



# Pharmacy News & Views

January 2013

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

## Tier 2 and Non-Preferred Antipsychotic Review Process

All claims for initial therapy (new patient to antipsychotic medication) for use of a Tier 2 or non-preferred antipsychotic in patients age 10 and older (18 and older for Abilify®) now 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. Listed below are key points of the prior authorization process with respect to the pharmacist role and *ensuring that disruptions in therapy does not occur*.

**MOST IMPORTANTLY - if prior authorization cannot be obtained in a timely manner by the prescriber, no patient should ever go without medication. Up to a 30 day supply of the Tier 2 or non-preferred medication can be dispensed to avoid any disruption in therapy.**

### Clinical Criteria for Approval:

*Clinical criteria for immediate approval:*

- The patient has had an adequate trial (at least 6 weeks at recommended dose) of at least one preferred antipsychotic drug where FDA indicated, or:
- The medication was started on an inpatient unit/other acute care setting, or:
- All preferred antipsychotics are medically contraindicated for the patient.

### Other Clinical Criteria

*can be found on the website:*

<http://mmcp.dhmfh.maryland.gov/pap/SitePages/Clinical%20Criteria.aspx>

### Pharmacist Responsibilities When a Claim Denies:

*Patient care and follow-up is important:*

- Consult with the patient
- Consult with the prescriber
- Prior authorization can be obtained by prescriber by phone or fax (forms available on MMPP website) with 24 hour turn around time
- Always ensure patient receives their medication - if unable to contact the prescriber, use professional judgment and follow-up!!!!
- Pharmacist should call claims processor Xerox 1-800-932-3918
- Up to one 30 day emergency supply is available by either pharmacist or prescriber request with a phone call to Xerox 1-800-932-3918
- Pharmacist may always request a 72 hour emergency supply as per COMAR (10.09.03.06D(3))

### Tier 2 and Non-Preferred Prior Authorization Review Process Resources:

- Clinical Criteria:  
<http://mmcp.dhmfh.maryland.gov/pap/SitePages/Clinical%20Criteria.aspx>
- Prior Authorization (PA) Form:  
<http://mmcp.dhmfh.maryland.gov/pap/docs/Tier%20and%20NPD%20Antipsychotic%20PA.pdf>
- Preferred Drug List (PDL), both Fee-for-Service (FFS) and MCO Formularies are available for free at Epocrates.com.
- The FFS PDL also available online at:  
<http://mmcp.dhmfh.maryland.gov/pap/SitePages/druglist.aspx>

For questions or further information call either:

- Xerox (ACS) 1-800-932-9318
- Maryland Medicaid at 1-800-492-5231 (opt 3)

**REMEMBER: NEVER  
LET THE PATIENT  
GO WITHOUT  
MEDICATION**

## 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 under age 10 years. It is anticipated that this program will expand to cover children under age 18 in 2013. The program is intended to:

- Improve appropriate use of antipsychotics
- Improve safety monitoring - obesity and metabolic side effects
- Give provider education (approved indications, monitoring guidelines)
- Promote appropriate psychosocial treatment

Unless the **prescriber** has contacted the Peer Review Call Center and obtained a Prior Authorization, the claim will be denied at the point of sale. The denial message will be "PA Required" and "Prescriber or their designee must call Antipsychotic Peer Review Center at **1-855-283-0876** for PA".

*Pharmacy provider MUST CONTACT the PRESCRIBER to obtain the PA. In turn, the prescriber must contact the Peer Review Call Center and proceed with consultation and decision related to PA (approve/deny). The Peer Review Program will notify the prescriber of the approval or denial of the prescription. The prescriber will in turn notify the pharmacy provider.*

Prior authorizations are usually provided for a period of 6 months unless all requested laboratory and clinical information has not been received.

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### Patient Care is critical and Follow-Up is important:

- Medicaid patients represent a vulnerable population
- Disruptions in therapy may result in hospital re-admission or ER visits
- Be sure no harm comes to patient or others

**REMEMBER: NEVER  
LET THE PATIENT  
GO WITHOUT  
MEDICATION**

### Pharmacist Responsibilities When a Claim Denies for the Peer Review Program

- Consult with the patient
- Consult with the prescriber
- Prior authorization can only be obtained by prescriber by phone or fax (forms available on MMPP website). The Peer Review PA process may take 24 to 48 hours
- Always ensure patient receives their medication - if unable to contact the prescriber, the Pharmacist may always request a 72 hour emergency supply of medication per COMAR (10.09.03.06D(3)) by calling the claims processor Xerox at 1-800-932-3918.
- Pharmacist should use professional judgment and follow-up!!!!

