*** Indicates a generic is available without prior authorization**

Virginia Medicaid Preferred Drug List
Posted 05/05/05
Effective July 1, 2005

First Health Clinical Call Center
1-800-932-6648
Fax 1-800-932-6651

Bolded Drugs do not require prior authorization, except where special conditions are noted.

ANALGESICS

NON-STEROIDAL ANTI-INFLAMMATORY DRUGS

Diclofenac (Potassium and Sodium)
Diflunisal
Etodolac
Fenoprofen
Flurbiprofen
Ibuprofen
Indomethacin (Capsule, SA)
Ketoprofen (Capsule, ER)
Ketorolac
Meclofenamate Sodium
Nabumetone
Naproxen
Naproxen Sodium
Oxaprozin
Piroxicam
Sulindac
Tolmetin Sodium

Requires Prior Authorization
Anaprox®* (tablet, DS)
Ansaid®*
Arthrotec® (50®, 75®)
Cataflam®*
Clinoril®*
Daypro®*
Dolobid®*
Feldene®*
Indocin®*
Lodine®* (Tablet, XL)
Mobic®
Motrin®*
Nalfon®*
Naprelan®*
Naprosyn®*
Orudis®*
Oruvail®*
Ponstel®
Prevacid-NapraPAC®
Relafen®*
Tolectin DS®*
Toradol®*
Voltaren®* (Tablet, XR)

*NON-STEROIDAL ANTI-INFLAMMATORY – COX II INHIBITORS***

Celebrex®

Long-Acting Narcotics***

Clinical Prior Authorization required (see below)
Avinza®
Duragesic®
Morphine Sulfate tablets SA®
Oramorph SR®

Requires Prior Authorization
Fentanyl
Kadian®
MS Contin®*
Palladone®
Oxycontin®
Oxycodone Long Acting®

ORAL ANTIFUNGALS – ONYCHOMYCOSIS

Lamisil®

Requires Prior Authorization
Itraconazole
Sporanox®

CEPHALOSPORINS – 2ND GENERATION

Cefaclor (capsule, ER, Susp)
Ceftin® 125 mg (until generic available)
Ceftin® Suspension
Cefuroxime
Cefzil® (Tablets, Suspension)
Lorabid® (Tablets, Suspension)
Raniclor®

Requires Prior Authorization
Ceclor®* (Tablet, CD)
Ceftin®*

CEPHALOSPORINS – 3RD GENERATION

Cedax® (Tablet, Suspension)
Omnicef® (Capsule, Suspension)
Spectracef®

Requires Prior Authorization
Cefpodoxime
Suprax® Suspension
Vantin® (Tablet, Suspension)

MACROLIDES

Biaxin® (Tablets, Susp, XL)
Erythrocin Stearate
Erythromycin Base
Erythromycin Ethylsuccinate
Erythromycin Estolate Suspension
Erythromycin Stearate
Erythromycin w/Sulfisoxazole
Zithromax® (Tablets, Suspension)

Requires Prior Authorization
Dynabac®
E.E.S. ®*
Eryc®*
Eryped®*
Ery-Tab®*
PCE®*

QUINOLONES – 2ND GENERATION

Ciprofloxacin (Tablet, Suspension)
Ofloxacin

Requires Prior Authorization
Cipro®* (TABLETs, Suspension, XR)
Floxin®*
Maxaquin®
Noroxin®

QUINOLONES – 3RD GENERATIOn

Avelox®
Avelox ABC Pack®

Requires Prior Authorization
Levaquin®
Tequin®
Zagam®

ASTHMA – ALLERGY

ANTIHISTAMINES – 2ND GEN

Alavert®
Claritin® OTC
Loratadine D (12hr, 24hr) OTC
Loratadine (Syrup, Tablets, Tablet rapid) OTC

Requires Prior Authorization
Allegra®
Allegra D®
Clarinex® (Tablet, syrup, Redi-Tab)
Claritin®*(Tablet, Syrup, RediTab) RX
Claritin D®* (12 hour, 24 hour) Rx
Zyrtec® (Tablet, Tablet chew)
Zyrtec® Syrup (No PA req. for under age 2)
Zyrtec D®

Bolded Drugs do not require prior authorization, except where special conditions are noted.

