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 (DMS) based on the Drug Review and Options for Consideration document prepared for the Pharmacy and Therapeutics (P&T) Advisory Committee's review on May 19, 2016, and the resulting official committee recommendations.

New Products to Market

Zembrace™ SymTouch™ – Non-prefer in PDL class: *Antimigraines, Triptans*

Length of Authorization: 1 year

Injection, for subcutaneous use, is a serotonin (5-HT1B/1D) receptor agonist (triptan) indicated for: Acute treatment of migraine, with or without aura, in adults.

- Is there any reason that the patient cannot be switched to a preferred medication? Document the details. Acceptable reasons include:
  - Adverse reaction to all preferred drugs;
  - Allergy to all preferred drugs; or
  - Contraindication to all preferred drugs.
- Has the patient had a documented therapeutic trial and treatment failure with **ALL** preferred drugs? If so, document the details.
- Sumatriptan generic products are covered without PA; document clinical reason as to why sumatriptan generic products cannot be used.

Quantity Limit = 8 units per month (to match all other pens/cartridges)

	Preferred:	Non-Preferred:
Anti-Migraine: 5-HT1 Receptor Agonists	Relpax™ QL rizatriptan QL rizatriptan ODT QL sumatriptan QL	*almotriptan QL* *Alsuma™ QL* *Amerge® QL* *Axert® QL* *Cambia™ QL* *Frova™ QL* *Imitrex® QL* *Maxalt® QL* *Maxalt-MLT® QL* *naratriptan QL* *Sumavel™ Dosepro™ QL* *Treximet™ QL* *Zecuity® QL* *Zembrace™ SymTouch™ QL* *zolmitriptan QL* *zolmitriptan ODT QL* *Zomig® QL* *Zomig-ZMT® QL*

Vraylar™ – Non-prefer in the PDL class: *Antipsychotics*

Length of Authorization: 1 year

Vraylar™ (cariprazine) capsules, for oral use, indicated for: Acute treatment of manic or mixed episodes associated with bipolar I disorder **OR** treatment of schizophrenia.

- Has a diagnosis of schizophrenia or acute treatment of manic or mixed episodes associated with bipolar I disorder.
- Had a failed 14-day trial of BOTH risperidone and 1 other atypical antipsychotic (i.e., Seroquel, Abilify, Clozaril, Invega, Zyprexa, Geodon, HIC3 H7T or H7X) **OR** medical justification why a trial is not appropriate.

Minimum Age = 18 years of age or older

Quantity Limit = 1 per day

	Preferred:	Non-Preferred:
Second-Generation Antipsychotics	aripiprazole ODT, solution, tablets CC, QL clozapine CC, QL clozapine ODT CC, QL Fanapt™ CC, QL Latuda® CC, QL olanzapine CC, QL quetiapine CC, QL risperidone CC, QL Saphris® CC, QL Seroquel® XR CC, QL ziprasidone CC, QL	*Abilify®* QL *Clozaril®* QL *FazaClo®* QL *Geodon®* QL *Invega®* QL *paliperidone* QL *Rexulti®* QL *Risperdal®* QL *Seroquel®* QL *Versacloz®* QL *Vraylar™* QL *Zyprexa®* QL

Zepatier™ – Non-prefer in PDL class: *Hepatitis C*

Length of Authorization: Depends upon regimen

Zepatier™ (elbasvir and grazoprevir) tablets for oral use is a fixed-dose combination product containing elbasvir, a hepatitis C virus (HCV) NS5A inhibitor, and grazoprevir, an HCV NS3/4A protease inhibitor, and is indicated with or without ribavirin for the treatment of chronic HCV genotypes 1 or 4 infection in adults.

- Indicated with or without ribavirin for treatment of chronic HCV genotypes 1 or 4 infection in adults.
- Must supply proof of genotypes 1 or 4 along with documentation of F3 or F4 fibrosis score.
- Documentation of *Readiness to Treat* is also required.
- Test patients with HCV genotype 1a infection for the presence of virus with NS5A resistance associated polymorphisms prior to initiation of treatment with Zepatier to determine dosage regimen and duration.
- Zepatier is contraindicated in patients with moderate hepatic impairment (Child-Pugh B) and in patients with severe hepatic impairment (Child-Pugh C). Must supply documentation of Child-Pugh classification.

