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MEDI-CAL/HEALTHY FAMILIES DRUG FORMULARY

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

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

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

PRESCRIPTION CLAIMS PROCESSOR

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

- Questions on processing claims, formulary status or rejected claims may be directed to the CVS/Caremark Help Desk at (800) 770-8014.
- Membership and eligibility concerns may be addressed by calling the Molina Membership Services at (888) 665-4621.
- Provider-related questions may be addressed by calling the Molina Provider Services Help Desk at (888) 665-4621.

PREFACE

USING THE MOLINA MEDI-CAL DRUG FORMULARY

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

CLINICAL CONSIDERATIONS

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

INDIVIDUAL PRESCRIPTIONS

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

GENERIC MEDICATIONS

Selected medications have FDA-approved generic equivalents available. The Molina drug endorsement states..."generic drugs will be dispensed whenever available".
If the use of a particular brand-name becomes medically necessary as determined by the physician, the physician must contact Molina for prior authorization. Molina encourages the use of quality generic products.

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

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

PRIOR AUTHORIZATION REQUEST PROCEDURE

Prescriptions for medications requiring prior approval or for medications not included on the Drug Formulary may be approved when medically necessary and when Formulary alternatives have demonstrated ineffectiveness. When these exceptional needs arise, the physician may fax a completed “Medication Prior Authorization Request” form to Molina. The forms may be obtained by accessing Molina Healthcare of California’s website at http://www.molinahealthcare.com/medicaid/providers/ca/drug/Pages/formulary.aspx or by calling the Molina Pharmacy Prior Authorization Department at (888) 665-4621.

STEP THERAPY PROCEDURE

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

PRESCRIPTION QUANTITY

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

URGENT AND AFTER-HOURS MEDICATION POLICY

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

Pharmacies may call Molina at (888) 665-4621 on the following business day to obtain authorization to allow the urgent or after-hours prescription to process on-line. It is advised and expected that the pharmacy will provide reasonable documentation of cases where medications were dispensed under these urgent circumstances.

TELEPHONE PRESCRIPTIONS

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

HEALTHY FAMILIES

All medications listed in this Drug Formulary, with the exception of Over-the-counter (OTC) products (excluding insulins and diabetic testing supplies), are covered for Healthy Families members. Molina Healthy Families members are required to pay a $5.00, $10.00, or $15.00 co-payment for most prescriptions. No co-payment is required for contraceptive drugs and devices. Healthy Families members have a $250 combined medical and pharmacy, annual out-of-pocket maximum per family. Department of Health Services (DHS) drug “carve-outs” for psychotropic and HIV medications do not apply for Healthy Families members.

DRUG FORMULARY

Chapter 1 ANALGESICS

1.1 Non-Narcotic Analgesics

Acetaminophen	TYLENOL – OTC*
(Chew Tab, Soln, Supp, & Dispersible Tab are limited to age ≤12)	
Aspirin	ASPIRIN – OTC*
Butalbital/APAP/Caffeine Tab	FIORICET
((Limited to age ≤65; limited to #6/day)	
Butalbital/ASA/Caffeine	FIORINAL
(Limited to age ≤65)	
Ketorolac Tromethamine	TORADOL
(Limited to age ≤65; limited to #5 day supply)	
Choline & Magnesium Salicylate	TRILISATE
Salsalate	DISALCID
Tramadol HCl	ULTRAM
(Limited to #8/day)	

PRIOR AUTHORIZATION/STEP THERAPY REQUIRED

Butorphanol (PA)	STADOL Nasal Spray

1.2 Narcotic Analgesics

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

Acetaminophen/Codeine 300/15mg, 300/30mg, 300/60mg Tab, Soln & Susp	TYLENOL/CODEINE
(Soln: Limited to age ≤12; 240mL/mo)	
Hydrocodone/APAP 5/500mg, 7.5/500mg, 10/500mg, 7.5/750mg Tab	VICODIN, VICODIN ES, LORCET, LORTAB
Hydrocodone/APAP 5/325mg, 10/325mg	NORCO
(Limited to #12/day, max of 3 dispensing in 75-day period)	
Hydromorphone (2mg and 4mg Tab)	DILAUDID
Methadone Tablets	DOLOPHINE, METHADOSE
Morphine Sulfate CR	MS CONTIN, ORAMORPH SR
(Generic only; 30mg CR: Limited to #4/day)	
Morphine Sulfate IR	MS IR
Oxycodone IR	Oxy IR
(5mg Cap & 5mg Tab: Limited to #8/day, 15mg & 30mg Tab: Limited to #4/day)	
Oxycodone/APAP 5/325mg Tab	PERCOCET
(5/325mg Tab: Limited to #12/day)	

PRIOR AUTHORIZATION/STEP THERAPY REQUIRED

Fentanyl Transdermal (ST)	DURAGESIC
(ST for failure of Morphine Sulfate ER or Methadone; limited to #10/mo)	

Generic Name/Common Brand Name
*OTC medications are not covered for Healthy Families
PA = Prior Authorization Required
ST = Step Therapy Restriction applied

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

1.3 Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)

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

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

1.3.1 COX-2 Inhibitor

Celocoxib (Limited to age ≥65)	CELEBREX

2nd Line:

PRIOR AUTHORIZATION/STEP THERAPY REQUIRED

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

1.4 Antirheumatics

Hydroxychloroquine	PLAQUENIL
Methotrexate	METHOTREXATE

1.5 Gout Agents

Allopurinol	ZYLOPRIM

(100mg: Limited to #3/day; 60 day supply available)

Indomethacin	INDOCIN
Probenecid	BENEMID

(60 day supply available)

1.6 Anti-TNF-Alpha – Monoclonoal Antibodies

PRIOR AUTHORIZATION/STEP THERAPY REQUIRED

Etanercept (PA)	ENBREL

(Rx limited to CVS/Caremark Specialty Pharmacy)

Adalimumab (PA)	HUMIRA

(Rx limited to CVS/Caremark Specialty Pharmacy)

1.7 Migraine

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

APAP/ASA/Caffeine	EXCEDRINE MIGRAINE – OTC*
Divalproex ER	DEPAKOTE ER

(250mg: Limited to #4/day; 500mg: Limited to #8/day)

Ergotamine/Caffeine	CAFERGOT
Isometheptene/ Dichloralphenazone/APAP	MIDRIN
Sumatriptan Tablet	IMITREX

(Limited to #9/45 day)

PRIOR AUTHORIZATION/STEP THERAPY REQUIRED

Dihydroergotamine (PA)	MIGRANAL Nasal Spray
Eletriptan (ST)	RELPAX

(ST for failure or intolerant to Imitrex Tab, limited to #9/45 day)

Sumatriptan(PA)	IMITREX Nasal Spray, Injection
Zolmitriptan (ST)	ZOMIG

(ST for failure or intolerant to Imitrex Tab, limited to #9/45 day)

Chapter 2 ANTIDIABETIC AGENTS

2.1 Sulfonylureas

2.1.1 1st Generation Sulfonylureas

PRIOR AUTHORIZATION/STEP THERAPY REQUIRED

Chlorpropamide (PA)	DIABINESE
Tolazamide (PA)	TOLINASE
Tolbutamide (PA)	ORINASE

2.1.2 2nd Generation Sulfonylureas and Combinations

Glimepiride	AMARYL

(4mg: Limited to #2/day; 60 day supply available)

Glipizide	GLUCOTROL

(60 day supply available)

Glipizide Extended Release	GLUCOTROL XL

(10mg: Limited to #2/day; 60 day supply available)

Glyburide	DIABETA, GLYNASE

(Limited to #2/day; 5mg #4/day; 60 day supply available)

Glyburide/Metformin	GLUCOVANCE

Generic Name/Common Brand Name

*OTC medications are not covered for Healthy Families

PA = Prior Authorization Required

ST = Step Therapy Restriction applied

(Limited to #2/day; 2.5/500mg #4/day; 60 day supply available)

2.2 Alpha-Glucosidase Inhibitors
Acarbose PRECOSE
(Limited to #3/day; 60 day supply available)

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

2.4 Meglitinides
PRIOR AUTHORIZATION/STEP THERAPY REQUIRED
Repaglinide (PA) PRANDIN

2.5 Thiazolidinediones & Thiazolidinediones Combinations
PRIOR AUTHORIZATION/STEP THERAPY REQUIRED
Pioglitazone (ST) ACTOS
(ST for concurrent use with Sulfonylurea, Metformin, or Basil insulin)
Pioglitazone/Metformin ACTOPLUS MET
(PA)

2.6 Dipeptidyl Peptidase IV Inhibitor
PRIOR AUTHORIZATION/STEP THERAPY REQUIRED
Sitagliptin (PA) JANUVIA
Sitagliptin/Metformin (PA) JANUMET
Saxagliptin (PA) ONGLYZA
Saxagliptin/Metformin (PA) KOMBIGLYZA

2.7 Insulins
(Limited to vials only. Prefilled insulin pens and cartridges are PA required).
- **All vial formulations of Humulin, Humalog, and Novo-Nordisk agents are formulary.**
- **Humulin, Humalog and Novo Nordisk agents are limited to 4 vials per month.**

Insulin Glulisine APIDRA
(Limited to 4 vials/mo)
Insulin Glargine LANTUS
(Limited to 3 vials/mo)

PRIOR AUTHORIZATION/ STEP THERAPY REQUIRED
Insulin Detemir (ST) LEVEMIR
(ST for failure or intolerant to Lantus)

2.8 Glucagon
Glucagon Injection GLUCAGON KIT

2.9 Diabetic Supplies
Blood Glucose Meter TRUERESULT
(Limited to 1 meter/yr)
Test Strips TRUETEST,
(Limited to #50/mo with oral diabetic medication; Limited to #150/mo for use with insulin or gestational diabetes)
Syringes Various
Lancets LANCETS, Various
(Limited to #50/mo with oral diabetic medication; Limited to #150/mo for use with insulin, gestational diabetes)

Chapter 3 ANTIHISTAMINES AND COMBINATIONS

3.1Single-Entity Products
Chlorpheniramine CHLOR-TRIMETON – OTC*
(Limited to age ≥3 and ≤65)
Clemastine Tab, Syrup TAVIST– OTC*

Generic Name/Common Brand Name
*OTC medications are not covered for Healthy Families
PA = Prior Authorization Required
ST = Step Therapy Restriction applied

(Tab: Limited to age ≥3 and ≤65; Syrup: Limited to age ≥3 and ≤12)
Cyproheptadine PERIACTIN – OTC*
(Limited to for age ≤65)
Diphenhydramine BENADRYL– OTC*
(Liquid: Limited to age ≤12; 25mg Tab & Cap: Limited to for age ≤65. Limited to #2/day; 50mg Tab & Cap: Limited to #6/day)
Hydroxyzine HCl ATARAX
(Limited to age ≤65; Tab #4/day; Syrup: Limited to age ≥12; 60mL/day)
Hydroxyzine Pamoate Cap VISTARIL
(Limited to age ≤65 and #4/day)

Lower Sedating Antihistamines:

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

3.2 Combination Products

All antihistamine combination products require a prior authorization for age <4.

