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 of 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 **November 15, 2018**, and the recommendations delivered by the P&T Committee members in attendance.

New Products to Market

Lucemyra™ – Non-prefer in the PDL class: *Opiate Dependence Treatments*
Length of Authorization: 5 days

- Lucemyra™ (lofexidine) is a central alpha-2 adrenergic agonist indicated for mitigation of opioid withdrawal symptoms to facilitate abrupt opioid discontinuation in adults.

Criteria for Approval:

- Medication is being used to mitigate opioid withdrawal symptoms and facilitate abrupt discontinuation of opioids; AND
- Patient is NOT pregnant or breastfeeding; AND
- Patient does NOT have a prolonged QT interval (> 450 msec for males, > 470 msec for females); AND
- If patient is currently taking methadone, prescriber attestation that a baseline electrocardiogram (ECG) has been performed; AND
- Patient has tried and failed, had a contraindication to, or experienced an adverse reaction/intolerance to buprenorphine OR methadone; AND
- Patient has tried and failed, had a contraindication to, or experienced an adverse reaction/intolerance to clonidine; AND
- Prescriber to provide verbal attestation of a comprehensive treatment plan between provider and patient; AND
- Prescriber to provide verbal attestation that the patient is capable of and instructed how to self-monitor for hypotension, orthostasis, bradycardia, and associated symptoms; AND
- Prescriber to provide verbal attestation that patient is NOT receiving prescribed concurrent opioid medication based on current medication list/orders, medical records, patient history and verified by KASPER query; AND
- Prescriber to provide verbal attestation that the patient has been provided with a tapering schedule and instructions on when to contact their healthcare provider for further guidance.

Age Limit: ≥ 18 years
Quantity Limit: 48 tablets with 1 refill (96 tabs per treatment course; 1 course per year)

Drug Class	Preferred Agents	Non-Preferred Agents
Opiate Dependence Treatments	*Suboxone® film* CC, QL	*Bunavail®* QL *buprenorphine* CC, QL *buprenorphine/naloxone* QL *Lucemyra™* CC, QL *Probuphine®* CC, QL *Sublocade™* CC, QL *Zubsolv®* QL

Tibsovo® – Prefer with clinical criteria in the PDL class: *Oncology, Oral – Hematologic Cancer (Oral Oncology, Hematologic Cancer)*

Length of Authorization: 1 year

- Tibsovo (ivosidenib) is an isocitrate dehydrogenase-1 (IDH1) indicated for the treatment of adult patients with relapsed or refractory acute myeloid leukemia (AML) with a susceptible IDH1 mutation as detected by the Abbott RealTime™ IDH1 FDA-approved companion diagnostic.

Criteria for Approval:

- Diagnosis acute myeloid leukemia; AND
- Documentation showing susceptible isocitrate dehydrogenase-1 (IDH1) mutation, as detected by an FDA-approved test; AND
- Must be used as single agent; AND
- Patient has relapsed or refractory disease; OR
- Patient is not a candidate for intensive remission induction therapy; OR
- Patient declines intensive therapy.

Renewal Criteria

- Patient continues to meet the above conditions; AND
- Evidence of tumor response or lack of disease progression.

Age Limit: ≥ 18 years

Quantity Limit: 2 tablets per day

Drug Class	Preferred Agents	Non-Preferred Agents
Oral Oncology, Hematologic Cancer	Alkeran®	*Bosulif®* QL
	Gleevec® QL	*Calquence®* CC, QL
	hydroxyurea	*Farydak®* QL
	Imbruvica® CC, QL	*Hydrea®*
	Jakafi® CC, QL	*Iclusig®* QL
	Leukeran®	*Idhifa®* CC, QL
	mercaptopurine	*imatinib* QL
	Purixan®	*melphalan*
	Revlimid®	*Ninlaro®*
	Rydapt® CC, QL	*Pomalyst®*
	Sprycel® QL	*Tasigna®* QL
	Thalomid®	*Venclexta™* QL

Drug Class	Preferred Agents	Non-Preferred Agents
	Tibsovo® CC, QL Zolinza® QL Zydelig® CC, QL	

Braftovi™ – Prefer with clinical criteria in the PDL class: *Oncology, Oral – Skin (Oral Oncology, Skin Cancer)*
Length of Authorization: 1 year
- Braftovi™ (encorafenib) is a kinase inhibitor indicated, in combination with binimetinib, for the treatment of patients with unresectable or metastatic melanoma with a BRAF V600E or V600K mutation, as detected by an FDA-approved test.

