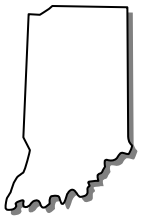

PROVIDER BULLETIN

BT200944 DECEMBER 1, 2009

To: All Pharmacy Providers and Prescribing Practitioners

Subject: Changes to the Preferred Drug List

Overview

Changes to the Preferred Drug List (PDL) were made at the November 20, 2009, Drug Utilization Review (DUR) Board meeting. These decisions are based on the recommendations from the Therapeutics Committee meeting held on November 6, 2009. Please refer to Table 1 for a summary of these changes. **The changes are effective January 1, 2010**.

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 tab 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 HP 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, 2010

Drug Class	Drug	PDL Status
Anti-Emetics	dronabinol	Non-Preferred with Smart PA™ criteria
Anti-Emetics	Marinol®	Non-Preferred with Smart PA criteria
Brand-Name Narcotics	Embeda™	Non-Preferred
Brand-Name Narcotics	Nucynta™	Non-Preferred with a quantity limit of six tablets/day
Brand-Name Narcotics	Ryzolt™	Non-Preferred with a quantity limit of one tablet/day
Brand-Name Narcotics	fentanyl (all strengths)	Preferred and maintain current quantity limit
Brand-Name Narcotics	Duragesic®	Non-Preferred and maintain current quantity limit
Brand-Name Narcotics	Ultracet®	Maintain as Non-Preferred but change quantity limit from 400mg/day to eight tablets/day

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Drug Class	Drug	PDL Status
Brand-Name Narcotics	Oxycontin®	Non-Preferred while maintaining current quantity limits; grandfather patients currently using Oxycontin® within the past 45 days for one year with an educational intervention with the prescriber before the end of the grandfathering period
Brand-Name Narcotics	All preferred long-acting branded agents	Add step-edit – patients must be tried on one generic long-acting narcotic (for example, fentanyl patches, morphine sulfate ER, or methadone) within the past six months; grandfather patients currently using Kadian® or Oramorph SR® within the last 45 days
Brand-Name Narcotics	All non-preferred agents	Add the following step-edit – patients must be tried on two preferred short-acting agents within the past six months if requesting a short-acting drug; patients must be tried on two preferred long-acting agents within the past six months if requesting a long-acting drug (examples of long-acting preferred agents include fentanyl patches, morphine sulfate ER, methadone, Kadian®, and Oramorph®; all other preferred agents are considered short-acting)
Brand-Name Narcotics	All agents	Add Smart PA rule pertaining to opiate overutilization
NSAID/PPI Combination	Prevacid Naprapac®	Remove from the PDL document
Antipsoriatic Agents	Enbrel ®	Preferred
Antipsoriatic Agents	Humira®	Preferred
Antipsoriatic Agents	Remicade®	Non-Preferred
Antipsoriatic Agents	Amevive®	Non-Preferred
Antidiabetic Agents	Onglyza®	Preferred
Antidiabetic Agents	Nateglinide	Non-Preferred
Bone Resorption Suppression Agents	calcitonin-salmon	Non-Preferred
Bone Resorption Suppression Agents	Actonel®	Non-Preferred and add step-edit – must have a trial of alendronate within the past 90 days; grandfather patients currently taking Actonel® for life

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Drug Class	Drug	PDL Status
Growth Hormones	Humatrope®	Non-Preferred with the following step-edit – patients with the diagnosis of Short Stature Homeobox-containing gene (SHOX) deficiency who meet other appropriate criteria for growth hormone therapy may receive Humatrope®
Growth Hormones	Norditropin® 30 mg/3mL pens	Preferred
Growth Hormones	Revision to Growth Hormone PA requirements for pediatric patients	Approvals will be granted for preferred medications only, with the exception of patients with the diagnosis of SHOX deficiency
Injectable Hypoglycemics	Novolog® cartridges, innolets, pens, and syringes	Preferred
Injectable Hypoglycemics	Novolin® cartridges, innolets, pens, and syringes	Preferred
Injectable Hypoglycemics	Apidra® Solostar	Non-Preferred
H2 Receptor Antagonists	ranitidine syrup	Preferred
H2 Receptor Antagonists	Zantac® syrup	Non-Preferred
Pancreatic Enzymes	Creon®, Pancrease MT®, Pancrecarb-MS®, Pancrelipase®, Ultrase®, Ultrase MT®, and Viokase®	Preferred
Proton Pump Inhibitors	omeprazole 40 mg	Preferred while adding a quantity limit of two capsules per day; remove the step-edit – two 20 mg capsules required
Proton Pump Inhibitors	Protonix® tablets and vials	Maintain as preferred and maintain the tablet quantity limit but change step-edit – must fail omeprazole within the past 90 days or be on concurrent clopidogrel therapy
Proton Pump Inhibitors	Kapidex™	Preferred with the following step-edit – must fail omeprazole within the past 90 days or be on clopidogrel therapy; add quantity limit – one capsule/day
Proton Pump Inhibitors	All non-preferred agents	Change step-edit – must fail omeprazole and then a preferred PPI for a total length of therapy of four weeks, unless patient is intolerant to these agents
Proton Pump Inhibitors	Zegerid®	Remove from PDL document
Ulcerative Colitis Agents	Asacol HD™	Preferred
Urinary Tract Antispasmodics	Gelnique™	Non-Preferred

