**DIVISION OF MEDICAID AND LONG-TERM CARE**

PHARMACEUTICAL AND THERAPEUTICS COMMITTEE
MEETING MINUTES

November 13, 2013 9am
Mahoney State Park, Peter Kiewit Lodge
Ashland, NE

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Members Present
Stacie Bleicher M.D.
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.
Kristi Johnson-Bohac, Master of Divinity

Joyce Juracek Pharm.D.
Eileen Rock M.D.
Ken Saunders Pharm.D.
Christopher Sorensen Pharm.D.
Eric Thomsen M.D

Members Absent:
Claire Baker M.D. (excused)
Kevin Reichmuth M.D. (excused)

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

Magellan Medicaid Administration
Contract Staff
Barbara Dowd R.P.
NE Clinical Account Manager
Glenn Sharp R. P. 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 October 11, 2013. A copy of the Open Meetings Act was posted in the middle of the meeting room and materials distributed to members were on display.

II. Introduction of new Committee Member: Stacie Bleicher M.D., Lincoln Pediatrician. Jenny Minchow announced that Angie Ward R.P. moved out of state and resigned from the Committee

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 15, 2013 meeting were unanimously approved, with the exception of members who were absent from the May meeting, as written.

VI. Election of Officers: Motions were made and seconded to nominate:

- Jeff Gotschall M.D. Chairman
- Chris Sorensen Pharm.D. Vice-Chairman

Votes for Slate of Officers as follows:

Bleicher-yes, Caudill-yes, Davenport-yes, Dering-Anderson-yes, Dube'-yes, Elsasser-yes, Farho-yes, Gotschall-abstain, Green–yes, Haberstich-yes, Humphries–yes, Johnson-Bohac–Absent, Juracek-Absent, , Rock-yes, Saunders-yes, Sorensen-abstain, Thomsen-yes

VII. Other: The Committee requested that a PDL savings report be presented at the next meeting.

VIII. Public Testimony

| Drug/Class | Status | Speaker | Affiliation |
|---|---|---|---|
| **COPD AGENTS** | | | |
| Daliresp | NP | Robert Jaramillo | Forest |
| Tudorza | NP | Robert Jaramillo | Forest |
| **CYTOKINE AND CAM ANT.** | | | |
| Xeljanz | NP | Nancy Bell | Pfizer |
| **ORAL BREAST CANCER AGENTS** | | | |
| Hormone Therapy | | Stacey Knox MD | SE Nebraska Cancer Center |
| **ONCOLOGY AGENTS, ORAL** | | | |
| Unspecified | | David Holmquist | American Cancer Society Cancer Action Network |
| Unspecified | | Natalie Mandolfo | Nebraska Oncology Society |
| Unspecified | | Michael West | Patient |
| Unspecified | | Twila West | Patient |
| Xtandi | NP | Jennifer Kammerer | Astellas |
| Gilotrif | NP | Mark Tiemann | Boehringer I. |
| Mekinist | NP | Scott Goldfarb | GSK |
| Tafinlar | NP | Scott Goldfarb | GSK |
| Votrient | NP | Scott Goldfarb | GSK |
| Tasigna | NP | Christopher Zacker | Novartis |
| Bosulif | NP | Elizabeth MacLean | Pfizer |
| Inlyta | NP | Elizabeth MacLean | Pfizer |
| Xalkori | NP | Elizabeth MacLean | Pfizer |

P= Preferred
NP= Non-preferred

IX. A motion was made and seconded to move into closed session at 10:15am.
Cost issues discussed in Closed Session.

X. A motion was made and seconded to move back into open session. Open Session resumed at 11:15am.

XI. Therapeutic Class Reviews
Classes reviewed and Committee recommendations as follows in Nebraska Medicaid Preferred Drug List P&T Recommendations November 2013:

XII. LUNCH 12-1PM

12:00 A motion was made to go into closed session for cost discussions. Decision unanimous.

1:00 pm A motion was made to resume open session. Decision unanimous.

XIII. Therapeutic Class Reviews
Classes reviewed and Committee recommendations as follows in Nebraska Medicaid Preferred Drug List P&T Recommendations November 2013:

# NEBRASKA MEDICAID
# PREFERRED DRUG LIST
# P&T RECOMMENDATIONS
# NOVEMBER 2013

**ALZHEIMER'S DRUGS**

| PREFERRED DRUGS | NON-PREFERRED DRUGS | PDL EXCEPTION CRITERIA: |
|---|---|---|
| **CHOLINESTERASE INHIBITORS** | | |
| donepezil (generic for Aricept)<br>donepezil ODT (generic for Aricept ODT)<br>EXELON Transdermal (rivastigmine) | donepezil 23 (generic for Aricept 23)<br>EXELON Oral Solution (rivastigmine)<br>galantamine (generic for Razadyne)<br>galantamine ER (generic for Razadyne ER)<br>rivastigmine (generic for Exelon oral capsules) | 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) | *NAMENDA XR (memantine ER)* | *Namenda XR: May authorize if patient has difficulty swallowing or is unable to be compliant with a twice daily dosing regimen.* |

**ANTIHISTAMINES, MINIMALLY SEDATING**

| PREFERRED DRUGS | NON-PREFERRED DRUGS | PDL EXCEPTION CRITERIA: |
|---|---|---|
| cetirizine (generic for Zyrtec) (swallow tablets and solution)<br>loratadine (generic for Claritin) (swallow tablets and solution) | cetirizine **chewable** (generic for Zyrtec)<br>desloratadine (generic for Clarinex)<br>desloratadine ODT (generic for Clarinex Reditabs)<br>*fexofenadine (generic for Allegra)*<br>levocetirizine (generic for Xyzal)<br>loratadine dispersible (generic for Claritin Reditabs) | 1. Adverse reaction to, contraindication to or<br>2. treatment failure with both cetirizine and loratadine |

