

2010/2011 Michigan Drug Formulary



Your Extended Family.

Table of Contents

I. Preface

Using the Molina Healthcare of Michigan Drug Formulary.....	pp 4
Specialty Bio-Pharmaceutical Medications.....	pp 5
Antineoplastics and Immunosuppressants	pp 6
State of Michigan, Carve Out.....	pp 7
Prior Authorization Helpful Hints	pp 8
Generic Medications.....	pp 9
Non-Covered Medications	pp 10
Pre-Authorization Request Procedure.....	pp 10
Prescription Quantities	pp 10
Telephone Prescriptions	pp 11
Individual Prescriptions	pp 11
Member After Hours Pharmacy Services	pp 11

II. Therapeutic Categories

Chapter 1. ANTIINFECTIVES	pp 12–15
Chapter 2. ENDOCRINE MEDICATIONS	pp 15–18
Chapter 3. CARDIOVASCULAR MEDICATIONS..	pp 19–23
Chapter 4. RESPIRATORY MEDICATIONS	pp 23–27
Chapter 5. GASTROINTESTINAL MEDICATIONS	pp 27–29
Chapter 6. GENITOURINARY	pp 29–30
Chapter 7. CENTRAL NERVOUS SYSTEM.....	pp 30–31
Chapter 8. ANALGESICS.....	pp 31–33
Chapter 9. NEURO-MUSCULAR.....	pp 34
Chapter 10. VITAMINS/ELECTROLYTES	pp 34–35
Chapter 11. HEMATOLOGICAL AGENTS	pp 35–36
Chapter 12. OPHTHALMIC MEDICATIONS.....	pp 36–38
Chapter 13. EAR, NOSE AND THROAT MEDICATIONS	pp 38–39
Chapter 14. DERMATOLOGICALS.....	pp 39–41
Chapter 15. MISCELLANEOUS.....	pp 42

III. Clinical Guidelines (MQIC)

Asthma (General Principles).....	pp 43
Asthma (Children 0-4 Years).....	pp 44
Asthma (Children 5-11 Years).....	pp 45
Asthma (Youth 12 and Older and Adults)	pp 46
Management of Diabetes Mellitus.....	pp 47
Outpatient Management of	
Uncomplicated Deep Venous Thrombosis.....	pp 48
Heart Failure	pp 49
Hypercholesterolemia.....	pp 50
Medical Management of Adults with Hypertension	pp 51
Chronic Kidney Disease	pp 52
Tobacco Control.....	pp 53
Obesity in Adults	pp 54
Childhood Overweight (Treatment)	pp 55
Childhood Overweight (Prevention).....	pp 56
Medical Management of Adults with Osteoarthritis.....	pp 57
Low Back Pain	pp 58
Management and Prevention of Osteoporosis.....	pp 59
Acute Pharyngitis in Children.....	pp 60
Acute Bronchitis.....	pp 61

IV. Index

Generic / BRAND Index.....	pp 62–76
----------------------------	----------

MOLINA HEALTHCARE DRUG FORMULARY

The Molina Healthcare of Michigan 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 Molina members receive high quality, cost-effective, rational drug therapy.

The Molina Healthcare of Michigan 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 providers 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 our Pharmacy Benefits Manager's Pharmacy and Therapeutics Advisory Panel. In addition, the Molina Pharmacy and Therapeutics Committee reviews prior authorization procedures to ensure medications are used safely, following manufacturer's guidelines and current medical practices.

If you are interested in serving on the Pharmacy and Therapeutics Committee, please contact the Pharmacy Department by calling (888) 898-7969, option 1, 5.

Please familiarize yourself with the Drug Formulary as you prescribe medications for Molina Healthcare of Michigan members. Thank you for your cooperation.

PREFACE

USING THE MOLINA HEALTHCARE OF MICHIGAN DRUG FORMULARY

The Molina Healthcare of Michigan Drug Formulary is a listing of preferred drug products eligible for reimbursement by Molina Healthcare of Michigan. All medications are listed by generic name. The medications are organized by therapeutic classes. For your convenience a table of contents by therapeutic category is found at the beginning and an index which lists formulary drugs by their brand and generic names is listed at the end of the Drug Formulary Book.

Specialty Bio-Pharmaceutical Medications

Caremark Specialty Pharmacy

In November 2003 Molina Healthcare of Michigan (MHM) entered into an exclusive contractual arrangement with *Caremark Specialty Pharmacy* to be the provider of specialty bio-pharmaceutical medications. This program allows our health plan to obtain the best possible price and at the same time, obtain other services to assist in the overall healthcare management of the member. Specialty medications may be delivered directly to the patient or to your office.

NOTE: *Caremark Specialty Pharmacy* requires the patient's telephone number to verify certain information such as continued insurance eligibility and availability to sign for the package. Please see below for a list of medications handled by *Caremark Specialty Pharmacy*.

If you have any questions, please feel free to call Pharmacy Services at (888) 898-7969. The pharmacy fax line is (888) 373-3059.

ACTIMMUNE	HERCEPTIN	NOVANTRONE	SEROSTIM
ADVATE	HUMATE P	NOVOSEVEN	SPRYCEL
ALPHANATE	HUMATROPE	NUTROPIN	STIMATE
ALPHANINE	HUMIRA	OCETREOTIDE	SUTENT
APLIGRAF	INCRELEX	PEGASYS	SYNAGIS
ARIXTRA	INFERGEN	PEG-INTRON	SYNAREL
ARANESP	INTRON A	PROCRIT	TARCEVA
AUTOPLEX	KINERET	PROFILNINE	TEMODAR
AVONEX	KOATE	PROPLEX	TEVTROPIN
BEBULIN	KOGENATE	PULMOZYME	THALOMID
BENEFIX	LEUKINE	RAPTIVA	THROMATE
BETASERON	LOVENOX	REBETOL	THYROGEN
COPAXONE	LUCENTIS	REBETRON	TOBI
COPEGUS	LUPRON	REBIF	TRACLEER
DDAVP	MONARCH M	RECOMBINATE	TYKERB
ELAPRASE	MONCLATE	REFACTO	TRELSTAR
ENBREL	MONONINE	REMODULIN	VIADUR
EPOGEN	MYOBLOC	REVATIO	VIDAZA
EUFLEXXA	NEUMEGA	REVLIMID	VANTAS
FEIBA-VH	NEULASTA	RHOGAM	VISUDYNE
FORTEO	NEUPOGEN	RIBAVIRIN	WHINRHO
FRAGMIN	NEXAVAR	REFERON	XELODA
GLEEVEC	NORDITROPIN	SAIZEN	XOLAIR
HELIXATE	NORDIFLEX	SANDOSTATIN	ZOLADEX

All medications on this list require Prior Authorization which must be faxed to Molina Healthcare of Michigan.

Antineoplastics and Immunosuppressants

All FDA-Approved, Non-injectable Antineoplastics and immunosuppressants are eligible for coverage. Injectable and certain high cost oral medications in this class are subject to Prior Authorization and must be filled through *Caremark Specialty Pharmacy*.

Generic Name	Brand Name
Melphalan	ALKERAN
Anastrozole	ARIMIDEX
Bicalutamide	CASODEX
Lomustine	CEENU
Mycophenolate Mofetil	CELLCEPT
Cyclophosphamide	CYTOXAN
Estramustine	EMCYT
Levamisole	ERGAMISOL
Flutamide	EULEXIN
Toremifine	FARESTON
Letrozole	FEMARA
Altrefamine	HEXALEN
Hydroxyurea	HYDREA
Azathioprine	IMURAN
Chlorambucil	LEUKERAN
Mitotane	LYSODREN
Procarbazine	MATULANE
Megestrol	MEGACE
Busulfan	MYLERAN
Tamoxifen	NOLVADEX
Tacrolimus	PROGRAF
Mercaptoprine	PURINETHOL
Sirolimus	RAPAMUNE
Methotrexate	RHEUMATREX
Cyclosporine	SANDIMUNNE
Cyclosporine	NEORAL
Testolactone	TESLAC
Thioguanine	THIOGUANINE
Etoposide	VEPESID
Pipobroman	VERCYTE
Tretinoin	VESANOID

Other medications are added in this class regularly. Please contact MHM for coverage information if the medication you are requesting does not appear on this list at (888) 898-7969.

State of Michigan, Carve Out

Effective October 2004, the State of Michigan enacted a Carve out for all Psychotropic and HIV/AIDS related medications. Effective April 2010, additional classes of medication have been added to the Carve Out. These classes include ADHD, Anti-Depressive, Sedative, Anti-Anxiety and Anti-Convulsant medications. Claims for these medications must be submitted directly to the State of Michigan, First Health. Molina members may be responsible for a \$1.00-\$3.00 co-pay on these medications as indicated by State rules.

Effective 10/1/2004	STELAZINE	DIASTAT, ACUDIAL	PHENOBARBITAL
ABILIFY	SUBOXONE	DILANTIN	PHENYTEK
AGENERASE	SUSTIVA	DORAL	PRISTIQ
AKINETON	SYMBYAX	EDLUAR	PROSOM
APTIVUS	THORAZINE	EFFEXOR, XR	PROVIGIL
ARTANE	TRILAFON	ELAVIL	PROZAC, WEEKLY
ATRIPLA	TRIZIVIR	EMSAM	REMERON
CAMPREL	TRUVADA	FELBATOL	RESTORIL
CLOZARIL	VIDEX, -EC	FOCALIN, XR	RITALIN, SR, LA
COGENTIN	VIRACEPT	GABITRIL	ROZEREM
COMBIVIR	VIRAMUNE	HALCION	SARAFEM
CRIVIVAN	VIREAD	INTUNIV	SECONAL SODIUM
EMTRIVA	ZERIT	KEPPRA, XR	SERAX
EPIVIR	ZIAGEN	KLONOPIN	SERZONE
EPZICOM	ZYPREXA, ZYDIS	LAMICTAL, ODT, XR	SINEQUAN
FAZACLO	Effective 4/1/2010	LEXAPRO	SOMNOTE, NOCTEC
FORTOVASE	ADDERALL, XR	LIBRIUM	SONATA
FUZEON	AMBIEN CR	LIMBITROL, DS	STAVZOR
GEODON	ANAFRANIL	LUDIOMIL	STRATTERA
HALDOL	APLENZIN, ER	LUMINAL	SURMONTIL
HIVID	ASENDIN	LUNESTA	TEGRETOL, XR
INAPSINE	ATIVAN	LUVOX, CR	TOFRANIL, PM
INVIRASE	BANZEL	LYRICA	TOPAMAX
KALETRA	BUSPAR, VANSAPAR	MARPLAN	TRANXENE T-TAB
KEMADRIN	BUTISOL SODIUM	MEBARAL	TRIAVIL, ETRAFON
LEXIVA	CARBATROL	METADATE ER, CD	TRILEPTAL
LOXITANE	CELEXA	MILTOWN	VALIUM
MELLARIL	CELONTIN	MYSOLINE	VIMPAT
MOBAN	CEREBYX	NARDIL	VIVACTIL
NAVANE	CONCERTA	NEURONTIN	VYVANSE
NORVIR	CYMBALTA	NIRAVAM	WELLBUTRIN, SR, XL
ORAP	DALMANE	NORPRAMIN	XANAX, -XR
PROLIXIN	DAYTRANA	NUVIGIL	ZARONTIN
RESCRIPTOR	DEPAKENE	PAMELOR	ZOLOFT
RETROVIR	DEPAKOTE, ER	PARNATE	ZONEGRAN
REYATAZ	DESYREL	PAXIL, CR	
RISPERDAL	DEXEDRINE	PEGANONE	
SEROQUEL	DEXTROSTAT	PEXEVA	

PRIOR AUTHORIZATION HELPFUL HINTS

To ensure the quickest response possible from MHM Pharmacy Department please provide the following information with the Prior Authorization request.

Class of Medication/Diagnosis	Requested Clinical Information
Cholesterol Lowering	Lipid Panel
Diabetics	A1c Report
Osteoperosis	Bone Density Study
Proton Pump Inhibitor (For BID dosing only)	Endoscopy Report
Onychomycosis	Culture and Sensitivity Report
Pain Management	Medication Log, Narcotic Contract and Progress Notes
Non-Formulary Medications	Medication Log and/or Progress Notes documenting previous use of formulary medications
Non-Preferred Medications for new Members	Medication Log and/or Progress Notes documenting previous use of requested medications

GENERIC MEDICATIONS

Selected medications have FDA-approved generic equivalents available. The Molina Healthcare of Michigan 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 provider, the provider must submit a Prior Authorization request and explain clinically why the branded drug product is medically necessary.

Molina Healthcare of Michigan encourages the use of quality generic products. Only those generic products which have received an “A” rating by the FDA should be utilized. Physicians are encouraged to write “Brand Only” or “DAW” only when medically necessary. Members are not permitted to ask for brand name drugs.

The Pharmacy and Therapeutics Committee recognizes that certain medications possess narrow therapeutic dose response characteristics. Therefore, the following drugs are not required to be generically substituted, unless the patient has been therapeutically maintained on the generic product for a period of time.

Generic Name	Brand Name
Digoxin	Lanoxin, Digitek
Levothyroxine	Synthroid or Levoxyl
Cyclosporine	Sandimmune, Neoral
Warfarin	Coumadin

NON-COVERED MEDICATIONS

Please note that certain medications are not covered. These include, but are not limited to:

- Medications for Cosmetic Purposes, including Retinoic Acid
- Experimental or Investigational Medications
- Convenience Dosage Forms (Transdermal Patches), not listed in the Formulary
- Fertility Drugs – Per MDCH Contract
- Erectile Dysfunction Drugs
- OTC Medications not found in formulary
- Medications used for non-FDA approved indications, unless approved by Medical Director
- Oxycontin
- Nutritional Supplements/Medical Foods (May be available through Utilization Management Department)

PRIOR AUTHORIZATION REQUEST PROCEDURE

Prescriptions for medications requiring prior approval or for medications not included on the Molina Drug Formulary may be approved when medically necessary and when formulary alternatives have demonstrated ineffectiveness. When these exceptional situations arise, the physician may fax a completed drug prior authorization form to Molina at (888) 373-3059. The forms may be obtained from Molina Healthcare of Michigan Pharmacy Prior Authorization Department by calling (888) 898-7969 and selecting 1 as a Provider and 5 for the Pharmacy Department or by visiting <http://www.molinahealthcare.com/medicaid/providers/mi/forms>. Trials of pharmaceutical samples do not guarantee or override prior authorization approval.

PRESCRIPTION QUANTITIES

Prescriptions should be written for a therapeutic supply of medications (the amount to appropriately treat a medical condition) up to a maximum of a 30-day supply. Trial quantities may be used when trying new treatments, if appropriate. Some drugs may have quantity limits.

TELEPHONE PRESCRIPTIONS

Whenever possible, the patient should be given the prescription in writing or delivered directly to the pharmacy via e-prescribing. This will allow the patient to make use of the most convenient network pharmacy and enable the pharmacy to fill the prescription after normal office hours.

INDIVIDUAL PRESCRIPTIONS

Each prescription must legally be prescribed for one individual only. If prescribing for a family, each family member must receive a prescription.

MEMBER AFTER HOURS PHARMACY SERVICES

POLICY - After normal business hours, which is defined as after the close of Molina Healthcare of Michigan Pharmacy Department (Mon-Fri) 8:00 AM-6:00 PM EST.

Molina specialized agents are available at the CVS/Caremark Help Desk and may be contacted for assistance at (800) 791-6856. The after hours pharmacy policy goes into effect as described in the Procedure section.

PURPOSE - This policy establishes the infrastructure and procedures for plan members to obtain medications on an emergency basis and on a 24-hour/day/7day/week basis.

SCOPE - This policy applies to CVS/Caremark contracted pharmacy providers dispensing medications to Molina Healthcare of Michigan members after the Plan's normal business hours.

PROCEDURE

During after hours situations contact the CVS/Caremark Helpdesk at (800) 791-6856 for an override to approve a three day supply of any medication which "when not given may cause the member's condition to worsen".

MOLINA HEALTHCARE OF MICHIGAN DRUG FORMULARY

Generic Available*

Generic Name

Brand Name

Chapter 1 ANTIINFECTIVES

1.1 Penicillins

- **ANTIBIOTICS IN SUSPENSION FORM DO NOT REQUIRE A PA FOR MEMBERS 12 YEARS AND YOUNGER**
- Bronchitis due to viral infections should not be treated with antibiotics.
- 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/proven PCN-resistant *S. pneumoniae*.
- The secondary choice for patients with contraindications to amoxicillin is SMZ/TMP (generic Bactrim, Septra).

First Line:

*	Dicloxacillin	DYNAPEN
*	Ampicillin	PRINCIPEN
*	Amoxicillin	TRIMOX
*	Penicillin VK	VEETIDS

2nd Line:

*	Amoxicillin/potassium clavulanate	AUGMENTIN (Max#20)
---	-----------------------------------	--------------------

1.2 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.

First Line:

*	Cefaclor	CECLOR
*	Cephalexin	KEFLEX

2nd Line:

*	Cefuroxime	CEFTIN
*	Cefadroxil Monohydrate	DURICEF

PRIOR AUTHORIZATION REQUIRED

*	Cefaclor	CECLOR CD [^]
*	Cefprozil	CEFZIL [^]
*	Cefdinir	OMNICEF [^]
	Cefixime	SUPRAX [^]

[^]SUSPENSION FORM - NO PA MEMBERS 12 & UNDER

MOLINA HEALTHCARE OF MICHIGAN DRUG FORMULARY

Generic Available*	Generic Name	Brand Name
1.3 Erythromycins		
<ul style="list-style-type: none"> 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 theophylline, carbamazepine (Tegretol), cyclosporin (Sandimmune, Neoral, Sangcya) and warfarin (Coumadin). 		
First Line:		
*	Erythromycin ethylsuccinate	EES
*	Erythromycin base, (enteric-coated)	ERY-TAB
*	Erythromycin stearate	ERYTHROCIN
2nd Line:		
*	Azithromycin	ZITHROMAX 250 MG (Max #6)

PRIOR AUTHORIZATION REQUIRED

*	Clarithromycin	BIAXIN [^]
*	Telithromycin	KETEK
*	Azithromycin	ZITHROMAX 1GM POWDER PACK**

[^]SUSPENSION FORM - NO PA MEMBERS 12 & UNDER

**NO PA REQUIRED WHEN BILLED AS A 1 DAY STAT DOSE

1.4 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.

*	Tetracycline	SUMYCIN
*	Doxycycline	VIBRAMYCIN

1.5 Quinolones

- Not generally considered First Line therapy for most infections.
- 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.

MOLINA HEALTHCARE OF MICHIGAN DRUG FORMULARY

Generic Available*	Generic Name	Brand Name
*	Ciprofloxacin	CIPRO (Max #20)
PRIOR AUTHORIZATION REQUIRED		
*	Moxifloxacin	AVELOX
	Ofloxacin	FLOXIN
	Levofloxacin	LEVAQUIN
<u>1.6 Aminoglycosides</u>		
*	Neomycin	
<u>1.7 Sulfonamides</u>		
*	Smz/tmp	BACTRIM, SEPTRA
*	Sulfisoxazole	GANTRISIN
*	Sulfisoxazole/ erythromycin Susp.	PEDIAZOLE
<u>1.8 Antituberculosis</u>		
*	Isoniazid	ISONIAZID
*	Ethambutol	MYAMBTOL
	Pyrazinamide	PYRAZINAMIDE
*	Rifampin	RIFADIN
*	Pyridoxine	VITAMIN B-6
<u>1.9 Antifungal</u>		
First Line:		
*	Griseofulvin	FULVICIN UF, FULVICIN PG
*	Clotrimazole	MYCELEX (troches only)
2nd Line:		
*	Terbinafine tablets	LAMISIL TABLETS (Max #30)
PRIOR AUTHORIZATION REQUIRED		
*	Fluconazole	DIFLUCAN
*	Ketoconazole	NIZORAL
	Posaconazole	NOXAFIL
<u>1.10 Antiviral</u>		
*	Amantadine	SYMMETREL
*	Acyclovir	ZOVIRAX (tab, capsules, ointment, cream)

MOLINA HEALTHCARE OF MICHIGAN DRUG FORMULARY

Generic Available*	Generic Name	Brand Name
<u>1.11 Antimalarial</u>		
	Pyrimethamine Primaquine Phosphate	DARAPRIM PRIMAQUINE
<u>1.12 Anthelmintics</u>		
*	Mebendazole	VERMOX
<u>1.13 Miscellaneous Antiinfectives</u>		
*	Clindamycin	CLEOCIN (150mg only)
*	Metronidazole Nitrofurantoin monohyd/ macrocrystals LA	FLAGYL MACROBID
*	Nitrofurantoin	MACRODANTIN
*	Trimethoprim	TRIMPEX

PRIOR AUTHORIZATION REQUIRED

Nitazoxanide	ALINIA
Entecavir	BARACLUDGE

Chapter 2

ENDOCRINE MEDICATIONS

2.1 Systemic Corticosteroids

2.1.1 Glucocorticosteroids

*	Hydrocortisone	CORTEF
*	Dexamethasone	DECADRON
*	Methylprednisolone	MEDROL
*	Prednisolone	ORAPRED (syrup- No PA for members 18 and under)
*	Prednisone	ORASONE
*	Prednisolone Prednisolone Syrup	PREDNISOLONE PRELONE

2.1.2 Mineralocorticoids

*	Fludrocortisone	FLORINEF
---	-----------------	----------

2.2 Estrogens

*	Estradiol Estrogens, conjugated	ESTRACE PREMARIN (tabs, vaginal cream)
---	------------------------------------	--

MOLINA HEALTHCARE OF MICHIGAN DRUG FORMULARY

Generic Available*	Generic Name	Brand Name
PRIOR AUTHORIZATION REQUIRED		
*	Estradiol Transdermal	ESTRADERM PATCH, VIVELLE
2.2.1	Estrogen/Progesterone Combination	FEMHRT PREMPHASE PREMPRO
<u>2.3 Oral Contraceptives #28 covered per 28 days</u>		
2.3.1 Mono-Phasic Oral Contraceptives		
*	Levonorgestrel/ethinyl estradiol	ALESSE
*	Levonorgestrel/ethinyl estradiol	LEVLEN
*	Norgestrel/ethinyl estradiol	LO OVRAL, OVRAL
*	Ethinyl estradiol/ norethindrone acetate	LOESTRIN
*	Ethinyl estradiol/norethindrone	MODICON
*	Levonorgestrel/ethinyl estradiol	NORDETTE
*	Ethinyl estradiol/desogestrel	ORTHO-CEPT
*	Ethinyl estradiol/norgestimate	ORTHO-CYCLEN
*	Norethindrone/ethinyl estradiol	ORTHO-NOVUM 1/35
*	Norethindrone/mestranol	ORTHO-NOVUM 1/50
*	Norethindrone/ethinyl estradiol	OVCON-35, OVCON-50
*	Ethinyl estradiol/Drosirenone	YASMIN
2.3.2 Bi-Phasic Oral Contraceptives		
*	Norethindrone/ethinyl estradiol	ORTHO-NOVUM 10/11
2.3.3 Tri-Phasic Oral Contraceptives		
*	Norethindrone/ethinyl estradiol	ESTROSTEP
*	Norethindrone/ethinyl estradiol	ORTHO-NOVUM 7/7/7
*	Norgestimate/ethinyl estradiol	ORTHO TRI-CYCLEN
*	Levonorgestrel/ethinyl estradiol	TRIPHASIL
2.3.4 Progestin Only Oral Contraceptives		
*	Norethindrone	MICRONOR
*	Norgestrel	OVRETTE
<u>2.4 Miscellaneous Contraceptives</u>		
*	Medroxyprogesterone acetate	DEPO-PROVERA (150mg/ml)
<u>2.4A Other Contraceptives</u>		
	Etonogestrel/ethinyl estradiol	NUVA RING
<u>2.5 Progestins</u>		
*	Norethindrone acetate	AYGESTIN
*	Medroxyprogesterone	PROVERA, CYCRIN

