



BUREAU FOR MEDICAL SERVICES
WEST VIRGINIA MEDICAID

PREFERRED DRUG LIST WITH PRIOR AUTHORIZATION CRITERIA
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EFFECTIVE
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Version 2012.7b

Attachment C

Therapeutic Drug Class	Preferred Agents	Non-Preferred Agents	PA Criteria
ACNE AGENTS (Topical)^{1st}			
		ANTI-INFECTIVE	
			Thirty (30) day trials each of one preferred retinoid and two unique chemical entities in two other subclasses, including the generic version of a requested non-preferred product, are required before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present. (In cases of pregnancy, a trial of retinoids will not be required.)
			PA required after 17 years of age for tretinoin products.
		RETINOLIDS	
			Acne kits are non-preferred.
		KERATOLYTICS	
		COMBINATION AGENTS	

ACNE AGENTS (Topical)^{1st}

ANTHRAQUINONE

AZELEX (azelaic acid)
clindamycin gel, lotion, medicated swab,
solution
erythromycin gel, solution
sulfacetamide suspension

ANTI-INFECTIVE

ACZONE (dapson)
AKNE-MYCIN (erythromycin)
CLEOCIN-T (clindamycin)
CLINDACIN PAC (clindamycin)
CLINDAGEL (clindamycin)
clindamycin foam
erythromycin medicated swab
EVOCLIN (clindamycin)
KLARON (sodium sulfacetamide)
OVACE/PLUS (sulfacetamide)
sulfacetamide cleanser

RETIN A MICRO (tretinoin)
TAZORAC (tazarotene)

RETINOLIDS

adapalene
ATRALIN (tretinoin)
AVITA (tretinoin)
DIFFERIN (adapalene)
RETIN-A (tretinoin)
tretinoin cream, gel

benzoyl peroxide cleanser OTC, 10% cream
OTC, gel Rx & OTC, lotion OTC, 5% &
10% wash OTC
TL 4.25% BPO MX (benzoyl peroxide)

KERATOLYTICS

BENZEFOAM (benzoyl peroxide)
BENZEFOAM ULTRA (benzoyl peroxide)
benzoyl peroxide cloths, medicated pads
benzoyl peroxide/foa OTC
benzoyl peroxide/urea
BPO (benzoyl peroxide)
DELOS (benzoyl peroxide)
DESSQUAM-X (benzoyl peroxide)
LAVOGLLEN (benzoyl peroxide)
PACNEX/HP/LP (benzoyl peroxide)
PANOXYL-4, -8 OTC (benzoyl peroxide)
PERSA-GEL OTC (benzoyl peroxide)
SASTID (sulfur)
SE-BPO (benzoyl peroxide)
SULPHO-LAC (sulfur)

COMBINATION AGENTS



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	TOBI (tobramycin)	CAVSTON (aztreonam)	A 28-day trial of the preferred agent is required before the non-preferred agent will be approved unless one of the exceptions on the PA form is present.

ANTICOAGULANTS^{cl}

ARIIXTRA (fondaparinux)
FRAGMIN (dalteparin)
LOVENOX (enoxaparin)

INJECTABLE

enoxaparin
fondaparinux
INNOHEP (tinzaparin)

Trials of each of the preferred agents will be required before a non-preferred agent will be approved unless one of the exceptions on the PA form is present.

PRADAXA (dabigatran)^{AP}
warfarin
XARELTO (rivaroxaban)^{AP}

ORAL

Pradaxa will be approved for the diagnosis of non-valvular atrial fibrillation.

Xarelto will be approved for the diagnosis of non-valvular atrial fibrillation.

Xarelto will be approved for the prophylaxis if treatment is limited to 35 days for hip replacement surgeries or 12 days for knee replacement surgeries.

