

**ILLINOIS DEPARTMENT OF PUBLIC HEALTH
AIDS DRUG ASSISTANCE PROGRAM (ADAP)
FORMULARY as of 12/7/2011**

CATEGORY I**REVERSE TRANSCRIPTASE INHIBITORS (RTIs)**

abacavir sulfate (Ziagen)
didanosine (ddI, dideoxyinosine, Videx, Videx EC)
emtricitabine (Emtriva, FTC)
lamivudine (3TC, Epivir)
stavudine (d4T, Zerit)
tenofovir DF (Viread)
zidovudine (AZT, azidothymidine, Retrovir)
**Combivir (Epivir and Retrovir Combination)
**Truvada (Emtriva and Viread combination)
**Epzicom (Epivir and Ziagen Combination)
***Trizivir (Epivir, Retrovir and Ziagen Combination)
***Atripla (efavirenz/emtricitabine/tenofovir)
***Complera (emtricitabine/rilpivirine/tenofovir)

PROTEASE INHIBITORS (PIs)

amprenavir (Agenerase), solution only
atazanavir (Reyataz)
darunavir (Prezista)
fosamprenavir calcium (Lexiva)
indinavir (Crixivan)
lopinavir/ritonavir (Kaletra)
nelfinavir mesylate (Viracept)
ritonavir (Norvir) – *reference prescribing guidelines*
saquinavir mesylate (Invirase)
tipranovir (Aptivus)

NON-NUCLEOSIDE (RTIs)

delavirdine (Rescriptor)
efavirenz (Sustiva)
etravirine (Intence)
nevirapine (Viramune)
rilpivirine (Edurant)

ENTRY INHIBITOR

maraviroc (Selzentry) - Requires Trofile assay

INTEGRASE INHIBITOR

raltegravir (Isentress)

CATEGORY II**TREATMENT and PROPHYLAXIS of PCP**

atovaquone (Mepron) – *Pre-Approval (required)*
*clindamycin HCl (Cleocin Hcl)
dapson
pentamidine isethionate (NebuPent, Pentam 300)
primaquine phosphate
trimethoprim (TMP, Proloprim, Trimplex)
sulfamethoxazole/trimethoprim (SMZ/TMP, Bactrim,)

HEPATITIS-B TREATMENTS

entecavir (Baraclude)

CATEGORY III**ANTIBIOTICS**

*azithromycin dihydrate (Zithromax)
amoxicillin (Amoxil, Trimox, Wymox)
cefixime (Suprax) suspension
cephalexin monohydrate (Keflex)
chlorhexidine gluconate (Peridex, PerioGard)
*clarithromycin (Biaxin)
dicloxacillin sodium (Dycill, Dynapen, Pathocil)
doxycycline hyclate (Doryx, Vibramycin, Vibra-Tabs)
metronidazole
penicillin VK

ANTI-FUNGALS:

amphotericin B (Fungizone) I.V. only
clotrimazole (Mycelex, Lotrimin)
*fluconazole (Diflucan)
itraconazole (Sporanox)
miconazole (Monistat)
nystatin (Mycostatin)

ANTI-VIRALS:

acyclovir (acycloguanosine, Zovirax)
cidofovir plus probenecid (Vistide) intravenous
famciclovir (Famvir)
valacyclovir hydrochloride (Valtrex)

CRYPTOSPORIDIOSIS:

paromomycin sulfate (Humatin)

MYCOBACTERIAL INFECTIONS:

*azithromycin dihydrate (Zithromax)
ciprofloxacin (Cipro)
*clarithromycin (Biaxin)
ethambutol (Myambutol)
isoniazid (isonicotinic acid hydrazide, INH)
isoniazid/pyrazinamide/rifampin (Rifater)
levofloxacin (Levaquin)
pyrazinamide
pyridoxine hydrochloride (B6)
rifabutin (Mycobutin)
rifampin (Rifadin, Rimactane)

ANTI-DIARRHEA or WASTING SYNDROME

diphenoxylate/atropine (Lomotil)
loperamide (Imodium)

TOXOPLASMOSIS:

*azithromycin dihydrate (Zithromax)
clindamycin phosphate (Cleocin Phosphate)
clindamycin palmitate (Cleocin pediatric granules) leucovorin calcium (folinic acid)
pyrimethamine (Daraprim)
sulfamethoxazole (Gantanol, Urobak)
sulfadiazine

CATEGORY IV (Other)

imiquimod cream (Aldara)
gabapentin (Neurontin)
testosterone enanthate, I.M only (*no Kits*)

LIPID REGULATING

pravastatin (Pravachol)
fenofibrate (Tricor)

CATEGORY V - REQUIRING PRIOR APPROVAL

enfuvirtide (Fuzeon); requires an additional application; limited to a cap of 15 clients.

valganciclovir hydrochloride (Valcyte) oral only;
Cap is limited to 35 clients concurrently.

atovaquone (Mepron) – prescriptions will require prior approval in all the following situations:

- 1) use for more than 21 days,
- 2) use as prophylaxis (rather than treatment); or
- 3) more than one prescription per year is written for a patient not approved for use of atovaquone as prophylaxis.

