Commissioner for the Department for Medicaid Services
Selections for Preferred Products

This is a summary of the final Preferred Drug List (PDL) selections made by the Commissioner for the Department for Medicaid Services based on the March 20, 2014 Pharmacy and Therapeutics Advisory Committee (PTAC) Meeting.

Description of Recommendation	Final Decision (s)
New Products to Market: Imbruvica™ Place this product preferred with similar quantity limits in the PDL class titled Oral Oncology Agents; however, only approve Imbruvica™ for a diagnosis of mantel cell lymphoma (MCL) or chronic lymphocytic leukemia (CLL).	Imbruvica™ will be added as preferred with similar quantity limits in the PDL class titled Oral Oncology Agents; however, Imbruvica™ will only be approved for a diagnosis of mantel cell lymphoma (MCL) or chronic lymphocytic leukemia (CLL).
New Products to Market: Farxiga® Dapagliflozin (Farxiga®) should only be approved for patients with a diagnosis of type 2 diabetes who have tried and failed maximum tolerated doses of metformin.	Dapagliflozin (Farxiga®) will only be approved for patients with a diagnosis of type 2 diabetes who have tried and failed maximum tolerated doses of metformin.
New Products to Market: Brisdelle™ Place this product non preferred in the PDL class titled SSRIs; however, Brisdelle™ (paroxetine capsules) should only be approved for patients meeting ALL of the following criteria: • Diagnosis of moderate to severe vasomotor symptoms in a post-menopausal woman; AND • Trial and failure or contraindication to ONE of the following: o Hormonal therapy (Examples: Premarin, Menest, Estrace, Prempro, Premphase, etc.); or o Other antidepressants-venlafaxine, other formulations of paroxetine, and other SSRIs.	Brisdelle™ will be added as non preferred in the PDL class titled SSRIs; however, Brisdelle™ (paroxetine capsules) will only be approved for patients meeting ALL of the following criteria: • Diagnosis of moderate to severe vasomotor symptoms in a post-menopausal woman; AND • Trial and failure or contraindication to ONE of the following: o Hormonal therapy (Examples: Premarin, Menest, Estrace, Prempro, Premphase, etc.); or o Other antidepressants-venlafaxine, other formulations of paroxetine, and other SSRIs.
New Products to Market: Brintellix™ Place this product non preferred in the PDL class titled Antidepressants, Other.	Brintellix™ will be added as non preferred in the PDL class titled Antidepressants, Other.
New Products to Market: Fetzima™ Place this product non preferred in the PDL class titled Antidepressants: SNRIs.	Fetzima™ will be added as non preferred in the PDL class titled Antidepressants: SNRIs.
New Products to Market: Fycompa™ Place this product non preferred in the PDL class titled Anticonvulsants: Second Generation.	Fycompa™ will be added as non preferred in the PDL class titled Anticonvulsants: Second Generation.

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New Products to Market: Adempas® Place this product non preferred in the PDL class titled Agents for Pulmonary Hypertension; however, approve riociguat (Adempas®) if the following are true: • Diagnosis of PAH (WHO Group I) after trial and failure of two preferred products; OR • Diagnosis of CTEPH (WHO Group 4) functional class II or III deemed inoperable or with residual PH after undergoing pulmonary endarterectomy.	The final PDL placement of Adempas® will be determined after a re-review of this product at the next meeting.
New Products to Market: Opsumit® Place this product non preferred in the PDL class titled Agents for Pulmonary Hypertension.	Opsumit® will be added as non preferred in the PDL class titled Agents for Pulmonary Hypertension.
New Products to Market: Aerospan™ Place this product non preferred with similar quantity limits in the PDL class titled Corticosteroids, Inhaled.	Aerospan™ will be added as non preferred with similar quantity limits in the PDL class titled Corticosteroids, Inhaled.
New Products to Market: Mirvaso® Place this product non preferred in the PDL class titled Topical Acne Agents; however, approve for a diagnosis of persistent rosacea.	Mirvaso® will be added as non preferred in the PDL class titled Topical Acne Agents; however, it will be approved for a diagnosis of persistent rosacea.

Description of Recommendation	Final Decision (s)

