

## Georgia Medicaid/PeachCare Preferred Drug List

**Effective December 1, 2006**

This Preferred Drug List is subject to change without notice. Generics are considered preferred unless noted. This list does not include all drugs covered under the Georgia Medicaid/PeachCare for Kids outpatient pharmacy program. **KEY: Preferred / P:** medications associated with a lower member copayment; **Non-Preferred / NP:** medications associated with a higher member copayment; **PA:** prior authorization required; **QLL:** quantity or therapy limits apply. The QLL listing and therapy limitation description are located in Part II of the Policies and Procedures for Pharmacy Services Manual located on the web portal, under Provider Manuals.

	Preferred	Non-Preferred	PA	QLL
<b>ANTIINFECTIVES</b>				
<b>ANTIBACTERIAL DRUGS</b>				
amox/clavulanate generic	P			QLL
AUGMENTIN ES	P			QLL
AUGMENTIN XR	P			QLL
AVELOX	P			QLL
AVELOX ABC	P			QLL
azithromycin generic	P			QLL
BIAXIN		NP	PA	QLL
BIAXIN SUSPENSION		NP	PA	QLL
BIAXIN XL		NP	PA	QLL
CECLOR		NP	PA	QLL
CECLOR CD		NP	PA	QLL
CECLOR SUSPENSION	P*	NP	PA (> 12yrs, < 65yrs)	QLL
CEDAX	P			QLL
CEDAX SUSPENSION	P*	NP	PA (> 12yrs, < 65yrs)	QLL
cefaclor er generic	P			QLL
cefaclor generic	P			QLL
cefadroxil generic	P			QLL
CEFTIN		NP	PA	QLL
CEFTIN SUSPENSION	P*	NP	PA (> 12yrs, < 65yrs)	QLL
cefprozil generic	P			QLL
cefuroxime generic	P			QLL
cephalexin generic	P			QLL
cephradine generic	P			QLL
CIPRO		NP	PA	QLL
CIPRO SUSPENSION	P			QLL
CIPRO XR	P			QLL
ciprofloxacin generic	P			QLL
clarithromycin/ER generic	P			QLL
DURICEF SUSP	P			
DYNAPEN SUSP	P			
E.E.S. 400	P			QLL
E-MYCIN	P			QLL
ERYC	P			QLL
ERYPED	P			QLL
ERY-TAB	P			QLL
erythromycin	P			QLL
FACTIVE		NP	PA	QLL
FLOXIN		NP	PA	QLL
GANTRISIN PEDIATRIC	P			
KETEK		NP	PA	QLL

P\* Available without PA for < or = to 12 yrs and > or = to 65 yrs

PA\* Requires PA after (3) prescriptions per year

REVISED 11/30/2006

## Georgia Medicaid/PeachCare Preferred Drug List

**Effective December 1, 2006**

This Preferred Drug List is subject to change without notice. Generics are considered preferred unless noted. This list does not include all drugs covered under the Georgia Medicaid/PeachCare for Kids outpatient pharmacy program. **KEY: Preferred / P:** medications associated with a lower member copayment; **Non-Preferred / NP:** medications associated with a higher member copayment; **PA:** prior authorization required; **QLL:** quantity or therapy limits apply. The QLL listing and therapy limitation description are located in Part II of the Policies and Procedures for Pharmacy Services Manual located on the web portal, under Provider Manuals.

	Preferred	Non-Preferred	PA	QLL
LEVAQUIN	P			QLL
LORABID		NP	PA	QLL
LORABID SUSPENSION	P*	NP	PA (> 12yrs, < 65yrs)	QLL
MACROBID	P			
MAXAQUIN		NP	PA	QLL
NOROXIN		NP	PA	QLL
ofloxacin generic	P			QLL
OMNICEF	P			QLL
OMNICEF SUSPENSION	P*	NP	PA (> 12yrs, < 65yrs)	QLL
PCE	P			QLL
PROQUIN XR		NP	PA	QLL
SPECTRACEF	P			QLL
SUPRAX		NP	PA	QLL
SUPRAX SUSPENSION	P*	NP	PA (> 12yrs, < 65yrs)	QLL
TEQUIN		NP	PA	QLL
TOBI	P			QLL
TROVAN		NP		
VANTIN		NP	PA	QLL
VANTIN SUSPENSION	P*	NP	PA (> 12yrs, < 65yrs)	QLL
VIBRAMYCIN SYRUP, SUSPENSION	P			
ZITHROMAX SUSPENSION		NP	PA	QLL
ZITHROMAX TABLETS		NP		QLL
ZMAX		NP	PA	QLL
<b>TOPICAL ANTIBACTERIAL DRUGS</b>				
BACTROBAN CREAM	P			
BACTROBAN NASAL	P			
<b>ORAL ANTIFUNGAL DRUGS</b>				
ANCOBON	P			
DIFLUCAN	P		PA	
DIFLUCAN 150MG TAB	P			QLL
GRIFULVIN V SUSP	P			
itraconazole generic	P		PA	QLL
LAMISIL	P		PA	
MYCELEX	P			
VFEND		NP	PA	
<b>TOPICAL ANTIFUNGALS</b>				
ERTACZO		NP		
EXELDERM		NP		
LAMISIL SOLUTION		NP		

P\* Available without PA for < or = to 12 yrs and > or = to 65 yrs

PA\* Requires PA after (3) prescriptions per year

REVISED 11/30/2006

## Georgia Medicaid/PeachCare Preferred Drug List

**Effective December 1, 2006**

This Preferred Drug List is subject to change without notice. Generics are considered preferred unless noted. This list does not include all drugs covered under the Georgia Medicaid/PeachCare for Kids outpatient pharmacy program. **KEY: Preferred / P:** medications associated with a lower member copayment; **Non-Preferred / NP:** medications associated with a higher member copayment; **PA:** prior authorization required; **QLL:** quantity or therapy limits apply. The QLL listing and therapy limitation description are located in Part II of the Policies and Procedures for Pharmacy Services Manual located on the web portal, under Provider Manuals.

	Preferred	Non-Preferred	PA	QLL
LOPROX		NP		
LOTRISONE LOTION		NP		
MENTAX		NP		
miconazole generic	P			QLL
MONISTAT 1	P			QLL
OXISTAT		NP		
PENLAC		NP	PA	
TERAZOL	P			QLL
<b>ANTIRETROVIRALS &amp; PROTEASE INHIBITORS</b>				
AGENERASE	P			
APTIVUS	P			
COMBIVIR	P			
CRIXIVAN	P			
EPIVIR	P			
FORTOVASE	P			
FUZEON	P		PA	QLL
HIVID	P			
INVIRASE	P			
KALETRA	P			QLL
LEXIVA	P			
NORVIR	P			
PREZISTA	P			
RESCRIPTOR	P			
RETROVIR	P			
REYATAZ	P			
SUSTIVA	P			
TRIZIVIR TABLET	P			
VIDEX	P			
VIDEX EC	P			
VIRACEPT	P			
VIREAD	P			
ZERIT	P			
ZIAGEN	P			
zidovudine generic	P			
<b>OTHER ANTIVIRAL DRUGS</b>				
BARACLUDE	P			
CYTOVENE	P			
EPIVIR HBV	P			
FAMVIR		NP		QLL
RELENZA		NP		QLL

P\* Available without PA for < or = to 12 yrs and > or = to 65 yrs

PA\* Requires PA after (3) prescriptions per year

REVISED 11/30/2006

## Georgia Medicaid/PeachCare Preferred Drug List

**Effective December 1, 2006**

This Preferred Drug List is subject to change without notice. Generics are considered preferred unless noted. This list does not include all drugs covered under the Georgia Medicaid/PeachCare for Kids outpatient pharmacy program. **KEY: Preferred / P:** medications associated with a lower member copayment; **Non-Preferred / NP:** medications associated with a higher member copayment; **PA:** prior authorization required; **QLL:** quantity or therapy limits apply. The QLL listing and therapy limitation description are located in Part II of the Policies and Procedures for Pharmacy Services Manual located on the web portal, under Provider Manuals.

