DIVISION OF MEDICAID AND LONG-TERM CARE

PHARMACEUTICAL AND THERAPEUTICS COMMITTEE MEETING
MINUTES

November 14, 2012 9am
Mahoney State Park, Peter Kiewit Lodge
Ashland, NE

Members Present
Claire Baker M.D.
Kristi Bohac, Master of Divinity
Chris Caudill M.D.
Allison Dering-Anderson Pharm.D.
James Dube' Pharm.D.
Gary Elsasser Pharm.D.
Linda Farho Pharm.D.
Jeff Gotschall M.D.
Nathan Green D.O.
Laurie Humphries M.D.
Joyce Juracek Pharm.D.
Kevin Reichmuth M.D.
Eileen Rock M.D.
Ken Saunders Pharm.D.
Christopher Sorensen Pharm.D.
Eric Thomsen M.D

Members Absent:
Yvonne Davenport M.D. (excused)
Thomas Tonniges M.D. (excused)
Angie Ward R.Ph. (excused)

DHHS Staff
Jenny Minchow Pharm.D.
Mary Robertson Staff Assistant

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

I. Call to Order: The meeting was called to order at 9:00am. The agenda was posted on the Nebraska Medicaid Pharmacy MMA web site on October 15, 2012. A copy of the Open Meetings Act was posted at the back of the meeting room.
II. Introduction of new Committee Member, Nathan Green D.O. Jenny Minchow announced that Grace Mims resigned from the Committee and a replacement has not been found yet.
III. Roll Call: see list above
IV. Conflict of Interest: No new conflicts of interest were reported.
V. Approval of minutes: The minutes of the May 09, 2012 meeting were unanimously approved as written with a motion from Dering-Anderson and second by Caudill.
VI. Public Testimony

Drug/Class	Status	Speaker	Affiliation
ANTIPARKINSON'S AGENTS			
Neupro	NP	Tammy Sova Pharm.D.	UCB, Inc.
COPD AGENTS			
Daliresp	NP	Amir Karimzadeh Pharm.D.	Forest Research Institute
CYTOKINE & CAM ANTAGONISTS			
Cimzia	NP	Tammy Sova Pharm.D.	UCB, Inc.

IMMUNOMODULATORS, ATOPIC DERMATITIS			
Protopic	NP	Lisa Pulkrabek RN	Astellas Pharma
ADHD MEDICATIONS			
Strattera	P	Brieana Buckley Pharm.D.	Lilly
Intuniv	NP	Nicole Griswold Pharm.D.	Shire

P= Preferred
NP= Non-preferred

VII. A motion was made and seconded to move into closed session.
Cost issues discussed in Closed Session.
VIII. A motion was made and seconded to move back into open session. Open Session resumed.
IX. **Consent Agenda**:
No items were removed from the Consent Agenda.
Motion to approve by Caudill and seconded by Dube' to accept recommendations as published.

ALZHEIMER'S DRUGS

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
CHOLINESTERASE INHIBITORS		
donepezil (generic for Aricept) donepezil ODT (generic for Aricept ODT) EXELON Transdermal (rivastigmine)	EXELON Oral Solution (rivastigmine) galantamine (generic for Razadyne) galantamine ER (generic for Razadyne ER) rivastigmine (generic for Exelon) rivastigmine (generic for Exelon oral)	1.Adverse reaction to, allergy or contraindication to preferred drugs, or 2 .Documentation of treatment failure with preferred drug when given more than 120 days in the previous six Months.
NMDA RECEPTOR ANTAGONIST		
NAMENDA (memantine)		

ANTIHYPERURICEMICS

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
allopurinol (generic for Zyloprim) probenecid probenecid/colchicine (generic for Col-Probenecid)	COLCRYS (colchicine)* ULORIC (febuxostat)*	**Colcrys™ (colchicine):** • **Diagnosis of familial Mediterranean fever (FMF);** o Maximum daily dose: 2.4mg o Minimum age: 4 o Length of approval: 12 months o Quantity limit: 120 per 30 days • **Or Diagnosis of Gout** o Approve if there has been a treatment failure with any preferred drug o Quantity limit: 60 per 28 days o Minimum age: 16 o Length of approval: 6 months

BRAND PRODUCTS IN UPPER CASE generic names in lower case. If only the generic name is listed as preferred, then the BRAND name of that product is non-preferred; unless the brand name product is ALSO listed as preferred.
*Indicates that a clinical prior authorization is required despite the medication's status as preferred or non-preferred.
QL indicates quantity limits.
NR indicates product was not reviewed. New Drug criteria will apply.

		Uloric: Allergy or adverse reaction to, treatment failure with, or contraindication to allopurinol.

BILE SALTS

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
ursodiol **capsule** (generic for Actigall, Urso)	CHENODAL (chenodiol) URSO (ursodiol) URSO FORTE (ursodiol) ursodiol **tablet**	1.Adverse reaction to, allergy or contraindication to preferred drugs, or 2 .Documentation of treatment failure with preferred drug.

OPHTHALMICS, ANTI-INFLAMMATORIES

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
CORTICOSTEROIDS		
dexamethasone (generic for Maxidex) FLAREX (fluorometholone) fluorometholone 0.1% (generic for FML) FML FORTE (fluorometholone 0.25%) FML S.O.P. (fluorometholone 0.1%) LOTEMAX **DROPS** (loteprednol 0.5%) MAXIDEX (dexamethasone) PRED MILD (prednisolone 0.12%) prednisolone acetate 1% (generic for Omnipred, Pred Forte)	DUREZOL (difluprednate) LOTEMAX **OINTMENT** (loteprednol) prednisolone sodium phosphate 1% (formerly generic for Inflamase) VEXOL (rimexolone)	1.Adverse reaction to, allergy or contraindication to preferred drugs, or 2 .Documentation of treatment failure with two preferred drugs.
NSAID		
diclofenac (generic for Voltaren) flurbiprofen (generic for Ocufen)	ACUVAIL (ketorolac 0.45%) bromfenac (generic for Bromday) ketorolac LS 0.4% (generic for Acular LS) ketorolac 0.5% (generic for Acular) NEVANAC (nepafenac)	1.Adverse reaction to, allergy or contraindication to preferred drugs, or 2 .Documentation of treatment failure with preferred drug.

