



# Preferred Therapy Drug List

If a prescription has not been filled for the targeted brand-name drug in the last six months (180 days) or the clinical program criteria is not met, the prescribing physician must be contacted to see if the drug prescribed can be changed to a drug listed in the Preferred Drug column.

**Note:** Program criteria must be followed as listed, for the targeted brand-name drug to be covered.

Category	Brand-Name Drug	Preferred Drug	Program Criteria
ADHD/ADD	Vyvanse® Kapvay®	<ul style="list-style-type: none"> <li>• Amphetamine-type product</li> </ul> AND <ul style="list-style-type: none"> <li>• Methylphenidate product</li> </ul>	For members 6 years of age and older who have demonstrated use of one amphetamine-type product AND a methylphenidate product.
Analgesics	Pennsaid® Voltaren® Gel Flector® patch	<ul style="list-style-type: none"> <li>• Oral diclofenac (Example: Cataflam®)</li> </ul> AND <ul style="list-style-type: none"> <li>• Two other oral traditional NSAIDS</li> </ul>	For FDA approved indications only. Member must have tried and failed or demonstrated intolerance to oral diclofenac <b>AND</b> at least two other oral, traditional NSAIDS. AND Coverage will NOT be provided in the presence of concurrent therapy with oral NSAIDS or a COX II inhibitor.
	Vimovo™	<ul style="list-style-type: none"> <li>• Generic omeprazole (Prilosec®) or Prilosec OTC®</li> </ul> AND <ul style="list-style-type: none"> <li>• Generic lansoprazole (Prevacid®)</li> </ul> AND <ul style="list-style-type: none"> <li>• Generic pantoprazole (Protonix®)</li> </ul>	Must have demonstrated use of generic products listed in the preferred drug column. Must also meet one of the following criteria: <ul style="list-style-type: none"> <li>• Age greater than 60 years</li> <li>• Receiving anticoagulant or antiplatelet therapy</li> <li>• Receiving chronic treatment with oral corticosteroids (≥ 60 days duration)</li> <li>• History of, or current diagnosis of peptic ulcer disease, clinically significant gastrointestinal bleeding and/or alcoholism</li> </ul>
	Duexis®	<ul style="list-style-type: none"> <li>• Generic ibuprofen (Motrin®)</li> </ul> AND <ul style="list-style-type: none"> <li>• Generic famotidine (Pepcid®)</li> </ul>	Must have demonstrated use of generic ibuprofen (Motrin®) and generic famotidine (Pepcid®) in combination <b>AND</b> documentation explaining why the requested medication is expected to work if the generic individual agents did not.



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Antidepressants	Forfivo XL <sup>®</sup>	<ul style="list-style-type: none"> <li>• Generic fluoxetine (Prozac<sup>®</sup>, Prozac<sup>®</sup> Weekly)</li> <li>• Generic paroxetine (Paxil CR<sup>®</sup>, Paxil<sup>®</sup>)</li> <li>• Generic citalopram (Celexa<sup>®</sup>)</li> <li>• Generic venlafaxine (Effexor<sup>®</sup>, Effexor XR<sup>®</sup>, Venlafaxine ER tablet)</li> <li>• Generic sertraline (Zoloft<sup>®</sup>)</li> <li>• Generic fluvoxamine (Luvox<sup>®</sup>)</li> <li>• Generic mirtazapine (Remeron<sup>®</sup>)</li> <li>• Generic escitalopram (Lexapro<sup>®</sup>)</li> </ul> <p>AND</p> <ul style="list-style-type: none"> <li>• Generic bupropion (Wellbutrin SR<sup>®</sup>, Wellbutrin XL<sup>®</sup>)</li> </ul>	Must have demonstrated use of one of the generic products listed in the preferred drug column <b>AND</b> use of generic bupropion (Wellbutrin SR <sup>®</sup> , Wellbutrin XL <sup>®</sup> )
	Luvox CR <sup>®</sup>	<ul style="list-style-type: none"> <li>• Generic fluoxetine (Prozac<sup>®</sup>, Prozac<sup>®</sup> Weekly)</li> <li>• Generic paroxetine (Paxil CR<sup>®</sup>, Paxil<sup>®</sup>)</li> <li>• Generic citalopram (Celexa<sup>®</sup>)</li> <li>• Generic bupropion (Wellbutrin SR<sup>®</sup>, Wellbutrin XL<sup>®</sup>)</li> <li>• Generic venlafaxine (Effexor<sup>®</sup>, Effexor XR<sup>®</sup>, Venlafaxine ER tablet)</li> <li>• Generic sertraline (Zoloft<sup>®</sup>)</li> <li>• Generic mirtazapine (Remeron<sup>®</sup>)</li> <li>• Generic escitalopram (Lexapro<sup>®</sup>)</li> </ul> <p>AND</p> <ul style="list-style-type: none"> <li>• Generic fluvoxamine (Luvox<sup>®</sup>)</li> </ul>	Must have demonstrated use of one of the generic products listed in the preferred drug column <b>AND</b> use of generic fluvoxamine (Luvox <sup>®</sup> ).
	Oleptro <sup>™</sup>	<ul style="list-style-type: none"> <li>• Generic trazodone</li> </ul>	Must have a diagnosis of major depressive disorder and had trial and failure of generic trazodone.