New Products to Market: Olysio™
Place this product preferred with appropriate quantity and duration limits in the PDL class titled Hepatitis C: Oral Protease Inhibitors. Approve simeprevir initially for 8 weeks of therapy if ALL of the following are true:
• Diagnosis of hepatitis C virus (HCV) with genotype 1; AND
• Patient CANNOT have failed therapy with an oral protease inhibitor indicated for HCV (e.g., Incivek®, Victrelis®, or Olysio™); AND
• Must have concurrent (or planning to start) therapy with ribavirin and peginterferon when starting simeprevir; AND
• Must be an adult patient age 18 and over; AND
• Patient has NOT had liver transplant; AND
• Patient is NOT infected with HCV genotype 1a containing the Q80K polymorphism; AND
• Patient is NOT co-infected with HCV/HIV; AND
• Patient is NOT receiving concomitant therapy with sofosbuvir (Sovaldi™).
After 8 weeks of therapy, approve simeprevir, peginterferon alfa and ribavirin for 4 additional weeks of therapy if HCV-RNA is less than 25 IU/mL at treatment week 4.
After 8 weeks of therapy, discontinue simeprevir, peginterferon alfa, and ribavirin if HCV-RNA is greater than or equal to 25 IU/mL at treatment week 4.
	Olysio™ will be added as preferred with appropriate quantity and duration limits in the PDL class titled Hepatitis C: Oral Protease Inhibitors. Simeprevir will be approved if ALL of the following are true:
	• Age ≥18 years old; AND
	• Patient must be treatment naïve to simeprevir. Limited to one course of therapy per lifetime; AND
	• Must be prescribed by or in consultation with a gastroenterologist, hepatologist, or infectious disease physician; AND
	• Diagnosis of hepatitis C virus (HCV) with genotype 1 showing fibrosis corresponding to a Metavir score of F3 or greater; AND
	• Patient has not actively participated in illicit substance abuse or alcohol abuse for 6 months prior to or during therapy attested by the prescribing physician(s) AND using one of the following confirmation tests:
	  ○ Patient has been evaluated for current substance abuse and alcohol with validated screening instruments such as Alcohol Use Disorders Identification Test (AUDIT C) or CAGE alcohol screen, or National Institute on Drug Abuse's (NIDA's) drug screening tool; OR
	  ▪ Acceptable alcohol consumption tests include: Serum gamma-glutamyl transpeptidase (GGT), mean corpuscular volume (MCV), carbohydrate-deficient transferrin (CDT), and urine ethylglucuronide (EtG) tests. Results must be documented in the patient's medical record to include, results of testing, and date tested; AND
	  ▪ Urine toxicology screen results for substance abuse are acceptable in lieu of the actual laboratory drug screen report. Results must be documented in the patient's medical record to include substances tested, results of testing, and date tested; AND

	• If patient has a prior history of substance or alcohol abuse, the patient has completed or is participating in a recovery program, or receiving substance or alcohol abuse counseling services, or seeing an addiction specialist as part of HCV treatment; AND
	• Patient CANNOT have failed therapy with an oral protease inhibitor indicated for HCV (e.g., Incivek®, Victrelis®, or Olysio™); AND
	• Patient has NOT had liver transplant; AND
	• Patient is NOT infected with HCV genotype 1a containing the Q80K polymorphism; AND
	• Patient is NOT co-infected with HCV/HIV; AND
	• Patient is NOT receiving concomitant therapy with sofosbuvir (Sovaldi™); AND
	• Baseline HCV-RNA is submitted:
	  ○ Approve [Triple therapy] combination with peginterferon and ribavirin for 8 weeks and request HCV RNA levels at treatment week (TW) 4 for renewal.
	  ○ Renewal (Authorization #2) approval if all of the following are true:
	  ▪ The patient has been compliant with drug therapy regimen (per pharmacy paid claims history); and
	  ▪ The patient is not actively participating in illicit substance abuse or alcohol abuse during therapy attested by the prescribing physician(s) AND using the same verification documentation listed for original authorization; and
	  ▪ HCV RNA levels are < 25 IU/mL at TW4, approve 4 additional weeks of therapy for a total duration of 12 weeks.

Description of Recommendation	Final Decision (s)
New Products to Market: Sovaldi™ Place this product preferred with appropriate quantity and duration limits in a new PDL class titled Hepatitis C: NS5B Polymerase Inhibitors; however, only approve sofosbuvir in the following instances: • For diagnosis of HCV with genotype 1 [Triple therapy] Combination with peginterferon and ribavirin – Approval for 12 weeks o Approve; **OR** o Approve for HCV/HIV-1 co-infection; **OR** o Approve for patients with compensated cirrhosis, including those with hepatocellular carcinoma. o Must have concurrent (or planning to start) therapy with ribavirin and peginterferon when starting sofosbuvir for a 12 week duration. • For diagnosis of HCV with genotype 1 [Dual therapy] Combination with ribavirin in patients who are interferon ineligible– Approval for 24 weeks o Approve; **OR** o Approve for HCV/HIV-1 co-infection; **OR** o Approve for patients with compensated cirrhosis, including those with hepatocellular carcinoma. o Must be used in combination with ribavirin therapy. • For diagnosis of HCV with genotype 2 [Dual therapy] Combination with ribavirin – Approval for 12 weeks o Approve; **OR** o Approve for HCV/HIV-1 co-infection; **OR** o Approve for patients with compensated cirrhosis, including those with hepatocellular carcinoma. o Must have concurrent (or planning to start) therapy with ribavirin when starting sofosbuvir for a 12 week duration. • For diagnosis of HCV with genotype 3 [Dual therapy] Combination with ribavirin – Approval for 24 weeks o Approve; **OR** o Approve for HCV/HIV-1 co-infection; **OR** o Approve for patients with compensated	Sovaldi™ will be added as preferred with appropriate quantity and duration limits in a new PDL class titled Hepatitis C: NS5B Polymerase Inhibitors; however, only approve sofosbuvir if ALL of the following are true: • Age ≥18 years old; AND • Patient must be treatment naïve to sofosbuvir. Limited to one course of therapy per lifetime; AND • Must be prescribed by or in consultation with a gastroenterologist, hepatologist, or infectious disease physician; AND • Patient is not receiving concomitant therapy with a hepatitis protease inhibitor (e.g., telaprevir (Incivek®), boceprevir (Victrelis®), simeprevir (Olysio™); AND • Patient does *not* have decompensated cirrhosis (which is defined as a Child-Pugh score greater than 6 [class B or C]); AND • Patient does *not* have severe renal impairment (eGFR <30 mL/min/1.73m^2) or end stage renal disease (ESRD) requiring hemodialysis; AND • Patient does not have a history of liver transplant; AND • Patient has not actively participated in illicit substance abuse or alcohol abuse for 6 months prior to or during therapy attested by the prescribing physician(s) AND using one of the following confirmation tests: o Patient has been evaluated for current substance abuse and alcohol with validated screening instruments such as Alcohol Use Disorders Identification Test (AUDIT C) or CAGE alcohol screen, or National Institute on Drug Abuse's (NIDA's) drug screening tool; OR ▪ Acceptable alcohol consumption tests include: Serum gamma-glutamyl transpeptidase (GGT), mean corpuscular volume (MCV), carbohydrate-deficient transferrin (CDT), and urine ethylglucuronide (EtG) tests. Results must be documented in the patient's medical record to include, results of

