**Idaho Medicaid Pharmacy and Therapeutics Committee Recommendations**
**February 22, 2010**

**The February 19, 2010 P&T Recommendations for the Hypoglycemics, TZD are:**

- Avandia®, Actos®, Avandamet®, Avandaryl®, Actoplus Met®, and Duetact® be designated as preferred agents.
- There were no agents designated as non-preferred.

**The February 19, 2010 P&T Recommendations for the Hypoglycemics, Meglitinides are:**

- Starlix® and Prandin® be designated as preferred agents.
- **Prandimet®** and **nateglinide** be designated as non-preferred agents that require prior authorization.

**The February 19, 2010 P&T Recommendations for the Lipotropics, Other are:**

- **Trilipix®**, Niacor®, Niaspan®, **Antara®**, **Tricor®** , gemfibrozil generic, colestipol generic, cholestyramine generic, be designated as preferred agents.
- **Fibricor®**, Zetia®, Triglide®, Welchol® , Lipofen®, Fenoglide®, **fenofibrate generic**, fenofibric acid, and Lovaza® be designated as non-preferred agents that require prior authorization.

**The February 19, 2010 P&T Recommendations for the Narcotic Analgesic, Short-Acting are:**

- **Reprexain®**, 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, and tramadol/acetaminophen generic be designated as preferred agents.
- **Nucynta®**, **Onsolis®**, levorphanol generic, **propoxyphene/acetaminophen 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, Ibudone, Dilaudid® liquid, Zamicet and dihydrocodeine/acetaminophen/caffeine generic be designated as non-preferred agents that require prior authorization.

**The February 19, 2010 P&T Recommendations for Narcotic Analgesics, Long Acting are:**

- methadone generic, Kadian®, **fentanyl transdermal generic** and morphine ER generic be designated as preferred agents.
- **Embeda®**, **Duragesic®**, **Duragesic Matrix®**, **Ultram ER®, Ryzolt®, Tramadol ER®,** Avinza®, Opana ER®, Oxycontin® and oxycodone extended release generic be designated as non-preferred agents that require prior authorization.
- Fentanyl transdermal generic will still require therapeutic prior authorization criteria be met.

**The February 19, 2010 Recommendations for Anticonvulsants are:**

- **Tegretol XR®** , Carbatrol®, Equetro®, carbamazepine XR, carbamazepine generic, Trileptal® suspension, oxcarbazepine tablets. levetiracetam generic[1], levetiracetam solution[1], Keppra tablets[1]. divalproex generic, valproic acid generic, Depakote® sprinkle, Depakote ER®, **divalproex ER**, **divalproex sprinkle**, methobarbital generic, phenobarbital generic, clonazepam generic, , phenytoin generic, Dilantin®**,** mephobarbital generic, primidone generic, Celontin® , Peganone®, Gabitril®, ethosuximide generic, zonisamide generic[1], Lyrica®[1], gabapentin generic[1] , lamotrigine generic[1] , **Lamictal XR®**[1], Topamax sprinkle®[1], **topiramate generic tablets[1]** and Diastat® be designated as preferred agents.
- **Banzel®, Vimpat®, Sabril®, Lamictal® and Lamictal ODT®, Keppra® solution, Keppra® XR**, **Depakote®**, **Trileptal® oral**, Stavzor®[1], Phenytek®, Felbatol® , **oxcarbazine suspension generic**, topiramate sprinkle**, Topamax tablets®** be designated as non-preferred agents that require prior authorization.
- [1] These anticonvulsants are recommended as preferred for epilepsy and other seizure orders only. Non-seizure indications will still require that therapeutic prior authorization criteria are met.
- Brand name anticonvulsants will be allowed for patients with seizure disorders who have been receiving them, are stable, and compliant.

**The February 19, 2010 Recommendations for Growth Hormone[1] are:**

- Genotropin®, Nutropin®, Nutropin AQ® and Norditropin® be designated as preferred agents.
- Saizen®, Tev-Tropin®, Serostim®, Humatrope®, Omnitrope® and Zorbtive® be designated as non-preferred agents that require prior authorization.
- [1] Current therapeutic criteria for growth hormone will continue to be required for all agents.
- Patients currently receiving non-preferred agents will be “grandfathered”. These agents will be non-preferred and require prior-authorization for new patients.

