DIVISION OF MEDICAID AND LONG-TERM CARE
Nebraska DHHS

PHARMACEUTICAL AND THERAPEUTICS COMMITTEE MEETING MINUTES
May 10, 2017 at 9 a.m., CST
Mahoney State Park, Peter Kiewit Lodge
Ashland, NE

Members Present
Eric Avery, M.D.
Claire Baker, M.D. (Co-Chair)
Stacie Bleicher, M.D.
Kristie Bohac, M.D.
Yvonne Davenport, M.D.
Allison Dering-Anderson, Pharm.D.
Gary Elsasser, Pharm.D
Wade Fornander, M.D.
Jeff Gotschall, M.D
Nancy Haberstich, R.N., M.S.
Laurie Humphries, M.D.
Joyce Juracek, Pharm.D.
Jessica Pohl, Pharm.D. (New Member)
Ken Saunders, Pharm.D.
Linda Sobeski, Pharm.D.
Eric Thomsen, M.D.

DHHS Staff
Jenny Minchow, Pharm.D.
Shelly Nickerson, Pharm.D.
Nicole Mattson
Lisa White, M.D

Magellan Rx Management
Contract Staff
Jessica Czechowski, Pharm. D., R.P., B.S.
Valarie Simmons, M.S

MCO Staff
Kevin Peterson, Nebraska Total Care, Inc.
Bernadette Ueda, United Healthcare
Shannon Nelson, Wellcare

Absent
Chris Caudill, M.D. (excused)

I. Call to Order: Co-Chair, Claire Baker, called the meeting to order at 9:00am. The agenda was posted on the Nebraska Medicaid Pharmacy MMA website on April 21, 2017. A copy of the Open Meetings Act and materials distributed to members were on display.

II. Introduction of new Committee Member, Jessica Pohl, Pharm.D. James Dube' and Chris Sorensen have resigned from the Committee.

III. Roll Call: see list above

IV. Conflict of Interest: No new conflicts of interest were reported.

V. Approval of November 2, 2016 Minutes. Motion was made by Thomsen and seconded by Davenport. Votes as follows: Avery-yes, Bleicher-yes, Bohac-yes, Davenport-yes, Dering-Anderson-yes, Elsasser-yes, Fornander-yes, Gotschall-yes, Haberstich-yes, Hammond-yes, Humphries-yes, Juracek-yes, Pohl-yes, Saunders-yes, Sobeski-yes, Thomsen-yes.

VI. Department information:

i. Heritage Health:
1. In January 2017 the Pharmacy benefit was carved into managed care. There are three MCOs, Nebraska Total Care, UnitedHeallthcare Community Plan of Nebraska and Wellcare of Nebraska. Each plan has approximately 75,000 individuals enrolled. Multiple provider calls were conducted to allow providers to ask questions of the plans. The plans will follow the Nebraska State PDL. The P&T Committee will continue to function as before, except that each MCO will have a non-voting P&T Committee member to attend the Pharmaceutical and Therapeutics Committee meetings.

VII. Public Testimony

No Changes Recommended:

DRUG CLASS	Drug Name	PDL Status	Speaker Name	Affiliation
ANTICOAGULANTS	Eliquis	P	Nancy Bell	Pfizer
ANTICOAGULANTS	Pradaxa	P	Julie McDavitt	Boehringer Ingelheim
ANTICOAGULANTS	Xarelto	P	Jennifer Stoffel	Janssen
PANCREATIC ENZYMES	Pertyze	NP	Nancy Bell	Pfizer

Classes with changes:

DRUG CLASS	Drug Name	PDL Status	Speaker Name	Affiliation
ANALGESICS, OPIOID	Oxycontin	P	Amarita Randhawa	Purdue
ANALGESICS, OPIOID	Embeda	NP	Nancy Bell	Pfizer
HYPOGLYCEMICS	Tresiba/Victoza/Xultophy	NP	Ryan Flugge	Novo Nordisk, Inc.
HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS	Glyxambi	NP	Julie McDavitt	Boehringer Ingelheim
HYPOGLYCEMICS, SGLT2	Jardiance/Synjardy	NP	Julie McDavitt	Boehringer Ingelheim
LIPOTROPICS, OTHER	Repatha	NP	Amanda Champ	Amgen
MULTIPLE SCLEROSIS DRUGS	Zinbryta	NP	Nikki Moon	AbbVie

VIII. A motion to move into closed session was made and seconded. Moved into closed session at 10:15am. Roll call vote was taken and the motion passed:

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

Motion Carried.

Co-Chair, Claire Baker, restated the reason for closed session, which is (a): “Strategy session with respect to collective bargaining”.
Cost issues discussed in Closed Session.

IX. A motion was made by Avery and seconded by Bleicher, and unanimously passed to move back into open session at 11:15am.

X. Consent Agenda (Therapeutic Categories with Unchanged Recommendations):

A motion was made by Thomsen and seconded by Juracek to move Anticoagulants to the General Session, Therapeutic Class Review section. Another motion was made by Gotschall and seconded by Davenport to move Proton Pump Inhibitors to the General Session, Therapeutic Class Review section.

ANDROGENIC DRUGS (Topical)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ANDROGEL (testosterone)	ANDRODERM (testosterone) AXIRON (testosterone) NATESTO (testosterone) testosterone gel **PACKET, PUMP** (generic for Androgel) testosterone (generic for Fortesta) testosterone (generics for Testim) testosterone (generic for Vogelxo)	▪ Non-preferred agents will be approved for patients who have failed ONE preferred agent within the last 6 months Drug-specific criteria: ▪ **Natesto®:** Approved for diagnosis of: Primary hypogonadism (congenital or acquired) OR Hypogonadotropic hypogonadism (congenital or acquired)

ANTIBIOITICS, GASTROINTESTINAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class 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)	▪ Note: Although azithromycin, ciprofloxacin, and trimethoprim/ sulfmethoxazole are not included in this review, they are available without prior authorization Drug-specific criteria: ▪ **Alinia®:** Trial and failure with metronidazole is required for a diagnosis of giardiasis ▪ **Dificid®:** Trial and failure with oral vancomycin OR metronidazole is required for a diagnosis of C. difficile diarrhea (pseudomembranous colitis) ▪ **Flagyl ER®:** Trial and failure with metronidazole is required ▪ **Flagyl®/Metronidazole 375mg capsules and Flagyl ER®/ Metronidazole 750mg ER tabs:** Clinical reason why the generic regular-release cannot be used ▪ **Tinidazole:** Trial and failure/ contraindication to metronidazole required Approvable diagnoses include: Giardia Amebiasis intestinal or liver abscess Bacterial vaginosis or trichomoniasis ▪ **Vancomycin capsules:** Trial and failure with metronidazole Trial may be bypassed if initial or recurrent episode of SEVERE C. difficile colitis SEVERE C. difficile colitis: Leukocytosis w/WBC ≥ 15,000 cells/microliter, OR Serum creatinine ≥ 1.5 times premorbid level Provider to provide labs for documentation ▪ **Xifaxan®:** Approvable diagnoses include: Travelers diarrhea resistant to quinolones Hepatic encephalopathy with treatment failure of lactulose or neomcin Diarrhea-Predominant IBS (IBS-D) 550mg strength only with treatment failure of Lomotil® AND Imodium®

ANTIBIOTICS, INHALED

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
BETHKIS (tobramycin)[CL] KITABIS PAK (tobramycin)[CL] TOBI-PODHALER (tobramycin)[CL]	CAYSTON (aztreonam lysine)[CL] tobramycin (generic for TOBI)[CL]	▪ Diagnosis of Cystic Fibrosis is required for all agents ICD10 Group = E84, ICD9 = 277.00, 277.01, 277.02, 277.03, 277.09 Drug-specific criteria: ▪ **Tobi Podhaler®:** Requires trial on inhaled solution or documentation why solution cannot be used ▪ **Cayston®:** Trial of tobramycin via nebulizer and demonstration of TOBI® compliance required

ANTIBIOTICS, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
bacitracin ointment bacitracin/polymyxin (generic for Polysporin) mupirocin OINTMENT (generic for Bactroban) neomycin/polymyxin/bacitracin (generic for Neosporin, Triple AB) neomycin/polymyxin/pramoxine	ALTABAX (retapamulin) CENTANY (mupirocin ointment) gentamicin OINTMENT, CREAM mupirocin CREAM (generic for Bactroban)	▪ Non-preferred agents will be approved for patients who have failed ALL preferred agents within the last 12 months Drug-specific criteria: ▪ **Altabax®:** Approvable diagnoses of impetigo due to *S. Aureus* OR *S. pyogenes* with clinical reason mupirocin ointment cannot be used ▪ **Mupirocin® Cream:** Clinical reason the ointment cannot be used

