Attachment A

A. Re-Review

1. Bethkis

ANTIBIOTICS, INHALED		
BETHKIS (tobramycin) TOBI (tobramycin)	CAYSTON (aztreonam) TOBI PODHALER tobramycin	A twenty-eight (28) day trial of the preferred agent and documentation of therapeutic failure is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.

2. Effient

PLATELET AGGREGATION INHIBITORS		
AGGRENOX (dipyridamole/ASA) BRILINTA (ticagrelor) clopidogrel EFFIENT (prasugrel)[CL*]	dipyridamole PERSANTINE (dipyridamole) PLAVIX (clopidogrel) TICLID (ticlopidine) ticlopidine	A thirty (30) day trial of a preferred agent is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. *Effient will be approved for acute coronary syndrome when it is to be managed by acute or delayed percutaneous coronary intervention (PCI).

3. Pradaxa

ANTICOAGULANTS		
	INJECTABLE[CL]	
FRAGMIN (dalteparin) LOVENOX (enoxaparin)	ARIXTRA (fondaparinux) enoxaparin fondaparinux INNOHEP (tinzaparin)	Trials of each of the preferred agents will be required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.
	ORAL	
COUMADIN (warfarin) ELIQUIS (apixaban)[AP] PRADAXA (dabigatran)[AP] warfarin XARELTO (rivaroxaban)[AP]		Eliquis will be authorized for the diagnosis of non-valvular atrial fibrillation. Pradaxa will be authorized for the following indications: 1. Non-valvular atrial fibrillation; 2. Treatment of acute DVT and PE in patients who have been treated with a parenteral anticoagulant for 5-10 days 3. To reduce the risk of recurrent DVT and PE in patients who have previously been treated. Xarelto will be authorized for the following indications: 1. Non-valvular atrial fibrillation **or** 2. Deep vein thrombosis (DVT), pulmonary embolism (PE), and reduction in risk of recurrence of DVT and PE **or** DVT prophylaxis if treatment is limited to thirty-five (35) days for hip replacement surgeries or twelve (12) days for knee replacement surgeries.

B. New Drug Review

1. Sovaldi – The P&T Committee tabled the decision on the status of Sovaldi until the August P&T Meeting

HEPATITIS C TREATMENTS[CL]		
INCIVEK (telaprevir)* PEGASYS (pegylated interferon) PEG-INTRON (pegylated interferon) ribavirin VICTRELIS (boceprevir)*	COPEGUS (ribavirin) INFERGEN (consensus interferon) REBETOL (ribavirin) RIBAPAK (ribavirin) RIBASPHERE 400mg, 600mg (ribavirin) ribavirin dose pack	For patients starting therapy in this class, a trail of the preferred agent of a dosage form is required before a non-preferred agent of that dosage form will be authorized. *See additional criteria for Incivek and Victrelis at http://www.dhhr.wv.gov/bms/Pharmacy/Pages/pac.aspx **See criteria for Sovaldi attached

C. Class Review

1. Proton Pump Inhibitors

PROTON PUMP INHIBITORS[AP]		
omeprazole (Rx) pantoprazole PREVACID SOLUTABS (lansoprazole)*	ACIPHEX (rabeprazole) ACIPHEX SPRINKLE (rabeprazole) DEXILANT (dexlansoprazole) esomeprazole strontium lansoprazole Rx NEXIUM (esomeprazole) omeprazole/sodium bicarbonate (Rx) PREVACID CAPSULES (lansoprazole) PRILOSEC Rx (omeprazole) PROTONIX (pantoprazole) rabeprazole ZEGERID Rx (omeprazole/sodium bicarbonate)	Sixty (60) day trials each of omeprazole (Rx) and pantoprazole at the maximum recommended dose**, inclusive of a concurrent thirty (30) day trial at the maximum dose of an H_2 antagonist** are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. *Prior authorization is required for Prevacid Solutabs for members eight (8) years of age or older. ** Maximum doses can be found at: http://www.dhhr.wv.gov/bms/Pharmacy/Pages/pac.aspx

2. Multiple Sclerosis Agents

MULTIPLE SCLEROSIS AGENTS[AP]		
INTERFERONS		
AVONEX (interferon beta-1a)[AP] AVONEX PEN (interferon beta-1a)[AP] BETASERON KIT (interferon beta-1b)[AP] REBIF (interferon beta-1a)[AP] REBIF REBIDOSE (interferon beta-1a)[AP]	EXTAVIA (interferon beta-1b)	A diagnosis of multiple sclerosis and a thirty (30) day trial of the preferred first-line agent in each class (interferon and non-interferon) will be required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.

