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MEDICAID INFORMATION RELEASE 2008-08

To: Prescribing Providers, Pharmacists, and Hospitals

From: Leslie M. Clement, Administrator
Division of Medicaid

Subject: Preferred Agents for Drug Classes Reviewed at Pharmacy and Therapeutics Committee Meetings on October 19, 2007, January 18, 2008, and February 15, 2008.

Drug/Drug Classes:	Noted below
Implementation Date:	Effective for dates of service on or after April 1, 2008

Idaho Medicaid is noting preferred agents and prior authorization (PA) criteria for the following drug classes as part of the Enhanced PA Program. The information is included in the attached Preferred Drug List.

The Enhanced PA Program and drug-class specific PA criteria are based on nationally recognized peer-reviewed information and evidence-based clinical criteria. Medicaid designates preferred agents within a drug class based primarily on objective evaluations of their relative safety, effectiveness, and clinical outcomes in comparison with other therapeutically interchangeable alternative drugs and, secondarily, on cost.

Questions regarding the Enhanced PA Program can be referred to the Idaho Medicaid Pharmacy Unit at: (208) 364-1829. A current listing of preferred and non-preferred agents and prior authorization criteria for all drug classes is available online at: **www.medicaidpharmacy.idaho.gov**

Agents **bolded** below indicate changes in the Preferred Drug List

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS*
Analgesics, Narcotics Long-Acting	methadone generic, Kadian®, and morphine extended release generic Duragesic® is recommended as preferred over generic fentanyl transdermal when the therapeutic prior authorization criteria are met.	Duragesic®, fentanyl transdermal generic, Avinza®, Opana ER®, Oxycontin®, and oxycodone extended release generic
Analgesics, Narcotics Short-Acting	propoxyphene/acetaminophen generic, acetaminophen/codeine generic, tramadol generic, hydrocodone/acetaminophen generic, aspirin/codeine generic, codeine generic, morphine IR generic, oxycodone IR generic, oxycodone/acetaminophen generic, pentazocine/naloxone generic, hydromorphone generic, oxycodone/aspirin generic, **pentazocine/acetaminophen generic**, **tramadol/acetaminophen generic**, and levorphanol generic	propoxyphene generic, meperidine oral generic, Darvon N®, Panlor DC/SS®, Opana®, fentanyl buccal generic, Fentora®, hydrocodone/ibuprofen generic, oxycodone/ibuprofen generic, butalbital compound/codeine generic, and dihydrocodeine/acetaminophen/caffeine generic
Angiotensin Modulators	Altace®, benazepril and benazepril/HCTZ generic, captopril and captopril/HCTZ generic, enalapril and enalapril/HCTZ generic, fosinopril and fosinopril/HCTZ generic, lisinopril and lisinopril/HCTZ generic, quinapril and quinapril/HCTZ generic, Diovan®, Diovan HCT®, Benicar, Benicar HCT®, Micardis®, Micardis HCT®, Cozaar®, Hyzaar®, Avapro®, and Avalide®	**Aceon®**, Teveten®, Tevetan HCT®, Atacand®, Atacand HCT®, moexepril and moexepril/HCTZ generic, **Tekturna®**, **Tekturna HCT®**, trandolapril, and **ramipril**

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS*
Angiotensin Modulator—Calcium Channel Blocker Combination Drugs	**Exforge®**, **Azor®**, **benazepril/amlodipine generic**, and Lotrel® as preferred agents	**Tarka®** and Lexxel®
Anticoagulants, Injectable	Fragmin®, Lovenox®, and Arixtra®	Innohep®
Anticonvulsants	methobarbital generic, phenobarbital generic, clonazepam generic, carbamazepine generic, Carbatrol®, Equetro®, phenytoin, Dilantin®, **mephobarbital generic**, primidone generic , valproic acid generic, Depakote® sprinkle, Depakote ER®, Depakote®, Celontin®, Peganone®, Gabitril®, ethosuximide generic, zonisamide generic[2], **oxcarbazine[2]**, Lyrica®[2], gabapentin generic[2], Topamax®[2], Keppra®[2], Lamictal®[2], and Diastat®	Phenytek®, Tegretol XR®[1], Felbatol®, and lamotrigine generic[2] *[1] Participants currently receiving Tegetrol XR® will be "grandfathered" and not need to switch to a preferred agent.* *[2] These anticonvulsants are recommended as preferred for epilepsy and other seizure disorders only. Non-seizure indications will still require that therapeutic prior authorization criteria are met.*
Antihistamines, Minimally Sedating	Zyrtec® OTC syrup, loratadine/loratadine-D generic, and cetirizine OTC tablet	**Clarinex**/Clarinex D®, Clarinex® syrup, Zyrtec/Zyrtec-D®, Xyzal®, Allegra® syrup , Allegra D® 12 hour and fexofenadine generic, and **Semprex D®** *All current therapeutic criteria will be removed.*
Antimigraine Agents, Triptans	**Relpax®**, Imitrex (oral)®, Imitrex (nasal)®, and Imitrex® SQ	**Amerge®**, **Maxalt**/Maxalt MLT®, Axert®, Frova®, Zomig/ZomigZMT®, and Zomig® (nasal) *Amerge®, Maxalt/Maxalt MLT®, and Zomig/ZomigZMT® will be "grandfathered" for current patients. These agents will be non-preferred and require prior-authorization for new patients.*

