Updated: June 2, 2006

			Updated: June 2, 2006
THERAPEUTIC	PREFERRED	NON-PREFERRED	PRIOR AUTHORIZATION / CLASS
DRUG CLASS	AGENTS	AGENTS	CRITERIA
ACE INHIBITORS	ACE IN	HIBITORS	Non-preferred agents may be approved if the patient has a
	ALTACE (ramipril)	ACEON (perindopril)	history of one preferred agent in the last 6 months.
	captopril	benazepril	
	enalapril	fosinopril	
	lisinopril	MAVIK (trandolapril)	
		quinapril	
		UNIVASC (moexepril)	
	ACE INHIBITOR/DIUI	RETIC COMBINATIONS	Non-preferred agents may be approved if the patient has a
	captopril/HCTZ	benazepril/HCTZ	history of one preferred agent in the last 6 months.
	enalapril/HCTZ	fosinopril/HCTZ	
	lisinopril/HCTZ	quinapril/HCTZ	
		UNIRETIC (moexepril/HCTZ)	
ACE INHIBITOR/CALCIUM CHANNEL BLOCKER COMBINATIONS	LOTREL (benazepril/amlodipine) TARKA (trandolapril/verapamil)	LEXXEL (enalapril/felodipine)	Non-preferred agents will be approved only after documented failure of a preferred agent within the last 6 months.
Effective 7/1/06			
ALZHEIMER'S AGENTS ^{CL}	CHOLINESTER	ASE INHIBITORS	Cholinesterase inhibitors will be approved only for patients
	ARICEPT (donepezil)	COGNEX (tacrine) EXELON (rivastigmine) RAZADYNE (galantamine)	meeting both of the following criteria: ■ Diagnosis of dementia (ICD-9=290.xx, 294.1, 331.0) ■ Mini Mental State Exam (MMSE) score of <23 or equivalent scale documenting mild to moderate dementia
			Non-Preferred agents will be approved for patients meeting at least one of the following criteria:
			 Documented history of failure to Preferred agent within previous 6 months More than 120 days of therapy with the same Non-preferred agent in the previous 6 months
	NMDA RECEPT	OR ANTAGONIST	Namenda will be approved only for patients meeting both of the
	NAMENDA (memantine)		following criteria: • Diagnosis of dementia (ICD-9=290.xx, 294.1, 331.0) • Mini Mental State Exam (MMSE) score of ≤15 or equivalent scale documenting moderate to severe dementia

Undated: June 2, 2006

			Updated: June 2, 2006
THERAPEUTIC	PREFERRED	NON-PREFERRED	PRIOR AUTHORIZATION / CLASS
DRUG CLASS	AGENTS	AGENTS	CRITERIA
ANALGESICS, NARCOTIC	SHORT ACTING		Non-preferred agents will be approved only after documented
(Non-parenteral)	acetaminophen/codeine	ACTIQ (fentanyl)	failure of 3 preferred agents.
,	aspirin/codeine	butalbital/APAP/caffeine/codeine	
Effective 7/1/06	codeine	butalbital/ASA/caffeine/codeine	Actiq will be approved only for breakthrough cancer pain in
	hydrocodone/APAP	COMBUNOX	patients already receiving, and tolerant to, opioid therapy.
	hydromorphone	(oxycodone/ibuprofen)	
	morphine	dihydrocodeine/ APAP/caffeine	
	oxycodone	hydrocodone/ibuprofen	
	oxycodone/APAP	meperidine	
	oxycodone/aspirin	PANLOR (dihydrocodeine/	
	pentazocine/naloxone	APAP/caffeine)	
	propoxyphene/APAP	pentazocine/APAP	
	tramadol	propoxyphene	
	uamado.	propoxyphene/ASA/caffeine	
		tramadol/APAP	
	LONG-ACTING		Duragesic patches will be approved for patients meeting one of
	morphine SR	AVINZA (morphine)	the following criteria:
	methadone	oxycodone ER	Inability to swallow capsules or tablets
	levorphanol	fentanyl patches	Allergy to morphine and/or methadone
	KADIAN (morphine)	To more years and the second	History of a preferred oral agent in previous 6 months
	DURAGESIC (fentanyl) ^{CL}		
	Borth GLore (Ionianyi)		Non-preferred agents will be approved for patients meeting one of the following criteria:
			Documented failure of at least a 30 day trial of a Preferred agent within previous 6 months
			Diagnosis of malignant pain (ICD-9=140-208, 99.25 or chemotherapy administration related CPT code)
ANGIOTENSIN II RECEPTOR	ANGIOTENSIN II REC	EPTOR BLOCKERS	Non-preferred agents will be approved only after documented
BLOCKERS (ARBs)	AVAPRO (irbesartan)	ATACAND (candesartan)	failure of a preferred agent within the last 6 months.
	BENICAR (olmesartan)	TEVETEN (eprosartan)	
Effective 7/1/06	COZAAR (losartan)		
	DIOVAN (valsartan)		
	MICARDIS (telmisartan)		
	moratorio (terminariari)		
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Updated: June 2, 2006

