

DIVISION OF MEDICAID AND LONG-TERM CARE
Nebraska DHHS

PHARMACEUTICAL AND THERAPEUTICS COMMITTEE MEETING MINUTES

November 12, 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 Dubé, 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.
Linda Sobeski, Pharm. D.
Christopher Sorensen, Pharm.D.
Eric Thomsen, M.D.

DHHS Staff

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

Magellan Medicaid Administration

Contract Staff

Barbara J. Dowd, R.Ph.
Sabrina Hellbusch, R.N., B.S.N
Mary K Roberts, R.Ph.

- 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 October 8, 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 Magellan Medicaid Administration Management Staff: Mary K. Roberts, R.Ph. and Magellan Behavioral Health Staff, Sabrina Hellbusch R.N., B.S.N.
- III. Roll Call: see list above
- IV. Conflict of Interest: No new conflicts of interest were reported.
- V. Approval of May 2014 Minutes: The May 14, 2014 meeting minutes were approved unanimously approved as corrected. The correction reflects the voting to go into closed session and the voting to go back into open session.
- VI. Department Updates: 1. At this time, pharmacy benefits will continue to be reimbursed under the fee-for-service system, as the decision to move pharmacy benefits to the managed care system has been postponed. 2. A request was made to review the Hepatitis C class at this meeting; however, this is not possible as the Multi-State Purchasing Pool is not reviewing the class in November. Therefore, this request is tabled until the May 2015 meeting. The DUR Board reviewed and recommended Hepatitis C clinical criteria in September. Expenditures for medications to treat Hepatitis C for the first three quarters of 2014 were reviewed. 3. Other: Pete Ricketts, winner of the gubernatorial election held on November 4th, will appoint a new DHHS Director who will appoint a new Medicaid Director.
- VII. Public Testimony

Drug/Class	Status	Speaker Name	Affiliation
BRONCHODILATORS, BETA AGONIST			

Striverdi Respimat	NP	Julie McDavitt	Boehringer Ingelheim
CYTOKINE AND CAM ANTAGONISTS			
Otezla	NP	Diane Hanna	Celgene
Xeljanz	NP	Rob Hansen	Pfizer
GLUCOCORTICOIDS, INHALED			
Pulmicort	NP	Kathryn Perrotta	AstraZeneca
ONCOLOGY AGENTS, ORAL			
Imbruvica	NP	Shane Grivna	Pharmacyclics

VIII. A motion to move into closed session was made by Davenport and seconded. Moved into closed session at 9:30am. Roll call vote was taken and the motion passed.

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

Motion Carried.

Chairperson, Jeff Gotschall, restated the reason for closed session, which is (a): “Strategy session with respect to collective bargaining”.
Cost issues discussed in Closed Session.

IX. A motion was made by Dering-Andersen, seconded, and unanimously passed to move back into open session at 10:30.

X. **Consent Agenda (Therapeutic Categories with Unchanged Recommendations):**
The following Therapeutic Class was extracted from the Consent Agenda: Anti-Parkinson’s Agents.

ANTI-HISTAMINES, MINIMALLY SEDATING

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

ANTI-HYPERURICEMICS

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
allopurinol (generic for Zyloprim) probenecid probenecid/colchicine (generic for Col-Probenecid)	COLCRYS (colchicine)* ULORIC (febuxostat)*	Colcrys™ (colchicine): • Diagnosis of familial Mediterranean fever (FMF);

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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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QL indicates quantity limits.

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

		<ul style="list-style-type: none"> ○ Maximum daily dose: 2.4mg ○ Minimum age: 4 ○ Length of approval: 12 months ○ Quantity limit: 120 per 30 days ● Or Diagnosis of Gout <ul style="list-style-type: none"> ○ Approve if there has been a treatment failure with any preferred drug ○ Quantity limit: 60 per 28 days ○ Minimum age: 16 ○ Length of approval: 6 months <p>Uloric: Allergy to, treatment failure with, or contraindication to allopurinol.</p>
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ANTIPSORIATICS, ORAL

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
SORIATANE (acitretin)	acitretin (generic for Soriatane) methoxsalen rapid (generic for OxSORALEN-Ultra) 8-MOP (methoxsalen)	1. Adverse reaction to, allergy or contraindication to preferred drug, or 2. Documentation of treatment failure with preferred drug. 3. Trial on acitretin (Category X) not required in pregnancy.

ANXIOLYTICS

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

EPINEPHRINE, SELF-INJECTED

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
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EPIPEN EPIPEN JR.	epinephrine ADRENACLICK AUVI-Q	<i>Epinephrine and ADRENACLICK require clinical reason that EpiPen cannot be used.</i> <i>AUVI-Q requires documentation of patient specific need for assistance with administration.</i>
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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 2. Documentation of treatment failure with preferred drug. AND 3. Trial on topical steroid.

IMMUNOMODULATORS, TOPICAL

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
ALDARA (imiquimod)	imiquimod (generic for Aldara) ZYCLARA (imiquimod)	1. Adverse reaction to, allergy or contraindication to preferred drug, or 2. Documentation of treatment failure with preferred drug.