Criteria for Approval:
- Diagnosis of unresectable or metastatic melanoma with a BRAF V600E or V600K mutation, as detected by an FDA-approved test; AND
- Used in combination with binimetinib.

Renewal Criteria:
- Meet initial approval criteria; AND
- Evidence of tumor response or lack of disease progression.

Age Limit: ≥ 18 years
Quantity Limit: 75 mg: 6 per day; 50 mg: 4 per day

Mektovi® – Prefer with clinical criteria in the PDL class: *Oncology, Oral – Skin (Oral Oncology, Skin Cancer)*
Length of Authorization: 1 year
- Mektovi® (binimetinib) is a kinase inhibitor indicated, in combination with encorafenib, for the treatment of patients with unresectable or metastatic melanoma with a BRAF V600E or V600K mutation, as detected by an FDA-approved test.

Criteria for Approval:
- Diagnosis of unresectable or metastatic melanoma with a BRAF V600E or V600K mutation, as detected by an FDA-approved test; AND
- Used in combination with encorafenib.

Renewal Criteria:
- Meet initial approval criteria; AND
- Evidence of tumor response or lack of disease progression.

Age Limit: ≥ 18 years
Quantity Limit: 6 per day

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

Doptelet® – Non-prefer in the PDL class: *Thrombopoiesis Stimulating Agents*
Length of Authorization: Date of Service; 1 fill per procedure

- Doptelet® (avatrombopag), a thrombopoietin (TPO) receptor agonist, is indicated for the treatment of thrombocytopenia in adult patients with chronic liver disease (CLD) who are scheduled to undergo a procedure.

Criteria for Approval:

- Diagnosis of chronic liver disease; AND
- Documentation of platelet count < 50 x 10^9/L; AND
- Dosed per FDA-approved labeling (10 tablets per 5 days for platelets ≥ 40 x 10^9/L or 15 tablets per 5 days for platelets < 40 x 10^9/L); AND
- Confirmation of a scheduled invasive procedure occurring 5 to 8 days following the last dose of avatrombopag.

Age Limit: ≥18 years
Quantity Limit: 15 tablets per fill

Mulpleta® – Non-prefer in the PDL class: *Thrombopoiesis Stimulating Agents*
Length of Authorization: Date of Service; 1 fill per procedure

- Mulpleta® (lusutrombopag), a thrombopoietin (TPO) receptor agonist, is indicated for the treatment of thrombocytopenia in adult patients with chronic liver disease (CLD) who are scheduled to undergo a procedure.

Criteria for Approval:

- Diagnosis of chronic liver disease (CLD); AND
- Documentation of platelet count < 50 x 10^9/L; AND
- NOT have severe hepatic impairment (Child-Pugh class C), absence of hepatopetal blood flow, a prothrombotic condition other than CLD or a history of splenectomy, partial splenic embolization, or thrombosis; AND
- Confirmation of a scheduled invasive procedure occurring 2 to 8 days following the last dose of lusutrombopag.

Age Limit: ≥18 years
Quantity Limit: 7 tablets per fill

Drug Class	Preferred Agents	Non-Preferred Agents
Thrombopoiesis Stimulating Agents	Promacta® CC	*Doptelet® CC, QL* *Mulpleta® CC, QL* *Nplate™ CC* *Tavalisse™ CC, QL*

Criteria Review

Movement Disorders: Austedo® (deutetrabenazine)

Austedo® (deutetrabenazine) is a vesicular monoamine transporter 2 (VMAT2) inhibitor approved for the treatment of chorea associated with Huntington's disease and the treatment of tardive dyskinesia.

Current criteria: Trial and failure of a preferred agent, unless contraindicated.

