DIVISION OF MEDICAID AND LONG-TERM CARE
Nebraska DHHS

PHARMACEUTICAL AND THERAPEUTICS COMMITTEE MEETING MINUTES
May 13, 2015 at 9 a.m., CST
Mahoney State Park, Peter Kiewit Lodge
Ashland, NE

Members Present
Claire Baker, M.D.
Stacie Bleicher, M.D.
Kristie Bohac, 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.
Nancy Haberstich, R.N., M.S.
Mary Hammond, Pharm.D.
Laurie Humphries, M.D.
Eileen Rock, M.D.
Ken Saunders, Pharm.D.
Christopher Sorensen, Pharm.D.
Linda Sobeski, Pharm. D.
Eric Thomsen, M.D.

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

Magellan Rx Management
Contract Staff
Julie Pritchard, Pharm. D., M.B.A
Sabrina Hellbusch, R.N., B.S.N

Absent:
Nathan Green D.O.
Kevin Reichmuth M.D.
Joyce Juracek Pharm.D.

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 9, 2015. 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 Rx Management staff: Julie Pritchard, Pharm. D., M.B.A
III. Roll Call: see list above
IV. Conflict of Interest: No new conflicts of interest were reported.
V. Approval of November 2014 Minutes: The November 12, 2014 meeting minutes were unanimously approved.
VI. Department information: Governor Pete Ricketts has appointed Courtney Phillips as the new Chief Execute Officer of the Nebraska Department of Health and Human Services. Calder Lynch assumes the position of Director, Division of Medicaid and Long-Term Care. Shelly Nickerson, Pharm.D has been appointed as the new Pharmacy Unit Manager for the Division of Medicaid and Long-Term Care.
VII. Other: There are two openings on the DHHS Pharmaceutical and Therapeutics Committee as Nathan Green, M.D. and Kevin Reichmuth, M.D. have submitted their resignations. Officer election will take place at the November 2015 meeting.
VIII. Public Testimony

Classes with changes

DRUG CLASS	Drug Name	PDL Status	Speaker Name	Affiliation
Anticoagulants	Xarelto	P	Jennifer Stoffel	Janssen
Anticoagulants	Savaysa	NP	Anh Singhania	Daiichi Sankyo
Anticoagulants	Eliquis	P	John Berry	Pfizer

Hepatitis C Agents	Sovaldi	NP	Michelle Puyear	Gilead Sciences, Inc.

DRUG CLASS	Drug Name	PDL Status	Speaker Name	Affiliation
Hepatitis C Agents	Harvoni	NP	Michelle Puyear	Gilead Sciences, Inc.
Hypoglycemics, Incretin Memetics/Enhancers	Victoza	NP	Thomas Pham	Novo Nordisk
Hypoglycemics, SGLT2	Xigduo XR	NP	Brad Haas	AstraZeneca
Hypoglycemics, SGLT2	Glyxambi	NP	Julie McDavitt	Boehringer
Hypoglycemics, SGLT2	Jardiance	NP	Julie McDavitt	Boehring
Multiple Sclerosis Agents	Tecfidera	NP	Luke Weedin	Biogen
Multiple Sclerosis Agents	Plegridy	NP	Luke Weedin	Biogen
Multiple Sclerosis Agents	Copaxone 40 mg TIW	NP	Chris Draheim	Teva Pharmaceuticals

IX. A motion to move into closed session was made by Baker and seconded. Moved into closed session at 9:59am. Roll call vote was taken and the motion passed:

Votes as follows: Baker-yes, Bleicher-yes, Bohac-yes, Caudill-yes, Davenport-yes, Dering-Anderson-yes, Dubé-yes, Elsasser-yes, Haberstitch-yes, Hammond-yes, Humphries-yes, Rock-yes, Saunders-yes, Sobeski-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.

X. A motion was made by Dering-Andersen, seconded, and unanimously passed to move back into open session at 11:15.

XI. **Consent Agenda (Therapeutic Categories with Unchanged Recommendations):**

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)*	ALINA: If giardiasis; require treatment failure with metronidazole or tindazole. If cryptosporidium: no treatment failure required with other agent. DIFICID: For diagnosis of Clostridium difficile

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		diarrhea; require contraindication to or treatment failure with oral vancomycin or metronidazole. FLAGYL ER**:** Requires trial on metronidazole or tindazole. tindazole: 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.

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

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		and children ≥ 9 months of age • Clinical reason that topical mupirocin ointment (generic Bactroban®) cannot be used. • ALTABAX® is not approved for MRSA and has not been proven any more effective than Bactroban®.

ANTIVIRALS, TOPICAL

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
	acyclovir 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.

BLADDER RELAXANT PREPARATIONS

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
oxybutynin (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. MYRBETRIQ: Allow when anticholinergic agent is contraindicated.

BONE RESORPTION SUPPRESSION AND RELATED DRUGS

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

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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.
	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.

