NEW YORK STATE MEDICAID
PREFERRED DRUG PROGRAM

ANNUAL REPORT
TO THE
GOVERNOR AND LEGISLATURE

STATE FISCAL YEAR
APRIL 1, 2006 – MARCH 31, 2007

New York State Medicaid Preferred Drug Program
Annual Report to the Governor and Legislature
State Fiscal Year April 1, 2006 – March 31, 2007

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APPENDICES

Acronyms

CCC	Clinical Call Center
CDRP	Clinical Drug Review Program
CPT	Certified Pharmacy Technician
DOH	New York State Department of Health
FDA	Federal Drug Administration
FHSC	First Health Services Corporation
IVR	Interactive Voice Response
MGDP	Mandatory Generic Drug Program
NMPI	National Medicaid Pooling Initiative
NYS	New York State
P&TC	Pharmacy and Therapeutics Committee
PA	Prior Authorization
PDL	Preferred Drug List
PDP	Preferred Drug Program
SFY	State Fiscal Year
VIPS	Voice Interactive Phone System

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Executive Summary

Background

In 2006 the Department of Health (DOH) implemented the Preferred Drug Program (PDP) and Clinical Drug Review Program (CDRP) authorized by Sections 270-277 of Article 2A of Chapter 58 of the Laws of 2005 (Appendix 1). Both programs promote cost effective and clinically appropriate prescription drug utilization in the Medicaid program, while maintaining patient access to effective treatment and safeguarding the public health. As required by the legislation, this report provides information about the volume of prior authorizations; the quality of the program's responsiveness; a summary of the complaints about the programs; savings attributable to the program; the aggregate amount of supplemental rebates; and the education and outreach conducted by the DOH relative to the programs.

Program Overview

The PDP encourages providers to prescribe drugs that are therapeutically appropriate and cost effective through the use of a Preferred Drug List (PDL). Preferred drugs on the PDL can be prescribed without any additional action taken by the prescriber; non-preferred drugs require prior authorization (PA) by calling or faxing the Clinical Call Center (CCC).

The CDRP is designed to ensure specific drugs are utilized in a medically appropriate manner. These drugs require PA because there are specific safety issues, public health concerns, the potential for fraud and abuse or the potential for significant overuse and misuse associated with these drugs. PA is a management tool that seeks to assure that the most medically appropriate, cost effective drug therapy is prescribed. All drugs available to Medicaid beneficiaries prior to implementation of these programs continue to be available.

The Pharmacy and Therapeutics Committee (P&TC) plays a critical role in the PDP and CDRP. Members of the P&TC are experienced, actively practicing physicians, nurse practitioners, pharmacists and consumer representatives who contribute specialized expertise in areas such as pharmacology, mental health, drug utilization review, geriatrics, internal medicine, HIV/AIDS, pediatrics and health care consumer advocacy (Appendix 2). The role of the P&TC is to advise the Commissioner on Medicaid pharmacy matters, including making recommendations on the PDP and CDRP. The P&TC meet in a public forum. To ensure transparency in the process, a notice of each meeting and the agenda is posted on the DOH website thirty (30) days prior to the meeting.

Interested parties are given an opportunity to submit materials to the P&TC for consideration and to provide public testimony on the agenda items. In SFY 06/07, the P&TC reviewed the testimony from nearly 278 interested parties.

Prior authorization activities are conducted by the Clinical Call Center. In SFY 06/07 the CCC handled 116,000 phone requests and 9,000 fax requests for prior authorization under the PDP and the CDRP. The CCC is available 24 hours a day, seven days a week and is staffed by certified pharmacy technicians, pharmacists and a physician for peer reviews. Nearly all phone requests (99.6%) were completed during the initial call and 99.7% of all faxed requests were responded to within twenty-four hours of receipt. The CCC can authorize an emergency seventy-two (72) hour supply of a drug when a drug requiring PA does not have a PA number and the pharmacy is unable to contact the prescriber to obtain the number. Fifty-two (52) emergency supply authorizations were processed in SFY 06/07. In addition, the CCC provided thousands of callers with general information or technical assistance, and identified and referred 28 potential instances of fraud and/or abuse.

Prescriber, Pharmacy and Patient Satisfaction

Feedback on the PDP and CDRP was obtained through two key sources, complaints and a satisfaction survey of prescribers and pharmacies.

Complaints about the program are received through a variety of sources including mail or email, through the CCC or Medicaid Helpline and from feedback at educational presentations. Overall, it is estimated that fewer than seventy-five (75) complaints about the PDP and CDRP were received during SFY 06/07. The Medicaid Helpline for beneficiaries receives very few calls on this topic, but when such calls are received they are referred to the DOH Medicaid pharmacy staff which provides direct assistance.

An independent survey conducted by Decision Support Systems Research, showed that the majority of prescribers and pharmacists were satisfied with the program. Two hundred twenty-seven (227) prescribers and four hundred sixty-eight (468) pharmacists responded to the survey and confirmed that prior authorizations are typically accomplished in a matter of minutes and that a staffed clinical call center is favored by prescribers over an automated voice response system. A few issues identified in the early stages of implementation were resolved by increasing the number of staff at the CCC, providing outreach to providers whose calls indicated a need for education or assistance, improving technology and operations to reduce service interruptions that require call backs, streamlining operational processes and providing additional training to CCC staff.

Program Savings

In SFY 06/07, Medicaid processed over 43 million pharmacy claims. Of these, 10.5% (4,594,690) were for a drug within one of the classes of drugs on the PDP. Of the drugs subject to the PDP, 97.7% of claims were for preferred drugs that did not require prior authorization. The remaining 2.3% (105,286 claims) were for non-preferred drugs that required prior authorization. This distribution between prescribing preferred and non-preferred drugs is attributable to the wide selection of preferred drugs within a class,

prescribers' general familiarity with PDLs and the extensive outreach and education conducted to enhance prescriber awareness of the Medicaid PDP.

The total gross savings attributable to the PDP for SFY 06/07 was $82.5 million. The vast majority of the savings, $80.5 million, resulted from supplemental rebates on preferred drugs. The remaining $1.95 million in savings resulted from a shift in market share from more expensive non-preferred drugs to more cost-effective preferred drugs within a drug class.

The CDRP was implemented in October 2006 and applied to only three drugs: Revatio®, Serostim® and Zyvox®. A total of 884 prior authorization requests were received for these drugs and all were approved using the criteria set forth in the legislation which allows a denial only on the basis of substantial evidence of fraud and abuse. Had the statute allowed for denial on the basis of medical necessity, 10% of the requests would have been denied, raising concerns in these cases about the ability of the CDRP as currently authorized to prevent inappropriate prescribing in these cases.

Although all CDRP prior authorization requests were approved, preliminary results comparing the number and dollar amount of claims paid in the quarter before and after implementation of the program show that it was successful in achieving cost avoidance. Both the number of claims and dollar spending on Serostim® and Zyvox® decreased in the quarter following the implementation of the CDRP. The third drug, Revatio®, was not available for outpatient pharmacy reimbursement by Medicaid prior to implementation of the CDRP and therefore a comparison could not be made.

Assuming that the amount paid for the CDRP drugs would have continued at the same trend as before institution of the CDRP, the cost avoidance for the six (6) month period after implementation of the CDRP is estimated to be $2,452,498 (gross).

Conclusion

Implementation of the PDP and CDRP and the first year of operation was successful largely due to:

- a transparent process for determining the selection of drugs for the PDP and CDRP;
- the responsiveness of the program's Clinical Call Center, including the easy to use PA process;
- continued patient access to medically necessary medications;
- extensive provider education and outreach efforts;
- careful monitoring of the program; and
- success in achieving cost savings and cost avoidance.

Phase-in of the programs and operation improvement continued into SFY 07/08. The P&TC re-reviewed all classes of drugs on the PDP to take into consideration drugs within the classes recently approved by the FDA, newly available clinical information and updated financial information. Eleven (11) new drug classes were reviewed for inclusion on the PDP by the end of 2007. Technological advancements including webcasts of P&TC meetings and email notification to interested parties whenever the PDL is changed further enhance the transparency of the PDP and CDRP. Education efforts for beneficiaries, prescribers and pharmacies will continue. Overall satisfaction with the program will be monitored closely by the Department.

New York State Medicaid Preferred Drug Program
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I. Background

New York State (NYS) Medicaid spending on pharmaceuticals grew from $1.7 billion in State Fiscal Year (SFY) 1998-99 to $5 billion in SFY 2005-06, with growth rates in excess of 20% per year. In absolute dollars, pharmacy spending continues to be a significant category of Medicaid spending. Higher prices for drugs, expensive new therapies, newly advanced specialty medications, direct to consumer advertising and improved treatment of chronic diseases continue to contribute to increases in spending.

To address rising drug costs and appropriate prescribing, many commercial insurers and state Medicaid programs use preferred drug lists and prior authorization programs. These tools encourage prescribers to use clinically effective drugs in a cost effective manner.

New York's Medicaid program initiated its first prior authorization process in 2000 for Zyvox®, a powerful antibiotic. In 2002, the human growth hormone, Serostim®, also became subject to prior authorization. In that same year, legislation was passed establishing the Medicaid Mandatory Generic Drug Program (MGDP) which requires prior authorization (PA) for brand name drugs with A-rated generic equivalents unless the drug is exempted by the Commissioner of Health. The Commissioner also appointed a Pharmacy and Therapeutics Committee (P&TC) to make clinical recommendations on Medicaid pharmacy issues. In 2003, with the recommendations of the P&TC, the Department implemented prior authorization of second generation prescription antihistamines. This was the first time an entire class of drugs became subject to NYS Medicaid's PA requirements.

In 2005, legislation was passed (Sections 270-277 of Article 2A of Chapter 58 of the Laws of 2005) establishing the Medicaid Preferred Drug Program (PDP) and Clinical Drug Review Program (CDRP). The legislation expanded the membership of the P&TC, established operational and administrative procedures and provided authority for the State to establish a Preferred Drug List (PDL) in order to receive supplemental rebates from drug manufacturers.

In 2006, the PDP and CDRP were implemented through a contract with First Health Services Corporation (FHSC), a subsidiary of Coventry Health Care. FHSC was selected through a competitive bid to operate the Clinical Call Center that supports the Medicaid PDP, CDRP, and MGDP; provide outreach and education services; assist with the clinical drug reviews; and obtain competitive pricing for prescription drugs through supplemental drug rebate agreements with drug manufacturers participating in the National Medicaid Pooling Initiative (NMPI).

II. Program Overview

A. The Preferred Drug Program (PDP)

The PDP promotes utilization of clinically appropriate, cost effective prescription drugs through the use of a Preferred Drug List (PDL).

In developing the PDL, the DOH works with the Pharmacy and Therapeutics Committee (P&TC) to select therapeutic drug classes where drugs in the class produce similar clinical effects or outcomes. The P&TC evaluates the clinical effectiveness, safety and patient outcomes among drugs in the therapeutic classes chosen for review. If the P&TC establishes that one drug is significantly more effective and safe than others in the class, that drug must be preferred without consideration of cost. If the P&TC ascertains that there is no substantial clinical difference among the drugs in the class, it then considers the net cost of the drug after rebates as a factor in determining preferred status. The P&TC also considers how its recommendations may impact current prescribing and dispensing practices and patient care. Recommendations are presented to the Commissioner of Health, who makes the final determination regarding which drugs will be listed as preferred or non-preferred.

The DOH issues the PDL (Appendix 4) which lists all drugs on the Preferred Drug Program and the Quick List (Appendix 5) which lists only preferred drugs within a therapeutic class. The PDL and Quick List are updated and given to prescribers and pharmacies whenever there is a change. The PDL and Quick List are also posted on the website (newyork.fhsc.com).

