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## HEALTH & WELFARE

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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	PREFERRED	NON-PREFERRED
DRUG CLASS	AGENTS	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	Daytrana <sup>®</sup> , Desoxyn <sup>®</sup> , Provigil <sup>®</sup> , Ritalin <sup>®</sup>
ADID Drugs	Adderall® XR, amphetamine salt combo, Concerta®, dextroamphetamine, Focalin® XR, Metadate® CD,	LA and Strattera®
	Focalin®, Focalin® XR, Metadate® CD,	
	methylphenidate, and methylphenidate	The current therapeutic prior authorization
	ER	guidelines for diagnosis and
		contraindications remain in effect.
Alzheimer Agents	Aricept®, Aricept ODT® for mild to	Cognex®, Razadyne® and Razadyne ER®
Anzheimei 1180mus	severe dementia ratings and Exclon®	
	for mild to moderate dementia ratings.	Current therapeutic prior authorization
•	Namenda® for moderate to severe	criteria will continue to be required.
	dementia ratings.	
Androgenic Agents	Androderm® and Androgel®	Testim <sup>©</sup>
	Atrovent HFA ® metered dose inhaler,	
Anticholenergic	Combivent® metered dose inhaler,	Duoneb® inhalation solution
Bronchodilators	ipratropium nebulizer solution and	
	Spiriva Handihaler® inhalation powder	·
		Y Bound Brown Brown Brown CD®
Antidepressants,	citalopram, fluoxetine, fluvoxamine, and sertraline	Lexapro <sup>®</sup> , paroxetine, Pexeva <sup>®</sup> , Paxil CR <sup>®</sup> , Prozac <sup>®</sup> Weekly, and Sarafem <sup>®</sup>
SSRIs	and servaime	1102ab Wookiy, and balaisin
•	-	• All individuals currently on Lexapro®,
		paroxetine, and Paxil CR® will be
		"grandfathered."
		Brand name drugs of preferred
		generics will still require prior authorization
		authorization
Antiemetics, Oral	Emend®, Zofran® and Zofran ODT®	Anzemet®, Kytril® and ondansetron
,		generic
	Current therapeutic prior	
	authorization criteria remain in effect for all of the class.	
	effect for all of the class.	
Antifungals, Oral	clotrimazole, fluconazole, ketoconazole,	Ancobon <sup>®</sup> , griseofulvin suspension, Grifulvin <sup>®</sup> V tablets, Gris-Peg <sup>®</sup> ,
, , , , , , , , , , , , , , , , , , , ,	and nystatin	Grifulvin® V tablets, Gris-Peg®,
		itraconazole, Lamisil <sup>®</sup> , Noxafil <sup>®</sup> and
		Vfend®
		Brand name drugs of preferred generics
		will still require prior authorization.
Antifungals, Topical	clotrimazole/betamethasone,	ciclopirox cream and suspension,
	ketoconazole shampoo, Naftin®,	econazole, Ertaczo®, Exelderm®,
	nystatin, and nystatin/triamicinolone	ketoconazole cream, Loprox® gel and
		shampoo, Mentax <sup>®</sup> , Oxistat <sup>®</sup> , Penlac <sup>®</sup> , Xolegel <sup>®</sup> and Vusion <sup>®</sup>
***		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 <sup>®</sup> , Requip <sup>®</sup> , selgiline, Stalevo <sup>TM</sup> and trihexyphenidyl	Azilect <sup>®</sup> , Comtan <sup>®</sup> , Mirapex <sup>®</sup> , Parcopa <sup>®</sup> , pergolide, Tasmar <sup>®</sup> and Zelapar <sup>®</sup> • Current Mirapex <sup>®</sup> patients will be "grandfathered".
Antivirals	acyclovir, amantadine, ganciclovir, Tamiflu <sup>®</sup> , Valcyte <sup>®</sup> , and Valtrex <sup>®</sup>	Famvir <sup>®</sup> , Relenza <sup>®</sup> 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 <sup>®</sup> , Fosamax Plus D <sup>®</sup> and Miacalcin <sup>®</sup> nasal	Actonel <sup>®</sup> , Actonel <sup>®</sup> w/calcium, Boniva <sup>®</sup> , Didronel <sup>®</sup> , Evista <sup>®</sup> , Fortical <sup>®</sup> and Forteo <sup>®</sup> subcutaneous
Oral Cephalosporins and Related Antibiotics	amoxicillin/clavulanate tablets and suspension, Cedax®, cefaclor, cefadroxil, cefuroxime, cefprozil, Cefzil®, cephalexin, Omnicef®, Spectracef®, and Suprax®	Augmentin XR <sup>®</sup> , cefdinir, cefpodoxime, Panixine <sup>®</sup> , and Raniclor <sup>®</sup> Brand name drugs of preferred generics will still require prior authorization.
Cytokine and CAM Antagonists	Enbrel <sup>®</sup> , Humira <sup>®</sup> , Kineret <sup>®</sup> and Raptiva <sup>®</sup>	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 <sup>®</sup> , Tyzeka <sup>®</sup> , Hepsera <sup>®</sup> and Baraclude <sup>®</sup>	
Incretin Hypoglycemics	Byetta® and Symlin®	Janumet® and Januvia ®  • Current therapeutic criteria for Byetta® and Symlin® will be retained.
Inhaled Glucocorticoids	AeroBid <sup>®</sup> , AeroBid-M <sup>®</sup> , Asmanex <sup>®</sup> Azmacort <sup>®</sup> and QVAR <sup>®</sup>	Advair Diskus <sup>®</sup> , Advair HFA <sup>®</sup> , Flovent <sup>®</sup> , Flovent HFA <sup>®</sup> , Pulmicort Flexhaler <sup>®</sup> , Pulmicort Respules <sup>®</sup> and Symbicort <sup>®</sup> • Current therapeutic criteria for Advair <sup>®</sup> and Pulmicort Respules <sup>®</sup> will remain in effect

Intranasal Rhinitis Agents	Astelin <sup>®</sup> , Flonase <sup>®</sup> , ipratropium nasal spray, Nasacort AQ <sup>®</sup> and Nasonex <sup>®</sup>	Atrovent <sup>®</sup> , Beconase AQ <sup>®</sup> , flunisolide, fluticasone, Nasarel <sup>®</sup> and Rhinocort Aqua <sup>®</sup>
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® and Exubera®
Leukotriene Modifiers	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 <sup>®</sup> , Acular <sup>®</sup> , Alrex <sup>®</sup> , cromolyn sodium, Elestat <sup>®</sup> , Optivar <sup>®</sup> , Patanol <sup>®</sup> , Pataday and Zaditor <sup>®</sup> OTC	Alocril®, Almast®, Alomide®, Emadine®, and ketotifen
Ophthalmic Fluoroquinolone Antibiotics	ciprofloxacin, ofloxacin, Vigamox <sup>TM</sup> and Zymar <sup>TM</sup>	Ciloxan <sup>®</sup> ointment and Quixin <sup>®</sup>
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 <sup>®</sup> ophthalmic, Acular PF <sup>®</sup> ophthalmic, flurbiprofen ophthalmic, Nevanac <sup>TM</sup> ophthalmic and Xibrom <sup>®</sup> ophthalmic	diclofenac ophthalmic
Platelet Aggregation Inhibitors	Aggrenox®, dipyridamole and Plavix®	ticlopidine

## **IDAHO MEDICAID PROVIDER HANDBOOK**

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

<sup>\*</sup>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