

# MEDICAID BULLETIN

**TO: Providers Indicated**

**SUBJECTS: South Carolina Medicaid Preferred Drug List**

The Preferred Drug List (PDL) has been revised to include several additional therapeutic classes. Attached to this bulletin is a comprehensive listing of products within all therapeutic classes that comprise the PDL.

**Effective with dates of service** on or after July 22, 2009, hard edits will be activated (*i.e.*, pharmacy claims without prior authorization [PA] approval will deny) for newly designated non-preferred products within the therapeutic classes listed below. The **complete PDL** (attached to this bulletin) includes the following changes:

<b>Additional PDL DRUG CLASSES</b>
1) Topical NSAID's and Anesthetics
2) Ophthalmic NSAID's
3) Calcitonins
4) Progestins for Cachexia
5) Ophthalmic Mast Cell Stabilizers
6) Topical Antivirals
7) Protein Tyrosine Kinase Inhibitors
8) Ranexa
9) Intranasal Antihistamines
<b>CHANGES TO EXISTING PDL DRUG CLASSES</b>
1) Topical Retinoids and Combinations

PREFERRED		NON-PREFERRED	
<b>Topical NSAID's and Anesthetics</b>			
		FLECTOR® PATCH LIDODERM® PATCH VOLTAREN® GEL	
<b>Ophthalmic NSAID's</b>			
ACULAR® ACULAR LS® ACULAR PL® DICLOFENAC SODIUM FLURBIPROFEN SODIUM NEVANAC®		OCUFEN® VOLTAREN® DROPS XIBROM®	
<b>Calcitonins</b>			
FORTICAL® NASAL SPRAY CALCITONIN SALMON		MICALCIN® NASAL SPRAY	
<b>Progestins for Cachexia</b>			
MEGESTEROL ORAL SUSP		MEGACE® ORAL SUSPENSION MEGACE ES® ORAL SUSPENSION	
<b>Ophthalmic Mast Cell Stabilizers</b>			
ALAMAST® ALOCRIL® ALOMIDE® CROMOLYN SODIUM		CROLOM® OPTICROM®	
<b>Topical Antivirals</b>			
ABREVA® ZOVIRAX® OINTMENT		DENAVIR® ZOVIRAX® CREAM	
<b>Protein Tyrosine Kinase Inhibitors</b>			
GLEEVEC®		SPRYCEL® SUTENT® TASIGNA®	
<b>Ranexa</b>			
RANEXA®			
<b>Intranasal Antihistamines</b>			
ASTELIN® ASTEPRO®		PATANASE®	
<b>Topical Retinoids and Combinations</b>			
DIFFERIN® EPIDUO® RETIN-A MICRO PUMP® RETIN-A MICRO® TRETINOIN	Added to PDL Added to PDL Added to PDL	ALTINAC® ATRALIN® AVITA® RETIN-A® TAZORAC® TRETIN X® ZIANA	

Prescribers are strongly encouraged to write prescriptions for "preferred" products. However, if a prescriber deems that the patient's clinical status necessitates therapy with a PA-required drug, the prescriber (or his/her designated office personnel) is responsible for initiating the PA request. A prospective, approved PA request will prevent rejection of prescription claims at the pharmacy due to the PA requirement.

All PA requests should be submitted via WebPA, telephone, or fax to the First Health Clinical Call Center by the prescriber or the prescriber's designated office personnel. To access the WebPA tool, see: <http://southcarolina.fhsc.com>, click on Prescribers and WebPA. New users will need to click on "UAC" in the right hand corner to request a user id and password. The toll-free telephone and fax numbers for the Clinical Call Center are 866-247-1181 and 888-603-7696, respectively. The First Health Clinical Call Center telephone number is reserved for use by healthcare professionals and should not be furnished directly to beneficiaries. [First Health's South Carolina Medicaid *beneficiary call center* telephone number for Pharmacy Services is 800-834-2680. Providers may furnish the beneficiary call center telephone number to Medicaid beneficiaries *for Pharmacy Services-related issues only.*] Providers are reminded that questions about Medicare eligibility issues and Part D drug plans should be directed to 1-800-MEDICARE.

