

**Commissioner for the Department for Medicaid Services  
Selections for Preferred Products**

This is a summary of the final Preferred Drug List (PDL) selections made by the Commissioner for the Department for Medicaid Services based on the November 15, 2012 Pharmacy and Therapeutics Advisory Committee (PTAC) Meeting.

<b>Description of Recommendation</b>	<b>Final Decision (s)</b>
<b><u>New Products to Market: Dymista<sup>®</sup></u></b> Place this product non preferred with similar quantity limits in the PDL class titled Intranasal Rhinitis Agents.	Dymista <sup>®</sup> will be placed non preferred with similar quantity limits in the PDL class titled Intranasal Rhinitis Agents.
<b><u>New Products to Market: Sklice<sup>™</sup></u></b> Place this product non preferred in the PDL class titled Dermatologics: Antiparasitics, Topical.	Sklice <sup>™</sup> will be placed non preferred in the PDL class titled Dermatologics: Antiparasitics, Topical.
<b><u>New Products to Market: Neupro<sup>®</sup></u></b> Place this product non preferred in the PDL class titled Non-Ergot Dopamine Receptor Agonists.	Neupro <sup>®</sup> will be placed non preferred in the PDL class titled Non-Ergot Dopamine Receptor Agonists.
<b><u>New Products to Market: Viokace<sup>™</sup></u></b> Place this product non preferred in the PDL class titled Pancreatic Enzymes.	Viokace <sup>™</sup> will be placed non preferred in the PDL class titled Pancreatic Enzymes.
<b><u>New Products to Market: Pertzye<sup>™</sup></u></b> Place this product non preferred in the PDL class titled Pancreatic Enzymes.	Pertzye <sup>™</sup> will be placed non preferred in the PDL class titled Pancreatic Enzymes.
<b><u>New Products to Market: Myrbetriq<sup>™</sup></u></b> Place this product preferred with similar quantity limits in the PDL class titled Urinary Tract Antispasmodics.	Myrbetriq <sup>™</sup> will be placed non preferred with similar quantity limits in the PDL class titled Urinary Tract Antispasmodics.
<b><u>New Products to Market: Tudorza<sup>™</sup> Pressair<sup>™</sup></u></b> Place this product non preferred with similar quantity limits in the PDL class titled COPD Agents.	Tudorza <sup>™</sup> Pressair <sup>™</sup> will be placed non preferred with similar quantity limits in the PDL class titled COPD Agents.
<b><u>New Products to Market: Xtandi<sup>®</sup></u></b> Place this product non preferred with similar quantity limits in the PDL class titled Oral Oncology Agents.	Xtandi <sup>®</sup> will be placed non preferred with similar quantity limits in the PDL class titled Oral Oncology Agents.
<b><u>New Products to Market: Bosulif<sup>®</sup></u></b> Place this product non preferred with similar quantity limits in the PDL class titled Oral Oncology Agents.	Bosulif <sup>®</sup> will be placed non preferred with similar quantity limits in the PDL class titled Oral Oncology Agents.

