

# Kentucky Department for Medicaid Services

## Drug Review Options

The following chart lists the agenda items scheduled and the options submitted for review at the July 16, 2009, meeting of the Pharmacy and Therapeutics Advisory Committee

Item	Options for Consideration
<b><u>High Potency Statins</u></b>	<ol style="list-style-type: none"> <li>1. DMS to select preferred agent(s) based on economic evaluation; however, at least simvastatin and EITHER Lipitor® or Crestor® should be preferred.</li> <li>2. Continue quantity limits on agents in this class based on maximum recommended dose.</li> <li>3. Agents not selected as preferred will be considered non preferred and require PA.</li> <li>4. For any new chemical entity in the High Potency Statin class, require a PA until reviewed by the P&amp;T Advisory Committee.</li> </ol>
<b><u>New Drugs to Market:</u></b> <b><u>Sancuso®</u></b>	<p>Place this product non preferred with appropriate quantity limits in the PDL category titled Anti-Emetics: 5-HT3 Antagonists; however allow for its use if the following criteria are met:</p> <p>Sancuso® will be approved if either of the following criteria are met:</p> <ul style="list-style-type: none"> <li>• Current treatment with chemotherapy to avoid the need for IV antiemetics (both active and new chemotherapy patients); OR,</li> <li>• Trial and failure of ondansetron.</li> </ul>
<b><u>Antibiotics:</u></b> <b><u>Oxazolidinones</u></b>	<ol style="list-style-type: none"> <li>1. DMS to select preferred agent(s) based on economic evaluation; however, at least linezolid should be preferred.</li> <li>2. Place PA criteria around linezolid to prevent over utilization and preserve it as a last line drug.</li> <li>3. Continue appropriate quantity limits.</li> <li>4. For any new chemical entity in the Oxazolidinones class, require a PA and quantity limit until reviewed by the P&amp;T Advisory Committee.</li> </ol>

Item	Options for Consideration
<p style="text-align: center;"><b><u>Zyvox® Clinical Criteria</u></b></p>	<p>1. Diagnoses to approve:</p> <ul style="list-style-type: none"> <li>• Vancomycin-Resistant Gram Positive Infections (VRE) via current culture and sensitivity testing <ul style="list-style-type: none"> <li>○ Enterococcus faecium</li> <li>○ Enterococcus faecalis</li> </ul> </li> <li>• Methicillin-Resistant Staph Aureus Infections (MRSA) via current culture and sensitivity testing</li> <li>• Empiric management of suspected MRSA infection without culture confirmation if any of the following are true: <ul style="list-style-type: none"> <li>○ Previously documented MRSA infection,</li> <li>○ Previous cellulitis caused by documented MRSA,</li> <li>○ Skin and soft tissue infection with abscess,</li> <li>○ Patient presents with any of the following risk factors: <ul style="list-style-type: none"> <li>▪ Health facility stay/visit (current or within the past month)</li> <li>▪ Surgery in the past month</li> <li>▪ Failure of antibiotics</li> <li>▪ Participation in team sports (current or past month)</li> <li>▪ Jail/Prison (current or in past month)</li> <li>▪ Military (current or in past month)</li> <li>▪ History of “spider bite” within the past month</li> <li>▪ Pediatrics enrolled in daycare or school (current or in past month)</li> <li>▪ Multiple areas of induration</li> <li>▪ HIV</li> <li>▪ Permanent indwelling catheters</li> <li>▪ Percutaneous implanted device</li> <li>▪ IV drug user</li> <li>▪ Previously colonized with multi-drug resistant pathogens including MRSA</li> <li>▪ Diabetic foot ulcer</li> <li>▪ End stage renal disease; AND</li> </ul> </li> </ul> </li> </ul> <p>2. Request is <b>NOT</b> for more than a 28 day supply (Pass to RPh if days supply exceeds this)</p> <p><b><u>Clinical consideration:</u></b>  If Zyvox® was initiated in the hospital; approve to complete the course of antibiotic therapy. Number of days of hospital therapy is included in 28-day total therapy.</p>
<p><b><u>New Drugs to Market: Degarelix Acetate®</u></b></p>	<p>Allow this product to pay unrestricted until the Gonadotropin Releasing Hormone Receptor Antagonists are reviewed for PDL placement.</p>
<p><b><u>New Drugs to Market: Afinitor™</u></b></p>	<p>Allow this product to pay after the following clinical criteria are met:</p> <p>Afinitor® (everolimus) will be approved if the patient has a history of either of the following agents within the past 90 days (unless ALL are contraindicated).</p> <ul style="list-style-type: none"> <li>• sunitinib (Sutent®)</li> <li>• sorafenib (Nexavar®)</li> </ul>

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<b><u>New Drugs to Market: Lamictal ODT<sup>®</sup></u></b>	Based on the Committee's recommendation when this class was reviewed, place this product preferred in the PDL category titled: Anticonvulsants: Second Generation.														
