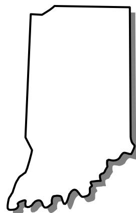

PROVIDER BULLETIN

BT200835 AUGUST 26, 2008

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

Changes to the Preferred Drug List (PDL) were made at the August 22, 2008, Drug Utilization Review (DUR) Board meeting. These decisions are based on the recommendations from the Therapeutics Committee meeting held August 1, 2008. Please refer to Table 1 for a summary of these changes. **The changes are effective October 1, 2008**.

The PDL can be accessed at 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 link at the bottom of the page titled **Calendar**. Information about the Therapeutics Committee and the PDL is available at http://www.indianapbm.com.

Please direct prior authorization requests and questions about the PDL to the Affiliated Computer Services (ACS) Clinical Call Center at 1-866-879-0106. Please direct questions about this bulletin 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 October 1, 2008

Drug Class	Drug	PDL Status
Beta Agonists	Foradil®	Preferred
Leukotriene Inhibitors	Singulair®	Preferred (step edit – adults ≥ 12 years of age must have had one of the following medications within the past six months: methylxanthine, beta agonist, and/or oral inhaled corticosteroid)
Nasal Preparations	Patanase®	Preferred
Nasal Preparations	Omnaris™	Non-preferred
Non–sedating Antihistamines	Allegra® suspension	Non-preferred (quantity limit – 10 mls/day)

Table 1 – Approved Changes to the PDL Effective October 1, 2008

Drug Class	Drug	PDL Status
Non–sedating Antihistamines	All non-preferred agents	Step edit – must first try cetirizine and loratadine within 90 days prior to receiving a non-preferred agent"; quantity limit – 10 mls/day" for all oral liquids
Oral Inhaled Corticosteroids	Pulmicort Flexhaler™	Non-preferred
Oral Inhaled Corticosteroids	Pulmicort Respules®	Preferred (five years of age and younger) Non-preferred (six years of age and older) Quantity limits: 240 mls/month (0.25 mg/2 ml vial); 120 mls/month (0.5 mg/2 ml vial); 60 mls/month (1 mg/2 ml vial)"
Agents to treat COPD	Combivent®	Preferred (quantity limit – "2 inhalers/month")
Cephalosporin (3rd generations)	Omnicef®	Preferred
Cephalosporin (3rd generations)	cefdinir	Non-preferred
Systemic Anti-fungals	Lamisil 125- and 187.5-mg oral granules	Non-preferred
Ophthalmic Antibiotics	Zymar®	Preferred (age limit – 30 years of age or older; step edit – patients under 30 years of age must first have a trial on at least one preferred agent within the past 30 days")
Ophthalmic Antibiotics	Vigamox®	Preferred (age limit – 30 years of age or older; step edit – patients under 30 years of age must first have a trial on at least one preferred agent within the past 30 days)
Otic Antibiotics	ofloxacin otic solution	Non-preferred
ACE/Calcium Channel Blockers	Amlodipine/benazepril	Non-preferred (quantity limit – 30 caps/month; all patients who have received amlodipine/benazepril within the past 90 days will be grandfathered)
ACE/Calcium Channel Blockers	Tarka®	Non-preferred (all patients who have received Tarka® within the past 90 days will be grandfathered)
Angiotensin II Receptor Blockers (ARBs) with Calcium Channel Blockers	Exforge®	Preferred
Alpha Beta Blockers, Beta Blockers	Bystolic™	Non-preferred

Table 1 – Approved Changes to the PDL Effective October 1, 2008

Drug Class	Drug	PDL Status
Alpha Beta Blockers, Beta Blockers	Toprol XL®	Non-preferred
Alpha Beta Blockers, Beta Blockers	Coreg® IR	Non-preferred (quantity limit – 2 tabs/day; step edit – must have prior trial on carvedilol; must be on an ACE or ARB)
Alpha Beta Blockers, Beta Blockers	Coreg CR™	Non-preferred (quantity limit – 1 cap/day; step edit – must have prior trial on carvedilol; must be on an ACE or ARB)
Direct Renin Inhibitors	Tekurna®	Preferred (step edit – trial of an ACE or ARB within the past 90 days)
Direct Renin Inhibitors	Tekurna HCT®	Preferred (step edit – trial of an ACE or ARB within the past 90 days)
Lipotropics – Other	Simcor®	Preferred
HMG CoA reductase inhibitor	Crestor®	Non-preferred (all patients who have received Crestor® within the past 90 days will be grandfathered)
Triptans	Treximet™	Preferred (quantity limit – 1 box - 9 tabs/month)
Multiple Sclerosis Agents	Copaxone®	Preferred (quantity limit –1 kit/month)
Multiple Sclerosis Agents	Avonex®	Preferred (quantity limit – 4 vials or syringes/month)
OTC Formulary	Vitamin E 400 IU (liquid and capsules)	Covered (quantity limit capsules - 30 caps/month; liquid – max 400IU/day with 30 day limit)
OTC Formulary	Vitamin E 100 IU and 200 IU capsules	Covered (quantity limit – 30 caps/month for both strengths)

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