NEW YORK STATE MEDICAID
PREFERRED DRUG PROGRAM

ANNUAL REPORT
TO THE
GOVERNOR AND LEGISLATURE

STATE FISCAL YEAR
APRIL 1, 2008 – MARCH 31, 2009

New York State Medicaid Preferred Drug Program
Annual Report to the Governor and Legislature
State Fiscal Year April 1, 2008 – March 31, 2009

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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
FHPlus	Family Health Plus
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 New York State 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. Effective October 1, 2008, the population eligible for the Preferred Drug Program was expanded to include Family Health Plus (FHPlus) enrollees. The pharmacy benefit for FHPlus enrollees was "carved-out" of the managed care plan benefit package and moved under the administration of the Medicaid fee-for-service program, whereby prescriptions for FHPlus enrollees became subject to Medicaid's PDP, CDRP, and Mandatory Generic Drug Program (MGDP). As required by 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 are posted on the DOH web site thirty (30) days prior to the meeting. The meetings are held in a public forum and webcast to increase public awareness of the process.

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 08/09, the P&TC heard testimony from 85 interested parties.

Prior authorization activities are conducted by the CCC. The CCC is available 24 hours a day, seven 7 days a week and is staffed by certified pharmacy technicians (CPT), pharmacists and a physician for peer reviews. In SFY 08/09, the CCC handled 294,070 phone requests and 40,476 fax requests for PAs under the PDP and the CDRP. Almost all phone requests (99.87 percent) were completed during the initial call and 99.96 percent of all faxed requests were responded to within 24 hours of receipt. In addition, the CCC provided more than 50,000 callers with general information or technical assistance, and identified and referred 52 potential instances of fraud and/or abuse.

Prescriber, Pharmacy and Patient Satisfaction

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

The annual independent survey was conducted by Decision Support Systems Research. Five hundred ninety-eight (598) prescribers and six hundred thirteen (613) pharmacists responded to the survey. Results demonstrate that overall satisfaction remains strong, with 84 percent of providers and pharmacists surveyed reporting their satisfaction with the PA process. Outcomes confirmed that the CCC continues to perform well, PAs are typically accomplished in a matter of minutes and the need for follow-up calls continued to decrease this year.

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. Occasionally, the Medicaid Helpline receives calls on this topic, but the volume is minimal. When such calls are received they are referred to the DOH Medicaid pharmacy staff who provides direct assistance. Overall, it is estimated that 54 complaints about the PDP and CDRP were received during SFY 08/09.

Program Expansion

Expansion of the programs and operational enhancements continued in SFY 08/09. The P&TC re-reviewed 42 therapeutic categories already subject to the Preferred Drug List (PDL) to take into consideration drugs within the classes recently approved by the Food and Drug Administration (FDA), newly available clinical information and updated financial information. Twelve (12) new drug classes were reviewed for inclusion in the PDP. By the end of the SFY there were a total of 52 drug classes subject to the PDP. In addition, four (4) new drugs were reviewed and recommended by the PT&C for inclusion to the CDRP. Those drugs were added to the program on 7/30/08.

Program Savings

In SFY 08/09, Medicaid processed over 48 million pharmacy claims. Of these, 30 percent (14,482,703) were for a drug within one of the classes of drugs on the PDP. Of the drugs subject to the PDP, 98.1 percent of claims were for preferred drugs that did not require PA. The remaining 1.9 percent (269,597 claims) was for non-preferred drugs that required PA. The extremely high percentage of prescriptions for preferred drugs is attributed 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. Success is further supported by the pharmacy provider community advising prescribers of preferred drug choices.

The total gross savings attributable to the PDP for SFY 08/09 was $268.6 million. Consistent with last year's experience, the majority of the savings, $171.6 million, resulted from supplemental rebates on preferred drugs. The remaining $97 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®. In SFY 08/09, the program was expanded to include four (4) additional drugs: Actiq®/ Fentanyl Citrate, Fentora®, Byetta® and Lidoderm®. Consistent with legislative guidelines, these additions to the CDRP were recommended by the PT&C and approved by the Commissioner due to their potential for misuse and to assure that the drug was appropriately prescribed for its FDA approved indications. The expansion of CDRP was implemented on July 30, 2008. For SFY 08/09, a combined total of 24,473 PA requests were received for CDRP drugs. 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 for requests that did not meet clinical criteria, 4 percent of the requests would have been denied. This is equivalent to results from last SFY.

Although all CDRP PA requests were approved, results comparing the number and dollar amount of claims paid in the baseline quarter before implementation of the program against the last quarter in SFY 08/09, continue to demonstrate that the program was successful in achieving cost avoidance. As compared to baseline observations, significant reductions in claims and respective payments were achieved during this reporting period for Actiq®/ Fentanyl Citrate , Byetta®, and Serostim® . Lidoderm® reflected the most dramatic reduction in claims/payments, with a 75 percent decrease in claims and a 71 percent decrease in payments as compared to the pre-CDRP baseline experience. Fentora® did not show significant changes from baseline, however did demonstrate a 16.7 percent reduction in claims and a corresponding 10.6 percent decrease in payments from 4th quarter 2008 to 1st quarter 2009 (Q408 to Q109). Zyvox® utilization reflected a prior decrease from baseline as compared to Q408, however comparisons with the last quarter of this SFY against baseline reflected an 8 percent increase in total paid. This is most likely attributed to an overall increased awareness and improved testing for use in treating Methicillin-resistant staphylococcus aureus (MRSA) and relative increases in cost per claim.

Revatio® was not available for outpatient pharmacy reimbursement by Medicaid prior to implementation of the CDRP and therefore a comparison could not be made. However,

review of PA requests this SFY reflect that 97 percent of all requests either met the clinical criteria established or were determined to be clinically justified (specifically off-label use supported in one or more of the official drug compendia) after discussion with the prescriber. This suggests that prescribers are using this drug consistent with approved clinical practices.

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 SFY is estimated to be $ 22,918,665 (gross).

Conclusion

The PDP and CDRP programs continue to be successful as a result of:

- a transparent process for determining the selection of drugs for the PDP and CDRP;
- the responsiveness of the program's CCC, including provider's satisfaction with the PA process and ease of use;
- continued patient access to medically necessary medications;
- ongoing, extensive provider education and outreach efforts;
- careful monitoring of the program; and
- achieving cost savings and cost avoidance.

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I. Background

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 Pharmacy and Therapeutics Committee (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 (CCC) that supports the Medicaid PDP, CDRP, and Mandatory Generic Drug Program (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).

Effective October 1, 2008, the pharmacy benefit for Family Health Plus (FHP) enrollees was "carved-out" of the managed care plan benefit package and incorporated in the Medicaid fee-for-service program. Pharmacy benefits for FHPlus enrollees became subject to Medicaid's PDP, CDRP and MGDP requirements.

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 New York State Department of Health (DOH) works with the 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 in the PDP, 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 web site (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.

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 through overuse and misuse. PA was obtained using an automated voice interactive phone system (VIPS). Legislation required that these drugs be transitioned to the CDRP. With that transition in October 2006, the PA process was changed from the VIPS process to the staffed CCC, 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 of Health.