ANTIEMETICS/ANTIVERTIGO AGENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CANNABINOIDS		▪ Non-preferred agents will be approved for patients who have failed ONE preferred agents within the same group Drug-specific criteria: ▪ **Akynzeo®/Emend®/Varubi®:** Approved for Moderately/Highly emetogenic chemotherapy with dexamethasone and a 5-HT3 antagonist WITHOUT trial of preferred agents Regimens include: AC combination (Doxorubicin or Epirubicin with Cyclophosphamide), Aldesleukin, Amifostine, Arsenic trioxide, Azacitidine, Bendamustine, Busulfan, Carmustine, Carbplatin, Cisplatin, Clofarabine, Cyclophosphamide, Cytarabine, Dacarbazine, Dactinomycin, Daunorubicin, Epirubicin, Etoposide, Hexamethylmelamine, Idarubicin, Ifosfamide, Imatinib, Interferon α, Irinotecan, Mechlorethamine, Melphalan, Methotrexate, Oxaliplatin, Procarbazine, Streptozotocin, Temozolomide. ▪ **Diclegis®:** Approved only for treatment of nausea and vomiting of pregnancy ▪ **Metozolv ODT®:** Documentation of inability to swallow or Clinical reason oral liquid cannot be used ▪ **Sancuso®/Zuplenz®:** Documentation of oral dosage form intolerance
dronabinol (generic for Marinol)[AL]	CESAMET (nabilone)	
5HT3 RECEPTOR BLOCKERS		
ondansetron (generic for Zofran)[QL] ondansetron ODT (generic for Zofran)[QL]	ANZEMET (dolasetron) granisetron (generic for Kytril) SANCUSO (granisetron)[CL] ZUPLENZ (ondansetron)	
NK-1 RECEPTOR ANTAGONIST		
	aprepitant[QL, CL] (generic for Emend) AKYNZEO (netupitant/palonosetron)[CL] VARUBI(rolapitant)[CL]	
TRADITIONAL ANTIEMETICS		
DICLEGIS (doxylamine/pyridoxine)[CL] 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)	

ANTIPARASITICS, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class 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, LOTION** lindane malathion (generic for Ovide) spinosad (generic for Natroba)	▪ Non-preferred agents will be approved for patients who have failed a trial with ONE preferred agent

ANTIVIRALS, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	acyclovir **OINTMENT** (generic for Zovirax) DENAVIR (penciclovir) XERESE (acyclovir/hydrocortisone) ZOVIRAX **CREAM** (acyclovir)	▪ Non-preferred agents will be approved for patients who have failed a trial with ONE preferred ORAL agent

BETA BLOCKERS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
BETA BLOCKERS		▪ Non-preferred agents will be approved for patients who have failed TWO preferred agents within the last 12 months Drug-specific criteria: ▪ **Bystolic®:** Only ONE trial is required with Diagnosis of Obstructive Lung Disease ▪ **Coreg CR®:** Requires clinical reason generic IR product cannot be used ▪ **Hemangeol®:** Covered for diagnosis of Proliferating Infantile Hemangioma ▪ **Sotylize®:** Covered for diagnosis of life –threatening ventricular arrhythmias OR maintenance of normal sinus rhythm in highly symptomatic atrial fibrillation/flutter (AFIB/AFL) Requires clinical reason generic sotalol cannot be used
atenolol (generic for Tenormin)	acebutolol (generic for Sectral)	
atenolol/chlorthalidone(generic for Tenoretic)	betaxolol (generic for Kerlone)	
bisoprolol/HCTZ (generic for Ziac)	bisoprolol (generic for Zebeta)	
metoprolol (generic for Lopressor)	BYSTOLIC (nebivolol)	
metoprolol XL (generic for Toprol XL)	DUTOPROL (metoprolol XR and HCTZ)	
propranolol (generic for Inderal)	HEMANGEOL (propranolol) oral solution	
propranolol extended release (Inderal LA)	INDERAL XL (propranolol)	
	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 (generic for Inderide)	
	timolol (generic for Blocadren)	
	TOPROL XL (metoprolol)	
BETA- AND ALPHA-BLOCKERS		
carvedilol (generic for Coreg)	COREG CR (carvedilol)	
labetalol (generic for Trandate)		
ANTIARRHYTHMIC		
sotalol (generic for Betapace)	SOTYLIZE (sotalol)	

BLADDER RELAXANT PREPARATIONS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
oxybutynin (generic for Ditropan) oxybutynin ER (generic for Ditropan XL) TOVIAZ (fesoterodine ER) VESICARE (solifenacin)	darifenacin ER (generic for Enablex) 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)	▪ Non-preferred agents will be approved for patients who have failed a trial with ONE preferred agent Drug-specific criteria: ▪ **Myrbetriq®:** Covered without trial in contraindication to anticholinergic agents

BONE RESORPTION SUPRESSION AND RELATED DRUGS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
BISPHOSPHONATES		▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within the same group Drug-specific criteria: ▪ **Actonel® Combinations:** Covered as individual agents without prior authorization ▪ **Atelvia DR®:** Requires clinical reason alendronate cannot be taken on an empty stomach ▪ **Binosto®:** Requires clinical reason why alendronate tablets OR Fosamax® solution cannot be used ▪ **Etidronate disodium:** Trial not required for diagnosis of hetertrophic ossification ▪ **Forteo®:** Covered for high risk of fracture High risk of fracture: BMD -3 or worse Postmenopausal women with history of non-traumatic fractures Postmenopausal women with 2 or more clinical risk factors – Family history of non-traumatic fractures, DXA BMD T-score ≤ -2.5 at any site, Glucocorticoid use ≥ 6 months at 7.5 dose of prednisolone equivalent, Rheumatoid Arthritis Postmenopausal women with BMD T-score ≤ -2.5 at any site with any clinical risk factors – more than 2 units of alcohol per day, current smoker Men with primary or hypogonadal osteoporosis Osteoporosis associated with sustained systemic glucocorticoid therapy Trial of Miacalcin not required
alendronate (generic for Fosamax) (daily and weekly formulations)	alendronate **SOLUTION** (generic for Fosamax oral solution)[QL] ATELVIA DR (risedronate) BINOSTO (alendronate effervescent) etidronate disodium (generic for Didronel) FOSAMAX PLUS D[QL] ibandronate (generic for Boniva)[QL] risedronate (generic for Actonel)[QL]	
OTHER BONE RESORPTION SUPPRESSION AND RELATED DRUGS		
calcitonin-salmon **NASAL** raloxifene (generic for Evista)	EVISTA (raloxifene) FORTEO (teriparatide) **SUBCUTANEOUS**[QL] FORTICAL (calcitonin) **NASAL**	

BENIGN PROSTATIC HYPERPLASIA (BPH) TREATMENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ALPHA BLOCKERS		▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within the same group Drug-specific criteria: ▪ **Avodart®:** Covered for males only ▪ **Cardura XL®:** Requires clinical reason generic IR form cannot be used ▪ **Flomax®:** Covered for males only Females covered for a 7 day supply with diagnosis of acute kidney stones ▪ **Jalyn®:** Requires clinical reason why individual agents cannot be used ▪ **Proscar®:** Covered for males only ▪ **Uroxatral®:** Covered for males only
alfuzosin (generic for Uroxatral) doxazosin (generic for Cardura) tamsulosin (generic for Flomax) terazosin (generic for Hytrin)	CARDURA XL (doxazosin) RAPAFLO (silodosin) UROXATRAL (alfuzosin)	
5-ALPHA-REDUCTASE (5AR) INHIBITORS		
dutasteride (generic for Avodart) finasteride (generic for Proscar)	dutasteride/tamsulosin (generic for Jalyn)	

FLUOROQUINOLONES, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ciprofloxacin (generic for Cipro) levofloxacin **TABLET** (generic for Levaquin)	ciprofloxacin ER ciprofloxacin **SUSPENSION** (generic for Cipro Suspension) levofloxacin **ORAL SOLUTION** moxifloxacin (generic for Avelox) ofloxacin	▪ Non-preferred agents will be approved for patients who have failed a 3-day trial of ONE preferred agent Drug-specific criteria: ▪ **Ciprofloxacin Suspension:** Coverable with documented swallowing disorders ▪ **Levofloxacin Suspension:** Coverable with documented swallowing disorders ▪ **Ofloxacin:** Trial of preferred not required for diagnoses of Pelvic Inflammatory Disease OR Acute Epididymitis (non-gonorrhea)

H. PYLORI TREATMENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
PYLERA (bismuth, metronidazole, tetracycline)QL	lansoprazole/amoxicillin/clarithromycin (generic for Prevpac)QL OMECLAMOX-PAK (omeprazole, clarithromycin, amoxicillin)QL	▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent

HYPOGLYCEMICS, MEGLITINIDES

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
repaglinide (generic for Prandin)	nateglinide (generic for Starlix) repaglinide/metformin (generic for Prandimet)	▪ Non-preferred agents will be approved for patients with: Failure of a trial of ONE preferred agent in another class OR T2DM and inadequate glycemic control

HYPOGLYCEMICS, METFORMINS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
glipizide/metformin glyburide/metformin (generic for Glucovance) metformin (generic for Glucophage) metformin ER (generic for Glucophage XR)	metformin ER (generic for Fortamet) metformin ER (generic for Glumetza) RIOMET (metformin oral solution)	▪ **Metformin ER (generic Fortamet®)/Glumetza®:** Requires clinical reason why generic Glucophage XR® cannot be used ▪ **Riomet®:** Prior authorization not required for age <7 years

HYPOGLYCEMICS, SULFONYLUREAS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class 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	▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent

HYPOGLYCEMICS, TZD

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
THIZAOLIDINEDIONES (TZDs)		▪ Non-preferred agents will be approved for patients who have failed a trial of THE preferred agent ▪ **Combination products:** Require clinical reason why individual ingredients cannot be used
pioglitazone (generic for Actos)	AVANDIA (rosiglitazone)	
TZD COMBINATIONS		
	ACTOPLUS MET XR (pioglitazone/metformin) pioglitazone/glimepiride (generic for Duetact) pioglitazone/metformin (generic for Actoplus Met)	

