

Georgia Medicaid/PeachCare Preferred Drug List

Effective June 1, 2008

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
ANTIINFECTIVES				
ANTIBACTERIAL DRUGS				
ADOXA		NP	PA	
ADOXA CK KIT, ADOXA TT KIT		NP	PA	QLL
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		QLL
BIAXIN SUSPENSION		NP	PA	QLL
BIAXIN XL		NP	PA	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
cefdinir	P			QLL
CEFTIN SUSPENSION	P			QLL
cefpodoxime generic	P			QLL
cefprozil generic	P			QLL
cefuroxime generic tabs	P			QLL
cefuroxime generic susp		NP	PA	QLL
cephalexin generic	P			QLL
cephradine generic	P			QLL
CIPRO		NP	PA	QLL
CIPRO SUSPENSION	P			QLL
CIPRO XR		NP		QLL
ciprofloxacin/SR generic	P			QLL
clarithromycin/ER generic	P			QLL
clarithromycin susp.		NP	PA	QLL
DORIBAX	P		PA	
doxycycline monohydrate caps/tabs		NP	PA	
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

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

PA* Requires PA after (3) prescriptions per year

PA** Requires PA if contingent therapy protocols not met

Georgia Medicaid/PeachCare Preferred Drug List

Effective June 1, 2008

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
FACTIVE		NP	PA	QLL
FLOXIN		NP	PA	QLL
GANTRISIN PEDIATRIC	P			
LEVAQUIN	P			QLL
MACROBID	P			
MAXAQUIN		NP	PA	QLL
MONODOX		NP	PA	
NOROXIN		NP	PA	QLL
ofloxacin generic	P			QLL
OMNICEF		NP		QLL
OMNICEF SUSPENSION	P*	NP	PA (> 12yrs, < 65yrs)	QLL
PCE	P			QLL
PROQUIN XR		NP	PA	QLL
SPECTRACEF	P			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
TOPICAL ANTIBACTERIAL DRUGS				
ALTABAX		NP	PA	QLL
BACTROBAN CREAM	P			
BACTROBAN NASAL	P			
BACTROBAN OINTMENT	P			
mupirocin ointment generic		NP	PA	
ORAL ANTIFUNGAL DRUGS				
ANCOBON	P			
DIFLUCAN		NP		
fluconazole generic	P			
DIFLUCAN 150MG TAB		NP		QLL
fluconazole 150mg tab generic	P			QLL
GRIFULVIN V SUSP	P			
GRIFULVIN V TAB	P			
griseofulvin oral susp	P			
GRIS-PEG	P			

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

PA* Requires PA after (3) prescriptions per year

PA** Requires PA if contingent therapy protocols not met

Georgia Medicaid/PeachCare Preferred Drug List

Effective June 1, 2008

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
itraconazole generic	P		PA	QLL
LAMISIL		NP	PA	
MYCELEX	P			
NOXAFIL		NP		
terbinafine	P		PA	
VFEND		NP	PA	
TOPICAL ANTIFUNGALS				
CNL8 NAIL KIT		NP	PA	QLL
ERTACZO		NP		
EXELDERM		NP		
LAMISIL SOLUTION		NP		
LOPROX		NP		
LOTRISONE LOTION		NP		
MENTAX		NP		
miconazole generic	P			QLL
MONISTAT 1	P			QLL
OXISTAT		NP		
PENLAC		NP	PA	
TERAZOL	P			QLL
XOLEGEL		NP	PA	
XOLEGEL DUO		NP	PA	
ANTIRETROVIRALS & PROTEASE INHIBITORS				
AGENERASE	P			
APTIVUS	P		PA	
COMBIVIR	P			
CRIXIVAN	P			
EPIVIR	P			
FUZEON	P		PA	QLL
HIVID	P			
INTELENCE	P		PA	
INVIRASE	P			
ISENTRESS	P		PA	
KALETRA	P			QLL
LEXIVA	P			
NORVIR	P			
PREZISTA	P		PA	
RESCRIPTOR	P			
RETROVIR	P			
REYATAZ	P			
SELZENTRY	P		PA	

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

PA* Requires PA after (3) prescriptions per year

PA** Requires PA if contingent therapy protocols not met

Georgia Medicaid/PeachCare Preferred Drug List

Effective June 1, 2008

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
SUSTIVA	P			
TRIZIVIR TABLET	P			
VIDEX	P			
VIDEX EC	P			
VIRACEPT	P			
VIREAD	P			
ZERIT	P			
ZIAGEN	P			
zidovudine generic	P			
OTHER ANTIVIRAL DRUGS				
BARACLUDE	P			
CYTOVENE	P			
EPIVIR HBV	P			
FAMVIR		NP		QLL
RELENZA		NP		QLL
TAMIFLU	P			QLL
TYZEKA		NP		
VALTREX	P			QLL
TOPICAL ANTIVIRAL DRUGS				
DENAVIR	P			
ZOVIRAX OINTMENT	P			
ANTIINFECTIVES SPECIALIZED INDICATIONS				
DAPSONE	P			
DARAPRIM	P			
MEPRON	P			
MINTEZOL	P			
MYCOBUTIN	P			
NEBUPENT	P			QLL
TINDAMAX		NP	PA	
VANCOCIN	P			
XIFAXAN		NP	PA	QLL
ZYVOX	P		PA	QLL
ANTINEOPLASTIC/ IMMUNOSUPPRESSANT DRUGS				
AGRYLIN	P			
ALIMTA	P		PA	
ALKERAN	P			
AMEVIVE		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

