

	Description of Recommendation	P & T Vote												
7	<p><u>New Drugs to Market: Edluar[®]</u> Place this product non preferred in the PDL category titled: Sedative Hypnotic Agents with the following clinical criteria:</p> <p>Edluar[®] will be approved if one of the following criteria is met:</p> <ul style="list-style-type: none"> • Diagnosis of dysphagia via an ICD-9 Override, OR <table border="1" data-bbox="302 527 1227 789"> <thead> <tr> <th data-bbox="302 527 932 564">Diagnosis</th> <th data-bbox="932 527 1227 564">ICD-9 Code</th> </tr> </thead> <tbody> <tr> <td data-bbox="302 564 932 602">dysphagia</td> <td data-bbox="932 564 1227 602">787.2</td> </tr> <tr> <td data-bbox="302 602 932 678">dysphagia - functional, hysterical, or nervous</td> <td data-bbox="932 602 1227 678">300.11</td> </tr> <tr> <td data-bbox="302 678 932 716">dysphagia - psychogenic</td> <td data-bbox="932 678 1227 716">306.4</td> </tr> <tr> <td data-bbox="302 716 932 753">dysphagia - sideropenic</td> <td data-bbox="932 716 1227 753">280.8</td> </tr> <tr> <td data-bbox="302 753 932 789">dysphagia - spastica</td> <td data-bbox="932 753 1227 789">530.5</td> </tr> </tbody> </table> <ul style="list-style-type: none"> • Trial and failure of 2 preferred sedative hypnotics, one of which must be zolpidem. 	Diagnosis	ICD-9 Code	dysphagia	787.2	dysphagia - functional, hysterical, or nervous	300.11	dysphagia - psychogenic	306.4	dysphagia - sideropenic	280.8	dysphagia - spastica	530.5	<p>Passed 9 For 0 Against</p>
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dysphagia - spastica	530.5													
8	<p><u>New Drugs to Market: Adcirca[™]</u> Place this product non preferred in the PDL category titled: Agents for Pulmonary Hypertension with the following clinical criteria:</p> <p>Adcirca[™] will be approved if both of the following criteria are met:</p> <ul style="list-style-type: none"> • Diagnosis of pulmonary hypertension via an ICD-9 Override (416.0, 416.8), AND • Trial and failure of sildenafil via a 90 day electronic look back. 	<p>Passed 9 For 0 Against</p>												
9	<p><u>New Drugs to Market: Acuvail[™]</u> Place this product non preferred in the PDL category titled: Ophthalmic NSAIDs.</p>	<p>Passed 9 For 0 Against</p>												
10	<p><u>New Drugs to Market: Effient[™]</u> Allow this product to pay as preferred until it can be reviewed at the next PTAC meeting when the Committee's Cardiologist is present.</p>	<p>Passed 9 For 0 Against</p>												

	Description of Recommendation	P & T Vote
11	<p><u>Protein Tyrosine Kinase Inhibitors</u></p> <ol style="list-style-type: none"> 1. DMS to select preferred agent(s) based on economic evaluation; however, at least imatinib should be preferred. 2. Agents not selected as preferred will be considered non preferred and require PA via a 90 day electronic look back. 3. All agents in the category will have no higher than a tier 2 copay regardless of PDL status. 4. DMS to allow continuation of therapy for existing users of non preferred products via a 90 day look back. 5. For any new chemical entity in the Protein Tyrosine Kinase Inhibitor class, require a PA until reviewed by the P&T Advisory Committee. 	<p>Passed 9 For 0 Against</p>
12	<p><u>Ranexa[®] Clinical Criteria</u></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"> • Beta Blocker • Nitrate • Calcium Channel Blocker 	<p>Passed 9 For 0 Against</p>
13	<p><u>Lidoderm[®] Clinical Criteria</u></p> <p>Lidoderm[®] will be approved if any one of the following criteria are met:</p> <ul style="list-style-type: none"> • Diagnosis of Post Herpetic Neuralgia via an ICD-9 override; OR • History of one agent in any of the following medication classes in the past 90 days: <ul style="list-style-type: none"> ○ Tricyclic antidepressant ○ Anticonvulsant ○ SNRI 	<p>Passed 9 For 0 Against</p>

	Description of Recommendation	P & T Vote
14	<p data-bbox="302 268 824 302"><u>Hepatitis C: Pegylated Interferons</u></p> <ol data-bbox="302 306 1224 842" style="list-style-type: none"> <li data-bbox="302 306 1003 340">1. Rename the category Hepatitis C: Interferons. <li data-bbox="302 344 1114 449">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 data-bbox="302 453 1130 516">3. Agents not selected as preferred will be considered non preferred. <li data-bbox="302 520 1224 596">4. PDL selected agents will apply for any new courses of therapy only. <li data-bbox="302 600 1156 663">5. All agents in the category will have no higher than a tier 2 copay regardless of PDL status. <li data-bbox="302 667 1162 743">6. Place clinical prior authorization around the entire class to ensure appropriate utilization. <li data-bbox="302 747 1172 842">7. For any new chemical entity in the Hepatitis C: Interferons class, require a PA until reviewed by the P&T Advisory Committee. 	<p data-bbox="1256 268 1370 302">Passed</p> <p data-bbox="1256 306 1338 340">9 For</p> <p data-bbox="1256 344 1390 378">0 Against</p>

