CONNECTICUT MEDICAID

Preferred Drug List (PDL)

• The Connecticut Medicaid *Preferred Drug List* (PDL) is a listing of prescription products selected by the Pharmaceutical and Therapeutics Committee as efficacious, safe and cost effective choices when prescribing for HUSKY A, HUSKY C, HUSKY D, Tuberculosis (TB) and Family Planning (FAMPL) clients.

• *Preferred* or *Non-preferred* status only applies to those medications that fall within the drug classes listed on this PDL

• HIV medications are excluded from the PDL and do not require prior authorization

• The brand-name of a generically available medication will not be covered without a PA, unless the brand is listed on the PDL

• Preferred brand-name medications with non-preferred generic equivalents are listed in BOLD

• UPDATED NOTATIONS: (DX Code Required) notation will appear for preferred agents that require ICD-10 code for reimbursement

• UPDATED NOTATIONS: CHEWABLE notation will appear for preferred agents

** New Therapeutic Class added to PDL effective 7/1/18
* New Drug added to the PDL effective 7/1/18

Non - PDL PA Requirements

Complete Section 15 on attached Prior Authorization Request Form below

- Intolerance of the preferred agents
- Adverse reaction to the preferred agents
- Inadequate response from the preferred agents
- Determined medically necessary appropriate
- Absence of appropriate formulation of the preferred agents

Step Therapy PA Requirements

Complete attached Step Therapy Prior Authorization Request Form below

‡ Agents from the following FIVE categories: ACNE AGENTS, TOPICAL, ANTIMIGRAINE AGENTS, CYTOKINE/CAM ANTAGONISTS, LIPOTROPICS, STATINS, PROTON PUMP INHIBITORS

Important Connecticut Medicaid Phone Numbers

DXC Technology
Pharmacy Prior Authorization Center
Phone #: 1-866-409-8386 (toll-free)
Fax #: 1-866-759-4110 (toll-free)

PA forms are also available on our website:
http://www.CTDSSMAP.com
Navigate to: *Pharmacy Information*
or: *information > publications > forms*

DXC Technology Provider Assistance Center
1-800-842-8440 (toll-free)

Dept of Social Services Rx Consultant
(860) 424-5150

Updated October 1, 2018 §

ACNE AGENTS, TOPICAL ‡
(STEP THERAPY CATEGORY)
(DX CODE REQUIRED - DIFFERIN and EPIDUO)
AZELEX 20% CREAM (TOPICAL)
CLINDAMYCIN PHOS 1% PLEGET (TOPICAL)
CLINDAMYCIN PHOS 1% SOLUTION (TOPICAL)
CLINDAMYCIN-BENZOYL PEROXIDE 1-5% PUMP (TOPICAL)
DIFFERIN 0.1% CREAM (TOPICAL) (DX CODE REQ.)
DIFFERIN 0.1% GEL (TOPICAL) (DX CODE REQ.)
DIFFERIN 0.1% LOTION (TOPICAL) (DX CODE REQ.)
DIFFERIN 0.3% GEL PUMP (TOPICAL) (DX CODE REQ.)
EPIDUO 0.1-2.5% GEL PUMP (TOPICAL) (DX CODE REQ.)
ERYTHROMYCIN 2% SOLUTION (TOPICAL)
RETIN-A CREAM (TOPICAL)
RETIN-A GEL (TOPICAL)

ALZHEIMER'S AGENTS
DONEPEZIL ODT (ORAL)
DONEPEZIL 5MG & 10MG TABLET (not 23MG) (ORAL)
EXELON PATCH (TRANSDERMAL)
GALANTAMINE ER CAPSULE (ORAL)
MEMANTINE IR TABLET (not ER CAPSULES) (ORAL)
MEMANTINE 5-10MG TITRATION PACK (ORAL)
RIVASTIGMINE CAPSULES (ORAL)

ANALGESICS, NARCOTICS SHORT
APAP / CODEINE ELIXIR (ORAL)
APAP / CODEINE #2, #3, #4 TABLET (ORAL)
CODEINE TABLET (ORAL)
HYDROCODONE / APAP CAPSULE (ORAL)
HYDROCODONE / APAP SOLUTION (ORAL)
HYDROCODONE / APAP TABLET (ORAL)
HYDROCODONE / IBUPROFEN (ORAL)
HYDROMORPHONE TABLET (IR) (ORAL)
MORPHINE CONC, SOLUTION, SYRUP (ORAL)
MORPHINE IR TABLET (ORAL)
OXYCODONE / APAP CAPSULE, TABLET (ORAL)
OXYCODONE TABLET (not CAPSULE) (ORAL)
OXYCODONE 5 MG/5 ML SOLUTION (ORAL)
TRAMADOL TABLET (ORAL)
TRAMADOL / APAP (ORAL)

ANDROGENIC AGENTS
ANDROGEL 1% GEL PACKET (TRANSDERM.)
ANDROGEL 1.62% GEL PACKET (TRANSDERM.)
ANDROGEL 1% GEL PUMP (TRANSDERM)
ANDROGEL 1.62% GEL PUMP (TRANSDERM)

ANGIOTENSIN MODULATORS
DIOVAN TABLET (ORAL)
ENALAPRIL, ENALAPRIL / HCTZ (ORAL)
ENTRESTO TABLET (ORAL)
LISINOPRIL, LISINOPRIL/ HCTZ (ORAL)
LOSARTAN, LOSARTAN / HCTZ (ORAL)
QUINAPRIL, QUINIPRIL / HCTZ (ORAL)
VALSARTAN / HCTZ (ORAL)

ANGIOTENSIN MODULATOR COMBINATIONS
AMLODIPINE / BENAZEPRIL (ORAL)
AMLODIPINE / OLMESARTAN (ORAL)
AMLODIPINE / VALSARTAN (ORAL)
AMLODIPINE / VALSARTAN / HCTZ (ORAL)

ANTHELMINTICS
ALBENZA TABLET (ORAL)
BILTRICIDE TABLET (ORAL)
IVERMECTIN TABLET (ORAL)
STROMECTOL TABLET (ORAL)

ANTI-ALLERGENS, ORAL
All agents requre non-PDL PA

ANTIBIOTICS, GI
METRONIDAZOLE TABLET (not CAPSULE) (ORAL)
VANCOMYCIN TABLET (ORAL)

ANTIBIOTICS, INHALED
BETHKIS AMPULE (INHALATION)
CAYSTON SOLUTION (INHALATION)
KITABIS PAK 300 MG/5 ML (INHALATION)
TOBI PODHALER 28MG INHALE CAPSULE (INHALATION)

ANTIBIOTICS, TOPICAL
GENTAMICIN 0.1% CREAM (TOPICAL)
GENTAMICIN 0.1% OINTMENT (TOPICAL)
MUPIROCIN 2% OINTMENT (not CREAM) (TOPICAL)

ANTIBIOTICS, VAGINAL
CLEOCIN OVULES (VAGINAL)
CLINDESSE 2% CREAM (VAGINAL)
METRONIDAZOLE 0.75% GEL (VAGINAL)

ANTICOAGULANTS
ELIQUIS TABLET (not STARTER PACK) (ORAL)
ENOXAPARIN SYRINGE (SUBCUTANEOUS)
FRAGMIN VIAL (SUBCUTANEOUS)
LOVENOX VIAL (SUBCUTANEOUS)
PRADAXA (ORAL)
WARFARIN (ORAL)
XARELTO (ORAL)
XARELTO STARTER PACK (ORAL)

ANTICONVULSANTS
CARBAMAZEPINE SUSPENSION, TAB CHEW, TABLET (ORAL
CARBAMAZEPINE ER CAPSULE (ORAL)
CARBAMAZEPINE ER TABLET (ORAL)
CELONTIN (ORAL)
CLONAZEPAM IR TABLET (not ODT or ER) (ORAL)
DIAZEPAM (RECTAL) (generic DIASTAT) §
DIAZEPAM DEVICE (RECTAL) (generic DIASTAT ACUDIAL) §
DIVALPROEX ER (ORAL)
DIVALPROEX SPRINKLE, TABLET (ORAL)

ANTICONVULSANTS, CONT.
ETHOSUXIMIDE SOLUTION (ORAL)
GABITRIL TABLET (ORAL)
LAMOTRIGINE CHEW DISPERS TAB (not ODT) (ORAL)
LAMOTRIGINE STARTER PACK (not ODT) (ORAL)
LAMOTRIGINE TABLET (IR) (not ER) (ORAL)
LEVETIRACETAM SOLUTION, IR TABLET (not ER) (ORAL)
OXCARBAZEPINE SUSPENSION, TABLET (ORAL)
PEGANONE TABLET (ORAL)
PHENOBARBITAL ELIXIR, TABLET (ORAL)
PHENYTOIN CHEW TABLET, SUSPENSION (ORAL)
PHENYTOIN SOD EXT CAPSULE (ORAL)
PRIMIDONE (ORAL)
TOPIRAMATE SPRINKLE CAPSULE (ORAL)
TOPIRAMATE TABLET (not ER) (ORAL)
VALPROIC ACID CAPSULE, SOLUTION (ORAL)
VIMPAT SOLUTION, TABLET (not STARTER KIT) (ORAL)
ZONISAMIDE CAPSULE (ORAL)

