

---

# **OHIO**

## **Pharmacy Benefit Management Program**

---

# **Preferred Drug List**

## **List Only**

**Effective October 1, 2005**



**Rev. 03/14/2006**

### ANALGESICS: COX-2 INHIBITORS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
CELEBREX <sup>®</sup> (no PA required for age 60 or older)	

- *COX II Inhibitors require Prior Authorization for anyone < 60 years of age.*

### ANALGESICS: NSAIDs

NO PA REQUIRED "PREFERRED"	PA REQUIRED
DICLOFENAC POTASSIUM (generic of Cataflam <sup>®</sup> ) DICLOFENAC SODIUM (generic of Voltaren <sup>®</sup> ) ETODOLAC (generic of Lodine <sup>®</sup> and Lodine XL <sup>®</sup> ) FENOPROFEN (generic of Nalfon <sup>®</sup> ) FLURBIPROFEN (generic of Ansaïd <sup>®</sup> ) IBUPROFEN (generic of Motrin <sup>®</sup> ) INDOMETHACIN (generic of Indocin <sup>®</sup> ) KETOPROFEN (generic of Orudis <sup>®</sup> ) KETOPROFEN ER (generic of Oruvail <sup>®</sup> ) KETOROLAC (generic of Toradol <sup>®</sup> )* MECLOFENAMATE SODIUM (generic of Meclomen <sup>®</sup> ) NABUMETONE (generic of Relafen <sup>®</sup> ) NAPROXEN (generic of Naprosyn <sup>®</sup> ) NAPROXEN EC (generic of EC-Naprosyn <sup>®</sup> ) NAPROXEN SODIUM (generic of Anaprox <sup>®</sup> ) OXAPROZIN (generic of Daypro <sup>®</sup> ) SULINDAC (generic of Clinoril <sup>®</sup> )	ARTHROTEC <sup>®</sup> DIFLUNISAL (generic of Dolobid <sup>®</sup> ) INDOMETHACIN SR (generic of Indocin SR <sup>®</sup> ) MOBIC <sup>®</sup> NAPRELAN <sup>®</sup> PONSTEL <sup>®</sup> PIROXICAM (generic of Feldene <sup>®</sup> ) TOLMETIN SODIUM (generic of Tolectin <sup>®</sup> and Tolectin DS <sup>®</sup> )

- Quantity limit for Ketorolac of 20 tablets per 30 days.

### ANALGESICS: OPIOIDS – Long-Acting Oral

NO PA REQUIRED "PREFERRED"	PA REQUIRED
<b>Extended Release Morphine Products</b>	
AVINZA <sup>®</sup> KADIAN <sup>®</sup> MORPHINE SULFATE ER (generic of MS Contin <sup>®</sup> )	ORAMORPH SR <sup>®</sup>
<b>Extended Release Oxycodone Products</b>	
OXYCODONE ER (generic of Oxycontin <sup>®</sup> )*	OXYCONTIN <sup>®</sup> * (PA Required effective 4/1/06)

- Quantity limit for Oxycontin<sup>®</sup> and oxycodone ER of 120 tablets per 30 days.

### ANALGESICS: OPIOIDS – Long-Acting Topical

NO PA REQUIRED "PREFERRED"	PA REQUIRED
DURAGESIC <sup>®</sup> PATCH	FENTANYL PATCH (generic of Duragesic <sup>®</sup> )

**ANALGESICS: OPIOIDS – Immediate-Release Single Entity**

<b>NO PA REQUIRED “PREFERRED”</b>		<b>PA REQUIRED</b>
<b>Codeine Products</b>		
CODEINE SULFATE TABLETS		
<b>Hydromorphone Products</b>		
HYDROMORPHONE HCL TABLETS (generic of Dilaudid®)		
<b>Meperidine Products</b>		
MEPERIDINE TABLETS (generic of Demerol®)		
<b>Methadone Products</b>		
METHADONE TABLETS (generic of Dolophine®)		
METHADOSE® DISPERSTABS		
<b>Morphine Products</b>		
MORPHINE SULFATE: IMMEDIATE-RELEASE TABLETS (generic of MSIR®)		
MORPHINE SULFATE TABLETS, SOLUBLE		
<b>Oxycodone Products</b>		
ROXICODONE® (OXYCODONE): IMMEDIATE-RELEASE TABLETS (generic of M-OXY®)		
OXYCODONE HCL TABLETS		
OXYCODONE HCL: IMMEDIATE-RELEASE CAPSULES (generic of OxyIR®)		

