

DIVISION OF MEDICAID AND LONG-TERM CARE
Nebraska DHHS

PHARMACEUTICAL AND THERAPEUTICS COMMITTEE MEETING MINUTES

November 7, 2018 at 9 a.m., CST
Mahoney State Park, Peter Kiewit Lodge
Ashland, NE

Committee Members Present:

Eric Avery, M.D.
Claire Baker, M.D. (Chair)
Stacie Bleicher, M.D.
Chris Caudill, M.D.
Kyle Clarey, Pharm.D.
Allison Dering-Anderson, Pharm.D.
Wade Fornander, M.D.
Mary Hammond, Pharm.D.
Laurie Humphries, M.D.
Joyce Juracek, Pharm.D.
Jessica Pohl, Pharm. D.
Ken Saunders, Pharm.D.
Linda Sobeski, Pharm.D. (Vice Chair)

Division of Medicaid and Long-Term Care Staff Present:

Jenny Minchow, Pharm.D.

Magellan Medicaid Administration Staff Present:

Jill Bot, Pharm.D., Clinical Account Manager
Valarie Simmons, M.S, Account Manager

Managed Care Staff Present:

Shannon Nelson, Pharm. D., WellCare Director
Kevin Peterson, Pharm. D., NTC Director
Bernadette Ueda, Pharm. D., UHC Director

Committee Members Absent (excused):

Gary Elsasser, Pharm.D.
Jeff Gotschall, M.D.

I. Opening of Public Meeting and Call to Order Committee Business

- i. Committee Chair called the meeting to order at 9:02am. The agenda was posted on the Nebraska Medicaid Pharmacy Magellan Medicaid website (<https://nebraska.fhsc.com/PDL/PTcommittee.asp>) on October 2, 2018. A copy of the Open Meetings Act and meeting materials distributed to members were made available to the public for review.
- ii. Roll Call: See list above
- iii. Conflict of Interest: Dr. Avery reported service on an Astra Zeneca Advisory Board. Otherwise, no new conflicts of interest were reported.
- iv. Dr. Dering-Anderson requested that notations in the minutes indicating a member had stepped out of the room were too detailed and requested that those notations be removed from the May minutes. With that change, approval of May 2, 2017 minutes was unanimously approved by all in attendance.
- v. Department information: Jenny Minchow, Pharmacist for DHHS, Medicaid and Long-Term Care Division provided a department update.

Dr. Minchow noted that Nancy Haberstick, Kris Bohac, Eric Thompson and Yvonne Davenport have resigned from the Committee.

- i. Staffing changes within the Medicaid Pharmacy program include the resignation of Shelly Nickerson and Nicole Mattson.
- ii. Following the previous day's election, Nebraska will undergo Medicaid Expansion as a part of the Affordable Care Act.

II. Public Testimony

Speaker Order	DRUG CLASS	Drug Name	PDL Status	Speaker Name	Affiliation
1	COPD	Lonhala Magnair	NP	Jamie Manion	Sunovion
2	Cytokine and CAM Antagonists	Kevzara	NP	Kevin Durkopf	Sanofi Genzyme
3	Immunodulator, Atopic Dermatitis	Dupixent	NP	Kevin Durkopf	Sanofi Genzyme
4	Cytokine and CAM Antagonists	Otezla	NP	Gia McLean	Celgene
5	Enzyme Replacement	Cerdelga	NP	Katrina Simmons	Sanofi Genzyme
6	Hemophilia Treatment	Advate & Adenovate	NP	Kevin Kassabian	Shire
7	Hemophilia Treatment	Jivi	NP	Robert Eschbacher	Bayer
8	Hemophilia Treatment	Hemlibra	NP	Michael Donze	Genentech
9	Hemophilia Treatment	Eloctate & Alprolix	NP	Kimberly Jacobson	Bioverativ
10	Immunodulator, Atopic Dermatitis	Eucrisa	NP	James Baumann	Pfizer
11	Oncology, Oral – Hematologic	Pomalyst	NP	Emily Preiffer	Celgene
12	Oncology, Oral – Lung	Alunbrig	NP	Kim Bogard	Takeda
13	Progesterone	Makena w/ Injector	P	Suzanne Westfall	Amag

III. Committee Closed Session

IV. Resume Open Session

During the public open session, committee members vote publicly on decisions with regard to the Nebraska Preferred Drug List recommendations. Per the State of Nebraska P&T Committee By-Laws, the minutes reflect how each member voted or if the member was absent or not voting. The chairperson votes only in the event of a tie. The details of each vote and the associated PDL recommendations are presented in the following tables.

i. Consent Agenda

Consent Agenda								
(1st) Motion: Avery								
(2nd) Motion: Juracek								
Discussion: Full approval of Consent Agenda w/ exception of Immunomodulators, Atopic Dermatitis, which Dr. Bleicher requested to be removed from the Consent Agenda								
Voting – P&T Committee Members	Yes	No	Abstain	Voting – P&T Committee Members	Yes	No	Abstain	
Avery, Eric, M.D	x			Fornander, Wade, M.D	x			
Baker, Claire, M.D (Chair) • <i>Votes only in the event of a tie</i>				Hammond, Mary, Pharm.D.	x			
Bleicher, Stacie, M.D	x			Humphries, Laurie, M.D	x			
Caudill, Christopher, M.D	x			Juracek, Joyce, Pharm.D.	x			
Clarey, Kyle, Pharm.D.	x			Pohl, Jessica, Pharm.D.	x			
Dering Anderson, Allison, Pharm.D.	x			Saunders, Kenneth, Pharm.D.	x			
				Sobeski, Linda, Pharm.D.	x			

Consent Agenda: Therapeutic categories (TC) with unchanged recommendations unless otherwise indicated.

Alzheimer's Agents	Leukotriene Modifiers
Anthelmintics	Methotrexate
Anti-Allergens, Oral	Movement Disorders
Antihistamines, Minimally Sedating	NSAIDS
Antihypertensives, Sympatholytics	Oncology, Oral – Other
Antipsoriatics, Oral	Ophthalmic, Allergic Conjunctivitis
Anxiolytics	Ophthalmic, Anti-Inflammatory/Immunomodulator
Bile Salts	Otic Anti-Infectives & Anesthetics
Bronchodilators, Beta Agonist	Otic Antibiotics
Cough and Cold, Opiate	Sedative Hypnotics
Epinephrine, Self-Injected	Steroids, Topical Medium
Histamine II Receptor Blockers	Steroids, Topical High
Idiopathic Pulmonary Fibrosis	Steroids, Topical Very High
Immunomodulators, Atopic Dermatitis – Changes Recommended	

Consent Agenda – Immunomodulators, Atopic Dermatitis

(1st) Motion: Fornander

(2nd) Motion: Pohl

Discussion: Add to Dupixent criteria: For moderate-to-severe atopic dermatitis whose disease is not adequately controlled with Eucrisa or when Eucrisa is not advisable.

Voting – P&T Committee Members	Yes	No	Abstain	Voting – P&T Committee Members	Yes	No	Abstain
Avery, Eric, M.D	x			Fornander, Wade, M.D	x		
Baker, Claire, M.D (Chair) • <i>Votes only in the event of a tie</i>				Hammond, Mary, Pharm.D.	x		
Bleicher, Stacie, M.D	x			Humphries, Laurie, M.D	x		
Caudill, Christopher, M.D	x			Juracek, Joyce, Pharm.D.	x		
Clarey, Kyle, Pharm.D.	x			Pohl, Jessica, Pharm.D.	x		
Dering Anderson, Allison, Pharm.D.	x			Saunders, Kenneth, Pharm.D.	x		
				Sobeski, Linda, Pharm.D.	x		

ii. Therapeutic Class Reviews

Review Agenda – Antihyperuricemics

(1st) Motion: Avery

(2nd) Motion: Saunders

Discussion: Prior authorization for Duzallo. Patient must have a diagnosis for a label indication and a trail of allopurinol used alone.

Voting – P&T Committee Members	Yes	No	Abstain	Voting – P&T Committee Members	Yes	No	Abstain
Avery, Eric, M.D	x			Fornander, Wade, M.D	x		
Baker, Claire, M.D (Chair) • <i>Votes only in the event of a tie</i>				Hammond, Mary, Pharm.D.	x		
Bleicher, Stacie, M.D	x			Humphries, Laurie, M.D	x		
Caudill, Christopher, M.D	x			Juracek, Joyce, Pharm.D.	x		
Clarey, Kyle, Pharm.D.	x			Pohl, Jessica, Pharm.D.	x		
Dering Anderson, Allison, Pharm.D.	x			Saunders, Kenneth, Pharm.D.	x		
				Sobeski, Linda, Pharm.D.	x		

Review Agenda – Antiparkinson's

(1st) Motion: Saunders

(2nd) Motion: Sobeski

Discussion: Approve as written.

Voting – P&T Committee Members	Yes	No	Abstain	Voting – P&T Committee Members	Yes	No	Abstain
Avery, Eric, M.D	x			Fornander, Wade, M.D	x		
Baker, Claire, M.D (Chair) • <i>Votes only in the event of a tie</i>				Hammond, Mary, Pharm.D.	x		
Bleicher, Stacie, M.D	x			Humphries, Laurie, M.D	x		
Caudill, Christopher, M.D	x			Juracek, Joyce, Pharm.D.		x	
Clarey, Kyle, Pharm.D.	x			Pohl, Jessica, Pharm.D.	x		
Dering Anderson, Allison, Pharm.D.	x			Saunders, Kenneth, Pharm.D.	x		
				Sobeski, Linda, Pharm.D.	x		

Review Agenda – Antipsoriatics, Topical

(1st) Motion: Dering Anderson

(2nd) Motion: Pohl

Discussion: Approve as written.

