DIVISION OF MEDICAID AND LONG-TERM CARE
Nebraska DHHS

PHARMACEUTICAL AND THERAPEUTICS COMMITTEE MEETING MINUTES

May 14, 2014 at 9 am, CST
Mahoney State Park, Peter Kiewit Lodge
Ashland, NE

Members Present
Claire Baker, M.D.
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.
Jeffrey Gotschall, M.D.
Nathan Green, D.O.
Nancy Haberstich, R.N., M.S.
Mary Hammond, Pharm.D.
Laurie Humphries, M.D.
Kristi Johnson-Bohac, M.Div.
Joyce Juracek, Pharm.D.
Kevin Reichmuth, M.D.
Eileen Rock, M.D.
Ken Saunders, Pharm.D.
Christopher Sorensen, Pharm.D.
Eric Thomsen, M.D.

Members Absent
Linda Sobeski, Pharm.D. (excused)

DHHS Staff
Jenny Minchow, Pharm.D.
Abigail Anderson, M.C.R.P.

Magellan Medicaid Administration Contract Staff
Absent due to flight cancellation at O'Hare Airport

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I. Call to Order: Chairperson, Jeff Gotschall, called the meeting to order at 9:00am. The agenda was posted on the Nebraska Medicaid Pharmacy MMA website on April 14, 2014. 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: Mary Hammond, Pharm. D., Norfolk, Nebraska, and introduction of new DHHS Staff, Abigail Anderson, M.C.R.P., Lincoln, Nebraska.
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 13, 2013 meeting were unanimously approved, with the exception of members who were absent from the November meeting, as written.
VI. Department Information: The pharmacy benefit will be included in the new Managed Care Physical Health contract which is anticipated to begin on July 1, 2015.
VII. Other: Department reported PDL savings resulting from market shift and supplemental rebates in the amount of approximately $31 million since PDL implementation and P&T Committee inception last quarter of 2009. This is savings to Nebraska taxpayers.
VIII. Public Testimony

Drug/Class	Status	Speaker	Affiliation
PLATELET AGGREGATION INHIBITORS			
Brilinta	NP	Todd Camp	AstraZeneca
ANTIBIOTICS, INHALED			
TOBI Podhaler	NP	Peter Murphy, M.D.	The Nebraska Regional Cystic Fibrosis Center, UNMC

ANTICOAGULANTS			
Xarelto	P	Matthew Johnson, M.D.	Bryan Heart Hospital
Eliquis	NP	Stephanie Maciejewski	Pfizer
ANTIPARASITICS, TOPICAL			
Sklice	NP	Jeannine Alameda	Sanofi Pasteur
HEPATITIS C AGENTS, NUCLEOTIDE ANALOG POLYMERASE INHIBITOR			
Sovaldi	NP	Joe Llewellyn	Gilead Sciences
HEPATITIS C AGENTS, PROTEASE INHIBITOR			
Olysio	NP	Kathleen Karnik, Pharm.D.	Janssen Scientific Affairs, LLC
HYPOGLYCEMICS, SGLT2			
Farxiga	NP	Molly Skelsey	AstraZeneca
Invokana	NP	Kathleen Karnik, Pharm.D.	Janssen Scientific Affairs, LLC
Invokana	NP	Anthony Ross, M.D.	Janssen, Speakers Bureau
Invokana	NP	Rebecca Newberry, APRN	Diabetes Education Center of the Midlands
LIPOTROPICS, OTHER			
Kynamro	NP	Dennis Jacobsen, Ph.D.	Genzyme, A Sanofi Company
MULTIPLE SCLEROSIS AGENTS			
Tecfidera	NP	Brienna Buckley	Biogen Idec
Gilenya	NP	Mai Duong, Pharm.D.	Novartis
Copaxone	P	John S. Vogel, D.O.	Teva Pharmaceuticals
PAH AGENTS, ORAL AND INHALED			
Opsumit	NP	Josephine Garcia-Ferrer	Actelion Pharmaceuticals
Adempas	NP	Suzanne Westfall	Bayer Healthcare Pharmaceuticals

P= Preferred
NP= Non-preferred

IX. A motion was made and seconded to move into closed session at 10:30am.The vote carried unanimously with the committee.

Cost issues discussed in Closed Session.

X. A motion was made and seconded to move back into open session. The vote carried unanimously with the committee.

XI. Open Session resumed at 11:30am.

XII. **Consent Agenda**:

The following Therapeutic Class was removed from the Consent Agenda: Hypoglycemics, Incretin Mimetics/Enhancers.

ANDROGENIC AGENTS (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.

ANGIOTENSIN MODULATOR /CALCIUM CHANNEL BLOCKER COMBINATIONS

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
benazepril/amlodipine (generic for Lotrel) TARKA (trandolapril/verapamil)	AMTURNIDE (aliskiren/**amlodipine**/HCTZ) AZOR (olmesartan/amlodipine) EXFORGE (valsartan/amlodipine) EXFORGE HCT (valsartan/amlodipine/HCTZ)	Individual prescriptions for the components of these products should be used for patients requiring these drug combinations.

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

	TEKAMLO (aliskiren/**amlodipine)** telmisartan/amlodipine (generic for Twynsta) TRIBENZOR (amlodipine/olmesartan/HCTZ)	Documentation of medical necessity required for use of combination product.

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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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**	

ANTIVIRALS, TOPICAL

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
	acyclovir OINTMENT (generic for Zovirax) 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.

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) alendronate Oral Solution (generic for Fosamax) ATELVIA DR (risedronate) BINOSTO (alendronate effervescent) etidronate disodium 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. 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 *raloxifene (generic for Evista)*	1.Adverse reaction to, allergy or contraindication to preferred drugs, or 2 .Documentation of treatment failure with preferred drug.

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	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. Injection must be administered by patient or caregivers.

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)	

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FLUOROQUINOLONES, ORAL

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
ciprofloxacin (generic for Cipro) levofloxacin **TABLETS** (generic for Levaquin)	CIPRO Suspension (ciprofloxacin) ciprofloxacin ER levofloxacin oral solution moxifloxacin (generic for Avelox) 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.

GROWTH HORMONE

Entire class requires prior authorization based on clinical criteria.