The PDP legislation specifically excludes the following therapeutic classes from PDP PA requirements:

- atypical anti-psychotics;
- anti-depressants;
- anti-retrovirals used in the treatment of HIV/AIDS; and
- anti-rejection drugs used for the treatment of organ and tissue transplant.

The PDP legislation also required the transition of the previous PA programs for proton pump inhibitors and second generation prescription antihistamines into the Preferred Drug Program. That transition was completed in October 2006.

B. The Clinical Drug Review Program (CDRP)

Implemented in October 2006, the CDRP requires PA for specific drugs for which there may be specific safety issues, public health concerns, the potential for fraud and abuse, or the potential for significant overuse and misuse.

Legislation prohibits cost as a basis for the selection of a drug into the CDRP or as a denial reason when a PA is requested.

Prior to the CDRP legislation, Serostim® and Zyvox® were subject to PA because of public health concerns and the potential for abuse thorough overuse and misuse. PA was obtained using an automated voice interactive phone system (VIPS). Legislation required that these drugs be transitioned to the Clinical Drug Review Program. With that transition in October 2006, the PA process was changed from the VIPS process to the staffed clinical call center, which allows for a clinical discussion with the prescriber.

The P&TC reviews drugs for inclusion in the CDRP. Their recommendations are based on review of established FDA approved clinical indications, clinical research and input from interested parties. When making the final determination, the following clinical criteria are considered by the Commissioner:

- whether the drug requires monitoring of prescribing protocols to protect both the long-term efficacy of the drug and the public health;
- the potential for, or a history of overuse, abuse, diversion or illegal utilization; and
- the potential for or a history of utilization inconsistent with approved indications.

The following drugs are currently subject to the Clinical Drug Review Program:

- Revatio® - a drug used to treat primary pulmonary hypertension. Revatio's active ingredient is sildenafil citrate, the same ingredient as Viagra®. Revatio® requires PA to assure the drug is appropriately prescribed, to prevent overuse and deter the potential for fraud and abuse.
- Serostim® [somatropin (rDNA origin) for injection] - a human growth hormone used in the treatment of AIDS wasting or cachexia. PA for Serostim® was implemented to assure that the drug was appropriately prescribed in accordance with its FDA approved indications and to deter fraud and inappropriate utilization.
- Zyvox® (linezolid) - a powerful antibiotic used for the treatment of aggressive, persistent infections caused by resistant bacteria. PA for Zyvox® was implemented to address potential misutilization and inappropriate prescribing protocols, which could result in bacterial resistance adversely affecting public health.

C. The Role of the Pharmacy and Therapeutics Committee (P&TC)

The P&TC plays a critical role in the PDP and CDRP. Members of the P&TC are experienced, actively practicing physicians, nurse practitioners, pharmacists and consumer representatives who contribute specialized expertise in areas such as pharmacology, mental health, drug utilization review, geriatrics, internal medicine, HIV/AIDS, pediatrics and health care consumer advocacy (Appendix 2).

The P&TC is subject to the Public Officers Law and meetings are subject to the Open Meeting Law. A notice of each meeting and the agenda is posted on the DOH website thirty (30) days prior to the meeting. Interested parties are given an opportunity to submit materials to the P&TC for consideration and to provide public testimony on the agenda items.

The P&TC hears public comments and first reviews clinical information relevant to the drugs under consideration during the public session. The clinical information consists of the most current therapeutic drug class reviews and evidence-based research obtained through the DOH's participation in the Oregon Health Sciences University Drug Effectiveness Review Project, and clinical information provided by FHSC and DOH staff. Materials submitted by interested parties prior to the meeting, as well as oral testimony provided during the public session, are discussed as well.

Following the clinical presentation and consideration of all the clinical information, the P&TC adjourns for an executive session in order to evaluate confidential drug pricing information with respect to supplemental rebates. The P&TC reconvenes in open session to discuss any remaining issues, then votes on the recommendations to be submitted to the Commissioner of Health.

A summary of the meeting's proceedings, including the P&TC's recommendations, is posted to the DOH website, which initiates a 30-day public comment opportunity. The P&TC's recommendations as well as the statements made during the public comment period are then presented to the Commissioner who makes the final determination.

The Commissioner's final determination is posted to the DOH website, and includes an analysis of the impact on state public health plan populations, providers and the fiscal impact to the State.

A list of the drug classes reviewed during SFY 06/07 appears in Appendix 3.

D. The Prior Authorization Process

The Clinical Call Center (CCC) operated by FHSC is the single point of entry for the Medicaid's pharmacy prior authorization programs. The CCC is available twenty-four (24) hours a day, seven (7) days a week. Performance is monitored closely by the Department of Health to ensure appropriate and timely response to prescriber and pharmacy requests, and to ensure that beneficiaries are afforded the protections required by law.

For SFY 06/07, the CCC received approximately 116,000 phone requests and 9,000 fax requests for prior authorization under the PDP and CDRP. Nearly all phone requests (99.6%) were completed during the initial call, and 99.7% of all faxed requests were responded to within twenty-four (24) hours of receipt. In addition, the CCC provided thousands of callers with general information or technical assistance with the PA

process and identified and referred 28 potential instances of fraud and/or abuse to the Department.

The CCC can authorize an emergency seventy-two (72) hour supply of a drug when a drug requiring PA does not have a PA number and the pharmacy is unable to contact the prescriber to obtain the number. In these cases, the pharmacy may initiate the PA request to assure the beneficiary has timely access to their medication. Fifty-two (52) emergency supply authorizations were processed in SFY 06/07.

PDP Prior Authorization Process

Under the PDP, prescribers or their authorized agents (such as a nurse or office staff), contact the CCC by phone or fax to present medical justification for non-preferred drugs. The criteria used by the CCC staff to evaluate a request for a non-preferred drug is set forth in legislation and consists of the following:

- the preferred drug has been tried by the patient and has failed to produce the desired health outcomes;
- the patient has tried the preferred drug and has experienced undesirable side effects;
- the patient has been established on a non-preferred drug and transition to the preferred drug would be medically contraindicated; or
- other clinical indications identified by the P&TC for the patient's use of the non-preferred drug, giving consideration to the medical needs of special populations, including children, elderly, chronically ill persons with mental health conditions, and persons affected by HIV/AIDS (e.g.: for the beta blocker drug class a question regarding heart failure was added to the clinical criteria).

Prescribers initially speak with a CPT when requesting authorization for a non-preferred drug. If the responses to the clinical criteria support the PA request, a PA is issued by the CPT. In the event the request does not meet the criteria, the call is referred to a pharmacist so that the prescriber may provide additional information to justify the use of the non-preferred drug. If, after that discussion, the clinical criteria are met, a PA is issued. However, as required by legislation, when a prescriber maintains that the use of the non-preferred drug is necessary, despite not meeting the clinical criteria, the prescriber's determination prevails and PA is granted. This occurred in 6% of the PDP PAs processed in SFY 06/07.

CDRP Prior Authorization Process

Only the prescriber who orders a CDRP drug can initiate the PA process. Initially, the prescriber speaks with a CPT when requesting authorization. If, in the course of the discussion, the clinical criteria for approval are not met, the request is referred to a pharmacist so that the prescriber may provide additional information to support the use of the drug. If the prescriber requests, a physician peer review may take place. Unlike the PDP which always allows the prescriber to prevail, the CDRP legislation allows for a

denial where there is substantial evidence of fraud or abuse. Under current statute requests may not be denied for lack of medical necessity.

III. Outreach and Education

Outreach and education efforts undoubtedly played an important role in the successful implementation of the PDP and CDRP. These efforts have focused on ensuring that providers and beneficiaries are informed about Medicaid's pharmacy PA programs and kept up-to-date on program changes.

Implementation of the PDP was phased in during the SFY 06/07. With each phase, prescribers and pharmacies were notified in advance when the Preferred Drug List was changing and the PA requirements that would apply to new non-preferred and CDRP drugs. Notification was done through direct mailings, the Medicaid Update (a monthly Medicaid provider communication,) and website postings (newyork.fhsc.com). Presentations and teleconferences were also held with various prescriber and pharmacy organizations throughout the period (Appendix 6).

Individualized mailings were sent to prescribers of drugs on the CDRP and prescribers of certain antibiotics under the PDP. This effort reinforced appropriate prescription protocols and emphasized the safe and therapeutic use of these particular drugs.

Beneficiary outreach efforts focused on providing information about how the programs might affect prescription coverage requirements. Pharmacies are provided informational program brochures for distribution to beneficiaries (Appendix 7) and the PDP website provides easy access to information for prescribers, pharmacists, beneficiaries and other interested parties (Appendix 8).

IV. Prescriber, Pharmacy and Patient Satisfaction

Feedback on the PDP and CDRP was obtained through two key sources: complaints and a satisfaction survey of prescribers and pharmacies. This information is used to address program performance and identify opportunities for improvement.

Complaints

Complaints may be received through a variety of sources including by mail or email, through the CCC or Medicaid Helpline and from feedback at educational presentations. Overall, it is estimated that fewer than seventy-five (75) complaints about the PDP and CDRP were received during SFY 06/07, primarily through phone calls and letters.

Initial feedback from providers centered almost exclusively on their difficulty in distinguishing whether PA was required for a drug through the PDP or the MGDP, as these programs have different PA requirements and processes. Focused educational efforts were made to clarify the differences between the two processes.

Issues related to particular PAs and questions about specific drugs are individually addressed by the DOH Medicaid pharmacy staff. These inquiries are used to identify providers who may need additional program education.

Beneficiary reaction to the PDP has also been very minimal. Medicaid's Helpline for beneficiaries receives very few calls on this topic, but when such calls are received they are referred to the DOH Medicaid pharmacy staff which provides direct assistance to the beneficiary and/or their providers.

Provider Satisfaction Survey

Using an independent third party vendor, Decision Support Systems Research, a satisfaction survey was sent to 1,000 prescribers and 1,000 pharmacists who utilized the Clinical Call Center. Two hundred twenty-seven (227) prescribers and four hundred sixty-eight (468) pharmacists responded.

Survey results demonstrated that the majority of prescribers and pharmacists were satisfied with the program, with two-thirds (2/3) offering positive responses. Responses substantiated that PAs are typically accomplished in a matter of minutes and that a staffed clinical call center is favored by prescribers over the automated VIPS.

Dispensing pharmacies must contact the CCC to validate PAs prior to payment. During implementation, the pharmacy spoke with a pharmacy technician or pharmacist at the CCC to validate the PA. In October 2006, this process was changed to use an interactive voice response (IVR) system to improve efficiency. Pharmacies responded that they found the IVR to be a time saver and appreciated still having the option to speak to a CPT when needed. Pharmacy comments indicated a strong desire to eliminate the pharmacy validation step completely. This request is being explored by the DOH.

Provider dissatisfaction was most often associated with the wait time for speaking with CCC staff or not being able to complete the PA during the original call (either because the CCC had to call the provider back or because the provider didn't have enough information to complete the PA). Those with more complicated calls tended to be less satisfied. These issues were identified in the early stages of implementation and were subsequently addressed by increasing the number of staff at the CCC; providing outreach to providers whose calls indicated a need for education or assistance; improving technology and operations to reduce service interruptions that require call backs; streamlining operational processes; and providing additional training to CCC staff. Currently, 97% of calls are answered within 2 minutes; the average speed of answer is 6 seconds.

The survey showed that providers utilize the CCC as the primary source of information about the program and for PAs. Only 24% of prescribers surveyed said they have requested a PA by fax, and only 9% of prescribers and 16% of pharmacists reported using the PDP website for program information or the latest PDL.