Votes as follows:
Baker-yes, Caudill-yes, Davenport-absent, Dering-Anderson-yes, Dube'-yes, Elsasser-yes, Farho-yes, Gotschall-yes, Green–yes, Humphries–yes, Johnson-Bohac–yes, Juracek-yes, Reichmuth–yes, Rock-yes, Sorensen-yes, Thomsen-yes, Tonniges-absent, Ward-absent.
Motion carried.

X. Therapeutic Class Reviews:

A. ANTIHISTAMINES, MINIMALLY SEDATING

Motion to approve by Dering-Anderson and seconded by Juracek to accept recommendations as published.

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
cetirizine (generic for Zyrtec) (swallow tablets and syrup) loratadine (generic for Claritin)	cetirizine **chewable** (generic for Zyrtec) desloratadine (generic for Clarinex)	1. Adverse reaction to, contraindication to or treatment failure with both cetirizine and

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(swallow tablets and syrup)	levocetirizine (generic for Xyzal) loratadine dispersible (generic for Claritin Reditabs)	loratadine

Votes as follows:
Baker-yes, Caudill-yes, Davenport-absent, Dering-Anderson-yes, Dube'-yes, Elsasser-yes, Farho-yes, Gotschall-yes, Green – yes, Humphries – yes, Johnson-Bohac – yes, Juracek-yes, Reichmuth – yes, Rock- yes, Sorensen-yes, Thomsen-yes, Tonniges-absent, Ward-absent.
Motion carried.

B. ANTIHYPERTENSIVES, SYMPATHOLYTICS

Motion to approve by Rock and seconded by Elsasser to accept recommendations as published.

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
CATAPRES-TTS (transdermal) clonidine ORAL (generic for Catapres) CLORPRES (chlorthalidone/clonidine) guanfacine (generic for Tenex) methyldopa methyldopa/hydrochlorothiazide	clonidine transdermal reserpine	1.Adverse reaction to, allergy or contraindication to preferred drugs, or 2 .Documentation of treatment failure with preferred drug.

Votes as follows:
Baker-yes, Caudill-yes, Davenport-absent, Dering-Anderson-yes, Dube'-yes, Elsasser-yes, Farho-yes, Gotschall-yes, Green – yes, Humphries – yes, Johnson-Bohac – yes, Juracek-yes, Reichmuth – yes, Rock- yes, Sorensen-yes, Thomsen-yes, Tonniges-absent, Ward-absent.
Motion carried

C. ANTIPARKINSON'S AGENTS

Motion to approve by Dering-Anderson and seconded by Dube' to accept recommendations as published.

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
ANTICHOLINERGICS		
benztropine (generic for Cogentin) trihexyphenidyl (generic for Artane)		
COMT INHIBITORS		
	COMTAN (entacapone) TASMAR (tolcapone)	Approve if using as add on therapy with a levodopa containing drug.
DOPAMINE AGONISTS		
bromocriptine (generic for Parlodel) pramipexole (generic for Mirapex) ropinirole (generic for Requip)	MIRAPEX ER (pramipexole) NEUPRO (rotigotine transdermal) REQUIP (ropinirole) ropinirole ER (generic for Requip XL)	1.Adverse reaction to, allergy or contraindication to one preferred drug with the same group, or 2 .Documentation of treatment failure with preferred drug. AND MIRAPEX ER will only be

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		approved for Parkinson's Disease. AND REQUIP XL will only approved for Parkinson's Disease **Neupro ®transdermal patch (rotigotine)** • For Parkinson's Disease: Is there a clinical reason (i.e. documented swallowing disorder) that a preferred oral agent cannot be used? If there is no clinical reason as noted above, approval requires trial of ONE preferred agent. • For Restless Legs Syndrome (RLS): Approval requires trial on both ropinirole and pramipexole, or clinical reasons these agents cannot be tried.
MAO-B INHIBITORS		1.Adverse reaction to, allergy or contraindication to one preferred drug within the same group, or 2 .Documentation of treatment failure with preferred drug.
selegiline **tablets** (generic for Eldepryl)	AZILECT (rasagiline) selegiline **capsules** (gen. for Eldepryl) ZELAPAR (selegiline dispersible)	
OTHER ANTIPARKINSON'S DRUGS		
carbidopa/levodopa (generic for Sinemet) carbidopa/levodopa ER (generic for Sinemet CR) STALEVO (levodopa/carbidopa/entacapone)	carbidopa/levodopa ODT (generic for Parcopa) levodopa/carbidopa/entacapone (generic for Stalevo)	**Zelapar®:** May approve if documented swallowing disorder. **Parcopa®:** May approve if documented swallowing disorder.

Votes as follows:
Baker-yes, Caudill-yes, Davenport-absent, Dering-Anderson-yes, Dube'-yes, Elsasser-yes, Farho-yes, Gotschall-yes, Green – yes, Humphries – yes, Johnson-Bohac – yes, Juracek-yes, Reichmuth – yes, Rock- yes, Sorensen-yes, Thomsen-yes, Tonniges-absent, Ward-absent.
Motion carried

D. BRONCHODILATORS, BETA AGONIST

Motion to approve by Caudill and seconded by Sorensen to accept recommendations as published; ***except*** to make the following changes in criteria:

1. Remove from Ventolin/Proair with Dose Counter "Will allow without prior authorization for children 18 and younger."
2. Criteria number 4. Correct Proventil to Proair.

