



Virginia Medicaid Preferred Drug List With Service Authorization Criteria  
Effective July 1, 2013



**Provider Synergies, an affiliate of Magellan Medicaid Administration,  
Virginia Medicaid's Pharmacy Service Administrator**

**Phone: 1-800-932-6648 Fax: 1-800-932-6651**

*General Information:*

- The PDL is a list of preferred drugs, by select therapeutic class, for which the Medicaid Fee-for-service program allows payment without requiring service authorization (SA).
- *Please note that not all drug classes are subject to the Virginia Medicaid PDL.* In the designated classes, drug products classified as non-preferred will be subject to SA. In some instances, other additional clinical criteria may apply to a respective drug class which could result in the need for a SA.
- This list is not all inclusive for non-preferred drugs.
- Fax requests receive a response within 24 hours.
- For urgent requests, please call **1-800-932-6648**.
- Not all medications listed are covered by all DMAS programs. Check individual program coverage.
- All new products included in a PDL class are non-preferred until reviewed by the P&T Committee.

For PDL drug coverage information, visit the following: <http://www.VirginiaMedicaidPharmacyServices.com>. **The following “routine” PDL criteria guidelines will be applied to non-preferred drugs requiring a Service Authorization. Some drug classes will have additional criteria that will be listed alongside the drug class.**

1. Is there any reason the patient cannot be changed to a medication not requiring service authorization within the same class?  
Acceptable reasons include:
  - Allergy to medications not requiring service authorization
  - Contraindication to or drug-to-drug interaction with medications not requiring service authorization
  - History of unacceptable/toxic side effects to medications not requiring service authorization
  - Patient's condition is clinically stable; changing to a medication not requiring service authorization might cause deterioration of the patient's condition.
2. The requested medication may be approved if both of the following are true:
  - If there has been a therapeutic failure of no less than a **one-month trial** of at least **one medication within the same class** not requiring service authorization
  - The requested medications corresponding generic (if a generic is available and covered by the State) has been attempted and failed or is contraindicated.

All changes from last posting will be highlighted in yellow.

*Drugs no longer available have been removed from this list.*



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	<i>Preferred Agents</i>	<i>Non-Preferred Agents</i>	<i>SA Criteria</i>
<b>Analgesics</b>			
<b>Narcotics - Long Acting</b>			
	fentanyl patch Kadian ER® *methadone 10 mg/5ml & 5mg/5ml oral soln *methadone 5mg & 10mg tab morphine sulfate tab SA	Avinza® Butrans® Conzip® ER *Dolophine® Duragesic® Embeda® Exalgo® *Methadose® morphine sulfate ER cap MS Contin® Nucynta® ER Opana® ER Oramorph® SR oxycodone-long acting OxyContin® oxymorphone ER Ryzolt™ tramadol ER Ultram ER®	<p><b>LENGTH OF AUTHORIZATIONS:</b> 6 months</p> <p><b>Routine PDL edit</b></p> <ul style="list-style-type: none"> <li>◆ <b>Step Edit</b> – Trial and failure of 2 different short acting narcotics. The step edit is not required for those patients that have been stabilized on Long Acting Narcotics or need relief of moderate to severe pain requiring around-the-clock opioid therapy for an extended period of time. <b>Still subject to PDL criteria edit.</b></li> <li>◆ <b>PDL Edit</b> – If patient has failed a preferred narcotic or there is any reason the patient cannot be changed to a medication not requiring service authorization.</li> <li>◆ <b>*Methadone Clinical Edits</b> – All methadone will receive a clinical edit to determine reason for use. Low dose strengths are generally used for pain. Please see criteria for clinical edit for methadone 40mg dispersible tablets and 10mg/ml oral concentrated solution for detoxification and maintenance treatment of narcotic addiction.</li> </ul>
<b>Narcotics - Short Acting</b>			
<b>Barbiturate &amp; Non-Salicylates Analgesic Combinations</b>			
	acetaminophen-butalbital	Orbivan CF® Phrenilin Forte® Sedapap®	<p><b>LENGTH OF AUTHORIZATIONS:</b> 3 months</p> <p><b>Routine PDL edit</b></p> <p><b>Clinical edit for narcotic lozenges ONLY.</b></p> <ul style="list-style-type: none"> <li>• The patient has a diagnosis of cancer, <b>AND</b></li> <li>• Is already receiving and tolerant of opioid therapy for their underlying persistent cancer pain. Patients considered opioid tolerant are those who are taking transdermal fentanyl 25 mcg/h, morphine 60 mg/day or more, oxycodone 30 mg/day, oral hydromorphone 8 mg/day, or an equi-analgesic dose of another opioid for one week or longer.</li> </ul>
<b>Lozenges- Narcotic</b>			
		Actiq® Fentora® fentanyl citrate Onsolis®	



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	<b>Opioid Dependency - Methadone products</b> * Diskets <sup>®</sup> 40mg * methadone 10mg/ml Intensol oral concentrated soln *methadone 10mg/ml oral concentrated soln *methadone 40 mg *Methadose <sup>®</sup> 10mg/ml oral concentrated soln *Methadose <sup>®</sup> 40 mg		<b>*Clinical edit for methadone 40mg dispersible tablets &amp; 10mg/ml oral concentrated solution</b> <ul style="list-style-type: none"> <li>FDA approved ONLY for detoxification and maintenance treatment of narcotic addiction</li> <li>Recipient must be enrolled in a methadone treatment program (opioid treatment program, OTP)</li> </ul> <p>Dispensed only by opioid treatment programs (and agencies, practitioners, or institutions by formal agreement with the program sponsor) certified by the Federal Substance Abuse and Mental Health Services Administration and registered by the Drug Enforcement Administration (DEA).</p>
	<b>Opioid Dependency - Buprenorphine products</b> **buprenorphine SL **Suboxone tablets <sup>®</sup> **Suboxone <sup>®</sup> film	** <i>buprenorphine and naloxone tablet</i>	<b>**Clinical edit for Suboxone<sup>®</sup> SL/Film &amp; buprenorphine SL tablets</b>  The following need to be true: <ul style="list-style-type: none"> <li>Diagnosis of opiate abuse/dependence.</li> <li>Prescribed by a qualified physician with Substance Abuse and Mental Health Services Administration Waiver</li> <li>Patient is receiving addiction counseling</li> <li>A chemical dependency assessment has been performed AND</li> <li>Criteria for chemical dependency is met</li> <li>Patient is 16 years of age or older (no exceptions allowed); AND</li> <li>Patient is not pregnant (<b>Suboxone only</b>).</li> <li>Max duration is 24 months</li> <li>Max dose is 16mg/day</li> </ul>
	<b>Short-Acting Narcotics</b> <b>codeine</b> <b>codeine/APAP</b> <b>codeine/APAP/caff/butal</b> <b>codeine/ASA</b> <b>codeine/ASA/caff/butal</b> <b>hydrocodone/APAP</b> <b>hydrocodone/ ASA</b> <b>hydrocodone/ ibuprofen</b> <b>hydrocodone bitartrate &amp; APAP</b> <b>hydromorphone</b> <b>meperidine</b> <b>morphine IR</b> <b>nalbuphine</b> <b>oxycodone IR</b> <b>oxycodone/APAP</b> <b>tramadol HCL</b>	<i>All Brands require a SA</i> <i>Abstral<sup>®</sup></i> <i>codeine solution</i> <i>dihydrocodeine / apap / caffeine</i> <i>Nucynta<sup>®</sup></i> <i>Oxecta<sup>®</sup></i> <i>oxycodone/ASA</i> <i>oxycodone / ibuprofen</i> <i>oxymorphone HCl</i> <i>Primlev<sup>™</sup></i> <i>tramadol HCL/APAP</i> <i>Ultracet<sup>®</sup></i> <i>Ultram<sup>®</sup></i> <i>Zydone</i> <i>Zolvit<sup>®</sup></i>	<p><b>Duration of SA is 3 months for a total of 24 months.</b></p>



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<b>Non-Steroidal Anti-Inflammatory Drugs</b>		
diclofenac potassium etodolac IR ibuprofen indomethacin IR ketoprofen IR ketorolac meloxicam tab nabumetone naproxen naproxen sodium piroxicam sulindac	Anaprox <sup>®</sup> Anaprox DS <sup>®</sup> Ansaid <sup>®</sup> Arthrotec <sup>®</sup> Cataflam <sup>®</sup> Celebrex <sup>®</sup> Clinoril <sup>®</sup> Daypro <sup>®</sup> diclofenac sodium SR <b>diclofenac sodium/misoprostol</b> diflunisal Dolobid <sup>®</sup> Duexis <sup>®</sup> etodolac SR Feldene <sup>®</sup> fenoprofen flurbiprofen Indocin <sup>®</sup> IR & SR <sup>®</sup> indomethacin IR, SR & rectal ketoprofen ER Lodine <sup>®</sup> IR & XL	Meclofenamate mefenamic meloxicam susp Mobic <sup>®</sup> Motrin <sup>®</sup> Nalfon <sup>®</sup> Naprelan <sup>®</sup> Naprosyn <sup>®</sup> naproxen EC Orudis <sup>®</sup> Oruvail <sup>®</sup> oxaprozin Ponstel <sup>®</sup> Prevacid Naprapac <sup>®</sup> Relafen <sup>®</sup> Sprix <sup>®</sup> nasal spray Tolectin DS <sup>®</sup> Toradol <sup>®</sup> tolmetin sodium Vimovo <sup>®</sup> Voltaren <sup>®</sup> Voltaren XR <sup>®</sup> Zipsor <sup>®</sup>
<b>LENGTH OF AUTHORIZATIONS:</b> 1 year <b>Routine PDL edit with exceptions noted below</b>  A one-month trial of at least <u>two medications within the same class</u> not requiring SA is required.  <b>*Step edit required for Celebrex<sup>®</sup></b> <ul style="list-style-type: none"> <li>History of a trial of a minimum of two (2) different non-COX2 NSAIDs within the past year, OR</li> <li>concurrent use of anticoagulants (i.e., warfarin, heparin, etc.), methotrexate, oral corticosteroids, OR</li> <li>history of previous GI bleed or conditions associated with GI toxicity risk factors (i.e., PUD, GERD, etc.), OR specific indication for Celebrex<sup>®</sup>, which medications not requiring Service Authorization are not indicated.</li> </ul>		
<b>Topical Analgesic Agents and Anesthetics</b>		
*Flector <sup>®</sup> patch *Voltaren <sup>®</sup> gel	**Lidoderm <sup>®</sup> patch *Pennsaid <sup>®</sup> topical soln <b>***Solaraze 3% Topical Gel</b>	<b>LENGTH OF AUTHORIZATIONS:</b> 1 year <b>Routine PDL edit</b> <b>*Clinical Criteria for Flector<sup>®</sup>, Voltaren<sup>®</sup> &amp; Pennsaid<sup>®</sup>:</b> Approval is based on patient failing the oral generic of the desired product and at least one other preferred NSAID (to equal a total of at least two preferred). For example, a patient who failed ibuprofen or naproxen will still need to try oral generic diclofenac for approval of Flector <sup>®</sup> .  Pennsaid <sup>®</sup> can only be approved for the FDA approved indication of osteoarthritis of the knee.  Quantity limit for Flector <sup>®</sup> Patch of 30 u per RX <b>(criteria continues on next page)</b>