OPIATE DEPENDENCE TREATMENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
SUBOXONE **FILM** (buprenorphine/ naloxone)[CL]	BUNAVAIL (buprenorphine/naloxone) buprenorphine **SL** buprenorphine/naloxone **SL** ZUBSOLV (buprenorphine/naloxone)	Buprenorphine PA Form Buprenorphine Informed Consent ▪ Non-preferred agents will be approved for patients who have failed a trial of THE preferred agent ▪ Approved for diagnosis of Opioid Use Disorder ▪ NO coverage for pain management *Drug-specific criteria:* ▪ ***buprenorphine:*** *Must provide documentation why combination product is not appropriate*

PAH AGENTS, ORAL AND INHALED

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ADCIRCA (tadalafil) (for PAH only)[CL] LETAIRIS (ambrisentan) sildenafil (generic for Revatio) (for PAH only)[CL] TRACLEER (bosentan) TYVASO INHALATION (treprostinil) VENTAVIS INHALATION (iloprost)	ADEMPAS (riociguat) OPSUMIT (macitentan) ORENITRAM ER (treprostinil) REVATIO **SUSPENSION** (for PAH only) UPTRAVI (selexipag)	▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within the last 6 months Drug-specific criteria: ▪ **Adcirca®/Revatio®:** Approved for diagnosis of Pulmonary Arterial Hypertension (PAH) ▪ **Adempas®:** PAH: Requires clinical reason preferred agent cannot be used CTEPH: Approved for persistent/recurrent diagnosis after surgical treatment or inoperable CTEPH NOT for use in Pregnancy ▪ **Revatio® suspension:** Requires clinical reason why sildenafil tablets cannot be used

PANCREATIC ENZYMES

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CREON (pancrelipase) ZENPEP (pancrelipase)	PANCREAZE (pancrelipase) PERTZYE (pancrelipase) VIOKACE (pancrelipase)	▪ Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents

PENICLLINS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
amoxicillin **CHEWABLE TABLET, CAPSULE, SUSP, TABLET** ampicillin **CAPSULE, SUSP** dicloxacillin penicillin VK	amoxicillin ER **TABLET** MOXATAG (amoxicillin)	▪ Non-preferred agents will be approved for patients who have failed a 3-day trial of ONE preferred agent

PHOSPHATE BINDERS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
calcium acetate **TABLET, CAPSULE** CALPHRON OTC (calcium acetate) PHOSLYRA (calcium acetate) RENAGEL (sevelamer HCl)	AURYXIA (ferric citrate) ELIPHOS (calcium acetate) FOSRENOL (lanthanum) PHOSLO (calcium acetate) RENVELA (sevelamer carbonate) VELPHORO (sucroferric oxyhydroxide)	▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within the last 6 months

SKELETAL MUSCLE RELAXANTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
baclofen (generic for Lioresal) chlorzoxazone (generic for Parafon) cyclobenzaprine (generic for Flexeril) methocarbamol (generic for Robaxin) tizanidine **TABLET** (generic for Zanaflex)	AMRIX (cyclobenzaprine)[CL] carisoprodol (generic for Soma) carisoprodol compound dantrolene (generic for Dantrium) FEXMID (cyclobenzaprine) LORZONE (chlorzoxazone)[CL] metaxalone (generic for Skelaxin) orphenadrine ER SOMA (carisoprodol) [CL] tizanidine **CAPSULE** ZANAFLEX (tizanidine) **CAPSULE, TABLET**	▪ Non-preferred agents will be approved for patients who have failed a 1-week trial of TWO preferred agents Drug-specific criteria: ▪ **Amrix®/Fexmid®:** Requires clinical reason why IR cyclobenzaprine cannot be used Approved only for acute muscle spasms NOT approved for chronic use ▪ **Carisoprodol:** Approved for Acute, musculoskeletal pain - NOT for chronic pain Use is limited to no more than 30 days Additional authorizations will not be granted for at least 6 months following the last day of previous course of therapy ▪ **Dantrolene:** Trial NOT required for treatment of spasticity from spinal cord injury ▪ **Lorzone®:** Requires clinical reason why chlorzoxazone cannot be used ▪ **Soma® 250mg:** Requires clinical reason why 350mg generic strength cannot be used ▪ **Zanaflex® Capsules:** Requires clinical reason generic cannot be used

TETRACYCLINES

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
doxycycline hyclate IR (generic for Vibramycin) doxycycline monohydrate **50MG, 100MG CAPSULE** minocycline HCl **CAPSULE** (generic for Minocin, Dynacin)	*ACTICLATE[NR] (doxycycline hyclate)* demeclocycline[CL] DORYX (doxycycline pelletized) doxycycline hyclate DR (generic for Vibratabs) doxycycline monohydrate **TABLET, SUSPENSION,40mg, 75MG and 150MG CAPSULES** (Monodox, Adoxa) doxycycline monohydrate (generic for Oracea) minocycline HCl **TABLET** (generic for Dynacin, Murac) minocycline HCl ER (generic for Solodyn) SOLODYN (minocycline HCl) tetracycline HCl (generic for Sumycin) VIBRAMYCIN **SUSPENSION** (doxycycline)	▪ Non-preferred agents will be approved for patients who have failed an 3-day trial of TWO preferred agents Drug-specific criteria: ▪ **Demeclocycline:** Approved for diagnosis of SIADH ▪ **Doryx®/doxycycline hyclate DR/ Dynacin®/Oracea®/Solodyn®:** Requires clinical reason why generic doxycycline, minocycline or tetracycline cannot be used ▪ **Vibramycin® suspension:** May be approved with documented swallowing difficulty

ULCERATIVE COLITIS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ORAL		▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent Drug-specific criteria: ▪ **Asacol HD®/Delzicol DR®/ Lialda®/Pentasa®:** Requires clinical reason why preferred mesalamine products cannot be used ▪ **Giazo®:** Requires clinical reason why generic balsalazide cannot be used FDA approved for use in males
APRISO (mesalamine) balsalazide (generic for Colazal) sulfasalazine / DR (generic for Azulfidine)	mesalamine 800mg (generic for Asacol HD) DELZICOL DR (mesalamine) DIPENTUM (olsalazine) GIAZO (balsalazide) LIALDA (mesalamine) PENTASA (mesalamine) UCERIS **ORAL** (budesonide)	
RECTAL		
CANASA (mesalamine)	mesalamine sf ROWASA (mesalamine) UCERIC **RECTAL** (budesonide)	

A motion was moved and seconded to accept recommendations as published for the Therapeutic Classes on the Consent Agenda, with the move of Anticoagulants and Protein Pump Inhibitors to the General Session, Therapeutic Class Review section. Roll Call vote was taken and the motion passed.

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

Motion Carried.

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

ACNE AGENTS, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
AZELEX (azelaic acid) BENZACLIN **W/PUMP** (clindamycin/benzoyl peroxide) benzoxyl peroxide **GEL, CREAM, WASH, LOTION** OTC clindamcyin phosphate **SOLUTION** DIFFERIN **LOTION, CREAM, GEL** (adapalene) erythromycin SOLUTION PANOXYL (benzoyl peroxide) OTC RETIN-A **GEL, CREAM**[AL]	ACANYA (clindamycin and benzoyl peroxide) ACZONE (dapsone) adapalene **CREAM, GEL, GEL W/PUMP** (generic Differin) ATRALIN (tretinoin) AVITA (tretinoin) BENZACLIN **GEL** (clindamycin/ benzoyl peroxide) BENZAPRO (benzoyl peroxide) benzoyl peroxide **FOAM** (generic for Benzepro Foam) benzoyl peroxide **GEL Rx** *clindamycin* **GEL, FOAM, *LOTION*** clindamycin/benzoyl peroxide (generic for Benzaclin) *clindamycin/benzoyl peroxide (generic for Duac)* clindamycin/tretinoin (generic for Veltin) clindamycin/tretinoin (generic for Ziana) EPIDUO (adapalene/benzoyl peroxide) EPIDUO FORTE GEL W/PUMP erythromycin **GEL** erythromycin-benzoyl peroxide (generic for Benzamycin) EVOCLIN (clindamycin) FABIOR (tazarotene foam) *ONEXTON (clindamycin/benzoyl peroxide)* RETIN-A MICRO (tretinoin microspheres) [AL] sulfacetamide sulfacetamide/sulfur SUMADAN (sulfacetamide/sulfur) tazarotene (generic for Tazorac) tretinoin **CREAM, GEL**[AL] tretinoin microspheres (generic for Retin-A Micro) [AL]	▪ Non-preferred agents will be approved for patients who have failed THREE preferred agents

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

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

Motion Carried.

