Washington State Department of Health Early Intervention Program (EIP)
FORMULARY FOR GROUP 1 & 3 BY DRUG CLASS

Washington State Department of Health

Effective Aug 08, 2012

Version 7, 2012

Ramsell™

		Generic Name	Brand Name	Restrictions or Notes
		1. ANTIRETROVIRALS		
A	•	abacavir	Ziagen	Effective 8/8/12, Generic abacavir is covered for copayments only for Group 1 patients
A	•	abacavir/lamivudine	Epzicom	
A	•	abacavir/lamivudine/zidovudine	Trizivir	
A	•	amprenavir	Agenerase	
A	•	atazanavir	Reyataz	
A	•	darunavir (TMC-114)	Prezista	
A	•	delavirdine	Rescriptor	
A	•	didanosine	Videx, Videx EC	Generic Videx EC covered for copayments only
A	•	efavirenz	Sustiva	
A	^	enfuvirtide	Fuzeon	Call for supplemental application form. Clinical criteria must be met every 6 mos.
A	•	emtricitabine	Emtriva	
A	•	emtricitabine/tenofovir/efavirez	Atripla	
A	•	emtricitabine/rilpivirine/tenofovir	Complera	Effective 1/1/2012
A	•	etravirine	Intelence	
A	•	fosamprenavir	Lexiva	Limited to a quantity of 60 tablets per month without prior authorization. PA is required for qty >60 and requires that prescriber certifies intolerance to ritonavir.
A	•	indinavir	Crixivan	
A	•	lamivudine (3TC)	Epivir	Effective 2/20/12, Generic Epivir is covered for copayments only for Group 1 patients
A	•	lopinavir/ritonavir	Kaletra	25mg-100mg, 50mg-200mg, 100mg-400mg/5ml solution
A	^	maraviroc	Selzentry	Prior authorization required. Trofile™ assay lab results must be faxed to Ramsell Public Health Rx
A	•	nelfinavir	Viracept	
A	•	nevirapine	Viramune	IR and XR formulations covered.Effective. 8/8/12,generic nevirapine is covered for copayments only for Group 1 patients
A	•	raltegravir	Isentress	
A	•	rilpivirine	Edurant	
A	•	ritonavir	Norvir	Dosage of 400mg or greater requires use of the free drug program though Abbott or prior authorization. Limited to copays only of ≤ $50 for dosages greater than 400mg daily.
A	•	saquinavir	Invirase	
A	•	stavudine (d4T)	Zerit	Generic Zerit covered for copayments only
A	•	tenofovir DF	Viread	
A	•	tenofovir/emtricitabine	Truvada	
A	^ •	tipranavir	Aptivus	Call for supplemental application form.
A	•	zalcitabine (ddC)	Hivid	
A	•	zidovudine (AZT)	Retrovir	
A	•	zidovudine/lamivudine (AZT/3TC)	Combivir	Effective 2/20/12, Generic Combivir is covered for copayments only for Group 1 patients
		2. ANALGESICS - Oral and transdermal only		
		Most drugs in this FDA class are covered. Common examples are:		
B		NSAIDs		
B		narcotics		
B		pregabalin	Lyrica	For the treatment of peripheral neuropathy
B		Selective serotonin agonist antimigraine medications (i.e. Maxalt, Imitrex) removed from formulary.		

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		3. ANTIANXIETY AGENTS		
		Most drugs in this FDA class are covered. Common examples are:		
B		benzodiazepines		All drugs in this FDA class are covered
B		buspirone	Buspar	
B		hydroxyzine	Vistaril	
		4. ANTIBIOTICS		
B		amoxicillin		
B		amoxicillin/potassium clavulanate	Augmentin	
B		ampicillin		
B	*	azithromycin	Zithromax	250mg tablet restrictions removed from formulary September 1st 2008. Z-pak units removed from formulary.
B		ceftriaxone	Rocephin	
B		cephalexin	Keflex	
B		cefpodoxime	Vantin	Available for treatment of gonorrhea.Doses of 400mg (2x200mg tabs) do not require prior authorization
B		ciprofloxacin	Cipro	>14 day supply requires PA
B	^	clarithromycin	Biaxin	Restricted to prevention or treatment of MAC also known as MAI or mycobacterium avium intracellulare complex infection
B		clindamycin		
B		clofazimine	Lamprene	
B		dicloxacillin		
B		doxycycline		
B		erythromycin		
B		ethambutol	Myambutol	
B		isoniazid		
B		levofloxacin	Levaquin	
B		moxifloxacin	Avelox	
B		mupirocin	Bactroban	For the topical treatment of impetigo
B		ofloxacin	Floxin	
B		penicillin		
B		pyrazinamide		For the treatment of tuberculosis
B		rifabutin	Mycobutin	
B		rifampin	Rifadin	
B		tetracycline		
B		trimethoprim		
B		trimethoprim/sulfamethoxazole	Bactrim,Septra, CoTrim	
B		vancomycin Oral		
		5. ANTIDEPRESSANTS		
		Most drugs in this FDA class are covered. Common examples are:		
B		SSRIs:		
B		citalopram	Celexa	Pill split 20mg
B		fluoxetine	Prozac	
B		fluvoxamine	Luvox	
B		paroxetine	Paxil	Pill split 10mg, 20mg
B		sertraline	Zoloft	Pill split 50mg
		TCAs:		
B		amitriptyline	Elavil	
B		clomipramine	Anafranil	
B		desipramine		
B		doxepin		
B		imipramine		
B		nortriptyline		

