Washington State Department of Health Early Intervention Program (EIP)

EIP formulary for clients with *NO* other coverage

This formulary does not apply to clients with other coverage

FORMULARY BY DRUG CLASS

Effective July 1, 2009

	Generic Name	Brand Name	Restrictions or Notes
	1. ANALGESICS - Oral and transdermal only		
	Most drugs in this FDA class are covered. Common examples are:		
	NSAIDs		
	methadone		
	morphine SR	MS Contin,	Oramorph SR, Kadian, and Avinza are not covered
	oxycodone		
	pregabalin	Lyrica	For the treatment of peripheral neuropathy
§	*As of 7/1/09 Avinza, Fentanyl, Kadian, Oramorph, Opana, Opana ER, Opium, Oxycodone ER and Oxycontin are no longer covered for EIP clients with NO other coverage.*		
	Selective serotonin agonist antimigraine medications (i.e. Maxalt, Imitrex) removed from formulary.		
	2. ANTIANXIETY AGENTS		
	Most drugs in this FDA class are covered. Common examples are:		
	benzodiazepines		All drugs in this FDA class are covered
	buspirone	Buspar	
	hydroxyzine	Vistaril	
	3. ANTIBIOTICS		
	amoxicillin		
	amoxicillin/potassium clavulanate	Augmentin	
	ampicillin		
*	azithromycin	Zithromax	250mg tablet restrictions removed from formulary September 1st 2008. Z-pak units removed from formulary.
	ceftriaxone	Rocephin	
	cephalexin	Keflex	
	cefpodoxime	Vantin	Available for treatment of gonorrhea. Doses of 400mg (2x200mg tabs) do not require prior authorization
	ciprofloxacin	Cipro	>14 day supply requires PA
^	clarithromycin	Biaxin	Restricted to prevention or treatment of MAC also known as MAI or mycobacterium avium intracellulare complex infection
	clindamycin		
	clofazimine	Lamprene	
	dicloxacillin		
§	doxycycline		As of 7/1/09, Oracea is no longer covered for EIP clients with NO other coverage.
	erythromycin		
	ethambutol	Myambutol	
	isoniazid		
	levofloxacin	Levaquin	
	moxifloxacin	Avelox	
	mupirocin	Bactroban	For the topical treatment of impetigo
	ofloxacin	Floxin	
	penicillin		
	pyrazinamide		For the treatment of tuberculosis
	rifabutin	Mycobutin	
	rifampin	Rifadin	

FORMULARY BY DRUG CLASS
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	Generic Name	Brand Name	Restrictions or Notes
	3. ANTIBIOTICS continued		
	tetracycline		
	trimethoprim		
	trimethoprim/sulfamethoxazole	Bactrim, Septra, CoTrim	
	vancomycin oral		
	4. ANTIDEPRESSANTS		
	Most drugs in this FDA class are covered. Common examples are:		
	SSRIs:		
	citalopram	Celexa	Pill split 20mg
	fluoxetine	Prozac	
	fluvoxamine	Luvox	
	paroxetine	Paxil	Pill split 10mg, 20mg
	sertraline	Zoloft	Pill split 50mg
	TCAs:		
	amitriptyline	Elavil	
	clomipramine	Anafranil	
	desipramine		
	doxepin		
	imipramine		
	nortriptyline		
	Others:		
§	bupropion	Wellbutrin	As of 7/1/09 Wellbutrin SR and Wellbutrin XL are **no longer covered** for EIP clients with NO other coverage
	nefazodone	Serzone	Pill split 50mg, 100mg
	trazodone		
	venlafaxine	Effexor	
	5. ANTIDIABETIC AGENTS		
	insulin, injection kits and glucose test strips		
	Most drugs in this FDA class are covered. Common examples are:		
	acarbose	Precose	
	glyburide	Diabeta	
	glipizide	Glucotrol	
	metformin	Glucophage	
	pioglitazone	Actos	
	repaglinide	Prandin	
	rosiglitazone	Avandia	
	6. ANTIFUNGAL		
	clotrimazole	Lotrimin, Mycelex	
	clotrimazole/betamethasone	Lotrisone Cr	
*	fluconazole	Diflucan	Not covered for onychmycosis. Use code 1 override for all other indications.
	ketoconazole	Nizoral	
	miconazole		
	nystatin		
	terconazole		

