

**AIDS DRUG ASSISTANCE PROGRAM (ADAP)
CALIFORNIA FORMULARY
FORMULARY BY CLASS
Effective 06/24/2016**



P: 888-311-7632

www.ramsellcorp.com

F: 800-848-4241 Version 6, 2016

Generic Name Brand Name Restrictions

ADAP 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
	codeine/ASA		Oral form only
	fenopropfen		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 generic 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
▲*	dextroamphetamine	Dexedrine, Dextrostat	Restricted to treatment of severe debilitating depression; only 5mg and 10mg tablet form covered
	fluoxetine	Prozac	Prozac weekly not covered
▲*	methylphenidate	Ritalin	Restricted to treatment of severe debilitating depression; restricted to 5mg, 10mg, 20mg tablets and 20mg ER tablets only
	mirtazapine	Remeron	SolTabs not covered; 15mg, 30mg, 45mg tablets form only

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

● = Drug must be dispensed with a minimum 30 day supply

▲ = Drug requires a prior authorization

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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
●	pioglitazone	Actos	15mg, 30mg, 45mg tablets only. NDC 67544-0066-45 not covered start 5/22/12
▲●	rosiglitazone maleate	Avandia	Supplemental form required

6. ANTIHELMINTICS

	albendazole	Albenza	
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7. ANTIBIOTICS

▲	amikacin sulfate	Amikin	Injectable and generic forms only
	amoxicillin	Amoxil	Oral form only
	atovaquone	Mepron	Brand Only
	azithromycin	Zithromax	
	cephalexin	Keflex	Oral generic forms only. Brand name Keflex discontinued 6/11/10
▲*	ciprofloxacin	Cipro	Oral and injectable forms for treatment of MAC only. Please provide treatment regimen.
	clarithromycin	Biaxin	
	clindamycin	Cleocin	Oral and injectable forms only
	clofazimine	Lamprene	
	dapsone		Oral forms only
	dicloxacillin	Dynapen	Oral forms only
	doxycycline	Vibramycin	Oral generic forms 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
▲*	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.
	metronidazole	Flagyl	Oral forms only
	minocycline HCL	Minocin	Oral forms only
	neomycin sulfate		Oral generic forms only

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7. ANTIBIOTICS (Continued)

	paromomycin		
	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	Trimplex, Proloprim	Oral forms only
	trimetrexate	Neutrexin	
	vancomycin	Vancocin	Oral capsule form only, IV not covered

8. ANTIFUNGALS

	amphotericin B	Fungizone	Injectable and oral solutions only
▲*	casposfungin	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 itraconazole)
	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 in patients refractory to or intolerant of other therapies (ie: amphotericin B, lipid formulations of amphotericin B, and /or itraconazole)

9. ANTITUBERCULOSIS

▲	amikacin sulfate	Amikin	Injectable and generic forms only
▲	capreomycin	Capastat	1 gram injection only. Use of this medication is restricted for use in the treatment of multi-drug resistant tuberculosis (MDR-TB). Documentation required
▲	cycloserine	Seromycin	250mg capsules only. Use of this medication is restricted for use in the treatment of multi-drug resistant tuberculosis (MDR-TB). Documentation required
	ethambutol	Myambutol	
▲	ethionamide	Trecator	250mg tablets only. Use of this medication is restricted for use in the treatment of multi-drug resistant tuberculosis (MDR-TB). Documentation required
▲*	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
	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
▲*	moxifloxacin	Avelox	400mg tablets only. Use of this medication is restricted for use in the treatment of multi-drug resistant tuberculosis (MDR-TB) Documentation of medications tried and failed required

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9. ANTITUBERCULOSIS (Continued)

▲*	para-aminosalicylate	Paser	4 gram packets only. Use of this medication is restricted for use in the treatment of multi-drug resistant tuberculosis (MDR-TB). Documentation of medications tried and failed required
	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	

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	Brand only; generic covered for co-pay only
●	abacavir/lamivudine	Epzicom	Brand only
●	abacavir/lamivudine/zidovudine	Trizivir	Brand only
●	didanosine	Videx, Videx EC	Brand only; generic covered for co-pay only
●	emtricitabine	Emtriva	Brand only
●	lamivudine	Epivir	Brand only; generic covered for co-pay only. Epivir HB is NOT covered
●	stavudine	Zerit	Brand only; generic covered for co-pay only
●	tenofovir disoproxil fumarate	Viread	Brand only
●	tenofovir/emtricitabine	Truvada	Brand only
●	tenofovir alafenamide/emtricitabine	Descovy	Brand only; coverage start 5/2/2016
●	zidovudine	Retrovir	
●	zidovudine/lamivudine	Combivir	Brand only; generic covered for co-pay only

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13b. ANTIRETROVIRALS-NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS

●	delavirdine	Rescriptor	Brand only
●	efavirenz	Sustiva	Brand only
●	etravirine	Intelence	Brand only
●	nevirapine	Viramune	Brand only; IR and XR formulations covered; generic covered for co-pay only
●	rilpivirine	Eduvant	Brand only; Coverage start 6/13/2011

