The MassHealth Drug List

MassHealth Drug List

The MassHealth Drug List ("the List") is an alphabetical list of commonly prescribed drugs and therapeutic class tables. The List specifies which drugs need prior authorization (PA) when prescribed for MassHealth members. The prior-authorization requirements specified in the List reflect MassHealth's policy described in the pharmacy regulations and provider bulletins, as well as MassHealth's and the Drug Utilization Review (DUR) Board's review of drugs within certain therapeutic classes. The List also specifies the generic over-the-counter drugs that are payable under MassHealth. Additional information can be found in the section titled "Prior-Authorization Status of Drugs."

The tables provide a view of drugs within their respective therapeutic classes, along with prior-authorization requirements and clinical information about the drug. **The tables may not include all medications, dosage forms, and combination products within that therapeutic class.** The clinical information included in the tables is not intended to be comprehensive prescribing information. Prescribers and pharmacists should review the List and its applicable therapeutic class table when prescribing a drug or filling a prescription for a MassHealth member.

Any drug that does not appear on the List requires prior authorization, except for drugs described in 130 CMR 406.413(B) "Limitations on Coverage of Drugs – Drug Exclusions," which are not available to MassHealth adult members. Prescribers may request PA for such drugs for members under 21 years old to determine medical necessity (130 CMR 450.144(A).

Updates to the List

The updates to the List are effective immediately, unless otherwise specified. For medications that have new prior-authorization requirements, MassHealth's policy permits an otherwise valid prescription written before the effective date to be filled for the life of the prescription without prior authorization. Nevertheless, MassHealth encourages prescribers to reevaluate the medication regimens of their MassHealth patients, and consider switching their MassHealth patients to a medication regimen that does not require prior authorization or discontinuing the affected medication(s), as soon as possible, if clinically appropriate.

MassHealth encourages the use of specialized prior authorization request forms for certain drugs or classes of drugs. These forms were created to help you provide the information MassHealth needs to evaluate your request. The specialized forms have the name of the drug or drug class in the title. If there is no specialized form, please use the standard Drug Prior Authorization Request form. All forms are available at www.mass.gov/druglist.

Future Updates

MassHealth may update the MassHealth Drug List as frequently as twice a month. MassHealth will update the List as necessary on the first business day of the month or 14 calendar days later, or both. To sign up for e-mail alerts that will notify you when the List has been updated, go to the MassHealth Drug List at http://www.mass.gov/druglist. Click on "Introduction to the MassHealth Drug List," then click on "Subscribe to E-Mail Alerts," in the Introduction section of the List and send the e-mail that automatically appears on your screen and you will be subscribed. To get a paper copy of an updated List, submit a written request to the following address or fax number.

MassHealth Publications
P.O. Box 9101
Somerville, MA 02145
Fax: 617-576-4487

Include your MassHealth provider number, address, and a contact name with your request. MassHealth Publications will send you the latest version of the List. You will need to submit another written request each time you want a paper copy.

1. Additions

The following newly marketed drugs have been added to the MassHealth Drug List.

Alimta (pemetrexed)
Caduet (amlodipine/atorvastatin) – **PA**
Elestat (epinastine)
Erbitux (cetuximab)
Ertaczo (sertaconazole) – **PA**
Estrasorb (estradiol) – **PA**
Fazaclo (clozapine, orally disintegrating tablet) – **PA**
Mirena (levonorgestrel IUD)
Myfortic (mycophenolate)
Orthovisc (hyaluronan) – **PA**
Plenaxis (abarelix) – **PA**
RhoPhylac (Rho (D) immune globulin IV, human)
Sensipar (cinacalcet) – **PA**
Spiriva (tiotropium)
Umecta (urea) – **PA**
Visicol (sodium phosphate)
Zantac EFFERdose (ranitidine, effervescent tablet) – **PA**
Zavesca (miglustat)
Zenapax (daclizumab)
ZoDerm (benzoyl peroxide) – **PA**
Zorbtive (somatropin) – **PA**
Zyprexa IM (olanzapine injection) – **PA**

2. New FDA "A"-Rated Generics

The following FDA "A"-rated generic drugs have been added to the MassHealth Drug List. The brand name is now listed with a # symbol, to indicate that prior authorization is required for the brand.

New FDA "A" – Rated Generic Drug	Generic Equivalent of
bupropion sustained release	Wellbutrin SR #
fludrocortisone	Florinef #
metformin extended release	Glucophage XR #
terconazole	Terazol #

3. Change in Prior-Authorization Requirements

a. MassHealth requires prior-authorization for quantity limits for the following medication, effective *September 1, 2004*.

ketorolac (Toradol #) – **PA > 20 units/month**

b. MassHealth requires prior-authorization for the dose for the following schedule II long-acting narcotic analgesics, effective *September 1, 2004.*

levorphanol (Levo-Dromoran #) – **PA > 32 mg/day**
methadone (Dolophine #, Methadose #) – **PA > 120 mg/day**
morphine controlled release (MS Contin #, Oramorph SR, generics) – **PA > 360 mg/day**
morphine sustained release (Kadian) – **PA > 360 mg/day**

c. MassHealth requires prior-authorization for the following schedule II short-acting narcotic analgesics for the dose, effective *October 1, 2004.*

codeine – **PA > 360 mg/day**
hydromorphone (Dilaudid #) – **PA > 60 mg/day**
meperidine (Demerol #) – **PA > 750 mg/day**
morphine immediate release (MS/L, MSIR, OMS, Roxanol, Roxanol-T) – **PA > 360 mg/day**
oxycodone immediate release (Endocodone, Oxydose, OxyFast, Oxy IR, Roxicodone) – **PA > 240 mg/day**

d. The following medications will continue to require prior-authorization.

Actiq (fentanyl transmucosal system) – **PA**
Avinza (morphine extended-release) – **PA**
Duragesic (fentanyl transdermal system) – **PA**
oxycodone controlled release (generics) – **PA**
OxyContin (oxycodone controlled release) – **PA**
Percocet (oxycodone/acetaminophen) – **PA**

e. MassHealth no longer requires prior-authorization for the following medication.

Sandostatin (ocreotide)

4. New or Revised Therapeutic Tables

Table 1 – Immune Globulins
Table 3 – Gastrointestinal Drugs – Histamine H_2 Antagonists/Proton Pump Inhibitors
Table 8 – Narcotic Agonist Analgesics
Table 9 – Growth Hormones
Table 11 – Nonsteroidal Anti-Inflammatory Drugs
Table 13 – Statins
Table 17 – Antidepressants
Table 22 – Calcium Channel Blocking Agents
Table 24 – Atypical Antipsychotics
Table 26 – Oral Antidiabetic Agents

Prior-Authorization Status of Drugs

Drugs may require prior authorization for a variety of reasons. MassHealth determines the prior-authorization status of drugs on the List on the basis of the following:

- MassHealth program requirements; and
- ongoing evaluation of the drugs' utilization, therapeutic efficacy, safety, and cost.

Drugs are evaluated first on safety and effectiveness, and second on cost. Some drugs require prior authorization because MassHealth and the Drug Utilization Review Board have concluded that there are more cost-effective alternatives. With regard to all such drugs, MassHealth also has concluded that the

more costly drugs have no significant clinically meaningful therapeutic advantage in terms of safety, therapeutic efficacy, or clinical outcome compared to those less-costly drugs used to treat the same condition.

Evaluation of a drug includes a thorough review by physicians and pharmacists using medical literature and consulting with specialists, other physicians, or both. References used may include *AHFS Drug Information*, *Drug Facts and Comparisons*, *Micromedex*, literature from peer-reviewed medical journals, *Drug Topics Red Book*, *Approved Drug Products with Therapeutic Equivalence Evaluations* (also known as the "*Orange Book*"), the *Massachusetts List of Interchangeable Drug Products*, and manufacturers' product information.

In general, MassHealth strongly advocates the use of generic drugs. However, because of prevailing federal patent and rebate regulations, new-to-market generic drugs may cost more than the brand-name equivalent. For this reason MassHealth may place a prior-authorization requirement on these generic drugs. This prior-authorization requirement typically lasts for six months, until the generic price drops.

List Conventions

The List uses the following conventions:

- Brand-name products are capitalized. Generic products are in lowercase.
- Formulations of a drug (for example, salt forms, sustained release, or syrups) are not specified on the List, unless a particular formulation requires prior authorization.
- Combination products are listed with the individual ingredients separated by a slash mark (/).
- Only the generic names of over-the-counter drugs that are payable under MassHealth appear on the List. The brand names of such drugs are not listed, and therefore require prior authorization.
- Only the generic names of antihistamine/decongestant combinations are listed. The brand names of such combinations are not listed, and therefore require prior authorization.

Drug List on the MassHealth Web Site

The MassHealth Drug List can be found at www.mass.gov/druglist. It can also be accessed from our home page at www.mass.gov/masshealth.

Questions or Comments

Pharmacists and prescribers who have questions or comments about the MassHealth Drug List may contact the Drug Utilization Review Program at 1-800-745-7318 or may e-mail the MassHealth Pharmacy Program at masshealthdruglist@nt.dma.state.ma.us. MassHealth does not answer all e-mail inquiries directly, but will use these inquiries to develop frequently asked questions about the MassHealth Drug List for its Web site.

When e-mailing a question or comment to the above e-mail address, please include your name, title, phone number, and fax number. This electronic mailbox should be used only for submitting questions or comments about the MassHealth Drug List. You will receive an automated response that acknowledges receipt of your e-mail. If you do not receive an automated reply, please resubmit your inquiry.

If a member has questions about the MassHealth Drug List, please refer the member to the MassHealth Customer Service Center at 1-800-841-2900 (TTY: 1-800-497-4648 for people with partial or total hearing loss).

Therapeutic Class Tables

Table No.	Table Name	Page
1	Immune Globulins	34
2	Hormones – Gonadotropin-Releasing Hormone Analogs	35
3	Gastrointestinal Drugs – Histamine H_2 Antagonists/Proton Pump Inhibitors	36
4	Hematologic Agents – Hematopoietic Agents	37
5	Immunologic Agents – Immunomodulators	38
6	Impotence Agents	39
7	Muscle Relaxants – Centrally Acting	40
8	Narcotic Agonist Analgesics	41
9	Growth Hormones	42
10	Dermatologic Agents – Retinoids	43
11	Nonsteroidal Anti-Inflammatory Drugs	44
12	Antihistamines	45
13	Statins	46
14	Triptans	47
15	Hypnotics	48
16	Topical Corticosteroids	49
17	Antidepressants	50
18	Angiotensin-Converting Enzyme (ACE) Inhibitors	51
19	Alpha-1 Adrenergic Blockers	52
20	Anticonvulsants	53
21	Beta-Adrenergic Blocking Agents	54
22	Calcium Channel Blocking Agents	55
23	Respiratory Inhalant Products	56
24	Atypical Antipsychotics	57
25	Intranasal Corticosteroids	58
26	Oral Antidiabetic Agents	59
27	5-HT_3 Receptor Antagonists	60

Prior Authorization Request Forms

Anticonvulsant Prior Authorization Request 61
Antidepressant Prior Authorization Request 63
Antipsychotic Prior Authorization Request 65
Erythropoietin Prior Authorization Request 67
Forteo Prior Authorization Request 69
Fuzeon Prior Authorization Request 71
G-CSF/GM-CSF Prior Authorization Request 73
Growth Hormone Adult Prior Authorization Request 75
Growth Hormone Pediatric Prior Authorization Request 77
Hypnotics Prior Authorization Request 79
Immune Globulin Intravenous (IGIV) Prior Authorization Request 81
Narcotic Prior Authorization Request 83
Nonsteroidal Anti-Inflammatory Drugs (NSAID) Prior Authorization Request 85
Proton Pump Inhibitor Prior Authorization Request 87
Statin Prior Authorization Request 89
Strattera Prior Authorization Request 91
Triptan Prior Authorization Request 93
Brand-Name Drug Prior Authorization Request (Use this form when requesting prior authorization for any other brand-name drug when there is an FDA "A"-rated generic available.) 95
Drug Prior Authorization Request (Use this form when requesting prior authorization for any drug.) 97

Policy Initiatives

Anticonvulsant Initiative 99
Antidepressant Initiative 100
Asthma Initiative 101
Atypical Antipsychotic Initiative 102
Pain Initiative 103

Other Information

MassHealth Drug List Quick Reference Guide 104
10 Tips for a Good Night's Sleep 105

Alphabetic List

A

A/B Otic (antipyrine/benzocaine)
abacavir
abacavir/lamivudine/zidovudine
abarelix – **PA**
Abelcet (amphotericin B)
Abilify (aripiprazole) – see Table 24, p. 57
acarbose – **PA;** see Table 26, p. 59
Accolate (zafirlukast) – **PA > 16 years**
AccuNeb (albuterol) – see Table 23, p. 56
Accupril (quinapril) – **PA**; see Table 18, p. 51
Accuretic (quinapril/hydrochlorothiazide) – **PA**; see Table 18, p. 51
Accutane # (isotretinoin) – see Table 10, p. 43
Accuzyme (papain/urea)
acebutolol – see Table 21, p. 54
Aceon (perindopril) – **PA**; see Table 18, p. 51
acetaminophen *
Acetasol # (acetic acid)
acetazolamide
acetic acid
acetohexamide – see Table 26, p. 59
acetohydroxamic acid
acetylcysteine
Achromycin # (tetracycline)
Aciphex (rabeprazole) – **PA**; see Table 3, p. 36
acitretin – see Table 10, p. 43
Aclovate (alclometasone) – **PA**; see Table 16, p. 49
Acova (argatroban) – **PA**
acrivastine/pseudoephedrine – **PA**; see Table 12, p. 45
Acthar (corticotropin)
Acticin (permethrin)
Actigall # (ursodiol)
Actimmune (interferon gamma-1b) – see Table 5, p. 38
Actiq (fentanyl transmucosal system) – **PA**; see Table 8, p. 41
Activella (estradiol/norethindrone)
Actonel (risedronate)
Actos (pioglitazone) – see Table 26, p. 59
Acular (ketorolac)
acyclovir
A&D, topical *
Adalat # (nifedipine) – see Table 22, p. 55
adalimumab – **PA;** see Table 5, p. 38
adapalene – **PA > 25 years;** see Table 10, p. 43
Adderall # (amphetamine salts)
adefovir
Adoxa (doxycycline)
Adrenalin (epinephrine)
Adriamycin # (doxorubicin)
Adrucil # (fluorouracil)
Advair (fluticasone/salmeterol) **–** see Table 23, p. 56
Advate (antihemophilic factor, recombinant)
Advicor (lovastatin/niacin) – **PA;** see Table 13, p. 46
AeroBid (flunisolide) – see Table 23, p. 56
AeroBid-M (flunisolide) – **PA;** see Table 23, p. 56
agalsidase – **PA**
Agenerase (amprenavir)
Aggrenox (dipyridamole/aspirin)
Agrylin (anagrelide)
A-Hydrocort # (hydrocortisone)
Ak-beta (levobunolol)
Akineton (biperiden)
Akne-Mycin (erythromycin)
Ak-Pentolate # (cyclopentolate)
Ak-Polybac # (bacitracin/polymyxin B)
Ak-Spore HC # (neomycin/polymyxin B/ hydrocortisone)
Ak-Sulf # (sulfacetamide)
Aktob # (tobramycin)
Ak-tracin # (bacitracin)
Ak-Trol # (neomycin/polymyxin B/ dexamethasone)
Alamast (pemirolast)
albendazole
Albenza (albendazole)
albumin
Albuminar-25 (albumin)
albuterol
albuterol, inhalation solution; see Table 23, p. 56
albuterol, ° inhaler – see Table 23, p. 56
albuterol/ipratropium, inhalation solution – see Table 23, p. 56
albuterol/ipratropium, inhaler – see Table 23, p. 56
alclometasone – **PA**; see Table 16, p. 49
Aldactazide # (spironolactone/hydrochlorothiazide)
Aldactone # (spironolactone)
Aldara (imiquimod)
Aldoril-25 # (methyldopa/hydrochlorothiazide)
Aldurazyme (laronidase) – **PA**
alefacept – **PA**; see Table 5, p. 38

PA Prior authorization is required. The prescriber must obtain prior authorization for the drug in order for the pharmacy to receive payment.

This is a brand-name drug with FDA "A"-rated generic equivalents. Prior authorization is required for the brand, unless a particular form of that drug (for example, tablet, capsule, or liquid) does not have an FDA "A"-rated generic equivalent.

* The generic OTC and, if any, generic prescription versions of the drug are payable under MassHealth without prior authorization.

° Prior-authorization status depends on the drug's formulation.

Note: Any drug that does not appear on the List requires prior authorization.

alendronate
Alesse # (ethinyl estradiol/levonorgestrel)
Alferon N (interferon alfa-n3, human leukocyte derived) – see Table 5, p. 38
alfuzosin – **PA**; see Table 19, p. 52
Alimta (pemetrexed)
Alinia (nitazoxanide) – **PA > 12 years**
alitretinoin – **PA**; see Table 10, p. 43
Alkeran (melphalan)
Allegra (fexofenadine) – **PA**; see Table 12, p. 45
Allegra-D (fexofenadine/pseudoephedrine) – **PA**; see Table 12, p. 45
Allergen (benzocaine/antipyrine)
allopurinol
almotriptan – **PA > 6 units/month**; see Table 14, p. 47
Alocril (nedocromil)
Alomide (lodoxamide)
Alora # (estradiol)
alosetron – **PA**
Aloxi (palonosetron)
Alphagan (brimonidine)
Alphanate (antihemophilic factor, human)
AlphaNine SD (factor IX, human)
alpha1–proteinase inhibitor**–**human
alprazolam
alprazolam extended release – **PA**
alprostadil – **PA**; see Table 6, p. 39
Alrex (loteprednol)
Altace (ramipril) – **PA**; see Table 18, p. 51
Altinac (tretinoin) – **PA > 25 years**
Altocor (lovastatin extended release) – **PA;** see Table 13, p. 46
Altoprev (lovastatin extended release) – **PA;** see Table 13, p. 46
aluminum carbonate *
aluminum chloride
aluminum hydroxide *
Alupent # (metaproterenol), inhalation solution **–** see Table 23, p. 56
Alupent (metaproterenol), inhaler – **PA;** see Table 23, p. 56
amantadine
Amaryl (glimepiride) – **PA**; see Table 26, p. 59
Ambien (zolpidem) – **PA > 10 units/month;** see Table 15, p. 48
Ambisome (amphotericin B)
amcinonide – see Table 16, p. 49
Amerge (naratriptan) – **PA;** see Table 14, p. 47
Americaine # (benzocaine)
A-Methapred # (methylprednisolone)
Amevive (alefacept) – **PA**; see Table 5, p. 38
Amicar # (aminocaproic acid)
amikacin
amiloride
amiloride/hydrochlorothiazide
Amino Acid Cervical (urea/sodium proprionate/methionine/cystine/inositol)
amino acid & electrolyte IV infusion
aminocaproic acid
Amino-Cerv pH 5.5 (urea/sodium proprionate/methionine/cystine/inositol)
aminoglutethimide
aminophylline
amiodarone
amitriptyline – see Table 17, p. 50
amitriptyline/chlordiazepoxide
amitriptyline/perphenazine
amlodipine – **PA**; see Table 22, p. 55
amlodipine/atorvastatin – **PA;** see Table 13, p. 46; see Table 22, p. 55
amlodipine/benazepril – **PA**; see Table 18, p. 51; see Table 22, p. 55
ammonium lactate
amoxapine – see Table 17, p. 50
amoxicillin
amoxicillin/clavulanate
Amoxil # (amoxicillin)
amphetamine salts
amphotericin B
ampicillin
ampicillin/sulbactam
amprenavir
amrinone
amylase/lipase/protease
Anadrol-50 (oxymetholone)
Anafranil # (clomipramine) – see Table 17, p. 50
anagrelide
anakinra – **PA**; see Table 5, p. 38
Anaprox # (naproxen) – see Table 11, p. 44
Anaspaz # (hyoscyamine)
anastrozole
Ancef # (cefazolin)
Ancobon (flucytosine)
Androderm (testosterone)
Androgel (testosterone)

PA Prior authorization is required. The prescriber must obtain prior authorization for the drug in order for the pharmacy to receive payment.

\# This is a brand-name drug with FDA “A”-rated generic equivalents. Prior authorization is required for the brand, unless a particular form of that drug (for example, tablet, capsule, or liquid) does not have an FDA “A”-rated generic equivalent.

* The generic OTC and, if any, generic prescription versions of the drug are payable under MassHealth without prior authorization.

º Prior-authorization status depends on the drug’s formulation.

Note: Any drug that does not appear on the List requires prior authorization.

Android (methyltestosterone)
Anexsia # (hydrocodone/acetaminophen) – see Table 8, p. 41
Anolor-300 (butalbital/acetaminophen/caffeine)
Ansaid # (flurbiprofen) – see Table 11, p. 44
Antabuse (disulfiram)
anthralin
antihemophilic factor, human
anithemophilic factor, recombinant
anti-inhibitor coagulant complex
antipyrine/benzocaine
antithymocyte globulin, equine – see Table 1, p. 34
antithymocyte globulin, rabbit – see Table 1, p. 34
Antivert # (meclizine)
Anusol-HC # (hydrocortisone) – see Table 16, p. 49
Anzemet (dolasetron) **– PA > 15 units/month;** See Table 27, p. 60
APF # (sodium fluoride)
Aphthasol 5% (amlexanox)
apraclonidine
aprepitant **– PA > 3 units/14 days**
Apri (ethinyl estradiol/desogestrel)
Aqua-Mephyton # (phytonadione)
Aralast (alpha$_1$–proteinase inhibitor–human)
Aralen Hydrochloride (chloroquine)
Aralen Phosphate # (chloroquine)
Aranesp (darbepoetin) – **PA**; see Table 4, p. 37
Arava (leflunomide)
Aredia # (pamidronate)
argatroban – **PA**
Aricept (donepezil)
Arimidex (anastrozole)
aripiprazole – see Table 24, p. 57
Aristocort (triamcinolone)
Aristocort # (triamcinolone), topical – see Table 16, p. 49
Aristocort A # (triamcinolone) – see Table 16, p. 49
Aristocort Forte (triamcinolone)
Aristospan (triamcinolone)
Arixtra (fondaparinux) – **PA > 11 doses/Rx**
Aromasin (exemestane)
Artane # (trihexyphenidyl)
Arthrotec (diclofenac/misoprostol) – **PA < 60 years**; see Table 11, p. 44
artificial tears *
Asacol (mesalamine)
ascorbic acid *
aspirin *
aspirin/buffers *
Astelin (azelastine) – **PA > 1 inhaler/month;** see Table 12, p. 45
Astramorph PF (morphine) – see Table 8, p. 41
Atacand (candesartan) – **PA**; see Table 18, p. 51
Atarax # (hydroxyzine) – see Table 12, p. 45
atazanavir
atenolol – see Table 21, p. 54
atenolol/chlorthalidone – see Table 21, p. 54
Atgam (antithymocyte globulin, equine) – see Table 1, p. 34
Ativan # (lorazepam)
atomoxetine – **PA**
atorvastatin **– PA > 30 units/month;** see Table 13, p. 46
atovaquone
atovaquone/proguanil
atropine
Atrovent (ipratropium), inhalation solution – see Table 23, p. 56
Atrovent (ipratropium), inhaler **–** see Table 23, p. 56
Atrovent (ipratropium), nasal spray
augmented betamethasone º **–** see Table 16, p. 49
Augmentin (amoxicillin/clavulanate)
Auralgan # (antipyine/benzocaine)
auranofin
Aurodex (antipyrine/benzocaine)
Aurolate (gold sodium thiomalate)
aurothioglucose
Auroto # (antipyrine/benzocaine)
Avalide (irbesartan/hydrochlorothiazide) – **PA**; see Table 18, p. 51
Avandamet (rosiglitazone/metformin) – **PA**; see Table 26, p. 59
Avandia (rosiglitazone) – see Table 26, p. 59
Avapro (irbesartan) – **PA**; see Table 18, p. 51
Avastin (bevacizumab)
AVC # (sulfanilamide)
Avelox (moxifloxacin)
Aventyl # (nortriptyline) – see Table 17, p. 50
Aviane # (ethinyl estradiol/levonorgestrel)
Avinza (morphine extended-release) – **PA**; see Table 8, p. 41

PA Prior authorization is required. The prescriber must obtain prior authorization for the drug in order for the pharmacy to receive payment.

\# This is a brand-name drug with FDA "A"-rated generic equivalents. Prior authorization is required for the brand, unless a particular form of that drug (for example, tablet, capsule, or liquid) does not have an FDA "A"-rated generic equivalent.

* The generic OTC and, if any, generic prescription versions of the drug are payable under MassHealth without prior authorization.

º Prior-authorization status depends on the drug's formulation.

Note: Any drug that does not appear on the List requires prior authorization.

Avita # (tretinoin) – **PA > 25 years;** see Table 10, p. 43
Avodart (dutasteride) – **PA**
Avonex (interferon beta-1a) – see Table 5, p. 38
Axert (almotriptan) – **PA > 6 units/month;** see Table 14, p. 47
Axid (nizatidine) – **PA;** see Table 3, p. 36
Axocet # (butalbital/acetaminophen)
Aygestin # (norethindrone)
Azactam (aztreonam)
azatadine – **PA**; see Table 12, p. 45
azatadine/pseudoephedrine – **PA**; see Table 12, p. 45
azathioprine
azelaic acid
azelastine – **PA > 1 inhaler/month;** see Table 12, p. 45
Azelex (azelaic acid)
azithromycin
Azmacort (triamcinolone) – see Table 23, p. 56
Azopt (brinzolamide)
aztreonam
Azulfidine # (sulfasalazine)

B

bacitracin *
bacitracin/polymyxin B
baclofen – see Table 7, p. 40
baclofen intrathecal – **PA**; see Table 7, p. 40
Bactrim # (trimethoprim/sulfamethoxazole)
Bactroban (mupirocin)
balsalazide
Banflex (orphenadrine) – see Table 7, p. 40
BayHep B (hepatitis B immune globulin, human) – see Table 1, p. 34
BayRab (rabies immune globulin IM, human) – see Table 1, p. 34
BayRho-D Full Dose (Rho(D) immune globulin IM) – see Table 1, p. 40
BayRho-D Mini Dose (Rho(D) immune globulin IM, micro-dose) – see Table 1, p. 34
BayTet (tetanus immune globulin IM, human) – see Table 1, p. 34
BCG vaccine
Bebulin VH Immuno (factor IX complex)
becaplermin
beclomethasone, inhaler – see Table 23, p. 56
beclomethasone, nasal spray – **PA > 1 inhaler/month;** see Table 25, p. 58
Beconase AQ (beclomethasone, nasal spray) **– PA > 1 inhaler/month;** see Table 25, p. 58
belladonna/phenobarbital
Benadryl # (diphenhydramine) – see Table 12, p. 45
benazepril – see Table 18, p. 51
BeneFix (factor IX, recombinant)
Benicar (olmesartan) – **PA**; see Table 18, p. 51
Bentyl # (dicyclomine)
Benzaclin (benzoyl peroxide/clindamycin)
Benzamycin (benzoyl peroxide/erythromycin)
benzocaine
benzoyl peroxide º
benzoyl peroxide/clindamycin
benzoyl peroxide/erythromycin
benzoyl peroxide/hydrocortisone
benzoyl peroxide/sulfur
benztropine
bepridil – **PA**; see Table 22, p. 55
Betagan # (levobunolol)
betaine
betamethasone
betamethasone, topical º – see Table 16, p. 49
Betapace # (sotalol) – see Table 21, p. 54
Betaseron (interferon beta 1-b) – see Table 5, p. 38
Beta-Val # (betamethasone) – see Table 16, p. 49
betaxolol – see Table 21, p. 54
bethanechol
Betimol (timolol)
bevacizumab
bexarotene
Bextra (valdecoxib) – **PA < 60 years**; see Table 11, p. 44
Bexxar (tositumomab) – **PA**
Biaxin (clarithromycin)
bicalutamide
Bicitra (sodium citrate/citric acid)
bimatoprost
biperiden
bisacodyl *
bismuth subsalicylate *
bismuth subsalicylate/tetracycline/metronidazole
bisoprolol – see Table 21, p. 54
bisoprolol/hydrochlorothiazide – see Table 21, p. 54
bleomycin
Bleph-10 # (sulfacetamide)
Blephamide (sulfacetamide/prednisolone)

PA Prior authorization is required. The prescriber must obtain prior authorization for the drug in order for the pharmacy to receive payment.

\# This is a brand-name drug with FDA "A"-rated generic equivalents. Prior authorization is required for the brand, unless a particular form of that drug (for example, tablet, capsule, or liquid) does not have an FDA "A"-rated generic equivalent.

* The generic OTC and, if any, generic prescription versions of the drug are payable under MassHealth without prior authorization.

º Prior-authorization status depends on the drug's formulation.

Note: Any drug that does not appear on the List requires prior authorization.

Blocadren # (timolol) – see Table 21, p. 54
bortezomib
bosentan
Botox (botulinum toxin type A) – **PA**
botulinum toxin type A – **PA**
botulinum toxin type B – **PA**
Brethine # (terbutaline)
Brevibloc (esmolol) – see Table 21, p. 54
Brevicon (ethinyl estradiol/norethindrone)
brimonidine
brinzolamide
bromocriptine
brompheniramine * – see Table 12, p.45
brompheniramine/pseudoephedrine * – see Table 12, p. 45
budesonide, inhalation suspension – see Table 23, p. 56
budesonide, inhaler – see Table 23, p. 56
budesonide, nasal spray – **PA > 1 inhaler/2 months;** see Table 25, p. 58
bumetanide
Bumex # (bumetanide)
Buphenyl (sodium phenylbutyrate)
bupivacaine
Buprenex (buprenorphine)
buprenorphine
buprenorphine/naloxone
bupropion – see Table 17, p. 50
bupropion extended-release tablets – **PA;** see Table 17, p. 50
bupropion sustained release – see Table 17, p. 50
Buspar # (buspirone)
buspirone
butabarbital
butalbital
butalbital/acetaminophen
butalbital/acetaminophen/caffeine
butalbital/acetaminophen/codeine/caffeine
butalbital/aspirin/caffeine
butalbital/aspirin/codeine/caffeine
butenafine
Butisol (butabarbital)
butoconazole
butorphanol, injection
butorphanol, nasal spray – **PA**

C

Cabergoline
Caduet (amlodipine/atorvastatin) – **PA;** see Table 13, p. 46; see Table 22, p. 55
Cafcit (caffeine)
caffeine
Cafergot (ergotamine/caffeine)
calamine lotion *
Calan # (verapamil) – see Table 22, p. 55
calcifediol
Calciferol (ergocalciferol)
Calcijex (calcitriol)
calcipotriene
calcitonin, human
calcitonin, salmon
calcitriol
calcium acetate
calcium carbonate *
calcium citrate *
calcium glubionate *
calcium gluconate *
calcium phosphate *
Calderol (calcifediol)
Camptosar (irinotecan)
Cancidas (caspofungin)
candesartan – **PA;** see Table 18, p. 51
Cantil (mepenzolate)
capecitabine
Capex (fluocinolone) – **PA**; see Table 16, p. 49
Capitrol (chloroxine)
Capoten # (captopril) – see Table 18, p. 51
Capozide # (captopril/hydrochlorothiazide) – see Table 18, p. 51
capsaicin *
captopril – see Table 18, p. 51
captopril/hydrochlorothiazide – see Table 18, p. 51
Carac (fluorouracil)
Carafate # (sucralfate)
carbamazepine – see Table 20, p. 53
carbamide peroxide *
Carbatrol (carbamazepine) – see Table 20, p. 53
carbenicillin
carbidopa
carbidopa/levodopa
carbidopa/levodopa/entacapone – **PA**
carbinoxamine – see Table 12, p. 45

PA Prior authorization is required. The prescriber must obtain prior authorization for the drug in order for the pharmacy to receive payment.

This is a brand-name drug with FDA "A"-rated generic equivalents. Prior authorization is required for the brand, unless a particular form of that drug (for example, tablet, capsule, or liquid) does not have an FDA "A"-rated generic equivalent.

* The generic OTC and, if any, generic prescription versions of the drug are payable under MassHealth without prior authorization.

º Prior-authorization status depends on the drug's formulation.

Note: Any drug that does not appear on the List requires prior authorization.

carbinoxamine/pseudoephedrine – see Table 12, p. 45
carboplatin
Cardene # (nicardipine) – see Table 22, p. 55
Cardizem # (diltiazem) – see Table 22, p. 55
Cardura # (doxazosin) – see Table 19, p. 52
Carimune (immune globulin IV, human) – **PA;** see Table 1, p. 34
carisoprodol – see Table 7, p. 40
Carmol (urea)
Carnitor (levocarnitine)
carteolol, oplthalmic
carteolol, oral – **PA**; see Table 21, p. 54
Cartia (diltiazem) – see Table 22, p. 55
Cartrol (carteolol) – **PA**; see Table 21, p. 54
carvedilol – **PA**; see Table 21, p. 54
casanthranol *****
Casodex (bicalutamide)
caspofungin
castor oil/peru balsam/trypsin
Cataflam # (diclofenac)
Catapres # (clonidine)
Caverject (alprostadil) – **PA**; see Table 6, p. 39
Cebocap (lactose)
Ceclor # (cefaclor)
Cedax (ceftibuten)
Ceenu (lomustine)
cefaclor
cefadroxil
cefazolin
cefdinir
cefditoren
cefepime
cefixime
Cefizox (ceftizoxime)
Cefotan (cefotetan)
cefotaxime
cefotetan
cefoxitin
cefpodoxime
cefprozil
ceftazidime
ceftibuten
Ceftin # (cefuroxime)
ceftizoxime
ceftriaxone
cefuroxime
Cefzil (cefprozil)
Celebrex (celecoxib) – **PA < 60 years**; see Table 11, p. 44
celecoxib – **PA < 60 years**; see Table 11, p. 44
Celestone (betamethasone)
Celexa (citalopram) – **PA**; see Table 17, p. 50
Cellcept (mycophenolate)
Celontin (methsuximide) – see Table 20, p. 53
Cenestin (estrogens, conjugated)
cephalexin
Cephulac # (lactulose)
Cerezyme (imiglucerase)
Cerumenex (triethanolamine)
cetirizine syrup – **PA > 12 years (except for LTC members)**; see Table 12, p. 45
cetirizine tablets – **PA**; see Table 12, p. 45
cetirizine/pseudoephedrine – **PA**; see Table 12, p. 45
cetuximab
cevimeline
Chemet (succimer)
chloral hydrate
chlorambucil
chloramphenicol
chlordiazepoxide
chlorhexidine gluconate *****
Chloroptic # (chloramphenicol)
chloroquine
chlorothiazide
chloroxine
chloroxylenol/pramoxine/hydrocortisone
chlorpheniramine *** –** see Table 12, p. 45
chlorpheniramine/phenylephrine – see Table 12, p. 45
chlorpheniramine/pseudoephedrine ***** – see Table 12, p. 45
chlorpheniramine/pyrilamine/phenylephrine – see Table 12, p. 45
chlorpromazine
chlorpropamide – see Table 26, p. 59
chlorthalidone
chlorzoxazone
cholestyramine
choline salicylate/magnesium salicylate
Cialis (tadalafil) – **PA**; see Table 6, p. 39
Cibacalcin (calcitonin, human)
ciclopirox
cidofovir
cilostazol

PA Prior authorization is required. The prescriber must obtain prior authorization for the drug in order for the pharmacy to receive payment.

