DIVISION OF MEDICAID AND LONG-TERM CARE
Nebraska DHHS

PHARMACEUTICAL AND THERAPEUTICS COMMITTEE MEETING MINUTES
May 11, 2016 at 9 a.m., CST
Mahoney State Park, Peter Kiewit Lodge
Ashland, NE

<u>Members Present</u>
Eric Avery, M.D.
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.
Wade Fornander, M.D.
Nancy Haberstich, R.N., M.S.
Mary Hammond, Pharm.D.
Laurie Humphries, M.D.
Joyce Juracek, Pharm.D.
Ken Saunders, Pharm.D.
Linda Sobeski, Pharm.D.
Christopher Sorensen, Pharm.D.
Eric Thomsen, M.D.

<u>DHHS Staff</u>
Jenny Minchow, Pharm.D.
Abigail Anderson, MCRP
Shelly Nickerson, Pharm.D.
Lisa Neeman, LMHP, LCSW

<u>Magellan Rx Management Contract Staff</u>
Jessica Czechowski, Pharm. D., R.P., B.S.
Sabrina Hellbusch, R.N., B.S.N

Julie Gilbert, Pharm.D.

<u>Absent</u>
Jeffrey Gotschall, M.D. (excused)

I. Call to Order: Chairperson, Christopher Sorensen, called the meeting to order at 9:00am. The agenda was posted on the Nebraska Medicaid Pharmacy MMA website on April 11, 2016. A copy of the Open Meetings Act was posted at the back of the meeting room and materials distributed to members were on display.
II. Introduction of new P&T Committee Member Wade Fornander, M.D. Dr. Fornander replaces resigned committee member Dr. Eileen Rock. Introduction of Lisa Neeman, Nebraska Medicaid Administrator of Delivery Systems.
III. Roll Call: see list above
IV. Conflict of Interest: No new conflicts of interest were reported.
V. Approval of November 2015 Minutes: The November 11, 2015 meeting minutes were unanimously approved.
VI. Department information:
    i. Jessica Czechowski is the new Magellan RX Management Clinical Account Manager.
    ii. DUR update:
        1. Recommendations have been adopted to limit short acting opioids to a total of 150 units per 30 days. There will be a May mailing to prescribers to allow time to taper for the October 1, 2016 implementation of the limit.
    iii. Heritage Health:
        1. Managed Care Contracts have been signed with United Healthcare Community Plan, with the PBM, Optum; Nebraska Total Care, Inc., subsidiary of Centene Corporation with the PBM, US Scripts; and Wellcare of Nebraska, Inc., with the PBM, CVS Caremark. The expected implementation date January 1, 2017.
        2. The NE Medicaid Pharmacy Benefit is being carved into Heritage Health, Managed Care contracts. Each MCO will appoint a non-voting member to attend the P&T Committee meeting for the life of the contract and the Managed Care Organizations (MCO) are expected to start attending with the next meeting. For consistency all of the Heritage Health MCOs will use the Nebraska Medicaid Preferred Drug List.

VII. Other: Review of NE Medicaid P&T Committee By-Law, Article II, Section V – Industry Communication, which states, “Pharmaceutical representatives shall not contact Committee Members in an attempt to influence voting on agenda items.” The By-Laws can be found on the Magellan website under the Preferred Drug List, P&T Committee tab. (https://nebraska.fhsc.com)

VIII. Public Testimony

Classes with changes				
DRUG CLASS	**Drug Name**	**PDL Status**	**Speaker Name**	**Affiliation**
Growth Hormone	Genotropin	NP	Rob Hansen	Pfizer
Multiple Sclerosis Drugs	Tecfidera and Plegridy	NP	Luke Weedin	Biogen
Multiple Sclerosis Drugs	All MS Disease Modifying Therapies		Mary Filipi	Saunders Medical Center
Multiple Sclerosis Drugs	Aubagio	NP	Lisa Bilek	Sanofi Genzyme
Pancreatic Enzymes	Pertzye	NP	John Columbo	NE Regional Cystic Fibrosis Center
Analgesics, Opiate Long-Acting	Embeda	NP	Nancy Bell	Pfizer
Anticoagulants	Pradaxa	P	Julie McDavitt	Boeringer-Ingelheim
Hypoglycemics, SGL2	Jardiance, Synjardy	NP	Julie McDavitt	Boeringer-Ingelheim
Anticoagulants	Xarelto	P	Steven Zona	Janssen Scientific Affairs
GI Motility (formerly IBS)	Movantik (for opioid-induced constipation)	NR	Bradley D. Haas	Astrazeneca
Hepatitis C Treatments	Harvoni and Sovaldi	NP	Michele Puyear	Gilead
Hepatitis C Treatments	Zepatier	NP	Michael Ferrari	Merck
Lipotropics, Other (non-statins) PCSK9	Repatha	NP	Amanda Champ	Amgen
Pulmonary Arterial Hypertension Agents	Uptravi	NP	Josephine Garcia-Ferrer	Acetelion
Analgesics, Opiate Long-Acting	Hysingla ER	P	Kelley Waara-Wolleat	Purdue

IX. A motion to move into closed session was made by Dering-Anderson and seconded. Moved into closed session at 10:18am. Roll call vote was taken and the motion passed:

Votes as follows: Avery-yes, Baker-yes, Bleicher-yes, Bohac-yes, Caudill-yes, Davenport-yes, Dering-Anderson-yes, Dubé-yes, Elsasser-yes, Fornander-yes, Haberstich-yes, Hammond-yes, Humphries-yes, Juracek-yes, Saunders-yes, Sobeski-yes, Thomsen-yes.

Motion Carried.

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

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.

X. A motion was made by Dering-Anderson, seconded, and unanimously passed to move back into open session at 11:24am.

XI. Consent Agenda (Therapeutic Categories with Unchanged Recommendations): A motion was made by Baker to extract the Multiple Sclerosis Agents from the Consent Agenda.

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 solution (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

ANTIBIOTICS, TOPICAL

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
bacitracin ointment bacitracin/polymyxin (generic for Polysporin) mupirocin **OINTMENT** (generic for Bactroban) neomycin/polymyxin/bacitracin (generic for Neosporin, Triple AB)	ALTABAX (retapamulin) CENTANY (mupirocin ointment) gentamicin **OINTMENT, CREAM** mupirocin **CREAM** (generic for Bactroban)	Non-preferred agents will be approved only after documented failure of the preferred agents. **Mupirocin CREAM**: requires clinical reason the mupirocin ointment cannot be used. **ALTABAX® (retapamulin)** • Diagnosis impetigo due to Staphylococcus aureus (methicillin-susceptible isolates only) or Streptococcus pyogenes in adults and children ≥ 9 months of age. • Clinical reason that topical mupirocin ointment (generic Bactroban®) cannot be used. • Altabax® is not approved for MRSA and has not been proven

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		any more effective than Bactroban®.