NON-INTERFERONS		
COPAXONE (glatiramer) [AP]	AMPYRA (dalfampridine) [CL*] AUBAGIO (teriflunomide) [CL**] GILENYA (fingolimod) [CL***] TECFIDERA (dimethyl fumarate) [CL****]	*Amypra will be authorized if the following criteria are met: 1. Diagnosis of multiple sclerosis **and** 2. No history of seizures **and** 3. No evidence of moderate or severe renal impairment **and** 4. Trial of the preferred first-line agent in each class (interferon and non-interferon) for thirty (30) days each **and** 5. Initial prescription will be authorized for thirty (30) days only. **Aubagio will be authorized if the following criteria are met: 1. Diagnosis of relapsing multiple sclerosis **and** 2. Trial of the preferred first-line agent in each class (interferon and non-interferon) for thirty (30) days each **and** 3. Measurement of transaminase and bilirubin levels within the (6) months before initiation of therapy and ALT levels at least monthly for six (6) months after initiation of therapy **and** 4. Complete blood cell count (CBC) within six (6) months before initiation of therapy **and** 5. Female patients must have a negative pregnancy test before initiation of therapy and be established on a reliable method of contraception if appropriate **and** 6. Patient is from eighteen (18) up to sixty-five (65) years of age **and** 7. Negative tuberculin skin test before initiation of therapy ***Gilenya will be authorized if the following criteria are met: A diagnosis of a relapsing form of multiple sclerosis **and** 1. Medication is prescribed by a neurologist **and** 2. Trial of the preferred first-line agent in each class (interferon and non-interferon) for thirty (30) days each **and** one (1) of the exceptions on the PA form is present **and** 3. Dosage is limited to one (1) tablet per day. ****Tecfidera will be authorized if the following criteria are met: 1. Diagnosis of relapsing multiple sclerosis **and** 2. Trial of the preferred first-line agent in each class (interferon and non-interferon) for thirty (30) days each **and** 3. Complete blood count (CBC) within six (6) months of initiation of therapy and six months after initiation **and** 4. Complete blood count (CBC) annually during therapy

3. Hypoglycemics, Incretin Mimetics/Enhancers

HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS

INJECTABLE

BYETTA (exenatide)[AP]* VICTOZA (liraglutide)[AP]*	BYDUREON (exenatide) ** SYMLIN (pramlintide) ***	A thirty (30) day trial of one (1) preferred agent with a chemical entity distinct from the requested non-preferred agent will be required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. *Byetta and Victoza will be authorized for six (6) month intervals if the following criteria are met: 1. Diagnosis of Type 2 Diabetes **and** 2. Previous history of a thirty (30) day trial of metformin, unless contraindicated **and** 3. No history of pancreatitis **and** 4. For concurrent therapy with insulin, treatment with a bolus insulin is contraindicated. Approvals will be given for six (6) month intervals. For re-authorizations, documentation that HgBA1C levels have decreased by at least 1% or are maintained at ≤8% is required. HgBA1C levels submitted must be for the most recent thirty (30) day period. ** Bydureon will not be authorized with insulin therapy of any kind. ***Symlin will be authorized with a history of bolus insulin utilization in the past ninety (90) days with no gaps in insulin therapy greater than thirty (30) days.

ORAL [AP]

JANUMET (sitagliptin/metformin) [AP] JANUVIA (sitagliptin) [AP] JUVISYNC (sitagliptin/simvastatin) [AP] TRADJENTA (linagliptin) [AP]	JANUMET XR (sitagliptin/metformin)* JENTADUETO (linagliptin/metformin) KAZANO (alogliptin/metformin) KOMBIGLYZE XR (saxagliptin/metformin) * NESINA (alogliptin) ONGLYZA (saxagliptin) ** OSENI (alogliptin/pioglitazone)	Thirty (30) day trials of each chemically distinct preferred agent are required before a non-preferred agent will be approved. **All** agents (preferred and non-preferred) require a previous history of a thirty (30) day trial of metformin. For concurrent insulin use, all agents will be approved in six (6) month intervals. For re-authorizations, documentation that HgBA1C levels have decreased by at least 1% or are maintained at ≤8% is required. HgBA1C levels submitted must be for the most recent thirty (30) day period. *Jentadueto and Janumet XR will be authorized after thirty (30) day trials of a preferred combination agent. All other restrictions are as above.

4. Hypoglycemics, SGLT2

HYPOGLYCEMICS, SGLT2		
	INVOKANA (canagliflozin)	Authorization of any drug in the SGLT2 class will now require the member to be currently taking metformin and at least one (1) other first line oral agent (e.g. TZD or sulfonylurea), unless one (1) of the exceptions on the PA form is present. Invokana will be authorized for six (6) months if the following criteria are met: 1. Diagnosis of Type 2 Diabetes **and** 2. Thirty (30) day trial of metformin or metformin combination and at least one other first line oral agent (as above) within the past six (6) months **and** 3. HgBA1C levels are equal or less than (≤) 10.5% **and** 4. Glomerular filtration rate is greater than or equal to (≥) 45 ml/min/1.73m2 **and** 5. Prior authorizations will be issued at six (6) month intervals if HgBA1C levels are less than or equal to (≤) 8% HgBA1C levels submitted must be for the most recent thirty (30) day period.