

Pharmacy News & Views

July 2014

Maryland Department of Health & Mental Hygiene / Office of Systems, Operations and Pharmacy

Maryland Medicaid Preferred Drug List

The Maryland Medicaid Preferred Drug List (PDL) shown includes updates effective July 1, 2014. Only drugs that are part of the listed therapeutic categories are affected by the PDL. Therapeutic categories not listed here are not part of the PDL and will continue to be covered as they always have for Maryland Medicaid patients. *Note: for most multi-source products, the generic product(s) are usually preferred and branded innovator product(s) are non-preferred. PDL products that are new to the market require prior authorization until they are reviewed.*

Key: Green shaded drugs = PDL change; All lowercase letters = generic product;
Leading capital letter = Brand name product; Brd = Brand; gen = generic.

Note: A 72-hour emergency supply of a non-preferred drug is available by calling 1-800-932-3918. A 30-day emergency supply is available for Tier 2 and Non-preferred Antipsychotic agents.

ANALGESICS

Analgesics, Narcotics (Long Acting)

Preferred

fentanyl patch (*Duragesic*)
methadone (*Dolophine*)
morphine sulfate SR (*MS Contin*)
Kadian (Brd only)

Requires Prior Authorization

hydromorphone ER (*Exalgo*)
morphine sulfate ER (*Kadian*) (gen only)
morphine sulfate ER (*Avinza*)
oxymorphone ER (*Opana ER*)
tramadol ER (*Ultram ER*, *Ryzolt*)
Butrans
Conzip
Nucynta ER
Oxycontin
Zohydro ER

Analgesics, Narcotics (Short Acting)

Preferred

apap w/codeine (*Tylenol w/codeine*)
butalbital/apap/codeine/caffeine
butalbital/aspirin/codeine/caffeine
codeine tab
hydrocodone/apap (*Vicodin*)
hydrocodone/ibuprofen (*Vicoprofen*)
hydromorphone tab (*Dilaudid*)
morphine sulfate tab
oxycodone
oxycodone/apap (*Percocet*)
pentazocine/apap (*Talacen*)
tramadol (*Ultram*)
tramadol/apap (*Ultracet*)

ANALGESICS

Analgesics, Narcotics (Short Acting) (continued)

Requires Prior Authorization

butorphanol nasal spray
carisoprodol/codeine/asa
codeine solution
dihydrocodeine/apap/caffeine
dihydrocodeine/aspirin/caffeine
(*Synalgos DC*)
fentanyl buccal (*Actiq*) *
hydromorphone supp & sol
levorphanol
meperidine (*Demerol*)
morphine supp
oxycodone/aspirin (*Percodan*)
oxycodone/ibuprofen (*Combunox*)
oxymorphone (*Opana*)
pentazocine/naloxone (*Talwin NX*)
Abstral *
Fentora *
Nucynta
Onsolis *
Oxecta
Primlev
Rybix ODT
Subsys *
Zamicet
Zolvit

* Clinical criteria apply. View criteria at:
<https://mmcp.dhmh.maryland.gov/pap/SitePages/Pharmacy%20Program%20Forms.aspx>

ANALGESICS

Anti-Hyperuricemics

Preferred

allopurinol (*Zyloprim*)
probenecid
probenecid/colchicine

Requires Prior Authorization

Colcrys
Uloric

Anti-Migraine Agents

Preferred

rizatriptan, rizatriptan ODT (*Maxalt*,
Maxalt MLT)
sumatriptan (*Imitrex*)
Relpax

Requires Prior Authorization

naratriptan (*Amerge*)
zolmitriptan, zolmitriptan ODT (*Zomig*,
Zomig ZMT)
Axert
Cambia
Frova
Sumavel
Treximet
Zomig nasal

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ANALGESICS

Neuropathic Pain

Preferred

capsaicin OTC
gabapentin cap (*Neurontin*)
Cymbalta * (Brd only)
Lidoderm (Brd only)
Lyrica cap

Requires Prior Authorization

duloxetine (*Cymbalta*) (gen only)
gabapentin tab & sol (*Neurontin*)
lidocaine patch (gen only)
Gralise
Horizant
Lyrica sol
Qutenza
Savella
Zostrix OTC

Nonsteroidal Anti-Inflammatories/ COX II Inhibitor (NSAIDS, Cyclooxygenase Inhibitor - Type II)

Preferred

diclofenac, diclofenac XL (*Cataflam*,
Voltaren XR)
diflunisal (*Dolobid*)
etodolac, etodolac XL (*Lodine*, *Lodine XL*)
fenoprofen
flurbiprofen (*Ansaid*)
ibuprofen Rx & OTC (*Motrin*)
indomethacin, indomethacin SR
(*Indocin*, *Indocin SR*)
ketoprofen (*Orudis*, *Oruvail*)
ketorolac (*Toradol*)
meclofenamate (*Meclomen*)
meloxicam tab (*Mobic*)
nabumetone (*Relafen*)
naproxen OTC & Rx (*Aleve*, *Naprosyn*)
oxaprozin (*Daypro*)
piroxicam (*Feldene*)
sulindac (*Clinoril*)
Voltaren gel

Requires Prior Authorization

diclofenac/misoprostol (*Arthrotec*)
mefenamic acid (*Ponstel*)
tolmetin, tolmetin DS (*Tolectin*, *Tolectin DS*)
Celebrex
Duexis
Flector
Indocin supp & susp
Pennsaid
Sprix
Vimovo
Zipsor
Zorvolex

ANALGESICS

Opiate Dependence Treatments

Preferred

buprenorphine (*Subutex*)
naltrexone (*Revia*)
Suboxone film

Requires Prior Authorization

buprenorphine/naloxone tab
(*Suboxone*)
Vivitrol
Zubsolv

Skeletal Muscle Relaxants

Preferred

baclofen (*Lioresal*)
carisoprodol 350mg (*Soma*)
chlorzoxazone (*Parafon*)
cyclobenzaprine (*Flexeril*)
dantrolene (*Dantrium*)
methocarbamol (*Robaxin*)
orphenadrine (*Norflex*)
tizanidine tab (*Zanaflex*)