- 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 CDRP:

- Revatio® (sildenafil)- 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.
- Byetta® (exenatide injection) - a synthetic peptide with incretin-mimetic actions. It was approved by the FDA as adjunctive therapy in patients with type 2 diabetes mellitus (DM) who are taking metformin, a sulfonylurea, a thiazolidinedione (TZD), or a combination of metformin and a sulfonylurea or a TZD, but have not achieved adequate glycemic control. Byetta® improves glycemic control by reducing fasting and postprandial glucose concentrations. Prior authorization for Byetta® was implemented to assure that the drug was appropriately prescribed for its FDA-approved indications and to deter misutilization.
- Actiq® (fentanyl citrate transmucosal lozenge) and Fentora® (fentanyl citrate buccal tablet) – FDA-approved for the treatment of breakthrough pain in patients with cancer who are already receiving and who are tolerant to opioid therapy for their underlying cancer pain. Prior authorization for fentanyl citrate transmucosal lozenge and buccal tablet was implemented to deter fraud, abuse and misutilization.
    - Actiq® (Fentanyl citrate transmucosal lozenge) - Actiq® is available in an oral transmucosal, solid drug matrix dosage form. The unit, which is sometimes referred to as a lozenge, is placed between the cheek and lower gum and moved from one side to the other.
    - Fentora® (fentanyl citrate buccal tablet) - Fentora® is available as a buccal tablet. The tablet should be placed in the buccal cavity located above the rear molar, between the upper cheek and gum and allowed to dissolve.
- Lidoderm® (lidocaine patch 5%) - a transdermal system FDA-approved for the relief of pain associated with post-herpetic neuralgia (PHN). PA for Lidoderm® was implemented to assure that the drug was appropriately prescribed for its one FDA-approved indication and to deter misutilization.

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 lists P & TC members.

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 are posted on the DOH web site 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 meetings are webcast and all webcasts are available on-demand for a minimum of 30 days.

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 web site, 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 of Health who makes the final determination.

The Commissioner of Health final determination is posted to the DOH web site 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 08/09 appears in Appendix 3.

D. The Prior Authorization (PA) Process

The (CCC) operated by FHSC is the single point of entry for Medicaid's pharmacy PA programs. The CCC is available 24 hours a day, 7 days a week. Performance is

monitored closely by DOH 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 08/09, the CCC received approximately 294,070 phone requests and 40,476 fax requests for PA under the PDP and CDRP. The significant increases in volume observed as compared to last year can be directly related to the increase in population served under the programs and the expansion of both the PDP and the CDRP. Performance remains consistent with the last SFY. Nearly all phone requests (99.87 percent) were completed during the initial call, and 99.96 percent of all faxed requests were responded to within 24 hours of receipt. In addition, the CCC provided more than 50,000 callers with general information or technical assistance with the PA process and identified and referred 52 potential instances of fraud and/or abuse to DOH.

The CCC can authorize an emergency 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. 48 emergency supply authorizations were processed in SFY 08/09.

I. PDP Prior Authorization (PA) 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.

Prescribers initially speak with a Certified Pharmacy Technician (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 1.3 percent of the PDP PAs processed in SFY 08/09.

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

II. CDRP Prior Authorization Process

Initially, the prescriber speaks with a CPT when requesting authorization. For select CDRP medications, only the prescriber who orders a CDRP drug can initiate the PA process. 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. In SFY 08/09, there were fourteen (14) physician peer reviews completed, however, consistent with last year, there were no denials rendered. 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 continued to play an important role in the ongoing success 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.

During the SFY 08/09, changes to the PDP occurred through the re-review of existing drug classes and addition of new drug classes. With each change, prescribers and pharmacies were notified in advance of the revised PDL 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 web site postings (newyork.fhsc.com). Presentations and teleconferences were also held with various prescriber and pharmacy organizations throughout the period. Organizations contacted are listed in Appendix 6.

In addition to general notices alerting prescribers and pharmacies to upcoming changes, individualized letters were sent to prescribers impacted by changes or additions to PA requirements as a result of changes to the PDL.

Enrollee outreach efforts focused on providing information about how the programs might affect prescription coverage requirements. With the addition of FHPlus, targeted initiatives, including provider email blasts, telecom and web site notices and outreach to managed care organizations were enacted to facilitate a smooth transition. Revised informational program brochures were provided to pharmacies, teaching and non-teaching hospitals, clinics and high volume prescribers for distribution to beneficiaries. Copies of the program brochures are included in Appendix 7. In addition, brochures

were translated into a number of alternative languages including Bosnian, Chinese, Yiddish, Russian, and Creole in order to effectively meet the needs of Medicaid enrollees. The PDP web site is another venue for access to information, offering 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 is obtained through two key sources: a satisfaction survey of prescribers and pharmacies and complaints. This information is used to address program performance and identify opportunities for improvement.

A. Provider Satisfaction Survey

Using an independent third party vendor, Decision Support Systems Research, a satisfaction survey was sent to 2,000 prescribers and 1,000 pharmacists who utilized the CCC. Five hundred ninety-eight (598) prescribers and six hundred thirteen (613) pharmacists responded.

Survey results demonstrated that the majority of prescribers and pharmacists (84percent) were satisfied with the program, with pharmacist satisfaction increasing significantly this year (84.4 percent as compared to 79.6 percent last year). Responses continued to support that PAs are typically accomplished in a matter of minutes. Ratings for accessibility to CCC representatives remained high.

Pharmacy comments indicated a strong desire to eliminate the pharmacy validation step completely. DOH continues to work towards this capability.

Opportunities for improvement were identified in the ability to reach a representative and promptness reaching a representative. Consistent with last year's survey results, those with more complicated calls tended to be less satisfied. As a result of this feedback, phone messaging will be revised to reduce access time and improve provider navigation within the phone system. Web site information will also be posted to assist providers in navigating phone prompts to minimize the time it takes for them to reach their intended party and complete their request. For the SFY 08/09, 95 percent of calls were answered within two minutes, with an average speed of answer of sixteen (16) seconds.

The survey reflected that providers utilize the CCC as the primary source of information about the program, particularly to confirm which drugs are preferred and for PAs.

While website use increased only slightly from last year, there was a significant increase in prescribers reporting that the information was "easily accessed" (87 percent reported easy access via web site this year as compared to 68 percent last year).

B. 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 fifty-four (54) complaints about the PDP and CDRP were received during SFY 08/09, primarily through phone calls and letters.

This year's education efforts focused on ensuring provider's awareness of and easy access to information about the program, particularly for FHPlus providers.

Issues related to policy are individually addressed by the DOH Medicaid pharmacy staff. These inquiries are also used to identify providers who may need additional program education.

Beneficiary reaction to the PDP remains positive. Medicaid's Helpline for beneficiaries receives very few calls about the PDP 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.

V. Outcomes and Cost Savings

A. Preferred Drug Program

Under the Medicaid Drug Rebate Program created by the federal 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's, 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, New York joined the National Medicaid Pooling Initiative (NMPI) administered by FHSC. New York is among thirteen (13) states that currently participate in the pool. Others include Alaska, Georgia, Hawaii, Kentucky, Michigan, Minnesota, Montana, Nevada, New Hampshire, Rhode Island, South Carolina, and the District of Columbia (Washington D.C). The NMPI comprises approximately 5.8 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 the reported Wholesale Acquisition Cost (WAC) for each individual drug. Each state maintains its own PDL and the ability to designate a drug as preferred or non-preferred. As of the end of the SFY 08/09, a total of eighty-three (83) manufacturers participate in the NMPI.

