

Georgia Medicaid/PeachCare Preferred Drug List

Effective June 1, 2007

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
ABILIFY		NP	PA	QLL
ACCOLATE	P		PA	QLL
ACCU-CHEK ACTIVE	P			QLL
ACCU-CHEK ACTIVE	P			QLL
ACCU-CHEK ADVANTAGE	P			QLL
ACCU-CHEK ADVANTAGE	P			QLL
ACCU-CHEK AVIVA	P			QLL
ACCU-CHEK AVIVA	P			QLL
ACCU-CHEK COMFORT CURVE	P			QLL
ACCU-CHEK COMPACT	P			QLL
ACCU-CHEK COMPACT	P			QLL
ACCU-CHEK COMPLETE	P			QLL
ACCU-CHEK EASY	P			QLL
ACCU-CHEK INSTANT/PLUS	P			QLL
ACCU-CHEK SIMPLICITY	P			QLL
ACCUNEB	P			QLL
ACCUPRIL		NP	PA	QLL
ACCURETIC		NP	PA	QLL
ACEON		NP	PA	QLL
ACIPHEX		NP	PA	QLL
ACLOVATE	P			
ACTIMMUNE	P		PA	
ACTIQ		NP	PA	QLL
ACTIVELLA		NP		
ACTONEL		NP	PA	QLL
ACTONEL WITH CALCIUM		NP	PA	QLL
ACTOPLUS MET	P			QLL
ACTOS	P			QLL
ACULAR	P			QLL
ACULAR LS	P			QLL
ACULAR PF		NP		QLL
ADALAT CC		NP		QLL
ADDERALL		NP	PA	QLL
ADDERALL XR	P		PA (> 21 years)	QLL
ADVAIR DISKUS/HFA	P			QLL
ADVICOR	P			QLL
AEROBID		NP	PA	QLL
AEROBID-M		NP	PA	QLL
afeditab cr generic	P			QLL

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

PA* Requires PA after (3) prescriptions per year

** Requires PA After (6) prescriptions per year for members >21 years old

Georgia Medicaid/PeachCare Preferred Drug List

Effective June 1, 2007

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
AGENERASE	P			
AGGRENOL	P			
AGRYLIN	P			
ALAMAST	P			QLL
albuterol for nebulization generic	P			QLL
albuterol inhaler generic	P			QLL
ALESSE	P			
ALFERON N	P		PA	
ALKERAN	P			
All generics are Preferred	P			QLL
ALLEGRA SUSP**		NP	PA	
ALLEGRA**, -D**		NP	PA	QLL
ALOCRIAL	P			QLL
ALOMIDE	P			QLL
ALPHAGAN-P	P			
alprazolam generic	P		PA* (≥ 21 yrs)	QLL
ALREX		NP		QLL
ALREX		NP		QLL
ALTACE	P			QLL
ALTINAC	P			QLL
ALTOPREV (previously Altacor)		NP	PA	QLL
aluminum carbonate generic	P		PA	
aluminum hydroxide generic	P		PA	
AMARYL	P			
AMBIEN, -CR	P			QLL
AMERGE	P			QLL
AMITIZA		NP	PA	
amox/clavulanate generic	P			QLL
amphetamine salt combination generic	P		PA (> 21 years)	QLL
ANCOBON	P			
ANDRODERM PATCH	P		PA	QLL
ANDROGEL		NP	PA	QLL
ANTARA	P			QLL
ANZEMET		NP		QLL
APIDRA		NP		QLL
APOKYN	P			
APTIVUS	P			
ARANESP	P		PA	QLL
ARAVA	P			QLL

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

PA* Requires PA after (3) prescriptions per year

** Requires PA After (6) prescriptions per year for members >21 years old

Georgia Medicaid/PeachCare Preferred Drug List

Effective June 1, 2007

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
ARICEPT	P			
ARIMIDEX	P			
ARIXTRA		NP		QLL
AROMASIN	P			
ARTHROTEC		NP	PA	QLL
ASACOL	P			
ASMANEX TWISTHALER	P			QLL
ASTELIN	P			QLL
ATACAND		NP	PA	QLL
ATACAND HCT		NP	PA	QLL
ATROVENT HFA	P			QLL
AUGMENTIN ES	P			QLL
AUGMENTIN XR	P			QLL
AVALIDE	P			QLL
AVANDAMET	P			QLL
AVANDARYL	P			QLL
AVANDIA	P			QLL
AVAPRO	P			QLL
AVELOX	P			QLL
AVELOX ABC	P			QLL
AVINZA		NP	PA	QLL
AVITA		NP	PA (> 21 years)	QLL
AVODART	P			QLL
AVONEX, -AD	P			QLL
AXERT	P			QLL
AZELEX		NP		
AZILECT		NP		
azithromycin generic	P			QLL
AZMACORT	P			QLL
AZOPT	P			
AZULFIDINE EN-TAB	P			
BACTROBAN CREAM	P			
BACTROBAN NASAL	P			
BARACLUDE	P			
BECONASE AQ		NP	PA	QLL
benazepril generic	P			QLL
benazepril HCTZ generic	P			QLL
BENICAR	P			QLL
BENICAR 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

