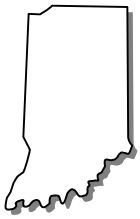
Indiana Health Coverage Programs



P R O V I D E R B U L L E T I N

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To: All Pharmacy Providers and Practitioners Prescribing and Dispensing Medications

Subject: Preferred Drug List—New Additions (Phase 8)

Note: The information in this bulletin does not apply to practitioners and providers rendering services to members enrolled in the risk-based managed care (RBMC) delivery system.

Overview

As stated in the Indiana Health Coverage Programs (IHCP) provider bulletin, *BT200247*, dated September 9, 2002, a Preferred Drug List (PDL) is being implemented for the fee-for-service benefits within the IHCP. The PDL is scheduled for completion in April 2003. A complete list of current preferred drugs is being compiled and will be made available on the Web at www.Indianapbm.com. The Drug Utilization Review (DUR) Board, at the February 21, 2003, Phase 8 meeting, approved PDL recommendations from the Therapeutics Committee for the following drug classes:

- Bile Acid Sequestrants
- Fibric Acids
- Skeletal Muscle Relaxants
- Urinary Tract Antispasmodics
- Brand Name Narcotics*
- Antidiabetic Agents.

**Note: The transition of certain Indiana Rational Drug Program (IRDP) products to the Preferred Drug List.*

Notice of meetings of the DUR Board and agendas are posted on the Family and Social Services Administration (FSSA) Web site at http://www.state.in.us/fssa/ under the heading **Calendar**. Information about the Therapeutics Committee and the PDL can be accessed at http://www.indianapbm.com.

The Therapeutics Committee recommends drugs for the PDL after extensive clinical review. The IHCP anticipates that prescribers and pharmacists will support and encourage the use of the PDL as it is implemented and further developed, as well as recognize and appreciate the clinical and cost effectiveness that it will bring to the IHCP. It is important to note that the cost savings to be realized from the PDL program will enable the OMPP to fund other critically needed services under the IHCP at a time when every possible means of conserving program costs is being explored.

Important Note: *Prior authorizations approved under the current IRDP clinical programs will be grandfathered to bypass PDL edits until those authorizations expire.* **Please note that other existing authorizations such as Early Refill, High Dose, 34-day Supply, and so forth will *not* be grandfathered and ProDUR edits will still apply when appropriate.**

Table 1 – POS Edit Codes

Codes	Description	Contact Name	Contact Number
3017	PDL/Non-PDL Brand Med Necessary associated With PDL / Non-PDL	ACS	1-866-879-0106
3002	IRDP – Indiana Rational Drug Program	HCE	(317) 347-4511 1-800-457-4518
4026	NDC / Days Supply Limits	HCE	(317) 347-4511 1-800-457-4518
0570	Refill Too Soon	HCE	(317) 347-4511 1-800-457-4518
6806	IRDP Therapy Exceeds Limitations	HCE	(317) 347-4511 1-800-457-4518
0573	Drug-Drug Interaction Severity Level 1	HCE	(317) 347-4511 1-800-457-4518
0571	High Dose	HCE	(317) 347-4511 1-800-457-4518
70	Medical Supply Billed POS to ACS	EDS	1-800-577-1278
41	Third Party Liability	EDS	1-800-577-1278

Phase 8 PDL Additions

Important: *In accordance with Indiana law, all antianxiety, antidepressant, antipsychotic, and "cross indicated" drugs are considered as being on the PDL.*

Important: *The brand products on the non-preferred drug list with generic equivalents are considered non-preferred on the PDL. The generic equivalents do not require prior authorization for non-PDL edits, unless noted otherwise.*

The following drugs are effective May 14, 2003:

Table 2 – Bile Acid Sequestrants

Preferred Drug List	Non-Preferred Drug List
cholestyramine (multi-dose powder containers), **Locholest**® powder and **Prevalite**® powder	**Questran**® all formulations, cholestyramine packets, **Prevalite**® packets
Colestid® (flavored granules multidose container)	**Colestid**® tablets, granule packets
	Welcol®

