

**Idaho Medicaid Pharmacy and Therapeutics Committee Recommendations
August 24, 2009**

The August 21, 2009 P&T Recommendations for the Vaginal Antibiotics are:

- Cleocin[®], clindamycin, Clindesse[®], Vandazole[®], and metronidazole be designated as preferred agents.
- There are no agents recommended by the committee as non-preferred.

The August 21, 2009 P&T Recommendations for the Topical Antivirals are:

- Denavir[®] and Zovirax[®] cream be designated as preferred agents.
- Zovirax[®] ointment as a non-preferred agent that requires prior authorization

The August 21, 2009 P&T Recommendations for the Topical Antiparasitics are:

- permethrin, peremethrin OTC, Eurax[®], and Ovide[®] be designated as preferred agents.
- lindane and malathion be designated as a non-preferred agents that require prior authorization

The August 21, 2009 P&T Recommendations for the Analgesics/Anesthetics are:

- Lidoderm[®] be designated as a preferred agent.
- Voltaren gel[®] and Flector[®] be designated as non-preferred agents that require prior authorization

The August 21, 2009 P&T Recommendations for the Pancreatic Enzymes are:

- pancrelipase, Creon[®] and Ultrase[®] be designated as preferred agents
- Pancrecarb[®] MS, Pancrease MT[®], and Viokase[®] be designated as non-preferred agents that require prior authorization.

The August 21, 2009 P&T Recommendations for the Stimulants and Related Agents are:

- Concerta[®], Vyvanse[®], Adderall XR[®], amphetamine salt combo, dexamethylphenidate, dextroamphetamine, Focalin[®], Focalin XR[®], Metadate CD[®], methylphenidate, and methylphenidate ER be designated as preferred agents.
- Daytrana[®], Desoxyn[®], Provigil[®], Ritalin LA[®], Nuvigil[®], Procenta[®], amphetamine salt combo ER, and Strattera[®] designated as non-preferred agents that require prior authorization.
- Current therapeutic prior authorization guidelines for diagnosis and contraindications will remain in effect.

The August 21, 2009 P&T Recommendations for the Alzheimer Agents are:

- Aricept[®], Aricept ODT[®] be designated as preferred for **mild to severe** dementia ratings. Exelon[®], Exelon patch[®], galantamine and galantamine ER be

designated as preferred agents for **mild to moderate** dementia ratings. Namenda® be designated as a preferred agent for **moderate to severe** dementia ratings.

- Cognex® be designated as a non-preferred agent that requires prior authorization.
- The Committee recommends that the current therapeutic prior authorization criteria continue to be required.

The August 21, 2009 P&T Recommendations for the Androgenic Agents are:

- Androderm® and Androgel® be designated as preferred agents.
- Testim® be designated as a non-preferred agent that requires prior authorization.

The August 21, 2009 P&T Recommendations for the Anticholinergic Bronchodilators are:

- Atrovent HFA® metered dose inhaler, Combivent® metered dose inhaler, ipratropium nebulizer solution and Spiriva Handihaler® inhalation powder be designated as preferred agents..
- ipratropium/albuterol nebulizer solution be designated as a non-preferred agent that requires prior authorization.

The August 21, 2009 P&T Recommendations for the Antidepressants classified as Others are:

- venlafaxine ER, Effexor XR®, mirtazapine, bupropion IR, bupropion SR, bupropion XL, Marplan®, Parnate® and Nardil® be designated as preferred agents.
- nefazodone, venlafaxine, Cymbalta®, Pristiq®, Emsam® patch, tranylcypromine sulfate, and Aplenzin® be designated as non-preferred agents that require prior authorization.

The August 21, 2009 P&T Recommendations for the SSRI Antidepressants are:

- citalopram, fluoxetine, fluvoxamine, and sertraline be designated as preferred agents.
- Lexapro®, paroxetine, paroxetine CR, Pexeva®, Prozac® Weekly, and Luvox® CR be designated as non-preferred agents that require prior authorization.

The August 21, 2009 Recommendations for Oral Antiemetics are:

- Emend®, ondansetron, and ondansetron ODT be designated as preferred agents.
- Anzemet®, granisetron, Marinol®, Cesamet®, Sancuso®, and dronabinol be designated as non-preferred agents that require prior authorization.
- The Committee recommends that current therapeutic prior authorization criteria remain in effect for all of these agents. The therapeutic criteria for Emend will be update.

The August 21, 2009 P&T Recommendations for the Oral Antifungals are:

- fluconazole, ketoconazole, and nystatin be designated as preferred agents
- clotrimazole, Ancobon®, griseofulvin suspension, Grifulvin®V tablets, Gris-Peg®, itraconazole, Lamisil®, Noxafil®, terbinafine and Vfend® be designated as non-preferred agents that require prior authorization.
- Brand name drugs of preferred generics will still require prior authorization.
 - It is recommended that the current therapeutic criteria for griseofulvin, itraconazole and terbinafine remain in effect.