ANALGESICS, OPIATE LONG-ACTING[QL]

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
BUTRANS (buprenorphine, transdermal) fentanyl patches 25, 50, 75, 100 mcg HYSINGLA ER (hydrocodone, extended release) morphine ER **TABLET** (generic for MS Contin, Oramorph SR) OXYCONTIN (oxycodone ER)	*ARYMO ER (morphine sulfate ER)*[QL] BELBUCA (buprenorphine, buccal)[CL] DURAGESIC MATRIX (fentanyl) EMBEDA (morphine sulfate+naltrexone) fentanyl 37.5, 62.5, 87.5 mcg (transdermal)[CL] hydromorphone ER (generic for Exalgo)[CL] *KADIAN (morphine ER capsule)* methadone [CL] morphine ER **CAPSULE** (generic for Avinza, Kadian) NUCYNTA ER (tapentadol)[CL] oxycodone ER (generic for re-formulated Oxycontin) oxymorphone ER (generic for OPANA ER) tramadol extended release (generic for ULTRAM ER)[CL] tramadol extended release (generic for CONZIP)[CL] *XTAMPZA ER (oxycodone myristate)*[QL] ZOHYDRO ER (hydrocodone bitartrate ER)	▪ Non-preferred agents will be approved for patients who have failed no less than 30-day trial of TWO preferred agents within the last 6 months Drug-specific criteria: ▪ **Exalgo®/Exalgo ER®:** Clinical reason why IR hydromorphone can't be used ▪ **Methadone:** Trial of preferred drug not required for end of life care ▪ **Oxycodone ER®:** Pain contract required for maximum quantity authorization ▪ **Tramadol ER:** Clinical reason why IR tramadol can't be used ▪ **Zohydro ER®:** Clinical reason why IR hydrocodone can't be used

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

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

Motion Carried.

ANALGESICS, OPIATE SHORT-ACTING[QL]

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ORAL		▪ Non-preferred agents will be approved for patients who have failed THREE preferred agents within the last 12 months ▪ *Note: for short acting opiate tablets and capsules there is a maximum quantity limit of #150 per 30 days.* Drug-specific criteria: ▪ **Abstral®/Actiq®/Fentora®/ Onsolis®/ Subsys® (fentanyl):** Approved only for diagnosis of cancer AND current use of long-acting opiate ▪ **Nucynta®:** Approved only for diagnosis of acute pain, for 30 days or less ▪ **Tramadol/APAP:** Clinical reason why individual ingredients can't be used ▪ **Xartemis XR®:** Approved only for diagnosis of acute pain
acetaminophen/codeine **ELIXIR, TABLET** codeine **ORAL** hydrocodone/APAP **SOLUTION, TABLET** hydrocodone/ibuprofen hydromorphone **TABLETS** morphine **ORAL** oxycodone **TABLET, SOLUTION** oxycodone/APAP tramadol	dihydrocodeine/APAP/caffeine dihydrocodeine/aspirin/caffeine (generic for Synalgos DC) hydromorphone **ORAL LIQUID, SUPPOSITORIES** (generic for Dilaudid) IBUDONE (hydrocodone/ibuprofen) levorphanol meperidine (generic for Demerol) morphine **SUPPOSITORIES** NUCYNTA (tapentadol)[CL] *OXAYDO (oxycodone)[CL,NR]* oxycodone **CAPSULE** *oxycodone/APAP **SOLUTION*** oxycodone/aspirin oxycodone CONCENTRATE oxycodone/ibuprofen (generic for Combunox) oxymorphone (generic for Opana) pentazocine/naloxone PRIMLEV (oxycodone/acetaminophen) REPREXAIN (hydrocodone/ibuprofen) ROXICODONE **TABLET** (oxycodone) tramadol/APAP –generic for Ultracet *TREZIX (dihydrocodeine/ APAP/caffeine)[NR]* XARTEMIS XR (oxycodone/ acetaminophen) ZAMICET (hydrocodone/ acetaminophen)	
NASAL		
	butorphanol nasal spray[QL] *LAZANDA (fentanyl citrate)*	
BUCCAL/TRANSMUCOSAL		
	ABSTRAL (fentanyl transmucosal)[CL] fentanyl transmucosal (generic for Actiq)[CL] FENTORA (fentanyl)[CL] SUBSYS (fentanyl spray)[CL]	

A motion was made by Avery and seconded by Elsasser to accept recommendations as published. Humphries requested reporting on the impact of limiting short acting opioids to #150 tablets or capsules per month. Roll Call vote was taken and the motion passed.

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

Motion Carried.

ANGIOTENSIN MODULATORS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ACE INHIBITORS		▪ Non-preferred agents will be approved for patients who have failed TWO preferred agents within the last 12 months ▪ Non-preferred combination products may be covered as individual prescriptions without prior authorization Drug-specific criteria: ▪ **Epaned®** ***and Qbrelis®*** **Oral Solution:** Clinical reason why oral tablet or compounded product is not apropriate
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) *QBRELIS (lisinopril)* ***SOLUTION*** trandolapril (generic for Mavik)	
ACE INHIBITOR/DIURETIC COMBINATIONS		
benazepril/HCTZ (generic for Lotensin HCT) enalapril/HCTZ (generic for Vaseretic) lisinopril/HCTZ (generic for 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)	candesartan (generic for Atacand) EDARBI (azilsartan medoxomil) EDARBYCLOR (azilsartan/ chlorthalidone) eprosartan (generic for Teveten) olmesartan (generic for Benicar) telmisartan (generic for Micardis)	

ANGIOTENSIN MODULATORS (Continued)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ANGIOTENSIN RECEPTOR BLOCKER/DIURETIC COMBINATIONS		▪ Non-preferred agents will be approved for patients who have failed TWO preferred agents within the last 12 months ▪ Non-preferred combination products may be covered as individual prescriptions without prior authorization
irbesartan/HCTZ (generic for Avalide) losartan/HCTZ (generic for Hyzaar) valsartan-HCTZ (generic for Diovan-HCT)	candesartan/HCTZ (generic for Atacand-HCT) olmesartan/HCTZ (generic for Benicar-HCT) telmisartan/HCTZ (generic for Micardis-HCT)	
ANGIOTENSIN MODULATOR/ CALCIUM CHANNEL BLOCKER COMBINATIONS		▪ **Angiotensin Modulator/Calcium Channel Blocker Combinations**: Combination agents may be approved if there has been a trial and failure with both preferred agents ▪ **Direct Renin Inhibitors/Direct Renin Inhibitor Combinations:** May be approved witha history of TWO preferred ACE Inhibitors or Angiotensin Receptor Blockers within the last 12 months
benazepril/amlodipine (generic for Lotrel)	amlodipine/olmesartan/HCTZ (generic for Tribenzor) PRESTALIA (perindopril/amlodipine) TEKAMLO (aliskiren/amlodipine) olmesartan/amlodipine (generic for Azor) telmisartan/amlodipine (generic for Twynsta) trandolapril/verapamil (generic for Tarka) valsartan/amlodipine (generic for Exforge) valsartan/amlodipine/HCTZ (generic for Exforge HCT)	
DIRECT RENIN INHIBITORS		
	TEKTURNA (aliskiren)	
DIRECT RENIN INHIBITOR COMBINATIONS		
	TEKTURNA/HCT (aliskiren/HCTZ)	
NEPRILYSIN INHIBITOR COMBINATION		▪ **Entresto®:** Approved only for NYHA Class II-IV Heart Failure with reduced ejection fraction **Does NOT require class criteria**
ENTRESTO (sacubitril/valsartan)[CL]		
ANGIOTENSIN RECEPTOR BLOCKER/BETA-BLOCKER COMBINATIONS		
	BYVALSON (nevibolol/valsartan)	▪ ***BYVALSON®**: approved for treatment of hypertension in those patients not adequately controlled on valsartan 80mg or nebivolol up to 10mg.*

A motion was made by Thomsen and seconded by Avery to accept recommendations as published. Roll Call vote was taken and the motion passed.

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

Motion Carried.

ANTIBIOTICS, VAGINAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CLEOCIN OVULES (clindamycin, vaginal suppositories) clindamycin (vaginal) (generic for Cleocin) *CLINDESSE (clindamycin, vaginal)* metronidazole (vaginal)	METROGEL (metronidazole, vaginal) NUVESSA (metronidazole, vaginal) VANDAZOLE (metronidazole, vaginal)	▪ Non-preferred agents will be approved for patients who have failed a therapeutic trial (duration = 3 days) with ONE preferred agent within the last 6 months

A motion was made by Juracek and seconded by Fornander to accept recommendations as published. Roll Call vote was taken and the motion passed.

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

Motion Carried.

ANTICOAGULANTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ELIQUIS (apixaban) enoxaparin (generic for Lovenox) PRADAXA (dabigatran) warfarin (generic for Coumadin) XARELTO (rivaroxaban)^{QL}	fondaparinux (generic for Arixtra) FRAGMIN (dalteparin) SAVAYSA (edoxaban)^{QL}	▪ Non-preferred agents will be approved for patients who have failed ONE preferred agents within the last 12 months Drug-specific criteria: ▪ **Coumadin®:** Clinical reason generic warfarin cannot be used ▪ **Savaysa®:** Approved diagnoses include: Stroke and systemic embolism (SE) risk reduction in nonvalvular atrial fibrillation (NVAF) OR Treatment of deep vein thrombosis (DVT) and pulmonary embolism (PE) following 5-10 days of parenteral anticoagulent therapy

Avery made a motion to limit the number of preferred novel oral anticoagulants in order to encourage more competitive bidding. Discussion followed with no second.

A motion was made by Thomsen and seconded by Elsasser to accept recommendations as published. Roll Call vote was taken and the motion passed.

Votes as follows: Avery-abstained, Bleicher-yes, Bohac-yes, Davenport-yes, Dering-Anderson-yes, Elsasser-yes, Fornander-yes, Gotschall-yes, Haberstich-yes, Hammond-yes, Humphries-yes, Juracek-yes, Pohl-yes, Saunders-yes, Sobeski-yes, Thomsen-yes.

Motion Carried.