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5-ALPHA-REDUCTASE (5AR) INHIBITORS		
finasteride (generic for Proscar)	AVODART (dutasteride) JALYN (dutasteride/tamsulosin)	

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)	CALAN SR (verapamil) diltiazem LA (generic for Cardizem LA) MATZIM LA (diltiazem) TIAZAC (diltiazem) verapamil ER **CAPSULE** verapamil 360mg capsule	

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 SUSPENSION**	amoxicilline/claquante XR (generic for Augmentin XR) AUGMENTIN **250MG/5ML** SUSPENSION AUGMENTIN (amoxicilline/claquante)	1. Adverse reaction or contraindication to preferred drugs. OR 2. Documentation of treatment 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 or contraindication to preferred drugs. OR 2. Documentation of treatment failure with preferred drug.
CEPHALOSPORINS – Second Generation		

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cefprozil (oral) (generic for Cefzil) cefuroxime (oral tablet) (generic for Ceftin)	cefaclor (oral) (generic for Ceclor) CEFTIN (cefuroxime) tablets, suspension	1. Adverse reaction or contraindication to preferred drugs. OR 2. Documentation of treatment failure with preferred drug.
CEPHALOSPORINS – Third Generation		
cefdinir (oral) (generic for Omnicef) SUPRAX **SUSPENSION, CAPSULE** (cefixime)	CEDAX (ceftibuten) cefditoren (generic for Spectracef) cefixime (generic for Suprax suspension) cefpodoxime (oral) (generic for Vantin) SUPRAX **CHEWABLE TABLET, TABLET** (cefixime)	1. Adverse reaction or contraindication to preferred drugs. OR 2. Documentation of treatment failure with preferred drug.

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

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
NEUPOGEN (filgrastim) **VIAL***	NEUPOGEN (filgrastim) **DISP SYR**	Entire class requires place of service determination. Only approved for self administration or administration by care giver in home. (not approved thru Pharmacy program for administration in office, clinic or hospital) • Documented myelosuppressive chemotherapy, bone marrow transplant, peripheral blood progenitor cell collection, severe chronic neutropenia; OR • Documented ANC < 750 cells/microliter in patients with Hepatitis C who are being treated with Interferon. • Not covered for AIDS, hairy cell leukemia, myelodysplasia, drug-induced congenital agranulocytosis, alloimmune neonatalneutropenia. Initial authorization is granted for six months.

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

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
EPOGEN (rHuEPO)* PROCRIT (rHuEPO)*		Entire class requires place of service determination. Only approved for self administration or administration by

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		care giver in home. (not approved thru Pharmacy program for administration in office, clinic or hospital) Length of authorization: varies • Anemia associated with chronic renal failure APPROVAL ONE YEAR • Anemia with chemotherapy, need length of chemo regimen auth 30 days longer • Anemia in HIV infected clients

FLUOROQUINOLONES, ORAL

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
ciprofloxacin (generic for Cipro) levofloxacin **TABLETS** (generic for Levaquin)	ciprofloxacin ER ciprofloxacin suspension (generic for Cipro Suspension) levofloxacin oral solution moxifloxacin (generic for Avelox)	1. Adverse reaction to, allergy, 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/NEfaxform_GH-201411.pdf

H.PYLORI TREATMENTS

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:

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PYLERA (bismuth, metronidazole, tetracycline) PREVPAC (lansoprazole, amoxicillin, clarithromycin)	OMECLAMOX-PAK (omeprazole, clarithromycin, amoxicillin) lansoprazole/amoxicillin/clarithromycin (generic for Prevpac)	1. Adverse reaction to, allergy, or contraindication to preferred drugs. OR 2. Documentation of treatment failure with preferred drug.

HYPOGLYCEMICS, ALPHA-GLUCOSIDASE INHIBITORS

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

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, 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.

HYPOGLYCEMICS, TZDS

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
THIAZOLIDINEDIONES (TZDs)		
pioglitazone (generic for Actos)	AVANDIA (rosiglitazone)	• Compliance demonstrated with metformin trial and have not received adequate glycemic control with metformin; OR • Intolerance to metformin; • HbA1C ≥7
TZD COMBINATIONS		
	ACTOPLUS MET XR (pioglitazone/metformin ER)	• Combination agents will require clinical reason separate agents

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	AVANDAMET (rosiglitazone/metformin) AVANDARYL (rosiglitazone/glipizide) pioglitazone/glimepiride (generic for Duetact) pioglitazone/metformin generic for Actoplus Met)	cannot be used. • HbA1C ≥7

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.

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: Requires 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

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.

PROTON PUMP INHIBITORS (ORAL)

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
omeprazole (generic for Prilosec) pantoprazole (generic for Protonix)	DEXILANT (dexlansoprazole) esomeprazole strontium lansoprazole (generic for Prevacid)	**https://nebraska.fhsc.com/Downloads/NEfaxform_MedicalNecessity-201210.pdf**

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	esomeprazole magnesium (generic for Nexium) NEXIUM SUSPENSION (esomeprazole) omeprazole/sodium bicarbonate (generic for Zegerid RX) PREVACID Rx, SOLU-TAB (lansoprazole) PRILOSEC (omeprazole) rabeprazole (generic for Aciphex)	

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)	1. The non-preferred agents will be approved for patients with documented failure of at least a one week trial each of two preferred agents. 2. Concurrent use with opioids requires prior authorization 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 AMRIX: Clinical reason regular release cannot be used. Only for short term use. 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)	demeclocycline* DORYX (doxycycline pelletized) doxycycline hyclate DR (generic for Vibratabs) doxycycline monohydrate **TABLET, SUSPENSION, 75MG and 150MG CAPSULES** (Monodox, Adoxa)	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

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	doxycycline monohydrate (generic for Oracea) minocycline HCl **tablets** (generic for Dynacin, Murac) minocycline HCl extended release (generic for Solodyn) ORACEA (doxycycline monohydrate) SOLODYN (minocycline HCl) VIBRAMYCIN SUSPENSION (doxycycline)	with two preferred drugs.