LEUKOTRIENE MODIFIERS

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

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:
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AROMATASE INHIBITORS		
anastrozole (generic for Arimidex) exemestane (generic for Aromasin) letrozole (generic for Femara)		
ANTIESTROGEN		Documentation of why tamoxifen not appropriate for patient.
tamoxifen	Fareston (toremifene)	

OPHTHALMIC ANTIBIOTIC-STEROID COMBINATIONS

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
BLEPHAMIDE (prednisolone, and sulfacetamide) BLEPHAMIDE S.O.P. neomycin/polymyxin/dexamethasone (generic for Maxitrol) PRED-G DROPS SUSP (prednisolone and gentamicin) PRED-G OINT (prednisolone and gentamicin) sulfacetamide/prednisolone TOBRADEX OINTMENT (tobramycin and dexamethasone) TOBRADEX SUSPENSION (tobramycin and dexamethasone)	neomycin/polymyxin/HC neomycin/bacitracin/poly/HC tobramycin/dexamethasone susp. (generic for Tobradex) TOBRADEX S.T. (tobramycin and dexamethasone <i>suspension</i>) ZYLET (loteprednol, tobramycin)	1. Adverse reaction to, allergy or contraindication to preferred drugs, or 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) MOXEZA (moxifloxacin) ofloxacin (generic for Ocuflax) VIGAMOX (moxifloxacin)	BESIVANCE (besifloxacin) CILOXAN ointment (ciprofloxacin) gatifloxacin 0.5% (generic for Zymaxid) levofloxacin generic	1. Adverse reaction to, allergy or contraindication to preferred drugs, or 2. Documentation of treatment failure with two preferred drugs.
MACROLIDES		
erythromycin	AZASITE (azithromycin)	1. Adverse reaction to, allergy or contraindication to preferred drugs, or 2. Documentation of treatment failure with preferred drug.
AMINOGLYCOSIDES		
gentamicin drops and ointment tobramycin (generic for Tobrex drops) TOBREX ointment (tobramycin)	GARAMYCIN DROPS (gentamicin) GARAMYCIN OINTMENT (gentamicin)	1. Adverse reaction to, allergy or contraindication to preferred drugs, or

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OTHER OPHTHALMIC ANTIBIOTICS		
polymyxin B/trimethoprim (generic for Polytrim)	bacitracin bacitracin/polymyxin B (generic for Polysporin) NATACYN (natamycin)* neomycin/bacitracin/polymyxin B ointment neomycin/polymyxin B/gramicidin (generic for Neosporin) sulfacetamide drops (generic for Bleph-10) sulfacetamide ointment	2. Documentation of treatment failure with preferred drug. NATACYN: Documented fungal infection.

OPHTHALMICS FOR ALLERGIC CONJUNCTIVITIS

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

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) acetic acid HC (generic for VoSol HC)	1. Adverse reaction to, allergy or contraindication to preferred drugs, or 2. Documentation of treatment failure with two preferred drugs.

OTIC ANTIBIOTICS

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

STERIODS, TOPICAL

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:

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LOW POTENCY		
hydrocortisone cream , ointment (generic for Cortaid) hydrocortisone OTC lotion hydrocortisone/aloe cream , ointment	alclometasone dipropionate (generic for Aclovate) CAPEX Shampoo (fluocinolone) DESONATE (desonide gel) desonide lotion (generic for Desowen) desonide cream , ointment (generic for former products Desowen, Tridesilon) fluocinolone 0.01% OIL (generic for Derma-Smoothe-FS) hydrocortisone Rx lotion hydrocortisone/aloe gel hydrocortisone/urea TEXACORT (hydrocortisone) VERDESO (desonide)	1.Adverse reaction to, allergy or contraindication to preferred drugs, or 2 .Documentation of treatment failure with two preferred drugs.
MEDIUM POTENCY		
fluticasone propionate cream , ointment (generic for Cutivate) mometasone furoate solution , cream , ointment (generic for Elocon)	betamethasone valerate (generic for Luxiq) clocortolone (generic for CLODERM) CORDRAN TAPE (flurandrenolide) fluocinolone acetonide (generic for Synalar) fluticasone propionate lotion (generic for Cutivate) hydrocortisone butyrate (generic for Locoid) hydrocortisone butyrate/emoll (generic for Locoid Lipocream) hydrocortisone valerate (generic for Westcort) MOMEXIN (mometasone) PANDEL (hydrocortisone probutate 0.1%) prednicarbate (generic for Dermatop)	1.Adverse reaction to, allergy or contraindication to preferred drugs, or 2 .Documentation of treatment failure with two preferred drugs.
HIGH POTENCY		
betamethasone valerate (generic for Beta-Val) fluocinonide cream, ointment, gel fluocinonide emollient triamcinolone acetonide ointment , cream (generic for Kenalog)	amcinonide cream, ointment, lotion betamethasone dipropionate (generic for Diprolene) betamethasone dipro/prop gly (augmented) desoximetasone (generic for Topicort) diflorasone diacetate (generic for	1.Adverse reaction to, allergy or contraindication to preferred drugs, or 2 .Documentation of treatment failure with two preferred drugs.