\# This is a brand-name drug with FDA "A"-rated generic equivalents. Prior authorization is required for the brand, unless a particular form of that drug (for example, tablet, capsule, or liquid) does not have an FDA "A"-rated generic equivalent.

* The generic OTC and, if any, generic prescription versions of the drug are payable under MassHealth without prior authorization.

º Prior-authorization status depends on the drug's formulation.

Note: Any drug that does not appear on the List requires prior authorization.

Ciloxan (ciprofloxacin)
cimetidine * – see Table 3, p. 36
cinacalcet – **PA**
Cinobac (cinoxacin)
cinoxacin
Cipro (ciprofloxacin)
ciprofloxacin
cisplatin
citalopram – **PA**; see Table 17, p. 50
citrate salts
Claforan # (cefotaxime)
Clarinex (desloratadine) – **PA**; see Table 12, p. 45
clarithromycin
clemastine – see Table 12, p. 45
Cleocin # (clindamycin)
Climara # (estradiol)
Clindagel (clindamycin)
clindamycin
Clindets # (clindamycin)
Clinoril # (sulindac) – see Table 11, p. 44
clobetasol º – see Table 16, p. 49
clocortolone – **PA**; see Table 16, p. 49
Cloderm (clocortolone) – **PA**; see Table 16, p. 49
clomipramine – see Table 17, p. 50
clonazepam – see Table 20, p. 53
clonazepam, orally disintegrating tablets – **PA;** see Table 20, p. 53
clonidine
clonidine/chlorthalidone
clopidogrel
clorazepate – see Table 20, p. 53
Clorpres (clonidine/chlorthalidone)
clotrimazole *
clotrimazole/betamethasone
clozapine – see Table 24, p. 57
clozapine, orally disintegrating tablet – **PA**
Clozaril # (clozapine) – see Table 24, p. 57
cod liver oil *
codeine – **PA > 360 mg/day (effective 10/01/04);** see Table 8, p. 41
codeine/acetaminophen – see Table 8, p. 41
codeine/aspirin – see Table 8, p. 41
Cogentin # (benztropine)
Cognex (tacrine)
Colazal (balsalazide)
colchicine/probenecid
colesevelam
Colestid (colestipol)
colestipol
colistimethate
colistin/hydrocortisone/neomycin
collagenase
colloidal oatmeal *
Col-Probenecid # (colchicine/probenecid)
Coly-Mycin (colistimethate)
CoLyte # (polyethylene glycol-electrolyte solution)
Combipatch (estradiol/norethindrone)
Combipres (clonidine/chlorthalidone)
Combivent (albuterol/ipratropium) – see Table 23, p. 56
Combivir (lamivudine/zidovudine)
Compazine # (prochlorperazine)
Compro (prochlorperazine)
Comtan (entacapone)
Concerta (methylphenidate)
Condylox (podofilox)
Constulose (lactulose)
Copaxone (glatiramer)
Copegus (ribavirin)
copper IUD
Cordarone # (amiodarone)
Cordran (flurandrenolide) – **PA**; see Table 16, p. 49
Coreg (carvedilol) – **PA;** see Table 21, p. 54
Corgard # (nadolol) – see Table 21, p. 54
Cormax # (clobetasol) – see Table 16, p. 49
Cortane-B (chloroxylenol/pramoxine/hydrocortisone)
Cortef # (hydrocortisone)
corticotropin
Cortifoam (hydrocortisone)
cortisone
Cortisporin # (neomycin/polymyxin B/hydrocortisone)
Cortisporin-TC (colistin/hydrocortisone/neomycin)
Cortomycin (neomycin/polymyxin B/hydrocortisone)
Cortrosyn (cosyntropin)
Corzide (nadolol/bendroflumethiazide) – see Table 21, p. 54
Cosopt (dorzolamide/timolol)
cosyntropin
Coumadin # (warfarin)
Covera-HS (verapamil) – see Table 22, p. 55
Cozaar (losartan) – **PA**; see Table 18, p. 51

PA Prior authorization is required. The prescriber must obtain prior authorization for the drug in order for the pharmacy to receive payment.

\# This is a brand-name drug with FDA "A"-rated generic equivalents. Prior authorization is required for the brand, unless a particular form of that drug (for example, tablet, capsule, or liquid) does not have an FDA "A"-rated generic equivalent.

* The generic OTC and, if any, generic prescription versions of the drug are payable under MassHealth without prior authorization.

º Prior-authorization status depends on the drug's formulation.

Note: Any drug that does not appear on the List requires prior authorization.

Creon (amylase/lipase/protease)
Crestor (rosuvastatin) – **PA > 30 units/month;** see Table 13, p. 46
Crixivan (indinavir)
Crolom (cromolyn)
cromolyn
cromolyn, inhalation solution – see Table 23, p. 56
cromolyn, inhaler – see Table 23, p. 56
crotamiton
Cubicin (daptomycin)
Cuprimine (penicillamine)
Cutivate (fluticasone) – **PA**; see Table 16, p. 49
cyanocobalamin *****
Cyclessa (ethinyl estradiol/desogestrel)
cyclobenzaprine – see Table 7, p. 40
Cyclocort # (amcinonide) – see Table 16, p. 49
Cyclogyl # (cyclopentolate)
Cyclomydril (cyclopentolate/phenylephrine)
cyclopentolate
cyclopentolate/phenylephrine
cyclophosphamide
cyclosporine
Cylert # (pemoline)
cyproheptadine – see Table 12, p. 45
Cystadane (betaine)
Cystagon (cysteamine)
cysteamine
Cystospaz # (hyoscyamine)
Cytadren (aminoglutethimide)
cytarabine
CytoGam (cytomegalovirus immune globulin IV, human) – see Table 1, p. 34
cytomegalovirus immune globulin IV, human – see Table 1, p. 34
Cytomel (liothyronine)
Cytosar-U # (cytarabine)
Cytotec # (misoprostol)
Cytovene (ganciclovir)
Cytoxan # (cyclophosphamide)
Cytra-2 (sodium citrate/citric acid)
Cytra-3 (potassium citrate/sodium citrate/citric acid)
Cytra-K (potassium citrate/citric acid)

D

dacarbazine
daclizumab
Dalmane # (flurazepam) – **PA > 10 units/month;** see Table 15, p. 48
dalteparin
danazol
Danocrine # (danazol)
Dantrium (dantrolene)
dantrolene
dapsone
Daranide (dichlorphenamide)
Daraprim (pyrimethamine)
darbepoetin alpha – **PA**; see Table 4, p. 37
Darvocet-N # (propoxyphene napsylate/ acetaminophen) – see Table 8, p. 41
Darvon # (propoxyphene) – see Table 8, p. 41
Darvon-N (propoxyphene napsylate) – see Table 8, p. 41
daptomycin
Daypro # (oxaprozin) – see Table 11, p. 44
DDAVP # (desmopressin)
Deca-Durabolin (nandrolone)
Declomycin (demeclocycline)
deferoxamine
Delatestryl (testosterone)
delavirdine
Delestrogen # (estradiol)
Deltasone # (prednisone)
Demadex # (torsemide)
demeclocycline
Demerol # (meperidine) – **PA > 750 mg/day (effective 10/01/04);** see Table 8, p. 41
Demser (metyrosine)
Demulen # (ethinyl estradiol/ethynodiol)
Denavir (penciclovir)
Depacon (valproate) – see Table 20, p. 53
Depakene # (valproic acid) – see Table 20, p. 53
Depakote (divalproex) – see Table 20, p. 53
Depen (penicillamine)
Depo-Estradiol (estradiol)
Depo-Medrol # (methylprednisolone)
Deponit (nitroglycerin)
Depo-Provera (medroxyprogesterone)
Depo-Testosterone (testosterone)
Derma-Smoothe/FS (fluocinolone) – **PA**; see Table 16, p. 49
Dermatop (prednicarbate) – **PA**; see Table 16, p. 49
Desferal (deferoxamine)
desipramine – see Table 17, p. 50

PA Prior authorization is required. The prescriber must obtain prior authorization for the drug in order for the pharmacy to receive payment.

\# This is a brand-name drug with FDA "A"-rated generic equivalents. Prior authorization is required for the brand, unless a particular form of that drug (for example, tablet, capsule, or liquid) does not have an FDA "A"-rated generic equivalent.

* The generic OTC and, if any, generic prescription versions of the drug are payable under MassHealth without prior authorization.

º Prior-authorization status depends on the drug's formulation.

Note: Any drug that does not appear on the List requires prior authorization.

desloratadine – **PA**; see Table 12, p. 45
desmopressin
Desogen # (ethinyl estradiol/desogestrel)
desonide – see Table 16, p. 49
DesOwen # (desonide) – see Table 16, p. 49
desoximetasone – see Table 16, p. 49
Desoxyn (methamphetamine) – **PA**
Desyrel # (trazodone) – see Table 17, p. 50
Detrol (tolterodine)
Dexacidin (neomycin/polymyxin B/ dexamethasone)
Dexacine (neomycin/polymyxin B/ dexamethasone)
dexamethasone
dexamethasone/neomycin
Dexasporin (neomycin/polymyxin B/ dexamethasone)
dexbrompheniramine/pseudoephedrine – see Table 12, p. 45
dexchlorpheniramine – see Table 12, p. 45
Dexedrine # (dextroamphetamine)
Dexferrum (iron dextran)
dexmethylphenidate
dextroamphetamine
dextrose
Dextrostat # (dextroamphetamine)
D.H.E. 45 (dihydroergotamine mesylate)
DHT (dihydrotachysterol)
DiaBeta (glyburide) – **PA**; see Table 26, p. 59
Diabinese # (chlorpropamide) – see Table 26, p. 59
Diamox # (acetazolamide)
Diastat (diazepam) – see Table 20, p. 53
diazepam – see Table 7, p. 40; see Table 20, p. 53
diazoxide
dichlorphenamide
diclofenac – see Table 11, p. 44
diclofenac/misoprostol – **PA < 60 years**; see Table 11, p. 44
dicloxacillin
dicyclomine
didanosine
Didronel (etidronate)
dienestrol
Differin (adapalene) – **PA > 25 years;** see Table 10, p. 43
diflorasone – see Table 16, p. 49
Diflucan (fluconazole)
diflunisal – see Table 11, p. 44
Digitek (digoxin)
digoxin
dihydrocodeine/aspirin/caffeine
dihydroergotamine
dihydrotachysterol
Dilacor # (diltiazem) – see Table 22, p 55
Dilantin (phenytoin) – see Table 20, p. 53
Dilatrate-SR (isosorbide)
Dilaudid # (hydromorphone) – **PA > 60 mg/day (effective 10/01/04);** see Table 8, p. 41
diltiazem – see Table 22, p. 55
Diovan (valsartan) – **PA**; see Table 18, p. 51
Diovan HCT (valsartan/hydrochlorothiazide) – **PA**; see Table 18, p. 51
Dipentum (olsalazine)
diphenhydramine * – see Table 12, p. 45
diphenhydramine/pseudoephedrine * – see Table 12, p. 45
diphenoxylate/atropine
dipivefrin
Diprolene (betamethasone) – **PA**; see Table 16, p. 49
Diprolene AF # (augmented betamethasone) – see Table 16, p. 49
dipyridamole
dipyridamole/aspirin
Diquinol (iodoquinol)
dirithromycin
Disalcid # (salsalate)
disopyramide
disulfiram
Ditropan # (oxybutynin)
Diuril # (chlorothiazide)
divalproex – see Table 20, p. 53
docetaxel
docusate sodium *
dofetilide
dolasetron – **PA > 15 units/month;** See Table 27, p. 60
Dolobid # (diflunisal) – see Table 11, p. 44
Dolophine # (methadone) – **PA > 120 mg/day (effective 09/01/04);** see Table 8, p. 41
Domeboro # (aluminum acetate)
donepezil
Doral (quazepam) – **PA**; see Table 15, p. 48
dornase alpha

PA Prior authorization is required. The prescriber must obtain prior authorization for the drug in order for the pharmacy to receive payment.

\# This is a brand-name drug with FDA "A"-rated generic equivalents. Prior authorization is required for the brand, unless a particular form of that drug (for example, tablet, capsule, or liquid) does not have an FDA "A"-rated generic equivalent.

* The generic OTC and, if any, generic prescription versions of the drug are payable under MassHealth without prior authorization.

º Prior-authorization status depends on the drug's formulation.

Note: Any drug that does not appear on the List requires prior authorization.

Doryx (doxycycline)
dorzolamide
dorzolamide/timolol
Dostinex (cabergoline)
Dovonex (calcipotriene)
doxazosin – see Table 19, p. 52
doxepin – see Table 17, p. 50
doxercalciferol
doxorubicin
doxycycline
Drisdol # (ergocalciferol)
dronabinol – **PA**
droperidol
Droxia (hydroxyurea)
Drysol (aluminum chloride)
DTIC-Dome # (dacarbazine)
DuoNeb (albuterol/ipratropium) – see Table 23, p. 56
Duphalac (lactulose)
Duragesic (fentanyl transdermal system) – **PA;** see Table 8, p. 41
Duramorph (morphine) – see Table 8, p. 41
Duricef # (cefadroxil)
dutasteride – **PA**
Dyazide # (triamterene/hydrochlorothiazide)
Dynabac (dirithromycin)
Dynacin # (minocycline)
Dynacirc (isradipine) – **PA;** see Table 22, p. 55
Dynapen (dicloxacillin)
Dyphylline-GG (dyphylline/guaifenesin)
dyphylline/guaifenesin

E

echothiophate iodine
econazole
Econopred # (prednisolone)
Edecrin (ethacrynic acid)
Edex (alprostadil) – **PA**; see Table 6, p. 39
efalizumab – **PA;** see Table 5, p. 38
efavirenz
Effexor (venlafaxine) – **PA**; see Table 17, p. 50
Efudex (fluorouracil)
Elavil # (amitriptyline) – see Table 17, p. 50
Eldepryl # (selegiline)
electrolyte solution, pediatric *****
Elestat (epinastine)
eletriptan – **PA;** see Table 14, p. 47
Elidel (pimecrolimus)
Eligard (leuprolide) – **PA**; see Table 2, p. 35
Elimite # (permethrin)
Elitek (rasburicase)
Elixophyllin-KI (theophylline/potassium iodide)
Ellence (epirubicin)
Elmiron (pentosan)
Elocon (mometasone) – **PA**; see Table 16, p. 49
Eloxatin (oxaliplatin)
Emadine (emedastine)
Embeline # (clobetasol) – see Table 16, p. 49
Emcyt (estramustine)
Emedastine
Emend (aprepitant) – **PA > 3 units/14 days**
Emgel # (erythromycin)
EMLA (lidocaine/prilocaine)
emtricitabine
Emtriva (emtricitabine)
E-Mycin # (erythromycin)
enalapril – see Table 18, p. 51
enalapril/felodipine – **PA**; see Table 18, p. 51; see Table 22, p. 55
enalapril/hydrochlorothiazide – see Table 18, p. 51
Enbrel (etanercept) – **PA**; see Table 5, p. 38
Endocet (oxycodone/acetaminophen) – see Table 8, p. 41
Endocodone (oxycodone) – **PA > 240 mg/day (effective 10/01/04);** see Table 8, p. 41
Endodan (oxycodone/aspirin) – see Table 8, p. 41
Enduron # (methyclothiazide)
Enduronyl (methyclothiazide/deserpidine)
enfuvirtide – **PA**
Engerix-B (hepatitis B, recombinant vaccine)
enoxaparin
Enpresse (levonorgestrel/ethinyl estradiol)
entacapone
entacapone/carbidopa/levodopa – **PA**
Entocort (budesonide)
Enulose (lactulose)
Epifoam (hydrocortisone/pramoxine)
Epifrin # (epinephrine)
epinastine
epinephrine
Epipen (epinephrine)
epirubicin
Epitol (carbamazepine) – see Table 20, p. 53
Epivir (lamivudine)
eplerenone – **PA**

PA Prior authorization is required. The prescriber must obtain prior authorization for the drug in order for the pharmacy to receive payment.

\# This is a brand-name drug with FDA "A"-rated generic equivalents. Prior authorization is required for the brand, unless a particular form of that drug (for example, tablet, capsule, or liquid) does not have an FDA "A"-rated generic equivalent.

* The generic OTC and, if any, generic prescription versions of the drug are payable under MassHealth without prior authorization.

º Prior-authorization status depends on the drug's formulation.

Note: Any drug that does not appear on the List requires prior authorization.

epoetin alfa – **PA**; see Table 4, p. 37
Epogen (epoetin alfa) – **PA**; see Table 4, p. 37
epoprostenol
eprosartan – **PA**; see Table 18, p. 51
Equagesic (meprobamate/aspirin)
Equanil (meprobamate)
Erbitux (cetuximab)
ergocalciferol
ergoloid
Ergomar (ergotamine)
ergotamine
ergotamine/caffeine
Ertaczo (sertaconazole) – **PA**
Eryped # (erythromycin)
Ery-tab (erythromycin)
Erythrocin (erythromycin)
erythromycin
erythromycin/sulfisoxazole
escitalopram – **PA**; see Table 17, p. 50
Esclim # (estradiol)
Esgic # (butalbital/acetaminophen/caffeine)
Eskalith # (lithium)
esmolol – see Table 21, p. 54
esomeprazole – **PA**; see Table 3, p. 36
estazolam – **PA > 10 units/month;** see Table 15, p. 48
Estinyl (ethinyl estradiol)
Estrace # (estradiol)
Estraderm (estradiol)
estradiol º
estradiol/medroxyprogesterone
estradiol/norethindrone
estramustine
Estrasorb (estradiol) – **PA**
Estratab # (estrogens, esterified)
Estring (estradiol)
estriol
estrogens, conjugated
estrogens, conjugated/medroxyprogesterone
estrogens, esterified
estrogens, esterified/methyltestosterone
estropipate
Estrostep Fe (ethinyl estradiol/norethindrone)
Estrostep 21 (ethinyl estradiol/norethindrone)
etanercept – **PA**; see Table 5, p. 38
ethacrynic acid
ethambutol
Ethezyme (papain/urea)
ethinyl estradiol
ethinyl estradiol/desogestrel
ethinyl estradiol/drospirenone
ethinyl estradiol/ethynodiol
ethinyl estradiol/levonorgestrel
ethinyl estradiol/norelgestromin
ethinyl estradiol/norethindrone
ethinyl estradiol/norgestimate
ethinyl estradiol/norgestrel
Ethmozine (moricizine)
ethosuximide – see Table 20, p. 53
ethotoin – see Table 20, p. 53
etidronate
etodolac – see Table 11, p. 44
etonogestrel/ethinyl estradiol
etoposide
etretinate – see Table 10, p. 43
Eulexin # (flutamide)
Eurax (crotamiton)
Evista (raloxifene)
Evoxac (cevimeline)
Exelderm (sulconazole)
Exelon (rivastigmine)
exemestane
ezetimibe – **PA**

F

Fabrazyme (agalsidase) – **PA**
factor IX complex
factor IX, human
factor IX, recombinant
famciclovir
famotidine * – see Table 3, p. 36
Famvir (famciclovir)
Farbital (butalbital/aspirin/caffeine)
Fareston (toremifene)
Faslodex (fulvestrant) – **PA**
fat emulsion, intravenous
Fazaclo (clozapine, orally disintegrating tablet) – **PA**
Feiba VH Immuno (anti-inhibitor coagulant complex)
felbamate – see Table 20, p. 53
Felbatol (felbamate) – see Table 20, p. 53
Feldene # (piroxicam) – see Table 11, p. 44
felodipine – **PA;** see Table 22, p. 55
Femara (letrozole)
Femhrt (ethinyl estradiol/norethindrone)
Femring (estradiol) – **PA**

PA Prior authorization is required. The prescriber must obtain prior authorization for the drug in order for the pharmacy to receive payment.

This is a brand-name drug with FDA "A"-rated generic equivalents. Prior authorization is required for the brand, unless a particular form of that drug (for example, tablet, capsule, or liquid) does not have an FDA "A"-rated generic equivalent.

* The generic OTC and, if any, generic prescription versions of the drug are payable under MassHealth without prior authorization.

º Prior-authorization status depends on the drug's formulation.

Note: Any drug that does not appear on the List requires prior authorization.

fenofibrate
fenoprofen – see Table 11, p. 44
fentanyl, injection – see Table 8, p. 41
fentanyl transdermal system – **PA;** see Table 8, p. 41
fentanyl, transmucosal system – **PA**; see Table 8, p. 41
Ferrlecit (sodium ferric gluconate complex)
ferrous fumarate *
ferrous gluconate *
ferrous sulfate *
fexofenadine – **PA**; see Table 12, p. 45
fexofenadine/pseudoephedrine – **PA**; see Table 12, p. 45
filgrastim – **PA**; see Table 4, p. 37
finasteride – **PA**
Finevin (azelaic acid)
Fioricet # (butalbital/acetaminophen/caffeine)
Fioricet/codeine # (butalbital/acetaminophen/codeine/caffeine)
Fiorinal # (butalbital/aspirin/caffeine)
Fiorinal/codeine # (butalbital/codeine/aspirin/caffeine)
Fiorpap (butalbital/acetaminophen/caffeine)
Fiortal (butalbital/aspirin/caffeine)
Flagyl # (metronidazole)
Flarex # (fluorometholone)
flavoxate
flecanide
Flexeril # (cyclobenzaprine) – see Table 7, p. 40
Flexoject (orphenadrine) – see Table 7, p. 40
Flexon (orphenadrine) – see Table 7, p. 40
Flolan (epoprostenol)
Flomax (tamsulosin) – **PA**; see Table 19, p. 52
Flonase (fluticasone), nasal spray – **PA > 1 inhaler/month;** see Table 25, p. 58
Florinef # (fludrocortisone)
flouormetholone
Flovent (fluticasone) – see Table 23, p. 56
Floxin (ofloxacin)
fluconazole
flucytosine
fludrocortisone
Flumadine # (rimantadine)
Flumist (influenza virus vaccine live, intranasal) – **PA**
flunisolide, º inhaler **–** see Table 23, p. 56
flunisolide, º nasal spray – **PA > 1 inhaler/month;** see Table 25, p. 58
fluocinolone º – see Table 16, p. 49
fluocinonide – see Table 16, p. 49
fluorides
Fluoritab (sodium fluoride)
fluorometholone
fluorometholone/sulfacetamide
Fluor-op (fluorometholone)
Fluoroplex (fluorouracil)
fluorouracil
fluoxetine ° – see Table 17, p. 50
fluoxetine/olanzapine – **PA;** see Table 17, p. 50; see Table 24, p. 57
fluoxymesterone
fluphenazine
flurandrenolide º – see Table 16, p. 49
flurazepam – **PA > 10 units/month;** see Table 15, p. 48
flurbiprofen – see Table 11, p. 44
fluroxamine
flutamide
fluticasone, inhalation – see Table 23, p. 56
fluticasone, nasal spray – **PA > 1 inhaler/month;** see Table 25, p. 58
fluticasone, topical – **PA**; see Table 16, p. 49
fluticasone/salmeterol – see Table 23, p. 56
fluvastatin – **PA > 30 units/month;** see Table 13, p. 46
fluvastatin extended release – **PA > 30 units/month;** see Table 13, p. 46
Fluvirin (influenza vaccine)
fluvoxamine – see Table 17, p. 50
FML # (fluorometholone)
FML-S (fluorometholone/sulfacetamide)
Focalin (dexmethylphenidate)
folic acid *
fondaparinux – **PA > 11 doses/Rx**
Foradil (formoterol) – see Table 23, p. 56
formaldehyde
Formaldehyde-10 (formaldehyde)
formoterol – see Table 23, p. 56
Fortaz (ceftazidime)
Forteo (teriparatide) – **PA**
Fortovase (saquinavir)
Fosamax (alendronate)
fosamprenavir
foscarnet

PA Prior authorization is required. The prescriber must obtain prior authorization for the drug in order for the pharmacy to receive payment.

\# This is a brand-name drug with FDA “A”-rated generic equivalents. Prior authorization is required for the brand, unless a particular form of that drug (for example, tablet, capsule, or liquid) does not have an FDA “A”-rated generic equivalent.

* The generic OTC and, if any, generic prescription versions of the drug are payable under MassHealth without prior authorization.

º Prior-authorization status depends on the drug’s formulation.

Note: Any drug that does not appear on the List requires prior authorization.

Foscavir (foscarnet)
fosfomycin
fosinopril – see Table 18, p. 51
Fragmin (dalteparin)
Frova (frovatriptan) – **PA**; see Table 14, p. 47
frovatriptan – **PA**; see Table 14, p. 47
fulvestrant – **PA**
Fulvicin # (griseofluvin)
Fungizone (amphotericin B)
Furacin (nitrofurazone)
Furadantin (nitrofurantoin)
furazolidone
furosemide
Furoxone (furazolidone)
Fuzeon (enfuvirtide) – **PA**

G

gabapentin – **PA > 18 years;** see Table 20, p. 53
gabapentin powder – **PA > 18 years;** see Table 20, p. 53
Gabitril (tiagabine) – **PA > 18 years;** see Table 20, p. 53
galantamine
Gamimune N (immune globulin IV, human) – **PA**; see Table 1, p. 34
Gammagard S/D (immune globulin IV, human) – **PA**; see Table 1, p. 34
Gammar-P IV (immune globulin IV, human) – **PA**; see Table 1, p. 34
Gamulin Rh (Rho(D) immune globulin IM) – see Table 1, p. 34
Gamunex (immune globulin IV, human) – **PA;** see Table 1, p. 34
ganciclovir
Gantrisin (sulfisoxazole)
Gastrocrom (cromolyn)
gatifloxacin
gefitinib
gelatin
gemcitabine
gemfibrozil
Gemzar (gemcitabine)
Gengraf (cyclosporine)
Genora (ethinyl estradiol/norethindrone)
Genotropin (somatropin) – **PA**; see Table 9, p. 42
Gentacidin (gentamicin)
Gentak (gentamicin)
gentamicin
Geocillin (carbenicillin)
Geodon (ziprasidone) – see Table 24, p. 57
Geodon (ziprasidone), injection
glatiramer
Gleevec (imatinib)
glimepiride – **PA**; see Table 26, p. 59
glipizide – see Table 26, p. 59
glipizide extended release – see Table 26, p. 59
glipizide/metformin – **PA**; see Table 26, p. 59
glucagon
gluconic acid/citric acid
Glucophage # (metformin) – see Table 26, p. 59
Glucophage XR # (metformin extended release) – see Table 26, p. 59
Glucotrol # (glipizide) – see Table 26, p. 59
Glucotrol XL # (glipizide extended release) **–** see Table 26, p. 59
Glucovance (glyburide/metformin) – **PA**; see Table 26, p. 59
glyburide ° – see Table 26, p. 59
glyburide/metformin – **PA**; see Table 26, p. 59
glyburide, micronized – see Table 26, p. 59
glycerin
glycopyrrolate
Glynase # (glyburide) – see Table 26, p. 59
Glyset (miglitol) – **PA;** see Table 26, p. 59
gold sodium thiomalate
GoLYTELY # (polyethylene glycol-electrolyte solution)
goserelin – **PA**; see Table 2, p. 35
granisetron – **PA > 15 units/month, liquid formulation; PA > 30mL/month;** See Table 27, p. 60
Granul-derm (castor oil/peru balsam/trypsin)
Granulex # (castor oil/peru balsam/trypsin)
Grifulvin # (griseofulvin)
griseofulvin
Gris-Peg # (griseofulvin)
guaifenesin/dyphylline
guanabenz
guanfacine
Gynazole-1 (butoconazole)
Gynodiol (estradiol)

PA Prior authorization is required. The prescriber must obtain prior authorization for the drug in order for the pharmacy to receive payment.

\# This is a brand-name drug with FDA "A"-rated generic equivalents. Prior authorization is required for the brand, unless a particular form of that drug (for example, tablet, capsule, or liquid) does not have an FDA "A"-rated generic equivalent.

* The generic OTC and, if any, generic prescription versions of the drug are payable under MassHealth without prior authorization.

° Prior-authorization status depends on the drug's formulation.

Note: Any drug that does not appear on the List requires prior authorization.

H

halcinonide – **PA**; see Table 16, p. 49
Halcion # (triazolam) – **PA > 10 units/month;** see Table 15, p. 48
Haldol # (haloperidol)
halobetasol – **PA**; see Table 16, p. 49
Halog (halcinonide) – **PA**; see Table 16, p. 49
Halog-E (halcinonide) – **PA**; see Table 16, p. 49
haloperidol
Haponal (belladonna/phenobarbital)
Havrix (hepatitus A vaccine, inactivated)
HBIG (hepatitis B immune globulin, human) – see Table 1, p. 34
Hectorol (doxercalciferol)
Helidac (bismuth subsalicylate/tetracycline/ metronidazole)
Helixate (antithemophilic factor, recombinant)
Hemofil-M (antithemophilic factor, recombinant)
Hep-Lock # (heparin)
heparin
heparin lock flush
hepatitis A vaccine, inactivated
hepatitis A vaccine inactivated/hepatitis B, recombinant vaccine
hepatitis B immune globulin, human – see Table 1, p. 34
hepatitis B, recombinant vaccine
Hepsera (adefovir)
Herceptin (trastuzumab)
hexachlorophene
Hiprex (methenamine)
Hivid (zalcitabine)
homatropine
Humate-P (antihemophilic factor, human)
Humatin # (paromomycin)
Humatrope (somatropin) – **PA**; see Table 9, p. 42
Humira (adalimumab) – **PA**; see Table 5, p. 38
Hyalgan (hyaluronate) – **PA**
hyaluronan – **PA**
hyaluronate – **PA**
hydralazine
hydralazine/hydrochlorothiazide
Hydra-zide # (hydralazine/hydrochlorothiazide)
Hydrea # (hydroxyurea)
Hydrocet # (hydrocodone/acetaminophen) – see Table 8, p. 41
hydrochlorothiazide
hydrocodone/acetaminophen – see Table 8, p. 41
hydrocortisone
hydrocortisone, topical º – see Table 16, p. 49
hydrocortisone/lidocaine
hydrogen peroxide *
hydromorphone – **PA > 60 mg/day (effective 10/01/04);** see Table 8, p. 41
hydromorphone powder – **PA;** see Table 8, p. 41
hydroxychloroquine
hydroxycobalamin
hydroxyprogesterone
hydroxyurea
hydroxyzine – see Table 12, p. 45
hylan polymers – **PA**
Hylutin (hydroxyprogesterone)
hyoscyamine
hyoscyamine/phenobarbital
Hyosol/SL (hyoscyamine, sublingual)
Hyospaz (hyoscyamine)
HyperHep (hepatitis B immune globulin, human) – see Table 1, p. 34
HypRho-D (Rho(D) immune globulin IM) – see Table 1, p. 34
HypRho-D Mini-Dose (Rho(D) immune globulin IM micro-dose) – see Table 1, p. 34
Hytakerol (dihydrotachysterol)
Hytone # (hydrocortisone) – see Table 16, p. 49
Hytrin # (terazosin) – see Table 19, p. 52
Hyzaar (losartan/hydrochlorothiazide) – **PA**; see Table 18, p. 51

I

ibritumomab – **PA**
ibuprofen * – see Table 11, p. 44
imatinib
Imdur # (isosorbide)
imiglucerase
imipenem/cilastatin
imipramine – see Table 17, p. 50
imiquimod
Imitrex (sumatriptan), injection – **PA > 2 units (4 injections)/month;** see Table 14, p. 47
Imitrex (sumatriptan), nasal spray – **PA;** see Table 14, p. 47
Imitrex (sumatriptan), tablet – **PA**; see Table 14, p. 47

PA Prior authorization is required. The prescriber must obtain prior authorization for the drug in order for the pharmacy to receive payment.

\# This is a brand-name drug with FDA "A"-rated generic equivalents. Prior authorization is required for the brand, unless a particular form of that drug (for example, tablet, capsule, or liquid) does not have an FDA "A"-rated generic equivalent.

* The generic OTC and, if any, generic prescription versions of the drug are payable under MassHealth without prior authorization.

º Prior-authorization status depends on the drug's formulation.

Note: Any drug that does not appear on the List requires prior authorization.

immune globulin IV, human – **PA**; see Table 1, p. 34
Imogam Rabies-HT (rabies immune globulin IM, human) – see Table 1, p. 34
Imovax (rabies vaccine)
Imuran # (azathioprine)
Inapsine # (droperidol)
indapamide
Inderal # (propranolol) – see Table 21, p. 54
Inderide # (propranolol/hydrochlorothiazide) – see Table 21, p. 54
indinavir
Indocin # (indomethacin) – see Table 11, p. 44
indomethacin – see Table 11, p. 44
Infed (iron dextran)
Infergen (interferon alfacon-1) – see Table 5, p. 38
Inflamase # (prednisolone/sodium phosphate)
infliximab – **PA**; see Table 5, p. 38
influenza vaccine
influenza virus vaccine live, intranasal – **PA**
Infumorph (morphine) – see Table 8, p. 41
InnoPran XL (propranolol extended-release) – **PA;** see Table 21, p. 54
Inspra (eplerenone) – **PA**
insulin, prefilled syringes – **PA**
insulins *****
Intal # (cromolyn), inhalation solution **–** see Table 23, p. 56
Intal (cromolyn), inhaler – see Table 23, p. 56
interferon alfa-2a – see Table 5, p. 38
interferon alfa-2b – see Table 5, p. 38
interferon alfa-2b/ribavirin – **PA;** see Table 5, p. 38
interferon alfacon-1 – see Table 5, p. 38
interferon alfa-n3, human leukocyte derived – see Table 5, p. 38
interferon beta-1a – see Table 5, p. 38
interferon beta-1b – see Table 5, p. 38
interferon gamma-1b – see Table 5, p. 38
Intron A (interferon alfa-2b) – see Table 5, p. 38
Inversine (mecamylamine)
Invirase (saquinavir)
iodine *****
iodoquinol/hydrocortisone
Iopidine (apraclonidine)
ipratropium, inhalation solution – see Table 23, p. 56
ipratropium, inhaler – see Table 23, p. 56
ipratropium, nasal spray
irbesartan – **PA**; see Table 18, p. 51
irbesartan/hydrochlorothiazide – **PA**; see Table 18, p. 51
Iressa (gefitinib)
irinotecan
iron dextran
iron sucrose
Ismo # (isosorbide)
isoetharine – see Table 23, p. 55
isoniazid
isopropyl alcohol *****
Isoptin # (verapamil) – see Table 22, p. 55
Isordil # (isosorbide)
isosorbide
isotretinoin – see Table 10, p. 43
isradipine – **PA;** see Table 22, p. 55
itraconazole
Iveegam EN (immune globulin IV, human) – **PA**; see Table 1, p. 34
ivermectin

J

Japanese encephalitis virus vaccine
Jenest-28 (ethinyl estradiol/norethindrone)
JE-Vax (Japanese encephalitis virus vaccine)

K

Kadian (morphine sustained release) – **PA > 360 mg/day (effective 09/01/04);** see Table 8, p. 41
Kaletra (lopinavir/ritonavir)
Kaochlor (potassium chloride)
kaolin/pectin *****
Kaon-Cl (potassium chloride)
Kariva (ethinyl estradiol/desogestrel)
Kayexalate # (sodium polystyrene sulfonate)
K-Dur # (potassium chloride)
Keflex # (cephalexin)
Keftab (cephalexin)
Kefurox # (cefuroxime)
Kemadrin (procyclidine)
Kenalog # (triamcinolone) – see Table 16, p. 49
Keppra (levetiracetam) – **PA;** see Table 20, p. 53
Kerlone # (betaxolol) – see Table 21, p. 54
ketamine – **PA**
ketoconazole

PA Prior authorization is required. The prescriber must obtain prior authorization for the drug in order for the pharmacy to receive payment.