It was moved by Dubé and seconded to accept recommendations as published for the Therapeutic Classes on the Consent Agenda. Roll Call vote was taken and the motion passed.

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

Motion Carried.

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

ACNE AGENTS, TOPICAL

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
AZELEX (azelaic acid) BENZACLIN W/PUMP (clindamycin/benzoyl peroxide) benzoyl peroxide generic OTC benzoyl peroxide generic Rx clindamycin phosphate **SOLUTION** DIFFERIN **GEL** DIFFERIN **LOTION, CREAM** (adapalene) 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) AVITA (tretinoin) BENZACLIN GEL (clindamycin/ benzoyl peroxide) BENZEPRO (benzoyl peroxide) benzoyl peroxide foam (generic for Benzefoam) benzoyl peroxide **gel Rx** CLINDAGEL (clindamycin) clindamycin **GEL, LOTION, FOAM** clindamycin/benzoyl peroxide (generic for Benzaclin) EPIDUO (adapalene/benzoyl peroxide) erythromycin-benzoyl peroxide (generic for Benzamycin and Duac) EVOCLIN (clindamycin) FABIOR (tazarotene foam)	Treatment failure with three preferred products.

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	INOVA (benzoyl peroxide) KLARON (sulfacetamide) NEUAC (clindamycin/benzoyl peroxide)[NR] RETIN-A GEL, CREAM RETIN-A MICRO (tretinoin microspheres) sulfacetamide sulfacetamide/sulfur SUMADAN (sulfacetamide/sulfur) TAZORAC (tazarotene) tretinoin **GEL** tretinoin microspheres (generic for Retin-A Micro) VELTIN (clindamycin and tretinoin) ZIANA (clindamycin and tretinoin)	

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, Bohac-yes, Caudill-yes, Davenport-yes, Dering-Anderson-yes, Dubé-yes, Elsasser-yes, Haberstitch-yes, Hammond-yes, Humphries-yes, Rock-yes, Saunders-yes, Sobeski-yes, Sorensen-yes, Thomsen-yes.

Motion Carried.

ANALGESICS, OPIATE LONG-ACTING

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
fentanyl patches 25, 50, 75, 100mcg KADIAN (morphine ER capsule) methadone morphine ER **TABLET** (generic for MS Contin, Oramorph SR) OXYCONTIN (oxycodone ER)	BUTRANS (buprenorphine, transdermal)* DURAGESIC MATRIX (fentanyl) EMBEDA (morphine/naltrexone) fentanyl patch **37.5, 62.5, 87.5 mcg** hydromorphone ER (generic for Exalgo)* HYSINGLA ER (hydrocodone) morphine ER capsule (generic for Avinza) morphine ER capsule (generic for Kadian) NUCYNTA ER (tapentadol)* oxycodone ER (generic for re-formulated Oxycontin) oxymorphone ER (generic for OPANA ER) tramadol extended release* (generic for ULTRAM ER) ZOHYDRO ER (hydrocodone bitartrate ER)	Non-preferred agents will be approved for patients meeting the following criteria: Documented failure of at least a 30 day trial of two preferred agents within previous 6 months. BUTRANS: Patient must meet all of the following criteria: • Diagnosis of moderate to severe chronic pain • Require < 80mg morphine equivalents per day • Require continuous around-the-clock analgesia • Need analgesic medication for an extended period of time • Patient is 18 years or older • Inability to take oral medication

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		OR Adequate trial with 3 preferred long or short acting opiate analgesic agents **NOT** approved for substance abuse or addiction. CONZIP, EXALGO, HYSLINGA ER, ULTRAM ER, and 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 to accept recommendations as published with the exception of OXYCONTIN, which will remain on the Preferred Drug List. Roll call vote was taken and the motion passed.

Votes as follows: Baker-yes, Bleicher-yes, Bohac-yes, Caudill-yes, Davenport-yes, Dering-Anderson-yes, Dubé-yes, Elsasser-yes, Haberstitch-yes, Hammond-yes, Humphries-yes, Rock-yes, Saunders-yes, Sobeski-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** oxycodone/APAP ROXICET **SOLUTION** (oxycodone/acetaminophen) tramadol	codeine **ORAL SOLUTION** dihydrocodeine/aspirin/caffeine (generic for Synalgos DC) HYCET (hydrocodone/acetaminophen) hydromorphone ORAL LIQUID, SUPPOSITORIES (generic for Dilaudid) IBUDONE (hydrocodone/ibuprofen) levorphanol meperidine (generic for Demerol) morphine **SUPPOSITORIES** NUCYNTA (tapentadol)* oxycodone **CAPSULE** oxycodone **CONCENTRATE** oxycodone/aspirin oxycodone/ibuprofen (generic for Combunox) oxymorphone (generic for Opana) pentazocine/APAP pentazocine/naloxone PRIMLEV (oxycodone/acetaminophen) ROXICODONE **TABLET** (oxycodone) tramadol/APAP –generic for Ultracet	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.