PA** Requires PA if contingent therapy protocols not met

Georgia Medicaid/PeachCare Preferred Drug List

Effective June 1, 2008

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
ARAVA	P			QLL
ARIMIDEX	P			
AROMASIN	P			
CASODEX	P			
CEENU	P			
CELLCEPT	P			
EMCYT	P			
ENBREL	P			QLL
FEMARA	P			
HUMIRA	P			QLL
IXEMPRA	P		PA	
KINERET		NP	PA	QLL
LEUKERAN	P			
LUPRON DEPOT	P			QLL
LYSODREN	P			
MATULANE	P			
MYFORTIC	P			
MYLERAN	P			
NEXAVAR	P			QLL
ORENCIA	P		PA	
PROGRAF	P			
PURINETHOL	P			
RAPAMUNE	P			
RAPTIVA	P		PA	
REMICADE	P			QLL
REVLIMID	P			
RIDAURA	P			
RITUXAN	P		PA	
SANDOSTATIN	P			
SOMATULINE DEPOT		NP	PA	
SPRYCEL	P		PA	
SUTENT	P		PA	
TARCEVA	P		PA	
TARGRETIN CAP	P			QLL
TARGRETIN GEL	P			QLL
TASIGNA	P		PA	
TEMODAR	P		PA	QLL
THIOGUANINE	P			
TORISEL	P			QLL
TREANDA	P			
TRELSTAR LA/-DEPOT	P			QLL
TYKERB	P			

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

PA* Requires PA after (3) prescriptions per year

PA** Requires PA if contingent therapy protocols not met

Georgia Medicaid/PeachCare Preferred Drug List

Effective June 1, 2008

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
VEPESID	P			
VESANOID	P			
VIDAZA	P		PA	QLL
XELODA	P			
ZOLINZA	P		PA	
<i>CARDIOVASCULAR MEDICATIONS</i>				
CALCIUM ANTAGONISTS				
ADALAT CC		NP		QLL
afeditab cr generic	P			QLL
amlodipine	P			QLL
CALAN		NP		QLL
CALAN SR		NP		QLL
CARDENE IV	P			
CARDENE SR		NP	PA	QLL
CARDIZEM		NP		QLL
CARDIZEM CD		NP		QLL
CARDIZEM LA	P			QLL
CARDIZEM INJECTABLE		NP		
CARTIA XT	P			QLL
COVERA HS		NP	PA	QLL
DILACOR XR		NP		QLL
DILTIA XT	P			QLL
diltiazem generic	P			QLL
diltiazem er generic	P			QLL
diltiazem xr generic	P			QLL
diltiazem injectable generic	P			
DYNACIRC CR	P			QLL
felodipine ER generic		NP	PA	QLL
ISOPTIN SR		NP		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		NP		QLL
PROCARDIA, -XL		NP		QLL
SULAR		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

PA** Requires PA if contingent therapy protocols not met

Georgia Medicaid/PeachCare Preferred Drug List

Effective June 1, 2008

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
TAZTIA XT	P			QLL
TIAZAC		NP		QLL
verapamil generic	P			QLL
VERELAN		NP		QLL
VERELAN PM		NP		QLL
CARDIAC GLYCOSIDES				
digoxin generic	P			
LANOXIN		NP		
LANOXICAPS		NP		
BETA-ADRENERGIC ANTAGONIST DRUGS				
All generics are Preferred	P			QLL
BETAPACE, -AF		NP		QLL
BYSTOLIC		NP	PA	QLL
COREG		NP		QLL
COREG CR		NP	PA	QLL
CORZIDE	P			QLL
INNOPRAN XL		NP	PA	QLL
LEVATOL	P			QLL
LOPRESSOR HCT	P			QLL
metoprolol HCTZ generic		NP	PA	QLL
metoprolol succinate ER generic		NP	PA	QLL
nadolol/bendroflumethiazide		NP	PA	QLL
TIMOLIDE	P			QLL
TOPROL XL	P			QLL
CENTRALLY ACTING ANTIHYPERTENSIVES				
CATAPRES-TTS	P			QLL
ANGIOTENSIN CONVERTING ENZYME INHIBITORS & COMBOS				
ACCUPRIL		NP		QLL
ACCURETIC		NP		QLL
ACEON		NP	PA	QLL
ALTACE CAPS	P			QLL
ALTACE TABS		NP	PA	
benazepril generic	P			QLL
benazepril HCTZ generic	P			QLL
CAPOTEN		NP		QLL
CAPOZIDE		NP		QLL
captopril generic	P			QLL
captopril HCTZ 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

PA** Requires PA if contingent therapy protocols not met

Georgia Medicaid/PeachCare Preferred Drug List

Effective June 1, 2008

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
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		QLL
LOTENSIN HCT		NP		QLL
MAVIK		NP		QLL
moexipril generic	P			QLL
moexipril HCTZ generic	P			QLL
MONOPRIL		NP		QLL
MONOPRIL HCT		NP		QLL
PRINIVIL		NP		QLL
PRINZIDE		NP		QLL
quinapril generic	P			QLL
quinaretic/quinapril HCTZ generic	P			QLL
ramipril caps generic		NP	PA	QLL
trandolapril generic	P			QLL
UNIRETIC		NP		QLL
UNIVASC	P			QLL
VASERETIC		NP		QLL
VASOTEC		NP		QLL
ZESTORETIC		NP		QLL
ZESTRIL		NP		QLL
ANGIOTENSIN II RECEPTOR ANTAGONISTS & COMBOS				
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
HYZAAR	P			QLL
MICARDIS	P			QLL
MICARDIS HCT	P			QLL
TEVETEN		NP	PA	QLL
TEVETEN HCT		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