** Requires PA After (6) prescriptions per year for members >21 years old

Georgia Medicaid/PeachCare Preferred Drug List

Effective June 1, 2007

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
BENZAMYCIN	P			
BETAPACE, -AF		NP	PA	QLL
BETASERON, C-	P			QLL
BETIMOL	P			
BETOPTIC S	P			
BIAXIN		NP		QLL
BIAXIN SUSPENSION		NP	PA	QLL
BIAXIN XL		NP	PA	QLL
BIDIL		NP	PA	QLL
BONIVA		NP	PA	QLL
BOTOX	P		PA (≥ 35 years)	QLL
bromocriptine generic	P			
bupropion/bupropion ER & SR generic	P			QLL
butorphanol nasal generic	P			QLL
BYETTA	P		PA	QLL
CADUET		NP	PA	QLL
CALAN		NP	PA	QLL
CALAN SR		NP	PA	QLL
CALCIBIND	P			
calcium carbonate generic	P		PA	
calcium carbonate/glycine generic	P		PA	
calcium lactate	P		PA	
CAMPRAL	P			
CAPOTEN		NP	PA	QLL
CAPOZIDE		NP	PA	QLL
captopril generic	P			QLL
captopril HCTZ generic	P			QLL
carbamazepine generic	P			
CARDENE IV	P			
CARDENE SR		NP	PA	QLL
CARDIZEM		NP	PA	QLL
CARDIZEM CD		NP	PA	QLL
CARDIZEM INJECTABLE		NP	PA	
CARDIZEM LA	P			QLL
CARDIZEM SR		NP	PA	QLL
CARIMUNE	P		PA	
CARTIA XT	P			QLL
CASODEX	P			
CATAPRES-TTS	P			QLL

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

PA* Requires PA after (3) prescriptions per year

** Requires PA After (6) prescriptions per year for members >21 years old

Georgia Medicaid/PeachCare Preferred Drug List

Effective June 1, 2007

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
CEDAX	P			QLL
CEDAX SUSPENSION	P*	NP	PA (> 12yrs, < 65yrs)	QLL
CEENU	P			
cefactor er generic	P			QLL
cefactor generic	P			QLL
cefadroxil generic	P			QLL
cefprozil generic	P			QLL
CEFTIN		NP	PA	QLL
CEFTIN SUSPENSION	P*	NP	PA (> 12yrs, < 65yrs)	QLL
cefuroxime generic	P			QLL
CELEBREX	P		PA	QLL
CELEXA		NP	PA	QLL
CELLCEPT	P			
CELONTIN	P			
CENESTIN		NP		
cephalexin generic	P			QLL
cephradine generic	P			QLL
CERUMENEX	P			
CESAMET		NP	PA	QLL
CHIBROXIN		NP		
chlordiazepoxide generic	P		PA* (≥ 21 yrs)	QLL
CILOXAN	P			QLL
cimetidine generic	P			QLL
CIPRO		NP	PA	QLL
CIPRO HC	P			
CIPRO SUSPENSION	P			QLL
CIPRO XR	P			QLL
CIPRODEX	P			QLL
ciprofloxacin generic	P			QLL
ciprofloxacin HCL drops	P			QLL
citalopram generic	P			QLL
CLARINEX REDITABS**		NP	PA	QLL
CLARINEX SYRUP**	P		PA (> 2 yr old)	QLL
CLARINEX TABLETS**	P		PA	QLL
CLARINEX-D**	P		PA	QLL
clarithromycin/ER generic	P			QLL
CLIMARA PRO PATCH	P			QLL
CLODERM		NP		
clonazepam generic	P		PA* (≥ 21 yrs)	QLL

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

PA* Requires PA after (3) prescriptions per year

** Requires PA After (6) prescriptions per year for members >21 years old

Georgia Medicaid/PeachCare Preferred Drug List

Effective June 1, 2007

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
clopidogrel generic	P			QLL
clorazepate dipotassium generic	P		PA* (≥ 21 yrs)	QLL
clozapine generic		NP		QLL
CLOZARIL		NP		QLL
COGNEX	P			
COLAZAL		NP		
COLESTID	P			
COMBIPATCH	P			
COMBIVENT	P			QLL
COMBIVIR	P			
COMBUNOX		NP	PA	QLL
COMTAN	P			
CONCERTA	P		PA (> 21 years)	QLL
COPAXONE	P			QLL
COPEGUS		NP		
CORDRAN		NP		QLL
COREG	P			
COREG CR		NP	PA	
CORTIFOAM	P			
CORZIDE	P			QLL
COSOPT	P			
COTAZYM	P			
COUMADIN		NP		
COVERA HS		NP	PA	QLL
COZAAR	P			QLL
CRESTOR	P		PA	QLL
CRINONE GEL		NP	PA	
CRIXIVAN	P			
CROLOM	P			QLL
cromolyn sodium generic	P			QLL
CUPRIMINE	P			
CUTIVATE	P			
CYCLESSA		NP		
CYMBALTA		NP	PA	QLL
CYTOGAM	P		PA	
CYTOMEL	P			
CYTOVENE	P			
DANTRIUM	P			
DAPSONE	P			

