PHARMACY

Prescription drug therapy is an integral component of your patient's comprehensive treatment program. The goal of Molina Healthcare is to provide our members high quality, cost effective drug therapy.

At Molina Healthcare, medications can fall into the following categories. Information on procedures to obtain these medications is described in detail within this document and also available on the website.

1. **Formulary Medications** - These medications do not require Prior Authorization (PA). Molina Healthcare covers up to a 30 day supply of medication. In some cases, your patients may only be able to receive certain quantities of medication. Information on quotas are included in this document and can also be found in the Formulary documents.

2. **Formulary Medications with Prior Authorization** -These medications may require the use of first line medications before they are approved. Information on PA criteria is included in this document.

3. **Non Formulary Medications**- These medications can be considered for exception when Formulary medications are not appropriate for a particular patient or have proven ineffective. Requests for Formulary exceptions are completed on the Molina Healthcare Prior Authorization form. Clinical evidence must be provided and is taken into account when evaluating the request to determine medical necessity**.**

4. **Drugs available but not covered by the Health Plans** - These medications are often called "carved out drugs" because they are a covered benefit but provided outside of the health plan. In Michigan, behavioral health drugs and drugs used to treat HIV are carved out from health plan coverage. Prior Authorization requests are made directly to Fee For Service through Magellan Medicaid Administration at**:** ***www.michigan.fhsc.com***

5. **Medications not covered by Medicaid** - These medications are not covered under the Medicaid benefit and therefore are excluded from coverage. For example, drugs used in the treatment of fertility are not part of the benefit. These exclusions are determined by the Michigan Department of Community Health.

Formulary Documents: Information on medication coverage is sent to providers throughout the year both by mail and via FAX. These documents are also available on the Molina Healthcare website under Providers, Michigan, Drug list or Forms:

1. Drug formulary book
2. Condensed formulary "*At a Glance*"
3. "*Ez Rx*" newsletters which address a variety of important information about formulary medications and other medication therapy issues
4. "*Just the Fax*" newsletters which address formulary additions and changes

Important Contact Numbers:

1. Rx PA Hotline: (888) 898-7969, Providers-Option 1, Pharmacies - Option 5
2. RX PA Fax Line: (888) 373-3059
3. For a 24 hour pharmacy over ride: Please call Rx PA Hotline and you will be transferred to after hour help desk.
4. Magellan Medicaid Administration information for carved out drugs:
    a. www.michigan.fhsc.com/Providers/Drug Information
    b. Magellan Medicaid Administration Clinical Call Center: (877) 864-9014

Drug Prior Authorization (PA) Procedures

This summary is intended to provide a quick reference to the Prior Authorization (PA) procedures for Formulary medications that require Prior Authorization

1. Please familiarize yourself with the Molina Healthcare Drug Formulary to learn which drugs require prior authorization. You also have access to the latest Drug Formulary information at www.molinahealthcare.com and ePocrates. If you need additional copies of the Molina Healthcare Drug formulary, please call your Territory Manager.
2. If a drug requires Prior Authorization you must fax a Molina Healthcare Prior Authorization Drug Request form to (888) 373-3059.
3. Drug prior authorizations are always processed in the order in which they are received. However, antibiotics and other urgent requests are given expedited attention. If all necessary information is presented, expect a response within two hours and not longer than one business day. If forms are NOT filled out completely, you may expect a FAX back with a request for additional information.
4. Once received, your PA request is reviewed by the Molina Healthcare Pharmacy Team to determine if it meets the Molina Healthcare PA criteria. The team can either APPROVE or PEND your request. If your request is PENDED, please submit the requested documentation to substantiate your request or choose one of the formulary alternatives indicated on the form.
5. Expect a written communication from Pharmacy personnel the following business day if you have not responded to the formulary suggestions or request for additional information. Molina Healthcare follows up on these requests to ensure that the member receives their medication in a timely fashion.
6. If your request is DENIED by the Medical Director or Pharmacy Director, you and the member will receive written documentation with the reason the request was denied. Providers and members can appeal this decision. Information regarding the appeal process will be provided in the letter.
7. Considerations when reviewing a request for Prior Authorization:
    - First line Formulary prescription or OTC Drugs take precedence over non-formulary drugs.
    - Prescription requests for medications requiring Prior Authorization or for medications not included on the Molina Healthcare Drug Formulary may be approved when medically necessary and when Formulary alternatives have proven ineffective. When these exceptions arise, the provider must FAX a completed PA form to Molina Healthcare Pharmacy Department at (888) 373-3059.
    - All non-FDA approved ("off label") drug requests will be DENIED and are subject to the review of the Medical or Pharmacy Director only.
    - The use of manufacturer's samples of non-formulary or "Prior Authorization Required" medications does not override Formulary requirements.
8. To assure excellent customer service, all authorization requests received before 5:00 PM EST will be processed the same day.