Brompheniramine/Decongestant CONTAC Tab – OTC*
Chlortrimeton/Decongestant DIMETAPP, RONDEC – OTC*
Tab, Elixir, Syrup
Pyril/Phenyltolox/Pheniramine POLY-HISTINE – OTC*
Triprolidine/Pseudoephedrine ACTIFED– OTC*
Tab, Syrup

Lower Sedating Combination Products

Certirizine/Pseudoephedrine ZYRTEC-D
Loraradine/Pseudoephedrine CLARITIN-D – OTC*

Chapter 4 ANTI-INFECTIVE AGENTS

4.1 Penicillins

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

1st line:

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

2nd Line:

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

4.2 Cephalosporins

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

Cefaclor CECLOR
(Susp: Limited to age ≤12; Limited to 300mL/10 day)
Cefdinir OMNICEF

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

PRIOR AUTHORIZATION/STEP THERAPY REQUIRED
Cefadroxil (PA) DURICEF
Cefprozil (PA) CEFZIL

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

1st Line:
Azithromycin ZITHROMAX
(Limited to #6/mo for 250mg Tab, #3/mo for Tri-Pak 500mg Tab, & 1 pack/90 days for Powder Pack. Susp: Limited to age ≤12 and 30mL/mo)
Clarithromycin
250mg, 500mg Tab BIAXIN
(Limited to #28/14 days)
Erythromycin Base ERY-TAB Enteric Coated
Erythromycin Ethylsuccinate Tab & Liquid E.E.S.
(Susp: Limited to age ≤12 and 400mL/mo)
Erythromycin Stearate ERYTHROCIN

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

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

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

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

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

PRIOR AUTHORIZATION/STEP THERAPY REQUIRED

Levofloxacin (PA)	LEVAQUIN
Ofloxacin (PA)	FLOXIN

4.6 Aminoglycosides

Neomycin	NEOMYCIN

4.7 Sulfonamides

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

4.8 Antituberculosis

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

4.9 Antifungal – Oral

Clotrimazole (Troches only)	MYCELEX
Fluconazole 150mg (Limited to female, #1/mo)	DIFLUCAN
Fluconazole 50mg, 100mg, 200mg Tablet; 70mg Suspension (Tablet limited to #1/day, Suspension limited to 70mL/fill)	DIFLUCAN
Ketoconazole 200mg (Limited to #1/day)	NIZORAL
Griseofulvin (Susp: Limited to age ≤12; #600mL/mo)	FULVICIN UF, FULVICIN P/G
Nystatin	MYCOSTATIN

PRIOR AUTHORIZATION/STEP THERAPY REQUIRED

Itraconazole (PA)	SPORANOX
Posaconazole (PA)	NOXAFIL
Terbinafine (PA)	LAMISIL
Voriconazole (PA)	VFEND

4.10 Antiviral

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

PRIOR AUTHORIZATION/STEP THERAPY REQUIRED

Boceprevir (PA) (Rx limited to CVS/Caremark Specialty Pharmacy)	VICTRELIS

Generic Name/Common Brand Name
*OTC medications are not covered for Healthy Families
PA = Prior Authorization Required
ST = Step Therapy Restriction applied

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

- **Patients may be referred to HIV Case Management. Please call (800) 526-8196, x 126400.**
- **Antiretroviral agents are currently being developed at a rapid rate. The provider must be aware of the newest guidelines, side effects and drug interactions of these drugs, as they have been brought to the market rapidly with post-market surveillance needed.**
- **Recommendations change rapidly. Combination therapy is now the standard of care.**
- **There are a significant number of contraindicated medications with some protease inhibitors.**
- **Consultation with an AIDS or Infectious Disease specialist should occur if there are any questions or current recommendations or drug interactions.**
- **Many HIV/AIDS medications are the financial responsibility of the Department of Health Services, through Medi-Cal Fee for Service Program. In such cases, pharmacies must bill these medications on-line to Medi-Cal Fee for Services. A complete listing of these medications may be obtained through the Molina Pharmacy Department at (888) 665-4621**
- ***See Carve Out List***

4.11 Antimalarial

Primaquine Phosphate	PRIMAQUINE
Pyrimethamine	DARAPRIM

4.12 Antielminitics

Mebendazole	VERMOX

4.13 Misc. Anti-Infectives

Clindamycin	CLEOCIN
Metronidazole	FLAGYL
Nitrofurantoin (Limited to age ≤65).	MACRODANTIN
Nitrofurantoin Monohydrate Macrocrystals LA (Limited to age ≤65, limited to #2/day)	MACROBID
Trimethoprim	TRIMPEX

Chapter 5 ANTILIPIDEMICS

CHOLESTEROL TREATMENT RISK FACTORS

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

TREATMENT DECISION BASED ON LDL CHOLESTEROL (mg/dL)

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

5.1 HMG CoA Reductase Inhibitors (Statins)

Lovastatin	MEVACOR
(Limited to #1/day; 40mg limited to #2/day; 60 day supply available)	
Pravastatin	PRAVACHOL
(Limited to #1/day; 60 day supply available)	
Simvastatin 5mg, 10mg, 20mg, 40mg	ZOCOR
(Limited to 1/day; 60 day supply available)	
PRIOR AUTHORIZATION/STEP THERAPY REQUIRED	
Simvastatin 80mg (PA)	ZOCOR
(PA: Limited to prior use)	
Atorvastatin (PA)	LIPITOR
Ezetimibe/Simvastatin (PA)	VYTORIN
Rosuvastatin (PA)	CRESTOR

5.1.1 HMG CoA Reductase Inhibitor Combinations

PRIOR AUTHORIZATION/STEP THERAPY REQUIRED	
Lovastatin/Niacin Extended Release (PA)	ADVICOR
Simvastatin/Niacin (PA)	SIMCOR

5.2 Fibrates

Micro Cap 67mg &134mg, Tab 54mg & 160mg)	LOFIBRA, TRICOR
Gemfibrozil	LOPID
(60 day supply available)	

5.3 Other Cholesterol Lowering Agents

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

Cholestyramine, Light	QUESTRAN, LIGHT
(Limited to 1 can/mo)	
Niacin, Niacin SR	NIACIN, SLO-NIACIN
Niacin Timed Released	NIASPAN
(750mg SR: Limited to #2/day; 60 day supply available)	
PRIOR AUTHORIZATION/STEP THERAPY REQUIRED	
Colesevelam (ST)	WELCHOL
(ST for failure or intolerant to Cholestyramine)	

Chapter 6 ANTINEOPLASTICS AND IMMUNOSUPPRESSANTS

6.1 Antineoplastics

Altretamine	HEXALEN
Anastrozole	ARIMIDEX
Bexarotene	TARGRETIN
Bicalutamide C	ASODEX
Busulfan	MYLERAN
Chlorambucil	LEUKERAN
Cyclophosphamide	CYTOXAN
Diethylstilbestrol	STILPHOSTROL
Estramustine	EMCYT

Etoposide	VEPESID
Exemestane	AROMASIN
Flutamide	EULEXIN
Hydroxyurea	HYDREA
Letrozole	FEMARA
Levamisole	ERGAMISOL
Lomustine	CEENU
Megestrol	MEGACE
Melphalan	ALKERAN
Mercaptopurine	PURINETHOL
Methotrexate	RHEUMATREX
Mitotane	LYSODREN
Procarbazine	MATULANE
Tamoxifen	NOLVADEX
Teremefine	FARESTON
Tretinoin	VESANOID
PRIOR AUTHORIZATION/STEP THERAPY REQUIRED	
Erlotinib (PA)	TARCEVA
Imatinib (PA)	GLEEVEC

6.2 Immunosuppressants

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

Chapter 7 CARDIOVASCULAR MEDICATIONS

7.1 Cardiac Glycosides

Digoxin (60 day supply available)	LANOXIN

7.2 Nitrates

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

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

7.3 Beta-Blockers

7.3.1 Beta-1 Specific

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

Metoprolol ER TOPROL XL
(60 day supply available)

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

7.3.3 Beta-Blockers Combinations
Atenolol/Chlorthalidone TENORETIC
(50/25mg & 100/25mg: Limited to #1/day; 60 day supply available)
Bisoprolol/HCTZ ZIAC
(2.5/6.25mg & 5.6/25mg: Limited to #2/day; 60 day supply available)

7.4 Calcium Antagonists
Amlodipine NORVASC
(60 day supply available)
Nifedipine Cap PROCARDIA
(Limited to age ≤65)
Nifedipine SR ADALAT CC
(60 day supply available)
Diltiazem, ER DILACOR XR, TIAZAC, CARDIZEM SR
(60 day supply available)
Verapamil, SR CALAN, SR
(60 day supply available)
PRIOR AUTHORIZATION/STEP THERAPY REQUIRED
Felodipine (ST) PLENDIL
(ST for failure or intolerance to Amlodipine)

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

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

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

7.6.1 Angiotensin Converting Enzyme Inhibitor / Diuretic

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

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

Losartan Potassium COZAAR
(Limited to #1/day; 60 day supply available)

7.7.1 ARB / Diuretic Combination
Losartan Potassium/ Hydrochlorothiazide HYZAAR
(Limited to #1/day; 60 day supply available)

7.8 Antiadrenergic Agents-Centrally Acting
Clonidine Tab CATAPRES
(Limited to age ≤65; Tab: Limited to #8/day; 60 day supply available)
Methyldopa ALDOMET
(60 day supply available)