<b><u>New Drugs to Market: Acanya<sup>™</sup></u></b>	Place this product non preferred in the PDL category titled Dermatologics: Antibiotic Agents for Acne.														
<b><u>New Drugs to Market: Aplenzin<sup>™</sup></u></b>	Place this product non preferred in the PDL category titled Antidepressants: New Generation.														
<b><u>New Drugs to Market: Asacol HD<sup>®</sup></u></b>	Place this product non preferred in the PDL category titled 5-ASA Derivatives, Oral Preparations.														
<b><u>New Drugs to Market: Besivance<sup>™</sup></u></b>	Place this product non preferred in the PDL category titled Ophthalmic Antibiotics, Quinolones.														
<b><u>New Drugs to Market: Exforge HCT<sup>®</sup></u></b>	Place this product non preferred in the PDL category titled Angiotensin Receptor Blockers + CCB (DHP).														
<b><u>New Drugs to Market: Gelnique<sup>™</sup></u></b>	Place this product non preferred in the PDL category titled Urinary Tract Antispasmodics; however, allow for its use in patients who cannot tolerate/swallow oral medications.														
<b><u>New Drugs to Market: Lovaza<sup>®</sup></u></b>	Place this product non preferred in the PDL category titled Lipotropics: Fibric Acid Derivatives.														
<b><u>New Drugs to Market: Nuvigil<sup>®</sup></u></b>	<p>Place this product non preferred with appropriate quantity limits in the PDL category titled Antihyperkinesia Agents with the following criteria:</p> <p>Nuvigil<sup>®</sup> (armodafinil) will be approved if both of the following criteria are met:</p> <ul style="list-style-type: none"> <li>One of the following approvable diagnosis (via ICD-9 override):</li> </ul> <table border="1" data-bbox="423 1167 1552 1419"> <tbody> <tr> <td data-bbox="423 1167 992 1199">Narcolepsy</td> <td data-bbox="992 1167 1552 1199">347.00</td> </tr> <tr> <td data-bbox="423 1199 992 1230"></td> <td data-bbox="992 1199 1552 1230">347.01</td> </tr> <tr> <td data-bbox="423 1230 992 1262"></td> <td data-bbox="992 1230 1552 1262">347.11</td> </tr> <tr> <td data-bbox="423 1262 992 1314">Sleep apnea/hypoapnea syndrome</td> <td data-bbox="992 1262 1552 1314">780.57</td> </tr> <tr> <td data-bbox="423 1314 992 1346"></td> <td data-bbox="992 1314 1552 1346">780.51</td> </tr> <tr> <td data-bbox="423 1346 992 1377"></td> <td data-bbox="992 1346 1552 1377">780.53</td> </tr> <tr> <td data-bbox="423 1377 992 1409">Shift work sleep disorder</td> <td data-bbox="992 1377 1552 1409">307.45</td> </tr> </tbody> </table> <ul style="list-style-type: none"> <li>Trial and failure of Provigil<sup>®</sup> (modafinil) via a 90 day look back</li> </ul>	Narcolepsy	347.00		347.01		347.11	Sleep apnea/hypoapnea syndrome	780.57		780.51		780.53	Shift work sleep disorder	307.45
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<b><u>New Drugs to Market: Ryzolt<sup>™</sup></u></b>	Place this product non preferred in the PDL category titled Non-Narcotics.														