The Medicaid program processed over 48 million pharmacy claims in SFY 08/09. Of these, 30 percent (14,482,703) were for a drug that fell within one of the classes of

drugs on the PDP. Of the drugs subject to the PDP, 98.1 percentof claims were for preferred drugs that did not require prior authorization (Appendix 9). The extremely high percentage of prescriptions for preferred drugs is attributed to the wide selection of preferred drugs within a class, prescriber familiarity with the Medicaid PDP, and education efforts. Success is further supported by the pharmacy provider community in advising prescribers of preferred drug choices. The remaining 1.9 percent (269,597) of claims was for non-preferred drugs that required prior authorization. Under the PDP, there was a shift in the highest volume of requests for non-preferred drugs this SFY to Long Acting Narcotics (20 percent), which are analgesics used to treat moderate to severe pain. These results are consistent with general trends towards increased use of prescription pain medications, as noted by an analysis conducted by the Agency for Healthcare Research and Quality (AHRQ), demonstrating that spending tripled for prescription analgesics in ten (10) years (1996-2006).

The other top classes for PA requests were sedative hypnotics (15 percent), which are used as sleep aids, and antihistamines (12 percent), used primarily to treat allergies, both of which remained steady from the prior year's results. Consistent with the experience last SFY, primary indicators for PDP PA requests to use a non-preferred drug include treatment failure on preferred medication, contraindications preventing transition to preferred medications; and adverse reactions to preferred medications. Education efforts, including targeted outreach, provider scorecard initiative and PDL change notifications have continued to encourage prescriber compliance with the PDL and resultant market shift towards preferred agents. Overall, after consultation with call center staff, approximately 1.4 percent of the total requests resulted in the prescriber agreeing to use the preferred drug in lieu of a non-preferred drug. The CCC representatives have continued to promote the use of preferred agents as clinically appropriate, attributing to the relative changes observed. For SFY 08/09, total gross savings for the PDP was $268.6 million. The overwhelming majority of the savings, $171.6 million, resulted from supplemental rebates. The remaining savings, $97 million, resulted from a change in market share from more expensive non-preferred drugs to less expensive preferred drugs within a drug class. This shift is typically observed six (6) months after the drug class is added to the PDP.

B. Outcomes and Cost Savings - Clinical Drug Review Program

In SFY 08/09, a total of 24,473 requests were processed for prior authorization of drugs under the CDRP as follows:

- 408 Revatio®;
- 290 Serostim®;
- 1315 Zyvox®;
- 1,064 Actiq®/Fentora®;
- 3,922 Byetta®; and
- 17,474 Lidoderm®.

All CDRP requests were authorized using the criteria in current statute. A denial can only be based on substantial evidence of fraud and abuse which is difficult to establish

during a PA phone call. If statute allowed denial on the basis of medical necessity, 4 percent of requests would have been denied, suggesting that an opportunity exists to enhance the program further to assure appropriate prescribing practices and protect patient safety in these cases.

Although all CDRP requests were authorized during SFY 08/09, a comparison of utilization and cost from baseline to the last quarter in SFY 08/09 shows a decrease in utilization and spending on the majority of the CDRP drugs, including those added to the CDRP on 07/30/08. In aggregate, there was a 63 percent reduction in claims and a 50 percent reduction in total payments since program inception (Q2 2006). 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 SFY is estimated to be $22,918,665
(gross).

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

VI. Conclusion

The second full fiscal year of operation of the PDP and CDRP proceeded smoothly. Results continue to 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, without impeding access to medically necessary drugs for Medicaid enrollees.

In SFY 08/09, the P&TC re-reviewed forty-two (42) classes of drugs in the PDP to include drugs recently approved by the FDA and newly available clinical and financial information. Eleven (11) new drug classes were reviewed for inclusion on the PDP. By the end of the SFY there were a total of fifty-two (52) drug classes subject to the PDP. In addition, the four (4) new drugs reviewed and recommended by the P&TC for inclusion to the CDRP were added to the program on 7/30/08.

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

Education efforts for enrollees, providers and interested parties will be maintained and enhanced to promote community awareness and understanding of the program. Distribution of revised enrollee brochures was expanded to include Medicaid enrollment sites, additional hospitals and clinic settings, and mailings to prescribers. Prescribers most affected by revisions to the PDL will continue to receive notifications that provide information about their patients who are currently taking drugs that will require PA.

The PDP, CDRP and MGDP will continue to be monitored closely by DOH staff. An annual review of the NMPI supplemental invoice process by an independent consultant, as well as by New York State, will be conducted to ensure appropriate protocol and accounting is maintained. The Pharmacy Prior Authorization Clinical Call Center satisfaction survey will be repeated again to monitor provider satisfaction. Complaints and feedback from the survey will be evaluated for potential enhancements to the process.

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.
   Instructor/Department of Pharmacy Practice, Albany College of Pharmacy and Health Sciences
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. Steven E. Barnes, D.O.
   Private Practice/Internal and Geriatric Medicine
6. Aaron Satloff, M.D.
   Pittsford Psychiatric Group/Psychiatry and Neurology
7. Glenn A. Martin, M.D.
   Psychiatry/Neurology Medicine
8. Marla Suzan Eglowstein, M.D.
   National Multiple Sclerosis Society
9. John Westerman, Jr., R.Ph.
   Independent Pharmacy Owner
10. Donna Chiefari, Pharm D.
    Empire/Wellpoint
11. David F. Lehmann, M.D., Pharm D.
    Professor of Medicine and Pharmacology
    SUNY Upstate Medical University
12. 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&TC Meeting	Drug Class	Posting Date	Date PA Required
30-Apr-08	ACE INHIBITORS	28-Jul-08	20-Aug-08
30-Apr-08	ACE/DIURETIC COMBINATIONS	28-Jul-08	20-Aug-08
30-Apr-08	CALCIUM CHANNEL BLOCKERS: DHP	28-Jul-08	20-Aug-08
30-Apr-08	ACE/CCB COMBINATIONS	28-Jul-08	20-Aug-08
30-Apr-08	ANGIOTENSIN RECEPTOR BLOCKERS	28-Jul-08	20-Aug-08
30-Apr-08	ARB/DIURETIC COMBINATIONS	28-Jul-08	20-Aug-08
30-Apr-08	BETA BLOCKERS	28-Jul-08	20-Aug-08
30-Apr-08	BETA BLOCKER/DIURETIC COMBINATIONS	28-Jul-08	20-Aug-08
30-Apr-08	STATINS	28-Jul-08	20-Aug-08
30-Apr-08	CHOLESTEROL ABSORPTION INHIBITOR	28-Jul-08	20-Aug-08
30-Apr-08	TRIG. LOWERING AGENTS	28-Jul-08	20-Aug-08
30-Apr-08	OPIATES: LONG ACTING	28-Jul-08	20-Aug-08
30-Apr-08	SEDATIVE HYPNOTICS	28-Jul-08	20-Aug-08
30-Apr-08	CNS STIMULANTS	28-Jul-08	20-Aug-08
30-Apr-08	ANTIHISTAMINES: LOW SEDATING	28-Jul-08	20-Aug-08
30-Apr-08	STEROIDS: NASAL	28-Jul-08	20-Aug-08
30-Apr-08	PROTON PUMP INHIBITORS	28-Jul-08	20-Aug-08
30-Apr-08	QUINOLONES: OPHTH	28-Jul-08	20-Aug-08
30-Apr-08	ANTIHISTAMINES: OPHTH	28-Jul-08	20-Aug-08
30-Apr-08	PROSTAGLANDIN AGONISTS: OPHTH	28-Jul-08	20-Aug-08
12-Jun-08	ANTICOAGULANTS: INJECTABLE	29-Aug-08	25-Sep-08
12-Jun-08	NIACIN DERIVATIVES	29-Aug-08	25-Sep-08
12-Jun-08	BONE OSSIFICATION SUPPRESSION AGENTS	29-Aug-08	25-Sep-08
12-Jun-08	CALCITONINS	29-Aug-08	25-Sep-08
12-Jun-08	COX-2 INHIBITORS	29-Aug-08	25-Sep-08
12-Jun-08	TRIPTANS	29-Aug-08	25-Sep-08
12-Jun-08	ANTI-EMETICS: ORAL	29-Aug-08	25-Sep-08
12-Jun-08	QUINOLONES: ORAL	29-Aug-08	25-Sep-08
12-Jun-08	CEPHALOSPORINS: 3RD GEN	29-Aug-08	25-Sep-08
12-Jun-08	QUINOLONES: OTIC	29-Aug-08	25-Sep-08
12-Jun-08	THIAZOLIDINEDIONES (TZD)	29-Aug-08	25-Sep-08
12-Jun-08	ALPHA BLOCKERS: BPH	29-Aug-08	25-Sep-08
12-Jun-08	URINARY TRACT ANTISPASMODICS	29-Aug-08	25-Sep-08
18-Sep-08	MULTIPLE SCLEROSIS AGENTS	19-Dec-08	18-Feb-09
18-Sep-08	DIPEPTIDYL PEPTIDASE-4 (DPP-4) INHIBITORS	19-Dec-08	18-Feb-09
18-Sep-08	BETA AGONISTS: SHORT-ACTING	19-Dec-08	18-Feb-09
18-Sep-08	BETA AGONISTS: LONG-ACTING	19-Dec-08	18-Feb-09
18-Sep-08	ANTICHOLINERGICS: RESPIRATORY	19-Dec-08	18-Feb-09
18-Sep-08	LEUKOTRIENE MODIFIERS	19-Dec-08	18-Feb-09
18-Sep-08	ANTIVIRALS: HERPES	19-Dec-08	18-Feb-09