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			<p><b>**Clinical Criteria for Lidoderm® Patch:</b>            Lidoderm® patches can be approved for relief of pain associated with post-herpetic neuralgia.</p> <p><b>***Solaraze® 3% Gel Clinical Criteria:</b></p> <ul style="list-style-type: none"> <li>Indicated for the topical treatment of actinic keratosis (AK).</li> <li>Sun avoidance is indicated during therapy.</li> <li>Precautions exist for patients with active GI ulceration or bleeding and severe renal or hepatic impairment</li> </ul>
<b>Antibiotic-Anti-Infective</b>			
<b>Oral Antifungals</b>			
	fluconazole tab/susp Griseofulvin® susp Gris-Peg® ketoconazole nystatin tab/susp terbinafine	*Ancobon® <i>clotrimazole (mucous mem)</i> Diflucan® tab/susp flucytosine Grifulvin V® tab griseofulvin tablets griseofulvin ultramicrosize itraconazole **Lamisil® tab/granules ***Onmel® Noxafil® ****Sporanox® cap/soln Terbinex™ kit ***** Vfend® tab/susp voriconazole tab	<p><b>LENGTH OF AUTHORIZATIONS:</b> Duration of the prescription (up to 12 months)  <b>Routine PDL edit plus</b></p> <p><b>* Ancobon® clinical criteria:</b></p> <ul style="list-style-type: none"> <li>Indicated for the treatment of :               <ul style="list-style-type: none"> <li><b>Candida:</b> Septicemia, endocarditis, and UTIs</li> <li><b>Cryptococcus:</b> meningitis, pulmonary infections</li> </ul> </li> <li>Can be approved if the patient has a serious illness that leaves them immunocompromised (i.e. AIDS, cancer, organ transplants).</li> </ul> <p><b>**Lamisil® granules clinical criteria</b></p> <ul style="list-style-type: none"> <li>indication is tinea capitis, AND</li> <li>must be over 4 years of age.</li> </ul> <p><b>** * Onmel® clinical criteria</b></p> <ul style="list-style-type: none"> <li>Indicated for the treatment of onychomycosis of the toenail caused by <i>Trichophyton rubrum</i> or <i>T. mentagrophytes</i>.</li> <li>Patient had a therapeutic trial and treatment failure with oral terbinafine, <b>OR</b></li> <li>Patient has a contraindication to oral terbinafine (i.e. heart failure, hepatic impairment, viral hepatitis).</li> </ul> <p><b>** *Sporanox® clinical criteria</b></p> <ul style="list-style-type: none"> <li>indication are Aspergillosis, Candidiasis (oral or esophageal), Histoplasmosis, Blastomycosis, empiric treatment of febrile neutropenia</li> </ul>



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			<p><b>**** Vfend<sup>®</sup> clinical criteria:</b></p> <ul style="list-style-type: none"> <li>Can be approved without failure on the preferred agent if the patient has any of the following diagnoses:               <ul style="list-style-type: none"> <li>Myelodysplastic Syndrome (MDS),</li> <li>Neutropenic Acute Myeloid Leukemia (AML)</li> <li>Graft versus Host Disease (GVHD)</li> <li>Candidemia (candida krusei)</li> <li>Esophageal Candidiasis</li> <li>Pulmonary or invasive aspergillosis</li> <li>Blastomycosis</li> <li>Serious fungal infections caused by <i>Scedosporium apiospermum</i> (asexual form of <i>Pseudallescheria boydii</i>) and <i>Fusarium</i> spp., including <i>Fusarium solani</i>, in patients intolerant of, or refractory to other therapy.</li> <li>Oropharyngeal/esophageal candidiasis refractory to fluconazole.</li> </ul> </li> <li>Can be approved if the patient has a serious illness that leaves them immunocompromised (i.e. AIDS, cancer, organ transplants).</li> </ul>
	<p align="center"><b>Oral Cephalosporins</b></p>		<p><b>LENGTH OF AUTHORIZATIONS:</b> date of service only; no refills  <b>Routine PDL edit</b></p> <p>Potential reasons for SA are:</p> <ul style="list-style-type: none"> <li>Infection caused by an organism resistant to medications not requiring service authorization</li> <li>A therapeutic failure to no less than a <b><u>three-day trial of one medication within the same class not</u></b> requiring service authorization</li> <li>The patient is completing a course of therapy with a medication requiring a service authorization, which was initiated in the hospital.</li> </ul>
	<p><b>Second Generation Cephalosporins</b></p>		
cefaclor cap cefprozil cap/susp cefuroxime tab	cefaclor ER cefaclor susp Cefitin <sup>®</sup> tab/susp Cefzil <sup>®</sup> tab/susp		
	<p><b>Third Generation Cephalosporins</b></p>		
cefdinir cap/susp Suprax <sup>®</sup> tab/susp	Cedax <sup>®</sup> cap/susp cefditoren pivoxil cefpodoxime proxetil cap/susp Omnicef <sup>®</sup> cap/susp Spectracef <sup>®</sup> Suprax <sup>®</sup> chewable tablet		



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<b>Oral Macrolides</b>				
<b>Macrolides &amp; Ketolides</b>				<b>LENGTH OF AUTHORIZATIONS:</b> date of service only; no refills <b>Routine PDL edit</b>
azithromycin pack/susp/tab clarithromycin tab/susp *E.E.S. <sup>®</sup> *EryC <sup>®</sup> *Eryped <sup>®</sup> 400 susp Ery-tab <sup>®</sup> erythrocin stearate erythromycin base erythromycin ethylsuccinate erythromycin estolate susp erythromycin stearate erythromycin/sulfisoxazole	Biaxin <sup>®</sup> tab/ susp/XL clarithromycin ER Dynabac <sup>®</sup> *Eryped <sup>®</sup> 200 susp erythromycin base DR cap **Ketek <sup>®</sup> PCE <sup>®</sup> Zithromax <sup>®</sup> tab/susp ZMAX <sup>®</sup> susp			
<b>Oral Quinolones</b>				
<b>Second Generation Quinolones</b>				<b>LENGTH OF AUTHORIZATIONS:</b> date of service only; no refills <b>Routine PDL edit</b>
Cipro <sup>®</sup> susp ciprofloxacin tab	Cipro <sup>®</sup> IR & XR ciprofloxacin susp/ER Noroxin <sup>®</sup> ofloxacin Proquin XR <sup>®</sup>			
<b>Third Generation Quinolones</b>				
Avelox <sup>®</sup> ABC PACK levofloxacin tab	Avelox <sup>®</sup> Factive <sup>®</sup> Levaquin <sup>®</sup> tab/susp	levofloxacin susp Proquin XR <sup>®</sup>		
<b>Otic Quinolones</b>				
Ciprodex <sup>®</sup> ofloxacin	Cetraxal <sup>®</sup> Cipro HC <sup>®</sup>		<b>LENGTH OF AUTHORIZATION</b> Date of service only; no refills <b>Routine PDL edit</b>	
<b>Topical</b>				
mupirocin ointment	*Altabax <sup>™</sup> Bactroban <sup>®</sup> cream/ointment Centany <sup>®</sup> Centany AT <sup>®</sup> Kit		<b>LENGTH OF AUTHORIZATIONS:</b> Date of service only; no refills <b>Routine PDL edit</b>  *Quantity Limit of 15 grams per 34 day	



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<b>Antivirals</b>			
	<b>Hepatitis C Agents</b>		
	<b>Interferon</b>		<p><b><u>LENGTH OF AUTHORIZATIONS:</u></b>            All products require a Clinical SA            ➤ <b><u>Interferon Clinical SA</u></b></p> <p><b><u>Clinical SA for initial 16 week SA:</u></b>            Initial approval periods limited to 16-weeks and viral titer obtained at week 12 of therapy.</p> <p><b><u>Clinical SA for established HCV reactors:</u></b></p> <ol style="list-style-type: none"> <li>1) Therapy is approvable for a total of 24 weeks in patients that are HCV genotypes 2 or 3 who have achieved a virologic response (either undetectable HCV RNA [<math>&lt;50</math> IU/mL] or at least a 2-log drop in HCV RNA titer from baseline) at 12 weeks of treatment.</li> <li>2) Therapy is approvable for total of 48 weeks in HCV genotype 1 or 4 patients who have achieved a virologic response (either undetectable HCV RNA [<math>&lt;50</math> IU/mL] or at least a 2-log drop in HCV RNA titer from baseline) at 12 weeks of treatment.</li> <li>3) If patient fails to achieve a virologic response by 12 weeks, further treatment is not indicated.</li> </ol> <p>➤ <b><u>*Protease Inhibitor Clinical SA</u></b></p> <p><b><u>Incivek Clinical SA (Triple Therapy)</u></b></p> <ol style="list-style-type: none"> <li>1) Confirm diagnosis of HCV with genotype 1, AND concurrent therapy with ribavirin and peginterferon, AND no previous protease inhibitor treatment for Hep C.</li> <li>2) At initial prescription fill, if above criteria are met – approve for 12 weeks. Lab work needs to be done at 4 weeks.</li> <li>3) Course of telaprevir should <i>not</i> be repeated.</li> </ol> <p><b><u>Victrelis Clinical SA (Triple Therapy)</u></b></p> <ol style="list-style-type: none"> <li>1) Confirm diagnosis of HCV with genotype 1, AND no previous protease inhibitor treatment for Hep C, AND completed ribavirin and peginterferon for at least</li> </ol>
	Pegasys® Pegasys Conv.Pack® Pegasys ProClick® Peg-Intron® Peg-Intron Redipen®		
	<b>Protease Inhibitor</b>		
	*Incivek® *Victrelis®		



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			<p>4 weeks, AND concurrent therapy with ribavirin and peginterferon</p> <p>2) Evaluate for the following conditions for longer duration of approval:</p> <ul style="list-style-type: none"> <li>a) cirrhosis – Approve for 44 weeks</li> <li>b) Previous treatment with peginterferon and ribavirin with documented lack of achievement of &gt; 2 log reduction at week 12 in previous treatment – Approve for 44 weeks.</li> <li>c) If none of above in a or b, then evaluate below to determine duration of therapy.</li> </ul> <p>3) At initial prescription fill, confirmed diagnosis of HCV with genotype 1 and completed 4 weeks of peginterferon and ribavirin with continuing therapy – approve for 24 weeks.</p> <p>4) After 24 weeks – require labs drawn at weeks 8 and 24. Depending on the result – determine the duration of approval:</p> <ul style="list-style-type: none"> <li>a) Treatment naïve patients: <ul style="list-style-type: none"> <li>i. If week 8 and 24 are both undetectable – triple therapy is completed. No further Victrelis therapy.</li> <li>ii. If week 8 results are detectable and week 24 results are undetectable – then approve Victrelis for 8 more weeks.</li> <li>iii. If week 24 results are detectable, discontinue all 3 therapies (Victrelis and peginterferon/ ribavirin).</li> </ul> </li> <li>b) Previously treated or relapsed patients: <ul style="list-style-type: none"> <li>i. If week 8 and 24 are both undetectable – approve for 8 more weeks for Victrelis and peginterferon/ribavirin (then discontinue all 3)</li> <li>ii. If week 8 results are detectable and week 24 results are undetectable – then approve Victrelis for 8 more weeks.</li> <li>iii. If week 24 results are detectable, discontinue all 3 therapies (Victrelis and peginterferon/ribavirin).</li> </ul> </li> </ul> <p>5) For ALL patients –If at week 12, the HCV-RNA level is &gt; 100 IU/mL, do not approve Victrelis.</p>



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			6) For ALL patients - If at week 24 HCV-RNA results are detectable, discontinue all 3 therapies (Victrelis and peginterferon/ribavirin). Lab work needs to be done at 8, 12, and 24 weeks.
<b>Herpes Oral</b>			
	acyclovir tab/susp famciclovir valacyclovir	Famvir® Valtrex® Zovirax® tab/susp	<b>LENGTH OF AUTHORIZATIONS:</b> 1 year <b>Routine PDL edit</b>
<b>Herpes Topical</b>			
	Abreva OTC® Zovirax® ointment	acyclovir ointment Denavir® Xerese® cream Zovirax® cream	<b>LENGTH OF AUTHORIZATIONS:</b> 1 year <b>Routine PDL edit</b>
<b>Influenza</b>			
	amantadine tab/syrup Relenza Disk® rimantadine Tamiflu® cap/susp	amantadine cap Flumadine® syrup/tab	<b>LENGTH OF AUTHORIZATIONS:</b> For diagnosis of influenza, the authorization is for the date of service only; no refills <b>Routine PDL edit</b>
<b>Bone Resorption Suppression and Related Agents</b>			
<b>Bisphosphonates</b>			
	alendronate Fosamax® soln	Actonel® Actonel® with CA Atelvia DR® Boniva® Binosto™	*Didronel® etidronate Fosamax® Fosamax® plus D ibandronate
			<b>LENGTH OF AUTHORIZATION:</b> 1 year <b>Routine PDL edit</b>  * Indicated only for treatment of Paget's disease of bone OR prevention and treatment of heterotopic ossification following total hip replacement or spinal cord injury.
<b>Calcitonins</b>			
	Miacalcin®	calcitonin-salmon nasal Fortical®	<b>LENGTH OF AUTHORIZATION:</b> 1 year <b>Routine PDL edit</b>
<b>Others</b>			
	Evista®	Forteo®	<b>LENGTH OF AUTHORIZATION:</b> Initial approval will be for 1 year with ONE renewal if demonstrated compliance. Maximum duration of therapy is 24 months during a patient's lifetime.