Drug Prior Authorization (PA) Helpful Hints

Prevent Rx Delays

Make extra copies of PA forms and keep them readily available. This will save time expediting your request. You may also download the PA form from our website: **www.molinahealthcare.com, Michigan, Providers, Forms**

Save Telephone Calls

Get to know your Territory Manager. They can provide: extra copies of Prior Authorization request forms, PA procedures, copies of formularies and other general assistance related to medication questions.

Save Time - Save Calls from Pharmacies

Use alphabetical listing in your formulary book index to look up which drugs require a PA.

Be Informed - Be Patient Oriented

Please familiarize yourself with the Molina Healthcare Drug Formulary. Please refer to the Molina Healthcare website and ePocrates for the most up-to-date Drug Formulary information. Drugs shaded in gray require a PA. Knowledge of this will save you calls from pharmacies and complaints from your patients. For your convenience we have included the abbreviated Prior Authorization criteria within this document.

Save Time - Save Calls or Faxes from Molina Healthcare

Fill out drug PA form completely; make sure you note your office phone and fax number with area code, member name, and recipient ID number, physician name and name of person completing the form and include use of any previous therapy.

Important - Please Note

Any questions or concerns may be directed to our pharmacy voice mail system. Please do not hesitate to request PA forms, status of requests, etc. Messages from our pharmacy voice mail system or direct calls at (888) 669-4322 are retrieved and answered promptly throughout the day. Your voice mail message/call is important to us and all messages are returned as soon as possible and no later than the same business day. If you or your staff are leaving for the day and will not be available when we return your call, please indicate who we should contact in the event you are out of the office.

Non Formulary Medication Prior Authorization Criteria

Prescriptions for Non-Formulary medications, whose drug class is represented on the Drug Formulary with other agents, may be approved if the drug(s) will be used within these guidelines:

1. Documented failure or intolerance to all Formulary agents of same drug class.
   - Eg., a request for the statin drug Crestor will require failure on Formulary agent simvastatin or pravastatin.

   - If the Formulary agents/drug class should require Prior Authorization, member will need to meet the Prior Authorization requirements for specific medication/drug class before it can be used.

OR,

2. Medication is being used for a unique treatment/condition that is not indicated for Formulary agents in same drug class.

OR,

3. All Formulary agents from same drug class are contraindicated for member per manufacturer recommendations.

OR,

4. Medication request is for a new member who is continuing therapy started while in another health plan. May be asked to provide documentation of previous use. A transition supply may be approved until the members can be started on a Formulary agent

Formulary alternatives will be recommended to requesting physician if any of the following apply:

A) Above criteria (1-4) are not met.
B) Pharmaceutical samples were dispensed to member before all Formulary agents within same drug class were tried.

Prior Authorizations generally will be denied if Formulary alternatives are not accepted by prescriber.

These guidelines for prior authorization approval are for reference only. They do not replace the professional judgment of the prescribing physician and do not necessarily apply to all patient-specific situations.

ABBREVIATED PRIOR AUTHORIZATION CRITERIA

Prior Authorization criteria is reviewed and approved by the Molina Healthcare Pharmacy and Therapeutics Committee. Medications under review are evaluated and compared to medications available on the formulary. Clinical evidence used to make decisions is evaluated from journals, medical associations, and from good scientific information. Changes to the PA criteria can be found in the formulary on the website, "At a Glance", or faxed or printed newsletters: *EZ Rx* newsletters and *Just the Fax.*

IMPORTANT NOTE: For these important medications, please complete a PA request before hospital discharge and before member takes Rx to pharmacy