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THERAPEUTIC	PREFERRED AGENTS	NON-PREFERRED AGENTS	PRIOR AUTHORIZATION / CLASS	
DRUG CLASS			CRITERIA	
	ARB/DIURETIC C		Non-preferred agents will be approved only after documented	
	AVALIDE (irbesartan/HCTZ)	ATACAND-HCT	failure of a preferred agent within the last 6 months.	
	BENICAR-HCT (olmesartan/HCTZ)	(candesartan/HCTZ)		
	DIOVAN-HCT (valsartan/HCTZ)	TEVETEN-HCT (eprosartan/HCTZ)		
	HYZAAR (losartan/HCTZ)			
	MICARDIS-HCT (telmisartan/HCTZ)			
ANTICOAGULANTS,	ARIXTRA (fondaparinux)			
INJECTABLE	FRAGMIN (dalteparin)			
	INNOHEP (tinzaparin)			
Effective 7/1/06	LOVENOX (enoxaparin)			
ANTIDEPRESSANTS, SECOND	SSF	lls	Non-preferred agents will be approved only after documented	
GENERATION	citalopram	PEXEVA (paroxetine)	failure of a preferred agent within the last 6 months.	
	fluoxetine	PROZAC WEEKLY (fluoxetine)		
	fluvoxamine	THOERO WEEKET (INDOMENTO)	Mirtazapine soluble tablets will be approved for patients unable	
	LEXAPRO (escitalopram)		to swallow tablets or capsules.	
	paroxetine			
	PAXIL CR (paroxetine)			
	** **			
	ZOLOFT (sertraline)			
	ОТН			
	bupropion IR	mirtazapine soluble tablets		
	bupropion SR			
	CYMBALTA (duloxetine)			
	EFFEXOR IR (venlafaxine)			
	EFFEXOR XR (venlafaxine)			
	mirtazapine tablets			
	nefazodone			
	WELLBUTRIN XL (bupropion)			

Updated: June 2, 2006

			Updated: June 2, 2006
THERAPEUTIC	PREFERRED	NON-PREFERRED	PRIOR AUTHORIZATION / CLASS
DRUG CLASS	AGENTS	AGENTS	CRITERIA
ANTIEMETICS		OR BLOCKERS	5HT ₃ Receptor Blockers will be approved only for patients
	ALOXI (palonosetron)	ANZEMET (dolasetron)	meeting one of the following criteria:
	ZOFRAN (ondansetron)	KYTRIL (granisetron)	Chemotherapy-induced nausea and vomiting
			Radiation-induced nausea and vomiting
			Hyperemesis gravidarum (ICD-9=643.1) that has failed at
			least 72 hours of at least one of the following therapies:
			- promethazine 150 mg/day
			- prochlorperazine 20 mg/day
			- trimethobenzamide 1200 mg/day
	NIME A DECEME	COD ANTA CONUCT	- metoclopramide 80 mg/day
		OR ANTAGONIST	Emend will be authorized only for patients who have had a prescription for Anzemet, Kytril or Zofran within the past 30
	EMEND (aprepitant) ^{CL}		days.
ANTIEPILEPTIC DRUGS	BARBI	TURATES	
	MEBARAL (mephobarbital)		
	phenobarbital		
	primidone		
	HYDA	NTOINS	
	DILANTIN (phenytoin)	PHENYTEK (phenytoin)	
	PEGANONE (ethotoin)		
	phenytoin		
	SUCC	NIMIDES	
	CELONTIN (methsuximide)		
	ethosuximide		
	BENZOD	IAZEPINES	
	clonazepam		
	DIASTAT (diazepam rectal)		