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			<p><b><u>Forteo® (teriparatide): Indications</u></b></p> <ul style="list-style-type: none"> <li>• Treatment of osteoporosis in postmenopausal women who are at high risk for fracture</li> <li>• Increase of bone mass in men with primary or hypogonadal osteoporosis who are at high risk for fractures</li> <li>• Treatment of men and women with osteoporosis associated with sustained systemic glucocorticoid therapy at high risk for fracture</li> </ul> <p><b>Forteo is indicated if:</b></p> <ul style="list-style-type: none"> <li>• Bone mineral density of -3 or worse or</li> <li>• Postmenopausal women with history of non-traumatic fracture(s) or</li> <li>• Postmenopausal women with two or more of the following clinical risk factors:             <ul style="list-style-type: none"> <li>○ Family history of non-traumatic fracture(s)</li> <li>○ Patient history of non-traumatic fracture(s)</li> <li>○ DXA BMD T-score <math>\leq</math>-2.5 at any site</li> <li>○ Glucocorticoid use* (<math>\geq</math>6 months of use at 7.5 dose of prednisolone equivalent)</li> <li>○ Rheumatoid Arthritis</li> <li>○ Postmenopausal women with BMD T-score <math>\leq</math>-2.5 at any site with any of the following clinical risk factors:                 <ul style="list-style-type: none"> <li>a. More than 2 units of alcohol per day</li> <li>b. Current smoker</li> <li>c. Men w/primary or hypogonadal osteoporosis</li> <li>d. Osteoporosis associated w/sustained systemic glucocorticoid therapy</li> </ul> </li> </ul> </li> </ul>



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<b>Cardiac</b>			
<b>ACE Inhibitors, Angiotensin Receptors Blockers, Beta-Blockers</b>			
<b>ACE Inhibitors</b>			<b>LENGTH OF AUTHORIZATION:</b> 1 year
benazepril captopril enalapril lisinopril ramipril	Accupril® Aceon® Altace® cap/tab fosinopril Lotensin® Mavik® moexipril Monopril®	perindopril Prinivil® quinapril ramipril trandolapril Univasc® Vasotec® Zestril®	<b>Routine PDL edit</b>
<b>ACE Inhibitors + Calcium Channel Blocker Combinations</b>			
amlodipine/benazepril (2.5/10, 5/10, 5/20 & 10/20) Lotrel® (5/40 and 10/40)	amlodipine/benazepril (5/50,10/40) Lotrel® (2.5/10, 5/10, 5/20 & 10/20) Tarka® trandolapril/verapamil hydrochloride ER		
<b>ACE Inhibitors + Diuretic Combinations</b>			
benazepril/HCTZ captopril/HCTZ lisinopril/HCTZ	Accuretic® enalapril/HCTZ fosinopril/HCTZ Lotensin HCT® moexipril/HCTZ	Prinzide® quinapril/HCTZ Uniretic® Univasc® Vaseretic® Zestoretic®	
<b>Angiotensin Receptor Blockers</b>			
*Diovan® losartan	Atacand® Avapro® Benicar® Cozaar® Edarbi®	eprosartan mesylate irbesartan Micardis® Teveten®	<b>*Step edit requires a trial and failure of losartan</b>
<b>Angiotensin Receptor Blockers + Calcium Channel Blocker Combinations</b>			
N/A	Azor® Exforge®	Exforge®HCT Tribenzor®	



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<i>Preferred Agents</i>		<i>Non-Preferred Agents</i>		<i>SA Criteria</i>
<b>Angiotensin Receptor Blockers + Diuretic Combinations</b>				<b>**Step edit requires a trial and failure of losartan/HCTZ</b>
**Diovan HCT <sup>®</sup> losartan/HCTZ	Atacand HCT <sup>®</sup> Avalide <sup>®</sup> Benicar HCT <sup>®</sup> candesartan/HCTZ Edarbyclor <sup>®</sup> Hyzaar <sup>®</sup>	irbesartan- hydrochlorothiazide Micardis HCT <sup>®</sup> Teveten HCT <sup>®</sup> valsartan/HCTZ		
<b>Beta Blockers</b>				
atenolol carvedilol labetalol metoprolol tartrate nadolol propranolol tab/soln Sorine <sup>®</sup> sotalol AF sotalol HCL	acebutaolol Betapace <sup>®</sup> IR / AF <sup>®</sup> betaxolol bisoprolol Bystolic <sup>®</sup> Coreg <sup>®</sup> IR & CR <sup>®</sup> Corgard <sup>®</sup> Innopran <sup>®</sup> XL Kerlone <sup>®</sup> Levatol <sup>®</sup>	Lopressor <sup>®</sup> metoprolol succinate pindolol propranolol LA Sectral <sup>®</sup> Tenormin <sup>®</sup> timolol maleate Toprol XL <sup>®</sup> Trandate <sup>®</sup> Zebeta <sup>®</sup>		
<b>Beta Blockers + Diuretic Combinations</b>				
atenolol/chlorthalidone bisoprolol/HCTZ nadolol/bendroflume- thiazide propranolol/HCTZ	Corzide <sup>®</sup> Dutoprol <sup>®</sup> Inderide <sup>®</sup> Lopressor HCT <sup>®</sup>	metoprolol/HCTZ Tenoretic <sup>®</sup> Ziac <sup>®</sup>		
<b>Direct Renin Inhibitors (includes combination)</b>				
N/A	Amturnide <sup>™</sup> Tekamlo <sup>®</sup> Tekturna <sup>®</sup>	Tekturna HCT <sup>®</sup> Twynta <sup>®</sup> Valturna <sup>®</sup>		
<b>Anticoagulants</b>				
<b>Low Molecular Weight Heparin includes FactorXA Inhibitor</b>			<b>LENGTH OF AUTHORIZATION:</b> 1 year	
Fragmin <sup>®</sup> Disp Syringe Lovenox <sup>®</sup>	Arixtra <sup>®</sup> enoxaparin fondaparinux Fragmin <sup>®</sup> Vial Innohep <sup>®</sup>		<b>Routine PDL edit</b>  * <b>Clinical edit Pradaxa<sup>®</sup></b> Length of Authorization: 1 year <ul style="list-style-type: none"> <li>• Diagnosis of non valvular atrial fibrillation;</li> <li>• If patient is taking a P-gp inducers such as rifampin;</li> </ul>	



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	<i>Preferred Agents</i>	<i>Non-Preferred Agents</i>	<i>SA Criteria</i>
	<p><b>Oral Anticoagulants</b></p> <p><b>warfarin</b></p> <p><b>*Pradaxa®</b></p> <p><b>**Xarelto®</b></p>	<p><i>Coumadin®</i></p> <p><b>***Eliquis™</b></p>	<p>Pradaxa® should not be used, an alternate antithrombotic therapy should be used (new)</p> <ul style="list-style-type: none"> <li>• If the patient taking a P-gp inhibitors such as; dronedarone (Multaq®) or systemic ketoconazole (Nizoral®, or others) in patients with moderate renal impairment (CrCl 30-50 mL/min): Consider reducing Pradaxa® dose to 75 mg twice daily and in patients with severe renal impairment (CrCl &lt;30mL/min): Pradaxa® use not recommended (new)</li> <li>• Use with caution in people over the age of 75 years</li> <li>• Assess renal function prior to initiation of treatment. Periodically assess renal function as clinically indicated (i.e., more frequently in clinical situations that may be associated with a decline in renal function) and adjust therapy accordingly.</li> <li>• For patients with CrCl 15-30 mL/min: 75 mg orally, bid</li> <li>• For patients with CrCl &gt;30 mL/min: 150 mg orally, bid</li> </ul> <p><b>**Clinical Edit for Xarelto® (rivaroxaban)</b></p> <p>Length of <b>authorization: 1 year</b></p> <ul style="list-style-type: none"> <li>• Prophylaxis of DVT/PE in patients after elective hip or knee replacement surgery <b>OR</b></li> <li>• Stroke prophylaxis and systemic embolism prophylaxis in patients with nonvalvular atrial fibrillation.</li> <li>• for the treatment of deep vein thrombosis (DVT), pulmonary embolism (PE),</li> <li>• reduction in the risk of recurrence of DVT and of PE</li> <li>• For hip replacement: 35 tablets/35 days</li> <li>• For knee replacement: 12 tablets/12 days</li> <li>• For atrial fibrillation: 30 tablets/30 days.</li> </ul> <p><b><u>Dosage and Administration:</u></b></p> <p><i>Nonvalvular Atrial Fibrillation:</i></p> <ul style="list-style-type: none"> <li>• If CrCl &gt;50 mL/min: 20 mg PO, QD with evening meal.</li> <li>• If CrCl 15 - 50 mL/min: 15 mg PO, QD with evening meal</li> <li>• Avoid use in patients with CrCl &lt;15 mL/min.</li> </ul> <p><i>Treatment of DVT, PE, and Reduction in the Risk of Recurrence of DVT and of PE:</i></p> <ul style="list-style-type: none"> <li>• 15 mg orally twice daily with food for the first 21</li> </ul>



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	<i>Preferred Agents</i>	<i>Non-Preferred Agents</i>	<i>SA Criteria</i>
			<p>days for the initial</p> <ul style="list-style-type: none"> <li>Treatment of acute DVT or PE. After the initial treatment period, 20 mg orally, once daily with food for the remaining treatment and the long-term reduction in the risk of recurrence of DVT and of PE</li> </ul> <p><u>Prophylaxis of DVT Following Hip or Knee Replacement Surgery:</u></p> <ul style="list-style-type: none"> <li>10 mg orally, once daily with or without food</li> </ul> <p><b>***Clinical Edit Eliquis™</b></p> <p>Length of Authorization: 1 year</p> <ul style="list-style-type: none"> <li>May be approved for the following diagnosis: nonvalvular atrial fibrillation; for prophylaxis of stroke and systemic embolism</li> <li>The recommended dose is 5 mg orally twice daily.</li> <li>In patients with at least 2 of the following characteristics: age ≥80 years, body weight ≤60 kg, or serum creatinine ≥1.5 mg/dL, the recommended dose is 2.5 mg orally twice daily.</li> <li>The dose of Eliquis™ should be decreased to 2.5 mg twice daily when it is co-administered with drugs that are strong dual inhibitors of CYP3A4 and P-gp, (e.g., ketoconazole, itraconazole, ritonavir, or clarithromycin)</li> <li>In patients already taking Eliquis™ at a dose of 2.5 mg twice daily, avoid coadministration with strong dual inhibitors of both CYP3A4 and P-gp</li> <li>Avoid concomitant use of Eliquis™ with strong dual inducers of CYP3A4 and P-gp (e.g., rifampin, carbamazepine, phenytoin, St. John's wort) because such drugs will decrease exposure to apixaban.</li> </ul>
<b>Calcium Channel Blockers: Dihydropyridine CCB &amp; Non-Dihydropyridine CCB</b>			
<b>Dihydropyridine Calcium Channel Blockers</b>			<b>LENGTH OF AUTHORIZATIONS:</b> 1 year
<p>Afeditab CR®            amlodipine            Nifediac CC®            Nifedical XL®            nifedipine            nifedipine ER            nifedipine SA</p>	<p>Adalat®            Adalat CC®            Cardene®            Cardene SR®            Dynacirc® IR &amp; CR®            felodipine ER            isradipine</p>	<p>nisoldipine            nicardipine            Norvasc®            Procardia®            Procardia XL®            Plendil®            Sular®</p>	<p><b>Routine PDL edit</b></p> <p>There are two main classes of Calcium Channel Blockers (each with different actions on the peripheral vasculature and cardiac tissue):</p> <ul style="list-style-type: none"> <li>Dihydropyridine Calcium Channel Blockers</li> <li>Non-Dihydropyridine Calcium Channel Blockers</li> </ul>