Voting – P&T Committee Members	Yes	No	Abstain	Voting – P&T Committee Members	Yes	No	Abstain
Avery, Eric, M.D	x			Fornander, Wade, M.D	x		
Baker, Claire, M.D (Chair) • <i>Votes only in the event of a tie</i>				Hammond, Mary, Pharm.D.	x		
Bleicher, Stacie, M.D	x			Humphries, Laurie, M.D	x		
Caudill, Christopher, M.D	x			Juracek, Joyce, Pharm.D.	x		
Clarey, Kyle, Pharm.D.	x			Pohl, Jessica, Pharm.D.	x		
Dering Anderson, Allison, Pharm.D.	x			Saunders, Kenneth, Pharm.D.	x		
				Sobeski, Linda, Pharm.D.	x		

Review Agenda – Colony Stimulating Factors

(1st) Motion: Avery

(2nd) Motion: Dering Anderson

Discussion: Approve as written.

Voting – P&T Committee Members	Yes	No	Abstain	Voting – P&T Committee Members	Yes	No	Abstain
Avery, Eric, M.D	x			Fornander, Wade, M.D	x		
Baker, Claire, M.D (Chair) • <i>Votes only in the event of a tie</i>				Hammond, Mary, Pharm.D.	x		
Bleicher, Stacie, M.D	x			Humphries, Laurie, M.D	x		
Caudill, Christopher, M.D	x			Juracek, Joyce, Pharm.D.	x		
Clarey, Kyle, Pharm.D.	x			Pohl, Jessica, Pharm.D.	x		
Dering Anderson, Allison, Pharm.D.	x			Saunders, Kenneth, Pharm.D.	x		
				Sobeski, Linda, Pharm.D.	x		

Review Agenda – COPD Agents

(1st) Motion: Dering Anderson

(2nd) Motion: Fornander

Discussion: Approve as written.

Voting – P&T Committee Members	Yes	No	Abstain	Voting – P&T Committee Members	Yes	No	Abstain
Avery, Eric, M.D	x			Fornander, Wade, M.D	x		
Baker, Claire, M.D (Chair) • <i>Votes only in the event of a tie</i>				Hammond, Mary, Pharm.D.	x		
Bleicher, Stacie, M.D Absent				Humphries, Laurie, M.D	x		
Caudill, Christopher, M.D	x			Juracek, Joyce, Pharm.D.	x		
Clarey, Kyle, Pharm.D.	x			Pohl, Jessica, Pharm.D.	x		
Dering Anderson, Allison, Pharm.D.	x			Saunders, Kenneth, Pharm.D.	x		
				Sobeski, Linda, Pharm.D.	x		

Review Agenda – Cytokine and CAM Antagonists

(1st) Motion: Sobeski

(2nd) Motion: Dering Anderson

Discussion: All preferred and non-preferred agents require an FDA approved indication. Non-preferred agents will be approved if no preferred agents are available for a specific indication.

Voting – P&T Committee Members	Yes	No	Abstain	Voting – P&T Committee Members	Yes	No	Abstain
Avery, Eric, M.D	x			Fornander, Wade, M.D	x		
Baker, Claire, M.D (Chair) • <i>Votes only in the event of a tie</i>				Hammond, Mary, Pharm.D.	x		
Bleicher, Stacie, M.D	x			Humphries, Laurie, M.D	x		
Caudill, Christopher, M.D	x			Juracek, Joyce, Pharm.D.	x		
Clarey, Kyle, Pharm.D.	x			Pohl, Jessica, Pharm.D.	x		
Dering Anderson, Allison, Pharm.D.	x			Saunders, Kenneth, Pharm.D.	x		
				Sobeski, Linda, Pharm.D.	x		

Review Agenda – Enzyme Replacement, Gauchers Disease

(1st) Motion: Saunders

(2nd) Motion: Pohl

Discussion: Approve as written.

Voting – P&T Committee Members	Yes	No	Abstain	Voting – P&T Committee Members	Yes	No	Abstain
Avery, Eric, M.D	x			Fornander, Wade, M.D	x		
Baker, Claire, M.D (Chair) • <i>Votes only in the event of a tie</i>				Hammond, Mary, Pharm.D.	x		
Bleicher, Stacie, M.D	x			Humphries, Laurie, M.D	x		
Caudill, Christopher, M.D	x			Juracek, Joyce, Pharm.D.	x		
Clarey, Kyle, Pharm.D.	x			Pohl, Jessica, Pharm.D.	x		
Dering Anderson, Allison, Pharm.D.	x			Saunders, Kenneth, Pharm.D.			
				Sobeski, Linda, Pharm.D.			

Review Agenda – Erythropoiesis Stimulating Proteins

(1st) Motion: Avery

(2nd) Motion: Hammond

Discussion: Move Procrit to non-preferred.

Voting – P&T Committee Members	Yes	No	Abstain	Voting – P&T Committee Members	Yes	No	Abstain
Avery, Eric, M.D	x			Fornander, Wade, M.D	x		
Baker, Claire, M.D (Chair) • <i>Votes only in the event of a tie</i>				Hammond, Mary, Pharm.D.	x		
Bleicher, Stacie, M.D	x			Humphries, Laurie, M.D	x		
Caudill, Christopher, M.D	x			Juracek, Joyce, Pharm.D.	x		
Clarey, Kyle, Pharm.D.	x			Pohl, Jessica, Pharm.D.	x		
Dering Anderson, Allison, Pharm.D.	x			Saunders, Kenneth, Pharm.D.	x		
				Sobeski, Linda, Pharm.D.	x		

Review Agenda – Glucocorticoids, Inhaled

(1st) Motion: Avery

(2nd) Motion: Fornander

Discussion: Approve as written.

Voting – P&T Committee Members	Yes	No	Abstain	Voting – P&T Committee Members	Yes	No	Abstain
Avery, Eric, M.D	x			Fornander, Wade, M.D	x		
Baker, Claire, M.D (Chair) • <i>Votes only in the event of a tie</i>				Hammond, Mary, Pharm.D.	x		
Bleicher, Stacie, M.D	x			Humphries, Laurie, M.D	x		
Caudill, Christopher, M.D	x			Juracek, Joyce, Pharm.D.	x		
Clarey, Kyle, Pharm.D.	x			Pohl, Jessica, Pharm.D.	x		
Dering Anderson, Allison, Pharm.D.	x			Saunders, Kenneth, Pharm.D.	x		
				Sobeski, Linda, Pharm.D.	x		

Review Agenda – Glucocorticoids, Oral

(1st) Motion: Fornander

(2nd) Motion: Juracek

Discussion: Approve as written.

Voting – P&T Committee Members	Yes	No	Abstain	Voting – P&T Committee Members	Yes	No	Abstain
Avery, Eric, M.D	x			Fornander, Wade, M.D	x		
Baker, Claire, M.D (Chair) • <i>Votes only in the event of a tie</i>				Hammond, Mary, Pharm.D.	x		
Bleicher, Stacie, M.D	x			Humphries, Laurie, M.D	x		
Caudill, Christopher, M.D	x			Juracek, Joyce, Pharm.D.	x		
Clarey, Kyle, Pharm.D.	x			Pohl, Jessica, Pharm.D.	x		
Dering Anderson, Allison, Pharm.D.	x			Saunders, Kenneth, Pharm.D.	x		
				Sobeski, Linda, Pharm.D.	x		

Review Agenda – Hemophilia Treatment

(1st) Motion: Saunders

(2nd) Motion: Juracek

Discussion: Approve as written. For future meetgs, the committee requested that different Factors be presented separately on the PowerPoint presentation, similar to how they are presented in the PDL.

Voting – P&T Committee Members	Yes	No	Abstain	Voting – P&T Committee Members	Yes	No	Abstain
Avery, Eric, M.D	x			Fornander, Wade, M.D	x		
Baker, Claire, M.D (Chair) • <i>Votes only in the event of a tie</i>				Hammond, Mary, Pharm.D.	x		
Bleicher, Stacie, M.D	x			Humphries, Laurie, M.D	x		
Caudill, Christopher, M.D	x			Juracek, Joyce, Pharm.D.	x		
Clarey, Kyle, Pharm.D.	x			Pohl, Jessica, Pharm.D.	x		
Dering Anderson, Allison, Pharm.D.	x			Saunders, Kenneth, Pharm.D.	x		
				Sobeski, Linda, Pharm.D.	x		

Review Agenda – Immunomodulators, Topical

(1st) Motion: Juracek

(2nd) Motion: Fornander

Discussion: Approve as written.

Voting – P&T Committee Members	Yes	No	Abstain	Voting – P&T Committee Members	Yes	No	Abstain
Avery, Eric, M.D	x			Fornander, Wade, M.D	x		
Baker, Claire, M.D (Chair) • <i>Votes only in the event of a tie</i>				Hammond, Mary, Pharm.D.	x		
Bleicher, Stacie, M.D	x			Humphries, Laurie, M.D	x		
Caudill, Christopher, M.D	x			Juracek, Joyce, Pharm.D.	x		
Clarey, Kyle, Pharm.D.	x			Pohl, Jessica, Pharm.D.	x		
Dering Anderson, Allison, Pharm.D.	x			Saunders, Kenneth, Pharm.D.	x		
				Sobeski, Linda, Pharm.D.	x		

Review Agenda – Intranasal Rhinitis Agents

(1st) Motion: Avery

(2nd) Motion: Pohl

Discussion: Approve as written. Discussion around a 1 year PA due to pregnancy for Budesonide. No motion was made.

Voting – P&T Committee Members	Yes	No	Abstain	Voting – P&T Committee Members	Yes	No	Abstain
Avery, Eric, M.D	x			Fornander, Wade, M.D	x		
Baker, Claire, M.D (Chair) • <i>Votes only in the event of a tie</i>				Hammond, Mary, Pharm.D.	x		
Bleicher, Stacie, M.D	x			Humphries, Laurie, M.D	x		
Caudill, Christopher, M.D	x			Juracek, Joyce, Pharm.D.	x		
Clarey, Kyle, Pharm.D.	x			Pohl, Jessica, Pharm.D.	x		
Dering Anderson, Allison, Pharm.D.	x			Saunders, Kenneth, Pharm.D.	x		
				Sobeski, Linda, Pharm.D.	x		

Review Agenda – Oncology, Oral - Breast

(1st) Motion: Avery

(2nd) Motion: Caudill

Discussion: For all oncology drugs: Non-preferred agent is NOT covered, if chemical equivalent preferred agent is available. Agents should be broken out by disease. Need to implement a hard stop for generic drugs with Brand Name Preferred product.