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.

ANTIPARASITICS, TOPICAL

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
NATROBA (spinosad) permethrin 1% OTC (generic for Nix) permethrin 5% RX (generic for Elimite) pyrethrin/piperonyl butoxide (generic for RID, A-200) SKLICE (ivermectin)	EURAX (crotamiton) **CREAM** EURAX (crotamiton**) LOTION** lindane malathion (generic for Ovide) spinosad (generic for Natroba) ULESFIA (benzyl alcohol)	1. Adverse reaction to, allergy, or contraindication to preferred drugs, or 2. Documentation of treatment failure with one preferred drug. **Lindane:** will process in claims system automatically without prior authorization if 2 preferred products have been filled within the previous 60 days. **ULFESIA:** Quantity limits based on hair length.

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]		

ANTIVIRALS, TOPICAL

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
	acyclovir OINTMENT (generic for Zovirax) DENAVIR (penciclovir) XERESE (acyclovir/hydrocortisone)	1. Adverse reaction to, allergy, or contraindication to preferred oral antiherpetic agent. *or*

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	ZOVIRAX Cream (acyclovir)	2. Documentation of treatment failure with a preferred oral antiherpetic drug.

BLADDER RELAXANT PREPARATIONS

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

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) VERELAN (verapamil) verapamil ER **CAPSULE** verapamil 360mg capsule	

FLUOROQUINOLONES, ORAL

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
ciprofloxacin (generic for Cipro) levofloxacin **TABLETS**	ciprofloxacin ER ciprofloxacin suspension	1. Adverse reaction to, allergy, or contraindication to preferred drugs.

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(generic for Levaquin)	(generic for Cipro Suspension) levofloxacin oral solution moxifloxacin (generic for Avelox) ofloxacin	*or* 2. Documentation of treatment failure with preferred drug. **Ofloxacin:** May be approved 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) ZOMACTIN (somatropin) ZORBTIVE (somatropin)	https://nebraska.fhsc.com/Downloads/NEcriteria_GH-201511.pdf

HYPOGLYCEMICS, ALPHA-GLUCOSIDASE INHIBITORS

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

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.

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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) pioglitazone/glimepiride (generic for Duetact) pioglitazone/metformin (generic for Actoplus Met)	• Combination agents will require clinical reason separate agents cannot be used. • HbA1C ≥7

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) fluvastatin ER (generic for Lescol XL) LIVALO (pitavastatin)	Non-preferred agents may be approved if the patient has a history of two preferred agents in the last 12 months. **ALTOPREV** AND **LESCOL XL** require documentation of medical necessity of long acting form.
STATIN COMBINATIONS		
	ADVICOR (lovastatin/niacin ER) atorvastatin/ amlodipine (generic for CADUET) 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 (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) FEXMID (cyclobenzaprine) LORZONE (chlorzoxazone)* metaxalone (generic for Skelaxin) orphenadrine (generic for Norflex) orphenadrine ER SOMA (carisoprodol)* tizanidine **CAPSULES** ZANAFLEX (tizanidine) (brand name tablets and capsules)	The non-preferred agents will be approved for patients with documented failure of at least a one-week trial each of two preferred agents. **carisoprodol:** • use will be limited to no more than 30 days • additional authorization will not be granted for at least six months following the last day of the previous course of therapy • approval will not be granted for patients with a history of meprobamate use in the previous two years Concurrent use with opioids requires prior authorization **AMRIX, FEXMID:** • Clinical reason regular release cannot be used. • Only for short-term use. **ZANAFLEX:** • Clinical reason generic cannot be used.

ULCERATIVE COLITIS

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

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	UCERIS **ORAL** (budesonide)	**ASACOL HD, DELZICOL DR, AND LIALDA:** • Clinical reason cannot use the preferred form of mesalamine. **GIAZO:** • Clinical reason required as to why the preferred generic balsalazide cannot be used. • Giazo is most likely used in males and will deny if claim is for a female patient (effectiveness in female patients was not demonstrated in clinical trials).
RECTAL		
CANASA (mesalamine)	mesalamine SFROWASA (mesalamine) ROWASA (mesalamine)	1. Adverse reaction to, allergy or contraindication to preferred drugs, or 2. Documentation of treatment failure with one preferred drug.

It was moved by Caudill and seconded to accept recommendations as published for the Therapeutic Classes on the Consent Agenda, with the extraction of the MS class. Roll Call vote was taken and the motion passed.

Votes as follows: Avery-yes, Baker-yes, Bleicher-yes, Bohac-yes, Caudill-yes, Davenport-yes, Dering-Anderson-yes, Dubé-yes, Elsasser-yes, Fornander-yes, Haberstich-yes, Hammond-yes, Humphries-yes, Juracek-yes, Saunders-yes, Sobeski-yes, Thomsen-yes.

Motion Carried.

XII. Extracted Therapeutic Class Review:

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) glatiramer 20mg (generic for Copaxone) COPAXONE **40**mg Syringe (glatiramer) EXTAVIA (interferon beta-1b) PLEGRIDY (peginterferon beta-1a) TECFIDERA (dimethyl fumarate)	1. Adverse reaction to, allergy, or contraindication to preferred drug. *or* 2. Documentation of treatment failure with one preferred drug. **AMPYRA:** • Initial authorization for 12 weeks, requiring gait disorder 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

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		score not greater than 7

After discussion related to routes of administration and therapeutic comparisons of the agents in the class, it was moved by Elsasser and seconded to accept recommendations as published for the Extracted Therapeutic Class. Roll Call vote was taken and the motion passed.

Votes as follows: Avery-yes, Baker-yes, Bleicher-yes, Bohac-yes, Caudill-yes, Davenport-yes, Dering-Anderson-no, Dubé-no, Elsasser-yes, Fornander-yes, Haberstich-yes, Hammond-no, Humphries-yes, Juracek-no, Saunders-yes, Sobeski-yes, Thomsen-yes.

Motion Carried.

XIII. 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 **LOTION** clindamycin phosphate **SOLUTION** erythromycin **SOLUTION** tretinoin **CREAM** tretinoin **GEL** DIFFERIN (adapalene) **LOTION, CREAM, GEL** DUAC (clindamycin/benzoyl peroxide)	ACANYA (clindamycin and benzoyl peroxide) ACZONE (dapsone) adapalene gel pump (generic for Differin gel pump) adapalene (generic for Differin) AKNE-MYCIN (erythromycin) ATRALIN (tretinoin) AVITA (tretinoin) BENZACLIN GEL (clindamycin/benzoyl peroxide) benzoyl peroxide foam (generic for Benzefoam) benzoyl peroxide **gel Rx** CLINDAGEL (clindamycin) clindamycin **GEL, LOTION, FOAM** clindamycin/benzoyl peroxide (generic for Benzaclin) clindamycin/benzoyl peroxide (generic for Duac) EPIDUO (adapalene/benzoyl peroxide) erythromycin **GEL** erythromycin-benzoyl peroxide (generic for Benzamycin) EVOCLIN (clindamycin) FABIOR (tazarotene foam) INOVA (benzoyl peroxide) KLARON (sulfacetamide) NEUAC (clindamycin/benzoyl peroxide)[NR]	Treatment failure with three preferred products.