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

HYPOGLYCEMICS, MEGLITINIDES

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

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

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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

Hypoglycemics: Additional Classes

The following hypoglycemic class and the drugs noted are not reviewed by the PDL process but are covered without prior authorization.

HYPOGLYCEMICS, SULFONYLUREAS

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
chlorpropamide *glimepiride (generic for Amaryl)* *glipizide (generic for Glucotrol)* *glipizide ER (generic for Glucotrol XL)* *glyburide/micronized (generic for Diabeta, Glynase)* *tolazamide* *tolbutamide*		

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.

PLATELET AGGREGATION INHIBITORS

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
AGGRENOX (dipyridamole/aspirin) aspirin clopidogrel (generic for Plavix) dipyridamole (generic for Persantine)	BRILINTA (ticagrelor)* EFFIENT (prasugrel)* ticlopidine (generic for Ticlid)	1.Adverse reaction to, allergy or contraindication to preferred drugs, or 2 .Documentation of treatment failure with preferred drug. 3. **OR** Documentation of clopidrogel resistance. BRILINTA: additional criteria -Acute coronary syndrome (ACS) (unstable angina, non-ST elevation myocardial infarction, or ST elevation

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		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.

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, ~~FEXMID~~: Clinical reason regular release cannot be used. Only for short term use.

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		ZANAFLEX: Clinical reason generic cannot be used.

TETRACYCLINES

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
doxycycline hyclate IR (generic for Vibramycin) doxycycline monohydrate **CAPSULES 50mg, 100mg** minocycline HCl **capsules** (generic for Minocin, Dynacin) tetracycline HCl (generic for Sumycin)	ADOXA (doxycycline monohydrate) demeclocycline* DORYX (doxycycline pelletized) doxycycline hyclate DR (generic for Vibratabs) doxycycline monohydrate **TABLET SUSPENSION, 150MG CAPSULES** 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.

It was moved by Baker and seconded by Dube' to accept recommendations as published for the Therapeutic Classes on the Consent Agenda with the exception of Hypoglycemics, Incretin Mimetics/Enhancers which was the only Therapeutic Class removed from the Consent Agenda. Roll call vote was taken and the motion passed.

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

ACNE AGENTS, TOPICAL

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
AZELEX (azelaic acid) BENZACLIN W/PUMP (clindamycin/benzoyl peroxide) benzoyl peroxide generic OTC (5%, 10%) benzoyl peroxide generic Rx clindamycin phosphate **SOLUTION** DIFFERIN (adapalene) **LOTION, CREAM** DUAC (clindamycin/benzoyl peroxide) erythromycin **GEL, SOLUTION** tretinoin **CREAM**	ACANYA (clindamycin and benzoyl peroxide) ACZONE (dapsone) adapalene gel, cream (generic Differin) AKNE-MYCIN (erythromycin) ATRALIN (tretinoin) BENZACLIN GEL (clindamycin/ benzoyl peroxide) benzoyl peroxide foam (generic for Benzefoam) *benzoyl peroxide **gel*** CLARIFOAM EF (sulfur and sulfacetamide)	Treatment failure with three preferred products.

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	CLINDAGEL (clindamycin) clindamycin **GEL, LOTION, FOAM** clindamycin/benzoyl peroxide (generic for Benzaclin, Duac) *DIFFERIN **GEL** (adapalene)* EPIDUO (adapalene/benzoyl peroxide) erythromycin-benzoyl peroxide (generic for Benzamycin) EVOCLIN (clindamycin) FABIOR (tazarotene foam) INOVA (benzoyl peroxide) RETIN-A GEL, CREAM *RETIN-A **MICRO** (tretinoin)* RETIN-A MICRO **PUMP** sulfacetamide sulfacetamide/sulfur (generic for Sulfacet-R) TAZORAC (tazarotene) tretinoin **GEL** tretinoin microspheres (generic for Retin-A Micro) VELTIN (clindamycin and tretinoin) ZIANA (clindamycin and tretinoin)	

It was moved by Thomsen and seconded by Saunders to accept recommendations as published. Roll call vote was taken and the motion passed.

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

Motion carried.

ANALGESICS, OPIATE LONG-ACTING

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
fentanyl patches KADIAN (morphine ER capsule) methadone morphine ER tablet (generic for MS Contin, Oramorph SR) OXYCONTIN (oxycodone ER)	BUTRANS (buprenorphine, transdermal)* CONZIP (tramadol extended release)* DURAGESIC MATRIX (fentanyl) EXALGO (hydromorphone)* morphine ER capsule (generic for Avinza) morphine ER capsule (generic for Kadian) NUCYNTA ER (tapentadol)* oxymorphone ER (generic for OPANA 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

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	tramadol extended release* (generic for RYZOLT ER, ULTRAM ER) *ZOHYDRO ER* *(hydrocodone bitartrate ER)*	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 long or short acting opiate analgesic agents **NOT** approved for substance abuse or addiction. **CONZIP, EXALGO, ULTRAM ER, *ZOHYDRO ER*:** Must document **clinical** reason why short-acting product with same active ingredient cannot be used.

It was moved by Dering-Anderson and seconded by Rock to accept recommendations as published with the word "narcotics" changed to "opiates" in the description of the Therapeutic Class. Roll call vote was taken and the motion passed.

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

Motion carried.

ANALGESICS, OPIATE SHORT-ACTING

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
ORAL		
acetaminophen/codeine codeine **ORAL** hydrocodone/APAP hydrocodone/ibuprofen hydromorphone **TABLETS** morphine **ORAL** oxycodone **TABLET, SOLUTION, CONCENTRATE** oxycodone/APAP ROXICET **SOLUTION** (oxycodone/acetaminophen) tramadol (generic for Ultram)	codeine **ORAL SOLUTION** dihydrocodeine/APAP/caffeine (generic for Panlor DC) ENDODAN (oxycodone/aspirin) HYCET (hydrocodone/acetaminophen) hydromorphone ORAL LIQUID, SUPPOSITORIES (generic for Dilaudid) IBUDONE (hydrocodone/ibuprofen) levorphanol meperidine (generic for Demerol) morphine **SUPPOSITORIES** NUCYNTA (tapentadol)* OXECTA (oxycodone) *oxycodone **CAPSULE*** *oxycodone/aspirin* oxycodone/ibuprofen (generic for	Non-preferred agents will be approved only after documented failure of 3 preferred agents. Note: Nucynta only approved for short term use for acute pain. Not approved for chronic pain. ~~*RYBIX ODT: Treatment failure or contraindication to oral*~~