**ANTIHYPERTENSIVES, SYMPATHOLYTICS**

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

**ANTIHYPERURICEMICS**

| PREFERRED DRUGS | NON-PREFERRED DRUGS | PDL EXCEPTION CRITERIA: |
|---|---|---|
| allopurinol (generic for Zyloprim)<br>probenecid | COLCRYS (colchicine)*<br>ULORIC (febuxostat)* | **Colcrys™ (colchicine):**<br>• **Diagnosis of familial** |

| | | |
|---|---|---|
| probenecid/colchicine<br>(generic for Col-Probenecid) | | **Mediterranean fever (FMF);**<br>o Maximum daily dose: 2.4mg<br>o Minimum age: 4<br>o Length of approval: 12 months<br>o Quantity limit: 120 per 30 days<br>• **Or Diagnosis of Gout**<br>o Approve if there has been a treatment failure with any preferred drug<br>o Quantity limit: 60 per 28 days<br>o Minimum age: 16<br>o Length of approval: 6 months<br>Uloric:<br>Allergy to, treatment failure with, or contraindication to allopurinol. |

**ANTIPARKINSON'S AGENTS**

| PREFERRED DRUGS | NON-PREFERRED DRUGS | PDL EXCEPTION CRITERIA: |
|---|---|---|
| **ANTICHOLINERGICS** | | |
| benztropine (generic for Cogentin)<br>trihexyphenidyl (generic for Artane) | | |
| **COMT INHIBITORS** | | |
| | entacapone (generic for Comtan)<br>TASMAR (tolcapone) | Approve if using as add on therapy with a levodopa containing drug. |
| **DOPAMINE AGONISTS** | | |
| bromocriptine (generic for Parlodel)<br>pramipexole (generic for Mirapex)<br>ropinirole (generic for Requip) | MIRAPEX ER (pramipexole)<br>NEUPRO (rotigotine transdermal)<br>REQUIP (ropinirole)<br>ropinirole ER (generic for Requip XL) | 1.Adverse reaction to, allergy or contraindication to *one preferred drug within the same group, or*<br>2 .Documentation of treatment failure with preferred drug.<br><br>AND MIRAPEX ER will only be approved for Parkinson's Disease.<br>AND REQUIP XL will only be approved for Parkinson's Disease<br>**<u>Neupro ®transdermal patch (rotigotine)</u>**<br>• For **Parkinson's Disease**:<br>Is there a clinical reason (i.e. documented swallowing disorder) that a preferred oral agent cannot be used?<br>If there is no clinical reason as noted above, approval requires trial of **ONE** preferred agent.<br>• For **Restless Legs Syndrome** (RLS):<br>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<br>2 .Documentation of treatment failure with preferred drug.<br><br>**Zelapar®:** May approve if documented swallowing disorder.<br>**Parcopa®:** May approve if documented swallowing disorder. |
| selegiline **tablets** (generic for Eldepryl) | AZILECT (rasagiline)<br>selegiline **capsules** (gen. for Eldepryl)<br>ZELAPAR (selegiline dispersible) | |
| **OTHER ANTIPARKINSON'S DRUGS** | | |
| carbidopa/levodopa (generic for Sinemet)<br>carbidopa/levodopa ER (generic for Sinemet CR)<br>STALEVO (levodopa/carbidopa/entacapone) | carbidopa/levodopa ODT (generic for Parcopa)<br><br>levodopa/carbidopa/entacapone (generic for Stalevo) | |

***ANTIPSORIATICS, ORAL***

| PREFERRED DRUGS | NON-PREFERRED DRUGS | PDL EXCEPTION CRITERIA: |
|---|---|---|
| *SORIATANE (acitretin)* | *acitretin (generic for Soriatane)*<br>*OXSORALEN-ULTRA (methoxsalen)*<br>*8-MOP (methoxsalen)* | *1.Adverse reaction to, allergy or contraindication to preferred drug, or*<br>*2 .Documentation of treatment failure with preferred drug.*<br>*3. Trial on acitretin (Category X) not required in pregnancy or while attempting or planning pregnancy.* |

***ANTIPSORIATICS, TOPICAL***

| PREFERRED DRUGS | NON-PREFERRED DRUGS | PDL EXCEPTION CRITERIA: |
|---|---|---|
| *calcipotriene **solution***<br>*DOVONEX **CREAM** (calcipotriene)* | *calcipotriene **OINTMENT, CREAM***<br>*calcitriol (generic for Vectical)*<br>*CALCITRENE (calcipotriene ointment)*<br>*SORILUX (calcipotriene foam)*<br>*TACLONEX OINTMENT*<br>*TACLONEX SCALP (calcipotriene/ betamethasone)* | *1. Adverse reaction to, allergy or contraindication to preferred drug, or*<br>*2. Documentation of treatment failure with preferred drug.* |

***ANXIOLYTICS***

| PREFERRED DRUGS | NON-PREFERRED DRUGS | PDL EXCEPTION CRITERIA: |
|---|---|---|
| *alprazolam tablet (generic for Xanax)*<br>*buspirone*<br>*chlordiazepoxide*<br>*clorazepate (generic for Tranxene-T)*<br>*diazepam solution*<br>*diazepam tablet*<br>*lorazepam INTENSOL*<br>*lorazepam tablet (generic for Ativan)* | *alprazolam ER (generic for Xanax XR)*<br>*alprazolam ODT*<br>*alprazolam INTENSOL*<br>*diazepam INTENSOL*<br>*meprobamate*<br>*NIRAVAM (alprazolam ODT))*<br>*oxazepam* | *1. Adverse reaction to, contraindication to two preferred drugs, or*<br>*2. Documentation of treatment failure with two preferred drugs.*<br>*3. Intensol: Documentation of treatment failure with one preferred oral **solution**.* |