ANTIDEPRESSANTS, OTHER
BUPROPION (ORAL)
BUPROPION SR, BUPROPION XL (ORAL)
DESVENLAFAXINE SUC ER (generic PRISTIQ) (ORAL)
EMSAM (TRANSDERMAL)*
FETZIMA ER, FETZIMA STARTER PACK (ORAL)
MARPLAN (ORAL)
MIRTAZAPINE TABLET, ODT (ORAL)
NEFAZODONE (ORAL)
PARNATE (ORAL)
PHENELZINE (ORAL)
TRAZODONE (ORAL)
TRINTELLIX (BRINTELLIX) (ORAL)
VENLAFAXINE ER CASPULES (ORAL)
VIIBRYD (ORAL)

ANTIDEPRESSANTS, SSRIs
CITALOPRAM TABLET, SOLUTION (ORAL)
ESCITALOPRAM SOLUTION, TABLET (ORAL)
FLUOXETINE CAPSULE, SOLUTION (ORAL) (not Tablet)
FLUVOXAMINE (ORAL)
PAROXETINE TABLET (ORAL)
SERTRALINE CONC, TABLET (ORAL)

ANTIEMETIC / ANTIVERTIGO AGENTS
EMEND CAPSULE (not TRIPACK or POWDER) (ORAL)
DICLEGIS (ORAL)
DRONABINOL CAPSULE (ORAL)
ONDANSETRON ODT, SOLUTION, TABLET (ORAL)

ANTIFUNGALS, ORAL
CLOTRIMAZOLE 10 MG TROCHE (MUCOUS MEM)
FLUCONAZOLE SUSPENSION, TABLET (ORAL)
GRISEOFULVIN SUSPENSION (not TABLET) (ORAL)
NYSTATIN SUSPENSION (not TABLET) (ORAL)
TERBINAFINE TABLET (ORAL)

ANTIFUNGALS, TOPICAL	ANTIPARKINSON'S AGENTS, CONT.	ANTIVIRALS, ORAL & INHALED	BRONCHODILATORS, BETA AGONIST
CLOTRIMAZOLE 1% CREAM (Rx ONLY) (TOPICAL)	PRAMIPEXOLE (IR) (ORAL)	ACYCLOVIR CAPSULE, TABLET (ORAL)	ALBUTEROL NEB SOLN 100 MG/20 ML (INHALATION)
CLOTRIMAZOLE 1% SOLUTION (Rx ONLY) (TOPICAL)	ROPINIROLE (IR) (ORAL)	ACYCLOVIR SUSPENSION (ORAL)	ALBUTEROL NEB SOLN 0.63, 1.25, 2.5 MG/3 ML (INHALATION
CLOTRIMAZOLE-BETAMETHASONE CREAM (TOPICAL)	SELEGILINE CAPSULE, TABLET (ORAL)	FAMCICLOVIR TABLET (ORAL)	ALBUTEROL NEB SOLN 2.5 MG/0.5 ML (INHALATION)
KETOCONAZOLE 2% SHAMPOO (TOPICAL)	CARBIDOPA-LEVODOPA-ENTACAPONE TABLET (ORAL) §	RELENZA 5 MG DISKHALER (INHALATION)	ALBUTEROL SOLUTION, SYRUP (not TABLET) (ORAL)
NYSTATIN CREAM, OINTMENT, POWDER (TOPICAL)	TRIHEXYPHENIDYL ELIXIR, TABLET (ORAL)	RIMANTADINE TABLET (ORAL)	FORADIL AEROLIZER (INHALATION)
		TAMIFLU CAPSULE (ORAL)	PROAIR HFA (INHALATION)
ANTIHISTAMINES, MINIMALLY SEDATING	**ANTIPSORIATICS, ORAL**	**TAMIFLU SUSPENSION (ORAL)**	PROVENTIL HFA (INHALATION)
CETIRIZINE SOLUTION (Rx ONLY) (ORAL)	ACITRETIN CAPSULE (ORAL)	VALACYCLOVIR TABLET (ORAL)	SEREVENT DISKUS (INHALATION)
FEXOFENADINE-D 12-HOUR OTC (ORAL)	METHOXSALEN 10MG CAPSULE (ORAL) §		TERBUTALINE TABLETS (ORAL)
FEXOFENADINE SUSPENSION OTC (ORAL)		**ANTIVIRALS, TOPICAL**	
LEVOCETIRIZINE TABLETS (ORAL)	**ANTIPSORIATICS, TOPICAL**	ZOVIRAX 5% CREAM (TOPICAL)	**CALCIUM CHANNEL BLOCKERS**
LORATADINE ODT, SOLUTION, TABLET (ORAL)	CALCIPOTRIENE 0.005% OINTMENT, SOLUTION (TOPICAL)	**ZOVIRAX 5% OINTMENT (TOPICAL)***	AMLODIPINE TABLET (ORAL)
LORATADINE-D OTC (ORAL)	**DOVONEX 0.005% CREAM (TOPICAL)**		DILTIAZEM 12HR ER CAPSULE (ORAL)
	TACLONEX OINTMENT (TOPICAL)	**ANXIOLYTICS**	DILTAIZEM 24HR ER CAPSULE (not TABLET) (ORAL)
ANTIHYPERTENSIVES, SYMPATHOLYTICS	**VECTICAL 3 MCG/G OINTMENT (TOPICAL)**	ALPRAZOLAM TABLET (IR) (ORAL)	DILTIAZEM TABLET (ORAL)
CATAPRES-TTS PATCH (TRANSDERM)		BUSPIRONE (ORAL)	NIFEDIPINE ER (ORAL)
CLONIDINE TABLET (ORAL)	**ANTIPSYCHOTICS**	CHLORDIAZEPOXIDE (ORAL)	VERAPAMIL TABLET (ORAL)
GUANFACINE (ORAL)	ABILIFY MAINTENA ER (INTRAMUSC.)	DIAZEPAM 5 MG/5 ML SOLUTION (ORAL)	VERAPAMIL TABLET ER TABLET (not CAPSULE) (ORAL)
METHYLDOPA (ORAL)	ABILIFY SOLUTION (ORAL)	DIAZEPAM TABLET (ORAL)	
METHYLDOPA / HCTZ (ORAL)	ADASUVE (INHALATION)	LORAZEPAM INTENSOL, TABLET (ORAL)	**CEPHALOSPORINS AND RELATED ANTIBIOTICS**
	ARIPIPRAZOLE SOLUTION, TABLET (ORAL)		AMOXICILLIN / CLAV SUSPENSION (ORAL)
ANTIHYPERURICEMICS	ARISTADA (INTRAMUSC)	**BETA-BLOCKERS**	AMOXICILLIN / CLAV TABLET (not CHEW TAB or ER) (ORAL)
ALLOPURINOL (ORAL)	CHLORPROMAZINE (ORAL)	ATENOLOL TABLET (ORAL)	CEFACLOR CAPSULE (not SUSPENSION) (ORAL)
COLCHICINE CAPSULE (not COLCRYS or TABLETS) (ORAL)	CLOZAPINE TABLET (ORAL)	ATENOLOL / CHLORTHALIDONE (ORAL)	CEFADROXIL CAPSULE, SUSPENSION (not TABLET) (ORAL)
PROBENECID (ORAL)	FANAPT (ORAL)	CARVEDILOL TABLET (not ER) (ORAL)	CEFDINIR CAPSULE, SUSPENSION (ORAL)
PROBENECID / COLCHICINE (ORAL)	**FAZACLO ODT (ORAL)**	LABETALOL TABLET (ORAL)	CEFIXIME SUSPENSION (ORAL)
	FLUPHENAZINE DECANOATE (INJECTION)	METOPROLOL TARTRATE (ORAL)	CEFPROZIL SUSPENSION, TABLET (ORAL)
ANTIMIGRAINE AGENTS, OTHER	FLUPHENAZINE ELIXIR/SOLN, TABLET (ORAL)	METOPROLOL SUCCINATE ER (ORAL)	CEFTIN SUSPENSION (ORAL)
DIHYDROERGOTAMINE 1 MG/ML AMP (INJECTION)*	GEODON VIAL (INTRAMUSC)	PROPRANOLOL SOLUTION, TABLET (ORAL)	CEFUROXIME TABLET (ORAL)
DIHYDROERGOTAMINE 4 MG/ML SPRY (NASAL)*	HALOPERIDOL (ORAL)	PROPRANOLOL ER CAPSULE(ORAL)	CEPHALEXIN CAPSULE, SUSPENSION (not TABLET) (ORAL)
ISOMETHEPT / CAFFIENE / APAP (ORAL) *	HALOPERIDOL DECANOATE, LACTATE (INJECTION)		SUPRAX CAPSULE, CHEW TAB (not SUSPENSION) (ORAL)
ISOMETHEPT / DICHLORALP / APAP (ORAL)*	HALOPERIDOL LACTATE CONC (ORAL)	**BILE SALTS**	
MIGERGOT SUPPOSITORY (RECTAL)*	INVEGA SUSTENNA (INTRAMUSC)	URSODIOL TABLET (not CAPSULE) (ORAL)	**COLONY STIMULATING FACTORS**
	INVEGA TRINZA (INTRAMUSC)		GRANIX SYRINGE (INJECTION)
ANTIMIGRAINE AGENTS, TRIPTANS ‡	LATUDA (ORAL)	**BLADDER RELAXANT PREPARATIONS**	NEULASTA ONPRO SYRINGE (INJECTION)
(STEP THERAPY CATEGORY)	LOXAPINE (ORAL)	OXYBUTYNIN ER TABLET (ORAL)	NEULASTA SYRINGE (INJECTION)
RELPAX (ORAL)	MOLINDONE (ORAL)	OXYBUTYNIN SYRUP, TABLET (ORAL)	NEUPOGEN DISP SYRINGE, VIAL (INJECTION)
RIZATRIPTAN ODT (ORAL)	NUPLAZID (ORAL)	TOVIAZ ER (ORAL)	
RIZATRIPTAN TABLET (ORAL)	OLANZAPINE TABLET, ODT (ORAL)	VESICARE (ORAL)	**CONTRACEPTIVES, ORAL**
SUMATRIPTAN NASAL SPRAY (NASAL)	PALIPERIDONE ER (ORAL)		***PREFERRED EMERGENCY CONTRACEPTIVES***
SUMATRIPTAN TABLET (ORAL)	PERPHENAZINE (ORAL)	**BONE RESORPTION SUPPRESSION & RELATED AGENTS**	AFTERA 1.5 MG TABLET (ORAL)*
SUMATRIPTAN VIAL (not SYRINGE) (SUBCUTANEOUS)	PERPHENAZINE / AMITRIPTYLINE (ORAL)	ALENDRONATE TABLET (ORAL)	ELLA 30 MG TABLET (ORAL)*
	PIMOZIDE (ORAL)	CALCITONIN-SALMON 200 UNITS SPRAY (NASAL)	OPCICON ONE-STEP 1.5 MG TABLET (ORAL)*
ANTIPARASITICS, TOPICAL	QUETIAPINE TABLET, ER TABLET (ORAL)		OPTION 2 1.5 MG TABLET (ORAL)*
PERMETHRIN 5% CREAM (TOPICAL)	REXULTI (ORAL)	**BOTULINUM TOXINS**	PLAN B ONE-STEP 1.5 MG TABLET (ORAL)*
PERMETHRIN 1% CRM RINSE, SHAMPOO (TOPICAL)	RISPERDAL CONSTA (INTRAMUSC.)	BOTOX 100, 200 UNIT VIAL (not COSMETIC) (INTRAMUSC)	TAKE ACTION OTC (ORAL)*
PIPERONYL BUTOXIDE / PYRETHRINS SHAMPOO OTC (TOP	RISPERIDONE ODT, SOLUTION, TABLET (ORAL)		ALTAVERA-28 (ORAL)
NATROBA 0.9% SUSPENSION (TOPICAL)	SAPHRIS (SUBLINGUAL)	**BPH TREATMENTS**	ALYACEN 1/35 (ORAL)
SKLICE (TOPICAL)	**SYMBYAX (ORAL)**	ALFUZOSIN ER TABLET (ORAL)	APRI-28 (ORAL)
	THIORIDAZINE (ORAL)	DOXAZOSIN MESYLATE TABLET (ORAL)	ARANELLE-28 (ORAL)
ANTIPARKINSON'S AGENTS	THIOTHIXENE (ORAL)	DUTASTERIDE CAPSULE (ORAL)	AVIANE-28 (ORAL)
AMANTADINE CAPSULE, SOLUTION (ORAL)	TRIFLUOPERAZINE (ORAL)	FINASTERIDE 5 MG TABLET (not 1 MG) (ORAL)	BLISOVI FE 1/20, BLISOVI FE 1.5/30 (ORAL)
BENZTROPINE (ORAL)	VRAYLAR (ORAL)	TAMSULOSIN CAPSULE (ORAL)	CAMILA 0.35 (ORAL)
BROMOCRIPTINE (ORAL)	ZIPRASIDONE CAPSULE (ORAL)	TERAZOSIN CAPSULE (ORAL)	CAZIANT-28 (ORAL)
CARBIDOPA / LEVODOPA TABLET, ODT (ORAL)	**ZYPREXA VIAL (INTRAMUSC)**		CHATEAL-28 (ORAL)
CARBIDOPA / LEVODOPA ER TABLET (ORAL)	ZYPREXA RELPREVV (INTRAMUSC)		CRYSELLE-28 (ORAL)
Updated October 1, 2018 §			

