ANNUAL REPORT TO THE
GOVERNOR AND LEGISLATURE

New York State Medicaid Preferred Drug Program

STATE FISCAL YEAR
APRIL 1, 2014 – MARCH 31, 2015

New York State Department of Health

New York State Medicaid Preferred Drug Program
Annual Report to the Governor and Legislature
State Fiscal Year April 1, 2014 – March 31, 2015

Table of Contents

Appendices

Acronyms

- **BLTG** Brand Less Than Generic
- **CCC** Clinical Call Center
- **CDRP** Clinical Drug Review Program
- **CPT** Certified Pharmacy Technician
- **DAW** Dispense As Written
- **DOH** New York State Department of Health
- **DURB** Drug Utilization Review Board
- **FDA** Federal Drug Administration
- **FHPlus** Family Health Plus
- **FQD** Frequency, Quantity, Duration
- **FUL** Federal Upper Limit
- **HID** Health Information Designs
- **IVR** Interactive Voice Response
- **MCO** Managed Care Organization
- **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
- **PSL** Preferred Supply List
- **SDC** State Direct Contracting
- **SFY** State Fiscal Year
- **SMAC** State Maximum Allowable Cost
- **VIPS** Voice Interactive Phone System

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 2-A of the Public Health Law (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) members (program has since ended effective 12/31/2014). The pharmacy benefit for FHPlus members 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 members became subject to Medicaid's Preferred Drug Program, Clinical Drug Review Program and Mandatory Generic Drug Program (MGDP).
- Effective October 1, 2011, members in mainstream Medicaid managed care and FHPlus no longer receive pharmacy services through NYS Medicaid Fee-For-Service (FFS) Pharmacy Benefit Programs.

As required by the Public Health Law, 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(s) Overview

The ***Preferred Drug Program (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) or PA may also be auto assigned if clinical criteria has been met at the point of service.

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 concerns, the potential for fraud and abuse or the potential for significant overuse and misuse associated with these drugs.

PA may be required if a drug is non-preferred or to override clinical criteria including frequency, quantity, duration (***FQD***) or step therapy requirements. Details regarding these limitations can be found by accessing the Preferred Drug List (PDL) at: https://newyork.fhsc.com/providers/PDP_about.asp

The ***Brand Less Than Generic (BLTG)*** program is designed to promote the use of certain multi-source brand name drugs when the cost of the brand name product net of all rebates is less than its generic equivalent.

The ***Preferred Diabetic Supply Program (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).

Additional Program Descriptions

Prior Authorization (PA) is a management tool that seeks to assure that medically necessary cost effective drug therapy is prescribed. All drugs with prior authorization requirements continue to be available to Medicaid members. Prior authorization activities are either automated, by comparing claims to pre-determined criteria at the point of service (POS), require a phone/fax request which is handled by the Clinical Call Center (CCC) or can be requested through PAXpress®, a web based tool. For SFY 14/15, 1,278,621 POS automated PAs were issued without prescriber involvement. The CCC handled 208,090 phone requests and 109,799 fax requests. Almost all phone requests (99.96%) were completed during the initial call. The CCC is available 24 hours a day, seven days a week and is staffed by certified pharmacy technicians, pharmacists and physicians for peer reviews. In addition, the CCC provided 40,926 callers with general information or technical assistance, and identified and referred two suspected instances of fraud and/or abuse to the DOH.

The Drug Utilization Review Board (DURB) (Appendix 2), is comprised of health care professionals appointed by the Commissioner of Health and includes physicians and pharmacists who actively practice in New York. The purpose of the DURB is to provide clinical guidance to the Commissioner regarding the utilization of pharmaceuticals within the Medicaid program, including but not limited to, the:

- Establishment and implementation of medical standards and criteria for the retrospective and prospective DUR program,
- Development, selection, application, and assessment of educational interventions for physicians, pharmacists and recipients that improve care, and
- Management of pharmacy programs including the PDP and CDRP.

The DURB meets in a public forum. To ensure transparency in the process, a notice of each meeting and the agenda is posted on the DOH website thirty (30) days prior to the meeting. The meetings are audio cast to enable public access to the process.

Interested parties are given an opportunity to submit materials to the DURB for consideration and to provide public testimony on the agenda items. In SFY 14/15, the DURB reviewed the testimony from 77 interested parties.

Prescriber, Pharmacy, and Patient Satisfaction

Complaints about the program are received through a variety of sources including mail or email, through the CCC or Medicaid Helpline. When such calls are received they are referred to the DOH Medicaid pharmacy staff where direct assistance is provided. Overall, it is estimated that 17 complaints about the PDP and CDRP were received during SFY 14/15; these complaints are listed below by the category in which they were logged. Twenty-eight fewer complaints were received this SFY than were received the previous year. All complaints received (particularly those that are logged as “Other”) are shared with the Quality Assurance Group (QAG) for review/follow-up and are used as a means for quality analysis/trending of data. Data are used as part of a continuous quality improvement process to ensure appropriate and timely response to complaints and to address opportunities for improvement.

Complaint Types

PDL Criteria	6
Hold Time	3
PA Requirements	3
Benefit Plan Issue	1
Other	4
Total	17

Three of the *PDL Criteria* complaints were regarding the prior authorization duration limit of 30-days on benzodiazepines. There were no other discernible patterns in the remaining complaints.

Program Savings

In SFY 14/15, 12.3 million pharmacy claims were paid. Of these, 38% were for a drug within one of the classes of drugs on the PDL. Of the drugs subject to the PDP, at the end of the fiscal year 89.2% of claims were for drugs that did not require prior authorization. The remaining 10.8% of claims were for drugs that required prior authorization. There were 170,141 prior authorizations administered for all pharmacy programs. 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 14/15, gross savings for the PDP resulting from supplemental rebates was $16,299,173. The remaining savings was attributable to market shifts to lower cost drugs. 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 were estimated to be $8.9 million after excluding the impact of the Hepatitis C Agents – Direct Acting Antivirals class. This class alone accounted for a -$21.3 million in Market Share shift. Total Savings (Supplemental Rebate + Market Share Shift) is $7.3 million in program savings for this time period once the Hepatitis C Agents – Direct Acting Antivirals class is excluded. When costly new drugs enter the market, they may pick up market share at the expense of lower cost products. To that point, a negative market shift is not necessarily reflective of a poor PDL performance, because without the PDL, the negative shift in market share towards the high-cost products could have been higher.

The CDRP was implemented in October 2006 and initially applied to only three drugs: Revatio®, Serostim® and Zyvox®. The following drugs were subject to the Clinical Drug Review Program at the end of SFY 14/15:

- becaplermin gel (Regranex)
- emtricitabine/tenofovir (Truvada)
- fentanyl mucosal agents (i.e., Abstral, Actiq)
- lidocaine patch (Lidoderm)
- oxazolidinone antibiotics (Sivextro™, Zyvox)
- palivizumab (Synagis)
- sodium oxybate (Xyrem)

- somatropin (rDNA origin) for injection (Serostim)

The following classes were subject to the Clinical Drug Review Program and also included on the Preferred Drug List (PDL) at the end of SFY 14/15:

- Anabolic Steroids
- Central Nervous System (CMS) Stimulants (for 18 years and older)
- Growth Hormones (for 21 years and older)
- Phosphodiesterase type-5 (PDE-5) Inhibitors for Pulmonary Arterial Hypertension (PAH)
- Topical Immunomodulators

Consistent with the legislative guidelines, drug or class additions to the CDRP were recommended by the DURB and approved by the Commissioner related to their potential for misuse and to assure that the drug was appropriately prescribed for its FDA approved indications. For SFY 14/15, a total of 10,244 prior authorization requests were received for CDRP drugs and all were approved using the criteria set forth in Article 2A of the Public Health Law § 273.8 which allows a denial only on the basis of substantial evidence of fraud and abuse. Had the statute allowed for denial on the basis of medical necessity, for requests that did not meet clinical criteria, 5% of the requests would have been denied. Results demonstrate a positive trend in overall prescriber patterns for these drugs toward medically necessary use, and support the CDRP as an effective means to encourage safety and appropriate medication use. Although all CDRP prior authorization requests were approved, results comparing the number and dollar amount of claims paid in the baseline quarter against the last quarter in SFY 14/15 continue to demonstrate that it was successful in achieving cost avoidance.

Assuming that the number of claims for the CDRP drugs would have stayed the same as before the institution of the CDRP, and adjusting for the MCO shift, the cost avoidance for the SFY is estimated to be $ $22,403,283.

The Preferred Diabetic Supply Program (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 April 1, 2014 through March 31, 2015, amounted to $7,516,554.

Conclusion

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

- An established process for determining the selection of drugs for the PDP and CDRP;
- The responsiveness of the program's Clinical Call Center, 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; and
- Success in achieving cost savings and cost avoidance.

The PDSP continues to be successful because of:

- An established process for determining the selection of blood glucose monitors and test strips;
- Careful monitoring of the program; and
- Success in achieving cost savings.

I. Background

In 2005, legislation was enacted (Chapter 58 of the Laws of 2005) that added Article 2-A to the Public Health Law to establish the Medicaid Preferred Drug Program (PDP) and Clinical Drug Review Program (CDRP). The legislation expanded the membership of the DURB, 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 (formerly known as First Health Services Corporation - FHSC). Magellan Medicaid Administration was selected through a competitive bid to operate the Clinical Call Center that supports the Medicaid PDP, CDRP, and Mandatory Generic Drug Program (MGDP); provide outreach and education services; assist with the clinical drug reviews; and obtain competitive pricing for prescription drugs through supplemental drug rebate agreements with drug manufacturers participating in the National Medicaid Pooling Initiative (NMPI). Additional programs that have been added since the inception of the Preferred Drug Program include the Brand Less Than Generic Program; Drug Utilization Program; and the Dose Optimization Program.

Effective October 1, 2008, the population eligible for the PDP was expanded to include Family Health Plus (FHPlus) members (program has since ended – 12/31/2014). The pharmacy benefit for FHPlus members 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 Family Health Plus members became subject to Medicaid’s Preferred, Clinical Drug Review and Mandatory Generic Drug Programs and eligible for supplemental drug rebates. Effective October 1, 2011, members in mainstream Medicaid managed care and FHPlus no longer received pharmacy services through NYS Medicaid FFS Pharmacy Benefit Programs. The Department of Health (DOH) has established a goal of having virtually all Medicaid enrollees served in care management by April, 2018.

Expansion of the programs and operational enhancements continued this SFY. The DURB re-reviewed 27 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 and updated financial information. Five new drug classes were reviewed for inclusion on the PDL. At the end of the SFY there were a total of 107 drug classes subject to the PDP. No new drugs were recommended by the DURB for inclusion to the CDRP.