Description of Recommendation	Final Decision (s)
<p><b>Truvada<sup>®</sup> Clinical Criteria</b></p> <p>Truvada<sup>®</sup> should be approved initially if any ONE of the following is true:</p> <ul style="list-style-type: none"> <li>• Treatment of HIV-1 infection; OR</li> <li>• Pre-exposure prophylaxis (PrEP) to reduce the risk of sexually acquired HIV-1 if ALL of the following are true: <ul style="list-style-type: none"> <li>○ Prior Authorization request is coming from the prescriber; AND</li> <li>○ High risk for contracting HIV-1, defined as: <ul style="list-style-type: none"> <li>○ Male who has sex with men (MSM) and are at high risk for HIV-1 infection.</li> <li>○ Transgender woman, (e.g. male who has undergone a sex change), who has sex with men and are at high risk for HIV-1 infection.</li> <li>○ Male or female in a heterosexual HIV-1 serodiscordant relationship; AND</li> </ul> </li> <li>○ Negative HIV-1 test immediately prior to initiating Truvada<sup>®</sup>; AND</li> <li>○ Risk-reduction and medication adherence counseling has been completed by prescriber.</li> </ul> </li> </ul> <p>**If the indication is pre-exposure prophylaxis (PrEP) to reduce the risk of sexually acquired HIV-1, Truvada<sup>®</sup> will only be approved for a duration of 3 months.</p> <p>Truvada<sup>®</sup> should be approved for continuation of therapy if any ONE of the following is true:</p> <ul style="list-style-type: none"> <li>• Treatment of HIV-1 infection; OR</li> <li>• Pre-exposure prophylaxis (PrEP) to reduce the risk of sexually acquired HIV-1 if ALL of the following are true: <ul style="list-style-type: none"> <li>○ Prior Authorization request is coming from the prescriber; AND</li> <li>○ Substantial, ongoing, high risk for acquiring HIV infection as defined below: <ul style="list-style-type: none"> <li>○ Male who has sex with men (MSM) and are at high risk for HIV-1 infection.</li> <li>○ Transgender woman, (e.g. male who has undergone a sex change), who has sex with men and are at high risk for HIV-1 infection.</li> <li>○ Male or female in a heterosexual HIV-1</li> </ul> </li> </ul> </li> </ul>	<p>Truvada<sup>®</sup> will be approved initially if any ONE of the following is true:</p> <ul style="list-style-type: none"> <li>• Treatment of HIV-1 infection; OR</li> <li>• Pre-exposure prophylaxis (PrEP) to reduce the risk of sexually acquired HIV-1 if ALL of the following are true: <ul style="list-style-type: none"> <li>○ Prior Authorization request is coming from the prescriber; AND</li> <li>○ High risk for contracting HIV-1, defined as: <ul style="list-style-type: none"> <li>○ Male who has sex with men (MSM) and are at high risk for HIV-1 infection.</li> <li>○ Transgender woman, (e.g. male who has undergone a sex change), who has sex with men and are at high risk for HIV-1 infection.</li> <li>○ Male or female in a heterosexual HIV-1 serodiscordant relationship; AND</li> </ul> </li> <li>○ Negative HIV-1 test immediately prior to initiating Truvada<sup>®</sup>; AND</li> <li>○ Risk-reduction and medication adherence counseling has been completed by prescriber.</li> </ul> </li> </ul> <p>**If the indication is pre-exposure prophylaxis (PrEP) to reduce the risk of sexually acquired HIV-1, Truvada<sup>®</sup> will only be approved for a duration of 3 months.</p> <p>Truvada<sup>®</sup> will be approved for continuation of therapy if any ONE of the following is true:</p> <ul style="list-style-type: none"> <li>• Treatment of HIV-1 infection; OR</li> <li>• Pre-exposure prophylaxis (PrEP) to reduce the risk of sexually acquired HIV-1 if ALL of the following are true: <ul style="list-style-type: none"> <li>○ Prior Authorization request is coming from the prescriber; AND</li> <li>○ Substantial, ongoing, high risk for acquiring HIV infection as defined below: <ul style="list-style-type: none"> <li>○ Male who has sex with men (MSM) and are at high risk for HIV-1 infection.</li> <li>○ Transgender woman, (e.g. male who has undergone a sex change), who has sex with men and are at high risk for HIV-1 infection.</li> <li>○ Male or female in a heterosexual HIV-1</li> </ul> </li> </ul> </li> </ul>

<p>serodiscordant relationship; AND</p> <ul style="list-style-type: none"> <li>○ Negative HIV-1 test; AND</li> <li>○ Risk-reduction and medication adherence counseling has been completed by prescriber no less frequently than every three months; AND</li> <li>○ The patient has strictly adhered to the dosing schedule, as evident by pill counts.</li> </ul> <p>**If the indication is pre-exposure prophylaxis (PrEP) to reduce the risk of sexually acquired HIV-1, Truvada® will only be approved for a duration of 3 months.</p>	<p>serodiscordant relationship; AND</p> <ul style="list-style-type: none"> <li>○ Negative HIV-1 test; AND</li> <li>○ Risk-reduction and medication adherence counseling has been completed by prescriber no less frequently than every three months; AND</li> <li>○ The patient has strictly adhered to the dosing schedule, as evident by pill counts.</li> </ul> <p>**If the indication is pre-exposure prophylaxis (PrEP) to reduce the risk of sexually acquired HIV-1, Truvada® will only be approved for a duration of 3 months.</p>
<p><b><u>Nucynta® ER Clinical Criteria</u></b></p> <p>Nucynta® ER should be authorized for the following diagnoses:</p> <ul style="list-style-type: none"> <li>• Pain after trial and failure of one preferred product; OR</li> <li>• Diabetic Peripheral Neuropathy after trial and failure of TWO of the following: <ul style="list-style-type: none"> <li>○ One SNRI; or</li> <li>○ One anticonvulsant; or</li> </ul> </li> <li>• One tricyclic antidepressant.</li> </ul>	<p>Nucynta® ER will be authorized for the following diagnoses:</p> <ul style="list-style-type: none"> <li>• Pain after trial and failure of one preferred product; OR</li> <li>• Diabetic Peripheral Neuropathy after trial and failure of TWO of the following: <ul style="list-style-type: none"> <li>○ One SNRI; or</li> <li>○ One anticonvulsant; or</li> </ul> </li> <li>• One tricyclic antidepressant.</li> </ul>
<p><b><u>First-Generation Antipsychotics</u></b></p> <ol style="list-style-type: none"> <li>1. DMS to select preferred agent(s) based on economic evaluation; however, at least four unique chemical entities, at least one representing an agent from each of the potency groups, should be preferred.</li> <li>2. Agents not selected as preferred will be considered non preferred and require prior authorization</li> <li>3. Allow continuation of therapy for non preferred single source branded products via a 90 day look back.</li> <li>4. For any new chemical entity in the First-Generation Antipsychotics class, require a PA until reviewed by the P&amp;T Advisory Committee.</li> </ol>	<p>Selected Preferred Agent (s)</p> <p>amitriptyline/perphenazine  chlorpromazine  fluphenazine  haloperidol  loxapine  Moban®  Orap®  perphenazine  thioridazine  thiothixene  trifluoperazine</p> <p>Non Preferred Agent (s)</p> <p>Loxitane®</p>