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	Combunox) oxymorphone (generic for Opana) ~~*PANLOR DC (dihydrocodeine/APAP/caffeine)*~~ ~~*pentazocine/APAP*~~ pentazocine/naloxone REPREXAIN (hydrocodone/ibuprofen) ROXICODONE **TABLET** (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)*~~	~~*morphine concentrate and inability to swallow.*~~ ~~*ZOLVIT- no prior authorization needed for children under 12.*~~
NASAL		
	butorphanol nasal spray	
BUCCAL/TRANSMUCOSAL		
	ABSTRAL (fentanyl transmucosal)* fentanyl transmucosal* (generic for Actiq) FENTORA (fentanyl)* ~~*ONSOLIS (fentanyl)**~~ SUBSYS (fentanyl spray)*	Diagnosis of cancer. Current use of long-acting opiate. NOT approved for acute pain, migraine, or fibromyalgia.

It was moved by Thomsen and seconded by Sorensen to accept recommendations as published with the word “narcotics” changed to “opiates” in the description of the Therapeutic Class. Roll call vote was taken and the motion passed.

Votes as follows:
Baker-yes, Bleicher-yes, Caudill-yes, Davenport-yes, Dering-Anderson-yes, Dube’-yes, Elsasser-yes, Green–yes, Haberstich–yes, Hammond-yes, Humphries–yes, Johnson-Bohac–yes, Juracek-yes, Reichmuth–yes, Rock-yes, Saunders-yes, Sorensen-yes, Thomsen-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)	*EPANED (enalapril) oral solution* 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. *Epaned: Requires documentation of why an oral tablet or compounded product is*

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ramipril (generic for Altace)		*not appropriate for patient.*
ACE INHIBITOR/DIURETIC COMBINATIONS		
benazepril/HCTZ (generic for Lotensin HCT) captopril/HCTZ (generic for Capozide) enalapril/HCTZ (generic for Vaseretic) lisinopril/HCTZ (generic Prinzide/Zestoretic)	fosinopril/HCTZ (generic for 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)	BENICAR (olmesartan) candesartan (generic for Atacand) EDARBI (azilsartan medoxomil) EDARBYCLOR (azilasartan/chlorthalidone) eprosartan (generic for Teveten) telmisartan (generic for Micardis)	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) telmisartan/HCTZ (generic for Micardis-HCT) 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.

It was moved by Dube' and seconded by Reichmuth to accept recommendations as published. Roll call vote was taken and the motion passed.

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

Motion carried.

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ANTIBIOTICS, INHALED

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
BETHKIS (tobramycin) TOBI (tobramycin) *TOBI-PODHALER (tobramycin)*	CAYSTON (aztreonam lysine)QL, * tobramycin (generic for TOBI)	**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. ***Tobi-Podhaler®*** *(tobramycin inhalation powder)* • *Approval requires diagnosis of Cystic Fibrosis* • *Tobi Inhalation Solution and Bethkis are covered without PA; clinical reason as to why these preferred products cannot be used.* • *Minimum age restriction of 6 years of age* • *Quantity limit = 8 capsules per day*

It was moved by Reichmuth and seconded by Caudill to accept recommendations as published with TOBI Podhaler changed to preferred as noted above and to allow authorization of Cayston with documentation of resistance to tobramycin. Roll call vote was taken and the motion passed.

Votes as follows:
Baker-yes, Bleicher-yes, Caudill-yes, Davenport-no, Dering-Anderson-yes, Dube'-yes, Elsasser-no, Green–yes, Haberstich–yes, Hammond-yes, Humphries–yes, Johnson-Bohac–no, Juracek-yes, Reichmuth–yes, Rock-no, Saunders-yes, Sorensen-no, Thomsen-yes.

Motion carried.

ANTIBIOTICS, TOPICAL

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
bacitracin ointment bacitracin/polymyxin (generic for Polysporin) mupirocin OINTMENT (generic for Bactroban) neomycin/polymyxin/bacitracin (generic for Neosporin, Triple AB)	ALTABAX (retapamulin) CENTANY (mupirocin ointment) *gentamicin **OINTMENT, CREAM*** mupirocin **CREAM** (generic for Bactroban)	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

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		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®.

It was moved by Thomsen and seconded by Sorensen to accept recommendations as published. Roll call vote was taken and the motion passed.

Votes as follows:
Baker-yes, Bleicher-yes, Caudill-yes, Davenport-yes, Dering-Anderson-no, Dube'-yes, Elsasser-yes, Green–yes, Haberstich–yes, Hammond-yes, Humphries–yes, Johnson-Bohac–yes, Juracek-yes, Reichmuth–yes, Rock-yes, Saunders-yes, Sorensen-yes, Thomsen-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)	*CLINDESSE (clindamycin vaginal)* *metronidazole (vaginal)* *VANDAZOLE (metronidazole)*	*1.Adverse reaction to, allergy or contraindication to preferred drugs, or* *2 .Documentation of treatment failure with preferred drug.*

It was moved by Caudill and seconded by Dube' to accept recommendations as published. Roll call vote was taken and the motion passed.

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

Motion carried.

LUNCH 12-1PM

At 12:00pm it was moved and seconded to go into closed session for cost discussions. The vote carried and was unanimous by the committee.

At 1:00pm it was moved and seconded to resume open session. The vote carried and was unanimous by the committee.

ANTICOAGULANTS

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

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It was moved by Sorensen and seconded by Saunders to accept recommendations as published with Eliquis changed to preferred as noted above. Roll call vote was taken and the motion passed.

