

Medi-Cal/Healthy Families Drug Formulary • 2010

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MEDI-CAL/HEALTHY FAMILIES DRUG FORMULARY

The Molina Healthcare Medi-Cal/Healthy Families Drug Formulary was created to help manage the quality of our members' pharmacy benefit. The Formulary is the cornerstone for a progressive program of managed care pharmacotherapy. Prescription drug therapy is an integral component of your patient's comprehensive treatment program. The Formulary was created to ensure that Molina members receive high quality, cost-effective, rational drug therapy.

The Molina Healthcare Pharmacy and Therapeutics Committee meets quarterly to review and recommend medications for Formulary consideration. This assures that the Formulary remains responsive to physician and patient needs. The Committee is composed of physicians and pharmacists representing various medical specialties. With a primary consideration to provide a safe, effective and comprehensive Formulary, the Committee evaluated all therapeutic categories and has selected the most cost-effective agent(s) in each class.

The Committee also uses reference materials from the CVS/Caremark Pharmacy and Therapeutics Advisory Panel. In addition, the Molina Healthcare Pharmacy and Therapeutics Committee reviews prior authorization procedures to ensure medications are used safely, following manufacturer's guidelines and current medical practices. Please familiarize yourself with the Drug Formulary as you prescribe medications for Molina members. Thank you for your cooperation.

PRESCRIPTION CLAIMS PROCESSOR

Molina Healthcare has selected CVS/Caremark as the Pharmacy Benefit Management (PBM) Company to manage the prescription benefit for Molina members.

- Questions on processing claims, formulary status or rejected claims may be directed to the CVS/Caremark Help Desk at (800) 770-8014.
- Membership and eligibility concerns may be addressed by calling the Molina Membership Services at (800) 526-8196 x 129522.
- Provider-related questions may be addressed by calling the Molina Provider Services Help Desk at (800) 526-8196 x 129516.

PREFACE

USING THE MOLINA MEDI-CAL DRUG FORMULARY

The Molina Medi-Cal Drug Formulary is a listing of preferred drug products eligible for reimbursement by Molina. All medications are listed by brand name. The medications are organized by therapeutic classes. For your convenience, an index by both brand and generic names is located at the end of the Drug Formulary. New dosage forms/line extensions of Formulary products are considered non-Formulary, unless otherwise indicated in this listing.

CLINICAL CONSIDERATIONS

The Molina Healthcare Pharmacy and Therapeutics Committee have developed Clinical Considerations for many categories of medications and several specific drugs. The Clinical Considerations should not be considered prescribing guidelines or restrictions on the provider's use of certain medications. As these drugs are evaluated for inclusion in the patient's drug-therapy plan, the Clinical Considerations are important, key reminders related to cautions, drug-interactions, adverse effects or patient monitoring.

INDIVIDUAL PRESCRIPTIONS

Each prescription must legally be prescribed for one individual only. If prescribing for a family, each family member must receive a prescription. For a member to receive a covered over the counter medication, a written prescription is required.

GENERIC MEDICATIONS

Selected medications have FDA-approved generic equivalents available. The Molina drug endorsement states..."generic drugs will be dispensed whenever available".

If the use of a particular brand-name becomes medically necessary as determined by the physician, the physician must contact Molina for prior authorization.

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Molina encourages the use of quality generic products. Only those generic products which have received an "AB" rating by the FDA should be utilized. Physicians are encouraged to write "Brand Only" or "DNS" only when medically necessary. The Pharmacy and Therapeutics Committee recognizes that certain medications possess narrow therapeutic dose response characteristics. Therefore, the following drugs are not recommended to be generically substituted, unless the patient has been therapeutically maintained on the generic product for a period of time.

Generic Name	Brand Name
Carbamazepine	TEGRETOL
Cyclosporine	SANDIMMUNE, NEORAL, SANGCYA
Digoxin	LANOXIN
Levothyroxine	SYNTHROID or LEVOXYL
Phenytoin	DILANTIN
Warfarin	COUMADIN

PRIOR AUTHORIZATION REQUEST PROCEDURE

Prescriptions for medications requiring prior approval or for medications not included on the Drug Formulary may be approved when medically necessary and when Formulary alternatives have demonstrated ineffectiveness. When these exceptional needs arise, the physician may fax a completed "Medication Prior Authorization Request" form to Molina. The forms may be obtained by accessing Molina Healthcare of California's website at <http://www.molinahealthcare.com/medicaid/providers/ca/drug/Pages/formulary.aspx> or by calling the Molina Pharmacy Prior Authorization Department at (800) 526-8196 x 127854.

STEP THERAPY PROCEDURE

Step-Therapy requires a trial of one or more "prerequisite" medications before a "Step-Therapy" medication will be covered. If it is medically necessary for a member to use a Step-Therapy medication as initial therapy, the treating physician can request coverage of such drug by submitting a Prior Authorization Request form.

PRESCRIPTION QUANTITY

Prescriptions should be written for a therapeutic supply of medications (the amount to appropriately treat a medical condition) up to a maximum of a 60-day supply. Trial quantities may be used when trying new treatments, if appropriate.

URGENT AND AFTER-HOURS MEDICATION POLICY

To prevent a member's condition from worsening in an urgent situation, it may be necessary to dispense a 72-hour supply of an acute medication before prior authorization may be obtained from Molina. (e.g., a member is discharged from a hospital after regular business hours with a special antibiotic prescription). Pharmacies are instructed to use their professional judgement. Molina will reimburse pharmacies for a 72-hour supply of an acute medication at contracted rates for these prescriptions. Pharmacies may contact CVS/Caremark Help Desk at (800) 770-8014 to obtain an override for a 72-hour supply.

Pharmacies may call Molina at (800) 526-8196 x 127854 on the following business day to obtain authorization to allow the urgent or after-hours prescription to process on-line. It is advised and expected that the pharmacy will provide reasonable documentation of cases where medications were dispensed under these urgent circumstances.

TELEPHONE PRESCRIPTIONS

Whenever possible, the member should be given the prescription in writing. This will allow the member to make use of the most convenient network pharmacy and enable the pharmacy to fill the prescription after normal office hours.

HEALTHY FAMILIES

All medications listed in this Drug Formulary, with the exception of Over-the-counter (OTC) products (excluding insulins and diabetic testing supplies), are covered for Healthy Families members. Molina Healthy Families members are required to pay a \$5.00, \$10.00, or \$15.00 co-payment for most prescriptions. No co-payment is required for contraceptive drugs and devices. Healthy Families members have a \$250 combined medical and pharmacy, annual out-of-pocket maximum

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per family. Department of Health Services (DHS) drug “carve-outs” for psychotropic and HIV medications do not apply for Healthy Families members.

DRUG FORMULARY

Chapter 1 ANALGESICS

1.1 Non-Narcotic Analgesics

Acetaminophen	TYLENOL – OTC*
(Chew Tab, Soln, Supp, & Dispersible Tab are limited to age ≤12)	
Aspirin	ASPIRIN – OTC*
Butalbital/APAP/Caffeine Tab	FIORICET
(Limited to #6/day)	
Butalbital/ASA/Caffeine	FIORINAL
Ketorolac Tromethamine	TORADOL
(Limited to #5 day supply)	
Choline & Magnesium Salicylate	TRILISATE
Salsalate	DISALCID
Tramadol HCl	ULTRAM
(Limited to #8/day)	

PRIOR AUTHORIZATION/STEP THERAPY REQUIRED

Butorphanol (PA)	STADOL Nasal Spray
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1.2 Narcotic Analgesics

- **These drugs all have abuse potential. Tolerance and dependence can occur with prolonged use.**
- **Prescriptions should not exceed recommended doses of acetaminophen, aspirin or codeine.**
- **Patients on full doses of these medications should be warned not to supplement their pain relief with OTC drugs to avoid toxic levels.**
- **Combining these agents with alcohol, muscle relaxants or antihistamines can cause excessive sedation and confusion.**
- **Patients should be cautioned not to use machinery or to do things that could be dangerous if they become drowsy or dizzy.**
- **Limited to 4 gram of APAP per day.**

Acetaminophen/Codeine 300/15mg, 300/30mg, 300/60mg Tab, Soln & Susp	TYLENOL/CODEINE
(Soln: Limited to age ≤12; 240mL/mo)	
Hydrocodone/APAP 5/500mg, 7.5/500mg, 10/500mg, 7.5/750mg Tab	VICODIN, VICODIN ES, LORCET, LORTAB
Hydromorphone (2mg and 4mg Tab)	DILAUDID
Methadone Tablets	DOLOPHINE, METHADOSE
Morphine Sulfate CR (Generic only; 30mg CR: Limited to #4/day)	MS CONTIN, ORAMORPH SR
Morphine Sulfate IR	MS IR
Oxycodone IR	Oxy IR
(5mg Cap & 5mg Tab: Limited to #8/day, 15mg & 30mg Tab: Limited to #4/day)	
Oxycodone/APAP 5/325mg Tab	PERCOCET
(5/325mg Tab: Limited to #12/day)	
Propoxyphene Napsylate/APAP 100- 650mg Tab	DARVOCET - N
(Limited to age <65)	

PRIOR AUTHORIZATION/STEP THERAPY REQUIRED

Fentanyl Transdermal (PA)	DURAGESIC
Hydrocodone/Acetaminophen 10/325mg (ST)	NORCO
(ST for failure of Hydrocodone/APAP 10/500mg; limited to #12/day)	

Generic Name/Common Brand Name

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Oxycodone HCl, CR (PA)	OXYCONTIN
Oxycodone/APAP 2.5/325mg, 7.5/500mg & 10/650mg (PA)	PERCOCET
Oxycodone/APAP 7.5/325mg, 10/325mg (ST)	PERCOCET
(ST for failure or intolerant to Oxycodone/APAP 5/325mg)	
Oxycodone/ASA (ST)	PERCODAN
(ST for failure of Oxycodone/APAP 5/325mg)	

1.3 Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)

- All NSAIDs have similar effectiveness and differ very little in their toxicity and side effects. Therefore, generically available NSAIDs should be considered as first line therapy.
- Combinations of two or more NSAIDs offer no advantage, but do increase the chances of drug interaction and toxicity. Patients may be taking OTC NSAIDs without MD awareness.
- NSAID use in the following conditions deserves special consideration of potential risks: History of GI bleeding or ulcer; chronic anticoagulation, asthma, aspirin allergy, renal failure, hypertension or congestive heart failure.

Diclofenac (25mg Tab: Limited to #3/day)	VOLTAREN
Etodolac (Tab: Limited to #2/day; Cap: Limited to #4/day)	LODINE
Flurbiprofen (50mg Tab: Limited to #4/day)	ANSAID
Ibuprofen (Cap & Tab: Limited to #4/day; Chewable Tab & Susp: Limited to age ≤12; 40mg/mL Susp: Limited to 240mL/mo)	MOTRIN – OTC*
Indomethacin (25mg Cap: Limited to #4/day)	INDOCIN
Meloxicam	MOBIC
Naproxen (Limited to #3/day)	NAPROSYN – OTC*
Naproxen Sodium (Limited to #3/day; 550mg Tab #4/day)	ANAPROX, ANAPROX DS – OTC*
Piroxicam	FELDENE
Sulindac	CLINORIL

1.3.1 COX-2 Inhibitor

Celcoxib (Limited to age ≥65)	CELEBREX
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2nd Line:

PRIOR AUTHORIZATION/STEP THERAPY REQUIRED

Diclofenac/Misoprostol (PA)	ARTHROTEC
Etodolac CR (PA)	LODINE XL
Oxaprozin (PA)	DAYPRO
Ketoprofen CR Cap (PA)	ORUVAIL
Nabumetone (PA)	RELAFEN

1.4 Antirheumatics

Hydroxychloroquine	PLAQUENIL
Methotrexate	METHOTREXATE

1.5 Gout Agents

Allopurinol (100mg: Limited to #3/day; 60 day supply available)	ZYLOPRIM
Colchicine (60 day supply available)	COLCHICINE
Indomethacin	INDOCIN
Probenecid (60 day supply available)	BENEMID

Generic Name/Common Brand Name

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1.6 Anti-TNF-Alpha – Monoclonal Antibodies

PRIOR AUTHORIZATION/STEP THERAPY REQUIRED

Adalimumab (PA) HUMIRA
(Rx limited to CVS/Caremark Specialty Pharmacy)

1.7 Migraine

- Patients with 3 or more migraine attacks per month may be appropriate candidates for prophylactic therapy with standard therapy, including beta blockers or tricyclics.
- In patients who do not respond to therapy, consider “rebound” effect. Migraine patients should be monitored for narcotic analgesic overuse or abuse.