Updated: June 2, 2006

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THERAPEUTIC	PREFERRED	NON-PREFERRED	PRIOR AUTHORIZATION / CLASS
DRUG CLASS	AGENTS	AGENTS	CRITERIA
	carbamazepine CARBATROL (carbamazepine) DEPAKOTE (divalproex) EQUETRO (carbamazepine) gabapentin ^{CL} GABITRIL (tiagabine) KEPPRA (levetiracetam) ^{CL} LAMICTAL (lamotrigine) ^{CL} LYRICA (pregabilin) ^{CL} TOPAMAX (topiramate) ^{CL} TRILEPTAL (oxcarbazepine) ^{CL} valproic acid zonisamide ^{CL}	ANTS	Gabapentin will be approved only for patients with one of the following diagnosis within the previous 2 years: • Seizure disorder (ICD-9=345) • Neuropathic pain associated with one of the following: - Hereditary and idiopathic peripheral neuropathy (ICD-9=356) - Inflammatory and toxic neuropathy (ICD-9=357) - Disorders of autonomic nervous system (ICD-9=337.0, 337.1) - Amyloidosis (ICD-9=277.3) - Diabetes with neurologic manifestations (ICD-9=250.6) - Mononeuritis of lower limb and mononeuritis multiplex (ICD-9=354) - Mononeuritis of upper limb and mononeuritis multiplex (ICD-9=355) - Neuralgia, neuritis, and radiculitis, unspecified (ICD-9=729) Keppra and zonisamide will be approved for patients with a diagnosis of seizure disorder (ICD-9=345) wihin the previous 2 years. Lamictal and Trileptal will be approved for patients with one of the following diagnoses within the previous 2 years: • Seizure disorder (ICD-9=345) • Bipolar disorder (ICD-9=296) Lyrica will be approved for patients meeting one of the following criteria: • Diagnosis of neuropathic pain associated with diabetic peripheral neuropathy (ICD-9=250.6) or postherpetic neuralgia (ICD-9=053.1) which has failed treatment with gabapentin in the last 2 years. • Diagnosis of epilepsy (ICD-9=345) which has failed treatment with at least 2 vears. Topamax will be approved for patients with one of the following diagnoses within the previous 2 years: • Seizure disorder (ICD-9=345) • Migraine headache (ICD-9=296)

Undated: June 2, 2006

	1	I	Updated: June 2, 2006
THERAPEUTIC	PREFERRED	NON-PREFERRED	PRIOR AUTHORIZATION / CLASS
DRUG CLASS	AGENTS	AGENTS	CRITERIA
ANTIFUNGALS, ORAL	ANCOBON (flucytosine) clotrimazole fluconazole ketoconazole MYCOSTATIN (nystatin) nystatin VFEND (voriconazole)	griseofulvin itraconazole LAMISIL (terbinafine)	 Itraconazole and Lamisil will be approved for patients meeting one of the following criteria: Diagnosis of aspergillosis (ICD-9=117.3), blastomycosis (ICD-9=116.xx) or histoplasmosis (ICD-9=115.xx). Diagnosis of onychomycosis (ICD-9=110.1) with confirmation by microbiological or histological test and extensive nail involvement resulting in significant debilitation or secondary infection. Griseofulvin will be approved for patients meeting one of the following criteria: Diagnosis of tinea capitis Tinea corporis, cruris or pedis failing to respond to at least 2 weeks of a topical agent
ANTIFUNGALS, TOPICAL	ANTIFUI	T	Penlac will be approved for patients meeting all fo the following
	ciclopirox econazole ERTACZO (sertaconazole) EXELDERM (sulconazole) ketoconazole LOPROX GEL (ciclopirox) LOPROX SHAMPOO (ciclopirox) MENTAX (butenafine) NAFTIN (naftifine) nystatin OXISTAT (oxiconazole) ANTIFUNGAL/STERO clotrimazole/betamethasone nystatin/triamcinolone	PENLAC (ciclopirox) DID COMBINATIONS	 Diagnosis of onychomycosis (ICD-9=110.1) within the last year Contraindication to oral itraconazole and Lamisil as defined by presence of heart failure, hepatic impairment or viral hepatitis Proof from prescriber that therapy is not for cosmetic purposes.