Recommended criteria (in addition to current criteria):

Length of Authorization: 1 year

Criteria for Approval:

- Patient is not concurrently using monoamine oxidase (MAO) inhibitors (e.g., isocarboxazid, phenelzine, rasagiline, safinamide, selegiline, tranylcypromine, etc within 14 days) **OR** reserpine (within 20 days) **OR** another VMAT2 inhibitor (e.g., tetrabenazine, valbenazine); **AND**
- Patient is not pregnant; **AND**
- Patient does not have hepatic impairment (e.g., Child-Pugh A-C); **AND**
- Patient meets the following criteria for either Huntington's chorea *or* tardive dyskinesia:

Huntington's Chorea

- Patient is diagnosed with chorea related to Huntington's disease; **AND**
- Patient is able to swallow; **AND**
- Patient does not have the following conditions:
  - History of, or current, untreated or inadequately treated depression; **OR**
  - Suicidal ideation.

Tardive Dyskinesia

- Diagnosis of tardive dyskinesia; **AND**
- Patient is able to swallow; **AND**
- Documentation that AIMS test has been completed (e.g., score or copy of AIMS assessment); **AND**
- Prescribed by or in consultation with a neurologist or psychiatrist (or other mental health provider), provided patient has reasonable access; **AND**
- Documentation or claims history of current or former chronic patient use of a dopamine antagonist (e.g., antipsychotic, metoclopramide, prochlorperazine, droperidol, promethazine, etc.).

Renewal Criteria:

- Patient continues to meet criteria defined for initial approval; **AND**
- Documentation of improvement in symptoms associated with respective condition (e.g., tardive dyskinesia or Huntington's chorea).

Age Limit: ≥ 18 years

Quantity Limit: 4 per day

Movement Disorders: Ingrezza™ (valbenazine)

Ingrezza™ (valbenazine) is a vesicular monoamine transporter 2 (VMAT2) inhibitor indicated for the treatment of adults with tardive dyskinesia (TD). Tardive dyskinesia is a side effect that can be seen in patients on long treatments of antipsychotic medications and medications used for gastrointestinal disease.

Current criteria: Trial and failure of a preferred agent, unless contraindicated.

Recommended criteria (in addition to current criteria):

Length of Authorization: 1 year

Criteria for Approval:

- Diagnosis of tardive dyskinesia; AND
- Documentation that AIMS test has been completed (e.g., score or copy of AIMS assessment); AND
- Prescribed by or in consultation with a neurologist or psychiatrist (or other mental health provider), provided patient has reasonable access; AND
- Documentation or claims history of current or former chronic use of a dopamine antagonist (e.g., antipsychotic, metoclopramide, prochlorperazine, droperidol, promethazine, etc.); AND
- NO concurrent use of MAO inhibitors (e.g., isocarboxazid, phenelzine, rasagiline, safinamide, selegiline, tranylcypromine, etc.) or strong CYP3A4 inducers (e.g., carbamazepine, phenytoin, phenobarbital, rifampin and related agents, St. John's wort, etc.).

Renewal Criteria:

- Patient continues to meet criteria defined for initial approval; AND
- Attestation or documentation of improvement in TD symptoms.

Age Limit: ≥ 18 years

Quantity Limit: 1 per day

Full Class Reviews

Acne Agents, Topical

Class Selection & Guidelines

Topical Acne Agents

- DMS to select preferred agent(s) based on economic evaluation; however, at least 5 products unique chemical entities or combinations should be preferred.
- Agents not selected as preferred will be considered non-preferred and require PA.
- For any new chemical entity in the *Topical Acne Agents* class, require PA until reviewed by the P&T Advisory Committee.

Drug Class	Preferred Agents	Non-Preferred Agents
Topical Acne Agents	clindamycin solution clindamycin/benzoyl peroxide (generic for BenzaClin® or Duac®; excluding pump) Differin® cream, gel erythromycin solution Retin-A® cream, gel	*Acanya™* *Aczone™* *adapalene cream, gel* *adapalene/benzoyl peroxide* *Atralin™* *Avar™* *Avar E™* *Avar E LS™* *Avar LS™* *Avita®* *BenzaClin®* *Benzamycin®* *BenzePro™* *benzoyl peroxide cleanser, kit, microspheres, gel, foam, medicated pad, towlette* *BP 10-1®* *BPO®* *BPO-5®* *BPO-10®* *BP Wash™* *Brevoxyl®* *Cleocin-T®* *Clindacin PAC™* *Clindagel®* *clindamycin gel, foam, lotion, medicated swab* *clindamycin/benzoyl peroxide pump* *clindamycin/tretinoin* *dapsone gel* *DermaPak Plus Kit* *Differin® lotion* *Duac®* *Effaclar Duo®* *Epiduo™* *Epiduo Forte™* *Erygel®* *Erythromycin gel, medicated swab* *erythromycin/benzoyl peroxide* *Fabior®* *Inova™* *Inova™ 4/1* *Inova™ 8/2* *Klaron®* *Neuac®* *Pacnex®*

