

Secretary for Health and Family Services Selections for Preferred Products

This is a summary of the final Preferred Drug List (PDL) selections made by the Secretary for Health and Family Services based on the March 19, 2009 Pharmacy and Therapeutics Advisory Committee (PTAC) Meetings.

Description of Recommendation	P & T Vote	Final Decisions (s)
<p><u>New Products Recommended to Pay Without Prior Authorization</u></p> <ul style="list-style-type: none"> • Astepro® – Preferred on PDL – Antihistamines, Intranasal • Banzel® – Preferred on PDL – Anticonvulsants, Second Generation; ICD-9 required for FDA approved indications on claim • Epiduo® - Preferred on PDL – Dermatologics, Topical Retinoids • Trilipix® - Preferred on PDL – Fibric Acid Derivatives • Xenazine® - Pays without PA – Not a PDL class 	<p>Passed 11 For 0 Against 1 Abstain</p>	<p><u>The following agents to pay without Prior Authorization</u></p> <ul style="list-style-type: none"> • Astepro® • Banzel® - ICD-9 required on claim for FDA approved indication • Epiduo® • Trilipix® • Xenazine®
<p><u>New Products Recommended to Require Prior Authorization</u></p> <ul style="list-style-type: none"> • Aczone® - Non-Preferred on PDL – Dermatologics: Antibiotic Agents for Acne • Apriso™ – Non-Preferred on PDL – 5-ASA Derivatives, Oral Products • Eliphos™ – Non-Preferred on PDL – Electrolyte Depleters • Moxatag® - Non-Preferred on PDL – Antibiotics: Penicillins • Prandimet™ – Non-preferred on PDL – Meglitinide Combination Products • Promacta® - Clinical PA required unless ICD-9 submitted on the claim for FDA approved indications • Xolegel™ – Non-Preferred on PDL – Dermatologics: Antifungals • Zacare™ – Non-Preferred on PDL – Dermatologics: Antibiotic Agents for Acne 	<p>Passed 11 For 0 Against</p>	<p><u>The following agents to require Prior Authorization</u></p> <ul style="list-style-type: none"> • Aczone® • Apriso™ • Eliphos™ • Moxatag® • Prandimet™ • Promacta® - Clinical PA required unless ICD-9 submitted on the claim for FDA approved indications • Xolegel™ • Zacare™
<p><u>Lyrica® Clinical Criteria</u> COVERED DIAGNOSES:</p> <ul style="list-style-type: none"> • Diabetic Peripheral Neuropathy (DPN) • Postherpetic Neuralgia (PHN) <ul style="list-style-type: none"> 1. Adequate trial and failure of OR intolerance OR contraindication to at least one of these first-line agents <ul style="list-style-type: none"> i. Tricyclic antidepressant (TCAs) ii. Anticonvulsant: gabapentin iii. Topical: Lidocaine 5% patch • Adjunct for partial onset seizure disorder via an ICD-9 override • Fibromyalgia – via ICD-9 override 	<p>Passed 11 For 0 Against</p>	<ul style="list-style-type: none"> • Place on the PDL as preferred with the following clinical criteria <p>COVERED DIAGNOSES:</p> <ul style="list-style-type: none"> • Diabetic Peripheral Neuropathy (DPN) • Postherpetic Neuralgia (PHN) <ul style="list-style-type: none"> 1. Adequate trial and failure of OR intolerance OR contraindication to at least one of these first-line agents <ul style="list-style-type: none"> i. Tricyclic antidepressant (TCAs) ii. Anticonvulsant: gabapentin iii. Topical: Lidocaine 5% patch • Adjunct for partial onset seizure disorder via an ICD-9 override