P&TC Meeting	Drug Class	Posting Date	Date PA Required
18-Sep-08	PHOSPHATE REGULATORS	19-Dec-08	18-Feb-09
18-Sep-08	ANTIVIRALS: HEPATITIS C	19-Dec-08	18-Feb-09
18-Sep-08	IMMUNOMODULATORS: TOPICAL	19-Dec-08	18-Feb-09
18-Sep-08	IMMUNOMODULATORS: ARTHRITIS	19-Dec-08	18-Feb-09

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NEW YORK STATE MEDICAID
PREFERRED DRUG LIST

All non-preferred drugs in these classes require prior authorization

NYS PREFERRED DRUG PROGRAM HTTP://NEWYORK.FHSC.COM

NYS MEDICAID PHARMACY CLINICAL CALL CENTER 877-309-9493

I. ANALGESICS

Cyclooxygenase II (COX II) Inhibitors

PREFERRED AGENTS
Celebrex®

NON-PREFERRED AGENTS
None

Narcotics – Long Acting

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

NON-PREFERRED AGENTS	
Avinza®	*oxycodone HCL CR*
MS Contin®	*Oxycontin®*

II. ANTI-INFECTIVES

Anti-Fungals

PREFERRED AGENTS	
ciclopirox (lacquer)	griseofulvin (suspension)
Grifulvin V® (tablet)	terbinafine (tablet)
Gris-PEG®	

NON-PREFERRED AGENTS	
Grifulvin V® (suspension)	*Penlac®*
itraconazole	*Sporanox®*
Lamisil® (tablet)	

Anti-Virals

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

NON-PREFERRED AGENTS
Famvir®
Zovirax® (capsule, suspension, tablet)

Cephalosporins – Third Generation

PREFERRED AGENTS	
Cedax®	cefpodoxime proxetil
cefdinir	Suprax®

NON-PREFERRED AGENTS	
Omnicef®	*Vantin®*
Spectracef®	

Fluoroquinolones - Oral

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

NON-PREFERRED AGENTS	
Cipro® (tablet)	*Levaquin®*
Cipro XR®	*Noroxin®*
ciprofloxacin ER	*Proquin XR®*
Factive®	*Tequin®*
Floxin® (tablet)	

Pegylated Interferons

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

NON-PREFERRED AGENTS
None

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

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NEW YORK STATE MEDICAID
PREFERRED DRUG LIST

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III. CARDIOVASCULAR

Angiotensin Converting Enzyme Inhibitors (ACEIs)

PREFERRED AGENTS	
Altace® (capsule)	lisinopril
benazepril	moexipril
captopril	ramipril (capsule)
enalapril maleate	trandolapril

NON-PREFERRED AGENTS	
Accupril®	*Monopril®*
Aceon®	*Prinivil®*
Altace® (tablet)	*quinapril*
Capoten®	*Univasc®*
fosinopril sodium	*Vasotec®*
Lotensin®	*Zestril®*
Mavik®	

ACEIs + Calcium Channel Blockers

PREFERRED AGENTS	
benazepril/amlodipine	Tarka®
Lotrel®	

NON-PREFERRED AGENTS
Lexxel®

ACEIs + Diuretics

PREFERRED AGENTS	
benazepril/HCTZ	lisinopril/HCTZ
captopril/HCTZ	moexipril/HCTZ
enalapril maleate/HCTZ	

NON-PREFERRED AGENTS	
Accuretic®	*quinapril/HCTZ*
Capozide®	*Quinaretic®*
fosinopril/HCTZ	*Uniretic®*
Lotensin HCT®	*Vaseretic®*
Monopril HCT®	*Zestoretic®*
Prinzide®	

Angiotensin Receptor Blockers (ARBs)

PREFERRED AGENTS	
Avapro®	Diovan®
Benicar®	Exforge®
Cozaar®	Micardis®

NON-PREFERRED AGENTS	
Atacand®	*Teveten®*
Azor®	

ARBs + Diuretics

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

NON-PREFERRED AGENTS
Atacand HCT®
Teveten HCT®

Beta Blockers

PREFERRED AGENTS	
acebutolol	metoprolol tartrate
atenolol	nadolol
betaxolol	pindolol
bisoprolol fumarate	propranolol
carvedilol	propranolol ER/SA
labetalol	timolol maleate

NON-PREFERRED AGENTS	
Bystolic®	*Levatol®*
Coreg®	*Lopressor®*
Coreg CR®	*metoprolol succinate*
Corgard®	*Sectral®*
Inderal®	*Tenormin®*
Inderal LA®	*Toprol XL®*
InnoPran XL®	*Trandate®*
Kerlone®	*Zebeta®*

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Beta Blockers + Diuretics

PREFERRED AGENTS		NON-PREFERRED AGENTS	
atenolol/chlorthalidone		*Corzide®*	*Tenoretic®*
bisoprolol fumarate/HCTZ		*Inderide®*	*Ziac®*
metoprolol tartrate/HCTZ		*Lopressor HCT®*	
nadolol/bendroflumethiazide			
propranolol/HCTZ			

Calcium Channel Blockers (Dihydropyridine)

PREFERRED AGENTS		NON-PREFERRED AGENTS	
Afeditab CR®	nicardipine HCl	*Adalat CC®*	*Plendil®*
amlodipine	Nifediac CC®	*Cardene®*	*Procardia®*
DynaCirc®	Nifedical XL®	*Cardene SR®*	*Procardia XL®*
DynaCirc CR®	nifedipine	*nisoldipine*	*Sular®*
felodipine ER	nifedipine ER/SA	*Norvasc®*	
isradipine			

Cholesterol Absorption Inhibitors

PREFERRED AGENTS	NON-PREFERRED AGENTS
Zetia®	*None*

HMG-CoA Reductase Inhibitors (Statins)