Votes as follows:
Baker-yes, Bleicher-yes, Caudill-yes, Davenport-yes, Dering-Anderson-yes, Dube'-yes, Elsasser-yes, Green–yes, Haberstich–yes, Hammond-yes, Humphries–yes, Johnson-Bohac–yes, Juracek-yes, Reichmuth–yes, Rock-yes, Saunders-yes, Sorensen-yes, Thomsen-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) *ZUPLENZ (ondansetron)*	1.Adverse reaction to, allergy or contraindication to preferred drugs, or 2 .Documentation of treatment failure with preferred drug. --- Sancuso and *Zuplenz*: 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		
DICLEGIS (doxylamine/pyridoxine) 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) promethazine suppositories **12.5mg, 25mg** TRANSDERM-SCOP (scopolamine)	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. *Diclegis:* • *Approve for the treatment of nausea and vomiting of pregnancy in women who do not respond to conservative management.*

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		METOZOLV ODT (metoclopramide): Inablilty to swallow or clinical reason can't utilize oral liquid.

It was moved by Davenport and seconded by Dube' to accept recommendations as published with Diclegis changed to preferred as noted above. Roll call vote was taken and the motion passed.

Votes as follows:
Baker-no, Bleicher-yes, Caudill-yes, Davenport-yes, Dering-Anderson-yes, Dube'-yes, Elsasser-no, Green–yes, Haberstich–yes, Hammond-yes, Humphries–yes, Johnson-Bohac–yes, Juracek-yes, Reichmuth–no, Rock-abstain, Saunders-no, Sorensen-no, Thomsen-no.

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) nystatin **TABLET**, **SUSPENSION** terbinafine (generic for Lamisil)	flucytosine (generic for Ancobon)* GRIFULVIN V (griseofulvin) griseofulvin **tablets** griseofulvin ultramicrosize itraconazole (generic for Sporanox) *ketoconazole (generic for Nizoral)* LAMISIL GRANULES (terbinafine) LAMSIL TABLETS (terbinafine) NOXAFIL (posaconazole)* nystatin **POWDER** for reconstitution ONMEL (itraconazole)* *ORAVIG (miconazole buccal)* 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. • Sporonox liquid only if unable to take capsules. • Onmel only FDA approved for onychomycosis. **NOXAFIL:** minimum age of 13. Prevention of infection with

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		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.

It was moved by Bleicher and seconded by Dering-Anderson to accept recommendations as published with the exception of making ketoconazole non-preferred due to black box warnings. Roll call vote was taken and the motion passed.

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

Motion carried.

ANTIFUNGALS, TOPICAL

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
ANTIFUNGAL		
clotrimazole (generic for Lotrimin) RX, OTC	BENSAL HP (~~*benzoic acid/*~~salicylic acid) CICLODAN ~~*CREAM*~~ (ciclopirox)	1. Adverse reaction to, allergy or contraindication to preferred

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econazole (generic for Spectazole) ketoconazole cream (generic for Nizoral) ketoconazole shampoo (generic for Nizoral) LAMISIL AT CREAM (terbinafine) OTC LAMISIL AT GEL (terbinafine) OTC LAMISIL SPRAY OTC (terbinafine) miconazole OTC **CREAM, SPRAY, POWDER** *NUZOLE (miconazole)* nystatin selenium sulfide 2.5% terbinafine OTC (generic for Lamisil AT) TINACTIN AERO POWDER (tolnaftate) OTC TINACTIN CREAM (tolnaftate) OTC tolnaftate OTC (generic for Tinactin)	ciclopirox cream/gel/suspension (generic for Ciclodan, Loprox) ciclopirox nail lacquer (solution) (generic for Ciclodan, Penlac) ciclopirox shampoo (generic for Loprox) DESENEX AERO POWDER OTC (miconazole) ERTACZO (sertaconazole) EXELDERM (sulconazole) EXTINA (ketoconazole) FUNGOID OTC ketoconazole **FOAM** (generic for Ketodan) LOTRIMIN AF CREAM OTC (clotrimazole) *LUZU (luliconazole)* MENTAX (butenafine) miconazole OTC **OINTMENT** NAFTIN (naftifine) OXISTAT (oxiconazole) selenium sulfide 2.25% VUSION (miconazole/ zinc oxide)	drugs, or 2. Documentation of treatment failure of two preferred drugs within the last 6 months.
ANTIFUNGAL/STEROID COMBINATIONS		
clotrimazole/betamethasone **CREAM** (gen. Lotrisone)	clotrimazole/betamethasone **LOTION** (gen. Lotrisone) nystatin/triamcinolone (gen. for Mycolog)	

It was moved by Sorensen and seconded by Elsasser to accept recommendations as published. Roll call vote was taken and the motion passed.

Votes as follows:
Baker-yes, Bleicher-yes, Caudill-yes, Davenport-yes, Dering-Anderson-yes, Dube'-yes, Elsasser-yes, Green–yes, Haberstich–yes, Hammond-yes, Humphries–yes, Johnson-Bohac–yes, Juracek-yes, Reichmuth–yes, Rock-yes, Saunders-yes, Sorensen-yes, Thomsen-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/Maxalt MLT) TREXIMET (sumatriptan/naproxen) zolmitriptan (generic for Zomig/	Non-preferred agents will be approved only if patient has tried and failed therapy with all preferred agents.

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	Zomig ZMT)	
NASAL		
IMITREX (sumatriptan)	sumatriptan generic nasal ZOMIG (zolmitriptan)	
INJECTABLE		
IMITREX (sumatriptan) ***Pen*** IMITREX (sumatriptan) ***Cartridge*** *sumatriptan* ***VIAL***	ALSUMA (sumatriptan) *Imitrex (sumatriptan)* ***VIAL*** sumatriptan **syringe and kit** SUMAVEL DOSEPRO (sumatriptan)	

It was moved by Dering-Anderson and seconded by Baker to accept recommendations as published. Roll call vote was taken and the motion passed.

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

Motion carried.

ANTIPARASITICS, TOPICAL

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

It was moved by Dering-Anderson and seconded by Juracek to accept recommendations as published. Roll call vote was taken and the motion passed.

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

Motion carried.

BETA BLOCKERS (Oral)

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
BETA BLOCKERS		
acebutolol (generic for Sectral) atenolol (generic for Tenormin)	betaxolol (generic for Kerlone) BYSTOLIC (nebivolol)	Non-preferred agent will be approved only after documented failure of two preferred agents

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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)	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(gen. Inderide) timolol (generic for Blocadren)	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 OK 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)		

It was moved by Reichmuth and seconded by Saunders to accept recommendations as published with metoprolol XL (generic for Toprol XL) changed back to preferred as noted above. Roll call vote was taken and the motion passed.