	Description of Recommendation	P & T Vote
15	<p><u>Hepatitis C: Pegylated Interferons Clinical Criteria</u> All preferred and non-preferred pegylated interferons will require a prior authorization after the initial 16 weeks of therapy.</p> <p><u>After the initial 16 weeks of therapy pegylated interferons will be approved if:</u></p> <ol style="list-style-type: none"> 1. HCV RNA Assay results obtained prior to initiation of therapy AND 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), THEN approve for duration of therapy as defined below. 2. If the assays were done BUT the difference between the two assays WAS NOT at least a 2 logarithmic unit decrease (example: from 2,000,000 IU to 20,000 IU), THEN refer the request to a clinical pharmacist who will deny the request. 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. <p><i>LIMITATION ON LENGTH OF THERAPY IS BASED ON PRODUCT</i></p> <ol style="list-style-type: none"> 1. Interferon alfacon-1 <ol style="list-style-type: none"> a. IFN naïve – 24 weeks total therapy b. INF relapse – 48 weeks total therapy 2. Peginterferon alfa-2a OR 2b <ol style="list-style-type: none"> a. Genotype 1, 4, age 2-17 years, OR HIV positive – 48 weeks total therapy b. Genotype 2, 3 – 24 weeks total therapy 	<p>Passed 9 For 0 Against</p>
16	<p><u>Hepatitis C: Ribavirins</u></p> <ol style="list-style-type: none"> 1. DMS to select preferred agent (s) based on economic evaluation; however, at least ribavirin should be preferred. 2. Agents not selected as preferred will be considered non preferred. 3. PDL selected agents will apply for any new courses of therapy only. 4. Place clinical prior authorization around the entire class of ribavirins to ensure appropriate utilization. 5. For any new chemical entity in the Hepatitis C: Ribavirins class, require a PA until reviewed by the P&T Advisory Committee. 	<p>Passed 9 For 0 Against</p>

	Description of Recommendation	P & T Vote
17	<p><u>Hepatitis C: Ribavirins Clinical Criteria</u> Ribavirins will pay at point-of-sale if there is concurrent interferon therapy in history.</p>	<p>Passed 9 For 0 Against</p>
18	<p><u>Antihyperkinesis Agents</u></p> <ol style="list-style-type: none"> 1. DMS to select preferred agent(s) based on economic evaluation; however, at least one short-acting, one intermediate-acting and one long-acting formulation of methylphenidate and dextroamphetamine as well as atomoxetine should be preferred. 2. Agents not selected as preferred will be considered non preferred and require trial and failure of one preferred product, preferred generics must be tried before multisource branded products will be approved. 3. Require appropriate ICD-9 on all prescriptions for agents within this class. 4. Continue to require prior authorization for modafinil and armodafinil to ensure utilization in FDA-approved indications only. 5. Place quantity limits on all agents based on the American Academy of Child and Adolescent Psychiatry and FDA-approved maximum recommended dose. 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. 7. Allow continuation of therapy for non preferred products via a 90 day look back. 8. For any new chemical entity in the Antihyperkinesis class, require a PA until reviewed by the P&T Advisory Committee. 	<p>Passed 9 For 0 Against</p>

