

**Michigan Department of Community Health
Preferred Drug List
Effective 10/15/2009**

Bolded Drugs do not require prior authorization, except as noted in chart at bottom of page

ANALGESICS

NARCOTICS—LONG ACTING

**Duragesic®
Kadian®
Methadone
Morphine Sulf. Tab SA**

Requires Prior Authorization

Avinza®
Fentanyl Patches (generic only)
Opana®ER
Oramorph SR®
MS Contin®
Oxycontin®

NARCOTICS – SHORT AND INTERMEDIATE ACTING

**Actiq®♦
Codeine
Codeine/ APAP
Codeine/APAP/Caff./Butalbital
Codeine/APAP/Caffeine
Codeine/ASA
Codeine/ASA/Caff./Butalbital
Codeine Phosphate
Hydrocodone/APAP
Hydromorphone oral tablets
Meperidine
Morphine Sulf Tabs/Soln
Oxycodone (Immed. Release)
Oxycodone/ APAP
Oxycodone/ ASA
Propoxyphene APAP
Propoxyphene Napsylate APAP
Tramadol**

Requires Prior Authorization

Anexsia®
Bancap HC®
Butorphanol
Capital w/Codeine®
Combunox®
Darvocet-N®
Darvocet A500®
Darvon®
Darvon-N®
Demerol® all forms
Dilaudid® all forms
Fentora♦
Fioricet W/Codeine®
Fiorinal W/Codeine®
Lorcet®
Lortab®
Norco®
Opana®
Opium
Oxydose®
Oxyfast®
OxylR®
Pentazocine and Naloxone
Percocet®
Percodan®
Roxanol®
Ryzolt ER®
Roxicodone®
Stadol®, Stadol NS®
Talwin®, Talwin NX®
Tylenol #2®
Tylenol #3®
Tylenol #4®
Tylenol W/Codeine Elixir®
Tylox®
Ultracet®
Ultram®/ Ultram ER®
Vicodin®
Vopac®
Wygesic®
Xodol 5/300®
Zydone®

**NON-STEROIDAL ANTI-
INFLAMMATORY – COX II
INHIBITORS**
Celebrex®²

**ANTIBIOTICS – ANTI-
INFECTIVES**

**ANTIFUNGALS –
ONYCHOMYCOSIS**

**Lamisil®♦
Griseofulvin
Griseofulvin microsize
Griseofulvin ultramicrosized**

Requires Prior Authorization
Penlac®
Sporanox®

ANTIFUNGALS - ORAL
Fluconazole
Nystatin Oral Susp®

Requires Prior Authorization
Ketoconazole
Mycelex®
Mycostatin®
Nilstat®
Nizoral®
Noxafil®
Nystatin® Tablets
Vfend®

ANTIVIRALS - HERPES
Acyclovir
Famciclovir
Valtrex®

Requires Prior Authorization
Zovirax®

ANTIVIRALS - INFLUENZA⁷
Relenza®
Tamiflu®

CEPHALOSPORIN 1ST GEN
Cefadroxil
Cephalexin

Requires Prior Authorization
Cephadrine
Duricef®
Keflex®
Velosef®

CEPHALOSPORIN 2ND GEN
Ceftin suspension®
Cefuroxime Axetil
Cefprozil suspension

Requires Prior Authorization
Ceclor®
Ceclor CD®
Cefaclor
Cefaclor ER
Cefzil®
Cefzil suspension®
Lorabid®

CEPHALOSPORIN 3RD GEN
Cefdinir
Cefpodoxime
Omnicef®
Suprax Suspension®

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Requires Prior Authorization

Cedax®
Spectracef®
Suprax®
Vantin®

HEPATITIS C

**Pegasys®
Ribavirin
Peg-Intron®**

Requires Prior Authorization

Copegus®
Infergen®
Intron A®
Rebetol®
Rebetron®
Roferon-A®

KETOLIDES

Requires Prior Authorization
Ketek®

MACROLIDES

**Azithromycin
Clarithromycin
Erythromycin Base
Erythromycin Estolate
Erythromycin Ethylsuccinate
Erythromycin Stearate
Erythromycin w/Sulfisoxazole**