ANTIFUNGALS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
clotrimazole (mucous membrane, troche) fluconazole (generic for Diflucan) griseofulvin **SUSPENSION,** *griseofulvin microsized **TABLET*** nystatin **SUSPENSION, TABLET** terbinafine (generic for Lamisil)	CRESEMBA (isavuconazonium)[CL] flucytosine (generic for Ancobon)[CL] GRIFULVIN V (griseofulvin) *griseofulvin ultramicrosize (generic for GRIS-PEG)* itraconazole (generic for Sporanox)[CL] ketoconazole (generic for Nizoral) NOXAFIL (posaconazole)[CL,AL] nystatin **POWDER** oral ONMEL (itraconazole) ORAVIG (miconazole buccal) SPORANOX (itraconazole)[CL] voriconazole (generic for VFEND)[CL]	▪ Non-preferred agents will be approved for patients who have failed TWO diagnosis-appropriate preferred agents Drug-specific criteria: ▪ **Cresemba®:** Approved for diagnosis of invasive aspergillosis or invasive mucomycosis ▪ **Flucytosine:** Approved for diagnosis of: Candida: Septicemia, endocarditis, UTIs Cryptococcus: Meningitis, pulmonary infections ▪ **Noxafil®:** No trial for diagnosis of Neutropenia Myelodysplastic Syndrome (MDS), Neutropenic Acute Myeloid Leukemia (AML), Neutropenic hematologic malignancies, Graft vs. Host disease(GVHD), Immunosuppression secondary to hematopoietic stem cell transplant ▪ **Noxafil® Suspension:** Oropharyngeal/esophageal candidiasis refractory to itraconazole and/or fluconazole ▪ **Ommel®:** Requires trial and failure or contraindication to terbinafine ▪ **Sporanox®/Itraconazole:** Approved for diagnosis of Aspergillosis, Blastomycosis, Histoplasmosis, Onychomycosis due to terbinafine-resistant dermatophytes, Oropharyngeal/ esophageal candidiasis refractory to fluconazole ▪ **Sporanox®:** Requires trial and failure of generic itraconazole ▪ **Sporanox® Liquid:** Clinical reason oral cannot be used ▪ **Vfend®:** No trial for diagnosis of Myelodysplastic Syndrome (MDS), Neutropenic Acute Myeloid Leukemia (AML), Graft vs. Host disease (GVHD), Candidemia (candida krusei), Esophageal Candidiasis, Blastomycosis, *S. apiospermum* and *Fusarium spp.*, Oropharyngeal/esophageal candidiasis refractory to fluconazole

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

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

Motion Carried.

ANTIFUNGALS, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ANTIFUNGAL		▪ Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within the last 6 months Drug-specific criteria: ▪ **Extina®:** Requires trial and failure or contraindication to other ketoconazole forms ▪ **Julia®:** Approved diagnoses include Onychomycosis of the toenails due to *T. rubrum* OR *T. mentagrophytes* ▪ **Nystatin/Triamcinolone:** individual ingredients available without prior authorization ▪ **Penlac®:** No trial required in diabetes, peripheral vascular disease (PVD), immunocompromised OR contraindication to oral terbinafine
clotrimazole (generic for Lotrimin) RX, OTC	ALEVAZOL (clotrimazole) OTC	
ketoconazole **CREAM, SHAMPOO** (generic for Nizoral)	BENSAL HP (salicylic acid)	
LAMISIL AT **CREAM** (terbinafine) OTC	ciclopirox **CREAM, GEL SUSPENSION** (generic for Ciclodan, Loprox)	
miconazole OTC **CREAM, SPRAY, POWDER**	ciclopirox nail lacquer **SOLUTION** (generic for Penlac)	
nystatin	ciclopirox **SHAMPOO** (generic for Loprox)	
selenium sulfide 2.5%	clotrimazole **SOLUTION RX** (generic for Lotrimin)	
terbinafine OTC (generic for Lamisil AT)	DESENEX AERO **POWDER** OTC (miconazole)	
tolnaftate OTC (generic for Tinactin)	econazole (generic for Spectazole)	
	ERTACZO (sertaconazole)	
	EXELDERM (sulconazole)	
	EXTINA (ketoconazole)	
	FUNGOID OTC	
	JUBLIA (efinaconazole)	
	ketoconazole **FOAM** (generic for Ketodan)	
	*LAMISIL AT **GEL, SPRAY** (terbinafine) OTC*	
	*LOPROX (ciclopirox) **SUSPENSION***	
	LOTRIMIN AF **CREAM** OTC (clotrimazole)	
	LOTRIMUM ULTRA (bufenafine)	
	LUZU (luliconazole)	
	MENTAX (butenafine)	
	miconazole OTC **OINTMENT**	
	naftifine (generic for Naftin)	
	oxiconazole (generic for Oxistat)	
	selenium sulfide 2.25%	
	tolnaftate **POWDER** (generic for Tinactin Aero OTC)	
ANTIFUNGAL/STEROID COMBINATIONS		
clotrimazole/betamethasone **CREAM** (generic for Lotrisone)	clotrimazole/betamethasone **LOTION** (generic for Lotrisone)	
	nystatin/triamcinolone (generic for Mycolog)	

A motion was made by Gotschall and seconded by Davenport to accept recommendations as published. Roll Call vote was taken and the motion passed.

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

Motion Carried.

ANTIMIGRAINE AGENTS, OTHER

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	CAFERGOT (ergotamine/caffeine) CAMBIA (diclofenac potassium) dihydroergotamine mesylate **NASAL** *ERGOMAR **SUBLINGUAL*** *(ergotamine tartrate)* MIGERGOT (ergotamine/caffeine) **RECTAL** MIGRANAL (dihydroergotamine) **NASAL**	▪ Non-preferred agents will be approved for patients who have a contraindication OR trial failure of a triptan Drug-specific criteria: • ***Cambia®:*** *Requires diagnosis of migraine and documentation of why solid dosing forms not appropriate*

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

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

Motion Carried.

XI. A motion to move into closed session was made and seconded at 12:00 Unanimous approval.

XII. A motion to move into open session was made and seconded. Unanimous approval. Open session resumed at 1:15pm.

ANTIMIGRAINE AGENTS, TRIPTANS[QL]

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
		▪ Non-preferred agents will be approved for patients who have failed ALL preferred agents Drug-specific criteria: ▪ **Sumavel® Dosepro:** Requires clinical reason sumatriptan injection cannot be used ▪ ***Onzetra, Zembrace****: approved for patients who have failed ALL preferred agents.*
ORAL		
RELPAX (eletriptan) rizatriptan (generic for Maxalt) rizatriptan ODT (generic for Maxalt MLT) sumatriptan generic oral	almotriptan (generic for Axert) frovatriptan (generic for Frova) IMITREX oral (sumatriptan) naratriptan (generic for Amerge) TREXIMET (sumatriptan/naproxen) zolmitriptan (generic for Zomig/Zomig ZMT)	
NASAL		
*sumatriptan **NASAL***	*IMITREX (sumatriptan)* *ONZETRA X SAIL (sumatriptan)* ZOMIG (zolmitriptan)	
INJECTABLE		
IMITREX (sumatriptan) **PEN, CARTRIDGE** *sumatriptan **KIT, SYRINGE**, VIAL*	ALSUMA (sumatriptan) *IMITREX (sumatriptan) **KIT**, VIAL* SUMAVEL DOSEPRO (sumatriptan) *ZEMBRACE SYMTOUCH (sumatriptan)*	

A motion was made by Gotschall to remove Sumatriptan kits from preferred status. A motion to remove the Sumatriptan kit admendment was made by Juracek and seconded by Bohac. A motion was made by Juracek and seconded by Bohac to accept recommendations as published with the exception of leaving the sumatriptan kit produced by Sun Pharma as non-preferred. Roll Call vote was taken and the motion passed.

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

Motion Carried.

ANTIVIRALS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ANTI-HERPETIC DRUGS		▪ Non-preferred agents will be approved for patients who have failed a 10-day trial of ONE preferred agent Drug-specific criteria: ▪ **Sitavig®:** Approved for recurrent herpes labialis (cold sores) in immunocompetent adults
acyclovir (generic for Zovirax) famciclovir (generic for Famvir) valacyclovir (generic for Valtrex)	SITAVIG (acyclovir buccal)	
ANTI-INFLUENZA DRUGS		
RELENZA (zanamivir) inhalation[QL] rimantadine (generic for Flumadine) TAMIFLU (oseltamivir)[QL]	*oseltamivir[QL] (generic for Tamiflu)*	

A motion was made by Juracek and seconded by Bohac to accept recommendations as published. Roll Call vote was taken and the motion passed.

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

Motion Carried.

CALCIUM CHANNEL BLOCKERS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
SHORT-ACTING		▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within the same group Drug-specific criteria: ▪ **Nimodipine:** Covered without trial for diagnosis of subarachnoid hemorrhage
Dihydropyridines		
nifedipine (generic for Procardia)	isradipine (generic for Dynacirc) nicardipine (generic for Cardene) nimodipine (generic for Nimotop) NYMALIZE (nimodipine solution)	
Non-dihydropyridines		
diltiazem (generic for Cardizem) verapamil (generic for Calan, Isoptin)		
LONG-ACTING		
Dihydropyridines		
amlodipine (generic for Norvasc) nifedipine ER (generic for Procardia XL/Adalat CC)	felodipine ER (generic for Plendil) nisoldipine (generic for Sular)	
Non-dihydropyridines		
diltiazem ER (generic for Cardizem CD) verapamil ER **TABLET**	CALAN SR (verapamil) diltiazem LA (generic for Cardizem LA) MATZIM LA (diltiazem) TIAZAC (diltiazem) verapamil 360mg **CAPSULE** verapamil ER **CAPSULE** *verapamil ER PM (generic for Verelan PM)*	

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

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

Motion Carried.

