



Virginia Medicaid Preferred Drug List With Service Authorization Criteria
Effective July 1, 2012



**Provider Synergies, an affiliate of Magellan Medicaid Administration,
Virginia Medicaid's Pharmacy Service Administrator
Phone: 1-800-932-6648 Fax: 1-800-932-6651**

General Information:

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

For PDL drug coverage information, visit the following: <http://www.VirginiaMedicaidPharmacyServices.com>.

The following “routine” PDL criteria guidelines will be applied to non-preferred drugs requiring a Service Authorization. Some drug classes will have additional criteria that will be listed along side the drug class.

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

All changes from last posting will be highlighted in Yellow



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	<i>Preferred Agents</i>	<i>Non-Preferred Agents</i>	<i>SA Criteria</i>
Analgesics			
	Narcotics - Long Acting		
	Duragesic [®] <i>will become non-preferred on 9/1/12</i> fentanyl patch Kadian ER[®] *methadone 10 mg/5ml & 5mg/5ml oral soln *methadone 5mg & 10mg tab morphine sulfate tab SA	Avinza [®] Butrans [®] *Dolophine[®] Embeda [®] Exalgo [®] *Methadose[®] morphine sulfate ER cap MS Contin [®] Nucynta [®] ER Opana [®] ER Oramorph [®] SR oxycodone-long acting Oxycontin [®] oxymorphone ER	LENGTH OF AUTHORIZATIONS: 6 months Routine PDL edit <ul style="list-style-type: none"> ◆ Step Edit – Trial and failure of 2 different short acting narcotics. The step edit is not required for those patients that have been stabilized on Long Acting Narcotics or need relief of moderate to severe pain requiring around-the-clock opioid therapy, for an extended period of time. Still subject to PDL criteria edit. ◆ PDL Edit – If patient has failed a preferred narcotic or there is any reason the patient cannot be changed to a medication not requiring service authorization. ◆ *Methadone Clinical Edits – All methadone will receive a clinical edit to determine reason for use. Low dose strengths are generally used for pain. Please see criteria for clinical edit for methadone 40mg dispersible tablets and 10mg/ml oral concentrated solution for detoxification and maintenance treatment of narcotic addiction.
	Narcotics - Short Acting		
	Barbiturate & Non-Salicylates Analgesic Combinations		
	acetaminophen-butalbital Bupap[®] Cephadyn[®]	Orbivan CF[®] Phrenilin Forte [®] Sedapap [®]	LENGTH OF AUTHORIZATIONS: 3 months Routine PDL edit
	Lozenges- Narcotic		
	fentanyl citrate	Actiq [®] Fentora [®] Onsolis [®]	Clinical edit for narcotic lozenges ONLY. <ul style="list-style-type: none"> • the patient has a diagnosis of cancer, AND • the patient is already receiving and tolerant of opioid therapy for their underlying persistent cancer pain. Patients considered opioid tolerant are those who are taking transdermal fentanyl 25 mcg/h, morphine 60 mg/day or more, oxycodone 30 mg/day, oral hydromorphone 8 mg/day, or an equianalgesic dose of another opioid for one week or longer.



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



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



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			<p>**Clinical Criteria for Lidoderm® Patch: Lidoderm® patches can be approved for relief of pain associated with post-herpetic neuralgia.</p>
Antibiotic-Anti-Infective			
	Oral Antifungals		
	<p>clotrimazole (mucous mem) fluconazole tab/susp Grifulvin V® tab Griseofulvin® susp Gris-Peg® ketoconazole nystatin tab/susp terbinafine</p>	<p>Ancobon® Diflucan® tab/susp flucytosine itraconazole *Lamisil® tab/granules Noxafil® **Sporanox® cap/soln Terbinex™ kit Vfend® tab/susp voriconazole tab</p>	<p>LENGTH OF AUTHORIZATIONS: Duration of the prescription (up to 6 months) Routine PDL edit plus</p> <p>*Lamisil® granules clinical criteria</p> <ul style="list-style-type: none"> • indication is tinea capitis, AND • patient must be over 4 years of age. <p>** Sporanox® clinical criteria</p> <ul style="list-style-type: none"> • indication are Aspergillosis, Candidiasis (oral or esophageal), Histoplasmosis, Blastomycosis, empiric treatment of febrile neutropenia
	Oral Cephalosporins		
	Second Generation Cephalosporins		<p>LENGTH OF AUTHORIZATIONS: date of service only; no refills Routine PDL edit</p> <p>Potential reasons for SA are:</p> <ul style="list-style-type: none"> ○ infection caused by an organism resistant to medications not requiring service authorization ○ a therapeutic failure to no less than a three-day trial of one medication within the same class not requiring service authorization ○ the patient is completing a course of therapy with a medication requiring a service authorization, which was initiated in the hospital.
	<p>cefaclor cap/susp cefprozil cap/susp cefuroxime tab Ranielor® <i>off the market</i></p>	<p>cefaclor ER Cefitin® tab/susp cefuroxime axetil suspension <i>off the market</i> Cefzil® tab/ susp</p>	
	Third Generation Cephalosporins		
	<p>cefdinir cap/susp Suprax® tab/susp</p>	<p>Cedax® cap/susp cefditoren pivoxil cefpodoxime proxetil cap/susp Omnicef® cap/susp Spectracef®</p>	



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Oral Macrolides			
Macrolides & Ketolides		LENGTH OF AUTHORIZATIONS: date of service only; no refills	
azithromycin pack/susp/tab clarithromycin tab/susp *E.E.S. [®] *EryC [®] *Eryped [®] 400 susp Ery-tab[®] erythrocin stearate erythromycin base erythromycin ethylsuccinate erythromycin estolate susp erythromycin stearate erythromycin/sulfisoxazole	Biaxin [®] tab/ susp/XL clarithromycin ER Dynabac [®] *Eryped [®] 200 susp erythromycin base DR cap **Ketek [®] PCE [®] Zithromax [®] tab/susp ZMAX [®] susp		Routine PDL edit Potential reasons for SA are: <ul style="list-style-type: none"> infection caused by an organism resistant to medications not requiring service authorization a therapeutic failure to no less than a three-day trial of one medication within the same class not requiring service authorization the patient is completing a course of therapy with a medication requiring a service authorization, which was initiated in the hospital. *Generics not available in some strengths/dosage forms **To receive a SA for Ketek [®] , a specific Ketek [®] SA request form must be completed and faxed or mailed to Magellan Medicaid Administration with the physician's signature.
Oral Quinolones			
Second Generation Quinolones		LENGTH OF AUTHORIZATIONS: date of service only; no refills	
Cipro [®] susp ciprofloxacin tab	Cipro [®] Cipro [®] XR ciprofloxacin susp/ER Floxin [®] Maxaquin [®] Noroxin [®] ofloxacin Proquin XR [®]		Routine PDL edit Potential reasons for SA are: <ul style="list-style-type: none"> infection caused by an organism resistant to medications not requiring service authorization a therapeutic failure to no less than a three-day trial of one medication within the same class not requiring service authorization the patient is completing a course of therapy with a medication requiring a service authorization, which was initiated in the hospital.
Third Generation Quinolones			
Avelox[®] ABC PACK levofloxacin tab	Avelox[®] Factive [®] Levaquin [®] tab/susp	levofloxacin susp Proquin XR [®] Zagam [®]	



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	Otic Quinolones		
	Ciprodex[®] ofloxacin	<i>Cetraxal[®]</i> <i>Cipro HC[®]</i> <i>Floxin[®] -off the market</i>	<u>LENGTH OF AUTHORIZATION</u> Date of service only; no refills Routine PDL edit
	Topical		
	mupirocin ointment	<i>*Altabax[™]</i> <i>Bactroban[®] cream/ointment</i> <i>Centany[®]</i> <i>Centany AT[®] Kit</i>	<u>LENGTH OF AUTHORIZATIONS:</u> Date of service only; no refills Routine PDL edit *Quantity Limit of 15 grams per 34 day
Antivirals			
	Hepatitis C Agents		
	Interferon		<u>LENGTH OF AUTHORIZATIONS:</u>
	Pegasys[®] Pegasys Conv.Pack[®] Pegasys ProClick[®] Peg-Intron[®] Peg-Intron Redipen[®]		All products require a Clinical SA ➤ <u>Interferon Clinical SA</u>
	Protease Inhibitor		<u>Clinical SA for initial 16 week SA:</u>
	*Incivek[®] *Victrelis[®]		Initial approval periods limited to 16-weeks and viral titer obtained at week 12 of therapy.
			<u>Clinical SA for established HCV reactors:</u>
			1) Therapy is approvable for a total of 24 weeks in patients that are HCV genotypes 2 or 3 who have achieved a virologic response (either undetectable HCV RNA [<50 IU/mL] or at least a 2-log drop in HCV RNA titer from baseline) at 12 weeks of treatment.
			2) Therapy is approvable for total of 48 weeks in HCV genotype 1 or 4 patients who have achieved a virologic response (either undetectable HCV RNA [<50 IU/mL] or at least a 2-log drop in HCV RNA titer from baseline) at 12 weeks of treatment.
			3) If patient fails to achieve a virologic response by 12 weeks, further treatment is not indicated.
			➤ <u>*Protease Inhibitor Clinical SA</u>
			<u>Incivek Clinical SA (Triple Therapy)</u>
			1) Confirm diagnosis of HCV with genotype 1, AND