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Drug Class	Drug	PDL Status
Urinary Tract Antispasmodics	oxybutynin ER	Non-preferred
Urinary Tract Antispasmodics	All Non-Preferred Agents	Change step-edit – from must fail oxybutynin IR to must fail oxybutynin IR and another preferred UTA for a total length of therapy of four weeks, unless patient is intolerant to these agents
Eye Antihistamine, Mast Cell Stabilizers	Bepreve™	Non-Preferred
Glaucoma Agents	apraclonidine	Non-Preferred
Topical Antiparasitics	Acticin® cream, Elimite® cream, permethrin 1percent lotion, permethrin 5 percent cream, pyrethrin products, and Ovide®	Preferred
Topical Antiparasitics	Eurax® cream, Eurax® lotion, lindane lotion, lindane shampoo, malathion, and Ulesfia™	Non-Preferred
Topical Post-Herpetic Neuralgia Agent	Lidoderm®	Non-Preferred with Smart PA criteria
Oral Contraceptives (Progestin Only)	Ortho-Micronor® and Nor-QD®	Preferred
Oral Contraceptives (Progestin Only)	Errin®, Camila®, Jolivette®, and Nora-Be®	Non-Preferred
Oral Contraceptives (Lo-Dose Monophasic)	Kelnor® 1-35, Zovia® 1-35, Aviane®, Lessina®, Lutera®, Sronyx®, Loestrin® 1.5-30, Loestrin® 1-20, Loestrin® FE 1.5-30, Junel® FE 1.5-30, Microgestin® FE 1.5-30, Loestrin® FE 1-20, Junel® FE 1-20, Microgestin® FE 1-20, Cryselle®, Low-Ogestre®l, Necon® 0.5-35, Nortrel® 0.5-35, Levora®, Portia®, Apri®, Reclipsen®, Solia®, Ortho-Cyclen®, Norinyl® 1+35, Necon® 1-35, Nortrel® 1-35, Necon® 1-50, Norinyl® 1+50, Balziva®, Zenchent®, and Yasmin®	Preferred

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Drug Class	Drug	PDL Status
Oral Contraceptives (Lo-Dose Monophasic)	Femcon® FE, Junel® 1.5-30, Microgestin® 1.5-30, Junel® 1-20, Microgestin® 1-20, Lo-ovral®, Modicon®, Brevicon®, Nordette®, Ortho-cept®, Desogen®, Mononessa®, Previfem®, Sprintec®, Ortho-Novum® 1-35, Ovcon®-35, and Ocella®	Non-Preferred
Oral Contraceptives (High-Dose Monophasic)	Zovia® 1-50, Ovcon®-50, and Ogestrel®	Preferred
Oral Contraceptives (Biphasic)	Mircette® and Necon®10-11	Preferred
Oral Contraceptives (Biphasic)	Azurette® and Kariva®	Non-Preferred
Oral Contraceptives (Triphasic)	Cyclessa®, Estrostep® FE, Ortho-Novum® 7-7-7, Ortho Tri-Cyclen®, Ortho Tri-Cyclen® Lo, Tri-Norinyl®, Leena®, Aranelle®, Enpresse®, and Trivora®	Preferred
Oral Contraceptives (Triphasic)	Cesia®, Caziant®, Velivet®, Tilia FE®, Tri-legest FE®, Necon® 7-7-7, Nortrel® 7-7-7, Trinessa®, Tri-Previfem®, Tri-Sprintec®, and Tri-Lo-Sprintec®	Non-Preferred
Oral Contraceptives (Emergency)	Plan B®	Preferred
Oral Contraceptives (Emergency)	Next Choice® (RX) and Plan B® One Step	Non-Preferred
Oral Contraceptives (Extended Cycle)	Loestrin® 24 FE, Loseasonique®, Seasonale®, Seasonique®, and Yaz®	Preferred
Oral Contraceptives (Extended Cycle)	Jolessa® and Quasense® 0.15-0.03 mg	Non-Preferred
Oral Contraceptives (Continuous Cycle)	Lybrel®	Preferred
Prenatal Vitamins	All legend generic	Preferred
Prenatal Vitamins	All legend brand-name	Non-Preferred
IgE Targeted Monoclonal Antibody	Xolair®	Non-Preferred with Smart PA criteria

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Drug Class	Drug	PDL Status
OTC Formulary Recommendations	Cough and cold products	Maintain all products as covered but add an age limit – four years of age and older
OTC Formulary Recommendations	Topical antiparasitics	Add pyrethrin products to the OTC formulary; maintain permethrin 1 percent lotion as covered

If you need additional copies of this bulletin, please download them from the IHCP Web site at http://www.indianamedicaid.com/ihcp/Publications/bulletin_results.asp. To receive e-mail notifications of future IHCP publications, subscribe to the IHCP E-mail Notifications at http://www.indianamedicaid.com/ihcp/mailing_list/default.asp.