Drug Class	Preferred Agents	Non-Preferred Agents
		Panoxyl® *Persa-Gel®* *PR benzoyl peroxide* *OC8®* *Onexton™* *Ovace®* *Ovace Plus®* *Retin-A Micro®* *Rosula®* *sodium sulfacetamide 10% CLNSG* *sodium sulfacetamide/sulfur 10-4% pad* *sodium sulfacetamide/sulfur cleanser* *sodium sulfacetamide/sulfur/urea* *SSS 10-5®* *sulfacetamide cleanser* *sulfacetamide/urea* *Sumadan™* *Sumadan™ XLT* *Sumaxin®* *Tazorac®* *tazarotene* *Tretin-X™* *tretinoin* *tretinoin (generic Atralin™)* *tretinoin microsphere* *Vanoxide-HC®* *Ziana™*

Anticholinergics/ Antispasmodics

Class Selection & Guidelines

Anticholinergics/ Antispasmodics

- DMS to select preferred agent(s) based on economic evaluation; however, at least 4 unique chemical entities should be preferred.
- Agents not selected as preferred will be considered non-preferred and will require PA.
- For any new chemical entity in the *Anticholinergics/Antispasmodics* class, require PA until reviewed by the P&T Advisory Committee.

Drug Class	Preferred Agents	Non-Preferred Agents
Antispasmodics/ Anticholinergics	dicyclomine glycopyrrolate hyoscyamine methscopolamine	*Anaspaz®* *Bentyl®* *chlordiazepoxide/clidinium* *Cuvposa®* *Donnatal®*

Drug Class	Preferred Agents	Non-Preferred Agents
		Hyosyne® *Levbid®* *Levsin®* *Librax®* *Oscimin®* *Phenohytro®* *propantheline* *Robinul®* *Robinul Forte®* *Symax®*

Antiemetics & Antivertigo Agents

Class Selection & Guidelines

Anti-Emetics: Other

- DMS to select preferred agent(s) based on economic evaluation; however, at least 5 unique chemical entities should be preferred.
- Agents not selected as preferred will be considered non-preferred and will require PA.
- For any new chemical entity in the *Anti-Emetics: Other* class, require PA until reviewed by the P&T Committee.

Oral Anti-Emetics: 5-HT3 Antagonists

- 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 PA.
- For any new chemical entity in the *Oral Anti-Emetics: 5-HT3 Antagonists* class, require PA until reviewed by the P&T Committee.

Oral Anti-Emetics: Delta-9-THC Derivatives

- 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 PA.
- For any new chemical entity in the *Oral Anti-Emetics: Delta-9-THC Derivatives* class, require PA until reviewed by the P&T Committee.

Oral Anti-Emetics: NK-1 Antagonists

- 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 PA.
- For any new chemical entity in the *Oral Anti-Emetics: NK-1 Antagonists* class, require PA until reviewed by the P&T Committee.

Drug Class	Preferred Agents	Non-Preferred Agents
Anti-Emetics: Other	meclizine metoclopramide oral solution, tablets prochlorperazine promethazine syrup, tablets promethazine 12.5, 25 mg suppositories Transderm-Scop®	*Compazine®* *Compro®* *Bonjesta® CC, QL* *Diclegis™ CC, QL* *metoclopramide ODT* *Phenadoz®* *Phenergan®* *promethazine 50 mg suppositories* *Reglan®* *scopolamine transdermal system* *Tigan®* *trimethobenzamide*
Oral Anti-Emetics: 5-HT3 Antagonists	ondansetron	*Aloxi® QL* *Anzemet®* *granisetron* *Sancuso® CC, QL* *Zofran®* *Zuplenz®*
Oral Anti-Emetics: NK-1 Antagonists	Emend® capsules QL	*Akynzeo® QL* *aprepitant QL* *Emend® powder packet QL* *Varubi® CC, QL*
Oral Anti-Emetics: Δ-9-THC Derivatives	dronabinol CC, QL	*Cesamet® CC, QL* *Marinol® CC, QL* *Syndros™ CC, QL*