Description of Recommendation	Final Decision (s)
<p><b><u>Second-Generation Antipsychotics</u></b></p> <ol style="list-style-type: none"> <li>DMS to select preferred agent(s) based on economic evaluation; however, at least five unique chemical entities, one of which must be lurasidone, should be preferred.</li> <li>Require appropriate ICD-9 on all prescriptions for agents within this class.</li> <li>Place quantity limits on all agents in the class.</li> <li>Allow only two agents at a time unless switching agents due to therapeutic failure or the patient is refractory to dual therapy.</li> <li>Allow continuation of therapy for non preferred single source branded products via a 90 day look back.</li> <li>All products in the category should have a tier 1 copay regardless of preferred or non preferred status.</li> <li>For any new chemical entity in the Second-Generation Antipsychotics class, require a PA until reviewed by the P&amp;T Advisory Committee.</li> </ol>	<p>Selected Preferred Agent (s)</p> <p>Abilify<sup>®</sup>  clozapine  clozapine ODT  Fanapt<sup>™</sup>  Latuda<sup>®</sup>  olanzapine  quetiapine  risperidone  Saphris<sup>®</sup>  Seroquel<sup>®</sup> XR  ziprasidone</p> <p>Non Preferred Agent (s)</p> <p>Clozaril<sup>®</sup>  FazaClo<sup>®</sup>  Geodon<sup>®</sup>  Invega<sup>®</sup>  Risperdal<sup>®</sup>  Seroquel<sup>®</sup>  Zyprexa<sup>®</sup></p>
<p><b><u>Second-Generation Antipsychotics Clinical Criteria</u></b></p> <p>Preferred Second-Generation Antipsychotics will be allowed for specific diagnoses only.</p> <p>*Non preferred Second-Generation Antipsychotics will be approved after a 2-week trial of ONE preferred Second-Generation Antipsychotic at an appropriate dose. If Invega<sup>®</sup> is selected as non preferred, approval will be granted if one of the following is true:</p> <ul style="list-style-type: none"> <li>Trial and failure of risperidone; OR  Patient has hepatic impairment evident by elevated liver enzymes or a diagnosis suggestive of hepatic impairment.</li> </ul> <p>** For a non-approvable diagnosis, a Second-Generation Antipsychotic may be approved if the prescriber can provide documented clinical evidence (peer reviewed literature or multiple case studies) supporting the use of the requested medication for the requested indication.</p> <p><b>Major Depressive Disorder (MDD) Criteria:</b>  Second-Generation Antipsychotics will be approved for MDD as adjunct therapy ONLY. Second-</p>	<p><b><u>Second-Generation Antipsychotics Clinical Criteria</u></b></p> <p>Preferred Second-Generation Antipsychotics will be allowed for specific diagnoses only.</p> <p>*Non preferred Second-Generation Antipsychotics will be approved after a 2-week trial of ONE preferred Second-Generation Antipsychotic at an appropriate dose. Invega<sup>®</sup> will be approved if one of the following is true:</p> <ul style="list-style-type: none"> <li>Trial and failure of risperidone; OR</li> <li>Patient has hepatic impairment evident by elevated liver enzymes or a diagnosis suggestive of hepatic impairment.</li> </ul> <p>** For a non-approvable diagnosis, a Second-Generation Antipsychotic may be approved if the prescriber can provide documented clinical evidence (peer reviewed literature or multiple case studies) supporting the use of the requested medication for the requested indication.</p> <p><b>Major Depressive Disorder (MDD) Criteria:</b>  Second-Generation Antipsychotics will be</p>

Generation Antipsychotics will be approved if any ONE of the following is true:

- An adequate trial (4 weeks) of at least one agent in two of the following classes of antidepressants (unless contraindicated or intolerant to):
  - Selective Serotonins Reuptake Inhibitor (SSRIs)
  - Serotonin-Norepinephrine Reuptake Inhibitor (SNRIs)
  - New Generation Antidepressants
  - Tricyclic antidepressants (TCAs); OR
- A diagnosis of Major Depressive Disorder (MDD) with psychotic features.

**Multiple Agents Criteria:**

Patients who are on more than 2 Second-Generation Antipsychotic agents will require PA. Approval will be granted for the following reasons:

- A maximum of 2 months to allow patients to taper to dual therapy.
- Additional agents may be added to existing dual therapy after a 2-week trial at the maximum tolerated dose of each agent.

