HealthPAC
Health Program of Alameda County

HEALTHPAC HIV LIHP FORMULARY
FORMULARY BY CLASS
Effective 8/1/2012

Ramsell™

P: 888-311-7632 www.ramsellcorp.com F: 800-848-4241

	Generic Name	Brand Name	Restrictions
This program mandates the use of generic products whenever possible in accordance with applicable law or regulations. Dispensing a brand name product when a generic is available requires prior authorization and a DAW 1 code. Exceptions are noted by drug.			
1. ANALGESICS			
	codeine sulfate		Oral form only
	codeine/APAP		Oral form only
	fenoprofen		Oral form only
^*	fentanyl	Duragesic	Restricted to hospice patients only with intolerance to oral analgesics
	hydrocodone/APAP	Vicodin	Oral form only
	hydrocodone/ibuprofen	Vicoprofen	Oral form only
	ibuprofen	Motrin	Oral form only; prescription strength only
	indomethacin	Indocin	Oral form only
	ketoprofen	Orudis	Oral form only
^	ketorolac tromethamine	Toradol	Injectable form only; limited to a max of 120mg/day and 5 days therapy
	levorphanol	Levo-Dromoran	Injectable, oral forms only
^*	methadone		Not payable for detoxification treatment; must indicate diagnosis on PA; Oral form only
	Morphine sulfate (immediate release)		Oral form only
	Morphine sulfate (sustained release)		Oral form only
	naproxen	Naprosyn	Oral form only
	oxycodone		Immediate release form only; Oral form only
	oxycodone/APAP	Percocet	Oral form only
	oxycodone/ASA	Percodan	Oral form only
	sulindac	Clinoril	Oral form only
2. ANTIANXIETY AGENTS			
	alprazolam	Xanax	Oral form only
	buspirone	Buspar	Oral form only
	lorazepam	Ativan	Oral form only
3. ANTICONVULSANTS			
	divalproex	Depakote	
	gabapentin	Neurontin	Oral form only
	lamotrigine	Lamictal	
	phenytoin	Dilantin	100mg Extended Release Capsules only; generic form only
4. ANTIDEPRESSANTS			
	amitriptyline	Elavil	Oral form only
*	bupropion	Wellbutrin	Not payable for smoking cessation, document diagnosis on original RX
	citalopram	Celexa	
	desipramine	Norpramin	Oral form only
	fluoxetine	Prozac	Prozac weekly not covered
	mirtazapine	Remeron	SolTabs not covered; 15mg, 30mg, 45mg tablets form only

^ = Drug requires a prior authorization

* = Drug restricted to specific diagnosis, dose, form or circumstance

● = Drug must be dispensed with a minimum 28 day supply

	Generic Name	Brand Name	Restrictions
This program mandates the use of generic products whenever possible in accordance with applicable law or regulations. Dispensing a brand name product when a generic is available requires prior authorization and a DAW 1 code. Exceptions are noted by drug.			
4. ANTIDEPRESSANTS (Continued)			
	nefazodone	Serzone	
	nortriptyline	Pamelor	Oral forms only
	paroxetine	Paxil	
	sertraline	Zoloft	
	trazodone	Desyrel	Oral forms only
	venlafaxine	Effexor, Effexor XR	
5. ANTIDIABETIC			
●	glipizide	Glucotrol	
●	glyburide/metformin	Glucovance	1.25mg/250mg, 2.5mg/500mg, 5mg/500mg tablets only
●	metformin	Glucophage, Glucophage XR	500mg, 850mg, 1000mg tablets and 500mg ER and 750mg ER tablets only
^●	rosiglitazone maleate	Avandia	Please call (510) -383 -1790 or check website: www.ramsellcorp.com, for special supplemental PA form
●	pioglitazone	Actos	15mg, 30mg, 45mg tablets only
6. ANTIHELMINITICS			
	albendazole	Albenza	
7. ANTIBIOTICS			
	amikacin sulfate	Amikin	
	amoxicillin	Amoxil	Oral form only
	atovaquone	Mepron	
	azithromycin	Zithromax	
	cephalexin	Keflex	Oral form forms only. Brand name Keflex discontinued
	ciprofloxacin	Cipro	
	clarithromycin	Biaxin	
	clindamycin	Cleocin	Oral and injectable forms only
	dapsone		Oral forms only
	dicloxacillin	Dynapen	Oral forms only
	doxycycline	Vibramycin	Oral form only; 50mg and 100mg strength only
	erythromycin base		Oral forms only
	erythromycin ethylsuccinate		Oral forms only
	erythromycin stearate		Oral forms only
^*	imipenem/cilastatin	Primaxin	500mg IM/IV vials only. Use of this medication is restricted for use in the treatment of EXTENSIVELY-drug resistant tuberculosis (XDR-TB). Documentation required
	levofloxacin	Levaquin	250mg, 500mg, 750mg tablets only

