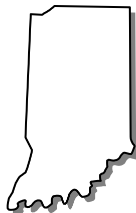

PROVIDER BULLETIN

BT200627 DECEMBER 4, 2006

To: All Pharmacy Providers and Prescribing Practitioners

Subject: Changes to the Preferred Drug List

Note: The information referenced below is not directed to those providers rendering services in the risk-based managed care (RBMC) delivery system.

Overview

This bulletin announces the Preferred Drug List (PDL) decisions made at the November 17, 2006, Drug Utilization Review (DUR) Board meeting. These decisions were based on the recommendations from the Therapeutics Committee meeting held on November 3, 2006. Refer to Table 1 for a summary of these changes. **These changes are effective January 1, 2007.**

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

Direct prior authorization requests and questions about the PDL to the ACS Clinical Call Center at 1-866-879-0106. Questions about this bulletin should be directed to EDS Customer Assistance at (317) 655-3240 in the Indianapolis local area, or toll free at 1-800-577-1278.

Table 1 – Approved Changes to the PDL Effective January 1, 2007

Drug Class	Drug	PDL Status
Antiemetics	Zofran solution for injection	Preferred
Antiemetics	Anzemet solution for injection	Non-preferred
Brand Name Narcotics	Oxycontin	Preferred (limit products 40mg or less to 120 tablets per 25 days, and limit products greater than 40mg to 60 tablets per 25 days)
Brand Name Narcotics	oxycodone ER (generic)	Non-preferred (limit products 40mg or less to 120 tablets per 25 days, and limit products greater than 40mg to 60 tablets per 25 days)
Brand Name Narcotics	Avinza	Non-Preferred
Brand Name Narcotics	Lynox	Non-Preferred
Brand Name Narcotics	Opana	Non-Preferred
Brand Name Narcotics	Opana ER	Non-Preferred
Brand Name Narcotics	Alcet	Non-preferred

(Continued)

Table 1 – Approved Changes to the PDL Effective January 1, 2007

Drug Class	Drug	PDL Status
Smoking Deterrent Agents	Chantix	Preferred (limit of 12 weeks of treatment per 365 days)
Antipsoriatic	Taclonex	Non-Preferred (step edit – must fail calcipotriene; limit of 4 weeks of therapy)
Antidiabetic Agents	Glumetza	Non-preferred
Antidiabetic Agents	Fortamet	Non-preferred
Antidiabetic Agents	glyburide/metformin (generic)	Preferred (step edit – must fail metformin or a sulfonylurea)
Antidiabetic Agents	glipizide/metformin (generic)	Preferred (step edit – must fail metformin or a sulfonylurea)
Antidiabetic Agents	Avandaryl	Preferred (step edit – must fail rosiglitazone or a sulfonylurea)
Antidiabetic Agents	Duetact	Non-preferred (step edit – must fail pioglitazone or a sulfonylurea)
Antidiabetic Agents	Avandamet	Preferred (step edit removed)
Antidiabetic Agents	Actoplus Met	Preferred (step edit removed)
Bone Resorption Suppression Agents	Actonel (5mg, 30mg and 35mg)	Preferred (step edit removed)
Bone Resorption Suppression Agents	Boniva	Non-preferred (step edit – patient must have been on Fosamax or Actonel in the previous 180 days)
Injectable Hypoglycemic	All Humulin vials (R, L, N, U, 50/50, 70/30)	Preferred (prefilled pen, innolets, syringes and cartridges are Non-preferred)
Injectable Hypoglycemic	All Humalog vials (plain, Mix 50/50, Mix 75/25)	Preferred (prefilled pen, innolets, syringes and cartridges are Non-preferred)
Injectable Hypoglycemic	All Novolin vials (R, L, N, 70/30)	Preferred (prefilled pen, innolets, syringes and cartridges are Non-preferred)
Injectable Hypoglycemic	All Novolog vials (plain, Mix 70/30)	Preferred (prefilled pen, innolets, syringes and cartridges are Non-preferred)
Injectable Hypoglycemic	All Relion vials (R, N, 70/30)	Preferred (prefilled pen, innolets, syringes and cartridges are Non-preferred)
Injectable Hypoglycemic	Lantus vials	Preferred (prefilled pen, innolets, syringes and cartridges are Non-preferred)
Injectable Hypoglycemic	Apidra	Non-preferred
Injectable Hypoglycemic	Levemir	Non-preferred
Injectable Hypoglycemic (incretin mimetic)	Byetta	Preferred (step edit – must currently be on metformin and/or sulfonylurea or combo including such)
Injectable Hypoglycemic (amylin analog)	Symlin	Preferred (step edit – must currently be on a mealtime insulin)
Note: Mealtime insulins include Apidra, Humalog, Novolog, Humulin R, Novolin R, Relion R and Exubera)		
Proton Pump Inhibitors	Zegerid	Non-preferred (step edit – patient must first try an H2 antagonist or OTC Prilosec, and then a preferred PPI)

(Continued)

Table 1 – Approved Changes to the PDL Effective January 1, 2007

Drug Class	Drug	PDL Status
Proton Pump Inhibitors	omeprazole (generic)	Non-preferred (step edit – patient must first try an H2 antagonist or OTC Prilosec, and then a preferred PPI)
Proton Pump Inhibitors	Nexium IV	Non-preferred (only Nexium Capsules are considered Preferred)
H2 Receptor Antagonists	Ranitidine capsules (generic)	Non-preferred
BPH Agents	Proscar	Non-preferred
BPH Agents	Cardura XL	Non-preferred
BPH Agents	finasteride 5mg (generic)	Preferred
Platelet Aggregation Inhibitors	clopidogrel (generic)	Non-preferred
Eye Antihistamines/Mast Cell Stabilizers	ketotifen (generic)	Non-preferred
Eye Antihistamines/Mast Cell Stabilizers	Elestat	Non-preferred
Eye Antihistamines/Mast Cell Stabilizers	Optivar	Preferred
Glaucoma Agents	Pilocar	Remove from PDL document
Wound Care Products	Allanderm T	Non-Preferred (limit of one manufacturer's standard package per month; maximum prior authorization approval length of 3 months)
Wound Care Products	Allanfil	Non-Preferred (limit of one manufacturer's standard package per month; maximum prior authorization approval length of 3 months)
Wound Care Products	Allanzyme	Non-Preferred (limit of one manufacturer's standard package per month; maximum prior authorization approval length of 3 months)
Wound Care Products	Optase	Non-Preferred (limit of one manufacturer's standard package per month; maximum prior authorization approval length of 3 months)

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