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		5. ANTIDEPRESSANTS continued		
		Others:		
B		bupropion	Wellbutrin	
B		nefazodone	Serzone	Pill split 50mg, 100mg
B		trazodone		
B		venlafaxine	Effexor	
		6. ANTIDIABETIC AGENTS		
B	•	Insulin, Injection kits and Glucose test strips		
B	•	*Most drugs in this FDA class are covered. Common examples are:*		
B	•	acarbose	Precose	
B	•	glyburide	Diabeta	
B	•	glipizide	Glucotrol	
B	•	metformin	Glucophage	
B	•	pioglitazone	Actos	
B	•	repaglinide	Prandin	
B	•	rosiglitazone	Avandia	
		7. ANTIFUNGALS		
B		clotrimazole	Lotrimin, Mycelex	
B		clotrimazole/betamethasone	Lotrisone Cr	
B	**^***	fluconazole	Diflucan	Not covered for onychmycosis. Use code 1 override for all other indications.Please include diagnosis on PA form
B	**^***	itraconazole	Sporonox	Not covered for onychmycosis. Use code 1 override for all other indications. Please include diagnosis on PA form
B		ketoconazole	Nizoral	
B		miconazole		
B		nystatin		
B		terconazole	Terazol	
		8. ANTIHYPERLIPIDEMIC		
B	•	*Most drugs in this FDA class are covered. Common examples are:*		
B	•	atorvastatin	Lipitor	Pill split removed from formulary September 1st 2008.
B	•	cholestyramine	Questran	
B	•	gemfibrozil	Lopid	
B	•	colestipol	Welchol	
B	•	lovastatin	Mevacor	
B	•	niacin		
B	•	pravastatin	Pravachol	
B	•	simvastatin	Zocor	
		9. ANTIPARASITICS		
B		albendazole		
B		atovaquone	Mepron	
B		dapsone		
B		lindane		
B		metronidazole	Flagyl, Metrogel Vaginal Gel	
B		paromomycin	Humatin	
B		permethrin		

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		9. ANTIPARASITICS Continued		
B		primaquine		
B		pyrimethamine	Daraprim	
B		sulfa/pyrimethamine	Fansidar	
B		sulfadiazine	Microsulfon	
		10. ANTIVIRALS - OTHER		
B		acyclovir	Zovirax	
B		cidofovir	Vistide	
B		fomivirsen	Vitravene	
B		foscarnet	Foscavir	
B		ganciclovir	Cytovene	IV and Oral
B		hepatitis B immune globulin	HBIG	
B		imiquimod cream	Aldara	
B		immune globulin IM	IGIM	
B		oseltamivir	Tamiflu	
B		podofilox	Condylox	
B	^	valacyclovir	Valtrex	Restricted to treatment of herpes zoster (shingles), zoster ophthalmicus or herpes simplex virus infections of the eye.
B		valganciclovir	Valcyte	
B		varicella zoster immune globulin	VZIG	
B		zanamivir	Relenza	
		11. BIPOLAR MEDICATION		
B		carbamazepine	Tegretol	
B		clozapine	Clozaril	
B	^	divalproex sodium	Depakote, Depakote ER	
B		gabapentin	Neurontin	
B		lamotrigine	Lamictal	
B		lithium		
B	^	olanzapine	Zyprexa	Covered after failed trial of formulary meds (Depakote or lithium).
B		oxcarbazepine	Trileptal	
B		quetiapine	Seroquel	
B		risperidone	Risperdal	
B		topiramate	Topamate	
B		valproic acid	Depakene	
		12. DERMATOLOGIC AGENTS		
B		selenium sulfide		
B		topical steroids		All drugs in this FDA class are covered
		13. GASTROINTESTINAL AGENTS		
B		dicyclomine	Bentyl	
B		diphenoxylate/atropine	Lomotil	
B	^	dronabinol	Marinol	Unintentional 10lb weight loss must be documented on PA for approval of initial 3 months treatment period. Treatment beyond 3 months requires additional documentation. Call for assistance.
B		hyoscyamine	Levbid, Levsin	
B		loperamide	Immodium	