Quantity Limits should be applied.

approved for MDD as adjunct therapy ONLY. Second-Generation Antipsychotics will be approved if any ONE of the following is true:

- An adequate trial (4 weeks) of at least one agent in two of the following classes of antidepressants (unless contraindicated or intolerant to):
  - Selective Serotonins Reuptake Inhibitor (SSRIs)
  - Serotonin-Norepinephrine Reuptake Inhibitor (SNRIs)
  - New Generation Antidepressants
  - Tricyclic antidepressants (TCAs); OR
- A diagnosis of Major Depressive Disorder (MDD) with psychotic features.

**Multiple Agents Criteria:**

Patients who are on more than 2 Second-Generation Antipsychotic agents will require PA. Approval will be granted for the following reasons:

- A maximum of 2 months to allow patients to taper to dual therapy.
- Additional agents may be added to existing dual therapy after a 2-week trial at the maximum tolerated dose of each agent.

Quantity Limits will be applied.

Description of Recommendation	Final Decision (s)
<p><b><u>Injectable Antipsychotics</u></b></p> <ol style="list-style-type: none"> <li>1. DMS to select preferred agent(s) based on economic evaluation. Generic formulations of first generation injectable antipsychotics should be preferred. Additionally, two unique second generation injectable antipsychotics, one of which should have a duration of action of 2 weeks or longer, should be preferred.</li> <li>2. Require appropriate ICD-9 on all prescriptions for agents within this class.</li> <li>3. Allow only two agents at a time unless switching agents due to therapeutic failure or the patient is refractory to dual therapy.</li> <li>4. Allow continuation of therapy for non preferred single source branded products via a 90 day look back.</li> <li>5. All products in the category should have a tier 1 copay regardless of preferred or non preferred status.</li> <li>6. For any new chemical entity in the Injectable Antipsychotics class, require a PA until reviewed by the P&amp;T Advisory Committee.</li> </ol>	<p>Selected Preferred Agent (s)</p> <p>Abilify<sup>®</sup>  fluphenazine decanoate  Geodon<sup>®</sup>  haloperidol decanoate  Invega<sup>®</sup> Sustenna<sup>®</sup>  olanzapine  Risperdal<sup>®</sup> Consta<sup>®</sup></p> <p>Non Preferred Agent (s)</p> <p>Haldol<sup>®</sup> Decanoate  Zyprexa<sup>®</sup>  Zyprexa<sup>®</sup> Relprevv</p>
<p><b><u>Injectable Antipsychotics Clinical Criteria</u></b></p> <p>Preferred Injectable Antipsychotics will be allowed for specific diagnoses only.</p> <p>*Non preferred Injectable Antipsychotics will be approved after a 2-week trial of ONE preferred Antipsychotic (oral or parenteral) at an appropriate dose. If Invega<sup>®</sup> Sustenna<sup>®</sup> is selected as non preferred, approval will be granted if one of the following is true:</p> <ul style="list-style-type: none"> <li>• Trial and failure of risperidone; OR</li> <li>• Patient has hepatic impairment evident by elevated liver enzymes or a diagnosis suggestive of hepatic impairment</li> </ul> <p>** For a non-approvable diagnosis, an injectable antipsychotic may be approved if the prescriber can provide documented clinical evidence (peer reviewed literature or multiple case studies) supporting the use of the requested medication for the requested indication.</p> <p><b>Multiple Therapy Criteria:</b>  Patients who are on more than two Second-Generation</p>	<p>Preferred Injectable Antipsychotics will be allowed for specific diagnoses only.</p> <p>*Non preferred Injectable Antipsychotics will be approved after a 2-week trial of ONE preferred Antipsychotic (oral or parenteral) at an appropriate dose.</p> <p>**For a non-approvable diagnosis, an injectable antipsychotic may be approved if the prescriber can provide documented clinical evidence (peer reviewed literature or multiple case studies) supporting the use of the requested medication for the requested indication.</p> <p><b>Multiple Therapy Criteria:</b>  Patients who are on more than two Second-Generation Antipsychotic agents will require PA. Approval will be granted for the following reasons:</p> <ul style="list-style-type: none"> <li>• A maximum of 2 months to allow patients to taper to dual therapy.</li> <li>• Additional agents may be added to existing dual therapy after a 2-week trial at the maximum</li> </ul>

<p>Antipsychotic agents will require PA. Approval will be granted for the following reasons:</p> <ul style="list-style-type: none"> <li>• A maximum of 2 months to allow patients to taper to dual therapy.</li> <li>• Additional agents may be added to existing dual therapy after a 2-week trial at the maximum tolerated dose if each agent.</li> </ul> <p>Quantity Limits should be applied.</p>	<p>tolerated dose if each agent.</p> <p>Quantity Limits will be applied.</p>
<p><b><u>Second-Generation Antipsychotic and SSRI Combinations</u></b></p> <ol style="list-style-type: none"> <li>1. DMS to select preferred agent(s) based on economic evaluation.</li> <li>2. Require prior authorization and quantity limits for agents in this class.</li> <li>3. Require prior authorization if this product is being used with more than one other second-generation antipsychotic unless switching agents due to therapeutic failure or the patient is refractory to dual second-generation antipsychotic therapy.</li> <li>4. Allow continuation of therapy for non preferred single source branded products via a 90 day look back.</li> <li>5. For any new chemical entity in the Second-Generation Antipsychotic and SSRI Combination class, require a PA until reviewed by the P&amp;T Advisory Committee.</li> </ol>	<p>Selected Preferred Agent (s) Symbyax<sup>®</sup></p> <p>Non Preferred Agent (s) olanzapine/fluoxetine</p>