ABBREVIATED PRIOR AUTHORIZATION/QUOTA CRITERIA ANTIBIOTICS

BRAND NAME	GENERIC NAME	CRITERIA
AUGMENTIN	Amoxicillin/ clavulanate	Quantity Limit - #20/fill. Suspension form – No PA for members <12
AVELOX	Moxifloxacin	Failure on first-line antibiotic, as indicated by nature of infection.
BIAXIN	Clarithromycin	Failure on first-line antibiotic, as indicated by nature of infection. OK as first-line for MAC and H. Pylori. Suspension form – No PA for members <12
CECLOR CD	Cefaclor	Failure on first-line antibiotic, as indicated by nature of infection. Suspension form – No PA for members <12
CEFZIL	Cefprozil	Failure on first-line antibiotic, as indicated by nature of infection. Suspension form – No PA for members <12
CIPRO	Ciprofloxacin	Quantity Limit - #20/fill. Suspension form – No PA for members <12
CLEOCIN	Clindamycin	150mg capsules only – No PA required
FLOXIN	Ofloxacin	Failure on 1st-line antibiotic, as indicated by nature of infection.
KETEK	Telithromycin	Failure on first-line antibiotic, as indicated by nature of infection.
LEVAQUIN	Levofloxacin	Failure on first-line antibiotic, as indicated by nature of infection.
OMNICEF	Cefdinir	Failure on first-line antibiotic, as indicated by nature of infection.
SUPRAX	Cefixime	Failure on first-line antibiotic, as indicated by nature of infection.
ZITHROMAX	Azithromycin	Zithromax Powder Pack – No PA required when billed as 1 day stat dose for STD treatment. 250mg-Quantity limit #6/14 days, 500mg #3/14 days

FORMULARY MEDICATIONS

BRAND NAME	GENERIC NAME	CRITERIA
ACCOLATE	Zafirlukast	Moderate to severe asthma; failure on inhaled steroids and Singulair (PA required).
ACTOPLUS	Pioglitazone/Metformin	Treatment of Type II diabetes with HbA1c > 6.0 and ≤8.5; Failed or intolerant to max doses of sulfonylureas and/or metformin,
ACTOS	Pioglitazone	Treatment of Type II diabetes with HbA1c > 6.0 and ≤8.5; Failed or intolerant to max doses of sulfonylureas and/or metformin,
ADVAIR	Fluticasone/ Salmeterol	Moderate to severe asthma or COPD. Failure on inhaled steroids.
ALINIA	Nitazoxanide	For the treatment of diarrhea caused by *Giarda lamblia* or *Cryptosporidium parvum*
ALLEGRA, -D	Fexofenadine Fexofenadine / pseudoephedrine	Treatment of allergic rhinitis/urticaria. Failure of OTC antihistamines (Including Claritin and Zyrtec) and nasal steroids.