7.9 Antiadrenergic Agents-Peripheral Acting
Doxazosin CARDURA
(60 day supply available)
Prazosin MINIPRESS
(Limited to #3/day; 5mg #8/day; 60 day supply available)
Terazosin HYTRIN
(Limited to #2/day; 60 day supply available)

7.10 Diuretics
7.10.1 Loop Diuretics
Bumetanide BUMEX
(60 day supply available)
Furosemide LASIX
(60 day supply available)

7.10.2 Thiazide & Related Diuretics
Hydrochlorothiazide HYDRODIURIL
(60 day supply available)
Indapamide LOZOL
(60 day supply available)
Metolazone ZAROXOLYN
(Limited to #2/day; 60 day supply available)

7.10.3 Potassium Sparing Diuretics
Spironolactone ALDACTONE
(Limited to #2/day; 60 day supply available)
Triamterene/HCTZ DYAZIDE, MAXZIDE 25 & 50
(60 day supply available)

7.10.4 Carbonic Anhydrase Inhibitors
Acetazolamide DIAMOX
(Tab: Limited to #2/day)
Methazolamide NEPTAZANE

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

Chapter 8 CENTRAL NERVOUS SYSTEM AGENTS

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

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

8.2 Antidepressants

8.2.1 Tricyclics
Amitriptyline ELAVIL
(Limited to #3/day; 150mg #2/day; 60 day supply available)
Amoxapine ASCENDIN

(Limited to #3/day; 60 day supply available)
Clomipramine ANAFRANIL
(Limited to #4/day; 75mg #3/day; 60 day supply available)
Desipramine NORPRAMIN
(Limited to #3/day; 150mg #2/day; 60 day supply available)
Doxepin SINEQUAN
(Limited to #3/day; 150mg #2/day; 60 day supply available)
Imipramine TOFRANIL
(Limited to #3/day; 50mg #6/day; 60 day supply available)
Nortriptyline PAMELOR
(Limited to #4/day; 60 day supply available)

8.2.2. Tetracyclics
Mirtazapine (regular tab) REMERON
(60 day supply available)

8.2.3 Triazolopyridines/Phenylpiperazines
Nefazodone SERZONE
(Limited to #2/day)
Trazodone DESYREL
(Limited to #2/day; 60 day supply available)

8.2.4 SSRIs
Citalopram CELEXA
(60 day supply available)
Fluoxetine Cap PROZAC
(40mg Cap: Limited to #2/day; 60 day supply available)
Paroxetine PAXIL
(60 day supply available)
Sertraline ZOLOFT
(60 day supply available)

8.2.5 Monoamine Oxidase Inhibitors
See Carve Out List/ Medi-Cal FFS

8.2.6 SNRIs
Venlafaxine, XR EFFEXOR, XR
(Tab: Limited to #3/day)

8.2.7 Miscellaneous Antidepressants
Bupropion WELLBUTRIN
(Limited to #3/day)
Bupropion SR WELLBUTRIN SR
(100mg, 150mg & 200mg Tab; limited to 2/day)

8.3 Antimania Agents
- ***See Carve Out List/ Medi-Cal FFS***

8.4 Antipsychotics
- **Many antipsychotic medications are the financial responsibility of the Department of Health Services, through Medi-Cal Fee for Service Program. In such cases, pharmacies must bill these medications on-line to Medi-Cal Fee for Services. A complete listing of these medications may be obtained through the Molina Pharmacy Department at (888) 665-4621.**
- ***See Carve Out List/ Medi-Cal FFS***

8.5 Sedatives & Hypnotics
- **Non-drug therapies such as promotion of good sleep habits, relaxation and behavioral therapies may improve quality of sleep.**

- **Drug therapies or conditions associated with insomnia include the SSRI antidepressants, beta blockers, clonidine, caffeine, nicotine, theophylline, nasal decongestants and alcohol or drug withdrawal.**
- **The use of sedatives/hypnotics should be restricted to short-term therapy. Recognize drug misuse patterns in patients and limit prescription quantities and refills.**
- **Flurazepam is not recommended for elderly patients due to its very long duration of action (> 24 hrs) from active metabolites.**

Chloral Hydrate	NOCTEC
Flurazepam (Limited to age ≤65)	DALMANE
Temazepam Cap 15mg & 30mg	RESTORIL
Triazolam	HALCION
Zolpidem (Limited to #14/mo)	AMBIEN
PRIOR AUTHORIZATION/STEP THERAPY REQUIRED	
Estazolam (PA)	PROSOM
Zaleplon (PA)	SONATA

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

Amphetamine, Mixed Salts, Extended Release	ADDERALL, XR
Atomoxetine (Limited to #1 cap, for monotherapy ONLY)	STRATTERA
Dextroamphetamine	DEXEDRINE
Methylphenidate	RITALIN, SR
Methylphenidate ER	METADATE CD
Lisdexamfetamine Dimesylate (Limited to age ≥6 to ≤18. PA for <6 and >18; limited to #1/day)	VYVANSE

8.7 Smoking Cessation Agents

PRIOR AUTHORIZATION/STEP THERAPY REQUIRED	
Bupropion SR (PA)	ZYBAN
Nicotine Inhaler (PA)	NICOTROL Inhaler
Nicotine Polacrilex (PA)	NICORETTE Gum – OTC
Nicotine Transdermal (PA)	NICODERM CQ, NICOTROL (15mg) - OTC
Varenicline (PA)	CHANTIX

8.8 Other CNS Agents

Disulfiram Tab	ANTABUSE

Chapter 9 CONTRACEPTIVES & SEX HORMONES

9.1 Contraceptives

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

9.1.1 Mono-Phasic Oral Contraceptives

Desogestrel & Ethinyl Estradiol Tab 0.15mg-30mcg	DESOGEN-28, ORTHO-CEPT
Desogest-Eth Estrad & Eth Estrad Tab 0.15-.02/.01mg (21/5)	MIRCETTE
Drospirenone-Ethinyl Estradiol Tab 3-0.03mg	YASMIN 28
Levonorgestrel & Ethinyl Estradiol Tab 0.10mg-	ALESSE, LEVLITE

Generic Name/Common Brand Name
*OTC medications are not covered for Healthy Families
PA = Prior Authorization Required
ST = Step Therapy Restriction applied

20mcg	
Levonorgestrel & Ethinyl Estradiol Tab 0.15mg-30mcg	LEVLEN, NORDETTE
Norethindrone & Ethinyl Estradiol Tab 0.4mg-35mcg	OVCON 35
Norethindrone & Ethinyl Estradiol Tab 0.5mg-35mcg	BREVICON, NECON, MODICON, GENORA
Norethindrone & Ethinyl Estradiol Tab 1mg-35mcg	NORINYL 1+35, ORTHO-NOVUM 1/35
Norethindrone & Ethinyl Estradiol Tab 1mg-50mcg	OVCON 50
Norethindrone Ace & Ethinyl Estradiol Tab 1mg-20mcg	LOESTRIN 1/20-21
Norethindrone Ace & Ethinyl Estradiol Tab 1.5mg-30mcg	LOESTRIN 1.5/30-21
Norethindrone & Mestranol Tab 1mg-50mcg	NORINYL 1+50, ORTHO-NOVUM 1/50
Norgestrel & Ethinyl Estradiol Tab 0.3mg-30mcg	LO-OVRAL
Norgestrel & Ethinyl Estradiol Tab 0.5mg-50mcg	OVRAL
Norgestimate & Ethinyl Estradiol Tab 0.25mg-35mcg	ORTHO-CYCLEN
Norethindrone Ace & Ethinyl Estradiol-Fe Tab 1mg-20mcg	LOESTRIN FE 1/20
Norethindrone Ace & Ethinyl Estradiol-Fe Tab 1.5mg-30mcg	LOESTRIN FE 1.5/30

9.1.2 Bi-Phasic Oral Contraceptives

Norethindone/Ethinyl Estradiol	ORTHO-NOVUM 10/11

9.1.3 Tri-Phasic Oral Contraceptives

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

9.1.4 Progestin Oral Contraceptives

Norethindone	MICRONOR, NOR-QD
Norgestrel	OVRETTE

9.1.5 Emergency Contraceptives

Levonorgestrel (Limit 2 per fill, 2 fills per year)	PLAN B
Levonorgestel (Limit 2 per fill, 2 fills per year)	NEXT CHOICE
Ulipristal Acetate Tab	ELLA

(Limit 2 per fill, 2 fills per year)

9.1.6 Transdermal Contraceptives

Norelgestromin/Ethinyl Estradiol	ORTHO EVRA PATCH

(Limited to female, age 12 to 50. Quantity limited to 3 patches/mo)

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

Etonogestrel/Ethinyl Estradiol	NUVARING

9.1.8 Injectable Contraceptives

Medroxyprogesterone Acetate	DEPO-PROVERA

9.1.9 Combined Oral Contraceptives
PRIOR AUTHORIZATION/STEP THERAPY REQUIRED

Estradiol Valerate Dienogest Tab (PA)	NATAZIA

9.1.10 Intrauterine Device Contraceptives

Levonorgestrel Releasing IUD (PA)	MIRENA

(Rx limited to CVS/Caremark Specialty Pharmacy)

9.2 Androgens
(Limited to male)

9.3 Estrogens
(All estrogen are limited to female; 60 day supply available. Limited to for age ≤65)

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

9.3.1 Estrogen/Progesterone Combination
(All estrogen/progesterone combination are limited to female; 60 day supply available. Limited to for age ≤65)

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

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

Medroxyprogesterone	PROVERA, CYCRIN
Norethindrone Acetate	AYGESTIN

9.5 Endometriosis Agents

Danazol	DANOCRINE
Nafarelin	SYNAREL

9.6 Uterine Stimulants

Methylergonovine	METHERGINE

Chapter 10 DERMATOLOGICALS & MUCOUS MEMBRANE AGENTS

10.1 Acne Medications

Benzoyl Peroxide, Gel	BENZOYL PEROXIDE
Clindamycin 1% Topical Gel, Solution (Limited to 60gm/mo)	CLEOCIN-T
Erythromycin Topical Gel, Soln (Limited to 60gm/mo)	ERYGEL, ERYCETTE
Tretinoin Cream & Gel (Limited to age 12 to 30, max 20gm/mo; Microgel is not covered)	RETIN A