cirrhosis, including those with hepatocellular carcinoma. ○ Must have concurrent (or planning to start) therapy with ribavirin when starting sofosbuvir for a 24 week duration • For diagnosis of HCV with genotype 4 [Triple therapy] Combination with peginterferon and ribavirin – Approval for 12 weeks ○ Approve; **OR** ○ Approve for HCV/HIV-1 co-infection; **OR** ○ Approve for patients with compensated cirrhosis, including those with hepatocellular carcinoma. ○ Must have concurrent (or planning to start) therapy with ribavirin and peginterferon when starting sofosbuvir for a 12 week duration • For diagnosis of hepatocellular carcinoma awaiting liver transplantation [Dual therapy] Combination with ribavirin – Approval for 48 weeks or until the time of liver transplantation, whichever occurs first ○ Approve in subjects with HCV genotype 1, 2, 3 or 4 infection, including those with hepatocellular carcinoma meeting Milan criteria, and awaiting liver transplantation ▪ Milan criteria defined as: ○ The presence of a tumor 5 cm or less in diameter in subjects with single hepatocellular carcinoma; **AND** ○ No more than three tumor nodules, each 3 cm or less in diameter, in subjects with multiple tumors; **AND** ○ No extrahepatic manifestations of the cancer and no evidence of vascular invasion of the tumor. ○ Must have concurrent (or planning to start) therapy with ribavirin when starting sofosbuvir for a 48 week duration or until the time of liver transplantation, whichever occurs first.	testing, and date tested; AND ▪ Urine toxicology screen results for substance abuse are acceptable in lieu of the actual laboratory drug screen report. Results must be documented in the patient's medical record to include substances tested, results of testing, and date tested; AND • If patient has a prior history of substance or alcohol abuse, the patient has completed or is participating in a recovery program, or receiving substance or alcohol abuse counseling services, or seeing an addiction specialist as part of HCV treatment; AND • Baseline HCV-RNA is submitted; AND • One of the following diagnoses: ○ For diagnosis of HCV with genotype 1 showing fibrosis corresponding to a Metavir score of F3 or greater with or without HIV-1 co-infection or with or without compensated cirrhosis, including those with hepatocellular carcinoma: ▪ Approve [Triple therapy] combination with peginterferon and ribavirin for 8 weeks and request HCV RNA levels at treatment week (TW) 4 for renewal. ▪ Renewal (Authorization #2) approval if all of the following are true: • The patient has been compliant with drug therapy regimen (per pharmacy paid claims history); and • The patient is not actively participating in illicit substance abuse or alcohol abuse during therapy attested by the prescribing physician(s) AND using the same verification documentation listed for original authorization; and • HCV RNA levels are < 25 IU/mL at TW4, approve 4 additional weeks of therapy for a total duration of 12 weeks. ○ For diagnosis of HCV with genotype 1 showing fibrosis corresponding to a Metavir score of F3 or greater with or without HIV-1 co-infection or with or without compensated

	cirrhosis, including those with hepatocellular carcinoma: ▪ Approve [Dual therapy] combination with ribavirin in patients who are interferon ineligible for 8 weeks and request HCV RNA levels at TW4 and TW12 for renewal. ▪ Renewal (Authorization #2) approval if all of the following are true: • The patient has been compliant with drug therapy regimen (per pharmacy paid claims history); and • The patient is not actively participating in illicit substance abuse or alcohol abuse during therapy attested by the prescribing physician(s) AND using the same verification documentation listed for original authorization; and • HCV RNA levels are < 25 IU/mL at TW4; then approve 8 additional weeks of therapy and request HCV RNA levels at TW12. ▪ Renewal (Authorization #3) approval if all of the following are true: • The patient has been compliant with drug therapy regimen (per pharmacy paid claims history); and • The patient is not actively participating in illicit substance abuse or alcohol abuse during therapy attested by the prescribing physician(s) AND using the same verification documentation listed for original authorization; and • HCV RNA levels are < 25 IU/mL at TW12; then approve 8 additional weeks of therapy for a total duration of 24 weeks. o For diagnosis of HCV with genotype 2 showing fibrosis corresponding to a Metavir score of F3 or greater with or without HIV-1 co-infection or with or without compensated cirrhosis, including those with hepatocellular carcinoma: ▪ Approve [Dual therapy] combination