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	RETIN-A GEL, CREAM RETIN-A MICRO (tretinoin microspheres) sulfacetamide sulfacetamide/sulfur SUMADAN (sulfacetamide/sulfur) TAZORAC (tazarotene) tretinoin microspheres (generic for Retin-A Micro) VELTIN (clindamycin and tretinoin) ZIANA (clindamycin and tretinoin)	

Discussion: In keeping with the mission of the committee to "provide appropriate pharmaceutical care to Medicaid recipients in a cost-effective manner" (Nebraska Medicaid Pharmaceutical and Therapeutics Committee By-Laws Article II, Section I), members expressed concerns related to accepting recommendations to make several generic medications non-preferred while preferring several brand name drugs in order to maximize cost effectiveness for the State of Nebraska.

It was moved by Dering-Anderson and seconded to accept recommendations as published with the following *exceptions*:

- Differin LOTION/CREAM/GEL, Retin-A CREAM/GEL and Duac changed to preferred, and
- adapalene (generic for Differin), clindamycin/benzoyl peroxide (generic for Duac), and trentinoin CREAM/GEL (generic for Retin-A) changed to non-preferred.

Roll Call vote was taken and the motion passed.

Votes as follows: Avery-yes, Baker-yes, Bleicher-yes, Bohac-yes, Caudill-yes, Davenport-yes, Dering-Anderson-yes, Dubé-yes, Elsasser-yes, Fornander-yes, Haberstich-yes, Hammond-yes, Humphries-yes, Juracek-yes, Saunders-yes, Sobeski-yes, Thomsen-yes.

Motion Carried.

ANALGESICS, OPIATE LONG-ACTING

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
BUTRANS (buprenorphine, transdermal) fentanyl patches 25, 50, 75,100mcg HYSINGLA ER (hydrocodone) KADIAN (morphine ER capsule) morphine ER **TABLET** (generic for MS Contin, Oramorph SR) OXYCONTIN (oxycodone ER)	BELBUCA (buprenorphine buccal) DURAGESIC MATRIX (fentanyl) EMBEDA (morphine/naltrexone) fentanyl patch **12**, **37.5, 62.5, 87.5 mcg** hydromorphone ER (generic for Exalgo)* methadone** morphine ER capsule (generic for Avinza) morphine ER capsule (generic for Kadian) NUCYNTA ER (tapentadol)* oxycodone ER (generic for re-formulated Oxycontin)	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 **methadone: trials of preferred drugs are not required with diagnosis of cancer. **CONZIP, EXALGO, ULTRAM ER, and ZOHYDRO ER:** • Must document **clinical** reason why short-acting product with same active ingredient cannot be used.

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	oxymorphone ER (generic for OPANA ER) tramadol extended release* (generic for CONZIP, RYZOLT, ULTRAM ER) ZOHYDRO ER (hydrocodone bitartrate ER)	

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

Votes as follows: Avery-yes, Baker-yes, Bleicher-yes, Bohac-yes, Caudill-yes, Davenport-yes, Dering-Anderson-yes, Dubé-yes, Elsasser-yes, Fornander-yes, Haberstich-yes, Hammond-yes, Humphries-yes, Juracek-yes, Saunders-yes, Sobeski-yes, Thomsen-yes.

Motion Carried.

ANALGESICS, OPIATE SHORT-ACTING

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
ORAL		
acetaminophen/codeine codeine **ORAL** hydrocodone/APAP hydrocodone/ibuprofen hydromorphone **TABLETS** morphine **ORAL** oxycodone **TABLET, SOLUTION** oxycodone/APAP ROXICET **SOLUTION** (oxycodone/acetaminophen) tramadol	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) (note: separate ingredients preferred) XARTEMIS XR (oxycodone/acetaminophen) ZAMICET (hydrocodone/acetaminophen)	Non-preferred agents will be approved only after documented failure of 3 preferred agents. **NUCYNTA** • only approved for short term use for acute pain. Not approved for chronic pain.
NASAL		

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	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: Avery-yes, Baker-yes, Bleicher-yes, Bohac-yes, Caudill-yes, Davenport-yes, Dering-Anderson-yes, Dubé-yes, Elsasser-yes, Fornander-yes, Haberstich-yes, Hammond-yes, Humphries-yes, Juracek-yes, Saunders-yes, Sobeski-yes, Thomsen-yes.

Motion Carried.

ANDROGENIC DRUGS (Topical)

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
ANDROGEL (testosterone)	ANDRODERM (testosterone) AXIRON (testosterone) FORTESTA (testosterone) NATESTO (testosterone nasal) 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 Dubé and seconded to accept recommendations as published. Roll Call vote was taken and the motion passed.

Votes as follows: Avery-yes, Baker-yes, Bleicher-yes, Bohac-yes, Caudill-yes, Davenport-yes, Dering-Anderson-yes, Dubé-yes, Elsasser-yes, Fornander-yes, Haberstich-yes, Hammond-yes, Humphries-yes, Juracek-yes, Saunders-yes, Sobeski-yes, Thomsen-yes.

Motion Carried.

XIV. An all in favor motion was made to move into closed session for lunch at 11:59. Resumed open session at 1:00

ANGIOTENSIN MODULATOR /CALCIUM CHANNEL BLOCKER COMBINATIONS

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
benazepril/amlodipine (generic for Lotrel)	AZOR (olmesartan/amlodipine) telmisartan/amlodipine (generic for Twynsta) trandolapril/verapamil (generic for TARKA) TRIBENZOR (amlodipine/olmesartan/HCTZ) valsartan/amlodipine (generic for Exforge) valsartan/amlodipine/HCTZ	Individual prescriptions for the components of these products should be used for patients requiring these drug combinations. Documentation of medical necessity required for use of combination product.

