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**MEDICAID INFORMATION RELEASE 2009-16**

**To:** Prescribing Providers, Pharmacists, and Hospitals

**From:** Leslie M. Clement, Administrator
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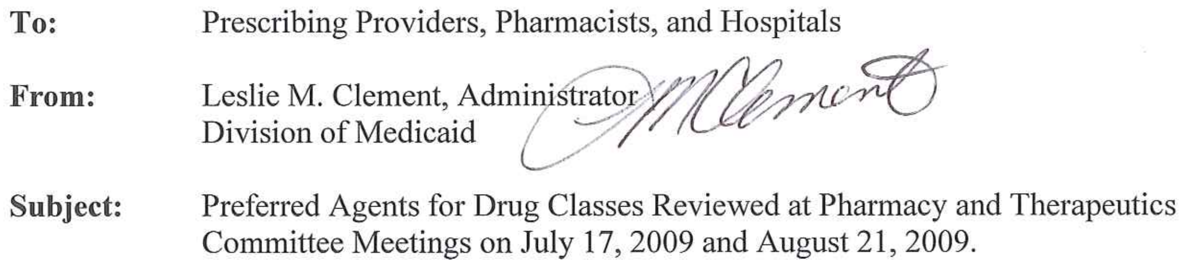

**Subject:** Preferred Agents for Drug Classes Reviewed at Pharmacy and Therapeutics Committee Meetings on July 17, 2009 and August 21, 2009.

| Drug/Drug Classes: | Noted below |
|---|---|
| Implementation Date: | Effective for dates of service on or after October 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: **www.medicaidpharmacy.idaho.gov**

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

| THERAPEUTIC DRUG CLASS | PREFERRED AGENTS | NON-PREFERRED AGENTS* |
|---|---|---|
| Antibiotics, Vaginal | Cleocin®, clindamycin, Clindesse® metronidazole and **Vandazole®** | There are no agents recommended by the committee as non-preferred. |
| Analgesics/Anesthetics | Lidoderm® | Voltaren gel ® and Flector® |
| Alzheimer Agents | Aricept® and Aricept ODT® preferred for **mild to severe** dementia ratings. Exelon®, Exelon® patch, **galantamine** and **galantamine ER** as preferred agents for **mild to moderate** dementia ratings. Namenda® as a preferred agent for **moderate to severe** dementia ratings.<br><br>Current therapeutic prior authorization criteria will continue to be required. | Cognex® |
| Androgenic Agents | Androderm® and Androgel ® | Testim® |
| Bronchodilators, Anticholenergic | Atrovent HFA ® metered dose inhaler, Combivent® metered dose inhaler, ipratropium nebulizer solution and Spiriva Handihaler® inhalation powder | ipratropium/albuterol nebulizer solution |
| Antidepressants, Other | **venlafaxine ER**, mirtazapine, buproprion IR, buproprion SR, buproprion XL,Effexor® XR, **Marplan®, Parnate® and Nardil®** | nefazodone, venlafaxine, Cymbalta®, Pristiq®, Emsam® patch, **tranylcypromine sulfate,** and **Aplenzin®** |
| Antidepressants, SSRI | citalopram, fluoxetine, fluvoxamine, and sertraline | Lexapro®, paroxetine, paroxetine CR, Pexeva®, Prozac® Weekly, and Luvox® CR |
| Antiemetics, Oral | Emend®, ondansetron, and ondansetron ODT<br><br>Current therapeutic prior authorization criteria will remain in effect for all of these agents. Therapeutic criteria for Emend® will be updated. | Anzemet®, granisetron, Marinol®, Cesamet®, **Sancuso®** and **dronabinol** |
| Antifungals, Oral | fluconazole, ketoconazole, and nystatin<br>Brand name drugs of preferred generics will still require prior authorization. | **clotrimazole**, Ancobon®, griseofulvin suspension, Grifulvin® V tablets, Gris-Peg®, itraconazole , Lamisil®, Noxafil®, terbinafine and Vfend® |

