



INDIANA MEDICAID PREFERRED DRUG LIST  
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INDIANA MEDICAID PREFERRED DRUG LIST

DRUG	LIMITS	DATE	DRUG	LIMITS	DATE
<b>CARDIOVASCULAR SYSTEM</b>					
<b>ACE INHIBITORS</b>					
<b>A4D</b>					
<b>Preferred Drugs</b>			<b>Non-Preferred Drugs</b>		
benazepril		07/06/04	Lotensin*		11/01/06
captopril	12 years and under	09/17/02	captopril	over 12 years old	09/17/02
			Capoten*		09/17/02
enalapril		09/17/02	Vasotec*		09/17/02
fosinopril		07/06/04	Monopril*		11/01/06
lisinopril		09/17/02	Prinivil*/Zestril*		09/17/02
moexipril		10/20/03	Univas*		10/20/03
quinapril		11/01/05	Accupril*		09/17/02
trandolapril		10/01/07	Mavik*		10/01/07
			Accon		09/17/02
			Altace	participants on Altace within past 180 days of effective date will be grandfathered***	10/01/07
<b>ACE INHIBITORS with CALCIUM CHANNEL BLOCKERS</b>					
<b>A4K</b>					
<b>Preferred Drugs</b>			<b>Non-Preferred Drugs</b>		
			amlodipine/benazepril	qty limit - 30 caps/month; participants on amlodipine/benazepril within past 90 days of effective date will be grandfathered***	10/01/08
			Lexxel		12/10/02
			Lotrel*	qty limit - 30 caps/month	10/01/07
			Tarka	participants on Tarka within past 90 days of effective date will be grandfathered***	10/01/08
<b>ACE INHIBITORS with DIURETICS</b>					
<b>A4J</b>					
<b>Preferred Drugs</b>			<b>Non-Preferred Drugs</b>		
benazepril/HCTZ		07/06/04	Lotensin HCT*		11/01/06
captopril/HCTZ		12/10/02	Capozide*		12/10/02
enalapril/HCTZ		12/10/02	Vaseretic*		12/10/02
fosinopril/HCTZ		11/01/05	Monopril HCT*		11/01/06
lisinopril/HCTZ		12/10/02	Prinzide*/Zestoretic*		12/10/02
moexipril /HCTZ		10/01/07	Uniretic*		10/01/07
quinapril/HCTZ		11/01/05	Accuretic*		12/10/02
<b>ANGIOTENSIN RECEPTOR BLOCKERS</b>					
<b>A4F</b>					
<b>Preferred Drugs</b>			<b>Non-Preferred Drugs</b>		
Avapro	1 tablet per day; step edit - prior use of ACE-I	10/01/07			
Benicar	step edit - prior use of ACE-I	03/04/04			
Cozaar	1 tablet per day; step edit - prior use of ACE-I	01/07/03			
Diovan	step edit - prior use of ACE-I	01/01/06			
Micardis	1 tablet per day; step edit - prior use of ACE-I	01/07/03			
			Atacand		01/07/03
			Teveten		01/07/03
<b>ANGIOTENSIN RECEPTOR BLOCKERS with CALCIUM CHANNEL BLOCKERS</b>					
<b>A4H</b>					
<b>Preferred Drugs</b>			<b>Non-Preferred Drugs</b>		
Exforge		10/01/08			
			Azor		05/01/08
<b>ANGIOTENSIN RECEPTOR BLOCKERS with DIURETICS</b>					
<b>A4I</b>					
<b>Preferred Drugs</b>			<b>Non-Preferred Drugs</b>		
Avalide	step edit - prior use of ACE-I	10/01/07			
Benicar HCT	step edit - prior use of ACE-I	10/20/03			
Diovan HCT	step edit - prior use of ACE-I	01/01/06			
Hyzaar	step edit - prior use of ACE-I; patients with a paid claim for Hyzaar within the past 180 days of effective date will be grandfathered	05/01/08			
Micardis HCT	step edit - prior use of ACE-I	12/10/02			
			Atacand HCT		12/10/02
			Teveten HCT		12/10/02
<b>ALPHA/BETA ADRENERGIC BLOCKERS</b>					
<b>J7A</b>					
<b>Preferred Drugs</b>			<b>Non-Preferred Drugs</b>		
carvedilol		05/01/08	Coreg IR*	qty limit - 2 tabs/day; step edit - must have prior trial on carvedilol; must be on an ACE or ARB	10/01/08
			Coreg CR	qty limit - 1 cap/day; step edit - must have prior trial on carvedilol; must be on an ACE or ARB	10/01/08
labetalol	all formulations	10/09/02	Trandate tabs*		10/09/02

<b>BETA ADRENERGIC BLOCKERS</b>					
<b>J7C</b>					
Preferred Drugs			Non-Preferred Drugs		
acebutolol		10/09/02	Sectral*		10/09/02
atenolol		10/09/02			
betaxolol		10/09/02	Kerlone*		10/09/02
bisoprolol		10/09/02	Zebeta*		10/09/02
Inderal**		10/09/02			
Inderal LA	all LA strengths	10/09/02			
			InnoPran XL		11/01/05
Lopressor**		10/20/03			
metoprolol	all formulations	10/09/02			
metoprolol succinate ER		04/17/07			
nadolol		10/09/02	Corgard*		10/09/02
pindolol		10/09/02	Visken*		10/09/02
propranolol	all formulations	10/09/02			
sotalol		10/09/02	Betapace*/Betapace AF*		10/09/02
Tenormin**		10/09/02			
timolol		10/09/02			
Toprol XL		04/01/09			
			Bystolic		10/01/08
			Levadol		10/09/02
<b>CALCIUM CHANNEL BLOCKERS</b>					
<b>A9A</b>					
Preferred Drugs			Non-Preferred Drugs		
amlodipine		10/01/07	Norvasc*		10/01/07
Calan SR		10/09/02			
			Calan (non-time released)*		11/01/05
diltiazem	long-acting formulations	10/09/02	Dilacor XR*		10/09/02
			Cardizem* (all formulations)		11/01/06
			diltiazem (non-time released)		11/01/05
			Tiazac*		11/01/05
felodipine ER		11/01/05	Plendil*		11/01/06
Isopтин SR		10/09/02			
nifedipine	long-acting formulations	10/09/02	Adalat CC*/Procardia XL*		10/09/02
nimodipine		10/01/07	Nimotop*		10/01/07
verapamil	long-acting formulations	10/09/02	Verelan*		11/01/05
			Covera-HS		11/01/05
verapamil ER PM		05/01/08	Verelan PM *		05/01/08
			Cardene (non-time released)*		10/09/02
			Cardene SR		10/09/02
			Dynacirc CR		11/01/05
			isradipine (non-time released)		11/01/06
			nicardipine (non-time released)		11/01/05
			nifedipine (short acting)		10/09/02
			nisoldipine		04/01/09
			Procardia*		10/09/02
			Sular		11/01/05
			verapamil (non-time released)		11/01/05
<b>CALCIUM CHANNEL BLOCKER with HMG CoA REDUCTASE INHIBITOR</b>					
<b>M4I</b>					
Preferred Drugs			Non-Preferred Drugs		
Caduet	all strengths	03/22/05			
<b>DIRECT RENIN INHIBITOR</b>					
<b>A4T</b>					
Preferred Drugs			Non-Preferred Drugs		
Tekturba	step edit - trial of an ACE or ARB within the past 90 days	10/01/08			
<b>DIRECT RENIN INHIBITOR with DIURETIC</b>					
<b>A4U</b>					
Preferred Drugs			Non-Preferred Drugs		
Tekturba HCT	step edit - trial of an ACE or ARB within the past 90 days	10/01/08			
<b>INSPIRA</b>					
<b>R1H</b>					
Preferred Drugs			Non-Preferred Drugs		
Inspira	step edit - requires previous therapy with spironolactone within the past 30 days	05/19/04	eplerenone	step edit - requires previous therapy with spironolactone within the past 30 days	04/01/09
<b>RESPIRATORY SYSTEM</b>					
<b>LEUKOTRIENE RECEPTOR ANTAGONISTS</b>					
<b>Z4B, Z4E</b>					
Preferred Drugs			Non-Preferred Drugs		
Accolate	step edit - patients 18 years of age and older must have had one of the following medications within the past 6 months: methylxanthine, beta agonist and/or oral inhaled corticosteroid	10/01/07			
Singular	step edit - patients 12 years of age and older must have had one of the following medications within the past 6 months: methylxanthine, beta agonist and/or oral inhaled corticosteroid	10/01/08			
			Zyflo		12/10/02
			Zyflo CR		05/01/08

