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 **September 15, 2016**, and the recommendations delivered by the P&T Committee members in attendance:

New Products to Market

Xtampza™ ER – Non-prefer in the PDL class: *Analgesics Narcotics, Long-Acting*

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

Xtampza™ ER (oxycodone extended-release capsule) is an opioid agonist product 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.

- Trial and failure of 2 different preferred long-acting narcotics; OR
- Must have no history of opioid abuse or illicit drug use within the past 365 days; OR
- Patient has current history of extended-release oxycodone use for previous opioid dependence and requires chronic pain management.

Age Limit = ≥ 18 years of age

Quantity Limit = 3 per day for the 9 mg, 13.5 mg, 18 mg, and 27 mg capsules.

Quantity Limit = 8 per day for the 36 mg capsules.

Maximum Daily Dosage = 288 mg

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Class	Preferred	Non-Preferred
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* *Xtampza™ ER QL* *Zohydro ER™ CC, QL*

AE – Age Edit; CC – Clinical Criteria; MD – Medications with Maximum Duration; QL – Quantity Limit; ST – Step Therapy

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Onzetra™ Xsail™ – Non-prefer in the PDL class: *Anti-Migraine: 5-HT1 Receptor Agonists (Antimigraines, Triptans)*

Length of Authorization: 1 year

Onzetra™ Xsail™ (sumatriptan succinate nasal powder) is a serotonin 5-HT1B/1D receptor agonist (triptan) indicated for the acute treatment of migraine, with or without aura, in adults. It is 11 mg per nosepiece, there are 2 nosepieces per dose; 22 mg is the full dose. This is not an inhaler or spray; the patient is to blow through the mouth into the piece which propels the powder into the nostril.

- Documented therapeutic trial and treatment failure with ALL preferred drugs.
- Sumatriptan generic oral and vial; Imitrex® Nasal; and Imitrex® Pen and Cartridge are covered without PA; clinical reason as to why sumatriptan generic oral and vial; Imitrex® Nasal; and Imitrex® Pen and Cartridge cannot be used.

Quantity Limit = 16 doses per 30 days (2 kits; each kit has 8 doses)

Class	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 *Onzetra™ Xsail™* QL *Sumavel ™DosePro™* QL *Treximet™* QL *Zecuity®* QL *Zembrace™ SymTouch™* QL *zolmitriptan* QL *zolmitriptan ODT* QL *Zomig®* QL *Zomig-ZMT®* QL

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Nuplazid™ – Non-prefer in the PDL class: *Second-Generation Antipsychotics* (*Antipsychotics)*

Length of Authorization: 1 year

Nuplazid™ (pimavanserin) tablet for oral use is a Selective Serotonin 5-HT2A Inverse Agonist/antagonist (SSIA). It is an atypical antipsychotic indicated for the treatment of hallucinations and delusions associated with Parkinson's disease psychosis.

- Must have diagnosis of Parkinson's Disease; AND
- Trial of dose adjustment or withdrawal of antiparkinson's medications prior to treatment with this agent, (e.g., anticholinergics, amantadine, dopamine agonists, COMT inhibitors, selegiline) because these are known to cause hallucinations.

Age Limit = ≥ 18 years

Quantity Limit = 2 tablets per day (60 tablets per 30 days)

Class	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® tablets* CC, QL *Clozaril®* QL *FazaClo®* QL *Geodon®* QL *Invega®* QL *Nuplazid™* QL *paliperidone* QL *Rexulti®* QL *Risperdal®* QL *Seroquel®* QL *Versacloz®* QL *Vraylar™* QL *Zyprexa®* QL

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Bevespi Aerosphere™ – Non-prefer in the PDL class: *COPD Agents*

Length of Authorization: 1 year

Bevespi Aerosphere™ (glycopyrrolate and formoterol) is indicated for the long-term maintenance treatment of airflow obstruction in patients with Chronic Obstructive Pulmonary Disease (COPD) including chronic bronchitis and/or emphysema.

- Must have diagnosis of COPD; AND
- Documentation of spirometry measurement (FEV_1); AND
- Must not use the medication for asthma or relief of acute symptoms or be using other Long-Acting Beta Adronergics (LABAs); AND
- Must have rescue therapy on file.

Age Limit = ≥ 18 years of age

Quantity Limit: 1 canister per 30 days

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

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Zinbryta™ – Non-prefer in PDL class: *Multiple Sclerosis Agents*

Length of Authorization: 6 months

Zinbryta™ (daclizumab) is a self-injectable subcutaneous injection of an interleukin-2 receptor blocking antibody indicated for use in adults with relapsing form of multiple sclerosis.