PRIOR AUTHORIZATION/STEP THERAPY REQUIRED

Sulfacetamide Sodium/Sulfur Lotion, Emulsion (PA)	CERISA WASH, AVAR

10.2 Topical Anti-Infectives

Bacitracin, Zinc Ointment	BACITRACIN – OTC
Bacitracin/Polymyxin B Oint	POLYSPORIN
Gentamicin Cream, Oint	GARAMYCIN
Mupirocin Oint (Limited to 22 gm/mo)	BACTROBAN
Neomycin/Bacitracin/ Polymyxin Oint	NEOSPORIN - OTC
Silver Sulfadiazine	SILVADENE
Metronidazole 0.75% Cream, Gel (Limited to 45gm/mo)	METROCREAM 0.75%, METROGEL 0.75%

PRIOR AUTHORIZATION/STEP THERAPY REQUIRED

Metronidazole Gel 1% (PA)	METROGEL 1%

10.3 Topical Antifungals

Clotrimazole Cream, Soln	MYCELEX – OTC
Miconazole Cream	MONISTAT – OTC
Nystatin Cream, Oint, Powder	MYCOSTATIN, NYSTAT-RX, NYAMYC
Nystatin/Triamcinolone	MYCOLOG II
Tolnaftate Cream	TINACTIN - OTC
Ketoconazole 1%, 2% Shampoo (Limited to 120mL/mo)	NIZORAL A-D, NIZORAL

PRIOR AUTHORIZATION/STEP THERAPY REQUIRED

Ciclopirox (PA)	LOPROX
Clotrimazole/Betamethasone (PA)	LOTRISONE
Ketoconazole 2% Cream (ST)	NIZORAL

(ST for Miconazole & Clotrimazole Cream; limited to 60gm/mo)

10.4 Topical Corticosteroids

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

GROUP IV (LOW POTENCY)

Aclometasone Dipropionate 0.05% Cream, Oint (Limited to 60gm/mo)	ACLOVATE
Desonide Cream, Oint	TRIDESILON
Hydrocortisone Cream, Oint, Lotion	HYTONE

PRIOR AUTHORIZATION/ STEP THERAPY REQUIRED

Desonide Lotion 0.05% (PA)	DESOWEN
Lidocaine-Hydrocortisone Acetate 3-0.5% Cream, Lotion (PA)	LIDAMANTLE

GROUP III (MEDIUM POTENCY)

Fluocinolone	SYNALAR
Triamcinolone Acetonide Cream, Oint	KENALOG
Fluocinolone Acetonide Oil	DERMA-SMOOTH OIL /FS BODY, DERMA-SMOOTH OIL/FS SCALP

(Limited to age ≤8, max 2 bottles/30 days; Age >8 PA required, ST ST for failure to Betamethasone Valisone lotion; limited to 118mL/mo)

PRIOR AUTHORIZATION/STEP THERAPY REQUIRED

Hydrocortisone Valerate Cream, Oint 0.2% (PA)	WESTCORT
Prednicarbate (PA)	DERMATOP
Mometasone Furoate Cream, Oint (PA)	ELOCON
Pramoxine-HC Aerosol Foam (PA)	EPIFOAM AER 1%
Triamcinolone Acetonide Aerosol Soln (PA)	KENALOG AER SPRAY
Triamcinolone Acetonide Lotion 0.025%, 0.1% (PA)	ARISTOCORT, KENALOG

GROUP II (HIGH POTENCY)

Fluocinonide	LIDEX

PRIOR AUTHORIZATION/STEP THERAPY REQUIRED

Betamethasone Dipropionate 0.05% Cream, Lotion	DIPROSONE
Betamethasone Valerate 0.1% Cream, Oint	VALISONE
Halcinonide (PA)	HALOG, HALOG-E
Desoximetasone 0.05%, 0.25% Cream, 0.05% Gel, 0.25% Oint (PA)	TOPICORT

GROUP 1 (VERY HIGH POTENCY)

PRIOR AUTHORIZATION/STEP THERAPY REQUIRED

Augmented Betamethasone Dipropionate (PA	DIPROLENE
Diflorasone Diacetate (PA)	FLORONE, FLORONE E, PSORCON
Halobetasol (PA)	ULTRAVATE
Clobetasol Propionate 0.05% Cream, Oint, Soln	TEMOVATE

Generic Name/Common Brand Name
*OTC medications are not covered for Healthy Families
PA = Prior Authorization Required
ST = Step Therapy Restriction applied

(ST)
(ST for failure or intolerant to respond to Fluocinonide; limited to qty 60gm/30 days for cream & oint & 50/30 days for soln)

10.5 Topical Corticosteroids in Combinations

HydrocortisonePramoxine	EPIFOAM

10.6 Scabicides/Pediculocides

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

PRIOR AUTHORIZATION/STEP THERAPY REQUIRED

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

10.7 Anorectal

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

10.8 Anti-Psoriatics

Anthralin	DITHROCREME

PRIOR AUTHORIZATION/STEP THERAPY REQUIRED

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

10.9 Misc. Topicals

Calamine Lotion	CALAMINE – OTC
Selenium Sulfide	SELSUN Shampoo- RX

PRIOR AUTHORIZATION/STEP THERAPY REQUIRED

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

10.10 Mucous Membrane Agents

Clotrimazole Troche	MYCELEX
Lidocaine Viscous	XYLOCAINE
Nystatin Susp	MYCOSTATIN

Chapter 11 ENDOCRINE AGENTS

11.1 Systemic Corticosteroids

11.1.1 Glucocorticoids

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

11.1.2 Mineralocorticoids

Fludrocortisone Tab	FLORINEF

11.2 Osteoporosis Agents

Alendronate 5mg, 10mg, 70mg	FOSAMAX
(Limited to age =/>50; Limited to #1/day for 5mg and10mg; and #4/month for 70mg)	
Calcitonin Salmon	MIACALCIN Nasal Spray
(Limited to age =/>50, 1 bottle/mo)	

PRIOR AUTHORIZATION/STEP THERAPY REQUIRED

Alendronate 35mg (PA)	FOSAMAX
Ibandronate (PA)	BONIVA
Raloxifene (PA)	EVISTA
Risedronate (PA)	ACTONEL

11.3 Thyroid Agents

11.3.1 Antithyroid Agents

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

11.3.2 Thyroid Hormones

Levothyroxine	LEVOXYL, SYNTHROID
(60 day supply available)	
Thyroid Dessicated	ARMOUR THYROID
(Limited to age ≤65; 60 day supply available)	

11.4 Other Endocrine Agents

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

11.5 Growth Hormone

PRIOR AUTHORIZATION/STEP THERAPY REQUIRED

Somatropin (PA)	TEV-TROPIN
(Rx Limited to CVS/Caremark Specialty Pharmacy)	

Chapter 12 GASTROINTESTINAL AGENTS

12.1 Helicobacter Pylori Agents

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

12.2 Histamine-2 Antagonists

Cimetidine Tab, Syrup	TAGAMET
(Syrup limited to age ≤12, max 300mL/mo)	
Famotidine	PEPCID AC - OTC
Ranitidine Tab, Syrup	ZANTAC
(Tab: limited of #2/day, Syrup: limited to age ≤10 and 600mL/mo)	

12.3 Proton Pump Inhibitors

Lansoprazole Cap Delayed Release 15mg, 30mg (Limited to #2/day)	PREVACID 24 HR– OTC
Lansoprazole Cap 30mg (Limited to #1/day)	PREVACID
Omeprazole DR 20mg Tab (Limited to #2/day)	PRILOSEC
Omeprazole Cap 10mg &	PRILOSEC

20mg	
Pantoprazole (Limited to #1/day)	PROTONIX

12.4 Antacids
(Limited to 4 fills/year)

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

12.5 Miscellaneous Agents

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

PRIOR AUTHORIZATION/STEP THERAPY REQUIRED

Misoprostol (ST)	CYTOTEC
(ST for concurrent use with an NSAIDs and age ≥ 55, limited to #4/day)	

12.6 Antiemetics

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

12.7 Gastrointestinal Anticholinergic/Antispasmodics

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

12.8 Inflammatory Bowel Agents

Balsalazide Disodium Cap	COLAZAL
(Formulary for age =/>21. Max #9/day)	
Mesalamine Tab, Cap	ASACOL
(250mg Cap: Limited to #4/day; 500mg Cap: Limited to #8/day; 400mg Tab: Limited to #6/day)	

Generic Name/Common Brand Name
*OTC medications are not covered for Healthy Families
PA = Prior Authorization Required
ST = Step Therapy Restriction applied

Sulfasalazine	AZULFIDINE
(Delayed Release: Limited to #4/day)	

PRIOR AUTHORIZATION/STEP THERAPY REQUIRED

Mesalamine Cap (PA)	PENTASA

12.9 Laxatives
(Limited to 4 fills/year)

Bisacodyl	DULCOLAX – OTC*
Docusate Sodium	COLACE – OTC*
Polyethylene Glycol 3350 Powder (can) (Limited to 527gm/30 days)	MIRALAX
Lactulose	CEPHULAC – OTC*
Senna	SENNA – OTC*
Sennosides/Docusate	SENOKOT S – OTC*

12.10 Antidiarrheals
(Limited to 4 fills/year)

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

12.11 Digestive Enzymes
PRIOR AUTHORIZATION/STEP THERAPY REQUIRED

Amylase/Lipase/Protease (PA)	ACREASE, VIOKASE, COTAZYME, CREON, PANCREAZE, ZENPEP

12.12 GI Preparations
(Limited to 4 fills/year)

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

Chapter 13 GENITOUINARY AGENTS

13.1 Vaginal Anti-Infectives
(Limited to female)

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

13.2 Anticholinergics

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

13.3 Cholinergic Drugs

Bethanechol	URECHOLINE
(Limited to #4/day)	

13.4 Urinary Analgesics

Phenazopyridine 100mg &	PYRIDIUM

200mg
(Limited to #12/mo)

13.5 Vaginal Estrogens
(Limited to female)

Conjugated Estrogen Vaginal Cream	PREMARIN
Estradiol Vaginal Cream	VAGIFEM

13.6 Peripheral Antiadrenergic Agents
(Limited to male)

Doxazosin	CARDURA
Terazosin Cap	HYTRIN

13.7 Prostatic Hypertrophy Agents
(Limited to male age ≥ 50)

Finasteride 5mg tablet (Limited to #1/day)	PROSCAR
Tamsulosin (Limited to #1/day)	FLOMAX

PRIOR AUTHORIZATION/STEP THERAPY REQUIRED

Alfuzosin (PA)	UROXATRAL

Chapter 14 HEMATOLOGICAL AGENTS

14.1 Hematopoeitic Agents

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

14.1.1 Erythropoiesis-Stimulating Agents

PRIOR AUTHORIZATION/STEP THERAPY REQUIRED

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

14.2 Anticoagulants

Warfarin Sodium (60 day supply available)	COUMADIN

PRIOR AUTHORIZATION/STEP THERAPY REQUIRED

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

14.3 Antiplatelets

Aspirin (60 day supply available)	ASPIRIN – OTC*
Clopidogrel	PLAVIX
DIpyridamole (Limited to age ≤65; 60 day supply available)	PERSANTINE

14.4 Hemorrheologic Agents

Pentoxifylline (60 day supply available)	TRENTAL

Chapter 15 NASAL AGENTS

15.1 Nasal Corticosteroids

Generic Name/Common Brand Name
*OTC medications are not covered for Healthy Families
PA = Prior Authorization Required
ST = Step Therapy Restriction applied

(All nasal corticosteroids are limited to 4 fills per year. Members with Asthma are excluded from the 4 fill limit.)