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

PA* Requires PA after (3) prescriptions per year

** Requires PA After (6) prescriptions per year for members >21 years old

Georgia Medicaid/PeachCare Preferred Drug List

Effective June 1, 2007

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
DARAPRIM	P			
DAYTRANA		NP	PA	QLL
DDAVP NASAL	P			
DDAVP TAB	P			
DELATESTRYL	P		PA	
DEMSER	P			
DENAVIR	P			
DEPAKOTE, -ER	P			
DEPO-TESTOSTERONE	P		PA	
DESOXYN		NP	PA	QLL
DETROL		NP	PA	QLL
DETROL LA	P			QLL
DEXEDRINE		NP	PA (> 21 years)	QLL
dextroamphetamine generic	P		PA (> 21 years)	QLL
DEXTROSTAT	P		PA (> 21 years)	QLL
DIASSTAT	P		PA (≥ 21 yrs)	QLL
DIATX	P		PA	
diazepam generic	P		PA* (≥ 21 yrs)	QLL
DIDRONEL		NP	PA	QLL
DIFFERIN	P		PA (> 21 years)	QLL
DIFLUCAN	P		PA	
DIFLUCAN 150MG TAB	P			QLL
digoxin generic	P			
DILACOR XR		NP	PA	QLL
DILANTIN		NP		
DILANTIN INFATAB		NP		
DILTIA XT	P			QLL
diltiazem er generic	P			QLL
diltiazem generic	P			QLL
diltiazem injectable generic	P			
diltiazem xr generic	P			QLL
DIOVAN	P			QLL
DIOVAN HCT	P			QLL
DIPENTUM		NP		
DIPROLENE	P			
DIPROLENE AF	P			
DITROPAN		NP		QLL
DITROPAN XL	P			QLL
docusate sodium/calcium	P		PA	

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

PA* Requires PA after (3) prescriptions per year

** Requires PA After (6) prescriptions per year for members >21 years old

Georgia Medicaid/PeachCare Preferred Drug List

Effective June 1, 2007

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
DOSTINEX	P			QLL
DOVONEX	P			
doxycycline monohydrate caps		NP	PA	
DRITHOCREME	P			
DRITHOCREME HP	P			
DRITHO-SCALP	P			
DUETACT		NP		QLL
DUONEB		NP	PA	QLL
DURAGESIC	P			QLL
DURICEF SUSP	P			
DYNACIRC CR	P			QLL
DYNAPEN SUSP	P			
E.E.S. 400	P			QLL
EFFEXOR, -XR	P			QLL
EFUDEX	P			
ELAPRASE	P		PA	
ELESTAT	P			QLL
ELIDEL	P		PA	QLL
ELIMITE	P			QLL
ELMIRON	P			
ELOCON	P			QLL
EMADINE	P			QLL
EMCYT	P			
EMEND		NP		QLL
EMSAM		NP	PA	QLL
E-MYCIN	P			QLL
ENABLEX	P			QLL
enalapril generic	P			QLL
enalapril HCTZ generic	P			QLL
enalaprilat generic	P			QLL
ENBREL	P			QLL
EPIPEN	P			QLL
EPIVIR	P			
EPIVIR HBV	P			
EPOGEN	P		PA	
ergocalciferol generic	P		PA	
ERTACZO		NP		
ERYC	P			QLL
ERYPED	P			QLL

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

PA* Requires PA after (3) prescriptions per year

** Requires PA After (6) prescriptions per year for members >21 years old

Georgia Medicaid/PeachCare Preferred Drug List

Effective June 1, 2007

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
ERY-TAB	P			QLL
erythromycin	P			QLL
estazolam generic	P		PA* (≥ 21 yrs)	QLL
ESTRACE	P			QLL
ESTRADERM	P			QLL
estradiol patch generic	P			QLL
ESTRASORB		NP		
ESTRATAB	P			
ESTROGEL		NP		QLL
ESTROSTEP FE		NP		
ETHMOZINE	P			
etidronate disodium generic	P			QLL
EURAX	P			QLL
EVISTA	P			
EVOXAC	P			
EXELDERM		NP		
EXELON	P			
EXJADE	P			
EXUBERA COMBINATION PACK		NP	PA	
EXUBERA KIT		NP	PA	QLL
FACTIVE		NP	PA	QLL
famotidine generic	P			QLL
FAMVIR		NP		QLL
FAZACLO		NP		QLL
FELBATOL	P			
felodipine ER generic	P			QLL
FEMARA	P			
FEMHRT	P			
FEMRING		NP		QLL
fenofibrate generic		NP	PA	QLL
fentanyl citrate generic (generic Actiq)	P		PA	QLL
fentanyl patch generic (generic Duragesic)		NP	PA	QLL
FENTORA		NP	PA	QLL
fexofenadine generic**		NP	PA	QLL
finasteride generic		NP	PA	QLL
flavoxate generic	P			QLL
FLOMAX	P			QLL
FLONASE	P			QLL
FLOVENT HFA	P			QLL

