Clinical PA required for appropriate diagnosis	A clinical PA is required for Inlyta to verify diagnosis and failure of one prior systemic therapies **Xalkori** will be considered for patients with a diagnosis of locally advanced or metastatic non-small cell lung cancer (NSCLC) that is anaplastic lymphoma kinase (ALK)-positive as detected by an FDA- approved test (please included a copy of test results; and is prescribed by an oncologist; quantity limit of 60 tablets per 30 days. **Zelboraf** will be considered for patients 18 years of age or older; has a diagnosis of unresectable or metastatic melanoma with BRAF mutation as detected be an FDA-approved test; prescriber is an oncologist with a quantity limit of 240 tablets per 30 days.
	MC/DEL		ANASTROZOLE TABS	MC		ALUNBRIG[1]		
	MC/DEL		AVASTIN	MC/DEL		ARIMIDEX		
	MC		ERBITUX	MC		BAVENCIO[1,8]		
	MC/DEL		LETROZOLE	MC/DEL		BOSULIF		
	MC		MEGACE ES	MC/DEL		BENDEKA[3]		
	MC/DEL		VIDAZA	MC		CABOMETYX[3]		
				MC		COMETRIQ[3,4,5]		

MC	COTELLIC		
MC	DARZALEX[3]		
MC/DEL	EMPLICITI(IV)[8]	4. Re-approval will require documentation of response without disease progression and tolerance to treatment	**Bosulif** requires a clinical PA, requiring diagnosis. Must have resistance or intolerance to prior therapy (such as imatinib [Gleevec®] or a TKI) seen in drug profile, monthly heptic enzyme tests should be preformed for the first three months of treatment , as clinically indicated.
MC/DEL	ERIVEDGE		**Iclusig** requires prior trail of TKI therapy, appropriate monitoring and has DDI with strong CYP3A4 inducers
MC	FARYDAK		
MC/DEL	FEMARA		**Stivarga** is non-preferred and is for the treatment of metastatic colorectal cancer (CRC) who have been previously treated with fluoropyrimidine- oxaliplatin- and irinotecan-based chemotherapy, an anti-VEGF therapy, and if KRAS wild type, an anti-EGFR therapy).The safety and efficacy of use in children under the age of 18 years have not been established.
MC	FOLOTYN		
MC/DEL	GILOTRIF[4,5]	5. Dosing limits apply, please see dosage consolidation list.	**DDI:** Cometriq, Ibrance and Tafinlar will require a prior authorization if it is currently being used in combination with drugs known to be significant CYP3A4 inhibitors (ketoconazole, itraconazole, clarithromycin, indinavir, nefazodone, nelfinavir, ritonavir, atazanavir, saquinavir and telithromycin).
MC/DEL	IBRANCE		**Gilotrif** needs to be prescribed by an oncologist
MC	ICLUSIG[3]		
MC	IMBRUVICA	6. Max daily dose of 300mg.	
MC/DEL	IMFINZI		**Xtandi** is non-preferred and is limited to adults treatment of metastatic castration-resistant prostate cancer, with previous trials of docetaxel.
MC	IMLYGIC	7. Monitor liver enzymes periodically and stop treatment upon Grade 3 or higher elevation of liver enzymes approved indication	
MC/DEL	INLYTA		
MC	JAKAFI		**Pomalyst** has a DDI with strong inhibitors of CYP1A2 and CYP3A4 drugs. Complete blood counts weelky for first 8 weeks, then monthly, patients have at least 2 prior therapies, including lenalidomide and bortezomib,female patients of reproductive potential must have 2 negative pregnancy tests and use 2 forms of contraception and providers must be certified with Pomalyst REMS Program.
MC/DEL	KEYTRUDA[1]		
MC	KISQALI[1]		
MC	KYPROLIS[1]		
MC	LARTRUVO[1]	8. For patients ≥ 12 years of age	**DDI:** Strong and moderate CYP3A inhibitors and Strong and moderate CYP3A inducers should be avoided with use of Lynparza
MC	LENVIMA		
MC	LONSURF		Clinical PA required for Ibrance to verify diagnosis and concomitant use with letrozole
MC	LYNPARZA[1]		
MC	NEXAVAR[1]		Farydak in combination with bortezomib and dexamethasone for the treatment of patients with multiple myeloma (MM) who have received ≥2 prior regimens, including bortezomib and an immunomodulatory agent
MC	NINLARO(PO)		
MC/DEL	MEKINIST[3,4]		DDI: Strong or moderate CYP3A inhibitors and strong or moderate CYP3A inducers (carbamazepine, efavirenz, phenytoin, rifampin and St. John's Wort) should be avoided with use of Cotellic
MC	ODOMZO[1,2,5]		
MC/DEL	OPDIVO[3]		
MC	POMALYST		
MC	PORTRAZZA[3]		
MC	RUBRACA		Ninlaro: prior to starting a new cycle of therapy, it is recommended that: the absolute neutrophil count be ≥ 1,000/ mm3, platelet count be ≥ 75,000/ mm3 and non-hematologic toxicities be recovered to patient's baseline condition or Grade 1 or lower
MC	RYDAPT		
MC/DEL	STIVARGA		
MC/DEL	SUTENT[1,2]	Use PA Form# 20420	
MC/DEL	SYLATRON		Lonsurf: Complete blood cell count should be obtained prior to an on day 15 of each cycle
MC/DEL	TAFINLAR[3,4,5,6]		Cycle of Lonsurf should not be started until: absolute neutrophil count (ANC) is ≥ 1500/mm3 or febrile neutropenia is resolved; platelets are >75,00/ mm3; and Grade 3 or 4 non-hematological adverse reactions are resolved to Grade 0 or 1.
MC	TECENTRIQ[1]		-Within a treatment cycle, withhold Lonsurf if: ANC <500/ mm3 or febrile neutropenia; platelets <50,000/ mm3; Grade 3 or 4 non-hematological adverse reactions
MC/DEL	TAGRISSO		- After Recovery, resume Lonsurf after reducing the dose by 5mg/m2/dose from the previous dose if the following occurs: febrile neutropenia; uncomplicated Grade 4 neutropenia or thrombocytopenia that results in >1 week delay in start of next cycle; or non-hematologic Grade 3 or Grade 4 adverse reaction except for Grade 3 nausea and/or vomiting controlled by antiemetic therapy or Grade 3 diarrhea responsive to antidiarrheal medication
MC	VENCLEXTA[3]		
MC/DEL	XALKORI		
MC/DEL	XTANDI		
MC/DEL	YERVOY		
MC	ZEJULA[1]		DDI: Avoid concomitant use of Tagrisso with strong CYP3A inhibitors, strong CYP3A inducers, drugs that are sensitive substrates of CYP3A, breast cancer resistance protein (BCRP), or CYP1A2 with narrow therapeutic indices.
MC/DEL	ZELBORAF		
MC	ZYDELIG		**DDI:** In patients concurrently taking a strong CYP3A4 inhibitor (e.g. boceprevir, clarithromycin, conivaptan, grapefruit juice, itraconazole, indinavir, ketoconazole, lopinavir/ritonavir, nefazodone, nelfinavir, posaconazole, ritonavir, saquinavir, telithromycin, and voriconazole), it is recommended to reduce the dose of **Cabometyx®** if the concomitant use cannot be avoided. In patients concurrently taking a strong CYP3A inducer (e.g. rifampin, phenytoin, carbamazepine, phenobarbital, rifabutin, rifapentine, and St. John's wort), it is recommended to increase the dose of Cabometyx® if the concomitant use cannot be avoided.
MC/DEL	ZYKADIA		
MC	ZYTIGA		**Portrazza®** requires clinical prior authorization to verify diagnosis and concurrent treatment with gemcitabine and cisplatin
			DDI: It is recommended to avoid the concomitant use of moderate CYP3A inhibitors (e.g. erythromycin, ciprofloxacin, diltiazem, dronedarone, fluconazole, or verapamil) or P-gp inhibitors (e.g. amiodarone, azithromycin, captopril, carvedilol, cyclosporine, felodipine, quercetin, quinidine, ranolazine, ticargrelo) with **Venclexta®**
			Rubraca® will be non-preferred and require clinical prior authorization to verify diagnosis (as identified by an FDA-approved companion diagnostic test) and prior trial/failure with at least 2 chemotherapies.

