PHARMACEUTICAL AND THERAPEUTICS COMMITTEE MEETING MINUTES

May 11, 2011, 9:00 am
Mahoney State Park, Peter Kiewit Lodge
Ashland, NE

Members Present
Claire Baker, M.D.
Kristi Bohac, Master of Divinity
Chris Caudill, M.D.
Yvonne Davenport, M.D.
Allison Dering-Anderson Pharm.D.
Gary Elsasser, Pharm.D.
Linda Farho, Pharm.D.
Jeff Gotschall, M.D.
Laurie Humphries, M.D.
Mark Hutchins, M.D.
Joyce Juracek, Pharm.D.
Grace Mims, Ph.D.
Kevin Reichmuth, M.D.
Eileen Rock, M.D.
Ken Saunders, Pharm.D.
Christopher Sorensen, Pharm.D.
Eric Thomsen, M.D.
Thomas Tonniges, M.D.
Angie Ward, R.Ph.

Members Absent:
James Dube' (excused)

DHHS Staff
Jenny Minchow, Pharm.D.
Barb Mart, R.Ph.
Candace Hupp, PDL Coordinator

Magellan Contract Staff
Barbara Dowd, R.Ph,
NE Clinical Account Manager

Call to Order: The meeting was called to order at 9:00 am by Ken Saunders, Vice-Chairman. The agenda was posted on the Magellan Medicaid Administration Nebraska Medicaid Pharmacy web site on 4/7/11. A copy of the Open Meetings Act and all non-confidential material was available in the meeting room for public inspection.

Roll Call: see list above

New member: Laurie Humphries M.D., a new physician member, was introduced. Dr. Humphries is a psychiatrist replacing Michelle Marsh M.D.

Conflict of Interest: No new updates

Approval of minutes: A motion was made by Elsasser and seconded by Caudill to approve the prior meeting minutes. The minutes of the August 25, 2010 meeting were approved as written. Voting was unanimous with the exception of Humphries who abstained.

New Business:

1. Changes in therapeutic classes: Provider Synergies changed the schedule for review on some of the drug classes. A few of the classes reviewed in August 2010 would be reviewed again in May 2011.

2. LB 466 is before the current NE Legislature. This bill proposes to add anticonvulsants, antidepressants and antipsychotics to the PDL. It does not appear to currently have enough support for passage.
3. Consent Calendar: members discussed the advantages of using a Consent Calendar. Consensus was expressed that a consent calendar would be useful for noncontroversial classes or therapeutic classes without changes.

Old Business:

A Committee Member had requested at the last meeting that the Department report outcomes information related to the non-preferred status of inhaled low dose albuterol. Jenny Minchow reported on the rates of low-dose albuterol claim denials comparing January 2010 with January 2011. The rate of post claim denial emergency room visits or hospitalizations was compared for patients who received prior authorization for low-dose albuterol, were switched to regular albuterol, or did not have any albuterol filled. Committee members felt that these results demonstrated that a market shift was achieved, with no evidence of serious complications related to low-dose albuterol being non-preferred.

Closed Executive Session

A motion was made by Sorensen and seconded by Saunders to go to closed session.

Votes as follows:
Baker-yes, Bohac – n/a, Caudill – yes, Davenport-yes, Dering-Anderson-yes, Elsasser - yes, Farho-yes, Gotschall - yes, Humphries – yes, Hutchins - yes, Juracek - yes, Mims – yes, Reichmuth – n/a, Rock-yes, Saunders-yes, Sorensen-yes, Thomsen-yes, Tonniges – yes, Ward-yes

Closed Executive Session:

Cost information was reviewed during closed session.
A motion was made and seconded to reconvene in open session. Voting was unanimous.

Public Testimony:

Affiliation	**Product**	**Speaker**
Amgen	Neulasta	Michele Puyear
Novartis	Gilenya	Dana Meier
Boehringer-Ingelheim	Pradaxa	John Robinson
Novo Nordisk	Victoza	Todd Paulsen
Merck	Vytorin/Zetia/Januvia/Janumet	Luciano Kolodny
UNMC	Cayston/Pancreaze	John Colombo
EMD Serono	Rebif	Julie Zatizabal
Pfizer	Genotropin	Susan Heineman
GlaxoSmithKline	Jalyn	Barbara Felt
Forest Pharmaceuticals	Bystolic	William Rowe
Bristol Myers Squibb	Kombiglyze XR/Onglyza	Shalley Gupta
Amylin	Byetta	Jesse Hong
Gilead Sciences	Cayston/Letairis	Ray Lancaster

THERAPEUTIC CLASS REVIEWS

A. Acne Agents Topical

A motion to approve the class as presented was made by Dering-Anderson and seconded by Tonniges.

Votes as follows:
Baker-yes, Bohac – yes, Caudill – yes, Davenport-yes, Dering-Anderson - yes, Elsasser - yes, Farho-yes, Gotschall - yes, Humphries – yes, Hutchins - yes, Juracek - yes, Mims – yes, Reichmuth – n/a, Rock-yes, Saunders – yes, Sorensen-yes, Thomsen-yes, Tonniges – yes, Ward-yes

PREFERRED DRUGS	NON-PREFERRED DRUGS	CRITERIA FOR USE OF NON-PREFERRED PRODUCTS
AZELEX (azelaic acid) BENZACLIN (clindamycin/ benzoyl peroxide) benzoyl peroxide generic OTC benzoyl peroxide generic Rx clindamycin phosphate DIFFERIN (adapalene) EPIDUO (adapalene/benzoyl peroxide) erythromycin RETIN-A MICRO (tretinoin) tretinoin	ACANYA (clindamycin and benzoyl peroxide) ACZONE (dapsone) adapalene gel, cream (generic for Differin) AKNE-MYCIN (erythromycin) ATRALIN (tretinoin) BENZEFOAM (benzoyl peroxide) CLARIFOAM EF (sulfur and sulfacetamide) CLINAC BPO (benzoyl peroxide) CLINDAGEL (clindamycin) clindamycin/benzoyl peroxide erythromycin-benzoyl peroxide EVOCLIN (clindamycin) INOVA (benzoyl peroxide) NUOX (benzoyl peroxide and sulfur) SE BPO (benzoyl peroxide) sodium sulfa-sulfur-mertan sulfacetamide sulfacetamide/sulfur (generic for Sulfacet-R) TAZORAC (tazarotene) VELTIN (clindamycin and tretinoin) ZIANA (clindamycin and tretinoin)	Treatment failure with three preferred products.

B. Analgesics, Opiates Long & Short Acting

(classes were voted on as one)

Analgesics, Opiates Long and Short Acting were voted as one class. There was significant discussion on whether Butans should be preferred or nonpreferred.

A motion was made and seconded to move Butrans to preferred and accept the rest of the class as presented.

Votes as follows:
Baker- no, Bohac -no, Caudill – yes, Davenport -yes, Dering-Anderson - no, Elsasser - yes, Farho - no, Gotschall -no, Humphries – no, Hutchins – yes, Juracek - no, Mims – no, Reichmuth – n/a, Rock- no, Saunders – no , Sorensen - yes, Thomsen-no, Tonniges – no, Ward – no

A motion was made by Dering-Anderson and seconded by Tonniges to accept the recommendations as presented and to have the Drug Utilization Review Board (DUR) create clinical criteria for Butrans, and have a report/status sent back to the P & T Committee.

Votes as follows:
Baker-yes, Bohac – yes, Caudill – yes, Davenport-yes, Dering-Anderson - yes, Elsasser - yes, Farho-yes, Gotschall - yes, Humphries – yes, Hutchins - yes, Juracek - yes, Mims – yes, Reichmuth – n/a, Rock-yes, Saunders – yes, Sorensen-yes, Thomsen-yes, Tonniges – yes, Ward-yes

Analgesics, Opiates Long Acting

PREFERRED DRUGS	NON-PREFERRED DRUGS	CRITERIA FOR USE OF NON-PREFERRED PRODUCTS
fentanyl patches KADIAN (morphine) methadone morphine ER oxycodone ER OXYCONTIN (oxycodone ER)	AVINZA (morphine) BUTRANS (buprenorphine transdermal)* DURAGESIC (fentanyl) DURAGESIC MATRIX (fentanyl) EMBEDA (morphine/naltrexone)* EXALGO (hydromorphone ER)* OPANA ER (oxymorphone) RYZOLT (tramadol extended release)* tramadol extended release* ULTRAM ER (tramadol extended release)*	Non-preferred agents will be approved for patients meeting the following criteria: • Documented failure of at least a 30 day trial of two preferred agents within previous 6 months **BUTRANS:** • Diagnosis of chronic pain AND • Inability to take oral medication OR • Adequate trial with long acting morphine and methadone. OR • Adequate trial with fentanyl patch NOT approved for substance abuse or addiction. **EMBEDA: per DUR** • History of drug abuse, or family member with history of drug abuse. • No concomitant use of other long-acting narcotics • Pain contract on file with prescriber **EXALGO:** Must document **clinical** reason why immediate-release cannot be used. **ULTRAM ER, RYZOLT (tramadol extended release)** Clinical reason regular release cannot be used.