The August 21, 2009 P&T Recommendations for the Antihyperuricemics are:

- allopurinol, colchicine, probenecid/colchicine, and probenecid be designated as preferred agents
- Uloric® as a non-preferred agent that requires prior authorization

The August 21, 2009 P&T Recommendations for the Topical Antifungals are:

- clotrimazole (OTC and RX), econazole, ketoconazole, clotrimazole/betamethasone, Naftin®, miconazole OTC, nystatin, terbinafine OTC, tolnaftate OTC, and nystatin/triamcinolone, be designated as preferred prescription agents..
 - ciclopirox cream /suspension/gel/solution/lacquer, Ertaczo®, Bensal HP®, Loprox® shampoo, Mentax®, Oxistat®, Xolegel®, CNL8®, Extina® and Vusion® be non-preferred agents that require prior authorization.
 - OTC products require an actual written prescription

The August 21, 2009 P&T Recommendations for the Antiparkinson's Agents are:

- benztropine, carbidopa/levodopa, ropinirole, selegiline, Stalevo® and trihexyphenidyl be designated as preferred agents.
- Requip XL, Azilect®, Comtan®, Mirapex®, Tasmar®, Zelapar®, and carbidopa/levodopa ODT be designated as non-preferred agents that require prior authorization.

The August 21, 2009 P&T Recommendations for the Antivirals, Oral are:

- rimantadine, Relenza®, acyclovir, amantadine, Tamiflu® and Valtrex® be designated as preferred agents.
- Famvir® and famciclovir be designated as non-preferred agents that require prior authorization.

The August 21, 2009 P&T Recommendations for the Atopic Dermatitis are:

- Elidel® and Protopic® be designated as preferred agents.

The August 21, 2009 P&T Recommendations for the Beta-Agonist Bronchodilators are:

- albuterol all formulations except low-dose nebulizer, Proair HFA[®] metered dose inhaler, Ventolin HFA[®] metered dose inhaler, Foradil[®] metered dose inhaler, Serevent Diskus[®] dry powder inhaler and terbutaline oral tablets be designated as the preferred agents.
- albuterol nebulizer low-dose, Maxair[®] inhaler, Xopenex HFA[®] metered dose inhaler, Proventil HFA[®] metered dose inhaler, metaproterenol all formulations, Performist[®], Brovana[®], and Xopenex[®] inhalation solution be designated as non-preferred agents that require prior authorization.

The August 21, 2009 P&T Recommendations for the Bone Resorption Suppression and Related Agents are:

- alendronate sodium, Boniva[®], Actonel[®], and Miacalcin[®] nasal be designated as preferred agents.
- Fosamax[®] solution, Fosamax PlusD[®], Actonel[®]w/calcium, Fortical[®], Forteo[®] subcutaneous, etidronate disodium, and calcitonin salmon be designated as nonpreferred agents that require prior authorization.

The August 21, 2009 P&T Recommendations for Oral Cephalosporins and Related Antibiotics are:

- Augmentin 125[®] suspension, Augmentin 250[®] suspension, amoxicillin/clavulanate tablets and suspension, cefdinir, cefaclor, cefprozil, cefadroxil, cefuroxime, cephalexin, and Suprax[®] be designated as preferred agents
- Cedax[®], Augmentin XR[®], Spectracef[®], and cefpodoxime be designated as non-preferred agents that require prior authorization
- Brand name drugs of preferred generics will still require prior authorization.

The August 21, 2009 Recommendations for Cytokine and CAM Antagonists are:

- Enbrel[®], Humira[®], Kineret[®] and Cimzia[®] be designated as preferred agents
- Amevive[®], Orencia[®] and Remicade[®] be designated as non-preferred agents that require prior-authorization

The August 21, 2009 P&T Recommendations for the Oral Fluoroquinolones are:

- Cipro[®] suspension, Levaquin[®], Avelox[®] and ciprofloxacin tablets be designated as preferred agents.
- ciprofloxacin ER, Factive[®], Noroxin[®], ofloxacin and Proquin XR[®] be designated as nonpreferred agents that require prior authorization.

The August 21, 2009 P&T Recommendations for Incretin Hypoglycemics are:

- Byetta[®], Symlin[®], Janumet[®] and Januvia[®] be designated as non-preferred agents.

The August 21, 2009 P&T Recommendations for the Inhaled Glucocorticoids are:

- Advair®, Advair HFA®, Flovent®, Flovent HFA®, Symbicort®, AeroBid®, AeroBid-M®, Asmanex®, Azmacort® and QVAR® be designated as preferred agents
- Pulmicort Flexhaler®, Pulmicort Respules®, Alvesco®, and budesonide respules be designated non-preferred agents that require prior authorization
- The Committee recommends that the current therapeutic criteria for long-acting beta agonist/inhaled glucocorticoid combinations and Pulmicort Respules® remain in effect.

