AIDS DRUG ASSISTANCE PROGRAM (ADAP)
CALIFORNIA FORMULARY
FORMULARY BY CLASS
Effective 02/27/2015

P: 888-311-7632 www.ramsellcorp.com F: 800-848-4241 Version 2, 2015

	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

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^ = Drug requires a prior authorization

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	Generic Name	Brand Name	Restrictions
	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	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 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	
●	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			
●	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
●	emtricitabine/tenofovir/efavirez	Atripla	Brand only
●	emtricitabine/tenofovir/rilpivirine	Complera	Brand only
●	dolutegravir/lamivudine/abacavir	Triumeq	Brand only; Coverage start 9/22/14
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 mesylate	Invirase	Brand or Generic
●	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
13h. ANTIRETROVIRALS-BOOSTING AGENT			
●	cobicistat	Tybost	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	

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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 @ ramsellcorp.com
^	sofosbuvir	Sovaldi	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 @ ramsellcorp.com
	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

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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	
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. 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.
28. MISCELLANEOUS			
	hydroxyurea	Hydrea	

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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.
8. 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 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
Avpak
AvKare, Inc.
Axcan Pharmaceutical
Aphena PhA
Bedford Labs/BenVenue
Bay labs
Biogen Pharmaceuticsl
Bleinheim Pharma
Blu Pharmaceuticals
Blupoint Laboratories
Bryand Ranch PR
Ceph International
CORE Pharmaceuticals
Dispense Express, Inc.
Dispensing Solutions Inc.
GSMS, INC.
HJ Harkin Co.
H L MOORE
Hospira
Kaiser Foundation Hospital
Liberty Pharmaceutical
Lupin Pharma
Nucare Pha
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
Walgreens Co.

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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