## ANALGESICS: OPIOIDS – Immediate-Release Combination

NO PA REQUIRED “PREFERRED”		PA REQUIRED
Codeine Combinations		
ACETAMINOPHEN w/CODEINE TABLETS (generic of Tylenol #2®, Tylenol #3®, Tylenol #4®) ASPIRIN w/CODEINE NO. 3 and NO. 4 TABLETS (generic of Empirin w/Codeine No.3® and No.4®)		
Dihydrocodeine Combinations		
	PANLOR DC® PANLOR SS®	
Hydrocodone Combinations		
HYDROCODONE/APAP 5mg/500mg, 7.5mg/500mg, 10mg/325mg	HYDROCODONE/APAP any strengths other than 5mg/500mg, 7.5mg/500mg or 10mg/325mg HYDROCODONE/ IBUPROFEN 5mg/200mg (generic of Vicoprofen®) LORCET® LORTAB® (5mg/500mg, 7.5mg/500mg generic available without PA) MAXIDONE® 10mg/750mg (Hydrocodone w/APAP) NORCO® (10mg/325mg generic available without PA) VICODIN® (5mg/500mg generic available without PA) VICOPROFEN® ZYDONE®	
Oxycodone Combinations		
ENDOCET® ENDODAN® OXYCODONE W/ ACETAMINOPHEN TABLETS 5mg/325mg (generic of Percocet®) OXYCODONE W/ ASPIRIN TABLETS 4.5mg/325mg (generic of Percodan®) ROXICET®	OXYCODONE W/ ACETAMINOPHEN any strengths other than 5mg/325mg tablets PERCODAN DEMI® TABLETS TYLOX®	
Propoxyphene Combinations		
PROPOXYPHENE (generic of Darvon-N®, Darvon®) PROPOXYPHENE COMPOUND (generic of Darvon Compound®) PROPOXYPHENE 65 HCL w/APAP 650 Tablets (generic of Wygesic®) PROPOXYPHENE NAPSYLATE 100 and APAP 650 Tablets (generic of Darvocet-N-100®)	DARVOCET-N-50®	
Pentazocine Combinations		
Not advocated for use	PENTAZOCINE and NALOXONE (Pentazocine 50mg and 0.5mg Naloxone) PENTAZOCINE HCL and APAP (25mg Pentazocine HCl and 650mg APAP) TALACEN® (25mg Pentazocine HCl and 650mg APAP) TALWIN COMPOUND® (12.5mg Pentazocine HCl and 325mg ASA) TALWIN NX® (Pentazocine 50mg and 0.5mg Naloxone)	

**ANALGESICS: CENTRAL, WITH OPIOID ACTIVITY**

NO PA REQUIRED "PREFERRED"	PA REQUIRED
<b>Tramadol Products</b>	
TRAMADOL (generic of Ultram®)*	ULTRACET® (Tramadol and Acetaminophen)

- Quantity limit for Tramadol of 8 tablets per day.

**ANALGESICS: OPIOIDS – Liquids and Oral Syrup Immediate-Release (Single Entity)**

NO PA REQUIRED "PREFERRED"	PA REQUIRED
CODEINE PHOSPHATE ORAL SOLN HYDROMORPHONE HCL LIQUID (generic of Dilaudid-5®) MEPERIDINE HCL SYRUP: 50 mg/5ml (generic of Demerol Oral Syrup®) METHADONE HCL SOLN 5mg/5ml METHADONE HCL ORAL CONCENTRATE and METHADONE INTENSOL® 10mg/ml MORPHINE SULFATE SOLN: 10 mg/5 mL, 20mg/5ml, 20mg/ml (generic of MSIR Soln® and Roxanol Soln®) ROXICODONE® (Oxycodone oral solution) 5mg/5ml (generic of Oxydose®) ROXICODONE INTENSOL® (Oxycodone oral solution concentrate: 20 mg/ml) (generic of Oxyfast®)	

**ANALGESICS: OPIOIDS – Liquids and Oral Syrup Immediate-Release (Combination)**

NO PA REQUIRED "PREFERRED"	PA REQUIRED
ACETAMINOPHEN W/ CODEINE ORAL SOLN 120mg/12mg (generic of Tylenol w/Codeine Elixir®) HYDROCODONE BITARTRATE W/ ACETAMINOPHEN ELIXIR 2.5mg/167mg (generic of Lortab Elixir®) ROXICET ORAL SOLN® (5mg Oxycodone/325mg APAP)	

**ANALGESICS: OPIOIDS – Nasal Inhalers**

NO PA REQUIRED "PREFERRED"	PA REQUIRED
BUTORPHANOL TARTRATE NS (generic of Stadol NS®)	

**ANALGESICS: OPIOIDS – Transmucosal System**

NO PA REQUIRED "PREFERRED"	PA REQUIRED
	ACTIQ® *

- Note: Clinical criteria must be met for Actiq® – approvable only for cancer pain.

**ANTI-HISTAMINES: SECOND GENERATION**

<b>NO PA REQUIRED "PREFERRED"</b>	<b>PA REQUIRED</b>
ALAVERT <sup>®</sup> (OTC generic of Claritin <sup>®</sup> ) LORATADINE TABLETS (generic of Claritin <sup>®</sup> ) LORATADINE SYRUP (generic of Claritin <sup>®</sup> Syrup) LORATADINE RAPID DISS TABLETS (generic of Claritin <sup>®</sup> Reditabs) ZYRTEC <sup>®</sup> CHEWABLE TABLETS (no PA required for age 6 or under) ZYRTEC SYRUP <sup>®</sup> (no PA required for age 6 or under)	ALLEGRA <sup>®</sup> CLARINEX <sup>®</sup> TABLETS CLARINEX REDI-TABS <sup>®</sup> CLARINEX <sup>®</sup> SYRUP ZYRTEC <sup>®</sup> TABLETS ZYRTEC <sup>®</sup> CHEWABLE TABLETS (PA required for age over 6) ZYRTEC SYRUP <sup>®</sup> (PA required for age over 6)

**ANTI-HISTAMINE/DECONGESTANT COMBO: SECOND GENERATION**

<b>NO PA REQUIRED "PREFERRED"</b>	<b>PA REQUIRED</b>
ALAVERT D-12HR <sup>®</sup> (OTC generic of Claritin-D <sup>®</sup> -12HR) LORATADINE-D (generic of Claritin-D <sup>®</sup> -12HR and 24HR)	ALLEGRA-D 12 HOUR <sup>®</sup> ALLEGRA-D 24 HOUR <sup>®</sup> CLARINEX-D 24 HOUR <sup>®</sup> CLARITIN-D 12 HOUR <sup>®</sup> <b>RX/OTC</b> CLARITIN-D 24 HOUR <sup>®</sup> <b>RX/OTC</b> ZYRTEC-D <sup>®</sup>