V. Outcomes and Cost Savings

Preferred Drug Program

Under the Medicaid Drug Rebate Program created by the Omnibus Reconciliation Act of 1990 (OBRA), drug manufacturers are required to enter into rebate agreements with the Centers for Medicare and Medicaid Services (CMS) for drug products reimbursed by Medicaid. Medicaid programs must cover all outpatient drugs of a manufacturer that signs a national rebate agreement. Many Medicaid programs, including New York, use a PDP in order to get supplemental rebates from manufacturers when their drugs are designated as preferred within the drug class.

In order to receive supplemental rebates, NYS joined the National Medicaid Pooling Initiative (NMPI) administered by FHSC. New York is among 14 states that currently participate in the pool. Others include Alaska, Georgia, Hawaii, Kentucky, Michigan, Minnesota, Montana, Nevada, New Hampshire, Rhode Island, South Carolina and Tennessee, and the District of Columbia (Washington D.C). NPMI comprises about 6.5 million member lives with New York representing the largest percentage. Negotiated rebates are dependent on the total number of lives in each state that designates a drug as preferred on their PDL. The supplemental rebate agreements with manufacturers have a three year guarantee; net prices may decrease during the guarantee period but they may not increase. Rebate amounts are based on reported Wholesale Acquisition Cost (WAC) for each individual drug. Each state maintains its own P&TC and the ability to designate a drug as preferred or non-preferred. Because the NMPI was already formed and operational in June 2006 when the PDP began, NY's Medicaid program had immediate access to rebate agreements with sixty (60) manufacturers. By the end of the SFY 06/07, twenty (20) additional manufacturers joined the NMPI.

The Medicaid program processed over 43 million pharmacy claims in SFY 06/07. Of these, 10.5% (4,594,690) were for a drug that fell within one of the classes of drugs on the PDP. Of the drugs subject to the PDP, 97.7% of claims were for preferred drugs that did not require prior authorization (Appendix 9). This extremely high percentage is attributable to the wide selection of preferred drugs within a class, prescriber familiarity with PDLs used by other insurance programs and prescriber awareness of the Medicaid PDP. The remaining 2.3% (105,286 claims) were for non-preferred drugs that required prior authorization. These claim counts include both the initial prescription and refills, which do not require another prior authorization so the number of claims is greater than the number of PA requests. Of the total PA requests, 20.3% were for beta blockers used primarily for cardiovascular indications, 17.7% were for antihistamines used to treat allergies and 16.7% were for long acting narcotics used to treat moderate to severe pain. All other classes comprised 14% or less of the total number of PA requests. When prescribers were asked why they were ordering a non-preferred drug, they most often cited contraindications preventing transition of a patient to a preferred drug, patient specific adverse reactions to the preferred drug and prescriber preference. In 2.8% of calls, the prescriber agreed to change the prescription to the preferred drug after consultation with CCC staff.

For SFY 06/07, total gross savings for the PDP was $82.5 million. The overwhelming majority of the savings, $80.5 million, resulted from supplemental rebates. The remaining savings, $1.95 million, resulted from a change in market share from more expensive non-preferred drugs to less expensive preferred drugs within a drug class which occurs within the six months after the drug class is added to the PDP. To illustrate, the market share of preferred ACE Inhibitors increased from 71.6% to 98.5%; the market share of preferred ACE/diuretic combination drugs increased from 44.6% to 92.2%; and the market share for preferred beta blockers increased from 54.2% to 84.3%.

Outcomes and Cost Savings - Clinical Drug Review Program

In SFY 06/07, a total of 884 requests were processed for prior authorization of drugs under the CDRP as follows:

- 84 Revatio®
- 203 Serostim®
- 597 Zyvox®

All CDRP requests were authorized using the criteria in current statute which allows a denial only on the basis of substantial evidence of fraud and abuse which is difficult to establish during a prior authorization phone call. If statute allowed denial on the basis of medical necessity, 10% of requests would have been denied raising concerns about the ability of the program as currently authorized to assure appropriate prescribing practices and protect patient safety in these cases.

The CDRP prior authorization process was implemented in October 2006. Although all CDRP requests were authorized during SFY 06/07, a comparison of utilization and cost of the in fourth quarter 2006 to third quarter 2006 shows a decrease in utilization and spending on Serostim® and Zyvox®. The total number of claims for Serostim® showed a 54% reduction with a corresponding 55.2% reduction in total payments. The total number of claims for Zyvox® showed a reduction of 8.3% with a corresponding 7% decrease in overall payments. Revatio® was not available for outpatient pharmacy reimbursement by Medicaid prior to implementation of the CDRP and therefore a comparison of third and fourth quarter 2006 was not done. Assuming that the amount paid for the CDRP drugs would have continued at the same trend as before institution of the CDRP, the cost avoidance for the six (6) month period after implementation of the CDRP is estimated to be $2,452,498 (gross).

In accordance with the requirements of the legislation, CDRP gross savings by county has been included in Appendix 10.

VI. Conclusion

Implementation and the first year of operation of the PDP and CDRP proceeded smoothly. Early results show that the PDP and CDRP programs are effective in assuring access to high quality, cost effective medications and have resulted in significant program savings.

In SFY 07/08, the P&TC re-reviewed all classes of drugs in the PDP to include drugs recently approved by the FDA and newly available clinical information. Eleven (11) new drug classes were reviewed for inclusion in the PDP by the end of 2007.

Technological advancements including webcasts of P&TC meetings and email notification to interested parties whenever the PDL is changed will further enhance the transparency of the PDP and CDRP process.

Education efforts for beneficiaries will be increased through collaboration with Medicaid managed care organizations, community-based organizations, social workers involved in discharge planning and local social services district offices. Distribution of beneficiary brochures will be expanded to include handouts at all presentations, Medicaid enrollment sites and mailings to prescribers. Prescribers most affected by revisions to the PDL will also receive notification letters that provide information about their patients who are currently taking drugs that will require PA.

The Preferred Drug Program, Clinical Drug Review Program, and Mandatory Generic Drug Program will continue to be monitored closely by DOH staff. The Clinical Call Center Satisfaction survey will be repeated and expanded to survey more providers. Complaints will continue to be monitored and necessary action and follow-up taken. The National Medicaid Pooling Initiative supplemental invoice process will be reviewed by DOH to assure appropriate accounting and record keeping and an independent review of the supplemental rebate program will be performed by an outside consultant.

Legislation
Article 2A of Chapter 58 of the Laws of 2005

PREFERRED DRUG LIST – Part C
3/25/2005

§ 9. The public health law is amended by adding a new article 2-A to read as follows:

ARTICLE 2-A PREFERRED DRUG PROGRAM

Section 270. Definitions.
271. Pharmacy and therapeutics committee.
272. Preferred drug program.
273. Preferred drug program prior authorization.
274. Clinical drug review program.
275. Applicability of prior authorization to EPIC.
276. Education and outreach.
277. Review and reports.

§ 270. Definitions. As used in this article, unless the context clearly requires otherwise:

1. "Administrator" means an entity with which the commissioner contracts for the purpose of administering elements of the preferred drug program, as established under section two hundred seventy-two of this article or the clinical drug review program established under section two hundred seventy-four of this article.

2. "Clinical drug review program" means the clinical drug review program created by section two hundred seventy-four of this article.

3. "Committee" or "pharmacy and therapeutics committee" means the pharmacy and therapeutics committee created by section two hundred seventy-one of this article.

4. "Emergency condition" means a medical or behavioral condition as determined by the prescriber or pharmacist, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, and for which delay in beginning treatment prescribed by the patient's health care practitioner would result in:

(a) placing the health or safety of the person afflicted with such condition or other person or persons in serious jeopardy;

(b) serious impairment to such person's bodily functions;

(c) serious dysfunction of any bodily organ or part of such person;

(d) serious disfigurement of such person; or

(e) severe discomfort.

5. “Non preferred drug” means a prescription drug that is in a therapeutic class that is included in the preferred drug program and is not one of the drugs on the preferred drug list in that class.

6. "Panel" means the elderly pharmaceutical insurance coverage panel established pursuant to section two hundred forty-four of the elder law.

7. “Preferred drug” means a prescription drug that is in a therapeutic class that is included in the preferred drug program and is one of the drugs on the preferred drug list in that class.

8. "Preferred drug program" means the preferred drug program established under section two hundred seventy-two of this article.

9. "Prescription drug" or "drug" means a drug defined in subdivision seven of section sixty-eight hundred two of the education law, for which a prescription is required under the federal food, drug and cosmetic act. Any drug that does not require a prescription under such act, but which would otherwise meet the criteria under this article for inclusion on the preferred drug list may be added to the preferred drug list under this article; and, if so included, shall be considered to be a prescription drug for purposes of this article; provided that it shall be eligible for reimbursement under a state public health plan when ordered by a prescriber authorized to prescribe under the state public health plan and the prescription is subject to the applicable provisions of this article and paragraph (a) of subdivision four of section three hundred sixty-five-a of the social services law.

10. "Prior authorization" means a process requiring the prescriber or the dispenser to verify with the applicable state public health plan or its authorized agent that the drug is appropriate for the needs of the specific patient.

11. "State public health plan" means the medical assistance program established by title eleven of article five of the social services law (referred to in this article as "Medicaid") and the elderly pharmaceutical insurance coverage program established by title three of article two of the elder law (referred to in this article as "EPIC").

12. "Supplemental rebate" means a supplemental rebate under subdivision ten of section two hundred seventy-two of this article.

13. "Therapeutic class" means a group of prescription drugs that produce a particular intended clinical outcome and are grouped together as a therapeutic class by the pharmacy and therapeutics committee.

§ 271. Pharmacy and therapeutics committee.

1. There is hereby established in the department a pharmacy and therapeutics committee. The committee shall consist of seventeen members, who shall be appointed by the commissioner and who shall serve three year terms; except that for the initial appointments to the committee, five members shall serve one year terms, seven shall serve two year terms, and five shall serve three year terms. Committee members may be reappointed upon the completion of their terms. No member of the committee shall be an employee of the state or any subdivision of the state, other than for his or her membership on the committee, except for employees of health care facilities or universities operated by the state, a public benefit corporation, the State University of New York or municipalities.

2. The membership shall be composed as follows:

(a) six persons licensed and actively engaged in the practice of medicine in the state;

(b) one person licensed and actively engaged in the practice of nursing as a nurse practitioner, or in the practice of midwifery in the state;

(c) six persons licensed and actively engaged in the practice of pharmacy in the state;

(d) one person with expertise in drug utilization review who is either a health care professional licensed under title eight of the education law, is a pharmacologist or has a doctorate in pharmacology; and

(e) three persons who shall be consumers or representatives of organizations with a regional or statewide constituency and who have been involved in activities related to health care consumer advocacy, including issues affecting Medicaid or EPIC recipients.

3. The committee shall, at the request of the commissioner, consider any matter relating to the preferred drug program established pursuant to section two hundred seventy-two of this article, and may advise the commissioner or the panel thereon. The committee may, from time to time, submit to the commissioner or the panel recommendations relating to such preferred drug program. The committee may also evaluate and provide recommendations to the commissioner or the panel on other issues relating to pharmacy services under Medicaid or EPIC, including, but not limited to: therapeutic comparisons; enhanced use of generic drug products; enhanced targeting of physician prescribing patterns; prior authorization of drugs subject to the clinical drug review program established pursuant to section two hundred seventy-four of this article; fraud, waste and abuse prevention; negotiations for rebates; pharmacy benefit management activity by an administrator; and negotiation of lower initial drug pricing.

4. The committee shall elect a chairperson from among its members, who shall serve a one year term as chairperson. The chairperson may serve consecutive terms.

5. The members of the committee shall receive no compensation for their services but shall be reimbursed for expenses actually and necessarily incurred in the performance of their duties.