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

PA* Requires PA after (3) prescriptions per year

** Requires PA After (6) prescriptions per year for members >21 years old

Georgia Medicaid/PeachCare Preferred Drug List

Effective June 1, 2007

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
FLOXIN		NP	PA	QLL
FLOXIN OTIC	P			
flunisolide generic	P			QLL
fluoxetine generic	P			QLL
fluphenazine deconate vial generic	P			QLL
fluticasone		NP	PA	QLL
fluvoxamine generic	P			QLL
FML-FORTE	P			QLL
FML-S	P			
FOCALIN	P		PA (> 21 years)	QLL
FOCALIN XR	P		PA (> 21 years)	QLL
folic acid 1mg generic	P			QLL
FORADIL	P			QLL
FORTAMET ER		NP	PA	QLL
FORTEO		NP	PA	
FORTOVASE	P			
FOSAMAX, -WEEKLY	P			QLL
FOSAMAX-D	P			QLL
fosinopril generic	P			QLL
fosinopril HCTZ generic	P			QLL
FRAGMIN	P			QLL
FROVA		NP	PA	QLL
FUZEON	P		PA	QLL
GAMMAGARD	P		PA	
GAMMAR	P		PA	
GAMUNEX	P		PA	
GANTRISIN PEDIATRIC	P			
gemfibrozil generic	P			QLL
generic NSAIDs	P			QLL
GENOTROPIN	P		PA	
GEODON	P			QLL
GEREF	P		PA	
glimepiride generic	P			
glipizide/metformin generic	P			QLL
GLUCOTROL XL	P			
GLUCOVANCE		NP	PA	QLL
GLUMETZA ER		NP	PA	QLL
GLUTOFAC-MX		NP	PA	
GLUTOFAC-ZX	P		PA	

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

PA* Requires PA after (3) prescriptions per year

** Requires PA After (6) prescriptions per year for members >21 years old

Georgia Medicaid/PeachCare Preferred Drug List

Effective June 1, 2007

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
glyburide	P			QLL
glyburide/metformin generic	P			QLL
glycolax generic	P		PA	QLL
GLYSET	P			
GRIFULVIN V SUSP	P			
HALOG, -E		NP		
haloperidol deconoate vial generic	P			QLL
HECTOROL	P		PA	
HELIDAC		NP		
HEPARIN SODIUM	P			
HIVID	P			
HUMALOG		NP	PA	QLL
HUMATROPE		NP	PA	
HUMIRA	P			QLL
HUMULIN 50/50	P			QLL
HUMULIN 70/30		NP	PA	QLL
Humulin cartridges and pens		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
hydrocortisone acetate cream generic	P			QLL
HYLIRA		NP	PA	
HYZAAR	P			QLL
IB STAT ORAL SPRAY		NP		QLL
ILETIN	P			QLL
IMITREX (tabs, inj, ns)	P			QLL
INCRELEX		NP	PA	
INFERGEN	P		PA	QLL
INNOHEP	P			QLL
INNOPRAN XL		NP	PA	QLL
INSPRA		NP		
INSULIN PEN DELIVERY SYSTEMS			PA (> 21 years)	QLL
INTAL INHALER	P			QLL
INTRON A	P		PA	
INVEGA		NP	PA	
INVIRASE	P			
IOPIDINE		NP		

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

PA* Requires PA after (3) prescriptions per year

** Requires PA After (6) prescriptions per year for members >21 years old

Georgia Medicaid/PeachCare Preferred Drug List

Effective June 1, 2007

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
IPLEX		NP	PA	
ipratropium generic	P			QLL
ipratropium generic	P			QLL
ISOPTIN SR		NP	PA	QLL
ISOPTO CARBACHOL	P			
isradipine generic	P			QLL
itraconazole generic	P		PA	QLL
IVEEGAM	P		PA	
JANUVIA		NP		
jolessa generic	P			QLL
KADIAN	P			QLL
KALETRA	P			QLL
KEPPRA	P			
KETEK		NP	PA	QLL
ketorolac generic	P			QLL
KINERET		NP	PA	QLL
KUZYME	P			
KYTRIL		NP		QLL
lactulose generic	P		PA	
LAMICTAL	P			
LAMISIL	P		PA	
LAMISIL SOLUTION		NP		
LANOXICAPS		NP		
LANOXIN		NP		
LANTUS	P			QLL
LANTUS OPTICLIK (cartridges)		NP	PA	QLL
LESCOL, -XL	P			QLL
LEUKERAN	P			
LEUKINE	P		PA	QLL
LEVAQUIN	P			QLL
LEVATOL	P			QLL
LEVEMIR	P			QLL
LEVEMIR FLEXPEN		NP	PA	QLL
levocarnitine generic	P			
levothyroxine generic	P			
LEXAPRO	P			QLL
LEXIVA	P			
LEXXEL	P			
LINDANE	P			QLL