<b>LONG-ACTING BETA AGONISTS</b>					
<b>JSD</b>					
Preferred Drugs			Non-Preferred Drugs		
Foradil		10/01/08	Perforomist		05/01/08
Serevent		12/10/02			
			Brovana		10/01/07
<b>SHORT-ACTING BETA AGONISTS</b>					
<b>JSD</b>					
Preferred Drugs			Non-Preferred Drugs		
albuterol	all strengths/formulations excluding tablets	10/20/03	Accuneb*		11/01/05
albuterol inhalers	3 canisters per month for ages 18 and younger; 2 canisters per month for ages 19 and over	12/10/02	albuterol tablets	brand and generic	10/20/03 12/10/02
albuterol HFA	3 canisters per month for ages 18 and younger; 2 canisters per month for ages 19 and over	11/01/05			
Proair HFA	3 canisters per month for ages 18 and younger; 2 canisters per month for ages 19 and over	04/17/07			
Proventil HFA	3 canisters per month for ages 18 and younger; 2 canisters per month for ages 19 and over	04/03/06			
Ventolin HFA	3 canisters per month for ages 18 and younger; 2 canisters per month for ages 19 and over	04/03/06			
Xopenex	2 prescriptions per 6 months, 1 box of 24 per prescription	01/18/05	Xopenex HFA	3 canisters per month for ages 18 and younger; 2 canisters per month for ages 19 and over	11/01/06
			Alupent*		12/10/02
			Maxair Autohaler		12/10/02
<b>BETA ADRENERGICS AND CORTICOSTEROIDS</b>					
<b>JSG</b>					
Preferred Drugs			Non-Preferred Drugs		
Advair 100/50		10/20/03			
Advair 250/50		10/20/03			
Advair 500/50	step edit - must have failed Advair 100/50, Advair 250/50, or Flovent within the past 30 days	03/25/04			
Advair HFA 45/21		04/17/07			
Advair HFA 115/21		04/17/07			
Advair HFA 230/21	step edit - must have failed Advair HFA 45/21, Advair HFA 115/21, or Flovent HFA within the past 30 days	04/17/07			
Symbicort		10/01/07			
<b>ORAL INHALED GLUCOCORTICOID</b>					
<b>PSA</b>					
Preferred Drugs			Non-Preferred Drugs		
Aerobid		11/01/06	Aerobid-M		10/01/07
Azmacort		10/01/07			
Flovent Diskus		10/01/07			
Flovent HFA		11/01/05			
Pulmicort Respules	5 years and younger; qty limits - 240 mls/month (0.25 mg/2 mL vial), 120 mls/month (0.5 mg/2 mL vial), 60 mls/month (1 mg/2 mL vial)	10/01/08	budesonide inhalation suspension	6 years and older; qty limits - 240 mls/month (0.25 mg/2 mL vial), 120 mls/month (0.5 mg/2 mL vial)	04/01/09
			Pulmicort Respules	6 years and older; qty limits - 240 mls/month (0.25 mg/2 mL vial), 120 mls/month (0.5 mg/2 mL vial), 60 mls/month (1 mg/2 mL vial)	10/01/08
Qvar		12/10/02			
			Asmanex		11/01/05
			Alvesco		04/01/09
			Pulmicort Flexhaler		10/01/08
			Pulmicort Turbohaler		10/01/07
<b>AGENTS TO TREAT COPD</b>					
<b>A1D, J5I</b>					
Preferred Drugs			Non-Preferred Drugs		
Atrovent HFA		11/01/05			
Atrovent Inhaler		10/26/04			
Combivent	qty limit - 2 inhalers/month	10/01/08			
ipratropium solution		10/26/04			
Spiriva		10/26/04			
			Duoneb*		10/26/04
			ipratropium/albuterol solution		05/01/08
<b>NASAL PREPARATIONS</b>					
<b>Q7A, Q7E, Q7P</b>					
Preferred Drugs			Non-Preferred Drugs		
Astelin		12/10/02	Astepro		04/01/09
Flonase		12/10/02	fluticasone		11/01/06
flunisolide		11/01/05			
ipratropium NS		11/01/05	Atrovent NS*		11/01/06
Nasacort AQ		11/01/05			
Nasarel		11/01/05			
Nasonex		10/01/07			
Patanase		10/01/08			
Veramyst		10/01/07			
			Beconase AQ		10/26/04
			Omnaris		10/01/08
			Rhinocort AQ		04/01/04