CONTRACEPTIVES, ORAL, CONT.	CONTRACEPTIVES, ORAL, CONT.	GLUCOCORTICOIDS, ORAL	HYPOGLYCEMICS, INSULIN & RELATED AGENTS, CONT.
CYCLAFEM 1/35, CYCLAFEM 7/7/7 (ORAL)	TRI-LO-ESTARYLLA (ORAL)	BUDESONIDE EC (ORAL)	HUMULIN N 100 UNITS/ML VIAL (SUBCUTANEOUS)
DASETTA 1/35, DASETTA 7/7/7 (ORAL)	TRINESSA LO (ORAL)	DEXAMETHASONE TABLET (ORAL)	HUMULIN R 100 UNITS/ML VIAL (SUBCUTANEOUS)
DEBLITANE 0.35 MG (ORAL)	TRI-PREVIFEM (ORAL)	HYDROCORTISONE TABLET (ORAL)	HUMULIN R 500 UNITS/ML VIAL (SUBCUTANEOUS)
ELINEST-28 (ORAL)	TRI-SPRINTEC (ORAL)	METHYLPREDNISOLONE DOSE PACK (4 MG) (ORAL)	LANTUS VIAL (SUBCUTANEOUS)
EMOQUETTE-28 (ORAL)	TRIVORA-28 (ORAL)	**ORAPRED ODT (ORAL)**	LANTUS SOLOSTAR (SUBCUTANEOUS)
ENPRESSE-28 (ORAL)	VIENVA-28 (ORAL)	PREDNISOLONE 15 MG/5 ML SOLUTION (ORAL)	LEVEMIR FLEXTOUCH, VIAL (SUBCUTANEOUS)
ESTARYLLA 0.25-0.035 MG (ORAL)	ZARAH (ORAL)	PREDNISOLONE SOD PH 5 MG/5 ML SOLUTION (ORAL)	NOVOLOG CARTRIDGE, FLEXPEN, VIAL (SUBCUTANEOUS)
ETHYNODIOL / ETH ESTRA 1MG / 35MCG (ORAL)*	ZENCHENT 0.4 MG/35 MCG (ORAL)	PREDNISOLONE SOD PH 25MG/5 ML SOLUTION (ORAL)	NOVOLOG MIX FLEXPEN, VIAL (SUBCUTANEOUS)
FALMINA-28 (ORAL)	ZOVIA 1/35, ZOVIA 1/50 (ORAL)	PREDNISONE TABLET (not DOSE PACK) (ORAL)	TRESIBA FLEXTOUCH (SUBCUTANEOUS)*
GENERESS FE CHEWABLE (ORAL)*			
GIANVI 3 MG-0.02 MG (ORAL)	**COPD AGENTS**	**GROWTH FACTORS**	**HYPOGLYCEMICS, MEGLITINIDES**
GILDESS FE 1/20, GILDESS FE 1.5/30 (ORAL) (not 24)	ALBUTEROL / IPRATROPIUM NEB SOLUTION (INHALATION)	EGRIFTA VIAL (SUBCUTANEOUS)	NATEGLINIDE TABLET (ORAL)
HEATHER (ORAL)	ANORO ELLIPTA (INHALATION)	INCRELEX VIAL (SUBCUTANEOUS)	REPAGLINIDE TABLET (ORAL)
JENCYCLA 0.35 MG (ORAL)*	ATROVENT HFA (INHALATION)		
JULEBER-28 (ORAL)	BEVESPI AEROSPHERE (INHALATION)*	**GROWTH HORMONE**	**HYPOGLYCEMICS, METFORMINS**
JUNEL FE 1/20, JUNEL FE 1.5/30 (ORAL)	DALIRESP TABLET (ORAL)	NORDITROPIN FLEXPRO (INJECTION)	**FORTAMET ER TABLET (ORAL)**
JUNEL FE 24 (ORAL)	IPRATROPIUM BR 0.02% SOLUTION (INHALATION)	NUTROPIN AQ NUSPIN INJECTOR (INJECTION)	GLIPIZIDE-METFORMIN (ORAL)
KELNOR 1/35 (ORAL)	IPRATROPIUM / ALBUTEROL NEB SOLUTION (INHALATION)		METFORMIN TABLET (ORAL)
KURVELO (ORAL)	SPIRIVA HANDIHALER (not RESPIMAT) (INHALATION)	**H. PYLORI TREATMENT**	METFORMIN ER TABLET (generic GLUCOPHAGE XR) (ORAL)
LARIN FE 1/20, LARIN FE 1.5/30 (ORAL) (not 24)	STIOLTO RESPIMAT (INHALATION)	PYLERA CAPSULE (ORAL)	
LESSINA-28 (ORAL)			**HYPOGLYCEMICS, SGLT2**
LEVONEST-28 (ORAL)	**CYTOKINE & CAM ANTAGONISTS ‡**	**HEPATITIS C AGENTS**	FARXIGA TABLET (ORAL)
LEVONOR-ETH ESTRADIOL-28 0.1/0.02 (ORAL) (not 91)	**(STEP THERAPY CATEGORY)**	EPCLUSA TABLET (ORAL)	INVOKANA TABLET (ORAL)
LEVONOR-ETH ESTRADIOL-28 0.15/0.03 (ORAL) (not 91)	ENBREL DISP SYRINGE, KIT, PEN (INJECTION)	MAVYRET TABLET (ORAL)	JARDIANCE TABLET (ORAL)
LEVORA-28 (ORAL)	HUMIRA KIT, PEN INJ KIT (INJECTION)	PEGASYS PROCLICK (SUBCUTANEOUS)	SYNJARDY TABLET (not XR) (ORAL)*
LOESTRIN 21 1/20, LOESTRIN 21 1.5/30 (ORAL)		PEGASYS SYRINGE, VIAL (SUBCUTANEOUS)	
LOESTRIN FE 1/20, LOESTRIN FE 1/5.30 (ORAL)	**EMOLLIENTS**	PEG-INTRON KIT (SUBCUTANE.)	**HYPOGLYCEMICS, TZD**
LORYNA 3 MG-0.02 MG (ORAL)	AMMONIUM LACTATE 12% CREAM (TOPICAL)	RIBAVIRIN TABLET (not CAPSULE) (ORAL)	PIOGLITAZONE TABLET (ORAL)
LOSEASONIQUE (ORAL)	AMMONIUM LACTATE 12% LOTION (TOPICAL)	VOSEVI TABLET (ORAL)	
LOW-OGESTREL-28 (ORAL)			**IMMUNOMODULATORS, ASTHMA**
MARLISSA-28 (ORAL)	**EPINEPHRINE, SELF-INJECTED**	**HISTAMINE II RECEPTOR BLOCKER**	XOLAIR VIAL (SUBCUTANEOUS)
MICROGESTIN FE 1/20, MICROGESTIN FE 1.5/30 (ORAL)	EPINEPHRINE 0.15 MG (49502-0101-02) (INJECTION)	CIMETIDINE TABLET OTC (not RX) (ORAL)	
MINASTRIN 24 FE CHEWABLE (ORAL)*	EPINEPHRINE 0.3 MG (49502-0102-02) (INJECTION)	FAMOTIDINE SUSPENSION (ORAL)	**IMMUNOMODULATORS, ATOPIC DERMATITIS**
MIRCETTE-28 (ORAL)		FAMOTIDINE TABLET, FAMOTIDINE TABLET OTC (ORAL)	ELIDEL 1% CREAM (TOPICAL)
MONO-LINYAH-28 (ORAL)	**ERYTHROPOIESIS STIMULATING PROTEINS**	RANITIDINE SYRUP, TABLET, OTC TABLET (ORAL)	EUCRISA 2% OINTMENT (TOPICAL)
MYZILRA-28 (ORAL)	ARANESP DISP SYRIN, VIAL (INJECTION)		**PROTOPIC 0.03% OINTMENT (TOPICAL)**
NATAZIA-28 (ORAL)	PROCRIT (INJECTION)	**HYPOGLYCEMICS, ALPHA-GLUCOSIDASE INHIBITORS**	**PROTOPIC 0.1% OINTMENT (TOPICAL)**
NECON 0.5/35, NECON 1/50, NECON 7/7/7 (ORAL)		ACARBOSE TABLET (ORAL)	
NIKKI 3 MG-0.02 MG (ORAL)	**FLUOROQUINOLONES, ORAL**	**GLYSET TABLET (ORAL)**	**IMMUNOMODULATORS, TOPICAL**
NORETHINDRONE 0.35 (ORAL)	**CIPRO SUSPENSION (ORAL)**		IMIQUIMOD 5% CREAM PACKET (TOPICAL) §
NORETHIN-ETH ESTRADIOL FE 0.4/35 CHEWABLE (ORAL)	CIPROFLOXACIN TABLET (IR) (ORAL)	**HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS**	
NORETHINDRONE-ETHINYL ESTRADIOL FE 1/20 (ORAL)	LEVOFLOXACIN TABLET (ORAL)	BYDUREON PEN INJECT, VIAL (SUBCUTANEOUS)	**IMMUNOSUPPRESSIVES, ORAL**
ORSYTHIA-28 (ORAL)		BYETTA DOSE PEN (SUBCUTANEOUS)	AZATHIOPRINE TABLET (ORAL)
ORTHO TRI-CYCLEN LO (ORAL)	**GI MOTILITY, CHRONIC**	GLYXAMBI TABLET (ORAL)*	CYCLOSPORINE MODIFIED CAPSULE (ORAL)
PORTIA-28 (ORAL)	AMITIZA CAPSULE (ORAL)	JANUMET TABLET (ORAL)	CYCLOSPORINE MODIFIED SOLUTION (ORAL)
PREVIFEM (ORAL)	LINZESS CAPSULE (ORAL)	JANUMET XR TABLET (ORAL)	MYCOPHENOLATE MOFETIL CAPSULE, TABLET (ORAL)
RECLIPSEN-28 (ORAL)	MOVANTIK TABLET (ORAL)	JANUVIA TABLET (ORAL)	TACROLIMUS CAPSULE (ORAL)
SAFYRAL (ORAL)	**GLUCOCORTICOIDS, INHALED**	JENTADUETO TABLET (IR) (not XR) (ORAL)	RAPAMUNE SOLUTION (ORAL)
SEASONIQUE (ORAL)	ADVAIR DISKUS (not HFA) (INHALATION)	TRADJENTA TABLET (ORAL)	**SANDIMMUNE CAPSULE (ORAL)**
SHAROBEL 0.35 MG (ORAL)	ASMANEX TWISTHALER (not HFA) (INHALATION)	VICTOZA PEN (SUBCUTANEOUS)	SANDIMMUNE SOLUTION (ORAL)
SPRINTEC-28 (ORAL)	BREO ELLIPTA (INHALATION)		SIROLIMUS TABLET (ORAL)
SRONYX 0.1/0.02 (ORAL)	DULERA (INHALATION)	**HYPOGLYCEMICS, INSULIN & RELATED AGENTS**	
SYEDA-28 (ORAL)	FLOVENT DISKUS, FLOVENT HFA (INHALATION)	HUMALOG CARTRIDGE, VIAL (SUBCUTANEOUS)	**INTRANASAL RHINITIS AGENTS**
TILIA FE-28 (ORAL)	**PULMICORT RESPULES (INHALATION)**	HUMALOG 100 UNITS/ML KWIKPEN (not JR) (SUBCUTANEOU	AZELASTINE 1% SPRAY (generic ASTELIN) (NASAL)
TRI-LEGEST FE-28 (ORAL)	PULMICORT FLEXHALER (INHALATION)	HUMALOG MIX KWIKPEN, MIX VIAL (SUBCUTANEOUS)	FLUTICASONE PROP 50 MCG SPRAY (NASAL)
TRI-LINYAH (ORAL)	SYMBICORT (INHALATION)	HUMULIN 70/30 VIAL (SUBCUTANEOUS)	FLUTICASONE PROP 50 MCG SPRAY OTC (NASAL)
Updated October 1, 2018 §			