| THERAPEUTIC DRUG CLASS | PREFERRED AGENTS | NON-PREFERRED AGENTS* |
|---|---|---|
| Antifungals, Topical | clotrimazole/betamethasone, ketoconazole topical and shampoo, Naftin®, nystatin, nystatin/triamicinolone, econazole. **clotrimazole OTC and RX, miconazole OTC, terbinafine OTC, tolnaftate OTC,** | ciclopirox cream / suspension/gel/solution/lacquer, Ertaczo®, Exelderm®, Loprox® shampoo, Mentax®, Oxistat®, **Bensal HP®**, Xolegel®, CNL8®, Extina and Vusion®<br><br>**OTC products require a written prescription.** |
| **Antihyperuricemics** | **allopurinol, colchicine, probenecid/colchicines and probenecid** | **Uloric®** |
| Antiparkinson's Agents | benztropine, carbidopa/levodopa, ropinirole, selegiline, Stalevo® and trihexyphenidyl | Requip XL®, Azilect ®, Comtan®, Mirapex®, Tasmar®, Zelapar® and carbidopa/levodopa OTC |
| Antiparasitics, Topical | permethrin, **permethrin OTC,** Eurax®, Ovide® | lindane and **malathion** |
| **Antipsychotics, Atypical** | **Fazaclo®, risperidone, Geodon®, Seroquel®, Seroquel XR®, Zyprexa®, Symbyax®, Invega®, Abilify® and Risperdal Consta®**<br><br>**All current patients will be "grandfathered."**<br><br>**All Atypical Antipsychotic agents will be subject to prior authorization for FDA labeled indications and evidence-based off label indications. Zyprexa will be limited to FDA labeled indications.** | **None** |
| **Antipsychotics, Typical** | **fluphenazine, amitriptyline/perphenazine, haloperidol, thiothixene, chlorpromazine, perphenazine, trifuloperazine, haloperidol decanoate, Moban®, fluphenazine/decanoate injection and clozapine**<br><br>**All current patients will be "grandfathered."** | **thioridazine** |

| THERAPEUTIC DRUG CLASS | PREFERRED AGENTS | NON-PREFERRED AGENTS* |
|---|---|---|
| Antivirals, Oral | **rimantadine, Relenza®**, acyclovir, amantadine, Tamiflu® and Valtrex® | Famvir® and **famciclovir** |
| Antivirals, Topical | Denavir® and Zovirax® cream | Zovirax® ointment |
| Atopic Dermatitis | Elidel® and Protopic® | None |
| Beta Agonist Bronchodilators | albuterol all formulations except low-dose nebulizer, Proair HFA® metered dose inhaler, Ventolin HFA® metered dose inhaler, Foradil Aerolizer® metered dose inhaler, Serevent Diskus® dry powder inhaler and terbutaline oral tablets | **albuterol nebulizer low-dose, Maxair® inhaler**, metaproterenol all formulations, Performist®, Brovana®, Xopenex® inhalation solution, **Xopenex® HFA metered dose inhaler, Proventil® HFA metered dose inhaler** |
| Bone Resorption Suppression & Related Agents | alendronate sodium, Actonel®, Miacalcin® nasal, Boniva® | Actonel® w/calcium, Fortical®, Forteo® subcutaneous, **Fosomax® solution, Fosomax PlusD®, etidronate disodium,** and calcitonin salmon |
| Oral Cephalosporins and Related Antibiotics | **Augmentin 125 suspension, Augmentin 250 suspension**, amoxicillin/clavulanate tablets and suspension, cefdinir, cefaclor, **cefprozil, cefadroxil**, cefuroxime, cephalexin, and Suprax ®.<br><br>Brand name drugs of preferred generics will still require prior authorization. | Cedax®, Augmentin XR®, Spectracef®, cefpodoxime |
| Cytokine and CAM Antagonists | Enbrel®, Humira®, Kineret® and **Cimzia®** | Amevive®, Orencia® and Remicade® |
| Oral Fluoroquinolones | **Cipro suspension**, Levaquin®, Avelox® and ciprofloxacin tablets | ciprofloxacin ER, Factive®, Noroxin®, ofloxacin and Proquin XR® |
| Incretin Hypoglycemics | none | **Byetta®, Symlin®**, Janumet® and Januvia® |
| Hypoglycemics, Insulin and Related Agents | Humalog®, Humalog® mixture, **Humalog® pens**, Humulin®, and **Humulin® pens**, Lantus® pens, Levemir®, Novolin®, Novolog® and Novolog® mixture and pens | Apidra® and **Apidra® pens** |
| Inhaled Glucocorticoids | **Advair®, Advair® HFA, Flovent®, Flovent® HFA**, Symbicort®, AeroBid®, AeroBid-M®, Asmanex®, Azmacort® and QVAR® | Pulmicort Flexhaler®, Pulmicort Respules®, Alvesco® and **budesonide respules** |