Requires Prior Authorization

Biaxin®/Biaxin XL®/Biaxin Susp.®
Dynabac®
E.E.S.®
EryPed®
Ery-Tab®
PCE®
Zithromax® tablets

Zithromax® suspension¹
Zmax®

OXALODINONES

Zyvox®

QUINOLONONES

**Avelox®
Ciprofloxacin**

Requires Prior Authorization

Cipro XR®
Factive®
Floxin®
Levaquin®
Maxaquin®
NegGram®
Noroxin®
Tequin®
Trovan®

**OPHTHALMIC
FLUOROQUINOLONONES**

**Ciprofloxacin
Ofloxacin
Vigamox®**

Requires Prior Authorization

Ciloxan®
Iquix®
Ocuflox®
Quixin®
Zymar®

OTIC QUINOLONONES

**Ciprodex®
Ofloxacin otic**

Requires Prior Authorization

Cipro HC®
Floxin Otic®

OPHTHALMIC MACROLIDES

Azasite®

TOPICAL ANTIBIOTICS

**Mupirican ointment
Altabax®**

Requires Prior Authorization

Bactroban®

ASTHMA – ALLERGY

INHALED ANTICHOLINERGICS

**Atrovent/Atrovent HFA®
Ipratropium
Spiriva®
Combivent®**

ANTI HISTAMINES – 2ND GEN

**Cetirizine
Loratadine**

Requires Prior Authorization

Allegra®
Allegra® Suspension
Clarinet®
Claritin® tablets, syrup
Claritin Redi-Tab®
Fexofenadine
Loratadine disp. tab¹
Xyzal®
Zyrtec® brand

NASAL ANTIHISTAMINES

**Astelin®
Astepro®**

Requires Prior Authorization

Patanase Nasal®

**BETA ADRENERGICS- SHORT
ACTING**

**Maxair Autohaler®
ProAir HFA®
Proventil HFA®
Ventolin HFA®**

Requires Prior Authorization

Alupent®
Xopenex HFA®

**BETA ADRENERGICS – LONG
ACTING**

**Serevent®
Foradil®**

Requires Prior Authorization

Brovana® Nebulizer Soln.
Perforomist®

**BETA ADRENERGICS FOR
NEBULIZERS**

Albuterol sulfate

Requires Prior Authorization

Accuneb®
Duoneb®
Metaproterenol
Xopenex®

**BETA ADRENERGIC /
CORTICOSTEROID INHALER
COMBINATIONS**

**Advair Diskus®/ Advair HFA®
Symbicort®**

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INHALED GLUCOCORTICOIDS

Alvesco®
Asmanex®
Azmacort®
Flovent® Diskus/Flovent HFA®
Pulmicort®Flexihaler
Pulmicort® Nebulizer Soln.
QVAR®

Requires Prior Authorization

AeroBid®

LEKOTRIENE INHIBITORS

Accolate®
Singulair®

Requires Prior Authorization

Zyflo®

NASAL STEROIDS

Flunisolide
Fluticasone
Nasonex®

Requires Prior Authorization

Flonase®
Nasacort®
Nasacort AQ®
Nasarel®
Omnaris®
Rhinocort® & Rhinocort Aqua®
Tri-Nasal®
Veramyst®

