

HEALTH & WELFARE

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TO: Prescribing Providers, Pharmacies and Hospitals

FROM: Veslie Clement, Administrator

SUBJECT: V Preferred Agents for Drug Classes Reviewed at July 21, 2006 and August 18, 2006

Pharmacy and Therapeutics Committee Meetings

Drug/Drug Classes: Noted below

Implementation Date: Effective for dates of service on or after October 1, 2006

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

The Enhanced PA Program and drug-class specific PA criteria are based on evidence-based clinical criteria and nationally recognized peer-reviewed information. The determination of medications to be considered preferred within a drug class is 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 Prior Authorization Program may be referred to Idaho Medicaid Pharmacy at (208) 364-1829. A current listing of preferred and non-preferred agents and prior authorization criteria for <u>all</u> drug classes is available online at <u>www.medicaidpharmacy.idaho.gov</u>

THERAPEUTIC	PREFERRED	NON-PREFERRED
DRUG CLASS	AGENTS	AGENTS*
Beta-Agonist	albuterol CFC metered dose inhaler,	Alupent [®] metered dose inhaler,
Bronchodilators	albuterol HFA metered dose inhaler,	
	albuterol inhalation solution, albuterol	metaproterenol oral syrup, metaproterenol
		tablets, Alupent® metered dose inhaler,
	HFA® metered dose inhaler, Ventolin	Accuneb inhalation solution, Xopenex
	HFA® metered dose inhaler, Xopenex	inhalation solution, Vospire ER®, Serevent

-	HFA® metered dose inhaler, Maxair Autoinhaler® metered dose inhaler, and	Diskus® dry powder inhaler and Foradil Aerolizer®metered dose inhaler
	terbutaline oral tablets	1000 Miles of Good Miles of Mi
Anticholenergic Bronchodilators	ipratropium nebulizer solution, Combivent® metered dose inhaler, Atrovent HFA ® metered dose inhaler and Spiriva Handihaler® inhalation powder	Duoneb® inhalation solution
Leukotriene	none	Accolate® Singulair® and Zyflo®
Modifiers		
Intranasal Rhinitis Agents	Astelin [®] , Nasacort AQ [®] , Nasonex [®] , Flonase [®] , and ipratropium nasal spray	Atrovent®, Beconase AQ®, Nasarel®, flunisolide, fluticasone and Rhinocort Aqua®
Inhaled Glucocorticoids	AeroBid ®, AeroBid-M®, Azmacort®, QVAR®, and Asmanex ® The Committee recommends that current Advair® patients receive a "grandfathered" prior authorization. The Committee recommends that Pulmicort Respules® not require prior authorization for children 1-8 years of age	Advair Diskus [®] , Pulmicort Respules [®] , Flovent [®] , Flovent HFA [®] , and Pulmicort Turbuhaler [®]
Non-Steroidal Anti- Inflammatory Agents	ibuprofen, piroxicam, ketorolac, naproxen, fenoprofen, indomethacin, flurbiprofen, oxaprozin, diclofenac, sulindac, Ponstel® and etodolac	meclofenamate, nabumetone, ketoprofen, tolmetin, Mobic [®] , meloxicam, Celebrex [®] and Arthrotec [®]
		The Committee recommends that Mobic [®] , meloxicam and Arthrotec [®] be added to the therapeutic prior authorization rule currently in place for Celebrex. [®] Brand name drugs of preferred generics will still require prior authorization.
Platelet Aggregation Inhibitors	Aggrenox [®] ,and Plavix [®]	dipyridamole and ticlopidine
Anti-Parkinson Agents	benztropine, trihexyphenidyl, Kemadrin [®] , Requip [®] , carbidopa/levodopa, selgiline, Mirapex [®] , Stalevo TM and Comtan [®]	Parcopa®, pergolide and Tasmar® Brand name drugs of preferred generics will still require prior authorization.
Bone Resorption Suppression & Related Agents	Fosamax [®] , Fosamax Plus D [®] , Boniva [®] , Miacalcin [®] nasal and Evista [®]	Actonel®, Actonel®w/calcium, Didronel®, Fortical®, and Forteo® subcutaneous
Androgenic Agents	Androderm [®] and Androgel [®]	Testim [®]
Alzheimer Agents	Aricept®, Aricept ODT®, and Exelon® The Committee recommends that Namenda® be designated as a preferred agent for moderate to severe dementia ratings. The Committee recommends that the current therapeutic prior authorization criteria continue to be required.	Cognex [®] , Razadyne [®] and Razadyne ER [®]

