
Ohio Health Plans Fee-For-Service

Pharmacy Benefit Management Program

Preferred Drug List

(List only)



Effective October 1, 2006

Revised August 3, 2006

Ohio Department of Job and Family Services

ANALGESICS: COX-2 INHIBITORS

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

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

ANALGESICS: OPIOIDS – Long-Acting Oral

| NO PA REQUIRED "PREFERRED" | PA REQUIRED |
|--|--------------------------|
| Extended Release Morphine Products | |
| AVINZA [®] KADIAN [®] MORPHINE SULFATE ER (generic of MS Contin [®]) | ORAMORPH SR [®] |
| Extended Release Oxycodone Products | |
| OXYCODONE ER (generic of Oxycontin [®])* | |

| Extended Release Tramadol Products | |
|---|-------------|
| | ULTRAM ER®* |

- * Quantity limit for oxycodone ER and Oxycontin® of 120 tablets per 30 days.
- * Quantity limit for Ultram ER® of 1 tablet per day

ANALGESICS: OPIOIDS – Long-Acting Topical

| NO PA REQUIRED “PREFERRED” | PA REQUIRED |
|-----------------------------------|--|
| DURAGESIC® PATCH | FENTANYL PATCH (generic of Duragesic®) |

ANALGESICS: OPIOIDS – Immediate-Release Single Entity

| NO PA REQUIRED “PREFERRED” | PA REQUIRED |
|--|--------------------|
| Codeine Products | |
| CODEINE SULFATE TABLETS | |
| Hydromorphone Products | |
| HYDROMORPHONE HCL TABLETS (generic of Dilaudid®) | |
| Meperidine Products | |
| MEPERIDINE TABLETS (generic of Demerol®) | |
| Methadone Products | |
| METHADONE TABLETS (generic of Dolophine®) METHADOSE® DISPERSTABS | |
| Morphine Products | |
| MORPHINE SULFATE: IMMEDIATE-RELEASE TABLETS (generic of MSIR®) MORPHINE SULFATE TABLETS, SOLUBLE | |
| Oxycodone Products | |
| 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 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 [®] PROPOXYPHENE 100MG and APAP 500MG (generic of Darvocet A500 [®]) |
| Pentazocine Combinations | |
| <i>Not advocated for use</i> | 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 |
|---|--|
| Tramadol Products | |
| TRAMADOL (generic of Ultram [®])* | TRAMADOL/APAP (generic of Ultracet [®]) ULTRACET [®] |

* Quantity limit for Tramadol, Tramadol/APAP, and Ultracet[®] 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/5ml (generic of Tylenol w/Codeine Elixir [®]) HYDROCODONE BITARTRATE w/ ACETAMINOPHEN ELIXIR 2.5mg-167mg/5ml (generic of Lortab Elixir [®]) ROXICET ORAL SOLN [®] (5mg Oxycodone-325mg APAP/5ml) | CAPITAL w/CODEINE ORAL SUSP 12mg codeine-120mg APAP/5ml |

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-EMETIC AGENTS

| NO PA REQUIRED "PREFERRED" | PA REQUIRED |
|---|---|
| EMEND [®] EMEND [®] TRIFOLD ZOFRAN [®] TABS 4mg, 8mg ZOFRAN [®] ORAL SOLUTION ZOFRAN [®] ODT | ANZEMET [®] KYTRIL [®] TABS KYTRIL [®] SOLUTION KYTRIL [®] VIAL ZOFRAN [®] TABS 24mg * |

* Zofran[®] 24mg tablets will only be approved if patient has history of lower-strength Zofran tablets and is undergoing chemotherapy treatments.