Minimum age = 18 years

Maximum Quantity Limit = 1 per day

	Preferred:	Non-Preferred:
Hepatitis C: Direct-Acting Antiviral Agents	Daklinza™ CC, QL Technivie™ CC, QL Viekira Pak® CC, QL	*Harvoni®* CC, QL *Olysio™* CC, QL *Sovaldi™* CC, QL *Zepatier™* CC, QL

Adzenys XR-ODT™ – Non-prefer in PDL class: *Stimulants & Related*

Length of Authorization: 1 year

Adzenys XR-ODT (amphetamine extended-release orally disintegrating tablets), CII, is a central nervous system (CNS) stimulant indicated for the treatment of Attention Deficit Hyperactivity Disorder (ADHD) in patients 6 years and older.

- Is there any reason that the patient cannot be switched to a preferred medication? Document the details:
  - Adverse reaction to preferred drugs
  - Allergy to preferred drugs
  - Contraindication to preferred drugs
- Has the patient had a therapeutic trial and treatment failure with **TWO** preferred drugs? Document the details.
- Patient has a swallowing disorder and cannot be given tablets or capsules.

Minimum age = 6 years

Quantity Limit = 1 per day

Dyanavel™ XR – Non-prefer in PDL class: *Stimulants & Related*

Length of Authorization: 1 year

Dyanavel XR (amphetamine) extended-release oral suspension, CII, is a central nervous system (CNS) stimulant indicated for the treatment of Attention Deficit Hyperactivity Disorder (ADHD).

- Is there any reason that the patient cannot be switched to a preferred medication? Document the details:
  - Adverse reaction to preferred drugs
  - Allergy to preferred drugs
  - Contraindication to preferred drugs
- Has the patient had a therapeutic trial and treatment failure with **TWO** preferred drugs? Document the details.
- Patient has a swallowing disorder and cannot be given tablets or capsules.

Minimum age = 6 years

Quantity Limit = 20 mg/d (2.5 mg/mL)

QuilliChew ER™ – Non-prefer in the PDL class: *Stimulants & Related*

Length of Authorization: 1 year

QuilliChew ER™ (methylphenidate hydrochloride) extended-release chewable tablets, for oral use, CII: QuilliChew ER is a central nervous system (CNS) stimulant indicated for the treatment of Attention Deficit Hyperactivity Disorder (ADHD).

- Is there any reason that the patient cannot be switched to a preferred medication? Document the details:
  - Adverse reaction to preferred drugs
  - Allergy to preferred drugs
  - Contraindication to preferred drugs
- Has the patient had a therapeutic trial and treatment failure with **TWO** preferred drugs? Document the details.
- Quillivant XR and Methylin Chewable Tablets are covered as preferred; document clinical reason as to why Quillivant XR and Methylin Chewable Tablets cannot be used.

Minimum age = 6 years

Quantity Limit = 1 per day (1QAM)

	Preferred:	Non-Preferred:
Stimulants and Related Agents	Adderall XR® CC, QL	*Adderall® QL*
	dexmethylphenidate IR CC, QL	*Adzenys XR-ODT™ QL*
	dextroamphetamine IR CC, QL	*Aptensio XR® QL*
	dextroamphetamine ER CC, QL	*clonidine ER QL*
	Focalin XR™ CC, QL	*Concerta® QL*
	guanfacine ER CC, QL	*Daytrana™ QL*
	Metadate CD® CC, QL	*Desoxyn® QL*
	Metadate ER® CC, QL	*Dexedrine® QL*
	Methylin® chewable tablets CC, QL	*dexmethylphenidate ER QL*
	methylphenidate IR tablets, capsules CC, QL	*dextroamphetamine solution QL*
	methylphenidate ER/SA/SR CC, QL	*Dyanavel™ XR QL*
	methylphenidate ER OROS CC, QL	*Evekeo™ QL*
	mixed amphetamine salts IR CC, QL	*Focalin™ QL*
	Quillivant™ XR CC, QL	*Intuniv™ QL*
	Strattera® CC, QL	*Kapvay™ QL*
	Vyvanse™ CC, QL	*methamphetamine QL*
		Methylin® solution QL
		methylphenidate (Generic for Metadate CD®) QL
		methylphenidate chewable (Generic for Methylin® chewable tablets) QL
		methylphenidate LA (Generic Ritalin LA®) QL
		methylphenidate solution QL
		mixed amphetamine salts ER QL
		Procentra™ QL
		QuilliChew ER™ QL
		Ritalin® QL
		Ritalin LA® QL
		Zenzedi™ QL

Class Review and Criteria Reviews

Acne Agents, 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 Acne Agents, Topical class, require a PA until reviewed by the P&T Committee.