Analgesics, Opiates Short Acting

PREFERRED DRUGS	NON-PREFERRED DRUGS	CRITERIA FOR USE OF NON-PREFERRED PRODUCTS
ORAL		
acetaminophen/codeine codeine hydrocodone/APAP hydrocodone/ibuprofen hydromorphone morphine IR oxycodone IR oxycodone/APAP oxycodone/aspirin tramadol	aspirin/codeine dihydrocodeine/APAP/caffeine (generic for Panlor DC) DILAUDID LIQUID (hydromorphone) HYCET (hydrocodone/acetaminophen) IBUDONE (hydrocodone/ibuprofen) levorphanol meperidine NUCYNTA (tapentadol) oxymorphone (generic for Opana) oxycodone/ibuprofen (generic for Combunox) pentazocine/APAP pentazocine/naloxone REPREXAIN (hydrocodone/ibuprofen) RYBIX ODT(tramadol ODT) tramadol/APAP –generic for Ultracet (note:separate ingredients are preferred) TREZIX (dihydrocodeine/APAP/caffeine) ZAMICET(hydrocodone/acetaminophen) ZOLVIT(hydrocodone/acetaminophen soln)	Non-preferred agents will be approved only after documented failure of 3 preferred agents. Note: Nucynta only approved for short term use for acute pain. Not approved for chronic pain. RYBIX ODT: Treatment failure or contraindication to oral morphine concentrate and inability to swallow. ZOLVIT- no prior authorization needed for children under 12.
BUCCAL/TRANSMUCOSAL		
	ABSTRAL (fentanyl transmucosal)* ACTIQ (fentanyl)* fentanyl transmucosal* FENTORA (fentanyl)* ONSOLIS (fentanyl)*	Diagnosis of cancer. Current use of long-acting opiate. NOT approved for acute pain, migraine, or fibromyalgia.

C. Androgenic Drugs

A motion was made to approve the class as recommended by Caudill and seconded by Davenport.

Votes as follows:
Baker-yes, Bohac – yes, Caudill – yes, Davenport-yes, Dering-Anderson - yes, Elsasser - yes, Farho-yes, Gotschall - yes, Humphries – yes, Hutchins - yes, Juracek - yes, Mims – yes, Reichmuth – n/a, Rock-yes, Saunders – yes, Sorensen-yes, Thomsen-yes, Tonniges – yes, Ward – yes

PREFERRED DRUGS	NON-PREFERRED DRUGS	CRITERIA FOR USE OF NON-PREFERRED PRODUCTS
ANDRODERM (testosterone) ANDROGEL (testosterone)	TESTIM (testosterone) FORTESTA (testosterone)	1.Adverse reaction to, allergy or contraindication to preferred drugs, or 2 .Documentation of treatment failure with preferred drug.

D. Angiotensin Modulators / Combinations

A motion was made by Dering-Anderson and seconded by Saunders to approve class as recommended.

Votes as follows:
Baker-yes, Bohac – yes, Caudill – yes, Davenport-yes, Dering-Anderson - yes, Elsasser - yes, Farho-yes, Gotschall - yes, Humphries – yes, Hutchins - yes, Juracek - yes, Mims – yes, Reichmuth – n/a, Rock-yes, Saunders – yes, Sorensen-yes, Thomsen-yes, Tonniges – yes, Ward-yes

PREFERRED DRUGS	NON-PREFERRED DRUGS	CRITERIA FOR USE OF NON-PREFERRED PRODUCTS
ACE INHIBITORS		
benazepril (generic for Lotensin) captopril (generic for Capoten) enalapril (generic for Vasotec) fosinopril (generic for Monopril) lisinopril (gen for Prinivil/Zestril) quinapril generic for Accupril) ramipril (generic for Altace)	moexepril (generic for Univasc) perindopril (generic for Aceon) trandolapril (generic for Mavik)	Non-preferred agents may be approved if the patient has a history of two preferred agents in the last 12 months.
ACE INHIBITOR/DIURETIC COMBINATIONS		
benazepril/HCTZ (generic for Lotensin HCT) captopril/HCTZ (generic for Capozide) enalapril/HCTZ (generic for Vaseretic) fosinopril/HCTZ (generic for Monopril HCT) lisinopril/HCTZ (generic for Prinzide/Zestoretic) quinapril/HCTZ ((generic for Accuretic)	moexepril/HCTZ (generic for Uniretic)	
ANGIOTENSIN RECEPTOR BLOCKERS		
AVAPRO (irbesartan) DIOVAN (valsartan) losartan (generic for COZAAR)	ATACAND (candesartan) BENICAR (olmesartan) MICARDIS (telmisartan) TEVETEN (eprosartan)	Non-preferred agents may be approved if the patient has a history of two preferred agents in the last 12 months.
ANGIOTENSIN RECEPTOR BLOCKER/DIURETIC COMBINATIONS		
AVALIDE (irbesartan/HCTZ)	ATACAND-HCT	

DIOVAN-HCT (valsartan/HCTZ) losartan/HCTZ (generic for HYZAAR)	(candesartan/HCTZ) BENICAR-HCT (olmesartan/HCTZ) MICARDIS-HCT (telmisartan/HCTZ) TEVETEN-HCT (eprosartan/HCTZ)	
ANGIOTENSIN MODULATOR / CALCIUM CHANNEL BLOCKER COMBINATIONS		
	AMTURNIDE (aliskiren/**amlodipine**/HCTZ) AZOR (olmesartan/amlodipine) benazepril/amlodipine (generic for LOTREL) EXFORGE (valsartan/amlodipine) EXFORGE HCT (valsartan/amlodipine/ hydrochlorothiazide) LOTREL (benazepril/amlodipine) TEKAMLO (aliskiren/**amlodipine)** trandolapril/verapamil (generic for TARKA) TRIBENZOR (amlodipine/olmesartan/HCTZ) TWYNSTA (telmisartan/amlodipine)	Individual prescriptions for the components of these products should be used for patients requiring these drug combinations. Documentation of medical necessity required for use of combination product.
DIRECT RENIN INHIBITORS		
	TEKTURNA (aliskiren)	Non-preferred agents may be approved if the patient has a history of two preferred ACE inhibitors or angiotensin receptor blockers in the last 12 months.
DIRECT RENIN INHIBITOR COMBINATIONS		
	AMTURNIDE (**aliskiren**/amlodipine/HCTZ) TEKAMLO (**aliskiren**/amlodipine) TEKTURNA/HCT (aliskiren/HCTZ) VALTURNA (aliskerin/valsartan)	Individual prescriptions for the components of these products should be used for patients requiring these drug combinations. Documentation of medical necessity required for use of combination product.

E. Antibiotics, Gastrointestinal

Hutchins had questions as to why vancomycin oral was recommended as off and if it should be added to the preferred list. Ward advised that an oral solution prepared from the intravenous solution was more cost effective and is used frequently in compounding. Farho suggested making the oral capsule of vancomycin non-preferred and the compounded oral solution preferred. Mart reminded the committee of the 72 hour emergency procedures if a non-preferred drug is needed.

A motion was made by Dering –Anderson and seconded by Juracek to make the capsule form of vancomycin be non-preferred and the compounded oral solution prepared from the injection be preferred, and the rest of the class to be approved as published.

Votes as follows:
Baker-yes, Bohac – yes, Caudill – yes, Davenport-yes, Dering-Anderson - yes, Elsasser - yes, Farho-yes, Gotschall - yes, Humphries – yes, Hutchins - yes, Juracek - yes, Mims – yes, Reichmuth – n/a, Rock-yes, Saunders – yes, Sorensen-yes, Thomsen-yes, Tonniges – yes, Ward-yes

PREFERRED DRUGS	NON-PREFERRED DRUGS	CRITERIA FOR USE OF NON-PREFERRED PRODUCTS
metronidazole neomycin TINDAMAX (tindazole) vancomycin oral solution (compounded)	ALINIA (nitazoxanide) FLAGYL **ER** (metronidazole) VANCOCIN HCL oral capsules (vancomycin) XIFAXAN (rifaximin)	Alinia-if giardiasis; require treatment failure with metronidazole or tindazole. If cryptosporidium: no treatment failure required with other agent Flagyl **ER:** require trial on metronidazole or tindazole. Vancocin: May bypass metronidazole if initial episode of SEVERE c. difficile colitis or recurrence. Severe defined as 1) leukocytosis w/WBC ≧15,000 cells/microliter OR 2) serum creatinine ≧1.5 x premorbid level Xifaxan- 1) Diagnosis of travelers diarrhea resistant to quinolone. Or 2. Hepatic encephalopathy with treatment failure of lactulose or neomycin.

F. Anitibiotics, Inhaled

A motion was made by Caudill and seconded by Sorensen to approve class as recommended.

Votes as follows:
Baker-yes, Bohac –yes, Caudill – yes, Davenport-yes, Dering-Anderson - yes, Elsasser - yes, Farho-yes, Gotschall - yes, Humphries – yes, Hutchins n/a, Juracek – n/a, Mims yes, Reichmuth – n/a, Rock-yes, Saunders – yes, Sorensen-yes, Thomsen-yes, Tonniges – yes, Ward-yes

PREFERRED DRUGS	NON-PREFERRED DRUGS	CRITERIA FOR USE OF NON-PREFERRED PRODUCTS
TOBI (tobramycin)	CAYSTON (aztreonam lysine)[QL, *]	Cayston: 1.Adverse reaction to, allergy, treatment failure, or contraindication to preferred drugs, or 2. Previous therapy with tobramycin via nebulizer, and 3. Demonstration of TOBI compliance, and 4.Diagnosis of cystic fibrosis, and 5. Quantity limits of 84ml per 28 days supply.

