

**Idaho Medicaid Pharmacy and Therapeutics Committee Recommendations  
August 15, 2008**

**The August 15, 2008 P&T Recommendations for the Vaginal Antibiotics are:**

- The Committee recommends that Cleocin<sup>®</sup>, clindamycin, Clindesse<sup>®</sup> and metronidazole be designated as preferred agents.
- There are no agents recommended by the committee as non-preferred.

**The August 15, 2008 P&T Recommendations for the Topical Antivirals are:**

- The Committee recommends that Zovirax<sup>®</sup> cream and Denavir<sup>®</sup> be designated as preferred agents.
- The Committee recommends that Zovirax<sup>®</sup> ointment be designated as a non-preferred agent that requires prior authorization.

**The August 15, 2008 P&T Recommendations for the Topical Antiparasitics are:**

- The Committee recommends that permethrin, Eurax<sup>®</sup>, and Ovide<sup>®</sup> be designated as preferred agents.
- The Committee recommends that lindane be designated as a non-preferred agent that requires prior authorization.

**The August 15, 2008 P&T Recommendations for the Analgesics/Anesthetics are:**

- The Committee recommends that Lidoderm<sup>®</sup> be designated as a preferred agent.
- The Committee recommends that Voltaren gel<sup>®</sup> and Flector<sup>®</sup> be designated as non-preferred agents that require prior authorization.

**The August 15, 2008 P&T Recommendations for the Pancreatic Enzymes are:**

- The Committee recommends that pancrelipase, Pancrease<sup>®</sup> MT, lapase, dygase, Viokase<sup>®</sup>, Lipram<sup>®</sup>, Creon<sup>®</sup> and Ultrase<sup>®</sup> be designated as preferred agents.
- The Committee recommends that Pancrecarb<sup>®</sup> MS be designated as a non-preferred agent that requires prior authorization.

**The August 15, 2008 P&T Recommendations for the Stimulants and Related Agents are:**

- The Committee recommends that Concerta<sup>®</sup>, Vyvanse<sup>®</sup>, Adderall<sup>®</sup> XR, amphetamine salt combo, dexamethylphenidate, dextroamphetamine, Focalin<sup>®</sup> XR, Metadate<sup>®</sup> CD, methylphenidate, and methylphenidate ER be designated as preferred agents.
- The Committee recommends that Daytrana<sup>®</sup>, Desoxyn<sup>®</sup>, Provigil<sup>®</sup>, Ritalin<sup>®</sup> LA and Strattera<sup>®</sup> be designated as non-preferred agents that require prior authorization.

- The Committee recommends that the current therapeutic prior authorization guidelines for diagnosis and contraindications remain in effect.

**The August 15, 2008 P&T Recommendations for the Alzheimer Agents are:**

- The Committee recommends that Aricept<sup>®</sup>, Aricept ODT<sup>®</sup> be designated preferred for **mild to severe** dementia ratings and Exelon<sup>®</sup>, Exelon<sup>®</sup> patch be designated as preferred agents for **mild to moderate** dementia ratings. The Committee recommends that Namenda<sup>®</sup> be designated as a preferred agent for **moderate to severe** dementia ratings.
- The Committee recommends that Cognex<sup>®</sup>, Razadyne<sup>®</sup> and Razadyne ER<sup>®</sup> be designated as non-preferred agents that require prior authorization.
- The Committee recommends that the current therapeutic prior authorization criteria continue to be required.

**The August 15, 2008 P&T Recommendations for the Androgenic Agents are:**

- The Committee recommends that Androderm<sup>®</sup> and Androgel<sup>®</sup> be designated as preferred agents.
- The Committee recommends that Testim<sup>®</sup> be designated as a non-preferred agent that requires prior authorization.

**The August 15, 2008 P&T Recommendations for the Anticholinergic Bronchodilators are:**

- The Committee recommends that Atrovent HFA<sup>®</sup> metered dose inhaler, Combivent<sup>®</sup> metered dose inhaler, ipratropium nebulizer solution and Spiriva Handihaler<sup>®</sup> inhalation powder be designated as preferred agents..
- The Committee recommends that Duoneb<sup>®</sup> inhalation solution and ipratropium/albuterol nebulizer solution be designated as non-preferred agents that require prior authorization.

**The August 15, 2008 P&T Recommendations for the Antidepressants classified as others are:**

- The Committee recommends that mirtazapine, bupropion IR, bupropion SR, bupropion XL, and Effexor<sup>®</sup> XR be designated as preferred agents.
- The Committee recommends that nefazodone, venlafaxine, Cymbalta<sup>®</sup>, Pristiq<sup>®</sup>, and Emsam<sup>®</sup> patch be designated as non-preferred agents that require prior authorization.