Requires Prior Authorization

carisoprodol 250mg (*Soma*)
carisoprodol compound (*Soma*)
metaxalone (*Skelaxin*)
orphenadrine compound (*Norflex Forte*)
tizanidine cap (*Zanaflex*)
Amrix
Lorzone

ANTI-INFECTIVES

Antibiotics, GI

Preferred

metronidazole tab (*Flagyl*)
neomycin
Alinia
Vancocin (Brd only)

Requires Prior Authorization

metronidazole cap (*Flagyl*)
tinidazole (*Tindamax*)
vancomycin cap (*Vancocin*) (gen only)
Dificid
Flagyl ER
Xifaxan

ANTI-INFECTIVES

Antibiotics, Inhaled

Preferred

TOBI inhalation sol (Brd only)
TOBI Podhaler (Step therapy) **

Requires Prior Authorization

tobramycin inhalation sol (*TOBI*)
(gen only)
Bethkis
Cayston

Antibiotics, Vaginal

Preferred

clindamycin (*Clindamax*)
metronidazole (*Metrogel*)
Cleocin ovules

Requires Prior Authorization

Vandazole

Antifungals, Oral (Antifungal Agents, Antifungal Antibiotics)

Preferred

fluconazole (*Diflucan*)
griseofulvin susp (*GriFulvin V*)
ketoconazole (*Nizoral*)
nystatin susp & tab
terbinafine (*Lamisil*)

Requires Prior Authorization

clotrimazole troche (*Mycelex*)
flucytosine (*Ancobon*)
griseofulvin tab (*Gris Peg*, *GriFulvin V*)
itraconazole (*Sporanox*)
nystatin powder
voriconazole (*Vfend*)
Lamisil granules
Noxafil
Onmel
Terbinex

* Clinical criteria apply. View criteria at:
<https://mmcp.dhmdh.maryland.gov/pap/SitePages/Clinical%20Criteria.aspx>
** Step therapy for Tobi Podhaler will allow it to process with a trial of Tobi Inhalation Soln.

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ANTI-INFECTIVES

Antifungals, Topical (Topical Antifungals)

Preferred

clotrimazole OTC & Rx
 clotrimazole/betamethasone (*Lotrisone*)
 econazole (*Spectazole*)
 ketoconazole cream & shampoo
 (*Nizoral*)
 miconazole OTC
 nystatin
 nystatin/triamcinolone (*Mycolog*)
 terbinafine OTC
 tolnaftate OTC
 tolnaftate aero powder

Requires Prior Authorization

butenafine OTC (*Mentax*)
 ciclopirox (*Loprox, Loprox Shampoo, Penlac*)
 ketoconazole foam
 Bensal HP
 CNL-8
 Ertaczo
 Exelderm
 Luzu
 Oxistat
 PEDIADERM AF
 Pedipirox-4
 Vusion

Antiparasitics, Topical

Preferred

permethrin OTC & Rx (*Elimite, Acticin*)
 piperonyl/pyrethrins OTC
 piperonyl/pyrethrins/permethrin OTC
 Ulesfia

Requires Prior Authorization

lindane
 malathion (*Ovide*)
 spinosad (*Natroba*)
 Eurax
 Sklice

Antivirals, Oral (Antivirals, General)

Preferred

acyclovir (*Zovirax*)
 amantadine (*Symmetrel*)
 rimantadine (*Flumadine*)
 valacyclovir (*Valtrex*)

Requires Prior Authorization

famciclovir (*Famvir*)
 Relenza
 Tamiflu

ANTI-INFECTIVES

Antivirals, Topical

Preferred

acyclovir ointment (*Zovirax*)
 Abreva OTC
 Denavir

Requires Prior Authorization

Xerese
 Zovirax cream

Cephalosporin & Related Agents

(Cephalosporins, Second & Third Generation, Penicillins)

Preferred

amoxicillin/clavulanate (*Augmentin, Augmentin ES*)
 cefaclor, cefaclor ER (*Ceclor, Ceclor CD*)
 cefadroxil cap (*Duricef*)
 cefdinir (*Omnicef*)
 cefprozil (*Cefzil*)
 cefuroxime (*Ceftin*)
 cephalexin (*Keflex*)
 Suprax cap & susp

Requires Prior Authorization

amoxicillin/clav ER (*Augmentin XR*)
 cefadroxil susp & tab (*Duricef*)
 cefditoren (*Spectracef*)
 cefpodoxime (*Vantin*)
 cefitibuten (*Cedax*)
 Ceftin suspension
 Suprax chew & tab

Fluoroquinolones (Quinolones)

Preferred

ciprofloxacin (*Cipro*)
 levofloxacin tab (*Levaquin*)

Requires Prior Authorization

ciprofloxacin ER (*Cipro XR*)
 levofloxacin sol (*Levaquin*)
 moxifloxacin (*Avelox*)
 ofloxacin (*Floxin*)
 Cipro susp
 Factive
 Noroxin

ANTI-INFECTIVES

Hepatitis C Agents (Hepatitis C Treatment Agents, Immunomodulators)

Preferred

ribavirin (*Copegus, Rebetol*)
 Incivek
 Pegasys
 Peg-Intron
 Sovaldi
 Victrelis

Requires Prior Authorization

Infergen
 Moderiba
 Olysio
 Rebetol sol
 Ribapak
 Ribasphere

Macrolides/Ketolides

Preferred

azithromycin (*Zithromax*)
 erythromycin base
 E.E.S.
 Ery-Tab
 EryPed
 Erythrocin

Requires Prior Authorization

clarithromycin, clarithromycin ER
 (*Biaxin, Biaxin XL*)
 Ketek
 PCE
 Zmax

Tetracyclines

Preferred

doxycycline hyclate (*Vibramycin*)
 doxycycline monohydrate 50mg, 100mg
 (*Monodox*)
 minocycline cap (*Minocin*)
 tetracycline (*Sumycin*)

Requires Prior Authorization

demeclocycline (*Declomycin*)
 doxycycline hyclate DR (*Doryx*)
 doxycycline monohydrate 75mg, 150mg
 (*Monodox*)
 doxycycline monohydrate sol
 (*Vibramycin*)
 minocycline tab
 minocycline ER
 Oracea
 Solodyn

