

South Carolina Department of Health and Human Services Preferred Drug List  
 Products Within PDL Therapeutic Classes Are Available Without Prior Authorization (PA)  
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August, 2009

**ANALGESIC**

**NSAIDs**

Diclofenac Potassium  
 Diclofenac Sodium  
 Diflunisal  
 Etodolac  
 Fenoprofen  
 Flurbiprofen  
 Ibuprofen  
 Indomethacin  
 Indomethacin SR  
 Ketoprofen  
 Ketoprofen ER  
 Ketorolac  
 Meclofenamate Sod.  
 Nabumetone  
 Naproxen  
 Naproxen Sodium  
 Oxaprozin  
 Piroxicam  
 Sulindac  
 Tolmetin Sodium

**NSAIDs, RECEPTOR SELECTIVE<sup>á</sup>**

Celebrex<sup>®</sup>  
 Meloxicam

<sup>á</sup> Class level PA is in effect for this class. Once criteria are met, the agents listed on the PDL are preferred.

**OPIOIDS, EXTENDED RELEASE**

Duragesic<sup>®</sup> Patch  
 Kadian<sup>®</sup>  
 Morphine Sulfate ER<sup>á</sup>

**TOPICAL NSAIDS AND ANESTHETICS**

<sup>á</sup> All agents in this class require Prior Authorization.

**ANTI-INFECTIVE**

**ANTIBACTERIALS**

**CEPHALOSPORINS, 2ND GENERATION**

Cefprozil  
 Cefuroxime

**CEPHALOSPORINS, 3RD GENERATION**

Cefdinir (all dosage forms)  
 Spectracef<sup>®</sup> Tablets

**MACROLIDES/KETOLIDES**

Azithromycin  
 Clarithromycin  
 Clarithromycin XL  
 EryPed<sup>®</sup>  
 Ery-Tab<sup>®</sup>  
 Erythromycin Base  
 Erythromycin Estolate  
 Erythromycin Ethylsuc.  
 Erythromycin Stearate  
 Erythrocin Stearate  
 Erythromycin & Sulfisox.

**QUINOLONES, 2ND AND 3RD GENERATION**

Avelox<sup>®</sup>  
 Ciprofloxacin  
 Ofloxacin

<sup>á</sup> Prescribers are encouraged to ensure compliance with FDA approved indications.

**ANTIFUNGALS, ORAL**

**ONYCHOMYCOSIS AGENTS**

Gris-Peg<sup>®</sup>  
 Griseofulvin  
 Terbinafine

**ANTIPROTOZOALS, ORAL**

**NITROIMIDAZOLES**

Metronidazole

**ANTIVIRALS, ORAL**

**HERPES ANTIVIRALS**

Acyclovir  
 Famciclovir  
 Valtrex<sup>®</sup>

**CARDIOVASCULAR**

**ACE INHIBITORS (ACEI)**

Benazepril  
 Benazepril/HCTZ  
 Captopril  
 Enalapril  
 Enalapril/HCTZ  
 Lisinopril  
 Lisinopril/HCTZ

**ACEI, CCB COMBINATIONS**

Lotrel<sup>®</sup>  
 Tarka<sup>®</sup>

**ANGIOTENSIN RECEPTOR BLOCKERS (ARB)**

Avalide<sup>®</sup>  
 Avapro<sup>®</sup>  
 Benicar<sup>®</sup>  
 Benicar HCT<sup>®</sup>  
 Cozaar<sup>®</sup>  
 Diovan<sup>®</sup>  
 Diovan HCT<sup>®</sup>  
 Hyzaar<sup>®</sup>  
 Micardis<sup>®</sup>  
 Micardis HCT<sup>®</sup>  
 Teveten<sup>®</sup>  
 Teveten HCT<sup>®</sup>

**BETA BLOCKERS**

Acebutolol  
 Atenolol  
 Atenolol/Chlorthalidone  
 Betaxolol  
 Bisoprolol Fumarate  
 Bisoprolol/HCTZ  
 Carvedilol  
 Labetolol  
 Metoprolol Tartrate  
 Nadolol  
 Pindolol  
 Propranolol  
 Propranolol ER  
 Propranolol/HCTZ  
 Sotalol  
 Timolol

**CALCIUM CHANNEL BLOCKERS (CCB), DIHYDROPYRIDINES**

Amlodipine  
 Dynacirc CR<sup>®</sup>  
 Felodipine  
 Isradipine  
 Nicardipine  
 Nifedical XL<sup>®</sup>  
 Nifedipine ER and SA

