

Effective July 1, 2011



**RESTRICTED DRUG CLASSES**

(Information subject to change)

This document is a listing of covered medications and coverage limitations within UPHP's restricted drug classes. It is not a comprehensive listing, but meant to assist in prescribing. Drugs not listed within these restricted drug classes are *usually* nonformulary and are not covered. Certain medications are listed as a "Preferred Drug" and should, unless contraindicated, be the first step in therapy.

Agents within other drug classes are *generally* covered but *may be* subject to benefit restrictions. Certain over-the-counter drugs are also covered as specified by Michigan Medicaid Fee-for-Service (FFS) program. Brand products in parentheses adjacent to their respective generic product are listed for reference only and are *not* covered if a generic equivalent is available. Prescribers may request prior authorization for nonformulary products. A complete formulary listing is available at [www.epocrates.com](http://www.epocrates.com).

Catalyst Rx is UPHP's Pharmacy Benefit Manager (PBM). For prior authorization, complete the Prior-Authorization Form available at [www.uphp.com](http://www.uphp.com) and fax it to Catalyst Rx.

**Catalyst Customer Service Call Center  
1-877-464-0084**

**Antibiotics**

**Antifungals:** Clotrimazole (fluconazole) Diflucan - Limit of 2 tabs per 30 days  
**Cephalosporins:**  
 1st and 2nd generations generics  
 cefadroxil (Duricef) cephalixin (Keflex)  
 cefuroxime (Ceftin) cephadrine (Velosef)  
 cefTRIAXone (Rocephin) IV/IM  
**Fluoroquinolones:** ofloxacin (Floxin)  
 ciprofloxacin (Cipro) levofloxacin (Levaquin)  
**Macrolides:**  
 azithromycin (Zithromax) tabs/susp (limit of 1 Rx per 21days)

**Asthma/Allergy Medications**

**Antihistamines—nonsedating or low sedating:**  
 • loratidine (Claritin OTC) •cetirizine (ZyrTEC)  
 • ZyrTEC syrup (age 6 months to 2 years only)  
**Bronchodilators-Inhaled:**  
 • albuterol (ProAir is the UPHP covered product)  
 • Atrovent • Combivent • Serevent  
 • Spiriva Step Therapy: failure on Atrovent or Combivent  
**Corticosteroids—Nasal:**  
 • Fluticasone Preferred Drug  
 • Rhinocort Aqua and Nasonex available as step therapy if failure after 30 day trial of fluticasone  
**Corticosteroids—Inhaled:** • Flovent (all strengths)  
 • Budenonide (Pulmicort) inhalation (inhalation suspension age 0–6 only)  
**Leukotriene Receptor Antagonist:**  
 • Singulair PA for asthma (except 0–10 years)  
 After trial of inhaled beta agonist or corticosteroid  
**Other:** Advair/Symbicort/Dulera Step Therapy  
*SPACERS COVERED 2 PER YEAR*

**Beta Blockers**

*ALL PRESCRIPTION GENERICS COVERED*  
 Innopran XL (for migraine prophylaxis only)

**Blood Pressure/Heart Medications**

**Patients new to ARB therapy must attempt an ACE trial for 30 days prior to ARB agents.**  
**ACE Inhibitors:**  
 benazepril (Lotensin) and benazepril/amlodipine (Lotrel)  
 enalapril (Vasotec/Vaseretic)  
 lisinopril (Zestril/Zestoretic/Prinivil/Prinzide)  
 captopril (Capoten/Capozide)

**Angiotensin Receptor Blockers (ARB): Step Therapy**

Preferred Drugs: generic losartan or losartan/hydrochlorothiazide (Cozaar/Hyzaar)  
**PA:** Atacand/Atacand HCT, Diovan/Diovan HCT approved for heart failure. **OTHERS NONformulary.**  
**Calcium Channel Blockers:** All generics covered

**CNS Medications**

•ADD/ADHD medications • Antidepressants  
 •Antiepileptics •Hypnotics

Coverage is through Michigan Medicaid Fee for Service  
 See MSA Bulletin 10-08 (March 1, 2010)

Call 1-877-864-9014

*Quantity Limits and Appropriate-Use Guidelines May Apply  
 Coverage at [www.michigan.fhsc.com](http://www.michigan.fhsc.com)*

**Diabetes Medications**

*ALL PRESCRIPTION GENERICS COVERED*  
**Oral:** •metFORMIN Preferred Drug • Glucotrol XL  
 • Precose • Actos & Avandia (Step Therapy)  
**Insulins:**  
 Vials and Pen delivery: NovoLIN/HumuLIN, NovoLOG/HumuLOG  
 Vials Only: Lantus/Levemir  
**Strips:** Max of 100 strips/month unless PA  
**Meters:** Bayer Contour and Breeze2 meters provided at no charge to eligible members.  
 Providers can call 1-800-348-8100 to request a meter.

