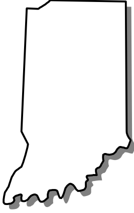
Indiana Health Coverage Programs



PROVIDER BULLETIN

BT200333 JUNE 2, 2003

To: All Pharmacy Providers and Practitioners Prescribing and Dispensing Medications

Subject: Preferred Drug List—New Additions (Phase 9)

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 was implemented 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 March 28, 2003, meeting, approved PDL recommendations from the Therapeutics Committee for the following drug classes:

- Ophthalmic Mast Cell Stabilizer, Eye Antihistamines
- Miotics/Other Intraocular Pressure Reducers
- Ophthalmic Antibiotics
- Otic Antibiotics
- Vitamin A Derivatives
- Antisporiatics
- Leukocyte (WBC) Stimulants
- Hematinics
- Ultracet
- Forteo
- Smoking Deterrent Agents

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 Indiana Rational Drug Program (IRDP) clinical programs will be grandfathered to bypass PDL edits until those authorizations expire. 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 9 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 July 21, 2003:

Table 2 – Ophthalmic Mast Cell Stabilizers

Preferred Drug List	Non-Preferred Drug List
Alamast®	Alocril®
Livostin®	Alomide®
cromolyn	Crolom®
Step edit for the following: Patanol®, Optivar®, Zaditor®. Patients must have been unresponsive to one of the PDL medications listed above; used during the last 12 months. (no grandfathering)	Emadine®
	Opticrom®

Table 3 – Miotics/Other Intraocular Pressure Reducers

Preferred Drug List		Non-Preferred Drug List	
betaxol	**Xalatan®**	Betoptic-S®	Humorsol®
levobunolol	**Travatan®**	Betagan®	Isopto-Eserine®
timolol	**Lumigan®**	Timoptic®	Phospholine Iodide
carteolol	**Iopidine®**	Timoptic® XE	Pilocar®
metipranolol	**Trusopt®**	Betimol®	Isopto-Carpine®
epinephrine	**Azopt®**	Ocupress®	Pilopine-HS®
physostigmine	Isopto-Carbachol®	Opti-Pranolol®	E-Pilo-X®
pilocarpine	Cosopt®	Rescula®	

Table 4 – Otic Antibiotics

Preferred Drug List	Non-Preferred Drug List
All generic products	Chloromycetin®
chloramphenicol	Coly-Mycin® S
neomycin, polymyxin B & hydrocortisone	Cortisoprin®
polymyxin B & hydrocortisone	Octicair®
Floxin®	Otobiotic®
	Otosporin®
	Pediotic®

Table 5 – Ophthalmic Antibiotics

Preferred Drug List		Non-Preferred Drug List	
All generic products	neomycin, polymyxin B & dexamethasone	Any brand name available generically	Neo-Decadron®
bacitracin	**polymyxin B & bacitracin**	AK-Tracin®	Neosporin®
chloramphenicol	**polymyxin B & trimethoprim**	Chloroptic®	Poly-Pred®
erythromycin	**terramycin & polymyxin B**	Ciloxin®	Polysporin®
gentamicin	**tobramycin**	Cortisporin®	Polytrim®
gentamicin & prednisolone	**Ocuflox®**	Ilotycin®	Pred-G®
natamycin		Garamycin®	Tobrex®
neomycin, polymyxin B & bacitracin		Maxitrol®	Tobradex®
neomycin, polymyxin B & gramicidin		Natacyn®	Quixin®
neomycin, polymyxin B & prednisolone		Neo-Dexameth®	

Table 6 – Vitamin A Derivatives

Preferred Drug List **Note: The medications in this class will be approved for patients** < or = **25 years of age**	**Non-Preferred Drug List**
All generic tretinoin products	Retin-A® (brand name products)
Accutane® (brand and generic)	Avita®
Differin® **Step edit (requires step edit of one year previous use of tretinoin product)**	

Table 7 – Antipsoriatics

Preferred Drug List	**Non-Preferred Drug List**
Dovonex®	Not Applicable
Drithocreme® HP	
Oxsoralen-Ultra®	
Psoriatic®	
Soriatane®	
Tazorac®	

Table 8 – Leukocyte (WBC) Stimulants

Preferred Drug List	**Non-Preferred Drug List**
Neupogen® (vials only)	Neupogen® (prefilled syringes)
Leukine® (vials only)	Neulasta® (vials and syringes)

Table 9 – Hematinics

Preferred Drug List	**Non-Preferred Drug List**
Aranesp®	**Not Applicable**
Epogen®	
Procrit®	

Table 10 – Ultracet®

Preferred Drug List **Limited to 400mg tramadol per day or 3 grams acetaminophen per day**	**Non-Preferred Drug List**
tramadol /acetominophen	**Ultracet®**

Table 11 – Forteo®

Preferred Drug List	Non-Preferred Drug List
Not Applicable	**Forteo® (Forteo PA Criteria)**

Table 12 – Smoking Deterrent Agents

Preferred Drug List Limited to 12 weeks of therapy every 365 days per statute	Non-Preferred Drug List
nicotine patch	**Nicoderm®**
Nicotrol® NS	**Habitrol®**
Nicotrol® Inhaler	**Nicotrol®**
nicotine gum	**Nicorette®**
Commit® lozenge	**Nicorette® DS**

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

Additional Information

Direct 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. Direct questions about the 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. Direct questions about this bulletin to the Customer Assistance Unit at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278.

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