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

PA* Requires PA after (3) prescriptions per year

** Requires PA After (6) prescriptions per year for members >21 years old

Georgia Medicaid/PeachCare Preferred Drug List

Effective June 1, 2007

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
LIPITOR		NP	PA	QLL
lisinopril generic	P			QLL
lisinopril HCTZ generic	P			QLL
lithium carbonate generic	P			
LIVOSTIN		NP		
LOCOID		NP		
LOFIBRA		NP	PA	QLL
LOPROX		NP		
LORABID		NP	PA	QLL
LORABID SUSPENSION	P*	NP	PA (> 12yrs, < 65yrs)	QLL
loratadine**, -D generic OTC**	P			QLL
lorazepam generic	P		PA* (≥ 21 yrs)	QLL
LOTEMAX		NP		QLL
LOTENSIN		NP	PA	QLL
LOTENSIN HCT		NP	PA	QLL
LOTREL	P			
LOTRISONE LOTION		NP		
LOTRONEX		NP		QLL
lovastatin generic	P			QLL
LOVENOX	P			QLL
LUMIGAN	P			QLL
LUNESTA	P			QLL
LUPRON DEPOT	P			QLL
LYRICA	P			QLL
LYSODREN	P			
MACROBID	P			
MAGNEBIND	P		PA	
magnesium carbonate generic	P		PA	
maprotiline generic	P			QLL
MARINOL	P		PA	
MATULANE	P			
MAVIK	P			QLL
MAXAIR AUTOHALER	P			QLL
MAXALT, -MLT	P			QLL
MAXAQUIN		NP	PA	QLL
MEGACE ES		NP	PA	
meloxicam generic		NP	PA	QLL
MENEST	P			
MENTAX		NP		

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

PA* Requires PA after (3) prescriptions per year

** Requires PA After (6) prescriptions per year for members >21 years old

Georgia Medicaid/PeachCare Preferred Drug List

Effective June 1, 2007

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
MEPHYTON	P			
MEPRON	P			
METADATE CD	P		PA (> 21 years)	QLL
METADATE ER	P		PA (> 21 years)	QLL
METAGLIP	P			QLL
metaproterenol for nebulization generic	P			QLL
metaproterenol inhaler generic	P			QLL
metformin generic	P			QLL
METHYLIN CHEW TABS & SOLN	P		PA (> 21 years)	QLL
METHYLIN ER	P		PA (> 21 years)	QLL
METHYLIN TABS	P		PA (> 21 years)	QLL
methylphenidate er generic	P		PA (> 21 years)	QLL
methylphenidate generic	P		PA (> 21 years)	QLL
metoprolol succinate ER generic	P			QLL
METROCREAM	P			
METROGEL	P			
METROLOTION	P			
metronidazole generic	P			
MEVACOR		NP	PA	QLL
MIACALCIN	P			QLL
MICARDIS	P			QLL
MICARDIS HCT	P			QLL
miconazole generic	P			QLL
midazolam generic	P		PA* (≥ 21 yrs)	QLL
MIGRANAL NS		NP	PA	QLL
MINTEZOL	P			
MIRALAX		NP	PA	QLL
MIRAPEX	P			
MIRENA		NP		QLL
mirtazapine generic	P			QLL
MOBAN	P			
MOBIC		NP	PA	QLL
moexipril generic	P			QLL
MONISTAT 1	P			QLL
MONODOX		NP	PA	
MONOPRIL		NP	PA	QLL
MONOPRIL HCT		NP	PA	QLL
morphine sulfate sa generic	P			QLL
MOVIPREP		NP		

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

PA* Requires PA after (3) prescriptions per year

** Requires PA After (6) prescriptions per year for members >21 years old

Georgia Medicaid/PeachCare Preferred Drug List

Effective June 1, 2007

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
MS CONTIN		NP	PA	QLL
MULTICLIX	P			QLL
MYCELEX	P			
MYCOBUTIN	P			
MYFORTIC	P			
MYLERAN	P			
MYOBLOC	P		PA	QLL
MYOZYME		NP		
NALFON		NP	PA	QLL
NAMENDA	P			
NAPRELAN		NP	PA	QLL
NARDIL	P			
NASACORT AQ	P			QLL
NASALIDE		NP	PA	QLL
NASAREL		NP	PA	QLL
NASCOBAL		NP	PA	QLL
NASONEX	P			QLL
NEBUPENT	P			QLL
nefazodone generic	P			QLL
neomycin/polymyxin/hc generic	P			QLL
neomycin/polymyxin/hc generic	P			QLL
NEPHRON FA		NP	PA	
NEULASTA	P		PA	QLL
NEUMEGA	P			QLL
NEUPOGEN	P		PA	QLL
NEURONTIN	P			
NEVANAC		NP		
NEXAVAR	P			QLL
NEXIUM	P		PA	QLL
niacin generic	P		PA	
NIASPAN	P			
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			