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<i>Preferred Agents</i>		<i>Non-Preferred Agents</i>		<i>SA Criteria</i>
<b>Non-Dihydropyridine Calcium Channel Blockers</b>				
<b>Cartia XT<sup>®</sup></b> <b>Diltia XT<sup>®</sup></b> <b>diltiazem IR, ER q 12hr &amp; 24hr</b> <b>diltiazem XR</b> <b>Taztia XT<sup>®</sup></b> <b>verapamil tab IR &amp; ER</b>	<b>Calan<sup>®</sup> IR &amp; SR</b> <b>Cardizem<sup>®</sup> IR, CD &amp; LA</b> <b>Dilacor XR<sup>®</sup></b> <b>diltiazem SR q 12hr</b> <b>Isoptin SR<sup>®</sup></b>	<b>Tiazac<sup>®</sup></b> <b>verapamil ER cap</b> <b>Verelan<sup>®</sup></b> <b>Verelan PM<sup>®</sup></b>		
<b>Lipotropics</b>				
<b>Bile Acid Sequestrants</b>			<b>LENGTH OF AUTHORIZATIONS:</b> 1 year	
<b>cholestyramine powder &amp; light</b> <b>colestipol tab</b> <b>Prevalite<sup>®</sup></b> <b>Welchol<sup>®</sup> tab</b>	<b>Colestid<sup>®</sup> granule/packet/tab</b> <b>colestipol HCl granules</b> <b>Questran<sup>®</sup> powder/powder Light</b> <b>Welchol<sup>®</sup> packet</b>		<b>Routine PDL edit plus</b> <ul style="list-style-type: none"> <li>Therapeutic failure to no less than <b>three-month trial of at least one medication not requiring service authorization.</b></li> </ul>	
<b>Cholesterol Absorption Inhibitor (CAI)</b>				
<b>Zetia<sup>®</sup></b>			<b>FDA announced on June 8, 2011 new safety restrictions (including contraindications &amp; dose limitations) for high-dose simvastatin. FDA recommendations:</b> <ul style="list-style-type: none"> <li>Maintain patients on simvastatin 80 mg or Vytorin 10/80 mg ONLY if they have been taking this dose chronically (for 12 months or more) <i>without</i> evidence of muscle toxicity.</li> <li>Do not start new patients on simvastatin 80 mg or Vytorin 10/80 mg.</li> <li>Place patients who do not meet their LDL-C goal on simvastatin 40 mg or Vytorin 10/40 mg on alternative LDL-C lowering treatment(s) that provides greater LDL-C lowering.</li> <li>Follow the recommendations in the simvastatin-containing medicines labels regarding drugs that may increase the risk for muscle injury when used with simvastatin.</li> <li>Switch patients who need to be initiated on a drug that interacts with simvastatin to an alternative statin with less potential for the drug-drug interaction.</li> </ul>	
<b>Fibric Acid Derivatives</b>				
<b>gemfibrozil</b> <b>Tricor<sup>®</sup></b>	<b>Antara<sup>®</sup></b> <b>fenofibrate (Tricor<sup>®</sup>)</b> <b>fenofibrate (Antara<sup>®</sup>)</b> <b>fenofibric acid</b> <b>Fenoglide<sup>®</sup></b>	<b>Lipofen<sup>®</sup></b> <b>Lofibra<sup>®</sup></b> <b>Lopid<sup>®</sup></b> <b>Triglide<sup>®</sup></b> <b>Trilipix<sup>™</sup></b>		
<b>HMG CoA Reductase Inhibitors and Combinations (High Potency Statins)</b>				
<b>atorvastatin</b> <b>simvastatin</b>	<b>amlodipine/atorvastatin</b> <b>Caduet<sup>®</sup></b> <b>Crestor<sup>®</sup></b>	<b>Lipitor<sup>®</sup></b> <b>Livalo<sup>®</sup></b> <b>Vytorin<sup>®</sup></b> <b>Zocor<sup>®</sup></b>		
<b>HMG CoA Reductase Inhibitors and Combinations (Statins)</b>				
<b>lovastatin</b> <b>pravastatin</b>	<b>Advicor<sup>®</sup></b> <b>Altoprev<sup>®</sup></b> <b>fluvastatin</b> <b>Lescol<sup>®</sup></b>	<b>Lescol XL<sup>®</sup></b> <b>Mevacor<sup>®</sup></b> <b>Pravachol<sup>®</sup></b>	<p>*Step edit requires a history of either a niacin or simvastatin product within the past 365 days</p>	



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<i>Preferred Agents</i>	<i>Non-Preferred Agents</i>	<i>SA Criteria</i>
<b>Microsomal Triglyceride Transfer Protein Inhibitor</b>		<b>**Clinical edit for Lovaza®:</b> <ul style="list-style-type: none"> <li>Step edit requires trial and failure of any other lipotropic.</li> <li>A SA may also be approved without a documented medication trial if they have documented very high triglycerides of (≥ 500 mg/dL) in adult patients.</li> </ul>
	***Juxtapid™	
<b>Niacin Derivatives</b>		
Niacor® Niaspan®		
<b>Niacin Derivatives &amp; HMG CoA Reductase Inhibitors Combination</b>		<b>***Clinical edit for ***Juxtapid™</b> <ul style="list-style-type: none"> <li>Diagnosis of homozygous familial hypercholesterolemia (HoFH).</li> <li>Prescriber must be certified with the Juxtapid™ REMS program.</li> <li>Minimum age restriction of 18 years of age.</li> <li>Patient has had treatment failure, maximum dosing with or contraindication to: statins, ezetimibe, niacin, fibric acid derivatives, omega-3 agents, and bile acid sequestrants.</li> </ul>
	*Simcor®	
<b>Omega 3 Fatty Acid Agent</b>		<b>***Clinical edit for Kynamro™</b> <ul style="list-style-type: none"> <li>Diagnosis of homozygous familial hypercholesterolemia (HoFH).</li> <li>Prescriber must be certified with the Kynamro™ REMS program.</li> <li>Minimum age restriction of 18 years of age.</li> <li>Patient has had treatment failure, maximum dosing with or contraindication to: statins, ezetimibe, niacin, fibric acid derivatives, omega-3 agents, and bile acid sequestrants</li> </ul>
	**Lovaza®	
<b>Oligonucleotide Inhibitor</b>		
	****Kynamro™	
<b>Platelet Inhibitors</b>		<b>LENGTH OF AUTHORIZATION:</b> 1 year <b>Routine PDL edit</b>
clopidogrel dipyridamole Effient® ticlopidine HCL	Aggrenox® Brilinta® Persantine® Plavix®	
<b>Pulmonary Arterial Hypertension Agents</b>		<b>LENGTH OF AUTHORIZATIONS:</b> 1 year <b>Routine PDL edit</b> <b>* Clinical edit for PD5</b> <ul style="list-style-type: none"> <li>Diagnosis of pulmonary hypertension in patients &gt;18 years is required.</li> </ul>
<b>Inhaled Prostacyclin Analogues</b>		
Tyvaso® Ventavis®		



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	<b>Oral Endothelin Receptor Antagonist</b>		<ul style="list-style-type: none"> <li>The requested medication may be approved if the following is true:               <ul style="list-style-type: none"> <li>The prescribing physician is a pulmonary specialist or cardiologist and will be followed by the prescribing physician.</li> </ul> </li> <li>Must have a rationale for not taking the oral Revatio® to receive a SA for the injectable Revatio®.</li> <li>PDE-5 contraindications where SA should not be approved:               <ul style="list-style-type: none"> <li>Concurrent use of nitrates (e.g., nitroglycerin)</li> <li>Hypersensitivity to product</li> </ul> </li> </ul>
	Letairis® Tracleer®		
	<b>Phosphodiesterase 5 Inhibitors</b>		
	*Adcirca™ sildenafil	*Revatio injection® *Revatio®	
<b>Central Nervous System</b>			
	<b>Antimigraine Agents</b>		
	Maxalt® MLT Relpax® sumatriptan succinate cartridge/nasal/pen/tab/vial	Alsuma® Amerge® Axert® Cambia® Frova® Imitrex® cartridge/nasal/pen/tab/vial Maxali® naratriptan rizatriptan tab/mlt Sumavel® Dosepro Treximet® Zomig® tab/nasal spray/ZMT	<b>LENGTH OF AUTHORIZATIONS:</b> 6 months <b>Routine PDL edit</b>
	<b>Non-Ergot Dopamine Receptor Agonist</b>		
	pramipexole ropinirole HCl	Mirapex® & ER Neupro® Requip® IR & XR ropinirole HCl ER	<b>LENGTH OF AUTHORIZATIONS:</b> 1 year <b>Routine PDL edit</b>
	<b>Sedatives / Hypnotics</b>		
	chloral hydrate syrup flurazepam temazepam 15mg & 30mg	Doral® estazolam Halcion®	Restoril® temazepam 7.5 mg & 22.5 mg triazolam
			<b>LENGTH OF AUTHORIZATIONS:</b> Length of the prescription (up to 3 months) <b>Routine PDL edit</b>



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<b>Sedatives / Hypnotics (Non-Benzodiazepine)</b>		
Rozerem <sup>®</sup> zolpidem	Ambien <sup>®</sup> IR & CR Edluar <sup>™</sup> Intermezzo <sup>®</sup> Lunesta <sup>®</sup> Silenor <sup>®</sup>	Somnote <sup>®</sup> Sonata <sup>®</sup> Zaleplon <sup>®</sup> zolpidem CR Zolpimist <sup>™</sup> spray
<b>Skeletal Muscle Relaxants</b>		
baclofen chlorzoxazone cyclobenzaprine HCL dantrolene sodium methocarbamol tizanidine tab	Amrix <sup>®</sup> *carisoprodol *carisoprodol/ASA *carisoprodol/ASA/ codeine cyclobenzaprine ER Dantrium <sup>®</sup> Fexmid <sup>®</sup> Flexeril <sup>®</sup> Lorzone <sup>®</sup> metaxalone Norflex <sup>®</sup> orphenadrine citrate	orphenadrine/ASA/caff eine Parafon Forte <sup>®</sup> DSC Robaxin <sup>®</sup> Skelaxin <sup>®</sup> *Soma <sup>®</sup> tizanidine cap Zanaflex <sup>®</sup>
<p><b>LENGTH OF AUTHORIZATIONS:</b></p> <ul style="list-style-type: none"> <li>• 1 year for chronic conditions (as defined on the next page)</li> <li>• Duration of prescription (up to 3 months) for acute conditions (as defined on the next page)</li> <li>• One month per every 6 months carisoprodol products</li> </ul> <p><b>Routine PDL edit</b></p> <p><b>*Clinical edit for carisoprodol products</b></p> <ul style="list-style-type: none"> <li>• The patient is at least 16 years of age.</li> <li>• Only approve for ACUTE, painful musculoskeletal conditions. Do not approve for chronic pain.</li> <li>• Quantity limit = 4 tablets per day</li> <li>• Limit approval to one month supply (120 tablets)</li> <li>• Additional authorization will not be granted for at least 6 months following the last day of the previous course of therapy.</li> </ul>		
<b>Smoking Cessation</b>		
bupropion SR Chantix <sup>®</sup> Chantix <sup>®</sup> Tab DS PK nicotine gum/ lozenge/ patch	Nicoderm CQ <sup>®</sup> Patch Nicorette <sup>®</sup> Gum/ Lozenges Nicotrol <sup>®</sup> Inhaler & NS Zyban <sup>®</sup>	<b>LENGTH OF AUTHORIZATIONS:</b> 6 months <b>Routine PDL edit</b>
<b>Stimulants/ADHD Medications</b>		
<b>Amphetamine Products</b>		
amphetamine salts combo dextroamphetamine Vyvanse <sup>®</sup>	Adderall <sup>®</sup> IR *Adderall <sup>®</sup> XR amphetamine salts combo XR Desoxyn <sup>®</sup>	Dexedrine <sup>®</sup> dextroamphetamine SR Dextrostat <sup>®</sup> methamphetamine Procentra <sup>®</sup> sol
<p><b>LENGTH OF AUTHORIZATION:</b> 1 year</p> <p><b>Routine PDL edit</b></p> <p><b>*Adderall XR<sup>®</sup></b></p> <p>If a trial &amp; failure of a preferred product occurs and the physician requests Adderall XR<sup>®</sup> or amphetamine salts combo XR. The brand Adderall XR<sup>®</sup> is preferred over the generic.</p>		