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	Apexicon) fluocinonide SOLUTION HALOG (halcinonide) KENALOG AEROSOL (triamcinolone) triamcinolone lotion TRIANEX Ointment (triamcinolone) VANOS (fluocinonide)	
VERY HIGH POTENCY		
clobetasol emollient (generic for Temovate-E) clobetasol propionate (generic for Temovate) halobetasol propionate (generic for Ultravate)	APEXICON-E (diflorasone) CLOBEX (clobetasol) clobetasol shampoo, lotion clobetasol propionate FOAM OLUX-E (clobetasol) OLUX/OLUX-E CP (clobetasol)	1. Adverse reaction to, allergy or contraindication to preferred drugs, or 2. Documentation of treatment failure with preferred drug.

It was moved by Sorensen and seconded to accept recommendations as published for the Therapeutic Classes on the Consent Agenda with the exception of Anti-Parkinson's. This 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, Dubé-yes, Elsasser-yes, Green-yes, Haberstitch-yes, Hammond-yes, Humphries-yes, Johnson-Bohac-yes, Juracek-yes, Reichmuth-yes, Rock-yes, Saunders-yes, Sobeski-yes, Sorensen-yes, Thomsen-yes.

Motion Carried.

XII. Therapeutic Class Review: (Therapeutic Categories with New Recommendations)

ANTIPARKINSON'S AGENTS

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
ANTICHOLINERGICS		
benztropine (generic for Cogentin) trihexyphenidyl (generic for Artane)		
COMT INHIBITORS		
	entacapone (generic for Comtan) TASMAR (tolcapone)	Approve if using as add on therapy with a levodopa containing drug.
DOPAMINE AGONISTS		
bromocriptine (generic for Parlodel) pramipexole (generic for Mirapex) ropinirole (generic for Requip)	MIRAPEX ER (pramipexole) NEUPRO (rotigotine transdermal) REQUIP (ropinirole) ropinirole ER (generic for Requip XL)	1. Adverse reaction to, allergy or contraindication to <i>one preferred drug within the same group, or</i>

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		<p>2 .Documentation of treatment failure with preferred drug.</p> <p>Extended-release Dopamine Agonists will be approved for RLS and Parkinson's Disease.</p> <p>Neupro ®transdermal patch (rotigotine)</p> <ul style="list-style-type: none"> • For Parkinson's Disease: Is there a clinical reason (i.e. documented swallowing disorder) that a preferred oral agent cannot be used? If there is no clinical reason as noted above, approval requires trial of ONE preferred agent. • For Restless Legs Syndrome (RLS): Approval requires trial on both ropinirole and pramipexole, or clinical reasons these agents cannot be tried.
MAO-B INHIBITORS		
selegiline tablets (generic for Eldepryl)	AZILECT (rasagiline) selegiline capsules (gen. for Eldepryl) ZELAPAR (selegiline dispersible)	<p>1. Adverse reaction to, allergy or contraindication to <i>one</i> preferred drug <i>within the same group</i>, or</p> <p>2 .Documentation of treatment failure with preferred drug.</p>
OTHER ANTIPARKINSON'S DRUGS		
carbidopa/levodopa (generic for Sinemet) carbidopa/levodopa ER (generic for Sinemet CR) STALEVO (levodopa/carbidopa entacapone)	carbidopa/levodopa ODT (generic for Parcopa) levodopa/carbidopa/entacapone (generic for Stalevo)	<p>1. Adverse reaction to, allergy or contraindication to <i>one</i> preferred drug <i>within the same group</i>, or</p> <p>2 .Documentation of treatment failure with preferred drug.</p> <p>Zelapar®: May approve if documented swallowing disorder.</p> <p>Carbidopa/levodopa (generic for Parcopa®): May approve if documented swallowing disorder.</p>

It was moved by Reichmuth and seconded to accept recommendations as published with the addition of RLS to the exception criteria for approval of extended-release dopamine agonists 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, Dubé-yes, Elsasser-yes, Green-yes, Haberstitch-yes, Hammond-yes, Humphries-yes, Johnson-Bohac-yes, Juracek-yes, Reichmuth-yes, Rock-yes, Saunders-yes, Sobeski-yes, Sorensen-yes, Thomsen-yes.

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Motion Carried.

ALZHEIMER'S DRUGS

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
CHOLINESTERASE INHIBITORS		
donepezil (generic for Aricept) donepezil ODT (generic for Aricept ODT) EXELON Transdermal (rivastigmine)	donepezil 23 (generic for Aricept 23) EXELON Oral Solution (rivastigmine) galantamine (generic for Razadyne) galantamine ER (generic for Razadyne ER) 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 (<i>memantine ER</i>)		

It was moved by Thomsen to accept recommendations as published and seconded. 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, Haberstitch-yes, Hammond-yes, Humphries-yes, Johnson-Bohac-yes, Juracek-yes, Reichmuth-yes, Rock-yes, Saunders-yes, Sorensen-yes, Thomsen-yes.

Motion Carried.

ANTIHYPERTENSIVES, SYMPATHOLYTICS

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

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

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

Motion Carried.

ANTIPSORIATICS, TOPICAL

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
<i>calcipotriene</i> CREAM calcipotriene SOLUTION	calcipotriene OINTMENT (generic for Calcitrene)	1. Adverse reaction to, allergy or

	calcipotriene/betamethasone (generic for Taclonex ointment) calcitriol OINTMENT (generic for Vectical) DOVONEX CREAM (calcipotriene) SORILUX (calcipotriene foam) TACLONEX SCALP (calcipotriene/ betamethasone)	contraindication to preferred drug, or 2. Documentation of treatment failure with preferred drug.
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It was moved by Dubé and seconded 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, Dubé-yes, Elsasser-yes, Green-yes, Haberstitch-yes, Hammond-yes, Humphries-yes, Johnson-Bohac-yes, Juracek-yes, Reichmuth-yes, Rock-yes, Saunders-yes, Sobeski-yes, Sorensen-yes, Thomsen-yes.

