

**DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HEALTH AND RECOVERY SERVICES ADMINISTRATION
Olympia, Washington**

To: All Prescribers
Managed Care Organizations
Nursing Facility Administrators
Pharmacists
Regional Support Networks

Memo: 09-04
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From: Douglas Porter, Assistant Secretary
Health and Recovery Services
Administration

For further information, go to:
<http://hrsa.dshs.wa.gov/pharmacy>

Subject: Prescription Drug Program: Additions to the List of Limitations on Certain Drugs and Changes to the Washington PDL and Expedited Authorization List

Effective for dates of service on and after March 1, 2009, the Department of Social and Health Services (DSHS) will:

- Make additions to the List of Limitations on Certain Drugs (antipsychotic drug age and dosing limits in children 17 years of age and younger);
- Make changes to the Washington Preferred Drug List; and
- Make changes and additions to the Expedited Authorization (EA) List.

Beginning in early 2009, DSHS will require prior authorization for therapeutic duplication of antipsychotic drugs prescribed for children.

Antipsychotic Drug Initiatives

DSHS has developed a program with the Pediatric Advisory Group as part of the Children's Mental Health Initiative to help safeguard clients 17 years of age and younger who receive specific antipsychotic drugs. The program establishes community standards and guidelines related to age-based dosing and the use of drug combinations. These community standards and guidelines were established by the statewide Pediatric Advisory Group and the University of Washington. The "Primary Care Principles for Child Mental Health" can be found at <http://palforkids.org/resources>.

Antipsychotic Drug Dosing Limits in Children Added to the List of Limitations on Certain Drugs

Beginning March 1, 2009, DSHS will require authorization and a DSHS-approved second opinion for clients who exceed the antipsychotic drug age and dosing limits listed in the table below.

DSHS will automatically authorize prescriptions for 90 days when:

- The patient is already taking the antipsychotic drug;
- The prescriber indicates the child is in crisis*; or
- The prescription is filled as an emergency fill after DSHS business hours.

***Child in Crisis:** DSHS makes an exception for a new start when the child is in crisis. If the prescriber has indicated that the child is in crisis, DSHS will approve the prescription for 90 days and initiate the second opinion process.

DSHS will refer prescriptions authorized for 90 days for a second opinion review by a DSHS-designated Mental Health Specialist from the Second Opinion Network.

Prescribers of new antipsychotic prescription drugs for children under the age limit or new doses above the dosing limits are required to obtain the DSHS-approved second opinion prior to submitting an authorization request to DSHS. DSHS will require additional clinical information and the recommendations of a DSHS-designated Mental Health Specialist from the Second Opinion Network Provider List. **This list is available at:**

<http://hrsa.dshs.wa.gov/pharmacy/News.html>.

Dosing Limitations by Client Age

Drug	Dosing Limitations**		
	Age 3 -5 years*	Age 6 -12 years	Age 13 -17 years
Abilify® (aripiprazole)	0	20mg per day	30mg per day
clozapine, Clozaril®, Fazaclo®	0	600mg per day	900mg per day
Geodon® (ziprasidone)	0	80mg per day	160mg per day
haloperidol, Haldol®	0	10mg per day	15mg per day
Invega® (paliperidone)	0	0	0
perphenazine, Trilafon®	0	12mg per day	24mg per day
risperidone, Risperdal®/M-Tab®	2mg per day	4mg per day	8mg per day
Seroquel®/XR (quetiapine)	0	300mg per day	600mg per day
Zyprexa®/Zydis® (olanzapine)	2.5mg per day	10mg per day	20mg per day

*A zero indicates the need for a DSHS-approved second opinion.

**Prescriptions exceeding dosing limitations for age require a DSHS-approved second opinion.

Pharmacies may request authorization by contacting DSHS by fax at (360) 725-2141 or by calling 1-800-848-2842 (option 2).

Note: DAW-1 by an endorsing prescriber does not override age or dosing limits for the antipsychotic drugs listed.

To view DSHS's current list of Limitations on Certain Drugs,
go to: <http://hrsa.dshs.wa.gov/pharmacy>

Notice of Future Implementation of Therapeutic Duplication of Antipsychotic Therapy for Children 17 Years of Age and Younger

Beginning early 2009, DSHS will implement a drug initiative to reduce the therapeutic duplication of antipsychotic drugs prescribed for children 17 years of age and younger. After 60 days of concurrent therapy of combinations of two or more of the antipsychotic drugs listed below, DSHS will require recommendations of a DSHS-designated Mental Health Specialist from the Second Opinion Network Provider List.

- aripiprazole (Abilify®)
- clozapine (Clozaril®, Fazaclor®)
- haloperidol/haloperidol decanoate (Haldol®)
- olanzapine (Zyprexa®/Zyprexa Zydis®/Symbyax®)
- paliperidone (Invega®)
- perphenazine (Trilafon®)
- quetiapine fumarate (Seroquel®/XR)
- risperidone (Risperdal®/Risperdal M-Tab®)
- ziprasidone HCl/mesylate (Geodon®)

Continuation of a combination may be authorized for up to 60 days, if necessary, to allow additional time to taper a client off a drug.

Second Opinion Network Provider List is available at
<http://hrsa.dshs.wa.gov/pharmacy/News.html>.

Note: DAW-1 by an endorsing prescriber does not override combination limits of the specified antipsychotic drugs for children 17 years of age and younger.

What Are the Changes to the Washington Preferred Drug List (PDL)?

Changes on the Washington PDL are highlighted in yellow.

Drug Class	Preferred Drugs	Nonpreferred Drugs
Attention Deficit/ Hyperactivity Disorder (Not subject to TIP. See pg. 1.)	Generic: amphetamine salt combo dexamethylphenidate dextroamphetamine dextroamphetamine SA methylphenidate methylphenidate SA Methylin® (methylphenidate HCl) tablet Methylin ER® (methylphenidate HCl) Brand: Adderall XR® (amphetamine salt combo) Concerta® (methylphenidate HCl) Daytrana™ (methylphenidate HCl) transdermal patch Focalin XR® (dexmethylphenidate) Metadate CD™ (methylphenidate HCl) Strattera® (atomoxetine HCl) Vyvanse™ (lisdexamfetamine dimesylate)	Generic: pemoline Brand: Adderall® (amphetamine salt combo) Dexedrine® (d-amphetamine) Dexedrine SA® (d-amphetamine) Dextrostat® (d-amphetamine) Focalin® (dexmethylphenidate) Metadate ER™ (methylphenidate HCl) Methylin® (methylphenidate HCl) chewable/solution Ritalin® (methylphenidate HCl) Ritalin LA® (methylphenidate HCl) Ritalin SR® (methylphenidate HCl)

Drug Class	Preferred Drugs	Nonpreferred Drugs
Estrogens	<p>Generic Oral: estradiol tablets</p> <p>Brand Oral: Menest® (<i>esterified estrogens</i>)</p>	<p>Generic Oral: estropipate</p> <p>Brand Oral: Cenestin® (<i>synthetic conjugated estrogens</i>) Enjuvia® (<i>synthetic conjugated estrogens</i>) Estrace® (<i>estradiol</i>) oral Femtrace® (<i>estradiol</i>) Ogen® (<i>estropipate</i>) Ortho-Est® (<i>estropipate</i>) Premarin® (<i>conjugated equine estrogens</i>) oral</p>
	<p>Generic Transdermal: estradiol transdermal patch</p> <p>Brand Transdermal:</p>	<p>Generic Transdermal:</p> <p>Brand Transdermal: Alora® (<i>estradiol</i>) transdermal Climara® (<i>estradiol</i>) transdermal Divigel® (<i>estradiol</i>) gel Elestrin™ (<i>estradiol</i>) gel Esclim® (<i>estradiol</i>) transdermal Estraderm® (<i>estradiol</i>) transdermal Estrasorb® (<i>estradiol</i>) emulsion Estrogel® (<i>estradiol</i>) gel Evamist® (<i>estradiol</i>) spray** Menostar® (<i>estradiol</i>) patch Vivelle® /DOT (<i>estradiol</i>) transdermal</p> <p>**Not subject to TIP or DAW-1 override.</p>
	<p>Generic Topical:</p> <p>Brand Topical: Vagifem® (<i>estradiol</i>) vaginal tablets</p>	<p>Generic Topical:</p> <p>Brand Topical: Estrace® (<i>estradiol</i>) vaginal cream Estring® (<i>estradiol</i>) vaginal ring Femring® (<i>estradiol</i>) vaginal ring Premarin® (<i>conjugated equine estrogen</i>) vaginal cream</p>