II. Program Overview

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 DURB to select therapeutic drug classes where drugs in the class produce similar clinical effects or outcomes. The DURB evaluates the clinical effectiveness, safety and patient outcomes among drugs in the therapeutic classes chosen for review. If the DURB 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 DURB 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 DURB also considers how its recommendations may impact current prescribing and dispensing practices and patient care. Recommendations are presented to the Commissioner of Health, who makes the final determination regarding which drugs will be listed as preferred or non-preferred.

The DOH issues the PDL (Appendix 4), which lists all drugs on the Preferred Drug Program. Revisions were made to the PDL to include links to other pharmacy management programs that may impact PDL drugs. The PDL is updated and posted on the website (newyork.fhsc.com) whenever there is a change. Appendix 10 lists the program's cost avoidance by county.

The Clinical Drug Review Program (CDRP)

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

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

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

The DURB reviews drugs for inclusion to the CDRP, as needed. 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; and
- The potential for or a history of utilization inconsistent with approved indications.

The complete list of drugs/drug classes subject to the CDRP at of the end of SFY 14/15 is as follows:

- **Anabolic Steroids** are indicated for replacement therapy in males for conditions associated with a deficiency or absence of endogenous testosterone. Prior authorization for anabolic steroids was implemented to reinforce appropriate use and provide an additional means to detect and deter overuse, misuse, or abuse.
- **Central Nervous System (CNS) Stimulants** (for patients 18 years of age and older) are indicated for the treatment of Attention Deficit Hyperactivity Disorder (ADHD). Prior authorization was implemented to reinforce appropriate use and provide an additional means to detect and deter overuse, misuse, or abuse.
- **Fentanyl Mucosal Agents** are FDA approved for management of breakthrough pain in patients with cancer who are already receiving and who are tolerant to opioid therapy for their underlying cancer pain. They are available in a variety of formulations. Prior authorization for fentanyl mucosal agents was implemented to deter fraud, abuse and misutilization.
- **Growth Hormone [somatropin (rDNA origin) for injection]** Genotropin®, Nutropin®, Nutropin AQ®, Saizen®, Humatrope®, Norditropin®, Omnitrope®, and Zomacton® 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. Prior authorization for Growth Hormone for members 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). Prior authorization for Lidoderm® was implemented to assure that the drug was appropriately prescribed for its one FDA approved indication and to deter misutilization.
- **Phosphodiesterase type-5 (PDE-5) Inhibitors** for pulmonary arterial hypertension (PAH) contain the same active ingredients found in medications used to treat erectile dysfunction (i.e., Cialis® and Viagra®). 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. PDE-5 Inhibitors for PAH require prior authorization to ensure that they are being used for documented treatment of primary PAH, an FDA approved indication, and other medical conditions supported in the Compendia of medical literature.
- **Regranex® (becaplermin gel)** Regranex is indicated for the treatment of lower extremity diabetic neuropathic ulcers that extend into the subcutaneous tissue or beyond and have an adequate blood supply. It is to be used as an adjunct to good wound care practices including initial sharp debridement, pressure relief and infection control. Prior authorization for Regranex® was implemented due to its black box warning for increased mortality secondary to malignancy, the need for proper wound care, and the data confirming potential over utilization throughout the State of New York.
- **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. Prior authorization 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. Prior authorization for Synagis® was implemented to reinforce appropriate use and to ensure utilization consistent with the approved indications and guidelines established by the American Academy of Pediatrics.
- **Topical Immunomodulators** are indicated as second-line therapy for the short-term and non-continuous chronic treatment of atopic dermatitis in non-immunocompromised adults and children who have failed to respond adequately to other topical prescription treatments, or when those treatments are not advisable.

These agents 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 topical immunomodulators. Prior authorization for topical immunomodulators has been implemented to reinforce appropriate use and to ensure utilization consistent with approved indications

- **Truvada® (emtricitabine and tenofovir disoproxil fumarate)** is indicated in combination with other antiretroviral agents for the treatment of HIV-1 infection. It is also indicated in combination with safer sex practices for pre-exposure prophylaxis (PrEP) to reduce the risk of sexually acquired HIV-1 in adults at high risk. Prior authorization for Truvada has been implemented to reinforce appropriate use and to ensure utilization consistent with approved indications.
- **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. Prior authorization for Xyrem® was implemented to ensure that the drug is appropriately prescribed for its FDA approved indications and to deter fraud and misutilization.
- **Zyvox® (linezolid) and Sivextro® (tedizolid)** are synthetic antibiotics in the oxazolidinone class. They are used for the treatment of infections caused by multi-resistant bacteria including methicillin-resistant Staphylococcus aureus (MRSA). Prior authorization for the oxazolidinone class was implemented to address potential misutilization and inappropriate prescribing, which could result in bacterial resistance adversely affecting the health of all New Yorkers.

Brand Less Than Generic (BLTG) Program

On April 26, 2010, New York State Medicaid implemented a cost containment initiative which promotes the use of certain multi-source brand name drugs when the cost of the brand name drug is less expensive than the generic equivalent. In conformance with State

Education Law, which intends that patients receive the lower cost alternative, brand name drugs included in this program:

- Do not require 'Dispense as Written' (DAW) or 'Brand Medically Necessary' on the prescription;
- Have a generic co-payment;
- Are paid at the Brand Name Drug reimbursement rate or usual and customary price, whichever is lower (SMAC/FUL are not applied); and
- Do not require a new prescription if the drug is removed from this program.

Once it is determined that the generic drug is more cost-effective than the brand name equivalent, the prior authorization requirement will be removed for the generic drug. In this SFY, the savings achieved by this program was $12,830,780.

Brand name drugs that were subject to this program at the end of SFY 14/15 include:

Accolate	Diastat	Patanase
Adderall XR	Diovan HCT	Protopic
Alphagan P 0.15%	Epivir HBV	Pulmicort Respules
Aldara	Exforge	Rapamune tablet
Astepro	Focalin XR (5mg,15mg,30mg,40mg)	Soriatane
Bactroban cream	Gabitril 2mg & 4mg	Symbyax
Baraclude	Hepsera	Tegretol suspension
Carac	Intuniv	TOBI
Carbatrol	Kadian	Toprol XL
Catapres-TTS	Lidoderm	Trileptal suspension
Cellcept suspension	Mepron	Trizivir
Combivir	Mycobutin	Wellbutrin
Depakote sprinkle	Myfortic	Xeloda

The Preferred Diabetic Supply Program (PDSP) Diabetic Supply Program

As a result of legislation enacted in 2008, the New York State Medicaid Program implemented, on October 1, 2009, the Preferred Diabetic Supply Program (PDSP). The PDSP was originally established for fee-for-service, Medicaid Managed Care and Family Health Plus members. The program does not include Medicare/Medicaid dually enrolled members. 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 14/15, a total of 89,400 diabetic supply claims were processed through the Diabetic Supply Rebate program. For SFY 14/15, gross savings for the Diabetic Supply Rebate program resulting from manufacturer rebates was $7,516,554. Diabetic supply rebates by county have been included in Appendix 10.

The Role of the Drug Utilization Review Board (DURB)

The DURB consists of nineteen members (without vacancies), fifteen of which are clinicians, preferably with experience in at least one of the following specialities: HIV, AIDS, geriatrics, pediatrics, mental health, or internal medicine and will be comprised of the following:

- One (1) chairperson representing the Department of Health
- Six (6) licensed and actively practicing physicians
- Six (6) licensed and actively practicing pharmacists
- One (1) licensed and actively practicing nurse practitioner or midwife
- Two (2) drug utilization review experts, at least one of who is a pharmacologist
- Three (3) consumers or consumer 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

The group provides clinical guidance to the Commissioner regarding the utilization of pharmaceuticals within the Medicaid program (Appendix 2).

The DURB 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 DURB for consideration and to provide public testimony on the agenda items. The meetings are audiocast and all audiocasts are available on-demand for a minimum of 30 days.

The DURB 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 by Magellan Medicaid Administration, DOH staff and through the DOH's participation in the Oregon Health Sciences University Drug Effectiveness Review Project. Materials submitted by interested parties prior to the meeting, as well as oral testimony provided during the public session, are discussed as well.

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

A summary of the meeting's proceedings, including the DURB's recommendations, is posted to the DOH website, which initiates a 5-day public comment opportunity. The DURB's recommendations as well as the statements made during the public comment period are then presented to the Commissioner who makes the final determination.

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

A list of the drug classes reviewed during SFY 14/15 appears in Appendix 3.

The Prior Authorization Process

Prior authorizations may occur automatically, through a comparison of claims to pre-determined criteria at the point-of-service, or they may be requested by the prescriber's office. The automated PA system utilizes pharmacy and medical claims data to process a request against pre-defined criteria to determine if the patient meets clinical criteria requirements instantaneously. The ability to incorporate pharmacy and medical claims data into criteria allows for the creation of more clinically driven criteria to help ensure appropriate medication utilization, and does so without prescriber involvement. Since the implementation of the automated prior authorization system on December 29, 2011, over 5 million electronic prior authorizations have been issued without prescriber involvement. Over 85% of all prior authorizations issued are issued electronically. The reduction in the need for prescriber involvement results in prescribers being able to devote more time to patient care that would have been otherwise been spent on the phone or completing paperwork.

The Clinical Call Center (CCC), operated by Magellan Medicaid Administration 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 members are afforded the protections required by law.

For SFY 14/15, the CCC received approximately 208,090 phone requests and 109,799 fax requests for prior authorization under the PDP and CDRP. Nearly all phone requests (99.96%) were completed during the initial call. In addition, the CCC provided approximately 40,926 callers with general information or technical assistance with the PA process and identified and referred two 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.

Medicaid enrolled prescribers can also initiate prior authorization requests using a web-based application. PAXpress® is a web based pharmacy PA request/response application that is accessible through eMedNY.

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 DURB 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.

In general, prescribers initially speak with a Certified Pharmacy Technician (CPT) when requesting authorization for a non-preferred drug or a drug requiring prior authorization due to FQD or step therapy requirements. 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 that would support 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 27.4% of the PDP PAs processed in SFY 14/15. Examples of PA requests where providers have utilized the prescriber prevails clause includes PA requests for:

- Second generation antipsychotics: patient does not meet diagnosis/age requirements in clinical criteria;
- Hepatitis C agents: prescriber does not provide clinical justification that would support the use of the preferred agent; and
- Inhaled antibiotics: prescriber is not familiar with the preferred agents and does not wish to try them.

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 14/15, there was one physician peer review 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 focus on ensuring that providers and members are informed about Medicaid's pharmacy PA programs and are kept up to date on program changes.

