



IDAHO DEPARTMENT OF HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG -- Director

LESLIE M. CLEMENT - Administrator
DIVISION OF MEDICAID
Post Office Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 334-5747
FAX: (208) 364-1811

March 5 2007

MEDICAID INFORMATION RELEASE 2007-07

TO: Prescribing Providers, Pharmacists and Hospitals

FROM: Leslie M. Clement
Administrator 

SUBJECT: Preferred Agents for Drug Classes Reviewed at October 20, 2006 and February 16, 2007
Pharmacy and Therapeutics Committee Meetings

Drug/Drug Classes: Noted below

Implementation Date: Effective for dates of service on or after April 1, 2007

Idaho Medicaid is designating preferred agents and prior authorization criteria for the following drug classes as part of the Enhanced Prior Authorization Program. The information is included in the attached Preferred Drug List.

The Enhanced PA Program and drug-class specific PA criteria are based on evidence-based clinical criteria and 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.

Questions regarding the Prior Authorization Program may be referred to Idaho Medicaid Pharmacy at (208) 364-1829. A current listing of preferred and non-preferred agents and prior authorization criteria for all drug classes is available online at www.medicaidpharmacy.idaho.gov.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS*
ACE Inhibitor/ Calcium Channel Blocker Combinations	Tarka [®] and Lotrel [®]	Lexxel [®]
Long-Acting Narcotic Analgesics	Kadian [®] and morphine extended release generic	Duragesic [®] , fentanyl transdermal generic, Avinza [®] , Opana ER [®] , Oxycontin [®] , and oxycodone extended release generic Duragesic [®] is recommended by the Committee as preferred over generic fentanyl transdermal when the therapeutic prior authorization criteria are met.

Short-Acting Narcotic Analgesics	propoxyphene/apap generic, apap/codeine generic, tramadol generic, hydrocodone/apap generic, asa/codeine generic, codeine generic, morphine IR generic, oxycodone IR generic, oxycodone/apap generic, pentazocine/naloxone generic, hydromorphone generic, oxycodone/asa generic, and levorphanol generic	propoxyphene compound generic, propoxyphene generic, meperidine oral generic, Darvon N [®] , Combunox [®] , pentazocine/acetaminophen generic, Panlor DC/SS [®] , Opana [®] , fentanyl buccal generic, hydrocodone/ibuprofen generic, tramadol/acetaminophen generic, butalbital compound/codeine generic, and dihydrocodeine/apap/caff generic
Angiotensin II Receptor Antagonists	Diovan [®] , Diovan HCT [®] , Benicar, Benicar HCT [®] , Micardis [®] , Micardis HCT [®] , Cozaar [®] , Hyzaar [®] , Avapro [®] Avalide [®]	Teveten [®] , Tevetan HCT [®] , Atacand [®] and Atacand HCT [®]
Injectable Anticoagulants	Fragmin [®] , Lovenox [®] , Arixtra [®]	Innohep [®]
Anticonvulsants	methobarbital generic, phenobarbital generic, clonazepam generic, carbamazepine generic, Carbatrol [®] , Equetro [®] , phenytoin, Dilantin [®] , Mebaral [®] , primidone generic, valproic acid generic, Depakote [®] sprinkle, Depakote ER [®] , Depakote [®] , Celontin [®] , Peganone [®] , Gabitril [®] , ethosuximide generic, zonisamide generic ² , Trileptal ^{®2} , Lyrica ^{®2} , gabapentin generic ² , Topamax ^{®2} , Keppra ^{®2} , Lamictal ^{®2} , and Diastat [®]	Phenytek [®] , Tegretol XR ^{®1} , Felbatol [®] and lamotrigine generic ² ¹ Clients currently receiving Tegetrol XR [®] will be “grandfathered” and not need to switch to a preferred agent. ² These anticonvulsants are recommended as preferred for epilepsy and other seizure orders only. Non-seizure indications will still require that therapeutic prior authorization criteria are met.
Other Antidepressants	mirtazapine generic, bupropion IR, bupropion SR generic, Wellbutrin XL [®] and Effexor XR [®]	nefazodone generic, venlafaxine generic, Cymbalta [®] and Emsam [®] Venlafaxine and Cymbalta [®] will be “grandfathered” for current patients. These agents will be non-preferred and require prior-authorization for new patients.
Minimally Sedating Antihistamines	Semprex-D [®] , loratadine/loratadine-D generic, and Clarinex [®] syrup	Zyrtec [®] syrup, Clarinex/Clarinex D [®] , Zyrtec/Zyrtec-D [®] oral, Allegra [®] and fexofenadine generic
Antimigraine Agents, Triptans	Imitrex (oral) [®] , Imitrex (nasal) [®] , Imitrex [®] SQ, Amerge [®] and Maxalt/Maxalt MLT [®]	Relpax [®] , Axert [®] , Zomig/ZomigZMT [®] , Frova [®] , and Zomig [®] (nasal) Zomig/Zomig ZMT [®] be “grandfathered” for current patients. These agents will be non-preferred and require prior-authorization for new patients.
Beta-Blockers	atenolol generic, metoprolol generic, propranolol generic, sotalol generic, nadolol generic, acebutolol generic, labetalol generic, pindolol generic, timolol generic, bisoprolol generic, betaxolol generic, Toprol XL [®] and Inderal LA [®]	Levatol [®] and Innopran XL [®] Coreg [®] will continue to require prior authorization for heart failure.
Bladder Relaxant Preparations	oxybutynin generic, Vesicare [®] , Oxytrol [®] transdermal, Enablex [®] , Sanctura [®] and Ditropan XL [®]	Detrol [®] and Detrol LA [®]
BPH Treatments	doxazosin generic, terazosin generic, Uroxatril [®] , Cardura XL [®] , Flomax [®] , Avodart [®] , and finasteride generic	no agents designated as non-preferred