Motion Carried.

BILE SALTS

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
<i>ursodiol tablet 250mg (generic for URSO)</i> <i>ursodiol tablet 500mg (generic for URSO Forte)</i>	CHENODAL (chenodiol) <i>ursodiol capsule 300mg (generic for Actigall)</i>	1. Adverse reaction to, allergy or contraindication to preferred drugs, or 2. Documentation of treatment failure with preferred drug.

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

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

Motion Carried.

BRONCHODILATORS, BETA AGONIST

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
INHALERS-Short Acting		
PROVENTIL HFA (albuterol)	PROAIR HFA (albuterol) VENTOLIN HFA (albuterol) XOPENEX HFA (levalbuterol)	1. Adverse reaction to, allergy or contraindication to preferred drugs, or 2. Documentation of treatment failure with a preferred drug. 3. Ventolin/Proair- May be approved without trials on preferred if prescriber documents need for dose counter on canister.

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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.

INHALERS – Long Acting		
FORADIL (formoterol) (Prior authorization of Foradil not required if diagnosis of COPD on claim or in Patient Clinical Health Conditions OR inhaled corticosteroid in claims history) STRIVERDI RESPIMAT (olodaterol)	ARCAPTA (indacaterol) SEREVENT (salmeterol)	1. Adverse reaction to, allergy or contraindication to preferred drug, or 2. Documentation of treatment failure with a preferred drug. In 2010 the FDA contraindicated the use of Long Acting Beta Agonists in asthma WITHOUT an asthma controller medication, such as an inhaled corticosteroid.
INHALATION SOLUTION		
albuterol (2.5mg/3ml premix or 2.5mg/0.5ml) albuterol/ipratropium (generic for Duoneb)	albuterol low dose (0.63mg/3ml & 1.25mg/3ml) BROVANA (arformoterol) levalbuterol (generic for Xopenex) PERFOROMIST (formoterol)	If the patient weighs less than 15kg (33lbs) the call center may approve the lower dose. OR May approve lower dose if it is felt that the parent is not able to reliably measure drug. 1. Adverse reaction to, allergy or contraindication to preferred drugs, or 2. Documentation of treatment failure with preferred drug.
ORAL		
albuterol syrup albuterol ER (generic for Vospire ER) terbutaline (generic for Brethine)	albuterol tablets metaproterenol (formerly generic for Alupent)	1. Adverse reaction to, allergy or contraindication to preferred drug, or 2. Documentation of treatment failure with preferred drug.

It was moved by Dering-Anderson and seconded to accept recommendations as published with Striverdi Respimat 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, Dubé-yes, Elsasser-no, Green-yes, Haberstick-yes, Hammond-yes, Humphries-yes, Johnson-Bohac-yes, Juracek-yes, Reichmuth-no, Rock-yes, Saunders-yes, Sobeski-yes, Sorensen-no, Thomsen-yes.

Motion Carried.

COPD AGENTS

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
INHALERS		
ATROVENT HFA (ipratropium) COMBIVENT RESPIMAT	ANORO ELLIPTA (umeclidinium/vilanterol)	1. Adverse reaction to, allergy or

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

It was moved by Johnson-Bohac and seconded 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, Dubé–yes, Elsasser–yes, Green–yes, Haberstitch–yes, Hammond–yes, Humphries–yes, Johnson-Bohac–yes, Juracek–yes, Reichmuth–yes, Rock–yes, Saunders–yes, Sobeski–yes, Sorensen–yes, Thomsen–yes.

Motion Carried.

CYTOKINE & CAM ANTAGONISTS

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
ENBREL (etanercept) HUMIRA (adalimumab) XELJANZ (tofacitinib oral)	<i>ACTEMRA subcutaneous (tocilizumab)</i> <i>ARCALYST (rilonacept)</i> CIMZIA (certolizumab pegol) KINERET (anakinra) ORENCIA (abatacept) S.C. <i>OTEZLA (apremilast oral)</i> SIMPONI (golimumab)	1. Adverse reaction to, contraindication to <i>one</i> preferred drugs, or 2. Documentation of treatment failure with preferred drug.

It was moved by Thomsen and seconded to accept recommendations as published. The motion was amended by Sorensen and seconded to change Xeljanz to preferred as noted above. Roll Call vote was taken and the motion to amend passed.

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*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.

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

Motion Carried.

Roll Call vote was taken on the amended motion and passed.

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

Motion Carried.

GLUCOCORTICIDS, INHALED

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

It was moved by Davenport and seconded to accept recommendations as published and change Pulmicort Flexhaler and Flovent HFA 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, Dubé-yes, Elsasser-yes, Green-yes, Haberstitch-yes, Hammond-yes, Humphries-yes, Johnson-Bohac-yes, Juracek-yes, Reichmuth-yes, Rock-yes, Saunders-yes, Sobeski-yes, Sorensen-yes, Thomsen-yes.

Motion Carried.