Flunisolide	NASAREL, NASALIDE
(Fills >4 per year limited to those with Asthma; imited to 25gm/mo)	
Fluticasone(ST)	FLONASE
(Fills >4 per year limited to those with Asthma; limited to 16gm/mo)	
Mometasone	NASONEX

(Limited to age ≤4. Fills >4 per year limited to those with Asthma; limited to 17gm/mo)

15.2 Miscellaneous Nasal Products

Cromolyn	NASALCROM – OTC*

Chapter 16 NEURO-MUSCULAR AGENTS

16.1 Anticonvulsants

Carbamazepine, SR	TEGRETOL, XR
(SR: Limited to #2/day; 60 day supply available)	
Clonazepam	KLONOPIN
(Limited to #4/day)	
Divalproex Sodium	DEPAKOTE, ER
(Sprinkle: Limited to #8/day; 250mg ER #4/day; 500mg ER #8/day; 60 day supply available)	
Ethosuximide	ZARONTIN
(60 day supply available)	
Gabapentin	NEURONTIN
(Limited to #6/day; 800mg Tab: #4/day)	
Phenobarbital	PHENOBARBITAL
(Tab: Limited to age ≤65; limited to #3/day, 100mg Tab #4/day; Soln: Age ≤12)	
Phenytoin	DILANTIN
(Limited to #6/day; 60 day supply available)	
Primidone	MYSOLINE
(60 day supply available)	
Lamotrigine 25mg, 100mg, 150mg, 200mg	LAMICTAL
(Limited to Neurologist or Psychiatrist; PA for other prescribers; 25mg, 100mg, 150mg max #2/day, 200mg max #3/day)	
Levetiracetam 250mg, 500mg, 750mg & 1000mg	KEPPRA
(Limited to Neurologist or Psychiatrist; PA for other prescribers; 250mg & 500mg, max #2/day, 750mg max #4/day, 1000mg max #3/day)	
Oxcarbazepine 150mg, 300mg & 600mg	TRILEPTAL
(Limited to Neurologist or Psychiatrist; PA for other prescribers; 150mg & 300mg max #2/day, 600mg max #3/day)	
Zonisamide 25mg, 50mg & 100mg	ZONEGRAN
(Limited to Neurologist or Psychiatrist; PA for other prescribers; 25mg & 50mg max #3/day, 100mg max #6/day)	
Valproic Acid	DEPAKENE
(60 day supply available)	

PRIOR AUTHORIZATION/STEP THERAPY REQUIRED

Carbamazepine Cap SR (PA)	CARBATROL
Diazepam Rectal Gel Delivery System (PA)	DIASTAT

)

Tiagabine (PA)	GABITRIL

Generic Name/Common Brand Name
*OTC medications are not covered for Healthy Families
PA = Prior Authorization Required
ST = Step Therapy Restriction applied

Topiramate (PA)	TOPAMAX
Valproic Acid Delayed Release (PA)	STAVZOR

)

16.2 Antiparkinson Agents

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

PRIOR AUTHORIZATION/STEP THERAPY REQUIRED

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

16.3 Skeletal Muscle Relaxants

Baclofen (Limited to #4/day)	LIORESAL
Carisoprodol Tab 350mg (Limited to age ≤65; limited to #4/day)	SOMA
Cyclobenzaprine Tab 10mg (Limited to age ≤65; limited to #3/day)	FLEXERIL
Methocarbamol (Limited to age ≤65; limited to #4/day)	ROBAXIN

PRIOR AUTHORIZATION/STEP THERAPY REQUIRED

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

16.4 Viscosupplements

PRIOR AUTHORIZATION/STEP THERAPY REQUIRED

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

16.5 Others

Pyridostigmine	MESTINON

16.6 Multiple Sclerosis Agents – Interferons

PRIOR AUTHORIZATION/STEP THERAPY REQUIRED

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

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

Chapter 17 NUTRITIONAL PRODUCTS

17.1 Vitamins

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

17.2 Prenatal Vitamins

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

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

17.3 Potassium Supplement

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

17.4 Others

Calcium Acetate (Limited to #12/day)	PHOSLO
Calcium Carbonate	OS-CAL, TUMS – OTC*
Ferrous Gluconate	FERGON – OTC*
Ferrous Sulfate Tab, Soln, Drops (Drops: Limited to age ≤5)	FEOSOL
Levocarnitine	CARNITOR
Magnesium Chloride	SLOW MAG
Magnesium Oxide	MAG OXIDE
Pediatric Electrolyte Soln	PEDIALYTE – OTC*
Sodium Fluoride Tab & Drops (60 day supply available)	LURIDE

PRIOR AUTHORIZATION/STEP THERAPY REQUIRED

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

Chapter 18 OPHTHALMIC AGENTS

18.1 Anti-Infectives

18.1.1 Antibiotics and Combinations

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

Generic Name/Common Brand Name
*OTC medications are not covered for Healthy Families
PA = Prior Authorization Required
ST = Step Therapy Restriction applied

PRIOR AUTHORIZATION/STEP THERAPY REQUIRED

Gatifloxacin (PA)	ZYMAR
Moxifloxacin (PA)	VIGAMOX

18.1.2 Antibiotics-Corticosteroid Combinations

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

18.1.3 Antifungals

Natamycin 5%	NATACYN

18.1.4 Antivirals

Trifluridine	VIROPTIC

18.2 Anti-Inflammatory Agents

18.2.1 Corticosteroids

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

18.2.2 NSAIDs

Diclofenac 0.1%	VOLTAREN
Flurbiprofen	OCUFEN
Ketorolac	ACULAR, LS

18.3 Anti-Allergic Agents

18.3.1 Others

Ketotifen	ZADITOR – OTC*

PRIOR AUTHORIZATION/STEP THERAPY REQUIRED

Olapatadine HCl Ophth Soln (ST)	PATANOL

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

18.4 Dilating Agents

18.4.1 Anticholinergics

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

18.5 Glaucoma Agents

18.5.1 Alpha-2 Adrenergic Agonists

Brimonidine 0.2%	ALPHAGAN
Brimonidine/Timolol	COMBIGAN

18.5.2 Symathomimetics

Dipivefrin	PROPINE
Epinephrine HCl	EPIFRIN

18.5.3 Beta-Adrenergic Antagonists

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

PRIOR AUTHORIZATION/STEP THERAPY REQUIRED

Betaxolol 0.25% & 0.5% (PA)	BETOPTIC S, BETOPIC

18.5.4 Miotics, Direct Acting

Pilocarpine HCl	PILOCAR

18.5.5 Carbonic Anhydrase Inhibitors

Dorzolamide HCl 1%	TRUSOPT

18.5.6 Prostaglandin Agonists

Latanoprost Ophth Soln (Limited to 2.5ml/30 days, 5ml/60 days; limited to age > 21)	XALATAN

PRIOR AUTHORIZATION/STEP THERAPY REQUIRED

Bimatoprost Ophth Soln (PA)	LUMIGAN
Travoprost Ophth Soln (PA)	TRAVATAN Z

Chapter 19 OTIC PREPARATION

19.1 Otic Anti-infectives and Combinations

Hydrocortisone/Neomycin/ Polymyxin B Otic	CORTISPORIN
Ofloxacin Otic (Limited to 7mL/mo)	FLOXIN

PRIOR AUTHORIZATION/STEP THERAPY REQUIRED

Ciprofloxacin/Dexamethasone (PA))	CIPRODEX

19.2 Miscellaneous Otic Products

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

PRIOR AUTHORIZATION/STEP THERAPY REQUIRED

Hydrocortisone/Acetic Acid (PA)	VOSOL HC

Chapter 20 RESPIRATORY AGENTS

20.1 Cough/Cold Products

- **OTC products may be used as first line therapy**
- **All Cough/cold products requires a prior authorization for age <4 and are limited to 4 fills per year.**
- **All Promethazine products are limited to age = 6 to ≤65..**

20.1.1 Cough/Cold Combinations

Brompheniramine/Decongestant Tab, Elixir	DIMETAPP– OTC*

Generic Name/Common Brand Name
*OTC medications are not covered for Healthy Families
PA = Prior Authorization Required
ST = Step Therapy Restriction applied

Brompheniramine/Pseudoephedrine Tab, Syrup	BROMDEC
Chlorpheniramine/Decongestant Cap	CONTACT 12 Hr – OTC*
Pyril/Phenyltolox/Pheniramine	POLY-HISTINE
Triprolidine/Pseudoephedrine Tab, Syrup	ACTIFED – OTC*
20.1.2 Pediatric Cough/Cold ProductsPseudoephedrine/Dextromethophan	PEDIACARE DECONGESTANT & COUGH – OTC*
Pseudoephedrine/Chloropheniramine/ Dextromethophan	PEDIACARE COUGH – OTC*

