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**HEALTH & WELFARE**


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**MEDICAID INFORMATION RELEASE 2008-18**

**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 July 18, 2008, and August 15, 2008.

Drug/Drug Classes:	Noted below
Implementation Date:	Effective for dates of service on or after October 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](http://www.medicaidpharmacy.idaho.gov)

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

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS*
Vaginal Antibiotics	<b>Cleocin<sup>®</sup></b> , <b>clindamycin</b> , <b>Clindesse<sup>®</sup></b> , and <b>metronidazole</b>	There are no agents recommended by the committee as non-preferred.
Topical Antivirals	<b>Zovirax<sup>®</sup> cream</b> and <b>Denavir<sup>®</sup></b>	<b>Zovirax<sup>®</sup> ointment</b>
Topical Antiparasitics	<b>permethrin</b> , <b>Eurax<sup>®</sup></b> , and <b>Ovide<sup>®</sup></b>	<b>lindane</b>
Analgesics/Anesthetics	<b>Lidoderm<sup>®</sup></b>	<b>Voltaren gel<sup>®</sup></b> and <b>Flector<sup>®</sup></b>
Pancreatic Enzymes	<b>pancrelipase</b> , <b>Pancrease<sup>®</sup> MT</b> , <b>lapase</b> , <b>dygase</b> , <b>Viokase<sup>®</sup></b> , <b>Lipram<sup>®</sup></b> , <b>Creon<sup>®</sup></b> , and <b>Ultras<sup>®</sup></b>	<b>Pancrecarb<sup>®</sup> MS</b>
Stimulants and Related Agents	Concerta <sup>®</sup> , Vyvanse <sup>®</sup> , Adderall <sup>®</sup> XR, amphetamine salt combo, <b>dexmethylphenidate</b> , dextroamphetamine, Focalin <sup>®</sup> XR, Metadate <sup>®</sup> CD, methylphenidate, and methylphenidate ER  Current therapeutic prior authorization guidelines for diagnosis and contraindications will remain in effect.	Daytrana <sup>®</sup> , Desoxyn <sup>®</sup> , Provigil <sup>®</sup> , Ritalin <sup>®</sup> LA, and Strattera <sup>®</sup>
Alzheimer Agents	Aricept <sup>®</sup> and Aricept ODT <sup>®</sup> preferred for <b>mild to severe</b> dementia ratings. Exelon <sup>®</sup> and <b>Exelon<sup>®</sup> patch</b> as preferred agents for <b>mild to moderate</b> dementia ratings. Namenda <sup>®</sup> as a preferred agent for <b>moderate to severe</b> dementia ratings.  Current therapeutic prior authorization criteria will continue to be required.	Cognex <sup>®</sup> , Razadyne <sup>®</sup> , and Razadyne ER <sup>®</sup>
Androgenic Agents	Androderm <sup>®</sup> and Androgel <sup>®</sup>	Testim <sup>®</sup>
Bronchodilators, Anticholenergetic	Atrovent HFA <sup>®</sup> metered dose inhaler, Combivent <sup>®</sup> metered dose inhaler, ipratropium nebulizer solution, and Spiriva Handihaler <sup>®</sup> inhalation powder	Duoneb <sup>®</sup> inhalation solution and ipratropium/albuterol nebulizer solution
Antidepressants, Other	mirtazapine, bupropion IR, bupropion SR, bupropion XL, and Effexor <sup>®</sup> XR	nefazodone, venlafaxine, Cymbalta <sup>®</sup> , Pristiq <sup>®</sup> , and Emsam <sup>®</sup> patch