Drug Class	Preferred Drugs	Nonpreferred Drugs
Multiple Sclerosis Drugs (Not subject to TIP)	Generic: mitoxantrone Brand: Avonex® (<i>interferon β 1a</i>) Betaseron® (<i>interferon β 1b</i>) Copaxone® (<i>glatiramer acetate</i>) Rebif® (<i>interferon β 1a</i>) Tysabri® (<i>natalizumab</i>)* *PA required	Brand: Novantrone® (<i>mitoxantrone</i>)
Skeletal Muscle Relaxants	Generic: baclofen cyclobenzaprine methocarbamol tizanidine	Generic: carisoprodol chlorzoxazone dantrolene orphenadrine Brand: Amrix® (<i>cyclobenzaprine</i>) Dantrium® (<i>dantrolene</i>) Fexmid® (<i>cyclobenzaprine</i>) Flexeril® (<i>cyclobenzaprine</i>) Norflex® (<i>orphenadrine</i>) Parafon Forte® (<i>chlorzoxazone</i>) Robaxin® (<i>methocarbamol</i>) Skelaxin® (<i>metaxalone</i>) Soma® (<i>carisoprodol</i>) Zanaflex® (<i>tizanidine</i>)

Changes to the Expedited Authorization (EA) List

Effective March 1, 2009, DSHS is adding the individual angiotensin receptor blockers to the EA list. They have been and will continue to be listed under angiotensin receptor blockers (ARBs) as well.

Drug	Code	Criteria
Atacand® (<i>candesartan cilexetil</i>)	092	Must have tried and failed, or have a clinically documented intolerance to an angiotensin converting enzyme (ACE) inhibitor.
Atacand HCT® (<i>candesartan cilexetil/HCTZ</i>)	092	Must have tried and failed, or have a clinically documented intolerance to an angiotensin converting enzyme (ACE) inhibitor.
Avalide® (<i>irbesartan/HCTZ</i>)	092	Must have tried and failed, or have a clinically documented intolerance to an angiotensin converting enzyme (ACE) inhibitor.
Avapro® (<i>irbesartan</i>)	092	Must have tried and failed, or have a clinically documented intolerance to an angiotensin converting enzyme (ACE) inhibitor.
Benicar® (<i>olmesartan medoxomil</i>)	092	Must have tried and failed, or have a clinically documented intolerance to an angiotensin converting enzyme (ACE) inhibitor.
Benicar HCT® (<i>olmesartan meoxomil/HCTZ</i>)	092	Must have tried and failed, or have a clinically documented intolerance to an angiotensin converting enzyme (ACE) inhibitor.
Cozaar® (<i>losartan potassium</i>)	092	Must have tried and failed, or have a clinically documented intolerance to an angiotensin converting enzyme (ACE) inhibitor.
Diovan® (<i>valsartan</i>)	092	Must have tried and failed, or have a clinically documented intolerance to an angiotensin converting enzyme (ACE) inhibitor.
Diovan HCT® (<i>valsartan/HCTZ</i>)	092	Must have tried and failed, or have a clinically documented intolerance to an angiotensin converting enzyme (ACE) inhibitor.
Hyzaar® (<i>losartan potassium/HCTZ</i>)	092	Must have tried and failed, or have a clinically documented intolerance to an angiotensin converting enzyme (ACE) inhibitor.
Micardis® (<i>telmisartan</i>)	092	Must have tried and failed, or have a clinically documented intolerance to an angiotensin converting enzyme (ACE) inhibitor.
Micardis HCT® (<i>telmisartan/HCTZ</i>)	092	Must have tried and failed, or have a clinically documented intolerance to an angiotensin converting enzyme (ACE) inhibitor.
Teveten® (<i>eprosartan mesylate</i>)	092	Must have tried and failed, or have a clinically documented intolerance to an angiotensin converting enzyme (ACE) inhibitor.
Teveten HCT® (<i>eprosartan mesylate/HCTZ</i>)	092	Must have tried and failed, or have a clinically documented intolerance to an angiotensin converting enzyme (ACE) inhibitor.

The following typographical error is being corrected.

Drug	Code	Criteria
Celebrex® (celecoxib)	062	All of the following must apply: a) An absence of a history of ulcer or gastrointestinal bleeding; and b) An absence of a history of cardiovascular disease.

Attachments

Attached are a new Expedited Authorization Code and Criteria List and Washington Preferred Drug List.

How can I get DSHS's/HRSA's provider documents?

1. To obtain DSHS's/HRSA's provider numbered memoranda and billing instructions, go to DSHS's/HRSA's website at <http://hrsa.dshs.wa.gov> (click the **Billing Instructions and Numbered Memos** link). These may be downloaded and printed.
2. To request a paper copy, contact DSHS using one of the following methods:
 - a. Internet: <http://hrsa.dshs.wa.gov/download/hardcopyplease.html>. Follow the instructions on the web page.
 - b. Facsimile: 1-360-725-2144. Please include the following in your fax: **i)** your name and provider number; **ii)** the name of the document you would like mailed to you; and **iii)** the address you want DSHS to send the document to.
 - c. Telephone: 1-800-562-3022, Option 2. (Orders take up to one week to fill.)

Expedited Authorization Codes and Criteria Table

Drug	Code	Criteria
Abilify® IM injection (<i>aripiprazole</i>)	065	All of the following must apply: a) Diagnosis of acute agitation associated with psychotic disorder, including bipolar disorder; b) Patient is 18 to 65 years of age; and c) Maximum dose of 30 mg in a 24 hour period.
Accutane® (<i>isotretinoin</i>)		Must not be used by patients who are pregnant or who may become pregnant while undergoing treatment. The following conditions must be absent : a) Paraben sensitivity; b) Concomitant tretinate therapy; and c) Hepatitis or liver disease.
	001	Diagnosis of severe (disfiguring), recalcitrant cystic acne, unresponsive to conventional therapy.
	002	Diagnosis of severe, recalcitrant acne rosacea in adults unresponsive to conventional therapy.
	003	Diagnosis of severe keratinization disorders when prescribed by, or in consultation with, a dermatologist.
	004	Prevention of skin cancers in patients with xeroderma pigmentosum.
	005	Diagnosis of mycosis fungoides (T-cell lymphoma) unresponsive to other therapies.
Aggrenox® (<i>aspirin/dipyridamole</i>)	037	To reduce the risk of stroke in patients who have had transient ischemia of the brain or completed ischemic stroke due to thrombosis, and have no sensitivity to aspirin.
Aloxi® Injection (<i>palonosetron</i>)	129	Administered as a single dose in conjunction with cancer chemotherapy treatment.
Altace® (<i>ramipril</i>)	020	Patients with a history of cardiovascular disease.

Prescription Drug Program

Drug	Code	Criteria
Ambien® (<i>zolpidem tartrate</i>)	006	Treatment of insomnia. Limited to a 30 units per 30 day supply on initial fill, and 10 units per 30 days on all subsequent fills.
Ambien CR® (<i>zolpidem tartrate</i>)	006	Treatment of insomnia. Limited to a 30 units per 30 day supply on initial fill, and 10 units per 30 days on all subsequent fills.
Amevive® (<i>alefacept</i>)	018	Treatment of plaque psoriasis when prescribed by a rheumatologist or dermatologist in patients who are candidates for systemic or phototherapy. Maximum dose of 7.5mg intravenous bolus or 15mg intramuscular injection once a week.
Amitiza® (<i>lubiprostone</i>)	007	Treatment of chronic constipation. Must have tried and failed a less costly alternative.
Angiotensin Receptor Blockers (ARBs)	092	Must have tried and failed, or have a clinically documented intolerance to an angiotensin converting enzyme (ACE) inhibitor.
<p>Atacand® (<i>candesartan cilexetil</i>) Atacand HCT® (<i>candesartan cilexetil/HCTZ</i>) Avalide® (<i>irbesartan/HCTZ</i>) Avapro® (<i>irbesartan</i>) Benicar® (<i>olmesartan medoxomil</i>) Benicar HCT® (<i>olmesartan medoxomil/HCTZ</i>) Cozaar® (<i>losartan potassium</i>) Diovan® (<i>valsartan</i>) Diovan HCT® (<i>valsartan/HCTZ</i>) Hyzaar® (<i>losartan potassium/HCTZ</i>) Micardis® (<i>telmisartan</i>) Micardis HCT® (<i>telmisartan/HCTZ</i>) Teveten® (<i>eprosartan mesylate</i>) Teveten HCT® (<i>eprosartan mesylate/HCTZ</i>)</p>		
Anzemet® (<i>dolasetron mesylate</i>)	127	Prevention of nausea or vomiting associated with moderately to highly emetogenic cancer chemotherapy.
Arava® (<i>leflunomide</i>)	034	Treatment of rheumatoid arthritis when prescribed by a rheumatologist at a loading dose of 100mg per day for three days and then up to 20mg daily thereafter.

