STATE OF MICHIGAN

JOHN ENGLER, Governor

DEPARTMENT OF COMMUNITY HEALTH

LEWIS CASS BUILDING
LANSING, MICHIGAN 48913
JAMES K. HAVEMAN, JR., Director

February 11, 2002

Dear Provider/Prescriber:

On February 1, 2002, the Michigan Department of Community Health began the implementation of the expanded prior authorization program for pharmaceuticals without denial of drugs that will require prior authorization. The week of February 1 – 8 was designated as a testing period and a time for prescribers to fax in or call in prior authorization requests. This pre-implementation prior authorization period will be extended to February 24, 2002. Thus, prior authorization will not be required to fill prescriptions until at least February 25, 2002. On February 25, 2002, the department will begin phasing in specific drug classes requiring prior authorization to dispense. The phase in will continue through March 18, 2002. The classes of drugs and dates of implementation of the prior authorization requirement are enclosed.

Prior authorization may be requested for any of the drugs that will require prior authorization at any time during this phase in by calling the First Health Services Corporation's [FHSC] Clinical Call Center at 1-877-864-9014 or by faxing your request to FHSC at 1-888-603-7696 or 1-800-250-6950. A fax form is enclosed and may be duplicated for your use. The form identifies the information that will be required to grant prior authorization.

FHSC will prioritize prior authorization requests according to the phase in date for the therapeutic class of drug requested. Requests for drugs in the February 25, 2002 phase in will be addressed prior to requests for drugs from later phase in dates.

Also enclosed is a list of drugs that do not require prior authorization in most cases. We urge providers to prescribe from this list and only call for prior authorization when clinically necessary.

Please note, drugs that required prior authorization before February 1, 2002 will continue to require prior authorization, and all related edits will remain in force. The department does not cover refills until 75 percent of the previous prescription has been used.

For general questions regarding this program, providers should contact the FHSC Technical Call Center at 1-877-624-5204.

Cordially,

James K. Haveman, Jr.

Michigan Department of Community Health

Timeline For Therapeutic Class Phase In of the Implementation of the Expanded Prior Authorization
February-March 2002

February 25, 2002

Antianxiety
Antihistamines
Glucocorticoids
Macrolides

March 4, 2002

CNS Stimulants
Oral Hypoglycemics
1st Gen. Cephalosporins
2nd Gen. Cephalosporins
Angiotensin Receptors
Beta Blockers
NSAIDs
Atypical Antipsychotics
Typical Antipsychotics

March 11, 2002

Alzheimers
ACE Inhibitors
Anti-Fungals
Coronary Vasodilators
Insulins
Anti-Hyperlipidemic Agents
Narcotics
Platelet Inhibitors
Quinolones
Respiratory Beta Adrenergic Inhalers
Sedative Hypnotics Non-Barbituates
Steroids, Nasal
Steroids, Topical
Topical Nitroglycerin

March 18, 2002

PPIs
Anti-Depressants
Calcium Channel Blockers
Osteoporosis Agents
Bipolar Agents
Antivirals
H2 Antagonists

Michigan Dept of Community Health

Summary of Changes to the MI Pharmaceutical Product List

These drugs do not require prior authorization for your beneficiaries in the Programs listed below.
[Only affected classes are listed.]

Complete MPPL and its subsequent changes are at:
http://www.michigan.fhsc.com

This applies to the following pharmacy programs:

- Medicaid Fee for Service
- EPIC
- CSHCS Fee For Service
- SMP
- Refugee Assistance Program

Note: EPIC program does not cover CNS Stimulants, Anti-Viral Protease Inhibitors, or Anti-Hemophiliac Factors, Immunosupressives, Over the Counter Drugs and Injectables other than insulin.

For questions contact First Health
Phone: 877-864-9014
Fax: 888-603-7696
Effective 2-1-02

Histamine-2 Receptor Antagonists (H-2RA)

Cimetidine
Famotidine
Ranitidine
Zantac Effervescent 2
Zantac Syrup 3

Hypoglycemics Oral Agents

Acetohexamide
Chlorpropamide
Glipizide
Glucophage
Glucovance
Glyburide
Glyburide Micronized
Prandin
Precose
Tolazamide
Tolbutamide

*Immunosuppressives

*Azathioprine
*CellCept
*Cyclosporine
*Gengraf
*Imuran
*Neoral
*Prograf
*Rapamune
*Sandimmune
*Simulect

Inhaled Systemic Glucocorticoids

Beclovent
Flovent
Vanceril

Nasal Steroids

Beconase
Flonase
Nasarel
Nasonex
Tri-Nasal

Osteoporosis Agents

Actonel
Evista
Fosamax

Platelet Inhibitors

Aggrenox
*Aspirin
Dipyridamole
Plavix
Pletal
Ticlopidine

Respiratory Beta Adrenergic Inhalers

Advair Diskus
Albuterol
Albuterol Sulfate
Maxair
Metaproterenol
Serevent

Sedative Hypnotic Non-Barbiturates

Chloral Hydrate
Chloral Hydrate Syrup
Diphenhydramine 1
Estazolam
Flurazepam 1
Temazepam 1
Triazolam 1

