NEW YORK STATE MEDICAID
PREFERRED DRUG PROGRAM

ANNUAL REPORT
TO THE
GOVERNOR AND LEGISLATURE

STATE FISCAL YEAR
APRIL 1, 2009 – MARCH 31, 2010

New York State Medicaid Preferred Drug Program
Annual Report to the Governor and Legislature
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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	U.S. Food and 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 PDP was expanded to include Family Health Plus (FHPlus) beneficiaries. The pharmacy benefit for FHPlus beneficiaries 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 beneficiaries became subject to Medicaid's PDP, CDRP and Mandatory Generic Drug Program (MGDP). As required by the legislation, this report provides information about the volume of prior authorizations; the quality of the program's responsiveness; a summary of the complaints about the programs; savings attributable to the program; the aggregate amount of supplemental rebates; and the education and outreach conducted by the DOH relative to the programs.

Program Overview

The PDP encourages providers to prescribe drugs that are therapeutically appropriate and cost effective through the use of a Preferred Drug List (PDL). Most 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 that 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. Implementation of the PDP and CDRP has not affected access to medically necessary drugs for Medicaid beneficiaries.

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 of Health on Medicaid pharmacy matters, including making recommendations on the PDP and CDRP. The P&TC meet in a public forum. To ensure transparency in the process, a notice of each meeting and the agenda is posted on the DOH website 30 days prior to the meeting. The meetings are webcast to enable public access to 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 09/10, the P&TC reviewed the testimony from 91 interested parties.

Prior authorization activities are conducted by the CCC. The CCC is available 24 hours a day, seven days a week and is staffed by certified pharmacy technicians (CPT), pharmacists and a physician for peer reviews. In SFY 09/10 the CCC handled 399,169 phone requests and 53,047 fax requests for prior authorization under the PDP and the CDRP. Almost all phone requests (99.84 percent) were completed during the initial call and 99.90 percent of all faxed requests were responded to within 24 hours of receipt. In addition, the CCC provided approximately 70,000 callers with general information or technical assistance, and identified and referred 11 potential instances of fraud and/or abuse to the DOH. This represents a decrease in individual fraud referrals over last SFY. However, CCC and quality assurance staff assisted in researching potential fraud and abuse cases with the Office of the Medicaid Inspector General (OMIG) and the Office of Attorney General (AG). Information collected included hundreds of call recordings from the CCC. Call recordings and the associated details from CCC records were integral to several large fraud investigations.

Prescriber, Pharmacy and Patient Satisfaction

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

The annual independent survey conducted by Decision Support Systems Research included 551 prescribers and 615 pharmacists who responded to the survey. Results demonstrate that overall satisfaction with operation of the programs remains strong. Approximately 88 percent of all prescribers and pharmacists who responded to the survey reported their satisfaction with the PA process. This represents a four percent increase in the satisfaction rate for SFY 08/09. Outcomes confirmed that the CCC continues to perform well, prior authorizations are typically accomplished in a matter of minutes and that 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, 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 which provides direct assistance. Overall, it is estimated that 55 complaints about the PDP and CDRP were received during SFY 09/10.

Program Expansion

Expansion of the programs and operational enhancements continued this SFY. Ten new drug classes were reviewed for inclusion on the PDL. The P&TC re-reviewed 61 therapeutic categories already subject to the PDL to take into consideration new drugs within the classes previously approved by the U.S. Food and Drug Administration (FDA), newly available clinical information and updated financial information. By the end of SFY 09/10 there were a total of 62 drug classes subject to the PDP. In addition, five new drugs and two drug classes were reviewed for inclusion in the CDRP. The GLP-1 Receptor class was re-reviewed and the P&TC recommended that it be removed from the CDRP. At the end of the SFY there were a total of 11 drugs and one drug class subject to the CDRP.

Program Savings

In SFY 09/10, Medicaid processed approximately 57 million pharmacy claims. Of these, 35 percent were for a drug within one of the classes of drugs on the PDL. Of the drugs subject to the PDP, 95.6 percent of claims were for preferred drugs that did not require PA. The remaining 4.4 percent were for non-preferred drugs that required PA. The 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. Program success is further supported by the pharmacy provider community assisting prescribers with preferred drug choices.

The total gross savings attributable to the PDP for SFY 09/10 is estimated at $380.5 million. Consistent with last year's experience, the majority of the savings, estimated $212.4 million[1], resulted from supplemental rebates on preferred drugs. The remaining $168.1 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 initially applied to only three drugs: Revatio®, Serostim® and Zyvox®. In SFY 09/10, the program was expanded to include four additional drugs: Adcirca®, Onsolis®, Synagis® and Victoza®. The Topical Immunomodulator drug class (Elidel® and Protopic®) was also added to the CDRP.

Consistent with legislative guidelines, these additions to the CDRP were recommended by the PT&C and approved by the Commissioner of Health due to their potential for misuse and to ensure that the drug is appropriately prescribed for its FDA-approved indications. For SFY 09/10, a combined total of 33,787 prior authorization requests were received for CDRP drugs and all were approved using the criteria set forth in the legislation, which allows a denial only on the basis of substantial evidence of fraud and abuse. Had the statute allowed for denial on the basis of medical necessity, 11 percent of the requests would have been denied for not meeting clinical criteria. This represents

[1] Due to passage of the federal Patient Protection and Affordable Care Act in March 2010, OBRA and supplemental rebate amounts for Q110 are estimated.

an increase of seven percent over last SFY of PAs issued under the "prescriber prevails" legislative language.

Although all CDRP PA requests were approved, results comparing the number and dollar amounts of claims paid in the baseline quarter before implementation of the program against the last quarter in SFY 09/10 continue to demonstrate that it was successful in achieving cost avoidance. As compared to baseline observations, significant reductions in claims and respective payments were achieved during this reporting period with Actiq®/ Fentanyl Citrate, Byetta®, Serostim®, and Synagis®. Lidoderm® reflecting the most dramatic reduction in claims/payments, with an 82 percent decrease in claims and a 79 percent decrease in payments as compared to the pre-CDRP baseline experience. Fentora® showed a 16.5 percent decrease from baseline and demonstrated a 2.3 percent reduction in claims from Q409 to Q110. Zyvox® utilization reflected a 12.5 percent decrease in claims from baseline.

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 91 percent of all requests either met the clinical criteria established or were determined to be clinically justified (specifically for use in treatment of scleroderma and other rheumatologic disorders) 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 $51,080,990.

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 providers' 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 and effective administration of the program; and
- success in 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 PDP and CDRP. The legislation expanded the membership of the P&TC, established operational and administrative procedures and provided authority for the State to establish a 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 Magellan Health Services. FHSC was selected through a competitive bid to operate the CCC that supports the Medicaid PDP, CDRP and MGDP; provide outreach and education services; assist with the clinical drug reviews; and obtain competitive pricing for prescription drugs through supplemental drug rebate agreements with drug manufacturers participating in the National Medicaid Pooling Initiative (NMPI).

Effective October 1, 2008, the pharmacy benefit for FHPlus beneficiaries was "carved-out" of the managed care plan benefit package and incorporated in the Medicaid fee-for-service program. Pharmacy benefits for FHPlus beneficiaries became subject to Medicaid's PDP, CDRP and MGDP requirements and eligible for supplemental drug rebates.

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 PDL.

In developing the PDL, the 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 determines that there is no

substantial clinical difference among the drugs in the class, it then considers the net cost of the drug after rebates as a factor in determining preferred status. The P&TC also considers how its recommendations may impact current prescribing and dispensing practices and patient care. Recommendations are presented to the Commissioner of Health, who makes the final determination regarding which drugs will be listed as preferred or non-preferred.

The DOH issues the PDL (Appendix 4) which lists all drugs on the PDP and the Quick List (Appendix 5) which lists only preferred drugs within a therapeutic class. The PDL and Quick List are updated and provided to prescribers and pharmacies whenever there is a change. The PDL and Quick List are also posted on the internet at 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 prior authorization (PA) for certain drugs and drug classes 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 for the CDRP or as a denial reason when a PA is requested.