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			<p>concurrent therapy with ribavirin and peginterferon, AND no previous protease inhibitor treatment for Hep C.</p> <p>2) At initial prescription fill, if above criteria are met – approve for 12 weeks. Lab work needs to be done at 4 weeks.</p> <p>3) Course of telaprevir should <i>not</i> be repeated.</p> <p><u>Victrelis Clinical SA (Triple Therapy)</u></p> <p>1) Confirm diagnosis of HCV with genotype 1, AND no previous protease inhibitor treatment for Hep C, AND completed ribavirin and peginterferon for at least 4 weeks, AND concurrent therapy with ribavirin and peginterferon</p> <p>2) Evaluate for the following conditions for longer duration of approval:</p> <p>a) cirrhosis – Approve for 44 weeks</p> <p>b) Previous treatment with peginterferon and ribavirin with documented lack of achievement of > 2 log reduction at week 12 in previous treatment – Approve for 44 weeks.</p> <p>c) If none of above in a or b, then evaluate below to determine duration of therapy.</p> <p>3) At initial prescription fill, confirmed diagnosis of HCV with genotype 1 and completed 4 weeks of peginterferon and ribavirin with continuing therapy – approve for 24 weeks.</p> <p>4) After 24 weeks – require labs drawn at weeks 8 and 24. Depending on the result – determine the duration of approval:</p> <p>a) Treatment naïve patients:</p> <p>i. If week 8 and 24 are both undetectable – triple therapy is completed. No further Victrelis therapy.</p> <p>ii. If week 8 results are detectable and week 24 results are undetectable – then approve Victrelis for 8 more weeks.</p> <p>iii. If week 24 results are detectable, discontinue all 3 therapies (Victrelis and peginterferon/ ribavirin).</p> <p>b) Previously treated or relapsed patients:</p> <p>i. If week 8 and 24 are both undetectable – approve for 8 more weeks for Victrelis and peginterferon/ribavirin (then discontinue all 3)</p>



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			ii. If week 8 results are detectable and week 24 results are undetectable – then approve Victrelis for 8 more weeks. iii. If week 24 results are detectable, discontinue all 3 therapies (Victrelis and peginterferon/ribavirin). 5) For ALL patients –If at week 12, the HCV-RNA level is > 100 IU/mL, do not approve Victrelis. 6) For ALL patients - If at week 24 HCV-RNA results are detectable, discontinue all 3 therapies (Victrelis and peginterferon/ribavirin). Lab work needs to be done at 8, 12, and 24 weeks.
Herpes Oral			
	acyclovir tab/susp famciclovir Valtrex®	Famvir® valacyclovir Zovirax® tab/susp	LENGTH OF AUTHORIZATIONS: 1 year Routine PDL edit
Herpes Topical			
	Abreva OTC® Zovirax® ointment	Denavir® Xerese® cream Zovirax® cream	LENGTH OF AUTHORIZATIONS: 1 year Routine PDL edit
Influenza			
	amantadine cap/syrup Relenza Disk® rimantadine Tamiflu® cap/susp	amantadine tab Flumadine® syrup/tab	LENGTH OF AUTHORIZATIONS: For diagnosis of influenza, the authorization is for the date of service only; no refills Routine PDL edit
Bone Resorption Suppression and Related Agents			
Bisphosphonates			
	alendronate Fosamax® soln	Actonel® Actonel® with CA Atelvia DR® Boniva® *Didronel®	etidronate Fosamax® Fosamax® plus D ibandronate
			LENGTH OF AUTHORIZATION: 1 year Routine PDL edit * Indicated only for treatment of Paget's disease of bone OR prevention and treatment of heterotopic ossification following total hip replacement or spinal cord injury.



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	Calcitonins		
	Miacalcin [®]	calcitonin-salmon nasal Fortical [®]	LENGTH OF AUTHORIZATION: 1 year Routine PDL edit
	Others		
	Evista [®]	Forteo [®]	<p>LENGTH OF AUTHORIZATION: Initial approval will be for 1 year with ONE renewal if demonstrated compliance. Maximum duration of therapy is 24 months during a patient's lifetime.</p> <p><u>Forteo[®] (teriparatide): Indications</u></p> <ul style="list-style-type: none"> • Treatment of osteoporosis in postmenopausal women who are at high risk for fracture • Increase of bone mass in men with primary or hypogonadal osteoporosis who are at high risk for fractures • Treatment of men and women with osteoporosis associated with sustained systemic glucocorticoid therapy at high risk for fracture <p>Forteo is indicated if:</p> <ul style="list-style-type: none"> • Bone mineral density of -3 or worse or • Postmenopausal women with history of non-traumatic fracture(s) or • Postmenopausal women with two or more of the following clinical risk factors: <ul style="list-style-type: none"> ○ Family history of non-traumatic fracture(s) ○ Patient history of non-traumatic fracture(s) ○ DXA BMD T-score \leq-2.5 at any site ○ Glucocorticoid use* (\geq6 months of use at 7.5 dose of prednisolone equivalent) ○ Rheumatoid Arthritis ○ Postmenopausal women with BMD T-score \leq-2.5 at any site with any of the following clinical risk factors: <ul style="list-style-type: none"> a. More than 2 units of alcohol per day b. Current smoker c. Men w/primary or hypogonadal osteoporosis d. Osteoporosis associated w/sustained systemic glucocorticoid therapy



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



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Angiotensin Receptor Blockers + Calcium Channel Blocker Combinations				
N/A	Azor® Exforge®	Exforge®HCT Tribenzor®	** Step edit requires a trial and failure of losartan/HCTZ	
Angiotensin Receptor Blockers + Diuretic Combinations				
**Diovan HCT® losartan/HCTZ	Atacand HCT® Avalide® Benicar HCT® Edarbyclor®	Hyzaar® irbesartan- hydrochlorothiazide Micardis HCT® Teveten HCT®		
Beta Blockers				
atenolol carvedilol labetalol metoprolol tartrate nadolol propranolol tab/soln Sorine® sotalol AF sotalol HCL	acebutaolol Betapace® IR / AF® betaxolol bisoprolol Blockadren® Bystolic® Cartrol® Coreg® IR & CR® Corgard® Inderal® IR & LA Innopran® XL Kerlone® Levatol®	Lopressor® metoprolol succinate Normodyne® pindolol propranolol LA Sectral® Tenormin® timolol maleate Toprol XL® Trandate® Visken® Zebeta®		
Beta Blockers + Diuretic Combinations				
atenolol/chlorthalidone bisoprolol/HCTZ nadolol/bendroflumethiazide propranolol/HCTZ	Corzide® Dutoprol® Inderide® Lopressor HCT® metoprolol/HCTZ	Tenoretic® Timolide® Ziac®		
Direct Renin Inhibitors (includes combination)				
N/A	Amturnide™ Tekturna® Tekturna HCT®	Twynsta® Valturna®		