G. Antibiotics, Topical

A motion was made by Gotschall and seconded by Caudill to accept the class as recommended.

Votes as follows:
Baker-yes, Bohac – yes, Caudill – yes, Davenport-yes, Dering-Anderson - yes, Elsasser - yes, Farho-yes, Gotschall - yes, Humphries – yes, Hutchins – n/a, Juracek – n/a, Mims – yes, Reichmuth – n/a, Rock-yes, Saunders – yes, Sorensen-yes, Thomsen-yes, Tonniges – yes, Ward-yes

PREFERRED DRUGS	NON-PREFERRED DRUGS	CRITERIA FOR USE OF NON-PREFERRED PRODUCTS
bacitracin ointment bacitracin/polymyxin (generic for Polysporin) gentamicin ointment mupirocin ointment (generic for Bactroban) neomycin/polymyxin/gramicidin (generic for Neosporin, Triple AB)	ALTABAX (retapamulin) BACTROBAN (mupirocin) CREAM	Non-preferred agents will be approved only after documented failure of the preferred agents. Bactroban CREAM requires clinical reason the mupirocin ointment cannot be used. **Altabax® (retapamulin)** Diagnosis impetigo due to Staphylococcus aureus (methicillin-susceptible isolates only) or Streptococcus pyogenes in adults and children ≥ 9 months of age Clinical reason that topical mupirocin ointment (generic Bactroban®) cannot be used Altabax® is not approved for MRSA and has not been proven any more effective than Bactroban®.

H. Antibiotics, Vaginal

A motion was made by Davenport to accept the class with Cleocin Ovules moved to preferred and seconded by Baker.

Votes as follows:
Baker-yes, Bohac – yes, Caudill – yes, Davenport-yes, Dering-Anderson - yes, Elsasser - yes, Farho-yes, Gotschall - yes, Humphries – yes, Hutchins – n/a, Juracek –n/a, Mims – yes, Reichmuth – n/a, Rock-yes, Saunders – yes, Sorensen-yes, Thomsen-yes, Tonniges – yes, Ward-yes

PREFERRED DRUGS	NON-PREFERRED DRUGS	CRITERIA FOR USE OF NON-PREFERRED PRODUCTS
CLEOCIN OVULES (clindamycin, vaginal suppositories) clindamycin vaginal (generic for Cleocin) METROGEL (metronidazole, vaginal)	CLINDESSE (clindamycin vaginal) metronidazole (vaginal) VANDAZOLE (metronidazole)	1.Adverse reaction to, allergy or contraindication to preferred drugs, or 2 .Documentation of treatment failurewith preferred drug. Note: Metrogel brand name preferred over generic metronidazole or Vandazole.

I. A motion was made by Tonniges and seconded by Saunders to move into closed session.

Votes as follows:

Baker-yes, Bohac – yes, Caudill – yes, Davenport-yes, Dering-Anderson - yes, Elsasser - yes, Farho-yes, Gotschall - yes, Humphries – yes, Hutchins - yes, Juracek - yes, Mims – yes, Reichmuth – n/a, Rock-yes, Saunders – yes, Sorensen-yes, Thomsen-yes, Tonniges – yes, Ward-yes

During closed session the committee asked to have all testimonies, including written testimonies to disclose any conflicts of interest.

The committee reviewed pricing questions with MMA and DHHS.

J. Anticoagulants & Platelet Aggregation Inhibitors
(classes were voted on together)

Hutchins asked why a brand product was preferred over its generic and why there was a pricing difference. Mart explained that federal rebates are sometimes tied to the Consumer Price Index (CPI) which can make the brand name product have a lower net cost to the state than the generic. Gotschall proposed an amendment to the criteria for Pradaxa to be changed to three months of uncontrolled INRs. A motion was made by Rock to accept the class with the amendment and seconded by Saunders.

Votes as follows:
Baker-yes, Bohac – yes, Caudill – yes, Davenport-yes, Dering-Anderson - yes, Elsasser - yes, Farho-yes, Gotschall - yes, Humphries – yes, Hutchins - yes, Juracek - yes, Mims – yes, Reichmuth – n/a, Rock-yes, Saunders – yes, Sorensen-yes, Thomsen-yes, Tonniges – yes, Ward-yes

Anticoagulants

PREFERRED DRUGS	NON-PREFERRED DRUGS	CRITERIA FOR USE OF NON-PREFERRED PRODUCTS
ARIXTRA (fondaparinux) FRAGMIN (dalteparin) LOVENOX (enoxaparin) warfarin (generic for Coumadin)	enoxaparin (generic for Lovenox) PRADAXA (dabigatran)*	Non-preferred agents will be approved only after documented failure of a preferred agent. PRADAXA: Diagnosis of nonvalvular atrial fibrillation AND Patient has taken warfarin for at least three months without INR stabilization (2 most recent INRs out of therapeutic range: between 2.0 and 3.0) OR Patient has taken warfarin for at least three months without dose stabilization (dose changing at least monthly) OR Allergy to warfarin

Platelet Aggregation Inhibitors

AGGRENOX (dipyridamole/aspirin) aspirin dipyridamole (generic for Persantine) PLAVIX (clopidogrel)	EFFIENT (prasugrel)* ticlopidine (generic for Ticlid)	1.Adverse reaction to, allergy or contraindication to preferred drugs, or 2 .Documentation of treatment failure with preferred drug. 3. **OR** Documentation of

		clopidrogel resistance. EFFIENT: Additional criteria • Patient has Acute Coronary Syndrome (ACS) and is going to be managed with Percutaneous Coronary Intervention (PCI) as follows: 1. Patients with unstable angina or NSTEMI or 2. Patients with STEMI when managed with primary or delayed PCI • Must be <75 years of age unless they are high risk patients (diabetes or prior MI) • Must not have active pathological bleeding or history of TIA or stroke.

K. Antiemetics/Antivertigo Agents

Dering-Anderson motioned to approve class as recommended and Tonniges seconded.

Votes as follows:
Baker-yes, Bohac – yes, Caudill – yes, Davenport-yes, Dering-Anderson - yes, Elsasser - yes, Farho-yes, Gotschall - yes, Humphries – yes, Hutchins - yes, Juracek - yes, Mims – yes, Reichmuth – n/a, Rock-yes, Saunders – yes, Sorensen-yes, Thomsen-yes, Tonniges – yes, Ward-yes

PREFERRED DRUGS	NON-PREFERRED DRUGS	CRITERIA FOR USE OF NON-PREFERRED PRODUCTS
CANNABINOIDS		
MARINOL (dronabinol)	CESAMET (nabilone) dronabinol (generic for Marinol)	1.Adverse reaction to, allergy or contraindication to preferred drugs, or 2 .Documentation of treatment failure with preferred drug.
5HT3 RECEPTOR BLOCKERS		
ondansetron (generic for Zofran) ondansetron ODT (generic for Zofran)	ANZEMET (dolasetron) granisetron (generic for Kytril) SANCUSO (granisetron)* ZUPLENZ (ondansetron oral soluble film)*	1.Adverse reaction to, allergy or contraindication to preferred drugs, or 2 .Documentation of treatment failure with preferred drug. ---------- SANCUSO: Unable to tolerate oral. ZUPLENZ: Inablilty to swallow. Clinical reason can't utilize ondansetron ODT.
NK-1 RECEPTOR ANTAGONIST		
	EMEND (aprepitant)*QL	See Clinical Criteria: Emend

		does NOT require treatment failure with preferred drugs when used for moderately or highly emetogenic chemotherapy.
TRADITIONAL ANTIEMETICS/ANTIVERTIGO		
dimenhydrinate (generic for Dramamine) meclizine (generic for Antivert) metoclopramide (generic for Reglan) prochlorperazine oral (generic for Compazine) promethazine (generic for Phenergan) SCOPACE (scopolamine) TRANSDERM-SCOP (scopolamine)	METOZOLV ODT (metoclopramide) prochlorperazine rectal (generic for Compazine) trimethobenzamide oral (generic for Tigan)	1.Adverse reaction to, allergy or contraindication to 2 preferred drugs, or 2 .Documentation of treatment failure with 2 preferred drugs. METOZOLV ODT (metoclopramide): Inablilty to swallow or clinical reason can't utilize oral liquid.

L. Antifungals, Oral & Topical
(classes were voted on as one)

A motion was made by Sorensen and seconded by Thomsen to approve the class as published.

