Washington State Department of Health Early Intervention Program (EIP)
FORMULARY FOR GROUP 2
BY DRUG CLASS
Effective 4/28/2016
Version 9, 2016

		GENERIC NAME	BRAND NAME	RESTRICTION or NOTES
		1. ANALGESICS - Oral and transdermal only		
		Most drugs in this FDA class are covered. Common examples are:		
B		Nonsteroidal Anti-inflammatory Agents (NSAIDs)		
B		diclofenac potassium	Voltaren	
B		diclofenac/misoprostol	Athrotec	
B		etodolac	Lodine	
B		ibuprofen	Motrin	
B		indomethacin	Indocin	
B		ketoprofen	Orudis	
B		ketorolac	Toradol	
B		meloxicam	Mobic	
B		nabumetone	Relafen	
B		naproxen	Naprosyn	
B		oxaprozin	Daypro	
B		piroxicam	Feldene	
B		sulindac	Clinoril	
B		tolmetin	Tolectin	
B		Cyclooxygenase 2 (COX-2) Inhibitors	celecoxib	
B		Narcotics		**Oxycontin & Oxycodone removed from the formulary**
B		acetaminophen w/ codeine	Tylenol with Codeine #3	
B		butalbital-acetaminophen-caffeine w/ Codeine	Fioricet/Codeine	
B		butalbital-aspirin-caffeine w/codeine	Fiorinal	
B		codeine sulfate		
B		hydrocodone bitartrate	Zohydro ER	
B		hydrocodone-acetaminophen	Norco, Lortab	
B		hydrocodone-ibuprofen	Vicoprofen	
B		hydromorphone	Dilaudid	
B		meperidine	Demerol	
B		methadone	Dolophine	
B		morphine sulfate	Avinza, Kadian, MS Contin	
B		morphine sulfate/ naltrexone	Embeda	
B		oxycodone HCl/APAP	Percocet	
B		oxycodone HCl/aspirin	Percodan	
B		oxymorphone HCl	Opana, Opana ER	
B		tapentadol ER	Nucynta ER	
B		tramadol HCl	Ultram, Ultram ER	
B		tramadol HCl / APAP	Ultracet	
B		fentanyl patches	Duragesic	
B		fentanyl sublingual spray	Subsys	
B		fentanyl citrate buccal tab	Fentora	
B		fentanyl citrate buccal soluble film	Abstral	
B		fentanyl citrate lollipop	Actiq	
B	*	pregabalin	Lyrica	For the treatment of peripheral neuropathy

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		Selective serotonin agonist antimigraine medications (i.e. Maxalt, Imitrex) **removed from formulary**.		
		Muscle Relaxants **removed from formulary** (i.e Carisoprodol, Tizanidine, Cyclobenzaprine, Baclofen, Methocarbamol, Skelaxin, Zanaflex, Orphenadrine)		
		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		alprazolam	Xanax, Xanax XR	
B		clorazepate	Tranxene	
B		diazepam	Valium	
B		lorazepam	Ativan	
B		meprobamate		
B		oxazepam	Serax	
B		buspirone	Buspar	
B		hydroxyzine	Vistaril	
		3. ANTIBIOTICS		
B		amoxicillin	Amoxil	
B		amoxicillin/potassium clavulanate	Augmentin	
B		ampicillin		
B	*	azithromycin	Zithromax	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	
B	^	clarithromycin	Biaxin	Restricted to prevention or treatment of MAC also known as Mycobacterium avium-intracellulare (MAI), Mycobacterium avium or Mycobacterium intracellulare
B		clindamycin	Cleocin	
B		clofazimine	Lamprene	
B		dicloxacillin		
B		doxycycline	Vibra-tabs	
B		erythromycin	Ery-Tab	
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	Veetids, Bicillin L-A	
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		Covered only after failure of oral metronidazole

