



AIDS DRUG ASSISTANCE PROGRAM (ADAP)

CALIFORNIA FORMULARY

FORMULARY BY CLASS

Effective 5/15/2010

P: 888-311-7632

www.publichealthrx.com

F: 800-848-4241

Generic Name	Brand Name	Restrictions
1. ANALGESICS		
codeine phosphate/sulfate		Oral generic only
codeine/APAP		Oral generic only
codeine/ASA		Oral generic only
fenopropfen		Oral form only
▲* fentanyl	Duragesic	Restricted to hospice patients only with intolerance to oral analgesics
hydrocodone/APAP	Vicodin	Oral generic only
hydrocodone/ibuprofen	Vicoprofen	Oral generic only
ibuprofen	Motrin	Oral generic only; prescription strength only
indomethacin	Indocin	Oral generic only
ketoprofen	Orudis	Oral generic 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 generic only
naproxen	Naprosyn	Oral generic only
oxycodone		Immediate release form only; oral generic only
oxycodone/APAP	Percocet	Oral generic only
oxycodone/ASA	Percodan	Oral generic only
sulindac	Clinoril	Oral generic only
2. ANTIANXIETY AGENTS		
alprazolam	Xanax	Oral generic only
bupirone	Buspar	Oral generic only
lorazepam	Ativan	Oral generic only
3. ANTICONVULSANTS		
divalproex	Depakote	
gabapentin	Neurontin	Oral generic only
lamotrigine	Lamictal	
phenytoin	Dilantin	100mg Extended Release Capsules only; generic form only
4. ANTIDEPRESSANTS		
amitriptyline	Elavil	Oral generic only
* bupropion	Wellbutrin	Not payable for smoking cessation, document diagnosis on original RX
citalopram	Celexa	
desipramine	Norpramin	Oral generic 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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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
● rosiglitazone maleate	Avandia	
● pioglitazone	Actos	15mg, 30mg, 45mg tablets only
6. ANTIHELMINTICS		
albendazole	Albenza	
7. ANTIBIOTICS		
▲ amikacin sulfate	Amikin	Injectable and generic forms only
amoxicillin	Amoxil	Oral generic only
atovaquone	Mepron	
azithromycin	Zithromax	
cephalexin	Keflex	Oral forms only
▲* ciprofloxacin	Cipro	Oral and injectable forms for treatment of MAC only
clarithromycin	Biaxin	
clindamycin	Cleocin	Oral and injectable forms only
clofazimine	Lamprone	
dapsone		Oral forms only
dicloxacillin	Dynapen	Oral forms only
doxycycline	Vibramycin	Oral 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)
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
metronidazole	Flagyl	Oral forms only
minocycline HCL	Minocin	Oral forms only
neomycin sulfate		Oral generic forms only
paromomycin	Humatin	
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



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7. ANTIBIOTICS (Continued)		
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	Trimplex, Proloprim	Oral forms only
trimetrexate	Neutrexin	
vancomycin	Vancocin	Oral tablet 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 aspergilliosis 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 aspergilliosis 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)
▲ cycloserine	Seromycin	250mg capsules only. Use of this medication is restricted for use in the treatment of multi-drug resistant tuberculosis (MDR-TB)
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)
▲ 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)
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)
▲ moxifloxacin	Avelox	400mg tablets only. Use of this medication is restricted for use in the treatment of multi-drug resistant tuberculosis (MDR-TB)
▲ 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)
pyrazinamide		
rifabutin	Mycobutin	
rifampin	Rifadin	
rifampin/isoniazid	Rifamate	



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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, Rubex	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
13. ANTIRETROVIRALS-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS			
● abacavir	Ziagen	Brand only	
● abacavir/lamivudine	Epzicom	Brand only	
● abacavir/lamivudine/zidovudine	Trizivir	Brand only	
● emtricitabine	Emtriva	Brand only	
● didanosine	Videx, Videx EC	Brand only; generic covered for co-pay only	
● lamivudine	EpiVir	Brand only; EpiVir HB is NOT covered	
● stavudine	Zerit	Brand only; generic covered for co-pay only	
● tenofovir/emtricitabine	Truvada	Brand only	
● zalcitabine	Hivid	Brand only	
● zidovudine	Retrovir	Brand only; generic covered for co-pay only	
● zidovudine/lamivudine	Combivir	Brand only	
● tenofovir disoproxil fumarate	Viread	Brand only	
14. ANTIRETROVIRALS-NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS			
● delavirdine	Rescriptor	Brand only	
● efavirenz	Sustiva	Brand only	
● etravirine	Intelence	Brand only, 100mg tablets only	
● nevirapine	Viramune	Brand only	
15. ANTIRETROVIRALS-FUSION INHIBITORS			
●^ enfuvirtide	Fuzeon	Brand only; please call for special supplemental application	
16. ANTIRETROVIRALS-COMBINATION TREATMENT			
● emtricitabine/tenofovir/efavirenz	Atripla	Brand only	