CEPHALOSPORINS AND RELATED ANTIBIOTICS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
BETA LACTAM/BETA-LACTAMASE INHIBITOR COMBINATIONS		▪ Non-preferred agents will be approved for patients who have failed a 3-day trial of ONE preferred agent Drug-specific criteria: ▪ **Suprax® Tablet/Chewable/ Suspension:** Requires clinical reason why capsule or generic suspension cannot be used
amoxicillin/clavulanate **TABLETS, CHEWABLE, SUSPENSION**	amoxicillin/clavulanate XR (generic for Augmentin XR) *AUGMENTIN* ***SUSPENSION*****, TABLET** (amoxicillin/clavulanate)	
CEPHALOSPORINS – First Generation		
cefadroxil (oral) **CAPSULE, SUSPENSION** (generic for Duricef) cephalexin **CAPSULE, SUSPENSION** (generic for Keflex)	cefadroxil (oral) **TABLET** (generic for Duricef) cephalexin **TABLET**	
CEPHALOSPORINS – Second Generation		
cefprozil (oral) (generic for Cefzil) cefuroxime (oral tablet) (generic for Ceftin)	cefaclor (oral) (generic for Ceclor) CEFTIN (cefuroxime) tablets, suspension	
CEPHALOSPORINS – Third Generation		
cefdinir (oral) (generic for Omnicef) cefixime **SUSPENSION** (generic for Suprax) SUPRAX **CAPSULE** (cefixime)	ceftibuten (generic for Cedax) cefpodoxime (oral) (generic for Vantin) SUPRAX **CHEWABLE TABLET, SUSPENSION, TABLET** (cefixime)	

A motion was made by Thomsen and seconded by Juracek to accept recommendations as published. Roll Call vote was taken and the motion passed.

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

Motion Carried.

CONTRACEPTIVES, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
All agents are recommended preferred at this time		

A motion was made by Gotschall and seconded by Davenport to accept recommendations as published. Roll Call vote was taken and the motion passed.

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

Motion Carried.

CYSTIC FIBROSIS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	*KALYDECO **PACKET, TABLET** (ivacaftor)* *ORKAMBI (lumacaftor/ivacaftor)*	*Drug-specific criteria:* ▪ ***Kalydeco®:** Diagnosis of CF and documentation of the drug-specific, FDA-approved mutation of CFTR gene* ▪ ***Orkambi®:** Diagnosis of CF and documentation of presence of two copies of the F580del mutation (homozygous) of CFTR gene*

A motion was made by Avery and seconded by Fornander to accept recommendations as published. Roll Call vote was taken and the motion passed.

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

Motion Carried.

DIURETICS

Preferred Agents	*Non-Preferred Agents*	*Prior Authorization/Class Criteria*
SINGLE-AGENT PRODUCTS		▪ *Non-preferred agents will be approved for patients who have failed a trial of **TWO** preferred agent within the same group*
*amiloride **TABLET*** *bumetanide **TABLET*** *chlorothiazide **TABLET*** *chlorthalidone **TABLET*** *furosemide **SOLUTION, TABLET*** *hydrochlorothiazide **TABLET*** *indapamide **TABLET*** *metolazone **TABLET*** *methyclothiazide **TABLET*** *spironolactone **TABLET*** *torsemide **TABLET***	*ALDACTONE TABLET (spironolactone)* *DIURIL **TABLET** (chlorothiazide)* *DYRENIUM **TABLET** (triamterene)* *eplerenone **TABLET** (generic for INSPRA)* *ethacrynic acid **CAPSULE** (generic for EDECRIN)* *hydrochlorothiazide **CAPSULE*** *LASIX **TABLET** (furosemide)* *MICROZIDE **TABLET** (hydrochlorothiazide)*	
COMBINATION PRODUCTS		
*amiloride/HCTZ **TABLET*** *spironolactone/HCTZ **TABLET*** *triamterene/HCTZ **CAPSULE, TABLET***	*ALDACTAZIDE **TABLET** (spironolactone/HCTZ)* *DYAZIDE **CAPSULE** (triamterene/HCTZ)* *MAXZIDE **TABLET** (triamterene/HCTZ)* *MAXZIDE-25 **TABLET** (triamterene/HCTZ)*	

A motion was made by Avery and seconded by Gotschall to make hydrochlorothiazide TABLETS PDL preferred. Roll Call vote was taken and the motion passed.

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

Motion Carried.

GI MOTILITY, CHRONIC

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
AMITIZA (lubiprostone)QL LINZESS (linaclotide)QL *MOVANTIK (naloxegol oxalate)CL*	alosetron (generic for Lotronex) *RELISTOR (methylnaltrexone) **TABLET*** *TRULANCE (plecanatide)QL* VIBERZI (eluxodoline)	▪ Non-preferred agents will be approved for patients who have failed a 30-day trial of ONE preferred agent Drug-specific criteria: ▪ **alosetron:** Covered for diagnosis of IBS Diarrhea Predominant type with trial and failure of loperamide AND diphenoxylate ▪ **Movantik®:** Covered for diagnosis of opioid-induced constipation in adults with chronic, non-cancer pain after trial of at least TWO OTC laxatives ▪ ***Relistor®:*** *Covered for diagnosis of opioid-induced constipation in adults with chronic, non-cancer pain after trial of at least TWO OTC laxatives* ▪ ***Trulance®:*** *Covered for diagnosis of chronic idiopathic constipation after trial of at least TWO OTC laxatives* ▪ **Viberzi®:** Covered for diagnosis of IBS Diarrhea Predominant type with trial and failure of loperamide AND diphenoxylate

A motion was made by Dering-Anderson and seconded by Juracek to add senna, bisacodyl, and casanthranol to the PDL as preferred. Roll Call vote was taken and the motion passed.

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

Motion Carried.

GROWTH HORMONE

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
GENOTROPIN (somatropin) NORDITROPIN (somatropin) NUTROPIN AQ (somatropin)	HUMATROPE (somatropin) OMNITROPE (somatropin) *SAIZEN (somatropin)* SEROSTIM (somatropin) ZOMACTON (somatropin) ZORBTIVE (somatropin)	Growth Hormone PA Form Growth Hormone Criteria

A motion was made by Bohac and seconded by Juracek to accept recommendations as published. Roll Call vote was taken and the motion passed.

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

Motion Carried.

HYPOGLYCEMICS, ALPHA-GLUCOSIDASE INHIBITORS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
acarbose (generic for Precose) Glyset (miglitol)	miglitol (generic for Glyset)	▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent

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

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

HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
GLUCAGON-LIKE PEPTIDE-1 RECEPTOR AGONIST (GLP-1 RA)		GLP-1 RA PA Form
BYDUREON (exenatide ER) subcutaneous[CL] BYDUREON **PEN** (exenatide ER) subcutaneous[CL]	*ADLYXIN (lixisenatide)* TANZEUM (albiglutide) TRULICITY (dulaglutide) VICTOZA (liraglutide) subcutaneous	▪ Preferred agents: require metformin trial and diagnosis of diabetes ▪ Non-preferred: Requires diagnosis of T2DM with inadequate glycemic control on metformin OR metformin intolerance with HbA1C ≥ 7 Requires trial of ONE preferred agent Drug-specific criteria: ▪ **Victoza®:** Requires T2DM with inadequate glycemic control on metformin OR metformin intolerance with HbA1C ≥ 7 Requires trial of ONE preferred agent OR compromised renal function
INSULIN/GLP-1 RA COMBINATIONS		
	XULTOPHY (insulin degludec/liraglutide) *SOLIQUA (insulin glargin/lixisenatide)*	

HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS (Continued)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
AMYLIN ANALOG		Amylin Analog PA Form
	SYMLIN (pramlintide) subcutaneous	ALL criteria must be met ▪ Concurrent use of short-acting mealtime insulin ▪ Current therapy compliance ▪ No diagnosis of gastroparesis ▪ HbA1C ≤ 9% within last 90 days ▪ Fingerstick monitoring of glucose during initiation of therapy
DIPEPTIDYL PEPTIDASE-4 (DPP-4) INHIBITOR		▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent
JANUMET (sitagliptin/metformin)QL JANUMET XR(sitagliptin/metformin)QL JANUVIA (sitagliptin)QL JENTADUETO (linagliptin/metformin)QL TRADJENTA (linagliptin)QL	alogliptin (generic for Nesina)QL alogliptin/metformin (generic for Kazano)QL alogliptin/pioglitazone (generic for Oseni) QL GLYXAMBI (empagliflozin/linagliptin) *JENTADUETO XR (linagliptin/metformin)QL* KOMBIGLYZE XR (saxagliptin/metformin)QL ONGLYZA (saxagliptin)QL	

A motion was made by Dering-Anderson and seconded by Hammond to make VICTOZA PDL preferred and to increase the required trail of preferred agents to two. Roll Call vote was taken and the motion passed.

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

Motion Carried.