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	(generic for Exforge HCT) PRESTALIA (perindopril/amlodipine)	

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

Votes as follows: Avery-yes, Baker-yes, Bleicher-yes, Bohac-yes, Caudill-yes, Davenport-yes, Dering-Anderson-yes, Dubé-absent, Elsasser-yes, Fornander-yes, Haberstich-yes, Hammond-yes, Humphries-yes, Juracek-yes, Saunders-yes, Sobeski-absent, 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) quinapril (generic for Accupril) ramipril (generic for Altace)	captopril (generic for Capoten) EPANED (enalapril) oral solution fosinopril (generic for Monopril) moexepril (generic for Univasc) perindopril (generic for Aceon) trandolapril (generic for Mavik)	Non-preferred agents may be approved if the patient has a history of two preferred agents in the last 12 months. **EPANED**: Requires documentation of why an oral tablet or compounded products 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		
ENTRESTO (sacubitril/valsartan)* irbesartan (generic for Avapro) losartan (generic for Cozaar) valsartan (generic for Diovan)	BENICAR (olmesartan) candesartan (generic for Atacand) DIOVAN (valsartan) EDARBI (azilsartan medoxomil) eprosartan (generic for Teveten) telmisartan (generic for Micardis)	*Entresto limited to FDA approved indications. 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) EDARBYCLOR (azilsartan/chlorthalidone) telmisartan/HCTZ (generic for Micardis-HCT)	
DIRECT RENIN INHIBITORS		
	TEKTURNA (aliskiren)	Non-preferred agents may be approved if the patient has a history of two preferred ACE inhibitors or angiotensin receptor blockers in the last 12 months.
DIRECT RENIN INHIBITOR COMBINATIONS		
	TEKTURNA/HCT (aliskiren/HCTZ)	

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

Votes as follows: Avery-yes, Baker-yes, Bleicher-yes, Bohac-yes, Caudill-yes, Davenport-yes, Dering-Anderson-yes, Dubé-absent, Elsasser-yes, Fornander-yes, Haberstich-yes, Hammond-yes, Humphries-yes, Juracek-yes, Saunders-yes, Sobeski-absent, Thomsen-yes.

Motion Carried.

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 diarrhea, require contraindication to or treatment failure with oral vancomycin or metronidazole. **FLAGYL ER:** • Require 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. **VACONCIN**: • 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** • Diagnosis of Traveler's Diarrhea resistant to quinolone. Or • Hepatic encephalopathy with treatment failure of lactulose or

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		neomycin. • Irritable bowel

It was clarified that although vancomycin compounded solution was not on the Power Point slide it is a Nebraska-specific added drug and is to be included in the complete class review.
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: Avery-yes, Baker-yes, Bleicher-yes, Bohac-yes, Caudill-yes, Davenport-yes, Dering-Anderson-yes, Dubé-absent, Elsasser-yes, Fornander-yes, Haberstich-yes, Hammond-yes, Humphries-yes, Juracek-yes, Saunders-yes, Sobeski-absent, Thomsen-yes.

Motion Carried.

ANTICOAGULANTS

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

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

Votes as follows: Avery-yes, Baker-yes, Bleicher-yes, Bohac-yes, Caudill-yes, Davenport-yes, Dering-Anderson-yes, Dubé-absent, Elsasser-yes, Fornander-yes, Haberstich-yes, Hammond-yes, Humphries-yes, Juracek-yes, Saunders-yes, Sobeski-absent, 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 drug. *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) EMEND (aprepitant)[QL, *]	Does NOT require treatment failure with preferred drugs when used for moderately or highly emetogenic chemotherapy.

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TRADITIONAL ANTIEMETICS		
DICLEGIS (doxylamine/pyridoxine)** **pregnancy 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) metoclopramide ODT (generic for Metozolv ODT) prochlorperazine rectal (generic for Compazine) promethazine suppositories 50mg trimethobenzamide oral (generic for Tigan) VARUBI (rolapitant HCL)	1. Adverse reaction to, allergy, or contraindication to 2 preferred drugs. *or* 2. Documentation of treatment failure with 2 preferred drugs. **METOZOLV ODT** (metoclopramide): Inablilty to swallow or clinical reason can't utilize oral liquid.

It was clarified that although hydroxyzine was not on the Power Point slide it is a Nebraska-specific added drug and is to be included in the complete class review.
It was moved by Dubé and seconded to accept recommendations as published. Roll Call vote was taken and the motion passed.

Votes as follows: Avery-yes, Baker-yes, Bleicher-yes, Bohac-yes, Caudill-yes, Davenport-yes, Dering-Anderson-yes, Dubé-yes, Elsasser-yes, Fornander-yes, Haberstich-yes, Hammond-yes, Humphries-yes, Juracek-yes, Saunders-yes, Sobeski-absent, Thomsen-yes.

Motion Carried.

ANTIFUNGALS, ORAL

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
clotrimazole (mucous membrane troche) fluconazole (generic for Diflucan) griseofulvin **suspension** griseofulvin ultramicrosize (generic for GRIS-PEG) nystatin **TABLET**, **SUSPENSION** terbinafine (generic for Lamisil)	CRESEMBRA (isavuconazonium sulfate)* flucytosine (generic for Ancobon)* GRIFULVIN V (griseofulvin) griseofulvin tablets GRIS-PEG (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, endocarditis, UTI • CRYPTOCOCCUS: meningitis, pulmonary infections. **CRESEMBRA:**

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		• Invasive aspergillosis • Invasive mucomycosis **ITRACONAZOLE:** diagnosis of: • Aspergillosis • Blastomycosis • Histoplasmosis • Onychomycosis resistant to terbinafine • Oropharyngeal/esophageal candidiasis refractory to fluconazole. • Sporonox liquid only if unable to take capsules. • Onmel only FDA approved for onychomycosis. **NOXAFIL:** minimum age of 13. Prevention of infection with diagnosis of: • Neutropenic Myelodysplastic Syndrome • Neutropenic hematologic malignancies • Graft vs. Host disease • Immunosuppression following hematopoetic stem cell transplant • Oropharyngeal/esophageal candidiasis refractory to itraconazole and/or fluconazole **VFEND:** • Myelodysplastic Syndrome (MDS), • Neutropenic Acute Myeloid Leukemia (AML) • Graft versus Host Disease (GVHD) • Candidemia (candida krusei), Esophageal Candidiasis • Pulmonary or invasive aspergillosis • Blastomycosis • Serious fungal infections caused by Scedosporium apiospermum (asexual form of pseudallescheria boydii) and Fusarium spp., including Fusarium solani, in patients intolerant of, or refractory to other therapy.

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		• Oropharyngeal/esophageal candidiasis refractory to fluconazole.

It was moved by Avery and seconded to accept recommendations, as published. with the exception to amend the criteria to verify that it is consistent with the National Comprehensive Cancer Network clinical practice guidelines related to the prevention and treatment of cancer related infections, Roll Call vote was taken and the motion passed.

Votes as follows: Avery-yes, Baker-yes, Bleicher-yes, Bohac-yes, Caudill-yes, Davenport-yes, Dering-Anderson-yes, Dubé-yes, Elsasser-yes, Fornander-yes, Haberstich-yes, Hammond-yes, Humphries-yes, Juracek-yes, Saunders-yes, Sobeski-absent, Thomsen-yes.