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Generic Name	Brand Name	Restrictions
17. ANTIRETROVIRALS-PROTEASE INHIBITORS		
● amprenavir	Agenerase	Brand only
● atazanavir	Reyataz	Brand only
● darunavir (TMC-114)	Prezista	Brand only
● indinavir	Crixivan	Brand only
● fosamprenavir	Lexiva	Brand only. 50mg/ml Oral suspension coverage start 11/04/2009
● lopinavir/ritonavir	Kaletra	Brand only
● nelfinavir	Viracept	Brand only
● ritonavir	Norvir	Brand only. 100mg tablet formulation coverage start 2/24/10
● saquinavir-soft gel caps	Fortovase	Brand only
● tipranavir	Aptivus	Brand only
● saquinavir mesylate	Invirase	Brand only
18. ANTIRETROVIRALS-CCR5 CO-RECEPTOR ANTAGONISTS		
●^ maraviroc	Selzentry	Brand only
19. CCR5 TROPISM LAB ASSAY		
^ Tropism lab assay	Trofile™	Only the Trofile™ lab assay from Monogram Biosciences is covered through the CA-ADAP program and requires a prior authorization.
20. ANTIRETROVIRALS-INTEGRASE INHIBITOR		
● raltegravir	Isentress	Brand only
21. ANTIVIRALS-HEPATITIS		
^ hepatitis A vaccine	Havrix, Vaqta	
^ hepatitis B vaccine	Engerix B, Recombivix HB	
^ interferon alfacon 1	Infergen	
^ interferon alfa-2a	Roferon-A	
^ interferon alfa-2b	Intron-A	
^ interferon alfa-N3	Alferon-N	
^ pegylated interferon	Peg-Intron, Pegasys	Peg-Intron is available thru Schering-Plough free drug program only
ribavirin	Rebetol, Copegus	Rebetol, Copegus; please note that not all generics are covered,
^ ribavirin/interferon alfa 2B	Rebetron	
22. ANTIVIRALS-MISCELLANEOUS		
acyclovir	Zovirax	
famcyclovir	Famvir	
▲* valacyclovir	Valtrex	Brand Only. Generic covered for co-pay only. Restricted to diagnosis of herpes simplex (HSV) or herpes zoster (HZV). HSV-max 10 days for acute treatment; acute treatment and chronic suppressive therapy only after failed trial of acyclovir. Acute HZV-max of 10 days for treatment only; NOT payable for chronic suppressive treatment. As of 4/18/10, Valtrex 1000mg NDCs: 00173-0565-04 & 00173-0565-10 have been taken off the ADAP formulary. The generic is covered for copayments ONLY.
cidofovir	Vistide	
fomivirsen	Vitrovene	
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



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23. ANTIDIARRHEALS		
diphenoxylate/atropine	Lomotil	
loperamide	Immodium	Generic form only
opium tincture		
24. ANTIEMETICS		
metoclopramide	Reglan	
prochlorperazine	Compazine	
promethazine	Phenergan	Oral and suppository forms only
25. DIGESTIVE ENZYMES		
pancrelipase		Enteric coated encapsulated microspheres/microtablets
26. GI STIMULANT/GERD		
metoclopramide	Reglan	
27. H2 ANTAGONISTS		
famotidine	Pepcid	Prescription strength only
ranitidine	Zantac	Prescription strength only; oral form only
28. 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
▲* 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
29. HEMATOLOGICAL AGENTS		
▲ epoetin alpha	Procrit	Procrit™ brand only; Epogen™ is NOT covered
▲ filgrastim	Neupogen	Must provide copy of the original RX with every request
30. STEROIDS		
dexamethasone	Decadron	Oral or injectable forms only
prednisone	Deltasone	Oral and generic forms only
31. URICOSURIC AGENTS		
probenecid	Benemid	
32. VACCINES		
▲ hepatitis A vaccine	Havrix, Vaqta	
▲ hepatitis B vaccine	Recombivax HB, Enderix B	
▲* hepatitis A/hepatitis B vaccine	Twinrix	Max 3 over 12 months
▲* pneumococcal vaccine	Pneumovax, Pnu-Immune	Single dose dispensing, 1 time dispensing every 6 years
33. TOPICAL AGENTS		
alitretinoin gel	Panretin	Gel form only
imiquimod	Aldara	
34. WASTING AND HYPOGONADISM		
dronabinol	Marinol	Brand only. Copays for generic reimbursement thru third party payers are allowed.
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



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Generic Name	Brand Name	Restrictions
▲* testosterone	Androderm, Testoderm TTS, Androgel, Testim	Long acting for wasting or hypogonadism; transdermal, gel and injectable forms covered. Maximum of 200mg weekly. Must provide copy of the original RX with every refill request.
35. 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 100.
8. ADAP mandates the use of generic products whenever possible in accordance with applicable law or regulations.
9. Dispensing a brand name product when a generic is available requires prior authorization and a DAW 1 code. Exceptions are noted by drug.
9. The following drug manufacturers are excluded from reimbursement thru the CA ADAP program:

- Able LABS, INC.
- Acura Pharmaceuticals aka HALSEY
- Allscripts
- Bedford LABS/BenVenue
- Ceph International
- Dispense Express , Inc./ Bay Labs
- Graceway Pharmaceuticals, LLC (except Aldara NDCs)
- GSMS, INC.
- H L MOORE
- Liberty Pharmaceutical
- Marlex Pharmaceuticals Inc.
- MOVA Pharmaceuticals
- Patheon Inc. (Puerto Rico)
- 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
- Sun Pharmaceuticals

10. CCR5 Tropism lab assay is covered through the CA-ADAP program. Only the lab assay manufactured by Monogram Biosciences is covered and also requires a prior authorization form.

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)