\# This is a brand-name drug with FDA "A"-rated generic equivalents. Prior authorization is required for the brand, unless a particular form of that drug (for example, tablet, capsule, or liquid) does not have an FDA "A"-rated generic equivalent.

* The generic OTC and, if any, generic prescription versions of the drug are payable under MassHealth without prior authorization.

º Prior-authorization status depends on the drug's formulation.

Note: Any drug that does not appear on the List requires prior authorization.

ketoprofen * – see Table 11, p. 44
ketorolac – **PA > 20 units/month (effective 09/01/04);** see Table 11, p. 44
ketotifen
Kineret (anakinra) – **PA**; see Table 5, p. 38
Kionex # (sodium polystyrene sulfonate)
Klaron (sulfacetamide)
Klonopin # (clonazepam) – see Table 20, p. 53
Klonopin Wafers (clonazepam, orally disintegrating tablets) – **PA;** see Table 20, p. 53
K-Lor # (potassium chloride)
Klor-Con # (potassium chloride)
Klotrix (potassium chloride)
K-Lyte (potassium bicarbonate)
K-Lyte/Cl # (potassium chloride/potassium bicarbonate)
Koate-DVI (antihemophilic factor, human)
Kogenate (antihemophilic factor, recombinant)
Konyne 80 (factor IX complex)
Kovia (papain/urea)
K-Phos M.F. (potassium phosphate/sodium phosphate)
K-Phos Neutral (potassium phosphate/dibasic sodium phosphate/monobasic sodium phosphate)
K-Phos No. 2 (potassium phosphate/sodium phosphate/phosphorus)
K-Phos Original (potassium phosphate)
Kristalose (lactulose)
K-Tab (potassium chloride)
Kutapressin (liver derivative complex)
K-Vescent Potassium Chloride (potassium chloride)
Kytril (granisetron) – **PA > 15 units/month, liquid formulation; PA > 30 mL/month;** See Table 27, p. 60

L

labetalol – see Table 21, p. 54
Lac-Hydrin # (ammonium lactate)
LAClotion (ammonium lactate)
lactic acid #
lactic acid/vitamin E
Lactinol (lactic acid)
Lactinol-E (lactic acid/vitamin E)
lactose
lactulose
Lamictal (lamotrigine) – see Table 20, p. 53
Lamisil (terbinafine)
lamivudine
lamivudine/zidovudine
lamotrigine – see Table 20, p. 53
lanolin *
Lanoxicaps (digoxin)
Lanoxin # (digoxin)
lansoprazole – **PA > 16 years (except suspension for LTC members)**; see Table 3, p. 36
lansoprazole, orally disintegrating tablet – **PA > 16 years;** see Table 3, p. 36
lansoprazole/amoxicillin/clarithromycin
lansoprazole/naproxen – **PA**; see Table 11, p. 44
Lantus (insulin glargine)
Lariam (mefloquine)
Larodopa (levodopa)
laronidase – **PA**
Lasix # (furosemide)
latanoprost
Lazer Formalyde (formaldehyde)
L-Carnitine (levocarnitine)
leflunomide
lepirudin – **PA**
Lescol (fluvastatin) – **PA > 30 units/month;** see Table 13, p. 46
Lescol XL (fluvastatin extended release) **PA > 30 units/month;** see Table 13, p. 46
letrozole
leucovorin
Leukeran (chlorambucil)
Leukine (sargramostim) – **PA**; see Table 4, p. 37
leuprolide – **PA**; see Table 2, p. 35
levalbuterol – **PA;** see Table 23, p. 56
Levaquin (levofloxacin)
Levatol (penbutolol) – **PA;** see Table 21, p. 54
Levbid (hyoscyamine)
levetiracetam – **PA;** see Table 20, p. 53
Levitra (vardenafil) – **PA;** see Table 6, p. 39
Levlen # (ethinyl estradiol/levonorgestrel)
Levlite (ethinyl estradiol/levonorgestrel)
Levo-Dromoran # (levorphanol) – **PA > 32 mg/day (effective 09/01/04);** see Table 8, p. 41
levocabastine
levocarnitine
levobunolol

PA Prior authorization is required. The prescriber must obtain prior authorization for the drug in order for the pharmacy to receive payment.

This is a brand-name drug with FDA "A"-rated generic equivalents. Prior authorization is required for the brand, unless a particular form of that drug (for example, tablet, capsule, or liquid) does not have an FDA "A"-rated generic equivalent.

* The generic OTC and, if any, generic prescription versions of the drug are payable under MassHealth without prior authorization.

º Prior-authorization status depends on the drug's formulation.

Note: Any drug that does not appear on the List requires prior authorization.

levodopa
levofloxacin
levonorgestrel
levonorgestrel IUD
Levora # (ethinyl estradiol/levonorgestrel)
levorphanol – **PA > 32 mg/day (effective 09/01/04);** see Table 8, p. 41
levorphanol powder – **PA;** see Table 8, p. 41
Levothroid (levothyroxine)
levothyroxine
Levoxyl (levothyroxine)
Levsin (hyoscyamine)
Levsin PB (hyoscyamine/phenobarbital)
Levsinex Timecaps # (hyoscyamine)
Lexapro (escitalopram) – **PA**; see Table 17, p. 50
Lexiva (fosamprenavir)
Lexxel (enalapril/felodipine) – **PA**; see Table 18, p. 51; see Table 22, p. 55
Lida-Mantle-HC Cream (hydrocortisone/lidocaine)
Lidex # (fluocinonide) – see Table 16, p. 49
lidocaine
lidocaine patch – **PA**
lidocaine/prilocaine
Lidoderm (lidocaine) – **PA**
lindane
linezolid
Lioresal # (baclofen) – see Table 7, p. 40
Lioresal Intrathecal (baclofen) – **PA**; see Table 7, p. 40
liothyronine
liothyronine/thyroxine
Liotrix (liothyronine/thyroxine)
Lipitor (atorvastatin) – **PA > 30 units/month;** see Table 13, p. 46
Liposyn # (fat emulsion, intravenous)
Lipram (amylase/lipase/protease)
lisinopril – see Table 18, p. 51
lisinopril/hydrochlorothiazide – see Table 18, p. 51
lithium
Lithobid # (lithium)
Lithostat (acetohydroxamic acid)
liver derivative complex
Livostin (levocabastine)
Lo/Ovral # (ethinyl estradiol/norgestrel)
LoCHOLEST # (cholestyramine)
Locoid (hydrocortisone) – **PA;** see Table 16, p. 49
lodoxamide
Lodine # (etodolac) – see Table 11, p. 44
Lodosyn (carbidopa)
Loestrin # (ethinyl estradiol/norethindrone)
Lomotil # (diphenoxylate/atropine)
lomustine
Lonox # (diphenoxylate/atropine)
loperamide *
Lopid # (gemfibrozil)
lopinavir/ritonavir
Lopressor # (metoprolol) – see Table 21, p. 54
Lopressor HCT (metoprolol/hydrochlorothiazide) – see Table 21, p. 54
Loprox (ciclopirox)
Lorabid (loracarbef)
loracarbef
loratadine – see Table 12, p. 45
lorazepam
Lorcet # (hydrocodone/acetaminophen) – see Table 8, p. 41
Lortab # (hydrocodone/acetaminophen) – see Table 8, p. 41
losartan – **PA**; see Table 18, p. 51
losartan/hydrochlorothiazide – **PA**; see Table 18, p. 51
Lotemax (loteprednol)
Lotensin # (benazepril); see Table 18, p. 51
loteprednol
Lotrel (amlodipine/benazepril) – **PA**; see Table 18, p. 51; see Table 22, p. 55
Lotrimin # (clotrimazole)
Lotrisone # (clotrimazole/betamethasone)
Lotronex (alosetron) – **PA**
lovastatin – **PA;** see Table 13, p. 46
lovastatin extended release – **PA;** see Table 13, p. 46
lovastatin/niacin – **PA;** see Table 13, p. 46
Lovenox (enoxaparin)
Low-Ogestrel # (ethinyl estradiol/norgestrel)
loxapine
Loxitane # (loxapine)
Lozol # (indapamide)
Lufyllin-GG (dyphylline/guaifenesin)
Lumigan (bimatoprost)
Lunelle (estradiol/medroxyprogesterone)
Lupron (leuprolide) – **PA**; see Table 2, p. 35

PA Prior authorization is required. The prescriber must obtain prior authorization for the drug in order for the pharmacy to receive payment.

\# This is a brand-name drug with FDA "A"-rated generic equivalents. Prior authorization is required for the brand, unless a particular form of that drug (for example, tablet, capsule, or liquid) does not have an FDA "A"-rated generic equivalent.

* The generic OTC and, if any, generic prescription versions of the drug are payable under MassHealth without prior authorization.

º Prior-authorization status depends on the drug's formulation.

Note: Any drug that does not appear on the List requires prior authorization.

Luride # (sodium fluoride)
Luvox # (fluvoxamine) – see Table 17, p. 50
Luxiq (betamethasone) – **PA**; see Table 16, p. 49

M

Macrobid (nitrofurantoin)
Macrodantin # (nitrofurantoin)
mafenide
magaldrate *
magnesium carbonate/citric acid/gluconolactone
magnesium citrate *
magnesium gluconate *
magnesium hydroxide *
magnesium trisalicylate *
Malarone (atovaquone/proguanil)
Mandelamine (methenamine)
maprotiline – see Table 17, p. 50
Marcaine # (bupivacaine)
Marinol (dronabinol) – **PA**
Marten-tab # (butalbital/acetaminophen)
Matulane (procarbazine)
Mavik (trandolapril) – **PA;** see Table 18, p. 51
Maxair (pirbuterol) – **PA;** see Table 23, p. 56
Maxalt (rizatriptan) – **PA**; see Table 14, p. 47
Maxalt-MLT (rizatriptan, orally disintegrating tablet) – **PA**; Table 14, p. 47
Maxidex (dexamethasone)
Maxidone (hydrocodone/acetaminophen) – **PA**; see Table 8, p. 41
Maxipime (cefepime)
Maxitrol # (neomycin/polymyxin B/ dexamethasone)
Maxzide # (triamterene/hydrochlorothiazide)
Mebaral (mephobarbital)
mebendazole
mecamylamine
mechlorethamine
meclizine *
meclofenamate – see Table 11, p. 44
Medrol # (methylprednisolone)
medroxyprogesterone
medroxyprogesterone/estrogen conjugated
mefenamic acid – **PA**; see Table 11, p. 44
mefloquine
Mefoxin # (cefoxitin)
Megace # (megestrol)
megestrol
Mellaril # (thioridazine)
meloxicam – **PA < 60 years**; see Table 11, p. 44
melphalan
memantine
Menest (estrogens, esterified)
meningococcal polysaccharide vaccine
Menomune-A/C/Y/W-135 (meningococcal polysaccharide vaccine)
Mentax (butenafine)
mepenzolate
meperidine – **PA > 750 mg/day (effective 10/01/04);** see Table 8, p. 41
mephobarbital
Mephyton (phytonadione)
meprobamate
meprobamate/aspirin
Mepron (atovaquone)
mercaptopurine
meropenem
Merrem (meropenem)
mesalamine
mesna
Mesnex (mesna)
mesoridazine
Mestinon # (pyridostigmine)
Metadate # (methylphenidate)
Metaglip (metformin/glipizide) – **PA**; see Table 26, p. 59
metaproterenol, inhalation solution – see Table 23, p. 56
metaproterenol, inhaler – **PA;** see Table 23, p. 56
metaxalone – see Table 7, p. 40
metformin – see Table 26, p. 59
metformin extended release – see Table 26, p. 59
metformin solution – see Table 26, p. 59
metformin/rosiglitazone – **PA**; see Table 26, p. 59
methadone – **PA > 120 mg/day (effective 09/01/04);** see Table 8, p. 41
methadone powder – **PA;** See Table 8, p. 41
Methadose # (methadone) – **PA > 120 mg/day (effective 09/01/04);** see Table 8, p. 41
methamphetamine – **PA**
methazolamide
methenamine
methenamine/benzoic acid/atropine/ hyoscyamine/methylene blue

---

PA Prior authorization is required. The prescriber must obtain prior authorization for the drug in order for the pharmacy to receive payment.

\# This is a brand-name drug with FDA "A"-rated generic equivalents. Prior authorization is required for the brand, unless a particular form of that drug (for example, tablet, capsule, or liquid) does not have an FDA "A"-rated generic equivalent.

* The generic OTC and, if any, generic prescription versions of the drug are payable under MassHealth without prior authorization.

º Prior-authorization status depends on the drug's formulation.

Note: Any drug that does not appear on the List requires prior authorization.

methenamine/benzoic acid/atropine/ hyoscyamine/phenyl salicylate/methylene blue
methenamine/benzoic acid/atropine/ hyoscyamine/saldol/methylene blue
methenamine/hyoscyamine/methylene blue
methenamine/sodium acid phosphate
Methergine (methylergonovine)
methimazole
Methitest (methyltestosterone)
methocarbamol – see Table 7, p. 40
methotrexate
methoxsalen
methscopolamine
methsuximide – see Table 20, p. 53
methyclothiazide
methyclothiazide/deserpidine
methyldopa
methyldopa/hydrochlorothiazide
methylergonovine
Methylin # (methylphenidate)
methylphenidate
methylprednisolone
methyltestosterone
methysergide
metipranolol
metoclopramide
metolazone
metoprolol – see Table 21, p. 54
metoprolol /hydrochlorothiazide – see Table 21, p. 54
Metrocream (metronidazole)
Metrogel (metronidazole)
Metrolotion (metronidazole)
metronidazole
metyrosine
Mevacor (lovastatin) – **PA;** see Table 13, p. 46
mexiletine
Mexitil # (mexiletine)
Miacalcin # (calcitonin, salmon)
Micanol (anthralin)
Micardis (telmisartan) – **PA**; see Table 18, p. 51
miconazole *****
MICRhoGAM (Rho(D) immune globulin IM micro-dose) – see Table 1, p. 34
Microgestin Fe # (ethinyl estradiol/ norethindrone)
Micro-K # (potassium chloride)
Micronase # (glyburide) – see Table 26, p. 59
Micronor (norethindrone)
Microzide # (hydrochlorothiazide)
Midamor # (amiloride)
midazolam
midodrine
miglitol – **PA;** see Table 26, p. 59
miglustat
Migranal (dihydroergotamine)
milrinone
mineral oil *****
Mini-Gamulin Rh (Rho(D) immune globulin IM micro-dose) – see Table 1, p. 34
Minitran # (nitroglycerin)
Minizide (prazosin/polythiazide) – see Table 19, p. 52
Minocin # (minocycline)
minocycline
minoxidil
Mintezol (thiabendazole)
Miralax (polyethylene glycol-electrolyte solution)
Mirapex (pramipexole)
Mircette # (ethinyl estradiol/desogestrel)
Mirena (levonorgestrel IUD)
mirtazapine – see Table 17, p. 50
mirtazapine, orally disintegrating tablet – **PA;** see Table 17, p. 50
misoprostol
mitomycin
mitoxantrone
Moban (molindrone)
Mobic (meloxicam) – **PA < 60 years**; see Table 11, p. 44
modafinil – **PA**
Modicon # (ethinyl estradiol/norethindrone)
Moduretic # (amiloride/hydrochlorothiazide)
moexipril – see Table 18, p. 51
moexipril/hydrochlorothiazide – **PA**; see Table 18, p. 51
Molindone
mometasone,º topical – see Table 16, p. 49
mometasone, nasal spray – **PA > 1 inhaler/month;** see Table 25, p. 58
Monarc-M (antihemophilic factor, human)
Monoclate-P (antihemophilic factor, human)
Monodox # (doxycycline)
Monoket # (isosorbide)
Mononine (factor IX, human)
Monopril # (fosinopril) – see Table 18, p. 51

PA Prior authorization is required. The prescriber must obtain prior authorization for the drug in order for the pharmacy to receive payment.

\# This is a brand-name drug with FDA "A"-rated generic equivalents. Prior authorization is required for the brand, unless a particular form of that drug (for example, tablet, capsule, or liquid) does not have an FDA "A"-rated generic equivalent.

* The generic OTC and, if any, generic prescription versions of the drug are payable under MassHealth without prior authorization.

º Prior-authorization status depends on the drug's formulation.

Note: Any drug that does not appear on the List requires prior authorization.

montelukast – **PA > 16 years**
Monurol (fosfomycin)
moricizine
morphine controlled release – **PA > 360 mg/day (effective 09/01/04);** see Table 8, p. 41
morphine extended-release – **PA;** see Table 8, p. 41
morphine immediate release – **PA > 360 mg/day (effective 10/01/04);** see Table 8, p. 41
morphine injection – see Table 8, p. 41
morphine powder – **PA**
morphine sustained release – **PA > 360 mg/day (effective 09/01/04);** see Table 8, p. 41
morphine suppositories – see Table 8, p. 41
Motofen (atropine/difenoxin)
Motrin # (ibuprofen *) – see Table 11, p. 44
moxifloxacin
MSIR (morphine) – **PA > 360 mg/day (effective 10/01/04);** see Table 8, p. 41
MS/L (morphine) – **PA > 360 mg/day (effective 10/01/04);** see Table 8, p. 41
MS Contin # (morphine) – **PA > 360 mg/day (effective 09/01/04);** see Table 8, p. 41
Mucomyst # (acetylcysteine)
Mucomyst-10 (acetylcysteine)
multivitamins *****
multivitamins/minerals *****
mupirocin
Murocoll-2 (scopolamine/phenylephrine)
Muse (alprostadil) – **PA**; see Table 6, p. 39
Mustargen (mechlorethamine)
Myambutol # (ethambutol)
Mycobutin (rifabutin)
Mycogen (nystatin/triamcinolone)
Mycolog II # (nystatin/triamcinolone)
mycophenolate
Mycostatin # (nystatin)
Mydfrin (phenylephrine)
Mydriacyl # (tropicamide)
Myfortic (mycophenolate)
Myobloc (botulinum toxin type B) – **PA**
Mysoline # (primidone) – see Table 20, p. 53

N

Nabi-HB (hepatitis B immune globulin, human) – see Table 1, p. 34
nabumetone – see Table 11, p. 44
nadolol – see Table 21, p. 54
nadolol/bendroflumethiazide – see Table 21, p. 54
nafarelin – **PA**; see Table 2, p. 35
nafcillin
naftifine
Naftin (naftifine)
nalbuphine
Nalfon # (fenoprofen) – see Table 11, p. 44
nalidixic acid
Nallpen (nafcillin)
naloxone
naltrexone
Namenda (memantine)
nandrolone
naphazoline
Naprosyn # (naproxen *) – see Table 11, p. 44
naproxen ***** – see Table 11, p. 44
naproxen/lansoprazole – **PA;** see Table 11, p. 44
Naqua (trichlormethiazide)
naratriptan – **PA**; see Table 14, p. 47
Nardil (phenelzine) – see Table 17, p. 50
Nasacort (triamcinolone nasal spray) – **PA > 1 inhaler/month;** see Table 25, p. 58
Nasacort AQ (triamcinolone nasal spray) – **PA > 1 inhaler/month;** see Table 25, p. 58
Nasalide # (flunisolide nasal spray) – **PA > 1 inhaler/month;** see Table 25, p. 58
Nasarel (flunisolide nasal spray) – **PA > 1 inhaler/month;** see Table 25, p. 58
Nasonex (mometasone nasal spray) – **PA > 1 inhaler/month;** see Table 25, p. 58
nateglinide – **PA;** see Table 26, p. 59
Navane # (thiothixene)
Navelbine (vinorelbine)
Nebcin # (tobramycin)
Nebupent (pentamidine)
Necon # (ethinyl estradiol/norethindrone)
nedocromil, inhaler – see Table 23, p. 56
nedocromil ophthalmic
nefazodone – see Table 17, p. 50
NegGram # (nalidixic acid)
nelfinavir
Nelova # (ethinyl estradiol/norethindrone)

PA Prior authorization is required. The prescriber must obtain prior authorization for the drug in order for the pharmacy to receive payment.

\# This is a brand-name drug with FDA "A"-rated generic equivalents. Prior authorization is required for the brand, unless a particular form of that drug (for example, tablet, capsule, or liquid) does not have an FDA "A"-rated generic equivalent.

* The generic OTC and, if any, generic prescription versions of the drug are payable under MassHealth without prior authorization.

º Prior-authorization status depends on the drug's formulation.

Note: Any drug that does not appear on the List requires prior authorization.

Nembutal # (pentobarbital)
Neo-Decadron (dexamethasone/neomycin)
neomycin *
neomycin/polymyxin B/dexamethasone
neomycin/polyxmyxin B/gramicidin
neomycin/polymyxin B/hydrocortisone
neomycin/polymyxin B/prednisolone
Neoral (cyclosporine)
Neosar # (cyclophosphamide)
Neosporin Ophthalmic Solution # (neomycin/polymyxin B/gramicidin)
neostigmine
Neptazane # (methazolamide)
Neulasta (pegfilgrastim) – **PA**; see Table 4, p. 37
Neumega (oprelvekin) – **PA**; see Table 4, p. 37
Neupogen (filgrastim) – **PA**; see Table 4, p. 37
Neurontin (gabapentin) – **PA > 18 years;** see Table 20, p. 53
nevirapine
Nexium (esomeprazole) – **PA**; see Table 3, p. 36
niacin *
niacin/lovastatin – **PA**; see Table 13, p. 46
niacinamide *
nicardipine – see Table 22, p. 55
nicotinic acid *
Nifedical (nifedipine) – see Table 22, p. 55
nifedipine – see Table 22, p. 55
Nilandron (nilutamide)
Nilstat # (nystatin)
nilutamide
nimodipine – see Table 22, p. 55
Nimotop (nimodipine) – see Table 22, p. 55
nisoldipine – **PA;** see Table 22, p. 55
nitazoxanide – **PA > 12 years**
nitisinone
Nitrek # (nitroglycerin)
Nitro-Bid # (nitroglycerin)
Nitrodisc (nitroglycerin)
Nitro-Dur # (nitroglycerin)
nitrofurantoin
nitrofurazone
nitroglycerin
Nitrol (nitroglycerin)
Nitrolingual (nitroglycerin)
Nitroquick (nitroglycerin)
Nitrostat # (nitroglycerin)
Nitrotab (nitroglycerin)
Nitro-Time (nitroglycerin)
nizatidine – **PA;** see Table 3, p. 36
Nizoral # (ketoconazole)
Nolvadex # (tamoxifen)
nonoxynol-9 *
Norco # (hydrocodone/acetaminophen) – see Table 8, p. 41
Nordette # (ethinyl estradiol/levonorgestrel)
Norditropin (somatropin) – **PA**; see Table 9, p. 42
norethindrone
Norflex # (orphenadrine) – see Table 7, p. 40
norfloxacin
Norgesic # (orphenadrine/aspirin/caffeine) – see Table 7, p. 40
Norgestimate/ethinyl estradiol
norgestrel
Norinyl # (ethinyl estradiol/norethindrone)
Noritate (metronidazole)
Normodyne # (labetalol) – see Table 21, p. 54
Noroxin (norfloxacin)
Norpace # (disopyramide)
Norpramin # (desipramine) – see Table 17, p. 50
Nor-Q-D # (norethindrone)
Nortrel (ethinyl estradiol/norethindrone)
nortriptyline – see Table 17, p. 50
Norvasc (amlodipine) – **PA;** see Table 22, p. 55
Norvir (ritonavir)
Novantrone (mitoxantrone) – see Table 5, p. 38
Novoseven (eptacog alfa)
Nulev (hyoscyamine)
NuLytely (polyethylene glycol-electrolyte solution)
Numorphan (oxymorphone) – see Table 8, p. 41
Nutropin (somatropin) – **PA**; see Table 9, p. 42
Nutropin AQ (somatropin) – **PA**; see Table 9, p. 42
NuvaRing (etonogestrel/ethinyl estradiol)
nystatin
nystatin/neomycin/triamcinolone/gramicidin
nystatin/triamcinolone

O

octreotide
Ocufen # (flurbiprofen)
Ocuflox (ofloxacin)
Ocupress # (carteolol)
Ocusulf-10 # (sulfacetamide)
ofloxacin

PA Prior authorization is required. The prescriber must obtain prior authorization for the drug in order for the pharmacy to receive payment.

This is a brand-name drug with FDA "A"-rated generic equivalents. Prior authorization is required for the brand, unless a particular form of that drug (for example, tablet, capsule, or liquid) does not have an FDA "A"-rated generic equivalent.

* The generic OTC and, if any, generic prescription versions of the drug are payable under MassHealth without prior authorization.

º Prior-authorization status depends on the drug's formulation.

Note: Any drug that does not appear on the List requires prior authorization.

Ogen # (estropipate)
Ogestrel # (ethinyl estradiol/norgestrel)
olanzapine – see Table 24, p. 57
olanzapine injection – **PA**
olanzapine, orally disintegrating tablets – **PA**; see Table 24, p. 57
olanzapine/fluoxetine – **PA;** see Table 17, p. 50; see Table 24, p. 57
olmesartan – **PA**; see Table 18, p. 51
olopatadine
olsalazine
Olux (clobetasol) – **PA**; see Table 16, p. 49
omalizumab – **PA**
omeprazole – **PA**; see Table 3, p. 36
Omnicef (cefdinir)
Omnipen # (ampicillin)
OMS (morphine) – **PA > 360 mg/day (effective 10/01/04);** see Table 8, p. 41
ondansetron 4 mg, 8 mg **– PA > 15 units/month;** see Table 27, p. 60
ondansetron 24 mg **– PA > 5 units/month;** see Table 27, p. 60
ondansetron solution – **PA > 50 mL/month;** see Table 27, p. 60
Onxol # (paclitaxel)
opium
oprelvekin – **PA**; see Table 4, p. 37
Opticrom # (cromolyn)
Optimine (azatadine) – **PA**; see Table 12, p. 45
Optipranolol # (metipranolol)
Optivar (azelastine)
Oralone # (triamcinolone)
Oramorph SR (morphine) – **PA > 360 mg/day (effective 09/01/04);** see Table 8, p. 41
Orap (pimozide)
Orapred (prednisolone)
Orasone (prednisone)
Oretic # (hydrochlorothiazide)
Orfadin (nitisinone)
orphenadrine – see Table 7, p. 40
orphenadrine/aspirin/caffeine – see Table 7, p. 40
Orphengesic # (orphenadrine/aspirin/caffeine) – see Table 7, p. 40
Ortho-Cept # (ethinyl estradiol/desogestrel)
Ortho-Cyclen (ethinyl estradiol/norgestimate)
Ortho-Dienestrol (dienestrol)
Ortho-Est # (estropipate)
Ortho-Evra (ethinyl estradiol/norelgestromin)
Ortho-Novum # (ethinyl estradiol/norethindrone)
Ortho-Prefest (estradiol/norgestimate)
OrthoTri-Cyclen (ethinyl estradiol/norgestimate)
OrthoTri-Cyclen Lo (ethinyl estradiol/ norgestimate)
Orthovisc (hyaluronan) – **PA**
Orudis # (ketoprofen *) – see Table 11, p. 44
Oruvail # (ketoprofen *) – see Table 11, p. 44
oseltamivir – **PA > 10 capsules/month**
Osmoglyn (glycerin)
Oticaine (benzocaine)
Otocain (benzocaine)
Ovcon (ethinyl estradiol/norethindrone)
Ovide (malathion)
Ovral # (ethinyl estradiol/norgestrel)
Ovrette (norgestrel)
oxacillin
oxaliplatin
Oxandrin (oxandrolone) – **PA**
oxandrolone – **PA**
oxaprozin – see Table 11, p. 44
oxazepam
oxcarbazepine – see Table 20, p. 53
oxiconazole
Oxistat (oxiconazole)
Oxsoralen (methoxsalen)
Oxsoralen-Ultra (methoxsalen)
Oxy IR (oxycodone) – **PA > 240 mg/day (effective 10/01/04);** see Table 8, p. 41
oxybutynin
oxybutynin patch – **PA**
oxycodone powder – **PA;** see Table 8, p. 41
oxycodone controlled release – **PA;** see Table 8, p. 41
oxycodone immediate release – **PA > 240 mg/day (effective 10/01/04);** see Table 8, p. 41
oxycodone/acetaminophen – see Table 8, p. 41
oxycodone/aspirin – see Table 8, p. 41
OxyContin (oxycodone controlled release) – **PA;** see Table 8, p. 41
Oxydose (oxycodone) – **PA > 240 mg/day (effective 10/01/04);** see Table 8, p. 41
OxyFast (oxycodone) – **PA > 240 mg/day (effective 10/01/04);** see Table 8, p. 41
oxymetholone
oxymorphone
oxytetracycline/polymyxin B

PA Prior authorization is required. The prescriber must obtain prior authorization for the drug in order for the pharmacy to receive payment.

\# This is a brand-name drug with FDA "A"-rated generic equivalents. Prior authorization is required for the brand, unless a particular form of that drug (for example, tablet, capsule, or liquid) does not have an FDA "A"-rated generic equivalent.

* The generic OTC and, if any, generic prescription versions of the drug are payable under MassHealth without prior authorization.

º Prior-authorization status depends on the drug's formulation.

Note: Any drug that does not appear on the List requires prior authorization.

oxytocin
Oxytrol (oxybutynin) patch – **PA**

P

P2E1 (pilocarpine/epinephrine)
Pacerone # (amiodarone)
paclitaxel
palivizumab – **PA**
palonosetron
Pamelor # (nortriptyline) – see Table 17, p. 50
pamidronate
Pamine (methscopolamine)
Panafil (papain/urea/chlorophyllin/copper complex)
Pancrease (amylase/lipase/protease)
Pancrecarb (amylase/lipase/protease)
Pancrelipase (amylase/lipase/protease)
Pancron (amylase/lipase/protease)
Pandel (hydrocortisone) – **PA**; see Table 16, p. 49
Pangestyme (amylase/lipase/protease)
Panglobulin (immune globulin IV, human) – **PA**; see Table 1, p. 34
Panokase (amylase/lipase/protease)
Panretin (alitretinoin) – **PA**; see Table 10, p. 43
pantoprazole – see Table 3, p. 36
papain/urea
papain/urea/chlorophyllin
papain/urea/chlorophyllin/copper complex
papaverine
Parafon Forte DSC # (chlorzoxazone) – see Table 7, p. 40
Paragard (copper IUD)
Paraplatin (carboplatin)
paregoric
paricalcitol
Parlodel # (bromocriptine)
Parnate (tranylcypromine) – see Table 17, p. 50
paromomycin
paroxetine º – see Table 17, p. 50
paroxetine controlled release – **PA;** see Table 17, p. 50
Patanol (olopatadine)
Paxil # (paroxetine); **PA** – see Table 17, p. 50
Paxil CR (paroxetine controlled release) – **PA;** see Table 17, p. 50
PBZ # (tripelennamine) – see Table 12, p. 45
PCE Dispertab (erythromycin)
Pediapred # (prednisolone)
pediatric multivitamins *
Pedi-Dri (nystatin)
Pediotic # (neomycin/polymyxin B/ hydrocortisone)
Peganone (ethotoin) – see Table 20, p. 53
Pegasys (peginterferon alfa-2a) – **PA > 4 doses/month;** see Table 5, p. 38
pegfilgrastim – **PA**; see Table 4, p. 37
peginterferon alfa-2a – **PA > 4 doses/month;** see Table 5, p. 38
peginterferon alfa-2b – **PA > 4 doses/month;** see Table 5, p. 38
PEG-Intron (peginterferon alfa-2b) – **PA > 4 doses/month;** see Table 5, p. 38
pegvisomant – **PA**
Pemadd # (pemoline)
pemetrexed
pemirolast
pemoline
penbutolol – **PA;** see Table 21, p. 54
penciclovir
penicillamine
penicillin G
penicillin V
Penlac (ciclopirox)
pentamidine
Pentasa (mesalamine)
pentazocine
pentazocine/acetaminophen
pentazocine/naloxone
pentosan
pentoxifylline
Pentoxil # (pentoxifylline)
Pepcid # (famotidine *) – see Table 3, p. 36
P-Ephrine (phenylephrine)
Percocet (oxycodone/acetaminophen) – **PA**; see Table 8, p. 41
Percodan # (oxycodone/aspirin) – see Table 8, p. 41
pergolide
Periactin # (cyproheptadine) – see Table 12, p. 45
perindopril – **PA**; see Table 18, p. 51
Periostat (doxycycline)
Permapen (penicillin G)
Permax # (pergolide)
permethrin *
perphenazine

PA Prior authorization is required. The prescriber must obtain prior authorization for the drug in order for the pharmacy to receive payment.

\# This is a brand-name drug with FDA "A"-rated generic equivalents. Prior authorization is required for the brand, unless a particular form of that drug (for example, tablet, capsule, or liquid) does not have an FDA "A"-rated generic equivalent.

* The generic OTC and, if any, generic prescription versions of the drug are payable under MassHealth without prior authorization.

º Prior-authorization status depends on the drug's formulation.

