NEW YORK STATE MEDICAID
PREFERRED DRUG PROGRAM

ANNUAL REPORT
TO THE
GOVERNOR AND LEGISLATURE

STATE FISCAL YEAR
APRIL 1, 2010 – MARCH 31, 2011

New York State Medicaid Preferred Drug Program
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Acronyms

- **CCC** Clinical Call Center
- **CDRP** Clinical Drug Review Program
- **CPT** Certified Pharmacy Technician
- **DOH** New York State Department of Health
- **FDA** Federal Drug Administration
- **FHPlus** Family Health Plus
- **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
- **PDSP** Preferred Diabetic Supply Program
- **SFY** State Fiscal Year
- **VIPS** Voice Interactive Phone System
- **CMS** Centers for Medicaid/Medicare Services
- **MMA** Magellan Medicaid Administration
- **FUL** Federal Upper Limit

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Executive Summary

Background

In 2006 the Department of Health (DOH) implemented the Preferred Drug Program (PDP) and Clinical Drug Review Program (CDRP) authorized by Sections 270-277 of Article 2A of Chapter 58 of the Laws of 2005 (Appendix 1). Both programs promote cost effective and clinically appropriate prescription drug utilization in the Medicaid program, while maintaining patient access to effective treatment and safeguarding the public health. Effective October 1, 2008, the population eligible for the Preferred Drug Program was expanded to include Family Health Plus (FHPlus) beneficiaries. The pharmacy benefit for Family Health Plus 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 Preferred Drug Program, Clinical Drug Review Program 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 Clinical Drug Review Program (CDRP) is designed to ensure specific drugs are utilized in a medically appropriate manner. These drugs require PA because there are specific safety issues, public health complaints, the potential for fraud and abuse or the potential for significant overuse and misuse associated with these drugs.

On April 26, 2010, New York State Medicaid implemented a new cost containment initiative promoting the use of certain multi-source brand name drugs when the cost of the brand name product is less than its generic equivalent. Generic drugs included in this program require PA and can be identified on the Medicaid List of Reimbursable Drugs with a "C" code in the "PA" Code Column available at http://www.emedny.org/info/formfile.html. Brand name drugs included in this program:

- have a generic copayment;
- have an enhanced dispensing fee (equal to generic dispensing fee);

- will be paid at the Brand Name Drug reimbursement rate or usual and customary price, whichever is lower (neither the SMAC nor FUL will be applied);
- will not require 'Dispense as Written' (DAW) or 'Brand Medically Necessary';
- will not require PA.

Once it is determined that the generic drug is more cost-effective than the brand name equivalent, the PA requirement is removed for the generic drug. Brand name drugs that were subject to this program at the end of SFY 10/11 include:

- Adderall XR
- Aricept (tablet, ODT)
- Astelin
- Diastat
- Duragesic
- Lovenox
- Valtrex

The Pharmacy and Therapeutics Committee (P&TC) plays a critical role in the PDP and CDRP. Members of the P&TC are experienced, actively practicing physicians, nurse practitioners, pharmacists and consumer representatives who contribute specialized expertise in areas such as pharmacology, mental health, drug utilization review, geriatrics, internal medicine, HIV/AIDS, pediatrics and health care consumer advocacy (Appendix 2). The role of the P&TC is to advise the Commissioner on Medicaid pharmacy matters, including making recommendations on the PDP and CDRP. The P&TC meet in a public forum. To ensure transparency in the process, a notice of each meeting and the agenda is posted on the website thirty (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 10/11, the P&TC reviewed the testimony from 65 interested parties.

PA 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, pharmacists and a physician for peer reviews. In SFY 10/11 the CCC handled 1,029,660 phone requests and 69,871 fax requests for PA under the PDP and the CDRP. Almost all phone requests (98.25%) were completed during the initial call and 99.96% of all faxed requests were responded to within twenty-four hours of receipt. In addition, the CCC provided approximately 96,000 callers with general information or technical assistance, and identified and referred seven potential instances of fraud and/or abuse to the DOH.

As a result of legislation passed in 2008, the New York State Medicaid Program implemented the Preferred Diabetic Supply Program (PDSP) in October 2009. The PDSP was established for fee-for-service, Medicaid Managed Care and Family Health Plus beneficiaries. The program does not include Medicare/Medicaid dually enrolled beneficiaries. The PDSP covers a wide variety of blood glucose monitors and test strips provided by pharmacies and durable medical equipment providers through use of a preferred supply list (PSL).

In SFY 10/11, a total of 880,505 diabetic supply claims were processed through the Preferred Diabetic Supply Program. For SFY 10/11, Preferred Diabetic Supply Program rebates collected from manufacturers was $46,625,152. Diabetic supply rebates by county has been included in Appendix11.

Prescriber, Pharmacy and Patient Satisfaction

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

The annual independent survey conducted by Decision Support Systems Research included 596 prescribers and 663 pharmacists that responded to the survey. Results demonstrate that overall satisfaction with the program remains strong. Nearly nine in ten prescribers and pharmacists report satisfaction with the Process. Outcomes confirmed that the CCC continues to perform well, PAs 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, through the CCC or Medicaid Helpline and from feedback at educational presentations. Occasionally, the Medicaid Helpline receives calls on this topic, but the volume is minimal. When such calls are received they are referred to the DOH Medicaid pharmacy staff which provides direct assistance. Overall, it is estimated that 45 complaints related to the PDP and CDRP were received during SFY 10/11.

Program Savings

In SFY 10/11, Medicaid processed over 61 million pharmacy claims. Of these, 41% were for a drug within one of the classes of drugs on the PDL. Of the drugs subject to the PDP, on average 95.5% of claims were for preferred drugs that did not require PA. The remaining 4.5% was for non-preferred drugs that required PA. As a result there were 438,534 PAs administered for non-preferred drugs. This distribution between prescribing preferred and non-preferred drugs is attributable to the wide selection of preferred drugs within a class, prescribers' general familiarity with PDLs and the extensive outreach and education conducted to enhance prescriber awareness of the Medicaid PDP.

For SFY 10/11, gross savings for the PDP totaled $193,728,913. The amount resulting from supplemental rebates was $165,411,265. The remaining savings was from market shift which is produced by a change in market share from more expensive non-preferred drugs to less expensive preferred drugs within a drug class. Market shift savings were estimated to be $28,317,648 for this SFY.

The CDRP was implemented in October 2006. The complete list of drugs subject to the CDRP at the end of SFY 10/11 is as follows: Abstral®, Actiq®, Adcirca®, Elidel®, Fentora®, Growth Hormone (for adults 21 years of age and older), Lidoderm®, Onsolis®, Protopic®, Revatio®, Serostim®, Synagis®, Xyrem®, Zyvox®.

Consistent with the legislative guidelines, additions to the CDRP are recommended by the PT&C and approved by the Commissioner related to the potential for misuse of a drug or drug class and to assure that the drug was appropriately prescribed for its FDA approved indications.

For SFY 10/11, a total of 31,138 PA 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, 9% of the requests would have been denied for not meeting clinical criteria.

Although all CDRP requests were authorized during SFY 10/11, a comparison of utilization and cost from the baseline quarter for each class to each quarter in SFY 10/11 showed a decrease in utilization and spending on the majority of the CDRP drugs. The assumption is that utilization of these drugs would have continued at their baseline levels if the CDRP had not been instituted and that if the CDRP controls were stopped, utilization of these drugs would return to baseline levels.

Assuming that utilization of the CDRP drugs would have continued at the same level as before institution of the CDRP, the cost avoidance for the SFY is estimated to be $69,060,894 (gross). This estimate excludes Synagis® (palivizumab) which is used seasonally (usually November–March) in the prevention of respiratory syncytial virus (RSV) infections.

As compared to baseline observations, significant reductions in claims and respective payments were achieved during this reporting period with Actiq®/Fentanyl Citrate, Serostim®, and Synagis®. Lidoderm® reflected the most dramatic reduction in claims/payments, with an 85.4% decrease in claims and an 81.8% decrease in payments as compared to the CDRP baseline experience. Zyvox® utilization reflected a 14.5% decrease in claims from baseline.

The PDSP covers a wide variety of blood glucose monitors and test strips provided by pharmacies and durable medical equipment providers through use of a preferred supply list (PSL). The total PDSP supplement rebates invoiced, for the period of October 1, 2010 through March 31, 2011, are estimated to be $46 million.

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 of the program;
- success in achieving cost savings and cost avoidance.

The PDSP has proven to be a successful program as a result of:

- a transparent process for determining the selection of blood glucose monitors and test strips PDSP;
- careful monitoring of the program;
- success in achieving cost savings;
- continued access to medically necessary blood glucose monitors and test strips.