ANTIHISTAMINES: SECOND GENERATION

| NO PA REQUIRED "PREFERRED" | PA REQUIRED |
|--|--|
| ALAVERT [®] (OTC generic of Claritin [®]) LORATADINE TABLETS (generic of Claritin [®]) LORATADINE SYRUP (generic of Claritin [®] Syrup) LORATADINE RAPID DISS TABLETS (generic of Claritin [®] Redi-tabs) ZYRTEC [®] CHEWABLE TABLETS (no PA required for age 6 or under) ZYRTEC SYRUP [®] (no PA required for age 6 or under) | CLARINEX [®] TABLETS CLARINEX REDI-TABS [®] CLARINEX [®] SYRUP FEXOFENADINE (generic of Allegra [®]) ZYRTEC [®] TABLETS ZYRTEC [®] CHEWABLE TABLETS (PA required for age over 6) ZYRTEC SYRUP [®] (PA required for age over 6) |

ANTIHISTAMINE/DECONGESTANT COMBO: SECOND GENERATION

| NO PA REQUIRED "PREFERRED" | PA REQUIRED |
|--|--|
| ALAVERT D-12HR [®] (OTC generic of Claritin-D [®] -12HR) LORATADINE-D (generic of Claritin-D [®] -12HR and 24HR) | ALLEGRA-D 12 HOUR [®] ALLEGRA-D 24 HOUR [®] CLARINEX-D 24 HOUR [®] CLARITIN-D 12 HOUR [®] RX/OTC CLARITIN-D 24 HOUR [®] RX/OTC ZYRTEC-D [®] |

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

| NO PA REQUIRED "PREFERRED" | PA REQUIRED |
|---|---|
| CEFADROXIL 500MG (generic of Duricef [®]) CEPHALEXIN (generic of Keflex [®]) | CEFADROXIL 1 gram (generic of Duricef [®]) PANIXINE [®] (Cephalexin tablets for oral suspension) VELOSEF [®] (Cephadrine) |

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

| NO PA REQUIRED “PREFERRED” | PA REQUIRED |
|--|---|
| CEPHALEXIN SUSPENSION (generic of Keflex [®] Suspension) DURICEF [®] SUSPENSION | VELOSEF [®] SUSPENSION (Cephadrine Suspension) |

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

| NO PA REQUIRED “PREFERRED” | PA REQUIRED |
|--|---|
| CEFACLOR (generic of Ceclor [®]) CEFUROXIME (generic of Cefdin [®]) | CEFACLOR ER (generic of Ceclor CD [®]) CEFPROZIL (generic of Cefzil [®]) LORABID [®] RANICLOR [®] (Cefaclor chewable tabs) |

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

| NO PA REQUIRED “PREFERRED” | PA REQUIRED |
|---|---|
| CEFACLOR SUSPENSION (generic of Ceclor [®] Susp.) CEFTIN [®] SUSPENSION (no PA required for age 12 or under) | CEFTIN [®] SUSPENSION (PA required for age over 12) CEFPROZIL SUSPENSION (generic of Cefzil [®] susp) LORABID [®] SUSPENSION |

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

| NO PA REQUIRED “PREFERRED” | PA REQUIRED |
|--|---|
| CEDAX [®] OMNICEF [®] | CEFPODOXIME (generic of Vantin [®]) SPECTRACEF [®] SUPRAX [®] |

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

| NO PA REQUIRED “PREFERRED” | PA REQUIRED |
|--|--|
| CEDAX [®] SUSPENSION OMNICEF [®] SUSPENSION | SUPRAX [®] SUSPENSION VANTIN [®] SUSPENSION |

ANTI-INFECTIVES: MACROLIDES

| NO PA REQUIRED "PREFERRED" | PA REQUIRED |
|--|---|
| AZITHROMYCIN TABLETS (generic of Zithromax [®]) BIAXIN [®] SUSPENSION BIAXIN XL [®] CLARITHROMYCIN TABLETS (generic of Biaxin [®]) CLAIRITHROMYCIN ER TABLETS (generic of Biaxin XL [®]) E-MYCIN [®] ERY-TAB [®] ERYPED [®] ERYTHROCIN STEARATE [®] ERYTHROMYCIN BASE ERYTHROMYCIN ESTOLATE ERYTHROMYCIN ETHYLSUCCINATE ERYTHROMYCIN STEARATE ERYTHROMYCIN W/SULFISOXAZOLE ZITHROMAX [®] SUSPENSION ZITHROMAX [®] 1GM PACKETS ZMAX [™] (Azithromycin E.R) FOR ORAL SUSPENSION | CLARITHROMYCIN SUSPENSION (generic of Biaxin [®]) PCE [®] |