	Description of Recommendation	P & T Vote																				
19	<p data-bbox="302 264 922 300">Antihyperkinesia Agents Clinical Criteria</p> <p data-bbox="302 300 932 336">Diagnosis to Approve via an ICD-9 Override:</p> <table border="1" data-bbox="302 373 1224 905"> <thead> <tr> <th data-bbox="302 373 802 415">Diagnosis</th> <th data-bbox="802 373 1224 415">ICD-9</th> </tr> </thead> <tbody> <tr> <td data-bbox="302 415 802 604" rowspan="5">Attention Deficit/Hyperreactivity Disorder (ADHD)</td> <td data-bbox="802 415 1224 451">314.1</td> </tr> <tr> <td data-bbox="802 451 1224 487">314.01</td> </tr> <tr> <td data-bbox="802 487 1224 522">314.2</td> </tr> <tr> <td data-bbox="802 522 1224 558">314.8</td> </tr> <tr> <td data-bbox="802 558 1224 594">314.9</td> </tr> <tr> <td data-bbox="302 604 802 640">Attention Deficit Disorder (ADD)</td> <td data-bbox="802 604 1224 640">314.00</td> </tr> <tr> <td data-bbox="302 640 802 751" rowspan="3">Narcolepsy</td> <td data-bbox="802 640 1224 676">347.00</td> </tr> <tr> <td data-bbox="802 676 1224 711">347.01</td> </tr> <tr> <td data-bbox="802 711 1224 747">347.11</td> </tr> <tr> <td data-bbox="302 751 802 863" rowspan="3">Sleep apnea/hypoapnea syndrome</td> <td data-bbox="802 751 1224 787">780.57</td> </tr> <tr> <td data-bbox="802 787 1224 823">780.51</td> </tr> <tr> <td data-bbox="802 823 1224 858">780.53</td> </tr> <tr> <td data-bbox="302 863 802 905">Shift work sleep disorder</td> <td data-bbox="802 863 1224 905">307.45</td> </tr> </tbody> </table> <p data-bbox="302 940 1203 1052">**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> <p data-bbox="302 1087 824 1123">Quantity Limits/Maximum Daily Dose</p> <ul data-bbox="347 1123 946 1900" style="list-style-type: none"> • Adderall® 60 mg per day • Adderall® XR 60 mg per day • Concerta® 108 mg per day • Daytrana™ 30 mg per day • Desoxyn® 25 mg per day • Dexedrine® IR 60 mg per day • Dexedrine® ER 60 mg per day • dexamethylphenidate 50 mg per day • dextroamphetamine IR 60 mg per day • dextroamphetamine ER 60 mg per day • DextroStat® 60 mg per day • Focalin™ 50 mg per day • Focalin™ XR 50 mg per day • Metadate® CD 100 mg per day • Metadate® ER 100 mg per day • methamphetamine 25 mg per day • Methylin® 100 mg per day • Methylin® ER 100 mg per day • methylphenidate IR 100 mg per day • methylphenidate SR 100 mg per day 	Diagnosis	ICD-9	Attention Deficit/Hyperreactivity 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	<p data-bbox="1253 264 1370 300">Passed</p> <p data-bbox="1253 300 1333 336">9 For</p> <p data-bbox="1253 336 1390 371">0 Against</p>
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	<ul style="list-style-type: none"> • mixed amphetamine salt IR 60 mg per day • mixed Amphetamine salt ER 60 mg per day • Nuvigil® 150 mg per day • Procentra™ 60 mg per day • Provigil® 400 mg per day • Ritalin® 100 mg per day • Ritalin® LA 100 mg per day • Ritalin® SR 100 mg per day • Strattera® 100 mg per day • Vyvanse™ 70 mg per day <p>Therapeutic Duplication 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, dexmethylphenidate, dextroamphetamine IR, DextroStat®, Focalin™, Methylin®, methylphenidate, mixed amphetamine salt IR, Ritalin®) stimulant at a time.</p>	
20	<p><u>Antihyperkinesia Agents, Special Formulations Clinical Criteria</u></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"> • Trial and failure of one preferred product, which must be the same chemical as the requested medication; OR • Inability to swallow/tolerate PO/whole tablets/capsules <ul style="list-style-type: none"> ○ For Daytrana™, inability to swallow/tolerate PO medications; OR ○ For Methylin® Solution, Methylin® Chewable Tabs, or Procentra™, inability to swallow tablets or capsules whole. 	<p>Passed 9 For 0 Against</p>

	Description of Recommendation	P & T Vote														
21	<p><u>Provigil® / Nuvigil® Clinical Criteria</u> Provigil® (modafinil) / Nuvigil® (armodafinil) will be approved if both of the following criteria are met:</p> <ul style="list-style-type: none"> One of the following approvable diagnosis (via ICD-9 override): <table border="1" data-bbox="302 489 1224 753"> <tbody> <tr> <td data-bbox="302 489 789 527">Narcolepsy</td> <td data-bbox="789 489 1224 527">347.00</td> </tr> <tr> <td data-bbox="302 527 789 564"></td> <td data-bbox="789 527 1224 564">347.01</td> </tr> <tr> <td data-bbox="302 564 789 602"></td> <td data-bbox="789 564 1224 602">347.11</td> </tr> <tr> <td data-bbox="302 602 789 640">Sleep apnea/hypoapnea syndrome</td> <td data-bbox="789 602 1224 640">780.57</td> </tr> <tr> <td data-bbox="302 640 789 678"></td> <td data-bbox="789 640 1224 678">780.51</td> </tr> <tr> <td data-bbox="302 678 789 716"></td> <td data-bbox="789 678 1224 716">780.53</td> </tr> <tr> <td data-bbox="302 716 789 753">Shift work sleep disorder</td> <td data-bbox="789 716 1224 753">307.45</td> </tr> </tbody> </table> <ul style="list-style-type: none"> For Nuvigil® (armodafinil) ONLY, trial and failure of Provigil® (modafinil) via a 90 day look back 	Narcolepsy	347.00		347.01		347.11	Sleep apnea/hypoapnea syndrome	780.57		780.51		780.53	Shift work sleep disorder	307.45	<p>Passed 9 For 0 Against</p>
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Shift work sleep disorder	307.45															
22	<p><u>Corticosteroids, Intranasal</u></p> <ol style="list-style-type: none"> DMS to select preferred agent (s) based on economic evaluation; however, at least two unique chemical entities, one of which must be fluticasone furoate, should be preferred. Agents not selected as preferred will be considered non preferred and require PA. Continue to maintain quantity limits based on maximum daily dose. For any new chemical entity in the Corticosteroids, Intranasal class, require a PA until reviewed by the P&T Advisory Committee. 	<p>Passed 6 For 2 Against 1 Abstention</p>														