**ANTI-INFECTIVES: CEPHALOSPORINS, FIRST GENERATION –****Oral Capsules and Tablets**

<b>NO PA REQUIRED "PREFERRED"</b>	<b>PA REQUIRED</b>
CEFADROXIL 500MG (generic of Duricef <sup>®</sup> ) CEPHALEXIN (generic of Keflex <sup>®</sup> )	CEFADROXIL 1 gram (generic of Duricef <sup>®</sup> ) PANIXINE <sup>®</sup> (Cephalexin tablets for oral suspension) VELOSEF <sup>®</sup> (Cephadrine)

**ANTI-INFECTIVES: CEPHALOSPORINS, FIRST GENERATION –****Oral Suspensions and Liquids**

<b>NO PA REQUIRED "PREFERRED"</b>	<b>PA REQUIRED</b>
CEPHALEXIN SUSPENSION (generic of Keflex <sup>®</sup> Suspension) DURICEF <sup>®</sup> SUSPENSION	VELOSEF <sup>®</sup> SUSPENSION (Cephadrine Suspension)

**ANTI-INFECTIVES: CEPHALOSPORINS, SECOND GENERATION –****Oral Capsules and Tablets**

<b>NO PA REQUIRED "PREFERRED"</b>	<b>PA REQUIRED</b>
CEFACLOL (generic of Ceclor <sup>®</sup> ) CEFUROXIME (generic of Cefitin <sup>®</sup> )	CEFACLOL ER (generic of Ceclor CD <sup>®</sup> ) CEFZIL <sup>®</sup> LORABID <sup>®</sup> RANICLOL <sup>®</sup> (Cefaclor chewable tabs)

**ANTI-INFECTIVES: CEPHALOSPORINS, SECOND GENERATION –****Oral Suspensions and Liquids**

<b>NO PA REQUIRED “PREFERRED”</b>	<b>PA REQUIRED</b>
CEFACLOR SUSPENSION (generic of Ceclor <sup>®</sup> Susp.) CEFZIL <sup>®</sup> SUSPENSION (no PA required for age 12 or under)	CEFTIN <sup>®</sup> SUSPENSION CEFZIL <sup>®</sup> SUSPENSION (PA required for age over 12) LORABID <sup>®</sup> SUSPENSION

**ANTI-INFECTIVES: CEPHALOSPORINS, THIRD GENERATION –****Oral Capsules and Tablets**

<b>NO PA REQUIRED “PREFERRED”</b>	<b>PA REQUIRED</b>
CEDAX <sup>®</sup> OMNICEF <sup>®</sup>	SPECTRACEF <sup>®</sup> SUPRAX <sup>®</sup> VANTIN <sup>®</sup>

**ANTI-INFECTIVES: CEPHALOSPORINS, THIRD GENERATION –****Oral Suspensions and Liquids**

<b>NO PA REQUIRED “PREFERRED”</b>	<b>PA REQUIRED</b>
CEDAX <sup>®</sup> SUSPENSION OMNICEF <sup>®</sup> SUSPENSION	SUPRAX <sup>®</sup> SUSPENSION VANTIN <sup>®</sup> SUSPENSION

**ANTI-INFECTIVES: MACROLIDES**

<b>NO PA REQUIRED “PREFERRED”</b>	<b>PA REQUIRED</b>
AZITHROMYCIN TABLETS BIAXIN <sup>®</sup> TABLETS BIAXIN <sup>®</sup> SUSPENSION BIAXIN XL <sup>®</sup> CLARITHROMYCIN TABLETS E-MYCIN <sup>®</sup> ERY-TAB <sup>®</sup> ERYPED <sup>®</sup> ERYTHROCIN STEARATE <sup>®</sup> ERYTHROMYCIN BASE ERYTHROMYCIN ESTOLATE ERYTHROMYCIN ETHYLSUCCINATE ERYTHROMYCIN STEARATE ERYTHROMYCIN W/SULFISOXAZOLE ZITHROMAX <sup>®</sup> TABLETS ZITHROMAX <sup>®</sup> SUSPENSION ZITHROMAX <sup>®</sup> 1GM PACKETS ZMAX <sup>™</sup> (Azithromycin E.R) FOR ORAL SUSPENSION	CLARITHROMYCIN SUSPENSION PCE <sup>®</sup>

**ANTI-INFECTIVES: QUINOLONES, FIRST GENERATION**

NO PA REQUIRED "PREFERRED"	PA REQUIRED
<ul style="list-style-type: none"><li>NOT USED IN CLINICAL PRACTICE TO AN APPRECIABLE DEGREE TO WARRANT CONSIDERATION</li></ul>	NEGGRAM®

**ANTI-INFECTIVES: QUINOLONES, SECOND GENERATION**

NO PA REQUIRED "PREFERRED"	PA REQUIRED
CIPROFLOXACIN (generic of Cipro®) CIPRO® SUSPENSION (no PA required for age 12 or under)	CIPRO® SUSPENSION (PA required for age over 12) CIPRO XR® MAXAQUIN® NOROXIN® OFLOXACIN (generic of Floxin®)