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Anticoagulants			
Low Molecular Weight Heparin includes FactorXA Inhibitor			LENGTH OF AUTHORIZATION: 1 year
Arixtra[®] Fragmin[®] Lovenox[®]	<i>enoxaparin</i> <i>fondaparinux</i> <i>Innohep[®]</i>	Routine PDL edit	* Clinical edit Pradaxa[®]
Oral Anticoagulants		<ul style="list-style-type: none"> • Diagnosis of non valvular atrial fibrillation; AND • Patient has at least one risk factor that meets PI • History of stroke, TIA, or systemic embolism; OR • Age ≥ 75 years; OR • Diabetes mellitus; OR • History of left ventricular dysfunction or heart failure; OR • Age ≥65 years with the presence of one of the following: diabetes mellitus, coronary artery disease (CAD), or hypertension; OR 	
warfarin *Pradaxa[®] **Xarelto[®]	<i>Coumadin[®]</i>	<p>Assess renal function prior to initiation of treatment. Periodically assess renal function as clinically indicated (i.e., more frequently in clinical situations that may be associated with a decline in renal function) and adjust therapy accordingly.</p> <p>•For patients with CrCl >30 mL/min: 150 mg orally, bid</p> <p>•For patients with CrCl 15-30 mL/min: 75 mg orally, bid</p>	
			**Clinical Edit for Xarelto[®] (rivaroxaban)
			<ul style="list-style-type: none"> ▪ Prophylaxis of DVT/PE in patients after elective hip or knee replacement surgery OR ▪ Stroke prophylaxis and systemic embolism prophylaxis in patients with nonvalvular atrial fibrillation. ▪ For hip replacement: 35 tablets/35 days ▪ For knee replacement: 12 tablets/12 days ▪ For atrial fibrillation: 30 tablets/30 days. Length of authorization: 1 year
			<ul style="list-style-type: none"> ▪ Dosage and Administration:
			<u>Nonvalvular Atrial Fibrillation:</u>
			<ul style="list-style-type: none"> • If CrCl >50 mL/min: 20 mg PO, QD with evening meal. • If CrCl 15 - 50 mL/min: 15 mg PO, QD with evening meal
			<ul style="list-style-type: none"> • Avoid use in patients with CrCl <15 mL/min.
			<u>Prophylaxis of DVT:</u>
			<ul style="list-style-type: none"> • 10 mg orally, once daily with or without food.



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Calcium Channel Blockers: Dihydropyridine CCB & Non-Dihydropyridine CCB		
Dihydropyridine Calcium Channel Blockers		LENGTH OF AUTHORIZATIONS: 1 year Routine PDL edit There are two main classes of Calcium Channel Blockers (each with different actions on the peripheral vasculature and cardiac tissue): <ul style="list-style-type: none"> ○ Dihydropyridine Calcium Channel Blockers ○ Non-Dihydropyridine Calcium Channel Blockers
Afeditab CR [®] amlodipine Nifediac CC [®] Nifedical XL [®] nifedipine nifedipine ER nifedipine SA	Adalat [®] Adalat CC [®] Cardene [®] Cardene SR [®] Dynacirc [®] IR & CR [®] felodipine ER isradipine	
Non-Dihydropyridine Calcium Channel Blockers		
Cartia XT [®] Diltia XT [®] diltiazem diltiazem ER q 24hr diltiazem ER q 12hr diltiazem XR Taztia XT [®] verapamil tab verapamil tab ER	Calan [®] IR & SR Cardizem [®] IR & CD Cardizem LA [®] & SR Covera HS [®] Dilacor XR [®] diltiazem SR q 12hr Isoptin SR [®]	
Lipotropics		
Bile Acid Sequestrants		LENGTH OF AUTHORIZATIONS: 1 year Routine PDL edit plus <ul style="list-style-type: none"> • Therapeutic failure to no less than three-month trial of at least one medication not requiring service authorization.
cholestyramine powder Colestid [®] packet/tab colestipol packet/tab Prevalite [®] Welchol [®] tab	cholestyramine powder light Colestid [®] granule colestipol HCl granules Questran [®] powder/powder Light Welchol [®] packet	
Cholesterol Absorption Inhibitor (CAI)		FDA announced on June 8, 2011 new safety restrictions (including contraindications & dose limitations) for high-dose simvastatin. FDA recommendations: <ul style="list-style-type: none"> • Maintain patients on simvastatin 80 mg or Vytorin 10/80 mg ONLY if they have been taking this dose chronically (for 12 months or more) <i>without</i> evidence of muscle toxicity. • Do not start new patients on simvastatin 80 mg or Vytorin 10/80 mg. • Place patients who do not meet their LDL-C goal on simvastatin 40 mg or Vytorin 10/40 mg on alternative LDL-C lowering treatment(s) that provides greater LDL-C lowering.
Zetia[®]		
Fibric Acid Derivatives		
gemfibrozil Tricor [®]	Antara [®] fenofibrate Fenoglide [®] Lipofen [®]	Lofibra [®] Lopid [®] Triglide [®] Trilipix [™]
HMG CoA Reductase Inhibitors and Combinations (High Potency Statins)		
simvastatin	amlodipine/ atorvastatin atorvastatin Caduet [®]	Crestor [®] Lipitor [®] Livalo [®] Vytorin [®] Zocor [®]



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HMG CoA Reductase Inhibitors and Combinations (Statins)		<ul style="list-style-type: none"> Follow the recommendations in the simvastatin-containing medicines labels regarding drugs that may increase the risk for muscle injury when used with simvastatin. Switch patients who need to be initiated on a drug that interacts with simvastatin to an alternative statin with less potential for the drug-drug interaction. <p>* Requires a history of either a niacin or simvastatin product within the past 365 days</p> <p>**Clinical edit for Lovaza</p> <ul style="list-style-type: none"> Step edit is the trial and failure of any other lipotropic. A SA may also be approved without any specific preferred medication trial, if they have documented very high triglycerides of (≥ 500 mg/dL) in adult patients. 	
lovastatin pravastatin	<i>Advicor</i> [®] <i>Altoprev</i> [®] <i>fluvastatin</i> <i>Lescol</i> [®]		<i>Lescol XL</i> [®] <i>Mevacor</i> [®] <i>Pravachol</i> [®]
Niacin Derivatives			
Niacor [®] Niaspan [®]			
Niacin Derivatives & HMG CoA Reductase Inhibitors (Statins) Combination			
*Simcor [®]			
Omega 3 Fatty Acid Agent			
**Lovaza			
Platelet Inhibitors			
Aggrenox [®] clopidogrel dipyridamole Effient [®] ticlopidine HCL	<i>Brilinta</i> [®] <i>Persantine</i> [®] <i>Plavix</i> [®]	LENGTH OF AUTHORIZATION: 1 year Routine PDL edit	
Pulmonary Arterial Hypertension Agents			
Inhaled Prostacyclin Analogues		LENGTH OF AUTHORIZATIONS: 1 year Routine PDL edit	
Tyvaso [®] Ventavis [®]			
Oral Endothelin Receptor Antagonist		<p>* Clinical edit for PD5</p> <ul style="list-style-type: none"> Diagnosis of pulmonary hypertension in patients >18 years is required. The requested medication may be approved if the following is true: <ul style="list-style-type: none"> The prescribing physician is a pulmonary specialist or cardiologist and will be followed by the prescribing physician. Must have a rationale for not taking the oral Revatio[®] to receive a SA for the injectable Revatio[®]. PDE-5 contraindications where SA should not be approved: <ul style="list-style-type: none"> Concurrent use of nitrates (e.g., nitroglycerin) Hypersensitivity to product 	
Letairis [®] Tracleer [®]			
Phosphodiesterase 5 Inhibitors			
*Adcirca [™] *Revatio [®]	*Revatio injection [®]		



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Central Nervous System			
Antimigraine Agents			
	Maxalt[®] MLT Relpax[®] sumatriptan succinate cartridge/nasal/pen/tab/vial	<i>Amerge[®]</i> <i>Axeri[®]</i> <i>Cambia[®]</i> <i>Frova[®]</i> <i>Imitrex[®] cartridge/nasal/pen/tab/vial</i> <i>Maxalt[®]</i> <i>naratriptan</i> <i>Treximet[®]</i> <i>Zomig[®] tab/nasal spray/ZMT</i>	<u>LENGTH OF AUTHORIZATIONS:</u> 6 months Routine PDL edit <u>Additional Information to aid in SA determination:</u> Service Authorization will not be given for prophylactic therapy of migraine headache unless the patient has exhausted or has contraindications to all other “controller” migraine medications (i.e., beta-blockers, calcium channel blockers, etc) and the physician and patient are aware of the adverse risk potential.
Non-Ergot Dopamine Receptor Agonist			
	pramipexole ropinirole HCl	<i>Mirapex[®]</i> <i>Mirapex[®] ER</i> <i>Requip[®]</i> <i>Requip[®] Dose Pack off the market</i> <i>Requip[®] XR</i> ropinirole HCl ER	<u>LENGTH OF AUTHORIZATIONS:</u> 1 year Routine PDL edit <u>Additional Information to aid in SA determination:</u> <ul style="list-style-type: none"> • If requested for treatment of Parkinson’s, may approve without the necessary trial of a preferred agent if the patient has swallowing issues that causes them to be unable to use a preferred product OR if the request is for continuation of established therapy. • If requested for treatment of restless legs, forward request to a pharmacist to be denied. • An indication that is unique to a non-preferred agent and is supported by peer-reviewed literature or an FDA-approved indication, or age specific indication, or medical co-morbidity, unique patient circumstance, other medical complications, or clinically unacceptable risk with a change in therapy to preferred agent.