**BILE SALTS**

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

**BRONCHODILATORS, BETA AGONIST**

| PREFERRED DRUGS | NON-PREFERRED DRUGS | PDL EXCEPTION CRITERIA: |
|---|---|---|
| **INHALERS-Short Acting** | | |
| PROVENTIL HFA (albuterol) | ~~MAXAIR (pirbuterol)~~<br>PROAIR HFA (albuterol)<br>VENTOLIN HFA (albuterol)<br>XOPENEX HFA (levalbuterol) | 1. Adverse reaction to, allergy or contraindication to preferred drugs, or<br>2. Documentation of treatment failure with a preferred drug.<br>3. Maxair – Documentation of treatment failure of preferred agent with use of a spacer.<br>4. Ventolin/Proair- May be approved without trials on preferred if prescriber documents need for dose counter on canister. |
| **INHALERS – Long Acting** | | |
| FORADIL (formoterol)<br>(Prior authorization of Foradil not required if diagnosis of COPD in claims history or co-administered with inhaled steroid.) | ARCAPTA (indacaterol)<br>SEREVENT (salmeterol) | Arcapta and Serevent:<br>1. Adverse reaction to, allergy or contraindication to preferred drug, or<br>2. Documentation of treatment failure with a preferred drug.<br><br>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)<br>albuterol/ipratropium (generic for Duoneb) | albuterol low dose (0.63mg/3ml & 1.25mg/3ml)<br>……<br>BROVANA (arformoterol)<br>levalbuterol (generic for Xopenex)<br>PERFOROMIST (formoterol) | If the patient weighs less than 15kg (33lbs) the call center may approve the lower dose.<br>OR May approve lower dose if it is felt that the parent is not able to reliably measure drug.<br>……<br>…<br>1. Adverse reaction to, allergy or contraindication to preferred drugs, or<br>3. Documentation of treatment failure with preferred drug. |
| **ORAL** | | |
| albuterol **syrup**<br>*albuterol ER (generic for* | *albuterol* ***tablets***<br>metaproterenol (formerly generic for | 1. Adverse reaction to, allergy or contraindication to preferred drug, or |

| | | |
|---|---|---|
| *Vospire ER)*<br>terbutaline (generic for Brethine) | Alupent) | 2. Documentation of treatment failure with preferred drug. |

**COPD AGENTS**

| PREFERRED DRUGS | NON-PREFERRED DRUGS | PDL EXCEPTION CRITERIA: |
|---|---|---|
| **INHALERS** | | |
| ATROVENT HFA (ipratropium)<br>~~COMBIVENT (albuterol/ipratropium)~~<br>COMBIVENT RESPIMAT (albuterol/ipratropium)<br>SPIRIVA (tiotropium) | *TUDORZA PRESSAIR (aclidinium br)* | *1. Adverse reaction to, allergy or contraindication to preferred drug, or*<br>*2. Documentation of treatment failure with preferred drug.* |
| **INHALATION SOLUTION** | | |
| albuterol/ipratropium (generic for Duoneb)<br>ipratropium solution (generic for Atrovent) | | |
| **ORAL AGENT** | | |
| | DALIRESP (roflumilast) | 1. Diagnosis of severe COPD associated with chronic bronchitis.<br>2. Require documentation that bronchodilators have been used.<br>3. Documentation of history of one exacerbation (office visit, hospitalization) in last year.<br>4. Limit of one per day.<br>5. Age 19 or older. |
| XANTHINES (not reviewed by the PDL process but are covered without prior authorization) | | |
| theophylline | | |

**CYTOKINE & CAM ANTAGONISTS**

| PREFERRED DRUGS | NON-PREFERRED DRUGS | PDL EXCEPTION CRITERIA: |
|---|---|---|
| ENBREL (etanercept)<br>HUMIRA (adalimumab) | CIMZIA (certolizumab pegol)<br>KINERET (anakinra)<br>ORENCIA (abatacept**) S.C.**<br>SIMPONI (golimumab)<br>*XELJANZ (tofacitinib oral)* | 1. Adverse reaction to, contraindication to *one* preferred drug~~s~~, or<br>2. Documentation of treatment failure with preferred drug. |

***EPINEPHRINE, SELF-INJECTED***

| PREFERRED DRUGS | NON-PREFERRED DRUGS | PDL EXCEPTION CRITERIA: |
|---|---|---|
| *EPIPEN*<br>*EPIPEN JR.* | *epinephrine*<br>*AUVI-Q* | *epinephrine generic: clinical reason the brand name product could not be used.*<br>*Auto-injector (Auvi-Q): Documentation of patient specific need for assistance with administration.* |

**GLUCOCORTICOIDS, INHALED**

| PREFERRED DRUGS | NON-PREFERRED DRUGS | PDL EXCEPTION CRITERIA: |
|---|---|---|
| **GLUCOCORTICOIDS** | | |
| ASMANEX (mometasone)<br>FLOVENT DISKUS (fluticasone) | ALVESCO (ciclesonide) | 1. Adverse reaction to, allergy or contraindication to preferred drugs, |

| | | |
|---|---|---|
| FLOVENT HFA (fluticasone)<br>PULMICORT FLEXHALER (budesonide)<br>QVAR (beclomethasone) | | or<br>2. Documentation of treatment failure with two preferred drugs within last 6 months. |
| **GLUCOCORTICOID/BRONCHODILATOR COMBINATIONS** | | |
| ADVAIR DISKUS (fluticasone/salmeterol)<br>ADVAIR HFA (fluticasone/salmeterol)<br>DULERA (mometasone/formoterol)<br>SYMBICORT (budesonide/formoterol) | *BREO ELLIPTA* *Not Reviewed*<br>*(fluticasone/vilanterol)* | 1. Adverse reaction to, allergy or contraindication to preferred drugs, or<br>2. Documentation of treatment failure with two preferred drugs. |
| **INHALATION SOLUTION** | | |
| | PULMICORT RESPULES (budesonide)<br>budesonide respules | No prior authorization required for use in children ages 1-8 years.<br>For age 9 and up, will require documentation of inability to use inhaler. |