ANTI-INFECTIVES: QUINOLONES, FIRST GENERATION

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

ANTI-INFECTIVES: QUINOLONES, SECOND GENERATION

| NO PA REQUIRED "PREFERRED" | PA REQUIRED |
|---|--|
| CIPROFLOXACIN TABS (generic of Cipro [®]) CIPRO [®] SUSPENSION (no PA required for age 12 or under) | CIPRO [®] SUSPENSION (PA required for age over 12) CIPRO XR [®] CIPROFLOXACIN SUSPENSION 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) VALTREX [®] | FAMVIR [®] |

ANTI-INFECTIVES: ANTIFUNGALS – Used for Onychomycosis

| NO PA REQUIRED "PREFERRED" | PA REQUIRED |
|---|--|
| FULVICIN U/F [®] GRIFULVIN V [®] GRIS-PEG [®] LAMISIL [®] PENLAC [®] | SPORANOX [®] 100mg/10ml oral solution ITRACONAZOLE CAPSULES (generic of Sporanox [®]) |

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

| NO PA REQUIRED "PREFERRED" | PA REQUIRED |
|---|--|
| DIFLUCAN [®] SUSPENSION FLUCONAZOLE TABLETS (generic of Diflucan [®]) KETOCONAZOLE (generic of Nizoral [®]) | FLUCONAZOLE suspension SPORANOX [®] 100mg/10ml oral solution ITRACONAZOLE CAPSULES (generic of Sporanox [®]) |

ANTI-INFECTIVES: ANTIFUNGALS - Topical

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

ANTI-MIGRAINE: TRIPTANS - "Fast" Onset

| NO PA REQUIRED "PREFERRED" | PA REQUIRED |
|-----------------------------------|--------------------------------|
| AXERT [®] | ZOMIG [®] |
| IMITREX [®] INJECTION | ZOMIG [®] NASAL SPRAY |
| IMITREX [®] NASAL SPRAY | ZOMIG ZMT [®] |
| IMITREX [®] TABLETS | |
| MAXALT [®] | |
| MAXALT-MLT [®] | |
| RELPAX [®] | |

ANTI-MIGRAINE: TRIPTANS - "Slow" Onset

| NO PA REQUIRED "PREFERRED" | PA REQUIRED |
|-----------------------------------|--------------------|
| AMERGE [®] | |
| FROVA [®] | |

ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS – IMMEDIATE RELEASE

| NO PA REQUIRED “PREFERRED” | PA REQUIRED |
|--|---|
| ADDERALL [®] AMPHETAMINE SALTS (generic of Adderall [®]) 5mg, 10mg, 20mg, 30mg DESOXYN [®] DEXEDRINE [®] TABLETS* DEXTROAMPHETAMINE (generic of Dexedrine [®])* DEXTROSTAT [®] * FOCALIN [®] METHYLIN [®] METHYLIN [®] SOLUTION METHYLPHENIDATE (generic of Ritalin [®]) STRATTERA [®] | AMPHETAMINE SALTS (generic of Adderall [®]) 7.5mg, 12.5mg, 15mg |

* Dextroamphetamine products require clinical PA for age 18 and over

ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS – EXTENDED RELEASE

| NO PA REQUIRED “PREFERRED” | PA REQUIRED |
|---|--|
| ADDERALL [®] XR CONCERTA [®] D-AMPHET [®] SA* DEXEDRINE [®] SPANSULE* FOCALIN [®] XR METADATE [®] CD METADATE [®] ER METHYLIN [®] ER METHYLPHENIDATE ER (generic of Ritalin SR [®]) | DAYTRANA [®] RITALIN [®] LA |

* Dextroamphetamine products require clinical PA for age 18 and over

HEMATOPOIETIC AGENTS

| NO PA REQUIRED “PREFERRED” | PA REQUIRED |
|---|---------------------|
| ARANESP [®] SYRINGE ARANESP [®] VIAL PROCRIT [®] | EPOGEN [®] |

HEPARIN RELATED AGENTS

| NO PA REQUIRED "PREFERRED" | PA REQUIRED |
|---|--------------------|
| ARIXTRA [®] FRAGMIN [®] SYRINGE FRAGMIN [®] VIAL INNOHEP [®] LOVENOX [®] AMPULE LOVENOX [®] PREFILLED SYRINGE LOVENOX [®] VIAL | |