	Preferred:	Non-Preferred:
Acne Agents, Topical	BenzaClin®	*Acanya™*
	clindamycin solution, gel, lotion	*Aczone™*
	Differin® cream, gel	*adapalene cream, gel*
	Duac®	*Akne-Mycin®*
	erythromycin solution, gel	*Atralin™*
	Retin-A cream, gel	*Avar™*
		Avar E™
		Avar E LS™
		Avar LS™
		Avita®
		BenoxylDoxy®
		Benzac AC®
		Benzamycin®
		Benzefoam™
		Benzefoam Ultra™
		BenzePro™
		benzoyl peroxide cleanser, kit, microspheres, gel, foam
		benzoyl peroxide/sulfur
		BP 10-1®
		BPO®
		BPO-5®
		BPO-10®
		BP Wash™
		Cerisa™
		Clarifoam® EF
		Cleocin-T®
		Clindacin PAC™
		Clindagel®
		clindamycin foam, medicated swab
		clindamycin/benzoyl peroxide
		DermaPak Plus Kit
		Desquam-X®
		Differin® lotion
		Effaclar Duo®
		Epiduo™

		Epiduo Forte™
		erythromycin medicated swab
		erythromycin/benzoyl peroxide
		Evoclin™
		Fabior®
		Inova™
		Inova™ 4/1
		Inova™ 8/2
		Klaron®
		Lavoclen™
		Neuac®
		Pacnex®
		Pacnex® HP
		Pacnex® LP
		Pacnex® MX
		Panoxyl®
		Persa-Gel®
		Prascion®
		PR-benzoyl peroxide
		OC8®
		Onexton™
		Ovace®
		Ovace Plus®
		Nu-Ox®
		Retin-A®
		Retin-A Micro®
		Rosula®
		SE 10-5 SS®
		SE BPO®
		sodium sulfacetamide 10% CLNSG
		sodium sulfacetamide/sulfur cleanser
		sodium sulfacetamide/sulfur 10-4% pad
		sodium sulfacetamide/sulfur/urea
		SSS 10-4®
		SSS 10-5®
		Sulfacetamide/sulfur cleanser
		Sumadan™
		Sumadan™ XLT
		Sumaxin®
		Tazorac®
		Tretin-X™
		tretinoin (Generic Atralin™)
		tretinoin cream, gel
		tretinoin microsphere
		Vanoxide-HC®
		Veltin™
		Zencia®
		Ziana™

Antivirals, Oral

HSV:

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

Influenza:

- DMS to select preferred agent (s) based on economic evaluation; however, at least oseltamivir and zanamivir should be preferred.
- Agents not selected as preferred will be considered non-preferred and require PA.
- DMS to consider CDC recommendation updates regarding antiviral therapy for the treatment of influenza. The Medical Director, with Commissioner approval, may make changes to the PDL listing based on the CDC recommendations until this class can be considered at the next scheduled review.
- For any new chemical entity in the Antivirals, Oral class, require a PA until reviewed by the P&T Advisory Committee.

NOTE: amantadine was removed from this class, it will remain in the AntiParkinson's Agents class going forward.

	Preferred:	Non-preferred:
Antivirals: Herpes Simplex Virus	Acyclovir capsule, tablet famciclovir valacyclovir Zovirax susp	*acyclovir susp* *Famvir®* *Sitavig®* *Valtrex®* *Zovirax® caps, tabs*
Antivirals: Influenza	Relenza® rimantadine Tamiflu® QL	*Flumadine®* *Symmetrel®*

Bone Resorption Suppression and Related Agents

- DMS to select preferred agent (s) based on economic evaluation; however, at least alendronate, calcitonin-salmon, and raloxifene should be preferred on the PDL. Additionally, at least one bisphosphonate with a once-weekly dosing formulation should be preferred on the PDL.
- Agents not selected as preferred will be considered non-preferred and require PA.
- For any new chemical entity in the Bone Resorption Suppression and Related Agents class, require a PA until reviewed by the P&T Advisory Committee.

