# West Virginia Medicaid PDL
# Recommended Changes Summary
# Pharmaceutical and Therapeutics Committee Meeting
# January 26, 2011

| TOPIC | Current PDL Status | 4/1/11 Planned PDL Status | Recommend Grandfather existing users | Comments |
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| **ACNE AGENTS, TOPICAL** | | | | |
| AVAR (sulfur/sulfacetamide) | New Dosage Form | Non-Preferred | N/A | Thirty (30) day trials each of one preferred retinoid and two unique chemical entities in two other subclasses, including the generic version of a requested non-preferred product, are required before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present. (In cases of pregnancy, a trial of retinoids will not be required.) In addition, thirty day trials of combinations of the corresponding preferred single agents available are required before non-preferred combination agents will be authorized. |
| ZENCIA WASH (sulfacetamide sodium/sulfur) | New Dosage Form | Non-Preferred | N/A | Thirty (30) day trials each of one preferred retinoid and two unique chemical entities in two other subclasses, including the generic version of a requested non-preferred product, are required before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present. (In cases of pregnancy, a trial of retinoids will not be required.) In addition, thirty day trials of combinations of the corresponding preferred single agents available are |

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| | | | | required before non-preferred combination agents will be authorized. |
| **ANGIOTENSIN MODULATORS** | | | | |
| TEKAMLO (aliskiren/amlodipine) (Auto PA)<br><br>AMTURNIDE (aliskiren/amlodipine/HCT)( Auto PA) | New Drug Combination<br><br>New Drug combination | Preferred | N/A | Tekturna HCT, Valturna, Tekamlo or Amturnide will be approved if the criteria for Tekturna is met and the patient needs the other drugs in the combination. |
| **ANTICOAGULANTS** | | | | |
| PRADAXA (dabigatran) (Auto PA) | New Drug | Preferred | N/A | Pradaxa will be approved for the diagnosis of non-valvular atrial fibrillation. |
| **ANTIEMETICS** | | | | |
| GRANISOL (granisetron) | New Dosage Form | Non-Preferred | N/A | A 3-day trial of a preferred agent is required before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present. PA is required for all agents when limits are exceeded. |

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| **ANTIPARKINSON'S AGENTS (ORAL)** | | | | |
| LODOSYN (carbidopa) | New Dosage Form | Non-Preferred | N/A | Patients starting therapy on drugs in this class must show a documented allergy to all of the preferred agents, in the corresponding class, before a non-preferred agent |

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| | | | | will be authorized. |
| **BONE RESORPTION SUPPRESSION AND RELATED AGENTS** | | | | |
| ATELVIA (risedronate) | New Dosage Form | Non-Preferred | N/A | A 30-day trial of the preferred agent is required before a non-preferred agent will be approved. |
| **COUGH & COLD/1$^{ST}$ GENERATION ANTIHISTAMINES** | | | | |
| codeine/promethazine | Preferred | Remove from PDL | No | |
| DELSYM (dextromethorphan) | Not Managed | Preferred | N/A | |
| guaifenesin/codeine | Preferred | Remove from PDL | No | |
| phenylephrine/codeine/promethazine | Preferred | Remove from PDL | No | |
| phenylephrine/phenyltoloxamine/chlorpheniramine | Preferred | Remove from PDL | No | |
| phenylephrine/pyrilamine/chlorpheniramine | Preferred | Remove from PDL | No | |
| benzonatate capsules | Preferred | Remove from PDL | No | |
| **HYPERURICEMIA AND GOUT AGENTS** | | | | |
| Allopurinol *Treatment and prevention (Although allopurinol can be used for treatment or prevention of gouty arthritis attacks, it may be necessary to add colchicines for the first few days of treatment. Acute attacks may increase or intensify during the first few days.)* | Not Managed | Preferred | N/A | A 30-day trial of one of the preferred agents for the prevention of gouty arthritis attacks is required before a non-preferred agent will be approved unless one of the exceptions on the PA form is present. *In the case of acute gouty attacks, a 10-day ( 20 tablets) supply of Colcrys will be approved. |
| colchicine/probenecid (*Used for prevention)* | Not Managed | Preferred | N/A | " |
| COLCRYS (colchicine) (*Treatment of acute attacks)* | Not Managed | Non-Preferred | N/A | " |