	with ribavirin in patients who are interferon ineligible for 8 weeks and request HCV RNA levels at TW4 for renewal. ▪ Renewal (Authorization #2) approval if all of the following are true: • The patient has been compliant with drug therapy regimen (per pharmacy paid claims history); and • The patient is not actively participating in illicit substance abuse or alcohol abuse during therapy attested by the prescribing physician(s) AND using the same verification documentation listed for original authorization; and • HCV RNA levels are < 25 IU/mL at TW4; then approve 4 additional weeks of therapy for a total duration of 12 weeks. o For diagnosis of HCV with genotype 3 showing fibrosis corresponding to a Metavir score of F3 or greater with or without HIV-1 co-infection or with or without compensated cirrhosis, including those with hepatocellular carcinoma: ▪ Approve [Dual therapy] combination with ribavirin in patients who are interferon ineligible for 8 weeks and request HCV RNA levels at TW4 and TW12 for renewal. ▪ Renewal (Authorization #2) approval if all of the following are true: • The patient has been compliant with drug therapy regimen (per pharmacy paid claims history); and • The patient is not actively participating in illicit substance abuse or alcohol abuse during therapy attested by the prescribing physician(s) AND using the same verification documentation listed for original authorization; and • HCV RNA levels are < 25 IU/mL at TW4; then approve 8 additional weeks of therapy and request HCV

	RNA levels at TW12. ▪ Renewal (Authorization #3) approval if all of the following are true: • The patient has been compliant with drug therapy regimen (per pharmacy paid claims history); and • Confirmation patient is not actively participating in illicit substance abuse The patient is not actively participating in illicit substance abuse or alcohol abuse during therapy attested by the prescribing physician(s) AND using the same verification documentation listed for original authorization; and • HCV RNA levels are < 25 IU/mL at TW12; then approve 8 additional weeks of therapy for a total duration of 24 weeks. o For diagnosis of HCV with genotype 4 showing fibrosis corresponding to a Metavir score of F3 or greater with or without HIV-1 co-infection or with or without compensated cirrhosis, including those with hepatocellular carcinoma: ▪ Approve [Triple therapy] combination with peginterferon and ribavirin for 8 weeks and request HCV RNA levels at treatment week (TW) 4 for renewal. ▪ Renewal (Authorization #2) approval if all of the following are true: • The patient has been compliant with drug therapy regimen (per pharmacy paid claims history); and • The patient is not actively participating in illicit substance abuse or alcohol abuse during therapy attested by the prescribing physician(s) AND using the same verification documentation listed for original authorization; and • HCV RNA levels are < 25 IU/mL at TW4; then approve 4 additional weeks of therapy for a total duration of 12 weeks. o For diagnosis of hepatocellular carcinoma

	awaiting liver transplantation in subjects with HCV genotype 1, 2, 3 or 4 infection, including those with hepatocellular carcinoma meeting Milan criteria, and awaiting liver transplantation: ▪ Approve [Dual therapy] combination with ribavirin for 8 weeks and request HCV RNA levels at TW4, TW12, TW20, TW28 and TW36 for renewal. ▪ Renewal (Authorization #2) approval if all of the following are true: • The patient has been compliant with drug therapy regimen (per pharmacy paid claims history); and • The patient is not actively participating in illicit substance abuse or alcohol abuse during therapy attested by the prescribing physician(s) AND using the same verification documentation listed for original authorization; and • HCV RNA levels are < 25 IU/mL at TW4; then approve 8 additional weeks of therapy or until scheduled transplant (whichever is sooner) and request HCV RNA levels at TW12, TW20, TW28 and TW36 for renewal. ▪ Renewal (Authorization #3) approval if all of the following are true: • The patient has been compliant with drug therapy regimen (per pharmacy paid claims history); and • The patient is not actively participating in illicit substance abuse or alcohol abuse during therapy attested by the prescribing physician(s) AND using the same verification documentation listed for original authorization; and • HCV RNA levels are < 25 IU/mL at TW12; then approve 8 additional weeks of therapy or until scheduled transplant (whichever is sooner) and request HCV RNA levels at TW20, TW28 and TW36 for renewal.

	▪ Renewal (Authorization #4) approval if all of the following are true: • The patient has been compliant with drug therapy regimen (per pharmacy paid claims history); and • The patient is not actively participating in illicit substance abuse or alcohol abuse during therapy attested by the prescribing physician(s) AND using the same verification documentation listed for original authorization; and • HCV RNA levels are < 25 IU/mL at TW20; then approve 8 additional weeks of therapy or until scheduled transplant (whichever is sooner) and request HCV RNA levels at TW28 and TW36 for renewal. ▪ Renewal (Authorization #5) approval if all of the following are true: • The patient has been compliant with drug therapy regimen (per pharmacy paid claims history); and • The patient is not actively participating in illicit substance abuse or alcohol abuse during therapy attested by the prescribing physician(s) AND using the same verification documentation listed for original authorization; and • HCV RNA levels are < 25 IU/mL at TW 28; then approve 8 additional weeks of therapy or until scheduled transplant (whichever is sooner) and request HCV RNA levels at TW36 for renewal. ▪ Renewal (Authorization #6) approval if all of the following are true: • The patient has been compliant with drug therapy regimen (per pharmacy paid claims history); and • The patient is not actively participating in illicit substance abuse or alcohol abuse during therapy attested by the prescribing physician(s) AND using the same