INTRANASAL RHINITIS AGENTS, CONT.	MACROLIDES/KETOLIDES	ONCOLOGY, ORAL - HEMATOLOGIC	ONCOLOGY, ORAL - PROSTATE, CONT.
IPRATROPIUM 0.03%, 0.06% SPRAY (NASAL)	AZITHROMYCIN 1GM POWDER PACKET (ORAL)	**ALKERAN TABLET (ORAL)**	ZYTIGA TABLET (ORAL)
OLOPATADINE 665 MCG SPRAY (NASAL)	AZITHROMYCIN SUSPENSION, TABLET (ORAL)	BOSULIF TABLET (ORAL)	
TRIAMCINOLONE 55 MCG SPRAY OTC (NASAL)	CLARITHROMYCIN TABLET (ORAL)	CALQUENCE CAPSULE (ORAL)	**ONCOLOGY, ORAL - RENAL CELL**
	ERY-TAB DR TABLET (ORAL)	FARYDAK CAPSULE (ORAL)	AFINITOR TABLET (ORAL) (not DISPERZ)
IRON, ORAL	ERYTHROCIN FILMTAB (ORAL)	**GLEEVEC TABLET (ORAL)**	CABOMETYX TABLET (ORAL)
BIFERA TABLET OTC (ORAL)	ERYTHROMYCIN FILMTAB (not CAPSULES) (ORAL)	HYDROXYUREA CAPSULE (ORAL)	INLYTA TABLET (ORAL)
CENTRATEX (ORAL)	**E.E.S 200 SUSPENSION (GRANULES) (ORAL)***	ICLUSIG TABLET (ORAL)	LENVIMA DAILY DOSE (ORAL)
FE C OTC (ORAL)		IDHIFA TABLET (ORAL)	NEXAVAR TABLET (ORAL)
FE FUMARATE/VIT C/B12-IF/FA (ORAL)	**METHOTREXATE**	IMBRUVICA CAPSULE (not TABLET) (ORAL)	SUTENT CAPSULE (ORAL)
FERATE OTC (ORAL)	METHOTREXATE SODIUM PF VIAL, VIAL (INJECTION)	JAKAFI TABLET (ORAL)	VOTRIENT TABLET (ORAL)
FERRALET 90 DUAL-IRON (ORAL)	METHOTREXATE TABLET, VIAL (ORAL)	LEUKERAN TABLET (ORAL)	
FERROUS FUMARATE TABLET OTC (ORAL)		MATULANE CAPSULE (ORAL)	**ONCOLOGY, ORAL - SKIN**
FERROUS FUMARATE/FA TABLET (ORAL)	**MOVEMENT DISORDERS**	MERCAPTOPURINE TABLET (ORAL)	COTELLIC TABLET (ORAL)
FERROUS FUMARATE/ASCORBIC ACID/B12-IF/FA CAPSULE	TETRABENAZINE (ORAL) §	MYLERAN TABLET (ORAL)	ERIVEDGE CAPSULE (ORAL)
FERROUS GLUCONATE OTC (ORAL)		NINLARO CAPSULE (ORAL)	MEKINIST TABLET (ORAL)
FERROUS SULFATE 65 MG TABLET OTC (ORAL)	**MULTIPLE SCLEROSIS AGENTS**	POMALYST CAPSULE (ORAL)	ODOMZO CAPSULE (ORAL)
FERROUS SULFATE DROPS (ORAL)	AUBAGIO TABLET (ORAL)	REVLIMID CAPSULE (ORAL)	TAFINLAR CAPSULE (ORAL)
FERROUS SULFATE OTC (ORAL)	AVONEX PEN, PREFILLED SYRINGE, VIAL (INTRAMUSC.)	RYDAPT CAPSULE (ORAL)	ZELBORAF TABLET (ORAL)
FERROUS SULFATE SOLUTION OTC (ORAL)	BETASERON KIT (not VIAL) (SUBCUTANEOUS)	SPRYCEL TABLET (ORAL)	
FERROUS SULFATE TABLET ER OTC (ORAL)	**COPAXONE 20 MG/ML SYRINGE (not 40 MG/ML) (SUBCUTAI**	TABLOID TABLET (ORAL)	**OPHTHALMICS FOR ALLERGIC CONJUNCTIVITIS**
FERROUS SULFATE, DRIED TABLET ER OTC (ORAL)	GILENYA CAPSULE (ORAL)	TASIGNA CAPSULE (ORAL)	ALREX 0.2% (OPHTHALMIC)
FOLITAB 500 OTC (ORAL)	REBIF SYRINGE, TITRATION PACK (SUBCUTANEOUS)	THALOMID CAPSULE (ORAL)	CROMOLYN SODIUM 4% (OPHTHALMIC)
HEMOCYTE PLUS (ORAL)	REBIF REBIDOSE, TITRATION PACK (SUBCUTANEOUS)	TRETINOIN CAPSULE (ORAL)	PAZEO 0.7% (OPTHALMIC)
IFEREX 150 FORTE (ORAL)	TECFIDERA CAPSULE, STARTER PACK (ORAL)	VENCLEXTA TABLET, STARTING PACK (ORAL)	
INTEGRA OTC, INTEGRA PLUS (ORAL)		ZOLINZA CAPSULE (ORAL)	**OPHTHALMIC ANTIBIOTICS**
IRON 45 MG TABLET OTC (ORAL)	**NEUROPATHIC PAIN**	ZYDELIG TABLET (ORAL)	BACITRACIN-POLYMYXIN B SULFATE OINTMENT (OPHTHALI
IRON POLYSACCHARIDES COMPLEX OTC (ORAL)	CAPSAICIN 0.025%, 0.075%, 0.1% CREAM (TOPICAL)		CIPROFLOXACIN 0.3% SOLUTION (OPHTHALMIC)
IRON PS CMPLX/VIT B12/FA (ORAL)	CAPSAICIN 0.15% LIQUID (TOPICAL)	**ONCOLOGY, ORAL - LUNG**	ERYTHROMYCIN 0.5% OINTMENT (OPHTHALMIC)
IRON,CARBONYL/ASCORBIC ACID OTC (ORAL)	DULOXETINE 20MG, 30MG, 60MG CAPSULES (not 40MG) (OR	ALECENSA CAPSULE (ORAL)	GENTAK 0.3% OINTMENT (OPHTHALMIC)
MV COMB18/FEFM-FEPOL CB1/FA (ORAL)	GABAPENTIN CAPSULE (ORAL)	ALUNBRIG TABLET, TABLET PACK (ORAL)	GENTAMICIN 0.3% SOLUTION (OPHTHALMIC)
SE-TAN PLUS (ORAL)	GABAPENTIN TABLET (ORAL)	GILOTRIF TABLET (ORAL)	MOXEZA 0.5% (OPHTHALMIC)
SLOW RELEASE IRON (ORAL)	LIDOCAINE 5% PATCH (TOPICAL)	HYCAMTIN CAPSULE (ORAL)	OFLOXACIN 0.3% SOLUTION (OPHTHALMIC)
TANDEM DUAL ACTION OTC, TANDEM PLUS (ORAL)	LYRICA CAPSULE (IR) (not CR) (ORAL)	IRESSA TABLET (ORAL)	POLYMYXIN B-TMP DROP (OPHTHALMIC)
TL-FOL 500 (ORAL)		TAGRISSO TABLET (ORAL)	TOBRAMYCIN 0.3% SOLUTON (OPHTHALMIC)
	NSAIDS	TARCEVA TABLET (ORAL)	TOBREX 0.3% OINTMENT (OPHTHALMIC)
LEUKOTRIENE MODIFIERS	FLECTOR 1.3% PATCH (TOPICAL)	XALKORI CAPSULE (ORAL)	**VIGAMOX 0.5% (OPHTHALMIC)**
MONTELUKAST CHEW TABLET (not GRANULES) (ORAL)	DICLOFENAC SODIUM TABLET (IR and ER) (ORAL)	ZYKADIA CAPSULE (ORAL)	
MONTELUKAST TABLET (ORAL)	IBUPROFEN SUSPENSION, TABLET (ORAL)		**OPHTHALMIC ANTIBIOTIC-STEROID COMBINATIONS**
	INDOCIN SUSPENSION (ORAL)	**ONCOLOGY, ORAL - OTHER**	BLEPHAMIDE EYE DROPS (OPHTHALMIC)
LIPOTROPICS, OTHER	INDOMETHACIN CAPSULE (IR) (not ER) (ORAL)	CAPRELSA TABLET (ORAL)	NEOMYCIN / POLY / DEXAMETHASONE OINTMENT (OPHTHA
