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 Drug Review and Options for Consideration document prepared for the Pharmacy and Therapeutics (P&T) Advisory Committee's review on March 17, 2016, and the resulting official committee recommendations.

New Products to Market

Belbuca™ — Non-prefer in PDL class: *Analgesics Narcotics, Long-Acting*

Length of Authorization: 6 months, or expected duration of treatment if less than 6 months.

- Indicated for the management of pain severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate.
- Is there any reason that the patient cannot be switched to a preferred medication? Document the details. Acceptable reasons include
  - Adverse reaction to preferred drugs;
  - Allergy to preferred drugs; and
  - Contraindication to preferred drugs.
- Patient has inability to take oral medication **OR** patient has a documented clinical trial with a combination of **three preferred LONG acting opiate analgesics** agents.
- Patient is 18 years or older.
- Refer all requests for concomitant use of long-acting narcotics to pharmacist for review.

Quantity Limit = 2 buccal films per day.

Narcotics: Long-Acting	fentanyl transdermal 12, 25, 50, 75, 100 mcg CC, QL Kadian® QL morphine sulfate SA (Generic for MS Contin®) QL	*Avinza™ QL* *Belbuca™ QL* *Butrans™ CC, QL* *ConZip™ QL* *Dolophine®* *Duragesic® CC, QL* *Embeda™ QL* *Exalgo™ QL* *fentanyl transdermal 37.5, 62.5, 87.5 mcg CC, QL* *hydromorphone ER QL* *Hysingla™ ER QL* *Ionsys® CC, QL* *morphine sulfate SA (Generic Kadian®, Avinza™) QL* *MS Contin® QL* *Nucynta® ER CC,QL* *Opana ER® QL* *Oramorph® SR QL* *oxycodone ER/SR QL* *OxyContin® QL* *oxymorphone ER QL* *Ryzolt™ QL* *tramadol ER QL* *Ultram® ER QL* *Zohydro ER™ CC,QL*

Vivlodex™ — Non-prefer in the PDL class: *NSAIDs*

Length of Authorization: 1 year

- Indicated for management of osteoarthritis (OA) pain.
- Is there any reason that the patient cannot be switched to a preferred medication in the class? Document the details. Acceptable reasons include
  - Adverse reaction to preferred drugs;
  - Allergy to preferred drugs; and
  - Contraindication to preferred drugs.
- Has the patient had a therapeutic trial and treatment failure of no less than 30 days with **TWO** preferred drugs in the class? Document the details.
- Meloxicam tablet is covered without PA; clinical reason as to why meloxicam tablet cannot be used.
- The safety and effectiveness of Vivlodex in pediatric patients have not been established.
- **Quantity Limit** = 1 capsule per day.

Non-Steroidal Anti-Inflammatory Drugs	celecoxib [QL]	*Anaprox®*
	diclofenac sodium	*Anaprox® DS*
	flurbiprofen	*Ansaid®*
	ibuprofen	*Arthrotec®*
	indomethacin	*Cataflam®*
	ketoprofen	*Celebrex® [QL]*
	ketorolac tromethamine [QL]	*Clinoril®*
	meloxicam tablets	*Daypro®*
	naproxen tablets	*DermacinRX Lexitral PharmaPak®*
	piroxicam	*diclofenac/misoprostol*
	sulindac	diclofenac potassium
		diclofenac topical
		diclofenac SR
		diflunisal
		Duexis® [CC]
		etodolac
		etodolac SR
		Feldene®
		fenoprofen
		Flector® [CC]
		Indocin®
		indomethacin ER
		ketoprofen ER
		meclofenamate
		mefenamic acid
		meloxicam suspension
		Mobic®
		nabumetone
		Nalfon®
		Naprelan® EC
		naproxen sodium
		naproxen suspension
		naproxen CR
		naproxen EC
		oxaprozin
		Pennsaid® [CC]
		Pennsaid® Pump [CC]
		Ponstel®
		Sprix™ [CC]
		Tivorbex®
		tolmetin
		Vimovo™ [CC, QL]
		Vivlodex™ [QL]
		Voltaren® Gel [CC]
		Voltaren® XR
		Zipsor™
		Zorvolex™

Ninlaro™ — Non-prefer in PDL class: *Oncology Oral, Hematologic*

Length of Authorization: 6 months initial, 1 year renewal

- Indicated in combination with lenalidomide and dexamethasone for the treatment of patients with multiple myeloma who have received at least one prior therapy.
- Safety and effectiveness have not been established in pediatric patients.