During the SFY 14/15, 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 and the Medicaid Update (a monthly Medicaid provider communication). The PDP website (newyork.fhsc.com) is another venue for information, offering easy access for prescribers, pharmacists, members and other interested parties (Appendix 7). Brochures for members are available on-line and in a number of languages including Bosnian, Chinese, Yiddish and Haitian Creole (Appendix 6).

IV. Prescriber, Pharmacy, and Patient Satisfaction

Complaints

Complaints may be received through a variety of sources including by mail or email, through the Clinical Call Center (CCC) or Medicaid Helpline. Seventeen complaints about the PDP and CDRP were received during SFY 14/15, 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.

Patient reaction to the PDP remains positive. Medicaid's Helpline for members 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 member and/or their providers.

V. Outcomes and Cost Savings

Preferred Drug Program

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

In order to receive supplemental rebates, New York State joined the National Medicaid Pooling Initiative (NMPI). Additionally, the New York State Direct Contracting Program (SDC) enables access to rebates for manufactures that do not participate in NMPI. Both programs are administered by Magellan Medicaid Administration. New York is among 11 states that currently participate in the NMPI. Others include Alaska, Kentucky, Michigan, Minnesota, Montana, New Hampshire, Rhode Island, South Carolina, North Carolina and the District of Columbia. At the end of the SFY 14/15 the NMPI includes more than 90 participating manufacturers and has approximately 3.5 million member lives.

Contracts with manufacturers have a three-year net price guarantee; net prices may decrease during the period but they may not increase. Rebate amounts are based on the Wholesale Acquisition Cost (WAC) for each individual drug. Each Participating State in the NMPI program maintains its own P&TC or DURB and the ability to designate a drug as preferred or non-preferred.

The Medicaid program processed approximately 12.3 million pharmacy claims in SFY 14/15. Of these, 38 percent were for a drug that fell within one of the classes of drugs on the PDP. Of the drugs subject to the PDP, at the end of the fiscal year 89.2% of claims were for drugs that did not require prior authorization. The remaining 10.8% was for drugs that required prior authorization. This 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.

Under the PDP, the highest volume of requests for prior authorizations during SFY 14/15 were for the following drug classes: long- and short-acting opioids (28 percent combined), used to treat moderate to severe pain; Proton Pump Inhibitors (8 percent), used to treat acid reflux; second generation antipsychotics (12 percent), primarily used to treat mental

health illnesses such as schizophrenia and bipolar disorder; SNRIs (4 percent) used to treat a variety of conditions, including depression, diabetic peripheral neuropathy and fibromyalgia, and second generation anticonvulsants (5 percent), used primarily to treat seizure disorders.

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 have continued to encourage prescriber compliance with the PDL and resultant market shift towards preferred agents. Overall, after consultation with CCC staff, 3.2 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. Market shift savings were estimated to be $-8.9 million after excluding the impact of the Hepatitis C Agents – Direct Acting Antivirals class. That class alone accounted for a -$21.3 million in Market Share shift. Total Savings (Supplemental Rebate + Market Share Shift) is $7.3 million in program savings for this time period once the Hepatitis C Agents – Direct Acting Antivirals class is excluded. When costly new drugs enter the market, they may pick up market share at the expense of lower cost products. To that point, a negative market shift is not necessarily reflective of a poor PDL performance, because without the PDL, the negative shift in market share towards the high-cost products could have been higher.

Outcomes and Cost Savings - Clinical Drug Review Program (CDRP)

In SFY 14/15, a total of 10,244 requests were approved for PA of drugs under the CDRP as follows:

- **Anabolic Steroids**: 659
- **CNS Stimulants**: 18 or Older: 6214
- **Fentanyl Mucosal Agents**: 122
- **Growth Hormones**: 21 or Older: 11
- **Immunomodulators**: Topical: 275
- **Lidoderm®**: 843
- **Phosphodiesterase type-5 (PDE-5) Inhibitors for PAH**: 132
- **Regranex®**: 26
- **Serostim®**: 13
- **Synagis®**: 128
- **Truvada®**: 1566

- **Xyrem®**: 2
- **Oxazolidinone Antibiotics®**: 253

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. Although it is difficult to obtain evidence or documentation that would serve to support a denial, if statute allowed denial on the basis of medical necessity, 5% 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.

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

VI. Conclusion

The ninth full fiscal year of operation of the PDP, and CDRP, proceeded smoothly. Results continue to show that the PDP and CDRP programs are effective in assuring access to high quality, cost effective medications and have resulted in significant program savings, while promoting access to medically necessary drugs for Medicaid members.

In SFY 14/15, the DURB re-reviewed 27 classes of drugs in the PDP to include drugs recently approved by the FDA and newly available clinical and financial information. Five new drug classes were reviewed for inclusion on the PDP. By the end of the SFY there were a total of 107 drug classes subject to the PDP. No new drugs were recommended for inclusion into the CDRP by the DUR Board in SFY 14/15.

Technological advancements including audiocasts of DURB meetings and email notification to interested parties whenever the PDL is changed have ensured the transparency of the PDP and CDRP process.

Providers continue to receive notification of PDL revisions through email distribution lists, website postings and Medicaid Update article publications.

Effective October 1, 2011, members in mainstream Medicaid managed care and FHPlus no longer receive pharmacy services through NYS Medicaid FFS Pharmacy Benefit Programs. This change explains the variance in rebates from this year compared to years past. The Medicaid FFS PDP continues to provide value to members that remain in FFS through the use of a preferred drug list which promotes clinically appropriate drug utilization, while also reducing costs.

The Pharmacy Prior Authorization programs continue to be monitored closely by DOH staff. An annual review of the NMPI and SDC supplemental invoice process by an independent consultant, as well as by NYS, is conducted to ensure appropriate protocol and accounting is maintained. Complaints are tracked to ensure appropriate resolution, and feedback from complaints is evaluated for potential enhancements to the process.

Article 2A of the Public Health Law

ARTICLE 2-A

PRESCRIPTION DRUGS

§ 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.

§ 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.

§ 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.

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

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

§ 273. Preferred drug program prior authorization. 1. For the purposes of this article, a prescription drug shall be considered to be not on the preferred drug list if it is a non preferred drug.

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

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

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

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

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

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

consideration of the medical needs of special populations, including children, elderly, chronically ill, persons with mental health conditions, and persons affected by HIV/AIDS.

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

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

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

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

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

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

7. No prior authorization under the preferred drug program shall be required when a prescriber prescribes a drug on the preferred drug list; provided, however, that the commissioner may identify such a drug for which prior authorization is required pursuant to the provisions of the clinical drug review program established under section two hundred seventy-four of this article.

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

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

of this article.

§ 274. Clinical drug review program. 1. In addition to the preferred drug program established by this article, the commissioner may establish a clinical drug review program. The commissioner may, from time to time, require prior authorization under such program for prescription drugs or patterns of utilization under state public health plans. When a prescriber prescribes a drug which requires prior authorization under this section, state public health plan reimbursement shall be denied unless such prior authorization is obtained.

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

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

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

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

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

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

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

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

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

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

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

authorization may be denied in cases where the department has substantial evidence that the prescriber or patient is engaged in fraud or abuse relating to the drug.

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

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

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

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

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

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

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

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

determining that the necessary steps have been taken to apply prior authorization under this article to EPIC, the panel shall, with reasonable prior public notice, make prescriptions under EPIC subject to prior authorization under this article as of a specified date. If necessary, the panel may provide that such applicability take effect on separate dates for the preferred drug program and the clinical drug review program.

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

§ 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.

§ 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.

Drug Utilization Review Board Membership

Drug Utilization Review Board Membership

DOH Designee - Chairperson
1. Jason Helgerson

Physicians
2. Renante Ignacio, MD
3. Glenn Martin, MD
4. John McIntyre, MD
5. Anita Radix, MD
6. James Saperstone, MD
7. Vacancy

Pharmacists
8. Leigh Briscoe-Dwyer, PharmD
9. Jeffrey Dubitsky, RPh
10. John Noviasky, PharmD
11. Michelle Rainka, PharmD
12. William Scheer, RPh
13. Vacancy

DUR Experts
14. Donna Chiefari, PharmD
15. Jadwiga Najib, PharmD

Nurse Practioner/Midwife
16. Nancy Balkon, PhD, NP

Consumers/Consumer Representatives
17. Marla Eglowstein, MD
18. Kathleen LeBeau
19. John Wikiera

08/01/2013

Drug Classes in the Preferred Drug Program

The following table lists drug classes that were reviewed at the DURB during SFY 14/15. Also included is the review date, the date the PDL was publicly posted, and the date some drugs within the class required PA.

P&TC Meeting	Drug Class	Posting Date	Date PA Required
September 18, 2014	Agents for Opioid Dependence	October 2, 2014	December 11, 2014
April 24, 2014	Alpha-2 Adrenergic Agonists - Ophthalmic (for Glaucoma)	May 6, 2014	July 16, 2014
September 18, 2014	Alpha-Glucosidase Inhibitors	October 2, 2014	December 11, 2014
September 18, 2014	ANTICOAGULANTS: ORAL	October 2, 2014	December 11, 2014
April 24, 2014	ANTICONVULSANTS: SECOND GENERATION	May 6, 2014	July 16, 2014
April 24, 2014	ANTICHOLINERGICS/COPD AGENTS	May 6, 2014	July 16, 2014
April 24, 2014	Antifungals - Topical	May 6, 2014	July 16, 2014
April 24, 2014	Antihistamines - Second Generation	May 6, 2014	July 16, 2014
April 24, 2014	ANTI-INFECTIVES, TOPICAL	May 6, 2014	July 16, 2014
April 24, 2014	Antipsychotics – Second Generation	May 6, 2014	July 16, 2014
April 24, 2014	CARBAMAZEPINE DERIVATIVES	May 6, 2014	July 16, 2014
April 24, 2014	CNS Stimulants	May 6, 2014	July 16, 2014
April 24, 2014	Corticosteroids - Inhaled	May 6, 2014	July 16, 2014
April 24, 2014	Intranasal Corticosteroids	May 6, 2014	July 16, 2014
April 24, 2014	Corticosteroids/Long Acting Beta Agonist Combinations	May 6, 2014	July 16, 2014
April 24, 2014	GROWTH HORMONES	May 6, 2014	July 16, 2014
April 24, 2014	Immunomodulators - Systemic	May 6, 2014	July 16, 2014
September 18, 2014	Meglitinides	October 2, 2014	December 11, 2014
April 24, 2014	MULTIPLE SCLEROSIS AGENTS	May 6, 2014	July 16, 2014
April 24, 2014	NSAIDs: Prescription	May 6, 2014	July 16, 2014
September 18, 2014	Opioid Antagonists	October 2, 2014	December 11, 2014
April 24, 2014	OPIOIDS: LONG ACTING	May 6, 2014	July 16, 2014
September 18, 2014	Oral Agents for Pulmonary Arterial Hypertension (PAH)	October 2, 2014	December 11, 2014
April 24, 2014	Phosphate Binders/Regulators	May 6, 2014	July 16, 2014
April 24, 2014	PLATELET INHIBITORS	May 6, 2014	July 16, 2014
April 24, 2014	Prostaglandin Agonists - Ophthalmic	May 6, 2014	July 16, 2014
April 24, 2014	SELECTIVE-SEROTONIN REUPTAKE INHIBITORS	May 6, 2014	July 16, 2014
April 24, 2014	Serotonin Norepinephrine Reuptake Inhibitors	May 6, 2014	July 16, 2014
September 18, 2014	Sodium Glucose co-transporter 2 (SGLT2) Inhibitors	October 2, 2014	December 11, 2014
April 24, 2014	Sulfasalazine Derivatives	May 6, 2014	July 16, 2014
April 24, 2014	Thiazolidinediones	May 6, 2014	July 16, 2014