CHOLESTYRAMINE LIGHT (with ASPARTAME) (ORAL)	MELOXICAM TABLET (ORAL)	COMETRIQ DAILY-DOSE PACK (ORAL)	NEOMYCIN / POLY / DEXAMETHASONE DROP (OPHTHALMIC
CHOLESTYRAMINE (with SUCROSE) (ORAL)	NABUMETONE TABLET (ORAL)	GLEOSTINE CAPSULE (ORAL)	PRED-G 1% DROP (OPHTHALMIC)
COLESTIPOL TABLET (ORAL)	NAPROXEN 250MG, 375MG, 500MG TABLET (ORAL)	HEXALEN CAPSULE (ORAL)	PRED-G S.O.P. OINTMENT (OPHTHALMIC)
EZETIMIBE TABLET (ORAL)*	NAPROXEN SUSPENSION (ORAL)	LONSURF TABLET (ORAL)	SULFACETAMIDE / PREDNISOLONE 10-0.23% (OPHTHALMIC
FENOFIBRATE 48 MG, 145 MG TABLET (ORAL)	NAPROXEN DR 375MG, 500MG TABLET (not ER) (ORAL)	LYNPARZA CAPSULE, TABLET (ORAL)	**TOBRADEX EYE DROP (OPHTHALMIC)**
GEMFIBROZIL TABLET (ORAL)	SULINDAC TABLET (ORAL)	RUBRACA TABLET (ORAL)	TOBRADEX EYE OINTMENT (OPHTHALMIC)
NIACIN ER TABLET (ORAL)	**VOLTAREN 1% GEL (TOPICAL)**	STIVARGA TABLET (ORAL)	
		TEMAZOLAMIDE CAPSULE (ORAL)	**OPHTHALMIC, ANTI-INFLAMMATORIES**
LIPOTROPICS, STATINS ‡	**ONCOLOGY, ORAL - BREAST**	ZEJULA CAPSULE (ORAL)	DICLOFENAC 0.1% DROP (OPHTHALMIC)
(STEP THERAPY CATEGORY)	ANASTROZOLE TABLET (ORAL)	**ONCOLOGY, ORAL - PROSTATE**	DUREZOL 0.05% DROP (OPHTHALMIC)
ATORVASTATIN TABLET (ORAL)	CYCLOPHOSPHAMIDE CAPSULE (ORAL)	BICALUTAMIDE TABLET (ORAL)	FLAREX 0.1% DROP (OPHTHALMIC)
CRESTOR TABLET (ORAL)	EXEMESTANE TABLET (ORAL)	EMCYT CAPSULE (ORAL)	FLUOROMETHOLONE 0.1% DROP (OPHTHALMIC)
LOVASTATIN TABLET (ORAL)	IBRANCE CAPSULE (ORAL)	ERLEADA TABLET (ORAL)	FLURBIPROFEN 0.03% DROP (OPHTHALMIC)
PRAVASTATIN TABLET (ORAL)	LETROZOLE TABLET (ORAL)	FLUTAMIDE CAPSULE (ORAL)	FML FORTE 0.25% DROP (not LIQUIFILM) (OPHTHALMIC)
SIMVASTATIN TABLET (ORAL)	TAMOXIFEN CITRATE TABLET (ORAL)	**NILANDRON TABLET (ORAL)**	FML S.O.P. 0.1% OINTMENT (OPHTHALMIC)
	XELODA TABLET (ORAL)	XTANDI CAPSULE (ORAL)	ILEVRO 0.3% DROP (OPHTHALMIC)
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OPHTHALMIC, ANTI-INFLAMMATORIES, CONT.	PHOSPHATE BINDERS	PRENATAL VITAMINS, CONT.	STEROIDS, TOPICAL VERY HIGH POTENCY
KETOROLAC 0.5% SOLUTION (not 0.4%) (OPHTHALMIC)	CALCIUM ACETATE CAPSULE, GELCAP, TABLET (ORAL)	VOL-NATE TABLET (ORAL)	CLOBETASOL EMOLLIENT 0.05% CREAM (TOPICAL)
LOTEMAX 0.5% DROP (not GEL) (OPHTHALMIC)	RENAGEL TABLET (ORAL)	VOL-PLUS TABLET (ORAL)	CLOBETASOL PROPIONATE 0.05% CREAM (TOPICAL)
MAXIDEX 0.1% DROPS (OPHTHALMIC)	**RENVELA TABLET (ORAL)**	VOL-TAB RX TABLET (ORAL)	CLOBETASOL PROPIONATE 0.05% GEL (TOPICAL)
PRED MILD 0.12% (not FORTE) (OPHTHALMIC)			CLOBETASOL PROPIONATE 0.05% OINTMENT (TOPICAL)
PREDNISOLONE ACETATE 1% DROP (OPHTHALMIC)	**PITUITARY SUPPRESSIVE AGENTS, LHRH**	**PROTON PUMP INHIBITORS ‡**	CLOBETASOL PROPIONATE 0.05% SOLUTION (TOPICAL)
PREDNISOLONE SOD PHOSPHATE 1% DROP (OPHTHALMIC	ELIGARD SYRINGE (SUBCUTANEOUS)	**(STEP THERAPY CATEGORY)**	**CLOBEX 0.05% SHAMPOO (TOPICAL)**
	LEUPROLIDE ACETATE KIT, VIAL (SUBCUTANEOUS)	ESOMEPRAZOLE 20MG, 40MG CAPSULE (Rx ONLY) (ORAL)	HALOBETASOL PROPIONATE 0.05% CREAM (TOPICAL)
OPHTHALMIC, ANTI-INFLAMMATORY/IMMUNOMODULATOR	LUPRON DEPOT KIT (INJECTION)	NEXIUM ORAL SUSPENSION (not CAPSULE) (ORAL)	HALOBETASOL PROPIONATE 0.05% OINTMENT (TOPICAL)
RESTASIS 0.05% EYE EMULSION (OPHTHALMIC)	LUPRON DEPOT-PED KIT (INJECTION)	OMEPRAZOLE 10MG, 40MG CAPSULE (Rx ONLY) (ORAL)	
RESTASIS MULTIDOSE 0.05% (OPHTHALMIC)	SYNAREL SPRAY (NASAL)	PANTOPRAZOLE TABLET (ORAL)	**STIMULANTS AND RELATED AGENTS (DX CODE REQ.)**
		PROTONIX SUSPENSION (ORAL)	**(DX CODE REQUIRED - ALL AGENTS)**
OPHTHALMICS, GLAUCOMA AGENTS	**PLATELET AGGREGATION INHIBITORS**		ADDERALL TABLET (ORAL) (DX CODE REQ.)
ALPHAGAN P 0.15% DROP (OPHTHALMIC)	**AGGRENOX CAPSULE (ORAL)**	**SEDATIVE HYPNOTICS**	**ADDERALL XR CAPSULE (ORAL) (DX CODE REQ.)**
AZOPT 1% DROP (OPHTHALMIC)	BRILINTA TABLET (ORAL)	FLURAZEPAM CAPSULE (ORAL)	AMPHETAMINE SALT COMBO TABLET (IR) (ORAL) (DX CODE
BETOPTIC S 0.25% (OPHTHALMIC)	CLOPIDOGREL TABLET (ORAL)	TEMAZEPAM 15MG, 30MG CAPSULE (ORAL)	APTENSIO XR CAPSULE (ORAL) (DX CODE REQ.)
BRIMONIDINE 0.2% DROP (OPHTHALMIC)	DIPYRIDAMOLE TABLET (ORAL)	ZOLPIDEM TARTRATE 5MG, 10MG TABLET (IR) (ORAL)	ATOMOXETINE CAPSULE (ORAL) (DX CODE REQ.)
CARTEOLOL 1% DROP (OPHTHALMIC)			**CONCERTA ER TABLET (ORAL) (DX CODE REQ.)**
COMBIGAN 0.2%-0.5% DROP (OPTHALMIC)	**PRENATAL VITAMINS**	**SKELETAL MUSCLE RELAXANTS**	DEXTROAMPHETAMINE TABLET (IR) (not ER) (ORAL) (DX CO
DORZOLAMIDE 2% DROP (OPHTHALMIC)	**CITRANATAL 90 DHA (ORAL)**	BACLOFEN TABLET (ORAL)	DEXTROAMPHETAMINE / AMPHETAMINE TABLET (IR) (ORAL
DORZOLAMIDE / TIMOLOL DROP (OPHTHALMIC)	**CITRANATAL ASSURE (ORAL)**	CHLORZOXAZONE TABLET (ORAL)	**FOCALIN TABLET (ORAL) (DX CODE REQ.)**