Updated: June 2, 2006

			Updated: June 2, 2006
THERAPEUTIC	PREFERRED	NON-PREFERRED	PRIOR AUTHORIZATION / CLASS
DRUG CLASS	AGENTS	AGENTS	CRITERIA
ANTIHISTAMINES, MINIMALLY	ANTIHISTAMINES		Class Criteria:
SEDATINGCL	CLARITIN (loratadine)	CLARINEX (desloratadine)	- Age <20 years
	loratadine	fexofenadine	- Diagnosis of allergic rhinitis or chronic urticaria
		ZYRTEC (cetirizine)	- Failure of treatment with at least 2 first generation
	ANTIHISTAMINE/DECON	GESTANT COMBINATIONS	antihistamines (brompheniramine, carbinoxime,
	CLARITIN-D (loratadine/pseudoephedrine) loratadine/pseudoephedrine	ALLEGRA-D (fexofenadine/ pseudoephedrine) ZYRTEC-D (cetirizine/pseudoephedrine)	chlorpheniramine, clemastine, cyproheptadine, dexchlorpheniramine, diphenhydramine, hydroxyzine) - Patient is not receiving other sedating medications (anticholinergics, TCAs, opiates, skeletal muscle relaxants, benzodiazepines, conventional antipsychotics)
			Prescription is required for all agents.
			Non-preferred agents will only be approved if patient has tried and failed therapy with the preferred agent within the last 6 months.
ANTIMIGRAINE AGENTS,	OI	RAL	Class Criteria:
TRIPTANSCL	AMERGE (naratriptan)	AXERT (almotriptan)	- Age ≥12 years
	IMITREX (sumatriptan)	FROVA (frovatriptan)	- No history of CAD, angina, uncontrolled HPT, CVD, PVD,
Effective 7/1/06	MAXALT (rizatriptan)	, ,	ischemic bowel disease
	RELPAX (eletriptan)		
	ZOMIG (zolmitriptan)		Non-preferred agents will be authorized only if patient has tried
	NASAL		and failed therapy with all of the preferred agents within the la-
	IMITREX (sumatriptan)	ZOMIG (zolmitriptan)	o monus.
	INJEC	TABLE	
	IMITREX (sumitriptan)		
ANTIVIRALS	` ' '	V AGENTS	
(oral)	ganciclovir		
•	VALCYTE (valganciclovir)		
		ES AGENTS	
	acyclovir		
	FAMVIR (famciclovir)		
	VALTREX (valacyclovir)		
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Updated: June 2, 2006

			Updated: June 2, 2006
THERAPEUTIC	PREFERRED	NON-PREFERRED	PRIOR AUTHORIZATION / CLASS
DRUG CLASS	AGENTS	AGENTS	CRITERIA
	ANTI-INFLUENZA AGEN		
	amantadine		
	RELENZA (zanamivir)		
	rimantadine		
	TAMIFLU (oseltamivir)		
ATOPIC DERMATITIS	ELIDEL (pimecrolimus)		
	PROTOPIC (tacrolimus)		
BETA BLOCKERS	BETA	BLOCKERS	Innopran XL and Levatol will be approved for patients with
(Oral)	acebutolol	INNOPRAN XL (propranolol)	documented failure to one of the preferred agents within the
	atenolol	LEVATOL (penbutolol)	past 6 months.
Effective 7/1/06	betaxolol	,	
	bisoprolol		
	INDERAL LA (propranolol)		
	metoprolol		
	nadolol		
	pindolol		
	propranolol		
	sotalol		
	timolol		
	TOPROL XL (metoprolol)		
	BETA- AND A	ALPHA- BLOCKERS	Coreg (carvedolol) will be approved only for patients with a
	COREG (carvedilol) ^{CL}		documented diagnosis of heart failure.
	labetalol		
BLADDER RELAXANT	DITROPAN XL (oxybutynin)	DETROL (tolterodine)	Non-preferred agents will be approved for patients with
PREPARATIONS	ENABLEX (darifenacin)	DETROL LA (tolterodine)	documented failure (inability to maintain continence) or
	oxybutynin		intolerance (dry mouth) on a preferred agent.
Effective 7/1/06	OXYTROL (oxybutynin)		
	SANCTURA (trospium)		
	VESICARE (solifenacin)		
BRONCHODILATORS, BETA	INHALERS	, SHORT-ACTING	Non-preferred agents will be approved for patients with
AGONIST	albuterol	ALUPENT (metaproterenol)	documented failure of albuterol.
		MAXAIR (pirbuterol)	
		XOPENEX HFA (albuterol)	