### Peer Review Program Prior Authorization Process Resources:

- Toll-free phone  
1-855-283-0876
- Toll-free fax  
1-866-671-8084
- Complete explanation of the Peer Review Program:  
<http://mmcp.dhmh.maryland.gov/pap/docs/PEER%20REVIEW%20FAQ%2011-13-12.pdf>
- Clinical PA form:  
<http://mmcp.dhmh.maryland.gov/pap/SitePages/Peer%20Review%20Program.aspx>



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# Maryland Medicaid Preferred Drug List

The Maryland Medicaid Preferred Drug List (PDL) shown includes updates effective January 1, 2013. 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 fee-for-service Medicaid patients. *Note: for most multi-source products, the gen product(s) are usually preferred and brded innovator product(s) are non-preferred. Most brded PDL products that are new to the market require prior authorization until they are reviewed.*

**Key:** Highlighted 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.

## ANALGESIC

### Analgesics, Narcotics (Long Acting)

#### Preferred

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

#### Requires Prior Authorization

morphine sulfate ER (*Kadian*) (gen only)  
oxycodone ER (*OxyContin*) (Brd & gen)  
oxymorphone ER  
tramadol ER (*Ultram ER, Ryzolt*) (Brd & gen)  
Avinza  
Butrans  
Conzip  
Duragesic Matrix  
Exalgo  
Nucynta ER  
Opana ER

### Analgesics, Narcotics (Short Acting)

#### Preferred

apap w/codeine (*Tylenol w/Codeine*)  
aspirin w/codeine  
butalbital/apap/codeine  
butalbital/apap/codeine/caffeine  
codeine  
dihydrocodeine/apap/caffeine (*Panlor SS*)  
dihydrocodeine/aspirin/caffeine (*Synalgos DC*)  
hydrocodone/apap (*Vicodin*)  
hydrocodone/ibuprofen (*Vicoprofen*)  
hydromorphone (*Dilaudid*)  
morphine sulfate  
oxycodone  
oxycodone/apap (*Percocet*)  
oxycodone/aspirin (*Percodan*)  
pentazocine/apap (*Talacen*)  
pentazocine/naloxone (*Talwin NX*)  
tramadol (*Ultram*)  
tramadol/apap (*Ultracet*)  
Roxicodone tabs  
Zydone

## ANALGESIC

*Analgesics, Narcotics Preferred (continued)*

#### Requires Prior Authorization

butorphanol nasal spray  
carisoprodol/codeine/asa  
fentanyl transmucosal & buccal (*Actiq & Fentora*) (Brd & gen) \*  
levorphanol  
meperidine (*Demerol*) (Brd & gen)  
oxycodone/ibuprofen (*Combunox*) (Brd & gen)  
oxymorphone (*Opana*) (Brd & gen)  
Abstral \*  
Dilaudid Liquid  
Ibudone  
Nucynta  
Onsolis \*  
Oxecta  
Panlor DC  
Primlev  
Reprexain  
Roxicodone solution  
Rybit ODT  
Subsys  
Trezix  
Zamicet  
Zolvit

### Anti-Hyperuricemics

#### Preferred

allopurinol (*Zyloprim*)  
probenecid  
probenecid/colchicine

#### Requires Prior Authorization

Colcrys  
Uloric

### Anti-Migraine Agents

#### Preferred

sumatriptain (*Imitrex*)  
Relpax

#### Requires Prior Authorization

naratriptan (*Amerge*) (Brd & gen)  
Axert  
Cambia  
Frova  
Maxalt, Maxalt MLT  
Sumavel Dosepro  
Treximet  
Zomig, Zomig Nasal, Zomig ZMT

## ANALGESIC

### Neuropathic Pain

#### Preferred

capsaicin OTC  
gabapentin (*Neurontin*)  
Lidoderm  
Lyrica  
Savella

#### Requires Prior Authorization

Cymbalta \*  
Gralise  
Horizant  
Qutenza  
Zostrix OTC

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

#### Preferred

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

#### Requires Prior Authorization

diclofenac/misoprostil (*Arthrotec*) (Brd & gen)  
mefenamic acid (*Ponstel*)  
tolmetin, tolmetin DS (*Tolectin, Tolectin DS*)  
Celebrex  
Duedis  
Flector  
Indocin Rectal, Indocin Suspension  
Mobic Suspension  
Pennsaid  
Sprix Nasal  
Vimovo  
Zipsor

\* Clinical criteria apply. View criteria at: [www.dhmh.maryland.gov/pap/SitePages/Clinical%20Criteria.aspx](http://www.dhmh.maryland.gov/pap/SitePages/Clinical%20Criteria.aspx)

# Maryland Medicaid Preferred Drug List (effective January 1, 2013)

## ANALGESIC

### Skeletal Muscle Relaxants

#### Preferred

baclofen (*Lioresal*)  
 carisoprodol, carisoprodol compound  
 (*Soma, Soma compound*)  
 chlorzoxazone (*Parafon*)  
 cyclobenzaprine (*Flexeril*)  
 dantrolene (*Dantrium*)  
 methocarbamol (*Robaxin*)  
 orphenadrine, orphenadrine compound  
 (*Norflex, Norflex Forte*)  
 tizanidine tabs (*Zanaflex*)

#### Requires Prior Authorization

cyclobenzaprine ER (*Amrix*) (Brd & gen)  
 metaxalone (*Skelaxin*) (Brd & gen)  
 tizanidine caps (*Zanaflex*) (Brd & gen)  
 Fexmid  
 Lorzone  
 Soma 250mg

