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Suite A
Frankfort, KY 40601

Pharmacy Provider Notice #153 – July 19, 2012 PTAC PDL Changes

September 27, 2012

Dear Kentucky Medicaid Provider:

Please be advised that the Department for Medicaid Services is making changes to the Kentucky Medicaid Fee-For-Service Pharmacy Preferred Drug List (PDL) based on recommendations from the Kentucky Medicaid Fee-For-Service Pharmacy & Therapeutics Advisory Committee at its March 15, 2012 meeting and as adopted by the Secretary of the Cabinet for Health and Family Services by order dated August 15, 2012.

On October 30, 2012, the following changes will be effective:

- **New Drugs to Market**
  - The following product (s) will become **preferred**:
    - Jentadueto™ (QL = 2 per day) (ST)
    - Janumet® (QL = 2 per day) (ST)
  - The following product (s) will become **preferred** and require PA:
    - Kalydeco™ (QL = 2 per day)
      - Kalydeco™ will only be approved if BOTH of the following are true: Presence of specific *G551D* mutation in the CFTR gene; AND absence of homozygous *F508del* mutation in the CFTR gene.
    - Inlyta® (QL = 1mg - 8 per day) (QL = 5mg - 4 per day)
      - Inlyta® will only be approved after confirmation of a diagnosis of renal cell carcinoma (RCC) and trial/failure of at least one systemic therapy (e.g. bavacizumab plus interferon alpha, temsirolimus, or cytokines).
    - Erivedge™ (QL = 1 per day)
      - Erivedge™ will only be approved for one of the following diagnoses: Metastatic basal cell carcinoma; OR locally advanced basal cell carcinoma if: There is recurrence following surgery OR patient is not a candidate for surgery OR patient is not a candidate for radiation therapy.
  - The following product (s) will become **non-preferred** and require PA:
    - Bydureon®
    - Zioptan® (QL = 1 per day)
    - Qnasl™ (QL = 0.29 per day/1 bottle per month)
    - Potiga™
  - The following product (s) will become **non-preferred** and require PA:
    - Omontys®

- Omontys® will only be approved for a diagnosis of Chronic Kidney Disease (CKD) in patients on dialysis.

On November 1, 2012, the following changes will be effective:

- **Clinical Criteria Reviews**
  - **Xolair® Clinical Criteria**
    - Xolair® (omalizumab) will be approved for a diagnosis of moderate to severe asthma (step 5 or higher) if ALL of the following are true:
      - Positive skin test or in vitro reactivity (RAST test) to a perennial aeroallergen; AND
      - FEV_1 of <80% while on asthma controller medication; AND
      - Has had failure of or contraindication to inhaled corticosteroid in combination with a second controller agent (such as a long-acting inhaled $beta_2$-agonist, ipratropium, leukotriene modifier, or theophylline) for a 60-day trial.
    - Xolair® (omalizumab) will be approved for continuation of therapy for a diagnosis of moderate to severe asthma (step 5 or higher) if one of the following is true:
      - During previous treatment with Xolair®, the patient experienced a reduction in asthma exacerbations (e.g., hospitalizations, urgent or emergent care visits, use of rescue medications, etc.) from their pre-Xolair® baseline, OR
      - The patient was receiving maintenance therapy with an oral corticosteroid prior to initiation of Xolair® and the patient has been able to reduce their oral corticosteroid dose to less than their pre-Xolair® baseline or to ≤ 5 mg daily, OR
      - The patient was receiving maintenance therapy with an inhaled corticosteroid prior to initiation of Xolair® and the patient has been able to reduce their inhaled corticosteroid dose to less than their pre-Xolair® baseline.

- **Existing Drug Classes**
  - **Lipotropics: High Potency Statins**
    - Atorvastatin and simvastatin will remain **preferred**.
    - Lipitor®, Livalo®, and Zocor® will remain **non-preferred** and require PA.
    - Crestor® and Vytorin™ will become **non-preferred** and require a PA.
  - **Agents for Pulmonary Hypertension**
    - Adcirca™, Letairis™, Tracleer®, and Ventavis® will remain **preferred**.
    - Tyvaso™ will remain **non-preferred** and require PA.
    - Revatio™ will become **non-preferred** and require PA.
  - **Sildenafil and Tadalafil Clinical Criteria**
    - Sildenafil and tadalafil will be **approved** for a diagnosis of Pulmonary Arterial Hypertension only. Non oral dosage forms will only be approved for patients who cannot tolerate/absorb medications by mouth.
  - **Proton Pump Inhibitors**
    - Nexium® and pantoprazole will remain **preferred**.
    - Prescription omeprazole will become **preferred**.
    - Aciphex®, Dexilant™, lansoprazole, omeprazole OTC, omeprazole/sodium bicarbonate, Prevacid®, Prevacid 24-HR®, Prilosec®, Protonix®, and Zegerid® OTC will remain **non-preferred** and require PA.
    - Prilosec OTC® will become **non-preferred** and require PA.
  - **Sedative Hypnotic Agents**

- Chloral hydrate, estazolam, flurazepam, temazepam 15mg and 30mg, triazolam, and zolpidem will remain **preferred**.
- Ambien®, Ambien® CR, Doral®, Edluar®, Halcion®, Lunesta®, Restoril®, Rozerem™, Silenor®, Somnote®, Sonata®, zolpidem ER, and Zolpimist™ will remain **non-preferred** and require PA.
- Intermezzo®, temazepam 22.5mg and 7.5mg, and zaleplon will become **non-preferred** and require PA.

