DIVISION OF MEDICAID AND LONG-TERM CARE

PHARMACEUTICAL AND THERAPEUTICS COMMITTEE
MEETING MINUTES

May 15, 2013 9am
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.
James Dube' Pharm.D.
Gary Elsasser Pharm.D.
Linda Farho Pharm.D.
Jeff Gotschall M.D.
Nathan Green D.O.
Nancy Haberstich R.N., M.S.
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
Angie Ward R.Ph

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

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

I. Call to Order: Chairperson, Ken Saunders, called the meeting to order at 9:00am. The agenda was posted on the Nebraska Medicaid Pharmacy MMA web site on April 15, 2013. A copy of the Open Meetings Act was posted at the back of the meeting room and materials distributed to members were on display.

II. Introduction of new Committee Member, Nancy Haberstich R.N. Nancy will be a Public Member. Jenny Minchow announced that Tom Tonniges resigned from the Committee. It was requested that a letter of appreciation be sent from the Committee to Dr. Tonniges.

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 November 14, 2012 meeting were unanimously approved as written, with the exception of members who were absent from the Nov. meeting.

VI. Minchow reported the following changes in the recommendations from the November 2012 meeting:

Committee's Recommendation	Department's Decision
STRATTERA (atomoxetine) Preferred	Strattera- Remain Non-preferred
ELIDEL (pimecrolimus) – Preferred PROTOPIC (tacrolimus) -Preferred	ELIDEL (pimecrolimus) – Preferred PROTOPIC (tacrolimus) – Non-preferred

VII. Other: It was recommended that the Department post the prior authorization criteria along with the posted Preferred Drug List. A motion was made by Dering-Anderson and seconded by Juracek. The question was called by Caudill.

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

VIII. Public Testimony

Drug/Class	Status	Speaker	Affiliation
PLATELET INHIBITORS			
Brilinta	NP	Joseph Ghobrial	Astra Zeneca
ANTICOAGULANTS			
Eliquis	NP	Dan Hilleman	Creighton Cardiology
Eliquis	NP	Kay Broscht	Bristol-Myers Squibb
Pradaxa	NP	Michael Donze	Boehringer-Ingelheim
ANTIPARASITICS, TOPICAL			
Sklice	NP	Maggie Murphy	Sanofi Pasteur
BLADDER RELAXANT			
Myrbetriq	NP	Mark Villmann	Astellas
COLONY STIMULATING			
Neulasta	NP	Risa Yun Reuscher	Amgen
HYPOGLYCEMICS			
Victoza	NP	Todd Paulsen	Novo Nordisk
MULTIPLE SCLEROSIS			
Gilenya	NP	Paul Goerdt	Novartis
ULCERATIVE COLITIS			
Lialda	NP	Rupal Gupta	Shire

P= Preferred
NP= Non-preferred

IX. A motion was made and seconded to move into closed session at 10am.
Cost issues discussed in Closed Session.

X. A motion was made and seconded to move back into open session. Open Session resumed at 11am.

XI. **Consent Agenda**:
The following items were removed from the Consent Agenda: Angiotensin Modulator Combinations, Growth Hormone, Thiazolidinedione Hypoglycemics, and Platelet Aggregation Inhibitors.

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QL indicates quantity limits.
NR indicates product was not reviewed. New Drug criteria will apply.

ANTIBIOTICS, GASTROINTESTINAL Note: Although azithromycin, ciprofloxacin, and trimethoprim/sulfamethoxazole are not included in this review, they are available without prior authorization.

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
metronidazole **TABLETS** neomycin vancomycin compounded oral solution	ALINIA (nitazoxanide) DIFICID (fidaxomicin) FLAGYL **ER** (metronidazole) metronidazole **CAPSULES** tinidazole (generic for Tindamax) vancomycin capsules (generic for Vancocin) XIFAXAN (rifaximin)	**Alinia**-if giardiasis; require treatment failure with metronidazole or tindazole. If cryptosporidium: no treatment failure required with other agent **Dificid**: for diagnosis of Clostridium difficile diarrhea; require contraindication to or treatment failure with oral vancomycin or metronidazole. Flagyl **ER:** require trial on metronidazole or tindazole. **Tindamax**: For treatment of Giardia, amebiasis intestinal or liver abscess, bacterial vaginosis or trichomoniasis: Treatment failure with or contraindication to metronidazole. **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.

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ANTIBIOTICS, INHALED

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
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.

ANTIBIOTICS, TOPICAL

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
bacitracin ointment bacitracin/polymyxin (generic for Polysporin) gentamicin cream and ointment mupirocin **ointment** (generic for Bactroban ointment) neomycin/polymyxin/bacitracin (generic for Neosporin, Triple AB)	ALTABAX (retapamulin) CENTANY (mupirocin) ointment mupirocin **cream** (generic for Bactroban cream)	Non-preferred agents will be approved only after documented failure of the preferred agents. Mupirocin 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®.

ANTIVIRALS, TOPICAL

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
	acyclovir (generic for Zovirax Ointment) DENAVIR (penciclovir) XERESE (acyclovir/hydrocortisone) ZOVIRAX Cream (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.