A pharmacy claim submitted for a PA-required product that has not been approved for Medicaid reimbursement will reject. If this occurs, the pharmacist should contact the prescriber so that a determination may be made regarding whether a drug *not* requiring PA is clinically appropriate for the patient.

Questions regarding this bulletin should be directed to the Department of Pharmacy Services at (803) 898-2876.

/S/  
Emma Forkner  
Director

EF/mgad

Attachment

**NOTE:** To Sign up for Electronic Funds Transfer of your Medicaid payment, please go to: <http://www.dhhs.state.sc.us/dhhsnew/hipaa/index.asp> and select "Electronic Funds Transfer (EFT)" for instructions.



South Carolina Department of Health and Human Services Preferred Drug List  
Products Within PDL Therapeutic Classes Are Available Without Prior Authorization (PA)  
Some therapeutic classes to have a PA requirement. These are noted within the posting.  
{Non-listed products belonging to therapeutic classes that comprise the PDL require PA}  
{Note that ALL therapeutic classes are not included on the PDL.}

June, 2009

**ANALGESIC**

**NSAIDs**

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

**NSAIDs, RECEPTOR SELECTIVE\***

Celebrex®  
Meloxicam

\* 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® Patch  
Kadian®  
Morphine Sulfate ER\*

**TOPICAL NSAIDS AND ANESTHETICS**

\*All agents in this class require Prior Authorization.

**ANTI-INFECTIVE**

**ANTIBACTERIALS**

**CEPHALOSPORINS, 2ND GENERATION**

Cefprozil  
Cefuroxime

**CEPHALOSPORINS, 3RD GENERATION**

Cefdinir (all dosage forms)

Spectracef® Tablets

**MACROLIDES/KETOLIDES**

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

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

Avelox®  
Ciprofloxacin  
Ofloxacin

\* Prescribers are encouraged to ensure compliance with FDA approved indications.

**ANTIFUNGALS, ORAL**

**ONYCHOMYCOSIS AGENTS**

Gris-Peg®  
Griseofulvin  
Terbinafine

**ANTIPROTOZOALS, ORAL**

**NITROIMIDAZOLES**

Metronidazole

**ANTIVIRALS, ORAL**

**HERPES ANTIVIRALS**

Acyclovir  
Famciclovir  
Valtrex®

**CARDIOVASCULAR**

**ACE INHIBITORS (ACEI)**

Benazepril  
Benazepril/HCTZ  
Captopril

Enalapril  
Enalapril/HCTZ  
Lisinopril  
Lisinopril/HCTZ

**ACEI, CCB COMBINATIONS**

Lotrel®  
Tarka®

**ANGIOTENSIN RECEPTOR BLOCKERS (ARB)**

Avalide®  
Avapro®  
Benicar®  
Benicar HCT®  
Cozaar®  
Diovan®  
Diovan HCT®  
Hyzaar®  
Micardis®  
Micardis HCT®  
Teveten®  
Teveten HCT®

**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®  
Felodipine  
Isradipine  
Nicardipine  
Nifedical XL®

Nifedipine ER and SA

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

Cartia XT®  
Diltia XT®  
Diltiazem  
Diltiazem ER and XR  
Taztia XT®  
Verapamil  
Verapamil ER  
Verapamil SR

**CCB/ARB COMBINATION PRODUCTS**

Exforge®  
Exforge HCT®

**DIRECT RENIN INHIBITORS**

Tekturma®\*  
Tekturma HCT®\*

\* Prior authorization is required if an ARB has not been prescribed previously for the patient.

**ENDOTHELIN RECEPTOR ANTAGONISTS**

Tracleer®\*

\*Patients currently established on non-preferred therapy will be grandfathered.