**The August 15, 2008 P&T Recommendations for the SSRI Antidepressants are:**

- The Committee recommends that, citalopram, fluoxetine, fluvoxamine, and sertraline be designated as preferred agents.

- The Committee recommends that Lexapro<sup>®</sup>, paroxetine, paroxetine CR, Pexeva<sup>®</sup>, Paxil CR<sup>®</sup>, Prozac<sup>®</sup> Weekly, and Luvox<sup>®</sup> CR be designated as non-preferred agents that require prior authorization.
- The Committee recommends that all individuals currently on Lexapro<sup>®</sup>, paroxetine, and Paxil CR<sup>®</sup> be “grandfathered.”

**The August 15, 2008 Recommendations for Oral Antiemetics are:**

- The Committee recommends that Emend<sup>®</sup>, ondansetron, ondansetron ODT and Zofran<sup>®</sup> ODT be designated as preferred agents.
- The committee recommends that Anzemet<sup>®</sup>, granisetron, Zofran<sup>®</sup> (non-ODT), Marinol<sup>®</sup>, and Cesamet<sup>®</sup> be designated as non-preferred agents that require prior authorization.
- The Committee recommends that current therapeutic prior authorization criteria remain in effect for all of these agents.

**The August 15, 2008 P&T Recommendations for the Oral Antifungals are:**

- The Committee recommends that clotrimazole, fluconazole, ketoconazole, and nystatin be designated as preferred agents.
- The Committee recommends that 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> be designated as non-preferred agents that require prior authorization.
- Brand name drugs of preferred generics will still require prior authorization.

**The August 15, 2008 P&T Recommendations for the Topical Antifungals are:**

- The Committee recommends that clotrimazole/betamethasone, ketoconazole topical and shampoo, Naftin<sup>®</sup>, nystatin, nystatin/triamcinolone, and econazole be designated as preferred prescription agents. In addition they recommend that the OTC preparations Tolnaftate<sup>®</sup> cream/powder/solution/spray, miconazole, Lamisil<sup>®</sup> AF, Tinactin<sup>®</sup> and clotrimazole be designated as preferred when a prescription is written.
- The Committee recommends that ciclopirox cream / suspension/gel/solution/lacquer, Ertaczo<sup>®</sup>, Exelderm<sup>®</sup>, Loprox<sup>®</sup> shampoo, Mentax<sup>®</sup>, Oxistat<sup>®</sup>, Xolegel<sup>®</sup>, CNL8<sup>®</sup>, Extina<sup>®</sup> and Vusion<sup>®</sup> be non-preferred agents that require prior authorization.
- The Committee recommends no changes to the current Penlac<sup>®</sup> prior authorization criteria.

**The August 15, 2008 P&T Recommendations for the Antiparkinson’s Agents are:**

- The Committee recommends that bromocriptine, benztropine, carbidopa/levodopa, ropinirole, selegiline, Stalevo<sup>®</sup> and trihexyphenidyl be designated as preferred agents.
- The Committee recommends that Azilect<sup>®</sup>, Comtan<sup>®</sup>, Mirapex<sup>®</sup>, Parcopa<sup>®</sup>, Tasmar<sup>®</sup> and Zelapar<sup>®</sup> be designated as non-preferred agents that require prior authorization.
- The Committee recommends that current Mirapex<sup>®</sup> patients be “grandfathered”.

**The August 15, 2008 P&T Recommendations for the Antivirals are:**

- The Committee recommends that acyclovir, amantadine, Tamiflu<sup>®</sup> and Valtrex<sup>®</sup> be designated as preferred agents.
- The Committee recommends that Relenza<sup>®</sup> inhalation, Famvir<sup>®</sup> and rimantadine be designated as non-preferred agents that require prior authorization.

**The August 15, 2008 P&T Recommendations for the Atopic Dermatitis are:**

- The Committee recommends that both Elidel<sup>®</sup> and Protopic<sup>®</sup> be designated as preferred agents.