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS*
Antidepressants, SSRI	citalopram, fluoxetine, fluvoxamine, and sertraline	Lexapro <sup>®</sup> , paroxetine, paroxetine CR, Pexeva <sup>®</sup> , Paxil CR <sup>®</sup> , Prozac <sup>®</sup> Weekly, and Luvox <sup>®</sup> CR  All individuals currently on Lexapro <sup>®</sup> , paroxetine, and Paxil CR <sup>®</sup> will be “grandfathered.”
Antiemetics, Oral	Emend <sup>®</sup> , ondansetron, ondansetron ODT, and Zofran <sup>®</sup> ODT  Current therapeutic prior authorization criteria will remain in effect for all of these agents.	Anzemet <sup>®</sup> , granisetron, Zofran <sup>®</sup> (non-ODT), Marinol <sup>®</sup> , and Cesamet <sup>®</sup>
Antifungals, Oral	clotrimazole, fluconazole, ketoconazole, and nystatin  Brand name drugs of preferred generics will still require prior authorization.	Ancobon <sup>®</sup> , griseofulvin suspension, Grifulvin <sup>®</sup> V tablets, Gris-Peg <sup>®</sup> , itraconazole, Lamisil <sup>®</sup> , Noxafil <sup>®</sup> , terbinafine, and Vfend <sup>®</sup>
Antifungals, Topical	<b>clotrimazole/betamethasone</b> , ketoconazole topical and shampoo, Naftin <sup>®</sup> , nystatin, nystatin/triamcinolone, and <b>econazole</b> . In addition, OTC preparations <b>tolnaftate cream/powder/solution/spray</b> , <b>miconazole</b> , <b>Lamisil<sup>®</sup> AF</b> , <b>Tinactin<sup>®</sup></b> , and clotrimazole is designated as preferred when a prescription is written.	ciclopirox cream / suspension/gel/solution/lacquer, Ertaczo <sup>®</sup> , Exelderm <sup>®</sup> , Loprox <sup>®</sup> shampoo, Mentax <sup>®</sup> , Oxistat <sup>®</sup> , Penlac <sup>®</sup> , Xolegel <sup>®</sup> , CNL8, Extina, and Vusion <sup>®</sup>  There will be no changes to the current Penlac <sup>®</sup> prior authorization criteria.
Antiparkinson's Agents	bromocriptine, bntropine, carbidopa/levodopa, ropinirole, selegiline, Stalevo <sup>®</sup> , and trihexyphenidyl	Azilect <sup>®</sup> , Comtan <sup>®</sup> , Mirapex <sup>®</sup> , Parcopa <sup>®</sup> , Tasmar <sup>®</sup> , and Zelapar <sup>®</sup>  Current Mirapex <sup>®</sup> patients will be “grandfathered”.
Antivirals	acyclovir, amantadine, Tamiflu <sup>®</sup> , and Valtrex <sup>®</sup>	Relenza <sup>®</sup> inhalation, Famvir <sup>®</sup> , and rimantadine
Atopic Dermatitis	Elidel <sup>®</sup> and Protopic <sup>®</sup>	None

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS*
Beta Agonist Bronchodilators	albuterol all formulations, Proair HFA <sup>®</sup> metered dose inhaler, Proventil HFA <sup>®</sup> metered dose inhaler, Ventolin HFA <sup>®</sup> metered dose inhaler, Xopenex HFA <sup>®</sup> metered dose inhaler, Maxair Autoinhaler <sup>®</sup> metered dose inhaler, <b>Foradil Aerolizer<sup>®</sup> metered dose inhaler, Serevent Diskus<sup>®</sup> dry powder inhaler,</b> and terbutaline oral tablets	Alupent <sup>®</sup> metered dose inhaler, metaproterenol all formulations, Performist <sup>®</sup> , Brovana <sup>®</sup> , and Xopenex <sup>®</sup> inhalation solution
Bone Resorption Suppression & Related Agents	<b>alendronate sodium, Actonel<sup>®</sup>,</b> Fosamax <sup>®</sup> solution, Fosamax Plus D <sup>®</sup> , and Miacalcin <sup>®</sup> nasal	Actonel <sup>®</sup> w/calcium, Boniva <sup>®</sup> , Didronel <sup>®</sup> , Fortical <sup>®</sup> , and Forteo <sup>®</sup> subcutaneous
Oral Cephalosporins and Related Antibiotics	amoxicillin/clavulanate tablets and suspension, cefdinir, cefaclor, cefuroxime, cephalexin, and Suprax <sup>®</sup> . Brand name drugs of preferred generics will still require prior authorization.	<b>cefadroxil, cefprozil, Cedax<sup>®</sup>,</b> Augmentin XR <sup>®</sup> , <b>Spectracef<sup>®</sup>,</b> cefpodoxime, and Raniclor <sup>®</sup>
Cytokine and CAM Antagonists	Enbrel <sup>®</sup> , Humira <sup>®</sup> , Kineret <sup>®</sup> , and Raptiva <sup>®</sup>	Amevive <sup>®</sup> , Orencia <sup>®</sup> , and Remicade <sup>®</sup>
Oral Fluoroquinolones	Levaquin <sup>®</sup> , Avelox <sup>®</sup> , and ciprofloxacin tablets	ciprofloxacin ER, Cipro <sup>®</sup> suspension, Factive <sup>®</sup> , Noroxin <sup>®</sup> , ofloxacin, and Proquin XR <sup>®</sup>
Hepatitis B Agents	Prescriber choice will be allowed within this drug class and Epivir-HBV <sup>®</sup> , Tyzeka <sup>®</sup> , Hepsera <sup>®</sup> , and Baraclude <sup>®</sup> be designated as preferred agents.	None
Incretin Hypoglycemics	Byetta <sup>®</sup> , Symlin <sup>®</sup> . Current therapeutic criteria for Byetta <sup>®</sup> and Symlin <sup>®</sup> will be retained.	Janumet <sup>®</sup> and Januvia <sup>®</sup>
Inhaled Glucocorticoids	<b>Symbicort<sup>®</sup>, AeroBid<sup>®</sup>, AeroBid-M<sup>®</sup>, Asmanex<sup>®</sup>, Azmacort<sup>®</sup>, and QVAR<sup>®</sup></b>	Advair Diskus <sup>®</sup> , Advair HFA <sup>®</sup> , Flovent <sup>®</sup> , Flovent HFA <sup>®</sup> , Pulmicort Flexhaler <sup>®</sup> , Pulmicort Respules <sup>®</sup> . Current therapeutic criteria for long-acting beta agonist/inhaled glucocorticoid combinations and Pulmicort Respules <sup>®</sup> will remain in effect.
Intranasal Rhinitis Agents	<b>Veramyst<sup>®</sup>, Astelin<sup>®</sup>,</b> ipratropium nasal spray, <b>fluticasone,</b> Nasacort AQ <sup>®</sup> , and Nasonex <sup>®</sup>	Omnaris <sup>®</sup> , Beconase AQ <sup>®</sup> , flunisolide, Nasarel <sup>®</sup> , and Rhinocort Aqua <sup>®</sup>

