

Washington State Department of Health Early Intervention Program (EIP)

FORMULARY FOR GROUP 2 BY DRUG CLASS



Effective Sept. 1, 2011

Version 6, 2012



Generic Name		Brand Name	Restrictions or Notes
1. 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.	
2. 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	
B		hydroxyzine	
3. 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	

Washington State Department of Health Early Intervention Program (EIP)

FORMULARY FOR GROUP 2 BY DRUG CLASS



Effective Sept. 1, 2011

Version 6, 2012



Generic Name		Brand Name	Restrictions or Notes
4. ANTIDEPRESSANTS			
	<i>Most drugs in this FDA class are covered. Common examples are:</i>		
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
	<u>TCAs:</u>		
B	amitriptyline	Elavil	
B	clomipramine	Anafranil	
B	desipramine		
B	doxepin		
B	imipramine		
B	nortriptyline		
	<u>Others:</u>		
B	bupropion	Wellbutrin	
B	nefazodone	Serzone	Pill split 50mg, 100mg
B	trazodone		
B	venlafaxine	Effexor	
5. ANTIDIABETIC AGENTS			
B	Insulin, Injection kits and Glucose test strips		
B	<i>Most drugs in this FDA class are covered. Common examples are:</i>		
B	acarbose	Precose	
B	glyburide	Diabeta	
B	glipizide	Glucotrol	
B	metformin	Glucophage	
B	pioglitazone	Actos	
B	repaglinide	Prandin	
B	rosiglitazone	Avandia	
6. ANTIFUNGALS			
B	clotrimazole	Lotrimin, Mycelex	
B	clotrimazole/betamethasone	Lotrisone Cr	
B	^* fluconazole	Diflucan	Not covered for onychomycosis. Use code 1 override for all other indications. Please include diagnosis on PA form
B	^* itraconazole	Sporonox	Not covered for onychomycosis. Use code 1 override for all other indications. Please include diagnosis on PA form
B	ketoconazole	Nizoral	
B	miconazole		
B	nystatin		
B	terconazole	Terazol	
7. ANTIHYPERLIPIDEMIC			
B	<i>Most drugs in this FDA class are covered. Common examples are:</i>		
B	atorvastatin	Lipitor	Pill split removed from formulary September 1st 2008.
B	cholestyramine	Questran	
B	gemfibrozil	Lopid	

Washington State Department of Health Early Intervention Program (EIP)

FORMULARY FOR GROUP 2 BY DRUG CLASS



Effective Sept. 1, 2011

Version 6, 2012



Generic Name		Brand Name	Restrictions or Notes
7. ANTIHYPERLIPIDEMIC Continued			
B	• colestipol	Welchol	
B	• lovastatin	Mevacor	
B	• niacin		
B	• pravastatin	Pravachol	
B	• simvastatin	Zocor	
8. ANTIPARASITICS			
B	albendazole		
B	atovaquone	Mepron	
B	dapsone		
B	lindane		
B	metronidazole	Flagl, Metrogel Vaginal Gel	
B	paromomycin	Humatin	
B	permethrin		
B	primaquine		
B	pyrimethamine	Daraprim	
B	sulfa/pyrimethamine	Fansidar	
B	sulfadiazine	Microsulfon	
9. 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	
10. 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	

Washington State Department of Health Early Intervention Program (EIP)

FORMULARY FOR GROUP 2 BY DRUG CLASS



Effective Sept. 1, 2011

Version 6, 2012



Generic Name		Brand Name	Restrictions or Notes
10. BIPOLAR MEDICATION Continued			
B		quetiapine	Seroquel
B		risperidone	Risperdal
B		topiramate	Topamate
B		valproic acid	Depakene
11. DERMATOLOGIC AGENTS			
B		selenium sulfide	
B		topical steroids	All drugs in this FDA class are covered
12. 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
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
13. 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.
14. 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	*	interferon alfa-2b	Intron-A Restricted to use in treatment of Hepatitis B or C

Washington State Department of Health Early Intervention Program (EIP)

FORMULARY FOR GROUP 2 BY DRUG CLASS



Effective Sept. 1, 2011

Version 6, 2012



Generic Name		Brand Name	Restrictions or Notes	
14. HEPATITIS TREATMENT Continued				
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 interruption in treatment.
B		ribavirin	Rebetol, Copegus	
15. 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.
B	^	oxandrolone	Oxandrin	Call for supplemental application to use with first fill. Call if use is required beyond 12 weeks.
B		testosterone products		
16. ORAL STEROIDS				
B		methylprednisolone		
B		prednisone		
17. RESTLESS LEG SYNDROME TREATMENT				
B		levodopa/carbidopa	Sinemet	
B		pramipexole	Mirapex	
B		ropinirole	Requip	
18. 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	
19. MISCELLANEOUS				
B		chlorhexidine gluconate	Peridex	
B		hydroxyurea		
B		leucovorin		oral only
B		mediset fills		
B		phenazopyridine	Pyridin, Pyridium	
B		pill splitter		

Washington State Department of Health Early Intervention Program (EIP)

FORMULARY FOR GROUP 2 BY DRUG CLASS



Effective Sept. 1, 2011

Version 6, 2012



Generic Name		Brand Name	Restrictions or Notes
19. MISCELLANEOUS Continued			
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 "A" 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.