PLATELET AGGREGATION INHIBITORS

| NO PA REQUIRED "PREFERRED" | PA REQUIRED |
|---|--------------------|
| AGGRENOX [®] CILOSTAZOL (generic of Pletal [®]) DIPYRIDAMOLE (generic of Persantine [®]) PLAVIX [®] TICLOPIDINE (generic of Ticlid [®]) | |

CARDIOVASCULAR: ACE INHIBITORS

| NO PA REQUIRED "PREFERRED" | PA REQUIRED |
|---|--|
| BENAZEPRIL (generic of Lotensin [®]) CAPTOPRIL (generic of Capoten [®]) ENALAPRIL (generic of Vasotec [®]) LISINOPRIL (generic of Zestril [®] , Prinivil [®]) | ACEON [®] ALTACE [®] MAVIK [®] FOSINOPRIL (generic of Monopril [®]) QUINAPRIL (generic of Accupril [®]) UNIVASC [®] |

CARDIOVASCULAR: ACE INHIBITORS/CCB Combination

| NO PA REQUIRED "PREFERRED" | PA REQUIRED |
|--|--|
| LOTREL [®] (Amlodipine and Benazepril) TARKA [®] (Verapamil and Trandolapril) | LEXXEL [®] (Felodipine and Enalapril) |

CARDIOVASCULAR: ACE INHIBITORS/DIURETIC Combination

| NO PA REQUIRED "PREFERRED" | PA REQUIRED |
|---|---|
| BENAZEPRIL/HCTZ (generic of Lotensin HCT [®]) CAPTOPRIL/HCTZ (generic of Capozide [®]) ENALAPRIL/HCTZ (generic of Vaseretic [®]) LISINOPRIL/HCTZ (generic of Zestoretic [®] , Prinzide [®]) | MONOPRIL HCT [®] QUINAPRIL/HCTZ (generic of Accuretic [®]) UNIRETIC [®] |

CARDIOVASCULAR: ANGIOTENSIN II RECEPTOR ANTAGONISTS

| NO PA REQUIRED "PREFERRED" | PA REQUIRED |
|--|--|
| AVAPRO [®] COZAAR [®] DIOVAN [®] MICARDIS [®] | ATACAND [®] BENICAR [®] TEVETEN [®] |

CARDIOVASCULAR: ANGIOTENSIN II RECEPTOR ANTAGONISTS/DIURETIC Combination

| NO PA REQUIRED "PREFERRED" | PA REQUIRED |
|---|--|
| AVALIDE [®] DIOVAN HCT [®] HYZAAR [®] MICARDIS HCT [®] | ATACAND HCT [®] BENICAR HCT [®] TEVETEN HCT [®] |

CARDIOVASCULAR: BETA-BLOCKERS

| NO PA REQUIRED "PREFERRED" | PA REQUIRED |
|---|--|
| ACEBUTOLOL (generic of Sectral [®]) ATENOLOL (generic of Tenormin [®]) BETAXOLOL (generic of Kerlone [®]) BISOPROLOL FUMARATE (generic of Zebeta [®]) COREG [®] INDERAL LA [®] LABETALOL (generic of Normodyne [®] , Trandate [®]) METOPROLOL (generic of Lopressor [®]) NADOLOL (generic of Corgard [®]) PINDOLOL (generic of Visken [®]) PROPRANOLOL (generic of Inderal [®]) SORINE [®] SOTALOL (generic of Betapace [®]) SOTALOL AF (generic of Betapace AF [®]) TIMOLOL (generic of Blocadren [®]) | INNOPRAN XL [®] LEVATOL [®] TOPROL XL [®] |

CARDIOVASCULAR: BETA-BLOCKERS/DIURETIC Combination

| NO PA REQUIRED "PREFERRED" | PA REQUIRED |
|---|--|
| ATENOLOL/CHLORTHALIDONE (generic of Tenoretic [®]) BISOPROLOL/HCTZ (generic of Ziac [®]) PROPRANOLOL/HCTZ (generic of Inderide [®]) | CORZIDE [®] INDERIDE LA [®] METOPROLOL/HCTZ (generic of Lopressor HCT [®]) |