- Must have documentation of relapsing form of multiple sclerosis (MS) as documented by laboratory report; (e.g., MRI); AND
- Must have documentation of trial and failure of at least 2 other drugs indicated for the treatment of MS (due to safety profile, try other agents first); AND
- Must have no history of hepatic impairment (ALT & AST < 2 times ULN) or disease; AND
- Documentation of baseline transaminases and bilirubin levels and confirmation that levels will be checked monthly; AND
- Documentation of negative tuberculosis (Tb), Hep B, and Hep C screening.

Age Limit = ≥ 18 years of age

Quantity Limit: 1 syringe (150 mg) per 28 days.

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

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Venclexta® – Non-prefer in PDL class: *Oral Oncology, Hematologic Cancer* (*Oncology Oral – Hematologic)*

Length of Authorization: 6 months

Venclexta® (venetoclax) tablet for oral use is a BCL-2 inhibitor indicated for the treatment of patients with chronic lymphocytic leukemia (CLL) with 17p deletion, as detected by an FDA approved test, who have received at least one prior therapy. Available as a starter pack for the first 4 weeks followed by 4 x 100 mg tablets orally per day.

- Diagnosis of Chronic Lymphocytic Leukemia (CLL); AND
- Prescriber to submit lab work documenting 17p deletion as detected by an FDA-approved test; AND
- Must have received at least one prior therapy for the treatment of CLL and has either relapsed or developed progressive disease; AND
- Is assessed for risk of tumor lysis syndrome; AND
- Is not receiving a strong CYP3A Inhibitor.

Age Limit = ≥ 18 years of age

Quantity Limit = Starter Pack (42 tablets per 28 days – one time fill)

Then 120 tablets per 30 days thereafter.

Maximum Daily Dosing = 400 mg

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

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Alecensa® – Non-prefer in PDL class: *Oral Oncology, Lung Cancer (Oncology Oral – Lung)*

Length of Authorization: 6 months

Alecensa® (alectinib) 150 mg capsules is indicated for the treatment of patients with anaplastic lymphoma kinase (ALK)-positive, metastatic non-small cell lung cancer (NSCLC) who have progressed on or are intolerant to crizotinib (Xalkori®).

- Must have a diagnosis of metastatic non-small cell lung cancer; AND
- Must have anaplastic lymphoma kinase (ALK) mutation-positive NSCLC as confirmed by an FDA approved test; AND
- Must have an intolerance to, or has disease progression, while on crizotinib (Xalkori®)

Age Limit = ≥ 18 years of age

Quantity Limit = 8 capsules per day (600 mg twice daily)

Tagrisso™ – Non-prefer in the PDL class: *Oral Oncology, Lung Cancer* (*Oncology Oral – Lung)*

Length of Authorization: 6 months

Tagrisso™ (osimertinib) is 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. Available as 40 mg and 80 mg tablets. (The 40 mg tablet is reserved for those who need dose modifications due to adverse effects.)

- Must have a diagnosis of metastatic non-small cell lung cancer; AND
- Prescriber must submit lab work documenting the T790M mutation as detected by an FDA-approved test; AND
- Must have progressed on or after EGFR tyrosine kinase inhibitor (TKI) therapy (erlotinib, gefitinib, or afatinib).

Age Limit = ≥ 18 years of age

Quantity Limit = 1 tablet per day

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

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Cabometyx™ – Prefer in PDL class: *Oral Oncology, Renal Cell Carcinoma* (*Oncology Oral – Renal)*

Length of Authorization: 6 months

Cabometyx™ (cabozantinib) is a kinase inhibitor, available as 20 mg, 40 mg, or 60 mg tablet. Indicated for the treatment of patients with advanced renal cell carcinoma (RCC) who have received prior anti-angiogenic therapy.

- Must have diagnosis of advanced renal cell carcinoma; AND
- Patient has received prior antiangiogenic therapy; AND
- Not have severe hepatic impairment (Child-Pugh Class C).