## ANTI-INFECTIVES

### Antibiotics, GI

#### Preferred

metronidazole tabs (*Flagyl*)  
 neomycin  
 vancomycin (*Vancocin*)  
 Alinia

#### Requires Prior Authorization

metronidazole caps (*Flagyl caps*)  
 tinidazole (*Tinamix*)  
 Difacid  
 Flagyl ER  
 Neo-Fradin  
 Xifaxan

### Antibiotics, Inhaled

#### Preferred

TOBI

#### Requires Prior Authorization

Cayston

#### Preferred

clindamycin (*Clindamax*)  
 metronidazole (*Metro-Gel*) (Brd & gen)  
 Cleocin Ovules  
 Vandazole

#### Requires Prior Authorization

Cleocin Cream

## ANTI-INFECTIVES

### Antifungals, Oral (Antifungal Agents, Antifungal Antibiotics)

#### Preferred

fluconazole (*Diflucan*)  
 griseofulvin ultra (*Gris Peg*)  
 ketoconazole (*Nizoral*)  
 nystatin  
 terbinafine (*Lamisil*)

#### Requires Prior Authorization

clotrimazole troche (*Mycelex*) (Brd & gen)  
 flucytosine (*Ancobon*)  
 griseofulvin suspension (*Fulvicin*,  
*GriFulvin V*) (Brd & gen)  
 itraconazole (*Sporanox*)  
 voriconazole (*Vfend*) (Brd & gen)  
 Lamisil Granules  
 Noxafil  
 Terbines

### Antifungals, Topical (Topical Antifungals)

#### Preferred

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

#### Requires Prior Authorization

butenafine OTC (*Mentax*) (Brd & gen)  
 ciclopirox (*Loprox*) (Brd & gen)  
 ciclopirox solution (*Penlac*) (Brd & gen)  
 ciclopirox shampoo (*Loprox*) (Brd & gen)  
 ketoconazole foam  
 tolnaftate aero powder  
 Bensal HP  
 CNL-8  
 Ertaczo  
 Exelderm  
 Extina  
 Ketocon Plus  
 Lamisil Solution  
 Naftin  
 Oxistat  
 Pediderm AF  
 Pediprox-4  
 Vusion

### Antiparasitics, Topical

#### Preferred

malathion (*Ovide*)  
 permethrin OTC  
 permethrin Rx (*Elimite, Acticin*)  
 piperonyl/pyrethrins OTC  
 piperonyl/pyrethrins/permethrin OTC  
 Eurax cream

#### Requires Prior Authorization

lindane  
 spinosad (*Natroba*) (gen only)  
 Eurax lotion  
 Sklice  
 Ulesfia

## ANTI-INFECTIVES

### Antivirals, Oral (Antivirals, General)

#### Preferred

acyclovir (*Zovirax*)  
 amantadine (*Symmetrel*)  
 rimantadine (*Flumadine*)  
 valacyclovir (*Valtrex*) (Brd & gen)

#### Requires Prior Authorization

famciclovir (*Famvir*) (Brd & gen)  
 Relenza  
 Tamiflu

### Antivirals, Topical

#### Preferred

Abreva OTC  
 Denavir  
 Zovirax Ointment

#### 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 (*Duricef*)  
 cefdinir (*Omnicef*)  
 cefprozil (*Cefzil*)  
 cefuroxime (*Ceftin*)  
 cephalixin (*Keflex*)  
 Suprax

#### Requires Prior Authorization

amoxicillin/clav ER (*Augmentin XR*)  
 (Brd & gen)  
 cefditoren (*Spectracef*) (Brd & gen)  
 cefpodoxime (*Vantin*) (Brd & gen)  
 Cedax  
 Ceftin Tabs/Suspension

### Fluoroquinolones (Quinolones)

#### Preferred

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

#### Requires Prior Authorization

ciprofloxacin ER (*Cipro XR*) (Brd & gen)  
 ofloxacin (*Floxin*) (Brd & gen)  
 Avelox  
 Cipro Suspension  
 Factive  
 Noroxin

### Hepatitis C Agents (Hepatitis C Treatment Agents, Immunomodulators)

#### Preferred

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

#### Requires Prior Authorization

Infergen  
 Pegasys Proclick  
 Ribapak  
 Ribasphere



The Maryland Medicaid Pharmacy Program Preferred Drug List (PDL) is included on Epocrates and updated weekly. Visit [www.epocrates.com](http://www.epocrates.com) and click on "Epocrates Online" or "My Account" to register for your free online account.

# Maryland Medicaid Preferred Drug List (effective January 1, 2013)

## ANTI-INFECTIVE

### Macrolides/Ketolides

#### Preferred

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

#### Requires Prior Authorization

clarithromycin, clarithromycin ER  
(*Biaxin, Biaxin XL*) (Brd & gen)  
Ketek  
PCE  
Zmax

### Tetracyclines

#### Preferred

doxycycline hyclate  
doxycycline hyclate DR  
doxycycline monohydrate  
minocycline (*Minocin*)  
tetracycline (*Sumycin*)

#### Requires Prior Authorization

demeclocycline (*Declomycin*)  
minocycline ER  
Adoxa CK, Adoxa TT  
Doryx  
Morgidox  
Oracea  
Solodyn  
Vibramycin Caps & Suspension