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I. Background

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

In 2006, the PDP and CDRP were implemented through a contract with Magellan Medicaid Administration (MMA) (formerly known as First Health Services Corporation (FHSC)). MMA was selected through a competitive bid to operate the CCC that supports the PDP, CDRP, and Mandatory Generic Drug Program (MGDP); provide outreach and education services; assist with the clinical drug reviews; and obtain competitive pricing for prescription drugs through supplemental drug rebate agreements with drug manufacturers participating in the National Medicaid Pooling Initiative (NMPI).

Expansion of the programs and operational enhancements continued this SFY. The P&TC re-reviewed 39 therapeutic categories already subject to the Preferred Drug List (PDL) to take into consideration drugs within the classes recently approved by the FDA, newly available clinical information for existing drugs and updated financial information. Nine (9) new drug classes were reviewed for inclusion on the PDL. By the end of the SFY there were a total of 70 drug classes subject to the PDP. In addition, one (1) new drug was reviewed and recommended by the P&TC for inclusion to the CDRP and one (1) new drug, Regranex, was added to the program for SFY 10/11. Two (2) drugs, Byetta and Victoza, were removed from the CDRP upon the recommendation of the P&TC and subsequent approval by the Commissioner.

II. Program Overview

A. The Preferred Drug Program (PDP)

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

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

The DOH issues the PDL (Appendix 4) which lists all drugs in the PDP and the Quick List (Appendix 5) which lists only preferred drugs within a therapeutic class. The PDL and Quick List are posted on the (newyork.fhsc.com) website and updated whenever there is a change.

SFY 10/11 PDP legislation specifically excluded the following therapeutic classes from PDP PA requirements:

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

B. The Clinical Drug Review Program (CDRP)

Implemented in October 2006, the CDRP requires PA for specific drugs for which there may be specific safety issues, public health complaints, 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.

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

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

The complete list of drugs subject to the CDRP at of the end of SFY 10/11 is as follows:

- **Abstral®** (fentanyl sublingual tablet) is a sublingual tablet that is FDA approved for management of breakthrough pain in adult patients using opioid therapy for chronic cancer pain. PA for fentanyl sublingual tablets was implemented to deter fraud, abuse and misutilization.
- **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.
- **Fentora®** 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. PAF for fentanyl citrate buccal tablet was implemented to deter fraud, abuse and 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.
- **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 (2) 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.

- **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. PA for Protopic® has been implemented to reinforce appropriate use and to ensure utilization consistent with approved indications.
- **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.
- **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.
- **Growth Hormone** [somatropin (rDNA origin) for injection] Genotropin®, Nutropin®, Nutropin AQ®, Saizen®, Humatrope®, Norditropin®, Omnitrope®, and Tev-Tropin® are indicated for the treatment of adults with either childhood-onset or adult-onset growth hormone deficiency. Zorbtive is only indicated for the treatment of Short Bowel Syndrome. 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 Growth Hormone for beneficiaries 21 years and older was implemented to assure that the drug was appropriately prescribed for its FDA approved indications and to deter fraud and misutilization.
- **Lidoderm**® (lidocaine patch 5%) 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.

- **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.
- **Xyrem**® (Sodium Oxybate) is an oral solution indicated for the treatment of excessive daytime sleepiness and cataplexy in patients with narcolepsy. Sodium oxybate is gamma-hydroxybutyric acid (GHB), a known drug of abuse. Abuse has been associated with some important central nervous system (CNS) adverse events (including death). Even at recommended doses, use has been associated with confusion, depression and other neuropsychiatric events. PA for Xyrem® was implemented to assure that the drug was appropriately prescribed for its FDA approved indications and to deter fraud and 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 Meeting Law. A notice of each meeting and the agenda is posted on the DOH website thirty (30) days prior to the meeting. Interested parties are given an opportunity to submit materials to the P&TC for consideration and to provide public testimony on the agenda items. The meetings are audio cast live.

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 Magellan Medicaid Administration (MMA) and DOH staff. Materials submitted by interested parties prior to the meeting, as well as public 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 in order to evaluate confidential drug pricing information with respect to supplemental rebates. The P&TC reconvenes in open session to discuss any remaining issues, then votes on the recommendations to be submitted to the Commissioner.

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 for 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 10/11 appears in Appendix 3.

D. The Prior Authorization Process

The Clinical Call Center (CCC) operated by MMA is the single point of entry for Medicaid's pharmacy PA programs. The CCC is available twenty-four (24) hours a day, seven (7) 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 10/11, the CCC received approximately 1,029,660 phone requests and 69,871 fax requests for PA under the PDP and CDRP. Nearly all phone requests (98.25%) were completed during the initial call, and 99.98% of all faxed requests were responded to within twenty-four (24) hours of receipt. In addition, the CCC provided approximately 96,000 callers with general information or technical assistance with the PA process and identified and referred seven potential instances of fraud and/or abuse to the Department. The CCC and quality assurance team continued to provide assistance to DOH, Office of Medicaid Inspector General (OMIG) and Office of the Attorney General (OAG) in collecting data related to suspected fraud cases. There were nine referrals from OAG to OMIG through DOH.

E. **The Preferred Diabetic Supply Program (PDSP) Diabetic Supply Program**

As a result of legislation passed in 2008, the New York State Medicaid Program implemented, the Preferred Diabetic Supply Program (PDSP) in October 2009. The PDSP was established for fee-for-service, Medicaid Managed Care and Family Health Plus beneficiaries. The program does not include Medicare/Medicaid dually enrolled beneficiaries. The PDSP covers a wide variety of blood glucose monitors and test strips provided by pharmacies and durable medical equipment providers through use of a preferred supply list (PSL).

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 1.3% of the PDP PAs processed in SFY 10/11.

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 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 10/11, there were 36 physician peer reviews completed, however, consistent with last year, there were no denials rendered. Unlike the PDP

which always allows the prescriber to prevail, the CDRP legislation allows for a denial where there is substantial evidence of fraud or abuse. Under current statute, requests may not be denied for lack of medical necessity.

III. Outreach and Education

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

During the SFY 10/11, 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 Preferred Drug List (PDL) was changing and the PA requirements that would apply to newly non-preferred and CDRP drugs. Notification was achieved via electronic notification, the Medicaid Update (a monthly Medicaid provider communication,) and website postings (newyork.fhsc.com). Presentations and teleconferences were also held with various prescriber and pharmacy organizations throughout the period (Appendix 7).

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

Beneficiary outreach efforts focused on providing information about how the programs might affect prescription coverage requirements. Revised informational program brochures were provided to pharmacies, teaching and non-teaching hospitals, clinics and high volume prescribers for distribution to beneficiaries (Appendix 8) via presentations, site visits, and inbound request. In addition, brochure templates are available translated into a number of alternative languages including Bosnian, Chinese, Yiddish, and Haitian Creole in order to effectively meet the needs of Medicaid and Family Health Plus 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 9).

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.

Complaints

Complaints may be received through a variety of sources including by mail or email, through the CCC or Medicaid Helpline and from feedback at educational presentations. Overall, it is estimated that forty-nine (49) complaints about the PDP and CDRP were received during SFY 10/11, 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.

The DOH Medicaid pharmacy staff individually addresses issues related to policy. These inquiries are also used to identify providers who may need additional program education.

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

Provider Satisfaction Survey

Using an independent third party vendor, Decision Support Systems Research, a satisfaction survey was sent to 2,000 prescribers and 1,000 pharmacists who utilized the CCC. 596 prescribers and 663 pharmacists responded.

Nearly nine in ten prescribers and pharmacists report satisfaction with the PA Process. Responses continued to support that PAs are typically accomplished in a matter of minutes and accessibility ratings for CCC representatives remained high.

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

Opportunities for improvement were identified 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. For the SFY 10/11, 96.57% of calls were answered within two minutes; with an average speed of answer of 18 seconds.

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

The survey reflects website use increased slightly from last year, however there was a significant increase in prescribers reporting that the information was "easily accessed." (94.0% reported easy access via website this year as compared to 92.3% last year)

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 CMS rebate agreement. Many Medicaid programs, including New York, 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 MMA. 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 10/11, a total of 88 manufacturers participated in the NMPI.

The Medicaid program processed approximately 61 million pharmacy claims in SFY 10/11. Of these, 41 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. 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 (16 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: Proton Pump Inhibitors (11 percent) used to treat acid reflux, Sedative Hypnotics (10 percent), which are used as sleep aids; prescription Non-Steroidal Anti-inflammatory drugs (8 percent), used primarily to treat pain and arthritis and Antihistamines (7 percent), used primarily to treat seasonal allergies.

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 1.3 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 10/11, gross savings for the PDP resulting from supplemental rebates was $165,411,265. The remaining savings was from market shift. This is produced by a

change in market share from more expensive non-preferred drugs to less expensive preferred drugs within a drug class. Market shift savings for SFY 10/11 were approximately $28 million.