6. The committee shall be a public body under article seven of the public officers law and subject to article six of the public officers law. In addition to the matters listed in section one hundred five of the public officers law, the committee may conduct an executive session for the purpose of receiving and evaluating drug pricing information related to supplemental rebates, or receiving and evaluating trade secrets, or other information which, if disclosed, would cause substantial injury to the competitive position of the manufacturer.

7. Committee members shall be deemed to be employees of the department for the purposes of section seventeen of the public officers law, and shall not participate in any matter for which a conflict of interest exists.

8. The department shall provide administrative support to the committee.

§ 272. Preferred drug program.

1. There is hereby established a preferred drug program to promote access to the most effective prescription drugs while reducing the cost of prescription drugs for persons in state public health plans.

2. When a prescriber prescribes a non-preferred drug, state public health plan reimbursement shall be denied unless prior authorization is obtained, unless no prior authorization is required under this article.

3. The commissioner shall establish performance standards for the program that, at a minimum, ensure that the preferred drug program and the clinical drug review program provide sufficient technical support and timely responses to consumers, prescribers and pharmacists.

4. Notwithstanding any other provision of law to the contrary, no preferred drug program or prior authorization requirement for prescription drugs, except as created by this article, paragraph (a-1) or (a-2) of subdivision four of section three hundred sixty-five-a of the social services law, and paragraph (g) of subdivision two of section three hundred sixty-five-a of the social services law, shall apply to the state public health plans.

5. The pharmacy and therapeutics committee shall consider and make recommendations to the commissioner for the adoption of a preferred drug program.

(a) In developing the preferred drug program, the committee shall, without limitation: (i) identify therapeutic classes of drugs to be included in the preferred drug program; (ii) identify preferred drugs in each of the chosen therapeutic classes; (iii) evaluate the clinical effectiveness and safety of drugs considering the latest peer-reviewed research and may consider studies submitted to the federal food and drug administration in connection with its drug approval system; (iv) consider the potential impact on patient care and the potential fiscal impact that may result from making such a therapeutic class subject to prior authorization; and (v) consider the potential impact of the preferred drug program on the health of special populations such as children, the elderly, the chronically ill, persons with HIV/AIDS and persons with mental health conditions.

(b) In developing the preferred drug program, the committee may consider preferred drug programs or evidence based research operated or conducted by or for other state governments, the federal government, or multi-state coalitions. Notwithstanding any inconsistent provision of section one hundred twelve or article eleven of the state finance law or section one hundred forty-two of the economic development law or any other law, the department may enter into contractual agreements with the Oregon Health and Science University Drug Effectiveness Review Project to provide technical and clinical support to the committee and the department in researching and recommending drugs to be placed on the preferred drug list.

(c) The committee shall from time to time review all therapeutic classes included in the preferred drug program, and may recommend that the commissioner add or delete drugs or classes of drugs to or from the preferred drug program, subject to this subdivision.

(d) The committee shall establish procedures to promptly review prescription drugs newly approved by the federal food and drug administration.

6. The committee shall recommend a procedure and criteria for the approval of non-preferred drugs as part of the prior authorization process. In developing these criteria, the committee shall include consideration of the following:

(a) the preferred drug has been tried by the patient and has failed to produce the desired health outcomes;

(b) the patient has tried the preferred drug and has experienced unacceptable side effects;

(c) the patient has been stabilized on a non-preferred drug and transition to the preferred drug would be medically contraindicated; and

(d) other clinical indications for the use of the non-preferred drug, which shall include consideration of the medical needs of special populations, including children, the elderly, the chronically ill, persons with mental health conditions, and persons affected by HIV/AIDS.

7. The commissioner shall provide thirty days public notice on the department's website prior to any meeting of the committee to develop recommendations concerning the preferred drug program. Such notice regarding meetings of the committee shall include a description of the proposed therapeutic class to be reviewed, a listing of drug products in the therapeutic class, and the proposals to be considered by the committee. The committee shall allow interested

parties a reasonable opportunity to make an oral presentation to the committee related to the prior authorization of the therapeutic class to be reviewed. The committee shall consider any information provided by any interested party, including, but not limited to, prescribers, dispensers, patients, consumers and manufacturers of the drug in developing their recommendations.

8. The commissioner shall provide notice of any recommendations developed by the committee regarding the preferred drug program, at least thirty days before any final determination by the commissioner, by making such information available on the department's website. Such public notice shall include: a summary of the deliberations of the committee; a summary of the positions of those making public comments at meetings of the committee; the response of the committee to those comments, if any; and the findings and recommendations of the committee.

9. Within ten days of a final determination regarding the preferred drug program, the commissioner shall provide public notice on the department's website of such determinations, including: the nature of the determination; an analysis of the impact of the commissioner's determination on state public health plan populations and providers; and the projected fiscal impact to the state public health plan programs of the commissioner's determination.

10. The commissioner shall adopt a preferred drug program and amendments after considering the recommendations from the committee and any comments received from prescribers, dispensers, patients, consumers and manufacturers of the drug.

(a) The preferred drug list in any therapeutic class included in the preferred drug program shall be developed based initially on an evaluation of the clinical effectiveness, safety and patient outcomes, followed by consideration of the cost-effectiveness of the drugs.

(b) In each therapeutic class included in the preferred drug program, the committee shall determine whether there is one drug which is significantly more clinically effective and safe, and that drug shall be included on the preferred drug list without consideration of cost. If, among two or more drugs in a therapeutic class, the difference in clinical effectiveness and safety is not clinically significant, then cost effectiveness (including price and supplemental rebates) may also be considered in determining which drug or drugs shall be included on the preferred drug list.

(c) In addition to drugs selected under paragraph (b) of this subdivision, any prescription drug in the therapeutic class, whose cost to the state public health plans (including net price and supplemental rebates) is equal to or less than the cost of another drug in the therapeutic class that is on the preferred drug list under paragraph (b) of this subdivision, may be selected to be on the preferred drug list, based on clinical effectiveness, safety and cost-effectiveness.

11. The commissioner shall provide an opportunity for pharmaceutical manufacturers to provide supplemental rebates to the state public health plan; such supplemental rebates shall be taken into consideration by the committee and the commissioner in determining the cost-effectiveness of drugs within a therapeutic class under the state public health plans. Such supplemental rebates shall be in addition to those required by applicable federal law and subdivision seven of section three hundred sixty-seven-a of the social services law. In order to be considered in connection with the preferred drug program, such supplemental rebates shall apply to the drug products dispensed under the Medicaid program and the EPIC program. The commissioner is prohibited from approving alternative rebate demonstrations, value added programs or guaranteed savings from other program benefits as a substitution for supplemental rebates.

12. No prior authorization shall be required under the preferred drug program for: (a) atypical anti-psychotics; (b) anti-depressants; (c) anti-retrovirals used in the treatment of HIV/AIDS; and (d) anti-rejection drugs used for the treatment of organ and tissue transplants; (e) any other therapeutic class for the treatment of mental illness or HIV/AIDS, recommended by the committee and approved by the commissioner under this section.

13. The commissioner may implement all or a portion of the preferred drug program through contracts with administrators with expertise in management of pharmacy services, subject to applicable laws.

14. For a period of eighteen months, commencing with the date of enactment of this article, and without regard to the preferred drug program or the clinical drug review program requirements of this article, the commissioner is authorized to implement, or continue, a prior authorization requirement for a drug which may not be dispensed without a prescription as required by section sixty-eight hundred ten of the education law, for which there is a non-prescription version within the same drug class, or for which there is a comparable non-prescription version of the same drug. Any such prior authorization requirement shall be implemented in a manner that is consistent with the process employed by the commissioner for such authorizations as of one day prior to the date of enactment of this article. At the conclusion of the eighteen month period, any such drug or drug class shall be subject to the preferred drug program requirements of this article; provided, however, that the commissioner is authorized to immediately subject any such drug to prior authorization without regard to the provisions of subdivisions five through eleven of this section.

§ 273. Preferred drug program prior authorization.

1. For the purposes of this article, a prescription drug shall be considered to be not on the preferred drug list if it is in a therapeutic class that is included on the preferred drug list and is not one of the drugs on the preferred list in that class.

2. The preferred drug program shall make available a twenty-four hour per day, seven days per week telephone call center that includes a toll-free telephone line and dedicated facsimile line to respond to requests for prior authorization. The call center shall include qualified health care professionals who shall be available to consult with prescribers concerning prescription drugs that are not on the preferred drug list. A prescriber seeking prior authorization shall consult with the program call line to reasonably present his or her justification for the prescription and give the program's qualified health care professional a reasonable opportunity to respond.

3. (a) When a patient's health care provider prescribes a prescription drug that is not on the preferred drug list, the prescriber shall consult with the program to confirm that in his or her reasonable professional judgment, the patient's clinical condition is consistent with the criteria for approval of the non-preferred drug. Such criteria shall include:

(i) the preferred drug has been tried by the patient and has failed to produce the desired health outcomes;

(ii) the patient has tried the preferred drug and has experienced unacceptable side effects;

(iii) the patient has been stabilized on a non-preferred drug and transition to the preferred drug would be medically contraindicated; or

(iv) other clinical indications identified by the committee for the patient's use of the non-preferred drug, which shall include consideration of the medical needs of special populations,

including children, elderly, chronically ill, persons with mental health conditions, and persons affected by HIV/AIDS.

(b) In the event that the patient does not meet the criteria in paragraph (a) of this subdivision, the prescriber may provide additional information to the program to justify the use of a prescription drug that is not on the preferred drug list. The program shall provide a reasonable opportunity for a prescriber to reasonably present his or her justification for prior authorization. If, after consultation with the program, the prescriber, in his or her reasonable professional judgment, determines that the use of a prescription drug that is not on the preferred drug list is warranted, the prescriber's determination shall be final.

(c) If a prescriber meets the requirements of paragraph (a) or (b) of this subdivision, the prescriber shall be granted prior authorization under this section.

(d) In the instance where a prior authorization determination is not completed within twenty-four hours of the original request, solely as the result of a failure of the program (whether by action or inaction), prior authorization shall be immediately and automatically granted with no further action by the prescriber and the prescriber shall be notified of this determination. In the instance where a prior authorization determination is not completed within twenty-four hours of the original request for any other reason, a seventy-two hour supply of the medication shall be approved by the program and the prescriber shall be notified of this determination.

4. When, in the judgment of the prescriber or the pharmacist, an emergency condition exists, and the prescriber or pharmacist notifies the program that an emergency condition exists, a seventy-two hour emergency supply of the drug prescribed shall be immediately authorized by the program.

5. In the event that a patient presents a prescription to a pharmacist for a prescription drug that is not on the preferred drug list and for which the prescriber has not obtained a prior authorization, the pharmacist shall, within a prompt period based on professional judgment, notify the prescriber. The prescriber shall, within a prompt period based on professional judgment, either seek prior authorization or shall contact the pharmacist and amend or cancel the prescription. The pharmacist shall, within a prompt period based on professional judgment, notify the patient when prior authorization has been obtained or denied or when the prescription has been amended or cancelled.

6. Once prior authorization of a prescription for a drug that is not on the preferred drug list is obtained, prior authorization shall not be required for any refill of the prescription.

7. No prior authorization under the program shall be required when a prescriber prescribes a drug on the preferred drug list.

8. The department shall monitor the prior authorization process for prescribing patterns which are suspected of endangering the health and safety of the patient or which demonstrate a likelihood of fraud or abuse. The department shall take any and all actions otherwise permitted by law to investigate such prescribing patterns, to take remedial action and to enforce applicable federal and state laws.

9. No prior authorization under the preferred drug program shall be required for any prescription under EPIC until the panel has made prior authorization applicable to EPIC under section two hundred seventy-five of this article.

§ 274. Clinical drug review program.