PREFERRED AGENTS		NON-PREFERRED AGENTS	
Crestor®	lovastatin	*Advicor®*	*Mevacor®*
Lescol®	pravastatin	*Altoprev®*	*Pravachol®*
Lescol XL®	Simcor®	*Caduet®*	*Vytorin®*
Lipitor®	simvastatin		*Zocor®*

Niacin Derivatives

PREFERRED AGENTS	NON-PREFERRED AGENTS
Niaspan	*None*

Triglyceride Lowering Agents

PREFERRED AGENTS		NON-PREFERRED AGENTS	
fenofibrate	Lovaza®	*Antara®*	*Lofibra®*
gemfibrozil	Tricor®	*Fenoglide®*	*Lopid®*
		Lipofen®	*Triglide®*

IV. CENTRAL NERVOUS SYSTEM

Carbamazepine Derivatives

PREFERRED AGENTS	NON-PREFERRED AGENTS
carbamazepine (chewable, suspension, tablet)	*None*
Carbatrol®	
Epitol®	
Equetro®	
oxcarbazepine	
Tegretol® (chewable, suspension, tablet)	
Tegretol XR®	
Trileptal®	

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NEW YORK STATE MEDICAID PREFERRED DRUG LIST

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Central Nervous System (CNS) Stimulants

PREFERRED AGENTS		NON-PREFERRED AGENTS	
Adderall XR®	Focalin XR®	*Adderall®*	*Metadate CD®*
amphetamine salt combo	Metadate ER®	*Daytrana®*	*Provigil®CC*
Concerta®	Methylin®	*Desoxyn®*	*Ritalin®*
dexmethylphenidate	Methylin ER®	*Dexedrine®*	*Ritalin LA®*
dextroamphetamine	methylphenidate	*Dexedrine Spansule®*	*Ritalin SR®*
dextroamphetamine SR	methylphenidate ER/SA	*Dextrostat®*	
Focalin®	Vyvanse®	*LiquADD®*	

Multiple Sclerosis Agents

PREFERRED AGENTS		NON-PREFERRED AGENTS
Avonex®	Copaxone®	*None*
Betaseron®	Rebif®	

Sedative Hypnotics/Sleep Agents

PREFERRED AGENTS		NON-PREFERRED AGENTS	
chloral hydrate	temazepam	*Ambien®*	*Prosom®*
estazolam	triazolam	*Ambien CR®*	*Restoril®*
flurazepam	zolpidem	*Dalmane®*	*Rozerem®*
		Doral®	*Somnote®*
		Halcion®	*Sonata®*
		Lunesta®	*zaleplon*

Serotonin Receptor Agonists (Triptans)

PREFERRED AGENTS		NON-PREFERRED AGENTS	
Imitrex®	Relpax®	*Amerge®*	*Treximet®*
Maxalt®	sumatriptan	*Axert®*	*Zomig®*
		Frova®	

V. ENDOCRINE AND METABOLIC AGENTS

Bisphosphonates – Oral

PREFERRED AGENTS		NON-PREFERRED AGENTS	
alendronate	Fosamax® Plus D	*Actonel®*	*Boniva®*
Fosamax®		*Actonel® with Calcium*	

Calcitonins – Intranasal

PREFERRED AGENTS	NON-PREFERRED AGENTS
Miacalcin®	*Fortical®*

Dipeptidyl Peptidase-4 (DPP-4) Inhibitors

PREFERRED AGENTS		NON-PREFERRED AGENTS
Janumet®	Januvia®	*None*

Growth Hormones

PREFERRED AGENTS		NON-PREFERRED AGENTS	
Genotropin®	Nutropin AQ®	*Humatrope®CC*	*Tev-Tropin®CC*
Nutropin®	Saizen®	*Norditropin®CC*	*Zorbtive®CC*
		Omnitrope®CC	

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NEW YORK STATE MEDICAID
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Thiazolidinediones (TZDs)

PREFERRED AGENT		NON-PREFERRED AGENT
Actoplus Met®	Avandaryl®	*None*
Actos®	Avandia®	
Avandamet®	Duetact®	

VI. GASTROINTESTINAL

Anti-Emetics

PREFERRED AGENTS		NON-PREFERRED AGENTS	
ondansetron (ODT, solution, tablet)		*Anzemet®*	*Kytril® (solution, tablet)*
		granisetron (tablet)	*Zofran® (ODT, solution, tablet)*
		Granisol®	

Proton Pump Inhibitors (PPIs)

PREFERRED AGENTS		NON-PREFERRED AGENTS	
Nexium® (capsule)		*Aciphex®*	*Prevacid NapraPAC®*
omeprazole OTC		*Nexium Packet®*	*Prilosec® Rx*
Prevacid® (capsule)		*omeprazole Rx*	*Protonix®*
		pantoprazole	*Zegerid®*
		Prevacid® (packet, solutab)	

VII. HEMATOLOGICAL AGENTS

Anticoagulants - Injectable

PREFERRED AGENTS		NON-PREFERRED AGENTS
Arixtra®	Innohep®	*None*
Fragmin®	Lovenox®	

Erythropoiesis Stimulating Agents (ESAs)

PREFERRED AGENTS		NON-PREFERRED AGENTS
Aranesp®	Procrit®	*Epogen®*

VIII. IMMUNOLOGIC AGENTS

Immunomodulators - Injectable

PREFERRED AGENTS		NON-PREFERRED AGENTS	
Enbrel®	Humira®	*Cimzia®*	*Kineret®*

Immunomodulators – Topical

PREFERRED AGENTS		NON-PREFERRED AGENTS
Elidel®	Protopic®	*None*

IX. MISCELLANEOUS

Progestins (for Cachexia)

PREFERRED AGENTS	NON-PREFERRED AGENTS	
megestrol acetate (suspension)	*Megace® (suspension)*	*Megace ES®*

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NEW YORK STATE MEDICAID
PREFERRED DRUG LIST

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X. OPHTHALMICS

Alpha-2 Adrenergic Agonists (for Glaucoma) – Ophthalmic

PREFERRED AGENTS		NON-PREFERRED AGENTS	
Alphagan P®	brimonidine	*Iopidine®*	

Antihistamines – Ophthalmic

PREFERRED AGENTS		NON-PREFERRED AGENTS	
Pataday®	Patanol®	*Elestat®*	*ketotifen RX*
		Emadine®	*Optivar®*

Fluoroquinolones – Ophthalmic

PREFERRED AGENTS		NON-PREFERRED AGENTS	
ciprofloxacin		*Ciloxan®*	*Quixin®*
ofloxacin		*IQUIX®*	*Zymar®*
Vigamox®		*Ocuflox®*	

Non-Steroidal Anti-Inflammatory Drugs (NSAIDS) – Ophthalmic

PREFERRED AGENTS		NON-PREFERRED AGENTS	
Acular®	Acular PF®	*diclofenac*	*Voltaren®*
Acular LS®	flurbiprofen	*Nevanac®*	*Xibrom®*
		Ocufen®	

Prostaglandin Agonists – Ophthalmic

PREFERRED AGENTS		NON-PREFERRED AGENTS	
Travatan®	Xalatan®	*Lumigan®*	
Travatan Z®			

XI. OTICS

Fluoroquinolones - Otic

PREFERRED AGENTS		NON-PREFERRED AGENTS	
Ciprodex®	ofloxacin	*Cipro HC®*	*Floxin®*

XII. RENAL AND GENITOURINARY

Phosphate Binders/Regulators

PREFERRED AGENTS		NON-PREFERRED AGENTS	
calcium acetate (capsule)	Phoslo®	*Renvela®*	
Fosrenol®	Renagel®		