BEHAVIORAL HEALTH

ATYPICAL ANTIPSYCHOTICS

Abilify
Clozapine
Fazaclo

Geodon
Invega
Risperidone
Seroquel/Seroquel XR
Zyprexa

**ANTIPSYCHOTIC-
ANTIDEPRESSANT COMB.**
Symbyax®

**ANTIDEPRESSANTS –
NEWER GENERATIONS**

Bupropion
Bupropion Hydrobromide ER
Citalopram
Cymbalta
Emsam
Fluoxetine
Fluvoxamine
Lexapro
Luvox CR
Mirtazapine
Nefazodone
Paroxetine
Pristiq
Prozac Weekly
Sertraline
Trazodone
Venlafaxine
Venlafaxine ER

**CARDIAC
MEDICATIONS**

ACE INHIBITORS

Benazepril
Benazepril HCT
Captopril

Captopril HCT
Enalapril
Enalapril HCT
Lisinopril
Lisinopril HCT

Requires Prior Authorization

Accupril®
Accuretic®
Aceon®
Altace®
Capoten®
Capozide®
Fosinopril
Mavik®
Moexipril/Moexipril HCT
Monopril®/ Monopril HCT®
Prinivil®
Prinzide®
Quinapril/Quinapril HCT
Unirectic ®
Univasco®
Vaseretic®
Vasotec®
Zestoretic®
Zestril®

**ANTIHYPERTENSIVE
COMBINATIONS: ACEI-CCB**

Lotrel®
Tarka®

**ANTIHYPERTENSIVE
COMBINATIONS: ARB-CCB**

Azor®
Exforge®

**ANGIOTENSIN RECEPTOR
ANTAGONISTS**

Benicar®
Benicar HCT®

Cozaar®
Diovan®
Diovan HCT®
Hyzaar®
Micardis®
Micardis HCT®

Requires Prior Authorization

Atacand®
Atacand HCT®
Avalide®
Avapro®
Teveten®
Teveten HCT®

DIRECT RENIN INHIBITORS

Requires Prior Authorization
Tekturna®
Tekturna HCT®

BETA BLOCKERS

Acebutolol
Atenolol
Atenolol/Chlorthalidone
Betaxolol
Bisoprolol Fumarate
Bisoprolol Fum./HCT
Bystolic®
Carvedilol
Coreg®CR
Labetalol
Metoprolol/HCT
Metoprolol Succinate
Metoprolol Tartrate
Nadolol
Pindolol
Propranolol/ Propranolol LA
Propranolol/HCT
Sotalol/ Sotalol AF
Timolol Maleate

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Betapace ®/ Betapace AF®
Blocadren®
Coreg®
Inderal®
Inderal LA®
Inderide®
Kerlone®
LevatoI®
Lopressor®
Normodyne®
Sectral®
Tenormin®
Toprol XL®
Trandate®
Visken®
Zebeta®

**CALCIUM CHANNEL BLOCKERS
- DIHYDROPYRIDINE**

Afeditab CR®
Amlodipine Besylate
Dynacirc®
Dynacirc CR®
Felodipine
Nicardipine
Nifediac CC
Nifedical XL
Nifedipine
Nifedipine SA
Nisoldipine

Requires Prior Authorization

Adalat CC®
Cardene®/ Cardene SR®
Norvasc®
Plendil®
Procardia/ Procardia XL®
Sular®

**CALCIUM CHANNEL
BLOCKERS - NON-
DIHYDROPYRIDINE**

Diltiazem
Diltiazem XR
Taztia XT®
Verapamil/ Verapamil SR
Verapamil Cap 24-hr Pellet

Requires Prior Authorization

Calan®
Cardizem® LA, SR, CD
Covera-HS®
Dilacor XR®
Isoptin®
Vascor®
Verelan® / Verelan PM®

**LIPOTROPIC-
ANTIHYPERTENSIVE
COMBINATION**

Caduet®

**LIPOTROPICS- NON-STATINS:
FIBRIC ACID DERIVATIVES**

Gemfibrozil
TriCor®

Requires Prior Authorization

Antara®
Fenoglide®
Lopid®
Lipofen®
Triglide®
Trilipix®

LIPOTROPICS: NON-STATINS

Cholestyramine
Cholestyramine Light
Colestid® tablets
Colestipol granules

Welchol®

Requires Prior Authorization

Questran Light®
Questran®

LIPOTROPICS: STATINS

Crestor®
Lescol®
Lescol XL®
Lipitor®
Lovastatin
Pravastatin
Simcor®
Simvastatin
Vytorin®

Requires Prior Authorization

Advicor®
Altoprev®
Pravachol®
Zocor®

LIPOTROPICS: NIACIN DERIV.