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ANTI-INFECTIVES

Topical Antibiotics

Preferred

bacitracin OTC
 bacitracin/polymyxin OTC
 gentamicin
 mupirocin oint (*Bactroban*)
 triple antibiotic OTC

Requires Prior Authorization

mupirocin cream (*Bactroban*)
 Altabax

CARDIOVASCULAR

Angiotensin Modulator Combinations

Preferred

amlodipine/benazepril (*Lotrel*)
 Azor/Tribenzor
 Exforge/Exforge HCT

Requires Prior Authorization

telmisartan/amlodipine (*Twynsta*)
 Tarka
 Tekamlo/Amturnide

Angiotensin Modulators

Preferred

benazepril, benazepril/HCTZ (*Lotensin*,
Lotensin HCT)
 captopril, captopril/HCTZ (*Capoten*,
Capozide)
 enalapril, enalapril/HCTZ (*Vasotec*,
Vaseretic)
 fosinopril, fosinopril/HCTZ (*Monopril*,
Monopril HCT)
 irbesartan, irbesartan/HCTZ
 (*Avapro*, *Avalide*)
 lisinopril, lisinopril/HCTZ (*Prinivil*,
Zestril, *Prinzide*, *Zestoretic*)
 losartan, losartan/HCTZ (*Cozaar*, *Hyzaar*)
 quinapril, quinapril/HCTZ (*Accupril*,
Accuretic)
 ramipril (*Altace*)
 telmisartan, telmisartan/HCTZ
 (*Micardis*, *Micardis HCT*)
 valsartan/HCTZ (*Diovan HCT*)
 Diovan

CARDIOVASCULAR

Angiotensin Modulators (continued)

Requires Prior Authorization

candesartan, candesartan/HCTZ
 (*Atacand*, *Atacand HCT*)
 eprosartan (*Teveten*)
 moexipril, moexipril/HCTZ (*Univasc*,
Uniretic)
 perindopril (*Aceon*)
 trandolapril (*Mavik*)
 Benicar, Benicar HCT
 Edarbi, Edarbyclor
 Tekturna, Tekturna HCT
 Teveten HCT

Anticoagulants

Preferred

enoxaparin (*Lovenox*)
 warfarin (*Coumadin*)
 Fragmin

Requires Prior Authorization

fondaparinux (*Arixtra*)
 Eliquis
 Pradaxa
 Xarelto

Antihypertensives, Sympatholytics

Preferred

clonidine oral (*Catapres*)
 guanfacine (*Tenex*)
 methyl dopa (*Aldomet*)
 methyl dopa/HCTZ (*Aldoril*)
 Catapres-TTS (Brd only)

Requires Prior Authorization

clonidine patch (gen only)
 reserpine
 Clorpres

CARDIOVASCULAR

Beta Blockers (Alpha/Beta-Adrenergic Blocking Agents, Beta-Adrenergic Blocking Agents)

Preferred

atenolol (*Tenormin*)
 atenolol/chlorthalidone (*Tenoretic*)
 bisoprolol/HCTZ (*Ziac*)
 carvedilol (*Coreg*)
 labetalol (*Normodyne*, *Trandate*)
 metoprolol tartrate (*Lopressor*)
 nadolol (*Corgard*)
 pindolol (*Visken*)
 propranolol (*Inderal*)
 propranolol/HCTZ (*Inderide*)
 propranolol LA (*Inderal LA*)
 sotalol, sotalol AF (*Betapace*,
Betapace AF)
 Toprol XL (Brd only)

Requires Prior Authorization

acebutolol (*Sectral*)
 betaxolol (*Kerlone*)
 bisoprolol (*Zebeta*)
 metoprolol/HCTZ (*Lopressor HCT*)
 metoprolol succinate XL (*Toprol XL*)
 (gen only)
 nadolol/bendroflumethiazide (*Corzide*)
 timolol (*Blocadren*)
 Bystolic
 Coreg CR
 Dutoprol
 Levatol

Calcium Channel Blocking Agents

Preferred

amlodipine (*Norvasc*)
 diltiazem (*Cardizem*)
 nifedipine (*Cardene*)
 nifedipine SR (*Adalat CC*, *Procardia XL*)
 verapamil (*Calan*)
 verapamil ER tab (*Calan SR*, *Verelan*)
 Cardizem LA (Brd only)

Requires Prior Authorization

diltiazem ER cap (*Cardizem CD*,
Tiazac)
 diltiazem ER tab (*Cardizem LA*) (gen only)
 felodipine (*Plendil*)
 isradipine (*Dynacirc*)
 nifedipine (*Adalat*, *Procardia*)
 nimodipine (*Nimotop*)
 nisoldipine (*Sular*)
 verapamil ER cap (*Verelan PM*)
 Nymalize

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CARDIOVASCULAR

Lipotropics, Other (Lipotropics, Bile Salt Sequestrants)

Preferred

cholestyramine (*Questran*)
fenofibric acid (*Trilipix*)
gemfibrozil (*Lopid*)
niacin ER (*Niaspan ER*)
Niacor
Tricor (Brd only)

Requires Prior Authorization

colestipol (*Colestid*)
fenofibrate (*Antara, Lofibra*)
fenofibrate nanocrystals (*Tricor*)
(gen only)
fenofibric acid (*Fibricor*)
omega 3 ethyl esters (*Lovaza*)
Lipofen
Triglide
Welchol
Zetia

Lipotropics, Statins (Lipotropics)

Preferred

atorvastatin (*Lipitor*)
fluvastatin (*Lescol*)
lovastatin (*Mevacor*)
pravastatin (*Pravachol*)
simvastatin (*Zocor*)
Lescol XL
Simcor

Requires Prior Authorization

amlodipine/atorvastatin (*Caduet*)
Advicor
Altoprev
Crestor
Liptruzet
Livalo
Vytorin

Platelet Aggregation Inhibitors

Preferred

clopidogrel (*Plavix*)
dipyridamole (*Persantine*)
ticlopidine (*Ticlid*)
Aggrenox