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

PA* Requires PA after (3) prescriptions per year

** Requires PA After (6) prescriptions per year for members >21 years old

Georgia Medicaid/PeachCare Preferred Drug List

Effective June 1, 2007

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
nitroglycerin patches generic	P			
NITROLINGUAL SPRAY	P			QLL
nizatidine generic	P			QLL
NORDITROPIN	P		PA	
NORITATE		NP		
NOROXIN		NP	PA	QLL
NORVASC	P			QLL
NORVIR	P			
NOVOLIN	P			QLL
Novolin cartridges and pens	P		PA (> 21 years)	QLL
NOVOLOG	P			QLL
NOXAFIL		NP		
NULYTELY		NP		QLL
NUTROPIN, -AQ, -DEPOT	P		PA	
NUVARING	P			
OCL	P			QLL
OCUFLOX	P			QLL
ofloxacin drops generic	P			QLL
ofloxacin generic	P			QLL
OMACOR		NP	PA	
omeprazole generic		NP	PA	QLL
OMNICEF	P			QLL
OMNICEF SUSPENSION	P*	NP	PA (> 12yrs, < 65yrs)	QLL
OPANA/ER		NP	PA	QLL
OPTIVAR	P			QLL
ORACEA		NP	PA	QLL
ORAMORPH SR	P			QLL
ORAPRED ODT		NP	PA	
ORENCIA	P		PA	
ORFADIN	P			QLL
ORGARAN	P			
ORTHO TRI-CYCLEN		NP		
ORTHO TRI-CYCLEN LO		NP		
ORTHO-EVRA	P			QLL
ORTHO-PREFEST		NP		
OVCON-35		NP		
OVCON-50		NP		
OVIDE		NP		QLL
oxazepam generic	P		PA* (≥ 21 yrs)	QLL

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

PA* Requires PA after (3) prescriptions per year

** Requires PA After (6) prescriptions per year for members >21 years old

Georgia Medicaid/PeachCare Preferred Drug List

Effective June 1, 2007

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
OXISTAT		NP		
oxybutynin ER generic	P			QLL
oxybutynin generic	P			QLL
oxycodone er generic		NP	PA	QLL
OXYCONTIN		NP	PA	QLL
OXYTROL	P			QLL
P1-E1 /P2-E1/P3-E1	P			
PANCREASE	P			
PANDEL		NP		
PANGLOBULIN	P		PA	
PANRETIN	P		PA	
PARNATE	P			
paroxetine generic	P			QLL
PATANOL	P			QLL
PAXIL		NP	PA	QLL
PAXIL CR	P			QLL
PCE	P			QLL
PEGASYS	P		PA	QLL
PEG-INTRON	P		PA	QLL
PENLAC		NP	PA	
PENTASA	P			
pergolide generic	P			
PEXEVA	P			QLL
phenytoin generic	P			
PHOSLO	P		PA	
PHOSPHOLINE IODIDE	P			
pilocarpine generic	P			
pilocarpine generic		NP	PA	QLL
PILOPINE H.S.	P			
PLAN B (covered < 18 yrs old)	P			QLL
PLAVIX	P			QLL
PLEXION CLEANSING CLOTHS		NP		QLL
polyethylene glycol generic	P		PA	
POLYGAM	P		PA	
PONSTEL		NP	PA	QLL
PRANDIN	P			
PRAVACHOL		NP	PA	QLL
pravastatin generic	P			QLL
PRECOSE	P			

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

PA* Requires PA after (3) prescriptions per year

** Requires PA After (6) prescriptions per year for members >21 years old

Georgia Medicaid/PeachCare Preferred Drug List

Effective June 1, 2007

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
PREMARIN	P			
PREMPHASE	P			
PREMPRO	P			
PREVACID CAPSULES, SUSPENSION	P		PA	QLL
PREVACID NAPRAPAC		NP	PA	QLL
PREVACID SOLUTAB		NP	PA	QLL
PREVPAC	P			QLL
PREZISTA	P			
PRILOSEC		NP	PA	QLL
PRINIVIL		NP	PA	QLL
PRINZIDE		NP	PA	QLL
PROAMATINE	P			
PROCARDIA, -XL		NP		QLL
PROCRIT	P		PA	
PROCTOFOAM-HC	P			
PROGRAF	P			
PROLEUKIN	P			
PROMETRIUM	P			
PROQUIN XR		NP	PA	QLL
PROSCAR	P			QLL
PROSTIGMIN	P			
PROTONIX		NP	PA	QLL
PROTOPIC	P		PA	QLL
PROTROPIN	P		PA	
PROVENTIL FOR NEBULIZATION		NP	PA	QLL
PROVENTIL HFA	P			QLL
PROVIGIL		NP	PA	QLL
PROZAC		NP	PA	QLL
PSORCON E		NP		
PULMICORT RESPULES	P			QLL
PULMICORT TURBUHALER/FLEXHALER		NP	PA	QLL
PURINETHOL	P			
pyridoxine (vitamin B-6) generic	P		PA	
quasense generic	P			QLL
quinapril generic	P			QLL
quinaretic generic	P			QLL
QUIXIN	P			QLL
QVAR	P			QLL
RADIACARE	P			