ANTICONVULSANTS

carbamazepine
CARBATROL (carbamazepine)
DEPAKOTE SPRINKLE (divalproex)
divalproex EC
divalproex ER
divalproex DR
EPITOL (carbamazepine)
FELBATOL (felbamate)
gabapentin
GABTRIL (tiagabine)
levetiracetam

ADJUVANTS

BANZEL (rufinamide)
carbamazepine XR
DEPAKENE (valproic acid)
DEPAKOTE (divalproex)
DEPAKOTE ER (divalproex)
EQUETRO (carbamazepine)
FANATEX SUSPENSION (gabapentin)^{AKR}
felbamate
GRALISE (gabapentin)
HORIZANT (gabapentin)
KEPPRA (levetiracetam)

A fourteen (14) day trial of one of the preferred agents in the corresponding group is required for treatment naïve patients with a diagnosis of a seizure disorder before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present.

A thirty (30) day trial of one of the



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THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
lamotrigine lamotrigine chewable LYRICA (pregabalin) oxcarbazepine tablets topiramate TRILEPTAL SUSPENSION (oxcarbazepine) valproic acid zonisamide	KEPPRA XR (levetiracetam) LAMICTAL (lamotrigine) LAMICTAL CHEWABLE (lamotrigine) LAMICTAL ODT (lamotrigine) LAMICTAL XR (lamotrigine) levetiracetam ER NEURONTIN (gabapentin) ONFI (clobazam) POTIGA (ezogabine) SABRIL (vigabatrin) STAVZOR (valproic acid) TEGRETOL (carbamazepine) TEGRETOL XR (carbamazepine) TOPAMAX (topiramate) TRILEPTAL TABLETS (oxcarbazepine) VIMPAT (lacosamide) ZONEGRAN (zonisamide)	<p>preferred agents in the corresponding group is required for patients with a diagnosis other than seizure disorders unless one of the exceptions on the PA form is present.</p> <p>Non-preferred anticonvulsants will be approved for patients on established therapies with a diagnosis of seizure disorders with no trials of preferred agents required. In situations where AB-rated generic equivalent products are available, *Brand Medically Necessary* must be hand-written by the prescriber on the prescription in order for the brand name product to be reimbursed.</p> <p>Requests for Gralise will be authorized if the following criteria are met:</p> <ol style="list-style-type: none"> 1. Diagnosis of post herpetic neuralgia 2. Trial of a tricyclic antidepressant for a least thirty days 3. Trial of gabapentin immediate release formulation (positive response without adequate duration) 4. Request is for once daily dosing with 1800 mg. maximum daily dosage. <p>Requests for Onfi will be authorized if the following criteria are met:</p> <ol style="list-style-type: none"> 1. Adjunctive therapy for Lennox-Gastaut OR 2. Generalized tonic, atonic or myoclonic seizures AND 3. Previous failure of at least two non-benzodiazepine anticonvulsants and previous 	
mephobarbital phenobarbital primidone	BARBITURATES^{4P} MEBARAL (mephobarbital) MYSSOLINE (primidone)		