<b><u>New Drugs to Market: Savella<sup>™</sup></u></b>	Place this product non preferred in the PDL category titled Antidepressants: SNRIs, and allow for its use in fibromyalgia only.														
<b><u>New Drugs to Market: Simponi<sup>®</sup></u></b>	Place this product non preferred in the PDL category titled Immunomodulators with quantity limits based on the FDA-approved maximum dose and clinical criteria similar to the other Immunomodulators.														
<b><u>New Drugs to Market: Zinotic ES<sup>®</sup></u></b>	Place this product non preferred in the PDL category titled Otic: Miscellaneous.														

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<b><u>Penicillins</u></b>	<ol style="list-style-type: none"> <li>1. DMS to select preferred agent(s) based on economic evaluation; however, at least amoxicillin, ampicillin, dicloxacillin and penicillin V should be preferred.</li> <li>2. Agents not selected as preferred will be considered non preferred and require PA.</li> <li>3. For any new chemical entity in the Penicillin class, require a PA until reviewed by the P&amp;T Advisory Committee.</li> </ol>
<b><u>Penicillin/Beta-Lactamase Inhibitor Combinations</u></b>	<ol style="list-style-type: none"> <li>1. DMS to select preferred agent(s) based on economic evaluation; however, at least amoxicillin/clavulanate should be preferred on the PDL.</li> <li>2. Agents not selected as preferred will be considered non preferred and require PA.</li> <li>3. For any new chemical entity in the Penicillin/Beta-Lactamase Inhibitor Combination class, require a PA until reviewed by the P&amp;T Advisory Committee.</li> </ol>
<b><u>First Generation Cephalosporins</u></b>	<ol style="list-style-type: none"> <li>1. DMS to select preferred agent(s) based on economic evaluation; however, at least cephalexin should be preferred.</li> <li>2. Agents not selected as preferred will be considered non preferred and require PA.</li> <li>3. For any new chemical entity in the First Generation Cephalosporin class, require a PA until reviewed by the P&amp;T Advisory Committee.</li> </ol>
<b><u>Second Generation Cephalosporins</u></b>	<ol style="list-style-type: none"> <li>1. DMS to select preferred agent(s) based on economic evaluation; however, at least cefuroxime should be preferred.</li> <li>2. Agents not selected as preferred will be considered non preferred and require PA.</li> <li>3. For any new chemical entity in the Second Generation Cephalosporin class, require a PA until reviewed by the P&amp;T Advisory Committee.</li> </ol>
<b><u>Third Generation Cephalosporins</u></b>	<ol style="list-style-type: none"> <li>1. DMS to select preferred agent(s) based on economic evaluation; however, at least cefixime and cefpodoxime should be preferred.</li> <li>2. Agents not selected as preferred will be considered non preferred and require PA.</li> <li>3. For any new chemical entity in the Third Generation Cephalosporin class, require a PA until reviewed by the P&amp;T Advisory Committee.</li> </ol>
<b><u>Ketolides</u></b>	<ol style="list-style-type: none"> <li>1. DMS to select preferred agent(s) based on economic evaluation.</li> <li>2. Maintain prior authorization criteria for telithromycin to ensure this product is being used for multi-drug resistant infections only.</li> <li>3. Continue current quantity limit (10 days supply per month).</li> <li>4. For any new chemical entity in the Ketolide class, require a PA until reviewed by the P&amp;T Advisory Committee.</li> </ol>

Item	Options for Consideration
<p><b><u>Ketek® Clinical Criteria</u></b></p>	<ol style="list-style-type: none"> <li>1. Diagnosis of Community Acquired Pneumonia (CAP) OR Acute Exacerbation of Chronic Bronchitis AND</li> <li>2. Must have previously used (within the past 28 days) ONE of the following:               <ol style="list-style-type: none"> <li>a. Penicillin (e.g., amoxicillin, amoxicillin-clavulanate, ampicillin-sulbactam, or piperacillin-tazobactam)</li> <li>b. 2nd or 3rd generation cephalosporins (e.g., cefuroxime, cefpodoxime, cefprozil, cefotaxime, ceftriaxone)</li> <li>c. Macrolide (e.g., azithromycin, clarithromycin, erythromycin)</li> <li>d. Fluoroquinolone (e.g., levofloxacin, gatifloxacin, moxifloxacin)</li> <li>e. Tetracycline (e.g., doxycycline)</li> <li>f. Trimethoprim/sulfamethaxole (e.g., Bactrim) AND</li> </ol> </li> <li>3. Request is not for more than a 10 day supply.</li> </ol> <p>Clinical Consideration If Ketek™ was initiated in the hospital; approve to complete the course of antibiotic therapy.</p>