1. In addition to the preferred drug program established by this article, the commissioner may establish a clinical drug review program. The commissioner may, from time to time, require

prior authorization under such program for prescription drugs or patterns of utilization under state public health plans. When a prescriber prescribes a drug which requires prior authorization under this section, state public health plan reimbursement shall be denied unless such prior authorization is obtained.

2. The clinical drug review program shall make available a twenty-four hour per day, seven days per week response system.

3. In establishing a prior authorization requirement for a drug under the clinical drug review program, the commissioner shall consider the following:

(a) whether the drug requires monitoring of prescribing protocols to protect both the long-term efficacy of the drug and the public health;

(b) the potential for, or a history of, overuse, abuse, drug diversion or illegal utilization; and

(c) the potential for, or a history of, utilization inconsistent with approved indications.

Where the commissioner finds that a drug meets at least one of these criteria, in determining whether to make the drug subject to prior authorization under the clinical drug review program, the commissioner shall consider whether similarly effective alternatives are available for the same disease state and the effect of that availability or lack of availability.

4. The commissioner shall obtain an evaluation of the factors set forth in subdivision three of this section and a recommendation as to the establishment of a prior authorization requirement for a drug under the clinical drug review program from the pharmacy and therapeutics committee. For this purpose, the commissioner and the committee, as applicable, shall comply with the following meeting and notice processes established by this article:

(a) the open meetings law and freedom of information law provisions of subdivision six of section two hundred seventy-one of this article; and

(b) the public notice and interested party provisions of subdivisions seven, eight and nine of section two hundred seventy-two of this article.

5. The committee shall recommend a procedure and criteria for the approval of drugs subject to prior authorization under the clinical drug review program. Such criteria shall include the specific approved clinical indications for use of the drug.

6. The commissioner shall identify a drug for which prior authorization is required, as well as the procedures and criteria for approval of use of the drug, under the clinical drug review program after considering the recommendations from the committee and any comments received from prescribers, dispensers, consumers and manufacturers of the drug. In no event shall the prior authorization criteria for approval pursuant to this subdivision result in denial of the prior authorization request based on the relative cost of the drug subject to prior authorization.

7. In the event that the patient does not meet the criteria for approval established by the commissioner in subdivision six of this section, the clinical drug review program shall provide a reasonable opportunity for a prescriber to reasonably present his or her justification for prior authorization. If, after consultation with the program, the prescriber, in his or her reasonable professional judgment, determines that the use of the prescription drug is warranted, the prescriber's determination shall be final and prior authorization shall be granted under this section; provided, however, that prior authorization may be denied in cases where the department has substantial evidence that the prescriber or patient is engaged in fraud or abuse relating to the drug.

8. In the event that a patient presents a prescription to a pharmacist for a prescription drug that requires prior authorization under this section and for which prior authorization has not been obtained, the pharmacist shall, within a prompt period based on professional judgment, notify the prescriber. The prescriber shall, within a prompt period based on professional judgment, either seek prior authorization or shall contact the pharmacist and amend or cancel the prescription. The pharmacist shall, within a prompt period based on professional judgment, notify the patient when prior authorization has been obtained or denied or when the prescription has been amended or cancelled.

9. In the instance where a prior authorization determination is not completed within twenty-four hours of the original request solely as the result of a failure of the program (whether by action or inaction), prior authorization shall be immediately and automatically granted without further action by the prescriber and the prescriber shall be notified of this determination. In the instance where a prior authorization determination is not completed within twenty-four hours of the original request for any other reason, a seventy-two hour supply of the medication will be approved by the program and the prescriber shall be notified of the determination.

10. When, in the judgment of the prescriber or the pharmacist, an emergency condition exists, and the prescriber or pharmacist notifies the program to confirm that such an emergency condition exists, a seventy-two hour emergency supply of the drug prescribed shall be immediately authorized by the program.

11. The department or the panel shall monitor the prior authorization process for prescribing patterns which are suspected of endangering the health and safety of the patient or which demonstrate a likelihood of fraud or abuse. The department or the panel shall take any and all actions otherwise permitted by law to investigate such prescribing patterns, to take remedial action and to enforce applicable federal and state laws.

12. The commissioner may implement all or a portion of the clinical drug review program through contracts with administrators with expertise in management of pharmacy services, subject to applicable laws.

13. No prior authorization under the clinical drug review program shall be required for any prescription under EPIC until the commissioner has made prior authorization applicable to EPIC under section two hundred seventy-five of this article.

14. For a period of eighteen months, commencing with the date of enactment of this article, the commissioner is authorized to continue prior authorization requirements for prescription drugs subject to prior authorization as of one day prior to the date of enactment of this article and which are not described in subdivision fourteen of section two hundred seventy-two of this article. At the conclusion of the eighteen month period, any such drug shall be subject to the clinical drug review program requirements of this section; provided, however, that the commissioner is authorized to immediately subject any such drug to prior authorization without regard to the provisions of subdivisions three through six of this section.

§ 275. Applicability of prior authorization to EPIC. The panel shall, no later than April first, two thousand eight, proceed to make prior authorization under the preferred drug program and the clinical review drug program, under this article, applicable to prescriptions under EPIC. The panel shall take necessary actions consistent with this article to apply prior authorization under this article to EPIC. Upon determining that the necessary steps have been taken to apply prior authorization under this article to EPIC, the panel shall, with reasonable prior public notice, make prescriptions under EPIC subject to prior authorization under this

article as of a specified date. If necessary, the panel may provide that such applicability take effect on separate dates for the preferred drug program and the clinical drug review program.

§ 276. Education and outreach. The department or the panel may conduct education and outreach programs for consumers and health care providers relating to the safe, therapeutic and cost-effective use of prescription drugs and appropriate treatment practices for containing prescription drug costs. The department or the panel shall provide information as to how prescribers, pharmacists, patients and other interested parties can obtain information regarding drugs included on the preferred drug list, whether any change has been made to the preferred drug list since it was last issued, and the process by which prior authorization may be obtained.

§ 277. Review and reports.

1. The commissioner, in consultation with the pharmacy and therapeutics committee, shall undertake periodic reviews, at least annually, of the preferred drug program which shall include consideration of:

(a) the volume of prior authorizations being handled, including data on the number and characteristics of prior authorization requests for particular prescription drugs;

(b) the quality of the program's responsiveness, including the quality of the administrator's responsiveness;

(c) complaints received from patients and providers;

(d) the savings attributable to the state, and to each county and the city of New York, due to the provisions of this article;

(e) the aggregate amount of supplemental rebates received in the previous fiscal year and in the current fiscal year, to date; and such amounts are to be broken out by fiscal year and by month;

(f) the education and outreach program established by section two hundred seventy-six of this article.

2. The commissioner and the panel shall, beginning March thirty-first, two thousand six and annually thereafter, submit a report to the governor and the legislature concerning each of the items subject to periodic review under subdivision one of this section.

3. The commissioner and the panel shall, beginning with the commencement of the preferred drug program and monthly thereafter, submit a report to the governor and the legislature concerning the amount of supplemental rebates received.

§ 10. Paragraph (a-1) of subdivision 4 of section 365-a of the social services law, as added by section 5 of part B of chapter 1 of the laws of 2002, is amended to read as follows:

(a-1) [~~A~~] a brand name drug for which a multi-source therapeutically and generically equivalent drug, as determined by the federal food and drug administration, is available, unless previously authorized by the department of health. The commissioner of health is authorized to exempt, for good cause shown, any brand name drug from the restrictions imposed by this paragraph. This paragraph shall not apply to any drug that is in a therapeutic class included on the preferred drug list under section two hundred seventy-two of the public health law or is in the clinical drug review program under section two hundred seventy-four of the public health law;

§ 11. Subdivision 4 of section 365-a of the social services law is amended by adding a new paragraph (a-2) to read as follows:

(a-2) drugs which may not be dispensed without a prescription as required by section sixty-eight hundred ten of the education law, and which are non-preferred drugs in a therapeutic class subject to the preferred drug program pursuant to section two hundred seventy-two of the public health law, or the clinical drug review program under section two hundred seventy-four of the public health law, unless prior authorization is granted or not required;

§ 12. Subdivision 5 of section 244 of the elder law is amended by adding a new paragraph (l) to read as follows:

(l) implement a preferred drug program and clinical drug review program in accordance with the provisions of article two-A of the public health law, including taking necessary actions consistent with this article to apply prior authorization under article two-A of the public health law to EPIC.

§ 12-a. Subdivision 1 of section 241 of the elder law is amended to read as follows:

1. "Covered drug" shall mean a drug dispensed subject to a legally authorized prescription pursuant to section sixty-eight hundred ten of the education law, and insulin, an insulin syringe, or an insulin needle. Such term shall not include: (a) any drug determined by the commissioner of the federal food and drug administration to be ineffective or unsafe; (b) any drug dispensed in a package, or form of dosage or administration, as to which the commissioner of health finally determines in accordance with the provisions of section two hundred fifty of this title that a less expensive package, or form of dosage or administration, is available that is pharmaceutically equivalent and equivalent in its therapeutic effect for the general health characteristics of the eligible program participant population; [and](c) any device for the aid or correction of vision[, or] ; and (d) any drug, including vitamins, which is generally available without a physician's prescription[.] , provided, however, that such drug shall be considered a covered drug or a prescription drug for purposes of this article if it is added to the preferred drug list under article two-A of the public health law. For the purpose of this title, except as otherwise provided in this section, a covered drug shall be dispensed in quantities no greater than a thirty day supply or one hundred units, whichever is greater. In the case of a drug dispensed in a form of administration other than a tablet or capsule, the maximum allowed quantity shall be a thirty day supply; the panel is authorized to approve exceptions to these limits for specific products following consideration of recommendations from pharmaceutical or medical experts regarding commonly packaged quantities, unusual forms of administration, length of treatment or cost effectiveness. In the case of a drug prescribed pursuant to section thirty-three hundred thirty-two of the public health law to treat one of the conditions that have been enumerated by the commissioner of health pursuant to regulation as warranting the prescribing of greater than a thirty day supply, such drug shall be dispensed in quantities not to exceed a three month supply.

§ 14. Notwithstanding any inconsistent provision of section 271 of the public health law, as added by section ten of this act, any pharmacy and therapeutics committee appointed by the commissioner of health in existence on the effective date of this act shall continue to function and shall be authorized to carry out the same duties and powers as prescribed pursuant to article 2-A of the public health law, as added by section ten of this act, until such committee is duly appointed pursuant to such section 271 of the public health law.

Medicaid Pharmacy and Therapeutics Committee Membership

Name and Affiliation:

1. Roxanne Hall Richardson, R.Ph.
Oswego Hospital

2. Andrew G. Flynn, R.Ph.
Albany College of Pharmacy, Community Practice Coordinator

3. William P. Scheer, R.Ph.
Independent Pharmacy Owner

4. Marc A. Johnson, M.D.
Affiliated with clinics in NYC serving AIDS/HIV patients

5. Scott C. Bello, M.D.
Private Practice/Pediatric Medicine

6. Steven E. Barnes, D.O.
Private Practice/Internal and Geriatric Medicine

7. Aaron Satloff, M.D.
Pittsford Psychiatric Group/Psychiatry and Neurology

8. Glenn A. Martin, M.D.
Psychiatry/Neurology Medicine

9. Janice W. Gay
Epilepsy Coalition of New York State, Inc.

10. Marla Suzan Eglowstein, M.D.
National Multiple Sclerosis Society

11. John Westerman, Jr. R.Ph.
Independent Pharmacy Owner

12. Susan P. Bruce, Pharm D.
Albany College of Pharmacy, Assistant Professor of Pharmacy Practice

13. Kevin Huang-Cruz
Asian & Pacific Islander Coalition on HIV/AIDS

14. Donna Chiefari, Pharm D.
Empire / Wellpoint

15. David F. Lehmann, M.D., Pharm D.
Professor of Medicine and Pharmacology
SUNY Upstate Medical University

16. Jeffrey Dubitsky, R.Ph.
NYC Health & Hospital Corporation

Drug Classes in the Preferred Drug Program

The following table lists each drug class included in the PDP as of the end of the SFY, the date that it was reviewed in the P&TC, the date the PDL was publicly posted, and the date non-preferred drugs within the class required PA.