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	<b>Methylphenidate Products</b> <b>Focalin XR®</b> <b>All methylphenidate generic IR tablets</b> <b>methylphenidate SR</b>	<i>Concerta®</i> <i>Daytrana®</i> <i>dexmethylphenidate</i> <i>Focalin®</i> <i>Metadate CD®</i> <i>Metadate ER®</i> <i>Methylin ER®</i> <i>Methylin chew®</i>	<i>Methylin® soln</i> <i>methylphenidate soln</i> <i>methylphenidate LA</i> <i>Ritalin®</i> <i>Ritalin LA®</i> <i>Ritalin SR®</i> <b>***Quillivant™ XR</b> <b>25 mg/5 mL Susp</b>	<b>***Quillivant™ XR criteria</b> <ul style="list-style-type: none"> <li>Methylphenidate SR and all methylphenidate IR tablets generic are covered without SA; clinical reason as to why the extended release suspension is required.</li> </ul>
	<b>Miscellaneous Products</b> <b>Strattera®</b>	<i>Intuniv®</i> <i>Kapvay® SR 12H</i> <b>**modafinil</b> <b>**Nuvigil™</b> <b>**Provigil®</b>	<b>**Clinical Criteria for Nuvigil™/Provigil®:</b> Length of Authorization: <ul style="list-style-type: none"> <li>1 year for sleep apnea and narcolepsy;</li> <li>6 months for shift work sleep disorder.</li> </ul> ➤ Approvable diagnosis include: <ul style="list-style-type: none"> <li><b>Sleep Apnea:</b> Requires documentation/confirmation via sleep study.</li> <li>Requires documentation that C-PAP has been maximized.</li> <li><b>Narcolepsy:</b> Documentation of diagnosis via sleep study.</li> <li><b>Shift Work Sleep disorder: ONLY APPROVABLE FOR 6 MONTHS,</b> work schedule must be verified and documented. Shift work is defined as working the all night shift.</li> </ul> ➤ Minimum age of <b>16 years</b> for <b>Provigil® (modafinil)</b> Minimum age of <b>17 years</b> for <b>Nuvigil™ (armodafinil)</b>	



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<b>Dermatologic</b>			
<b>Dermatologic Agents</b>			
<b>Combination Benzoyl Peroxide &amp; Clindamycin for Acne</b>			<b>LENGTH OF AUTHORIZATION:</b> 1 year
<b>benzoyl peroxide clindamycin phosphate gel/soln</b>	<i>Acanya™</i> <i>Azelex®</i> <i>Benzaclin®</i> <i>Benzefoam™</i> <i>Benzefoam Ultra™</i> <i>Benzaclin™</i> <i>W/Pump</i> <i>benzoyl peroxide cleanser/Micro- spheres cleanser</i> <i>BPO Kit</i> <i>Cleocin T® Gel</i> <i>Cleocin T® Lotion</i> <i>Cleocin T® Med. Swab</i> <i>Clindacin™ Pac Kit</i> <i>Clindagel®</i>	<i>clindamycin 1%/Benzoyl Peroxide 5%</i> <i>clindamycin phosphate foam/lotion/med.swab</i> <i>Delos Lotion™</i> <i>Duac® gel</i> <i>Evoclin™</i> <i>Inova™</i> <i>Lavoclen™ Cleanser</i> <i>Lavoclen™ Kit</i> <i>Pacnex®</i> <i>Pacnex® HP</i> <i>Pacnex® LP</i> <i>Se BPO 7-5.5% Wash Kit</i> <i>Se BPO Cleanser</i>	<b>Routine PDL edit plus</b>  Failure to respond to a therapeutic trial of at least two weeks of one preferred medication.  <b>Clinical Edit for Dermatologic Acne Agents</b> <ul style="list-style-type: none"> <li>• Products will automatically pay for children &lt; 18</li> <li>• All adults over the age of 18 will require a SA to determine diagnosis for treatment</li> <li>• Products are intended for Acne <b>only</b>; a SA for a <b>Cosmetic indication cannot be approved</b></li> </ul>
<b>Topical Agents for Psoriasis</b>			
<b>Dovonex® Calcipotriene Solution</b>	<i>anthralin</i> <i>calcipotriene cr/oint</i> <i>Calcitrene®</i> <i>calcitriol</i> <i>Dovonex® Scalp</i>	<i>Micanol®</i> <i>Sorilux™</i> <i>Taclonex®</i> <i>Taclonex® Scalp</i> <i>Vectical</i>	
<b>Topical Retinoids/Combinations for Acne</b>			
<b>Differin® cream 0.1%</b> <b>Differin® gel 0.1% &amp; 0.3%</b> <b>Differin® 0.1% topical lotion</b> <b>Retin®-A Micro</b> <b>Retin®-A Micro Pump</b> <b>tretinoin</b>	<i>adapalene 0.1% cream</i> <i>adapalene 0.1% topical gel</i> <i>Altinac®</i> <i>Atralin</i> <i>Avita® Cream &amp; Gel</i>	<i>Epiduo®</i> <i>Retin®-A cream/gel</i> <i>Tazorac®</i> <i>tretinoin microsphere gel &amp; gel pump</i> <i>Tretin®-X</i> <i>Ziana®</i>	



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<i>Preferred Agents</i>	<i>Non-Preferred Agents</i>	<i>SA Criteria</i>
<b>Endocrine and Metabolic Agents</b>		
<b>Androgenic Agents (Testosterone – Topical)</b>		
<b>Androgel<sup>®</sup></b>	<b>Androderm<sup>®</sup></b> <i>Axiron<sup>®</sup> soln</i> <i>Fortesta<sup>®</sup></i> <i>Testim<sup>®</sup></i>	<b>LENGTH OF AUTHORIZATION:</b> 1 year <b>Routine PDL edit plus</b> Failure to respond to a therapeutic trial of at least one week of one preferred medication
<b>Antihyperuricemics</b>		
<b>allopurinol</b> <b>Probenecid<sup>®</sup></b> <b>probenecid &amp; colchicine</b>	<i>*Colcrys<sup>®</sup></i> <i>Uloric<sup>®</sup></i> <i>Zyloprim<sup>®</sup></i>	<b>LENGTH OF AUTHORIZATION:</b> 1 year <b>Routine PDL edit</b>  <b>*Clinical Criteria for: Colcrys<sup>™</sup></b> Approve if one of the following is true: <ul style="list-style-type: none"> <li>• Diagnosis of Familial Mediterranean Fever; OR</li> <li>• For Acute Gout Flare: <ul style="list-style-type: none"> <li>○ Trial and failure of one of the following: <ul style="list-style-type: none"> <li>▪ NSAID (i.e., indomethacin, naproxen, ibuprofen, sulindac, ketoprofen) OR</li> <li>▪ Corticosteroid</li> </ul> </li> </ul> </li> </ul>
<b>Contraceptives</b>		
<b>Etonogestrel/Ethinyl Estradiol Vaginal Ring</b>		<b>LENGTH OF AUTHORIZATION:</b> 1 year <b>Routine PDL edit</b>
<b>NuvaRing<sup>®</sup></b>		
<b>Norelgestromin/Ethinyl Estradiol Transdermal</b>		
<b>Ortho Evra<sup>®</sup></b>		
<b>Oral Contraceptives</b>		
<b>Apri<sup>®</sup></b> <b>Cryselle<sup>™</sup></b> <b>Enpresse<sup>®</sup></b> <b>Femcon Fe<sup>®</sup></b> <b>Junel Fe<sup>®</sup></b> <b>Loestrin<sup>®</sup></b> <b>Loestrin Fe<sup>®</sup></b> <b>Microgestin<sup>®</sup></b> <b>Microgestin Fe<sup>®</sup></b> <b>Mircette<sup>®</sup></b> <b>Micronor<sup>®</sup></b> <b>Norinyl 1+50<sup>®</sup></b>	<i>All other oral contraceptives</i> <i>Lo-Ovral-28<sup>®</sup></i> <i>Ortho-Cyclen<sup>®</sup></i> <i>Portia<sup>®</sup></i>	



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	<i>Preferred Agents</i>	<i>Non-Preferred Agents</i>	<i>SA Criteria</i>
	Nor-Q-D <sup>®</sup> Nortrel <sup>®</sup> Ortho-Novum <sup>®</sup> Ortho Tri-Cyclen <sup>®</sup> Ortho Tri-Cyclen Lo <sup>®</sup> Ovcon <sup>®</sup> -50 Sprintec <sup>®</sup> Tri-Sprintec <sup>®</sup> Trivora-28 <sup>®</sup> Yasmin <sup>®</sup> 28 Yaz <sup>®</sup> Zovia <sup>®</sup> 1-35E & 1-50E		
<b>Diabetes Hypoglycemics: Injectable Amylin Analogs</b>			
		*Symlin <sup>®</sup> *Symlin <sup>®</sup> Pens	<b><u>LENGTH OF AUTHORIZATION:</u></b> 1 year <b>*Clinical edit</b> <ul style="list-style-type: none"> <li>• The recipient must have a history of at least a 90 day trial of insulin.</li> <li>• Symlin<sup>®</sup> is only indicated as adjunct therapy with insulin.</li> <li>• Member meeting ALL of the following criteria may be approved:               <ul style="list-style-type: none"> <li>○ Diagnosis of Type 1 or 2 diabetes</li> <li>○ On insulin therapy</li> <li>○ Failure to achieve adequate glycemic control (HbA1c ≤ 6.5%)</li> </ul> </li> </ul>
<b>Diabetes Hypoglycemics: Injectable Incretin Mimetics</b>			
	Byetta <sup>®</sup>	Bydureon <sup>™</sup> Victoza <sup>®</sup>	<b><u>LENGTH OF AUTHORIZATION:</u></b> 1 year <b>Routine PDL edit</b>
<b>Diabetes Hypoglycemics: Injectable Insulins</b>			
<b>Insulin Mix</b>			
	Humalog <sup>®</sup> Mix 50/50 vial Humalog <sup>®</sup> Mix 75/25 vial Humulin <sup>®</sup> 70/30/vial Novolog <sup>®</sup> Mix 70/30 pen/vial Novolin <sup>®</sup> 70/30 vial	Humalog <sup>®</sup> Mix 50/50 Kwikpen Humalog <sup>®</sup> Mix 75/25 Kwikpen Humulin <sup>®</sup> 70/30 pen otc	<b><u>LENGTH OF AUTHORIZATION:</u></b> 1 year <b>Routine PDL edit</b>