13c. ANTIRETROVIRALS-FUSION INHIBITORS

●^	enfuvirtide	Fuzeon	Brand only; please call or check website for special supplemental PA form
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13d. ANTIRETROVIRALS-COMBINATION TREATMENT

●	atazanavir/cobicistat	Evotaz	Coverage start 2/27/2015
●	darunavir/cobicistat	Prezcobix	Coverage start 2/27/2015
●	elvitegravir/cobicistat/emtricitabine/tenofovir	Stribild	Brand only; coverage start 9/26/12
●	elvitegravir/cobicistat/emtricitabine/tenofovir alafenamide	Genvoya	Brand only; coverage start 12/02/15
●	emtricitabine/tenofovir/efavirez	Atripla	Brand only
●	emtricitabine/tenofovir/rilpivirine	Complera	Brand only
●	emtricitabine/rilpivirine/tenofovir alafenamide	Odefsey	Brand Only, coverage start 3/30/2016
●	dolutegravir/lamivudine/abacavir	Triumeq	Brand only; Coverage start 9/22/14

13e. ANTIRETROVIRALS-PROTEASE INHIBITORS

●	atazanavir	Reyataz	Brand only
●	darunavir (TMC-114)	Prezista	Brand only - 800mg tablet covered effective 11/19/12
●	fosamprenavir	Lexiva	Brand only
●	indinavir	Crixivan	Brand only
●	lopinavir/ritonavir	Kaletra	Brand only
●	nelfinavir	Viracept	Brand only
●	ritonavir	Norvir	Brand only
●	saquinavir mesylate	Invirase	Brand or Generic
●	tipranavir	Aptivus	Brand only

13f. ANTIRETROVIRALS-CCR5 CO-RECEPTOR ANTAGONISTS

●^	maraviroc	Selzentry	Brand only
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13g. ANTIRETROVIRALS-INTEGRASE INHIBITOR

●	raltegravir	Isentress	Brand only
●	dolutegravir	Tivicay	Brand only
●	elvitegravir	Vitekta	Brand only

13h. ANTIRETROVIRALS-BOOSTING AGENT

●	cobicistat	Tybost	Brand only
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14. ANTIVIRALS-HEPATITIS

^	hepatitis A vaccine	Havrix, Vaqta	
^	hepatitis B vaccine	Engerix B, Recombivix HB	
^	interferon alfa-2b	Intron-A	
^	interferon alfacon 1	Infergen	
^	interferon alfa-2a	Roferon-A	

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14. ANTIVIRALS-HEPATITIS (continued)

^	interferon alfa-N3	Alferon-N	
^	pegylated interferon	Peg-Intron, Pegasys	Peg-Intron is available through Merck's free drug program only. Please call or check website for supplemental PA form
	ribavirin	Rebetol, Copegus	Rebetol, Copegus; please note that not all generics are covered.
^	ribavirin/interferon alfa 2B	Rebetron	
^	simprevir	Olysio	Dispensing of this Hep C drug will only be approved after the PA criteria is FULLY met. Requires a fully completed supplemental PA form and claim form with request. Please call Ramsell for supplemental form or access it at www.ramsellcorp.com
^	sofosbuvir	Sovaldi	
^	ledipasvir/sofosbuvir	Harvoni	
^	ombitasvir/paritaprevir/ritonavir	Technivie	
^	ombitasvir/paritaprevir/ritonavir + dasabuvir	Viekira Pak	

15. ANTIVIRALS-MISCELLANEOUS

	acyclovir	Zovirax	
	famciclovir	Famvir	
^*	valacyclovir	Valtrex 500mg	Brand Only. Generic covered for co-pay only. Drug is restricted to diagnosis of herpes simplex (HSV) or herpes zoster (HZV). HSV-max 10 days for acute treatment. Acute treatment and chronic suppressive therapy is approved only after failed trial of acyclovir. Drug is not payable for chronic suppressive treatment.
		Valtrex 1000mg	Valtrex 1000mg NDCs: 00173-0565-04 & 00173-0565-10 have been taken off the ADAP formulary.
	cidofovir	Vistide	
	fomivirsen	Vitrovene	
	foscarnet	Foscavir	
^*	ganciclovir	Cytovene	Oral form does not require a prior authorization; only the implant or injectable forms requires a prior authorization
^*	valganciclovir	Valcyte	Restricted to a diagnosis of CMV. Payable for active treatment or suppressive treatment only; not payable for primary prophylaxis of CMV. Generic covered for copayment ONLY effective 2/13/2015

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. (Axcan Products: Ultase MT 12, Ultrase MT 20, Ultrase MT 18 and Ultrase MS4 have been removed from the formulary effective 12/28/10)
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19. GI STIMULANT/GERD

	metoclopramide	Reglan	
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20. H2 ANTAGONISTS

	famotidine	Pepcid	Prescription strength only
	ranitidine	Zantac	Prescription strength only; Oral form only