Preferred and Non-Preferred Drug List

Revised: March 23, 2015

New York State Medicaid Fee-For-Service Pharmacy Programs

OVERVIEW OF CONTENTS

For more information on the NYS Medicaid Pharmacy Programs: http://www.health.ny.gov/health_care/medicaid/program/pharmacy.htm
To contact the NYS Medicaid Pharmacy Clinical Call Center please call 1-877-309-9493
To download a copy of the Prior Authorization fax form go to https://newyork.fhsc.com/providers/PA_forms.asp

1

Revised: March 23, 2015

NYS Medicaid Fee-For-Service Preferred Drug List

PREFERRED DRUG LIST – TABLE OF CONTENTS

1 = Preferred as of 12/11/2014
2 = Non-preferred as of 12/11/2014

Revised: March 23, 2015

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
I. ANALGESICS		
Non-Steroidal Anti-Inflammatory Drugs (NSAIDS) – Prescription		
diclofenac sodium diclofenac sodium XR flurbiprofen ibuprofen indomethacin ketoprofen ketorolac meloxicam nabumetone naproxen naproxen EC naproxen sodium piroxicam sulindac Voltaren® Gel	Anaprox® Anaprox® DS Arthrotec® Cambia™ Cataflam® Celebrex® CC Daypro® diclofenac / misoprostol diclofenac potassium diclofenac topical solution diflunisal Duexis® etodolac etodolac ER Feldene® fenoprofen Flector® patch Indocin® indomethacin SR ketoprofen SA meclofenamate mefenamic acid Mobic® Naprelan® Naprosyn® Naprosyn® EC oxaprozin Pennsaid® Ponstel® Sprix® tolmetin Vimovo® Voltaren® XR Zipsor® Zorvolex™	**CLINICAL CRITERIA (CC)** ➢ Celebrex® (celecoxib) – one of the following criteria will not require PA ▪ Over the age of 65 years ▪ Concurrent use of an anticoagulant agent ▪ History of GI Bleed/Ulcer or Peptic Ulcer Disease
Opioid Antagonists		
naloxone (syringe, vial) naltrexone ReVia®	Evzio™	Prior Authorization for non-preferred agents required as of 12/11/2014
Opioid Dependence Agents CC, F/Q/D		
buprenorphine Suboxone® (film)	Bunavail™ buprenorphine / naloxone (tablet) Zubsolv®	Prior Authorization for non-preferred agents required as of 12/11/2014 **CLINICAL CRITERIA (CC)** ➢ Medical necessity rationale for opioid therapy is required for patients on established buprenorphine therapy **QUANTITY LIMIT:** ➢ Buprenorphine sublingual (SL): Six (6) tablets dispensed as a 2-day supply; not to exceed 24 mg per day ➢ Buprenorphine / naloxone tablet and film (Bunavail™, Suboxone®, Zubsolv®): Three (3) sublingual tablets or films per day; maximum of 90 tablets or films dispensed as a 30-day supply, not to exceed 24 mg-6 mg of Suboxone, or it's equivalent per day

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Revised: March 23, 2015

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
Opioids – Long-Acting [cc]		
fentanyl patch [F/Q/D] Kadian® [F/Q/D] morphine sulfate SR (tablet) [F/Q/D]	Avinza® [F/Q/D] Butrans™ Conzip™ [ST, F/Q/D] Duragesic® [F/Q/D] Embeda® ER Exalgo® [F/Q/D] hydromorphone ER Hysingla™ ER [F/Q/D] morphine sulfate ER (capsule) [F/Q/D] MS Contin® [F/Q/D] Nucynta® ER [ST, F/Q/D] Opana ER® [F/Q/D] oxycodone ER [F/Q/D] Oxycontin® [F/Q/D] oxymorphone ER [F/Q/D] tramadol ER [ST, F/Q/D] Ultram® ER [ST, F/Q/D] Zohydro™ ER [F/Q/D]	**CLINICAL CRITERIA (CC)** ➢ Limited to a total of four (4) opioid prescriptions every 30 days; Exemption for diagnosis of cancer or sickle cell disease ➢ Medical necessity rationale for opioid therapy is required for patients on established buprenorphine therapy ➢ PA required for initiation of long-acting opioid therapy in opioid-naïve patients. ▪ Exemption for diagnosis of cancer or sickle cell disease. ➢ PA required for any additional long-acting opioid prescription for patients currently on long-acting opioid therapy. ▪ Exemption for diagnosis of cancer or sickle cell disease. ➢ PA required for initiation of opioid therapy in patients currently on benzodiazepine therapy **STEP THERAPY (ST)** ➢ Nucynta® ER (tapentadol ER): Trial with tapentadol IR before tapentadol ER for patients who are naïve to a long-acting opioid ➢ Tramadol ER (tramadol naïve patients): attempt treatment with IR formulations before the following ER formulations: Conzip®, tramadol ER , Ultram® ER **FREQUENCY/QUANTITY/DURATION (F/Q/D)** ➢ Embeda® (morphine ER/naltrexone): ➢ maxiumum 2 (two) units per day ➢ Nucynta® ER (tapentadol ER): ▪ maximum 2 (two) units per day ➢ Nucynta® ER (tapentadol ER): ▪ maximum daily dose of tapentadol IR and tapentadol ER formulations if used in combination should not exceed 500mg/day ➢ Tramadol ER (Conzip®, Ultram® ER): ▪ maximum 30 tablets dispensed as a 30 day supply ➢ Zohydro ER (hydrocodone ER): ▪ maximum 2 (two) units per day, 60 units per 30 days ➢ Hysingla™ ER (hydrocodone ER): ▪ maximum 1 (one) unit per day; 30 units per 30 days **Patients *without* documented cancer or sickle cell diagnosis for the following:** ➢ Hydromorphone ER, oxymorphone ER: ▪ maximum 4 (four) units per day, 120 units per 30 days ➢ Oxycodone ER: ▪ maximum 2 (two) units per day, 60 units per 30 days. Not to exceed a total daily dose of 160 mg ➢ Fentanyl transdermal patch: ▪ maximum 10 patches per 30 days; maximum 100mcg/hr (over a 72 hour dosing interval) ➢ Morphine ER (excluding MS Contin products): ▪ maximum 2 (two) units per day, 60 units per 30 days ➢ Morphine ER (MS Contin 15mg, 30mg, 60mg only): ▪ maximum 3 (three) units per day, 90 units per 30 days ➢ Morphine ER (MS Contin 100mg only): ▪ maximum 4 units per day, up to 3 times a day, maximum 120 units per 30 days ➢ Morphine ER (MS Contin 200mg only): ▪ maximum 2 units per day, maximum 60 units per 30 days

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Revised: March 23, 2015

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
Opioids – Short-Acting CC		
butalbital/APAP/codeine F/Q/D codeine F/Q/D codeine/ APAP F/Q/D hydrocodone/ APAP F/Q/D hydrocodone/ ibuprofen F/Q/D morphine IR F/Q/D oxycodone/ APAP F/Q/D tramadol Verdrocet™ F/Q/D Xylon™ F/Q/D	butalbital compound/ codeine F/Q/D butorphanol nasal spray Demerol® dihydrocodeine/ APAP/ caffeine F/Q/D dihydrocodeine/ aspirin/ caffeine F/Q/D Dilaudid® F/Q/D Endodan® F/Q/D Fioricet®/codeine F/Q/D Fiorinal®/codeine F/Q/D hydromorphone F/Q/D Ibudone™ F/Q/D levorphanol Magnacet® F/Q/D meperidine Nucynta® ST, F/Q/D Opana® F/Q/D Oxecta® F/Q/D oxycodone F/Q/D oxycodone/ aspirin F/Q/D oxycodone/ ibuprofen F/Q/D oxymorphone F/Q/D pentazocine/naloxone Percocet® 2.5/325mg F/Q/D Percodan® F/Q/D Primlev™ F/Q/D Roxicet® (caplets, solution) F/Q/D Roxicodone® F/Q/D Synalgos® DC F/Q/D tramadol/ APAP F/Q/D Tylenol®/ codeine #3 F/Q/D Tylenol®/ codeine #4 F/Q/D Ultracet® F/Q/D Ultram® Vicoprofen® F/Q/D Xartemis™ XR F/Q/D Xodol® F/Q/D Zamicet™ F/Q/D	**CLINICAL CRITERIA (CC)** ➢ Limited to a total of four (4) opioid prescriptions every 30 days; Exemption for diagnosis of cancer or sickle cell disease ➢ For opioid- naïve patients - limited to a 15 days supply for all initial opioid prescriptions, except for patients with diagnosis of sickle cell disease or cancer ➢ Medical necessity rationale for opioid therapy is required for patients on established buprenorphine therapy ➢ PA required for initiation of opioid therapy in patients currently on benzodiazepine therapy **STEP THERAPY (ST)** ➢ Nucynta® (tapentadol IR) - Trial with tramadol and one (1) preferred opioid before tapentadol immediate-release (IR) **FREQUENCY/QUANTITY/DURATION (F/Q/D)** **Quantity Limits:** ➢ Nucynta® (tapentadol IR): ▪ maximum 6 (six) units per day; 180 units per 30 days ➢ Nucynta® (tapentadol IR): ▪ maximum daily dose of tapentadol IR and tapentadol ER formulations used in combination not to exceed 500mg/day ➢ Morphine and congeners immediate-release (IR) non-combination products (codeine, hydromorphone, morphine, oxycodone, oxymorphone): ▪ maximum 6 (six) units per day, 180 (one hundred eighty) units per 30 (thirty) days ▪ Additional/alternate parameters: To be applied to patients without a documented cancer or sickle cell diagnosis ➢ Morphine and congeners immediate-release (IR) combination products maximum recommended: ▪ acetaminophen (4 grams) ▪ aspirin (4 grams) ▪ ibuprofen (3.2 grams) ▪ or the FDA approved maximum opioid dosage as listed in the PI, whichever is less ▪ Additional/alternate parameters: To be applied to patients without a documented cancer or sickle cell diagnosis **Duration Limits:** ➢ 90 days for patients without a diagnosis of cancer or sickle-cell disease.

