

June 1, 2004

MEDICAID INFORMATION RELEASE 2004-35

TO: Prescribing Providers, Pharmacists, Pharmacies, Hospitals, and Long-Term Care Facilities

FROM: Randy May, Deputy Administrator

SUBJECT: NEW PRIOR AUTHORIZATION CRITERIA FOR ACE INHIBITORS and CALCIUM CHANNEL BLOCKERS DRUG CLASS

Drug/Drug Class: ACE INHIBITORS and CALCIUM CHANNEL BLOCKERS
Implementation Date: Effective for dates of service on or after JULY 1, 2004

Idaho Medicaid is implementing an Enhanced Prior Authorization Program for select therapeutic classes including the identification of preferred agents. The Enhanced Prior Authorization Program (EPAP) is designed to provide Medicaid participants the most effective drug at the right price. Beginning July 1, 2004, ACE Inhibitors and Calcium Channel Blockers will be the next drug classes to have new prior authorization requirements. The Pharmacy & Therapeutics Committee recommends allowing prescriber choice of product in these two classes while optimizing utilization of multi-source generics.

Enhanced Prior Authorization drug class	Preferred Agent(s)	Non-preferred Agents[^]
ACE INHIBITORS	<ul style="list-style-type: none">• Benazepril (generic only)• Benazepril/HCTZ (generic only)• Captopril (generic only)• Captopril/HCTZ (generic only)• Enalapril maleate (generic only)• Enalapril maleate/HCTZ (generic only)• Fosinopril (generic only)• Fosinopril/HCTZ (Monopril HCT[®])	<ul style="list-style-type: none">• Capoten[®]• Capozide[®]• Lotensin[®]• Lotensin/HCT[®]• Monopril[®]• Prinivil[®]• Prinzide[®]• Univasc[®]• Vasoretic[®]• Vasotec[®]• Zestoretic[®]• Zestril[®]

	<ul style="list-style-type: none"> • Lisinopril (generic only) • Lisinopril/HCTZ (generic only) • Moexipril (generic only) • Moexipril/HCT (Uniretic®) • Perindopril (Aceon®) • Quinapril (Accupril®) • Quinapril/HCTZ (Accuretic®) • Ramipril (Altace®) • Trandolapril (Mavik®) 	
<p>CALCIUM CHANNEL BLOCKERS</p>	<ul style="list-style-type: none"> • Amlodipine (Norvasc®) • Bepridil (Vasacor®) • Diltiazem HCL (generic only) • Diltiazem ER capsule (generic only) • Diltiazem ER tablet (Cardizem LA®) • Felodipine (Plendil®) • Isradipine (DynaCirc®) • Isradipine CR (DynaCirc CR®) • Nicardipine HCL (generic only) • NicardipineSR (Cardene SR®) • Nifedipine (generic only) • Nifedipine ER (generic only) • Nimodipine (Nimotop®) • Nisoldipine (Sular®) • Verapamil HCL (generic only) • Verapamil ER tablet (Covera HS® and generic) • Verapamil SR (generic only) • Verapamil ER capsule (Verelan PM®) 	<ul style="list-style-type: none"> • Adalat® • Adalat CC® • Calan® • Calan SR® • Cardene® • Cardizem® • Cardizem CD® (where multi-source available) • Cardizem SR® • Dilacor XR® • Isoptin SR® • Procardia® • Procardia XL® • Tiazac® (where multi-source available) • Verelan®

^Use of non-preferred agents must meet prior authorization requirements for brand name products

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For prior approval, contact the Medicaid Drug Prior Authorization help desk at (208) 364-1829 or fax a PA request form to (208) 364-1864 to initiate a review and potentially authorize claims.¹

The Enhanced PA Program and drug class specific PA criteria are based on evidence-based clinical criteria and available nationally recognized peer-reviewed information. The determination of medications considered preferred within a drug class is based primarily on objective evaluations of their relative safety, effectiveness, and clinical outcomes in comparison with other therapeutically interchangeable alternative drugs. A secondary consideration is cost.