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BPH - BENIGN PROSTATIC HYPERPLASIA TREATMENTS

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
ALPHA BLOCKERS		
alfuzosin (generic for Uroxatral) doxazosin (generic for Cardura) tamsulosin (generic for Flomax) terazosin (generic for Hytrin)	CARDURA XL (doxazosin) JALYN (dutasteride/tamsulosin) RAPAFLO (silodosin) UROXATRAL (alfuzosin)	Treatment failure with one preferred agent. JALYN: Must meet criteria for approval of Avodart and clinical reason can't take individual agents.
5-ALPHA-REDUCTASE (5AR) INHIBITORS		
finasteride (generic for Proscar)	AVODART (dutasteride) JALYN (dutasteride/tamsulosin)	

COLONY STIMULATING FACTORS (Entire class requires prior authorization when administered outside physician office or hospital)

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
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

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		six months.

ERYTHROPOIESIS STIMULATING PROTEINS (Entire class requires prior authorization when administered outside physician office or hospital)

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
ARANESP (darbepoetin) PROCRIT (rHuEPO)	EPOGEN (rHuEPO)	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) 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

FLUOROQUINOLONES, ORAL

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
ciprofloxacin (generic for Cipro) levofloxacin **TABLETS** (generic for Levaquin)	AVELOX (moxifloxacin) CIPRO Suspension (ciprofloxacin) ciprofloxacin ER FACTIVE (gemifloxacin) levofloxacin oral solution NOROXIN (norfloxacin) ofloxacin	1. Adverse reaction to, allergy to or contraindication to preferred drugs, or 2. Documentation of treatment failure with preferred drug. Ofloxacin 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.

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HEPATITIS C AGENTS

PREFERRED DRUGS	NON-PREFERRED DRUGS	CRITERIA FOR USE OF NON-PREFERRED PRODUCTS
INTERFERON		See clinical criteria. https://nebraska.fhsc.com/Downloads/NEcriteria_HepatitisC-20121106.pdf
PEGASYS (pegylated interferon alfa-2a)* PEG-INTRON (pegylated interferon alfa-2b)*	INFERGEN (interferon alfacon-1)*	
RIBAVIRIN		
ribavirin 200mg tablets and capsules*	REBETOL SOLUTION (ribavirin)	

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
INCIVEK (telaprevir)* VICTRELIS (boceprevir)*		1. Must also be on peginterferon and ribarivin. https://nebraska.fhsc.com/Downloads/NEcriteria_HepatitisC-20121106.pdf 2. Diagnosis of CHRONIC HCV with genotype 1. 3. Adult (18 and over) with **compensated** liver disease. 4. **Recent** baseline RNA viral load to be submitted with request. 5. Quantity limit of 28 day supply per fill. Victrelis: #336/28 days, Max 11 mo treatment. Incivek: #168/28 days, Max 3 month treatment. 6. Will not be approved in post-transplant recurrent HCV. 7. Will not be approved in HIV/HCV coinfected patients. 8. Not approvable if previous treatment failure with another protease inhibitor. VICTRELIS: 1. Begin after four weeks of peginterferon/ribavirin. 2. Initial approval for 12 weeks. (through treatment week 16) 3. Treatment week 12: If HCV-RNA levels $\geq$ 100 IV/ml, STOP all therapy. 4. Treatment week 24: If HCV-RNA levels DETECTABLE, STOP all therapy. INCIVEK: 1. Treatment week 12: If HCV RNA > 1000 IU/ml, STOP all therapy. 2. Treatment week 24: If HCV RNA DETECTABLE, stop peginterferon and ribavirin.

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HYPOGLYCEMICS, INSULIN AND RELATED DRUGS

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
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. **Insulin pens /cartridges** 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)

HYPOGLYCEMICS, MEGLITINIDES

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
	nateglinide (generic for Starlix) PRANDIMET (repaglinide/metformin) PRANDIN (repaglinide)	• Compliance demonstrated with metformin trial and have not received adequate glycemic control with metformin; or • Intolerance to metformin; • HbA1C ≥ 7

Hypoglycemics: Additional Classes The following hypoglycemic classes and the drugs noted are not reviewed by the PDL process but are covered without prior authorization.		
HYPOGLYCEMICS,ALPHA-GLUCOSIDASE INHIBITORS		
acarbose (generic for Precose) Glyset (miglitol)		
HYPOGLYCEMICS,BIGUANIDES		
metformin (generic for Glucophage) metformin XR (generic for Glucophage XR)		

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HYPOGLYCEMICS, SULFONYLUREAS		
chlorpropamide glimepiride (generic for Amaryl) glipizide (generic for Glucotrol) glipizide ER (generic for Glucotrol XL) glyburide/micronized (generic for Diabeta, Glynase) tolazamide tolbutamide		

LIPOTROPICS, OTHER (non-statins) Note: Several other forms of OTC niacin and fish oil are also covered under Medicaid with a prescription without prior authorization.