- **Antibiotics: Quinolones**
  - Ciprofloxacin will remain **preferred**.
  - Levofloxacin tablets will become **preferred**.
  - Ciprofloxacin ER, Cipro®, Cipro XR®, Levaquin®, levofloxacin solution, and Noroxin® will remain **non-preferred** and require PA.
  - Avelox®, Factive®, and ofloxacin will become **non-preferred**.
- **Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)**
  - Celebrex®, dicolfenac potassium, etodolac, flurbiprofen, ibuprofen, indomethacin, ketoprofen, ketorolac tromethamine, meloxicam tablets, naproxen sodium, naproxen tablets, piroxicam, and sulindac will remain **preferred**.
  - Anaprox®, Anaprox® DS, Ansaid®, Arthrotec®, Cataflam®, Clinoril®, Daypro®, Duexis®, Feldene®, Flector®, Indocin®, Mobic®, nabumetone, Nalfon®, Naprelan® EC, Naprosyn®, Pennsaid®, Ponstel®, Sprix®, tolmetin, Vimovo®, Voltaren® Gel, Voltaren® XR, and Zipsor™ will remain **non-preferred**.
  - Diclofenac sodium, diclofenac SR , diflunisal, etodolac SR, fenoprofen, indomethacin ER, ketoprofen ER, meclofenamate, mefenamic acid, meloxicam suspension, Naprosyn® EC, naproxen suspension, naproxen EC, and oxaprozin will become **non-preferred**.
- **Topical Diclofenac Clinical Criteria**
  - Topical diclofenac products will be approved if ONE of the following is true:
    - Patient is unable to tolerate, swallow, or absorb oral NSAIDs: OR
    - Patient has a contraindication to an oral NSAID (e.g., GI bleed)

On November 6, 2012, the following changes will be effective:

- **Narcotics: Short Acting**
  - Butalbital compound/codeine, Codeine/APAP, hydrocodone/APAP, hydrocodone/ibuprofen, hydromorphone, meperidine, morphine immediate-release, oxycodone, oxycodone/APAP, and tramadol will remain **preferred**.
  - Dihydrocodeine bitartrate/APAP/caffeine, oxycodone/ibuprofen, and oxymorphone IR will become **preferred**.
  - Capital®, Combunox®, Dazidox®, Demerol®, Dilaudid®, Endocet®, Endodan®, Hycet®, Ibudone®, Lazanda®, levorphanol, Lorcet®, Lortab®, Magnacet®, Margesic H®, Maxidone®, Norco®, Nucynta®, Opana®, Oxecta®, OxyIR®, Panlor SS®, Percocet®, Percodan®, Primlev®, Reprexain™, Rybix™ ODT, Synalgos DC®, Trezix®, Tylenol #3®, Tylenol #4®, Tylox®, Ultracet®, Ultram®, Vicodin®, Vicodin ES®, Vicodin HP®, Vicoprofen®, Xodol®, Xolox®, Zamicet™, and Zolvit™ will remain **non-preferred** and require PA.
  - Codeine, oxycodone/ASA, and tramadol/acetaminophen will become **non-preferred** and require PA.
- **Narcotics: Long Acting**

- Fentanyl transdermal, Kadian®, methadone, and morphine sulfate controlled release will remain **preferred**.
- Avinza™, Butrans™, ConZip™, Dolophine™, Duragesic®, Embeda™, Exalgo™, morphine sulfate extended release (Generic for Kadian®), MS Contain®, Nucynta® ER, Opana® ER, Or morph® SR, oxycodone controlled release, OxyContin®, oxymorphone ER, Ryzolt™, and Ultram® ER will remain **non-preferred** and require PA.
- Methadone concentrate andtramadol extended release will become **non-preferred** and require PA.

