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## MEDICAID INFORMATION RELEASE 2009-05

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 January 16, 2009, and February 20, 2009.

Drug/Drug Classes:

Noted below

Implementation Date:

Effective for dates of service on or after April 1, 2009

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 <a href="https://www.medicaidpharmacy.idaho.gov">www.medicaidpharmacy.idaho.gov</a>

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

THERAPEUTIC	PREFERRED	NON-PREFERRED
DRUG CLASS	AGENTS	AGENTS*
Analgesics, Narcotics Long-Acting	Duragesic <sup>®</sup> , methadone generic, Kadian <sup>®</sup> , and morphine extended release generic  Duragesic <sup>®</sup> is recommended as preferred over generic fentanyl	fentanyl transdermal generic, Avinza <sup>®</sup> , Opana ER <sup>®</sup> , Oxycontin <sup>®</sup> , and oxycodone extended release generic
	transdermal when the therapeutic prior authorization criteria are met.	
Analgesics, Narcotics Short-Acting	propoxyphene/acetaminophen generic 100mg, 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, tramadol/acetaminophen generic	levorphanol generic, pentazocine/acetaminophen generic, oxycodone/aspirin 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	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 <sup>®</sup> , Teveten <sup>®</sup> , Teveten HCT <sup>®</sup> , Atacand <sup>®</sup> , Atacand HCT <sup>®</sup> , moexepril and moexepril/HCTZ generic, Tekturna <sup>®</sup> , Tekturna HCT <sup>®</sup> , trandolapril generic, and ramipril generic

THERAPEUTIC	PREFERRED	NON-PREFERRED
DRUG CLASS Angiotensin	AGENTS Exforge® and Azor®	AGENTS* benazepril/amlodipine generic, Tarka®
Modulator—Calcium	Extorge and Azor	benazeprivamiouipme generic, Tarka
Channel Blocker		Separate component drugs must be used in
Combination Drugs		place of benazepril/amlodipine combinations.
Anticoagulants,	Fragmin <sup>®</sup> , Lovenox <sup>®</sup> , and	Innohep®
Injectable	Arixtra®	Ппопор
Anticonvulsants	Trileptal® suspension,	Trileptal® oral, Stavzor®, Phenytek®,
1 introdity and alits	divalproex generic,	Tegretol XR <sup>®1</sup> , Felbatol <sup>®</sup> , lamotrigine
	methobarbital generic,	generic <sup>2</sup> and levetiracetam generic <sup>2</sup>
	phenobarbital generic,	general manufacture general
	clonazepam generic,	<sup>1</sup> Participants currently receiving Tegetrol
	carbamazepine generic,	XR® will be "grandfathered" and will not
	Carbatrol®, Equetro®, phenytoin	need to switch to a preferred agent.
	generic, mephobarbital generic,	
	primidone generic, valproic	<sup>2</sup> These anticonvulsants are recommended as
	acid generic, Depakote®	preferred for epilepsy and other seizure
	sprinkle, Depakote ER®,	disorders only. Non-seizure indications will
	Depakote <sup>®</sup> , Celontin <sup>®</sup> ,	still require that therapeutic prior
	Peganone <sup>®</sup> , Gabitril <sup>®</sup> ,	authorization criteria are met.
	ethosuximide generic,	
	zonisamide generic <sup>2</sup> ,	
	oxcarbazine generic <sup>2</sup> , Lyrica <sup>®2</sup> ,	
	gabapentin generic <sup>2</sup> ,	
	Topamax <sup>®2</sup> , Keppra XR <sup>®2</sup> ,	
A	Lamictal®2, and Diastat®	
Antihistamines,	loratadine generic and	Claritin® chew, Semprex D®, cetirizine
Minimally Sedating	loratadine syrup, cetirizine	syrup RX, cetirizine RX generic,
	generic and syrup	Clarinex/Clarinex D <sup>®</sup> , Clarinex <sup>®</sup> syrup,
		Zyrtec/Zyrtec-D <sup>®</sup> , Xyzal <sup>®</sup> , Xyzal <sup>®</sup> syrup,
		Allegra®syrup, Allegra® ODT, fexofenadine
		generic, loratadine D generic, cetirizine D generic
Antimigraine Agents,	Maxalt/Maxalt MLT®,	sumatriptan generic, Treximet <sup>®</sup> , Amerge <sup>®</sup> ,
Triptans	Relpax <sup>®</sup> , Imitrex (oral) <sup>®</sup> ,	Axert <sup>®</sup> , Frova <sup>®</sup> , Zomig/ZomigZMT <sup>®</sup> , and
xixheem	Imitrex (nasal) ®, and Imitrex®	Zomig® (nasal)
	SQ , und mindex	
		Amerge <sup>®</sup> , and Zomig/ZomigZMT <sup>®</sup> will be
		"grandfathered" for current patients. These
		agents will be non-preferred and require
		prior-authorization for new patients.