BRAND NAME	GENERIC NAME	CRITERIA
AMITIZA	Lubiprostone	For the treatment of chronic idiopathic constipation or IBS in adults.
APRISO	Mesalamine	Maintenance of remission. Quantity limit - #120/month
ARTHROTEC	Diclofenac / misoprostol	Treatment of arthritis in patients at high risk for ulcers. Failure of formulary preferred Voltaren and Mobic.
BARACLUDE	Entecavir	For the treatment of chronic HBV infection in adults with evidence of active viral replication and either evidence of persistent elevations in serum aminotransferases (ALT or AST) or histologically active disease
BENICAR,-HCT	Olmesartan,-HCTZ	For the treatment of hypertension; failure or intolerant to ACE inhibitor, losartan.
CHANTIX	Varenicline	Failure or intolerant to Nicotine patches, gum, and Zyban.
LIPITOR	Atorvastatin	Failure or intolerant to simvastatin. Step Therapy – No PA required after 3 consistent months of maximum dose simvastatin
DAYPRO	Oxaprozin	Use in patients with documented treatment failure on at least three generic NSAIDs, each treatment course being at least 2 weeks.
DETROL LA	Tolterodine	Treatment of overactive bladder. Failure/contraindication to oxybutynin, -XL. Rx'd by Urologist.
DIFLUCAN	Fluconazole	Quantity Limit - #2/fill. 150mg tablet only
DURICEF	Cefadroxil	Failure on first-line antibiotic, as indicated by nature of infection.
ELIDEL	Pimecrolimus	Treatment of short-term and intermittent long-term therapy in the treatment of mild to moderate atopic dermatitis in patients >2 years of age; failure of topical steroids, unless treated area is on face.
ESTRADERM	Estradiol Transdermal	Failure of formulary oral estradiol
EVISTA	Raloxifene	Failure of formulary Fosamax.
EXELON	Rivastigmine	For the treatment of mild to moderate dementia of the Alzheimer type; failure of formulary oral alternatives
FLOMAX	Tamsulosin	Treatment of Benign Prostatic Hyperplasia (BPH); failure/intolerance Hytrin/Cardura
FORADIL	Fomoterol	Failure on inhaled corticosteroids (ICS). Approved in conjunction with ICS
GLUCOMETER	TRUE TRACK / RESULT & supplies	Quantity limit #200/month for members actively filling insulin or prenatal vitamins. Quantity limit #50/month for all other members
HALOG, -E	Halcinonide	Use in patients with documented treatment failure on non-Prior Auth Formulary high potency (Group II) steroids (e.g, Lidex, Valisone, Topicort, Diprosone).
INSULIN PEN DEVICES	All insulins	Insulin Pen Delivery systems to be authorized when member is either blind or disabled. Will not be authorized for convenience purposes.
JANUMET	Sitagliptin/ Metformin	Treatment of Type II diabetes with HbA1c > 6.0 and ≤8.5; Failed or intolerant to max doses of sulfonylureas and/or metformin,
JANUVIA	Sitagliptin	Treatment of Type II diabetes with HbA1c > 6.0 and ≤8.5; Failed or intolerant to max doses of sulfonylureas and/or metformin,
LAMISIL	Terbinafine HCl	Quantity Limit - #30 TABLETS / fill
LOVENOX	Enoxaparin	≤ 7 day supply at retail; continued use – Caremark Specialty Pharmacy
KADIAN	Morphine Sulfate CR	Failure or intolerant to formulary Morphine Sulfate (MsContin and/or MSIR), Methadone and Dilaudid
MIACALCIN SPRAY	Calcitonin Salmon	Failure of formulary Fosamax.
MIGRANAL	Dihydroergotamine Nasal Spray	Acute treatment of migraine with or without aura; failure or intolerance of Formulary agents. Prophylactic therapy needed in patients with 2 or more attacks per month.
MULTAQ	Dronedarone	Step Therapy – Three month consistent use of amiodarone
NAMENDA	Memantine	Failure of formulary Aricept
NICORETTE GUM (OTC)	Nicotine polacrilex	For smoking cessation. Treatment course limited to 3 months. For continued use member must be enrolled in the American Cancer Society Smoking Cessation program. Step Therapy – Trial and failure of Zyban and Nicotine Patches
NICOTROL PATCH (OTC)	Nicotine transdermal	For smoking cessation. Treatment course limited to 3 months. For continued use member must be enrolled in American Cancer Society Smoking Cessation program
NORGESIC, NORGESIC FORTE	Orphenadrine/ ASA/Caffeine	Failure of non-Prior Auth Formulary skeletal muscle relaxants (e.g., Flexeril, Soma, Lioresal, Norflex)