Outcomes and Cost Savings - Clinical Drug Review Program

In SFY 10/11, a total of 31,138 requests were approved for PA of drugs under the CDRP as follows:

- **Actiq®/Fentora®:** 1,266
- **Byetta®:** 1,119
- **Victoza®:** 712
- **Growth Hormones:** 21 or Older: 83
- **Immunomodulators:** Topical: 8,585
- **Lidoderm®:** 16,947
- **Adcirca®:** 131
- **Revatio®:** 481
- **Serostim®:** 247
- **Synagis®:** 256
- **Xyrem®:** 31
- **Zyvox®:** 1,280

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, 9 percent of requests would have been denied. This suggests that although the program has a strong sentinel effect, helping to ensure appropriate prescribing practices and protect patient safety, opportunities exist to enhance the program further.

Although all CDRP requests were authorized during SFY 10/11, a comparison of utilization and cost from the baseline quarter for each class to each quarter in SFY 10/11 showed a decrease in utilization and spending on the majority of the CDRP drugs. Assuming that utilization of the CDRP drugs would have continued at the same pace as before institution of the CDRP, the cost avoidance for the SFY is estimated to be $69,060,894 (gross). This estimate excludes Synagis® (palivizumab) which is used seasonally (usually November–March) in the prevention of respiratory syncytial virus (RSV) infections.

In SFY 10/11, a total of 880,505 diabetic supply claims were processed through the Preferred Diabetic Supply Program. For SFY 10/11, the State collected manufacturer rebates totaling $46,625,152 through this program. Diabetic supply rebates by county has been included in Appendix 10.

In accordance with the requirements of the legislation, CDRP gross savings by county has been included in Appendix 11.

VI. Conclusion

The fifth full fiscal year of operation of the Preferred 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 10/11, the P&TC re-reviewed 39 classes of drugs in the PDP to include drugs recently approved by the FDA and newly available clinical and financial information. Nine (9) new drug classes were reviewed for inclusion on the PDP. By the end of the SFY there were a total of 70 drug classes subject to the PDP. In addition, one (1) new drug was reviewed and recommended by the PT&C for inclusion to the CDRP and one (1) new drug, Regranex, was added to the program. Two (2) drugs, Byetta and Victoza, were removed from the CDRP.

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

The PDP, CDRP, and ManGen Program 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 NYS, 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 will continue to be tracked to ensure appropriate resolution, and feedback from complaints and the satisfaction survey will be evaluated for potential enhancements to the process.

Legislation

Article 2A of Chapter 58 of the Laws of 2005

PREFERRED DRUG LIST – Part C
3/25/2005

* ARTICLE 2-A

PRESCRIPTION DRUGS

* NB Repealed June 15, 2012

*** § 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 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.

* NB Repealed June 15, 2012

§ **271. Pharmacy and therapeutics committee.** 1. There is hereby established in the department a pharmacy and therapeutics committee. The committee shall consist of eighteen 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. With the exception of the chairperson, 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;

(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; and

(f) a chairperson designated pursuant to subdivision four of this section.

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 commissioner shall designate a member of the department to serve as chairperson of the committee.

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.

* NB Repealed June 15, 2012

§ 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.

(d) Notwithstanding any provision of this section to the contrary, the commissioner may designate therapeutic classes of drugs, including classes with only one drug, as all preferred prior to any review that may be conducted by the committee pursuant to this section.

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 the commissioner has not reached a manufacturer agreement with the pharmaceutical manufacturer, then the commissioner may designate some or all of the drugs manufactured or marketed by the pharmaceutical manufacturer as 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.

** NB Repealed September 27, 2011

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.

* NB Repealed June 15, 2012

*** § 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.

* NB Repealed June 15, 2012

*** § 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.

* NB Repealed June 15, 2012

§ 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.

* NB Repealed June 15, 2012

*** § 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.

* NB Repealed June 15, 2012

§ 276-a. Prescription drug retail price lists. 1. The department shall make prescription drug retail price lists of pharmacies, with the name and address of each pharmacy, available to the public in a database on its website at all times. The website shall enable consumers to search the database for drug retail prices of pharmacies selected by zip code of the pharmacy and other appropriate factors, including enabling consumers to display and compare prices for one or more selected drugs as well as for the full list. The website shall enable consumers to download and print displayed information. The website shall accommodate reasonably anticipated and actual public use of the database. The database shall display drug retail prices for the compendium of the one hundred fifty most frequently prescribed drugs received by the department from the department of education under section sixty-eight hundred twenty-six of the education law.

2. The department shall extract pharmacy retail price information, showing the actual price to be paid to the pharmacy by a retail purchaser for any listed drug at the listed dosage, from usual and customary price data collected by the medical assistance program under title eleven of article five of the social services law. Provided, however, that any pharmacy participating in the medical assistance program shall provide the usual and customary price data for the one hundred fifty most frequently prescribed drugs under section sixty-eight hundred twenty-six of the education law to the department through the same mechanism that the usual and customary price data is received under the medical assistance program. If the department is unable to process such data, the pharmacy shall fax or electronically transmit to the department the usual and customary price data for the one hundred fifty most frequently prescribed drugs under section sixty-eight hundred twenty-six of the education law. The prescription drug retail price list database shall be subject to and conform with applicable state and federal requirements, including those concerning privacy, confidentiality and use of information. The commissioner shall seek a waiver of any federal requirement necessary for development and implementation of the database under this section. Upon implementation of this system, this section shall apply in place of any inconsistent provision of section sixty-eight hundred twenty-six of the education law. The prescription drug retail price list database on the department's website shall list a pharmacy's price information extracted under this subdivision as the pharmacy's retail price for each drug. The

department shall update the prescription drug retail price list at least weekly using the most recent retail price for each drug for each pharmacy as reasonably practicable.

2-a. Pharmacies which do not provide usual and customary price data in the manner specified in subdivision two of this section shall transmit the drug retail price list compiled pursuant to section sixty-eight hundred twenty-six of the education law to the department in a manner and frequency prescribed by the department and the department shall extract the usual and customary price data information from such drug retail price list; provided that the commissioner may exempt any category of pharmacy not required to compile such list pursuant to section sixty-eight hundred twenty-six of the education law.

3. The prescription drug retail price list database on the department's website shall contain an advisory statement by the department alerting consumers of the need to tell their health care practitioner and pharmacist about all the medications they may be taking and to ask them how to avoid harmful interactions between the drugs, if any. A pharmacy may submit to the department a brief statement, acceptable to the department, to be included on the website in conjunction with the pharmacy's prescription drug retail price information: (a) concerning discounts from its listed retail prices that may be available to consumers and (b) any limitations that the pharmacy may have as to what group or groups of customers it serves.

4. In developing and implementing the prescription drug retail price list database system, the department may seek and shall receive the assistance of the departments of education and law.

5. The commissioner shall provide an interim progress report concerning efforts to develop and implement the database system under this section not later than January thirty-first, two thousand six. The report shall include a projected completion date, a description of obstacles to development and implementation of the database system, and an estimate of the costs to complete the implementation of the database system.

6. As used in this section, "pharmacy" means any place in which drugs or prescriptions are possessed for the purpose of retailing, or in which drugs or prescriptions are retailed, or in which drugs or prescriptions are by advertising or otherwise offered for sale at retail.

§ 276-b. Prescriber education. The department shall develop in collaboration with an academic institution a program designed to provide prescribers with an evidence-based, non-commercial source of the latest objective information about pharmaceuticals. Information shall be presented to prescribers by specially-trained pharmacists, nurses or other health professionals to assist the prescriber in making appropriate therapeutic recommendations.

* NB Repealed June 15, 2012

§ 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.

* NB Repealed June 15, 2012

§ 280. Prescription drug discount program. The prescription drug discount program is hereby established in the department. The drug discount card shall be available to any resident between the ages of fifty and sixty-four, and any resident of any age who has been determined to meet the disability criteria in 20 C.F.R. § 404.1505, who: meets the income eligibility levels established under subdivision one or two of section two hundred forty-two of the elder law; is not in receipt of medical assistance under title eleven of article five of the social services law. The drug discount card shall offer discounts on drug purchases which are not covered by other public or private third party payment sources. Provided, however, that participation by a provider pharmacy and drug manufacturers shall be voluntary and reimbursement to the provider pharmacy under the drug discount card program shall be adjudicated and paid within two business days for any rebates, dispensing fees and drug costs not paid by the resident eligible for such program at the point of sale.