Motion Carried.

ANTIMIGRAINE, OTHER

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
	CAFERGOT (ergotamine/caffeine) dihydroergotamine mesylate (nasal) isometheptene/caffeine/APAP isometheptene/dihloralphenazone/APAP MIGEROT (ergotamine/caffeine) Rectal MIGRANAL (dihydroertogamine) Nasal NODOLOR (isomethept/dichlphn/acetaminophen)	Trial on or contraindication to triptan.

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: Avery-yes, Baker-yes, Bleicher-yes, Bohac-yes, Caudill-yes, Davenport-yes, Dering-Anderson-yes, Dubé-yes, Elsasser-yes, Fornander-yes, Haberstich-yes, Hammond-yes, Humphries-yes, Juracek-absent, Saunders-yes, Sobeski-absent, 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) rizatriptan (generic for Maxalt) sumatriptan generic oral	AXERT (almotriptan) FROVA (frovatriptan) IMITREX oral (sumatriptan) naratriptan (generic for Amerge) 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.
OTHER ROUTES		
IMITREX (sumatriptan) Nasal	sumatriptan generic Nasal ZOMIG (zolmitriptan) Nasal	
IMITREX (sumatriptan) **PEN, CARTRIDGE** sumatriptan generic **VIAL**	IMITREX (sumatriptan) **VIAL** sumatriptan **SYRINGE, KIT** SUMAVEL DOSEPRO (sumatriptan) ZECUITY TRANSDERMAL	

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	(sumatriptan)	

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

Votes as follows: Avery-yes, Baker-yes, Bleicher-yes, Bohac-yes, Caudill-yes, Davenport-yes, Dering-Anderson-yes, Dubé-yes, Elsasser-yes, Fornander-yes, Haberstich-yes, Hammond-yes, Humphries-yes, Juracek-absent, Saunders-yes, Sobeski-absent, Thomsen-yes.

Motion Carried.

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) dutasteride/tamsulosin (generic for Jalyn) RAPAFLO (silodosin) UROXATRAL (alfuzosin)	Treatment failure with one preferred agent. **JALYN:** Must meet criteria for approval of Avodart and clinical reason can't take individual agents.
5-ALPHA-REDUCTASE (5AR) INHIBITORS		
dutasteride (generic for Avodart) finasteride (generic for Proscar)	dutasteride/tamsulosin (generic for Jalyn)	

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

Votes as follows: Avery-yes, Baker-yes, Bleicher-yes, Bohac-absent, Caudill-yes, Davenport-yes, Dering-Anderson-yes, Dubé-yes, Elsasser-yes, Fornander-yes, Haberstich-yes, Hammond-yes, Humphries-yes, Juracek-absent, Saunders-yes, Sobeski-absent, 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) metoprolol XL (generic for Toprol XL) propranolol (generic for Inderal) propranolol extended release (Inderal LA)	acebutolol (generic for Sectral) betaxolol (generic for Kerlone) bisoprolol (generic for Zebeta) BYSTOLIC (nebivolol) DUTOPROL (metoprolol XR and 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)	Non-preferred agent will be approved only after documented failure of two preferred agents within the past 12 months. Drug Interactions: Non-preferred beta-blocker may be approved if necessary to avoid drug interaction with preferred agent. Such as, allow pindolol 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

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	propranolol/hydrochlorothiazide (generic for Inderide) timolol (generic for Blocadren) TOPROL XL (metoprolol)	obstructive lung disease.
BETA- AND ALPHA- BLOCKERS		
carvedilol (generic for Coreg) labetalol (generic for Trandate)* *preferred in pregnancy	COREG CR (carvedilol)	**Coreg CR:** Clinical reason the generic regular-release cannot be used.
ANTIARRHYTHMIC		
sotalol (generic for Betapace)	SOTYLIZE (sotalol oral solution)	

It was moved by Dering-Anderson and seconded to accept recommendations as published with the exception of allowing generic labetolol to be Preferred without limiting its use to pregnancy. Roll Call vote was taken and the motion passed.

Votes as follows: Avery-yes, Baker-yes, Bleicher-yes, Bohac-yes, Caudill-yes, Davenport-yes, Dering-Anderson-yes, Dubé-yes, Elsasser-yes, Fornander-yes, Haberstich-yes, Hammond-yes, Humphries-yes, Juracek-absent, Saunders-yes, Sobeski-absent, Thomsen-yes.

Motion Carried.

BONE RESORPTION SUPPRESSION AND RELATED DRUGS

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
BISPHOSPHONATES		
alendronate (generic for Fosamax) (daily and weekly formulations)	BINOSTO (alendronate effervescent) etidronate disodium (generic for Didronel) FOSAMAX Oral Solution (alendronate) FOSAMAX PLUS D ibandronate (generic for Boniva) risedronate (generic for Actonel) (alendronate) risedronate (generic for Atelvia DR)	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		
calcitonin-salmon nasal raloxifene (generic for Evista)	FORTICAL (calcitonin) nasal FORTEO (teriparatide) subcutaneous[QL] MIACALCIN (calcitonin) nasal	1. Adverse reaction to, allergy, or contraindication to preferred drugs. *or* 2. Documentation of treatment failure with preferred drug.
	Forteo® (teriparatide) Criteria: May approve if the client is unable to use preferred products (i.e. intolerance, contraindication, allergy, and previous trial/failure) **OR** the client is at high risk of fracture as defined below. Patients at high risk of fracture include: • Bone mineral density of -3 or worse • Postmenopausal women with history of non-traumatic fracture(s) • Postmenopausal women with two or more of the following clinical risk	

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	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.

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

Votes as follows: Avery-yes, Baker-yes, Bleicher-yes, Bohac-yes, Caudill-yes, Davenport-yes, Dering-Anderson-yes, Dubé-yes, Elsasser-yes, Fornander-yes, Haberstich-yes, Hammond-yes, Humphries-yes, Juracek-absent, Saunders-yes, Sobeski-absent, Thomsen-yes.

Motion Carried.

CEPHALOSPORINS (Oral) and RELATED ANTIBIOTICS

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
BETA LACTAM/BETA-LACTAMASE INHIBITOR COMBINATIONS		
amoxicillin/clavulanate **TABLETS, CHEW TABLETS, SUSPENSION** AUGMENTIN **125MG/5ML SUSPENSION**	amoxicilline/clavuante XR (generic for Augmentin XR) AUGMENTIN **250MG/5ML** SUSPENSION AUGMENTIN (amoxicilline/claquante)	1. Adverse reaction to, allergy, 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 to, allergy, or contraindication to preferred drugs. *or* 2. Documentation of treatment failure with preferred drug.
CEPHALOSPORINS – Second Generation		
cefprozil (oral) (generic for Cefzil) cefuroxime (oral tablet)	cefaclor (oral) (generic for Ceclor) CEFTIN (cefuroxime) tablets,	1. Adverse reaction to, allergy, or contraindication to preferred drugs.