Antifungals, Topical

Class Selection & Guidelines

Topical Antifungal Agents

- DMS to select preferred agent(s) based on economic evaluation; however, at least 4 unique chemical entities or combinations should be preferred.
- Agents not selected as preferred will be considered non-preferred and will require PA.
- For any new chemical entity in the *Topical Antifungal Agents* class, require PA until reviewed by the P&T Committee.

Drug Class	Preferred Agents	Non-Preferred Agents
Topical Antifungal Agents	clotrimazole cream, solution clotrimazole/betamethasone cream ketoconazole cream, shampoo nystatin cream, ointment, powder nystatin/triamcinolone cream, ointment	*Ciclodan® cream, kit, solution* *ciclopirox* *clotrimazole/betamethasone lotion* *econazole* *Ertazczo®* *Exelderm®* *Extina®* *Jublia® CC* *Kerydin™ CC* *ketoconazole foam* *Ketodan™* *Loprox®* *Lotrimin®* *Lotrisone®* *luliconazole* *Luzu®* *Mentax®* *naftifine* *Naftin®* *Nizoral Shampoo®* *Nyamyc®* *nystatin/triamcinolone cream* *Nystop®* *Oxistat®* *oxiconazole* *Penlac®* *Therazole Pak™ QL* *Vusion® CC*

Antiparasitics, Topical

Class Selection & Guidelines

Topical Antiparasitic Agents

- 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 will require PA.
- For any new chemical entity in the *Topical Antiparasitic Agents* class, require PA until reviewed by the P&T Committee.

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

Bile Salts

Class Selection & Guidelines

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

Drug Class	Preferred Agents	Non-Preferred Agents
Bile Salts	ursodiol capsules, tablets	*Actigall®* *Chenodal®* *Cholbam®* *Ocaliva®* *Urso®/Urso Forte®*

Cytokine and CAM Antagonists

Class Selection & Guidelines

Immunomodulators

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

New agent in the class: Ilumya™

Non-prefer in the PDL class: *Cytokine and CAM Antagonists (Immunomodulators)*

Length of Authorization: 1 year

- Ilumya™ (tildrakizumab-asmn), a high affinity, humanized IgG1 kappa monoclonal antibody that targets the p19 subunit of interleukin 23 (IL-23), is indicated for the treatment of adults with moderate-to-severe plaque psoriasis (PSO) who are candidates for systemic therapy or phototherapy.

Criteria for Approval:

- Diagnosis of moderate to severe plaque psoriasis; AND
- Symptoms persistent for ≥ 6 months with at least 1 of the following:
  - Involvement of at least 10% of body surface area (BSA); OR
  - Psoriasis Area and Severity Index (PASI) score of 12 or greater; OR
  - Incapacitation due to plaque location (i.e., head and neck, palms, soles or genitalia); AND
- Negative tuberculosis (TB) screening prior to initiating treatment; AND
- Trial and failure of 2 of the following therapies:
  - Methotrexate
  - Cyclosporine
  - Oral retinoid (e.g., Soriatane®, acitretin)
  - Topical corticosteroids
  - Phototherapy/UV light
  - Coal tar preparations; AND
- Trial and failure of, or contraindication to, a preferred immunomodulator (i.e., Enbrel® or Humira®); AND
- NOT to be used in combination with a TNF inhibitor, anakinra, abatacept, apremilast or other biologic response modifier.

Renewal Criteria:

- Patient continues to meet criteria identified above; AND
- Ongoing monitoring for TB; AND
- Disease response as indicated by improvement in signs and symptoms compared to baseline, such as redness, thickness, scaliness, and/or the amount of surface area involvement.