Requires Prior Authorization

Brilinta
Effient

CARDIOVASCULAR

Pulmonary Arterial Hypertension Agents, Oral and Inhaled Agents

Preferred

sildenafil * (*Revatio*)
Letairis
Tracleer
Ventavis

Requires Prior Authorization

Adcirca *
Adempas
Opsumit
Tyvaso

CENTRAL NERVOUS SYSTEM

Anticonvulsants

Preferred

carbamazepine tab (*Tegretol*)
clonazepam (*Klonopin*)
divalproex (*Depakote, Depakote ER*)
lamotrigine (*Lamictal*)
levetiracetam (*Keppra*)
oxcarbazepine tab (*Trileptal*)
phenobarbital
phenytoin (*Dilantin, Dilantin Infatabs*)
primidone (*Mysoline*)
topiramate (*Topamax*)
valproic acid (*Depakene*)
zonisamide (*Zonegran*)
Carbatrol ER (Brd only)
Celontin
Depakote sprinkle (Brd only)
Diastat (Brd only)
Gabitril (Brd only)
Peganone
Tegretol susp (Brd only)
Trileptal susp (Brd only)

CENTRAL NERVOUS SYSTEM

Anticonvulsants (continued)

Requires Prior Authorization

carbamazepine ER (*Carbatrol*) (gen only)
carbamazepine susp (*Tegretol*) (gen only)
carbamazepine XR (*Tegretol XR*)
clonazepam ODT (*Klonopin ODT*)
diazepam rectal (*Diastat*) (gen only)
divalproex sprinkles (*Depakote*)
(gen only)
ethosuximide (*Zarontin*)
felbamate (*Felbatol*)
lamotrigine ER (*Lamictal XR*)
levetiracetam ER (*Keppra XR*)
oxcarbazepine susp (*Trileptal*) (gen only)
tiagabine (*Gabitril*) (gen only)
topiramate sprinkles (*Topamax*)

Aptiom

Banzel
Equetro
Fycompa
Lamictal ODT
Onfi
Potiga
Sabril
Stavzor
Trokendi XR
Vimpat

Antidepressants, Other (Alpha-2 Receptor Antagonist Antidepressants, Serotonin-2 Antagonist/ Reuptake Inhibitors, Serotonin-Norepinephrine Reuptake-Inhib, Norepinephrine & Dopamine Reuptake Inhib)

Preferred

bupropion, bupropion SR, bupropion XL
(*Wellbutrin, Wellbutrin SR, Wellbutrin XL*)
mirtazapine, mirtazapine ODT
(*Remeron, Remeron Soltab*)
phenelzine (*Nardil*)
trazodone (*Desyrel*)
venlafaxine (*Effexor*)
venlafaxine ER cap (*Effexor XR*)
Marplan
Parnate (Brd only)

Requires Prior Authorization

nefazodone (*Serzone*)
tranylcypromine (gen only)
venlafaxine ER tab
Aplenzin
Brintellix
Emsam
Fetzima
Forfivo XL
Khedezla
Oleptro ER
Pristiq
Viibryd

* Clinical criteria apply. View criteria at:
<https://mmcp.dhmh.maryland.gov/pap/docs/PAH-Drugs-PA-form.pdf>

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CENTRAL NERVOUS SYSTEM

Antidepressants, Selective Serotonin Reuptake Inhibitors (SSRIs)

Preferred

citalopram (*Celexa*)
 escitalopram (*Lexapro*)
 fluoxetine (all strengths except 60mg) (*Prozac, Sarafem*)
 fluvoxamine (*Luvox*)
 paroxetine (*Paxil*)
 sertraline (*Zoloft*)

Requires Prior Authorization

fluoxetine 60 mg
 fluoxetine weekly (*Prozac weekly*)
 fluvoxamine ER (*Luvox CR*)
 paroxetine CR (*Paxil CR*)
 Brisdelle
 Paxil susp
 Pexeva

Antipsychotics **

Preferred

FIRST TIER:

chlorpromazine (*Thorazine*)
 clozapine (*Clozaril*)
 fluphenazine (*Prolixin*)
 fluphenazine decanoate inj (*Prolixin*)
 haloperidol (*Haldol*)
 haloperidol decanoate inj (*Haldol IM*)
 perphenazine (*Trilafon*)
 perphenazine/amitriptyline (*Triavil*)
 quetiapine (*Seroquel*)
 risperidone (*Risperdal*)
 thioridazine (*Mellaril*)
 thiothixene (*Navane*)
 trifluoperazine (*Stelazine*)
 ziprasidone (*Geodon*)
 Abilify (*Age 17 and younger*)
 Abilify Maintena
 Geodon IM
 Invega Sustenna
 Orap
 Risperdal Consta

SECOND TIER:

olanzapine, olanzapine IM (*Zyprexa, Zyprexa IM*)
 olanzapine ODT (*Zyprexa Zydis*)
 Abilify (*Age 18 or older*)
 Latuda

Requires Prior Authorization

clozapine ODT (*Fazaclio*)
 olanzapine/fluoxetine (*Symbyax*)
 Abilify IM
 Adasuve
 Fanapt
 Invega
 Saphris
 Seroquel XR
 Versacloz
 Zyprexa Relprevv

CENTRAL NERVOUS SYSTEM

Sedative Hypnotics

Preferred

chloral hydrate
 flurazepam (*Dalmane*)
 temazepam, 15 mg, 30 mg (*Restoril*)
 triazolam (*Halcion*)
 zaleplon (*Sonata*)
 zolpidem (*Ambien*)

Requires Prior Authorization

estazolam (*ProSom*)
 eszopiclone (*Lunesta*) *
 temazepam 7.5 & 22.5mg (*Restoril*)
 zolpidem ER (*Ambien CR*)
 Doral
 Edluar
 Intermezzo
 Rozerem
 Silenor
 Zolpimist

Stimulants & Related Agents

(Tx for Attention Deficit Hyperact (ADHD)/ Narcolepsy; Adrenergics, Aromatic, Non-Catecholamine)