Topical Steroids

Augmented Betamethasone
Dipropionate
Betamethasone Dipropionate
Betamethasone Valerate
Capex Shampoo
Clobetasol Propionate
Clobevate
Desonide
Desoximetasone
Diflorasone Diacetate
Fluocinolone Acetonide
Fluocinonide
Fluocinonide-Emollient
FS Shampoo
Halog-E
Hydrocortisone
Pandel
Triamcinolone Acetonide

1 PA Required if Beneficiary is Over the Age of 65
2 PA Not Required if Beneficiary is Over the Age of 60
3 PA Not Required if Beneficiary is Under the Age of 12
4 PA Required on New Prescriptions Only

CR, ER, SR, XL, XR = Extended Release
APAP = Acetaminophen
ASA = Aspirin
HCT = Hydrochlorothiazide

* NOT Covered for EPIC

Drugs Not Requiring Prior Authorization For the Michigan Programs Listed
Please Prescribe from this List

Alzheimer's Dementia
Exelon
Reminyl

Analgesic –Narcotics
Actiq
Butalbital Compound W/Codeine
Codeine
Codeine Phosphate
Codeine/ APAP
Codeine/ASA
Darvon-N
Dolophine
Fiorinal W/Codeine #3
Fiortal W/Codeine #3
Hydrocodone/APAP
Hydromorphone
Kadian
Meperidine
Methadone
Methadose
Morphine Sulfate
Morphine Sulfate ER
Morphine Sulfate Solution
M-Oxy
*Nalbuphine
*Nubain
Opium
Oxycodone
Oxycodone/ APAP
Oxycodone/ ASA
Panlor DC
Phenaphen W/Codeine
Propoxyphene APAP
Propoxyphene Compound
Propoxyphene Napsylate APAP
Roxicet
Roxilox
Zydone

Analgesic Non-Steriodal - Anti-Inflammatory Drugs (NSAIDS)
Celebrex 2
Diclofenac Potassium
Diclofenac Sodium
Etodolac
Fenoprofen Calcium
Flurbiprofen
Ibuprofen
Indomethacin
Ketoprofen
Ketorolac
Meclofenamate Sodium
Naproxen
Naproxen Sodium
Oxaprozin
Piroxicam
Sulindac
Tolmetin Sodium
Toradol
Vioxx 2

Angiotensin Receptor Antagonists
Atacand
Atacand HCT
Micardis
Micardis HCT
Teveten

Anti-Anxiety
Alprazolam
Buspar
Buspirone
Chlordiazepoxide 1
Clorazepate
Diazepam 1
Doxepin 1
Hydroxyzine HCL
Hydroxyzine Pamoate
Lorazepam
Meprobamate
Oxazepam

Antibiotics - Cephalosporin First Generation
Cefadroxil
Cephalexin

Antibiotics - Cephalosporin 2nd Generation
Cefaclor
Cefaclor ER
Ceftin
Cefzil
*Ceptaz
*Rocephin

Antibiotics - Macrolides
Biaxin
Biaxin XL
Dynabac
Erythrocin Stearate
Erythromycin Base
Erythromycin Estolate
Erythromycin Ethylsuccinate
Erythromycin Stearate
Erythromycin w/Sulfisoxazole
PCE
Zithromax

Antibiotics - Quinolones
Cinobac
Levaquin
Maxaquin
NegGram
Noroxin

Anti-Depressants – Other
Maprotiline
Remeron SolTab
Trazodone
Wellbutrin SR

Anti-Depressants – SSRIs
Fluoxetine
Paxil

Anti-Depressants – Tricyclics
Amitriptyline 1
Amoxapine 1
Clomipramine
Desipramine
Doxepin 1
Elavil 1
Imipramine 1
Nortriptyline
Protriptyline
Sinequan 1

Anti-Fungals - Oral
Diflucan 150 mg tablet
Griseofulvin
Nystatin Oral Susp.

Anti- Fungals - Topicals/Derm
Carrington Antifungal
Clotrim Antifungal
Clotrimazole
Clotrimazole/Betamethasone
Fungizone
Fungoid
Ketoconazole
Micaderm
Miconazole Nitrate
Micro-Guard
N.T.A.
Nystatin
Nystatin w/Triamcinolone
Tri-Statin II

***Antihemophilic Factor**
*Autoplex T
*Bioclate
*Feiba VH Immuno
*Helixate
*Hemofil-M
*Humate-P
*Kogenate
*Monoclate-P
*Recombinate
*ReFacto

Antihistamines - Second Generation
Allegra D
Allegra
Claritin D 12 hour
Claritin D 24 hour
Claritin Redi-Tab
Claritin Syrup
Claritin

Anti-Hyper-Lipidemic Agents
Cholestyramine
Cholestyramine Light
Colestid
Gemfibrozil
Lescol
Lescol XL
Lipitor
Niacin
Niacor
Niaspan
Pravachol