| THERAPEUTIC DRUG CLASS | PREFERRED AGENTS | NON-PREFERRED AGENTS* |
|---|---|---|
| Intranasal Rhinitis Agents | **Astepro®**, Astelin®, ipratropium nasal spray, fluticasone, Nasonex® | Patanase®**, Nasacort AQ®, Veramyst®**, Omnaris®, Beconase AQ®, flunisolide, Rhinocort Aqua® |
| Leukotriene Modifiers | Accolate® and Singulair® | Zyflo CR ® |
| Macrolides/Ketolides | Zmax®, azithromycin, clarithromycin, erythromycin | clarithromycin ER and Ketek.® Ketek® will continue to be subject to prior authorization with strict adherence to the package insert. |
| NSAIDS | diclofenac, etodolac, fenoprofen, flurbiprofen, ibuprofen (RX), **ibuprofen OTC**, ketoprofen, indomethacin, ketorolac, meloxicam, nabumetone, naproxen (RX), oxaprozin, piroxicam and sulindac | Arthrotec®, Celebrex®, **meclofenamate**, and tolmetin<br><br>The therapeutic prior authorization rule currently in place for Celebrex ® will remain |
| Ophthalmics for Allergic Conjunctivitis | Alrex®, **ketotifen OTC**, cromolyn sodium, Patanol®, and Pataday® | **Elestat®, Optivar®, Acular®**, Alocril®, Almast®, Alomide®, Emadine®, |
| Ophthalmics, Antibiotics | **neomycin-polymyxin-gramicidian, bacitracin, bacitracin/polymyxin, gentamicin, sulfacetamide, tobramycin, Tobrex® ointment, Ciloxin® ointment, triple antibiotic**, erythromycin, ciprofloxacin, ofloxacin, Vigamox® | **Azasite®**, Zymar®, Iquix®, Natacyn®, Quixin®, Ciloxin® solution and Tobrex® solution |
| Ophthalmic Glaucoma Agents | Propine®, Combigan®, Alphagan P®, Azopt®, betaxolol, Betimol®, Betoptic S ®, brimonidine, carteolol, Cosopt ®, Istalol®, levobunolol, Lumigan 5 ml and 7.5 ml, , metipranolol, pilocarpine, timolol, Travatan®, Travatan Z®, Trusopt® and Xalatan® | dorzolamide/timolol, dorzolamide, and **Lumigan 2.5 ml**<br><br>Brand name agents not listed as preferred agents will still require prior authorization. |
| Pancreatic Enzymes | pancrelipase, Creon® and Ultrase® | Pancrecarb® MS, **Pancrease® MT** and **Viokase®** |
| Platelet Aggregation Inhibitors | Aggrenox®, dipyridamole and Plavix® | Ticlopidine |

| THERAPEUTIC DRUG CLASS | PREFERRED AGENTS | NON-PREFERRED AGENTS* |
|---|---|---|
| Stimulants and Related Agents | Concerta®, Vyvanse®, Adderall® XR, amphetamine salt combo, dexmethylphenidate, dextroamphetamine, **Focalin®**, Focalin® XR, Metadate® CD, methylphenidate, and methyl-phenidate ER. Current therapeutic prior authorization guidelines for diagnosis and contraindications will remain in effect. | Daytrana®, Desoxyn®, Provigil®, Ritalin® LA, Strattera®, **Nuvigil®, Procenta®** and **amaphetamine salt combo ER** |

*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.