<u>NON-SEDATING ANTIHISTAMINES</u>					
<u>Z20, Z20</u>					
New patients must first try cetirizine and loratadine within 90 days prior to receiving a non-preferred agent. All patients with an existing prior authorization are not subject to the step edit.					
Preferred Drugs			Non-Preferred Drugs		
cetirizine 5mg non-chewable OTC tabs		04/01/08	Zyrtec 5mg chewable and non-chewable (Rx) tabs	step edit - must have trial on both cetirizine and loratadine within the past 90 days	10/01/08
cetirizine 10mg non-chewable OTC tabs		04/01/08	Zyrtec 10mg chewable and non-chewable (Rx) tabs	step edit - must have trial on both cetirizine and loratadine within the past 90 days	10/01/08
			Zyrtec-D tabs	step edit - must have trial on both cetirizine and loratadine within the past 90 days	10/01/08
cetirizine 1mg/ml OTC syrup	qty limit - 10 mls/day	10/01/08			
loratadine 10mg OTC tabs		06/17/04	Claritin 10mg tabs	step edit - must have trial on both cetirizine and loratadine within the past 90 days	10/01/08
loratadine 10mg OTC redi-tabs		06/17/04	Claritin 10mg Reditabs	step edit - must have trial on both cetirizine and loratadine within the past 90 days	10/01/08
loratadine 1mg/1ml OTC syrup	qty limit - 10 mls/day	10/01/08	Claritin 1mg/ml Syrup	step edit - must have trial on both cetirizine and loratadine within the past 90 days; qty limit - 10 mls/day	10/01/08
loratadine/pseudoephedrine 12 hour OTC tabs		06/17/04	Claritin-D tabs	step edit - must have trial on both cetirizine and loratadine within the past 90 days	10/01/08
loratadine/pseudoephedrine 24 hour OTC tabs		06/17/04			
Zyrtec 1mg/ml (Rx) Syrup	qty limit - 10 mls/day	10/01/08			
			Allegra* 180mg tabs	step edit - must have trial on both cetirizine and loratadine within the past 90 days	10/01/08
			Allegra* 30mg tabs	step edit - must have trial on both cetirizine and loratadine within the past 90 days	10/01/08
			Allegra* 60mg tabs/caps	step edit - must have trial on both cetirizine and loratadine within the past 90 days	10/01/08
			Allegra-D* tabs	step edit - must have trial on both cetirizine and loratadine within the past 90 days	10/01/08
			Allegra 30mg/5ml Suspension	step edit - must have trial on both cetirizine and loratadine within the past 90 days; qty limit - 10 mls/day	10/01/08
			Clarinet 5mg tabs	step edit - must have trial on both cetirizine and loratadine within the past 90 days	10/01/08
			Clarinet 2.5mg Reditabs	step edit - must have trial on both cetirizine and loratadine within the past 90 days	10/01/08
			Clarinet 5mg Reditabs	step edit - must have trial on both cetirizine and loratadine within the past 90 days	10/01/08
			Clarinet 0.5mg/ml Syrup	step edit - must have trial on both cetirizine and loratadine within the past 90 days; qty limit - 10 mls/day	10/01/08
			Clarinet-D tabs	step edit - must have trial on both cetirizine and loratadine within the past 90 days	10/01/08
			fexofenadine	step edit - must have trial on both cetirizine and loratadine within the past 90 days	10/01/08
			fexofenadine/pseudoephedrine	step edit - must have trial on both cetirizine and loratadine within the past 90 days	10/01/08
			Xyzal 5mg tabs	step edit - must have trial on both cetirizine and loratadine within the past 90 days	10/01/08
<u>SYNAGIS</u>					
<a href="#">Click here for Synagis PA Form</a>					
Preferred Drugs			Non-Preferred Drugs		
Synagis	PA required	07/01/09			
<u>ANTI-INFECTIVES</u>					
<u>FLUOROQUINOLONES*</u>					
<u>W1Q</u>					
All fluoroquinolones will be limited to a 14-day supply.					
Preferred Drugs			Non-Preferred Drugs		
Avelox		1/7/2003			
Avelox ABC PAC	1 pack per month	01/07/03			
ciprofloxacin		09/23/04	Cipro*	step edit - must have trial on both cetirizine and loratadine within the past 90 days	10/26/04
			ciprofloxacin ER	3 tablets per prescription; no refills	10/01/07
			Cipro XR*	3 tablets per prescription; no refills	10/01/07
			Proquin XR		11/01/06
Levaquin		01/07/03			
Levaquin Oral Solution		03/22/05			
ofloxacin		10/26/04	Floxin*		10/26/04
			Factive		11/01/05
			Noroxin		11/01/05
<u>1st GENERATION CEPHALOSPORINS</u>					
<u>W1W</u>					
Preferred Drugs			Non-Preferred Drugs		
First generation cephalosporins	all generic formulations	01/07/03			
			Duricef*		01/07/03
			Keflex*		01/07/03

<u>3rd GENERATION CEPHALOSPORINS</u>				
<u>W1V</u>				
Preferred Drugs			Non-Preferred Drugs	
Omnicef		10/01/08	cefdinir	10/01/08
Suprax		01/07/03		
Spectracef		05/19/04		
			Cedax	01/07/03
			cefepodoxime	10/26/04
			Vantam*	01/07/03
<u>ANTIFUNGALS</u>				
<u>W3A, W3B</u>				
Preferred Drugs			Non-Preferred Drugs	
fluconazole	50mg-3 tablets per month; 150mg-2 tablets per month	10/26/04	Diflucan*	50mg-3 tablets per month; 150mg-2 tablets per month
			Diflucan* 100mg	11/01/05
			Diflucan* 200mg	11/01/05
			Diflucan* Suspension	11/01/05
itraconazole		11/01/05	Sporanox*	01/07/03
ketoconazole		01/07/03	Nizoral*	01/07/03
terbinafine		05/01/08	Lamisil*	01/07/03
			Noxafil	04/17/07
				must have failed therapy with fluconazole for treatment of oropharyngeal candidiasis or must be severely immunocompromised and need prophylaxis against invasive Aspergillus or Candida infections
			Vfend	01/07/03
<u>MACROLIDES</u>				
<u>W1D</u>				
Preferred Drugs			Non-Preferred Drugs	
azithromycin oral tablets	limit of one package per month on six-tablet and three-tablet package	04/01/06	Zithromax* Oral Tablets	limit of one package per month on six-tablet and three-tablet package
azithromycin suspension		04/17/07	Zithromax* Suspension	04/17/07
			Zmax	11/01/05
erythromycin	all generic formulations	01/07/03	Erythromycin*	01/07/03
clarithromycin		11/01/05	Biaxin*	11/01/05
			Biaxin XL*	11/01/05
			Biaxin XL PAC	11/01/05
				1 pack per month
<u>KETOLIDES</u>				
<u>W9A</u>				
Preferred Drugs			Non-Preferred Drugs	
			Ketek	10/26/04
<u>OTIC ANTIBIOTICS</u>				
<u>08F, 08W</u>				
Preferred Drugs			Non-Preferred Drugs	
all generic products		07/21/03		
Ciprodex		10/26/04		
Floxin Otic Singles		10/01/07		
Floxin Otic Solution (multi-use bottle)		11/01/06	ofloxacin otic solution	10/01/08
neomycin, polymyxin B & hydrocortison		07/21/03	Cortisporin*/Pediotic	07/21/03
			Cipro HC	10/26/04
			Coly-Mycin S	07/21/03
<u>ANTIVIRAL (ANTI-HERPETIC) AGENTS</u>				
<u>W5A</u>				
Preferred Drugs			Non-Preferred Drugs	
acyclovir	all formulations	10/20/03	Zovirax* 200 mg caps	10/26/04
			Zovirax* 400 mg tabs	10/26/04
			Zovirax* 800 mg tabs	08/06/03
			Zovirax* Suspension	10/20/03
Valtrex	step edit - requires HIV therapy	10/20/03		
			famciclovir	05/01/08
			Famvir	08/06/03
<u>ANTIVIRAL (INFLUENZA) AGENTS</u>				
<u>H6A, W5A</u>				
Preferred Drugs			Non-Preferred Drugs	
amantidine		08/06/03	Symmetrel*	08/06/03
Relenza		04/01/09		
rimantadine	60 years and older	04/01/04	rimantadine	under 60 years old
			Flumadine*	08/06/03
Tamiflu	*Temporarily Preferred due to the Swine flu outbreak	05/01/09		