	Preferred	Non-Preferred	PA	QLL
TAMIFLU	P			QLL
VALTREX	P			QLL
<b>TOPICAL ANTIVIRAL DRUGS</b>				
DENAVIR	P			
ZOVIRAX OINTMENT	P			
<b>ANTIINFECTIVES SPECIALIZED INDICATIONS</b>				
DAPSONE	P			
DARAPRIM	P			
MEPRON	P			
MINTEZOL	P			
MYCOBUTIN	P			
NEBUPENT	P			QLL
TINDAMAX		NP	PA	
VANCOCIN	P			
XIFAXAN		NP	PA	
ZYVOX	P		PA	
<b>ANTINEOPLASTIC/</b>				
<b>IMMUNOSUPPRESSANT DRUGS</b>				
AGRYLIN	P			
ALKERAN	P			
ARAVA	P			QLL
ARIMIDEX	P			
AROMASIN	P			
CASODEX	P			
CEENU	P			
CELLCEPT	P			
EMCYT	P			
ENBREL	P			QLL
FEMARA	P			
HUMIRA	P			QLL
KINERET		NP	PA	QLL
LEUKERAN	P			
LUPRON DEPOT	P			QLL
LYSODREN	P			
MATULANE	P			
MYFORTIC	P			
MYLERAN	P			
NEXAVAR	P			QLL
ORENCIA		NP	PA	

P\* Available without PA for < or = to 12 yrs and > or = to 65 yrs

PA\* Requires PA after (3) prescriptions per year

REVISED 11/30/2006

## Georgia Medicaid/PeachCare Preferred Drug List

**Effective December 1, 2006**

This Preferred Drug List is subject to change without notice. Generics are considered preferred unless noted. This list does not include all drugs covered under the Georgia Medicaid/PeachCare for Kids outpatient pharmacy program. **KEY: Preferred / P:** medications associated with a lower member copayment; **Non-Preferred / NP:** medications associated with a higher member copayment; **PA:** prior authorization required; **QLL:** quantity or therapy limits apply. The QLL listing and therapy limitation description are located in Part II of the Policies and Procedures for Pharmacy Services Manual located on the web portal, under Provider Manuals.

	Preferred	Non-Preferred	PA	QLL
PROGRAF	P			
PURINETHOL	P			
RAPAMUNE	P			
RAPTIVA	P		PA	
REMICADE	P			QLL
REVLIMID	P			
RIDAURA	P			
RITUXAN	P		PA	
SANDOSTATIN	P			
SUTENT	P		PA	
TARCEVA	P		PA	
TARGRETIN CAP	P			QLL
TARGRETIN GEL	P			QLL
TEMODAR	P		PA	QLL
THIOGUANINE	P			
TRELSTAR LA/DEPOT	P			QLL
VEPESID	P			
VESANOID	P			
VIDAZA	P		PA	QLL
XELODA	P			
<b><i>CARDIOVASCULAR MEDICATIONS</i></b>				
<b>CALCIUM ANTAGONISTS</b>				
ADALAT CC		NP		QLL
afeditab cr generic	P			QLL
CALAN		NP	PA	QLL
CALAN SR		NP	PA	QLL
CARDENE IV	P			
CARDENE SR		NP	PA	QLL
CARDIZEM		NP	PA	QLL
CARDIZEM CD		NP	PA	QLL
CARDIZEM LA	P			QLL
CARDIZEM SR		NP	PA	QLL
CARDIZEM INJECTABLE		NP	PA	
CARTIA XT	P			QLL
COVERA HS		NP	PA	QLL
DILACOR XR		NP	PA	QLL
DILTIA XT	P			QLL
diltiazem generic	P			QLL
diltiazem er generic	P			QLL
diltiazem xr generic	P			QLL
diltiazem injectable generic	P			

P\* Available without PA for < or = to 12 yrs and > or = to 65 yrs

PA\* Requires PA after (3) prescriptions per year

REVISED 11/30/2006

## Georgia Medicaid/PeachCare Preferred Drug List

**Effective December 1, 2006**

This Preferred Drug List is subject to change without notice. Generics are considered preferred unless noted. This list does not include all drugs covered under the Georgia Medicaid/PeachCare for Kids outpatient pharmacy program. **KEY: Preferred / P:** medications associated with a lower member copayment; **Non-Preferred / NP:** medications associated with a higher member copayment; **PA:** prior authorization required; **QLL:** quantity or therapy limits apply. The QLL listing and therapy limitation description are located in Part II of the Policies and Procedures for Pharmacy Services Manual located on the web portal, under Provider Manuals.

	Preferred	Non-Preferred	PA	QLL
DYNACIRC CR	P			QLL
felodipine ER generic	P			QLL
ISOPTIN SR		NP	PA	QLL
isradipine generic	P			QLL
nicardipine generic	P			QLL
nifediac cc generic	P			QLL
nifedical xl generic	P			QLL
nifedipine er 30mg, 60mg generic	P			QLL
nifedipine er 90mg generic	P			QLL
nifedipine ir generic	P			QLL
nifedipine sa generic	P			QLL
NIMOTOP	P			
NORVASC	P			QLL
PROCARDIA, -XL		NP		QLL
SULAR	P			QLL
TAZTIA XT	P			QLL
TIAZAC		NP	PA	QLL
verapamil generic	P			QLL
VERELAN		NP	PA	QLL
VERELAN PM	P			QLL
<b>CARDIAC GLYCOSIDES</b>				
digoxin generic	P			
LANOXIN		NP	PA	
LANOXICAPS		NP	PA	
<b>BETA-ADRENERGIC ANTAGONIST DRUGS</b>				
All generics are Preferred	P			QLL
BETAPACE, -AF		NP	PA	QLL
COREG	P			
CORZIDE	P			QLL
INNOPRAN XL		NP	PA	QLL
LEVATOL	P			QLL
TIMOLIDE	P			QLL
TOPROL XL		NP	PA	QLL
<b>CENTRALLY ACTING ANTIHYPERTENSIVES</b>				
CATAPRES-TTS	P			QLL
<b>ANGIOTENSIN CONVERTING ENZYME INHIBITORS &amp; COMBOS</b>				
ACCUPRIL		NP	PA	QLL
ACCURETIC		NP	PA	QLL

P\* Available without PA for < or = to 12 yrs and > or = to 65 yrs

PA\* Requires PA after (3) prescriptions per year

REVISED 11/30/2006

## Georgia Medicaid/PeachCare Preferred Drug List

**Effective December 1, 2006**

This Preferred Drug List is subject to change without notice. Generics are considered preferred unless noted. This list does not include all drugs covered under the Georgia Medicaid/PeachCare for Kids outpatient pharmacy program. **KEY: Preferred / P:** medications associated with a lower member copayment; **Non-Preferred / NP:** medications associated with a higher member copayment; **PA:** prior authorization required; **QLL:** quantity or therapy limits apply. The QLL listing and therapy limitation description are located in Part II of the Policies and Procedures for Pharmacy Services Manual located on the web portal, under Provider Manuals.

	Preferred	Non-Preferred	PA	QLL
ACEON		NP	PA	QLL
ALTACE	P			QLL
benazepril generic	P			QLL
benazepril HCTZ generic	P			QLL
CAPOTEN		NP	PA	QLL
CAPOZIDE		NP	PA	QLL
captopril generic	P			QLL
captopril HCTZ generic	P			QLL
enalapril generic	P			QLL
enalapril HCTZ generic	P			QLL
enalaprilat generic	P			QLL
fosinopril generic	P			QLL
fosinopril HCTZ generic	P			QLL
lisinopril generic	P			QLL
lisinopril HCTZ generic	P			QLL
LOTENSIN		NP	PA	QLL
LOTENSIN HCT		NP	PA	QLL
MAVIK	P			QLL
moexipril generic	P			QLL
MONOPRIL		NP	PA	QLL
MONOPRIL HCT		NP	PA	QLL
PRINIVIL		NP	PA	QLL
PRINZIDE		NP	PA	QLL
quinapril generic	P			QLL
quinaretic generic	P			QLL
UNIRETIC	P			QLL
UNIVASC	P			QLL
VASERETIC		NP	PA	QLL
VASOTEC		NP	PA	QLL
ZESTORETIC		NP	PA	QLL
ZESTRIL		NP	PA	QLL
<b>ANGIOTENSIN II RECEPTOR ANTAGONISTS &amp; COMBOS</b>				
ATACAND		NP	PA	QLL
ATACAND HCT		NP	PA	QLL
AVALIDE	P			QLL
AVAPRO	P			QLL
BENICAR	P			QLL
BENICAR HCT	P			QLL
COZAAR	P			QLL
DIOVAN	P			QLL
DIOVAN HCT	P			QLL