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Sedatives / Hypnotics			
	chloral hydrate syrup flurazepam temazepam 15mg & 30mg	Dalmane [®] Doral [®] estazolam Halcion [®] Prosom [®] Restoril [®] temazepam 7.5 mg & 22.5 mg triazolam	LENGTH OF AUTHORIZATIONS: Length of the prescription (up to 3 months) Routine PDL edit
Sedatives / Hypnotics (Non-Benzodiazepine)			
	Rozerem [®] zolpidem	Ambien [®] IR & CR Edluar [™] Intermezzo [®] Lunesta [®] Silenor [®] Somnote [®]	Sonata [®] Zaleplon [®] zolpidem CR Zolpimist [™] spray
Skeletal Muscle Relaxants			
	baclofen *carisoprodol *carisoprodol/ASA *carisoprodol/ASA/codeine chlorzoxazone cyclobenzaprine HCL dantrolene sodium methocarbamol tizanidine tab	Amrix [®] cyclobenzaprine ER Dantrium [®] Fexmid [®] Flexeril [®] Lorzone [®] metaxalone Norflex [®] orphenadrine citrate orphenadrine/ASA/caffeine Parafon Forte [®] DSC Robaxin [®] Skelaxin [®] *Soma [®] tizanidine cap Zanaflex [®]	LENGTH OF AUTHORIZATIONS: <ul style="list-style-type: none"> • 1 year for chronic conditions • Duration of prescription (up to 3 months) for acute conditions • One month per every 6 months carisoprodol products Routine PDL edit <p>*Clinical edit for carisoprodol products</p> <ul style="list-style-type: none"> • The patient is at least 16 years of age. • Only approve for ACUTE, painful musculoskeletal conditions. Do not approve for chronic pain. • Quantity limit = 4 tablets per day • Limit approval to one month supply (120 tablets) • Additional authorization will not be granted for at least 6 months following the last day of the previous course of therapy. <p>Additional Information to Aid in SA determination</p> <p>1) If there is a specific indication for a medication requiring service authorization, for which medications not requiring</p>



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			<p>service authorization are not indicated, then may approve the requested medication. This medication should be reviewed for need at each request for reauthorization.</p> <p>2) <u>Chronic Conditions:</u></p> <ul style="list-style-type: none"> • Multiple Sclerosis • Spasticity • Cerebral Palsy • Muscle rigidity as a result of spinal cord/ brain injury or disease <p>3) <u>Acute Conditions:</u></p> <ul style="list-style-type: none"> • Muscle spasm associated with acute painful musculoskeletal conditions (ex. Generalized back, neck, or shoulder pain and muscle spasms attributed to trauma)
Smoking Cessation			
	bupropion SR Chantix® Chantix® Tab DS PK Nicotrol® Inhaler & NS nicotine gum/ lozenge/ patch	Commit® Lozenge Nicoderm CQ® Patch Nicorette® Gum Nicorette® Lozenges Zyban®	<u>LENGTH OF AUTHORIZATIONS:</u> 6 months Routine PDL edit
Stimulants/ADHD Medications			
Amphetamine Products			
	amphetamine salts combo dextroamphetamine Vyvanse®	Adderall® IR *Adderall® XR (see criteria) amphetamine salts combo XR Desoxyn® Dexedrine® dextroamphetamine SR Dextrostat® methamphetamine Procentra® soln	<u>LENGTH OF AUTHORIZATION:</u> 1 year Routine PDL edit <u>Additional Information to aid in SA determination:</u> <ul style="list-style-type: none"> • If the patient requires a service authorized medication based on a specific medical need that is not covered by the FDA indications of one of the preferred medications, a SA will be granted for a non-preferred medication. • This should be reviewed for need at each request for reauthorization. <p>*Adderall XR® If a trial & failure of a preferred product occurs and the physician requests Adderall XR® or amphetamine salts</p>



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	<p>Methylphenidate Products</p> <p>Concerta[®] will become non-preferred on 9/1/12</p> <p>Focalin XR[®]</p> <p>All methylphenidate generic IR tablets</p> <p>methylphenidate SR</p> <p>Miscellaneous Products</p> <p>Strattera[®]</p>	<p><i>Daytrana[™]</i> <i>dexmethylphenidate</i> <i>Focalin[®]</i> <i>Metadate CD[®]</i> <i>Metadate ER[®]</i> <i>Methylin ER[®]</i> <i>Methylin chew[®]</i></p> <p><i>Intuniv[®]</i> <i>Kapvay[®] SR 12H</i> <i>*modafinil</i> <i>*Nuvigil[™]</i> <i>*Provigil[®]</i></p>	<p>combo XR. The brand Adderall XR[®] is preferred over the generic.</p> <p>*Clinical Criteria for Nuvigil[™]/Provigil[®]:</p> <p>Length of Authorization:</p> <ul style="list-style-type: none"> • 1 year for sleep apnea and narcolepsy; • 6 months for shift work sleep disorder. <p>➤ Approvable diagnosis include:</p> <ul style="list-style-type: none"> • Sleep Apnea: Requires documentation/confirmation via sleep study. • Requires documentation that C-PAP has been maximized. • Narcolepsy: Documentation of diagnosis via sleep study. • Shift Work Sleep disorder: ONLY APPROVABLE FOR 6 MONTHS, work schedule must be verified and documented. Shift work is defined as working the all night shift. <p>➤ Minimum age of 16 for Provigil[®] (modafinil) Minimum age of 17 for Nuvigil[™] (armodafinil)</p>



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Dermatologic			
Dermatologic Agents			
Combination Benzoyl Peroxide & Clindamycin for Acne			LENGTH OF AUTHORIZATION: 1 year
	benzoyl peroxide clindamycin clindamycin phosphate gel/ lotion /med.swab/soln	<i>Acanya</i> TM <i>Azelex</i> [®] <i>Benzaclin</i> [®] <i>Benzaclin</i> [®] CareKit <i>Benzefoam</i> TM <i>Benzefoam Ultra</i> TM <i>Benziq</i> TM gel <i>Benziq</i> TM susp <i>benzoyl peroxide towelette</i> <i>BPO Kit</i> <i>Cleocin T</i> [®] Gel <i>Cleocin T</i> [®] Lotion <i>Cleocin T</i> [®] Med. Swab <i>Clindacin</i> TM Pac Kit <i>Clindagel</i> [®] <i>clindamycin 1%/Benzoyl Peroxide 5%</i> <i>clindamycin phosphate foam</i> <i>Delos Lotion</i> TM <i>Duac</i> [®] gel <i>Evoclin</i> TM <i>Inova</i> TM <i>Lavoclen</i> TM Cleanser <i>Lavoclen</i> TM Kit <i>Nuox</i> TM <i>Pacnex</i> [®] <i>Pacnex</i> [®] HP <i>Pacnex</i> [®] LP <i>Se BPO 7-5.5% Wash Kit</i> <i>Se BPO Cleanser</i>	Routine PDL edit plus Failure to respond to a therapeutic trial of at least two weeks of one preferred medication. Clinical Edit for Dermatologic Acne Agents <ul style="list-style-type: none"> • Products will automatically pay for children less than 18 • All adults over the age of 18 will require a SA to determine diagnosis for treatment • Products are intended for Acne only; a SA for a Cosmetic indication can not be approved Additional Information to Aid in SA determination <ul style="list-style-type: none"> • Topical retinoids will reject for 21 and older - this can not be overridden. • Renova and other products considered to have only a cosmetic indication are not covered by Virginia Medicaid. • If the patient is completing a course of therapy with a medication requiring service authorization, which was initiated in the hospital or other similar location, or if the patient has just become Medicaid eligible and is already on a course of treatment with a medication requiring service authorization, then the requested medication may be approved.
Topical Agents for Psoriasis			
	calcipotriene Dovonex[®] Psoriatee[®] off the market	<i>anthralin</i> <i>Calcitrene</i> [®] <i>calcitriol</i> <i>Dovonex</i> [®] Scalp	<i>Micanol</i> [®] <i>Taclonex</i> [®] <i>Taclonex</i> [®] Scalp <i>Vectical</i> [®]