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
INHALERS-Short Acting		
PROVENTIL HFA (albuterol)	MAXAIR (pirbuterol) PROAIR HFA (albuterol) VENTOLIN HFA (albuterol) XOPENEX HFA (levalbuterol)	1. Adverse reaction to, allergy or contraindication to preferred drugs, or 2. Documentation of treatment

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		failure with a preferred drug. 3. Maxair – Documentation of treatment failure of preferred agent with use of a spacer. 4. Ventolin/~~Proventil~~ *(Corrected to Proair with Dose Counter)* May be approved without trials on preferred if prescriber documents need for dose counter on canister. ~~Will allow without prior authorization for children 18 and younger.~~
INHALERS – Long Acting		
FORADIL (formoterol) (Prior authorization of Foradil not required if diagnosis of COPD in claims history or co-administered with inhaled steroid.)	ARCAPTA (indacaterol) SEREVENT (salmeterol)	Arcapta and Serevent: 1. Adverse reaction to, allergy or contraindication to preferred drug, or 2. Documentation of treatment failure with a preferred drug. In 2010 the FDA contraindicated the use of Long Acting Beta Agonists in asthma WITHOUT an asthma controller medication, such as an inhaled corticosteroid.
INHALATION SOLUTION		
albuterol (2.5mg/3ml premix or 2.5mg/0.5ml)	albuterol low dose (0.63mg/3ml & 1.25mg/3ml) …… albuterol/ipratropium (generic for Duoneb) …… BROVANA (arformoterol) levalbuterol (generic for Xopenex) PERFOROMIST (formoterol)	If the patient weighs less than 15kg (33lbs) the call center may approve the lower dose. OR May approve lower dose if it is felt that the parent is not able to reliably measure drug. …… Combination agent covered as separate prescriptions. …… 1. Adverse reaction to, allergy or contraindication to preferred drugs, or 2. Documentation of treatment failure with preferred drug.
ORAL		
albuterol **tablets, syrup** terbutaline (generic for Brethine)	albuterol ER (generic for Vospire ER) metaproterenol (formerly generic for Alupent)	1. Adverse reaction to, allergy or contraindication to preferred drugs, or 2. Documentation of treatment failure with preferred drug.

Votes as follows:
Baker-yes, Caudill-yes, Davenport-absent, Dering-Anderson-yes, Dube'-yes, Elsasser-yes, Farho-yes, Gotschall-yes, Green – yes, Humphries – yes, Johnson-Bohac – yes, Juracek-yes, Reichmuth – yes, Rock- yes, Sorensen-yes, Thomsen-yes, Tonniges-absent, Ward-absent.
Motion carried

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E. COPD AGENTS

Motion to approve by Dering-Anderson and seconded by Elsasser to list theophylline separately from Daliresp as oral agent, to remove aminophylline and to make the following changes in the recommendations for the Daliresp criteria:
Criteria number 2. Change to: Require documentation that bronchodilators have been *utilized*.
Criteria number 3. Change to: Documentation of history of *one* exacerbation (office visits, hospitalization) in last year.
Additional Criteria: For annual renewal of Daliresp, would not require documentation of exacerbation while on Daliresp.

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
INHALERS		
ATROVENT HFA (ipratropium) COMBIVENT (albuterol/ipratropium) SPIRIVA (tiotropium)	COMBIVENT RESPIMAT (albuterol/ipratropium) Becomes preferred when national supply of plain Combivent exhausted.]	
INHALATION SOLUTION		
ipratropium solution (generic for Atrovent)	albuterol/ipratropium (generic for Duoneb)	Combination agent covered as separate prescriptions.
ORAL AGENT		
theophylline	DALIRESP (roflumilast)	1. Diagnosis of severe COPD associated with chronic bronchitis. 2. Require documentation that bronchodilators have been ~~maximized~~ change to "used". 3. Documentation of history of ~~two~~ change to "one" exacerbation~~s~~ (office visits, hospitalization) in last year. 4. Limit of one per day. 5. Age 19 or older.

Votes as follows:
Baker-yes, Caudill-yes, Davenport-absent, Dering-Anderson-yes, Dube'-yes, Elsasser-yes, Farho-yes, Gotschall-yes, Green – yes, Humphries – yes, Johnson-Bohac – yes, Juracek-yes, Reichmuth – yes, Rock- yes, Sorensen-yes, Thomsen-yes, Tonniges-absent, Ward-absent.
Motion carried

F. CYTOKINE & CAM ANTAGONISTS

Motion to approve by Gotschall and seconded by Rock to accept recommendations as published.

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:

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ENBREL (etanercept) HUMIRA (adalimumab)	CIMZIA (certolizumab pegol) KINERET (anakinra) ORENCIA (abatacept**) S.C.** SIMPONI (golimumab)	1. Adverse reaction to, contraindication to *one* preferred drug~~s~~, or 2. Documentation of treatment failure with preferred drug.

Votes as follows:
Baker-yes, Caudill-yes, Davenport-absent, Dering-Anderson-yes, Dube'-yes, Elsasser-yes, Farho-yes, Gotschall-yes, Green – yes, Humphries – yes, Johnson-Bohac – yes, Juracek-yes, Reichmuth – yes, Rock- yes, Sorensen-yes, Thomsen-yes, Tonniges-absent, Ward-absent.
Motion carried

G. GLUCOCORTICOIDS, INHALED

Motion to approve by Dering-Anderson and seconded by Juracek to accept recommendations as published.