MOLINA HEALTHCARE OF MICHIGAN DRUG FORMULARY

Generic Available*	Generic Name	Brand Name
<u>2.6 Oral Hypoglycemics</u>		
	Pioglitazone/Metformin	ACTOPLUS (Step Therapy: Three month trial of Metformin and A1c < 8.5)
	Pioglitazone	ACTOS (Step Therapy: Three month trial of Metformin and A1c < 8.5)
*	Glimepiride	AMARYL
*	Glyburide	DIABETA
*	Chlorpropamide	DIABINESE
*	Metformin	GLUCOPHAGE
*	Metformin, Extended-Release	GLUCOPHAGE XR
*	Glipizide	GLUCOTROL
*	Glipizide extended release	GLUCOTROL XL
*	Metformin/Glipizide	GLUCOVANCE
*	Glyburide	GLYNASE
	Sitagliptin/Metformin	JANUMET (Step Therapy: Three month trial of Metformin and A1c < 8.5)
	Sitagliptin	JANUVIA (Step Therapy: Three month trial of Metformin and A1c < 8.5)
*	Tolbutamide	ORINASE
*	Tolazamide	TOLINASE
PRIOR AUTHORIZATION REQUIRED		
*	Acarbose	PRECOSE

2.7 Insulins/Supplies

- Insulin PENS are covered for all members under 16 years of age
- Insulin PEN Step Therapy for members over 16 years of age: Covered for patients with documented retinopathy and neuropathy

Insulin Lispro	HUMALOG, NOVOLOG
Insulin-Human, recombin	HUMULIN, NOVOLIN
Insulin Glargine	LANTUS
Glucometer	TRUE TRACK/ TRUE RESULT
Glucose Test Strips	TRUE TRACK/ TRUE TEST
Insulin Syringes, OTC	
Lancets, OTC	

MOLINA HEALTHCARE OF MICHIGAN DRUG FORMULARY

Generic Available*	Generic Name	Brand Name
<u>2.8 Glucagon</u>		
	Glucagon	GLUCAGON KIT
<u>2.9 Antithyroid Drugs</u>		
*	Propylthiouracil	PTU
*	Methimazole	TAPAZOLE
<u>2.10 Thyroid Hormones</u>		
*	Thyroid desiccated Levothyroxine	ARMOUR THYROID SYNTHROID, LEVOXYL
<u>2.11 Endometriosis Therapy</u>		
*	Danazol Nafarelin	DANOCRINE SYNAREL
<u>2.12 Osteoporosis Drugs</u>		
*	Alendronate	FOSAMAX
PRIOR AUTHORIZATION REQUIRED		
*	Raloxifene Calcitonin Salmon	EVISTA^ MIACALCIN NASAL SPRAY^
^NO PA REQUIRED FOR MEMBERS OVER 50 YEARS OF AGE. TO EXPEDITE RESPONSE PLEASE SUBMIT CURRENT BONE DENSITY STUDY		
<ul style="list-style-type: none"> • Management of osteoporosis should start with: <ul style="list-style-type: none"> • Adequate dietary calcium, including calcium supplementation in therapeutic doses. • Weight bearing exercise. • Estrogen replacement, if not contraindicated. • Reduction of caffeine intake. • Bisphosphonate patients should be carefully selected to ensure that they are able to be compliant with dosing/absorption requirements. • Fosamax 5mg is the only strength indicated for prevention, rather than treatment of osteoporosis. • Evista is not considered first-line therapy for a majority of patients. Its use should be reserved for those patients unable to tolerate estrogen or HRT therapy, due to intolerable adverse effects or those at a very high risk of breast cancer. Long term effects of Evista are not known at this time. 		
<u>2.13 Other Endocrine Drugs</u>		
*	Ergocalciferol	CALCIFEROL
*	Bromocriptine	PARLODEL

MOLINA HEALTHCARE OF MICHIGAN DRUG FORMULARY

Generic Available*

Generic Name

Brand Name

Chapter 3

CARDIOVASCULAR MEDICATIONS

3.1 Cardiac Glycosides

- Digitalis toxicity is increased by hypokalemia.
- Co-administration of digoxin with verapamil or quinidine increases digoxin levels and may cause toxicity.

Digoxin Solution

DIGOXIN SOLUTION
(No PA for members 12 and under)

*

Digoxin

DIGITEK, LANOXIN

3.2 Nitrates

- Tolerance to oral nitrates such as isosorbide dinitrate (Isordil) may result in an increase in the dose required. Oral nitrates should be prescribed no more frequently than TID with a nitrate-free period of 10-12 hours per day.

*

Isosorbide dinitrate SR
Isosorbide mononitrate

DILATRATE SR
IMDUR, MONOKET,
ISMO

*

Isosorbide dinitrate

ISORDIL (excluding Tembids)

*

Nitroglycerin SR

NITRO-BID

*

Nitroglycerin patch

NITRO-DUR,
DEPONIT

*

Nitroglycerin spray

NITROLINGUAL
SPRAY

*

Nitroglycerin Oint

NITROL OINT

*

Nitroglycerin

NITROSTAT

NOTE: IN THE TREATMENT OF HYPERTENSION, JNC VII GUIDELINES CONTINUE TO RECOMMEND DIURETICS OR BETA-BLOCKERS TO BE FIRST LINE, COST EFFECTIVE THERAPY, EXCEPT IN AFRICAN AMERICANS.

3.3 Metabolic Modulators

PRIOR AUTHORIZATION REQUIRED

Ranolazine

RANEXA

3.4 Beta-Blockers

3.4.1 Beta-1 Specific

*

Carvedilol

COREG

*

Metoprolol

LOPRESSOR

*

Atenolol/Chlorthalidone

TENORETIC

MOLINA HEALTHCARE OF MICHIGAN DRUG FORMULARY

Generic Available*	Generic Name	Brand Name
	Atenolol	TENORMIN
	Metoprolol ER	TOPROL XL
3.4.2 Non-Selective		
	Nadolol	CORGARD
	Propranolol	INDERAL
	Propranolol ER	INNOPRAN XL
	Penbutolol	LEVATOL
	Labetalol	NORMODYNE
	Bisoprolol	ZEBETA
3.4.3 Beta-Blocker Combinations		
	Bisoprolol/HCTZ	ZIAC
<u>3.5 Calcium Antagonists</u>		
	Nifedipine SR	ADALAT-CC
	Verapamil	CALAN
	Verapamil SR	CALAN SR
	Diltiazem & Diltiazem ER	DILACOR XR, TIAZAC, CARDIZEM, -CD, -SR
	Isradipine	DYNACIRC, DYNACIRC CR
	Amlodipine	NORVASC
	Nifedipine	PROCARDIA

3.6 Antidysrhythmic Drugs

- Avoid combining agents of the same class or agents with potentially additive side effects (QT interval prolongation, negative inotropic effects, etc.) Antiarrhythmics may provoke arrhythmia (proarrhythmia); hypokalemia enhances the proarrhythmic effect of many drugs.
- The risk of proarrhythmia increases with worsening left ventricular function and ischemia.

*	Amiodarone	CORDARONE, PACERON
*	Procainamide SR	PROCANBID
*	Procainamide	PRONESTYL
*	Quinidine gluconate	QUINAGLUTE
	Quinidine sulfate SR	QUINIDEX
*	Quinidine Sulfate	QUINIDINE SULFATE
	Dronedarone	MULTAQ (Step Therapy: Three month trial of Amiodarone)

3.7 Angiotensin Converting Enzyme Inhibitor

- ACE inhibitors may precipitate acute renal failure and hyperkalemia in patients with severe heart failure, pre-existing renal disease, or hypovolemic states.

MOLINA HEALTHCARE OF MICHIGAN DRUG FORMULARY

Generic Available*	Generic Name	Brand Name
	<ul style="list-style-type: none"> • 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. • Co-administration of ACE inhibitors with potassium or potassium-sparing diuretics increases the risk of hyperkalemia. 	
*	Quinapril	ACCUPRIL
*	Captopril	CAPOTEN
*	Benazepril	LOTENSIN
*	Trandolapril	MAVIK
*	Lisinopril	ZESTRIL
3.7.1	Angiotensin Converting Enzyme Inhibitor/Diuretic Combinations	
*	Quinapril/HCTZ	ACCURETIC
*	Captopril/HCTZ	CAPOZIDE
*	Benazepril/HCTZ	LOTENSIN - HCT
*	Lisinopril/HCTZ	ZESTORETIC
3.7.2	Angiotensin Converting Enzyme Inhibitor/Calcium Channel Blocker Combinations	
	Trandolapril/Verapamil ER	TARKA
3.7.2	Angiotensin Converting Enzyme Inhibitor/Diuretic Combinations	
*	Enalapril	VASOTEC
3.7.2	Angiotensin Converting Enzyme Inhibitor/Calcium Channel Blocker Combinations	
*	Enalapril/HCTZ	VASORETIC
3.7.3	Angiotensin II Receptor Antagonists	
	<ul style="list-style-type: none"> • 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. 	
	Olmesartan	BENICAR (Step Therapy: Three month trial of ACE Inhibitor)
	Telmisartan	MICARDIS (Step Therapy: Three month trial of ACE Inhibitor)
3.7.4	Angiotensin II Antagonist Combination	
	Olmesartan/HCTZ	BENICAR HCT (Step Therapy: Three month trial of ACE Inhibitor)
	Telmisartan/HCTZ	MICARDIS HCT (Step Therapy: Three month trial of ACE Inhibitor)

MOLINA HEALTHCARE OF MICHIGAN DRUG FORMULARY

Generic Available*	Generic Name	Brand Name
<u>3.8 Antiadrenergic Agents-Centrally Acting</u>		
*	Methyldopa	ALDOMET
*	Clonidine	CATAPRES (tablets only)
*	Doxazosin	CARDURA
<u>3.9 Alpha Blockers</u>		
*	Terazosin	HYTRIN
*	Prazosin	MINIPRESS
<u>3.10 Vasodilators</u>		
*	Hydralazine	APRESOLINE
<u>3.11 Diuretics</u>		
3.11.1 Loop Diuretics		
*	Bumetanide	BUMEX
*	Furosemide	LASIX
*	Furosemide Solution	LASIX SOLUTION (No PA for members 12 and under)
3.11.2 Thiazide & Related Diuretics		
*	Hydrochlorothiazide	HYDRODIURIL
*	Indapamide	LOZOL
*	Metolazone	ZAROXOLYN
3.11.3 Potassium Sparing Diuretics		
*	Spironolactone/HCTZ	ALDACTAZIDE
*	Spironolactone	ALDACTONE
*	Triamterene/HCTZ	DYAZIDE
*	Triamterene/HCTZ	MAXZIDE-25, MAXZIDE-51
3.11.4 Carbonic Anhydrase Inhibitor		
*	Acetazolamide	DIAMOX
*	Methazolamide	NEPTAZANE
<u>3.12 Cholesterol Lowering Agents</u>		
<ul style="list-style-type: none"> • Drug treatment for lowering cholesterol should be considered only when patients have not responded to non-drug therapies such as dietary restrictions, smoking cessation and exercise programs. Patients who are unwilling to be compliant with lifestyle modifications may not be appropriate candidates for drug therapy. • The selection of a cholesterol-lowering drug should be based upon a) patient risk factors for coronary artery disease and b) the percentage decrease in levels that is required. Treatment criteria are based on nationally recognized treatment guidelines. 		

MOLINA HEALTHCARE OF MICHIGAN DRUG FORMULARY

Generic Available*	Generic Name	Brand Name
3.12.1 HMG CoA Reductase		
	Rosuvastatin	CRESTOR (Step Therapy: Three month trial of Simvastatin)
*	Simvastatin	ZOCOR

PRIOR AUTHORIZATION REQUIRED

Ezetimibe/Simvastatin VYTORIN

**TO EXPEDITE RESPONSE PLEASE INCLUDE CURRENT
LIPID PANEL ALONG WITH REQUEST FORM**

3.12.2 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.

	Niacin - Lovastatin	ADVICOR
*	Colestipol	COLESTID TABLETS
*	Fenofibrate	LOFIBRA
*	Gemfibrozil	LOPID
*	Niacin, Niacin SR	NIACIN, SLO-NIACIN, NIASPAN
*	Cholestyramine	QUESTRAN (can only)
*	Cholestyramine	QUESTRAN LIGHT (can only)

3.13 Miscellaneous Cardiovascular Drugs

*	Pentoxifylline	TRENTAL
---	----------------	---------

Chapter 4

RESPIRATORY MEDICATIONS

4.1 Antihistamines

- Nasonex not covered without documented trial and failure of Flonase.
- Use of OTC, first generation antihistamines is recommended as initial therapy. Antihistamines should be used with caution in patients taking MAO inhibitors, alcohol or other CNS depressants.

4.1.1 Single-Entity Products

Consider OTC PRODUCTS as first line therapy

*	Fluticasone	FLONASE
	Azelastrine	ASTELIN
*	Hydroxyzine	ATARAX, VISTARIL
*	Diphenhydramine	BENADRYL OTC BENADRYL (syrup)

MOLINA HEALTHCARE OF MICHIGAN DRUG FORMULARY

Generic Available*	Generic Name	Brand Name
*	Chlorpheniramine	CHLOR-TRIMETON OTC
	Cromolyn-Nasal inhaler	NASALCROM OTC
*	Cyproheptadine	PERIACTIN
*	Clemastine	TAVIST

PRIOR AUTHORIZATION REQUIRED

Azelastine	ASTEPRO
Mometasone	NASONEX

Lower Sedating Antihistamines

- The use of lower sedating antihistamines is usually reserved for those patients who engage in high risk activities that would be compromised from a preferred antihistamine.

*	Loratadine	CLARITIN OTC
*	Loratadine	CLARITIN SYRUP OTC (No PA for members 18 and under)
	Loratadine/pseudoeph	CLARITIN-D OTC
*	Cetirizine	ZYRTEC OTC
*	Ceririzine	ZYRTEC SYRUP OTC (No PA for members 6 and under)
*	Cetirizine/Pseudoephedrine	ZYRTEC-D OTC

PRIOR AUTHORIZATION REQUIRED

*	Fexofenadine	ALLEGRA
*	Fexofenadine/Pseudoephedrine	ALLEGRA-D

4.1.2 Combination Products

OTC Products May Be Used As First Line Therapy

*	Triprolidine/ Pseudoephedrine, OTC	ACTIFED OTC (tabs)
	Brompheniramine/ Pseudoephedrine	BROMFED, -PD
*	Chlortrimeton/Decong.	CONTAC OTC (12 hour caps)
	Chlorpheniramine/ Pseudoephedrine	DECONAMINE SR
*	Bromphen/Decong	DIMETAPP OTC (tabs)
*	Carbinoxamine/phenylephrine	CERON (tabs)

MOLINA HEALTHCARE OF MICHIGAN DRUG FORMULARY

Generic Available*	Generic Name	Brand Name
4.2 Decongestant Products		
*	Pseudoephedrine, OTC	SUDAFED OTC (tabs)
4.3 Antitussives & Expectorants		
*	Hydrocodone/Phenyl/CTM	HISTUSSIN HC
*	Guaifenesin/ Dextromethorphan	HUMIBID DM, FENESIN DM
*	Guaifenesin	HUMIBID LA
*	Phenylephrine/promethazine	PHENERGAN VC
*	Dextromethorphan/ promethazine	PHENERGAN DM
*	Codeine/promethazine	PHENERGAN/ CODEINE
*	Codeine/phenylephrine/ promethazine	PHENERGAN VC & COD
*	Guaifenesin, OTC	ROBITUSSIN OTC
*	Guaifenesin/Codeine	ROBITUSSIN AC
	Guaifenesin/ Pseudoephedrine/ Codeine	ROBITUSSIN DAC
*	Guaifenesin/ Dextromethorphan	ROBITUSSIN DM OTC
*	Benzonate	TESSALON PERLES
*	Guaifenesin/ Dextromethorphan	TUSSI-ORGANIDIN- DM NR
*	Guaifenesin/Codeine	TUSSI-ORGANIDIN NR
4.4 Antiasthmatics		
4.4.1 Adrenergic Stimulants-Inhalers		
*	Albuterol	PROAIR HFA INHALER
*	Metaproterenol Pirbuterol	ALUPENT INHALER MAXAIR AUTOHALER
PRIOR AUTHORIZATION REQUIRED		
	Fomoterol	FORADIL^
	Salmeterol	SEREVENT^
^ NO PA REQUIRED AFTER MEDICATION HAS BEEN FILLED CONSISTENTLY FOR THREE MONTHS		
4.4.2 Adrenergic Stimulants-Solutions		
*	Metaproterenol	ALUPENT
*	Albuterol	PROVENTIL

MOLINA HEALTHCARE OF MICHIGAN DRUG FORMULARY

Generic Available*	Generic Name	Brand Name
4.4.3 Adrenergic Stimulants-Oral Tabs		
	Terbutaline	BRETHINE
*	Albuterol	PROVENTIL
4.4.4 Xanthine Derivatives		
<ul style="list-style-type: none"> Theophylline levels may be decreased by cigarette smoking. There are a significant number of drug interactions with theophylline and commonly prescribed medicines such as phenytoin, isoniazid, beta-blockers, oral contraceptives and erythromycin. 		
*	Theophyllines, 8-12 hour	SLO-BID GYROCAPS
*	Theophyllines, 8-24 hour	THEO-DUR
*	Theophyllines	UNIPHYL
4.4.5 Cortico-steroids For Inhalation		
<ul style="list-style-type: none"> Inhaled corticosteroids are useful for chronic maintenance treatment and prevention of asthma/COPD symptoms. They should be considered as first-line therapy for patients with moderate to severe, chronic symptoms of asthma. Inhaled corticosteroids are not effective for PRN treatment of acute symptoms. Use of short-acting inhaled beta-2 agonists more than 2 times a week may indicate the need to initiate long-term control therapy. ONLY ONE INHALED CORTICOSTERIOD COVERED PER MONTH 		
	Beclomethasone	QVAR
	Flunisolide	AEROBID
	Triamcinolone acetonide	AZMACORT
	Budesonide	PULMICORT RESPULES (No PA for members 9 and under)

PRIOR AUTHORIZATION REQUIRED

Fluticasone/Salmeterol	ADVAIR
Budesonide/Formoterol	SYMBICORT

4.4.6 Leukotriene Inhibitors

- These products are not indicated for acute attacks, but are used to help prevent asthma symptoms.
- They may be less effective than inhaled corticosteroids.
- Exercise great caution when reducing doses of corticosteroids in patients taking Singulair. Aggressive corticosteroid reduction could lead to Churg-Strauss syndrome, which can cause neurological, pulmonary, or cardiac complications.

PRIOR AUTHORIZATION REQUIRED

Zafirlukast	ACCOLATE
Montelukast	SINGULAIR^

^NO PA REQUIRED FOR CHEW TAB FOR MEMBERS 9 YEARS OF AGE AND UNDER

MOLINA HEALTHCARE OF MICHIGAN DRUG FORMULARY

Generic Available*	Generic Name	Brand Name
4.4.7 Other Drugs For Asthma/Respiratory Use		
	Inhaler enhancement device	AEROCHAMBER, & MASK, EASIVENT, MICROCHAMBER
*	Ipratropium	ATROVENT INHALER SOLUTION
	Sodium Chloride solution-canister	BRONCHO SALINE
*	Ipratropium/Albuterol	COMBIVENT
	Cromolyn	CROMOLYN NEBULIZER SOLUTION, INTAL
	Tiotropium Bromide	SPIRIVA
<ul style="list-style-type: none"> • Spacers consistently increase the delivery of inhaled medications in all age groups, regardless of technique and are strongly recommended. 		

Chapter 5

GASTROINTESTINAL MEDICATIONS

- Recommended lifestyle changes to include: Smoking cessation, weight loss, elevating head of bed, avoidance of spicy foods, late night snacks and alcoholic beverages.
- Antacids are effective in treating many gastrointestinal problems, including duodenal ulcer. They are as effective as H2 blockers in non-ulcer dyspepsia and should be considered initially.
- Non prescription strength famotidine (PEPCID AC) is effective for dyspepsia and is also a cost-effective alternative to other drugs.
- Initial therapy of duodenal ulcer may include H2 blockers, sucralfate or antacids for 8 weeks. Maintenance H2 therapy should be considered for patients with recurrence or bleeding complications.