HYPOGLYCEMICS, INSULIN AND RELATED DRUGS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
HUMALOG (insulin lispro) U-100 **CARTRIDGE, PEN, VIAL** HUMALOG MIX **VIAL** (insulin lispro/lispro protamine) HUMULIN (insulin) **VIAL** HUMULIN 70/30 **VIAL** HUMULIN U-500 **VIAL** LANTUS SOLOSTAR **PEN** (insulin glargine) LANTUS (insulin glargine) **VIAL** LEVEMIR (insulin detemir) **PEN, VIAL** NOVOLOG (insulin aspart) **CARTRIDGE, PEN, VIAL** NOVOLOG MIX **PEN, VIAL** (insulin aspart/aspart protamine)	AFREZZA (insul reg, inhaled) APIDRA (insulin glulisine) *BASAGLAR (insulin glargine, rec) **PEN*** HUMULIN 70/30 **PEN** HUMULIN U-500 **PEN** HUMULIN OTC **PEN** HUMALOG (insulin lispro) U-200 **PEN** *HUMALOG MIX **PEN** (insulin lispro/lispro protamine)* NOVOLIN (insulin) NOVOLIN 70/30 **VIAL** TOUJEO SOLOSTAR **PEN** (insulin glargine) TRESIBA FLEXTOUCH **PEN** (Insulin degludec)	▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent Drug-specific criteria: ▪ **Afrezza®:** Approved for T1DM on long-acting insulin with no current history of smoking or chronic lung disease ▪ **Humulin® U-500:** Approved for physical reasons – such as dexterity problems and vision impairment • Usage must be for self-administration, not only convenience • Patient requires >300 units/day • Safety reason patient can't use vial/syringe

A motion was made by Thomsen and seconded by Juracek to accept recommendations as published. Roll Call vote was taken and the motion passed.

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

Motion Carried.

HYPOGLYCEMICS, SGLT2

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
FARXIGA (dapagliflozin) INVOKANA (canagliflozin)[CL]	*INVOKAMET (canagliflozin/ metformin)[CL]* *INVOKAMET XR (canagliflozin/metformin)[CL]* JARDIANCE (empagliflozin) SYNJARDY (empagliflozin/metformin) *SYNJARDY XR (empagliflozin/ metformin)[NR]* XIGDUO XR (dapagliflozin/metformin)	▪ **Invokana®/*Farxiga*®:** Approved for diagnosis of diabetes AND a trial of metformin

A motion was made by Elsasser and seconded by Juracek to accept recommendations as published. Roll Call vote was taken and the motion passed.

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

Motion Carried.

LIPOTROPICS, OTHER

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
BILE ACID SEQUESTRANTS		▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within the same group Drug-specific criteria: ▪ **Juxtapid®/ Kynamro®:** Approved for diagnosis of homozygous familial hypercholesterolemia (HoFH) OR Treatment failure/maximized dosing/contraindication to ALL the following: statins, ezetimibe, niacin, fibric acid derivatives, omega-3 agents, bile acid sequestrants Require faxed copy of REMS PA form ▪ **Lovaza®:** Approved for TG ≥ 500 ▪ **Praluent®:** Approved for diagnoses of atherosclerotic cardiovascular disease (ASCVD) OR heterozygous familial hypercholesterolemia (HeFH) AND Maximized high-intensity statin WITH ezetimibe for at 3 continuous months AND Failure to reach target LDL-C levels: ASCVD - < 70 mg/dL, HeFH - < 100 mg/dL ▪ **Repatha®:** Approved for adult diagnoses of atherosclerotic cardiovascular disease (ASCVD) OR heterozygous familial hypercholesterolemia (HeFH) OR homozygous familial hypercholesterolemia (HoFH) in age ≥ 13 OR statin-induce rhabdomyolysis AND Maximized high-intensity statin WITH ezetimibe for at 3 continuous months AND Failure to reach target LDL-C levels: ASCVD - < 70 mg/dL, HeFH - < 100 mg/dL Concurrent use of maximally-tolerated statin must continue ▪ **Vascepa®:** Approved for TG ≥ 500 ▪ **WelChol®:** Trial not required for diabetes control and monotherapy with metformin, sulfonylurea, or insulin has been inadequate ▪ **Zetia®:** Approvd for diagnosis of hypercholesterolemia AND failed statin monotherapy OR statin intolerance/contraindication
cholestyramine (generic for Questran) colestipol (generic for Colestid) **TABLETS**	colestipol **GRANULES** (generic for Colestid) QUESTRAN LIGHT (cholestyramine) WELCHOL (colesevalam)	
TREATMENT OF HOMOZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA		
	JUXTAPID (lomitapide)CL KYNAMRO (mipomersen)CL	
FIBRIC ACID DERIVATIVES		
fenofibrate (generic for Tricor) *fenofibric acid (generic for Trilipix)* gemfibrozil (generic for Lopid)	fenofibrate (generic for Antara, Fenoglide, Lofibra) fenofibric acid (generic for Fibricor) fenofibrate (generic for Lipofen) TRICOR (fenofibrate) TRIGLIDE (fenofibrate) *TRILIPIX (fenofibric acid)*	
NIACIN		
niacin ER (generic for Niaspan)	ADVICOR (lovastatin/niacin ER) NIACOR (niacin IR) NIASPAN (niacin ER)	
Several other forms of OTC Niacin and fish oil are also covered without prior authorization under Medicaid with a prescription		
OMEGA-3 FATTY ACIDS		
	omega-3 fatty acids (generic for Lovaza)CL VASCEPA (icosapent)CL	
CHOLESTEROL ABSORPTION INHIBITORS		
	ezetimibe (generic for Zetia)	
PROPROTEIN CONVERTASE SUBTILISIN/KEXIN TYPE 9 (PCSK9) INHIBITORS		
	PRALUENT (alorocumab)CL REPATHA (evolocumab)CL	

A motion was made by Avery and seconded by Bohac to accept recommendations as published. Roll Call vote was taken and the motion passed.

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

Motion Carried.

LIPOTROPICS, STATINS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
STATINS		▪ Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agent within the last 12 months Drug-specific criteria: ▪ **Altoprev®:** One of the TWO trials must be IR lovastatin ▪ **Combination products:** Require clinical reason why individual ingredients cannot be used ▪ **Lescol XL®:** Requires trial of TWO preferred agents AND trial of IR fluvastatin OR clinical reason IR cannot be used ▪ **Liptruzet®/Vytorin®:** Approved for 3-month continuous trial of ONE standard dose statin
atorvastatin (generic for Lipitor)	ALTOPREV (lovastatin)	
lovastatin (generic for Mevacor)	*CRESTOR (rosuvastatin)*	
pravastatin (generic for Pravachol)	fluvastatin (generic for Lescol)	
rosuvastatin (generic for Crestor)	LESCOL / XL (fluvastatin/ER)	
simvastatin (generic for Zocor)	LIVALO (pitavastatin)	
STATIN COMBINATIONS		
	ADVICOR (lovastatin/niacin ER)	
	atorvastatin/ amlodipine (generic for CADUET)	
	LIPTRUZET (ezetimibe/atorvastatin)	
	SIMCOR (simvastatin/niacin ER)	
	VYTORIN (simvastatin/ezetimibe)	

A motion was made by Fornander and seconded by Juracek to accept recommendations as published. Roll Call vote was taken and the motion passed.

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

Motion Carried.

MACROLIDES AND KETOLIDES, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
KETOLIDES		▪ **Ketek®:** Requires clinical resaon why patient cannot use preferred macrolide ▪ **Macrolides:** Require clinical reason why preferred products cannot be used AND ≥ 3-day trial on a preferred macrolide
	KETEK (telithromycin)	
MACROLIDES		
azithromycin (generic for Zithromax)	clarithromycin ER (generic for Biaxin XL)	
clarithromycin IR (generic for Biaxin)	EES 400 **TABLET**	
clarithromycin **SUSPENSION**	*ERYPED **SUSPENSION***	
EES 200 **SUSPENSION**	*ERY-TAB*	
*erythromycin base **CAPSULE DR***	ERYTHROCIN	
	erythromycin base **TABLET**	
	PCE (erythromycin)	
	ZMAX (azithromycin ER)	
	ZITHROMAX (azithromycin)	

A motion was made by Elsasser and seconded by Dering-Anderson to move erythromycin to non-preferred. Roll Call vote was taken and the motion passed.

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

Motion Carried.

MULTIPLE SCLEROSIS DRUGS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
AVONEX (interferon beta-1a)[QL] BETASERON (interferon beta-1b)[QL] COPAXONE **20mg** Syringe Kit (glatiramer)[QL] GILENYA (fingolimod)[QL,CL] REBIF (interferon beta-1a)[QL]	AMPYRA (dalfampridine)[QL] AUBAGIO (teriflunomide) COPAXONE **40mg** Syringe (glatiramer)[QL] EXTAVIA (interferon beta-1b)[QL] *glatiramer 20 mg/mL (generic for Copaxone)* PLEGRIDY (peginterferon beta-1a)[QL] TECFIDERA (dimethyl fumarate) *ZINBRYTA (daclizumab)*	▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent Drug-specific criteria: ▪ **Ampyra®:** Approved for diagnosis of gait disorder associated with MS AND EDSS score ≤ 7 ▪ **Gilenya®:** Requires trial of preferred injectable agent (Avonex®, Betaseron®, Copaxone®, Rebif®) ▪ **Plegridy®:** Approved for diagnosis of relapsing MS

A motion was made by Bohac and seconded by Juracek to accept recommendations as published. Roll Call vote was taken and the motion passed.

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

Motion Carried.