Voting – P&T Committee Members	Yes	No	Abstain	Voting – P&T Committee Members	Yes	No	Abstain
Avery, Eric, M.D	x			Fornander, Wade, M.D	x		
Baker, Claire, M.D (Chair) • <i>Votes only in the event of a tie</i>				Hammond, Mary, Pharm.D.	x		
Bleicher, Stacie, M.D	x			Humphries, Laurie, M.D	x		
Caudill, Christopher, M.D	x			Juracek, Joyce, Pharm.D.	x		
Clarey, Kyle, Pharm.D.	x			Pohl, Jessica, Pharm.D.	x		
Dering Anderson, Allison, Pharm.D.	x			Saunders, Kenneth, Pharm.D.	x		
				Sobeski, Linda, Pharm.D.	x		

Review Agenda – Oncology, Oral - Hematologic

(1st) Motion: Avery

(2nd) Motion: Caudill

Discussion: For all oncology drugs: Non-preferred agent is NOT covered, if chemical equivalent preferred agent is available. Agents should be broken out by disease. Need to implement a hard stop for generic drugs with Brand Name Preferred Product. Move Tasigna to non-preferred.

Voting – P&T Committee Members	Yes	No	Abstain	Voting – P&T Committee Members	Yes	No	Abstain
Avery, Eric, M.D	x			Fornander, Wade, M.D	x		
Baker, Claire, M.D (Chair) • <i>Votes only in the event of a tie</i>				Hammond, Mary, Pharm.D.	x		
Bleicher, Stacie, M.D	x			Humphries, Laurie, M.D	x		
Caudill, Christopher, M.D	x			Juracek, Joyce, Pharm.D.	x		
Clarey, Kyle, Pharm.D.	x			Pohl, Jessica, Pharm.D.	x		
Dering Anderson, Allison, Pharm.D.	x			Saunders, Kenneth, Pharm.D.	x		
				Sobeski, Linda, Pharm.D.	x		

Review Agenda – Oncology, Oral - Lung

(1st) Motion: Avery

(2nd) Motion: Juracek

Discussion: Approve as written.

Voting – P&T Committee Members	Yes	No	Abstain	Voting – P&T Committee Members	Yes	No	Abstain
Avery, Eric, M.D	x			Fornander, Wade, M.D	x		
Baker, Claire, M.D (Chair) • <i>Votes only in the event of a tie</i>				Hammond, Mary, Pharm.D.	x		
Bleicher, Stacie, M.D	x			Humphries, Laurie, M.D	x		
Caudill, Christopher, M.D	x			Juracek, Joyce, Pharm.D.	x		
Clarey, Kyle, Pharm.D.	x			Pohl, Jessica, Pharm.D.	x		
Dering Anderson, Allison, Pharm.D.	x			Saunders, Kenneth, Pharm.D.	x		
				Sobeski, Linda, Pharm.D.	x		

Review Agenda – Oncology, Oral - Prostate

(1st) Motion: Avery

(2nd) Motion: Fornander

Discussion: For all oncology drugs: Non-preferred agent is NOT covered, if chemical equivalent preferred agent is available. Agents should be broken out by disease. Need to implement a hard stop for generic drugs with Brand Name Preferred Product. Remove “males only” verbiage from criteria.

Voting – P&T Committee Members	Yes	No	Abstain	Voting – P&T Committee Members	Yes	No	Abstain
Avery, Eric, M.D	x			Fornander, Wade, M.D	x		
Baker, Claire, M.D (Chair) • <i>Votes only in the event of a tie</i>				Hammond, Mary, Pharm.D.	x		
Bleicher, Stacie, M.D	x			Humphries, Laurie, M.D	x		
Caudill, Christopher, M.D	x			Juracek, Joyce, Pharm.D.	x		
Clarey, Kyle, Pharm.D.	x			Pohl, Jessica, Pharm.D.	x		
Dering Anderson, Allison, Pharm.D.	x			Saunders, Kenneth, Pharm.D.	x		
				Sobeski, Linda, Pharm.D.	x		

Review Agenda – Oncology, Oral – Renal Cell

(1st) Motion: Avery

(2nd) Motion: Juracek

Discussion: For all oncology drugs: Non-preferred agent is NOT covered, if chemical equivalent preferred agent is available. Agents should be broken out by disease. Need to implement a hard stop for generic drugs with Brand Name Preferred product.

Voting – P&T Committee Members	Yes	No	Abstain	Voting – P&T Committee Members	Yes	No	Abstain
Avery, Eric, M.D	x			Fornander, Wade, M.D	x		
Baker, Claire, M.D (Chair) • <i>Votes only in the event of a tie</i>				Hammond, Mary, Pharm.D.	x		
Bleicher, Stacie, M.D	x			Humphries, Laurie, M.D	x		
Caudill, Christopher, M.D	x			Juracek, Joyce, Pharm.D.	x		
Clarey, Kyle, Pharm.D.	x			Pohl, Jessica, Pharm.D.	x		
Dering Anderson, Allison, Pharm.D.	x			Saunders, Kenneth, Pharm.D.	x		
				Sobeski, Linda, Pharm.D.	x		

Review Agenda – Oncology, Oral - Skin

(1st) Motion: Avery

(2nd) Motion: Caudill

Discussion: For all oncology drugs: Non-preferred agent is NOT covered, if chemical equivalent preferred agent is available. Agents should be broken out by disease. Need to implement a hard stop for generic drugs with Brand Name Preferred Product. Move Odomzo to non-preferred; Move Mektovi / Braftovi to preferred.

Voting – P&T Committee Members	Yes	No	Abstain	Voting – P&T Committee Members	Yes	No	Abstain
Avery, Eric, M.D	x			Fornander, Wade, M.D	x		
Baker, Claire, M.D (Chair) • <i>Votes only in the event of a tie</i>				Hammond, Mary, Pharm.D.	x		
Bleicher, Stacie, M.D	x			Humphries, Laurie, M.D	x		
Caudill, Christopher, M.D	x			Juracek, Joyce, Pharm.D.	x		
Clarey, Kyle, Pharm.D.	x			Pohl, Jessica, Pharm.D.	x		
Dering Anderson, Allison, Pharm.D.	x			Saunders, Kenneth, Pharm.D.	x		
				Sobeski, Linda, Pharm.D.	x		

Review Agenda – Ophthalmic, Antibiotics

(1st) Motion: Fornander

(2nd) Motion: Caudill

Discussion: Approve as written.

Voting – P&T Committee Members	Yes	No	Abstain	Voting – P&T Committee Members	Yes	No	Abstain
Avery, Eric, M.D	x			Fornander, Wade, M.D	x		
Baker, Claire, M.D (Chair) • <i>Votes only in the event of a tie</i>				Hammond, Mary, Pharm.D.	x		
Bleicher, Stacie, M.D	x			Humphries, Laurie, M.D	x		
Caudill, Christopher, M.D	x			Juracek, Joyce, Pharm.D.	x		
Clarey, Kyle, Pharm.D.	x			Pohl, Jessica, Pharm.D.	x		
Dering Anderson, Allison, Pharm.D.	x			Saunders, Kenneth, Pharm.D.	x		
				Sobeski, Linda, Pharm.D.	x		

Review Agenda – Ophthalmic Antibiotic-Steroid Combinations

(1st) Motion: Juracek

(2nd) Motion: Pohl

Discussion: Approve as written.

Voting – P&T Committee Members	Yes	No	Abstain	Voting – P&T Committee Members	Yes	No	Abstain
Avery, Eric, M.D	x			Fornander, Wade, M.D	x		
Baker, Claire, M.D (Chair) • <i>Votes only in the event of a tie</i>				Hammond, Mary, Pharm.D.	x		
Bleicher, Stacie, M.D	x			Humphries, Laurie, M.D	x		
Caudill, Christopher, M.D	x			Juracek, Joyce, Pharm.D.	x		
Clarey, Kyle, Pharm.D.	x			Pohl, Jessica, Pharm.D.	x		
Dering Anderson, Allison, Pharm.D.	x			Saunders, Kenneth, Pharm.D.	x		
				Sobeski, Linda, Pharm.D.	x		

Review Agenda – Ophthalmic Anti-Inflammatories

(1st) Motion: Saunders

(2nd) Motion: Humphries

Discussion: Approve as written.

Voting – P&T Committee Members	Yes	No	Abstain	Voting – P&T Committee Members	Yes	No	Abstain
Avery, Eric, M.D	x			Fornander, Wade, M.D	x		
Baker, Claire, M.D (Chair) • <i>Votes only in the event of a tie</i>				Hammond, Mary, Pharm.D.	x		
Bleicher, Stacie, M.D	x			Humphries, Laurie, M.D	x		
Caudill, Christopher, M.D	x			Juracek, Joyce, Pharm.D.	x		
Clarey, Kyle, Pharm.D.	x			Pohl, Jessica, Pharm.D.	x		
Dering Anderson, Allison, Pharm.D.	x			Saunders, Kenneth, Pharm.D.	x		
				Sobeski, Linda, Pharm.D.	x		

Review Agenda – Ophthalmic, Glaucoma Agents

(1st) Motion: Humphries

(2nd) Motion: Juracek

Discussion: Approve as written.

Voting – P&T Committee Members	Yes	No	Abstain	Voting – P&T Committee Members	Yes	No	Abstain
Avery, Eric, M.D	x			Fornander, Wade, M.D	x		
Baker, Claire, M.D (Chair) • <i>Votes only in the event of a tie</i>				Hammond, Mary, Pharm.D.	x		
Bleicher, Stacie, M.D	x			Humphries, Laurie, M.D	x		
Caudill, Christopher, M.D	x			Juracek, Joyce, Pharm.D.	x		
Clarey, Kyle, Pharm.D.	x			Pohl, Jessica, Pharm.D.	x		
Dering Anderson, Allison, Pharm.D.	x			Saunders, Kenneth, Pharm.D.	x		
				Sobeski, Linda, Pharm.D.	x		

Review Agenda – Progesterone (hydroxyprogesterone caproate)

(1st) Motion: Juracek

(2nd) Motion: Pohl

Discussion: Approve as written.