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
GLUCOCORTICOIDS		
ASMANEX (mometasone) FLOVENT DISKUS (fluticasone) FLOVENT HFA (fluticasone) PULMICORT FLEXHALER (budesonide) QVAR (beclomethasone)	ALVESCO (ciclesonide)	1. Adverse reaction to, allergy or contraindication to preferred drugs, or 2. Documentation of treatment failure with two preferred drugs within last 6 months.
GLUCOCORTICOID/BRONCHODILATOR COMBINATIONS		
ADVAIR DISKUS (fluticasone/salmeterol) ADVAIR HFA (fluticasone/salmeterol) DULERA (mometasone/formoterol) SYMBICORT (budesonide/formoterol)		1. Adverse reaction to, allergy or contraindication to preferred drugs, or 2. Documentation of treatment failure with two preferred drugs.
INHALATION SOLUTION		
	budesonide respules PULMICORT RESPULES (budesonide)	No prior authorization required for use in Children ages 1-8. For age 9 and up, will require documentation of inability to use inhaler.

Votes as follows:
Baker-yes, Caudill-yes, Davenport-absent, Dering-Anderson-yes, Dube'-yes, Elsasser-yes, Farho-absent, Gotschall-yes, Green – yes, Humphries – yes, Johnson-Bohac – yes, Juracek-yes, Reichmuth – yes, Rock- yes, Sorensen-yes, Thomsen-yes, Tonniges-absent, Ward-absent.
Motion carried

H. IMMUNOMODULATORS, ATOPIC DERMATITIS

Motion by Gotschall and seconded by Caudill to classify both Elidel and Protopic as preferred *but*,
- require trial on topical steroid for both,
- and also require trial on Elidel for Protopic approval.
- *Not* require a retrial on a steroid for annual reauthorization.

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:

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ELIDEL (pimecrolimus) PROTOPIC (tacrolimus)		1. Adverse reaction to, allergy or contraindication to preferred drug, or 2. Documentation of treatment failure with preferred drug. **AND** 3. Trial on topical steroid.

Votes as follows:
Baker-yes, Caudill-yes, Davenport-absent, Dering-Anderson-yes, Dube'-yes, Elsasser-yes, Farho-absent, Gotschall-yes, Green – yes, Humphries – yes, Johnson-Bohac – yes, Juracek-yes, Reichmuth – yes, Rock- yes, Sorensen-yes, Thomsen-yes, Tonniges-absent, Ward-absent.
Motion carried

12:00 a motion was made by Dering-Anderson and seconded by Juracek to go into closed session for cost discussions. Decision unanimous.

12:50 A motion was made by Dube' and seconded by Baker to resume open session. Decision unanimous.

I. INTRANASAL RHINITIS DRUGS

Motion to approve by Sorensen and seconded by Rock to accept recommendations as published.

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
ANTICHOLINERGICS		
ipratropium (generic for Atrovent)		
ANTIHISTAMINES		
ASTELIN (azelastine) ASTEPRO (azelastine) PATANASE (olopatadine)	azelastine (generic for Astelin) DYMISTA (azelastine/fluticasone)	1. Adverse reaction to, allergy or contraindication to preferred drug, or 2. Documentation of treatment failure with preferred drug.
CORTICOSTEROIDS		
fluticasone (generic for Flonase) NASACORT AQ (triamcinolone) NASONEX (mometasone)	BECONASE AQ (beclomethasone) flunisolide (generic for product formerly known as Nasalide) OMNARIS (ciclesonide) QNASL (beclomethasone) RHINOCORT AQUA (budesonide) triamcinolone (generic for Nasocort) VERAMYST (fluticasone) ZETONNA (ciclesonide)	1. Adverse reaction to, allergy or contraindication to preferred drugs, or 2. Documentation of treatment failure with preferred drug. Rhinocort Aqua: is Pregnancy Category B, so allow during pregnancy. Veramyst: prior authorization NOT required for children 12 and younger.

Votes as follows:
Baker-yes, Caudill-yes, Davenport-absent, Dering-Anderson-yes, Dube'-yes, Elsasser-yes, Farho-yes, Gotschall-yes, Green – yes, Humphries – yes, Johnson-Bohac – yes, Juracek-yes, Reichmuth – yes, Rock- yes, Sorensen-yes, Thomsen-yes, Tonniges-absent, Ward-absent.
Motion carried

J. LEUKOTRIENE MODIFIERS

Motion to approve by Reichmuth and seconded by Rock to accept recommendations as amended below:

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:

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ACCOLATE (zafirlukast) montelukast (generic for Singulair CHEWABLE AND SWALLOW TABLETS)	montelukast granules (generic for SINGULAIR **GRANULES)** zafirlukast (generic for Accolate) ZYFLO (zileuton) ZYFLO CR (zileuton)	1. Adverse reaction to, allergy or contraindication to preferred drugs, or 2. Documentation of treatment failure with preferred drug. 3. ~~Accolate~~ CHANGED TO ZYFLO: allow to be added on to Singulair when step-up therapy is required.

Votes as follows:
Baker-yes, Caudill-yes, Davenport-absent, Dering-Anderson-yes, Dube'-yes, Elsasser-yes, Farho-yes, Gotschall-yes, Green – yes, Humphries – yes, Johnson-Bohac – yes, Juracek-yes, Reichmuth – yes, Rock- yes, Sorensen-yes, Thomsen-yes, Tonniges-absent, Ward-absent.
Motion carried

K. NSAIDS

Motion to approve by Rock and seconded by Baker to accept recommendations as published.