PA** Requires PA if contingent therapy protocols not met

Georgia Medicaid/PeachCare Preferred Drug List

Effective June 1, 2008

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
OTHER ANTIHYPERTENSIVES				
amlodipine/benazepril		NP	PA	
AZOR		NP	PA	
EXFORGE		NP	PA	
INSPRA		NP		
LEXXEL	P			
LOTREL	P			
TARKA	P			
TEKTURNA	P		PA	
TEKTURNA HCT	P		PA	
NITRATES				
nitroglycerin patches generic	P			
NITROLINGUAL SPRAY	P			QLL
ANTIDYSRHYTHMIC DRUGS				
ETHMOZINE	P			
TONOCARD	P			
ANTILIPIDEMIC DRUGS				
ADVICOR	P			QLL
ALTOPREV (previously Altacor)		NP	PA	QLL
CADUET		NP	PA	QLL
COLESTID	P			
colestipol generic		NP	PA	
cholestyramine/cholestyramine lite generic	P			
CRESTOR	P		PA	QLL
LESCOL, -XL	P			QLL
LIPITOR		NP	PA	QLL
lovastatin generic	P			QLL
MEVACOR		NP		QLL
NIASPAN	P			
PRAVACHOL		NP	PA	QLL
pravastatin generic	P			QLL
PREVALITE	P			
simvastatin generic	P			QLL
SIMCOR		NP	PA	QLL
VYTORIN		NP	PA	QLL
WELCHOL		NP	PA	
XENICAL	P		PA	
ZETIA		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

PA** Requires PA if contingent therapy protocols not met

Georgia Medicaid/PeachCare Preferred Drug List

Effective June 1, 2008

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
ZOCOR		NP		QLL
FIBRIC ACID DERIVATIVES				
ANTARA		NP	PA	QLL
fenofibrate generic		NP	PA	QLL
FENOGLIDE		NP	PA	QLL
gemfibrozil generic	P			QLL
LIPOFEN		NP	PA	QLL
LOFIBRA		NP	PA	QLL
TRICOR	P			QLL
TRIGLIDE		NP	PA	QLL
OTHER CARDIOVASCULAR DRUGS				
BIDIL		NP	PA	QLL
LOVAZA (formerly OMACOR)		NP	PA	
PROAMATINE	P			
RANEXA		NP	PA	
DRUGS FOR PULMONARY HYPERTENSION				
epoprostenol	P			
FLOLAN		NP		
LETAIRIS		NP		
REVATIO	P		PA	QLL
REMODULIN	P			
TRACLEER	P			
VENTAVIS	P		PA	QLL
DRUGS FOR PHEOCHROMOCYTOMA				
DEMSER	P			
AUTONOMIC AND CNS MEDICATIONS				
NARCOTIC ANALGESICS				
ACTIQ		NP	PA	QLL
AVINZA		NP	PA	QLL
butorphanol nasal generic	P			QLL
COMBUNOX		NP	PA	QLL
DURAGESIC	P			QLL
fenentanyl citrate generic (generic Actiq)		NP	PA	QLL
fenentanyl patch generic (generic Duragesic)		NP	PA	QLL
FENTORA		NP	PA	QLL
KADIAN	P			QLL
morphine sulfate sa 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

PA** Requires PA if contingent therapy protocols not met

Georgia Medicaid/PeachCare Preferred Drug List

Effective June 1, 2008

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
OPANA/ER		NP	PA	QLL
ORAMORPH SR	P			QLL
oxycodone er generic		NP	PA	QLL
oxycodone/ibuprofen 5/400mg generic		NP	PA	QLL
OXYCONTIN		NP	PA	QLL
SUBOXONE	P		PA	QLL
SUBUTEX	P		PA	QLL
OTHER ANALGESICS				
tramadol generic	P			QLL
tramadol/acetaminophen generic	P			QLL
ULTRACET		NP		QLL
ULTRAM ER		NP		QLL
DRUGS TO PREVENT AND TREAT HEADACHES				
AMERGE	P			QLL
AXERT	P			QLL
FROVA	P			QLL
IMITREX (tabs, inj, ns)	P			QLL
MAXALT, -MLT	P			QLL
MIGRANAL NS		NP	PA	QLL
RELPAK	P			QLL
TREXIMET		NP	PA	QLL
ZOMIG, -ZMT	P			QLL
ANXIOLYTICS				
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
oxazepam generic	P		PA* (≥ 21 yrs)	QLL
temazepam generic	P		PA* (≥ 21 yrs)	QLL
SEDATIVE/HYPNOTIC DRUGS				
AMBIEN		NP		QLL
AMBIEN CR	P			QLL
LUNESTA	P			QLL

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

PA* Requires PA after (3) prescriptions per year

PA** Requires PA if contingent therapy protocols not met

Georgia Medicaid/PeachCare Preferred Drug List

Effective June 1, 2008

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
ROZEREM	P			QLL
SONATA	P			QLL
zolpidem generic	P			QLL
ANTIMANIA DRUGS				
lithium carbonate generic	P			
ANTICONVULSANT DRUGS				
carbamazepine generic	P			
CELONTIN	P			
DEPAKOTE, -ER	P			
DIASTAT	P		PA (≥ 21 yrs)	QLL
DILANTIN		NP		
DILANTIN INFATAB	P			
FELBATOL	P			
gabapentin	P			
GABITRIL		NP	PA	
KEPPRA	P			
LAMICTAL	P			
lamotrigine chewable dispersable tab generic		NP	PA	
LYRICA	P			QLL
NEURONTIN		NP	PA	
oxcarbazepine generic	P			
phenytoin generic	P			
TEGRETOL		NP		
TEGRETOL XR	P			
TOPAMAX	P			
TRILEPTAL		NP		
ZONEGRAN		NP	PA	
zonisamide generic	P			
SELECTIVE SEROTONIN REUPTAKE INHIBITORS				
CELEXA		NP		QLL
citalopram generic	P			QLL
fluoxetine generic	P			QLL
fluvoxamine generic	P			QLL
LEXAPRO	P			QLL
LUVOX CR		NP	PA	QLL
paroxetine generic	P			QLL
paroxetine SR		NP	PA	QLL
PAXIL		NP		QLL
PAXIL CR	P			QLL