Prior to the CDRP legislation, Serostim® and Zyvox® were subject to PA due to 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 and drug classes were subject to the CDRP at the end of SFY 09/10:

- **Actiq**® (fentanyl citrate oral transmucosal lozenge) 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. This group of medications is 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. PA for fentanyl citrate oral transmucosal lozenge was implemented to deter fraud, abuse and misutilization.
- **Adcirca**® (tadalafil) has the same active ingredient found in Cialis®, which is used to treat erectile dysfunction. The Medicaid program is prohibited from covering drugs used for the treatment of erectile dysfunction, unless those drugs are approved by the FDA to treat other conditions. Adcirca® requires PA to ensure that it will only be used for documented treatment of primary pulmonary arterial hypertension, an FDA approved indication, and other medical conditions supported in the Compendia of medical literature.
- **Byetta**® (exenatide injection) is 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. PA for Byetta® was implemented to assure that the drug was appropriately prescribed for its FDA approved indications and to deter misutilization.
- **Fentora**® (fentanyl) is available as a buccal tablet. The tablet should be placed in the buccal cavity located above the rear molar tooth, between the upper cheek and gum and allowed to dissolve. This group of medications is 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. PA for fentanyl citrate buccal tablet was implemented to deter fraud, abuse and misutilization.
- **Lidoderm**® (lidocaine patch 5 percent) is 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.

- **Onsolis**® (fentanyl buccal soluble film) is indicated only for the management of breakthrough pain in patients with cancer, 18 years of age and older who are already receiving and who are tolerant to opioid therapy for their underlying persistent cancer pain. PA for fentanyl buccal soluble film was implemented to deter fraud, abuse and misutilization.
- **Revatio**® (sildenafil citrate) has the same active ingredient found in Viagra®. The Medicaid program is prohibited from covering drugs used for the treatment of erectile dysfunction, unless those drugs are used to treat other conditions, and have received approval from the FDA for that purpose. Revatio® requires PA to ensure that it will only be used for documented treatment of primary pulmonary arterial hypertension, an FDA approved indication, and other medical conditions supported in the Compendia of medical literature.
- **Serostim**® (somatropin [rDNA origin] for injection) is a human growth hormone (HGH) produced by recombinant DNA technology. It has been approved by the FDA for the treatment of AIDS wasting or cachexia. Growth hormone has been reported to be abused by athletes, bodybuilders and aging adults for its ability to increase muscle mass and decrease body fat, as well as its purported potential to improve athletic performance and reverse the effects of aging. PA for Serostim was implemented to assure that the drug was appropriately prescribed for its FDA approved indications and to deter fraud and misutilization.
- **Synagis**® (palivizumab) is a humanized monoclonal antibody (IgG1κ) that is indicated for the prevention of serious lower respiratory tract disease caused by respiratory syncytial virus (RSV) in pediatric patients at high risk of RSV disease. PA for Synagis® was implemented to reinforce appropriate use and to ensure utilization consistent with the approved indications and guidelines established by the American Academy of Pediatrics.
- **Topical Immunomodulators**

  1. **Elidel**® (pimecrolimus) is a topical agent indicated as second-line therapy for the short-term and non-continuous chronic treatment of mild to moderate atopic dermatitis in non-immunocompromised adults and children two years of age and older, who have failed to respond adequately to other topical prescription treatments, or when those treatments are not advisable. Topical Calcineurin Inhibitors, including Elidel®, have a black box warning associated with them as their long term safety has not been established. Although a causal relationship has not been established, rare cases of malignancy (e.g., skin and lymphoma) have been reported in patients treated with Elidel®. PA for Elidel® has been implemented to reinforce appropriate use and to ensure utilization consistent with approved indications.
  2. **Protopic**® (tacrolimus ointment) is a topical agent indicated as second-line therapy for the short term and non-continuous chronic treatment of moderate to severe atopic dermatitis in non-immunocompromised adults and children who have failed to respond adequately to other topical prescription treatments for atopic dermatitis, or when those treatments are not advisable. Topical Calcineurin Inhibitors, including Protopic®, have a black box warning

associated with them as their long term safety has not been established. Although a causal relationship has not been established, rare cases of malignancy (e.g., skin and lymphoma) have been reported in patients treated with Protopic® has been implemented to reinforce appropriate use and to ensure utilization consistent with approved indications.

- **Victoza®** (liraglutide [rDNA origin] injection) is a glucagon-like peptide-1 (GLP-1) receptor agonist indicated as an adjunct to diet and exercise to improve glycemic control in adults with DM. Victoza® improves glycemic control by reducing fasting and postprandial glucose concentrations. Victoza is not recommended as first-line therapy to treat DM. PA for Victoza® was implemented to assure that the drug was appropriately prescribed for its FDA approved indications and to deter misutilization.
- **Zyvox®** (linezolid) is a synthetic antibiotic, the first of the oxazolidinone class, used for the treatment of infections caused by multi-resistant bacteria including methicillin-resistant *Staphylococcus aureus* (MRSA). PA for Zyvox® was implemented to address potential misutilization and inappropriate prescribing, which could result in bacterial resistance adversely affecting the health of all New Yorkers.

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

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

The P&TC is subject to the Public Officers Law and meetings are subject to the Open Meetings Law. A notice of each meeting and the agenda is posted on the DOH website 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 before the meeting, as well as oral testimony provided during the public session, are discussed as well.

Following the clinical presentation and consideration of all clinical information, the P&TC adjourns for an executive session to evaluate confidential drug pricing information with respect to supplemental rebates. The P&TC reconvenes in open session to discuss

any remaining issues, then votes on the recommendations to be submitted to the Commissioner of Health.

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

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

A list of the drug classes reviewed during SFY 09/10 appears in Appendix 3.

D. The Prior Authorization 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, seven days a week. Performance is monitored closely by the 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 09/10, the CCC received 399,169 phone requests and 53,047 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 expansion of the PDP and CDRP. Performance remains consistent with the last SFY. Nearly all phone requests (99.84 percent) were completed during the initial call, and 99.90 percent of all faxed requests were responded to within 24 hours of receipt. In addition, the CCC provided approximately 70,000 callers with general information or technical assistance with the PA process and identified and referred 11 potential instances of fraud and/or abuse to the DOH. CCC and Quality Assurance (QA) staff assisted in researching potential fraud and abuse cases with the OMIG and the OAG. Information collected included hundreds of call recordings from the CCC. Call recordings and the associated details from CCC records were integral to several large fraud investigations.

Preferred Drug Program (PDP) Prior Authorization Process

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

- the preferred drug has been tried by the patient and has failed to produce the desired health outcomes;
- the patient has tried the preferred drug and has experienced undesirable side effects;

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

Prescribers initially speak with a 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 3,847 (1.1 percent) of the PDP PAs processed in SFY 09/10.

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

Clinical Drug Review Program (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 call center pharmacist so that the prescriber may provide additional information to support the use of the drug. At the prescriber's request, a physician peer review may take place. In SFY 09/10, there were twenty (20) 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. In SFY 09/10, there were no denials issued under the CDRP.

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 SFY 09/10, changes to the PDP occurred through the re-review of existing classes and addition of new drug classes. With each change, prescribers and pharmacies were notified in advance when the PDL was changing and informed of the PA requirements that would apply to newly non-preferred and CDRP drugs. Notification was done via direct mailings, the Medicaid Update (a monthly Medicaid provider

communication) and internet postings (newyork.fhsc.com). Presentations and teleconferences were also held with various prescriber and pharmacy organizations throughout the period (Appendix 6).

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

Beneficiary outreach efforts focused on providing information about how the programs might affect prescription coverage requirements. Informational program brochures were provided to pharmacies, teaching and non-teaching hospitals, clinics and high volume prescribers for distribution to beneficiaries (Appendix 7). In addition, brochures were translated into a number of alternative languages including Bosnian, Chinese, Yiddish, and Creole, to effectively meet the needs of Medicaid beneficiaries. The PDP website 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: complaints and a satisfaction survey of prescribers and pharmacies. This information is used to address program performance and identify opportunities for improvement.

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 pharmacies who utilized the CCC. Five hundred fifty-one prescribers and 615 pharmacies responded.

Survey results demonstrated that the majority of prescribers and pharmacies (88 percent) were satisfied with the program, with pharmacist satisfaction increasing this year (89 percent as compared to 84.4 percent last year). Responses continued to support that PAs are typically accomplished in a matter of minutes and accessibility ratings for CCC representatives remained high.