* NB Repealed June 15, 2012

Medicaid Pharmacy and Therapeutics Committee Membership

Name and Affiliation:

1. **Mary Lee Wong, M.D.**
   Internal and Pediatric Medicine, Allergy and Immunology
   Beth Israel Medical Center
2. **Andrew T. Cheng, M.D.**
   Private Practice/Otolaryngology - Head & Neck Surgery
3. **Glenn A. Martin, M.D.**
   Psychiatry/Neurology Medicine
4. **David F. Lehmann, M.D., Pharm D.**
   Professor of Medicine and Pharmacology
   SUNY Upstate Medical University
5. Physician vacancy
6. **Andrew G. Flynn, R.Ph.**
   Albany College of Pharmacy and Health Sciences,
   Community Practice Coordinator
7. **William P. Scheer, R.Ph.**
   Independent Pharmacy Owner
8. **Roxanne Hall Richardson, R.Ph.**
   Oswego Hospital
9. **John Westerman, Jr. R.Ph.**
   Independent Pharmacy Owner
10. **Donna Chiefari, Pharm D.**
    Empire / Wellpoint
11. **Jeffrey Dubitsky, R.Ph.**
    NYC Health & Hospital Corporation
12. **Nancy Balkon, Ph.D., NP**
    Stony Brook University School of Nursing,
    Clinical Associate Professor
13. **Tamara Goldberg, Pharm D.**
    Arnold & Marie Schwartz College of Pharmacy and Health Sciences
    Assistant Professor of Pharmacy Practice
14. **Marla Suzan Eglowstein, M.D.**
    National Multiple Sclerosis Society

Drug Classes in the Preferred Drug Program

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

P&TC Meeting	Drug Class	Posting Date	Date PA Required
04-Nov-10	Insulin - Long-Acting	02-May-11	04-May-11
04-Nov-10	Insulin - Rapid-Acting	02-May-11	04-May-11
04-Nov-10	Insulin - Mixes	02-May-11	04-May-11
16-Sept-10	Atypical Antipsychotics	01-Nov-10	10-Nov-10
16-Sept-10	Benzodiazepines – Rectal	01-Nov-10	10-Nov-10
16-Sept-10	Inhaled Beta-2 Adrenergic Agents - Short Acting	01-Nov-10	10-Nov-10
16-Sept-10	Skeletal Muscle Relaxants	01-Nov-10	10-Nov-10
16-Sept-10	Anti-Fungals	01-Nov-10	10-Nov-10
16-Sept-10	Inhaled Beta-2 Adrenergic Agents - Long Acting	01-Nov-10	10-Nov-10
16-Sept-10	Inhaled Anticholinergics	01-Nov-10	10-Nov-10
16-Sept-10	Corticosteroids – Inhaled	01-Nov-10	10-Nov-10
16-Sept-10	Thiazolidinediones	01-Nov-10	10-Nov-10
16-Sept-10	Long Acting Narcotics	01-Nov-10	10-Nov-10
16-Sept-10	Prescription Non-Steroidal Anti-Inflammatory Agents	01-Nov-10	10-Nov-10
16-Sept-10	Alzheimer's Agents	01-Nov-10	10-Nov-10
16-Sept-10	Anti-Virals	01-Nov-10	10-Nov-10
11-June-10	Platelet Inhibitors	21-July-10	28-July-10
11-June-10	Ophthalmic Beta Blockers	21-July-10	28-July-10
11-June-10	Ophthalmic Alpha-2 Adrenergic Agonists	21-July-10	28-July-10
11-June-10	Ophthalmic Prostaglandin Agonists	21-July-10	28-July-10
11-June-10	Topical Anti-Virals	21-July-10	28-July-10
11-June-10	Multiple Sclerosis Agents	21-July-10	28-July-10
11-June-10	Non-Ergot Dopamine Receptor Agonists	21-July-10	28-July-10
11-June-10	Ophthalmic Antihistamines	21-July-10	28-July-10
11-June-10	Ophthalmic NSAIDs	21-July-10	28-July-10
11-June-10	Ophthalmic Fluoroquinolones	21-July-10	28-July-10
11-June-10	Topical Antibiotics	21-July-10	28-July-10
11-June-10	Topical Agents for Psoriasis	21-July-10	28-July-10
11-June-10	Oral Antihistamines	21-July-10	28-July-10
11-June-10	Nasal Antihistamines	21-July-10	28-July-10
11-June-10	Nasal Corticosteroids	21-July-10	28-July-10
29-April-10	Biguanides	21-July-10	28-July-10
29-April-10	Xanthine Oxidase Inhibitors	21-July-10	28-July-10
29-April-10	Third Generation Cephalosporins	21-July-10	28-July-10
29-April-10	Oral Fluoroquinolones	21-July-10	28-July-10
29-April-10	Phosphate Binder/Regulators	21-July-10	28-July-10
29-April-10	Progestins (for Cachexia)	21-July-10	28-July-10
29-April-10	Selective Alpha Adrenergic Blockers	21-July-10	28-July-10
29-April-10	Sulfasalazine Derivatives	21-July-10	28-July-10
29-April-10	Serotonin Receptor Agonists –Triptans	21-July-10	28-July-10
29-April-10	Anti-Emetics	21-July-10	28-July-10
29-April-10	Injectable Immunomodulators	21-July-10	28-July-10
29-April-10	Otic Fluoroquinolones	21-July-10	28-July-10
29-April-10	Sedative Hypnotics/Sleep Agents	21-July-10	28-July-10
29-April-10	Central Nervous System Stimulants	21-July-10	28-July-10
29-April-10	Anticoagulants – Injectable	21-July-10	28-July-10
29-April-10	Urinary Tract Antispasmodics	21-July-10	28-July-10
29-April-10	Erythropoiesis Stimulating Agents (ESAs)	21-July-10	28-July-10

Preferred And Non-Preferred Drug List

Revised 10/19/2010

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

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®	Opana ER®
Kadian®	Oramorph SR®
morphine sulfate SR	

Narcotics – Long Acting

NON-PREFERRED AGENTS	
Avinza®	*MS Contin®*
Embeda®	*oxycodone HCL CR*
Exalgo™	*Oxycontin®*
fentanyl patch[2]	

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	Voltaren® Gel[1]

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

NON-PREFERRED AGENTS	
Anaprox®	*Nalfon®*
Anaprox® DS	*Naprelan®*
Arthrotec®	*Naprosyn®*
Cambia™	*Naprosyn® EC*
Cataflam®	*Pennsaid®*
Clinoril®	*Ponstel®*
Daypro®	*Vimovo™*
Feldene®	*Voltaren®*
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® (tablet)	*Penlac®*
itraconazole	*Sporanox®*
Lamisil® (tablet)	

Anti-Virals - Oral

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

Anti-Virals - Oral

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

[1] Preferred as of 11/10/2010
[2] Non-Preferred as of 11/10/2010
CC Subject to Clinical Criteria (See: https://newyork.fhsc.com)
CDRP All drugs in class are subject to Clinical Drug Review Program PA requirements (See: https://newyork.fhsc.com)

Revised 10/19/2010

NEW YORK STATE MEDICAID
PREFERRED DRUG LIST

All non-preferred drugs in these classes require prior authorization (PA)
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NYS MEDICAID PHARMACY CLINICAL CALL CENTER 877-309-9493

Cephalosporins – Third Generation

PREFERRED AGENTS	
cefdinir	Suprax®
cefpodoxime proxetil	

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

Fluoroquinolones – Oral

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

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

Pegylated Interferons

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

NON-PREFERRED AGENTS
None

III. CARDIOVASCULAR

Angiotensin Converting Enzyme Inhibitors (ACEIs)

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

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

ACEIs + Calcium Channel Blockers

PREFERRED AGENTS	
benazepril/amlodipine	Tarka®
Lotrel®	trandolapril/verapamil ER

NON-PREFERRED AGENTS
None

ACEIs + Diuretics

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

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

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

Revised 10/19/2010

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

Angiotensin Receptor Blockers (ARBs)

PREFERRED AGENTS	
Cozaar®	losartan
Diovan®	Micardis®

Angiotensin Receptor Blockers (ARBs)

NON-PREFERRED AGENTS	
Atacand®	*Benicar®*
Avapro®	*Teveten®*

ARBs + Calcium Channel Blockers

PREFERRED AGENTS	
Exforge®	Exforge® HCT

ARBs + Calcium Channel Blockers

NON-PREFERRED AGENTS	
Azor®	*Twynsta®*
Tribenzor™	

ARBs + Diuretics

PREFERRED AGENTS	
Diovan HCT®	losartan/HCTZ
Hyzaar®	Micardis HCT®

ARBs + Diuretics

NON-PREFERRED AGENTS	
Atacand HCT®	*Benicar HCT®*
Avalide®	*Teveten 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®*

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

Revised 10/19/2010

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

Cholesterol Absorption Inhibitors

PREFERRED AGENTS	
Zetia®	

Cholesterol Absorption Inhibitors

NON-PREFERRED AGENTS	
None	

Direct Renin Inhibitors

PREFERRED AGENTS	
Tekturna®	Valturna®
Tekturna HCT®	

Direct Renin Inhibitors

NON-PREFERRED AGENTS	
Tekamlo™	

HMG-CoA Reductase Inhibitors (Statins)