**LIPOTROPICS**

**BILE ACID SEQUESTERING RESINS**

Cholestyramine  
Cholestyramine Light  
Colestipol  
Welchol®



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**June, 2009**

<b>FIBRIC ACID DERIVATIVES</b> Gemfibrozil Lofibra® Tricor® Trilipix®	Carbatrol® Epitol® Oxcarbazepine	<i>then Documents, then Pharmacy Quantity Limits.)</i>	<i>* Prior authorization is required if patient is not currently receiving insulin therapy.</i>
<b>NIACIN DERIVATIVES</b> Niaspan®	<b>FIRST GENERATION ANTICONVULSANTS</b>	<b>ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS</b>	<b>BIGUANIDES</b>
<b>NIACIN/STATIN COMBINATIONS</b> Advicor® Simcor®	Celontin® Depakote ER® Divalproex Sprinkles Ethosuximide Felbatol® Mephobarbital Phenytoin Phenytoin Sodium ER Primidone Valproic Acid	Adderall XR® Amphetamine Salt Combination Dexmethylphenidate Immediate Release Dextroamphetamine Dextroamphetamine SR Metadate ER® Methylin® Methylin ER® Methylphenidate Methylphenidate ER/SR Ritalin LA®* Concerta®* Focalin XR®* Vyvanse®*	Metformin Metformin ER
<b>STATINS</b>	<i>* Prior authorization is not required for Dilantin® if "Brand Medically Necessary" criteria are met.</i>	<i>* Generic agents considered "first-line" when appropriate.</i>	<b>BIGUANIDE COMBINATION AGENTS</b>
Altoprev® Crestor® Lescol® Lescol XL® Lipitor® Lovastatin Pravastatin Simvastatin Vytorin®	<b>SECOND GENERATION ANTICONVULSANTS</b>	<b>MULTIPLE SCLEROSIS AGENTS</b>	ActoPlus Met® Avandamet®
<b>CHOLESTEROL-ABSORPTION INHIBITORS</b> Zetia®	Gabapentin Levetiracetam Lamictal® Lyrica® Topiramate Zonisamide	Avonex® Avonex Administration Pack® Betaseron® Copaxone® Rebif®	<b>DPP-4 INHIBITORS AND COMBINATIONS*</b>
<b>NON-NITRATE ANTIANGINALS</b> Ranexa®		<b>PARKINSON'S AGENTS</b>	Janumet® Januvia®
<b>CENTRAL NERVOUS SYSTEM</b>		<b>NON-ERGOT DOPAMINE RECEPTOR AGONISTS</b>	<i>* Prior authorization is required if metformin, a thiazolidinedione or a sulfonylurea has not been prescribed previously for the patient.</i>
<b>ALZHEIMER'S AGENTS</b>		<b>SEDATIVE/HYPNOTICS, NON-BARBITURATES</b>	<b>INCRELIN MIMETICS*</b>
<b>CHOLINESTERASE INHIBITORS</b>	<b>ANTI-MIGRAINE AGENTS</b>	Temazepam Zolpidem	<i>* Prior authorization is required if metformin, a thiazolidinedione or a sulfonylurea product has not been prescribed previously for the patient.</i>
<b>NMDA RECEPTOR ANTAGONIST</b> Namenda®	<b>SELECTIVE SEROTONIN AGONISTS*</b>	<b>ENDOCRINE AND METABOLIC</b>	<b>INSULINS</b>
<b>ANTI-CONVULSANT AGENTS</b>	Sumatriptan Tablets Sumatriptan Injection Sumatriptan Nasal Spray Treximet®	<b>ANTI-DIABETICS</b>	Lantus® Vial Levemir® Vial Novolin® N Novolin® R Novolin® 70/30 Novolog® Novolog® Mix 70/30 Humalog® 50/50
<b>CARBAMAZEPINE DERIVATIVES</b>	<i>* 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,</i>	<b>ALPHA-GLUCOSIDASE INHIBITORS</b>	<b>MEGLITINIDES</b>
Carbamazepine (all dosage forms)	<i>)</i>	<b>AMYLIN ANALOGS*</b>	Starlix®
		Glyset® Acarbose Symlin®	<b>SULFONYLUREAS, SECOND GENERATION</b>
			Glimperide Glipizide Glipizide ER Glyburide Glyburide Micronized