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5

Revised: March 23, 2015

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
II. ANTI-INFECTIVES		
Anti-Fungals – Oral for Onychomycosis		
griseofulvin (suspension) griseofulvin ultramicronized terbinafine (tablet)	Grifulvin V® (tablet) Gris-PEG® griseofulfin micronized (tablet) itraconazole Lamisil® (tablet) Omnel™ Sporanox®	
Anti-Virals – Oral		
acyclovir valacyclovir	famciclovir Famvir® Valtrex® Zovirax®	
Cephalosporins – Third Generation		
cefdinir cefpodoxime proxetil Suprax®	Cedax® Cefditoren ceftibuten Spectracef®	
Fluoroquinolones – Oral		
Cipro® (suspension) ciprofloxacin (suspension, tablet) levofloxacin (tablet)	Avelox® Avelox ABC Pack® Cipro® (tablet) Cipro® XR ciprofloxacin ER Factive® Levaquin® levofloxacin (solution) moxifloxacin Noroxin® ofloxacin (tablet)	
Hepatitis B Agents		
Baraclude® Epivir-HBV® Hepsera® Tyzeka®	adefovir dipivoxil entecavir lamivudine 100mg	
Hepatitis C Agents – Injectable F/Q/D		
Pegasys® PegIntron®	None	**FREQUENCY/QUANTITY/DURATION (F/Q/D)** ➢ PA required for the initial 14 weeks therapy to determine appropriate duration of therapy based on genotype. ➢ Further documentation required for continuation of therapy at weeks 14 and 26. ➢ After 12 weeks of therapy obtain a quantitative HCV RNA. Continuation is supported if undetectable HCV RNA or at least a 2 log decrease compared to baseline. ➢ After 24 weeks of therapy obtain a HCV RNA. Continuation for genotype 1 and 4 is supported if undetectable HCV RNA.

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Revised: March 23, 2015

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
Hepatitis C Agents – Direct Acting Antivirals ST, F/Q/D		
Incivek® ST ribavirin Victrelis® ST	Copegus® Harvoni® Moderiba™ Olysio® ST Rebetol® Ribapak® Ribasphere™ Sovaldi® ST	**STEP THERAPY (ST)** ➢ **Incivek® (telaprevir) and Olysio (simeprevir)** – step therapy assuring concomitant peginterferon and ribavirin therapy ➢ **Sovaldi™ (sofosbuvir)** – step therapy assuring concomitant peginterferon and ribavirin therapy or simeprevir (Olysio) ➢ **Victrelis® (boceprevir)** – step therapy assuring four (4) consecutive weeks of peginterferon and ribavirin therapy immediately before initiation of boceprevir **FREQUENCY/QUANTITY/DURATION (F/Q/D)** ➢ Harvoni™ (ledipasvir/sofosbuvir): ➢ Quantity limit: maxiumum 1 (one) unit per day; 28 units per 28 days ▪ Duration limit: Duration limit: Initially 56 days, pending results of quantitative HCV RNA testing after 4 weeks of ledipasvir/sofosbuvir treatment ❖ Maximum 12 consecutive weeks over beneficiary lifetime, pending results of quantitative HCV RNA testing for patients without cirrhosis ❖ Maximum 24 consecutive weeks over beneficiary lifetime, pending results of quantitative HCV RNA testing for treatment-experienced patients with cirrhosis ➢ Incivek® (telaprevir): ▪ Quantity limit: maximum 6 (six) units per day, 168 units per 28 days ▪ Quantity limit: minimum 9 (nine) tablets per day, 252 units per 28 days for beneficiaries receiving efavirenz ▪ Duration limit: Initially 56 days, pending results of quantitative HCV RNA testing after 4 weeks of treatment. ❖ Maximum 12 consecutive weeks over beneficiary lifetime, pending results of quantitative HCV RNA testing ➢ Olysio™ (simeprevir): ▪ Quantity limit: maximum 1 (one) unit per day, 28 units per 28 days ▪ Duration limit: Initially 56 days, pending results of quantitative HCV RNA testing after 4 weeks of simeprevir treatment ❖ For Olysio plus peginterferon and ribavirin: maximum 12 consecutive weeks over beneficiary lifetime ❖ For Olysio plus Sovaldi: maximum 12 consecutive weeks for patients without cirrhosis and 24 weeks for patients with cirrhosis over beneficiaries lifetime ➢ Sovaldi™ (sofosbuvir): ▪ Quantity limit: maximum 1 (one) unit per day, 28 units per 28 days ▪ Duration limit: maximum 12 consecutive weeks for genotypes 1 if used with peginterferon and ribavirin or with Olysio in patients with cirrhosis, 2 and 4; 24 weeks for genotype 3; maximum of up to 48 weeks in patients with hepatocellular carcinoma awaiting liver transplantation ➢ Victrelis® (boceprevir): ▪ Quantity limit: maximum 12 units per day, 336 units per 28 days ▪ Duration limit: Initially 84 days, pending results of quantitative HCV RNA testing after 4 and 8 weeks of boceprevir treatment (i.e., triple therapy weeks 8 and 12) ▪ Subsequent limit of 84 days, pending results of quantitative HCV RNA testing after 20 weeks of boceprevir treatment (i.e. week 24 of triple therapy) ❖ Maximum 44 consecutive weeks over beneficiary lifetime, pending results of quantitative HCV RNA testing if: ○ Prior peginterferon/ribavirin non responder ○ Compensated cirrhosis ○ Maximum 32 consecutive weeks over beneficiary lifetime, pending results of quantitative HCV RNA testing for all other beneficiaries ➢ Click here to access the Hepatitis C Worksheets

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7

Revised: March 23, 2015

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
Tetracyclines		
demeclocycline doxycycline hyclate minocycline (capsule) Morgidox™ (capsule) tetracycline	Adoxa® Doryx® ST, F/Q/D doxycycline hyclate DR ST, F/Q/D doxycycline monohydrate Dynacin® minocycline (tablet) minocycline ER Oracea® Solodyn® Vibramycin®	**STEP THERAPY (ST)** ➢ Trial of a more cost effective doxycycline IR before progressing to doxycycline DR **FREQUENCY/QUANTITY/DURATION (F/Q/D)** ➢ doxycycline DR (Doryx®): ➢ maximum 28 tablets/capsules per fill
III. CARDIOVASCULAR		
Angiotensin Converting Enzyme Inhibitors (ACEIs)		
benazepril captopril enalapril maleate lisinopril moexipril ramipril (capsule) trandolapril	Accupril® Aceon® Altace® Epaned™ fosinopril sodium Lotensin® Mavik® perindopril Prinivil® quinapril Univasc® Vasotec® Zestril®	
ACE Inhibitors / Calcium Channel Blockers		
benazepril / amlodipine Lotrel® Tarka® trandolapril / verapamil ER	None	
ACE Inhibitors / Diuretics		
benazepril/ HCTZ captopril HCTZ enalapril / HCTZ lisinopril / HCTZ moexipril / HCTZ	Accuretic® fosinopril / HCTZ Lotensin HCT® quinapril / HCTZ Uniretic® Vaseretic® Zestoretic®	

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Revised: March 23, 2015

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs		Non-Preferred Drugs		Prior Authorization/Coverage Parameters
Angiotensin Receptor Blockers (ARBs) ST				
Diovan® DO	losartan	Atacand®	eprosartan	**DOSE OPTIMIZATION (DO)** ➢ See Dose Optimization Chart for affected drugs and strengths **STEP THERAPY (ST)** ➢ Trial of a product containing ACE inhibitor prior to preferred ARB ➢ Trial containing either an ACE inhibitor or ARB prior preferred direct renin inhibitor (DRI)
		Avapro®	irbesartan	
		Benicar® DO	Micardis® DO	
		candesartan	telmisartan	
		Cozaar®	Teveten®	
		Edarbi™		
ARBs / Calcium Channel Blockers ST				
Exforge® DO Exforge HCT® valsartan / amlodipine / HCTZ		Azor® telmisartan / amlodipine Tribenzor™ Twynsta® valsartan / amlodipine		**DOSE OPTIMIZATION (DO)** ➢ See Dose Optimization Chart for affected drugs and strengths **STEP THERAPY (ST)** ➢ Trial of product containing ACE Inhibitor prior to preferred ARB ➢ Trial of product containing either ACE inhibitor or ARB prior to initiating DRI
ARBs / Diuretics ST				
Diovan HCT® DO	losartan/ HCTZ	Atacand HCT®	irbesartan/ HCTZ	**DOSE OPTIMIZATION (DO)** ➢ See Dose Optimization Chart for affected drugs and strengths **STEP THERAPY (ST)** ➢ Trial of product containing ACE Inhibitor prior to preferred ARB ➢ Trial of a product containing either an ACE inhibitor or an ARB prior to preferred DRI
		Avalide®	Micardis HCT® DO	
		Benicar HCT® DO	telmisartan / HCTZ	
		candesartan/HCTZ	Teveten HCT®	
		Edarbyclor™ DO	valsartan/ HCTZ	
		Hyzaar®		
Beta Blockers				
atenolol	metoprolol tartrate	acebutolol	Lopressor®	**DOSE OPTIMIZATION (DO)** ➢ See Dose Optimization Chart for affected drugs and strengths
carvedilol	propranolol (tablet)	betaxolol	metoprolol succ. XL	
labetalol	Toprol XL® DO	bisoprolol	nadolol DO	
		Bystolic® DO	pindolol	
		Coreg®	propranolol (solution)	
		Coreg CR® DO	propranolol ER/SA	
		Corgard®	Sectral®	
		Inderal LA®	Tenormin®	
		Inderal XL®	timolol	
		InnoPran XL®	Trandate®	
		Levatol®	Zebeta®	