	verification documentation listed for original authorization; and • HCV RNA levels are < 25 IU/mL at TW36; then approve 8 additional weeks of therapy or until scheduled transplant (whichever is sooner) for a total duration of 48 weeks.
Injectable Insulins 1. DMS to select preferred agent (s) based upon economic evaluation; however, at least one insulin per class (bolus, basal, premixed, rapid-acting, biphasic, and long-acting) should be preferred. 2. Agents not selected as preferred will be considered non preferred and require PA. **3.** For any new chemical entity in the Injectable Insulins class, require a PA until reviewed by the P & T Advisory Committee.	Selected Preferred Agent (s) Humalog® Vial Humalog® Mix Vial/Pen Humulin® N/R Vial Humulin® 70/30 Vial Lantus® Vial Levemir® Vial/Pen Novolog® Vial/Pen/Cartridge Novolog® Mix Vial/Pen Non Preferred Agent (s) Apidra™ Vial/Cartridge/Solostar Humalog® Pen/Cartridge Humulin® 500 Vial Humulin® Pen/Kwikpen Humulin® 70/30 Pen/Kwikpen Lantus® Solostar Pen Novolin® N/R Vial Novolin® 70/30 Vial
Insulin Pen/Cartridge Clinical Criteria Non-Preferred Insulin Pens/Cartridges will be approved after trial and failure of one preferred insulin pen/cartridge belonging to the same insulin class (bolus, basal, premixed, rapid-acting, biphasic, and long-acting) if any one of the following is true: • Patient is 15 years of age and under; OR • Patient or active care-giver is unable to manipulate vials/syringes due to issues related to poor eyesight, dexterity, or comprehension.	Non-Preferred Insulin Pens/Cartridges will be approved after trial and failure of one preferred insulin pen/cartridge belonging to the same insulin class (bolus, basal, premixed, rapid-acting, biphasic, and long-acting) if any one of the following is true: • Patient is 15 years of age and under; OR • Patient or active care-giver is unable to manipulate vials/syringes due to issues related to poor eyesight, dexterity, or comprehension.
Amylin Analogue 1. DMS to place this product non preferred on the Preferred Drug List (PDL). 2. Allow for use of pramlintide with active insulin therapy only. 3. Agents not selected as preferred will be considered non preferred and require PA. 4. For any new chemical entity in the Amylin Analogue class, require a PA until reviewed by the P&T Advisory Committee.	Selected Preferred Agent (s) N/A Non Preferred Agent (s) Symlin®

Description of Recommendation	Final Decision (s)
Amylin Analogue Clinical Criteria Pramlintide (Symlin®) will be approved if insulin is seen in history within the past 90 days.	Pramlintide (Symlin®) will be approved if insulin is seen in history within the past 90 days.
GLP-1 Receptor Agonists 1. DMS to select preferred agent (s) based on economic evaluation; however, at least one unique chemical entity should be preferred. 2. Continue to require PA for all agents in this class to ensure appropriate utilization. **3.** For any new chemical entity in the GLP-1 Receptor Agonists class, require a PA until reviewed by the P&T Advisory Committee.	Selected Preferred Agent (s) Byetta™ Non Preferred Agent (s) Bydureon® Victoza®
GLP-1 Receptor Agonists Clinical Criteria GLP-1 Receptor Agonists will be approved if metformin, a sulfonylurea, insulin, a DPP-4 Inhibitor, or a TZD is seen in history within the past 90 days.	GLP-1 Receptor Agonists will be approved if metformin, a sulfonylurea, insulin, a DPP-4 Inhibitor, or a TZD is seen in history within the past 90 days.
Alpha-Glucosidase Inhibitors 1. DMS to select preferred agent (s) based on economic evaluation; however, at least one unique chemical entity should be preferred. 2. Agents not selected as preferred will be considered non preferred and require PA. **3.** For any new chemical entity in the Alpha-Glucosidase Inhibitor class, require a PA until reviewed by the P&T Advisory Committee.	Selected Preferred Agent (s) acarbose Glyset® Non Preferred Agent (s) Precose®
Meglitinides 1. DMS to select preferred agent (s) based on economic evaluation; however, at least one single entity agent should be preferred. 2. Agents not selected as preferred will be considered non preferred and require PA. **3.** For any new chemical entity in the Meglitinides class, require a PA until reviewed by the P&T Advisory Committee.	Selected Preferred Agent (s) Prandin® Starlix® Non Preferred Agent (s) nateglinide PrandiMet™ repaglinide

Description of Recommendation	Final Decision (s)
Sulfonylureas 1. DMS to select preferred agent (s) based on economic evaluation; however, at least two unique second generation sulfonylureas should be preferred. 2. Agents not selected as preferred will be considered non preferred and require PA. 3. For any new chemical entity in the Sulfonylureas class, require a PA until reviewed by the P&T Advisory Committee.	Selected Preferred Agent (s) chlorpropamide glimepiride glipizide glipizide extended-release glyburide glyburide micronized tolazamide tolbutamide Non Preferred Agent (s) Amaryl® Diabeta® Glucotrol® Glucotrol XL® Glynase PresTab® Micronase®
Androgenic Agents 1. DMS to select preferred agent (s) based on economic evaluation; however, at least one topical formulation of testosterone should be preferred. 2. Agents not selected as preferred will be considered non preferred and require PA. 3. For any new chemical entity in the Androgenic Agents class, require a PA until reviewed by the P&T Advisory Committee.	Selected Preferred Agent (s) Androderm® Androgel® Non Preferred Agent (s) Axiron® Fortesta® Testim®
Erythropoiesis Stimulating Proteins 1. DMS to select preferred agent (s) based upon economic evaluation. 2. All erythropoiesis stimulating agents should require Prior Authorization. 3. For any agent not selected as preferred, DMS should allow continuation of therapy if there is a paid claim in the past 90 days. 4. For any new chemical entity in the Erythropoiesis Stimulating Proteins class, require a PA until reviewed by the PTAC.	Selected Preferred Agent (s) Aranesp® Epogen® Procrit® Non Preferred Agent (s) N/A