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

PA* Requires PA after (3) prescriptions per year

PA** Requires PA if contingent therapy protocols not met

Georgia Medicaid/PeachCare Preferred Drug List

Effective June 1, 2008

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
PEXEVA	P			QLL
PROZAC		NP		QLL
RAPIFLUX		NP	PA	QLL
SARAFEM		NP	PA	QLL
sertraline generic	P			QLL
ZOLOFT		NP		QLL
NEW GENERATION ANTIDEPRESSANTS				
CYMBALTA		NP	PA	QLL
EFFEXOR, -XR	P			QLL
budeprion XL		NP	PA	QLL
bupropion/bupropion ER & SR generic	P			QLL
maprotiline generic	P			QLL
mirtazapine generic	P			QLL
nefazodone generic	P			QLL
PRISTIQ		NP	PA	QLL
REMERON		NP		QLL
trazodone generic	P			QLL
venlafaxine generic		NP	PA	QLL
WELLBUTRIN, -SR		NP		QLL
WELLBUTRIN-XL 150mg	P			QLL
WELLBUTRIN-XL 300mg		NP		QLL
MAO INHIBITORS				
EMSAM		NP	PA	QLL
NARDIL	P			
PARNATE	P			
ANTIVERTIGO AND ANTIEMETIC DRUGS				
ANZEMET		NP		QLL
CESAMET		NP	PA	QLL
EMEND		NP		QLL
EMEND SOLN.		NP	PA	QLL
granisetron		NP	PA	QLL
KYTRIL		NP		QLL
MARINOL	P		PA	
ondansetron generic	P			QLL
TRANSDERM-SCOP	P			
ZOFRAN, -ODT		NP		QLL
ZOFRAN inj.	P			
ZOFRAN soln.	P			QLL

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

PA* Requires PA after (3) prescriptions per year

PA** Requires PA if contingent therapy protocols not met

Georgia Medicaid/PeachCare Preferred Drug List

Effective June 1, 2008

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
ANTIPARKINSON DRUGS				
APOKYN	P			
AZILECT		NP		
bromocriptine generic	P			
COMTAN	P			
MIRAPEX	P			
REQUIP	P			
ropinirole		NP	PA	
ZELAPAR		NP	PA	
ATYPICAL ANTIPSYCHOTIC DRUGS				
ABILIFY		NP	PA	QLL
clozapine generic		NP		QLL
CLOZARIL		NP		QLL
FAZACLO		NP		QLL
GEODON	P			QLL
INVEGA	P			QLL
RISPERDAL CONSTA		NP	PA	QLL
RISPERDAL M-TAB		NP	PA	QLL
RISPERDAL TABS & SOLN	P			QLL
SEROQUEL	P			QLL
SEROQUEL XR	P			QLL
SYMBYAX		NP	PA	QLL
ZYPREXA		NP	PA	QLL
ZYPREXA INJECTABLE		NP		QLL
ZYPREXA ZYDIS		NP	PA	QLL
OTHER ANTIPSYCHOTIC DRUGS				
fluphenazine deconoate vial generic	P			QLL
haloperidol deconoate vial generic	P			QLL
MOBAN	P			
CNS STIMULANT DRUGS				
ADDERALL		NP	PA	QLL
ADDERALL XR	P		PA (≥ 21 years)	QLL
amphetamine salt combination generic	P		PA (≥ 21 years)	QLL
CONCERTA	P		PA (≥ 21 years)	QLL
DAYTRANA		NP	PA	QLL
DESOXYN		NP	PA	QLL
DEXEDRINE		NP	PA (≥ 21 years)	QLL
dextroamphetamine generic	P		PA (≥ 21 years)	QLL
DEXTROSTAT	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

PA** Requires PA if contingent therapy protocols not met

Georgia Medicaid/PeachCare Preferred Drug List

Effective June 1, 2008

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
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
METHYLIN CHEW TABS & SOLN	P		PA (≥ 21 years)	QLL
METHYLIN TABS	P		PA (≥ 21 years)	QLL
METHYLIN ER	P		PA (≥ 21 years)	QLL
methylphenidate generic	P		PA (≥ 21 years)	QLL
methylphenidate er generic	P		PA (≥ 21 years)	QLL
PROVIGIL		NP	PA	QLL
RITALIN		NP	PA (≥ 21 years)	QLL
RITALIN LA	P		PA (≥ 21 years)	QLL
RITALIN SR		NP	PA (≥ 21 years)	QLL
STRATTERA		NP	PA	QLL
VYVANSE	P		PA (≥ 21 years)	QLL
OTHER CNS/AUTONOMIC DRUGS				
PROSTIGMIN	P			
VIVITROL	P		PA	QLL
XYREM		NP	PA	QLL
ANTIDEMENTIA DRUGS				
ARICEPT	P			
COGNEX	P			
EXELON	P			
NAMENDA	P			
RAZADYNE (previously Reminyl)	P			
DRUGS TO TREAT MULTIPLE SCLEROSIS				
AVONEX, -AD	P			QLL
BETASERON, C-	P			QLL
COPAXONE	P			QLL
REBIF	P			QLL
TYSABRI	P		PA	QLL
MISCELLANEOUS				
BOTOX	P		PA (≥ 35 years)	QLL
CAMPRAL	P			
MYOBLOC	P		PA	QLL
DERMATOLOGICAL MEDICATIONS				
TOPICAL CORTICOSTEROID				

