# AIDS DRUG ASSISTANCE PROGRAM (ADAP)
# CALIFORNIA FORMULARY
## FORMULARY BY CLASS
## Effective 3/7/14

P: 888-311-7632 www.ramsellcorp.com F: 800-848-4241 Version 3 2014

| | 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 |
| | 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 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. ANTIHELMINITICS** | | |
| | albendazole | Albenza | |
| | **7. ANTIBIOTICS** | | |
| ^ | amikacin sulfate | Amikin | Injectable and generic forms only |
| | amoxicillin | Amoxil | Oral form only |
| | atovaquone | Mepron | |
| | 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 treament 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. Please call or check website for special supplemental PA form |
| | 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 | Trimpex, 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 |
| ^* | 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 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 |
| ● | delavirdine | Rescriptor | Brand only |
| ● | didanosine | Videx, Videx EC | Brand only; generic covered for co-pay only |
| ● | efavirenz | Sustiva | Brand 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 |

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| **13b. ANTIRETROVIRALS-NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS** | | | |
| ● | tenofovir disoproxil fumarate | Viread | Brand only |
| ● | tenofovir/emtricitabine | Truvada | Brand only |
| ● | zalcitabine | Hivid | Brand only |
| ● | zidovudine | Retrovir | Generic covered for 300mg formulation only effective 10/30/12; all other formulations Brand required; generic covered for co-pay only other than 300mg formulation |
| ● | zidovudine/lamivudine | Combivir | Brand only; generic covered for co-pay only |
| ● | etravirine | Intelence | Brand only |
| ● | nevirapine | Viramune | Brand only; IR and XR formulations covered;generic covered for co-pay only |
| ● | rilpivirine | Edurant | 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 |
| **13d. ANTIRETROVIRALS-COMBINATION TREATMENT** | | | |
| ● | elvitegravir/cobicistat/emtricitabine/tenofovir | Stribild | Brand only; coverage start 9/26/12 |
| ● | emtricitabine/tenofovir/efavirez | Atripla | Brand only |
| ● | emtricitabine/tenofovir/rilpivirine | Complera | Brand only |
| **13e. ANTIRETROVIRALS-PROTEASE INHIBITORS** | | | |
| ● | amprenavir | Agenerase | Brand only |
| ● | 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-soft gel caps | Fortovase | Brand only |
| ● | saquinavir mesylate | Invirase | Brand only |
| ● | tipranavir | Aptivus | Brand only |
| **13f. ANTIRETROVIRALS-CCR5 CO-RECEPTOR ANTAGONISTS** | | | |
| ●^ | maraviroc | Selzentry | Brand only |
| **13g. ANTIRETROVIRALS-INTEGRASE INHIBITOR** | | | |
| ● | raltegravir | Isentress | Brand only |
| ● | dolutegravir | Tivicay | Brand only |
| **14. ANTIVIRALS-HEPATITIS** | | | |
| ^ | hepatitis A vaccine | Havrix, Vaqta | |
| ^ | hepatitis B vaccine | Engerix B, Recombivix HB | |
| ^ | inteferon alfa-2b | Intron-A | |
| ^ | interferon alfacon 1 | Infergen | |
| ^ | interferon alfa-2a | Roferon-A | |
| ^ | interferon alfa-N3 | Alferon-N | |

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| **14. ANTIVIRALS-HEPATITIS (continued)** | | | |
| ^ | 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 | |
| **15. ANTIVIRALS-MISCELLANEOUS** | | | |
| | acyclovir | Zovirax | |
| | famcyclovir | 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 | Vitravene | |
| | 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 |
| **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 romoved form the formulary effective 12/28/10) |
| **19. GI STIMULANT/GERD** | | | |
| | metoclopramide | Reglan | |
| **20. H2 ANTAGONISTS** | | | |
| | famotidine | Pepcid | Prescription strength only |
| | ranitidine | Zantac | Prescription strength only; Oral form only |
| **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 |

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| **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 | |
| **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 evey 6 years |
| **26. TOPICAL AGENTS** | | | |
| | alitretinoin gel | Panretin | Gel form only |
| | imiquimod | Aldara | |
| **27. WASTING AND HYPOGONADISM** | | | |
| | dronabinol | Marinol | Brand only.<br>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 | |

Program Dispensing Policies
1. Drugs marked with "•" are to be dispensed with a minimum 28 day supply. Exceptions will require 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, Ramsell will request additional information (client and drug specific) before considering the authorization.
4. All drugs are to be dispensed with a maximum 30 – day supply. Exceptions will require a prior authorization.
5. 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.
6. 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.
7. Prior authorization is required for DEA class II and III drugs when quantity exceeds 120 and 240 respectively.
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9. All Antiretroviral combinations are screened against the most recent DHHS guidelines for the use antiretroviral therapy in adolesescents 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.
Acura Pharmaecuticals aka HALSEY
Allscripts
Alvogen
Avpak
AvKare, Inc.
Axcan Pharmaceutical
Bedford Labs/BenVenue
Bay labs
Biogen Pharmaceuticsl
Bleinheim Pharma
Blu Pharmaceuticals
Bryand Ranch PR
Ceph International
CORE Pharmaceuticals
Dispense Express, Inc.
GSMS, INC.
HJ Harkin Co.
H L MOORE
Hospira
Liberty Pharmaceutical
Lupin Pharma
Marlex Pharmaceuticals Inc.
Middlebrook Pharmaceutical Inc.
MOVA Pharmaceuticals
Palmetto State
Patheon Inc. (Puerto Rico)
Polygen Pharmaceuticals
Physicians Total Care
Pre-Package Specialists/PD-RX Pharmaceuticals
Prescript Pharmaceuticals
Quality Care/Lake Erie Medical & Surgical Supply
Rebel Distributors Corp (now Physician Partners)
Southwood Pharmaceuticals
Stat Rx USA
Sun Pharmaceuticals

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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