

The February 20, 2009 P&T Recommendations for the Hypoglycemics, TZD are:

- Avandia[®], Actos[®], Avandamet[®], Avandaryl[®], Actoplus Met[®], and Duetact[®] be designated as preferred agents.
- There were no agents designated as non-preferred.

The February 20, 2009 P&T Recommendations for the Meglitinides are:

- Starlix[®] and Prandin[®] be designated as preferred agents.
- There were no agents designated as non-preferred.

The February 20, 2009 P&T Recommendations for the Lipotropics, Other are:

- Niacor[®], Niaspan[®], gemfibrozil generic, colestipol generic, Tricor[®], cholestyramine generic, and fenofibrate generic be designated as preferred agents.
- Zetia[®], Triglide[®], Welchol[®], Lipofen[®], Antara[®], Fenoglide[®], and Lovaza[®] be designated as non-preferred agents that require prior authorization.

The February 20, 2009 P&T Recommendations for the Narcotic Analgesic, Short-acting are:

- propoxyphene/acetaminophen generic 100mg, acetaminophen/codeine generic, tramadol generic, hydrocodone/acetaminophen generic, aspirin/codeine generic, codeine generic, morphine IR generic, oxycodone IR generic, oxycodone/acetaminophen generic, pentazocine/naloxone generic, hydromorphone generic, and tramadol/acetaminophen generic be designated as preferred agents.
- levorphanol generic, pentazocine/acetaminophen generic, oxycodone/aspirin generic, propoxyphene generic, meperidine oral generic, Darvon N[®], Panlor DC/SS[®], Opana[®], fentanyl buccal generic, Fentora[®], hydrocodone/ibuprofen generic, oxycodone/ibuprofen generic, butalbital compound/codeine generic, and dihydrocodeine/acetaminophen/caffeine generic be designated as non-preferred agents that require prior authorization.

The February 20, 2009 P&T Recommendations for Narcotic Analgesics, Long Acting are:

- Duragesic[®], methadone generic, Kadian[®], and morphine ER generic be designated as preferred agents.
- fentanyl transdermal generic, Avinza[®], Opana ER[®], Oxycontin[®] and oxycodone extended release generic be designated as non-preferred agents that require prior authorization.
- Duragesic[®] is recommended by the Committee as preferred over generic fentanyl transdermal when the therapeutic prior authorization criteria are met.

The February 20, 2009 Recommendations for Anticonvulsants are:

- Trileptal[®] suspension, divalproex generic, methobarbital generic, phenobarbital generic, clonazepam generic, carbamazepine generic, Carbatrol[®], Equetro[®], phenytoin generic,, mephobarbital generic, primidone generic , valproic acid generic, Depakote[®] sprinkle, Depakote ER[®], Depakote[®], Celontin[®], Peganone[®], Gabitril[®], , ethosuximide generic, zonisamide generic², oxcarbazine generic², Lyrica^{®2}, gabapentin generic², Topamax^{®2}, Keppra^{®2} solution and tablets, Keppra^{®2} XR, Lamictal^{®2}, and Diastat[®] be designated as preferred agents.
- Trileptal[®] oral, Stavzor[®], Phenytek[®], Tegretol XR^{®1}, Felbatol[®], lamotrigine generic² and levetiracetam generic be designated as non-preferred agents that require prior authorization.
- ¹ Clients currently receiving Tegetrol XR[®] will be “grandfathered” and not need to switch to a preferred agent.
- ² These anticonvulsants are recommended as preferred for epilepsy and other seizure orders only. Non-seizure indications will still require that therapeutic prior authorization criteria are met.

The February 20, 2009 Recommendations for Growth Hormone¹ are:

- Genotropin[®], Nutropin[®], Nutropin AQ[®] and Norditropin[®] be designated as preferred agents.
- Saizen[®], Tev-Tropin[®], Serostim[®], Humatrope[®], Omnitrope[®] and Zorbtive[®] be designated as non-preferred agents that require prior authorization.
- ¹ Current therapeutic criteria for growth hormone will continue to be required for all agents.
- Patients currently receiving non-preferred agents will be “grandfathered”. These agents will be non-preferred and require prior-authorization for new patients.