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Preferred Agents	Non-Preferred Agents	SA Criteria
Topical Retinoids/Combinations for Acne		
Differin[®] cream 0.1% Differin[®] gel 0.1% & 0.3% Differin[®] 0.1% topical lotion Retin[®]-A Micro Retin[®]-A Micro Pump tretinoin	<i>adapalene 0.1% cream</i> <i>adapalene 0.1% topical gel</i> <i>Altinac[®]</i> <i>Atralin</i> Avita[®] Cream Avita[®] Gel <i>Epiduo[®]</i> <i>Retin- A cream/gel</i> <i>Tazorac[®]</i> <i>Tretin[®]-X</i> <i>Ziana[®]</i>	
Endocrine and Metabolic Agents		
Androgenic Agents (Testosterone – Topical)		
Androderm[®] Androgel[®]	<i>Axiron[®] soln</i> <i>Fortesta[®]</i> <i>Testim[®]</i>	<u>LENGTH OF AUTHORIZATION:</u> 1 year Routine PDL edit plus Failure to respond to a therapeutic trial of at least one week of one preferred medication
Antihyperuricemics		
allopurinol Probenecid[®] probenecid & colchicine	<i>*Colcrys[®]</i> <i>Uloric[®]</i> Zyloprim[®]	<u>LENGTH OF AUTHORIZATION:</u> 1 year Routine PDL edit *Clinical Criteria for: Colcrys[™] Approve if one of the following is true: <ul style="list-style-type: none"> • Diagnosis of Familial Mediterranean Fever; OR • For Acute Gout Flare: <ul style="list-style-type: none"> ○ Trial and failure of one of the following: <ul style="list-style-type: none"> ▪ NSAID (i.e., indomethacin, naproxen, ibuprofen, sulindac, ketoprofen) OR ▪ Corticosteroid
Contraceptives		
Etonogestrel/Ethinyl Estradiol Vaginal Ring		<u>LENGTH OF AUTHORIZATION:</u> 1 year Routine PDL edit
NuvaRing[®]		



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	Norelgestromin/Ethinyl Estradiol Transdermal		<u>Additional Information to aid in SA determination:</u>
	Ortho Evra[®]		If there is a specific indication for a medication requiring service authorization, for which medications not requiring service authorization are not indicated, then request may be approved.
	Oral Contraceptives		
	Apri[®] Cryselle[™] Enpresse[®] Femcon Fe[®] Junel Fe[®] Loestrin[®] Loestrin Fe[®] Microgestin[®] Microgestin Fe[®] Mircette[®] Micronor[®] Norinyl 1+50[®] Nor-Q-D[®] Nortrel[®] Ortho-Novum[®] Ortho Tri-Cyclen[®] Ortho Tri-Cyclen Lo[®] Ovcon[®] -50 Sprintec[®] Tri-Sprintec[®] Trivora-28[®] Yasmin[®] 28 Yaz[®] Zovia[®] 1-35E Zovia[®] 1-50E	<i>All other oral contraceptives</i> Lo-Ovral-28[®] Ortho-Cyclen[®] Portia[®]	



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Diabetes Hypoglycemics: Injectable Amylin Analogs		
	* <i>Symlin</i> [®] * <i>Symlin</i> [®] Pens	<u>LENGTH OF AUTHORIZATION:</u> 1 year *Clinical edit <ul style="list-style-type: none"> ▪ The recipient must have a history of at least a 90 day trial of insulin. ▪ <i>Symlin</i>[®] is only indicated as adjunct therapy with insulin. ▪ Member meeting ALL of the following criteria may be approved: <ul style="list-style-type: none"> ○ Diagnosis of Type 1 or 2 diabetes ○ On insulin therapy ○ Failure to achieve adequate glycemic control (HbA1c ≤ 6.5%)
Diabetes Hypoglycemics: Injectable Incretin Mimetics		
<i>Byetta</i> [®]	<i>Bydureon</i> [™] <i>Victoza</i> [®]	<u>LENGTH OF AUTHORIZATION:</u> 1 year Routine PDL edit
Diabetes Hypoglycemics: Injectable Insulins		
Insulin Mix		<u>LENGTH OF AUTHORIZATION:</u> 1 year Routine PDL edit
<i>Humalog</i> [®] Mix 50/50 vial <i>Humalog</i> [®] Mix 50-50 Kwikpen <i>Humalog</i> [®] Mix 75/25 vial <i>Humalog</i> [®] Mix 75-25 Kwikpen <i>Novolog</i> [®] Mix 70/30 pen/vial <i>Humulin</i> [®] 70/30 pen/vial <i>Novolin</i> [®] 70/30 vial		<u>Additional Information to aid in SA determination:</u> <ul style="list-style-type: none"> • Therapeutic failure of one non-preferred medication. For approval of a non-preferred insulin, the patient must have a failure on the equivalent preferred product if one is available (ex. Approval of <i>Humalog</i>[®] would require a failure on <i>Novolog</i>[®]). • Pens/cartridges should only be approved if there is a physical reason (such as dexterity problems, vision impairment) vials cannot be used. Approvals should not be granted based on issues of convenience or compliance. SA may be approved for individuals meeting the following criteria: <ul style="list-style-type: none"> ○ Member or caregiver has poor eyesight such that dosing errors may occur ○ Member or caregiver has problems with manual dexterity which may result in dosing errors (i.e.
Insulin N		
<i>Humulin</i> [®] N pen/vial <i>Novolin</i> [®] N vial		
Insulin R		
<i>Humulin</i> [®] R vial <i>Novolin</i> [®] R vial		
Long-Acting Insulins		
<i>Lantus</i> [®] vial <i>Levemir</i> [®] pen/vial	<i>Lantus Solostar</i> [®] and cartridge	



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Rapid-Acting Insulins		Parkinson's disease, rheumatoid arthritis in the finger/hand joints, multiple sclerosis) o Member is under 18 years of age <u>Additional information to aid in SA determination</u> If Humalog® is authorized and the patient is to mix with Humulin® (any formulation), then approve the Humulin® medication(s).
Humalog® cartridge/ Kwikpen®/vial Novolog® cartridge/ Flexpen Syringe/vial	<i>Apidra® cartridge, Solostar, and vial</i>	
Diabetes Oral Hypoglycemics		
Oral Hypoglycemics Alpha-Glucosidase Inhibitors		<u>LENGTH OF AUTHORIZATION:</u> 1 year Routine PDL edit
acarbose Glyset®	<i>Precose®</i>	
Oral Hypoglycemics Biguanides		
metformin metformin ER	<i>Fortamet® Glucophage® IR & XR Glutmetza® Riomet® susp</i>	
Oral Hypoglycemics Biguanide Combination Products		
glipizide/metformin glyburide/metformin	<i>Glucovance® Metaglip®</i>	
Oral Hypoglycemics DPP-IV Inhibitors and Combination		
Janumet® Janumet XR® Januvia® Jentadueto™ Kombiglyze XR™ Onglyza™ Tradjenta™	<i>Juvisync™</i>	
Oral Hypoglycemics Meglitinides		
Starlix®	<i>nateglinide Prandin® PrandiMet™</i>	



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Oral Hypoglycemics Second Generation Sulfonylureas			
	glimepiride glipizide glipizide ER glyburide glyburide micronized	<i>Amaryl</i> [®] <i>Diabeta</i> [®] <i>Glucotrol</i> [®] <i>Glucotrol XL</i> [®] <i>Glynase</i> [®]	
Oral Hypoglycemics Thiazolidinediones			
	Actoplus Met [®] Actos [®] Avandamet [®] Avandia [®]	<i>Actoplus Met XR</i> [®] <i>Avandaryl</i> [®] <i>Duetact</i> [®]	<p><u>Rosiglitazone REMS Program-</u> After November 18, 2011 rosiglitazone medicines will be withdrawn from local pharmacies, and the distribution of rosiglitazone-containing medicines will be limited to only specially-certified, mail-order pharmacies. To receive a rosiglitazone-containing medicines (<i>Avandia</i>[®], <i>Avandamet</i>[®], and <i>Avandaryl</i>[®]). The physician must be enrolled in the Avandia[®]-Rosiglitazone Medicines Access Program and adhere to the new restrictions to obtain the products if they wish to prescribe rosiglitazone medicines to outpatients or patients in long-term care facilities after November 18, 2011. <i>These products are not included as preferred or non-preferred on DMAS' PDL.</i></p>
Erythropoiesis Stimulating Proteins: Epogen[®], Procrit[®] (Erythropoietin) & Aranesp[®] (Darbepoetin)			
	Procrit [®]	<i>Aranesp</i> [®] <i>Epogen</i> [®] <i>Omontys</i> [®]	<p><u>LENGTH OF AUTHORIZATION:</u> for duration of the prescription up to 6 months Routine PDL edit</p> <p><u>Clinical Information for Pharmacists:</u> RENEWAL REQUESTS for patients with anemia due to chronic renal failure/end stage renal disease should be approved, even if the Hgb or Hct are above the cutoff point.</p>
Growth Hormone			