BRAND NAME	GENERIC NAME	CRITERIA
NOXAFIL	Posaconazole	For the treatment of oropharyngeal candidiasis, including oropharyngeal candidiasis refractory to itraconazole and/or fluconazole.
ORAMORPH SR	Morphine Sulfate CR	Failure or intolerant to formulary Morphine Sulfate (MsContin and/or MSIR), Methadone and Dilaudid
ORUVAIL	Ketoprofen CR	Use in patients with documented treatment failure on at least three generic NSAIDs, each treatment course being at least 2 weeks.
PENTASA	Mesalamine	Treatment of active Ulcerative Colitis. Failure or intolerant to Asacol
PRECOSE	Acarbose	Treatment of mealtime blood sugar spikes. Failure or intolerant to Metformin. A1c < 8.5
PREVACID	Lansoprazole	Treatment of GERD, Duodenal/Gastric Ulcer, Erosive Esophagitis, Hypersecretory conditions. Failure on Omeprazole 20mg. Authorizations provided will be for Prevacid OTC. No PA required for members under 12. Up to #30/month
PROTONIX	Pantoprazole	Treatment /maintenance of healing of erosive esophagitis associated with GERD, and treatment of pathological hypersecretory conditions; documented failure of Omeprazole 20mg and Prevacid OTC 15mg.
PROTOPIC	Tacrolimus	For short-term and intermittent long-term treatment of moderate to severe atopic dermatitis. Must fail topical corticosteroids first, unless affected area is face/neck.
PULMICORT	Budesonide	Respules: No PA required for members 9 and under. Inhaler: Failure of inhaled corticosteroids. Exception: Pregnancy.
RANEXA	Ranolazine	For the treatment of chronic angina. Failure of nitrate monotherapy.
RAZADYNE	Galatamine	Failure of formulary Aricept
RELAFEN	Nabumetone	Use in patients with documented treatment failure on at least three generic NSAIDs, each treatment course being at least 2 weeks.
SEREVENT	Salmeterol	Failure of ICS monotherapy. Approved in conjunction with ICS.
SINGULAIR	Montelukast	Moderate to severe asthma; Recent failure on inhaled steroids. Not covered for diagnosis of allergies. Chew tab – No PA required for members 9 and under
SYMBICORT	Budesonide/ Formoterol	Failure on inhaled corticosteroids
TORADOL (tablets)	Ketoralac tromethamine	Use in patients with documented treatment failure on at least three generic NSAIDs, each treatment course being at least 2 weeks.
UROXATRAL	Alfuzosin	Treatment of Benign Prostatic Hyperplasia (BPH); failure /intolerance to Hytrin/Cardura and Flomax.
VIVELLE	Estradiol transdermal	Failure of formulary oral estradiol
VOLMAX	Albuterol ER	Failure of formulary Albuterol tabs
VYTORIN	Ezetimibe/ Simvastatin	Failure of formulary simvastatin and Lipitor as monotherapy.
ZOFRAN tabs	Ondansetron	Quantity limit - #12/ month
ZYBAN	Bupropion SR	For smoking cessation. Treatment course limited to 3 months. For continued use member must be enrolled in American Cancer Society Smoking Cessation program
ZYMAR	Gatifloxacin	Treatment of bacterial keratitis, endophthalmitis, or prophylaxis for ocular surgeries; prescribed by ophthalmologist. Failure of formulary alternatives.

NON-FORMULARY

Requests for non formulary medications must be submitted on a Molina Healthcare Prior Authorization form. Requests for non formulary medications will be evaluated on an individual basis. In order to evaluate the request, providers must submit information on prior use and failure of Formulary medications unless unique indications exist. Listed below is a table that contains important information when submitting a request for a non formulary medication exception.