20.1.3 Decongestants

Pseudoephedrine Tab, Syrup (Limited to age ≥2)	SUDAFED – OTC*

20.1.4 Antitussives & Expectorants

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

20.2 Beta Adrenergic Agonist

20.2.1 Inhalers

Albuterol	PROAIR HFA
Metaproterenol	ALUPENT
Pirbuterol	MAXAIR AUTOHALER

20.2.2 Solutions

Albuterol Neb Solution (Limited to 600mL/30 days)	PROVENTIL, VENTOLIN, ACCUNEB

20.2.3 Oral Tablets

Albuterol	PROVENTIL
Albuterol Extended Release	VOLMAX
Terbutaline	BRETHINE

20.3 Long-Acting Beta Agonist

PRIOR AUTHORIZATION/STEP THERAPY REQUIRED

Formoterol Fumarate (ST) (Not for acute symptoms; ST for concurrent use with an inhaled corticosteroids; combo with Advair or Symbicort not allowed)	FORADIL
Salmeterol (ST)	SEREVENT, DISKUS

Generic Name/Common Brand Name
*OTC medications are not covered for Healthy Families
PA = Prior Authorization Required
ST = Step Therapy Restriction applied

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

20.4 Xanthine Derivatives

Theophylline	UNIPHYL
Theophylline 8-12 Hr SR	SLO-BID GYROCAPS
Theophylline 8-24 Hr SR	THEO-DUR

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

20.5 Corticosteroids Inhalation

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

Beclomethasone	QVAR
Budesonide Inh Soln	PULMICORT RESPULES

(Limited to age ≤6; limited to 60 vials/mo)

Fluticasone	FLOVENT, FLOVENT DISKUS, FLOVENT HFA

PRIOR AUTHORIZATION/STEP THERAPY REQUIRED

Mometasone Furoate (PA)	ASMANEX

20.6 Corticosteroids/ Long-Acting Beta Agonist Combinations

PRIOR AUTHORIZATION/STEP THERAPY REQUIRED

Fluticasone/Salmetero (ST)l	ADVAIR DISKUS, HFA

(ST for inhaled corticosteroid (ICS) in last 30 days; limited to age <12; limited to #1/mo)

Mometasone Furoate-Fumarate (ST)	DULERA

(ST for inhaled corticosteroid (ICS) in last 30 days; limited to 13gm/mo)

Budesonide/Formoterol (ST)	SYMBICORT

(ST for inhaled corticosteroid (ICS) in last 30 days))

20.7 Leukotriene Inhibitors

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

PRIOR AUTHORIZATION/STEP THERAPY REQUIRED

Montelukast (ST)	SINGULAIR

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

Zafirlukast (PA)	ACCOLATE

20.8 Anticholinergics

Ipratropium Inhaler & Neb Soln	ATROVENT

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

PRIOR AUTHORIZATION/STEP THERAPY REQUIRED

Tiotropium (PA)	SPIRIVA

20.8.1 Anticholinergic/Beta Agonist combination

Ipratropium/Albuterol Aerosol	COMBIVENT

(Limited to age ≥12; Limited to 29.4gm (2 boxes/mo)

20.9 Mast Cell Stabilizers

Cromolyn Neb Soln	INTAL
Nedocromil Sodium Inhaler	TILADE

20.10 Respiratory Devices

Vaporizer	VAPORIZER – Various OTC*
Inhaler Enhancement Device	AEROCHAMBER, E-Z SPACER, MICROCHAMBER, OPTICHAMBER, INSPIREASE EASIVENT

(Spacers with mask is limited to age ≤7; spacers limited to age ≤15; limited to 1 space device/yr)

Spacers consistently increase the delivery of inhaled medications in all age groups, regardless of technique, and are strongly recommended.

Chapter 21 MISCELLANEOUS

Condoms	CONDOMS – Various OTC*
Diaphragm	DIAPHRAGM - Various
Epinephrine Inj Device (Epipen/Epipen JR Limited to 2/mo)	EPIPEN, EPIPEN JR, TWINJECT
Spermicidal Jelly, Foam, Film	SPERMICIDAL – Various OTC*
Tablet Splitter (Limited to 1/yr)	TABLET SPLITTER – Various OTC*

PRIOR AUTHORIZATION/STEP THERAPY REQUIRED

Epinephrine Inj (PA)	TWINJECT INJECTABLE

BRAND NAME	GENERIC NAME	ABBREVIATED PRIOR AUTHORIZATION CRITERIA
ACCOLATE	Zafirlukast	Moderate to severe Asthma; after failure on inhaled steroids. Cannot be authorized as steroid replacement.
ACTONEL	Risedronate	Treatment of Osteoporosis. Treatment and prevention of glucocorticoid-induced Osteoporosis. Prevention of Osteoporosis in postmenopausal women with one or more additional risk factors besides menopause. Treatment of Paget's disease of bone. Bone mineral density (BMD) is required prior to initiating therapy for prevention of glucocorticoid-induced Osteoporosis.
ACTOS, ACTOSPLUS MET	Pioglitazone, Pioglitazone/Metformin	Must be given concurrently with basal insulin, Sulfonylurea or Metformin.
ADDERALL XR (for age ≥18)	Amphetamine, Mixed Salts	Treatment of ADHD, with documented ADHD diagnosis by Psychiatry. Prior Authorization is not required for ages <18.
ADVAIR	Fluticasone-Salmeterol	Prevention of Asthma attacks after failure of low to medium dose inhaled corticosteroids or currently on both an inhaled corticosteroid and a long acting beta agonist.
ALDARA Cream (NF)	Imiquimod	Treatment of external genital and Perianal Warts/Condyloma acuminate in adults; treatment of clinically typical, non-hyperkeratotic/non-hypertrophic Actinic Keratoses on face or scalp; treatment of biopsy-confirmed, primary superficial Basal Cell Carcinoma, with maximum tumor diameter of 2cm. Treatment course must be consistent with product label.
AMBIEN CR (NF)	Zolpidem Controlled Release	Ambien CR requests approved as immediate release Ambien.
ARAVA (NF)	Leflunomide	Treatment of active Rheumatoid Arthritis; failure on/intolerance to Methotrexate and Sulfasalazine. Prescribed by Rheumatologist.
ARTHROTEC	Diclofenac / Misoprostol	Treatment of Arthritis in patients at high risk for ulcers.
ATROVENT Soln	Ipratropium	Formulary for members up to age 10, PA required for age > 10
BECONASE AQ	Beclomethasone	Failure of generic formulary agents Fluticasone and Flunisolide
BIAXIN	Clarithromycin	Failure on first-line antibiotic, as indicated by nature of infection. OK as first-line for MAC and *H. Pylori*. For *H. Pylori*, use Prevpac.
BONIVA	Ibandronate	Limited to the treatment of Osteoporosis,treatment and prevention of glucocorticoid-induced Osteoporosis, or prevention of Osteoporosis in postmenopausal women with one or more additional risk factors besides menopause. Bone mineral density (BMD) is required prior to initiating therapy for prevention of glucocorticoid-induced Osteoporosis. Must have tried and failed Alendronate.
BYETTA (NF)	Exenatide	Treatment of Type II Diabetes with HbA1c < 9.0. Failure of Metformin and TZD's combinations; Requested by Diabetes specialist or Endocrinologist.
CELLCEPT	Mycophenolate Mofetil	Prophylaxis of organ rejection in patients receiving allogeneic renal, cardiac or hepatic transplants.
CHANTIX	Varenicline	For smoking cessation. Member must be enrolled in a smoking cessation program. Treatment course limited to 12 weeks. Member must have documented 4-week continuous abstinence during the initial 12 weeks to be approved for the second 12 weeks. Limit of one trial every 52 weeks.
COREG CR (NF)	Carvedilol	Coreg CR is approved as immediate release Coreg
CRESTOR	Rosuvastatin Calcium	Treatment of Hypercholesterolemia. Failure on Simvastatin 80mg, limited to #15/month.
DAYPRO	Oxaprozin	Use in patients with documented treatment failure on at least two generic NSAIDs, each treatment course being at least 2 weeks.
DAYTRANA (NF)	Methylphenidate Patch	Treatment of ADHD in patients 6 yr and older who is unable to take oral formulations due to specific medical condition. "Unable to swallow" justification must have prior failure to formulations with sprinkle capability (i.e., Metadate CD, Adderall XR)