Oral Oncology, Hematologic Cancer	Alkeran® cladribine Gleevec® QL hydroxyurea Imbruvica™ CC, QL Jakafi™ CC, QL mercaptopurine Purixan® Sprycel® QL Zolinza® QL Zydelig® CC, QL	*Bosulif® QL* *Farydak® QL* *Hydrea®* *Iclusig™ QL* *Leustatin®* *Ninlaro™* *Purinethol®* *Tasigna® QL*

****Alecensa® —** Non-prefer in the PDL class: *Oncology Oral, Lung* **(TABLED)**

- Indicated for the treatment of patients with anaplastic lymphoma kinase (ALK)-positive, metastatic non-small cell lung cancer who have progressed on or are intolerant to crizotinib
- Monitor ALT, AST, and total bilirubin every 2 weeks during the first 2 months of treatment, then periodically during treatment (discontinue based on severity of drug reaction).
- Ensure patient is not pregnant
- When clinically appropriate, use Alecensa instead of Zykadia.

Quantity Limit = 2 capsules per day

**Tagrisso™ — Non-prefer in PDL class: *Oncology Oral, Lung* (TABLED)

Length of Authorization: 1 year

- Indicated for the treatment of patients with metastatic epidermal growth factor receptor (EGFR) T790M mutation-positive non-small cell lung cancer (NSCLC), as detected by an FDA-approved test, who have progressed on or after EGFR TKI therapy.
- Prescriber needs to submit lab work documenting this mutation as detected by an FDA-approved test.
- The safety and effectiveness of Tagrisso have not been established in pediatric patients.

Quantity Limit = 1 tablet per day.

Oral Oncology, Lung Cancer	Iressa® QL Tarceva® QL Xalkori® CC, QL	*Alecensa® QL* *Gilotrif™ CC, QL* *Tagrisso™ QL* *Zykadia™ QL*

**Cotellic® — Non-prefer in PDL class: *Oncology Oral, Other (Skin)* (TABLED)

Length of Authorization: 1 year

- Indicated for the treatment of patients with unresectable or metastatic melanoma with a BRAF V600E or V600K mutation, in combination with vemurafenib.
- Prescriber needs to submit lab work documenting this mutation as detected by an FDA-approved test.
- The safety and effectiveness of Cotellic have not been established in pediatric patients.

Limitation of Use: Cotellic is not indicated for treatment of patients with wild-type BRAF melanoma.

Oral Oncology, Other	Caprelsa® QL Erivedge™ CC, QL Mekinist™ CC, QL Tafinlar® CC, QL temozolomide Xeloda®	*capecitabine* *Cometriq™ QL* *Cotellic®* *Lenvima™ QL* *Lonsurf®* *Lynparza™ QL* *Odomzo® CC, QL* *Stivarga® CC, QL* *Temodar®* *Zelboraf™ QL*

Uptravi® — Non-prefer in the PDL class: *PAH Agents, Oral & Inhaled*

Length of Authorization: Initial approval = 6 months, renewals = 1 year

- Indicated for the treatment of pulmonary arterial hypertension (PAH, WHO Group I) to delay disease progression and reduce the risk of hospitalization for PAH.
- Is there any reason that the patient cannot be switched to a preferred medication in the class? Document the details. Acceptable reasons include
  - Adverse reaction to preferred drugs;
  - Allergy to preferred drugs; and
  - Contraindication to preferred drugs.
- Has the patient had a therapeutic trial and treatment failure with **ONE** preferred drug in the class in the last 6 months? Document the details.
- The safety and effectiveness of Uptravi in pediatric patients have not been established.