**The August 15, 2008 P&T Recommendations for the Beta-Agonist Bronchodilators are:**

- The Committee recommends that 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, Foradil Aerolizer<sup>®</sup> metered dose inhaler, Serevent Diskus<sup>®</sup> dry powder inhaler and terbutaline oral tablets be designated as the preferred agents.
- The Committee recommends that Accuneb<sup>®</sup> inhalation solution, Alupent<sup>®</sup> metered dose inhaler, metaproterenol all formulations, Performist<sup>®</sup>, Brovana<sup>®</sup>, Vospire ER<sup>®</sup> and Xopenex<sup>®</sup> inhalation solution be designated as non-preferred agents that require prior authorization.

**The August 15, 2008 P&T Recommendations for the Bone Resorption Suppression and Related Agents are:**

- The Committee recommends that alendronate sodium, Actonel<sup>®</sup>, Fosamax<sup>®</sup> solution, Fosamax Plus D<sup>®</sup> and Miacalcin<sup>®</sup> nasal be designated as preferred agents.
- The Committee recommends that, Actonel<sup>®</sup>w/calcium, Boniva<sup>®</sup>, Didronel<sup>®</sup>, Fortical<sup>®</sup> and Forteo<sup>®</sup> subcutaneous be designated as non-preferred agents that require prior authorization.

**The August 15, 2008 P&T Recommendations for Oral Cephalosporins and Related Antibiotics are:**

- The Committee recommends that amoxicillin/clavulanate tablets and suspension, cefdinir, cefaclor, cefuroxime, cephalexin, and Suprax<sup>®</sup> be designated as preferred agents.
- The Committee recommends that cefadroxil, cefprozil, Cedax<sup>®</sup>, Augmentin XR<sup>®</sup>, Spectracef<sup>®</sup>, cefpodoxime, and Ranicl<sup>®</sup> be designated as non-preferred agents that require prior authorization.
- Brand name drugs of preferred generics will still require prior authorization.

**The August 15, 2008 Recommendations for Cytokine and CAM Antagonists are:**

- The Committee recommends that Enbrel<sup>®</sup>, Humira<sup>®</sup>, Kineret<sup>®</sup> and Raptiva<sup>®</sup>, be designated as preferred agents.
- The Committee recommends that Amevive<sup>®</sup>, Orencia<sup>®</sup> and Remicade<sup>®</sup> be designated as non-preferred agents that require prior-authorization.

**The August 15, 2008 P&T Recommendations for the Oral Fluoroquinolones are:**

- The Committee recommends that Levaquin<sup>®</sup>, Avelox<sup>®</sup> and ciprofloxacin tablets be designated as preferred agents.
- The Committee recommends that , ciprofloxacin ER, Cipro<sup>®</sup> suspension, Factive<sup>®</sup>, Noroxin<sup>®</sup>, ofloxacin and Proquin XR<sup>®</sup> be designated as non-preferred that require prior authorization.

**The August 15, 2008 Recommendations for Hepatitis B Agents are:**

- The Committee recommends that prescriber choice be allowed within this drug class and that Epivir–HBV<sup>®</sup>, Tyzeka<sup>®</sup>, Hepsera<sup>®</sup> and Baraclude<sup>®</sup> be designated as preferred agents.
- There are no agents recommended as non-preferred.

**The August 15, 2008 P&T Recommendations for Incretin Hypoglycemics are:**

- The Committee recommends that Byetta<sup>®</sup> and Symlin<sup>®</sup> be designated as preferred.
- The Committee recommends that Janumet<sup>®</sup> and Januvia<sup>®</sup> be designated as non-preferred.
- The Committee recommends that current therapeutic criteria for Byetta<sup>®</sup> and Symlin<sup>®</sup> be retained.

**The August 15, 2008 P&T Recommendations for the Inhaled Glucocorticoids are:**

- The Committee recommends that Symbicort<sup>®</sup>, AeroBid<sup>®</sup>, AeroBid-M<sup>®</sup>, Asmanex<sup>®</sup>, Azmacort<sup>®</sup> and QVAR<sup>®</sup> be designated as preferred agents.

- The Committee recommends that Advair Diskus<sup>®</sup>, Advair HFA<sup>®</sup>, Flovent<sup>®</sup>, Flovent HFA<sup>®</sup>, Pulmicort Flexhaler<sup>®</sup>, Pulmicort Respules<sup>®</sup> and be designated non-preferred agents that require prior authorization.
- The Committee recommends that the current therapeutic criteria for long-acting beta agonist/inhaled glucocorticoid combinations and Pulmicort Respules<sup>®</sup> remain in effect.