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<b>THIAZOLIDINEDIONES</b> Actos® Avandia®	* 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>ANTICOAGULANTS –          LOW MOLECULAR          WEIGHT HEPARINS</b> Arixtra® Fragmin® Lovenox®	<b>IMMUNOMODULATORS,          ORAL AND          INJECTABLE</b>
<b>THIAZOLIDINEDIONE /          SULFONYLUREA          COMBINATIONS*</b> Avandaryl® Duetact®	<b>HISTAMINE-2          RECEPTOR          ANTAGONISTS</b> Famotidine Ranitidine	<b>HEMATOPOIETIC          AGENTS</b> Aranesp® Procrit®	<b>HEPATITIS B THERAPY</b> Baraclude® Epivir HBV® Hepsera® Tyzeka®
* Prior authorization is required if a single agent thiazolidinedione or sulfonylurea product has not been prescribed previously for the patient.	<b>PROTON PUMP          INHIBITORS*</b> Nexium® Capsules Prevacid® Omeprazole OTC	<b>PLATELET INHIBITORS</b> Aggrenox® Plavix®	*Viread® is unaffected by the PDL and is available without Prior Authorization.
<b>ELECTROLYTE          DEPLETERS</b> Fosrenol® Phoslo® Renagel®	* Class level PA is in effect for this class. Once criteria are met, the agents listed on the PDL are preferred.	<b>PROTEIN TYROSINE          KINASE INHIBITORS</b> Gleevec®	<b>HEPATITIS C THERAPY,          PEGYLATED          INTERFERONS*</b> Pegasys® & Conv. Pack Peg-Intron® & Redipen
<b>BIPHOSPHONATES -          OSTEOPOROSIS</b> Alendronate	<b>ULCERATIVE COLITIS          THERAPY</b> Asacol® Balsalazide Disodium Canasa® Rectal Supp. Mesalamine Enema Pentasa® Sulfasalazine	<b>HORMONE          RELATED          THERAPY</b>	<b>HEPATITIS C THERAPY,          RIBAVIRINS *</b> Ribavirin
<b>CALCITONINS</b> Calcitonin Nasal Spray Fortical® Nasal Spray	<b>PROGESTINS FOR          CACHEXIA</b> Megestrol Oral Susp	<b>ANDROGENIC AGENTS</b> Androderm® Androgel® Testim®	* Class level PA is in effect for all Hepatitis C medications. Once criteria are met, the agents listed on the PDL are preferred.
<b>GROWTH HORMONE</b> Genotropin® Norditropin® Saizen®	<b>GENITOURINARY</b>	<b>ANDROGEN HORMONE          INHIBITOR</b> Avodart® Finasteride	<b>IMMUNOSUPPRESSANT          S</b> Azasan® Azathioprene Cellcept® Injection & Suspension Cyclosporine Gengraf® Imuran® Mycophenolate Mofetil Myfortic® Neoral® Prograf® Rapamune® Sandimmune®
* Class level PA is in effect for this class. Once criteria are met, the agents listed on the PDL are preferred.	<b>ALPHA BLOCKERS FOR          BPH</b> Flomax® Uroxatral®	<b>IMMUNOLOGICS</b>	<b>OPHTHALMICS</b>
<b>GASTROINTESTINAL</b>	<b>ANTISPASMODICS</b> Detrol LA® Enablex® Oxybutynin Oxytrol® Sanctura® VESicare®	<b>IMMUNOMODULATORS,          INJECTABLE</b> Enbrel® Humira®	<b>ANTI-HISTAMINES,          OPHTHALMIC</b> Pataday® Patanol® Elestat®
<b>ANTI-EMETICS (ORAL)</b>	<b>HEMATOLOGICAL &amp;          ONCOLOGICAL          AGENTS</b>	<b>IMMUNOMODULATORS,          TOPICAL</b> Elidel® * Protopic® *  * Prescribers: Please use these agents as advised by the respective manufacturer and reserve for only those patients who have failed traditional eczema therapy.	
<b>NK1 ANTAGONISTS</b> Emend®	<b>SEROTONIN          RECEPTOR          ANTAGONISTS</b> Granisetron Ondansetron		