SSRI Antidepressants	citalopram, fluoxetine, fluvoxamine, Lexapro [®] , Paxil CR [®] and Zoloft	paroxetine, Pexeva [®] , Prozac [®] Weekly, Sarafem [®] , and sertraline
		The Committee recommends that all individuals currently on paroxetine be "grandfathered."
ADHD Drugs	Adderall® XR, amphetamine salt combo, Concerta®, dextroamphetamine, Focalin®, Focalin® XR, Metadate® CD, methylphenidate, and methylphenidate	pemoline, Ritalin® LA, Strattera® and Provigil® The Committee recommends that the current
· f	ER	therapeutic prior authorization guidelines for diagnosis and contraindications remain in effect. The Committee recommends the following change for the Strattera® therapeutic criteria: Strattera® Documented trial and failure of at least
		one stimulant within two months, or Diagnosis of tics or anxiety disorder or a history of substance abuse. The Committee recommends that patients on Ritalin® LA be grandfathered.
ACE Inhibitors	benazepril, benazepril/HCTZ, catopril, captopril/HCTZ, enalapril, enalapril/HCTZ, lisinopril, lisinopril/HCTZ, Altace® and Aceon®	Mavik [®] , fosinopril, fosinopril/HCTZ, quinapril/HCTZ, Uniretic [®] , and Univasc [®] Brand name drugs of preferred generics will still require prior authorization.
Ophthalmic Antibiotics	erythromycin,tobramycin, sulfacetamide, polymixin B/trimethoprim, gentamicin, bacitracin, bacitacin/polymyxin B, Vigamox TM and neomycin/polymixin B/gramicidin	ofloxacin, Zymar TM , ciprofloxacin solution, Quixin [®] and Ciloxan [®] ointment
Ophthalmics for Allergic Conjunctivitis	Alrex [®] , Elestat [®] , Acular [®] , Patanol [®] and cromolyn sodium	Optivar [®] , Zaditor [®] , Emadine [®] , Alomide [®] , Alocril [®] and Almast [®]
Ophthalmic Glaucoma Agents	Prescriber choice is allowed within this drug class. Levobunolol, dipivefrin, pilocarpine, timolol, Azopt [®] , Travatan [®] , Betimol [®] , metipranolol, Lumigan [®] , Betoptic [®] S, Trusopt [®] , brimonidine, Alphagan P, Istalol [®] , betaxolol, carteolol, Xalatan and Cosopt [®]	No agents are recommended as non-preferred at this time. Brand name agents not listed as preferred agents will still require prior authorization.
	Prescriber choice is allowed within this drug class. Acyclovir, amantadine, Famvir, [®] ganciclovir, Relenza [®] , rimantadine, Tamiflu [®] , Valcyte [®] , and Valtrex [®]	No agents are recommended as non-preferred at this time. Brand name drugs of preferred generics will still require prior authorization.
Oral Antifungals	ketoconazole, fluconazole, nystatin, clotrimazole, Ancobon [®] and Vfend	griseofulvin suspension, Grifulvin® V tablets, Gris-Peg®, itraconazole and Lamisil® be designated as non-preferred and subject to therapeutic prior authorization criteria. Brand name drugs of preferred generics will still require prior authorization.
Topical	clotrimazole/betamethasone, econazole,	ciclopirox cream and suspension, Penlac®,

Antifymmala	Exelderm®, ketoconazole cream and	Ertaczo [®] , Loprox [®] gel and shampoo Mentax [®] ,
Antifungals	shampoo, Naftin [®] , nystatin,	Oxistat [®] , and Vusion [®]
	nystatin/triamicinolone	Brand name drugs of preferred generics will
	injustice of the control of the cont	still require prior authorization.
		The Committee recommends no changes to the
		current Penlac® prior authorization criteria
Oral	amoxicillin/clavulanate tablets and	Panixine®, Raniclor® and Lorabid®
Cephalosporins	suspension, Augmentin XR®, Cedax®,	,
and Related	cefaclor, cefadroxil, cefpodoxime,	Brand name drugs of preferred generics will
	cefacior, cefadroxil, cefpodoxime, cefuroxime, Cefzil [®] , cephalexin,	still require prior authorization.
Antibiotics	Omnicef [®] , Spectracef [®] , cefprozil and	
	Suprax ®	
Oral	Avelox [®] , Cipro [®] (suspension), and	Cipro [®] XR, Factive [®] , Proquin XR [®] ,
Fluoroquinolones	ciprofloxacin generic	Levaquin [®] , and ofloxacin
Macrolides &	Biaxin® XL, clarithromycin generic,	Ketek®
Ketolides	erythromycin generic, Zithromax®	
Actorides	powder/suspension, azithromycin	
	generic, and Zmax®	
Atopic	Elidel® and Protopic®	None
Dermatitis		
Insulins	Humulin [®] , Novolin [®] , Humalog [®] ,	Apidra [®]
***************************************	Humulin [®] , Novolin [®] , Humalog [®] , Novolog [®] , Levemir [®] , Lantus [®] , Novolog [®]	•
	mixture, and Humalog® mixturebe	,
Diabetes	Symlin [®] and Byetta [®]	None
Treatment		
Injectables	The Committee recommends that their	
Injections	use be limited to package label	
	guidelines.	
C-4al-i-a-a-J	Provider choice is allowed within this	None
Cytokine and	class. Keneret [®] , Enbrel [®] , Raptiva [®] ,	NONG
CAM	Orencia [®] , Humira [®] , Amevive [®] and	
Antagonists	Orencia [®] , Humira [®] , Amevive [®] and Remicade [®]	
Oral Antiemetics	Emend®, Zofran and Zofran ODT®	Kytril® and Anzemet®
- I WA I AMERICAN COLOR	The Committee recommends that current	The Committee recommends that current
	therapeutic prior authorization criteria	therapeutic prior authorization criteria remain
	remain in effect for all of these agents.	in effect for all of these agents.
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IDAHO MEDICAID PROVIDER HANDBOOK

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

^{*}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 Food and Drug Administration (FDA) guidelines or indications