PREFERRED AGENTS	
Crestor®	pravastatin
Lipitor®	Simcor®
lovastatin	simvastatin

HMG-CoA Reductase Inhibitors (Statins)

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

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®*
fenofibric acid	*Lopid®*
Fenoglide®	*Triglide®*
Fibricor®	

IV. CENTRAL NERVOUS SYSTEM

Alzheimer's Agents

PREFERRED AGENTS	
Aricept® 5 mg, 10 mg	galantamine ER
Exelon® (patch, solution)	Namenda®
galantamine	rivastigmine

Alzheimer's Agents

NON-PREFERRED AGENTS	
Aricept® 23 mg	*Razadyne ER®*
Exelon® (capsule)[2]	
Razadyne®	

Atypical Antipsychotics

PREFERRED AGENTS	
Abilify®	risperidone
clozapine	Risperdal®
Clozaril®	Saphris®
Fanapt™	Seroquel®
FazaClo®	Seroquel XR®
Geodon®	Zyprexa®
Invega®	

Atypical Antipsychotics

NON-PREFERRED AGENTS (NO PA REQUIRED)
None

[2] Non-Preferred as of 11/10/2010

CC Subject to Clinical Criteria (See: https://newyork.fhsc.com)

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

Revised 10/19/2010

NEW YORK STATE MEDICAID
PREFERRED DRUG LIST

All non-preferred drugs in these classes require prior authorization (PA)
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NYS PREFERRED DRUG PROGRAM HTTP://NEWYORK.FHSC.COM

NYS MEDICAID PHARMACY CLINICAL CALL CENTER 877-309-9493

Benzodiazepines - Rectal

PREFERRED AGENTS	
Diastat® 2.5mg	Diastat® AcuDial™

NON-PREFERRED AGENTS (PA REQUIRED AS OF 11/10/2010)
diazepam rectal gel

Carbamazepine Derivatives

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

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®

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

Multiple Sclerosis Agents

PREFERRED AGENTS	
Avonex®	Copaxone®
Betaseron®	Rebif®

NON-PREFERRED AGENTS	
Extavia®	*Gilenya™*

Non-Ergot Dopamine Receptor Agonists

PREFERRED AGENTS	
Mirapex®	ropinirole
pramipexole	

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

Sedative Hypnotics/Sleep Agents

PREFERRED AGENTS	
chloral hydrate	temazepam
estazolam	triazolam
flurazepam	zolpidem

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

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

Revised 10/19/2010

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

Serotonin Receptor Agonists (Triptans)

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

V. DERMATOLOGIC AGENTS

Antibiotics – Topical

PREFERRED AGENTS		NON-PREFERRED AGENTS	
Altabax®	mupirocin ointment	*Bactroban® ointment*	*Centany™ ointment*
Bactroban® cream		*Bactroban Nasal® ointment*[CC]	

Anti-Virals – Topical

PREFERRED AGENTS		NON-PREFERRED AGENTS	
Abreva®	Zovirax® ointment	*Denavir®*	*Zovirax® cream*
		Xerese™	

Immunomodulators – Topical[CDRP]

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

Psoriasis Agents – Topical

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

VI. ENDOCRINE AND METABOLIC AGENTS

Biguanides

PREFERRED AGENTS		NON-PREFERRED AGENTS	
metformin HCl	metformin HCl ER	*Fortamet®*	*Glumetza®*
		Glucophage®	*Riomet® solution*
		Glucophage XR®	

Bisphosphonates – Oral

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

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

Revised 10/19/2010

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

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 FOR AGE 21 YEARS & OLDER)		NON-PREFERRED AGENTS (SUBJECT TO CDRP 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®	*Actoplus Met® XR*	*Avandaryl®*
Actos®		*Avandamet®*	*Avandia®*

VII. GASTROINTESTINAL

Anti-Emetics

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

Proton Pump Inhibitors (PPIs)

PREFERRED AGENTS	NON-PREFERRED AGENTS	
Nexium® (capsule)	*Aciphex®*	*pantoprazole*
omeprazole OTC	*Dexilant™*	*Prevacid® OTC*
omeprazole Rx	*lansoprazole Rx*	*Prevacid® Rx*
Prilosec® OTC	*Nexium Packet®*	*Prilosec® Rx*
	omeprazole/sodium bicarbonate Rx	*Protonix®*

Sulfasalazine Derivatives

PREFERRED AGENTS		NON-PREFERRED AGENTS	
Apriso®	Pentasa®	*Asacol HD®*	*balsalazide*
Asacol®	sulfasalazine IR	*Azulfidine®*	*Colazal®*
Dipentum®	sulfasalazine DR/EC	*Azulfidine Entab®*	*Lialda®*

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Revised 10/19/2010

NEW YORK STATE MEDICAID
PREFERRED DRUG LIST

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VIII. HEMATOLOGICAL AGENTS

Anticoagulants – Injectable

PREFERRED AGENTS		NON-PREFERRED AGENTS	
Arixtra®	Lovenox®	*enoxaparin sodium*	*Innohep®*
Fragmin®			

Erythropoiesis Stimulating Agents (ESAs)

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

Platelet Inhibitors

PREFERRED AGENTS		NON-PREFERRED AGENTS	
Aggrenox®	Effient®	*Persantine®*	*ticlopidine*
dipyridamole	Plavix®		

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®*	*metaxalone*
chlorzoxazone	orphenadrine compound	*carisoprodol*	*Parafon Forte® DSC*
cyclobenzaprine	orphenadrine comp. forte	*carisoprodol compound*	*Robaxin®*
dantrolene	tizanidine	*carisoprodol compound-codeine*	*Skelaxin®*
methocarbamol		*Dantrium®*	*Soma®*
		Fexmid®	*Soma® 250*
			Zanaflex®

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Revised 10/19/2010

NEW YORK STATE MEDICAID
PREFERRED DRUG LIST

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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®	*azelastine*	*Emadine®*
		Bepreve®	*Optivar®*
		Elestat®	

Beta Blockers – Ophthalmics

PREFERRED AGENTS		NON-PREFERRED AGENTS	
betaxolol	Istalol®	*Betagan®*	*Timoptic® in Ocudose®*
Betimol®	levobunolol	*Optipranolol®*	*Timoptic-XE®*
Betoptic S®	metipranolol	*Timoptic®*	
carteolol	timolol maleate (gel, solution)		
Combigan®			

Fluoroquinolones – Ophthalmic

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

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

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

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®	

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Revised 10/19/2010

NEW YORK STATE MEDICAID
PREFERRED DRUG LIST

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NYS MEDICAID PHARMACY CLINICAL CALL CENTER 877-309-9493

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	
tamsulosin	Uroxatral®	*Flomax®*	*Rapaflo™*

Urinary Tract Antispasmodics

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

Xanthine Oxidase Inhibitors

PREFERRED AGENTS		NON-PREFERRED AGENTS	
allopurinol		*Uloric®*	*Zyloprim®*

XV. RESPIRATORY

Anticholinergics – Inhaled

PREFERRED AGENTS		NON-PREFERRED AGENTS
Atrovent HFA®	ipratropium/albuterol	*DuoneB®*
Combivent®	Spiriva®	
ipratropium		

Antihistamines – Intranasal

PREFERRED AGENTS		NON-PREFERRED AGENTS
Astelin®	Patanase®	*azelastine*
Astepro™		

Antihistamines – Second Generation

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

Beta$_2$ Adrenergic Agents – Inhaled Long Acting

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

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Revised 10/19/2010

NEW YORK STATE MEDICAID
PREFERRED DRUG LIST

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$Beta_2$ Adrenergic Agents – Inhaled Short Acting

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

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

Corticosteroids – Inhaled

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

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

Corticosteroid/$Beta_2$ Adrenergic Agent (Long-Acting) Combinations – Inhaled

PREFERRED AGENTS	
Advair Diskus®	Symbicort®
Advair HFA®	

NON-PREFERRED AGENTS
Dulera®

Corticosteroids – Intranasal

PREFERRED AGENTS	
fluticasone	Nasacort AQ®

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

Leukotriene Modifiers

PREFERRED AGENTS	
Accolate®	Singulair®

NON-PREFERRED AGENTS
None

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

Preferred Drug Preferred Drug Quick List

Revised 10/19/2010

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®	Opana ER®
Kadian®	Oramorph SR®
morphine sulfate 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	Voltaren Gel[1]

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
cefpodoxime proxetil
Suprax®