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	Pristiq®	<ul style="list-style-type: none"> <li>• Generic fluoxetine (Prozac® , Prozac® Weekly)</li> <li>• Generic paroxetine (Paxil CR® , Paxil®)</li> <li>• Generic citalopram (Celexa®)</li> <li>• Generic bupropion (Wellbutrin SR® , Wellbutrin XL®)</li> <li>• Generic sertraline (Zoloft®)</li> <li>• Generic mirtazapine (Remeron®)</li> <li>• Generic fluvoxamine (Luvox®)</li> <li>• Generic escitalopram (Lexapro®)</li> </ul> AND <ul style="list-style-type: none"> <li>• Generic venlafaxine (Effexor® , Effexor XR® , Venlafaxine ER)</li> </ul>	Must have demonstrated use of one of the generic products listed in the preferred drug column <b>AND</b> use of generic venlafaxine (Effexor® , Effexor XR® , Venlafaxine ER).
Antiemetics	Zuplenz™	<ul style="list-style-type: none"> <li>• Generic ondansetron ODT (Zofran ODT®)</li> </ul> AND <ul style="list-style-type: none"> <li>• Generic oral granisetron (Kytril®)</li> </ul>	Must have demonstrated treatment failure or intolerance to generic ondansetron (Zofran ODT®) AND oral granisetron (Kytril®).
Antihistamine	Clarinetx® Clarinetx-D®	<ul style="list-style-type: none"> <li>• Generic loratadine (Claritin®) or Claritin OTC®</li> </ul> AND <ul style="list-style-type: none"> <li>• Generic cetirizine (Zyrtec®) or Zyrtec OTC®</li> </ul> AND <ul style="list-style-type: none"> <li>• Generic fexofenadine (Allegra®) or Allegra OTC®</li> </ul> AND <ul style="list-style-type: none"> <li>• Generic levocetirizine (Xyzal®)</li> </ul>	Must have demonstrated use of Claritin OTC® or generic loratadine (Claritin®) AND use of Zyrtec OTC® or generic cetirizine (Zyrtec®) AND Allegra OTC® or generic fexofenadine (Allegra®) AND generic levocetirizine (Xyzal®).
Antihypertensives	Nexiclon XR® (tablet and liquid)	<ul style="list-style-type: none"> <li>• Oral clonidine HCl (Catapres®)</li> </ul> OR <ul style="list-style-type: none"> <li>• Transdermal clonidine HCl (Catapres TTS®)</li> </ul>	Must have a diagnosis of hypertension <b>AND</b> demonstrated use of one of the generic products listed in the preferred drug column.



