New Hampshire Department of Health and Human Services
Preferred Drug List (PDL)

NOTES:

* Indicates a generic is available without PA.
** Indicates when additional Prior Approval is required for the **therapeutic class**, even when using a preferred product.
*** Indicates when quantity limits apply.

This list may not include all available formulations listed specifically by name.

CARDIOVASCULAR - ACE INHIBITORS & COMBOS

Preferred

Benazepril (generic for Lotensin®)
Benazepril HCT (generic for Lotensin HCT®)
Captopril (generic for Capoten®)
Captopril-HCTZ (generic for Capozide®)
Enalapril (generic for Vasotec®)
Enalapril HCTZ (generic for Vaseretic®)
Lisinopril (generic for Prinivil® and Zestril®)
Lisinopril HCTZ (generic for Prinzide® and Zestoretic®)
Lotrel®

Non-Preferred

Accupril®
Accuretic®
Aceon®
Altace®
Capoten®*
Capozide®*
Fosinopril
Fosinopril HCT
Lexxel®
Lotensin®*
Lotensin HCT®*
Mavik®
Moexipril
Monopril®
Monopril HCT®
Prinivil®*
Prinzide®*
Quinapril
Quinapril/HCTZ
Quinaretic®
Tarka®
Uniretic®
Univasc®
Vaseretic®*
Vasotec®*
Zestoretic®*
Zestril®*

CARDIOVASCULAR – ANGIOTENSIN II RECEPTOR BLOCKERS & COMBOS

Preferred

Cozaar®
Diovan®
Diovan HCT®
Hyzaar®

Non-Preferred

Atacand®
Atacand HCT®
Avalide®
Avapro®
Benicar®
Benicar HCT®
Micardis®
Micardis HCT®
Teveten®
Teveten HCT®

CARDIOVASCULAR - CALCIUM CHANNEL BLOCKERS (DHP) & COMBOS

Preferred

Afeditab CR® (generic for Adalat CC®)
Dynacirc®
Dynacirc CR®
Felodipine (generic for Plendil®)
Lotrel®
Nicardipine (generic for Cardene®)
Nifediac CC (generic for Adalat CC®)
Nifedical XL (generic for Procardia XL®)
Nifedipine IR (generic for Procardia®)
Nifedipine SA/ER (generic for Procardia XL®)
Norvasc®
Plendil®
Sular®

Non-Preferred

Adalat®*
Adalat CC®*
Caduet®
Cardene®*
Cardene SR®
Lexxel®
Nimotop®
Procardia®*
Procardia XL®*

CARDIOVASCULAR – CALCIUM CHANNEL BLOCKERS (NON-DHP) & COMBOS

Preferred

Cartia XT®
Diltia XT®
Diltiazem ER (generic for Cardizem CD®)
Diltiazem HCL (generic for Cardizem®)
Diltiazem SR (generic for Cardizem SR®)
Diltiazem XR (generic for Dilacor XR®)
Taztia XT®
Verapamil (generic for Calan®, Isoptin® and Verelan®)
Verapamil ER (generic for Calan SR® and Isoptin SR®)

Non-Preferred

Calan®*
Calan SR®*
Cardizem®*
Cardizem CD®*
Cardizem LA®
Cardizem SR®*
Covera-HS®
Dilacor XR®*
Isoptin®*
Isoptin SR®*
Tarka®
Tiazac®
Vascor®
Verelan®*
Verelan PM®

New Hampshire Department of Health and Human Services
Preferred Drug List (PDL)

CARDIOVASCULAR - BETA-BLOCKERS & COMBOS

Preferred

Acebutolol (generic for Sectral®)
Atenolol (generic for Tenormin®)
Atenolol/Chlorthalidone (generic for Tenoretic®)
Betaxolol (generic for Kerlone®)
Bisoprolol (generic for Zebeta®)
Bisoprolol /HCTZ(generic for Ziac®)
Inderal LA®
Labetalol (generic for Normodyne® and Trandate®)
Metoprolol (generic for Lopressor®)
Nadolol (generic for Corgard®)
Pindolol (generic for Visken®)
Propanolol (generic for Inderal®)
Propranolol/HCTZ (generic for Inderide®)
Sotalol (generic for Betapace AF®)
Sotalol HCL (generic for Betapace®)
Timolol (generic for Blocadren®)

