

Montana AIDS Drug Assistance Program (ADAP) Formulary September 2008

* Denotes restricted drug

Nucleoside Analogs (NRTI)

Combivir (AZT + 3TC) (zidovudine/lamivudine)
Emtriva (FTC) (emtricitabine)
Epivir (3TC) (lamivudine)
Epzicom (Epivir/Ziagen)
Retrovir (AZT, ZDV) (zidovudine)
Videx EC (ddl) (didanosine)
***Trizivir** (Combivir/Ziagen)
Truvada (Emtriva/Viread)
Viread (TDF) (tenofovir disoproxil fumarate)
Zerit (d4T) (stavudine)
Ziagen (ABC) (abacavir)

Non-Nucleoside Reverse Transcriptase Inhibitors (NNRTI)

***Intelence** (etravirine)
Rescriptor (DLV) (delavirdine)
Sustiva (EFV) (efavirenz)
Viramune (NVP) (nevirapine)

Combination NRTI and NNRTI

Atripla (Sustiva, Viread and Emtriva)

Protease Inhibitors (PI)

***Aptivus** (TPV) (tipranavir)
Crixivan (IDV) (indinavir)
Invirase (SQV) (saquinavir)
Kaletra (LPV/r) (lopinavir/ritonavir)
Lexiva (FPV) (fosamprenavir)
Norvir (RTV) (ritonavir)
***Prezista** (DRV) (darunavir)
Reyataz (ATV) (atazanavir sulfate)
Viracept (NFV) (nelfinavir)

Fusion Inhibitors

***Fuzeon** (enfuvirtide) **Access limited to one person at a time**

Entry Inhibitor

***Selzentry** (maraviroc)

Integrase Inhibitor

***Isentress** (raltegravir)

#28 ART #34 OI #66 Others 127 total

Guidelines available at

<http://www.aidsinfo.nih.gov/guidelines/GuidelineDetail.aspx?MenuItem=Guidelines&Search=Off&GuidelineID=7&ClassID=1>

3/4/2009

Opportunistic Infection Medications

Antivirals

Acyclovir 800 (1/2 BID)
Aldera Cream
Foscavir (foscarnet)
Valcyte (Valgancyclovir)
Valtrex (valacyclovir)

Anti-Influenza

Amantadine
Tamiflu

Antibiotics

Amoxicillin
Bactrim (SMZ/TMP)
Biaxin (clarithromycin)
Ciprofloxacin
Cleocin (clindamycin)
Dapsone (diaminodiphenylsulfone or DDS)
Daraprim/Fansidar (pyrimethamine)
INH (isoniazid) – if not covered by County Health
Mepron (atovaquone)
Myambutol (ethambutol HCl)
Mycobutin (rifabutin)
NebuPent/Pentam (pentamidine)
Rifampin – if not covered by County Health
Rifater (pyrazinamide)
Sulfadiazine
Zithromax (azithromycin)

Antifungals

Fungizone (Amphotercin B--standard formulation)
*Amphotercin B (lipid formulations)
*Cancidas (caspofungin)
Clotrimazole tablets
Fluconazole
Nystatin
Itraconazole
*Vfend (voriconazole)

Blood Cell Modulators

*Epogen (erythropoietin alfa)
Leucovorin calcium (folinic acid)
Neupogen (filgrastim)

Other Medications

Lipid Lowering Agents

Crestor (rosuvastatin calcium)
Lipitor (atorvastatin)
Lopid (gemfibrozil)
Pravachol (pravastatin)
Tricor (fenofibrate)
Zetia (ezetimibe)

Neuropathic Pain Agents

Amitriptyline
*Neurontin (gabapentin)

Appetite Stimulants

Megace (megestrol acetate)
*Testosterone – various formulations

***denotes drugs requiring prior approval**

ADAP covers only formulary medications dispensed on an outpatient basis through Broadway Pharmacy in Missoula.

Fax: 406-327-1651

Phone 406-866-327-1650

The use of all formulary medications must be in accordance with FDA approval, and national standards of use. Medical criteria may change to reflect more current recommendations or accepted medical practices.

***Montana AIDS Drug Assistance Program Prior Authorization Criteria**

Aptivus

Genotyping and resistance testing recommended. Consultation with formulary board member needed before approval. Call HIV-certified provider Kathy Hall at (406) 247-3380 or 247-3350 to have her paged. Or call pharmacist Gary Myers at (406) 247-3330.

Amphotercin B (lipid formulation)

Present compelling reason(s) for use of lipid over standard formulations

Cancidas/Vfend

Present compelling reason(s) for use or demonstrate alternate product failure

Combination drugs such as Trizivir, Atripla

Not appropriate first line therapy for treatment naïve HIV patients

Epogen

Present compelling reason(s)/laboratory data for use

Fuzeon

Prior Authorization Algorithm is available from the AIDS Drug Assistance Program manager by calling (406) 444-4744 or by e-mailing jnielsen@mt.gov

Intelence (etravirine)

Not first line therapy

Isentress

Not first line therapy

Neurontin

Documented failure of tricyclic agent (amitriptyline or other) before Approved

Prezista

Not first line therapy

Selzentry

Not first line therapy. Patient must have CCR5 mono-tropic HIV **ONLY** as confirmed by tropism assay

Testosterone

Any product (patch, injection, gel, etc.) approved for appetite stimulation or wasting only