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		4. ANTIDEPRESSANTS		
		Most drugs in this FDA class are covered. Common examples are:		
B		**Selective Serotonin Receptor Inhibitors (SSRIs):**		
B		citalopram	Celexa	
B		fluoxetine	Prozac	
B		fluvoxamine	Luvox	
B		paroxetine	Paxil	
B		sertraline	Zoloft	
B		venlafaxine	Effexor	
		Tricyclic Antidepressants (TCAs):		
B		amitriptyline	Elavil	
B		clomipramine	Anafranil	
B		desipramine	Norpramin	
B		doxepin	Silenor	
B		imipramine	Tofranil	
B		nortriptyline	Pamelor	
		Serotonin Modulator		
B		vilazodone	Viibryd	
B		nefazodone	Serzone	
B		trazodone, trazodone SR	Trazodone, Oleptro	
		Others:		
B		bupropion	Wellbutrin	
		5. ANTIDIABETIC AGENTS		
B	•	Insulin		
B	•	Injection kits		
B	•	Glucose test strips		
		Most drugs in this FDA class are covered. Common examples are:		
B	•	**Biguanide**		
B	•	metformin	Glucophage	
B	•	**Sulfonylureas**		
B	•	glyburide	Diabeta, Micronase	
B	•	glyburide micronized	Glynase, Glycron	
B	•	glimepiride	Amaryl	
B	•	glipizide	Glucotrol	
B	•	tolbutamide	Orinase	
B	•	tolazamide	Tolinase	
B	•	chlorpropamide	Diabinese	
B	•	**Alpha-Glucosidase Inhibitors**		
B	•	acarbose	Precose	
B	•	Miglitol	Glyset	
B	•	**Thiazolidinediones**		
B	•	pioglitazone	Actos	
B	•	rosiglitazone	Avandia	
B	•	**Meglitinide**		
B	•	repaglinide	Prandin	
B	•	nateglinide	Starlix	
B	•	**Dipeptidyl Peptidase - 4 (DPP-4) Inhibitors**		
B	•	sitagliptin	Januvia	
B	•	saxagliptin	Onglyza	
B	•	alogliptin	Nesina	

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		5. ANTIDIABETIC AGENTS Continued		
B	•	linagliptin	Tradjenta	
B	•	**Antidiabetic combinations**		
B	•	metformin/sitagliptin	Janumet	
B	•	metformin/repaglinide	PrandiMet	
B	•	metformin/saxagliptin	Kombiglyze XR	
B	•	metformin/glyburide	Glucovance	
B	•	metformin/rosiglitazone	Avandamet	
B	•	metformin/pioglitazone	Actoplus Met	
B	•	metformin/glipizide	Metaglip	
B	•	metformin/linagliptin	Jentadueto	
B	•	metformin/alogliptin	Kazano	
B	•	rosiglitazone/glimepiride	Avandaryl	
		6. ANTIFUNGALS		
B		clotrimazole	Lotrimin, Mycelex	
B		clotrimazole/ betamethasone	Lotrisone Cream	
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	Monistat	
B		nystatin		
B		terconazole	Terazol	
		7. ANTIHYPERLIPIDEMIC		
		Most drugs in this FDA class are covered. Common examples are:		
B	•	**Statins**		
B	•	atorvastatin	Lipitor	
B	•	lovastatin	Mevacor	
B	•	pravastatin	Pravachol	
B	•	simvastatin	Zocor	
B	•	fluvastatin	Lescol	
B	•	pitavastain	Livalo	
B	•	rosuvastatin	Crestor	
B	•	**Antihyperlipidemics combinations**		
B	•	lovastatin/niacin	Advicor	
B	•	simvastatin/ezetimibe	Vytorin	
B	•	**Bile Acid Sequestrants Agents (Resins)**		
B	•	cholestyramine	Questran	
B	•	colestipol	Colestid	
B	•	colesevelam	Welchol	
B	•	**Fibrates**		
B	•	gemfibrozil	Lopid	
B	•	fenofibric acid	Triplix	
B	•	fenofibrate	Tricor, Antara	
B	•	niacin	Vitamin B3	
B	•	ezetimibe	Zetia	

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		8. ANTIPARASITICS		
B		albendazole	Albenza	
B	^	atovaquone	Mepron	
B		dapsone	Aczone	
B		lindane		
B		metronidazole	Flagyl, Metrogel Vaginal Gel	
B		paromomycin	Humatin	
B		permethrin	Elimite	
B		primaquine		
B		pyrimethamine	Daraprim	
B		sulfadoxine/pyrimethamine	Fansidar	
B		sulfadiazine	Microsulfon	
		9. ANTIVIRALS - OTHER		
B		acyclovir	Zovirax	
B		cidofovir	Vistide	
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	Lithobid	
B		olanzapine	Zyprexa	
B		oxcarbazepine	Trileptal	
B		quetiapine	Seroquel	
B		risperidone	Risperdal	
B		topiramate	Topamate	
B		valproic acid	Depakene	
B		ziprasidone	Geodon	