Note: Any drug that does not appear on the List requires prior authorization.

petrolatum *
Pexeva (paroxetine) – **PA;** see Table 17, p. 50
Pfizerpen # (penicillin G)
Pharmaflur (sodium fluoride)
phenazopyridine
phenelzine – see Table 17, p. 50
Phenergan # (promethazine) – see Table 12, p. 45
phenobarbital – see Table 20, p. 53
phentolamine
phenylephrine
phenyltoloxamine/pyrilamine/pheniramine/pseudoephedrine – see Table 12, p. 45
Phenytek (phenytoin) – see Table 20, p. 53
phenytoin – see Table 20, p. 53
Phisohex (hexachlorophene)
Phos-Flur (sodium fluoride)
Phoslo (calcium acetate)
Phospholine Iodide (echothiophate)
Phrenilin # (butalbital/acetaminophen)
phytonadione
Pilocar # (pilocarpine)
pilocarpine
pilocarpine/epinephrine
Pilopine (pilocarpine)
Piloptic (pilocarpine)
pimecrolimus
pimozide
pindolol – see Table 21, p. 54
pioglitazone – see Table 26, p. 59
piperacillin/tazobactam
pirbuterol – **PA;** see Table 23, p. 56
piroxicam – see Table 11, p. 44
Plan B (levonorgestrel)
Plaquenil # (hydroxychloroquine)
Platinol-AQ # (cisplatin)
Plavix (clopidogrel)
Plenaxis (abarelix) – **PA**
Plendil (felodipine) – **PA;** see Table 22, p. 55
Pletal (cilostazol)
Plexion (sulfacetamide/sulfur)
pneumococcal vaccine
Pneumovax (pneumococcal vaccine)
Pnu-Imune # (pneumococcal vaccine)
podofilox
Polaramine # (dexchlorpheniramine) – see Table 12, p. 45
Polycitra (citric acid/sodium citrate/potassium citrate)
Polycitra-K (citric acid/potassium citrate)
Polycitra-LC (citric acid/sodium citrate/potassium citrate)
polyethylene glycol-electrolyte solution
Polygam S/D (immune globulin IV, human) – **PA**; see Table 1, p. 34
polymyxin B
Poly-Pred (neomycin/polymyxin B/prednisolone)
polythiazide
Polytrim # (trimethoprim/polymyxin B)
Ponstel (mefenamic acid) – **PA**; see Table 11, p. 44
Portia (levonorgestrel/ethinyl estradiol)
potassium bicarbonate
potassium chloride/potassium bicarbonate
potassium chloride/sodium chloride/sodium bicarbonate
potassium citrate
potassium citrate/citric acid
potassium citrate/sodium citrate/citric acid
potassium iodide
potassium phosphate
potassium phosphate/dibasic sodium phosphate/monobasic sodium phosphate
potassium phosphate/sodium phosphate
potassium phosphate/sodium phosphate/phosphorus
povidone *
pramipexole
Pramosone # (pramoxine/hydrocortisone)
pramoxine/hydrocortisone
Prandin (repaglinide) – **PA;** see Table 26, p. 59
Pravachol (pravastatin) – **PA;** see Table 13, p. 46
pravastatin – **PA;** see Table 13, p. 46
pravastatin/aspirin – **PA;** see Table 13, p. 46
Pravigard PAC (pravastatin/aspirin) – **PA;** see Table 13, p. 46
prazosin – see Table 19, p. 52
prazosin/polythiazide – see Table 19, p. 52
Precose (acarbose) – **PA;** see Table 26, p. 59
Pred-Forte # (prednisolone)
Pred-G (prednisolone/gentamicin)
prednicarbate – **PA;** see Table 16, p. 49
prednisolone
prednisolone/gentamicin
prednisone
Prelone # (prednisolone)
Premarin (estrogens, conjugated)

PA Prior authorization is required. The prescriber must obtain prior authorization for the drug in order for the pharmacy to receive payment.

\# This is a brand-name drug with FDA "A"-rated generic equivalents. Prior authorization is required for the brand, unless a particular form of that drug (for example, tablet, capsule, or liquid) does not have an FDA "A"-rated generic equivalent.

* The generic OTC and, if any, generic prescription versions of the drug are payable under MassHealth without prior authorization.

º Prior-authorization status depends on the drug's formulation.

Note: Any drug that does not appear on the List requires prior authorization.

Premphase (medroxyprogesterone/estrogens, conjugated)
Prempro (medroxyprogesterone/estrogens, conjugated)
prenatal vitamins *****
Prevacid (lansoprazole) capsule – **PA > 16 years**; see Table 3, p. 36
Prevacid NapraPAC (lansoprazole/naproxen) – **PA**; see Table 11, p. 44
Prevacid SoluTab (lansoprazole, orally disintegrating tablet) – **PA > 16 years;** see Table 3, p. 36
Prevacid (lansoprazole) suspension – **PA > 16 years (except for LTC members)**; see Table 3, p. 36
Prevalite # (cholestyramine)
Preven (ethinyl estradiol/levonorgestrel)
Prevident (sodium fluoride)
Prevpac (lansoprazole/amoxicillin/ clarithromycin)
Prilosec (omeprazole) – **PA**; see Table 3, p. 36
primaquine
Primaxin (imipenem/cilastatin)
primidone – see Table 20, p. 53
Primsol (trimethoprim)
Principen # (ampicillin)
Prinivil # (lisinopril) – see Table 18, p. 51
Prinzide # (lisinopril/hydrochlorothiazide) – see Table 18, p. 51
Proamatine (midodrine)
probenecid
probenecid/colchicine
procainamide
Procanbid (procainamide)
procarbazine
Procardia # (nifedipine) – see Table 22, p. 55
prochlorperazine
Procrit (epoetin alfa) – **PA**; see Table 4, p. 37
Proctocort # (hydrocortisone)
Proctocream-HC # (pramoxine/hydrocortisone)
Proctofoam-HC (pramoxine/hydrocortisone)
Procto-Kit # (hydrocortisone)
Proctozone-HC # (hydrocortisone)
procyclidine
Profilnine SD (factor IX complex)
progesterone
Proglycem (diazoxide)
Prograf (tacrolimus)
Prolastin (alpha1–proteinase inhibitor–human)
Prolixin # (fluphenazine)
Proloprim # (trimethoprim)
promethazine – see Table 12, p. 45
promethazine/phenylephrine – see Table 12, p. 45
Promethegan (promethazine)
Prometrium (progesterone)
Pronestyl # (procainamide)
propafenone
propantheline
Propine # (dipivefrin)
Proplex T (factor IX complex)
propoxyphene – see Table 8, p. 41
propoxyphene napsylate – see Table 8, p. 41
propoxyphene napsylate/acetaminophen – see Table 8, p. 41
propranolol – see Table 21, p. 54
propranolol extended release – **PA;** see Table 21, p. 54
propranolol/hydrochlorothiazide – see Table 21, p. 54
propylthiouracil
Proscar (finasteride) – **PA**
Prosed/DS (methenamine/benzoic acid/atropine/hyoscyamine/saldol/methylene blue)
ProSom # (estazolam) – **PA > 10 units/month;** see Table 15, p. 48
Prostigmin (neostigmine)
Protonix (pantoprazole) – see Table 3, p. 36
Protopic (tacrolimus)
protriptyline – see Table 17, p. 50
Protropin (somatrem) – **PA**; see Table 9, p. 42
Proventil #
Proventil, inhaler (albuterol) – **PA;** see Table 23, p. 56
Proventil HFA, inhaler (albuterol) – **PA;** see Table 23, p. 56
Provera # (medroxyprogesterone)
Provigil (modafinil) – **PA**
Prozac # (fluoxetine) – see Table 17, p. 50
Prozac Weekly (fluoxetine) – **PA;** see Table 17, p. 50
Prudoxin (doxepin)
pseudoephedrine *****
Psorcon # (diflorasone) – see Table 16, p. 49
psyllium *****
Pulmicort (budesonide), inhalation suspension – see Table 23, p. 56

PA Prior authorization is required. The prescriber must obtain prior authorization for the drug in order for the pharmacy to receive payment.

\# This is a brand-name drug with FDA “A”-rated generic equivalents. Prior authorization is required for the brand, unless a particular form of that drug (for example, tablet, capsule, or liquid) does not have an FDA “A”-rated generic equivalent.

* The generic OTC and, if any, generic prescription versions of the drug are payable under MassHealth without prior authorization.

º Prior-authorization status depends on the drug’s formulation.

Note: Any drug that does not appear on the List requires prior authorization.

Pulmicort (budesonide), inhaler – see Table 23, p. 56
Pulmozyme (dornase alpha)
Purinethol (mercaptopurine)
pyrazinamide
Pyridium (phenazopyridine)
pyridostigmine bromide
pyridoxine *
pyrilamine/phenylephrine – see Table 12, p. 45
pyrimethamine

Q

quazepam – **PA**; see Table 15, p. 48
Questran # (cholestyramine)
quetiapine – see Table 24, p. 57
Quibron (theophylline/guafenesin)
Quibron-T/SR (theophylline)
quinacrine
Quinaglute # (quinidine)
quinapril – **PA**; see Table 18, p. 51
quinapril/hydrochlorothiazide – **PA**; see Table 18, p. 51
Quinidex # (quinidine)
quinidine
quinine
Quixin (levofloxacin)
Qvar (beclomethasone), inhaler – see Table 23, p. 56

R

Rabavert (rabies vaccine)
rabeprazole – **PA**; see Table 3, p. 36
rabies immune globulin IM, human – see Table 1, p. 34
rabies vaccine
Radiacare (oxybenzone/pedimate)
raloxifene
ramipril – **PA**; see Table 18, p. 51
ranitidine * – see Table 3, p. 36
ranitidine, effervescent tablet – **PA;** see Table 3, p 36
Rapamune (sirolimus)
Raptiva (efalizumab) – **PA;** see Table 5, p. 38
rasburicase
Rebetol (ribavirin) – **PA**
Rebetol solution (ribavirin) – **PA > 18 years**
Rebetron (interferon alfa-2b/ribavirin) – **PA;** see Table 5, p. 38
Rebif (interferon beta-1a) – see Table 5, p. 38
Recombinate (antihemophilic factor, recombinant)
Recombivax HB (hepatitis B, recombinant vaccine)
Refacto (antihemophilic factor, recombinant)
Refludan (lepirudin) – **PA**
Regitine (phentolamine)
Reglan # (metoclopramide)
Regranex (becaplermin)
Relafen # (nabumetone) – see Table 11, p. 44
Relenza (zanamivir) – **PA > 20 units/month**
Relpax (eletriptan) – **PA;** see Table 14, p. 47
Remeron # (mirtazapine) – see Table 17, p. 50
Remeron Sol Tab (mirtazapine, orally disintegrating tablet) – **PA**; see Table 17, p. 50
Remicade (infliximab) – **PA;** see Table 5, p. 38
Reminyl (galantamine)
Remodulin (treprostinil)
Remular-S # (chlorzoxazone)
Renacidin (magnesium carbonate/citric acid/gluconolactone)
Renagel (sevelamer)
Renese (polythiazide)
repaglinide – **PA;** see Table 26, p. 59
Repan # (butalbital/acetaminophen/caffeine)
Repan-CF # (butalbital/acetaminophen)
Requip (ropinirole)
Rescriptor (delavirdine)
Rescula (unoprostone)
reserpine
RespiGam (respiratory syncytial virus immune globulin IV) – **PA**; see Table 1, p. 34
respiratory syncytial virus immune globulin IV – **PA**; see Table 1, p. 34
Restasis (cyclosporine)
Restoril # (temazepam) – **PA > 10 units/month**; see Table 15, p. 48
Retin-A # (tretinoin) – **PA > 25 years;** see Table 10, p. 43
Retinol *
Retrovir (zidovudine)
Revia # (naltrexone)
Reyataz (atazanavir)
Rheumatrex # (methotrexate)
Rhinocort Aqua (budesonide, nasal spray) – **PA > 1 inhaler/2 months;** see Table 25, p. 58
Rho(D) immune globulin IM – see Table 1, p. 34

PA Prior authorization is required. The prescriber must obtain prior authorization for the drug in order for the pharmacy to receive payment.

This is a brand-name drug with FDA "A"-rated generic equivalents. Prior authorization is required for the brand, unless a particular form of that drug (for example, tablet, capsule, or liquid) does not have an FDA "A"-rated generic equivalent.

* The generic OTC and, if any, generic prescription versions of the drug are payable under MassHealth without prior authorization.

º Prior-authorization status depends on the drug's formulation.

Note: Any drug that does not appear on the List requires prior authorization.

Rho(D) immune globulin IM micro-dose – see Table 1, p. 34
Rho(D) immune globulin IV, human – see Table 1, p. 34
RhoGAM (Rho(D) immune globulin IM) – see Table 1, p. 34
RhoPhylac (Rho (D) immune globulin IV, human) – see Table 1, p. 34
ribavirin
ribavirin solution – **PA > 18 years**
riboflavin *****
Ridaura (auranofin)
rifabutin
Rifadin # (rifampin)
Rifamate (rifampin/isoniazid)
rifampin
rifampin/isoniazid
Rilutek (riluzole)
riluzole
Rimactane # (rifampin)
rimantadine
rimexolone
Riomet (metformin solution) – see Table 26, p. 59
risedronate
Risperdal (risperidone) – see Table 24, p. 57
Risperdal Consta (risperidone injection) – see Table 24, p. 57
Risperdal M (risperidone, orally disintegrating tablet) – **PA;** see Table 24, p. 57
risperidone – see Table 24, p. 57
risperidone injection – see Table 24, p. 57
risperidone, orally disintegrating tablet – **PA;** see Table 24, p. 57
Ritalin # (methylphenidate)
ritonavir
ritonavir/lopinavir
Rituxan (rituximab)
rituximab
rivastigmine
rizatriptan – **PA**; see Table 14, p. 47
rizatriptan, orally disintegrating tablets – **PA**; see Table 14, p. 47
RMS (morphine) – see Table 8, p. 41
Robaxin # (methocarbamol) – see Table 7, p. 40
Robinul # (glycopyrrolate)
Rocaltrol # (calcitriol)
Rocephin (ceftriaxone)
rofecoxib – **PA < 60 years**; see Table 11, p. 44
Roferon-A (interferon alfa-2a) – see Table 5, p. 38
ropinirole
rosiglitazone – see Table 26, p. 59
rosiglitazone/metformin – **PA;** see Table 26, p. 59
rosuvastatin – **PA > 30 units/month;** see Table 13, p. 46
Rowasa (mesalamine)
Roxanol (morphine) – **PA > 360 mg/day (effective 10/01/04);** see Table 8, p. 41
Roxanol-T (morphine) – **PA > 360 mg/day (effective 10/01/04);** see Table 8, p. 41
Roxicet (oxycodone/acetaminophen) – see Table 8, p. 41
Roxicodone (oxycodone) – **PA > 240 mg/day (effective 10/01/04);** see Table 8, p. 41
Roxiprin (oxycodone/aspirin) – see Table 8, p. 41
Rozex (metronidazole)
Rx-Otic (antipyrine/benzocaine)
Rythmol # (propafenone)

S

Saizen (somatropin) – **PA**; see Table 9, p. 42
Salagen (pilocarpine)
salicylic acid/sulfur colloidal
salmeterol – see Table 23, p. 56
salsalate
Sal-Tropine (atropine)
Sandimmune # (cyclosorpine)
Sandoglobulin (immune globulin IV, human) – **PA**; see Table 1, p. 34
Sandostatin (octreotide)
Sansert (methysergide)
Santyl (collagenase)
saquinavir
Sarafem (fluoxetine) – **PA;** see Table 17, p. 50
sargramostim – **PA**; see Table 4, p. 37
scopolamine
scopolamine/phenylephrine
Seasonale (ethinyl estradiol/levonorgestrel)
secobarbital
secobarbital/amobarbital
Seconal # (secobarbital)
Sectral # (acebutolol) – see Table 21, p. 54
selegiline
selenium sulfide *****

PA Prior authorization is required. The prescriber must obtain prior authorization for the drug in order for the pharmacy to receive payment.

\# This is a brand-name drug with FDA "A"-rated generic equivalents. Prior authorization is required for the brand, unless a particular form of that drug (for example, tablet, capsule, or liquid) does not have an FDA "A"-rated generic equivalent.

* The generic OTC and, if any, generic prescription versions of the drug are payable under MassHealth without prior authorization.

º Prior-authorization status depends on the drug's formulation.

Note: Any drug that does not appear on the List requires prior authorization.

Semprex-D (acrivastine/pseudoephedrine) – **PA**; see Table 12, p. 45
senna *
Sensipar (cinacalcet) – **PA**
Sensorcaine # (bupivacaine)
Septisol (hexachlorophene)
Septra # (trimethoprim/sulfamethoxazole)
Serax # (oxazepam)
Serentil (mesoridazine)
Serevent (salmeterol) – see Table 23, p. 56
Seroquel (quetiapine) – see Table 24, p. 57
Serostim (somatropin) – **PA**; see Table 9, p. 42
sertaconazole – **PA**
sertraline – **PA**; see Table 17, p. 50
Serzone # (nefazodone) – see Table 17, p. 50
sevelamer
Shohl's Solution (sodium citrate/citric acid)
Sildec (carbinoxamine/pseudoephedrine)
sildenafil – **PA**; see Table 6, p. 39
Silvadene # (silver sulfadiazine)
silver sulfadiazine
simethicone *
simvastatin – **PA**; see Table 13, p. 46
Sinemet # (carbidopa/levodopa)
Sinequan # (doxepin) – see Table 17, p. 50
Singulair (montelukast) – **PA > 16 years**
sirolimus
Skelaxin (metaxalone) – see Table 7, p. 40
Skelid (tiludronate)
Slo-Bid # (theophylline)
Slo-Phyllin (theophylline)
sodium bicarbonate *
sodium chloride solution for inhalation *
sodium citrate/citric acid
sodium ferric gluconate complex
sodium fluoride
sodium phenylbutyrate
sodium phosphate
sodium polystyrene sulfonate
Solaraze (diclofenac)
Solganal (aurothioglucose)
Solu-Cortef # (hydrocortisone)
Solu-Medrol # (methylprednisolone)
Soma # (carisoprodol) – see Table 7, p. 40
somatrem – **PA**; see Table 9, p. 42
somatropin – **PA**; see Table 9, p. 42
Somavert (pegvisomant) – **PA**
Somnote (chloral hydrate)
Sonata (zaleplon) – **PA > 10 units/month**; see Table 15, p. 48
Sorbitrate # (isosorbide)
Soriatane (acitretin) – see Table 10, p. 43
sotalol – see Table 21, p. 54
Spectazole # (econazole)
Spectracef (cefditoren)
Spiriva (tiotropium)
spironolactone
spironolactone/hydrochlorothiazide
Sporanox (itraconazole)
SPS # (sodium polystyrene sulfonate)
SSKI (potassium iodide)
Stadol, injection # (butorphanol)
Stadol, nasal spray (butorphanol) – **PA**
Stalevo (carbidopa/levodopa/entacapone) – **PA**
stanozolol
Starlix (nateglinide) – **PA;** see Table 26, p. 59
Stelazine # (trifluoperazine)
Stimate (desmopressin)
Strattera (atomoxetine) – **PA**
Stromectol (ivermectin)
Suboxone (buprenorphine/naloxone)
Subutex (buprenorphine)
succimer
sucralfate
Sular (nisoldipine) – **PA;** see Table 22, p. 55
sulconazole
sulfacetamide
sulfacetamide/prednisolone
sulfacetamide/sulfur
Sulfacet-R (sulfacetamide/sulfur)
sulfadiazine
Sulfamide (sulfacetamide)
Sulfamylon (mafenide)
sulfanilamide
sulfasalazine
Sulfatrim # (trimethoprim/sulfamethoxazole)
Sulfazine # (sulfasalazine)
sulfinpyrazone
sulfisoxazole
Sulfoxyl (benzoyl peroxide/sulfur)
sulindac – see Table 11, p. 44
sumatriptan, injection – **PA > 2 units (4 injections)/month;** see Table 14, p. 47
sumatriptan, nasal spray – **PA**; see Table 14, p. 47
sumatriptan, tablet – **PA**; see Table 14, p. 47
Sumycin # (tetracycline)

PA Prior authorization is required. The prescriber must obtain prior authorization for the drug in order for the pharmacy to receive payment.

\# This is a brand-name drug with FDA "A"-rated generic equivalents. Prior authorization is required for the brand, unless a particular form of that drug (for example, tablet, capsule, or liquid) does not have an FDA "A"-rated generic equivalent.

* The generic OTC and, if any, generic prescription versions of the drug are payable under MassHealth without prior authorization.

º Prior-authorization status depends on the drug's formulation.

Note: Any drug that does not appear on the List requires prior authorization.

Suprax (cefixime)
Surmontil (trimipramine) – see Table 17, p. 50
Sustiva (efavirenz)
Symbyax (fluoxetine/olanzapine) – **PA;** see Table 17, p. 50; see Table 24, p. 57
Symmetrel # (amantadine)
Synagis (palivizumab) – **PA**
Synalar # (fluocinolone) – see Table 16, p. 49
Synalgos-DC (dihydrocodeine/aspirin/caffeine)
Synarel (nafarelin) – **PA**; see Table 2, p. 35
Synthroid (levothyroxine)
Synvisc (hylan polymers) – **PA**
Syprine (trientine)

T

tacrine
tacrolimus
tadalafil – **PA**; see Table 6, p. 39
Tagamet # (cimetidine *) – see Table 3, p. 36
Talacen # (pentazocine/acetaminophen)
Talwin (pentazocine)
Tambocor (flecainide)
Tamiflu (oseltamivir) – **PA > 10 capsules/month**
tamoxifen
tamsulosin – **PA**; see Table 19, p. 52
TAO (troleandomycin)
Tapazole # (methimazole)
Targretin (bexarotene)
Tarka (trandolapril/verapamil) – **PA**; see Table 18, p. 51; see Table 22, p. 55
Tasmar (tolcapone)
Tavist # (clemastine) – see Table 12, p. 45
Taxol # (paclitaxel)
Taxotere (docetaxel)
tazarotene – **PA > 25 years;** see Table 10, p. 43
Tazicef # (ceftazidime)
Tazidime # (ceftazidime)
Tazorac (tazarotene) – **PA > 25 years;** see Table 10, p. 43
TBC # (trypsin/balsam peru/castor oil)
tegaserod – **PA**
Tegison (etretinate) – see Table 10, p. 43
Tegretol # (carbamazepine) – see Table 20, p. 53
telmisartan – **PA**; see Table 18, p. 51
temazepam – **PA > 10 units/month;** see Table 15, p. 48
Temodar (temozolomide)
Temovate # (clobetasol) – see Table 16, p. 49
temozolomide
Tenex # (guanfacine)
tenofovir
Tenoretic # (atenolol/chlorthalidone) – see Table 21, p. 54
Tenormin # (atenolol) – see Table 21, p. 54
Tequin (gatifloxacin)
Terak (oxytetracycline/polymyxin B)
Terazol # (terconazole)
terazosin – see Table 19, p. 52
terbinafine
terbutaline
terconazole
teriparatide – **PA**
Teslac (testolactone)
Tessalon # (benzonatate)
Testim (testosterone)
Testoderm (testosterone)
testolactone
testosterone
Testred (methyltestosterone)
tetanus immune globulin IM, human – see Table 1, p. 34
tetracycline
Teveten (eprosartan) – **PA**; see Table 18, p. 51
Texacort # (hydrocortisone) – see Table 16, p. 49
thalidomide – see Table 5, p. 38
Thalitone (chlorthalidone)
Thalomid (thalidomide) – see Table 5, p. 38
Theo-24 (theophylline)
Theochron # (theophylline)
Theo-Dur # (theophylline)
Theolair (theophylline)
Theolair-SR # (theophylline)
Theolate (theophylline/guaifenesin)
theophylline
theophylline/guaifenesin
theophylline/potassium iodide
Thera-Flur-N (sodium fluoride)
Thermazene # (silver sulfadiazine)
thiabendazole
thiamine *
thiethylperazine
thioguanine

PA Prior authorization is required. The prescriber must obtain prior authorization for the drug in order for the pharmacy to receive payment.

This is a brand-name drug with FDA “A”-rated generic equivalents. Prior authorization is required for the brand, unless a particular form of that drug (for example, tablet, capsule, or liquid) does not have an FDA “A”-rated generic equivalent.

* The generic OTC and, if any, generic prescription versions of the drug are payable under MassHealth without prior authorization.

º Prior-authorization status depends on the drug’s formulation.

Note: Any drug that does not appear on the List requires prior authorization.

Thiola (tiopronin)
thioridazine
thiothixene
Thorazine # (chlorpromazine)
Thymoglobulin (antithymocyte globulin, rabbit) – see Table 1, p. 34
thyroid
Thyrolar (liotrix)
Thyrox (levothyroxine)
tiagabine – **PA > 18 years;** see Table 20, p. 53
Tiazac (diltiazem) – see Table 22, p. 55
ticarcillin/clavulanate
TICE BCG (BCG vaccine)
Ticlid # (ticlopidine)
ticlopidine
Tikosyn (dofetilide)
Tilade (nedocromil) – see Table 23, p. 56
tiludronate
Timentin (ticarcillin/clavulanate)
Timolide (timolol/hydroclorothiazide) – see Table 21, p. 54
timolol – see Table 21, p. 54
timolol/hydroclorothiazide – see Table 21, p. 54
Timoptic # (timolol)
tiopronin
tiotropium
tizanidine – see Table 7, p. 40
TOBI (tobramycin/sodium chloride)
TobraDex (tobramycin/dexamethasone)
tobramycin
tobramycin/dexamethasone
tobramycin/sodium chloride
Tobrex # (tobramycin)
tocainide
Tofranil # (imipramine) – see Table 17, p. 50
tolazamide – see Table 26, p. 59
tolbutamide – see Table 26, p. 59
tolcapone
Tolectin # (tolmetin) – see Table 11, p. 44
Tolinase # (tolazamide) – see Table 26, p. 59
tolmetin – see Table 11, p. 44
tolnaftate *
tolterodine
Tonocard (tocainide)
Topamax (topiramate) – **PA > 18 years;** see Table 20, p. 53
Topicort # (desoximetasone) – see Table 16, p. 49
Topicort LP # (desoximetasone) – see Table 16, p. 49
topiramate – **PA > 18 years;** see Table 20, p. 53
Toprol (metoprolol) – see Table 21, p. 54
Toradol # (ketorolac) – **PA > 20 units/month (effective 09/01/04);** see Table 11, p. 44
Torecan (thiethylperazine)
toremifene
torsemide
tositumomab – **PA**
T-Phyl (theophylline)
Tracleer (bosentan) – **PA**
tramadol
tramadol/acetaminophen – **PA**
Trandate # (labetalol) – see Table 21, p. 54
trandolapril – **PA**; see Table 18, p. 51
trandolapril/verapamil – **PA**; see Table 18, p. 51; see Table 22, p. 55
Transderm-Nitro (nitroglycerin)
Transderm-Scop (scopolamine)
Tranxene T # (clorazepate) – see Table 20, p. 53
tranylcypromine – see Table 17, p. 50
trastuzumab
Travasol (amino acid and electrolyte IV infusion)
Travatan (travoprost)
travoprost
trazodone – see Table 17, p. 50
Trelstar (triptorelin) – **PA**; see Table 2, p. 35
Trental # (pentoxifylline)
treprostinil
tretinoin – **PA > 25 years;** see Table 10, p. 43
Trexall (methotrexate)
triamcinolone, inhaler – see Table 23, p. 56
triamcinolone, nasal spray – **PA > 1 inhaler/month;** see Table 25, p. 58
triamcinolone, oral
triamcinolone, topical – see Table 16, p. 49
triamterene/hydrochlorothiazide
triazolam – **PA > 10 units/month;** see Table 15, p. 48
Tri-Chlor (trichloroacetic acid)
trichlormethiazide
trichloroacetic acid
Tricor # (fenofibrate)
Tricosal (choline salicylate/magnesium salicylate)
trientine
triethanolamine
trifluoperazine
trifluridine

PA Prior authorization is required. The prescriber must obtain prior authorization for the drug in order for the pharmacy to receive payment.

\# This is a brand-name drug with FDA "A"-rated generic equivalents. Prior authorization is required for the brand, unless a particular form of that drug (for example, tablet, capsule, or liquid) does not have an FDA "A"-rated generic equivalent.

* The generic OTC and, if any, generic prescription versions of the drug are payable under MassHealth without prior authorization.

º Prior-authorization status depends on the drug's formulation.

Note: Any drug that does not appear on the List requires prior authorization.

trihexyphenidyl
Trilafon # (perphenazine)
Trileptal (oxcarbazepine) – see Table 20, p. 53
Tri-Levlen # (ethinyl estradiol/levonorgestrel)
Trilisate (choline salicylate/magnesium salicylate)
trimethoprim
trimethoprim/polymyxin B
trimethoprim/sulfamethoxazole
trimipramine – see Table 17, p. 50
Trimox # (amoxicillin)
Trinalin Repetabs (azatadine/pseudoephedrine) – **PA;** see Table 12, p. 45
Tri-Norinyl (ethinyl estradiol/norethindrone)
tripelennamine – see Table 12, p. 45
Triphasil # (ethinyl estradiol/levonorgestrel)
triprolidine/pseudoephedrine
triptorelin – **PA**; see Table 2, p. 35
Tri-Statin II (nystatin/triamcinolone)
Trivora # (ethinyl estradiol/levonorgestrel)
Trizivir (abacavir/lamivudine/zidovudine)
troleandomycin
tropicamide
Trusopt (dorzolamide)
trypsin/balsam peru/castor oil
Tuinal (secobarbital/amobarbital)
Twinrix (hepatitis A, inactived/hepatitis B, recombinant vaccine)
Tylenol/codeine # (codeine/acetaminophen) – see Table 8, p. 41
Tylox # (oxycodone/acetaminophen) – see Table 8, p. 41
Typhim Vi (typhoid vaccine)
typhoid vaccine

U

Ultracet (tramadol/acetaminophen) – **PA**
Ultram # (tramadol)
Ultrase (amylase/lipase/protease)
Ultravate (halobetasol) – **PA**; see Table 16, p. 49
Umecta (urea) – **PA**
Unasyn (ampicillin/sulbactam)
Uni-Dur (theophylline)
Uniphyl (theophylline)
Uniretic (moexipril/hydrochlorothiazide) – **PA**; see Table 18, p. 51
Unithroid (levothyroxine)
Univasc # (moexipril) – see Table 18, p. 51
unoprostone
urea º
urea/sodium proprionate/methionine/cystine/inositol
Urecholine (bethanechol)
Urex # (methenamine)
Urimax (methenamine/hyoscyamine/methylene blue)
Urised (methenamine/benzoic acid/atropine/hyoscyamine/methylene blue)
Urispas (flavoxate)
Urocit-K (potassium citrate)
Uroquid-Acid No. 2 (methenamine/sodium biphosphate)
Uroxatral (alfuzosin) – **PA**; see Table 19, p. 52
URSO (ursodiol)
ursodiol
Usept (methenamine/benzoic acid/atropine/hyoscyamine/phenylsalicylate/methylene blue)

V

Vagifem (estradiol)
valacyclovir
Valcyte (valganciclovir)
valdecoxib – **PA < 60 years**; see Table 11, p. 44
valganciclovir
Valisone # (betamethasone) – see Table 16, p. 49
valproate – see Table 20, p. 53
valproic acid – see Table 20, p. 53
valsartan – **PA**; see Table 18, p. 51
valsartan/hydrochlorothiazide – **PA**; see Table 18, p. 51
Valtrex (valacyclovir)
Vanceril (beclomethasone), inhaler – see Table 23, p. 56
Vancocin # (vancomycin)
Vancoled # (vancomycin)
vancomycin
Vanoxide-HC (benzoyl peroxide/hydrocortisone)
Vantin (cefpodoxime)
vardenafil – **PA;** see Table 6, p. 39
varicella-zoster immune globulin IM, human – see Table 1, p. 34
Vascor (bepridil) – **PA;** see Table 22, p. 55
Vaseretic # (enalapril/hydrochlorothiazide) – see Table 18, p. 51

PA Prior authorization is required. The prescriber must obtain prior authorization for the drug in order for the pharmacy to receive payment.

\# This is a brand-name drug with FDA "A"-rated generic equivalents. Prior authorization is required for the brand, unless a particular form of that drug (for example, tablet, capsule, or liquid) does not have an FDA "A"-rated generic equivalent.

* The generic OTC and, if any, generic prescription versions of the drug are payable under MassHealth without prior authorization.

º Prior-authorization status depends on the drug's formulation.

Note: Any drug that does not appear on the List requires prior authorization.

Vasocidin # (sulfacetamide/prednisolone)
vasopressin
Vasotec # (enalapril) – see Table 18, p. 51
Veetids # (penicillin V)
Velcade (bortezomib)
venlafaxine – **PA**; see Table 17, p. 50
Venofer (iron sucrose)
Venoglobulin-I (immune globulin IV, human) – **PA**; see Table 1, p. 34
Venoglobulin-S (immune globulin IV, human) – **PA**; see Table 1, p. 34
Ventolin # (albuterol)
Ventolin, inhaler (albuterol) – **PA;** see Table 23, p. 56
Ventolin HFA, inhaler (albuterol) – **PA;** see Table 23, p. 56
Vepesid # (etoposide)
verapamil – see Table 22, p. 55
Verelan # (verapamil) – see Table 22, p. 55
Vermox # (mebendazole)
Versed # (midazolam)
verteporfin
Vesanoid (tretinoin) – see Table 10, p. 43
Vexol (rimexolone)
Viadur (leuprolide) – **PA**; see Table 2, p. 35
Viagra (sildenafil) – **PA**; see Table 6, p. 39
Vibramycin # (doxycyline)
Vicodin # (hydrocodone/acetaminophen) – see Table 8, p. 41
vidarabine
Videx (didanosine)
vinblastine
vincristine
vinorelbine
Viokase (amylase/lipase/protease)
Vioxx (rofecoxib) – **PA < 60 years**; see Table 11, p. 44
Vira-A (vidarabine)
Viracept (nelfinavir)
Viramune (nevirapine)
Viread (tenofovir)
Viroptic # (trifluridine)
Visicol (sodium phosphate)
Visken # (pindolol) – see Table 21, p. 54
Vistaril # (hydroxyzine) – see Table 12, p. 45
Vistide (cidofovir)
Visudyne (verteporfin)
vitamin A * (retinol)
vitamin B_1 * (thiamine)
vitamin B_2 * (riboflavin)
vitamin B_3 * (niacin)
vitamin B_6 * (pyridoxine)
vitamin B_{12} * (cyanocobalamin)
vitamin B complex *
vitamin C *
vitamin D *
vitamin D/dihydrotachysterol/ergocalciferol
vitamins, multiple *
vitamins, multiple/minerals *
vitamins, pediatric *
vitamins, prenatal *
Vivactil # (protriptyline) – see Table 17, p. 50
Vivelle # (estradiol)
Vivelle-Dot (estradiol)
Vivotif Berna Vaccine (typhoid vaccine)
Volmax (albuterol)
Voltaren # (diclofenac) – see Table 11, p. 44
Vosol # (acetic acid)
Vytone (iodoquinol/hydrocortisone)

W

warfarin
water for inhalation *
Welchol (colesevelam)
Wellbutrin # (bupropion) – see Table 17, p. 50
Wellbutrin SR # (bupropion sustained–release) – see Table 17, p. 50
Wellbutrin XL (bupropion extended–release) – **PA;** see Table 17, p. 50
Westcort # (hydrocortisone) – see Table 16, p. 49
WinRho SDF (Rho(D) immune globulin IV, human) – see Table 1, p. 34
Winstrol (stanozolol)
witch hazel *
Wycillin (penicillin G)

X

Xalatan (latanoprost)
Xanax # (alprazolam)
Xanax XR (alprazolam extended release) – **PA**
Xeloda (capecitabine)
Xerac AC (aluminum chloride)
Xolair (omalizumab) – **PA**
Xopenex (levalbuterol), inhalation solution – **PA;** see Table 23, p. 56

PA Prior authorization is required. The prescriber must obtain prior authorization for the drug in order for the pharmacy to receive payment.