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®

1 Preferred as of 11/10/2010
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Revised 10/19/2010

NEW YORK STATE MEDICAID
PREFERRED DRUG QUICK LIST

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IV. CENTRAL NERVOUS SYSTEM

Alzheimer's Agents

PREFERRED AGENTS
Aricept® 5 mg, 10 mg
Exelon® (patch, solution)
galantamine
galantamine ER
Namenda®
rivastigmine

Atypical Antipsychotics

PREFERRED AGENTS	
Abilify®	risperidone
clozapine	Risperdal®
Clozaril®	Saphris®
Fanapt™	Seroquel®
FazaClo®	Seroquel XR®
Geodon®	Zyprexa®
Invega®	

Benzodiazepines - Rectal

PREFERRED AGENTS
Diastat® 2.5 mg
Diastat® AcuDial™

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

Multiple Sclerosis Agents

PREFERRED AGENTS	
Avonex®	Copaxone®
Betaseron®	Rebif®

Non-Ergot Dopamine Receptor Agonists

PREFERRED AGENTS	
Mirapex®	ropinirole
pramipexole	

Sedative Hypnotics / Sleep Agents

PREFERRED AGENTS	
chloral hydrate	temazepam
estazolam	triazolam
flurazepam	zolpidem

Serotonin Receptor Agonists (Triptans)

PREFERRED AGENTS	
Maxalt-MLT®	sumatriptan
Relpax®	

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Revised 10/19/2010

Revised 10/19/2010

NEW YORK STATE MEDICAID
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V. DERMATOLOGIC AGENTS

Antibiotics - Topical

PREFERRED AGENTS	
Altabax®	mupirocin ointment
Bactroban® cream	

Anti-Virals - Topical

PREFERRED AGENTS	
Abreva®	
Zovirax® ointment	

Immunomodulators - Topical CDRP

PREFERRED AGENTS	
Elidel®	
Protopic®	

Psoriasis Agents - Topical

PREFERRED AGENTS	
calcipotriene scalp solution	
Dovonex® cream	

VI. ENDOCRINE AND METABOLIC AGENTS

Biguanides

PREFERRED AGENTS	
metformin	metformin ER

Bisphosphonates - Oral

PREFERRED AGENTS	
alendronate	Fosamax® (solution)

Calcitonins - Intranasal

PREFERRED AGENTS	
calcitonin-salmon	Miacalcin®

Dipeptidyl Peptidase-4 (DPP-4) Inhibitors

PREFERRED AGENTS	
Janumet®	Januvia®

Growth Hormones CDRP

PREFERRED AGENTS (Subject to CDRP for ages 21 years and older)	
Genotropin®	Nutropin AQ®
Nutropin®	Saizen®

Thiazolidinediones (TZDs)

PREFERRED AGENTS	
Actoplus Met®	Duetact®
Actos®	

VII. GASTROINTESTINAL

Anti-Emetics

PREFERRED AGENTS
ondansetron (ODT, solution, tablet)

Proton Pump Inhibitors (PPIs)

PREFERRED AGENTS	
Nexium® (capsule)	omeprazole RX
omeprazole OTC	Prilosec® OTC

Sulfasalazine Derivatives

PREFERRED AGENTS	
Apriso®	Pentasa®
Asacol®	sulfasalazine IR
Dipentum®	sulfasalazine DR/EC

VIII. HEMATOLOGICAL AGENTS

Anticoagulants - Injectable

PREFERRED AGENTS	
Arixtra®	Lovenox®
Fragmin®	

Erythropoiesis Stimulating Agents (ESAs)

PREFERRED AGENTS	
Aranesp®	Procrit®

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Revised 10/19/2010

NEW YORK STATE MEDICAID
PREFERRED DRUG QUICK LIST

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Platelet Inhibitors

PREFERRED AGENTS	
Aggrenox®	Effient®
dipyridamole	Plavix®

IX. IMMUNOLOGIC AGENTS

Immunomodulators - Injectable

PREFERRED AGENTS	
Enbrel®	Humira®

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®

Beta-Blockers - Ophthalmic

PREFERRED AGENTS	
betaxolol	Istalol®
Betimol®	levobunolol
Betoptic S®	metipranolol
carteolol	timolol maleate (gel, solution)
Combigan®	

Fluoroquinolones - Ophthalmic

PREFERRED AGENTS
ciprofloxacin
ofloxacin
Vigamox®

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

PREFERRED AGENTS	
diclofenac	ketorolac
flurbiprofen	

Prostaglandin Agonists - Ophthalmic

PREFERRED AGENTS	
Travatan®	Xalatan®
Travatan Z®	

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NEW YORK STATE MEDICAID
PREFERRED DRUG QUICK LIST

Revised 10/19/2010

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

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
tamsulosin
Uroxatral®

Urinary Tract Antispasmodics

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

Xanthine Oxidase Inhibitors

PREFERRED AGENTS
allopurinol

XV. RESPIRATORY

Anticholinergics - Inhaled

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

Antihistamines - Intranasal

PREFERRED AGENTS	
Astelin®	Patanase®
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®

$Beta_2$ Adrenergic Agents - Inhaled Short Acting

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

Corticosteroids - Inhaled

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

Corticosteroid / $Beta_2$ Adrenergic Agent (Long-Acting) Combinations - Inhaled

PREFERRED AGENTS	
Advair Diskus®	Symbicort®
Advair HFA®	

Corticosteroids - Intranasal

PREFERRED AGENTS	
fluticasone	Nasacort AQ®

Leukotriene Modifiers

PREFERRED AGENTS	
Accolate®	Singulair®

1 Preferred as of 11/10/2010
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Preferred Supply List

Effective 3/1/11

NYS Medicaid Preferred Diabetic Supply Program
Preferred Supply List (PSL)
https://newyork.fhsc.com/providers/diabeticsupplies.asp

MANUFACTURER	PRODUCT DESCRIPTION	NDC	STRIPS/ METERS
Abbott Diabetes	Freestyle Lite Meter	99073070805	Meter
Abbott Diabetes	Freestyle Lite Test Strip	99073070822	Strips
Abbott Diabetes	Freestyle Lite Test Strip	99073070827	Strips
Abbott Diabetes	Freestyle Freedom Lite Meter	99073070914	Meter
Bayer Diag Div	Ascensia Breeze 2 Monitor Kit	00193144001	Meter
Bayer Diag Div	Breeze 2 Meter	00193146001	Meter
Bayer Diag Div	Breeze 2 Meter	00193146101	Meter
Bayer Diag Div	Ascensia Breeze 2 10-Test Disc	00193146550	Strips
Bayer Diag Div	Ascensia Breeze 2 10-Test Disc	00193146621	Strips
Bayer Diag Div	Ascensia Autodisc Test Strip	00193361050	Strips
Bayer Diag Div	Ascensia Autodisc Strips	00193362721	Strips
Bayer Diag Div	Ascensia Elite Test Strips	00193391125	Strips
Bayer Diag Div	Ascensia Elite Test Strip	00193391850	Strips
Bayer Diag Div	Ascensia Elite Test Strips	00193394221	Strips
Bayer Diag Div	Ascensia Contour Test Strips	00193707025	Strips
Bayer Diag Div	Ascensia Contour Strips	00193708050	Strips
Bayer Diag Div	Ascensia Contour Strips	00193709021	Strips
Bayer Diag Div	Ascensia Contour System	00193715101	Meter
Bayer Diag Div	Contour Meter	00193718201	Meter
Bayer Diag Div	Contour Meter	00193718301	Meter
Bayer Diag Div	Contour Meter	00193718401	Meter
Bayer Diag Div	Contour Meter	00193719001	Meter
Bayer Diag Div	Contour Meter	00193719101	Meter
LifeScan	Fast Take Test Strips	53885004810	Strips
LifeScan	SureStep Test Strips	53885005210	Strips
LifeScan	One Touch Test Strips	53885019725	Strips
LifeScan	One Touch Test Strips	53885019850	Strips
LifeScan	One Touch Ultramini Meter	53885020801	Meter
LifeScan	One Touch Ultra Test Strips	53885024450	Strips
LifeScan	One Touch Ultra Test Strips	53885024510	Strips
LifeScan	One Touch Ultra System Kit	53885024701	Meter
LifeScan	SureStep Test Strips	53885035950	Strips
LifeScan	One Touch Test Strips	53885037410	Strips
LifeScan	One Touch Ultramini Meter	53885041901	Meter
LifeScan	One Touch Ultramini Meter	53885042001	Meter
LifeScan	One Touch Ultramini Meter	53885042101	Meter
LifeScan	Fast Take Test Strips	53885044450	Strips
LifeScan	One Touch Ultra 2 Glucose Syst	53885044801	Meter
LifeScan	One Touch Ultra Smart Meter	53885052401	Meter

Effective 3/1/11

NYS Medicaid Preferred Diabetic Supply Program
Preferred Supply List (PSL)
https://newyork.fhsc.com/providers/diabeticsupplies.asp