Votes as follows:
Baker-yes, Bleicher-yes, Caudill-yes, Davenport-yes, Dering-Anderson-no, Dube'-yes, Elsasser-no, Green–yes, Haberstich–yes, Hammond-yes, Humphries–yes, Johnson-Bohac–no, Juracek-no, Reichmuth–yes, Rock-yes, Saunders-yes, Sorensen-yes, Thomsen-yes.

Motion carried.

BLADDER RELAXANT PREPARATIONS

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
oxybutynin IR (generic for Ditropan) oxybutynin syrup (generic for Ditropan) *oxybutynin ER (generic for Ditropan XL)* TOVIAZ (fesoterodine ER) VESICARE (solifenacin)	ENABLEX (darifenacin) GELNIQUE (oxybutynin) MYRBETRIQ (mirabegron) OXYTROL (oxybutynin) tolterodine (generic for Detrol) tolterodine ER (generic for Detrol LA) 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.

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It was moved by Saunders and seconded by Thomsen to accept recommendations as published. Roll call vote was taken and the motion passed.

Votes as follows:
Baker-yes, Bleicher-yes, Caudill-yes, Davenport-yes, Dering-Anderson-yes, Dube'-yes, Elsasser-yes, Green–yes, Haberstich–yes, Hammond-yes, Humphries–yes, Johnson-Bohac–yes, Juracek-yes, Reichmuth–yes, Rock-yes, Saunders-yes, Sorensen-yes, Thomsen-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) NYMALIZE (nimodipine solution)	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 Adalat CC, 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** verapamil ER PM (generic for Verelan PM)	CARDIZEM LA (diltiazem LA) MATZIM LA (diltiazem) TIAZAC (diltiazem) verapamil ER **CAPSULE** *verapamil 360mg capsule*	

It was moved by Elsasser and seconded by Dering-Anderson to accept recommendations as published. Roll call vote was taken and the motion passed.

Votes as follows:
Baker-yes, Bleicher-yes, Caudill-yes, Davenport-yes, Dering-Anderson-yes, Dube'-yes, Elsasser-yes, Green–yes, Haberstich–yes, Hammond-yes, Humphries–yes, Johnson-Bohac–yes, Juracek-yes, Reichmuth–yes, Rock-yes, Saunders-yes, Sorensen-yes, Thomsen-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, CHEW TABLETS, SUSPENSION** AUGMENTIN **125MG/5ML**	amoxicillin/clavulanate ER (generic for Augmentin XR) AUGMENTIN (amoxicillin/clavulanate)	1. Adverse reaction to, contraindication to preferred drugs, or 2. Documentation of treatment

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SUSPENSION		failure with preferred drug.
CEPHALOSPORINS – First Generation		
cefadroxil **CAPSULE, SUSPENSION** (generic for Duricef) cephalexin **CAPSULE, SUSPENSION** (generic for Keflex)	cefadroxil **TABLET** (generic for Duricef) cephalexin ***TABLET***	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 ***CAPSULE*, SUSPENSION** (cefixime)	cefpodoxime (oral) (generic for Vantin) ceftibuten (generic for Cedax) SUPRAX **CHEW TABLET, *TABLET*** (cefixime)	1. Adverse reaction to, contraindication to preferred drugs, or 2. Documentation of treatment failure with preferred drug.

It was moved by Sorensen and seconded by Juracek to accept recommendations as published. Roll call vote was taken and the motion passed.

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

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

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
NEUPOGEN VIAL (filgrastim)	~~*LEUKINE (sargramostim)*~~ ~~*NEULASTA (pegfilgrastim*~~ *NEUPOGEN SYRINGE (filgrastim)*	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.

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		• Not covered for AIDS, hairy cell leukemia, myelodysplasia, drug-induced congenital agranulocytosis, alloimmune neonatalneutropenia. Initial authorization is granted for six months.

It was moved by Baker and seconded by Saunders to accept recommendations as published with Neupogen Syringe changed to non-preferred with only Neupogen Vial preferred as noted above. Roll call vote was taken and the motion passed.

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

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)*~~ *EPOGEN (rHuEPO)** PROCRIT (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

It was moved by Thomsen and seconded by Davenport to accept recommendations as published. Roll call vote was taken and the motion passed.

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

H.PYLORI TREATMENTS

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.
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PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
HELIDAC (bismuth, metronidazole, tetracycline) *PYLERA (bismuth, metronidazole, tetracycline)* *PREVPAC (lansoprazole, amoxicillin, clarithromycin)*	*OMECLAMOX-PAK (omeprazole, clarithromycin, amoxicillin)* *lansoprazole/amoxicillin/clarithromycin (generic for Prevpac)*	*1. Adverse reaction to, allergy to or contraindication to preferred drugs, or* *2. Documentation of treatment failure with preferred drug.*

It was moved by Thomsen and seconded by Reichmuth to accept recommendations as published. Roll call vote was taken and the motion passed.

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

Motion carried.

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)	

NUCLEOTIDE ANALOG POLYMERASE INHIBITOR		
	*SOVALDI (sofosbuvir)**	To be determined.

PROTEASE INHIBITOR		
PREFERRED DRUGS	**NON-PREFERRED DRUGS**	**PDL EXCEPTION CRITERIA:**
	*INCIVEK (telaprevir)** *OLYSIO (simeprevir)** *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,

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		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 ≥ 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.

It was moved by Thomsen and seconded by Elsasser to accept recommendations as published. Roll call vote was taken and the motion passed.

Votes as follows:
Baker-yes, Bleicher-yes, Caudill-yes, Davenport-yes, Dering-Anderson-yes, Dube'-yes, Elsasser-yes, Green–yes, Haberstich–yes, Hammond-yes, Humphries–yes, Johnson-Bohac–yes, Juracek-yes, Reichmuth–no, Rock-yes, Saunders-yes, Sorensen-yes, Thomsen-yes.

Motion carried.

The Committee requested that the Hepatitis C class be revisited in six months as more data becomes available and that the Department work with the DUR Board for development of criteria for Olysio and Sovaldi

HYPOGLYCEMICS,ALPHA-GLUCOSIDASE INHIBITORS

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
acarbose (generic for Precose) *Glyset (miglitol)*		

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It was moved by Thomsen and seconded by Dube' to accept recommendations as published. Roll call vote was taken and the motion passed.