Description of Recommendation	Final Decision (s)
Erythropoiesis Stimulating Proteins Clinical Criteria Erythropoiesis stimulating agents should be approved for recipients meeting one of the following criteria: • The patient has a hemoglobin of less than 12 g/dL **AND one** of the following diagnoses: o Anemia associated with chronic renal failure **OR** anemia associated with kidney transplantation; **OR** o Treatment of chemotherapy induced anemia for non-myeloid malignancies; **OR** o Drug-induced anemia (examples, not all inclusive: Retrovir® **or** Combivir® **or** ribavirin); **OR** o Autologous blood donations by patients scheduled to undergo nonvascular surgery.	Erythropoiesis stimulating agents will be approved for recipients meeting one of the following criteria: • The patient has a hemoglobin of less than 12 g/dL **AND one** of the following diagnoses: o Anemia associated with chronic renal failure **OR** anemia associated with kidney transplantation; **OR** o Treatment of chemotherapy induced anemia for non-myeloid malignancies; **OR** o Drug-induced anemia (examples, not all inclusive: Retrovir® **or** Combivir® **or** ribavirin); **OR** o Autologous blood donations by patients scheduled to undergo nonvascular surgery.
Thrombopoiesis Stimulating Proteins 1. DMS to select preferred agent (s) based on economic evaluation; however, at least one product indicated for the treatment of thrombocytopenia in patients with chronic immune (idiopathic) thrombocytopenic purpura (ITP) and one product indicated for the prevention of severe thrombocytopenia and the reduction of platelet transfusions following myelosuppressive chemotherapy should be preferred. 2. All agents in this class should require PA to ensure appropriate utilization. 3. For any new chemical entity in the Thrombopoiesis Stimulating Proteins class, require a PA until reviewed by the P&T Advisory Committee.	Selected Preferred Agent (s) Neumega® Promacta® Non Preferred Agent (s) Nplate™
Thrombopoiesis Stimulating Proteins Clinical Criteria • Promacta® will be approved for a diagnosis of chronic immune (idiopathic) thrombocytopenic purpura (ITP) OR for the treatment of thrombocytopenia in patients with chronic hepatitis C. • Nplate™ will be approved for a diagnosis of chronic immune (idiopathic) thrombocytopenic purpura (ITP). • Neumega® will be approved for a diagnosis of severe thrombocytopenia following myelosuppressive chemotherapy.	• Promacta® will be approved for a diagnosis of chronic immune (idiopathic) thrombocytopenic purpura (ITP) OR for the treatment of thrombocytopenia in patients with chronic hepatitis C. • Nplate™ will be approved for a diagnosis of chronic immune (idiopathic) thrombocytopenic purpura (ITP). • Neumega® will be approved for a diagnosis of severe thrombocytopenia following myelosuppressive chemotherapy.

Description of Recommendation	Final Decision (s)
Antihyperuricemics 1. DMS to select preferred agent (s) based on economic evaluation; however, at least two unique chemical entities, one of which is allopurinol, should be preferred. 2. Agents not selected as preferred will be considered non preferred and require PA. 3. For any new chemical entity in the Antihyperuricemics class, require a PA until reviewed by the P&T Advisory Committee.	Selected Preferred Agent (s) allopurinol probenecid probenecid/colchicine Non Preferred Agent (s) Colcrys® Uloric® Zyloprim®
Febuxostat Clinical Criteria Febuxostat (Uloric®) will be approved after and adequate trial (at least 3 months) of allopurinol without achievement of serum urate level below 6mg/dL OR intolerance OR contraindication to allopurinol.	Febuxostat (Uloric®) will be approved after an adequate trial (at least 3 months) of allopurinol without achievement of serum urate level below 6mg/dL OR intolerance OR contraindication to allopurinol.
Colchicine Clinical Criteria Colchicine (Colcrys®) will be approved if any one of the following is true: • Diagnosis of Familial Mediterranean Fever; OR • Diagnosis of pericarditis; OR • Trial and failure of one of the following: o NSAID (i.e., indomethacin, naproxen, ibuprofen, sulindac, ketoprofen) or o Corticosteroid.	Colchicine (Colcrys®) will be approved if any one of the following is true: • Diagnosis of Familial Mediterranean Fever; OR • Diagnosis of pericarditis; OR • Trial and failure of one of the following: o NSAID (i.e., indomethacin, naproxen, ibuprofen, sulindac, ketoprofen) or o Corticosteroid.
Phosphate Binders 1. DMS to select preferred agent (s) based on economic evaluation; however, at least two unique chemical entities, one of which should be a calcium based phosphate binder, should be preferred. 2. Agents not selected as preferred will be considered non preferred and require PA. 3. For any new chemical entity in the Phosphate Binders class, require a PA until reviewed by the P&T Advisory Committee.	Selected Preferred Agent (s) calcium acetate Fosrenol® MagneBind® 400 RX Renagel® Non Preferred Agent (s) Eliphos™ PhosLo® Phoslyra™ Renvela™ sevelamer carbonate