BETA ADRENERGICS-SHORT ACTING

Albuterol
Alupent® MDI
Combivent®
Maxair Autohaler®
Proventil® HFA
Ventolin® HFA

Requires Prior Authorization
Proventil®*
Ventolin®*
Albuterol HFA

BETA ADRENERGICS – LONG ACTING

Foradil®
Serevent Diskus®
Serevent®

BETA ADRENERGICS FOR NEBULIZERS

Accuneb®
Albuterol sulfate
Duoneb®
Metaproterenol
Xopenex®

Requires Prior Authorization
Proventil®*

BETA ADRENERGIC/ CORTICOSTEROID INHALER COMBINATIONS

Advair Diskus®

INHALED SYSTEMIC GLUCOCORTICOIDS

AeroBid®
AeroBid M®
Azmacort®
Flovent®
Pulmicort Respules®
QVAR®

Requires Prior Authorization
Flovent Rotadisk®
Pulmicort Turbuhaler®

LEUKOTRIENE INHIBITORS

Accolate®
Singulair®

NASAL STEROIDS

Flonase®
Flunisolide
Nasarel®

Requires Prior Authorization
Beconase AQ®
Nasacort®
Nasacort AQ®
Nasonex® (No PA req. for under age 4)
Rhinocort Aqua®
Tri-Nasal®

ACE INHIBITORS

Captopril
Captopril HCT
Enalapril
Enalapril HCT
Lisinopril
Lisinopril HCT

Requires Prior Authorization
Accupril®
Accuretic®
Aceon®
Altace®
Benazepril
Capoten®*
Capozide®*
Fosinopril
Fosinopril/HCT
Lotensin®
Lotensin HCT®
Mavik®
Moexipril
Monopril®
Monopril HCT®
Prinivil®*
Prinzide®*
Quinapril
Quinapril/HCTZ
Uniretic®
Univasc®
Vaseretic®*
Vasotec®*
Zestoretic®*
Zestril®*

ACE INHIBITORS/ CALCIUM CHANNEL BLOCKERS

Lotrel®

Requires Prior Authorization
Lexxel®
Tarka®
Teczem®

ANGIOTENSIN RECEPTOR ANTAGONISTS

Benicar®
Benicar HCT®
Diovan®
Diovan HCT®
Micardis®
Micardis HCT®
Cozaar®
Hyzaar®

Requires Prior Authorization
Atacand®
Atacand /HCT®
Avalide®
Avapro®
Teveten®
Teveten®/HCT

BETA BLOCKERS

Acebutolol
Atenolol
Atenolol /Chlorthalidone
Betaxolol
Bisoprolol Fumarate
Bisoprolol /HCTZ
Coreg®
Labetalol
Metoprolol
Metoprolol/HCT
Nadolol
Pindolol
Propranolol
Propranolol/HCTZ
Sorine
Sotalol
Sotalol AF
Timolol

Requires Prior Authorization
Betapace®*
Betapace AF®*
Blocadren®*
Cartrol®
Corgard®*
Corzide®
Demser®
Inderal®*
Inderal LA®

Bolded Drugs do not require prior authorization, except where special conditions are noted.

Inderide®*
Innopran XL®
Kerlone®*
Levatol®
Lopressor®*
Lopressor HCT®
Sectral®*
Tenoretic®®*
Tenormin®*
Timolide®
Toprol XL®
Trandate®*
Zebeta®*
Ziac®*

CALCIUM CHANNEL BLOCKERS - DIHYDROPYRIDINE

Afeditab CR®
Dynacirc®
Dynacirc CR®
Nicardipine
Nifediac CC®
Nifedical XL®
Nifedipine ER
Nifedipine – Immediate Release
Nifedipine SA
Norvasc®
Plendil®
Sular®

Requires Prior Authorization
Adalat CC®*
Cardene®* (Tablet, SR)
Procardia®* (Tablet, XL)

CALCIUM CHANNEL BLOCKERS - NON-DIHYDROPYRIDINE

Cartia XT®
Diltia XT®
Diltiazem (Tablets, Capsules, ER, SR)
Taztia XT®
Verapamil (Tablets, Capsules, ER, SR)

Requires Prior Authorization
Calan®* (Tablet, SR)
Cardizem®* (Tablet, LA, SR, CD)
Covera-HS®
Dilacor XR®*
Isoptin SR®*
Tiazac®*
Verelan®* (Tablet, PM)

LIPOTROPICS: STATINS

Advicor®
Altoprev®
Lescol® (Tablet, XL)
Lovastatin®
Pravachol®
Zocor®

Requires Prior Authorization
Caduet®
Crestor®
Lipitor®
Mevacor®*

CNS STIMULANTS/ADHD MEDICATIONS

Adderall XR®
Amphetamine Salt Combo
Concerta®
Dextroamphetamine
Dextroamphetamine SR
Dextrostat®
Focalin®
Metadate® (CD, ER)
Methylin® (Tablets, ER)
Methylphenidate (Tablets, SR)
Pemoline
Ritalin LA®
Strattera®