Prescription Drug Program

Drug	Code	Criteria
Atacand® (<i>candesartan cilexetil</i>)	092	Must have tried and failed, or have a clinically documented intolerance to an angiotensin converting enzyme (ACE) inhibitor.
Atacand HCT® (<i>candesartan cilexetil/HCTZ</i>)	092	Must have tried and failed, or have a clinically documented intolerance to an angiotensin converting enzyme (ACE) inhibitor.
Avalide® (<i>irbesartan/HCTZ</i>)	092	Must have tried and failed, or have a clinically documented intolerance to an angiotensin converting enzyme (ACE) inhibitor.
Avapro® (<i>irbesartan</i>)	092	Must have tried and failed, or have a clinically documented intolerance to an angiotensin converting enzyme (ACE) inhibitor.
Avinza® (<i>morphine sulfate</i>)	040	Diagnosis of cancer-related pain.
Azor® (<i>amlodipine/olmesartan</i>)	093	Must have tried and failed, or have a clinically documented intolerance to an angiotensin converting enzyme (ACE) inhibitor, and must have a history of dihydropyridine calcium channel blocker and/or angiotensin receptor blocker (ARB) therapy.
Benicar® (<i>olmesartan medoxomil</i>)	092	Must have tried and failed, or have a clinically documented intolerance to an angiotensin converting enzyme (ACE) inhibitor.
Benicar HCT® (<i>olmesartan meoxomil/HCTZ</i>)	092	Must have tried and failed, or have a clinically documented intolerance to an angiotensin converting enzyme (ACE) inhibitor.
bupropion/SR	014	Not for smoking cessation.
Calcium w/Vitamin D Tablets	126	Confirmed diagnosis of osteoporosis, osteopenia, or osteomalacia.

Prescription Drug Program

Drug	Code	Criteria
Campral® (<i>acamprosate sodium</i>)	041	<p>Diagnosis of alcohol dependency. Must be used as adjunctive treatment with a Division of Alcohol and Substance Abuse (DASA) state-certified intensive outpatient chemical dependency treatment program. See WAC 388-805-610. Treatment is limited to 12 months. The patient must also meet all of the following criteria:</p> <ul style="list-style-type: none"> a) Must have finished detoxification and must be abstinent from alcohol before the start of treatment; b) Must not be a poly-substance abuser; and c) Must be able to clear the drug renally (creatinine clearance greater than 30 ml/min). <p>Note: A Campral authorization form, DSHS 13-749, must be completed and kept on file with the pharmacy before the drug is dispensed. To download a copy, go to: http://www1.dshs.wa.gov/msa/forms/eforms.html.</p>
Celebrex®	062	<p>All of the following must apply:</p> <ul style="list-style-type: none"> c) An absence of a history of ulcer or gastrointestinal bleeding; and d) An absence of a history of cardiovascular disease.
Clarinex® syrup (<i>desloratadine</i>)	012	Patient is at least 6 months, but less than 2 years, of age.
Copegus® (<i>ribavirin</i>)	010	Diagnosis of chronic hepatitis C virus infection in patients 18 years of age or older. Patient must be on concomitant alpha interferon or pegylated alpha interferon therapy (not to be used as monotherapy).
Coreg® (<i>carvedilol</i>)	057	Diagnosis of congestive heart failure.
Cozaar® (<i>losartan potassium</i>)	092	Must have tried and failed, or have a clinically documented intolerance to an angiotensin converting enzyme (ACE) inhibitor.
Cymbalta® (<i>duloxetine</i>)	163	Treatment of diabetic peripheral neuropathy.
	166	Treatment of fibromyalgia.
Diovan® (<i>valsartan</i>)	092	Must have tried and failed, or have a clinically documented intolerance to an angiotensin converting enzyme (ACE) inhibitor.

Prescription Drug Program

Drug	Code	Criteria
Diovan HCT® (<i>valsartan/ HCTZ</i>)	092	Must have tried and failed, or have a clinically documented intolerance to an angiotensin converting enzyme (ACE) inhibitor.
Dolophine® (<i>methadone HCl</i>)	040	Diagnosis of cancer-related pain.
Duragesic® (<i>fentanyl</i>)	040	Diagnosis of cancer-related pain.
Enbrel® (<i>etanercept</i>)	017	Treatment of rheumatoid arthritis or ankylosing spondylitis when prescribed by a rheumatologist up to 50mg subcutaneously per week for patients who have had an inadequate response to one or more Disease Modifying Anti Rheumatoid Drug (DMARD).
	024	Treatment of psoriatic arthritis when prescribed by a rheumatologist or dermatologist up to 50mg subcutaneously per week for patients who have had an inadequate response to one or more DMARD.
	025	Treatment of plaque psoriasis in patients 18 years of age and older when prescribed by a rheumatologist or dermatologist. Dose not to exceed 50mg subcutaneously twice weekly for the first three months of therapy and not to exceed 50mg weekly thereafter.
	026	Treatment of moderately to severely active polyarticular juvenile idiopathic arthritis when prescribed by a rheumatologist for patients ages 2 and older who have had an inadequate response to one or more DMARD. Dose not to exceed 0.8 mg/kg subcutaneously per week and/or 50 mg per week.
Exforge® (<i>amlodipine/ valsartan</i>)	093	Must have tried and failed, or have a clinically documented intolerance to an angiotensin converting enzyme (ACE) inhibitor, and must have a history of dihydropyridine calcium channel blocker and/or angiotensin receptor blocker (ARB) therapy.
Gabitril® (<i>tiagabine HCl</i>)	036	Treatment of seizures.

Prescription Drug Program

Drug	Code	Criteria
Geodon® IM Injection <i>(ziprasidone mesylate)</i>	058	All of the following must apply: a) Diagnosis of acute agitation associated with schizophrenia; b) Patient is 18 years of age or older; and c) Maximum dose of 40mg per day and no more than 3 consecutive days of treatment.
<p>Note: Because Geodon® prolongs the QT interval (< Seroquel® > Risperdal® > Zyprexa®), it is contraindicated in patients with a known history of QT prolongation (including a congenital long QT syndrome), with recent acute myocardial infarction, or with uncompensated heart failure; and in combination with other drugs that prolong the QT interval.</p>		
Glycolax Powder® <i>(polyethylene glycol)</i>	021	Treatment of occasional constipation. Must have tried and failed a less costly alternative.

Prescription Drug Program

Drug	Code	Criteria
Humira® (<i>adalimumab</i>)	022	Treatment of Crohn’s disease when prescribed by a gastroenterologist for patients who have tried and failed conventional therapy. 160mg subcutaneous dose to start, 80mg at week 2, and then maximum dose of 40mg subcutaneously every other week.
	023	Treatment of rheumatoid arthritis or ankylosing spondylitis when prescribed by a rheumatologist for patients who have had an inadequate response to one or more Disease Modifying Anti Rheumatoid Drug (DMARD). Maximum dose is 40mg subcutaneously every other week if taking concomitant methotrexate, and is 40mg per week if patient is not taking methotrexate.
	028	Treatment of psoriatic arthritis when prescribed by a rheumatologist or dermatologist for patients who have had an inadequate response to one or more DMARD. Maximum dose is 40mg subcutaneously every other week if taking concomitant methotrexate, and is 40mg per week if patient is not taking methotrexate.
	056	Treatment of plaque psoriasis in patients 18 years of age and older when prescribed by a rheumatologist or dermatologist. Maximum dose is 40mg subcutaneously every other week after the initial single 80mg loading dose.
	061	Treatment of moderately to severely active polyarticular juvenile idiopathic arthritis when prescribed by a rheumatologist for patients age 4 years and older who have had an inadequate response to one or more DMARD. Maximum dose is 20mg subcutaneously every other week in patients weighing 15kg to <30kg, and 40mg every other week in patients weighing ≥30kg.
Hyzaar® (<i>losartan potassium/HCTZ</i>)	092	Must have tried and failed, or have a clinically documented intolerance to an angiotensin converting enzyme (ACE) inhibitor.
Infergen® (<i>interferon alphcon-1</i>)	134	Treatment of chronic hepatitis C in patients 18 years of age and older with compensated liver disease who have anti-HCV serum antibodies and/or presence of HCV RNA.