	Preferred:	Non-Preferred:
Bone Resorption Suppression and Related Agents	alendronate tablets QL Fortical® raloxifene	*Actonel® QL* *Actonel with Calcium® QL* *alendronate solution QL* *Atelvia™ QL* *Binosto® QL* *Boniva® QL* *calcitonin-salmon* *Didronel®* *etidronate* *Evista®* *Forteo™ QL* *Fosamax® QL* *Fosamax Plus D™ QL* *ibandronate QL* *Miacalcin®* *Prolia™* *Reclast® QL* *risedronate QL* *Skelid® QL* *zoledronic acid QL*

Cytokine and CAM Antagonists

- DMS to select preferred agent (s) based on economic evaluation; however, at least two self-administrable products should be preferred.
- Agents not selected as preferred will be considered non-preferred and require trial and failure of preferred product (s) with an FDA-approved indication for the requested diagnosis.
- All agents in the category should be approved for their FDA-approved indications only.
- Allow continuation of therapy for non-preferred single-source branded products.
- Maintain quantity limits on agents within the category according to their maximum recommended dose, taking into consideration any escalating doses needed during initial therapy.
- For any new chemical entity in the Cytokine and CAM Antagonists and Related Agents class, require a PA until reviewed by the P&T Advisory Committee.

Note: Taltz as non-preferred (NPD) will have length of authorization of one year with standard NPD product criteria of - document why a preferred agent cannot be used.

	Preferred:	Non-Preferred:
Immunomodulators (Cytokine & CAM Antagonists)	Enbrel® CC QL Humira® CC, QL	*Actemra® CC, QL* *Cimzia® CC, QL* *Cosentyx® CC, QL* *Entyvio™ CC, QL* *Kineret® CC, QL* *Orencia® CC, QL* *Otezla® CC, QL* *Remicade® CC* *Simponi™ CC, QL* *Simponi™ARI CC, QL* *Stelara™ CC, QL* *Taltz® CC, QL* *Xeljanz™ CC, QL* *Xeljanz™ XR CC, QL*

Glucocorticoids, Inhaled

- DMS to select preferred agent (s) based on economic evaluation; however, at least three unique chemical entities should be preferred.
- Agents not selected as preferred will be considered non-preferred and will require PA.
- Continue quantity limits on agents in this class.
- Continue to allow budesonide respules without PA for patients less than 8 years of age.
- For any new chemical entity in the Glucocorticoids, Inhaled class, require a PA until reviewed by the P&T Advisory Committee.

	Preferred:	Non-Preferred:
Glucocorticoids, Inhaled	Asmanex® Twisthaler QL Flovent Diskus® QL Flovent HFA® QL Pulmicort Respules® QL, AE QVAR® QL	*Aerospan™ QL* *Alvesco® QL* *Anruity™ Ellipta® QL* *Asmanex® HFA QL* *budesonide inhalation suspension QL* *Pulmicort Flexhaler® QL*

Glucocorticoids, Inhaled Beta Agonists: Combination Products	Advair® Diskus QL Advair® HFA QL Dulera® QL Symbicort® QL	*Breo® Ellipta® QL*

Glucocorticoids, Oral

- DMS to select preferred agent (s) based on economic evaluation; however, at least generic formulations of budesonide, dexamethasone, methylprednisolone, prednisolone, and prednisone should be preferred.
- The orally-disintegrating formulation of prednisolone should be available for children < 12 years of age.
- Agents not selected as preferred will be considered non-preferred and require PA.
- For any new chemical entity in the Glucocorticoids, Oral class, require a PA until reviewed by the P&T Advisory Committee.