<u>OPHTHALMIC ANTIBIOTICS</u>					
<u>Q6W</u>					
Preferred Drugs			Non-Preferred Drugs		
all generic products		07/21/03			
bacitracin		07/21/03			
chloramphenicol		07/21/03			
ciprofloxacin		10/26/04	Ciloxan Drops*		10/26/04
			Ciloxan Ointment		10/20/03
erythromycin		07/21/03			
gentamicin		07/21/03			
neomycin, polymyxin B & bacitracin		07/21/03			
neomycin, polymyxin B & gramicidin		07/21/03	Neosporin*		07/21/03
ofloxacin		10/26/04	Ocuflax*		10/26/04
polymyxin B & bacitracin		07/21/03			
polymyxin B & trimethoprim		07/21/03	Polytrim*		07/21/03
tetracycline & polymyxin B		07/21/03			
tobramycin		07/21/03	Tobrex*		07/21/03
Vigamox	age limit - 30 years of age or older; step edit - patients under 30 years of age must 1st have a trial on at least one preferred agent within the past 30 days	10/01/08			
Zymar	age limit - 30 years of age or older; step edit - patients under 30 years of age must 1st have a trial on at least one preferred agent within the past 30 days	10/01/08			
			Azasisite		05/01/08
			Cortisporin*		07/21/03
			Iquix		10/26/04
			Natacyn		07/21/03
			Quixin		07/21/03
<u>EYE ANTIBIOTIC / CORTICOSTEROID COMBINATIONS</u>					
<u>Q6W</u>					
Preferred Drugs			Non-Preferred Drugs		
all generic products		07/21/03			
gentamicin & prednisolone		07/21/03	Pred-G*		07/21/03
neomycin, polymyxin B & dexamethasone		07/21/03	Maxitrol*		07/21/03
			Poly-Pred		07/21/03
			Tobradex*		07/21/03
			Zylet		11/01/06
<u>TOPICAL ANTI-FUNGAL AGENTS</u>					
<u>Q6W</u>					
Preferred Drugs			Non-Preferred Drugs		
all generic products		08/06/03			
ciclopirox		11/01/05	Loprox*		09/02/04
			Penlac*		08/06/03
clotrimazole		08/06/03	Lotrimin		08/06/03
econazole		08/06/03	Spectazole*		08/06/03
miconazole		08/06/03	Micatin		08/06/03
			Ertaczo		05/19/04
			Exelderm		08/06/03
			Extina		05/01/08
			Lamisil AT		08/06/03
			Monax		08/06/03
			Naftin		08/06/03
			Nizoral*		08/06/03
			Oxistat		08/06/03
			Tinactin		08/06/03
			Xolegel		04/17/07
<u>TOPICAL ANTIVIRALS</u>					
<u>Q6W</u>					
Preferred Drugs			Non-Preferred Drugs		
Abreva cream		07/01/09			
Zovirax ointment		07/01/09	Zovirax cream		07/01/09
			Denavir cream		07/01/09
<u>VAGINAL ANTIMICROBIALS</u>					
<u>Q4E, Q4W</u>					
Preferred Drugs			Non-Preferred Drugs		
clotrimazole		08/06/03	Gyne-Lotrimin		08/06/03
			Mycelex		08/06/03
metronidazole vaginal gel		04/17/07	Metrogel Vaginal Gel*		10/01/07
			Vandazole Vaginal Gel		04/01/06
miconazole		08/06/03	Monistat		08/06/03
tioconazole		08/06/03	Vagistat-1		08/06/03
			Cleocin Vaginal	cream/ovule	08/06/03
			Clindesse		11/01/05
			Gynazole 1		08/06/03
			Terazol*		08/06/03
<u>HEPATITIS C AGENTS</u>					
<u>WSG</u>					
Preferred Drugs			Non-Preferred Drugs		
Copegus		10/01/07			
Pegasys		10/01/07			
Pegintron		10/01/07			
Rebetol		10/01/07			
ribavirin		10/01/07			

<b>LIPOTROPICS</b>					
<b>BILE ACID SEQUESTRANTS</b>					
<b>D7L</b>					
Preferred Drugs			Non-Preferred Drugs		
cholestyramine multi-dose containers		05/14/03	cholestyramine packets		05/14/03
			Questram*		05/14/03
Colestid multi-dose containers		05/14/03	Colestid*	tablets, granule packets	05/14/03
colestipol granules for suspension		04/17/07	colestipol	tablets	10/01/07
Prevalite powder		05/14/03	Prevalite packets		05/14/03
			Welchol		05/14/03
<b>FIBRIC ACIDS</b>					
<b>M4E</b>					
Preferred Drugs			Non-Preferred Drugs		
gemfibrozil		05/14/03	Lopid*		05/14/03
TriCor (all strengths)		11/01/06	Antara		01/01/06
			fenofibrate		11/01/06
			Lipofen		05/01/08
			Lofibra (all strengths)		11/01/06
			Triglide		01/01/06
<b>HMG CoA REDUCTASE INHIBITORS</b>					
<b>M4D</b>					
Preferred Drugs			Non-Preferred Drugs		
Lescol		12/10/02			
Lescol XL		12/10/02			
Lipitor		12/10/02			
lovastatin		12/10/02	Altoprev		10/01/07
			Mevacor*		12/10/02
pravastatin	step edit - patient must have a clinically significant drug-drug interaction with other statin-type cholesterol-lowering agents	11/01/06	Pravachol*	step edit - patient must have a clinically significant drug-drug interaction with other statin-type cholesterol-lowering agents	11/01/06
simvastatin		11/01/06	Zocor*		11/01/06
			Crestor	participants on Crestor within past 90 days of effective date will be grandfathered***	10/01/08
<b>OTHER LIPOTROPICS</b>					
<b>M4E, M4L, M4M</b>					
Preferred Drugs			Non-Preferred Drugs		
Advicor		05/19/04			
Niaspan		05/19/04	Niacor		11/01/05
Simcor		10/01/08			
Vytorin		10/26/04			
Zetia	step edit - patients currently or previously on an HMG-CoA reductase inhibitor or fenofibrate within the past 180 days may receive Zetia	10/01/07			
<b>BLOOD PRODUCTS</b>					
<b>PLATELET AGGREGATION INHIBITORS</b>					
<b>M9P</b>					
Preferred Drugs			Non-Preferred Drugs		
Aggrenox		12/21/04			
cilostazol		06/28/05	Pletal*		06/28/05
Plavix 75mg tablets		10/09/02	clopidogrel		01/01/07
Plavix 300mg tablets	quantity limit - 1 tablet per prescription	07/01/08	Ticlid*		10/09/02
			ticlopidine		10/09/02
<b>HEPARIN AND RELATED PRODUCTS</b>					
<b>M9K</b>					
Preferred Drugs			Non-Preferred Drugs		
Arixtra	quantity limit - 1 syringe/day	01/01/09			
Fragmin	pre-filled syringes only	02/26/03	Fragmin	formulations other than pre-filled syringes	02/26/03
heparin	generic products only	02/26/03			
Lovenox	pre-filled syringes only	02/26/03	Lovenox	formulations other than pre-filled syringes	02/26/03
			Innohep		02/26/03
<b>HEMATINICS</b>					
<b>N1B</b>					
Preferred Drugs			Non-Preferred Drugs		
Aranesp		07/21/03			
Epogen		07/21/03			
Procrit		07/21/03			
<b>LEUKOCYTE STIMULANTS</b>					
<b>N1C</b>					
Preferred Drugs			Non-Preferred Drugs		
Leukine		07/21/03			
Neupogen	vials only	07/21/03	Neupogen	prefilled syringes	07/21/03
			Neulasta		07/21/03