5.1 Antidiarrheal Preparations

- Pepto Bismol should be avoided in children because it contains salicylate. Administration of salicylic acid derivatives (ASA) to children, including teenagers, with acute febrile illness has been associated with the development of Reye's syndrome.
- | | | |
|---|------------------------|------------------------------|
| * | Loperamide HCl | IMODIUM OTC |
| * | Diphenoxylate/atropine | LOMOTIL |
| * | Attapulgite | PARAPECTOLIN, KAOPECTATE OTC |
| * | Bismuth Subsalicylate | PEPTO BISMOL OTC |

MOLINA HEALTHCARE OF MICHIGAN DRUG FORMULARY

Generic Available*	Generic Name	Brand Name
5.2 Ulcer Therapy		
5.2.1 H2 Antagonists		
	• Caution should be used in co-administration of cimetidine with warfarin, theophylline, phenytoin, benzodiazepines and other drugs.	
*	Famotidine	PEPCID AC OTC (20mg)
*	Cimetidine	TAGAMET
*	Ranitidine	ZANTAC (syrup, tabs)
5.2.2 Proton-pump inhibitors		
*	Omeprazole caps	OMEPRAZOLE (20mg)
PRIOR AUTHORIZATION REQUIRED		
*	Lansoprazole	PREVACID (No PA for members 12 and under)
*	Pantoprazole	PROTONIX
TO EXPEDITE RESPONSE FOR TWICE DAILY DOSING REQUESTS PLEASE INCLUDE MOST RECENT ENDOSCOPY REPORT		
5.2.3 Other anti-ulcer products, antacids		
*	Sucralfate	CARAFATE
*	Misoprostol	CYTOTEC
*	Antacid Liquid	MAALOX/MAALOX TC OTC
*	Antacid Liquid	MYLANTA/II OTC
*	Simethicone	MYLICON OTC
*	Sodium Bicarbonate	SODIUM BICARBONATE (Max #60)
*	Calcium carbonate	TUMS OTC
5.2.4 H. Pylori treatments		
	• H. Pylori has been shown to be the cause of a large percentage of duodenal ulcers. Treatment of H. pylori, when present, greatly reduces ulcer recurrence rates.	
	Bismuth Subsalicylate/ metronidazole/TCN	HELIDAC
	Prevacid/Biaxin/Amoxicillin	PREVPAC
	Ranitidine bismuth citrate	TRITEC
5.3 Antiemetic		
*	Meclizine	ANTIVERT
*	Prochlorperazine	COMPazine
*	Promethazine	PHENERGAN
*	Trimethobenzamide	TIGAN
*	Ondansetron	ZOFRAN (Max #12 tabs)

MOLINA HEALTHCARE OF MICHIGAN DRUG FORMULARY

Generic Available*	Generic Name	Brand Name
<u>5.4 Digestants/Stool Softeners/Laxative</u>		
*	Lactulose	CEPHULAC
*	Docusate sodium	COLACE OTC
*	Lipase/protease/amylase	COTAZYM, CREON, CREASE, VIOKASE
*	Bisacodyl	DULCOLAX (limit 2 months)
*	Docusate/casanthrol	PERI-COLACE OTC
*	Psyllium powder	METAMUCIL POWDER
*	Polyethylene Glycol	MIRALAX POWDER
<u>5.5 Antispasmodics & Drugs Affecting GI Motility</u>		
*	Dicyclomine	BENTYL
*	PEG Solution	COLYTE, COLYTE FLAVORED
*	Belladonna alkaloids/ phenobarbital	DONNATAL
*	Hyoscyamine sulfate	LEVSIN, LEVSINEX
*	CDZ/Clidinium	LIBRAX
*	Metoclopramide	REGLAN
	Lubiprostone	AMITIZA (Step Therapy: MIRALAX, LACTULOSE and COLACE trial)
<u>5.6 Sulfonamide/Mesalamine Products</u>		
*	Mesalamine	ASACOL
*	Sulfasalazine	AZULFIDINE
PRIOR AUTHORIZATION REQUIRED		
	Mesalamine	PENTASA

Chapter 6

GENITOURINARY

6.1 Vaginal Antiinfectives

OTC Products may be used as First Line Therapy

*	Acetic Acid/Oxquin	ACI-JEL
*	Clindamycin	CLEOCIN (vag cream)
*	Fluconazole Tablet	DIFLUCAN 150mg tab (Max #2)
*	Miconazole	MONISTAT

MOLINA HEALTHCARE OF MICHIGAN DRUG FORMULARY

Generic Available*	Generic Name	Brand Name
*	Clotrimazole	MYCELEX-G, GYNE-LOTTRIMIN
*	Nystatin	MYCOSTATIN
*	Triple sulfa vag cream	SULTRIN (vag cream)
*	Metronidazole	VANDAZOLE

6.2 Miscellaneous Vaginal

Amino Acid/Urea Cervical Cream	AMINO-CERV
-----------------------------------	------------

6.3 Anticholinergic-Antispasmodics

*	Oxybutynin	DITROPAN
---	------------	----------

PRIOR AUTHORIZATION REQUIRED

*	Tolterodine Tartrate ER Propanthelene	DETROL LA PRO-BANTHINE
---	--	---------------------------

6.4 Cholinergic Drugs

*	Bethanechol	URECHOLINE
---	-------------	------------

6.5 Urinary Analgesics

*	Phenazopyridine	PYRIDIDIUM
---	-----------------	------------

6.6 Miscellaneous Genitourinary

*	Terazosin	HYTRIN
*	Doxazosin	CARDURA

PRIOR AUTHORIZATION REQUIRED

Alfuzosin	UROXATROL
-----------	-----------

Chapter 7

CENTRAL NERVOUS SYSTEM

7.1 Dementia

Donepezil	ARICEPT
-----------	---------

PRIOR AUTHORIZATION REQUIRED

Rivastigmine	EXELON
Galatamine	RAZADYNE
Memantine	NAMENDA

7.2 Other CNS Drugs

*	Nicotine transdermal	NICOTROL PATCH (limit 3 months)
*	Bupropion SR	ZYBAN (limit 3 months)

MOLINA HEALTHCARE OF MICHIGAN DRUG FORMULARY

Generic Available*	Generic Name	Brand Name
PRIOR AUTHORIZATION REQUIRED		
*	Varenicline	CHANTIX
	Nicotine polacrilex	NICORETTE GUM
	Nicotine Inhaler	NICOTROL INHALER
	Nicotine Nasal Spray	NICOTROL SPRAY
QUANTITY LIMITS MAY APPLY		

Chapter 8 ANALGESICS

8.1 Non-Narcotic Analgesics

*	Aspirin-Tabs,	ASPIRIN OTC
*	Aspirin- enteric coated Tabs	ASPIRIN OTC
*	Salsalate	DISALCID, MONOGESIC
*	Butalbital/APAP/Caffeine	FIORICET
*	Butalbital/APAP/Caffeine/ Codeine	FIORICET w/CODEINE
*	Butalbital/ASA/Caffeine	FIORINAL
*	Butalbital/ASA/Caffeine/ Codeine	FIORINAL w/CODEINE
*	Acetaminophen	TYLENOL OTC
*	Tramadol HCL	ULTRAM

8.2 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 other things that could be dangerous if they become drowsy or dizzy.

*	Aspirin/Codeine	ASPIRIN, CODEINE
*	Propoxyphene/APAP	DARVOCET-N
*	Propoxyphene Compound	DARVON COMPOUND
*	Propoxyphene	DARVON, WYGESIC
*	Hydromorphone	DILAUDID
*	Hydrocodone/Acetaminophen	LORCET

MOLINA HEALTHCARE OF MICHIGAN DRUG FORMULARY

Generic Available*	Generic Name	Brand Name
*	Hydrocodone Bitartrate/APAP	LORTAB (elixir only)
*	Methadose	METHADONE
*	Morphine sulfate CR	MS CONTIN (Max #90/30 days)
*	Morphine sulfate IR	MSIR (Max #90/30 days)
*	Hydrocodone/Acetaminophen	NORCO
*	Oxycodone/APAP	PERCOCET
*	Oxycodone/ASA	PERCODAN
*	Acetaminophen/codeine	TYLENOL w/CODEINE
*	Oxycodone/APAP	TYLOX
*	Hydrocodone/ Acetaminophen	VICODIN, VICODIN ES

PRIOR AUTHORIZATION REQUIRED

Morphine sulfate CR	ORAMORPH SR, KADIAN
---------------------	------------------------

- Use of high-dose, long-acting narcotic analgesics should be under direct supervision of a pain management specialist or oncologist.
- Patients on high-dose, long-acting narcotic analgesics may be candidates for case management.

8.3 Non-Steroidal Anti-Inflammatory Drugs

- 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.
- Concurrent use of an H2 blocker with an NSAID has not been shown to reduce the incidence of gastric ulceration or bleeding. Misoprostol (Cytotec) may be a better choice for preventing ulcer formation in patients at risk.
- NSAID use in the following conditions deserves special consideration of potential risks: History of GI bleeding or ulcer; chronic anti-coagulation, asthma, aspirin allergy, renal failure, hypertension or congestive heart failure.

*	Naproxen Sodium	ANAPROX. ANAPROX DS
*	Sulindac	CLINORIL
*	Piroxicam	FELDENE
*	Indomethacin	INDOCIN
*	Etodolac	LODINE, -XL
*	Meloxicam	MOBIC
*	Ibuprofen	MOTRIN
*	Naproxen	NAPROSYN
*	Diclofenac	VOLTAREN

MOLINA HEALTHCARE OF MICHIGAN DRUG FORMULARY

Generic Available*	Generic Name	Brand Name
PRIOR AUTHORIZATION REQUIRED		
*	Diclofenac/Misoprostol	ARTHROTEC
*	Oxaprozin	DAYPRO
*	Ketoprofen CR Capsules	ORUVAIL
*	Nabumentone	RELAFEN
*	Ketoralac tromethamine	TORADOL (tabs)

8.4 Antirheumatics

*	Methotrexate	METHOTREXATE
*	Hydroxychloroquine	PLAQUENIL

8.5 Drugs To Prevent And Treat Gout

*	Probenecid	BENEMID
*	Colchicine	COLCHICINE
*	Indomethacin	INDOCIN
*	Allopurinol	ZYLOPRIM

8.6 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.
- **Only one migraine medication may be filled every 30 days.**

• QUANTITY LIMITS MAY APPLY

*	Ergotamine/caffeine	CAFERGOT
*	APAP/ASA/Caffeine	EXCEDRIN MIGRAINE OTC
*	Sumatriptan	IMITREX (Max #9/45)
*	Isometheptene/ dichloralphenazone/APAP	MIDRIN
	Eletriptan Hydrobromide	RELMAX (Max #6/30)
	Zolmitriptan	ZOMIG (Max #6/30)

PRIOR AUTHORIZATION REQUIRED

Dihydroergotamine	MIGRANAL NASAL SPRAY
-------------------	-------------------------

MOLINA HEALTHCARE OF MICHIGAN DRUG FORMULARY

**Generic
Available***

**Generic
Name**

**Brand
Name**

Chapter 9

NEURO-MUSCULAR

9.1 Antiparkinson Drugs

*	Biperiden HCL	AKINETON
*	Selegiline	ELDEPRYL
*	Bromocriptine	PARLODEL
*	Carbidopa/levodopa	SINEMET
*	Amantadine HCL	SYMMETREL

9.2 Skeletal Muscle Relaxants

*	Cyclobenzaprine	FLEXERIL (10mg)
*	Baclofen	LIORESAL
*	Orphenadrine	NORFLEX
*	Methocarbamol	ROBAXIN
*	Carisoprodol/ASA	SOMA COMPOUND
*	Carisoprodol	SOMA (350mg)
*	Tizanidine	ZANAFLEX

PRIOR AUTHORIZATION REQUIRED

*	Orphenadrine/ASA/Caffeine	NORGESIC, NORGESIC FORTE
---	---------------------------	-----------------------------

9.3 Other

*	Pyridostigmine	MESTINON
---	----------------	----------

Chapter 10

VITAMINS/ELECTROLYTE

10.1 Prenatal Vitamins

*	Chewable Prenatal Vitamin	NATACHEW
*	Prenatal vitamins	NATALINS RX
*	Prenatal vitamins	NIFEREX PN, PN FORTE
*	Prenatal vitamins	PRENATE 90

10.2 Vitamins

*	Vitamin D	DRISDOL (Max #4)
*	Vitamin K	MEPHYTON
*	Multi-Vitamins & fluoride	POLY-VI-FLOR, POLY-VI-SOL (tabs, drops)

MOLINA HEALTHCARE OF MICHIGAN DRUG FORMULARY

Generic Available*	Generic Name	Brand Name
*	Multi-Vitamin w/ fluoride & iron	POLY-VI-FLOR w/ IRON, POLY-VI-SOL w/IRON
*	Calcitrol	ROCALTROL
*	Multi-Vitamin	THERAPEUTIC TAB, CHILDRENS CHEWABLE VITAMIN
*	Multi-Vitamin w/iron	THERA-M, CHILDRENS CHEWABLE VITAMIN w/IRON
*	Multi-Vitamins & fluoride	TRI-VI-FLOR (tabs, drops)
<u>10.3 Other</u>		
*	Levocarnitine	CARNITOR
*	Ferrous Sulfate	FEOSOL OTC (tabs, solution)
*	Ferrous Gluconate	FERGON OTC
*	Sodium Fluoride drops/tabs	LURIDE
*	Calcium Carbonate	OS-CAL, TUMS OTC
*	Ped. Electrolyte Solution	PEDIALYTE OTC
<u>10.4 Potassium Supplements</u>		
*	Potassium Cl Liquid	K-DUR-10, K-DUR 20
*	Potassium Cl tab	KLOTRIX, K-TABS
*	Potassium Cl efferv Tabs	K-LYTE/CL

<h3 style="margin: 0;">Chapter 11</h3> <h2 style="margin: 0;">HEMATOLOGICAL AGENTS</h2>

11.1 Hematopoetic

*	Folic acid	
*	Folic acid/B-12/Iron	NIFEREX-150 FORTE

11.2 Anticoagulant Drugs

*	Warfarin	COUMADIN
	Enoxaparin	LOVENOX

Lovenox treatment lasting longer than 7 days requires PA and must be filled through Caremark Specialty Pharmacy.

MOLINA HEALTHCARE OF MICHIGAN DRUG FORMULARY

Generic Available*	Generic Name	Brand Name
11.3 Antiplatelet Drugs		
	<ul style="list-style-type: none"> Aspirin-OTC remains as the first-line antiplatelet drug. Plavix should be reserved for those patients who are unable to tolerate or are resistant to aspirin therapy. 	
*	Dipyridamole/ASA Aspirin- Tabs, enteric coated tabs Clopidogrel	AGGRENEX ASPIRIN OTC PLAVIX
PRIOR AUTHORIZATION REQUIRED		
*	Ticlopidine	TICLID

Chapter 12

OPHTHALMIC MEDICATION

12.1 Alpha-adrenoreceptor agonists

Brimonidine 0.2%	ALPHAGAN P
------------------	------------

12.2 Anti-Inflammatory Agents

12.2.1 Corticosteroids

*	Dexamethasone 0.1%	DECADRON, AK-DEX SOLN
	Fluorometholone 0.1%	FML, FML FORTE, FML S.O.P
*	Prednisolone 0.12%, 1%	PRED FORTE, PRED MILD

12.2.2 Non-Steroidal Anti-Inflammatory Drugs (NSAIDS)

	Ketorolac	ACULAR
	Ketorolac 0.4%	ACULAR LS
	Nedrocromil	ALOCRIAL
*	Flurbiprofen	OCUFEN
*	Diclofenac 0.1%	VOLTAREN
*	Ketotifen	ZADITOR OTC

12.3 Anti-Allergic Agents

*	Lodoxamide	ALOMIDE
	Cromolyn sodium 4%	OPTICROM
	Olopatadine	PATADAY
	Olopatadine 0.1%	PATANOL
	Naphazoline/Antazoline	VASOCON-A

MOLINA HEALTHCARE OF MICHIGAN DRUG FORMULARY

Generic Available*	Generic Name	Brand Name
<u>12.4 Antimicrobial agents</u>		
12.4.1 Antibiotics and Antibiotic Combinations		
*	Bacitracin	AK-TRACIN
*	Sulfacetamide	BLEPH 10, SODIUM SULAMYD
*	Gentamicin	GENOPTIC
*	Erythromycin	ILOTYCIN OPTH OINT
*	Gramicidin/neomycin/polymyxin B	NEOSPORIN
*	Ofloxacin	OCUFLOX
*	Polymyxin/TMP	POLYTRIM
*	Tobramycin	TOBREX
PRIOR AUTHORIZATION REQUIRED		
	Gatifloxacin	ZYMAR
12.4.2 Antibiotic-Corticosteroid Combinations		
*	Sulfacetamide/prednisolone	BLEPHAMIDE
*	Hydrocortisone/neomycin/polymyxin B	CORTISPORIN
	Prednisolone acetate 0.5%/neomycin/polymyxin B	POLY PRED SUSP
	Prednisolone acetate 1%/gentamicin	PRED-G DROPS
	Prednisolone acetate 0.6%/gentamicin	PRED-G S.O.P. OINT
*	Tobramycin/dexamethsone	TOBRA-DEX
*	Sulfacetamide/Pred	VASOCIDIN
12.4.3 Antifungal		
	Natamycin 5%	NATACYN
12.4.4 Antiviral		
*	Trifluridine 1%	VIROPTIC
<u>12.5 Beta-adrenoreceptor Antagonists</u>		
*	Levobunolol 0.25%, 0.5%	BETAGAN
*	Betaxolol	BETOPTIC 0.25% SUSP, BETOPTIC 0.5% SOLN.
*	Timolol maleate 0.25%, 0.5%	TIMOPTIC SOLUTION
*	Timolol maleate 0.25%, 0.5%	TIMOPTIC-XE GEL
<u>12.6 Carbonic Anhydrase Inhibitors</u>		
*	Dorzolamide HCL 1%	TRUSOPT

MOLINA HEALTHCARE OF MICHIGAN DRUG FORMULARY

Generic Available*	Generic Name	Brand Name
<u>12.7 Dilating Agents</u>		
12.7.1 Anticholinergic		
*	Cyclopentolate	CYCLOGYL
*	Atropine	ISOPTO ATROPINE
*	Homatropine	ISOPTO HOMATROPINE
*	Scopolamine	ISOPTO HYOSCINE
*	Tropicamide	MYDRIACYL
12.7.2 Sympathomimetic		
*	Phenylephrine	NEOSYNEPHRINE
<u>12.8 Miotics</u>		
*	Pilocarpine hydrochloride	PILOCAR
<u>12.9 Prostaglandins</u>		
*	Dorzolamide/Timolol	COSOPT
*	Latanoprost 0.005%	XALATAN
<u>12.10 Sympathomimetics</u>		
*	Dipivefrin	PROPINE
<u>12.11 Miscellaneous Ophthalmic Products</u>		
*	Polyvinyl Alcohol	ARTIFICIAL TEARS
*	Cyclosporine	RESTASIS

Chapter 13

EAR, NOSE AND THROAT MEDICATIONS

13.1 OTIC Antiinfectives

*	Chloramphenicol	CHLOROMYCETIN
*	Ciprofloxacin/ Dexamethasone	CIPRODEX
*	Ofloxacin	FLOXIN OTIC

- FLOXIN OTIC is indicated for use in patients with chronic suppurative otitis media with perforated TM, and for acute otitis media with tympanostomy tubes. For patients with common otitis externa, use of cortisporin is recommended.

13.2 OTIC Steroid-Anti-infective Combinations

*	Hydrocortisone/neo/ polymyxin B	CORTISPORIN OTIC
*	Acetic Acid	VOSOL

MOLINA HEALTHCARE OF MICHIGAN DRUG FORMULARY

Generic Available*	Generic Name	Brand Name
<u>13.3 Miscellaneous OTIC Products</u>		
*	Benzocaine/antipyrine	AURALGAN
*	Carbamide peroxide 6.5%	DEBROX OTC
*	Hydrocort./acetic acid	VOSOL HC OTIC
<u>13.4 Throat Medications</u>		
*	Clotrimazole	MYCELEX TROCHE
*	Nystatin suspension	MYCOSTATIN
*	Lidocaine viscous	XYLOCAINE VISCIOUS
<u>13.5 Corticosteroids, Inhaled Nasal</u>		
	• Nasonex not covered without documented trial and failure of Flonase	
*	Fluticasone	FLONASE
PRIOR AUTHORIZATION REQUIRED		
	Mometasone	NASONEX

Chapter 14

DERMATOLOGICALS

All topical dosage forms of listed items are formulary items.

14.1 Anti-Acne Medications

*	Erythromycin/Benzoyl peroxide	BENZAMYCIN
*	Clindamycin 1%, topical solution, lotion, gel	CLEOCIN-T
*	Benzoyl peroxide gel	DESQUAM-E, DESQUAM-X
*	Erythromycin, topical solution, gel, pads	ERYCETTE
*	Benzoyl peroxide lotion 5%, 10%	OTC
*	Tretinoin	RETIN A (cream only)

14.2 Topical Antiinfectives

*	Gentamicin	GARAMYCIN
*	Bacitracin ointment	OTC
*	Triple Antibiotic ointment	OTC
*	Polysporin ointment	OTC
*	Silver Sulfadiazine	SILVADENE

MOLINA HEALTHCARE OF MICHIGAN DRUG FORMULARY

Generic Available*	Generic Name	Brand Name
14.3 Topical Anti-Fungals		
*	Augmented betamethasone dipropionate	DIPROLENE AF
*	Clotrimazole-cream/solution	MYCELEX OTC
*	Triamcinolone/nystatin	MYCOLOG II (30gm limit)
*	Nystatin	MYCOSTATIN
*	Ciclopirox	LOPROX
*	Clotrimazole/ betamethasone	LOTRISONE
*	Tolnaftate cream	TINACTIN OTC
14.4 Topical Corticosteroids		
<ul style="list-style-type: none"> • Pediatric patients may have greater susceptibility to topical corticosteroid-induced HPA axis suppression than adults. • Avoid using high potency steroids on the face, neck, groin, or axilla. Occlusive dressings or diapers increase the potency of the steroid. 		
GROUP IV (LOW POTENCY)		
*	Hydrocortisone	HYTONE
*	Desonide	TRIDESILON
GROUP III (MEDIUM POTENCY)		
*	Prednicarbate	DERMATOP
*	Momentasone furoate	ELOCON
*	Triamcinolone acetonide	KENALOG
*	Fluocinolone acetonide	SYNALAR
PRIOR AUTHORIZATION REQUIRED		
*	Desoximetasone	TOPICORT LP
GROUP II (HIGH POTENCY)		
*	Betamethasone dipropionate	DIPROSONE
*	Fluocinonide	LIDEX
*	Hydrocortisone valerate	WESTCORT
PRIOR AUTHORIZATION REQUIRED		
	Halcinonide	HALOG, HALOG-E
GROUP I (VERY HIGH POTENCY)		
*	Augmented betamethasone dipropionate Diflorasone diacetate	DIPROLENE FLORONE, FLORONE E PSORCON, -E
*	Halobetasol	ULTRAVATE
*	Betamethasone valerate	VALISONE

MOLINA HEALTHCARE OF MICHIGAN DRUG FORMULARY

Generic Available*	Generic Name	Brand Name
PRIOR AUTHORIZATION REQUIRED		
*	Desoximetasone	TOPICORT
14.5 Topical Corticosteroids in Combination		
	Hydrocortisone/pramoxine	EPIFOAM
14.6 Topical Non-Steroid Anti-Inflammatory		
• PROTOPIC and ELIDEL are not indicated in patients under 2 years of age.		
PRIOR AUTHORIZATION REQUIRED		
	Tacrolimus	PROTOPIC
	Pimecrolimus	ELIDEL
14.7 Scabicides/Pediculocides		
Treatment of choice is OTC Nix		
*	Lindane lotion, shampoo	KWELL
*	Permethrin	NIX-OTC
*	Pyrethins combo.	A-200 OTC
*	Permethrin	ELIMITE
14.8 Anorectal		
*	Hydrocortisone Acetate	ANUSOL HC SUPP
*	Hydrocortisone/pramoxine	PROCTOCREAM HC
*	Hydrocortisone	PROCTOCREAM HC 2.5%
14.9 Anti-Psoriatics		
	Calcipotriene	DOVONEX
*	Anthralin	DRITHOCREME
14.10 Miscellaneous Topicals		
*	Calamine Lotion	
*	Mupirocin	BACTROBAN
*	Podofilox	CONDYLOX
*	Aluminum Chloride	DRYSOL
	Fluoruracil	EFUDEX
*	Lidocaine/Prilocaine	EMLA
*	Nystatin	MYCOSTATIN POWDER
	Hexachlorophene	PHISOHEX
*	Selenium Sulfide	SELSUN SHAMPOO- RX
*	Lidocaine	XYLOCAINE (cream only)
*	Acyclovir	ZOVIRAX (No PA for members 12 and over)