Undated: June 2, 2006

			Updated: June 2, 200
THERAPEUTIC	PREFERRED	NON-PREFERRED	PRIOR AUTHORIZATION / CLASS
DRUG CLASS	AGENTS	AGENTS	CRITERIA
	INHALERS, LONG-ACTING		
	FORADIL (formoterol)		
	SEREVENT (salmeterol)		
	INHALA [*]	FION SOLUTION	Non-preferred agents will be approved for patients wit
	albuterol	ACCUNEB (albuterol)	documented failure of albuterol.
		metaproterenol	
		XOPENEX (levalbuterol)	
BPH AGENTS	ALPH	A BLOCKERS	
	doxazosin		
	FLOMAX (tamsulosin)		
	terazosin		
	UROXATRAL (alfuzosin)		
	5-ALPHA-REDUCTASE (5AR) INHIBITORS		
	AVODART (dutasteride)		
	PROSCAR (finasteride)		
CALCIUM CHANNEL	SHO	RT-ACTING	
BLOCKERS	diltiazem		
(Oral)	DYNACIRC (isradipine)		
	nicardipine		
	nifedipine		
	NIMOTOP (nimodipine)		
	verapamil		
	LO	NG-ACTING	
	CARDENE SR (nicardipine)	COVERA-HS (verapamil)	
	CARDIZEM LA (diltiazem)	VERELAN (verapamil)	
	diltiazem ER		
	DYNACIRC CR (isradipine)		
	felodipine ER		
	nifedipine ER		
	NORVASC (amlodipine)		
	SULAR (nisoldipine)		
	TIAZAC 420 mg (diltiazem)		
	verapamil ER		
	VERELAN PM (verapamil)		

Updated: June 2, 2006

		T	Updated: June 2, 2006
THERAPEUTIC	PREFERRED	NON-PREFERRED	PRIOR AUTHORIZATION / CLASS
DRUG CLASS	AGENTS	AGENTS	CRITERIA
CEPHALOSPORINS AND	BETA LACTAM/BETA-LACTAMA	SE INHIBITOR COMBINATIONS	
RELATED ANTIBIOTICS	amoxicillin/clavulanate		
(Oral)	AUGMENTIN XR		
	(amoxicillin/clavulanate)		
	CEPHALOSPORINS	- First Generation	
	cefadroxil		
	cephalexin		
	cephradine		
	PANIXINE (cephalexin)		
	CEPHALOSPORINS -	Second Generation	
	cefaclor		
	cefprozil		
	cefuroxime		
	LORABID (loracarbef)		
	RANICLOR (cefaclor)		
	CEPHALOSPORINS	- Third Generation	
	CEDAX (ceftibuten)]
	cefpodoxime		
	OMNICEF (cefdinir)		
	SPECTRACEF (cefditoren)		
	SUPRAX (cefixime)		
CYTOKINE & CAM	AMEVIVE (alefacept)		
ANTAGONISTS	ENBREL (etanercept)		
	HUMIRA (adalimumab)		
	KINERET (anakinra)		
	RAPTIVA (efalizumab)		
	REMICADE (infliximab)		
ERYTHROPOIESIS		EDOCENI (*II.:EDO)	New professed assets will only be approved if notices has tried
STIMULATING PROTEINS	ARANESP (darbepoetin)	EPOGEN (rHuEPO)	Non-preferred agents will only be approved if patient has tried and failed therapy with the preferred agent within the last 6
OTHIOLATING TROTLING	PROCRIT (rHuEPO)		months.
Implement 7/1/06			
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Updated: June 2, 2006

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THERAPEUTIC	PREFERRED AGENTS	NON-PREFERRED AGENTS	PRIOR AUTHORIZATION / CLASS
DRUG CLASS			CRITERIA
ESTROGENS	OR/	AL	
	CENESTIN		
	(conjugated estrogens, synthetic)		
	estradiol		
	estropipate		
	GYNODIOL 1.5 mg (estradiol)		
	MENEST (estrogens, esterified)		
	PREMARIN (estrogens, conjugated)		
	TRANSD	ERMAL	
	ALORA (estradiol)		
	CLIMARA (estradiol)		
	ESCLIM (estradiol)		
	ESTRADERM (estradiol)		
	estradiol		
	ESTROGEL (estradiol)		
	VIVELLE (estradiol)		
	VIVELLE-DOT (estradiol)		
	VAGI		
	ESTRING (estradiol)	ESTRACE (estradiol)	
	FEMRING (estradiol)		
	OGEN (estropipate)		
	PREMARIN (estrogens, conjugated)		
	VAGIFEM (estadiol)		
FLUOROQUINOLONES, ORAL	AVELOX (moxifloxacin)		
	CIPRO Suspension (ciprofloxacin)		
	CIPRO XR (ciprofloxacin)		
	ciprofloxacin		
	FACTIVE (gemifloxacin)		
	LEVAQUIN (levofloxacin)		
	ofloxacin		
GLUCOCORTICOIDS, INHALED	FLOVENT (fluticasone)	AEROBID (flunisolide)	Non-preferred agents will only be approved if patient has tried
,	PULMICORT (budesonide)	AEROBID-M (flunisolide)	and failed therapy with the preferred agents within the last 6
	, , ,	AZMACORT (triamcinolone)	months.
		QVAR (beclomethasone)	