### Topical Antibiotics

#### Preferred

bacitracin OTC  
bacitracin/polymyxin OTC  
gentamicin  
mupirocin (*Bactroban Ointment*)  
triple antibiotic cream, ointment &  
packet, OTC

#### Requires Prior Authorization

Altabax  
Bactroban Cream  
Centany

### Angiotensin Modulator Combinations

#### Preferred

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

#### Requires Prior Authorization

trandolapril/verapamil (*Tarka*)  
(Brd & gen)  
Tekamlo/Amturnide  
Twynsta

## CARDIOVASCULAR

### Angiotensin Modulators (Hypotensives, Angiotensin Receptor Antagonist)

#### Preferred

benazepril, benazepril HCTZ (*Lotensin,  
Lotensin HCT*)  
captopril, captopril HCTZ (*Capoten, Capozide*)  
enalapril, enalapril HCTZ (*Vasotec, Vaserecic*)  
fosinopril, fosinopril HCTZ (*Monopril,  
Monopril HCT*)  
lisinopril, lisinopril HCTZ (*Prinivil,  
Zestril, Prinzide, Zestoretic*)  
losartan (*Cozaar*)  
losartan/HCTZ (*Hyzaar*)  
quinapril (*Accupril*)  
quinaretic (*Accuretic*)  
ramipril (*Altace*)  
valsartan, valsartan HCTZ (*Diovan,  
Diovan HCT*)

#### Requires Prior Authorization

eprosartan (*Teveten*) (Brd & gen)  
irbesartan, irbesartan HCTZ (*Avapro,  
Avalide*) (Brd & gen)  
moexipril (*Univasc*) (Brd & gen)  
moexipril HCTZ (*Uniretic*) (Brd & gen)  
perindopril (*Aceon*) (Brd & gen)  
trandolapril (*Mavik*) (Brd & gen)  
Atacand, Atacand HCT  
Benicar, Benicar HCT  
Edarbi, Edarbiclor  
Micardis, Micardis HCT  
Tekturna, Tekturna HCT  
Teveten HCT

### Anticoagulants

#### Preferred

warfarin (*Coumadin*)  
Fragmin  
Lovenox (Brd only)

#### Requires Prior Authorization

enoxaparin (gen only)  
fondaparinux (*Arixtra*) (Brd & gen)  
Pradaxa  
Xarelto

### Antihypertensives, Sympatholytics

#### Preferred

clonidine oral (*Catapres*)  
guanfacine (*Tenex*)  
methyldopa (*Aldmet*)  
methyldopa HCTZ (*Aldoril*)  
Catapres-TTS (Brd only)

#### Requires Prior Authorization

clonidine transdermal (gen only)  
reserpine  
Clorpres

## CARDIOVASCULAR

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

#### Preferred

acebutolol (*Sectral*)  
atenolol (*Tenormin*)  
atenolol/chlorthalidone (*Tenoretic*)  
bisoprolol (*Zebeta*)  
bisoprolol HCTZ (*Ziac*)  
carvedilol (*Coreg*)  
labetalol (*Normodyne, Trandate*)  
metoprolol tartrate (*Lopressor*)  
metoprolol tartr/HCTZ (*Lopressor HCTZ*)  
metoprolol succinate XL (*Toprol XL*)  
nadolol (*Corgard*)  
nadolol/bendroflumethiazide (*Corzide*)  
pindolol (*Visken*)  
propranolol, propranolol LA  
(*Inderal, Inderal LA*)  
propranolol HCTZ (*Inderide*)  
sotalol, sotalol AF (*Betapace, Betapace AF*)  
timolol (*Blocadren*)

#### Requires Prior Authorization

betaxolol (*Kerlone*) (Brd & gen)  
Bystolic  
Coreg CR  
Dutropol  
Innopran XL  
Levatol

### Calcium Channel Blocking Agents

#### Preferred

amlodipine (*Norvasc*)  
diltiazem (*Cardizem*)  
diltiazem CD, diltiazem ER (*Cardizem SR,  
Cardizem CD, Dilacor XR, Tiazac*)  
felodipine (*Plendil*)  
isradipine (*Dynacirc*)  
nicardipine (*Cardene*)  
nifedipine SR (*Adalat CC, Procardia XL*)  
verapamil (*Calan*)  
verapamil ER, verapamil SR (*Calan SR,  
Verelan*)

#### Requires Prior Authorization

nifedipine (*Adalat, Procardia*) (Brd & gen)  
nimodipine (*Nimotop*) (Brd & gen)  
nisoldipine (*Sular*) (Brd & gen)  
verapamil ER caps (*Verelan PM*)  
(Brd & gen)  
Cardizem LA  
Covera HS  
DynaCirc CR  
Matzim LA

### Lipotropics, Other (Lipotropics, Bile Salt Sequestrants)

#### Preferred

cholestyramine (*Questran, Light*)  
fenofibrate nanocrystals (*Tricor*)  
gemfibrozil (*Lopid*)  
Niacor  
Niaspan ER  
Trilipix

#### Requires Prior Authorization

colestipol (*Colestid*) (Brd & gen)  
fenofibrate (*Lofibra*) (Brd & gen)  
fenofibric acid (*Fibricor*) (Brd & gen)  
Antara  
Lipofen  
Lovaza  
Triglide  
Welchol  
Zetia

