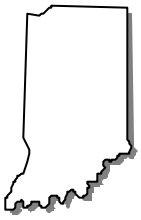
Indiana Health Coverage Programs



P R O V I D E R B U L L E T I N

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To: All Pharmacy Providers and Practitioners Prescribing and Dispensing Medications

Subject: Preferred Drug List—New Additions (Phase 6)

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

Overview

As stated in a previous bulletin (*BT200235*, dated June 28, 2002), an Indiana Health Coverage Programs (IHCP) Preferred Drug List (PDL) is being implemented. The PDL is scheduled to be completed in April 2003. A complete list of current preferred drugs is available on the Web at www.Indianapbm.com. At its November 15, 2002, (Phase 6) meeting, the Drug Utilization Review (DUR) Board accepted the recommendations of the Therapeutics Committee regarding macrolides, fluoroquinolones, cephalosporins, antifungals, and angiotensin receptor blockers (ARBs). The recommendations from the meeting are set out in this bulletin and constitute the sixth group of drugs to be subject to the PDL.

The Therapeutics Committee was very concerned about the current problem of bacterial resistance to antibiotics and that limiting drug choice would worsen this problem. Consequently, all macrolides and fluoroquinolones were included on the PDL. The committee elected to include all generically available first- and second-generation cephalosporin products on the PDL as well as two third-generation agents for the treatment of resistant organisms and to expand the spectrum of bacterial coverage. In the antifungal class, fluconazole was selected for the PDL because it possesses desirable pharmacologic properties. It is important to note that only systemic antifungal agents were included in this review. Other antifungal agents that have indications for topical infections will be reviewed at a later time. The Therapeutics Committee felt that the clinical merits and prevention of further bacterial resistance outweighed the cost of these drug classes.

Important Information

1. **Effective March 2003, refills will not be permitted for any antibiotic prescription without the appropriate ICD-9 code written on the prescription.**
   - Appropriate ICD-9 codes include diagnoses such as but not limited to: chronic otitis media, chronic UTI, prostatitis, chronic bronchitis, chronic sinusitis, cystic fibrosis, and so forth.
   - Prescriptions coded with the appropriate ICD-9 code will not require prior authorization.
2. **Beginning January 2003, all antibiotic products packaged in a unit dose pack (such as Z-PAK) will be limited to one pack per month.**

3. Beginning January 2003, all fluoroquinolones will be limited to a 14-day supply.

Phase 6 PDL Additions

The following are effective January 7, 2003:

> *Note: ICD-9 codes will be required beginning in March 2003 for refills for antibiotics.*

Preferred Drug List (Macrolides)	Non-Preferred Drug List (Macrolides)
Zithromax® (azithromycin): Note: More than one Z-PAK® per month will require prior authorization	Brand erythromycin products*
Biaxin® (clarithromycin): Note: More than one Biaxin XL PAC® per month will require prior authorization	
Dynabac® (dirithromycin): Note: More than one D-5 PAC® per month will require prior authorization	
Erythromycin generic products	

Preferred Drug List (Fluoroquinolones)	Non-Preferred Drug List (Fluoroquinolones)
Cipro® (ciprofloxacin)	
Tequin® (gatifloxacin): Note: More than one TEQ-PAC® per month will require prior authorization	
Levaquin® (levofloxacin)	
Maxaquin® (lomefloxacin)	
Avelox® (moxifloxacin): Note: More than one ABC PAC® per month will require prior authorization	
Noroxin® (norfloxacin)	
Floxin® (ofloxacin)	
Zagam® (sparfloxacin)	

Preferred Drug List (Cephalosporins)	Non-Preferred Drug List (Cephalosporins)
All generic first and second generation cephalosporins	Ceftin® brand*
Omnicef® (cefdinir)	Ceclor® brand*
Suprax® (cefixime)	Cefzil® (cefprozil)
	Lorabid® (loracarbef)
	Vantin® (cefpodoxime)
	Cedax® (ceftibuten)
	Spectracef® (cefditoren)

Preferred Drug List (Antifungals)	**Non-Preferred Drug List (Antifungals)**
Diflucan® (fluconazole) all doses and all formulations: Diflucan 150 mg is limited to two tablets every fourteen days.	Nizoral® brand*
Ketoconazole generic products	Sporanox® (itraconazole)
	Lamisil® (terbinafine)
	Vfend® (voriconazole)

Preferred Drug List (ARBs) **This class must go through the ACEI step edit process. Patients must have failed an ACEI within the previous year.**	**Non-Preferred Drug List (ARBs)**
Cozaar® (losartan): Limited to 1 tablet per day	Atacand® (candesartan)
Micardis® (telmisartan): Limited to 1 tablet per day	Avapro® (irbesartan)
	Diovan® (valsartan)
	Benicar® (olmesartan)
	Teveten® (eprosartan)

*When a brand name drug having generic equivalents is included in the *Non-Preferred Drug List* listing, please note that the generic equivalents for the brand name drug are considered as being **on** the PDL, and therefore do not require prior authorization.

Note: In accordance with Indiana law, all antianxiety, antidepressant, antipsychotic, and cross indicated *drugs are considered as being on the PDL.*

Effective January 7, 2003, macrolides, fluoroquinolones, cephalosporins, antifungals, and ARBs not on the PDL will require prior authorization from ACS State Healthcare at 1-866-879-0106.

Note: Prior authorization will be required for all:
1) Non-preferred drugs in a class
2) Requests for quantities of preferred drugs in a class that exceed the stated limit

Clarification

The previous preferred drug list recommendations for the short-acting beta agonists were stated in IHCP bulletin *BT200255*, dated November 11, 2002. All formulations of generic albuterol are considered preferred. Please note that albuterol inhalers are limited to three canisters per month for individuals younger than 19 years old, and two canisters per month for individuals 19 years old and older.

Further Information

- Please direct any questions about the PDL and PA needed for non-PDL drugs to ACS State Health Care at 1-866-879-0106.
- Please direct any questions about this bulletin to EDS Customer Assistance at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278.
- Please direct any questions about PA to the Health Care Excel PA Department at (317) 347-4511 in the Indianapolis local area or 1-800-457-4518.

Edit Code	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 limitation	HCE	(317) 347-4511 1-800-457-4518

As additional categories of drugs are reviewed by the Therapeutics Committee, and recommendations are subsequently made to the DUR Board, providers will be given 30 days advance notice of additions to the PDL.

The Therapeutics Committee is scheduled to review the following classes of drugs at the December 6, 2002, meeting:

- Bone resorption suppression agents (P4L)
- SERMs (V1T)
- Heparin and related products (M9K)
- Antiemetic and antivertigo agents (H6L)

Notice of meetings of the Therapeutics Committee and agendas for the meetings are posted in accordance with public notice requirements on the FSSA Web site at http://www.state.in.us/fssa, under the heading, *Calendar and News*. Additional information about the Therapeutics Committee and the PDL may be accessed at http://www.indianapbm.com. Please also note that additional information about the PDL and related processes will be provided in the near future via banner page messages or bulletins.