This is a brand-name drug with FDA "A"-rated generic equivalents. Prior authorization is required for the brand, unless a particular form of that drug (for example, tablet, capsule, or liquid) does not have an FDA "A"-rated generic equivalent.

* The generic OTC and, if any, generic prescription versions of the drug are payable under MassHealth without prior authorization.

º Prior-authorization status depends on the drug's formulation.

Note: Any drug that does not appear on the List requires prior authorization.

Xylocaine # (lidocaine)
Xylocaine-MPF # (lidocaine)

Y

Yasmin (ethinyl estradiol/drospirenone)

Z

Zaditor (ketotifen)
zafirlukast – **PA > 16 years**
zalcitabine
zaleplon – **PA > 10 units/month;** see Table 15, p. 48
Zanaflex # (tizanidine) – see Table 7, p. 40
zanamivir – **PA > 20 units/month**
Zantac # (ranitidine *) – see Table 3, p. 36
Zantac EFFERdose (ranitidine, effervescent tablet) – **PA;** see Table 3, p. 36
Zarontin # (ethosuximide) – see Table 20, p. 53
Zaroxolyn # (metolazone)
Zavesca (miglustat)
Zebeta # (bisoprolol) – see Table 21, p. 54
Zebutal (butalbital/acetaminophen/caffeine)
Zelnorm (tegaserod) – **PA**
Zemaira (alpha1–proteinase inhibitor–human)
Zemplar (paricalcitol)
Zenapax (daclizumab)
Zerit (stavudine)
Zestoretic # (lisinopril/hydrochlorothiazide) – see Table 18, p. 51
Zestril # (lisinopril) – see Table 18, p. 51
Zetia (ezetimibe) – **PA**
Zevalin (ibritumomab) – **PA**
Ziac # (bisoprolol/hydrochlorothiazide) – see Table 21, p. 54
Ziagen (abacavir)
zidovudine
zileuton – **PA > 16 years**
Zinacef # (cefuroxime)
zinc oxide *
zinc sulfate
Zincate (zinc sulfate)
Ziox (papain/urea/chlorophyllin)
ziprasidone – see Table 24, p. 57
Zithromax (azithromycin)
Zocor (simvastatin) – **PA;** see Table 13, p. 46
Zocort HC (chloroxylenol/pramoxine/ hydrocortisone)
ZoDerm (benzoyl peroxide) – **PA**
Zofran (ondansetron) 4mg, 8mg – **PA > 15 units/month;** see Table 27, p. 60
Zofran (ondansetron) – **24mg – PA > 5 units/month;** see Table 27, p. 60
Zofran (ondansetron) solution – **PA > 50 mL/month;** see Table 27, p. 60
Zoladex (goserelin) – **PA**; see Table 2, p. 35
zoledronic acid
zolmitriptan, nasal spray – **PA**; see Table 14, p. 47
zolmitriptan, orally disintegrating tablet – **PA > 6 units/month;** see Table 14, p. 47
zolmitriptan, tablet – **PA > 6 units/month;** see Table 14, p. 47
Zoloft (sertraline) – **PA**; see Table 17, p. 50
zolpidem – **PA > 10 units/month;** see Table 15, p. 48
Zometa (zoledronic acid)
Zomig (zolmitriptan) – **PA > six units/month**; see Table 14, p. 47
Zomig Nasal Spray (zolmitriptan) – **PA;** see Table 14, p. 47
Zomig-ZMT (zolmitriptan, orally disintegrating tablet) – **PA > 6 units/month;** see Table 14, p. 47
Zonalon (doxepin)
Zone-A Forte (pramoxine/hydrocortisone)
Zonegran (zonisamide) – see Table 20, p. 53
zonisamide – see Table 20, p. 53
Zorbtive (somatropin) – **PA** – see Table 9, p. 42
Zosyn (piperacillin/tazobactam)
Zoto-HC (chloroxylenol/pramoxine/ hydrocortisone)
Zovia # (ethinyl estradiol/ethynodiol)
Zovirax # (acyclovir)
Zydone (hydrocodone/acetaminophen) – **PA**; see Table 8, p. 41
Zyflo (zileuton) – **PA > 16 years**
Zyloprim # (allopurinol)
Zymar (gatifloxacin)
Zyprexa (olanzapine) – see Table 24, p. 57
Zyprexa IM (olanzapine injection) – **PA**
Zyprexa Zydis (olanzapine, orally disintegrating tablets) – **PA**; see Table 24, p. 57
Zyrtec (cetirizine) syrup – **PA > 12 years (except for LTC members)**; see Table 12, p. 45
Zyrtec (cetirizine) tablets – **PA**; see Table 12, p. 45
Zyrtec-D (cetirizine/pseudoephedrine) – **PA**; see Table 12, p. 45
Zyvox (linezolid)

PA Prior authorization is required. The prescriber must obtain prior authorization for the drug in order for the pharmacy to receive payment.

\# This is a brand-name drug with FDA "A"-rated generic equivalents. Prior authorization is required for the brand, unless a particular form of that drug (for example, tablet, capsule, or liquid) does not have an FDA "A"-rated generic equivalent.

* The generic OTC and, if any, generic prescription versions of the drug are payable under MassHealth without prior authorization.

º Prior-authorization status depends on the drug's formulation.

Note: Any drug that does not appear on the List requires prior authorization.

Therapeutic Class Tables

Table 1 – Immune Globulins

Drug Name	PA Status	Clinical Notes
cytomegalovirus immune globulin IV, human (CMV-IGIV) – CytoGam		*Rate and Route of Administration*: • Administer only at rate, route, and concentration indicated for product; too rapid IV administration rate may lead to a precipitous drop in blood pressure, fluid overload, and a possible thrombotic event. Cautious use in patients with history of cardiovascular disease or thrombotic episodes. *Renal Risk*: • IGIV (human) products have been associated with renal dysfunction, acute renal failure, and osmotic nephrosis. Risk factors include age > 65 years, preexisting renal dysfunction, volume depletion, concurrent use of nephrotoxic drugs, diabetes, and sepsis. An additional risk appears to be associated with IGIV products containing sucrose as a stabilizer (Panglobulin, Gammar-P) when a total dose ≥ 400mg/kg was given. Note that RespiGam also contains sucrose. *Hypersensitivity Reactions*: • reportedly rare, however incidence may increase with use of large IM doses or repeated injections of immune globulins *Live Virus Vaccines (measles, mumps, rubella, varicella):* • Antibodies present in immune globulin preparations may interfere with the immune response of live virus vaccines, especially when large doses of immunoglobulins are given. For many immune globulins, a live virus vaccine should not be administered within 3 months of immune globulin administration; a few immune globulins require an even longer period (5-11 months) before a live virus vaccine should be given; check individual manufacturer's recommendations for each product.
hepatitis B immune globulin, human (HBIG) – BayHep B, H-BIG, HyperHep, Nabi-HB		
immune globulin IM, human (IGIM; gamma globulin; IgG) – immune serum globulin USP [1], BayGam		
immune globulin IV, human (IGIV) – Carimune, Gamimune N, Gammagard S/D, Gammar-P IV, Gamunex, Iveegam EN, Panglobulin, Polygam S/D, Sandoglobulin, Venoglobulin-I, Venoglobulin-S	PA	
antithymocyte globulin (equine) (ATG equine, LIG) – Atgam		
antithymocyte globulin (rabbit) (ATG rabbit) – Thymoglobulin		
rabies immune globulin IM, human (RIG) – BayRab, Imogam Rabies – HT		
Rho(D) immune globulin IM (Rho(D) IGIM) – BayRho-D Full Dose, Gamulin Rh, HypRho-D, RhoGAM		
Rho(D) immune globulin IM micro-dose (Rho(D) IG Micro-dose) – BayRho-D Mini Dose, HypRho-D Mini-Dose, MICRhoGAM, Mini-Gamulin Rh		
Rho(D) immune globulin IV, human (Rho(D) IGIV) – RhoPhylac, WinRho SDF		
respiratory syncytial virus immune globulin IV, human (RSV-IGIV) – RespiGam	PA	
tetanus immune globulin IM, human (TIG) – BayTet		
varicella-zoster immune globulin IM, human (VZIG) [1]		

[1] Product must be obtained through the Massachusetts Public Health Biologic Laboratories.

Table 2 – Hormones – Gonadotropin-Releasing Hormone Analogs

Drug Name	PA Status	Clinical Notes
Eligard (leuprolide)	PA	*For PA drugs*, one of the following FDA-approved indications must be met. For unlabeled uses, approval will be considered based on current medical evidence. • breast cancer (advanced) – Zoladex • central precocious puberty – Lupron, Synarel • endometrial thinning – Zoladex • endometriosis – Lupron, Synarel, Zoladex • prostatic cancer (advanced) – Eligard, Lupron, Trelstar, Viadur, Zoladex • prostatic carcinoma (Stage B2-C) – Zoladex • uterine leiomyomata – Lupron *Contraindication*s: • pregnancy and lactation – all products • undiagnosed, abnormal vaginal bleeding: leuprolide, Lupron, Viadur, Zoladex
Lupron (leuprolide)	PA	
Synarel (nafarelin)	PA	
Trelstar (triptorelin)	PA	
Viadur (leuprolide)	PA	
Zoladex (goserelin)	PA	

Table 3 – Gastrointestinal Drugs – Histamine H_2 Antagonists/Proton Pump Inhibitors

H_2 Antagonists

Drug Name	PA Status	Clinical Notes
Axid (nizatidine)	PA	*Optimize Dosing Regimen*: • For duodenal or gastric ulcer treatment, administer total daily dose between evening meal and bedtime – ulcer healing is directly proportional to degree of nocturnal acid reduction. *Duration of Therapy*: • duodenal ulcer (DU) – 4 weeks • gastric ulcer (GU) – 8 weeks
nizatidine (generic)	PA	
Pepcid # (famotidine *)		
Tagamet # (cimetidine *)		
Zantac # (ranitidine *)		
Zantac EFFERdose (ranitidine, effervescent tablet)	PA	

Proton Pump Inhibitors (PPIs)

Drug Name	PA Status	Clinical Notes
Aciphex (rabeprazole)	PA	*Optimize Dosing Regimen*: • For maximum efficacy, a PPI must be taken in a fasting state, just before or with breakfast. In general, for patients on PPIs it is not necessary to prescribe other antisecretory agents (e.g., H_2 antagonists, prostaglandins). If an antisecretory agent is prescribed with a PPI, the PPI should not be taken within 6 hours of the H_2 antagonist or prostaglandin. PPIs should not be taken on an "as needed" basis. *QD Dosing versus BID Dosing*: • QD dosing is adequate for most individuals except for H. pylori treatment (PPI is BID for 1st two weeks of therapy). For pathological hypersecretory conditions, such as ZE Syndrome, a BID PPI regimen may be needed for high total daily doses. When/if a second dose is prescribed, it should be given just before the evening meal. *Apparent PPI Non-responder*: • Careful history should be obtained to ensure appropriate timing of drug administration and no significant drug interactions (see above), before prescribing a second dose or switching to another PPI. *Duration of Therapy*: • duodenal ulcer (DU) – 4 weeks (QD dosing) • gastric ulcer (GU) – 8 weeks (QD dosing) • H. pylori – 2 weeks (BID dosing) + 2 more weeks if DU using QD dosing and 6 more weeks if GU using QD dosing • acute symptomatic GERD – 4-8 weeks (QD dosing) *NG Tube Administration:* Prevacid (lansoprazole) capsules can be opened and the intact granules mixed with 40 ml of apple juice and then administered through the NG tube. After administration, flush NG tube with additional apple juice. Prevacid suspension is not recommended for NG tube administration. It is a viscous liquid, and will thicken over time. *Tablet/Capsule Administration:* PPI tablets or the contents of PPI capsules should not be chewed, split, or crushed. For patients who have difficulty swallowing PPI capsules, the capsule can be opened and the intact granules can be sprinkled on applesauce. See specific product information for further information on liquids and foods compatible with capsule contents.
Nexium (esomeprazole)	PA	
omeprazole (generic)	PA	
Prevacid (lansoprazole) capsules	PA > 16 years	
Prevacid SoluTab (lansoprazole, orally disintegrating tablet)	PA > 16 years	
Prevacid (lansoprazole) suspension	PA > 16 years (except for LTC members)	
Prilosec (omeprazole)	PA	
Protonix (pantoprazole)		

This is a brand-name drug with FDA "A"-rated generic equivalents. Prior authorization is required for the brand, unless a particular form of that drug (for example, tablet, capsule, or liquid) does not have an FDA "A"-rated generic equivalent.
* The generic OTC and, if any, generic prescription versions of the drug are payable under MassHealth without prior authorization.

Table 4 – Hematologic Agents – Hematopoietic Agents

Drug Name	PA Status	Clinical Notes
Colony-Stimulating Factors		*For PA drugs*, an FDA-approved indication must be met. For unlabeled uses, approval will be considered based on current medical evidence. *Monitoring:* • colony-stimulating factors (G-CSF, GM-CSF) – Certain drugs, such as corticosteroids and lithium may potentiate the myeloproliferative effects of colony-stimulating factors; GM-CSF: fluid retention, occasional transient supraventricular arrhythmias, and dyspnea may occur – use cautiously in patients with cardiac or pulmonary disease. • erythropoietin – Evaluate iron status before and during therapy. Transferrin saturation should be at least 20% and serum ferritin at least 100 ng/ml. Most patients will eventually require supplemental iron. • oprelvekin – Fluid retention will occur. Use cautiously in patients with CHF or preexisting fluid collections (e.g., ascites, pericardial or pleural effusions).
Leukine (sargramostim; GM-CSF)	PA	
Neulasta (pegfilgrastim)	PA	
Neupogen (filgrastim; G-CSF)	PA	
Interleukins		
Neumega (oprelvekin; IL-11)	PA	
Recombinant Human Erythropoietin		
Aranesp (darbepoetin alfa)	PA	
Epogen (epoetin alfa; EPO)	PA	
Procrit (epoetin alfa; EPO)	PA	

Table 5 – Immunologic Agents – Immunomodulators

Drug Name	PA Status	Clinical Notes
Actimmune (interferon gamma-1b)		*For PA drugs*, one of the following FDA-approved indications must be met. For unlabeled uses, approval will be considered based on current medical evidence. • AIDS-related Kaposi's sarcoma – Intron A, Roferon-A • Chronic granulomatous disease – Actimmune • CML – Roferon-A • Condylomata acuminata – Alferon N, Intron A • Crohn's disease – Remicade • Erythema nodosum leprosum – Thalomid • Follicular lymphoma – Intron A • Hairy cell leukemia – Intron A, Roferon-A • Hepatitis B (chronic) – Intron A • Hepatitis C (chronic) – Infergen, Intron A, Pegasys, PEG-Intron, Rebetron • Malignant melanoma – Intron A • Multiple sclerosis – Avonex, Betaseron, Novantrone, Rebif • Osteopetrosis – Actimmune • Psoriasis, severe – Amevive, Enbrel, Raptiva • Psoriatic arthritis – Enbrel • Rheumatoid arthritis, severe – Enbrel, Humira, Kineret, Remicade • Rheumatoid arthritis, juvenile – Enbrel *Alfa interferons Precautions:* • Life-threatening or fatal neuropsychiatric, autoimmune, ischemic, and infectious disorders may be caused or aggravated by alfa interferons. Monitor patients closely with periodic clinical and laboratory evaluations. See manufacturers' information for full details.
Alferon N (interferon alfa-n3, human leukocyte derived)		
Amevive (alefacept)	PA	
Avonex (interferon beta-1a)		
Betaseron (interferon beta-1b)		
Enbrel (etanercept)	PA	
Humira (adalimumab)	PA	
Infergen (interferon alfacon-1)		
Intron A (interferon alfa-2b; IFN-alfa2; rIFN-α2; α-2-interferon)		
Kineret (anakinra)	PA	
Novantrone (mitoxantrone)		
Pegasys (peginterferon alfa-2a)	PA > 4 doses/month	
PEG-Intron (peginterferon alfa-2b)	PA > 4 doses/month	
Raptiva (efalizumab)	PA	
Rebetron (interferon alfa-2b/ribavirin)	PA	
Rebif (interferon beta-1a)		
Remicade (infliximab)	PA	
Roferon-A (interferon alfa-2a; rIFN-A; IFLrA)		
Thalomid (thalidomide)	S.T.E.P.S. (restricted drug distribution program; only prescribers and pharmacists registered with this program may prescribe and dispense the drug)	

Table 6 – Impotence Agents

Drug Name	PA Status	Clinical Notes
Caverject (alprostadil, prostaglandin E_1; PE_1)	PA	• MassHealth does not pay for any drug used to promote male or female fertility. MassHealth does not pay for medications used to treat male or female sexual dysfunction, without prior authorization. • Sildenafil, tadalafil, and vardenafil may potentiate the hypotensive effects of nitrates, which in any form are contraindicated with use of sildenafil, tadalafil, and vardenafil. • Sildenafil, tadalafil, and vardenafil are metabolized by cytochrome P450 enzymes 3A4 (major route) and 2C9 (minor route); use sildenafil, tadalafil, and vardenafil cautiously with 3A4 inhibitors such as ketoconazole, erythromycin, or cimetidine. • Sildenafil, tadalafil, and vardenafil may potentiate the hypotensive effects of alpha blockers. Concomitant use may be contraindicated or require dose adjustments. Consult the manufacturer's literature for specific recommendations.
Cialis (tadalafil)	PA	
Edex (alprostadil, prostaglandin E_1; PE_1)	PA	
Levitra (vardenafil)	PA	
Muse (alprostadil, prostaglandin E_1; PE_1)	PA	
Viagra (sildenafil)	PA	

Table 7 – Muscle Relaxants – Centrally Acting

Drug Name	PA Status	Clinical Notes
Banflex (orphenadrine)		*PA for Lioresal Intrathecal*: Use for spasticity of spinal cord origin (FDA-approved indication) or, in children for reducing spasticity in cerebral palsy (unlabeled use). Other unlabeled uses will be considered based on current medical evidence. *Precautions:* • All agents within this class may cause drowsiness and dizziness. Patients should be advised of this and to avoid alcohol and other CNS depressants. • anticholinergic effects – baclofen, cyclobenzaprine, orphenadrine, tizanidine • cyclobenzaprine – structurally related to tricyclic antidepressants (TCAs); consider potential for similar adverse effects and drug interactions as with TCAs • tizanidine – an $alpha_2$ agonist structurally related to clonidine; may cause hypotension; hepatocellular injury reported — monitor LFTs *Urine Discoloration:* • orange or red-purple: chlorzoxazone • brown, black, or green: methocarbamol
diazepam		
Flexeril # (cyclobenzaprine)		
Flexoject (orphenadrine)		
Flexon (orphenadrine)		
Lioresal Intrathecal (baclofen)	PA	
Lioresal # (baclofen)		
Maolate (chlorphenesin)		
Norflex # (orphenadrine)		
Norgesic # (orphenadrine/aspirin/caffeine)		
Parafon Forte DSC # (chlorzoxazone)		
Remular-S # (chlorzoxazone)		
Robaxin # (methocarbamol)		
Skelaxin (metaxalone)		
Soma # (carisoprodol)		
Zanaflex # (tizanidine)		

This is a brand-name drug with FDA "A"-rated generic equivalents. Prior authorization is required for the brand, unless a particular form of that drug (for example, tablet, capsule, or liquid) does not have an FDA "A"-rated generic equivalent.

Table 8 – Narcotic Agonist Analgesics

Drug Name	PA Status	Clinical Notes
Diphenylheptanes		*Allergy:* • True systemic narcotic allergy, such as a generalized rash, or angioedema, is unusual. A local, itchy wheal formation at the site of narcotic injection, generalized pruritus (no rash) or flushing may occur, and is due to histamine release. Meperidine is less likely to release histamine than morphine or other phenanthrenes; histamine release is not associated with fentanyl or methadone. *Cross-Hypersensitivity*: • Systemic allergy manifestations, such as a generalized rash, or angioedema, although uncommon, are most likely to occur with natural opium alkaloids, such as morphine and codeine. If systemic allergy to morphine or codeine, a narcotic from a different chemical classification (i.e., diphenylheptanes, phenylpiperidines) should be selected. Ultram (tramadol) is structurally unrelated to opiates; however, the manufacturer states that it should not be used if there is previous hypersensitivity reaction to opiates. *Renal Dysfunction:* • Accumulation of certain narcotics in patients with significant renal dysfunction can lead to excess sedation, respiratory depression, delirium, myoclonus, or seizures. - avoid use: meperidine - cautious use: codeine, hydrocodone, morphine *Constipation:* • Common adverse effect with chronic narcotic use; prescribe stool softener +/- laxative with narcotic. *Acetaminophen Hepatotoxicity:* • Acetaminophen has been associated with severe hepatotoxicity following acute and chronic ingestion. • Maximum recommended dose of acetaminophen for adults is four grams/day. • Be sure to consider and ask about all potential sources of acetaminophen (e.g., OTC, combination analgesics) when determining daily acetaminophen dose. • Risk may increase with concurrent alcohol use, underlying liver disease, and/or the fasting state.
methadone (Dolophine #, Methadose #)	PA > 120 mg/day (effective 9/1/04)	
methadone powder	PA	
propoxyphene (Darvon #)		
propoxyphene napsylate (Darvon N)		
propoxyphene napsylate/acetaminophen (Darvocet-N #)		
Phenanthrenes		
codeine	PA > 360 mg/day (effective 10/1/04)	
codeine/acetaminophen (Tylenol/codeine #) codeine/aspirin (generics)		
hydrocodone/acetaminophen (Anexsia #, Hydrocet #, Lorcet #, Lortab #, Norco #, Vicodin #)		
hydrocodone/acetaminophen (Maxidone, Zydone)	PA	
hydromorphone (Dilaudid #)	PA > 60 mg/day (effective 10/1/04)	
hydromorphone powder	PA	
levorphanol (Levo-Dromoran #)	PA > 32 mg/day (effective 9/1/04)	
levorphanol powder	PA	
morphine injection (Astramorph PF, Duramorph, Infumorph)		
morphine immediate release (MS/L, MSIR, OMS, Roxanol, Roxanol-T)	PA > 360 mg/day (effective 9/1/04)	
morphine controlled release (MS Contin #, Oramorph SR)	PA > 360 mg/day (effective 9/1/04)	
morphine extended-release (Avinza)	PA	
morphine powder	PA	
morphine sustained release (Kadian)	PA > 360 mg/day (effective 9/1/04)	
morphine suppositories (RMS, Roxanol)		
oxycodone immediate release (Endocodone, Oxydose, OxyFAST, Oxy IR, Roxicodone)	PA > 240 mg/day (effective 10/1/04)	
oxycodone/acetaminophen (Endocet, Roxicet, Tylox #)		
oxycodone/acetaminophen (Percocet)	PA	
oxycodone/aspirin (Endodan, Percodan #, Roxiprin)		
oxycodone powder	PA	
oxycodone controlled release (OxyContin)	PA	
oxymorphone (Numorphan)		
Phenylpiperidines		
fentanyl injection		
fentanyl transdermal system (Duragesic)	PA	
fentanyl transmucosal system (Actiq)	PA	
meperidine (Demerol #)	PA > 750 mg/day (effective 10/1/04)	

This is a brand-name drug with FDA "A"-rated generic equivalents. Prior authorization is required for the brand, unless a particular form of that drug (for example, tablet, capsule, or liquid) does not have an FDA "A"-rated generic equivalent.

Table 9 – Growth Hormones

Drug Name	PA Status	Clinical Notes
somatrem – Protropin	PA	*For PA drugs*, one of the following FDA-approved indications must be met. For unlabeled uses, approval will be considered based on current medical evidence. • growth failure in children due to lack of endogenous growth hormone secretion – all products except Serostim • growth failure in children due to Prader-Willi Syndrome – Genotropin • growth failure in children associated with chronic renal insufficiency – Nutropin, Nutropin AQ • short stature associated with Turner Syndrome – Nutropin, Nutropin AQ, Humatrope • growth hormone deficiency in adults – Genotropin, Humatrope, Nutropin, Nutropin AQ • AIDS wasting or cachexia – Serostim • Short Bowel Syndrome in patients receiving specialized nutritional support – Zorbtive *Contraindications*: • active malignancy • growth promotion in children with fused epiphyses
somatropin – Genotropin Humatrope Norditropin Nutropin, Nutropin AQ Saizen Serostim Zorbtive	PA	

Table 10 – Dermatologic Agents – Retinoids

Drug Name	PA Status	Clinical Notes
Accutane # (isotretinoin; 13-cis-Retinoic Acid)		*For PA drugs*, one of the following FDA-approved indications must be met. For unlabeled uses, approval will be considered based on current medical evidence. • acne vulgaris – Altinac, Avita, Differin, Retin-A, Tazorac • Kaposi's sarcoma cutaneous lesions – Panretin • psoriasis (stable) – Tazorac *Contraindicated in Pregnancy*: • Accutane, Soriatane, Tazorac, and Tegison • Accutane – Prescribers must comply with the manufacturer's S.M.A.R.T. program: System to Manage Accutane Related Teratogenicity (see manufacturer's product information for full details). *Photosensitivity Reactions*: • Minimize exposure to ultraviolet light or sunlight. • other drugs that may also increase sensitivity to sun: quinolones, sulfonamides, thiazide diuretics, phenothiazines
Avita [1] # (tretinoin; trans-retinoic acid; vitamin A acid) [1]	PA > 25 years	
Differin [1] (adapalene)	PA > 25 years	
Panretin [1] (alitretinoin)	PA	
Retin-A [1] # (tretinoin; trans-retinoic acid; vitamin A acid) [1]	PA > 25 years	
Soriatane (acitretin)		
Tazorac [1] (tazarotene)	PA > 25 years	
Tegison (etretinate)		
Vesanoid [2] (tretinoin)		

This is a brand-name drug with FDA "A"-rated generic equivalents. Prior authorization is required for the brand, unless a particular form of that drug (for example, tablet, capsule, or liquid) does not have an FDA "A"-rated generic equivalent.

[1] topical products

[2] indicated for acute promyelocytic leukemia

Table 11 – Nonsteroidal Anti-inflammatory Drugs

Non-Selective NSAIDs

Drug Name	PA Status	Clinical Notes
Acetic Acid Derivatives		*Risk factors for NSAID-related GI toxicity*: • age > 60 years, history of gastric or duodenal ulcer, history of GI bleed, perforation or obstruction, concurrent use of anticoagulants, aspirin (including low doses for cardiovascular prophylaxis), corticosteroids, high daily NSAID doses *To avoid or minimize GI toxicity*: • Lowest effective dose should be prescribed for the shortest possible duration. • GI toxicity may be lower with ibuprofen, naproxen, ketoprofen, diclofenac, and higher with indomethacin, flurbiprofen, and piroxicam. *If risk factors are present for NSAID-related GI toxicity as above, consider:* • etodolac, nabumetone and meloxicam, all of which are preferential COX-2 inhibitors; however, with higher doses of etodolac and nabumetone, preferential inhibition of COX-2 is diminished. • highly selective COX-2 inhibitor (see table below). • an antisecretory agent (PPI or misoprostol) with a non-selective NSAID. *Risk factors for NSAID-related renal toxicity*: • preexisting renal disease, severe CHF liver disease, or diuretic use
Clinoril # (sulindac)		
Indocin # (indomethacin)		
Lodine # (etodolac)		
Relafen # (nabumetone)		
Tolectin # (tolmetin)		
Anthranilic Acid Derivatives		
meclofenamate		
Ponstel (mefenamic acid)	PA	
Enolic Acid Derivatives		
Feldene # (piroxicam)		
Mobic (meloxicam)	PA < 60 years	
Phenylacetic Acid Derivatives		
Arthrotec (diclofenac/ misoprostol)	PA < 60 years	
Voltaren # (diclofenac)		
Propionic Acid Derivatives		
Anaprox # (naproxen *)		
Ansaid # (flurbiprofen)		
Daypro # (oxaprozin)		
Motrin # (ibuprofen *)		
Nalfon # (fenoprofen)		
Naprosyn # (naproxen *)		
Prevacid NapraPAC (lansoprazole/naproxen)	PA	
Orudis # (ketoprofen *)		
Oruvail # (ketoprofen *)		
Toradol # (ketorolac)	PA > 20 units/month (effective 9/1/04)	
Salicylic Acid Derivative		
Dolobid # (diflunisal)		

COX-2 (Highly Selective) NSAIDs

Drug Name	PA Status	Clinical Notes
Bextra (valdecoxib)	PA < 60 years	*Osteoarthritis(OA)/Rheumatoid Arthritis (RA) Dosing*: • Bextra: OA: 10 mg QD; RA: 10 mg QD • Celebrex: OA: 200 mg QD or 100 mg BID; RA: 100-200 mg BID • Vioxx: OA: 12.5-25 mg QD; RA: 25 mg QD *Sulfonamide Allergy*: • Celebrex and Bextra are both sulfonamide derivatives. The labeling for Celebrex and Bextra state that use is contraindicated in sulfonamide-allergic patients. Vioxx, a methylsulfone derivative, is considered safe in patients with sulfonamide allergy. *Cardiovascular Risks*: • Limited published evidence suggests that there may be an increased risk of cardiovascular events in patients taking COX-2 NSAID; however, prospective comparative studies +/- low-dose aspirin specifically designed to determine the incidence of significant CV risks are needed to assess this risk.
Celebrex (celecoxib)	PA < 60 years	
Vioxx (rofecoxib)	PA < 60 years	

This is a brand-name drug with FDA "A"-rated generic equivalents. Prior authorization is required for the brand, unless a particular form of that drug (for example, tablet, capsule, or liquid) does not have an FDA "A"-rated generic equivalent.

* The generic OTC and, if any, generic prescription versions of the drug are payable under MassHealth without prior authorization.

Table 12 – Antihistamines

First Generation (Non-Selective) Antihistamines

Drug Name [1]	PA Status	Sedative Effect [2]	Antihistamine Effect [2]	Anticholinergic Effect [2]
Alkylamines				
brompheniramine *		1+	3+	2+
Chlor-Trimeton # (chlorpheniramine *)		1+	2+	2+
Polaramine # (dexchlorpheniramine)		1+	3+	2+
Ethanolamines				
Benadryl # (diphenhydramine *)		3+	1+/2+	3+
carbinoxamine		1+	1+/2+	1+
Tavist # (clemastine)		2+	1+/2+	3+
Ethylenediamine				
PBZ # (tripelennamine)		2+	1+/2+	+/-
Phenothiazine				
Phenergan # (promethazine)		3+	3+	3+
Piperazines				
Atarax # (hydroxyzine)		3+	2+/3+	2+
Vistaril # (hydroxyzine)		3+	2+/3+	2+
Piperidines				
Optimine (azatadine)	PA	2+	2+	2+
Periactin # (cyproheptadine)		1+	2+	2+
Trinalin Repetabs (azatadine/ pseudoephedrine)	PA	2+	2+	2+

Second Generation (Peripherally Selective) Antihistamines

Drug Name [1]	PA Status	Sedative Effect [2]	Antihistamine Effect [2]	Anticholinergic Effect [2]
Alkylamine				
Semprex-D (acrivastine/pseudoephedrine)	PA	+/-	2+/3+	+/-
Phthalazinone				
Astelin (azelastine)	PA > 1 inhaler/month	+/-	2+/3+	+/-
Piperazines				
Zyrtec (cetirizine), syrup	PA > 12 years (except for LTC members)	+/-	2+/3+	+/-
Zyrtec (cetirizine), tablets	PA			
Zyrtec-D (cetirizine/pseudoephedrine)	PA			
Piperidines				
Allegra (fexofenadine)	PA	+/-	2+/3+	+/-
Allegra-D (fexofenadine/pseudoephedrine)	PA			
Clarinex (desloratadine)	PA	+/-	3+	+/-
loratadine (generics)		+/-	2+/3+	+/-

This is a brand-name drug with FDA "A"-rated generic equivalents. Prior authorization is required for the brand, unless a particular form of that drug (for example, tablet, capsule, or liquid) does not have an FDA "A"-rated generic equivalent.

* The generic OTC and, if any, generic prescription versions of the drug are payable under MassHealth without prior authorization.

[1] Combinations of antihistamines and decongestants (for example, brompheniramine/pseudoephedrine) are payable under MassHealth, but are not listed in the antihistamine table unless PA is required for the combination.

[2] low to none = +/-; low = 1+; moderate = 2+; high = 3+ (Note: Pseudoephedrine, a sympathomimetic that may cause mild CNS stimulation, may lessen the sedative effect of antihistamines. Occasionally however, pseudoephedrine may also cause drowsiness. The antihistaminic and anticholinergic effects of antihistamines are not likely to be affected by the addition of pseudoephedrine.)

Table 13 – Statins

(All Statins are subject to a quantity limit of 30 units/month.)

Drug Name	PA Status	Clinical Notes
Advicor (lovastatin/niacin)	PA	The NCEP ATP III guidelines can be found on the following website: www.nhlbi.nih.gov/guidelines/cholestrol *Adverse Effects:* • *Hepatotoxicity:* Although the risk of liver toxicity is low, the risk may increase with dose increments. Liver function tests should be performed before and at 8 or 12 weeks, following therapy initiation, increase in dose and semiannually. Any increase in ALT, AST, or CPK of greater than 3 times ULN, dose reduction or withdrawal is recommended • *Myopathy:* Severe myopathy has been reported and is dose-related. It can lead to myoglobinuria and acute renal failure. Risk factors for statin-induced myopathy are drug-drug interactions, hepatic or renal failure, acute infection, or hypothyroidism.
Altocor (extended-release lovastatin)	PA	
Altoprev (extended-release lovastatin)	PA	
Caduet (amlodipine/atorvastatin)	PA	
Crestor (rosuvastatin)	PA > 30 units/month	
Lescol (fluvastatin)	PA > 30 units/month	
Lescol XL (fluvastatin extended-release)	PA > 30 units/month	
Lipitor (atorvastatin)	PA > 30 units/month	
lovastatin	PA > 30 units/month	
Mevacor (lovastatin)	PA	
Pravachol (pravastatin)	PA	
Pravigard PAC (pravastatin/aspirin)	PA	
Zocor (simvastatin)	PA	

This is a brand-name drug with FDA "A"-rated generic equivalents. Prior authorization is required for the brand, unless a particular form of that drug (for example, tablet, capsule, or liquid) does not have an FDA "A"-rated generic equivalent.