P\* Available without PA for < or = to 12 yrs and > or = to 65 yrs

PA\* Requires PA after (3) prescriptions per year

REVISED 11/30/2006

## Georgia Medicaid/PeachCare Preferred Drug List

**Effective December 1, 2006**

This Preferred Drug List is subject to change without notice. Generics are considered preferred unless noted. This list does not include all drugs covered under the Georgia Medicaid/PeachCare for Kids outpatient pharmacy program. **KEY: Preferred / P:** medications associated with a lower member copayment; **Non-Preferred / NP:** medications associated with a higher member copayment; **PA:** prior authorization required; **QLL:** quantity or therapy limits apply. The QLL listing and therapy limitation description are located in Part II of the Policies and Procedures for Pharmacy Services Manual located on the web portal, under Provider Manuals.

	Preferred	Non-Preferred	PA	QLL
HYZAAR	P			QLL
MICARDIS	P			QLL
MICARDIS HCT	P			QLL
TEVETEN	P			QLL
TEVETEN HCT	P			QLL
<b>OTHER ANTIHYPERTENSIVES</b>				
INSPRA		NP		
LEXXEL	P			
LOTREL	P			
TARKA	P			
<b>NITRATES</b>				
nitroglycerin patches generic	P			
NITROLINGUAL SPRAY	P			QLL
<b>ANTIDYSRHYTHMIC DRUGS</b>				
ETHMOZINE	P			
TONOCARD	P			
<b>ANTILIPIDEMIC DRUGS</b>				
ADVICOR	P			QLL
ALTOPREV (previously Altacor)	P			QLL
CADUET		NP	PA	QLL
COLESTID	P			
CRESTOR		NP	PA	QLL
LESCOL, -XL	P			QLL
LIPITOR		NP	PA	QLL
lovastatin generic	P			QLL
MEVACOR		NP	PA	QLL
NIASPAN	P			
PRAVACHOL		NP	PA	QLL
pravastatin generic		NP	PA	QLL
PRAVIGARD PAC		NP	PA	QLL
simvastatin generic		NP	PA	QLL
VYTORIN	P			QLL
WELCHOL		NP		
XENICAL	P		PA	
ZETIA	P		PA	QLL
ZOCOR	P			QLL
<b>FIBRIC ACID DERIVATIVES</b>				

P\* Available without PA for < or = to 12 yrs and > or = to 65 yrs

PA\* Requires PA after (3) prescriptions per year

REVISED 11/30/2006

## Georgia Medicaid/PeachCare Preferred Drug List

**Effective December 1, 2006**

This Preferred Drug List is subject to change without notice. Generics are considered preferred unless noted. This list does not include all drugs covered under the Georgia Medicaid/PeachCare for Kids outpatient pharmacy program. **KEY: Preferred / P:** medications associated with a lower member copayment; **Non-Preferred / NP:** medications associated with a higher member copayment; **PA:** prior authorization required; **QLL:** quantity or therapy limits apply. The QLL listing and therapy limitation description are located in Part II of the Policies and Procedures for Pharmacy Services Manual located on the web portal, under Provider Manuals.

	Preferred	Non-Preferred	PA	QLL
ANTARA	P			QLL
fenofibrate generic		NP	PA	QLL
gemfibrozil generic	P			QLL
LOFIBRA	P			QLL
TRICOR	P			QLL
TRIGLIDE	P			QLL
<b>OTHER CARDIOVASCULAR DRUGS</b>				
BIDIL		NP	PA	QLL
OMACOR		NP	PA	
PROAMATINE	P			
RANEXA		NP	PA	
REVATIO	P		PA	QLL
VENTAVIS	P		PA	QLL
<b>DRUGS FOR PHEOCHROMOCYTOMA</b>				
DEMSER	P			
<b>AUTONOMIC AND CNS MEDICATIONS</b>				
<b>NARCOTIC ANALGESICS</b>				
ACTIQ		NP	PA	QLL
AVINZA	P			QLL
butorphanol nasal generic	P			QLL
COMBUNOX		NP	PA	QLL
DURAGESIC	P			QLL
fentanyl citrate generic (generic Actiq)	P		PA	QLL
fentanyl patch generic (generic Duragesic)		NP	PA	QLL
FENTORA		NP	PA	QLL
KADIAN	P			QLL
morphine sulfate sa generic	P			QLL
MS CONTIN	P			QLL
OPANA/ER		NP	PA	QLL
ORAMORPH SR		NP	PA	QLL
oxycodone er generic		NP	PA	QLL
OXYCONTIN		NP	PA	QLL
PALLADONE		NP	PA	QLL
<b>OTHER ANALGESICS</b>				
tramadol generic	P			QLL
tramadol/acetaminophen generic	P			QLL
ULTRACET		NP		QLL
ULTRAM ER		NP		QLL

P\* Available without PA for < or = to 12 yrs and > or = to 65 yrs

PA\* Requires PA after (3) prescriptions per year

REVISED 11/30/2006

## Georgia Medicaid/PeachCare Preferred Drug List

**Effective December 1, 2006**

This Preferred Drug List is subject to change without notice. Generics are considered preferred unless noted. This list does not include all drugs covered under the Georgia Medicaid/PeachCare for Kids outpatient pharmacy program. **KEY: Preferred / P:** medications associated with a lower member copayment; **Non-Preferred / NP:** medications associated with a higher member copayment; **PA:** prior authorization required; **QLL:** quantity or therapy limits apply. The QLL listing and therapy limitation description are located in Part II of the Policies and Procedures for Pharmacy Services Manual located on the web portal, under Provider Manuals.

	Preferred	Non-Preferred	PA	QLL
<b>DRUGS TO PREVENT AND TREAT HEADACHES</b>				
AMERGE	P			QLL
AXERT	P			QLL
FROVA		NP	PA	QLL
IMITREX (tabs, inj, ns)	P			QLL
MAXALT, -MLT	P			QLL
MIGRANAL NS		NP	PA	QLL
RELPAK	P			QLL
ZOMIG, -ZMT	P			QLL
<b>ANXIOLYTICS</b>				
alprazolam generic	P		PA* (≥ 21 yrs)	QLL
chlordiazepoxide generic	P		PA* (≥ 21 yrs)	QLL
clonazepam generic	P		PA* (≥ 21 yrs)	QLL
clorazepate dipotassium generic	P		PA* (≥ 21 yrs)	QLL
diazepam generic	P		PA* (≥ 21 yrs)	QLL
estazolam generic	P		PA* (≥ 21 yrs)	QLL
lorazepam generic	P		PA* (≥ 21 yrs)	QLL
midazolam generic	P		PA* (≥ 21 yrs)	QLL
NIRAVAM		NP	PA* (≥ 21 yrs)	QLL
oxazepam generic	P		PA* (≥ 21 yrs)	QLL
temazepam generic	P		PA* (≥ 21 yrs)	QLL
XANAX XR		NP	PA* (≥ 21 yrs)	QLL
<b>SEDATIVE/HYPNOTIC DRUGS</b>				
AMBIEN, -CR	P			QLL
LUNESTA	P			QLL
ROZEREM	P			QLL
SONATA	P			QLL
<b>ANTIMANIA DRUGS</b>				
lithium carbonate generic	P			
<b>ANTICONVULSANT DRUGS</b>				
carbamazepine generic	P			
CELONTIN	P			
DEPAKOTE, -ER	P			
DIASTAT	P		PA (≥ 21 yrs)	QLL
DILANTIN		NP		
DILANTIN INFATAB		NP		
FELBATOL	P			

P\* Available without PA for < or = to 12 yrs and > or = to 65 yrs

PA\* Requires PA after (3) prescriptions per year

REVISED 11/30/2006

## Georgia Medicaid/PeachCare Preferred Drug List

**Effective December 1, 2006**

This Preferred Drug List is subject to change without notice. Generics are considered preferred unless noted. This list does not include all drugs covered under the Georgia Medicaid/PeachCare for Kids outpatient pharmacy program. **KEY: Preferred / P:** medications associated with a lower member copayment; **Non-Preferred / NP:** medications associated with a higher member copayment; **PA:** prior authorization required; **QLL:** quantity or therapy limits apply. The QLL listing and therapy limitation description are located in Part II of the Policies and Procedures for Pharmacy Services Manual located on the web portal, under Provider Manuals.