<p><b><u>Tetracyclines</u></b></p>	<ol style="list-style-type: none"> <li>1. DMS to select preferred agent(s) based on economic evaluation; however, at least generic formulations of doxycycline, minocycline, and tetracycline should be preferred.</li> <li>2. Agents not selected as preferred will be considered non preferred and require PA.</li> <li>3. For any new chemical entity in the Tetracycline class, require a PA until reviewed by the P&amp;T Advisory Committee.</li> </ol>
<p><b><u>Sulfonamides, Folate Antagonist</u></b></p>	<ol style="list-style-type: none"> <li>1. DMS to select preferred agent (s) based on economic evaluation; however, at least trimethoprim/sulfamethoxazole should be preferred.</li> <li>2. Agents not selected as preferred will be considered non preferred and require PA.</li> <li>3. For any new chemical entity in the Sulfonamides, Folate Antagonist class, require a PA until reviewed by the P&amp;T Advisory Committee.</li> </ol>
<p><b><u>Oral Antifungals</u></b></p>	<ol style="list-style-type: none"> <li>1. DMS to select preferred agent(s) based on economic evaluation; however, all currently available unique chemical entities should be preferred on the PDL.</li> <li>2. Agents not selected as preferred will be considered non preferred and require PA.</li> <li>3. Remove prior authorization requirements from terbinafine; however, continue prior authorization requirements for itraconazole.</li> <li>4. For any new chemical entity in the Oral Antifungal class, require a PA until reviewed by the P&amp;T Advisory Committee.</li> </ol>

Item	Options for Consideration
<p><b><u>Terbinafine/Itraconazole</u></b> <b><u>Clinical Criteria</u></b></p>	<p>Diagnoses to approve:</p> <ul style="list-style-type: none"> <li>• Tinea corporis (body ringworm), Tinea cruris (jock itch), or Tinea pedis (athlete's foot): <ul style="list-style-type: none"> <li>• If the patient has NOT had a therapeutic failure on at least one topical antifungal medication, refer the request to a clinical pharmacist.</li> <li>• If the patient has had a failure on at least one topical antifungal medication, approve: itraconazole capsules for once daily dosing for a 4-week continuous course of therapy.</li> </ul> </li> <li>• Patient can receive itraconazole automatically if diagnosis is Tinea Capitis for up to 4 weeks</li> <li>• Onychomycosis (fungal infection of the fingernails or toenails): <ul style="list-style-type: none"> <li>• Approval is based on initial vs. continuation or retreatment as follows: <ul style="list-style-type: none"> <li>• For the initial treatment of a fingernail or toenail infection (rather than continuation of therapy or retreatment) AND ALSO</li> <li>• For retreatment if there has been an interval of 3 months between the initial treatment of fingernail infection and a second treatment or an interval of 6 months between the initial treatment of toenail infection and a second treatment: <ul style="list-style-type: none"> <li>• Fingernail Infection: Approve: itraconazole capsules for twice daily dosing for an 8-week continuous course of therapy.</li> <li>• Toenail Infection: Approve: itraconazole capsules for once daily dosing for a 12-week continuous course of therapy.</li> </ul> </li> </ul> </li> <li>• For the treatment of a systemic or other serious fungal infection (e.g., esophageal candidiasis, blastomycosis, aspergillosis, cutaneous sporotrichosis), approve the requested quantity for 6 months.</li> </ul> </li> </ul>
<p><b><u>Antivirals: Herpes</u></b></p>	<ol style="list-style-type: none"> <li>1. DMS to select preferred agent (s) based on economic evaluation; however, at least acyclovir should be preferred.</li> <li>2. Agents not selected as preferred will be considered non preferred and require PA.</li> <li>3. For any new chemical entity in the Antivirals, Herpes class, require a PA until reviewed by the P&amp;T Advisory Committee.</li> </ol>