Updated: June 2, 2006

			Updated: June 2, 2006
THERAPEUTIC	PREFERRED	NON-PREFERRED	PRIOR AUTHORIZATION / CLASS
DRUG CLASS	AGENTS	AGENTS	CRITERIA
GROWTH HORMONE ^{CL} Implement 7/1/06	GENOTROPIN (somatropin) NORDITROPIN (somatropin) NUTROPIN AQ (somatropin) SAIZEN (somatropin) SEROSTIM (somatropin) TEV-TROPIN (somatropin)	HUMATROPE (somatropin) NUTROPIN (somatropin)	Growth hormone will be approved for patients with any of the following diagnoses and meeting the criteria defined on the PA Form: - Chronic Renal Impairment awaiting renal transplantation (ICD-9 585) - Growth Hormone Deficiency (ICD-9=253.2, 253.3) - Prader-Willi Syndrome (ICD-9=759.81) - Turner Syndrome (ICD-9=758.6) - HIV plus Cachexia (ICD-9=042, 079.53, V08 or 795.71 plus 799.4) Non-preferred agents will only be approved if patient has tried and failed therapy with the preferred agents within the last 6 months. Patients currently on a Non-preferred agent will be authorized to continue therapy with that agent.
HEPATITIS C TREATMENTS Implement 7/1/06	PEG-INTRON (pegylated interferon alfa-2b) PEGASYS (pegylated interferon alfa-2a) REBETOL (ribavirin)	COPEGUS (ribavirin) INFERGEN (consensus interferon) ribavirin	Non-preferred agents will only be approved if patient has tried and failed therapy with a preferred agents within the last 6 months.
HYPOGLYCEMICS, MEGLITINIDES	PRANDIN (repaglinide) STARLIX (nateglinide)		
HYPOGLYCEMICS, SULFONYLUREAS	acetohexamide chlorpropamide glimepiride glipizide glyburide	tolazamide tolbutamide	
HYPOGLYCEMICS, TZDS	THIAZOLIN	IEDIONES	
	ACTOS (pioglitazone) AVANDIA (rosiglitazone)		

Updated: June 2, 2006

			Updated: June 2, 2006
THERAPEUTIC	PREFERRED	NON-PREFERRED	PRIOR AUTHORIZATION / CLASS
DRUG CLASS	AGENTS	AGENTS	CRITERIA
	TZD COMBINATIONS		
	ACTOPLUS MET		
	(pioglitazone/metformin)		
	AVANDAMET		
	(rosiglitazone/metformin)		
	AVANDARYL (rosiglitazone/glipizide)		
LEUKOTRIENE RECEPTOR	ACCOLATE (zafirlukast)		Leukotriene receptor modifiers will be approved for patients with
MODIFIERS ^{CL}	SINGULAIR (montelukast)		one of the following diagnosis:
	,		 asthma (ICD-9=493.00, 493.01, 493.02) AND
			- are ≤16 years of age
			- are >16 years of age and are currently on or have
			failed therapy with an inhaled corticosteroid
			allergic rhinitis (ICD-9=477.xx)
LIPOTROPICS, OTHER	BILE ACID SEQUESTRANTS		
(non-statins)	cholestyramine	WELCHOL (colesevalam)	
	COLESTID (colestipol)		
Implement 7/1/06	` '		Zetia will be approved for patients who have a diagnosis of
,	CHOLESTERUL ABSO	DRPTION INHIBITORS	hypercholesterolemia and have either failed HMG-CoA
		ZETIA (ezetimibe)	reductase monotherapy or have a documented intolerance to
			HMG-CoA reductase treatment.
			Zetia treatment is only approved as an adjunct to concurrent
			HMG-CoA reductase therapy unless there is a documented intolerance to the HMG-CoA reductase inhibitors.
	FIRRIC ACID	DEDIVATIVES	intolerance to the hing-coa reductase inhibitors.
		DERIVATIVES	
	fenofibrate	ANTARA (fenofibrate)	
	gemfibrozil	TRIGLIDE (fenofibrate)	
	TRICOR (fenofibrate)		
	<u>NIACIN</u>		
	NIASPAN (niacin)	NIACELS (niacin)	
		NIADELAY (niacin)	
		SLO-NIACIN (niacin)	