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	(note: separate ingredients preferred) VICOPROFEN (hydrocodone/ibuprofen) XARTEMIS XR (oxycodone/acetaminophen) XODOL (hydrocodone/acetaminophen)	
NASAL		
	butorphanol nasal spray	
BUCCAL/TRANSMUCOSAL		
	ABSTRAL (fentanyl transmucosal)* fentanyl transmucosal* (generic for Actiq) FENTORA (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 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, Bohac-yes, Caudill-yes, Davenport-yes, Dering-Anderson-yes, Dubé-yes, Elsasser-yes, Haberstitch-yes, Hammond-yes, Humphries-yes, Rock-yes, Saunders-yes, Sobeski-yes, Sorensen-yes, Thomsen-yes.

Motion Carried.

ANDROGENIC DRUGS (Topical)

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
ANDROGEL (testosterone)	ANDRODERM (testosterone) AXIRON (testosterone) FORTESTA (testosterone) TESTIM (testosterone) testosterone (generics for Androgel, Fortesta, Testim, and Vogelxo) VOGELXO (testosterone)	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, roll call vote was taken and the motion passed.

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

Motion Carried.

ANGIOTENSIN MODULATORS

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
ACE INHIBITORS		
benazepril (generic for Lotensin) enalapril (generic for Vasotec) lisinopril (generic for Prinivil/Zestril)	captopril (generic for Capoten) EPANED (enalapril) oral solution fosinopril (generic for Monopril)	Non-preferred agents may be approved if the patient has a history of two preferred agents in the last

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quinapril (generic for Accupril) ramipril (generic for Altace)	moexepril (generic for Univasc) perindopril (generic for Aceon) trandolapril (generic for Mavik)	12 months. EPANED: Requires documentation of why an oral tablet or compounded product are not appropriate for patient.
ACE INHIBITOR/DIURETIC COMBINATIONS		
benazepril/HCTZ (generic for Lotensin HCT) enalapril/HCTZ (generic for Vaseretic) lisinopril/HCTZ (generic Prinzide/Zestoretic)	captopril/HCTZ (generic for Capozide) fosinopril/HCTZ (generic for Monopril HCT) moexepril/HCTZ (generic for Uniretic) quinapril/HCTZ (generic for Accuretic)	
ANGIOTENSIN RECEPTOR BLOCKERS		
irbesartan (generic for Avapro) losartan (generic for Cozaar) valsartan (generic for Diovan)	BENICAR (olmesartan) candesartan (generic for Atacand) DIOVAN (valsartan) EDARBI (azilsartan medoxomil) EDARBYCLOR (azilsartan/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		
irbesartan/HCTZ (generic for Avalide) losartan/HCTZ (generic for Hyzaar) valsartan-HCTZ (generic for Diovan-HCT)	BENICAR-HCT (olmesartan/HCTZ) candesartan/HCTZ (generic for Atacand-HCT) DIOVAN-HCT (valsartan/HCTZ) telmisartan/HCTZ (generic for Micardis-HCT) TEVETEN-HCT (eprosartan/HCTZ)	
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 Thomsen and seconded to accept recommendations as published, roll call vote was taken and the motion passed.

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

Motion Carried.

ANGIOTENSIN MODULATOR/CALCIUM CHANNEL BLOCKER COMBINATIONS

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
benazepril/amlodipine (generic for Lotrel)	AMTURNIDE (aliskiren/**amlodipine**/HCTZ) AZOR (olmesartan/amlodipine) EXFORGE (valsartan/amlodipine) TEKAMLO (aliskiren/**amlodipine)** telmisartan/amlodipine (generic for Twynsta) trandolapril/verapamil (generic for TARKA) TRIBENZOR (amlodipine/olmesartan/HCTZ) valsartan/amlodipine (generic for Exforge) valsartan/amlodipine/HCTZ (generic for Exforge HCT)	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 Saunders and seconded to accept recommendations as published, roll call vote was taken and the motion passed.

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

Motion Carried.

ANTIBIOTICS, INHALED

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
BETHKIS (tobramycin) KITABIS PAK (tobramycin) TOBI-PODHALER (tobramycin)*	CAYSTON (aztreonam lysine)QL, * TOBI (tobramycin) 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) • Step thru with solution

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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, Bohac-yes, Caudill-yes, Davenport-yes, Dering-Anderson-yes, Dubé-yes, Elsasser-yes, Haberstitch-yes, Hammond-yes, Humphries-yes, Rock-yes, Saunders-yes, Sobeski-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) metronidazole (vaginal)	CLINDESSE (clindamycin vaginal) METROGEL (metronidazole, vaginal) NUVESSA (metronidazole gel) 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 Sobeski and seconded to accept recommendations as published, roll call vote was taken and the motion passed.

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

Motion Carried.