Non-Preferred

Betapace®*
Betapace AF®*
Blocadren®*
Cartrol®
Corgard®*
Corzide®*
Inderal®*
Inderide®
Innopran XL®
Kerlone®*
Levatol®
Lopressor®*
Normodyne®*
Sectral®*
Sorine®
Tenormin®*
Tenoretic®
Timolide®
Toprol XL®
Trandate®*
Zebeta®*
Ziac®

CARDIOVASCULAR – STATINS & COMBOS

Preferred

Altoprev® (formerly Altocor®)
Lescol®
Lescol XL®
Lovastatin (generic for Mevacor®)

Non-Preferred

Advicor®
Mevacor®*
Pravachol®
Pravigard PAC®

CARDIOVASCULAR – HIGH POTENCY STATINS & COMBOS

Preferred

Crestor®
Zocor®
Vytorin®

Non-Preferred

Caduet®
Lipitor®

GASTROINTESTINAL – PROTON PUMP INHIBITORS & COMBOS

*** Indicates when additional Prior Approval is required for the therapeutic class, including when using preferred product.*

Preferred**

Nexium®
Prevacid® capsules
Prilosec® (OTC)

****Criteria for approval:**
First 8 weeks do not require prior approval for preferred drugs.
Erosive Esophagitis Grade 2 or greater
Barrett's Esophagus
Zollinger-Ellison Syndrome
GERD
+ H. Pylori diagnosis
Active GI Bleed
Hyperacidity in CF patients
LTC, Hospice, or End of Life patients

Non-Preferred**

Aciphex®
Omeprazole (generic for Prilosec®) (RX/OTC)
Prevacid Solutab®
Prevacid Susp®
Prevacid Naprapac®
Prevacid PrevPAK®
Prilosec® (RX)
Protonix®
Zegerid®

New Hampshire Department of Health and Human Services
Preferred Drug List (PDL)

GASTROINTESTINAL - HEPATITIS C AGENTS

Pegylated Interferon Alpha Products

Preferred	Non-Preferred
Pegasys®	PEG-Intron®
Pegasys® Conv. Pack	PEG-Intron® Redipen

Ribavirin Products

Preferred	Non-Preferred	
Copegus®	Rebetol®	Ribasphere
	Ribavirin	

ENDOCRINOLOGY - BISPHOSPHONATES

Preferred	Non-Preferred
Actonel®	Fosamax®
	Fosamax Sol®

ENDOCRINOLOGY - INSULINS

Rapid Acting

Preferred	Non-Preferred
Novolog®	Humalog®

Short Acting

Preferred	Non-Preferred
Novolin R®	Humulin R®
Relion R®	

Intermediate Acting

Preferred	Non-Preferred
Humulin L®	Humulin N®
Novolin N®	
Relion N®	

Long Acting

Preferred	Non-Preferred
Lantus®	
Humulin U®	

Premixed Combinations

Preferred	Non-Preferred
Novolin 70/30®	Humulin 50/50®
Novolog Mix 70/30®	Humulin 70/30®
Relion 70/30®	Humulog Mix 75/25®

ENDOCRINOLOGY – BIGUANIDES & COMBOS

Preferred	Non-Preferred	
Metformin (generic for Glucophage®)	Avandamet®	Metaglip®
Metformin-Glyburide (generic for Glucovance®)	Glucophage®*	Riomet®
Metformin XL	Glucophage XL®*	
	Glucovance®*	

New Hampshire Department of Health and Human Services
Preferred Drug List (PDL)

ENDOCRINOLOGY - MEGLITINIDES

Preferred	Non-Preferred
Starlix®	Prandin®

ENDOCRINOLOGY – ALPHA-GLUCOSIDASE INHIBITORS

Preferred	Non-Preferred
Glyset® Precose®	

ENDOCRINOLOGY- 2ND GENERATION SULFONYLUREAS & COMBOS

Preferred	Non-Preferred	
Glipizide (generic for Glucotrol®) Glipizide ER (generic for Glucotrol XL®) Glyburide (generic for Micronase®, DiaBeta®) Glyburide Micronized (Glynase®) Glyburide-Metformin (generic for Glucovance®)	Amaryl® Diabeta®* Glucotrol®* Glucotrol XL®*	Glucovance®* Glynase®* Micronase®*

ENDOCRINOLOGY – THIAZOLIDINEDIONES & COMBOS

Preferred	Non-Preferred
Actos®	Avandia® Avandamet®

ANALGESICS – LONG ACTING NARCOTICS

Preferred	Non-Preferred
Avinza® Duragesic® Kadian® Morphine Sulfate SA (generic MS Contin®) Oramorph SA (generic for MS Contin®) Oxycontin®	MS Contin® Oxycodone SA Fentanyl Patch