Voting – P&T Committee Members	Yes	No	Abstain	Voting – P&T Committee Members	Yes	No	Abstain
Avery, Eric, M.D	x			Fornander, Wade, M.D	x		
Baker, Claire, M.D (Chair) • <i>Votes only in the event of a tie</i>				Hammond, Mary, Pharm.D.	x		
Bleicher, Stacie, M.D	x			Humphries, Laurie, M.D	x		
Caudill, Christopher, M.D	x			Juracek, Joyce, Pharm.D.	x		
Clarey, Kyle, Pharm.D.	x			Pohl, Jessica, Pharm.D.	x		
Dering Anderson, Allison, Pharm.D.		x		Saunders, Kenneth, Pharm.D.	x		
				Sobeski, Linda, Pharm.D.	x		

Review Agenda – Steroids, Topical Low

(1st) Motion: Pohl

(2nd) Motion: Hammond

Discussion: Approve as written.

Voting – P&T Committee Members	Yes	No	Abstain	Voting – P&T Committee Members	Yes	No	Abstain
Avery, Eric, M.D	x			Fornander, Wade, M.D	x		
Baker, Claire, M.D (Chair) • <i>Votes only in the event of a tie</i>				Hammond, Mary, Pharm.D.	x		
Bleicher, Stacie, M.D	x			Humphries, Laurie, M.D	x		
Caudill, Christopher, M.D	x			Juracek, Joyce, Pharm.D.	x		
Clarey, Kyle, Pharm.D.	x			Pohl, Jessica, Pharm.D.	x		
Dering Anderson, Allison, Pharm.D.	x			Saunders, Kenneth, Pharm.D.	x		
				Sobeski, Linda, Pharm.D.	x		

Review Agenda – Stimulants and Related Drugs

(1st) Motion: Avery

(2nd) Motion: Saunders

Discussion: All preferred and non-preferred agents require an FDA approved indication. Requested implementation by March 1, 2019.

Voting – P&T Committee Members	Yes	No	Abstain	Voting – P&T Committee Members	Yes	No	Abstain
Avery, Eric, M.D	x			Fornander, Wade, M.D	x		
Baker, Claire, M.D (Chair) • <i>Votes only in the event of a tie</i>				Hammond, Mary, Pharm.D.	x		
Bleicher, Stacie, M.D	x			Humphries, Laurie, M.D	x		
Caudill, Christopher, M.D	x			Juracek, Joyce, Pharm.D.			
Clarey, Kyle, Pharm.D.	x			Pohl, Jessica, Pharm.D.	x		
Dering Anderson, Allison, Pharm.D.	x			Saunders, Kenneth, Pharm.D.	x		
				Sobeski, Linda, Pharm.D.	x		

**Nebraska Medicaid
Preferred Drug List
with
Prior Authorization Criteria**

November 2018 P&T Proposed Changes *Highlights* indicate proposed changes

ALZHEIMER'S DRUGS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CHOLINESTERASE INHIBITORS		<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a 120-day trial of ONE preferred agent within the last 6 months OR Current, stabilized therapy of the non-preferred agent within the previous 45 days
donepezil (generic for Aricept) donepezil ODT (generic for Aricept ODT) EXELON Transdermal (rivastigmine)	donepezil 23 (generic for Aricept 23) galantamine (generic for Razadyne) SOLUTION, TABLET galantamine ER (generic for Razadyne ER) rivastigmine (generic for Exelon)	
NMDA RECEPTOR ANTAGONIST		<p>Drug-specific criteria:</p> <ul style="list-style-type: none"> Donepezil 23: Requires donepezil 10mg/day for at least 3 months AND clinical reason as to why 5mg or 10mg tablets can't be used (to deliver 20mg or 25mg)
memantine (generic for Namenda)	memantine ER (generic for Namenda XR) memantine soln (generic for Namenda) NAMENDA (memantine) NAMENDA SOLUTION NAMZARIC (memantine/donepezil)	

ANTHELMINTICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ALBENZA (albendazole) BILTRICIDE (praziquantel) ivermectin pyrantel pamoate OTC STROMECTOL (ivermectin)	EMVERM (mebendazole) praziquantel (generic for Biltricide)	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agents within the last 6 months <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> Emverm: Approval will be considered for indications not covered by preferred agents

ANTI-ALLERGENS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	ORALAIR (sweet vernal/orchard/rye/timothy/kentucky blue grass mixed pollen allergen extract)	<p>Class Criteria:</p> <ul style="list-style-type: none"> Approved for immunotherapy for the treatment of grass pollen-induced allergic rhinitis with or without conjunctivitis. Patient has had treatment failure with or contraindication to: antihistamines AND montelukast Clinical reason as to why allergy shots cannot be used. <p>Drug-specific criteria:</p> <p>ORALAIR</p> <ul style="list-style-type: none"> Confirmed by positive skin test or in vitro testing for pollen-specific IgE antibodies for Sweet Vernal, Orchard, Perennial Rye, Timothy, and Kentucky Blue Grass Mixed Pollens. For use in patients 10 through 65 years of age.

ANTI-HISTAMINES, MINIMALLY SEDATING

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
cetirizine TABLET, SOLUTION (generic for Zyrtec) loratadine TABLET, SOLUTION (generic for Claritin) levocetirizine TABLET (generic for Xyzal)	cetirizine CHEWABLE (generic for Zyrtec) desloratadine (generic for Clarinex) desloratadine ODT (generic for Clarinex Reditabs) fexofenadine (generic for Allegra) levocetirizine (generic for Xyzal) SOLUTION loratadine CAPSULE, CHEWABLE, DISPERSABLE TABLET (generic for Claritin Reditabs)	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed TWO preferred agents Combination products not covered – individual products may be covered

ANTI-HYPERTENSIVES, SYMPATHOLYTICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CATAPRES-TTS (clonidine) clonidine TABLET (generic for Catapres) guanfacine (generic for Tenex) methyldopa	clonidine TRANSDERMAL CLORPRES (chloralidone/clonidine) methyldopa/hydrochlorothiazide reserpine	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a 30-day trial with ONE preferred agent

ANTIHYPERTENSIVES

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
allopurinol (generic for Zyloprim) colchicine CAPSULE (generic for Mitigare) probenecid probenecid/colchicine (generic for Col-Probenecid)	colchicine TABLET (generic for Colcrys) ^{CL} <i>DUZALLO (allopurinol/lesinurad)</i> ULORIC (febuxostat) ^{CL} ZURAMPIC (lesinurad) ^{CL}	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial with ONE preferred agent colchicine tablet®: Approved without trial for familial Mediterranean fever OR pericarditis Uloric®: Clinical reason why allopurinol cannot be used Zurampic®: Requires trial of allopurinol and Uloric®

ANTIPARKINSON'S DRUGS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ANTICHOLINERGICS		<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed ONE preferred agents within the same group
benztropine (generic for Cogentin) trihexyphenidyl (generic for Artane)		
COMT INHIBITORS		Drug-specific criteria: <ul style="list-style-type: none"> Carbidopa/Levodopa ODT: Approved for documented swallowing disorder COMT Inhibitors: Approved if using as add-on therapy with levodopa-containing drug Gocovri: <i>Required diagnosis of Parkinson's disease and had trial of or is intolerant to amantadine AND must be used as an add-on therapy with levodopa-containing drug</i> Neupro®: <ul style="list-style-type: none"> For Parkinsons: Clinical reason required why preferred agent cannot be used For Restless Leg (RLS): Requires trial OR Contraindication to ropinirole AND pramipexole Osmolex ER: <i>Required diagnosis of Parkinson's disease or drug-induced extrapyramidal reactions and had trial of or is intolerant to amantadine IR</i> Pramipexole ER: Required diagnosis of Parkinson's along with preferred agent trial Ropinirole ER: Required diagnosis of Parkinson's along with preferred agent trial Zelapar®: Approved for documented swallowing disorder
	entacapone (generic for Comtan) tolcapone (generic for Tasmar)	
DOPAMINE AGONISTS		
bromocriptine (generic for Parlodel) pramipexole (generic for Mirapex) ropinirole (generic for Requip)	NEUPRO (rotigotine) ^{CL} pramipexole ER (generic for Mirapex ER) ^{CL} ropinirole ER (generic for REQUIP XL) ^{CL}	
MAO-B INHIBITORS		
selegiline TABLET (generic for Eldepryl)	rasagiline ^{QL} (generic for Azilect) selegiline CAPSULE (gen. for Eldepryl) XADAGO (safinamide) ZELAPAR (selegiline) ^{CL}	
OTHER ANTIPARKINSON'S DRUGS		
amantadine CAPSULE, SYRUP (generic for Symmetrel) carbidopa/levodopa (generic for Sinemet) carbidopa/levodopa ER (generic for Sinemet CR) levodopa/carbidopa/entacapone (generic for Stalevo)	amantadine TABLET carbidopa (generic for Lodosyn) carbidopa/levodopa ODT (generic for Parcopa) DUOPA (carbidopa/levodopa) <i>GOCOVRI (amantadine)^{QL}</i> <i>OSMOLEX ER (amantadine)^{QL}</i> RYTARY (carbidopa/levodopa) STALEVO (levodopa/carbidopa/entacapone)	

ANTIPSORIATICS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
acitretin (generic for Soriatane)	methoxsalen (generic for Oxsoralen-Ultra) SORIATANE (acitretin)	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial with THE preferred agent Trial of acitretin (Pregnancy category X) not required in pregnancy or while attempting or planning pregnancy

ANTIPSORIATICS, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
calcipotriene CREAM, OINTMENT, SOLUTION,	calcitriol (generic for Vectical) calcipotriene/betamethasone (generic for Taclonex) CALCITRENE (calcipotriene) DOVONEX CREAM (calcipotriene) ENSTILAR (calcipotriene/betamethasone) SORILUX (calcipotriene) TACLONEX SCALP (calcipotriene/betamethasone)	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial with ONE preferred agent

ANXIOLYTICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
alprazolam TABLET (generic for Xanax) buspirone (generic for Buspar) chlordiazepoxide diazepam TABLET, SOLUTION (generic for Valium) lorazepam INTENSOL, TABLET (generic for Ativan)	alprazolam ER (generic for Xanax XR) alprazolam ODT alprazolam INTENSOL clorazepate (generic for Tranxene-T) diazepam INTENSOL meprobamate oxazepam	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial with TWO preferred agents <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> Diazepam Intensol®: Requires clinical reason why diazepam solution cannot be used Alprazolam Intensol®: Requires trial of diazepam solution OR lorazepam Intensol®

BILE SALTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ursodiol 250mg TABLET (generic for URSO) ursodiol 500mg TABLET (generic for URSO FORTE)	CHENODAL (chenodiol) CHOLBAM (cholic acid) OCALIVA (obeticholic acid) ursodiol CAPSULE 300mg (generic for Actigall)	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial with ONE preferred agent

BRONCHODILATORS, BETA AGONIST

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
INHALERS – Short Acting		<ul style="list-style-type: none">Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within the same group <p>Drug-specific criteria:</p> <ul style="list-style-type: none">Ventolin HFA®: Requires trial and failure on Proventil HFA® AND Proair HFA® OR allergy/contraindication/side effect to BOTHXopenex®: Covered for cardiac diagnoses or side effect of tachycardia with albuterol product
PROAIR HFA (albuterol) PROVENTIL HFA (albuterol)	PROAIR RESPICLICK (albuterol) levalbuterol HFA (generic for Xopenex HFA) VENTOLIN HFA (albuterol)	
INHALERS – Long Acting		
SEREVENT (salmeterol)	ARCAPTA NEOHALER (indacaterol) STRIVERDI RESPIMAT (olodaterol)	
INHALATION SOLUTION		
albuterol (2.5mg/3ml premix or 2.5mg/0.5ml) albuterol 100 mg/20 mL albuterol low dose (0.63mg/3ml & 1.25mg/3ml)	BROVANA (arformoterol) levalbuterol (generic for Xopenex) PERFOROMIST (formoterol)	
ORAL		
albuterol SYRUP terbutaline (generic for Brethine)	albuterol TABLET albuterol ER (generic for Vospire ER) metaproterenol (formerly generic for Alupent)	

COLONY STIMULATING FACTORS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
NEUPOGEN (filgrastim) VIAL	GRANIX (tbo-filgrastim) NEUPOGEN (filgrastim) DISP SYR <i>NIVESTYM (filgrastim-aafi) SYR</i> ZARXIO (filgrastim-sndz)	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent

COPD (CHRONIC OBSTRUCTIVE PULMONARY DISEASE) AGENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
INHALERS		<ul style="list-style-type: none">Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent in the same group OR Patient specific documentation of inability to use traditional inhaler device. <p>Drug-specific criteria:</p> <ul style="list-style-type: none">Daliresp®:<ul style="list-style-type: none">Covered for diagnosis of severe COPD associated with chronic bronchitisRequires trial of a bronchodilatorRequires documentation of one exacerbation in last year upon initial review
ATROVENT HFA (ipratropium) BEVESPI AEROSPHERE (glycopyrolate/formoterol) <i>COMBIVENT RESPIMAT (albuterol/ ipratropium)</i> <i>STIOLTO RESPIMAT (tiotropium/olodaterol)</i> SPIRIVA (tiotropium)	ANORO ELLIPTA (umeclidinium/vilanterol) INCRUSE ELIPTA (umeclidinium) SEEBRI NEOHALER (glycopyrolate) SPIRIVA RESPIMAT (tiotropium) TUDORZA PRESSAIR (aclidinium br) UTIBRON NEOHALER (indacaterol/glycopyrolate)	
INHALATION SOLUTION		
albuterol/ipratropium (generic for Duoneb) ipratropium SOLUTION (generic for Atrovent)	<i>LONHALA (glycopyrrolate inhalation soln)</i>	
ORAL AGENT		
DALIRESP (roflumilast) ^{CL}		

COUGH AND COLD, OPIATE COMBINATION

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
guaifenesin/codeine LIQUID promethazine/codeine SYRUP	hydrocodone/homatropine SYRUP promethazine/phenylephrine/codeine SYRUP pseudoephedrine/codeine/ guaifenesin (generic for Lortuss EX, Tusnel C, Virtussin DAC)	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent

CYTOKINE & CAM ANTAGONISTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
COSENTYX (secukinumab) ^{CL} ENBREL (etanercept) KIT, <i>MINI CART</i>, PEN^{QL} HUMIRA (adalimumab) ^{QL}	ACTEMRA (tocilizumab) SUB-Q ARCALYST (nilonacept) CIMZIA (certolizumab pegol) ^{QL} <i>ILUMYA (tildrakizumab) SUB-Q</i> KEVZARA (sarilumab) SUB-Q, PEN, SYRINGE KINERET (anakinra) <i>OLUMIANT (baricitinib) ORAL^{QL}</i> ORENCIA (abatacept) SUB-Q OTEZLA (apremilast) ORAL^{QL} SILIQ (brodalumab) SIMPONI (golimumab) STELARA (ustekinumab) SUB-Q TALTZ (ixekizumab) ^{AL} TREMFYA (guselkumab) ^{QL} XELJANZ (tofacitinib) ORAL^{QL} XELJANZ XR (tofacitinib) ORAL^{QL}	<ul style="list-style-type: none"> Non-preferred agents will be approved for FDA-approved indications in patients who have failed a trial of ONE preferred agent Drug-specific criteria: <ul style="list-style-type: none"> Cosentyx: Requires trial of Humira

ENZYME REPLACEMENT, GAUCHERS DISEASE

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<i>ZAVESCA (miglustat)</i>	CERDELGA (eliglustat) miglustat (generic Zavesca)	<ul style="list-style-type: none"> Non-preferred agents DO NOT require a trial of a preferred agent, but DO require an FDA-approved indication

EPINEPHRINE, SELF-INJECTED

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
epinephrine (generic for Epipen/ Epipen Jr.)	epinephrine (generic for Adrenaclick) EPIPEN EPIPEN JR.	<ul style="list-style-type: none"> Non-preferred agents require clinical documentation why the preferred product is not appropriate Brand name product may be authorized in event of documented national shortage of generic product.

ERYTHROPOIESIS STIMULATING PROTEINS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
PROCIT (rHuEPO) <i>RETACRIT (EPOETIN ALFA- EPBX)</i>	<i>EPOGEN (rHuEPO)</i>	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent

GLUCOCORTICOIDS, INHALED

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
GLUCOCORTICOIDS		<ul style="list-style-type: none">Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within the last 6 months <p>Drug-specific criteria:</p> <ul style="list-style-type: none">Budesonide respules: Covered without PA for age ≤ 8 years OR for diagnosis of eosinophilic esophagitis in patients ≥ 9 years, by GI biopsy or upper endoscopy
ASMANEX (mometasone) ^{QL,AL} FLOVENT HFA (fluticasone) PULMICORT FLEXHALER (budesonide)	AEROSPAN (flunisolide) ALVESCO (ciclesonide) ^{AL,CL} ARMONAIR RESPICLICK (fluticasone) ^{AL} ARNUITY ELLIPTA (fluticasone) ASMANEX HFA (mometasone) ^{AL,QL} FLOVENT DISKUS (fluticasone) QVAR (beclomethasone) <i>QVAR Redihaler (beclomethasone)</i>	
GLUCOCORTICOID/BRONCHODILATOR COMBINATIONS		
ADVAIR DISKUS (fluticasone/salmeterol) ^{QL} DULERA (mometasone/formoterol) SYMBICORT (budesonide/ formoterol)	ADVAIR HFA (fluticasone/salmeterol) ^{QL} BREO ELLIPTA (fluticasone/vilanterol) fluticasone/salmeterol (generic for Airduo Respiclick) <i>TRELEGY ELLIPTA (fluticasone/umeclidinium/vilanterol)</i>	
INHALATION SOLUTION		
	budesonide RESPULES (generic for Pulmicort)	

GLUCOCORTICOIDS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
budesonide EC CAPSULE (generic for Entocort EC) dexamethasone SOLN, TABLET dexamethasone ELIXIR hydrocortisone TABLET methylprednisolone DOSE PAK methylprednisolone tablet (generic for Medrol) prednisolone SOLUTION prednisolone sodium phosphate prednisone DOSE PAK prednisone TABLET	CORTEF (hydrocortisone) cortisone TABLET dexamethasone INTENSOL DEXPAK (dexamethasone) EMFLAZA (deflazacort) SUSPENSION, TABLET^{CL} ENTOCORT EC (budesonide) <i>methylprednisolone 8mg, 16mg</i> ORAPRED ODT (prednisolone sodium phosphate) PEDIAPRED (prednisolone sodium phosphate) prednisolone sodium phosphate (generic for Millipred/Veripred) prednisolone sodium phosphate ODT <i>prednisone SOLUTION</i> prednisone INTENSOL RAYOS DR (prednisone) TABLET	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agents within the last 6 months <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> Emflaza: Indicated for the treatment of Duchenne muscular dystrophy (DMD) in patients 5 years of age and older <ul style="list-style-type: none"> Approved after trial/failure with prednisone Intensol Products: Patient specific documentation of why the less concentrated solution is not appropriate for the patient

HEMOPHILIA TREATMENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
FACTOR VIII		▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent
ADVATE ALPHANATE HUMATE-P MONOCLATE-P NOVOEIGHT NUWIQ RECOMBIMATE XYNTHA KIT, SOLOFUSE	ADYNOVATE AFSTYLA ELOCTATE HELIXATE FS HEMOFIL-M JIVI ^{AL} KOATE-DVI KIT, VIAL KOGENATE FS KOVALTRY OBIZUR	
FACTOR IX		
BENEFIX MONONINE PROFILNINE SD	ALPHANINE SD ALPROLIX BEBULIN IDELVION IXINITY REBINYN RIXUBIS	
FACTOR VIIa AND PROTHROMBIN COMPLEX-PLASMA DERIVED		
NOVOSEVEN RT	FEIBA NF	
FACTOR X AND XIII PRODUCTS		
CORIFACT ^{CL}	COAGADEX ^{CL} TRETEN ^{CL}	
VON WILLEBRAND PRODUCTS		
WILATE	VONVENDI ^{CL}	
OTHER		
	HEMLIBRA ^{CL}	