	Preferred	Non-Preferred	PA	QLL
KEPPRA	P			
LAMICTAL	P			
NEURONTIN	P			
phenytoin generic	P			
TEGRETOL, -XR		NP		
TOPAMAX	P			
TRILEPTAL	P			
ZONEGRAN	P			
<b>SELECTIVE SEROTONIN REUPTAKE INHIBITORS</b>				
CELEXA		NP	PA	QLL
citalopram generic	P			QLL
fluoxetine generic	P			QLL
fluvoxamine generic	P			QLL
LEXAPRO	P			QLL
paroxetine generic	P			QLL
PAXIL		NP	PA	QLL
PAXIL CR	P			QLL
PEXEVA	P			QLL
PROZAC		NP	PA	QLL
RAPIFLUX		NP	PA	QLL
SARAFEM		NP	PA	QLL
sertraline generic		NP	PA	QLL
ZOLOFT	P			QLL
<b>NEW GENERATION ANTIDEPRESSANTS</b>				
CYMBALTA		NP	PA	QLL
EFFEXOR, -XR	P			QLL
bupropion/bupropion ER & SR generic	P			QLL
maprotiline generic	P			QLL
mirtazapine generic	P			QLL
nefazodone generic	P			QLL
REMERON		NP		QLL
trazodone generic	P			QLL
venlafaxine generic	P			QLL
WELLBUTRIN, -SR		NP	PA	QLL
WELLBUTRIN-XL	P			QLL
<b>MAO INHIBITORS</b>				
EMSAM		NP	PA	QLL
NARDIL	P			
PARNATE	P			

P\* Available without PA for < or = to 12 yrs and > or = to 65 yrs

PA\* Requires PA after (3) prescriptions per year

REVISED 11/30/2006

## Georgia Medicaid/PeachCare Preferred Drug List

**Effective December 1, 2006**

This Preferred Drug List is subject to change without notice. Generics are considered preferred unless noted. This list does not include all drugs covered under the Georgia Medicaid/PeachCare for Kids outpatient pharmacy program. **KEY: Preferred / P:** medications associated with a lower member copayment; **Non-Preferred / NP:** medications associated with a higher member copayment; **PA:** prior authorization required; **QLL:** quantity or therapy limits apply. The QLL listing and therapy limitation description are located in Part II of the Policies and Procedures for Pharmacy Services Manual located on the web portal, under Provider Manuals.

	Preferred	Non-Preferred	PA	QLL
<b>ANTIVERTIGO AND ANTIEMETIC DRUGS</b>				
ANZEMET		NP		QLL
CESAMET		NP	PA	QLL
EMEND		NP		QLL
KYTRIL		NP		QLL
MARINOL	P		PA	
TRANSDERM-SCOP	P			
ZOFRAN, -ODT	P			QLL
<b>ANTIPARKINSON DRUGS</b>				
APOKYN	P			
bromocriptine generic	P			
COMTAN	P			
MIRAPEX	P			
pergolide generic	P			
REQUIP	P			
<b>ATYPICAL ANTIPSYCHOTIC DRUGS</b>				
ABILIFY		NP	PA	QLL
clozapine generic		NP		QLL
CLOZARIL		NP		QLL
FAZACLO		NP		QLL
GEODON	P			QLL
RISPERDAL CONSTA		NP	PA	QLL
RISPERDAL M-TAB		NP	PA	QLL
RISPERDAL TABS & SOLN	P			QLL
SEROQUEL	P			QLL
SYMBYAX		NP	PA	QLL
ZYPREXA		NP	PA	QLL
ZYPREXA INJECTABLE		NP		QLL
ZYPREXA ZYDIS		NP	PA	QLL
<b>OTHER ANTIPSYCHOTIC DRUGS</b>				
fluphenazine deconoate vial generic	P			QLL
haloperidol deconoate vial generic	P			QLL
MOBAN	P			
<b>CNS STIMULANT DRUGS</b>				
ADDERALL		NP	PA	QLL
ADDERALL XR	P		PA (> 21 years)	QLL
amphetamine salt combination generic	P		PA (> 21 years)	QLL

P\* Available without PA for < or = to 12 yrs and > or = to 65 yrs

PA\* Requires PA after (3) prescriptions per year

REVISED 11/30/2006

## Georgia Medicaid/PeachCare Preferred Drug List

**Effective December 1, 2006**

This Preferred Drug List is subject to change without notice. Generics are considered preferred unless noted. This list does not include all drugs covered under the Georgia Medicaid/PeachCare for Kids outpatient pharmacy program. **KEY: Preferred / P:** medications associated with a lower member copayment; **Non-Preferred / NP:** medications associated with a higher member copayment; **PA:** prior authorization required; **QLL:** quantity or therapy limits apply. The QLL listing and therapy limitation description are located in Part II of the Policies and Procedures for Pharmacy Services Manual located on the web portal, under Provider Manuals.

	Preferred	Non-Preferred	PA	QLL
CONCERTA	P		PA (> 21 years)	QLL
DAYTRANA		NP	PA	QLL
DESOXYN		NP	PA	QLL
DEXEDRINE	P		PA (> 21 years)	QLL
dextroamphetamine generic	P		PA (> 21 years)	QLL
DEXTROSTAT	P		PA (> 21 years)	QLL
FOCALIN	P		PA (> 21 years)	QLL
FOCALIN XR	P		PA (> 21 years)	QLL
METADATE CD	P		PA (> 21 years)	QLL
METADATE ER	P		PA (> 21 years)	QLL
methamphetamine generic		NP	PA	QLL
METHYLIN CHEW TABS & SOLN	P		PA (> 21 years)	QLL
METHYLIN TABS	P		PA (> 21 years)	QLL
METHYLIN ER	P			QLL
methylphenidate generic	P			QLL
methylphenidate er generic	P			QLL
PROVIGIL		NP	PA	QLL
RITALIN	P		PA (> 21 years)	QLL
RITALIN LA	P		PA (> 21 years)	QLL
RITALIN SR	P		PA (> 21 years)	QLL
STRATTERA		NP	PA	QLL
<b>OTHER CNS/AUTONOMIC DRUGS</b>				
PROSTIGMIN	P			
VIVITROL	P		PA	QLL
XYREM		NP	PA	QLL
<b>ANTIDEMENTIA DRUGS</b>				
ARICEPT	P			
COGNEX	P			
EXELON	P			
NAMENDA	P			
RAZADYNE (previously Reminyl)	P			
<b>DRUGS TO TREAT MULTIPLE SCLEROSIS</b>				
AVONEX, -AD	P			QLL
BETASERON, C-	P			QLL
COPAXONE	P			QLL
REBIF	P			QLL
TYSABRI		NP	PA	QLL
<b>MISCELLANEOUS</b>				

P\* Available without PA for < or = to 12 yrs and > or = to 65 yrs

PA\* Requires PA after (3) prescriptions per year

REVISED 11/30/2006

## Georgia Medicaid/PeachCare Preferred Drug List

**Effective December 1, 2006**

This Preferred Drug List is subject to change without notice. Generics are considered preferred unless noted. This list does not include all drugs covered under the Georgia Medicaid/PeachCare for Kids outpatient pharmacy program. **KEY: Preferred / P:** medications associated with a lower member copayment; **Non-Preferred / NP:** medications associated with a higher member copayment; **PA:** prior authorization required; **QLL:** quantity or therapy limits apply. The QLL listing and therapy limitation description are located in Part II of the Policies and Procedures for Pharmacy Services Manual located on the web portal, under Provider Manuals.