^ = Drug requires a prior authorization
* = Drug restricted to specific diagnosis, dose, form or circumstance
● = Drug must be dispensed with a minimum 28 day supply

	Generic Name	Brand Name	Restrictions
This program mandates the use of generic products whenever possible in accordance with applicable law or regulations. Dispensing a brand name product when a generic is available requires prior authorization and a DAW 1 code. Exceptions are noted by drug.			
7. ANTIBIOTICS (Continued)			
^*	linezolid	Zyvox	600mg tablets only; restricted to treatment of Community Acquired MRSA resistant to Vancomycin or the treatment of EXTENSIVELY drug resistant tuberculosis (XDR-TB). Documentation required. Please call or check website for special supplemental PA form
	metronidazole	Flagyl	Oral forms only
	minocycline HCL	Minocin	Oral forms only
	neomycin sulfate		Oral form forms only
	paromomycin	Humatin	
	penicillin G benzathine	Bicillin LA	Only the 1.2 MU per syringe (2ml) and 2.4MU per syringe (4ml) covered
	penicillin V potassium	Pen-Vee K	Oral forms only
	pentamidine	Nebupent, Pentam	Inhaled or injections forms only
	pyrimethamine	Daraprim	
	sulfadiazine		Oral forms only
	sulfamethoxazole/TMP	Bactrim, Septra	Oral or injectable forms only
	tetracycline	Sumycin	Oral forms only
	trimethoprim	Trimpex, Proloprim	Oral forms only
	vancomycin	Vancocin	Oral tablet form only, IV not covered
8. ANTIFUNGALS			
	amphotericin B	Fungizone	Injectable and oral solutions only
^*	caspofungin	Cancidas	50mg and 70mg IV forms only; Use is restricted to treatment of invasive aspergillosis in patients refractory to or intolerant of other therapies (ie: amphotericin B, lipid formulations of amphotericin B, and /or voriconazole)
	clotrimazole	Lotrimin, Mycelex	Oral, topical, vaginal forms only
	fluconazole	Diflucan	
	flucytosine	Ancobon	
^*●	itraconazole	Sporanox	Restricted to use for indications other than onychomycosis. Prior Authorization required
	ketoconazole	Nizoral	Oral and topical creams only
	nystatin	Mycostatin	Oral, topical and vaginal forms only
^*	voriconazole	Vfend	50mg and 200mg tablets and 200mg IV forms only; Use is restricted to treatment of invasive aspergillosis.
9. ANTITUBERCULOSIS			
	amikacin sulfate	Amikin	
	capreomycin	Capastat	

^ = Drug requires a prior authorization
* = Drug restricted to specific diagnosis, dose, form or circumstance
● = Drug must be dispensed with a minimum 28 day supply