Votes as follows:
Baker-yes, Bohac – yes, Caudill – yes, Davenport-yes, Dering-Anderson - yes, Elsasser - yes, Farho-yes, Gotschall - yes, Humphries – yes, Hutchins - yes, Juracek - yes, Mims – yes, Reichmuth – n/a, Rock-yes, Saunders – yes, Sorensen-yes, Thomsen-yes, Tonniges – yes, Ward-yes

Antifungals, Oral

PREFERRED DRUGS	NON-PREFERRED DRUGS	CRITERIA FOR USE OF NON-PREFERRED PRODUCTS
fluconazole (generic for Diflucan) GRIS-PEG (griseofulvin) griseofulvin suspension ketoconazole (generic for Nizoral) nystatin terbinafine (generic for Lamisil,)	clotrimazole (mucous membrane, troche) GRIFULVIN V (griseofulvin) LAMISIL GRANULES (terbinafine) ORAVIG (miconazole) buccal --- ANCOBON (flucytosine)* itraconazole (SPORANOX)* NOXAFIL (posaconazole)* voriconazole (generic for VFEND)*	1. Adverse reaction to, allergy or contraindication to preferred drugs, or 2. Documentation of treatment failure with two preferred drugs. --- **These meds do not necessarily require trial and failure on a preferred medication, if clinical criteria are met. Tech: may approve:** **All: allow if immunocompromised** **ANCOBON: diagnosis of:** • CANDIDA: septicemia, endocarditis, UTI • CRYPTOCOCCUS: meningitis, pulmonary infections. **ITRACONAZOLE:** diagnosis of: • Aspergillosis • Blastomycosis • Histoplasmosis • Onchomycosis resistant to terbinafine • Oropharyngeal/esophageal

		candidiasis refractory to fluconazole. • Sporonox liquid only if unable to take capsules. **NOXAFIL:** minimum age of 13. Prevention of infection with diagnosis of: • Neutropenic Myelodysplastic Syndrome • Neutropenic hematologic malignancies • Graft vs. Host disease • Immunosuppression following hematopoetic stem cell transplant Oropharyngeal/esophageal candidiasis refractory to itraconazole and/or fluconazole **VFEND:** • Myelodysplastic Syndrome (MDS), • Neutropenic Acute Myeloid Leukemia (AML) • Graft versus Host Disease (GVHD) • Candidemia (candida krusei), Esophageal Candidiasis • Pulmonary or invasive aspergillosis • Blastomycosis • Serious fungal infections caused by *Scedosporium apiospermum* (asexual form of *Pseudallescheria boydii*) and *Fusarium* spp., including *Fusarium solani*, in patients intolerant of, or refractory to other therapy. • Oropharyngeal/esophageal candidiasis refractory to fluconazole.

Antifungals, Topical

PREFERRED DRUGS	NON-PREFERRED DRUGS	CRITERIA FOR USE OF NON-PREFERRED PRODUCTS
ANTIFUNGAL		
clotrimazole (generic for Lotrimin) Rx, OTC econazole (generic for Spectazole) ketoconazole (generic for Nizoral) ketoconazole shampoo (generic for Nizoral) miconazole OTC nystatin selenium sulfide 1%	BENSAL HP (benzoic acid/salicylic acid) ciclopirox cream/gel/suspension (generic for Loprox) ciclopirox nail lacquer (solution) (generic for Penlac) ciclopirox shampoo (generic for Loprox) ERTACZO (sertaconazole)	1. Adverse reaction to, allergy or contraindication to preferred drugs, or 2. Documentation of treatment failure of two preferred drugs within the last 6 months.

selenium sulfide 2.5% terbinafine OTC (generic for Lamisil AT) tolnaftate OTC (generic for Tinactin)	EXELDERM (sulconazole) EXTINA (ketoconazole) LAMISIL SOLUTION (terbinafine) MENTAX (butenafine) NAFTIN (naftifine) NUZOLE (miconazole) OXISTAT (oxiconazole) selenium sulfide 2.25% VUSION (miconazole/ zinc oxide) XOLEGEL (ketoconazole)	
ANTIFUNGAL/STEROID COMBINATIONS		
clotrimazole/betamethasone (generic for Lotrisone) nystatin/triamcinolone (generic for Mycolog)		

M. Antimigraine Drugs, Triptans

A motion was made by Thomsen and seconded by Rock to accept class as published.
Votes as follows:
Baker-yes, Bohac – yes, Caudill – yes, Davenport-yes, Dering-Anderson - yes, Elsasser - yes, Farho-yes, Gotschall - yes, Humphries – yes, Hutchins - yes, Juracek - yes, Mims – yes, Reichmuth – n/a, Rock-yes, Saunders – yes, Sorensen-yes, Thomsen-yes, Tonniges – yes, Ward-yes

PREFERRED DRUGS	NON-PREFERRED DRUGS	CRITERIA FOR USE OF NON-PREFERRE PRODUCTS
ORAL		
RELPAX (eletriptan) sumatriptan generic oral	AMERGE (naratriptan) AXERT (almotriptan) FROVA (frovatriptan) IMITREX (sumatriptan oral) MAXALT/MLT (rizatriptan) TREXIMET (sumatriptan/naproxen) ZOMIG/ZMT (zolmitriptan)	Non-preferred agents will be approved only if patient has tried and failed therapy with all preferred agents.
NASAL		
IMITREX (sumatriptan nasal)	sumatriptan nasal ZOMIG (zolmitriptan nasal)	
INJECTABLE		
IMITREX (sumitriptan injection)	sumatriptan injection	

N. Antiparasitics, Topical

A motion was made by Tonniges and seconded by Rock to approve the class as published.

Votes as follows:
Baker-yes, Bohac – yes, Caudill – yes, Davenport - yes, Dering-Anderson - yes, Elsasser - yes, Farho - yes, Gotschall - yes, Humphries – yes, Hutchins - yes, Juracek - yes, Mims – yes, Reichmuth – n/a, Rock - yes, Saunders – yes, Sorensen-yes, Thomsen-yes, Tonniges – yes, Ward - yes

PREFERRED DRUGS	NON-PREFERRED DRUGS	CRITERIA FOR USE OF NON-PREFERRED PRODUCTS
EURAX (crotamiton) permethrin 1% OTC (generic for Nix)	lindane malathion (generic for Ovide)	1. Adverse reaction to, allergy or contraindication to preferred drugs,

permethrin 5% RX (generic for Elimite) pyrethrin /piperonyl butoxide (generic for RID, A-200) OVIDE (malathion)	NATROBA (spinosad) ULESFIA (benzyl alcohol)	or 2. Documentation of treatment failure with two preferred drugs. Note: Ulefsia and Lindane will process in claims system automatically without prior authorization if 2 preferred products have been filled within the previous 60 days. Ulesfia: *Quantity limits based on hair length.*

O. Antivirals, Oral & Topical
(classes were voted on together)

A motion was made by Dering –Anderson and seconded by Farho to approve the class as published.

Votes as follows:
Baker-yes, Bohac – yes, Caudill – yes, Davenport - yes, Dering-Anderson - yes, Elsasser - yes, Farho - yes, Gotschall - yes, Humphries – yes, Hutchins - yes, Juracek - yes, Mims – yes, Reichmuth – n/a, Rock - yes, Saunders – yes, Sorensen - yes, Thomsen - yes, Tonniges – yes, Ward - yes

Antivirals, Oral

PREFERRED DRUGS	NON-PREFERRED DRUGS	CRITERIA FOR USE OF NON-PREFERRED PRODUCTS
ANTI-HERPETIC DRUGS		
acyclovir (generic for Zovirax) VALTREX (valacyclovir)	famciclovir (generic for Famvir) valacyclovir (generic for Valtrex)	1. Adverse reaction to, allergy or contraindication to preferred drugs, or 2. Documentation of treatment failure with a preferred drug.
ANTI-INFLUENZA DRUGS		
amantadine (generic for Symmetrel) RELENZA (zanamivir) inhalation[QL] rimantadine (generic for Flumadine) TAMIFLU (oseltamivir) [QL]		

Antivirals, Topical

PREFERRED DRUGS	NON-PREFERRED DRUGS	CRITERIA FOR USE OF NON-PREFERRED PRODUCTS
	DENAVIR (penciclovir) XERESE (acyclovir/hydrocortisone) ZOVIRAX Cream (acyclovir) ZOVIRAX Ointment (acyclovir)	1. Adverse reaction to, allergy or contraindication to preferred oral antiherpetic agent or 2. Documentation of treatment failure with a preferred oral antiherpetic drug.

P. Beta Blockers

A motion was made by Gotschall to amend the recommendations and remove acebutolol, Innopran XL, Levatol, pindolol, & timolol and the motion was seconded by Davenport.

Votes as follows:

Baker-yes, Bohac – yes, Caudill – yes, Davenport-yes, Dering-Anderson - yes, Elsasser - yes, Farho-yes, Gotschall - yes, Humphries – yes, Hutchins - yes, Juracek - yes, Mims – yes, Reichmuth – n/a, Rock-yes, Saunders – yes, Sorensen-yes, Thomsen-yes, Tonniges – yes, Ward-yes

PREFERRED DRUGS	NON-PREFERRED DRUGS	CRITERIA FOR USE OF NON-PREFERRED PRODUCTS
BETA BLOCKERS		Non-preferred agent will be approved only after documented failure of two preferred agents within the past 12 months. Bystolic: Non-preferred agent will be approved only after documented failure of one preferred agent within the past 12 months in patients with obstructive lung disease.
atenolol (generic for Tenormin) atenolol/chlorthalidone (generic for Tenoretic) bisoprolol (generic for Zebeta) bisoprolol/HCTZ (generic for Ziac) metoprolol (generic for Lopressor) metoprolol/HCTZ (generic for Lopressor HCT) metoprolol XL (generic for Toprol XL) nadolol (generic for Corgard) nadolol/bendroflumethiazide (gen. Corzide) propranolol/ER (generic for Inderal) propranolol/HCTZ sotalol (generic for Betapace)	acebutolol (generic for Sectral) betaxolol (generic for Kerlone) BYSTOLIC (nebivolol) INNOPRAN XL (propranolol) LEVATOL (penbutolol) pindolol (generic for Viskin) timolol (generic for Blocadren) TOPROL XL (metoprolol)	
BETA- AND ALPHA- BLOCKERS		
carvedilol (generic for Coreg) labetalol (generic for Trandate)	COREG CR (carvedilol)	Coreg CR:Clinical reason the generic regular-release can not be used.