**ANALGESIC ANTI-INFLAMMATORY – **COX 2 INHIBITORS

*** Indicates when additional Prior Approval is required for the therapeutic class, including when using preferred product.*

**Preferred	**Non-Preferred
Celebrex®	

****Criteria for approval:**
Hx of GI bleed or PUD, or concurrent steroid. No PA needed if age > 75 (as of 6/1/05).

ANTIBIOTICS – 2ND GENERATION CEPHALOSPORINS

Preferred	Non-Preferred	
Cefaclor Susp (generic for Ceclor®) Cefuroxime (generic for Ceftin®) Cefzil Susp®	Ceclor®* Ceclor CD® Cefaclor Caps® Cefaclor CD/ER® Ceftin®*	Ceftin Susp® Cefzil Tabs® Lorabid® Lorabid Susp® Raniclor®

New Hampshire Department of Health and Human Services
Preferred Drug List (PDL)

ANTIBIOTICS – 3RD GENERATION CEPHALOSPORINS

Preferred	Non-Preferred
Cedax®	Spectracef®
Cedax Susp®	Vantin®
Cefpodoxime (generic for Vantin®)	Vantin Susp®*
Omnicef®	
Omnicef Susp®	
Suprax ®	

ANTIBIOTICS - MACROLIDES

Preferred	Non-Preferred
Biaxin®	Dynabac®
Biaxin Susp®	E.E.S®*
Biaxin XL®	E-Mycin®*
Ery-Tab®	Eryc®*
Erythromycin Stearate	Eryped* Susp/Chew®
Erythromycin Base (generic for E-Mycin®)	Eryped 200* Susp®
Erythromycin Ethylsuccinate (generic for E.E.S.®)	Eryped 400* Susp®
Erythromycin/Sulfisoxazole (generic for Pediazole®)	Pediazole®
Zithromax®	PCE®*
Zithromax Susp®	

ANTIFUNGALS - **ONYCHOMYCOSIS

*** Indicates when additional Prior Approval is required for the therapeutic class, including when using preferred product.*

**Preferred	**Non-Preferred
Lamisil®	Itraconazole
Penlac®	Sporanox®

**Criteria for approval:
Positive KOH/PAS stain or + fungal culture. PT has pain. For Sporonox®, PT must also have immunosuppression, diabetes, or peripheral vascular compromise. Penlac® requires failure of Lamisil®/Sporanox®

ANTIBIOTICS – ***2ND GENERATION QUINOLONES

Qty limits apply

***Preferred	***Non-Preferred	
Ciprofloxacin	Cipro®*	Maxaquin®
Cipro Susp®	Cipro XR®	Noroxin®
Ofloxacin (generic for Floxin®)	Floxin®	

ANTIBIOTICS – ***3RD GENERATION QUINOLONES

Qty limits apply

***Preferred	***Non-Preferred
Avelox®	Factive®
Avelox ABC®	Levaquin®
	Levaquin Oral Suspension®
	Tequin®

ANTIBIOTICS – HERPETIC ANTIVIRALS

Preferred	Non-Preferred
Acyclovir (generic for Zovirax®)	Valtrex®
Famvir®	Zovirax®*
	Zovirax Susp®*

New Hampshire Department of Health and Human Services
Preferred Drug List (PDL)

RESPIRATORY – SHORT ACTING BETA ADRENERGICS – INHALERS/NEBS

Preferred

Albuterol (generic for Proventil® and Ventolin®) MDI/Neb
Metaproterenol (generic for Alupent®) Neb

Non-Preferred

Albuterol HFA
Alupent®*
Brethair®
Maxair®
Proventil®*
Proventil HFA®
Ventolin®*
Ventolin HFA®
Accuneb®*
Airet®* neb
Alupent®* neb
Proventil®* neb and sol
Ventolin®* neb and sol
Xopenex®

RESPIRATORY – LONG ACTING BETA ADRENERGICS

Preferred

Serevent Diskus®

Non-Preferred

Foradil®

RESPIRATORY – INHALED CORTICOSTEROIDS

Preferred

Azmacort®
Flovent®
Flovent HFA®
QVAR®

Non-Preferred

Aerobid/Aerobid M®
Beclovent®
Flovent Rotadisk®
Pulmicort® (No PA required for children age 5 and under)
Vanceril®