**The February 19, 2010 Recommendations for Hepatitis C Agents are:**

- Pegasys®, Peg-Intron®, Peg-Intron® Redipen, and ribavirin generic be designated as preferred agents.
- Infergen® as a non-preferred agent that requires prior authorization.

**The February 19, 2010 Recommendations for Multiple Sclerosis Agents are:**

- Betaseron®, Avonex®, Rebif® and Copaxone® be designated as preferred agents.
- **Extavia®** be designated as a non-preferred agent that requires prior authorization.

**The February 19, 2010 Recommendations for Erythropoiesis Stimulating Protiens are:**

- **Epogen®**, Aranesp® and Procrit® be designated as preferred agents.
- There were no agents in this class recommended as non-preferred.

**The February 10, 2010 Recommendations for Otic Antibiotic Preparations are:**

- **Coly-Mycin S®, Cortisporin TC®, neomycin/polymyxin/HC,** Floxin®, ofloxacin generic otic and Ciprodex® otic as preferred agents.
- **Cetraxal®**, and Cipro®HC, as non-preferred agents that require prior authorization.

**The February 19, 2010 Recommendations for Phosphate Binders are:**

- PhosLo®, and Renagel® as preferred agents.
- **Eliphos®, Fosrenol®**, Renvela®, and calcium acetate generic as non-preferred agents that require prior authorization.

**The February 19, 2010 Recommendations for Sedative-Hypnotics are:**

- **zaleplon generic,** chloral hydrate generic, temazepam generic, and zolpidem generic as preferred agents.
- **Edluar®, temazepam 22.5mg, temazepam 7.5mg, Restoril® 7.5mg**, **triazolam generic**, Lunesta®, flurazepam generic, Rozerem®, Ambien CR®, Doral®, and estazolam generic as non-preferred agents that require prior authorization.

**The February 19, 2010 Recommendations for Proton Pump Inhibitors are:**

- **omeprazole generic and OTC, Aciphex®**, and Nexium® capsule as preferred agents.
- **Prilosec® OTC and suspension, Kapidex®, Prevacid® capsule and OTC, Prevacid® solutab ,** lansoprazole generic, **Nexium® suspension**, pantoprazole generic, and Protonex® suspension as non-preferred agents that require prior authorization.

**The February 19, 2010 Recommendations for Injectable Anticoagulants are:**

- Fragmin®, Lovenox®, and Arixtra® as preferred agents.
- There are no agents in this class designated as non-preferred.

**The February 19, 2010 Recommendations for Angiotensin Modulator/Calcium Channel Blocker Combinations are:**

- Exforge® and Azor® as preferred agents.
- **benazepril/amlodipine generic**, Tarka®, and **Twynsta®** as non-preferred agents that require prior authorization.
- The separate component drugs must be used in place of benazepril/amlodipine combinations.

**The February 19, 2010 Recommendations for Angiotensin Modulators are:**

- **ramipril generic**, 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®, and Avapro® Avalide® as preferred agents.

- Teveten®, Tevetan HCT®, Atacand®, Atacand HCT®, moexepril and moexepril/HCTZ generic, perindopril, Tekturna®, Tekturna HCT®, **Valturna®** and trandolapril generic as non-preferred agents that require prior authorization.

**The February 19, 2010 Recommendations for Benign Prostatic Hyperplasia Treatment Agents are:**

- doxazosin generic, terazosin generic, Proscar®, Uroxatral®, Cardura XL®, and Flomax®, as preferred agents.
- **Rapaflo®, Avodart® and finasteride generic** be designated as non-preferred agents that require prior authorization.

**The February 19, 2010 Recommendations for Bladder Relaxant Preparations are:**

- **Toviaz®, Enablex®**, oxybutynin generic, and Vesicare® as preferred agents.
- **Oxytrol® transdermal**, **Detrol LA®,** Detrol®, **Gelnique®**, Sanctura®, Sanctura XR®, and oxybutynin ER generic be designated as non-preferred agents that require prior authorization.

**The February 19, 2010 Recommendations for Lipotropics, Statins are:**

- **Crestor®,** Simcor®, Lescol/Lescol XL®, Lipitor®, lovostatin generic, pravastatin generic and simvastatin generic as preferred agents.
- **Caduet®, Altoprev®**, Advicor®, and Vytorin® be designated as non-preferred agents that require prior authorization.