Table 14 – Triptans

Drug Name	PA Status	Clinical Notes
Amerge (naratriptan) tablet	PA	*FDA-Approved Indications:* • acute treatment of migraine (all triptans) • acute treatment of cluster headache episodes—Imitrex injection only • Triptans are NOT intended for prophylactic therapy of migraines. *General contraindications (consult prescribing information for specific information regarding individual agents):* • history, presence, symptoms, or signs of ischemic heart disease (e.g., angina, MI, stroke, TIA), coronary artery vasospasm, or other significant underlying cardiovascular disease • uncontrolled hypertension • concurrent use or use within 24 hours of ergotamine-containing products or ergot-type medications (e.g., dihydroergotamine, methysergide) • concurrent use with MAO inhibitor therapy or within two weeks of MAO inhibitor discontinuation • use within 24 hours of treatment with another triptan • management of hemiplegic or basilar migraine • hypersensitivity to the product or any of its ingredients *Do not exceed the maximum recommended dose per 24-hour period.* *Orally Disintegrating Tablets:* • Place tablet on tongue, where it will be dissolved and swallowed with saliva. • Inform phenylketonurics that tablets contain phenylalanine. *Migraine prophylaxis (e.g., amitriptyline, propranolol, timolol) may be considered for the following conditions:* • migraine occurs ≥ twice monthly and produces disability lasting ≥ three days per month • contraindication to, or failure of, acute treatments • abortive medications are used > twice per week • other severe migraine conditions
Axert (almotriptan) tablet	PA > six units/ month	
Frova (frovatriptan) tablet	PA	
Imitrex (sumatriptan), injection	PA > 2 units (4 injections)/month	
Imitrex (sumatriptan), nasal spray, tablet	PA	
Maxalt (rizatriptan) tablet	PA	
Maxalt-MLT (rizatriptan), orally disintegrating tablet	PA	
Relpax (eletriptan) tablet	PA	
Zomig Nasal Spray (zolmitriptan)	PA	
Zomig (zolmitriptan) tablet	PA > six units/ month	
Zomig-ZMT (zolmitriptan), orally disintegrating tablet	PA > six units/ month	

Table 15 – Hypnotics

Drug Name	PA Status	Duration of Action	Clinical Notes
Ambien (zolpidem)	PA > 10 units/month	short	• Hypnotics are primarily FDA-approved for transient or short-term treatment of insomnia. • There is limited medical evidence on the safety and efficacy of prolonged use of hypnotics. • Nonpharmacologic treatments, such as practicing good sleep hygiene, relaxation training, and cognitive therapy may be more effective than medications in some individuals. • To avoid tolerance and dependence, use the lowest dose, intermittently, and for the shortest possible duration. • Recommended hypnotic dosages are generally lower in the elderly. See "10 Tips for a Good Night's Sleep" (www.state.ma/masshealth/providers/pharmacy/10-tips_GoodNightSleep.pdf).
Dalmane # (flurazepam)	PA > 10 units/month	long	
Doral (quazepam)	PA	long	
Halcion # (triazolam)	PA > 10 units/month	short	
ProSom # (estazolam)	PA > 10 units/month	intermediate	
Restoril # (temazepam)	PA > 10 units/month	intermediate	
Sonata (zaleplon)	PA > 10 units/month	ultra-short	

This is a brand-name drug with FDA "A"-rated generic equivalents. Prior authorization is required for the brand, unless a particular form of that drug (for example, tablet, capsule, or liquid) does not have an FDA "A"-rated generic equivalent.

Table 16 – Topical Corticosteroids

Drug Name	PA Status	Clinical Notes
I. Low Potency		*Product Potency:* • Relative potency of a product depends on the characteristics and concentration of the drug and the vehicle. • Generally, ointments and gels are more potent than creams or lotions; however, some products have been formulated to yield comparable potency. *Product Selection:* • Selection of a specific corticosteroid, strength and vehicle depends on the nature, location, and extent of the skin condition, patient's age, and anticipated duration of treatment. • Use the least potent corticosteroid that would be effective. • Low potency agents are preferred for the face, intertriginous areas (e.g., groin, axilla), large areas, and children, to reduce the potential for side effects. • Reserve higher potency agents for areas and conditions resistant to treatment with milder agents. *Adverse Reactions:* • Systemic absorption of topical corticosteroids has produced reversible HPA axis suppression, Cushing's syndrome, hyperglycemia, and glycosuria. • Conditions that augment systemic absorption include application of more potent steroids, use over large surface areas, prolonged use, addition of occlusive dressings, and patient's age. • Perform appropriate clinical and laboratory tests if a topical corticosteroid is used for long periods or over large areas of the body. • With chronic conditions, gradual discontinuation of therapy may reduce the chance of rebound.
alclometasone dipropionate 0.05% C, O (Aclovate)	PA	
desonide C, L, O 0.05% (DesOwen #)		
fluocinolone acetonide 0.01% C, S (Synalar #)		
fluocinolone acetonide 0.01% oil (Derma-Smoothe/FS), shampoo (Capex)	PA	
hydrocortisone 0.5% C, L; 1% C, L, O, S; 2.5% C, L, O (Anusol-HC #, Hytone #, Texacort #)		
II. Medium Potency		
betamethasone dipropionate 0.05% L (generics)		
betamethasone dipropionate 0.05% L (Diprosone)	PA	
betamethasone valerate 0.12% A (Luxiq)	PA	
betamethasone valerate 0.1% C, L (Beta-Val #, Valisone #)		
clocortolone pivalate 0.1% C (Cloderm)	PA	
desoximetasone 0.05% C (Topicort LP #)		
fluocinolone acetonide 0.025% C, O (Synalar #)		
flurandrenolide 0.05% L (generics)		
flurandrenolide 0.025% C, O; 0.05% C, L, O, T (Cordran)	PA	
fluticasone propionate 0.05% C, 0.005% O (Cutivate)	PA	
hydrocortisone butyrate 0.1% C, O, S (Locoid)	PA	
hydrocortisone probutate 0.1% C (Pandel)	PA	
hydrocortisone valerate 0.2% C, O (Westcort #)		
mometasone furoate 0.1% O (generics)		
mometasone furoate 0.1% C, L, O (Elocon)	PA	
prednicarbate 0.1% C , O (Dermatop)	PA	
triamcinolone acetonide 0.025% C, L, O; 0.1% C, L, O; (Kenalog #, Aristocort #, Aristocort A #)		
III. High Potency		
amcinonide 0.1% C, L, O (Cyclocort #)		
augmented betamethasone, L (Diprolene)	PA	
augmented betamethasone, C (Diprolene AF #)		
betamethasone dipropionate 0.05% C, O (generics)		
betamethasone dipropionate 0.05% C, O; 0.1% A (Diprosone)	PA	
betamethasone dipropionate 0.05% G (Diprolene)		
betamethasone valerate 0.1% O (Beta-Val #, Valisone #)		
desoximetasone 0.05% G; 0.25% C, O (Topicort #)		
diflorasone diacetate 0.05% C (Psorcon #)		
fluocinonide 0.05% C, G, O, S (Lidex #)		
halcinonide 0.1% C, O, S (Halog, Halog-E)	PA	
triamcinolone acetonide 0.5% C, O (Aristocort #, Aristocort A # Kenalog#)		
IV. Very High Potency		
augmented betamethasone dipropionate 0.05% O (generics)		
augmented betamethasone dipropionate 0.05% O (Diprolene)	PA	
clobetasol propionate 0.05% C, G, O, S (Cormax#, Embeline #, Temovate #)		
clobetasol propionate 0.05% A (Olux)	PA	
diflorasone diacetate 0.05% O (Psorcon #)		
halobetasol propionate 0.05% C, O (Ultravate)	PA	

A=aerosol, C=cream, G=gel, L=lotion, O=ointment, S=solution

This is a brand-name drug with FDA "A"-rated generic equivalents. Prior authorization is required for the brand, unless a particular form of that drug (for example, tablet, capsule, or liquid) does not have an FDA "A"-rated generic equivalent.

Table 17 – Antidepressants

Drug Name	PA Status	Clinical Notes
Selective Serotonin Reuptake Inhibitors		*Dosing and administration:* • Recommended initial doses are generally lower in the elderly. • In general, the recommended initial dose of fluoxetine is 10-20 mg per day. A lower initial dose (5-10 mg) or longer dosing interval is recommended in the elderly. • Members should be counseled about the short- and long-term side effects of antidepressants. • Tertiary amine TCAs are generally associated with more potent anticholinergic and sedative properties than secondary amine TCAs (amoxapine, desipramine, nortriptyline and protriptyline). • Blood pressure should be monitored during venlafaxine therapy because it may cause a dose-related increase in diastolic blood pressure. *Monoamine oxidase (MAO) inhibitors:* • Hypertensive crisis may occur when MAO inhibitors are coadministered with certain drugs, including prescription and over-the-counter products, and foods, especially those high in tyramine. • Members should be counseled about dietary and medication restrictions. *Nefazodone and hepatic failure:* • Nefazodone has been reported to cause life-threatening hepatic failure, resulting in death or transplant. • Members should be counseled about the signs and symptoms of liver dysfunction and to contact their doctor immediately if they occur. *Bupropion and seizures:* • The risk of seizures appears to correlate with the bupropion dose (e.g., at doses up to 450 mg/day immediate release, the incidence is about 0.4%). • Additional risk factors may include history of head trauma or seizures, central nervous system tumor, severe hepatic cirrhosis, or concurrent medications that lower seizure threshold. • Recommendations to reduce the risk of seizures with immediate-release bupropion include the following: total daily dose not to exceed (NTE) 450 mg, daily dose is administered 3 times/day, single dose NTE 150 mg, and doses are gradually increased. • Recommendations to reduce the risk of seizures with sustained-release bupropion include the following: total daily dose NTE 400 mg, daily dose is administered 2 times/day, single dose NTE 200 mg, and doses are gradually increased. *See Pharmacy Program Antidepressant Initiative (www.state.ma/masshealth/providers/pharmacy/Antidepressant-Initiative.pdf) for more information about PA requirements for antidepressants.*
citalopram (Celexa)	PA	
escitalopram (Lexapro)	PA	
fluoxetine (Prozac #)		
fluoxetine (Prozac Weekly, Sarafem)	PA	
fluvoxamine (Luvox #)		
fluoxetine/olanzapine (Symbyax)	PA	
paroxetine (Paxil #)	PA < 18 years	
paroxetine (Pexeva)	PA	
paroxetine contolled release (Paxil CR)	PA	
sertraline (Zoloft)	PA	
Mixed Norepinephrine/Dopamine Reuptake Inhibitors		
bupropion (Wellbutrin #)		
bupropion extended release tablets (Wellbutrin XL)	PA	
bupropion sustained release (Wellbutrin SR #)		
Mixed Serotonin Effects		
nefazodone (Serzone #)		
trazodone (Desyrel #)		
Mixed Serotonin/Norepinephrine Reuptake Inhibitors		
venlafaxine (Effexor)	PA	
Monoamine Oxidase (MAO) Inhibitors		
phenelzine (Nardil)		
tranylcypromine (Parnate)		
Tetracyclic Antidepressants		
maprotiline (generics)		
mirtazapine (Remeron #)		
mirtazapine, orally disintegrating tablet (generics, Remeron Sol Tab)	PA	
Tricyclic Antidepressants (TCA)		
amitriptyline (Elavil #)		
amoxapine (generics)		
clomipramine (Anafranil #)		
desipramine (Norpramin #)		
doxepin (Sinequan #)		
imipramine (Tofranil #)		
nortriptyline (Aventyl #, Pamelor #)		
protriptyline (Vivactil #)		
trimipramine (Surmontil)		

This is a brand-name drug with FDA "A"-rated generic equivalents. Prior authorization is required for the brand, unless a particular form of that drug (for example, tablet, capsule, or liquid) does not have an FDA "A"-rated generic equivalent.

Table 18 – Renin Angiotensin System Antagonists

Drug Name	PA Status	Clinical Notes
Angiotensin – Converting Enzyme (ACE) Inhibitors		*Dose and administration:* • Initial doses may need to be lower in the elderly, and in patients who are on a diuretic or are volume depleted. *Nonproductive dry cough:* • Incidence is about 10-20% on an ACE inhibitor, but very uncommon in the angiotensin II receptor antagonists. • Cough usually resolves within 1-4 days after therapy is discontinued. *Adverse reactions:* • Higher incidence of skin rash and dysgeusia with captopril, compared to other ACE inhibitors, has been attributed to its sulfhydryl group. • Risk factors for hyperkalemia may include renal insufficiency, diabetes, concomitant nonsteroidal anti-inflammatory drugs, potassium supplements, and/or potassium-sparing diuretics. • Angioneurotic edema is less likely to occur with angiotensin II receptor blockers than ACE inhibitors, but cross-reactivity has been reported. *Pregnancy:* • May cause fetal or neonatal injury or death when used during the second or third trimester of pregnancy. • When pregnancy is detected, discontinue these drugs as soon as possible.
amlodipine/benazepril (Lotrel)	PA	
benazepril (Lotensin #)		
captopril (Capoten #)		
captopril/hydrochlorothiazide (Capozide #)		
enalapril (Vasotec #)		
enalapril/hydrochlorothiazide (Vaseretic #)		
enalapril/felodipine (Lexxel)	PA	
fosinopril (Monopril #)		
lisinopril (Prinivil #, Zestril #)		
lisinopril/hydrochlorothiazide (Prinzide #, Zestoretic #)		
moexipril (Univasc #)		
moexipril/hydrochlorothiazide (Uniretic)	PA	
perindopril (Aceon)	PA	
quinapril (Accupril)	PA	
quinapril/hydrochlorothiazide (Accuretic)	PA	
ramipril (Altace)	PA	
trandolapril (Mavik)	PA	
trandolapril/verapamil (Tarka)	PA	
Angiotensin II Receptor Antagonists		
candesartan (Atacand)	PA	
eprosartan (Teveten)	PA	
irbesartan (Avapro)	PA	
irbesartan/hydrochlorothiazide (Avalide)	PA	
losartan (Cozaar)	PA	
losartan/hydrochlorothiazide (Hyzaar)	PA	
olmesartan (Benicar)	PA	
telmisartan (Micardis)	PA	
valsartan (Diovan)	PA	
valsartan/hydrochlorothiazide (Diovan HCT)	PA	

This is a brand-name drug with FDA "A"-rated generic equivalents. Prior authorization is required for the brand, unless a particular form of that drug (for example, tablet, capsule, or liquid) does not have an FDA "A"-rated generic equivalent.

Table 19 – Alpha-1 Adrenergic Blockers

Drug Name	PA Status	Clinical Notes
alfuzosin (Uroxatral)	PA	*FDA-approved indications:* • Hypertension: doxazosin, prazosin, prazosin/polythiazide, terazosin • Benign prostatic hyperplasia (BPH): alfuzosin, doxazosin, tamsulosin, terazosin *Dose and administration:* • Doxazosin, prazosin, and terazosin: take first dose and subsequent first increased dose at bedtime to minimize lightheadedness and syncope. • Titrate to therapeutic maintenance doses to minimize dizziness and orthostatic hypotension. • If therapy is discontinued or interrupted for two or more days, reinstitute therapy cautiously. *PSA levels:* • Alpha-1 adrenergic receptor antagonists do not affect PSA levels.
doxazosin (Cardura #)		
prazosin (generics)		
prazosin/polythiazide (Minizide)		
tamsulosin (Flomax)	PA	
terazosin (Hytrin #)		

This is a brand-name drug with FDA "A"-rated generic equivalents. Prior authorization is required for the brand, unless a particular form of that drug (for example, tablet, capsule, or liquid) does not have an FDA "A"-rated generic equivalent.

Table 20 – Anticonvulsants

Drug Name	PA Status	Clinical Notes
carbamazepine (Carbatrol, Epitol, Tegretol #)		*For PA drugs*, one of the following FDA-approved indications must be met. • epilepsy, adjunctive therapy-gabapentin, levetiracetam, tiagabine, topiramate • postherpetic neuralgia-gabapentin For unlabeled uses, approval will be considered based on current medical evidence. *Precautions/warnings:* • About 25% to 30% of patients who experience a hypersensitivity reaction to carbamazepine will experience a hypersensitivity reaction to oxcarbazepine. • Carbamazepine has been associated with aplastic anemia and agranulocytosis. Hematologic studies should be performed before therapy is initiated. • Felbamate is not a first-line antiepileptic agent and is recommended only in patients who have shown an inadequate response to alternative treatments and whose epilepsy is so severe that the benefits outweigh the potential risks of aplastic anemia or liver failure. • Lamotrigine has been associated with serious rashes, which required hospitalization and/or discontinuation of treatment. Most cases of life-threatening rashes occurred within the first 2 to 8 weeks of treatment. • Phenytoin may cause gingival hyperplasia; the incidence may be reduced by good oral hygiene, including frequent brushing and flossing. • Valproic acid and its derivatives have been associated with hepatic failure resulting in fatalities. Liver function tests should be performed prior to initiating therapy and subsequently at frequent intervals, especially during the first 6 months of therapy. *See Pharmacy Program Anticonvulsant Initiative* (*www.state.ma/masshealth/providers/pharmacy/Anticonvulsant Initiative.pdf*) for more information about PA requirements for *anticonvulsants*.
clonazepam (Klonopin #)		
clonazepam, orally disintegrating tablet (Klonopin Wafers)	PA	
clorazepate (Tranxene-T #)		
diazepam (generics, Diastat)		
divalproex (Depakote)		
ethosuximide (Zarontin #)		
ethotoin (Peganone)		
felbamate (Felbatol)		
gabapentin (Neurontin)	PA > 18 years	
gabapentin powder	PA > 18 years	
lamotrigine (Lamictal)		
levetiracetam (Keppra)	PA	
methsuximide (Celontin)		
oxcarbazepine (Trileptal)		
phenobarbital (generics)		
phenytoin (Dilantin, Phenytek)		
primidone (Mysoline #)		
tiagabine (Gabitril)	PA > 18 years	
topiramate (Topamax)	PA > 18 years	
valproate (Depacon, Depakene #)		
valproic acid (Depakene #)		
zonisamide (Zonegran)		

This is a brand-name drug with FDA "A"-rated generic equivalents. Prior authorization is required for the brand, unless a particular form of that drug (for example, tablet, capsule, or liquid) does not have an FDA "A"-rated generic equivalent.

Table 21 – Beta-Adrenergic Blocking Agents

Drug Name	PA Status	Adrenergic Receptor Blocking Activity	Clinical Notes
acebutolol (Sectral #)		β_1	*Receptor blocking selectivity:* • β_1 receptors are predominant in the heart and kidney; β_2 receptors are predominant in the arteriolar smooth muscle, liver, lungs, and pancreas. • Cardioselective beta-blockers possess greater affinity for β_1 receptors than β_2 receptors. • At low doses, cardioselective beta-blockers may be safer than nonselective agents in patients with asthma, diabetes, COPD, and peripheral vascular disease. • Cardioselective agents may also inhibit β_2 receptors at higher doses. • Alpha-blockade has the potential to produce more orthostatic hypotension. *Intrinsic sympathomimetic activity (ISA):* • Acebutolol, carteolol, penbutolol, and pindolol possess ISA. • Agents with ISA may not be as cardioprotective as other beta-blockers and should not be used for myocardial infarction (MI) prophylaxis. *Use in heart failure:* • Metoprolol extended-release and carvedilol are approved for heart failure. *Use in diabetes:* • Beta-blockers may mask some symptoms of hypoglycemia. • Nonselective beta-blockers may potentiate insulin-induced hypoglycemia and delay recovery of serum glucose levels. *Other concomitant disorders:* • Beta-blockers may offer advantages for hypertensive patients with the following conditions: angina, migraines, selected ventricular and supraventricular arrhythmias. • All patients should receive a beta-blocker post MI, unless they have an absolute contraindication or have shown intolerance.
atenolol (Tenormin #)		β_1	
atenolol/chlorthalidone (Tenoretic #)			
betaxolol (Kerlone #)		β_1	
bisoprolol (Zebeta #)		β_1	
bisoprolol/hydrochlorothiazide (Ziac #)			
carteolol (Cartrol)	PA	β_1 β_2	
carvedilol (Coreg)	PA	β_1 β_2 α_1	
esmolol (Brevibloc)		β_1	
labetalol (Trandate #, Normodyne #)		β_1 β_2 α_1	
metoprolol (Lopressor #, Toprol)		β_1	
metoprolol/ hydrochlorothiazide (Lopressor HCT)			
nadolol (Corgard #)		β_1 β_2	
nadolol/bendroflumethiazide (Corzide)			
penbutolol (Levatol)	PA	β_1 β_2	
pindolol (Visken #)		β_1 β_2	
propranolol (Inderal #)		β_1 β_2	
propranolol extended-release (InnoPran XL)	PA		
propranolol/ hydrochlorothiazide (Inderide #)			
sotalol (Betapace #)		β_1 β_2	
timolol (Blocadren #)		β_1 β_2	
timolol/ hydrochlorothiazide (Timolide)			

This is a brand-name drug with FDA "A"-rated generic equivalents. Prior authorization is required for the brand, unless a particular form of that drug (for example, tablet, capsule, or liquid) does not have an FDA "A"-rated generic equivalent.

Table 22 – Calcium Channel Blocking Agents

Drug Name	PA Status	Clinical Notes
Benzothiazepines		*Indications:* • Nimodipine is only FDA approved for subarachnoid hemorrhage. • Bepridil, diltiazem (short acting), nifedipine (immediate release), and nimodipine are not FDA approved for the treatment of essential hypertension. • Sustained-release nifedipine and amlodipine have been shown to have comparable efficacy in African-Americans with hypertension. *Precautions/warnings:* • Formulations of calcium channel blockers that contain the same active ingredient may not be "A" rated to each other and therefore, should not be interchanged. • Two sustained-release verapamil products (Covera-HS and Verelan PM – not interchangeable) were designed to be given at bedtime. With a 4-5 hour delay in release, it is intended to prevent the early morning surge in blood pressure. *Adverse events:* • Side effects caused by vasodilation such as dizziness, flushing, headache, and peripheral edema, occur more frequently with dihydropyridines.
bepridil (Vascor)	PA	
diltiazem (Cardizem #, Cartia, Dilacor #, Tiazac)		
Dihydropyridines		
amlodipine (Norvasc)	PA	
amlodipine/atorvastatin (Caduet)	PA	
amlodipine/benazepril (Lotrel)	PA	
enalapril/felodipine (Lexxel)	PA	
felodipine (Plendil)	PA	
isradipine (Dynacirc)	PA	
nicardipine (Cardene #)		
nifedipine (Adalat #, Procardia #, Nifedical)		
nimodipine (Nimotop)		
nisoldipine (Sular)	PA	
Diphenylalkylamines		
trandolapril/verapamil (Tarka)	PA	
verapamil (Calan #, Verelan #, Isoptin #, Covera-HS)		

This is a brand-name drug with FDA "A"-rated generic equivalents. Prior authorization is required for the brand, unless a particular form of that drug (for example, tablet, capsule, or liquid) does not have an FDA "A"-rated generic equivalent.

Table 23 – Respiratory Inhalant Products

Drug Name	PA Status	Clinical Notes
Anticholinergics		*Quick-relief medications:* • Inhaled short-acting selective beta$_2$-agonists are therapy of choice for relief of acute symptoms. • Increasing use of short-acting beta$_2$- agonists or use of more than one canister/month may indicate over reliance on this drug and inadequate asthma control. • Daily scheduled use of short-acting beta$_2$-agonists is generally not recommended. • Salmeterol, a long acting beta$_2$-agonist, is not recommended for treatment of acute symptoms or exacerbations. *Long-term-control medications:* • Corticosteroids are the most potent and effective anti-inflammatory medications currently available. • The incidence of oral candidiasis with inhaled corticosteroids may be reduced by using a spacer/holding chamber, rinsing the mouth with water after inhalation and, if appropriate, administering the inhaled corticosteroid less frequently. • Long-acting inhaled beta$_2$-agonists should be used in conjunction with anti-inflammatory medications and are especially beneficial in managing nighttime symptoms. • Formoterol and salmeterol are long-acting inhaled beta$_2$-agonists. *Exercise-induced bronchospasm:* • Inhaled selective beta$_2$-agonists are the treatment of choice. *See Pharmacy Program Asthma Initiative (www.state.ma/masshealth/providers/pharmacy/Asthma Initiative.pdf) for more information about PA requirements for respiratory inhalant products.*
ipratropium, inhalation solution, inhaler (Atrovent #)		
Combination Products		
albuterol/ipratropium, inhalation solution (DuoNeb), inhaler (Combivent)		
fluticasone/salmeterol, diskus (Advair)		
Corticosteroids		
beclomethasone, inhaler (Qvar, Vanceril)		
budesonide, inhalation suspension, inhaler (Pulmicort)		
flunisolide, inhaler (AeroBid)		
flunisolide, inhaler (AeroBid -M)	PA	
fluticasone, diskus, inhaler, rotadisk (Flovent)		
triamcinolone, inhaler (Azmacort)		
Mast Cell Stabilizers		
cromolyn, inhalation solution, inhaler (Intal #)		
nedocromil, inhaler (Tilade)		
Sympathomimetics		
albuterol, inhalation solution (AccuNeb, Proventil)		
albuterol, inhaler (generics)		
albuterol, inhaler (Proventil, Proventil HFA, Ventolin, Ventolin HFA)	PA	
formoterol (Foradil)		
isoetharine, inhalation solution		
levalbuterol, inhalation solution (Xopenex)	PA	
metaproterenol, inhalation solution (Alupent #)		
metaproterenol, inhaler (Alupent)	PA	
pirbuterol, inhaler (Maxair)	PA	
salmeterol, diskus, inhaler (Serevent)		

This is a brand-name drug with FDA "A"-rated generic equivalents. Prior authorization is required for the brand, unless a particular form of that drug (for example, tablet, capsule, or liquid) does not have an FDA "A"-rated generic equivalent.

Table 24 – Atypical Antipsychotics

Drug Name	PA Status	Clinical Notes
aripiprazole (Abilify)		*Division initiatives:* • MassHealth does not consider olanzapine a first-line therapy for treatment of psychiatric illnesses due to its side effect profile and cost. • PA is required when a patient has an overlap of 60 days or more in prescriptions of aripiprazole, olanzapine, quetiapine, risperidone, and/or ziprasidone because there is limited scientific data to support the concomitant use of these atypical antipsychotics. *Additional information:* • Aripiprazole has a 75-hour half-life. Dosages should not be increased until after at least 2 weeks of therapy. Dosages higher than 10 or 15 mg/day have not been shown to be more effective than 10 or 15 mg/day. • Clozapine may cause agranulocytosis; therefore, white blood cell counts must be performed before initiating therapy, during therapy (initially weekly then biweekly if appropriate), and for 4 weeks after discontinuing therapy. • Olanzapine and clozapine should be used cautiously in patients with diabetes with periodic monitoring of weight and fasting glucose. • Risperidone doses greater than 6 mg/day are associated with more extrapyramidal symptoms. *See Pharmacy Program Atypical Antipsychotics Initiative (www.state.ma/masshealth/providers/pharmacy/Atypical Antipsychotics-Initiative.pdf) for more information about PA requirements for atypical antipsychotics.*
clozapine (Clozaril #)		
clozapine, orally disintegrating tablet (Fazaclo)	PA	
fluoxetine/olanzapine (Symbyax)	PA	
olanzapine (Zyprexa)		
olanzapine injection (Zyprexa IM)	PA	
olanzapine, orally disintegrating tablet (Zyprexa Zydis)	PA	
quetiapine (Seroquel)		
risperidone (Risperdal)		
risperidone injection (Risperdal Consta)		
risperidone, orally disintegrating tablet (Risperdal M)	PA	
ziprasidone (Geodon)		

This is a brand-name drug with FDA "A"-rated generic equivalents. Prior authorization is required for the brand, unless a particular form of that drug (for example, tablet, capsule, or liquid) does not have an FDA "A"-rated generic equivalent.

Table 25 – Intranasal Corticosteroids

Drug Name	PA Status	Clinical Notes
beclomethasone (Beconase AQ), nasal spray	PA > 1 inhaler/month	• Intranasal corticosteroids are effective in managing symptoms of itching, nasal congestion, rhinorrhea and sneezing associated with perennial and seasonal rhinitis. • Symptoms may begin to improve in 2-3 days but full benefit may not be achieved for 2-3 weeks. • Dosage may be reduced after a response has been achieved. • At the recommended doses, side effects are usually minimal and include stinging, sneezing, headache and epistaxis.
budesonide (Rhinocort Aqua), nasal spray	PA > 1 inhaler/2 months	
flunisolide (generics, Nasalide #, Nasarel), nasal spray	PA > 1 inhaler/month	
fluticasone (Flonase), nasal spray	PA > 1 inhaler/month	
mometasone (Nasonex), nasal spray	PA > 1 inhaler/month	
triamcinolone (Nasacort, Nasacort AQ), nasal spray	PA > 1 inhaler/month	

This is a brand-name drug with FDA "A"-rated generic equivalents. Prior authorization is required for the brand, unless a particular form of that drug (for example, tablet, capsule, or liquid) does not have an FDA "A"-rated generic equivalent.

Table 26 – Oral Antidiabetic Agents

Drug Name	PA Status	Clinical Notes
Alpha-Glucosidase Inhibitors		*Alpha-glucosidase inhibitors*: • If hypoglycemia occurs, must treat with glucose rather than sucrose. • Not recommended for patients with significant renal dysfunction (serum creatinine > 2 mg/dL). • Contraindications include inflammatory bowel disease, colonic ulceration, and intestinal obstruction. *Biguanides:* • Hold metformin therapy for 48 hours after receiving iodinated contrast. • May cause lactic acidosis; contraindicated in patients predisposed to acidosis (e.g., major surgery, congestive heart failure, hepatic failure). • Contraindicated in females and males with renal disease or dysfunction (e.g., serum creatinine greater than or equal to 1.4 mg/dL and 1.5 mg/dL, respectively). • In small studies, some obese women with polycystic ovary syndrome experienced a return of normal menses and ovulation when treated with metformin. *Meglitinides:* • Take <u>before</u> meals; hold dose if meal is missed. • Use with caution in patients with hepatic impairment. *Sulfonylureas:* • Use with caution in elderly patients, and patients with renal or hepatic impairment. *Thiazolindinediones:* • Use with caution in patients with edema. • Not recommended for patients with NYHA class III-IV cardiac status. • Not recommended for patients with liver function tests greater than 2.5 times normal. • May cause resumption of ovulation in premenopausal anovulatory women with insulin resistance. *Pregnancy/lactation:* • Insulin is the agent of choice during pregnancy and lactation.
acarbose (Precose)	PA	
miglitol (Glyset)	PA	
Biguanides		
metformin (Glucophage #)		
metformin extended-release (Glucophage XR #)		
metformin solution (Riomet)		
Meglitinides		
nateglinide (Starlix)	PA	
repaglinide (Prandin)	PA	
Sulfonylureas - First Generation		
acetohexamide		
chlorpropamide (Diabenese #)		
tolazamide (Tolinase #)		
tolbutamide		
Sulfonylureas - Second Generation		
glimepiride (Amaryl)	PA	
glipizide (Glucotrol #)		
glipizide extended-release (Glucotrol XL #)		
glyburide (Diabeta)	PA	
glyburide (Micronase #)		
glyburide, micronized (Glynase #)		
Thiazolidinediones		
pioglitazone (Actos)		
rosiglitazone (Avandia)		
Combination Products		
glipizide/metformin (Metaglip)	PA	
glyburide/metformin (Glucovance)	PA	
metformin/rosiglitazone (Avandamet)	PA	

This is a brand-name drug with FDA "A"-rated generic equivalents. Prior authorization is required for the brand, unless a particular form of that drug (for example, tablet, capsule, or liquid) does not have an FDA"A"-rated generic equivalent.

Table 27 – $5HT_3$ Receptor Antagonists

Drug Name	PA Status	Clinical Notes
Anzemet (dolasetron) tablet	PA > 15 units/month	• Granisetron and ondansetron are FDA approved for the prevention/treatment of postoperative, chemotherapy-induced, and radiation-induced nausea and vomiting. • Anzemet is not FDA approved for the prevention of radiation-induced nausea and vomiting. • Anzemet is associated with more drug interactions than Kytril or Zofran. • Anzemet has a cardiac warning and can prolong the QTc interval. • Dolasetron is FDA approved for prevention/treatment of postoperative and chemotherapy-induced nausea and vomiting. • Dolasetron should be administered with caution in patients who have or may develop prolongation of cardiac conduction intervals, particularily QTc. These include patients with hypokalemia or hypomagnesmia, patients taking diuretics with potential for inducing electrolyte abnormalities, patients with congenital QT syndrome, patients taking antiarrythmic drugs or other drugs that lead to QT prolongation, and cumulative high-dose anthracycline therapy.
Kytril (granisetron) tablet	PA > 15 units/month	
Kytril (granisetron) solution (2 mg/10 ml)	PA > 30 mL/month	
Zofran (ondansetron) 4 mg and 8 mg tablets	PA > 15 units/month	
Zofran (ondansetron) 24 mg tablets	PA > 5 units/month	
Zofran (ondansetron) orally disintegrating tablets	PA > 15 units/month	
Zofran (ondansetron) solution (4 mg/5 ml)	PA > 50 mL/month	

Commonwealth of Massachusetts
MassHealth Drug Utilization Review Program
P.O. Box 2586
Worcester, MA 01613-2586
Fax: 1-877-208-7428 **Phone:** 1-800-745-7318

Anticonvulsant Prior Authorization Request

MassHealth reviews requests for prior authorization (PA) on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

PA is required for Keppra. PA is required for Gabitril, Neurontin, and Topamax for members older than 18 years. Information about anticonvulsants can be found within the MassHealth Drug List at **www.mass.gov/masshealth.**

Member information

Last name	First name	MI	MassHealth member ID no.	Date of birth	Sex (Circle one.) f m
Member's place of residence	☐ home	☐ nursing facility			

Medication information: Section I

Anticonvulsant request
(Check one or all that apply)

- ☐ Gabitril (tiagabine)
- ☐ Keppra (levetiracetam)
- ☐ Neurontin (gabapentin)
- ☐ Topamax (topiramate)

Dose, frequency, and duration of requested drug

Drug NDC (if known) or service code

Indication for anticonvulsant requested (Check one or all that apply.)

- ☐ Seizure disorder
  Type: _____
- ☐ Postherpetic neuralgia (gabapentin only)
- ☐ Other (describe): _____

Please list all other medications currently prescribed for the member for this indication.