Age Limit: ≥18 years

Quantity Limit: 1 syringe per fill

Drug Class	Preferred Agents	Non-Preferred Agents
Immunomodulators	Enbrel® CC QL Cosentyx® CC, QL Humira® CC, QL	*Actemra® CC, QL* *Cimzia® CC, QL* *Entyvio™ CC, QL* *Ilumya™ CC, QL* *Kevzara® CC, QL* *Kineret® CC, QL* *Orencia® CC, QL* *Otezla® CC, QL* *Siliq™ CC, QL* *Simponi™ CC, QL* *Stelara™ CC, QL* *Taltz® CC, QL* *Tremfya™ CC, QL* *Xeljanz® CC, QL* *Xeljanz® XR CC, QL*

Multiple Sclerosis Agents

Class Selection & Guidelines

- DMS to select preferred agent(s) based on economic evaluation; however, at least 5 unique chemical entities should be preferred.
- Agents not selected as preferred will be considered non-preferred and will require PA.
- For any new chemical entity in the *Multiple Sclerosis Agents* class, require PA until reviewed by the P&T Advisory Committee.

Criteria review: Gilenya™ (fingolimod)
Current criteria and PDL status: Preferred with clinical PA

- Requires a step through an injectable agent (e.g., Avonex®, Betaseron®, Copaxone®, Rebif®).

Recommended PDL status: Preferred

- Clinical step edit is removed from Gilenya and is available without a PA.

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

Ophthalmics for Allergic Conjunctivitis

Class Selection & Guidelines

Ophthalmic Antihistamines

- 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 PA.
- For any new chemical entity in the *Ophthalmic Antihistamines* class, require PA until reviewed by the P&T Committee.

Ophthalmic Mast Cell Stabilizers

- 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 PA.
- For any new chemical entity in the *Ophthalmic Mast Cell Stabilizers* class, require PA until reviewed by the P&T Committee.

Drug Class	Preferred Agents	Non-Preferred Agents
Ophthalmic Antihistamines	olopatadine 0.1% (generic for Patanol®) Pataday™ Pazeo™	*azelastine* *Bepreve™* *Elestat™* *Emadine®* *epinastine* *Lastacaft™* *olopatadine 0.2% (generic for Pataday™)* *Optivar®* *Patanol®*
Ophthalmic Mast Cell Stabilizers	cromolyn sodium	*Alocril®* *Alomide®*

Ophthalmic Antibiotics

Class Selection & Guidelines

Ophthalmic Antibiotics, Non-Quinolones

- DMS to select preferred agent(s) based on economic evaluation; however, at least 5 unique chemical entities or combinations should be preferred.
- Agents not selected as preferred will be considered non-preferred and will require PA.
- For any new chemical entity in the *Ophthalmic Antibiotics, Non-Quinolones* class, require PA until reviewed by the P&T Committee.

Ophthalmic Antifungals

- DMS to select preferred agent(s) based on economic evaluation.
- Agents not selected as preferred will be considered non-preferred and will require PA.
- For any new chemical entity in the *Ophthalmic Antifungals* class, require PA until reviewed by the P&T Committee.

Ophthalmic Macrolides

- 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 PA.
- For any new chemical entity in the *Ophthalmic Macrolides* class, require PA until reviewed by the P&T Committee.

Ophthalmic Quinolones

- DMS to select preferred agent(s) based on economic evaluation; however, at least 3 unique chemical entities should be preferred.
- Agents not selected as preferred will be considered non-preferred and will require PA.
- For any new chemical entity in the *Ophthalmic Quinolones* class, require PA until reviewed by the P&T Committee.

Drug Class	Preferred Agents	Non-Preferred Agents
Ophthalmic Antibiotics, Non-Quinolones	bacitracin bacitracin/polymyxin B gentamicin solution/ointment polymyxin B/trimethoprim sulfacetamide solution tobramycin solution	*Bleph®-10* *Garamycin®* *Neocidin®* *neomycin/polymyxin B/bacitracin* *neomycin/polymyxin B/gramicidin* *Neosporin®* *Polytrim®* *sulfacetamide ointment* *Tobrex®*
Ophthalmic Antifungals	N/A	*Natacyn®*
Ophthalmic Macrolides	erythromycin 0.5% ointment	*AzaSite™* *Ilotycin®*
Ophthalmic Quinolones	ciprofloxacin ophthalmic solution Moxeza™ ofloxacin Vigamox™	*Besivance™* *Ciloxan®* *gatifloxacin* *levofloxacin 0.5%* *moxifloxacin (generic Vigamox™)* *Ocuflox®* *Quixin®* *Zymaxid™*

Otic Antibiotics

Class Selection & Guidelines

- DMS to select preferred agent(s) based on economic evaluation; however, at least 3 unique chemical entities or combinations should be preferred.
- Agents not selected as preferred will be considered non-preferred and will require PA.
- For any new chemical entity in the *Otic Antibiotics* class, require PA until reviewed by the P&T Committee.