**The February 19, 2010 Recommendations for Calcium Channel Blockers are:**

- Dynacirc CR®, verapamil generic, diltiazem generic, nifedipine IR/ER generic, felodipine ER generic and amlodipine generic as preferred agents.
- nisoldipine generic, Cardizem LA®, verapamil ER PM, nicardipine generic, Cardene SR®, Covera-HS®, isradipine generic and Sular® as non-preferred agents that require prior authorization.

**The February 19, 2010 Recommendations for Beta-Blockers are:**

- Levatol®, Innopran XL®, atenolol generic, metoprolol generic, propranolol generic, sotalol generic, nadolol generic, acebutolol generic, labetalol generic, pindolol generic, timolol generic, bisoprolol generic, and carvedilol generic as preferred agents.
- Bystolic®, betaxolol generic, Toprol XL, and Coreg CR ® as non-preferred agents that require prior authorization.

**The February 19, 2010 Recommendations for Antimigraine Agents, Triptans are:**

- Maxalt/Maxalt MLT®, Relpax®, Imitrex (oral) ®, Imitrex (nasal) ®, and Imitrex® SQ as preferred agents.
- sumatriptan generic, Treximet®, Amerge®, Axert®, Frova®, Zomig/ZomigZMT®, and Zomig® (nasal) be designated as non-preferred agents that require prior authorization.

**The February 19, 2010 Recommendations for Minimally Sedating Antihistamines are:**

- **Allegra®**, loratadine generic, loratadine syrup, cetirizine generic, cetirizine syrup OTC and **cetirizine syrup RX** as preferred agents.
- Claritin® chew, Semprex D®, Clarinex/Clarinex D®, Clarinex® syrup, Xyzal, ®, Xyzal® syrup, Allegra®syrup , Allegra ODT, and fexofenadine generic as non-preferred agents that require prior authorization.

**The February 19, 2010 Recommendations for Ulcerative Colitis Agents are:**

- **Apriso®**, sulfasalazine generic, Asacol®, Pentasa®, and Canasa® as preferred agents.
- **Sfrowasa®, mesalamine rectal generic, balsalazide generic,** Dipentum® and Lialda ® as non-preferred agents that require prior authorization.

**The February 19, 2010 Recommendations for Skeletal Muscle Relaxants are:**

- baclofen generic, chlorzoxazone generic, cyclobenzaprine generic, dantrolene generic, methocarbamol generic, and tizanidine generic as preferred agents.
- Amrix®, orphenadrine generic, orphenadrine compound generic, carisoprodol generic, carisoprodol compound, Soma®, Skelaxin®, Zanaflex®, and Fexmid® as non-preferred agents that require prior authorization.
- All current therapeutic prior authorization criteria for carisoprodol remain in effect.

**The February 19, 2010 Recommendations for Topical Impetigo Agents are:**

- mupirocin ointment generic as a preferred agent.
- Altabax® and Bactroban® cream as non-preferred agents that require prior authorization.

**The February 19, 2010 Recommendations for Pulmonary Arterial Hypertension Agents, Oral are:**

- **Tracleer®**, Revatio® and Letairis® as preferred agents.
- Adcirca® as a non-preferred agent that requires prior authorization.

**The February 19, 2010 Recommendations for Cough and Cold Agents are:**

- All generic products both prescription and non-prescription as preferred agents.
- All branded products as non-preferred agents that require prior authorization.
- Cough and Cold preparations restricted to participants 7 years and older. Quantity limits of 4 oz. per prescription and no more than two prescriptions per six months per participant.

**The February 19, 2010 Recommendations for Fibromyalgia Agents are:**

- **Savella® , Lyrica®** and **Cymbalta®** as preferred agents.
- No agents are designated as non-preferred at this time.
- **All prescriptions will require a fibromyalgia diagnosis.**

**The February 19, 2010 Recommendations for Immunosuppressives are:**

- **azathioprine generic, Cellcept®, cyclosporine modified generic, Gengraf®, mycophenolate mofetil generic, Neoral®, Prograf®, Rapamune®, Sandimmune®,** and **tacrolimus®** as preferred agents.
- **Azasan®, cyclosporine generic,** and **Myfortic®** as non-preferred agents that require prior authorization.