**RESPIRATORY – *****NASAL CORTICOSTEROIDS

***Preferred

Flunisolide (generic for Nasarel®)
Nasalide®
Nasonex®

Qty limits apply

***Non-Preferred

Beconase AQ®
Flonase®
Nasacort AQ®
Nasarel®
Rhinocort®
Rhinocort Aqua®
Tri-Nasal®
Vancenase®
Vancenase AQ®

RESPIRATORY – LEUKOTRIENE MODIFIERS

Recipients ≤ 10 years of age will be exempt from the PDL in the LTRA category

Preferred

Accolate®

Non-Preferred

Singulair®

OPHTHALMIC/GLAUCOMA – ALPHA 2 ADRENERGIC AGENTS

Preferred

Alphagan P®
Brimonidine (generic for Alphagan®)
Iopidine®

Non-Preferred

OPHTHALMIC/GLAUCOMA – BETA BLOCKER AGENTS

Preferred

Betaxolol (generic for Betoptic®)
Betoptic S®
Carteolol (generic for Ocupress®)
Levobunolol (generic for Betagan®)
Metipranolol (generic for OptiPranolol®)
Timolol (generic for Timoptic®)
Timolol XE (generic for Timoptic XE®)

Non-Preferred

Akbeta®*
Betagan®*
Betimol®*
Betoptic®*
Istalol®*
Ocupress®*
Optipranolol®*
Timoptic®*
Timoptic XE®*

New Hampshire Department of Health and Human Services
Preferred Drug List (PDL)

OPHTHALMIC/GLAUCOMA – CARBONIC ANHYDRASE INHIBITORS

Preferred	Non-Preferred
Azopt® Trusopt®	Cosopt®

OPHTHALMIC/GLAUCOMA – PROSTAGLANDIN AGONISTS

Preferred	Non-Preferred
Lumigan® Travatan®	Rescula® Xalatan®

OPHTHALMIC/ANTIHISTAMINES – ANTIHISTAMINES

Preferred	Non-Preferred
Elestat® Zaditor®	Emadine® Livostin® Optivar® Patanol®

OPHTHALMIC/ANTIBIOTIC – QUINOLONES

Preferred	Non-Preferred
Ciprofloxacin (generic for Ciloxan®) Vigamox®	Ciloxan®* Ocuflox® Ofloxacin Quixin® Zymar®

BEHAVIORAL HEALTH – ATYPICAL ANTIPSYCHOTICS & COMBOS

Preferred

Clozapine (generic for Clozaril®)
Risperdal®
Seroquel®

Failure on one agent qualifies recipient for progression to a non-preferred agent.

Non-Preferred

Abilify®
Abilify Oral Solution®
Clozaril®*
Fazalco®
Geodon®
Geodon IM®
Risperdal MT®
Risperdal Consta®
Symbyax®
Zyprexa®
Zyprexa IM®
Zyprexa Zydis®

BEHAVIORAL HEALTH – NOVEL ANTIDEPRESSANTS

Preferred

Bupropion (generic for Wellbutrin®)
Bupropion SA (generic for Wellbutrin SR®)
Budeprion SR (generic for Wellbutrin SR®)
Mirtazapine (generic for Remeron®)
Mirtazapine RapDis (generic for Remeron Sol-Tabs®)
Nefazodone (generic for Serzone®)
Trazodone (generic for Desyrel®)

Non-Preferred

Cymbalta®
Desyrel®*
Effexor®
Effexor XR®
Remeron®*
Remeron Sol-Tabs®*
Serzone®*
Wellbutrin®*
Wellbutrin SR®*
Wellbutrin XL®

New Hampshire Department of Health and Human Services
Preferred Drug List (PDL)

BEHAVIORAL HEALTH – ANXIOLYTICS

Preferred

Alprazolam (generic for Xanax®)
Buspirone (generic for Buspar®)
Chlordiazepoxide (generic for Librium®)
Clonazepam (generic for Klonopin®)
Clorazepate (generic for Tranxene®)
Diazepam (generic for Valium®)
Lorazepam (generic for Ativan®)
Oxazepam (generic for Serax®)

Non-Preferred

Ativan®*
Buspar®*
Klonopin®*
Klonopin Wafers®
Serax®*
Tranxene®*
Xanax®*
Xanax XR®

BEHAVIORAL HEALTH – SEROTONIN REUPTAKE INHIBITORS & COMBOS

Preferred

Citalopram (generic for Celexa®)
Fluoxetine (generic for Prozac®)
Fluvoxamine (generic for Luvox®)
Lexapro®
Paroxetine (generic for Paxil®)