Votes as follows:
Baker-yes, Bleicher-yes, Caudill-yes, Davenport-yes, Dering-Anderson-yes, Dube'-yes, Elsasser-yes, Green–yes, Haberstich–yes, Hammond-yes, Humphries–yes, Johnson-Bohac–yes, Juracek-yes, Reichmuth–yes, Rock-yes, Saunders-yes, Sorensen-yes, Thomsen-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
Amlyn 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.

It was moved by Baker and seconded by Davenport to accept recommendations as published with the addition of Bydureon. Roll call vote was taken and the motion tied. Chair Gotschall voted yes. **Motion carried.**

Votes as follows:
Baker-yes, Bleicher-yes, Caudill-no, Davenport-yes, Dering-Anderson-yes, Dube'-yes, Elsasser-no, Green–no, Haberstich–no, Hammond-yes, Humphries–no, Johnson-Bohac–no, Juracek-yes, Reichmuth–yes, Rock-no, Saunders-yes, Sorensen-no, Thomsen-no

It was moved by Saunders and seconded by Caudill to amend the main motion to accept recommendations as published by changing Byetta Pens and Bydureon to preferred as noted above with two step edits including diagnosis of diabetes and trial on metformin. Roll call vote was taken and motion passed.

Votes as follows:
Baker-yes, Bleicher-yes, Caudill-yes, Davenport-yes, Dering-Anderson-yes, Dube'-yes, Elsasser-yes, Green–yes, Haberstich–yes, Hammond-yes, Humphries–yes, Johnson-Bohac–yes, Juracek-absent, Reichmuth–yes, Rock-yes, Saunders-yes, Sorensen-yes, Thomsen-yes

HYPOGLYCEMICS, INSULIN AND RELATED DRUGS

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
HUMALOG (insulin lispro) HUMALOG MIX	APIDRA (insulin glulisine) NOVOLIN (insulin)	1.Adverse reaction to, allergy or contraindication to preferred

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(insulin lispro/lispro protamine) HUMULIN (insulin) LANTUS (insulin glargine) *LEVEMIR (insulin detemir)*	NOVOLOG (insulin aspart) NOVOLOG MIX (insulin aspart/aspart protamine) Insulin pens /cartridges*	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)

It was moved by Sorensen and seconded by Thomsen to accept recommendations as published. Roll call vote was taken and the motion passed.

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

HYPOGLYCEMICS, METFORMINS

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
glipizide/metformin *glyburide/metformin (generic for Glucovance)* *metformin (generic for Glucophage)* *metformin ER (generic for Glucophage XR)*	*metformin ER (generic for Fortamet)* *GLUMETZA (metformin extended release)* *RIOMET (metformin oral solution)*	*Fortamet and Glumetza require documentation of why generic for Glucophage XR not appropriate for patient.* *Riomet:* • *Liquid for ages < 6 years of age do not require a prior authorization.* • *The liquid formulation should only be approved for clients 6 years of age and older if medical necessity is documented.*

It was moved by Rock and seconded by Baker to accept recommendations as published. Roll call vote was taken and the motion passed.

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

HYPOGLYCEMICS, SGLT2

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
	FARXIGA (dapagliflozin) *INVOKANA (canagliflozin)*	• *Compliance demonstrated with metformin trial and*

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		have not received adequate glycemic control with metformin; or • *Intolerance to metformin*

It was moved by Baker and seconded by Dube' to accept recommendations as published. After further discussion, the main motion was amended by Humphries and seconded by Dube' by addition of two step edits including 1) patient is intolerant to metformin or has inadequate glycemic control indicated by HbA1c > 7 and 2) the eGFR is quantified at 60 mL/min/1.73m^2 or higher for Farxiga and 45ml/min/1.73m^2 or higher for Invokana. Roll call vote was taken and the motion passed.

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

IRRITABLE BOWEL SYNDROME

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
	AMITIZA (lubiprostone) *LINZESS (linaclotide)* *LOTRONEX (alosetron)*	*Lotronex:* • *Diagnosis of irritable bowel syndrome, severe diarrhea-predominant.*

It was moved by Reichmuth and seconded by Thomsen to accept recommendations as published. Roll call vote was taken and the motion failed.

Votes as follows:
Baker-yes, Bleicher-yes, Caudill-yes, Davenport-yes, Dering-Anderson-no, Dube'-no, Elsasser-no, Green–yes, Haberstich–no, Hammond-no, Humphries–no, Johnson-Bohac–no, Juracek-absent, Reichmuth–yes, Rock-no, Saunders-yes, Sorensen-no, Thomsen-yes.
Motion failed.

It was moved by Dering-Andersen and seconded by Elsasser to approve addition of this drug class with no preferred drugs on the PDL as noted above. Roll call vote was taken and the motion passed.

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

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)	fenofibrate (generic for Antara)	

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TRICOR (fenofibrate) TRILIPIX (fenofibric acid)	fenofibrate (generic for Lofibra) fenofibrate (generic for Tricor) fenofibric acid (generic for Fibricor) fenofibric acid (generic for Trilipix) LIPOFEN (fenofibrate) TRIGLIDE (fenofibrate)	
NIACIN		
NIACOR (niacin IR) NIASPAN (niacin ER)	ADVICOR (lovastatin/niacin ER) niacin ER (generic for Niaspan)	
OMEGA-3 FATTY ACIDS		
	LOVAZA (omega-3 fatty acids)* *VASCEPA (icosapent)**	*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 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.
APOLIPOPROTEIN B SYNTHESIS INHIBITORS		
	*JUXTAPID (lomitapide)** *KYNAMRO (mipomersen)**	(see below)

JUXTAPID™ (lomitapide)

Patient must have a diagnosis of homozygous familial hypercholesterolemia (HoFH).