	Preferred	Non-Preferred	PA	QLL
BOTOX	P		PA (≥ 35 years)	QLL
CAMPRAL	P			
LYRICA	P			QLL
MYOBLOC	P		PA	QLL
<b>DERMATOLOGICAL MEDICATIONS</b>				
<b>TOPICAL CORTICOSTEROID</b>				
ACLOVATE	P			
CLODERM		NP		
CORDRAN		NP		QLL
CUTIVATE	P			
DIPROLENE	P			
DIPROLENE AF	P			
ELOCON	P			QLL
HALOG, -E		NP		
LOCOID		NP		
PANDEL		NP		
PSORCON E		NP		
ULTRAVATE	P			
XENADERM		NP	PA	QLL
<b>TOPICAL ANTIACNE DRUGS</b>				
AZELEX		NP		
ALTINAC	P			QLL
AVITA		NP	PA (> 21 years)	QLL
DIFFERIN	P		PA (> 21 years)	QLL
METROCREAM	P			
metronidazole generic	P			
METROGEL	P			
METROLOTION	P			
NORITATE		NP		
PLEXION CLEANSING CLOTHS		NP		QLL
RENOVA		NP	PA (> 21 years)	QLL
RETIN-A MICRO	P		PA (> 21 years)	QLL
TAZORAC	P		PA (> 21 years)	QLL
tretinoin generic	P		PA (> 21 years)	QLL
<b>COMBINATION ANTIACNE DRUGS</b>				
BENZAMYCIN	P			
<b>ANTIPSORIASIS AND ANTIECZEMA DRUGS</b>				
DOVONEX	P			

P\* Available without PA for < or = to 12 yrs and > or = to 65 yrs

PA\* Requires PA after (3) prescriptions per year

REVISED 11/30/2006

## Georgia Medicaid/PeachCare Preferred Drug List

**Effective December 1, 2006**

This Preferred Drug List is subject to change without notice. Generics are considered preferred unless noted. This list does not include all drugs covered under the Georgia Medicaid/PeachCare for Kids outpatient pharmacy program. **KEY:** **Preferred / P:** medications associated with a lower member copayment; **Non-Preferred / NP:** medications associated with a higher member copayment; **PA:** prior authorization required; **QLL:** quantity or therapy limits apply. The QLL listing and therapy limitation description are located in Part II of the Policies and Procedures for Pharmacy Services Manual located on the web portal, under Provider Manuals.

	Preferred	Non-Preferred	PA	QLL
DRITHOCREME	P			
DRITHOCREME HP	P			
DRITHO-SCALP	P			
<b>OTHER TOPICAL DERMATOLOGICAL DRUGS</b>				
EFUDEX	P			
ELIDEL	P		PA	QLL
HYLIRA		NP	PA	
MIMYX		NP	PA	QLL
OPTASE		NP	PA	
PANRETIN	P		PA	
PROTOPIC	P		PA	QLL
REGRANEX	P		PA	QLL
VUSION		NP	PA	
<b>SCABICIDES</b>				
ELIMITE	P			QLL
EURAX	P			QLL
LINDANE	P			QLL
OVIDE		NP		QLL
<b>ROSACEA AGENTS</b>				
ORACEA		NP	PA	QLL
<b>EAR-NOSE-THROAT MEDICATIONS</b>				
<b>DRUGS AFFECTING THE EAR</b>				
CERUMENEX	P			
CIPRODEX	P			QLL
CIPRO HC	P			
FLOXIN OTIC	P			
neomycin/polymyxin/hc generic	P			QLL
<b>DRUGS AFFECTING THE NOSE</b>				
ASTELIN	P			QLL
BECONASE AQ		NP	PA	QLL
FLONASE	P			QLL
flunisolide generic	P			QLL
fluticasone generic		NP	PA	QLL
ipratropium generic	P			QLL
NASACORT AQ		NP	PA	QLL
NASALIDE		NP	PA	QLL
NASAREL		NP	PA	QLL

P\* Available without PA for < or = to 12 yrs and > or = to 65 yrs

PA\* Requires PA after (3) prescriptions per year

REVISED 11/30/2006

## Georgia Medicaid/PeachCare Preferred Drug List

**Effective December 1, 2006**

This Preferred Drug List is subject to change without notice. Generics are considered preferred unless noted. This list does not include all drugs covered under the Georgia Medicaid/PeachCare for Kids outpatient pharmacy program. **KEY: Preferred / P:** medications associated with a lower member copayment; **Non-Preferred / NP:** medications associated with a higher member copayment; **PA:** prior authorization required; **QLL:** quantity or therapy limits apply. The QLL listing and therapy limitation description are located in Part II of the Policies and Procedures for Pharmacy Services Manual located on the web portal, under Provider Manuals.

	Preferred	Non-Preferred	PA	QLL
NASONEX	P			QLL
RHINOCORT AQ	P			QLL
VANCENASE, -AQ		NP	PA	QLL
<b>DRUGS AFFECTING THE THROAT AND MOUTH</b>				
EVOXAC	P			
pilocarpine generic	P			
RADIACARE	P			
SALAGEN	P			
<b>ENDOCRINE MEDICATIONS</b>				
<b>BONE OSSIFICATION AGENTS</b>				
ACTONEL		NP	PA	QLL
ACTONEL WITH CALCIUM		NP	PA	QLL
BONIVA		NP	PA	QLL
DIDRONEL		NP	PA	QLL
etidronate disodium generic	P			QLL
FOSAMAX, -WEEKLY	P			QLL
FOSAMAX-D	P			QLL
MIACALCIN	P			QLL
<b>INSULIN</b>				
APIDRA		NP		QLL
EXUBERA COMBINATION PACK		NP	PA	
EXUBERA KIT		NP	PA	QLL
HUMALOG		NP	PA	QLL
HUMULIN 50/50	P			QLL
HUMULIN 70/30		NP	PA	QLL
HUMULIN L	P			QLL
HUMULIN N		NP	PA	QLL
HUMULIN R 100		NP	PA	QLL
HUMULIN R 500	P			QLL
HUMULIN U	P			QLL
ILETIN	P			QLL
INSULIN PEN DELIVERY SYSTEMS			PA (> 21 years)	QLL
INSULIN CARTRIDGES			PA (> 21 years)	QLL
LANTUS	P			QLL
LEVEMIR	P			QLL
NOVOLIN	P			QLL
NOVOLOG	P			QLL
VELOSULIN	P			QLL

P\* Available without PA for < or = to 12 yrs and > or = to 65 yrs

PA\* Requires PA after (3) prescriptions per year

REVISED 11/30/2006

## Georgia Medicaid/PeachCare Preferred Drug List

**Effective December 1, 2006**

This Preferred Drug List is subject to change without notice. Generics are considered preferred unless noted. This list does not include all drugs covered under the Georgia Medicaid/PeachCare for Kids outpatient pharmacy program. **KEY: Preferred / P:** medications associated with a lower member copayment; **Non-Preferred / NP:** medications associated with a higher member copayment; **PA:** prior authorization required; **QLL:** quantity or therapy limits apply. The QLL listing and therapy limitation description are located in Part II of the Policies and Procedures for Pharmacy Services Manual located on the web portal, under Provider Manuals.