Prescription Drug Program

Drug	Code	Criteria
Intron A® (<i>interferon alpha-2b recombinant</i>)	030	Diagnosis of hairy cell leukemia in patients 18 years of age and older.
	031	Diagnosis of recurring or refractory condyloma acuminata (external genital/perianal area) for intralesional treatment in patients 18 years of age and older.
	032	Diagnosis of AIDS-related Kaposi's sarcoma in patients 18 years of age and older.
	033	Diagnosis of chronic hepatitis B in patients 1 year of age and older.
	107	Diagnosis of malignant melanoma in patients 18 years of age and older.
	109	Treatment of chronic hepatitis C in patients 18 years of age and older.
	135	Diagnosis of follicular non-Hodgkin's lymphoma in patients 18 years of age and older.
Kadian® (<i>morphine sulfate</i>)	040	Diagnosis of cancer-related pain.
Keppra® /XR (<i>levetiracetam</i>)		See criteria for Gabitril®.
Kineret® Injection (<i>anakinra</i>)	029	Treatment of rheumatoid arthritis when prescribed by a rheumatologist for patients 18 years of age and older who have tried and failed one or more DMARD. Daily dose not to exceed 100mg subcutaneously.
Kytril® (<i>granisetron HCl</i>)	127	Prevention of nausea or vomiting associated with moderately to highly emetogenic cancer chemotherapy.
	128	Prevention of nausea or vomiting associated with radiation therapy.
Lamisil® (<i>terbinafine HCl</i>)		Treatment of onychomycosis for up to 12 months is covered if patient has one of the following conditions:
	042	Diabetic foot;
	043	History of cellulitis secondary to onychomycosis and requiring systemic antibiotic therapy;
	051	Peripheral vascular disease; or
	052	Patient is immunocompromised.

Prescription Drug Program

Drug	Code	Criteria
Levorphanol	040	Diagnosis of cancer-related pain.
Lotrel® (<i>amlodipine-besylate/ benazepril</i>)	038	Treatment of hypertension as a second-line agent when blood pressure is not controlled by any: a) ACE inhibitor alone; or b) Calcium channel blocker alone; or c) ACE inhibitor and a calcium channel blocker as two separate concomitant prescriptions.
Lunesta™ (<i>eszopiclone</i>)	006	Treatment of insomnia. Limited to a 30 units per 30 day supply on initial fill, and 10 units per 30 days on all subsequent fills.
Lyrica® (<i>pregabalin</i>)	035	Treatment of post-herpetic neuralgia.
	036	Treatment of seizures.
	063	Treatment of diabetic peripheral neuropathy.
	066	Treatment of fibromyalgia.
Micardis® (<i>telmisartan</i>)	092	Must have tried and failed, or have a clinically documented intolerance to an angiotensin converting enzyme (ACE) inhibitor.
Micardis HCT® (<i>telmisartan/ HCTZ</i>)	092	Must have tried and failed, or have a clinically documented intolerance to an angiotensin converting enzyme (ACE) inhibitor.
Miralax® (<i>polyethylene glycol</i>)		See criteria for Glycolax Powder®.
MS Contin® (<i>morphine sulfate ER</i>)	040	Diagnosis of cancer-related pain.
Nasonex® (<i>mometasone furoate</i>)	015	Patient is 2 to 6 years of age.
Naltrexone		See criteria for ReVia®.

Prescription Drug Program

Drug	Code	Criteria
Nephrocaps®, Nephro-Fer®, Nephro-vite®, Nephro-Vite® Rx, Nephro- vite® +Fe, and Nephron® FA	096	Treatment of patients with renal disease.
Neurontin® (gabapentin)	035	Treatment of post-herpetic neuralgia.
	036	Treatment of seizures.
	063	Treatment of diabetic peripheral neuropathy.
Non-Steroidal Anti- Inflammatory Drugs (NSAIDs)	141	An absence of a history of ulcer or gastrointestinal bleeding.
<p>Arthrotec® (<i>diclofenac/misoprostol</i>) diclofenac potassium diflunisal diclofenac sodium SR/ER/EC etodolac /ER fenoprofen Flector® (<i>diclofenac epolamine</i>) flurbiprofen ibuprofen ibuprofen/hydrocodone (Vicoprofen®) indomethacin /SR ketoprofen /SR ketorolac meclofenamate meloxicam nabumetone naproxen /EC naproxen sodium /ER oxaprozin piroxicam Ponstel® (<i>mefenamic acid</i>) salsalate sulindac tolmetin Voltaren® (<i>diclofenac sodium</i>) gel</p>		

Prescription Drug Program

Drug	Code	Criteria
Opana ER® (<i>Oxymorphone HCl ER</i>)	040	Diagnosis of cancer-related pain.
Orencia® (<i>abatacept</i>)	044	Treatment of rheumatoid arthritis when prescribed by a rheumatologist in patients who have tried and failed one or more DMARDs. Maintenance dose is limited to 1000mg as an intravenous infusion every 4 weeks after the initial 4 weeks of therapy (allowed to be dosed every 2 weeks during first 4 weeks of therapy).
Oxandrin® (<i>oxandrolone</i>)		Before any code is allowed, there must be an absence of all of the following: a) Hypercalcemia; b) Nephrosis; c) Carcinoma of the breast; d) Carcinoma of the prostate; and e) Pregnancy.
	110	Treatment of unintentional weight loss in patients who have had extensive surgery, severe trauma, chronic infections (such as AIDS wasting), or who fail to maintain or gain weight for no conclusive pathophysiological cause.
	111	To compensate for the protein catabolism due to long-term corticosteroid use.
	112	Treatment of bone pain due to osteoporosis.
OxyContin® (<i>oxycodone HCl</i>)	040	Diagnosis of cancer-related pain.
Parcopa® (<i>carbidopa/levodopa</i>)	049	Diagnosis of Parkinson's disease and one of the following: a) Must have tried and failed generic carbidopa/levodopa; or b) Be unable to swallow solid oral dosage forms.
Plavix® (<i>clopidogrel bisulfate</i>)	116	When used in conjunction with stent placement in coronary arteries. Supply limited to 9 months after stent placement.
	136	For use in patients with atherosclerosis documented by recent myocardial infarction, recent stroke, or established peripheral artery disease and have failed aspirin. A patient that is considered an aspirin failure has had an atherosclerotic event (MI, stroke, intermittent claudication) after the initiation of once-a-day aspirin therapy.

Prescription Drug Program

Drug	Code	Criteria
Pravastatin	039	Patient has a clinical drug-drug interaction with other statin-type cholesterol-lowering agents.
Prevacid® SoluTab™ (lansoprazole)	050	Inability to swallow oral tablets or capsules.
Pulmozyme® (dornase alpha)	053	Diagnosis of cystic fibrosis and the patient is 5 years of age or older.
Raptiva® (efalizumab)	027	Treatment of plaque psoriasis when prescribed by a dermatologist for patients 18 years or older. Weekly dose is not to exceed 200mg subcutaneously.
Rebetol® (ribavirin)		See criteria for Copegus®.
Rebetron® (ribavirin/ interferon alpha-2b, recombinant)	008	Treatment of chronic hepatitis C in patients with compensated liver disease who have relapsed following alpha interferon therapy.
	009	Treatment of chronic hepatitis C in patients with compensated liver disease.
Remicade Injection® (infliximab)	046	Treatment of ulcerative colitis when prescribed by a gastroenterologist in those patients who have tried and failed conventional therapy. Maximum maintenance dose is 5mg/kg given every 8 weeks after the induction regimen of 5mg/kg given at week 2 and week 6 of therapy.
Rena-Vite® Rena-Vite RX® (folic acid/vit B comp W-C)	096	Treatment of patients with renal disease.