Description of Recommendation	Final Decision (s)
<p><b><u>Second-Generation Antipsychotic and SSRI Combinations Clinical Criteria</u></b></p> <p>Olanzapine/fluoxetine will be approved if ONE of the following is true:</p> <ul style="list-style-type: none"> <li>• Diagnosis of depressive episodes associated with bipolar disorder after trial and failure of ONE of the following: <ul style="list-style-type: none"> <li>○ Lithium; OR</li> <li>○ Lamotrigine; OR</li> <li>○ Bupropion; OR</li> <li>○ Paroxetine.</li> </ul> </li> <li>• Diagnosis of treatment-resistant depression after trial and failure of one agent from THREE of the following classes of medications: <ul style="list-style-type: none"> <li>○ SSRI;</li> <li>○ SNRI;</li> <li>○ New Generation Antidepressant;</li> <li>○ Tricyclic Antidepressant; <ul style="list-style-type: none"> <li>○ MAOI.</li> </ul> </li> </ul> </li> </ul> <p>** For a non-approvable diagnosis, olanzapine/fluoxetine may be approved if the prescriber can provide documented clinical evidence (peer reviewed literature or multiple case studies) supporting the use of the requested medication for the requested indication.</p> <p><b>Multiple Therapy Criteria:</b> Patients who are on more than 2 Second-Generation Antipsychotic agents will require PA. Approval will be granted for the following reasons:</p> <ul style="list-style-type: none"> <li>• A maximum of 2 months to allow patients to taper to dual therapy.</li> <li>• Additional agents may be added to existing dual therapy after a 2-week trial at the maximum tolerated dose of each agent.</li> </ul> <p>Quantity Limit of 1 per day should be applied.</p>	<p>Olanzapine/fluoxetine will be approved if ONE of the following is true:</p> <ul style="list-style-type: none"> <li>• Diagnosis of depressive episodes associated with bipolar disorder after trial and failure of ONE of the following: <ul style="list-style-type: none"> <li>○ Lithium; OR</li> <li>○ Lamotrigine; OR</li> <li>○ Bupropion; OR</li> <li>○ Paroxetine.</li> </ul> </li> <li>• Diagnosis of treatment-resistant depression after trial and failure of one agent from THREE of the following classes of medications: <ul style="list-style-type: none"> <li>○ SSRI;</li> <li>○ SNRI;</li> <li>○ New Generation Antidepressant;</li> <li>○ Tricyclic Antidepressant;</li> <li>○ MAOI.</li> </ul> </li> </ul> <p>** For a non-approvable diagnosis, olanzapine/fluoxetine may be approved if the prescriber can provide documented clinical evidence (peer reviewed literature or multiple case studies) supporting the use of the requested medication for the requested indication.</p> <p><b>Multiple Therapy Criteria:</b> Patients who are on more than 2 Second-Generation Antipsychotic agents will require PA. Approval will be granted for the following reasons:</p> <ul style="list-style-type: none"> <li>• A maximum of 2 months to allow patients to taper to dual therapy.</li> <li>• Additional agents may be added to existing dual therapy after a 2-week trial at the maximum tolerated dose of each agent.</li> </ul> <p>Quantity Limit of 1 per day will be applied.</p>

<b>Description of Recommendation</b>	<b>Final Decision (s)</b>
<p><b><u>First Generation Anticonvulsants</u></b></p> <ol style="list-style-type: none"> <li>1. DMS to select preferred agent (s) based on economic evaluation; however, at least all generic products should be preferred.</li> <li>2. Agents not selected as preferred will be considered non preferred and require prior authorization.</li> <li>3. Require therapeutic failure of one preferred agent prior to approval of a non-preferred agent.</li> <li>4. For any agent not selected as preferred, DMS to allow continuation of therapy if there is a paid claim in the past 90 days.</li> <li>5. For any new chemical entity in the First Generation Anticonvulsants class, require a PA until reviewed by the P&amp;T Advisory Committee.</li> </ol>	<p>Selected Preferred Agent (s)</p> <p>Celontin<sup>®</sup>  clonazepam  DiaStat<sup>®</sup>  divalproex delayed-release  divalproex sodium extended-release  ethosuximide  mephobarbital  Peganone<sup>®</sup>  phenobarbital  Phenytek<sup>®</sup>  phenytoin ER  primidone  valproic acid</p> <p>Non Preferred Agent (s)</p> <p>Depakene<sup>®</sup>  Depakote<sup>®</sup>  Depakote ER<sup>®</sup>  diazepam rectal gel  Dilantin<sup>®</sup>  Klonopin<sup>®</sup>  Mysoline<sup>®</sup>  Onfi<sup>™</sup>  Stavzor<sup>™</sup>  Zarontin<sup>®</sup></p>