BRAND NAME	GENERIC NAME	CRITERIA
ACIPHEX	Rabeprazole	Documented failure of Omeprazole 20mg and Prevacid OTC 15mg & Protonix
ACTONEL	Risedronate	Documented failure / intolerance to Fosamax
APIDRA	Insulin Glulisine	Documented failure / intolerance to both Long Acting (Humulin, Lantus etc) & Short Acting (Humalog/Novolog)
ARAVA	Leflunomide	Treatment of active rheumatoid arthritis; failure on/intolerance to methotrexate and sulfasalazine. Prescribed by rheumatologist.
AVODART	Dutasteride	Documented failure / intolerance to Proscar. Diagnosis of BPH with enlarged prostate
BONIVA	Ibandronate	Documented failure / intolerance to Fosamax, Actonel and Miacalcin
BYETTA	Exenatide	Documented failure / intolerance to Lantus, maximum dose Metformin, TZD (Actos) and/or sulfonylurea. A1c < 8.0
BYSTOLIC	Nebivolol	Documented failure / intolerance to at least two formulary beta blockers. Coreg, Lopressor, Tenoretic, Tenormin, Toprol XL
CELEBREX	Celecoxib	Treatment of signs and symptoms of osteoarthritis or rheumatoid arthritis in patients with documented risk of ulcer dz or bleeding disorder. Etodolac and sulindac are Formulary options for GI upset/GERD on other NSAIDs.
CRESTOR	Rosuvastatin	Documented failure of Zocor and Lipitor.
DETROL	Tolterodine	Documented failure to formulary agents. Tx of overactive bladder. Failure/contraindication to oxybutynin. Rx'd by Urologist.
DIOVAN	Valsartan	Documented failure / intolerance to ACE, Losartan and Benicar.
DITROPAN XL	Oxybutynin ER	Treatment of overactive bladder. Documented failure on regular oxybutynin.
DURAGESIC	Fentanyl transdermal	Treatment of severe chronic pain with documented failure on / intolerance to oral formulary long-acting analgesics; documented evaluation/recommendation by pain management specialist or oncology
FORTEO	Teriparatide	Documented failure / intolerance to Fosamax, Actonel and Miacalcin
IMITREX Inj & nasal spray	Sumatriptan Succinate	Abortive treatment of migraine attacks. Documented failure on oral Imitrex.
KYTRIL	Granisetron	Prevention of nausea/vomiting associated with initial and repeat courses of emetogenic chemotherapy, including high dose cisplatin; nausea and vomiting associated with radiation.
LEVEMIR	Insulin Detemir	Documented failure / intolerance to Lantus, maximum dose Metformin, TZD (Actos) and/or sulfonylurea
LOVAZA	Omega-3	Documented triglycerides ≥ 500 mg/dL or documented triglycerides ≥ 350 mg/dL following at least three consistent months treatment with fenofibrate.
MIGRANAL	Dihydroergotamine Nasal Spray	Acute treatment of migraine with or without aura; documented failure or intolerance of Formulary agents. Prophylactic therapy needed in patients with 2 or more attacks per month.
NICOTROL NASAL SPRAY	Nicotine nasal spray	For smoking cessation. Treatment course limited to 3 months. For continued use member must be enrolled in American Cancer Society Smoking Cessation program
Non-Formulary GLUCOMETER & Supplies		Documented failure/inability to use True Track Glucometer (True Track Test Strips) AND True Result Glucometer (True Test Test Strips). Approved for confirmed diabetic patients.
OXYCONTIN	Oxycodone CR	Treatment of severe chronic pain with documented failure on other formulary long-acting analgesics; documented evaluation/recommendation by pain management specialist/oncology. Only approved QD or BID dosing, no prn use
PROSCAR	Finasteride	Diagnosis of BPH with enlarged prostate
STADOL NASAL SPRAY	Butorphanol	Treatment of acute pain; failure or intolerance to Formulary narcotics. If used for migraines member must have documented failed Formulary Triptans

BRAND NAME	GENERIC NAME	CRITERIA
STARLIX	Nateglinide	Documented failure / intolerance to Precose.
SYMLIN	Pramlintide	Documented failure / intolerance to Lantus, maximum dose Metformin
Testosterone	Testosterone	Treatment of hypogonadism (primary and secondary). Documented Total Testosterone deficiency. Will not be approved for the treatment Erectile Dysfunction.
TRICOR	Fenofibrate	Treatment of hypertriglyceridemia when patient is at risk of pancreatitis. Lofibra generic fenofibrate covered.
VFEND	Voriconazole	Treatment of invasive aspergillosis; treatment of serious fungal infections caused by *Scedosporium apiospermum* or *Fusarium sp*, in patients intolerant of, or refractory to other therapy.
WEIGHT LOSS MEDICATIONS	Various FDA-approved	After failure on structured weight loss and diet programs, member must have a BMI $\geq$33 plus two or more of the following risk factors: poorly controlled HTN, diabetes, uncontrolled dyslipidemia, significant cardiac disease, symptomatic sleep apnea, restrictive lung disease, or DJD/osteoarthritis of the hip and/or knee.
WELCHOL	Colesevelam	Documented failure / intolerance to Zetia. Documented elevated LFTs and/or myalgia on statin
XOPENEX	Levalbuterol	Documented unexpected cardiac side effects while on regular nebulized albuterol; in clinical trials, Xopenex has not been shown to be more effective than equipotent doses of albuterol on an outpatient basis.
ZETIA	Ezetimibe	Documented elevated LFTs and/or myalgia on statin

To request a copy of a prior authorization request form, or to request full-length criteria for a medication listed above (if applicable), call (888) 669-4322.

OVER THE COUNTER (OTC) DRUG LIST

Over-the-counter (OTC) medications are a covered benefit with no out-of-pocket expense to members only when a prescription is written by a provider. The following is a list of covered OTC medications. Please consider these OTC medications as First Line Therapy when treating your patients. Please remember that generic medications will be dispensed when available.