**ANTI-INFECTIVES: QUINOLONES, THIRD GENERATION**

NO PA REQUIRED "PREFERRED"	PA REQUIRED
AVELOX® AVELOX ABC PACK®	LEVA-PAK® LEVAQUIN® TEQUIN®

**ANTI-INFECTIVES: QUINOLONES, FOURTH GENERATION**

NO PA REQUIRED "PREFERRED"	PA REQUIRED
	FACTIVE®

**ANTI-INFECTIVES: ANTIVIRALS - HERPES**

NO PA REQUIRED "PREFERRED"	PA REQUIRED
ACYCLOVIR (generic of Zovirax®) ACYCLOVIR SUSPENSION (generic of Zovirax® 200mg/5ml suspension) FAMVIR® VALTREX®	



**ANTI-INFECTIVES: ANTIFUNGALS – Used for Onychomycosis**

<b>NO PA REQUIRED “PREFERRED”</b>	<b>PA REQUIRED</b>
FULVICIN U/F <sup>®</sup> GRIFULVIN V <sup>®</sup> GRIS-PEG <sup>®</sup> LAMISIL <sup>®</sup> PENLAC <sup>®</sup>	SPORANOX <sup>®</sup> 100mg/10ml oral solution ITRACONAZOLE CAPSULES (generic of Sporanox <sup>®</sup> )

**ANTI-INFECTIVES: ANTIFUNGALS – ORAL – Used for Systemic Infections**

<b>NO PA REQUIRED “PREFERRED”</b>	<b>PA REQUIRED</b>
DIFLUCAN <sup>®</sup> SUSPENSION FLUCONAZOLE TABLETS (generic of Diflucan <sup>®</sup> ) KETOCONAZOLE (generic of Nizoral <sup>®</sup> )	SPORANOX <sup>®</sup> 100mg/10ml oral solution ITRACONAZOLE CAPSULES (generic of Sporanox <sup>®</sup> )

**ANTI-INFECTIVES: ANTIFUNGALS - Topical**

<b>NO PA REQUIRED “PREFERRED”</b>	<b>PA REQUIRED</b>
CLOTRIMAZOLE (generic of Lotrimin <sup>®</sup> ) CLOTRIMAZOLE/BETAMETHASONE (generic of Lotrisone <sup>®</sup> ) FUNGIZONE <sup>®</sup> FUNGOID <sup>®</sup> KETOCONAZOLE Cream & Shampoo (generic of Nizoral <sup>®</sup> ) LOPROX <sup>®</sup> MICONAZOLE MICRO-GUARD <sup>®</sup> NAFTIN <sup>®</sup> NYSTATIN (generic of Nystop <sup>®</sup> , Mycostatin <sup>®</sup> , Nilstat <sup>®</sup> ) NYSTATIN W/TRIAMCINOLONE (generic of Mytrex <sup>®</sup> ) OXISTAT <sup>®</sup> PEDI-DRI <sup>®</sup> TRI-STATIN II <sup>®</sup>	CICLOPIROX (generic of Loprox <sup>®</sup> ) ECONAZOLE (generic of Spectazole <sup>®</sup> ) ERTACZO <sup>®</sup> EXELDERM <sup>®</sup> LAMISIL <sup>®</sup> MENTAX <sup>®</sup>

**ANTI-MIGRAINE: TRIPTANS - “Fast” Onset**

<b>NO PA REQUIRED “PREFERRED”</b>	<b>PA REQUIRED</b>
AXERT <sup>®</sup> IMITREX <sup>®</sup> INJECTION IMITREX <sup>®</sup> NASAL SPRAY IMITREX <sup>®</sup> TABLETS MAXALT <sup>®</sup> MAXALT-MLT <sup>®</sup> RELPAX <sup>®</sup> ZOMIG <sup>®</sup> ZOMIG <sup>®</sup> NASAL SPRAY ZOMIG ZMT <sup>®</sup>	

**ANTI-MIGRAINE: TRIPTANS - “Slow” Onset**

<b>NO PA REQUIRED “PREFERRED”</b>	<b>PA REQUIRED</b>
AMERGE <sup>®</sup> FROVA <sup>®</sup>	

**CARDIOVASCULAR: ACE INHIBITORS**

<b>NO PA REQUIRED “PREFERRED”</b>	<b>PA REQUIRED</b>
BENAZEPRIL (generic of Lotensin <sup>®</sup> ) CAPTOPRIL (generic of Capoten <sup>®</sup> ) ENALAPRIL (generic of Vasotec <sup>®</sup> ) LISINOPRIL (generic of Zestril <sup>®</sup> , Prinivil <sup>®</sup> )	ACEON <sup>®</sup> ALTACE <sup>®</sup> MAVIK <sup>®</sup> MONOPRIL <sup>®</sup> QUINAPRIL (generic of Accupril <sup>®</sup> ) UNIVASC <sup>®</sup>

**CARDIOVASCULAR: ACE INHIBITORS/CCB Combination**

<b>NO PA REQUIRED “PREFERRED”</b>	<b>PA REQUIRED</b>
LOTREL <sup>®</sup> (Amlodipine and Benazepril) TARKA <sup>®</sup> (Verapamil and Trandolapril)	LEXXEL <sup>®</sup> (Felodipine and Enalapril)

**CARDIOVASCULAR: ACE INHIBITORS/DIURETIC Combination**

<b>NO PA REQUIRED “PREFERRED”</b>	<b>PA REQUIRED</b>
BENAZEPRIL/HCTZ (generic of Lotensin HCT <sup>®</sup> ) CAPTOPRIL/HCTZ (generic of Capozide <sup>®</sup> ) ENALAPRIL/HCTZ (generic of Vaseretic <sup>®</sup> ) LISINOPRIL/HCTZ (generic of Zestoretic <sup>®</sup> , Prinzide <sup>®</sup> )	MONOPRIL HCT <sup>®</sup> QUINARETIC <sup>®</sup> (Quinapril/HCTZ) (generic of Accuretic <sup>®</sup> ) UNIRETIC <sup>®</sup>