Description of Recommendation	Final Decision (s)
Ophthalmic Antivirals 1. DMS to select preferred agent (s) based on economic evaluation; however, at least one unique chemical entity in a self administrable dosage form should be preferred. 2. Agents not selected as preferred will be considered non preferred and require PA. 3. For any new chemical entity in the Ophthalmic Antivirals class, require a PA until reviewed by the P&T Advisory Committee.	Selected Preferred Agent (s) trifluridine Non Preferred Agent (s) Viroptic® Vitrasert® intraocular implant Zirgan®
Ophthalmic Antifungals 1. DMS to select preferred agent (s) based on economic evaluation; however, at least one unique chemical entity should be preferred. 2. Agents not selected as preferred will be considered non preferred and require PA. 3. For any new chemical entity in the Ophthalmic Antifungals class, require a PA until reviewed by the P&T Advisory Committee.	Selected Preferred Agent (s) Natacyn® Non Preferred Agent (s) N/A
Ophthalmic Quinolones 1. DMS to select preferred agent (s) based on economic evaluation; however, at least two unique chemical entities, one of which is a fourth generation agent, should be preferred. 2. Agents not selected as preferred will be considered non preferred and require PA. 3. For any new chemical entity in the Ophthalmic Antibiotics, Quinolones class, require a PA until reviewed by the P&T Advisory Committee.	Selected Preferred Agent (s) ciprofloxacin solution Moxeza™ ofloxacin Vigamox™ Non Preferred Agent (s) Besivance™ Ciloxan® gatifloxacin Iquix® levofloxacin 0.5% Ocuflox® Quixin® Zymar™ Zymaxid™
Ophthalmic Macrolides 1. DMS to select preferred agent (s) based upon economic evaluation; however, at least one ophthalmic macrolide should be preferred. 2. Agents not selected as preferred will be considered non-preferred and will require Prior Authorization. 3. For any new chemical entity in the Ophthalmic Macrolide class, require a PA until reviewed by the P&T Advisory Committee.	Selected Preferred Agent (s) erythromycin Non Preferred Agent (s) AzaSite™ Ilotycin® Romycin®

Description of Recommendation	Final Decision (s)
Ophthalmic Antibiotics, Non-Quinolones 1. DMS to select preferred agent (s) based on economic evaluation; however, at least four unique chemical entities should be preferred. 2. Agents not selected as preferred will be considered non preferred and require PA. 3. For any new chemical entity in the Ophthalmic Antibiotics, Non-Quinolones class, require a PA until reviewed by the P&T Advisory Committee.	Selected Preferred Agent (s) bacitracin bacitracin/polymyxin B gentamicin solution/ointment neomycin/polymyxin B/gramicidin polymyxin B/trimethoprim sulfacetamide solution tobramycin solution Non Preferred Agent (s) Bleph®-10 Garamycin® Neocidin® neomycin/polymyxin B/bacitracin Neosporin® Polytrim® sulfacetamide ointment Tobrex®
Ophthalmic Antibiotic-Steroid Combinations 1. DMS to select preferred agent (s) based on economic evaluation; however, at least two unique chemical entities should be preferred. 2. Agents not selected as preferred will be considered non preferred and require PA. 3. For any new chemical entity in the Ophthalmic Antibiotics-Steroid Combinations class, require a PA until reviewed by the P&T Advisory Committee.	Selected Preferred Agent (s) Blephamide® Blephamide® S.O.P. dexamethasone/neomycin sulfate/polymyxin B sulfate hydrocortisone/bacitracin zinc/neomycin sulfate/polymyxin B sulfates Pred-G® Pred-G® S.O.P Tobradex® Non Preferred Agent (s) dexamethasone/tobramycin hydrocortisone/neomycin sulfate/polymyxin B sulfate Maxitrol® prednisolone acetate/sulfacetamide sodium prednisolone sodium phosphate/sulfacetamide sodium Tobradex® ST Zylet™

Description of Recommendation	Final Decision (s)
Ophthalmic Vasoconstrictors 1. DMS to select preferred agent (s) based on economic evaluation; however, at least one unique chemical entity should be preferred. 2. Agents not selected as preferred will be considered non preferred and require PA. 3. For any new chemical entity in the Ophthalmic Vasoconstrictors class, require a PA until reviewed by the P&T Advisory Committee.	Selected Preferred Agent (s) naphazoline phenylephrine Non Preferred Agent (s) Altafrin® Mydfrin® Neofrin®
Ophthalmic Antihistamines 1. DMS to select preferred agent (s) based on economic evaluation; however, at least one unique chemical entity should be preferred. 2. Agents not selected as preferred will be considered non preferred and require PA. 3. For any new chemical entity in the Ophthalmic Antihistamines class, require a PA until reviewed by the P&T Advisory Committee.	Selected Preferred Agent (s) Pataday™ Non Preferred Agent (s) azelastine Bepreve™ Elestat™ Emadine® epinastine Lastacaft™ Optivar® Patanol®
Ophthalmic Mast Cell Stabilizers 1. DMS to select preferred agent (s) based on economic evaluation; however, at least one unique chemical entity should be preferred. 2. Agents not selected as preferred will be considered non preferred and require PA. 3. For any new chemical entity in the Ophthalmic Mast Cell Stabilizers class, require a PA until reviewed by the P&T Advisory Committee.	Selected Preferred Agent (s) cromolyn Non Preferred Agent (s) Alamast® Alocril® Alomide®

