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**ILLINOIS DEPARTMENT OF PUBLIC HEALTH
AIDS Drug Assistance Program (ADAP)
FORMULARY as of 10/14/2016**

172 DRUGS

Drug Name	Drug Name	Drug Name
abacavir sulfate (Ziagen)	clonidine (Catapres)	estradiol, Injectable – <i>Pre-Approval (required)</i>
acyclovir (acycloguanosine, Zovirax)	clotrimazole (Mycelex, Lotrimin)	ethambutol (Myambutol)
adefovir Dipivoxil (Hepsera)	cobicistat (Tybust)	etravirine (Intelence)
amitriptyline	**combivir (Epivir and Retrovir Combination)	**evotaz (atazanavir and cobicistat)
amlodipine (Norvasc)	***complera(emtricitabine/rilpivirine/tenofovir)	famciclovir (Famvir)
amoxicillin (Amoxil, Trimox, Wymox)	daklinza – <i>Pre-Approval (required)</i>	felodipine (Plendil)
amphotericin B (Fungizone) I.V. only	dapsone	fenofibrate (Tricor)
amprenavir (Agenerase), solution only	darunavir (Prezista)	finasteride – <i>Pre-Approval (required)</i>
atazanavir (Reyataz)	delavirdine (Rescriptor)	fluconazole (Diflucan)
atenolol/chlorthalidone (Tenoretic)	**descovy (emtricitabine and tenofovir alafenamide)	fluoxetine (Prozac)
atenolol (Tenormin)	dicloxacillin sodium (Dycill, Dynapen, Pathocil)	fosamprenavir calcium (Lexiva)
atorvastatin (Lipitor)	didanosine (ddI, dideoxyinosine, Videx, Videx EC)	furosemide (Lasix)
atovaquone (Mepron) – <i>Pre-Approval (required)</i>	diltiazem (Cardizem, Taztia XT)	gabapentin (Neurontin)
***atripla (efavirenz/emtricitabine/tenofovir)	diphenoxylate/atropine (Lomotil)	***genvoya(elvitegravir,cobicistat,emtricitabine, tenofovir alafenamide)
*azithromycin dihydrate (Zithromax)	divalproex sodium (Depakote)	glipizide (Glucotrol, XL)
bupropion (Wellbutrin SR Wellbutrin XL)	dolutegravir (Tivicay)	glyburide (Diabeta)
benazepril (Lotensin)	doxycycline hyclate (Doryx, Vibramycin, Vibra-Tabs)	glyburide/metformin (Glucovance)
carvedilol (Coreg)	doxepin	GX epzicom
cefixime (Suprax) suspension	duloxetine (Cymbalta)	**harvoni (ledipasvir/sofosbuvir) – <i>Pre-Approval (required)</i>
ceftriaxone 250 mg (Rocephin)	efavirenz (Sustiva)	hctz/triamterene (Dyazide Yazide, Maxide)
cephalexin monohydrate (Keflex)	emtricitabine (Emtriva, FTC)	humalog (all formulations)

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chlorhexidine gluconate (Peridex, PerioGard)	enalapril (Vasotec)	humalog Mix
cidofovir plus probenecid (Vistide) intravenous	enalapril/hctz (Vaseretic)	humulin (all formulations)
ciprofloxacin (Cipro)	enfuvirtide (Fuzeon) – <i>Pre-Approval (required)</i>	hydrochlorothiazide
citalopram (Celexa)	entecavir (Baraclude)	imiquimod cream (Aldara)
*clarithromycin (Biaxin)	**epzicom (Epivir and Ziagen Combination) - abacavir sulfate/lamivudine	indinavir (Crixivan)
clindamycin HCl (Cleocin Hcl)	escitalopram (Lexapro)	insulin glargine (Lantus)
clindamycin palmitate (Cleocin pediatric granules)	estradiol, Oral – <i>Pre-Approval (required)</i>	itraconazole (Sporanox)
clindamycin phosphate (Cleocin Phosphate)	estradiol, Transdermal – <i>Pre-Approval (required)</i>	isoniazid (isonicotinic acid hydrazide, INH)
keppra (Levetiracetam)	penicillin VK	isoniazid/pyrazinamide/rifampin (Rifater)
lamivudine (3TC, Epivir)	pentamidine isethionate (NebuPent, Pentam 300)	sulfamethoxazole/trimethoprim (SMZ/TMP, Bactrim)
levofloxacin (Levaquin)	pioglitazone (Actos)	technivie – <i>Pre-Approval (required)</i>
leucovorin calcium (folinic acid)	pravastatin (Pravachol)	tenofovir DF (Viread)
lisinopril/hctz (Prinzide, Zestoretic)	premarin	testosterone cypionate (no Kits)
lisinopril (Prinivil, Zestril)	prezcobix (darunavir, cobicistat)	testosterone enanthate, I.M only (no Kits)
loperamide (Imodium)	progesterin – <i>Pre-Approval (required)</i>	timolol (Blocadren)
lopinavir/ritonavir (Kaletra)	primaquine phosphate	tipranovir (Aptivus)
losartan (Cozaar)	propranolol (Inderal LA)	trimethoprim (TMP, Proloprim, Trimplex)
losartan/hctz (Hzaar)	pyrazinamide	***triumeq (Dolutegravir/Lamivudine/Abacavir)
maraviroc (Selzentry) - <i>Requires Trofile assay</i>	pyridoxine hydrochloride (B6)	***trizivir (Epivir, Retrovir and Ziagen Combination)
metformin (Glucophage Glucophage XL)	pyrimethamine (Daraprim)	**truvada (Emtriva and Viread combination)
metoprolol (Lopressor, Toprol XL)	quetiapine (Seroquel, XR)	valacyclovir hydrochloride (Valtrex)
metronidazole	quinapril (Accupril)	valganciclovir hydrochloride (Valcyte) – <i>Pre-Approval (required)</i>
miconazole (Monistat)	raltegravir (Isentress)	valproic acid (Depakene and/or Stavzor)
minoxidil	ramipril (Altace)	valsartan (Diovan)
mirtazapine (Remeron)	ribavirin – <i>Pre-Approval (required)</i>	valsartan/hctz (Diovan HCT)
nelfinavir mesylate (Viracept)	rifabutin (Mycobutin)	venlafaxine (Effexor, Effexor XR)
nevirapine (Viramune)	rifampin (Rifadin, Rimactane)	verapamil (Covera HS)
nifedipine XL, ER (Procardia, Adalat)	rilpivirine (Edurant)	verapamil (Verelan, Isoptin SR, Calan, Calan SR)
nitroglycerin sublingual tab, spray, cap	risperidone (Risperdal)	viekira pak – <i>Pre-Approval (required)</i>
novolin (all formulations)	ritonavir (Norvir) – <i>Reference prescribing guidelines</i>	vitekta (Elvitegravir)
novolog (all formulations)	rosiglitazone/metformin (Avandamet)	zepatier – <i>Pre-Approval (required)</i>
novolog Mix Flexpen	saquinavir mesylate (Invirase)	zidovudine (AZT, azidothymidine, Retrovir)
nystatin (Mycostatin)	sertraline (Zoloft)	
***odefsey (emtricitabine, rilpivirine, tenofovir)	sovaldi (sofosbuvir) – <i>Pre-Approval (required)</i>	
olanzapine (Zyprexa)	spironolactone – <i>Pre-Approval (required)</i>	