Description of Recommendation	Final Decision (s)
<p><b><u>Second Generation Anticonvulsants</u></b></p> <ol style="list-style-type: none"> <li>1. DMS to select preferred agent (s) based on economic evaluation; however, at least seven unique chemical entities should be preferred.</li> <li>2. Agents not selected as preferred will be considered non preferred and require prior authorization.</li> <li>3. Require therapeutic failure of one preferred agent prior to approval of a non-preferred agent.</li> <li>4. For any agent not selected as preferred, DMS to allow continuation of therapy if there is a paid claim in the past 90 days.</li> <li>5. For any new chemical entity in the Second Generation Anticonvulsants class, require a PA until reviewed by the P&amp;T Advisory Committee.</li> </ol>	<p>Selected Preferred Agent (s)</p> <p>Banzel™ felbamate Gabitril® gabapentin lamotrigine levetiracetam Lyrica® Sabril® topiramate zonisamide</p> <p>Non Preferred Agent (s)</p> <p>Fanatrex™ Felbatol® Gralise™ Keppra™ Keppra XR™ Lamictal® levetiracetam XR Neurontin® Potiga® Topamax® Vimpat® Zonegran®</p>
<p><b><u>Banzel™ Clinical Criteria</u></b></p> <p>Banzel™ should be approved if:</p> <ul style="list-style-type: none"> <li>• Diagnosis of Lennox-Gastaut syndrome; OR</li> <li>• Trial and failure of one other anticonvulsant.</li> </ul>	<p>Banzel™ will be approved if:</p> <ul style="list-style-type: none"> <li>• Diagnosis of Lennox-Gastaut syndrome; OR</li> <li>• Trial and failure of one other anticonvulsant.</li> </ul>
<p><b><u>Lyrica® Clinical Criteria</u></b></p> <p>Lyrica® should be approved if any ONE of the following is true:</p> <ul style="list-style-type: none"> <li>• Diabetic Peripheral Neuropathy (DPN); OR</li> <li>• Neuropathic pain associated with spinal cord injury; OR</li> <li>• Postherpetic Neuralgia (PHN) AFTER adequate trial and failure of OR intolerance OR contraindication to at least one of these first-line agents <ul style="list-style-type: none"> <li>○ Tricyclic antidepressant (TCAs); or</li> <li>○ Anticonvulsant: gabapentin; or</li> <li>○ Topical: Lidocaine 5% patch.</li> </ul> </li> <li>• Adjunct for partial onset seizure disorder; OR</li> <li>• Fibromyalgia.</li> </ul>	<p>Lyrica® will be approved if any ONE of the following is true:</p> <ul style="list-style-type: none"> <li>• Diabetic Peripheral Neuropathy (DPN); OR</li> <li>• Neuropathic pain associated with spinal cord injury; OR</li> <li>• Postherpetic Neuralgia (PHN) AFTER adequate trial and failure of OR intolerance OR contraindication to at least one of these first-line agents <ul style="list-style-type: none"> <li>○ Tricyclic antidepressant (TCAs); or</li> <li>○ Anticonvulsant: gabapentin; or</li> <li>○ Topical: Lidocaine 5% patch.</li> </ul> </li> <li>• Adjunct for partial onset seizure disorder; OR</li> <li>• Fibromyalgia.</li> </ul>

<b>Description of Recommendation</b>	<b>Final Decision (s)</b>
<p><b><u>Sabril® Clinical Criteria</u></b>            Sabril® should be approved if:</p> <ul style="list-style-type: none"> <li>• Diagnosis of infantile spasms; OR</li> <li>• Trial and failure of one other anticonvulsant.</li> </ul>	<p>Sabril® will be approved if:</p> <ul style="list-style-type: none"> <li>• Diagnosis of infantile spasms; OR</li> <li>• Trial and failure of one other anticonvulsant.</li> </ul>
<p><b><u>Anticonvulsants, Carbamazepine Derivatives</u></b></p> <ol style="list-style-type: none"> <li>1. DMS to select preferred agent (s) based on economic evaluation; however, at least two unique chemical entities should be preferred.</li> <li>2. Agents not selected as preferred will be considered non preferred and require prior authorization.</li> <li>3. Require therapeutic failure of one preferred agent prior to approval of a non-preferred agent.</li> <li>4. For any agent not selected as preferred, DMS to allow continuation of therapy if there is a paid claim in the past 90 days.</li> <li>5. For any new chemical entity in the Anticonvulsants, Carbamazepine Derivatives class, require a PA until reviewed by the P&amp;T Advisory Committee.</li> </ol>	<p>Selected Preferred Agent (s)</p> <p>Carbatrol®            carbamazepine            carbamazepine XR            Equetro™            oxcarbazepine</p> <p>Non Preferred Agent (s)</p> <p>carbamazepine extended release (Generic for Carbatrol®)            Tegretol®            Tegretol® XR            Trileptal®</p>