Preferred

FIRST TIER:

amphetamine salt combo (*Adderall*)
 dextroamphetamine tab
 methylphenidate, methylphenidate ER (*Ritalin, Ritalin SR*)
 methylphenidate CR (*Concerta*)
 Adderall XR (Brd only)
 Daytrana
 Dexedrine ER (Brd only)
 Focalin tab, XR (Brd only)
 Intuniv ***
 Metadate CD (Brd only)
 Methylin oral sol (Brd only)
 Quillivant XR
 Ritalin LA (Brd only)
 Vyvanse

SECOND TIER:

Strattera * (*Ages 17 and under*)

Requires Prior Authorization

amphetamine salt combo ER (*Adderall XR*) (gen only)
 clonidine ER (*Kapvay*) ***
 dexmethylphenidate, dexmethylphenidate XR (*Focalin, Focalin XR*) (gen only)
 dextroamphetamine ER (*Dexedrine ER*) (gen only)
 dextroamphetamine sol (*Procentra*)
 methamphetamine (*Desoxy*)
 methylphenidate CD cap (*Metadate CD*) (gen only)
 methylphenidate ER cap (*Ritalin LA*) (gen only)
 methylphenidate oral sol (*Methylin*) (gen only)
 modafinil (*Provigil*)
 Methylin chew
 Nuvigil

ENDOCRINE

Androgenic Agents

Preferred

Androgel
 Testim

Requires Prior Authorization

Androderm
 Axiron
 Fortesta

Bone Resorption Suppression & Related Agents (Bone Resorption Inhibitors, Bone Formation Stim. Agents - Parathyroid Hormone)

Preferred

alendronate (*Fosamax*)
 calcitonin salmon nasal (*Miacalcin*)
 Fortical

Requires Prior Authorization

alendronate sol (*Fosamax*)
 etidronate (*Didronel*)
 ibandronate (*Boniva*)
 raloxifene (*Evista*)
 Actonel
 Atelvia
 Binosto
 Forteo
 Fosamax Plus D
 Prolia

Hypoglycemics, Incretin Mimetics & Enhancers

Preferred

Byetta
 Janumet, Janumet XR
 Januvia
 Jentadueto
 Juvisync
 Symlin
 Tradjenta

Requires Prior Authorization

Bydureon
 Kazano
 Kombiglyze XR
 Nesina
 Onglyza
 Oseni
 Victoza

* Clinical criteria apply. View criteria at: <https://mmcp.dhmh.maryland.gov/pap/SitePages/Clinical%20Criteria.aspx>

** Additional clinical edits may apply to Tier 2 products. An adequate trial of a Tier 1 preferred drug is required prior to use of any Tier 2 product.

*** For recipients 6-17 years old, Intuniv and Kapvay are part of the mental health formulary and billed fee-for-service. For individuals not in this age range, it continues to be part of the MCO pharmacy benefit.

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ENDOCRINE

Hypoglycemics, Insulins

Preferred

Humalog, Humalog Mix
Humulin
Lantus
Levemir
Novolin
Novolog, Novolog Mix

Requires Prior Authorization

Apidra

Hypoglycemics, Meglitinides

(Hypoglycemics, Insulin Release Stimulant Type)

Preferred

nateglinide (*Starlix*)
repaglinide (*Prandin*)

Requires Prior Authorization

Prandimet

Hypoglycemics, SGLT2 Inhibitors

(Hypoglycemics, Sodium-Glucose Co-Transporter 2Type)

Preferred

Invokana (Step therapy) *

Requires Prior Authorization

Farxiga

Hypoglycemics, TZDs

(Hypoglycemics, Insulin-Response Enhancers)

Preferred

pioglitazone (*Actos*)
pioglitazone/glimepiride (*Duetact*)

Requires Prior Authorization

pioglitazone/metformin (*ActoPlusMet*)
ActoPlusMet XR
Avandamet
Avandaryl
Avandia

GASTROINTESTINAL

Antiemetic/Antivertigo Agents

Preferred

dimenhydrinate Rx & OTC
meclizine Rx & OTC (*Bonine, Antivert*)
metoclopramide (*Reglan*)
ondansetron (*Zofran, Zofran ODT*)
prochlorperazine (*Compazine, Compro*)
promethazine (*Phenergan*)
Emend cap
TransDerm-Scop

Requires Prior Authorization

dronabinol (*Marinol*)
granisetron (*Kytril*)
trimethobenzamide (*Tigan*)
Aloxi
Anzemet
Cesamet
Diclegis
Emend IV
Metozolv ODT
Sancuso

Bile Salts

Preferred

ursodiol cap (*Actigall*)

Requires Prior Authorization

ursodiol tab (*URSO Forte*)
Chenodal

Irritable Bowel Syndrome

Preferred

Amitiza
Linzess

Requires Prior Authorization

Lotronex

Pancreatic Enzymes

Preferred

pancrelipase
Creon
Zenpep

Requires Prior Authorization

Pancreaze
Pertzye
Ultresa
Viokace

GASTROINTESTINAL

Phosphate Binders & Related Agents

Preferred

calcium acetate (*PhosLo*)
calphron OTC

Requires Prior Authorization

sevelamer (*Renvela*)
Fosrenol
Phoslyra
Renagel
Velphoro

Proton Pump Inhibitors

(Gastric Acid Secretion Reducers)

Preferred

lansoprazole (*Prevacid*)
omeprazole (*Prilosec*)
pantoprazole (*Protonix*)
Prevacid solutab
Protonix susp

Requires Prior Authorization

esomeprazole strontium
omeprazole/sodium bicarb (*Zegerid*)
rabeprazole (*Aciphex*)
Aciphex sprinkle
Dexilant
Nexium
Prilosec susp

Ulcerative Colitis Agents

Preferred

balsalazide (*Colazal*)
sulfasalazine, sulfasalazine DR
(*Azulfidine, Azulfidine DR*)
Apriso
Asacol
Canasa
Delzicol

Requires Prior Authorization

mesalamine enemas (*Rowasa, sfRowasa*)
Asacol HD
Dipentum
Giazo
Lialda
Pentasa

Maryland Medicaid Preferred Drug List (effective July 1, 2014)