The August 21, 2009 P&T Recommendations for the Intranasal Rhinitis Agents are:

- Astepro®, Astelin®, ipratropium nasal spray, fluticasone, Nasonex® be designated as preferred agents
- Patanase®, Nasacort AQ®, Veramyst®, Omnaris®, Beconase AQ®, flunisolide, and Rhinocort Aqua® be designated as non-preferred agents that require prior authorization

The August 21, 2009 P&T Recommendations for Insulins are:

- Humalog®, Humalog® mixture, Humalog® Pens, Humulin® and Humulin pens®, Lantus pens®, Levemir®, Novolin®, Novolog®, and Novolog® mixture and pens be designated as preferred agents
- Apidra® and Apidra pens® be designated as non-preferred agents that require prior-authorization

The August 21, 2009 P&T Recommendations for the Leukotriene Modifiers are:

- Accolate® and Singulair® be designated as the preferred agents
- Zflo CR® be designated as a non-preferred agent that requires prior authorization

The August 21, 2009 P&T Recommendations for Macrolides/Ketolides are:

- Zmax®, azithromycin, clarithromycin® and erythromycin be designated as preferred agents
- clarithromycin ER and Ketek® be designated as non-preferred agents that require prior authorization
- The Committee recommends that Ketek® continue to be subject to prior authorization with strict adherence to the package insert.

The August 21, 2009 P&T Recommendations for the NSAIDS are:

- diclofenac, etodolac, fenoprofen, flurbiprofen, ibuprofen (RX), ibuprofen OTC, ketoprofen, indomethacin, ketorolac, meloxicam, nabumetone, naproxen (RX), oxaprozin, piroxicam and sulindac be designated as preferred agents

- Arthrotec[®], Celebrex[®], meclufenamate and tolmetin be designated as non-preferred agents that require prior authorization
- The Committee recommends that the therapeutic prior authorization rule currently in place for Celebrex[®] remain.

The August 21, 2009 P&T Recommendations for the Ophthalmics for Allergic Conjunctivitis are:

- Alrex[®], ketotifen OTC, cromolyn sodium, Patanol[®], and Pataday[®] be designated as preferred agents
- Elestat[®], Optivar[®], Acular[®], Alocril[®], Alamast[®], Alomide[®], and Emadine[®] be designated as non-preferred agents that require prior authorization

The August 21, 2009 P&T Recommendations for the Ophthalmic Antibiotics are:

- neomycin-polymyxin-gramicidial, bacitracin, bacitracin/polymyxin, gentamicin, sulfacetamide, tobramycin, Tobrex[®] ointment, Ciloxan[®] ointment, triple antibiotic, erythromycin, ciprofloxacin, ofloxacin and Vigamox[®] be designated as preferred agents
- Azasite[®], Zymar[®], Iquix[®], Natacyn[®], Quixin[®], Ciloxan[®] solution and Tobrex[®] solution be designated as non-preferred agents that require prior authorization

The August 21, 2009 P&T Recommendations for the Ophthalmics, Glaucoma Agents are:

- Propine[®], Combigan[®], Alphagan P[®], Azopt[®], betaxolol, Betimol[®], Betoptic S[®], brimonidine, carteolol, Cosopt[®], Istalol[®], levobunolol, Lumigan[®] 5 ml and 7.5 ml, metipranolol, pilocarpine, timolol, Travatan[®], Travatan Z[®], Trusopt[®] and Xalatan[®] be designated as preferred agents
- dorzolamide/timolol, dorzolamide and Lumigan[®] 2.5 ml be designated as non-preferred agents that require prior authorization
- Brand name agents not listed as preferred agents will still require prior authorization.

The August 21, 2009 Recommendations for Ophthalmics, Anti-Inflammatories are:

- flurbiprofen, fluorometholone, Lotemax[®], FML Forte[®], Pred Mild[®], Maxidex[®], Flarex[®], FML S.O.P.[®], dexamethasone, and diclofenac be designated as preferred agents
- Vexol[®], Acular PF[®], Acular LS[®], Nevanac[®], Xibrom[®], Durezol[®], Triesence[®] and Retisert[®] be designated as non-preferred agents that require prior authorization

The August 21, 2009 P&T Recommendations for the Platelet Aggregation Inhibitors are:

- Aggrenox[®], dipyridamole and Plavix[®] be designated as preferred agents
- ticlopidine be designated as a non-preferred agent that requires prior authorization

The August 21, 2009 P&T Recommendations for the Antipsychotics are:

- fluphenazine, amitriptyline/perphenazine, haloperidol, thiothixene, chlorpromazine, perphenazine, trifluoperazine, Fazaclon[®], risperidone, haloperidol decanoate, Movanon[®], Geodon[®], fluphenazine/decanoate injection, Geodon[®], Seroquel[®], Seroquel XR[®], Zyprexa[®], clozapine, Symbyax[®], Invega[®], Abilify[®], and Risperdal Consta[®] be designated as preferred agents
- thioridazine is recommended by the Committee as a non-preferred agent that requires prior authorization.
- All current patients will be "grandfathered."
- All Atypical Antipsychotic agents will be subject to prior authorization for FDA labeled indications and evidence-based off label indications. Zyprexa[®] will be limited to FDA labeled indications.