Description of Recommendation	Final Decision (s)
<p><b><u>Stimulants and Related Agents</u></b></p> <ol style="list-style-type: none"> <li>1. DMS to select preferred agent(s) based on economic evaluation; however, at least one sort-acting, one intermediate-acting and one long-acting formulation of methylphenidate and dextroamphetamine as well as atomoxetine should be preferred.</li> <li>2. Agents not selected as preferred will be considered non preferred and require prior approval.</li> <li>3. Require appropriate ICD-9 on all prescriptions for agents within this class.</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 the American Academy of Child and Adolescent Psychiatry and FDA-approved 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 single-source branded products via a 90 day look back.</li> <li>8. For any new chemical entity in the Stimulants and Related Agents class, require a PA until reviewed by the P&amp;T Advisory Committee.</li> </ol>	<p>Selected Preferred Agent (s)</p> <p>Adderall XR<sup>®</sup>  Concerta<sup>®</sup>  dexmethylphenidate IR  dextroamphetamine ER  dextroamphetamine IR  Focalin XR<sup>™</sup>  Intuniv<sup>™</sup>  Metadate CD<sup>®</sup>  Metadate ER<sup>®</sup>  Methylin<sup>®</sup>  Methylin<sup>®</sup> Chewable  methylphenidate IR  methylphenidate SA  methylphenidate SR  mixed amphetamine salts IR  Strattera<sup>®</sup>  Vyvanse<sup>™</sup></p> <p>Non Preferred Agent (s)</p> <p>Adderall<sup>®</sup>  Daytrana<sup>™</sup>  Desoxyn<sup>®</sup>  Dexedrine<sup>®</sup>  Focalin<sup>™</sup>  Kapvay<sup>™</sup>  methamphetamine  Methylin<sup>®</sup> Solution  methylphenidate (generic for Concerta<sup>®</sup>, Metadate CD<sup>®</sup>, Ritalin LA<sup>®</sup>)  mixed amphetamine salts ER  modafinil  Nuvigil<sup>®</sup>  Procentra<sup>™</sup>  Provigil<sup>®</sup>  Ritalin<sup>®</sup>  Ritalin LA<sup>®</sup>  Ritalin SR<sup>®</sup></p>

Description of Recommendation	Final Decision (s)
<p><b><u>Stimulants and Related Agents Clinical Criteria</u></b></p> <p>Stimulants and Related Agents should be approved for specific diagnoses only.</p> <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> <p>Daytrana™, Methylin® Solution, Methylin® Chewable Tabs, or Procentra™ will be approved if either of the following criteria is 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; <b>OR</b></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; <b>OR</b></li> <li>○ For Methylin® Solution, Methylin® Chewable Tabs, or Procentra™, inability to swallow tablets or capsules whole.</li> </ul> </li> </ul> <p><b><u>Therapeutic Duplication</u></b></p> <p>Prior authorization will be required for more than one long-acting (Adderall XR®, Concerta®, Daytrana™, Dexedrine®, dextroamphetamine ER, Metadate CD®, Metadate ER®, Focalin XR™, Methylin ER®, methylphenidate ER, methylphenidate ER OROS, methylphenidate SR, mixed amphetamine salt ER, Ritalin LA®, Ritalin SR®, Strattera®, Vyvanse™), or more than one short-acting (Adderall®, Desoxyn®, dexmethylphenidate IR, dextroamphetamine IR, DextroStat®, Focalin™, methamphetamine, Methylin®, methylphenidate IR, mixed amphetamine salt IR, Procentra™, Ritalin®) stimulant at a time.</p>	<p>Stimulants and Related Agents will be approved for specific diagnoses only.</p> <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> <p>Daytrana™, Methylin® Solution, Methylin® Chewable Tabs, or Procentra™ will be approved if either of the following criteria is 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; <b>OR</b></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; <b>OR</b></li> <li>○ For Methylin® Solution, Methylin® Chewable Tabs, or Procentra™, inability to swallow tablets or capsules whole.</li> </ul> </li> </ul> <p><b><u>Therapeutic Duplication</u></b></p> <p>Prior authorization will be required for more than one long-acting (Adderall XR®, Concerta®, Daytrana™, Dexedrine®, dextroamphetamine ER, Metadate CD®, Metadate ER®, Focalin XR™, Methylin ER®, methylphenidate ER, methylphenidate ER OROS, methylphenidate SR, mixed amphetamine salt ER, Ritalin LA®, Ritalin SR®, Strattera®, Vyvanse™), or more than one short-acting (Adderall®, Desoxyn®, dexmethylphenidate IR, dextroamphetamine IR, DextroStat®, Focalin™, methamphetamine, Methylin®, methylphenidate IR, mixed amphetamine salt IR, Procentra™, Ritalin®) stimulant at a time.</p>