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
COX-I SELECTIVE		
diclofenac potassium (generic for Cataflam) diclofenac sodium (generic for Voltaren) etodolac (generic for Lodine) fenoprofen (generic for Nalfon) flurbiprofen (generic for Ansaid) ibuprofen OTC, Rx (generic for Advil, Motrin,) indomethacin capsule (generic for Indocin) ketoprofen (generic for Orudis, Oruvail) ketorolac (generic for Toradol) meclofenamate (generic for Meclomen) meloxicam tablet (generic for Mobic) nabumetone (generic for Relafen) naproxen Rx, OTC (generic for Naprosyn) naproxen **suspension** (Naprosyn) oxaprozin (generic for Daypro) sulindac (generic for Clinoril)	diclofenac SR (generic for Voltaren-XR) diflunisal (generic for Dolobid) etodolac SR indomethacin ER, and rectal ketoprofen ER mefenamic acid (generic for Ponstel) melixocam **suspension** naproxen EC piroxicam (generic for Feldene) tolmetin (generic for Tolectin) **TOPICAL:** FLECTOR PATCH (diclofenac) PENNSAID SOLUTION (diclofenac) VOLTAREN GEL (diclofenac) **ALL BRAND NAME NSAIDs ARE NON-PREFERRED.** CAMBIA (diclofenac oral solution) DUEXIS (ibuprofen/famotidine) SPRIX (ketorolac nasal) VIMOVO (naprosyn/esomeprazole) ZIPSOR (diclofenac)	1.Adverse reaction to, allergy or contraindication to preferred drugs, or 2 .Documentation of treatment failure of no less than a 30 day trial with two preferred drugs. SPRIX: • Patient is unable to tolerate, swallow or absorb oral NSAIDS (check to see if there are any current PO meds on profile) OR • Contraindication to oral NSAID (e.g. active GI bleed) OR • Patient has tried 2 preferred oral NSAID agents Approvals for Date Of Service only – recommended maximum duration of therapy is 5 days.
NSAID/GI PROTECTANT COMBINATIONS		
	ARTHROTEC (diclofenac/misoprostol)	diclofenac and misoprostol both available individually without prior authorization.

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COX-II SELECTIVE		
	CELEBREX (celecoxib)*	https://nebraska.fhsc.com/Downloads/NEcriteria_CoxII-20110809.pdf

Additional Criteria:

FLECTOR® (diclofenac epolamine) Patch:

- Indicated for acute pain due to sprain/strain/contusion; should be applied to the most painful site.
- Oral generic diclofenac products should be recommended and tried first unless patient is unable to take oral dosage form (i.e. difficulty swallowing).
- Review of medication history should not indicate concurrent use of an oral NSAID. If found, verify and document that the oral dosage form has been discontinued.

PENNSAID® (diclofenac sodium) 1.5% Topical Solution:

- Indicated for treatment of signs and symptoms of osteoarthritis of the knee(s)
- Oral generic diclofenac products should be recommended and tried first unless patient is unable to take oral dosage form (i.e. difficulty swallowing).
- Review of medication history should not indicate concurrent use of an oral NSAID. If found, verify and document that the oral dosage form has been discontinued.

VOLTAREN® (diclofenac sodium) 1% Gel:

- Indicated for the topical treatment of osteoarthritis.
- Oral generic diclofenac products should be recommended and tried first unless patient is unable to take oral dosage form (i.e. difficulty swallowing).
- Review of medication history should not indicate concurrent use of an oral NSAID. If found, verify and document that the oral dosage form has been discontinued.

CAMBIA® (diclofenac potassium) Oral Solution:
This medication is **ONLY APPROVABLE FOR THE DIAGNOSIS OF MIGRAINE**. For approval, there must be a reason why oral diclofenac tablets and other NSAIDs are not appropriate for the client.

DUEXIS® (ibuprofen/famotidine): Separate ingredients are available without prior authorization.
VIMOVO® (naprosyn/esomeprazole): Naproxen and several proton pump inhibitors available without prior authorization.
ZIPSOR® (diclofenac potassium) Liquid Filled Capsules: Oral generic diclofenac products should be recommended and tried first.

Votes as follows:
Baker-yes, Caudill-yes, Davenport-absent, Dering-Anderson-yes, Dube'-yes, Elsasser-yes, Farho-yes, Gotschall-yes, Green – yes, Humphries – yes, Johnson-Bohac – yes, Juracek-yes, Reichmuth – yes, Rock- yes, Sorensen-yes, Thomsen-yes, Tonniges-absent, Ward-absent.
Motion carried

L. OPHTHALMIC ANTIBIOTIC-STEROID COMBINATION

Motion to approve by Baker and seconded by Rock to accept recommendations as published.

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
BLEPHAMIDE (prednisolone and sulfacetamide) BLEPHAMIDE S.O.P. neomycin/polymyxin/dexamethasone (generic for Maxitrol) neomycin/bacitracin/poly/HC	neomycin/polymyxin/HC tobramycin/dexamethasone susp. (generic for Tobradex) TOBRADEX S.T. (tobramycin and dexamethasone *suspension*) ZYLET (loteprednol, tobramycin)	1. Adverse reaction to, allergy or contraindication to preferred drugs, or 2. Documentation of treatment failure with two preferred drugs.

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PRED-G DROPS SUSP (prednisolone and gentamicin) PRED-G OINT (prednisolone and gentamicin) sulfacetamide/prednisolone TOBRADEX OINTMENT (tobramycin and dexamethasone) TOBRADEX SUSPENSION (tobramycin and dexamethasone)		

Votes as follows:
Baker-yes, Caudill-yes, Davenport-absent, Dering-Anderson-yes, Dube'-yes, Elsasser-yes, Farho-yes, Gotschall-yes, Green – yes, Humphries – yes, Johnson-Bohac – yes, Juracek-yes, Reichmuth – yes, Rock- yes, Sorensen-yes, Thomsen-yes, Tonniges-absent, Ward-absent.
Motion carried

M. OPHTHALMICS, ANTIBIOTICS

Motion to approve by Dering-Anderson and seconded by Juracek to accept recommendations as published.