XIII. An all in favor motion was made to move break for lunch at 12:10p, Resumed open session at 1:05pm.

ANTICOAGULANTS

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
ELIQUIS (apixaban) enoxaparin (generic for Lovenox) FRAGMIN (dalteparin) PRADAXA (dabigatran) warfarin (generic for Coumadin) XARELTO (rivaroxaban)	fondaparinux (generic for Arixtra) SAVAYSA (edoxaban) XARELTO DOSE PACK	1. Non-preferred agents will be approved ~~only after documented failure of a preferred agent.~~ OR 2. Allergy/ inability to control INR with Warfarin. OR 3. Contraindication to preferred agent.

It was moved by Saunders and seconded to approve the recommendation but also include Eliquis as preferred. After further discussion, it was moved by Dering-Anderson and seconded to amend the main motion by changing the PDL exception criteria from requiring a treatment failure with a preferred agent to "contraindication to preferred agent." Further discussion ensued.

It was then moved by Baker to amend the amendment to remove Pradaxa from the Preferred Drug List, except for individuals who are already prescribed the drug. As the public testimony had been deferred, an offer was extended to the public to testify to this motion.

DRUG CLASS	Drug Name	PDL Status	Speaker Name	Affiliation

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Anticoagulants	Pradaxa	P	Julie McDavitt	Boehringer

Votes as follows for the amendment to the amendment: Baker-yes, Bleicher-no, Bohac-no, Caudill-no, Davenport-no, Dering-Anderson-yes, Dubé-yes, Elsasser-no, Haberstitch-no, Hammond-no, Humphries-yes, Rock-no, Saunders-no, Sobeski-yes, Sorensen-no, Thomsen-no.

Motion Failed.

Discussion was then reopened on the amendment to the main motion and after further discussion, roll call vote was taken and the amendment passed. The main motion as amended was read aloud, "to accept the amendment to the main motion by changing the PDL exception criteria from requiring a treatment failure with a preferred agent to contraindication to preferred agent."

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

Motion Carried.

The amended motion was read aloud, " to accept recommendations as published with the addition of ELIQUIS to the Preferred Drug List and to add to the PDL Exception Criteria - contraindication to preferred agent". Roll call vote was taken on the amended motion and passed.

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

Motion Carried.

ANTIEMETICS /ANTIVERTIGO AGENTS

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
CANNABINOIDS		
dronabinol (generic for Marinol)	CESAMET (nabilone) MARINOL (dronabinol)	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		
	AKYNZEO (netupitant/palonosetron)	Does NOT require treatment

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	EMEND (aprepitant)[QL, *]	failure with preferred drugs when used for moderately or highly emetogenic chemotherapy.
TRADITIONAL ANTIEMETICS		
DICLEGIS (doxylamine/pyridoxine)* **females only dimenhydrinate (generic for Dramamine) hydroxyzine (generic for Vistaril) meclizine (generic for Antivert) metoclopramide (generic for Reglan) phosphoric acid/dextrose/fructose solution (generic for Emetrol) prochlorperazine oral (generic for Compazine) promethazine oral (generic for Phenergan) promethazine suppositories 12.5mg, 25mg TRANSDERM-SCOP (scopolamine)	COMPRO (prochlorperazine rectal) METOZOLV ODT (metoclopramide) prochlorperazine rectal (generic for Compazine) promethazine suppositories 50mg trimethobenzamide oral (generic for Tigan)	1. Adverse reaction to, allergy or contraindication to 2 preferred drugs. OR 2. Documentation of treatment failure with 2 preferred drugs. METOZOLV ODT: Inablilty to swallow or clinical reason can't utilize oral liquid.

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, Bohac-yes, Caudill-yes, Davenport-yes, Dering-Anderson-yes, Dubé-yes, Elsasser-yes, Haberstitch-yes, Hammond-yes, Humphries-yes, Rock-yes, Saunders-yes, Sobeski-yes, Sorensen-yes, Thomsen-yes.

Motion Carried.

ANTIFUNGALS, ORAL

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
clotrimazole (mucous membrane troche) fluconazole (generic for Diflucan) griseofulvin **suspension** GRIS-PEG (griseofulvin) 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) 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,

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		endocarditis, UTI • Cryptococcus: meningitis, pulmonary infections. **ITRACONAZOLE:** diagnosis of: • Aspergillosis • Blastomycosis • Histoplasmosis • Onychomycosis resistant to terbinafine • Oropharyngeal/esophageal candidiasis refractory to fluconazole. • SPORANOX liquid only if unable to take capsules. • ONMEL only FDA approved for onychomycosis. **NOXAFIL:** minimum age of 13. Prevention of infection with diagnosis of: • Neutropenic Myelodysplastic Syndrome • Neutropenic hematologic malignancies • Graft vs. Host disease • Immunosuppression following hematopoetic stem cell transplant • Oropharyngeal/esophageal candidiasis refractory to itraconazole and/or fluconazole **VFEND:** • Myelodysplastic Syndrome (MDS), • Neutropenic Acute Myeloid Leukemia (AML) • Graft versus Host Disease (GVHD) • Candidemia (candida krusei), Esophageal Candidiasis • Pulmonary or invasive aspergillosis • Blastomycosis • Serious fungal infections caused by Scedosporium apiospermum (asexual form of

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		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 Sorensen and seconded to accept recommendations as published, roll call vote was taken and the motion passed.

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

Motion Carried.