Q. Bladder Relaxant Preparations

Tonniges questioned Enablex being moved to non-preferred. Farho advised that there are tolerance issues throughout the class and that she does not recommend changing someone on a current well tolerated therapy.
Davenport made a motion to approve the class as published with an amendment to add grandfathering for patients currently on Enablex, Ward seconded the motion.

Votes as follows:
Baker-yes, Bohac – yes, Caudill – yes, Davenport-yes, Dering-Anderson - yes, Elsasser - yes, Farho-yes, Gotschall - yes, Humphries – yes, Hutchins - yes, Juracek – n/a, Mims – yes, Reichmuth – n/a, Rock-yes, Saunders – yes, Sorensen-yes, Thomsen-yes, Tonniges – yes, Ward-yes

PREFERRED DRUGS	NON-PREFERRED DRUGS	CRITERIA FOR USE OF NON-PREFERRED PRODUCTS
oxybutynin IR (generic for Ditropan) TOVIAZ (fesoterodine) VESICARE (solifenacin)	DETROL (tolterodine) DETROL LA (tolterodine) ENABLEX (darifenacin) *(w/grandfathering)* GELNIQUE (oxybutynin transdermal) oxybutynin ER (generic for Ditropan XL)* OXYTROL (oxybutynin transdermal) SANCTURA XR (trospium) trospium (generic for SANCTURA)	The non-preferred agent will be approved only after documented failure of a preferred agent. Oxybutynin ER –Treatment failure with preferred LONG ACTING agent.

R. Bone Resorption Suppression & Related Drugs

Tonniges asked why so many clients were still on Boniva which was made non-preferred. Minchow advised that Boniva became nonpreferred in October of 2010. The cost sheet is based on information from the third quarter of 2010, therefore the cost sheet does not reflect a market shift.
A motion was made by Elsasser and seconded by Ward to approve the class as published.

Votes as follows:
Baker-yes, Bohac – yes, Caudill – yes, Davenport-yes, Dering-Anderson - yes, Elsasser - yes, Farho-yes, Gotschall - yes, Humphries – yes, Hutchins - yes, Juracek – n/a, Mims – yes, Reichmuth – n/a, Rock-yes, Saunders – yes, Sorensen-yes, Thomsen-yes, Tonniges – yes, Ward-yes

PREFERRED DRUGS	NON-PREFERRED DRUGS	CRITERIA FOR USE OF NON-PREFERRED PRODUCTS
BISPHOSPHONATES		
alendronate (generic for Fosamax) (daily and weekly)	ACTONEL (risedronate) ACTONEL WITH CALCIUM (risedronate/ calcium) ATELVIA DR (risedronate) BONIVA (ibrandronate) DIDRONEL (etidronate) etidronate disodium FOSAMAX Oral Solution (alendronate) FOSAMAX PLUS D	1.Adverse reaction to, allergy or contraindication to preferred drugs, or 2 .Documentation of treatment failure with preferred drug. ATELVIA DR: Clinical reason can't take alendronate on empty stomach. Note: products with calcium or vitamin D will be prescribed separately.
OTHER BONE RESORPTION SUPPRESSION AND RELATED DRUGS		
EVISTA (raloxifene) MIACALCIN (calcitonin) nasal	calcitonin-salmon nasal (generic for Miacalcin) FORTEO (teriparatide) subcutaneous*QL FORTICAL (calcitonin) nasal	1.Adverse reaction to, allergy or contraindication to preferred drugs, or 2 .Documentation of treatment failure with preferred drug. Forteo® (teriparatide): May approve if the client is unable to use preferred products (i.e. intolerance, contraindication, allergy, and previous trial/failure) **OR** the client is at high risk of fracture as defined below. Patients at high risk of fracture include: • Bone mineral density of -3 or worse • Postmenopausal women with history of non-traumatic fracture(s) • Postmenopausal women with two or more of the following clinical risk factors: 1. Family history of non-traumatic fracture(s) 2. Patient history of non-traumatic fracture(s) 3. DXA BMD T-score ≤-2.5 at

		any site 4. Glucocorticoid use* (≥6 months of use at 7.5 mg dose of prednisolone equivalent) 5. Rheumatoid Arthritis • Postmenopausal women with BMD T-score ≤-2.5 at any site with any of the following clinical risk factors: 1. More than 2 units of alcohol per day 2. Current smoker • Men w/primary or hypogonadal osteoporosis • Osteoporosis associated w/sustained systemic glucocorticoid therapy* Initial approval will be for 1 year with ONE renewal if demonstrated compliance. Maximum duration of therapy is 24 months during a patient's lifetime. Approval does not require trial and failure on Miacalcin®. Quantity limit of 2.4ml per claim for a 30 day supply. Combination therapy with biphosphonates (Actonel®, Boniva®, Didronel®, Fosamax®, alendronate) is not recommended and will NOT be approved. Not approved for pediatric patients or young adults with open epiphyses. Injection must be administered by patient or caregivers.

S. Benign Prostatic Hyperplasia (BPH) Treatments

A motion was made by Thomsen and seconded by Mims to approve the class as published.

Votes as follows:
Baker-yes, Bohac – yes, Caudill – yes, Davenport-yes, Dering-Anderson - yes, Elsasser - yes, Farho-yes, Gotschall - yes, Humphries – yes, Hutchins - yes, Juracek – n/a, Mims – yes, Reichmuth – n/a, Rock-yes, Saunders – yes, Sorensen-yes, Thomsen-yes, Tonniges – yes, Ward-yes

PREFERRED DRUGS	NON-PREFERRED DRUGS	CRITERIA FOR USE OF NON-PREFERRED PRODUCTS
doxazosin (generic for Cardura) tamsulosin (generic for Flomax) terazosin (generic for Hytrin) UROXATRAL (alfuzosin)	CARDURA XL (doxazosin) JALYN (dutasteride/**tamsulosin)** RAPAFLO (silodosin)	Treatment failure with one preferred agent. JALYN: Must meet criteria for
5-ALPHA-REDUCTASE (5AR) INHIBITORS		

finasteride (generic for Proscar)	AVODART (dutasteride) JALYN (**dutasteride/**tamsulosin)	approval of Avodart and clinical reason can't take individual agents.

T. Calcium Channel Blockers (Oral)

A motion was made by Rock and seconded by Thomsen to approve the class as published.

Votes as follows:
Baker-yes, Bohac – yes, Caudill – yes, Davenport-yes, Dering-Anderson - yes, Elsasser - yes, Farho-yes, Gotschall - yes, Humphries – yes, Hutchins - yes, Juracek - yes, Mims – yes, Reichmuth – n/a, Rock-yes, Saunders – yes, Sorensen-yes, Thomsen-yes, Tonniges – yes, Ward-yes

PREFERRED DRUGS	NON-PREFERRED DRUGS	CRITERIA FOR USE OF NON-PREFERRED PRODUCTS
SHORT-ACTING		
diltiazem (generic for Cardizem) nicardipine (generic for Cardene) nifedipine (generic for Procardia) verapamil (generic for Calan, Isoptin)	isradipine (generic for Dynacirc) nimodipine (generic for Nimotop)	Isradipine : The non-preferred agent will be approved only after documented failure of a preferred agent. Nimodipine requires the diagnosis of subarachnoid hemorrhage or cerebrovascular spasm.
LONG-ACTING		
amlodipine (generic for Norvasc) diltiazem ER (generic for Cardizem CD) felodipine ER (generic for Plendil) nifedipine ER (generic for Procardia XL) verapamil ER verapamil ER PM (generic for Verelan PM)	CARDENE SR (nicardipine) CARDIZEM CD (verapamil) COVERA-HS (verapamil) diltiazem LA (generic for Cardizem LA) DYNACIRC CR (isradipine) nisoldipine (generic for Sular)	Non-preferred agents will be approved only after documented failure of a preferred agent.

U. Cephalosporins (Oral) and Related Antibiotics

A motion was made by Tonniges and seconded by Rock to approve the class as published.