APAP/ASA/Caffeine EXCEDRINE MIGRAINE – OTC*
Divalproex ER DEPAKOTE ER
(250mg: Limited to #4/day; 500mg: Limited to #8/day)
Ergotamine/Caffeine CAFERGOT
Isometheptene/ MIDRIN
Dichloralphenazone/APAP
Sumatriptan Tablet IMITREX
(Limited to #9/45 day)

PRIOR AUTHORIZATION/STEP THERAPY REQUIRED

Dihydroergotamine (PA) MIGRANAL Nasal Spray
Eletriptan (ST) RELPAX
(ST for failure or intolerant to Imitrex Tab, limited to #9/45 day)
Sumatriptan (PA) IMITREX Nasal Spray, Injection
Zolmitriptan (ST) ZOMIG
(ST for failure or intolerant to Imitrex Tab, limited to #9/45 day)

Chapter 2 ANTIDIABETIC AGENTS

2.1 Sulfonylureas

2.1.1 1st Generation Sulfonylureas

Chlorpropamide DIABINESE
(100mg: Limited to #2/day; 250mg: Limited to #3/day)
Tolazamide TOLINASE
(60 day supply available)
Tolbutamide ORINASE
(60 day supply available)

2.1.2 2nd Generation Sulfonylureas and Combinations

Glimepiride AMARYL
(4mg: Limited to #2/day; 60 day supply available)
Glipizide GLUCOTROL
(60 day supply available)
Glipizide Extended Release GLUCOTROL XL
(10mg: Limited to #2/day; 60 day supply available)
Glyburide DIABETA, GLYNASE
(Limited to #2/day; 5mg #4/day; 60 day supply available)
Glyburide/Metformin GLUCOVANCE
(Limited to #2/day; 2.5/500mg #4/day; 60 day supply available)

2.2 Alpha-Glucosidase Inhibitors

Acarbose PRECOSE
(Limited to #3/day; 60 day supply available)

2.3 Biguanides

Metformin, SR GLUCOPHAGE, XR
(1000mg: Limited to #2/day; 500mg SR: Limited to #4/day; 750mg SR: Limited to #3/day; 60 day supply available)

Generic Name/Common Brand Name

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2.4 Meglitinides

PRIOR AUTHORIZATION/STEP THERAPY REQUIRED

Repaglinide (PA) PRANDIN

2.5 Thiazolidinediones and Combinations

PRIOR AUTHORIZATION/STEP THERAPY REQUIRED

Pioglitazone (ST) ACTOS
(ST for concurrent use with Sulfonylurea, Metformin, or Basil insulin)
Pioglitazone/Metformin (ST) ACTOPLUS MET
(ST for Actos)

2.6 Dipeptidyl Peptidase IV Inhibitor

PRIOR AUTHORIZATION/STEP THERAPY REQUIRED

Sitagliptin (PA) JANUVIA
Sitagliptin/Metformin (PA) JANUMET

2.7 Insulins

(Limited to vials only. Prefilled insulin pens and cartridges are PA required).

- All vial formulations of Humulin, Humalog, and Novo-Nordisk agents are formulary.
- Humulin, Humalog and Novo Nordisk agents are limited to 4 vials per month.

Insulin Detemir LEVEMIR
(Limited to 3 vials/mo)
Insulin Glargine LANTUS
(Limited to 3 vials/mo)

2.8 Glucagon

Glucagon Injection GLUCAGON KIT

2.9 Diabetic Supplies

Blood Glucose Meter TRUE RESULTS, TRUE TRACK
(Limited to 1 meter/yr)
Test Strips TRUE TEST, TRUE TRACK
(Limited to 150/mo)
Syringes Various
Lancets LANCETS, Various

Chapter 3 ANTIHISTAMINES AND COMBINATIONS

3.1 Single-Entity Products

Cetirizine ZYRTEC
(Syrup: Limited to age ≤10)
Chlorpheniramine CHLOR-TRIMETON – OTC*
(Limited to age ≥3 and ≤65)
Clemastine Tab, Syrup TAVIST– OTC*
(Tab: Limited to age ≥3 and ≤65; Syrup: Limited to age ≥3 and ≤12)
Cyproheptadine PERIACTIN – OTC*
Diphenhydramine BENADRYL– OTC*
(Liquid: Limited to age ≤12; 25mg Tab & Cap: Limited to #2/day; 50mg Tab & Cap: Limited to #6/day)
Hydroxyzine HCl ATARAX
(Limited to age ≤65; Tab #4/day; Syrup: Limited to age ≥12; 60mL/day)
Hydroxyzine Pamoate Cap VISTARIL
(Limited to age ≤65 and #4/day)

Lower Sedating Antihistamines:

Loratadine Tab, Syrup CLARITIN– OTC*
(Syrup: Limited to age ≤10)

3.2 Combination Products

Brompheniramine/Decongestant CONTAC Tab – OTC*
Chlortrimeton/Decongestant DIMETAPP, RONDEC – OTC*
Tab, Elixir, Syrup

Generic Name/Common Brand Name

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Pyril/Phenyltolox/Pheniramine POLY-HISTINE – OTC*
Triprolidine/Pseudoephedrine ACTIFED– OTC*
Tab, Syrup
Lower Sedating Combination Products
Certirizine/Pseudoephedrine ZYRTEC-D
Lorradine/Pseudoephedrine CLARITIN-D – OTC*

Chapter 4 ANTI-INFECTIVE AGENTS

4.1 Penicillins

- **Use with caution in patients with a reported allergy to cephalosporins and in patients with renal impairment.**
- **Despite increasing antibiotic resistance, Amoxicillin continues to remain the drug of choice for otitis media in children.**
- **Amoxicillin doses of 60-90mg/kg/day (in divided doses) may be needed for suspect/documentated PCN-resistant *S. pneumoniae*.**

1st line:

Ampicillin PRINCIPEN
(Susp: Limited to age ≤12 and 400mL/10 day)
Amoxicillin TRIMOX
(Chewable Tab & Susp: Limited to age ≤12; Susp: Limited to 300mL/10 day; Chewable Tab: Limited to #3/day)
Dicloxacillin DYNAPEN
Penicillin VK VEETIDS
(Susp: Limited to age ≤12)

2nd Line:

Amoxicillin/Clavulanate AUGMENTIN
Potassium
(Chewable Tab & Susp: Limited to age ≤12; Limited to 300mL/mo; 500mg Tab: Limited to #3/day; 750mg Tab: Limited to #2/day)

4.2 Cephalosporins

- **Dosage may need to be modified in patients with renal impairment. Inappropriately large doses may cause seizures.**
- **Use with caution in patients with a reported sensitivity or allergy to penicillin due to cross-sensitivity in about 10% of patients.**

Cefaclor CECLOR
(Susp: Limited to age ≤12; Limited to 300mL/10 day)
Cefdinir OMNICEF
(Cap: Limited to #2/day; Susp: Limited to age ≤12; Limited to 100mL/mo)
Cefixime 400mg SUPRAX
(Limited to #1 tab/fill and diagnosis of STD)
Cefuroxime Susp CEFTIN
(Limited to age ≤12; Limited to 200mL/10 day)
Cephalexin KEFLEX
(Susp: Limited to age ≤12; Limited to 400mL/mo)
Cephadrine VELOSEF

PRIOR AUTHORIZATION/STEP THERAPY REQUIRED

Cefadroxil (PA) DURICEF
Cefprozil (PA) CEFZIL

4.3 Macrolides

- **Erythromycin is the most cost-effective alternative to penicillin for the treatment of many infections in penicillin-allergic patients.**
- **Co-administration may increase levels of several medications including theophylline, carbamazepine (Tegretol), cyclosporine (Sandimmune, Neoral) and warfarin (Coumadin).**

1st Line:

Azithromycin ZITHROMAX
(Limited to #6/mo for 250mg Tab, #3/mo for Tri-Pak 500mg Tab, & 1 pack/90 days for Powder Pack. Susp: Limited to age ≤12 and 30mL/mo)

Generic Name/Common Brand Name

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Clarithromycin BIAXIN
250mg, 500mg Tab
(Limited to #28/14 days)
Erythromycin Base ERY-TAB Enteric Coated
Erythromycin Ethylsuccinate E.E.S.
Tab & Liquid
(Susp: Limited to age ≤12 and 400mL/mo)
Erythromycin Stearate ERYTHROCIN

4.4 Tetracyclines

- **Contraindicated for children less than 8 years old or pregnant and nursing mothers.**
- **Absorption is decreased by dairy products, iron, bismuth and antacids.**
- **Doxycycline is minimally affected.**

Doxycycline Hyclate Cap
50mg & 100mg, Tab VIBRATAB
100mg
(Limited to age ≥8 and #2/day)
Tetracycline Cap & Tab SUMYCIN
(Limited to age ≥8)

PRIOR AUTHORIZATION/STEP THERAPY REQUIRED

Minocycline Cap 50mg,
100mg (ST) MINOCIN
(ST for failure of Doxycycline Hyclate or Tetracycline in members age ≥8; limited to #60/mo)

4.5 Quinolones

- **Not generally considered First Line therapy for most infections.**
- **Not recommended for children less than 18 years of age.**
- **Consider use for:**
- **Sensitive staphylococcal infections when another effective, less expensive oral antibiotic is not an option.**
- **Gram negative, soft tissue, bone, renal and wound infections when the only other option is parenteral antibiotics.**
- **Respiratory infections in cystic fibrosis patients as an alternative to parenteral antibiotics.**
- **Co-administration with theophylline may increase serum theophylline levels. Co-administration with warfarin (Coumadin) may increase Coumadin's effects.**
- **Common side effects for ciprofloxacin (Cipro) are restlessness and vomiting.**

Ciprofloxacin 250mg, 500mg CIPRO
& 750mg Tab
(Limited to #28/mo)

PRIOR AUTHORIZATION/STEP THERAPY REQUIRED

Levofloxacin (PA) LEVAQUIN
Ofloxacin (PA) FLOXIN

4.6 Aminoglycosides

Neomycin NEOMYCIN

4.7 Sulfonamides

SMZ/TMP BACTRIM, SEPTRA
Sulfisoxazole GRANTRISIN
Sulfisoxazole/Erythromycin
Susp PEDIAZOLE

4.8 Antituberculosis

Ethambutol MYAMBUTOL
Isoniazid ISONIAZID
(100mg: Limited to #3/day; Syrup: Limited to age ≤12; 900mL/mo)
Pyrazinamide PYRAZINAMIDE
Pyridoxine VITAMIN B-6
Rifampin RIFADIN
(Limited to #4/day)

Generic Name/Common Brand Name

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4.9 Antifungal – Oral

Clotrimazole (Troches only)	MYCELEX
Fluconazole 150mg (Limited to #1/ mo)	DIFLUCAN
Griseofulvin (Susp: Limited to age ≤12; #600mL/mo)	FULVICIN UF, FULVICIN P/G
Nystatin	MYCOSTATIN

PRIOR AUTHORIZATION/STEP THERAPY REQUIRED

Fluconazole (PA)	DIFLUCAN
Itraconazole (PA)	SPORANOX
Ketoconazole (PA)	NIZORAL
Posaconazole (PA)	NOXAFIL
Terbinafine (PA)	LAMISIL
Voriconazole (PA)	VFEND

4.10 Antiviral

Acyclovir	ZOVIRAX
Amantadine	SYMMETREL
Oseltamivir (Capsule: Limited to #10/ fill; Suspension: Limited to 75mL/ fill)	TAMIFLU
Zanamivir Inhalation (Limited to 1 inhaler/ 28 day)	RELENZA

PRIOR AUTHORIZATION/STEP THERAPY REQUIRED

Peginterferon Alfa-2A (PA)	PEGASYS Inj (Rx limited to CVS/Caremark Specialty Pharmacy)
Peginterferon Alfa-2B (PA)	PEG-INTRON Inj (Rx limited to CVS/Caremark Specialty Pharmacy)

- **Patients may be referred to HIV Case Management. Please call (800) 526-8196, x 126400.**
- **Antiretroviral agents are currently being developed at a rapid rate. The provider must be aware of the newest guidelines, side effects and drug interactions of these drugs, as they have been brought to the market rapidly with post-market surveillance needed.**
- **Recommendations change rapidly. Combination therapy is now the standard of care.**
- **There are a significant number of contraindicated medications with some protease inhibitors.**
- **Consultation with an AIDS or Infectious Disease specialist should occur if there are any questions or current recommendations or drug interactions.**
- **Many HIV/AIDS medications are the financial responsibility of the Department of Health Services, through Medi-Cal Fee for Service Program. In such cases, pharmacies must bill these medications on-line to Medi-Cal Fee for Services. A complete listing of these medications may be obtained through the Molina Pharmacy Department at 800-526-8196 x 127854**
- **See Carve Out List**

4.11 Antimalarial

Primaquine Phosphate	PRIMAQUINE
Pyrimethamine	DARAPRIM

4.12 Anthelmintics

Mebendazole	VERMOX
-------------	--------

4.13 Misc. Anti-Infectives

Clindamycin	CLEOCIN
Metronidazole	FLAGYL
Nitrofurantoin	MACRODANTIN
Nitrofurantoin Monohydrate	MACROBID
Macrocrystals LA (Limited to #2/day)	
Trimethoprim	TRIMPEX