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
FLUOROQUINOLONES		
ciprofloxacin **solution** (generic for Ciloxan) MOXEZA (moxifloxacin) ofloxacin (generic for Floxin) VIGAMOX (moxifloxacin)	BESIVANCE (besifloxacin) CILOXAN (ciprofloxacin) levofloxacin generic OCUFLOX (generic for ofloxacin) ZYMAXID (gatifloxacin 0.5%)	1. Adverse reaction to, allergy or contraindication to preferred drugs, or 2. Documentation of treatment failure with two preferred drugs.
MACROLIDES		
erythromycin	AZASITE (azithromycin) ILOTYCIN (erythromycin)	1. Adverse reaction to, allergy or contraindication to preferred drugs, or 2. Documentation of treatment failure with preferred drug.
AMINOGLYCOSIDES		
gentamicin drops and ointment tobramycin (generic for Tobrex drops) TOBREX **ointmen**t (tobramycin)	GARAMYCIN (gentamicin)	1. Adverse reaction to, allergy or contraindication to preferred drugs, or 2. Documentation of treatment failure with preferred drug.
OTHER ANTIBIOTICS		
NEOSPORIN **SOLUTION** (neomycin,gramicidin, polymyxin) polymyxin B/trimethoprim (generic for Polytrim) sulfacetamide (generic for Bleph-10)	bacitracin bacitracin/polymyxin B (formerly generic for Polysporin) NATACYN (natamycin) neomycin/polymyxin B/gramicidin neomycin/bacitracin/polymyxin B **OINTMENT**	NATACYN: Documented fungal infection.

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Votes as follows:
Baker-yes, Caudill-yes, Davenport-absent, Dering-Anderson-yes, Dube'-yes, Elsasser-yes, Farho-yes, Gotschall-yes, Green – yes, Humphries – yes, Johnson-Bohac – yes, Juracek-yes, Reichmuth – yes, Rock- yes, Sorensen-yes, Thomsen-yes, Tonniges-absent, Ward-absent.
Motion carried

N. OPHTHALMICS FOR ALLERGIC CONJUNCTIVITIS

Motion to approve by Gotschall and seconded by Rock to accept recommendations as published.

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
ALREX (loteprednol 0.2%) cromolyn (generic for Opticrom) ketotifen OTC (generic for Zaditor) PATADAY (olopatadine 0.2%)	ALOCRIL (nedocromil) ALOMIDE (lodoxamide) azelastine (generic for Optivar) BEPREVE (bepotastine besilate) EMADINE (emedastine) epinastine (generic for Elestat) LASTACAFT (alcaftadine) PATANOL (olopatadine 0.1%)	1. Adverse reaction to, allergy or contraindication to preferred drugs, or 2. Documentation of treatment failure with two preferred drugs.

Votes as follows:
Baker-yes, Caudill-yes, Davenport-absent, Dering-Anderson-yes, Dube'-yes, Elsasser-yes, Farho-yes, Gotschall-yes, Green – yes, Humphries – yes, Johnson-Bohac – yes, Juracek-yes, Reichmuth – yes, Rock- yes, Sorensen-yes, Thomsen-yes, Tonniges-absent, Ward-absent.
Motion carried

O. OPHTHALMICS, GLAUCOMA DRUGS

Motion to approve by Dering-Anderson and seconded by Thomsen to accept recommendations as published.

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
MIOTICS		
pilocarpine		
SYMPATHOMIMETICS		
ALPHAGAN P (brimonidine 0.15%) brimonidine 0.2% (formerly generic for Alphagan)	apraclonidine (generic for Iopidine) brimonidine P 0.1%(generic for AlphaganP) brimonidine P 0.15%(generic for Alphagan P)	1.Adverse reaction to, allergy or contraindication to preferred drugs, or 2 .Documentation of treatment failure with preferred drug.
BETA BLOCKERS		
betaxolol (generic for Betoptic) BETIMOL (timolol) BETOPTIC S (betaxolol) carteolol (generic for Ocupress) ISTALOL (timolol) levobunolol (generic for Betagan) metipranolol (generic for Optipranolol) timolol (generic for Timoptic)	TIMOPTIC XE (timolol gel forming solution)	
CARBONIC ANHYDRASE INHIBITORS		

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AZOPT (brinzolamide) dorzolamide (generic for Trusopt)	TRUSOPT (dorzolamide)	1.Adverse reaction to, allergy or contraindication to preferred drugs, or 2 .Documentation of treatment failure with preferred drug.
PROSTAGLANDIN ANALOGS		
latanoprost (generic for Xalatan) TRAVATAN (travoprost) TRAVATAN Z (travoprost)	LUMIGAN (bimatoprost) XALATAN (latanoprost) ZIOPTAN (tafluprost)	1.Adverse reaction to, allergy or contraindication to preferred drugs, or 2 .Documentation of treatment failure with preferred drug.
COMBINATION DRUGS		
COMBIGAN (brimonidine/timolol) dorzolamide/timolol (generic for Cosopt)	COSOPT PF (dorzolamide/timolol)	1.Adverse reaction to, allergy or contraindication to preferred drugs, or 2 .Documentation of treatment failure with preferred drug.