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

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

Votes as follows: Avery-yes, Baker-yes, Bleicher-yes, Bohac-yes, Caudill-yes, Davenport-yes, Dering-Anderson-yes, Dubé-yes, Elsasser-yes, Fornander-yes, Haberstich-yes, Hammond-yes, Humphries-yes, Juracek-absent, Saunders-yes, Sobeski-absent, Thomsen-yes.

Motion Carried.

GI MOTILITY (formerly IRRITABLE BOWEL SYNDROME)

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
AMITIZA (lubiprostone) LINZESS (linaclotide)	alosetron (generic for Lotronex) MOVANTIK (naloxegol oxalate) VIBERZI (eluxodoline)	Lotronex: • Diagnosis of irritable bowel syndrome, severe diarrhea-predominant. MOVANTIK: •

It was moved by Saunders and seconded to accept recommendations as published, with PDL exception criteria for Movantik to include: Treatment failure of opioid-induced constipation in patients taking opioids with 2 or more OTC laxatives. Roll Call vote was taken and the motion passed.

Votes as follows: Avery-yes, Baker-yes, Bleicher-yes, Bohac-yes, Caudill-yes, Davenport-yes, Dering-Anderson-yes, Dubé-yes, Elsasser-yes, Fornander-yes, Haberstich-yes, Hammond-yes, Humphries-yes, Juracek-absent, Saunders-yes, Sobeski-absent, Thomsen-yes.

Motion Carried.

H.PYLORI TREATMENTS

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

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

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Votes as follows: Avery-yes, Baker-yes, Bleicher-yes, Bohac-yes, Caudill-yes, Davenport-yes, Dering-Anderson-yes, Dubé-yes, Elsasser-yes, Fornander-yes, Haberstich-yes, Hammond-yes, Humphries-yes, Juracek-absent, Saunders-yes, Sobeski-absent, Thomsen-yes.

Motion Carried.

HEPATITIS C AGENTS

PREFERRED DRUGS	NON-PREFERRED DRUGS	CRITERIA FOR USE OF NON-PREFERRED PRODUCTS
INTERFERON		See clinical criteria.
PEGASYS (pegylated interferon alfa-2a)* PEG-INTRON (pegylated interferon alfa-2b)*		
RIBAVIRIN		
ribavirin 200mg tablets and capsules*	REBETOL SOLUTION (ribavirin)	
DIRECT ACTING ANTIVIRALS		
DAKLINZA (daclatasvir)* TECHNIVIE (ombitasvir/paritaprev/ritonav)* VIEKIRA PAK * (ombitasvir, paritaprevir, ritonavir, dasabuvir)	HARVONI (sofosbuvir/ledipasvir)* OLYSIO (simeprevir)* SOVALDI (sofosbuvir)* ZEPATIER (elbasvir/grazoprevir)*	https://nebraska.fhsc.com/Downloads/NEcriteria_Sovaldi-201512.pdf

It was moved by Dubé and seconded to accept recommendations as published. Roll Call vote was taken and the motion passed. The Committee requested a re-review at the November 2016 meeting if new products come to market impacting rebates across the class.

Votes as follows: Avery-yes, Baker-yes, Bleicher-yes, Bohac-yes, Caudill-yes, Davenport-yes, Dering-Anderson-yes, Dubé-yes, Elsasser-yes, Fornander-yes, Haberstich-yes, Hammond-yes, Humphries-yes, Juracek-absent, Saunders-yes, Sobeski-absent, 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)**		****Requires metformin trial and diagnosis of diabetes.**
BYDUREON (exenatide ER) subcutaneous BYDUREON **PEN** (exenatide ER) subcutaneous BYETTA (exenatide) subcutaneous	TANZEUM (albiglutide) TRULICITY (dulaglutide) VICTOZA (liraglutide) subcutaneous**	****VICTOZA®:** May be approved in patients with compromised renal function.
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	GLYXAMBI (empagliflozin/linagliptin) KAZANO (alogliptin/metformin)QL KOMBIGLYZE XR (saxagliptin/metformin)QL	Trial on sitagliptin or linagliptin.

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JANUVIA (sitagliptin)[QL] JENTADUETO (linagliptin/metformin)[QL] TRADJENTA (linagliptin)[QL]	NESINA (alogliptin)[QL] ONGLYZA (saxagliptin)[QL] OSENI (alogliptin/pioglitazone)[QL]	

It was moved by Baker and seconded to accept recommendations as published. Roll Call vote was taken and the motion passed. Dering-Anderson suggested that in the future costs of combination products be compared to costs of the individual ingredients.

Votes as follows: Avery-yes, Baker-yes, Bleicher-yes, Bohac-yes, Caudill-yes, Davenport-yes, Dering-Anderson-yes, Dubé-yes, Elsasser-yes, Fornander-yes, Haberstich-yes, Hammond-yes, Humphries-yes, Juracek-absent, Saunders-yes, Sobeski-absent, Thomsen-yes.

Motion Carried.

HYPOGLYCEMICS, INSULIN AND RELATED DRUGS

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
HUMALOG (insulin lispro) HUMALOG (insulin lispro) **PEN, CARTRIDGE** HUMALOG MIX **VIAL, PEN** (insulin lispro/lispro protamine) HUMULIN (insulin) HUMULIN 70/30 *LANTUS (insulin glargine)* *LANTUS (insulin glargine) SOLOSTAR PEN* LEVEMIR (insulin detemir) **VIAL, PEN** NOVOLOG (insulin aspart) **VIAL, PEN** NOVOLOG MIX **VIAL, PEN**	AFREZZA (insulin human regular) APIDRA (insulin glulisine) NOVOLIN (insulin) (insulin aspart/aspart protamine) TOUJEO SOLOSTAR PEN (insulin glargine) TRESIBA (Insulin degludec) Humulin U-500 pen	1. Adverse reaction to, allergy, or contraindication to preferred drugs. *or* 2. Documentation of treatment failure with preferred drug.

It was moved by Baker and seconded to accept recommendations as published with the addition of the following exception criteria for the Humulin-500 **PEN** to include:

- Physical reasons - such as dexterity problems and vision impairment;
- Usage must be for self-administration, and not just for convenience;
- Patient requires greater than 300 units of insulin daily;
- Other reasons the patient is unable to safely dose U-500 insulin using syringe and vial.

Roll Call vote was taken and the motion passed.

Votes as follows: Avery-yes, Baker-yes, Bleicher-yes, Bohac-yes, Caudill-yes, Davenport-yes, Dering-Anderson-yes, Dubé-yes, Elsasser-yes, Fornander-yes, Haberstich-yes, Hammond-yes, Humphries-yes, Juracek-absent, Saunders-yes, Sobeski-absent, Thomsen-yes.

