

The February 15, 2008 P&T Recommendations for the Hypoglycemics, TZD are:

- The Committee recommends Avandia[®], Actos[®], Avandamet[®], Avandaryl[®] Actosplus Met[®], and Duetact[®] be designated as preferred agents.
- There were no agents designated as non-preferred.

The February 15, 2008 P&T Recommendations for the Meglitinides are:

- The Committee recommends Starlix[®] and Prandin[®] be designated as preferred agents.
- There were no agents designated as non-preferred.

The February 15, 2008 P&T Recommendations for the Lipotropics, Other are:

- The Committee recommends Niaspan[®], gemfibrozil generic, colestipol generic, Tricor[®], cholestyramine generic, fenofibrate generic, and Antara[®] be designated as preferred agents.
- The Committee recommends Zetia[®], Triglide[®], Welchol[®], Lipofen[®] and Lovaza[®] be designated as non-preferred agents that require prior authorization.

The February 15, 2008 P&T Recommendations for the Narcotic Analgesic, short-acting are:

- The Committee recommends propoxyphene/acetaminophen generic, acetaminophen/codeine generic, tramadol generic, hydrocodone/acetaminophen generic, aspirin/codeine generic, codeine generic, morphine IR generic, oxycodone IR generic, oxycodone/acetaminophen generic, pentazocine/naloxone generic, hydromorphone generic, oxycodone/aspirin generic, pentazocine/acetaminophen generic, tramadol/acetaminophen generic and levorphanol generic be designated as preferred agents.
- The Committee recommends propoxyphene generic, meperidine oral generic, Darvon N[®], Panlor DC/SS[®], Opana[®], fentanyl buccal generic, Fentora[®], hydrocodone/ibuprofen generic, oxycodone/ibuprofen generic, butalbital compound/codeine generic, and dihydrocodeine/acetaminophen/caffeine generic be designated as non-preferred agents that require prior authorization.

The February 15, 2008 P&T Recommendations for Narcotic Analgesics, Long Acting are:

- The Committee recommends methadone generic, Kadian[®], and morphine extended release generic be designated as preferred agents.
- The Committee recommends Duragesic[®], fentanyl transdermal generic, Avinza[®], Opana ER[®], Oxycontin[®] and oxycodone extended release generic be designated as non-preferred agents that require prior authorization.
- Duragesic[®] is recommended by the Committee as preferred over generic fentanyl transdermal when the therapeutic prior authorization criteria are met.

The February 15, 2008 Recommendations for Anticonvulsants are:

- The Committee recommends methobarbital generic, phenobarbital generic, clonazepam generic, carbamazepine generic, Carbatrol[®], Equetro[®], phenytoin, Dilantin[®], mephobarbital generic, primidone generic, valproic acid generic, Depakote[®] sprinkle, Depakote ER[®], Depakote[®], Celontin[®], Peganone[®], Gabitril[®], ethosuximide generic, zonisamide generic², oxcarbazine², Lyrica^{®2}, gabapentin generic², Topamax^{®2}, Keppra^{®2}, Lamictal^{®2}, and Diastat[®] be designated as preferred agents.
- The Committee recommends Phenytek[®], Tegretol XR^{®1}, Felbatol[®] and lamotrigine generic² be designated as non-preferred agents that require prior authorization.
- ¹ Clients currently receiving Tegretol XR[®] will be “grandfathered” and not need to switch to a preferred agent.
- ² These anticonvulsants are recommended as preferred for epilepsy and other seizure orders only. Non-seizure indications will still require that therapeutic prior authorization criteria are met.

The February 15, 2008 Recommendations for Growth Hormone¹ are:

- The Committee recommends Saizen[®], Nutropin[®], Nutropin AQ[®] and Norditropin[®] be designated as preferred agents.
- The Committee recommends Tev-Tropin[®], Serostim[®], Genotropin[®], Humatrope[®], Omnitrope[®] and Zorbtive[®] be designated as non-preferred agents that require prior authorization.
- ¹ Current therapeutic criteria for growth hormone will continue to be required for all agents.
- The Committee recommends that patients currently receiving non-preferred agents be “grandfathered”. These agents will be non-preferred and require prior authorization for new patients.