Age Limit = ≥ 18 years of age

Quantity Limit = 2 tablets per day (60 mg per day is the *recommended* dosing)

Maximum Daily Dosing = 80 mg per day

Class	Preferred	Non-Preferred
Oral Oncology, Renal Cell Carcinoma	Afinitor® tablets QL Cabometyx™ CC, QL Nexavar® QL Sutent® QL Votrient® QL	*Afinitor Disperz® QL* *Inlyta® CC, QL* *Lenvima™ QL*

Cotellic™ – Non-prefer in the PDL class: *Oral Oncology, Skin Cancer* (*Oncology Oral – Skin)*

Length of Authorization: 6 months

Cotellic™ (cobimetinib) 20 mg tablets, indicated for the treatment of patients with unresectable or metastatic melanoma with a BRAF V600E or V600K mutation, in combination with vemurafenib.

- Must have diagnosis of unresectable or metastatic melanoma with V600E or V600K mutations in the BRAF gene as determined by an FDA approved diagnostic test; AND
- Prescriber to submit lab work documenting this mutation; AND
- Must be used with vemurafenib (Zelboraf®).

Quantity Limit = 63 tablets per 28 days

Class	Preferred	Non-Preferred
Oral Oncology, Skin Cancer	Erivedge™ CC, QL Mekinist™ CC, QL Tafinlar® CC, QL	*Cotellic™ QL* *Odomzo® QL* *Zelboraf™ QL*

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Class Review and Criteria Reviews

Anticonvulsants

New addition to the class: Briviact® (brivaracetam)

Length of Authorization: 1 year

Available as tablets, solution, and injection – interchangeable on a mg per mg basis. It is a Schedule V controlled substance indicated as adjunctive therapy for the treatment of partial-onset seizures in epileptic patients 16 years of age or older.

For approval, patient must:

- Be ≥ 16 years of age; AND
- Have diagnosis of partial-onset seizures; AND
- Have tried and failed at least 1 other medication as adjunctive treatment for partial-onset seizures; AND
- Patient is currently taking ≥ 1 other maintenance therapy for partial-onset seizures.

Limitation of use: Do not approve if patient has chronic hepatic impairment (e.g., Child-Pugh Class A, B, or C,) or for end stage renal disease (ESRD) patients on dialysis.

Quantity Limit = 200 mg per day

First Generation:

- DMS to select preferred agent(s) based on economic evaluation; however, at least 6 unique chemical entities should be preferred.
- Agents not selected as preferred will be considered non-preferred and require prior authorization.
- For any agent not selected as preferred, DMS to allow continuation of therapy if there is a paid claim in the past 90 days.
- For any new chemical entity in the First-Generation Anticonvulsants class, require a PA until reviewed by the P&T Advisory Committee.

Second Generation:

- DMS to select preferred agent(s) based on economic evaluation; however, at least 7 unique chemical entities should be preferred.
- Agents not selected as preferred will be considered non-preferred and require prior authorization.
- For any agent not selected as preferred, DMS to allow continuation of therapy if there is a paid claim in the past 90 days.
- For any new chemical entity in the Second-Generation Anticonvulsants class, require a PA until reviewed by the P&T Advisory Committee.

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Carbamazepine Derivatives:

- DMS to select preferred agent(s) based on economic evaluation; however, at least 2 unique chemical entities should be preferred.
- Agents not selected as preferred will be considered non-preferred and require prior authorization.
- For any agent not selected as preferred, DMS to allow continuation of therapy if there is a paid claim in the past 90 days.
- For any new chemical entity in the Anticonvulsants, Carbamazepine Derivatives class, require a PA until reviewed by the P&T Advisory Committee.

Class	Preferred	Non-Preferred
Anticonvulsants: First Generation	Celontin® clonazepam tablets DiaStat® QL divalproex delayed-release divalproex sprinkle ethosuximide felbamate mephobarbital CC Peganone® phenobarbital CC Phenytek® phenytoin IR/ER primidone CC valproate valproic acid	*clonazepam ODT* *Depakene®* *Depakote®* *Depakote ER®* *Depakote® Sprinkle* *diazepam rectal gel* QL *Dilantin®* *divalproex sodium ER* *Felbatol®* *Klonopin®* *Mysoline®* *Onfi™* CC *Stavzor™* *Zarontin®*
Anticonvulsants: Second Generation	Banzel™ CC Gabitril® gabapentin capsules, solution lamotrigine IR tablets, ODT levetiracetam IR tablets, solution Lyrica® CC Sabril® CC topiramate IR zonisamide	*Briviact® QL* *Fycompa™* *gabapentin tablets* *Gralise™* *Keppra™ tablets, solution* *Keppra XR™* *Lamictal®* *Lamictal ODT®* *Lamictal® XR* *lamotrigine ER* *levetiracetam ER* *Neurontin®* *Potiga®* *Qudexy XR™* *tiagabine* *Topamax®* *topiramate ER* *Trokendi XR™* *Vimpat®* *Zonegran®*
Anticonvulsants: Carbamazepine Derivatives	carbamazepine carbamazepine extended-release (Generic Carbatrol®) Equetro™ Oxcarbazepine Tegretol® suspension Tegretol® XR	*Aptiom®* *Carbamazepine suspension* *carbamazepine extended-release* *Carbatrol®* *Epitol®* *Oxtellar™ XR* *Tegretol® tablet* *Trileptal®*