**CARDIOVASCULAR: ANGIOTENSIN II RECEPTOR ANTAGONISTS**

<b>NO PA REQUIRED “PREFERRED”</b>	<b>PA REQUIRED</b>
AVAPRO <sup>®</sup> BENICAR <sup>®</sup> COZAAR <sup>®</sup> DIOVAN <sup>®</sup> MICARDIS <sup>®</sup>	ATACAND <sup>®</sup> TEVETEN <sup>®</sup>

**CARDIOVASCULAR: ANGIOTENSIN II RECEPTOR ANTAGONISTS/DIURETIC Combination**

<b>NO PA REQUIRED “PREFERRED”</b>	<b>PA REQUIRED</b>
AVALIDE <sup>®</sup> BENICAR HCT <sup>®</sup> DIOVAN HCT <sup>®</sup> HYZAAR <sup>®</sup> MICARDIS HCT <sup>®</sup>	ATACAND HCT <sup>®</sup> TEVETEN HCT <sup>®</sup>

**CARDIOVASCULAR: BETA-BLOCKERS**

<b>NO PA REQUIRED “PREFERRED”</b>	<b>PA REQUIRED</b>
ACEBUTOLOL (generic of Sectral <sup>®</sup> ) ATENOLOL (generic of Tenormin <sup>®</sup> ) BETAXOLOL (generic of Kerlone <sup>®</sup> ) BISOPROLOL FUMARATE (generic of Zebeta <sup>®</sup> ) COREG <sup>®</sup> INDERAL LA <sup>®</sup> LABETALOL (generic of Normodyne <sup>®</sup> , Trandate <sup>®</sup> ) METOPROLOL (generic of Lopressor <sup>®</sup> ) NADOLOL (generic of Corgard <sup>®</sup> ) PINDOLOL (generic of Viskin <sup>®</sup> ) PROPRANOLOL (generic of Inderal <sup>®</sup> ) SOTALOL (generic of Betapace <sup>®</sup> ) SOTALOL AF (generic of Betapace AF <sup>®</sup> , Sorine <sup>®</sup> ) TIMOLOL (generic of Blocadren <sup>®</sup> )	INNOPRAN XL <sup>®</sup> LEVATOL <sup>®</sup> TOPROL XL <sup>®</sup>

**CARDIOVASCULAR: BETA-BLOCKERS/DIURETIC Combination**

<b>NO PA REQUIRED “PREFERRED”</b>	<b>PA REQUIRED</b>
ATENOLOL/CHLORTHALIDONE (generic of Tenoretic <sup>®</sup> ) BISOPROLOL/HCTZ (generic of Ziac <sup>®</sup> ) PROPRANOLOL/HCTZ (generic of Inderide <sup>®</sup> )	CORZIDE <sup>®</sup> INDERIDE LA <sup>®</sup> LOPRESSOR HCT <sup>®</sup>

### CARDIOVASCULAR: CALCIUM CHANNEL BLOCKERS- Dihydropyridine (DHPCCB)

NO PA REQUIRED "PREFERRED"	PA REQUIRED
AFEDITAB CR (generic of Adalat CC <sup>®</sup> ) DYNACIRC <sup>®</sup> DYNACIRC CR <sup>®</sup> NICARDIPINE (generic of Cardene <sup>®</sup> ) NIFEDIAC CC (generic of Adalat CC <sup>®</sup> ) NIFEDICAL XL (generic of Procardia XL <sup>®</sup> ) NIFEDIPINE ER (generic of Procardia XL <sup>®</sup> , Adalat CC <sup>®</sup> ) NORVASC <sup>®</sup> SULAR <sup>®</sup>	CARDENE SR <sup>®</sup> FELODIPINE (generic of Plendil <sup>®</sup> ) NIFEDIPINE IMMEDIATE RELEASE (generic of Procardia <sup>®</sup> ) NIMOTOP <sup>®</sup>

### CARDIOVASCULAR: CALCIUM CHANNEL BLOCKERS- NON-Dihydropyridine (NDHPCCB)

NO PA REQUIRED "PREFERRED"	PA REQUIRED
CARTIA XT (generic of Cardizem CD <sup>®</sup> ) DILTIA XT (generic of Dilacor XR <sup>®</sup> ) DILTIAZEM (Generic of Cardizem <sup>®</sup> ) DILTIAZEM ER (Generic of Cardizem CD <sup>®</sup> q24h, Dilacor XR <sup>®</sup> q24h) DILTIAZEM SR (Generic of Cardizem SR <sup>®</sup> q12h) TAZTIA XT (Generic of Tiazac <sup>®</sup> ) VERAPAMIL (Generic of Calan <sup>®</sup> ) VERAPAMIL SR/ER (Generic of Calan SR <sup>®</sup> , Isoptin SR <sup>®</sup> , Verelan <sup>®</sup> )	CARDIZEM LA <sup>®</sup> COVERA HS <sup>®</sup> VERELAN PM <sup>®</sup>

### CARDIOVASCULAR: CALCIUM CHANNEL BLOCKERS – Combination Products

NO PA REQUIRED "PREFERRED"	PA REQUIRED
CADUET <sup>®</sup> (Amlodipine/Atorvastatin) *	