Niacin & Niacin ER
Niacor®
Niaspan®

LIPOTROPICS: OTHER

Zetia®

Requires Prior Authorization

Lovaza® (formerly Omacor®)

**CENTRAL NERVOUS
SYSTEM DRUGS**

ALZHEIMER'S DEMENTIA

Aricept®
Exelon® tablet and patch
Galantamine
Namenda®

Requires Prior Authorization

Cognex®
Razadyne®

ANTI-ANXIETY - GENERAL

Alprazolam
Buspirone
Chlordiazepoxide³
Clorazepate
Diazepam³
Hydroxyzine HCL
Hydroxyzine Pamoate
Lorazepam
Oxazepam

Requires Prior Authorization

Alprazolam extended release
Atarax®
Ativan®
Buspar®
Meprobamate/ Miltown®³
Niravam®
Serax®
Tranxene®
Vistaril®
Vistaril suspension®
Xanax/Xanax XR®

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DRUGS FOR ADHD◆

Adderall XR®
Amphetamine Salts
Concerta®
Dexmethylphenidate
Dextroamphetamine
Dextrostat®
Focalin®
Focalin XR®
Metadate CD®
Methylin®/Methylin®ER
Methylphenidate
Methylphenidate SR
Ritalin LA®
Vyvanse®2

Requires Prior Authorization

Cylert®
Daytrana®
Dexedrine®
Methylin® chewable/soln.
Ritalin®
Ritalin SR®

AGENTS FOR MULTIPLE SCLEROSIS:

Avonex®
Betaseron®
Copaxone®
Rebif®

NON-ERGOT DOPAMINE RECEPTOR AGONISTS

Mirapex®
Requip XL®
Ropinirole

Requires Prior Authorization

Neupro® patch
Requip®

SEDATIVE HYPNOTIC NON-BARBITURATES

Estazolam
Rozerem®5
Temazepam³
Triazolam³
Zolpidem

Requires Prior Authorization

Ambien®
Ambien CR®
Doral®
Halcion®
Lunesta®
ProSom®
Restoril®³
Somnote®
Sonata®²

SEROTONIN RECEPTOR AGONISTS

Imitrex®
Imitrex injection®
Imitrex nasal®
Maxalt® / Maxalt MLT®
Relpax®
Treximet®

Requires Prior Authorization

Amerge®
Axert®
Frova®
Zomig®/ Zomig ZMT®

DIABETES

AMYLIN ANALOGS

Symlin®

SECRETIN MIMETICS

Byetta®

INSULINS, BASAL

Lantus®
Levemir®

INSULINS, RAPID ACTING

Apidra®
Humalog®
Novolog®

INSULIN MIXES

Humalog 50/50®
Humalog 75/25®
Humulin 50/50®
Humulin 70/30®
Novolin 70/30®
Novolog 70/30®

INSULINS, TRADITIONAL

Humulin R 500-U®
Novolin N®
Novolin R®
Velosulin BR®

Requires Prior Authorization

Humulin N®
Humulin R®

ORAL HYPOGLYCEMICS – ALPHA-GLUCOSIDASE INH.