THERAPEUTIC	PREFERRED	NON-PREFERRED
DRUG CLASS	AGENTS	AGENTS*
Beta Blockers	Levatol <sup>®</sup> , Innopran XL <sup>®</sup> , atenolol generic, metoprolol generic, propranolol generic, sotalol generic, nadolol generic, acebutolol generic, labetalol generic, pindolol generic, timolol generic, bisoprolol generic, and carvedilol generic	Bystolic®, betaxolol generic, Coreg CR®
Bladder Relaxant Preparations	oxybutynin generic, Vesicare®, Oxytrol®transdermal, and Detrol LA®	Enablex <sup>®</sup> , Sanctura <sup>®</sup> , Sanctura XR <sup>®</sup> , oxybutynin ER generic, and Detrol <sup>®</sup>
BPH Treatments	doxazosin generic, terazosin generic, <b>Proscar</b> ®, Uroxatral®, Cardura XL®, Flomax®, Avodart®, and finasteride generic	There are no agents designated as non-preferred.
Calcium Channel	Dynacirc CR®, verapamil	verapamil ER PM, generic, Cardizem
Blockers	generic, , diltiazem generic, nifedipine IR/ER generic, felodipine ER generic, and amlodipine generic	LA®, nicardipine generic, Cardene SR®, Covera-HS®, isradipine generic, and Sular®
Erythropoiesis Stimulating Proteins	Aranesp <sup>®</sup> and Procrit <sup>®</sup>	Epogen®
Growth Hormone	Genotropin®, Nutropin®, Nutropin AQ®, and Norditropin®	Saizen <sup>®</sup> , Tev-Tropin <sup>®</sup> , Serostim <sup>®</sup> , Humatrope <sup>®</sup> , Omnitrope <sup>®</sup> , and Zorbtive <sup>®</sup>
		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 <sup>®</sup> , Peg-Intron <sup>®</sup> , <b>Peg-Intron Redipen<sup>®</sup></b> , and ribavirin generic	Infergen <sup>®</sup>
Hypoglycemics, Meglitinides	Starlix® and Prandin®	There are no agents designated as non-preferred

THERAPEUTIC	PREFERRED	NON-PREFERRED
DRUG CLASS	AGENTS Avandia <sup>®</sup> , Actos <sup>®</sup> ,	AGENTS*
Hypoglycemics, TZD		There are no agents designated as
	Avandamet <sup>®</sup> , Avandaryl <sup>®</sup> ,	non-preferred.
	Actoplus Met <sup>®</sup> , and Duetact <sup>®</sup>	
Immation Aponta		Altabax® 10G and 15G, and
Impetigo Agents,	mupirocin ointment generic, and Altabax® 5G tube	Bacroban® cream
Topical Lipotropics, Other	Niacor <sup>®</sup> , Niaspan <sup>®</sup> ,	Antara®, Zetia®, Triglide®, Welchol®,
Lipotropics, Other	gemfibrozil generic,	Lipofen <sup>®</sup> , and Lovaza <sup>®</sup>
	colestipol generic, Tricor <sup>®</sup> ,	Lipoten, and Lovaza
	cholestyramine generic, and	
	fenofibrate generic	
Lipotropics, Statins	Simcor®, Altoprev®,	Advicor <sup>®</sup> , Crestor <sup>®</sup> ,
Lipotropies, Status	Caduet®, Lescol/Lescol	and Vytorin®
	XL <sup>®</sup> , Lipitor <sup>®</sup> , lovostatin	and vytorm
	generic, pravastatin	
	generic, and simvastatin	
	generic	
Multiple Sclerosis	Betaseron®, Avonex®,	There were no agents designated as
Agents	Rebif <sup>®</sup> , and Copaxone <sup>®</sup>	non-preferred.
Otic Fluoroquinolones	Floxin®, ofloxacin generic	Cipro® HC otic
One Praoroquinolones	otic and Ciprodex® otic	Cipro Tie oue
Phosphate Binders	PhosLo®, Fosrenol®, and	Renvela®, and calcium acetate
	Renagel <sup>®</sup>	generic
Proton Pump	Prevacid®solutab and	Prilosec® OTC,, Zegerid®, Aciphex®,
Inhibitors	suspension, Nexium®	omeprazole generic, pantoprazole
Illinoitors	capsule and suspension, and	generic
	Prevacid® capsule	generie
	and the same of th	All current therapeutic criteria except
		those associated with the solutab form of
		Prevacid will be removed
Sedative Hypnotics	chloral hydrate generic,	Lunesta®, flurazepam generic,
bedative riyphotics	temazepam generic,	Rozerem <sup>®</sup> , Ambien CR <sup>®</sup> , Doral <sup>®</sup> ,
	triazolam generic, Restoril®	estazolam generic, and zaleplon generic
	7.5 mg, and zolpidem	Betterne, with think proving contract
	generic	Lunesta® will be "grandfathered" for
	, b	current patients.
Skeletal Muscle	baclofen generic,	orphenadrine compound generic,
Relaxants	chlorzoxazone generic,	orphenadrine generic, carisoprodol
	cyclobenzaprine generic,	generic, carisoprodol compound, Soma®,
	dantrolene generic,	Skelaxin <sup>®</sup> , Zanaflex <sup>®</sup> , and Fexmid <sup>®</sup>
	methocarbamol generic, and	
	tizanidine generic	

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS*
Ulcerative Colitis Agents	balsalazide generic, sulfasalazine generic, mesalamine rectal generic, Asacol <sup>®</sup> , Pentasa <sup>®</sup> , and Canasa <sup>®</sup>	Dipentum <sup>®</sup> and Lialda <sup>®</sup>
Pulmonary Arterial Hypertension (PAH) Agents, Oral	Revatio® and Letairis®	Tracleer®
Cough and Cold Agents	All generic products both prescription and non-prescription Cough and Cold preparations are restricted to Medicaid participants 7 years and older. Quantity limits of 4 oz. per prescription and no more than two prescriptions per six months per participant.	All branded products

<sup>\*</sup>Use of non-preferred agents must meet prior authorization requirements.

## Idaho Medicaid Provider Handbook

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

<sup>\*</sup>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.