_____

_____

Is member currently hospitalized for this condition? ☐ Yes ☐ No

Has member ever been hospitalized for this condition? ☐ Yes. Dates of most recent hospitalization: _____
☐ No

Is member under the care of a neurologist? ☐ Yes ☐ No

Is member under the care of a psychiatrist? ☐ Yes ☐ No

Name of neurologist and/or psychiatrist: _____ Telephone no.: _____

Date of last visit with neurologist and/or psychiatrist: _____

Medication information: Section II

Please complete this section if indication is NOT for a seizure disorder. (This section does not need to be completed if indication is for a seizure disorder.)

Has member tried other medications for this condition?

- ☐ Yes. Complete box A.
- ☐ No. Explain why not. _____

A. Drug name

Dates of use	Dose and frequency

Briefly describe details of adverse reaction, inadequate response, intolerance, or other.

Note: You may be asked to provide supporting documentation (e.g., copies of medical records, office notes, and/or completed FDA MedWatch form).

Has member previously tried requested anticonvulsant?

- ☐ Yes. Complete box B.
- ☐ No. Explain why not. _____

B. Drug name

Dates and length of use	Maximum daily dose

Briefly describe how member responded to the requested anticonvulsant.

Note: You may be asked to provide supporting documentation (e.g., copies of medical records, office notes, and/or completed FDA MedWatch form).

Pharmacy information

Name	Pharmacy provider no.	Telephone no. ( )	Fax no. ( )	
Address		City	State	Zip

Prescriber information

Last name	First name	MI	MassHealth provider no.	DEA no.	
Address			City	State	Zip
E-mail address			Telephone no. ( )	Fax no. ( )	

Signature

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Prescriber's signature (Stamp not accepted.) Date

Commonwealth of Massachusetts
MassHealth Drug Utilization Review Program
P.O. Box 2586
Worcester, MA 01613-2586
Fax: 1-877-208-7428 **Phone:** 1-800-745-7318

Antidepressant Prior Authorization Request

MassHealth reviews requests for prior authorization (PA) on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

PA is required for Celexa, Effexor, Effexor XR, Lexapro, mirtazapine orally disintegrating tablets, paroxetine for members < 18 yrs of age, Paxil CR, Pexeva, Prozac Weekly, Remeron Soltab, Sarafem, Zoloft, Wellbutrin XL, and brand-name multiple-source antidepressants that have an FDA "A"-rated generic equivalent. PA is not needed for amoxapine, bupropion, fluoxetine, fluvoxamine, MAOIs, maprotiline, mirtazapine, nefazadone, paroxetine for members > 18 years of age, trazodone, tricyclic antidepressants, or Wellbutrin SR. Additional information about antidepressants can be found within the MassHealth Drug List at www.mass.gov/masshealth.

Member information

Last name	First name	MI	MassHealth member ID no.	Date of birth	Sex (Circle one.) f m
Member's place of residence	☐ home	☐ nursing facility			

Medication information

Antidepressant request

- ☐ Celexa
- ☐ Effexor
- ☐ Effexor XR
- ☐ Lexapro
- ☐ mirtazapine orally disintegrating tablet
- ☐ paroxetine for member <18 yrs of age
- ☐ Paxil CR
- ☐ Pexeva
- ☐ Prozac Weekly
- ☐ Remeron Soltab
- ☐ Sarafem
- ☐ Zoloft
- ☐ Wellbutrin XL
- ☐ Brand Name
- ☐ Other_____

Dose, frequency, and duration of requested drug

Drug NDC (if known)

Indication for antidepressant requested (Check all that apply.)

- ☐ Depression
- ☐ Panic disorder
- ☐ Obsessive-compulsive disorder
- ☐ Premenstrual dysphoric disorder
- ☐ Other (describe): _____

Please list all other psychotropic medications currently prescribed for the member.

_____

Has member been hospitalized for this condition?

☐ Yes. Dates of most recent hospitalization _____ ☐ No

Is member under the care of a psychiatrist? ☐ Yes ☐ No

Name of psychiatrist _____ Telephone no. _____

Date of last visit or consult with psychiatrist_____

Medication information continued

Has member tried fluoxetine, fluvoxamine, or paroxetine?

☐ Yes. Complete box A.

☐ No. Explain why not.

_____

_____

_____

_____

_____

_____

A. Drug name

Dates of use	Dose and frequency

Did member experience any of the following?

☐ Adverse reaction ☐ Inadequate response ☐ Intolerance ☐ Other

☐ Concern about drug interaction with _____

Briefly describe details of adverse reaction, inadequate response, intolerance, or other.

_____

_____

Note: You may be asked to provide supporting documentation (e.g., copies of medical records, office notes, and/or completed FDA MedWatch form).

Has member previously tried requested antidepressant?

☐ Yes. Complete box B.

☐ No.

_____

_____

_____

_____

_____

B. Drug name

Dates and length of use	Maximum daily dose

Briefly describe how member responded to the requested antidepressant.

_____

_____

_____

Note: You may be asked to provide supporting documentation (e.g., copies of medical records, office notes, and/or completed FDA MedWatch form).

Pharmacy information

Name	Pharmacy provider no.	Telephone no. ( )	Fax no. ( )	
Address		City	State	Zip

Prescriber information

Last name	First name	MI	MassHealth provider no.	DEA no.	
Address			City	State	Zip
E-mail address			Telephone no. ( )	Fax no. ( )	

Signature

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

_____

Prescriber's signature (Stamp not accepted.) Date

Commonwealth of Massachusetts
MassHealth Drug Utilization Review Program
P.O. Box 2586
Worcester, MA 01613-2586
Fax: 1-877-208-7428 **Phone:** 1-800-745-7318

Antipsychotic Prior Authorization Request

MassHealth reviews requests for prior authorization (PA) on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

PA is required for Risperdal M and Zyrexa Zydis. Brand-name Clozaril requires PA because it has an FDA "A"-rated generic. (Please use the Brand Name Drug Prior Authorization Request form for PA requests for brand-name Clozaril.)

PA is required for duplicative antipsychotic pharmacotherapy, or an overlap of 60 days or more in prescriptions (for any dosage form), of two or more of the following atypical antipsychotics: Abilify, Geodon, Risperdal, Seroquel, and Zyprexa. Additional information about antipsychotics can be found within the MassHealth Drug List at **www.mass.gov/masshealth**

Member information

Last name	First name	MI	MassHealth member ID no.	Date of birth	Sex (Circle one.) f m
Member's place of residence	☐ home	☐ nursing facility			

Medication information

Indication for antipsychotic requested (Check one or all that apply.)

☐ Schizophrenia ☐ Bipolar disorder ☐ Other: _____

Has member been hospitalized for this condition?

☐ Yes. Dates of most recent hospitalization: _____ ☐ No

Is member under the care of a psychiatrist? ☐ Yes ☐ No

Name of psychiatrist: _____ Telephone no.: _____

Date of last visit with psychiatrist: _____

Section I

Please complete Section I for a PA request for any of the following:

☐ Risperdal M
☐ Zyrexa Zydis
☐ Other: _____

Dose, frequency, and duration of requested antipsychotic

Drug NDC (if known) or service code

Please explain rationale for requested dosage form(s) or other.

Has member tried other medications to treat this condition?

☐ Yes. Please provide details of previous treatment(s), including drug name(s), dates of use and response to treatment(s).

☐ No. Explain why not.

Please list all other psychotropic medications currently prescribed for this member.

Medication information (cont.)

Section II

Please complete Section II for a PA request due to duplicative antipsychotic pharmacotherapy.

- ☐ Abilify (aripiprazole)
- ☐ Geodon (ziprasidone)
- ☐ Risperdal (risperidone)
- ☐ Seroquel (quetiapine)
- ☐ Zyprexa (olanzapine)

Dose, frequency, and duration of fi st requested antipsychotic	Drug NDC (if known) or service code
Dose, frequency, and duration of second requested antipsychotic	Drug NDC (if known) or service code

Please describe trial with each individual agent as monotherapy and start dates.

Please list all other psychotropic medications currently prescribed for the member.

Pharmacy information

Name	Pharmacy provider no.	Telephone no. ( )	Fax no. ( )	
Address		City	State	Zip

Prescriber information

Last name	First name	MI	MassHealth provider no.	DEA no.	
Address			City	State	Zip
E-mail address			Telephone no. ( )	Fax no. ( )	

Signature

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Prescriber's signature (Stamp not accepted.) Date

Commonwealth of Massachusetts
MassHealth Drug Utilization Review Program
P.O. Box 2586
Worcester, MA 01613-2586
Fax: 1-877-208-7428 **Phone:** 1-800-745-7318

Erythropoietin Prior Authorization Request

MassHealth reviews requests for prior authorization (PA) on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

Prior authorization is required for all erythropoietin products. Information about which drugs require PA can be found within the MassHealth Drug List at **www.mass.gov/masshealth**.

Member information

Last name	First name	MI	MassHealth member ID no.	Date of birth	Sex (Circle one.) f m
Member's place of residence	☐ home	☐ nursing facility	Height	Weight	

Medication information (When appropriate, please consider multidose vial use.)

Drug name requested	Dose, frequency, and duration	Drug NDC (if known) or service code

Indication for erythropoietin (Check one or all that apply.):

☐ Chronic renal failure
Is the member on hemodialysis? ☐ Yes ☐ No
(Please Note: If member is on hemodialysis, please contact dialysis clinic for proper billing procedure.)
Please provide most recent serum creatinine and/or creatinine clearance.

☐ Renal transplant

☐ Cancer chemotherapy
Please provide type of cancer and dates chemotherapy will be given.

☐ Hepatitis C
Please provide antiviral medication regimen and any dose adjustments attempted.

☐ HIV
Please provide medication regimen.

☐ Anemic surgical patient
Type of procedure: _____
Date of procedure: _____

Please provide medical necessity for the use of erythropoietin:

☐ Other
Please provide medical necessity for the use of erythropoietin

Laboratory information

Current Hematocrit/Hemoglobin: _____ date: _____

Erythropoietin level (if available): _____

Have other causes of anemia been ruled out (hemolysis, iron, vitamin B12, and folate deficiency)? Yes ☐ No ☐

If no, please provide further justificatiion for erythropoietin.

_____

Continuation of therapy

Please complete sections above about indication for erythropoietin and labratory information.

Please provide documentation of member's response to therapy (e.g., quality of life, activities of daily living).

_____

Has member been transfused in past six months? ☐ Yes ☐ No

If yes, please provide explanation. _____

Target hematocrit: _____

If target hematocrit has been met, please provide plan for decreasing dose. _____

Pharmacy information

Name	Pharmacy provider no.	Telephone no. ( )	Fax no. ( )	
Address		City	State	Zip

Prescriber information

Last name	First name	MI	MassHealth provider no.	DEA no.	
Address			City	State	Zip
E-mail address			Telephone no. ( )	Fax no. ( )	

Signature

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

_____

Prescriber's signature (Stamp not accepted.) Date

Commonwealth of Massachusetts
MassHealth Drug Utilization Review Program
P.O. Box 2586
Worcester, MA 01613-2586
Fax: 1-877-208-7428 **Phone:** 1-800-745-7318

Forteo Prior Authorization Request

MassHealth reviews requests for prior authorization (PA) on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

PA is required for Forteo.

Additional information about Forteo can be found within the MassHealth Drug List at **www.mass.gov/masshealth.**

Member information

Last name	First name	MI	MassHealth member ID no.	Date of birth	Sex (Circle one.) f m
Member's place of residence	☐ home	☐ nursing facility			

Medication information

Section I

Forteo 20 mcg SQ once a day

Forteo _____ (Please specify dosing regimen and rationale for this regimen.)

Indication for Forteo (Check one or all that apply.)

☐ Post menopausal osteoporosis (PMO) ☐ Primary/Hypogonadal osteoporosis ☐ Other: _____

Has member had a radiographically confirmed fracture?

☐ Yes. Please provide site of fracture and date of occurence (if known): _____

☐ No.

Date/results of baseline BMD measurements: Please provide baseline T-scores of total hip and lumbar vertebrae (L1-L4).

_____

_____

Date/results of any subsequent BMD measurements: Please provide T-scores of total hip and lumbar vertebrae (L1-L4).

_____

_____

Is member under the care of a rheumatologist or endocrinologist? ☐ Yes ☐ No

Name of rheumatologist or endocrinologist: _____

Date of last visit with rheumatologist or endocrinologist: _____

Please list all supplements and medications currently prescribed for this member.

_____

_____

Please list all non-modifiable risk factors for fracture in this member.

_____

_____

Medication information (cont.)

Section II

Has member tried alendronate (Fosamax) to treat this condition?

☐ Yes. Complete box A. ☐ No. Explain why not. _____

A. Dates of use	Dose and frequency

Did member experience any of the following? ☐ Adverse reaction ☐ Inadequate response ☐ Other

Briefly describe details of adverse reaction, inadequate response, or other: _____

Has member tried risedronate (Actonel) to treat this condition?

☐ Yes. Complete box B. ☐ No. Explain why not. _____

B. Dates of use	Dose and frequency

Did member experience any of the following? ☐ Adverse reaction ☐ Inadequate response ☐ Other

Briefly describe details of adverse reaction, inadequate response, or other: _____

Has member tried raloxifene (Evista) to treat this condition?

☐ Yes. Complete box C. ☐ No. Explain why not. _____

C. Dates of use	Dose and frequency

Did member experience any of the following? ☐ Adverse reaction ☐ Inadequate response ☐ Other

Briefly describe details of adverse reaction, inadequate response, or other: _____

Pharmacy information

Name	Pharmacy provider no.	Telephone no. ( )	Fax no. ( )	
Address		City	State	Zip

Prescriber information

Last name	First name	MI	MassHealth provider no.	DEA no.	
Address			City	State	Zip
E-mail address			Telephone no. ( )	Fax no. ( )	

Signature

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

_____

Prescriber's signature (Stamp not accepted.) Date

Commonwealth of Massachusetts
MassHealth Drug Utilization Review Program
P.O. Box 2586
Worcester, MA 01613-2586
Fax: 1-877-208-7428 **Phone:** 1-800-745-7318

Fuzeon Prior Authorization Request

MassHealth reviews requests for prior authorization (PA) on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

Prior authorization is required for Fuzeon. Additional information about which drugs require PA can be found within the MassHealth Drug List at **www.mass.gov/masshealth**.

Member information

Last name	First name	MI	MassHealth member ID no.	Date of birth	Sex (Circle one.) f m
Member's place of residence	☐ home	☐ nursing facility	Height	Weight	

Medical and medication information (Please provide copies of all pertinent medical records.)

Laboratory Results

Date	CD4 (cells/ml)	Plasma RNA (copies/ml)

If the CD4 count is > 500 cells/ml or plasma RNA is < 1000 copies/ml, please provide further justification for Fuzeon use.

Resistance testing
Please provide documentation of 2-class resistance, including copies of genotype/phenotype. If not available, please provide further justification for Fuzeon use (treatment history, etc.).

Intolerance to medications
Please list adverse reactions to antiretroviral medications.

Treatment plan
Please provide proposed treatment plan.

Medical and medication information (cont.)

Fuzeon dose ☐ 90 mg SC BID
Other (specify) _____

Please explain rationale for doses other than Fuzeon 90 mg SC BID.

_____

_____

Continuation of therapy

If member is currently receiving Fuzeon therapy, please provide date started: _____

Please list baseline (CD4 (cells/ml) and plasma RNA (copies/ml) prior to start of Fuzeon.)

_____

_____

Pharmacy information

Name	Pharmacy provider no.	Telephone no. ( )	Fax no. ( )	
Address		City	State	Zip

Prescriber information

Last name	First name	MI	MassHealth provider no.	DEA no.	
Address			City	State	Zip
E-mail address			Telephone no. ( )	Fax no. ( )	

Signature

I understand that if this patient does not show an adequate response to this medication within six months, reapproval will not be granted. I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

_____

Prescriber's signature (Stamp not accepted.) Date

Commonwealth of Massachusetts
MassHealth Drug Utilization Review Program
P.O. Box 2586
Worcester, MA 01613-2586
Fax: 1-877-208-7428 **Phone:** 1-800-745-7318

G-CSF/GM-CSF Prior Authorization Request

MassHealth reviews requests for prior authorization (PA) on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

Prior authorization is required for all G-CSF/GM-CSF products. Information about which drugs require PA can be found within the MassHealth Drug List at **www.mass.gov/masshealth**.

Member information

Last name	First name	MI	MassHealth member ID no.	Date of birth	Sex (Circle one.) f m
Member's place of residence	☐ home	☐ nursing facility	Height	Weight	

Medication information

Drug name requested	Dose, frequency, and duration	Drug NDC (if known) or service code

Indication for G-CSF/GM-CSF (Check one or all that apply):

☐ Autologous bone marrow transplant

☐ Chronic neutropenia

Etiology _____

☐ Peripheral blood progenitor cell collection and therapy

☐ Other (please explain):

☐ Drug induced neutropenia (Check one or all that apply.)

☐ Cancer chemotherapy:
Indicate type of cancer and chemotherapy regimen including dates, frequency, and duration.

☐ Hepatitis C
Indicate dates and current dosages of medication regimen.

Has dose adjustment been attempted?
(Check one or all that apply.):
☐ Yes. Please provide details.
☐ No. Explain why not.

☐ HIV
Is member currently receiving antiretroviral therapy?
(Check one or all that apply.):
☐ Yes. Please provide details.
☐ No. Explain why not.

Laboratory monitoring

Please provide date and results of the most recent CBC with differential or absolute neutrophil count (ANC).

_____

_____

_____

Pharmacy information

Name	Pharmacy provider no.	Telephone no. ( )	Fax no. ( )	
Address		City	State	Zip

Prescriber information

Last name	First name	MI	MassHealth provider no.	DEA no.	
Address			City	State	Zip
E-mail address			Telephone no. ( )	Fax no. ( )	

Signature

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

_____

Prescriber's signature (Stamp not accepted.) Date

Commonwealth of Massachusetts
MassHealth Drug Utilization Review Program
P.O. Box 2586
Worcester, MA 01613-2586
Fax: 1-877-208-7428 **Phone:** 1-800-745-7318

Growth Hormone Adult Prior Authorization Request

MassHealth reviews requests for prior authorization (PA) on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

Prior authorization is required for all growth hormone products. Information about which drugs require PA can be found within the MassHealth Drug List at **www.mass.gov/masshealth**.

Member information

Last name	First name	MI	MassHealth member ID no.	Date of birth	Sex (Circle one.) f m
Member's place of residence	☐ home	☐ nursing facility			

Medication information

Drug name requested	Dose, frequency, and duration	Drug NDC (if known) or service code

Indication for GH: For HIV wasting, fill out Section A. For growth hormone deficiency (GHD) syndrome in adults, fill out Section B.

Section A
HIV wasting - Initial prior authorization

Current height	Current weight	Date

Premorbid weight	Date	Diagnosis

CD4 count	Date	Has member intentionally lost weight? ☐ Yes ☐ No

Describe attempted nutritional supplementation _____

Has member attempted therapy with dronabinol (Marinol) or megestrol acetate (Megace)? If so, provide dates and duration. If not, please explain why.

Describe current antiretroviral therapy. _____

Any known tumors? ☐ Yes ☐ No	Is this a female patient who is pregnant? ☐ Yes ☐ No

HIV wasting - Reauthorization

Current height	Current weight	Date

Has member maintained or gained weight with GH treatment? _____

Medication information (cont.)

Section B
Growth hormone deficiency (GHD) syndrome in adults

Current height	Current weight	Date

Is the growth hormone deficiency adult onset? ☐ Yes ☐ No

If so, provide etiology of GH deficiency. _____

Please provide dates and results of GH stimulation tests performed. If stimulation test was not performed, please explain why not. _____

IGF-I level	Date

Provide detailed signs and symptoms of growth hormone deficiency syndrome and provide documentation of diagnostic procedures, lab tests, radiological tests, and clinical findings. _____

Any known tumors? ☐ Yes ☐ No	Is this a female patient who is pregnant? ☐ Yes ☐ No

Provide date of last appointment with endocrinologist

Pharmacy information

Name	Pharmacy provider no.	Telephone no. ( )	Fax no. ( )	
Address		City	State	Zip

Prescriber information

Last name	First name	MI	MassHealth provider no.	DEA no.	
Address			City	State	Zip
E-mail address			Telephone no. ( )	Fax no. ( )	

Signature

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

_____

Prescriber's signature (Stamp not accepted.) Date

Commonwealth of Massachusetts
MassHealth Drug Utilization Review Program
P.O. Box 2586
Worcester, MA 01613-2586
Fax: 1-877-208-7428 **Phone:** 1-800-745-7318

Growth Hormone Pediatric Prior Authorization Request

MassHealth reviews requests for prior authorization (PA) on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

Prior authorization is required for all growth hormone products. Information about which drugs require PA can be found within the MassHealth Drug List at **www.mass.gov/masshealth**.

Member information

Last name	First name	MI	MassHealth member ID no.	Date of birth	Sex (Circle one.) f m
Member's place of residence	☐ home	☐ nursing facility			

Medication information

Drug name requested	Dose, frequency, and duration	Drug NDC (if known) or service code

GH pediatric indications

Indication for growth hormone requested (Check one or all that apply.)

- ☐ Growth hormone deficienc
- ☐ Growth reduction due to chronic renal failure
- ☐ Noonan syndrome
- ☐ Prader Willi syndrome (Provide documentation of genetic testing)
- ☐ Small for gestational age with failed catch-up by age 2
- ☐ Turner syndrome (Provide documentation of genetic testing.)
- ☐ Other: _____

Fill in applicable information below. You may be asked to provide supporting documents (e.g., copies of medical records, office notes, growth charts, diagnostic studies, laboratory tests and/or completed MedWatch form).

Current height	Current weight	Date

Growth rate in past year cm	Date of GH stimulation tests

Provide type of GH stimulation tests performed and results _____

IGF-I level	Date	Bone age exam results	Date

Any known tumors? ☐ Yes ☐ No	Is this a female patient who is pregnant? ☐ Yes ☐ No

Provide date of last appointment with endocrinologist.

Pharmacy information

Name	Pharmacy provider no.	Telephone no. ( )	Fax no. ( )	
Address		City	State	Zip

Prescriber information

Last name	First name	MI	MassHealth provider no.	DEA no.	
Address			City	State	Zip
E-mail address			Telephone no. ( )	Fax no. ( )	

Signature

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Prescriber's signature (Stamp not accepted.) Date

Commonwealth of Massachusetts
MassHealth Drug Utilization Review Program
P.O. Box 2586
Worcester, MA 01613-2586
Fax: 1-877-208-7428 **Phone:** 1-800-745-7318

Hypnotic Prior Authorization Request

MassHealth reviews requests for prior authorization (PA) on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

PA is required for Doral (single-source brand-name benzodiazepine) and any brand-name multiple-source benzodiazepine that has an FDA "A"-rated generic equivalent as identified by the ***Approved Drug Products with Therapeutic Equivalence Evaluations*** (also called the "Orange Book").

PA is also required for quantity requests greater than 10 units per month for hypnotics. Additional information about hypnotic use can be found within the MassHealth Drug List at **www.mass.gov/masshealth.**

Member information

Last name	First name	MI	MassHealth member ID no.	Date of birth	Sex (Circle one.) f m
Member's place of residence	☐ home	☐ nursing facility			

Medication information

Hypnotic request	**Quantity**
☐ Ambien (zolpidem)	____
☐ Dalmane # (flurazepam)	____
☐ Doral (quazepam)	____
☐ Halcion # (triazolam)	____
☐ ProSom # (estazolam)	____
☐ Restoril # (temazepam)	____
☐ Sonata (zaleplon)	____
☐ Other _____	____

Dose, frequency, and duration of requested drug	Drug NDC (if known)

A. If request is for Doral or any brand-name multiple-source benzodiazepine (as denoted by the # symbol), please complete Sections **I** and **II**.

B. If request is for quantities greater than 10 units per month, please complete Section **II**.

Section I

Please complete this section for requests for Doral or brand-name multiple-source benzodiazepine.

Attach supporting documentation (e.g., copies of medical records, office notes, and/or completed FDA MedWatch form).

Has member tried a generic benzodiazepine?

☐ Yes. Please complete the following information.

Drug name

Dates of use

Dose and frequency

☐ No. Explain why not.

_____

_____

_____

_____

Did member experience any of the following?

☐ Adverse reaction ☐ Inadequate response ☐ Other

Briefly describe details of adverse reaction, inadequate response, or other.

_____

_____

_____

☐ No.

Medication information

Section II

Please attach supporting documentation (e.g., copies of medical records, office notes, sleep evaluation) for your response to **each** question.

If the request is for quantities greater than 10 units per month of a hypnotic, please attach a detailed description of your treatment plan of the condition for which you have requested the hypnotic. Include all nonpharmacologic and pharmacologic interventions, therapeutic endpoints, and a list of the member's current medications.

A. Indication for hypnotic

☐ Acute insomnia ☐ Transient insomnia

☐ Other _____

B. Is insomnia secondary to a vital concurrent medication or diagnosis?

☐ Yes. Briefly describe and attach documentation.

_____

_____

☐ No.

C. Has member had a sleep evaluation?

☐ Yes. Briefly describe and attach documentation.

_____

_____

☐ No. Explain why not.

_____

_____

D. Has member been counseled on good sleep hygiene practices?

☐ Yes. Briefly describe and attach documentation.

_____

_____

☐ No. Explain why not.

_____

_____

E. Is request for quantities greater than 10 units per month of a hypnotic?

☐ Yes. Briefly describe and attach documentation, including detailed treatment plan.

_____

_____

☐ No.

Pharmacy information

Name	Pharmacy provider no.	Telephone no. ( )	Fax no. ( )	
Address		City	State	Zip

Prescriber information

Last name	First name	MI	MassHealth provider no.	DEA no.	
Address			City	State	Zip
E-mail address			Telephone no. ( )	Fax no. ( )	

Signature

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

_____

Prescriber's signature (Stamp not accepted.) Date

Commonwealth of Massachusetts
MassHealth Drug Utilization Review Program
P.O. Box 2586
Worcester, MA 01613-2586
Fax: 1-877-208-7428 **Phone:** 1-800-745-7318

Immune Globulin Intravenous (IGIV) Prior Authorization Request

MassHealth reviews requests for prior authorization (PA) on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

IGIV requires prior authorization. Additional information about which drugs require PA can be found within the MassHealth Drug List at **www.mass.gov/masshealth**.

Member information

Last name	First name	MI	MassHealth member ID no.	Date of birth	Sex (Circle one.) f m
Member's place of residence	☐ home	☐ nursing facility	Height	Weight	

Medication information

Drug name requested	Dose, frequency, and duration	Drug NDC (if known) or service code

Provide rate of administration. **Note:** Rate of administration may require adjustment for members with or at risk for renal dysfunction.

Indication for IGIV (Check one or all that apply.):

☐ Immunodeficiency syndrome

☐ Idiopathic thrombocytopenic purpura (ITP)

☐ B-cell chronic lymphocytic leukemia (CLL)

☐ Kawasaki disease
Provide date of onset. _____

☐ Bone marrow transplantation
Provide type and date of transplant.
_____
_____

☐ Pediatric HIV infection
Provide date and result of most recent CD4 count _____
_____

☐ Other (describe):
_____
_____
_____
_____
_____
_____

Pharmacy information

Name	Pharmacy provider no.	Telephone no. ( )	Fax no. ( )	
Address		City	State	Zip

Prescriber information

Last name	First name	MI	MassHealth provider no.	DEA no.	
Address			City	State	Zip
E-mail address			Telephone no. ( )	Fax no. ( )	

Signature

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Prescriber's signature (Stamp not accepted.) Date

Commonwealth of Massachusetts
MassHealth Drug Utilization Review Program
P.O. Box 2586
Worcester, MA 01613-2586
Fax: 1-877-208-7428 **Phone:** 1-800-745-7318

Narcotic Prior Authorization Request

MassHealth reviews requests for prior authorization (PA) on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

PA is required for quantity requests greater than 30 patches/month for Duragesic and/or 90 tablets/month for OxyContin. PA is also required for dosages that exceed 200 mcg/hour for Duragesic and/or 240 mg/day for OxyContin.

Effective May 1, 2004, hydromorphone powder, levorphanol powder, and oxycodone powder will require PA. Effective June 1, 2004, Duragesic and OxyContin will require PA. Additional information about which drugs require PA can be found within the MassHealth Drug List at **www.mass.gov/masshealth**.

Member information

Last name	First name	MI	MassHealth member ID no.	Date of birth	Sex (Circle one.) f m
Member's place of residence	☐ home	☐ nursing facility			

Medication information

Section I

Narcotic request **Strength** **Quantity**
(Complete a separate line for each strength prescribed.)

☐ Duragesic (fentanyl) _____ _____
☐ Duragesic (fentanyl) _____ _____
☐ OxyContin (oxycodone) _____ _____
☐ OxyContin (oxycodone) _____ _____
☐ Other: _____

Dose, frequency, and duration of requested drug

Drug NDC (if known) or service code

Indication (Check one or all that apply.)

☐ Cancer pain (specify type and stage): _____
☐ AIDS: _____ ☐ Other (specify): _____

Please specify: ☐ Active treatment ☐ Palliative care

Please complete for all narcotic PA requests.

Has member tried sustained-release morphine or methadone?

☐ Yes. Complete box below. ☐ No. Explain why not. _____

Drug name

Dates of use

Dose and frequency

Did member experience any of the following?

☐ Adverse reaction ☐ Inadequate response ☐ Other

Details of adverse reaction, inadequate response, or other:

How is the member's response to treatment being measured (e.g., pain-assessment scales, activity level)?

Medication information (cont.)

Section II

Please complete if the request is for Duragesic at doses > 200 mcg/hour, for OxyContin at doses > 240 mg/day, or for compounds.

Is the member under the care of a pain specialist? ☐ Yes ☐ No

Name of specialist: _____ Phone no.: ( ) _____

Date of last visit or consult with pain specialist: _____

What is the complete pain-management regimen, including other pain medications, adjunctive therapy, and/or controlled substances? Please include the names and doses of these medications. _____

Has the member had a psychological evaluation? ☐ Yes ☐ No

Does the member:

have a history of substance abuse or dependence? ☐ Yes ☐ No

have a history of alcohol abuse or dependence? ☐ Yes ☐ No

Does the member have a treatment agreement (e.g., lock-in pharmacy and prescriber, early refill policy, consequences of nonadherence to treatment)?

☐ Yes (Attach copies.) ☐ No (Explain why not.)

Pharmacy information

Name	Pharmacy provider no.	Telephone no. ( )	Fax no. ( )	
Address		City	State	Zip

Prescriber information

Last name	First name	MI	MassHealth provider no.	DEA no.	
Address			City	State	Zip
E-mail address			Telephone no. ( )	Fax no. ( )	

Signature

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Prescriber's signature (Stamp not accepted.) Date

Commonwealth of Massachusetts
MassHealth Drug Utilization Review Program
P.O. Box 2586
Worcester, MA 01613-2586
Fax: 1-877-208-7428 **Phone:** 1-800-745-7318

Nonsteroidal Anti-Inflammatory Drugs (NSAID) Prior Authorization Request

MassHealth reviews requests for prior authorization (PA) on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

PA is required for Bextra, Celebrex, Vioxx, Mobic, and Arthrotec. In addition, PA is required for Ponstel (single-source brand-name NSAID) and any brand-name multiple-source NSAID that has an FDA "A"-rated generic equivalent as identified by the ***Approved Drug Products with Therapeutic Equivalence Evaluations*** (also called the "Orange Book"). Additional information about nonsteroidal use can be found within the MassHealth Drug List at **www.mass.gov/masshealth**.

Member information

Last name	First name	MI	MassHealth member ID #	Date of birth	Sex (Circle one.) f m
Member's place of residence	☐ home	☐ nursing facility			

Medication information

Please complete section 1 below **or** section 2 on back, depending on the drug requested.

1. Cox-2 Inhibitor/Arthrotec request

☐ Arthrotec (misoprostol/diclofenac)
☐ Celebrex (celecoxib) ☐ Bextra (valdecoxib)
☐ Mobic (meloxicam) ☐ Vioxx (rofecoxib)

Dose, frequency, and duration of requested drug

Drug NDC (if known)

Is member under 60 years of age? ☐ Yes ☐ No

Indications (Check one.)
☐ Osteoarthritis ☐ Primary dysmenorrhea ☐ Familial adenomatous polyposis (celecoxib only: FDA-approved)
☐ Rheumatoid arthritis ☐ Acute pain ☐ Other, specify _____

Is member at risk for a clinically significant gastrointestinal event, as defined by one of the following?

☐ Yes (Check one.)
- ○ Previous history: ☐ Major GI bleed ☐ Perforation ☐ Obstruction — Dates
- ○ Previous history of a peptic ulcer documented by endoscopy or radiograph — Dates

☐ Concomitant therapy with any of the following (Check one.)
- ○ Aspirin
- ○ Oral corticosteroid: dose, frequency, and duration _____
- ○ Warfarin: dose, frequency, and duration _____

☐ No. Has member tried two generic NSAID products?
- ○ Yes. Complete boxes 3A and 3B on back (Generic NSAID product courses).
- ○ No. Explain why not. _____

Medication information continued

2.

Brand-name multiple-source NSAID or Ponstel request	Dose, frequency, and duration of requested drug	Drug NDC (if known)
Diagnosis pertinent to requested medication		

Has member tried two generic products?

☐ Yes. Complete boxes 3A and 3B below (Generic NSAID product courses).

☐ No. Explain why not. _____

3. Generic NSAID product courses

A. Drug name		**B.** Drug name	
Dates of generic use	Dose and frequency	Dates of generic use	Dose and frequency
Did member experience any of the following? ☐ Adverse reaction ☐ Inadequate response ☐ Other		Did member experience any of the following? ☐ Adverse reaction ☐ Inadequate response ☐ Other	
Details of adverse reaction, inadequate response, or other		Details of adverse reaction, inadequate response, or other	

Pharmacy information

Name	Pharmacy provider no.	Telephone ( )	Fax ( )	
Address		City	State	Zip

Prescriber information

Last name	First name	MI	MassHealth provider no.	DEA #	
Address			City	State	Zip
E-mail address			Telephone ( )	Fax ( )	

Signature

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Prescriber's signature (Stamp not accepted.) Date

DUR program use only

Reviewer's decision ☐ Approved ☐ Pended ☐ Denied

Comments/reasons for pended or denied decision _____

Commonwealth of Massachusetts
MassHealth Drug Utilization Review Program
P.O. Box 2586
Worcester, MA 01613-2586
Fax: 1-877-208-7428 **Phone:** 1-800-745-7318

Proton Pump Inhibitor Prior Authorization Request

MassHealth reviews requests for prior authorization (PA) on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

PA is required for Aciphex, Nexium, and omperazole and brand-name multiple-source proton pump inhibitors that have an FDA "A"-rated generic equivalent. PA is required for Prevacid for members older than 16 years old (except for use of Prevacid suspension for members in long-term-care facilities). Protonix does not require PA. Additional information about PPI use can be found within the MassHealth Drug List at **www.mass.gov/masshealth**.