IMMUNOLOGICS

Immunosuppressives, Oral

Preferred

azathioprine (*Imuran*)
 cyclosporine (*Sandimmune*)
 cyclosporine modified (*Gengraf, Neoral*)
 mycophenolate mofetil (*Cellcept*)
 sirolimus (*Rapamune*)
 tacrolimus (*Prograf*)

Requires Prior Authorization

mycophenolic acid (*Myfortic*)
 Astagraf XL
 Azasan
 Zortress

INJECTABLES

Colony Stimulating Factors

Preferred

Neupogen

Requires Prior Authorization

Granix
 Leukine
 Neulasta

Cytokine & CAM Antagonists

(Anti-inflammatory, Pyrimidine Synthesis Inhibitor, Anti-inflammatory, Tumor Necrosis Factor Inhibitor, Anti-Flam, Interleukin-1 Receptor Antagonist, Drugs to Tx Chronic Inflamm Disease of Colon, Antimetabolites)

Preferred

Enbrel
 Humira

Requires Prior Authorization

Actemra
 Cimzia
 Kineret
 Orencia
 Remicade
 Simponi
 Stelara
 Xeljanz

Erythropoietins (Hematinics, Other)

Preferred

Aranesp
 Procrit

Requires Prior Authorization

Epogen

Growth Hormones (Clinical PA Required)

Preferred

Genotropin
 Norditropin
 Nutropin, Nutropin AQ

Requires Prior Authorization

Humatrope
 Omnitrope
 Saizen
 Serostim
 Tev-Tropin

NEUROLOGICS

Alzheimer's Agents

Preferred

donepezil, donepezil ODT (all strengths except 23 mg) (*Aricept, Aricept ODT*)
 rivastigmine cap (*Exelon*)
 Exelon patch
 Namenda

Requires Prior Authorization

donepezil 23 mg (*Aricept*)
 galantamine (*Razadyne ER*)
 Exelon sol
 Namenda XR

Anti-Parkinson's Agents

Preferred

benztropine (*Cogentin*)
 carbidopa (*Lodosyn*)
 levodopa/carbidopa IR & ER (*Sinemet, Sinemet CR*)
 levodopa/carbidopa/entacapone (*Stalevo*)
 pramipexole (*Mirapex*)
 ropinirole (*Requip*)
 selegiline tab (*Eldepryl*)
 trihexyphenidyl (*Artane*)

Requires Prior Authorization

bromocriptine (*Parlodel*)
 entacapone (*Comtan*)
 levodopa/carbidopa ODT (*Parcopa*)
 ropinirole ER (*Requip XL*)
 selegiline cap (*Eldepryl*)
 Azilect
 Mirapex ER
 Neupro
 Tasmar
 Zelapar

Multiple Sclerosis Agents

Preferred

Avonex
 Betaseron
 Copaxone 20mg
 Rebif

Requires Prior Authorization

Ampyra
 Aubagio
 Copaxone 40 mg
 Extavia
 Gilenya
 Tecfidera

OPHTHALMICS

Ophthalmics, Allergic Conjunctivitis

(Eye Anti-inflammatory Agents, Eye Antihistamines, Ophthalmic Mast Cell Stabilizers)

Preferred

cromolyn (*Crolom*)
 ketotifen OTC (*Zaditor OTC*)
 Alex
 Pataday

Requires Prior Authorization

azelastine (*Optivar*)
 epinastine (*Elestat*)
 Alocril
 Alomide
 Bepreve
 Emadine
 Lastacaft
 Patanol

Ophthalmics, Antibiotics

Preferred

bacitracin/polymixin
 ciprofloxacin solution (*Ciloxan*)
 erythromycin
 gentamicin drops (*Garamycin*)
 neomycin/polymixin/gramicidin (*Neosporin*)
 ofloxacin (*Ocuflox*)
 polymyxin/trimethoprim (*Polytrim*)
 sulfacetamide sol (*Bleph-10*)
 tobramycin drops (*Tobrex*)
 triple antibiotic
 Ciloxan ointment
 Moxeza
 Tobrex ointment
 Vigamox

Requires Prior Authorization

bacitracin
 gatifloxacin (*Zymaxid*)
 levofloxacin (*Quixin*)
 sulfacetamide ointment
 AzaSite
 Besivance
 Natacyn

Maryland Medicaid Preferred Drug List (effective July 1, 2014)

OPHTHALMICS

Ophthalmics, Antibiotic/Steroid Combinations

Preferred

neomycin/bacitracin/polymyxin/HC
neomycin/poly/dexamethasone
(*Maxitrol*)
sulfacetamide/prednisolone
Blephamide
Pred-G
Tobradex drops (Brd only)
Tobradex ointment

Requires Prior Authorization

neomycin/polymyxin/HC
tobramycin/dexamethasone drops
(gen only)
Tobradex ST
Zylet

Ophthalmics, Glaucoma Agents

Preferred

betaxolol
brimonidine (*Alphagan P 0.1%*)
carteolol (*Ocupress*)
dorzolamide (*Trusopt*)
dorzolamide/timolol (*Cosopt*)
latanoprost (*Xalatan*)
levobunolol (*Betagan*)
metipranolol (*OptiPranolol*) (Brd & gen)
pilocarpine (*Pilocar*)
timolol (*Timoptic*, *Timoptic XE*)
Alphagan P 0.15% (Brd only)
Azopt
Betimol
Betoptic S
Simbrinza
Travatan Z

Requires Prior Authorization

apraclonidine (*Lopidine*)
brimonidine 0.15% (*Alphagan P*) (gen only)
travoprost
Combigan
Cosopt PF
Lumigan
Rescula
Zioptan

OPHTHALMICS

Ophthalmics, Anti-Inflammatories

Preferred

dexamethasone (*Decadron*)
diclofenac (*Voltaren*)
fluorometholone (*FML*)
flurbiprofen (*Ocufen*)
ketorolac, ketorolac LS (*Acular*, *Acular LS*)
prednisolone acetate (*Omnipred*)
prednisolone sodium (*Pred Forte*)
Durezol
Flarex
FML Forte
FML SOP
Lotemax drops
Maxidex
Pred Mild