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

| NO PA REQUIRED "PREFERRED" | PA REQUIRED |
|---|---|
| AFEDITAB CR (generic of Adalat CC [®]) DYNACIRC [®] DYNACIRC CR [®] FELODIPINE (generic of Plendil [®]) NICARDIPINE (generic of Cardene [®]) NIFEDIAC CC (generic of Adalat CC [®]) NIFEDICAL XL (generic of Procardia XL [®]) NIFEDIPINE ER (generic of Procardia XL [®] , Adalat CC [®]) NORVASC [®] SULAR [®] | CARDENE SR [®] ISRADIPINE (generic of Dynacirc [®]) NIFEDIPINE IMMEDIATE RELEASE (generic of Procardia [®]) NIMOTOP [®] |

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

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

CARDIOVASCULAR: LIPOTROPICS - STATINS

| NO PA REQUIRED "PREFERRED" | PA REQUIRED |
|--|--|
| ADVICOR [®] (Lovastatin and Niacin) CRESTOR [®] LESCOL [®] LESCOL XL [®] LIPITOR [®] * LOVASTATIN (generic of Mevacor [®]) ZOCOR [®] * | ALTOPREV [®] PRAVASTATIN (generic of Pravachol [®]) PRAVIGARD PAC [®] (Pravastatin and Buffered Aspirin) SIMVASTATIN (generic of Zocor [®])* |

* Quantity limits for Lipitor[®], Simvastatin, and Zocor[®] of one tablet per day.

CARDIOVASCULAR: LIPOTROPICS - FIBRIC ACID DERIVATIVES

| NO PA REQUIRED "PREFERRED" | PA REQUIRED |
|---|--|
| GEMFIBROZIL (generic of Lopid [®]) TRICOR [®] | ANTARA [®] LOFIBRA [®] TRIGLIDE [®] |

CARDIOVASCULAR: LIPOTROPICS - NICOTINIC ACID DERIVATIVES

| NO PA REQUIRED PREFERRED | PA REQUIRED |
|---|--------------------|
| NIACIN NIACOR [®] NIASPAN [®] | |

CARDIOVASCULAR: LIPOTROPICS - OMEGA-3 POLYUNSATURATED FATTY ACIDS

| NO PA REQUIRED "PREFERRED" | PA REQUIRED |
|-----------------------------------|---------------------|
| | OMACOR [®] |

CARDIOVASCULAR: LIPOTROPICS - SELECTIVE CHOLESTEROL ABSORPTION INHIBITOR

| NO PA REQUIRED "PREFERRED" | PA REQUIRED |
|-----------------------------------|--------------------|
| ZETIA [®] | |

CARDIOVASCULAR: LIPOTROPICS – STATIN / SELECTIVE CHOLESTEROL ABSORPTION INHIBITOR Combination

| NO PA REQUIRED "PREFERRED" | PA REQUIRED |
|--|--------------------|
| VYTORIN [®] (Simvastatin/Ezetimibe) | |

CARDIOVASCULAR: LIPOTROPICS – STATIN / CCB Combination

| NO PA REQUIRED "PREFERRED" | PA REQUIRED |
|---|--------------------|
| CADUET [®] (Amlodipine/Atorvastatin) * | |

CHRONIC CONSTIPATION AGENTS

| NO PA REQUIRED "PREFERRED" | PA REQUIRED |
|-----------------------------------|----------------------|
| ZELNORM [®] | AMITIZA [®] |

ELECTROLYTE DEPLETERS FOR HYPERPHOSPHATEMIA

| NO PA REQUIRED "PREFERRED" | PA REQUIRED |
|---|--------------------|
| CALCIUM CARBONATE FOSRENOL [®] MAGNEBIND [®] PHOSLO [®] RENAGEL [®] | |

ENDOCRINE: DIABETES - INSULINS - Rapid and Short Acting*

| NO PA REQUIRED "PREFERRED" | PA REQUIRED |
|--|--|
| NOVOLIN R [®] NOVOLOG [®] | APIDRA [®] HUMALOG [®] HUMULIN R [®] HUMULIN R 500-U [®] ILETIN I REG [®] ILETIN II PORK R [®] RELION R [®] |

*Patients on current insulin regimens will be grandfathered.