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	7. ANTIHYPERLIPIDEMIC		
	Most drugs in this FDA class are covered. Common examples are:		
	atorvastatin	Lipitor	Pill split removed from formulary September 1st 2008.
	cholestyramine	Questran	
	gemfibrozil	Lopid	
	lovastatin	Mevacor	
	niacin		
	pravastatin	Pravachol	
	simvastatin	Zocor	
§	*As of 7/1/09, colestipol (Welchol) is no longer covered for EIP clients with no other coverage*		
	8. ANTIPARASITIC		
	aerosolized pentamidine	Nebupent	
	albendazole		
	atovaquone	Mepron	
	dapsone		
	lindane		
	metronidazole	Flagyl, Metrogel Vaginal Gel	
	paromomycin	Humatin	
	permethrin		
	primaquine		
	pyrimethamine	Daraprim	
	sulfa/pyrimethamine	Fansidar	
	sulfadiazine	Microsulfon	
	9. ANTIRETROVIRALS		
	abacavir	Ziagen	
	abacavir/lamivudine	Epzicom	
	abacavir/lamivudine/zidovudine	Trizivir	
	amprenavir	Agenerase	
	atazanavir	Reyataz	
	darunavir	Prezista	
	delavirdine	Rescriptor	
	didanosine	Videx, Videx EC	Generic Videx EC covered for copayments only
	efavirenz	Sustiva	
^	enfuvirtide	Fuzeon	Call for supplemental application form. Clinical criteria must be met every 6 mos.
	emtricitabine/tenofovir/efavirez	Atripla	
	emtricitabine	Emtriva	
	etravirine	Intelence	
	fosamprenavir	Lexiva	Limited to a quantity of 60 tablets per month without prior authorization. PA is required for qty >60 and requires that prescriber certifies intolerance to ritonavir.
	indinavir	Crixivan	
	lamivudine (3TC)	Epivir	
	lopinavir/ritonavir	Kaletra	25mg-100mg, 50mg-200mg, 100mg-400mg/5ml solution
^	maraviroc	Selzentry	Prior authorization required. Trofile™ assay lab results must be faxed to Ramsell Public Health Rx
	nelfinavir	Viracept	
	nevirapine	Viramune	
	raltegravir	Isentress	

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	9. ANTIRETROVIRALS continued		
	ritonavir	Norvir	Dosage of 400mg or greater requires use of the free drug program though Abbott or prior authorization. Limited to copays only of ≤ $50 for dosages greater than 400mg daily.
	saquinavir	Invirase	
	stavudine (d4T)	Zerit	
	tenofovir DF	Viread	
	tenofovir/emtricitabine	Truvada	
^	tipranavir	Aptivus	Call for supplemental application form.
	zalcitabine (ddC)	Hivid	
	zidovudine (AZT)	Retrovir	
	zidovudine/lamivudine (AZT/3TC)	Combivir	
	10. ANTIVIRALS - OTHER		
	acyclovir	Zovirax	
	cidofovir	Vistide	
	fomivirsen	Vitravene	
	foscarnet	Foscavir	
	ganciclovir	Cytovene	IV and Oral
	hepatitis B immune Globulin	HBIG	
	immune globulin IM	IGIM	
	podofilox	Condylox	
^	valacyclovir	Valtrex	Restricted to treatment of herpes zoster (shingles). Pill split removed from formulary September 1st 2008.
	valganciclovir	Valcyte	
	varicella zoster immune globulin	VZIG	
	11. BIPOLAR MEDICATION		
	carbamazepine	Tegretol	
	clozapine	Clozaril	
* §	gabapentin	Neurontin	Only covered for Peripheral Neuropathy
§	lamotrigine	Lamictal	Generic Only as of 7/1/2009
	lithium		
	oxcarbazepine	Trileptal	
§	risperidone	Risperdal	Generic Only as of 7/1/2009
	topiramate	Topamate	
	valproic acid	Depakene	
	12. DERMATOLOGIC AGENTS		
	selenium sulfide		
	topical steroids		All drugs in this FDA class are covered
	13. GASTROINTESTINAL		
	dicyclomine	Bentyl	
	diphenoxylate/Atropine	Lomotil	
	hyoscyamine	Levbid, Levsin	
	loperamide	Immodium	
	etoclopramide	Reglan	
^	ondansetron hydrochloride	Zofran	Covered after failed trial of Reglan and either Compazine or Phenergan
	opium tincture		
	prochlorperazine	Compazine	
	promethazine	Phenergan	

