

IHCP *bulletin*

INDIANA HEALTH COVERAGE PROGRAMS BT201104 MARCH 1, 2011



Changes to the Preferred Drug List

Changes to the Preferred Drug List (PDL) were made at the February 18, 2011, Drug Utilization Review (DUR) Board meeting. These decisions are based on the recommendations from the Therapeutics Committee meeting held February 4, 2011. Please refer to the table on the next page for a summary of these changes. The changes are effective April 1, 2011.

The PDL can be accessed online at the [Indiana Pharmacy Benefit Manager](http://www.indianapbm.com) Web site (<http://www.indianapbm.com>) under Pharmacy Services. Notice of the DUR Board meetings and agendas are posted on the [Family and Social Services Administration \(FSSA\) Web site](http://www.state.in.us/fssa) (<http://www.state.in.us/fssa>). Click “More Events” near the middle of the page to access the events calendar. Information about the Therapeutics Committee is available online at the [Indiana Pharmacy Benefit Manager](http://www.indianapbm.com) Web site (<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.

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Approved changes to the PDL effective April 1, 2011

| Drug class | Drug | PDL status |
|--|----------------------------------|--|
| Antiviral Monoclonal Antibodies | Synagis | Non-preferred with PA. Statement on the bottom of the PA form will read as follows: Usual dosage is five (5) monthly injections during RSV season of November 1 through March 31 Implementation date of May 1, 2011 |
| Leukotriene Receptor Antagonists | zafirlukast | Non-preferred with same step edit as Accolate |
| Beta Adrenergics and Corticosteroids | Dulera | Non-preferred |
| Oral Inhaled Glucocorticoids | budesonide suspension | Preferred for children 3 years old and younger Non-preferred for children 4 years old and older Quantity limit of 120 mls/mo for the 0.25 mg/2 ml vial |
| Oral Inhaled Glucocorticoids | Pulmicort Respules | Non-preferred with age limit of 4 years old and older Quantity limit of 120 mls/mo for the 0.25 mg/2 ml vial |
| Pulmonary Antihypertensives – PDE 5 Inhibitors | Adcirca | Preferred with SmartPA™ criteria |
| Pulmonary Antihypertensives – PDE 5 Inhibitors | Revatio | Preferred with SmartPA criteria |
| Cephalosporins – 3 rd Generation | Cedax suspension | Non-preferred for 180 mg/5 ml concentration (new strength) |
| Oral Non-systemic Antifungals | clotrimazole troches | Preferred |
| Oral Non-systemic Antifungals | nystatin suspension and tablets | Preferred |
| Oral Non-systemic Antifungals | Oravig | Non-preferred |
| Angiotensin Receptor Blockers | losartan | Preferred with current quantity limit and step edit |
| Angiotensin Receptor Blockers | Cozaar | Non-preferred with current quantity limit and step edit |
| ARBs with CCBs and Diuretics | Tribenzor | Non-preferred with step edit “trial of an ARB, CCB or diuretic within the past 90 days” |
| ARBs with Diuretics | losartan/ hydrochlorothiazide | Preferred with current step edit |
| ARBs with Diuretics | Hyzaar | Non-preferred with current step edit |
| Bile Acid Sequestrants | Welchol tablets and suspension | Non-preferred with SmartPA criteria |
| Lipotropics | Simcor | Preferred for 500 mg/40 mg and 1,000 mg/40 mg formulations (new strengths) |
| Antimigraine Preparations | Alsuma | Not covered |
| Antimigraine Preparations | naratriptan | Preferred with quantity limit of 9 tabs/mo |

| Drug class | Drug | PDL status |
|------------|---------|---|
| MS Agents | Ampyra | Preferred with quantity limit of 2 tabs/day and the following PA criteria: For initial authorization – patient must have a diagnosis of MS and a prescription written by a neurologist; approval for 3 months 2 nd authorization – Neurologist documentation of improvement in gait; approval for 1 year Subsequent authorizations – Neurologist documentation of impression of continued clinical benefit in gait; approval for 1 year |
| MS Agents | Gilenya | Non-preferred with quantity limit of 1 cap/day |
| MS Agents | | Step edit for all non-preferred agents: “trial of at least 1 preferred agent written by, or in consultation with, a neurologist within the past 12 months” |

Questions?

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