All pre-approval forms are located on the IDPH website (www.idph.state.il.us).

*Duplicate drug appears more than once.

**Indicates a fixed combination of two-drugs that are considered two drugs in the 5+ drug limit;

***Trizivir and Atripla are a three-drug combination and are considered three drugs.

See ADAP Prescribing Guidelines for quantity limits on some drugs.

Prescriptions for multi-source drugs should be written indicating “**product substitution permitted**” to ensure all efforts for fiscal stewardship on behalf of ADAP. In addition, this procedure will reduce the number of call-backs to prescribers by dispensing pharmacy.

All prescriptions for multi-source drugs (drugs available in a brand-name and equal or greater than 1 generic formulation) will be filled with the lowest cost option available. Use of brand name drugs on the ADAP formulary is for informational purposes only.

**ILLINOIS DEPARTMENT OF PUBLIC HEALTH
AIDS DRUG ASSISTANCE PROGRAM (ADAP)
PRESCRIBING GUIDELINES**

Drugs provided by the AIDS Drug Assistance Program (ADAP) **MUST** not exceed a \$2,000 per month benefits cap and **MUST** be prescribed in accordance with these guidelines. Revisions to prescribing guidelines may be made upon recommendations of the Department's ADAP Medical Issues Advisory Board.

CATEGORY I

- Category I anti-retroviral therapies should be prescribed in accordance with the latest Public Health Service (PHS) guidelines. The Website is: <http://aidsinfo.nih.gov/contentfiles/AdultandAdolescentGL.pdf>
- All newly FDA approved anti-retroviral therapies will be considered for addition to the formulary, however:
 - a. **No more than five (5) drugs* from Category I (and Fuzeon)** prescribed concurrently (Up to two protease inhibitors or a protease inhibitor and an NNRTI may be provided concurrently), except with prior approval from ADAP. **There are no exceptions to this prescribing guideline.** except ritonavir (Norvir), at a reduced dosage may be prescribed for pharmacokinetic (PK) boosting, and
 - b. Any change in Category I therapies will require a discontinue order of the old prescription to be sent or faxed to CVS Caremark Pharmacy before the new order can be filled.
 - * Combivir, Truvada, and Epzicom are fixed dose combinations and are considered two (2) drugs when ordered.
 - * Trizivir and Atripla are fixed-dosage combinations of 3 drugs and are considered three (3) drugs when ordered.
 - * Kaletra contains Norvir at a reduced dosage and is considered one plus PK boosted drug when ordered.
- HIV co-receptor (CCR5 and/or CXCR4) tropism assay must be run prior to prescribing Selzentry.

CATEGORY II

- atovaquone (Mepron) prescriptions will require prior approval in all the following situations: **1)** use for more than 21 days, **2)** use as prophylaxis (rather than treatment); or **3)** more than one prescription per year is written for a patient not approved for use of atovaquone as prophylaxis. Pre-approval form will be available on the IDPH website (www.idph.state.il.us).
- ritonavir (Norvir) - tablets will be dispensed unless other formations are required by prescriber due to tolerance issues. ADAP may require prior approval for other formulations.

CATEGORY V

- enfurvirtide (Fuzeon); requires a separate application. Re-approval in 2011 is also required for all current prescriptions. Eligibility is based on medical criteria, with a cap limit of 15 clients. Prior approval by the Department will be faxed, via electronic file to the pharmacy as authorization. Fuzeon is considered one of the five (5) drugs along with those in Category 1.
- valganciclovir (Valcyte) oral only: limited to a cap of 35 clients concurrently.
- atovaquone (Mepron) – see notes under Category II.
- Neither enfurvirtide (Fuzeon) nor valganciclovir (Valcyte) are considered within the \$2,000 benefits cap.

OTHER GENERAL GUIDELINES

- **All prescriptions** for multi-source drugs (drugs available in a brand-name and equal or greater than 1 generic formulation) will be filled with the lowest cost option available. Use of brand name drugs on the ADAP formulary is for informational purposes only.
- For coverage under ADAP, prescriptions for multi-source drugs should be written indicating “**product substitution permitted**” to ensure all efforts for fiscal stewardship are able to be implemented by ADAP through its dispensing pharmacy. In addition, this procedure will reduce the number of call-backs to prescribers by dispensing pharmacy.
- **All prescriptions** must be written for **no more than 3 refills**. Then the client will be required to re-visit their HIV Care Provider before a new prescription can be written.
- **All pre-approval** form can be located on the IDPH website (www.idph.state.il.us) for all prescriptions requiring pre-approval.