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Central Nervous System	Amrix <sup>®</sup> (cyclobenzaprine ER)	<ul style="list-style-type: none"> <li>• Generic cyclobenzaprine (Flexeril<sup>®</sup>)</li> </ul>	Must have demonstrated use of the generic product listed in the preferred drug column.
	Aricept <sup>®</sup> 23 mg	<ul style="list-style-type: none"> <li>• Aricept<sup>®</sup> 10mg</li> </ul>	Must have tolerated treatment with Aricept <sup>®</sup> 10mg for 3 months within the last year.
	Gralise <sup>®</sup>	<ul style="list-style-type: none"> <li>• Generic gabapentin (Neurontin<sup>®</sup>)</li> <li>AND</li> <li>• A Tricyclic Antidepressant (TCA)</li> </ul>	Must have demonstrated use of the generic products listed in the preferred drug column AND have a diagnosis of neuropathic pain associated with post-herpetic neuralgia (If the patient is 65 years of age or more only a trial of gabapentin is required).
	Horizant <sup>®</sup>	<ul style="list-style-type: none"> <li>• Generic pramipexole (Mirapex<sup>®</sup>)</li> <li>AND</li> <li>• Generic ropinirole (Requip<sup>®</sup>)</li> <li>AND</li> <li>• Generic gabapentin (Neurontin<sup>®</sup>)</li> </ul>	Must have demonstrated use of the generic product listed in the preferred drug column AND documentation explaining why the requested medication is expected to work if generic gabapentin did not.
	Mirapex ER <sup>™</sup>	<ul style="list-style-type: none"> <li>• Generic pramipexole (Mirapex<sup>™</sup>)</li> </ul>	Coverage approved for the treatment of Parkinson's. Requires trial and failure of generic pramipexole (Mirapex <sup>™</sup> ).
Cholesterol Lowering Drugs	Advicor <sup>®</sup>	<ul style="list-style-type: none"> <li>• Generic lovastatin (Mevacor<sup>®</sup>)</li> <li>AND</li> <li>• niacin-extended release</li> </ul>	Requires documentation that member has had at least 3 months of treatment with lovastatin and niacin extended release as individual agents when used concomitantly.
	Simcor <sup>®</sup>	<ul style="list-style-type: none"> <li>• Generic simvastatin (Zocor<sup>®</sup>)</li> <li>AND</li> <li>• niacin-extended release</li> </ul>	Requires documentation that member has had at least 3 months of treatment with simvastatin and niacin extended release as individual agents when used concomitantly.
Migraine Therapy	Cambia <sup>®</sup>	<ul style="list-style-type: none"> <li>• Generic diclofenac</li> <li>AND</li> <li>• A different generic non-steroidal anti-inflammatory (NSAID) other than generic diclofenac</li> </ul>	Must have demonstrated use of the generic products listed in the preferred drug column.



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	Sumavel™ DosePro™ (sumatriptan injection)	<ul style="list-style-type: none"> <li>• Generic sumatriptan injection</li> </ul> AND <ul style="list-style-type: none"> <li>• Maxalt MLT®</li> </ul>	Must have demonstrated use of the generic products listed in the preferred drug column.
	Treximet™	<ul style="list-style-type: none"> <li>• Generic sumatriptan (Imitrex®)</li> </ul> AND <ul style="list-style-type: none"> <li>• Generic naproxen (concurrently)</li> </ul> AND <ul style="list-style-type: none"> <li>• Maxalt®</li> </ul>	Requires prior use of Imitrex® [g] and Naprosyn® [g] in combination <b>AND</b> documentation indicating why use of the individual agents is harmful to the member <b>AND</b> documentation of trial and failure of formulary option Maxalt®.
Narcotic Analgesics	Butrans™	<ul style="list-style-type: none"> <li>• Generic extended release morphine (Oramorph®, MS Contin®)</li> <li>• Generic fentanyl transdermal patch (Duragesic®)</li> <li>• Generic methadone (Dolophine®, Methadose™)</li> </ul>	Covered for the management of moderate to severe chronic pain in patients requiring around the clock opioid analgesia for an extended period of time. Criteria also require trial and failure, or intolerance to two of the following: extended-release morphine, fentanyl patch or methadone.
	Exalgo®	<ul style="list-style-type: none"> <li>• Generic extended release morphine (Oramorph®, MS Contin®)</li> <li>• Generic fentanyl transdermal patch (Duragesic®)</li> <li>• Generic methadone (Dolophine®, Methadose™)</li> </ul>	Covered for the management of moderate to severe chronic pain in opioid tolerant patients requiring around the clock opioid analgesia for an extended period of time. Criteria also require trial and failure, or intolerance to two of the following: extended-release morphine, fentanyl patch or methadone.
	Opana® ER Oxycontin®	<ul style="list-style-type: none"> <li>• Generic extended release morphine (Oramorph®, MS Contin®)</li> <li>• Generic fentanyl transdermal patch (Duragesic®)</li> <li>• Generic methadone (Dolophine®, Methadose™)</li> </ul>	Requires documentation that the member has experienced treatment failure of or intolerance to two of the following long-acting formulary agents: methadone, morphine sulfate extended-release, fentanyl transdermal patch. Additional information regarding opiate therapy may be requested from the prescriber.