***HISTAMINE II RECEPTOR BLOCKERS***

| ***PREFERRED DRUGS*** | ***NON-PREFERRED DRUGS*** | ***PDL EXCEPTION CRITERIA:*** |
|---|---|---|
| *cimetidine tablet (generic for Tagamet)*<br>*famotidine tablet (generic for Pepcid)*<br>*ranitidine **TABLET** (generic for Zantac)*<br>*ranitidine syrup* | *cimetidine solution*<br>*ranitidine **CAPSULE***<br>*famotidine **SUSPENSION***<br>*nizatidine (generic for Axid)* | *1. Adverse reaction to, allergy or contraindication to preferred drug, or*<br>*2. Documentation of treatment failure with preferred drug.* |

**IMMUNOMODULATORS, ATOPIC DERMATITIS**

| **PREFERRED DRUGS** | **NON-PREFERRED DRUGS** | **PDL EXCEPTION CRITERIA:** |
|---|---|---|
| ELIDEL (pimecrolimus) | PROTOPIC (tacrolimus) | 1. Adverse reaction to, allergy or contraindication to preferred drug, or<br>2. Documentation of treatment failure with preferred drug.<br>**AND**<br>3. Trial on topical steroid. |

***IMMUNOMODULATORS, TOPICAL***

| **PREFERRED DRUGS** | **NON-PREFERRED DRUGS** | **PDL EXCEPTION CRITERIA:** |
|---|---|---|
| *ALDARA (imiquimod)* | *imiquimod*<br>*ZYCLARA (imiquimod)* | *Documentation of clinical reason why the preferred product could not be used.* |

**INTRANASAL RHINITIS DRUGS**

| **PREFERRED DRUGS** | **NON-PREFERRED DRUGS** | **PDL EXCEPTION CRITERIA:** |
|---|---|---|
| **ANTICHOLINERGICS** | | |
| ipratropium (generic for Atrovent) | | |
| **ANTIHISTAMINES** | | |
| ASTELIN (azelastine)<br>ASTEPRO (azelastine)<br>PATANASE (olopatadine) | azelastine (generic for Astelin)<br>DYMISTA (azelastine/fluticasone) | 1. Adverse reaction to, allergy or contraindication to preferred drug, or<br>2. Documentation of treatment failure with preferred drug. |

| CORTICOSTEROIDS | | |
|---|---|---|
| fluticasone (generic for Flonase)<br>NASONEX (mometasone) | BECONASE AQ (beclomethasone)<br>flunisolide (generic for product formerly known as Nasalide)<br>*NASACORT AQ (triamcinolone)*<br>OMNARIS (ciclesonide)<br>QNASL (beclomethasone)<br>RHINOCORT AQUA (budesonide)<br>triamcinolone (generic for Nasacort)<br>VERAMYST (fluticasone)<br>ZETONNA (ciclesonide) | 1. Adverse reaction to, allergy or contraindication to preferred drugs, or<br>2. Documentation of treatment failure with preferred drug.<br>*Rhinocort Aqua is Pregnancy Category B, so allow during pregnancy.*<br>Veramyst: prior authorization NOT required for children 12 and younger. |

**LEUKOTRIENE MODIFIERS**

| PREFERRED DRUGS | NON-PREFERRED DRUGS | PDL EXCEPTION CRITERIA: |
|---|---|---|
| ACCOLATE (zafirlukast)<br>montelukast (generic for Singulair) (CHEWABLE AND SWALLOW TABLETS) | montelukast granules (generic for SINGULAIR **GRANULES)**<br>zafirlukast (generic for Accolate)<br>ZYFLO (zileuton)<br>ZYFLO CR (zileuton) | 1. Adverse reaction to, allergy or contraindication to preferred drugs, or<br>2. Documentation of treatment failure with preferred drug.<br>3. ZYFLO: allow to be added on to Singulair when step-up therapy is required.<br>4. Montelukast GRANULES do not require prior authorization for children less than 2 years of age. |

**NSAIDS**

| PREFERRED DRUGS | NON-PREFERRED DRUGS | PDL EXCEPTION CRITERIA: |
|---|---|---|
| **COX-I SELECTIVE** | | |
| diclofenac potassium (generic for Cataflam)<br>diclofenac sodium (generic for Voltaren)<br>etodolac (generic for Lodine)<br>flurbiprofen (generic for Ansaid)<br>ibuprofen OTC, Rx (generic for Advil, Motrin,)<br>indomethacin **capsule** (generic for Indocin)<br>ketoprofen (generic for Orudis, Oruvail)<br>ketorolac (generic for Toradol)<br>meloxicam **tablet** (generic for Mobic)<br>nabumetone (generic for Relafen)<br>naproxen Rx, OTC (generic for Naprosyn)<br>naproxen **suspension** (Naprosyn)<br>sulindac (generic for Clinoril) | diclofenac SR (generic for Voltaren-XR)<br>diflunisal (generic for Dolobid)<br>etodolac SR<br>*fenoprofen (generic for Nalfon)*<br>indomethacin ER<br>INDOCIN RECTAL<br>INDOCIN SUSPENSION<br>ketoprofen ER<br>*meclofenamate (generic for Meclomen)*<br>mefenamic acid (generic for Ponstel)<br>meloxicam **suspension**<br>naproxen EC<br>*oxaprozin (generic for Daypro)*<br>piroxicam (generic for Feldene)<br>tolmetin (generic for Tolectin)<br><br>**TOPICAL:**<br>FLECTOR PATCH (diclofenac) | 1.Adverse reaction to, allergy or contraindication to preferred drugs, or<br>2 .Documentation of treatment failure of no less than a 30 day trial with two preferred drugs.<br><br>*meclofenamate: May authorize without trial on preferred for primary dysmenorrhea or excessive menstrual blood loss.*<br><br>SPRIX:<br>• Patient is unable to tolerate, swallow or absorb oral NSAIDS (check to see if there are any current PO meds on profile) OR |