Prescription Drug Program

Drug	Code	Criteria
ReVia® <i>(naltrexone HCl)</i>	067	Diagnosis of past opioid dependency or current alcohol dependency. Must be used as adjunctive treatment within a state-certified intensive outpatient chemical dependency treatment program. See WAC 388-805-610. For maintenance of opioid-free state in a detoxified person, treatment may be started only after a minimum of 7-10 days free from opioid use. Treatment period must be limited to 12 weeks or less, and the patient must have an absence of all of the following:
		a) Acute liver disease; and b) Liver failure; and c) Pregnancy.
Note: A ReVia® (<i>Naltrexone</i>) Authorization Form, DSHS 13-677, must be on file with the pharmacy before the drug is dispensed. To download a copy, go to: http://www1.dshs.wa.gov/msa/forms/eforms.html		
Ribavirin		See criteria for Copegus®.
Risperdal® Consta® IM Injection <i>(risperidone microspheres)</i>	059	All of the following must apply: a) There is an appropriate DSM IV diagnosis with a psychotic disorder; b) Patient is 18 to 65 years of age; c) Patient has established tolerance to oral risperidone prior to initiating Risperdal Consta®; and d) Total daily dose is not more than 9mg/day (injectable plus oral at an injectable conversion rate of 25 mg every two weeks IM = 2 mg every day oral).
Rituxan® <i>(rituximab)</i>	054	Treatment of non-Hodgkin's lymphoma.
	055	Treatment of rheumatoid arthritis when prescribed by a rheumatologist in combination with methotrexate in patients who have failed another tumor necrosis factor (TNF) inhibitor. Limited to 2 1000mg intravenous infusions separated by 2 weeks.

Prescription Drug Program

Drug	Code	Criteria
Roferon-A® (<i>interferon alpha-2a recombinant</i>)	030	Diagnosis of hairy cell leukemia in patients 18 years of age and older.
	032	Diagnosis of AIDS-related Kaposi's sarcoma in patients 18 years of age and older.
	080	Diagnosis of chronic phase, Philadelphia chromosome (Ph) positive chronic myelogenous leukemia (CML) when treatment started within one year of diagnosis.
	109	Treatment of chronic hepatitis C in patients 18 years of age and older.
Sonata® (<i>zaleplon</i>)	006	Treatment of insomnia. Limited to a 30 units per 30 day supply on initial fill, and 10 units per 30 days on all subsequent fills.
Soriatane® (<i>acitretin</i>)	064	Treatment of severe, recalcitrant psoriasis in patients 16 years of age and older. Prescribed by, or in consultation with, a dermatologist, and the patient must have an absence of all of the following: a) Current pregnancy or pregnancy which may occur while undergoing treatment; and b) Hepatitis; and c) Concurrent retinoid therapy.
Sporanox® (<i>itraconazole</i>)		Must not be used for a patient with cardiac dysfunction such as congestive heart failure.
	047	Treatment of systemic fungal infections and dermatomycoses.
		Treatment of onychomycosis for up to 12 months is covered if patient has one of the following conditions:
	042	Diabetic foot;
	043	History of cellulitis secondary to onychomycosis and requiring systemic antibiotic therapy;
	051	Peripheral vascular disease; or
	052	Patient is immunocompromised.

Prescription Drug Program

Drug	Code	Criteria
Symbyax® (olanzapine/ fluoxetine HCl)	048	All of the following must apply: a) Diagnosis of depressive episodes associated with bipolar disorder; and b) Patient is 6 years of age or older.
Talacen® (pentazocine HCl/ acetaminophen) Talwin NX® (pentazocine/ naloxone)	091	Patient must be 12 years of age or older and has tried and failed two NSAIDs or failed one other narcotic analgesic and is allergic or sensitive to codeine.
Teveten® (eprosartan mesylate)	092	Must have tried and failed, or have a clinically documented intolerance to an angiotensin converting enzyme (ACE) inhibitor.
Teveten HCT® (eprosartan mesylate/HCTZ)	092	Must have tried and failed, or have a clinically documented intolerance to an angiotensin converting enzyme (ACE) inhibitor.
Toprol XL® (metoprolol succinate)	057	Diagnosis of congestive heart failure.
Topamax®/ Topamax® Sprinkle (topiramate)	036	Treatment of seizures.
	045	Migraine prophylaxis.
Vancomycin oral	069	Diagnosis of clostridium difficile toxin and one of the following: a) The patient has failed to respond after 2 days of metronidazole treatment; or b) The patient is intolerant to metronidazole; or c) Metronidazole is contraindicated due to drug-drug interaction(s).
Vitamin E	105	Confirmed diagnosis of tardive dyskinesia or is clinically necessary for Parkinsonism and all of the following: a) Caution is addressed for concurrent anticoagulant treatment; and b) Dosage does not exceed 3,000 IU per day.

Prescription Drug Program

Drug	Code	Criteria
Wellbutrin SR® and XL® (<i>bupropion HCl</i>)	014	Not for smoking cessation.
Zofran® (<i>ondansetron HCl</i>)		See criteria for Kytril®.
Zolpidem	006	Treatment of insomnia. Limited to a 30 units per 30 day supply on initial fill, and 10 units per 30 days on all subsequent fills.
Zometa® (<i>zoledronic acid</i>)	011	Diagnosis of Hypercalcemia associated with malignant neoplasms with or without metastases; or multiple myeloma; or bone metastases of solid tumors.
Zyprexa® IM Injection (<i>olanzapine</i>)	060	All of the following must apply: a) Diagnosis of acute agitation associated with psychotic disorder, including bipolar disorder; b) Before any subsequent doses are given, patient has been evaluated for postural hypotension and no postural hypotension is present; c) Patient is 18 to 65 years of age; and d) Maximum dose of 30 mg in a 24 hour period.
Zyvox® Injectable (<i>linezolid</i>)	013	Treatment of vancomycin resistant infection.
Zyvox® Oral (<i>linezolid</i>)	013	Treatment of vancomycin resistant infection
	016	Outpatient treatment of methacillin resistant staph aureus (MRSA) infections when IV vancomycin is contraindicated, such as: a) Allergy; or b) Inability to maintain IV access.

Washington Preferred Drug List

What is the Washington Preferred Drug List?

DSHS, in coordination with the Health Care Authority (HCA) and Labor & Industries (L & I), have developed a list of preferred drugs within a chosen therapeutic class that are selected based on clinical evidence of safety, efficacy, and effectiveness. The drugs within a chosen therapeutic class are studied by an evidence-based practice center (EPC). A written report on the comparative safety, efficacy, and effectiveness from the EPC is evaluated by the Washington State Pharmacy and Therapeutic Committee which makes recommendations to the state agencies regarding the selection of the preferred drugs on the Washington Preferred Drug List (PDL). [WAC 388-530-4100]

What is the process to obtain drugs on the Washington PDL?

1. **Preferred Drugs** - Prescription claims for preferred drugs submitted to DSHS are reimbursed without authorization requirements unless the drug requires authorization for:
 - a. Safety criteria;
 - b. Special subpopulation criteria; or
 - c. Limits based on age, gender, dose, or quantity.
2. **Non-preferred Drugs** - Prescription claims for non-preferred drugs submitted to DSHS are reimbursed without authorization requirements when written by an Endorsing Practitioner who has indicated “DAW” on the prescription unless the drug requires restrictions for safety. See WAC 388-530-4150.
3. Prescription claims for non-preferred drugs submitted to DSHS are reimbursed only after authorizing criteria are met if written by a non-endorsing practitioner.
4. Pharmacies must call DSHS for authorization when required. Call 1-800-848-2842 (Option 2) or fax to **1-360-725-2141**.

What are the authorization criteria that must be met to obtain a non-preferred drug?

- For most drug classes on the Washington PDL, the authorization criteria is that the client must have tried and failed, or is intolerant to, at least one preferred drug. Drugs may have criteria that go beyond these basic criteria for the reasons stated in #1 on the previous page.
- Drugs that are in drug classes on the Washington PDL that have not been studied by the evidence-based practice center(s) and have not been reviewed by the P&T committee will be treated as non-preferred drugs and will require authorization.

DSHS requires pharmacies to obtain authorization for non-preferred drugs when a therapeutic equivalent is on the Washington PDL. The following table shows the preferred and non-preferred drug in each therapeutic drug class on the Washington PDL:

Note: DSHS changed the format for multiple drug listings. A slash (/) is used to denote multiple forms of a drug. For example: “Cardizem[®] /CD/LA/SR” represents immediate release Cardizem, as well as the CD, LA, and SR forms. A hyphen (-) is used to indicate combination products. For example: “benazepril-HCTZ” represents the combination product of benazepril and hydrochlorothiazide, rather than benazepril AND the combination product.