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		11. DERMATOLOGIC AGENTS		
		Topical Steriods are not covered		
B		selenium sulfide	Tersi	
		12. GASTROINTESTINAL AGENTS		
B		crofelemer	Fulyzaq	
B		dicyclomine	Bentyl	
B		diphenoxylate/atropine	Lomotil	
B		dronabinol	Marinol	
B		hyoscyamine	Levbid, Levsin	
B		loperamide	Imodium	
B		metoclopramide	Reglan	
B		ondansetron hydrochloride	Zofran	
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.
B		esomeprazole	Nexium	
B		lansoprazole	Prevacid	
B		omeprazole	Prilosec	
B		pantoprazole	Protonix	
B		rabeprazole	Aciphex	
		13. HEMATOPOIETIC AGENTS		
B		epoetin-alpha	Procrit, Epogen	Hepatitis C/Oncology use only - copy of original prescription indicating a diagnosis is required.
B		filgrastim (G-CSF)	Neupogen	Hepatitis C/Oncology use only - copy of original prescription indicating a diagnosis is required.
		15. HEPATITIS TREATMENT		
		Supplemental form required for Hepatitis C Treatments. Download form from www.ramsellcorp.com		**Clinical criteria MUST be met prior to approval.**
B		adefovir	Hepsera	
B	^*	elbasvir and grazoprevir	Zepatier	Coverage effective 4/18/2016. Utilization Cap Applicable
B		entecavir	Baraclude	Restricted to use in the treatment of Hepatitis B. Supplemental form required.
B	^*	ledipasvir and sofosbuvir	Harvoni	Coverage effective 2/26/2015. Utilization Cap Applicable
B	^*	sofosbuvir	Sovaldi	Coverage effective 2/26/2015. Utilization Cap Applicable
B	^*	simeprevir sodium	Olysio	Coverage effective 2/26/2015. Utilization Cap Applicable
B	^*	ombitasvir, paritaprevir, ritonavir and dasabuvir	Vierkira Pak	Coverage effective 2/26/2015. Utilization Cap Applicable
B	^*	ombitasvir, paritaprevir and ritonavir	Technivie	Coverage effective 4/18/2016. Utilization Cap Applicable
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
B	^	pegylated interferons	Pegasys	Restricted to use in treatment of Hepatitis C.
B		ribavirin	Copegus	

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		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	Examples include: Androderm, AndroGel, Striant, Testim, Testoderm, Testoderm TTS	
B	*^	tesamorelin	Egrifta	Treatment will not be authorized for cosmetic use or weight loss.
		16. ORAL STEROIDS		
B		methylprednisolone	Medrol, Methylpred	
B		prednisone	Prednisone	
		17. VACCINES		
B		**Multiple-dose vials <u>are not covered</u>**		
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	Afluria, Fluarix	
B		diphtheria & tetanus toxoids & pertussis vaccine	Adacel, Boostrix	
B		diphtheria & tetanus toxoids	Tenivac	
B		pneumococcal vaccine	Pneumovax, Pnu-Immune	
B		varicella zoster vaccine	Zostavax	Pharmacy administration costs are still being researched and only the vaccine is covered at this time Pharmacies will be notified once changes are made
		18. SUBSTANCE ABUSE		
B		acamprostate	Campral	For alcohol addiction
B		buprenorphine/naloxone	Suboxone	For alcohol addiction
B		disulfiram	Antabuse	For alcohol addiction
B		naltrexone	ReVia	For alcohol and opioid addiction
B		clonidine	Catapres	Used for reducing cravings in alcohol and opioid addiction
		19. MISCELLANEOUS		
B		chlorhexidine gluconate	Peridex	
B		hydroxyurea	Hydrea	
B		leucovorin		oral only
B		mediset fills		
B		phenazopyridine	Pyridin, Pyridium	

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19. MISCELLANEOUS Continued				
B		pill splitter		
B	^	prednisolone 1% soln	OmniPred, PredForte	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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