Quantity Limit = 2 tablets per day for Uptravi 200 mcg, 400 mcg, 600 mcg, 800 mcg, 1,000 mcg, 1,200 mcg, 1,400 mcg, and 1,600 mcg tablets. No quantity limit on the Uptravi Titration Pack.

Pulmonary Arterial Hypertension (PAH) Agents	Letairis™ sildenafil [CC] Tracleer® Ventavis®	*Adcirca™* *Adempas® [CC]* *Opsumit®* *Orenitram™* *Revatio™* *Tyvaso™* *Uptravi® [QL]*

Enstilar® — Non-prefer in PDL class: *Antipsoriatics, Topical*

Length of Authorization: 4 weeks

- Indicated for the topical treatment of plaque psoriasis in patients 18 years of age and older.
- Is there any reason that the patient cannot be switched to a preferred medication in the class? Document the details. Acceptable reasons include
  - Adverse reaction to preferred drugs;
  - Allergy to preferred drugs; and
  - Contraindication to preferred drugs.
- Has the patient had a therapeutic trial and treatment failure with **ONE** preferred drug in the class? Document the details.
- Minimum age restriction of 18 years of age.

Apply Enstilar® Foam to affected area(s) once daily for up to 4 weeks.

Topical Psoriasis Agents	calcipotriene salicylic acid 6% gel, shampoo urea cream	*Aluvea®* *Bensal HP®* *BP® 50%* *calcipotriene/betamethasone* *Calcitrene™* *calcitriol ointment* *Carb-O-Philic®* *Cem-Urea®* *Dovonex®* *Enstilar®* *Keralyt®* *Latrix®* *Realo®* *Remeven®* *Salacyn® cream, lotion* *salicylic acid 3%, 6% cream, lotion* *salicylic acid 26% liquid* *salicylic acid 27.5% combo pkg, kit, liquid, lotion* *salicylic acid 28.5%* *Salex® combo pkg, kit, shampoo* *Sorilux™* *Taclonex® ointment, suspension* *Taclonex® Scalp* *Tazorac®* *Umecta® emulsion, foam, kit, suspension* *Umecta PD® emulsion, suspension* *Uramaxin®* *Uramaxin® GT* *Urea emulsion, foam, gel, kit, lotion, nail film suspension, suspension* *Urevaz®* *Vectical™* *X-Viate®*

Seebri™ Neohaler® — Non-prefer in PDL class: *COPD Agents*

Length of Authorization: 1 year

- Indicated for the long-term, maintenance treatment of airflow obstruction in patients with chronic obstructive pulmonary disease (COPD).
- Ensure diagnosis is for COPD (not indicated for use in asthma)
- Is there any reason that the patient cannot be switched to a preferred medication in the class? Document the details. Acceptable reasons include
  - Adverse reaction to preferred drugs;
  - Allergy to preferred drugs; and
  - Contraindication to preferred drugs.
- Has the patient had a therapeutic trial and treatment failure with **ONE** preferred drug in the same class? If so, document the details and approve.
- Seebri Neohaler is not indicated for use in children. The safety and efficacy of Seebri Neohaler in pediatric patients have not been established.

Quantity Limit = 2 inhalations per day (1 inhaler per month)

Utibron™ Neohaler® — Non-prefer in the PDL class: *COPD Agents*

Length of Authorization: 1 year

- Indicated for the long-term, maintenance treatment of airflow obstruction in patients with chronic obstructive pulmonary disease (COPD).
- Ensure diagnosis is COPD (not indicated for use in asthma)
- Is there any reason that the patient cannot be switched to a preferred medication? Document the details. Acceptable reasons include
  - Adverse reaction to preferred drugs;
  - Allergy to preferred drugs; and
  - Contraindication to preferred drugs.
- Has the patient had a therapeutic trial and treatment failure with **ONE** preferred drug in the same class? If so, document the details and approve.
- Utibron Neohaler is not indicated for use in children. The safety and efficacy of Utibron Neohaler in pediatric patients have not been established.