MANUFACTURER	PRODUCT DESCRIPTION	NDC	STRIPS/ METERS
Abbott Diabetes	Freestyle Lite Meter	99073070805	Meter
Abbott Diabetes	Freestyle Lite Test Strip	99073070822	Strips
Abbott Diabetes	Freestyle Lite Test Strip	99073070827	Strips
Abbott Diabetes	Freestyle Freedom Lite Meter	99073070914	Meter
Bayer Diag Div	Ascensia Breeze 2 Monitor Kit	00193144001	Meter
Bayer Diag Div	Breeze 2 Meter	00193146001	Meter
Bayer Diag Div	Breeze 2 Meter	00193146101	Meter
Bayer Diag Div	Ascensia Breeze 2 10-Test Disc	00193146550	Strips
Bayer Diag Div	Ascensia Breeze 2 10-Test Disc	00193146621	Strips
Bayer Diag Div	Ascensia Autodisc Test Strip	00193361050	Strips
Bayer Diag Div	Ascensia Autodisc Strips	00193362721	Strips
Bayer Diag Div	Ascensia Elite Test Strips	00193391125	Strips
Bayer Diag Div	Ascensia Elite Test Strip	00193391850	Strips
Bayer Diag Div	Ascensia Elite Test Strips	00193394221	Strips
Bayer Diag Div	Ascensia Contour Test Strips	00193707025	Strips
Bayer Diag Div	Ascensia Contour Strips	00193708050	Strips
Bayer Diag Div	Ascensia Contour Strips	00193709021	Strips
Bayer Diag Div	Ascensia Contour System	00193715101	Meter
Bayer Diag Div	Contour Meter	00193718201	Meter
Bayer Diag Div	Contour Meter	00193718301	Meter
Bayer Diag Div	Contour Meter	00193718401	Meter
Bayer Diag Div	Contour Meter	00193719001	Meter
Bayer Diag Div	Contour Meter	00193719101	Meter
LifeScan	Fast Take Test Strips	53885004810	Strips
LifeScan	SureStep Test Strips	53885005210	Strips
LifeScan	One Touch Test Strips	53885019725	Strips
LifeScan	One Touch Test Strips	53885019850	Strips
LifeScan	One Touch Ultramini Meter	53885020801	Meter
LifeScan	One Touch Ultra Test Strips	53885024450	Strips
LifeScan	One Touch Ultra Test Strips	53885024510	Strips
LifeScan	One Touch Ultra System Kit	53885024701	Meter
LifeScan	SureStep Test Strips	53885035950	Strips
LifeScan	One Touch Test Strips	53885037410	Strips
LifeScan	One Touch Ultramini Meter	53885041901	Meter
LifeScan	One Touch Ultramini Meter	53885042001	Meter
LifeScan	One Touch Ultramini Meter	53885042101	Meter
LifeScan	Fast Take Test Strips	53885044450	Strips
LifeScan	One Touch Ultra 2 Glucose Syst	53885044801	Meter
LifeScan	One Touch Ultra Smart Meter	53885052401	Meter

Contacted Organizations/Societies

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

- AARP (American Association of Retired People)
- American Academy of Pediatrics-District II
- American Yugoslav Medical Society
- Argentine – American Medical Society
- Asian American Physician Association of Western New York
- Association of Chinese American Physicians
- Association of Haitian Physicians Abroad
- Bangladesh Medical Association of North America
- Bay Ridge Medical Society
- Bronx County Medical Society,INC.
- Broome County Medical Society, INC.
- CAIPA (Chinese American Independent Practice Association)
- CHCANYS
- Chinese American Medical Society
- Clinton County Medical Society
- Colombian Medical Society
- Committee on Interns and Residents
- Doctors First Association
- Dominican American Medical Society
- Eastern Chinese American Physicians IPA, INC (ECAP)
- Empire State Medical Association
- Erie County Consortia
- Foreign Medical Graduate (FMG) Organization
- GNYHA (Greater New York Healthcare Association)
- HCANYS (Home Care Association of NYS)
- Hellenic Medical Society of New York
- HHC-NYC (NY City Health and Hospital Corporation)
- Hudson Valley Indian Physician Practitioners
- Hungarian Medical Association of America
- Iranian American Medical Association
- Japanese Medical Society of America
- Lupus Foundation of America
- Manhattan, Phelps & Phillips
- Medical Society of Lewis County
- Medical Society of Ontario County
- Medical Society of Montgomery County
- Medical Society of the County of Franklin
- Medical Society of the County of Chemung
- Medical Society of Kings County
- Medical Society of Yates County
- Medical Society of the County of Columbia
- Medical Society of Jefferson County
- Medical Society of Tioga County
- Medical Society of Washington County

- Medical Society of Livingston County
- Medical Society of Madison County
- Medical Society of Oneida County
- Medical Society of Monroe County
- Medical Society of Nassau County
- Medical Society of New York County
- Medical Society of Niagara County
- Medical Society of Orleans County
- Medical Society of Onondaga County
- Medical Society of Oswego County
- Medical Society of Otsego County
- Medical Society of Rensselaer County
- Medical Society of Richmond County
- Medical Society of Rockland County
- Medical Society of Schenectady County
- Medical Society of Schoharie County
- Medical Society of Schuyler County
- Medical Society of Seneca County
- Medical Society of Queens County
- Medical Society of St. Lawrence County
- Medical Society of Steuben County
- Medical Society of Suffolk County
- Medical Society of Warren County
- Medical Society of Putnam County
- Medical Society of Sullivan County
- Medical Society of the County of Greene
- Medical Society of the County of Herkimer
- Medical Society of The County of Albany
- Medical Society of the County of Allegany
- Medical Society of the County of Cattaraugus
- Medical Society of the County of Cayuga, INC.
- Medical Society of the County of Chautauqua
- Medical Society of the County of Chenango
- Medical Society of the County of Cortland
- Medical Society of the County of Delaware
- Medical Society of the County of Dutchess
- Medical Society of the County of Erie
- Medical Society of the County of Essex
- Medical Society of the County of Fulton
- Medical Society of the County of Genesee
- Medical Society of Tompkins County
- Medical Society of Ulster County
- Medical Society of Orange County
- Medical Society of Wayne County
- Medical Society of Westchester County
- Medical Society of Wyoming County
- Medical Society of Saratoga County
- Morgagni (Italian) Medical Society
- MSSNY

- NAMI-NYS (National Alliance on Mental Illness)
- NASW (National Association of Social Workers) NYC
- NASW (National Association of Social Workers) NYS
- National Association of Chain Drug Stores(NACDS)
- National Hispanic Medical Association
- National Hispanic Medical Association-New York State
- New York Chapter American College of Physicians
- New York Chapter of the American of College of Surgeons, Inc
- New York Medical Group Management Association NYMGMA
- New York State Academy of Family Physicians (NYSAFP)
- New York State Association of American Chinese Physicians(ACAP)
- New York State Council of Health System Pharmacist (NYSCHP)
- New York State Diabetes Association
- New York State Ophthalmological Society
- New York State Osteopathic Society (NYSOMS)
- New York State Podiatric Medical Society (NYSPMA)
- Nurse Practitioners Association New York State
- NYAAC (NY Association of Ambulatory Care)
- NYPWA (NY Public Welfare Association)
- NYS Dental Association
- NYS Psychiatric Association, Inc.
- NYS Society of Dermatology and Dermatological Surgery
- NYS Society of Orthopedic Surgeons, Inc.
- NYSAC (NYS Association of Counties)
- NYSACHO (New York State Association of County Health Officials)
- NYSHFA (NYS Health Facilities Association)
- NYSHPA (NYS Health Plan Association)
- OASAS (Office of Alcohol and Substance Abuse Services)
- OMH (Office of Mental Health)
- OMRDD (Office of Mental Retardation and Developmental Disabilities)
- Philippine Medical Association of America
- Provident Clinical Society
- PSSNY (Pharmacy Society of State of NY)
- Rajasthan Medical Alumni Association
- Romanian Medical Society of New York
- SEIU 1199 United Healthcare Workers
- Society of Asian-Indian Surgeons of America
- Spanish-American Medical Society
- Turkish American Physicians Association

Enrollee 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.