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**MAST CELL STABILIZERS, OPHTHALMIC**

Alamast®  
Alocril®  
Alomide®  
Cromolyn Sodium

**NSAIDs, OPHTHALMIC**

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

**INTRANASAL ANTIHISTAMINES**

Astelin®  
Asteopro®

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

Ventolin® HFA  
Xopenex® HFA

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

Serevent Diskus®\*

\* Prescribers are reminded of the warnings associated with the use of long acting beta agonists.

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

\* Both agents in this class require Prior Authorization.

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

Albuterol  
Metaproterenol  
Xopenex®\*

\* Generic agents should be considered as "first-line" therapy when appropriate.

**GLUCOCORTICOIDS**

**INHALATION DEVICES**

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

**INTRANASAL STEROIDS**

Fluticasone propionate  
Nasonex®

**GLUCOCORTICOIDS AND LONG-ACTING BETA-2 ADRENERGICS**

Advair® Diskus  
Advair® HFA

\* Prescribers are reminded of the warnings associated with the use of long acting beta agonists

**LEUKOTRIENE RECEPTOR ANTAGONISTS**

Accolate®  
Singulair®

**TOPICAL AGENTS FOR ACNE**

**BENZOYL PEROXIDE/CLINDAMYCIN COMBOS**

Benzaclin®  
Duac CS®

**TOPICAL RETINOIDS**

Differin®  
Epiduo®  
Retin-A Micro®  
Retin-A Micro® Pump  
Tretinoin

**TOPICAL AGENTS FOR PSORIASIS**

**TOPICAL AGENTS FOR PSORIASIS**

Dovonex®  
Psoriatec®

**TOPICAL ANTIINFECTIVES**

**TOPICAL ANTIBIOTICS**

Mupirocin Ointment  
Altabax®\*  
Bactroban®\* Cream

\* Generic agents should be considered "first line" therapy when appropriate.

**TOPICAL ANTIVIRALS**

Abreva®  
Zovirax® Ointment



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**Listing Updated: December, 2008**

### A

ABREVA  
ACARBOSE  
ACCOLATE  
ACEBUTOLOL  
ACTOPLUS MET  
ACTOS  
ACULAR  
ACULAR LS  
ACULAR PL  
ACYCLOVIR  
ADDERALL XR  
ADVAIR DISKUS  
ADVAIR HFA  
ADVICOR  
AGGRENOX  
ALAMAST  
ALBUTEROL  
ALENDRONATE  
ALOCRIL  
ALOMIDE  
ALPHAGAN P  
ALTABAX  
ALTOPREV  
AMLODIPINE  
AMPHETAMINE SALT COMBINATION  
ANDRODERM  
ANDROGEL  
ARANESP  
ARICEPT TABLETS  
ARIXTRA  
ASACOL  
ASMANEX  
ASTELIN  
ASTEPRO  
ATENOLOL  
ATENOLOL/CHLORTHALIDONE  
ATROVENT HFA  
AVALIDE  
AVANDAMET  
AVANDARYL  
AVANDIA

AVAPRO  
AVELOX  
AVODART  
AVONEX ADMINISTRATION PACK  
AVONEX  
AZASAN  
AZATHIOPRENE  
AZITHROMYCIN  
AZMACORT  
AZOPT

### B

BACTROBAN CREAM  
BALSALAZIDE DISODIUM  
BARACLUDE  
BENZAEPRI  
BENZAEPRI/HCTZ  
BENICAR HCT  
BENICAR  
BENZACLIN  
BETASERON  
BETAXOLOL  
BETAXOLOL HCL  
BISOPROLOL FUMARATE  
BISOPROLOL/HCTZ  
BRIMONIDINE TARTRATE  
BYETTA