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	<p>Genotropin[®] Nutropin AQ[®] NuSpin[™]</p>	<p><i>Humatrope[®] cartridge/vial</i> <i>Norditropin cartridge[®]</i> <i>Norditropin FlexPro[®] & Nordiflex[®]</i> <i>Nutropin[®]</i> <i>Nutropin AQ[®] cartridge/vial</i> <i>Ommitrope[®]</i> <i>Saizen[®] cartridge/vial</i> <i>Serostim[®]</i> <i>Tev-Tropin[®]</i> <i>Zorbtive[®]</i></p>	<p>All Growth Hormones require a clinical SA</p> <p>Clinical Criteria for PEDIATRIC Patients (18 years of age and under):</p> <p><u>LENGTH OF AUTHORIZATION</u> (pediatrics): 1 year</p> <ul style="list-style-type: none"> • Prescriber is an endocrinologist, nephrologists, infectious disease specialist or HIV specialist or one has been consulted on this case, • The patient has open epiphysis and one of the following diagnoses <ul style="list-style-type: none"> ○ Turner Syndrome ○ Prader-Willi Syndrome ○ Renal insufficiency ○ Small for gestational age (SGA) - including Russell-Silver variant and patient is < 2 years old ○ Idiopathic Short Stature (for request for renewal only (a) information is required to be approved) ○ Growth hormone deficiency (physician should provide the required information below) ○ Newborn with hypoglycemia and a diagnosis of hypopituitarism or panhypopituitarism. • Height is more than 2 SD (standard deviations) below average for the population mean height for age and sex, and a height velocity measured over one year to be 1 SD below the mean for chronological age, or for children over two years of age, a decrease in height SD of more than 0.5 over one year; AND • Growth hormone response of less than 10ng/ml to at least two provocative stimuli of growth hormone release: insulin, levodopa, L-Arginine, clonidine, or glucagon <p><u>Requests for Renewal (pediatrics):</u></p> <ul style="list-style-type: none"> ○ For renewal, a response must be documented. Patient must demonstrate improved/normalized growth velocity. (Growth velocity has increased by at least 2 cm in the first year and is greater than 2.5 cm per year), AND ○ Patient height is less than 5' 6" for males or 5' 1"



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



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			<p>initial; then 1 year. Renewal is contingent upon improvement in lean body mass or weight measurements.</p> <p><u>Requests for Renewal (adults)</u> Renewal is contingent upon prescriber affirmation of positive response to therapy (improved body composition, reduced body fat, and increased lean body mass).</p>
Progestational Agents			
	medroxyprogesterone acetate (tablet only) norethindrone acetate progesterone injection Prometrium® Provera®	<i>Aygestin®</i> <i>progesterone cap</i>	<p><u>LENGTH OF AUTHORIZATION:</u> 1 year <u>Routine PDL edit plus</u></p> <p>Failure to respond to a therapeutic trial of at least one week of one non-service authorized medication</p>
Progestins Used For Cachexia			
	megestrol acetate	<i>Megace®</i> <i>Megace® ES</i>	<p><u>LENGTH OF AUTHORIZATION:</u> 1 year <u>Routine PDL edit</u></p>
Vaginal Estrogens			
	Premarin® Vaginal cream Vagifem® Vaginal tab	<i>Estrace® Vaginal cream</i> <i>Estring® Vaginal ring</i> <i>Femring® Vaginal ring</i>	<p><u>LENGTH OF AUTHORIZATION:</u> 6 months <u>Routine PDL edit</u></p>
Gastrointestinal			
Histamine-2 Receptor Antagonists (H-2 RA)			
	famotidine (OTC & RX) ranitidine tab/syrup (OTC & RX)	<i>Axid® cap/soln (OTC & RX)</i> <i>cimetidine tab/syrup (OTC & RX)</i> <i>famotidine oral susp (OTC & RX)</i> <i>nizatidine cap/susp</i> <i>Pepcid® oral susp/tab (OTC & RX)</i> <i>ranitidine cap (OTC & RX)</i> <i>Tagamet® (OTC & RX)</i> <i>Zantac® syrup/ tab (OTC & RX)</i>	<p><u>LENGTH OF AUTHORIZATION:</u> 1 year <u>Routine PDL edit</u></p> <p><u>Additional information to aid in SA determination</u></p> <ul style="list-style-type: none"> • Patient's condition is clinically unstable—patient has had an ER visit or at least two hospitalizations for asthma in the past thirty days—changing to a medication not requiring service authorization might cause deterioration of the patient's condition. • Approve if treatment was initiated in the hospital for the treatment of a condition such as a GI bleed. •



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Motility Agents – GI Stimulants			
	metoclopramide	Metozolv [®] ODT Reglan [®]	<p>LENGTH OF AUTHORIZATION: 12 weeks Routine PDL edit</p> <p>This medication should be reviewed for need at each request for reauthorization. Black box warning placed on product for TARDIVE DYSKINESIA 2/27/2009</p>
Proton Pump Inhibitors			
	omeprazole OTC 20mg pantoprazole Prevacid [®] OTC	Aciphex [®] Dexilant [®] lansoprazole Nexium [®] omeprazole RX 20mg omeprazole/sodium bicarbonate Prevacid [®] RX Prevacid[®] -susp (no SA required if age < 12yrs) Prevacid [®] solutab (no SA required if age < 12yrs) Prilosec [®] (Rx & OTC) Prilosec [®] susp Protonix [®] Zegerid [®] cap Zegerid [®] OTC Zegerid [®] susp packet	<p>LENGTH OF AUTHORIZATIONS: 12 weeks; unless recipient meets an exception; then 1 year Routine PDL edit</p> <p>Additional PDL edit criteria The requested medication may be approved if both of the following are true:</p> <ul style="list-style-type: none"> • If there has been a therapeutic failure of no less than a three-month trial of at least two different medication within the same class not requiring service authorization • The requested medications corresponding generic (if a generic is available and covered by the State) has been attempted and failed or is contraindicated) <p>Exceptions that allow a 1 year SA for PPIs (Exceptions apply to the duration of the SA only. PDL edit still prevails before a non-preferred may be approved)</p> <ul style="list-style-type: none"> ○ Erosive Esophagitis ○ Active GI Bleed ○ Zollinger-Ellison Syndrome ○ Greater than 65 years of age ○ Under the care of a Gastroenterologist and has ruled out a nonsecretory condition
Ulcerative Colitis Oral and Rectal Preparations (5-ASA DERIVATIVES)			
Ulcerative Colitis – Oral			
	Asacol [®] Apriso [®] balsalazide disodium Pentasa [®] sulfasalazine DR & IR	Asacol [®] HD Azulfidine [®] DR Azulfidine [®] IR	Colazal [®] Dipentum Lialda [®]



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	Ulcerative Colitis – Rectal		
	Canasa[®] rectal supp mesalamine enema	<i>Fiv-Asa[®] Rowasa[®] Enema Rowasa[®] Enema Kit</i>	<i>Rowasa[®] supp. rect SFRowasa[®]</i>
Genitourinary			
Alpha-Blockers and Androgen Hormone Inhibitors For Benign Prostatic Hypertrophy (BPH)			
Alpha-Blockers for BPH			<u>LENGTH OF AUTHORIZATION:</u> 1 year Routine PDL edit
tamsulosin HCL	<i>alfuzosin Flomax[®] Rapaflo[®] Uroxatral[®]</i>		
Androgen Hormone Inhibitors for BPH			
*Avodart[®] finasteride	<i>Jalyn[®] Proscar[®]</i>		*Step edit for Avodart[®] - the generic finasteride must be tried and failed before approval
Phosphodiesterase (PDE) 5 Inhibitor for BPH			
	<i>*Cialis[®]</i>		Cialis[®] - must try and fail both Alpha Blockers and Androgen Hormone Inhibitors for BPH and the physician must attest that the recipient is not on the state list of sex offenders. The patient must have had a consult or been evaluated by an Urologist.
Phosphate Binders			
Fosrenol[®] Phoslo[®] Renagel[®]	<i>Calcium Acetate 667MG Eliphos[®] Phoslyra[®] Renvela[®] powder/tablet</i>		<u>LENGTH OF AUTHORIZATION:</u> 1 year Routine PDL edit
Urinary Antispasmodics			
Enablex[®] oxybutynin tab/syrup Oxytrol[®] transdermal Sanctura[®] XR Toviaz[™]	<i>Detrol[®] & Detrol[®] LA Ditropan[®] & *Ditropan[®] XL Gelnique[™] gel *oxybutynin ER Sanctura[®] trospium VESIcare[®]</i>		<u>LENGTH OF AUTHORIZATION:</u> 1 year Routine PDL edit *Oxybutynin ER, Ditropan XL[®]: • Allow PDL exception for children age 6-18 with a diagnosis of neurogenic bladder.