Item	Options for Consideration
<p><b><u>Antivirals:</u></b> <b><u>Influenza</u></b></p>	<ol style="list-style-type: none"> <li>1. DMS to select preferred agent (s) based on economic evaluation; however, at least amantadine, oseltamivir, rimantadine and zanamivir should be preferred.</li> <li>2. Agents not selected as preferred will be considered non preferred and require PA.</li> <li>3. DMS to consider CDC recommendation updates regarding antiviral therapy for the treatment of influenza. The Medical Director, with Secretary approval, may make changes to the PDL listing based on the CDC recommendations until this class can be considered at the next scheduled review.</li> <li>4. For any new chemical entity in the Antivirals, Influenza class, require a PA until reviewed by the P&amp;T Advisory Committee.</li> </ol>
<p><b><u>Hepatitis C:</u></b> <b><u>Pegylated</u></b> <b><u>Interferons</u></b></p>	<ol style="list-style-type: none"> <li>1. Rename the category Hepatitis C: Interferons.</li> <li>2. DMS to select preferred agent (s) based on economic evaluation; however, at least peginterferon alfa-2a and peginterferon alfa-2b should be preferred.</li> <li>3. Agents not selected as preferred will be considered non preferred.</li> <li>4. PDL selected agents will apply for any new courses of therapy only.</li> <li>5. Place clinical prior authorization around the entire class to ensure appropriate utilization.</li> <li>6. For any new chemical entity in the Hepatitis C: Interferons class, require a PA until reviewed by the P&amp;T Advisory Committee.</li> </ol>
<p><b><u>Hepatitis C:</u></b> <b><u>Pegylated</u></b> <b><u>Interferons Clinical</u></b> <b><u>Criteria</u></b></p>	<p>All preferred and non-preferred pegylated interferons will require a prior authorization after the initial 16 weeks of therapy.</p> <p><b><u>After the initial 16 weeks of therapy pegylated interferons will be approved if:</u></b></p> <ol style="list-style-type: none"> <li>1. HCV RNA Assay results obtained prior to initiation of therapy <b>AND</b> 12 weeks after initiation of therapy must be provided. If the difference between the two assays is at least a 2 logarithmic unit decrease (example: from 2,000,000 IU to 20,000 IU), <b>THEN</b> approve for duration of therapy as defined below.</li> <li>2. If the assays were done <b>BUT</b> the difference between the two assays <b>WAS NOT</b> at least a 2 logarithmic unit decrease (example: from 2,000,000 IU to 20,000 IU), <b>THEN</b> refer the request to a clinical pharmacist who will deny the request.</li> <li>3. If there is any other valid medical reason why the patient should require this therapy, a clinical pharmacist may approve the request for the total length of therapy as listed below.</li> </ol> <p><b><i>LIMITATION ON LENGTH OF THERAPY IS BASED ON PRODUCT</i></b></p> <ol style="list-style-type: none"> <li>1. Interferon alfacon-1 <ol style="list-style-type: none"> <li>a. IFN naïve – 24 weeks total therapy</li> <li>b. INF relapse – 48 weeks total therapy</li> </ol> </li> <li>2. Peginterferon alfa-2a OR 2b <ol style="list-style-type: none"> <li>a. Genotype 1, 4, age 2-17 years, OR HIV positive – 48 weeks total therapy</li> <li>b. Genotype 2, 3 – 24 weeks total therapy</li> </ol> </li> </ol>

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<b><u>Hepatitis C: Ribavirins</u></b>	<ol style="list-style-type: none"> <li>1. DMS to select preferred agent (s) based on economic evaluation; however, at least ribavirin should be preferred.</li> <li>2. Agents not selected as preferred will be considered non preferred.</li> <li>3. PDL selected agents will apply for any new courses of therapy only.</li> <li>4. Place clinical prior authorization around the entire class of ribavirins to ensure appropriate utilization.</li> <li>5. For any new chemical entity in the Hepatitis C: Ribavirins class, require a PA until reviewed by the P&amp;T Advisory Committee.</li> </ol>												
<b><u>Hepatitis C: Ribavirins Clinical Criteria</u></b>	Ribavirins will pay at point-of-sale if there is concurrent interferon therapy in history.												
