Attachment D

West Virginia Medicaid PDL
Recommended Changes Summary
Pharmaceutical & Therapeutics Committee Meeting
April 25, 2012

Therapeutic Drug Class	Brand Name (Route)	P&T Committee Recommendations	PA Criteria (DRAFT)
ANALGESICS, NARCOTICS SHORT	OXECTA (ORAL)	Non-preferred	Six (6) day trials of at least four (4) chemically distinct preferred agents (based on narcotic ingredient only) , including the generic formulation 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.
ANGIOTENSIN MODULATORS	EDARBYCLOR (ORAL)	Non-preferred	Fourteen (14) day trials of each of the preferred agents in the corresponding group, with the exception of the Direct Renin Inhibitors, are required before a non-preferred agent will be authorized unless one of the exceptions on the PA form is present.
ANTICONVULSANTS	ONFI (ORAL)	Non-preferred	1)**A**djunctive therapy for Lennox-Gastaut **or** 2)Generalized tonic, atonic or myoclonic seizures **and 3)** previous failure of at least two non-benzodiazepine anticonvulsants **and** previous failure of clonazepam. (For continuation prescriber must include information regarding improved response/effectiveness with this medication)
BETA-BLOCKERS	DUTOPROL (ORAL)	Non-preferred	Fourteen (14) day trials of three (3) chemically distinct preferred agents, including the generic formulation of a requested non-preferred product,

			are required before one of the non-preferred agents will be approved unless one of the exceptions on the PA form is present.
HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS	BYETTA PENS (SUBCUTANE.)	Non-preferred	Byetta, Bydureon and Victoza will be authorized for six-month intervals if each of the following criteria are met: 1) Diagnosis of Type 2 Diabetes 2) Previous history of a thirty (30) day trial of metformin 3)Concurrent therapy with a basal insulin 4) No history of pancreatitis. Initial approval will be given for six (6) months with no HgBA1C level required. For re-authorization, HgBA1C levels must be ≤7.
HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS	VICTOZA (SUBCUTANE.)	Non-preferred	Byetta, Bydureon and Victoza will be authorized for six-month intervals if each of the following criteria are met: 1) Diagnosis of Type 2 Diabetes 2) Previous history of a thirty (30) day trial of metformin 3)Concurrent therapy with a basal insulin 4) No history of pancreatitis. Initial approval will be given for six (6) months with no HgBA1C level required. For re-authorization, HgBA1C levels must be ≤7.
HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS	BYDUREON (SUBCUTANE)	Non-preferred	Byetta, Bydureon and Victoza will be authorized for six-month intervals if each of the following criteria are met: 1) Diagnosis of Type 2 Diabetes 2) Previous history of a thirty (30) day trial of Metformin 3)Concurrent therapy with a basal insulin 4) No history of pancreatitis. Initial approval will be given for six (6) months with no HgBA1C level required. For re-authorization,

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			HgBA1C levels must be ≤7.
HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS	SYMLIN (SUBCUTANE.)	Non-preferred	Symlin will be approved with a history of bolus insulin utilization in the past 90 days with not gaps in insulin therapy greater than 30 days.
HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS	SYMLIN PENS (SUBCUTANE.)	Non-preferred	Symlin will be approved with a history of bolus`insulin utilization in the past 90 days with not gaps in insulin therapy greater than 30 days.
HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS	JENTADUETO (ORAL)	Non-preferred	Jentajueto and Janumet will be approved after thirty (30) day trials of the preferred combination agents, Janumet and Kombiglyze XR.
HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS	JANUMET XR (ORAL	Non-Preferred	Jentajueto and Janumet will be approved after thirty (30) day trials each of the preferred combination agents, Janumet and Kombiglyze XR.
			A fourteen (14) day trial of one preferred agent is required before a non-preferred agent will be approved unless one of the exceptions on the PA form is present. (Non-preferred agents will be grandfathered for patients currently on these therapies.)
IMMUNOSUPPRESSIVES, ORAL	AZASAN (ORAL)	Non-Preferred	
IMMUNOSUPPRESSIVES, ORAL	AZATHIOPRINE (ORAL)	Preferered	
IMMUNOSUPPRESSIVES, ORAL	CELLCEPT CAPSULE (ORAL)	Non-Preferred	
IMMUNOSUPPRESSIVES, ORAL	CELLCEPT SUSPENSION (ORAL)	Non-preferred	
IMMUNOSUPPRESSIVES, ORAL	CELLCEPT TABLET (ORAL)	Non-preferred	
IMMUNOSUPPRESSIVES, ORAL	CYCLOSPORINE CAPSULE (ORAL)	Preferred	
IMMUNOSUPPRESSIVES, ORAL	CYCLOSPORINE SOFTGEL (ORAL)	Preferred	
IMMUNOSUPPRESSIVES, ORAL	CYCLOSPORINE, MODIFIED CAPSULE (ORAL)	Preferred	
IMMUNOSUPPRESSIVES, ORAL	CYCLOSPORINE, MODIFIED SOLUTION (ORAL)	Preferred	
IMMUNOSUPPRESSIVES, ORAL	IMURAN (ORAL)	Non-Preferred	
IMMUNOSUPPRESSIVES, ORAL	MYCOPHENOLATE MOFETIL CAPSULE (ORAL)	Preferred	
IMMUNOSUPPRESSIVES, ORAL	MYCOPHENOLATE MOFETIL TABLET (ORAL)	Preferred	
IMMUNOSUPPRESSIVES, ORAL	MYFORTIC (ORAL)	Non-Preferred	
IMMUNOSUPPRESSIVES, ORAL	NEORAL CAPSULE (ORAL)	Non-Preferred	
IMMUNOSUPPRESSIVES, ORAL	NEORAL SOLUTION (ORAL)	Non-Preferred	