- Caduet<sup>®</sup> is indicated in patients for whom treatment with both amlodipine and atorvastatin is appropriate. Both components are available separately without a PA.*

### CARDIOVASCULAR: LIPOTROPICS - STATINS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
ADVICOR <sup>®</sup> (Lovastatin and Niacin) ALTOPREV <sup>®</sup> CRESTOR <sup>®</sup> LESCOL <sup>®</sup> LESCOL XL <sup>®</sup> LIPITOR <sup>®</sup> * LOVASTATIN (generic of Mevacor <sup>®</sup> ) ZOCOR <sup>®</sup> *	PRAVACHOL <sup>®</sup> PRAVIGARD PAC <sup>®</sup> (Pravastatin and Buffered Aspirin)

- Quantity limits for Lipitor<sup>®</sup> and Zocor<sup>®</sup> of one tablet per day.**

**CARDIOVASCULAR: LIPOTROPICS - FIBRIC ACID DERIVATIVES**

NO PA REQUIRED "PREFERRED"	PA REQUIRED
ANTARA <sup>®</sup> GEMFIBROZIL (generic of Lopid <sup>®</sup> ) TRICOR <sup>®</sup>	LOFIBRA <sup>®</sup> TRIGLIDE <sup>®</sup>

**CARDIOVASCULAR: LIPOTROPICS - NICOTINIC ACID DERIVATIVES**

NO PA REQUIRED PREFERRED	PA REQUIRED
NIACIN NIACOR <sup>®</sup> NIASPAN <sup>®</sup>	

**CARDIOVASCULAR: LIPOTROPICS - SELECTIVE CHOLESTEROL ABSORPTION INHIBITOR**

NO PA REQUIRED "PREFERRED"	PA REQUIRED
ZETIA <sup>®</sup>	

**CARDIOVASCULAR: LIPOTROPICS – STATIN / SELECTIVE CHOLESTEROL ABSORPTION INHIBITOR Combination**

NO PA REQUIRED "PREFERRED"	PA REQUIRED
VYTORIN <sup>®</sup> (Simvastatin/Ezetimibe)	

**CARDIOVASCULAR: LIPOTROPICS – STATIN / CCB Combination**

NO PA REQUIRED "PREFERRED"	PA REQUIRED
CADUET <sup>®</sup> (Amlodipine/Atorvastatin) *	

- Caduet<sup>®</sup> is indicated in patients for whom treatment with both amlodipine and atorvastatin is appropriate. Both components are available separately without a PA.*

**ELECTROLYTE DEPLETERS FOR HYPERPHOSPHATEMIA**

NO PA REQUIRED "PREFERRED"	PA REQUIRED
CALCIUM CARBONATE FOSRENOL <sup>®</sup> MAGNEBIND <sup>®</sup> PHOSLO <sup>®</sup> RENAGEL <sup>®</sup>	

**ENDOCRINE: DIABETES - INSULINS - Rapid and Short Acting\***

NO PA REQUIRED "PREFERRED"	PA REQUIRED
NOVOLIN R <sup>®</sup> NOVOLOG <sup>®</sup>	HUMALOG <sup>®</sup> HUMULIN R <sup>®</sup> HUMULIN R 500-U <sup>®</sup> ILETIN I REG <sup>®</sup> ILETIN II PORK R <sup>®</sup> RELION R <sup>®</sup>

**ENDOCRINE: DIABETES - INSULINS - Intermediate Acting\***

NO PA REQUIRED "PREFERRED"	PA REQUIRED
HUMULIN L <sup>®</sup> NOVOLIN N <sup>®</sup> NOVOLIN 70/30 <sup>®</sup> NOVOLOG MIX 70/30 <sup>®</sup>	HUMALOG MIX 75/25 <sup>®</sup> HUMULIN 50/50 <sup>®</sup> HUMULIN N <sup>®</sup> HUMULIN 70/30 <sup>®</sup> ILETIN I LENTE <sup>®</sup> ILETIN I NPH <sup>®</sup> ILETIN II PORK L <sup>®</sup> ILETIN II PORK N <sup>®</sup> RELION 70/30 <sup>®</sup> RELION N <sup>®</sup>

**ENDOCRINE: DIABETES - INSULINS - Long Acting\***

NO PA REQUIRED "PREFERRED"	PA REQUIRED
LANTUS <sup>®</sup>	HUMULIN U <sup>®</sup>

**\*Patients on current insulin regimens will be grandfathered.**

**ENDOCRINE: DIABETES – ORAL HYPOGLYCEMICS, ALPHA-GLUCOSIDASE INHIBITORS**

NO PA REQUIRED "PREFERRED"	PA REQUIRED
GLYSET <sup>®</sup> PRECOSE <sup>®</sup>	

**ENDOCRINE: DIABETES – ORAL HYPOGLYCEMICS, BIGUANIDES**

NO PA REQUIRED "PREFERRED"	PA REQUIRED
METFORMIN (generic of Glucophage <sup>®</sup> ) METFORMIN ER 500mg (generic of Glucophage XR <sup>®</sup> )	FORTAMET <sup>®</sup> RIOMET <sup>®</sup> 500mg/5ml (Metformin)

**ENDOCRINE: DIABETES – ORAL HYPOGLYCEMICS, BIGUANIDES Combination**

NO PA REQUIRED “PREFERRED”	PA REQUIRED
ACTOPLUS MET <sup>®</sup> AVANDAMET <sup>®</sup>	GLYBURIDE-METFORMIN (generic of Glucovance <sup>®</sup> ) METAGLIP <sup>®</sup>