Selective Alpha Adrenergic Blockers

PREFERRED AGENTS		NON-PREFERRED AGENTS	
Flomax®	Uroxatral®	*None*	

Urinary Tract Antispasmodics

PREFERRED AGENTS		NON-PREFERRED AGENTS	
Detrol LA®	Sanctura®	*Detrol®*	*Ditropan XL®*
Enablex®	Sanctura XR®	*Ditropan®*	*oxybutynin ER*
oxybutynin	Vesicare®		
Oxytrol®			

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NEW YORK STATE MEDICAID
PREFERRED DRUG LIST

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XIII. RESPIRATORY

Anticholinergics – Inhaled

PREFERRED AGENTS		NON-PREFERRED AGENTS
Atrovent HFA®	Ipratropium/albuterol[1]	*Duoneb®*
Combivent®	Spiriva®	
Ipratropium		

Antihistamines – Second Generation

PREFERRED AGENTS		NON-PREFERRED AGENTS	
OTC cetirizine		*Allegra®* CC	*Semprex-D®*
OTC cetirizine-D		*Allegra-D®*	*Xyzal®*
OTC loratadine		*Clarinex®* CC	
OTC loratadine-D		*Clarinex-D®*	
		fexofenadine	

Beta$_2$ Adrenergic Agents – Inhaled Long Acting

PREFERRED AGENTS		NON-PREFERRED AGENTS	
Foradil®	Serevent Diskus®	*Brovana®*	*Perforomist®*

Beta$_2$ Adrenergic Agents – Inhaled Short Acting

PREFERRED AGENTS		NON-PREFERRED AGENTS	
albuterol	Ventolin HFA®	*Accuneb®*	*Proventil HFA®* [2]
Maxair Autohaler®		*Alupent®*	*Xopenex® (solution)* [2]
		metaproterenol	*Xopenex HFA®*
		ProAir HFA®	

Corticosteroids – Inhaled

PREFERRED AGENTS		NON-PREFERRED AGENTS	
Advair Diskus®	Flovent Diskus®	*Aerobid®*	*Symbicort®*
Advair HFA®	Flovent HFA®	*Aerobid-M®*	
Asmanex®	QVAR®	*Alvesco®*	
Azmacort®		*Pulmicort® (Flexhaler, Turbuhaler)* CC	

Corticosteroids – Intranasal

PREFERRED AGENTS		NON-PREFERRED AGENTS	
fluticasone	Nasonex®	*Beconase AQ®*	*Nasarel®*
		Flonase®	*Omnaris®*
		flunisolide	*Rhinocort Aqua®*
		Nasacort AQ®	*Veramyst®*

Leukotriene Modifiers

PREFERRED AGENT		NON-PREFERRED AGENT
Accolate®	Singulair®	*None*

[1] Preferred as of 02/18/09
[2] Non-Preferred as of 02/18/09
CC-Clinical Criteria (Please see: https://newyork.fhsc.com/downloads/providers/NYRx_PDP_clinical_criteria.pdf)

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NEW YORK STATE MEDICAID
PREFERRED DRUG QUICK LIST

These drugs are preferred and do not require prior authorization

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NYS MEDICAID PHARMACY CLINICAL CALL CENTER 877-309-9493

I. ANALGESICS

Cyclooxygenase II (COX II) Inhibitors

PREFERRED AGENTS
Celebrex®

Narcotics - Long Acting

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

II. ANTI-INFECTIVES

Anti-Fungals

PREFERRED AGENTS	
ciclopirox (lacquer)	griseofulvin (suspension)
Grifulvin V® (tablet)	terbinafine (tablet)
Gris-PEG®	

Anti-Virals

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

Cephalosporins - Third Generation

PREFERRED AGENTS
Cedax®
cefdinir
cefpodoxime proxetil
Suprax®

Fluoroquinolones - Oral

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

Pegylated Interferons

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

III. CARDIOVASCULAR

Angiotensin Converting Enzyme Inhibitors (ACEIs)

PREFERRED AGENTS	
Altace® (capsule)	lisinopril
benazepril	moexipril
captopril	ramipril (capsule)
enalapril maleate	trandolapril

ACEIs + Calcium Channel Blockers

PREFERRED AGENTS
benazepril/amlodipine
Lotrel®
Tarka®

ACEIs + Diuretics

PREFERRED AGENTS
benazepril/HCTZ
captopril/HCTZ
enalapril maleate/HCTZ
lisinopril/HCTZ
moexipril/HCTZ

Angiotensin Receptor Blockers (ARBs)

PREFERRED AGENTS	
Avapro®	Diovan®
Benicar®	Exforge®
Cozaar®	Micardis®

[1] Preferred as of 02/18/2009

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NEW YORK STATE MEDICAID
PREFERRED DRUG QUICK LIST

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ARBs + Diuretics

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

Beta Blockers

PREFERRED AGENTS	
acebutolol	metoprolol tartrate
atenolol	nadolol
betaxolol	pindolol
bisoprolol fumarate	propranolol
carvedilol	propranolol ER/SA
labetalol	timolol maleate

Beta Blockers + Diuretics

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

Calcium Channel Blockers (Dihydropyridine)

PREFERRED AGENTS	
Afeditab CR®	Nifediac CC®
amlodipine	Nifedical XL®
DynaCirc®	nifedipine
DynaCirc CR®	nifedipine ER/SA
felodipine ER	
isradipine	
nicardipine HCl	

Cholesterol Absorption Inhibitors

PREFERRED AGENTS
Zetia®

HMG-CoA Reductase Inhibitors (Statins)

PREFERRED AGENTS	
Crestor®	lovastatin
Lescol®	pravastatin
Lescol XL®	Simcor®
Lipitor®	simvastatin

Niacin Derivatives

PREFERRED AGENTS
Niaspan®

Triglyceride Lowering Agents

PREFERRED AGENTS	
fenofibrate	Lovaza®
gemfibrozil	Tricor®

IV. CENTRAL NERVOUS SYSTEM

Carbamazepine Derivatives

PREFERRED AGENTS
carbamazepine (chewable, suspension, tablet)
Carbatrol®
Epitol®
Equetro®
oxcarbazepine
Tegretol® (chewable, suspension, tablet)
Tegretol XR®
Trileptal®

Central Nervous System (CNS) Stimulants

PREFERRED AGENTS	
Adderall XR®	Metadate ER®
amphetamine salt combo	Methylin®
Concerta®	Methylin ER®
dexmethylphenidate	methylphenidate
dextroamphetamine	methylphenidate ER/SA
dextroamphetamine SR	Vyvanse®
Focalin®	
Focalin XR®	

Multiple Sclerosis Agents

PREFERRED AGENTS	
Avonex®	Copaxone®
Betaseron®	Rebif®

Sedative Hypnotics / Sleep Agents

PREFERRED AGENTS	
chloral hydrate	temazepam
estazolam	triazolam
flurazepam	zolpidem

[1] Preferred as of 02/18/2009

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NEW YORK STATE MEDICAID
PREFERRED DRUG QUICK LIST

These drugs are preferred and do not require prior authorization

NYS PREFERRED DRUG PROGRAM HTTP://NEWYORK.FHSC.COM

NYS MEDICAID PHARMACY CLINICAL CALL CENTER 877-309-9493

Serotonin Receptor Agonists (Triptans)

PREFERRED AGENTS	
Imitrex®	sumatriptan
Maxalt®	
Relpax®	

V. ENDOCRINE AND METABOLIC AGENTS

Bisphosphonates - Oral

PREFERRED AGENTS	
alendronate	Fosamax® Plus D
Fosamax®	

Calcitonins - Intranasal

PREFERRED AGENTS
Miacalcin®

Dipeptidyl Peptidase-4 (DPP-4) Inhibitors

PREFERRED AGENTS
Janumet®
Januvia®

Growth Hormones

PREFERRED AGENTS	
Genotropin®	Nutropin AQ®
Nutropin®	Saizen®

Thiazolidinediones (TZDs)