P&T Meeting	Drug Class	Posting Date	Date PA Required
02-Feb-06	ACE INHIBITORS	30-Mar-06	28-Jun-06
02-Feb-06	ACEI/CCB COMBINATION	30-Mar-06	28-Jun-06
02-Feb-06	ACEI/DIURETIC COMBINATION	30-Mar-06	28-Jun-06
02-Feb-06	ANGIOTENSIN RECEPTOR BLOCKERS	30-Mar-06	28-Jun-06
02-Feb-06	ARB/DIURETIC COMBINATION	30-Mar-06	28-Jun-06
09-Mar-06	BETA BLOCKERS	27-Apr-06	28-Jun-06
09-Mar-06	BONE OSSIFICATION SUPRESSION AGENTS	27-Apr-06	28-Jun-06
09-Mar-06	CALCIUM CHANNEL BLOCKERS: DIHYDROPYRIDINE	27-Apr-06	28-Jun-06
30-Mar-06	CALCITONINS	12-May-06	18-Oct-06
30-Mar-06	CCB/STATIN COMBINATION	12-May-06	18-Oct-06
30-Mar-06	STATINS: HIGHER POTENCY	12-May-06	18-Oct-06
30-Mar-06	STATINS: LOWER POTENCY	12-May-06	18-Oct-06
30-Mar-06	STEROIDS: NASAL	12-May-06	18-Oct-06
30-Mar-06	TRIG. LOWERING AGENTS	12-May-06	18-Oct-06
05-May-06	ANTI-EMETICS: ORAL	07-Sep-06	18-Oct-06
05-May-06	BETA BLOCKER/DIURETIC COMBINATIONS	07-Sep-06	18-Oct-06
05-May-06	OPIATES: LONG ACTING	07-Sep-06	18-Oct-06
05-May-06	SEDATIVE HYPNOTICS	07-Sep-06	18-Oct-06
05-May-06	SEROTONIN RECEPTOR AGONISTS	07-Sep-06	18-Oct-06
09-Jun-06	ANTIHISTAMINES: LOW SED/DECONGESTANT COMB	07-Sep-06	18-Oct-06
09-Jun-06	ANTIHISTAMINES: LOW SEDATING	07-Sep-06	18-Oct-06
09-Jun-06	ANTIVIRALS: HEPATITIS C	07-Sep-06	18-Oct-06
09-Jun-06	LEUKOTRIENE MODIFIERS	07-Sep-06	18-Oct-06
09-Jun-06	PROTON PUMP INHIBITORS	07-Sep-06	18-Oct-06
09-Jun-06	THIAZOLIDINEDIONE/SULFONYLUREA COMB	07-Sep-06	18-Oct-06
09-Jun-06	THIAZOLIDINEDIONES	07-Sep-06	18-Oct-06
09-Jun-06	THIAZOLIDINEDIONES/METFORMIN COMBINATIONS	07-Sep-06	18-Oct-06
19-Sep-06	ADVAIR	17-Nov-06	01-Feb-07
19-Sep-06	ANTICHOLINERGICS: RESPIRATORY	17-Nov-06	01-Feb-07
19-Sep-06	BETA AGONISTS: LONG-ACTING	17-Nov-06	01-Feb-07
19-Sep-06	BETA AGONISTS: NEBULIZERS	17-Nov-06	01-Feb-07
19-Sep-06	BETA AGONISTS: SHORT-ACTING	17-Nov-06	01-Feb-07
19-Sep-06	IMMUNOMODULATORS: TOPICAL	17-Nov-06	01-Feb-07
19-Sep-06	PHOSPHATE REGULATORS	17-Nov-06	01-Feb-07
19-Sep-06	STEROIDS: INHALED	17-Nov-06	01-Feb-07
10-Nov-06	ANTIFUNGALS: ONYCHOMYCOSIS	11-Jan-07	01-Feb-07
10-Nov-06	ANTIVIRALS: HERPES	11-Jan-07	01-Feb-07
10-Nov-06	CEPHALOSPORINS: 3RD GEN	11-Jan-07	01-Feb-07
10-Nov-06	QUINOLONES	11-Jan-07	01-Feb-07
08-Dec-06	ANTIHISTAMINES: OPHTHALMIC	16-Jan-07	01-Feb-07
08-Dec-06	IMMUNOMODULATORS: ANTIARTHRITIS	16-Jan-07	01-Feb-07
08-Dec-06	QUINOLONES: OPHTHALMIC	16-Jan-07	01-Feb-07
08-Dec-06	QUINOLONES: OTIC	16-Jan-07	01-Feb-07
08-Dec-06	ZETIA	16-Jan-07	01-Feb-07

NEW YORK STATE MEDICAID
PREFERRED DRUG LIST (as of March 2007)

All non-preferred drugs in these classes require prior authorization

ACE Inhibitors

PREFERRED AGENTS

Altace®
benazepril
captopril
enalapril maleate
lisinopril
Mavik®
moexipril

ACE Inhibitors

NON-PREFERRED AGENTS - PA Required Effective 6/28/06

Accupril®
Aceon®
Capoten®
fosinopril sodium
Lotensin®
Monopril®
Prinivil®
quinapril
Univasc®
Vasotec®
Zestril®

ACE Inhibitors + Calcium Channel Blocker

PREFERRED AGENTS

Lotrel®
Tarka®

ACE Inhibitors + Calcium Channel Blocker

NON-PREFERRED AGENTS - PA Required Effective 6/28/06

Lexxel®

ACE Inhibitors + Diuretic

PREFERRED AGENTS

benazepril/HCTZ
captopril/HCTZ
enalapril maleate/HCTZ
lisinopril/HCTZ
Uniretic®

ACE Inhibitors + Diuretic

NON-PREFERRED AGENTS - PA Required Effective 6/28/06

Accuretic®
Capozide®
fosinopril/HCTZ
Lotensin HCT®
Monopril HCT®
Prinzide®
quinapril/HCTZ
Quinaretic®
Vaseretic®
Zestoretic®

Angiotensin Receptor Blockers

PREFERRED AGENTS

Benicar®
Cozaar®
Diovan®
Micardis®

Angiotensin Receptor Blockers

NON-PREFERRED AGENTS - PA Required Effective 6/28/06

Atacand®
Avapro®
Teveten®

Angiotensin Receptor Blocker + Diuretic

PREFERRED AGENTS

Benicar HCT®
Diovan HCT®
Hyzaar®
Micardis HCT®

Angiotensin Receptor Blocker + Diuretic

NON-PREFERRED AGENTS - PA Required Effective 6/28/06

Atacand HCT®
Avalide®
Teveten HCT®

Anti-Emetics - Oral

PREFERRED AGENTS

Kytril® (tablet, solution)
Zofran® (tablet, solution, ODT)

Anti-Emetics - Oral

NON-PREFERRED AGENTS - PA Required Effective 10/18/06

Anzemet®

CC-Clinical Criteria (Please see: https://newyork.fhsc.com/downloads/providers/NYRx_PDP_clinical_criteria.pdf)
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Anti-Fungals

PREFERRED AGENTS

Fulvicin U/F®
Grifulvin V® (tablet)
Gris-PEG®
griseofulvin (suspension)
Lamisil®

Anti-Fungals

NON-PREFERRED AGENTS - PA Required Effective 2/01/07

Grifulvin V® (suspension)
itraconazole (capsule)
Penlac®
Sporanox® (capsule, solution)

Antihistamines - Second Generation

PREFERRED AGENTS

OTC loratadine

OTC loratadine-D

Antihistamines - Second Generation CC

NON-PREFERRED AGENTS - PA Required Effective 10/18/06

Allegra® (tablet, capsule, suspension)
Allegra-D®
Clarinex®
Clarinex-D®
fexofenadine
Semprex-D®
Zyrtec® CC
Zyrtec-D®

Anti-Virals

PREFERRED AGENTS

acyclovir (tablet, capsule, suspension)
Famvir®
Valtrex®

Anti-Virals

NON-PREFERRED AGENTS - PA Required Effective 2/01/07

Zovirax® (tablet, capsule, suspension)

Beta Blockers

PREFERRED AGENTS

acebutolol
atenolol
betaxolol
bisoprolol fumarate
labetalol
metoprolol tartrate
nadolol
pindolol
propranolol
timolol maleate

Beta Blockers CC

NON-PREFERRED AGENTS - PA Required Effective 6/28/06

Blocadren®
Coreg® CC
Coreg CR® CC
Corgard®
Inderal LA®
Inderal®
InnoPran XL®
Kerlone®
Levatol®
Lopressor®
Sectral®
Tenormin®
Toprol XL® CC
Trandate®
Zebeta®

Beta Blocker + Diuretic

PREFERRED AGENTS

atenolol/chlorthalidone
bisoprolol fumarate/HCTZ
metoprolol tartrate/HCTZ
propranolol/HCTZ

Beta Blocker + Diuretic

NON-PREFERRED AGENTS - PA Required Effective 10/18/06

Corzide®
Inderide®
Inderide LA®
Lopressor HCT®
Tenoretic®
Timolide®
Ziac®

Bisphosphonates - Oral

PREFERRED AGENTS

Fosamax® (tablet, solution)
Fosamax® Plus D

Bisphosphonates - Oral

NON-PREFERRED AGENTS - PA Required Effective 6/28/06

Actonel®
Actonel® with Calcium
Boniva®

CC-Clinical Criteria (Please see: https://newyork.fhsc.com/downloads/providers/NYRx_PDP_clinical_criteria.pdf)

Calcitonins - Nasal

PREFERRED AGENTS

Miacalcin®

Calcitonins - Nasal

NON-PREFERRED AGENTS - PA Required Effective 10/18/06

Fortical®

Calcium Channel Blockers (DHP)

PREFERRED AGENTS

Afeditab CR®
Dynacirc®
Dynacirc CR®
felodipine ER
isradipine
nicardipine HCl
Nifediac CC®
Nifedical XL®
nifedipine
nifedipine ER
nifedipine SA
Norvasc®
Sular®

Calcium Channel Blockers (DHP)

NON-PREFERRED AGENTS - PA Required Effective 6/28/06

Adalat CC®
Cardene®
Cardene SR®
Plendil®
Procardia®
Procardia XL®

Cephalosporins – Third Generation

PREFERRED AGENTS

Cedax® (capsule, suspension)
cefpodoxime proxetil (tablet)
Omnicef® (capsule, suspension)
Suprax®

Cephalosporins – Third Generation

NON-PREFERRED AGENTS - PA Required Effective 2/01/07

Spectracef®
Vantin® (tablet, suspension)

Cholesterol Absorption Inhibitors (CAIs)

PREFERRED AGENTS

Zetia®

Cholesterol Absorption Inhibitors (CAIs)

NON-PREFERRED AGENTS - PA Required Effective 5/01/07

None

Fluoroquinolones (Oral)

PREFERRED AGENTS

Avelox®
Avelox ABC Pack®
ciprofloxacin (tablet, suspension)
ofloxacin

Fluoroquinolones (Oral)

NON-PREFERRED AGENTS - PA Required Effective 2/01/07

Cipro® (tablet, suspension)
Cipro XR®
Factive®
Floxin®
Levaquin® (tablet, solution)
Maxaquin®
Noroxin®
Proquin XR®
Tequin®