BRAND NAME	GENERIC NAME	ABBREVIATED PRIOR AUTHORIZATION CRITERIA
DERMATOP	Prednicarbate	Use in patients with documented treatment failure on non-Prior Auth Formulary medium potency (Group III) steroids (e.g., Kenalog, Synalar, Topicort LP, Westcort).
DETROL(NF)	Tolterodine	Tx of Overactive Bladder. Failure/contraindication to Oxybutynin. Prescription is prescribed or recommended by a Urologist.
DIFLUCAN	Fluconazole	Treatment of oropharyngeal, esophageal, or other forms of serious Candidiasis; also Cryptococcal Meningitis. Single-dose 150mg tablet is available without Prior Authorization for Vaginal Candidiasis.
DIPROLENE	Augmented Betamethasone	Failure on lower potency steroids, unless indicated by specific condition.
DITROPAN XL (NF)	Oxybutynin ER	Treatment of Overactive Bladder. Failure on regular oxybutynin. Prescription is prescribed or recommended by a Urologist.
DOVONEX	Calcipotriene	Treatment of moderate Plaque Psoriasis.
DURAGESIC	Fentanyl Transdermal	Formulary with Step Therapy for Morphine Sulfate ER or Methadone. Max 10 patch/month.
DURICEF (Suspension Only)	Cefadroxil	Failure on first-line antibiotic, as indicated by nature of infection.
EFUDEX	Fluoruracil Topical	Treatment of Actinic or Solar Keratoses
ELIDEL	Pimecrolimus	Treatment of short-term and intermittent long-term therapy of mild to moderate Atopic Dermatitis in patients > 2 years of age; failure of topical steroids. Limited to 30gm per fill.
ELOCON	Mometasone	Use in patients with documented treatment failure on non-Prior Auth Formulary medium potency (Group III) steroids (e.g., Kenalog, Synalar, Topicort LP, Westcort).
FLORONE, E	Diflorasone Diacetate	Failure on lower potency steroids, unless indicated by specific condition.
FLOXIN	Ofloxacin	Failure on 1st line antibiotic, as indicated by nature of infection. may be used as 1st-line for STDs.
FLOXIN OTIC	Ofloxacin	Chronic Suppurative OM with Perforated Tympanic Membrane or acute OM with tympanostomy tubes. For Otitis Externa patients, Cortisporin is first-line agent.
FOSAMAX	Alendronate	Formulary for age =/>50. PA required for members age <50, limited to Dx = Osteoporosis and BMD T-Score less than -2.5
GEODON	Ziprasidone	Treatment of Schizophrenia; **NOTE- In LA, San Bernardino, Riverside, and GMC counties, GEODON is billed to Medi-Cal Fee-For-Service for all Medi-Cal members*
GLEEVEC	Imatinib Mesylate	Newly diagnosed adult patients with Philadelphia Chromosome Positive (Ph+) Chronic Myeloid Leukemia (CML); (CML) in blast crisis, accelerated phase or chronic phase after failure of interferon therapy; treatment of patients with Kit-(CD 117) positive unresectable and/or metastatic malignant gastrointestinal stromal tumors (GISTs); Treatment of pediatric patients with (Ph+) Chronic Myeloid Leukemia (CML) in chronic phase, and for children whose disease has recurred after stem cell transplant or who are resistant to interferon alpha therapy.
HALOG, E	Halcinonide	Use in patients with documented treatment failure on non-Prior Auth Formulary high potency (Group II) steroids (e.g., Lidex, Valisone, Topicort, Diprosone).
HESPERA	Adefovir	Treatment of chronic Hepatitis B in adults with evidence of active viral replication and either evidence of persistent elevations in LFTs or histologically active disease.
HIV Medications	Miscellaneous	Most HIV medications are to be billed to Medi-Cal Fee-For-Service on-line for all Medi-Cal members. This applies to members residing in LA, San Bernardino, Riverside, and GMC-Sacramento counties. For all others, medication will be authorized once Molina Medical Case Management is notified of member's condition.
IMITREX Injection, Nasal Spray	Sumatriptan Succinate	Abortive treatment of migraine attacks. Failure on oral Imitrex. Prophylactic therapy needed in patients with 2 or more attacks per

BRAND NAME	GENERIC NAME	ABBREVIATED PRIOR AUTHORIZATION CRITERIA
		month.
INSULIN PEN Device (NF)	All Insulins	Insulin Pen Delivery systems to be authorized when member is either blind or disabled. Cannot be authorized for convenience purposes.
JANUVIA, JANUMET	Sitagliptin Sitagliptin/Metformin	Treatment of Type II Diabetes with HbA1c > 7; Failed or intolerant to max doses of Sulfonylureas/Metformin, or in addition to Insulin.
KEPPRA	Levetiracetam	Limited to use by a Neurologist or Psychiatrist.
KYTRIL Tablet	Granisetron	Prevention of nausea/vomiting associated with initial and repeat courses of emetogenic chemotherapy, including high dose cisplatin; nausea and vomiting associated with radiation. Must fail Zofran prior to approval.
LAMICTAL	Lamotrigine	Treatment of Seizures, with therapy initiated by Neurology; Maintenance treatment of adults with Bipolar Disorder, with therapy managed by Psychiatry.
LAMISIL (Tablet Only)	Terbinafine HCl	Tx of Onychomycosis with (+) KOH/PAS stain; member must be experiencing pain that interferes with normal activity, or be diabetic, have peripheral vascular dz, or be immunocompromised; normal baseline LFTs required
LEVAQUIN	Levofloxacin	Failure on first-line antibiotic, as indicated by nature of infection. Dosage for uncomplicated UTI (with failure to first-line abx) is 250mg QD x 3 Days.
LIPITOR	Atorvastatin	Failure on Simvastatin 80mg, limited to #15/month.
LODINE XL	Etodolac CR	Use in patients with documented treatment failure on at least two generic NSAIDs, each treatment course being at least 2 weeks.
LOPROX	Ciclopirox	Treatment of Dermatomycosis; failure on Formulary OTC antifungals.
LOTRISONE	Clotrimazole / Betamethasone	Treatment of Dermatomycosis; failure on Formulary OTC antifungals or when an additional steroid is required.
LUNESTA (NF)	Eszopiclone	Treatment of Insomnia in adult patients who has history of failure to formulary alternatives. Complete medical summary with documentation of nature of failure to prior therapies is required. Requested by Sleep specialist, Neurologist or Psychiatrist.
LYRICA (NF)	Pregabalin	Documented failure to Neurontin for treatment of partial onset Seizures as adjunctive therapy, Neuropathic pain associated with Diabetic Neuropathy, post Herpetic Neuralgia and Fibromyalgia.
MIACALCIN Nasal Spray	Calcitonin	Formulary for age =/>50. PA required for members age <50, limited to Dx = Osteoporosis and BMD T-Scores less than -2.5
MIGRANAL	Dihydroergotamine Nasal Spray	Acute treatment of migraine with or without aura; failure or intolerance of formulary agents. Prophylactic therapy needed in patients with 2 or more attacks per month.
MINOCIN	Minocycline HCl	Limited to 50mg & 100mg; Failure of Doxycycline Hyclate or Tetracycline. Limited to age 8 and older; max of #60/month.
NASACORT AQ	Triamcinolone Acetonide	Failure of generic formulary agent: Fluticasone and Flunisolide.
NASONEX	Mometasone	Failure of generic formulary agent: Fluticasone and Flunisolide. For diagnosis of allergic rhinitis in children under 4 years of age, limited to 17gm/month.
NICORETTE Gum (OTC)	Nicotine Polacrilex	For smoking cessation. Treatment course limited to 3 months. Member must be enrolled in a smoking cessation program. Max 96 pieces/month. Limit of onecourse every 52 weeks.
NICOTROL 15mg Patch (OTC)	Nicotine Transdermal	For smoking cessation. Treatment course limited to 3 months. Member must be enrolled in smoking cessation program. Limit of one course every 52 weeks.
NICOTROL Nasal Spray	Nicotine Nasal Spray	For smoking cessation. Treatment course limited to 3 months. Member must be enrolled smoking cessation program. Max 4 boxes/month. Limit of one course every 52 weeks.
NIZORAL	Ketoconazole	Oral: Treatment of systemic fungal infections and severe Recalcitrant Cutaneous Dermatophyte infections not responding to topical therapy or Griseofulvin. Topical: Treatment of Dermatomycosis; failure on formulary OTC antifungals. Shampoo: Limited to failure of Selenium

BRAND NAME	GENERIC NAME	ABBREVIATED PRIOR AUTHORIZATION CRITERIA
		Sulfide.
NON-FORMULARY Drugs	Miscellaneous	Failure on all formulary drugs within same drug class, unless unique indication exists that is not treatable with those agents or other formulary alternatives.
NORGESIC, NORGESIC FORTE	Orphenadrine/ASA/ Caffeine	Failure of non-Prior Auth Formulary skeletal muscle relaxants (e.g., Flexeril, Soma, Lioresal, Norflex)
NOXAFIL	Posaconazole	Treatment or prophylaxis of invasive Candida and Aspergillus infections in severely immunocompromised patients; Treatment of systemic fungal infections Failure of Itraconazole and/or Fluconazole.
OMACOR (NF)	Omega-3-Acid Ethyl Esters	Treatment of severe Hypertriglyceridemia (≥ 500mg/dL) in patients who Gemfibrozil and Niacin are contraindicated.
ORUVAIL	Ketoprofen CR	Use in patients with documented treatment failure on at least two generic NSAIDs, each treatment course being at least 2 weeks.
OXYCONTIN	Oxycodone CR	Treatment of severe chronic pain with documented failure on other formulary long-acting analgesics; documented evaluation/recommendation by Pain Management specialist or Oncology; Approved only for QD or BID dosing, no prn use
PERCOCET 7.5/325mg & 10/325mg	Oxycodone/APAP	For intolerance to Oxycodone/APAP 5/325mg or those requiring higer dose of Oxycodone without increasing APAP dose.
PERCODAN	Oxycodone/ASA	For intolerant or failure to respond to Oxycodone/APAP 5/325mg.
PLENDIL	Felodipine	Failure or intolerance to Amlodipine.
PRANDIN	Repaglinide	Treatment of Type II Diabetes and failure on Sulfonylureas and Metformin
PREVACID	Lansoprazole	Treatment /maintenance of healing of Erosive Esophagitis associated with GERD, and treatment of Pathological Hypersecretory conditions; BID dosing allowed only in extreme circumstances.
PROGRAF Capsule	Tacrolimus	Prophylaxis of organ rejection in patients receiving allogeneic renal or hepatic transplants.
PROSOM	Estazolam	Failure or intolerant to formulary sedatives/hypnotics (e.g., Dalmane, Restoril)
PROTONIX	Pantoprazole	Treatment /maintenance of healing of Erosive Esophagitis associated with GERD and treatment of pathological hypersecretory conditions.
PROTOPIC	Tacrolimus	Treatment of short-term and intermittent long-term therapy of mild to moderate Atopic Dermatitis in patients > 2 years of age; failure of topical steroids. Maximum quantity limit of 30 gram per fill.
PROVENTIL Soln	Albuterol	Formulary for age ≤10. Prior Authorization required for age > 10; limited to severe Asthma or COPD.
PSORCON	Diflorasone Diacetate	Failure on lower potency steroids, unless indicated by specific condition.
RAPAFLO	Silodosin	For diagnosis of BPH and failure on Doxazosin, Terazosin, or Tamsulosin
RAPAMUNE	Sirolimus	Prophylaxis of organ rejection in patients receiving allogeneic renal transplants.
REGRANEX (NF)	Becaplermin	Tx of lower-extremity Diabetic Neuropathic ulcers that extend into the subcutaneous tissue or beyond and have an adequate blood supply, in addition to debridement, pressure relief and infection control. Ulcer must be <10cm^2 and Diabetes must be under control (HgA1c≤10). Must be prescribed by an Orthopedic Surgeon/Podiatrist. Max 15g/month x 5 months.
RELAFEN	Nabumetone	Use in patients with documented treatment failure on at least two generic NSAIDs, each treatment course being at least 2 weeks.
RELENZA (NF)	Zanamivir	Treatment of Influenza within 48 hours of onset. Member must have pre-existing medical condition that would be significantly worsened by Influenza. Must be >7 years old.