\* Clinical criteria apply. View criteria at: [www.dhmh.maryland.gov/pap/SitePages/Clinical%20Criteria.aspx](http://www.dhmh.maryland.gov/pap/SitePages/Clinical%20Criteria.aspx)

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## CARDIOVASCULAR

### Lipotropics, Statins (Lipotropics)

#### Preferred

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

#### Requires Prior Authorization

amlodipine/atorvastatin (*Caduet*) (Brd & gen)  
Advicor  
Altoprev  
Crestor  
Livalo  
Vytorin

### Platelet Aggregation Inhibitors

#### Preferred

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

#### Requires Prior Authorization

Brilinta  
Effient

### Pulmonary Arterial Hypertension Agents, Oral and Inhaled Agents

#### Preferred

sildenafil \* (*Revatio*)  
Adcirca \*  
Letairis  
Tracleer  
Ventavis

#### Requires Prior Authorization

Tyvaso

## CENTRAL NERVOUS SYSTEM

### Anticonvulsants

#### Preferred

carbamazepine (*Tegretol*)  
carbamazepine susp. (*Tegretol suspension*) (Brd & gen)  
clonazepam (*Klonopin*)  
divalproex (*Depakote, Depakote ER*)  
lamotrigine (*Lamictal*)  
levetiracetam (*Keppra*)  
oxcarbazepine tabs (*Trileptal*)  
oxcarbazepine susp. (*Trileptal suspension*) (Brd & gen)  
phenobarbital  
phenytoin (*Dilantin*)  
primidone (*Mysoline*)  
tiagabine (*Gabitril*)  
topiramate (*Topamax*)  
valproic acid (*Depakene*)  
zonisamide (*Zonegran*)  
Carbatrol (Brd only)  
Celontin  
Depakote Sprinkle (Brd only)  
Diastat Rectal (Brd only)  
Dilantin Infatabs  
Peganone

## CENTRAL NERVOUS SYSTEM

### Anticonvulsants (continued)

#### Requires Prior Authorization

carbamazepine ER caps (gen only)  
carbamazepine XR (*Tegretol XR*)  
clonazepam ODT (*Klonopin ODT*)  
diazepam rectal (gen only)  
divalproex sprinkles (gen only)  
ethosuximide (*Zarontin*) (Brd & gen)  
felbamate (*Felbatol*)  
levetiracetam ER (*Keppra XR*) (Brd & gen)  
topiramate sprinkles (*Topamax*) (Brd & gen)  
Banzel  
Equetro  
Lamictal ODT, Lamictal XR  
Onfi  
Phenytek  
Potiga  
Sabril  
Stavzor  
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 soltab (*Remeron, Remeron Soltab*)  
phenelzine (*Nardil*)  
trazodone (*Desyrel*)  
venlafaxine (*Effexor*)  
venlafaxine ER caps (*Effexor XR*)  
Marplan  
Parnate (Brd only)

#### Requires Prior Authorization

nefazodone (*Serzone*)  
tranylcypromine (gen only)  
venlafaxine ER tabs  
Aplenzin  
Emsam  
Oleptro ER  
Pristiq  
Viibryd

#### Antidepressants, Selective Serotonin Reuptake Inhibitors (SSRIs)

#### Preferred

citalopram (*Celexa*)  
escitalopram (*Lexapro*)  
fluoxetine (*Prozac*)  
fluvoxamine (*Luvox*)  
paroxetine (*Paxil*)  
sertraline (*Zoloft*)  
Requires Prior Authorization  
fluoxetine weekly (*Prozac weekly*) (Brd & gen)  
paroxetine CR (*Paxil CR*) (Brd & gen)  
selfemra (*Sarafem*) (Brd & gen)  
Luvox CR  
Pexeva

\* Clinical criteria apply. View criteria at: [www.dhmd.maryland.gov/pap/SitePages/Clinical%20Criteria.aspx](http://www.dhmd.maryland.gov/pap/SitePages/Clinical%20Criteria.aspx)

## CENTRAL NERVOUS SYSTEM

### Antipsychotics

#### Preferred

##### **FIRST TIER:**

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

##### **SECOND TIER: \*\***

olanzapine IM (*Zyprexa IM*)  
olanzapine ODT (*Zyprexa Zydys*)  
olanzapine (*Zyprexa*)

##### Abilify

\*\* 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.

#### Requires Prior Authorization

ziprasidone (gen only)  
Abilify IM  
Fanapt  
Fazaclo  
Invega  
Latuda  
Saphris  
Seroquel XR  
Zyprexa Relprev

### Sedative Hypnotics

#### Preferred

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

#### Requires Prior Authorization

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

\*\*\*Step therapy may allow it to process without a prior authorization.