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

PA* Requires PA after (3) prescriptions per year

PA** Requires PA if contingent therapy protocols not met

Georgia Medicaid/PeachCare Preferred Drug List

Effective June 1, 2008

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
all generics	P			
ACLOVATE		NP		
CAPEX SHAMPOO		NP	PA	
clobetasol foam		NP	PA	
CLOBEX		NP	PA	
CLODERM		NP	PA	
CORDRAN		NP	PA	QLL
DERMA-SMOOTHIE OIL/FS		NP	PA	
DESONATE		NP	PA	
DESOWEN KIT		NP	PA	
CUTIVATE		NP	PA	
DIPROLENE OINT		NP		
DIPROLENE LOTION		NP	PA	
DIPROLENE AF		NP		
ELOCON		NP		QLL
HALOG, -E		NP	PA	
KENALOG		NP	PA	
LOCOID LIPO		NP	PA	
LUXIQ		NP	PA	
OLUX, -E		NP	PA	
PANDEL		NP	PA	
PSORCON E		NP	PA	
TEXACORT SOLN		NP	PA	
ULTRAVATE		NP		
ULTRAVATE KIT		NP	PA	
VANOS		NP	PA	
VERDESO		NP	PA	
ZYTOPIC		NP	PA	
TOPICAL ANTIACNE DRUGS				
ATRALIN GEL		NP	PA (≥ 21 years)	QLL
AVAR/AVAR-E		NP	PA (≥ 21 years)	
AZELEX		NP		
AVITA	P		PA (≥ 21 years)	QLL
BENZACLIN	P			
DIFFERIN	P		PA (≥ 21 years)	QLL
DUAC/DUAC CS	P			
METROCREAM	P			
metronidazole generic	P			
METROGEL	P			
METROLOTION	P			
NORITATE		NP		

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

PA* Requires PA after (3) prescriptions per year

PA** Requires PA if contingent therapy protocols not met

Georgia Medicaid/PeachCare Preferred Drug List

Effective June 1, 2008

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
PLEXION CLEANSING CLOTHS		NP		QLL
RETIN-A MICRO	P		PA (≥ 21 years)	QLL
ROSANIL		NP	PA (≥ 21 years)	
SALKERA		NP	PA	
TAZORAC	P		PA (≥ 21 years)	QLL
tretinoin generic	P		PA (≥ 21 years)	QLL
ZIANA		NP	PA (≥ 21 years)	
ORAL ANTIACNE DRUGS				
isotretinoin generic	P		PA	
COMBINATION ANTIACNE DRUGS				
BENZAMYCIN	P			
ANTIPSORIASIS AND ANTIECZEMA DRUGS				
calcipotriene soln.		NP	PA	
DOVONEX	P			
DRITHOCREME	P			
DRITHOCREME HP	P			
DRITHO-SCALP	P			
TACLONEX		NP	PA	
OTHER TOPICAL DERMATOLOGICAL DRUGS				
EFUDEX	P			
ELIDEL	P		PA	QLL
fluorouracil		NP	PA	
PANRETIN	P		PA	
PROTOPIC	P		PA	QLL
REGRANEX	P		PA	QLL
VUSION		NP	PA	
SCABICIDES				
ELIMITE	P			QLL
EURAX	P			QLL
LINDANE	P			QLL
OVIDE		NP		QLL
ROSACEA AGENTS				
ORACEA		NP	PA	QLL
EAR-NOSE-THROAT MEDICATIONS				
DRUGS AFFECTING THE EAR				

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

PA* Requires PA after (3) prescriptions per year

PA** Requires PA if contingent therapy protocols not met

Georgia Medicaid/PeachCare Preferred Drug List

Effective June 1, 2008

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
CERUMENEX	P			
CIPRODEX	P			QLL
CIPRO HC	P			
FLOXIN OTIC	P			
neomycin/polymyxin/hc generic	P			QLL
ofloxacin otic		NP	PA	
DRUGS AFFECTING THE NOSE				
ASTELIN	P			QLL
BECONASE AQ	P			QLL
FLONASE		NP	PA	QLL
flunisolide generic		NP	PA	QLL
fluticasone generic	P			QLL
ipratropium generic	P			QLL
NASACORT AQ	P			QLL
NASAREL		NP	PA	QLL
NASONEX	P			QLL
OMNARIS		NP	PA	QLL
PATANASE		NP	PA	QLL
RHINOCORT AQ		NP	PA	QLL
VANCENASE, -AQ		NP	PA	QLL
VERAMYST		NP	PA	QLL
DRUGS AFFECTING THE THROAT AND MOUTH				
EVOXAC	P			
pilocarpine tabs generic	P			
RADIACARE	P			
SALAGEN	P			
ENDOCRINE MEDICATIONS				
BONE OSSIFICATION AGENTS				
ACTONEL		NP	PA	QLL
ACTONEL WITH CALCIUM		NP	PA	QLL
alendronate generic		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
RECLAST		NP	PA	

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

PA* Requires PA after (3) prescriptions per year

PA** Requires PA if contingent therapy protocols not met

Georgia Medicaid/PeachCare Preferred Drug List

Effective June 1, 2008

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
INSULIN				
APIDRA		NP	PA	QLL
EXUBERA COMBINATION PACK		NP	PA	
EXUBERA KIT		NP	PA	QLL
HUMALOG		NP	PA	QLL
HUMALOG MIX 50/50	P			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
Humulin cartridges and pens		NP	PA	QLL
Novolin cartridges and pens	P		PA (≥ 21 years)	QLL
LANTUS	P			QLL
LANTUS pens and cartridges		NP	PA (≥ 21 years)	QLL
LEVEMIR	P			QLL
LEVEMIR FLEXPEN		NP	PA (≥ 21 years)	QLL
NOVOLIN	P			QLL
NOVOLOG	P			QLL
NOVOLOG pens and cartridges	P		PA (≥ 21 years)	QLL
ORAL HYPOGLYCEMIC DRUGS				
acarbose		NP	PA	
AMARYL	P			
glimepiride generic	P			
GLUCOTROL XL	P			
GLYSET	P			
PRANDIN	P			
PRECOSE	P			
STARLIX	P			
MISC. ANTIDIABETICS				
ACTOPLUS MET	P			QLL
ACTOS	P			QLL
AVANDAMET	P			QLL
AVANDARYL	P			QLL
AVANDIA	P			QLL
BYETTA	P		PA	QLL