HISTAMINE II RECEPTOR BLOCKERS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
famotidine TABLET (generic for Pepcid) ranitidine TABLET, SYRUP (generic for Zantac)	cimetidine TABLET, SOLUTION (generic for Tagamet) famotidine SUSPENSION nizatidine (generic for Axid) ranitidine CAPSULE	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> Cimetidine: Approved for viral <i>M. contagiosum</i> or common wart <i>V. Vulgaris</i> treatment Nizatidine/Cimetidine Solution/Famotidine Suspension: Requires clinical reason why ranitidine syrup cannot be used

IDIOPATHIC PULMONARY FIBROSIS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	ESBRIET (pirfenidone) OFEV (nintedanib esylate)	<ul style="list-style-type: none"> Non-preferred agents require: Use limited to FDA-approved indications

IMMUNOMODULATORS, ATOPIC DERMATITIS^{AL}

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ELIDEL (pimecrolimus)	tacrolimus (generic for Protopic) ^{CL} DUPIXENT (dupilumab) ^{CL} EUCRISA (crisaborole)	<ul style="list-style-type: none"> Non-preferred agents require: Trial of a topical steroid AND Trial of one preferred product <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> Dupixent: For atopic dermatitis, must follow non-preferred drug criteria; For moderate to severe asthma, must have eosinophilic phenotype or oral corticosteroid dependent asthma uncontrolled with maintenance controller medication

IMMUNOMODULATORS, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
imiquimod (generic for Aldara)	ALDARA (imiquimod) imiquimod (generic for Zyclara) <i>podofilox (generic for Condyllox)</i> <i>VEREGEN (sinecatechins)</i> ZYCLARA (imiquimod)	<ul style="list-style-type: none"> Non-preferred agents require clinical reason why preferred agent cannot be used

INTRANASAL RHINITIS DRUGS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ANTICHOLINERGICS		<ul style="list-style-type: none">Non-preferred agents will be approved for patients who have failed a 30-day trial of ONE preferred agent within the same group
ipratropium (generic for Atrovent)		
ANTI-HISTAMINES		Drug-specific criteria: <ul style="list-style-type: none">Mometasone: Prior authorization NOT required for children ≤ 12 yearsBudesonide: Approved for use in Pregnancy (Pregnancy Category B)Veramyst®: Prior authorization NOT required for children ≤ 12 years
azelastine 0.1% (generic for Astelin)	<i>azelastine 0.15% (generic for Astepro)</i> DYMISTA (azelastine/fluticasone) <i>olopatadine (generic for Patanase)</i>	
CORTICOSTEROIDS		
fluticasone (generic for Flonase)	BECONASE AQ (beclomethasone) budesonide Rx (generic for Rhinocort) flunisolide (generic for Nasalide) mometasone (generic for Nasonex) OMNARIS (ciclesonide) QNASL 40 & 80 (beclomethasone) TICANASE (fluticasone) VERAMYST (fluticasone) <i>XHANCE (fluticasone)</i> ZETONNA (ciclesonide)	

LEUKOTRIENE MODIFIERS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
montelukast TABLET/CHEWABLE (generic for Singulair)	montelukast GRANULES (generic for Singulair) zafirlukast (generic for Accolate) zileuton ER (generic for Zflo CR) ZYFLO (zileuton)	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a 30-day trial of THE preferred agent Drug-specific criteria: <ul style="list-style-type: none"> Montelukast granules: PA not required for age < 2 years

METHOTREXATE

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
methotrexate PF VIAL, TABLET, VIAL	OTREXUP (methotrexate) SUB-Q RASUVO (methotrexate) SUB-Q TREXALL (methotrexate) TABLET XATMEP (methotrexate) SOLUTION	<ul style="list-style-type: none"> Non-preferred agents will be approved for FDA-approved indications Drug-specific criteria: <ul style="list-style-type: none"> Xatmep™: Indicated for pediatric patients only

MOVEMENT DISORDERS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	AUSTEDO (deutetrabenazine) ^{CL} INGREZZA (valbenazine) ^{CL} tetrabenazine (generic for Xenazine) ^{CL}	Drug-specific criteria: <ul style="list-style-type: none"> ▪ Austedo: Diagnosis of chorea associated with Huntington's Disease OR Tardive Dyskinesia ▪ Ingrezza: Diagnosis of Tardive Dyskinesia in adults ▪ Tetrabenazine: Diagnosis of chorea with Huntington Disease

NSAIDS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
COX-I SELECTIVE		<ul style="list-style-type: none"> ▪ Non-preferred agents will be approved for patients who have failed no less than 30-day trial of TWO preferred agents
diclofenac sodium (generic for Voltaren) diclofenac SR (generic for Voltaren-XR) ibuprofen OTC, Rx (generic for Advil, Motrin) CHEW, DROPS, SUSPENSION, TABLET indomethacin CAPSULE (generic for Indocin) ketorolac (generic for Toradol) meloxicam TABLET (generic for Mobic) nabumetone (generic for Relafen) naproxen Rx, OTC (generic for Naprosyn) naproxen enteric coated sulindac (generic for Clinoril)	diclofenac potassium (generic for Cataflam, Zipsor) diflunisal (generic for Dolobid) etodolac & SR (generic for Lodine/XL) fenoprofen (generic for Nalfon) flurbiprofen (generic for Ansaid) ibuprofen OTC (generic for Advil, Motrin) CAPSULE indomethacin ER (generic for Indocin) INDOCIN RECTAL, SUSPENSION ketoprofen & ER (generic for Orudis) meclofenamate (generic for Meclomen) mefenamic acid (generic for Ponstel) meloxicam SUSPENSION (generic Mobic) naproxen CR (generic for Naprelan) naproxen SUSPENSION (generic for Naprosyn) naproxen sodium (generic for Anaprox) oxaprozin (generic for Daypro) piroxicam (generic for Feldene) tolmetin (generic for Tolectin)	
		Drug-specific criteria: <ul style="list-style-type: none"> ▪ Arthrotec®: Requires clinical reason why individual ingredients cannot be used ▪ Duexis®/Vimovo®: Requires clinical reason why individual agents cannot be used ▪ Meclofenamate: Approvable without trial of preferred agents for menorrhagia ▪ Meloxicam suspension: Approved for age ≤ 11 years

NSAID (Continued)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
COX-I SELECTIVE (continued)		<ul style="list-style-type: none">Non-preferred agents will be approved for patients who have failed no less than 30-day trial of TWO preferred agents <p>Drug-specific criteria:</p> <ul style="list-style-type: none">Sprix®: Approved for patients unable to tolerate, swallow OR absorb oral NSAIDs OR contraindication OR trial of TWO preferred oral NSAIDsTivorbex®: Requires clinical reason why indomethacin capsules cannot be usedZorvolex®: Requires trial of oral diclofenac OR clinical reason why diclofenac potassium/sodium cannot be used
	ALL BRAND NAME NSAIDs including: CAMBIA (diclofenac oral solution) DUEXIS (ibuprofen/famotidine) SPRIX (ketorolac) ^{QL} TIVORBEX (indomethacin) VIMOVO (naprosyn/esomeprazole) VIVLODEX (meloxicam submicronized) ZIPSOR (diclofenac) ZORVOLEX (diclofenac)	
NSAID/GI PROTECTANT COMBINATIONS		
	diclofenac/misoprostol (generic for Arthrotec)	
COX-II SELECTIVE		
celecoxib (generic for Celebrex)		

NSAIDS, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	diclofenac (generic for Pennsaid Solution) FLECTOR PATCH (diclofenac) PENNSAID PACKET, PUMP (diclofenac) VOLTAREN GEL (diclofenac)	<ul style="list-style-type: none"> Flector®: Approved for diagnosis of acute pain due to sprain/strain/contusion AND trial of oral diclofenac OR clinical reason patient cannot use oral dosage form Pennsaid®: Approved for osteoarthritis of the knees AND trial of oral diclofenac OR clinical reason patient cannot use oral dosage form Pennsaid® Pump: Requires clinical reason why 1.5% solution cannot be used Voltaren®: Approved for diagnosis of osteoarthritis AND trial of oral diclofenac OR clinical reason patient cannot use oral dosage form

NOTE: Other oral oncology agents not listed here may also be available. See <https://nebraska.fhsc.com/default.asp> for coverage information and prior authorization status for products not listed.

ONCOLOGY AGENTS, ORAL, BREAST CANCER

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
anastrozole (generic for Arimidex) cyclophosphamide exemestane (generic for Aromasin) IBRANCE (palbociclib) letrozole (generic for Femara) tamoxifen citrate XELODA (capecitabine)	capecitabine (generic for Xeloda) FARESTON (toremifene) KISQALI (ribociclib) KISQALI FEMARA CO-PACK NERLYNX (neratinib) TALZENNA (talazoparib tosylate) ^{NR, QL} TYKERB (lapatinib) VERZENIO (abemaciclib)	Non-preferred agents DO NOT require a trial of a preferred agent, but DO require an FDA-approved indication OR documentation submitted supporting off-label use from current treatment guidelines Drug-specific criteria <ul style="list-style-type: none"> ▪ Anastrozole: May be approved for malignant neoplasm of male breast (male breast cancer) ▪ Fareston®: Require clinical reason why tamoxifen cannot be used ▪ Letrozole: Approved for diagnosis of breast cancer with day supply greater than 12 – NOT approved for short term use

ONCOLOGY AGENTS, ORAL, HEMATOLOGIC

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ALKERAN (melphalan) GLEEVEC (imatinib) hydroxyurea (generic for Hydrea) IMBRUVICA (irutinib) JAKAFI (ruxolitinib) LEUKERAN (chlorambucil) MATULANE (procarbazine) mercaptopurine MYLERAN (busulfan) REVLIMID (lenalidomide) SPRYCEL (dasatinib) TASIGNA (nilotinib)	BOSULIF (bosutinib) CALQUENCE (acalabrutinib)^{QL} FARYDAK (panobinostat) HYDREA (hydroxyurea) ICLUSIG (ponatinib) IDHIFA (enasidenib) imatinib (generic for Gleevec) melphalan (generic for Alkeran) NINLARO (ixazomib) POMALYST (pomalidomide) PURIXAN (mercaptopurine) RYDAPT (midostaurin) TABLOID (thioguanine) THALOMID (thalidomide) TIBSOVO (ivosidenib)^{QL} tretinoin (generic for Vesanoid) VENCLEXTA (venetoclax) ZOLINZA (vorinostat) ZYDELIG (idelalisib)	Non-preferred agents DO NOT require a trial of a preferred agent, but DO require an FDA-approved indication OR documentation submitted supporting off-label use from current treatment guidelines Drug-specific criteria <ul style="list-style-type: none"> ▪ Hydrea®: Requires clinical reason why generic cannot be used ▪ Tabloid (thioguanine): Prior authorization not required for age < 19

NOTE: Other oral oncology agents not listed here may also be available. See <https://nebraska.fhsc.com/default.asp> for coverage information and prior authorization status for products not listed.