Motion Carried.

HYPOGLYCEMICS, MEGLITINIDES

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
repaglinide (generic for Prandin)	nateglinide (generic for Starlix) PRANDIMET (repaglinide/metformin)	• Compliance demonstrated with metformin trial and have not received adequate glycemic

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		control with metformin; or • Intolerance to metformin; • HbA1C >7

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

Votes as follows: Avery-yes, Baker-yes, Bleicher-yes, Bohac-yes, Caudill-yes, Davenport-yes, Dering-Anderson-yes, Dubé-yes, Elsasser-yes, Fornander-yes, Haberstich-yes, Hammond-yes, Humphries-yes, Juracek-absent, Saunders-yes, Sobeski-absent, Thomsen-yes.

Motion Carried.

HYPOGLYCEMICS, SGLT2

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

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

Votes as follows: Avery-yes, Baker-yes, Bleicher-yes, Bohac-yes, Caudill-yes, Davenport-yes, Dering-Anderson-yes, Dubé-yes, Elsasser-yes, Fornander-yes, Haberstich-yes, Hammond-yes, Humphries-yes, Juracek-absent, Saunders-yes, Sobeski-absent, Thomsen-yes.

Motion Carried.

HYPOGLYCEMICS, SULFONYLUREAS

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

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

Votes as follows: Avery-yes, Baker-yes, Bleicher-yes, Bohac-yes, Caudill-yes, Davenport-yes, Dering-Anderson-yes, Dubé-yes, Elsasser-yes, Fornander-yes, Haberstich-yes, Hammond-yes, Humphries-yes, Juracek-absent, Saunders-yes, Sobeski-absent, Thomsen-yes.

Motion Carried.

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

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
BILE ACID SEQUESTRANTS		The non-preferred agent will be approved only after documented
cholestyramine	colestipol (generic for Colestid)	

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(generic for Questran) colestipol (generic for Colestid) **TABLETS**	**GRANULES** QUESTRAN LIGHT (cholestyramine) WELCHOL (colesevalam)	failure of the preferred agents.
FIBRIC ACID DERIVATIVES		
fenofibrate (generic for Tricor) gemfibrozil (generic for Lopid) TRILIPIX (fenofibric acid)	fenofibrate (generic for Antara) fenofibrate (generic for Lofibra) fenofibrate (generic for Fenoglide) fenofibrate (generic for Lipofen) fenofibric acid (generic for Fibricor) fenofibric acid (generic for Trilipix) TRICOR (fenofibrate) TRIGLIDE (fenofibrate)	
NIACIN		
niacin ER (generic for Niaspan)	ADVICOR (lovastatin/niacin ER) NIACOR (niacin IR) NIASPAN (niacin ER)	
OMEGA-3 FATTY ACIDS		
	LOVAZA (omega-3 fatty acids)* VASCEPA (icosapent)*	*May approve if TG ≥500. (Verified by faxed copy of lab report). If TG ≤500, OTC fish oils covered without prior authorization.
CHOLESTEROL ABSORPTION INHIBITORS		
	ZETIA (ezetimibe)	**ZETIA:** • will be approved for patients who have a diagnosis of hypercholesterolemia and have either failed statin monotherapy or have a documented intolerance to statins. • Zetia treatment is only approved as an adjunct to concurrent statin therapy unless there is a documented intolerance to the statins.
APOLIPOPROTEIN B SYNTHESIS INHIBITORS		
	JUXTAPID (lomitapide)* KYNAMRO (mipomersen)*	(see below)
PROPROTEIN CONVERTASE SUBTILISIN/KEXIN TYPE 9 (PCSK9) INHIBITORS		
	PRALUENT (alorocumab)* REPATHA (evolocumab)*	• Secondary prevention for patients with a documentation of Statin intolerance. (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%

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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.

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™.

PRALUENT (alirocumab):

- Request is made by cardiologist, lipidologist, or endocrinologist (or PCP has consulted with).
- Diagnosis of atherosclerotic cardiovascular disease (ASCVD) or heterozygous familial hypercholesterolemia (HeFH).
- Patient has had treatment with the highest available dose or maximally-tolerated dose of high intensity statin (atorvastatin or rosuvastatin) **AND** ezetimibe for at least three continuous months.
- Patient has failed to reach target LDL-C levels (documentation/labs required for initial approval and renewal):
  ASCVD: LDL-C is <70 mg/dL
  HeFH: LDL-C is <100 mg/dL
- Request is being made for the lowest approved Praluent® dose (75 mg every 2 weeks)
  Requests for an escalated dose (150 mg every 2 weeks) must contain a lipid panel documenting suboptimal reduction in LDL-C after at least 4 weeks (2 doses) of Praluent® at the lower (75 mg every 2 weeks) dose.
- Minimum age restriction of 18 years of age.
- **Renewal Criteria:**
  Requestor to forward lipid panel showing a further reduction in LDL-C compared to the labs prior to initiating Praluent®

Confirm compliance to statin.

REPATHA (evolocumab):

- Age ≥ 18 years if diagnosis is atherosclerotic cardiovascular disease (ASCVD) OR heterozygous familial hypercholesterolemia (HeFH)
- Age ≥ 13 years if diagnosed with homozygous familial hypercholesterolemia (HoFH)
- Request made by or in consultation with a specialist(i.e. cardiologist, lipidologist, endocrinologist)
- Patient has not had a prior trial and failure of an alternative PCSK9 inhibitor
- Maximally-tolerated statin will continue to be used in conjucntion with Repatha®.
- Diagnosis:
    - ASCVD
    - HeFH as confirmed by genotyping (or Simon Broome or WHO/Dutch Lipid Network criteria)
    - HoFH as confirmed by either:
        1. Documented DNA test OR
        2. A history of an untreated LDL-C concentration > 500 mg/dL and triglycerides <300 mg/dL and both parents with documented untreated TC >250 mg/dL
- Patient must have prior treatment with the highest available or maximally tolerated dose of atorvastatin or rosuvastatin AND ezetimibe for 3 continuous months with failure to reach target LDL-C:
    - 70mg/dl for patients with ASCVD
    - 100mg/dl for patients with HeFH or HoFH
- Approval may also be granted if the patient has been diagnosed with statin-induced rhabdomyolysis.

Renewal criteria:

- Lipid panel showing a further reduction in LDL-C compared to the labs prior to initiating Repatha®
- Continued adherence to maximally-tolerated statin dose established prior to the original Repatha® approval

It was moved by Caudill and seconded to accept recommendations as published with the addition of "secondary prevention for patients with a documentation of Statin intolerance", to the PCSK-9 exception criteria. Minchow noted that for Repatha, "Patient has not had a prior trial and failure of an alternative PCSK9 inhibitor" will be removed from criteria as it is not supported in product information. Roll Call vote was taken and the motion passed.