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Revised: March 23, 2015

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
Beta Blockers / Diuretics		
atenolol / chlorthalidone bisoprolol / HCTZ propranolol / HCTZ	Corzide® Dutoprol™ Lopressor HCT® metoprolol tartrate / HCTZ nadolol / bendroflumethiazide Tenoretic® Ziac®	
Calcium Channel Blockers (Dihydropyridine)		
Afeditab CR® amlodipine felodipine ER isradipine nicardipine HCl Nifedical XL® nifedipine nifedipine ER/SA	Adalat CC® Cardene SR® nisoldipine Norvasc® Procardia® Procardia XL® Sular®	
Cholesterol Absorption Inhibitors		
cholestyramine cholestyramine light Colestid® (tablet) colestipol (tablet) Prevalite®	Colestid (granules) colestipol (granules) Questran® Questran Light® Welchol™ Zetia®	
Direct Renin Inhibitors ST		
Tekturna® Tekturna HCT®	Amturnide™ Tekamlo™	**STEP THERAPY (ST)** ➢ Trial of product containing ACE Inhibitor prior to preferred ARB ➢ Trial of product containing either an ACE inhibitor or an ARB prior to initiating preferred DRI
HMG-CoA Reductase Inhibitors (Statins)		
atorvastatin lovastatin pravastatin DO Simcor® simvastatin	Advicor® Altoprev® atorvastatin/ amlodipine Caduet® Crestor® DO fluvastatin Lescol® Lescol XL® Lipitor® Liptruzet™ Livalo® Mevacor® Pravachol® Vytorin® Zocor®	**DOSE OPTIMIZATION (DO)** ➢ See Dose Optimization Chart for affected drugs and strengths
Niacin Derivatives		
niacin ER	Niaspan® DO	**DOSE OPTIMIZATION (DO)** ➢ See Dose Optimization Chart for affected drugs and strengths

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Revised: March 23, 2015

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
Phosphodiesterase type-5 (PDE-5) Inhibitors for PAH CDRP		
Adcirca® sildenafil	Revatio®	**CLINICAL DRUG REVIEW PROGRAM (CDRP)** ➢ All prescriptions for Adcirca®, Revatio® and sildenafil must have PA ➢ Prescribers are required to respond to a series of questions that identify prescriber, patient and reason for prescribing drug ➢ Please be prepared to fax clinical documentation upon request ➢ Prescriptions can be written for a 30-day supply with up to 5 refills ➢ The CDRP Phosphodiesterase type-5 (PDE-5) Inhibitors for PAH Prescriber Worksheet provides step-by-step assistance in completing the prior authorization process
Pulmonary Arterial Hypertension (PAH) Oral Agents, Other		
Letairis® Tracleer®	Adempas® 2 Orenitram™ 2 Opsumit®	
Triglyceride Lowering Agents		
fenofibrate (generic for Tricor®) fenofibric acid (generic for Trilipix®) gemfibrozil	Antara® fenofibrate (generic for Antara®) fenofibrate (generic for Fibricor®) fenofibrate (generic for Lofibra®) fenofibric acid (generic for Lipofen®) Fenoglide® Fibricor® Lipofen® Lofibra® Lopid® Lovaza® ST, F/Q/D Tricor® Triglide® Trilipix® Vascepa® ST, F/Q/D	**STEP THERAPY (ST)** ➢ Lovaza® (omega-3-acid ethyl-esters) and Vascepa® (icosapent ethyl) – Trial of fibric acid derivative OR niacin prior to treatment with omega-3-acid ethyl-esters **FREQUENCY/QUANTITY/DURATION (F/Q/D)** ➢ Lovaza® (omega-3-acid ethyl-esters) and Vascepa® (icosapent ethyl) – Required dosage equal to 4 (four) units per day

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Revised: March 23, 2015

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
IV. CENTRAL NERVOUS SYSTEM		
Alzheimer's Agents		
donepezil 5mg, 10mg Exelon® (patch) galantamine galantamine ER Namenda® rivastigmine	Aricept® donepezil 23 mg Exelon® (capsule) Namenda XR™ CC, ST Razadyne® Razadyne ER®	**CLINICAL CRITERIA (CC)** ➢ Memantine extended-release (Namenda XR™) - Requires confirmation of diagnosis of dementia or Alzheimer's disease **STEP THERAPY (ST)** ➢ Memantine extended-release (Namenda XR™) - Requires trial with memantine immediate-release (Namenda®)
Anticonvulsants – Second Generation		
felbamate gabapentin (capsule, solution) Gabitril® (2mg, 4mg) lamotrigine levetiracetam levetiracetam ER Lyrica® DO, ST Topiragen™ CC topiramate CC zonisamide	Banzel® CC Felbatol® CC Fycompa™ gabapentin (tablet) Gabitril® (12mg, 16mg) CC Keppra® CC Keppra XR® CC Lamictal® CC Lamictal® XR™ CC lamotrigine ER CC Neurontin® CC Onfi® CC, ST Potiga™ CC Qudexy™ XR Sabril® CC tiagabine CC Topamax® CC topiramate ER CC Trokendi XR™ CC Vimpat® CC Zonegran® CC	**DOSE OPTIMIZATION (DO)** ➢ See Dose Optimization Chart for affected drugs and strengths **CLINICAL CRITERIA (CC)** ➢ Clinical editing will allow patients currently stabilized on a non-preferred agent to continue to receive that agent without PA ➢ Topiramate IR/ER (Qudexy™, Topamax®, Topiragen™,Trokendi XR™) – Require confirmation of FDA approved, compendia supported, or Medicaid covered diagnosis ➢ Onfi® (clobazam): ▪ Require confirmation of FDA approved or compendia supported use ▪ PA required for initiation of clobazam therapy in patients currently on opioid or oral buprenorphine therapy ➢ PA required for any clobazam prescription in patients currently on benzodiazepine therapy **STEP THERAPY (ST)** ➢ Lyrica® (pregabalin) - Requires a trial with a tricyclic antidepressant **OR** gabapentin for treatment of Diabetic Peripheral Neuropathy (DPN) ➢ Onfi® (clobazam) – Requires a trial with an SSRI or SNRI for treatment of anxiety

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Revised: March 23, 2015

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs		Prior Authorization/Coverage Parameters
Antipsychotics – Second Generation CC, ST			
clozapine Fanapt™ Latuda® DO olanzapine (tablet) DO quetiapine F/Q/D risperidone DO Saphris® Seroquel XR® DO, F/Q/D ziprasidone	Abilify® CC, DO clozapine ODT CC Clozaril® FazaClo® Geodon® Invega® DO, F/Q/D	olanzapine ODT DO Risperdal® Seroquel® F/Q/D Versacloz™ Zyprexa® DO	**DOSE OPTIMIZATION (DO)** ➢ See Dose Optimization Chart for affected drugs and strengths **CLINICAL CRITERIA (CC)** ➢ Clinical editing will allow patients currently stabilized on a non-preferred agent to continue to receive that agent without PA ➢ Diagnosis is required for new prescriptions for all Second Generation Antipsychotics ➢ Abilify® - PA is not required when prescribed for treatment of bipolar disorder or schizophrenia as verified by Medicaid claims information ➢ PA is required for initial prescription for beneficiaries younger than the drug-specific minimum age as indicated below:

aripiprazole (Abilify®)	6 years
asenapine (Saphris®)	18 years
clozapine (Clozaril®, Fazaclo®)	12 years
iloperidone (Fanapt®)	18 years
lurasidone HCl (Latuda®)	18 years
olanzapine (Zyprexa®)	10 years
paliperidone (Invega®)	12 years
quetiapine fum. (Seroquel®, Seroquel XR®)	10 years
risperidone (Risperdal®)	5 years
ziprasidone HCl (Geodon®)	18 years

➢ Require confirmation of FDA approved, compendia supported, or Medicaid covered diagnosis for initial prescriptions for beneficiaries between minimum age as indicated above and 18 years of age

➢ Require confirmation of diagnosis that supports the concurrent use of a Second Generation Antipsychotic and a CNS Stimulant for patients < 18 years of age

STEP THERAPY (ST)

➢ For all Second Generation Antipsychotics used the treatment of Major Depressive Disorder in the absence of other psychiatric comorbidities, trial with at least two different antidepressant agents is required

➢ Trial of risperidone prior to paliperidone (Invega®) therapy

FREQUENCY/QUANTITY/DURATION (F/Q/D)

➢ Invega® 1.5mg, 3mg, 9mg tablets: maximum 1 (one) unit per day

➢ Invega® 6mg tablets: maximum 2 (two) units per day

➢ quetiapine/quetiapine extended-release (Seroquel®/Seroquel XR®): minimum 100mg/day; maximum 800mg/day

➢ quetiapine (Seroquel®): maximum 3 (three) units per day, 90 units per 30 days

➢ Seroquel XR® (150mg and 200mg): 1 (one) unit per day, 30 units per 30 days

➢ Seroquel XR® (50mg, 300mg and 400mg): 2 (two) units/day, 60 units per 30 days

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Revised: March 23, 2015

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
Benzodiazepines – Rectal		
Diastat® 2.5mg Diastat® AcuDial™	diazepam (rectal gel)	
Carbamazepine Derivatives [cc]		
carbamazepine (chewable, tablet) carbamazepine XR (tablet) Carbatrol® Epitol® Equetro® oxcarbazepine (tablet) Tegretol® (chewable, suspension) Trileptal® (suspension)	Aptiom® carbamazepine (suspension) carbamazepine ER (capsule) oxcarbazepine (suspension) Oxtellar XR™ Tegretol® (tablet) Tegretol XR® Trileptal® (tablet)	CLINICAL CRITERIA (CC) ➢ Clinical editing will allow patients currently stabilized on a non-preferred agent to continue to receive that agent without PA