HISTAMINE II RECEPTOR BLOCKERS

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
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famotidine tablet (generic for Pepcid) ranitidine TABLET (generic for Zantac) ranitidine syrup	cimetidine solution <i>cimetidine tablet (generic for Tagamet)</i> ranitidine CAPSULE famotidine SUSPENSION nizatidine (generic for Axid)	1. Adverse reaction to, allergy or contraindication to preferred drug, or 2. Documentation of treatment failure with preferred drug.
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It was moved by Saunders and seconded 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, Dubé-yes, Elsasser-yes, Green-yes, Haberstitch-yes, Hammond-yes, Humphries-yes, Johnson-Bohac-yes, Juracek-yes, Reichmuth-yes, Rock-yes, Saunders-yes, Sobeski-yes, Sorensen-yes, Thomsen-yes.

Motion Carried.

INTRANASAL RHINITIS DRUGS

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

It was moved by Dering-Anderson and seconded 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, Dubé-yes, Elsasser-yes, Green-yes, Haberstitch-yes, Hammond-yes, Humphries-yes, Johnson-Bohac-yes, Juracek-yes, Reichmuth-yes, Rock-yes, Saunders-yes, Sobeski-yes, Sorensen-yes, Thomsen-yes.

Motion Carried.

NSAIDS, (Oral)

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
COX-I SELECTIVE		
diclofenac potassium (generic for Cataflam) diclofenac sodium (generic for Voltaren) flurbiprofen (generic for Ansaid) ibuprofen OTC, Rx (generic for Advil, Motrin,) indomethacin capsule (generic for Indocin) ketoprofen (generic for Orudis, Oruvail) ketorolac (generic for Toradol) <i>meclufenamate (generic for Meclomen)</i> meloxicam tablet (generic for Mobic) nabumetone (generic for Relafen) naproxen Rx, OTC (generic for Naprosyn) naproxen suspension (Naprosyn) sulindac (generic for Clinoril)	diclofenac SR (generic for Voltaren-XR) diflunisal (generic for Dolobid) <i>etodolac (generic for Lodine)</i> etodolac SR fenoprofen (generic for Nalfon) indomethacin ER INDOCIN RECTAL INDOCIN SUSPENSION ketoprofen ER mefenamic acid (generic for Ponstel) meloxicam suspension naproxen EC oxaprozin (generic for Daypro) piroxicam (generic for Feldene) tolmetin (generic for Tolectin) TOPICAL: diclofenac (generic for Pennsaid Solution) FLECTOR PATCH (diclofenac) PENNSAID PUMP (diclofenac) VOLTAREN GEL (diclofenac) ALL BRAND NAME NSAIDs ARE NON-PREFERRED. CAMBIA (diclofenac oral solution) DUEXIS (ibuprofen/famotidine) SPRIX (ketorolac nasal) VIMOVO (naprosyn/esomeprazole) ZIPSOR (diclofenac) <i>ZORVOLEX (diclofenac)</i>	1. Adverse reaction to, allergy or contraindication to preferred drugs, or 2. Documentation of treatment failure of no less than a 30 day trial with two preferred drugs.
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:

CAMBIA® (diclofenac potassium):

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QL indicates quantity limits.

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

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.

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.

SPRIX (ketorolac Nasal)

- • Patient is unable to tolerate, swallow or absorb oral NSAIDS (check to see if there are any current PO meds on profile) OR
- • Contraindication to oral NSAID (e.g. active GI bleed) OR
- • Patient has tried 2 preferred oral NSAID agents
- Approvals for Date Of Service only – recommended maximum duration of therapy is 5 days.

VIMOVO- Naproxen and several proton pump inhibitors available without prior authorization.

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.

ZIPSOR® (diclofenac potassium liquid filled capsules) -Oral generic diclofenac products should be recommended and tried first.

ZORVOLEX (diclofenac)

- *A clinical trial and failure on oral diclofenac is required. Diclofenac potassium and diclofenac sodium are covered without PA; clinical reason as to why diclofenac potassium and diclofenac sodium cannot be used.*
- *Has the patient had a therapeutic trial and treatment failure of no less than 30 days with **TWO** preferred drugs other than diclofenac potassium and diclofenac sodium? Document the details and approve.*

It was moved by Davenport and seconded to accept recommendations as published and changed Meclomen to the 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, Dubé–yes, Elsasser–yes, Green–yes, Haberstitch–yes, Hammond–yes, Humphries–yes, Johnson–Bohac–yes, Juracek–yes, Reichmuth–yes, Rock–yes, Saunders–yes, Sobeski–yes, Sorensen–yes, Thomsen–yes.

Motion Carried.