Description of Recommendation	Final Decision (s)
Ophthalmic Anti-Inflammatory Steroids 1. DMS to select preferred agent (s) based on economic evaluation; however, at least three unique chemical entities should be preferred. 2. Agents not selected as preferred will be considered non preferred and require PA. 3. For any new chemical entity in the Ophthalmic Anti-inflammatory Steroids class, require a PA until reviewed by the P&T Advisory Committee.	Selected Preferred Agent (s) dexamethasone sodium phosphate Flarex® fluorometholone prednisolone acetate prednisolone sodium phosphate Non Preferred Agent (s) Alrex® Durezol™ FML® FML Forte® FML S.O.P.® Lotemax™ Maxidex® Omnipred™ Ozurdex™ Pred Forte® Pred Mild® Retisert™ Triesence® Vexol®
Ophthalmic NSAIDs 1. DMS to select preferred agent (s) based on economic evaluation; however, at least two unique chemical entities should be preferred. 2. Agents not selected as preferred will be considered non preferred and require PA. 3. For any new chemical entity in the Ophthalmic NSAIDs class, require a PA until reviewed by the P&T Advisory Committee.	Selected Preferred Agent (s) Bromday™ diclofenac flurbiprofen ketorolac Non Preferred Agent (s) Acular® Acular LS® Acuvail® bromfenac Ilevro™ Nevanac™ Ocufen® Prolensa™ Voltaren®

Description of Recommendation	Final Decision (s)
Ophthalmic Carbonic Anhydrase Inhibitors 1. DMS to select preferred agent (s) based on economic evaluation; however, at least one unique chemical entity should be preferred. 2. Agents not selected as preferred will be considered non preferred and require PA. 3. For any new chemical entity in the Ophthalmic Carbonic Anhydrase Inhibitors class, require a PA until reviewed by the P&T Advisory Committee.	Selected Preferred Agent (s) Azopt® dorzolamide Non Preferred Agent (s) Trusopt®
Ophthalmic Prostaglandin Analogs 1. DMS to select preferred agent (s) based on economic evaluation; however, at least one unique chemical entity should be preferred. 2. Agents not selected as preferred will be considered non preferred and require PA. 3. Continue current quantity limits on agents in this class. 4. For any new chemical entity in the Ophthalmic Prostaglandin Analogs class, require a PA until reviewed by the P&T Advisory Committee.	Selected Preferred Agent (s) latanoprost Non Preferred Agent (s) Lumigan® Rescula® Travatan Z® travoprost Xalatan® Zioptan®
Ophthalmic Glaucoma Direct Acting Miotics 1. DMS to select preferred agent (s) based on economic evaluation; however, at least one unique chemical entity should be preferred. 2. Agents not selected as preferred will be considered non preferred and require PA. 3. For any new chemical entity in the Ophthalmic Glaucoma Direct Acting Miotics class, require a PA until reviewed by the P&T Advisory Committee.	Selected Preferred Agent (s) pilocarpine Non Preferred Agent (s) Isopto Carpine® Pilopine HS® 4%
Ophthalmic Sympathomimetics 1. DMS to select preferred agent (s) based on economic evaluation; however, at least one unique chemical entity should be preferred. 2. Agents not selected as preferred will be considered non preferred and require PA. 3. For any new chemical entity in the Ophthalmic Sympathomimetics class, require a PA until reviewed by the P&T Advisory Committee.	Selected Preferred Agent (s) apraclonidine Alphagan P® 0.15% brimonidine 0.2% Non Preferred Agent (s) Alphagan P® 0.1% brimonidine 0.15% Iopidine®

Description of Recommendation	Final Decision (s)
Ophthalmic Combinations for Glaucoma 1. DMS to select preferred agent (s) based on economic evaluation; however, at least one combination product containing an ophthalmic beta-agonist should be preferred. 2. Agents not selected as preferred will be considered non preferred and require PA. 3. For any new chemical entity in the Ophthalmic Combinations for Glaucoma class, require a PA until reviewed by the P&T Advisory Committee.	Selected Preferred Agent (s) Combigan™ dorzolamide/timolol Simbrinza™ Non Preferred Agent (s) Cosopt® Cosopt PF®
Ophthalmic Immunomodulator 1. DMS to select preferred agent (s) based on economic evaluation; however, at least one unique chemical entity should be preferred. 2. Agents not selected as preferred will be considered non preferred and require PA. 3. For any new chemical entity in the Ophthalmic Immunomodulator class, require a PA until reviewed by the P&T Advisory Committee.	Selected Preferred Agent (s) Restasis® Non Preferred Agent (s) N/A
Cyclosporine Ophthalmic Clinical Criteria Cyclosporine ophthalmic 0.05% emulsion (Restasis®) will be approved if one of the following is true: • Patient is status-post corneal transplant; **OR** • Patient has tried/failed polyvinyl alcohol (Artificial Tears) in the past 90 days.	Cyclosporine ophthalmic 0.05% emulsion (Restasis®) will be approved if one of the following is true: • Patient is status-post corneal transplant; **OR** • Patient has tried/failed polyvinyl alcohol (Artificial Tears) in the past 90 days.
Ophthalmic Mydriatics & Mydriatic Combinations 1. DMS to select preferred agent (s) based on economic evaluation; however, at least two unique chemical entities, one of which should be atropine, should be preferred. 2. Agents not selected as preferred will be considered non preferred and require PA. 3. For any new chemical entity in the Ophthalmic Mydriatics & Mydriatic Combos class, require a PA until reviewed by the P&T Advisory Committee.	Selected Preferred Agent (s) atropine sulfate cyclopentolate tropicamide Non Preferred Agent (s) Cyclogyl® Cyclomydril® Homatropaire® homatropine Isopto Atropine® Isopto Homatropine® Isopto Hyoscine® Mydriacyl® Paremyd®