The February 15, 2008 Recommendations for Hepatitis C Agents are:

- The Committee recommends Pegasys[®], Peg-Intron[®] and ribavirin generic be designated as preferred agents.
- The Committee recommends Infergen[®] as non-preferred agents and require prior authorization.

The February 15, 2008 Recommendations for Multiple Sclerosis Agents are:

- The Committee recommends Betaseron[®], Avonex[®], Rebif[®] and Copaxone[®] be designated as preferred agents.
- There were no agents designated as non-preferred.

The February 15, 2008 Recommendations for Erythropoiesis Stimulating Proteins are:

- The Committee recommends Aranesp[®] and Procrit[®] be designated as preferred agents.
- The Committee recommends Epogen[®] as a non-preferred agent that requires prior authorization.

The February 15, 2008 Recommendations for Otic Fluroquinolone Preparations are:

- The Committee recommends ofloxacin generic otic and Ciprodex[®] otic as preferred agents.
- The Committee recommends Cipro[®]HC otic as a non-preferred agent that requires prior authorization.

The February 15, 2008 Recommendations for Phosphate Binders are:

- The Committee recommends PhosLo[®], Fosrenol[®] and Renagel[®] as preferred agents.
- There were no agents designated as non-preferred.

The February 15, 2008 Recommendations for Sedative-Hypnotics are:

- The Committee recommends chloral hydrate generic, temazepam generic, triazolam generic, Restoril[®] 7.5 mg and zolpidem generic as preferred agents.
- The Committee recommends Lunesta[®], flurazepam generic, Rozerem[®], Ambien CR[®], Sonata[®], Doral[®], estazolam generic, as non-preferred agents that require prior authorization.
- The Committee recommends that Lunesta[®] be grandfathered for current patients.

The February 15, 2008 Recommendations for Proton Pump Inhibitors are:

- The Committee recommends Prilosec[®] OTC, Nexium[®] capsule and suspension, and Prevacid[®] capsule, as preferred agents.
- The Committee recommends Prevacid[®] solutab and suspension, Zegerid[®], Aciphex[®], Protonix[®] and omeprazole generic as non-preferred agents that require prior authorization.
- The Committee recommends all current therapeutic criteria except those associated with the solutab form of Prevacid be removed.

The February 15, 2008 Recommendations for Injectable Anticoagulants are:

- The Committee recommends Fragmin[®], Lovenox[®], and Arixtra[®] as preferred agents.
- The Committee recommends Innohep[®] as a non-preferred agent that requires prior authorization.

The February 15, 2008 Recommendations for Angiotensin Modulator/Calcium Channel Blocker Combinations are:

- The Committee recommends Exforge[®], Azor[®], benazepril/amlodipine generic and Lotrel[®] as preferred agents.
- The Committee recommends Tarka[®] and Lexxel[®] as non-preferred agents that require prior authorization.

The February 15, 2008 Recommendations for Angiotensin Modulators are:

- The Committee recommends Altace[®], benazepril and benazepril/HCTZ generic, captopril and captopril/HCTZ generic, enalapril and enalapril/HCTZ generic, fosinopril and fosinopril/HCTZ generic, lisinopril and lisinopril/HCTZ generic, quinapril and quinapril/HCTZ generic, Diovan[®], Diovan HCT[®], Benicar, Benicar HCT[®], Micardis[®], Micardis HCT[®], Cozaar[®], Hyzaar[®], Avapro[®] Avalide[®] as preferred agents.
- The Committee recommends Aceon[®], Teveten[®], Tevetan HCT[®], Atacand[®], Atacand HCT[®], moexepiril and moexepiril/HCTZ generic, Tekturna[®], Tekturna HCT[®] and trandolapril as non-preferred agents that require prior authorization.

The February 15, 2008 Recommendations for Benign Prostatic Hyperplasia Treatment Agents are:

- The Committee recommends doxazosin generic, terazosin generic, Uroxatral[®], Cardura XL[®], Flomax[®], Avodart[®], and finasteride generic as preferred agents.
- There are no agents designated as non-preferred.