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:
Antiandrogens		
<i>bicalutamide (generic for Casodex)</i> FLUTAMIDE XTANDI (enzalutamide) ZYTIGA (abiraterone)	NILANDRON (<i>nilutamide</i>)	
Kinase Inhibitors		
AFINITOR (everolimus) BOSULIF (bosutinib) CAPRELSA (vandetanib) COMETRIQ (cabozantinib) GILOTRIF (afatinib) GLEEVEC (imatinib) ICLUSIG (<i>ponatinib</i>) IMBRUVICA (<i>irutinib</i>) INLYTA (axitinib) JAKAFI (ruxolitinib) MEKINIST (trametinib) NEXAVAR (sorafenib) SPRYCEL (dasatinib) STIVARGA (regorafenib) SUTENT (sunitinib) TAFINLAR (dabrafenib) TARCEVA (erlotinib) TASIGNA (nilotinib) TYKERB (lapatinib) VOTRIENT (pazopanib) XALKORI (crizotinib) ZELBORAF (vemurafenib) ZYDELIG (<i>idelalisib</i>) ZYKADIA (<i>ceritinib</i>)	AFINITOR DISPERZ*	See below: Clinical criteria must be met for authorization.
Others		
ALKERAN (melphalan) ERIVEDGE (vismodegib) hydroxyurea (generic for Hydrea) mercaptopurine TEMODAR (temozolomide)	capecitabine (generic for Xeloda) HYDREA (hydroxyurea) temozolomide (generic for Temodar)*	

XELODA (capecitabine) ZOLINZA (vorinostat)	PURIXAN (mercaptopurine oral suspension)	
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AFINITOR DISPERZ®

- For treatment of children aged 1 and older who have tuberous sclerosis complex (TSC) and an accompanying rare brain tumor, subependymal giant cell astrocytoma (SEGA), that cannot be treated with surgery.

Casodex (bicalutamide)

- *Documentation of clinical reason the generic product cannot be used.*

capecitabine (generic for Xeloda)

- Documentation of clinical reason the brand name product cannot be used.

HYDREA® (hydroxyurea)

- Documentation of clinical reason the generic form cannot be used.

ICLUSIG® (ponatinib)

- *Approve for the treatment of adult patients with chronic phase, accelerated phase, or blast phase chronic myeloid leukemia (CML) that is resistant or intolerant to prior tyrosine kinase inhibitor therapy OR Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ ALL) that is resistant or intolerant to prior tyrosine kinase inhibitor therapy.*
 - *Tyrosine kinase inhibitor therapy includes the following (patient should have trialed and failed at least one of these):*
 - *Bosulif® (bosutinib)*
 - *Sprycel® (dasatinib)*
 - *Gleevec® (imatinib)*
 - *Tasigna® (nilotinib)*

IMBRUVICA® (ibrutinib)

Approve for patients with a diagnosis of:

- *Mantle cell lymphoma (MCL) for patients who have received at least one prior therapy (document previous therapy); Recommended dose is 560 mg taken orally once daily (four 140 mg capsules once daily).*
- *Chronic lymphocytic leukemia (CLL) for patients who have received at least one prior therapy (document previous therapy). Recommended dose is 420mg daily (three 140mg capsules daily).*
- *Chronic lymphocytic leukemia with 17p deletion. Recommended dose is 420mg daily (three 140mg capsules daily).*

NILANDRON (nilutamide)

Approve for patients with a diagnosis of:

- *Metastatic prostate cancer*

PURIXAN (mercaptopurine oral suspension)

- *Patient has a diagnosis of acute lymphoblastic leukemia (ALL).*
- *May be approved if the patient has inability to swallow, and there is a clinical reason the patient cannot utilize mercaptopurine tablet.*

temozolomide (generic for Temodar)

- Documentation of clinical reason the brand name product cannot be used.

ZYDELIG (idelalisib)

Approve For the treatment of patients with:

- Relapsed chronic lymphocytic leukemia (CLL), in combination with rituximab, in patients for whom rituximab alone would be considered appropriate therapy due to other co-morbidities; **OR**
- Relapsed follicular B-cell non-Hodgkin lymphoma (FL) in patients who have received at least two prior systemic therapies; **OR**
- Relapsed small lymphocytic lymphoma (SLL) in patients who have received at least two prior systemic therapies.

ZYKADIA (ceritinib)

Approve for the treatment of patients with:

Anaplastic lymphoma kinase (ALK)-positive metastatic non-small cell lung cancer (NSCLC) who have progressed on or are intolerant to Xalkori (crizotinib).

It was moved by Green to accept recommendations as published with ICLUSIG, IMBRUVICA, ZYDELIG, and ZYTIGA changed to preferred and their criteria not be implemented 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, Dubé-yes, Elsasser-yes, Green-yes, Haberstitch-yes, Hammond-yes, Humphries-yes, Johnson-Bohac-yes, Juracek-yes, Reichmuth-yes, Rock-yes, Saunders-yes, Sobeski-yes, Sorensen-yes, Thomsen-yes.

Motion Carried.

OPHTHALMICS, ANTI-INFLAMMATORIES

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
CORTICOSTEROIDS		
dexamethasone (generic for Maxidex) DUREZOL (difluprednate) FLAREX (fluorometholone) fluorometholone 0.1% (generic for FML) FML FORTE (fluorometholone 0.25%) FML S.O.P. (fluorometholone 0.1%) LOTEMAX DROPS (loteprednol 0.5%) MAXIDEX (dexamethasone) PRED MILD (prednisolone 0.12%)	LOTEMAX OINTMENT, GEL (loteprednol) <i>prednisolone acetate 1% (generic for Omnipred, Pred Forte)</i> prednisolone sodium phosphate 1% VEXOL (rimexolone)	1. Adverse reaction to, allergy or contraindication to preferred drugs, or 2. Documentation of treatment failure with two preferred drugs.
NSAID		
diclofenac (generic for Voltaren)	ACUVAIL (ketorolac 0.45%)	1. Adverse reaction to, allergy or