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<i>Preferred Agents</i>	<i>Non-Preferred Agents</i>	<i>SA Criteria</i>
<b>Insulin N</b>		
Humulin <sup>®</sup> N vial Novolin <sup>®</sup> N vial	Humulin <sup>®</sup> N pen	
<b>Insulin R</b>		
Humulin <sup>®</sup> R vial Novolin <sup>®</sup> R vial		
<b>Long-Acting Insulins</b>		
Lantus <sup>®</sup> vial Levemir <sup>®</sup> pen/vial	Lantus Solostar <sup>®</sup> and cartridge	
<b>Rapid-Acting Insulins</b>		
Humulin 500 U/M vial Humalog <sup>®</sup> vial Novolog <sup>®</sup> cartridge/ Flexpen Syringe/vial	Apidra <sup>®</sup> cartridge, Solostar, and vial Humalog <sup>®</sup> Cartridge Humalog Kwikpen <sup>®</sup>	
<b>Diabetes Oral Hypoglycemics</b>		
<b>Oral Hypoglycemics Alpha-Glucosidase Inhibitors</b>		<b>LENGTH OF AUTHORIZATION:</b> 1 year Routine PDL edit
acarbose Glyset <sup>®</sup>	Precose <sup>®</sup>	
<b>Oral Hypoglycemics Biguanides</b>		
metformin metformin ER	Fortamet <sup>®</sup> Glucophage <sup>®</sup> IR & XR Glutmetza <sup>®</sup> Riomet <sup>®</sup> susp	
<b>Oral Hypoglycemics Biguanide Combination Products</b>		
glyburide/metformin	glipizide/metformin Glucovance <sup>®</sup> Metaglip <sup>®</sup>	
<b>Oral Hypoglycemics DPP-IV Inhibitors and Combination</b>		
Janumet <sup>®</sup> Janumet XR <sup>®</sup> Januvia <sup>®</sup> Jentadueto <sup>™</sup> Tradjenta <sup>™</sup>	Juvisync <sup>™</sup> Kazano <sup>™</sup> Kombiglyze XR <sup>™</sup> Nesina <sup>™</sup> Onglyza <sup>™</sup> Oseni <sup>™</sup>	



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	<i>Preferred Agents</i>	<i>Non-Preferred Agents</i>	<i>SA Criteria</i>
<b>Oral Hypoglycemics Meglitinides</b>			
	<b>Starlix<sup>®</sup></b>	<i>nateglinide</i> <i>Prandin<sup>®</sup></i> <i>PrandiMet<sup>TM</sup></i>	
<b>Oral Hypoglycemics Second Generation Sulfonylureas</b>			
	<b>glimepiride</b> <b>glipizide</b> <b>glipizide ER</b> <b>glyburide</b> <b>glyburide micronized</b>	<i>Amaryl<sup>®</sup></i> <i>Diabeta<sup>®</sup></i> <i>Glucotrol<sup>®</sup></i> <i>Glucotrol XL<sup>®</sup></i> <i>Glynase<sup>®</sup></i>	
<b>Oral Hypoglycemics Sodium Glucose Co-Transporter 2 Inhibitor (SGLT2)</b>			
		<i>Invokana<sup>TM</sup></i>	
<b>Oral Hypoglycemics Thiazolidinediones</b>			
	<b>Avandamet<sup>®</sup></b> <b>Avandia<sup>®</sup></b> <b>pioglitazone</b>	<i>Actoplus Met<sup>®</sup></i> <i>Actos<sup>®</sup></i> <i>Actoplus Met XR<sup>®</sup></i> <i>Avandaryl<sup>®</sup></i> <i>Duetact<sup>®</sup></i> <i>pioglitazone / metformin</i>	
<b>Erythropoiesis Stimulating Proteins: Epogen<sup>®</sup>, Procrit<sup>®</sup> (Erythropoietin) &amp; Aranesp<sup>®</sup> (Darbepoetin)</b>			
	<b>Procrit<sup>®</sup></b>	<i>Aranesp<sup>®</sup></i> <i>Epogen<sup>®</sup></i>	<p><b>LENGTH OF AUTHORIZATION:</b> for duration of the prescription up to 6 months  <b>Routine PDL edit</b></p> <p><b>Clinical Information for Pharmacists:</b></p> <p>RENEWAL REQUESTS for patients with anemia due to chronic renal failure/end stage renal disease should be approved, even if the Hgb or Hct are above the cutoff point.</p> <p><i>Omontys<sup>®</sup> is not PDL eligible, medical only</i></p>



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	<i>Preferred Agents</i>	<i>Non-Preferred Agents</i>	<i>SA Criteria</i>
	<p><b>Growth Hormone</b></p> <p>Genotropin<sup>®</sup>            Nutropin AQ<sup>®</sup> NuSpin<sup>™</sup></p>	<p>Humatrope<sup>®</sup> cartridge/vial            Norditropin cartridge<sup>®</sup>            Norditropin FlexPro<sup>®</sup> &amp; Nordiflex<sup>®</sup>            Nutropin<sup>®</sup>            Nutropin AQ<sup>®</sup> cartridge/vial            Omnitrope<sup>®</sup>            Saizen<sup>®</sup> cartridge/vial            Serostim<sup>®</sup>            Tev-Tropin<sup>®</sup>            Zorbtive<sup>®</sup></p>	<p><b>All Growth Hormones require a clinical SA</b></p> <p><b>Clinical Criteria for PEDIATRIC Patients (18 years of age and under):</b></p> <p><b><u>LENGTH OF AUTHORIZATION</u></b> (pediatrics): 1 year</p> <ul style="list-style-type: none"> <li>• Prescriber is an endocrinologist, nephrologist, infectious disease specialist or HIV specialist or one has been consulted on this case,</li> <li>• The patient has open epiphysis and one of the following diagnoses               <ul style="list-style-type: none"> <li>○ Turner Syndrome</li> <li>○ Prader-Willi Syndrome</li> <li>○ Renal insufficiency</li> <li>○ Small for gestational age (SGA) - including Russell-Silver variant and patient is &lt; 2 years old</li> <li>○ Idiopathic Short Stature (for request for renewal only (a) information is required to be approved)</li> <li>○ Growth hormone deficiency (physician should provide the required information below)</li> <li>○ Newborn with hypoglycemia and a diagnosis of hypopituitarism or panhypopituitarism.</li> </ul> </li> <li>• Height is more than 2 SD (standard deviations) below average for the population mean height for age and sex, and a height velocity measured over one year to be 1 SD below the mean for chronological age, or for children over two years of age, a decrease in height SD of more than 0.5 over one year; AND</li> <li>• Growth hormone response of less than 10ng/ml to at least two provocative stimuli of growth hormone release: insulin, levodopa, L-Arginine, clonidine, or glucagon</li> </ul> <p><b><u>Requests for Renewal (pediatrics):</u></b></p> <ul style="list-style-type: none"> <li>○ For renewal, a response must be documented. Patient must demonstrate improved/normalized growth velocity. (Growth velocity has increased by at least 2 cm in the first year and is greater than 2.5</li> </ul>



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	<i>Preferred Agents</i>	<i>Non-Preferred Agents</i>	<i>SA Criteria</i>
			<p>cm per year), AND</p> <ul style="list-style-type: none"> <li>o Patient height is more than 1 standard deviation (2”) below mid-parental height (unless parental height is diminished due to medical or nutritional reasons).</li> </ul> <p><b>Clinical Criteria for ADULTS (&gt; 18 years of age)</b>  <b><u>LENGTH OF AUTHORIZATION: 1 year (Serostim® – 3 months * see below)</u></b></p> <ul style="list-style-type: none"> <li>• Prescriber is an endocrinologist</li> <li>• Diagnosis of growth hormone deficiency confirmed by growth hormone stimulation tests and rule-out of other hormonal deficiency, as follows: growth hormone response of fewer than five nanograms per mL to at least two provocative stimuli of growth hormone release: insulin, levodopa, L-Arginine, clonidine or glucagon when measured by polyclonal antibody (RIA) or fewer than 2.5 nanograms per mL when measured by monoclonal antibody (IRMA);</li> <li>• Cause of growth hormone deficiency is Adult Onset Growth Hormone Deficiency (AO-GHD), alone or with multiple hormone deficiencies, such as hypopituitarism, as a result of hypothalamic or pituitary disease, radiation therapy, surgery or trauma</li> <li>• Other hormonal deficiencies (thyroid, cortisol or sex steroids) have been ruled out or stimulation testing would not produce a clinical response such as in a diagnosis of panhypopituitarism.</li> </ul> <p><b>Zorbtive®</b> - Diagnosis of short bowel syndrome</p> <p><b>Serostim®</b></p> <ul style="list-style-type: none"> <li>• Diagnosis of AIDS Wasting or cachexia</li> <li>• Patient has a documented failure, intolerance, or contraindication to appetite stimulants and/or other anabolic agents (both Megace® and Marinol®)</li> </ul> <p><b>*Length of Authorization</b> (Serostim® only): 3 months initial; then 1 year.  Renewal is contingent upon improvement in lean body mass or weight measurements.</p>



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	<i>Preferred Agents</i>	<i>Non-Preferred Agents</i>	<i>SA Criteria</i>
			<b>Requests for Renewal (adults)</b> Renewal is contingent upon prescriber affirmation of positive response to therapy (improved body composition, reduced body fat, and increased lean body mass).
<b>Progestational Agents</b>			
	medroxyprogesterone acetate (tablet only) norethindrone acetate progesterone injection Prometrium® Provera®	Aygestin® progesterone cap	<b>LENGTH OF AUTHORIZATION:</b> 1 year <b>Routine PDL edit plus</b>  Failure to respond to a therapeutic trial of at least one week of one non-service authorized medication
<b>Progestins Used For Cachexia</b>			
	megestrol acetate	Megace® Megace® ES	<b>LENGTH OF AUTHORIZATION:</b> 1 year <b>Routine PDL edit</b>
<b>Vaginal Estrogens</b>			
	Premarin® Vaginal cream Vagifem® Vaginal tab	Estrace® Vaginal cream Estring® Vaginal ring Femring® Vaginal ring	<b>LENGTH OF AUTHORIZATION:</b> 6 months <b>Routine PDL edit</b>
<b>Gastrointestinal</b>			
<b>Histamine-2 Receptor Antagonists (H-2 RA)</b>			
	famotidine (OTC & RX) ranitidine tab/syrup (OTC & RX)	Axid® cap/soln (OTC & RX) cimetidine tab/syrup (OTC & RX) famotidine oral susp (OTC & RX) nizatidine cap/susp Pepcid® oral susp/tab (OTC & RX) ranitidine cap (OTC & RX) Tagamet® (OTC & RX) Zantac® syrup/ tab (OTC & RX)	<b>LENGTH OF AUTHORIZATION:</b> 1 year <b>Routine PDL edit</b>
<b>Motility Agents – GI Stimulants</b>			
	metoclopramide	Metozolv® ODT Reglan®	<b>LENGTH OF AUTHORIZATION:</b> 12 weeks <b>Routine PDL edit</b>  This medication should be reviewed for need at each request for reauthorization. <b>Black box warning placed on product for TARDIVE DYSKINESIA 2/27/2009</b>



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	<i>Preferred Agents</i>	<i>Non-Preferred Agents</i>	<i>SA Criteria</i>
<b>Proton Pump Inhibitors</b>			
	<p>pantoprazole  Prilosec® OTC</p>	<p>Aciphex®  Dexilant®  lansoprazole  Nexium®  omeprazole RX &amp; OTC 20mg  omeprazole/sodium bicarbonate  Prevacid® RX &amp; OTC  Prevacid® solutab (no SA required if age &lt; 12yrs)  Prilosec® Rx  Prilosec® susp  Protonix®  Zegerid® cap  Zegerid® OTC  Zegerid® susp packet</p>	<p><b>LENGTH OF AUTHORIZATIONS:</b>  12 weeks; unless recipient meets an exception; then 1 year  <b>Routine PDL edit</b></p> <p><b>Additional PDL edit criteria</b>  The requested medication may be approved if both of the following are true:</p> <ul style="list-style-type: none"> <li>• If there has been a therapeutic failure of no less than a <b>three-month trial</b> of <b>at least two different</b> medication within the same class not requiring service authorization</li> <li>• The requested medications corresponding generic (if a generic is available and covered) has been attempted and failed or is contraindicated)</li> </ul> <p><b>Exceptions that allow a 1 year SA for PPIs</b>  (Exceptions apply to the duration of the SA only. PDL edit still prevails before a non-preferred may be approved)</p> <ul style="list-style-type: none"> <li>○ Erosive Esophagitis</li> <li>○ Active GI Bleed</li> <li>○ Zollinger-Ellison Syndrome</li> <li>○ Greater than 65 years of age</li> <li>○ Under the care of a Gastroenterologist and has ruled out a nonsecretory condition</li> </ul>
<b>Ulcerative Colitis Oral and Rectal Preparations (5-ASA DERIVATIVES)</b>			
<b>Ulcerative Colitis – Oral</b>			
<p>Asacol®  Apriso®  balsalazide disodium  Pentasa®  sulfasalazine DR &amp; IR</p>	<p>Asacol® HD  Azulfidine® DR  Azulfidine® IR  Colazal®  Delzicol™</p>	<p>Dipentum  *Giazo™  Lialda®  Uceris™</p>	<p><b>LENGTH OF AUTHORIZATION:</b> 1 year  <b>Routine PDL edit</b></p> <p>*Giazo is limited to an 8 week supply</p>
<b>Ulcerative Colitis – Rectal</b>			
<p>Canasa® rectal supp  mesalamine enema</p>	<p>Fiv-Asa®  mesalamine kit  Rowasa® enema &amp; kit</p>	<p>Rowasa® supp. rect  SFRowasa®</p>	
<b>Genitourinary</b>			