**Antiemetic/Antivertigo Therapy**

*ALL PRESCRIPTION GENERICS COVERED*  
 granisetron (Kytril) #4 tabs or 30 ml per month  
 ondansetron (Zofran) #5 tabs of 24 mg, #12 of 8 mg, #12 of 4 mg or 30 ml per month

**Lipotropics/Statins**

**Preferred Drugs:** • simvastatin • lovastatin  
 • Gemfibrozil • Niacin products • Colestipol  
 • cholestyramine

**Step-Therapy Drugs:**  
 simvastatin/ezetimibe (Vytorin)  
 lovastatin/niacin (Advicor)

**PA Drugs:** atorvastatin (Lipitor), rosuvastatin (Crestor), ezetimibe (Zetia)

**(Selective and Nonselective) NSAIDs**

Generic and OTC products available.  
 • ibuprofen: OTC, 400 mg, 600 mg, 800 mg  
 • naproxen OTC (Aleve OTC)  
 • piroxicam (Feldene) • ketoprofen (Orudis)  
 • sulindac (Clinoril) • indomethacin (Indocin)  
 • diclofenac (Voltaren) • flurbiprofen (Ansaid)  
 • meclofenamate (Meclomen)  
 CeleBREX (celecoxib) only available with PA with documentation of inability to utilize a NSAID plus the PPI omeprazole OTC

**Migraine Therapy**

• **Preferred Drug:** SUMAtriptan (Imitrex) (9/mo)  
**Others PA:** must document failure of adequate trials of oral sumatriptan  
 • Maxalt, Maxalt MLT, Relpax, Zomig, Zomig ZMT (9/mo)  
 • Imitrex Nasal (1/month) or Syringe (2/month)  
 • Innopran XL available for migraine prophylaxis only

**Long-Acting Opioids**

• Preferred Drugs morphine sulfate and methadone  
 • OxyCONTIN and fentaNYL reserved for CA Patients

**Oral Contraceptive Therapy**

List of covered generic equivalents and therapeutic alternatives at [www.uphp.com](http://www.uphp.com) and [www.epocrates.com](http://www.epocrates.com).

**Antihistamine/Decongestant Ophthalmic Products**

Selected OTC agents covered, including generic naphazoline, generic naphazoline/pheniramine (Opcon A, Naphcon A), Optivar, Zaditor  
 Step therapy: Patanol (after a trial of OTC agents)

**Smoking-Cessation Products**

Benefit is **90 days** of therapy per calendar year.  
 • Nicotine patches • Nicotine gum  
 • Zyban generic (buPROPion SR)  
 • Chantix (varenicline)

**Topical/Skin/Acne**

• benzoyl peroxide, salicylic acid, metronidazole, clindamycin 1% topical  
 • tretinoin topical in acne PA if older than 30 years  
 • PA: isotretinoin (Accutane)

**Ulcer Medications**

**PPI:** omeprazole (PriLOSEC OTC), Zegerid OTC, lansoprazole (Prevacid 24 OTC) per protocol  
 omeprazole 20mg caps (age 0–12 only for compd)  
 Others NON-formulary  
**H2 antagonists:** cimetidine (Tagamet), famotidine (Pepcid), ranitidine (Zantac)

**Urinary (Overactive Bladder/BHP/Enuresis)**

Preferred Drug: oxybutynin, terazosin, doxazosin  
 Step Therapy: Detrol LA/Ditropan XL, Flomax, Uroxatral for failure on generic  
 desmopressin (DDAVP) requires PA

**Antiviral Agents**

• acyclovir (Zovirax) preferred agent  
 • Tamiflu/Relenza therapy - 1 treatment per 180 days

**Miscellaneous Medications Requiring Prior Authorizations (PA)/Benefit Exception**

• Anti-obesity agents (PA per protocol)  
 • Testosterone (PA per protocol)  
 • Colony stimulating agents • Immunologicals  
 • Multiple Sclerosis agents • Growth hormones  
 • Synagis (PA per protocol) • Interferons  
 •Lovenox (enoxaparin) 10 days supply limit per fill  
 Providers will be contacted for specialty distribution when applicable.