flurbiprofen (generic for Ocufen)	bromfenac 0.09% (generic for Bromday) ILEVRO (nepafenac 0.3%) ketorolac LS 0.4% (generic for Acular LS) ketorolac 0.5% (generic for Acular) NEVANAC (nepafenac 0.1%) PROLENSA (bromfenac 0.07%)	contraindication to preferred drugs, or 2 .Documentation of treatment failure with preferred drug.
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It was moved by Dubé and seconded 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, Dubé–yes, Elsasser–yes, Green–yes, Haberstitch–yes, Hammond–yes, Humphries–yes, Johnson–Bohac–yes, Juracek–abstained, Reichmuth–yes, Rock–yes, Saunders–yes, Sobeski–yes, Sorensen–yes, Thomsen–yes.

Motion Carried.

OPHTHALMICS, GLAUCOMA DRUGS

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
MIOTICS		
pilocarpine		
SYMPATHOMIMETICS		
ALPHAGAN P 0.15% (brimonidine) brimonidine 0.2% (generic for Alphagan)	ALPHAGAN P 0.1% (brimonidine) apraclonidine (generic for lopidine) brimonidine P 0.15%(gen. for Alphagan P)	1.Adverse reaction to, allergy or contraindication to preferred drugs, or 2 .Documentation of treatment failure with preferred drug.
BETA BLOCKERS		
betaxolol (generic for Betoptic) carteolol (generic for Ocupress) ISTALOL (timolol) levobunolol (generic for Betagan) metipranolol (generic for Optipranolol) timolol (generic for Timoptic)	<i>BETIMOL (timolol)</i> <i>BETOPTIC S (betaxolol)</i> TIMOPTIC OCUDOSE TIMOPTIC XE (timolol gel forming solution)	1.Adverse reaction to, allergy or contraindication to preferred drug, or 2 .Documentation of treatment failure with preferred drug.
CARBONIC ANHYDRASE INHIBITORS		
AZOPT (brinzolamide) dorzolamide (generic for Trusopt)	TRUSOPT (dorzolamide)	1.Adverse reaction to, allergy or contraindication to preferred drugs, or 2 .Documentation of treatment failure with preferred drug.
PROSTAGLANDIN ANALOGS		

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

It was moved by Saunders and seconded 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, Dubé–yes, Elsasser–yes, Green–yes, Haberstitch–yes, Hammond–yes, Humphries–yes, Johnson–Bohac–yes, Juracek– abstained, Reichmuth–yes, Rock–yes, Saunders–yes, Sobeski–yes, Sorensen–yes, Thomsen–yes.

Motion Carried.

SEDATIVE HYPNOTICS

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
BENZODIAZEPINES		
estazolam (generic for ProSom) temazepam 15mg, 30mg (generic for Restoril)	flurazepam (generic for Dalmane) temazepam 7.5mg, 22.5mg triazolam (generic for Halcion)	1. Adverse reaction to, allergy or contraindication to preferred drugs, or 2. Documentation of treatment failure with two preferred drugs.
OTHERS		
zaleplon (generic for Sonata) zolpidem (generic for Ambien)	EDLUAR (zolpidem sublingual) eszopiclone (generic for Lunesta) <i>HETLIOZ (tasimelteon)</i> INTERMEZZO (zolpidem sublingual) ROZEREM (ramelteon) SILENOR (doxepin)* zolpidem ER (generic for Ambien CR) ZOLPIMIST(zolpidem oral spray)	1. Adverse reaction to, allergy or contraindication to preferred drugs, or 2. Documentation of treatment failure with preferred drug. <i>Hetlioz:</i> <ul style="list-style-type: none"> • For the treatment of Non-24-Hour Sleep-Wake Disorder (Non-24). • The patient is completely blind. • Is there any reason that the patient cannot be switched to a preferred medication? Document the details. Acceptable reasons include:

		<ol style="list-style-type: none"> 1. <i>Adverse reaction to preferred drugs</i> 2. <i>Allergy to preferred drugs</i> 3. <i>Contraindication to preferred drugs</i> <ul style="list-style-type: none"> • <i>Require a therapeutic trial and treatment failure with generic zolpidem within the last 12 months AND</i> • <i>Trial and failure or clinical reason as to why zaleplon and preferred benzodiazepines are not appropriate. (I.e. patient has hx of substance abuse, patient on another benzo for another disorder).</i> <p>Silenor: In addition, would also require patient specific clinical reason patient could not use generic doxepin.</p>
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It was moved by Rock and seconded 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, Dubé-yes, Elsasser-yes, Green-yes, Haberstitch-yes, Hammond-yes, Humphries-yes, Johnson-Bohac-yes, Juracek-yes, Reichmuth-yes, Rock-yes, Saunders-yes, Sobeski-yes, Sorensen-yes, Thomsen-yes.

Motion Carried.

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.