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS*
Insulins	Humalog <sup>®</sup> , Humalog <sup>®</sup> mixture, Humulin <sup>®</sup> , Lantus <sup>®</sup> , Levemir <sup>®</sup> , Novolin <sup>®</sup> , Novolog <sup>®</sup> , and Novolog <sup>®</sup> mixture	Apidra
Leukotriene Modifiers	<b>Accolate<sup>®</sup></b> and Singulair <sup>®</sup>	Zyflo CR <sup>®</sup>
Macrolides/Ketolides	<b>Zmax<sup>®</sup></b> , azithromycin generic, clarithromycin generic, and erythromycin generic	<b>clarithromycin ER</b> and Ketek <sup>®</sup>  Ketek <sup>®</sup> will continue to be subject to prior authorization with strict adherence to the package insert.
NSAIDS	diclofenac, etodolac, fenoprofen, flurbiprofen, ibuprofen (RX), indomethacin, ketorolac, <b>meclofenamate, meloxicam, nabumetone, naproxen (RX),</b> oxaprozin, piroxicam, and sulindac	Arthrotec <sup>®</sup> , Celebrex <sup>®</sup> , ketoprofen, mefenamic acid, Prevacid Naprapac <sup>®</sup> , and tolmetin  The therapeutic prior authorization rule currently in place for Celebrex <sup>®</sup> will remain
Ophthalmics for Allergic Conjunctivitis	Acular <sup>®</sup> , Alrex <sup>®</sup> , cromolyn sodium, Elestat <sup>®</sup> , Optivar <sup>®</sup> , Patanol <sup>®</sup> , and Pataday <sup>®</sup>	Alocril <sup>®</sup> , Almast <sup>®</sup> , Alomide <sup>®</sup> , Emadine <sup>®</sup> , and ketotifen
Ophthalmic Fluoroquinolone Antibiotics	<b>erythromycin</b> , ciprofloxacin, <b>Iquix<sup>®</sup></b> , ofloxacin, Vigamox <sup>®</sup> , and Zymar <sup>®</sup>	<b>Azasite<sup>®</sup></b> , Ciloxan <sup>®</sup> ointment, and Quixin <sup>®</sup>
Ophthalmic Glaucoma Agents	Combigan <sup>®</sup> , Alphagan P <sup>®</sup> , Azopt <sup>®</sup> , betaxolol, Betimol <sup>®</sup> , Betoptic S <sup>®</sup> , brimonidine, carteolol, Cosopt <sup>®</sup> , dipivefrin, Istalol <sup>®</sup> , levobunolol, Lumigan <sup>®</sup> , metipranolol, pilocarpine, timolol, Travatan <sup>®</sup> , Travatan Z <sup>®</sup> , Trusopt <sup>®</sup> , and Xalatan <sup>®</sup>	None  Brand name agents not listed as preferred agents will still require prior authorization.
Ophthalmics, NSAIDS	Acular LS <sup>®</sup> ophthalmic, Acular PF <sup>®</sup> ophthalmic, flurbiprofen ophthalmic, Nevanac <sup>®</sup> ophthalmic, and Xibrom <sup>®</sup> ophthalmic	diclofenac ophthalmic
Platelet Aggregation Inhibitors	Aggrenox <sup>®</sup> , dipyridamole, and Plavix <sup>®</sup>	ticlopidine

\*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.