Votes as follows:
Baker-yes, Caudill-yes, Davenport-absent, Dering-Anderson-yes, Dube'-yes, Elsasser-yes, Farho-yes, Gotschall-yes, Green – yes, Humphries – yes, Johnson-Bohac – yes, Juracek-yes, Reichmuth – yes, Rock- yes, Sorensen-yes, Thomsen-yes, Tonniges-absent, Ward-absent.
Motion carried

P. OTIC ANTI-INFECTIVES & ANESTHETICS

Motion to change acetic acid/aluminum (generic for Otic Domboro) to Non-Preferred Status and accept the rest of the class as published by Dering-Anderson and seconded by Baker.

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
acetic acid acetic acid/aluminum -→-→-→ (generic for Otic Domeboro) antipyrine/benzocaine (generic similar to Auralgan)	acetic acid HC (generic for VoSol HC)	1.Adverse reaction to, allergy or contraindication to preferred drugs, or 2 .Documentation of treatment failure with two preferred drugs.

Votes as follows:
Baker-yes, Caudill-yes, Davenport-absent, Dering-Anderson-yes, Dube'-yes, Elsasser-yes, Farho-yes, Gotschall-yes, Green – yes, Humphries – yes, Johnson-Bohac – yes, Juracek-yes, Reichmuth – yes, Rock- yes, Sorensen-yes, Thomsen-yes, Tonniges-absent, Ward-absent.
Motion carried

Q. OTIC ANTIBIOTICS

Motion to approve by Caudill and seconded by Reichmuth to accept recommendations as published.

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
CIPRODEX (ciprofloxacin/dexamethasone) neomycin/polymyxin/hydrocortisone (generic for Cortisporin) ofloxacin (generic for Floxin)	CIPRO HC (ciprofloxacin/hydrocortisone) COLY-MYCIN S (neomycin/hydrocortisone/colistin) CORTISPORIN-TC (neomycin/hydrocortisone/colistin)	1.Adverse reaction to, allergy or contraindication to preferred drugs, or 2 .Documentation of treatment failure with one preferred drug~~s~~.

Votes as follows:

Baker-yes, Caudill-yes, Davenport-absent, Dering-Anderson-yes, Dube'-yes, Elsasser-yes, Farho-yes, Gotschall-yes, Green – yes, Humphries – yes, Johnson-Bohac – yes, Juracek-yes, Reichmuth – yes, Rock- yes, Sorensen-yes, Thomsen-yes, Tonniges-absent, Ward-absent.
Motion carried.

R. SEDATIVE HYPNOTICS

Motion to approve by Thomsen and seconded by Sorensen to accept recommendations as published.

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
BENZODIAZEPINES		
estazolam (generic for ProSom) temazepam 15mg, 30mg (generic for Restoril)	flurazepam (generic for Dalmane) temazepam 7.5mg, 22.5mg triazolam (generic for Halcion)	1.Adverse reaction to, allergy or contraindication to preferred drugs, or 2 .Documentation of treatment failure with two preferred drugs.
OTHERS		
zaleplon (generic for Sonata) zolpidem (generic for Ambien)	EDLUAR (zolpidem sublingual) INTERMEZZO (zolpidem sublingual) LUNESTA (eszopiclone) ROZEREM (ramelteon) SILENOR (doxepin)* zolpidem ER (generic for Ambien CR) ZOLPIMIST(zolpidem oral spray)	1.Adverse reaction to, allergy or contraindication to preferred drugs, or 2 .Documentation of treatment failure with preferred drug. Silenor: In addition, would also require patient specific clinical reason patient could not use generic doxepin.

Votes as follows:
Baker-yes, Caudill-yes, Davenport-absent, Dering-Anderson-yes, Dube'-yes, Elsasser-yes, Farho-yes, Gotschall-yes, Green – yes, Humphries – yes, Johnson-Bohac – yes, Juracek-yes, Reichmuth – yes, Rock- yes, Sorensen-yes, Thomsen-yes, Tonniges-absent, Ward-absent.
Motion carried

S. STEROIDS, TOPICAL

Motion to approve by Juracek and seconded by Farho to accept recommendations as published.

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
LOW POTENCY		
desonide **cream , ointment** (generic for Desonate, Verdeso) hydrocortisone **cream , ointment** (generic for Cortaid) hydrocortisone **OTC lotion** hydrocortisone/aloe **cream, ointment**	alclometasone dipropionate (generic for Aclovate) CAPEX Shampoo (fluocinolone) DERMA-SMOOTHE-FS (fluocinolone) DESONATE (desonide) desonide **lotion** hydrocortisone **Rx lotion** hydrocortisone/aloe **gel** hydrocortisone/urea PEDIADERM HC (hydrocortisone 2%) VERDESO (desonide)	1.Adverse reaction to, allergy or contraindication to preferred drugs, or 2 .Documentation of treatment failure with two preferred drugs.
MEDIUM POTENCY		
fluocinolone acetonide (generic for Synalar) fluticasone propionate (generic for Cutivate)	CLODERM (clocortolone) CORDRAN TAPE (flurandrenolide) CUTIVATE (fluticasone) hydrocortisone butyrate	1.Adverse reaction to, allergy or contraindication to preferred drugs, or 2 .Documentation of treatment failure with two preferred drugs.