	Preferred	Non-Preferred	PA	QLL
<b>ORAL HYPOGLYCEMIC DRUGS</b>				
AMARYL	P			
glimepiride generic	P			
GLUCOTROL XL	P			
GLYSET	P			
PRANDIN	P			
PRECOSE	P			
STARLIX	P			
<b>MISC. ANTIDIABETICS</b>				
ACTOPLUS MET	P			QLL
ACTOS	P			QLL
AVANDAMET	P			QLL
AVANDARYL	P			QLL
AVANDIA	P			QLL
BYETTA	P		PA	QLL
DUETACT		NP		QLL
FORTAMET ER		NP	PA	QLL
glipizide/metformin generic	P			QLL
glyburide	P			QLL
glyburide/metformin generic	P			QLL
GLUCOVANCE		NP	PA	QLL
GLUMETZA ER		NP	PA	QLL
JANUVIA		NP		
METAGLIP	P			QLL
metformin generic	P			QLL
RIOMET		NP	PA	QLL
SYMLIN	P		PA	QLL
<b>THYROID SUPPLEMENTS</b>				
CYTOMEL	P			
levothyroxine generic	P			
SYNTHROID		NP		
THYROLAR	P			
THYROID STRONG	P			
<b>MISC. ENDOCRINE DRUGS</b>				
DDAVP NASAL	P			
DDAVP TAB	P			
DOSTINEX	P			QLL
ELAPRASE	P		PA	
EVISTA	P			

P\* Available without PA for < or = to 12 yrs and > or = to 65 yrs

PA\* Requires PA after (3) prescriptions per year

REVISED 11/30/2006

## Georgia Medicaid/PeachCare Preferred Drug List

**Effective December 1, 2006**

This Preferred Drug List is subject to change without notice. Generics are considered preferred unless noted. This list does not include all drugs covered under the Georgia Medicaid/PeachCare for Kids outpatient pharmacy program. **KEY: Preferred / P:** medications associated with a lower member copayment; **Non-Preferred / NP:** medications associated with a higher member copayment; **PA:** prior authorization required; **QLL:** quantity or therapy limits apply. The QLL listing and therapy limitation description are located in Part II of the Policies and Procedures for Pharmacy Services Manual located on the web portal, under Provider Manuals.

	Preferred	Non-Preferred	PA	QLL
FORTEO		NP	PA	
MYOZYME	P			
ORFADIN	P			QLL
SKELID		NP		
<b><i>GASTROINTESTINAL MEDICATIONS</i></b>				
<b>ANTIULCER DRUGS</b>				
cimetidine generic	P			QLL
famotidine generic	P			QLL
nizatidine generic	P			QLL
ranitidine generic	P			QLL
ZANTAC SYRUP	P			QLL
<b>PROTON PUMP INHIBITORS (PPI)</b>				
ACIPHEX		NP	PA	QLL
NEXIUM	P		PA	QLL
omeprazole generic		NP	PA	QLL
PREVACID CAPSULES, SUSPENSION	P		PA	QLL
PREVACID NAPRAPAC		NP	PA	QLL
PREVACID SOLUTAB		NP	PA	QLL
PRILOSEC		NP	PA	QLL
PROTONIX		NP	PA	QLL
ZEGERID		NP	PA	QLL
<b>HELICOBACTER PYLORI DRUGS</b>				
HELIDAC		NP		
PREVPAC	P			QLL
<b>OTHER GI DRUGS</b>				
AMITIZA		NP	PA	
ASACOL	P			
AZULFIDINE EN-TAB	P			
COLAZAL		NP		
CORTIFOAM	P			
COTAZYM	P			
DIPENTUM		NP		
glycolax generic	P		PA	
hydrocortisone acetate cream generic	P			QLL
IB STAT ORAL SPRAY		NP		QLL
KUZYME	P			
lactulose generic	P		PA	
LOTRONEX		NP		QLL

P\* Available without PA for < or = to 12 yrs and > or = to 65 yrs

PA\* Requires PA after (3) prescriptions per year

REVISED 11/30/2006

## Georgia Medicaid/PeachCare Preferred Drug List

**Effective December 1, 2006**

This Preferred Drug List is subject to change without notice. Generics are considered preferred unless noted. This list does not include all drugs covered under the Georgia Medicaid/PeachCare for Kids outpatient pharmacy program. **KEY: Preferred / P:** medications associated with a lower member copayment; **Non-Preferred / NP:** medications associated with a higher member copayment; **PA:** prior authorization required; **QLL:** quantity or therapy limits apply. The QLL listing and therapy limitation description are located in Part II of the Policies and Procedures for Pharmacy Services Manual located on the web portal, under Provider Manuals.

	Preferred	Non-Preferred	PA	QLL
MIRALAX		NP	PA	
NULYTELY		NP		QLL
OCL	P			QLL
PANCREASE	P			
PENTASA	P			
polyethylene glycol generic	P		PA	
PROCTOFOAM-HC	P			
ROWASA	P			
URSO	P			
VIKASE	P			
ZELNORM	P		PA	
<b><i>IMMUNOLOGICALS</i></b>				
ACTIMMUNE	P		PA	
ALFERON N	P		PA	
ARANESP	P		PA	QLL
CARIMUNE	P		PA	
COPEGUS		NP		
CYTOGAM	P		PA	
EPOGEN	P		PA	
GAMIMUNE	P		PA	
GAMMAGARD	P		PA	
GAMMAR	P		PA	
GAMUNEX	P		PA	
INFERGEN	P		PA	QLL
INTRON A	P		PA	
IVEEGAM	P		PA	
LEUKINE	P		PA	QLL
NEULASTA	P		PA	QLL
NEUMEGA	P			QLL
NEUPOGEN	P		PA	QLL
PANGLOBULIN	P		PA	
PEGASYS	P		PA	QLL
PEG-INTRON	P		PA	QLL
POLYGAM	P		PA	
PROCRIT	P		PA	
PROLEUKIN	P			
REBETOL	P			
REBETRON	P		PA	QLL
RESPIGAM	P		PA	
ribavirin generic	P			
ROFERON-A	P		PA	

P\* Available without PA for < or = to 12 yrs and > or = to 65 yrs

PA\* Requires PA after (3) prescriptions per year

REVISED 11/30/2006

## Georgia Medicaid/PeachCare Preferred Drug List

**Effective December 1, 2006**

This Preferred Drug List is subject to change without notice. Generics are considered preferred unless noted. This list does not include all drugs covered under the Georgia Medicaid/PeachCare for Kids outpatient pharmacy program. **KEY: Preferred / P:** medications associated with a lower member copayment; **Non-Preferred / NP:** medications associated with a higher member copayment; **PA:** prior authorization required; **QLL:** quantity or therapy limits apply. The QLL listing and therapy limitation description are located in Part II of the Policies and Procedures for Pharmacy Services Manual located on the web portal, under Provider Manuals.

	Preferred	Non-Preferred	PA	QLL
SYNAGIS	P		PA	QLL
VENOGLOBULIN	P		PA	
VIVAGLOBIN	P		PA	
<b>GROWTH HORMONES</b>				
GENOTROPIN	P		PA	
GEREF	P		PA	
HUMATROPE		NP	PA	
INCRELEX		NP	PA	
IPLEX		NP	PA	
NORDITROPIN	P		PA	
NUTROPIN, -AQ, -DEPOT	P		PA	
PROTROPIN	P		PA	
SAIZEN		NP	PA	
SEROSTIM		NP	PA	
TEV-TROPIN		NP	PA	
<b>MUSCULOSKELETAL MEDICATIONS</b>				
<b>NON-STEROIDAL ANTIINFLAMMATORY AGENTS</b>				
ARTHROTEC		NP	PA	QLL
CELEBREX		NP	PA	QLL
generic NSAIDs	P			QLL
meloxicam generic		NP	PA	QLL
MOBIC		NP	PA	QLL
NALFON		NP	PA	QLL
NAPRELAN		NP	PA	QLL
PONSTEL		NP	PA	QLL
<b>OTHER DRUGS FOR ARTHRITIS</b>				
CUPRIMINE	P			
<b>SKELETAL MUSCLE RELAXANTS</b>				
DANTRIUM	P			
<b>NUTRITION / BLOOD MODIFIERS / ELECTROLYTES</b>				
<b>END STAGE RENAL DISEASE</b>				
ACETICAL	P		PA	
ALU-CAP, -TAB	P		PA	
aluminum carbonate generic	P		PA	
aluminum carbonate/glycine generic	P		PA	
aluminum hydroxide generic	P		PA	
calcium carbonate generic	P		PA	

P\* Available without PA for < or = to 12 yrs and > or = to 65 yrs

PA\* Requires PA after (3) prescriptions per year

REVISED 11/30/2006

## Georgia Medicaid/PeachCare Preferred Drug List

**Effective December 1, 2006**

This Preferred Drug List is subject to change without notice. Generics are considered preferred unless noted. This list does not include all drugs covered under the Georgia Medicaid/PeachCare for Kids outpatient pharmacy program. **KEY: Preferred / P:** medications associated with a lower member copayment; **Non-Preferred / NP:** medications associated with a higher member copayment; **PA:** prior authorization required; **QLL:** quantity or therapy limits apply. The QLL listing and therapy limitation description are located in Part II of the Policies and Procedures for Pharmacy Services Manual located on the web portal, under Provider Manuals.