MOLINA HEALTHCARE OF MICHIGAN DRUG FORMULARY

Generic Available*	Generic Name	Brand Name
Chapter 15		
MISCELLANEOUS		
	Insect Sting Kit	ANA-GUARD, ANA-KIT
*	Caffeine Citrate	CAFFEINE CITRATE SOLUTION (No PA for members 2 and under)
*	Barium Enema Prep Kit	FLEETS PREP KIT
	Sodium Polystyrene	KAYEXALATE
*	Methylergonovine	METHERGINE
*	Acetylcysteine	MUCOMYST (5 day supply only)
*	Condoms	OTC various (Max #12)
	Spermicidal Jelly/foam	OTC various
*	Chlorhexidine Gluconate	PERIDEX
*	Calcium Acetate	PHOSLO
	Diaphragm	VARIOUS

Michigan Quality Improvement Consortium Guideline

General Principles for the Diagnosis and Management of Asthma

The following guideline recommends general principles and key clinical activities for the diagnosis and management of asthma.	
Eligible Population	Recommendation and Level of Evidence
<p>Children and adults with the following:</p> <ul style="list-style-type: none"> • Wheezing • History of cough (worse particularly at night), recurrent wheeze, recurrent difficulty in breathing, recurrent chest tightness • Symptoms occur or worsen in the presence of exercise, viral infection, inhalant allergens, irritants, changes in weather, strong emotional expression (laughing or crying hard), stress, menstrual cycles • Symptoms occur or worsen at night, awakening the patient 	<p>Key Components</p> <p>Diagnosis and management goals</p> <ul style="list-style-type: none"> • Detailed medical history and physical exam to determine that symptoms of recurrent episodes of airflow obstruction are present • Use spirometry in all patients ≥5 years of age to determine that airway obstruction is at least partially reversible [C]. <p>Goals of therapy are to achieve control by [A]:</p> <ul style="list-style-type: none"> • Reducing impairment (prevent chronic symptoms, minimize need for rescue therapy with short-acting beta₂-agonists (SABA), maintain near-normal lung function and activity levels) • Reducing risk (prevent exacerbations, minimize need for emergency care or hospitalization, prevent loss of lung function or prevent reduced lung growth in children, have minimal or no adverse effects of therapy) • Assess asthma severity to initiate therapy. (Use severity classification chart, assessing both domains of impairment [B] and risk [C] to determine initial treatment.) • Assess asthma control to monitor and adjust therapy [B]. (Use asthma control chart, assessing both domains of impairment and risk to determine if therapy should be maintained or adjusted. (Step up if necessary; step down if possible.)) • Obtain lung function measures by spirometry at least every 1-2 years [B], more frequently for not well-controlled asthma. • Schedule follow-up care. In general, consider scheduling patients at 2- to 6-week intervals while gaining control [D]; at 1- to 6-month intervals if a step-down in therapy is anticipated [D]. • Assess asthma control, medication technique, written asthma action plan, patient adherence and concerns at every visit. <p>Education</p> <ul style="list-style-type: none"> • Provide self-management education [A]. Teach and reinforce: self-monitoring to assess control and signs of worsening asthma (either symptom or peak flow monitoring) [B], using written asthma action plan (review differences between long-term control and quick-relief medication); taking medication correctly (inhaler technique and use of devices); a voiding environmental and occupational factors that worsen asthma. • Tailor education to literacy level of patient; integrate education into all points of care; appreciate potential role of patient's cultural beliefs and practices in asthma management [C]. • Develop written action plan in partnership with patient [B]. <p>Control environmental factors and comorbid conditions</p> <ul style="list-style-type: none"> • Recommend measures to control exposures to allergens and pollutants or irritants that make asthma worse [A] • Consider allergen immunotherapy for patients with persistent asthma and when there is clear evidence of a relationship between symptoms and exposure to an allergen to which the patient is sensitive [B]. • Treat comorbid conditions (e.g., allergic bronchopulmonary aspergillosis [A], gastroesophageal reflux [B], obesity [B], obstructive sleep apnea [D], rhinitis and sinusitis [B], chronic stress or depression) [D] • Inactivated influenza vaccine for all patients over 6 months of age [A] unless contraindicated <p>Medications</p> <ul style="list-style-type: none"> • Select medication and delivery devices to meet patient's needs. • Use a stepwise approach to pharmacologic therapy to gain and maintain asthma control [A]. (See age-specific guidelines.) • Initiate corticosteroids (ICS) are the most effective long-term control therapy [A]. Optimize ICS use before advancing to other therapies. When choosing among treatment options, consider patient's impairment and risk, history of response to medication, willingness and ability to use medication. <p>Referral</p> <ul style="list-style-type: none"> • Refer to an asthma specialist for consultation or comanagement if there are difficulties achieving or maintaining control (See age-specific guidelines.); immunotherapy or omalizumab is considered; additional testing is indicated; or if the patient required 2 bursts of oral systemic corticosteroids in the past year or a hospitalization [D].

Levels of Evidence for the most significant recommendations: A = randomized controlled trials; B = controlled trials; no randomization; C = observational studies; D = opinion of expert panel

This guideline lists core management steps. It is based on the 2007 National Asthma Education and Prevention Program Expert Panel Report 3, Guidelines for the Diagnosis and Management of Asthma, National Heart, Lung and Blood Institute (www.nhlbi.nih.gov). Individual patient considerations and advances in medical sciences may supersede or modify these recommendations.

Key Components		Recommendation and Level of Evidence					
First, assess severity to decide initial therapy		Assess Asthma Severity					
Components of Severity Impairment	Intermittent	Persistent (Mild)	Persistent (Moderate)	Persistent (Severe)			
Symptoms Nighttime awakenings Short-acting beta ₂ -agonist use for symptoms Interference with normal activity	≤ 2 days/week 0 ≤ 2 days/week	> 2 days/week, not daily 1-2x/month > 2 days/week, not daily	Daily 3 - 4x/month Daily	Throughout day > 1x/week Several times daily			
Risk	None	Minor limitation	Some limitation	Extremely limited			
Exacerbations requiring oral steroids	0-1/year	≥ 2 in 6 months requiring oral steroids, or ≥ 4 in 1 year lasting > 1 day and have risk factors for persistent asthma					
Recommended step for initiating treatment	Step 1	Step 2	Step 3				
	Re-evaluate control in 2-6 weeks and adjust therapy accordingly.						
On follow-up, assess control and step therapy up or down		Assess Asthma Control					
Components of Control Impairment	Well-Controlled	Not Well-Controlled					
Symptoms Nighttime awakenings Short-acting beta ₂ -agonist use for symptoms Interference with normal activity	≤ 2 days/week, but not > 1 day ≤ 1x/month ≤ 2 days/week	> 2 days/week or many times on ≤ 2 days/week > 2 days/week	Throughout day > 1x/week Several times daily				
Exacerbations requiring oral steroids Treatment-related adverse effects	None 0-1x/year	Some limitation 2-3x/year	Extremely limited > 3x/year				
Recommended treatment and follow-up	Intensity of medication-related side effects does not correlate to specific levels of control, but should be considered in overall assessment of risk. • Maintain current step • Regular follow-up every 1-6 months • Consider step down if well-controlled ≥ 3 months	Step up 1 step		• Consider oral steroids • Step up 1-2 steps			
Step approach for asthma management (Use lowest treatment level required to maintain control.)	<ul style="list-style-type: none"> Quick relief medication for all patients: Inhaled short-acting beta₂-agonist (SABA), as needed for symptoms. Intensity of treatment depends on severity of symptoms; up to 3 treatments at 20-minute intervals as needed. Short course of systemic oral corticosteroids may be needed. Use of SABA > 2 days a week for symptom control (not prevention of exercise-induced bronchospasm) indicates inadequate control and the need to step up treatment. Patient education and environmental control at each step Persistent asthma: Daily long-term control therapy [A]; consult with asthma specialist step 4 or higher [D]; consider consultation at step 3 [D] 	Step up 1 step		• Re-evaluate in 2-6 weeks • If no clear benefit in 4-6 weeks, consider alternative diagnosis or adjust therapy [D]			
Intermittent Step 1	Mild Persistent Step 2	Moderate Persistent Step 3	Severe Persistent Step 4	Severe Persistent Step 5	Severe Persistent Step 6		
Preferred Short-acting beta ₂ -agonist as required	Preferred Low-dose inhaled corticosteroid [A]	Preferred Medium-dose inhaled corticosteroid	Preferred Medium-dose inhaled corticosteroid + either a long-acting beta ₂ -agonist or montelukast [D]	Preferred High-dose inhaled corticosteroid + either a long-acting beta ₂ -agonist or montelukast [D]	Preferred High-dose inhaled corticosteroid + either a long-acting beta ₂ -agonist or montelukast [D]		

Levels of Evidence for the most significant recommendations: A = randomized controlled trials; B = controlled trials, no randomization; C = observational studies; D = opinion of expert panel. This guideline lists core management steps. It is based on the 2007 National Asthma Education and Prevention Program Expert Panel Report 3, Guidelines for the Diagnosis and Management of Asthma, National Heart, Lung and Blood Institute (www.nhlbi.nih.gov). Individual patient considerations and advances in medical science may supersede or modify these recommendations.

Michigan Quality Improvement Consortium Guideline Management of Asthma in Children 5 to 11 Years

Key Components		Recommendation and Level of Evidence							
Classification of Asthma Severity		Intermittent		Persistent (Mild)		Persistent (Moderate)		Persistent (Severe)	
First assess severity to decide initial therapy	Components of Severity Impairment	Symptoms	≤ 2 days/week	> 2 days/week not daily	Daily	> 1 week, not nightly	Daily	Inconspicuous	Inconspicuous
		Impairment	Short-acting beta ₂ -agonist use for symptoms	≤ 2 days/week	> 2 days/week, not daily	Daily	> 1 week, not nightly	Daily	Several times daily
Risk	Components of Severity Risk	Lung function:	None	Minor limitation	Some limitation	Some limitation	Some limitation	Some limitation	Extremely limited
		FEV ₁ /FVC	> 85%	> 80%	> 80%	> 80%	60% - 80%	75% - 80%	< 60%
Recommended step for initial treatment	Risk	Exacerbations requiring oral steroids	0-1/year	> 1/year	> 2/year	> 2/year	> 2/year	> 2/year	> 2/year
		Frequency & severity may fluctuate over time for patient of any severity class.							
On follow-up, assess control and step therapy up or down	Recommended step for follow-up treatment	Step 1		Step 2		Step 3		Step 4	
		Re-evaluate control in 2-3 weeks and adjust therapy accordingly		Re-evaluate control in 2-3 weeks and adjust therapy accordingly		Re-evaluate control in 2-3 weeks and adjust therapy accordingly		Re-evaluate control in 2-3 weeks and adjust therapy accordingly	
Step approach for asthma management (Use lowest treatment level required to maintain control.)	Components of Control Impairment	Symptoms	Well-Controlled	Not Well-Controlled	Not Well-Controlled	Not Well-Controlled	Not Well-Controlled	Not Well-Controlled	Very Poorly Controlled
		Impairment	≤ 2 days/week, but not > 1/day	> 2 days/week or many times on ≤ 2 days/week	> 2 days/week	> 2 days/week	> 2 days/week	> 2 days/week	> 2 days/week
Step approach for asthma management (Use lowest treatment level required to maintain control.)	Risk	Negative awakenings	≤ 1x/month	> 1x/month	> 1x/month	> 1x/month	> 1x/month	> 1x/month	Several times/day
		Interference with normal activity	None	> 80%	> 80%	> 80%	> 80%	> 80%	> 80%
Step approach for asthma management (Use lowest treatment level required to maintain control.)	Recommended action for treatment	FEV ₁ or Peak Flow	> 80%	> 80%	> 80%	> 80%	> 80%	> 80%	< 60%
		FEV ₁ /FVC	> 85%	> 80%	> 80%	> 80%	> 80%	> 80%	> 80%
Step approach for asthma management (Use lowest treatment level required to maintain control.)	Recommended action for treatment	Exacerbations requiring oral steroids	0-1/year	> 1/year	> 2/year	> 2/year	> 2/year	> 2/year	> 2/year
		Treatment-related adverse effects	Intensity of medication-related side effects does not correlate to specific levels of control, but should be considered in overall assessment of risk.	Intensity of medication-related side effects does not correlate to specific levels of control, but should be considered in overall assessment of risk.	Intensity of medication-related side effects does not correlate to specific levels of control, but should be considered in overall assessment of risk.	Intensity of medication-related side effects does not correlate to specific levels of control, but should be considered in overall assessment of risk.	Intensity of medication-related side effects does not correlate to specific levels of control, but should be considered in overall assessment of risk.	Intensity of medication-related side effects does not correlate to specific levels of control, but should be considered in overall assessment of risk.	Intensity of medication-related side effects does not correlate to specific levels of control, but should be considered in overall assessment of risk.
Step approach for asthma management (Use lowest treatment level required to maintain control.)	Recommended action for treatment	Regular follow-up every 1, 6 months	Step up 1 step	Step up 1 step	Step up 1 step	Step up 1 step	Step up 1 step	Step up 1 step	Step up 1 step
		Consider step down 1 well-controlled ≥ 2 months	Re-evaluate in 2-6 weeks	Re-evaluate in 2-6 weeks	Re-evaluate in 2-6 weeks	Re-evaluate in 2-6 weeks	Re-evaluate in 2-6 weeks	Re-evaluate in 2-6 weeks	Re-evaluate in 2-6 weeks
Step approach for asthma management (Use lowest treatment level required to maintain control.)	Recommended action for treatment	Quick relief medication for all patients: Inhaled short-acting beta ₂ -agonist (SABA) as needed for symptoms (AI). Intensity of treatment depends on severity of symptoms; up to 3 treatments at 20-minute intervals are needed. Short course of systemic oral corticosteroids may be needed. Use of SABA > 2 days a week for symptom control (not prevention) of symptoms is a sign of poor control and the need to step up treatment.	Step up 1 step	Step up 1 step	Step up 1 step	Step up 1 step	Step up 1 step	Step up 1 step	Step up 1 step
		Persistent asthma. Daily long-term control of therapy (AI): consult with asthma specialist at step 4 or higher (D); consider consultation at step 3 (D)	Step up 1 step	Step up 1 step	Step up 1 step	Step up 1 step	Step up 1 step	Step up 1 step	Step up 1 step
Step approach for asthma management (Use lowest treatment level required to maintain control.)	Recommended action for treatment	Step 1	Step 2	Step 3	Step 4	Step 5	Step 6	Step 7	Step 8
		Preferred	Preferred	Preferred	Preferred	Preferred	Preferred	Preferred	Preferred
Step approach for asthma management (Use lowest treatment level required to maintain control.)	Recommended action for treatment	Short-acting beta ₂ -agonist as required	Low-dose inhaled corticosteroid (A)	Medium-dose inhaled corticosteroid + either a long-acting beta ₂ -agonist (B)	Medium-dose inhaled corticosteroid + either a long-acting beta ₂ -agonist (B)	High-dose inhaled corticosteroid + long-acting beta ₂ -agonist (B)	High-dose inhaled corticosteroid + long-acting beta ₂ -agonist (B)	High-dose inhaled corticosteroid + long-acting beta ₂ -agonist (B)	High-dose inhaled corticosteroid + long-acting beta ₂ -agonist (B)
		Alternative	Alternative	Alternative	Alternative	Alternative	Alternative	Alternative	Alternative
Step approach for asthma management (Use lowest treatment level required to maintain control.)	Recommended action for treatment	Cromolyn	Leukotriene receptor antagonist, or Nedocromil, or Theophylline (B)	Leukotriene receptor antagonist, or theophylline (B)	Leukotriene receptor antagonist, or theophylline (B)	Leukotriene receptor antagonist, or theophylline (B)	Leukotriene receptor antagonist, or theophylline (B)	Leukotriene receptor antagonist, or theophylline (B)	Leukotriene receptor antagonist, or theophylline (B)
		Alternative	Alternative	Alternative	Alternative	Alternative	Alternative	Alternative	Alternative
Step approach for asthma management (Use lowest treatment level required to maintain control.)	Recommended action for treatment	High-dose inhaled corticosteroid + oral systemic corticosteroid + either a leukotriene receptor antagonist or theophylline (D)	High-dose inhaled corticosteroid + either a leukotriene receptor antagonist or theophylline (B)	High-dose inhaled corticosteroid + either a leukotriene receptor antagonist or theophylline (B)	High-dose inhaled corticosteroid + either a leukotriene receptor antagonist or theophylline (B)	High-dose inhaled corticosteroid + either a leukotriene receptor antagonist or theophylline (B)	High-dose inhaled corticosteroid + either a leukotriene receptor antagonist or theophylline (B)	High-dose inhaled corticosteroid + either a leukotriene receptor antagonist or theophylline (B)	High-dose inhaled corticosteroid + either a leukotriene receptor antagonist or theophylline (B)
		Alternative	Alternative	Alternative	Alternative	Alternative	Alternative	Alternative	Alternative

Source of Evidence for this guideline from randomized trials. A systematic literature search was conducted using Medline, Cochrane, and other sources. This guideline is a core management strategy. It is based on the 2007 National Asthma Education and Prevention Program Expert Panel Report 3. Guidelines for the Diagnosis and Management of Asthma, National Heart, Lung and Blood Institute (www.nhlbi.nih.gov). Individual patient considerations and advances in medical science may supersede or modify these recommendations.

Key Components	Recommendation and Level of Evidence					
	Classification of Asthma Severity					
First, assess severity to decide initial therapy	Intermittent	Mild Persistent	Moderate Persistent	Severe Persistent	Step 1	Step 2
Components of Severity Impairment	Symptoms Slight awakenings	Symptoms Short-acting beta ₂ -agonist use for < 2 days/week	Symptoms Short-acting beta ₂ -agonist use for > 2 days/week	Symptoms Short-acting beta ₂ -agonist use for > 2 days/week, not daily	Symptoms Short-acting beta ₂ -agonist use for > 2 days/week, not daily	Symptoms Short-acting beta ₂ -agonist use for > 2 days/week, not daily
Normal/FEV ₁ /FVC:	8-19 years/85%	20-39 years/85%	40-59 years/75%	60-80 years/70%	Normal FEV ₁ between exacerbations	Normal FEV ₁ between exacerbations
Risk	Exacerbations requiring oral steroids	Exacerbations requiring oral steroids	Exacerbations requiring oral steroids	Exacerbations requiring oral steroids	Exacerbations requiring oral steroids	Exacerbations requiring oral steroids
Recommended step for initiating treatment	Step 1	Step 2	Step 3	Step 4 or 5	Step 1	Step 2
On follow-up, assess control and step therapy up or down	Classification of Asthma Control					
Components of Control	Well-Controlled	Well-Controlled	Well-Controlled	Well-Controlled	Well-Controlled	Well-Controlled
Impairment	Symptoms Nighttime awakenings Short-acting beta ₂ -agonist use for symptoms	Symptoms Nighttime awakenings Short-acting beta ₂ -agonist use for symptoms	Symptoms Nighttime awakenings Short-acting beta ₂ -agonist use for symptoms	Symptoms Nighttime awakenings Short-acting beta ₂ -agonist use for symptoms	Symptoms Nighttime awakenings Short-acting beta ₂ -agonist use for symptoms	Symptoms Nighttime awakenings Short-acting beta ₂ -agonist use for symptoms
Risk	Interference with normal activity FEV ₁ or Peak Flow	Interference with normal activity FEV ₁ or Peak Flow	Interference with normal activity FEV ₁ or Peak Flow	Interference with normal activity FEV ₁ or Peak Flow	Interference with normal activity FEV ₁ or Peak Flow	Interference with normal activity FEV ₁ or Peak Flow
Recommended action for treatment	Step 1	Step 2	Step 3	Step 4 or 5	Step 1	Step 2
Step approach for asthma management (Use lowest treatment level required to maintain control)	Preferred Short-acting beta ₂ -agonist as required	Preferred Low-dose inhaled corticosteroid [A] Alternative Cromolyn Or Leukotriene receptor antagonist; or Nedocromil; or Theophylline [B]	Preferred Low-dose inhaled corticosteroid + long-acting beta ₂ -agonist [A] Alternative Medium-dose inhaled corticosteroid [A]	Preferred Medium-dose inhaled corticosteroid + long-acting beta ₂ -agonist [B] Alternative Low-dose inhaled corticosteroid + either a leukotriene receptor antagonist [A], theophylline [B], or zileuton [D]	Preferred High-dose inhaled corticosteroid + long-acting beta ₂ -agonist [B] and consider omalizumab for patients who have IgE-mediated allergies [B]	Preferred High-dose inhaled corticosteroid + long-acting beta ₂ -agonist + oral corticosteroid [D] and consider omalizumab for patients who have IgE-mediated allergies [B]

Levels of Evidence for the most significant recommendations: A = randomized controlled trials; B = controlled trials; no randomization; C = observational studies; D = opinion of expert panel. This guideline sets core management steps. It is based on the 2007 National Asthma Education and Prevention Program Expert Panel Report 3, Guidelines for the Diagnosis and Management of Asthma, National Heart, Lung and Blood Institute (www.nhlbi.nih.gov). Individual patient considerations and advances in medical science may necessitate modifications to the management recommendations. Approved by NCI's National Director 07/08 www.mqic.org

The following guideline applies to patients with type 1 and type 2 diabetes mellitus. It recommends specific interventions for periodic medical assessment, laboratory tests and education to guide effective patient self-management.

Eligible Population	Key Components	Recommendation and Level of Evidence	Frequency
Patients 18-75 years of age with type 1 or type 2 diabetes mellitus	Periodic assessment	<p>Assessment should include:</p> <ul style="list-style-type: none"> • Height, weight, BMI, blood pressure [A] (adult target of < 130/80) • Assess cardiovascular risks (smoking, hypertension, dyslipidemia, sedentary lifestyle, obesity, stress, family history, age > 40) • Comprehensive foot exam (including monofilament testing annually) [B] • Screen for depression [D] • Dilated eye exam by ophthalmologist or optometrist [B], or gliscope [B] 	<ul style="list-style-type: none"> • At least annually and more frequently as needed • In the absence of retinopathy repeat in 2 years • A1C 2 - 4 times annually based on individual therapeutic goal; other tests at least annually
Laboratory tests		<p>Tests should include:</p> <ul style="list-style-type: none"> • A1C [D] • Urine microalbumin measurement [D] • Serum creatinine and calculated GFR [D] • Fasting lipid profile • Comprehensive diabetes self-management education (DSME) from a collaborative team or diabetic educator if available 	At diagnosis and as needed
Education, counseling and risk factor modification		<p>Education should be individualized, based on the National Standards for DSME [B] and include:</p> <ul style="list-style-type: none"> • Assessment of patient knowledge, attitude, self-management skills and health status; strategies for making health behavior changes and addressing psychosocial concerns [C] • Description of diabetes disease process and treatment; safe and effective use of medications; prevention, detection and treatment of acute and chronic complications • Importance of nutrition management and regular physical activity [A] • Role of self-monitoring of blood glucose in glycemic control [A] • Cardiovascular risk reduction • Smoking cessation intervention [B] and secondhand smoke avoidance [C] • Self-care of feet [B]; zincocapton counseling [D]; encourage patients to receive dental care [D] 	At each visit until therapeutic goals are achieved
Medical recommendations		<p>Care should focus on smoking, hypertension, lipids and glycemic control:</p> <ul style="list-style-type: none"> • Medications for tobacco dependence unless contraindicated • Treatment of hypertension using up to 3-4 anti-hypertensive medications to achieve adult target of < 130 systolic [B] and < 80 diastolic [A] • Prescription of ACE inhibitor or angiotensin receptor blocker in patients with hypertension or albuminuria [A]² • Statin therapy for primary prevention against macrovascular complications in patients with diabetes who are ≥ age 40 or who have an LDL-C > 100 mg/dl [A]³ • Anti-platelet therapy [A]: low dose aspirin daily for primary prevention in adults at increased cardiovascular risk with type 1 [C] and type 2 [A] diabetes, unless contraindicated • Adjust the plan to eventually achieve normal or near-normal glycemia with an A1C goal for most patients of < 7%. Less stringent treatment goals may be appropriate for patients with a history of severe hypoglycemia, patients with limited life expectancies, very young children or older adults and individuals with comorbid conditions. More stringent treatment goals (i.e., a normal A1C < 6%) for individual patients and in pregnancy. Note: Insulin and sulfonylureas sometimes result in weight gain. • Assurance of appropriate immunization status (tetanus, diphtheria, pertussis, influenza, pneumococcal vaccine) [C] 	At each visit until therapeutic goals are achieved

¹ See http://care.diabetesjournals.org/ce031/Supplement_1/

² Consider referral of patients with serum creatinine value > 2.0 mg/dl (adult value) or persistent albuminuria to nephrologist for evaluation.