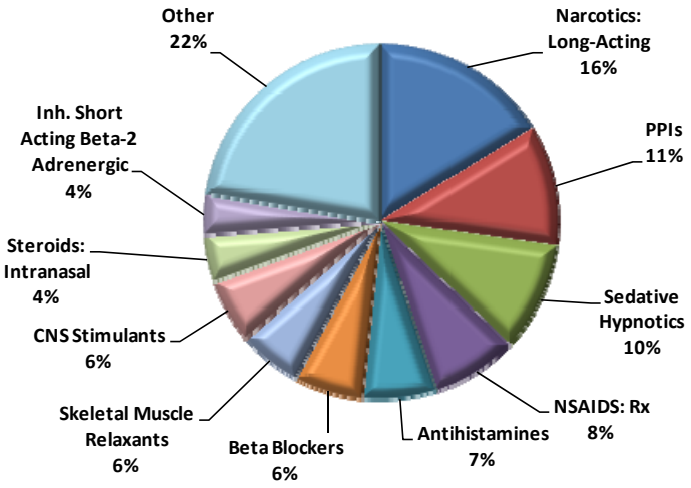
State of New York
Department of Health

6/08

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 = 438,534

Of the 438,534 PAs issued in SFY 10/11, the following PDP drug classes are listed by the number of PAs requested:

1. Narcotics: Long-Acting: 71,267
2. PPIs: 48,096
3. Sedative Hypnotics: 43,415
4. NSAIDS: Rx: 34,181
5. Antihistamines: 29,475
6. Beta Blockers: 27,726
7. Skeletal Muscle Relaxants: 25,237
8. CNS Stimulants: 25,208
9. Steroids: Intranasal: 19,032
10. Inh. Short Acting Beta-2 Adrenergic: 16,569
11. ARBs: 12,801
12. Bisphosphonates: 10,193
13. ARB/Diuretic Combinations: 8,779
14. Triptans: 7,641
15. Fluoroquinolones: 6,238
16. Statins: 5,092
17. Urinary Tract Antispasmodics: 3,344
18. Ophthalmics: Antihistamines: 3,339
19. Ophthalmics: NSAIDs: 3,024
20. Inhaled Corticosteroids: 2,884
21. ACE Inhibitors: 2,601
22. Thiazolidinediones: 2,582
23. ARB/CCB Combinations: 2,290
24. Sulfasalazine Derivatives: 2,120
25. Ophthalmics: Prostaglandin Agonists: 2,005
26. Antivirals: Topical: 1,921
27. DPP-4 Inhibitors: 1,866
28. Triglyceride Agents: 1,607
29. Antivirals: 1,574
30. Biguanides: 1,496
31. Selective Alpha Adrenergic Blockers: 1,429
32. Ophthalmics: Quinolones: 1,318
33. Psoriasis Agents: Topical: 1,304
34. Calcium Channel Blockers (DHP): 1,231
35. Antihistamines: Nasal: 1,110
36. Antifungals: 1,045
37. Xanthine Oxidase Inhibitors: 1,016
38. Growth Hormones: 1,009
39. Inh. Long Acting Beta-2 Adrenergic: 727
40. Immunomodulators: Injectable: 672
41. Antiemetics: 589
42. Antibiotics: Topical: 575
43. Progestins: 524
44. Non-Ergot Dopamine Receptor Agonist: 508
45. Otics: Quinolones: 407
46. ACE Inhibitor/Diuretic Combinations: 225
47. Inhaled Steroid/Beta2 LA Combo: 215
48. Anticoagulants: Injectable: 166
49. Phosphate Binders/Regulators: 154
50. ESAs: 146
51. Inhaled Anticholinergics: 116
52. Alzheimer's Agents: 113
53. Cephalosporins: Third Generation: 71
54. Multiple Sclerosis Agents: 68
55. Benzodiazepines: Rectal: 51
56. Ophthalmics: Alpha-2 Adrenergics: 37
57. Direct Renin Inhibitors: 29
58. Platelet Inhibitors: 22
59. Beta Blocker/Diuretic Combinations: 21
60. Calcitonin: 19
61. Ophthalmics: Beta Blockers: 14

PDP and CDRP Total Cost Avoidance by County

County	CDRP	PDP	Diabetic Supplies	Total	% Total
Albany	$598,407	$1,570,512	$290,381	$2,459,300	0.79%
Allegany	$86,612	$394,007	$68,543	$549,162	0.18%
Broome	$425,184	$1,557,453	$234,074	$2,216,711	0.72%
Cattaraugus	$31,495	$704,206	$109,595	$845,296	0.27%
Cayuga	$125,980	$484,777	$79,349	$690,106	0.22%
Chautauqua	$559,038	$1,250,122	$204,623	$2,013,783	0.65%
Chemugn	$157,476	$806,463	$134,967	$1,098,906	0.36%
Chenango	$55,116	$444,169	$76,594	$575,880	0.19%
Clinton	$173,223	$664,997	$122,202	$960,421	0.31%
Columbia	$149,602	$356,432	$70,715	$576,749	0.19%
Cortland	$110,233	$395,406	$51,169	$556,807	0.18%
Delaware	$94,485	$294,940	$49,792	$439,217	0.14%
Dutchess	$464,553	$1,111,303	$202,557	$1,778,413	0.57%
Erie	$3,291,239	$6,388,211	$1,342,681	$11,022,131	3.56%
Essex	$86,612	$256,854	$46,719	$390,185	0.13%
Franklin	$141,728	$403,318	$66,000	$611,047	0.20%
Fulton	$322,825	$564,303	$67,801	$954,929	0.31%
Genesee	$39,369	$355,765	$53,288	$448,421	0.14%
Greene	$251,961	$340,073	$60,598	$652,631	0.21%
Hamilton	-	$18,913	$1,907	$20,820	0.01%
Herkimer	$102,359	$533,690	$89,784	$725,833	0.23%
Jefferson	$236,213	$890,311	$123,526	$1,250,050	0.40%
Lewis	$31,495	$201,239	$31,093	$263,827	0.09%
Livingston	$31,495	$374,206	$53,076	$458,777	0.15%
Madison	$259,835	$425,744	$59,909	$745,487	0.24%
Monroe	$1,433,027	$5,092,657	$997,211	$7,522,896	2.43%
Montgomery	$70,864	$509,638	$90,420	$670,922	0.22%
Nassau	$2,425,123	$4,057,014	$968,713	$7,450,850	2.41%
Niagara	$1,015,717	$1,632,453	$274,437	$2,922,607	0.94%
Oneida	$401,563	$2,040,046	$363,797	$2,805,405	0.91%
Onondaga	$992,096	$2,842,337	$540,187	$4,374,619	1.41%
Ontario	$244,087	$491,794	$73,575	$809,456	0.26%
Orange	$1,779,473	$1,924,367	$345,417	$4,049,257	1.31%
Orleans	$102,359	$302,624	$47,567	$452,550	0.15%
Oswego	$204,718	$1,060,403	$169,557	$1,434,677	0.46%
Otsego	$125,980	$352,024	$59,432	$537,437	0.17%
Putnam	$259,835	$171,938	$25,002	$456,774	0.15%
Rensselaer	$409,436	$976,799	$164,366	$1,550,601	0.50%
Rockland	$2,110,172	$1,464,860	$329,420	$3,904,452	1.26%
St. Lawrence	$259,835	$1,024,439	$167,703	$1,451,976	0.47%
Saratoga	$685,019	$843,079	$125,856	$1,653,955	0.53%
Schenectady	$566,912	$1,013,422	$210,449	$1,790,784	0.58%
Schoharie	$15,748	$192,234	$37,132	$245,113	0.08%
Schuyler	$70,864	$149,049	$23,572	$243,485	0.08%
Seneca	$55,116	$204,366	$30,511	$289,993	0.09%
Steuben	$299,204	$812,396	$114,574	$1,226,173	0.40%
Suffolk	$2,181,036	$5,039,242	$879,936	$8,100,214	2.62%
Sullivan	$196,844	$642,524	$102,497	$941,866	0.30%
Tioga	$275,582	$357,988	$58,585	$692,155	0.22%
Tompkins	$55,116	$428,187	$65,524	$548,827	0.18%

County	CDRP	PDP	Diabetic Supplies	Total	% Total
Ulster	$370,067	$992,867	$182,905	$1,545,840	0.50%
Warren	$62,990	$405,723	$60,280	$528,993	0.17%
Washington	$330,699	$431,189	$73,946	$835,833	0.27%
Wayne	$102,359	$545,028	$88,089	$735,476	0.24%
Westchester	$2,181,036	$4,127,181	$992,179	$7,300,396	2.36%
Wyoming	$141,728	$201,600	$39,780	$383,109	0.12%
Yates	$7,874	$172,300	$25,743	$205,917	0.07%
Total for above	**$27,259,014**	**$61,289,183**	**$11,419,301**	**$99,967,498**	**32.31%**
New York City	$41,731,016	$131,356,093	$35,065,799	$208,152,908	67.27%
OMH	$31,495	$597,689	$73,575	$702,760	0.23%
OMR	$23,621	$485,948	$66,477	$576,046	0.19%
NYS DOH	$15,748	-	-	$15,748	0.01%
Grand Total	**$69,060,894**	**$193,728,913**	**$46,625,152**	**$309,414,959**	