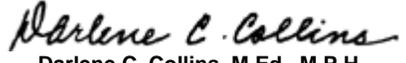


	MEDICAL ASSISTANCE BULLETIN COMMONWEALTH OF PENNSYLVANIA * DEPARTMENT OF PUBLIC WELFARE	
	NUMBER: 01-96-06, 02-96-04, 11-96-05, 19-96-06, 23-96-02, 26-96-05, 28-96-04, 30-96-04, 35-96-03, 36-96-03, 37-96-01, 45-96-01, 49-96-05	ISSUE DATE: March 1, 1996
SUBJECT: The Addition of Invirase to the Special Pharmaceutical Benefits Program Formulary		BY:  Darlene C. Collins, M.Ed., M.P.H. Deputy Secretary for Medical Assistance Programs

PURPOSE:

The purpose of this bulletin is to notify providers that the SPECIAL PHARMACEUTICAL BENEFITS PROGRAM (SPBP) formulary has expanded to include Invirase (saquinavir mesylate), the first protease inhibitor approved recently by the Food and Drug Administration.

SCOPE:

This bulletin applies to all medical assistance providers who prescribe and dispense drugs for eligible SPBP participants with a diagnosis of HIV/AIDS.

BACKGROUND:

The SPBP covers the costs of specific drugs and some drug administration supplies used for treatment of low and moderate income persons living with HIV/AIDS, and the drug Clozaril for mental health clients suffering from schizophrenia. The SPBP is for clients who ARE NOT ELIGIBLE for pharmaceutical coverage through the Medical Assistance Program ACCESS Card.

Effective February 1, 1996, the SPBP covers the cost of Invirase (saquinavir mesylate), for eligible SPBP clients.

Please refer to the reverse side of this bulletin for a complete list of compensable drugs on the SPBP formulary.

**CURRENT LIST OF
SPECIAL PHARMACEUTICAL BENEFITS PROGRAM
COVERED DRUGS AND SUPPLIES
FOR CLIENTS WITH A DIAGNOSIS OF HIV/AIDS**

Acyclovir	Kanamycin Sulfate*
Alpha Interferon	Ketoconazole
Amikacin*	Leucovorin
Amphotericin B*	Marinol
Azithromycin B*	Megace
Bactrim/Septra	Mepron
Biaxin	Neutrexin

Bleomycin*	Nystatin*
Capreomycin	Ofloxacin*
Ciprofloxacin	Paramomycin Sulfate*
Clindamycin*	Pentamidine
Clofazimine*	Prednisone*
Clotrimazole	Primaquine Phosphate*
Cycloserine*	Pyrazinamide*
Dapsone	Retrovir-AZT
Dexamethasone*	Rifabutin
Doxorubicin*	Ritampin*
EpiVir-3TC*	Ritater*
Ethambutol*	Saquinavir Mesylate+
Ethionide	Sulfadiazine*
Etoposide*	Sulfadoxine/Pyrimethamine*
Fluconazole	Terconazole*
Flucytosine*	TMP SMX
Foscavir	Triple Sulfa*
Ganciclovir	Videx-DDI
Hivid-DDC	Vinblastine Sulfate*
Itraconazole	Vincristine*
Isoniazid*	Zerit

PLEASE NOTE: DRUGS NOT LISTED ON THE CURRENT FORMULARY ARE NOT COVERED.

IN ADDITION TO DRUGS, THE SPBP ALSO COVERS THE COST OF AEROSOLIZED PENTAMIDINE TREATMENTS IN AN OUTPATIENT HOSPITAL SETTING OR DOCTOR'S OFFICE. THE SPBP ALSO COVERS THE RESPIRGARD II NEBULIZER AND A 12 PIECE IV SUPPLY PACKAGE USED WITH GANCYCLOVIR/FOSCAVIR THERAPY.

CD4 T-CELL TESTS ARE AVAILABLE TO SPBP CLIENTS THROUGH THE DEPARTMENT OF HEALTH. CALL 1-800-662-6080 TO FIND OUT THE LOCATION OF A TEST SITE IN YOUR AREA.

THE SPBP STAFF IS AVAILABLE MONDAY THROUGH FRIDAY, 9:00 A.M. TO 5:00 P.M. WITH THE EXCEPTION OF STATE HOLIDAYS, AT 1-800-922-9384.

*ADDED TO SPBP 12/1/95
+ADDED TO SPBP 2/1/96
CURRENT LIST 2/1/96

COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:
CALLS, COMMENTS, ETC SPBP STAFF AT 1-800-922-9384

Visit the Office of Medical Assistance Programs website at www.dpw.state.pa.us/omap.