| | | |
|---|---|---|
| | PENNSAID SOLUTION (diclofenac)<br>VOLTAREN GEL (diclofenac)<br><br>**ALL BRAND NAME NSAIDs ARE NON-PREFERRED.**<br>CAMBIA (diclofenac oral solution)<br>DUEXIS (ibuprofen/famotidine)<br>SPRIX (ketorolac nasal)<br>VIMOVO (naprosyn/esomeprazole)<br>ZIPSOR (diclofenac) | • Contraindication to oral NSAID ~~*(e.g. active GI bleed)*~~ OR<br>• Patient has tried 2 preferred oral NSAID agents<br>• *For patients ≥ 65 years of age, renally impaired patients, and adult patients less than 50 kg (110 lbs.), the recommended dose is 15.75 mg SPRIX (**one** 15.75 mg spray in **only one** nostril) every 6 to 8 hours.*<br>Approvals for Date Of Service only – recommended maximum duration of therapy is 5 days. |
| **NSAID/GI PROTECTANT COMBINATIONS** | | |
| | diclofenac/misoprostol (generic for Arthrotec) | Diclofenac and misoprostol both available individually without prior authorization. |
| **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):**
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 –** Separate ingredients are available without prior authorization.
**VIMOVO-** 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.

***ONCOLOGY AGENTS, ORAL, BREAST CANCER***

***Note: other oral oncology agents not listed here may also be available. See https://nebraska.fhsc.com/default.asp for coverage information and prior authorization status for products not listed below.***

| PREFERRED DRUGS | NON-PREFERRED DRUGS | PDL EXCEPTION CRITERIA: |
|---|---|---|
| **AROMATASE INHIBITORS** | | |
| *anastrozole (generic for Arimidex)*<br>*exemestane (generic for Aromasin)*<br>*letrozole (generic for Femara)* | | |
| **ANTIESTROGEN** | | *Documentation of why tamoxifen not appropriate for patient.* |
| *tamoxifen* | *Fareston (toremifene)* | |

***ONCOLOGY AGENTS, ORAL***

***Note: other oral oncology agents not listed here may also be available. See https://nebraska.fhsc.com/default.asp for coverage information and prior authorization status for products not listed below.***

| PREFERRED DRUGS | NON-PREFERRED DRUGS | PDL EXCEPTION CRITERIA: |
|---|---|---|
| **Kinase Inhibitors** | | |
| *AFINITOR (everolimus)*<br>*BOSULIF (bosutinib)*<br>*CAPRELSA (vandetanib)*<br>*COMETRIQ (cabozantinib)*<br>*GILOTRIF (afatinib)*<br>*GLEEVEC (imatinib)*<br>*INLYTA (axitinib)*<br>*JAKAFI (ruxolitinib)*<br>*MEKINIST (trametinib)*<br>*NEXAVAR (sorafenib)*<br>*SPRYCEL (dasatinib)*<br>*STIVARGA (regorafenib)*<br>*SUTENT (sunitinib)*<br>*TAFINLAR (dabrafenib)*<br>*TARCEVA (erlotinib)*<br>*TASIGNA (nilotinib)*<br>*TYKERB (lapatinib)*<br>*VOTRIENT (pazopanib)*<br>*XALKORI (crizotinib)*<br>*ZELBORAF (vemurafenib)* | *AFINITOR **DISPERZ****<br>*~~ICLUSIG (ponatinib)*~~* | *Afinitor Disperz: Documentation of clinical reason why Afinitor not appropriate for patient.* |
| **Others** | | |
| *ALKERAN (melphalan)*<br>*ERIVEDGE (vismodegib)*<br>*FLUTAMIDE*<br>*hydroxyurea*<br>*mercaptopurine*<br>*TEMODAR (temozolomide)*<br>*XELODA (capecitabine)*<br>*XTANDI (enzalutamide)*<br>*ZOLINZA (vorinostat)*<br>*ZYTIGA (abiraterone)* | *HYDREA*<br>*temozolomide (generic for Temodar)** | *HYDREA: Clinical documentation of why the preferred generic product is inappropriate for the patient.*<br><br>*temozolomide: Clinical documentation of why the preferred brand product is inappropriate for the patient.* |