ISTALOL 0.5% DROP (OPHTHALMIC)	CITRANATAL B-CALM (ORAL)	CYCLOBENZAPRINE TABLET (ORAL)	**FOCALIN XR CAPSULE (ORAL) (DX CODE REQ.)**
LATANOPROST 0.005% DROP (OPHTHALMIC)	CITRANATAL DHA (ORAL)	METHOCARBAMOL TABLET (ORAL)	GUANFACINE ER TABLET (ORAL) (DX CODE REQ.)
LEVOBUNOLOL 0.5% DROP (OPHTHALMIC)	CITRANATAL HARMONY CAPSULE (ORAL)	TIZANIDINE TABLET (not CAPSULE) (ORAL)*	**METHYLIN SOLUTION (ORAL) (DX CODE REQ.)**
PILOCARPINE 1%, 2%, 4% DROPS (OPHTHALMIC)	COMPLETE NATAL DHA (ORAL)		METHYLPHENIDATE TABLET (IR) (not ER) (ORAL)
SIMBRINZA 1%-0.2% DROP (OPHTHALMIC)	COMPLETENATE TABLET CHEWABLE (ORAL)	**SMOKING CESSATION**	MODAFINIL (ORAL) (DX CODE REQ.) §
TIMOLOL 0.25%, 0.5% EYE DROP (OPHTHALMIC)	CONCEPT DHA CAPSULE (ORAL)	CHANTIX TABLET (ORAL)	QUILLICHEW ER CHEWABLE TABLET (ORAL) (DX CODE REQ
TIMOLOL 0.25%, 0.5% GEL-SOLUTION (OPHTHALMIC)	FOLIVANE-OB CAPSULE (ORAL)	CHANTIX STARTING MONTH BOX, CONT MONTH BOX (ORA	QUILLIVANT XR SUSPENSION (ORAL) (DX CODE REQ.)
TRAVATAN Z 0.004% DROP (OPHTHALMIC)	NIVA-PLUS TABLET (ORAL)	NICOTINE GUM OTC (not BRAND) (BUCCAL)	VYVANSE CAPSULE (ORAL) (DX CODE REQ.)
	PNV 29-1 TABLET (ORAL)	NICOTINE LOZENGE OTC (not BRAND) (MUCOUS MEM)	VYVANSE CHEWABLE TABLET (ORAL) (DX CODE REQ.)
OPIATE DEPENDENCE TREATMENTS	PNV PRENATAL PLUS MULTIVIT TAB (ORAL)	NICOTINE PATCH OTC (not BRAND) (TRANSDERMAL)	
BUPRENORPHINE HCL TABLET (SUBLINGUAL)	PNV-DHA + DOCUSATE SOFTGEL (ORAL)		**TETRACYCLINES**
NALOXONE CARPUJECT, SYRINGE, VIAL (INJECTION)	PRENAISSANCE NEXT TABLET (ORAL)	**STEROIDS, TOPICAL HIGH POTENCY**	DOXYCYCLINE HYCLATE 50MG CAPSULE (ORAL)
NALTREXONE TABLET (ORAL)	PRENATA CHEWABLE TABLET (ORAL)	BETAMETHASONE DIPROPIONATE 0.05% CREAM (TOPICAL	DOXYCYCLINE HYCLATE 100MG TABLET (not DR) (ORAL)
NARCAN NASAL SPRAY (NASAL)	PRENATAL VITAMIN PLUS LOW IRON (ORAL)	BETAMETHASONE DIPROPIONATE 0.05% LOTION (TOPICAL	DOXYCYCLINE MONOHYDRATE 50 MG, 100 MG CAPSULE (O
SUBOXONE FILM (SUBLINGUAL)	PREPLUS CA-FE 27 MG-FA 1 MG TB (ORAL)	BETAMETHASONE VALERATE 0.1% CREAM (TOPICAL)	DOXYCYCLINE MONOHYDRATE TABLET (ORAL)
VIVITROL VIAL (SUBCUTANEOUS)*	SELECT-OB + DHA PACK (ORAL)*	BETAMETHASONE VALERATE 0.1% LOTION (TOPICAL)	MINOCYCLINE CAPSULE (not TABLET) (ORAL)
	SELECT-OB CHEWABLE CAPLET (ORAL)	BETAMETHASONE VALERATE 0.1% OINTMENT (TOPICAL)	
OTIC ANTIBIOTICS	SE-NATAL 19 CHEWABLE TABLET (ORAL)	TRIAMCINOLONE ACETONIDE 0.025%, 0.1%, 0.5% CREAM (T	**ULCERATIVE COLITIS AGENTS**
CIPRODEX OTIC SUSPENSION (OTIC)	SE-NATAL 19 TABLET (ORAL)	TRIAMCINOLONE ACETONIDE 0.025%, 0.1% LOTION (TOPIC	APRISO ER CAPSULE (ORAL)
FLOXIN 0.3% DROP (OTIC)	THRIVITE 19 TABLET (ORAL)	TRIAMCINOLONE ACETONIDE 0.1%, 0.5% OINTMENT (TOPIC	CANASA SUPPOSITORY (RECTAL)
NEOMYCIN / POLYMYXIN / HC SOLUTION, SUSPENSION (O	THRIVITE RX TABLET (ORAL)		**LIALDA DR TABLET (ORAL)**
OFLOXACIN 0.3% DROP (OTIC)	TRICARE PRENATAL TABLET (ORAL)	**STEROIDS, TOPICAL LOW POTENCY**	SULFASALAZINE TABLET (ORAL)
	TRINATAL RX 1 TABLET (ORAL)	CAPEX SHAMPOO (TOPICAL)	SULFASALAZINE DR TABLET (ORAL)
OTIC ANTI-INFECTIVES & ANESTHETICS	TRIVEEN-DUO DHA COMBO PACK (ORAL)	**DERMA-SMOOTHE-FS (TOPICAL) §**	
ACETIC ACID 2% SOLUTION (OTIC)	TRUST NATAL DHA (ORAL)	HYDROCORTISONE 1% ABSORBASE (TOPICAL)	**VASODILATORS, CORONARY**
	VEMAVITE-PRX 2 CAPSULE (ORAL)	HYDROCORTISONE 1%, 2.5% CREAM (TOPICAL)	ISOSORBIDE DINITRATE TABLET (ORAL)
PAH AGENTS, ORAL AND INHALED	VIRT-ADVANCE TABLET (ORAL)	HYDROCORTISONE 1%, 2.5% LOTION (TOPICAL)	ISOSORBIDE MONONITRATE TABLET (ORAL)
(DX CODE REQUIRED - SILDENAFIL)	VIRT-NATE TABLET (ORAL)	HYDROCORTISONE 0.5%, 1%, 2.5% OINTMENT (TOPICAL)	ISOSORBIDE MONONITRATE ER/SR TABLET (ORAL)
LETAIRIS TABLET (ORAL)	VIRTPREX CAPSULE (ORAL)	HYDROCORTISONE RECTAL CREAM 2.5% (TOPICAL)	NITRO-BID 2% OINTMENT (TRANSDERM)
SILDENAFIL (ORAL) (generic REVATIO) (DX CODE REQ.)	VITAFOL FE+ DOCUSATE COMBO PCK (ORAL)*		NITROGLYCERIN PATCH (TRANSDERM)
TRACLEER TABLET (ORAL)	VITAFOL NANO TABLET (ORAL)*	**STEROIDS, TOPICAL MEDIUM POTENCY**	NITROGLYCERIN SL TABLET (SUBLINGUAL)
VENTAVIS SOLUTION (INHALATION)	VITAFOL ULTRA SOFTGEL (ORAL)	FLUTICASONE PROPIONATE 0.05% CREAM (TOPICAL)	NITROGLYCERIN ER CAPSULE (ORAL)
	VITAFOL-OB CAPLET (ORAL)*	FLUTICASONE PROPIONATE 0.005% OINTMENT (TOPICAL)	NITROGLYCERIN SPRAY (TRANSLINGUAL)
PANCREATIC ENZYMES	VITAFOL-OB+DHA COMBO PACK (ORAL)*	MOMETASONE FUROATE 0.1% CREAM (TOPICAL)	
CREON CAPSULE (ORAL)	VITAFOL-ONE CAPSULE (ORAL)*	MOMETASONE FUROATE 0.1% OINTMENT (TOPICAL)	
ZENPEP CAPSULE (ORAL)	VP-GGR-B6 TABLET (ORAL)	MOMETASONE FUROATE 0.1% SOLUTION (TOPICAL)	
Updated October 1, 2018 §			