Member information

Last name	First name	MI	MassHealth member ID #	Date of birth	Sex (Circle one.) f m

Member's place of residence ☐ home ☐ nursing facility

Indication for proton pump inhibitor

☐ **GERD**

- ☐ Moderate-severe erosive esophagitis
- ☐ Uncomplicated non-erosive esophagitis
  - Has an H_2 antagonist previously been tried?
  - ☐ Yes. State drug name, dose, frequency, and duration. _____
  - ☐ No. Explain why not. _____
- ☐ Barrett's esophagus or esophageal strictures
- ☐ GERD in child with one of the following conditions:
  - ☐ Severe chronic respiratory disease (specify): _____
  - ☐ Neurologic disability (specify): _____
  - ☐ Other (specify): _____

☐ **Condition associated with extraesophageal symptoms secondary to gastric reflux**

- ☐ Non-cardiac chest pain
- ☐ Asthma
- ☐ Idiopathic hoarseness
- ☐ Chronic laryngitis
- ☐ Other (explain): _____

☐ **Duodenal ulcer** ☐ **Gastric ulcer**

- ☐ Helicobacter pylori:
  - ☐ Positive ☐ Negative
- ☐ Drug-induced:
  - ☐ Treatment: List causative agent(s): _____
  - ☐ Prevention: List risk factor(s): _____
- ☐ Other cause (specify): _____

☐ **Non-ulcer or functional dyspepsia**

- Has an H_2 antagonist previously been tried?
  - ☐ Yes. State drug name, dose, frequency, and duration. _____
  - ☐ No. Explain why not. _____

☐ **Pathological hypersecretory syndromes**

- ☐ Zollinger-Ellison syndrome
- ☐ MEN Type I
- ☐ Other: _____

☐ **Other** (explain):

Diagnostic studies performed (include dates of studies)

Describe any diagnostic studies performed, including dates of studies.

Medication information

Important Note: For maximum efficacy, a proton pump inhibitor (PPI) must be taken in a fasting state, just before or with breakfast. If a second dose is necessary, the second dose should be given just before the evening meal. In general, it is not necessary to prescribe other antisecretory agents (H_2 antagonists, prostaglandins) for patients on PPIs. If an antisecretory agent is prescribed with a PPI, the PPI should not be taken within six hours of the antisecretory agent.

PPI requested	Dose, frequency, and duration of PPI	Drug or service code

Has member tried Protonix? (**Note:** Protonix does not require prior authorization.)

☐ Yes. Provide the following information about the use of Protonix.

Dates of use	Dose and frequency

If member received Protonix, why was it discontinued? (Check one or all that apply.)

☐ Adverse reaction ☐ Inadequate response ☐ Intolerance ☐ Other

Details of adverse reaction, inadequate response, intolerance, or other:

☐ No. Explain why not.

Pharmacy information

Name	Pharmacy provider no.	Telephone no. ( )	Fax no. ( )	
Address		City	State	Zip

Prescriber information

Last name	First name	MI	MassHealth provider no.	DEA no.	
Address			City	State	Zip
E-mail address			Telephone no. ( )	Fax no. ( )	

Signature

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Prescriber's signature (Stamp not accepted.) Date

Commonwealth of Massachusetts
MassHealth Drug Utilization Review Program
P.O. Box 2586
Worcester, MA 01613-2586
Fax: 1-877-208-7428 **Phone:** 1-800-745-7318

Statin Prior Authorization Request

MassHealth reviews requests for prior authorization (PA) on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

PA is required for quantities greater than 30 units per month for all statins. In addition to the quantity limits, PA is required for Advicor, Altocor, Mevacor, Pravachol, and Zocor. **PA will not be required for quantities less than or equal to 30 units per month for Crestor, Lescol, Lescol XL, Lipitor, or generic lovastatin.** Additional information about statins can be found within the MassHealth Drug List at **www.mass.gov/masshealth.**

Member information

Last name	First name	MI	MassHealth member ID no.	Date of birth	Sex (Circle one.) f m
Member's place of residence	☐ home	☐ nursing facility			

Medication information

Please complete if the request is for quantities greater than 30 units/month.

Statin request	Quantity per month
☐ Advicor	_____
☐ Altocor	_____
☐ Crestor	_____
☐ Lescol	_____
☐ Lescol XL	_____
☐ Lipitor	_____
☐ lovastatin	_____
☐ Mevacor (brand name)	_____
☐ Pravachol	_____
☐ Zocor	_____

Dose, frequency, and duration of requested drug

Drug or service code

Indication for statin requested (Check one or all that apply.)

☐ Hypertriglyceridemia ☐ Primary hypercholesterolemia
☐ Mixed dyslipidemia ☐ Secondary prevention of cardiovascular event
☐ Other. Specify pertinent medical history, diagnostic studies, and/or laboratory results.

_____
_____
_____
_____
_____
_____

Section I Please complete Section I if your request is for more than 30 units per month.

Please provide a rationale for requested dose quantity and frequency, including a detailed treatment plan. (Specify pertinent medical history, diagnostic studies and/or lab results.)

_____
_____

Is member a candidate for dose consolidation? (e.g., member is on Lipitor 10 mg BID, and dose can be consolidated to Lipitor 20 mg QD, **which does not require PA**). ☐ Yes ☐ No

Please provide rationale for a regimen of greater than one unit per day. _____
_____

Medication information (cont.)

Section II Please complete Section II if your request is for Advicor, Altocor, Mevacor (brand name), Pravachol, or Zocor.

Has member tried two of the following statins: Crestor, Lescol/Lescol XL, Lipitor, or generic lovastatin?

☐ Yes. Complete boxes A and B.

☐ No. Explain why not.

A. Drug name

Dates of use	Dose and frequency

Did member experience any of the following?

☐ Adverse reaction ☐ Inadequate response ☐ Other

Briefly describe details of adverse reaction, inadequate response, or other.

B. Drug name

Dates of use	Dose and frequency

Did member experience any of the following?

☐ Adverse reaction ☐ Inadequate response ☐ Other

Briefly describe details of adverse reaction, inadequate response, or other.

Note: You may be asked to provide supporting documentation (e.g., copies of medical records, office notes, and/or completed FDA MedWatch form).

Pharmacy information

Name	Pharmacy provider no.	Telephone no. ( )	Fax no. ( )	
Address		City	State	Zip

Prescriber information

Last name	First name	MI	MassHealth provider no.	DEA no.	
Address			City	State	Zip
E-mail address			Telephone no. ( )	Fax no. ( )	

Signature

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Prescriber's signature (Stamp not accepted.) Date

Commonwealth of Massachusetts
MassHealth Drug Utilization Review Program
P.O. Box 2586
Worcester, MA 01613-2586
Fax: 1-877-208-7428 **Phone:** 1-800-745-7318

Strattera Prior Authorization Request

MassHealth reviews requests for prior authorization (PA) on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

PA is required for Strattera (atomoxetine). Additional information about which drugs require PA can be found within the MassHealth Drug List at **www.mass.gov/masshealth.**

Member information

Last name	First name	MI	MassHealth member ID no.	Date of birth	Sex (Circle one.) f m
Member's place of residence	☐ home	☐ nursing facility			

Medication information

Strattera request (Check one or all that apply.)	Dose, frequency, and duration	Drug NDC (if known) or service code
☐ Strattera 10 mg ☐ Strattera 18 mg ☐ Strattera 25 mg ☐ Strattera 40 mg ☐ Strattera 60 mg	**Note:** The manufacturer recommends an initial dose of 0.5 mg/kg/day for children and adolescents weighing < 70 kg with a target dose of 1.2 mg/kg/day. The maximum dose is 1.4 mg/kg/day or 100 mg, whichever is lower. In patients weighing more than 70 kg, the recommended initial dose is 40 mg daily with a targeted dose up to 80 mg. Daily dose of Strattera should not exceed 100 mg. Indication (Check one or all that apply.) ☐ Attention Deficit Hyperactivity Disorder (ADHD) ☐ Other (Explain.) _____	

Is member under the care of a psychiatrist or behavioral specialist? ☐ Yes ☐ No

Name of psychiatrist or behavioral specialist _____

Telephone no.: _____ Date of last visit: _____

Please list all medications currently prescribed for this member for this condition.

_____

_____

Please describe your new treatment plan for managing this member's condition, including discontinuation of any medications as a result of the addition of Strattera.

_____

_____

Medication information (cont.)

Has member tried other medications in the methylphenidate class (i.e., Concerta, Focalin, Metadate, Methylin, or Ritalin) to treat this condition? ☐ Yes. Complete box A. ☐ No. Explain why not. _____

A. Drug name	Dates of use	Dose and frequency

Did member experience any of the following? ☐ Adverse reaction ☐ Inadequate response ☐ Intolerance ☐ Other

Briefly describe details of adverse reaction, inadequate response, intolerance, or other. _____

Has member tried other medications in the amphetamine/dextroamphetamine class (i.e., Adderall or Dexedrine) to treat this condition?

☐ Yes. Complete box B. ☐ No. Explain why not. _____

B. Drug name	Dates of use	Dose and frequency

Did member experience any of the following? ☐ Adverse reaction ☐ Inadequate response ☐ Intolerance ☐ Other

Briefly describe details of adverse reaction, inadequate response, intolerance, or other. _____

Has member tried other non-stimulant medications to treat this condition?

☐ Yes. Complete box C. ☐ No. Explain why not. _____

C. Drug name	Dates of use	Dose and frequency

Did member experience any of the following? ☐ Adverse reaction ☐ Inadequate response ☐ Intolerance ☐ Other

Briefly describe details of adverse reaction, inadequate response, intolerance, or other. _____

Note: You may be asked to provide supporting documentation (e.g., copies of medical records, office notes, and/or completed FDA MedWatch form).

Pharmacy information

Name	Pharmacy provider no.	Telephone no. ( )	Fax no. ( )	
Address		City	State	Zip

Prescriber information

Last name	First name	MI	MassHealth provider no.	DEA no.	
Address			City	State	Zip
E-mail address			Telephone no. ( )	Fax no. ( )	

Signature

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

_____

Prescriber's signature (Stamp not accepted.) Date

Commonwealth of Massachusetts
MassHealth Drug Utilization Review Program
P.O. Box 2586
Worcester, MA 01613-2586

Fax: 1-877-208-7428 **Phone:** 1-800-745-7318

Triptan Prior Authorization Request

MassHealth reviews requests for prior authorization (PA) on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

PA is required for Amerge, Frova, Imitrex tablets and nasal spray, Maxalt, Maxalt-MLT, Relpax and Zomig nasal spray. **PA is not needed for Axert, Zomig, or Zomig-ZMT for quantity requests less than or equal to six units per month or for Imitrex injections for quantity requests less than or equal to two units (four injections) per month.** Additional information about triptans can be found within the MassHealth Drug List at **www.mass.gov/masshealth.**

Member information

Last name	First name	MI	MassHealth member ID no.	Date of birth	Sex (Circle one.) f m

Member's place of residence ☐ home ☐ nursing facility

Medication information

Triptan request / **Quantity request**

- ☐ Amerge tablet _____
- ☐ Axert tablet _____
- ☐ Frova tablet _____
- ☐ Imitrex injection _____
- ☐ Imitrex nasal spray _____
- ☐ Imitrex tablet _____
- ☐ Maxalt tablet _____
- ☐ Maxalt-MLT tablet _____
- ☐ Relpax tablet _____
- ☐ Zomig nasal spray _____
- ☐ Zomig tablet _____
- ☐ Zomig-ZMT tablet _____
- ☐ Other: _____

Dose, frequency, and duration of requested drug

Drug NDC (if known)

Indication for triptan requested (Check one.)

☐ Acute treatment of migraine

Frequency of migraine attacks (number/month) _____

Is member currently on migraine prophylaxis?

☐ No. Explain why not. _____

☐ Yes. Specify agent(s), dose, and frequency. _____

☐ Other. Specify pertinent medical history, diagnostic studies, and/or laboratory tests.

Please attach supporting documentation (e.g., copies of medical records and/or office notes).

Has member tried the following triptans: Axert and Zomig, or Zomig-ZMT?

☐ Yes. Complete boxes A and B.

☐ No. Explain why not.

A. Dates of Axert use

Dose and frequency

Did member experience any of the following?

☐ Adverse reaction ☐ Inadequate response ☐ Other

Briefly describe details of adverse reaction, inadequate response, or other.

Please attach supporting documentation (e.g., copies of medical records, office notes, and/or completed FDA MedWatch form).

Is the member under the care of a neurologist?

☐ Yes.

☐ No.

Name of neurologist

Telephone No. _____

Date of last visit or consult

B. Dates of Zomig or Zomig-ZMT use

Dose and frequency

Did member experience any of the following?

☐ Adverse reaction ☐ Inadequate response ☐ Other

Briefly describe details of adverse reaction, inadequate response, or other.

Please attach supporting documentation (e.g., copies of medical records, office notes, and/or completed FDA MedWatch form).

Pharmacy information

Name	Pharmacy provider no.	Telephone no. ( )	Fax no. ( )	
Address		City	State	Zip

Prescriber information

Last name	First name	MI	MassHealth provider no.	DEA no.	
Address			City	State	Zip
E-mail address			Telephone no. ( )	Fax no. ( )	

Signature

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Prescriber's signature (Stamp not accepted.) Date

Commonwealth of Massachusetts
MassHealth Drug Utilization Review Program
P.O. Box 2586
Worcester, MA 01613-2586
Fax: 1-877-208-7428 **Phone:** 1-800-745-7318

Brand-Name Drug Prior Authorization Request

MassHealth reviews requests for prior authorization (PA) on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

Prescribers must obtain PA from MassHealth for any brand-name multiple-source drug that has an FDA "A"-rated generic equivalent as identified by the ***Approved Drug Products with Therapeutic Equivalence Evaluations*** (also called the "Orange Book"). Additional information about which drugs require PA can be found within the MassHealth Drug List at **www.mass.gov/masshealth**.

Member information

Last name	First name	MI	MassHealth member ID No.	Date of birth	Sex (Circle one.) f m
Member's place of residence	☐ home	☐ nursing facility			

Medication information

Brand-name drug requested	Dose, frequency, and duration of brand-name drug	Drug or service code
Diagnosis pertinent to requested medication		

Has member tried a generic product?

☐ Yes. Provide the following information.

Drug name	
Dates of generic use	Dose and frequency

Did member experience any of the following?

☐ Adverse reaction ☐ Inadequate response ☐ Other

Details of adverse reaction, inadequate response, or other: _____

☐ No. Explain why not.

_____

Pharmacy information

Name	Pharmacy provider no.	Telephone No. ( )	Fax No. ( )	
Address		City	State	Zip

Prescriber information

Last name	First name	MI	MassHealth provider no.	DEA No.	
Address			City	State	Zip
E-mail address			Telephone No. ( )	Fax No. ( )	

Signature

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Prescriber's signature (Stamp not accepted.) Date

Commonwealth of Massachusetts
MassHealth Drug Utilization Review Program
P.O. Box 2586
Worcester, MA 01613-2586
Fax: 1-877-208-7428 **Phone:** 1-800-745-7318

Drug Prior Authorization Request

MassHealth reviews requests for prior authorization (PA) on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

Information about which drugs require PA can be found within the MassHealth Drug List at **www.mass.gov/masshealth**

Member information

Last name	First name	MI	MassHealth member ID no.	Date of birth	Sex (Circle one.) f m
Member's place of residence	☐ home	☐ nursing facility	Height	Weight	

Medication information

Drug name requested	Dose, frequency, and duration	Drug NDC (if known) or service code
Diagnosis and/or indication		
Goals of therapy for requested medication		

Has member tried other medications to treat this condition?

☐ Yes. Provide the information to the right. You may be asked to provide supporting documentation (e.g., copies of medical records, office notes, and/or completed FDA MedWatch form).

☐ No. Explain why not.

Drug name

Dates of use | Dose and frequency

Did member experience any of the following?

☐ Adverse reaction ☐ Inadequate response ☐ Other

Briefly describe details of adverse reaction, inadequate response, or other.

Drug name

Dates of use | Dose and frequency

Did member experience any of the following?

☐ Adverse reaction ☐ Inadequate response ☐ Other

Briefly describe details of adverse reaction, inadequate response, or other.

Medication information (cont.)

Explain medical necessity of requested drug.

List all current medications.

Other pertinent information:

Diagnostic studies and/or laboratory tests performed (include dates and results)

Pharmacy information

Name	Pharmacy provider no.	Telephone no. ( )	Fax no. ( )	
Address		City	State	Zip

Prescriber information

Last name	First name	MI	MassHealth provider no.	DEA no.	
Address			City	State	Zip
E-mail address			Telephone no. ( )	Fax no. ( )	

Signature

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Prescriber's signature (Stamp not accepted.) Date

Commonwealth of Massachusetts
Executive Office of Health and Human Services
Division of Medical Assistance
www.state.ma.us/dma/

MassHealth Pharmacy Program Anticonvulsant Initiative

1. **The following generic anticonvulsants DO NOT require prior authorization (PA). PA is required for the brand name product, unless a particular form of that drug does not have a FDA "A" rated generic equivalent. Brand name Dilantin (phenytoin), however, does not require PA.**

   carbamazepine
   clonazepam
   clorazepate
   diazepam
   ethosuximide
   phenobarbital
   phenytoin
   primidone
   valproate
   valproic acid

2. **The following brand name anticonvulsants, in any dosage form, DO NOT require PA:**

   Carbatrol (carbamazepine)
   Celontin (methsuximide)
   Depakote (divalproex)
   Dilantin (phenytoin)
   Felbatol (felbamate)
   Lamictal (lamotrigine)
   Mebaral (mephobarbital)
   Peganone (ethotoin)
   Phenytek (phenytoin)
   Trileptal (oxcarbazepine)
   Zonegran (zonisamide)

3. **The following anticonvulsants DO require prior authorization effective 6/2/03:**

Gabitril (tiagabine)	PA > 18 years
Keppra (levetiracetam)	PA
Neurontin (gabapentin)	PA > 18 years
Topamax (topiramate)	PA > 18 years

Commonwealth of Massachusetts
Executive Office of Health and Human Services
www.mass.gov/masshealth

MassHealth Pharmacy Program Antidepressant Initiative

A. The following antidepressant drugs DO NOT require prior authorization (PA):

amoxapine
bupropion
fluoxetine
fluvoxamine
MAO Inhibitors
maprotiline
mirtazapine
nefazodone
paroxetine – No PA > 18 years
trazodone
tricyclic antidepressants
Wellbutrin SR (bupropion sustained release)

B. The following antidepressant drugs DO require prior authorization:

mirtazapine, orally disintegrating tablet – PA (effective 05/03/04)
Remeron (mirtazapine) – PA
Remeron Sol Tab (mirtazapine, orally disintegrating tablet) – PA (effective 05/03/04)
Symbyax (fluoxetine/olanzapine) – PA
Wellbutrin XL (buproprion extended-release) – PA

C. The following antidepressant drugs DO require prior authorization, unless criteria D.i. and/or D.ii. below have been met:

Celexa (citalopram) – PA
Effexor (venlafaxine) – PA
Effexor-XR (venlafaxine extended-release) – PA
Lexapro (escitalopram) – PA
Luvox (fluvoxamine) – PA
paroxetine – PA < 18 years
Paxil (paroxetine) – PA
Paxil CR (paroxetine controlled-release) – PA
Pexeva (paroxetine) – PA
Prozac (fluoxetine) – PA
Prozac Weekly (fluoxetine) – PA
Sarafem (fluoxetine) – PA
Serzone (nefazodone) – PA
Zoloft (sertraline) – PA

D. Antidepressant drug PA modifications for stable patients, treatment failure, and duplicative therapy:

i. **Stable patients**
No PA will be required for an antidepressant prescription (and the prescriber will not be required to submit a paper PA form) if, over the last six months, the patient has filled a prescription for a cumulative supply of at least 100 days of any antidepressant medication, **except** when the addition of this drug would constitute polypharmacy (see C. iii. below). *

ii. **Treatment failure**
Any antidepressant listed in Section B. Prescriber must provide documentation that member has failed treatment with **at least** one generic selective serotonin reuptake inhibitor.

iii. **Duplicative Therapy**
PA is required when the patient has an overlap of 60 days or more in prescriptions for any dosage form of two or more of the following drugs:

Celexa (citalopram)
Effexor (venlafaxine)
Effexor-XR (venlafaxine extended-release)
fluoxetine
fluvoxamine
Lexapro (escitalopram)
Luvox (fluvoxamine)
paroxetine
Paxil (paroxetine)
Paxil CR (paroxetine controlled-release)
Pexeva (paroxetine)
Prozac (fluoxetine)
Prozac Weekly (fluoxetine)
Sarafem (fluoxetine)
Zoloft (sertraline)

MassHealth encourages prescribers to use the Antidepressant Prior Authorization Request form when requesting prior authorization for any of the above antidepressants. See the Antidepressants Table for more information about selected antidepressants.

** Note: The decision on whether PA is required is based upon information available in the MassHealth pharmacy database. The MassHealth database contains member drug utilization information exclusive to MassHealth, and no other health plans*

Commonwealth of Massachusetts
Executive Office of Health and Human Services
Division of Medical Assistance
www.state.ma.us/dma/

MassHealth Pharmacy Program Asthma Initiative

1. **Respiratory inhalant products that DO NOT require prior authorization (PA):**

Inhaled Short-Acting Beta-2 Agonists
albuterol (generic)
metaproterenol (generic)
inhalation solution

Inhaled Long-Acting Beta-2 Agonists
Foradil (formoterol)
Serevent (salmeterol)

Inhaled Corticosteroids
AeroBid (flunisolide)
Azmacort (triamcinolone)
Flovent (fluticasone)
Qvar (beclomethasone)
Pulmicort (budesonide)
Vanceril (beclomethasone)

Inhaled Combination Products
Advair (fluticasone/salmeterol)
DuoNeb (albuterol/ipratropium)
Combivent (albuterol/ipratropium)

Miscellaneous Inhaled Products
Atrovent #(ipratropium)
Intal # (cromolyn)
Tilade (nedocromil)

2. **Respiratory inhalant products that DO require PA effective June 2, 2003:**

Inhaled Beta-2 Agonists
Alupent (metaproterenol) inhaler
Maxair (pirbuterol)
Proventil (albuterol)
Proventil HFA (albuterol)
Ventolin (albuterol)
Ventolin HFA (albuterol)
Xopenex (levalbuterol)

Inhaled Corticosteroids
AeroBid-M (flunisolide)

3. **Use of more than one canister per month of a short-acting beta-2 agonist may indicate inadequate control of asthma and the need for initiating or intensifying anti-inflammatory therapy.**

4. **The following oral asthma medications require PA (and the prescriber is required to submit a paper PA form) if, over the last six months, the member has not filled a prescription for an inhaled short- or long-acting beta-2 agonist or corticosteroid effective June 2, 2003. ***

Accolate (zafirlukast) PA > 16 years
Singulair (montelukast) PA > 16 years
Zyflo (zileuton) PA > 16 years

 # This is a brand-name drug with FDA "A" rated-generic equivalents. PA is required for the brand, unless a particular form of that drug does not have an FDA "A"rtated generic equivalent.

**Note: The decision on whether PA is required is based upon information available in the MassHealth pharmacy database. The MassHealth database contains member drug utilization information exclusive to MassHealth, and no other health plans.*

Commonwealth of Massachusetts
Executive Office of Health and Human Services
www.mass.gov/masshealth

MassHealth Pharmacy Program Atypical Antipsychotic Initiative

1. **PA is required for most atypical antipsychotic duplicative therapy, which is defined as an overlap of 60 days or more in prescriptions (for any dosage form) of two or more of the following atypical antipsychotics:**

   Abilify (aripiprazole)
   Geodon (ziprasidone)
   Risperdal (risperidone)
   Seroquel (quetiapine)
   Zyprexa (olanzapine)

2. **Generic clozapine does not require prior authorization (PA) when prescribed either alone or in concert with another atypical antipsychotic. Brand name Clozaril requires PA because it has an FDA "A"-rated generic.**

3. **Risperdal Consta (risperidone injection) does not require PA when prescribed either alone or in concert with another atypical antipsychotic.**

4. **The following atypical antipsychotics require prior authorization:**

   Fazaclo (clozapine, orally disintegrating tablet) – PA
   Risperdal M (risperidone, orally disintegrating tablet) – PA
   Symbyax (olanzapine/fluoxetine) – PA
   Zyprexa Zydis (olanzapine, orally disintegrating tablet) – PA
   Zyprexa IM (olanzapine injection) – PA

MassHealth encourages prescribers to use the Antipsychotic Prior Authorization Request form when requesting prior authorization for any of the above antipsychotics. See the Atypical Antipsychotics Table for more information about selected antipsychotics.

** Note: The decision on whether PA is required is based upon information available in the MassHealth pharmacy database. The MassHealth database contains member drug utilization information exclusive to MassHealth, and no other health plans.*

Commonwealth of Massachusetts
Executive Office of Health and Human Services
www.mass.gov/masshealth

MassHealth Pharmacy Program Pain Initiative

1) **The following schedule II long-acting narcotic analgesics will require prior authorization (PA) for dose effective September 1, 2004:**

   levorphanol (Levo-Dromoran #) – PA > 32 mg/day
   methadone (Dolophine #, Methadose #) – PA > 120 mg/day
   morphine controlled-release (MS Contin #, Oramorph SR, generics) – PA > 360 mg/day
   morphine sustained-release (Kadian) – PA > 360 mg/day

2) **The following schedule II short-acting narcotic analgesics require PA for dose effective October 1, 2004:**

   codeine – PA > 360 mg/day
   hydromorphone (Dilaudid #) – PA > 60 mg/day
   meperidine (Demerol #) – PA > 750 mg/day
   morphine immediate release (MS/L, MSIR, OMS, Roxanol, Roxanol-T) – PA > 360 mg/day
   oxycodone immediate release (Endocodone, Oxydose, OxyFast, Oxy IR, Roxicodone) – PA > 240 mg/day

3) **The following drugs will continue to require PA:**

   butorphanol, nasal spray (Stadol nasal spray) – PA
   fentanyl transmucosal system (Actiq) – PA
   fentanyl transdermal system (Duragesic) – PA[1]
   hydromorphone powder – PA
   ketamine powder – PA
   levorphanol powder – PA
   morphine extended-release (Avinza) – PA
   oxycodone powder – PA
   oxycodone/acetaminophen (Percocet) – PA
   oxycodone controlled release (OxyContin, generics) – PA

This is a brand-name drug with FDA "A"- rated-generic equivalents. PA is required for the brand, unless a particular form of that drug does not have an FDA "A"- rated generic equivalent.

[1]**For fentanyl transdermal system (Duragesic) and oxycodone controlled release (OxyContin, generics):**
Members will be exempt from PA if a pharmacy received a paid claim for these drugs for the Member within the past 90 days and are filling no more than 30 patches/month or 200 mcg/hr of Duragesic (fentanyl transdermal system) or 90 tablets/month of OxyContin (oxycodone controlled release). Note: The decision on whether PA is required is based on information available in the MassHealth pharmacy database. The MassHealth database contains member drug utilization information exclusive to MassHealth, and no other health plans.

MassHealth Quick Reference Guide

Alpha-1 Adrenergic Blockers

doxazosin
prazosin
terazosin
Flomax — **PA**
Uroxatral — **PA**

Angiotensin Converting Enzyme Inhibitors

benazepril
captopril
enalapril
fosinopril
lisinopril
moexipril
Accupril — **PA**
Aceon — **PA**
Altace — **PA**
Mavik — **PA**

Angiotensin II Receptor Antagonists

Atacand — **PA**
Avapro — **PA**
Benicar — **PA**
Cozaar — **PA**
Diovan — **PA**
Micardis — **PA**
Teveten — **PA**

Anticonvulsants

carbamazepine
clonazepam
clorazepate
diazepam
ethosuximide
phenobarbital
phenytoin
primidone
valproate
valproic acid
Carbatrol
Celontin
Depakote
Dilantin
Felbatol
Lamictal
Mebaral
Peganone
Trileptal
Zonegran
Gabitril — **PA > 18 yrs.**
Keppra — **PA**
Neurontin — **PA > 18 yrs.**
Topamax — **PA > 18 yrs.**

Antidepressants

buproprion
buproprion SR
fluoxetine
fluvoxamine
MAOIs
maprotiline
mirtazapine
nefazodone
paroxetine — **no PA > 18 yrs.**
TCAs
trazodone
Celexa — **PA**
Effexor — **PA**
Lexapro — **PA**
Paxil CR — **PA**
Prozac Weekly — **PA**
Sarafem — **PA**
Wellbutrin XL — **PA**
Zoloft — **PA**

Antidiabetic Agents

acetohexamide
chlorpropamide
glipizide
glipizide ER
glyburide
metformin
metformin ER
tolazamide
tolbutamide
Actos
Avandia
Amaryl — **PA**
Diabeta — **PA**
Glyset — **PA**
Insulin, Prefilled Syr — **PA**
Prandin — **PA**
Precose — **PA**
Starlix — **PA**

Antihistamines

brompheniramine
chlorpheniramine
diphenhydramine
loratadine
Allegra — **PA**
Clarinex — **PA**
Zyrtec Syrup — **PA > 12 yrs.** except in **LTC**

Antipsychotics

Abilify *
clozapine
Fazaclo — **PA**
Geodon*
Risperdal *
Risperdal M — **PA**
Seroquel *
Zyprexa *
Zyprexa IM — **PA**
Zyprexa Zydis — **PA**

**PA* required for polypharmacy (overlap of more than 60 days).*

Asthma

albuterol
Advair
Aerobid
Atrovent #
Azmacort
Combivent
Flovent
Foradil
Intal #
Pulmicort
Qvar
Serevent
Tilade
Vanceril
Aerobid-M — **PA**
Alupent — **PA**
Maxair — **PA**
Proventil HFA — **PA**
Ventolin HFA — **PA**
Xopenex — **PA**

Beta Adrenergic Blocking Agents

acebutolol
atenolol
betaxolol
bisoprolol
esmolol
labetalol
nadolol
pindolol
propranolol
sotalol
timolol
Inderal LA #
Toprol XL
Cartrol — **PA**
Coreg — **PA**
Innopran XL — **PA**
Levatol — **PA**

Calcium Channel Blocking Agents

diltiazem
nicardipine
nifedipine
verapamil
Nimotop
Dynacirc — **PA**
Norvasc — **PA**
Plendil — **PA**
Sular — **PA**
Vascor — **PA**

COX-2 NSAIDs

Bextra — **PA < 60 yrs.**
Celebrex — **PA < 60 yrs.**
Vioxx — **PA < 60 yrs.**

Generic non-selective NSAID formulations do not require prior authorization.

H_2 Antagonists

cimetidine
famotidine
nizatidine — **PA**
ranitidine

Hypnotics

estazolam — **Q**
flurazepam — **Q**
temazepam — **Q**
triazolam — **Q**
Ambien — **Q**
Sonata — **Q**

***PA** > 10 units/ month for above hypnotics.*

Leukotrienes

Accolate — **PA > 16 yrs.**
Singulair — **PA > 16 yrs.**
Zyflo — **PA > 16 yrs.**

Narcotic Agonist Analgesics

Duragesic — **PA**
levorphanol — **Q**
methadone — **Q**
morphine CR — **Q**
morphine SR — **Q**
oxycodone ER — **PA**
Oxycontin — **PA**

Nasal Steroids

flunisolide — **Q**
Beconase AQ — **Q**
Flonase — **Q**
Nasacort — **Q**
Nasacort AQ — **Q**
Nasalide # — **Q**
Nasarel — **Q**
Nasonex — **Q**

***PA**> 1 unit/month for all except Rhinocort Aqua (**PA** > 1unit 2months).*

Proton Pump Inhibitors

Protonix
omeprazole — **PA**
Aciphex — **PA**
Nexium — **PA**
Prevacid — **PA > 16 yrs. (except for SUSP for LTC)**

Statins

lovastatin — **Q**
Crestor — **Q**
Lescol — **Q**
Lescol XL — **Q**
Lipitor — **Q**
Advicor — **PA**
Altocor — **PA**
Pravachol — **PA**
Zocor — **PA**

***Quantity limit** > 30 units/month for all statins.*

Triptans

Amerge — **PA**
Axert — **Q**
Frova — **PA**
Imitrex Tab — **PA**
Imitrex Nasal — **PA**
Imitrex Inj. — **Q**
Maxalt — **PA**
Relpax — **PA**
Zomig — **Q**

August 2004

This document does not represent the complete MassHealth Drug List. For more information, please visit the MassHealth website at www.mass.gov/masshealth.

MassHealth may update the Drug List as frequently as twice a month. MassHealth will update the List as necessary on the first business day of the month or 14 calendar days later or both.

PA denotes prior authorization is required. Prior-authorization forms can be found at www.mass.gov/masshealth

This is a brand-name drug with FDA "A"-rated generic equivalents. PA is required for the brand, unless a particular form of that drug does not have an FDA "A"-rated generic equivalent.

Q PA is required to exceed certain quantity limits. **LTC** denotes Long Term Care

10 Tips for a Good Night's Sleep

1. **Keep consistent bedtimes and wake times seven days a week** (even after a "bad" night).

2. A person should only stay in bed equal to the number of hours of sleep they are achieving per night (for example, if you are getting six hours of sleep per night you should plan bedtime and wake time as six hours apart). **Many insomniacs spend far too much time in bed**, attempting to "squeeze" out a few more minutes of sleep.

3. If you have difficulty getting to sleep within 20 minutes, **get out of bed** and do something relaxing and distracting. For many people this is reading. **Do not do housework, bills, work, or anything that is too stimulating within two hours of bedtime or during a nighttime awakening**.

4. Although some people's insomnia is helped by a **nap** at midday, for most, it **will interfere with falling asleep that night**.

5. **Avoid alcohol** within five hours of bedtime. Alcohol is a poor hypnotic and causes nighttime awakenings.

6. **Avoid caffeine** (coffee, tea, soda, chocolate) after noon. Even if it doesn't prevent you from falling asleep, it can cause shallow sleep or nighttime awakenings.

7. **Avoid** going to bed on either an **empty stomach or a full stomach**. A light snack may be of value.

8. **Bedrooms should be quiet, safe, and relaxing**. Clocks should face away from the bed, so as not to "count down" the minutes until morning.

9. **Daily exercise** will improve insomnia, although the effects may not be immediate.

10. **Schedule "worry time"** earlier in the day, so as to consider the day's problems and find some resolution **before** getting into bed.

John Winkelman, MD, PhD
Medical Director, Sleep Health Center
Brigham and Women's Hospital
Assistant Professor of Psychiatry
Harvard Medical School

The MassHealth Drug List is updated monthly, as needed.
Check our Web site for the most up-to-date information.
www.mass.gov/druglist

Commonwealth of Massachusetts
Executive Office of Health and Human Services
MassHealth