Prescriber comments indicate a desire to streamline the PA process. DOH has identified opportunities for improvement regarding the provider's ability to reach a CCC representative and the promptness reaching a CCC 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. Website 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 SFY 09/10, 95.43 percent of calls were answered within two minutes, with an average speed of answer of 18 seconds.

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

The survey reflected the following:

- that providers utilize the CCC as the primary source of information about the program, particularly to confirm which drugs are preferred and which require PA; and
- that website usage increased slightly from last year; however there was a significant increase in prescribers reporting that the information was "easily accessed." Ninety-two.3 percent reported easy access via website this year as compared to 87.2 percent last year).

Complaints

Complaints may be received through mail or email, the CCC or Medicaid Helpline and from feedback at educational presentations. Overall, it is estimated that 55 complaints about the PDP and CDRP were received during SFY 09/10, primarily via phone calls and letters.

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

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 received no calls on this topic in SFY 09/10. If calls had been received they would have been referred to the DOH Medicaid pharmacy staff to provide direct assistance to the beneficiary and/or their providers.

V. Outcomes and Cost Savings

Preferred Drug Program

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

In order to receive supplemental rebates, New York State joined the National Medicaid Pooling Initiative (NMPI) administered by FHSC. New York is among 12 states that currently participate in the pool. Others include Alaska, Kentucky, Michigan,

Minnesota, Montana, Nevada, New Hampshire, Rhode Island, South Carolina, North Carolina and the District of Columbia. The NMPI comprises approximately 7.4 million member lives, with New York representing the largest percentage. Manufacturer bid prices are dependent on the number of member lives and the number of competing preferred drugs in a particular drug class. 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 P&TC and the ability to designate a drug as preferred or non-preferred. At the end of the SFY 09/10, a total of 91 manufacturers participated in the NMPI.

The Medicaid program processed approximately 57 million pharmacy claims in SFY 09/10. Of these, 35 percent were for a drug that fell within one of the classes of drugs on the PDP. Of the drugs subject to the PDP, 95.6 percent of claims were for preferred drugs that did not require PA (Appendix 9). This high percentage is attributable 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 4.4 percent of claims were for non-preferred drugs that required PA.

Under the PDP, the highest volume of requests for non-preferred drugs this SFY was the 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 Agency for Healthcare Research and Quality (AHRQ), demonstrating spending tripled for prescription analgesics in ten years (1996-2006). The other top classes for PA requests were: Sedative Hypnotics (13 percent), which are used as sleep aids; Proton Pump Inhibitors (9 percent), used to treat acid reflux; Antihistamines (7 percent), used primarily to treat allergies, which remained relatively stable from the prior year's results.

Consistent with the experience last SFY, primary indicators for PDP PA requests to prescribe 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 CCC staff, approximately 1.6 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 09/10, total gross savings for the PDP was an estimated $380.5 million. More than half of the estimated savings, $212.4 million, resulted from supplemental rebates. The remaining savings, $168.1 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 months after the drug class is added to the PDP.

Clinical Drug Review Program

In SFY 09/10, a total of 33,787 requests were approved for PA of drugs under the CDRP as follows:

- **Zyvox®** totaled 1,434
- **Victoza®** totaled 194
- **Adcirca®** totaled 24
- **Byetta®** totaled 6,147
- **Synagis®** totaled 91
- **Immunomodulators: Topical** totaled 3,630
- **Serostim®** totaled 243
- **Revatio®** totaled 499
- **Actiq/Fentora®** totaled 1,386
- **Lidoderm®** totaled 20,139
- **Onsolis®** totaled 0

All CDRP requests were authorized using the criteria in current statute, which allows a denial only on the basis of substantial evidence of fraud and abuse, which is difficult to establish during a PA phone call. If statute allowed denial on the basis of medical necessity, 11 percent of requests would have been denied, suggesting that an opportunity exists to enhance the program further to ensure appropriate prescribing practices and protect patient safety in these cases.

Although all CDRP requests were authorized during SFY 09/10, a comparison of utilization and cost from baseline to the last quarter in SFY 09/10 showed a decrease in utilization and spending on the majority of the CDRP drugs. In aggregate, there was a 75 percent reduction in claims and a 71.5 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 $51,080,989 (gross).

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

VI. Conclusion

The third 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 beneficiaries.

In SFY 09/10, the P&TC re-reviewed 61 classes of drugs in the PDP to include drugs recently approved by the FDA and newly available clinical and financial information. Ten new drug classes were reviewed for inclusion on the PDP. By the end of the SFY there were a total of 62 drug classes subject to the PDP. In addition, five new drugs and two drug classes were reviewed and recommended by the PT&C for inclusion to the CDRP. At the end of the SFY there were 11 drugs and one drug class subject to the CDRP.

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.

Educational efforts for beneficiaries, providers and interested parties will be maintained and enhanced to promote community awareness and understanding of the program. Distribution of revised beneficiary 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 written notifications that provide information about their patients who are currently taking prescription drugs that will require PA.

The PDP and CDRP 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 DOH, will be conducted to ensure appropriate protocol and accounting is maintained. The CCC satisfaction survey will be repeated to gain feedback from providers, to monitor satisfaction with the process and to address opportunities for continuous quality improvement. Complaints and feedback from the satisfaction survey will be evaluated for potential enhancements to the process.

Legislation

Article 2A of Chapter 58 of the Laws of 2005

*** § 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 pharmacists, 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 included in the preferred drug program and is not one of the drugs on the preferred drug list because it is either: (a) 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 or (b) manufactured by a Pharmaceutical manufacturer with whom the commissioner is negotiating or has negotiated a manufacturer agreement and is not a preferred drug under a manufacturer agreement.

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 either (a) in a therapeutic class that is included in the preferred drug program and is (a) one of the drugs on the preferred drug list in that class or (b) a preferred drug under a manufacturer agreement.

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"), the elderly pharmaceutical insurance coverage program established by title three of article two of the elder law (referred to in this article as "EPIC"), and the family health plus program established by section three hundred sixty-nine-ee of the social services law to the extent that section provides that the program shall be subject to this article.

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.

14. "Manufacturer agreement" means an agreement between the commissioner and a pharmaceutical manufacturer under paragraph (b) of subdivision eleven of section two hundred seventy-two of this article.

§ 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, paragraph (g) of subdivision two of section three hundred sixty-five-a of the social services law, subdivision one of section two hundred forty-one of the elder law and 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 or 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 five 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; and 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. (a) The commissioner shall provide an opportunity for pharmaceutical manufacturers to provide supplemental rebates to the state public health plans for drugs within a therapeutic class; 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.

(b) The commissioner may designate a pharmaceutical manufacturer as one with whom the commissioner is negotiating or has negotiated a manufacturer agreement, and all of the drugs it manufactures or markets shall be included in the preferred drug program. The commissioner may negotiate directly with a pharmaceutical manufacturer for rebates relating to any or all of the drugs it manufactures or markets. A manufacturer agreement shall designate any or all of the drugs manufactured or marketed by the pharmaceutical manufacturer as being preferred or non preferred drugs. When a pharmaceutical manufacturer has been designated by the commissioner under this paragraph but has not reached a manufacturer agreement with the pharmaceutical manufacturer, then all of the drugs manufactured or marketed by the pharmaceutical manufacturer shall be non preferred drugs. However, notwithstanding this paragraph, any drug that is selected to be on the preferred drug list under paragraph (b) of subdivision ten of this section on grounds that it is significantly more clinically effective and safer than other drugs in its therapeutic class shall be a preferred drug.

(c) Supplemental rebates under this subdivision 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 a non preferred drug.

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 of 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 preferred drug program shall be required when a prescriber prescribes a drug on the preferred drug list; provided, however, that the commissioner may identify such a drug for which prior authorization is required pursuant to the provisions of the clinical drug review program established under section two hundred seventy-four of this article.

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 the 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 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.