Hepatitis C Agents

PREFERRED AGENTS

PEG-Intron®
PEG-Intron Redipen®
Pegasys®
Pegasys Convenience Pack®

Hepatitis C Agents

NON-PREFERRED AGENTS - PA Required Effective 10/18/06

None

HMG-CoA Reductase Inhibitors (Statins)

PREFERRED AGENTS

Advicor®
Altoprev®
Crestor®
Lescol®
Lescol XL®
Lipitor®
Vytorin®
Zocor®

HMG-CoA Reductase Inhibitors (Statins)

NON-PREFERRED AGENTS - PA Required Effective 10/18/06

Caduet®
lovastatin
Mevacor®
Pravachol®
pravastatin
PravigardPAC®

Immunomodulators (Injectable)

PREFERRED AGENTS

Enbrel®
Humira®

Immunomodulators (Injectable)

NON-PREFERRED AGENTS - PA Required Effective 5/01/07

Kineret®

Immunomodulators (Topical)

PREFERRED AGENTS

Elidel®
Protopic®

Immunomodulators (Topical)

NON-PREFERRED AGENTS - PA Required Effective 2/01/07

None

Inhaled Anticholinergics

PREFERRED AGENTS

Atrovent®
Atrovent HFA®
Combivent®
ipratropium
Spiriva®

Inhaled Anticholinergics

NON-PREFERRED AGENTS - PA Required Effective 2/01/07

Duoneb®

Inhaled $beta_2$ Adrenergic Agents – Long Acting

PREFERRED AGENTS

Foradil®
Serevent Diskus®

Inhaled $beta_2$ Adrenergic Agents – Long Acting

NON-PREFERRED AGENTS - PA Required Effective 2/01/07

None

Inhaled $beta_2$ Adrenergic Agents – Short Acting

PREFERRED AGENTS

albuterol
Maxair Autohaler®
Proventil HFA®
Ventolin HFA®
Xopenex®
Xopenex HFA®

Inhaled $beta_2$ Adrenergic Agents – Short Acting

NON-PREFERRED AGENTS - PA Required Effective 2/01/07

Accuneb®
Alupent®
metaproterenol
ProAir HFA®
Proventil®

Inhaled Corticosteroids

PREFERRED AGENTS

Advair Diskus®
Advair HFA®
Asmanex®
Azmacort®
Flovent HFA®
Qvar®

Inhaled Corticosteroids CC

NON-PREFERRED AGENTS - PA Required Effective 2/01/07

Aerobid®
Aerobid-M®
Pulmicort Turbuhaler® CC

Leukotriene Modifiers

PREFERRED AGENTS

Accolate®
Singulair®

Leukotriene Modifiers

NON-PREFERRED AGENTS - PA Required Effective 10/18/06

None

CC-Clinical Criteria (Please see: https://newyork.fhsc.com/downloads/providers/NYRx_PDP_clinical_criteria.pdf)
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Narcotics - Long Acting

PREFERRED AGENTS

Duragesic®
fentanyl patch
Kadian®
morphine sulfate SR
Oramorph SR®

Narcotics - Long Acting

NON-PREFERRED AGENTS - PA Required Effective 10/18/06

Avinza®
MS Contin®
Opana ER®
oxycodone HCL CR
Oxycontin®

Ophthalmic Antihistamines

PREFERRED AGENTS

Patanol®

Ophthalmic Antihistamines

NON-PREFERRED AGENTS - PA Required Effective 5/01/07

Elestat®
Emadine®
ketotifen
Optivar®
Zaditor®

Ophthalmic Quinolones

PREFERRED AGENTS

ciprofloxacin
ofloxacin
Vigamox®

Ophthalmic Quinolones

NON-PREFERRED AGENTS - PA Required Effective 5/01/07

Ciloxan® (solution, ointment)
Ocuflox®
Quixin®
Zymar®

Otic Quinolones

PREFERRED AGENTS

Ciprodex®
Floxin®

Otic Quinolones

NON-PREFERRED AGENTS - PA Required Effective 5/01/07

Cipro HC®

Phosphate Binders/Regulators

PREFERRED AGENTS

Fosrenol®
Phoslo®
Renagel®

Phosphate Binders/Regulators

NON-PREFERRED AGENTS - PA Required Effective 2/01/07

None

Proton Pump Inhibitors

PREFERRED AGENTS

Nexium®
Prevacid® (capsule)
Prilosec® OTC

Proton Pump Inhibitors

NON-PREFERRED AGENTS - PA Required Effective 10/18/06

Aciphex®
omeprazole
Prevacid NapraPAC®
Prevacid® (solutab, suspension)
Prilosec®
Protonix®
Zegerid® (capsule, packet)

Sedative Hypnotics / Sleep Agents

PREFERRED AGENTS

Ambien CR®
chloral hydrate
estazolam
flurazepam
temazepam
triazolam

Sedative Hypnotics / Sleep Agents

NON-PREFERRED AGENTS - PA Required Effective 10/18/06

Ambien®
Dalmane®
Doral®
Halcion®
Lunesta®
Prosom®
Restoril®
Rozerem®
Somnote®
Sonata®

CC-Clinical Criteria (Please see: https://newyork.fhsc.com/downloads/providers/NYRx_PDP_clinical_criteria.pdf)
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Serotonin Receptor Agonists (Triptans)

PREFERRED AGENTS

Imitrex® (tablet, nasal, injection)
Maxalt® (tablet, MLT)

Serotonin Receptor Agonists (Triptans)

NON-PREFERRED AGENTS - PA Required Effective 10/18/06

Amerge®
Axert®
Frova®
Relpax®
Zomig® (tablet, nasal, ZMT)

Steroids - Intranasal

PREFERRED AGENTS

Nasacort AQ®
Nasonex®

Steroids - Intranasal

NON-PREFERRED AGENTS - PA Required Effective 10/18/06

Beconase AQ®
Flonase®
flunisolide
fluticasone
Nasarel®
Rhinocort Aqua®

Thiazolidinediones

PREFERRED AGENTS

Actos®
Actoplus met®
Avandia®
Avandamet®
Avandaryl®

Thiazolidinediones

NON-PREFERRED AGENTS - PA Required Effective 10/18/06

Duetact®

Triglyceride Lowering Agents

PREFERRED AGENTS

gemfibrozil
Lofibra®

Triglyceride Lowering Agents

NON-PREFERRED AGENTS - PA Required Effective 10/18/06

Antara®
fenofibrate
Lopid®
Omacor®
Tricor®
Triglide®

CC-Clinical Criteria (Please see: https://newyork.fhsc.com/downloads/providers/NYRx_PDP_clinical_criteria.pdf)
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NYS MEDICAID
PREFERRED DRUG
QUICK LIST

These drugs are preferred and do not require prior authorization

ACE Inhibitors

PREFERRED AGENTS	
Altace®	lisinopril
benazepril	Mavik®
captopril	moexipril
enalapril maleate	

ACE Inhibitors + Calcium Channel Blocker

PREFERRED AGENTS
Lotrel®
Tarka®

ACE Inhibitors + Diuretic

PREFERRED AGENTS	
benazepril/HCTZ	lisinopril/HCTZ
captopril/HCTZ	Uniretic®
enalapril maleate/HCTZ	

Angiotensin Receptor Blockers

PREFERRED AGENTS	
Benicar®	Diovan®
Cozaar®	Micardis®

Angiotensin Receptor Blockers + Diuretic

PREFERRED AGENTS	
Benicar HCT®	Hyzaar®
Diovan HCT®	Micardis HCT®

Anti-Emetics- Oral

PREFERRED AGENTS
Kytril® (tablet, solution)
Zofran® (tablet, solution, ODT)

Anti-Fungals

PREFERRED AGENTS
Fulvicin U/F®
Grifulvin V® (tablet)
Gris-PEG®
griseofulvin (suspension)
Lamisil®

Antihistamines-Second Generation

PREFERRED AGENTS
OTC loratadine
OTC loratadine-D

Anti-Virals

PREFERRED AGENTS
acyclovir (tablet, capsule, suspension)
Famvir®
Valtrex®

Beta Blockers

PREFERRED AGENTS	
acebutolol	metoprolol tartrate
atenolol	nadolol
betaxolol	pindolol
bisoprolol fumarate	propranolol
labetalol	timolol maleate

Beta Blockers + Diuretic

PREFERRED AGENTS
atenolol/chlorthalidone
bisoprolol fumarate/HCTZ
metoprolol tartrate/HCTZ
propranolol/HCTZ

Bisphosphonates- Oral

PREFERRED AGENTS
Fosamax® (tablet, solution)
Fosamax® Plus D

Calcitonins- Nasal

PREFERRED AGENTS
Miacalcin®

Calcium Channel Blockers (DHP)

PREFERRED AGENTS	
Afeditab CR®	Nifedical XL®
Dynacirc®	nifedipine
Dynacirc CR®	nifedipine ER
felodipine ER	nifedipine SA
isradipine	Norvasc®
nicardipine HCl	Sular®
Nifediac CC®	

Cephalosporins – Third Generation

PREFERRED AGENTS
Cedax® (capsule, suspension)
cefpodoxime proxetil (tablet)
Omnicef® (capsule, suspension)
Suprax®

Cholesterol Absorption Inhibitors (CAIs)

PREFERRED AGENTS
Zetia®

Fluoroquinolones (Oral)

PREFERRED AGENTS
Avelox®
Avelox ABC Pack®
ciprofloxacin (tablet, suspension)
ofloxacin

Hepatitis C Agents

PREFERRED AGENTS
PEG-Intron®
PEG-Intron Redipen®
Pegasys®
Pegasys Convenience Pack®

HMG-CoA Reductase Inhibitors (Statins)

PREFERRED AGENTS	
Advicor®	Lescol XL®
Altoprev®	Lipitor®
Crestor®	Vytorin®
Lescol®	Zocor®

Immunomodulators (Injectable)

PREFERRED AGENTS
Enbrel®
Humira®

Immunomodulators (Topical)

PREFERRED AGENTS
Elidel®
Protopic®

Inhaled Anticholinergics

PREFERRED AGENTS	
Atrovent®	ipratropium
Atrovent HFA®	Spiriva®
Combivent®	

Inhaled $beta_2$ Adrenergic Agents – Long Acting

PREFERRED AGENTS
Foradil®
Serevent Diskus®

Inhaled $beta_2$ Adrenergic Agents – Short Acting

PREFERRED AGENTS	
albuterol	Ventolin HFA®
Maxair Autohaler®	Xopenex®
Proventil HFA®	Xopenex HFA®

Inhaled Corticosteroids

PREFERRED AGENTS	
Advair Diskus®	Azmacort®
Advair HFA®	Flovent HFA®
Asmanex®	Qvar®

Leukotriene Modifiers

PREFERRED AGENTS
Accolate®
Singulair®

Narcotics- Long Acting

PREFERRED AGENTS	
Duragesic®	morphine sulfate SR
fentanyl patch	Oramorph SR®
Kadian®	

Ophthalmic Antihistamines

PREFERRED AGENTS
Patanol®

Ophthalmic Quinolones

PREFERRED AGENTS
ciprofloxacin
ofloxacin
Vigamox®

Otic Quinolones

PREFERRED AGENTS
Ciprodex®
Floxin®

Phosphate Binders/Regulators

PREFERRED AGENTS
Fosrenol®
Phoslo®
Renagel®

Proton Pump Inhibitors

PREFERRED AGENTS
Nexium®
Prevacid® (capsule)
Prilosec® OTC

Sedative Hypnotics / Sleep Agents

PREFERRED AGENTS	
Ambien CR®	flurazepam
chloral hydrate	temazepam
estazolam	triazolam

Serotonin Receptor Agonists (Triptans)