Chapter 5 ANTILIPIDEMICS

CHOLESTEROL TREATMENT RISK FACTORS

- **Cigarette smoking**

Generic Name/Common Brand Name

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- Hypertension ($\geq 140/90$ mmHg or on antihypertensive medication)
- Low HDL cholesterol (< 40 mg/dL)
- Family history of premature CHD (CHD in male first degree relative < 55 yrs; CHD in female first degree relative < 65 yrs)
- Age (men ≥ 45 yrs; women ≥ 55 yrs)
- CHD RISK EQUIVALENT
- Other clinical forms of atherosclerotic disease (peripheral arterial disease, abdominal aortic aneurysm, and symptomatic carotid artery disease);
- Diabetes;
- Multiple risk factors that confer a 10-yr risk for CHD $> 20\%$. In the presence of high HDL cholesterol, one risk factor is subtracted (i.e. HDL ≥ 60 mg/dL)

TREATMENT DECISION BASED ON LDL CHOLESTEROL (mg/dL)

- Patient Characteristics Initiate Consider LDL Diet Drug* Goal
- Lower risk¹: 0 - 1 risk factors $\geq 160 \geq 190 < 160$
- Moderate risk¹: 2+ risk factors 10-yr risk $< 10\% \geq 130 \geq 160 < 130$
- Moderately high risk¹: 2+ risk factors 10-yr risk $10\%-20\% \geq 130 \geq 130 < 130$
- High risk¹: CHD or CHD risk equivalent 10-yr risk $> 20\% \geq 100 \geq 100 < 100$
- ¹ Please refer to ATP III for more detail description and for definition of risk categories

5.1 HMG CoA Reductase Inhibitors (Statins)

Simvastatin ZOCOR

(60 day supply available)

PRIOR AUTHORIZATION/STEP THERAPY REQUIRED

Atorvastatin (ST) LIPITOR

(ST for failure or intolerant to Simvastatin 80mg; limited to #15/mo)

Ezetimibe/Simvastatin (ST) VYTORIN

(ST for failure or intolerant to Simvastatin 80mg)

Lovastatin (ST) MEVACOR

(ST for failure or intolerant to Simvastatin; limited to #30/mo; 40mg limited to #60/mo; 60 day supply available)

Lovastatin/Niacin Extended Release (PA) ADVICOR

Pravastatin (ST) PRAVACHOL

(ST for failure or intolerant to Simvastatin 80mg; limited to #30/mo; 60 day supply available)

Rosuvastatin (ST) CRESTOR

(ST for failure or intolerant to Simvastatin 80mg; limited to #15/mo)

Simvastatin/Niacin (ST) SIMCOR

(ST for failure or intolerant to simvastatin and reduction of TG)

5.2 Fibrates

Gemfibrozil LOPID

(60 day supply available)

PRIOR AUTHORIZATION/STEP THERAPY REQUIRED

Fenofibrate Micro Cap 67mg LOFIBRA

& 134mg, Tab 54mg (ST)

(ST for failure or intolerant to Gemfibrozil or concurrent use with Simvastatin; Limited to #30/mo)

5.3 Other Cholesterol Lowering Agents

- Niacin has several side effects including flushing, itchy skin, GI distress, liver toxicity, hyperglycemia and hyperuricemia. To avoid flushing, give niacin with meals and start with a low dose, titrating up slowly. One aspirin or ibuprofen given 1 hour before the niacin dose helps against persistent flushing.

Cholestyramine, Light QUESTRAN, LIGHT

(Limited to 1 can/mo)

Niacin, Niacin SR NIACIN, SLO-NIACIN

Niacin Timed Released NIASPAN

(750mg SR: Limited to #2/day; 60 day supply available)

PRIOR AUTHORIZATION/STEP THERAPY REQUIRED

Colesevelam (ST) WELCHOL

(ST for failure or intolerant to Cholestyramine)

Generic Name/Common Brand Name

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Chapter 6 ANTINEOPLASTICS AND IMMUNOSUPPRESSANTS

6.1 Antineoplastics

Altretamine	HEXALEN
Anastrozole	ARIMIDEX
Bexarotene	TARGRETIN
Bicalutamide C	ASODEX
Busulfan	MYLERAN
Chlorambucil	LEUKERAN
Cyclophosphamide	CYTOXAN
Diethylstilbestrol	STILPHOSTROL
Estramustine	EMCYT
Etoposide	VEPESID
Exemestane	AROMASIN
Flutamide	EULEXIN
Hydroxyurea	HYDREA
Letrozole	FEMARA
Levamisole	ERGAMISOL
Lomustine	CEENU
Megestrol	MEGACE
Melphalan	ALKERAN
Mercaptopurine	PURINETHOL
Methotrexate	RHEUMATREX
Mitotane	LYSODREN
Procarbazine	MATULANE
Tamoxifen	NOLVADEX
Teremefine	FARESTON
Tretinoin	VESANOID

PRIOR AUTHORIZATION/STEP THERAPY REQUIRED

Erlotinib (PA)	TARCEVA
Imatinib (PA)	GLEEVEC

6.2 Immunosuppressants

Azathioprine	IMURAN
PRIOR AUTHORIZATION/STEP THERAPY REQUIRED	
Cyclosporine (PA)	SANDIMMUNE, NEORAL
Mycophenolate Mofetil (PA)	CELLCEPT
Sirolimus (PA)	RAPAMUNE
Tacrolimus (PA)	PROGRAF

Chapter 7 CARDIOVASCULAR MEDICATIONS

7.1 Cardiac Glycosides

Digoxin (60 day supply available)	LANOXIN
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7.2 Nitrates

Isosorbide Dinitrate Tab & SL (Limited to #4/day; 60 day supply available)	DILATRATE SR
Isosorbide Mononitrate, SR (Limited to #1/day; 10mg Tab: #2/day; 60 day supply available)	IMDUR, MONOKET, ISMO, ISORDIL
Nitroglycerin Oint	NITROL
Nitroglycerin Patch (60 day supply available)	NITRO-DUR
Nitroglycerin 0.4mg Pump Spray	NITROLINGUAL
Nitroglycerin SR Cap (Limited to age ≥12; 2.5mg & 9mg Cap: #4/day; 60 day supply available)	NITRO-BID CR
Nitroglycerin SL Tab (60 day supply available)	NITROSTAT

Generic Name/Common Brand Name

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Note: With the exception of certain races or comorbid conditions, JNC VII guidelines for the treatment of hypertension continue to recommend diuretics or beta blockers to be the first line therapy.

7.3 Beta-Blockers

7.3.1 Beta-1 Specific

Atenolol (60 day supply available)	TENORMIN
Bisoprolol Fumerate (60 day supply available)	ZEBETA
Metoprolol (Limited to #5/day; 60 day supply available)	LOPRESSOR
Metoprolol ER (60 day supply available)	TOPROL XL

7.3.2 Non-Selective

Carvedilol (Limited to #2/day; 60 day supply available)	COREG
Labetalol (60 day supply available)	NORMODYNE
Nadolol (120mg: Limited to 2/day; 60 day supply available)	CORGARD
Propranolol (80mg: Limited to #6/day)	INDERAL

7.3.3 Beta-Blockers Combinations

Bisoprolol/HCTZ (2.5/6.25mg & 5.6/25mg: Limited to #2/day; 60 day supply available)	ZIAC
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7.4 Calcium Antagonists

Amlodipine (60 day supply available)	NORVASC
Nifedipine Cap (Limited to female; age ≥12 and ≤45)	PROCARDIA
Nifedipine SR (60 day supply available)	ADALAT CC
Diltiazem, ER (60 day supply available)	DILACOR XR, TIAZAC, CARDIZEM SR
Verapamil, SR (60 day supply available)	CALAN, SR

PRIOR AUTHORIZATION/STEP THERAPY REQUIRED

Felodipine (ST) (ST for failure or intolerance to Amlodipine)	PLENDIL
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7.5 Antiarrhythmic Drugs

Amiodarone (60 day supply available)	CORDARONE, PACERONE
Dronedarone	MULTAQ
Flecainide (60 day supply available)	TAMBOCOR
Procainamide, SR (60 day supply available)	PRONESTYL, PROCANBID
Propafenone (60 day supply available)	RYTHMOL
Quinidine Gluconate (60 day supply available)	QUINAGLUTE
Quinidine Sulfate, SR (SR: Limited to #6/day; 60 day supply available)	QUINIDEX
Sotalol, AF (60 day supply available)	BETAPACE, AF

Generic Name/Common Brand Name

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7.6 Angiotensin Converting Enzyme (ACE) Inhibitor

- ACE inhibitors may precipitate acute renal failure and hyperkalemia in patients with severe heart failure, pre-existing renal disease, or hypovolemic states.
- Co-administration of ACE inhibitors with potassium or potassium-sparing diuretics increases the risk of hyperkalemia.
- Use of ACE inhibitors in the second and third trimesters of pregnancy can harm or even kill a developing fetus and are contraindicated in pregnancy.
- Combination therapy with ARB requires prior authorization.

Benazepril (Limited to #2/day; 60 day supply available)	LOTENSIN
Captopril (Limited to #3/day; 60 day supply available)	CAPOTEN
Enalapril (Limited to #2/day; 60 day supply available)	VASOTEC
Lisinopril (Limited to #2/day; 60 day supply available)	ZESTRIL
Quinapril (Limited to #2/day; 60 day supply available)	ACCUPRIL

7.6.1 Angiotensin Converting Enzyme Inhibitor / Diuretic

Combination

Captopril/HCTZ (Limited to #2/day; 60 day supply available)	CAPOZIDE
Lisinopril/HCTZ (60 day supply available)	ZESTORETIC

7.7 Angiotensin II Receptor Blockers

- ARBs may be useful in those patients who require treatment with an ACE, but are unable to tolerate common ACE adverse effects, such as cough.
- Combination therapy with ACE Inhibitors requires prior authorization.

PRIOR AUTHORIZATION/STEP THERAPY REQUIRED

Olmесartan (ST)	BENICAR
(ST for failure or intolerant to an ACE inhibitor; limited to #30/mo)	
Telmisartan (ST)	MICARDIS
(ST for failure or intolerant to an ACE inhibitor; limited to #30/mo)	

7.7.1 ARB / Diuretic Combination

PRIOR AUTHORIZATION/STEP THERAPY REQUIRED

Olmесartan/HCTZ (ST)	BENICAR HCT
(ST for failure or intolerant to ACE inhibitor)	
Telmisartan/HCTZ (ST)	MICARDIS HCT
(ST for failure or intolerant to ACE inhibitor)	

7.8 Antiadrenergic Agents-Centrally Acting

Clonidine Tab & Patch (Limited to age ≤65; Tab: Limited to #8/day; 60 day supply available)	CATAPRES
Methyldopa (60 day supply available)	ALDOMET

7.9 Antiadrenergic Agents-Peripheral Acting

Doxazosin (60 day supply available)	CARDURA
Prazosin (Limited to #3/day; 5mg #8/day; 60 day supply available)	MINIPRESS
Terazosin (Limited to #2/day; 60 day supply available)	HYTRIN

7.10 Diuretics

7.10.1 Loop Diuretics

Generic Name/Common Brand Name

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Bumetanide BUMEX
(60 day supply available)
Furosemide LASIX
(60 day supply available)

7.10.2 Thiazide & Related Diuretics

Hydrochlorothiazide HYDRODIURIL
(60 day supply available)
Indapamide LOZOL
(60 day supply available)
Metolazone ZAROXOLYN
(Limited to #2/day; 60 day supply available)

7.10.3 Potassium Sparing Diuretics

Spironolactone ALDACTONE
(Limited to #2/day; 60 day supply available)
Triamterene/HCTZ DYZAZIDE, MAXZIDE 25 & 50
(60 day supply available)

7.10.4 Carbonic Anhydrase Inhibitors

Acetazolamide DIAMOX
(Tab: Limited to #2/day)
Methazolamide NEPTAZANE

7.11 Vasodilators

Hydralazine APRESOLINE
(Limited to #4/day; 60 day supply available)

Chapter 8 CENTRAL NERVOUS SYSTEM AGENTS

The Department of Health Services through the Medi-Cal Fee for Service program has assumed financial responsibility for select psychiatric medications in Los Angeles, San Bernadino, Riverside, Sacramento (GMC), and San Diego counties. Pharmacies must bill these medications on-line to Medi-Cal Fee-For-Service when prescribed to members residing in these counties. In these instances, Prior Authorization from the plan is not required. These medications are notated in the Formulary with “Medi-Cal FFS”.

8.1 Antianxiety Agents

Alprazolam XANAX
(Limited to #3/day; 2mg #5/day)
Buspirone BUSPAR
(Limited to #2/day)
Chlordiazepoxide LIBRIUM
(Limited to age ≤65)
Diazepam VALIUM
(Tab: Limited to #4/day; Soln: Limited to maximum of 300mL/mo)
Lorazepam ATIVAN
(Limited to #3/day; 2mg #5/day)
Oxazepam SERAX
(Limited to #4/day)

8.2 Antidepressants

8.2.1 Tricyclics

Amitriptyline ELAVIL
(Limited to #3/day; 150mg #2/day; 60 day supply available)
Amoxapine ASCENDIN
(Limited to #3/day; 60 day supply available)
Clomipramine ANAFRANIL
(Limited to #4/day; 75mg #3/day; 60 day supply available)
Desipramine NORPRAMIN
(Limited to #3/day; 150mg #2/day; 60 day supply available)

Generic Name/Common Brand Name

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Flurazepam (Limited to age ≤65)	DALMANE
Temazepam Cap 15mg & 30mg	RESTORIL
Triazolam	HALCION
Zolpidem (Limited to #14/mo)	AMBIEN

PRIOR AUTHORIZATION/STEP THERAPY REQUIRED

Estazolam (PA)	PROSOM
Zaleplon (PA)	SONATA

8.6 ADHD Agents

- All ADHD medication is limited to age ≥6 and ≤18 only.
- Prior authorization required for ages <6 and >18.