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
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) **TABLETS**	colestipol (generic for Colestid) **GRANULES** QUESTRAN LIGHT (cholestyramine) WELCHOL (colesevalam)	
FIBRIC ACID DERIVATIVES		
gemfibrozil (generic for Lopid) TRICOR (fenofibrate) TRILIPIX (fenofibric acid)	fenofibrate (generic for Antara) fenofibrate (generic for Lofibra) fenofibrate (generic for Tricor) fenofibric acid (generic for Fibricor) LIPOFEN (fenofibrate) LOFIBRA (fenofibrate) TRIGLIDE (fenofibrate)	
NIACIN		
NIACOR (niacin IR) NIASPAN (niacin ER)	ADVICOR (lovastatin/niacin ER)	
OMEGA-3 FATTY ACIDS		
	LOVAZA (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.
CHOLESTEROL ABSORPTION INHIBITORS		
	ZETIA (ezetimibe)	Zetia will be approved for patients who have a diagnosis of hypercholesterolemia and have

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		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	PDL EXCEPTION CRITERIA:
STATINS		
atorvastatin (generic for Lipitor) lovastatin (generic for Mevacor) pravastatin (generic for Pravachol) simvastatin (generic for Zocor)	ALTOPREV (lovastatin) CRESTOR (rosuvastatin) fluvastatin (generic for Lescol) 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) atorvastatin/ amlodipine (generic for CADUET) VYTORIN (simvastatin/ezetimibe)	Vytorin will be approved for patients failing a minimum 3 month trial of standard dose statin

MACROLIDES AND KETOLIDES (Oral)

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
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) clarithromycin ER (generic for Biaxin XL) clarithromycin IR (generic for Biaxin) erythromycin	PCE (erythromycin) ZMAX (azithromycin ER) ZITHROMAX (azithromycin)	1. Adverse reaction to, allergy or contraindication to preferred drugs, or 2. Documentation of treatment failure with preferred drug.

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PROTON PUMP INHIBITORS (ORAL)

Criteria for use of non-preferred PPI:

https://nebraska.fhsc.com/Downloads/NEfaxform_PPI-20101028.pdf

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
omeprazole (generic for Prilosec) pantoprazole (generic for Protonix)	ACIPHEX (rabeprazole) DEXILANT (dexlansoprazole) lansoprazole (generic for Prevacid) NEXIUM (esomeprazole) NEXIUM SUSPENSION (esomeprazole) omeprazole/sodium bicarbonate (generic for Zegerid RX) PREVACID Rx, SOLU-TAB (lansoprazole) PRILOSEC (omeprazole)	See existing prior authorization criteria.

SKELETAL MUSCLE RELAXANTS

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
baclofen (generic for Lioresal) chlorzoxazone (generic for Parafon) cyclobenzaprine (generic for Flexeril) methocarbamol (generic for Robaxin) tizanidine **TABLETS** (generic for Zanaflex)	AMRIX (cyclobenzaprine)* carisoprodol (generic for Soma) carisoprodol compound dantrolene (generic for Dantrium) LORZONE (chlorzoxazone)* metaxalone (generic for Skelaxin) orphenadrine (generic for Norflex) orphenadrine compound SOMA (carisoprodol)* tizanidine **CAPSULES** ZANAFLEX (tizanidine) (brand name tablets and capsules)	The non-preferred agents will be approved for patients with 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: Clinical reason regular release cannot be used. Only for short

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		term use. ZANAFLEX: Clinical reason generic cannot be used.

TETRACYCLINES

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
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 (*Adoxa*, Monodox) minocycline HCl **tablets** (generic for Dynacin, Murac) minocycline HCl extended release (generic for Solodyn) ORACEA (doxycycline monohydrate) SOLODYN (minocycline HCl) VIBRAMYCIN SUSPENSION (doxycycline)	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.

Motion to approve by Caudill and seconded by Gotschall to accept recommendations as published with the exception of drug classes which were extracted.

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

XII. GROWTH HORMONE

Entire class requires prior authorization based on clinical criteria.

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
NORDITROPIN (somatropin) NUTROPIN (somatropin) NUTROPIN AQ (somatropin)	GENOTROPIN (somatropin) HUMATROPE (somatropin) OMNITROPE (somatropin) *SAIZEN (somatropin)* SEROSTIM (somatropin) TEV-TROPIN (somatropin) ZORBTIVE (somatropin)	See clinical criteria. https://nebraska.fhsc.com/Downloads/NEcriteria_GH-201211.pdf

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Motion to approve by Baker and seconded by Rock to accept recommendations with Saizen changed to non-preferred as noted above.

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

XIII. HYPOGLYCEMICS, TZDS

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
THIAZOLIDINEDIONES (TZDs)		
pioglitazone (generic for Actos)	AVANDIA (rosiglitazone)	• Compliance demonstrated with metformin trial and have not received adequate glycemic control with metformin; or • Intolerance to metformin; • HbA1C ≥ 7
TZD COMBINATIONS		
	ACTOPLUS MET XR (pioglitazone/metformin ER) AVANDAMET (rosiglitazone/metformin) AVANDARYL (rosiglitazone/glipizide) pioglitazone/glimepiride (generic for Duetact) pioglitazone/metformin (generic for Actoplus Met)	• Combination agents will require clinical reason separate agents cannot be used. • HbA1C ≥ 7

Motion to approve by Baker and seconded by Reichmuth to accept recommendations with pioglitazone (generic for Actos) changed to preferred as noted above.