Votes as follows:
Baker-yes, Bohac – yes, Caudill – yes, Davenport-yes, Dering-Anderson - yes, Elsasser - yes, Farho-yes, Gotschall - yes, Humphries – yes, Hutchins - yes, Juracek - yes, Mims – yes, Reichmuth – n/a, Rock-yes, Saunders – yes, Sorensen-yes, Thomsen-yes, Tonniges – yes, Ward-yes

PREFERRED DRUGS	NON-PREFERRED DRUGS	CRITERIA FOR USE OF NON-PREFERRED PRODUCTS
BETA LACTAM/BETA-LACTAMASE INHIBITOR COMBINATIONS		
amoxicillin/clavulanate tablets and 200, 400, 600mg/5ml suspension AUGMENTIN 125mg/5ml Suspension AUGMENTIN 250mg/5ml Suspension	amoxicillin/clavulanate extended release (generic for Augmentin XR) (all forms of brand name AUGMENTIN are non-preferred, *except* 125 and 250mg/5ml)	1. Adverse reaction to, contraindication to preferred drugs, or 2. Documentation of treatment failure with preferred drug.
CEPHALOSPORINS – First Generation		

cephalexin (oral) (generic for Keflex) cefadroxil (oral) (generic for Duricef)		1. Adverse reaction to, contraindication to preferred drugs, or 2. Documentation of treatment failure with preferred drug.
CEPHALOSPORINS – Second Generation		
cefuroxime (oral *tablet*) (generic for Ceftin) cefprozil (oral) (generic for Cefzil)	cefaclor (oral) (generic for Ceclor) CEFTIN (cefuroxime) tablets, suspension cefuroxime oral suspension (generic for Ceftin)	1. Adverse reaction to, contraindication to preferred drugs, or 2. Documentation of treatment failure with preferred drug.
CEPHALOSPORINS – Third Generation		
CEDAX (ceftibuten) cefdinir (oral) (generic for Omnicef) SUPRAX (cefixime)	cefpodoxime (oral) (generic for Vantin) cefditoren (generic for Spectracef)	1. Adverse reaction to, contraindicationto preferred drugs, or 2. Documentation of treatment failure with preferred drug.

V. Colony Stimulating Factors & Erythropoiesis Stimulating Proteins

A motion was made by Hutchins and seconded by Rock to approve the class as published

Votes as follows:
Baker-yes, Bohac – yes, Caudill – yes, Davenport-yes, Dering-Anderson - yes, Elsasser - yes, Farho-yes, Gotschall - yes, Humphries – yes, Hutchins - yes, Juracek - yes, Mims – yes, Reichmuth – n/a, Rock-yes, Saunders – yes, Sorensen-yes, Thomsen-yes, Tonniges – yes, Ward-yes

Colony Stimulating Factors

PREFERRED DRUGS	NON-PREFERRED DRUGS	CRITERIA FOR USE OF NON-PREFERRED PRODUCTS
NEUPOGEN (filgrastim)*	LEUKINE (sargramostim)* NEULASTA (pegfilgrastim)*	Entire class requires place of service determination. Only approved for self administration or administration by care giver in home. (not approved thru Pharmacy program for administration in office, clinic or hospital) • Documented myelosuppressive chemotherapy, bone marrow transplant, peripheral blood progenitor cell collection, severe chronic neutropenia; or • Documented ANC < 750 cells/microliter in patients with Hepatitis C who are being treated with Interferon. • Not covered for AIDS, hairy cell leukemia, myelodysplasia, drug-induced congenital agranulocytosis, alloimmune neonatalneutropenia. Initial authorization is granted for six months.

Erythropoiesis Stimulating Proteins

PREFERRED DRUGS	NON-PREFERRED DRUGS	CRITERIA FOR USE OF NON-PREFERRED PRODUCTS
ARANESP (darbepoetin)* EPOGEN (rHuEPO)* PROCRIT (rHuEPO)*		Entire class requires place of service determination. Only approved for self administration or administration by care giver in h ome. (not approved thru Pharmacy program for administration in office, clinic or hospital) Length of authorization: varies • Anemia associated with chronic renal failure APPROVAL ONE YEAR • Anemia with chemotherapy, need length of chemo regimen auth 30 days longer • Anemia in HIV infected clients • Anemia associated with hepatitis C treatment • See RP for any other diagnosis

W. Fluoroquinolones, Oral

The Department had recommended making Levaquin preferred, because a generic version is expected soon. The potential for Levaquin to become less expensive was discussed and Dering-Anderson recommended not changing the recommendations as prescribing habits have been changed. DHHS will monitor the cost of generic levofloxacin when it becomes available and make changes if significant cost savings develop.

Votes as follows:
Baker-yes, Bohac – yes, Caudill – yes, Davenport-yes, Dering-Anderson - yes, Elsasser - yes, Farho-yes, Gotschall - yes, Humphries – yes, Hutchins - yes, Juracek - yes, Mims – yes, Reichmuth – n/a, Rock-yes, Saunders – yes, Sorensen-yes, Thomsen-yes, Tonniges – yes, Ward-yes

PREFERRED DRUGS	NON-PREFERRED DRUGS	CRITERIA FOR USE OF NON-PREFERRED PRODUCTS
AVELOX (moxifloxacin) ciprofloxacin (generic for Cipro)	CIPRO Suspension (ciprofloxacin) ciprofloxacin ER (generic for Cipro XR) FACTIVE (gemifloxacin) LEVAQUIN (levofloxacin) NOROXIN (norfloxacin) ofloxacin (generic for Floxin) PROQUIN XR (ciprofloxacin)	1. Adverse reaction to, allergy to or contraindication to preferred drugs, or 2. Documentation of treatment failure with preferred drug. Ofloxacin and levofloxacin may be approved drug without trial on preferred with diagnosis of: Pelvic Inflammatory Disease or Acute Epididymitis not caused by gonorrhea. Non-preferred quinolone may be approved upon inpatient hospital discharge to complete a course of antibiotic therapy initiated during

		inpatient care.

X. Growth Hormone

Tonniges asked why there are still a significant percentage of clients on non-preferred products. Minchow advised that the previous authorizations were for 1 year. Cost sheets were based on utilization in third quarter of 2010.

A motion was made by Baker and seconded by Rock to approve the class as published.

Votes as follows:
Baker-yes, Bohac – yes, Caudill – yes, Davenport-yes, Dering-Anderson - yes, Elsasser - abstained, Farho-yes, Gotschall - yes, Humphries – yes, Hutchins - yes, Juracek - yes, Mims – yes, Reichmuth – n/a, Rock-yes, Saunders – yes, Sorensen-yes, Thomsen-yes, Tonniges – yes, Ward-yes

PREFERRED DRUGS	NON-PREFERRED DRUGS	CRITERIA FOR USE OF NON-PREFERRED PRODUCTS
NORDITROPIN (somatropin)* NUTROPIN (somatropin)* NUTROPIN AQ (somatropin)* SAIZEN (somatropin)*	GENOTROPIN (somatropin)* HUMATROPE (somatropin)* OMNITROPE (somatropin)* SEROSTIM (somatropin)* TEV-TROPIN (somatropin)* ZORBTIVE (somatropin)*	See clinical criteria.

Y. Hepatitis C Treatments

A motion was made by Thomsen and seconded by Farho to approve class as published.

Votes as follows:
Baker-yes, Bohac – n/a, Caudill – yes, Davenport-yes, Dering-Anderson - yes, Elsasser - yes, Farho-yes, Gotschall - yes, Humphries – yes, Hutchins - yes, Juracek - yes, Mims – yes, Reichmuth – n/a, Rock-yes, Saunders – yes, Sorensen-yes, Thomsen-yes, Tonniges – yes, Ward-yes

PREFERRED DRUGS	NON-PREFERRED DRUGS	CRITERIA FOR USE OF NON-PREFERRED PRODUCTS
INTERFERON		See clinical criteria. PEG-INTRON: clinical reason Pegasys cannot be used.
PEGASYS (pegylated interferon alfa-2a)*	INFERGEN (interferon alfacon-1)* PEG-INTRON (pegylated interferon alfa-2b)*	
RIBAVIRIN		
ribavirin 200mg tablets and capsules*		

Z. Hypoglycemics Incretin Mimetics/Enhancers & Hypoglycemics, Insulin & Related Drugs
(classes were voted on together)

It was confirmed the pen is available for those clients needing low dose therapy. Baker asked about store brand relabeling of insulin through retail chains and if they were included on the list. Mart advised no as these medications do not qualify for federal rebates.

A motion was made by Baker and seconded by Caudill to approve the class as published.

Votes as follows:
Baker-yes, Bohac – yes, Caudill – yes, Davenport-yes, Dering-Anderson - yes, Elsasser - yes, Farho-yes, Gotschall - yes, Humphries – yes, Hutchins - yes, Juracek - yes, Mims – yes, Reichmuth – n/a, Rock-yes, Saunders – yes, Sorensen-yes, Thomsen-yes, Tonniges – yes, Ward-no

Hypoglycemics Incretin Mimetics/Enhancers

PREFERRED DRUGS	NON-PREFERRED DRUGS	CRITERIA FOR USE OF NON-PREFERRED PRODUCTS
	BYETTA (exenatide) subcutaneous* VICTOZA (liraglutide) subcutaneous*	(See clinical criteria) VICTOZA may be approved after trial on BYETTA or with compromised renal function.
	JANUVIA (sitagliptin)* JANUMET (sitagliptin/metformin)* KOMBIGLYZE XR (saxagliptin/metformin)* ONGLYZA (saxagliptin)*	JANUVIA, ONGLYZA: • Type 2 diabetes who have not achieved adequate glycemic control and have demonstrated compliance with a regimen of metformin, a sulfonylurea or a thiazolinedione. • HbA1C ≥ 7 JANUMET: Approve if has been on metformin and meets criteria for Januvia. KOMBIGLYZE XR: • Would need to meet criteria for Onglyza (saxagliptin)- which is failure to achieve glycemic control following use of metformin, a sulfonylurea or TZD.
	SYMLIN (pramlintide)*	SYMLIN see clinical criteria

Hypoglycemics, Insulin & Related Drugs

PREFERRED DRUGS	NON-PREFERRED DRUGS	CRITERIA FOR USE OF NON-PREFERRED PRODUCTS
HUMALOG (insulin lispro) HUMALOG MIX (insulin lispro/lispro protamine) HUMULIN (insulin) LANTUS (insulin glargine)	APIDRA (insulin glulisine) LEVEMIR (insulin detemir) NOVOLIN (insulin) NOVOLOG (insulin aspart) NOVOLOG MIX (insulin aspart/aspart protamine) …… Insulin pens /cartridges	1.Adverse reaction to, allergy or contraindication to preferred drugs, or 2 .Documentation of treatment failure with preferred drug. …… 1. Physical reasons, such as dexterity problems, vision impairment. 2. Must be Self Administered.