Table 3 – Fibric Acids

Preferred Drug List	Non-Preferred Drug List
gemfibrozil (all formulations)	**Lopid®**
TriCor® 160mg, 200mg tablets Patients currently taking other doses of TriCor® are grandfathered.	**TriCor®** 54mg and **TriCor®** 67mg
Lofibra® 200mg tablets	

Table 4 – Skeletal Muscle Relaxants

Preferred Drug List	Non-Preferred Drug List
methocarbamol	**Robaxin®**
cyclobenzaprine HCL	**Flexeril®**
baclofen	**Lioresal®**
chlorzoxazone	**Paraflex®, Parafon Forte®**
orphenadrine citrate	**Norflex®, Norgesic Forte®**
tizanidine HCL	**Zanaflex®**
dantrolene sodium	**Dantrium®**
	Skelaxin®
	Soma® (all formulations including combination products)
	carisoprodol (all formulations including combination products)

Table 5 – Urinary Tract Antispasmodic

Preferred Drug List	Non-Preferred Drug List
oxybutynin (Step edit for the long acting formulations. Patients must have been unresponsive to the immediate release formulation to be eligible for a long acting medication.)	**Ditropan®**
	Ditropan® XL Patients currently taking this medication are grandfathered.
	Detrol®
	Detrol® LA Patients currently taking this medication are grandfathered.
	Urispas®

Table 6 – Brand Name Narcotics

Preferred Drug List ***All acetaminophen containing products are limited to 3 grams of acetaminophen/day**	**Non-Preferred Drug List**
All generic narcotic products are considered PDL	
acetaminophen*/codeine #2, #3, #4	**Tylenol® #2, #3, #4**
aspirin with codeine	**Empirin®**
oxycodone* (all combinations)	**Percocet®**, **Percodan®**
hydromorphone	**Dilaudid®**
pentazocine lactate (all formulations)	**Talwin®** (all formulations)
tramadol HCL The limit for any tramadol formulation is 400 milligrams/day	**Ultram®**
hydrocodone* (all formulations) The limit for any hydrocodone formulation is 1500mg/30 days	**Lorcet® Maxidone® Norco® Zydone® Vicoprofen® Lortab®, Vicodin®**
propoxyphene* (all formulations)	**Darvon® Darvocet N® Darvon® Compound Wygesic®**
Duragesic® Limit: 10 patches/30 day period	**Kadian®**
OxyContin® Limit: 120 tabs/25 days except 80mg tab 60 tabs/25 days.	**Actiq®**
butorphanol nasal spray Limit: 1 vial/25 days (2 vials/25 days with prior authorization).	**Stadol® NS**

Table 7 – Antidiabetic Agents

Preferred Drug List	**Non-Preferred Drug List** **All first generation sulfonylureas are non-preferred**
Glyset®	tolazamide, **Tolinase®**
Precose®	tolbutamide, **Orinase®**
Prandin®	chlorpropamide, **Diabinese®**
Starlix®	acetohexamide, **Dymelor®**
glyburide	**Micronase®**, **Diabeta®**
metformin	**Glucophage®**, **Glucophage® XR**
glipizide, **Glucotrol® XL**	**Glucotrol®**
Amaryl®	
Glucovance® Requires previous use of one of the agents in the combination. Patients currently taking these medications are grandfathered and will be reviewed in six months.	

Table 7 – Antidiabetic Agents

Preferred Drug List	Non-Preferred Drug List All first generation sulfonylureas are non-preferred
Metagip® Requires previous use of one of the agents in the combination. Patients currently taking these medications are grandfathered and will be reviewed in six months.	
Avandamet® Requires previous use of one of the agents in the combination. Patients currently taking these medications are grandfathered and will be reviewed in six months.	

Prior authorization is required for all non-preferred drugs and/or requests for quantities of drugs that exceed the State limit.

Additional Information

Please direct all questions about the PDL and prior authorization needed for non-PDL drugs to the ACS-State Health Care Clinical Call Center at 1-866-879-0106. Please direct any questions about IRDP or ProDUR prior authorizations to the Health Care Excel (HCE) Prior Authorization Department at (317) 347-4511 in the Indianapolis local area or 1-800-457-4518. Please direct questions about this bulletin to Customer Assistance at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278.