								Kisqali requires prior authorization to verify diagnosis and concomitant use with any aromatase inhibitor Rydapt requires clinical prior authorization to verify the diagnosis, appropriate FLT-3 testing and use of recommended concurrent chemotherapy with AML diagnosis, OR the appropriate diagnosis of categories of mast cell disease DDI: Avoid the concomitant use of strong CYP3A inhibitors with Alunbrig®, including but not limited to certain antivirals (e.g. boceprevir, cobicistat, indinavir, lopinavir, nelfinavir, ritonavir, saquinavir), macrolide antibiotics (e.g. clarithromycin), antifungals (e.g. itraconazole, ketoconazole, posaconazole, voriconazole), and conivaptan. In addition, avoid grapefruit or grapefruit juice Imfinzi will be considered for patients with locally advanced or metastatic urothelial carcinoma who have disease progression during or following platinum-containing chemotherapy or have disease progression within 12 months of neoadjuvant or adjuvant treatment with platinum-containing chemotherapy
IMMUNOSUPPRESSANTS								
IMMUNOSUPPRESSANTS	MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		CYCLOSPORINE MODIFIED GENGRAF CAPS MYCOPHENOLATE MYFORTIC NEORAL RAPAMUNE SANDIMMUNE **TACROLIMUS**	MC/DEL MC/DEL MC/DEL MC MC		CELLCEPT CYCLOSPORINE CAPS CYCLOSPORINE SOL. MODIFIED ENVARSUS XR PROGRAF CAPS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **DDI:** Cyclosporine will now be non-preferred and require prior authorization if it is currently being used in combination with either Lipitor (doses greater than 20mg/day), Crestor, or lovastatin (doses greater than 20mg). **DDI:** Cyclosporine will require prior authorization when used with Livalo. **DDI:** All preferred immunosuppressants will require clinical PA for patients over 60 that are currently on fluoroquinolone therapy.
PURINE ANALOG								
PURINE ANALOG	MC MC/DEL		AZASAN TABS **AZATHIOPRINE TABS**	MC/DEL		**IMURAN TABS**	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
K REMOVING RESINS								
K REMOVING RESINS	MC/DEL MC MC/DEL MC/DEL MC/DEL		KAYEXALATE POWD KIONEX POWD SODIUM POLYSTYRENE SULFON SPS SUSP SPS 30GM/120ML ENEMA SUSP	MC		VELTASSA	Use PA Form# 20420	

New drugs are initially non-preferred until reviewed by the DUR Committee and the State. According to State policy, any drug requiring specific diagnosis still requires the specific diagnosis unless otherwise noted within this document.

ANTI-CONVULSANTS INDICATION CHART

	SEIZURES	POST HERPETIC NEURALGIA	DIABETIC PERIPHERAL NEUROPATHY	MONOTHERAPY BIPOLAR	ADJUNCTIVE BIPOLAR	MIGRAINE PROPHYLAXIS	FIBROMYALGIA
GABITRIL	**X**			**9**	**8**		
LAMICTAL	**X**			**4**	**4**		
LYRICA	**X**	**X(2nd line)**	**X(2nd line)**				**X(2nd line)**
TOPAMAX	**X**			**9**	**6**	**X (2nd line)**	
TRILEPTAL	**X**			**5**	**5**		

PEDIATRIC ANTI-CONVULSANTS INDICATION CHART

	SEIZURES	MONOTHERAPY BIPOLAR	ADJUNCTIVE BIPOLAR	

LITHIUM		1	1
CARBMAZEPINE	X	1	1
VALPROATE	X	1	1
ATYPICAL ANTIPSYCHOTICS EXC. CLOZAPINE	X	1	1
LAMICTAL	X	1	1
TRILEPTAL	X	5	5
CLOZAPINE	X	6	6

Last update 01/17

PDL DOSAGE CONSOLIDATION LIST

Tabs/Caps/Patches: Quantities in units

Sprays/Inhalers/Nebulizers: Quantities in GM, ML, OR MCG

Injectibles: Quantities in ML

Shaded areas are non-preferred agents - Quantities of these non-preferred agents are available up the limit only with prior authorization