# Maryland Medicaid Preferred Drug List (effective January 1, 2013)

## CENTRAL NERVOUS SYSTEM

**Stimulants & Related Agents** (Tx for Attention Deficit Hyperact (ADHD)/ Narcolepsy; Adrenergics, Aromatic, Non-Catecholamine)

### Preferred

#### **FIRST TIER:**

amphetamine salt combo (*Adderall*)  
dexamethylphenidate (*Focalin*) (Brd & gen)  
dextroamphetamine tabs (*Dexedrine*)  
methylphenidate, methylphenidate ER (*Ritalin, Ritalin-SR*)  
methylphenidate CR (*Concerta*)  
Adderall XR (Brd only)  
Daytrana  
Dexedrine ER caps (Brd only)  
Focalin XR  
Intuniv \*\*  
Metadate CD (Brd only)  
Methylin Chew & Solution  
Vyvanse

#### **SECOND TIER:**

Strattera \* (for ages 17 and under)

### Requires Prior Authorization

amphetamine salt combo ER (gen only)  
dextroamphetamine ER caps (gen only)  
methamphetamine (*Desoxyn*) (Brd & gen)  
methylphenidate CD (gen only)  
methylphenidate ER (*Ritalin LA*) (Brd & gen)  
methylphenidate liquid (*Procentra*) (Brd & gen)  
modafinil (*Provigil*) (Brd & gen)  
Kapvay \*\*  
Nuvigil

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

## ENDOCRINE

### Androgenic Agents

#### Preferred

Androderm  
Androgel

#### Requires Prior Authorization

Axiron  
Fortesta  
Testim

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

#### Preferred

alendronate (*Fosamax*)  
Miacalcin (Brd only)

#### Requires Prior Authorization

calcitonin salmon nasal (gen only)  
etidronate (*Didronel*) (Brd & gen)  
ibandronate (*Boniva*) (Brd & gen)  
Actonel  
Atelvia  
Evista  
Forteo  
Fortical  
Fosamax Plus D, Fosamax Solution  
Prolia

## ENDOCRINE

### Hypoglycemics, Incretin Mimetics & Enhancers

#### Preferred

Byetta  
Janumet  
Januvia  
Jentadueto  
Kombiglyze XR  
Onglyza  
Symlin  
Tradjenta

#### Requires Prior Authorization

Bydureon  
Janumet XR  
Juvvisync  
Victoza

### Hypoglycemics, Insulins

#### Preferred

Humalog, Humalog Mix  
Humulin  
Lantus  
Novolin  
Novolog, Novolog Mix

#### Requires Prior Authorization

Apidra  
Levemir

### Hypoglycemics, Meglitinides

(Hypoglycemics, Insulin Release Stimulant Type)

#### Preferred

nateglinide (*Starlix*)  
Prandin

#### Requires Prior Authorization

Prandimet

### Hypoglycemics, TZDs

(Hypoglycemics, Insulin-Response Enhancers)

#### Preferred

pioglitazone (*Actos*)  
ActoPlusMet  
Duetact

#### Requires Prior Authorization

ActoPlusMet XR  
Avandamet  
Avandaryl  
Avandia

## GASTROINTESTINAL

### Antiemetic/Antivertigo Agents

#### Preferred

dimenhydrinate OTC & inj.  
meclizine Rx & OTC (*Bonine, Antivert*)  
metoclopramide oral & IV (*Reglan*)  
ondansetron, ondansetron ODT (*Zofran, Zofran ODT*)  
prochlorperazine (*Compazine, Compro*)  
promethazine oral & rectal (*Phenergan*)  
Marinol (Brd only)  
Emend (oral only)  
Metozolv ODT  
TransDerm-Scop

#### Requires Prior Authorization

dronabinol (gen only)  
granisetron oral & IV (*Kytril*) (Brd & gen)  
trimethobenzamide (*Tigan*) (Brd & gen)  
Aloxi IV  
Anzemet (oral & IV)  
Cesamet  
Emend IV  
Sancuso  
Zuplenz

## GASTROINTESTINAL

### Bile Salts

#### Preferred

ursodiolcapsule (*Actigall*)

#### Requires Prior Authorization

ursodiol tab (*URSO Forte*)  
Chenodal

### Pancreatic Enzymes

#### Preferred

pancrelipase  
Creon  
Zenpep

#### Requires Prior Authorization

Pancreaze

### Phosphate Binders & Related Agents

#### Preferred

Calphron OTC  
Eliphos  
PhosLo (Brd only)  
Renagel  
Renvela tab

#### Requires Prior Authorization

calcium acetate (gen only)  
Fosrenol  
Magnebind 400 RX  
Phoslyra  
Renvela powder packet

### Proton Pump Inhibitors

(Gastric Acid Secretion Reducers)

#### Preferred

lansoprazole, lansoprazole OTC (*Prevacid, Prevacid OTC*)  
omeprazole, omeprazole OTC (*Prilosec, Prilosec OTC*)  
pantoprazole (*Protonix*)  
Prevacid Solutab (Brd only)  
Protonix Suspension

#### Requires Prior Authorization

omeprazole/sodium bicarb (*Zegerid OTC*) (Brd & gen)  
Aciphex  
Dexilant  
Prilosec Suspension  
Nexium

### Ulcerative Colitis Agents

#### Preferred

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

#### Requires Prior Authorization

mesalamine enemas (*Rowasa*) (Brd & gen)  
Asacol HD  
Dipentum  
Lialda  
Pentasa  
sFRowasa