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Revised: March 23, 2015

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
Central Nervous System (CNS) Stimulants CC, CDRP, F/Q/D		
Adderall® Adderall XR® amphetamine salt combo immediate-release Dexedrine® (tablet) dexmethylphenidate dextroamphetamine Focalin XR® DO Metadate® ER Methylin® methylphenidate (tablet) methylphenidate ER (generic for Concerta®) methylphenidate SR 10 mg, 20 mg (tablet) Vyvanse® DO	amphetamine salt combo extended-release Concerta® DO Daytrana® Desoxyn® Dexedrine Spansule® dexmethylphenidate ER (generic for Focalin XR®) dextroamphetamine ER dextroamphetamine solution Focalin® Metadate CD® DO methamphetamine methylphenidate CD (generic for Metadate CD®) methylphenidate ER (generic for Ritalin LA®) methylphenidate (solution) modafinil Nuvigil® CC Procentra® Provigil® CC, DO Quillivant XR™ Ritalin® Ritalin LA® DO Ritalin SR® Zenzedi™	**CLINICAL CRITERIA (CC)** ➢ Confirm diagnosis for an FDA-approved or Compendia supported indication for beneficiaries less than 18 years of age. ➢ Prior authorization is required for initial prescriptions for stimulant therapy for beneficiaries less than 3 years of age ➢ Patient-specific considerations for drug selection include treatment of excessive sleepiness associated with shift work sleep disorder or as an adjunct to standard treatment for obstructive sleep apnea. **CLINICAL DRUG REVIEW PROGRAM (CDRP)** ➢ For patients 18 years of age and older: ▪ Require confirmation of FDA approved, compendia supported, or Medicaid covered diagnosis ▪ Require confirmation of diagnoses that support concurrent use of CNS Stimululant and Second Generation Antipsychotic agent ➢ Click here for a copy of the CNS Stimulant for patients 18 years and older fax form **DOSE OPTIMIZATION (DO)** ➢ See Dose Optimization Chart for affected drugs and strengths **FREQUENCY/QUANTITY/DURATION (F/Q/D)** ➢ Quantity limits based on daily dosage as determined by FDA labeling ➢ Quantity limits for patients less than 18 years of age to include: ▪ Short-acting CNS stimulants: not to exceed 3 dosage units daily with maximum of 90 days per strength (for titration) ▪ Long-acting CNS stimulants: not to exceed 1 dosage unit daily with maximum of 90 days ➢ Quantity limits for patients 18 years of age and older to include: ▪ Short-acting CNS stimulants: not to exceed 3 dosage units daily with maximum of 30 days ▪ Long-acting CNS stimulants: not to exceed 1 dosage unit daily with maximum of 30 days ➢ For patients 18 years of age and older: a 90 day supply may be obtained with confirmation of FDA approved, Compendia supported or Medicaid covered diagnosis
Multiple Sclerosis Agents		
Avonex® Copaxone® 20 mg/mL Extavia®	Aubagio® Betaseron® Copaxone® 40 mg/mL Gilenya™ Plegridy™ Rebif® Tecfidera™	

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Revised: March 23, 2015

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs		Non-Preferred Drugs		Prior Authorization/Coverage Parameters
Non-Ergot Dopamine Receptor Agonists				
pramipexole	ropinirole	Mirapex® Mirapex ER® Neupro®	Requip® Requip® XL™ DO ropinirole ER	**DOSE OPTIMIZATION (DO)** ➢ See Dose Optimization Chart for affected strengths
Other Agents for Attention Deficit Hyperactivity Disorder (ADHD) CC				
Intuniv™ DO	Strattera® DO	clonidine ER guanfacine ER DO	Kapvay™	**CLINICAL CRITERIA (CC)** ➢ Confirm diagnosis for an FDA-approved or Compendia supported indication for beneficiaries < 18 years of age. ➢ Prior authorization is required for initial prescriptions for non-stimulant therapy for beneficiaries less than 6 years of age **DOSE OPTIMIZATION (DO)** ➢ See Dose Optimization Chart for affected strengths

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Revised: March 23, 2015

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
Sedative Hypnotics/Sleep Agents		
estazolam CC, F/Q/D flurazepam CC, F/Q/D temazepam 15mg, 30mg CC, F/Q/D zolpidem F/Q/D	Ambien® F/Q/D Ambien CR® F/Q/D Doral® CC, F/Q/D Edluar™ F/Q/D eszopiclone F/Q/D Halcion® CC, F/Q/D Intermezzo® F/Q/D Lunesta® DO, F/Q/D Restoril® CC, F/Q/D Rozerem® F/Q/D Silenor® Sonata® F/Q/D temazepam 7.5mg, 22.5mg CC, F/Q/D triazolam CC, F/Q/D zaleplon F/Q/D zolpidem ER F/Q/D Zolpimist™ F/Q/D	**DOSE OPTIMIZATION (DO)** ➢ See Dose Optimization Chart for affected strengths **CLINICAL CRITERIA (CC)** Benzodiazepine Agents (Doral®, estazolam, flurazepam, Halcion®, Restoril®, temazepam, triazolam): ▪ Require confirmation of FDA approved or compendia supported use ▪ PA required for initiation of benzodiazepine therapy in patients currently on opioid or oral buprenorphine therapy ▪ PA required for any additional benzodiazepine prescription in patients currently on benzodiazepine therapy **FREQUENCY/QUANTITY/DURATION (F/Q/D)** ➢ Frequency and duration limits for the following products: ▪ For non-zaleplon containing products: ❖ 30 dosage units per fill/1 dosage unit per day/30 days ▪ For zaleplon-containing products: ❖ 60 dosage units per fill/2 dosage units per day/30 days ➢ Duration limit equivalent to the maximum recommended duration: ▪ 360 days for immediate-release zolpidem products ▪ 180 days for eszopiclone and ramelteon products ▪ 168 days for ER zolpidem products ▪ 30 days for zaleplon products ▪ 30 days for benzodiazepine agents (Doral®, estazolam, flurazepam, Halcion®, Restoril®, temazepam, triazolam) for the treatment of insomnia ➢ Additional/Alternate parameters: ▪ For patients naïve to non-benzodiazepine sedative hypnotics (NBSH): ❖ First-fill duration and quantity limit of 10 dosage units as a 10 day supply, except for zaleplon-containing products which the quantity limit is 20 dosage units as a 10 day supply

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Revised: March 23, 2015

NYS Medicaid Fee-For-Service Preferred Drug List

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Selective Serotonin Reuptake Inhibitors (SSRIs)			
citalopram escitalopram (tablet) fluoxetine 10mg, 20mg, 40mg fluoxetine solution paroxetine sertraline	Brintellix™ Brisdelle™ Celexa® escitalopram solution fluoxetine 60 mg fluoxetine DR weekly fluvoxamine CC, DO fluvoxamine ER CC Lexapro® DO	Luvox CR® CC paroxetine CR Paxil® Paxil CR® Pexeva® Prozac® Sarafem® Viibryd™ DO Zoloft®	**DOSE OPTIMIZATION (DO)** ➢ See Dose Optimization Chart for affected strengths **CLINICAL CRITERIA (CC)** ➢ Clinical editing will allow patients currently stabilized on fluvoxamine or fluvoxamine ER to continue to receive that agent without PA ➢ Clinical editing to allow patients with a diagnosis of Obsessive Compulsive Disorder (OCD) to receive fluvoxamine and fluvoxamine ER without prior authorization
Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs) ST			
duloxetine venlafaxine venlafaxine ER (capsule)	Cymbalta® Desvenlafaxine base ER Desvenlafaxine fumarate ER Effexor XR® DO Fetzima™ Khedezla™ Pristiq® DO Savella® venlafaxine ER (tablet)		**DOSE OPTIMIZATION (DO)** ➢ See Dose Optimization Chart for affected strengths **STEP THERAPY (ST)** ➢ Trial of an SSRI prior to an SNRI ▪ Step therapy is not required for the following indications: ❖ Chronic musculoskeletal pain (CMP) ❖ Diabetic peripheral neuropathy (DPN) ❖ Fibromyalgia (FM) ➢ Cymbalta® (duloxetine) - Requires a trial with a tricyclic antidepressant **OR** gabapentin for treatment of Diabetic Peripheral Neuropathy (DPN)

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Revised: March 23, 2015

NYS Medicaid Fee-For-Service Preferred Drug List

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Serotonin Receptor Agonists (Triptans)		
rizatriptan (tablet) F/Q/D rizatriptan ODT F/Q/D sumatriptan F/Q/D	Amerge® F/Q/D Axert® F/Q/D Frova® F/Q/D Imitrex® F/Q/D Maxalt® F/Q/D Maxalt-MLT® F/Q/D naratriptan F/Q/D Relpax® F/Q/D Sumavel® DosePro F/Q/D Treximet® F/Q/D zolmitriptan F/Q/D Zomig® F/Q/D	**FREQUENCY/QUANTITY/DURATION (F/Q/D)** Amerge®: 18 units every 30 days Axert® 6.25mg Frova® Imitrex® tablets Imitrex® Nasal Spray Naratriptan Relpax® 20mg sumatriptan tablets Treximet® Sumavel DosePro zolmitriptan (tablet, ODT) 2.5mg zolmitriptan (tablet, ODT) 5mg Zomig/Zomig® ZMT 2.5mg Zomig® /Zomig® ZMT 5mg Zomig® Nasal Spray Axert® 12.5mg: 24 tablets every 30 days Maxalt® /Maxalt MLT® Relpax® 40mg rizatriptan (tablet, ODT)
V. DERMATOLOGIC AGENTS		
Agents for Actinic Keratosis		
Carac® diclofenac 3% gel F/Q/D Efudex® Fluoroplex® fluorouracil 5% cream	fluorouracil 0.5% cream Solaraze® F/Q/D	**FREQUENCY/QUANTITY/DURATION (F/Q/D)** ➢ Solaraze®/ diclofenac 3% gel: ▪ Maximum 100 (one hundred) grams as a 90 day supply ▪ Limited to one (1) prescription per year

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Revised: March 23, 2015

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
Antibiotics – Topical		
Altabax® Bactroban® (cream) mupirocin (ointment)	Bactroban® (ointment) Bactroban Nasal® (ointment) CC Centany™ (ointment) mupirocin (cream)	**CLINICAL CRITERIA** ➢ Bactroban Nasal® ointment – Patient-specific considerations for drug selection include concerns related to use for the eradication of nasal colonization with methicillin-resistant *Staphylococcus aureus* (MRSA) in patients older than 12 years.
Anti-Fungals – Topical		
clotrimazole OTC Lamisil AT® miconazole OTC Nyamyc™ nystatin (cream, ointment, powder) nystatin / triamcinolone Nystop® Pedi-Dri® terbinafine OTC tolnaftate OTC	Alevazol Ciclodan® ST ciclopirox (cream, gel, suspension) ST clotrimazole / betamethasone ST clotrimazole Rx ST econazole ST Ertaczo® ST Exelderm® ST Extina® ST ketoconazole ST Ketodan™ ST Loprox® ST Lotrisone® ST Luzu™ ST Mentax® ST Naftin® ST Oxistat® ST Vusion® F/Q/D	**STEP THERAPY (ST)** ➢ Trial of a preferred product (of comparable coverage) before using a non-preferred product **FREQUENCY/QUANTITY/DURATION (F/Q/D)** ➢ Vusion® 50gm ointment - Maximum 100 (one hundred) grams in a 90 day time period
Anti-Infectives, Topical		
Benzaclin pump clindamycin (gel) clindamycin (lotion, solution) erythromycin (gel, solution)	Acanya® Akne-mycin® Benzaclin® (gel) Benzamycin® Cleocin T® Clindacin™ Clindagel® clindamycin (foam, pledget) clindamycin / benzoyl peroxide Duac® Erygel® erythromycin (pledget) erythromycin / benzoyl peroxide Evoclin®	