ONCOLOGY AGENTS, ORAL, LUNG

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ALECENSA (alectinib) GILOTRIF (afatinib) HYCAMTIN (topotecan) IRESSA (gefitinib) TAGRISSO (osimertinib) TARCEVA (erlotinib) XALKORI (crizotinib)	ALUNBRIG (brigatinib) VIZIMPRO (dacomitinib) ^{NR, QL} ZYKADIA (ceritinib)	Non-preferred agents DO NOT require a trial of a preferred agent, but DO require an FDA-approved indication OR documentation submitted supporting off-label use from current treatment guidelines

ONCOLOGY AGENTS, ORAL, OTHER

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CAPRELSA (vandetanib) GLEOSTINE (lomustine) temozolomide (generic for Temodar)	COMETRIQ (cabozantinib) HEXALEN (altretamine) LONSURF (trifluridine/tipiracil) LYNPARZA (olaparib) RUBRACA (rucaparib) STIVARGA (regorafenib) ZEJULA (niraparib)	<ul style="list-style-type: none"> Non-preferred agents DO NOT require a trial of a preferred agent, but DO require an FDA-approved indication OR documentation submitted supporting off-label use from current treatment guidelines

ONCOLOGY AGENTS, ORAL, PROSTATE

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
bicalutamide (generic for Casodex) flutamide	CASODEX (bicalutamide) EMCYT (estramustine) ERLEADA (apalutamide)^{QL} nilutamide (generic for Nilandron) XTANDI (enzalutamide) ZYTIGA (abiraterone) YONSA (abiraterone acet, submicronized)	Non-preferred agents DO NOT require a trial of a preferred agent, but DO require an FDA-approved indication OR documentation submitted supporting off-label use from current treatment guidelines <ul style="list-style-type: none"> Nilandron®: Approved for males only for metastatic

NOTE: Other oral oncology agents not listed here may also be available. See <https://nebraska.fhsc.com/default.asp> for coverage information and prior authorization status for products not listed.

ONCOLOGY AGENTS, ORAL, RENAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
INLYTA (axitinib) <i>LENVIMA (lenvatinib)</i> NEXAVAR (sorafenib) SUTENT (sunitinib) VOTRIENT (pazopanib)	<i>AFINITOR (everolimus)</i> AFINITOR DISPERZ (everolimus) ^{CL} CABOMETYX (cabozantinib)	Non-preferred agents DO NOT require a trial of a preferred agent, but DO require an FDA-approved indication OR documentation submitted supporting off-label use from current treatment guidelines Drug-specific criteria <ul style="list-style-type: none"> ▪ Afinitor Disperz®: Requires clinical reason why Afinitor® cannot be used

ONCOLOGY AGENTS, ORAL, SKIN

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
COTELLIC (cobimetinib) ERIVEDGE (vismodegib) MEKINIST (trametinib) ODOMZO (sonidegib) TAFINLAR (dabrafenib) ZELBORAF (vemurafenib)	<i>BRAFTOVI (encorafenib)</i> <i>MEKTOVI (binimetinib)</i>	Non-preferred agents DO NOT require a trial of a preferred agent, but DO require an FDA-approved indication OR documentation submitted supporting off-label use from current treatment guidelines

OPHTHALMICS, ALLERGIC CONJUNCTIVITIS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ALREX (loteprednol 0.2%) cromolyn (generic for Opticrom) ketotifen OTC (generic for Zaditor) PAZEO (olopatadine 0.7%)	ALOCRIL (nedocromil) ALOMIDE (lodoxamide) azelastine (generic for Optivar) BEPREVE (bepotastine besilate) EMADINE (emedastine) epinastine (generic for Elestat) LASTACAFT (alcaftadine) olopatadine 0.1% (generic for Patanol) olopatadine 0.2% (generic for Pataday) PATADAY (olopatadine 0.2%)	<ul style="list-style-type: none"> ▪ Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents

OPHTHALMICS, ANTIBIOTICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
FLUOROQUINOLONES		<ul style="list-style-type: none">Non-preferred agents will be approved for patients who have failed a one month trial of TWO preferred agent within the same groupAzasite®: Approval only requires trial of erythromycin <p>Drug-specific criteria:</p> <ul style="list-style-type: none">Natacyn®: Approved for documented fungal infection
ciprofloxacin SOLUTION (generic for Ciloxan) MOXEZA (moxifloxacin) ofloxacin (generic for Ocuflox)	BESIVANCE (besifloxacin) CILOXAN (ciprofloxacin) gatifloxacin 0.5% (generic for Zymaxid) levofloxacin moxifloxacin (generic for Vigamox) <i>VIGAMOX (moxifloxacin)</i>	
MACROLIDES		
erythromycin	AZASITE (azithromycin)	
AMINOGLYCOSIDES		
gentamicin SOLUTION, OINTMENT tobramycin (generic for Tobrex drops) TOBREX OINTMENT (tobramycin)		
OTHER OPHTHALMIC AGENTS		
polymyxin B/trimethoprim (generic for Polytrim)	bacitracin bacitracin/polymyxin B (generic Polysporin) NATACYN (natamycin) ^{CL} neomycin/bacitracin/polymyxin B OINTMENT neomycin/polymyxin B/gramicidin NEOSPORIN (neomycin/polymyxin B/gramicidin) sulfacetamide SOLUTION (generic for Bleph-10) sulfacetamide OINTMENT	

OPHTHALMICS, ANTIBIOTIC-STEROID COMBINATIONS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
neomycin/polymyxin/dexamethasone (generic for Maxitr) sulfacetamide/prednisolone TOBRADEX SUSPENSION, OINTMENT (tobramycin and dexamethasone)	BLEPHAMIDE (prednisolone and sulfacetamide) BLEPHAMIDE S.O.P. neomycin/polymyxin/HC neomycin/bacitracin/poly/HC PRED-G SUSPENSION, OINTMENT (prednisolone/gentamicin) tobramycin/dexamethasone SUSPENSION (generic for Tobradex) TOBRADEX S.T. (tobramycin and	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents

OPHTHALMICS, ANTI-INFLAMMATORIES

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CORTICOSTEROIDS		<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents NSAID class: Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent
DUREZOL (difluprednate) fluorometholone 0.1% (generic for FML) OINTMENT LOTEMAX SOLUTION (loteprednol 0.5%) MAXIDEX (dexamethasone) PRED MILD (prednisolone 0.12%)	dexamethasone (generic for Maxidex) FLAREX (fluorometholone) FML (fluorometholone 0.1% SOLUT.) FML FORTE (fluorometholone 0.25%) FML S.O.P. (fluorometholone 0.1%) LOTEMAX OINTMENT, GEL (loteprednol) prednisolone acetate 1% (gen. for Omnipred, Pred Forte) prednisolone sodium phosphate	
NSAID		
diclofenac (generic for Voltaren) flurbiprofen (generic for Ocufen) ketorolac 0.5% (generic for Acular)	ACUVAIL (ketorolac 0.45%) BROMSITE (bromfenac) bromfenac 0.09% (generic for Bromday) ILEVRO (nepafenac 0.3%) ketorolac LS 0.4% (generic for Acular LS) NEVANAC (nepafenac) PROLENSA (bromfenac 0.07%)	

OPHTHALMICS, ANTI-INFLAMMATORY / IMMUNOMODULATORS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
RESTASIS (cyclosporine) RESTASIS MULTIDOSE (cyclosporine)	XIIDRA (lifitegrast)	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent

OPHTHALMICS, GLAUCOMA

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
MIOTICS		<ul style="list-style-type: none">Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within the same groupDrug-specific criteria:<ul style="list-style-type: none">Rhopressa: <i>Approved for patients who have failed a trial of ONE generic agent, within ophthalmics-glaucoma within 180 days</i>
pilocarpine	PHOSPHOLINE IODIDE (echothiophate iodide)	
SYMPATHOMIMETICS		
brimonidine 0.2% (generic for Alphagan)	Alphagan P (brimonidine 0.1%) <i>Alphagan P (brimonidine 0.15%)</i> apraclonidine (generic for Iopidine)	
BETA BLOCKERS		
levobunolol (generic for Betagan) metipranolol (generic for Optipranolol) timolol (generic for Timoptic)	betaxolol (generic for Betoptic) BETIMOL (timolol) BETOPTIC S (betaxolol) <i>carteolol (generic for Ocupress)</i> timolol (generic for Istalol) TIMOPTIC OCUDOSE TIMOPTIC XE (timolol gel forming solution)	
CARBONIC ANHYDRASE INHIBITORS		
AZOPT (brinzolamide) dorzolamide (generic for Trusopt)		
PROSTAGLANDIN ANALOGS		
latanoprost (generic for Xalatan) TRAVATAN Z (travoprost)	bimatoprost (generic for Lumigan) <i>VYZULTA (latanoprostene)</i> XALATAN (latanoprost) ZIOPTAN (tafluprost)	
COMBINATION DRUGS		
COMBIGAN (brimonidine/timolol) dorzolamide/timolol (generic for Cosopt) SIMBRINZA (brinzolamide/brimonidine)	dorzolamide/timolol PF (generic for Cosopt PF)	
OTHER		
<i>RHOPRESSA (netarsudil)^{CL}</i>		