Requires Prior Authorization

bromfenac (*Xibrom*)
Acuvail
Ilevro
Lotemax ointment & gel
Nevanac
Ozurdex
Prolensa
Retisert
Triesence
Vexol

OTIC

Otic Antibiotics

Preferred

neomycin/polymyxin/HC sol (*Cortisporin*)
ofloxacin otic (*Floxin*)
Ciprodex

Requires Prior Authorization

Cipro HC
Coly-Mycin S

RESPIRATORY

Antihistamines, Minimally Sedating

Preferred

cetirizine, cetirizine-D Rx & OTC (*Zyrtec*, *Zyrtec D*)
fexofenadine OTC (*Allegra*)
levocetirizine tab (*Xyzal*)
loratadine, loratadine-D Rx & OTC
(*Claritin*, *Claritin-D*)

Requires Prior Authorization

desloratadine (*Clarinex*, *Clarinex-D*, *Clarinex RDT*)
fexofenadine Rx (*Allegra*)
fexofenadine D (*Allegra-D*)
levocetirizine sol (*Xyzal*)
Semprex-D

Beta₂-Agonist Bronchodilators

(Beta-Adrenergic Agents)

Preferred

albuterol neb (0.083% & 5mg/ml)
albuterol syrup & tab (*Proventil*, *Ventolin*)
terbutaline (*Brethine*)
Foradil
ProAir HFA
Proventil HFA

Requires Prior Authorization

albuterol ER (*Vospire ER*)
albuterol neb 0.63mg/3ml & 1.25mg/3ml
(*Accuneb*)
levalbuterol (*Xopenex*)
metaproterenol (*Alupent*)
Arcapta
Brovana
Maxair
Perforomist
Serevent
Ventolin HFA
Xopenex HFA

COPD Agents

Preferred

ipratropium neb (*Atrovent*)
ipratropium neb/albuterol (*DuoNeb*)
Atrovent HFA
Combivent Respimat
Spiriva

Requires Prior Authorization

Anoro Ellipta
Daliresp
Tudorza

Maryland Medicaid Preferred Drug List (effective July 1, 2014)

RESPIRATORY

Glucocorticoids, Inhaled

(Beta-Adrenergics & Glucocorticoids Combination, Glucocorticoids)

Preferred

Advair Diskus, Advair HFA
Asmanex
Dulera
Flovent Diskus, Flovent HFA
Pulmicort Flexhaler
Pulmicort respules 0.25mg & 0.5mg (Brd only) *
QVAR
Symbicort

Requires Prior Authorization

budesonide respules (generic/all ages)
Aerospan
Alvesco
Breo Ellipta
Pulmicort respules 1mg

Intranasal Rhinitis Agents

(Nasal Anti-Inflammatory Steroids)

Preferred

azelastine nasal (*Astepro*)
fluticasone nasal (*Flonase*)
ipratropium nasal (*Atrovent*)
Astelin (Brd only)
Nasonex
Patanase

Requires Prior Authorization

azelastine nasal (*Astelin*) (gen only)
budesonide nasal (*Rhinocort Aqua*)
flunisolide (*Nasarel, Nasalide*)
triamcinolone nasal (*Nasacort AQ*)
Beconase AQ
Dymista
Omnaris
QNasal
Veramyst
Zetonna

Leukotriene Modifiers

Preferred

montelukast chew & tab (*Singulair*)
zafirlukast (*Accolate*)

Requires Prior Authorization

montelukast granules (*Singulair*)
Zyflo, Zyflo CR

* Available without prior authorization for children 1 to 8 years of age.

TOPICAL DERMATOLOGICS

Acne Agents, Topical

Preferred

benzoyl peroxide Rx & OTC
clindamycin (all forms except foam)
erythromycin
tretinoin
Azelex
Differin cream (Brd only)
Differin lotion
Panoxyl-4 OTC
Panoxyl-8 OTC

Requires Prior Authorization

adapalene cream (gen only)
adapalene gel (*Differin*)
benzoyl peroxide cleanser, gel
benzoyl peroxide kit, towelette
bp-10-1
cerisa
clindamycin foam
clindamycin/benzoyl peroxide
erythromycin/benzoyl peroxide
sulfacetamide
sulfacetamide/sulfur
sulfacetamide/sulfur/urea
tretinoin micro (*Retin-A Micro*)
Acanya
Aczone
Akne-Mycin
Atralin
Avar
BenzaClin
Clindacin
Epiduo
Fabior
Inova
Ovace
Pacnex
SE 10-5
SE BPO
SSS 10-4
Sumadan
Sumadan XLT
Sumaxin
Tazorac
Veltin
Ziana

Atopic Dermatitis

Preferred

Elidel

Requires Prior Authorization

Protopic

UROLOGIC

Benign Prostatic Hyperplasia

(Alpha-Adrenergic Blocking Agents)

Preferred

alfuzosin (*Uroxatral*)
doxazosin (*Cardura*)
finasteride (*Proscar*)
tamsulosin (*Flomax*)
terazosin (*Hytrin*)

Requires Prior Authorization

Avodart
Cardura XL
Jalyn
Rapaflo

Bladder Relaxant Preparations

(Urinary Tract Antispasmodic/Anti-incontinence Agent)

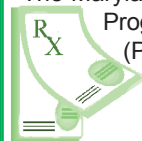
Preferred

oxybutynin, oxybutynin ER (*Ditropan, Ditropan XL*)
Toviaz

Requires Prior Authorization

flavoxate
tolterodine, tolterodine ER (*Detrol, Detrol LA*)
trospium, trospium ER (*Sanctura, Sanctura XR*)
Enablex
Gelnique
Myrbetriq
Oxytrol
Vesicare

The Maryland Medicaid Pharmacy Program Preferred Drug List (PDL) is included on Epocrates and updated weekly.



Visit www.epocrates.com and click on "Epocrates Online" or "My Account" to register for your free online account.