Amphetamine, Mixed Salts, Extended Release	ADDERALL, XR
Atomoxetine (Limited to #1 cap, for monotherapy ONLY)	STRATTERA
Dextroamphetamine	DEXEDRINE
Methylphenidate	RITALIN, SR
Methylphenidate ER (Limited to #1/day)	METADATE CD

8.7 Smoking Cessation Agents

PRIOR AUTHORIZATION/STEP THERAPY REQUIRED

Bupropion SR (PA)	ZYBAN
Nicotine Inhaler (PA)	NICOTROL Inhaler
Nicotine Polacrilex (PA)	NICORETTE Gum – OTC
Nicotine Transdermal (PA)	NICODERM CQ, NICOTROL (15mg) - OTC
Varenicline (PA)	CHANTIX

8.8 Other CNS Agents

Disulfiram Tab	ANTABUSE
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Chapter 9 CONTRACEPTIVES & SEX HORMONES

9.1 Contraceptives

(All contraceptives are limited to female, age 12 to 50; 60 day supply available.)

9.1.1 Mono-Phasic Oral Contraceptives

Desogestrel & Ethinyl Estradiol Tab 0.15mg- 30mcg	DESOGEN-28, ORTHO-CEPT
Desogest-Eth Estrad & Eth Estrad Tab 0.15-.02/.01mg (21/5)	MIRCETTE
Drospirenone-Ethinyl Estradiol Tab 3-0.03mg	YASMIN 28
Levonorgestrel & Ethinyl Estradiol Tab 0.10mg- 20mcg	ALESSE, LEVLITE
Levonorgestrel & Ethinyl Estradiol Tab 0.15mg- 30mcg	LEVLEN, NORDETTE
Norethindrone & Ethinyl Estradiol Tab 0.4mg- 35mcg	OVCON 35
Norethindrone & Ethinyl Estradiol Tab 0.5mg- 35mcg	BREVICON, NECON, MODICON, GENORA
Norethindrone & Ethinyl	NORINYL 1+35, ORTHO-NOVUM 1/35

Generic Name/Common Brand Name

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Estradiol Tab 1mg-35mcg	
Norethindrone & Ethinyl	OVCON 50
Estradiol Tab 1mg-50mcg	
Norethindrone Ace & Ethinyl	LOESTRIN 1/20-21
Estradiol Tab 1mg-20mcg	
Norethindrone Ace & Ethinyl	LOESTRIN 1.5/30-21
Estradiol Tab 1.5mg-30mcg	
Norethindrone & Mestranol	NORINYL 1+50, ORTHO-NOVUM 1/50
Tab 1mg-50mcg	
Norgestrel & Ethinyl	LO-OVRAL
Estradiol Tab 0.3mg-30mcg	
Norgestrel & Ethinyl	OVRAL
Estradiol Tab 0.5mg-50mcg	
Norgestimate & Ethinyl	ORTHO-CYCLEN
Estradiol Tab 0.25mg-35mcg	
Norethindrone Ace & Ethinyl	LOESTRIN FE 1/20
Estradiol-Fe Tab 1mg-20mcg	
Norethindrone Ace & Ethinyl	LOESTRIN FE 1.5/30
Estradiol-Fe Tab 1.5mg-30mcg	

9.1.2 Bi-Phasic Oral Contraceptives

Norethindrone/Ethinyl	ORTHO-NOVUM 10/11
Estradiol	

9.1.3 Tri-Phasic Oral Contraceptives

Levonorgestrel/Ethinyl	TRIPHASIL
Estradiol	
Norethindrone/Ethinyl	ESTROSTEP, ORTHO-NOVUM 7/7/7
Estradiol	
Norgestimate/Esthynyl	ORTHO TRI-CYCLEN
Estradiol	

9.1.4 Progestin Oral Contraceptives

Norethindrone	MICRONOR, NOR-QD
Norgestrel	OVRETTE

9.1.5 Emergency Contraceptives

Levonorgestrel	PLAN B
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9.1.6 Transdermal Contraceptives

Norelgestromin/Ethinyl	ORTHO EVRA PATCH
Estradiol	
(Limited to female, age 12 to 50. Quantity limited to 3 patches/mo)	

9.1.7 Intravaginal Contraceptives

(Limited to female, age 12 to 50; Limited to 1/mo)

Etonogestrel/Ethinyl	NUVARING
Estradiol	

9.1.8 Injectable Contraceptives

Medroxyprogesterone	DEPO-PROVERA
Acetate	

Generic Name/Common Brand Name

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9.2 Androgens

(Limited to male)

PRIOR AUTHORIZATION/STEP THERAPY REQUIRED

Testosterone Transdermal System (PA) TESTODERM Patch

9.3 Estrogens

(All estrogen are limited to female; 60 day supply available)

Estradiol ESTRACE
Estradiol Transdermal ESTRADERM Patch, VIVELLE
Estrogens, Esterified ESTRATAB
Estrogens, Conjugated PREMARIN

9.3.1 Estrogen/Progesterone Combination

(All estrogen/progesterone combination are limited to female; 60 day supply available)

Estrogen, Conjugated, Medroxyprogesterone PREMPRO, PREMPRO LOW-DOSE, PREMPHASE
Estradiol/Norethindrone Transdermal COMBIPATCH
(Limited to 8/mo)
Ethinyl FEMHRT
Estradiol/Norethindrone (60 day supply available)

9.4 Progestins

(All Progestins are limited to female; 60 day supply available)

Medroxyprogesterone PROVERA, CYCRIN
Norethindrone Acetate AYGESTIN

9.5 Endometriosis Agents

Danazol DANOCRINE
Nafarelin SYNAREL

9.6 Uterine Stimulants

Methylergonovine METHERGINE

Chapter 10 DERMATOLOGICALS & MUCOUS MEMBRANE AGENTS

10.1 Acne Medications

Benzoyl Peroxide Liquid, Lotion, Gel BENZOYL PEROXIDE, DESQUAM-E, DESQUAM-X - OTC
Clindamycin 1% Topical Solution CLEOCINT Soln
Erythromycin Topical Soln ERYCETTE
Sulfacetamide Sodium/Sulfur Lotion, Emulsion CERISA WASH, AVAR
Tretinoin Cream & Gel RETIN A
(Limited to age 12 to 22, max 20 gm/mo; Microgel is not covered.)

10.2 Topical Anti-Infectives

Bacitracin, Zinc Ointment BACITRACIN – OTC
Bacitracin/Polymyxin B Oint POLYSPORIN
Gentamicin Cream, Oint GARAMYCIN
Mupirocin Oint BACTROBAN
(Limited to 22 gm/mo)
Neomycin/Bacitracin/Polymyxin Oint NEOSPORIN - OTC
Silver Sulfadiazine SILVADENE

10.3 Topical Antifungals

Clotrimazole Cream, Soln MYCELEX – OTC

Generic Name/Common Brand Name

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Miconazole Cream	MONISTAT – OTC
Nystatin Cream, Oint, Powder	MYCOSTATIN, NYSTAT-RX, NYAMYC
Nystatin/Triamcinolone	MYCOLOG II
Tolnaftate Cream	TINACTIN - OTC

PRIOR AUTHORIZATION/STEP THERAPY REQUIRED

Ciclopirox (PA)	LOPROX
Clotrimazole/Betamethasone (PA)	LOTRISONE
Ketoconazole (PA)	NIZORAL

10.4 Topical Corticosteroids

- **Use with caution in pediatric patients due to potential for stria and sensitization.**

GROUP IV (LOW POTENCY)

Desonide	TRIDESILON
Hydrocortisone (Cream & Oint: Limited to 60gm/mo)	HYTONE

GROUP III (MEDIUM POTENCY)

Desoximetasone Cream	TOPICORT LP
Fluocinolone	SYNALAR
Hydrocortisone Valerate	WESTCORT
Triamcinolone Acetonide	KENALOG

PRIOR AUTHORIZATION/STEP THERAPY REQUIRED

Mometasone Furoate (PA)	ELOCON
Prednicarbate (PA)	DERMATOP

GROUP II (HIGH POTENCY)

Betamethasone Dipropionate	DIPROSONE
Betamethasone Valerate	VALISONE
Desoximetasone	TOPICORT
Fluocinonide	LIDEX

PRIOR AUTHORIZATION/STEP THERAPY REQUIRED

Halcinonide (PA)	HALOG, HALOG-E
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GROUP 1 (VERY HIGH POTENCY)

PRIOR AUTHORIZATION/STEP THERAPY REQUIRED

Augmented Betamethasone Dipropionate (PA)	DIPROLENE
Diflorasone Diacetate (PA)	FLORONE, FLORONE E, PSORCON
Halobetasol (PA)	ULTRAVATE

10.5 Topical Corticosteroids in Combinations

HydrocortisonePramoxine	EPIFOAM
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10.6 Scabicides/Pediculocides

Permethrin	NIX – OTC
Permethrin	ELIMITE
Permethrin Combo	RID, A-200 - OTC

PRIOR AUTHORIZATION/STEP THERAPY REQUIRED

Benzyl Alcohol Lotion (ST)	ULESFIA (ST for failure of OTC Nix, Rid, or Lindane; limited 4 fills/year)
Malathion (ST)	OVIDE (ST for failure of OTC Nix or Rid)

10.7 Anorectal

Hydrocortisone Rectal Crm	PROCTOCREAM HC 2.5%
Hydrocortisone Acetate	ANUSOL HC Supp

10.8 Anti-Psoriatics

Anthralin	DITHROCREME
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PRIOR AUTHORIZATION/STEP THERAPY REQUIRED

Generic Name/Common Brand Name

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Calcipotriene (PA) DOVONEX
Tazarotene Topical Gel (PA) TAZORAC

10.9 Misc. Topicals

Calamine Lotion CALAMINE – OTC
Selenium Sulfide SELSUN Shampoo- RX

PRIOR AUTHORIZATION/STEP THERAPY REQUIRED

Fluorouracil Topical (PA) EFUDEX 5%
Pimecrolimus Ointment (PA) ELIDEL
Tacrolimus Ointment (PA) PROTOPIC

10.10 Mucous Membrane Agents

Clotrimazole Troche MYCELEX
Lidocaine Viscous XYLOCAINE
Nystatin Susp MYCOSTATIN

Chapter 11 ENDOCRINE AGENTS

11.1 Systemic Corticosteroids

11.1.1 Glucocorticoids

Hydrocortisone CORTEF
Dexamethasone DECADRON
Methylprednisolone MEDROL
Prednisolone Tab 5mg, PRELONE
Syrup, Powder
Prednisone Tab, Sol ORASONE
(Tablet: 60 day supply available)

11.1.2 Mineralocorticoids

Fludrocortisone Tab FLORINEF

11.2 Osteoporosis Agents

PRIOR AUTHORIZATION/STEP THERAPY REQUIRED

Alendrotene (PA) FOSAMAX
Calcitonin Salmon (PA) MIACALCIN Nasal Spray
Ibandronate (PA) BONIVA
Raloxifene (PA) EVISTA
Risedronate (PA) ACTONEL

11.3 Thyroid Agents

11.3.1 Antithyroid Agents

Methimazole TAPAZOLE
(60 day supply available)
Propylthiouracil PTU
(60 day supply available)

11.3.2 Thyroid Hormones

Levothyroxine LEVOXYL, SYNTHROID
(60 day supply available)
Thyroid Dessicated ARMOUR THYROID
(60 day supply available)

11.4 Other Endocrine Agents

Bromocriptine PARLODEL
(5mg Cap: Limited to #6/day)
Desmopressin DDAVP
Ergocalciferol CALCIFEROL

11.5 Growth Hormone

PRIOR AUTHORIZATION/STEP THERAPY REQUIRED

Somatropin (PA) TEV-TROPIN

Generic Name/Common Brand Name

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Chapter 12 GASTROINTESTINAL AGENTS

12.1 Helicobacter Pylori Agents

Bismuth Subsalicylate/ HELIDAC
Metronidazole/TCN
(Limited to 1 fill/lifetime)

12.2 Histamine-2 Antagonists

Cimetidine TAGAMET
Famotidine PEPCID AC - OTC
Ranitidine Tab, Syrup ZANTAC
(Tab: limited of #2/day, Syrup: limited to age ≤10 and 600mL/mo)

12.3 Proton Pump Inhibitors

Omeprazole Cap 10mg & PRILOSEC
20mg

PRIOR AUTHORIZATION/STEP THERAPY REQUIRED

Lansoprazole (ST) PREVACID 24 Hr – OTC
(ST for failure or intolerant to Omeprazole or concurrent use with Plavix; limited to #60/mo).
Pantoprazole (PA) PROTONIX

12.4 Antacids

(Limited to 4 fills/year)