BRAND NAME	GENERIC NAME	ABBREVIATED PRIOR AUTHORIZATION CRITERIA
RELPAX	Eletriptan	For failure of Imitrex tablet, max of #9/30 days
RESTASIS	Cyclosporine Ophthalmic	Limited to diagnosis Keratoconjunctivitis Sicca due to an autoimmune disease; Prescribed by Ophthalmology; must have failed artificial tears/gel.
REVATIO (NF)	Silfenadil	Treatment of Pulmonary Arterial Hypertension. Requested by Pulmonology.
RISPERDAL	Risperidone	Treatment of Psychotic Disorders; Prescribed by Psychiatrist. *NOTE- In LA, San Bernardino, Riverside, and GMC counties, Risperdal is billed to Medi-Cal Fee-For-Service for all Medi-Cal members.
ROZEREM (NF)	Ramelteon	Treatment of Insomnia in adult patients with failure or intolerant to formulary alternative (Zolpidem or hypnotic benzodiazepine)..
SANDIMMUNE/ NEORAL/ GENGRAF	Cyclosporine	Prophylaxis of organ rejection in patients receiving allogeneic renal, cardiac or hepatic transplants. Treatment of patients with severe active, Rheumatoid Arthritis, failure of Methotrexate. Treatment of adult, non-immunocompromised patients with severe, recalcitrant, Plaque Psoriasis who have failed to respond to at least one systemic therapy or in patients for whom other systemic therapies are contraindicated, or cannot be tolerated.
SAVELLA	Milnacipran	For diagnosis of Fibromyalgia and failure on Gabapentin, TCAs, or other agents for Fibromyalgia
SIMCOR	Simvastatin/Niacin	Failure of Simvastatin 80mg per day or reduction in TG not attainable with Simvastatin 80mg alone.
SINGULAIR	Montelukast	Moderate to severe Asthma with recent failure on inhaled corticosteroids. Cannot be authorized as steroid replacement: must be given concurrently with a steroid. For allergies, failure of Formulary agents must be documented as Singulair has not been shown to be more effective in clinical trials than any Formulary agents.
SONATA	Zaleplon	Short-term treatment of Insomnia. Failure/intolerance to Formulary agents including Restoril, Elavil, Dalmane. Limited to #14/month, for special circumstances when prescribed by Psychiatrist.
SPIRIVA	Tiotropium	Maintenance treatment of COPD-induced bronchospasm; must be either prescribed or recommended by Pulmonary specialist.
SPORANOX	Itraconazole	Tx of Onychomycosis with (+) KOH/PAS stain; member must be experiencing pain that interferes with normal activity, or be Diabetic, have peripheral vascular dz, or be immunocompromised; normal baseline LFTs required
STADOL Nasal Spray	Butorphanol	Treatment of acute pain; failure or intolerance to Formulary narcotics. If used for migraines member must have failed Formulary Triptans and will be on prophylaxis while on Stadol.
STRATTERA (FOR AGE ≥18)	Atomoxetine	Treatment of ADHD, with documented ADHD diagnosis by Psychiatry. **QD dosing only. 1 capsule max/day for all strengths except 40mg. #2 capsule max/day for 40mg. No Prior Auth required for ages <18.
SUPRAX	Cefixime	Failure on first-line antibiotic, as indicated by nature of infection.
SYMBICORT	Budesonide/ formoterol	Prevention of Asthma attacks. Failure of low to medium dose inhaled corticosteroids or currently on both an inhaled corticosteroid and a long acting beta agonist.
SYMLIN (NF)	Pramlintide	Treatment of Type I Diabetes. Patient must demonstrate compliance on their diabetes medications. Failure on Insulin; Requested by Diabetes specialist or Endocrinologist.
TARCEVA	Erlotinib	Tx of patients with locally advanced or metastatic non-small cell lung cancer as monotherapy Failure of platinum-based; requested by Oncology.
TAZORAC GEL	Tazarotene	Treatment of stable Plaque Psoriasis. Treatment of Cystic Acne, prescribed by Dermatologist (0.1% only).
TESTODERM Patch	Testosterone transdermal	Treatment of Hypogonadism (primary and secondary). Max 30/month. Must be prescribed by Endocrinologist. (Limited to males).
TOPAMAX	Topiramate	Treatment of Seizures, with therapy initiated by Neurology; not approved for Psychiatric use.

BRAND NAME	GENERIC NAME	ABBREVIATED PRIOR AUTHORIZATION CRITERIA
TRILEPTAL	Oxcarbazepine	Treatment of Seizures, with therapy initiated by Neurology; not approved for Psychiatric use.
ULTRAVATE	Halobetasol	Failure on lower potency steroids, unless indicated by specific condition.
UROXATRAL	Alfuzosin	Treatment of Benign Prostatic Hyperplasia (BPH); failure /intolerance to Hytrin/Cardura.
VFEND	Voriconazole	Treatment of invasive Aspergillosis; treatment of serious fungal infections caused by Scedosporium Apiospermum or Fusarium sp, in patients intolerant of, or refractory to other therapy.
VIGAMOX	Moxifloxacin	Treatment of bacterial Keratitis, Endophthalmitis, or prophylaxis for ocular surgeries; prescribed by Ophthalmologist.
VYTORIN	Ezetimibe and simvastatin	Treatment of Hypercholesterolemia. Failure on Simvastatin 80mg
WEIGHT LOSS Medication **(**NF)	Various FDA-approved	Failure on structured weight loss and diet programs, member must have a BMI ≥33 plus two or more of the following risk factors: poorly controlled HTN, Diabetes, uncontrolled Dyslipidemia, significant Cardiac dz (except for Meridia), symptomatic sleep Apnea, restrictive lung disease, or DJD/Osteoarthritis of the hip and/or knee.
WELCHOL	Coleseyelam HCl	Failure or intolerant to Cholestyramine.
WELLBUTRIN XL	Bupropion	Treatment of Depression and failure to Bupropion SR Not for smoking cessation (see ZYBAN).
XOPENEX (NF)	Levalbuterol	PRN “Rescue” treatment of Asthma; significant, unexpected cardiac side effects while on regular nebulized Albuterol; in clinical trials, Xopenex has not been shown to be more effective than equipotent doses of Albuterol on an outpatient basis.
ZOFRAN Tab	Ondansetron	Prevention of post-operative nausea/vomiting; prevention of nausea/vomiting associated with radiotherapy. No PA required for prevention of chemotherapy induced nausea/vomiting. Limited to #9/21 day.
ZOMIG	Zolmitriptan	Failure or intolerant to Imitrex tablets, limited to #9/45 days
ZYBAN	Bupropion SR	For smoking cessation. Treatment course limited to 3 months per 52 weeks. Member must be enrolled in Molina “Free and Clear” program or equivalent.
ZYMAR	Gatifloxacin	Treatment of bacterial Keratitis, Endophthalmitis, or prophylaxis for ocular surgeries; prescribed by Ophthalmologist.
ZYPREXA	Olanzapine	Treatment of Psychotic Disorders and Bipolar Mania; Prescribed by Psychiatrist. *NOTE: In LA, San Bernardino, Riverside, and GMC counties, pharmacy is to bill Medi-Cal Fee-For-Service on-line for all Medi-Cal members.

NF= Non-formulary item

These guidelines for prior approval are for reference only. They do not replace the professional judgment of the prescribing physician and do not necessarily apply to all patient-specific situations. All requests are looked at on a case by case basis. Use of pharmaceutical samples in lieu of Formulary first-line agents does not guarantee authorization.

To request a copy of a prior authorization request form, or to request full-length criteria for a medication listed above (if applicable), call (888) 665-4621.

CARVED-OUT DRUGS

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

PSYCHIATRIC DRUGS (Listed by Generic Name)		
Amantadine HCl (SYMMETREL)	Haloperidol Lactate (HALDOL)	Phenelzine Sulfate (NARDIL)
Aripiprazole (ABILIFY)	Iloperidone (FANAPT)	Pimozide (ORAP)
Asenapine (SAPHRIS)	Isocarboxazid (MARPLAN)	Procyclidine HCl (KEMADRIN)
Benztropine Mesylate (COGENTIN)	Lithium Carbonate (LITHOBID, LITHONATE, ESKALITH)	Promazine HCl (SPARINE)
Biperiden HCl(AKINETON)	Lithium Citrate (various generic)	Quetiapine (SEROQUEL XR, SEROQUEL)
Biperiden Lactate (AKINETON)	Loxapine HCl (LOXITANE)	Risperidone, Risperidone Microspheres (RISPERDAL, RISPERDALCONSTA)
Chlorpromazine HCl (THORAZINE)	Loxapine Succinate (LOXITANE)	Selegiline Transdermal (EMSAM)
Chlorprothixene	Mesoridazine Mesylate (SERENTIL)	Thioridazine HCl (MELLARIL)
Clozapine (CLOZARIL)	Molindone HCl (MOBAN)	Thiothixene HCl (NAVANE)
Fluphenazine Decanoate (PROLIXIN)	Olanzapine (ZYPREXA)	Tranylcypromine Sulfate (VESPERIN)
Fluphenazine Enanthate (PROLIXIN)	Olanzapine/Fluoxetine (SYMBYAX)	Trifluroperazine HCl (STELAZINE)
Fluphenazine HCl (PERMITIL, PROLIXIN)	Olanzapine Pamoate Monohydrate (Zyprexa Relprevv)	Triflupromazine HCl (VESPERIN)
Haloperidol (HALDOL)	Paliperidone (INVEGA)	
Haloperidol Decanoate (HALDOL-D)	Paliperidone Palmitate (Invega Sustenna)	Trihexyphenidyl HCl (ARTANE, TRIHEXY-5)
	Perphenazine (TRILAFON)	Ziprasidone (GEODON)

- List may not be inclusive.

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

-List may not be inclusive.

Detoxification/Dependency Agents (Listed by Generic Name)		
Acamprosate Calcium (CAMPRAL)	Buprenorphine HCl (SUBUTEX, BUPRENEX)	Naltrexone Microsphere Injectable Suspension (VIVITROL)
Buprenorphine/Naloxone HCl (SUBOXONE)	Buprenorphine transdermal patch (Butrans)	

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