Limitations of Use: Not indicated for the relief of acute bronchospasm or for the treatment of asthma.

Quantity Limit = 2 inhalations per day (1 inhaler per month)

COPD Agents	albuterol-ipratropium inhalation solution QL Atrovent® HFA QL Combivent® Respimat® QL ipratropium inhalation solution QL Spiriva Handihaler® QL	*Anoro™ Ellipta™ CC, QL* *Daliresp™ QL* *Incruse™ Ellipta® QL* *Seebri™ Neohaler® QL* *Spiriva® Respimat® QL* *Stiolto™ Respimat® QL* *Tudorza™ Pressair™ QL* *Utibron™ Neohaler® QL*

Viberzi® — Non-prefer in the PDL class: *GI Motility, Chronic* **(TABLED)**

Length of Authorization: 1 year

- Indicated in adults for the treatment of irritable bowel syndrome with diarrhea (IBS-D).
- The safety and effectiveness of Viberzi have not been established in pediatric patients.

Quantity Limit = 2 tablets per day.

GI Motility Agents	Amitiza® CC Linzess® CC	*alosetron* CC *Lotronex®* CC *Movantik®* *Viberzi®QL*

Tresiba® — Non-prefer in the PDL class: *Hypoglycemics, Insulins & Related*

Length of Authorization: 1 year

- Indicated to improve glycemic control in adults with diabetes mellitus.
- Is there any reason that the patient cannot be switched to a preferred medication in the class? Document the details. Acceptable reasons include
  - Adverse reaction to preferred drugs;
  - Allergy to preferred drugs; and
  - Contraindication to preferred drugs.
- Has the patient had a therapeutic trial and treatment failure with **ONE** preferred drug in the same class? Document the details.
- Insulin Pens
  - Physical reasons such as dexterity problems/vision impairment;
  - Must be self-administered; and
  - NOT just for convenience.

Limitations of Use: Not recommended for treating diabetic ketoacidosis.

Diabetes: Injectable Insulins	Humalog® Vial Humalog® Mix Vial/Pen Humulin® N Vial Humulin® R Vial Humulin® R 500 Vial Humulin® 70/30 Vial Lantus® Vial Lantus® Solostar Pen Levemir® Vial/Pen Novolog® Vial/Pen/Cartridge Novolog® Mix Vial/Pen	*Afrezza®* *Apidra™ Vial/Pen* Humalog® KwikPen Humalog® Pen/Cartridge *Humulin® Pen* *Humulin® 70/30 Pen* *Novolin® Vial* *Novolin® 70/30 Vial* *Toujeo®* *Tresiba®*

Class Review and Criteria Reviews

Antipsoriatics, Topical

- DMS to select preferred agent (s) based upon economic evaluation; however, at least one unique chemical entity should be preferred.
- Agents not selected as preferred will be considered non-preferred and will require Prior Authorization (PA).
- For any new chemical entity in the Topical Psoriasis Agents, require a PA until reviewed by the P&T Committee.

Topical Psoriasis Agents	calcipotriene salicylic acid 6% gel, shampoo urea cream	*Aluvea®* *Bensal HP®* *BP® 50%* *calcipotriene/betamethasone* *Calcitrene™* *calcitriol ointment* *Carb-O-Philic®* *Cem-Urea®* *Dovonex®* *Enstilar®* *Keralyt®* *Latrix®* *Realo®* *Remeven®* *Salacyn® cream, lotion* *salicylic acid 3%, 6% cream, lotion* *salicylic acid 26% liquid* *salicylic acid 27.5% combo pkg, kit, liquid, lotion* *salicylic acid 28.5%* *Salex® combo pkg, kit, shampoo* *Sorilux™* *Taclonex® ointment, suspension* *Taclonex® Scalp* *Tazorac®* *Umecta® emulsion, foam, kit, suspension* *Umecta PD® emulsion, suspension* *Uramaxin®* *Uramaxin® GT* *Urea emulsion, foam, gel, kit, lotion, nail film suspension, suspension* *Urevaz®* *Vectical™* *X-Viate®*