ANTIFUNGALS, TOPICAL

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
ANTIFUNGAL		
clotrimazole (generic for Lotrimin) RX, OTC 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) tolnaftate OTC (generic for Tinactin)	ALEVAZOL (clotrimazole)[NR] BENSAL HP (salicylic acid) ciclopirox cream/gel/suspension (generic for Ciclodan, Loprox) ciclopirox nail lacquer (solution) (generic for Penlac) ciclopirox shampoo (generic for Loprox) DESENEX AERO POWDER OTC (miconazole) econazole (generic for Spectazole) ERTACZO (sertaconazole) EXELDERM (sulconazole) EXTINA (ketoconazole) FUNGOID OTC JUBLIA (efinaconazole) ketoconazole **FOAM** (generic for Ketodan) LOTRIMIN AF CREAM OTC (clotrimazole) LOTRIMIN ULTRA LUZU (luliconazole) MENTAX (butenafine) miconazole OTC **OINTMENT** NAFTIN (naftifine) OXISTAT (oxiconazole) selenium sulfide 2.25% TINACTIN AERO POWDER (tolnaftate) OTC	1. Adverse reaction to, allergy, or contraindication to preferred drugs. OR 2. Documentation of treatment failure of two preferred drugs within the last 6 months.

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	TINACTIN CREAM (tolnaftate) OTC VUSION (miconazole/ zinc oxide)	
ANTIFUNGAL/STEROID COMBINATIONS		
clotrimazole/betamethasone **CREAM** (gen. Lotrisone)	clotrimazole/betamethasone **LOTION** (gen. Lotrisone) nystatin/triamcinolone (gen. for Mycolog)	

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, Bohac-yes, Caudill-yes, Davenport-yes, Dering-Anderson-yes, Dubé-yes, Elsasser-yes, Haberstitch-yes, Hammond-yes, Humphries-yes, Rock-yes, Saunders-yes, Sobeski-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) rizatriptan ODT (generic for Maxalt MLT) sumatriptan generic oral	AXERT (almotriptan) FROVA (frovatriptan) IMITREX oral (sumatriptan) naratriptan (generic for Amerge) rizatriptan (generic for Maxalt) TREXIMET (sumatriptan/naproxen) zolmitriptan (generic for Zomig/Zomig ZMT)	Non-preferred agents will be approved only if patient has tried and failed therapy with all preferred agents.
NASAL		
IMITREX (sumatriptan)	sumatriptan generic nasal ZOMIG (zolmitriptan)	
INJECTABLE		
IMITREX (sumatriptan) **PEN, CARTRIDGE** sumatriptan generic **VIAL**	IMITREX (sumatriptan) **VIAL** sumatriptan **SYRINGE, KIT** SUMAVEL DOSEPRO (sumatriptan)	

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

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

Motion Carried.

ANTIPARASITICS, TOPICAL

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
NATROBA (spinosad) permethrin 1% OTC (generic for Nix) permethrin 5% RX (generic for Elimite)	EURAX (crotamiton) **CREAM** EURAX (crotamiton**) LOTION** lindane	1. Adverse reaction to, allergy, or contraindication to preferred drugs. OR

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pyrethrin/piperonyl butoxide (generic for RID, A-200) SKLICE (ivermectin)	malathion (generic for Ovide) spinosad (generic for Natroba) ULESFIA (benzyl alcohol)	2. Documentation of treatment failure with one preferred drug. Note: 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 Saunders and seconded to accept recommendations as published, roll call vote was taken and the motion passed.

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

Motion Carried.

ANTIVIRALS, ORAL

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

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, Bohac-yes, Caudill-yes, Davenport-yes, Dering-Anderson-yes, Dubé-yes, Elsasser-yes, Haberstitch-yes, Hammond-yes, Humphries-yes, Rock-yes, Saunders-yes, Sobeski-yes, Sorensen-yes, Thomsen-yes.

Motion Carried.

BETA BLOCKERS (Oral)

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
BETA BLOCKERS		
atenolol (generic for Tenormin) atenolol/chlorthalidone(generic for Tenoretic) bisoprolol/HCTZ (generic for Ziac) metoprolol (generic for Lopressor)	acebutolol (generic for Sectral) betaxolol (generic for Kerlone) bisoprolol (generic for Zebeta) BYSTOLIC (nebivolol) DUTOPROL (metoprolol XR and	Non-preferred agent will be approved only after documented failure of two preferred agents within the past 12 months.

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metoprolol XL (generic for Toprol XL) propranolol (generic for Inderal) propranolol extended release (Inderal LA)	HCTZ) HEMANGEOL (propranolol oral solution) INDERAL XL 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) TOPROL XL (metoprolol)	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)	SOTYLIZE (sotalol oral solution)	

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, Bohac-yes, Caudill-yes, Davenport-yes, Dering-Anderson-yes, Dubé-yes, Elsasser-yes, Haberstitch-yes, Hammond-yes, Humphries-yes, Rock-yes, Saunders-yes, Sobeski-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)*		
RIBAVIRIN		
ribavirin 200mg tablets and capsules*	REBETOL SOLUTION (ribavirin)	
NUCLEOTIDE ANALOG POLYMERASE INHIBITOR		
VIEKIRA PAK * (ombitasvir,	HARVONI (sofosbuvir/ledipasvir)*	https://nebraska.fhsc.com/Downloa

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paritaprevir, ritonavir, dasabuvir)	SOVALDI (sofosbuvir)*	ds/NEcriteria_Sovaldi-201409.pdf
PROTEASE INHIBITOR		
PREFERRED DRUGS	**NON-PREFERRED DRUGS**	**PDL EXCEPTION CRITERIA:**
	OLYSIO (simeprevir)	

It was moved by Bohac and seconded to accept recommendations as published, roll call vote was taken and the motion passed.