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Immunological Agents			
Atopic Dermatitis: Topical			
	*Elidel®	*Protopic®	<p><u>LENGTH OF AUTHORIZATION:</u> 1 year Routine PDL edit</p> <p>*Clinical edit for Elidel® and Protopic®</p> <ul style="list-style-type: none"> • Patient must have a FDA approved diagnosis: <ul style="list-style-type: none"> ○ Atopic dermatitis (a type of eczema): ○ Elidel®: mild to moderate for ages > 2 years. ○ Protopic® 0.03%: moderate to severe for ages > 2 years. ○ Protopic® 0.1%: moderate to severe for ages > 18 years. • Failure to topical corticosteroids (i.e., desonide, fluticasone propionate, hydrocortisone butyrate, etc.) <p><u>Critical information</u></p> <ul style="list-style-type: none"> • Black box warnings are in place for both products as well as a requirement for a patient guide to be given with each product dispensed. • Use Elidel® and Protopic® only as second-line agents for short-term and intermittent treatment of atopic dermatitis (eczema) in patients unresponsive to, or intolerant to topical corticosteroids (i.e., desonide, fluticasone propionate, hydrocortisone butyrate, etc.) • Avoid use of Elidel® and Protopic® in children younger than 2 years of age. The effect of Elidel and Protopic on the developing immune system in infants and children is not known. In clinical studies, infants and children younger than 2 years old treated with Elidel® had a higher rate of upper respiratory infections than did those treated with placebo cream. • Use Elidel® and Protopic® only for short periods of time, not continuously. The long term safety of Elidel® and Protopic® are unknown • Children and adults with a weakened or compromised immune system should not use Elidel® or Protopic®. • Use the minimum amount of Elidel® or Protopic® needed to control the patient's symptoms. In animals, increasing the dose resulted in higher rates of cancer.



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Multiple Sclerosis			
	Avonex® Avonex® Adm Pack Betaseron® Copaxone® Rebif®	*Ampyra® Extavia® Gilenya®	<p><u>LENGTH OF AUTHORIZATION:</u> 1 year Routine PDL edit</p> <p>Gilenya® is to be used as monotherapy ONLY</p> <p>* <u>Clinical edit for AMPYRA®</u></p> <ul style="list-style-type: none"> • The patient has a diagnosis of Multiple Sclerosis and a gait disorder or difficulty walking • Patient has no history of seizures • Patient's Creatinine Clearance [CrCL] ≥ 50 mL/min. • If patient has a gait disorder, they may receive an 8 week trial of Ampyra® • If after 8 week trial the physician states that the patient showed improvement or that the drug was effective (by improved Timed 25-foot Walk), the patient may receive authorization for Ampyra® for one year. <p><u>LENGTH OF AUTHORIZATION FOR AMPYRA®:</u> Initial 8 weeks then, 1 year after successful trial</p>
Self Administered Drugs for Rheumatoid Arthritis			
	Enbrel® Humira®	Cimzia® Cimzia® SyringeKit Kineret®	Orenzia® Simponi®
			<p><u>LENGTH OF AUTHORIZATION:</u> 1 year Routine PDL edit</p>



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Ophthalmic			
Antibiotics			
	bacitracin/ polymyxin b sulfate ointment ciprofloxacin drops erythromycin gentamicin drops/ointment Moxeza® drops neomycin/polymyxin/gramicidin ofloxacin drops polymyxin/trimethoprim Quixin® drops off the market sulfacetamide soln tobramycin Vigamox® drops	<i>AzaSite™ drop</i> bacitracin <i>Besivance® drops</i> Bleph® - 10 <i>Ciloxan® drops/ointment</i> <i>Garamycin® Drops</i> <i>Garamycin® Ointment</i> <i>Ilotycin®</i> <i>Iqix® drops off the market</i> <i>levofloxacin drops</i> <i>Natacyn®</i> <i>neomycin/bacitracin/polymyxin ointment</i> <i>Neosporin®</i> <i>Ocuflox® drops</i> <i>Polytrim®</i> <i>sulfacetamide ointment</i> <i>Tobrex® Drops</i> <i>Tobrex® Ointment</i> <i>Zymar® drops off the market</i> <i>Zymaxid® drops</i>	<p>LENGTH OF AUTHORIZATION: for the date of service only; no refills Routine PDL edit</p> <p>Additional information to aid in SA determination</p> <ul style="list-style-type: none"> • If the infection is caused by an organism resistant to medications not requiring service authorization, then may approve the requested medication. • Therapeutic failure to no less than a three-day trial of one medication within the same class not requiring service authorization • If the patient is completing a course of therapy with a medication requiring service authorization, which was initiated in the hospital, then may approve the requested medication to complete the course of therapy.
Antihistamines/Mast Cell Stabilizers			
Antihistamines			
	Alaway OTC® ketotifen fumerate Optivar® drops Pataday® drops Zaditor® OTC drops	<i>azelastine drops</i> <i>Bepreve®</i> <i>Elestat® drops</i> <i>Emadine® drop</i> <i>epinastine 0.05% eye drops</i> <i>Lastacaft® drops</i> <i>Patanol® drops</i>	<p>LENGTH OF AUTHORIZATION: 1 year Routine PDL edit</p> <p>Additional information to aid in SA determination</p> <ul style="list-style-type: none"> • Therapeutic failure to no less than a three-day trial of one medication within the same class not requiring service authorization • If the patient is completing a course of therapy with a medication requiring service authorization, which was initiated in the hospital, then may approve the requested medication to complete the course of therapy.
Mast Cell Stabilizers			
	cromolyn sodium	<i>Alamast® drops</i> <i>Alocril® drops</i> <i>Alomide® drops</i> <i>Crolom® drops</i>	



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Anti-inflammatory		
diclofenac sodium flurbiprofen sodium ketorolac 0.4% ketorolac 0.5% Nevanac [®]	Acular [®] Acular LS [®] Acular PF [®] Acuvail [®] Bromday [®] bromfenac 0.09% Ocufen [®] Voltaren [®]	LENGTH OF AUTHORIZATION: for the date of service only; no refills Routine PDL edit Additional information to aid in SA determination <ul style="list-style-type: none"> Therapeutic failure to no less than a three-day trial of one medication within the same class not requiring service authorization. If the patient is completing a course of therapy with a medication requiring service authorization, which was initiated in the hospital, then may approve the requested medication to complete the course of therapy.
Glaucoma Agents		
Alpha 2 Adrenergic Agents		LENGTH OF AUTHORIZATION: 1 year Routine PDL edit
Alphagan P [®] 0.1 & 0.15% brimonidine 0.2% \\ Iopidine [®] 0.5% & 1%	<i>apraclonidine 0.5% drops</i> <i>brimonidine tartrate 0.15%</i>	
Beta Blockers		
betaxolol 0.5% Betimol [®] 0.25% & 0.5% Betoptic-S [®] 0.25% carteolol 1% Combigan [®] levobunolol 0.25% & 0.5% metipranolol 0.3% timolol maleate 0.25% & 0.5% timolol maleate 0.5 % Sol-Gel	Betagan [®] 0.25% & 0.5% Istalol [®] 0.5% Ocupress [®] 1% optipranolol 0.3% s Timoptic [®] drops 0.25% & 0.5% Timoptic [®] XE 0.25% & 0.5% Sol-Gel	
Carbonic Anhydrase Inhibitors		
Azopt [®] 1% dorzolamide dorzolamide/timolol	<i>Cosopt[®] 0.5%-2%</i> <i>Cosopt[®] PF</i> <i>Trusopt[®] 2%</i>	