### C

CALCITONIN NASAL SPRAY  
CANASA RECTAL SUPP.  
CAPTOPRIL  
CARBAMAZEPINE  
CARBATROL  
CARTEOLOL HCL  
CARTIA XT  
CARVEDILOL  
CEFDINIR  
CEFPROZIL  
CEFUROXIME  
CELEBREX  
CELLCEPT

CELONTIN  
CETIRIZINE  
CHOLESTYRAMINE  
CHOLESTYRAMINE LIGHT  
CIPRODEX  
CIPROFLOXACIN  
CIPROFLOXACIN HCL  
CLARITHROMYCIN  
CLARITHROMYCIN XL  
COLESTIPOL  
COMBIGAN  
COMBIVENT  
CONCERTA  
COPAXONE  
COZAAR  
CRESTOR  
CROMOLYN SODIUM  
CYCLOSPORINE

### D

DEPAKOTE ER  
DETROL LA  
DEXMETHYLPHENIDATE IMMEDIATE  
RELEASE  
DEXTROAMPHETAMINE  
DEXTROAMPHETAMINE SR  
DICLOFENAC POTASSIUM  
DICLOFENAC SODIUM  
DICLOFENAC SODIUM EYE DROPS  
DIFFERIN  
DIFLUNISAL  
DILTIA XT  
DILTIAZEM  
DILTIAZEM ER AND XR  
DIOVAN  
DIOVAN HCT  
DIVALPROEX SPRINKLES  
DORZOLAMIDE  
DORZOLAMIDE -TIMOLOL  
DOVONEX  
DUAC CS  
DUETACT  
DURAGESIC PATCH

**First Health Clinical Call Center**  
**Telephone: 866-247-1181 (toll-free)**  
**Fax: 888-603-7696 (toll-free)**





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DYNACIRC CR

**E**

ELESTAT  
ELIDEL  
EMEND  
ENABLEX  
ENALAPRIL  
ENALAPRIL/HCTZ  
ENBREL  
EPIDUO  
EPITOL  
EPIVIR HBV  
ERYPED  
ERY-TAB  
ERYTHROCIN STEARATE  
ERYTHROMYCIN & SULFISOX.  
ERYTHROMYCIN BASE  
ERYTHROMYCIN ESTOLATE  
ERYTHROMYCIN ETHYLSUC.  
ERYTHROMYCIN STEARATE  
ETHOSUXIMIDE  
ETODOLAC  
EXELON  
EXFORGE  
EXFORGE HCT

**F**

FAMCICLOVIR  
FAMOTIDINE  
FELBATOL  
FELODIPINE  
FENOPROFEN  
FINASTERIDE  
FLOMAX  
FLOVENT DISKUS  
FLOVENT HFA  
FLURBIPROFEN  
FLURBIPROFEN EYE DROPS  
FLUTICASONE PROPIONATE  
FOCALIN XR  
FORTICAL NASAL SPRAY  
FOSRENOL  
FRAGMIN

**G**

GABAPENTIN  
GALANTAMINE  
GEMFIBROZIL  
GENGRAF  
GENOTROPIN  
GLEEVEC  
GLIMEPIRIDE  
GLIPIZIDE  
GLIPIZIDE ER  
GLYBURIDE  
GLYBURIDE MICRONIZED  
GLYSET  
GRANISETRON  
GRISEOFULVIN  
GRIS-PEG

**H**

HEPSERA  
HUMIRA  
HUMALOG 50/50  
HYZAAR

**I**

IBUPROFEN  
IMURAN  
INDOMETHACIN  
INDOMETHACIN SR  
ISRADIPINE

**J**

JANUMET  
JANUVIA

**K**

KADIAN  
KETOPROFEN  
KETOPROFEN ER  
KETOROLAC

**L**

LABETOLOL  
LAMICTAL  
LANTUS VIAL  
LESCOL

LESCOL XL  
LEVEMIR VIAL  
LEVETIRACETAM  
LEVOBUNOLOL HCL  
LIPITOR  
LISINOPRIL  
LISINOPRIL/HCTZ  
LOFIBRA  
LORATADINE OTC  
LORATADINE-D OTC  
LOTREL  
LOVASTATIN  
LOVENOX  
LUMIGAN  
LYRICA