Drug Class	Preferred Drugs	Non-preferred Drugs
ACE Inhibitors	<p>Generic: benazepril captopril enalapril lisinopril ramipril*</p> <p>*EA required</p>	<p>Generic: fosinopril moexipril quinapril trandolapril</p> <p>Brand: Accupril[®] (<i>quinapril</i>) Aceon[®] (<i>perindopril</i>) Altace[®] (<i>ramipril</i>) Capoten[®] (<i>captopril</i>) Lotensin[®] (<i>benazepril</i>) Mavik[®] (<i>trandolapril</i>) Monopril[®] (<i>fosinopril</i>) Prinivil[®] (<i>lisinopril</i>) Univasc[®] (<i>moexipril</i>) Vasotec[®] (<i>enalapril</i>) Zestril[®] (<i>lisinopril</i>)</p>

Prescription Drug Program

Drug Class	Preferred Drugs	Non-preferred Drugs
<p>Alzheimer's Drugs</p> <p>(Not subject to therapeutic interchange program (TIP). See pg. 1.)</p>	<p>Brand: Aricept® /ODT(<i>donepezil</i>) Namenda™ (<i>memantine</i>)</p>	<p>Brand: Cognex® (<i>tacrine</i>) Exelon® (<i>rivastigmine</i>) patch** Exelon® (<i>rivastigmine</i>) capsule/solution Razadyne® /ER (<i>galantamine</i>)</p> <p>**Not subject to DAW-1 override.</p>
<p>Antiemetics</p>	<p>Generic: ondansetron tablet/solution/ injection*</p> <p>*EA required</p>	<p>Generic: granisetron tablet/injection</p> <p>Brand: Aloxi® (<i>palonosetron</i>) injection* Anzemet® (<i>dolasetron</i>) tablet/injection* Granisol® (<i>granisetron</i>) solution Kytril® (<i>granisetron</i>) tablet/solution/injection* Sancuso® (<i>granisetron</i>) transdermal patch** Zofran®/ODT® (<i>ondansetron</i>) tablet/solution/injection*</p> <p>*EA required **Not subject to TIP or DAW-1 override.</p>
<p>Antiplatelets</p> <p>(Not subject to TIP. See pg. 1.)</p>	<p>Generic:</p> <p>Brand: Aggrenox® (<i>dipyridamole/aspirin ER</i>)* Plavix® (<i>clopidogrel bisulfate</i>)*</p> <p>*EA required</p>	<p>Generic: ticlopidine</p> <p>Brand: Ticlid® (<i>ticlopidine</i>)</p>

Drug Class	Preferred Drugs	Non-preferred Drugs
<p>Attention Deficit/ Hyperactivity Disorder</p> <p>(Not subject to TIP. See pg. 1.)</p>	<p>Generic: amphetamine salt combo dexmethylphenidate dextroamphetamine dextroamphetamine SA methylphenidate methylphenidate SA Methylin® (methylphenidate HCl) tablet Methylin ER® (methylphenidate HCl)</p> <p>Brand: Adderall XR® (amphetamine salt combo) Concerta® (methylphenidate HCl) Daytrana™ (methylphenidate HCl) transdermal patch Focalin XR® (dexmethylphenidate) Metadate CD™ (methylphenidate HCl) Strattera® (atomoxetine HCl) Vyvanse™ (lisdexamfetamine dimesylate)</p>	<p>Generic: pemoline</p> <p>Brand: Adderall® (amphetamine salt combo) Dexedrine® (d-amphetamine) Dexedrine SA® (d-amphetamine) Dextrostat® (d-amphetamine) Focalin® (dexmethylphenidate) Metadate ER™ (methylphenidate HCl) Methylin® (methylphenidate HCl) chewable/solution Ritalin® (methylphenidate HCl) Ritalin LA® (methylphenidate HCl) Ritalin SR® (methylphenidate HCl)</p>

Drug Class	Preferred Drugs	Non-preferred Drugs
<p>Atypical Antipsychotic Drugs (Not subject to TIP. See pg. 1.)</p>	<p>Generic: clozapine tablet risperidone tablet/solution</p> <p>Brand: Abilify® (<i>aripiprazole</i>) tablet/solution/Discmelt® Abilify® (<i>aripiprazole</i>) IM injection* Fazacllo® (<i>clozapine</i>) disintegrating tablet Geodon® (<i>ziprasidone HCl</i>) capsule Geodon® (<i>ziprasidone mesylate</i>) IM injection* Invega™ (<i>paliperidone</i>) tablet Risperdal® (<i>risperidone</i>) M-tab® Risperdal Consta® (<i>risperidone</i>) injection* Seroquel® (<i>quetiapine</i>) tablet /XR Zyprexa® (<i>olanzapine</i>) tablet/ Zydis® tablet Zyprexa® (<i>olanzapine</i>) IM injection*</p> <p>*EA required</p>	<p>Generic:</p> <p>Brand: Clozaril® (<i>clozapine</i>) tablet Risperdal® (<i>risperidone</i>) tablet/solution</p>

Drug Class	Preferred Drugs	Non-preferred Drugs
Beta Blockers	<p>Generic: acebutolol atenolol bisoprolol carvedilol* labetalol metoprolol succinate* metoprolol tartrate nadolol pindolol propranolol timolol</p> <p>*EA required</p>	<p>Generic: betaxolol propranolol ER</p> <p>Brand: Blocadren® (<i>timolol</i>) Bystolic® (<i>nebivolol</i>)** Cartrol® (<i>carteolol</i>) Coreg® /CR® (<i>carvedilol</i>) Corgard® (<i>nadolol</i>) Inderal® /LA (<i>propranolol</i>) InnoPran XL® (<i>propranolol</i>) Kerlone® (<i>betaxolol</i>) Levatol® (<i>penbutolol</i>) Lopressor® (<i>metoprolol tartrate</i>) Sectral® (<i>acebutolol</i>) Tenormin® (<i>atenolol</i>) Toprol XL (<i>metoprolol succinate</i>) Trandate® (<i>labetalol</i>) Zebeta® (<i>bisoprolol</i>)</p> <p>**Not subject to TIP or DAW-1 override.</p>
Calcium Channel Blockers	<p>Generic: amlodipine diltiazem /XR felodipine ER nicardipine nifedipine ER verapamil /XR</p>	<p>Generic: isradipine nifedipine</p> <p>Brand: Adalat® /CC (<i>nifedipine</i>) Calan® /SR (<i>verapamil</i>) Cardene® SR (<i>nicardipine</i>) Cardizem® /CD/LA (<i>diltiazem</i>) Cartia XT® (<i>diltiazem</i>) Dilacor® XR (<i>diltiazem</i>) Diltia XT® (<i>diltiazem</i>) DynaCirc® /CR (<i>isradipine</i>) Isoptin® /SR (<i>verapamil</i>) Norvasc® (<i>amlodipine</i>) Plendil® (<i>felodipine</i>) Procardia® /XL (<i>nifedipine</i>) Sular® (<i>nisoldipine</i>) Taztia XT® (<i>diltiazem</i>) Tiazac® (<i>diltiazem</i>) Verelan® /PM (<i>verapamil</i>)</p>

Drug Class	Preferred Drugs	Non-preferred Drugs
Estrogens	<p>Generic Oral: estradiol tablets</p> <p>Brand Oral: Menest® (<i>esterified estrogens</i>)</p>	<p>Generic Oral: estropipate</p> <p>Brand Oral: Cenestin® (<i>synthetic conjugated estrogens</i>) Enjuvia® (<i>synthetic conjugated estrogens</i>) Estrace® (<i>estradiol</i>) oral Femtrace® (<i>estradiol</i>) Ogen® (<i>estropipate</i>) Ortho-Est® (<i>estropipate</i>) Premarin® (<i>conjugated equine estrogens</i>) oral</p>
	<p>Generic Transdermal: estradiol transdermal patch</p> <p>Brand Transdermal:</p>	<p>Generic Transdermal:</p> <p>Brand Transdermal: Alora® (<i>estradiol</i>) transdermal Climara® (<i>estradiol</i>) transdermal Divigel® (<i>estradiol</i>) gel Elestrin™ (<i>estradiol</i>) gel Estraderm® (<i>estradiol</i>) transdermal Estrasorb® (<i>estradiol</i>) emulsion Estrogel® (<i>estradiol</i>) gel Evamist® (<i>estradiol</i>) spray** Menostar® (<i>estradiol</i>) patch Vivelle® /DOT (<i>estradiol</i>) transdermal</p> <p>**Not subject to TIP or DAW-1 override.</p>
	<p>Generic Topical:</p> <p>Brand Topical: Vagifem® (<i>estradiol</i>) vaginal tablets</p>	<p>Generic Topical:</p> <p>Brand Topical: Estrace® (<i>estradiol</i>) vaginal cream Estring® (<i>estradiol</i>) vaginal ring Femring® (<i>estradiol</i>) vaginal ring Premarin® (<i>conjugated equine estrogen</i>) vaginal cream</p>

