Idaho Medicaid Pharmacy and Therapeutics Committee Recommendations
August 17, 2007

The August 17, 2007 P&T Recommendations for the ACE Inhibitors are:

- The Committee recommends that Altace®, Aceon® benazepril, benazepril/HCTZ , captopril, captopril/HCTZ, enalapril, enalapril/HCTZ, fosinopril, fosinopril/HCTZ, lisinopril, lisinopril/HCTZ, quinapril, and quinapril/HCTZ, be designated as preferred agents.
- The Committee recommends that moexipril, moexipril/HCTZ and trandolapril be designated as non-preferred agents and require further prior authorization.
- Brand name drugs of preferred generics will still require prior authorization.
- The Committee recommends that the Department re-evaluate when new CMS Federal Upper Limit prices are published in January 2008.

The August 17, 2007 P&T Recommendations for the ADHD Drugs are:

- The Committee recommends that Adderall® XR, amphetamine salt combo, Concerta®, dextroamphetamine, Focalin®, Focalin® XR, Metadate® CD, methylphenidate, and methylphenidate ER be designated as preferred agents.
- The Committee recommends that Daytrana®, Desoxyn®, Provigil®, Ritalin® LA and Strattera® be designated as non-preferred and require additional prior authorization.
- The Committee recommends that the current therapeutic prior authorization guidelines for diagnosis and contraindications remain in effect.

The August 17, 2007 P&T Recommendations for the Alzheimer Agents are:

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

The August 17, 2007 P&T Recommendations for the Androgenic Agents are:

- The Committee recommends that Androderm® and Androgel ®be designated as preferred agents.
- The Committee recommends that Testim® be designated as a non-preferred agent and require prior authorization.

The August 17, 2007 P&T Recommendations for the Anticholenergic Bronchodilators are:

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

The August 17, 2007 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®, paroxetine, Pexeva®, Paxil CR®, Prozac® Weekly, and Sarafem® be designated as non-preferred and require prior authorization.
- The Committee recommends that all individuals currently on Lexapro®, paroxetine, and Paxil CR® be “grandfathered.”
- Brand name drugs of preferred generics will still require prior authorization.

The August 17, 2007 Recommendations for Oral Antiemetics are:

- The Committee recommends that Emend®, Zofran® and Zofran ODT ® be designated as preferred agents.
- The committee recommends that Anzemet®, Kytril® and ondansetron generic be designated as non-preferred agents.
- The Committee recommends that current therapeutic prior authorization criteria remain in effect for all of these agents.

The August 17, 2007 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®,griseofulvin suspension, Grifulvin® V tablets, Gris-Peg®, itraconazole , Lamisil® , Noxafil® and Vfend® be designated as non-preferred and subject to therapeutic prior authorization criteria.
- Brand name drugs of preferred generics will still require prior authorization.

The August 17, 2007 P&T Recommendations for the Topical Antifungals are:

- The Committee recommends that clotrimazole/betamethasone, ketoconazole shampoo, Naftin®, nystatin, and nystatin/triamicinolone be designated as preferred agents.
- The Committee recommends that ciclopirox cream and suspension, econazole , Ertaczo®, Exelderm® , ketoconazole cream, Loprox® gel and shampoo, Mentax® , Oxistat®, Penlac®, Xolegel® and Vusion® be non-preferred.
- Brand name drugs of preferred generics will still require prior authorization.
- The Committee recommends no changes to the current Penlac® prior authorization criteria.

The August 17, 2007 P&T Recommendations for the Anti-Parkinson agents are:

- The Committee recommends that benztropine, carbidopa/levodopa, Kemadrin® , Requip®, eselgiline, Stalevo™ and trihexyphenidyl be designated as preferred agents.
- The Committee recommends that Azilect ®, Comtan® , Mirapex® , Parcopa®, pergolide , Tasmar® and Zelapar® be designated as non-preferred agents and require prior authorization.
- The Committee recommends that current Mirapex® patients be “grandfathered”.

The August 17, 2007 P&T Recommendations for the Antivirals are:

- The Committee recommends that acyclovir, amantadine, ganciclovir, Tamiflu®, Valcyte®, and Valtrex® be designated as preferred agents.
- The Committee recommends that Famvir®, Relenza® and rimantadine be designated as non-preferred and require further prior authorization.
- Brand name drugs of preferred generics will still require prior authorization.

The August 17, 2007 P&T Recommendations for the Atopic Dermatitis are:

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

The August 17, 2007 P&T Recommendations for the Beta-Agonist Bronchodilators are:

- The Committee recommends that 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 be designated as the preferred agents for this class.
- The Committee recommends that 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 be designated as non-preferred agents and require prior authorization.

The August 17, 2007 P&T Recommendations for the Bone Resorption Suppression and Related Agents are:

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

The August 17, 2007 P&T Recommendations for Oral Cephalosporins and Related Antibiotics are:

- The Committee recommends that amoxicillin/clavulanate tablets and suspension, Cedax®, cefaclor, cefadroxil, cefuroxime, cefprozil ,

Cefzil®, cephalexin, Omnicef®, Spectracef® , and Suprax ® be designated as preferred agents.
- The Committee recommends that Augmentin XR®, cefdinir, cefpodoxime, Panixine®, and Raniclor® be designated as non-preferred.
- Brand name drugs of preferred generics will still require prior authorization.