Drug Name	Strength	Limit/Day	Limit/Days
ARIPIPRAZOLE	5MG	0.5	18/35
ARIPIPRAZOLE	10MG	0.5	18/35
ARIPIPRAZOLE	15MG	0.5	18/35
ARIPIPRAZOLE	20MG	0.5	18/35
ARIPIPRAZOLE	30MG	0.5	18/35
ABILIFY SOLUTION	1MG/ML	30ML	1020/34
ACCUPRIL	5MG	1	35/35
ACCUPRIL	10MG	1	35/35
ACCUPRIL	20MG	1	35/35
ACEON	2MG	1	35/35
ACEON	4MG	1	35/35
ACTONEL	5MG	1	35/35
ACTONEL	35MG	1/WK	5/35
ACTOS	All Strengths	1	35/35
ADDERALL XR	All Strengths	1	35/35
ADEMPAS	All Strengths	1	35/35
ADVAIR DISKUS	All Strengths	2	60/30
ADVAIR HFA	All Strengths	4	120/30
ADZENYS XR	All Strengths	1	30/30
AEROBID	250MCG	8 INHALATIONS	21/35
AEROBID-M	250MCG	8 INHALATIONS	21/35
ALAVERT-NON DROW	TAB	1	96/96
ALENDRONATE	All Strengths	1/WK	35/35
ALTABAX	5GM		1 TUBE/30
ALTABAX	15GM		1 TUBE/30
ALTABAX	30GM		1 TUBE/30
ALTACE	1.25MG	1	35/35
ALTACE	2.5MG	1	35/35
ALTACE	5MG	1	35/35
AMARYL	1MG	1	35/35
AMARYL	2MG	1	35/35
AMBIEN	5MG		12/34
AMBIEN	10MG		12/34
AMBIEN CR	6.25MG		12/34
AMBIEN CR	12.5MG		12/34
AMERGE (Step 8)	1MG		12/30
AMERGE (Step 8)	2.5MG	2.5MG	12/30
AMLODIPINE	2.5MG	1.5	53/35 DAYS
AMLODIPINE	5MG	1.5	53/35 DAYS
AMMONIUM LACTATE CREA	12%		1 TUBE/10
AMMONIUM LACTATE LOTN	12%		1TUBE/8
AMPHETAMINE SALT	5,10,15MG	3	105/35
AMPHETAMINE SALT	20MG	2	70/35
AMPHETAMINE SALT	30MG	1	35/35
ANDRODERM	2.5MG	2	60/30
ANDRODERM	5MG	1	30/30
ARAVA	10MG	1	35/35
ARCAPTA	75MCG	1 INHALATION	35/35
ARICEPT	5MG	1	35/35
ARICEPT	10MG	1	35/35
ARIXTRA INJECTION	2.5MG/0.5ML		7/30
ARIXTRA INJECTION	5MG/0.4ML		7/30
ARIXTRA INJECTION	7.5MG/0.6ML		7/30
ARIXTRA INJECTION	10MG/0.8ML		7/30
ASMANEX 30 UNITS	220MCG	1 INHALATION	30U/30
ASMANEX 60 UNITS	220MCG	2 INHALATIONS	60U/30
ASMANEX 120 UNITS	220MCG	4 INHALATIONS	120U/30
ATACAND	4MG	1.5	53/35
ATROVENT HFA	17MCG	12 INHALATIONS	25.8/34
ATROVENT 30ML	0.03%	12 SPRAYS	30/30
ATROVENT 15ML	0.06%	16 SPRAYS	45/30
AVANDIA	2MG	1.5	53/35
AVANDIA	4MG	1	35/35
AVAPRO	75MG	1.5	53/35
AVAPRO	150MG	1	35/35
AXERT (Step 8)	6.25MG		12/30
AXERT (Step 8)	12.5MG		12/30
AZELEX	20%		1 TUBE/18
AZILECT	All Strengths	1	35/35
BACTROBAN CREAM			1 TUBE/30
BECONASE AQ	42MCG	8 INHALATIONS	50/30
BENAZEPRIL	5MG	1	35/35
BENAZEPRIL	10MG	1.5	53/35
BENAZEPRIL	20MG	1	35/35
BENAZEP/HCTZ	5-6.25	1	35/35
BENAZEP/HCTZ	10/12.5	1	35/35
BEVESPI AERO		4 INHALATIONS	120/30
BONIVA	2.5MG	1	35/35
BOTOX (ADULTS)	100U/ML	1 session/90 days	600U/90
BOTOX (CHILDREN>12)	100U/ML	1 session/90 days	400U/90
BREO ELLIPTA	100/25MCG	1 INHALATIONS	28/28
BRILINTA	All Strengths	2	70/35
BRINTELLIX	All Strengths	1	35/35
BUTRANS		1 patch/WK	4/28
BYETTA	5mcg inj	0.04ML	1.2ML/30
BYETTA	10mcg inj	0.08ML	2.4ML/30
CALAN SR	120MG	1	35/35
CALAN SR	180MG	2	70/35
CALAN SR	240MG	2	70/35
CARDIZEM CD	120MG/24	1	35/35
CARDIZEM CD	180MG/24	1	35/35
CARDIZEM CD	240MG/24	1	35/35
CARDIZEM CD	300MG/24	1	35/35
CARDIZEM CD	360MG/24	1	35/35
CARDIZEM LA	120MG/24	1	35/35
CARDIZEM LA	180MG/24	1	35/35
CARDIZEM LA	240MG/24	1	35/35
CARDIZEM LA	300MG/24	1	35/35
CARDIZEM LA	360MG/24	1	35/35
CARDURA	1MG	1	35/35
CARDURA	2MG	1.5	53/35
CARDURA	4MG	1.5	53/35
CARTIA XT	120MG	1	90/90
CARTIA XT	180MG	1	90/90
CARTIA XT	240MG	1	90/90
CARTIA XT	300MG	1	90/90
CATAPRES-TTS1	0.1 MG/24HR		5/35
CATAPRES- TTS2	0.2 MG/24HR		5/35
CATAPRES- TTS3	0.3 MG/24HR		5/35
CELEBREX	100MG	1	35/35
CELEBREX	200MG	2	70/35
CELEXA	20mg	0.5	17/34
CELEXA	40mg	1	51/34
CITALOPRAM	10MG	0.5	45/90
CITALOPRAM	20MG	0.5	45/90
CITALOPRAM	40MG	1	90/90