**OPHTHALMIC ANTIBIOTIC-STEROID COMBINATIONS**

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

**OPHTHALMICS, ANTIBIOTICS**

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

**OPHTHALMICS FOR ALLERGIC CONJUNCTIVITIS**

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

**OPHTHALMICS, ANTI-INFLAMMATORIES**

| PREFERRED DRUGS | NON-PREFERRED DRUGS | PDL EXCEPTION CRITERIA: |
|---|---|---|
| **CORTICOSTEROIDS** | | |
| dexamethasone (generic for Maxidex)<br>*DUREZOL (difluprednate)*<br>FLAREX (fluorometholone)<br>fluorometholone 0.1% (generic for FML)<br>FML FORTE (fluorometholone 0.25%)<br>FML S.O.P. (fluorometholone 0.1%)<br>LOTEMAX **DROPS** (loteprednol 0.5%)<br>MAXIDEX (dexamethasone)<br>PRED MILD (prednisolone 0.12%)<br>prednisolone acetate 1% (generic for Omnipred, Pred Forte) | LOTEMAX **OINTMENT, GEL** (loteprednol)<br>prednisolone sodium phosphate 1% (formerly generic for Inflamase)<br>VEXOL (rimexolone) | 1.Adverse reaction to, allergy or contraindication to preferred drugs, or<br>2 .Documentation of treatment failure with two preferred drugs. |
| **NSAID** | | |
| diclofenac (generic for Voltaren)<br>flurbiprofen (generic for Ocufen) | ACUVAIL (ketorolac 0.45%)<br>bromfenac 0.09% (generic for Bromday)<br>*ILEVRO (nepafenac 0.3%)*<br>ketorolac LS 0.4% (generic for Acular LS)<br>ketorolac 0.5% (generic for Acular)<br>NEVANAC (nepafenac 0.1%)<br>*PROLENSA (bromfenac 0.07%)* | 1.Adverse reaction to, allergy or contraindication to preferred drugs, or<br>2 .Documentation of treatment failure with preferred drug. |

**OPHTHALMICS, GLAUCOMA DRUGS**

| PREFERRED DRUGS | NON-PREFERRED DRUGS | PDL EXCEPTION CRITERIA: |
|---|---|---|
| **MIOTICS** | | |
| pilocarpine | *PILOPINE HS* | |
| **SYMPATHOMIMETICS** | | |
| ALPHAGAN P 0.15% (brimonidine)<br>brimonidine 0.2% (formerly generic for Alphagan) | ALPHAGAN P 0.1% (brimonidine)<br>apraclonidine (generic for Iopidine)<br>brimonidine P 0.15%(gen. for | 1.Adverse reaction to, allergy or contraindication to preferred drugs, or<br>2 .Documentation of treatment failure |

| | | |
|---|---|---|
| | Alphagan P) | with preferred drug. |
| **BETA BLOCKERS** | | |
| betaxolol (generic for Betoptic)<br>BETIMOL (timolol)<br>BETOPTIC S (betaxolol)<br>carteolol (generic for Ocupress)<br>ISTALOL (timolol)<br>levobunolol (generic for Betagan)<br>metipranolol (generic for Optipranolol)<br>timolol (generic for Timoptic) | TIMOPTIC OCUDOSE<br>TIMOPTIC XE (timolol gel forming solution) | |
| **CARBONIC ANHYDRASE INHIBITORS** | | |
| AZOPT (brinzolamide)<br>dorzolamide (generic for Trusopt)<br>*SIMBRINZA (brinzolamide/brimonidine)* | TRUSOPT (dorzolamide) | 1.Adverse reaction to, allergy or contraindication to preferred drugs, or<br>2 .Documentation of treatment failure with preferred drug. |
| **PROSTAGLANDIN ANALOGS** | | |
| latanoprost (generic for Xalatan)<br>TRAVATAN Z (travoprost) | LUMIGAN (bimatoprost)<br>*RESCULA (unoprostone isopropyl)*<br>travoprost (generic for Travatan)<br>XALATAN (latanoprost)<br>ZIOPTAN (tafluprost) | 1.Adverse reaction to, allergy or contraindication to preferred drugs, or<br>2 .Documentation of treatment failure with preferred drug. |
| **COMBINATION DRUGS** | | |
| dorzolamide/timolol (generic for Cosopt) | *COMBIGAN (brimonidine/timolol)*<br>COSOPT (dorzolamide/timolol) | 1.Adverse reaction to, allergy or contraindication to preferred drugs, or<br>2 .Documentation of treatment failure with preferred drug. |

**OTIC ANTI-INFECTIVES & ANESTHETICS**

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

**OTIC ANTIBIOTICS**

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

**SEDATIVE HYPNOTICS**

| PREFERRED DRUGS | NON-PREFERRED DRUGS | PDL EXCEPTION CRITERIA: |
|---|---|---|
| **BENZODIAZEPINES** | | |
| estazolam (generic for ProSom)<br>temazepam 15mg, 30mg<br>(generic for Restoril) | flurazepam (generic for Dalmane)<br>temazepam 7.5mg, 22.5mg<br>triazolam (generic for Halcion) | 1.Adverse reaction to, allergy or contraindication to preferred drugs, or<br>2 .Documentation of treatment failure with two preferred drugs. |
| **OTHERS** | | |
| zaleplon (generic for Sonata)<br>zolpidem (generic for Ambien) | EDLUAR (zolpidem sublingual)<br>INTERMEZZO (zolpidem sublingual)<br>LUNESTA (eszopiclone)<br>ROZEREM (ramelteon)<br>SILENOR (doxepin)*<br>zolpidem ER (generic for Ambien CR)<br>ZOLPIMIST(zolpidem oral spray) | 1.Adverse reaction to, allergy or contraindication to preferred drugs, or<br>2 .Documentation of treatment failure with preferred drug.<br>Silenor: In addition, would also require patient specific clinical reason patient could not use generic doxepin.<br>*Zolpidem Dose Changes:*<br>*The recommended dose of zolpidem for women has been lowered from 10 mg to 5 mg for immediate-release products (Ambien, Edluar, and Zolpimist) and from 12.5 mg to 6.25 mg for extended-release products (Ambien CR).* |