The February 20, 2009 Recommendations for Hepatitis C Agents are:

- Pegasys[®], Peg-Intron[®], Peg-Intron[®] Redipen, and ribavirin generic be designated as preferred agents.
- Infergen[®] as a non-preferred agent that requires prior authorization.

The February 20, 2009 Recommendations for Multiple Sclerosis Agents are:

- Betaseron[®], Avonex[®], Rebif[®] and Copaxone[®] be designated as preferred agents.
- There were no agents designated as non-preferred.

The February 20, 2009 Recommendations for Erythropoiesis Stimulating Proteins are:

- Aranesp[®] and Procrit[®] be designated as preferred agents.
- Epogen[®] as a non-preferred agent that requires prior authorization.

The February 20, 2009 Recommendations for Otic Fluoroquinolone Preparations are:

- Floxin[®], ofloxacin generic otic and Ciprodex[®] otic as preferred agents.
- Cipro[®]HC as a non-preferred agent that requires prior authorization.

The February 20, 2009 Recommendations for Phosphate Binders are:

- PhosLo[®], Fosrenol[®] and Renagel[®] as preferred agents.
- Renvela[®], and calcium acetate generic as non-preferred agents that require prior authorization.

The February 20, 2009 Recommendations for Sedative-Hypnotics are:

- chloral hydrate generic, temazepam generic, triazolam generic, Restoril[®] 7.5 mg and zolpidem generic as preferred agents.
- Lunesta[®], flurazepam generic, Rozerem[®], Ambien CR[®], Doral[®], zaleplon generic and estazolam generic as non-preferred agents that require prior authorization.
- Lunesta[®] will be grandfathered for current patients.

The February 20, 2009 Recommendations for Proton Pump Inhibitors are:

- Prevacid[®] solutab and suspension, Nexium[®] capsule and suspension, and Prevacid[®] capsule, as preferred agents.
- pantoprazole generic, Zegerid[®], Aciphex[®], Prilosec OTC, and omeprazole generic as non-preferred agents that require prior authorization.
- All current therapeutic criteria except those associated with the solutab form of Prevacid will be removed.

The February 20, 2009 Recommendations for Injectable Anticoagulants are:

- Fragmin[®], Lovenox[®], and Arixtra[®] as preferred agents.
- Innohep[®] as a non-preferred agent that requires prior authorization.

The February 20, 2009 Recommendations for Angiotensin Modulator/Calcium Channel Blocker Combinations are:

- Exforge[®] and Azor[®] as preferred agents.
- benazepril/amlodipine generic and Tarka[®] as non-preferred agents that require prior authorization.
- The separate component drugs must be used in place of benazepril/amlodipine combinations.

The February 20, 2009 Recommendations for Angiotensin Modulators are:

- benazepril and benazepril/HCTZ generic, captopril and captopril/HCTZ generic, enalapril and enalapril/HCTZ generic, fosinopril and fosinopril/HCTZ generic, lisinopril and lisinopril/HCTZ generic, quinapril and quinapril/HCTZ generic, Diovan[®], Diovan HCT[®], Benicar, Benicar HCT[®], Micardis[®], Micardis HCT[®], Cozaar[®], Hyzaar[®], Avapro[®], and Avalide[®] as preferred agents.
- Aceon[®], Teveten[®], Tevetan HCT[®], Atacand[®], Atacand HCT[®], moexepiril and moexepiril/HCTZ generic, Tekturna[®], Tekturna HCT[®], trandolapril generic and ramipril generic as non-preferred agents that require prior authorization.

The February 20, 2009 Recommendations for Benign Prostatic Hyperplasia Treatment Agents are:

- doxazosin generic, terazosin generic, Proscar[®], Uroxatral[®], Cardura XL[®], Flomax[®], Avodart[®], and finasteride generic as preferred agents.
- There are no agents designated as non-preferred.

The February 20, 2009 Recommendations for Bladder Relaxant Preparations are:

- oxybutynin generic, Vesicare[®], Oxytrol[®] transdermal, and Detrol LA[®] as preferred agents.
- Enablex[®], Detrol[®], Sanctura[®], and Sanctura XR[®], and oxybutynin ER generic as non-preferred agents that require prior authorization.