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

PA* Requires PA after (3) prescriptions per year

** Requires PA After (6) prescriptions per year for members >21 years old

Georgia Medicaid/PeachCare Preferred Drug List

Effective June 1, 2007

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
RANEXA		NP	PA	
ranitidine generic	P			QLL
RAPAMUNE	P			
RAPIFLUX		NP	PA	QLL
RAPTIVA	P		PA	
RAZADYNE (previously Reminyl)	P			
REBETOL	P			
REBETRON	P		PA	QLL
REBIF	P			QLL
REGRANEX	P		PA	QLL
RELENZA		NP		QLL
RELPAX	P			QLL
REMERON		NP		QLL
REMICADE	P			QLL
RENAGEL		NP	PA	QLL
RENAX	P		PA	
RENOVA		NP	PA (> 21 years)	QLL
REQUIP	P			
RESCRIPTOR	P			
RESPIGAM	P		PA	
RESTASIS	P			QLL
RETIN-A MICRO	P		PA (> 21 years)	QLL
RETISERT		NP	PA	
RETROVIR	P			
REVATIO	P		PA	QLL
REVLIMID	P			
REYATAZ	P			
RHINOCORT AQ		NP	PA	QLL
ribavirin generic	P			
RIDAURA	P			
RIOMET		NP	PA	QLL
RISPERDAL CONSTA		NP	PA	QLL
RISPERDAL M-TAB		NP	PA	QLL
RISPERDAL TABS & SOLN	P			QLL
RITALIN		NP	PA (> 21 years)	QLL
RITALIN LA	P		PA (> 21 years)	QLL
RITALIN SR		NP	PA (> 21 years)	QLL
RITUXAN	P		PA	
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

** Requires PA After (6) prescriptions per year for members >21 years old

Georgia Medicaid/PeachCare Preferred Drug List

Effective June 1, 2007

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
ROWASA	P			
ROZEREM	P			QLL
SAIZEN		NP	PA	
SALAGEN	P			
SANCTURA	P			QLL
SANDOSTATIN	P			
SARAFEM		NP	PA	QLL
SEASONALE		NP		QLL
SEASONIQUE		NP		QLL
SEMPREX-D	P			
SENSIPAR		NP		
SEREVENT, -DISKUS	P			QLL
SEROQUEL	P			QLL
SEROSTIM		NP	PA	
sertraline generic	P			QLL
simvastatin generic	P			QLL
SINGULAIR	P		PA	QLL
SKELID		NP		
SLO-BID		NP	PA	QLL
sodium bicarbonate generic	P		PA	
SOFT TOUCH	P			QLL
SOFTCLIX	P			QLL
SONATA	P			QLL
SPECTRACEF	P			QLL
SPIRIVA	P			QLL
STARLIX	P			
STRATTERA		NP	PA	QLL
SULAR	P			QLL
SUPRAX SUSPENSION	P*	NP	PA (> 12yrs, < 65yrs)	QLL
SUSTIVA	P			
SUTENT	P		PA	
SYMBYAX		NP	PA	QLL
SYMLIN	P		PA	QLL
SYNAGIS	P		PA	QLL
SYNAREL	P			
SYNTHROID		NP		
TAMIFLU	P			QLL
TARCEVA	P		PA	
TARGRETIN CAP	P			QLL

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

PA* Requires PA after (3) prescriptions per year

** Requires PA After (6) prescriptions per year for members >21 years old

Georgia Medicaid/PeachCare Preferred Drug List

Effective June 1, 2007

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
TARGRETIN GEL	P			QLL
TARKA	P			
TAZORAC	P		PA (> 21 years)	QLL
TAZTIA XT	P			QLL
TEGRETOL, -XR	P			
temazepam generic	P		PA* (≥ 21 yrs)	QLL
TEMODAR	P		PA	QLL
TEQUIN		NP	PA	QLL
TERAZOL	P			QLL
TESTIM		NP	PA	QLL
testosterone injection generic	P		PA	
TEVETEN		NP	PA	QLL
TEVETEN HCT		NP	PA	QLL
TEV-TROPIN		NP	PA	
theophylline generic	P			
thiamine (vitamin B-1) generic	P		PA	
THIOGUANINE	P			
THYROID STRONG	P			
THYROLAR	P			
TIAZAC		NP	PA	QLL
TILADE	P			QLL
TIMOLIDE	P			QLL
TINDAMAX		NP	PA	
TOBI	P			QLL
TOBRADEX	P			
TONOCARD	P			
TOPAMAX	P			
TOPROL XL		NP	PA	QLL
tramadol generic	P			QLL
tramadol/acetaminophen generic	P			QLL
TRANSDERM-SCOP	P			
TRAVATAN/Z	P			QLL
trazodone generic	P			QLL
TRELSTAR LA-DEPOT	P			QLL
tretinoin generic	P		PA (> 21 years)	QLL
TRICOR	P			QLL
TRIGLIDE		NP	PA	QLL
TRILEPTAL	P			
TRINALIN		NP		