ATACAND	8MG	1.5	53/35
ATACAND	16MG	1	35/35
ATRIPLA	600MG	1	35/35
Drug Name	**Strength**	**Limit/Day**	**Limit/Days**
COMETRIQ	80MG	1	35/35
COMETRIQ	20MG	3	105/35
CONCERTA	All Strengths	1	35/35
COPAXONE INJ	20MG		1/32
COPAXONE KIT	20MG/ML		1/30
COREG CR	All Strengths	1	34/34
COSENTYX	150MG	1	1/30
CRESTOR	5MG	1	35/35
CRESTOR	10MG	1	35/35
CRESTOR	20MG	1	35/35
CRESTOR	40MG	1	35/35
CYMBALTA	All Strengths	1	35/35
DALMANE	15MG		10/30
DALMANE	30MG		10/30
DAYPRO	600MG	2	70/35
DAYTRANA	10mg/9hr (27.5mg)	1	34/34
DAYTRANA	15mg/9hr (41.3mg)	1	34/34
DAYTRANA	20mg/9hr (55.0mg)	1	34/34
DAYTRANA	30mg/9hr (82.5mg)	1	34/34
DDAVP	5ML		15/34
DENAVIR CREAM			2gm/30
DEPO-PROVERA	150MG/ML		1/90
DEPO-PROVERA	400MG/ML		2.5/90
DEPO-TESTOSTERONE	200MG/ML		20/90
DESMOPRESSIN	0.1MG	12	420/35
DESMOPRESSIN	0.2MG	6	210/35
DESONIDE	0.05%		2 TUBES/30
DESOWEN	0.05%		2 TUBES/30
DETROL LA	2MG	1	35/35
DEXEDRINE	All Strengths	3	90/30
DEXILANT	All Strengths	1	35/35
DEXTROAMPHETAMINE	All Strengths	3	90/30
DIFLUCAN	150MG		1/7
DILACOR XR	240MG/24	1	35/35
DILACOR XR	120MG/24	1	35/35
DILACOR XR	180MG/24	1	35/35
DILTIA - XT	120MG/24	1	90/90
DILTIA - XT	180MG	1	90/90
DILTIA - XT	240MG/24	1	90/90
DILTIAZEM CAP ER	120MG	1	90/90
DILTIAZEM CAP XR	120MG	1	90/90
DILTIAZEM CAP	120MG/24	1	90/90
DILTIAZEM CAP	180MG/24	1	90/90
DILTIAZEM CAP ER	240MG	1	90/90
DILTIAZEM CAP XR	240MG	1	90/90
DILTIAZEM XR CAP	240MG/24	1	90/90
DILTIAZEM CAP	240MG/24	1	90/90
DILTIAZEM CAP	300MG/24	1	90/90
DILTIAZEM CAP	360MG/24	1	90/90
DIOVAN	80MG	1	35/35
DIOVAN - HCT	80 - 12.5	1	35/35
DITROPAN XL	5MG	1	35/35
DITROPAN XL	10MG	2	70/35
DORAL	7.5MG		10/30
DORAL	15MG		10/30
DOXAZOSIN	1MG	1	90/90
DOXAZOSIN	2MG	1.5	135/90
DOXAZOSIN	4MG	1.5	135/90
DRYSOL SOL	20%		1 BOTTLE/30DAYS
DURAGESIC PATCHES	12.5MCG/HR		11/33

CLARINEX	REDI TAB	1	35/35
CLEOCIN-T		1 PACKAGE	1/30
CLINDAMYCIN PHOSPHATE		1 PACKAGE	1/30
COMBIVENT	103-18MCG	12 INHALATIONS	30/35
Drug Name	**Strength**	**Limit/Day**	**Limit/Days**
EFFEXOR XR	37.5MG	1	35/35
EFFEXOR XR	75MG	1	35/35
EMSAM	All Strengths	1	34/34
ENALAPRIL	2.5	1	90/90
ENALAPRIL	5MG	1.5	135/90
ENALAPRIL	10MG	1.5	135/90
ENALAPR/HCTZ	5-12.5	1	90/90
ENBREL	25MG/ML		8/28
ENBREL SURECLICK			8/28
ESTAZOLAM	1MG		10/30
ESTAZOLAM	2MG		10/30
ESTRING MIS	2MG		1/90
FELODIPINE	2.5MG	1	90/90
FELODIPINE	5MG	1.5	135/90
FENTANYL	25MCG/HR		11/33
FENTANYL	50MCG/HR		11/33
FENTANYL	75MCG/HR		11/33
FENTANYL	100MCG/HR		22/33
FETZIMA	All Strengths	1	35/35
FINASTERIDE	5MG	1	90/90
FLONASE	50MCG	4 SPRAYS	32/34
FLOVENT HFA 44MCG	44MCG	4 INHALATIONS	10.6/30
FLOVENT HFA 110MCG	110MCG	4 INHALATIONS	12/30
FLOVENT HFA 220MCG	220MCG	8 INHALATIONS	24/30
FLOVENT DISKUS	50MCG, 100MCG	4 INHALATIONS	60/30
FLOVENT DISKUS	250MCG	3 INHALATIONS	120/30
FLUCONAZOLE	150MG		1/7
FLUNISOLIDE SOLN	0.025%	16 SPRAYS	75/30
FLUOXETINE CAP	20MG	4	140/35
FLURAZEPAM	15MG		10/30
FLURAZEPAM	30MG		10/30
FLUTICASONE SPR		4 SPRAYS	32/34
FLUVOXAMINE	25MG	1	90/90
FLUVOXAMINE	50MG	1	90/90
FOCALIN	All Strengths	3	105/35
FOCALIN XR	All Strengths	1	35/35
FORFIVO XL	All Strengths	1	35/35
FOSAMAX	5MG	1	35/35
FOSAMAX	10MG	1	35/35
FOSAMAX	70MG	1/WK	5/35
FOSAMAX	40MG	2/WK	10/35
FOSINOPRIL	10MG	1.5	135/90
FOSINOPRIL	20MG	2	180/90
FRAGMIN INJ	10000U/ML	2ML	14/7
FRAGMIN INJ	2500U/.2ML	0.4ML	2.80/7
FRAGMIN INJ	25000U/ML	0.8ML	5.6/7
FRAGMIN INJ	5000U/.2ML	0.4ML	2.80/7
FRAGMIN INJ	7500U/.3ML	0.6ML	4.2/7
FROVA TAB (Step 8)	2.5MG		12/30
FULYZAQ	125MG	2	70/35
FUZEON	KIT	1	1/30
FYCOMPA	All Strengths	1	35/35
GABAPENTIN	300MG	9	810/90
GABAPENTIN	400MG	9	810/90
GEODON	20MG	2	70/35
GEODON	40MG	2	70/35
GEODON	60MG	2	70/35
GEODON	80MG	2	70/35
GEODON	INJ	2	70/35