PREFERRED AGENTS	
Actoplus Met®	Avandaryl®
Actos®	Avandia®
Avandamet®	Duetact®

VI. GASTROINTESTINAL

Anti-Emetics

PREFERRED AGENTS
ondansetron (ODT, solution, tablet)

Proton Pump Inhibitors (PPIs)

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

VII. HEMATOLOGICAL AGENTS

Anticoagulants - Injectable

PREFERRED AGENTS	
Arixtra®	Innohep®
Fragmin®	Lovenox®

Erythropoiesis Stimulating Agents (ESAs)

PREFERRED AGENTS
Aranesp®
Procrit®

VIII. IMMUNOLOGIC AGENTS

Immunomodulators - Injectable

PREFERRED AGENTS
Enbrel®
Humira®

Immunomodulators - Topical

PREFERRED AGENTS
Elidel®
Protopic®

IX. MISCELLANEOUS

Progestins (for Cachexia)

PREFERRED AGENTS
megestrol acetate (suspension)

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X. OPHTHALMICS

Alpha-2 Adrenergic Agonists (for Glaucoma) - Ophthalmic

PREFERRED AGENTS	
Alphagan P®	brimonidine

Antihistamines - Ophthalmic

PREFERRED AGENTS	
Pataday®	Patanol®

Fluoroquinolones - Ophthalmic

PREFERRED AGENTS	
ciprofloxacin	Vigamox®
ofloxacin	

Non-Steroidal Anti-Inflammatory Drugs (NSAIDs) - Ophthalmic

PREFERRED AGENTS	
Acular®	Acular PF®
Acular LS®	flurbiprofen

Prostaglandin Agonists - Ophthalmic

PREFERRED AGENTS	
Travatan®	Xalatan®
Travatan Z®	

XI. OTICS

Fluoroquinolones - Otic

PREFERRED AGENTS
Ciprodex®
ofloxacin

XII. RENAL AND GENITOURINARY

Phosphate Binders / Regulators

PREFERRED AGENTS
calcium acetate (capsule)
Fosrenol®
Phoslo®
Renagel®

Selective Alpha Adrenergic Blockers

PREFERRED AGENTS
Flomax®
Uroxatral®

Urinary Tract Antispasmodics

PREFERRED AGENTS	
Detrol LA®	Sanctura®
Enablex®	Sanctura XR®
oxybutynin	Vesicare®
Oxytrol®	

XIII. RESPIRATORY

Anticholinergics - Inhaled

PREFERRED AGENTS	
Atrovent HFA®	ipratropium
Combivent®	ipratropium/albuterol[1]
	Spiriva®

Antihistamines - Second Generation

PREFERRED AGENTS
OTC cetirizine
OTC cetirizine-D
OTC loratadine
OTC loratadine-D

Beta$_2$ Adrenergic Agents - Inhaled Long Acting

PREFERRED AGENTS
Foradil®
Serevent Diskus®

Beta$_2$ Adrenergic Agents - Inhaled Short Acting

PREFERRED AGENTS	
albuterol	Ventolin HFA®
Maxair Autohaler®	

[1] Preferred as of 02/18/2009

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NEW YORK STATE MEDICAID
PREFERRED DRUG QUICK LIST

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Corticosteroids - Inhaled

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

Corticosteroids - Intranasal

PREFERRED AGENTS
fluticasone
Nasonex®

Leukotriene Modifiers

PREFERRED AGENTS
Accolate®
Singulair®

[1] Preferred as of 02/18/2009

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Contacted Organizations/Societies

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

AARP (American Association of Retired People)

CHCANYS (Community Health Care Association of New York State)

Committee on Interns and Residents

Cystic Fibrosis Foundation

Erie County Consortia

GNYHA (Greater New York Healthcare Association)

HANYS (Healthcare Association of New York State)

HCANYS (Home Care Association of New York State)

HHC-NYC (NYC Health and Hospital Corporation)

Lupus Foundation of America

Manatt, Phelps & Phillips

MSSNY (Medical Society of State of New York)

NACDS (National Association of Chain Drugstores)

NAFC (National Association for Continence)

NAMI-NYS (National Alliance on Mental Illness)

NASW (National Association of Social Workers) NYC

NASW (National Association of Social Workers) NYS

NPA (Nurse Practitioners Association)

NYAAC (New York Association of Ambulatory Care)

NYMGMA (NY Medical Group Management Association)

NYPWA (New York Public Welfare Association)

NYS Dental Association

NYS Prepaid Health Services Plan

NYSAC (New York State Association of Counties)

NYSACHO (New York State Association of County Health Officials)

NYSAFP (New York State Academy of Family Physicians)

NYSCHP (New York State Council of Health System Pharmacists)

NYSHFA (New York State Health Facilities Association)

NYSHPA (New York State Health Plan Association)

NYSOMS (New York State Osteopathic Medical Society)

NYSPMA (NYS Podiatric Medical Society)

NYSSPA (NYS Society of Physician Assistants)

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 NY)

SEIU United Healthcare Workers

ENROLLEE BROCHURE, ENGLISH VERSION

New York State Medicaid Preferred Drug Program

A GUIDE FOR PEOPLE WITH MEDICAID AND FAMILY HEALTH PLUS

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.

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.

Need help? Call the Medicaid Helpline:
1-800-541-2831

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.

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.

For more information, visit the NYS Medicaid Preferred Drug Program Website:
https://newyork.fhsc.com

State of New York
Department of Health

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New York State Medicaid Generic Drug Program

A GUIDE FOR PEOPLE WITH MEDICAID AND FAMILY HEALTH PLUS

What is the Generic Drug Program?

The law requires doctors to prescribe the generic version of a drug, unless they get special approval for a brand name drug.

What is a generic drug?

A generic drug is a copy of a brand name drug. It is the same medicine with the same active ingredients as the brand name drug, but usually made by another company.

Is a generic drug as good as a brand name drug?

Yes. The federal government makes certain that the generic drug is as safe and effective as the brand name drug. (You may already be taking generic drugs).

What if I am taking a brand name drug that has a generic version?

Medicaid will not pay for your brand name drug unless your doctor calls Medicaid to get approval, and writes the approval number on your prescription.

Need help? Call the Medicaid Helpline:
1-800-541-2831

Remember:

- Only your doctor can decide which drugs you should take.
- Generic drugs are safe and effective copies of brand name drugs and are approved by the federal government.
- Ask your doctor and pharmacist about generic drugs.

What if my doctor forgets to get the approval for my brand name drug?

The pharmacist can call your doctor to discuss if the generic drug is right for you.

What if I really need my medicine and the doctor's office is closed?

In an emergency, if you have a valid prescription, the pharmacist may give you a small supply of the brand name drug until you can talk to someone at your doctor's office or clinic.

Why are my pills a different color than they used to be?

Generic pills may look different because they are made by another company. They may be a different color or shape, but they are as safe and effective as the brand name drug.