OTIC ANTI-INFECTIVES & ANESTHETICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
acetic acid (generic for Vosol)	acetic acid/aluminum (generic for Otic Domeboro) acetic acid/hydrocortisone (generic for Vosol HC)	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial of the preferred agent

OTIC ANTIBIOTICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CIPRODEX (ciprofloxacin/dexamethasone) neomycin/polymyxin/hydrocortisone (generic for Cortisporin) ofloxacin (generic for Floxin)	CIPRO HC (ciprofloxacin/ hydrocortisone) ciprofloxacin COLY-MYCIN S(neomycin/ hydrocortisone/colistin) OTOVEL (ciprofloxacin/fluocinolone)	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent

PROGESTERONE (hydroxyprogesterone caproate)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
MAKENA AUTO INJECTOR <i>(hydroxyprogesterone caproate)</i> MAKENA MDV, SDV (hydroxyprogesterone caproate)	hydroxyprogesterone caproate (generic Makena)	<ul style="list-style-type: none"> When filled as outpatient prescription, use limited to: <ul style="list-style-type: none"> Singleton pregnancy AND Previous Pre-term delivery AND No more than 20 doses (administered between 16 -36 weeks gestation) Maximum of 30 days per dispensing <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> Makena Auto Injector: Provide patient specific clinical documentation of why the preferred product is not appropriate for the patient

SEDATIVE HYPNOTICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
BENZODIAZEPINES		<ul style="list-style-type: none"> ▪ Lunesta®/ Rozerem®/Zolpidem ER: Requires a trial with generic zolpidem within the last 12 months AND Trial OR Clinical reason why zaleplon and preferred benzodiazepines cannot be used ▪ Ativan®/Klonopin®/Valium®: Requires trial of generic Approvable for seizure diagnosis and documentation of seizure activity on generic therapy ▪ Edluar®: Requires a trial with generic zolpidem within the last 12 months AND Trial OR Clinical reason why zaleplon and preferred benzodiazepines cannot be used Requires documentation of swallowing disorder ▪ Flurazepam/Triazolam: Requires trial of BOTH preferred benzodiazepines ▪ Hetlioz®: Requires trial with generic zolpidem within last 12 months AND clinical reason why zaleplon AND preferred benzodiazepines cannot be used ▪ Silenor®: Must meet one of the following: <ul style="list-style-type: none"> ○ Contraindication to preferred oral sedative hypnotics ○ Medical necessity for doxepin dose < 10mg ○ Age greater than 65 years old or hepatic impairment (3mg dose will be approved if this criteria is met) ▪ Temazepam 7.5mg/22.5mg: Requires clinical reason why 15mg/30mg cannot be used ▪ Zolpidem/Zolpidem ER: Maximum daily dose for females: Zolpidem 5mg; Zolpidem ER® 6.25mg ▪ Zolpidem SL: Requires clinical reason why half of zolpidem tablet cannot be used ▪ Zolpimist®: Requires documentation of swallowing disorder
temazepam 15mg, 30mg (generic for Restoril)	estazolam (generic for ProSom) flurazepam (generic for Dalmane) temazepam (generic for Restoril) 7.5mg, 22.5mg triazolam (generic for Halcion)	
OTHERS		
zaleplon (generic for Sonata) zolpidem (generic for Ambien)	BELSOMRA (suvorexant) EDLUAR (zolpidem sublingual) eszopiclone (generic for Lunesta) HETLIOZ (tasimelteon) ^{CL} ROZEREM (ramelteon) SILENOR (doxepin) zolpidem ER (generic for Ambien CR) zolpidem SL (generic for Intermezzo) ZOLPIMIST (zolpidem oral spray)	

STEROIDS, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
LOW POTENCY		<ul style="list-style-type: none"> Low Potency Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent
hydrocortisone OTC & RX CREAM, LOTION, OINTMENT hydrocortisone/aloe OINTMENT, CREAM SCALPICIN OTC (hydrocortisone)	ALA-CORT (hydrocortisone) CREAM ALA-SCALP HP (hydrocortisone) alclometasone dipropionate (generic for Aclovate) CAPEX SHAMPOO (fluocinolone) DESONATE (desonide) GEL desonide LOTION (generic for Desowen) desonide CREAM, OINTMENT (generic for former products Desowen, Tridesilon) fluocinolone 0.01% OIL (generic for DERMA-SMOOTH-ES) MICORT-HC (hydrocortisone) TEXACORT (hydrocortisone)	
MEDIUM POTENCY		<ul style="list-style-type: none"> Medium Potency Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents
fluticasone propionate CREAM, OINTMENT (generic for Cutivate) mometasone furoate CREAM, OINTMENT, SOLUTION (generic for Elocon)	betamethasone valerate (generic for Luxiq) clocortolone (generic for Cloderm) fluocinolone acetonide (generic for Synalar) flurandrenolide (generic for Cordran) fluticasone propionate LOTION (generic for Cutivate) hydrocortisone butyrate (generic for Locoid) hydrocortisone butyrate/emoll (generic for Locoid Lipocream) hydrocortisone valerate (generic for Westcort) PANDEL (hydrocortisone probutate 0.1%) prednicarbate (generic for Dermatop)	

STEROIDS, TOPICAL (Continued)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
HIGH POTENCY		<ul style="list-style-type: none"> High Potency Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents
triamcinolone acetonide OINTMENT, CREAM (generic for Kenalog) triamcinolone LOTION	amcinonide CREAM, LOTION, OINTMENT betamethasone dipropionate (generic for Diprolene) betamethasone dipro/prop gly (augmented) betamethasone valerate (generic for Beta-Val) desoximetasone (generic for Topicort) diflorasone diacetate fluocinonide SOLUTION fluocinonide CREAM, GEL, OINTMENT fluocinonide emollient HALOG (halcinonide) KENALOG AEROSOL (triamcinolone) SERNIVO (betamethasone dipropionate) triamcinolone SPRAY (generic for Kenalog spray) TRIANEX OINTMENT (triamcinolone) VANOS (fluocinonide)	
VERY HIGH POTENCY		<ul style="list-style-type: none"> Very High Potency Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents
clobetasol emollient (generic for Temovate-E) clobetasol propionate (generic for Temovate) halobetasol propionate (generic for Ultravate)	APEXICON-E (diflorasone) clobetasol SHAMPOO, LOTION clobetasol propionate FOAM, SPRAY CLOBEX (clobetasol) OLUX-E /OLUX/OLUX-E CP (clobetasol)	

STIMULANTS AND RELATED ADHD DRUGS^{AL}

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CNS STIMULANTS		<ul style="list-style-type: none">Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within the same group
Amphetamine type		
ADDERALL XR (amphetamine salt combo) amphetamine salt combination IR VYVANSE (lisdexamfetamine) CAPSULE, CHEWABLE	ADZENYS ER (amphetamine) SUSPENSION ADZENYS XR (amphetamine) amphetamine salt combination ER (generic for Adderall XR) amphetamine sulfate (generic for Evekeo) dextroamphetamine (generic for Dexedrine) dextroamphetamine SOLUTION (generic for Procentra) dextroamphetamine ER (generic for Dexedrine ER) DYANAVEL XR (amphetamine) MYDAYIS (amphetamine salt combo) ^{QL} methamphetamine (generic for Desoxyn) ZENZEDI (dextroamphetamine)	Drug-specific criteria: <ul style="list-style-type: none">Procentra®: May be approved with documentation of swallowing disorderZenzedi®: Requires clinical reason generic dextroamphetamine IR cannot be used

STIMULANTS AND RELATED ADHD DRUGS (Continued)^{AL}

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria	
Methylphenidate type		<ul style="list-style-type: none">Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents Drug-specific criteria: <ul style="list-style-type: none">Daytrana®: May be approved in history of substance abuse by parent/caregiver or patient May be approved with documentation of difficulty swallowing	
FOCALIN (dexamethylphenidate) FOCALIN XR (dexamethylphenidate)	dexamethylphenidate (generic for Focalin) dexamethylphenidate XR (generic for Focalin XR)		
APTENSIO XR (methylphenidate) methylphenidate (generic for Ritalin)	COTEMPLA XR-ODT (methylphenidate) methylphenidate CHEWABLE, SOLUTION (generic for Methylin) RITALIN (methylphenidate)		
methylphenidate ER 10mg, 20mg (generic for Ritalin SR, Metadate ER)	DAYTRANA (methylphenidate) methylphenidate 30/70 (generic for Metadate CD) methylphenidate 50/50 (generic for RITALIN LA) methylphenidate ER (generic for Ritalin SR)		
QUILLICHEW ER (methylphenidate) QUILLIVANT XR (methylphenidate suspension)	CONCERTA (methylphenidate ER) 18mg, 27mg, 36mg, 54mg methylphenidate ER 18mg, 27mg, 36mg, 54mg (generic Concerta) methylphenidate ER 72mg (generic for RELEXXI) ^{QL}		
MISCELLANEOUS			
atomoxetine (generic for Strattera) guanfacine ER (generic for Intuniv)	clonidine ER (generic for Kapvay) ^{CL} STRATTERA (atomoxetine)		
ANALEPTICS			
	modafinil (generic for Provigil) ^{CL} armodafinil (generic for Nuvigil) ^{CL}		<ul style="list-style-type: none">Armodafinil: Requires trial of Provigil Approved ONLY for: Sleep Apnea, Narcolepsy, Shift Work Sleep disorderModafinil: Approved ONLY for: Sleep Apnea, Narcolepsy, Shift Work Sleep disorder

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.

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

CL – Prior Authorization / Class Criteria apply

QL – Quantity/Duration Limit

AL – Age

Limit

NR – Product was not reviewed - New Drug criteria will apply

VI. Adjournment / Other Business

A vote to conclude the meeting was made at 3:30pm it was unanimously approved by all in attendance.

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

Date: Wednesday, May 15, 2019

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.