³ Target LDL-C < 100 mg/dl [B]. For patients with overt CVD, a lower LDL-C goal of < 70 mg/dl is an option [B].

Levels of evidence for the most significant recommendations: A = randomized controlled trials; B = controlled trials; C = observational studies; D = opinion of expert panel. This guideline lists core management steps. It is based on several sources, including the 2008 American Diabetes Association Clinical Practice Recommendations (www.diabetes.org). Individual patient considerations and advances in medical science may supersede or modify these recommendations.

Michigan Quality Improvement Consortium Guideline

Outpatient Management of Uncomplicated Deep Venous Thrombosis

Michigan Quality Improvement Consortium	Key Components	Recommendation and Level of Evidence
<p>Eligible Population</p> <p>Adult patients ≥ 18 years of age</p> <p>Diagnosis of acute DVT, confirmed by duplex ultrasonography or venography. [A]</p> <p>No contraindications to anticoagulation or use of low molecular weight heparin (LMWH).</p>	<p>Initial assessment</p>	<ul style="list-style-type: none"> Perform initial comprehensive history and physical examination; consider conditions predisposing to DVT. Assess patient/caregiver ability and compliance for outpatient therapy, and need for home care resources. Assess for relative or absolute contraindications to outpatient anticoagulation therapy, including: <ul style="list-style-type: none"> • Severe HTN • Thrombocytopenia <100,000 • History of heparin induced thrombocytopenia Pulmonary embolism • Extensive iliofemoral thrombus • Known potential for non-compliance • Active bleeding • Renal clearance <30 mL/min or creatinine >2.5 mg/dL
<p>Initiating and monitoring pharmacologic interventions</p>	<p>Outpatient therapy is preferred if no contraindications.</p> <p>Contraindications to warfarin therapy:</p> <p>Absolute: pregnancy</p> <p>Relative: dementia, certain psychoses, diminished mental capacity, or childbearing age without contraception</p> <p>Begin LMWH.</p> <p>Begin warfarin after 1st dose of LMWH [A], on the same day, titrate to INR range of 2.0 - 3.0.</p> <p>Continue LMWH (along with warfarin) at least 5 days, and until INR range 2.0 - 3.0 for 2 consecutive days. [A]</p> <p>Maintain warfarin therapy at least 3 months in therapeutic INR range [A], longer if risk of recurrence.</p> <p>Ask about any changes in diet, medications, supplements and herbal products, and compliance before any dosage adjustment.</p> <p>If known hypercoagulable state, consider referral to a coagulation specialist.</p>	<p>• Obtain baseline lab values: aPTT, PT/INR, CBC with platelet count. Consider platelet count 3 to 5 days into anticoagulation therapy.</p> <p>• Monitor warfarin therapy using INR; no lab monitoring required for LMWH unless special circumstances such as renal insufficiency or extremes of body weight.</p> <p>• Frequent INR monitoring is necessary at the onset of warfarin therapy (e.g. at least 2 checks in the first week of therapy); then at least 2-3 times per week for the next 1-2 weeks. When stable, monitor every 4-8 weeks.</p> <p>• Monitor common bleeding sites; gums, nose, GI, GU and skin.</p> <p>• Monitor for signs/symptoms of pulmonary embolism, and medication side effects.</p> <p>• Maintain an Anticoagulant Monitoring Log (or dose adjustment system) for each patient treated with warfarin.</p> <p>• Management through a systematic program is essential (either in office or a specialized program for anticoagulation monitoring).</p>
<p>Testing/Monitoring</p>	<p>Initial assessment</p>	<ul style="list-style-type: none"> Inform patient/caregiver of the reasons and benefits of therapy, potential side effects, importance of follow-up monitoring, warfarin dosage adjustment, compliance, dietary recommendations (i.e. a diet that is constant in vitamin K), the potential for drug interactions, safety precautions, recognizing internal bleeding, and risk of hormonal contraception/therapies. Instruct patient/caregiver on symptoms of pulmonary embolism, extension of DVT and self-injection of LMWH. The patient should be encouraged to be ambulatory after an appropriate weight-based dose of LMWH [D]. Compression stockings should be used routinely to prevent post-thrombotic syndrome [A], beginning as soon as possible of the diagnosis of DVT and continuing for a minimum of 2 years. If stockings cannot be used initially due to swelling, compression wraps should be used until it is possible to use stockings.
<p>Patient education</p>	<p>Initial assessment</p>	<p>Levels of Evidence for the most significant recommendations: A = randomized controlled trials; B = controlled trials, no randomization; C = observational studies; D = opinion of expert panel</p> <p>This guideline represents core management steps. It is based on several sources including: Management of Venous Thromboembolism: A Clinical Practice Guideline from the American College of Physicians and the American Academy of Family Physicians. Ann Intern Med. 2007;146:204-10, and New Antithrombotic Drugs. American College of Chest Physicians. CHEST 2008;133:234S-266S. Individual patient considerations and advances in medical science may supersede or modify these recommendations.</p> <p>Approved by Michigan Medical Directors, August 2009, revised March 2010</p> <p>mlqic.org</p>



Michigan Quality Improvement Consortium Guideline

Adults with Systolic Heart Failure

The following guideline recommends diagnostic evaluation, pharmacologic treatment and education that support effective patient self-management.

Eligible Population	Key Components	Recommendation and Level of Evidence
Adults with suspicion of left-ventricular systolic dysfunction, including heart failure	Evaluation	<p>Initial assessment should include:</p> <ul style="list-style-type: none"> • Thorough history and physical examination [C] • Depression screening • Assessment for coronary artery disease and risk factors • Chest X-ray [C] • 12-lead electrocardiogram [C] • Lipid profile, CBC, electrolytes, calcium, magnesium, BUN, creatinine, blood glucose, liver function tests, TSH, urinalysis [C] • Two-dimensional echocardiography with Doppler [C] • Serial monitoring should include: weight, volume status, electrolytes, renal function and activity tolerance.
Adults diagnosed with left-ventricular systolic dysfunction, including heart failure	Pharmacological management	<p>Drugs recommended for routine use:</p> <ul style="list-style-type: none"> • ACE inhibitors in all patients, unless contraindicated¹ [A] • Recommend beta-blockers (carvedilol, sustained-release metoprolol, bisoprolol) in all stable patients, unless contraindicated^{1,2} [A] <p>Drugs recommended for use in select patients:</p> <ul style="list-style-type: none"> • Diuretics and sodium restriction for evidence of fluid retention [A] • Spironolactone for patients with moderate or severe symptoms of heart failure, preserved renal function (creatinine < 2.0 in women; creatinine < 2.5 in men) and normal serum potassium concentration [A] • In patients who cannot tolerate ACE inhibitors due to cough or angioedema, angiotensin receptor blockers are recommended [A]. • In patients who cannot tolerate ACE inhibitors or ARBs due to angioedema or renal insufficiency, hydralazine and nitrate combination is recommended [A]. • African-American patients who remain symptomatic despite therapy with ACE inhibitors, beta-blockers and PRN diuretics, may be candidates for adding the combination of hydralazine and isosorbide dinitrate [A].
	Education, counseling and risk factor modification	<p>Educate patient and family regarding:</p> <ul style="list-style-type: none"> • Daily self-monitoring of weight and adherence to recommended patient action plan • Recognition of symptoms and when to seek medical attention • Moderate dietary sodium restriction (e.g., 2,000-2,500 mg sodium/day) • Risk factor modification (regular exercise 5 times per week as tolerated [B]; smoking cessation; control of BP, DM, lipids) • Avoid excessive alcohol intake, illicit drug use, and the use of NSAIDs • Vaccination against influenza and pneumococcal disease

¹ Contraindications include: life-threatening adverse reactions (angioedema or anuric renal failure), pregnancy, hypotensive patients at immediate risk of cardiogenic shock, systolic blood pressure < 80 mm Hg, serum creatinine > 3 mg/dL, bilateral renal artery stenosis, or serum potassium > 5.5 mmol/L.

² Contraindications include: patients with current or recent fluid retention history, unstable or poorly controlled reactive airway disease, symptomatic bradycardia or advanced heart block (unless treated with a pacemaker), or recent treatment with an intravenous positive inotropic agent.

Levels of Evidence for the most significant recommendations: A = randomized controlled trials; B = controlled trials, no randomization; C = observational studies; D = opinion of expert panel

This guideline lists core management steps. It is based on the ACC/AHA 2005 Guideline Update for the Diagnosis and Management of Chronic Heart Failure in the Adult: A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines (www.acc.org). Individual patient considerations and advances in medical science may supersede or modify these recommendations.



Michigan Quality Improvement Consortium Guideline Screening and Management of Hypercholesterolemia

The following guideline recommends risk assessment, stratification, education, counseling and pharmacological interventions for the management of low-density lipoprotein cholesterol (LDL-C)

Eligible Population	Key Components	Recommendation and Level of Evidence
Age ≥ 18 years	Risk Assessment	<ul style="list-style-type: none"> • Screening: Initial fasting lipid profile (i.e., total, LDL-C, HDL-C, triglycerides); If normal, repeat at least every five years; [D] • Treatment is based on LDL-C, major risk factors and presence of CHD or equivalent.
	<p>Major Risk Factors:</p> <ul style="list-style-type: none"> • Cigarette smoking • Hypertension (BP ≥ 140/90) • On antihypertensives, regardless of current BP levels • HDL-C: < 40 (HDL-C ≥ 60 = negative risk factor) • Family history (first degree) of premature CHD (men < 55 years; women < 65 years) • Age (men ≥ 45 years; women ≥ 55 years) 	<p>CHD Risk Equivalents:</p> <ul style="list-style-type: none"> • Other clinical forms of atherosclerotic disease (e.g., peripheral arterial disease, abdominal aortic aneurysm, and/or symptomatic carotid artery disease) • Diabetes plus one additional risk factor (diabetes alone is not considered a risk equivalent) • Multiple risk factors confer a 10-year risk for CHD > 20% • CHD and CHD risk equivalents give a > 20% risk of a CHD event within 10 years
Risk Stratification	<p>• Calculate short-term risk for patients with 2+ risk factors using Framingham projection of 10-year absolute risk [D]:</p> <p>Categorical Risk</p> <ul style="list-style-type: none"> • CHD or CHD risk equivalents < 100 mg/dL • 10-year risk: > 20% • 2+ risk factors < 10-year risk: ≤ 20% • 0 - 1 risk factor < 160 mg/dL 	
Education and risk factor modification	<p>Educate patient/family regarding Therapeutic Lifestyle Changes (TLC):</p> <ul style="list-style-type: none"> • Reduce saturated fats and cholesterol [A], increase plant sterols/sterol (e.g. cholesterol-lowering margarines), increase viscous soluble fiber (e.g. oats, barley, lentils, beans), consider increasing fish consumption (Omega-3 fatty acids). • Decrease weight and increase exercise to moderate level of activity for 30 minutes, most days of the week [A]. 	
Pharmacologic interventions	<ul style="list-style-type: none"> • TLC and/or drug therapy may be initiated based on the LDL-C level and/or presence of CHD risk or CHD risk factors. • Initiate statin therapy for patients with CHD, CHD risk equivalents, or if the LDL-C is not at goal by 3 months after TLC have begun in earnest. • Statins are the most commonly used lipid-lowering agents. Liver function test monitoring is recommended at 3 months following treatment initiation, or dosage increases, or any statin. For prolonged myalgias, consider dosage reduction or statin change. • Evaluate and adjust drug therapy every 3 months until goal achieved. • For patients who do not reach LDL-C goal, consider referral to lipid specialist. 	

*Not all national guidelines agree

Levels of Evidence for the most significant recommendations: A = randomized controlled trials; B = controlled trials, no randomization; C = observational studies; D = opinion of expert panel
This guideline represents core management steps. It is based on several sources including: Lipid Management in Adults, Institute for Clinical Systems Improvement, 2007 (iclsi.org). Individual patient considerations and advances in medical science may supersede or modify these recommendations.



Michigan Quality Improvement Consortium Guideline Medical Management of Adults with Hypertension

The following guideline recommends diagnosis, education and pharmacologic treatment that support effective patient self-management.	
Eligible Population	Recommendation and Level of Evidence
<p>Adult patients ≥ 18 years of age. Not pregnant.</p> <p>Classification based on mean of 2 or more seated BP readings on each of 2 or more office visits.</p> <p>Normal BP <120/80</p> <p>Prehypertension 120-130/80-89</p> <p>Hypertension: Stage 1 140-159/90-99</p> <p>Stage 2 ≥160/≥100</p>	<p>Key Components</p> <p>Initial assessment</p> <ul style="list-style-type: none"> The objectives of the initial evaluation are to assess lifestyle, cardiovascular risk, factors, concomitant disorders, reveal identifiable causes of hypertension and check for target organ damage and cardiovascular disease. Physical examination: 2 or more BP measurements using regularly calibrated equipment with the appropriate sized cuff and separated by at least 2 minutes, verification in contralateral arm, tuncoscopic exam, neck exam (bruits), heart and lung exam, abdominal exam for bruits or aortic aneurysm, extremity pulses. [A] Laboratory tests prior to initiating therapy: Potassium, creatinine, glucose, hematocrit, calcium, urinalysis, lipid panel, EKG. [D] <p>Patient education and nonpharmacologic interventions</p> <ul style="list-style-type: none"> Lifestyle modification: weight reduction (BMI goal <25), reduction of dietary sodium to less than 2.4 gm/day, DASH diet [A] (i.e. diet high in fruits and vegetables, reduced saturated and total fat), aerobic physical activity ≥ 30 minutes most days of the week, tobacco avoidance, increased dietary potassium and calcium, moderation of alcohol consumption. [A] Use of self BP monitoring. Check accuracy of home measurement device regularly. Mean self measured BP > 135/85 generally considered to be hypertensive. If no other risk factors: target BP <140/90. Patients with risk factors: target BP <140/80 (<130/80 for patients with diabetes or kidney disease). [D] Caution: low diastolic or orthostatic symptoms may limit ability to control systolic. Use extreme caution if diastolic is below 60. For diabetics, mortality increases if diastolic is below 70. <p>Goals of Therapy</p> <p>Pharmacologic interventions</p> <ul style="list-style-type: none"> Hypertension, Stage 1 (140-159/90-99): start with thiazide-type diuretics for most patients. ACE-I and long-acting DHP-CCB² (e.g. amlodipine) are first-choice additional agents. Hypertension, Stage 2 (≥160/≥100): consider two-drug combination (thiazide plus ACE-I or DHP-CCB²). In general, diuretics and DHP-CCB² appear to be more effective as an initial treatment in African-Americans. ACE-I recommended in patients with diabetes or heart failure. [A] Beta-blockers are recommended in patients with ischemic heart disease or heart failure. Use angiotensin-receptor blockers (ARB) if ACE-I not tolerated. Intensify treatment until treatment goals are met; 3 or more drugs may be necessary for some patients to achieve goal BP. Caution: NSAIDs may complicate management of hypertension and worsen renal function.
<p>Monitoring and adjustment of therapy [D]</p>	<ul style="list-style-type: none"> Prehypertension without other risk factors: annual BP check with lifestyle modification counselling. Hypertension, Stage 1: initiate therapy and recheck at monthly intervals until goal is reached. Hypertension, Stage 2: initiate therapy and recheck weekly or more often if indicated. Symptomatic Stage 2 may require hospital monitoring and treatment. Modify antihypertensive therapy as needed if adverse effects become intolerable. Once BP controlled with medication: recheck every 3-6 months. Check serum potassium and creatinine at least 1-2 times/year for patients on diuretics/ACE-I/ARB.

¹Moderate alcohol consumption is generally defined as up to two drinks per day for men, one drink per day for women.

²DHP-CCB = long-acting dihydropyridine calcium channel blocker (e.g. amlodipine, felodipine)

Levels of Evidence for the most significant recommendations: A = randomized controlled trials; B = controlled trials; C = observational studies; D = opinion of expert panel. This guideline represents core management steps. It is based on several sources including: Hypertension Diagnosis and Treatment, Institute for Clinical Systems Improvement, November 2008 (icli.org). Individual patient considerations and advances in medical science may supersede or modify these recommendations.

Michigan Quality Improvement Consortium Guideline Diagnosis and Management of Adults with Chronic Kidney Disease

The following guideline recommends diagnosis and aggressive management of chronic kidney disease by clinical stage.

Eligible Population	Key Components	Recommendation and Level of Evidence	Frequency
All adults at increased risk for CKD	Screening & Diagnosis	<p>For patients at increased risk for CKD (e.g., diabetes, hypertension, family history of kidney failure, kidney stones, etc.) assess for markers of kidney damage:</p> <ul style="list-style-type: none"> • Measure blood pressure [A] • Obtain estimated GFR¹ (serum creatinine levels should not be used as sole means to assess renal function) • Protein-to-creatinine ratio or albumin-to-creatinine ratio (first morning or random spot urine specimen) • Urinalysis, fasting lipid profile, electrolytes, BUN • Evaluation and management of comorbid conditions (e.g. diabetes, hypertension, urinary tract obstruction, cardiovascular disease)² • Review medications for dose adjustment, drug interactions, adverse effects, therapeutic levels • Educate on therapeutic lifestyle changes: dietary sodium intake < 2.4 g/d recommended for patients with CKD and hypertension [A], weight maintenance if BMI < 25, weight loss if BMI ≥ 25; exercise and physical activity, moderation of alcohol intake, smoking cessation 	<ul style="list-style-type: none"> • Semi-annual blood pressure monitoring; more frequent monitoring if indicated • Monitor GFR every 1-2 years
Adults with CKD	Risk Factor Management & Patient Education	<p>All of the above plus:</p> <ul style="list-style-type: none"> • Develop clinical action plan for each patient, based on disease stage as defined by the National Kidney Foundation, Kidney Disease Outcomes Quality Initiative (K/DOQI) [B] • Incorporate self-management behaviors into treatment plan at all stages of CKD [B] 	At each routine health exam
	Core Principles of Treatment	<ul style="list-style-type: none"> • Stage 1 (GFR ≥ 90): Monitor GFR annually, smoking cessation, consider ASA, consider ACE and/or ARB therapy, BP goal <130/80, LDL-C goal < 100 • Stage 2 (GFR 60-89): Nephrology referral if GFR decline > 4ml/min/1.73m, maintain BP and lipid goals as above • Stage 3 (GFR 30-59): Consult Nephrologist and Renal Dietician; Suppress PTH with Vit D to level appropriate for CKD stage; Phosphorus lowering treatment if > 4.6 mg/dl; Correct iron deficiency before start of erythropoiesis stimulating agent (ESA); ESA if Hgb (Hct) < 10 (30%); Renal-specific vitamins; Update vaccines: HBV, influenza, Tdap and Pneumovax • Stage 4 (GFR 15-29): Nephrology and vascular access surgery referrals, ESA if Hgb < 10 g/dL, Optimize Ca x P product to < 55 with specific agents, update vaccines as indicated, CKD education classes • Stage 5 (GFR < 15): Renal replacement therapy 	As indicated

¹ If not calculated by lab, refer to the National Kidney Foundation website for GFR calculator (<http://www.kidney.org/professionals/foolst/>)

² Reference MOIC guidelines on diabetes, hypertension, hyperlipidemia and obesity (www.mqic.org).

Levels of Evidence for the most significant recommendations: A = randomized controlled trials; B = controlled trials, no randomization; C = observational studies; D = opinion of expert panel. This guideline lists core management steps. It is based on the Henry Ford Health System, Divisions of Nephrology & Hypertension and General Internal Medicine Chronic Kidney Disease (CKD) Clinical Practice Recommendations for Primary Care Physicians and Healthcare Providers, Edition 5.0 (www.ghsrenal.com). Individual patient considerations and advances in medical science may supersede or modify these recommendations.



Michigan Quality Improvement Consortium Guideline Tobacco Control

The following guideline recommends specific interventions for cessation services for current smokers and tobacco users.

Eligible Population	Key Components	Recommendation and Level of Evidence	Frequency
All patients 12 years of age and older (regardless of prior use status)	Identification of tobacco use and exposure status (never, former, current) and type (all forms, including smokeless tobacco, pipe, snuff, cigars, hookah [water pipe] and second hand smoke)	<ul style="list-style-type: none"> Ask and document tobacco use status in the medical record and/or problem list. [A] 	At each outpatient visit and inpatient admission
All patients identified as current smokers/tobacco users	Intervention to promote cessation of tobacco use	<ul style="list-style-type: none"> Advise to quit [A] avoid second-hand smoke. Assess patient willingness to attempt to quit. [C] Assist patients who are ready to quit by: <ul style="list-style-type: none"> - Establishing a quit date. - Providing self-help materials (e.g. Free Quit Kits; see www.michigan.gov/tobacco). - Offering nicotine replacement therapy (adults only) and/or non-nicotine medications e.g., sustained release bupropion [A] (adolescents and adults). - Recommending a smoking cessation program (e.g. MI Quit Line 1-800-480-7848 or your preferred program). - The combination of medication plus a smoking cessation program is more effective than either alone. [A] Arrange follow-up contact, either in person or by telephone [D]: <ul style="list-style-type: none"> First week after quit date. First month after quit date. 	At each periodic health exam, more frequently at the discretion of the physician

SPECIAL CIRCUMSTANCES

- Pregnant Smokers:** Due to the serious risks to the mother and fetus, pregnant smokers should be offered interventions such as referral to a smoking cessation program.
- Hospitalized Smokers:** Clinicians should provide appropriate pharmacotherapy and counseling during hospitalization to reduce nicotine withdrawal symptoms and assist smokers in quitting.
- Smokers with Psychiatric Comorbidity:** Nicotine withdrawal symptoms may exacerbate depression among patients with a prior history of affective disorder. Stopping smoking may affect the pharmacokinetics of certain psychiatric agents. Clinicians should monitor closely the actions or side effects of psychiatric medications in smokers/tobacco users who are attempting to quit.

