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, 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 generic[2], oxcarbazine generic[2], Lyrica®[2], gabapentin generic[2] , 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 generic[2] 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 Hormone[1] 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 Protiens 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 Fluroquinolone 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®, 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® Avalide® as preferred agents.
- Aceon®, Teveten®, Tevetan HCT®, Atacand®, Atacand HCT® , moexepril and moexepril/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 February20, 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.