- *Prescriber must be certified with the Juxtapid™ REMS program.*
- *Must fax a copy of the completed Juxtapid™ REMS Program Prescription Authorization Form.*
  - *http://www.juxtapidremsprogram.com/_pdf/JUXTAPID%20REMS_Program_Prescription_Authorization%20Form.pdf*
- *Minimum age restriction of 18 years of age.*
- *Patient has had treatment failure, maximized dosing with, or contraindication to all of the following,(document name of medication, date of trial and outcome, dose if maximized,or reason for contraindication):*
  - *statins*
  - *ezetimibe*
  - *niacin*
  - *fibric acid derivatives*
  - *omega-3 agents*
  - *bile acid sequestrants*
  - *see PDL Lipotropic (other) criteria for examples of the above and PDL Lipotropic: Statins.*
- *Maximum daily dose: 60 mg*
- ***Juxtapid™ REMS program:** Because of the risk of hepatotoxicity associated with lomitapide therapy, lomitapide is available through a restricted program under the REMS. Under the Juxtapid™ REMS, only certified health care providers and pharmacies may prescribe and distribute lomitapide. Further information is available at http://www.JUXTAPIDREMSProgram.com.*
- *Prescribers must use a REMS Program Prescription Authorization Form for each new prescription to ensure safe use of JUXTAPID™.*

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KYNAMRO™ Subcutaneous Injection *(mipomersen sodium)*

- *Patient must have a diagnosis of homozygous familial hypercholesterolemia (HoFH).*
- *Prescriber must be certified with the Kynamro™ REMS program.*
- *Must fax a copy of the completed Kynamro™ REMS Program Prescription Authorization Form.*
    1. *http://www.kynamrorems.com/~/media/Kynamro/Files/Prescription-Authorization-Form.pdf*
- *Minimum age restriction of 18 years of age.*
- *Patient has had treatment failure, maximum dosing with or contraindication to: statins, ezetimibe, niacin, fibric acid derivatives, omega-3 agents, and bile acid sequestrants.*

Kynamro™ REMS program: *Because of the risk of hepatotoxicity, Kynamro™ is available only through a limited program under the REMS. Under the Kynamro™ REMS, only certified healthcare providers and pharmacies may prescribe and distribute Kynamro™. Further information is available at www.KynamroREMS.com. Prescribers must use a REMS Program Prescription Authorization Form for each new prescription to ensure safe use of KYNAMRO™.*

It was moved by Dube' and seconded by Rock to accept recommendations as published. Roll call vote was taken and the motion passed.

Votes as follows:
Baker-yes, Bleicher-yes, Caudill-yes, Davenport-yes, Dering-Anderson-yes, Dube'-yes, Elsasser-yes, Green–yes, Haberstich–yes, Hammond-yes, Humphries–yes, Johnson-Bohac–yes, Juracek-absent, Reichmuth–yes, Rock-yes, Saunders-yes, Sorensen-yes, Thomsen-yes.

Motion carried.

LIPOTROPICS, STATINS

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
STATINS		
atorvastatin (generic for Lipitor) *CRESTOR (rosuvastatin)** lovastatin (generic for Mevacor) pravastatin (generic for Pravachol) simvastatin (generic for Zocor)	ALTOPREV (lovastatin) 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		
	ADVICOR (lovastatin/niacin ER) atorvastatin/ amlodipine (generic for CADUET) *LIPTRUZET (ezetimibe/atorvastatin)* *SIMCOR (simvastatin/niacin ER)* VYTORIN (simvastatin/ezetimibe)	Vytorin *and Liptruzet* will be approved for patients failing a minimum 3 month trial of standard dose statin

It was moved by Dube' and seconded by Johnson-Bohac to accept recommendations as published with Crestor changed to preferred as noted above. Roll call vote was taken and the motion passed.

Votes as follows:
Baker-yes, Bleicher-yes, Caudill-yes, Davenport-yes, Dering-Anderson-yes, Dube'-yes, Elsasser-yes, Green–yes, Haberstich–yes, Hammond-yes, Humphries–yes, Johnson-Bohac–yes, Juracek-absent, Reichmuth–yes, Rock-yes, Saunders-yes, Sorensen-yes, Thomsen-yes.

Motion carried.

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

It was moved by Elsasser and seconded by Dering-Anderson to amend the main motion by changing Crestor to preferred only with exception criteria of intolerance/failure on atorvastatin 40 mg or greater. Roll call vote was taken and the motion passed.

Votes as follows:

Baker-yes, Bleicher-yes, Caudill-yes, Davenport-yes, Dering-Anderson-yes, Dube'-yes, Elsasser-yes, Green–yes, Haberstich–yes, Hammond-yes, Humphries–yes, Johnson-Bohac–yes, Juracek-absent, Reichmuth–yes, Rock-yes, Saunders-yes, Sorensen-yes, Thomsen-yes.

Motion carried.

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) clarithromycin suspension *ERYTAB* *EES 200 SUSPENSION* *ERYPED 200 SUSPENSION* *ERYPED 400 SUSPENSION* *PCE (erythromycin)*	*ERYTHROCIN* *EES 400* ***TABLET*** *erythromycin base* *erythromycin base CAPSULE DR* ZMAX (azithromycin ER) ZITHROMAX (azithromycin)	1. Adverse reaction to, allergy or contraindication to preferred drugs, or 2. Documentation of treatment failure with preferred drug.

It was moved by Dube' and seconded by Sorensen to accept recommendations as published. Roll call vote was taken and the motion passed.

Votes as follows:

Baker-yes, Bleicher-yes, Caudill-yes, Davenport-yes, Dering-Anderson-yes, Dube'-yes, Elsasser-yes, Green–yes, Haberstich–yes, Hammond-yes, Humphries–yes, Johnson-Bohac–yes, Juracek-absent, Reichmuth–yes, Rock-yes, Saunders-yes, Sorensen-yes, Thomsen-yes.

Motion carried.

MULTIPLE SCLEROSIS DRUGS

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
AUBAGIO (teriflunomide) AVONEX (interferon beta-1a) COPAXONE **20**mg (glatiramer) *EXTAVIA (interferon beta-1b)* REBIF (interferon beta-1a) *GILENYA (fingolimod)* *TECFIDERA (dimethyl fumarate)*	AMPYRA (dalfampridine) *BETASERON (interferon beta-1b)* *COPAXONE* ***40****mg Syringe (glatiramer)*	1.Adverse reaction to, allergy or contraindication to preferred drug, or 2 .Documentation of treatment failure with one preferred drug . **Ampyra:** Initial authorization for 12 weeks, requiring gait disorder

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		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

It was moved by Dering-Anderson and seconded by Caudill to accept recommendations as published with Gilenya and Tecfidera changed to preferred as noted above.. Roll call vote was taken and the motion passed.