Precose®
Glyset®

ORAL HYPOGLYCEMICS – BIGUANIDES

Metformin/ Metformin XR

Requires Prior Authorization

Glucophage®
Glucophage XR®

ORAL HYPOGLYCEMICS – COMBINATIONS

Actoplus Met®
Avandamet®
Avandaryl®
Duetact®
Glyburide/Metformin
Glipizide/Meformin
Janumet®
Prandimet®

Requires Prior Authorization

Glucovance®
Metaglip®

ORAL HYPOGLYCEMICS – DPP4 INHIBITORS

Januvia®

ORAL HYPOGLYCEMICS – MEGLITINIDES

Starlix®

Requires Prior Authorization

Prandin®

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**ORAL HYPOGLYCEMICS – 2ND
GENERATION SULFONYLUREAS**

Glimepiride
Glipizide/ Glipizide ER
Glyburide
Glyburide Micronized

Requires Prior Authorization

Amaryl®
Glucotrol®
Glucotrol XL®
Glynase®
Micronase®

**ORAL HYPOGLYCEMICS –
THIAZOLIDINEIONES**

Actos®
Avandia®

GASTROINTESTINAL

NAUSEA AGENTS - ORAL

Granisetron
Ondansetron
Sancuso®10

Requires Prior Authorization

Anzemet®
Kytril® Brand
Zofran®/Zofran ODT® Brand

**SUBSTANCE P RECEPTOR
AGONIST**

Emend®

PROTON PUMP INHIBITORS♦

Nexium®
Prevacid®
Prilosec OTC®

Requires Prior Authorization

Aciphex®
Kapidex®
Omeprazole¹
Prevacid SoluTab®¹
Prilosec®
Protonix®
Zegerid®

LAXATIVES, NEW GENERATION

Amitiza®

ULCERATIVE COLITIS - ORAL

Asacol®
Pentasa®
Sulfasalazine

Requires Prior Authorization

Apriso®
Azulfidine DR®
Balsalazide
Colazal®
Dipentum®
Lialda®

OPHTHALMICS

**GLAUCOMA – ALPHA 2
ADRENERGICS**

Alphagan®
Alphagan P®
Brimonidrine tartrate
lopidine®

**GLAUCOMA – BETA
BLOCKERS**

Betaxolol
Betimol®
Betagan®

Carteolol HCl
Levobunolol HCl
Metipranolol
Timolol maleate

Requires Prior Authorization

Betoptic S®
Istalol ®
Ocupress®
Optipranolol®
Timoptic®
Timoptic XE®

**GLAUCOMA –
PROSTAGLANDIN INHIBITORS**

Travatan Z®
Xalatan®

Requires Prior Authorization

Lumigan®
Rescula®

**GLAUCOMA – CARBONIC
ANHYDRASE INHIBITORS**

Azopt®
Cosopt®
Dorzolamide HCl

Requires Prior Authorization

Trusopt®

**GLAUCOMA – COMBINATION
ALPHA 2 ADRENERGIC-BETA
BLOCKER**

Combigan®

OPHTHALMIC ANTIHISTAMINES

Ketotifen fumarate (OTC Only)
Pataday®
Patanol®
Zaditor®

Requires Prior Authorization

Elestat®⁵
Emadine®
Ketotifen fumarate (RX Only)
Livostin®
Optivar®

**OPHTHALMIC MAST CELL
STABILIZERS**

Alocril®
Cromolyn Sodium

Requires Prior Authorization

Alamast®
Alomide®
Crolom®
Opticrom®

OPHTHALMIC NSAIDS

Acular®
Flurbiprofen sodium
Diclofenac Ophth.