**CALCIUM CHANNEL BLOCKERS (CCB), NON-DIHYDROPYRIDINES**

Cartia XT<sup>®</sup>  
 Diltia XT<sup>®</sup>  
 Diltiazem  
 Diltiazem ER and XR  
 Taztia XT<sup>®</sup>  
 Verapamil  
 Verapamil ER  
 Verapamil SR

**CCB/ARB COMBINATION PRODUCTS**

Exforge<sup>®</sup>  
 Exforge HCT<sup>®</sup>

**DIRECT RENIN INHIBITORS**

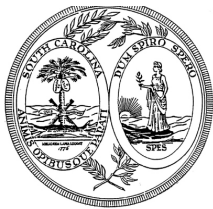
Tekturna<sup>®</sup><sup>á</sup>  
 Tekturna HCT<sup>®</sup><sup>á</sup>

<sup>á</sup> Prior authorization is required if an ARB has not been prescribed previously for the patient.

**ENDOTHELIN RECEPTOR ANTAGONISTS**

Tracleer<sup>®</sup><sup>á</sup>

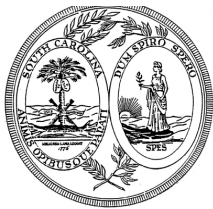
<sup>á</sup> Patients currently established on non-preferred therapy will be grandfathered.



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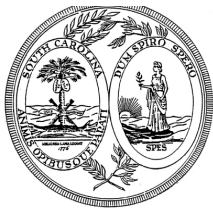
<b>LIPOTROPICS</b>	<b>NMDA RECEPTOR ANTAGONIST</b>	<b>ANTI-MIGRAINE AGENTS</b>	<b>SEDATIVE/HYPNOTICS, NON-BARBITURATES</b>
<b>BILE ACID SEQUESTERING RESINS</b>	Namenda®	<b>SELECTIVE SEROTONIN AGONISTS<sup>á</sup></b>	Temazepam Zolpidem
Cholestyramine Cholestyramine Light Colestipol Welchol®	<b>ANTI-CONVULSANT AGENTS</b>	Sumatriptan Tablets Sumatriptan Injection Sumatriptan Nasal Spray Treximet®	<b>ENDOCRINE AND METABOLIC</b>
<b>FIBRIC ACID DERIVATIVES</b>	<b>CARBAMAZEPINE DERIVATIVES</b>	<sup>á</sup> See the listing at: <a href="http://southcarolina.fhsc.com">http://southcarolina.fhsc.com</a> for the quantity limits for this class. (Click on Providers, then Documents, then Pharmacy Quantity Limits.)	<b>ANTI-DIABETICS</b>
Gemfibrozil Lofibra® Tricor® Trilipix®	Carbamazepine (all dosage forms) Carbatrol® Eptol® Oxcarbazepine	<b>ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS</b>	<b>ALPHA-GLUCOSIDASE INHIBITORS</b>
<b>NIACIN DERIVATIVES</b>	<b>FIRST GENERATION ANTICONVULSANTS</b>	Adderall XR® Amphetamine Salt Combination Dexmethylphenidate Immediate Release Dextroamphetamine Dextroamphetamine SR Metadate ER® Methylin® Methylin ER® Methylphenidate Methylphenidate ER/SR Ritalin LA® <sup>á</sup> Concerta® <sup>á</sup> Focalin XR® <sup>á</sup> Vyvanse® <sup>á</sup>	Glyset® Acarbose
Niaspan®	Celontin® Depakote ER® Divalproex Sprinkles Ethosuximide Felbatol® Mephobarbital Phenytoin Phenytoin Sodium ER Primidone Valproic Acid	<sup>á</sup> Generic agents considered "first-line" when appropriate.	<b>AMYLIN ANALOGS<sup>á</sup></b>
<b>NIACIN/STATIN COMBINATIONS</b>	<sup>á</sup> Prior authorization is not required for Dilantin® if "Brand Medically Necessary" criteria are met.		Symlin®
Advicor® Simcor®	<b>SECOND GENERATION ANTICONVULSANTS</b>		<sup>á</sup> Prior authorization is required if patient is not currently receiving insulin therapy.
<b>STATINS</b>	Gabapentin Levetiracetam Lyrica® Topiramate Zonisamide	<b>MULTIPLE SCLEROSIS AGENTS</b>	<b>BIGUANIDES</b>
Altoprev® Crestor® Lescol® Lescol XL® Lipitor® Lovastatin Pravastatin Simvastatin Vytorin®		Avonex® Avonex Administration Pack® Betaseron® Copaxone® Rebif®	Metformin Metformin ER
<b>CHOLESTEROL-ABSORPTION INHIBITORS</b>		<b>PARKINSON'S AGENTS</b>	<b>BIGUANIDE COMBINATION AGENTS</b>
Zetia®		<b>NON-ERGOT DOPAMINE RECEPTOR AGONISTS</b>	ActoPlus Met® Avandamet®
<b>NON-NITRATE ANTIANGINALS</b>		Ropinirole	<b>DPP-4 INHIBITORS AND COMBINATIONS<sup>á</sup></b>
Ranexa®			Janumet® Januvia®
<b>CENTRAL NERVOUS SYSTEM</b>			<sup>á</sup> Prior authorization is required if metformin, a thiazolidinedione or a sulfonylurea has not been prescribed previously for the patient.
<b>ALZHEIMER'S AGENTS</b>			<b>INCRELIN MIMETICS<sup>á</sup></b>
<b>CHOLINESTERASE INHIBITORS</b>			Byetta®
Aricept® tablets Exelon® (Oral & Patches) Galantamine			<sup>á</sup> Prior authorization is required if metformin, a thiazolidinedione or a sulfonylurea product has not been prescribed previously for the patient.