Maryland Medicaid Preferred Drug List (effective July 1, 2014)

Generic vs. Brand Status on Maryland's Preferred Drug List

Medicaid's Preferred Drug List, encompassing about 1700 drugs, covers most of the generic versions of preferred multisource brand drugs without any type of prior authorization. If the prescription for a brand name drug is to be dispensed as written, the prescriber must complete and submit a Medwatch form, available from the DHMH website at <http://mmcp.dhmh.maryland.gov/pap/docs/Maryland%20Medwatch%20Form.pdf>. The State's clinical pharmacy team will review the Medwatch form and notify the prescriber whether the request for the brand name drug was approved or denied. The State will forward the Medwatch form to the FDA.

The Maryland Medicaid Pharmacy Program (MMPP) wants to alert you to changes in the exceptions to this rule that are included in the attached updated Preferred Drug List (PDL) that is effective July 1, 2014. Brand name Sandimmune®, Marinol®, Lovenox® and Metrogel® are no longer preferred over their generic equivalents. Please refer to our website for a complete list of the PDL at the following link: <https://mmcp.dhmh.maryland.gov/pap/SitePages/Preferred%20Drug%20List.aspx>

Not All Generics are Preferred

In order for the State to enhance the benefit of the PDL, in some instances the multisource brand name drug is preferred over its generic equivalents, because the branded drug is less costly than its generic counterpart. This happens most often in cases of newly released generics. When manufacturer rebates are taken into consideration, the brand name drug has a lower net cost to the State.

When the brand name drug is preferred, no Medwatch no authorization is needed¹. Enter a DAW code of 6 on the claim to have it correctly priced. If any problems are encountered during the on-line claim adjudication of Preferred Brands, contact Xerox 24-hour Help Desk at 800-932-3918 for additional system overrides related to the use of the correct DAW code (for example, when there is other insurance that is primary).

Please maintain this for a reference together with any updates that follow. This information is available at www.epocrates.com on your desktop computer or PDA/Smartphone. Epocrates is updated weekly.

¹Unless the Program has established clinical criteria for the drug

The Brand Preferred exceptions are as follows:

Preferred Brands

Adderall XR
Alphagan P 0.15%
Astelin
Carbatrol ER
Cardizem LA
Catapres TTS
Cymbalta
Depakote Sprinkles
Dexedrine ER
Diastat
Differin cream
Focalin
Focalin XR
Gabitril
Kadian
Lidoderm
Metadate CD
Methylin Oral Solution
Parnate
Pulmicort respules 0.25mg and 0.5mg
Ritalin LA
Tegretol suspension
Tobi Inhalation Solution
Tobradex drops
Toprol XL
Tricor
Trileptal suspension
Vancocin

Non-Preferred Generics

amphetamine salt combo ER
brimonidine 0.15%
azelastine nasal
carbamazepine ER
diltiazem ER tablets
clonidine patches
duloxetine
divalproex sprinkles
dextroamphetamine ER
diazepam rectal
adapalene cream
dexmethylphenidate
dexmethylphenidate XR
tiagabine
morphine sulfate ER
lidocaine patch
methylphenidate CD cap
methylphenidate oral solution
tranylcypromine
budesonide respules
methylphenidate ER cap
carbamazepine suspension
tobramycin inhalation solution
tobramycin/dexamethasone drops
metoprolol succinate XL
fenofibrate nanocrystals
oxcarbazepine suspension
vancomycin cap

In the following instance, both the multisource brand and the generic are preferred:

Brand also Preferred

Optipranolol

Preferred generics

metipranolol



Maryland Department of
Health and Mental Hygiene
Office of Systems, Operations
and Pharmacy



Pharmacy News & Views

Maryland Medicaid Pharmacy Program

201 West Preston Street, 4th Floor

Baltimore, Maryland 21201

1-800-492-5231 (select option 3)

<http://mmcp.dhmf.maryland.gov/pap>

Martin O'Malley, *Governor*

Anthony G. Brown, *Lt. Governor*

Joshua M. Sharfstein, MD, *Secretary, DHMH*

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MMPP Newsletters and Advisories at:[www.
marylandmedicaidpharmacyinformation.com](http://www.marylandmedicaidpharmacyinformation.com)

Tier 2 and Non-Preferred Antipsychotic Review Process

All claims for Tier 2 or non-preferred antipsychotics for patients age 18 or older require authorization. The claim will deny at point of service and will not process. An electronic message will display on your system with instructions as to how to proceed. The Tier 2 and Non-Preferred Prior Authorization Form can be found at:
<http://mmcp.dhmf.maryland.gov/pap/docs/Tier%20and%20NPD%20Antipsychotic%20PA.pdf>

Maryland Medicaid Peer Review Program for Atypical Antipsychotics

Maryland Medicaid has put in place a pre-authorization program for the use of antipsychotics in children. This program covers all children under age 18. Please refer to this link:
<https://mmcp.dhmf.maryland.gov/>

30-day Emergency Supply of Atypical Antipsychotic Agents

When the prescriber is not available to obtain prior authorization for an antipsychotic medication that is non-preferred or second tier, the pharmacist can obtain a one-time only authorization to dispense up to a 30-day emergency supply.

Do not let patients leave the pharmacy without medication if there is concern that the patient will be unwilling or unable to return at a later time that day after prior authorization is approved.

To obtain authorization for an emergency supply of an antipsychotic, call Xerox Technical Assistance (ACS) at 800-932-3918. During the 30-day window, the pharmacist must notify the prescriber of the need to obtain a PA before the prescription can be filled a second time and make a note for his or her records of the date, time and person contacted at the prescriber's office.

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TELEPHONE NUMBERS

Xerox Technical Assistance

1-800-932-3918

24 hours a day, 7 days a week

Maryland Medicaid Pharmacy Access Hotline

1-800-492-5231 (*select option three*)

Monday-Friday, 8:00 am to 5:00 pm

Kidney Disease Program

1-410-767-5000 or 5002

Monday-Friday, 8:00 am to 5:00 pm

Breast & Cervical Cancer Diagnosis and Treatment

1-410-767-6787

Monday-Friday, 8:00 am to 4:30 pm

Maryland AIDS Drug Assistance Program

1-410-767-6535

Monday-Friday, 8:30 am to 4:30 pm