Drug Name	Strength	Limit/Day	Limit/Days
DURAGESIC PATCHES	25MCG/HR		11/33
DURAGESIC PATCHES	50MCG/HR		11/33
DURAGESIC PATCHES	75MCG/HR		11/33
DURAGESIC PATCHES	100MCG/HR		22/33
EDEX	All Strengths		1/30
ILARIS			2/28
HALCION	0.125MG		10/35
HALCION	0.25		10/35
HUMIRA	40mg/0.8ml		4/28
HYTRIN	1MG	1	35/35
HYTRIN	5MG	1	35/35
HYZAAR	50-12.5	1	35/35
IMDUR	30MG	1.5	53/35
IMDUR	60MG	1.5	53/35
IMITREX (step 8)	25MG		12/30
IMITREX (step 8)	50MG		12/30
IMITREX (step 8)	100MG		12/30
IMITREX INJ	4MG/.5ML		6 boxes/30
IMITREX INJ	6MG/.5ML		6 boxes/30
IMITREX KIT	6MG/.5ML		6/30
IMITREX SPR	5MG		12/30
IMITREX SPR	20MG		12/30
IMIQUIMOD	5%		12/30
IMIQUIMOD	5%		12/30
INTAL	800MCG	8 INHALATIONS	28.4/34
INVOKANA	All Strengths	1	35/35
IPRATROPIUM 30ML	0.03%	12 SPRAYS	90/90
IPRATROPIUM 15ML	0.06%	16 SPRAYS	135/90
ISOPTIN SR	240MG	2	70/35
ISOSORBIDE MONO	30MG	1.5	135/90
ISOSORBIDE MONO	60 MG	1.5	135/90
JANUMET	All Strengths	2	70/35
JANUVIA	All Strengths	1	35/35
JUVISYNC	All Strengths	1	35/35
KETOPROFEN	100MG	2	180/90
KETOPROFEN	200MG	1	90/90
KETOROLAC	10MG	4.8	24/30
KHEDEZLA	All Strengths	1	35/35
LAC-HYDRIN CREAM	12%		1TUBE/30
LAMICTAL	25MG	6	210/35
LAMICTAL	25MG CHW	6	210/35
LAMICTAL	100MG	2	70/35
LAMISIL	250MG	1	35/35
LAMOTRIGINE	25MG	6	540/90
LAMOTRIGINE	100MG	2	180/90
LATUDA	All Strengths	0.5	17/34
LEFLUNOMIDE	10MG	1	90/90
LESCOL	20MG	1	35/35
LEVAQUIN	250MG	1	35/35
LEXAPRO	5MG	0.5	15/30
LIPITOR	10MG	1	35/35
LIPITOR	20MG	1	35/35
LIPITOR	40MG	1.5	53/35
LISINOP/HCTZ	10/12.5MG	1	90/90
LOTENSIN	5MG	1	35/35
LOTENSIN	10MG	1.5	35/35
LOTENSIN	20MG	1	53/35
LOTENSIN - HCT	5 - 6.25	1	35/35
LOTENSIN - HCT	10 - 12.5	1	35/35
LOVASTATIN	10MG	1.5	135/90
LOVASTATIN	20MG	1.5	135/90
LOVENOX INJ	30MG/.3ML	0.6	14 injections/7
GILENYA	0.5MG	1	30/30
GILOTRIF	All Strengths	1	35/35
GLIMEPIRIDE	1MG	1	90/90
GLIMEPIRIDE	2MG	1	90/90
GLUCOSE TES STRP		12	420/35
GLUCAGEN INJ. HYPOKIT			2/30
GLYCOLAX*	255GM		255GM/90

* Available for once daily dosing to members under the age of 18 years

Drug Name	Strength	Limit/Day	Limit/Days
LUNESTA	2MG		12/34
LUNESTA	3MG		12/34
LUPRON DEPOT INJ	11.25MG	KIT	1/90
LUPRON DEPOT INJ	22.5	KIT	1/90
LUPRON DEPOT INJ	30MG		1/90
LUPRON DEPOT INJ	30MG	KIT	1/90
LYRICA	25,50,75MG	3	102/35
LYRICA	100,150,200MG	3	102/35
LYRICA	225,300MG	2	70/35
MAVIK	1MG	1	35/35
MAVIK	2MG	1	35/35
MAXAIR AUTO	200MCG	12 INHALATIONS	14/30
MAXALT (step 8)	5MG		12/30
MAXALT (step 8)	10MG		12/30
MAXALT MLT (step 1)	5MG		12/30
MAXALT MLT (step 1)	10MG		12/30
MEDROXYPR AC	150MG/ML		1/90
MELOXICAM	7.5MG	1	35/35
MELOXICAM	15MG	1	35/35
METFORMIN ER	500MG	4	360/90
METHYLIN	All Strengths	3	90/30
METHYLPHENIDATE ER	36mg	2	180/90
METHYLPHENIDATE	All Strengths	3	90/30
METROCREAM		1 PACKAGE	1/30
METROGEL		1 PACKAGE	1/30
METROLOTION		1 PACKAGE	1/30
METRONIDAZOLE CREAM		1 PACKAGE	1/30
METRONIDAZOLE GEL		1 PACKAGE	1/30
METRONIDAZOLE LOTION		1 PACKAGE	1/30
MEVACOR	10MG	1.5	53/35
MEVACOR	20MG	1.5	53/35
MIACALCIN		3.75ml	1 bottle/34
MICARDIS	40MG	1.5	53/35
MIRALAX	255G	8.5G	1 bottle/30
MIRALAX	17G/PACKET	0.5 packet	15 packets/30
MIRTAZAPINE	15mg	1.5	53/35
MOBIC	7.5 MG	1	35/35
MOBIC	15MG	1	35/35
MOEXIPRIL	7.5	1.5	135/90
MONOPRIL	10MG	1.5	53/35
MONOPRIL	20MG	2	70/35
MUPIROCIN			1 TUBE/30
NABUMETONE	500MG	2	180/90
NABUMETONE	750MG	2	180/90
NARATRIPTAN			12/30
NARCAN NS		2Units	2units/28
NASACORT AERS	55 MCG	4 SPRAYS	9.3/25
NASACORT AQ	55MCG	4 SPRAYS	17/30
NASONEX	50MCG	4 SPRAYS	17/30
NATROBA		120ML	1 bottle/30
NEUPOGEN INJ	300MCG/ML		10/30
NEUPOGEN INJ	480MCG/1.6		16/30
NEUPOGEN INJ	300MCG/.5ML		5/30