<b>NERVOUS SYSTEM</b>					
<b>TRIPTANS</b>					
<b>H3F</b>					
Preferred Drugs			Non-Preferred Drugs		
Amerge	1 box-9 tablets/month	10/26/04			
Axert	1 box-6 tablets/month	12/10/02			
Imitrex tablets	1 box-9 tablets/month	12/10/02	sumatriptan tablets	1 box-9 tablets/month	04/01/09
Imitrex nasal spray	1 box-6 inhalers/month	12/10/02	sumatriptan nasal spray	1 box-6 inhalers/month	04/01/09
Imitrex stat dose or stat dose refill package	1 box-2 injections/month	12/10/02	sumatriptan stat dose or stat dose refill package	1 box-2 injections/month	04/01/09
Imitrex vial	2 vials-2 injections/month	12/10/02	sumatriptan vial	2 vials-2 injections/month	04/01/09
Maxalt MLT	1 box-12 tablets/month	10/01/07	Maxalt	1 box-12 tablets/month	10/01/07
Relpax	1 box-6 tablets/month	04/01/04			
Treximet	1 box-9 tablets/month	10/01/08			
			Frova	1 box-9 tablets/month	10/26/04
			Zomig	1 box-6 tablets/month	10/26/04
			Zomig Nasal Spray	1 box-6 inhalers/month	10/26/04
			Zomig ZMT	1 box-6 tablets/month	10/26/04
<b>ANTIEMETIC / ANTIVERTIGO AGENTS</b>					
<b>H6J</b>					
Preferred Drugs			Non-Preferred Drugs		
Emend oral capsules	6 caps per prescription	10/20/03	Emend 115 mg vial		07/01/08
ondansetron oral tablets	10 tabs per prescription	01/01/08	Zofran oral tablets	10 tabs per prescription	01/01/08
ondansetron oral disintegrating tablets	10 tabs per prescription	01/01/08	Zofran oral disintegrating tablets	10 tabs per prescription	01/01/08
ondansetron oral solution	1 bottle per prescription	01/01/08	Zofran oral solution	1 bottle per prescription	01/01/08
ondansetron solution for injection		06/24/07	Zofran solution for injection		01/01/08
			Aloxi	1 vial per prescription	07/27/04
			Anzemet oral tabs	10 tabs per prescription	02/26/03
			Anzemet solution for injection		01/01/07
			granisetron oral tablets		07/01/08
			granisetron solution for injection		07/01/08
			Granisol oral solution		07/01/08
			Kytril oral solution		12/21/04
			Kytril oral tabs	10 tabs per prescription	12/21/04
			Kytril solution for injection		06/28/05
			Sancuso transdermal system	step edit - physician documentation required indicating oral medications are unsuitable for patient use	07/01/09
<b>SKELETAL MUSCLE RELAXANTS</b>					
<b>H6H</b>					
Preferred Drugs			Non-Preferred Drugs		
baclofen		05/14/03	Lioresal		05/14/03
chlorzoxazone		05/14/03	Parafon Forte*		05/14/03
cyclobenzaprine		05/14/03	Amrix	step edit - must have a trial of cyclobenzaprine within the past 30 days	01/01/09
			Fexmid	step edit - must have a trial of cyclobenzaprine within the past 30 days	01/01/09
			Flexeril*		05/14/03
dantrolene		06/28/05	Dantrium*		05/14/03
methocarbamol		05/14/03	Robaxin*		05/14/03
orphenadrine citrate		05/14/03	Norflex*/Norgesic Forte*		
tizanidine		05/14/03	Zanaflex*		05/14/03
			carisoprodol	quantity limit - 4 tabs/day	01/01/09
			carisoprodol combination products	quantity limit - 8 tabs/day	01/01/09
			Skelaxin	quantity limit - 4 tabs/day;	05/14/03
			Soma	step edit - must have a trial of generic carisoprodol in the past 30 days	01/01/09
			Soma combination products	quantity limit - 8 tabs/day; step edit - must have a trial of generic carisoprodol combination product in the past 30 days	01/01/09
<b>ELECTROLYTE DEPLETERS</b>					
<b>C1A, C1F</b>					
Preferred Drugs			Non-Preferred Drugs		
calcium carbonate		10/01/07			
Fosrenol	step edit - prior trial of Renagel within past 90 days or previous use of Fosrenol within past 180 days	10/01/07			
Magnebind		10/01/07			
Magnebind Rx		10/01/07			
Phoslo		10/01/07	calcium acetate		04/01/09
Renagel		10/01/07			
			Calphron		05/01/08
<b>MULTIPLE SCLEROSIS AGENTS</b>					
<b>H0E, Z2R</b>					
Preferred Drugs			Non-Preferred Drugs		
Avonex	qty limit - 4 vials or syringes/month	10/01/08			
Betaseron		10/01/07			
Copaxone	qty limit - 1 kit/month	10/01/08			
Rebif		10/01/07			
			Tysabri		10/01/07

<b>GASTROINTESTINAL SYSTEM</b>						
<b>PROTON PUMP INHIBITORS</b>						
<b>D4J</b>						
New patients must first try omeprazole 20 mg within 90 days before receiving Protonix. Additionally, a new patient must first try omeprazole 20 mg and then a preferred PPI for a total length of therapy of 4 weeks, unless the patient is intolerant to these agents, before receiving a non-preferred PPI. All patients with an existing PPI prior authorization are not subject to the step edit.						
Preferred Drugs			Non-Preferred Drugs			
Nexium packets	step edit - must be 12 years of age or younger; quantity limit - 1 packet/day	01/01/09				
omeprazole (10 mg, 20 mg)		07/01/09	omeprazole 40 mg	step edit - two 20 mg capsules required	07/01/09	
omeprazole OTC	*Omeprazole OTC will no longer be covered beginning July 1, 2009.	07/01/08				
Prilosec OTC	*Prilosec OTC will no longer be covered beginning October 1, 2009.	04/01/04				
Prevacid Solutab	step edit - must be 12 years of age or younger; quantity limit - 1 tab/day	01/01/08	Prevacid Solutab	step edit - over 12 years of age; must fail omeprazole 20 mg and then a preferred PPI for a total length of therapy of 4 weeks, unless patient is intolerant to these agents	07/01/09	
Protonix (tablets and vials)	step edit - must fail omeprazole 20 mg within past 90 days unless on clopidogrel therapy; quantity limit - 1 tab/day	07/01/08	Protonix delayed-release suspension	must fail omeprazole 20 mg and then a preferred PPI for a total length of therapy of 4 weeks, unless patient is intolerant to these agents	07/01/09	
			pantoprazole tabs	must fail omeprazole 20 mg and then a preferred PPI for a total length of therapy of 4 weeks, unless patient is intolerant to these agents	07/01/09	
			Aciphex	must fail omeprazole 20 mg and then a preferred PPI for a total length of therapy of 4 weeks, unless patient is intolerant to these agents	07/01/09	
			Kapindex	must fail omeprazole 20 mg and then a preferred PPI for a total length of therapy of 4 weeks, unless patient is intolerant to these agents	07/01/09	
			Nexium caps	must fail omeprazole 20 mg and then a preferred PPI for a total length of therapy of 4 weeks, unless patient is intolerant to these agents	07/01/09	
			Nexium IV		01/01/07	
			Prevacid caps	must fail omeprazole 20 mg and then a preferred PPI for a total length of therapy of 4 weeks, unless patient is intolerant to these agents	07/01/09	
			Prevacid suspension	must fail omeprazole 20 mg and then a preferred PPI for a total length of therapy of 4 weeks, unless patient is intolerant to these agents	07/01/09	
			Prilosec* caps	must fail omeprazole 20 mg and then a preferred PPI for a total length of therapy of 4 weeks, unless patient is intolerant to these agents	07/01/09	
			Prilosec packets	step edit - must be 12 years of age or younger; must fail Nexium packets or Prevacid Solutabs for a total length of therapy of 4 weeks, unless patient is intolerant to these agents; quantity limit - 1 packet/day	07/01/09	
			Zegerid (all dosage forms and strengths)	must fail omeprazole 20 mg and then a preferred PPI for a total length of therapy of 4 weeks, unless patient is intolerant to these agents	07/01/09	
<b>ANTIULCER/H.PYLORI AGENTS</b>						
<b>D4F</b>						
Preferred Drugs			Non-Preferred Drugs			
			Helidac		08/06/03	
			Prevpac		08/06/03	
			Pylera		01/01/08	