- **Fentanyl Transdermal Clinical Criteria**
  - Fentanyl transdermal will be approved for a diagnosis of chronic pain after trial and failure of extended/controlled release morphine.
- **Butrans™ (buprenorphine) Clinical Criteria**
  - Butrans™ will be **approved** if all of the following are true:
    - Diagnosis of chronic pain; AND
    - Trial and failure of extended/controlled release morphine (Of note: failure does not necessarily mean lack of efficacy. It could mean intolerance due to allergy or side effects.); AND
    - Patient does not have a history of opioid addiction.
- **Topical Immunomodulators**
  - Elidel® will remain **preferred**.
  - Protopic® will now become **non-preferred** and require PA.
- **Dermatologics: Antibiotic Agents**
  - Gentamicin 0.1% (cream and ointment) and mupirocin will remain **preferred**.
  - Bacitracin ointment, bacitracin zinc ointment, bacitracin zinc/neomycin/polymyxin B sulfate ointment, bacitracin zinc/neomycin/polymyxin B sulfate/pramoxine ointment, bacitracin zinc/polymyxin B ointment, and neomycin/polymyxin/pramoxine will become **preferred**.
  - Bacroban® and Centany® will remain **non-preferred** and require PA.
  - Altabax™ will become **non-preferred** and require PA.
- **Ophthalmic Antihistamines**
  - Pataday™ will remain **preferred**.
  - Azelastine, Bepreve™, Elestat™, Emadine®, epinastine, Lastacaft™, and Optivar® will remain **non-preferred** and require PA.
  - Patanol® will become **non-preferred** and require PA.
- **Ophthalmic Mast Cell Stabilizers**
  - Cromolyn will remain **preferred**.
  - Alamast® and Alomide® will remain **non-preferred** and require PA.
  - Alocril® and Crolom® will become **non-preferred** and require PA.
- **Ophthalmic Sympathomimetics**
  - Apraclonidine and brimonidine will remain **preferred**.
  - Iopidine® will remain **non-preferred** and require PA.
  - Alphagan P® will become **non-preferred** and require PA.
- **Ophthalmic Prostaglandin Agonists**
  - Latanoprost will remain **preferred**.
  - Lumigan® and Xalatan® will remain **non-preferred** and require PA.
  - Travatan Z® and Zioptan® will become **non-preferred** and require PA.

On November 8, 2012, the following changes will be effective:

- **Alpha blockers for BPH**
  - Alfuzosin, doxazosin, tamsulosin, and terazosin will remain **preferred**.
  - Cadura®, Flomax®, Rapaflo™, and Uroxatral® will remain **non-preferred** and require PA.
  - Cardura XL® and Hytrin® will become **non-preferred** and require PA.
- **Otic Anti-Infective & Anesthetic**
  - Acetic acid, acetic acid in aluminum acetate, and antipyrine/benzocaine will remain **preferred**.
  - Pramoxine/hydrocortisone will become **preferred**.
  - Neotic®, Otic Care®, Pramotic®, Pramotic® HC, Vosol® HC, Zinotic®, and Zinotic® ES will remain **non-preferred** and require PA.
  - Acetic acid/hydrocortisone, Aurax®, Myoxin®, Otozin®, Pinnacaine®, PR Otic®, Treagan®, Trioxin®, and Vosol® will become **non-preferred** and require PA.

- **New Classes Reviews**
  - **GI Antibiotics**
    - Alinia® tablets, metronidazole tablets, and vancomycin will become **preferred**.
    - Alinia® suspension, Dificid®, Flagyl®, Flagyl® ER, metronidazole capsules, neomycin, Neo-Fradin®, Tindamax®, tinidazole, Xifaxan® (QL 200 mg = 9 per month; 550 mg = 2 per day), Vancocin® will become **non-preferred** and require PA.
  - **Xifaxan® Clinical Criteria**
    - Xifaxan® will be **approved** if ONE of the following is true:
      - Diagnosis of travelers diarrhea caused by non-invasive strains of E. coli after trial and failure of ciprofloxacin (three day course of therapy only); OR
      - Diagnosis of hepatic encephalopathy after trial and failure of lactulose OR neomycin.
  - **Oral Anti-Arrhythmics**
    - Amiodarone 200mg, disopyramide, flecainide, mexiletine, procainamide, propafenone, quinidine gluconate, quinidine sulfate, quinidine sulfate CR, and Tikosyn® will become **preferred**.
    - Amiodarone 400mg, Cordarone®, Multaq®, Norpace®, Norpace® CR, Pacerone®, Pronestyl®, propafenone sustained-release, Rythmol®, Rythmol® SR, and Tambocor® will become **non-preferred** and require PA.

Please note that for future prior authorization requests, Magellan Medicaid Administration is now offering real time service! Please contact the Clinical Support Center at (800) 477-3071 to speak with a live agent. The only drugs that are now required to be submitted via fax are Brand Medically Necessary, Suboxone®/Subutex®, Synagis®, and Zyvox®.

Prior authorization forms are located at https://kentucky.magellanmedicaid.com. Please fax all requests to Magellan Medicaid Administration at the following numbers:

- Non-Urgent: (800) 365-8835
- Urgent: (800) 421-9064
- Mental Health Providers: (800) 453-2273
- Long Term Care: (800) 453-2273

Thank you for helping Kentucky Medicaid members maintain access to prescription coverage by selecting drugs on the preferred drug list whenever possible.

* Please note the dates that are associated with the above changes are subject to change.

Sincerely,

Kasie Purvis
Provider Relations Manager