	Preferred:	Non-Preferred:
Glucocorticoids, Oral	cortisone	*Baycadron®*
	budesonide EC	*Celestone®*
	dexamethasone solution, tablets	*Celestone® Soluspan*
	hydrocortisone	*Cortef®*
	methylprednisolone dose pack, tablets	*dexamethasone elixir*
	prednisolone solution	*dexamethasone intensol*
	prednisolone sodium phosphate	*DexPak®*
	prednisone dose pack, tablets, solution	*DexPak JR®*
		Entocort EC®
		Flo-Pred®
		Medrol®
		methylprednisolone 8 mg, 16 mg tablets
		Millipred®
		Orapred® AE
		Orapred ODT® AE
		prednisone intensol
		prednisolone sodium phosphate ODT
		Prelone®
		Rayos®
		Veripred 20®

Growth Hormone

- DMS to select preferred agents based upon economic evaluation; however, one preferred agent should be supplied in a pediatric convenient dosing form.
- Continue to require clinical PA for all agents, preferred or non-preferred.
- For any new chemical entity in the Growth Hormone class, require a PA until reviewed by the P & T Advisory Committee.

NOTE: DMS will allow grandfathering on the product moving to Non-Preferred; patients already on this therapy prior to the status change may remain on this product if they wish.

	Preferred:	Non-Preferred:
Growth Hormone	Genotropin® CC Norditropin® CC Norditropin Flexpro® CC	*Humatrope® CC* *Omnitrope® CC* *Nutropin AQ® CC* *Saizen® CC* *Serostim® CC* *Zomacton® CC* *Zorbtive® CC*

Hepatitis B Agents

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

	Preferred:	Non-Preferred:
Anti-Infectives: Hepatitis B	Baraclude™ Epivir-HBV® Hepsera® Tyzeka®	*adefovir* *entecavir* *lamivudine HBV*

Immunomodulators, Atopic Dermatitis

- 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 require PA.
- For any new chemical entity in the Immunomodulators, Atopic Dermatitis class, require a PA until reviewed by the P&T Advisory Committee.

	Preferred:	Non-Preferred:
Immunomodulators, Atopic Dermatitis	Elidel®	*Protopic®* *tacrolimus*

Immunosuppressants, Oral

- DMS to select preferred agent (s) based on economic evaluation; however, at least four unique chemical entities should be preferred.
- Agents not selected as preferred will be considered non-preferred and will require PA.
- DMS to allow continuation of therapy if there is a paid claim in the past 90 days.
- For any new chemical entity in the Immunosuppressants, Oral class, require a PA until reviewed by the P&T Advisory Committee.

NOTE: DMS will allow those patients on the generic prior to the status change to continue on the generic if they wish.

	Preferred:	Non-Preferred:
Immunosuppressants, Oral	azathioprine	*Astagraf XL™*
	CellCept® susp	*Azasan®*
	cyclosporine	*CellCept® caps*
	cyclosporine modified	*Envarsus® XR*
	Gengraf®	*Hecoria®*
	mycophenolate mofetil caps & tabs	*Imuran®*
	Myfortic®	*mycophenolic acid*
	sirolimus	*mycophenolate mofetil susp*
	tacrolimus	*Neoral®*
		Prograf®
		Rapamune®
		Sandimmune®
		Zortress®

Multiple Sclerosis Agents

- DMS to select preferred agent (s) based on economic evaluation; however, at least glatiramer, one interferon ß-1b, and one interferon ß-1a product should be preferred.
- Agents not selected as preferred will be considered non-preferred and require PA.
- Place quantity limits on these products based on maximum recommended dose.
- For any new chemical entity in the Multiple Sclerosis Agents class, require a PA and quantity limit until reviewed by the P&T Advisory Committee.

	Preferred:	Non-Preferred:
Multiple Sclerosis Agents	Avonex® QL	*Ampyra™ QL, CC*
	Betaseron® QL	*Aubagio® QL*
	Copaxone® 20 mg QL	*Copaxone® 40 mg QL*
	Gilenya™ CC,QL	*Extavia® QL*
	Rebif® QL	*Glatopa™ QL*
		Plegridy® QL
		Tecfidera™ QL

Pancreatic Enzymes

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

	Preferred:	Non-Preferred:
Pancreatic Enzymes	Creon® pancrelipase Zenpep®	*Pancreaze™* *Pertzye™* *Ultresa™* *Viokace™*

Progestins for Cachexia

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

	Preferred:	Non-Preferred:
Progestins for Cachexia	megestrol acetate 40 mg/mL, tablets	*Megace®* *Megace ES®* *megestrol acetate 625 mg/5 mL*

Steroids Topical, High, Medium, Low, Very High

- DMS to select preferred agent(s) based on economic evaluation; however, at least one agent in each of the potency categories (i.e., low, medium, high and very high) should be preferred.
- Agents not selected as preferred will be considered non-preferred and require PA.
- For any new chemical entity in the Steroids, Topical class, require a PA until reviewed by the P&T Advisory Committee.