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

PA* Requires PA after (3) prescriptions per year

PA** Requires PA if contingent therapy protocols not met

Georgia Medicaid/PeachCare Preferred Drug List

Effective June 1, 2008

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
DUETACT	P			QLL
FORTAMET ER	P			QLL
glipizide/metformin generic	P			QLL
glyburide	P			QLL
glyburide/metformin generic	P			QLL
GLUCOVANCE		NP		QLL
GLUMETZA ER		NP	PA	QLL
JANUMET	P		PA	
JANUVIA	P		PA	
METAGLIP		NP		QLL
metformin generic	P			QLL
RIOMET		NP	PA	QLL
SYMLIN	P		PA	QLL
THYROID SUPPLEMENTS				
CYOMEL	P			
levothyroxine generic	P			
SYNTHROID		NP		
THYROLAR	P			
THYROID STRONG	P			
MISC. ENDOCRINE DRUGS				
DDAVP NASAL	P			
DDAVP TAB	P			
DOSTINEX	P			QLL
ELAPRASE	P		PA	
EVISTA	P			
FORTEO		NP	PA	
MYOZYME		NP		
ORAPRED ODT		NP	PA	
ORFADIN	P			QLL
SKELID		NP		
ANABOLIC STEROIDS				
ANADROL-50	P		PA	
oxandrolone	P		PA	QLL
GASTROINTESTINAL MEDICATIONS				
ANTIULCER DRUGS				
cimetidine 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

PA** Requires PA if contingent therapy protocols not met

Georgia Medicaid/PeachCare Preferred Drug List

Effective June 1, 2008

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
famotidine generic	P			QLL
nizatidine generic	P			QLL
ranitidine generic	P			QLL
ZANTAC SYRUP	P			QLL
PROTON PUMP INHIBITORS (PPI)				
ACIPHEX		NP	PA	QLL
NEXIUM	P		PA	QLL
omeprazole generic		NP	PA	QLL
pantoprazole 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
HELICOBACTER PYLORI DRUGS				
HELIDAC		NP		
PREVPAC	P			QLL
PYLERA		NP		
OTHER GI DRUGS				
AMITIZA		NP	PA	
ASACOL	P			
AZULFIDINE EN-TAB	P			
balsalazide		NP	PA	
CIMZIA		NP	PA	QLL
COLAZAL		NP		
CORTIFOAM	P			
COTAZYM	P			
DIPENTUM		NP		
glycolax generic	P		PA	QLL
hydrocortisone acetate cream generic	P			QLL
IB STAT ORAL SPRAY		NP		QLL
KUZYME	P			
lactulose generic	P		PA	
LIALDA		NP		
LOTRONEX		NP		QLL
MIRALAX		NP	PA	QLL
MOVIPREP		NP		
NULYTELY		NP		QLL

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

PA* Requires PA after (3) prescriptions per year

PA** Requires PA if contingent therapy protocols not met

Georgia Medicaid/PeachCare Preferred Drug List

Effective June 1, 2008

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
OCL	P			QLL
PANCREASE	P			
PENTASA	P			
polyethylene glycol generic	P		PA	
PROCTOFOAM-HC	P			
RELISTOR		NP	PA	QLL
ROWASA	P			
ULTRASE/ULTRASE MT	P			
URSO	P			
VIOKASE	P			
<i>IMMUNOLOGICALS</i>				
ACTIMMUNE	P		PA	
ALFERON N	P		PA	
ARANESP	P		PA	QLL
CARIMUNE	P		PA	
COPEGUS		NP		
CYTOGAM	P		PA	
EPOGEN	P		PA	
GAMMAGARD	P		PA	
GAMMAR	P		PA	
GAMUNEX	P		PA	
HEPAGAM B		NP	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	
SYNAGIS	P		PA	QLL

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

PA* Requires PA after (3) prescriptions per year

PA** Requires PA if contingent therapy protocols not met

Georgia Medicaid/PeachCare Preferred Drug List

Effective June 1, 2008

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
VENOGLOBULIN	P		PA	
VIVAGLOBIN	P		PA	
GROWTH HORMONES				
GENOTROPIN	P		PA	
HUMATROPE		NP	PA	
NORDITROPIN	P		PA	
NUTROPIN, -AQ	P		PA	
OMNITROPE		NP	PA	
SAIZEN		NP	PA	
SEROSTIM		NP	PA	
TEV-TROPIN		NP	PA	
GROWTH FACTORS				
INCRELEX		NP	PA	
MUSCULOSKELETAL MEDICATIONS				
NON-STEROIDAL ANTIINFLAMMATORY AGENTS				
ARTHROTEC		NP	PA	QLL
CELEBREX	P		PA	QLL
FLECTOR PAD		NP	PA	
generic NSAIDs	P			QLL
ketorolac generic	P			QLL
meloxicam suspension generic		NP	PA	QLL
meloxicam tabs generic	P			QLL
MOBIC		NP		QLL
NALFON		NP	PA	QLL
NAPRELAN		NP	PA	QLL
PONSTEL		NP	PA	QLL
VOLTAREN GEL		NP	PA	
OTHER DRUGS FOR ARTHRITIS				
CUPRIMINE	P			
SKELETAL MUSCLE RELAXANTS				
AMRIX		NP	PA	
DANTRIUM	P			
NUTRITION / BLOOD MODIFIERS / ELECTROLYTES				
END STAGE RENAL DISEASE				
aluminum carbonate generic	P		PA	
aluminum hydroxide 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