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Therapeutic Drug Class	Preferred Agents	Non-Preferred Agents	PA Criteria
GROWTH HORMONE^{cl}	<p>GENOTROPIN (somatropin) NORDITROPIN NORIDIFLEX (somatropin) NORDITROPIN FLEXPRO (somatropin) NUTROPIN AQ NUSPIN (somatropin)</p>	<p>HUMATROPE (somatropin) INCRELEX (mecasermin) NUTROPIN (somatropin) NUTROPIN AQ (somatropin) OMNITROPE (somatropin) SAZEN (somatropin) SEROSTIM (somatropin) TEV-TROPIN (somatropin) ZORBTIVE (somatropin)</p>	<p>The preferred agents must be tried before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present.</p> <p>Patients already on a non-preferred agent will receive authorization to continue therapy on that agent for the duration of the existing PA.</p>
H. PYLORI COMBINATION TREATMENTS	<p>Please use individual components: preferred PPI (Dexilant, omeprazole or pantoprazole) amoxicillin tetracycline metronidazole clarithromycin bismuth</p>	<p>HELIDAC (bismuth/metronidazole/tetracycline) OMECLAMOX-PAK (omeprazole/amoxicillin/clarithromycin) PREVPAC (lansoprazole/amoxicillin/clarithromycin) PYLERA (bismuth/metronidazole/tetracycline)</p>	<p>A trial of all the individual preferred components (with Dexilant, omeprazole or pantoprazole) at the recommended dosages, frequencies and duration is required before the brand name combination packages will be approved unless one of the exceptions on the PA form is present.</p>
HEPATITIS B TREATMENTS	<p>EPIVIR HBV (lamivudine) HEPSERA (adefovir) TYZKA (telbivudine)</p>	<p>BARACLUDE (entecavir)</p>	<p>A thirty (30) day trial of one of the preferred agents is required before the non-preferred agent will be authorized unless one of the exceptions on the PA form is present.</p>
HEPATITIS C TREATMENTS^{cl}	<p>INCIVEK (telaprevir)^{cl} PEGASYS (pegylated Interferon) PEG-INTRON (pegylated Interferon) ribavirin VICTRELIS (boceprevir)^{cl}</p>	<p>COPEGUS (ribavirin) INFERGEN (consensus interferon) REBETOL (ribavirin) RIBAPAK DOSEPAK (ribavirin) RIBASPHERE (ribavirin)</p>	<p>Patients starting therapy in this class must try the preferred agent of a dosage form before a non-preferred agent of that dosage form will be authorized.</p> <p>See additional criteria for Incivек and Victrelis at http://www.dhnr.wv.gov/bms/Pharmacv/Pages/pac.aspx</p>



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LIPOTROPICS, OTHER (Non-stats) ¹²	cholestyramine	COLESTID (cholestipol)	A twelve (12) week trial of one of the preferred agents is required before a non-preferred agent in the corresponding category will be authorized.
	colostipol	QUESTRAN (cholestyramine) WELCHOL (colesevelam)	
LEUKOTRIENE MODIFIERS	ACCOLATE (zafirlukast)	zafirlukast	Thirty (30) day trials each of the preferred agents are required before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present.
	montelukast SINGULAIR (montelukast)	ZYFLO (zileuton)	
CORTICOSTEROIDS	fluticasone propionate	BECONASE AQ (beclomethasone) flunisolide	Thirty (30) day trials of each preferred agent in the corticosteroid group are required before a non-preferred corticosteroid agent will be authorized unless one of the exceptions on the PA form is present.
	NASACORT AQ (triamcinolone)	FLONASE (fluticasone propionate) NASALIDE (flunisolide)	
	NASONEX (mometasone)	NASAREL (flunisolide) OMNARIS (ciclesonide) QNASL (beclomethasone)	
		RHINOCORT AQUA (budesonide) Itracincholone	
		VERAMYST (fluticasone furoate) ZETONNA (ciclesonide)	
COMBINATIONS		DYMISTA (azelastine / fluticasone)	the non-preferred agent will be approved unless one of the exceptions on the PA form is present.
BILE ACID SEQUESTRANTS			



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IMMUNOSUPPRESSIVES	<p>azathioprine cyclosporine, modified cyclosporine mycophenolate mofetil RAPAMUNE (sirolimus) tacrolimus</p>	<p>AZASAN (azathioprine) CELLCEPT (mycophenolate mofetil) MYFORTIC (mycophenolic acid) NEORAL (cyclosporine, modified) PROGRAF (tacrolimus) SANDIMMUNE (cyclosporine) ZORTRESS (everolimus)</p>	<p>A fourteen (14) day trial of the preferred agent is required before a non-preferred agent will be authorized, unless one of the exceptions on the PA form is present (non-preferred agents will be grandfathered for patients currently on these therapies).</p>
IMPETIGO AGENTS (Topical)	<p>bacitracin gentamicin sulfate mupirocin</p>	<p>ALTABAX (relapamulin) BACTROBAN (mupirocin) CORTISPORIN (bacitracin/neomycin/poly/myxin/Hc)</p>	<p>Ten (10) day trials of at least one preferred agent, including the generic formulation of a requested non-preferred agent, are required before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present.</p>
INTRANASAL RHINITIS AGENTS^{AP}	<p>ipratropium</p>	<p>ANTICHOLINERGICS ATROVENT (ipratropium)</p>	<p>Thirty (30) day trials of the preferred nasal anti-cholinergic, an antihistamine, and corticosteroid groups are required before a non-preferred anti-cholinergic will be approved unless one of the exceptions on the PA form is present.</p>
	<p>ASTELIN (azelastine) PATANASE (olopatadine)</p>	<p>ANTIHISTAMINES ASTEPRO (azelastine) azelastine</p>	<p>Thirty (30) day trials of both preferred intranasal antihistamines and a thirty (30) day trial of one of the preferred intranasal corticosteroids are required before</p>