Votes as follows: Baker-yes, Bleicher-yes, Bohac-yes, Caudill-yes, Davenport-yes, Dering-Anderson-yes, Dubé-yes, Elsasser-yes, Haberstitch-yes, Hammond-yes, Humphries-yes, Rock-yes, Saunders-yes, Sobeski-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) subcutaneous** BYDUREON **PEN** (exenatide ER) subcutaneous** BYETTA (exenatide) subcutaneous** TANZEUM (albiglutide)** ****** Requires metformin trial and diagnosis of diabetes.	TRULICITY (dulaglutide) VICTOZA (liraglutide) subcutaneous	https://nebraska.fhsc.com/Downloads/NEfaxform_GLP-1_RA-201406.pdf
Amlyn Analog		
	SYMLIN (pramlintide) subcutaneous*	https://nebraska.fhsc.com/Downloads/NEfaxform_Amylin-201403.pdf
Dipeptidyl peptidase-4 (DPP-4) Inhibitor		
JANUMET (sitagliptin/metformin)[QL] JANUMET XR(sitagliptin/metformin)[QL] JANUVIA (sitagliptin)[QL] JENTADUETO (linagliptin/metformin)[QL] TRADJENTA (linagliptin)[QL]	GLYXAMBI (empagliflozin/linagliptin) KAZANO (alogliptin/metformin)[QL] KOMBIGLYZE XR (saxagliptin/metformin)[QL] NESINA (alogliptin)[QL] ONGLYZA (saxagliptin)[QL] OSENI (alogliptin/pioglitazone)[QL]	Trial on sitagliptin or linagliptin.

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

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

Motion Carried.

HYPOGLYCEMICS, INSULIN AND RELATED DRUGS

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
HUMALOG (insulin lispro)	AFREZZA (insulin human regular)	1. Adverse reaction to, allergy, or

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HUMALOG MIX (insulin lispro/lispro protamine) HUMULIN (insulin) LANTUS (insulin glargine) LEVEMIR (insulin detemir)	APIDRA (insulin glulisine) NOVOLIN (insulin) NOVOLOG (insulin aspart) NOVOLOG MIX (insulin aspart/aspart protamine) Insulin pens /cartridges* TOUJEO SOLOSTAR PEN (insulin glargine)	contraindication to preferred drugs, OR 2 .Documentation of treatment failure with preferred drug. **Insulin pens/cartridges :** 1. Physical reasons, such as dexterity problems, vision impairment. 2. Must be Self Administered. 3. NOT just for convenience. OR 4. Low dose (≤40 units per day)

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

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

Motion Carried.

HYPOGLYCEMICS, SGLT2

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
INVOKANA (canagliflozin)	FARXIGA (dapagliflozin)* INVOKAMET (canagliflozin/metformin) JARDIANCE (empagliflozin) XIGDUO XR (dapagliflozin/metformin)	• Compliance demonstrated with Metformin trial and have not received adequate glycemic control with Metformin. OR • Intolerance to Metformin

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

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

Motion Carried.

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:

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

LIPOTROPICS, OTHER (non-statins)

Note: Several other forms of OTC niacin and fish oil are also covered under Medicaid with a prescription without prior authorization.

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
BILE ACID SEQUESTRANTS		The non-preferred agent will be approved only after documented failure of the preferred agents.
cholestyramine (generic for Questran) colestipol (generic for Colestid) **TABLETS**	colestipol (generic for Colestid) **GRANULES** QUESTRAN LIGHT (cholestyramine) WELCHOL (colesevalam)	
FIBRIC ACID DERIVATIVES		
gemfibrozil (generic for Lopid) TRICOR (fenofibrate) TRILIPIX (fenofibric acid)	fenofibrate (generic for Antara) fenofibrate (generic for Lofibra) fenofibrate (generic for Tricor) fenofibric acid (generic for Fibricor) fenofibric acid (generic for Trilipix) LIPOFEN (fenofibrate) TRIGLIDE (fenofibrate)	
NIACIN		
NIASPAN (niacin ER)	ADVICOR (lovastatin/niacin ER) niacin ER (generic for Niaspan) NIACOR (niacin IR)	
OMEGA-3 FATTY ACIDS		
	omega-3 fatty acids* (generic for Lovaza) 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		

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	ZETIA (ezetimibe)	ZETIA: • Only approved as an adjunct to concurrent statin therapy unless there is a documented intolerance to the statins. • Will be approved for patients who have a diagnosis of hypercholesterolemia and have: either failed statin monotherapy OR • Have a documented intolerance to 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™.

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.

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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 Caudill and seconded to accept recommendations as published, roll call vote was taken and the motion passed.