Prescription Drug Program

Drug Class	Preferred Drugs	Non-preferred Drugs
Estrogen-Progestin Combinations	Brand Oral: Activella® (<i>estradiol/norethindrone</i>) Premphase® (<i>conjugated equine estrogens/medroxyprogesterone</i>) Prempro® (<i>conjugated equine estrogens/medroxyprogesterone</i>)	Brand Oral: Angeliq® (<i>estradiol/drospirenone</i>) Femhrt® (<i>ethinyl estradiol/norethindrone</i>) Prefest® (<i>estradiol/norgestimate</i>)
	Brand Transdermal: Climara Pro® (<i>estradiol/levonorgestrel</i>)	Brand Transdermal: Combipatch® (<i>estradiol/norethindrone</i>)
Hepatitis C drugs (pegylated interferons) (Not subject to TIP. See page 1.)	Pegasys® (<i>peginterferon alfa-2a</i>)	PegIntron® (<i>peginterferon alfa-2b</i>)
Histamine-2 Receptor Antagonist (H2RA) (Not subject to TIP. See pg. 1.)	Generic: ranitidine	Generic: cimetidine famotidine nizatidine Brand: Axid® (<i>nizatidine</i>) Pepcid® (<i>famotidine</i>) Tagamet® (<i>cimetidine</i>) Zantac® (<i>ranitidine</i>)

Drug Class	Preferred Drugs	Non-preferred Drugs
Inhaled Beta-Agonists	<p>Generic short-acting nebulized: albuterol inhalation solution metaproterenol inhalation solution</p> <p>Brand short-acting nebulized: Xopenex® (<i>levalbuterol</i>) inhalation solution</p> <p>Generic short-acting inhaled: albuterol inhaler</p> <p>Brand short-acting inhaled: Alupent® (<i>metaproterenol</i>) inhaler Ventolin® HFA (<i>albuterol</i>) inhaler Xopenex® HFA (<i>levalbuterol</i>) inhaler</p> <p>Brand long-acting : Foradil® Aerolizer® (<i>formoterol</i>) Serevent® Diskus® (<i>salmeterol</i>)</p>	<p>Brand short-acting nebulized: Accuneb® (<i>albuterol</i>) inhalation solution Proventil® (<i>albuterol</i>) inhalation solution</p> <p>Brand short-acting inhaled: Maxair Autohaler™ (<i>pirbuterol</i>) inhaler ProAir™ HFA (<i>albuterol</i>) inhaler Proventil® (<i>albuterol</i>) inhaler Proventil® HFA (<i>albuterol</i>) inhaler</p> <p>Brand long-acting (nebulized): Brovana™ (<i>arformoterol</i>)** Perforomist™ (<i>formoterol</i>)**</p> <p>**Not subject to TIP or DAW-1 override.</p>
Inhaled Corticosteroids	<p>Generic:</p> <p>Brand: Aerobid/Aerobid-M® (<i>flunisolide</i> <i>MDI</i>) Asmanex Twisthaler® (<i>mometasone furoate DPI</i>) Azmacort® (<i>triamcinolone</i> <i>acetone MDI</i>) Flovent® HFA/Diskus® (<i>fluticasone propionate HFA/DPI</i>) Qvar® (<i>beclomethasone</i> <i>dipropionate MDI</i>) Pulmicort Respules® (<i>budesonide</i> <i>inhalation suspension</i>) Pulmicort Turbuhaler®/Flexhaler® (<i>budesonide DPI</i>)</p>	<p>Generic:</p> <p>Brand: Alvesco® (<i>ciclesonide HFA</i>)**</p> <p>**Not subject to TIP or DAW-1 override.</p>

Prescription Drug Program

Drug Class	Preferred Drugs	Non-preferred Drugs
<p>Insulin-release stimulant type oral hypoglycemics</p>	<p>Generic immediate release: glipizide glyburide glyburide micronized</p>	<p>Generic: chlorpropamide glimepiride glipizide XR tolazamide tolbutamide</p> <p>Brand: Amaryl® (<i>glimepiride</i>) Diabinese® (<i>chlorpropamide</i>) DiaBeta® (<i>glyburide</i>) Glucotrol® /XR (<i>glipizide</i>) Glynase® (<i>glyburide micronized</i>) Micronase® (<i>glyburide</i>) Prandin® (<i>repaglinide</i>) Starlix® (<i>nateglinide</i>) Tolinase® (<i>tolazamide</i>)</p>
<p>Long-Acting Opioids (oral tabs/caps/liquids) (Not subject to TIP. See pg. 1.)</p>	<p>Generic: methadone morphine sulfate /SA/SR</p>	<p>Generic: fentanyl transdermal levorphanol oxycodone ER Oramorph® SR</p> <p>Brand: Avinza® (<i>morphine sulfate ER</i>) Dolophine® (<i>methadone</i>) Duragesic® (<i>fentanyl</i>) transdermal Kadian® (<i>morphine sulfate SR</i>) Kadian® 200mg (<i>morphine sulfate SR</i>)** Levo-Dromoran® (<i>levorphanol</i>) MS Contin® (<i>morphine sulfate SA</i>) Opana ER® (<i>oxymorphone HCl</i>) OxyContin® (<i>oxycodone ER</i>)</p> <p>**Not subject to DAW-1 or EA overrides due to safety concerns (to prevent potential error/overdose).</p>

Drug Class	Preferred Drugs	Non-preferred Drugs
<p>Macrolides (Not subject to TIP. See pg. 1.)</p>	<p>Generic: azithromycin – all forms clarithromycin immediate release tablet/suspension erythromycin EC erythromycin ethylsuccinate erythromycin filmtab erythromycin stearate</p> <p>Brand: Ery-Tab 333mg® (<i>erythromycin base EC</i>)</p>	<p>Generic:</p> <p>Brand: Biaxin® (<i>clarithromycin</i>) tablet/suspension Biaxin XL® (<i>clarithromycin</i>) EES® (<i>erythromycin ethylsuccinate</i>) granules/suspension/filmtab Eryc® (<i>erythromycin base EC</i>) Eryped® (<i>erythromycin ethylsuccinate</i>) drops/granules Ery-Tab® (<i>erythromycin base EC</i>) Erythrocin® (<i>erythromycin stearate</i>) filmtab PCE Dispertab® (<i>erythromycin base</i>) Zithromax® (<i>azithromycin</i>) capsule/powder packet/suspension/tablet Zmax® (<i>azithromycin SR</i>)</p>
<p>Multiple Sclerosis Drugs (Not subject to TIP. See pg. 1.)</p>	<p>Generic: mitoxantrone</p> <p>Brand: Avonex® (<i>interferon β 1a</i>) Betaseron® (<i>interferon β 1b</i>) Copaxone® (<i>glatiramer acetate</i>) Rebif® (<i>interferon β 1a</i>) Tysabri® (<i>natalizumab</i>)*</p> <p>*PA required</p>	<p>Brand: Novantrone® (<i>mitoxantrone</i>)</p>

Drug Class	Preferred Drugs	Non-preferred Drugs
Nasal Corticosteroids	<p>Generic:</p> <p>Brand: Nasacort AQ® (<i>triamcinolone acetonide</i>) Nasonex® (<i>mometasone furoate</i>)*</p> <p>*EA required</p>	<p>Generic: flunisolide fluticasone propionate</p> <p>Brand: Beconase AQ® (<i>beclomethasone dipropionate</i>) Flonase® (<i>fluticasone propionate</i>) Nasacort® (<i>triamcinolone acetonide</i>) Nasarel® (<i>flunisolide</i>) Omnaris® (<i>ciclesonide</i>)** Rhinocort Aqua® (<i>budesonide</i>) Veramyst™ (<i>fluticasone</i>)**</p> <p>**Not subject to DAW-1 override or TIP.</p>
Newer Antihistamines (formerly Non-Sedating Antihistamines)	<p>Generic: loratadine OTC</p> <p>Brand: Clarinex® (<i>desloratadine</i>) syrup*</p> <p>*EA required</p>	<p>Generic: cetirizine fexofenadine</p> <p>Brand: Allegra /ODT® (<i>fexofenadine</i>) Clarinex® (<i>desloratadine</i>) Claritin® (<i>loratadine</i>) Zyrtec® (<i>cetirizine</i>) Xyzal® (<i>levocetirizine</i>)**</p> <p>**Not subject to TIP or DAW-1 override.</p>
Newer Sedative/Hypnotics	<p>Generic: zolpidem*</p> <p>*EA required</p>	<p>Generic: zaleplon*</p> <p>Brand: Ambien /CR® (<i>zolpidem tartrate</i>)* Lunesta® (<i>eszopiclone</i>)* Sonata® (<i>zaleplon</i>)*</p> <p>*EA required</p>