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mometasone furoate **cream** (generic for Elocon)	(generic for Locoid) hydrocortisone valerate (generic for Westcort) LUXIQ (betamethasone valerate) mometasone furoate **solution, ointment** (generic for Elocon) prednicarbate (generic for Dermatop) MOMEXIN (mometasone) PANDEL (hydrocortisone probutate 0.1%)	
HIGH POTENCY		
betamethasone valerate (generic for Beta-Val) fluocinonide (generic for Vanos) fluocinonide emollient triamcinolone acetonide **ointment, cream** (generic for Kenalog)	amcinonide betamethasone dipropionate (generic for Diprolene) desoximetasone (generic for Topicort) diflorasone diacetate (generic for Apexicon) HALOG (halcinonide) KENALOG AEROSOL (triamcinolone) triamcinolone **lotion** VANOS (fluocinonide)	1.Adverse reaction to, allergy or contraindication to preferred drugs, or 2 .Documentation of treatment failure with two preferred drugs.
VERY HIGH POTENCY		
clobetasol emollient (generic for Temovate-E) clobetasol propionate (generic for Temovate) halobetasol propionate (generic for Ultravate)	APEXICON-E (diflorasone) CLOBEX (clobetasol) clobetasol shampoo, lotion clobetasol propionate **FOAM** HALONATE (halobetasol propionate) OLUX-E (clobetasol) OLUX/OLUX-E CP (clobetasol)	1.Adverse reaction to, allergy or contraindication to preferred drugs, or 2 .Documentation of treatment failure with preferred drug.

Votes as follows:
Baker-yes, Caudill-yes, Davenport-absent, Dering-Anderson-yes, Dube'-yes, Elsasser-yes, Farho-yes, Gotschall-yes, Green – yes, Humphries – yes, Johnson-Bohac – yes, Juracek-yes, Reichmuth – absent, Rock- yes, Sorensen-yes, Thomsen-yes, Tonniges-absent, Ward-absent.

Motion carried

T. STIMULANTS, ADHD, AND RELATED DRUGS

Motion to approve by Dering-Anderson and seconded by Caudill to accept recommendations as published, with the stipulation that a report on impact due to change of status of Strattera be presented at the next meeting.

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
CNS STIMULANTS		
Amphetamine type		Note: CNS stimulants will not be approved for weight loss. 1.Adverse reaction to, allergy or contraindication to preferred drugs, or 2 .Documentation of treatment failure with two preferred drugs.
ADDERALL (amphetamine salt combo) ADDERALL XR (amphetamine salt (combo)	amphetamine salt combination ER (generic for Adderall XR) amphetamine salt combination IR (generic for Adderall) dextroamphetamine (generic for Dexedrine)	

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VYVANSE (lisdexamfetamine)	dextroamphetamine ER (generic for Dexedrine Spansule) methamphetamine (generic for Desoxyn) PROCENTRA (dextroamphetamine)	
Methylphenidate type		
FOCALIN (dexmethylphenidate) FOCALIN XR (dexmethylphenidate)	dexmethylphenidate (generic for Focalin)	
METHYLIN CHEWABLE (methylphenidate) METHYLIN SOLUTION (methylphenidate) methylphenidate (generic for Ritalin) Ritalin (methylphenidate)		
METADATE **ER** (methylphenidate ER) methylphenidate ER (generic for Ritalin-SR, Metadate ER)	DAYTRANA (methylphenidate patch) methylphenidate CD 30/70 (generic for METADATE **CD)** methylphenidate ER 50/50 (generic for RITALIN LA) RITALIN-SR (methylphenidate ER)	DAYTRANA® (methylphenidate): • May approve if requested because there is a history of substance abuse in the parent/caregiver or patient. • May approve if there is a swallowing disorder and the patient cannot be given oral medication. • Daytrana has a maximum age of 18. If preferreds are refused and patient meets criteria (clinical or PDL) age edit may be approved.
	methylphenidate ER (18mg, 27mg, 36mg, 54mg (generic Concerta)	
MISCELLANEOUS ADHD		
STRATTERA (atomoxetine) Note: generic guanfacine and clonidine are available without prior authorization.	INTUNIV (guanfacine extended-release)* KAPVAY (clonidine)*	INTUNIV: 1. Only approved in children, minimum age 6. 2. Diagnosis of ADHD. 3. Patient shows some therapeutic benefit from the immediate release guanfacine preparation taken at least twice daily and there is a therapeutic need to administer the guanfacine once daily. 4. Maximum dose 4mg/day. KAPVAY: 1. Only approved in children, minimum age 6. 2. Diagnosis of ADHD. 3. Patient shows some therapeutic benefit from the immediate release clonidine preparation taken at least three

		times daily and there is a therapeutic need to administer the clonidine twice daily. 4. Total daily dose not to exceed 0.4mg per day.
ANALEPTICS		
	modafanil (generic for Provigil)* NUVIGIL (armodafinil)*	**NUVIGIL:** Minimum age 18. **Require trial of Provigil.** **For Sleep apnea**: Documentation of sleep apnea with sleep study. **For Narcolepsy**: Documentation of diagnosis in sleep study. **Shift Work Sleep disorder**: Only approve for six months to verify work schedule. **PROVIGIL:** Minimum age 18. **For Sleep apnea**: Documentation of sleep apnea with sleep study. **For Narcolepsy**: Documentation of diagnosis in sleep study. **Shift Work Sleep disor**der: Only approve for six months to verify work schedule.

Votes as follows:
Baker-yes, Caudill-yes, Davenport-absent, Dering-Anderson-yes, Dube'-yes, Elsasser-yes, Farho-yes, Gotschall-yes, Green – yes, Humphries – yes, Johnson-Bohac – yes, Juracek-absent, Reichmuth – yes, Rock- no, Sorensen-yes, Thomsen-yes, Tonniges-absent, Ward-absent.
Motion carried

U. An all in favor motion was made by Saunders to conclude the meeting at 2pm.

Next meeting:
The next scheduled meeting of the Nebraska Medicaid Pharmaceutical and Therapeutics Committee is scheduled for:
Wednesday, May 15, 2013, 9 am
Mahoney State Park, Ashland, NE

Recorded by: Jenny Minchow R.P., Pharm. D.
Pharmacy Consultant
Nebraska Medicaid & Long-Term Care

APPROVED: May 15, 2013

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