PA** Requires PA if contingent therapy protocols not met

Georgia Medicaid/PeachCare Preferred Drug List

Effective June 1, 2008

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
calcitriol generic	P			
calcium carbonate generic	P		PA	
calcium carbonate/glycine generic	P		PA	
calcium lactate	P		PA	
DIATX	P		PA	
docusate sodium/calcium	P		PA	
ergocalciferol generic	P			
folic acid 1mg generic	P			QLL
FOSRENOL		NP	PA	
GLUTOFAC-MX		NP	PA	
GLUTOFAC-ZX	P		PA	
HECTOROL		NP	PA	
levocarnitine generic	P			
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	P		PA	QLL
RENAX	P		PA	
REVELA		NP	PA	QLL
SENSIPAR		NP		
sodium bicarbonate generic	P		PA	
thiamine (vitamin B-1) generic	P		PA	
vitamin B complex generic	P		PA	
vitamin B-12 injection generic	P			
vitamin E capsules & drops	P		PA	
ZEMPLAR		NP	PA	
ORAL ANTICOAGULANTS, VITAMIN K				
COUMADIN		NP		
MEPHYTON	P			
warfarin sodium generic	P			
HEPARIN AND HEPARIN ANTAGONISTS				
ARIXTRA		NP		QLL
FRAGMIN	P			QLL
HEPARIN SODIUM	P			
INNOHEP	P			QLL
LOVENOX	P			QLL

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

PA* Requires PA after (3) prescriptions per year

PA** Requires PA if contingent therapy protocols not met

Georgia Medicaid/PeachCare Preferred Drug List

Effective June 1, 2008

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
ORGARAN	P			
ANTIPLATELET DRUGS				
AGGRENOX	P			
clopidogrel generic	P			QLL
PLAVIX	P			QLL
CHELATING AGENT				
EXJADE	P			
COMPLEMENT INHIBITORS				
Soliris	P		PA	
OTHER				
KUVAN	P			
OBSTETRICAL & GYNECOLOGICAL MEDICATIONS				
SPECIALIZED OB/GYN DRUGS				
SYNAREL	P			
ANDROGEN DRUGS				
ANDRODERM PATCH	P		PA	QLL
ANDROGEL		NP	PA	QLL
DELATESTRYL	P		PA	
DEPO-TESTOSTERONE	P		PA	
TESTIM		NP	PA	QLL
testosterone injection generic	P		PA	
ESTROGEN DRUGS				
ALORA	P			QLL
CENESTIN		NP		
CLIMARA PRO PATCH	P			QLL
DIVIGEL		NP	PA	
ELESTRIN		NP	PA	
ESTRACE	P			QLL
ESTRADERM	P			QLL
estradiol patch generic	P			QLL
ESTRASORB		NP	PA	
ESTRATAB	P			
ESTROGEL		NP	PA	QLL
EVAMIST		NP	PA	
MENEST	P			

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

PA* Requires PA after (3) prescriptions per year

PA** Requires PA if contingent therapy protocols not met

Georgia Medicaid/PeachCare Preferred Drug List

Effective June 1, 2008

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			
VIVELLE, -DOT	P			QLL
ESTROGEN/PROGESTIN COMBINATIONS				
ACTIVELLA		NP		
COMBIPATCH	P			
estradiol/norethindrone		NP	PA	
FEMHRT	P			
FEMRING		NP		QLL
ORTHO-PREFEST		NP		
PREMPHASE	P			
PREMPRO	P			
PROGESTIN DRUGS				
CRINONE GEL		NP	PA	
MEGACE ES		NP	PA	
PROMETRIUM	P			
CONTRACEPTIVES				
ALESSE	P			
CYCLESSA		NP		
ESTROSTEP FE		NP		
jolessa generic	P			QLL
LYBREL	P		PA	
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
quasense generic	P			QLL
SEASONALE		NP		QLL
SEASONIQUE		NP		QLL
TRI-NORINYL		NP		
YASMIN		NP		
OPHTHALMIC MEDICATIONS				
OPHTHALMIC QUINOLONES				
CILOXAN ophth. soln.		NP	PA	QLL
CILOXAN ophth. oint.	P			

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

PA* Requires PA after (3) prescriptions per year

PA** Requires PA if contingent therapy protocols not met

Georgia Medicaid/PeachCare Preferred Drug List

Effective June 1, 2008

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
ciprofloxacin HCL drops	P			QLL
IQUIX		NP	PA	
OCUFLOX		NP	PA	QLL
ofloxacin drops generic	P			QLL
QUIXIN		NP	PA	QLL
VIGAMOX	P			QLL
ZYMAR		NP	PA	QLL
OPHTHALMIC CORTICOSTEROID DRUGS				
ALREX		NP		QLL
FML-FORTE	P			QLL
LOTEMAX		NP		QLL
VEXOL		NP		QLL
OPHTHALMIC COMBINATIONS				
COMBIGAN		NP	PA	QLL
FML-S	P			
TOBRADEX	P			
TOPICAL ANTIGLAUCOMA DRUGS				
ALPHAGAN-P	P			
AZOPT	P			
BETIMOL	P			
BETOPTIC S	P			
COSOPT	P			
ISOPTO CARBACHOL	P			
LUMIGAN		NP	PA	QLL
P1-E1 /P2-E1/P3-E1	P			
PHOSPHOLINE IODIDE	P			
pilocarpine generic		NP	PA	QLL
PILOPINE H.S.	P			
TRAVATAN/Z	P			QLL
TRUSOPT	P			
XALATAN	P			QLL
OPHTHALMIC ANTIHISTAMINES				
ELESTAT		NP	PA	QLL
EMADINE		NP	PA	QLL
OPTIVAR	P			QLL
PATADAY	P			
PATANOL	P			QLL