The February 15, 2008 Recommendations for Bladder Relaxant Preparations are:

- The Committee recommends oxybutynin generic, Vesicare[®], Oxytrol[®] transdermal, Enablex[®], Sanctura[®], Sanctura XR[®], Ditropan XL[®] and Detrol LA[®] as preferred agents.
- The Committee recommends Detrol[®] as a non-preferred agent that requires prior authorization.

The February 15, 2008 Recommendations for Lipotropics, Statins are:

- The Committee recommends Caduet[®], Lescol/Lescol XL[®], Lipitor[®], lovostatin generic, pravastatin generic and simvastatin generic as preferred agents.
- The Committee recommends , Advicor[®], Crestor[®], Altoprev[®] and Vytorin[®] as non-preferred agents that require prior authorization.

The February 15, 2008 Recommendations for Calcium Channel Blockers are:

- The Committee recommends Dynacirc CR[®], verapamil generic, verapamil ER PM, Cardizem LA[®], diltiazem, nifedipine generic, felodipine ER generic and amlodipine generic as preferred agents.
- The Committee recommends nicardipine generic, Cardene SR[®], Covera-HS[®], isradipine generic and Sular[®] as non-preferred agents that require prior authorization.

The February 15, 2008 Recommendations for Beta-Blockers are:

- The Committee recommends atenolol generic, metoprolol generic, propranolol generic, sotalol generic, nadolol generic, acebutolol generic, labetalol generic, pindolol generic, timolol generic, bisoprolol generic, betaxolol generic, and carvedilol generic as preferred agents.
- The Committee recommends Coreg CR[®], Levatol[®] Innopran XL[®], as non-preferred agents that require prior authorization.
- The Committee recommends that the therapeutic prior authorization criteria for carvedilol be removed.

The February 15, 2008 Recommendations for Antimigraine Agents, Triptans are:

- The Committee recommends Relpax[®], Imitrex (oral)[®], Imitrex (nasal)[®], and Imitrex[®] SQ as preferred agents.
- The Committee recommends Amerge[®], Maxalt/Maxalt MLT[®], Axert[®], Frova[®], Zomig/ZomigZMT[®], and Zomig[®] (nasal) as non-preferred agents that require prior authorization.
- The Committee recommends that Amerge[®], Maxalt/Maxalt MLT[®], and Zomig/ZomigZMT[®] be “grandfathered” for current patients. These agents will be non-preferred and require prior-authorization for new patients.

The February 15, 2008 Recommendations for Minimally Sedating Antihistamines are:

- The Committee recommends Zyrtec[®] OTC syrup, loratadine/loratadine-D generic and cetirizine OTC tablet as preferred agents.
- The Committee recommends, Clarinex/Clarinex D[®], Clarinex[®] syrup, Zyrtec/Zyrtec-D[®], Xyzal,[®] Allegra[®] syrup, Allegra D[®] 12 hour and fexofenadine generic as non-preferred agents that require prior authorization.

The February 15, 2008 Recommendations for Ulcerative Colitis Agents are:

- The Committee recommends sulfasalazine generic, Colazal[®], mesalamine rectal generic, Asacol[®], Pentasa[®], and Canasa[®] as preferred agents.
- The Committee recommends Dipentum[®] and Lialda[®] as non-preferred agents that require prior authorization.

The February 15, 2008 Recommendations for Skeletal Muscle Relaxants are:

- The Committee recommends baclofen generic, chlorzoxazone generic, cyclobenzaprine generic, dantrolene generic, methocarbamol generic, orphenadrine generic, orphenadrine compound generic and tizanidine generic as preferred agents.
- The Committee recommends carisoprodol generic, carisoprodol compound, Soma[®], Skelaxin[®], Zanaflex[®], Fexmid[®] and Amrix[®] as non-preferred agents that require prior authorization.

The February 15, 2008 Recommendations for Topical Impetigo Agents are:

- The Committee recommends mupirocin ointment generic as a preferred agent.
- The Committee recommends Altabax®, and Bacroban® cream as non-preferred agents that require prior authorization.