Votes as follows: Avery-yes, Baker-yes, Bleicher-yes, Bohac-yes, Caudill-yes, Davenport-yes, Dering-Anderson-yes, Dubé-yes, Elsasser-yes, Fornander-yes, Haberstich-yes, Hammond-yes, Humphries-yes, Juracek-absent, Saunders-yes, Sobeski-absent, 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 EES 200 SUSPENSION	clarithromycin ER (generic for Biaxin XL) ERYTHROCIN EES 400 **TABLET**	1. Adverse reaction to, allergy, or contraindication to preferred drugs. *or* 2. Documentation of treatment failure

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ERYTAB ERYPED 400 SUSPENSION PCE (erythromycin)	ERYPED 200 SUSPENSION erythromycin base tablet erythromycin base CAPSULE DR ZMAX (azithromycin ER) ZITHROMAX (azithromycin)	with preferred drug.

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

Votes as follows: Avery-yes, Baker-yes, Bleicher-yes, Bohac-yes, Caudill-yes, Davenport-yes, Dering-Anderson-yes, Dubé-yes, Elsasser-yes, Fornander-yes, Haberstich-yes, Hammond-yes, Humphries-yes, Juracek-absent, Saunders-yes, Sobeski-absent, Thomsen-yes.

Motion Carried.

OPIATE DEPENDENCE TREATMENTS

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
SUBOXONE FILM (buprenorphine/ naloxone)*	BUNAVAIL (buprenorphine/ naloxone) buprenorphine SL buprenorphine/naloxone SL ZUBSOLV (buprenorphine/ naloxone)	https://nebraska.fhsc.com/Downloads/NEfaxform-Suboxone.pdf 1. Adverse reaction to, allergy, or contraindication to preferred drugs. *or* 2. Documentation of treatment failure with two preferred drugs.

It was moved by Dering-Anderson and seconded to accept recommendations as published with the exception of only requiring a trial on one drug, since there is only one preferred agent. Roll Call vote was taken and the motion passed.

Votes as follows: Avery-absent, Baker-yes, Bleicher-yes, Bohac-yes, Caudill-yes, Davenport-yes, Dering-Anderson-yes, Dubé-yes, Elsasser-yes, Fornander-yes, Haberstich-yes, Hammond-yes, Humphries-yes, Juracek-absent, Saunders-yes, Sobeski-absent, Thomsen-yes.

Motion Carried.

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

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
ADCIRCA (tadalafil) (for PAH only)* LETAIRIS (ambrisentan) sildenafil (generic for Revatio) (for PAH only*) TRACLEER (bosentan) TYVASO INHALATION (treprostinil) VENTAVIS INHALATION (iloprost)	ADEMPAS (riociguat) OPSUMIT (macitentan) ORENITRAM ER (treprostinil) REVATIO SUSPENSION (for PAH only*) UPTRAVI (selexipag)	**Sildenafil** (Revatio) and **ADCIRCA** require diagnosis of PAH. Trial on a preferred agent or documentation of why not appropriate for patient.

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

Votes as follows: Avery-absent, Baker-yes, Bleicher-yes, Bohac-absent, Caudill-yes, Davenport-yes, Dering-Anderson-yes, Dubé-yes, Elsasser-yes, Fornander-yes, Haberstich-yes, Hammond-yes, Humphries-yes, Juracek-absent, Saunders-yes, Sobeski-absent, Thomsen-yes.

Motion Carried.

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.

PENICILLINS

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
amoxicillin capsule amoxicillin tablet amoxicillin suspension amoxicillin tablet chew ampicillin capsule ampicillin suspension dicloxacillin	amoxicillin ER tablet MOXATAG (amoxicillin)	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: Avery-absent, Baker-yes, Bleicher-absent, Bohac-yes, Caudill-yes, Davenport-yes, Dering-Anderson-yes, Dubé-yes, Elsasser-yes, Fornander-yes, Haberstich-yes, Hammond-yes, Humphries-yes, Juracek-absent, Saunders-yes, Sobeski-absent, Thomsen-yes.

Motion Carried.

PHOSPHATE BINDERS

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

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

Votes as follows: Avery-yes, Baker-yes, Bleicher-yes, Bohac-yes, Caudill-yes, Davenport-yes, Dering-Anderson-yes, Dubé-yes, Elsasser-yes, Fornander-yes, Haberstich-yes, Hammond-yes, Humphries-yes, Juracek-absent, Saunders-yes, Sobeski-absent, Thomsen-yes.

Motion Carried.

PLATELET AGGREGATION INHIBITORS

PREFERRED DRUGS	NON-PREFERRED DRUGS	PDL EXCEPTION CRITERIA:
AGGRENOX (aspirin dipyridamole) aspirin BRILINTA (ticagrelor) clopidogrel (generic for Plavix) dipyridamole (generic for Persantine) EFFIENT (prasugrel)	aspirin dipyridamole (generic for Aggrenox) DURLAZA (aspirin) 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.

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

Votes as follows: Avery-yes, Baker-yes, Bleicher-yes, Bohac-yes, Caudill-yes, Davenport-yes, Dering-Anderson-yes, Dubé-yes, Elsasser-yes, Fornander-yes, Haberstich-yes, Hammond-yes, Humphries-yes, Juracek-absent, Saunders-yes, Sobeski-absent, Thomsen-yes.

Motion Carried.

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)	demeclocycline* DORYX (doxycycline pelletized) doxycycline hyclate DR (generic for Vibratabs) doxycycline monohydrate **TABLET, SUSPENSION, 75MG and 150MG CAPSULES** (Monodox, Adoxa) 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) tetracycline HCl (generic for Sumycin) VIBRAMYCIN SUSPENSION (doxycycline)	1. Adverse reaction to, allergy, or contraindication to preferred drugs. *or* 2. Documentation of treatment failure with two preferred drugs. **Demeclocycline:** Treatment of Syndrome of Inappropriate Antidiuretic Hormone (SIADH)

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

Votes as follows: Avery-yes, Baker-yes, Bleicher-yes, Bohac-yes, Caudill-yes, Davenport-yes, Dering-Anderson-yes, Dubé-yes, Elsasser-yes, Fornander-yes, Haberstich-yes, Hammond-yes, Humphries-yes, Juracek-absent, Saunders-yes, Sobeski-absent, Thomsen-yes.

Motion Carried.

XII. Other Business:

An all in favor motion was made to conclude the meeting at 2:24 p.m.
The next meeting of the Nebraska Medicaid Pharmaceutical and Therapeutics Committee is scheduled:
Wednesday November 2, 2016 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.

Minutes approved by P&T Committee on November 2, 2016.

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