COPD Agents

- DMS to select preferred agent (s) based on economic evaluation; however, at least three unique chemical entities should be preferred. At least one combination product and tiotropium should be among the preferred products.
- Agents not selected as preferred will be considered non-preferred and will require PA.
- Continue quantity limits on agents in this class.
- For any new chemical entity in the COPD Agents class, require a PA until reviewed by the P&T Advisory Committee.

COPD Agents	albuterol-ipratropium inhalation solution QL Atrovent® HFA QL Combivent® Respimat® QL ipratropium inhalation solution QL Spiriva Handihaler® QL	*Anoro™ Ellipta™ CC, QL* *Daliresp™ QL* *Incruse™ Ellipta® QL* *Seebri™ Neohaler® QL* *Spiriva® Respimat® QL* *Stiolto™ Respimat® QL* *Tudorza™ Pressair™ QL* *Utibron™ Neohaler® QL*

COPD Clinical Criteria:

Length of Authorization: 1 Year

Daliresp® is approvable if

- The diagnosis is COPD **AND** the patient has tried/failed **ONE** of the following:
  - Ipratropium; OR
  - Ipratropium/Albuterol; OR
  - Spiriva; OR
  - A beta agonist (short or long acting) used on a scheduled basis

Criteria to approve a non-preferred agent in this class:

- For renewals: has the patient's symptoms improved?
  - If YES, then ask for spirometry meansurement and may approve. (new products are symptom based, if no improvement in symptoms, then consider stepping-down from the agent)
- Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include
  - Allergy to medications not requiring prior approval;
  - Contraindication to or drug-to-drug interaction with medications not requiring prior approval; and
  - History of unacceptable/toxic side effects to medications not requiring prior approval.
- The requested non-preferred medication may be approved if **both** of the following are true:
  - If there has been a therapeutic failure to no less than a **two-week** trial of at least **two** preferred medications; **AND**
  - The requested medication's corresponding generic (if covered by the Commonwealth) has been attempted with **multiple** manufacturers (if available) and failed or is contraindicated.

GI Motility, Chronic

- DMS to select preferred agent (s) based on economic evaluation; however, at least one unique chemical entity should be preferred.
- Agents not selected as preferred will be considered non-preferred and will require PA.
- For any new chemical entity in the GI Motility, Chronic class, require a PA until reviewed by the P&T Committee.

GI Motility Agents	Amitiza® CC Linzess® CC	*alosetron* CC *Lotronex®* CC Movantik® *Viberzi®* QL

Hypoglycemics, Alpha-glucosadase Inhibitors

- DMS to select preferred agent (s) based on economic evaluation; however, at least one unique chemical entity should be preferred.
- Agents not selected as preferred will be considered non-preferred and will require PA.
- For any new chemical entity in the Alpha-Glucosidase Inhibitor class, require a PA until reviewed by the P&T Advisory Committee.

Diabetes: Alpha-Glucosidase Inhibitors	acarbose Glyset®	*Precose®*

Hypoglycemics, Amylin Analogues

- DMS to select preferred agent (s) based on economic evaluation.
- Allow for use of pramlintide with active insulin therapy only.
- Agents not selected as preferred will be considered non-preferred and will require PA.
- For any new chemical entity in the Amylin Analogue class, require a PA until reviewed by the P&T Advisory Committee.

Diabetes: Amylin Analogue	N/A	*Symlin®* ST

Hypoglycemics, DPP-4 Inhibitors

- DMS to select preferred agent (s) based on economic evaluation; however, at least one single entity agent should be preferred.
- Agents not selected as preferred will be considered non-preferred and will require PA.
- For any new chemical entity in the DPP4-Inhibitors class, require a PA until reviewed by the P&T Advisory Committee.