ENDOCRINE: DIABETES - INSULINS - Intermediate Acting*

| NO PA REQUIRED "PREFERRED" | PA REQUIRED |
|--|--|
| HUMULIN L [®] NOVOLIN N [®] NOVOLIN 70/30 [®] NOVOLOG MIX 70/30 [®] | HUMALOG MIX 75/25 [®] HUMULIN 50/50 [®] HUMULIN N [®] HUMULIN 70/30 [®] ILETIN II PORK L [®] ILETIN II PORK N [®] RELION 70/30 [®] RELION N [®] |

*Patients on current insulin regimens will be grandfathered.

ENDOCRINE: DIABETES - INSULINS - Long Acting*

| NO PA REQUIRED "PREFERRED" | PA REQUIRED |
|-----------------------------------|--|
| LANTUS [®] | HUMULIN U [®] LEVEMIR [®] |

*Patients on current insulin regimens will be grandfathered.

ENDOCRINE: DIABETES – ORAL HYPOGLYCEMICS, ALPHA-GLUCOSIDASE INHIBITORS

| NO PA REQUIRED "PREFERRED" | PA REQUIRED |
|---|--------------------|
| GLYSET [®] PRECOSE [®] | |

ENDOCRINE: DIABETES – ORAL HYPOGLYCEMICS, BIGUANIDES

| NO PA REQUIRED "PREFERRED" | PA REQUIRED |
|--|--|
| METFORMIN (generic of Glucophage [®]) METFORMIN ER (generic of Glucophage XR [®]) | FORTAMET [®] RIOMET [®] 500mg/5ml (Metformin) |

ENDOCRINE: DIABETES – ORAL HYPOGLYCEMICS, BIGUANIDES Combination

| NO PA REQUIRED “PREFERRED” | PA REQUIRED |
|---|--|
| ACTOPLUS MET [®] AVANDAMET [®] | GLIPIZIDE/METFORMIN (generic of Metaglip [®]) GLYBURIDE/METFORMIN (generic of Glucovance [®]) |

ENDOCRINE: DIABETES – ORAL HYPOGLYCEMICS, MEGLITINIDES

| NO PA REQUIRED “PREFERRED” | PA REQUIRED |
|-----------------------------------|----------------------|
| STARLIX [®] | PRANDIN [®] |

ENDOCRINE: DIABETES – ORAL HYPOGLYCEMICS, THIAZOLIDINEDIONES, SULFONYLUREAS Combination

| NO PA REQUIRED “PREFERRED” | PA REQUIRED |
|-----------------------------------|--------------------|
| AVANDARYL [®] | |

ENDOCRINE: DIABETES – ORAL HYPOGLYCEMICS, THIAZOLIDINEDIONES

| NO PA REQUIRED “PREFERRED” | PA REQUIRED |
|--|--------------------|
| ACTOS [®] AVANDIA [®] | |

ENDOCRINE: DIABETES – ORAL HYPOGLYCEMICS, SULFONYLUREAS SECOND GENERATION

| NO PA REQUIRED “PREFERRED” | PA REQUIRED |
|--|--------------------|
| GLIMEPIRIDE (generic of Amaryl [®]) GLIPIZIDE (generic of Glucotrol [®]) GLIPIZIDE ER (generic of Glucotrol XL [®]) GLYBURIDE (generic of Diabeta [®] , Micronase [®]) GLYBURIDE MICRONIZED (generic of GlynasePressTabs [®]) | |

ENDOCRINE: BONE OSSIFICATION ENHANCERS - ORAL BISPHOSPHONATES

| NO PA REQUIRED “PREFERRED” | PA REQUIRED |
|---|--|
| BONIVA [®] DIDRONEL [®] ETIDRONATE (generic of Didronel [®]) FOSAMAX [®] FOSAMAX [®] ORAL SOLN 70mg/75ml FOSAMAX PLUS D [™] | ACTONEL [®] ACTONEL [®] WITH CALCIUM SKELID [®] |