<u>H2 ANTAGONISTS</u>					
<u>Z2D</u>					
Preferred Drugs			Non-Preferred Drugs		
cimetidine	60 tablets per 30 days	09/12/03	Tagamet* (solid oral dosage forms only)		09/12/03
cimetidine liquid		01/01/08			
famotidine	60 tablets per 30 days	09/12/03	Fluxid		12/21/04
			Pepcid* (solid oral dosage forms only)		09/12/03
			Pepcid Suspension		01/01/08
nizatidine	60 tablets per 30 days	09/12/03	Axid* (solid oral dosage forms only)		09/12/03
			Axid Oral Solution		01/01/08
ranitidine tabs	60 tablets per 30 days	09/12/03	ranitidine capsules		01/01/07
			Zantac* (solid oral dosage forms only)		09/12/03
Zantac Syrup		01/01/08	ranitidine syrup		01/01/08
OTC products	60 tablets per 30 days; OTC products are covered if it has a MAC and is on the Indiana OTC drug list	09/12/03	Zantac Effervescent		06/28/05
<u>CHRONIC CONSTIPATION AGENTS</u>					
<u>D6S</u>					
Preferred Drugs			Non-Preferred Drugs		
Amitiza	step edit - requires previous therapy with lactulose or sorbitol or polyethylene glycol within past 90 days	01/01/08			
<u>ULCERATIVE COLITIS AGENTS</u>					
<u>D6F, O3E, W2A</u>					
Preferred Drugs			Non-Preferred Drugs		
Asacol		01/01/08			
Canasa		01/01/08			
Colazal		01/01/08	balsalazide		07/01/08
Dipentum		01/01/08			
mesalamine		01/01/08	Apriso		07/01/09
			Lialda		01/01/08
			Rowasa*		01/01/08
Pentasa		01/01/08			
sulfasalazine		01/01/08	Azulfidine*, Azulfidine* En-tabs, Sulfazine EC		01/01/08
<u>TOPICAL AGENTS</u>					
<u>EYE ANTIHISTAMINES</u>					
<u>O6R</u>					
Preferred Drugs			Non-Preferred Drugs		
Alaway		06/24/07	Ketotifen		01/01/07
Optivar		01/01/07			
Pataday		01/01/08			
Patanol		12/21/04			
Zaditor		12/21/04			
			Elestat		01/01/07
			Emadine		07/21/03
<u>OPHTHALMIC MAST CELL STABILIZERS</u>					
<u>O6U</u>					
Preferred Drugs			Non-Preferred Drugs		
cromolyn		07/21/03	Crolon*		07/21/03
			Alamast		10/20/03
			Alocril		01/01/09
			Alomide		01/01/06
<u>MIOTICS / OTHER INTRAOCULAR PRESSURE REDUCERS</u>					
<u>O6G, O6J</u>					
Preferred Drugs			Non-Preferred Drugs		
Azopt		07/21/03			
brimonidine		07/27/04	Alphagan P*	patients on agent prior to effective date were grandfathered***	03/25/04
betaxolol		07/21/03	Betoptic-S		07/21/03
carteolol		07/21/03			
Combigan		01/01/09			
Cosopt		07/21/03	dorzolamide/timolol		07/01/09
dipivefrin		07/21/03	Propine*		07/21/03
Isopto-Carbachol		07/21/03			
Iopidine		07/21/03			
levobunolol		07/21/03	Betagan*		07/21/03
metipranolol		07/21/03	Optipranolol*		07/21/03
pilocarpine		07/21/03	Isopto-Carpine		07/21/03
			Piloptine-HS		07/21/03
timolol		07/21/03	Betimol		07/21/03
			Istalol		06/28/05
			Timoptic*		07/21/03
			Timoptic XE*		07/21/03
Travatan		07/21/03			
Travatan Z		06/24/07			
Trusopt		07/21/03	dorzolamide		07/01/09
Xalatan		07/21/03			
			Lumigan	patients on agent prior to effective date were grandfathered***	04/01/04
			Phospholine Iodide		07/21/03
<u>TOPICAL ESTROGEN AGENTS</u>					
<u>O4K</u>					
Preferred Drugs			Non-Preferred Drugs		
Premarin Vaginal Cream		04/01/04			
Vagifem		01/01/06			
Estring		01/01/06			
			Estrace Vaginal Cream		04/01/04
			Femring		04/01/04

<b>TOPICAL IMMUNOMODULATORS</b>					
<b>OSK</b>					
Preferred Drugs			Non-Preferred Drugs		
Elidel		01/01/08	Protopic		01/01/08
<b>WOUND CARE PRODUCTS</b>					
<b>LOB, LOC</b>					
As of December 4, 2006 the following drugs have been determined to be DESI (less than effective) by the FDA, and are therefore no longer reimbursable by Indiana Medicaid Allanderm T, Granulderm, Granulex, Optase, TBC Aerosol and Xenaderm Ointment					
Preferred Drugs			Non-Preferred Drugs		
Gladase	limit of one manufacturer's standard package per month	04/01/06	Accuzyme	limit of one manufacturer's standard package per month; maximum prior authorization approval length of three months	04/01/06
			Allanzyme	limit of one manufacturer's standard package per month; maximum prior authorization approval length of three months	01/01/07
			EtheZyme	limit of one manufacturer's standard package per month; maximum prior authorization approval length of three months	04/01/06
			Kovia	limit of one manufacturer's standard package per month; maximum prior authorization approval length of three months	04/01/06
Gladase-C	limit of one manufacturer's standard package per month	04/01/06	Allanfil	limit of one manufacturer's standard package per month; maximum prior authorization approval length of three months	01/01/07
			Panafil	limit of one manufacturer's standard package per month; maximum prior authorization approval length of three months	04/01/06
			Ziox	limit of one manufacturer's standard package per month; maximum prior authorization approval length of three months	04/01/06
Santyl	limit of two manufacturer's standard packages per month	04/24/09			
Regranex	step-edit - must be on diabetic medication in the past 90 days; quantity limit of one-15 gm tube per 28 days	04/01/06			
<b>ENDOCRINE SYSTEM</b>					
<b>THIAZOLIDINEDIONES</b>					
<b>C4N</b>					
Preferred Drugs			Non-Preferred Drugs		
Actos	34 tablets per month	10/20/03			
Avandia	34 tablets per month	12/21/04			
<b>ANTIDIABETIC AGENTS</b>					
<b>C4F, C4I, C4K, C4L, C4M, C4N, C4R, C4S, C4T</b>					
Preferred Drugs			Non-Preferred Drugs		
acarbose		01/01/09	Precose*		01/01/09
Actoplus Met		01/01/06			
Avandamet		12/21/04			
Avandaryl	step edit - must fail thiazolidinedione or a sulfonylurea	07/01/06			
Duetact	step-edit - must fail thiazolidinedione or a sulfonylurea	01/01/08			
glimepiride		07/01/06	Amaryl*		07/01/06
glipizide		05/14/03	Glucotrol*		05/14/03
glipizide ER		07/27/04	Glucotrol XL*		07/27/04
glipizide/metformin	step edit - must fail metformin or a sulfonylurea	07/01/06	MetaGlip*	step edit - must fail metformin or a sulfonylurea	07/01/06
glyburide		05/14/03	Diabeta/Micronase*		05/14/03
			Glynase*		05/14/03
glyburide/metformin	step edit - must fail metformin or a sulfonylurea	07/06/04	Glucovance*	step edit - must fail metformin or a sulfonylurea	01/01/06
Glyset		05/14/03			
Janumet		01/01/08			
Januvia		06/24/07			
metformin		05/14/03	Glucophage*		05/14/03
			Riomet		07/27/04
metformin ER		07/27/04	Glucophage XR*		05/14/03
			Fortamet		01/01/07
			Glumetza		01/01/07
Prandin		01/01/09	Prandimet		07/01/09
Starlix		05/14/03			
			acetohexamide		05/14/03
			chlorpropamide/Diabinese*		05/14/03
			tolazamide/Tolinase*		05/14/03
			tolbutamide		05/14/03
<b>RAPID-ACTING INSULINS</b>					
<b>C4G</b>					
Preferred Drugs			Non-Preferred Drugs		
Humalog (all formulations)		01/01/08			
Novolog vials only		01/01/07	Novolog (prefilled pen, innolets, syringes and cartridges are non-preferred)		01/01/07
			Apidra		01/01/07
<b>SHORT-ACTING INSULINS</b>					
<b>C4G</b>					
Preferred Drugs			Non-Preferred Drugs		
Humulin (all formulations)		01/01/08			
Novolin R vials only		01/01/07	Novolin R (prefilled pen, innolets, syringes and cartridges are non-preferred)		01/01/07
Relion R vials only		01/01/07	Relion R (prefilled pen, innolets, syringes and cartridges are non-preferred)		01/01/07