**The August 15, 2008 P&T Recommendations for the Intranasal Rhinitis Agents are:**

- The Committee recommends that Veramyst<sup>®</sup>, Astelin<sup>®</sup>, ipratropium nasal spray, fluticasone, Nasacort AQ<sup>®</sup> and Nasonex<sup>®</sup> be designated as preferred agents.
- The Committee recommends that Omnaris<sup>®</sup>, Beconase AQ<sup>®</sup>, flunisolide, Nasarel<sup>®</sup> and Rhinocort Aqua<sup>®</sup> be designated as non-preferred agents that require prior authorization.

**The August 15, 2008 P&T Recommendations for Insulins are:**

- The Committee recommends that 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 be designated as preferred agents.
- The Committee recommends that Apidra<sup>®</sup> be designated as a non-preferred agent that requires prior-authorization.

**The August 15, 2008 P&T Recommendations for the Leukotriene Modifiers are:**

- The Committee recommends that Accolate<sup>®</sup> and Singulair<sup>®</sup> be designated as the preferred agent.
- The Committee recommends that Zyflo CR<sup>®</sup> be designated as a non-preferred agent that requires prior authorization.

**The August 15, 2008 P&T Recommendations for Macrolides/Ketolides are:**

- The Committee recommends that Zmax<sup>®</sup>, azithromycin generic, clarithromycin generic and erythromycin generic be designated as preferred agents.
- The Committee recommends that clarithromycin ER and Ketek<sup>®</sup> and be designated as non-preferred agents that require prior authorization.
- The Committee recommends that Ketek<sup>®</sup> continue to be subject to prior authorization with strict adherence to the package insert.

**The August 15, 2008 P&T Recommendations for the Non-Steroidal Anti-inflammatory agents (NSAIDS) are:**

- The Committee recommends that diclofenac, etodolac, fenoprofen, flurbiprofen, ibuprofen (RX), indomethacin, ketorolac, meclofenamate, meloxicam, nabumetone, naproxen (RX), oxaprozin, piroxicam and sulindac, be designated as preferred agents.

- The Committee recommends that Arthrotec<sup>®</sup>, Celebrex<sup>®</sup>, ketoprofen, mefenamic acid, Prevacid Naprapac<sup>®</sup> and tolmetin be designated as non-preferred agents that require prior authorization.
- The Committee recommends that the therapeutic prior authorization rule currently in place for Celebrex<sup>®</sup> remain.

**The August 15, 2008 P&T Recommendations for the Ophthalmics for Allergic Conjunctivitis are:**

- The Committee recommends that Acular<sup>®</sup>, Alrex<sup>®</sup>, cromolyn sodium, Elestat<sup>®</sup>, Optivar<sup>®</sup>, Patanol<sup>®</sup>, and Pataday<sup>®</sup> be designated as preferred agents.
- The Committee recommends that Alocril<sup>®</sup>, Almast<sup>®</sup>, Alomide<sup>®</sup>, Emadine<sup>®</sup>, and ketotifen be designated as non-preferred agents that require prior authorization.

**The August 15, 2008 P&T Recommendations for the Ophthalmic Fluoroquinolone Antibiotics are:**

- The Committee recommends that erythromycin, ciprofloxacin, Iquix<sup>®</sup>, ofloxacin, Vigamox<sup>®</sup> and Zymar<sup>®</sup> be designated as preferred agents.
- The Committee recommends that Azasite<sup>®</sup>, Ciloxan<sup>®</sup> ointment and Quixin<sup>®</sup> be designated as non-preferred agents that require prior authorization.

**The August 15, 2008 P&T Recommendations for the Ophthalmic Glaucoma Agents are:**

- The Committee recommends that prescriber choice be allowed within this drug class and that 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> be designated as preferred agents.
- No agents are recommended as non-preferred at this time.
- Brand name agents not listed as preferred agents will still require prior authorization.

**The August 15, 2008 Recommendations for Ophthalmics, NSAIDs are:**

- The Committee recommends that Acular LS<sup>®</sup> ophthalmic, Acular PF<sup>®</sup> ophthalmic, flurbiprofen ophthalmic, Nevanac<sup>®</sup> ophthalmic and Xibrom<sup>®</sup> ophthalmic be designated as preferred agents.
- The Committee recommends that diclofenac ophthalmic be designated as non-preferred agents that require prior authorization.

**The August 15, 2008 P&T Recommendations for the Platelet Aggregation Inhibitors are:**

- The Committee recommends that Aggrenox<sup>®</sup>, dipyridamole and Plavix<sup>®</sup> be designated as preferred agents.
- The Committee recommends that ticlopidine be designated as a non-preferred agent that requires prior authorization.