ENDOCRINE: BONE OSSIFICATION ENHANCERS - CALCITONIN-SALMON

| NO PA REQUIRED “PREFERRED” | PA REQUIRED |
|-----------------------------------|-----------------------|
| MIACALCIN [®] | FORTICAL [®] |

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 |
|--|--|
| NEXIUM [®] PREVACID [®] Capsules PREVACID SOLUTAB [®] (No PA required for age 6 or under) | ACIPHEX [®] OMEPRAZOLE (generic of Prilosec [®]) PREVACID GRANULES [®] PREVACID NAPRA-PAC [®] PREVACID SOLUTAB [®] (PA required for age over 6) PRILOSEC OTC [®] PROTONIX [®] ZEGERID [®] (Omeprazole/sodium bicarbonate capsules and granules for suspension) |

GENITOURINARY AGENTS: URINARY ANTISPASMODICS

| NO PA REQUIRED "PREFERRED" | PA REQUIRED |
|---|--|
| DETROL LA [®] ENABLEX [®] FLAVOXATE (generic of Urispas [®]) OXYBUTYNIN (generic of Ditropan [®]) OXYBUTYNIN 5mg/5ml SYRUP (generic of Ditropan [®]) VESICARE [®] | DETROL [®] DITROPAN XL [®] OXYTROL [®] SANCTURA [®] |

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 |
|-----------------------------------|---|
| REBETOL [®] RIBAVIRIN | RIBASPHERE [®] COPEGUS [®] |

HEPATITIS C: INTERFERON/RIBAVIRIN Combination

| NO PA REQUIRED "PREFERRED" | PA REQUIRED |
|-----------------------------------|-----------------------|
| | REBETRON [®] |

MULTIPLE SCLEROSIS AGENTS

| NO PA REQUIRED "PREFERRED" | PA REQUIRED |
|---|--------------------|
| AVONEX [®] BETASERON [®] COPAXONE [®] REBIF [®] TITRATION PACK REBIF [®] SYRINGE | |

OPHTHALMICS: ANTIBACTERIAL - QUINOLONES

| NO PA REQUIRED "PREFERRED" | PA REQUIRED |
|--|---|
| CIPROFLOXACIN (generic of Ciloxan [®]) VIGAMOX [®] ZYMAR [®] | QUIXIN [®] OFLOXACIN (generic of Ocuflor [®]) |

OPHTHALMICS: ANTIHISTAMINES

| NO PA REQUIRED "PREFERRED" | PA REQUIRED |
|-----------------------------------|---|
| | EMADINE [®] LIVOSTIN [®] |

OPHTHALMICS: ANTIHISTAMINE/MAST CELL STABILIZERS

| NO PA REQUIRED "PREFERRED" | PA REQUIRED |
|--|----------------------|
| OPTIVAR [®] PATANOL [®] ZADITOR [®] | ELESTAT [®] |

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

| NO PA REQUIRED "PREFERRED" | PA REQUIRED |
|--|--|
| ALBUTEROL (generic of Proventil [®] , Ventolin [®]) ALBUTEROL SULFATE HFA MAXAIR AUTOHALER [®] VENTOLIN HFA [®] XOPENEX HFA [®] | ALUPENT MDI [®] PROVENTIL HFA [®] |

RESPIRATORY: BETA-ADRENERGIC, SHORT-ACTING Nebulizers

| NO PA REQUIRED "PREFERRED" | PA REQUIRED |
|---|--|
| ACCUNEB [®] (Albuterol – pediatric dosing of premixed nebs) (age 2 to 12 only) ALBUTEROL (generic of Proventil [®] , Ventolin [®]) .083% Premixed nebulizers, 0.5% Concentrated Solution) METAPROTERENOL (generic of Alupent [®] for Nebulization) XOPENEX [®] | ACCUNEB [®] (Albuterol – pediatric dosing of premixed nebs) (below age 2 or above age 12) |

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

| NO PA REQUIRED "PREFERRED" | PA REQUIRED |
|-----------------------------------|----------------------|
| SEREVENT DISKUS [®] | FORADIL [®] |

RESPIRATORY: BETA-ADRENERGIC Combination

| NO PA REQUIRED "PREFERRED" | PA REQUIRED |
|---|--------------------|
| ADVAIR DISKUS [®] (Salmeterol/Fluticasone) | |