LOVENOX INJ	40MG/.4ML	0.8	14 injections/7
LOVENOX INJ	60MG/.6ML	1.2	14 injections/7
LOVENOX INJ	80MG/.8ML	1.6	14 injections/7
LOVENOX INJ	100MG/ML	2	14 injections/7
LOVENOX INJ	120MG/.8ML	1.6	14 injections/7
LOVENOX INJ	150MG/ML	2	14 injections/7
LUNESTA	1MG		12/34
Drug Name	**Strength**	**Limit/Day**	**Limit/Days**
NIFEDIPINE ER	90MG	1	90/90
NIFEDIPINE ER,CR	30MG	1	90/90
NORVASC	2.5MG	1.5	53/35 DAYS
NORVASC	5MG	1.5	53/35 DAYS
NUVARING		1/MO	1/28
ODOMZO	200mg	1	30/30
OMEPRAZOLE	10MG	1	30/30
OMEPRAZOLE	20MG	2	120/60
OMNARIS	50MCG	4 sprays	12.5/30
ONDANSETRON*	4MG	3	90/30
ONDANSETRON*	8MG	1.5	45/30
ONDANSETRON*	24MG	0.5	15/30
ONDANSETRON INJ*			
ONGLYZA	All Strengths	1	35/35
OPSUMIT	All Strengths	1	35/35
ORUVAIL	100MG	2	70/35
ORUVAIL	200MG	1	35/35
OXAPROZIN	600MG	2	180/90
OXYCODONE ER	10,20,40MG	2	70/35
OXYCODONE ER	80MG	4	140/35
OXYCONTIN**	10,20,30,40MG	2	70/35
OXYCONTIN**	80MG	4	140/35
PAROXETINE	10MG	1.5	135/90
PAROXETINE	20MG	1	90/90
PAXIL	10MG	1.5	53/35
PAXIL	20MG	1	35/35
PEGASYS KIT		KIT	1/28
PLAN B			2/15 or 4/30
PLENDIL	2.5MG	1	35/35
PLENDIL	5MG	1.5	53/35
PRAVACHOL	10MG	1	35/35
PRAVACHOL	20MG	1	35/35
PRAVACHOL	40MG	1	35/35
PRAVACHOL	80MG	1	35/35
PRAVASTATIN	10MG	1	35/35
PRAVASTATIN	20MG	1	35/35
PRAVASTATIN	40MG	2	180/90
PRAVASTATIN	80MG	1	35/35
PREVPAC MIS	500MG-30MG		14/30
PRILOSEC OTC	20MG	2	168/84
PRINIVIL	2.5MG	1	35/35
PRINIVIL	5MG	1	35/35
PRINIVIL	10MG	1.5	53/35
PRINIVIL	20MG	1.5	53/35
PRINZIDE	10-12.5	1	35/35
PROAIR HFA	90mcg	12 INHALATIONS	17/34
PROTONIX	20MG	2	70/35
PROTONIX	40MG	2	70/35
PROZAC	10MG	1.5	53/35
PULMICORT	200MCG	8 INHALATIONS	1/25
PULMICORT FLEX	All Strengths	8 Inhalations	2/30
QUETIAPINE	25MG	1.5	135/90
QUETIAPINE	50MG	1.5	135/90
QUETIAPINE	100MG	1.5	135/90
QUINAPRIL	5MG	1	90/90

NEUPOGEN INJ	480MCG/.8ML		8/30
NEURONTIN	300MG	3	105/35
NEURONTIN	600MG	3	105/35
NEXIUM	20MG	1	35/35
NEXIUM	40MG	2	70/35
NIFEDIPINE CR	90MG	1	90/90
NIFEDIPINE ER	60MG	1	90/90
NIFEDIPINE ER	30MG	1	90/90
NIFEDIPINE ER	60MG	1	90/90
Drug Name	**Strength**	**Limit/Day**	**Limit/Days**
RELPAX	All Strengths		12/30
REMODULIN	All Strengths		1 MDV/30
RESTORIL	7.5MG		10/30
RESTORIL	15MG		10/30
RESTORIL	30MG		10/30
RETIN-A		1 TUBE	1 TUBE/30
REVLIMID	All Strengths	1	35/35
RHINOCORT AQ	32MCG	8 SPRAYS	18/30
REFRESH PLUS		15 ML	1 bottle/30
REFRESH PLUS		30 ML	2 bottles/30
REFRESH TEARS		15 ML	1 bottle/30
REFRESH TEARS		30 ML	2 bottles/30
RESCULA			2 bottles/35
REYATAZ	All Strengths	1	35/35
RISPERDAL	0.5MG	1.5	53/35
RISPERDAL	0.25MG	1.5	53/35
RISPERDAL	1MG	1.5	53/35
RISPERDAL	2MG	1.5	53/35
RISPERDAL	3MG	2	70/35
RISPERDAL	4MG	2	70/35
RISPERDAL INJ	25MG		2/28
RISPERDAL INJ	37.5		2/28
RISPERDAL INJ	50MG		2/28
RISPERDAL M-TAB	0.5MG	1.5	53/35
RISPERDAL M-TAB	1MG	1.5	53/35
RISPERDAL M-TAB	2MG	4	140/35
RISPERDAL SOL.	1MG/ML	8ML	280/35
RISPERIDONE	0.5MG	1.5	53/35
RISPERIDONE	0.25MG	1.5	53/35
RISPERIDONE	1MG	1.5	53/35
RISPERIDONE	2MG	1.5	53/35
RISPERIDONE	3MG	2	70/35
RISPERIDONE	4MG	2	70/35
RISPERIDONE SOL.	1MG/ML	8ML	280/35
RITALIN LA	All Strengths	1	35/35
SAVELLA	All Strengths	2	70/35
SEREVENT DISKUS	50MCG	2 INHALATIONS	60/30
SEROQUEL	100MG		45/30
SEROQUEL XR	150MG	1	35/35
SEROQUEL XR	200MG	1	35/35
SEROQUEL XR	300MG	2	70/35
SEROQUEL XR	400MG	2	70/35
SERTRALINE	25MG	0.5	18/35
SERTRALINE	50MG	0.5	18/35
SERTRALINE	100MG	3	105/35
SIMVASTATIN	5MG	1	35/35
SIMVASTATIN	10MG	1.5	53/35
SIMVASTATIN	20MG	1.5	53/35
SIMVASTATIN	40MG	1.5	53/35
SIMVASTATIN	80MG	1	35/35
SINGULAIR	4MG	1	35/35