**ENDOCRINE: DIABETES – ORAL HYPOGLYCEMICS, MEGLITINIDES**

NO PA REQUIRED “PREFERRED”	PA REQUIRED
STARLIX <sup>®</sup>	PRANDIN <sup>®</sup>

**ENDOCRINE: DIABETES – ORAL HYPOGLYCEMICS, THIAZOLIDINEDIONES, SULFONYLUREAS Combination**

NO PA REQUIRED “PREFERRED”	PA REQUIRED
AVANDARYL <sup>®</sup>	

**ENDOCRINE: DIABETES – ORAL HYPOGLYCEMICS, THIAZOLIDINEDIONES**

NO PA REQUIRED “PREFERRED”	PA REQUIRED
ACTOS <sup>®</sup> AVANDIA <sup>®</sup>	

**ENDOCRINE: DIABETES – ORAL HYPOGLYCEMICS, SULFONYLUREAS SECOND GENERATION**

NO PA REQUIRED “PREFERRED”	PA REQUIRED
GLIMEPIRIDE (generic of Amaryl <sup>®</sup> ) GLIPIZIDE (generic of Glucotrol <sup>®</sup> ) GLIPIZIDE ER (generic of Glucotrol XL <sup>®</sup> ) GLYBURIDE (generic of Diabeta <sup>®</sup> , Micronase <sup>®</sup> ) GLYBURIDE MICRONIZED (generic of GlynasePressTabs <sup>®</sup> )	

**ENDOCRINE: BONE OSSIFICATION ENHANCERS - ORAL BISPHOSPHONATES**

NO PA REQUIRED “PREFERRED”	PA REQUIRED
ACTONEL <sup>®</sup> FOSAMAX <sup>®</sup> FOSAMAX <sup>®</sup> ORAL SOLN 70mg/75ml FOSAMAX PLUS D <sup>TM</sup>	BONIVA <sup>®</sup> DIDRONEL <sup>®</sup> SKELID <sup>®</sup>

**ENDOCRINE: BONE OSSIFICATION ENHANCERS - CALCITONIN-SALMON**

NO PA REQUIRED “PREFERRED”	PA REQUIRED
MIACALCIN <sup>®</sup>	

### GASTROINTESTINALS: H2RAs

NO PA REQUIRED "PREFERRED"	PA REQUIRED
CIMETIDINE (generic of Tagamet®) FAMOTIDINE (generic of Pepcid®) RANITIDINE (generic of Zantac®) ZANTAC SYRUP® (No PA required for age 12 or under)	NIZATIDINE (generic of Axid®) ZANTAC® EFFERVESCENT TABLET ZANTAC SYRUP® (PA required for age over 12)

### GASTROINTESTINALS: PPIs

NO PA REQUIRED "PREFERRED"	PA REQUIRED
PREVACID® Capsules PREVACID SOLUTAB® (no PA required for age 6 or under) NEXIUM®	ACIPHEX® OMEPRAZOLE (generic of Prilosec®) PREVACID GRANULES® PREVACID NAPRA-PAC® PREVACID SOLUTAB® (PA required for age over 6) PRILOSEC OTC® PROTONIX® ZEGERID® (Omeprazole granules for suspension)

### GENITOURINARY AGENTS: URINARY ANTISPASMODICS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
DETROL LA® DITROPAN XL® ENABLEX® OXYBUTYNIN (generic of Ditropan®) OXYBUTYNIN 5mg/5ml SYRUP (generic of Ditropan®) OXYTROL® SANCTURA® VESICARE®	DETROL® URISPAS®



**HEPATITIS C: PEGYLATED INTERFERONS**

NO PA REQUIRED "PREFERRED"	PA REQUIRED
PEGASYS® PEGASYS CONV. PACK® PEG-INTRON® PEG-INTRON REDIPEN®	

**HEPATITIS C: RIBAVIRINS**

NO PA REQUIRED "PREFERRED"	PA REQUIRED
COPEGUS® REBETOL® RIBAVIRIN	RIBASPHERE®

**HEPATITIS C: INTERFERON/RIBAVIRIN Combination**

NO PA REQUIRED "PREFERRED"	PA REQUIRED
	REBETRON®

**OPHTHALMICS: ANTIBACTERIAL – QUINOLONE SOLUTIONS**

NO PA REQUIRED “PREFERRED”	PA REQUIRED
CIPROFLOXACIN (generic of Ciloxan®) OFLOXACIN (generic of Ocuflox®) VIGAMOX®	QUIXIN® ZYMAR®

**OPHTHALMICS: ANTIHISTAMINES**

NO PA REQUIRED “PREFERRED”	PA REQUIRED
	EMADINE® LIVOSTIN®

**OPHTHALMICS: ANTIHISTAMINE/MAST CELL STABILIZERS**

NO PA REQUIRED “PREFERRED”	PA REQUIRED
PATANOL® ZADITOR®	ELESTAT® OPTIVAR®

**OPHTHALMICS: GLAUCOMA - PROSTAGLANDIN AGONISTS**

NO PA REQUIRED “PREFERRED”	PA REQUIRED
LUMIGAN® TRAVATAN® XALATAN®	

**RESPIRATORY: BETA-ADRENERGIC, SHORT-ACTING****Metered Dose Inhalers or Other Devices**

NO PA REQUIRED “PREFERRED”	PA REQUIRED
ALBUTEROL (generic of Proventil®, Ventolin®) VENTOLIN HFA®	ALBUTEROL SULFATE HFA ALUPENT MDI® MAXAIR AUTOHALER® PROVENTIL HFA®