Drug Class	Preferred Agents	Non-Preferred Agents
Otic Antibiotics	CiproDex® Otic ciprofloxacin ofloxacin hydrocortisone/neomycin sulfate/polymyxin B solution, suspension	*Cipro HC® Otic* *Coly-mycin® S* *Floxin™* *Otovel™*

Steroids, Topical (Low Potency)

Class Selection & Guidelines

Topical Steroids (Low Potency)

- DMS to select preferred agent(s) based on economic evaluation; however, at least 3 unique chemical entities should be preferred.
- Agents not selected as preferred will be considered non-preferred and will require PA.
- For any new chemical entity in the *Steroids, Topical (Low Potency)* class, require PA until reviewed by the P&T Committee.

Drug Class	Preferred Agents	Non-Preferred Agents
Topical Steroids	alclometasone dipropionate betamethasone valerate cream, ointment clobetasol propionate cream, gel, ointment, solution Clobex® shampoo Derma-Smoothe/FS® fluocinonide solution fluticasone propionate cream, ointment halobetasol propionate hydrocortisone cream, gel, lotion, ointment mometasone furoate cream, ointment, solution triamcinolone acetonide cream, lotion, ointment	*Aqua Glycolic®* *Aqua Glycolic HC®* *amcinonide* *ApexiCon®/ApexiCon E®* *Balneol®* *betamethasone dipropionate* *betamethasone dipropionate augmented* *betamethasone valerate foam, lotion* *Capex® Shampoo* *clobetasol emollient* *clobetasol propionate foam, lotion, shampoo, spray* *Clobex® lotion, spray* *clocortolone* *Clodan®* *Cloderm®* *Cordran® Tape* *Cutivate®* *DermacinRx® Silapak* *DermacinRx® Silazone PharmPak* *Dermatop®* *Desonate®* *desonide* *desoximetasone* *diflorasone diacetate* *Diprolene®* *Diprolene AF®* *fluocinolone acetonide oil* *fluocinonide emollient* *fluocinonide cream, gel, ointment* *fluocinolone acetonide* *flurandrenolide* *fluticasone propionate lotion* *Halog®* *hydrocortisone-aloe* *hydrocortisone butyrate* *hydrocortisone butyrate/emollient* *hydrocortisone valerate* *hydrocortisone-urea* *Kenalog®* *Locoid®* *Locoid Lipocream®* *Luxiq®* *Micort-HC®* *Olux®/Olux-E®*

		Pandel® *prednicarbate* *Psorcon®* *Sernivo™* *Silazone-II™* *Synalar®*

Classes Reviewed by Consent Agenda

No change in PDL status:

- Acne Agents, Oral
- Anti-Ulcer Protectants
- Antibiotics, Topical
- Antidiarrheals
- Antipsoriatics, Oral
- Antipsoriatics, Topical
- Antivirals, Topical
- GI Motility, Chronic
- H. Pylori Treatment
- Histamine II Receptor Blockers
- Immunomodulators, Atopic Dermatitis
- Immunosuppressives, Oral
- Laxatives and Cathartics
- Ophthalmic Immunomodulators
- Ophthalmics, Antibiotic-Steroid Combinations
- Ophthalmics, Anti-inflammatories
- Ophthalmics, Antivirals
- Ophthalmics, Glaucoma Agents
- Ophthalmics, Mydriatic
- Ophthalmics, Vasoconstrictors
- Otic Anti-Infectives and Anesthetics
- Otics, Anti-Inflammatory
- Proton Pump Inhibitors
- Rosacea Agents, Topical
- Steroids, Topical (Medium, High, Very High)
- Ulcerative Colitis Agents