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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 AND lansoprazole. Unrestricted in the treatment of erosive esophagitis and H. Pylori related Peptic Ulcer Disease. Documentation required

22. HEMATOLOGICAL AGENTS

Must Provide copy of the original RX with every refill request

▲	epoetin alpha	Procrit	Procrit™ brand only; Epogen™ is NOT covered
▲	filgrastim	Neupogen	

23. STEROIDS

	dexamethasone	Decadron	Oral or injectable forms only
	prednisone	Deltasone	Oral and generic forms only

24. URICOSURIC AGENTS

	probenecid	Benemid	
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25. VACCINES

▲	hepatitis A vaccine	Havrix, Vaqta	
▲	hepatitis B vaccine	Engerix B, Recombivix HB	
▲*	hepatitis A/hepatitis B vaccine	Twinrix	
▲*	pneumococcal vaccine	Pneumovax, Pnu-Immune	Single dose dispensing, 1 time dispensing every 6 years
	pneumococcal conjugate vaccine (PCV13)		Effective 07/10/2015
	Meningococcal Vaccine		Prior Authorization (PA) requirement removed effective 6/24/2016
*	Human Papillomavirus (HPV) 9-valent recombinant vaccine	Gardasil 9	This vaccine will be available to clients up to 26 years of age. Clients who turn 27 years of age after the vaccine series has begun will continue to be covered to ensure completion of the treatment series. Effective 4/22/2016

26. TOPICAL AGENTS

	alitretinoin gel	Panretin	Gel form only
	imiquimod	Aldara	

27. WASTING AND HYPOGONADISM

	dronabinol	Marinol	Brand only. Generic covered for co-pay only.
	megestrol	Megace, Megace ES	
▲*	nandrolone	Deca-Durabolin	Long acting for wasting only. Commercially available products only. Compounded products not approved.
▲*	oxandrolone	Anavar, Oxandrin	Restricted to treatment in females only
▲*	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	Injectable weekly maximum of 200mg weekly. Topical and transdermal forms are limited to 700mg/week with some limitations and exceptions. Must provide copy of the original RX with every start or change in treatment.

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28. MISCELLANEOUS

hydroxyurea	Hydrea	
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Program Dispensing Policies

- Drugs marked with "*" are to be dispensed with a minimum 28 day supply. Exceptions will require prior authorization.
- 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.
- Drugs marked with "^" require a prior authorization, Ramsell will request additional information (client and drug specific) before considering the authorization.
- All drugs are to be dispensed with a maximum 30 – day supply. Exceptions will require a prior authorization.
- 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.
- All ADAP prescriptions must be reauthorized by the prescriber every 6 months. The claims adjudication system will accept 5 as the maximum number of refills.
- Prior authorization is required for DEA class II and III drugs when quantity exceeds 120 and 240 respectively.
- ADAP 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. Brand ARVs preferred

9. All Antiretroviral combinations are screened against the most recent DHHS guidelines for the use antiretroviral therapy in adolescents and adults (<http://aidsinfo.nih.gov/contentfiles/lvguidelines/adultandadolescentgl.pdf>) for high dosage and non-recommended combinations. Regimens not conforming to these guidelines may be rejected at adjudication.

10. The following drug manufacturers are excluded from reimbursement thru the CA ADAP program:

Able LABS, INC.	Hospira
Acura Pharmaceuticals aka HALSEY	Kaiser Foundation Hospital
Allscripts	Liberty Pharmaceutical
Amneal Pharmaceuticals	Lupin Pharma
Avpak	New Horizon Rx Group
AvKare, Inc.	Nucare Pha
Axcan Pharmaceutical	Marlex Pharmaceuticals Inc.
Aphena PhA	Middlebrook Pharmaceutical Inc.
Bedford Labs/BenVenue	MHC Pharma LLC
Bay labs	MOVA Pharmaceuticals
Biogen PharmaceuticalsI	Palmetto State
Bleinheim Pharma	Patheon Inc. (Puerto Rico)
Blu Pharmaceuticals	Polygen Pharmaceuticals
BluePoint Laboratories	Physicians Total Care
Bryand Ranch PR	Pre-Package Specialists/PD-RX Pharmaceuticals
Ceph International	Prescript Pharmaceuticals
Cipla USA	Quality Care/Lake Erie Medical & Surgical Supply
CORE Pharmaceuticals	Rebel Distributors Corp (now Physician Partners)
Dispense Express, Inc.	Southwood Pharmaceuticals
Dispensing Solutions Inc.	Stat Rx USA
GSMS, INC.	Virtus Pharmaceuticals
Graceway Pharmaceuticals, LLC (Labeler code 00089 only)	Walgreens Co.
3M Pharmaceuticals (Labeler code 00089)	
HJ Harkin Co.	
H L MOORE	

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)

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