Drug Class	Preferred Drugs	Non-preferred Drugs
Nonsteroidal anti-inflammatory drugs (NSAID) including Cyclo-oxygenase - 2 (Cox-II) Inhibitors	<p>Generic: diclofenac potassium* diclofenac sodium /SR/ER/EC* diflunisal* etodolac /ER* fenoprofen* flurbiprofen* ibuprofen* indomethacin /SR* ketoprofen /SR* ketorolac* meclofenamate* meloxicam* nabumetone* naproxen /EC* naproxen sodium /ER/SA* oxaprozin* piroxicam* salsalate* sulindac* tolmetin*</p> <p>* EA required</p>	<p>Generic:</p> <p>Brand: Amigesic® (<i>salsalate</i>)* Anaprox® /DS (<i>naproxen sodium</i>)* Ansaid® (<i>flurbiprofen</i>)* Cataflam® (<i>diclofenac potassium</i>)* Celebrex® (<i>celecoxib</i>)** Clinoril® (<i>sulindac</i>)* Dolobid® (<i>diflunisal</i>) Daypro® (<i>oxaprozin</i>)* Feldene® (<i>piroxicam</i>)* Flector® (<i>diclofenac epolamine</i>)** Indocin® /SR (<i>indomethacin</i>)* Lodine® /XL (<i>etodolac</i>)* Mobic® (<i>meloxicam</i>)* Motrin® (<i>ibuprofen</i>)* Nalfon® (<i>fenoprofen</i>)* Naprelan® (<i>naproxen sodium ER</i>)* Naprosyn® EC/DS (<i>naproxen</i>)* Oruvail® (<i>ketoprofen SA</i>)* Ponstel® (<i>mefenamic acid</i>) Relafen® (<i>nabumetone</i>)* Salflex® (<i>salsalate</i>)* Voltaren® /XR (<i>diclofenac sodium</i>)* Voltaren® (<i>diclofenac sodium</i>) gel***</p> <p>* EA required ** Not subject to TIP and EA required *** Not subject to TIP or DAW-1 override, and EA required.</p>

Drug Class	Preferred Drugs	Non-preferred Drugs
Overactive Bladder/Urinary Incontinence	<p>Generic short acting: oxybutynin chloride tablets/syrup</p> <p>Generic long acting: oxybutynin ER</p> <p>Brand long acting: Oxytrol® (<i>oxybutynin chloride</i>) Vesicare® (<i>solifenacin succinate</i>)</p>	<p>Generic short acting: flavoxate HCl</p> <p>Brand short acting: Detrol® (<i>tolterodine tartrate</i>) Ditropan® (<i>oxybutynin chloride</i>) Sanctura® (<i>trospium chloride</i>) Urispas® (<i>flavoxate HCl</i>)</p> <p>Brand long acting: Detrol LA® (<i>tolterodine tartrate</i>) Ditropan XL® (<i>oxybutynin chloride</i>) Enablex® (<i>darifenacin hydrobromide</i>) Sanctura XR® (<i>trospium chloride</i>)</p>
Proton Pump Inhibitors	<p>Generic: omeprazole OTC omeprazole Rx pantoprazole</p> <p>Brand: Prilosec OTC® (<i>omeprazole magnesium</i>) tablets Prevacid® (<i>lansoprazole</i>) capsules Prevacid® SoluTab™ (<i>lansoprazole</i>)* Prevacid® (<i>lansoprazole</i>) suspension* Zegerid® (<i>omeprazole sodium bicarbonate</i>)</p> <p>*EA required</p>	<p>Generic:</p> <p>Brand: Aciphex® (<i>rabeprazole</i>) Nexium® (<i>esomeprazole</i>) Prilosec® Rx (<i>omeprazole</i>) Protonix® (<i>pantoprazole</i>)</p>

Prescription Drug Program

Drug Class	Preferred Drugs	Non-preferred Drugs
Second Generation Antidepressants (Not subject to TIP. See pg. 1.)	<p>Generic: bupropion /SR* citalopram fluoxetine HCl mirtazapine/soltab paroxetine HCl sertraline venlafaxine HCl</p> <p>Brand: Effexor® XR (<i>venlafaxine HCl</i>)</p> <p>*EA required</p>	<p>Generic: fluvoxamine nefazodone paroxetine CR venlafaxine XR</p> <p>Brand: Celexa® (<i>citalopram</i>) Cymbalta® (<i>duloxetine HCl</i>) Effexor® (<i>venlafaxine HCl</i>) Lexapro® (<i>escitalopram</i>) Luvox CR (<i>fluvoxamine</i>)** Paxil® /CR (<i>paroxetine HCl</i>) Pexeva® (<i>paroxetine mesylate</i>) Pristiq® (<i>desvenlafaxine</i>)** Prozac® /Prozac Weekly® (<i>fluoxetine HCl</i>) Remeron® /SolTab (<i>mirtazapine</i>) Wellbutrin® /SR/XL (<i>bupropion/SR/XL</i>) Zoloft® (<i>sertraline</i>)</p> <p>**Not subject to DAW-1 override.</p>
Skeletal Muscle Relaxants	<p>Generic: baclofen cyclobenzaprine methocarbamol tizanidine</p>	<p>Generic: carisoprodol chlorzoxazone dantrolene orphenadrine</p> <p>Brand: Amrix® (<i>cyclobenzaprine</i>) Dantrium® (<i>dantrolene</i>) Fexmid® (<i>cyclobenzaprine</i>) Flexeril® (<i>cyclobenzaprine</i>) Norflex® (<i>orphenadrine</i>) Parafon Forte® (<i>chlorzoxazone</i>) Robaxin® (<i>methocarbamol</i>) Skelaxin® (<i>metaxalone</i>) Soma® (<i>carisoprodol</i>) Zanaflex® (<i>tizanidine</i>)</p>

Drug Class	Preferred Drugs	Non-preferred Drugs
Statin-type cholesterol-lowering agents	<p>Generic: lovastatin pravastatin simvastatin</p> <p>Brand: Crestor[®] (<i>rosuvastatin</i>)</p>	<p>Generic:</p> <p>Brand: Altoprev[®] (<i>lovastatin</i>) Lescol[®] /XL (<i>fluvastatin</i>) Lipitor[®] (<i>atorvastatin</i>) Mevacor[®] (<i>lovastatin</i>) Pravachol[®] (<i>pravastatin</i>) Zocor[®] (<i>simvastatin</i>)</p>
Targeted Immune Modulators (Not subject to TIP. See pg. 1.)	<p>Generic:</p> <p>Brand: Enbrel[®] (<i>etanercept</i>)* Humira[®] (<i>adalimumab</i>)* Remicade[®] (<i>infliximab</i>)*</p> <p>*EA required</p>	<p>Generic:</p> <p>Brand: Amevive[®] (<i>alefacept</i>)* Kineret[®] (<i>anakinra</i>)* Orencia[®] (<i>abatacept</i>)* Raptiva[®] (<i>efalizumab</i>)* Rituxan[®] (<i>rituximab</i>)*</p> <p>*EA required</p>
Thiazolidinediones (TZDs)	<p>Generic:</p> <p>Brand: Avandia[®] tablet (<i>rosiglitazone maleate</i>)</p>	<p>Generic:</p> <p>Brand: Actos[®] tablet (<i>pioglitazone HCl</i>)</p>
Triptans	<p>Generic:</p> <p>Brand: Imitrex[®] (<i>sumatriptan</i>) tablet/nasal spray/injection Relpax[®] (<i>eletriptan</i>) Zomig[®] (<i>zolmitriptan</i>) tablet/nasal spray/ZMT[®]</p>	<p>Generic:</p> <p>Brand: Amerge[®] (<i>naratriptan</i>) Axert[®] (<i>almotriptan</i>) Frova[®] (<i>frovatriptan</i>) Maxalt[®] (<i>rizatriptan</i>) tablet/MLT[®]</p>