Levels of Evidence for the most significant recommendations: A = randomized controlled trials; B = controlled trials, no randomization; C = observational studies; D = opinion of expert panel

This guideline lists core management steps. It is based on several sources including the Clinical Practice Guideline for the Management of Tobacco Use, Veterans Health Administration/Department of Defense, 2004 (cop.med.va.gov). Individual patient considerations and advances in medical science may supersede or modify these recommendations.



Michigan Quality Improvement Consortium Guideline Management of Overweight and Obesity in the Adult

The following guideline recommends specific interventions for treatment of overweight and obese conditions in adults.		
Eligible Population	Key Components	Recommendation and Level of Evidence
Adults 18 years or older	Assessment of Body Mass Index (BMI)	<ul style="list-style-type: none"> Measure height and weight, and calculate patient's BMI¹ to determine if patient is overweight or obese, and pattern of weight change [C]. If overweight, assess for complicating risk factors: <ul style="list-style-type: none"> Hypertension Family history of premature CHD Diabetes mellitus Diabetes mellitus Sleep apnea Assees current eating, exercise behaviors, history of weight loss attempts and psychological factors or medications that contribute to weight gain?²
Patients with BMI ≥ 25	Interventions to promote weight management	<p>Help your patients establish their own realistic lifestyle goals³:</p> <ul style="list-style-type: none"> Help your patient set a realistic goal for reducing calories and adjusting to maintain gradual weight loss(A), ideally to maintain a 1- to 2-pound weight loss per week and improve dietary quality. Help your patient set a realistic goal for physical activity, at a minimum, more activity than present; ideally 30 minutes of moderate physical activity most days of the week (A). Recommend weight loss strategies and resources as needed. (See www.michigan.gov/surgeongeneral) Arrange follow-up with patients to monitor progress and provide support.
Patients with BMI > 30 or > 27 with other risk factors or diseases	Interventions to promote weight management	<p>All of the above plus:</p> <ul style="list-style-type: none"> Consider referral to a program that provides guidance on nutrition, physical activity and psychosocial concerns. Consider pharmacotherapy only for patients with increased medical risk because of their weight, with co-existing risk factors or comorbidities (monitor for weight loss and medication side effects; periodically review need for medication). Insurance coverage for weight loss medications varies; consult health plan for eligibility.
BMI ≥ 40 or BMI ≥ 35 with uncontrolled ⁴ comorbid conditions ⁵	Surgical treatment	<ul style="list-style-type: none"> Weight loss surgery should be considered⁶ only for patients in whom other methods of treatment have failed and who have clinically severe obesity, i.e., BMI ≥ 40 or BMI ≥ 35 with life-threatening comorbid conditions⁷ [B]. Evaluate for psychological readiness for surgical intervention and post-surgical lifestyle commitment.

¹ BMI is an accurate proxy for body fat in average adults but may be misleading in muscular individuals.

² Weight gain may be associated with medications: antidiabetics, SSRI and tricyclic antidepressants, atypical antipsychotics, anticonvulsants, beta-blockers and corticosteroids.

³ Avoid weight gain or maintain weight loss, initial goal of 10% weight loss and reassess after goal achieved, maximum weight loss of 1/2 pound per week if overweight and 1-2 pounds per week if BMI > 30 .

⁴ Insurance coverage for bariatric surgery varies; consult health plan for eligibility.

⁵ Comorbidities: Severe cardiac disease (CHD, pulmonary hypertension, congestive heart failure, and cardiomyopathy); Type 2 diabetes; obstructive sleep apnea and other respiratory disease (chronic asthma) hypoventilation syndrome, Pickwickian syndrome); end-organ damage; pseudo-tumor cerebri; gastroesophageal reflux disease; hypertension; hyperlipidemia; severe joint or disc disease if interferes with daily functioning

Levels of Evidence for the most significant recommendations: A = randomized controlled trials; B = controlled trials, no randomization; C = observational studies; D = opinion of expert panel
This guideline represents core management steps. It is based on the Prevention and Management of Obesity (Mature Adolescents and Adults), Institute for Clinical Systems Improvement, 2006; and the National Institutes of Health, National Heart, Lung and Blood Institute Obesity Education Initiative, The Practical Guide: Identification, Evaluation and Treatment of Overweight and Obesity in Adults, 2000 (www.nhlb.nih.gov). Individual patient considerations and advances in medical science may supersede or modify these recommendations.

Michigan Quality Improvement Consortium Treatment of Childhood Overweight and Obesity



The following guideline recommends specific treatment interventions for childhood overweight and obesity.

Eligible Population	Key Components	Recommendation and Level of Evidence	Frequency
Children 2 years or older with a BMI \geq 85th percentile	Identify presence of weight related risk factors and complications	<p>Reinforce Prevention Recommendations (See also <i>MOIC Prevention and Identification of Childhood Overweight Guideline</i>)</p> <ul style="list-style-type: none"> • History and physical exam [D]; • Family history, evaluate general comorbidities, including but not limited to cardiovascular disease and diabetes • History of medication use including nutritional supplements • Symptoms of gallbladder disease, Type 2 diabetes, obstructive sleep disorders, hypothyroidism • Presence of acanthosis nigricans • Weight-related orthopedic problems • Pulse and blood pressure, using appropriate technique and cuff size for age • Be alert to secondary causes of obesity. If aberrant findings are noted (short stature, hypotonia, hirsutism, etc.) then consider genetic and other endogenous causes of obesity. • Patient or parental concern about weight • Testing: Annual lipid profile and fasting glucose 	Each periodic health exam, more frequently as case requires
Children 2 years or older with a BMI \geq 85th-94th percentile (overweight) without risk factors or complications	Lifestyle intervention to reach weight maintenance	<p>Consider all of the above, plus:</p> <p>Intervention to promote weight management/treatment [D]:</p> <ul style="list-style-type: none"> • Reinforce lifestyle intervention and behavior modification. Focus is appropriate weight maintenance. • Family must be involved; small gradual changes are recommended towards the stated goal • Monitor for increasing BMI percentile • Monitor for the development of risk factors or complications 	Consider management of childhood obesity as a medium- to long-term intervention
Children 2 years or older with a BMI \geq 85th-94th percentile with risk factors or complications	Lifestyle intervention with treatment of risk factors and complications as needed	<p>All of the above, plus:</p> <ul style="list-style-type: none"> • Primary goal of childhood weight interventions is regulation of body weight and fat with adequate nutrition for growth and development. • Treat risk factors and complications as needed. • Substantial slowing of weight gain may be achieved by relatively small but consistent changes in energy (200-500 kcal/day) intake, expenditure or both. If weight loss is desired, an appropriate starting goal is about 1 lb of weight loss per month. • Consider referral to multidisciplinary pediatric obesity treatment center, pediatric endocrinologist or registered dietitian. 	
Children 2 years or older with BMI \geq 95th percentile (obese) with or without risk factors or complications	Weight loss with concomitant treatment of risk factors and complications as needed	<p>All of the above, plus:</p> <ul style="list-style-type: none"> • Long-term goal should be a body mass index below 85th percentile for age and sex. • Consider aggressive approach to weight loss and treatment for patients after conservative approaches have failed. • Consider AST, ALT, BUN and creatinine. 	

Levels of Evidence for the most significant recommendation: A = randomized controlled trials; B = controlled trials, no randomization; C = observational studies; D = opinion of expert panel
This guideline lists core management steps. It is based on several sources, including: the American Medical Association 2007 Expert Committee Recommendations on the Treatment of Pediatric Obesity (www.ama-assn.org). Individual patient circumstances and advances in medical science may supersede or modify these recommendations.

Approved by **MOIC Medical Directors 06/08**

www.moic.org

Michigan Quality Improvement Consortium Guideline Prevention and Identification of Childhood Overweight

June, 2008

The following guideline recommends specific interventions for prevention and identification of childhood overweight and obesity.		Recommendation and Level of Evidence	Frequency
Eligible Population	Key Components		At each periodic health exam
Parents of children younger than 2 years old	Education of parents regarding obesity and prevention of risk	<p>Prevention to promote healthy weight:</p> <ul style="list-style-type: none"> Encourage breastfeeding; discourage overfeeding of bottle fed infants [A]. Avoid premature introduction of solids and base timing for introduction of solids on child's development, usually between 4 months and 6 months of age. Preserve natural satiety by respecting a child's appetite. Educate caregivers on the importance of age-specific meals and snacks, consistent mealtimes, appropriate snacking, serving sizes, reading nutritional labeling and daily physical activity. Educate parents about the importance of parental role modeling for healthy lifestyle behaviors and of parental controls [D]. Avoid high-calorie, nutrient-poor beverages (e.g., soda, fruit punch or any juice drink less than 100% juice). Limit intake of 100% juice to <6 oz per day; may offer in a cup, starting at 6 months of age. Evaluate general comorbidities, including but not limited to cardiovascular disease of parents. No television or computer screen time [D]. <p>General assessment:</p> <ul style="list-style-type: none"> History (including focused family history) and physical exam Measure and record weight and height on CDC BM-for-age growth chart, calculate and plot patients' BMI [weight (kg)/height squared (m²) or (pounds x 703)/inches²]¹ Dietary patterns (e.g. frequency of eating outside the home, consumption of breakfast, adequate fruits and vegetables, excessive portion sizes, etc). Risk factors for overweight² including pattern of weight change [C]. Watch for increases of 3-4 BMI units/year 	
Children 2 years or older	Assessment of body mass index, risk factors for overweight and excessive weight gain relative to linear growth	<p>Preschool:</p> <ul style="list-style-type: none"> Limit television and computer screen time to 1-2 hours per day, remove television and computer screens from primary sleeping area. Replace whole milk with skim, avoid high-calorie, nutrient-poor beverages (soda, fruit punch, juice drinks); limit intake of 100% juice. Eat breakfast daily; limit eating out and portion sizes, particularly fast foods. Promote a healthy diet (include fruit and vegetables and low-fat dairy) that encourages family mealtimes, regular eating times and minimizes nutritionally poor food prepared outside the home. Respect the child's appetite and allow him or her to self-regulate food intake. Provide structure and boundaries around healthy eating with adult supervision. Promote physical activity including unstructured play at home, during child care and in the community. <p>School-aged, the above plus:</p> <ul style="list-style-type: none"> Accumulate at least 60 minutes, and up to several hours, of age-appropriate physical activity on all or most days of the week (emphasize lifestyle exercise, i.e., outdoor play, yard work, and household chores). Consider barriers (e.g., social support, unsafe neighborhoods or lack of school-based physical education) and explore individualized solutions. Reinforce making healthy food and physical activity choices at home and outside of parental influence. 	
Children 2 years or older, BMI for age < 85th percentile	Prevention to promote healthy weight	<p>Age specific prevention messages:</p> <ul style="list-style-type: none"> Limit television and computer screen time to 1-2 hours per day, remove television and computer screens from primary sleeping area. Replace whole milk with skim, avoid high-calorie, nutrient-poor beverages (soda, fruit punch, juice drinks); limit intake of 100% juice. Eat breakfast daily; limit eating out and portion sizes, particularly fast foods. Promote a healthy diet (include fruit and vegetables and low-fat dairy) that encourages family mealtimes, regular eating times and minimizes nutritionally poor food prepared outside the home. Respect the child's appetite and allow him or her to self-regulate food intake. Provide structure and boundaries around healthy eating with adult supervision. Promote physical activity including unstructured play at home, during child care and in the community. <p>School-aged, the above plus:</p> <ul style="list-style-type: none"> Accumulate at least 60 minutes, and up to several hours, of age-appropriate physical activity on all or most days of the week (emphasize lifestyle exercise, i.e., outdoor play, yard work, and household chores). Consider barriers (e.g., social support, unsafe neighborhoods or lack of school-based physical education) and explore individualized solutions. Reinforce making healthy food and physical activity choices at home and outside of parental influence. 	

¹ See <http://apps.nccd.cdc.gov/epi/nbmi/ekalculator.aspx>

² Low or high birth weight; low income, minority; television or computer screen time > 2 hrs; low physical activity; poor eating; depression

Levels of evidence by the most significant recommendations: A = randomized controlled trials; B = controlled trials; no randomization; C = observational studies; D = opinion of expert panel
This guideline lists core management steps. It is based on several sources, including the American Medical Association 2007 Expert Committee Recommendations on the Treatment of Pediatric Obesity (www.ama-assn.org). Individual patient considerations and advances in medical science may supersede or modify these recommendations.



Michigan Quality Improvement Consortium Guideline Medical Management of Adults with Osteoarthritis

The following guideline recommends initial evaluation, nonpharmacologic and pharmacologic interventions for the management of osteoarthritis.

Eligible Population	Key Components	Recommendation and Level of Evidence
Adults with clinical suspicion or confirmed diagnosis of osteoarthritis	Initial evaluation	<ul style="list-style-type: none"> Detailed history (aspirin use, pain control with over-the-counter medications, activity tolerance and limitations) Physical examination Assess gastrointestinal (GI) risk: <ul style="list-style-type: none"> History of GI bleeding History of peptic ulcer disease and/or non-steroidal induced GI symptoms Concomitant use of corticosteroids and/or warfarin (A) High dose, chronic, or multiple NSAIDs including aspirin Age > 60 yrs
	Nonpharmacologic modalities	Treatment plan should include: <ul style="list-style-type: none"> education and counseling regarding weight reduction and joint protection range-of-motion (B), aerobic and muscle strengthening exercises for patients with functional limitations, consider physical and occupational therapy self-management resources (e.g., American Arthritis Foundation self help course and book) For select patients: <ul style="list-style-type: none"> assistive devices for ambulation and activities of daily living appropriate footwear, orthotics (e.g., wedged insoles)
Pharmacologic Therapy		
Therapies other than NSAIDs		<ul style="list-style-type: none"> Initial drug of choice: Acetaminophen at maximum recommended dose, modify dose for patients at risk for toxicity (note patients with hepatic toxicity risk factors, especially those on aspirin, or warfarin). Warn patients that many over the counter products contain acetaminophen and to monitor dose carefully. Topical capsaicin
NSAID analgesics:	No or low NSAID GI risk	NSAID GI risk
<ul style="list-style-type: none"> No cardiovascular risk 	<ul style="list-style-type: none"> NSAID Add PPI¹ if on aspirin, plus risk warrants GI protection 	<ul style="list-style-type: none"> NSAID plus PPI¹ If NSAID not-tolerated, Cyclo-oxygenase-2 (COX-2) selective inhibitor For those with prior GI bleed avoid all NSAIDs/COX-2, if must use, then COX-2 plus PPI¹ [D]
<ul style="list-style-type: none"> Cardiovascular risk 	<ul style="list-style-type: none"> Naproxen^{2,3} Add PPI¹ if GI risk of aspirin/NSAID combination warrants GI protection 	<ul style="list-style-type: none"> Naproxen^{2,3} plus PPI¹ if cardiovascular risk > GI risk COX-2 plus PPI¹ if GI risk > cardiovascular risk
Other pharmacologic agents	<ul style="list-style-type: none"> Nonacetylated salicylate, tramadol, opioids, intra-articular glucocorticoids or hyaluronate, lidoderm or methylsalicylate 	

¹ Mesoprostol at full dose (200 µg four times a day) may be substituted for PPI.

² Naproxen probably has lowest cardiovascular risk of NSAID/COX-2 class.

³ If aspirin is used daily, COX-2 offers no advantage over NSAID.

Levels of Evidence for the most significant recommendations: A = randomized controlled trials; B = controlled trials, nonrandomized; C = observational studies; D = opinion of expert panel. This guideline lists core management steps and is based on the following sources: The ICSI Diagnosis and Treatment of Adult Degenerative Joint Disease (DJD)/Osteoarthritis (OA) of the Knee, Institute for Clinical Systems Improvement, 2007 (iclsi.org) and Scherman JM. Summing the Risk of NSAID Therapy. Lancet 2007; 369:1560-1. Individual patient considerations and advances in medical science may supersede or modify these recommendations.

**Michigan Quality Improvement Consortium Guideline
Management of Acute Low Back Pain**



The following guideline recommends assessment, diagnosis and treatment interventions for the management of acute low back pain in adults.

Eligible Population	Key Components	Recommendation and Level of Evidence
Adults with low back pain or back-related leg symptoms for < 6 weeks	Patients with low risk of serious pathology (no red flags)	<p>Reassure patient that 90% of episodes resolve within six weeks regardless of treatment [C]. Advise that minor flare-ups may occur in the subsequent year.</p> <p>Therapy:</p> <ul style="list-style-type: none"> Stay active and continue ordinary activity within the limits permitted by pain. Avoid bedrest [A]. Early return to work is associated with less disability. Injury prevention (e.g. use of proper body mechanics, safe back exercises) Recommend ice for painful areas and stretching exercises [D]. McKenzie exercises [A] are helpful for pain radiating below the knee. <p>Referral:</p> <ul style="list-style-type: none"> If no improvement at 1-2 weeks, refer for goal-directed manual physical therapy, not modalities such as heat, traction, ultrasound, TENS. Surgical referral usually not required if no "red flags." <p>Medication Strategies:</p> <ul style="list-style-type: none"> Medication treatment depending on pain severity with acetaminophen or NSAIDs [A] COX-2 inhibitors and muscle relaxants have not been shown to be more effective than NSAIDs [A]. Opiate analgesics have not been shown to be more effective than NSAIDs in acute low back pain. <p>Testing:</p> <ul style="list-style-type: none"> Diagnostic tests or imaging usually not required. If no improvement after 6 weeks, consider imaging.
Assessment to identify potential serious pathology	<p>Fracture</p> <ul style="list-style-type: none"> Traumatic injury or onset, cumulative trauma Steroid use history Women age > 50 <p>Infection</p> <ul style="list-style-type: none"> Steroid use history Diabetes Mellitus Immune suppression History UTI or other infection Constitutional symptoms (e.g. fever, weight loss) No relief at bedtime or worsening when supine 	<p>Cancer</p> <ul style="list-style-type: none"> Men and women age > 50 Cancer history Insidious onset No relief at bedtime or worsening when supine Constitutional symptoms (e.g. fever, weight loss) Male with diffuse osteoporosis or compression fracture Cauda Equina syndrome or severe or progressive neurologic deficit — Refer for emergency studies and definitive care [C] Spinal fracture or compressions — Plain LS spine X-ray [B]. After 10 days, if fracture still suspected or multiple sites of pain, consider either bone scan [C] or referral [D] before considering CT or MRI. Cancer or infection — CBC, urinalysis, ESR [C]. If still suspicious consider referral or seek further evidence (e.g. bone scan [C], other labs — negative plain film X-ray does not rule out disease).
Patients with high risk of serious pathology (red flags)	<p>Assessment to identify potential serious pathology</p>	<p>Fracture</p> <ul style="list-style-type: none"> Traumatic injury or onset, cumulative trauma Steroid use history Women age > 50 <p>Infection</p> <ul style="list-style-type: none"> Steroid use history Diabetes Mellitus Immune suppression History UTI or other infection Constitutional symptoms (e.g. fever, weight loss) No relief at bedtime or worsening when supine <p>Cancer</p> <ul style="list-style-type: none"> Men and women age > 50 Cancer history Insidious onset No relief at bedtime or worsening when supine Constitutional symptoms (e.g. fever, weight loss) Male with diffuse osteoporosis or compression fracture Cauda Equina syndrome or severe or progressive neurologic deficit — Refer for emergency studies and definitive care [C] Spinal fracture or compressions — Plain LS spine X-ray [B]. After 10 days, if fracture still suspected or multiple sites of pain, consider either bone scan [C] or referral [D] before considering CT or MRI. Cancer or infection — CBC, urinalysis, ESR [C]. If still suspicious consider referral or seek further evidence (e.g. bone scan [C], other labs — negative plain film X-ray does not rule out disease).

Levels of Evidence for the most significant recommendations: A = randomized controlled trials; B = controlled trials, no randomization; C = observational studies; D = opinion of expert panel
This guideline lists core management steps. It is based on several sources, including the ICSI Adult Low Back Pain Guideline, Institute for Clinical Systems Improvement, 2006 (www.icsi.org). Individual patient considerations and advances in medical science may supersede or modify these recommendations.



Michigan Quality Improvement Consortium Guideline Management and Prevention of Osteoporosis

The following guideline recommends assessment and management of patients with osteopenia and osteoporosis.

Eligible Population	Key Components	Recommendation and Level of Evidence	Frequency
Patients at potential risk for osteoporosis	Assessment	<ul style="list-style-type: none"> ■ Assess for loss of height (> 1.5 inches) and back pain. ■ Assess other risk factors: <ul style="list-style-type: none"> • Current cigarette smoking • Low body weight (<127 lbs or BMI < 20) • Female gender • Menopause • Endocrine disorders: <ul style="list-style-type: none"> • Premature or surgical menopause • Chronic corticosteroid therapy • Estrogen or testosterone deficiency • Excessive thyroid hormone replacement • Calcium or vitamin D deficiency • Depo-Provera use ■ Bone mineral density (BMD) testing using DEXA for high risk patients or moderate risk patients at risk for falls. ■ CT scan for screening is not recommended. 	<ul style="list-style-type: none"> • Adult height assessments at periodic well exams
Patients requiring therapy to reduce high risk of fracture	Core Principles of Treatment and Prevention	<ul style="list-style-type: none"> ■ Regardless of risk factors: <ul style="list-style-type: none"> • Dietary calcium 1200 mg/d and 800 - 1000 IU vitamin D₃ [B] • Weight-bearing exercise [A] • Address modifiable risk factors above 	<ul style="list-style-type: none"> • BMD testing more often than every two years is generally not useful. • Consider rechecking BMD after at least two years of pharmacologic treatment to monitor effectiveness. [D]
Patients requiring therapy to reduce high risk of fracture	Patient Selection for Pharmacological Management Based on DEXA	<ul style="list-style-type: none"> • Treatment to prevent fractures in osteopenia [T-score between -1 and -2.0] without risk factors is not useful. [D] • Treat patients on corticosteroid therapy with a T-score \leq -1.0. [A] • Treat patients with osteopenia and a T-score between -2.0 and -2.5 at increased risk. [D] • Patients with osteoporosis [T-score < -2.5] (Osteopenia associated with atraumatic fracture should be treated as osteoporosis [D]). 	
Patients requiring therapy to reduce high risk of fracture	Pharmacological Management	<ul style="list-style-type: none"> • Consider oral bisphosphonate, generic, if available. • Consider referral to endocrine or bone and mineral metabolism specialist if patient does not tolerate treatment or shows progression or recurrent fracture after 2 years on treatment. 	

¹ Use caution in patients with active upper GI disorders. Take medication on an empty stomach with water, remain upright, no food or beverage for 30 minutes. (60 minutes for ibandronate).

Levels of Evidence for the most significant recommendations: A = randomized controlled trials; B = controlled trials, no randomization; C = observational studies; D = opinion of expert panel. This guideline represents core management steps. It is based on The Guide to Clinical Preventive Services 2007, Recommendations of the U.S. Preventive Services Task Force (www.preventiveservices.hhs.gov) and the Diagnosis and Treatment of Osteoporosis Guideline, Institute for Clinical Systems Improvement, 2008 (www.icsi.org). Individual patient considerations and advances in medical science may supersede or modify these recommendations.