Votes as follows: Baker-yes, Bleicher-yes, Bohac-yes, Caudill-yes, Davenport-yes, Dering-Anderson-yes, Dubé-yes, Elsasser-yes, Haberstitch-yes, Hammond-yes, Humphries-yes, Rock-yes, Saunders-yes, Sobeski-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 IR (generic for Biaxin) clarithromycin suspension ERYTAB ERYPED 200 SUSPENSION ERYPED 400 SUSPENSION PCE (erythromycin)	clarithromycin ER (generic for Biaxin XL) ERYTHROCIN EES 200 SUSPENSION 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 Saunders and seconded to accept recommendations as published, roll call vote was taken and the motion passed.

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

Motion Carried.

MULTIPLE SCLEROSIS DRUGS

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
AVONEX (interferon beta-1a) BETASERON (interferon beta-1b) COPAXONE **20**mg (glatiramer) GILENYA (fingolimod) REBIF (interferon beta-1a)	AMPYRA (dalfampridine)* AUBAGIO (teriflunomide) COPAXONE **40**mg Syringe (glatiramer) EXTAVIA (interferon beta-1b) PLEGRIDY (peginterferon beta-1a)	1. Adverse reaction to, allergy, or contraindication to preferred drug. OR 2. Documentation of treatment failure with one preferred drug

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	TECFIDERA (dimethyl fumarate)	AMPYRA: • Initial authorization for 12 weeks, requiring gait disorder associated with MS, no seizure diagnosis, no moderate or severe renal impairment, and baseline 25 foot, timed walk. • Additional prior authorizations every 6 months, based on maintained 20% improvement of baseline in 25-foot walk. EDSS score not greater than 7.

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, Bohac-yes, Caudill-yes, Davenport-yes, Dering-Anderson-yes, Dubé-yes, Elsasser-yes, Haberstitch-yes, Hammond-yes, Humphries-yes, Rock-yes, Saunders-yes, Sobeski-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) ORENITRAM ER (treprostinil) REVATIO SUSPENSION (for PAH only*)	Trial on a preferred agent or documentation of why not appropriate for patient. Sildenafil and ADCIRCA: Require diagnosis of PAH.

It was moved by Bohac and seconded to accept recommendations as published, roll call vote was taken and the motion passed.

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

Motion Carried.

PHOSPHATE BINDERS

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
calcium acetate **TABLET** CALPHRON OTC (calcium acetate) PHOSLYRA (calcium acetate) RENAGEL (sevelamer HCl)	AURYXIA (ferric citrate) calcium acetate **CAPSULE** ELIPHOS (calcium acetate) 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.

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It was moved by Sobeski and seconded to accept recommendations as published, roll call vote was taken and the motion passed.

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

Motion Carried.

PLATELET AGGREGATION INHIBITORS

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
AGGRENOX (dipyridamole/aspirin) aspirin BRILINTA (ticagrelor) clopidogrel (generic for Plavix) dipyridamole (generic for Persantine) EFFIENT (prasugrel)	ticlopidine (generic for Ticlid) ZONTIVITY (vorapaxar)	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 and seconded to accept recommendations as published, roll call vote was taken and the motion passed.

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

Motion Carried.

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) UCERIS **ORAL** (budesonide)	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	1. Adverse reaction to, allergy, or

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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.

	SFROWASA (mesalamine) UCERIS **RECTAL FOAM** (budesonide)	contraindication to preferred drugs. OR 2. Documentation of treatment failure with one preferred drug.

It was moved by Sobeski and seconded to accept recommendations as published and the motion passed. Votes as follows: Baker-yes, Bleicher-yes, Bohac-yes, Caudill-yes, Davenport-yes, Dering-Anderson-yes, Dubé-yes, Elsasser-yes, Haberstitch-yes, Hammond-yes, Humphries-yes, Rock-yes, Saunders-yes, Sobeski-yes, Sorensen-yes, Thomsen-yes.

Motion Carried.

XII. Other Business:

i. Committee members requested the following information be made available to committee members: the number of requests and approvals for non-preferred drugs (specifically drugs that are prescribed to treat/prevent acute life threatening conditions).

ii. Committee members expressed concerns that prescribers fail to understand the following: 1) Medicaid's Preferred vs. Non-Preferred drug list is different than the private sector's Formulary vs. Non-formulary drug list. This difference makes every drug available to a Medicaid member, which is not the case for members served by the private sector. Dering-Anderson suggested that use of a pharmacy student to develop educational material for providers. 2) The PDL may not be easily accessible for prescribers. However, it was also noted that the PDL is the top result when "Nebraska Medicaid PDL" is typed into Google search.

An all in favor motion was made to conclude the meeting at 1:52 p.m.

Next meeting:
The next meeting of the Nebraska Medicaid Pharmaceutical and Therapeutics Committee is scheduled for:
Monday November 11, 2015 at 9:00a.m. CST
Mahoney State Park, Ashland, NE

Recorded by: Sabrina Hellbusch, R.N., B.S.N., Recovery Care Management, Magellan Medicaid Administration and Abigail Anderson, M.R.C.P., Program Specialist, Nebraska Medicaid & Long-Term Care, DHHS.

**These minutes were approved by the P&T Committee on 11 NOV 2015.

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