NITROFURAN DERIVATIVES

Preferred Agents	*Non-Preferred Agents*	*Prior Authorization/Class Criteria*
*nitrofurantoin **SUSPENSION** (generic for Furadantin)* *nitrofurantoin macrocrystals **CAPSULE** (generic for Macrodantin)* *nitrofurantoin monohydrate-macrocrystals **CAPSULE** (generic for Macrobid)*	*MACROBID **CAPSULE** (nitrofurantoin monohydrate macrocrystals)* *MACRODANTIN **CAPSULE** (nitrofurantoin macrocrystals)* *FURADANTIN **SUSPENSION** (nitrofurantoin)*	▪ *Non-preferred agents will be approved for patients who have failed a trial of **ONE** preferred agent*

A motion was made by Thomsen and seconded by Bohac to accept recommendations as published. Roll Call vote was taken and the motion passed.

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

PLATELET AGGREGATION INHIBITORS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
AGGRENOX (dipyridamole/aspirin) Aspirin OTC BRILINTA (ticagrelor) clopidogrel (generic for Plavix) dipyridamole (generic for Persantine)	aspirin/dipyridamole (generic for Aggrenox) DURLAZA (aspirin) *EFFIENT (prasugrel)* ticlopidine (generic for Ticlid) *YOSPRALA (aspirin/omeprazole)* ZONTIVITY (vorapaxar)^{CL}	▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent OR documented clopidogrel resistance Drug-specific criteria: ▪ **Zontivity®:** Approved for reduction of thrombotic cardiovascular events in history of MI or with peripheral artery disease (PAD) Use with aspirin and/or clopidogrel

A motion was made by Elsasser and seconded by Bohac to accept recommendations as published. Roll Call vote was taken and the motion passed.

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

PRENATAL VITAMINS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
bal-care DHA essential *citranatal B-calm* *completenate **CHEW TABLET*** *CONCEPT DHA/OB* *EXPECTA PRENATAL OTC* *fe c/vit c/vit b12/FA RX/OTC* *KPN OTC* *marnatal-F* *MINI PRENATAL OTC* *OB complete DHA/one/premier* *obtrex DHA* *o-cal FA/prenatal* *ONE-A-DAY WOMEN'S PRENATAL DHA OTC* *pnv11-iron fum-folic acid-om3* *pnv 87/iron bisgly/FA/DHA* *pnv no.15/iron fum & PS CMP/FA* *pnv w-ca no.37/iron/FA/Omega-3* *pnv w-ca no.40/iron fum/FA CMB no.1* *pnv with ca, no.68/iron/FA No.1/DHA* *pnv with ca, no.70/iron/FA/DHA* *pnv with ca, no.72/iron, carb/FA* *pnv with ca, no.72/iron/FA* *pnv with ca, no.74/iron/FA* *pnv#16/iron fum & PS/FA/OM-3* *pnv#21/iron PS& heme polyp/FA* *PNV103/FA/OMEGA3/DHA/FISH OIL* *pnv115/iron fumarate/FA/DSS* *pnv119/iron fumarate/FA/DSS OTC* *pnv2/iron B-G suc-p/FA/omega-3* *pnv22/iron CBN&gluc/FA/DSS/DHA* *pnv53/ironB-G hcl-p/FA/omega3* *pnv66/iron fumarate/FA/DSS/DHA* *pnv69/iron, carbonyl/FA/DSS/DHA* *pnv80/iron fumarate/FA/DSS/DHA* *pnv81/sod iron EDTA& PS/FA/OM3* *pnv-vp-u* *pr natal 400 EC* *pr natal 430/EC* *prenata **CHEW TABLET*** *prenatabs FA*	*icar-C plus* *natelle one* *nestabs/nestabs DHA* *ob complete* *pnv #19/iron ps&heme/folic/DHA* *prefera OB/prefera-OB one* *select-OB* *tricare DHA*	▪ *Non-preferred agents will be approved for patients who have failed a trial of THREE preferred agent*

PRENATAL VITAMINS (continued)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
prenatal #48/iron CB&glu/FA/B6 OTC *prenatal + DHA OTC* *prenatal complete OTC* *prenatal formula OTC* *prenatal formula-DHA OTC* ***CAPSULE*** *prenatal multi + DHA OTC* *prenatal multi OTC* *prenatal one OTC* *prenatal OTC* ***CHEW TABLET*** *prenatal vit 15/iron CB/FA/DSS* *prenatal vit 16/iron CB/FA/DSS* *prenatal vit 18/iron CB/FA/DSS* *prenatal vit 86/iron bisgly/FA* *prenatal vit no.73/iron/FA* *prenatal vit no.78/iron/FA* *prenatal vit/Fe fumarate/FA OTC* *prenatal vit27&calcium/iron/FA* *prenatal vitamin + DHA OTC* *prenatal vitamins OTC* *prenatal-1 OTC* *prenatal-U* *preque 10* *pureFe OB plus* *pureFe plus* *select-OB + DHA* *taron-prex prenatal* *tricare* *trinate* *ultimatecare one NF* *vitafol-OB* *vitafol-OB + DHA* *vitafol-one* *vol-plus* *vp-ch-pnv* *zatean-ch*		▪ *Non-preferred agents will be approved for patients who have failed a trial of THREE preferred agent*

A motion was made by Dering-Anderson and seconded by Avery to move Citranatal B-calm and Obtrex DHA to non-preferred. Roll Call vote was taken and the motion passed.

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

Motion Carried.

PROTON PUMP INHIBITORS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
omeprazole (generic for Prilosec) **RX only** pantoprazole (generic for Protonix)	DEXILANT (dexlansoprazole) esomeprazole magnesium (generic for Nexium) esomeprazole strontium lansoprazole (generic for Prevacid) NEXIUM SUSPENSION (esomeprazole) omeprazole/sodium bicarbonate (generic for Zegerid RX) PREVACID Rx, SOLU-TAB (lansoprazole) PRILOSEC (omeprazole) rabeprazole (generic for Aciphex)	▪ Non-preferred agents will be approved for patients who have failed an 8-week trial of BOTH preferred agents Drug-specific criteria: ▪ **Prilosec®OTC/Omeprazole OTC:** EXCLUDED from coverage Acceptable as trial instead of Omeprazole 20mg ***Pediatric Patients:*** *Patients ≤ 4 years of age – No PA required for Prevacid 30mg or omeprazole 20mg capsules (used to compound suspensions).* ***Prevacid Solutab**: may be approved after trial of compounded suspension.* *Patients ≥ 5 years if age- Only approve non-preferred for GI diagnosis if:* • *Child can not swallow whole generic omeprazole capsules OR,* • *Documentation that contents of capsule may not be sprinkled in applesauce.*

A motion was made by Fornander and seconded by Avery to accept recommendations as published. Roll Call vote was taken and the motion passed.

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

SINUS NODE INHIBITORS

Preferred Agents	*Non-Preferred Agents*	*Prior Authorization/Class Criteria*
	CORLANOR (ivabradine)	*Drug-specific criteria:* ▪ *Diagnosis of Chronic Heart Failure with left ventricular ejection fraction less than or equal to 35%, AND* ▪ *Sinus rhythm with resting heart rate oreater than or equal to 70 beats per minute, AND* ▪ *On maximally tolerated doses of beta-blockers OR have a contraindication to beta-blocker use.*

A motion was made by Bohac and seconded by Elsasser to accept recommendations as published. Roll Call vote was taken and the motion passed.

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

Motion Carried.

THYROID HORMONES

Preferred Agents	*Non-Preferred Agents*	*Prior Authorization/Class Criteria*
*levothyroxine **TABLET** (generic for Synthroid)* *liothyronine **TABLET** (generic for Cytomel)* *thyroid, pork **TABLET***	*CYTOMEL **TABLET** (liothyronine)* *SYNTHROID **TABLET** (levothyroxine)* *THYROLAR **TABLET** (liotrix)* *TIROSINT **TABLET** (levothyroxine)*	▪ *Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent*

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

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

Motion Carried.

VASODILATORS, CORONARY

Preferred Agents	*Non-Preferred Agents*	*Prior Authorization/Class Criteria*
*isosorbide dinitrate **TABLET***	*BIDIL (isosorbide dinitrate/hydralazine)*	▪ *Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent*
*isosorbide mononitrate **TABLET***	*DILATRATE-SR (isosorbide dinitrate)*	
*isosorbide mononitrate SR **TABLET***	*GONITRO (nitroglycerin)*	
*nitroglycerin **SUBLINGUAL, TRANSDERMAL***	*ISORDIL (isosorbide dinitrate)*	
*nitroglycerin ER **TABLET***	*NITRO-BID **OINTMENT** (nitroglycerin)*	
*NITROSTAT **SUBLINGUAL** (nitroglycerin)*	*NITRO-DUR (nitroglycerin)*	
	*nitroglycerin **TRANSLINGUAL** (generic for Nitrolingual)*	
	NITROLINGUAL SPRAY	
	NITROMIST (nitroglycerin)	

A motion was made by Thomsen and seconded by Elsasser to accept recommendations as published. Roll Call vote was taken and the motion passed.

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

Motion Carried.

XIII. Other Business:

Chair election to be held during next meeting.

Board asked that only classes requiring no discussion are included on the Consent Agenda.

A motion was made by Saunders and seconded by Pohl to conclude the meeting at 3:00 p.m.

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

Date: November 8, 2017

Time: 9:00a.m – 3:00p.m CST

Location: Mahoney State Park, Peter Kiewit Lodge, 28500 West Park Hwy, Ashland, NE 68003

Recorded by: Valarie Simmons, M.S – Account Operations Executive, Magellan Rx Management, Magellan Health.

Approved November 8, 2017