Medicaid Pharmacy and Therapeutics Committee Membership

Name and Affiliation:

1. **Mary Lee Wong, M.D.**
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13. **Nancy Balkon, Ph.D., N.P.**
    Stony Brook University School of Nursing,
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15. **Marla Suzan Eglowstein, M.D.**
    National Multiple Sclerosis Society

Drug Classes in the Preferred Drug Program

The following table lists each PDP drug class that was reviewed by the P&TC during SFY 09/10, the date that it was reviewed, 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
24-Apr-09	ACE INHIBITORS	14-Jul-09	19-Aug-09
24-Apr-09	ACE/DIURETIC COMBINATIONS	14-Jul-09	19-Aug-09
24-Apr-09	CALCIUM CHANNEL BLOCKERS: DHP	14-Jul-09	19-Aug-09
24-Apr-09	ACE/CCB COMBINATIONS	14-Jul-09	19-Aug-09
24-Apr-09	ANGIOTENSIN RECEPTOR BLOCKERS	14-Jul-09	19-Aug-09
24-Apr-09	ARB/DIURETIC COMBINATIONS	14-Jul-09	19-Aug-09
24-Apr-09	BETA BLOCKERS	14-Jul-09	19-Aug-09
24-Apr-09	BETA BLOCKER/DIURETIC COMBINATIONS	14-Jul-09	19-Aug-09
24-Apr-09	STATINS	14-Jul-09	19-Aug-09
24-Apr-09	TRIG. LOWERING AGENTS	14-Jul-09	19-Aug-09
24-Apr-09	BONE OSSIFICATION SUPPRESSION AGENTS	14-Jul-09	19-Aug-09
24-Apr-09	CALCITONINS	14-Jul-09	19-Aug-09
24-Apr-09	ERYTHROPOIESIS STIMULATING AGENTS (ESAs)	14-Jul-09	19-Aug-09
24-Apr-09	PROGESTINS (CACHEXIA)	14-Jul-09	19-Aug-09
24-Apr-09	ANTICOAGULANTS: INJECTABLE	14-Jul-09	19-Aug-09
24-Apr-09	ANTI-EMETICS: ORAL	14-Jul-09	19-Aug-09
24-Apr-09	CNS STIMULANTS	14-Jul-09	19-Aug-09
24-Apr-09	PROTON PUMP INHIBITORS	14-Jul-09	19-Aug-09
24-Apr-09	ALPHA BLOCKERS: BPH	14-Jul-09	19-Aug-09
24-Apr-09	URINARY TRACT ANTISPASMODICS	14-Jul-09	19-Aug-09
24-Apr-09	STEROIDS: INHALED	14-Jul-09	19-Aug-09
10-Jun-09	ALPHA-2 AGONISTS: OPHTH	21-Aug-09	21-Oct-09
10-Jun-09	ANTIHISTAMINES: LOW SEDATING	21-Aug-09	21-Oct-09
10-Jun-09	ANTIHISTAMINES: OPHTH	21-Aug-09	21-Oct-09
10-Jun-09	CEPHALOSPORINS: 3RD GEN	21-Aug-09	21-Oct-09
10-Jun-09	IMMUNOMODULATORS: ARTHRITIS	21-Aug-09	21-Oct-09
10-Jun-09	IMMUNOMODULATORS: TOPICAL	21-Aug-09	21-Oct-09
10-Jun-09	LEUKOTRIENE MODIFIERS	21-Aug-09	21-Oct-09
10-Jun-09	NSAIDS: OPHTH	21-Aug-09	21-Oct-09
10-Jun-09	PHOSPHATE REGULATORS	21-Aug-09	21-Oct-09
10-Jun-09	PROSTAGLANDIN AGONISTS: OPHTH	21-Aug-09	21-Oct-09
10-Jun-09	QUINOLONES: ORAL	21-Aug-09	21-Oct-09
10-Jun-09	QUINOLONES: OPHTH	21-Aug-09	21-Oct-09
10-Jun-09	QUINOLONES: OTIC	21-Aug-09	21-Oct-09
10-Jun-09	SEDATIVE HYPNOTICS	21-Aug-09	21-Oct-09
10-Jun-09	STEROIDS: NASAL	21-Aug-09	21-Oct-09
10-Jun-09	TRIPTANS	21-Aug-09	21-Oct-09
11-Sep-09	ANTIVIRALS: HEPATITIS C	21-Dec-09	12-Jan-10
11-Sep-09	BETA AGONISTS: SHORT-ACTING	21-Dec-09	12-Jan-10
11-Sep-09	BETA AGONISTS: LONG-ACTING	21-Dec-09	12-Jan-10
11-Sep-09	ANTIVIRALS: HERPES	21-Dec-09	12-Jan-10
11-Sep-09	GROWTH HORMONES	21-Dec-09	12-Jan-10

P&TC Meeting	Drug Class	Posting Date	Date PA Required
11-Sep-09	THIAZOLIDINEDIONES (TZD)	21-Dec-09	12-Jan-10
11-Sep-09	ANTICHOLINERGICS: RESPIRATORY	21-Dec-09	12-Jan-10
11-Sep-09	ANTIFUNGALS: ONYCHOMYCOSIS	21-Dec-09	12-Jan-10
11-Sep-09	OPIATES: LONG ACTING	21-Dec-09	12-Jan-10
11-Sep-09	MULTIPLE SCLEROSIS AGENTS	21-Dec-09	12-Jan-10
11-Sep-09	ALZHEIMER AGENTS	21-Dec-09	12-Jan-10
11-Sep-09	SULFASALAZINE DERIVATIVES	21-Dec-09	12-Jan-10
11-Mar-10	ACE INHIBITORS	27-May-10	17-Jun-10
11-Mar-10	ACE/DIURETIC COMBINATIONS	27-May-10	17-Jun-10
11-Mar-10	CALCIUM CHANNEL BLOCKERS: DHP	27-May-10	17-Jun-10
11-Mar-10	ACE/CCB COMBINATIONS	27-May-10	17-Jun-10
11-Mar-10	ANGIOTENSIN RECEPTOR BLOCKERS	27-May-10	17-Jun-10
11-Mar-10	ARB/DIURETIC COMBINATIONS	27-May-10	17-Jun-10
11-Mar-10	BETA BLOCKERS	27-May-10	17-Jun-10
11-Mar-10	BETA BLOCKER/DIURETIC COMBINATIONS	27-May-10	17-Jun-10
11-Mar-10	STATINS	27-May-10	17-Jun-10
11-Mar-10	TRIG. LOWERING AGENTS	27-May-10	17-Jun-10
11-Mar-10	BONE OSSIFICATION SUPPRESSION AGENTS	27-May-10	17-Jun-10
11-Mar-10	CALCITONINS	27-May-10	17-Jun-10
11-Mar-10	PROTON PUMP INHIBITORS	27-May-10	17-Jun-10
11-Mar-10	DIPEPTIDYL PEPTIDASE-4 (DPP-4) INHIBITORS	27-May-10	17-Jun-10

Preferred And Non-Preferred Drug List

Revised 11/18/2009

NEW YORK STATE MEDICAID PREFERRED DRUG LIST

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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®

Cyclooxygenase II (COX II) Inhibitors

NON-PREFERRED AGENTS
None

Narcotics – Long Acting

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

Narcotics – Long Acting

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

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

PREFERRED AGENTS	
diclofenac potassium	ketorolac
diclofenac sodium	meclofenamate
diclofenac sodium XR	mefenamic acid
diflunisal	meloxicam
etodolac	nabumetone
etodolac SA	naproxen
fenoprofen	naproxen sodium
flurbiprofen	naproxen EC
ibuprofen	oxaprozin
indomethacin	piroxicam
indomethacin SR	sulindac
ketoprofen	tolmetin
ketoprofen SA	

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

NON-PREFERRED AGENTS	
Anaprox®	*Nalfon®*
Anaprox® DS	*Naprelan®*
Arthrotec®	*Naprosyn®*
Cataflam®	*Naprosyn® EC*
Clinoril®	*Ponstel®*
Daypro®	*Voltaren®*
Feldene®	*Voltaren® Gel*
Flector® patch	*Voltaren® XR*
Indocin®	*Zipsor®*
Mobic®	

II. ANTI-INFECTIVES

Anti-Fungals

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

Anti-Fungals

NON-PREFERRED AGENTS	
Grifulvin V® (suspension)	*Lamisil® (tablet)*
Grifulvin V® (tablet)[2]	*Penlac®*
itraconazole	*Sporanox®*

Anti-Virals - Oral

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

Anti-Virals - Oral

NON-PREFERRED AGENTS	
Famvir®	*Zovirax® (capsule, suspension, tablet)*
famciclovir[2]	
valacyclovir	

Cephalosporins – Third Generation

PREFERRED AGENTS	
cefdinir	Suprax®
cefpodoxime proxetil	

Cephalosporins – Third Generation

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

[2] Non-Preferred as of 1/12/2010
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Fluoroquinolones – Oral