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Topical Antifungal Agents (Antifungals, Topical)

- DMS to select preferred agent(s) based on economic evaluation; however, at least agents representing multiple mechanisms of action as well as a combination product should be preferred.
- Agents not selected as preferred will be considered non-preferred and require PA.
- Before utilization, the combination product miconazole/zinc oxide should be subject to trial and failure of conventional therapies for diaper dermatitis.
- For any new chemical entity in the Antifungals, Topical class, require a PA until reviewed by the P&T Advisory Committee.

Class	Preferred	Non-Preferred
Topical Antifungal Agents	clotrimazole cream, solution clotrimazole/betamethasone econazole ketoconazole cream, shampoo nystatin cream, ointment, powder nystatin/triamcinolone cream, ointment	*Ciclodan® cream, kit, solution* *ciclopirox* *CNL-8™* *Ecoza™* *Ertaczo®* *Exelderm®* *Extina®* *Jublia® CC* *Kerydin™ CC* *ketoconazole foam* *Ketodan™* *Kuric®* *Loprox®* *Lotrimin®* *Lotrisone®* *Luzu®* *Mentax®* *naftifine* *Naftin®* *Nizoral Shampoo®* *Nyamyc®* *Nystop®* *Oxistat®* *Pedi-Dri®* *Pediaderm AF®* *Pedipirox-4™* *Penlac®* *Vusion® CC* *Xolegel®*

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Minimally Sedating Antihistamines (Antihistamines, Minimally Sedating)

- DMS to select preferred agent(s) based on economic evaluation; however, at least 1 unique chemical entity should be preferred.
- Agents not selected as preferred will be considered non-preferred and will require Prior Authorization.
- For any new chemical entity in the Antihistamines, Minimally Sedating class, require a PA until reviewed by the P&T Advisory Committee.

Class	Preferred	Non-Preferred
Minimally Sedating Antihistamines	cetirizine OTC tablets, ODT cetirizine RX 5 mg/5 mL solution levocetirizine tablets loratadine OTC loratadine-pseudoephedrine 12-Hour OTC loratadine-pseudoephedrine 24-Hour OTC	*cetirizine RX chewable tablets* *cetirizine-pseudoephedrine OTC* *cetirizine OTC capsules and solution* *Clarinex®* *Clarinex-D® 12 Hr* *Clarinex-D® 24 Hr* *desloratadine* *levocetirizine* *Semprex D®* *Xyzal®*

Topical Antiparasitic Agents (Antiparasitics, Topical)

- DMS to select preferred agent(s) based on economic evaluation; however, at least 1 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 Antiparasitics, Topical class, require a PA until reviewed by the P&T Advisory Committee.

Class	Preferred	Non-Preferred
Topical Antiparasitic Agents	Natroba® permethrin 5% cream CC	*Elimite™* *Eurax®* *lindane* *malathion* *Ovide®* *Prioderm®* *Sklice®* *spinosad* *Ulesfia®*

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Topical Antiviral Agents (Antivirals, Topical)

- DMS to select preferred agent(s) based on economic evaluation; however, at least 1 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 Antivirals, Topical class, require a PA until reviewed by the P&T Advisory Committee.

Class	Preferred	Non-Preferred
Topical Antiviral Agents	Zovirax® cream Zovirax® ointment	*acyclovir ointment* *Denavir®* *Xerese™*

Self-Injectable Epinephrine (Epinephrine, Self-Injectable)

- DMS to select preferred agent(s) based on economic evaluation; however, at least 1 product available in an adult and pediatric dose should be preferred.
- Agents not selected as preferred will be considered non-preferred and will require Prior Authorization.
- For any new chemical entity in the Epinephrine, Self-injectable class, require a PA until reviewed by the P&T Advisory Committee.