<b><u>Antihyperkinesia Agents</u></b>	<ol style="list-style-type: none"> <li>1. DMS to select preferred agent(s) based on economic evaluation; however, at least three distinct stimulant agents should be preferred, one of which should be methylphenidate and an extended release formulation.</li> <li>2. Require appropriate ICD-9 on all prescriptions for agents within this class.</li> <li>3. If atomoxetine is non preferred, allow for its use in patients with ADHD/ADD and a history of substance abuse or tic disorder.</li> <li>4. Continue to require prior authorization for modafinil and armodafinil to ensure utilization in FDA-approved indications only.</li> <li>5. Place quantity limits on all agents based on maximum recommended dose.</li> <li>6. Allow only one agent at a time for an extended release product and one agent at a time for an immediate release product unless switching agents due to therapeutic failure.</li> <li>7. Allow continuation of therapy for non preferred products via a 90 day look back.</li> <li>8. For any new chemical entity in the Antihyperkinesia class, require a PA until reviewed by the P&amp;T Advisory Committee.</li> </ol>												
<b><u>Antihyperkinesia Agents Clinical Criteria</u></b>	<p>Diagnosis to Approve via an ICD-9 Override:</p> <table border="1" data-bbox="459 1178 1554 1667"> <thead> <tr> <th data-bbox="459 1178 1016 1211"><b><u>Diagnosis</u></b></th> <th data-bbox="1016 1178 1554 1211"><b><u>ICD-9</u></b></th> </tr> </thead> <tbody> <tr> <td data-bbox="459 1211 1016 1388">Attention Deficit/Hyperactivity Disorder (ADHD)</td> <td data-bbox="1016 1211 1554 1388">314.1 314.01 314.2 314.8 314.9</td> </tr> <tr> <td data-bbox="459 1388 1016 1421">Attention Deficit Disorder (ADD)</td> <td data-bbox="1016 1388 1554 1421">314.00</td> </tr> <tr> <td data-bbox="459 1421 1016 1526">Narcolepsy</td> <td data-bbox="1016 1421 1554 1526">347.00 347.01 347.11</td> </tr> <tr> <td data-bbox="459 1526 1016 1631">Sleep apnea/hypoapnea syndrome</td> <td data-bbox="1016 1526 1554 1631">780.57 780.51 780.53</td> </tr> <tr> <td data-bbox="459 1631 1016 1667">Shift work sleep disorder</td> <td data-bbox="1016 1631 1554 1667">307.45</td> </tr> </tbody> </table> <p>**Agents may be approved for other diagnosis via the prior authorization process based on a review of the current literature by a clinical pharmacist.</p>	<b><u>Diagnosis</u></b>	<b><u>ICD-9</u></b>	Attention Deficit/Hyperactivity Disorder (ADHD)	314.1 314.01 314.2 314.8 314.9	Attention Deficit Disorder (ADD)	314.00	Narcolepsy	347.00 347.01 347.11	Sleep apnea/hypoapnea syndrome	780.57 780.51 780.53	Shift work sleep disorder	307.45
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<p><b><u>Antihyperkinesia</u></b>  <b><u>Agents Clinical Criteria</u></b>  <b><u>Continued</u></b></p>	<p>Quantity Limits/Maximum Daily Dose</p> <ul style="list-style-type: none"> <li>• Adderall® 60 mg per day</li> <li>• Adderall® XR 30 mg per day</li> <li>• Concerta® 72 mg per day</li> <li>• Daytrana™ 30 mg per day</li> <li>• Desoxyn® 25 mg per day</li> <li>• Dexedrine® IR 60 mg per day</li> <li>• Dexedrine® ER 60 mg per day</li> <li>• dexamethylphenidate 20 mg per day</li> <li>• dextroamphetamine IR 60 mg per day</li> <li>• dextroamphetamine ER 60 mg per day</li> <li>• DextroStat® 60 mg per day</li> <li>• Focalin™ 