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<i>Preferred Agents</i>	<i>Non-Preferred Agents</i>	<i>SA Criteria</i>
<b>Alpha-Blockers and Androgen Hormone Inhibitors For Benign Prostatic Hypertrophy (BPH)</b>		
<b>Alpha-Blockers for BPH</b>		<b>LENGTH OF AUTHORIZATION:</b> 1 year <b>Routine PDL edit</b>  <b>*Step edit for</b> <b>Avodart®</b> - the generic finasteride must be tried and failed before approval <b>Cialis®</b> - must try and fail both Alpha Blockers and Androgen Hormone Inhibitors for BPH and the physician must attest that the member is not on the state list of sex offenders. The patient must have had a consult or been evaluated by an Urologist.
alfuzosin tamsulosin HCL	Flomax® Rapaflo® Uroxatral®	
<b>Androgen Hormone Inhibitors for BPH</b>		
*Avodart® finasteride	Jalyn® Proscar®	
<b>Phosphodiesterase (PDE) 5 Inhibitor for BPH</b>		
	*Cialis®	
<b>Phosphate Binders</b>		
Calcium Acetate 667mg cap Fosrenol® Renagel®	Calcium Acetate 667mg tab Eliphos® Phoslo®	Phoslyra® Renvela® powder/tablet
<b>LENGTH OF AUTHORIZATION:</b> 1 year <b>Routine PDL edit</b>		
<b>Urinary Antispasmodics</b>		
oxybutynin tab/syrup Oxytrol® transdermal Sanctura® XR Toviaz™	Detrol® & Detrol® LA Ditropan® & *Ditropan® XL Enablex® Gelnique™ gel	Myrbetriq™ *oxybutynin ER Sanctura® trospium IR & ER VESIcare®
<b>LENGTH OF AUTHORIZATION:</b> 1 year <b>Routine PDL edit</b> <b>*Oxybutynin ER, Ditropan XL®:</b> • Allow PDL exception for children age 6-18 with a diagnosis of neurogenic bladder.		
<b>Immunological Agents</b>		
<b>Atopic Dermatitis: Topical</b>		
*Elidel®	*Protopic®	<b>LENGTH OF AUTHORIZATION:</b> 1 year <b>Routine PDL edit</b> <b>*Clinical edit for Elidel® and Protopic®</b> <ul style="list-style-type: none"> <li>• Patient must have a FDA approved diagnosis:               <ul style="list-style-type: none"> <li>○ Atopic dermatitis (a type of eczema):</li> <li>○ Elidel®: mild to moderate for ages &gt; 2 years.</li> <li>○ Protopic® 0.03%: moderate to severe for ages &gt; 2 years.</li> <li>○ Protopic® 0.1%: moderate to severe for ages &gt; 18 years.</li> </ul> </li> <li>• Failure to topical corticosteroids (i.e., desonide, fluticasone propionate, hydrocortisone butyrate, etc.)</li> </ul>



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	<i>Preferred Agents</i>	<i>Non-Preferred Agents</i>	<i>SA Criteria</i>
			<p><b><u>Critical information</u></b></p> <ul style="list-style-type: none"> <li>• Black box warnings are in place for both products as well as a requirement for a patient guide to be given with each product dispensed.</li> <li>• Use Elidel<sup>®</sup> and Protopic<sup>®</sup> only as second-line agents for short-term and intermittent treatment of atopic dermatitis (eczema) in patients unresponsive to, or intolerant to topical corticosteroids (i.e., desonide, fluticasone propionate, hydrocortisone butyrate, etc.)</li> <li>• Avoid use of Elidel<sup>®</sup> and Protopic<sup>®</sup> in children younger than 2 years of age. The effect of Elidel and Protopic on the developing immune system in infants and children is not known. In clinical studies, infants and children younger than 2 years old treated with Elidel<sup>®</sup> had a higher rate of upper respiratory infections than did those treated with placebo cream.</li> <li>• Use Elidel<sup>®</sup> and Protopic<sup>®</sup> only for short periods of time, not continuously. The long term safety of Elidel<sup>®</sup> and Protopic<sup>®</sup> are unknown</li> <li>• Children and adults with a weakened or compromised immune system should not use Elidel<sup>®</sup> or Protopic<sup>®</sup>.</li> <li>• Use the minimum amount of Elidel<sup>®</sup> or Protopic<sup>®</sup> needed to control the patient's symptoms. In animals, increasing the dose resulted in higher rates of cancer.</li> </ul>
<b>Multiple Sclerosis</b>			
	<p>Avonex<sup>®</sup>            Avonex<sup>®</sup> Adm Pack            Betaseron<sup>®</sup>            Copaxone<sup>®</sup>            Rebif<sup>®</sup></p>	<p>*Ampyra<sup>®</sup>            Aubagio<sup>®</sup>            Extavia<sup>®</sup>            Gilenya<sup>®</sup>            Rebif<sup>®</sup> Rebidose<sup>®</sup>            Tecfidera<sup>™</sup></p>	<p><b><u>LENGTH OF AUTHORIZATION:</u></b> 1 year</p> <p><b><u>Routine PDL edit</u></b>            Gilenya<sup>®</sup> is to be used as monotherapy ONLY.</p> <p><b><u>* Clinical edit for AMPYRA<sup>®</sup></u></b></p> <ul style="list-style-type: none"> <li>• The patient has a diagnosis of Multiple Sclerosis and a gait disorder or difficulty walking</li> <li>• Patient has no history of seizures</li> <li>• Patient's Creatinine Clearance [CrCL] ≥ 50 mL/min.</li> <li>• If patient has a gait disorder, they may receive an 8 week trial of Ampyra<sup>®</sup></li> <li>• If after 8 week trial the physician states that the patient showed improvement or that the drug was effective (by improved Timed 25-foot Walk), the patient may receive</li> </ul>



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	<i>Preferred Agents</i>	<i>Non-Preferred Agents</i>	<i>SA Criteria</i>	
			authorization for Ampyra <sup>®</sup> for one year.  <b><u>LENGTH OF AUTHORIZATION FOR AMPYRA<sup>®</sup>:</u></b> Initial 8 weeks then, 1 year after successful trial	
<b>Self Administered Drugs for Rheumatoid Arthritis</b>				
	Enbrel <sup>®</sup> Humira <sup>®</sup>	Cimzia <sup>®</sup> Cimzia <sup>®</sup> SyringeKit Kineret <sup>®</sup> Orencia <sup>®</sup> Simponi <sup>®</sup> * Xeljanz <sup>™</sup>	<b><u>LENGTH OF AUTHORIZATION:</u></b> 1 year <b>Routine PDL edit</b>  <b>* Xeljanz<sup>™</sup> Clinical Criteria</b> <ul style="list-style-type: none"> <li>• For the treatment of moderately to severely active rheumatoid arthritis in patients who have had an inadequate response or intolerance to methotrexate.</li> <li>• The patient had a therapeutic trial and treatment failure with <b>ONE</b> of the following preferred drugs: Enbrel<sup>®</sup>, or Humira<sup>®</sup>, AND</li> <li>• Confirm failure of methotrexate therapy, AND</li> <li>• Confirm absence of concurrent use of biologic DMARD, azathioprine, and cyclosporine.</li> </ul>	
<b>Ophthalmic</b>				
	<b>Antibiotics</b>			
	bacitracin/ polymyxin b sulfate ointment ciprofloxacin drops erythromycin gentamicin drops/ointment Moxeza <sup>®</sup> drops neomycin/polymyxin/gramicidin ofloxacin drops polymyxin/trimethoprim sulfacetamide soln tobramycin Vigamox <sup>®</sup> drops	AzaSite <sup>™</sup> drop bacitracin Besivance <sup>®</sup> drops Bleph <sup>®</sup> - 10 Ciloxan <sup>®</sup> drops/ointment Garamycin <sup>®</sup> drops/ointment Ilotycin <sup>®</sup> levofloxacin drops	Natacyn <sup>®</sup> neomycin/bacitracin/polymyxin ointment Neosporin <sup>®</sup> Ocuflox <sup>®</sup> drops Polytrim <sup>®</sup> sulfacetamide ointment Tobrex <sup>®</sup> drops /ointment Zymaxid <sup>®</sup> drops	<b><u>LENGTH OF AUTHORIZATION:</u></b> for the date of service only; no refills <b>Routine PDL edit</b>



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<i>Preferred Agents</i>		<i>Non-Preferred Agents</i>		<i>SA Criteria</i>
<b>Antihistamines/Mast Cell Stabilizers</b>				
<b>Antihistamines</b>				<b>LENGTH OF AUTHORIZATION:</b> 1 year <b>Routine PDL edit</b>  *Illevro™ is limited to 1 bottle plus 1 refill
Alaway OTC®	azelastine drops			
ketotifen fumerate	Bepreve®			
Optivar® drops	Elestat® drops			
Pataday® drops	Emadine® drop			
Zaditor® OTC drops	epinastine 0.05% eye drops			
	*Illevro™ 0.3% drops			
	Lastacaft® drops			
	Patanol® drops			
<b>Mast Cell Stabilizers</b>				
<b>cromolyn sodium</b>	Alamast® drops			
	Alocril® drops			
	Alomide® drops			
	Crolom® drops			
<b>Anti-inflammatory</b>				
<b>diclofenac sodium</b>	Acular®	bromfenac 0.09%	<b>LENGTH OF AUTHORIZATION:</b> for the date of service only; no refills <b>Routine PDL edit</b>	
<b>flurbiprofen sodium</b>	Acular LS®	Lotemax™ 0.5%		
<b>ketorolac 0.4%</b>	Acular PF®	Gel		
<b>ketorolac 0.5%</b>	Acuvail®	Ocufen®		
<b>Nevanac®</b>	Bromday®	Prolensa™		
		Voltaren®		
<b>Glaucoma Agents</b>				
<b>Alpha 2 Adrenergic Agents</b>				<b>LENGTH OF AUTHORIZATION:</b> 1 year <b>Routine PDL edit</b>
<b>Alphagan P® 0.1 &amp; 0.15%</b>	apraclonidine 0.5% drops			
<b>brimonidine 0.2%</b>	brimonidine tartrate 0.15%			
<b>Iopidine® 0.5% &amp; 1%</b>				
<b>Beta Blockers</b>				
<b>betaxolol 0.5%</b>	Betagan® 0.25% & 0.5%			
<b>Betimol® 0.25% &amp; 0.5%</b>	Istalol® 0.5%			
<b>Betoptic-S® 0.25%</b>	Ocupress® 1%			
<b>carteolol 1%</b>	optipranolol 0.3%			
<b>Combigan®</b>	Timoptic® drops 0.25% & 0.5%			
<b>levobunolol 0.25% &amp; 0.5%</b>	Timoptic® XE 0.25% & 0.5% Sol-Gel			
<b>metipranolol 0.3%</b>				
<b>timolol maleate 0.25% &amp; 0.5%</b>				
<b>timolol maleate 0.5 % Sol-Gel</b>				