The February 20, 2009 Recommendations for Lipotropics, Statins are:

- Simcor[®], Altoprev[®], Caduet[®], Lescol/Lescol XL[®], Lipitor[®], lovostatin generic, pravastatin generic and simvastatin generic as preferred agents.
- Advicor[®], Crestor[®], and Vytorin[®] as non-preferred agents that require prior authorization.

The February 20, 2009 Recommendations for Calcium Channel Blockers are:

- Dynacirc CR[®], verapamil generic, diltiazem generic, nifedipine IR/ER generic, felodipine ER generic and amlodipine generic as preferred agents.
- nisoldipine generic, Cardizem LA[®], verapamil ER PM, nicardipine generic, Cardene SR[®], Covera-HS[®], isradipine generic and Sular[®] as non-preferred agents that require prior authorization.

The February 20, 2009 Recommendations for Beta-Blockers are:

- Levatol[®], Innopran XL[®], atenolol generic, metoprolol generic, propranolol generic, sotalol generic, nadolol generic, acebutolol generic, labetalol generic, pindolol generic, timolol generic, bisoprolol generic, and carvedilol generic as preferred agents.
- Bystolic[®], betaxolol generic, and Coreg CR[®] as non-preferred agents that require prior authorization.

The February 20, 2009 Recommendations for Antimigraine Agents, Triptans are:

- Maxalt/Maxalt MLT[®], Relpax[®], Imitrex (oral)[®], Imitrex (nasal)[®], and Imitrex SQ as preferred agents.
- sumatriptan generic, Treximet[®], Amerge[®], Axert[®], Frova[®], Zomig/ZomigZMT[®], and Zomig[®] (nasal) as non-preferred agents that require prior authorization.
- Amerge[®] and Zomig/ZomigZMT[®] will be “grandfathered” for current patients. These agents will be non-preferred and require prior-authorization for new patients.

The February 20, 2009 Recommendations for Minimally Sedating Antihistamines are:

- loratadine generic, loratadine syrup, cetirizine generic, and cetirizine syrup as preferred agents.
- Claritin[®] chew, Semprex D[®], cetirizine syrup RX, cetirizine RX generic, Clarinex/Clarinex D[®], Clarinex[®] syrup, Xyzal[®], Xyzal[®] syrup, Allegra[®] syrup,

Allegra ODT, fexofenadine generic, loratadine D generic, and cetirizine D generic as non-preferred agents that require prior authorization.

The February 20, 2009 Recommendations for Ulcerative Colitis Agents are:

- balsalazide generic, sulfasalazine generic, mesalamine rectal generic, Asacol[®], Pentasa[®], and Canasa[®] as preferred agents.
- Dipentum[®] and Lialda[®] as non-preferred agents that require prior authorization.

The February 20, 2009 Recommendations for Skeletal Muscle Relaxants are:

- baclofen generic, chlorzoxazone generic, cyclobenzaprine generic, dantrolene generic, methocarbamol generic, and tizanidine generic as preferred agents.
- orphenadrine generic, orphenadrine compound generic, carisoprodol generic, carisoprodol compound, Soma[®], Skelaxin[®], Zanaflex[®], and Fexmid[®] as non-preferred agents that require prior authorization.
- All current therapeutic prior authorization criteria for carisoprodol remain in effect.

The February 20, 2009 Recommendations for Topical Impetigo Agents are:

- mupirocin ointment generic and Altabax[®] 5G tube as preferred agents.
- Altabax[®] 10G and 15G, and Bactroban[®] cream as non-preferred agents that require prior authorization.

The February 20, 2009 Recommendations for Pulmonary Arterial Hypertension Agents, Oral are:

- Revatio[®] and Letairis[®] as preferred agents.
- Tracleer[®] as a non-preferred agent that requires prior authorization.

The February 20, 2009 Recommendations for Cough and Cold Agents are:

- All generic products both prescription and non-prescription as preferred agents.
- All branded products as non-preferred agents that require prior authorization.
- Cough and Cold preparations restricted to participants 7 years and older. Quantity limits of 4 oz. per prescription and no more than two prescriptions per six months per participant.