20 mg per day</li> <li>• Focalin™ XR 20 mg per day</li> <li>• Metadate® CD 60 mg per day</li> <li>• Metadate® ER 60 mg per day</li> <li>• methamphetamine 25 mg per day</li> <li>• Methylin® 60 mg per day</li> <li>• Methylin® ER 60 mg per day</li> <li>• methylphenidate IR 60 mg per day</li> <li>• methylphenidate SR 60 mg per day</li> <li>• mixed amphetamine salt IR 60 mg per day</li> <li>• mixed Amphetamine salt ER 30 mg per day</li> <li>• Nuvigil® 150 mg per day</li> <li>• Procentra™ 40 mg per day</li> <li>• Provigil® 400 mg per day</li> <li>• Ritalin®60 mg per day</li> <li>• Ritalin® LA 60 mg per day</li> <li>• Ritalin® SR 60 mg per day</li> <li>• Strattera® 60/30 days 100 mg per day</li> <li>• Vyvanse™ 60/30 days 70 mg per day</li> </ul> <p><b>Therapeutic Duplication</b>  Prior authorization will be required for more than one long-acting (Adderall® XR, Concerta®, Daytrana™, Desoxyn®, Dexedrine® ER, dextroamphetamine ER, Metadate® CD, Metadate® ER, methamphetamine, Focalin™ XR, Methylin® ER, methylphenidate SR, mixed amphetamine salt ER, Procentra™, Ritalin® LA, Ritalin® SR, Strattera®, Vyvanse™), or more than one short-acting (Adderall®, amphetamine salt combo, Dexedrine® IR, dexamethylphenidate, dextroamphetamine IR, DextroStat®, Focalin™, Methylin®, methylphenidate, mixed amphetamine salt IR, Ritalin®) stimulant at a time.</p>

Item	Options for Consideration														
<p align="center"><b><u>Special Formulations of Antihyperkineses Agents Clinical Criteria</u></b></p>	<p>Daytrana™, Methylin® Solution, Methylin® Chewable Tabs, or Procentra™ will be approved if either of the following criteria are met:</p> <ul style="list-style-type: none"> <li>• Trial and failure of two preferred products, one of which must be the same chemical as the requested medication; OR</li> <li>• Inability to swallow/tolerate PO/whole tablets/capsules <ul style="list-style-type: none"> <li>○ For Daytrana™ , inability to swallow/tolerate PO medications; OR</li> <li>○ For Methylin® Solution, Methylin® Chewable Tabs, or Procentra™, inability to swallow tablets or capsules whole.</li> </ul> </li> </ul>														
<p align="center"><b><u>Strattera® Clinical Criteria</u></b></p>	<p>Strattera® (atomoxetine) will be approved if both of the following criteria are met:</p> <ul style="list-style-type: none"> <li>• Diagnosis of:</li> </ul> <table border="1" data-bbox="574 667 1550 911"> <thead> <tr> <th data-bbox="574 667 1084 701">Diagnosis</th> <th data-bbox="1084 667 1550 701">ICD-9</th> </tr> </thead> <tbody> <tr> <td data-bbox="574 701 1084 735">Attention Deficit/Hyperreactivity Disorder (ADHD)</td> <td data-bbox="1084 701 1550 735">314.1</td> </tr> <tr> <td data-bbox="574 735 1084 768"></td> <td data-bbox="1084 735 1550 768">314.01</td> </tr> <tr> <td data-bbox="574 768 1084 802"></td> <td data-bbox="1084 768 1550 802">314.2</td> </tr> <tr> <td data-bbox="574 802 1084 835"></td> <td data-bbox="1084 802 1550 835">314.8</td> </tr> <tr> <td data-bbox="574 835 1084 869"></td> <td data-bbox="1084 835 1550 869">314.9</td> </tr> <tr> <td data-bbox="574 869 1084 911">Attention Deficit Disorder (ADD)</td> <td data-bbox="1084 869 1550 911">314.00</td> </tr> </tbody> </table> <p>AND;</p> <ul style="list-style-type: none"> <li>• Any one of the following criteria: <ul style="list-style-type: none"> <li>○ Trial and failure of two preferred antihyperkineses agents; OR</li> <li>○ History of substance abuse/diversion; OR</li> <li>○ History of tic disorder, including Tourette's.</li> </ul> </li> </ul>	Diagnosis	ICD-9	Attention Deficit/Hyperreactivity Disorder (ADHD)	314.1		314.01		314.2		314.8		314.9	Attention Deficit Disorder (ADD)	314.00