PREFERRED AGENTS		NON-PREFERRED AGENTS	
Avelox®	ciprofloxacin (tablet)	*Cipro® (tablet)*	*Levaquin®*
Avelox ABC Pack®	ofloxacin (tablet)	*Cipro XR®*	*Noroxin®*
Cipro® (suspension)		*ciprofloxacin ER*	*Proquin XR®*
		Factive®	

Pegylated Interferons

PREFERRED AGENTS	NON-PREFERRED AGENTS
PegIntron®	*None*
PegIntron Redipen®	
Pegasys®	
Pegasys Convenience Pack®	

III. CARDIOVASCULAR

Angiotensin Converting Enzyme Inhibitors (ACEIs)

PREFERRED AGENTS		NON-PREFERRED AGENTS	
benazepril	moexipril	*Accupril®*	*Monopril®*
captopril	ramipril (capsule)	*Aceon®*	*perindopril*
enalapril maleate	trandolapril	*Altace® (capsule)*	*Prinivil®*
lisinopril		*Altace® (tablet)*	*quinapril*
		Capoten®	*Univasc®*
		fosinopril sodium	*Vasotec®*
		Lotensin®	*Zestril®*
		Mavik®	

ACEIs + Calcium Channel Blockers

PREFERRED AGENTS		NON-PREFERRED AGENTS
benazepril/amlodipine	Tarka®	*Lexxel®*
Lotrel®		

ACEIs + Diuretics

PREFERRED AGENTS		NON-PREFERRED AGENTS	
benazepril/HCTZ	lisinopril/HCTZ	*Accuretic®*	*quinapril/HCTZ*
captopril/HCTZ	moexipril/HCTZ	*Capozide®*	*Quinaretic®*
enalapril maleate/HCTZ		*fosinopril/HCTZ*	*Uniretic®*
		Lotensin HCT®	*Vaseretic®*
		Monopril HCT®	*Zestoretic®*
		Prinzide®	

Angiotensin Receptor Blockers (ARBs)

PREFERRED AGENTS		NON-PREFERRED AGENTS	
Avapro®	Diovan®	*Atacand®*	*Twynsta®*
Benicar®	Exforge®	*Azor®*	*Valturna®*
Cozaar®	Micardis®	*Teveten®*	

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ARBs + Diuretics

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

ARBs + Diuretics

NON-PREFERRED AGENTS	
Atacand HCT®	*Teveten HCT®*
Exforge HCT®	

Beta Blockers

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

Beta Blockers

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

Beta Blockers + Diuretics

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

Beta Blockers + Diuretics

NON-PREFERRED AGENTS	
Corzide®	*Tenoretic®*
Lopressor HCT®	*Ziac®*

Calcium Channel Blockers (Dihydropyridine)

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

Calcium Channel Blockers (Dihydropyridine)

NON-PREFERRED AGENTS	
Adalat CC®	*Plendil®*
Cardene SR®	*Procardia®*
nisoldipine	*Procardia XL®*
Norvasc®	*Sular®*

Cholesterol Absorption Inhibitors

PREFERRED AGENTS
Zetia®

Cholesterol Absorption Inhibitors

NON-PREFERRED AGENTS
None

Direct Renin Inhibitors

PREFERRED AGENTS	
Tekturna®	Tekturna HCT®

Direct Renin Inhibitors

NON-PREFERRED AGENTS
None

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HMG-CoA Reductase Inhibitors (Statins)

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

HMG-CoA Reductase Inhibitors (Statins)

NON-PREFERRED AGENTS	
Advicor®	*Pravachol®*
Altoprev®	*Vytorin®*
Caduet®	*Zocor®*
Mevacor®	

Niacin Derivatives

PREFERRED AGENTS
Niaspan®

Niacin Derivatives

NON-PREFERRED AGENTS
None

Triglyceride Lowering Agents

PREFERRED AGENTS	
gemfibrozil	Tricor®
Lovaza®	Trilipix®

Triglyceride Lowering Agents

NON-PREFERRED AGENTS	
Antara®	*Lipofen®*
fenofibrate	*Lofibra®*
Fenoglide®	*Lopid®*
Fibricor®	*Triglide®*

IV. CENTRAL NERVOUS SYSTEM

Alzheimer's Agents

PREFERRED AGENTS	
Aricept® (ODT, tablet)	galantamine ER
Exelon®	Namenda®
galantamine	

Alzheimer's Agents

NON-PREFERRED AGENTS (PA required as of 01/12/2010)	
Cognex®	*Razadyne ER®*
Razadyne®	

Carbamazepine Derivatives

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

Carbamazepine Derivatives

NON-PREFERRED AGENTS
None

Central Nervous System (CNS) Stimulants

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

Central Nervous System (CNS) Stimulants

NON-PREFERRED AGENTS	
Adderall®	*Metadate CD®*
amphetamine salt combo extended release	*Nuvigil™ CC*
Daytrana®	*Procentra®*
Desoxyn®	*Provigil® CC*
Dexedrine Spansule®	*Ritalin®*
Dextrostat®	*Ritalin LA®*
	Ritalin SR®

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Multiple Sclerosis Agents

PREFERRED AGENTS	
Avonex®	Copaxone®
Betaseron®	Rebif®

NON-PREFERRED AGENTS	
Extavia®	

Non-Ergot Dopamine Receptor Agonists

PREFERRED AGENTS	
Mirapex®	ropinirole

NON-PREFERRED AGENTS	
Requip®	*Requip® XL™*

Sedative Hypnotics/Sleep Agents

PREFERRED AGENTS	
chloral hydrate	temazepam
estazolam	triazolam
flurazepam	zolpidem

NON-PREFERRED AGENTS	
Ambien®	*Prosom®*
Ambien CR®	*Restoril®*
Dalmane®	*Rozerem®*
Doral®	*Somnote®*
Edluar™	*Sonata®*
Halcion®	*zaleplon*
Lunesta®	

Serotonin Receptor Agonists (Triptans)

PREFERRED AGENTS	
Imitrex®	sumatriptan
Maxalt®	Treximet®
Relpax®	

NON-PREFERRED AGENTS	
Amerge®	*Frova®*
Axert®	*Zomig®*

V. DERMATOLOGIC AGENTS

Antibiotics – Topical

PREFERRED AGENTS	
Altabax®	mupirocin ointment
Bactroban® cream	

NON-PREFERRED AGENTS	
Bactroban® ointment	*Centany™ ointment*
Bactroban Nasal® ointment	

Anti-Virals – Topical

PREFERRED AGENTS	
Abreva®	Zovirax® ointment

NON-PREFERRED AGENTS	
Denavir®	*Zovirax® cream*

Immunomodulators – Topical[CDRP]

PREFERRED AGENTS	
Elidel®	Protopic®

NON-PREFERRED AGENTS
None

Psoriasis Agents – Topical

PREFERRED AGENTS
calcipotriene scalp solution
Dovonex® cream

NON-PREFERRED AGENTS	
Dovonex® scalp solution	*Taclonex Scalp®*
Taclonex®	*Vectical™*

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VI. ENDOCRINE AND METABOLIC AGENTS

Bisphosphonates – Oral

PREFERRED AGENTS		NON-PREFERRED AGENTS	
alendronate	Fosamax® (solution)	*Actonel®*	*Fosamax® (tablet)*
		Actonel® with Calcium	*Fosamax® Plus D*
		Boniva®	

Calcitonins – Intranasal

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

Dipeptidyl Peptidase-4 (DPP-4) Inhibitors

PREFERRED AGENTS		NON-PREFERRED AGENTS
Janumet®	Januvia®	*Onglyza®*

Growth Hormones[CDRP]

PREFERRED AGENTS (Subject to CDRP as of 3/10/2010 for Age 21 Years & Older)		NON-PREFERRED AGENTS (Subject to CDRP as of 3/10/2010 for Age 21 Years & Older)	
Genotropin®	Nutropin AQ®	*Humatrope®*	*Tev-Tropin®*
Nutropin®	Saizen®	*Norditropin®*	*Zorbtive®*
		Omnitrope®	

Thiazolidinediones (TZDs)

PREFERRED AGENTS		NON-PREFERRED AGENTS	
Actoplus Met®	Duetact®	*Avandamet®2*	*Avandia®2*
Actos®		*Avandaryl®2*	

