

**Washington State Department of Health Early Intervention Program (EIP)**

**EIP formulary for clients with other coverage**

This formulary does not apply to clients with ONLY EIP Coverage

**FORMULARY BY DRUG CLASS**

Effective July 1, 2009



Generic Name	Brand Name	Restrictions or Notes	
<b>1. ANALGESICS - Oral and transdermal only</b>			
<i>Most drugs in this FDA class are covered. Common examples are:</i>			
NSAIDs			
narcotics			
pregabalin	Lyrica	For the treatment of peripheral neuropathy	
<i>Selective serotonin agonist antimigraine medications (i.e. Maxalt, Imitrex) removed from formulary.</i>			
<b>2. ANTIANXIETY AGENTS</b>			
<i>Most drugs in this FDA class are covered. Common examples are:</i>			
benzodiazepines		All drugs in this FDA class are covered	
bupirone	Buspar		
hydroxyzine	Vistaril		
<b>3. ANTIBIOTICS</b>			
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	
	cefprozime	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	Lamprone	
	dicloxacillin		
	doxycycline		
	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	
	tetracycline		
	trimethoprim		
	trimethoprim/sulfamethoxazole	Bactrim, Septra, CoTrim	
	vancomycin Oral		
<b>4. ANTIDEPRESSANTS</b>			
<i>Most drugs in this FDA class are covered. Common examples are:</i>			
SSRIs:			
citalopram	Celexa	Pill split 20mg	
fluoxetine	Prozac		

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<b>4. ANTIDEPRESSANTS continued</b>			
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		
nefazodone	Serzone	Pill split 50mg, 100mg	
trazodone			
venlafaxine	Effexor		
<b>5. ANTIDIABETIC AGENTS *</b>			
Insulin, Injection kits and Glucose test strips			
<i>Most drugs in this FDA class are covered. Common examples are:</i>			
acarbose	Precose		
glyburide	Diabeta		
glipizide	Glucotrol		
metformin	Glucophage		
pioglitazone	Actos		
repaglinide	Prandin		
rosiglitazone	Avandia		
<b>6. ANTIFUNGALS</b>			
clotrimazole	Lotrimin, Mycelex		
clotrimazole/betamethasone	Lotrisone Cr		
*	fluconazole	Diffucan	Not covered for onychomycosis. Use code 1 override for all other indications.
*	itraconazole	Sporonox	Not covered for onychomycosis. Use code 1 override for all other indications.
	ketoconazole	Nizoral	
	miconazole		
	nystatin		
	terconazole	Terazol	
<b>7. ANTIHYPERLIPIDEMIC *</b>			
<i>Most drugs in this FDA class are covered. Common examples are:</i>			
atorvastatin	Lipitor	Pill split removed from formulary September 1st 2008.	
cholestyramine	Questran		
gemfibrozil	Lopid		
colestipol	Welchol		
lovastatin	Mevacor		
niacin			
pravastatin	Pravachol		
simvastatin	Zocor		

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<b>8. ANTIPARASITICS</b>		
albendazole		
atovaquone	Mepron	
dapsone		
lindane		
metronidazole	Flagl, Metrogel Vaginal Gel	
paromomycin	Humatin	
permethrin		
primaquine		
pyrimethamine	Daraprim	
sulfa/pyrimethamine	Fansidar	
sulfadiazine	Microsulfon	
<b>9. ANTIRETROVIRALS *</b>		
abacavir	Ziagen	
abacavir/lamivudine	Epzicom	
abacavir/lamivudine/zidovudine	Trizivir	
amprenavir	Agenerase	
atazanavir	Reyataz	
darunavir (TMC-114)	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	
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	

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<b>10. ANTIVIRALS - OTHER</b>			
	acyclovir	Zovirax	
	cidofovir	Vistide	
	fomivirsen	Vitrovene	
	foscarnet	Foscavir	
	ganciclovir	Cytovene	IV and Oral
	hepatitis B immune globulin	HBIG	
	imiquimod cream	Aldara	
	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	
<b>11. BIPOLAR MEDICATION</b>			
	carbamazepine	Tegretol	
	clozapine	Clozaril	
^	divalproex sodium	Depakote, Depakote ER	
	gabapentin	Neurontin	
	lamotrigine	Lamictal	
	lithium		
^	olanzapine	Zyprexa	Covered after failed trial of formulary meds (Depakote or lithium).
	oxcarbazepine	Trileptal	
	quetiapine	Seroquel	
	risperidone	Risperdal	
	topiramate	Topamate	
	valproic acid	Depakene	
<b>12. DERMATOLOGIC AGENTS</b>			
	selenium sulfide		
	topical steroids		All drugs in this FDA class are covered
<b>13. GASTROINTESTINAL AGENTS</b>			
	dicyclomine	Bentyl	
	diphenoxylate/atropine	Lomotil	
^	dronabinol	Marinol	Unintentional 10lb weight loss must be documented on PA for approval of initial 3 mo treatment period. Treatment beyond 3 mo requires additional documentation. Call for assistance.
	hyoscyamine	Levbid, Levsin	
	loperamide	Immodium	
	metoclopramide	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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<b>13. GASTROINTESTINAL AGENTS continued</b>		
	<b>H2-Antagonists</b>	
	cimetidine	Tagamet
	famotidine	Pepcid
	nizatidine	Axid
	ranitidine	Zantac
^	<b>Proton Pump Inhibitors</b>	Covered for treatment of GERD, erosive esophagitis, or H. pylori. Restricted to use after trial of H2-blockers in treatment of ulcer or gastritis.
	esomeprazole	Nexium
	lansoprazole	Prevacid
	omeprazole	Prilosec
	pantoprazole	Protonix
	rabeprazole	Aciphex
<b>14. HEMATOPOIETIC AGENTS</b>		
^	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.
<b>15. HEPATITIS TREATMENT</b>		
	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
*	interferon 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 interruption in treatment.
	ribavirin	Rebetol, Copegus
<b>16. HORMONES</b>		
	estrogen	Premarin
	medroxyprogesterone	Depo-Provera, Provera
	megestrol acetate	Megace
^	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 products	
<b>17. MISCELLANEOUS</b>		
	chlorhexidine gluconate	Peridex
	hydroxyurea	
	leucovorin	oral only
	mediset fills	
	phenazopyridine	Pyridin, Pyridium
	pill splitter	

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<b>18. ORAL STEROIDS</b>		
methyprednisolone		
prednisone		
<b>19. RESTLESS LEG SYNDROME TREATMENT</b>		
levodopa/carbidopa	Sinemet	
pramipexole	Mirapex	
ropinirole	Requip	
<b>20. VACCINES</b>		
<i>Multi-dose vials are not covered</i>		
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		
diphtheria & tetanus toxoids		
pneumococcal vaccine	Pneumovax, Pnu-Immune	
<b>Program Dispensing Policies</b>		
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 "A" 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 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.		
Ramsell Public Health Rx		WA State DOH
<a href="http://www.publichealthrx.com">www.publichealthrx.com</a>		<a href="http://www.doh.wa.gov/cfh/hiv.htm">www.doh.wa.gov/cfh/hiv.htm</a>
Phone 1-888-311-7632		Phone 1-877-376-9316
Fax 1-800-848-4241		