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| Probenecid (*Used for prevention only)* | Not Managed | Preferred | N/A | " |
| ULORIC (febuxostat) (*Treatment and prevention- May also require colchicines in the first few weeks)* | Not Managed | Non-Preferred | N/A | " |
| ZYLOPRIM (allopurinol) (*Treatment and prevention)* | Not Managed | Non-Preferred | N/A | " |
| **HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS** | | | | |
| KOMBIGLYZE XR (saxagliptin/metformin) | New Drug Combination | Preferred | N/A | Januvia/Janumet,Onglyza and Kombiglyze XR will be subject to the following clinical edits:<br>1. Previous history of a 30day trial of an oral agent (sulfonylurea, thiazolindinedione (TZD) or metformin)<br>2. Onglyza and Kombiglyze XR will not be approved for concurrent therapy with insulin.<br>3 Januvia/Janumet will be approved for concurrent therapy with insulin for three month intervals,<br>For authorization, HgBA1C levels must Be ≤ 7. Current lab values must submitted.. |
| **MULTIPLE SCLEROSIS AGENTS** | | | | |
| GILENYA (fingolimod)<br><br>**Preferred Agents are**:<br><u>Interferons</u><br>Avonex (interferon beta-1a)<br>Betaseron (interferon beta-1b)<br>Rebif (interferon beta-1a)<br><br><u>Non-Interferons</u><br>Copaxone (glatiramer) | New | Non-Preferred | N/A | Currrent Criteria:<br>A 30-day trial of a preferred agent will be required before a non-preferred agent will be approved<br><br>A 30-day trial of the preferred agent will be required before a non-preferred agent will be approved.<br><br>*Amypra will be prior authorized if the following |

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| A 30-day trial of a preferred agent will be required before a non-preferred agent will be approved<br><br>**Non-Preferred Agents**<br>Interferons<br>Extavia (interferon beta-1b)<br><br>**Non-Interferons**<br><br>AMPYRA (dalfampridine)<br>GILENYA (fingolimod)<br>TYSABRI (natalizumab | | | | conditions are met:<br>1. Diagnosis of multiple sclerosis<br>2. No history of seizures<br>3. No evidence of moderate or severe renal impairment<br>4. Initial prescription will be approved for 30 days only.<br><br>Tysabri will only be approved for members who are enrolled in the TOUCH Prescribing Program. AP does not apply.<br><br>PA Criteria for Gilenya:<br>1) A diagnosis of relapse remitting multiple sclerosis or progressive secondary multiple sclerosis AND<br>2) Medication is prescribed by a neurologist AND<br>3) History of thirty (30) trial of one of the preferred agents for multiple sclerosis unless one of the exceptions on the PA form is present AND<br>4) Dosage is limited to one tablet per day. |
| **OPTHALMIC ANTI-INFLAMMATORIES** | | | | |
| BROMDAY (bromfenac) | New Dosage Form | Non-Preferred | N/A | Five (5) day trials of each of the preferred ophthalmic anti-inflammatory agents are required before non-preferred agents will be authorized unless one of the exceptions on the PA form is |

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| | | | | present. |
| **MISC. BRAND/GENERIC** | | | | |
| BEYAZ (ethinyl estradiol/drospirenone/levomefolate)<br>Other agents in this sub-category are:<br><br>LO SEASONIQUE (ethinyl estradiol/levonorgestrel)<br>SEASONIQUE (ethinyl estradiol/levonorgestrel)<br>YASMIN (ethinyl estradiol/drospirenone) | New Drug | Non-Preferred | N/A | A thirty (30) day trial of each preferred unique chemical entity in the corresponding therapeutic category is required before a non-preferred agent will be authorized. |