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<b>INSULINS</b> Lantus® Vial Levemir® Vial Novolin® N Novolin® R Novolin® 70/30 Novolog® Novolog® Mix 70/30 Humalog® 50/50	<b>GROWTH HORMONE</b> Genotropin® Norditropin® Saizen®  <i>á Class level PA is in effect for this class. Once criteria are met, the agents listed on the PDL are preferred.</i>	<b>PROGESTINS FOR CACHEXIA</b> Megesterol Oral Susp  <b>GENITOURINARY</b>  <b>ALPHA BLOCKERS FOR BPH</b> Flomax® Uroxatral®	<b>ANDROGEN HORMONE INHIBITOR</b> Avodart® Finasteride
<b>MEGLITINIDES</b> Starlix®	<b>GASTROINTESTINAL</b>	<b>ANTISPASMODICS</b> Detrol LA® Enablex® Oxybutynin Oxytrol® Sanctura® VESicare®	<b>IMMUNOLOGICS</b>
<b>SULFONYLUREAS, SECOND GENERATION</b> Glimepiride Glipizide Glipizide ER Glyburide Glyburide Micronized	<b>ANTI-EMETICS (ORAL)</b>	<b>ANTICOAGULANTS – LOW MOLECULAR WEIGHT HEPARINS</b> Arixtra® Fragmin® Lovenox®	<b>IMMUNOMODULATORS, INJECTABLE</b> Enbrel® Humira®  <b>IMMUNOMODULATORS, TOPICAL</b> Elidel® á Protopic® á  <i>á Prescribers: Please use these agents as advised by the respective manufacturer and reserve for only those patients who have failed traditional eczema therapy.</i>
<b>THIAZOLIDINEDIONES</b> Actos® Avandia®	<b>NK1 ANTAGONISTS</b> Emend®	<b>HEMATOLOGICAL &amp; ONCOLOGICAL AGENTS</b>	<b>IMMUNOMODULATORS, ORAL AND INJECTABLE</b>
<b>THIAZOLIDINEDIONE / SULFONYLUREA COMBINATIONS</b> á Avandaryl® Duetact®  <i>á Prior authorization is required if a single agent thiazolidinedione or sulfonylurea product has not been prescribed previously for the patient.</i>	<b>SEROTONIN RECEPTOR ANTAGONISTS</b> Granisetron Ondansetron  <i>á See the listing at: <a href="http://southcarolina.fhsc.com">http://southcarolina.fhsc.com</a> for the quantity limits for this class. (Click on Providers, then Documents, then Pharmacy Quantity Limits.)</i>	<b>HEMATOPOIETIC AGENTS</b> Aranesp® Procrit®	<b>HEPATITIS B THERAPY</b> Baraclude® Epivir HBV® Hepsera® Tyzeka®  <i>*Viread® is unaffected by the PDL and is available without Prior Authorization.</i>
<b>ELECTROLYTE DEPLETERS</b> Fosrenol® Phoslo® Renagel®	<b>HISTAMINE-2 RECEPTOR ANTAGONISTS</b> Famotidine Ranitidine	<b>PLATELET INHIBITORS</b> Aggrenox® Plavix®	<b>HEPATITIS C THERAPY, PEGYLATED INTERFERONS*</b> Pegasys® & Conv. Pack Peg-Intron® & Redipen
<b>BIPHOSPHONATES - OSTEOPOROSIS</b> Alendronate	<b>PROTON PUMP INHIBITORS</b> á Nexium® Capsules Prevacid® Omeprazole OTC  <i>á Class level PA is in effect for this class. Once criteria are met, the agents listed on the PDL are preferred.</i>	<b>PROTEIN TYROSINE KINASE INHIBITORS</b> Gleevec®	<b>HEPATITIS C THERAPY, RIBAVIRINS *</b> Ribavirin
<b>CALCITONINS</b> Calcitonin Nasal Spray Fortical® Nasal Spray	<b>ULCERATIVE COLITIS THERAPY</b> Asacol® Balsalazide Disodium Canasa® Rectal Supp. Mesalamine Enema Pentasa® Sulfasalazine	<b>HORMONE RELATED THERAPY</b>  <b>ANDROGENIC AGENTS</b> Androderm® Androgel® Testim®	<i>á Class level PA is in effect for all Hepatitis C medications. Once criteria are met, the agents listed on the PDL are preferred.</i>