State of New York
Department of Health

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Preferred Drug Program Website Information

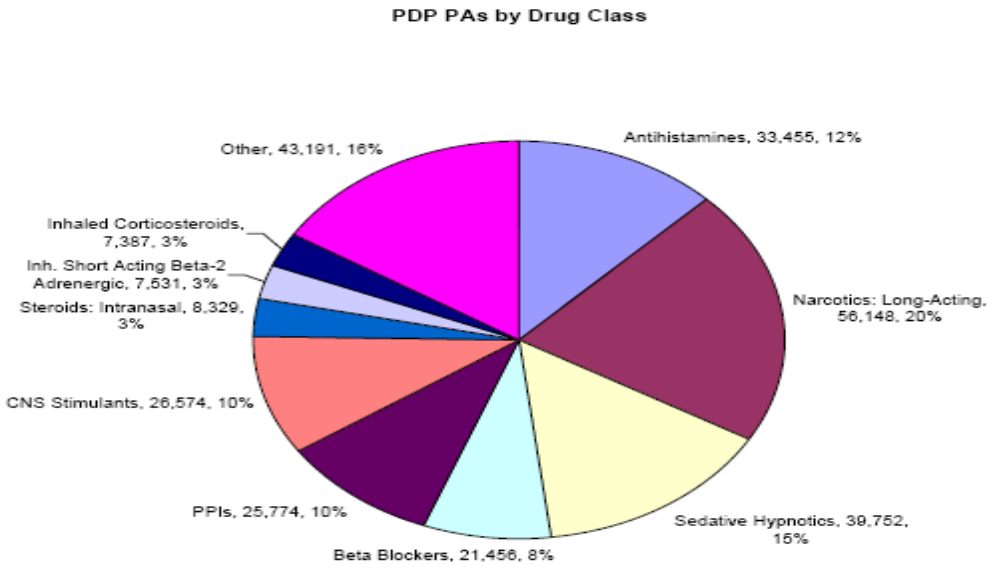
- Information about the NYS PDP can be accessed on the Internet at: https://newyork.fhsc.com/ or http://www.health.state.ny.us/

- 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

Prior Authorizations by Class



Total PDP PAs = 269,597

Of the 269,597 PAs issued in SFY 08/09, the following PDP drug classes are ranked by the number of PAs requested

1. Narcotics: Long-Acting: 56,148
2. Sedative Hypnotics: 39,752
3. Antihistamines: 33,455
4. CNS Stimulants: 26,574
5. PPIs: 25,774
6. Beta Blockers: 21,400
7. Steroids: Intranasal: 8,329
8. Beta Agonist Inhalers: 7,965
9. Inhaled Corticosteroids: 7,387
10. Statins: 5,783
11. Fluoroquinolones: 5,278
12. Bisphosphonates: 5,420
13. Triptans: 3,490
14. Ophthalmics (combined): 3,350
15. Triglyceride Agents: 3,322
16. ACE Inhibitors: 3,029
17. ARBs: 2,732
18. Urinary Tract Antispasmodics: 2,719
19. Inhaled Anticholinergics: 1,640
20. Calcium Channel Blockers (DHP): 1,542
21. Antifungals: 982
22. Growth Hormones: 756
23. Antiemetics: 481
24. Progestins: 474
25. Otics: Quinolones: 353
26. Phosphate Binders: 325
27. ARB/Diuretic Combinations: 299
28. ACE Inhibitor/Diuretic Combinations: 262
29. ESA's: 195
30. Immunomodulators Injectable: 92
31. Cephalosporins: Third Generation: 85
32. Antivirals: 76
33. Calcitonin: 62
34. Beta Blocker/Diuretic Combinations: 56
35. ACE Inhibitor/CCB Combinations: 10

PDP and CDRP Total Cost Avoidance by County

County	CDRP	PDP	Total	% Total
Albany	$194,752	$2,054,996	$2,249,748	0.77%
Allegany	$29,001	$583,652	$612,653	0.21%
Broome	$156,140	$1,952,645	$2,108,785	0.72%
Cattaraugus	$50,652	$956,552	$1,007,204	0.35%
Cayuga	$40,872	$678,715	$719,587	0.25%
Chautauqua	$88,076	$1,722,360	$1,810,436	0.62%
Chemung	$70,043	$1,068,009	$1,138,052	0.39%
Chenango	$54,779	$597,486	$652,265	0.22%
Clinton	$90,959	$994,214	$1,085,173	0.37%
Columbia	$39,685	$454,954	$494,640	0.17%
Cortland	$34,541	$497,799	$532,339	0.18%
Delaware	$34,541	$385,103	$419,644	0.14%
Dutchess	$74,000	$1,266,930	$1,340,930	0.46%
Erie	$945,492	$8,613,821	$9,559,313	3.28%
Essex	$18,373	$362,204	$380,577	0.13%
Franklin	$44,660	$575,579	$620,239	0.21%
Fulton	$58,171	$762,999	$821,170	0.28%
Genesee	$27,248	$454,108	$481,356	0.17%
Greene	$31,940	$431,271	$463,212	0.16%
Hamilton	$2,996	$28,866	$31,862	0.01%
Herkimer	$59,697	$660,338	$720,036	0.25%
Jefferson	$122,108	$1,220,101	$1,342,209	0.46%
Lewis	$18,599	$291,341	$309,940	0.11%
Livingston	$32,619	$457,824	$490,443	0.17%
Madison	$33,976	$528,543	$562,519	0.19%
Monroe	$478,880	$6,851,550	$7,330,429	2.51%
Montgomery	$56,645	$626,311	$682,955	0.23%
Nassau	$264,625	$4,636,574	$4,901,199	1.68%
Niagara	$191,586	$2,021,733	$2,213,318	0.76%
Oneida	$225,957	$2,589,176	$2,815,133	0.97%
Onondaga	$277,570	$3,624,335	$3,901,905	1.34%
Ontario	$38,555	$613,282	$651,837	0.22%
Orange	$246,591	$2,488,518	$2,735,109	0.94%
Orleans	$28,435	$372,239	$400,675	0.14%
Oswego	$96,330	$1,325,735	$1,422,065	0.49%
Otsego	$37,254	$471,369	$508,624	0.17%
Putnam	$11,646	$188,556	$200,202	0.07%
Rensselaer	$77,618	$1,259,497	$1,337,115	0.46%
Rockland	$119,734	$1,773,277	$1,893,011	0.65%
St. Lawrence	$120,017	$1,455,011	$1,575,028	0.54%
Saratoga	$78,579	$995,721	$1,074,300	0.37%
Schenectady	$102,379	$1,194,766	$1,297,145	0.44%
Schoharie	$15,433	$236,542	$251,975	0.09%
Schuyler	$16,451	$175,878	$192,329	0.07%
Seneca	$12,607	$246,948	$259,555	0.09%
Steuben	$61,959	$1,131,398	$1,193,357	0.41%
Suffolk	$325,679	$5,671,340	$5,997,019	2.06%
Sullivan	$85,872	$781,913	$867,784	0.30%
Tioga	$32,958	$469,511	$502,469	0.17%
Tompkins	$44,773	$541,366	$586,139	0.20%
Ulster	$105,714	$1,208,538	$1,314,252	0.45%
Warren	$35,898	$499,244	$535,142	0.18%
Washington	$37,707	$561,291	$598,997	0.21%
Wayne	$43,869	$674,709	$718,578	0.25%
Westchester	$407,197	$5,486,521	$5,893,719	2.02%
Wyoming	$15,942	$259,791	$275,733	0.09%
Yates	$7,914	$231,937	$239,852	0.08%
Total for above counties:	$6,056,292	$78,264,990	$84,321,282	28.92%
New York City	$16,834,786	$188,870,246	$205,705,032	70.54%
OMH	$10,345	$551,132	$561,477	0.19%
OMR	$7,632	$905,820	$913,452	0.31%
NYS DOH	$9,610	$104,561	$114,171	0.04%