		3. NOT just for convenience. 4. or low dose (≦40 units per day)

A.A. Hypoglycemics, Meglitinides & Hypoglycemics, TZDs

A motion was made by Baker and seconded by Thomsen to accept the classes as published.

Votes as follows:
Baker-yes, Bohac – yes, Caudill – yes, Davenport-yes, Dering-Anderson - yes, Elsasser - yes, Farho-yes, Gotschall - yes, Humphries – yes, Hutchins - yes, Juracek - yes, Mims – yes, Reichmuth – n/a, Rock-yes, Saunders – yes, Sorensen-yes, Thomsen-yes, Tonniges – yes, Ward-yes

Hypoglycemics, Meglitinides

PREFERRED DRUGS	NON-PREFERRED DRUGS	CRITERIA FOR USE OF NON-PREFERRED PRODUCTS
PRANDIN (repaglinide)	nateglinide (generic for Starlix) PRANDIMET (repaglinide/metformin)	Non-preferred agents may be approved if the patient has a history of one preferred agent in the last 6 months.

Hypoglycemics, TZDs

PREFERRED DRUGS	NON-PREFERRED DRUGS	CRITERIA FOR USE OF NON-PREFERRED PRODUCTS
THIAZOLINEDIONES		
ACTOS (pioglitazone)	AVANDIA (rosiglitazone)	Avandia will be approved for patients failing to respond to one preferred agent.
TZD COMBINATIONS		
	ACTOPLUS MET (pioglitazone/metformin) ACTOPLUS MET XR AVANDAMET (rosiglitazone/metformin) AVANDARYL (rosiglitazone/glipizide) DUETACT (pioglitazone/glimepiride)	Combination agents will require clinical reason separate agents cannot be used.

B.B. Lipotropics, Other (non-statins) & Lipotropics, Statins

Questions were asked regarding why there are still claims for Zetia and it was advised that these were likely due to intolerance of statins.

A motion was made by Elsasser and seconded by Caudill

Votes as follows:
Baker-yes, Bohac – yes, Caudill – yes, Davenport-yes, Dering-Anderson - yes, Elsasser - yes, Farho-yes, Gotschall - yes, Humphries – yes, Hutchins - yes, Juracek - yes, Mims – yes, Reichmuth – n/a, Rock-yes, Saunders – yes, Sorensen-yes, Thomsen-yes, Tonniges – yes, Ward-yes

Lipotropics, Other (non-statins)

PREFERRED DRUGS	NON-PREFERRED DRUGS	CRITERIA FOR USE OF NON-PREFERRED PRODUCTS
BILE ACID SEQUESTRANTS		The non-preferred agent will be approved only after documented failure of the preferred agents.
cholestyramine (generic for Questran) colestipol (generic for Colestid)	WELCHOL (colesevalam)	
FIBRIC ACID DERIVATIVES		
gemfibrozil (generic for Lopid) TRICOR (fenofibrate) TRILIPIX (fenofibric acid)	ANTARA (fenofibrate) fenofibric acid fenofibrate FENOGLIDE (fenofibrate) FIBRICOR (fenofibric acid) LIPOFEN (fenofibrate) TRIGLIDE (fenofibrate)	
NIACIN		
NIACOR (niacin) NIASPAN (niacin ER)		
OMEGA-3 FATTY ACIDS		*May approve if TG ≥500. (verified by faxed copy of lab report) . If TG <500, OTC fish oils covered without prior authorization.
LOVAZA (omega-3 fatty acids)*		
CHOLESTEROL ABSORPTION INHIBITORS		
	ZETIA (ezetimibe)	Zetia will be approved for patients who have a diagnosis of hypercholesterolemia and have either failed statin monotherapy or have a documented intolerance to statins. Zetia treatment is only approved as an adjunct to concurrent statin therapy unless there is a documented intolerance to the statins.

Lipotropics, Statins

PREFERRED DRUGS	NON-PREFERRED DRUGS	CRITERIA FOR USE OF NON-PREFERRED PRODUCTS
STATINS		
CRESTOR (rosuvastatin) LIPITOR (atorvastatin) lovastatin (generic for Mevacor) pravastatin (generic for Pravachol) simvastatin (generic for Zocor)	ALTOPREV (lovastatin) LESCOL (fluvastatin) LESCOL XL (fluvastatin) LIVALO (pitavastatin**)**	Non-preferred agents may be approved if the patient has a history of two preferred agents in the last 12 months. ALTOPREV AND LESCOL XL require documentation of medical necessity of long acting form.
STATIN COMBINATIONS		
SIMCOR (simvastatin/niacin ER)	ADVICOR (lovastatin/niacin ER) CADUET (atorvastatin/ amlodipine)	Vytorin will be approved for patients failing a minimum 3

	VYTORIN (simvastatin/ezetimibe)	month trial of standard dose statin

C.C. Macrolides & Ketolides (Oral)

Gary Elsasser made a motion to amend that clarithromycin could be authorized if there is a diagnosis of *mycobacterium avium intracellulare (*MAI) infection and a second was made by Hutchins.

After further discussion, Dering-Anderson called the question and Juracek seconded to pass the class with the recommended amendment.

Votes as follows:
Baker-yes, Bohac – yes, Caudill – yes, Davenport-yes, Dering-Anderson - yes, Elsasser - yes, Farho-yes, Gotschall - yes, Humphries – yes, Hutchins - yes, Juracek - yes, Mims – yes, Reichmuth – n/a, Rock-yes, Saunders – yes, Sorensen-yes, Thomsen-yes, Tonniges – yes, Ward-yes

PREFERRED DRUGS	NON-PREFERRED DRUGS	CRITERIA FOR USE OF NON-PREFERRED PRODUCTS
KETOLIDES		
	KETEK (telithromycin)	1. Documentation of any antibiotic use within the last 28 days and 2. Diagnosis is Community Acquired Pneumonia. 3. 18 years of age or older
MACROLIDES		
azithromycin (generic for Zithromax) erythromycin	clarithromycin ER (generic for Biaxin XL) clarithromycin IR (generic for Biaxin) PCE (brand name erythromycin) ZMAX (brand name azithromycin ER) ZITHROMAX (brand name azithromycin)	1. Adverse reaction to, allergy or contraindication to preferred drugs, or 2. Documentation of treatment failure with preferred drug. Clarithromycin: May be approved for diagnosis of 1) helicobacter pylori when there is concurrent administration of a proton pump inhibitor. (allow 28 days of treatment per 365 days) 2) atypical mycobacterial disease including *mycobacterium avium intracellulare (*MAI)

D.D. Multiple Sclerosis Drugs

Motion was made by Thomsen and seconded by Humphries to approve the class as published.

Votes as follows:
Baker-yes, Bohac – yes, Caudill – yes, Davenport-yes, Dering-Anderson - yes, Elsasser - yes, Farho-yes, Gotschall - yes, Humphries – yes, Hutchins - yes, Juracek - yes, Mims – yes, Reichmuth – n/a, Rock - n/a, Saunders – yes, Sorensen-yes, Thomsen-yes, Tonniges – yes, Ward-yes

PREFERRED DRUGS	NON-PREFERRED DRUGS	CRITERIA FOR USE OF NON-PREFERRED PRODUCTS
AVONEX (interferon beta-1a) BETASERON (interferon beta-1b)	REBIF (interferon beta-1a) EXTAVIA (interferon beta-1b)	Extavia, Rebif: Non-preferred agents will be

COPAXONE (glatiramer)	GILENYA (fingolimod) AMPYRA (dalfampridine)	approved only after documented failure of one preferred agent. Ampyra: DUR Initial authorization for 12 weeks, requiring gait disorder associated with MS, no seizure diagnosis, no moderate or severe renal impairment, and baseline 25 foot, timed walk. Additional prior authorizations every 6 months, based on maintained 20% improvement of baseline in 25-foot walk. EDSS score not greater than 7. Gilenya: Treatment failure with or contraindication to one preferred agent.

E.E. (PAH) Pulmonary Arterial Hypertension Agents (Oral & inhaled)

A motion was made by Dering-Anderson and seconded by Juracek to approve the class as published.