	Generic Name	Brand Name	Restrictions
This program mandates the use of generic products whenever possible in accordance with applicable law or regulations. Dispensing a brand name product when a generic is available requires prior authorization and a DAW 1 code. Exceptions are noted by drug.			
9. ANTITUBERCULOSIS (Continued)			
	cycloserine	Seromycin	
	ethambutol	Myambutol	
	ethionamide	Trecator	
	imipenem/cilastatin	Primaxin	
	isoniazid		
^*	linezolid	Zyvox	600mg tablets only; restricted to treatment of Community Acquired MRSA resistant to Vancomycin or the treatment of extensively drug resistant tuberculosis (XDR-TB) Documentation required.Please call (510) -383 -1790 or check website: www.ramsellcorp.com, for special supplemental PA form
	moxifloxacin	Avelox	
	para-aminosalicylate	Paser	
	pyrazinamide		
	rifabutin	Mycobutin	
	rifampin	Rifadin	
	rifampin/isoniazid	Rifamate	
10. ANTICHOLESTEROL			
●	atorvastatin	Lipitor	
●	fenofibrate	Tricor	48mg, 54mg, 145mg, 160mg tablets only
●	gemfibrozil	Lopid	
●	pravastatin	Pravachol	
●	rosuvastatin	Crestor	5mg, 10mg, 20mg, 40mg tablets only
●	simvastatin	Zocor	
11. ANTINEOPLASTICS			
Must Provide copy of the original RX with every refill request			
^	bleomycin	Blenoxane	Generic and injectable forms only
	cyclophosphamide	Cytoxan	Oral, injectable and generic forms only
^	daunorubicin	DaunoXome	
^	doxorubicin	Adriamycin	Generic form available
	leucovorin		
	methotrexate	Rheumatrex, Trexall	Oral and injectable forms only
^*	paclitaxel	Taxol	Restricted for use in Kaposi's Sarcoma
^	vinblastine	Velban	Injectable and generic forms only
^	vincristine	Oncovin	

^ = Drug requires a prior authorization
* = Drug restricted to specific diagnosis, dose, form or circumstance
● = Drug must be dispensed with a minimum 28 day supply

HealthPAC
Health Program of Alameda County

HEALTHPAC HIV
LIHP FORMULARY
FORMULARY BY CLASS
Effective 8/1/2012

Ramsell™

P: 888-311-7632 www.ramsellcorp.com F: 800-848-4241

	Generic Name	Brand Name	Restrictions
This program mandates the use of generic products whenever possible in accordance with applicable law or regulations. Dispensing a brand name product when a generic is available requires prior authorization and a DAW 1 code. Exceptions are noted by drug.			
12. ANTIPSYCHOTICS			
	aripiprazole	Abilify	Discmelt not covered; 2mg, 5mg, 10mg, 15mg, 20mg, 30mg tablets only
	olanzapine	Zyprexa	
	quetiapine	Seroquel	
	risperidone	Risperdal	
	ziprasidone	Geodon	20mg, 40mg, 60mg, 80mg capsules only
13a. ANTIRETROVIRALS-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS			
●	abacavir	Ziagen	
●	abacavir/lamivudine	Epzicom	
●	abacavir/lamivudine/zidovudine	Trizivir	
●	didanosine	Videx, Videx EC	
●	emtricitabine	Emtriva	
●	lamivudine	Epivir	Epivir HB is NOT covered
●	stavudine	Zerit	
●	tenofovir disoproxil fumarate	Viread	
●	tenofovir/emtricitabine	Truvada	
●	zidovudine	Retrovir	
●	zidovudine/lamivudine	Combivir	
13b. ANTIRETROVIRALS-NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS			
●	delavirdine	Rescriptor	
●	efavirenz	Sustiva	
●	etravirine	Intelence	
●	nevirapine	Viramune	
●	rilpivirine	Edurant	
13c. ANTIRETROVIRALS-FUSION INHIBITORS			
●^	enfuvirtide	Fuzeon	Please call (510) 383-1790 for special supplemental PA form
13d. ANTIRETROVIRALS-COMBINATION TREATMENT			
●	emtricitabine/tenofovir/efavirez	Atripla	
●	emtricitabine/tenofovir/rilpivirine	Complera	
13e. ANTIRETROVIRALS-PROTEASE INHIBITORS			
●	atazanavir	Reyataz	
●	darunavir (TMC-114)	Prezista	
●	fosamprenavir	Lexiva	
●	indinavir	Crixivan	
●	lopinavir/ritonavir	Kaletra	
●	nelfinavir	Viracept	
●	ritonavir	Norvir	
●	saquinavir mesylate	Invirase	
●	tipranavir	Aptivus	