Class	Preferred	Non-Preferred
Self Injectable Epinephrine	epinephrine 0.3 mg QL epinephrine 0.15 mg QL Epi Pen® QL Epi Pen Jr.® QL	*N/A*

Intranasal Antihistamines, Anticholinergics, Corticosteroids (Intranasal Rhinitis Agents)

- DMS to select preferred agent(s) based on economic evaluation; however, at least 1 unique chemical entity should be preferred.
- Agents not selected as preferred will be considered non-preferred and require PA.
- Continue to maintain quantity limits based on maximum daily dose.
- For any new chemical entity in the Intranasal Rhinitis Agents class, require a PA until reviewed by the P&T Advisory Committee.

Class	Preferred	Non-Preferred
Intranasal Antihistamines	Astepro® Patanase™	*azelastine* *olopatadine*
Intranasal Anticholinergics	ipratropium nasal spray	*Atrovent®*

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Class	Preferred	Non-Preferred
Intranasal Corticosteroids	fluticasone propionate QL	*Beconase AQ®* QL *budesonide* QL *Children's Qnasl™* QL *Dymista®* QL *flunisolide* QL *Nasonex®* QL *Omnaris™* QL *Qnasl™* QL *Rhinocort Aqua®* QL *triamcinolone* QL *Veramyst®* QL *Zetonna™* QL

Lipotropics, Statins

- DMS to select preferred agent(s) based on economic evaluation; however, at least 1 agent representing each of the treatment intensity levels (high-intensity, moderate-intensity and lower-intensity) should be preferred.
- Continue quantity limits on agents in this class based on maximum recommended dose.
- Agents not selected as preferred will be considered non-preferred and require PA.
- For any new chemical entity in the Lipotropics, Statins class, require a PA until reviewed by the P&T Advisory Committee.

Class	Preferred	Non-Preferred
Lipotropics: Statins	atorvastatin QL lovastatin QL pravastatin QL simvastatin QL	*Advicor™* QL *Altoprev®* QL *amlodipine/atorvastatin* QL *Caduet®* QL *Crestor®* QL *fluvastatin* QL *fluvastatin ER* QL *Lescol®* QL *Lescol XL®* QL *Lipitor®* QL *Liptruzet®* QL *Livalo®* QL *Mevacor®* QL *Pravachol®* QL *Simcor®* QL *Vytorin™* QL *Zocor®* QL

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Otic Antibiotics

- DMS to select preferred agent(s) based on economic evaluation; however, at least 1 single entity otic fluoroquinolone, one otic fluoroquinolone/steroid combination product and one non-fluoroquinolone combination product should be preferred.
- Agents not selected as preferred will be considered non-preferred and require PA.
- For any new chemical entity in the Otic Antibiotics class, require a PA until reviewed by the P&T Advisory Committee.

Class	Preferred	Non-Preferred
Otic Antibiotics	CIPRODEX® Otic ciprofloxacin 0.2% hydrocortisone 1%/neomycin sulfate 5 mg/polymyxin B 10,000 units solution, suspension	*Cetraxal®* *Cipro HC® Otic* *Coly-mycin® S* *Cortisporin® solution* *Cortisporin® – TC* *ofloxacin 0.3% solution*

Phosphate Binders

- DMS to select preferred agent(s) based on economic evaluation; however, at least 2 unique chemical entities, one of which should be a calcium based phosphate binder, should be preferred.
- Agents not selected as preferred will be considered non-preferred and require PA.
- For any new chemical entity in the Phosphate Binders class, require a PA until reviewed by the P&T Advisory Committee.

Class	Preferred	Non-Preferred
Phosphate Binders	calcium acetate Fosrenol® chewable tablet MagneBind® 400 RX Phoslyra™ Renagel® Renvela™ tablet	*Auryxia™* *Eliphos™* *Fosrenol® powder pack* *PhosLo®* *sevelamer* *Renvela™ powder pack* *Velphoro®*

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Consent Agenda

The therapeutic classes listed below have no suggested changes by the Department to their currently posted Preferred Drug List (PDL) status.

- Alzheimer's Agents
- Androgenic Agents
- Angiotensin Modulators
- Angiotensin Modulator Combinations
- Antidepressants, Other
- Antidepressants, SSRIs
- Antihyperuricemics
- Antipsoriatics, Oral
- Beta-blockers
- Bladder Relaxant Preparations
- Erythropoiesis Stimulating Proteins
- Leukotriene Modifiers
- Nasal Preparations – Antibiotics
- Otics, Anti-inflammatories
- PAH Agents, Oral & Inhaled
- Rosacea Agents, Topical
- Ulcerative Colitis Agents
- Vasodilators, Coronary

*NOTE: Rosacea Agents, Topical had a brand/generic switch within the class.

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