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	<i>Preferred Agents</i>	<i>Non-Preferred Agents</i>	<i>SA Criteria</i>
	<b>Carbonic Anhydrase Inhibitors</b>		
	<b>Azopt<sup>®</sup> 1% dorzolamide dorzolamide/timolol</b>	<i>Cosopt<sup>®</sup> 0.5%-2% Cosopt<sup>®</sup> PF Trusopt<sup>®</sup> 2%</i>	
	<b>Prostaglandin Analogs</b>		
	<b>latanoprost Travatan Z<sup>®</sup></b>	<i>Lumigan<sup>®</sup> 0.03% &amp; 0.01% travoprost 0.004% Xalatan<sup>®</sup> 0.005% Zioptan<sup>™</sup></i>	
<b>Respiratory</b>			
<b>Antihistamines: First and Second Generation</b>			
<b>First Generation Antihistamines</b>			<b>LENGTH OF AUTHORIZATION:</b> 1 year
<b>Generic only class</b>	<i>All Brands require a SA</i>		<b>Routine PDL edit</b>
<b>Second Generation Antihistamines and Combinations</b>			
<b>cetirizine liquid 1mg/1ml (RX &amp; OTC) cetirizine tabs (OTC) loratadine tab &amp; syrup (OTC)</b>	<i>Allegra<sup>®</sup> tab/ susp/ ODT Allegra-D<sup>®</sup> 12 h &amp; 24 hr cetirizine chew tab( OTC) cetirizine liquid 5mg/5ml OTC cetirizine D tab( OTC) Clarinex<sup>®</sup> syrup/tab/Rapid Tab Clarinex- D<sup>®</sup> 24 &amp; 12 hr Claritin-D<sup>®</sup> Rx &amp; OTC forms Claritin<sup>®</sup> tab/Chewable (RX &amp; OTC) <b>desloratadine ODT</b> fexofenadine fexofenadine/PSE &amp; 60/120 ER levocetirizine loratadine ODT loratadine D 12 &amp;24 HR Xyzal<sup>®</sup> Zyrtec<sup>®</sup> tab/chew/syrup(OTC &amp; RX) Zyrtec-D<sup>®</sup> (OTC &amp; RX)</i>		
<b>Beta-Adrenergic Agents</b>			
<b>Long Acting Beta Adrenergic agents (LABA) Metered Dose Inhalers or Nebulizers</b>			<b>LENGTH OF AUTHORIZATION:</b> 1 year
<b>*Foradil<sup>®</sup> *Serevent Diskus<sup>®</sup></b>	<i>*Arcapta Neohaler<sup>®</sup> *Brovana<sup>®</sup> *Perforomist<sup>®</sup></i>		<b>Routine PDL edit</b>



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	<i>Preferred Agents</i>	<i>Non-Preferred Agents</i>	<i>SA Criteria</i>																						
	<p><b>Short Acting Metered Dose Inhalers or Devices</b></p> <p><b>Proventil<sup>®</sup> HFA</b></p>	<p><i>Maxair Autohaler</i>  <i>Proair<sup>®</sup> HFA</i>  <i>Ventolin<sup>®</sup> HFA</i>  <i>Xopenex<sup>®</sup> HFA</i></p>	<p><b>*Clinical edit for LABAs</b>  <b>Length of Authorization 3 months</b>            Each product listed below will require a SA for ages less than the FDA/PI indicated age.</p> <table border="1"> <thead> <tr> <th data-bbox="1312 412 1577 440"><b>Brand Name</b></th> <th data-bbox="1577 412 1944 440"><b>Age where SA is required</b></th> </tr> </thead> <tbody> <tr> <td data-bbox="1312 440 1577 505">Advair<sup>®</sup> Diskus 250/50, &amp; 500/50</td> <td data-bbox="1577 440 1944 505">Children &lt; 12 years</td> </tr> <tr> <td data-bbox="1312 505 1577 545">Advair<sup>®</sup> Diskus 100/50</td> <td data-bbox="1577 505 1944 545">Children &lt; 4 years</td> </tr> <tr> <td data-bbox="1312 545 1577 586">Advair<sup>®</sup> HFA</td> <td data-bbox="1577 545 1944 586">Children &lt; 12 years</td> </tr> <tr> <td data-bbox="1312 586 1577 626">Arcapta<sup>®</sup> Neohaler</td> <td data-bbox="1577 586 1944 626">Children &amp; Adolescents &lt; 18 years</td> </tr> <tr> <td data-bbox="1312 626 1577 667">Brovana<sup>®</sup></td> <td data-bbox="1577 626 1944 667">Children &amp; Adolescents &lt; 18 years</td> </tr> <tr> <td data-bbox="1312 667 1577 708">Dulera<sup>®</sup></td> <td data-bbox="1577 667 1944 708">Children &lt; 12 years</td> </tr> <tr> <td data-bbox="1312 708 1577 748">Foradil<sup>®</sup> Aerolizer</td> <td data-bbox="1577 708 1944 748">Children &lt; 5 years</td> </tr> <tr> <td data-bbox="1312 748 1577 789">Perforomist<sup>®</sup></td> <td data-bbox="1577 748 1944 789">Children &amp; Adolescents &lt; 18 years</td> </tr> <tr> <td data-bbox="1312 789 1577 829">Serevent<sup>®</sup> Diskus</td> <td data-bbox="1577 789 1944 829">Children &lt; 4 years</td> </tr> <tr> <td data-bbox="1312 829 1577 870">Symbicort<sup>®</sup></td> <td data-bbox="1577 829 1944 870">Children &lt; 12 years</td> </tr> </tbody> </table> <p>Controller medication should be used first, LABAs must be used for the shortest duration of time required to achieve control of symptoms and discontinued, if possible, once control is achieved. Patients should then be maintained on a controller medication (i.e. inhaled corticosteroid).</p>	<b>Brand Name</b>	<b>Age where SA is required</b>	Advair <sup>®</sup> Diskus 250/50, & 500/50	Children < 12 years	Advair <sup>®</sup> Diskus 100/50	Children < 4 years	Advair <sup>®</sup> HFA	Children < 12 years	Arcapta <sup>®</sup> Neohaler	Children & Adolescents < 18 years	Brovana <sup>®</sup>	Children & Adolescents < 18 years	Dulera <sup>®</sup>	Children < 12 years	Foradil <sup>®</sup> Aerolizer	Children < 5 years	Perforomist <sup>®</sup>	Children & Adolescents < 18 years	Serevent <sup>®</sup> Diskus	Children < 4 years	Symbicort <sup>®</sup>	Children < 12 years
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Serevent <sup>®</sup> Diskus	Children < 4 years																								
Symbicort <sup>®</sup>	Children < 12 years																								
	<p><b>COPD: Bronchodilators and Phosphodiesterase 4 (PDE4) Inhibitors</b></p> <p><b>Atrovent HFA<sup>®</sup></b>  <b>Combivent<sup>®</sup> MDI</b>  <b>Combivent<sup>®</sup> Respimat</b>  <b>ipratropium bromide soln</b>  <b>ipratropium/albuterol nebs</b>  <b>Spiriva<sup>®</sup></b></p>	<p><i>Daliresp<sup>®</sup></i>  <i>Duoneb<sup>®</sup></i>  <i>Tudorza<sup>™</sup></i></p>	<p><b>LENGTH OF AUTHORIZATION:</b> 1 year  <b>Routine PDL edit</b></p> <p><b>Specific Information for Daliresp<sup>®</sup></b></p> <ul style="list-style-type: none"> <li>• If the patient has a diagnosis of severe COPD associated with chronic bronchitis and a history of exacerbations <u>and</u></li> <li>• Trial/failure on at least one first-line or second-line agent (inhaled anticholinergics, long acting beta agonists or inhaled corticosteroids) <u>and</u></li> <li>• Adjunctive therapy (Daliresp<sup>®</sup> must be used in conjunction with first-line or second-line agent)</li> </ul>																						



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<i>Preferred Agents</i>	<i>Non-Preferred Agents</i>	<i>SA Criteria</i>
<b>Corticosteroids: Inhaled and Nasal Steroids</b>		
<b>Inhaled Corticosteroids: Combination Products (Glucocorticoid and Long Acting Beta Adrenergic)</b>		<b>LENGTH OF AUTHORIZATION:</b> 1 year <b>Routine PDL edit</b>
*Advair <sup>®</sup> Diskus & HFA *Dulera <sup>®</sup> *Symbicort <sup>®</sup>		
<b>Inhaled Corticosteroids: Metered Dose Inhalers</b>		
Asmanex <sup>®</sup> Flovent <sup>®</sup> Diskus & HFA Pulmicort Flexhaler <sup>®</sup> QVAR <sup>®</sup>	Alvesco <sup>®</sup>	
<b>Inhaled Corticosteroids: Nebulizer Solution</b>		
Pulmicort <sup>®</sup> Respules	Budesonide	
<b>Nasal Steroids</b>		
Nasacort <sup>®</sup> AQ Nasonex <sup>®</sup>	Beconase AQ <sup>®</sup> Dymista <sup>™</sup> Flonase <sup>®</sup> flunisolide fluticasone Nasarel <sup>®</sup> Omnaris <sup>®</sup>	Qnasl <sup>™</sup> Rhinocort Aqua <sup>®</sup> triamcinolone acetonide Tri-Nasal <sup>®</sup> Veramyst <sup>®</sup> Zetonna <sup>™</sup>
<b>Cough and Cold Agents</b>		
<b>Drug Name and GNN</b>	All other <u>legend</u> cough and cold product are non-preferred  Tessalon ®perle	<b>LENGTH OF AUTHORIZATION:</b> Date of Service <b>Routine PDL edit</b>  <b>Clinical Edit for Cough and Cold Agents – All children under 6 will not be eligible for cough and cold products.</b>
Ala-Hist DM-brompheniramine/ phenylephrine/ dextromethorphan		
benzonatate cap		
Carbatuss-12 <sup>®</sup> Carbetapen Cit, Carbetap Tan, PE HCl, PE Tan		
Centergy <sup>®</sup> phenylephrine/ chlorpheniramine		
codeine/ promethazine		
guaifenesin/codeine phosphate		
hydrocodone/ homatropine		
iophen-C NR guaifenesin/codeine phosphate		



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	<i>Preferred Agents</i>	<i>Non-Preferred Agents</i>	<i>SA Criteria</i>
	<b>Lohist-DM syrup</b> <i>brompheniramine/  dextromethorphan/  phenylephrine</i>		
	<b>phenylephrine HCl/promethazine HCl</b>		
	<b>poly hist DHC</b> <i>pyrilamine/  phenylephrine/  dihydrocodeine</i>		
	<b>poly-tussin DHC</b> <i>brompheniramine/  phenylephrine/  dihydrocodeine</i>		
	<b>promethazine DM syrup</b>		
	<b>Tusnel<sup>®</sup> Pediatric Drops</b> <i>dextromethorphan/guaiifenesin/pseudoephedrine</i>		
<b>Intranasal Antihistamines</b>			
	<b>Astelin<sup>®</sup></b> <b>Patanase<sup>®</sup></b>	<i>azelastine 0.1%</i> <i>Astepro<sup>®</sup> 0.15%</i>	<b><u>LENGTH OF AUTHORIZATION:</u></b> 1 year <b>Routine PDL edit</b>
<b>Leukotriene Receptor Antagonists</b>			
	<b>Accolate<sup>®</sup></b> <b>montelukast tabs and chew tabs</b> <b>Singulair<sup>®</sup> 4 mg Granules</b>	<i>Singulair<sup>®</sup> tablets and chew tabs</i> <i>zafirlukast</i> <i>Zyflo<sup>™</sup></i> <i>Zyflo CR<sup>™</sup></i>	<b><u>LENGTH OF AUTHORIZATION:</u></b> 1 year <b>Routine PDL edit</b>