Alum/Mag Hydroxide MAALOX, MAALOX TC – OTC*
Alum/Mag Hydroxide MYLANTA, MYLANTA II – OTC*
/Simethicone
Calcium Carbonate Tab, TUMS, ROLAIDS – OTC*
Chewable Tab

12.5 Miscellaneous Agents

Misoprostol CYTOTEC
Simethicone MYLICON – OTC*
(Limited to 4 fills/year)
Sucralfate CARAFATE

12.6 Antiemetics

Meclizine Tab & Chewable ANTIVERT
Tab
(Limited to age ≤65 and #2/day)
Ondansetron Tab, ODT ZOFRAN
(Limited to #9/21 day)
Prochlorperazine COMPAZINE
(5mg Tab: Limited to #4/day; 10mg Tab: Limited to #2/day; Supp: Limited to 12/fill)
Promethazine PHENERGAN
(Limited to age ≥3 and ≤65; Supp: QL 12/fill, 2 fills/mo)
Trimethobenzamide TIGAN
(Limited to age ≤65; Limited to #2/day)

12.7 Gastrointestinal Anticholinergic/Antispasmodics

Belladonna DONNATAL
Alkaloids/Phenobarbital
(Limited to age ≤65; Tab: Limited to #8/day; Elixir: Limited to 12mL/day;)
CDZ/Clindinium LIBRAX
(Limited to age ≤65 Limited to #8/day)
Dicyclomine BENTYL
(Limited to age ≤65 10mg Cap: Limited to #16/day; 20mg Tab: Limited to #8/day; Soln: Limited to 40mL/day)
L-Hyoscyamine Sulfate Tab, LEVSIN, LEVSINEX
SL, SR, and Soln
(Limited to age ≤65; SR: Limited to #4/day)

Generic Name/Common Brand Name

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Metoclopramide REGLAN
(10mg Tab: Limited to #4/day; Soln: Limited to age ≤12)
Probanthelene PRO-BANTHINE

12.8 Sulfonamides/Mesalamine Agents

Mesalamine Tab, Cap ASACOL, PENTASA
(250mg Cap: Limited to #4/day; 500mg Cap: Limited to #8/day; 400mg Tab: Limited to #6/day)
Sulfasalazine AZULFIDINE
(Delayed Release: Limited to #4/day)

12.9 Laxatives

(Limited to 4 fills/year)

Bisacodyl DULCOLAX – OTC*
Docusate Sodium COLACE – OTC*
Polyethylene Glycol 3350 MIRALAX
Powder (can)
(Limited to 527gm/30 days, no fill limit)
Lactulose CEPHULAC – OTC*
Senna SENNA – OTC*
Sennosides/Docusate SENOKOT S – OTC*

12.10 Antidiarrheals

(Limited to 4 fills/year)

Attapulgite KAOPECTATE – OTC*
Bismuth Subsalicylate PEPTO BISMOL – OTC*
Diphenoxylate/Atropine LOMOTIL
Loperamide IMMIDIUM – OTC*

12.11 Digestive Enzymes

Amylase/Lipase/Protease ACREASE, VIOKASE, COTAZYME, CREON

12.12 GI Preparations

(Limited to 4 fills/year)

Barium Enema Prep Kit FLEET PREP KIT
PEG Solution COLYTE, Flavored

Chapter 13 GENITOUINARY AGENTS

13.1 Vaginal Anti-Infectives

(Limited to female)

Butoconazole FEMSTAT 3 – OTC*
Clindamycin CLEOCIN VAG Cream
Clotrimazole GYNE-LOTRIMIN – OTC*
Fluconazole 150mg DIFLUCAN
(Limited to #1/mo)
Metronidazole Vag Cream METROGEL VAGINAL
Miconazole Cream, Supp MONISTAT 3, 7 – OTC*
Nystatin Vaginal Tab MYCOSTATIN
Triple Sulfa Vag Cream GYNE SULF – OTC*

13.2 Anticholinergics

Oxybutynin DITROPAN
(Tab: Limited to #4/day; Syrup: Limited to age ≤12)

13.3 Cholinergic Drugs

Bethanechol URECHOLINE
(Limited to #4/day)

13.4 Urinary Analgesics

Phenazopyridine 100mg & 200mg PYRIDIUM

Generic Name/Common Brand Name

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(Limited to #12/mo)

13.5 Vaginal Estrogens (Limited to female)

Conjugated Estrogen Vaginal Cream	PREMARIN
Estradiol Vaginal Cream	VAGIFEM

13.6 Peripheral Antiadrenergic Agents (Limited to male)

Doxazosin	CARDURA
Terazosin Cap	HYTRIN

PRIOR AUTHORIZATION/STEP THERAPY REQUIRED

Alfuzosin (PA)	UROXATRAL
Tamsulosin (PA)	FLOMAX

Chapter 14 HEMATOLOGICAL AGENTS

14.1 Hematopoietic Agents

Folic Acid 1mg	FOLVITE
Folic Acid/B-12/Iron (Limited to female, age 12 to 50; 60 day supply available)	NIFEREX-150 FORTE
Vitamin A	AQUASOL A

14.1.1 Erythropoiesis-Stimulating Agents

PRIOR AUTHORIZATION/STEP THERAPY REQUIRED

Epoetin Alfa, Recombinant (PA) (Rx limited to CVS/Caremark Specialty Pharmacy)	PROCRIT
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14.2 Anticoagulants

Warfarin Sodium (60 day supply available)	COUMADIN
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PRIOR AUTHORIZATION/STEP THERAPY REQUIRED

Enoxaparin (PA) (Limited to max of 14/7 day at retail; limit 2 fills per year , PA required for >7 day supply or more than 2 fills per year)	LOVENOX
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14.3 Antiplatelets

Aspirin (60 day supply available)	ASPIRIN – OTC*
Clopidogrel	PLAVIX
Dipyridamole (60 day supply available)	PERSANTINE

14.4 Hemorrhologic Agents

Pentoxifylline (60 day supply available)	TRENTAL
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Chapter 15 NASAL AGENTS

15.1 Nasal Corticosteroids

Flunisolide	NASAREL
Fluticasone	FLONASE

PRIOR AUTHORIZATION/STEP THERAPY REQUIRED

Mometasone (PA) (Limited to age ≤4 and diagnosis of allergic rhinitis; Limited to 17gm/mo)	NASONEX
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15.2 Miscellaneous Nasal Products

Cromolyn	NASALCROM – OTC*
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Chapter 16 NEURO-MUSCULAR AGENTS

16.1 Anticonvulsants

Generic Name/Common Brand Name

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Carbamazepine, SR (SR: Limited to #2/day; 60 day supply available)	TEGRETOL, XR
Clonazepam (Limited to #4/day)	KLONOPIN
Divalproex Sodium (Sprinkle: Limited to #8/day; 250mg ER #4/day; 500mg ER #8/day; 60 day supply available)	DEPAKOTE, ER
Ethosuximide (60 day supply available)	ZARONTIN
Gabapentin (Limited to #6/day; 800mg Tab: #4/day)	NEURONTIN
Phenobarbital (Tab: Limited to age age ≤65; limited to #3/day, 100mg Tab #4/day; Soln: Age ≤12)	PHENOBARBITAL
Phenytoin (Limited to #6/day; 60 day supply available)	DILANTIN
Primidone (60 day supply available)	MYSOLINE
Valproic Acid (60 day supply available)	DEPAKENE

PRIOR AUTHORIZATION/STEP THERAPY REQUIRED

Carbamazepine Cap SR (PA)	CARBATROL
Diazepam Rectal Gel Delivery System (PA)	DIASTAT
Lamotrigine (PA)	LAMICTAL
Levetiracetam (PA)	KEPPRA
Oxcarbazepine (PA)	TRILEPTAL
Tiagabine (PA)	GABITRIL
Topiramate (PA)	TOPAMAX
Valproic Acid Delayed Release (PA)	STAVZOR
Zonisamide (PA)	ZONEGRAN

16.2 Antiparkinson Agents

Amantadine (Limited to #3/day)	SYMMETREL
Benzotropine (Carved out, bill Medi-Cal FFS)	COGENTIN
Biperiden HCl (Carved out, bill Medi-Cal FFS)	AKINETON
Bromocriptine	PARODEL
Carbidopa/Levodopa, CR (60 day supply available)	SINEMET, CR
Carbidopa/Levodopa/ Entacapone (Limited to #8/day; 50-200-200mg Tab #6/day)	STALEVO
Selegiline (Carved out, bill Medi-Cal FFS)	ELDERPRYL
Trihexyphenidyl (Carved out, bill Medi-Cal FFS)	ARTANE

PRIOR AUTHORIZATION/STEP THERAPY REQUIRED

Entacapone (PA)	COMTAN
Pramipexole (PA)	MIRAPEX
Ropinirole (PA)	REQUIP

16.3 Skeletal Muscle Relaxants

Baclofen (Limited to #4/day)	LIORESAL
Carisoprodol Tab 350mg (Limited to #4/day)	SOMA
Cyclobenzaprine Tab 10mg	FLEXERIL

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(Limited to #3/day)
Methocarbamol ROBAXIN
(Limited to #4/day)

PRIOR AUTHORIZATION/STEP THERAPY REQUIRED

Orphenadrine Citrate (PA) NORFLEX
Orphenadrine/ASA/Caffeine NORGESIC, FORTE
(PA)

16.4 Viscosupplements

PRIOR AUTHORIZATION/STEP THERAPY REQUIRED

Sodium Hyaluronate Intra- EUFLEXXA
Articular (PA)
(Rx limited to CVS/Caremark Specialty Pharmacy)

16.5 Others

Pyridostigmine MESTINON

16.6 Multiple Sclerosis Agents – Interferons

PRIOR AUTHORIZATION/STEP THERAPY REQUIRED

Glatiramer Acetate Inj Kit COPAXONE
(PA)
(Rx limited to CVS/Caremark Specialty Pharmacy)
Interferon Beta-1A IM Inj Kit AVONEX
(PA)
(Rx limited to CVS/Caremark Specialty Pharmacy)

Chapter 17 NUTRITIONAL PRODUCTS

17.1 Vitamins

Calcitriol ROCALTROL
(Limited to #2/day)
Multi-Vitamin & Flouride, FE POLY-VI-FLOR, FE, TRI-VI-FLOR, FE
Tab & Drops
(Limited to children age ≤5; 60 day supply available)
Vitamin K MEPHYTON

17.2 Prenatal Vitamins

(Limited to females, age 12 to 50; 60 day supply available)

Prenatal Vitamin FE PRENAVITE, PRENATAL-S, NIFEREX ON, PN FORTE

17.3 Potassium Supplement

Potassium Chloride Tab, K-DUR, K-TABS, KLOTRIX, KLOR-CON
Cap, Liquid
(15mEq: Limited to #5/day; 60 day supply available)

17.4 Others

Calcium Acetate **Error!** PHOSLO
Bookmark not defined.
(Limited to #12/day)
Calcium Carbonate OS-CAL, TUMS – OTC*
Ferrous Gluconate FERGON – OTC*
Ferrous Sulfate Tab, Soln, FEOSOL
Drops
(Drops: Limited to age ≤5)
Levocarnitine CARNITOR
Magnesium Chloride SLOW MAG
Magnesium Oxide MAG OXIDE
Pediatric Electrolyte Soln PEDIALYTE – OTC*
Sodium Fluoride Tab & LURIDE
Drops
(60 day supply available)

Generic Name/Common Brand Name

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PRIOR AUTHORIZATION/STEP THERAPY REQUIRED

Sevelamer (ST) RENVELA, RENAGEL
(ST for failure or intolerant to Phos-Lo)

Chapter 18 OPHTHALMIC AGENTS**18.1 Anti-Infectives****18.1.1 Antibiotics and Combinations**

Bacitracin	AK-TRACIN
Chloramphenicol	CHLOROPTIC
Erythromycin Ophth Oint	ILOTYCIN
Gentamicin	GENOPTIC
(Limited to 5mL/mo)	
Neomycin/Polymyxin B/ Gramicidin	NEOSPORIN
Ofloxacin	OCUFLOX
(Limited to 5mL/mo)	
Polymycin/TMP	POLYTRIM
(Limited to 10mL/mo)	
Sulfacetamide	BLEPH-10, SODIUM SULAMYD
(Limited to 15mL/mo)	
Tobramycin	TOBEX
(Limited to 5mL/mo)	

PRIOR AUTHORIZATION/STEP THERAPY REQUIRED

Gatifloxacin (PA)	ZYMAR
Moxifloxacin (PA)	VIGAMOX

18.1.2 Antibiotics-Corticosteroid Combinations

Hydrocortisone/Neomycin Polymyxin B	CORTISPORIN
Prednisolone 1%/Gentamicin	PRED-G
Prednisolone 0.5%/ Neomycin/Polymyxin B	POLYPRED
Prednisolone 0.6%/ Tobramycin/Dexamethasone	TOBRADEX
(Limited to 5mL/mo)	
Sulfacetamide/Prednisolone	BLEPHAMIDE

18.1.3 Antifungals

Natamycin 5%	NATACYN
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18.1.4 Antivirals

Trifluridine	VIROPTIC
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18.2 Anti-Inflammatory Agents**18.2.1 Corticosteroids**