^ = Drug requires a prior authorization
* = Drug restricted to specific diagnosis, dose, form or circumstance
● = Drug must be dispensed with a minimum 28 day supply

HealthPAC
Health Program of Alameda County

HEALTHPAC HIV
LIHP FORMULARY
FORMULARY BY CLASS
Effective 8/1/2012

Ramsell™

P: 888-311-7632 www.ramsellcorp.com F: 800-848-4241

Generic Name	Brand Name	Restrictions
This program mandates the use of generic products whenever possible in accordance with applicable law or regulations. Dispensing a brand name product when a generic is available requires prior authorization and a DAW 1 code. Exceptions are noted by drug.		
13f. ANTIRETROVIRALS-CCR5 CO-RECEPTOR ANTAGONISTS		
●^ maraviroc	Selzentry	Please call (510)-383-1790 for special supplemental PA form
13g. ANTIRETROVIRALS-INTEGRASE INHIBITOR		
● raltegravir	Isentress	
14. ANTIVIRALS-HEPATITIS		
^ interferon alfacon 1	Infergen	
^ inteferon alfa-2b	Intron-A	
^ interferon alfa-N3	Alferon-N	
^ pegylated interferon	Peg-Intron, Pegasys	
ribavirin	Rebetol, Copegus	
15. ANTIVIRALS-MISCELLANEOUS		
acyclovir	Zovirax	
famcyclovir	Famvir	
^* valacyclovir	Valtrex	
cidofovir	Vistide	
foscarnet	Foscavir	
^* ganciclovir	Cytovene	Oral form does not require a prior authorization; only the implant or injectable forms requires a prior authorization. Please provide a copy of the original prescription with PA form.
^* valganciclovir	Valcyte	Restricted to a diagnosis of CMV. Payable for active treatment or suppressive treatment only; not payable for primary prophylaxis of CMV
16. ANTIDIARRHEALS		
diphenoxylate/atropine	Lomotil	
loperamide	Immodium	Generic form only
opium tincture		
17. ANTIEMETICS		
metoclopramide	Reglan	
prochlorperazine	Compazine	
promethazine	Phenergan	Oral and suppository forms only
18. DIGESTIVE ENZYMES		
pancrelipase		Enteric coated encapsulated microspheres/microtablets.
19. GI STIMULANT/GERD		
metoclopramide	Reglan	
20. H2 ANTAGONISTS		
famotidine	Pepcid	Prescription strength only
ranitidine	Zantac	Prescription strength only; oral form only

^ = Drug requires a prior authorization
* = Drug restricted to specific diagnosis, dose, form or circumstance
● = Drug must be dispensed with a minimum 28 day supply