VII. GASTROINTESTINAL

Anti-Emetics

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

Proton Pump Inhibitors (PPIs)

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

2 Non-Preferred as of 1/12/2010
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Sulfasalazine Derivatives

PREFERRED AGENTS		NON-PREFERRED AGENTS (PA required as of 01/12/2010)	
Asacol®	sulfasalazine IR	*Asacol HD®*	*balsalazide*
Dipentum®	sulfasalazine DR/EC	*Apriso®*	*Colazal®*
Pentasa®		*Azulfidine®*	*Lialda®*
		Azulfidine Entab®	

VIII. 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®*

IX. IMMUNOLOGIC AGENTS

Immunomodulators – Injectable

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

X. MISCELLANEOUS

Progestins (for Cachexia)

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

XI. MUSCULOSKELETAL AGENTS

Skeletal Muscle Relaxants

PREFERRED AGENTS		NON-PREFERRED AGENTS	
baclofen	orphenadrine	*Amrix®*	*Skelaxin®*
chlorzoxazone	orphenadrine compound	*carisoprodol*	*Soma®*
cyclobenzaprine	orphenadrine comp. forte	*carisoprodol compound*	*Soma® 250*
dantrolene	tizanidine	*carisoprodol compound-codeine*	*Soma® Compound*
methocarbamol		*Dantrium®*	*Soma® Compound with codeine*
		Fexmid®	*Zanaflex® capsule*
		Parafon Forte® DSC	*Zanaflex® tablet*
		Robaxin®	

CC Subject to Clinical Criteria (See: https://newyork.fhsc.com/downloads/providers/NYRx_PDP_clinical_criteria.pdf)
CDRP All drugs in class are subject to Clinical Drug Review Program PA requirements (See: https://newyork.fhsc.com)

Revised 11/18/2009

NEW YORK STATE MEDICAID
PREFERRED DRUG LIST

All non-preferred drugs in these classes require prior authorization (PA)
Preferred drugs that require prior authorization are indicated by footnote

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

NYS MEDICAID PHARMACY CLINICAL CALL CENTER 877-309-9493

XII. OPHTHALMICS

Alpha-2 Adrenergic Agonists (for Glaucoma) – Ophthalmic

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

Antihistamines – Ophthalmic

PREFERRED AGENTS		NON-PREFERRED AGENTS	
Pataday®	Patanol®	*Bepreve®*	*Emadine®*
		Elestat®	*Optivar®*

Fluoroquinolones – Ophthalmic

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

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

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

Prostaglandin Agonists – Ophthalmic

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

XIII. OTICS

Fluoroquinolones – Otic

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

XIV. RENAL AND GENITOURINARY

Phosphate Binders/Regulators

PREFERRED AGENTS		NON-PREFERRED AGENTS	
calcium acetate (capsule)	Renagel®	*Eliphos™*	*Renvela® (oral powder)*
Fosrenol®	Renvela® (tablet)		
Phoslo®			

Selective Alpha Adrenergic Blockers

PREFERRED AGENTS		NON-PREFERRED AGENTS	
Flomax®	Uroxatral®	*Rapaflo™*	

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Revised 11/18/2009

NEW YORK STATE MEDICAID PREFERRED DRUG LIST

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NYS MEDICAID PHARMACY CLINICAL CALL CENTER 877-309-9493

Urinary Tract Antispasmodics

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

Urinary Tract Antispasmodics

NON-PREFERRED AGENTS	
Detrol®	*Gelnique™*
Ditropan®	*oxybutynin ER*
Ditropan XL®	*Toviaz™*

XV. RESPIRATORY

Anticholinergics – Inhaled

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

Anticholinergics – Inhaled

NON-PREFERRED AGENTS
Duoneb®

Antihistamines – Intranasal

PREFERRED AGENTS	
Astelin®	Astepro™

Antihistamines – Intranasal

NON-PREFERRED AGENTS
Patanase®

Antihistamines – Second Generation

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

Antihistamines – Second Generation

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

Beta$_2$ Adrenergic Agents – Inhaled Long Acting

PREFERRED AGENTS	
Foradil®	Serevent Diskus®

Beta$_2$ Adrenergic Agents – Inhaled Long Acting

NON-PREFERRED AGENTS	
Brovana®	*Perforomist®*

Beta$_2$ Adrenergic Agents – Inhaled Short Acting

PREFERRED AGENTS	
albuterol	Proventil HFA®[1]
Maxair Autohaler®	Ventolin HFA®

Beta$_2$ Adrenergic Agents – Inhaled Short Acting

NON-PREFERRED AGENTS	
Accuneb®	*ProAir HFA®*
Alupent®	*Xopenex® (solution)*
levalbuterol (solution)	*Xopenex HFA®*
metaproterenol	

Corticosteroids – Inhaled

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

Corticosteroids – Inhaled

NON-PREFERRED AGENTS
Aerobid®
Aerobid-M®
Alvesco®
Pulmicort® (Flexhaler) CC

[1] Preferred as of 1/12/2010
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CDRP All drugs in class are subject to Clinical Drug Review Program PA requirements (See: https://newyork.fhsc.com)

Revised 11/18/2009

NEW YORK STATE MEDICAID
PREFERRED DRUG LIST

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

NYS MEDICAID PHARMACY CLINICAL CALL CENTER 877-309-9493

Corticosteroids – Intranasal

PREFERRED AGENTS	
fluticasone	Nasonex®

Corticosteroids – Intranasal

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

Leukotriene Modifiers

PREFERRED AGENTS	
Accolate®	Singulair®

Leukotriene Modifiers

NON-PREFERRED AGENTS

None

CC Subject to Clinical Criteria (See: https://newyork.fhsc.com/downloads/providers/NYRx_PDP_clinical_criteria.pdf)
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Preferred Drug Quick List

Revised 11/18/2009

NEW YORK STATE MEDICAID
PREFERRED DRUG QUICK LIST

These drugs are preferred and do not require prior authorization (PA) unless otherwise indicated

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

TO OBTAIN A COPY OF THE FULL PREFERRED DRUG LIST PLEASE CALL 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®

Non-Steroidal Anti-Inflammatory Drugs (NSAIDS) - Prescription

PREFERRED AGENTS	
diclofenac potassium	ketorolac
diclofenac sodium	meclofenamate
diclofenac sodium XR	mefenamic acid
diflunisal	meloxicam
etodolac	nabumetone
etodolac SA	naproxen
fenoprofen	naproxen sodium
flurbiprofen	naproxen EC
ibuprofen	oxaprozin
indomethacin	piroxicam
indomethacin SR	sulindac
ketoprofen	tolmetin
ketoprofen SA	

II. ANTI-INFECTIVES

Anti-Fungals

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

Anti-Virals - Oral

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

Cephalosporins - Third Generation

PREFERRED AGENTS	
cefdinir	Suprax®
cefpodoxime proxetil	

Fluoroquinolones - Oral

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

Pegylated Interferons

PREFERRED AGENTS
PegIntron®
PegIntron Redipen®
Pegasys®
Pegasys Convenience Pack®

III. CARDIOVASCULAR

Angiotensin Converting Enzyme Inhibitors (ACEIs)

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

ACEIs + Calcium Channel Blockers

PREFERRED AGENTS
benazepril/amlodipine
Lotrel®
Tarka®

1 Preferred as of 01/12/2010
CDRP All drugs in class are subject to Clinical Drug Review Program PA (Please see https://newyork.fhsc.com)

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Revised 11/18/2009

NEW YORK STATE MEDICAID
PREFERRED DRUG QUICK LIST

These drugs are preferred and do not require prior authorization unless otherwise indicated

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

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ACEIs + Diuretics

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

ARBs + Diuretics

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

Beta Blockers + Diuretics

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

Cholesterol Absorption Inhibitors

PREFERRED AGENTS
Zetia®

HMG-CoA Reductase Inhibitors (Statins)

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

Triglyceride Lowering Agents

PREFERRED AGENTS	
gemfibrozil	Tricor®
Lovaza®	Trilipix®

Angiotensin Receptor Blockers (ARBs)

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

Beta Blockers

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

Calcium Channel Blockers (Dihydropyridine)