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS*
Beta Blockers	atenolol generic, metoprolol generic, propranolol generic, sotalol generic, nadolol generic, acebutolol generic, labetalol generic, pindolol generic, timolol generic, bisoprolol generic, betaxolol generic, and **carvedilol generic**	Coreg CR®, Levatol®, and Innopran XL® *Therapeutic prior authorization criteria for carvedilol will be removed.*
Bladder Relaxant Preparations	oxybutynin generic, Vesicare®, Oxytrol® transdermal, Enablex®, Sanctura®, Sanctura XR®, Ditropan XL®, and **Detrol LA®**	Detrol®
BPH Treatments	doxazosin generic, terazosin generic, Uroxatral®, Cardura XL®, Flomax®, Avodart®, and finasteride generic	There are no agents designated as non-preferred.
Calcium Channel Blockers	Dynacirc CR®, verapamil generic, verapamil ER PM, Cardizem LA®, diltiazem, nifedipine generic, felodipine ER generic, and amlodipine generic	nicardipine generic, Cardene SR®, Covera-HS®, isradipine generic, and **Sular®**
Erythropoiesis Stimulating Proteins	Aranesp® and Procrit®	Epogen®
Growth Hormone	Saizen®, **Nutropin®**, Nutropin AQ®, and **Norditropin®**	**Tev-Tropin®**, **Serostim®**, **Genotropin®**, Humatrope®, Omnitrope®, and Zorbtive® *Current therapeutic criteria for growth hormone will continue to be required for all agents.* *Patients currently receiving non-preferred agents will be "grandfathered."*
Hepatitis C Agents	Pegasys®, **Peg-Intron®**, and ribavirin generic	Infergen®
Hypoglycemics, Meglitinides	Starlix® and Prandin®	There are no agents designated as non-preferred
Hypoglycemics, TZD	Avandia®, Actos®, Avandamet®, Avandaryl®, Actoplus Met®, and Duetact®	There are no agents designated as non-preferred.
Impetigo Agents, Topical	**mupirocin ointment generic**	**Altabax® and Bacroban® cream**

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS*
Lipotropics, Other	Niaspan®, gemfibrozil generic, colestipol generic, Tricor®, cholestyramine generic, fenofibrate generic, and **Antara®**	Zetia®, Triglide®, Welchol®, Lipofen®, and Lovaza®
Lipotropics, Statins	**Caduet®**, Lescol/Lescol XL®, Lipitor®, lovostatin generic, pravastatin generic, and simvastatin generic	**Advicor®**, Crestor®, **Altoprev®** and Vytorin®, and **Simcor®**
Multiple Sclerosis Agents	Betaseron®, Avonex®, Rebif®, and Copaxone®	There were no agents designated as non-preferred.
Otic Fluoroquinolones	ofloxacin generic otic and Ciprodex® otic	Cipro® HC otic
Phosphate Binders	PhosLo®, Fosrenol®, and Renagel®	There are no agents designated as non-preferred.
Proton Pump Inhibitors	Prilosec® OTC, Nexium® capsule and suspension, and Prevacid® capsule	**Prevacid®** solutab and **suspension**, Zegerid®, Aciphex®, Protonix®, and omeprazole generic *All current therapeutic criteria except those associated with the solutab form of Prevacid will be removed*
Sedative Hypnotics	chloral hydrate generic, temazepam generic, triazolam generic , **Restoril® 7.5 mg**, and zolpidem generic	**Lunesta®**, flurazepam generic, Rozerem®, Ambien CR®, Sonata®, Doral®, and estazolam generic *Lunesta® will be "grandfathered" for current patients.*
Skeletal Muscle Relaxants	baclofen generic, chlorzoxazone generic, cyclobenzaprine generic, dantrolene generic, methocarbamol generic, orphenadrine generic, **orphenadrine compound generic**, and tizanidine generic	**carisoprodol generic**, carisoprodol compound, **Soma®**, **Skelaxin®**, **Zanaflex®**, **Fexmid®**, **and Amrix®**
Ulcerative Colitis Agents	sulfasalazine generic, Colazal®, mesalamine rectal generic, Asacol®, **Pentasa®**, and Canasa®	Dipentum® and Lialda ®

*Use of non-preferred agents must meet prior authorization requirements.
*Use of any covered product may be subject to prior authorization for quantities or uses outside the Food and Drug Administration (FDA) guidelines or indications.

Idaho Medicaid Provider Handbook

This Information Release does **not** replace information in your Idaho Medicaid Handbook.