Updated: June 2, 2006

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THERAPEUTIC	PREFERRED	NON-PREFERRED	PRIOR AUTHORIZATION / CLASS
DRUG CLASS	AGENTS	AGENTS	CRITERIA
LIPOTROPICS, STATINS	STATINS		Statins will be authorized only for patients ≥8 years of age
	ALTOPREV (lovastatin)	CRESTOR (rosuvastatin)	Crestor will be approved for patients with documented failure of
	LESCOL (fluvastatin)	simvastatin	2 preferred agents or 2 different doses of a single preferred
	LESCOL XL (fluvastatin)		agent for at least 150 days in the last 6 months.
	LIPITOR (atorvastatin)		A quantity limit of one dosage per day applies to all but the highest strength of each agent.
	lovastatin		Thighest strongth of each agent.
	pravastatin		
	ZOCOR (simvastatin)		
	STATIN COMBINATIONS		Caduet will be approved for patients with documented failure of
	ADVICOR (lovastatin/niacin)	CADUET (atorvastatin/amlodipine)	2 preferred agents or 2 different doses of a single preferred
		VYTORIN (simvastatin/ezetimibe)	agent for at least 150 days in the last 6 months.
			Vytorin will be authorized for patients failing a minimum 3 month trial of standard dose statin.
MACROLIDES / KETOLIDES	KETOL	IDES	Ketek will be approved if there is documentation of any antibiotic
		KETEK (telithromycin)	use within the past 28 days.
	MACRO	LIDES	
	azithromycin		
	BIAXIN XL (clarithromycin)		
	clarithromycin		
	erythromycin		
	ZITHROMAX Powder Packet		
	(azithromycin)		
	ZITHROMAX Suspension		
MULTIPLE COLEDONS	(azithromycin)		
MULTIPLE SCLEROSIS AGENTS	AVONEX (interferon beta-1a)		
ACENTO	BETASERON (interferon beta-1b)		
	COPAXONE (glatiramer)		
	REBIF (interferon beta-1a)		

Updated: June 2, 2006

THERAPEUTIC	PREFERRED	NON-PREFERRED	PRIOR AUTHORIZATION / CLASS
DRUG CLASS	AGENTS	AGENTS	CRITERIA
NSAIDS, COX-II SELECTIVE ^{CL}	CELEBREX (celecoxib)		Celebrex will be approved for patients with rheumatoid arthritis, osteoarthritis, acute pain or dysmenorrhea and who have any of the following risk factors for a gastrointestinal bleed: • previous or current PUD or GI bleed • concurrent therapy with corticosteroids, anticoagulants or antiplatelets • inability to tolerate at least two nonselective NSAIDs • Familial Adenomatous Polyposis Acute pain treatment is limited to 14 days
OTIC ANTIBIOTIC	CIPRODEX	CIPRO HC	Non-preferred agents will be authorized for patients failing to
PREPARATIONS	(ciprofloxacin/dexamethasone)	(ciprofloxacin/hydrocortisone)	respond to the preferred agents.
	COLY-MYCIN S	CORTISPORIN TC	
Effective 7/1/06	(neomycin/hydrocortisone)	(neomycin/hydrocortisone)	
	FLOXIN (ofloxacin)		
	neomycin/polymyxin/hydrocortisone		
PHOSPHATE BINDERS	FOSRENOL (lanthanum)		
	MAGNEBIND 400		
	(magnesium/calcium carbonate)		
	PHOSLO (calcium acetate)		
	RENAGEL (sevelamer)		
PLATELET AGGREGATION	AGGRENOX (dipyridamole/aspirin)		
INHIBITORS	dipyridamole		
	PLAVIX (clopidogrel)		
	ticlopidine		