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

PA* Requires PA after (3) prescriptions per year

PA** Requires PA if contingent therapy protocols not met

Georgia Medicaid/PeachCare Preferred Drug List

Effective June 1, 2008

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
OPHTHALMIC MAST CELL STABILIZERS				
ALAMAST	P			QLL
ALOCRIIL	P			QLL
ALOMIDE	P			QLL
CROLOM	P			QLL
cromolyn sodium generic	P			QLL
OTHER OPTHALMIC DRUGS				
ACULAR	P			QLL
ACULAR LS	P			QLL
ACULAR PF		NP		QLL
ALREX		NP		QLL
AZASITE		NP	PA	
CHIBROXIN		NP		
diclofenac		NP	PA	
IOPIDINE		NP		
LIVOSTIN		NP		
neomycin/polymixin/hc generic	P			QLL
NEVANAC		NP		
RESTASIS	P			QLL
RETISERT		NP	PA	
VOLTAREN		NP	PA	
XIBROM		NP		
RESPIRATORY MEDICATIONS				
BRONCHODILATORS AND RELATED DRUGS				
ACCUNEB		NP	PA	QLL
albuterol inhaler generic	P			QLL
albuterol for nebulization generic 2.5mg/3ml, 5mg/ml	P			QLL
albuterol for nebulization generic 0.63mg/3ml, 1.25mg/3ml		NP	PA	QLL
ALUPENT	P			
BROVANA		NP	PA	
FORADIL	P			QLL
MAXAIR AUTOHALER	P			QLL
metaproterenol for nebulization generic	P			QLL
PERFOROMIST NEB		NP	PA	QLL
PROVENTIL FOR NEBULIZATION		NP		QLL
PROVENTIL HFA	P			QLL
SEREVENT DISKUS	P			QLL
theophylline generic	P			
UNIPHYL		NP		

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

PA* Requires PA after (3) prescriptions per year

PA** Requires PA if contingent therapy protocols not met

Georgia Medicaid/PeachCare Preferred Drug List

Effective June 1, 2008

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
VENTOLIN HFA	P			QLL
XOPENEX		NP	PA (> 8 years)	QLL
XOPENEX HFA		NP	PA	QLL
COPD ANTICHOLINERGICS				
albuterol/ipratropium neb soln generic		NP	PA	QLL
ATROVENT HFA	P			QLL
DUONEB		NP	PA	QLL
COMBIVENT	P			QLL
ipratropium generic	P			QLL
SPIRIVA	P			QLL
OTHER DRUGS FOR ASTHMA				
INTAL INHALER	P			QLL
TILADE	P			QLL
XOLAIR		NP	PA	
PULMONARY ANTIINFLAMMATORY DRUGS				
ADVAIR DISKUS/HFA	P			QLL
AEROBID		NP	PA	QLL
AEROBID-M		NP	PA	QLL
ASMANEX TWISTHALER	P			QLL
AZMACORT	P			QLL
FLOVENT HFA	P			QLL
PULMICORT TURBUHALER/FLEXHALER		NP	PA	QLL
PULMICORT RESPULES	P			QLL
QVAR	P			QLL
SYMBICORT	P			QLL
LEUKOTRIENE MODIFIERS				
ACCOLATE	P		PA	QLL
SINGULAIR	P		PA	QLL
ZYFLO CR		NP	PA	QLL
ANTIHISTAMINE AND DECONGESTANT DRUGS				
ALLEGRA, ALLEGRA ODT	P		PA	QLL
ALLEGRA-D	P		PA	QLL
ALLEGRA SUSP	P		PA	QLL
CLARINEX-D	P		PA	QLL
CLARINEX TABLETS	P		PA	QLL
CLARINEX REDITABS	P		PA	QLL
CLARINEX SYRUP	P		PA (> 2 yr old)	QLL

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

PA* Requires PA after (3) prescriptions per year

PA** Requires PA if contingent therapy protocols not met

Georgia Medicaid/PeachCare Preferred Drug List

Effective June 1, 2008

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
fexofenadine generic	P		PA	QLL
loratadine, -D generic OTC	P			QLL
SEMPREX-D	P			
XYZAL		NP	PA	QLL
XYZAL soln.		NP	PA	QLL
ZYRTEC SYRUP	P		PA (≥ 2 yr old)	QLL
ZYRTEC	P		PA	QLL
ZYRTEC-D	P		PA	QLL
OTHER RESPIRATORY DRUGS				
EPIPEN	P			QLL
UROLOGICAL/RENAL MEDICATIONS				
CALCIBIND	P			
DETROL	P			QLL
DETROL LA	P			QLL
DITROPAN XL		NP	PA	QLL
ELMIRON	P			
ENABLEX	P			QLL
flavoxate generic	P			QLL
oxybutynin generic	P			QLL
oxybutynin ER generic		NP	PA	QLL
OXYTROL	P			QLL
SANCTURA	P			QLL
SANCTURA XR	P			QLL
VESICARE	P			QLL
DRUGS FOR BPH				
AVODART	P			QLL
finasteride generic		NP	PA	QLL
FLOMAX	P			QLL
PROSCAR	P			QLL
UROXATRAL	P			QLL
DIABETIC SUPPLIES				
METERS				
ACCU-CHEK ACTIVE	P		PA**	QLL
ACCU-CHEK ADVANTAGE	P		PA**	QLL
ACCU-CHEK AVIVA	P		PA**	QLL
ACCU-CHEK COMPACT	P		PA**	QLL
ACCU-CHEK COMPLETE	P		PA**	QLL

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

PA* Requires PA after (3) prescriptions per year

PA** Requires PA if contingent therapy protocols not met

Georgia Medicaid/PeachCare Preferred Drug List

Effective June 1, 2008

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
TEST STRIPS				
ACCU-CHEK ACTIVE	P		PA**	QLL
ACCU-CHEK ADVANTAGE	P		PA**	QLL
ACCU-CHEK AVIVA	P		PA**	QLL
ACCU-CHEK COMFORT CURVE	P		PA**	QLL
ACCU-CHEK COMPACT	P		PA**	QLL
ACCU-CHEK EASY	P		PA**	QLL
ACCU-CHEK INSTANT/PLUS	P		PA**	QLL
ACCU-CHEK SIMPLICITY	P		PA**	QLL
LANCETS				
SOFTCLIX	P		PA**	QLL
SOFT TOUCH	P		PA**	QLL
MULTICLIX	P		PA**	QLL

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

PA* Requires PA after (3) prescriptions per year

PA** Requires PA if contingent therapy protocols not met