	Generic Name	Brand Name	Restrictions
This program mandates the use of generic products whenever possible in accordance with applicable law or regulations. Dispensing a brand name product when a generic is available requires prior authorization and a DAW 1 code. Exceptions are noted by drug.			
21. PROTON PUMP INHIBITORS			
^*	lansoprazole	Prevacid	Restricted to use after trial of famotidine or ranitidine. Unrestricted in the treatment of erosive esophagitis and H. Pylori related Peptic Ulcer Disease. Documentation required
^*	omeprazole	Prilosec	Restricted to use after trial of famotidine or ranitidine. Unrestricted in the treatment of erosive esophagitis and H. Pylori related Peptic Ulcer Disease. Documentation required
21. HEMATOLOGICAL AGENTS			
Must Provide copy of the original RX with every refill request			
^	epoetin alpha	Procrit, Epogen	Please provide documentation of Hgb on prior authorization request form.
^	filgrastim	Neupogen	Please provide documentation of ANC on prior authorization request form.
23. STEROIDS			
	dexamethasone	Decadron	Oral or injectable forms only
	prednisone	Deltasone	Oral and generic forms only
24. URICOSURIC AGENTS			
	probenecid	Benemid	
25. TOPICAL AGENTS			
	alitretinoin gel	Panretin	Gel form only
	imiquimod	Aldara	
26. WASTING AND HYPOGONADISM			
	dronabinol	Marinol	
	megestrol	Megace, Megace ES	
^*	oxandrolone	Anavar, Oxandrin	Restricted to treatment in females only
^*	nandrolone	Deca-Durabolin	Long acting for wasting only. Commercially available products only. Compounded products not approved.
^*	somatropin	Serostim	Restricted to HIV/AIDS wasting syndrome; requires supplemental form and PA form with each request; limited to 28-days supply
^*	testosterone	Androderm, Testoderm TTS, Androgel, Testim	Long acting for wasting or hypogonadism; transdermal, gel and injectable forms covered. **Maximum of 200mg weekly.** Must provide copy of the original RX with every refill request.

^ = Drug requires a prior authorization
* = Drug restricted to specific diagnosis, dose, form or circumstance
● = Drug must be dispensed with a minimum 28 day supply

HealthPAC
Health Program of Alameda County

HEALTHPAC HIV
LIHP FORMULARY
FORMULARY BY CLASS
Effective 8/1/2012

Ramsell™

P: 888-311-7632 www.ramsellcorp.com F: 800-848-4241

Generic Name	Brand Name	Restrictions
This program mandates the use of generic products whenever possible in accordance with applicable law or regulations. Dispensing a brand name product when a generic is available requires prior authorization and a DAW 1 code. Exceptions are noted by drug.		
28. MISCELLANEOUS		
hydroxyurea	Hydrea	

Program Dispensing Policies
1. Drugs marked with "•"are to be dispensed with a minimum 28 day supply. Exceptions will require a prior authorization.
2. Drugs marked with "*" Code 1 are restricted by a specific diagnosis, dose, form or circumstance of the client. Prior authorization may be required and granted only when Code 1 requirements are met.
3. Drugs marked with "^" require a prior authorization; Log onto Ramsell's website: www.ramsellcorp.com, or call HealthPAC HIV at (510) 383 - 1790 for a copy of the PA form. HealthPAC HIV will request additional information (client and drug specific) before considering the authorization.
4. Please fax completed PA forms to HealthPAC HIV at (510) 567- 6850.
5. All drugs are to be dispensed with a maximum 30 – day supply. Exceptions will require a prior authorization.
6. Refills may be obtained after 80% of the previously dispensed days-supply has been used; however, there is an annual maximum of 13 fills per prescription.
7. All HealthPAC HIV prescriptions must be reauthorized by the prescriber every 6 months. The claims adjudication system will accept 5 as the maximum number of refills.
8. Prior authorization is required for DEA class II and III drugs when quantity exceeds 120 and 240 respectively.
9. HealthPAC HIV mandates the use of generic products whenever possible in accordance with applicable law or regulations. Dispensing a brand name product when a generic is available requires prior authorization and a DAW 1 code. Exceptions are noted by drug.
PLEASE NOTE: There may be some SPECIFIC DOSE FORMS of products on this formulary that may NOT BE COVERED OR REQUIRE PRIOR AUTHORIZATION. You can verify drug coverage by dialing the toll free Ramsell number listed below and select the Electronic Verification option. You will need your pharmacy NCPDP# and the drug's 11 digit national drug code (NDC).
(Ramsell Corporation 1-888-311-7632)

^ = Drug requires a prior authorization
* = Drug restricted to specific diagnosis, dose, form or circumstance
● = Drug must be dispensed with a minimum 28 day supply