PREFERRED AGENTS
Imitrex® (tablet, nasal, injection)
Maxalt® (tablet, MLT)

Steroids - Intranasal

PREFERRED AGENTS
Nasacort AQ®
Nasonex®

Thiazolidinediones

PREFERRED AGENTS	
Actos®	Avandamet®
Actoplus met®	Avandaryl®
Avandia®	

Triglyceride Lowering Agents

PREFERRED AGENTS
gemfibrozil
Lofibra®

Contacted Organizations/Societies

The following organizations/societies have been contacted and given information regarding the Medicaid PDP:

- AARP (American Association of Retired People)
- American Heart Association
- CAIPA (Chinese American Independent Practice Association)
- CHCANYS (Community Health Care Association of New York State)
- GNYHA (Greater New York Healthcare Association)
- HANYS (Healthcare Association of New York State)
- HHCNYC (NYC Health and Hospital Corporation)
- Lupus Foundation of America
- MGMA (Medical Group Management Association)
- MSSNY (Medical Society of State of New York)
- NACDS (National Association of Chain Drugstores)
- NAMINYS (National Alliance on Mental Illness)
- National Association for Continence
- NPA (Nurse Practitioners Association)
- NYAAC (New York Association of Ambulatory Care)
- NYS Dental Association
- NYSAC (New York State Association of Counties)
- NYPWA (New York Public Welfare Association)
- NYSAFP (New York State Academy of Family Physicians)
- NYSHFA (New York State Health Facilities Association)
- NYSHPA (New York State Health Plan Association)
- NYSOMS (New York State Osteopathic Medical Society)
- OASAS (Office of Alcohol and Substance Abuse Services)
- OMH (Office of Mental Health)
- OMRDD (Office of Mental Retardation and Developmental Disabilities)
- PSSNY (Pharmacy Society of State of New York)

REMEMBER:

- All drugs that Medicaid currently covers are still available.
- Only your doctor can decide which drugs you should take.
- Ask your doctor or pharmacist if you have questions about your medicine.

Need help?

Call the Medicaid Helpline:

1-800-541-2831

DOH

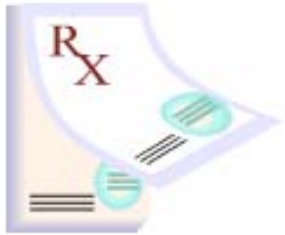
Richard F. Daines, M.D.
Commissioner

NYS Department of Health
Office of Health Insurance Programs
The Governor Nelson A. Rockefeller
Empire State Plaza
Corning Tower
Albany, New York 12237

Medicaid Helpline: 1-800-541-2831
Fax: (518) 473-5508

NYS Medicaid Preferred Drug Program
Website: https://newyork.fhsc.com

The Medicaid Preferred Drug Program



A Guide for People with NYS Medicaid

THE NYS MEDICAID PREFERRED DRUG PROGRAM

What is the Medicaid Preferred Drug Program (PDP)?
This program encourages doctors to prescribe certain drugs, called "preferred" drugs. When they prescribe other similar drugs which are not included on the preferred drug list, they need to get special approval (prior authorization) before you can receive the drug.

Will this program affect all of my prescriptions?
Probably not. There are only a limited number of types of drugs that are included in the list of preferred drugs. There is no change for all other types of drugs. If you are already taking a preferred drug, your doctor does not have to make any changes.

What if I take a medicine that is not "preferred"?
If you are taking a drug now that is not on the preferred drug list, you can continue to get that drug until the refills on your current prescription run out. When you get a new prescription, your doctor may either change your medicine to one that is on the preferred drug list or request prior authorization to continue your current drug.

Who decides which drugs are "preferred"?
A committee made up of doctors, pharmacists, and patient advocates works with the Department of Health to review drugs and identify those that are safe, effective and less expensive. Preferred drugs have been found to be as effective as non-preferred drugs.

What if I don't want to change my medications?
Only your doctor can decide which drugs you should take. Ask your doctor or pharmacist if you have questions about changes made to your prescriptions.

What if I need my medication and the doctor's office is closed?
If your doctor cannot be contacted, and you have a valid prescription, the pharmacist can give you a 72-hour emergency supply of medicine until your doctor can be contacted.

Will I still have a co-pay?
Yes, Medicaid co-payments for prescriptions have not changed. Brand name drug co-pays remain at $3.00 and generic drug co-pays are still $1.00.

Preferred Drug Program Website Information

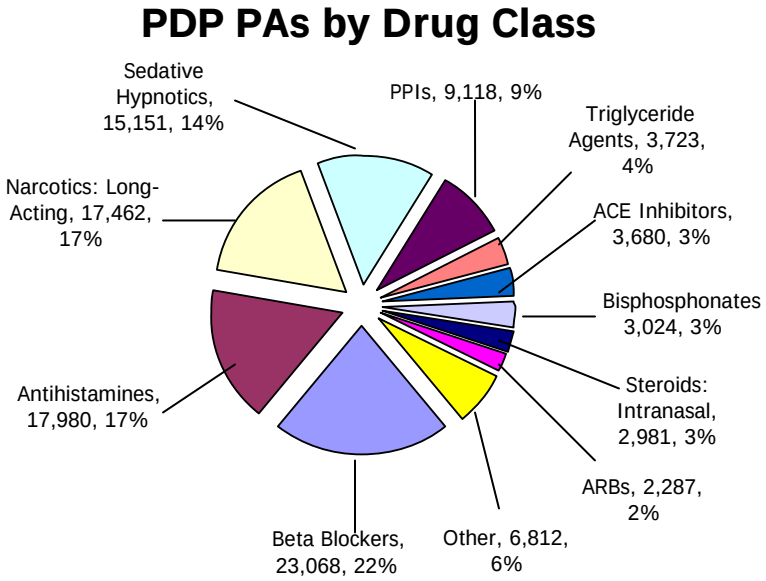
- Information about the NYS PDP can be accessed on the Internet at: https://newyork.fhsc.com/ or http://www.health.state.ny.us/

- The current Quick List can be accessed at: https://newyork.fhsc.com/downloads/providers/NYRx_PDP_PDLquicklist.pdf

- The complete current Preferred Drug List can be accessed at: https://newyork.fhsc.com/downloads/providers/NYRx_PDP_PDL.pdf

- Clinical criteria can be accessed at: https://newyork.fhsc.com/downloads/providers/NYRx_PDP_clinical_criteria.pdf

PDP Prior Authorizations by Class & Claim Volume



Total PDP Pas = 105,286

Of the 105,286 PAs issued in SFY 06/07, the following PDP drug classes are ranked by the number of PAs requested

1. Beta Blockers: 23,068
2. Antihistamines: 17,980
3. Narcotics: Long-Acting: 17,462
4. Sedative Hypnotics: 15,151
5. PPIs: 9,118
6. Triglyceride Agents: 3,723
7. ACE Inhibitors: 3,680
8. Bisphosphonates: 3,024
9. Steroids: Intranasal: 2,981
10. ARBs: 2,287
11. Statins: 1,941
12. ARB/Diuretic Combinations: 1,429
13. Triptans: 1,377
14. Fluoroquinolones: 647
15. ACE Inhibitor/Diuretic Combinations: 303
16. Antifungals: 216
17. Inhaled Corticosteroids: 198
18. Inhaled. Short Acting Beta-2 Adrenergic: 191
19. Calcium Channel Blockers (DHP): 138
20. Inhaled Anticholinergics: 134
21. Antiemetics: 63
22. Cephalosporins: Third Generation: 59
23. Beta Blocker/Diuretic Combinations: 58
24. Calcitonin: 20
25. Thiazolidinediones: 15
26. ACE Inhibitor/CCB Combinations: 14
27. Antivirals: 9
28. Hepatitis C Agents: 0
29. Leukotriene Modifiers: 0

PDP and CDRP Total Cost Avoidance by County

County	CDRP	PDP	Total	% Total
Albany	$23,640	$568,867	$592,508	0.70%
Allegany	$4,298	$184,858	$189,156	0.22%
Broome	$10,746	$524,491	$535,236	0.63%
Cattaraugus	$8,596	$282,871	$291,467	0.35%
Cayuga	$6,447	$200,966	$207,413	0.25%
Chautauqua	$8,596	$549,196	$557,792	0.66%
Chemung	$0	$294,938	$294,938	0.35%
Chenango	$0	$166,591	$166,591	0.20%
Clinton	$12,895	$310,901	$323,795	0.38%
Columbia	$0	$121,737	$121,737	0.14%
Cortland	$0	$138,150	$138,150	0.16%
Delaware	$8,596	$100,927	$109,523	0.13%
Dutchess	$19,342	$344,812	$364,154	0.43%
Erie	$40,833	$2,913,591	$2,954,424	3.50%
Essex	$0	$102,172	$102,172	0.12%
Franklin	$2,149	$179,785	$181,934	0.22%
Fulton	$10,746	$191,203	$201,949	0.24%
Genesee	$0	$133,143	$133,143	0.16%
Green	$4,298	$128,281	$132,580	0.16%
Hamilton	$0	$8,822	$8,822	0.01%
Herkimer	$2,149	$176,764	$178,913	0.21%
Jefferson	$12,895	$384,473	$397,368	0.47%
Lewis	$0	$75,692	$75,692	0.09%
Livingston	$10,746	$133,328	$144,074	0.17%
Madison	$0	$142,575	$142,575	0.17%
Monroe	$77,368	$2,234,166	$2,311,534	2.74%
Montgomery	$2,149	$151,264	$153,413	0.18%
Nassau	$49,429	$1,479,156	$1,528,585	1.81%
Niagara	$6,447	$613,098	$619,546	0.73%
Oneida	$21,491	$776,020	$797,511	0.95%
Onondaga	$27,938	$1,166,229	$1,194,167	1.42%
Ontario	$4,298	$170,764	$175,062	0.21%
Orange	$49,429	$647,950	$697,380	0.83%
Orleans	$2,149	$101,987	$104,136	0.12%
Oswego	$4,298	$371,491	$375,789	0.45%
Otsego	$0	$128,136	$128,136	0.15%
Putnam	$0	$53,053	$53,053	0.06%
Rensselaer	$6,447	$346,680	$353,127	0.42%
Rockland	$23,640	$458,045	$481,685	0.57%

County	CDRP	PDP	Total	% Total
St. Lawrence	$6,447	$440,692	$447,139	0.53%
Saratoga	$4,298	$249,462	$253,761	0.30%
Schenectady	$10,746	$353,714	$364,460	0.43%
Schoharie	$6,447	$61,240	$67,687	0.08%
Schuyler	$0	$49,887	$49,887	0.06%
Seneca	$0	$69,400	$69,400	0.08%
Steuben	$2,149	$349,223	$351,373	0.42%
Suffolk	$88,113	$1,626,565	$1,714,679	2.03%
Sullivan	$2,149	$231,897	$234,046	0.28%
Tioga	$2,149	$121,234	$123,383	0.15%
Tompkins	$0	$151,092	$151,092	0.18%
Ulster	$6,447	$332,864	$339,311	0.40%
Warren	$2,149	$127,857	$130,007	0.15%
Washington	$2,149	$149,397	$151,546	0.18%
Wayne	$0	$179,109	$179,109	0.21%
Westchester	$27,938	$1,623,042	$1,650,980	1.96%
Wyoming	$0	$68,472	$68,472	0.08%
Yates	$6,447	$61,213	$67,660	0.08%
Total for above counties:	**$629,688**	**$23,303,534**	**$23,933,222**	**28.38%**
New York City	$1,212,095	$58,571,923	$59,784,017	70.89%
OMH	$0	$140,071	$140,071	0.17%
OMR	$4,298	$441,447	$445,745	0.53%
NYS DOH	$4,298	$29,553	$33,852	0.04%