Michigan Quality Improvement Consortium Guideline Acute Pharyngitis in Children

The following guideline recommends assessment, diagnosis and treatment interventions for the management of acute pharyngitis in children and adolescents.

Eligible Population	Key Components	Recommendation and Level of Evidence
Children 2-18 years old with suspected GABHS pharyngitis	Assessment	<p>Assess past history of rheumatic fever (especially carditis or valvular disease) or household contact with a history of rheumatic fever to identify high-risk patients.</p> <p>Assess the likelihood of strep pharyngitis by looking for the following:</p> <ul style="list-style-type: none"> • Sudden onset • Headache • Nausea, vomiting and abdominal pain • Presentation in winter or early spring • Fever • Inflammation of pharynx and tonsils • History of exposure • Patchy discrete exudate • Tender, enlarged anterior cervical nodes • No cough
Not high-risk for rheumatic fever	Diagnosis	<p>Testing (intermediate or high):</p> <p>Probability of GABHS: Throat culture</p> <p style="text-align: center;">Or</p> <p>Rapid screen</p> <p>Start antibiotics immediately. Obtain throat culture. If negative, stop antibiotics.</p>
High-risk for rheumatic fever or household contact with history of rheumatic fever or confirmed strep	Treatment	<ul style="list-style-type: none"> • See www.med.umich.edu/1info/FHP/practiceguides/pharyngitis/pharyn.pdf for detailed drug and dosing recommendations. <p>Preferred Treatment for Strep Pharyngitis:</p> <ol style="list-style-type: none"> 1) Penicillin VK: 250-500 mg bid-tid x 10 days 2) Amoxicillin: 40 mg/kg/d divided bid-tid x 10 days [A] or 750 mg daily x 10 days if compliance is a concern 3) Benzathine penicillin G IM x1 4) If allergic to penicillin: erythromycin ethyl succinate: 40 mg/kg/day bid-qid (max 1 gm/day) x 10 days or azithromycin 5) With oral antibiotics, a full 10-day course is required (ex-ception: azithromycin). <p>Alternative Treatment for Strep Pharyngitis:</p> <ol style="list-style-type: none"> 6) Cephalixin
Re-evaluation, referral		<ol style="list-style-type: none"> 1) If failure to respond clinically after 48 hours of treatment, rule out peritonsillar or retropharyngeal abscess. If present, prompt ENT evaluation is recommended. 2) Assess the potential for a compliance problem.
Culture optional for age 16 and older		

Levels of Evidence for the most significant recommendations: A = randomized controlled trials; B = controlled trials, no randomization; C = observational studies; D = opinion of expert panel
 This guideline lists core management steps. It is based on several sources including the ICSI Diagnosis and Treatment of Respiratory Illness in Children and Adults Guideline, Institute for Clinical Systems Improvement, 2008 (www.icsi.org). Individual patient considerations and advances in medical science may supersede or modify these recommendations.
 Approved by MQIC Medical Directors 01/09 www.mqic.org

Management of Uncomplicated Acute Bronchitis in Adults

The following guideline recommends assessment, diagnosis, treatment and counseling interventions for the management of uncomplicated acute bronchitis in adults.

Eligible Population	Key Components	Recommendation and Level of Evidence
Adults 18 years or older with clinical suspicion of uncomplicated acute bronchitis	Assessment	<ul style="list-style-type: none"> • Perform thorough history (including tobacco use status [A]) and physical exam • Assess the likelihood of uncomplicated acute bronchitis using the following items: <ul style="list-style-type: none"> - Acute respiratory infection (ARI) manifested predominantly by cough, with or without sputum production lasting no more than 3 weeks - No clinical evidence of pneumonia - Common cold, acute asthma, or exacerbation of COPD have been ruled out as cause of cough - Consider other diagnoses if cough persists greater than 3 weeks
	Diagnosis	<p>Clinical Information and Testing:</p> <ul style="list-style-type: none"> • Presumed diagnosis of acute bronchitis: <ul style="list-style-type: none"> - ARI and cough with or without sputum production lasting no more than 3 weeks - No clinical evidence of pneumonia • Viral cultures, serologic assays and sputum analyses should not be routinely performed [C] • Chest x-ray is not indicated if all of the following are present [B]: <ul style="list-style-type: none"> - Acute cough and sputum production suggestive of acute bronchitis - Heart rate < 100 beats/min - Respiratory rate < 24 breaths/min - Oral temperature < 38° C (100.4° F) - Chest exam lacks findings of focal consolidation, egophony or fremitus
	Treatment	<ul style="list-style-type: none"> • Condition is a self-limited respiratory disorder. Symptomatic treatment only. Routine treatment with antibiotics is not justified and should not be offered. Avoid antibiotics [A] • Beta₂-agonist bronchodilators should not be routinely used to alleviate cough. In select patients with wheezing, treatment with beta₂-agonists bronchodilators may be useful [C] • Antitussive agents can be offered for short-term symptomatic relief of coughing [C] • Mucokinetic (mucolytic) agents are not recommended (no consistent favorable effect) [D]
	Education and counseling	<p>Educate patient/family regarding:</p> <ul style="list-style-type: none"> • Condition often does not require medical treatment • Inform patient that cough may last for 3 weeks • Routine use of antibiotics is not recommended [A] • Use the term "chest cold" which is associated with less patient belief that antibiotics are needed • Rest and increasing fluid intake • Smoking cessation and second-hand smoke avoidance [C] (See also <i>MOIC Tobacco Control Guideline</i>)

Levels of Evidence for the most significant recommendations: A = randomized controlled trials; B = controlled trials, no randomization; C = observational studies; D = opinion of expert panel

This guideline lists core management steps. It is based on several sources including the American College of Chest Physicians Chronic Cough Due to Acute Bronchitis: ACCP Evidence-Based Clinical Practice Guidelines, 2008 (www.chestjournal.org). Individual patient considerations and advances in medical science

A	
A-200	41
ABILIFY	7
Acarbose	17
ACCOLATE	26
ACCUPRIL	21
ACCURETIC	21
Acetaminophen	31
Acetaminophen/codeine	32
Acetazolamide	22
Acetic Acid	38
Acetic Acid/Oxquin	29
Acetylcysteine	42
ACI-JEL	29
ACTIFED	24
ACTIMMUNE	5
ACTOPLUS	17
ACTOS	17
ACULAR	36
ACULAR LS	36
Acyclovir	14, 41
ADALAT-CC	20
ADDERALL	7
ADDERALL, XR	7
ADVAIR	26
ADVATE	5
ADVICOR	23
AEROBID	26
AEROCHAMBER, & MASK	27
AGENERASE	7
AGGRENOLX	36
AK-DEX SOLN	36
AKINETON	7, 34
AK-TRACIN	37
Albuterol	25, 26
ALDACTAZIDE	22
ALDACTONE	22
ALDOMET	22
Alendronate	18
ALESSE	16
Alfuzosin	30
ALINIA	15
ALKERAN	6
ALLEGRA	24
ALLEGRA-D	24
Allopurinol	33
ALOCRIAL	36
ALOMIDE	36
ALPHAGAN P	36
ALPHANATE	5
ALPHANINE	5
Altrefamine	6
Aluminum Chloride	41
ALUPENT	25
ALUPENT INHALER	25
Amantadine	14
Amantadine HCL	34
AMARYL	17
AMBIEN CR	7
Amino Acid/Urea Cervical Cream ...	30
AMINO-CERV	30
Amiodarone	20
AMITIZA	29
Amlodipine	20
Amoxicillin	12
Amoxicillin/potassium clavulanate ...	12
Ampicillin	12
ANAFRANIL	7
ANA-GUARD	42
ANA-KIT	42
ANAPROX	32
ANAPROX DS	32
Anastrozole	6
Antacid Liquid	28
Anthralin	41
ANTIVERT	28
ANUSOL HC SUPP	41
APAP/ASA/Caffeine	33
APLENZIN, ER	7
APRESOLINE	22
APLIGRAF	5
APTIVUS	7
ARICEPT	30
ARIMIDEX	6
ARANESP	5
ARIXTRA	5
ARMOUR THYROID	18
ARTANE	7
ARTHROTEC	33
ARTIFICIAL TEARS	38
ASACOL	29
ASENDIN	7
ASPIRIN	31, 36
Aspirin / Codeine	31
ASTELIN	23
ASTEPRO	24
ATARAX	23
Atenolol	20
Atenolol/Chlorthalidone	19
ATIVAN	7

ATRIPLA	7	BETOPTIC	37
Atropine.....	38	BIAXIN.....	13
ATROVENT INHALER.....	27	Bicalutamide.....	6
Attapulgit.....	27	Biperiden HCL.....	34
Augmented betamethasone dipropionate.....	40	Bisacodyl.....	29
AUGMENTIN.....	12	Bismuth Subsalicylate.....	27
AURALGAN.....	39	Bismuth Subsalicylate/ metronidazole/TCN.....	28
AUTOPLEX	5	Bisoprolol	20
AVELOX	14	Bisoprolol / HCTZ.....	20
AVONEX.....	5	BLEPH 10.....	37
AYGESTIN.....	16	BLEPHAMIDE.....	37
Azathioprine.....	6	BRETHINE	26
Azelastine.....	23, 24	Brimonidine	36
Azithromycin	13	BROMFED, -PD.....	24
AZMACORT	26	Bromocriptine.....	18, 34
AZULFIDINE.....	29	Bromphen/Decong	24
B		Brompheniramine/ Pseudoephedrine.....	24
Bacitracin	37	BRONCHO SALINE	27
Bacitracin ointment.....	39	Budesonide.....	26
Baclofen	34	Budesonide/Formoterol	26
BACTRIM	14	Bumetanide	22
BACTROBAN	41	BUMEX	22
BANZEL	7	Bupropion SR.....	30
BARACLUDE.....	15	BUSPAR, VANSPAR.....	7
Barium Enema Prep Kit	42	Busulfan.....	6
BEBULIN.....	5	Butalbital/APAP/Caffeine.....	31
Beclomethasone	26	Butalbital/APAP/Caffeine/ Codeine.....	31
Belladonna alkaloids/ phenobarbital.....	29	Butalbital/ASA/Caffeine	31
BENADRYL.....	23	Butalbital/ASA/Caffeine/ Codeine.....	31
BENADRYL SYRUP	23	BUTISOL SODIUM	7
Benazepril.....	21	C	
Benazepril/HCTZ	21	CAFERGOT	33
BENEFIX	5	Caffeine Citrate.....	42
BENEMID	33	CAFFEINE CITRATE SOLUTION	42
BENICAR	21	Calamine Lotion	41
BENICAR HCT.....	21	CALAN.....	20
BENTYL	29	CALAN SR	20
BENZAMYCIN	39	CALCIFEROL	18
Benzocaine/antipyrine.....	39	Calcipotriene.....	41
Benzonatate	25	Calcitonin Salmon	18
Benzoyl peroxide.....	39	Calcitrol	35
BETAGAN	37	Calcium Acetate	42
Betamethasone.....	40	Calcium carbonate.....	28, 35
Betamethasone valerate.....	40	CAMPREL.....	7
BETASERON	5		
Betaxolol.....	37		
Bethanechol.....	30		

CAPOTEN.....	21	Chlorpheniramine/ Pseudoephedrine.....	24
CAPOZIDE	21	Chlorpropamide	17
Captopril	21	CHLOR-TRIMETON	24
Captopril/HCTZ.....	21	Chlortrimeton/Decong.....	24
CARAFATE.....	28	Cholestyramine.....	23
Carbamide peroxide	39	Ciclopirox.....	40
CARBATROL	7	Cimetidine.....	28
Carbidopa/levodopa	34	CIPRO	14
Carbinoxamine/phenylephrine.....	24	CIPRODEX	38
CARDIZEM, -CD, -SR	20	Ciprofloxacin.....	14
CARDURA	22, 30	Ciprofloxacin/Dexamethasone	38
Carisoprodol	34	Clarithromycin.....	13
Carisoprodol/ASA.....	34	CLARITIN OTC.....	24
CARNITOR.....	35	CLARITIN SYRUP	24
Carvedilol	19	CLARITIN-D OTC.....	24
CASODEX	6	Clemastine.....	24
CATAPRES	22	CLEOCIN.....	15
CDZ/Clidinium	29	CLEOCIN VAG CREAM.....	29
CECLOR.....	12	CLEOCIN-T.....	39
CECLOR CD	12	Clindamycin.....	15, 29, 39
CEENU	6	CLINORIL.....	32
Cefaclor	12	Clonidine.....	22
Cefadroxil Monohydrate	12	Clopidogrel.....	36
Cefdinir.....	12	Clotrimazole.....	14, 29, 39
Cefixime	12	Clotrimazole/- betamethasone	40
Cefprozil.....	12	Clotrimazole-cream/solution.....	40
CEFTIN	12	CLOZARIL.....	7
Cefuroxime.....	12	Codeine/phenylephrine/ promethazine	25
CEFZIL	12	Codeine/promethazine.....	25
CELEXA	7	COGENTIN	7
CELLCEPT	6	CONCERTA	7
CELONTIN	7	COLACE.....	29
Cephalexin.....	12	COLCHICINE	33
CEPHULAC	29	COLESTID TABLETS.....	23
CEREBYX.....	7	Colestipol	23
Ceririzine.....	24	COLYTE	29
CERON.....	24	COLYTE FLAVORED	29
Cetirizine	24	COMBIVENT	27
Cetirizine/Pseudoephedrine.....	24	COMBIVIR.....	7
CHANTIX	31	COMPAZINE.....	28
Chewable Prenatal Vitamin.....	34	CONCERTA	7
Childrens Chewable Vitamin	35	Condoms	42
CHILDRENS Chewable Vitamin w/iron.....	35	CONDYLOX	41
Chlorambucil	6	CONTAC.....	24
Chloramphenicol.....	38	COPAXONE	5
Chlorhexidine Gluconate	42	COPEGUS	5
CHLOROMYCETIN	38	CORDARONE	20
Chlorpheniramine.....	24		

COREG.....	19	DESQUAM-X	39
CORGARD.....	20	DESYREL	7
CORTEF	15	DETROL LA.....	30
CORTISPORIN.....	37	Dexamethasone.....	15, 36
CORTISPORIN OTIC.....	38	DEXEDRINE.....	7
COSOPT.....	38	Dextromethorphan/ promethazine	25
COTAZYM.....	29	DEXTROSTAT	7
COUMADIN	9, 35	DIABETA.....	17
CREASE.....	29	DIABINESE.....	17
CREON.....	29	DIAMOX.....	22
CRESTOR.....	23	Diaphragm	42
CRIVAN	7	DIASTAT, ACUDIAL	7
Cromolyn	27	Diclofenac.....	32, 36
CROMOLYN NEBULIZER SOLUTION	27	Diclofenac/Misoprostol.....	33
Cromolyn sodium.....	36	Dicloxacillin	12
Cromolyn-Nasal inhaler.....	24	Dicyclomine	29
Cyclobenzaprine	34	Diflorasone diacetate.....	40
CYCLOGYL.....	38	DIFLUCAN	14, 29
Cyclophentolate.....	38	DIGITEK	9, 19
Cyclophosphamide	6	Digoxin.....	9, 19
Cyclosporine	6, 9, 38	Digoxin Solution.....	19
CYCRIN.....	16	DIGOXIN SOLUTION.....	19
CYMBALTA.....	7	Dihydroergotamine	33
Cyproheptadine	24	DILACOR XR	20
CYTOTEC.....	28	DILANTIN	7
CYTOXAN.....	6	DILATRATE SR.....	19
D		DILAUDID.....	31
DALMANE.....	7	Diltiazem & Diltiazem ER.....	20
Danazol.....	18	DIMETAPP	24
DANOCRINE	18	Diphenhydramine.....	23
DARAPRIM	15	Diphenoxylate/atropine.....	27
DARVOCET-N.....	31	Dipivefrin	38
DARVON.....	31	DIPROLENE	40
DARVON COMPOUND	31	DIPROLENE AF	40
DAYPRO.....	33	DIPROSONE	40
DAYTRANA	7	Dipyridamole/ASA	36
DDAVP	5	DISALCID	31
DEBROX.....	39	DITROPAN	30
DECADRON.....	15, 36	Docusate sodium	29
DECONAMINE SR	24	Docusate/casanthrol	29
DEPAKENE.....	7	Donepezil	30
DEPAKOTE, -ER.....	7	DONNATAL.....	29
DEPONIT.....	19	DORAL.....	7
DEPO-PROVERA.....	16	Dorzolamide HCL	37
DERMATOP.....	40	Dorzolamide/Timolol.....	38
Desonide.....	40	DOVONEX.....	41
Desoximetasone	40, 41	Doxazosin	22, 30
DESQUAM-E.....	39	Doxycycline	13
		DRISDOL.....	34

DRITHOCREME.....	41
Dronedarone	20
DRYSOL	41
DULCOLAX.....	29
DURICEF	12
DYAZIDE	22
DYNACIRC.....	20
DYNACIRC CR.....	20
DYNAPEN.....	12

E

EASIVENT	27
EDLUAR	7
EES.....	13
EFFEXOR, -XR.....	7
EFUDEX.....	41
ELAPRASE	5
ELAVIL	7
ELDEPRYL.....	34
Eletriptan Hydrobromide.....	33
ELIDEL.....	41
ELIMITE.....	41
ELOCON.....	40
EMSAM	7
EMCYT	6
EMTRIVA	7
Enalapril	21
Enalapril / HCTZ.....	21
ENBREL.....	5
Enoxaparin.....	35
Entecavir.....	15
EPIFOAM.....	41
EPIVIR.....	7
EPOGEN	5
EPZICOM	7
ERGAMISOL.....	6
Ergocalciferol	18
Ergotamine/caffeine.....	33
ERYCETTE.....	39
ERY-TAB.....	13
ERYTHROCIN	13
Erythromycin.....	37, 39
Erythromycin base.....	13
Erythromycin ethylsuccinate.....	13
Erythromycin stearate	13
Erythromycin/ Benzoyl peroxide.....	39
ESTRACE	15
ESTRADERM PATCH.....	16
Estradiol	15

Estradiol Transdermal	16
Estramustine.....	6
Estrogen/Progesterone.....	16
Estrogens, conjugated.....	15
ESTROSTEP	16
Ethambutol.....	14
Ethinyl estradiol/desogestrel	16
Ethinyl estradiol/Drosirenone.....	16
Ethinyl estradiol/norethindrone ...	16
Ethinyl estradiol/ norethindrone acetate.....	16
Ethinyl estradiol/norgestimate.....	16
Etodolac.....	32
Etonogestrel/ethinyl estradiol	16
Etoposide	6
ETRAFON.....	7
EUFLEXXA.....	5
EULEXIN.....	6
EVISTA	18
EXCEDRIN MIGRAINE	33
EXELON.....	30
Ezetimibe / Simvastatin	23

F

Famotidine	28
FARESTON	6
FAZACLO	7
FEIBA-VH	5
FELBATOL	7
FELDENE.....	32
FEMARA	6
FEMHRT	16
FENESIN DM	25
Fenofibrate	23
FEOSOL.....	35
FERGON	35
Ferrous Gluconate.....	35
Ferrous Sulfate	35
Fexofenadine	24
Fexofenadine/Pseudoephedrine....	24
FIORICET	31
FIORICET W/CODEINE.....	31
FIORINAL.....	31
FIORINAL W/CODEINE	31
FLAGYL.....	15
FLEETS PREP KIT.....	42
FLEXERIL 10MG.....	34
FLONASE	23, 39
FLORINEF.....	15
FLORONE.....	40

FLORONE E.....	40	GLUCOPHAGE XR.....	17
FLOXIN	14	Glucose Test Strips.....	17
FLOXIN OTIC	38	GLUCOTROL	17
Fluconazole	14	GLUCOTROL XL	17
Fluconazole Tablet	29	GLUCOVANCE	17
Fludrocortisone.....	15	Glyburide.....	17
Flunisolide.....	26	GLYNASE	17
Fluocinolone acetonide	40	GEODON.....	7
Fluocinonide	40	Gramicidin/neomycin/ polymyxin B	37
Fluorometholone	36	Griseofulvin.....	14
Fluoruracil, topical.....	41	Guaifenesin.....	25
Flurbiprofen	36	Guaifenesin/Codeine	25
Flutamide.....	6	Guaifenesin/ Dextromethorphan.....	25
Fluticasone	23, 39	Guaifenesin/Pseudoephedrine/ Codeine.....	25
Fluticasone/Salmeterol	26	GYNE-LOTRIMIN	30
FML	36		
FML FORTE.....	36	H	
FML S.O.P.....	36	Halcinonide.....	40
FOCALIN, XR.....	7	HALCION	7
Folic acid.....	35	HALDOL.....	7
Folic acid/B-12/Iron	35	Halobetasol.....	40
Fomoterol.....	25	HALOG	40
FORADIL	25	HALOG-E.....	40
FORTEO.....	5	HELIDAC	28
FORTOVASE	7	HELIXATE.....	5
FOSAMAX	18	HERCEPTIN	5
FRAGMIN	5	Hexachlorophene.....	41
FULVICIN PG.....	14	HEXALEN	6
FULVICIN UF.....	14	HISTUSSIN HC.....	25
Furosemide.....	22	HIVID.....	7
Furosemide Solution	22	Homatropine.....	38
FUZEON	7	HUMALOG.....	17
G		HUMATE P	5
GABITRIL	7	HUMATROPE.....	5
Galatamine	30	HUMIBID DM	25
GANTRISIN.....	14	HUMIBID LA	25
GARAMYCIN	39	HUMIRA	5
Gatifloxacin	37	HUMULIN.....	17
Gemfibrozil	23	HUMULIN PENS.....	17
GENOPTIC.....	37	Hydralazine	22
Gentamicin.....	37, 39	HYDREA	6
GLEEEVC.....	5	Hydrochlorothiazide.....	22
Glimepiride	17	Hydrocodone Bitartrate/APAP	32
Glipizide	17	Hydrocodone/Acetaminophen .	31, 32
Glipizide extended release	17	Hydrocodone/Phenyl/CTM	25
Glucagon	18	Hydrocort./acetic acid	39
GLUCAGON KIT	18	Hydrocortisone	15, 40, 41
Glucometer.....	17		
GLUCOPHAGE.....	17		