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paromomycin sulfate (Humatin)	stavudine (d4T, Zerit)	
paroxetine (Paxil, Paxil CR)	tenofovir disoproxil fumarate)	
penicillin G benzathine	sulfadiazine	
penicillin LA	sulfamethoxazole (Gantanol, Urobak)	

Prior Approval Drugs

"**Category V**" drugs are pre-approval drugs only, all pre-approval forms are located on the IDPH/ADAP website (<http://hivcareconnect.com/adap/>)

Enfurvirtide (Fuzeon); requires pre-approval and limited to a cap of 15 clients concurrently.

Valganciclovir Hydrochloride (Valcyte); Oral only and is limited to a cap of 35 clients concurrently.

Atovaquone (Mepron) - requires prior approval in all of 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.

Hepatitis C Medications available are as follows- requires prior approval and will be limited to a cap of 100 clients concurrently.

- a. **Harvoni** (Ledipasvir/Sofosbuvir)
- b. **Viekira Pak**
- c. **Sovaldi** (Sofosbuvir)
- d. **Ribavirin**
- e. **Zepatier**
- f. **Technivie**
- g. **Daklinza**

Pre Approval for Gender Transition and Maintenance only (See "Prescribing Guidelines" for link on guidelines and protocols)

Estradiol, Oral

Estradiol, Transdermal

Estradiol, Injectable

Finasteride

Progestin

Spirolactone

Premarin

* Duplicate drug appears in more than one sub category

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

*** Indicates a fixed three-drug combination and are considered three drugs in the 5+ drug limit.

**** Stribild is a three-drug combination and is considered four drugs in the 5+ drug limit.

**** Genvoya is a three-drug combination and is considered four drugs in the 5+ drug limit.

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 perscriptions 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.

PROTECTING HEALTH, IMPROVING LIVES

**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, cobicistat (Tybust), and
 - b. Any change in Category I therapies will require a discontinuation 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, Atripla, Stribild, Complera and Triumeq 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 and submitted to ADAP 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 formulations are required by prescriber due to tolerance issues. ADAP may require prior approval for other formulations.

CATEGORY V

- enfuvirtide (Fuzeon); requires a separate application. 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 I.
- valganciclovir (Valcyte) oral only: limited to a cap of 35 clients concurrently.
- atovaquone (Mepron) – see notes under Category II.
- Neither enfuvirtide (Fuzeon) nor valganciclovir (Valcyte) are considered within the \$2,000 dollar monthly benefits cap.
- Hepatitis C – Harvoni (ledipasvir/sofosbuvir), Viekira Pak, Sovaldi (sofosbuvir), Ribavirin, Zepatier; Technivie, Daklinza will be limited to a cap of 100 clients concurrently and then will move to a waiting list. Treatment is a 12, 16 or 24 week regimen. Hepatitis C drugs will not count toward the \$2,000 dollar monthly benefit cap. Hepatitis C drugs will require prior approval, which the prior approval form can be found on the IDPH website. To be eligible one must meet the following:
 - a. Be currently enrolled in ADAP and eligible for ADAP assistance for the full duration of treatment
 - b. Be a patient who has Fibrosis Stage 2 (F2) and above
 - c. Have been denied medication coverage by their insurance plan (if they have insurance) – **Documentation required**
 - d. **For Zepatier:** If Genotype 1a – Need baseline NS5A resistance test and documentation.

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Revised: 10/14/2016

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

- e. Physician has reviewed the Manufacturers Prescribing Guidelines for possible drug interactions and issues associated with the Hepatitis C medication regimen they are prescribing in conjunction with their client's current HIV regimen.

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.

Guidance References for Primary Care Protocol for Hormone Treatment for Gender Transition and Maintenance:

1) The Center for Excellence for Transgender Health - *Primary Care Protocol - Hormone Administration*: <http://transhealth.ucsf.edu/trans?page=protocol-hormones>

2) The World Professional Association for Transgender Health - *Standards of Care*:
http://www.wpath.org/uploaded_files/140/files/Standards%20of%20Care,%20V7%20Full%20Book.pdf