<b>Description of Recommendation</b>	<b>Final Decision (s)</b>
<p><b><u>Strattera® Clinical Criteria</u></b>  Strattera® (atomoxetine) will be approved if both of the following criteria are met:</p> <ul style="list-style-type: none"> <li>• Specific diagnoses only AND;</li> <li>• Any one of the following criteria: <ul style="list-style-type: none"> <li>○ Trial and failure of one preferred stimulant and related agent in the past 90 days; OR</li> <li>○ History of substance abuse or diversion on the part of the patient or caregiver; OR</li> <li>○ History of stimulant-induced weight loss after trial of two stimulants; OR</li> <li>○ History of tic disorder, including Tourette's; OR</li> <li>○ Co-morbid mood or anxiety disorder.</li> </ul> </li> </ul>	<p>Strattera® (atomoxetine) will be approved if both of the following criteria are met:</p> <ul style="list-style-type: none"> <li>• Specific diagnoses only AND;</li> <li>• Any one of the following criteria: <ul style="list-style-type: none"> <li>○ Trial and failure of one preferred stimulant and related agent in the past 90 days; OR</li> <li>○ History of substance abuse or diversion on the part of the patient or caregiver; OR</li> <li>○ History of stimulant-induced weight loss after trial of two stimulants; OR</li> <li>○ History of tic disorder, including Tourette's; OR</li> <li>○ Co-morbid mood or anxiety disorder.</li> </ul> </li> </ul>
<p><b><u>Provigil®/Nuvigil® Clinical Criteria</u></b>  Provigil® (modafinil) / Nuvigil® (armodafinil) will be approved if both of the following criteria are met:</p> <ul style="list-style-type: none"> <li>• Specific diagnoses (via ICD-9 override) only; AND</li> <li>• For Nuvigil® (armodafinil) ONLY, trial and failure of Provigil® (modafinil)</li> </ul>	<p><b><u>Provigil®/Nuvigil® Clinical Criteria</u></b>  Provigil® (modafinil) / Nuvigil® (armodafinil) will be approved if both of the following criteria are met:</p> <ul style="list-style-type: none"> <li>• Specific diagnoses (via ICD-9 override) only; AND</li> <li>• For Nuvigil® (armodafinil) ONLY, trial and failure of Provigil® (modafinil)</li> </ul>
<p><b><u>SSRIs</u></b></p> <ol style="list-style-type: none"> <li>1. DMS to select preferred agent(s) based upon economic evaluation; however, at least three unique chemical entities should be preferred.</li> <li>2. Agents not selected as preferred will be considered non-preferred and will require Prior Authorization.</li> <li>3. Any new chemical entity in the SSRI class should require a PA until reviewed by the P&amp;T Advisory Committee.</li> </ol>	<p>Selected Preferred Agent (s)</p> <p>citalopram  fluoxetine  fluoxetine ER  fluvoxamine  paroxetine  sertraline</p> <p>Non Preferred Agent (s)</p> <p>Celexa®  escitalopram  Lexapro™  Luvox® CR  paroxetine controlled release  Paxil®  Paxil® CR  Pexeva®  Prozac®  Prozac Weekly™  Sarafem®  Viibryd®  Zoloft®</p>

Description of Recommendation	Final Decision (s)
<p><b><u>SNRIs</u></b></p> <ol style="list-style-type: none"> <li>1. DMS to select preferred agent(s) based upon economic evaluation; however, at least one long acting SNRI should be preferred.</li> <li>2. Agents not selected as preferred will be considered non-preferred and will require Prior Authorization.</li> <li>3. Clinical criteria should be placed on milnacipran to ensure it is being used for its FDA-approved indication only.</li> <li>4. Any new chemical entity in the SNRI class should require a PA until reviewed by the P&amp;T Advisory Committee.</li> </ol>	<p>Selected Preferred Agent (s)</p> <p>Savella™ venlafaxine venlafaxine ER capsules</p> <p>Non Preferred Agent (s)</p> <p>Cymbalta® Effexor® Effexor XR® Pristiq® venlafaxine ER tablets</p>
<p><b><u>Cymbalta® Clinical Criteria</u></b></p> <p>Cymbalta® should be authorized for the following diagnoses:</p> <ul style="list-style-type: none"> <li>• Depression/Major Depressive Disorder/Generalized Anxiety Disorder/Social Anxiety Disorder/Panic Disorder: Approval after trial and failure or intolerance or contraindication to one preferred SNRI.</li> <li>• Diabetic peripheral neuropathic pain</li> <li>• Fibromyalgia</li> <li>• Chronic musculoskeletal pain: Approval after trial and failure of or intolerance or contraindication to one NSAID.</li> </ul>	<p>Cymbalta® will be authorized for the following diagnoses:</p> <ul style="list-style-type: none"> <li>• Depression/Major Depressive Disorder/Generalized Anxiety Disorder/Social Anxiety Disorder/Panic Disorder: Approval after trial and failure or intolerance or contraindication to one preferred SNRI.</li> <li>• Diabetic peripheral neuropathic pain</li> <li>• Fibromyalgia</li> <li>• Chronic musculoskeletal pain: Approval after trial and failure of or intolerance or contraindication to one NSAID.</li> </ul>