Dexamethasone 0.1%	DECADRON, AK-DEX
Fluorometholone 0.1%	FML, FML FORTE
Prednisolone 0.12%, 1%	PRED MILD, PRED FORTE

18.2.2 NSAIDs

Diclofenac 0.1%	VOLTAREN
Flurbiprofen	OCUFEN
Ketorolac	ACULAR, LS

18.3 Anti-Allergic Agents**18.3.1 Others**

Ketotifen	ZADITOR – OTC*
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PRIOR AUTHORIZATION/STEP THERAPY REQUIRED

Olopatadine HCl Ophth Sol	PATANOL
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Generic Name/Common Brand Name

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(ST)

(ST for Zaditor/Alaway and age ≤18; limited to 5mL/30 day)

18.4 Dilating Agents

18.4.1 Anticholinergics

Atropine	ISOPTO ATROPINE
Cyclopentolate	CYCLOGYL
Homatropine	ISOPTO HOMATROPINE
Scopolamine	ISOPTO HYOSCINE
Tropicamide	MYDRIACIL

18.4.2 Sympathomimetics

Phenylephrine	NEOSYNEPHRINE
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18.5 Glaucoma Agents

18.5.1 Alpha-2 Adrenergic Agonists

Brimonidine 0.2%	ALPHAGAN
Brimonidine/Timolol	COMBIGAN

18.5.2 Sympathomimetics

Dipivefrin	PROPINE
Epinephrine HCl	EPIFRIN

18.5.3 Beta-Adrenergic Antagonists

Betaxolol 0.25% & 0.5%	BETOPTIC
Levobunolol	BETAGAN
Timolol Maleate 0.25% & 0.5% Soln, XE Gel	TIMOPTIC, XE

18.5.4 Miotics, Direct Acting

Pilocarpine HCl	PILOCAR
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18.5.5 Carbonic Anhydrase Inhibitors

Dorzolamide HCl 1%	TRUSOPT
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18.5.6 Prostaglandin Agonists

Bimatoprost	LUMIGAN
Latanoprost 0.005%	XALATAN

Chapter 19 OTIC PREPARATION

19.1 Otic Anti-infectives and Combinations

Ciprofloxacin/Dexamethasone	CIPRODEX
Hydrocortisone/Neomycin/ Polymyxin B Otic	CORTISPORIN

PRIOR AUTHORIZATION/STEP THERAPY REQUIRED

Ofloxacin Otic (PA)	FLOXIN
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19.2 Miscellaneous Otic Products

Acetic Acid	VOSOL
Benzocaine/Antipyrine	AURALGAN
Carbamide Peroxide	DEBROX – OTC*
Hydrocortisone/Acetic Acid	VOSOL HC
Triethanolamine/ Chlorobutanol	CERUMENEX

Chapter 20 RESPIRATORY AGENTS

20.1 Cough/Cold Products

- OTC products may be used as first line therapy
- All Cough/cold products are limited to 4 fills per year.
- All Dextromethophan products are limited to age 2 years and older.

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- All Promethazine products are limited to age 6 years and older.

20.1.1 Cough/Cold Combinations

Brompheniramine/Decongestant Tab, Elixir	DIMETAPP– OTC*
Brompheniramine/Pseudoephedrine Tab, Syrup	BROMDEC
Chlorpheniramine/Decongestant Cap	CONTACT 12 Hr – OTC*
Pyril/Phenyltolox/Pheniramine	POLY-HISTINE
Triprolidine/Pseudoephedrine Tab, Syrup	ACTIFED – OTC*

20.1.2 Pediatric Cough/Cold Products

Pseudoephedrine/Dextromethophan	PEDIACARE DECONGESTANT & COUGH – OTC*
Pseudoephedrine/Chlorpheniramine/ Dextromethophan	PEDIACARE COUGH – OTC*

20.1.3 Decongestants

Guaifenesin/Pseudoephedrine 120/600mg	ENTEX PSE
Pseudoephedrine Tab, Syrup (Limited to age ≥2)	SUDAFED – OTC*

20.1.4 Antitussives & Expectorants

Benzonatate (Limited to #60/10 day)	TESSALON PERLES
Codeine/Promethazine	PHENERGAN/CODEINE
Codeine/Promethazine/ Phenylephrine	PHENERGAN VC/CODEINE
Dextromethorphan	FENESIN DM
Dextromethorphan/ Hydrocodone/Phenyl/CTM	HISTUSSIN HC, HISTINEX HC
Dextromethorphan/ Promethazine	PHENERGAN DM
Guaifenesin (Limited to age ≥2)	HUMIBID DM, ROBITUSSIN Syrup– OTC*
Guaifenesin/Codeine	TUSSI-ORGANIDIN NR, ROBITUSSIN AC
Guaifenesin/ Dextromethorphan	ROBITUSSIN DM – OTC*
Guaifenesin/DM	TUSSI-ORGANIDIN DM NR
Pseudoephedrine/ Carbinoxamine/DM	RONDEC DM

20.2 Beta Adrenergic Agonist

20.2.1 Inhalers

Albuterol	PROAIR HFA
Metaproterenol	ALUPENT
Pirbuterol	MAXAIR AUTOHALER

20.2.2 Solutions

Albuterol (Limited to age ≤10, PA for age >10)	PROVENTIL, VENTOLIN
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20.2.3 Oral Tablets

Albuterol	PROVENTIL
Albuterol Extended Release	VOLMAX
Terbutaline	BRETHINE

Generic Name/Common Brand Name

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20.3 Long-Acting Beta Agonist

PRIOR AUTHORIZATION/STEP THERAPY REQUIRED

Formoterol Fumarate (ST) FORADIL

(Not for acute symptoms; ST for concurrent use with an inhaled corticosteroids; combo with Advair or Symbicort not allowed)

Salmeterol (ST) SEREVENT, DISKUS

(Not for acute symptoms; ST for concurrent use with an inhaled corticosteroids; combo with Advair or Symbicort not allowed)

20.4 Xanthine Derivatives

Theophylline UNIPHYL

Theophylline 8-12 Hr SR SLO-BID GYROCAPS

Theophylline 8-24 Hr SR THEO-DUR

(400mg Tab: Limited to #2/day)

20.5 Corticosteroids Inhalation

- **Per NIH guidelines, inhaled steroids are primary, 1st line treatment for all forms of persistent asthma.**
- **Use of short-acting inhaled beta-2 agonists more than 2 times a week may indicate the need to initiate long-term control therapy.**
- **Combination therapy with Advair or Symbicort is not allowed.**

Beclomethasone QVAR

Budesonide Inh Soln PULMICORT

Respules
(Limited to age ≤6)

Flunisolide AEROBID

Fluticasone FLOVENT

Mometasone Furoate ASMANEX

20.6 Corticosteroids/Beta Agonist Combinations

Budesonide/Formoterol (ST) SYMBICORT

(ST for failure of low to medium dose inhaled corticosteroid therapy)

Fluticasone/Salmeterol (ST) ADVAIR

(ST for failure of low to medium dose inhaled corticosteroid therapy)

20.7 Leukotriene Inhibitors

- **Per NIH guidelines, they are reserved as alternative treatment for those patients who have failed combinations of inhaled steroids and long-acting beta agonists.**
- **They may be less effective than inhaled corticosteroids.**
- **Prior Authorization requests for Leukotriene inhibitors will not be authorized when they are used as a steroid replacement. Continued use on inhaled steroids will be required.**
- **They are no more effective than formulary alternatives for the treatment for allergic rhinitis.**

PRIOR AUTHORIZATION/STEP THERAPY REQUIRED

Montelukast (ST) SINGULAIR

(ST for failure of 2-months of inhaled corticosteroids)

Zafirlukast (PA) ACCOLATE

20.8 Anticholinergics

Ipratropium Inhaler & Neb ATROVENT

Soln
(Soln: Limited to children age ≤10; Inhaler: Limited to age ≥12)

PRIOR AUTHORIZATION/STEP THERAPY REQUIRED

Tiotropium (PA) SPIRIVA

20.8.1 Anticholinergic/Beta Agonist combination

PRIOR AUTHORIZATION/STEP THERAPY REQUIRED

Ipratropium/Albuterol (PA) COMBIVENT

20.9 Mast Cell Stabilizers

Cromolyn Neb Soln INTAL

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BRAND NAME	GENERIC NAME	ABBREVIATED PRIOR AUTHORIZATION CRITERIA
ACCOLATE	Zafirlukast	Moderate to severe Asthma; after failure on inhaled steroids. Cannot be authorized as steroid replacement.
ACTONEL	Risedronate	Treatment of Osteoporosis. Treatment and prevention of glucocorticoid-induced Osteoporosis. Prevention of Osteoporosis in postmenopausal women with one or more additional risk factors besides menopause. Treatment of Paget's disease of bone. Bone mineral density (BMD) is required prior to initiating therapy for prevention of glucocorticoid-induced Osteoporosis.
ACTOS, ACTOSPLUS MET	Pioglitazone, Pioglitazone/Metformin	Must be given concurrently with basal insulin, Sulfonylurea or Metformin.
ADDERALL XR (for age ≥18)	Amphetamine, Mixed Salts	Treatment of ADHD, with documented ADHD diagnosis by Psychiatry. Prior Authorization is not required for ages <18.
ADVAIR	Fluticasone-Salmeterol	Prevention of Asthma attacks after failure of low to medium dose inhaled corticosteroids or currently on both an inhaled corticosteroid and a long acting beta agonist.
ALDARA Cream _{NF}	Imiquimod	Treatment of external genital and Perianal Warts/Condyloma acuminata in adults; treatment of clinically typical, non-hyperkeratotic/non-hypertrophic Actinic Keratoses on face or scalp; treatment of biopsy-confirmed, primary superficial Basal Cell Carcinoma, with maximum tumor diameter of 2cm. Treatment course must be consistent with product label.
AMBIEN CR _{NF}	Zolpidem Controlled Release	Ambien CR requests approved as immediate release Ambien.
APIDRA _{NF}	Insulin Glulisine	Treatment of Diabetes in patients 18 yr and older in conjunction with a longer acting insulin or basal insulin analog; after failure of Humalog, Novolog due to intolerance/hypersensitivity reaction.
ARAVA _{NF}	Leflunomide	Treatment of active Rheumatoid Arthritis; failure on/intolerance to Methotrexate and Sulfasalazine. Prescribed by Rheumatologist.
ARTHROTEC	Diclofenac / Misoprostol	Treatment of Arthritis in patients at high risk for ulcers.
ATROVENT Soln	Ipratropium	Formulary for members up to age 10, PA required for age > 10
BECONASE AQ	Beclomethasone	Failure of generic formulary agents Fluticasone and Flunisolide
BENICAR, BENICAR HCT	Olmesartan, Olmesartan/HCTZ	Failure or intolerance to formulary angiotensin converting enzyme (ACE)
BIAXIN	Clarithromycin	Failure on first-line antibiotic, as indicated by nature of infection. OK as first-line for MAC and <i>H. Pylori</i> . For <i>H. Pylori</i> , use Prevpac.
BONIVA	Ibandronate	Treatment of Osteoporosis. Treatment and prevention of glucocorticoid-induced Osteoporosis. Prevention of Osteoporosis in postmenopausal women with one or more additional risk factors besides menopause. Bone mineral density (BMD) is required prior to initiating therapy for prevention of glucocorticoid-induced Osteoporosis.
BYETTA _{NF}	Exenatide	Treatment of Type II Diabetes with HbA1c < 9.0. Failure of Metformin and TZD's combinations; Requested by Diabetes specialist or Endocrinologist.
CEFZIL	Cefprozil	Failure on first-line antibiotic, as indicated by nature of infection.
CELLCEPT	Mycophenolate Mofetil	Prophylaxis of organ rejection in patients receiving allogeneic renal, cardiac or hepatic transplants.
CHANTIX	Varenicline	For smoking cessation. Member must be enrolled in a smoking cessation program. Treatment course limited to 12 weeks. Member must have documented 4-week continuous abstinence during the initial 12 weeks to be approved for the second 12 weeks. Limit of one trial every 52 weeks.