<ul style="list-style-type: none"> DMS to allow continuation of therapy for patients who have a history within the last 90 days 		<ul style="list-style-type: none"> Fibromyalgia – via ICD-9 override DMS to allow continuation of therapy for patients who have a history of Lyrica® within the last 90 days
<p><u>Caduet® Clinical Criteria</u></p> <ul style="list-style-type: none"> Caduet will be approved for patients who: <ul style="list-style-type: none"> Are receiving amlodipine therapy, and Have tried and failed, or have a contraindication or intolerance to simvastatin plus one other preferred high potency statin. DMS to allow continuation of therapy for patients who have a history within the last 90 days. 	<p>Passed 10 For 1 Against 1 Abstain</p>	<ul style="list-style-type: none"> Place on the PDL as preferred with the following clinical criteria Caduet will be approved for patients who: <ul style="list-style-type: none"> Are receiving amlodipine therapy, and Have tried and failed, or have a contraindication or intolerance to simvastatin plus one other preferred high potency statin. DMS to allow continuation of therapy for patients who have a history of Caduet® within the last 90 days.
<p><u>Suboxone®/Subutex® Clinical Criteria</u></p> <ol style="list-style-type: none"> Patient must be 16 years of age or older Prescriber must possess a Drug Addiction Treatment Act waiver There must have evidence of active substance abuse counseling Prescriber must perform a monthly KASPER report Request must come from the prescriber 	<p>Passed Criteria: 10 For 2 Against KASPER: 7 For 5 Against Prescriber only: 11 For 1 Against</p>	<p><u>Suboxone®/Subutex® to require PA with the following clinical criteria.</u></p> <ol style="list-style-type: none"> Patient must be 16 years of age or older Prescriber must possess a Drug Addiction Treatment Act waiver There must have evidence of active substance abuse counseling Prescriber must perform a monthly KASPER report Request must come from the prescriber
<p><u>Topical Agents for Psoriasis</u></p> <ul style="list-style-type: none"> DMS to select preferred agent (s) based upon economic evaluation; however, at least one agent should be preferred. Agents not selected as preferred will be considered non-preferred and will require Prior Authorization. DMS to allow continuation of therapy for agents selected as non-preferred for patients who have a history within the last 90 days. For any new chemical entity in the Topical Agents for Psoriasis, require a PA until reviewed by the P&T Advisory Committee. 	<p>Passed 12 For 0 Against</p>	<p><u>Selected Preferred Agent (s)</u> Psoriatec® calcipotriene scalp solution Dovonex® cream/gel</p>
<p><u>Progestins for Cachexia</u></p> <ul style="list-style-type: none"> DMS to select preferred agent (s) based upon economic evaluation; however, Megace ES® must be preferred. Agents not selected as preferred will be considered non-preferred and will require Prior Authorization. 	<p>Passed 12 For 0 Against</p>	<p><u>Selected Preferred Agent (s)</u> megestrol acetate Megace® Megace ES®</p>

<ul style="list-style-type: none"> For any new chemical entity in the Progestins for Cachexia class, require a PA until reviewed by the P&T Advisory Committee. 		
<p><u>Direct Renin Inhibitors</u></p> <ul style="list-style-type: none"> DMS to select preferred agent (s) based upon economic evaluation. Require a Step Therapy Edit for either an ACE or an ARB within the last 180 days. Agents not selected as preferred will be considered non-preferred and will require Prior Authorization. DMS to allow continuation of therapy for patients who have a history within the last 90 days. For any new chemical entity in the Direct Renin Inhibitor Class, require a PA until reviewed by the P&T Advisory Committee. 	<p>Passed 12 For 0 Against</p>	<p><u>Selected Preferred Agent (s)</u> Tekturna^{®ST} Tekturna HCT^{®ST}</p> <ul style="list-style-type: none"> Place on the PDL as Preferred with the following clinical criteria Tekturna[®] or Tekturna HCT[®] will be automatically approved if any ACE or ARB is located in history within the past 180 days.
<p><u>Hematopoietic Agents</u></p> <ul style="list-style-type: none"> DMS to select preferred agent (s) based upon economic evaluation. All hematopoietic agents will require Prior Authorization. For any agent not selected as preferred, DMS to allow continuation of therapy if there is a paid claim in the past 90 days. For any new chemical entity in the hematopoietic class, require a PA until reviewed by the PTAC. 	<p>Passed 12 For 0 Against</p>	<p><u>Selected Preferred Agent (s)</u> Aranesp^{®CC} Epogen^{®CC} Procrit^{®CC}</p>
<p><u>Hematopoietic Agents Clinical Criteria</u> Erythropoiesis stimulating agents will be approved for recipients meeting one of the following criteria:</p> <ul style="list-style-type: none"> The patient has a hemoglobin of less than 12 g/dL AND one of the following diagnoses: <ul style="list-style-type: none"> Anemia associated with chronic renal failure (patients may be on dialysis or pre-dialysis) OR anemia associated with kidney transplantation Treatment of chemotherapy induced anemia for non-myeloid malignancies Drug-induced anemia (examples, not all inclusive: Retrovir[®] or Combivir[®] or ribavirin) Autologous blood donations by patients scheduled to undergo nonvascular surgery; OR, The patient is an infant (up to 6 months old) with a diagnosis of Anemia of Prematurity (no lab work required-allow 8 weeks of therapy). Hemoglobin of less than 8g/dl: OR Hemoglobin of 8-9.4 g/dl and patient is 18 years of age or more OR Hemoglobin of 9.5-10.9 g/dl and patient is 70 years of age or more OR 	<p>Passed 12 For 0 Against</p>	<p>Add the following criteria to the entire class of Hematopoietic Agents: Erythropoiesis stimulating agents will be approved for recipients meeting one of the following criteria:</p> <ul style="list-style-type: none"> The patient has a hemoglobin of less than 12 g/dL AND one of the following diagnoses: <ul style="list-style-type: none"> Anemia associated with chronic renal failure (patients may be on dialysis or pre-dialysis) OR anemia associated with kidney transplantation Treatment of chemotherapy induced anemia for non-myeloid malignancies Drug-induced anemia (examples, not all inclusive: Retrovir[®] or Combivir[®] or ribavirin) Autologous blood donations by patients scheduled to undergo nonvascular surgery; OR, The patient is an infant (up to 6 months old) with a diagnosis of Anemia of Prematurity (no lab work required-