RESPIRATORY: COPD ANTICHOLINERGICS

| NO PA REQUIRED "PREFERRED" | PA REQUIRED |
|---|--|
| ATROVENT [®] MDI (Ipratropium) ATROVENT HFA [®] (Ipratropium) COMBIVENT MDI [®] (Ipratropium/Albuterol) IPRATROPIUM nebulizer solution (generic of Atrovent [®]) SPIRIVA [®] (Tiotropium) | DUONEB [®] (Ipratropium/Albuterol) nebulizer solution |

RESPIRATORY: GLUCOCORTICOIDs – Inhaled

| NO PA REQUIRED "PREFERRED" | PA REQUIRED |
|--|-----------------------------------|
| AEROBID [®] AEROBID-M [®] ASMANEX [®] AZMACORT [®] FLOVENT [®] HFA QVAR [®] | PULMICORT TURBUHALER [®] |

RESPIRATORY: GLUCOCORTICOIDs – Nebulizers

| NO PA REQUIRED "PREFERRED" | PA REQUIRED |
|---|--------------------|
| PULMICORT [®] NEBULIZER SOLUTION | |

RESPIRATORY: GLUCOCORTICOIDs - Nasal

| NO PA REQUIRED "PREFERRED" | PA REQUIRED |
|--|---|
| FLONASE [®] NASONEX [®] NASACORT AQ [®] | BECONASE AQ [®] FLUNISOLIDE (generic of Nasarel [®]) FLUTICASONE (generic of Flonase [®]) RHINOCORT AQ [®] |

RESPIRATORY: LEUKOTRIENE RECEPTOR ANTAGONISTS

| NO PA REQUIRED "PREFERRED" | PA REQUIRED |
|--|--------------------|
| ACCOLATE [®] SINGULAIR [®] CHEWABLE TABLETS SINGULAIR [®] TABLETS * SINGULAIR [®] ORAL GRANULES | |

* **Quantity limit for Singulair[®] 10mg of one tablet per day**

SEDATIVE-HYPNOTICS, NON-BARBITURATE

| NO PA REQUIRED "PREFERRED" | PA REQUIRED |
|---|--|
| AMBIEN [®] CR * ESTAZOLAM (generic of Prosom [®]) FLURAZEPAM (generic of Dalmane [®]) LUNESTA [®] * ROZEREM [®] * TEMAZEPAM (generic of Restoril [®]) TRIAZOLAM (generic of Halcion [®]) | AMBIEN [®] * DORAL [®] RESTORIL [®] 7.5mg & 22.5mg SONATA [®] * |

* **Quantity limits for Ambien[®], Ambien CR[®], Lunesta[®], Rozerem[®], and Sonata[®] of one unit per day.**

SKELETAL MUSCLE RELAXANTS - ORAL

| NO PA REQUIRED "PREFERRED" | PA REQUIRED |
|--|---|
| BACLOFEN (generic of Lioresal [®]) CHLORZOXAZONE (generic of Parafon Forte [®] , Remular-S [®]) CYCLOBENZAPRINE (generic of Flexeril [®]) METHOCARBAMOL (generic of Robaxin [®] , Robomol [®]) ORPHENADRINE (generic of Norflex [®]) ORPHENADRINE COMPOUND (generic of Norgesic [®]) ORPHENADRINE COMPOUND FORTE (generic of Norgesic Forte [®]) ORPHENGESIC (generic of Norgesic [®]) ORPHENGESIC FORTE (generic of Norgesic Forte [®]) TIZANIDINE (generic of Zanaflex [®]) | CARISOPRODOL (generic of Soma [®] , Vanadom [®]) * CARISOPRODOL COMPOUND (generic of Soma Compound [®]) * DANTRIUM [®] SKELAXIN [®] |

* **Note: Clinical criteria must be met for Soma[®]/Carisoprodol products**

TOPICAL IMMUNOMODULATORS

| NO PA REQUIRED "PREFERRED" | PA REQUIRED |
|--|--------------------|
| ELIDEL [®] * PROTOPIC [®] * | |

* Elidel[®] & Protopic[®] have age restriction of 2 yrs or older