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13. GASTROINTESTINAL AGENTS continued				
B		metoclopramide	Reglan	
B	^	ondansetron hydrochloride	Zofran	Covered after failed trial of Reglan and either Compazine or Phenergan
B		opium tincture		
B		prochlorperazine	Compazine	
B		promethazine	Phenergan	
		H2-Antagonists		
B		cimetidine	Tagamet	
B		famotidine	Pepcid	
B		nizatidine	Axid	
B		ranitidine	Zantac	
B	^	**Proton Pump Inhibitors**		Covered for treatment of GERD, erosive esophagitis, or H. pylori. Restricted to use after trial of H2-blockers in treatment of ulcer or gastritis.
B		esomeprazole	Nexium	
B		lansoprazole	Prevacid	
B		omeprazole	Prilosec	
B		pantoprazole	Protonix	
B		rabeprazole	Aciphex	
14. HEMATOPOIETIC AGENTS				
B	^	epoetin-alpha	Procrit, Epogen	Restricted to treatment of ribavirin-related anemia and Hepatitis C diagnosis. Documented history of previous Ribavirin treatment required.
B	^	filgrastim (G-CSF)	Neupogen	Restricted to treatment of interferon-related neutropenia with a diagnosis of Hepatitis C or B. Documented history of previous Hep C interferon treatment required.
15. HEPATITIS TREATMENT				
B		adefovir	Hepsera	
B	^	entecavir	Baraclude	Call for supplemental PA application for use with first fill only
B	*	interferon alfa-2a	Roferon-A	Restricted to use in treatment of Hepatitis B or C
B	*	inteferon alfa-2b	Intron-A	Restricted to use in treatment of Hepatitis B or C
B	^	pegylated interferons	Peg-Intron, Pegasys	Restricted to use in treatment of Hepatitis C, call for application form for initial dose. Free Peg-Intron is still available. Pegasys is restricted to cases when free Peg-Intron cannot be accessed thru the free Peg-Intron program or in patients that are continuing treatment with Pegasys to avoid interuption in treatment.
B		ribavirin	Rebetol, Copegus	
16. HORMONES				
B		estrogen	Premarin	
B		medroxyprogesterone	Depo-Provera, Provera	
B		megestrol acetate	Megace	
B	^	nandrolone	Deca-Durabolin	Call for supplemental application to use with first fill. Call if use is required beyond 6 months.

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		16. HORMONES Continued		
B	^	oxandrolone	Oxandrin	Call for supplemental application to use with first fill. Call if use is required beyond 12 weeks.
B		testosterone products		
		17. ORAL STEROIDS		
B		methylprednisolone		
B		prednisone		
		18. RESTLESS LEG SYNDROME TREATMENT		
B		levodopa/carbidopa	Sinemet	
B		pramipexole	Mirapex	
B		ropinirole	Requip	
		19. VACCINES		
B		*Multi-dose vials are not covered*		
B		hemophilus influenza type B vaccine	Hib	
B		hepatitis A vaccine	Havrix, Vaqta	
B		hepatitis B vaccine	Recombivax HB, Engerix B	
B		hepatitis A/hepatitis B vaccine	Twinrix	
B		influenza virus vaccine, split or whole virus		
B		diphtheria & tetanus toxoids & pertussis vaccine		
B		diphtheria & tetanus toxoids		
B		pneumococcal vaccine	Pneumovax, Pnu-Immune	
		20. MISCELLANEOUS		
B		chlorhexidine gluconate	Peridex	
B		hydroxyurea		
B		leucovorin		oral only
B		mediset fills		
B		phenazopyridine	Pyridin, Pyridium	
B		pill splitter		
B	^	prednisolone 1% soln		Restricted to treatment zoster ophthalmicus or herpes simplex virus infections of the eye.
B	^	trifluridine	Viroptic	Restricted to treatment zoster ophthalmicus or herpes simplex virus infections of the eye.

Program Dispensing Policies

1. Drugs marked with "•" are to be dispensed with a minimum 28 day supply. Exceptions will require prior authorization.
2. All drugs are to be dispensed with a maximum 30 day supply. Exceptions will require a prior authorization.
3. Drugs marked with "^" require a prior authorization. Document PA requirements as indicated for each drug on the PA form or on supplemental PA application if noted.
4. Drugs marked with an asterisk (*) after the drug names are code 1 restricted to use in a specific diagnosis. Transmit with the code 1 override or DAW 9 if the restriction is met. Document diagnosis on original prescription.
5. Prior authorization is required for DEA Class II and Class III drugs when quantities exceed 120 and 240 respectively.
6. Drugs followed by [P/S] are included in the pill splitting program.
7. Fills/refills may be obtained after 80% of the previous dispensed days-supply has been used.
8. Must dispense generic when available; DAW overrides will require prior authorization.
9. OTC meds on the formulary are available by prescription only.
10. Trofile™ assay lab results confirming CCR5 only co-receptor must be confirmed prior to initiation with maraviroc.

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