<b>INTERMEDIATE-ACTING INSULINS</b>					
<b>C4G</b>					
Preferred Drugs			Non-Preferred Drugs		
Humalog Mix 50/50 (all formulations)		01/01/08			
Humalog Mix 75/25 (all formulations)		01/01/08			
Humulin N (all formulations)		01/01/08			
Humulin 50/50 (all formulations)		01/01/08			
Humulin 70/30 (all formulations)		01/01/08			
Novolin N vials only		01/01/07	Novolin N (prefilled pen, innolets, syringes and cartridges are non-preferred)		01/01/07
Novolin 70/30 vials only		01/01/07	Novolin 70/30 (prefilled pen, innolets, syringes and cartridges are non-preferred)		01/01/07
Novolog Mix 70/30 vials only		01/01/07	Novolog Mix 70/30 (prefilled pen, innolets, syringes and cartridges are non-preferred)		01/01/07
Relion N vials only		01/01/07	Relion N (prefilled pen, innolets, syringes and cartridges are non-preferred)		01/01/07
Relion 70/30 vials only		01/01/07	Relion 70/30 (prefilled pen, innolets, syringes and cartridges are non-preferred)		01/01/07
<b>LONG-ACTING INSULINS</b>					
<b>C4G</b>					
Preferred Drugs			Non-Preferred Drugs		
Lantus vials only		01/01/07	Lantus (prefilled pens, innolets, syringes and cartridges are non-preferred)		01/01/07
Levemir vials only		01/01/08	Levemir flexpen		01/01/07
<b>AMYLIN ANALOG</b>					
<b>C4H</b>					
Preferred Drugs			Non-Preferred Drugs		
Symlin pens and vials	step-edit - must currently be on mealtime insulin (Apidra, Humalog, Humulin R, Novolin R, Novolog, or Relion R;	07/01/08			
<b>INCRETIN MIMETIC</b>					
<b>C4I</b>					
Preferred Drugs			Non-Preferred Drugs		
Byetta	step-edit - must currently be on metformin and/or a sulfonylurea and/or a thiazolidinedione or combo including such	01/01/07			
<b>GROWTH HORMONES</b>					
<a href="#">Click here for PA Form for Growth Hormone for patients &lt; 18 years</a> <a href="#">Click here for PA Form for Growth Hormone for patients &gt; 18 years</a>					
<b>PIA</b>					
Preferred Drugs			Non-Preferred Drugs		
Genotropin	PA required	01/01/08			
Humatrope	PA required	01/01/08			
Norditropin	PA required	01/01/08			
Nutropin/Nutropin AQ	PA required	01/01/08			
Omnitrope	PA required	01/01/08			
Saizen	PA required	01/01/08			
Serostim	PA required	01/01/08			
Tev-Tropin	PA required	01/01/08			
Zorbtive	PA required	01/01/08			
<b>BONE AGENTS</b>					
<b>SERMs/BONE RESORPTION INHIBITORS</b>					
<b>P4I, P4N, P4O</b>					
Preferred Drugs			Non-Preferred Drugs		
Actonel Tablets		01/01/07	Actonel with Calcium		01/01/06
alendronate		07/01/08	Fosamax/Fosamax Plus D		07/01/08
Evista		02/26/03			
Etidronate		07/01/06	Didronel		02/26/03
Fosamax Solution		07/27/04			
Miacalcin		12/21/04	Fortical		01/01/06
			Boniva Tablets		07/01/08
			Boniva Pre-filled Syringe	one single-use, pre-filled syringe per 90 days	07/01/06
			Skelid		02/26/03
<b>BONE FORMATION STIMULATING AGENTS</b>					
<a href="#">Click here for Forteo PA Form</a>					
<b>P4B</b>					
Preferred Drugs			Non-Preferred Drugs		
			Forteo	PA required	01/01/09
<b>SKIN</b>					
<b>ACNE AGENTS</b>					
<b>L1B, L1B, L1SH</b>					
Preferred Drugs			Non-Preferred Drugs		
Amnesteem/ Claravis/Sotret	25 years and under	07/29/09			
Azelex	25 years and under	07/27/04	Azelex	over 25 years old	07/27/04
Benzaclin	25 years and under	07/27/04	Benzaclin	over 25 years old	07/27/04
Duac/Duac CS	25 years and under	07/01/08	Duac/Duac CS	over 25 years old	07/01/08
			Acanya		07/01/09
Differin	25 years and under; step edit - must have failed a tretinoin product	07/21/03	Differin	over 25 years old	07/21/03
			Epiduo		07/01/09
Retin-A	25 years and under	10/20/03	Retin-A*	over 25 years old	10/20/03
sulfacetamide topical lotion	25 years and under	06/24/07	sulfacetamide/Klaron*	over 25 years old	06/24/07
tretinoin	all formulations; 25 years and under	07/21/03	tretinoin/Avita*	all formulations; over 25 years old	7/21/2003
			Atralin		07/01/08
			Ziana	over 25 years old	06/24/07
			Acezone		07/01/09