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#### IMMUNOSUPPRESSANTS

Azasan®  
Azathioprene  
Cyclosporine  
Gengraf®  
Imuran®  
Mycophenolate Mofetil  
Myfortic®  
Neoral®  
Prograf®  
Rapamune®  
Sandimmune®

#### OPHTHALMICS

##### ANTI-HISTAMINES, OPHTHALMIC

Pataday®  
Patanol®  
Elestat®

##### MAST CELL STABILIZERS, OPHTHALMIC

Alamast®  
Alocril®  
Alomide®  
Cromolyn Sodium

##### NSAIDs, OPTHALMIC

Acular®  
Acular LS®  
Acular PL®  
Diclofenac Sodium  
Flurbiprofen Sodium  
Nevanac®

##### GLAUCOMA THERAPY

##### ALPHA-2 ADRENERGICS

Brimonidine Tartrate  
Alphagan P®

##### BETA BLOCKERS

Betaxolol HCl  
Carteolol HCl  
Combigan®  
Levobunolol HCl  
Metipranolol  
Timolol Maleate

#### CARBONIC ANHYDRASE INHIBITORS

Azopt®  
Dorzolamide  
Dorzolamide -Timolol

#### PROSTAGLANDIN AGONISTS

Lumigan®  
Travatan®  
Travatan Z®  
Xalatan®

#### QUINOLONES & MACROLIDES, OPHTHALMIC

Ciprofloxacin HCl  
Vigamox®  
Zymar®

#### OTICS

##### QUINOLONES, OTIC

Ciprodex®  
Ofloxacin Otic Drops

#### RESPIRATORY

##### ANTI-CHOLINERGICS

Atrovent® HFA  
Combivent®  
Spiriva®

##### ANTI-HISTAMINES, 2nd GENERATION AND DECONGESTANT COMBINATIONS

Cetirizine  
Loratadine OTC  
Loratadine-D OTC

##### NASAL ANTIHISTAMINES

Astelin®  
Astepro®

#### BETA ADRENERGIC DEVICES, SHORT- ACTING INHALERS

Ventolin® HFA  
Xopenex® HFA

#### BETA ADRENERGIC DEVICES, LONG-ACTING METERED DOSE INHALERS

Serevent Diskus®  
á Prescribers are reminded of  
the warnings associated with  
the use of long acting beta  
agonists.

#### BETA ADRENERGIC AGENTS, LONG-ACTING NEBULIZERS

á Both agents in this class  
require Prior Authorization.

#### BETA ADRENERGIC AGENTS, SHORT-ACTING NEBULIZERS

Albuterol  
Metaproterenol  
Xopenex®  
á Generic agents should be  
considered as "first-line"  
therapy when appropriate.

#### GLUCOCORTICIDS

##### INHALATION DEVICES

Asmanex®  
Azmacort®  
Flovent Diskus®  
Flovent HFA®  
Qvar®

##### INTRANASAL STEROIDS

Fluticasone propionate  
Nasonex®

##### GLUCOCORTICIDS AND LONG-ACTING BETA-2 ADRENERGICS

Advair® Diskus  
Advair® HFA

#### LEUKOTRIENE RECEPTOR ANTAGONISTS

Accolate®  
Singulair®

#### TOPICAL AGENTS FOR ACNE

##### BENZOYL PEROXIDE/ CLINDAMYCIN COMBOS

Benzaclin®  
Duac CS®

##### TOPICAL RETINOIDS

Differin®  
Epiduo®  
Retin-A Micro®  
Tretinoin

#### TOPICAL AGENTS FOR PSORIASIS

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Dovonex®  
Psoriatic®

#### TOPICAL ANTIINFECTIVES

##### TOPICAL ANTIBIOTICS

Mupirocin Ointment  
Altabax®  
Bactroban®  
á Cream  
á Generic agents should  
be considered "first line"  
therapy when appropriate.

##### TOPICAL ANTIVIRALS

Abreva®  
Zovirax® Ointment