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Nasal Steroids	Veramyst <sup>®</sup>	<ul style="list-style-type: none"> <li>• Generic fluticasone (Flonase<sup>®</sup>)</li> <li>• Generic flunisolide (Nasarel<sup>®</sup>)</li> <li>• Generic triamcinolone acetonide (Nasacort AQ<sup>®</sup>)</li> </ul>	Must have demonstrated use of two generic products listed in the preferred drug column.
Proton Pump Inhibitors	Aciphex <sup>®</sup> Dexilant <sup>®</sup> Nexium <sup>®</sup>	<ul style="list-style-type: none"> <li>• Generic omeprazole (Prilosec<sup>®</sup>) or Prilosec OTC<sup>®</sup></li> </ul> AND <ul style="list-style-type: none"> <li>• Generic lansoprazole (Prevacid<sup>®</sup>) or Prevacid OTC<sup>®</sup></li> </ul> AND <ul style="list-style-type: none"> <li>• Generic pantoprazole (Protonix<sup>®</sup>)</li> </ul>	Must have demonstrated use of generic omeprazole (Prilosec <sup>®</sup> ) and generic lansoprazole (Prevacid <sup>®</sup> ) and generic pantoprazole (Protonix <sup>®</sup> ).
Sleep Aids/ Sedatives	Edluar <sup>®</sup> Zolpimist <sup>®</sup>	<ul style="list-style-type: none"> <li>• Generic zolpidem (Ambien<sup>®</sup>, Ambien CR<sup>®</sup>)</li> </ul> AND <ul style="list-style-type: none"> <li>• Generic zaleplon (Sonata<sup>®</sup>)</li> </ul>	Must have demonstrated use of the generic products listed in the preferred drug column.
	Intermezzo <sup>®</sup>	<ul style="list-style-type: none"> <li>• Generic zolpidem extended release (Ambien CR<sup>®</sup>)</li> </ul> AND <ul style="list-style-type: none"> <li>• Generic zaleplon (Sonata<sup>®</sup>)</li> </ul>	Must have demonstrated use of the generic products listed in the preferred drug column. Also, coverage will not be approved for combination therapy with other sedative hypnotics.
Tetracyclines	Adoxa <sup>®</sup> Doryx <sup>®</sup> Oracea <sup>®</sup>	<ul style="list-style-type: none"> <li>• Generic doxycycline (Adoxa<sup>®</sup>, Doryx<sup>®</sup>)</li> </ul>	Requires documentation that the patient has experienced treatment failure of, or intolerance to, generic doxycycline.
	Solodyn <sup>™</sup> Dynacin <sup>®</sup>	<ul style="list-style-type: none"> <li>• Generic minocycline (Solodyn<sup>™</sup>)</li> </ul>	Requires documentation that the patient has experienced treatment failure of, or intolerance to, generic minocycline.
Weight Loss Preparations	Suprenza <sup>®</sup>	<ul style="list-style-type: none"> <li>• Generic phentermine (Adipex-P<sup>®</sup>)</li> </ul>	Must have demonstrated use of the generic products listed in the preferred drug column <b>AND</b> documentation explaining why the requested medication is expected to work if generic phentermine did not.