STATE OF CONNECTICUT DEPARTMENT OF SOCIAL SERVICES
DRUG PRIOR AUTHORIZATION REQUEST FORM
TELEPHONE: 1-866-409-8386 FAX: 1-866-759-4110 OR (860) 269-2035
(This and other PA forms are posted on www.ctdssmap.com and can be accessed by clicking on the pharmacy icon)

1. Prescriber's Name (Last, First)	5. Member's Name (Last, First)
2. Prescriber's NPI	6. Member's ID
3. Prescriber's Phone	7. Member's Date of Birth (MMDDCCYY)
4. Prescriber's Fax	8. Pharmacy's Fax
9. Drug Requested	
10. Strength 11. Quantity 12. Frequency of Dosing	

Please complete only the section(s) that pertains to the type of PA being requested. Incomplete requests will be denied.

13. Brand Medically Necessary Request

☐ Allergic reaction to excipients in generic product. Provide clinical symptoms:

_____
_____
_____
_____

A completed federal MedWatch form (FDA 3500) must be submitted with this request when a reported allergic reaction to the generic product is the reason for BMN.

☐ Therapeutic failure to generic product. Explain:

_____
_____
_____
_____

Documentation must be maintained in your files in case of an audit. At a minimum, documentation must include date, drug and length of trial. If an audit cannot find and verify documentation, recoupment will be initiated.

14. Early Refill Request

☐ Change in Directions
Previous Directions
_____
New Directions
_____
Last Date of Fill (MM/DD/CCYY)
_____

☐ Lost /Stolen/Other
Last Date of Fill (MM/DD/CCYY)
_____

Documentation of lost, stolen or destroyed meds MUST be attached for approval.

☐ Vacation Supply
Date of Departure (MM/DD/CCYY)
_____
Date of Return (MM/DD/CCYY)
_____

15. Non-Preferred Drug Request

☐ Intolerance of the preferred agents. Provide clinical symptoms:

_____
_____
_____
_____

☐ Adverse reaction to the preferred agents. Provide clinical symptoms:

_____
_____
_____
_____

☐ Inadequate response to the preferred agents

☐ Absence of appropriate formulation of preferred agents

☐ Medically necessary/medically appropriate

16. Optimal Dose Request

☐ Therapeutic failure to once daily dosing:

☐ Medically Necessary/medically appropriate:

I certify that documentation is maintained in my files and the information given is true and accurate for the medication requested, subject to penalty under Connecticut Gen. Stat. Section 17b-99 and Regs. Conn. State Agencies Sections 17-83k-1-3 and 4a –7, inclusive. I certify that the client is under my clinic's/practice's ongoing care. I understand that Prior Authorizations will not exceed 6 months from date of fill for controlled medications and 1 year for non-controlled medications, except for Early Refill Requests, which are valid one time only.

17. Signature of Prescriber* _____ 18. Date (MM/DD/CCYY)_____

* Mandatory (others may not sign for prescriber). **In accordance to mandates set forth in the Affordable Care Act (ACA), providers who order, prescribe, or refer clients for services must be enrolled in the Connecticut Medical Assistance Program (CMAP). Effective 10/1/2013, any prescriptions or services provided by a non-enrolled provider will no longer be considered/covered by CMAP.**

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(Direction Sheet) Informational Only

No.	Name	Description
1.	Prescriber's Name (Last, First)	Enter the prescribing practitioner's last name and first name
2.	Prescriber's NPI	Enter the prescribing practitioner's National Provider Identification (NPI) number
3.	Prescriber's Phone	Enter the prescribing practitioner's phone number where a PA customer service representative can contact the practitioner for additional information or clarification, if necessary
4.	Prescriber's Fax	Enter the prescribing practitioner's fax number where a PA customer service representative can contact the practitioner for additional information or clarification, if necessary
5.	Member's Name (Last, First)	Enter the member's name as it appears on the member's CONNECT Card or as obtained from the Automated Eligibility Verification System (AEVS)
6.	Member's ID	Enter the member's 9-digit identification number as it appears on the member's CONNECT Card or as obtained from the Automated Eligibility Verification System (AEVS)
7.	Member's Date of Birth (MMDDCCYY)	Enter the member's date of birth in MM/DD/CCYY format
8.	Pharmacy's Fax (optional)	Enter the pharmacy's fax number, if known
9.	Drug Requested	Enter the drug for which the Prior Authorization is being requested (brand/generic)
10.	Strength	Enter the strength of the drug in milligrams
11.	Quantity	Enter the quantity of the drug being prescribed
12.	Frequency of Dosing	Enter the dosing frequency
13.	Brand Medically Necessary Request	Enter the justification for the brand medically necessary request: • For allergic reaction – the prescriber must indicate the clinical symptoms of the reaction and submit a completed MedWatch form (FDA 3500) with the BMN PA request • For therapeutic failure – the prescriber must explain the number and length of trials of generic medication
14.	Early Refill Request	Enter the justification for the early refill request: • For change in dose – the prescriber must provide the previous frequency of dosing, as well as the new frequency of dosing to justify the increased utilization • For lost/stolen/other – the prescriber must document the Last Date of Fill as well as documentation of the lost or destroyed medication o Appropriate written documentation for lost medication can be: insurance report, police report, letter from the prescriber or pharmacist on formal company letterhead explaining the extenuating circumstance, record of admittance to an institutional facility such as a hospital, record of arrest or incarceration during the time in question, etc. o Documentation for destroyed medication can be a fire marshal's report, insurance report, police report, or record of an institutional facility destruction of medication in the presence of a witness, etc. • For vacation supply – the prescriber must document the *date of departure* and *date of return* for the client in MM/DD/CCYY format. Only one early refill authorization will be granted for a specific medication for a vacation supply every six months with the authorized quantity equal to one refill.
15.	Non-Preferred Drug Request	Enter the justification for the non-preferred drug request: • For intolerance to preferred agents – the prescriber must provide clinical symptoms of intolerance • For adverse reaction to preferred agents – the prescriber must provide clinical symptoms of adverse reaction and is asked to complete and submit a MedWatch form to the FDA (optional) • For inadequate response to preferred agents, absence of appropriate formulation of preferred agents, or medically necessary/medically appropriate – no further information is required • Prior authorizations will not exceed 6 months fom date of fill for controlled medications and 1 year for non-controlled medications.
16.	Optimal Dose Request	Enter the justification for the optimal dose request: • For therapeutic failure to once daily dosing – the prescriber must provide clinical symptoms of response to once daily dosing • For medically necessary/medically appropriate – the prescriber must provide clinical symptoms that justify medical necessity or appropriateness
17.	Signature of Prescriber	The prescribing practitioner must sign the PA form; agent's signature is not acceptable
18.	Date (MM/DD/CCYY)	Enter the date the form was completed, signed, and submitted in MM/DD/CCYY format