## IMMUNOLOGICS

### Immunosuppressives, Oral

#### Preferred

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

#### Requires Prior Authorization

cyclosporine (gen only)  
Azasan  
Myfortic  
Zortress

\* Clinical criteria apply. View criteria at: [www.dhmh.maryland.gov/pap/SitePages/Clinical%20Criteria.aspx](http://www.dhmh.maryland.gov/pap/SitePages/Clinical%20Criteria.aspx)

# Maryland Medicaid Preferred Drug List (effective January 1, 2013)

## INJECTABLES

### Colony Stimulating Factors

**Preferred**  
Neupogen

**Requires Prior Authorization**  
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 IV, Orencia Sub-Q  
Remicade  
Simponi  
Stelara

### Erythropoietins (Hematinics, Other)

**Preferred**  
Aranesp  
Procrit

**Requires Prior Authorization**  
Epogen  
Omontys

### 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 (*Aricept*,  
*Aricept ODT*)  
rivastigmine caps (*Exelon*)  
Exelon Transdermal Patch  
Namenda

**Requires Prior Authorization**  
galantamine (*Razadyne*, *Razadyne ER*)  
(Brd & gen)  
Exelon Solution

### Anti-Parkinson's Agents

**Preferred**  
benztropine (*Cogentin*)  
levodopa/carbidopa Immediate & ER  
(*Sinemet*, *Sinemet CR*)  
levodopa/carbidopa/entacapone  
(*Stalevo*)  
ropinirole (*Requip*)  
pramipexole (*Mirapex*)  
selegiline tabs (*Eldepryl*)  
trihexyphenidyl (*Artane*)

## NEUROLOGICS

*Anti-Parkinson's Agents (continued)*

**Requires Prior Authorization**  
bromocriptine (*Parlodel*) (Brd & gen)  
entacapone (*Comtan*) (Brd & gen)  
levodopa/carbidopa ODT (*Parcopa*) (Brd & gen)  
ropinirole ER (*Requip XL*) (Brd & gen)  
selegiline caps (*Eldepryl*) (Brd & gen)  
Azilect  
Mirapex ER  
Tasmar  
Zelapar

### Multiple Sclerosis Agents

**Preferred**  
Avonex  
Betaseron  
Copaxone  
Rebif

**Requires Prior Authorization**  
Ampyra  
Extavia  
Gilenya

## OPHTHALMICS

**Ophthalmics, Allergic Conjunctivitis**  
(Eye Anti-inflammatory Agents, Eye Antihistamines,  
Ophthalmic Mast Cell Stabilizers)

**Preferred**  
cromolyn (*Crolom*)  
ketotifen OTC (*Zaditor OTC*)  
Alrex  
Pataday

**Requires Prior Authorization**  
azelastine (*Optivar*) (Brd & gen)  
epinastine (*Elestat*) (Brd & gen)  
Alocril  
Alomide  
Bepreve  
Emadine  
Lastacaft  
Patanol

### Ophthalmics, Antibiotics

**Preferred**  
bacitracin  
bacitracin/polymyxin  
ciprofloxacin solution (*Ciloxan*)  
erythromycin  
gentamicin (*Garamycin*)  
neomycin/polymyxin/gramicidin  
(*Neosporin*)  
ofloxacin (*Ocuflax*)  
polymyxin/trimethoprim (*Polytrim*)  
sulfacetamide (*Bleph-10*)  
terramycin/polymyxin  
tobramycin (*Tobrex*)  
triple antibiotic  
Besivance  
Ciloxan Ointment  
Moxeza  
Tobrex Ointment  
Vigamox

**Requires Prior Authorization**  
levofloxacin (*Quixin*) (Brd & gen)  
AzaSite  
Garamycin Ointment  
Iquix  
Natacyn  
Zymaxid

## OPHTHALMICS

### Ophthalmics, Antibiotic/Steroid Combinations

**Preferred**  
neomycin/bacitracin/polymyxin/HC  
neomycin/polymyxin/dexamethasone  
(*Maxitrol*)  
neomycin/polymyxin/HC  
sulfacetamide/prednisolone  
Blephamide, Blephamide SOP  
Pred-G Ointment, Drops  
Tobradex Drops (Brd only), Ointment

**Requires Prior Authorization**  
tobramycin/dexamethasone susp.  
Tobradex ST  
Zylet

### Ophthalmics, Glaucoma Agents

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

**Requires Prior Authorization**  
apraclonidine (*Iopidine*) (Brd & gen)  
brimonidine tartrate 0.15% (gen only)  
Lumigan  
Zioptan

### Ophthalmics, Anti-Inflammatories

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

**Requires Prior Authorization**  
bromfenac (*Xibrom*)  
Acuvail  
Bromday  
Durezol  
Lotemax Ointment  
Nevanac  
Ozurdex  
Pred Forte  
Retisert  
Triescence  
Vexol