Requires Prior Authorization

Nevanac®
Voltaren®
Xibrom®

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MISCELLANEOUS

GROWTH HORMONES◆

Genotropin®
Humatrope®
Norditropin®
Norditropin Nordiflex®
Nutropin®
Nutropin AQR®
Omnitrope®
Saizen®
Serostim®
Tev-Tropin®
Zorbtive®

OSTEOPOROSIS AGENTS:

BISPHOSPHONATES

Alendronate Sodium

Requires Prior Authorization

Actonel®
Boniva®
Didronel®
Fosamax®
Fosamax Plus D®

OSTEOPOROSIS AGENTS:

OTHER

Miacalcin®

Requires Prior Authorization

Forteo®
Fortical®

OSTEOPOROSIS AGENTS:

SERMS

Evista®

URINARY TRACT

ANTISPASMODICS

Detrol LA®
Enblex®
Oxybutynin Chloride
Vesicare®

Requires Prior Authorization

Detrol®⁵
Ditropan/ Ditropan XL®
Flavoxate HCL
Gelnique®
Oxybutynin Extended Release
Oxytrol®⁵
Sanctura®\nToviaz®
Urispas®

TOPICAL

IMMUNOMODULATORS◆

Elidel®
Protopic®

ELECTROLYTE DEPLETERS

Fosrenol®
Phoslo®
Renagel®
Renvela®

ALPHA BLOCKERS FOR BPH

Flomax®
Prazosin
Terazosin
Uroxatral®

Requires Prior Authorization

Rapaflo®

BIOLOGIC

IMMUNOMODULATORS

Enbrel®
Humira®
Cimizia®

Requires Prior Authorization

Kineret®

HEMATOPOIETIC AGENTS◆

Aranesp®
Epogen®
Procrit®

LOW MOLECULAR WEIGHT

HEPARINS

Arixtra®
Fragmin®
Lovenox®

Requires Prior Authorization

Innohep®

**COMBINATION BENZOYL
PEROXIDE AND CLINDAMYCIN**

Duac CS®

Requires Prior Authorization

Benzaclin®

**SKELETAL MUSCLE
RELAXANTS**

Baclofen
Chlorzoxazone
Cyclobenzaprine
Dantrolene Sodium
Methocarbamol

Orphenadrine Citrate
Tizanidine HCl

Requires Prior Authorization

Amrix®
Dantrium®
Fexmid®
Norflex®
Orphenadrine Compound
Parafon Forte DSC®
Robaxin®
Skelaxin®
Zanaflex® capsules and tablets

Note: Not all medications listed are covered by all MDCH Programs. Check individual program coverage. For program drug coverage information, go to www.michigan.fhsc.com Open "Drug Coverage" and click on "MPPL Including Coverage Information" for all programs.

1 Prior Authorization Not Required for Beneficiaries Under the Age of 12

2 Quantity limits apply – See MPPL on website for details

3 Prior Authorization Required if Beneficiary is Over the Age of 65

4 Prior Authorization Required for Beneficiaries Under Age of 6.

5 PA required if a benzodiazepine is found in beneficiary drug history

7 Providers should consult yearly CDC guidelines for Influenza

8 Electronic Step edit: at least 1 component of the product must be in beneficiary drug history
10 PA required if no history of oral anti-nausea drugs in beneficiary drug history

APAP = Acetaminophen ASA = Aspirin Version 10152009v.4
CR, ER, SR, XL, XR, SA, LA = Extended Release HCT = Hydrochlorothiazide
◆ Clinical PA required; refer to MPPL, MI Provider Manual or www.michigan.fhsc.com for Other restrictions

Michigan Department of Community Health
Preferred Drug List
Effective 10/15/2009

Bolded Drugs do not require prior authorization, except as noted in chart at bottom of page

Michigan Department of Community Health, in conjunction with First Health Services Corporation, is pleased to offer an alternative means to submit pharmacy prior authorization (PA) requests for prescription drugs. This web-based process is designed to save prescribers time by providing a real-time pharmacy prior authorization. This process will supplement the more traditional means of requesting PAs by phone or fax, which will still be available to providers. In order to use WebPA, provider designees will need to register to receive a logon and password for the WebPA system. Detailed information on user registration and WebPA, including a web based tutorial, and a complete instruction is available at

www.michigan.fhsc.com

For questions or assistance with registration, call the First Health Services Web Support Call Center at (800) 241-8726.

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