Votes as follows:
Baker-yes, Bohac – yes, Caudill – yes, Davenport-yes, Dering-Anderson - yes, Elsasser - yes, Farho-yes, Gotschall - yes, Humphries – yes, Hutchins - yes, Juracek - yes, Mims – yes, Reichmuth – n/a, Rock - n/a, Saunders – yes, Sorensen-yes, Thomsen-yes, Tonniges – yes, Ward-yes

PREFERRED DRUGS	NON-PREFERRED DRUGS	CRITERIA FOR USE OF NON-PREFERRED PRODUCTS
ADCIRCA (tadalafil)* REVATIO (sildenafil)* TRACLEER (bosentan) VENTAVIS INHALATION (iloprost)	LETAIRIS (ambrisentan) TYVASO INHALATION (treprostinil)	Revatio and Adcirca require diagnosis of PAH. LETAIRIS: 1.Adverse reaction to, allergy or contraindication to bosentan, or 2 .Documentation of treatment failure with bosentan.

F.F. Pancreatic Enzymes

A motion was made by Saunders and seconded by Sorensen to approve the class as published.
Votes as follows:
Baker-yes, Bohac – yes, Caudill – yes, Davenport-yes, Dering-Anderson - yes, Elsasser - yes, Farho-yes, Gotschall - yes, Humphries – yes, Hutchins – n/a, Juracek - yes, Mims – yes, Reichmuth – n/a, Rock-n/a, Saunders – yes, Sorensen-yes, Thomsen-yes, Tonniges – yes, Ward-yes

PREFERRED DRUGS	NON-PREFERRED DRUGS	CRITERIA FOR USE OF NON-PREFERRED PRODUCTS
CREON 6000, 12,000, 24,000 units PANCRELIPASE™ (pancrelipase) (authorized generic) ZENPEP (pancrelipase)	PANCREAZE (pancrelipase)	1.Adverse reaction to, allergy or contraindication to preferred drugs, or 2 .Documentation of treatment failure with two preferred drugs.

G.G. Phosphate Binders

A motion was made by Thomsen and seconded by Rock to accept the class as published.

Votes as follows:
Baker-yes, Bohac – yes, Caudill – yes, Davenport-yes, Dering-Anderson - yes, Elsasser - yes, Farho-yes, Gotschall - yes, Humphries – yes, Hutchins – n/a, Juracek - yes, Mims – yes, Reichmuth – n/a, Rock-yes, Saunders – yes, Sorensen-yes, Thomsen-yes, Tonniges – yes, Ward-yes

PREFERRED DRUGS	NON-PREFERRED DRUGS	CRITERIA FOR USE OF NON-PREFERRED PRODUCTS
PHOSLO (calcium acetate) RENAGEL (sevelamer HCl)	calcium acetate ELIPHOS (calcium acetate) FOSRENOL (lanthanum) RENVELA (sevelamer carbonate)	Non-preferred agents may be approved if the patient has a history of one preferred agent in the last 6 months

H.H. Proton Pump Inhibitors (Oral)

Gotschall made a motion to add pantoprazole as a preferred product. It was seconded by Dering-Anderson.

Votes as follows:
Baker-yes, Bohac – yes, Caudill – yes, Davenport-yes, Dering-Anderson - yes, Elsasser - yes, Farho-yes, Gotschall - yes, Humphries – yes, Hutchins - yes, Juracek - yes, Mims – yes, Reichmuth – n/a, Rock-yes, Saunders – yes, Sorensen-yes, Thomsen-yes, Tonniges – yes, Ward-yes

PREFERRED DRUGS	NON-PREFERRED DRUGS	CRITERIA FOR USE OF NON-PREFERRED PRODUCTS
omeprazole pantoprazole (generic for Protonix)	ACIPHEX (rabeprazole) DEXILANT, KAPIDEX (dexlansoprazole) lansoprazole (generic for Prevacid) NEXIUM (esomeprazole) NEXIUM SUSPENSION (esomeprazole) omeprazole/sodium bicarbonate (generic for Zegerid Rx) PREVACID (lansoprazole) PREVACID SOLU-TAB PRILOSEC (omeprazole)	See existing prior authorization criteria.

I.I. Skeletal Muscle Relaxants

A motion was made by Dering-Anderson and seconded by Elsasser to pass the class as published.

Votes as follows:
Baker-yes, Bohac – yes, Caudill – yes, Davenport-yes, Dering-Anderson - yes, Elsasser - yes, Farho-yes, Gotschall - yes, Humphries – yes, Hutchins - yes, Juracek - yes, Mims – yes, Reichmuth – n/a, Rock-yes, Saunders – yes, Sorensen-yes, Thomsen-yes, Tonniges – yes, Ward-yes

PREFERRED DRUGS	NON-PREFERRED DRUGS	CRITERIA FOR USE OF NON-PREFERRED PRODUCTS
baclofen (generic for Liorisal)	AMRIX (cyclobenzaprine)	The non-preferred agents will be approved for patients with

chlorzoxazone (generic for Parafon) cyclobenzaprine (generic for Flexeril) methocarbamol (generic for Robaxin) tizanidine tabs (generic for Zanaflex)	carisoprodol (generic for Soma) carisoprodol compound dantrolene (generic for Dantrium) FEXMID (cyclobenzaprine) orphenadrine (generic for Norflex) orphenadrine compound metaxalone (generic for Skelaxin) SOMA (carisoprodol) ZANAFLEX (tizanidine) (brand name tablets and capsules)	documented failure of at least a one week trial each of two preferred agents. For carisoprodol: • use will be limited to no more than 30 days • additional authorization will not be granted for at least six months following the last day of the previous course of therapy • approval will not be granted for patients with a history of meprobamate use in the previous two years Concurrent use with opioids requires prior authorization AMRIX, FEXMID: Clinical reason regular release cannot be used. Only for short term use. ZANAFLEX: Clinical reason generic cannot be used.

J.J. Tetracyclines

A motion was made by Caudill and seconded by Elsasser to pass the class as published.

Votes as follows:
Baker-yes, Bohac – yes, Caudill – yes, Davenport-yes, Dering-Anderson - yes, Elsasser - yes, Farho-yes, Gotschall - yes, Humphries – yes, Hutchins - yes, Juracek - yes, Mims – yes, Reichmuth – n/a, Rock-yes, Saunders – yes, Sorensen-yes, Thomsen-yes, Tonniges – yes, Ward-yes

PREFERRED DRUGS	NON-PREFERRED DRUGS	CRITERIA FOR USE OF NON-PREFERRED PRODUCTS
doxycycline hyclate IR (generic for Vibramycin) minocycline HCl **capsules** (generic for Minocin, Dynacin) tetracycline HCl (generic for Sumycin)	demeclocycline* DORYX (doxycycline pelletized) doxycycline hyclate DR (generic for Vibratabs) doxycycline monohydrate (generic for Monodox) minocycline HCl **tablets** (generic for Dynacin, Murac) minocycline HCl extended release (generic for Solodyn) ORACEA (doxycycline monohydrate) SOLODYN (minocycline HCl) VIBRAMYCIN SUSPENSION (doxycycline suspension)	Demeclocycline:* Treatment of Syndrome of Inappropriate Antidiuretic Hormone (SIADH) --- 1. Adverse reaction to, allergy or contraindication to preferred drugs, or 2. Documentation of treatment failure with two preferred drugs.

K.K. Ulcerative Colitis Drugs

A motion was made to make Pentasa preferred and approve the rest of the class as published by Sorensen and seconded by Tonniges.

Votes as follows:
Baker-yes, Bohac – yes, Caudill – yes, Davenport-yes, Dering-Anderson - yes, Elsasser - yes, Farho-yes, Gotschall - yes, Humphries – yes, Hutchins - yes, Juracek - yes, Mims – yes, Reichmuth – n/a, Rock-yes, Saunders – yes, Sorensen-yes, Thomsen-yes, Tonniges – yes, Ward-yes

PREFERRED DRUGS	NON-PREFERRED DRUGS	CRITERIA FOR USE OF NON-PREFERRED PRODUCTS
ORAL		
APRISO (mesalamine) ASACOL (mesalamine) 400MG balsalazide (generic for Colazal) PENTASA (mesalamine) sulfasalazine (generic for Azulfidine)	ASACOL **HD** (mesalamine) 800MG DIPENTUM (olsalazine) LIALDA (mesalamine)	1. Adverse reaction to, allergy or contraindication to preferred drugs, or 2. Documentation of treatment failure with one preferred drug. ASACOL **HD** AND LIALDA: Clinical reason cannot use the preferred form of mesalamine.
RECTAL		
CANASA (mesalamine)	mesalamine SFROWASA (mesalamine)	1. Adverse reaction to, allergy or contraindication to preferred drugs, or 2. Documentation of treatment failure with one preferred drug.

L.L. Conflicts of Interest

A motion was made by Tonniges and seconded by Elsasser to require speakers to declare if they have a conflict of interest. Letters written to the Department would not be forwarded to the Committee if conflict of information is not included with the letter. Voting was unanimous.

M.M. Request for feedback
Dr. Tonniges requested that the Department report back to the Committee on cost savings generated and any other feedback on the workings of the Committee. Minchow reported that the Department is very happy with the savings and the quality of input from all of the members on the Committee. In fact, the Department recently recommended that the PDL be expanded.

N.N. Adjournment

A motion was made by Caudill and seconded by Baker to adjourn at 3:30 pm. Voting was unanimous in favor of adjournment.

Next meeting:
The next scheduled meeting of the Nebraska Medicaid Pharmaceutical and Therapeutics Committee is scheduled for:
Wednesday, November 9, 2011, 9 am
Mahoney State Park, Ashland, NE

Recorded by: Candace Hupp, Project Coordinator
Nebraska Medicaid & Long-Term Care