<u>ANTIPSORIATICS</u>					
<u>D6A, L1A, L5E, S2L, T0A</u>					
Preferred Drugs			Non-Preferred Drugs		
Amevive		07/27/04			
Dovonex		07/21/03	calcipotriene topical solution		01/01/09
			Taclonex ointment	step-edit - must fail calcipotriene; limit of 4 weeks of therapy	01/01/07
			Taclonex scalp suspension	step-edit - must fail calcipotriene; limit of 8 weeks of therapy	01/01/09
Drithocreme HP, Dritho-Scalp		07/21/03			
Oxsoalene-Ultra		07/21/03			
Psoriatec		07/21/03			
Soriatane		07/21/03			
Tazarotac		07/21/03			
			Vectical		07/01/09
<u>ANALGESICS</u>					
<u>NARCOTICS</u>					
<u>H3A, H3N</u>					
Preferred Drugs			Non-Preferred Drugs		
Products containing acetaminophen are limited to 3 grams of acetaminophen per day			Products containing acetaminophen are limited to 3 grams of acetaminophen per day		
acetaminophen/codeine #2, #3, #4		05/14/03	Tylenol* #2, #3, #4		05/14/03
			apap/caffeine/dihydrocodeine		01/01/08
			Panlor DC		01/01/08
			Panlor* SS		01/01/08
			Zerlor		01/01/08
all generic products		05/14/03			
aspirin with codeine		05/14/03	Empirin		05/14/03
butorphanol nasal spray	1 bottle per month	05/14/03	Stadol NS*		05/14/03
Duragesic	10 patches per 30 days	05/14/03	fentanyl 12-, 50-, 75-, and 100-mcg	10 patches per 30 days	01/01/06
fentanyl 25 mcg	10 patches per 30 days (Generic fentanyl 25 mcg patches are preferred due to the recent recall on brand Duragesic 25 mcg patches.)	02/13/08	Actiq	must meet PA criteria	04/01/04
			fentanyl oral transmucosal	must meet PA criteria	06/24/07
			Fentora	must meet PA criteria	07/01/08
hydrocodone	all formulations - limit 1500mg per month	05/14/03	Anexsia		07/01/06
			Hycet		01/01/06
			Lorcet/Lortab/Maxidone/ Narco/Vicodin/Zamicec/Zydone		01/01/09
			Stagesic		01/01/06
			Vicoprofen <sup>®</sup> Reprexain		07/01/09
			Xadol		01/01/06
hydromorphon		05/14/03	Dilaudid*		05/14/03
Kadian		12/21/04			
Oramorph SR		05/14/03	Avinza		01/01/07
			MS Contin*		05/14/03
Oxycontin 10mg, 15mg, 20mg, 30mg, 40mg	120 tablets per 25 days	07/01/08	oxycodone ER 10 mg, 20 mg, 40 mg	120 tablets per 25 days	01/01/07
Oxycontin 60mg, 80mg	60 tablets per 25 days	07/01/08	oxycodone ER 80 mg	60 tablets per 25 days	01/01/07
			Alcet		01/01/07
			Combunox		06/28/05
			Lynox		01/01/07
			Magnacet		06/24/07
			oxycodone/ibuprofen		07/01/08
			Percocet (all formulations)		05/14/03
			Percodan* (all formulations)		05/14/03
pentazocine		05/14/03	Talwin NX*		05/14/03
propoxyphene		05/14/03	Darvon*		05/14/03
			Darvocet A 500		01/01/06
tramadol	400mg per day	05/14/03	Ultram*	400mg per day	05/14/03
			Ultram ER	1 tablet per day	07/01/06
tramadol/APAP		01/01/06	Ultracet*	400mg per day	07/21/03
			Opana IR/ER		07/01/08
<u>NARCOTIC ANTITUSSIVE/1st GENERATION ANTIHISTAMINE COMBINATIONS</u>					
<u>B4D</u>					
Preferred Drugs			Non-Preferred Drugs		
promethazine with codeine	age limit- 6 years and older; quantity limit - 6 ounces per prescription	07/01/09			
Tussionex	age limit- 6 years and older; qty limit - 4 ounces per prescription	07/01/08	Tussionex	less than 6 years of age	07/01/08
			Tussicaps	age limit- 6 years and older; qty limit - 2 caps per prescription	07/01/08
<u>COX-2 INHIBITORS</u>					
<a href="#">Click here for PA Form for Cox-2 Inhibitors</a>					
<u>S2B</u>					
Preferred Drugs			Non-Preferred Drugs		
Celebrex	No PA required for patients 70 years of age or older	09/17/03	Celebrex	PA required for patients less than 70 years of age	09/17/03
<u>TOPICAL ANTI-INFLAMMATORY NSAIDS</u>					
<u>O5E</u>					
Preferred Drugs			Non-Preferred Drugs		
			Flector Patch	step edit - physician documentation required indicating oral medications are unsuitable for patient use	07/01/09
			Voltaren Gel	step edit - physician documentation required indicating oral medications are unsuitable for patient use	07/01/09

<b>NSAID/PPI COMBINATION</b>					
<b>S2P</b>					
Preferred Drugs			Non-Preferred Drugs		
			Prevacid NapraPAC	PA required	07/27/04
<b>GENTOURINARY SYSTEM</b>					
<b>BENIGN PROSTATIC HYPERTROPHY AGENTS</b>					
<b>O9B</b>					
Preferred Drugs			Non-Preferred Drugs		
Avodart		10/20/03			
finasteride 5 mg		01/01/07	Proscar*		01/01/07
Flomax		12/10/02			
			Rapaflo		07/01/09
			Uroxatral		01/01/08
<b>ALPHA ADRENERGIC BLOCKERS</b>					
<b>J7B</b>					
Preferred Drugs			Non-Preferred Drugs		
doxazosin		10/09/02	Cardura tabs*		10/09/02
			Cardura XL		01/01/07
prazosin		10/09/02	Minipress caps*		10/09/02
terazosin		10/09/02	Hytrin caps*		10/09/02
<b>URINARY TRACT ANTISPASMODIC / ANTI-INCONTINENCE AGENTS</b>					
<b>RIA, R11</b>					
Preferred Drugs			Non-Preferred Drugs		
Detrol	step edit - must fail oxybutynin IR	01/01/08	Detrol LA	step edit - must fail oxybutynin IR	01/01/09
			Toviaz	step edit - must fail oxybutynin IR	07/01/09
Enablex	step edit - must fail oxybutynin IR or have prior trial of any cholinesterase inhibitor or memantine (Namenda) within the past 180 days	07/01/08			
flavoxate	step edit - must fail oxybutynin IR	01/01/06	Urispas*	step edit - must fail oxybutynin IR	01/01/06
oxybutynin IR		05/14/03	Ditropan*	step edit - must fail oxybutynin IR	05/14/03
oxybutynin ER	step edit - must fail oxybutynin IR	06/24/07	Ditropan XL.*	step edit - must fail oxybutynin IR and ER	05/14/03
Oxytrol	step edit - must fail oxybutynin IR	03/11/04			
Sanctura	step edit - must fail oxybutynin IR	01/01/09			
Sanctura XR	step edit - must fail oxybutynin IR	01/01/09			
			Vesicare	step edit - must fail oxybutynin IR	11/01/05
<b>SMOKING CESSATION</b>					
<b>SMOKING DETERRENT AGENTS</b>					
<b>J3A, J3C, H7N</b>					
Limited to 12 weeks of therapy every 365 days per statute					
Preferred Drugs			Non-Preferred Drugs		
bupropion SR 150		06/28/05	Zyban*		01/01/06
Chantix		01/01/07			
Commit lozenge		07/21/03			
Nicoderm		12/21/04			
Nicorette		12/21/04			
nicotine gum		07/21/03	Nicorelief		01/01/06
nicotine patch		07/21/03			
			Nicotrol NS		01/01/08
			Nicotrol Inhaler		01/01/08
<p>Prior authorization for Brand Medically Necessary is not required for the drugs specifically exempted by the DUR Board from a prior authorization for the Brand Medically Necessary requirements. This includes those drugs typically referred to as 'narrow therapeutic index' drugs.</p> <p>*Brand name medications with an available substitutable generic are non-preferred unless otherwise specified. Please note that when a brand name drug having a generic equivalent has a Preferred Drug List classification of "Non-Preferred", the generic equivalents for the brand name drug are considered as "Preferred", unless otherwise specified.</p> <p>**In accordance with Indiana law, all anti-anxiety, antidepressant, antipsychotic, and "cross indicated" drugs are considered as being preferred. Drugs that are (1) classified in a central nervous system drug category or classification (according to Drug Facts and Comparisons) created after March 12, 2002, and (2) prescribed for the treatment of a mental illness (as defined by the most recent publication of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders) are also considered as being preferred.</p> <p>***For purposes of the Indiana Medicaid PDL, the term 'grandfathered' refers to the process whereby a participant is granted approval for a non-preferred product without the need of a PA if they were on the agent prior to the effective date.</p> <p>A "PDL neutral" drug is a new drug in a class, that class having been reviewed for PDL status, but the drug itself has not yet been up for review by the T. Committee or the DUR Board.</p> <p>A "PDL neutral reviewed" drug is a new drug in a class, that class having been reviewed for the PDL status, when the drug HAS been up for review by the T Committee/DUR Board, but the drug has not been assigned a preferred or non-preferred status.</p> <p>For purposes of the Indiana Medicaid PDL, a 'line extension' of a drug product is a new strength, formulation, or dosage form of the chemical entity that was the subject of the original new drug application as approved by the Food and Drug Administration. The PDL status of such drugs is the same as the status of the chemical entity that was the subject of the new drug application, unless determined otherwise by the Therapeutics Committee and DUR Board.</p>					