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

X1V. PLATELET AGGREGATION INHIBITORS

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
AGGRENOX (dipyridamole/aspirin) aspirin	BRILINTA (ticagrelor)* EFFIENT (prasugrel)* ticlopidine (generic for Ticlid)	1.Adverse reaction to, allergy or contraindication to preferred drugs, or

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clopidogrel (generic for Plavix) dipyridamole (generic for Persantine)		2 .Documentation of treatment failure with preferred drug. 3. **OR** Documentation of clopidrogel resistance. BRILINTA: additional criteria -Acute coronary syndrome (ACS) (unstable angina, non-ST elevation myocardial infarction, or ST elevation myocardial infarction). 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 and > 60kg (or adjust dose if <60kg) • Must not have active pathological bleeding or history of TIA or stroke.

Motion to approve by Dube' and seconded to accept recommendations as published with criteria modifications to Brilinta and Effient as noted above.

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

ACNE AGENTS, TOPICAL

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
AZELEX (azelaic acid)	ACANYA (clindamycin and	Treatment failure with three

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BENZACLIN ***W/PUMP*** (clindamycin/benzoyl peroxide) benzoyl peroxide generic OTC benzoyl peroxide generic Rx clindamycin phosphate **SOLUTION** DIFFERIN (adapalene) *DUAC (clindamycin/benzoyl peroxide)* erythromycin RETIN-A **MICRO** (tretinoin) tretinoin **CREAM**	benzoyl peroxide) ACZONE (dapsone) adapalene gel, cream (generic Differin) AKNE-MYCIN (erythromycin) ATRALIN (tretinoin) BENZACLIN ***GEL*** (clindamycin/benzoyl peroxide) BENZEFOAM (benzoyl peroxide) CLARIFOAM EF (sulfur and sulfacetamide) CLINDAGEL (clindamycin) clindamycin **GEL, LOTION, FOAM** clindamycin/benzoyl peroxide (generic for Benzaclin) EPIDUO (adapalene/benzoyl peroxide) erythromycin-benzoyl peroxide (generic for Benzamycin) EVOCLIN (clindamycin) INOVA (benzoyl peroxide) RETIN-A GEL, CREAM RETIN-A MICRO **PUMP** sulfacetamide sulfacetamide/sulfur (generic for Sulfacet-R) TAZORAC (tazarotene) tretinoin **GEL** VELTIN (clindamycin and tretinoin) ZIANA (clindamycin and tretinoin)	preferred products.

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

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

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ANALGESICS, OPIATE LONG-ACTING

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
fentanyl patches KADIAN (morphine) methadone morphine ER OXYCONTIN (oxycodone ER)	AVINZA (morphine) BUTRANS (buprenorphine, transdermal)* CONZIP ER (tramadol extended release)* DURAGESIC MATRIX (fentanyl) EXALGO (hydromorphone)* morphine ER (generic for Kadian) MS CONTIN (morphine ER) NUCYNTA ER (tapentadol)* oxymorphone ER (generic for OPANA ER) tramadol extended release* (generic for Ultram ER)	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:** Patient must meet all of the following criteria: •Diagnosis of moderate to severe chronic pain •Require < 80mg morphine equivalents per day •Require continuous around-the-clock analgesia •Need analgesic medication for an extended period of time •Patient is 18 years or older •Inability to take oral medication OR Adequate trial with 3 preferred agents NOT approved for substance abuse or addiction. **EXALGO:** Must document **clinical** reason why immediate-release cannot be used. **ULTRAM ER, CONZIP (tramadol extended release)** Clinical reason regular release cannot be used.

Motion to approve by Elsasser and seconded by Juracek to accept recommendations with Oxycontin remaining preferred as noted above.

Votes as follows:

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

LUNCH 12-1PM

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

1:00 pm A motion was made by Dube' and seconded by Baker to resume open session. Decision unanimous.

ANGIOTENSIN MODULATOR /CALCIUM CHANNEL BLOCKER COMBINATIONS

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
LOTREL (benazepril/amlodipine) *TARKA (trandolapril/verapamil)*	AMTURNIDE (aliskiren/**amlodipine**/HCTZ) AZOR (olmesartan/amlodipine) benazepril/amlodipine (generic for LOTREL) EXFORGE (valsartan/amlodipine) EXFORGE HCT (valsartan/amlodipine/HCTZ) 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.

Motion to approve by Gotschall and seconded by Rock to accept recommendations with Lotrel and Tarka changed to preferred as noted above.

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

ANALGESICS, OPIATE SHORT-ACTING

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
ORAL		
acetaminophen/codeine	*butorphanol **NASAL** (generic for*	Non-preferred agents will be

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codeine hydrocodone/APAP hydrocodone/ibuprofen hydromorphone ***TABLETS*** morphine IR oxycodone IR oxycodone/APAP oxycodone/aspirin ROXICET SOLUTION (oxycodone/acetaminophen) tramadol	*Stadol)* *codeine **ORAL SOLUTION*** dihydrocodeine/APAP/caffeine (generic for Panlor DC) HYCET (hydrocodone/acetaminophen) *hydromorphone (generic for Dilaudid oral liquid)* *hydromorphone suppositories (rectal)* IBUDONE (hydrocodone/ibuprofen) levorphanol meperidine (generic for Demerol) *morphine suppositories (rectal)* NUCYNTA (tapentadol)* OXECTA (oxycodone) *OXYCODONE/ASA Brand* oxycodone/ibuprofen (generic for Combunox) oxymorphone (generic for Opana) PANLOR DC (dihydrocodeine/APAP/caffeine) pentazocine/APAP pentazocine/naloxone PRIMLEV (acetaminophen/oxycodone) REPREXAIN (hydrocodone/ibuprofen) *ROXICODONE (oxycodone)* RYBIX (tramadol ODT)* SYNALGOS-DC (dihydrocodeine, aspirin/caffeine) tramadol/APAP –generic for Ultracet (note: separate ingredients preferred) VICOPROFEN (hydrocodone/ibuprofen) XODOL (hydrocodone/acetaminophen) ZAMICET (hydrocodone /acetaminophen solution) ZOLVIT (hydrocodone/acetaminophen solution) ZYDONE(hydrocodone/acetaminophen)	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)*	Diagnosis of cancer.