Category	Generic Name	Brand Name
1. Anti-Acne Medications	Benzoyl peroxide lotion 5%, 10%	
2. Antibiotics and Antibiotic Combinations	Bacitracin ointment	
3. Antidiarrheal Preparations	Attapulgite	Parapectolin/Kaopectate
4. Antidiarrheal Preparations	Bismuth Subsalicylate	Pepto Bismol
5. Antifungal-Vaginal Anti-infective	Clotrimazole	Mycelex-G, Gyne-Lotrimin, Lotrimin, Mycelex
6. Antihistamines	Diphenhydramine 25mg Loratadine & Loratadine	Benedryl Claritin & Claritin-D
7. Antihistamines Single-Entity Products	Pseudoephedrine	Nolahist
8. Antihistamines Single-Entity Products	Phenindamine	Chlor-Trimeton
9. Antitussives & Expectorants	Cholrpheniramine	Robitussin
10. Antitussives & Expectorants	Guaifenesin	Robitussin DM
11. Decongestant Products	Guaifenesin/Dextromethorphan Pseudoephedrine	Sudafed Tabs, Syrup
12. Digestants/Stool Softeners	Docusate sodium	Colace
13. Digestants/Stool Softeners	Psyllium	Matamucil
14. Digestants/Stool Softeners	Bisacodyl	Dulcolax
15. Insulins/supplies	Glucose Test Strips	True Track/True Test
16. Insulins/Supplies	Insulin Syringes, Lancets	
17. Miscellaneous	Condoms (max 12)	
18. Miscellaneous	Spermicidal Jelly/foam	
19. Miscellaneous	Vaporizer	
20. Miscellaneous Nasal Products	Cromolyn-nasal inhaler	Nasalcrom
21. Miscellaneous OTIC Products	Carbamide peroxide 6.5%	Debrox
22. Non-Narcotic Analgesic	Aspirin-Tabs, enteric coated Tabs	Aspirin
23. Non-Narcotic Analgesic	Acetaminophen	Tylenol
24. Non-Steroidal Anti-Inflammatory Drugs	Ibuprofen	Motrin
25. Nutritional Products-Other	Calcium Carbonate	Os-Cal, Tums
26. Nutritional Products-Other	Ferrous Gluconate	Fergon
27. Nutritional Products-Other	Ferrous Sulfate	Feosol Tabs, solution
28. Nutritional Products-Other	Ped. Electrolyte Solution	Pedialyte solution
29. Other Anti-Ulcer Products, Antacids	Antacid Liquid	Maalox/Maalox TC
30. Other Anti-Ulcer Products, Antacids	Antacid Liquid	Mylanta/Mylanta II
31. Other Anti-Ulcer Products, Antacids	Simethicone	Mylicon
32. Other CNS Drugs	Nicotine Gum	Nicorette Gum (PA required)
33. Other CNS Drugs	Nicotine Transdermal	Nicotrol Patch
34. Respiratory Medications-Combination	Bromphen/Decongestant	Dimetapp Tabs, Elixir
35. Respiratory Medications-Combination	Chlortimeton/Decongestant	Contac-12 Hour Caps
36. Respiratory Medications-Combination	Tripolidine/Pseudophedrine	Actifed Tabs, Syrup
37. Scabicides/Pediculocides	Permethrin	NIX
38. Scabicides/Pediculocides	Pyrethens combo	RID, A-200
39. Topical Anti-Fungal	Tolnaftate cream	Tinactin
40. Topical Anti-infective	Polysporin ointment	
41. Topical Anti-infective	Triple Antibiotic Ointment	
42. Ulcer Therapy-H2 Antagonists	Famotidine	Pepcid AC
43. Ulcer Therapy-PPI	Omeprazole	Prilosec OTC

Member After Hours Pharmacy Services

POLICY
After normal business hours, which are defined as after the close of Molina Healthcare Pharmacy Department (Monday-Friday), 8:00am-6:00pm EST, network pharmacies are to contact the after hour Help Desk at (800) 791-6856 to obtain an override to fill an emergency three day (72 hour) supply of medication, which "when not given may cause the member's condition to worsen".

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 members after Molina Healthcare's normal business hours.

PROCEDURE

1. After normal business hours as defined in the POLICY statement, CVS/Caremark / Molina Healthcare contracted pharmacy providers are required to exercise professional judgment in the dispensing of medications to members requiring after hours pharmacy services.

2. Members have the ability to obtain prescription drugs on a 24-hour/day/7 day/week basis.

3. Pharmacists are instructed to contact the CVS/Caremark Help Desk at (800) 770-8014 to obtain an override code. This will assure the timely adjudication of prescription claims.