The August 17, 2007 Recommendations for Cytokine and CAM Antagonists are:

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

The August 17, 2007 P&T Recommendations for the Oral Fluroquinolones are:

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

The August 17, 2007 Recommendations for Hepatitis B Agents are:

- The Committee recommends that prescriber choice be allowed within this drug class and that Epivir–HBV ®, Tyzeka®, Hepsera® and Baraclude® be designated as preferred agents.

The August 17, 2007 P&T Recommendations for Incretin Hypoglycemics are:

- The Committee recommends that Byetta® and Symlin® be designated as preferred.
- The Committee recommends that Janumet® and Januvia ®be designated as non-preferred and require prior-authorization.
- The Committee recommends that current therapeutic criteria for Byetta® and Symlin® be retained.

The August 17, 2007 P&T Recommendations for the Inhaled Glucocorticoids are:

- The Committee recommends that AeroBid ®, AeroBid-M®, Asmanex ® Azmacort® and QVAR® be designated as preferred agents.
- The Committee recommends that Advair Diskus®, Advair HFA®, Flovent®, Flovent HFA®, Pulmicort Flexhaler®, Pulmicort Respules® and Symbicort® (not reviewed) be designated non-preferred and require prior authorization.
- The Committee recommends that the current therapeutic criteria for Advair® and Pulmicort Respules® remain in effect.

The August 17, 2007 P&T Recommendations for the Intranasal Rhinitis Agents are:

- The Committee recommends that Astelin®, Flonase®, ipratropium nasal spray, Nasacort AQ® and Nasonex® be designated as preferred agents for this class.
- The Committee recommends that Atrovent®, Beconase AQ®, flunisolide, fluticasone, Nasarel® and Rhinocort Aqua® be designated as non-preferred agents and require prior authorization.

The August 17, 2007 P&T Recommendations for Insulins are:

- The Committee recommends that Humalog®,Humalog® mixture, Humulin®, Lantus®, Levemir®, Novolin®, Novolog®, and Novolog® mixture be designated as preferred agents.
- The Committee recommends that Apidra® and Exubera® be designated non-preferred and require prior-authorization.

The August 17, 2007 P&T Recommendations for the Leukotriene Modifiers are:

- The Committee recommends that Singulair® be designated as the preferred agent.
- The Committee recommends that Accolate® and Zyflo® be designated as non-preferred agents.
- The Committee recommends that the current therapeutic prior authorization criteria be altered to include diagnosis criteria only**.**

The August 17, 2007 P&T Recommendations for Macrolides/Ketolides are:

- The Committee recommends that azithromycin generic, clarithromycin generic and erythromycin generic be designated as preferred agents.

- The Committee recommends that Biaxin® XL, Ketek® and Zmax® be designated as non-preferred agents and require prior authorization.
- The Committee recommends that Ketek® be subject to prior authorization with strict adherence to the package insert.

The August 17, 2007 P&T Recommendations for the Non-Steroidal Anti-inflammatory agents are:

- The Committee recommends that diclofenac, etodolac , fenoprofen, flurbiprofen, ibuprofen, indomethacin, ketorolac, naproxen, oxaprozin, piroxicam and sulindac, be designated as preferred agents.
- The Committee recommends that Arthrotec® , Celebrex®, ketoprofen, meclofenamate, mefenamic acid, meloxicam, Mobic®, nabumetone, Prevacid Naprapac and tolmetin be designated as non-preferred and require prior authorization.
- The Committee recommends that the therapeutic prior authorization rule currently in place for Celebrex® remain.
- Brand name drugs of preferred generics will still require prior authorization.

The August 17, 2007 P&T Recommendations for the Ophthalmics for Allergic Conjunctivitis are:

- The Committee recommends that Alaway®, Acular® , Alrex® , cromolyn sodium, Elestat®, Optivar® ,Patanol® , Pataday and Zaditor® OTC be designated as preferred agents.
- The Committee recommends that Alocril®, Almast®, Alomide®, Emadine®, and ketotifen be designated as non-preferred and require further prior authorization.

The August 17, 2007 P&T Recommendations for the Ophthalmic Fluoroquinolone Antibiotics are:

- The Committee recommends that ciprofloxacin, ofloxacin, Vigamox™ and Zymar™ be designated as preferred agents.
- The Committee recommends that Ciloxan® ointment and Quixin® be designted non-preferred and require prior authorization.

The August 17, 2007 P&T Recommendations for the Ophthalmic Glaucoma Agents are:

- The Committee recommends that prescriber choice be allowed within this drug class and that Alphagan P®, Azopt®, betaxolol, Betimol®, Betoptic S ® , brimonidine, carteolol, Cosopt ® , dipivefrin , Istalol®

levobunolol, Lumigan®, metipranolol, pilocarpine, timolol, Travatan®, Travatan Z®, Trusopt® and Xalatan® 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 17, 2007 Recommendations for Ophthalmics, NSAIDs are:

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

The August 17, 2007 P&T Recommendations for the Platelet Aggregation Inhibitors are:

- The Committee recommends that Aggrenox®, dipyridamole and Plavix® be designated as preferred agents.
- The Committee recommends that ticlopidine be designated as a non-preferred agent and require prior-authorization.

These are non-binding recommendations to the Department of Health and Welfare.

All final decisions relative to the implementation of these recommendations will be the responsibility of the Department.