In the coming months additional therapeutic drug classes will be added to the Enhanced Prior Authorization (EPAP) program. Please watch future information releases and the Medicaid Pharmacy website at www.idahohealth.org for details.

As always, your support is critical to the success of this Medicaid Pharmacy initiative. Our goal is to partner with you to provide quality, cost-effective health care to your patients. Questions regarding the Prior Authorization program may be referred to Medicaid Pharmacy at (208) 364-1829.

RM/cb

¹ Specific Prior Authorization criteria and fax forms for all drug classes may be obtained from the Department of Health and Welfare Pharmacy Program website at: <http://www.idahohealth.org>

Medicaid
Enhanced Prior Authorization Program
Drug Class Listing
Effective July 1, 2004

<i>Cox-2s*</i>	
<i>Preferred Agents</i>	<i>Non-preferred Agents[^]</i>
Vioxx[®]	Bextra[®]
	Celebrex[®]
*Entire Cox-2 drug class requires prior authorization and non-preferred agents require additional PA criteria for approval	
<i>Proton Pump Inhibitors</i>	
<i>Preferred Agents</i>	<i>Non-preferred Agents[^]</i>
Prevacid[®] Aciphex[®] Prilosec OTC[®]	Protonix[®] Nexium[®] Prilosec[®] Omeprazole – various generics
<i>Triptans</i>	
<i>Preferred Agents</i>	<i>Non-preferred Agents[^]</i>
Imitrex[®] Zomig[®] Zomig ZMT[®] Maxalt[®] Maxalt MT[®]	Amerge[®] Frova[®] Relpax[®] Axert[®]
<i>ACE Inhibitors</i>	
<i>Preferred Agents</i>	<i>Non-preferred Agents[^]</i>
Benazepril (generic only) Benazepril/HCTZ (generic only) Captopril (generic only) Captopril/HCTZ (generic only) Enalapril maleate (generic only) Enalapril maleate/HCTZ (generic only) Fosinopril (generic only) Fosinopril/HCTZ (Monopril HCT[®]) Lisinopril (generic only) Lisinopril/HCTZ (generic only) Moexipril (generic only)	Capoten[®] Capozide[®] Lotensin[®] Lotensin/HCT[®] Monopril[®] Prinivil[®] Prinzide[®] Univasc[®] Vasotec[®] Vaseretic[®] Zestril[®] Zestoretic[®]

<p>Moexipril/HCT (Uniretic®) Perindopril (Aceon®) Quinapril (Accupril®) Quinapril/HCTZ (Accuretic®) Ramipril (Altace®) Trandolapril (Mavik®)</p>	
<p><i>Calcium Channel Blockers</i></p>	
<p><i>Preferred Agents</i></p>	<p><i>Non-preferred Agents[^]</i></p>
<p>Amlodipine (Norvasc®) Bepidil (Vascor®) Diltiazem HCL (generic only) Diltiazem ER capsule (generic only) Diltiazem ER tablet (Cardizem LA®) Felodipine (Plendil®) Isradipine (DynaCirc®) Isradipine CR (DynaCirc CR®) Nicardipine HCL (generic only) NicardipineSR (Cardene SR®) Nifedipine (generic only) Nifedipine ER (generic only) Nimodipine (Nimotop®) Nisoldipine (Sular®) Verapamil HCL (generic only) Verapamil ER tablet (Covera HS® and generic) Verapamil SR (generic only) Verapamil ER capsule (Verelan PM®)</p>	<p>Adalat® Adalat CC® Calan® Calan SR® Cardene® Cardizem® Cardizem CD® Cardizem SR® Dilacor XR® Isoptin SR® Procardia® Procardia XL® Tiazac® Verelan®</p> <p>Strengths where multi-source available</p>

[^]Use of non-preferred agents requires prior authorization approval