Calcium Channel Blockers	Dynacirc CR [®] , verapamil generic, Sular [®] , Cardizem LA [®] , Diltiazem [®] , Verelan PM [®] , nifedipine ER generic, felodipine ER generic and Norvasc [®]	nifedipine IR generic, nicardipine generic, Cardene SR [®] , Covera-HS [®] and isradipine generic
Erythropoiesis Stimulating Proteins	Aranesp [®] and Procrit [®]	Epogen [®]
Growth Hormone	Saizen [®] , Tev-Tropin [®] , Serostim [®] , Genotropin [®] , and Nutropin AQ [®]	Nutropin ^{®2} and Humatrope ^{®2} and Norditropin ^{®2} and Zorbtive [®] ¹ Current therapeutic criteria for growth hormone will continue to be required for all agents. The Committee recommends that Nutropin ^{®2} , Humatrope ^{®2} and Norditropin ^{®2} be “grandfathered” for current patients. These agents will be non-preferred and require prior-authorization for new patients.
Hepatitis C Agents	Pegasys [®] and ribavirin generic	Copegus [®] , Infergen [®] , Rebetol [®] Peg-Intron and Peg-Intron Redipen [®] Peg-Intron will be “grandfathered” for current patients. These agents will be non-preferred and require prior-authorization for new patients.
Hypoglycemics, Meglitinides	Starlix [®] and Prandin [®]	no agents designated as non-preferred
Hypoglycemics, TZDs	Avandia [®] , Actos [®] , Avandamet [®] , Avandaryl [®] Actosplus Met [®] , and Duetact [®]	no agents designated as non-preferred
Lipotropics, Other	Niaspan [®] , gemfibrozil generic, colestipol generic, Tricor [®] , cholestyramine generic and fenofibrate generic	Zetia [®] , Triglide [®] , Antara [®] Omacor [®] and Welchol [®]
Lipotropics, Statins	Advicor [®] , Altoprev [®] , Lescol/Lescol XL [®] , Lipitor [®] , lovostatin generic, pravastatin generic, and simvastatin generic	Caduet [®] , Crestor [®] and Vytorin [®]
Multiple Sclerosis Agents	Betaseron [®] , Avonex [®] , Rebif [®] and Copaxone [®]	no agents designated as non-preferred
Otic Fluoroquinolones	Floxin [®] otic and Ciprodex [®] otic	Cipro [®] HC otic
Phosphate Binders	PhosLo [®] , Fosrenol [®] and Renagel [®]	no agents designated as non-preferred
Proton Pump Inhibitors	Prilosec [®] OTC, Nexium [®] and Prevacid [®] capsule, Prevacid [®] solutab and suspension	Zegerid [®] , Aciphex [®] , Protonix [®] and omeprazole generic
Sedative Hypnotics	chloral hydrate generic, temazepam generic, triazolam generic, Lunesta [®] and Ambien [®]	flurazepam generic, Rozerem [®] , Ambien CR [®] Sonata [®] , Doral [®] , estazolam generic, Restoril [®] 7.5 mg
Ulcerative Colitis Agents	sulfasalazine generic, Colazal [®] , mesalamine rectal generic, Asacol [®] , and Canasa [®]	Dipentum [®] and Pentasa [®]

*Use of non-preferred agents must meet prior authorization requirements

*Use of any covered product may be subject to prior authorization for quantities or uses outside Food and Drug Administration (FDA) guidelines or indications

IDAHO MEDICAID PROVIDER HANDBOOK

This Information Release does **not** replace information in your Idaho Medicaid Handbook.