Hydrocortisone Acetate.....	41	ISOPTO HYOSCINE.....	38
Hydrocortisone valerate	40	ISORDIL.....	19
Hydrocortisone/neo/ polymyxin B	38	Isosorbide dinitrate.....	19
Hydrocortisone/neomycin/ polymyxin B.....	37	Isosorbide dinitrate SR	19
Hydrocortisone/pramoxine.....	41	Isosorbide mononitrate.....	19
HYDRODIURIL	22	Isradipine.....	20
Hydromorphone.....	31	J	
Hydroxychloroquine.....	33	JANUMET	17
Hydroxyurea.....	6	JANUVIA	17
Hydroxyzine	23	K	
Hyoscyamine sulfate	29	KADIAN.....	32
HYTONE.....	40	KALETRA.....	7
HYTRIN	22, 30	KAOPECTATE	27
I		KAYEXALATE.....	42
Ibuprofen.....	32	K-DUR 20.....	35
ILOTYCIN OPTH OINT	37	K-DUR-10	35
IMDUR.....	19	KEFLEX	12
IMITREX.....	33	KEMADRIN.....	7
IMODIUM.....	27	KENALOG	40
IMURAN	6	KEPPRA, XR	7
INAPSINE	7	KETEK.....	13
INCRELEX	5	Ketoconazole	14
Indapamide	22	Ketoprofen CR Capsules.....	33
INDERAL.....	20	Ketoralac tromethamine.....	33
INDOCIN	32, 33	Ketorolac	36
Indomethacin.....	32, 33	Ketotifen	36
INFERGEN	5	KINERET.....	5
Inhaler enhancement device	27	KLONOPIN	7
INNOPRAN XL.....	20	KLOTRIX	35
Insect Sting Kit.....	42	K-LYTE/Cl.....	35
Insulin Glargine	17	KOATE.....	5
Insulin Lispro.....	17	KOGENATE.....	5
Insulin Syringes.....	17	K-TABS.....	35
Insulin-Human, recombin	17	KWELL	41
INTAL.....	27	L	
INTRON A	5	Labetalol.....	20
INTUNIV	7	Lactulose.....	29
INVIRASE	7	LAMICTAL, ODT, XR.....	7
Ipratropium.....	27	LAMISIL TABLETS	14
Ipratropium / Albuterol.....	27	Lancets.....	17
ISMO	19	LANOXIN	9, 19
Isometheptene/ dichloralphenazone/ APAP	33	Lansoprazole	28
Isoniazid	14	LANTUS.....	17
ISONIAZID.....	14	LANTUS SOLOSTAR.....	17
ISOPTO ATROPINE.....	38	LASIX	22
ISOPTO HOMATROPINE.....	38	LASIX SOLUTION	22
		Latanoprost	38

Letrozole	6	LOZOL	22
LEUKERAN.....	6	Lubiprostone	29
LEUKINE	5	LUCENTIS	5
Levamisole.....	6	LUDIOMIL	7
LEVAQUIN	14	LUMINAL	7
LEVATOL.....	20	LUNESTA	7
LEVLEN.....	16	LUPRON	5
Levobunolol	37	LURIDE.....	35
Levocarnitine	35	LUVOX, CR.....	7
Levofloxacin	14	LYRICA.....	7
Levonorgestrel/ ethinyl estradiol.....	16	LYSODREN	6
Levothyroxine	9, 18	M	
LEVOXYL	9, 18	MAALOX/MAALOX TC	28
LEVSIN.....	29	MACROBID.....	15
LEVSINEX.....	29	MACRODANTIN	15
LEXAPRO.....	7	MARPLAN	7
LEXIVA.....	7	MATULANE.....	6
LIBRAX	29	MAVIK.....	21
LIBRIUM.....	7	MAXAIR AUTOHALER.....	25
LIDEX.....	40	MAXZIDE-25	22
Lidocaine	41	MAXZIDE-51	22
Lidocaine viscous.....	39	MEBARAL.....	7
Lidocaine/Prilocainc.....	41	Mebendazole	15
LIMBITROL, DS.....	7	Meclizine	28
Lindane lotion, shampoo	41	MEDROL	15
LIORESAL.....	34	Medroxyprogesterone.....	16
Lipase/protease/amylase	29	Medroxyprogesterone acetate	16
Lisinopril	21	MEGACE	6
Lisinopril /HCTZ.....	21	Megestrol	6
LO OVRAL.....	16	MELLARIL	7
LODINE, -XL	32	Meloxicam.....	32
Lodoxamide.....	36	Melphalan.....	6
LOESTRIN	16	Memantine	30
LOFIBRA	23	MEPHYTON.....	34
LOMOTIL	27	Mercaptoprine.....	6
Lomustine.....	6	Mesalamine	29
Loperamide HCl.....	27	MESTINON	34
LOPID.....	23	METADATE ER, CD.....	7
LOPRESSOR	19	METAMUCIL POWDER.....	29
LOPROX	40	Metaproterenol	25
Loratadine	24	Metformin.....	17
Loratadine/pseudoeph.....	24	Metformin / Glipizide	17
LORCET	31	Metformin, Extended-Release	17
LORTAB	32	METHADONE	32
LOTENSIN	21	Methadose	32
LOTENSIN - HCT.....	21	Methazolamide	22
LOTRISONE	40	METHERGINE	42
LOVENOX.....	5, 35		
LOXITANE.....	7		

Methimazole.....	18	Multi-vitamins & fluoride.....	34, 35
Methocarbamol.....	34	Mupirocin.....	41
Methotrexate	6, 33	MYAMBUTOL.....	14
METHOTREXATE	33	MYCELEX	14, 39
Methyldopa	22	MYCELEX TROCHE.....	39
Methylergonovine.....	42	MYCELEX-G.....	30
Methylprednisolone.....	15	MYCOLOG II.....	40
Metoclopramide.....	29	Mycophenolate Mofetil.....	6
Metolazone	22	MYCOSTATIN	30, 39, 40
Metoprolol.....	19	MYCOSTATIN POWDER.....	41
Metoprolol ER.....	20	MYDRIACYL	38
Metronidazole	15, 30	MYLANTA/ II	28
MIACALCIN		MYLERAN	6
NASAL SPRAY	18	MYLICON.....	28
MICARDIS.....	21	MYOBLOC	5
MICARDIS HCT	21	MYSOLINE	7
Miconazole.....	29		
MICROCHAMBER.....	27	N	
MICRONOR.....	16	Nabumentone	33
MIDRIN	33	Nadolol	20
MIGRANAL NASAL SPRAY.....	33	Nafarelin.....	18
MILTOWN	7	NAMENDA.....	30
MINIPRESS.....	22	Naphazoline/Antazoline.....	36
MIRALAX POWDER.....	29	NAPROSYN	32
Misoprostol	28	Naproxen	32
Mitotane	6	Naproxen Sodium.....	32
MOBAN.....	7	NARDIL.....	7
MOBIC.....	32	NASALCROM.....	24
MODICON	16	NASONEX.....	24, 39
Momentasone furoate	40	NATACHEW	34
Mometasone.....	24, 39	NATACYN	37
MONARCH M.....	5	NATALINS RX	34
MONCLATE.....	5	Natamycin 5%.....	37
MONISTAT	29	NAVANE.....	7
MONOGESIC.....	31	Nedrocromil.....	36
MONOKET.....	19	Neomycin	14
MONONINE	5	NEORAL.....	6, 9
Montelukast	26	NEOSPORIN	37
Morphine sulfate CR	32	NEOSYNEPHRINE.....	38
Morphine sulfate IR.....	32	NEPTAZANE	22
MOTRIN	32	NEULASTA	5
Moxifloxacin	14	NEUMEGA	5
MS CONTIN.....	32	NEUPOGEN	5
MSIR.....	32	NEURONTIN	7
MUCOMYST	42	NEXAVAR.....	5
MULTAQ	20	NIACIN	23
Multi-Vitamin.....	35	Niacin - Lovastatin.....	23
Multi-Vitamin w/ iron.....	35	Niacin, Niacin SR.....	23
Multi-Vitamin w/fluoride		NIASPAN	23
& iron.....	35	NICORETTE GUM.....	31

Nicotine Inhaler	31	NOVOLIN	17
Nicotine Nasal Spray.....	31	NOVOLOG	17
Nicotine polacrilex.....	31	NOVOLOG PENS.....	17
Nicotine transdermal.....	30	NOVOSEVEN	5
NICOTROL INHALER.....	31	NOXAFIL	14
NICOTROL PATCH	30	NUTROPIN.....	5
NICOTROL SPRAY	31	NUVA RING	16
Nifedipine.....	20	NUVIGIL.....	7
Nifedipine SR	20	Nystatin	30, 40, 41
NIFEREX PN	34	Nystatin suspension.....	39
NIFEREX-150 FORTE.....	35		
NIRAVAM	7	O	
Nitazoxanide	15	OCETREOTIDE.....	5
NITRO-BID	19	OCUFEN.....	36
NITRO-DUR.....	19	OCUFLOX.....	37
Nitrofurantoin	15	Ofloxacin	14, 37, 38
Nitrofurantoin monohyd/ macrocrystals LA.....	15	Olmesartan.....	21
Nitroglycerin	19	Olmesartan / HCTZ	21
Nitroglycerin Oint	19	Olopatadine.....	36
Nitroglycerin patch.....	19	OMEPRAZOLE	28
Nitroglycerin spray	19	Omeprazole caps.....	28
Nitroglycerin SR.....	19	OMNICEF.....	12
NITROL OINT	19	Ondansetron	28
NITROLINGUAL SPRAY.....	19	OPTICROM.....	36
NITROSTAT.....	19	ORAMORPH SR	32
NIX-OTC.....	41	ORAP	7
NIZORAL.....	14	ORAPRED.....	15
NOLVADEX.....	6	ORASONE.....	15
NORCO.....	32	ORINASE	17
NORDETTE.....	16	Orphenadrine.....	34
NORDIFLEX.....	5	Orphenadrine/ASA/ Caffeine.....	34
NORDITROPIN.....	5	ORTHO TRI-CYCLEN	16
Norethindrone	16	ORTHO-CEPT.....	16
Norethindrone acetate.....	16	ORTHO-CYCLEN	16
Norethindrone ethinyl estradiol.....	16	ORTHO-NOVUM 1/35	16
Norethindrone/mestranol.....	16	ORTHO-NOVUM 1/50	16
NORFLEX	34	ORTHO-NOVUM 10/11	16
NORGESIC	34	ORTHO-NOVUM 7/7/7	16
NORGESIC FORTE.....	34	ORUVAIL	33
Norgestimate/ ethinyl estradiol.....	16	OS-CAL	35
Norgestrel.....	16	OVCON-35	16
Norgestrel/ethinyl estradiol.....	16	OVCON-50	16
NORMODYNE.....	20	OVRAL	16
NORPRAMIN.....	7	OVRETTE	16
NORVASC.....	20	Oxaprozin.....	33
NOVANTRONE.....	5	Oxybutynin	30
NORVIR	7	Oxycodone/APAP	32
		Oxycodone/ASA.....	32

P	
PACERON	20
PAMELOR	7
Pantoprazole.....	28
PARAPECTOLIN.....	27
PARLODEL	18, 34
PARNATE.....	7
PATADAY.....	36
PATANOL.....	36
PAXIL, CR	7
Ped. Electrolyte Solution	35
PEDIALYTE	35
PEDIAZOLE.....	14
PEGANONE.....	7
PEGASYS.....	5
PEG-INTRON.....	5
PEG Solution.....	29
Penbutolol.....	20
Penicillin VK	12
PENTASA	29
Pentoxifylline.....	23
PEPCID AC	28
PEPTO BISMOL.....	27
PERCOCET.....	32
PERCODAN.....	32
PERIACTIN	24
PERI-COLACE.....	29
PERIDEX.....	42
Permethrin	41
PEXEVA	7
Phenazopyridine	30
PHENERGAN	28
PHENERGAN / CODEINE	25
PHENERGAN DM	25
PHENERGAN VC.....	25
PHENERGAN VC & COD.....	25
PHENOBARBITAL.....	7
Phenylephrine	38
Phenylephrine/ promethazine	25
PHENYTEK	7
PHISOHEX	41
PHOSLO.....	42
PILOCAR	38
Pilocarpine hydrochloride.....	38
Pimecrolimus.....	41
Pioglitazone.....	17
Pioglitazone/Metformin.....	17
Pipobroman	6
Pirbuterol	25
Piroxicam	32
PLAQUENIL	33
PLAVIX.....	36
Podofilox	41
POLY PRED SUSP	37
Polyethylene Glycol.....	29
Polymyxin/TMP.....	37
Polysporin ointment.....	39
POLYTRIM	37
POLY-VI-FLOR.....	34
POLY-VI-FLOR w/ iron.....	35
Polyvinyl Alcohol	38
POLY-VI-SOL	34
POLY-VI-SOL w/iron	35
Posaconazole	14
Potassium Cl efferv Tabs	35
Potassium Cl Liquid	35
Potassium Cl tab	35
Prazosin	22
PRECOSE	17
PRED FORTE.....	36
PRED MILD.....	36
PRED-G DROPS.....	37
PRED-G S.O.P. OINT	37
Prednicarbate	40
Prednisolone	15, 36
PREDNISOLONE.....	15
Prednisolone acetate/ neomycin/ polymixin B.....	37
Prednisolone acetate/ gentamicin.....	37
Prednisolone acetate/ gentamicin.....	37
Prednisolone Syrup.....	15
Prednisone.....	15
PRELONE.....	15
PREMARIN.....	15
PREMPHASE.....	16
PREMPRO	16
Prenatal vitamins	34
PRENATE 90	34
PREVACID	28
Prevacid/Biaxin/ Amoxicillin	28
PREVPAC	28
PRIMAQUINE.....	15
Primaquine Phosphate	15
PRINCIPEN	12
PRISTIQ	7
PROAIR HFA INHALER.....	25

PRO-BANTHINE	30	Quinapril	21
Probenecid.....	33	Quinapril/HCTZ.....	21
Procainamide	20	QUINIDEX	20
Procainamide SR.....	20	Quinidine gluconate.....	20
PROCANBID.....	20	Quinidine Sulfate.....	20
Procarbazine.....	6	QUINIDINE SULFATE.....	20
PROCARDIA	20	Quinidine sulfate SR.....	20
Prochlorperazine.....	28	QVAR.....	26
PROCRIT	5		
PROCTOCREAM HC.....	41	R	
PROFILNINE.....	5	Raloxifene.....	18
PROGRAF	6	RANEXA	19
PROLIXIN.....	7	Ranitidine.....	28
Promethazine.....	28	Ranitidine bismuth citrate	28
PRONESTYL.....	20	Ranolazine.....	19
Propanthelene	30	RAPAMUNE	6
PROPINE	38	RAPTIVA	5
PROPLEX	5	RAZADYNE	30
Propoxyphene.....	31	REBETOL	5
Propoxyphene Compound.....	31	REBETRON.....	5
Propoxyphene/APAP	31	REBIF.....	5
Propranolol	20	RECOMBINATE.....	5
Propranolol ER	20	REFACTO	5
Propylthiouracil.....	18	REFERON.....	5
PROSOM.....	7	REGLAN.....	29
PROTONIX.....	28	RELAFEN	33
PROTOPIC.....	41	RELPAK.....	33
PROVENTIL	25, 26	REMERON.....	7
PROVERA	16	REMODULIN	5
PROVIGIL.....	7	RESCRIPTOR.....	7
PROZAC, WEEKLY	7	RESTASIS	38
Pseudoephedrine	25	RESTORIL.....	7
PSORCON, -E.....	40	RETIN A.....	39
Psyllium powder	29	RETROVIR.....	7
PTU.....	18	REVATIO	5
PULMICORT RESPULES.....	26	REVLIMID	5
PULMOZYME	5	REYATAZ.....	7
PURINETHOL.....	6	RHEUMATREX	6
Pyrazinamide	14	RHOGAM	5
PYRAZINAMIDE	14	RIBAVIRIN.....	5
Pyrethins combo.....	41	RIFADIN	14
PYRIDIUM	30	Rifampin.....	14
Pyridostigmine.....	34	RISPERDAL	7
Pyridoxine	14	RITALIN, SR, LA.....	7
Pyrimethamine	15	Rivastigmine.....	30
		ROBAXIN.....	34
Q		ROBITUSSIN.....	25
QUESTRAN	23	ROBITUSSIN AC.....	25
QUESTRAN LIGHT.....	23	ROBITUSSIN DAC.....	25
QUINAGLUTE	20	ROBITUSSIN DM.....	25

ROCALTROL	35
Rosuvastatin	23
ROZEREM	7

S

SAIZEN	5
Salmeterol	25
Salsalate	31
SANDIMUNNE	6
SANDOSTATIN	5
SARAFEM	7
Scopolamine	38
SECONAL SODIUM	7
Selegiline	34
Selenium Sulfide	41
SELSUN SHAMPOO- Rx	41
SEPTRA	14
SERAX	7
SEREVENT	25
SEROQUEL	7
SEROSTIM	5
SERZONE	7
SILVADENE	39
Silver Sulfadiazine	39
Simethicone	28
Simvastatin	23
SINEMET	34
SINEQUAN	7
SINGULAIR	26
Sirolimus	6
Sitagliptin	17
Sitagliptin/Metformin	17
SLO-BID GYROCAPS	26
SLO-NIACIN	23
Smz/tmp	14
Sodium Bicarbonate	28
SODIUM BICARBONATE TABS	28
Sodium Chloride solution-canister	27
Sodium Fluoride drops/tabs	35
Sodium Polystyrene	42
SODIUM SULAMYD	37
SOMA 350 mg	34
SOMA COMPOUND	34
SOMNOTE, NOCTEC	7
SONATA	7
Spermicidal Jelly/foam	42
SPIRIVA	27

Spirololactone	22
Spirololactone/HCTZ	22
SPRYCEL	5
STAVZOR	7
STELAZINE	7
STIMATE	5
STRATTERA	7
SUBOXONE	7
Sucralfate	28
SUDAFED	25
Sulfacetamide	37
Sulfacetamide/prednisolone	37
Sulfasalazine	29
Sulfisoxazole	14
Sulfisoxazole/ erythromycin Susp.	14
Sulindac	32
SULTRIN VAG CREAM	30
Sumatriptan	33
SUMYCIN	13
SUPRAX	12
SURMONTIL	7
SUSTIVA	7
SUTENT	5
SYMBICORT	26
SYMBYAX	7
SYMMETREL	14, 34
SYNAGIS	5
SYNAREL	5, 18
SYNALAR	40
SYNTHROID	9, 18

T

Tacrolimus	6, 41
TAGAMET	28
Tamoxifen	6
TAPAZOLE	18
TARCEVA	5
TARKA	21
TAVIST	24
TEGRETOL, XR	7
Telithromycin	13
Telmisartan	21
Telmisartan/HCTZ	21
TEMODAR	5
TENORETIC	19
TENORMIN	20
Terazosin	22, 30
Terbinafine tablets	14
Terbutaline	26

TESLAC	6	Triamcinolone acetonide.....	26, 40
TESSALON PERLES.....	25	Triamcinolone/ nystatin	40
Testolactone.....	6	Triamterene/HCTZ.....	22
Tetracycline	13	TRIAVIL, ETRAFON.....	7
TEVTROPIN	5	TRIDESILON.....	40
THALOMID.....	5	Trifluridine	37
THEO-DUR.....	26	TRILEPTAL.....	7
Theophyllines.....	26	TRILAFON.....	7
THERA-M.....	35	Trimethobenzamide	28
THERAPEUTIC TAB	35	Trimethoprim	15
THIOGUANINE	6	TRIMOX.....	12
THORAZINE	7	TRIMPEX.....	15
Thyroid desiccated.....	18	TRIPHASIL	16
THROMATE	5	Triple Antibiotic ointment	39
THYROGEN	5	Triple sulfa vag cream.....	30
THIAZAC	20	Tripolidine/ Pseudoephedrine.....	24
TICLID.....	36	TRITEC	28
Ticlopidine	36	TRI-VI-FLOR.....	35
TIGAN.....	28	TRIZIVIR	7
Timolol maleate	37	Tropicamide	38
TIMOPTIC SOLUTION	37	TRUE TRACK/ TRUE~RESULT	17
TIMOPTIC-XE GEL.....	37	TRUE TRACK/ TRUE TEST.....	17
TINACTIN	40	TRUSOPT	37
Tiotropium Bromide	27	TRUVADA.....	7
Tizanidine.....	34	TUMS	28, 35
TOBI	5	TUSSI-ORGANIDIN NR.....	25
TOBRA-DEX.....	37	TUSSI-ORGANIDIN- DM NR.....	25
Tobramycin	37	TYKERB	5
Tobramycin /dexamethsone.....	37	TYLENOL	31
TOBREX.....	37	TYLENOL W/ CODEINE.....	32
TOFRANIL, PM.....	7	TYLOX.....	32
Tolazamide	17		
Tolbutamide.....	17	U	
TOLINASE	17	ULTRAM.....	31
Tolnaftate cream.....	40	ULTRAVATE.....	40
Tolterodine Tartrate ER.....	30	UNIPHYL.....	26
TOPAMAX	7	URECHOLINE	30
TOPICORT	41	UROXATROL.....	30
TOPICORT LP.....	40		
TOPROL XL.....	20	V	
TORADOL	33	VALISONE	40
Toremifine	6	VALIUM	7
TRACLEER.....	5	VANDAZOLE.....	30
Tramadol HCL.....	31	Varenicline.....	31
Trandolapril.....	21	VASOCIDIN.....	37
Trandolapril / Verapamil ER.....	21	VASOCON-A	36
TRANXENE T-TAB.....	7		
TRELSTAR	5		
TRENTAL.....	23		
Tretinoin.....	6, 39		

VASORETIC.....	21
VASOTEC.....	21
VEETIDS.....	12
VEPESID.....	6
Verapamil.....	20
Verapamil SR.....	20
VERCYTE.....	6
VERMOX.....	15
VESANOID.....	6
VIADUR.....	5
VIBRAMYCIN.....	13
VICODIN.....	32
VICODIN ES.....	32
VIDAZA.....	5
VIDEX, EC.....	7
VIMPAT.....	7
VIOKASE.....	29
VIRACEPT.....	7
VIRAMUNE.....	7
VIREAD.....	7
VIROPTIC.....	37
VISTARIL.....	23
VISUDYNE.....	5
VITAMIN B-6.....	14
Vitamin D.....	34
Vitamin K.....	34
VIVACTIL.....	7
VIVELLE.....	16
VOLTAREN.....	32, 36
VOSOL.....	38
VOSOL HC OTIC.....	39
VYTORIN.....	23
VYVANSE.....	7

W

Warfarin.....	9, 35
WELLBUTRIN, SR, XL.....	7
WESTCORT.....	40
WHINRHO.....	5
WYGESIC.....	31

X

XALATAN.....	38
XANAX, XR.....	7
XELODA.....	5
XOLAIR.....	5
XYLOCAINE.....	41
XYLOCAINE VISCOUS.....	39

Y

YASMIN.....	16
-------------	----

Z

ZADITOR OTC.....	36
Zafirlukast.....	26
ZANAFLEX.....	34
ZANTAC.....	28
ZARONTIN.....	7
ZAROXOLYN.....	22
ZEBETA.....	20
ZERIT.....	7
ZESTORETIC.....	21
ZESTRIL.....	21
ZIAC.....	20
ZIAGEN.....	7
ZITHROMAX.....	13
ZITHROMAX 1GM POWDER PACK.....	13
ZOCOR.....	23
ZOFRAN.....	28
ZOLADEX.....	5
Zolmitriptan.....	33
ZOLOFT.....	7
ZOMIG.....	33
ZONEGRAN.....	7
ZOVIRAX.....	14, 41
ZYBAN.....	30
ZYLOPRIM.....	33
ZYMAR.....	37
ZYPREXA, ZYDIS.....	7
ZYRTEC OTC.....	24
ZYRTEC SYRUP OTC.....	24
ZYRTEC-D OTC.....	24



100 W. Big Beaver Rd., Suite 600
Troy, MI 48084
www.MolinaHealthcare.com

RX Prior Authorizations
Rx Phone Hotline
888-898-7969

Fax Hotline
888-373-3059

Please refer to the Molina website for the
most up-to-date Drug Formulary.