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	Prostaglandin Analogs latanoprost Travatan Z[®] Travatan[®] 0.0004%	<i>Lumigan[®] 0.03%</i> <i>Lumigan[®] 0.01%</i> <i>Xalatan[®] 0.005%</i> Zioptan[™]	
Respiratory			
Antihistamines: First and Second Generation			
First Generation Antihistamines			<u>LENGTH OF AUTHORIZATION:</u> 1 year
Generic only class	<i>All Brands require a SA</i>		Routine PDL edit
Second Generation Antihistamines and Combinations			
cetirizine liquid/tabs (OTC) loratadine tab/Rapidtabs/syrup (OTC)	<i>Allegra[®] tab/ susp/ ODT</i> <i>Allegra-D[®] 12 h & 24 hr</i> <i>cetirizine chew/tab(OTC)</i> <i>cetirizine D tab(OTC)</i> <i>Clarinex[®] syrup/tab/Rapid Tab</i> <i>Clarinex- D[®] 24 & 12 hr</i> <i>Claritin-D[®] -Rx & OTC forms</i> <i>Claritin[®] tab/Chewable (RX & OTC)</i> <i>fexofenadine</i> <i>fexofenadine/PSE & 60/120 ER</i> levocetirizine <i>loratadine D 12 &24 HR</i> <i>Xyzal[®]</i> <i>Zyrtec[®] tab/chew/syrup(OTC & RX)</i> <i>Zyrtec-D[®] (OTC&RX)</i>		
Beta-Adrenergic Agents			
Long Acting Metered Dose Inhalers or Nebulizers			<u>LENGTH OF AUTHORIZATION:</u> 1 year
Foradil[®] Serevent Diskus[®]	<i>Arcapta Neohaler[®]</i> <i>Brovana[®]</i> <i>Perforomist[®]</i>		Routine PDL edit <u>Additional information to aid in SA determination</u> Therapeutic failure to no less than a two-week trial of at least one medication not requiring service authorization within the same class and formulation. (i.e. nebulizers for nebulizers)



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Short Acting Metered Dose Inhalers or Devices		
Proventil[®] HFA	<i>Maxair Autohaler</i> <i>Proair[®] HFA</i> <i>Ventolin[®] HFA</i> <i>Xopenex[®] HFA</i>	
Short Acting Nebulizers		
albuterol sulfate metaproterenol Xopenex[®]	<i>Accuneb[®] pediatric dosing, premixed nebs</i> <i>albuterol sulfate premix</i> <i>levalbuterol 0.125%</i> <i>Proventil[®]</i>	
COPD: Bronchodilators and Phosphodiesterase 4 (PDE4) Inhibitors		
Atrovent HFA[®] Combivent[®] MDI ipratropium bromide soln Spiriva[®]	<i>Atrovent AER[®] Removed from market</i> <i>Daliresp[®]</i> <i>Duoneb[®]</i> <i>ipratropium/albuterol nebs</i>	<u>LENGTH OF AUTHORIZATION:</u> 1 year Routine PDL edit <u>Additional information to aid in SA determination</u> <ul style="list-style-type: none"> • Patient's condition is clinically unstable—patient has had an ER visit or at least two hospitalizations for COPD in the past thirty days—and changing to a medication not requiring service authorization might cause deterioration of the patient's condition. <u>Specific Information for Daliresp[®]:</u> <ul style="list-style-type: none"> • If the patient has a diagnosis of severe COPD associated with chronic bronchitis and a history of exacerbations and • Trial/failure on at least one first-line or second-line agent (inhaled anticholinergics, long acting beta agonists or inhaled corticosteroids) and • Adjunctive therapy (Daliresp[®] must be used in conjunction with first-line or second-line agent)
Corticosteroids: Inhaled and Nasal Steroids		
Inhaled Corticosteroids: Combination Products (Glucocorticoid and Beta Adrenergic)		
Advair[®] Diskus & HFA Dulera[®] Symbicort[®]		<u>LENGTH OF AUTHORIZATION:</u> 1 year Routine PDL edit <u>Additional information to aid in SA determination</u> <ul style="list-style-type: none"> • Patient's condition is clinically unstable—patient has had an ER visit or at least two hospitalizations for asthma in the past thirty days—and changing to a medication not requiring service authorization might cause deterioration of the patient's condition.



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	Inhaled Corticosteroids: Metered Dose Inhalers		<ul style="list-style-type: none"> • Therapeutic failures to no less than one-month trials of at least two medications not requiring service authorization • If the patient is a child <13 years old or a patient with a significant disability, and unable to use an inhaler which does not require service authorization, or is non-compliant on an inhaler not requiring service authorization because of taste, dry mouth, or infection.
	Aerobid[®] Aerobid[®] M Asmanex[®] Azmacort[®] Flovent[®] Diskus Flovent[®] HFA QVAR[®]	<i>Alvesco[®]</i> <i>Flovent[®]</i> <i>Flovent Rotadisk[®]</i> <i>Pulmicort Flexhaler[®]</i>	
	Inhaled Corticosteroids: Nebulizer Solution		
	Pulmicort[®] Respules	<i>budesonide</i>	
	Nasal Steroids		
	fluticasone Nasacort[®] AQ	<i>Beconase AQ[®]</i> <i>Flonase[®]</i> <i>flunisolide</i> <i>Nasacort[®]</i> <i>Nasarel[®]</i> <i>Nasonex[®]</i> <i>Omnaris[®]</i>	<i>QnaslTM</i> <i>Rhinocort Aqua[®]</i> <i>triamcinolone</i> <i>acetonide</i> <i>Tri-Nasal[®]</i> <i>Veramyst[®]</i>
	Cough and Cold Agents		
	Drug Name and GNN	All other legend cough and cold product are non-preferred	<u>LENGTH OF AUTHORIZATION:</u> Date of Service Routine PDL edit
	Ala-Hist DM <i>brompheniramine/ phenylephrine/ dextromethorphan</i>	Tessalon[®] perle	
	Ala-hist LQ <i>off the market</i> <i>phenylephrine/ diphenhydramine</i>		<u>Clinical Edit for Cough and Cold Agents</u> – All children under 6 will not be eligible for cough and cold products.
	benzonatate cap		
	Carbatuss-12[®] <i>Carbetapen Cit, Carbetap Tan, PE HCl, PE Tan</i>		
	Centergy[®] <i>phenylephrine/ chlorpheniramine</i>		
	codeine/ promethazine <i>codeine/ promethazine</i>		
	guaifenesin/ codeine phosphate		



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	<i>Preferred Agents</i>	<i>Non-Preferred Agents</i>	<i>SA Criteria</i>
	guaifenesin/ codeine phosphate hydrocodone/ homatropine hydrocodone/ homatropine iophen-C NR guaifenesin/codeine phosphate lohist-DM syrup brompheniramine/ dextromethorphan/ phenylephrine phenylephrine hcl/promethazine hcl phenylephrine hcl/ promethazine hcl poly hist DHC pyrilamine/ phenylephrine/ dihydrocodeine poly-tussin DHC brompheniramine/ phenylephrine/ dihydrocodeine promethazine DM syrup promethazine/ dextromethorphan Tusnel[®] Pediatric Drops dextromethorphan/ guaifenesin/pseudoephedrine		
	Intranasal Antihistamines		
	Astelin[®] Astepro[®] 0.1% off the market	azelastine 0.1% Astepro [®] 0.15% Patanase [®]	<u>LENGTH OF AUTHORIZATION:</u> 1 year Routine PDL edit <u>Additional information to aid in SA determination</u> Patient's condition is clinically unstable—patient has had an ER visit or at least two hospitalizations for asthma in the past thirty days—changing to a medication not requiring service authorization might cause deterioration of the patient's condition. <ul style="list-style-type: none"> • Therapeutic failures to no less than one-month trials of



Virginia Medicaid Preferred Drug List With Service Authorization Criteria
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	<i>Preferred Agents</i>	<i>Non-Preferred Agents</i>	<i>SA Criteria</i>
			at least two medications not requiring service authorization <ul style="list-style-type: none"> If the patient is a child <13 years old or a patient with a significant disability, and unable to use an inhaler which does not require service authorization, or is non-compliant on an inhaler not requiring service authorization because of taste, dry mouth, infection The requested medications corresponding generic (if a generic is available) has been attempted and failed or is contraindicated.
Leukotriene Receptor Antagonists			
	Accolate[®] Singulair[®]	<i>zafirlukast</i> <i>Zyflo[™]</i> <i>Zyflo CR[™]</i>	<u>LENGTH OF AUTHORIZATION:</u> 1 year Routine PDL edit
Self Injectable Epinephrine			
	EpiPen[®] EpiPen[®] Jr	<i>Twinject[®]</i> <i>Twinject Jr.[®]</i>	<u>LENGTH OF AUTHORIZATION:</u> 1 year Routine PDL edit