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	ACTIQ (fentanyl)* fentanyl buccal (generic for Actiq)* FENTORA (fentanyl)* ONSOLIS (fentanyl)* *SUBSYS (fentanyl spray)**	Current use of long-acting opiate. NOT approved for acute pain, migraine, or fibromyalgia.

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

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

ANDROGENIC DRUGS (Topical)

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
ANDROGEL (testosterone) *TESTIM (testosterone)*	*ANDRODERM (testosterone)* AXIRON (testosterone) FORTESTA (testosterone)	1. Adverse reaction to, allergy or contraindication to preferred drugs, or 2. Documentation of treatment failure with preferred drug.

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

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

ANGIOTENSIN MODULATORS

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
ACE INHIBITORS		
benazepril (generic for Lotensin) captopril (generic for Capoten) enalapril (generic for Vasotec) fosinopril (generic for Monopril) lisinopril (generic 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	fosinopril/HCTZ (generic for	

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Lotensin HCT) captopril/HCTZ (generic for Capozide) enalapril/HCTZ (generic for Vaseretic) lisinopril/HCTZ (generic Prinzide/Zestoretic)	Monopril HCT) moexepril/HCTZ (generic for Uniretic) quinapril/HCTZ ((generic for Accuretic)	
ANGIOTENSIN RECEPTOR BLOCKERS		
DIOVAN (valsartan) *irbesartan (generic for Avapro)* losartan (generic for Cozaar)	ATACAND (candesartan) BENICAR (olmesartan) EDARBI (azilsartan medoxomil) EDARBYCLOR (azilasartan/chlorthalidone) eprosartan (generic for Teveten) MICARDIS (telmisartan)	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		
DIOVAN-HCT (valsartan/HCTZ) *irbesartan/HCTZ (generic for Avalide)* losartan/HCTZ (generic for Hyzaar)	BENICAR-HCT (olmesartan/HCTZ) candesartan/HCTZ (generic for Atacand_HCT) MICARDIS-HCT (telmisartan/HCTZ) TEVETEN-HCT (eprosartan/HCTZ) valsartan-HCTZ (generic for Diovan-HCT)	
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)	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.

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NR indicates product was not reviewed. New Drug criteria will apply.

Motion to approved by Dube' and seconded by Davenport to accept recommendations as published.

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

ANTIBIOTICS, VAGINAL

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
CLEOCIN OVULES (clindamycin, vaginal suppositories) clindamycin (vaginal) (generic for Cleocin) METROGEL (metronidazole, vaginal) metronidazole (vaginal) *VANDAZOLE (metronidazole)*		

Motion to approved by Sorensen and seconded by Farho to accept recommendations as published.

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

ANTICOAGULANTS

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
enoxaparin (generic for Lovenox) FRAGMIN (dalteparin) warfarin (generic for Coumadin) *XARELTO (rivaroxaban)*	*ELIQUIS (apixaban)* fondaparinux (generic for Arixtra) PRADAXA (dabigatran)*	Non-preferred agents will be approved only after documented failure of another preferred agent or allergy/inability to control INR on warfarin.

Motion to approved by Dering-Anderson and seconded by Caudill to accept recommendations with Xarelto changed to preferred as noted above.

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NR indicates product was not reviewed. New Drug criteria will apply.

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

ANTIEMETICS /ANTIVERTIGO AGENTS

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
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)	1.Adverse reaction to, allergy or contraindication to preferred drugs, or 2 .Documentation of treatment failure with preferred drug. --- SANCUSO: Unable to tolerate oral.
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		
dimenhydrinate (generic for Dramamine) hydroxyzine (generic for Vistaril) meclizine (generic for Antivert) metoclopramide (generic for Reglan) prochlorperazine oral (generic for Compazine) promethazine *oral* (generic for Phenergan)	METOZOLV ODT (metoclopramide) prochlorperazine rectal (generic for Compazine) promethazine *50mg suppositories* 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.

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promethazine suppositories 12.5mg, 25mg TRANSDERM-SCOP (scopolamine)		

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

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

ANTIFUNGALS, ORAL

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
clotrimazole (mucous membrane troche) fluconazole (generic for Diflucan) griseofulvin suspension GRIS-PEG (griseofulvin) ketoconazole (generic for Nizoral) nystatin **TABLET**, **SUSPENSION** terbinafine (generic for Lamisil)	flucytosine (generic for Ancobon)* GRIFULVIN V (griseofulvin) griseofulvin **tablets** griseofulvin ultramicrosize itraconazole (generic for Sporanox) LAMISIL GRANULES (terbinafine) LAMSIL TABLETS (terbinafine) NOXAFIL (posaconazole)* nystatin **POWDER** for reconstitution *ONMEL (itraconazole)** SPORANOX (itraconazole)* 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 • Onychomycosis resistant to terbinafine • Oropharyngeal/esophageal candidiasis refractory to fluconazole.