QUINAPRIL	10MG	1	90/90
QUINAPRIL	20MG	1	90/90
QVAR AERS	All Strengths	8 Inhalations	14.6/25
RANITIDINE SYRUP***	15MG/ML	20ML	700ML/35
RELAFEN	500MG	2	70/35
RELAFEN	750MG	2	70/35
REMERON	15MG	1.5	53/35
Drug Name	**Strength**	**Limit/Day**	**Limit/Days**
SULAR	10MG	1.5	53/35
SULAR	20MG	1	35/35
SUMATRIPTAN (step 1)	All Strengths		12/30
SYMBICORT	All Strengths	4 Inhalations	10.2/30
SYNVISC INJ	8MG/ML		2/30
SYRINGES		10	1000/100
TAFINLAR	50MG	6	210/35
TAFINLAR	75MG	4	140/35
TAMIFLU CAPS	75MG		10/30
TAZTIA XT CAP	120MG/24	1	90/90
TAZTIA XT CAP	180MG/24	1	90/90
TAZTIA XT CAP	240MG/24	1	90/90
TAZTIA XT CAP	300MG/24	1	90/90
TAZTIA XT CAP	360MG/24	1	90/90
TEMAZEPAM	7.5MG		10/30
TEMAZEPAM	15MG		10/30
TEMAZEPAM	30MG		10/30
TEQUIN	200MG	1	35/35
TERAZOSIN	1MG	1	90/90
TERAZOSIN	5MG	1	90/90
TERBINAFINE	250MG	1	35/35
TEST STRIPS	Blood Glucose	12	420/35
TIAZAC	120MG/24	1	35/35
TIAZAC	180MG/24	1	35/35
TIAZAC	240MG/24	1	35/35
TIAZAC	300MG/24	1	35/35
TIAZAC	360MG/24	1	35/35
TIAZAC	420MG/24	1	35/35
TILADE	1.75MG	8 INHALATIONS	48.6/35
TOPAMAX SPRINKLES	All Strengths	1	35/35
TOPIRAMATE SPRINKLES	All Strengths	1	35/35
TOPROL XL	25MG	1.5	53/35
TOPROL XL	50MG	1.5	53/35
TRADJENTA	All Strengths	1	35/35
TRAMADOL	50MG	8	720/90
TRAMADOL/ APAP	37.5/325MG	8	720/90
TRETINOIN		1 TUBE	1 TUBE/30
TREXIMET	85/500	2.5	12/30
TRIAZOLAM	0.125MG		10/30
TRIAZOLAM	0.25MG		10/30
TROKENDI XR	25MG	1	35/35
TROKENDI XR	50MG	1	35/35
TROKENDI XR	100MG	1	35/35
TROKENDI XR	200MG	2	70/35
ULTRAM	50MG	8	280/35
UNIVASC	7.5MG	1.5	53/35 DAYS
UTIBRON	7.5mcg/15.6mc	2 INHALATIONS	60/30
VASERETIC	5-12.5MG	1	35/35
VASOTEC	2.5MG	1	35/35
VASOTEC	5MG	1.5	53/35
VASOTEC	10MG	1.5	53/35
VENLAFAXINE	37.5	1	90/90
VENLAFAXINE	75	1	90/90
VENLAFAXINE	150	2	180/90
VENLAFAXINE	225	1	90/90

SINGULAIR	5MG	1	35/35
SINGULAIR	10MG	1	35/35
SONATA	5MG		12/34
SONATA	10MG		12/34
SPIRIVA	HANDIHLR	1 INHALTION	30/30
SPORANOX SOL	10MG/ML	10ML/ML	300cc/30
SPORANOX PULSEPAK	F		30/30
SPORANOX	100MG		30/30
STADOL INJ	1MG/ML		9/35
STADOL INJ	2MG/ML		9/35
STRATTERA	All Strengths	1	35/35
SUPRAX	400MG	1	1/7

Drug Name	**Strength**	**Limit/Day**	**Limit/Days**
XOPENEX HFA		12 INHALATIONS	2 INHALERS/34
XOPENEX NEB		12CC	408/34
ZALEPLON	All Strengths		30/30
ZECUITY	6.5		4/28
ZEMBRACE	All Strengths		3boxes/30
ZESTORETIC	10-12.5	1	35/35
ZESTRIL	2.5MG	1	35/35
ZESTRIL	5MG	1	35/35
ZESTRIL	10MG	1.5	53/35
ZESTRIL	20MG	1.5	53/35
ZETONNA	37MCG	2	60/30
ZOCOR	5MG	1	35/35
ZOCOR	10MG	1.5	53/35
ZOCOR	20MG	1.5	53/35
ZOCOR	40MG	1.5	53/35
ZOFRAN*	4MG	3	90/30
ZOFRAN*	8MG	1.5	45/30
ZOFRAN*	24MG	0.5	15/30
ZOFRAN*	4MG/5ML	15ML	450/30
ZOLOFT	25MG	0.5	18/35
ZOLOFT	50MG	0.5	18/35
ZOLOFT	100MG	3	105/35
ZOLPIDEM (step 1)	5MG		30/30
ZOLPIDEM (step 1)	10MG		30/30
ZOMIG (Step 8)	5MG		12/30
ZYPREXA	2.5MG	1.5	53/35
ZYPREXA	5MG	1	35/35
ZYPREXA	7.5MG	1	35/35
ZYPREXA	10MG	1	35/35
ZYPREXA	15MG	1	35/35
ZYPREXA	20MG	1	35/35
ZYPREXA ZYDIS	5MG	1	35/35
ZYPREXA ZYDIS	10MG	1	35/35
ZYPREXA ZYDIS	15MG	1	35/35
ZYPREXA ZYDIS	20MG	1	35/35