Diabetes: DPP-4 Inhibitors	Janumet™ ST, QL Janumet XR™ ST, QL Januvia™ ST, QL Jentadueto™ ST, QL Tradjenta™ ST, QL	*Glyxambi®* QL *Kazano®* QL *Kombiglyze™ XR* QL *Nesina®* QL *Onglyza™* QL *Oseni®* QL

Hypoglycemics, GLP-1 Receptor Agonists

- DMS to select preferred agent (s) based on economic evaluation; however, at least one unique chemical entity should be preferred.
- Continue to require PA for all agents in this class to ensure appropriate utilization.
- For any new chemical entity in the GLP-1 Receptor Agonists class, require a PA until reviewed by the P&T Advisory Committee.

Diabetes: GLP-1 Receptor Agonists	Bydureon® Byetta™ ST	*Tanzeum™* *Trulicity™* *Victoza®*

Hypoglycemics, Insulins & Related

- 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.
- Agents not selected as preferred will be considered non-preferred and will require PA.
- For any new chemical entity in the Injectable Insulins class, require a PA until reviewed by the P & T Advisory Committee.

Diabetes: Injectable Insulins	Humalog® Vial Humalog® Mix Vial/Pen Humulin® N Vial Humulin® R Vial Humulin® R 500 Vial Humulin® 70/30 Vial Lantus® Vial Lantus® Solostar Pen Levemir® Vial/Pen Novolog® Vial/Pen/Cartridge Novolog® Mix Vial/Pen	*Afrezza®* *Apidra™ Vial/Pen* Humalog® KwikPen Humalog® Pen/Cartridge *Humulin® Pen* *Humulin® 70/30 Pen* *Novolin® Vial* *Novolin® 70/30 Vial* *Toujeo®* *Tresiba®*

Hypoglycemics, Meglitinides

- DMS to select preferred agent (s) based on economic evaluation; however, at least one single entity agent should be preferred.
- Agents not selected as preferred will be considered non-preferred and will require PA.
- For any new chemical entity in the Meglitinides class, require a PA until reviewed by the P&T Advisory Committee.

Diabetes: Meglitinides	repaglinide Starlix®	nateglinide PrandiMet™ Prandin®

Hypoglycemics, Metformins

- DMS to select preferred agent (s) based on economic evaluation; however, at least metformin should be preferred.
- Agents not selected as preferred will be considered non-preferred and will require PA.
- For any new chemical entity in the Hypoglycemics, Metformins class, require a PA until reviewed by the P&T Advisory Committee.

Diabetes: Metformins	glyburide/metformin metformin metformin XR	*Fortamet™* *glipizide/metformin* *Glucophage®* *Glucophage XR®* *Glumetza™* *Metaglip™* *metformin ER (Generic Fortamet™)* *Riomet™*

Hypoglycemics, SGLT2 Inhibitors

- DMS to select preferred agent (s) based on economic evaluation; however, at least one unique chemical entity should be preferred.
- Agents not selected as preferred will be considered non-preferred and will require PA.
- For any new chemical entity in the Diabetes: SGLT2 Inhibitors class, require a PA until reviewed by the P&T Advisory Committee.

Diabetes: SGLT2 Inhibitors	Invokamet™ Invokana® ST	Farxiga™ Jardiance® Synjardy® Xigduo™ XR

Hypoglycemics, Sulfonylureas

- DMS to select preferred agent (s) based on economic evaluation; however, at least two unique second generation sulfonylureas should be preferred.
- Agents not selected as preferred will be considered non-preferred and will require PA.
- For any new chemical entity in the Sulfonylureas and Combination class, require a PA until reviewed by the P&T Advisory Committee.