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		• Sporonox liquid only if unable to take capsules. • *Onmel only FDA approved for onychomycosis.* **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.

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

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

ANTIFUNGALS, TOPICAL

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
ANTIFUNGAL		
clotrimazole (generic for Lotrimin) RX, OTC econazole (generic for Spectazole) ketoconazole ***CREAM*** (generic for Nizoral) ketoconazole shampoo (gen. for Nizoral) LAMISIL **SPRAY** OTC (terbinafine) LAMISIL AT **CREAM, GEL** OTC miconazole **CREAM**,***SPRAY, POWDER*** OTC nystatin selenium sulfide 1% selenium sulfide 2.5% terbinafine OTC (generic for Lamisil AT) TINACTIN AERO POWDER OTC TINACTIN CREAM OTC tolnaftate OTC (generic for Tinactin)	BENSAL HP (benzoic acid/salicylic acid) CICLODAN (ciclopirox) ciclopirox cream/gel/suspension (generic for Loprox) ciclopirox nail lacquer (solution) (generic for Penlac) ciclopirox shampoo (generic for Loprox) *DESENEX AERO POWDER OTC (miconazole)* ERTACZO (sertaconazole) EXELDERM (sulconazole) EXTINA (ketoconazole) *FUNGOID OTC* ketoconazole **FOAM** KETODAN **FOAM** *LOTRIMIN AF CREAM OTC (clotrimazole*) MENTAX (butenafine) *miconazole OTC **OINTMENT*** NAFTIN (naftifine) NUZOLE (miconazole) OXISTAT (oxiconazole) selenium sulfide 2.25% VUSION (miconazole/ zinc oxide) XOLEGEL (ketoconazole)	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.
ANTIFUNGAL/STEROID COMBINATIONS		
clotrimazole/betamethasone	*clotrimazole/betamethasone*	

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CREAM (gen. Lotrisone)	***LOTION*** *(gen. Lotrisone)* *nystatin/triamcinolone (gen. for Mycolog)*	

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

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

ANTIMIGRAINE DRUGS[QL], TRIPTANS Note: There are Quantity Limits for entire class.

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
ORAL		
RELPAX (eletriptan) sumatriptan generic oral	AXERT (almotriptan) FROVA (frovatriptan) IMITREX oral (sumatriptan) naratriptan (generic for Amerge) rizatriptan (generic for Maxalt) rizatriptan rapid dissolve (generic for Maxalt MLT) TREXIMET (sumatriptan/naproxen) ZOMIG (zolmitriptan) ZOMIG ZMT (zolmitriptan)	Non-preferred agents will be approved only if patient has tried and failed therapy with all preferred agents.
NASAL		
IMITREX (sumatriptan)	sumatriptan generic nasal ZOMIG (zolmitriptan)	
INJECTABLE		
IMITREX (sumatriptan)	*ALSUMA (sumatriptan)* sumatriptan generic injection SUMAVEL DOSEPRO (sumatriptan)	

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

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

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QL indicates quantity limits.
NR indicates product was not reviewed. New Drug criteria will apply.

ANTIPARASITICS, TOPICAL

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
EURAX (crotamiton) **CREAM** permethrin 1% OTC (generic for Nix) permethrin 5% RX (generic for Elimite) pyrethrin/piperonyl butoxide (generic for RID, A-200)	EURAX (crotamiton**) LOTION** lindane malathion (generic for Ovide) *SKLICE (ivermectin)* spinosad (generic for Natroba) ULESFIA (benzyl alcohol)	1. Adverse reaction to, allergy or contraindication to preferred drugs, or 2. Documentation of treatment failure with *one* 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.

Motion to approve by Humphries and seconded by Farho to accept recommendations as published with treatment failure with only one preferred drug required for authorization of non-preferred drug. After discussion the question was called by Caudill.

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

ANTIVIRALS, ORAL

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
ANTI-HERPETIC DRUGS		
acyclovir (generic for Zovirax) valacyclovir (generic for Valtrex)	famciclovir (generic for Famvir)	1. Adverse reaction to, allergy or contraindication to preferred drugs, or 2. Documentation of treatment failure with a preferred drug.
ANTI-INFLUENZA DRUGS		
amantadine **CAPSULE, SYRUP** (generic for Symmetrel) RELENZA (zanamivir) inhalation QL rimantadine (generic for Flumadine) TAMIFLU (oseltamivir) QL	amantadine ***TABLET***	

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

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QL indicates quantity limits.
NR indicates product was not reviewed. New Drug criteria will apply.