	Preferred:	Non-Preferred:
Steroids, Topical	*betamethasone dipropionate cream, lotion* *betamethasone valerate cream, ointment* *clobetasol propionate ointment, cream, solution, gel* *Clobex® shampoo* *desonide* *fluocinolone acetonide cream, ointment, solution* *fluocinonide gel, soln, emollient, cream* *fluticasone propionate cream, ointment* *halobetasol propionate* *hydrocortisone cream, gel, ointment, lotion* *hydrocortisone valerate* *mometasone furoate ointment, cream, solution* *triamcinolone acetonide ointment, cream, lotion*	*Aclovate®* *ADV Allergy Collection Kit* *alclometasone dipropionate* *Ala-Cort®* *Ala-Scalp®* *Aqua Glycolic HC®* *amcinonide* *ApexiCon®/ApexiCon E®* *Balneol for Her®* *betamethasone dipropionate gel, ointment* *betamethasone dipropionate augmented* *betamethasone valerate lotion, foam* *Caldecort®* *Capex® Shampoo* *clobetasol emollient* *clobetasol propionate foam, lotion, shampoo, spray* *Clobex® lotion, spray* *clocortolone* *Clodan®* *Cloderm®* *Cordran®* *Cordran® Tape* *Cormax®* *Cutivate®* *Cyclocort®* *Derma-Smoothe/FS®* *DermacinRx® Silapak* *DermacinRx® Silazone PharmPak* *Dermatop®* *Desonate®* *Desowen®* *desoximetasone* *diflorasone diacetate* *Diprolene AF®* *Elocon®* *fluocinolone acetonide oil* *fluticasone propionate lotion* *Halac Kit®* *Halog®*

Topical Steroids (continued)	*See Previous Page*	*Halonate®* *hydrocortisone-aloe* *hydrocortisone butyrate/emollient* *hydrocortisone butyrate soln, cream, oint* *hydrocortisone-urea* *Kenalog®* *Lipocream®* *Locoid®* *Luxiq®* *Momexin™* *NuZon™* *Olux®/Olux-E®* *Olux-Olux E® Complete Pack* *Elocon®* *fluocinolone acetonide oil* *fluocinonide ointment* *fluticasone propionate lotion* *Halac Kit®* *Halog®* *Halonate®* *hydrocortisone-aloe* *hydrocortisone butyrate soln, cream, oint* *hydrocortisone butyrate/emollient* *hydrocortisone-urea* *Kenalog®* *Lipocream®* *Locoid®* *Luxiq®* *Momexin™* *NuZon™* *Olux®/Olux-E®* *Olux-Olux E® Complete Pack* *Pandel®* *Pediaderm HC™* *Pediaderm TA™* *prednicarbate* *Psorcon®* *Scalacort®* *Scalacort-DK® Kit* *Synalar®* *Temovate®* *Temovate E®* *Texacort®* *Topicort®* *Topicort® Topical Spray* *triamcinolone acetonide spray* *Triderm®* *Trianex®*

Topical Steroids (continued)	*See Previous Pages*	Ultravate® *Ultravate® PAC Kit* *Ultravate® X* *Vanos™* *Verdeso™* *Westcort®* *Whytederm TD Pack®*

Viberzi® criteria – Old Business

Viberzi Clinical Criteria Review – Clarification of criteria regarding covered antidiarrheals:

This agent was initially reviewed as a new product to market during the March 17, 2016 P&T meeting. The Committee voted at that time to table discussion over to the May 19, 2016 agenda and to include step therapy in the revised criteria. Below is the criteria as reviewed at the May 19, 2016 P&T meeting:

Non-prefer in the PDL class: *GI Motility, Chronic*

Length of Authorization: 1 Year

- The safety and effectiveness of Viberzi have not been established in pediatric patients.
- Indicated in adults for the treatment of irritable bowel syndrome with diarrhea (IBS-D).
- Trial and failure of two (2) covered antidiarrheals.
  (RX: loperamide or diphenoxylate/atropine. OTC: loperamide)

Quantity Limit = 2 tablets per day.