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

PA* Requires PA after (3) prescriptions per year

** Requires PA After (6) prescriptions per year for members >21 years old

Georgia Medicaid/PeachCare Preferred Drug List

Effective June 1, 2007

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
TRI-NORINYL		NP		
TRIZIVIR TABLET	P			
TROVAN		NP		
TRUSOPT	P			
TYSABRI	P		PA	QLL
TYZEKA		NP		
ULTRACET		NP		QLL
ULTRAM ER		NP		QLL
ULTRAVATE	P			
UNIPHYL		NP		
UNIRETIC	P			QLL
UNIVASC	P			QLL
UROXATRAL	P			QLL
URSO	P			
VALTREX	P			QLL
VANCENASE, -AQ		NP	PA	QLL
VANCOCIN	P			
VANTIN		NP	PA	QLL
VANTIN SUSPENSION	P*	NP	PA (> 12yrs, < 65yrs)	QLL
VASERETIC		NP	PA	QLL
VASOTEC		NP	PA	QLL
venlafaxine generic	P			QLL
VENOGLOBULIN	P		PA	
VENTAVIS	P		PA	QLL
VENTOLIN HFA	P			QLL
VEPESID	P			
verapamil generic	P			QLL
VERDESO		NP		
VERELAN		NP	PA	QLL
VERELAN PM	P			QLL
VESANOID	P			
VESICARE	P			QLL
VEXOL		NP		QLL
VFEND		NP	PA	
VIBRAMYCIN SYRUP, SUSPENSION	P			
VIDAZA	P		PA	QLL
VIDEX	P			
VIDEX EC	P			
VIGAMOX	P			QLL

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

PA* Requires PA after (3) prescriptions per year

** Requires PA After (6) prescriptions per year for members >21 years old

Georgia Medicaid/PeachCare Preferred Drug List

Effective June 1, 2007

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
VIOKASE	P			
VIRACEPT	P			
VIREAD	P			
vitamin B complex generic	P		PA	
vitamin B-12 injection generic	P			
vitamin E capsules & drops	P		PA	
VIVAGLOBIN	P		PA	
VIVELLE, -DOT	P			QLL
VIVITROL	P		PA	QLL
VOLTAREN	P			
VUSION		NP	PA	
VYTORIN		NP	PA	QLL
warfarin sodium generic	P			
WELCHOL		NP		
WELLBUTRIN, -SR		NP	PA	QLL
WELLBUTRIN-XL	P			QLL
XALATAN	P			QLL
XELODA	P			
XENICAL	P		PA	
XIBROM		NP		
XIFAXAN		NP	PA	QLL
XOLEGEL		NP	PA	
XOPENEX		NP	PA (> 8 years)	QLL
XOPENEX HFA		NP	PA	QLL
XYREM		NP	PA	QLL
YASMIN		NP		
ZADITOR (Rx)	P			QLL
ZANTAC SYRUP	P			QLL
ZEGERID		NP	PA	QLL
ZELAPAR		NP	PA	
ZELNORM	P		PA	
ZEMPLAR	P		PA	
ZERIT	P			
ZESTORETIC		NP	PA	QLL
ZESTRIL		NP	PA	QLL
ZETIA	P			QLL
ZIAGEN	P			
zidovudine generic	P			
ZITHROMAX SUSPENSION		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

** Requires PA After (6) prescriptions per year for members >21 years old

Georgia Medicaid/PeachCare Preferred Drug List

Effective June 1, 2007

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
ZITHROMAX TABLETS		NP		QLL
ZMAX		NP	PA	QLL
ZOCOR		NP	PA	QLL
ZOFRAN, -ODT	P			QLL
ZOLOFT		NP	PA	QLL
ZOMIG, -ZMT	P			QLL
ZONEGRAN	P			
ZOVIRAX OINTMENT	P			
ZYFLO	P		PA	QLL
ZYMAR	P			QLL
ZYPREXA		NP	PA	QLL
ZYPREXA INJECTABLE		NP		QLL
ZYPREXA ZYDIS		NP	PA	QLL
ZYRTEC SYRUP**	P (< 2 yr old)	NP (≥ 2yr old)	PA (≥ 2 yr old)	QLL
ZYRTEC**		NP	PA	QLL
ZYRTEC-D**		NP	PA	QLL
ZYVOX	P		PA	

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

PA* Requires PA after (3) prescriptions per year

** Requires PA After (6) prescriptions per year for members >21 years old