

2004

Last Update 12/16/2003

## PA Drugs, Step Therapy, and Quantity Limitation Drug List

(Current list available at [www.uniteddrugs.com](http://www.uniteddrugs.com))

HMG-CoA Reductase Inhibitors	Drugs	Cost Index
atorvastatin	LIPITOR For 10mg use 1/2 of a 20mg tablet For 20mg use 1/2 of a 40mg tablet For 40mg use 1/2 of an 80mg tablet	\$\$\$
pravastatin	PRAVACHOL For 10mg use 1/2 of a 20mg tablet For 20mg use 1/2 of a 40mg tablet For 40mg use 1/2 of an 80mg tablet	\$\$\$
rosuvastatin	CRESTOR 40mg needs PA	\$\$\$
<i>Cox-2 Selective Inhibitors</i>		
celecoxib	CELEBREX <b>Step Therapy</b> PA < 75 yrs of age automatic approval over 75 years of age	\$\$\$\$
rofecoxib	VIOXX PA < 75 yrs of age automatic approval over 75 years of age	\$\$\$\$
oxycodone, ext. rel.	OXYCONTIN (CII) (PA)	\$\$\$\$\$
fentanyl transdermal	DURAGESIC (CII) # (PA)	\$\$\$\$\$\$
<b>Migraine Agents</b>		
rizatriptan	MAXALT (limit 12 tabs/mo)	\$\$\$\$\$\$
sumatriptan	MAXALT-MLT (limit 12 tabs/mo) IMITREX all forms (limit 9 tabs, 1 kit/mo)	\$\$\$\$\$ \$\$\$\$\$ \$\$\$\$\$
zolmitriptan	ZOMIG (limit 12 tabs/mo) ZOMIG-ZMT (limit 12 tabs/mo)	\$\$\$\$\$ \$\$\$\$\$
frovatriptan	FROVA# (limit 9 tabs/mo)	\$\$\$\$\$
<b>ANTICONVULSANT MEDICATIONS</b>		
diazepam	DIASTAT (CIV) (Limit 2 boxes per month)	\$\$\$\$\$
<b>Selective Serotonin Reuptake Inhibitors (SSRIs)</b>		
escitalopram	LEXAPRO For 10mg use 1/2 of a 20mg tablet	\$\$\$
citalopram	CELEXA For 10mg use 1/2 of a 20mg tablet For 20mg use 1/2 of a 40mg tablet	\$\$\$
fluoxetine* (20mg capsules only)	PROZAC	\$\$\$\$\$
sertraline	ZOLOFT For 25mg use 1/2 of a 50mg tablet For 50mg, use 1/2 of a 100mg tablet	\$\$\$\$\$
<b>ANTIPARKINSON AGENTS</b>		
carbidopa/levodopa/entacapone	STALEVO <b>Step Therapy Protocols</b>	\$\$\$\$\$
<b>ANTIPSYCHOTICS</b>		
<b>Other Agents (Psychosis/Bipolar)</b>		
risperidone*	RISPERDAL For 0.25mg use 1/2 of 0.5 mg For 0.5mg use 1/2 of a 1 mg For 1mg use 1/2 of a 2 mg For 2mg use 1/2 of a 4 mg	\$\$\$\$\$
<b>ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD)</b>		
atomoxetine	STRATTERA # (PA)	\$\$\$
<b>MULTIPLE SCLEROSIS AGENTS</b>		
glatiramer	COPAXONE# (PA)	\$\$\$\$\$
interferon beta-1a	AVONEX (PA)	\$\$\$\$\$
interferon beta-1a	REBIF (PA)	\$\$\$\$\$
interferon beta-1b	BETASERON (PA)	\$\$\$\$\$
<b>SEDATIVES/HYPNOTICS</b>		
zaleplon	SONATA (CIV) # <b>QTY limitations</b> <b>14 tablets per month x 3 months</b>	\$\$\$
zolpidem	AMBIEN (CIV) # <b>QTY limitations</b> <b>14 tablets per month x 3 months</b>	\$\$\$
<b>- DERMATOLOGY -</b>		
<b>ACNE</b>		
<b>Oral</b>		
minocycline*	MINOCIN (caps only)	\$\$\$
isotretinoin *	ACUTANE <b>Age Limitations</b> (approved for less than 30 years of age)	\$\$\$\$\$

<b>Topical</b>		
tretinoin *	RETIN-A <b>Age Limitations</b>	\$
	(approved for less than 30 years of age)	
tretinoin	RETIN-A <b>Micro # Age Limitations</b>	\$\$\$\$\$\$
	(approved for less than 30 years of age)	

**MISCELLANEOUS AGENTS**

ammonium lactate*	AMLACTIN (OTC but a prescription is required for reimbursement)	\$
podofilox	CONDYLOX# (solution only)	\$\$\$\$\$\$
tacrolimus	PROTOPIC#	\$\$\$\$\$

– EENT –

**ALLERGY/COUGH/COLD**

**Antihistamines**

**Ethanolamines**

clemastine*	TAVIST (liquid and 2.68 mg only)	\$\$
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**Piperidines (oral, non-sedating)**

loratidine*	OTC (requires prescription)	\$
fexofenadine 30mg capsules only	ALLEGRA Qty limitation: 30tabs/month	\$\$\$
fexofenadine/pseudoephedrine	ALLEGRA D Qty limitation: 30tabs/month	\$\$\$

**OPHTHALMIC**

**Antiglaucoma**

**Oral**

acetazolamide*	DIAMOX, (not Sequels)	\$
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**Topical**

**ADRENERGIC AGONISTS**

brimonidine*	ALPHAGAN (ALPHAGAN P NOT COVERED)	\$\$
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– EMERGENCY KITS –

epinephrine	EPIPEN # QTY 2 per year limitation	\$\$\$\$
	EPIPEN Jr. # QTY 2 per year limitation	\$\$\$\$

– ENDOCRINOLOGY –

**ANTIDIABETIC AGENTS**

**Insulins (vials)**

human insulin aspart	NOVOLOG	\$\$\$
human insulin lispro	HUMALOG	\$\$\$\$\$
insulin glargine	LANTUS	\$\$\$\$\$
human insulin	HUMULIN	\$\$
	NOVLIN	\$\$
rosiglitazone	AVANDIA	\$\$\$\$\$
pioglitazone	<b>Step Therapy Protocol</b> ACTOS	\$\$\$\$\$\$
repaglinide	<b>Step Therapy Protocol</b> PRANDIN	\$\$\$\$\$\$
rosiglitazone/metformin	<b>Step Therapy Protocol</b> AVANDAMET	\$\$\$\$
	<b>Step Therapy Protocol</b>	

**PROTON PUMP INHIBITORS**

omeprazole*	PRILOSEC OTC (requires Rx for coverage)	\$
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– INFECTIOUS DISEASE –

**HIV**

All oral medications in this class are covered if FDA approved

– MUSCULOSKELETAL –

**SKELETAL MUSCLE RELAXANTS**

**Centrally Acting**

dantrolene sodium	DANTRIUM # (PA)	\$\$\$\$\$
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– UROLOGICAL –

**Antispasmodics**

oxybutynin transdermal patch	OXYTROL (PA)	\$\$\$
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**Benign Prostatic Hypertrophy (BPH)**

**Alpha Blockers**

terazosin*	HYTRIN (caps only)	\$\$\$
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