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BRAND NAME	GENERIC NAME	ABBREVIATED PRIOR AUTHORIZATION CRITERIA
COMBIVENT	Ipratropium/Albuterol	Tx of Chronic Obstructive Pulmonary Disease (COPD) as single drug tx (no separate rescue medication needed); or compliance issue related to manual dexterity.
COREG CR _{NF}	Carvedilol	Coreg CR is approved as immediate release Coreg
CRESTOR	Rosuvastatin Calcium	Treatment of Hypercholesterolemia. Failure on Simvastatin 80mg, limited to #15/month.
DAYPRO	Oxaprozin	Use in patients with documented treatment failure on at least two generic NSAIDs, each treatment course being at least 2 weeks.
DAYTRANA _{NF}	Methylphenidate Patch	Treatment of ADHD in patients 6 yr and older who is unable to take oral formulations due to specific medical condition. "Unable to swallow" justification must have prior failure to formulations with sprinkle capability (i.e., Metadate CD, Adderall XR)
DERMATOP	Prednicarbate	Use in patients with documented treatment failure on non-Prior Auth Formulary medium potency (Group III) steroids (e.g., Kenalog, Synalar, Topicort LP, Westcort).
DETROL _{NF}	Tolterodine	Tx of Overactive Bladder. Failure/contraindication to Oxybutynin. Prescription is prescribed or recommended by a Urologist.
DIFLUCAN	Fluconazole	Treatment of oropharyngeal, esophageal, or other forms of serious Candidiasis; also Cryptococcal Meningitis. Single-dose 150mg tablet is available without Prior Authorization for Vaginal Candidiasis.
DIPROLENE	Augmented Betamethasone	Failure on lower potency steroids, unless indicated by specific condition.
DITROPAN XL _{NF}	Oxybutynin ER	Treatment of Overactive Bladder. Failure on regular oxybutynin. Prescription is prescribed or recommended by a Urologist.
DOVONEX	Calcipotriene	Treatment of moderate Plaque Psoriasis.
DURAGESIC	Fentanyl Transdermal	Treatment of severe chronic pain with documented failure on / intolerance to oral formulary long-acting analgesics; documented evaluation/recommendation by Pain Management specialist or oncology
DURICEF (Suspension Only)	Cefadroxil	Failure on first-line antibiotic, as indicated by nature of infection.
EFUDEX	Fluoruracil Topical	Treatment of Actinic or Solar Keratoses
ELIDEL	Pimecrolimus	Treatment of short-term and intermittent long-term therapy of mild to moderate Atopic Dermatitis in patients > 2 years of age; failure of topical steroids. Limited to 30gm per fill.
ELOCON	Mometasone	Use in patients with documented treatment failure on non-Prior Auth Formulary medium potency (Group III) steroids (e.g., Kenalog, Synalar, Topicort LP, Westcort).
FLOMAX	Tamsulosin	Treatment of Benign Prostatic Hyperplasia (BPH); failure/intolerance Hytrin/Cardura.
FLORONE, E	Diflorasone Diacetate	Failure on lower potency steroids, unless indicated by specific condition.
FLOXIN	Ofloxacin	Failure on 1 st line antibiotic, as indicated by nature of infection. Ok as 1st-line for STDs.
FLOXIN OTIC	Ofloxacin	Chronic Suppurative OM with Perforated Tympanic Membrane or acute OM with tympanostomy tubes. For Otitis Externa patients, Cortisporin is first-line agent.
FOSAMAX	Alendronate	Treatment of Osteoporosis. Treatment and prevention of glucocorticoid-induced Osteoporosis. Prevention of Osteoporosis in postmenopausal women with one or more additional risk factors besides menopause. Treatment of Paget's disease of bone. Bone mineral density (BMD) is required prior to initiating therapy for prevention of glucocorticoid-induced Osteoporosis.
GEODON	Ziprasidone	Treatment of Schizophrenia; <i>*NOTE- In LA, San Bernardino, Riverside, and GMC counties, GEODON is billed to Medi-Cal Fee-For-Service for all Medi-Cal members</i>

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BRAND NAME	GENERIC NAME	ABBREVIATED PRIOR AUTHORIZATION CRITERIA
GLEEVEC	Imatinib Mesylate	Newly diagnosed adult patients with Philadelphia Chromosome Positive (Ph+) Chronic Myeloid Leukemia (CML); (CML) in blast crisis, accelerated phase or chronic phase after failure of interferon therapy; treatment of patients with Kit-(CD 117) positive unresectable and/or metastatic malignant gastrointestinal stromal tumors (GISTs); Treatment of pediatric patients with (Ph+) Chronic Myeloid Leukemia (CML) in chronic phase, and for children whose disease has recurred after stem cell transplant or who are resistant to interferon alpha therapy.
HALOG, E	Halcinonide	Use in patients with documented treatment failure on non-Prior Auth Formulary high potency (Group II) steroids (e.g., Lidex, Valisone, Topicort, Diprosone).
HESPERA	Adefovir	Treatment of chronic Hepatitis B in adults with evidence of active viral replication and either evidence of persistent elevations in LFTs or histologically active disease; failure of Eпивir HBV
HIV Medications	Miscellaneous	Most HIV medications are to be billed to Medi-Cal Fee-For-Service on-line for all Medi-Cal members. This applies to members residing in LA, San Bernadino, Riverside, and GMC-Sacramento counties. For all others, medication will be authorized once Molina Medical Case Management is notified of member's condition.
IMITREX Injection, Nasal Spray	Sumatriptan Succinate	Abortive treatment of migraine attacks. Failure on oral Imitrex. Prophylactic therapy needed in patients with 2 or more attacks per month. Quantity limits - Inject. - 1 kit per month; 20 mg NS - 6 per month.
INSULIN PEN Device NF	All Insulins	Insulin Pen Delivery systems to be authorized when member is either blind or disabled. Cannot be authorized for convenience purposes.
JANUVIA JANUMET	Sitagliptin Sitagliptin/Metformin	Treatment of Type II Diabetes with HbA1c > 7; Failed or intolerant to max doses of Sulfonylureas/Metformin, or in addition to Insulin.
KEPPRA	Levetiracetam	Treatment of Seizures, with therapy initiated by Neurology; not approved for Psychiatric use.
KYTRIL Tablet	Granisetron	Prevention of nausea/vomiting associated with initial and repeat courses of emetogenic chemotherapy, including high dose cisplatin; nausea and vomiting associated with radiation. Must fail Zofran prior to approval.
LAMICTAL	Lamotrigine	Treatment of Seizures, with therapy initiated by Neurology; Maintenance treatment of adults with Bipolar Disorder, with therapy managed by Psychiatry. 50mg dose approved as 100mg ½ tab. 100mg dose approved as 200mg ½ tab.
LAMISIL (Tablet Only)	Terbinafine HCl	Tx of Onychomycosis with (+) KOH/PAS stain; member must be experiencing pain that interferes with normal activity, or be diabetic, have peripheral vascular dz, or be immunocompromised; normal baseline LFTs required
LEVAQUIN	Levofloxacin	Failure on first-line antibiotic, as indicated by nature of infection. Dosage for uncomplicated UTI (with failure to first-line abx) is 250mg QD x 3 Days.
LEVEMIR	Insulin Detemir	Treatment of Diabetes in patients with prior failure of formulary long acting insulins due to intolerance/hypersensitivity reaction. Limited to max of 20mL/30days.
LIPITOR	Atorvastatin	Failure on Simvastatin 80mg, limited to #15/month.
LODINE XL	Etodolac CR	Use in patients with documented treatment failure on at least two generic NSAIDs, each treatment course being at least 2 weeks.
LOFIBRA	Fenofibrate	Failure on Gemfibrozil or concurrent use with Simvastatin, limited to #30/month.
LOPROX	Ciclopirox	Treatment of Dermatocycosis; failure on Formulary OTC antifungals.
LOTRISONE	Clotrimazole / Betamethasone	Treatment of Dermatocycosis; failure on Formulary OTC antifungals or when an additional steroid is required.
LUNESTA NF	Eszopiclone	Treatment of Insomnia in adult patients who has history of failure to formulary alternatives. Complete medical summary with documentation

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BRAND NAME	GENERIC NAME	ABBREVIATED PRIOR AUTHORIZATION CRITERIA
		of nature of failure to prior therapies is required. Requested by Sleep specialist, Neurologist or Psychiatrist.
LYRICA _{NF}	Pregabalin	Documented failure to Neurontin for treatment of partial onset Seizures as adjunctive therapy, Neuropathic pain associated with Diabetic Neuropathy, post Herpetic Neuralgia and Fibromyalgia.
MEVACOR	Lovastatin	Failure or intolerant to Simvastatin
MIACALCIN Nasal Spray	Calcitonin	Treatment of postmenopausal Osteoporosis in females greater than 5 years postmenopause.
MICARDIS, MICARDIS HCT	Telmisartan, Telmisartan/HCTZ	Failure or intolerance to formulary angiotensin converting enzyme (ACE)
MIGRANAL	Dihydroergotamine Nasal Spray	Acute treatment of migraine with or without aura; failure or intolerance of formulary agents. Prophylactic therapy needed in patients with 2 or more attacks per month.
MINOCIN	Minocycline HCl	Limited to 50mg & 100mg; Failure of Doxycycline Hyclate or Tetracycline. Limited to age 8 and older; max of #60/month.
NASACORT AQ	Triamcinolone Acetonide	Failure of generic formulary agent: Fluticasone and Flunisolide.
NASONEX	Mometasone	Failure of generic formulary agent: Fluticasone and Flunisolide. For diagnosis of allergic rhinitis in children under 4 years of age, limited to 17gm/month.
NICORETTE Gum (OTC)	Nicotine Polacrilex	For smoking cessation. Treatment course limited to 3 months. Member must be enrolled in a smoking cessation program. Max 96 pieces/month. Limit of one trial every 52 weeks.
NICOTROL 15mg Patch (OTC)	Nicotine Transdermal	For smoking cessation. Treatment course limited to 3 months. Member must be enrolled in smoking cessation program. Limit of one trial every 52 weeks.
NICOTROL Nasal Spray	Nicotine Nasal Spray	For smoking cessation. Treatment course limited to 3 months. Member must be enrolled smoking cessation program. Max 4 boxes/month. Limit of one trial every 52 weeks.
NIZORAL	Ketoconazole	Oral- Treatment of systemic fungal infections and severe Recalcitrant Cutaneous Dermatophyte infections not responding to topical therapy or Griseofulvin. Topical- Treatment of Dermatomycosis; failure on formulary OTC antifungals. Shampoo: Limited to failure of Selenium Sulfide.
NON-FORMULARY Drugs _{NF}	Miscellaneous	Failure on <u>all</u> formulary drugs within same drug class, unless unique indication exists that is not treatable with those agents or other formulary alternatives.
NORGESIC, NORGESIC FORTE	Orphenadrine/ASA/Caffeine	Failure of non-Prior Auth Formulary skeletal muscle relaxants (e.g., Flexeril, Soma, Lioresal, Norflex)
NOXAFIL	Posaconazole	Treatment or prophylaxis of invasive Candida and Aspergillus infections in severely immunocompromised patients; Treatment of systemic fungal infections Failure of Itraconazole and/or Fluconazole.
OMACOR _{NF}	Omega-3-Acid Ethyl Esters	Treatment of severe Hypertriglyceridemia ($\geq 500\text{mg/dL}$) in patients who Gemfibrozil and Niacin are contraindicated.
ORUVAIL	Ketoprofen CR	Use in patients with documented treatment failure on at least two generic NSAIDs, each treatment course being at least 2 weeks.
OXYCONTIN	Oxycodone CR	Treatment of severe chronic pain with documented failure on other formulary long-acting analgesics; documented evaluation/recommendation by Pain Management specialist or Oncology; Approved only for QD or BID dosing, no prn use
PERCOCET 7.5/325mg & 10/325mg	Oxycodone/APAP	For intolerance to Oxycodone/APAP 5/325mg or those requiring higher dose of Oxycodone without increasing APAP dose.
PERCODAN	Oxycodone/ASA	For intolerant or failure to respond to Oxycodone/APAP 5/325mg.
PLENDIL	Felodipine	Failure or intolerance to formulary agent Amlodipine.