Recipients aged < 12 exempt from PDL in SSRI category

Non-Preferred

Celexa®*
Luvox®*
Pexeva®
Paxil®*
Paxil CR®
Prozac®*
Prozac Weekly®
Sarafem®
Symbyax®
Zoloft®

BEHAVIORAL HEALTH – SEDATIVE HYPNOTICS

Preferred

Estazolam (generic for Prosom®)
Flurazepam (generic for Dalmane®)
Temazepam (generic for Restoril®)
Triazolam (generic for Halcion®)

Non-Preferred

Ambien®
Dalmane®*
Doral®
Halcion®*
Lunesta®
Prosom®*
Restoril®*
Sonata®

BEHAVIORAL HEALTH – ALZHEIMER'S AGENTS

Preferred

Aricept®
Exelon®

Non-Preferred

Cognex®
Razadyne® (formerly Reminyl®)
Namenda® - (not a cholinesterase inhibitor)

BEHAVIORAL HEALTH – **ANTIHYPERKINESIS

*** Indicates when additional Prior Approval is required for the therapeutic class, including when using preferred product.*

**Preferred

Adderall XR®
Ampehtamine Salt Combo (generic for Adderall®)
Dextroamphetamine (generic for Dexedrine®)
Dextroamphetamine SA (generic for Dexedrine SA®)
Dextrostat® (generic for Dexedrine®)
Focalin®
Metadate CD®
Metadate ER®
Methamphetamine (generic for Desoxyn®)
Methylin® (generic for Ritalin®)
Methylin ER® (generic for Ritalin SR®)
Methylphenidate(generic for Ritalin®)
Methylphenidate SR (generic for Ritalin SR®)
Ritalin LA®

**Non-Preferred

Adderall®*
Concerta®
Desoxyn®*
Dexedrine®*
Dexedrine Elixir®
Dexedrine SA®*
Ritalin®*
Ritalin SR®*
Strattera®

****Criteria for approval**:
≤ 21 years of age exempt from prior approval for preferred drugs.
> 21 years of age requires:
Dx = narcolepsy, DSM-IV-TR-2000.
See ADHD clinical criteria.

New Hampshire Department of Health and Human Services
Preferred Drug List (PDL)

MISC – TRIPTANS

Qty limits apply

Preferred	Non-Preferred	
Maxalt®	Amerge®	Imitrex®
Maxalt MLT®	Axert®	Imitrex RDT®
Zomig®	Frova®	Imitrex Kit®
Zomig Nasal®	Relpax®	Imitrex Vial®
Zomig ZMT®		Imitrex Nasal®

MISC – ANTIEMETICS

Qty limits apply

Preferred	Non-Preferred	
Kytril®	Anzemet®	Zofran®
Kytril Sol®	Emend®	Zofran ODT®
		Zofran Sol®

MISC – LOW SEDATING ANTIHISTAMINES & COMBOS

Preferred	Non-Preferred		
Alavert®	Allegra®	Claritin Syrup OTC®*	Loratadine Dis (RX)
Loratadine (OTC) (generic for Claritin® OTC)	Allegra D®	Claritin Dis OTC ®*	Zyrtec®
Loratadine Syrup (OTC) (generic for Claritin Syrup® OTC)	Clarinex®	Claritin D OTC®*	Zyrtec D®
Loratadine Dis (OTC) (generic for Claritin Dis® OTC)	Clarinex Dis®	Loratadine (RX)	Zyrtec Chew®
Loratadine D (OTC) (generic for Claritin D® OTC)	Claritin OTC®*	Loratadine Syrup (RX)	Zyrtec Syrup®

MISC – **ERECTILE DYSFUNCTION AGENTS

*** Indicates when additional Prior Approval is required for the therapeutic class, including when using preferred product.*

Qty limits apply

**Preferred	**Non-Preferred
Levitra®	Cialis®
Viagra®	

****Criteria for Approval:**
Males Age ≥ 21 years
Dx of CAD, HTN, PVD, DM,
Coronary Bypass, Chemo, MS,
Prostatectomy, Trans-urethral resection,
Colon Surgery, Spinal Cord Inj

MISC – URINARY ANTISPASMODICS

Preferred	Non-Preferred
Oxybutynin (generic for Ditropan®)	Vesicare®
Enablex®	Ditropan XL®
Detrol LA®	Ditropan®*
	Sanctura®
	Detrol®