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

BETA BLOCKERS (Oral)

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
BETA BLOCKERS		
acebutolol (generic for Sectral) atenolol (generic for Tenormin) atenolol/chlorthalidone(generic for Tenoretic) bisoprolol (generic for Zebeta) bisoprolol/HCTZ (generic for Ziac) metoprolol (generic for Lopressor) metoprolol XL (generic for Toprol XL) propranolol (generic for Inderal) propranolol extended release (Inderal LA) TOPROL XL (metoprolol)	betaxolol (generic for Kerlone) BYSTOLIC (nebivolol) DUTOPROL (metoprolol XR and HCTZ) *INNOPRAN XL (propranolol)* LEVATOL (penbutolol) *metoprolol/HCTZ (generic for Lopressor HCT)* *nadolol (generic for Corgard)* nadolol/bendroflumethiazide (generic for Corzide) *pindolol (generic for Viskin)* *propranolol/hydrochlorothiazide (generic for Inderide)* *timolol (generic for Blocadren)*	Non-preferred agent will be approved only after documented failure of two preferred agents within the past 12 months. *Drug Interactions: Non-preferred beta blocker may be approved if necessary to avoid drug interaction with preferred agent. Such as allow pindolol with MAO inhibitor or SSRI.* 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.
BETA- AND ALPHA- BLOCKERS		
carvedilol (generic for Coreg)	COREG CR (carvedilol) *labetalol (generic for Trandate)*	Coreg CR: Clinical reason the generic regular-release cannot be used. *Labetalol: Allow without trial on preferred agent for pregnancy induced hypertension.*
ANTIARRHYTHMIC		
sotalol (generic for Betapace)		

Motion to approve by Dering-Anderson and seconded by Reichmuth to accept recommendations as published with criteria additions as noted above.

Votes as follows:

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QL indicates quantity limits.
NR indicates product was not reviewed. New Drug criteria will apply.

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

BLADDER RELAXANT PREPARATIONS

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
oxybutynin IR (generic for Ditropan) oxybutynin syrup (generic for Ditropan) TOVIAZ (fesoterodine ER) VESICARE (solifenacin)	DETROL LA (tolterodine) ENABLEX (darifenacin) GELNIQUE (oxybutynin) *MYRBETRIQ (mirabegron)* oxybutynin ER (generic for Ditropan XL) OXYTROL (oxybutynin) tolterodine (generic for Detrol) trospium (generic for Sanctura) trospium ER (generic for Sanctura XR)	The non-preferred agent will be approved only after documented failure of a preferred agent. Oxybutynin ER –Treatment failure with preferred LONG ACTING agent. *Myrbetriq: Allow when anticholinergic agent is contraindicated.*

Motion to approve by Johnson-Bohac and seconded by Humphries to accept recommendations as published with criteria addition for Myrbetriq.

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

BONE RESORPTION SUPPRESSION AND RELATED DRUGS

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
BISPHOSPHONATES		
alendronate (generic for Fosamax) (daily and weekly formulations)	ACTONEL (risedronate) ATELVIA DR (risedronate) *BINOSTO (alendronate effervescent)* etidronate disodium FOSAMAX Oral Solution (alendronate) FOSAMAX PLUS D ibandronate (generic for Boniva)	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.

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		Note: products with calcium or vitamin D will be prescribed separately.
OTHER BONE RESORPTION SUPPRESSION AND RELATED DRUGS		
EVISTA (raloxifene) *FORTICAL (calcitonin) nasal*	calcitonin-salmon nasal FORTEO (teriparatide) subcutaneous[QL] *MIACALCIN (calcitonin) nasal*	1.Adverse reaction to, allergy or contraindication to preferred drugs, or 2 .Documentation of treatment failure with preferred drug.
	Forteo® (teriparatide) Criteria: 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 calcitonin nasal. Quantity limit of 2.4ml per claim for a 30 day supply. Combination therapy with bisphosphonates (Actonel®, Boniva®, Didronel®, Fosamax®, alendronate) is not recommended and will NOT be approved. Not approved for pediatric patients or young adults with open epiphyses.	

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	Injection must be administered by patient or caregivers.

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

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

CALCIUM CHANNEL BLOCKERS (Oral)

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
SHORT-ACTING		
Dihydropyridines		
nifedipine (generic for Procardia)	isradipine (generic for Dynacirc) *nicardipine (generic for Cardene)* 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.
Non-dihydropyridine		
diltiazem (generic for Cardizem) verapamil (generic for Calan, Isoptin)		
LONG-ACTING		
Dihydropyridines		Non-preferred agents will be approved only after documented failure of a preferred agent.
amlodipine (generic for Norvasc) nifedipine ER (generic for Procardia XL)	CARDENE SR (nicardipine) *felodipine ER (generic for Plendil)* nisoldipine (generic for Sular)	
Non-dihydropyridines		
diltiazem ER (generic for Cardizem CD) verapamil ER ***TABLET***	CARDIZEM LA (diltiazem LA) verapamil ER ***CAPSULE***	

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verapamil ER PM (generic for Verelan PM) verapamil 360mg Capsule (generic for Verelan)		