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	panitoprazole	<p>NEXIUM (esomeprazole) NEXIUM PACKETS (esomeprazole) omeprazole/sodium bicarbonate (Rx/OTC) PREVACID capsules (lansoprazole) PREVACID Solu-Tab (lansoprazole) PRILLOSEC (omeprazole) PROTONIX (panitoprazole) ZEGERID OTC (omeprazole)</p>	<p>concurrent thirty (30) day trial at the maximum dose of an H₂ antagonist are required before a non-preferred agent will be approved unless one of the exceptions on the PA form is present Prior authorization is not required for Prevacid Solu-Tab for patients 58 years of age.</p>
PSORIATIC AGENTS - TOPICAL	<p>calcipotriene cream, ointment DOVONEX (calcipotriene) TAZORAC (tazarotene)</p>	<p>calcipotriene solution calcitriol SORILUX (calcipotriene) TACLONEX (calcipotriene/betamethasone) VECTICAL (calcitriol)</p>	<p>Thirty (30) day trials of two (2) preferred unique chemical entities are required before non-preferred agents will be approved unless one of the exceptions on the PA form is present.</p>
PULMONARY ANTIHYPERTENSIVES - ENDOTHELIN RECEPTOR ANTAGONISTS^{cc}	<p>LETAIRIS (ambrisentan) TRACLEER (bosentan)</p>		<p>Letairis will be approved for the treatment of pulmonary artery hypertension (PAH) World Health Organization (WHO) Group I to improve exercise ability and decrease the rate of clinical deterioration. Tracleer will be approved for the treatment of pulmonary artery hypertension (PAH) (WHO Group I) in patients with World Health Organization (WHO) Class II, III, or IV symptoms to improve exercise capacity and decrease the rate of clinical deterioration AND when there has been a failure with Letairis.</p>
PULMONARY ANTIHYPERTENSIVES – PDE5s^{cc}			
	<p>ADCIRCA (tadalafil) REVATIO (sildenafil)</p>		



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THERAPEUTIC
DRUG CLASS

PREFERRED AGENTS

NON-PREFERRED AGENTS

PA CRITERIA

PULMONARY ANTIHYPERTENSIVES – PROSTACYCLINS^{cl}

epoprostenol
VENTAVIS (Iloprost)

FLOLAN (epoprostenol)
REMODULIN (treprostinil sodium)
TYVASO (treprostinil)

Ventavis will only be approved for the treatment of pulmonary artery hypertension (WHO Group 1) in patients with NYHA Class III or IV symptoms.

Remodulin and Tyvaso will be approved only after a 30-day trial of Ventavis unless one of the exceptions on the PA form is present.

SEDATIVE HYPNOTICS^{AP}

temazepam

BENZODIAZEPINES

DALMANE (flurazepam)
DORAL (quazepam)
estazolam
flurazepam
HALCION (triazolam)
RESTORIL (temazepam)
triazolam

Fourteen (14) day trials of the preferred agents in both categories are required before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present.

OTHERS

zolpidem

AMBIEN (zolpidem)
AMBIEN CR (zolpidem)
chloral hydrate
EDLUAR SL (zolpidem)
INTERMEZZO (zolpidem)
LUNESTA (eszopiclone)
ROZEREM (ramelteon)
SILENOR (doxepin)
SOMNOTE (chloral hydrate)
SONATA (zaleplon)
zaleplon
zolpidem tartrate ER
ZOLPIMIST SPRAY (zolpidem)

STIMULANTS AND RELATED AGENTS