Diabetes: Sulfonylureas	chlorpropamide	*Amaryl®*
	glimepiride	*Diabeta®*
	glipizide	*Glucotrol®*
	glipizide extended-release	*Glucotrol XL®*
	glyburide	*Glynase PresTab®*
	glyburide micronized	*Micronase®*
	tolazamide	
	tolbutamide	

Hypoglycemics, Thiazolidinediones (TZDs)

- DMS to select preferred agent (s) based on economic evaluation; however, at least one unique chemical entity should be preferred.
- Continue quantity limits based on maximum recommended dose.
- Agents not selected as preferred will be considered non-preferred and will require PA.
- For any new chemical entity in the Diabetes: Thiazolidinediones class, require a PA until reviewed by the P&T Advisory Committee.

Diabetes: Thiazolidinediones	pioglitazone QL	Actos® QL
		ACTOplus Met® QL
		ActoPlus Met® XR QL
		Avandamet® QL
		Avandia® QL
		Avandaryl® QL
		DuetAct™ QL
		pioglitazone/glimepiride QL
		pioglitazone/metformin QL

Hypoglycemics, Clinical Criteria Review

INSULINS

Length of Authorization: 1 Year

- Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
  - Allergy to medications not requiring prior approval;
  - Contraindication to or drug-to-drug interaction with medications not requiring prior approval; and
  - History of unacceptable/toxic side effects to medications not requiring prior approval.
- The requested non-preferred medication may be approved if **both** of the following are true:
  - If there has been a therapeutic failure of at least **one preferred medication within the last 90 days, within the same class; AND**
  - The requested medication's corresponding generic (if covered by the Commonwealth) has been attempted with **multiple manufacturers** (if available) and failed or is contraindicated.

For Pens and Cartridges not preferred:

- Patient is 15 years of age and under; OR
- Patients or active care-givers that are unable to manipulate vials/syringes due to issues related to poor eyesight, dexterity, or comprehension can be approved for non-preferred pens/cartridges.

GLP-1 AGONISTS

Preferred GLP-1 Agonists (Byetta & Bydureon) will be approved if metformin, a sulfonylurea, insulin, a DDP-4 inhibitor, OR a thiazolidinedione (TZD) is seen in history within the past 90 days.

SYMLIN

A trial of ANY insulin in the last 90 days will suffice for approval on this medication.

ORAL AGENTS (other than those with specific criteria)

Length of Authorization: 1 Year

- Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include
  - Allergy to medications not requiring prior approval;
  - Contraindication to or drug-to-drug interaction with medications not requiring prior approval; and
  - History of unacceptable/toxic side effects to medications not requiring prior approval.
- The requested non-preferred medication may be approved if both of the following are true:
  - If there has been a therapeutic failure to no less than a **one-month** of at least **two** preferred medications (unless only 1 available); **AND**
  - The requested medication's corresponding generic (if covered by the state) has been attempted with **multiple manufacturers** (if available) and failed or is contraindicated.

SGLT2 INHIBITORS

SGLT2 Inhibitors should only be approved for patients with a diagnosis of type 2 diabetics who have tried and failed maximum tolerated doses of metformin.

PRANDIMET

- Diagnosis is Diabetes Mellitus Type 2 AND patient is currently treated with a meglitinide and metformin; **OR**
- Patient is inadequately controlled on a meglitinide alone or metformin alone.

DPP-4 INHIBITORS

Length of Authorization: 1 Year

A preferred DPP-4 Inhibitor will be approved for one of the following reasons:

- Metformin, insulin, sulfonylurea, or a thiazolidinedione is seen in history within the past 90 days; **OR**
- The patient has a diagnosis of Chronic Renal Insufficiency or Chronic Renal Failure (ICD-10 = 585.9).

Approval criteria for a non-preferred DPP4 Inhibitor:

- Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
  - Allergy to medications not requiring prior approval;
  - Contraindication to or drug-to-drug interaction with medications not requiring prior approval; and
  - History of unacceptable/toxic side effects to medications not requiring prior approval.
- The requested non-preferred medication may be approved if **both** of the following are true:
  - If there has been a therapeutic failure of at least **two** preferred medications; **AND**
  - The requested medication's corresponding generic (if covered by the Commonwealth) has been attempted with multiple manufacturers (if available) and failed or is contraindicated.