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

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

CEPHALOSPORINS (Oral) and RELATED ANTIBIOTICS

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
BETA LACTAM/BETA-LACTAMASE INHIBITOR COMBINATIONS		
amoxicillin/clavulanate tablets and suspension AUGMENTIN **125MG/5ML SUSPENSION**	amoxicillin/clavulanate ER (generic for Augmentin XR) AUGMENTIN (amoxicillin/clavulanate)	1. Adverse reaction to, contraindication to preferred drugs, or 2. Documentation of treatment failure with preferred drug.
CEPHALOSPORINS – First Generation		
cefadroxil **CAPSULE, SUSPENSION** (generic for Duricef) cephalexin (oral) (generic for Keflex)	cefadroxil ***TABLET*** (generic for Duricef)	1. Adverse reaction to, contraindication to preferred drugs, or 2. Documentation of treatment failure with preferred drug.
CEPHALOSPORINS – Second Generation		
cefprozil (oral) (generic for Cefzil) cefuroxime (oral tablet) (generic for Ceftin)	cefaclor (oral) (generic for Ceclor) CEFTIN (cefuroxime) tablets, suspension	1. Adverse reaction to, contraindication to preferred drugs, or 2. Documentation of treatment failure with preferred drug.
CEPHALOSPORINS – Third Generation		
cefdinir (oral) (generic for Omnicef) SUPRAX (cefixime) **TABLET, SUSPENSION**	CEDAX (ceftibuten) cefpodoxime (oral) (generic for Vantin) *SUPRAX **CHEWABLE** TABLET*	1. Adverse reaction to, contraindicationto preferred drugs, or 2. Documentation of treatment failure with preferred drug.

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

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QL indicates quantity limits.
NR indicates product was not reviewed. New Drug criteria will apply.

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

HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
Glucagon-Like Peptide-1 Receptor Agonist (GLP-1 RA)	BYDUREON (exenatide ER)* BYETTA (exenatide) subcutaneous* VICTOZA (liraglutide) subcutaneous*	https://nebraska.fhsc.com/Downloads/NEfaxform_GLP-1_RA-201210.pdf
Amylin Analog	SYMLIN (pramlintide) subcutaneous*	https://nebraska.fhsc.com/Downloads/NEfaxform_Amylin-2013103.pdf
Dipeptidyl peptidase-4 (DPP-4) Inhibitor		
JANUMET(sitagliptin/metformin) *JANUMET XR (sitagliptin/metformin)* *JANUVIA (sitagliptin)* *JENTADUETO (linagliptin/metformin)* *JUVISYNC (sitagliptin/simvastatin)* *TRADJENTA (linagliptin)*	*KAZANO (alogliptin/metformin)* KOMBIGLYZE XR (saxagliptin/metformin) *NESINA(alogliptin)* ONGLYZA (saxagliptin) *OSENI (alogliptin/pioglitazone)*	*Trial on sitagliptin or linagliptin.*

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

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

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MULTIPLE SCLEROSIS DRUGS

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
AVONEX (interferon beta-1a) BETASERON (interferon beta-1b) COPAXONE (glatiramer) *REBIF (interferon beta-1a)*	AMPYRA (dalfampridine) *AUBAGIO (teriflunomide)* EXTAVIA (interferon beta-1b) GILENYA (fingolimod)	**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 **Aubagio: Extavia Gilenya:** Treatment failure with or contraindication to one preferred agent.

Motion to approve by Johnson-Bohac and seconded by Rock to accept recommendations as published with criteria modification as noted above.

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

(PAH) PULMONARY ARTERIAL HYPERTENSION AGENTS (Oral and inhaled)

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
LETAIRIS (ambrisentan) sildenafil (generic for Revatio) (for PAH only*) TRACLEER (bosentan) *TYVASO INHALATION (treprostinil)* VENTAVIS INHALATION (iloprost)	*ADCIRCA (tadalafil) (for PAH only*)*	Sildenafil (Revatio) and Adcirca require diagnosis of PAH.

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

Votes as follows:

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

PANCREATIC ENZYMES

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
CREON PANCRELIPASE™ (pancrelipase) ZENPEP (pancrelipase)	PANCREAZE (pancrelipase) *PERTYZE (pancrelipase)* *ULTRESA (pancrelipase)* *VIOKACE (pancrelipase)*	1.Adverse reaction to, allergy or contraindication to preferred drugs, or 2 .Documentation of treatment failure with two preferred drugs.

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

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

PHOSPHATE BINDERS

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
calcium acetate tablet *CALPHRON OTC (calcium acetate)* RENAGEL (sevelamer HCl)	*calcium acetate CAPSULE* *ELIPHOS (calcium acetate)* FOSRENOL (lanthanum) PHOSLO (calcium acetate) PHOSLYRA (calcium acetate) RENVELA (sevelamer carbonate)	Non-preferred agents may be approved if the patient has a history of one preferred agent in the last 6 months

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

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

ULCERATIVE COLITIS

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
ORAL		
APRISO (mesalamine)	ASACOL **HD** 800mg (mesalamine)	1. Adverse reaction to, allergy or contraindication to preferred drugs,

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ASACOL (mesalamine) 400MG balsalazide (generic for Colazal) sulfasalazine (generic for Azulfidine) sulfasalazine DR (generic for Azulfidine DR)	DIPENTUM (olsalazine) *GIAZO (balsalazide)* LIALDA (mesalamine) PENTASA (mesalamine)	or 2. Documentation of treatment failure with one preferred drug. ASACOL **HD** AND LIALDA: Clinical reason cannot use the preferred form of mesalamine. *Giazo: Clinical reason required as to why the preferred generic balsalazide cannot be used. Giazo is most likely used in males and will deny if claim is for a female patient (effectiveness in female patients was not demonstrated in clinical trials).*
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.

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

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

An all in favor motion was made by Saunders to conclude the meeting at 2:45pm.

Next meeting:
The next scheduled meeting of the Nebraska Medicaid Pharmaceutical and Therapeutics Committee is scheduled for:
Wednesday, November 13, 2013, 9 am
Mahoney State Park, Ashland, NE

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

Approved November 13, 2013

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