	Preferred	Non-Preferred	PA	QLL
calcium carbonate/glycine generic	P		PA	
calcium lactate	P		PA	
Coenzyme Q10		NP	PA	
DHT		NP	PA	
DIATX/-FE	P		PA	
dioctyl sodium/calcium sulfosuccinate generic	P		PA	
ergocalciferol generic	P		PA	
folic acid 1mg generic	P			QLL
GLUTOFAC-MX		NP	PA	
GLUTOFAC-ZX	P		PA	
HECTOROL	P		PA	
HYTAKEROL	P		PA	
levocarnitine generic	P		PA	
magnesium carbonate generic	P		PA	
MAGNEBIND	P		PA	
NASCOBAL		NP	PA	QLL
NEPHRON FA		NP	PA	
niacin generic	P		PA	
PHOSLO	P		PA	
pyridoxine (vitamin B-6) generic	P		PA	
RENAGEL		NP	PA	QLL
RENAX	P		PA	
SENSIPAR		NP		
sodium bicarbonate generic	P		PA	
thiamine (vitamin B-1) generic	P		PA	
vitamin B complex w/ C generic	P		PA	
vitamin B-12 injection generic	P		PA	
vitamin E capsules & drops	P		PA	
ZEMPLAR	P		PA	
<b>ORAL ANTICOAGULANTS, VITAMIN K</b>				
COUMADIN		NP	PA	
MEPHYTON	P			
warfarin sodium generic	P			
<b>HEPARIN AND HEPARIN ANTAGONISTS</b>				
ARIEXTRA		NP		QLL
FRAGMIN	P			QLL
HEPARIN SODIUM	P			
INNOHEP	P			QLL
LOVENOX	P			QLL
ORGARAN	P			

P\* Available without PA for < or = to 12 yrs and > or = to 65 yrs

PA\* Requires PA after (3) prescriptions per year

REVISED 11/30/2006

## Georgia Medicaid/PeachCare Preferred Drug List

**Effective December 1, 2006**

This Preferred Drug List is subject to change without notice. Generics are considered preferred unless noted. This list does not include all drugs covered under the Georgia Medicaid/PeachCare for Kids outpatient pharmacy program. **KEY: Preferred / P:** medications associated with a lower member copayment; **Non-Preferred / NP:** medications associated with a higher member copayment; **PA:** prior authorization required; **QLL:** quantity or therapy limits apply. The QLL listing and therapy limitation description are located in Part II of the Policies and Procedures for Pharmacy Services Manual located on the web portal, under Provider Manuals.

	Preferred	Non-Preferred	PA	QLL
<b>ANTIPLATELET DRUGS</b>				
AGGRENOX	P			
clopidogrel generic	P			QLL
PLAVIX	P			QLL
<b>CHELATING AGENT</b>				
EXJADE	P			
<b>OBSTETRICAL &amp; GYNECOLOGICAL MEDICATIONS</b>				
<b>SPECIALIZED OB/GYN DRUGS</b>				
SYNAREL	P			
<b>ANDROGEN DRUGS</b>				
ANDRODERM PATCH	P		PA	QLL
ANDROGEL		NP	PA	QLL
DELATESTRYL	P		PA	
DEPO-TESTOSTERONE	P		PA	
TESTIM		NP	PA	QLL
TESTODERM		NP	PA	
testosterone injection generic	P		PA	
<b>ESTROGEN DRUGS</b>				
CENESTIN		NP		
CLIMARA PRO PATCH	P			QLL
ESTRACE	P			QLL
ESTRADERM	P			QLL
estradiol patch generic	P			QLL
ESTRASORB		NP		
ESTRATAB	P			
ESTROGEL		NP		QLL
MENEST	P			
PREMARIN	P			
VIVELLE, -DOT	P			QLL
<b>ESTROGEN/PROGESTIN COMBINATIONS</b>				
ACTIVELLA		NP		
COMBIPATCH	P			
FEMHRT	P			
FEMRING		NP		QLL
ORTHO-PREFEST		NP		
PREMPHASE	P			

P\* Available without PA for < or = to 12 yrs and > or = to 65 yrs

PA\* Requires PA after (3) prescriptions per year

REVISED 11/30/2006

## Georgia Medicaid/PeachCare Preferred Drug List

**Effective December 1, 2006**

This Preferred Drug List is subject to change without notice. Generics are considered preferred unless noted. This list does not include all drugs covered under the Georgia Medicaid/PeachCare for Kids outpatient pharmacy program. **KEY: Preferred / P:** medications associated with a lower member copayment; **Non-Preferred / NP:** medications associated with a higher member copayment; **PA:** prior authorization required; **QLL:** quantity or therapy limits apply. The QLL listing and therapy limitation description are located in Part II of the Policies and Procedures for Pharmacy Services Manual located on the web portal, under Provider Manuals.

	Preferred	Non-Preferred	PA	QLL
PREMPRO	P			
<b>PROGESTIN DRUGS</b>				
CRINONE GEL		NP	PA	
MEGACE ES		NP	PA	
PROMETRIUM	P			
<b>CONTRACEPTIVES</b>				
ALESSE	P			
CYCLESSA		NP		
ESTROSTEP FE		NP		
IMPLANON		NP		QLL
joessa generic	P			QLL
LUNELLE	P			QLL
MIRENA		NP		QLL
NUVARING	P			
ORTHO TRI-CYCLEN		NP		
ORTHO TRI-CYCLEN LO		NP		
ORTHO-EVRA	P			QLL
OVCON-50		NP		
OVCON-35		NP		
PLAN B (covered < 18 yrs old)	P			QLL
PREVEN		NP		QLL
quasense generic	P			QLL
SEASONALE		NP		QLL
SEASONIQUE		NP		QLL
TRI-NORINYL		NP		
YASMIN		NP		
<b>OPHTHALMIC MEDICATIONS</b>				
<b>OPHTHALMIC QUINOLONES</b>				
CILOXAN	P			QLL
ciprofloxacin HCL drops	P			QLL
OCUFLOX	P			QLL
ofloxacin drops generic	P			QLL
QUIXIN	P			QLL
VIGAMOX	P			QLL
ZYMAR	P			QLL
<b>OPHTHALMIC CORTICOSTEROID DRUGS</b>				
ALREX		NP		QLL
FML-FORTE	P			QLL

P\* Available without PA for < or = to 12 yrs and > or = to 65 yrs

PA\* Requires PA after (3) prescriptions per year

REVISED 11/30/2006

## Georgia Medicaid/PeachCare Preferred Drug List

**Effective December 1, 2006**

This Preferred Drug List is subject to change without notice. Generics are considered preferred unless noted. This list does not include all drugs covered under the Georgia Medicaid/PeachCare for Kids outpatient pharmacy program. **KEY: Preferred / P:** medications associated with a lower member copayment; **Non-Preferred / NP:** medications associated with a higher member copayment; **PA:** prior authorization required; **QLL:** quantity or therapy limits apply. The QLL listing and therapy limitation description are located in Part II of the Policies and Procedures for Pharmacy Services Manual located on the web portal, under Provider Manuals.