# Maryland Medicaid Preferred Drug List (effective January 1, 2013)

## OTIC

### Otic Antibiotics

#### Preferred

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

#### Requires Prior Authorization

Cipro HC  
Coly-Mycin S  
Cortisporin TC

## RESPIRATORY

### Antihistamines, Minimally Sedating

#### Preferred

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

#### Requires Prior Authorization

desloratadine (*Clarinex*, *Clarinex-D*)  
(Brd & gen)  
fexofenadine (*Allegra*)  
fexofenadine D, 12 & 24 hour (*Allegra-D*)  
(Brd & gen)  
Semprex-D  
Xyzal Syrup

### Beta<sub>2</sub>-Agonist Bronchodilators

(Beta-Adrenergic Agents)

#### Preferred

albuterol syrup & tab (*Proventil*, *Ventolin*)  
albuterol neb solution (except low dose)  
terbutaline (*Brethine*)  
Foradil  
Maxair  
ProAir HFA  
Proventil HFA

#### Requires Prior Authorization

albuterol ER (*Vospire ER*)  
albuterol neb low dose (*Accuneb*)  
levalbuterol neb (*Xopenex*) (Brd & gen)  
metaproterenol (*Alupent*)  
Arcapta  
Brovana  
Perforomist  
Serevent  
Ventolin HFA  
Xopenex HFA

### COPD Agents

#### Preferred

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

#### Requires Prior Authorization

Combivent Respimat  
Daliresp

## RESPIRATORY

### Glucocorticoids, Inhaled (Beta-Adrenergics & Glucocorticoids Combination, Glucocorticoids)

#### Preferred

Advair Diskus, Advair HFA  
Asmanex  
Dulera  
Flovent Diskus, Flovent HFA  
Qvar  
Pulmicort Flexhaler  
Pulmicort Respules 0.25 & 0.5 mg  
(Brd only) \*  
Symbicort

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

#### Requires Prior Authorization

budesonide respules (generic/all ages)  
Alvesco  
Pulmicort Respules 1mg

### Intranasal Rhinitis Agents

(Nasal Anti-Inflammatory Steroids)

#### Preferred

fluticasone nasal (*Flonase*)  
ipratropium (*Atrovent Nasal*)  
Astellin (Brd only)  
Astepro  
Nasacort AQ (Brd only)  
Nasonex  
Patanase

#### Requires Prior Authorization

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

### Leukotriene Modifiers

#### Preferred

montelukast (*Singulair*)  
zafirlukast (*Accolate*)

#### Requires Prior Authorization

Singulair Granules  
Zyflo, Zyflo CR

## TOPICAL DERMATOLOGICS

### Acne Agents, Topical

#### Preferred

benzoyl peroxide cleanser, gel, kit,  
med. pad, & towelette  
clindamycin foam, gel, lotion,  
med. swab, & solution  
erythromycin gel, med. swab & solution  
sulfacetamide/sulfur/urea  
sulfacetamide/sulfur (all forms, strengths)  
tretinoin  
Azelex  
Desquam-X OTC  
Differin (Brd only)  
Panoxyl-8 OTC  
Retin-A (all forms, strengths)  
SE BPO 7-5.5 Wash Kit  
SSS 10-4  
TL 4.25% BPO MX Cleanser OTC

## TOPICAL DERMATOLOGICS

*Acne Agents, Topical (continued)*

#### Requires Prior Authorization

adapalene (gen only)  
benzoyl peroxide OTC (all forms, strengths)  
clindamycin-benzoyl peroxide  
erythromycin-benzoyl peroxide  
sodium sulfa-sulfur-meratan  
sulfacetamide  
Acanya  
Aczone  
Akne-Mycin  
Atralin  
Avar (all forms, strengths)  
Avita  
BenzaClin  
Benzamycin  
Benzefoam (all forms, strengths)  
Benziq  
BP-10  
Brevoxyl  
Cerisa  
Clarifoam EF  
Clenia  
Cleocin T (all forms, strengths)  
Clindacin Pac Kit  
Clindagel  
Delos  
Epiduo  
Evoclin  
Garimide  
Inova (all forms, strengths)  
Klaron  
Lavoclen (all forms, strengths)  
Nuox  
Ovace (all forms, strengths)  
Panex (all forms, strengths)  
Panoxyl-4 OTC  
Plexicon  
Prascion RA  
Sastid  
SE 10-5  
SE BPO Cleanser  
Sulfo-Lo OTC  
Sulfo-Lac  
Sumadan (all forms, strengths)  
Sumaxin (all forms, strengths)  
Tazorac (all forms, strengths)  
Veltin  
Ziana

### Atopic Dermatitis

#### Preferred

Elidel

#### Requires Prior Authorization

Protopic



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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  
410-767-1455

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

Martin O'Malley, Governor

Anthony G. Brown, Lt. Governor

Joshua M. Sharfstein, MD, Secretary, DHMH

### In This Issue . . .

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- Peer Review Program
- Maryland Medicaid Preferred Drug List



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## 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 (*Ditropan*)  
Toviaz  
Vesicare

#### Requires Prior Authorization

flavoxate  
oxybutynin XL (*Ditropan XL*) (Brd & gen)  
trospium, trospium ER (*Sanctura*, *Sanctura ER*) (Brd & gen)  
Detrol, Detrol LA  
Enablex  
Gelnique  
Oxytrol

## 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 antipsychotic, call Xerox (formerly 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.

## 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

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