<p>ADDERALL XR (amphetamine salt (combo) amphetamine salt combination IR (generic for Adderall IR)</p> <p>VYVANSE (lisdexamfetamine)</p>	<p>amphetamine salt combination ER (generic for Adderall XR) dextroamphetamine (generic for Dexedrine) dextroamphetamine ER (generic for Dexedrine Spansule) dextroamphetamine solution (generic for Procentra) methamphetamine (generic for Desoxyn) <i>ZENZEDI (dextroamphetamine)</i></p>	<p>1. Adverse reaction to, allergy or contraindication to preferred drugs, or 2. Documentation of treatment failure with two preferred drugs.</p> <p><i>ZENZEDI (dextroamphetamine):</i></p> <ul style="list-style-type: none"> <i>In addition to PDL criteria, must provide clinical reason the generic dextroamphetamine IR products cannot be used.</i>
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CNS Stimulants -Methylphenidate type		
<p>FOCALIN (dexmethylphenidate) FOCALIN XR (dexmethylphenidate)</p>	<p>dexmethylphenidate (generic for Focalin) dexmethylphenidate XR (generic for Focalin XR)</p>	<p>Daytrana® (methylphenidate):</p> <ul style="list-style-type: none"> May approve if requested because there is a history of substance abuse in the parent/caregiver or patient. May approve if there is a swallowing disorder and the patient cannot be given oral medication. Daytrana has a maximum age of 18. If preferreds are refused and patient meets criteria (clinical or PDL) age edit may be approved.
<p>METHYLIN CHEWABLE (methylphenidate) methylphenidate (generic for Ritalin)</p>	<p>methylphenidate solution <i>METHYLIN SOLUTION (methylphenidate)</i> <i>RITALIN (methylphenidate)</i></p>	
<p>METADATE ER (methylphenidate ER) methylphenidate ER (generic for Ritalin-SR, Metadate ER)</p>	<p>DAYTRANA (methylphenidate patch) methylphenidate CD 30/70 (generic for METADATE CD)</p>	
<p>QUILLIVANT XR (methylphenidate suspension)</p>	<p>methylphenidate ER 50/50 (generic for RITALIN LA) methylphenidate ER (generic for Ritalin SR)</p> <p>-----</p> <p>CONCERTA (methylphenidate ER (18mg, 27mg, 36mg, 54mg) methylphenidate ER (18mg, 27mg, 36mg, 54mg (generic Concerta)</p>	

MISCELLANEOUS ADHD		
<p>Note: generic guanfacine and clonidine are available without prior authorization.</p> <p><i>STRATTERA (atomoxetine)</i></p>	<p>clonidine ER (generic for Kapvay) INTUNIV (guanfacine extended-release)*</p>	<p>INTUNIV:</p> <ol style="list-style-type: none"> Only approved in children, minimum age 6. Diagnosis of ADHD. Patient shows some therapeutic benefit from the immediate release guanfacine preparation taken at

		<p>least twice daily and there is a therapeutic need to administer the guanfacine once daily.</p> <p>4. Maximum dose 4mg/day.</p> <p>KAPVAY:</p> <ol style="list-style-type: none"> 1. Only approved in children, minimum age 6. 2. Diagnosis of ADHD. 3. Patient shows some therapeutic benefit from the immediate release clonidine preparation taken at least three daily and there is a therapeutic need to administer the clonidine twice daily. 4. Total daily dose not to exceed 0.4mg per day. <p>STRATTERA:</p> <ol style="list-style-type: none"> 1. Documented trial and failure of at least one stimulant within two months OR 2. Diagnosis of tics or anxiety disorder or a history of substance abuse. 3. Family or parent refusal to use controlled substance.
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CNS Stimulants -ANALEPTICS		
	<p>modafanil (generic for Provigil)* NUVIGIL (armodafinil)*</p> <p>.....</p> <p>NUVIGIL: Minimum age 18. Require trial of Provigil. For Sleep apnea: Documentation of sleep apnea with sleep study. For Narcolepsy: Treatment failure with amphetamine and documentation of diagnosis in sleep study. Shift Work Sleep disorder: Only approve for six months to verify work schedule.</p> <p>PROVIGIL: Minimum age 18. For Sleep apnea: Documentation of sleep apnea with sleep study. For Narcolepsy: Treatment failure with amphetamine and documentation of diagnosis in sleep study. Shift Work Sleep disorder: Only approve for six months to verify work schedule.</p>	

It was moved by Reichmuth and seconded to accept recommendations as published with the removal or the requirement of a trial on an amphetamine for requests for modafanil and armodafanil in sleep disorders. Roll Call vote was taken and the motion passed.

Votes as follows: Baker–yes, Bleicher–yes, Caudill–yes, Davenport–yes, Dering–Anderson–yes, Dubé–yes, Elsasser–yes, Green–yes, Haberstitch–yes, Hammond–yes, Humphries–yes, Johnson–Bohac–yes, Juracek–yes, Reichmuth–yes, Rock–yes, Saunders–yes, Sobeski–yes, Sorensen–yes, Thomsen–yes.

Motion Carried.

An all in favor motion was made to conclude the meeting at 12:23 p.m.

Next meeting:

The next meeting of the Nebraska Medicaid Pharmaceutical and Therapeutics Committee is scheduled for:

Wednesday, May 13, 2015, at 9 am CST
Mahoney State Park, Ashland, NE

Recorded by: Sabrina Hellbusch, R.N., B.S.N., Recovery Care Management, Magellan Medicaid Administration

Abigail Anderson, M.R.C.P., Program Specialist, Nebraska Medicaid & Long-Term Care, DHHS

Minutes Approved May 13, 2015