**STEROIDS, TOPICAL**

| PREFERRED DRUGS | NON-PREFERRED DRUGS | PDL EXCEPTION CRITERIA: |
|---|---|---|
| **LOW POTENCY** | | |
| hydrocortisone **cream , ointment** (generic for Cortaid)<br>hydrocortisone **OTC lotion**<br>hydrocortisone/aloe ***cream, ointment*** | alclometasone dipropionate (generic for Aclovate)<br>CAPEX Shampoo (fluocinolone)<br>DESONATE (desonide gel)<br>desonide **lotion** (generic for Desowen)<br>*desonide **cream , ointment***<br>*(generic for former products Desowen, Tridesilon)*<br>fluocinolone 0.01% **OIL**<br>fluocinolone (generic for Derma-Smoothe-FS)<br>hydrocortisone ***Rx* lotion**<br>hydrocortisone/aloe **gel**<br>hydrocortisone/urea<br>TEXACORT (hydrocortisone)<br>VERDESO (desonide foam) | 1.Adverse reaction to, allergy or contraindication to preferred drugs, or<br>2 .Documentation of treatment failure with two preferred drugs. |
| **MEDIUM POTENCY** | | |
| fluticasone propionate **cream**, **ointment** (generic for Cutivate)<br>mometasone furoate ***solution,*** **cream,** ***ointment*** | betamethasone valerate (generic for Luxiq)<br>CLODERM (clocortolone)<br>CORDRAN TAPE (flurandrenolide) | 1.Adverse reaction to, allergy or contraindication to preferred drugs, or<br>2 .Documentation of treatment failure with two preferred drugs. |

| | | |
|---|---|---|
| (generic for Elocon) | *fluocinolone acetonide (generic for Synalar)*<br>fluticasone propionate **lotion** (generic for Cutivate)<br>hydrocortisone butyrate (generic for Locoid)<br>hydrocortisone valerate (generic for Westcort)<br>MOMEXIN (mometasone)<br>PANDEL (hydrocortisone probutate 0.1%)<br>prednicarbate (generic for Dermatop) | |
| **HIGH POTENCY** | | |
| betamethasone valerate (generic for Beta-Val)<br>fluocinonide **cream, ointment, gel**<br>fluocinonide emollient<br>triamcinolone acetonide **ointment, cream** (generic for Kenalog) | amcinonide cream, ointment, lotion<br>betamethasone dipropionate (generic for Diprolene)<br>betamethasone dipro/prop gly (augmented)<br>desoximetasone (generic for Topicort)<br>diflorasone diacetate (generic for Apexicon)<br>*fluocinonide SOLUTION*<br>HALOG (halcinonide)<br>KENALOG AEROSOL (triamcinolone)<br>triamcinolone **lotion**<br>*TRIANEX Ointment (triamcinolone)*<br>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)<br>clobetasol propionate (generic for Temovate)<br>halobetasol propionate (generic for Ultravate) | APEXICON-E (diflorasone)<br>CLOBEX (clobetasol)<br>clobetasol shampoo, lotion<br>clobetasol propionate **FOAM**<br>HALONATE (halobetasol propionate)<br>OLUX-E (clobetasol)<br>OLUX/OLUX-E CP (clobetasol) | 1.Adverse reaction to, allergy or contraindication to preferred drugs, or 2 .Documentation of treatment failure with preferred drug. |

**STIMULANTS, ADHD, AND RELATED DRUGS**

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

| | | |
|---|---|---|
| | *dextroamphetamine solution*<br>*generic for Procentra)*<br>methamphetamine (generic for Desoxyn)<br>PROCENTRA (dextroamphetamine)<br>*ZENZEDI (dextroamphetamine)* | |
| **Methylphenidate type** | | |
| FOCALIN (dexmethylphenidate)<br>FOCALIN XR (dexmethylphenidate)<br>---<br>METHYLIN CHEWABLE (methylphenidate)<br>METHYLIN SOLUTION (methylphenidate)<br>methylphenidate (generic for Ritalin)<br>RITALIN (methylphenidate)<br>---<br>METADATE **ER** (methylphenidate ER)<br>methylphenidate ER (generic for Ritalin-SR, Metadate ER)<br>*QUILLIVANT XR (methylphenidate suspension)*<br>---<br>Note: generic guanfacine and clonidine are available without prior authorization. | dexmethylphenidate (generic for Focalin)<br>dexmethylphenidate XR (generic for Focalin XR)<br>---<br>methylphenidate solution<br>---<br>DAYTRANA (methylphenidate patch)<br>methylphenidate CD 30/70 (generic for METADATE **CD)**<br>methylphenidate ER 50/50 (generic for RITALIN LA)<br>methylphenidate ER (generic for Ritalin SR)<br>---<br>CONCERTA (methylphenidate ER (18mg, 27mg, 36mg, 54mg)<br>methylphenidate ER (18mg, 27mg, 36mg, 54mg (generic Concerta)<br>clonidine HCL ER (generic for Kapvay)<br>INTUNIV (guanfacine extended release)*<br>STRATTERA (atomoxetine) | ***Daytrana® (methylphenidate):***<br>• *May approve if requested because there is a history of substance abuse in the parent/caregiver or patient.*<br>• *May approve if child has difficulty swallowing tablets or capsules. ~~there is a swallowing disorder and the patient cannot be given oral medication.~~*<br>• *Daytrana has a maximum age of 18. If preferred medications are refused and patient meets criteria (clinical or PDL) age edit may be approved.*<br>INTUNIV:<br>1. Only approved in children, minimum age 6.<br>2. Diagnosis of ADHD.<br>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.<br>4. Maximum dose 4mg/day.<br>KAPVAY:<br>1. Only approved in children, minimum age 6.<br>2. Diagnosis of ADHD.<br>3. Patient shows some therapeutic |
| **MISCELLANEOUS ADHD** | | |