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

Direct Renin Inhibitors

PREFERRED AGENTS
Tekturna®
Tekturna HCT®

Niacin Derivatives

PREFERRED AGENTS
Niaspan®

1 Preferred as of 01/12/2010

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Revised 11/18/2009

NEW YORK STATE MEDICAID
PREFERRED DRUG QUICK LIST

These drugs are preferred and do not require prior authorization unless otherwise indicated

IV. CENTRAL NERVOUS SYSTEM

Alzheimer's Agents

PREFERRED AGENTS
Aricept® (ODT, tablet)
Exelon®
galantamine
galantamine ER
Namenda®

Carbamazepine Derivatives

PREFERRED AGENTS
carbamazepine (chewable, suspension, tablet)
carbamazepine XR
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-immediate release	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®

Non-Ergot Dopamine Receptor Agonists

PREFERRED AGENTS
Mirapex®
ropinirole

Sedative Hypnotics / Sleep Agents

PREFERRED AGENTS	
chloral hydrate	temazepam
estazolam	triazolam
flurazepam	zolpidem

Serotonin Receptor Agonists (Triptans)

PREFERRED AGENTS	
Imitrex®	sumatriptan
Maxalt®	Treximet®
Relpax®	

V. DERMATOLOGIC AGENTS

Antibiotics - Topical

PREFERRED AGENTS
Altabax®
Bactroban® cream
mupirocin ointment

Anti-Virals - Topical

PREFERRED AGENTS
Abreva®
Zovirax® ointment

1 Preferred as of 01/12/2010
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Revised 11/18/2009

NEW YORK STATE MEDICAID
PREFERRED DRUG QUICK LIST

These drugs are preferred and do not require prior authorization unless otherwise indicated

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

TO OBTAIN A COPY OF THE FULL PREFERRED DRUG LIST PLEASE CALL 877-309-9493

Immunomodulators - Topical - CDRP

PREFERRED AGENTS

Elidel®
Protopic®

Psoriasis Agents - Topical

PREFERRED AGENTS

calcipotriene scalp solution
Dovonex® cream

VI. ENDOCRINE AND METABOLIC AGENTS

Bisphosphonates - Oral

PREFERRED AGENTS

alendronate
Fosamax® solution

Calcitonins - Intranasal

PREFERRED AGENTS

calcitoniin-salmon
Miacalcin®

Dipeptidyl Peptidase-4 (DPP-4) Inhibitors

PREFERRED AGENTS

Janumet®
Januvia®

Growth Hormones - CDRP

PREFERRED AGENTS (Subject to CDRP as of 3/10/2010 for ages 21 years and older)

Genotropin®
Nutropin®
Nutropin AQ®
Saizen®

Thiazolidinediones (TZDs)

PREFERRED AGENTS

Actoplus Met®
Actos®
Duetact®

VII. GASTROINTESTINAL

Anti-Emetics

PREFERRED AGENTS

ondansetron (ODT, solution, tablet)

Proton Pump Inhibitors (PPIs)

PREFERRED AGENTS

Nexium® (capsule)
omeprazole OTC
Prevacid® OTC
Prevacid® RX (capsule)
Prilosec® OTC

Sulfasalazine Derivatives

PREFERRED AGENTS

Asacol®
Dipentum®
Pentasa®
sulfasalazine IR
sulfasalazine DR/EC

VIII. HEMATOLOGICAL AGENTS

Anticoagulants - Injectable

PREFERRED AGENTS

Arixtra®
Fragmin®
Innohep®
Lovenox®

Erythropoiesis Stimulating Agents (ESAs)

PREFERRED AGENTS

Aranesp®
Procrit®

IX. IMMUNOLOGIC AGENTS

Immunomodulators - Injectable

PREFERRED AGENTS

Enbrel®
Humira®

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Revised 11/18/2009

NEW YORK STATE MEDICAID
PREFERRED DRUG QUICK LIST

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

TO OBTAIN A COPY OF THE FULL PREFERRED DRUG LIST PLEASE CALL 877-309-9493

X. MISCELLANEOUS

Progestins (for Cachexia)

PREFERRED AGENTS
megestrol acetate (suspension)

XI. MUSCULOSKELETAL AGENTS

Skeletal Muscle Relaxants

PREFERRED AGENTS	
baclofen	orphenadrine
chlorzoxazone	orphenadrine compound
cyclobenzaprine	orphenadrine comp. forte
dantrolene	tizanidine
methocarbamol	

XII. 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®	diclofenac
Acular LS®	flurbiprofen
Acular PF®	ketorolac

Prostaglandin Agonists - Ophthalmic

PREFERRED AGENTS	
Travatan®	Xalatan®
Travatan Z®	

XIII. OTICS

Fluoroquinolones - Otic

PREFERRED AGENTS
Ciprodex®
ofloxacin

XIV. RENAL AND GENITOURINARY

Phosphate Binders / Regulators

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

Selective Alpha Adrenergic Blockers

PREFERRED AGENTS
Flomax®
Uroxatral®

1 Preferred as of 01/12/2010

CDRP All drugs in class are subject to Clinical Drug Review Program PA (Please see https://newyork.fhsc.com)

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Revised 11/18/2009

NEW YORK STATE MEDICAID
PREFERRED DRUG QUICK LIST

These drugs are preferred and do not require prior authorization unless otherwise indicated

Urinary Tract Antispasmodics

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

XV. RESPIRATORY

Anticholinergics - Inhaled

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

Antihistamines - Intranasal

PREFERRED AGENTS
Astelin®
Astepro™

Antihistamines - Second Generation

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

Beta2 Adrenergic Agents - Inhaled Long Acting

PREFERRED AGENTS
Foradil®
Serevent Diskus®

Beta2 Adrenergic Agents - Inhaled Short Acting

PREFERRED AGENTS	
albuterol	Proventil HFA®[1]
Maxair Autohaler®	Ventolin HFA®

Corticosteroids - Inhaled

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

Corticosteroids - Intranasal

PREFERRED AGENTS
fluticasone
Nasonex®

Leukotriene Modifiers

PREFERRED AGENTS
Accolate®
Singulair®

1 Preferred as of 01/12/2010

CDRP All drugs in class are subject to Clinical Drug Review Program PA (Please see https://newyork.fhsc.com)

Contacted Organizations/Societies

The following organizations/societies have been contacted via email and/or telephone correspondence and given information regarding the NYPDP:

- AARP (American Association of Retired People)
- Brooklyn/Queens chapter NPA
- CAIPA (Chinese American Independent Practice Association)
- CHCANYS (Community Health Care Association of NYS)
- Committee on Interns and Residents
- Cystic Fibrosis Foundation
- Erie County Consortia
- GNYHA (Greater New York Healthcare Association)
- HANYS (Healthcare Association of NYS)
- HCANYS (Home Care Association of NYS)
- HHC-NYC (NY City Health and Hospital Corporation)
- Lupus Foundation of America
- Manatt, Phelps & Phillips
- MSSNY (Medical Group Society of State of NY)
- NACDS (National Association of Chain Drug Stores)
- 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
- National Kidney Foundation
- New York State Council of Health System Pharmacists (NYSCHP)
- New York State Diabetes Association
- NPA (Nurse Practitioners Association)
- NYAAC (NY Association of Ambulatory Care)
- NYMGMA (NY Medical Group Management Association)
- NYPWA (NY Public Welfare Association)
- NYS Dental Association
- NYS Society of Dermatology and Dermatological Surgery
- NYSAC (NYS Association of Counties)
- NYSACHO (New York State Association of County Health Officials)
- NYSAFP (NYS Academy of Family Physicians)
- NYSHFA (NYS Health Facilities Association)
- NYSHPA (NYS Health Plan Association)
- NYSOMS (NYS 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 1199 United Healthcare Workers