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BRAND NAME	GENERIC NAME	ABBREVIATED PRIOR AUTHORIZATION CRITERIA
PRANDIN	Repaglinide	Treatment of Type II Diabetes and failure on Sulfonylureas and Metformin
PRAVACHOL	Pravastatin	Failure or intolerant to Simvastatin or unable to use Simvastatin due to drug-drug interaction
PREVACID	Lansoprazole	Treatment /maintenance of healing of Erosive Esophagitis associated with GERD, and treatment of Pathological Hypersecretory conditions; documented failure (via pharmacy claims history) of OTC Prilosec 2-month trial for Medi-Cal members, H2 blocker trial for Healthy Families members. BID dosing allowed only in extreme circumstances.
PROGRAF Capsule	Tacrolimus	Prophylaxis of organ rejection in patients receiving allogeneic renal or hepatic transplants.
PROSOM	Estazolam	Failure on non-Prior Auth Formulary sedatives/hypnotics (e.g., Dalmane, Restoril)
PROTONIX	Pantoprazole	Treatment /maintenance of healing of Erosive Esophagitis associated with GERD and treatment of pathological hypersecretory conditions; documented failure (via pharmacy claims history) of OTC Prilosec 2-month trial for Medi-Cal members, H2 blocker trial for Healthy Families members.
PROTOPIC	Tacrolimus	Treatment of short-term and intermittent long-term therapy of mild to moderate Atopic Dermatitis in patients > 2 years of age; failure of topical steroids. Maximum quantity limit of 30 gram per fill.
PROVENTIL Soln	Albuterol	Age > 10: limited to severe Asthma or COPD.
PSORCON	Diflorasone Diacetate	Failure on lower potency steroids, unless indicated by specific condition.
RAPAFLO	Sildenafil	For diagnosis of BPH and failure on Doxazosin, Terazosin, or Tamsulosin
RAPAMUNE	Sirolimus	Prophylaxis of organ rejection in patients receiving allogeneic renal transplants.
REGRANEX _{NF}	Becaplermin	Tx of lower-extremity Diabetic Neuropathic ulcers that extend into the subcutaneous tissue or beyond and have an adequate blood supply, in addition to debridement, pressure relief and infection control. Ulcer must be <10cm ² and Diabetes must be under control (HgA1c≤10). Must be prescribed by an Orthopedic Surgeon/Podiatrist. Max 15g/month x 5 months.
RELAFEN	Nabumetone	Use in patients with documented treatment failure on at least two generic NSAIDs, each treatment course being at least 2 weeks.
RELENZA _{NF}	Zanamivir	Treatment of Influenza within 48 hours of onset. Member must have pre-existing medical condition that would be significantly worsened by Influenza. Must be >7 years old.
RELPAK	Eletriptan	For failure of Imitrex tablet, max of #9/45 days
RESTASIS	Cyclosporine Ophthalmic	To increase tear production in patients diagnosed with condition Keratoconjunctivitis Sicca; Prescribed by Ophthalmology
REVATIO _{NF}	Sildenafil	Treatment of Pulmonary Arterial Hypertension. Requested by Pulmonology. Approved as Sildenafil 50mg or 100mg, ½ tablets for 25mg and 50mg doses.
RISPERDAL	Risperidone	Treatment of Psychotic Disorders; Prescribed by Psychiatrist. *NOTE- In LA, San Bernardino, Riverside, and GMC counties, Risperdal is billed to Medi-Cal Fee-For-Service for all Medi-Cal members.
ROZEREM _{NF}	Ramelteon	Treatment of Insomnia in adult patients who have history of failure to formulary alternatives or in whom formulary hypnotics are contraindicated. Complete medical summary with documentation of nature of failure to prior therapies is required. Requested by Sleep specialist, Neurologist or Psychiatrist.
SANDIMMUNE/ NEORAL/ GENGRAF	Cyclosporine	Prophylaxis of organ rejection in patients receiving allogeneic renal, cardiac or hepatic transplants. Treatment of patients with severe active, Rheumatoid Arthritis, failure of Methotrexate. Treatment of adult, non-immunocompromised patients with severe, recalcitrant, Plaque Psoriasis who have failed to respond to at least one systemic therapy or

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BRAND NAME	GENERIC NAME	ABBREVIATED PRIOR AUTHORIZATION CRITERIA
		in patients for whom other systemic therapies are contraindicated, or cannot be tolerated.
SAVELLA	Milnacipran	For diagnosis of Fibromyalgia and failure on Gabapentin, TCAs, or other agents for Fibromyalgia
SIMCOR	Simvastatin/Niacin	Failure of Simvastatin 80mg per day or reduction in TG not attainable with Simvastatin 80mg alone.
SINGULAIR	Montelukast	Moderate to severe Asthma with recent failure on inhaled corticosteroids. Cannot be authorized as steroid replacement: must be given concurrently with a steroid. For allergies, failure of Formulary agents must be documented as Singulair has not been shown to be more effective in clinical trials than any Formulary agents.
SONATA	Zaleplon	Short-term treatment of Insomnia. Failure/intolerance to Formulary agents including Restoril, Elavil, Dalmane. Limited to #14/month, for special circumstances when prescribed by Psychiatrist.
SPIRIVA	Tiotropium	Maintenance treatment of COPD-induced bronchospasm; must be either prescribed or recommended by Pulmonary specialist.
SPORANOX	Itraconazole	Tx of Onychomycosis with (+) KOH/PAS stain; member must be experiencing pain that interferes with normal activity, or be Diabetic, have peripheral vascular dz, or be immunocompromised; normal baseline LFTs required
STADOL Nasal Spray	Butorphanol	Treatment of acute pain; failure or intolerance to Formulary narcotics. If used for migraines member must have failed Formulary Triptans and will be on prophylaxis while on Stadol.
STRATTERA (FOR AGES ≥18)	Atomoxetine	Treatment of ADHD, with documented ADHD diagnosis by Psychiatry. **QD dosing only. 1 capsule max/day for all strengths except 40mg. #2 capsule max/day for 40mg. No Prior Auth required for ages <18.
SUPRAX	Cefixime	Failure on first-line antibiotic, as indicated by nature of infection.
SYMBICORT	Budesonide/ formoterol	Prevention of Asthma attacks. Failure of low to medium dose inhaled corticosteroids or currently on both an inhaled corticosteroid and a long acting beta agonist.
SYMLIN _{NF}	Pramlintide	Treatment of Type I Diabetes. Patient must demonstrate compliance on their diabetes medications. Failure on Insulin; Requested by Diabetes specialist or Endocrinologist.
TARCEVA	Erlotinib	Tx of patients with locally advanced or metastatic non-small cell lung cancer as monotherapy Failure of platinum-based; requested by Oncology.
TAZORAC GEL	Tazarotene	Treatment of stable Plaque Psoriasis. Treatment of Cystic Acne, prescribed by Dermatologist (0.1% only).
TESTODERM Patch	Testosterone transdermal	Treatment of Hypogonadism (primary and secondary). Max 30/month. Must be prescribed by Endocrinologist. (Limited to males).
TOPAMAX	Topiramate	Treatment of Seizures, with therapy initiated by Neurology; not approved for Psychiatric use.
TRICOR	Fenofibrate	Treatment of Hypertriglyceridemia, when patient is at risk of pancreatitis. Failure or intolerance to Lipid.
TRILEPTAL	Oxcarbazepine	Treatment of Seizures, with therapy initiated by Neurology; not approved for Psychiatric use.
ULTRAVATE	Halobetasol	Failure on lower potency steroids, unless indicated by specific condition.

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BRAND NAME	GENERIC NAME	ABBREVIATED PRIOR AUTHORIZATION CRITERIA
UROXATRAL	Alfuzosin	Treatment of Benign Prostatic Hyperplasia (BPH); failure /intolerance to Hytrin/Cardura.
VFEND	Voriconazole	Treatment of invasive Aspergillosis; treatment of serious fungal infections caused by <i>Scedosporium Apiospermum</i> or <i>Fusarium</i> sp, in patients intolerant of, or refractory to other therapy.
VIGAMOX	Moxifloxacin	Treatment of bacterial Keratitis, Endophthalmitis, or prophylaxis for ocular surgeries; prescribed by Ophthalmologist.
VYTORIN	Ezetimibe and simvastatin	Treatment of Hypercholesterolemia. Failure on Simvastatin 80mg
WEIGHT LOSS Medication _{NF}	Various FDA-approved	Failure on structured weight loss and diet programs, member must have a BMI ≥ 33 plus two or more of the following risk factors: poorly controlled HTN, Diabetes, uncontrolled Dyslipidemia, significant Cardiac dz (except for Meridia), symptomatic sleep Apnea, restrictive lung disease, or DJD/Osteoarthritis of the hip and/or knee.
WELCHOL	Colesevelam HCl	Failure or intolerant to Cholestyramine.
WELLBUTRIN SR	Bupropion	Treatment of Depression. Not for smoking cessation (see ZYBAN).
XOPENEX _{NF}	Levalbuterol	PRN "Rescue" treatment of Asthma; significant, unexpected cardiac side effects while on regular nebulized Albuterol; in clinical trials, Xopenex has not been shown to be more effective than equipotent doses of Albuterol on an outpatient basis.
ZOFRAN Tab	Ondansetron	Prevention of post-operative nausea/vomiting; prevention of nausea/vomiting associated with radiotherapy. No PA required for prevention of chemotherapy induced nausea/vomiting. Limited to #9/21 day.
ZOMIG	Zolmitriptan	Failure or intolerant to Imitrex tablets, limited to #9/45 days
ZYBAN	Bupropion SR	For smoking cessation. Treatment course limited to 3 months. Member must be enrolled in Molina "Free and Clear" program or equivalent.
ZYMAR	Gatifloxacin	Treatment of bacterial Keratitis, Endophthalmitis, or prophylaxis for ocular surgeries; prescribed by Ophthalmologist.
ZYPREXA	Olanzapine	Treatment of Psychotic Disorders and Bipolar Mania; Prescribed by Psychiatrist. *NOTE: In LA, San Bernardino, Riverside, and GMC counties, pharmacy is to bill Medi-Cal Fee-For-Service on-line for all Medi-Cal members.
ZYRTEC, D	Cetirizine, Cetirizine/Pse	Treatment of Allergic Rhinitis/Urticaria; Failure of OTC antihistamines (Including Claritin and Nolahist) and nasal steroids. Not for use in combination with nasal steroids (combo no more effective than single agent)

NF= Non-formulary item

These guidelines for prior approval are for reference, only. They do not replace the professional judgment of the prescribing physician and do not necessarily apply to all patient-specific situations. All requests are looked at on a case by case basis.

Use of pharmaceutical samples in lieu of Formulary first-line agents does not guarantee authorization.

To request a copy of a prior authorization request form, or to request full-length criteria for a medication listed above (if applicable), call (800) 526-8196, x 127854.

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CARVED-OUT DRUGS

The Department of Health Services through the Medi-Cal Fee for Service program has assumed financial responsibility for select psychiatric medications in Los Angeles, San Bernadino, Riverside, Sacramento (GMC), and San Diego counties. Pharmacies must bill these medications on-line to Medi-Cal Fee-For-Service when prescribed to members residing in these counties. In these instances, Prior Authorization from the plan is not required. These medications are notated in the Formulary with "Medi-Cal FFS".

Psychiatric Drugs (Listed by Generic Name)		
Amantadine HCl (SYMMETREL)	Haloperidol Lactate (HALDOL)	Pimozide (ORAP)
Aripiprazole (ABILIFY)	lloperidone (FANAPT)	Procyclidine HCl (KEMADRIN)*
Asenapine (SAPHRIS)	Isocarboxazid (MARPLAN)	Promazine HCl (SPARINE)*
Benzotropine Mesylate (COGENTIN)	Lithium Carbonate (LITHOBID, LITHONATE, ESKALITH)	Quetiapine (SEROQUEL XR, SEROQUEL)
Biperiden HCl (AKINETON)*	Lithium Citrate (various generic)	Risperidone (RISPERDAL, RISPERDAL CONSTA)
Biperiden Lactate (AKINETON)*	Loxapine HCl (LOXITANE)	Selegiline (ELDEPRYL, EMSAM, ZELAPAR)
Chlorpromazine HCl (THORAZINE)	Loxapine Succinate (LOXITANE)	Thioridazine HCl (MELLARIL)
Chlorprothixene *	Mesoridazine Mesylate (SERENTIL)*	Thiothixene HCl (NAVANE)*
Clozapine(CLOZARIL)	Molindone HCl (MOBAN)	Tranlycypromine Sulfate (VESPERIN)
Fluphenazine Decanoate (PROLIXIN)	Olanzapine (ZYPREXA)	Trifluoperazine HCl (STELAZINE)
Fluphenazine Enanthate (PROLIXIN)	Olanzapine/Fluoxetine (SYMBYAX)	Triflupromazine HCl (VESPERIN)*
Fluphenazine HCl (PERMITIL, PROLIXIN)	Paliperidone (INVEGA)	Trihexyphenidyl HCl (ARTANE, TRIHEXY-5)
Haloperidol (HALDOL)	Perphenazine (TRILAFON)	Ziprasidone (GEODON)
Haloperidol Decanoate (HALDOL-D)	Phenelzine Sulfate (NARDIL)	

-List may not be inclusive. *Medications that are no longer made

HIV DRUGS (Listed by Generic Name)		
Abacavir/Lamivudine/Zidovudine Combination (TRIZIVIR)	Enfuvirtide (FUZEON)	Raltegravir Potassium (ISENTRESS)
Abacavir Sulfate (ZIAGEN)	Etravirine (INTELENCE)	Saquinavir (INVIRASE, FORTOVASE)
Amprenavir (AGENERASE)*	Fosamprenavir Calcium (LEXIVA)	Stavudine (ZERIT)
Atazanavir (REYATAZ)	Indinavir Sulfate (CRIVIVAN)	Telbivudine (TYZEKA) for Dx: HIV
Darunavir Ethanolate (PREZISTA)	Lamivudine (EPIVIR)	Tenofovir Disoproxil-Emtricitabine (TRUVADA)
Delavirdine Mesylate (RESCRIPTOR)	Lopinavir/Ritonavir (KALETRA)	Tenofovir Disoproxil (VIREAD)
Didanosine (VIDEX)	Maraviroc (SELZENTRY)	Tipranavir (APTIVUS)
Efavirenz (SUSTIVA)	Nelfinavir Mesylate (VIRACEPT)	Zidovudine/Lamivudine combination (COMBIVIR)
Efavirenz/Emtricitabine/ Tenofovir Disoproxil Fumarate (ATRIPLA)	Nevirapine (VIRAMUNE)	
Emtricitabine (EMTRIVA)	Ritonavir (NORVIR)	

-List may not be inclusive. *Medications that are no longer made

Detoxification/Dependency Agents (Listed by Generic Name)		
Acamprosate Calcium (CAMPRAL)	Buprenorphine HCl (SUBUTEX, BUPRENEX)	Naltrexone (Oral and Injectable) (REVIA, VIVITROL)
Buprenorphine/Naloxone HCl (SUBOXONE)		

-List may not be inclusive. *Medications that are no longer made

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