| | | |
|---|---|---|
| | | benefit from the immediate release clonidine preparation taken at least three daily and there is a therapeutic need to administer the clonidine twice daily.<br>4. Total daily dose not to exceed 0.4mg per day.<br>STRATTERA:<br>1. Documented trial and failure of at least one stimulant within two months OR<br>2. Diagnosis of tics or anxiety disorder or a history of substance abuse.<br>3. Family or parent refusal to use controlled substance. |
| **ANALEPTICS** | | |
| | modafanil (generic for Provigil)*<br>NUVIGIL (armodafinil)*<br><br>**NUVIGIL:** Minimum age 18.<br>**Require trial of Provigil.**<br>**For Sleep apnea**: Documentation of sleep apnea with sleep study.<br>**For Narcolepsy**: Treatment failure with amphetamine and documentation of diagnosis in sleep study.<br>**Shift Work Sleep disorder**: Only approve for six months to verify work schedule.<br>**PROVIGIL:** Minimum age 18.<br>**For Sleep apnea**: Documentation of sleep apnea with sleep study.<br>**For Narcolepsy**: Treatment failure with amphetamine and documentation of diagnosis in sleep study.<br>**Shift Work Sleep disor**der: Only approve for six months to verify work schedule. | |

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.
Italics font indicates changes.

XIV. Final voting results (after amendments) for preferred status and criteria reflected in the following voting records:
(See page 19, 20)

**An all in favor motion was made to conclude the meeting at 3:30pm.**

Next meeting:
The next scheduled meeting of the Nebraska Medicaid Pharmaceutical and Therapeutics Committee is scheduled for:
Wednesday, May 14, 2014, 9 am
Mahoney State Park, Ashland, NE
***Minutes approved May 14, 2014.***
Recorded by: Jenny Minchow R.P., Pharm. D.
Pharmacy Consultant, Nebraska Medicaid & Long-Term Care

| Member Name | Bleicher | Caudill | Davenport | Dering-Anderson | Dube' | Elsasser | Farho | Green | Haberstich | Humphries | Johnson-Bohac | Juracek | Rock | Saunders | Sorensen | Thomsen |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ***Nov. 2013 THERAPEUTIC CLASS*** | | | | | | | | | | | | | | | | |
| ***Consent Agenda:*** | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y |
| ANTIHYPERTENSIVES, SYMPATHOLYTICS | | | | | | | | | | | | | | | | |
| ANTIHYPERURICEMICS | | | | | | | | | | | | | | | | |
| ALZHEIMER'S AGENTS | | | | | | | | | | | | | | | | |
| BILE SALTS | | | | | | | | | | | | | | | | |
| GLUCOCORTICOIDS, INHALED | | | | | | | | | | | | | | | | |
| IMMUNOMODULATORS, ATOPIC DERMATITIS | | | | | | | | | | | | | | | | |
| LEUKOTRIENE MODIFIERS | | | | | | | | | | | | | | | | |
| OPHTHALMICS FOR ALLERGIC CONJUNCTIVITIS | | | | | | | | | | | | | | | | |
| OTIC ANTIBIOTICS | | | | | | | | | | | | | | | | |
| OTIC ANTI-INFECTIVES & ANESTHETICS | | | | | | | | | | | | | | | | |
| ***Individual Classes:*** | | | | | | | | | | | | | | | | |
| ANTIHISTAMINES, MINIMALLY SEDATING | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y |
| ANTIPARKINSON'S AGENTS | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y |
| ANTIPSORIATICS, ORAL | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y |
| ANTIPSORIATICS, TOPICAL | Y | Y | Y | Y | Y | A | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y |
| ANXIOLYTICS | Y | Y | Y | Y | Y | A | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y |
| BRONCHODILATORS, BETA AGONIST | Y | Y | Y | Y | Y | A | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y |
| COPD AGENTS | Y | Y | Y | Y | Y | A | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y |
| CYTOKINE AND CAM ANTAGONISTS | Y | Y | Y | Y | Y | A | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y |
| EPINEPHRINE, SELF-INJECTED | Y | Y | Y | Y | Y | A | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y |
| HISTAMINE II RECEPTOR BLOCKER | Y | Y | Y | Y | Y | A | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y |

| Member Name | Bleicher | Caudill | Davenport | Dering-Anderson | Dube' | Elsasser | Farho | Green | Haberstich | Humphries | Johnson-Bohac | Juracek | Rock | Saunders | Sorensen | Thomsen |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| IMMUNOMODULATORS, TOPICAL | Y | Y | Y | Y | Y | A | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y |
| INTRANASAL RHINITIS AGENTS | Y | Y | Y | Y | Y | A | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y |
| NSAIDS | Y | Y | Y | Y | Y | A | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y |
| ONCOLOGY AGENTS, BREAST CANCER | Y | Y | Y | Y | Y | A | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y |
| ONCOLOGY AGENTS, ORAL | Y | Y | Y | Y | Y | A | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y |
| OPHTHALMIC ANTIBIOTICS | Y | Y | Y | Y | Y | A | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y |
| OPHTHALMIC ANTIBIOTIC-STEROID COMBINATIONS | Y | Y | Y | Y | Y | A | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y |
| OPHTHALMICS, ANTI-INFLAMMATORIES | Y | Y | Y | Y | Y | A | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y |
| OPHTHALMICS, GLAUCOMA AGENTS | Y | Y | Y | Y | Y | A | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y |
| SEDATIVE HYPNOTICS | Y | Y | Y | Y | Y | A | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y |
| STEROIDS, TOPICAL | Y | Y | Y | Y | Y | A | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y |
| STIMULANTS AND RELATED AGENTS | Y | Y | Y | Y | Y | A | A | Y | Y | Y | Y | Y | Y | Y | Y | Y |

Y = yes

N = no

A = absent