IMMUNOSUPPRESSIVES, ORAL	PROGRAF (ORAL)	Non-preferred	
IMMUNOSUPPRESSIVES, ORAL	RAPAMUNE SOLUTION (ORAL)	Preferred	
IMMUNOSUPPRESSIVES, ORAL	RAPAMUNE TABLET (ORAL)	Preferred	
IMMUNOSUPPRESSIVES, ORAL	SANDIMMUNE CAPSULE (ORAL)	Non-Preferred	
IMMUNOSUPPRESSIVES, ORAL	SANDIMMUNE SOLUTION (ORAL)	Non-Preferred	
IMMUNOSUPPRESSIVES, ORAL	TACROLIMUS (ORAL)	Preferred	
IMMUNOSUPPRESSIVES, ORAL	ZORTRESS (ORAL)	Non-Preferred	
			Thirty (30) day trials of each of the preferred agents are required unless one of the exceptions on the PA form is present.
OPHTHALMIC ANTIBIOTIC-STEROID COMBINATIONS	BLEPHAMIDE (OPHTHALMIC)	Preferred	
OPHTHALMIC ANTIBIOTIC-STEROID COMBINATIONS	BLEPHAMIDE S.O.P. (OPHTHALMIC)	Preferred	
OPHTHALMIC ANTIBIOTIC-STEROID COMBINATIONS	MAXITROL DROPS SUSP (OPHTHALMIC)	Non-Preferred	
OPHTHALMIC ANTIBIOTIC-STEROID COMBINATIONS	MAXITROL OINT. (OPHTHALMIC)	Preferred	
OPHTHALMIC ANTIBIOTIC-STEROID COMBINATIONS	NEOMYCIN/BACITRACIN/POLY/HC (OPHTHALMIC)	Non-Preferred	
OPHTHALMIC ANTIBIOTIC-STEROID COMBINATIONS	NEOMYCIN/POLYMYXIN/DEXAMETHASONE (OPHTHALMIC)	Preferred	
OPHTHALMIC ANTIBIOTIC-STEROID COMBINATIONS	NEOMYCIN/POLYMYXIN/HC (OPHTHALMIC)	Non-Preferred	
OPHTHALMIC ANTIBIOTIC-STEROID COMBINATIONS	PRED-G DROPS SUSP (OPHTHALMIC)	Non-Preferred	
OPHTHALMIC ANTIBIOTIC-STEROID COMBINATIONS	PRED-G OINT. (OPHTHALMIC)	Non-Preferred	
OPHTHALMIC ANTIBIOTIC-STEROID COMBINATIONS	SULFACETAMIDE / PREDNISOLONE (OPHTHALMIC)	Preferred	
OPHTHALMIC ANTIBIOTIC-STEROID COMBINATIONS	TOBRADEX OINTMENT (OPHTHALMIC)	Non-Preferred	
OPHTHALMIC ANTIBIOTIC-STEROID COMBINATIONS	TOBRADEX ST (OPHTHALMIC)	Non-Preferred	
OPHTHALMIC ANTIBIOTIC-STEROID COMBINATIONS	TOBRADEX SUSPENSION (OPHTHALMIC)	Preferred	

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OPHTHALMIC ANTIBIOTIC-STEROID COMBINATIONS	TOBRAMYCIN / DEXAMETHASONE SUSPENSION (OPHTHALMIC)	Non-Preferred	
OPHTHALMIC ANTIBIOTIC-STEROID COMBINATIONS	ZYLET (OPHTHALMIC)	Non-Preferred	
OPHTHALMICS, GLAUCOMA AGENTS	COSOPT PF (OPHTHALMIC)	Non-Preferred	Authorization of a non-preferred agent will only be given if there is an allergy to the preferred agents.
OPHTHALMICS, GLAUCOMA AGENTS	ZIOPTAN (OPHTHALMIC)	Non-Preferred	Authorization of a non-preferred agent will only be given if there is an allergy to the preferred agents