Beneficiary Brochure

PDP

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

6/08

MGDP

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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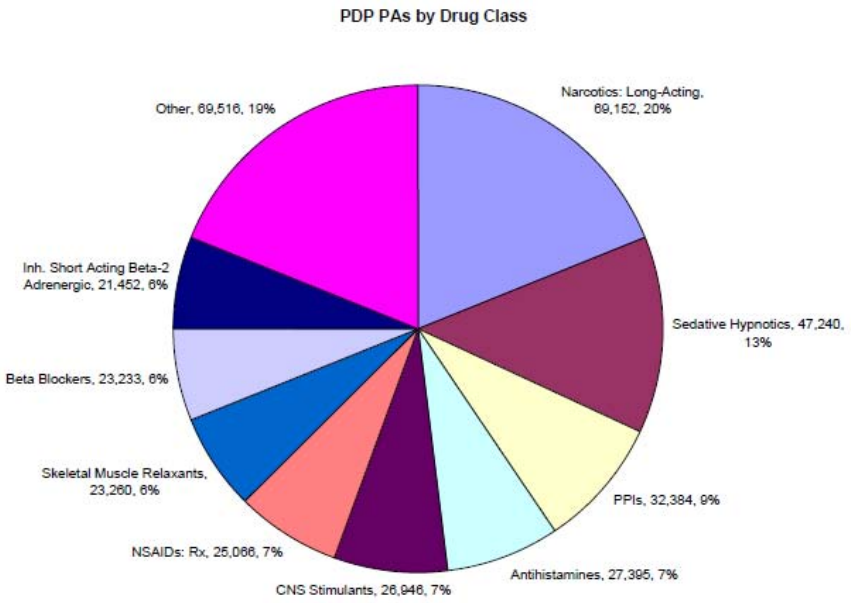
Preferred Drug Program Website Information

- Information about the NY Medicaid Pharmacy Prior Authorization Programs can be accessed on the Internet at: https://newyork.fhsc.com/ or http://www.health.state.ny.us
- The abridged PDL (the “Quicklist”) can be accessed at: https://newyork.fhsc.com/downloads/providers/NYRx_PDP_PDLquicklist.pdf
- The complete PDL can be accessed at: https://newyork.fhsc.com/downloads/providers/NYRx_PDP_PDL.pdf
- The Clinical criteria can be accessed at: https://newyork.fhsc.com/downloads/providers/NYRx_PDP_clinical_criteria.pdf

PDP Prior Authorizations by Class



Total PDP PAs = 365,644

Of the 365,644 PAs issued in SFY 09/10, the following PDP drug classes are listed by the number of PAs requested

1. Narcotics: Long-Acting: 69,152
2. Sedative Hypnotics: 47,240
3. PPIs: 32,384
4. Antihistamines: 27,395
5. CNS Stimulants: 26,946
6. NSAIDS: Rx: 25,066
7. Skeletal Muscle Relaxants: 23,260
8. Beta Blockers: 23,233
9. Inhaled Short Acting Beta-2 Adrenergic: 21,452
10. Steroids: Intranasal: 9,867
11. Bisphosphonates: 7,911
12. Fluoroquinolones: 6,087
13. Statins: 5,907
14. Inhaled Corticosteroids: 5,532
15. Ophthalmics (combined): 4,655
16. Triptans: 3,862
17. ARBs: 3,769
18. ACE Inhibitors: 2,958
19. Urinary Tract Antispasmodics: 2,874
20. Triglyceride Agents: 1,873
21. Antivirals: Topical: 1,617
22. Calcium Channel Blockers (DHP): 1,501
23. Antihistamines: Nasal: 1,060
24. Thiazolidinediones: 992
25. Antifungals: 964
26. Psoriasis Agents: Topical: 800
27. Growth Hormones: 757
28. Inhaled Long Acting Beta-2 Adrenergic: 60829. Antiemetics: 603
30. ARB/Diuretic Combinations: 602
31. Phosphate Binders/Regulators: 504
32. Antivirals: 465
33. Progestins: 450
34. Immunomodulators Injectable: 416
35. Antibiotics: Topical: 411
36. Sulfasalazine Derivatives: 407
37. Selective Alpha Adrenergic Blockers: 370
38. Otics: Quinolones: 366
39. Non-Ergot Dopamine Receptor Agonist: 321
40. DPP-4 Inhibitors: 292
41. ACE Inhibitor/Diuretic Combinations: 212
42. ESA's: 202
43. Inhaled Anticholinergics: 152
44. Cephalosporins: Third Generation: 95
45. Beta Blocker/Diuretic Combinations: 25
46. Calcitonin: 22
47. Multiple Sclerosis Agents: 7

PDP and CDRP Total Cost Avoidance by County

County	CDRP	PDP	Total	% Total
Albany	$688,522	$2,935,727	$3,624,250	0.84%
Allegany	$119,508	$796,153	$915,661	0.21%
Broome	$486,392	$2,993,136	$3,479,527	0.81%
Cattaraugus	$212,950	$1,367,367	$1,580,318	0.37%
Cayuga	$137,459	$943,829	$1,081,287	0.25%
Chautauqua	$211,475	$2,444,461	$2,655,935	0.62%
Chemung	$309,343	$1,513,436	$1,822,779	0.42%
Chenango	$177,786	$861,671	$1,039,457	0.24%
Clinton	$238,278	$1,342,179	$1,580,457	0.37%
Columbia	$115,082	$681,081	$796,162	0.18%
Cortland	$123,688	$784,408	$908,096	0.21%
Delaware	$135,491	$566,977	$702,468	0.16%
Dutchess	$338,851	$1,879,913	$2,218,765	0.51%
Erie	$2,082,043	$12,536,359	$14,618,402	3.39%
Essex	$63,197	$511,450	$574,646	0.13%
Franklin	$162,540	$817,067	$979,607	0.23%
Fulton	$177,049	$1,077,696	$1,254,745	0.29%
Genesee	$94,180	$690,835	$785,015	0.18%
Greene	$83,114	$645,993	$729,107	0.17%
Hamilton	$6,885	$40,020	$46,905	0.01%
Herkimer	$177,786	$1,004,306	$1,182,092	0.27%
Jefferson	$334,917	$1,761,718	$2,096,635	0.49%
Lewis	$50,410	$410,442	$460,852	0.11%
Livingston	$143,852	$707,730	$851,582	0.20%
Madison	$112,869	$798,801	$911,670	0.21%
Monroe	$1,216,718	$9,967,328	$11,184,046	2.59%
Montgomery	$174,344	$980,250	$1,154,594	0.27%
Nassau	$935,899	$6,708,413	$7,644,311	1.77%
Niagara	$502,130	$3,149,031	$3,651,160	0.85%
Oneida	$636,883	$3,816,467	$4,453,351	1.03%
Onondaga	$912,784	$5,371,585	$6,284,369	1.46%
Ontario	$113,852	$904,357	$1,018,209	0.24%
Orange	$963,194	$3,526,595	$4,489,789	1.04%
Orleans	$100,082	$565,004	$665,086	0.15%
Oswego	$275,409	$2,022,493	$2,297,902	0.53%
Otsego	$165,245	$672,295	$837,541	0.19%
Putnam	$32,705	$279,315	$312,020	0.07%
Rensselaer	$314,015	$1,839,382	$2,153,398	0.50%
Rockland	$615,736	$2,719,026	$3,334,762	0.77%
St. Lawrence	$319,425	$2,044,064	$2,363,490	0.55%
Saratoga	$310,573	$1,526,879	$1,837,452	0.43%
Schenectady	$378,687	$1,778,321	$2,157,008	0.50%
Schoharie	$57,049	$347,828	$404,877	0.09%
Schuyler	$62,213	$279,954	$342,167	0.08%
Seneca	$51,393	$372,121	$423,515	0.10%
Steuben	$220,081	$1,580,123	$1,800,204	0.42%
Suffolk	$1,437,045	$8,812,826	$10,249,871	2.37%
Sullivan	$287,212	$1,162,886	$1,450,098	0.34%
Tioga	$98,114	$702,999	$801,114	0.19%
Tompkins	$154,426	$829,177	$983,603	0.23%
Ulster	$383,851	$1,826,633	$2,210,484	0.51%
Warren	$103,032	$759,074	$862,107	0.20%
Washington	$157,868	$805,249	$963,118	0.22%
Wayne	$112,869	$999,758	$1,112,626	0.26%
Westchester	$1,487,454	$7,734,984	$9,222,438	2.14%
Wyoming	$88,524	$389,894	$478,418	0.11%
Yates	$34,180	$358,952	$393,132	0.09%
Total for above counties:	$19,486,661	$114,946,019	$134,432,680	31.15%
New York City	$31,513,919	$263,861,896	$295,375,814	68.43%
OMH	$18,443	$672,441	$690,884	0.16%
OMR	$29,262	$911,554	$940,816	0.22%
NYS DOH	$32,705	$148,005	$180,709	0.04%