IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

LESLIE M. CLEMENT - Administrator
DIVISION OF MEDICAID
Post Office Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 334-5747
FAX: (208) 364-1811

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MEDICAID INFORMATION RELEASE #2007-20

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 April 20, June 15, and August 17, 2007

Drug/Drug Classes: **Noted below**

Implementation Date: **Effective for dates of service on or after October 1, 2007**

Idaho Medicaid is noting 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 nationally recognized peer-reviewed information and evidence-based clinical criteria. 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 all drug classes is available online at www.medicaidpharmacy.idaho.gov

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS*
ACE Inhibitors	Altace®, Aceon® benazepril, benazepril/HCTZ , captopril, captopril/HCTZ, enalapril, enalapril/HCTZ, fosinopril, fosinopril/HCTZ, lisinopril, lisinopril/HCTZ, quinapril, and quinapril/HCTZ	moexipril, moexipril/HCTZ and trandolapril • Brand name drugs of preferred generics will still require prior authorization.

ADHD Drugs	Adderall® XR, amphetamine salt combo, Concerta®, dextroamphetamine, Focalin®, Focalin® XR, Metadate® CD, methylphenidate, and methylphenidate ER	Daytrana®, Desoxyn®, Provigil®, Ritalin® LA and Strattera® The current therapeutic prior authorization guidelines for diagnosis and contraindications remain in effect.
Alzheimer Agents	Aricept®, Aricept ODT® for **mild to severe** dementia ratings and Exelon® for **mild to moderate** dementia ratings. Namenda® for **moderate to severe** dementia ratings.	Cognex®, Razadyne® and Razadyne ER® • Current therapeutic prior authorization criteria will continue to be required.
Androgenic Agents	Androderm® and Androgel ®	Testim®
Anticholenergic Bronchodilators	Atrovent HFA ® metered dose inhaler, Combivent® metered dose inhaler, ipratropium nebulizer solution and Spiriva Handihaler® inhalation powder	Duoneb® inhalation solution
Antidepressants, SSRIs	citalopram, fluoxetine, fluvoxamine, and sertraline	Lexapro®, paroxetine, Pexeva®, Paxil CR®, Prozac® Weekly, and Sarafem® • All individuals currently on Lexapro®, paroxetine, and Paxil CR® will be "grandfathered." • Brand name drugs of preferred generics will still require prior authorization
Antiemetics, Oral	Emend®,Zofran® and Zofran ODT ® • Current therapeutic prior authorization criteria remain in effect for all of the class.	Anzemet®, Kytril® and ondansetron generic
Antifungals, Oral	clotrimazole, fluconazole, ketoconazole, and nystatin	Ancobon®,griseofulvin suspension, Grifulvin® V tablets, Gris-Peg®, itraconazole , Lamisil® , Noxafil® and Vfend® • Brand name drugs of preferred generics will still require prior authorization.
Antifungals, Topical	clotrimazole/betamethasone, ketoconazole shampoo, Naftin®, nystatin, and nystatin/triamicinolone	ciclopirox cream and suspension, econazole , Ertaczo®, Exelderm® , ketoconazole cream, Loprox® gel and shampoo, Mentax®, Oxistat®, Penlac®, Xolegel® and Vusion® • Current therapeutic prior authorization criteria for Penlac® will continue to be required. • Brand name drugs of preferred generics will still require prior authorization.

