

June 1, 2005

MEDICAID INFORMATION RELEASE 2005-15

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

FROM: Randy May, Deputy Administrator

SUBJECT: NEW PRIOR AUTHORIZATION CRITERIA FOR 2ND GENERATION ANTIHISTAMINE DRUG CLASS

Drug/Drug Class: 2ND GENERATION ANTIHISTAMINES
Implementation Date: Effective for dates of service on or after June 1, 2005

Idaho Medicaid is designating preferred agents for the 2nd Generation Antihistamine therapeutic drug class as part of the Enhanced Prior Authorization Program. The Enhanced Prior Authorization Program (EPAP) is designed to provide Medicaid participants the most effective drug at the right price. **Beginning June 1, 2005**, the preferred agents for the 2nd Generation Antihistamine drug class will be the following:

EPAP Drug Class	Preferred Agent(s)**	Non-preferred Agents***^
2 ND GENERATION ANTIHISTAMINE	<ul style="list-style-type: none">• Loratadine OTC• Claritin[®] OTC	<ul style="list-style-type: none">• Allegra[®]• Allegra-D[®]• Clarinex[®]• Zyrtec[®]• Zyrtec-D[®]

** Use of 2nd Generation Antihistamines must meet existing therapeutic prior authorization criteria.

^ Use of non-preferred agents must meet prior authorization requirements.

To assist our providers with providing the right care at the right time with the right price, the Department is presenting the relative cost ranking of the preferred agents net of all rebates in this class. The Department requests that all Medicaid providers consider this ranking as a *secondary* factor when determining the most appropriate drug therapy for their patients.

Lowest to Highest Relative Cost (Cost to Medicaid after rebates)	
2ND GENERATION ANTIHISTAMINE AGENTS	
Loratadine OTC	100%
Claritin OTC	390%
Clarinex	430%
Zyrtec	440%
Zyrtec-D	460%
Allegra-D	640%
Allegra	710%

Point-of-service pharmacy claims will be routed through an automated computer system to apply PA criteria specifically designed to assure effective drug utilization. Through this process, therapy will automatically and transparently be approved for those patients who meet the system approval criteria. For those patients who do not meet the system approval criteria, it will be necessary for you to 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. **To assist in managing patients affected by these changes, Medicaid will be sending in a separate mailing to prescribing providers, a list of their patients currently receiving therapy whose drug claims will be affected.**

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 to be 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 and secondarily on cost.

Additional therapeutic drug classes will be added in the coming months to the Enhanced Prior Authorization (EPAP) program. Please watch for further information releases on the Medicaid Pharmacy website at www.medicaidpharmacy.idaho.gov.

A current listing of all the preferred agents by drug class and prior authorization criteria is also available online at www.medicaidpharmacy.idaho.gov.

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