Votes as follows:
Baker-no, Bleicher-yes, Caudill-no, Davenport-no, Dering-Anderson-yes, Dube'-yes, Elsasser-no, Green–yes, Haberstich–no, Hammond-no, Humphries–no, Johnson-Bohac–yes, Juracek-absent, Reichmuth–yes, Rock-no, Saunders-yes, Sorensen-yes, Thomsen-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*) *ADEMPAS (riociguat)** *OPSUMIT (macitentan)**	Sildenafil (Revatio) and Adcirca require diagnosis of PAH.

ADEMPAS ® *(riociguat)*

- *For diagnosis of PAH: Is there any reason that the patient cannot be switched to a preferred medication? Document the details. Acceptable reasons include: Adverse reaction to preferred drugs; Allergy to preferred drugs; Contraindication to preferred drugs.*
- *Approve for the treatment of persistent/recurrent Chronic Thromboembolic Pulmonary Hypertension (CTEPH) (WHO Group 4) after surgical treatment or inoperable CTEPH to improve exercise capacity and WHO functional class.*
- *Do not administer Adempas to a pregnant female because it may cause fetal harm.*
  - *Females of reproductive potential: Exclude pregnancy before start of treatment, monthly during treatment, and 1 month after treatment discontinuation. Prevent pregnancy during treatment and for one month after treatment discontinuation by use of acceptable methods of contraception.*
  - *For females, Adempas is available only through a restricted program called the Adempas REMS Program.*
- *Maximum of 3 tablets per day*

OPSUMIT® *(macitentan)*

- *For diagnosis of PAH: Is there any reason that the patient cannot be switched to a preferred medication? Document the details. Acceptable reasons include: Adverse reaction to preferred drugs; Allergy to preferred drugs; Contraindication to preferred drugs.*
- *Do not administer Opsumit to a pregnant female because it may cause fetal harm.*
  - *Females of reproductive potential: Exclude pregnancy before start of treatment, monthly during treatment, and 1 month after treatment discontinuation. Prevent pregnancy during treatment and for one month after treatment discontinuation by use of acceptable methods of contraception.*
  - *For females, Opsumit is available only through a restricted program called the Opsumit REMS Program.*
- *Maximum of 1 tablet per day.*

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It was moved by Dube' and seconded by Reichmuth to accept recommendations as published. Roll call vote was taken and the motion passed.

Votes as follows:
Baker-yes, Bleicher-yes, Caudill-yes, Davenport-yes, Dering-Anderson-yes, Dube'-yes, Elsasser-yes, Green–yes, Haberstich–yes, Hammond-yes, Humphries–yes, Johnson-Bohac–yes, Juracek-absent, Reichmuth–yes, Rock-yes, Saunders-yes, Sorensen-yes, Thomsen-yes.

Motion carried.

PHOSPHATE BINDERS

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

It was moved by Thomsen and seconded by Saunders to accept recommendations as published. Roll call vote was taken and the motion passed.

Votes as follows:
Baker-yes, Bleicher-yes, Caudill-yes, Davenport-yes, Dering-Anderson-yes, Dube'-yes, Elsasser-yes, Green–yes, Haberstich–yes, Hammond-yes, Humphries–yes, Johnson-Bohac–yes, Juracek-absent, Reichmuth–yes, Rock-yes, Saunders-yes, Sorensen-yes, Thomsen-yes.

Motion carried.

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)	DEXILANT (dexlansoprazole) *esomeprazole strontium* lansoprazole (generic for Prevacid) NEXIUM (esomeprazole) NEXIUM SUSPENSION (esomeprazole) omeprazole/sodium bicarbonate (generic for Zegerid RX) PREVACID Rx, SOLU-TAB (lansoprazole) PRILOSEC (omeprazole) rabeprazole (generic for Aciphex)	See existing prior authorization criteria.

It was moved by Rock and seconded by Johnson-Bohac to accept recommendations as published. Roll call vote was taken and the motion passed.

Votes as follows:
Baker-yes, Bleicher-yes, Caudill-yes, Davenport-yes, Dering-Anderson-yes, Dube'-yes, Elsasser-yes, Green–yes, Haberstich–yes, Hammond-yes, Humphries–yes, Johnson-Bohac–yes, Juracek-absent, Reichmuth–yes, Rock-yes, Saunders-yes, Sorensen-yes, Thomsen-yes.

Motion carried.

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ULCERATIVE COLITIS

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
ORAL		
APRISO (mesalamine) balsalazide (generic for Colazal) sulfasalazine (generic for Azulfidine) sulfasalazine DR (generic for Azulfidine DR)	ASACOL **HD** 800mg (mesalamine) *DELZICOL DR (mesalamine)* DIPENTUM (olsalazine) GIAZO (balsalazide) LIALDA (mesalamine) PENTASA (mesalamine)	1. Adverse reaction to, allergy or contraindication to preferred drugs, or 2. Documentation of treatment failure with one preferred drug. ASACOL **HD,** *DELZICOL DR*, 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.

It was moved by Saunders and seconded by Rock to accept recommendations as published. Roll call vote was taken and the motion passed.

Votes as follows:
Baker-yes, Bleicher-yes, Caudill-yes, Davenport-yes, Dering-Anderson-yes, Dube'-yes, Elsasser-yes, Green–yes, Haberstich–yes, Hammond-yes, Humphries–yes, Johnson-Bohac–yes, Juracek-absent, Reichmuth–yes, Rock-yes, Saunders-yes, Sorensen-yes, Thomsen-yes.

Motion carried.

An all in favor motion was made and carried to conclude the meeting at 4:00pm.

Next meeting:
The next meeting of the Nebraska Medicaid Pharmaceutical and Therapeutics Committee is scheduled for:
Wednesday, November 12, 2014, at 9 am CST
Mahoney State Park, Ashland, NE

Recorded by: Barbara J Dowd, R.Ph., Clinical Account Manager, Magellan Medicaid Administration
Abigail Anderson, M.R.C.P., Program Specialist, Nebraska Medicaid & Long-Term Care, DHHS

Minutes approved on 11/12/2014.

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