*Cancer diagnosis with non-daily chemotherapy required

**Available without pa with CA and HO diag.

*** Ranitidine syrup available without PA to users less than 6 years old.

MDV=Multidose Vial

VENTOLIN HFA	90MCG	12 INHALATIONS	36/34
VERAPAMIL ER, SR	120MG	1	90/90
VERAPAMIL ER, CR, SR	180MG	2	90/90
VERAPAMIL ER, CR, SR	240MG	2	90/90
VERELAN	180MG	1	35/35
VERELAN SR	120MG	1	35/35
VERELAN SR	180MG	1	35/35
VERELAN SR	240MG	2	70/35
VERAMYST	27.5MCG	4 sprays	10/30
VYVANSE	All Strengths	1	35/35
VYVANSE CHEW	All Strengths	1	35/35

CELEXA/CITALOPRAM SPLITTING TABLE

The most cost effective way to utilize Celexa/citalopram

NON PREFERRED: PA NEEDED				DESIRED DOSE	PREFERRED: NO PA Required (splitting tabs)				savings per 30 day supply
10MG	20MG	40MG	COST/DAY	MG/DAY	10MG	20MG	40MG	COST/ DAY	
30			$1.50	10mg		15		$0.75	**$22.50**
	30		$1.50	20mg			15	$0.75	**$22.50**
	45		$3.00	30mg		15	15	$1.50	**$45.00**
		30	$1.50	40mg			30	$1.50	**N/A**

**** Citalopram requires splitting of 20mg and/or 40mg scored tabs to avoid PA. Celexa is non-preferred but still requires splitting with a PA.***

**** At present these represent the most commonly written scripts. The shaded areas require no changes since they do not offer savings opportunities. Celexa is flat priced across all strengths. They are scored and easily split. The unshaded rows on the left side all have less expensive ways of being written involving splitting of the***

**** Max daily dose of Celexa / citalopram is 40mg. Clinical studies of effectiveness did not demonstrate an advantage for the 60mg/day dose over the 40mg/day dose. There is an increased risk of side effects at doses greater than 40mg/day. (Celexa® Package Insert 2005 Forest Laboratories, Inc.)***

ZOLOFT/ SERTRALINE SPLITTING TABLE

The most cost effective way to utilize Zoloft/Sertraline

NON PREFERRED: PA NEEDED				DESIRED DOSE	PREFERRED: NO PA Required (splitting tabs)				savings per 30 day supply
25MG	50MG	100MG	COST/DAY	MG/DAY	25MG	50MG	100MG	COST/ DAY	

15 tabs			$1.00
30			$2.00
45			$3.00
	30		$2.00
	45		$3.00
		30	$2.00
30		30	$4.00
	30	30	$4.00
30	30	30	$6.00
		60	$4.00
30		60	$6.00
	30	60	$6.00
30	30	60	$8.00
		90	$6.00

12.5mg
25*
37.5
50*
75
100*
125
150*
175
200*
225
250*
275
300*

15 tabs			$1.00	N/A
	15		$1.00	**$30.00**
15	15		$2.00	**$30.00**
		15	$1.00	**$30.00**
	15	15	$2.00	**$30.00**
		30	$2.00	N/A
	15	30	$3.00	**$30.00**
		45	$3.00	**$30.00**
	15	45	$4.00	**$60.00**
		60	$4.00	N/A
	15	60	$5.00	**$30.00**
		75	$5.00	**$30.00**
	15	75	$6.00	**$60.00**
		90	$6.00	N/A

**** Sertraline requires splitting of scored tabs to avoid PA. Zoloft is non-preferred but still requires splitting with a PA.***

**** At present these represent the most commonly written scripts. The shaded areas require no changes since they do not offer savings opportunities. Zoloft is flat priced across all strengths. They are scored and easily split. The unshaded rows on the left side all have less expensive ways of being written involving splitting of the Zoloft scored tabs.***

ABILIFY SPLITTING TABLE

The most cost effective way to utilize Abilify

NON PREFERRED: PA NEEDED						DESIRED DOSE	PREFERRED: NO PA Required (splitting tabs)					
2MG	5MG	10MG	15MG	20MG	30MG	MG/DAY	2MG	5MG	10MG	15MG	20MG	30MG
30						2.5		15				
	30					5			15			
		30				10					15	
			30			15						15
				30		20						
					30	30						

Pain Management Policy

Beginning January 2017, all current opiate users who are above the maximum combined daily dose of 100 MME titrate their total daily dose of opioid medications below 300 MME. Also, the maximum daily supply of an opiate prescription for acute pain will be limited to 7-day supplies. The maximum day supply of an opiate prescription fo pain will be limited to 30-day supplies. As of July 1, 2017 all users of opioid medications must comply with the ma combined daily dose of 100 MME.

However, for MaineCare members, effective January 1, 2017, opioid prescription(s) for more than a 7-day supply more than 30 MME/ day will require a prior authorization. Please note that MaineCare implemented a 30 MME lir January 1, 2013 that is still effective.

The following are general exceptions: pain associated with cancer treatment, end-of-life and hospice care, palliat and symptoms related to HIV/AIDS. Per MaineCare criteria, the diagnosis of cancer must be written on the presc palliative care exception for any MaineCare opioid prescription will require prior authorization (PA) with appropria documentation.

Post-surgical members may receive prior authorizations for opiates up to a 60 days in length if medical necessity provided by the surgical provider.

An MME conversion chart is available at www.mainecarepdl.org. Click on “General Pharmacy Info.”

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