**M**

MECLOFENAMATE SOD.  
MEGESTEROL ORAL SUSPENSION  
MELOXICAM  
MEPHOBARBITAL  
MESALAMINE ENEMA  
METADATE ER  
METAPROTERENOL  
METFORMIN  
METFORMIN ER  
METHYLIN ER  
METHYLIN  
METHYLPHENIDATE  
METHYLPHENIDATE ER/SR  
METIPRANOLOL  
METOPROLOL TARTRATE  
METRONIDAZOLE  
MICARDIS  
MICARDIS HCT  
MORPHINE SULFATE ER  
MUPIROCIN OINTMENT  
MYCOPHENOLATE MOFETIL  
MYFORTIC

**N**

NABUMETONE  
NADOLOL  
NAMENDA  
NAPROXEN

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**South Carolina Department of Health and Human Services Preferred Drug List**  
**Products Within PDL Therapeutic Classes Are Available Without Prior Authorization (PA)**  
**Some therapeutic classes to have a PA requirement. These are noted within the posting.**  
{Non-listed products belonging to therapeutic classes that comprise the PDL require PA}  
{Note that ALL therapeutic classes are not included on the PDL.}

**June, 2009**

NAPROXEN SODIUM  
NASONEX  
NEORAL  
NEVANAC  
NEXIUM CAPSULES  
NIASPAN  
NICARDIPINE  
NIFEDICAL XL  
NIFEDIPINE ER AND SA  
NORDITROPIN  
NOVOLIN  
NOVOLOG

**O**

OFLOXACIN  
OFLOXACIN OTIC DROPS  
OMEPRAZOLE OTC  
ONDANSETRON  
OXAPROZIN  
OXCARBAZEPINE  
OXYBUTYNIN  
OXYTROL

**P**

PATADAY  
PATANOL  
PEGASYS  
PEG-INTRON  
PENTASA  
PHENYTOIN  
PHENYTOIN SODIUM ER  
PHOSLO  
PINDOLOL  
PIROXICAM  
PLAVIX  
PRAVASTATIN  
PREVACID  
PRIMIDONE  
PROCRIT  
PROGRAF  
PROPRANOLOL  
PROPRANOLOL ER  
PROPRANOLOL/HCTZ  
PROTOPIC  
PSORiatec

**Q**

QVAR

**R**

RANEXA  
RANITIDINE  
RAPAMUNE  
REBIF  
RENAGEL  
RETIN-A MICRO  
RETIN-A MICRO PUMP  
RIBAVIRIN  
RITALIN LA  
ROPIROLE

**S**

SAIZEN  
SANCTURA  
SANDIMMUNE  
SEREVENT DISKUS  
SIMCOR  
SIMVASTATIN  
SINGULAIR  
SOTALOL  
SPECTRACEF TABLETS  
SPIRIVA  
STARLIX  
SULFASALAZINE  
SULINDAC  
SUMATRIPTAN  
SYMLIN

**T**

TARKA  
TAZTIA XT  
TEKTURN  
TEKTURN HCT  
TEMAZEPAM  
TERBINAFINE  
TESTIM  
TEVETEN  
TEVETEN HCT  
TIMOLOL  
TIMOLOL MALEATE  
TOLMETIN SODIUM  
TOPIRAMATE

TRACLEER  
TRAVATAN  
TRAVATAN Z  
TRETINOIN  
TREXIMET  
TRICOR  
TRILIPIX  
TYZEKA

**U**

UROXATRAL

**V**

VALPROIC ACID  
VALTRESX  
VENTOLIN HFA  
VERAPAMIL  
VERAPAMIL ER  
VERAPAMIL SR  
VESICARE  
VIGAMOX  
VYTORIN  
VYVANSE

**W**

WELCHOL

**X**

XALATAN  
XOPENEX  
XOPENEX HFA

**Y**

**Z**

ZETIA  
ZOLPIDEM  
ZONISAMIDE  
ZOVIRAX OINTMENT  
ZYMAR OPHTHALMIC

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