Undated: June 2, 2006

T	1		Updated: June 2, 2006
THERAPEUTIC	PREFERRED	NON-PREFERRED	PRIOR AUTHORIZATION / CLASS
DRUG CLASS	AGENTS	AGENTS	CRITERIA
PROTON PUMP INHIBITORS (Oral) ^{CL} Effective 7/1/06	NEXIUM (esomeprazole) PREVACID Capsules (lansoprazole) PREVACID Suspension (lansoprazole) PRILOSEC OTC (omeprazole)	ACIPHEX (rabeprazole) omeprazole PREVACID Solutabs (lansoprazole) PROTONIX (pantoprazole) ZEGERID (omeprazole/ sodium bicarbaonate)	Proton pump inhibitors will be approved for patients meeting one of the following criteria: Non-selective NSAID treatment with: History of peptic ulcer disease or GI bleed Concurrent use of warfarin or corticosteroids Diagnosis of: Zollinger-Ellison Syndrome Systemic mastocytosis Esophageal reflux Esophagitis Perforation, stricture or ulceration of esophagus Concurrent or history of GI bleed, obstruction or perforation Concurrent or history of complicated PUD Cystic fibrosis and on pancreatic enzyme treatment GI organ cancer NSAID-induced ulcer that requires continued nonselective NSAID therapy Current H. pylori associated with PUD as part of a 2-4 drug eradication regimen (limited to 3 month duration) Non-preferred agents will only be approved if patient has tried and failed therapy with two preferred agents within the last 6 months. Quantity limits of one dose per day apply to this class
SEDATIVE HYPNOTICS	BENZODIAZEPINES		Non-preferred agents will only be approved if patient has tried
	DORAL (quazepam)	flurazepam	and failed therapy with a preferred agents within the last 6
Implement 7/1/06	estazolam	•	months.
	RESTORIL 7.5 mg (temazepam)		
	temazepam		
	triazolam		
	ОТН		
	AMBIEN (zolpidem)	AMBIEN CR (zolpidem)	
	chloral hydrate	ROZEREM (ramelteon)	
	LUNESTA (eszopiclone)	SONATA (zaleplon)	

Updated: June 2, 2006

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THERAPEUTIC	PREFERRED	NON-PREFERRED	PRIOR AUTHORIZATION / CLASS
DRUG CLASS	AGENTS	AGENTS	CRITERIA
STIMULANTS AND RELATED AGENTS ^{CL}	ADDERALL XR (amphetamine salt combination) amphetamine salt combination CONCERTA (methylphenidate) DESOXYN (methamphetamine) dextroamphetamine FOCALIN (dexmethylphenidate) FOCALIN XR (dexmethylphenidate) METADATE CD (methylphenidate) methylphenidate RITALIN LA (methylphenidate)	ANTS	Stimulants will be authorized for patients with one of the following diagnoses in the previous 2 years: - ADD/ADHD (ICD-9=314) – amphetamine salt combination products, dextroamphetamine, methylphenidate products, Focalin, Focalin XR, Desoxyn - Narcolepsy (ICC-9=347) - amphetamine salt combination products, dextroamphetamine, methylphenidate products, Focalin, Focalin XR Stimulants will not be authorized for patients with any of the following diagnoses in previous 2 years: - opiate abuse (ICD-9=305.5) - drug dependence: opioids (ICD-9=304.0), cocaine (ICD-9=304.2), amphetamine (ICD-9=304.4), hallucinogen (ICD-9=304.5) - hypertension (ICD-9=401-405) - hyperthyroidism (ICD-9=242) - glaucoma (ICD-9=365) Amphetamine salt combination products, dextroamphetamine and Desoxyn will be authorized only for patients ≥3 years of age. Methylphenidate products, Focalin and Focalin XR will be
	NON-STIM	UI ANTS	authorized only for patients <a>_6 years of age. Strattera will be approved for patients meeting at least one of
	IAOIA-2 I IIWI	PROVIGIL (modafanil) STRATTERA (atomoxetine)	the following criteria: - documented trial and failure of 2 stimulants within 2 months - diagnosis of tics, anxiety disorder or a history of substance abuse Provigil will be approved for patients ≥16 years of age with any of the following diagnoses in the previous 2 years: - diagnosis of narcoloepsy (ICD-9=347) - obstructive sleep apnea (ICD-9=780.51, 780.53) - shift work sleep disorder (ICD-9=307.45)

Updated: June 2, 2006

THERAPEUTIC	PREFERRED	NON-PREFERRED	PRIOR AUTHORIZATION / CLASS
DRUG CLASS	AGENTS	AGENTS	CRITERIA
ULCERATIVE COLITIS AGENTS	ORAL		
	ASACOL (mesalamine)		
Implement 7/1/06	COLAZAL (balsalazide)		
	DIPENTUM (olsalazine)		
	PENTASA (mesalamine)		
	sulfasalazine		
	RECTAL		
	CANASA (mesalamine)		
	mesalamine		