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<p align="center"><b><u>Provigil® / Nuvigil® Clinical Criteria</u></b></p>	<p>Provigil® (modafinil) / Nuvigil® (armodafinil) will be approved if both of the following criteria are met:</p> <ul style="list-style-type: none"> <li>• One of the following approvable diagnosis (via ICD-9 override):</li> </ul> <table border="1" data-bbox="574 1220 1550 1463"> <tbody> <tr> <td data-bbox="574 1220 1084 1253">Narcolepsy</td> <td data-bbox="1084 1220 1550 1253">347.00</td> </tr> <tr> <td data-bbox="574 1253 1084 1287"></td> <td data-bbox="1084 1253 1550 1287">347.01</td> </tr> <tr> <td data-bbox="574 1287 1084 1320"></td> <td data-bbox="1084 1287 1550 1320">347.11</td> </tr> <tr> <td data-bbox="574 1320 1084 1354">Sleep apnea/hypoapnea syndrome</td> <td data-bbox="1084 1320 1550 1354">780.57</td> </tr> <tr> <td data-bbox="574 1354 1084 1388"></td> <td data-bbox="1084 1354 1550 1388">780.51</td> </tr> <tr> <td data-bbox="574 1388 1084 1421"></td> <td data-bbox="1084 1388 1550 1421">780.53</td> </tr> <tr> <td data-bbox="574 1421 1084 1463">Shift work sleep disorder</td> <td data-bbox="1084 1421 1550 1463">307.45</td> </tr> </tbody> </table> <ul style="list-style-type: none"> <li>• For Nuvigil® (armodafinil) ONLY, trial and failure of Provigil® (modafinil) via a 90 day look back</li> </ul>	Narcolepsy	347.00		347.01		347.11	Sleep apnea/hypoapnea syndrome	780.57		780.51		780.53	Shift work sleep disorder	307.45
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<p align="center"><b><u>Ranexa® Clinical Criteria</u></b></p>	<p>Ranexa® (ranolazine) will be approved if the patient has a history of one agent in any of the following drug classes within the past 90 days (unless ALL are contraindicated).</p> <ul style="list-style-type: none"> <li>• Beta Blocker</li> <li>• Nitrate</li> <li>• Calcium Channel Blocker</li> </ul>														

Item	Options for Consideration
<p><b><u>Lidoderm® Clinical Criteria</u></b></p>	<p>Lidoderm® will be approved if any one of the following criteria are met:</p> <ul style="list-style-type: none"> <li>• Diagnosis of Post Herpetic Neuralgia via an ICD-9 override; OR</li> <li>• History of one agent in any of the following medication classes in the past 90 days: <ul style="list-style-type: none"> <li>○ Tricyclic antidepressant</li> <li>○ Anticonvulsant</li> <li>○ SNRI</li> </ul> </li> </ul>
<p><b><u>Protein Tyrosine Kinase Inhibitors</u></b></p>	<ol style="list-style-type: none"> <li>1. DMS to select preferred agent(s) based on economic evaluation; however, at least imatinib should be preferred.</li> <li>2. Agents not selected as preferred will be considered non preferred and require PA.</li> <li>3. DMS to allow continuation of therapy for existing users of non preferred products via a 90 day look back.</li> <li>4. For any new chemical entity in the Protein Tyrosine Kinase Inhibitor class, require a PA until reviewed by the P&amp;T Advisory Committee.</li> </ol>