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STEP THERAPY CATEGORIES

ACNE AGENTS, TOPICAL

Preferred Step Therapy Agents	Non-Preferred Agents Requiring Step Therapy PA Request	
AZELEX 20% CREAM	ACANYA	ERYTHROMYCIN 2% PLEDGETS
CLINDAMYCIN PHOSPHATE 1% PLEGET	ACZONE	ERYTHROMYCIN-BENZOYL
CLINDAMYCIN PHOSPHATE 1% SOLUTION	ADAPALENE	EVOCLIN
CLINDAMYCIN-BENZOYL PEROXIDE 1-5% GEL **PUMP**	ATRALIN	FABIOR
DIFFERIN 0.1% CREAM	AVAR	KLARON
DIFFERIN 0.1% GEL	BENZACLIN	NEUAC
DIFFERIN 0.1% LOTION	BENZAMYCIN	ONEXTON
DIFFERIN 0.3% GEL PUMP	BENZOYL PEROXIDE	OVACE
EPIDUO 0.1-2.5% GEL PUMP	BPO	RETIN-A MICRO
ERYTHROMYCIN 2% SOLUTION	CLEOCIN T	ROSANIL
RETIN-A CREAM	CLINDACIN	ROSULA
RETIN-A GEL	CLINDAMYCIN PHOS LOTION, GEL, FOAM	SEB-PREV
	CLIND PH-BENZOYL PEROX 1.2-5%	SODIUM SULFACETAMIDE - SULFUR
	CLINDAMYCIN-BENZOYL 1-5% GEL	SSS CREAM, FOAM
	DAPSONE	SUMADAN
	DUAC	SUMAXIN
	EPIDUO **FORTE**	TAZORAC
	ERY 2% PADS	TRETINOIN
	ERYGEL	ZIANA
	ERYTHROMYCIN 2% GEL	

CYTOKINE/CAM ANTAGONISTS

Preferred Step Therapy Agents	Non-Preferred Agents Requiring Step Therapy PA Request	
ENBREL (INJECTION)	ACTEMRA	OTEZLA
HUMIRA (INJECTION)	ARCALYST	REMICADE
	CIMZIA	RENFLEXIS
	COSENTYX	SILIQ
	ENTYVIO	SIMPONI
	ILARIS	STELARA
	INFLECTRA	TALTZ
	KEVZARA	TREMFYA
	KINERET	XELJANZ
	ORENCIA	

ANTIMIGRAINE AGENTS

Preferred Step Therapy Agents	Non-Preferred Agents Requiring Step Therapy PA Request	
RELPAX TABLET	ALMOTRIPTAN	ONZETRA
RIZATRIPTAN ODT	AMERGE	SUMATRIPTAN CARTRIDGE
RIZATRIPTAN TABLET	AXERT	SUMATRIPTAN SYRINGE
SUMATRIPTAN NASAL SPRAY	ELETRIPTAN	SUMATRIPTAN - NAPROXEN
SUMATRIPTAN TABLET	FROVA	SUMAVEL
SUMATRIPTAN VIAL	FROVATRIPTAN	TREXIMET
	IMITREX	ZEMBRACE
	MAXALT	ZOLMITRIPTAN
	MIGRANOW	ZOMIG
	NARATRIPTAN	

LIPOTROPICS, STATINS

Preferred Step Therapy Agents	Non-Preferred Agents Requiring Step Therapy PA Request	
ATORVASTATIN	ALTOPREV	LIVALO
CRESTOR	AMLODIPINE-ATORVAST	PRAVACHOL
LOVASTATIN	CADUET	ROSUVASTATIN
PRAVASTATIN	EZETIMIBE-SIMVASTATIN	VYTORIN
SIMVASTATIN	FLUVASTATIN	ZOCOR
	LESCOL	ZYPITAMAG
	LIPITOR	

PROTON PUMP INHIBITORS

Preferred Step Therapy Agents	Non-Preferred Agents Requiring Step Therapy PA Request	
ESOMEPRAZOLE CAPSULES 20MG & 40MG (Rx ONLY)	ACIPHEX	OMEPRAZOLE-BICARB
NEXIUM SUSPENSION	DEXILANT	PREVACID
OMEPRAZOLE CAPSULES 10 & 40MG (Rx ONLY)	ESOMEPRAZOLE (OTC VERSIONS)	PRIOLOSEC
PANTOPRAZOLE	LANSOPRAZOLE	PROTONIX TABLET
PROTONIX SUSPENSION	NEXIUM CAPSULE	RABEPRAZOLE
	OMEPRAZOLE (OTC VERSIONS)	ZEGERID

STATE OF CONNECTICUT DEPARTMENT OF SOCIAL SERVICES
TELEPHONE: 1-866-409-8386 FAX: 1-866-759-4110 OR (860) 269-2035

STEP THERAPY PA REQUEST FORM - Proton Pump Inhibitors, Statins, Anti-migraine, Topical Acne Agents and Cytokine & CAM Antagonists

[This and other pharmacy PA forms are available at www.ctdssmap.com and can be accessed by clicking on the pharmacy icon]

PA Criteria for Step Therapy Drug Products

- The Pharmacy team will validate the client's history for the use of preferred agent(s) before approving a non-preferred agent. Non-Preferred drug approvals require documented evidence that the patient has tried and failed, is intolerant to, or has a contraindication to a normal course of therapy with at least one preferred drug in the class.
- For clients new to Medicaid, a pharmacy profile history showing previously failed preferred products, outcomes and compliance with the medication regimen length shall be provided with the non-preferred product request form.
- Clinical prior authorization must be obtained for any non-preferred step therapy drug **using this form only, not the standard drug PA form.**
- A copy of your filed FDA 3500 Med Watch Form is required if patients have experienced significant adverse effect

Prescriber and Member Information

Please Print: **Note - Incomplete requests will not be granted.**

1. Prescriber's Name (Last, First)	5. Member's Name (Last, First)
2. Prescriber's NPI	6. Member's ID
3. Prescriber's Phone	7. Member's Date of Birth (MM/DD/CCYY)
4. Prescriber's Fax	8. Pharmacy Name & Fax
9. Drug & Dosage Form (print)	
10. Route ☐ Oral ☐ Topical ☐ Inhalation ☐ Injectable	
11. Strength 12. Quantity 13. Frequency of Dosing	

Medical History

Note - Incomplete requests will be denied.

Please explain why the patient cannot be treated with a preferred alternative. You MUST indicate which preferred product has been utilized in the past, circle a reason for the failure (listed below), AND supply a specific written clinical explanation.

14. Preferred Product Trial (Name & Daily Dose)	15. Reason	16. Clinical Explanation (including length of therapy, date commenced, and outcome)
	1 2 3 4	

1. Use of the preferred alternative is contraindicated.
2. The patient has experienced significant adverse effects from the preferred alternative, Completed FDA 3500 MedWatch form attached and filed with the FDA.
3. Use of the preferred alternative has resulted in therapeutic failure after the normal course of treatment.
4. Pediatric patient (younger than 12 years of age).

I certify that documentation is maintained in my files and the information given is true and accurate for the medication requested, subject to penalty under Connecticut Gen. Stat. Section 17b-99 and Regulations of Conn. State Agencies Sections 17-83k-1-3 and 4a –7, inclusive. I certify that this member is under my clinic's/practice's ongoing care.

17. Signature of Prescriber* _____ 18. Date (MM/DD/CCYY) _____

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6.	Member's ID	Enter the member's 9-digit identification number as it appears on the member's CONNECT Card or as obtained from the Automated Eligibility Verification System (AEVS)
7.	Member's Date of Birth (MMDDCCYY)	Enter the member's date of birth in MM/DD/CCYY format
8.	Pharmacy's Name & Fax (optional)	Enter the pharmacy's name and fax number, if known
9.	Drug & Dosage Form	Print the drug info for which the Prior Authorization is being requested
10.	Route	Select the route of the drug being requested
11.	Strength	Enter the strength of the drug in milligrams
12.	Quantity	Enter the quantity of the drug being prescribed
13.	Frequency of Dosing	Enter the dosing frequency
14.	Preferred Product	Indicate which preferred drug the patient has tried and failed in the past including the dosage per day. Preferred Drug List
15.	Reason	Circle the number on the form which corresponds to the type of failure experienced, and submit any required documentation.
16.	Clinical Explanation	Provide a written clinical explanation of the indicated failure to a preferred product including length of therapy, outcome and when commenced.
17.	Signature of Prescriber	The prescribing practitioner must sign the PA form; agent's signature is not acceptable
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