Anti-Parkinson Agents	benztropine, carbidopa/levodopa, Kemadrin®, Requip®, selgiline, Stalevo™ and trihexyphenidyl	Azilect®, Comtan®, Mirapex®, Parcopa®, pergolide, Tasmar® and Zelapar® • Current Mirapex® patients will be "grandfathered".
Antivirals	acyclovir, amantadine, ganciclovir, Tamiflu®, Valcyte®, and Valtrex®	Famvir®, Relenza® and rimantadine • Brand name drugs of preferred generics will still require prior authorization.
Atopic Dermatitis	Elidel® and Protopic®	No agents are recommended as non-preferred at this time.
Beta-Agonist Bronchodilators	albuterol CFC metered dose inhaler, albuterol HFA metered dose inhaler, albuterol inhalation solution, albuterol oral syrup, albuterol tablets, Proair HFA® metered dose inhaler, Proventil HFA® metered dose inhaler, Ventolin HFA® metered dose inhaler, Xopenex HFA® metered dose inhaler, Maxair Autoinhaler® metered dose inhaler, and terbutaline oral tablets	Accuneb® inhalation solution, Alupent® metered dose inhaler, Foradil Aerolizer® metered dose inhaler, metaproterenol inhalation solution, metaproterenol oral syrup, metaproterenol tablets, Serevent Diskus® dry powder inhaler, Vospire ER® and Xopenex® inhalation solution
Bone Resorption Suppression and Related Agents	Fosamax®, Fosamax Plus D® and Miacalcin® nasal	Actonel®, Actonel® w/calcium, Boniva®, Didronel®, Evista®, Fortical® and Forteo® subcutaneous
Oral Cephalosporins and Related Antibiotics	amoxicillin/clavulanate tablets and suspension, Cedax®, cefaclor, cefadroxil, cefuroxime, cefprozil, Cefzil®, cephalexin, Omnicef®, Spectracef®, and Suprax®	Augmentin XR®, cefdinir, cefpodoxime, Panixine®, and Raniclor® • Brand name drugs of preferred generics will still require prior authorization.
Cytokine and CAM Antagonists	Enbrel®, Humira®, Kineret® and Raptiva®	Amevive®, Orencia® and Remicade®
Fluroquinolones, Oral	Avelox®, ciprofloxacin tablets and Levaquin®	ciprofloxacin ER, Cipro®, Factive®, Noroxin®, ofloxacin and Proquin XR®
Hepatitis B Agents	Epivir–HBV®, Tyzeka®, Hepsera® and Baraclude®	
Incretin Hypoglycemics	Byetta® and Symlin®	Janumet® and Januvia® • Current therapeutic criteria for Byetta® and Symlin® will be retained.
Inhaled Glucocorticoids	AeroBid®, AeroBid-M®, Asmanex® Azmacort® and QVAR®	Advair Diskus®, Advair HFA®, Flovent®, Flovent HFA®, Pulmicort Flexhaler®, Pulmicort Respules® and Symbicort® • Current therapeutic criteria for Advair® and Pulmicort Respules® will remain in effect

Intranasal Rhinitis Agents	Astelin®, Flonase®, ipratropium nasal spray, Nasacort AQ® and Nasonex®	Atrovent®, Beconase AQ®, flunisolide, fluticasone, Nasarel® and Rhinocort Aqua®
Insulins	Humalog®,Humalog® mixture, Humulin®, Lantus®, Levemir®, Novolin®, Novolog®, and Novolog® mixture	Apidra® and Exubera®
Leukotriene Modifiers	Singulair® • Singulair® will still require therapeutic prior authorization for diagnosis for participants older than age 16	Accolate® and Zyflo®
Macrolides/Ketolides	azithromycin generic, clarithromycin generic and erythromycin generic	Biaxin® XL, Ketek® and Zmax® • Ketek® will be subject to prior authorization with strict adherence to the package insert.
Non-Steroidal Anti-inflammatory Agents	diclofenac, etodolac , fenoprofen, flurbiprofen, ibuprofen, indomethacin, ketorolac, naproxen, oxaprozin, piroxicam and sulindac,	Arthrotec®, Celebrex®, ketoprofen, meclofenamate, mefenamic acid, meloxicam, Mobic®, nabumetone, Prevacid Naprapac and tolmetin • The therapeutic prior authorization rule currently in place for Celebrex® will remain. • Brand name drugs of preferred generics will still require prior authorization.
Opthalmics for Allergic Conjunctivitis	Alaway®, Acular®, Alrex®, cromolyn sodium, Elestat®, Optivar®,Patanol®, Pataday and Zaditor® OTC	Alocril®, Almast®, Alomide®, Emadine®, and ketotifen
Ophthalmic Fluoroquinolone Antibiotics	ciprofloxacin, ofloxacin, Vigamox™ and Zymar™	Ciloxan® ointment and Quixin®
Ophthalmic Glaucoma Agents	Alphagan P®, Azopt®, betaxolol, Betimol®, Betoptic S®, brimonidine, carteolol, Cosopt®, dipivefrin , Istalol® levobunolol, Lumigan®, metipranolol, pilocarpine, timolol, Travatan®, Travatan Z®, Trusopt® and Xalatan® Prescriber choice will be allowed within this drug class. • Brand name agents not listed as preferred agents will still require prior authorization.	

Ophthalmics, NSAIDs	Acular LS ® ophthalmic, Acular PF ® ophthalmic, flurbiprofen ophthalmic, Nevanac ™ ophthalmic and Xibrom® ophthalmic	diclofenac ophthalmic
Platelet Aggregation Inhibitors	Aggrenox®, dipyridamole and Plavix®	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 Food and Drug Administration (FDA) guidelines or indications

IDAHO MEDICAID PROVIDER HANDBOOK

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