4. Members, pharmacists or medical providers requiring medication assistance after normal business hours should call (888) 898-7969. The answering service will refer callers to CVS/Caremark for assistance.

MEMBER AND PROVIDER PATIENT SAFETY NOTIFICATION

Molina Healthcare has a process to notify members and providers regarding a variety of safety issues which include voluntary recalls, FDA required recalls and drug withdrawals for patient safety reasons. This is also a requirement as an NCQA accredited organization. Letters are sent to members instructing them to obtain an additional supply of the medication. Included in this document is a State of Michigan approved member notification letter which is sent to Molina Healthcare members. In all cases, providers are notified at the same time. If you have any questions regarding this safety initiative, please contact the pharmacy department.

Medication Recall Notification

Month day, year

Dear Member:

Please read this letter carefully. It contains information about a medicine that you or your family member received from a pharmacy under the Molina Healthcare Plan.

The name of the medicine is:

The medicine listed above is being removed from the market because of a safety problem. The safety problem comes only from the company that made the product. The medicine should not be used. This letter is being sent to you only about the company listed. It does not apply to any other company or product with the same name.

Molina members are asked to do the following:

- Stop using the medicine as soon as possible
- If you have any medicine left, please return to it to your pharmacy
- If the medicine is still needed, get a new supply at the pharmacy

If you have any questions or concerns, please talk with the provider. You can also call Member Services at 1-888-898-7969 if you need help or have questions about this letter.

Thank you,

Member Services Department

MIC-PH02-revised 8/5/09

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, Magellan Medicaid Administration. Molina members may be responsible for $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
CRIXIVAN	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, VANSPAR	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	

Caremark Specialty Pharmacy

Molina Healthcare of Michigan has 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. These specialty medications may be delivered directly to the patient or to your office. **All medications on this list require Prior Authorization and the Molina Healthcare PA form must be submitted to obtain authorization.** This information should be faxed to Molina Healthcare Pharmacy.

IMPORTANT NOTE: *Caremark Specialty Pharmacy* requires the patient's telephone number to verify certain information such as insurance eligibility and availability to sign for the package. Listed below are the medications handled by *Caremark Specialty Pharmacy.* Please see below for a list of some of the preferred medications handled by Caremark Specialty Pharmacy. **Other medications are non-formulary.**

If you have any questions, please call Pharmacy Services at (888) 898-7969. The pharmacy FAX line is (888) 373-3059. This list is subject to change as new medications become available.

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

**** Formulary Preferred**

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

MIChild Formulary Information

MIChild provides prescription drug coverage which includes medications on the Molina Healthcare Formulary with a few exceptions. Please refer to the Molina Healthcare website at: www.molinahealthcare.com/Providers/Michigan/Drug list for the most up to date and comprehensive information on MIChild prescription coverage. In addition, Formulary questions may be directed to Molina Healthcare pharmacy services: 1-888-898-7969 Monday through Friday 8 am to 5 pm (EST).

Differences between Molina MIChild Drug formulary and Molina Medicaid drug formulary:

Antibiotics – Formulary antibiotic suspensions are covered without age limitations. Quantity limits still apply. Please refer to the Formulary for a complete list of Formulary medications in this category.

Asthma Therapy - Molina Healthcare encourages the use of inhaled corticosteroids (QVAR preferred) as an important component of treatment of asthma. However, if necessary, Singulair chew tabs and tablets are covered without age limitations. Quantity limits still apply.

Anticonvulsants - Covered under MIChild but require Prior Authorization

Community Mental Health Prescriptions - Prescriptions written by Community Mental Health providers are not covered by Molina Healthcare MIChild. This would include medications such as ADHD, anticonvulsant and antidepressants. Therefore, these medications require Prior Authorization.

Digoxin solution - Digoxin solution is covered without age limits.

Drugs "carved out" of the health plan benefits - Drugs that have been carved out of the health plan prescription coverage are included for MIChild members. This includes psychotropic and anticonvulsants. However, Prior Authorization is required for these categories.

Estrogen Replacement Therapy - These medications are not covered as part of the MIChild Formulary.

Insulin Pens - Medications available as an insulin pen are covered and do not require authorization for this dosage form. Quantity limits still apply.

Narcotics - Prescriptions for narcotics require Prior Authorization.