**RESPIRATORY: BETA-ADRENERGIC, SHORT-ACTING Nebulizers**

NO PA REQUIRED “PREFERRED”	PA REQUIRED
ACCUNEB® (Albuterol – pediatric dosing of premixed nebs) ALBUTEROL (generic of Proventil®, Ventolin®) 0.083% Premixed nebulizers, 0.5% Concentrated Solution) METAPROTERENOL (generic of Alupent® for nebulization) XOPENEX®	

**RESPIRATORY: BETA-ADRENERGIC, LONG-ACTING Metered Dose Inhalers / DPIs**

NO PA REQUIRED "PREFERRED"	PA REQUIRED
SEREVENT DISKUS <sup>®</sup>	FORADIL <sup>®</sup>

**RESPIRATORY: BETA-ADRENERGIC Combination**

NO PA REQUIRED "PREFERRED"	PA REQUIRED
ADVAIR DISKUS <sup>®</sup> (Salmeterol/Fluticasone)	

**RESPIRATORY: COPD ANTICHOLINERGICS**

NO PA REQUIRED "PREFERRED"	PA REQUIRED
ATROVENT <sup>®</sup> (Ipratropium) ATROVENT HFA <sup>®</sup> (Ipratropium) COMBIVENT MDI <sup>®</sup> (Ipratropium/Albuterol) SPIRIVA <sup>®</sup> (Tiotropium)	DUONEB <sup>®</sup> (Ipratropium/Albuterol) nebulizer solution

**RESPIRATORY: GLUCOCORTICOIDs – Inhaled**

NO PA REQUIRED "PREFERRED"	PA REQUIRED
ASMANEX <sup>®</sup> AZMACORT <sup>®</sup> FLOVENT <sup>®</sup> HFA QVAR <sup>®</sup>	AEROBID <sup>®</sup> AEROBID-M <sup>®</sup> PULMICORT TURBUHALER <sup>®</sup>

**RESPIRATORY: GLUCOCORTICOIDs – Nebulizers**

NO PA REQUIRED "PREFERRED"	PA REQUIRED
PULMICORT <sup>®</sup> NEBULIZER SOLUTION	

**RESPIRATORY: GLUCOCORTICOIDs - Nasal**

NO PA REQUIRED "PREFERRED"	PA REQUIRED
FLONASE <sup>®</sup> NASONEX <sup>®</sup> RHINOCORT AQ <sup>®</sup>	BECONASE AQ <sup>®</sup> FLUNISOLIDE (generic of Nasarel <sup>®</sup> ) NASACORT AQ <sup>®</sup>

**RESPIRATORY: LEUKOTRIENE RECEPTOR ANTAGONISTS**

NO PA REQUIRED "PREFERRED"	PA REQUIRED
ACCOLATE <sup>®</sup> SINGULAIR <sup>®</sup> CHEWABLE TABLETS SINGULAIR <sup>®</sup> TABLETS * SINGULAIR <sup>®</sup> ORAL GRANULES	

- Quantity limit for Singulair<sup>®</sup> 10mg of one tablet per day

## SEDATIVE-HYPNOTICS, NON-BARBITURATE

NO PA REQUIRED "PREFERRED"	PA REQUIRED
ESTAZOLAM (generic of Prosom <sup>®</sup> ) FLURAZEPAM (generic of Dalmane <sup>®</sup> ) LUNESTA <sup>®</sup> TEMAZEPAM (generic of Restoril <sup>®</sup> ) TRIAZOLAM (generic of Halcion <sup>®</sup> )	AMBIEN <sup>®</sup> * AMBIEN CR <sup>®</sup> DORAL <sup>®</sup> RESTORIL <sup>®</sup> 7.5mg & 22.5mg ROZEREM <sup>®</sup> SONATA <sup>®</sup> *

- Quantity limits for Ambien<sup>®</sup> and Sonata<sup>®</sup> of one unit per day.

## SKELETAL MUSCLE RELAXANTS - ORAL

NO PA REQUIRED "PREFERRED"	PA REQUIRED
BACLOFEN (generic of Lioresal <sup>®</sup> ) CHLORZOXAZONE (generic of Parafon Forte <sup>®</sup> , Remular-S <sup>®</sup> ) CYCLOBENZAPRINE 5 and 10mg (generic of Flexeril <sup>®</sup> ) METHOCARBAMOL (generic of Robaxin <sup>®</sup> , Robomol <sup>®</sup> ) ORPHENADRINE (generic of Norflex <sup>®</sup> ) ORPHENADRINE COMPOUND (generic of Norgesic Forte <sup>®</sup> ) ORPHENADRINE COMPOUND FORTE (generic of Norgesic Forte <sup>®</sup> ) ORPHENGISIC FORTE (generic of Norgesic Forte <sup>®</sup> ) TIZANIDINE (generic of Zanaflex <sup>®</sup> )	CARISOPRODOL (generic of Soma <sup>®</sup> , Vanadom <sup>®</sup> ) * CARISOPRODOL COMPOUND (generic of Soma Compound <sup>®</sup> ) * DANTRIUM SKELAXIN <sup>®</sup>

- Note: Clinical criteria must be met for Soma<sup>®</sup>/Carisoprodol products— approvable only if no other muscle relaxant or agent to treat fibromyalgia, or any musculoskeletal condition, would serve the clinical needs of the patient.

## TOPICAL IMMUNOMODULATORS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
ELIDEL <sup>®</sup> * PROTOPIC <sup>®</sup> *	

- Elidel<sup>®</sup> & Protopic<sup>®</sup> have age restriction of 2 yrs or older