	Preferred	Non-Preferred	PA	QLL
HMS LIQUIFILM	P			QLL
LOTEMAX		NP		QLL
VEXOL		NP		QLL
<b>OPHTHALMIC COMBINATIONS</b>				
FML-S	P			
TOBRADEX	P			
<b>TOPICAL ANTIGLAUCOMA DRUGS</b>				
ALPHAGAN-P	P			
AZOPT	P			
BETIMOL	P			
BETOPTIC S	P			
COSOPT	P			
ISOPTO CARBACHOL	P			
LUMIGAN	P			QLL
P1-E1 /P2-E1/P3-E1	P			
PHOSPHOLINE IODIDE	P			
PILOPINE H.S.	P			
TRAVATAN/Z	P			QLL
TRUSOPT	P			
XALATAN	P			QLL
<b>OPHTHALMIC ANTIHISTAMINES</b>				
ELESTAT	P			QLL
EMADINE	P			QLL
OPTIVAR	P			QLL
PATANOL	P			QLL
ZADITOR	P			QLL
<b>OPHTHALMIC MAST CELL STABILIZERS</b>				
ALAMAST	P			QLL
ALOCRIAL	P			QLL
ALOMIDE	P			QLL
CROLOM	P			QLL
cromolyn sodium generic	P			QLL
<b>OTHER OPHTHALMIC DRUGS</b>				
ACULAR	P			QLL
ACULAR LS	P			QLL
ACULAR PF		NP		QLL
ALREX		NP		QLL

P\* Available without PA for < or = to 12 yrs and > or = to 65 yrs

PA\* Requires PA after (3) prescriptions per year

REVISED 11/30/2006

## Georgia Medicaid/PeachCare Preferred Drug List

**Effective December 1, 2006**

This Preferred Drug List is subject to change without notice. Generics are considered preferred unless noted. This list does not include all drugs covered under the Georgia Medicaid/PeachCare for Kids outpatient pharmacy program. **KEY: Preferred / P:** medications associated with a lower member copayment; **Non-Preferred / NP:** medications associated with a higher member copayment; **PA:** prior authorization required; **QLL:** quantity or therapy limits apply. The QLL listing and therapy limitation description are located in Part II of the Policies and Procedures for Pharmacy Services Manual located on the web portal, under Provider Manuals.

	Preferred	Non-Preferred	PA	QLL
CHIBROXIN		NP		
IOPIDINE		NP		
LIVOSTIN		NP		
neomycin/polymixin/hc generic	P			QLL
NEVANAC		NP		
RESTASIS	P			QLL
RETISERT		NP	PA	
VOLTAREN	P			
XIBROM		NP		
<b>RESPIRATORY MEDICATIONS</b>				
<b>BRONCHODILATORS AND RELATED DRUGS</b>				
ACCUNEB	P			QLL
albuterol inhaler generic	P			QLL
albuterol for nebulization generic	P			QLL
FORADIL	P			QLL
MAXAIR	P			QLL
MAXAIR AUTOHALER	P			QLL
metaproterenol inhaler generic	P			QLL
metaproterenol for nebulization generic	P			QLL
PROVENTIL FOR NEBULIZATION		NP	PA	QLL
PROVENTIL HFA	P			QLL
SEREVENT, -DISKUS	P			QLL
SLO-BID		NP	PA	QLL
THEO-DUR		NP	PA	
theophylline generic	P			
TORNALATE		NP		QLL
UNI-DUR		NP	PA	
UNIPHYL		NP		
VENTOLIN HFA	P			QLL
XOPENEX		NP	PA (> 8 years)	QLL
XOPENEX HFA		NP	PA	QLL
<b>COPD ANTICHOLINERGICS</b>				
ATROVENT HFA	P			QLL
DUONEB	P			QLL
COMBIVENT	P			QLL
ipratropium generic	P			QLL
SPIRIVA		NP	PA	QLL
<b>OTHER DRUGS FOR ASTHMA</b>				
INTAL INHALER	P			QLL

P\* Available without PA for < or = to 12 yrs and > or = to 65 yrs

PA\* Requires PA after (3) prescriptions per year

REVISED 11/30/2006

## Georgia Medicaid/PeachCare Preferred Drug List

**Effective December 1, 2006**

This Preferred Drug List is subject to change without notice. Generics are considered preferred unless noted. This list does not include all drugs covered under the Georgia Medicaid/PeachCare for Kids outpatient pharmacy program. **KEY: Preferred / P:** medications associated with a lower member copayment; **Non-Preferred / NP:** medications associated with a higher member copayment; **PA:** prior authorization required; **QLL:** quantity or therapy limits apply. The QLL listing and therapy limitation description are located in Part II of the Policies and Procedures for Pharmacy Services Manual located on the web portal, under Provider Manuals.

	Preferred	Non-Preferred	PA	QLL
TILADE	P			QLL
<b>PULMONARY ANTIINFLAMMATORY DRUGS</b>				
ADVAIR DISKUS/HFA	P			QLL
AEROBID	P			QLL
AEROBID-M	P			QLL
ASMANEX TWISTHALER	P			QLL
AZMACORT	P			QLL
FLOVENT HFA	P			QLL
PULMICORT TURBUHALER		NP	PA	QLL
PULMICORT RESPULES	P			QLL
QVAR	P			QLL
<b>LEUKOTRIENE MODIFIERS</b>				
ACCOLATE	P		PA	QLL
SINGULAIR	P		PA	QLL
ZYFLO	P		PA	QLL
<b>ANTIHISTAMINE AND DECONGESTANT DRUGS</b>				
ALLEGRA, -D		NP	PA	QLL
CLARINEX-D	P		PA	QLL
CLARINEX TABLETS	P		PA	QLL
CLARINEX REDITABS		NP	PA	QLL
CLARINEX SYRUP	P		PA (> 2 yr old)	QLL
fexofenadine generic		NP		QLL
loratadine, -D generic OTC	P			QLL
SEMPREX-D	P			
TRINALIN		NP		
ZYRTEC SYRUP	P (< 2 yr old)	NP (> 2yr old)	PA (> 2 yr old)	QLL
ZYRTEC-D		NP	PA	QLL
<b>OTHER RESPIRATORY DRUGS</b>				
ANA-GUARD	P			QLL
ANA-KIT	P			QLL
EPIPEN	P			QLL
<b>UROLOGICAL/RENAL MEDICATIONS</b>				
CALCIBIND	P			
DETROL		NP	PA	QLL
DETROL LA	P			QLL
DITROPAN		NP		QLL
DITROPAN XL	P			QLL

P\* Available without PA for < or = to 12 yrs and > or = to 65 yrs

PA\* Requires PA after (3) prescriptions per year

REVISED 11/30/2006

## Georgia Medicaid/PeachCare Preferred Drug List

**Effective December 1, 2006**

This Preferred Drug List is subject to change without notice. Generics are considered preferred unless noted. This list does not include all drugs covered under the Georgia Medicaid/PeachCare for Kids outpatient pharmacy program. **KEY: Preferred / P:** medications associated with a lower member copayment; **Non-Preferred / NP:** medications associated with a higher member copayment; **PA:** prior authorization required; **QLL:** quantity or therapy limits apply. The QLL listing and therapy limitation description are located in Part II of the Policies and Procedures for Pharmacy Services Manual located on the web portal, under Provider Manuals.

	Preferred	Non-Preferred	PA	QLL
ELMIRON	P			
ENABLEX	P			QLL
flavoxate generic	P			QLL
oxybutynin generic	P			QLL
oxybutynin ER generic	P			QLL
OXYTROL	P			QLL
SANCTURA	P			QLL
VESICARE	P			QLL
<b>DRUGS FOR BPH</b>				
AVODART	P			QLL
finasteride generic		NP	PA	QLL
FLOMAX	P			QLL
PROSCAR	P			QLL
UROXATRAL	P			QLL
<b>DIABETIC SUPPLIES</b>				
<b>METERS</b>				
ACCU-CHEK ACTIVE	P			QLL
ACCU-CHEK ADVANTAGE	P			QLL
ACCU-CHEK AVIVA	P			QLL
ACCU-CHEK COMPACT	P			QLL
ACCU-CHEK COMPLETE	P			QLL
<b>TEST STRIPS</b>				
ACCU-CHEK ACTIVE	P			QLL
ACCU-CHEK ADVANTAGE	P			QLL
ACCU-CHEK AVIVA	P			QLL
ACCU-CHEK COMFORT CURVE	P			QLL
ACCU-CHEK COMPACT	P			QLL
ACCU-CHEK EASY	P			QLL
ACCU-CHEK INSTANT/PLUS	P			QLL
ACCU-CHEK SIMPLICITY	P			QLL
<b>LANCETS</b>				
SOFTCLIX	P			QLL
SOFT TOUCH	P			QLL
MULTICLIX	P			QLL

P\* Available without PA for < or = to 12 yrs and > or = to 65 yrs

PA\* Requires PA after (3) prescriptions per year

REVISED 11/30/2006