<ul style="list-style-type: none"> • Patient is 18 years of age or more with cardiovascular disease and/or signs of anemia 		<p>allow 8 weeks of therapy).</p> <ul style="list-style-type: none"> • Hemoglobin of less than 8g/dl: OR • Hemoglobin of 8-9.4 g/dl and patient is 18 years of age or more OR • Hemoglobin of 9.5-10.9 g/dl and patient is 70 years of age or more OR • Patient is 18 years of age or more with cardiovascular disease and/or signs of anemia
<p><u>COPD Anticholinergics</u></p> <ul style="list-style-type: none"> • DMS to select preferred agent (s) based upon economic evaluation; however, tiotropium must be a preferred agent. • Agents not selected as preferred based on economic evaluation will require PA. • Continue quantity limits based on maximum recommended dose. • For any new chemical entity in the Inhaled Anticholinergics class, require a PA until reviewed by the PTAC. 	<p>Passed 12 For 0 Against</p>	<p><u>Selected Preferred Agent (s)</u> Atrovent[®] HFA^{QL} Combivent[®] ^{QL} ipratropium inhalation solution^{QL} ipratropium-albuterol solution^{QL} Spiriva[®] ^{QL}</p>
<p><u>Insulins</u></p> <ul style="list-style-type: none"> • DMS to prefer at least one brand of human insulin per class (bolus, basal, premixed, rapid-acting, intermediate-acting and long-acting) based upon economic evaluation. This will include at least one 50/50 mix AND at least one 70/30 OR 75/25 mix. • DMS to require PA for pen delivery systems for patients unable to manipulate vials/syringes (eyesight, dexterity, comprehension). • For any agent not selected as preferred, DMS to allow continuation of therapy if there is a paid claim in the past 90 days. • For any new chemical entity in the insulin class, require a PA until reviewed by the P & T Advisory Committee. 	<p>Passed 7 For 3 Against 2 Abstain</p>	<p><u>Selected Preferred Agent (s)</u> Lantus[®] Vials Levemir[®] Vials Novolin N[®] Vials Novolin R[®] Vials Novolin 70/30[®] Vials Novolog[®] Vials Novolog Mix 70/30[®] Vials Humulin50/50[®] Vials</p>
<p><u>Insulin Pen Clinical Criteria</u></p> <ul style="list-style-type: none"> • Allow without PA for patients 15 years of age and under • Patients <u>or active care-givers</u> that are unable to manipulate vials/syringes due to issues related to poor eyesight, dexterity, or comprehension. 	<p>Passed 11 For 0 Against 1 Abstain</p>	<p><u>Place on the PDL as Non Preferred with the following clinical criteria</u></p> <ul style="list-style-type: none"> • Allow without PA for patients 15 years of age and under • Patients <u>or active care-givers</u> that are unable to manipulate vials/syringes due to issues related to poor eyesight, dexterity, or comprehension.
<p><u>Bisphosphonates</u></p> <ul style="list-style-type: none"> • DMS to select preferred agent (s) based upon economic evaluation; however, at least one bisphosphonate should be preferred. • Agents not selected as preferred based on economic evaluation will require PA. • Continue quantity limits based on maximum recommended dose. 	<p>Passed 12 For 0 Against</p>	<p><u>Selected Preferred Agent (s)</u> alendronate Fosamax[®] oral solution</p>

- For any new chemical entity in the Bisphosphonate class, require a PA until reviewed by the PTAC.