Antipsychotics - Atypical
Clozapine
Clozaril
Geodon 4
Risperdal
Seroquel
Zyprexa
Zyprexa Zydis 4

Antipsychotics - Typical
Chlorpromazine
Fluphenazine
Haloperidol
Loxapine
Moban
Perphenazine
Thiothixene
Trifluoperazine

Antivirals - Herpes
Acyclovir
Valcyte
Valtrex

AntiVirals - Influenza
Amantadine
Flumadine
Relenza
Tamiflu

***AntiVirals - Protease Inhibitors**
*Agenerase
*Crixivan
*Fortovase
*Invirase
*Kaletra
*Norvir
*Viracept

Beta Blockers
Acebutolol
Atenolol
Atenolol/HCT
Atenolol/Chlorthalidone
Betaxolol
Bisoprolol Fumarate
Bisoprolol/HCT
Coreg
Labetalol
Metoprolol
Nadolol
Pindolol
Propranolol
Propranolol/HCT
Sotalol
Timolol

Bi-polar Disorders
Eskalith
Lithium Carbonate
Lithium Citrate
Lithobid

Calcium Channel Blockers (CCB)
Cardene
Diltiazem
Diltiazem SR
DynaCirc
Nicardipine
Nifedical XL
Nifedipine
Norvasc
Sular
Verelan PM
Verapamil
Verapamil SR

Cardiovascular ACE Inhibitors
Captopril
Captopril HCT
Enalapril
Enalapril HCT
Lotensin
Lotensin HCT
Mavik
Monopril
Monopril HCT
Unirectic
Univasc
Zestoretic
Zestril

***Central Nervous System Stimulants**
*Concerta
*Dexedrine
*Dextroamphetamine Sulfate
*Dextrostat
*Methylin
*Methylphenidate
*Methylphenidate SR

CMV Retinitis
Cytovene (CMV Retinitis)

Coronary Vasodilators Oral
Dilatrate-SR
Isosorbide Dinitrate
Isosorbide Mononitrate
Isotrate ER
Monoket
Nitroglycerin
Nitroglyn
NitroQuick
Nitrostat
NitroTab
Nitro-Time

Coronary Vasodilators - Topical
Deponit
Nitrek
Nitroglycerin Patches

Diabetes
Actos
Avandia
Humulin 50/50
Humalog 75/25
Humulin R 500-U
Humulin U
Lantus
Novolin 70/30
Novolin L
Novolin N
Novolin R
Novolog
Velosulin BR

Gastrointestinal Proton Pump inhibitors (PPI)
Prevacid
Protonix

Glucocorticoids-Systemic
Aristocort
Celestone
Cortisone Acetate
Dexamethasone
Hydrocortisone
Methylprednisolone
Orapred
Pediapred
Prednisolone
Prednisone
Prelone

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MICHIGAN DEPARTMENT OF COMMUNITY HEALTH PHARMACY PROGRAM
REQUEST FOR PRIOR AUTHORIZATION

PRESCRIBING PHYSICIAN:

Name:_____
First Last
Direct Phone #: (_ _ _) - _ _ _ - _ _ _ _

Fax #: (_ _ _) - _ _ _ - _ _ _ _

Physician specialty: _____

BENEFICIARY:

Name:_____
First Last
Medicaid #: _____

Date of Birth: _ _ - _ _- _ _ _ _

Sex: ❒ Female ❒ Male

Name and title of person completing form (please print): _____

PARTICIPATING PHARMACY:

Request Date: _ _ / _ _ / _ _ _ _

Name: _____

Phone #: (_ _ _) - _ _ _ - _ _ _ _

Drug name: **Strength:** **Administration Schedule:** **Length of Therapy:** **Quantity Requested:**

1. **Patient's diagnosis for use of this medication:** _____
2. **Previous history of a medical condition, allergies or other pertinent medical information, that necessitates the use of this medication:**
   _____
3. **Has the patient been seen by any other provider for this condition?** ❒ Yes ❒ No
   If so, what was the prescriber's specialty? _____
4. **Previous non-prior authorized and prior authorized medications tried and failed for this condition:**

Name of medication	Reason for failure	Date:
_____	_____	_ _/_ _/_ _ _ _
_____	_____	_ _/_ _/_ _ _ _
_____	_____	_ _/_ _/_ _ _ _

5. **Pertinent laboratory test or procedure: (if applicable)**

Procedure:	Findings:	Date:
_____	_____	_ _/_ _/_ _ _ _
_____	_____	_ _/_ _/_ _ _ _
_____	_____	_ _/_ _/_ _ _ _

6. **Other Information:**

First Health Services use only

Date: _ _ / _ _ / _ _ _ _ ❒ Approved ❒ Changed ❒ Denied

MAP RPh/Tech: _____ **NDC:** _____

Comments:

Submit Requests to:

First Health Services
MAP Department
4300 Cox Road
Glenn Allen, VA 23060

Fax: 1-888-603-7696 or 1-800-250-6950
Tel: 1-877-864-9014