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	Generic Name	Brand Name	Restrictions or Notes
	13. GASTROINTESTINAL continued		
	H2-Antagonists		
	cimetidine	Tagamet	
	famotidine	Pepcid	
	nizatidine	Axid	
	ranitidine	Zantac	
^	**Proton Pump Inhibitors**		Covered for treatment of GERD, erosive esophagitis, or H. pylori. Restricted to use after trial of H2-blockers in treatment of ulcer or gastritis.
	omeprazole OTC	Prilosec OTC	As of 7/1/09, Prilosec OTC is covered
	14. HEMATOPOIETIC AGENTS		
^	epoetin-alpha	Procrit, Epogen	Restricted to treatment of ribavirin-related anemia and Hepatitis C diagnosis. Documented history of previous Ribavirin treatment required.
^	filgrastim (G-CSF)	Neupogen	Restricted to treatment of interferon-related neutropenia with a diagnosis of Hepatitis C or B. Documented history of previous Hep C interferon treatment required.
	15. HEPATITIS TREATMENT		
	adefovir	Hepsera	
^	entecavir	Baraclude	Call for supplemental PA application for use with first fill only
*	interferon alfa-2a	Roferon-A	Restricted to use in treatment of Hepatitis B or C
*	inteferon alfa-2b	Intron-A	Restricted to use in treatment of Hepatitis B or C
^	pegylated interferons	Peg-Intron, Pegasys	Restricted to use in treatment of Hepatitis C, call for application form for initial dose. Free Peg-Intron is still available. Pegasys is restricted only in cases when free Peg-Intron cannot be accessed thru the free Peg-Intron program or in patients that are continuing treatment with Pegasys to avoid interuption in treatment.
	ribavirin	Rebetol, Copegus	
	16. HORMONES		
	estrogen	Premarin	
	medroxyprogesterone	Depo-Provera, Provera	
§	megestrol acetate	Megace	Generic only. Megace ES is no longer covered as of 7/1/09.
^	nandrolone	Deca-Durabolin	Call for supplemental application to use with first fill. Call if use is required beyond 6 months.
^	oxandrolone	Oxandrin	Call for supplemental application to use with first fill. Call if use is required beyond 12 weeks.
§	testosterone cypionate		As of 7/1/09 Androderm, Androgel and Testim are no longer covered for EIP clients with NO other coverage
	17. MISCELLANEOUS		
	chlorhexidine gluconate	Peridex	
	hydroxyurea		
	leucovorin		Oral only
	mediset fills		
	phenazopyridine	Pyridin, Pyridium	
	pill splitter		

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	Generic Name	Brand Name	Restrictions or Notes
	18. ORAL STEROIDS		
	methylprednisolone		
	prednisone		
	19. RESTLESS LEG SYNDROME TREATMENT		
	levodopa/carbidopa	Sinemet	
	pramipexole	Mirapex	
	ropinirole	Requip	
	20. VACCINES		
	Multi-dose vials are not covered		
	hemophilus influenza type B vaccine	Hib	
	hepatitis A vaccine	Havrix, Vaqta	
	hepatitis B vaccine	Recombivax HB, Engerix B	
	hepatitis A/hepatitis B vaccine	Twinrix	
	influenza virus vaccine, split or whole virus		
	diphtheria & tetanus toxoids & pertussis vaccine		
	piphtheria & petanus toxoids		
	pneumococcal vaccine	Pneumovax, Pnu-Immune	

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 withan asterisk (*) after the drug names are code 1 restricted to use in a specific diagnosis. Transmit with the code 1 override of DAW 9 if the restriction is met. Document diagnosis on original prescription.
5. Prior authorization is required for DEA class II and III drugs when quantity exceeds 100.
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.
11. For drugs marked with (§), reference the notes regarding coverage change or restrictions for the EIP clients with **no** other coverage.

	Ramsell Public Health Rx		**WA State DOH**
	www.publichealthrx.com		**www.doh.wa.gov/cfh/hiv.htm**
	Phone 1-888-311-7632		**Phone 1-877-376-9316**
	Fax 1-800-848-4241		