Requires Prior Authorization
Adderall®*
Cylert®*
Desoxyn®*
Dexedrine®*
Dexedrine Spansules®*
Methamphetamine HCl
Provigil®
Ritalin®*
Ritalin SR®*

SEDATIVE HYPNOTIC NON-BARBITURATES

Estazolam
Flurazepam
Restoril® 7.5 mg (until generic available)
Temazepam
Triazolam

Requires Prior Authorization
Ambien®
Dalmane®*
Doral®
Halcion®*
Lunesta®
ProSom®*
Restoril®*
Somnote®
Sonata®

DIABETES

ORAL HYPOGLYCEMICS – ALPHAGLUCOSIDASE INH.

Glyset®
Precose®

ORAL HYPOGLYCEMICS – BIGUANIDES

Metformin/ Metformin ER

Requires Prior Authorization
Glucophage®*
Glucophage XR®*
Fortamet®
Riomet®

ORAL HYPOGLYCEMICS – BIGUANIDE COMBINATIONS

Avandamet® (When returned to market)
Glyburide–Metformin HCl
Metaglip®
Glucovance®*

ORAL HYPOGLYCEMICS – MEGLITINIDES

Starlix®

Requires Prior Authorization
Prandin®

ORAL HYPOGLYCEMICS – 2ND GENERATION SULFONYLUREAS

Glipizide/ Glipizide ER
Glyburide
Glyburide Micronized

Bolded Drugs do not require prior authorization, except where special conditions are noted.

Requires Prior Authorization
Amaryl®
Diabeta®*
Glucotrol®* (Tablet, XL)
Glynase®*
Micronase®*

ORAL HYPOGLYCEMICS – Thiazolidinediones
Actos®
Avandia®

GASTROINTESTINAL

HISTAMINE-2 RECEPTOR ANTAGONISTS (H-2RA)
Ranitidine

Requires Prior Authorization
Axid®
Cimetidine
Famotidine
Nizatadine
Pepcid® (Tablet, Suspension, Solutab)
Tagamet®
Zantac®* (Tablet, Effervescent)
Zantac® Syrup (No PA req. For under age 12)

PROTON PUMP INHIBITORS
Prilosec® OTC
Protonix®

Requires Prior Authorization
Aciphex®
Nexium ®
Omeprazole (No PA req. for under age 12)
Prevacid Caps® (No PA req. for under age 12)
Prevacid SoluTab®
Prevacid Susp® (No PA req. for under age 12)
Prilosec®

MISCELLANEOUS

OSTEOPOROSIS AGENTS – BISPHOSPHONATES
Actonel®
Fosamax®
Fosamax Solution®

SEROTONIN RECEPTOR AGONISTS (Triptans)
Imitrex® (kit, nasal, tablets, vial)
Maxalt®
Maxalt-MLT®

Requires Prior Authorization
Amerge®
Axert®
Frova®
Relpax®
Zomig® (Tablet, ZMT, spray)

GLAUCOMA – ALPHA-2 ADRENERGICS
Alphagan P®
Brimonidine Tartrate
Lopidine®

Requires Prior Authorization
Alphagan®*

GLAUCOMA – BETA-BLOCKERS
Betaxolol HCl
Betimol®
Betoptic S®
Carteolol HCl
Levobunolol HCl
Metipranolol
Timolol Maleate

Requires Prior Authorization
Betagan®*
Istalol ®
Ocupress®*
Optipranolol®
Timoptic®*
Timoptic XE®*

GLAUCOMA – CARBONIC ANHYDRASE INHIBITORS
Azopt®
Cosopt®
Trusopt®

GLAUCOMA – PROSTAGLANDIN ANALOGS
Lumigan®
Travatan®
Xalatan®

Requires Prior Authorization
Rescula®

Phone Numbers for DMAS PDL Program

First Health Clinical Call Center PA Requests

Fax: 1-800-932-6651
Tel: 1-800-932-6648

Note: Fax requests are responded to within 24 hours. For urgent requests, please telephone.

Note: Not all medications listed are covered by all DMAS programs. Check individual program coverage.

For program drug coverage information, go to http://www.dmas.virginia.gov/ or https://virginia.fhsc.com/