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Revised: March 23, 2015

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
Anti-Virals – Topical		
Abreva® acyclovir (ointment)	Denavir® Sitavig® Xerese™ Zovirax® (cream, ointment)	
Immunomodulators – Topical CDRP		
Elidel® Protopic®	tacrolimus	**CLINICAL DRUG REVIEW PROGRAM (CDRP)** ➢ All prescriptions require prior authorization ➢ Refills on prescriptions are allowed ➢ Click here for CDRP Topical Immunomodulators Prescriber Worksheet
Psoriasis Agents – Topical		
calcipotriene (cream, ointment, scalp solution)	calcipotriene / betamethasone dipropionate Calcitrene™ (ointment) calcitriol (ointment) Dovonex® (cream, scalp solution) Sorilux® Taclonex® Taclonex® Scalp® Vectical™	
Steroids, Topical – Low Potency		
hydrocortisone acetate OTC hydrocortisone acetate Rx hydrocortisone/aloe vera	alclometasone ST fluocinolone (oil) ST Derma-Smoothe/FS® ST Texacort® ST Desonate® ST Verdeso™ ST desonide ST	**STEP THERAPY (ST)** ➢ Trial of preferred product (of comparable potency) before using non-preferred product.
Steroids, Topical – Medium Potency		
clocortolone hydrocortisone butyrate (ointment, solution) hydrocortisone valerate mometasone furoate	Cloderm® ST Cordran® ST Cutivate® ST Dermatop® ST Elocon® ST fluocinolone acetonide (cream, ointment, solution) ST fluticasone propionate ST hydrocortisone butyrate (cream) ST Luxiq® ST Pandel® ST prednicarbate ST Synalar® ST	**STEP THERAPY (ST)** ➢ Trial of preferred product (of comparable potency) before using non-preferred product

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Revised: March 23, 2015

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
Steroids, Topical – High Potency		
amcinonide fluocinonide fluocinonide emollient fluocinonide-E triamcinolone acetonide	Apexicon-E® ST Beta-Val® ST betamethasone dipropionate ST betamethasone dipropionate, augmented ST betamethasone valerate ST desoximetasone ST diflorasone ST Diprolene® ST Diprolene® AF ST fluocinonide 0.1% cream ST Halog® ST Kenalog® ST Topicort® ST Trianex® ST Vanos™ ST	**STEP THERAPY (ST)** ➢ Trial of preferred product (of comparable potency) before using non-preferred product
Steroids, Topical – Very High Potency		
clobetasol (cream, gel, ointment, solution) halobetasol	clobetasol (foam, lotion, spray) ST Clobex® ST Cormax® ST Olux® ST Olux-E® ST Temovate® ST Temovate-E® ST Ultravate® ST	**STEP THERAPY (ST)** ➢ Trial of preferred product (of comparable potency) before using non-preferred product.
VI. ENDOCRINE AND METABOLIC AGENTS		
Alpha-Glucosidase Inhibitors ST		
acarbose Glyset®	Precose®	Prior Authorization for non-preferred agents required as of 12/11/2014 **STEP THERAPY (ST)** ➢ Requires a trial with metformin with or without insulin prior to initiating alpha-glucosidase inhibitor therapy, unless there is a documented contraindication.
Amylin Analogs ST		
Symlin®	None	**STEP THERAPY (ST)** ➢ Requires a trial with metformin with or without insulin prior to initiating amylin analogue therapy, unless there is a documented contraindication.

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Revised: March 23, 2015

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
Anabolic Steroids – Topical CDRP, F/Q/D		
Androgel® Testim®	Androderm® Axiron® Fortesta™ testosterone gel Vogelxo™	**CLINICAL DRUG REVIEW PROGRAM (CDRP)** ➢ For diagnosis of hypogonadotropic or primary hypogonadism: ▪ Requires documented low testosterone concentration with two tests prior to initiation of therapy. ▪ Require documented testosterone therapeutic concentration to confirm response after initiation of therapy. ➢ For diagnosis of delayed puberty: ▪ Requires documentation that growth hormone deficiency has been ruled out prior to initiation of therapy. ➢ Click here for a copy of the Anabolic Steroid fax form **FREQUENCY/QUANTITY/DURATION (F/Q/D)** ➢ Limitations for anabolic steroid products based on approved FDA labeled daily dosing and documented diagnosis: ▪ Duration limit of six (6) months for delayed puberty ▪ Duration limit of one (1) month for all used of oxandrolone products
Biguanides		
metformin HCl metformin ER (generic for Glucophage XR®)	Fortamet® Glucophage® Glucophage XR® Glumetza® metformin ER (generic for Fortamet®) Riomet® (solution)	
Bisphosphonates – Oral F/Q/D		
alendronate	Actonel® Atelvia® Binosto™ Boniva® Fosamax® Fosamax® Plus D Ibandronate risedronate 150mg	**FREQUENCY/QUANTITY/DURATION (F/Q/D)** Actonel® 150mg — 1 tablet every 28 days Boniva® 150mg — 1 tablet every 28 days ibandronate sodium 150 mg — 1 tablet every 28 days risedronate sodium150 mg — 1 tablet every 28 days Actonel® 35 mg — 4 tablets every 28 days alendronate sodium 35 mg — 4 tablets every 28 days alendronate sodium 70 mg — 4 tablets every 28 days Atelvia® 35 mg — 4 tablets every 28 days Fosamax® 35 mg — 4 tablets every 28 days Fosamax® 70mg — 4 tablets every 28 days Fosamax® Plus D — 4 tablets every 28 days alendronate solution 70mg/75mL single-dose bottle — 4 bottles every 28 days

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Revised: March 23, 2015

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
Calcitonins – Intranasal		
calcitonin-salmon Miacalcin®	Fortical®	
Dipeptidyl Peptidase-4 (DPP-4) Inhibitors ST		
Janumet® Janumet® XR Januvia® DO Jentadueto™ Tradjenta™	Kazano™ Kombiglyze XR™ Nesina™ Onglyza® DO Oseni™	DOSE OPTIMIZATION (DO) ➢ See Dose Optimization Chart for affected strengths STEP THERAPY (ST) ➢ Requires a trial with metformin with or without insulin prior to DPP-4 Inhibitor therapy, unless there is a documented contraindication.
Glucagon-like Peptide-1 (GLP-1) Agonists ST		
Byetta®	Bydureon™ Tanzeum™ Trulicity™ Victoza®	STEP THERAPY (ST) ➢ Requires a trial with metformin plus another oral antidiabetic agent prior to a GLP-1 agonist. ➢ Prior authorization is required with lack of covered diagnosis in medical history.
Glucocorticoids – Oral		
cortisone dexamethasone (tablet, solution) hydrocortisone methylprednisolone (4mg, 8mg, 32mg) methylprednisolone dose-pack prednisone (dose-pack, solution, tablet) prednisolone (solution)	budesonide EC Cortef® dexamethasone (elixir) dexamethasone intensol Dexpak® Flo-Pred® Medrol® (dose-pack, tablet) methylprednisolone 16mg Millipred® Orapred® prednisolone ODT prednisone intensol Rayos® Uceris® Veripred®	

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Revised: March 23, 2015

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs		Non-Preferred Drugs		Prior Authorization/Coverage Parameters
Growth Hormones CC, CDRP				
Genotropin® Norditropin®	Nutropin® Nutropin AQ®	Humatrope® Omnitrope® Saizen®	Tev-Tropin® Zorbtive®	**CLINICAL DRUG REVIEW PROGRAM (CDRP)** ➢ Prescriptions for enrollees that are 21 years of age or older require PA under the CDRP ➢ Prescribers, not authorized agents, are required to call the clinical call center toll free number 1-877-309-9493 and respond to a series of questions that identify prescriber, patient and reason for prescribing a drug in this class for enrollees 21 years of age or older ➢ Refills on prescriptions are allowed ➢ Refer to the Preferred Drug Program web page and review list of preferred and non-preferred drugs when prescribing for enrollees under the age of 21 ➢ Click here for a copy of the CDRP Growth Hormone Prescriber Fax Form and Instructions **CLINICAL CRITERIA (CC)** ➢ Patient-specific considerations for drug selection include concerns related to use of a non-preferred agent for FDA approved indications that are not listed for a preferred agent. ➢ Appropriate diagnosis is required for all Growth Hormones, regardless of age or preferred status.
Insulin – Long-Acting				
Lantus®	Levemir	None		
Insulin – Mixes				
Humalog® Mix	Novolog® Mix	None		
Insulin – Rapid-Acting				
Apidra® Humalog®	Novolog®	Afrezza®		
Meglitinides ST				
nateglinide	repaglinide	Starlix® Prandimet®	Prandin®	Prior Authorization for non-preferred agents required as of 12/11/2014 **STEP THERAPY (ST)** ➢ Requires a trial with metformin with or without insulin prior to initiating meglitinide therapy, unless there is a documented contraindication.
Pancreatic Enzymes				
Creon® pancrelipase	Zenpep®	Pancreaze® Pertzye™	Ultresa™ Viokace®	

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Revised: March 23, 2015

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
Sodium Glucose Co-Transporter 2 (SGLT2) Inhibitors ST		
Invokana®	Farxiga™ Invokamet™ Jardiance® Xigduo XR™	Prior Authorization for non-preferred agents required as of 12/11/2014 **STEP THERAPY (ST)** Requires a trial with metformin with or without insulin prior to initiating SGLT2 Inhibitor therapy, unless there is a documented contraindication.
Thiazolidinediones (TZDs) ST		
pioglitazone	Actoplus Met® Actoplus Met® XR DO Actos® DO Avandamet® Avandaryl® Avandia® Duetact® pioglitazone/ glimepiride pioglitazone/ metformin	**DOSE OPTIMIZATION (DO)** ➢ See Dose Optimization Chart for affected strengths **STEP THERAPY (ST)** ➢ Requires a trial with metformin with or without insulin prior to initiating TZD therapy, unless there is a documented contraindication.
VII. GASTROINTESTINAL		
Anti-Emetics		
ondansetron (ODT, solution, tablet)	Anzemet® granisetron (tablet) Sancuso® Zofran® (ODT, solution, tablet) Zuplenz®	
Gastrointestinal Antibiotics		
metronidazole (tablet) neomycin vancomycin	Alinia® Dificid® Flagyl® Flagyl® ER metronidazole (capsule) paromomycin Tindamax® tinidazole Vancocin® Xifaxan® CC, ST, F/Q/D	**CLINICAL CRITERIA (CC)** ➢ Xifaxan® - Requires confirmation of diagnosis of Traveler's diarrhea or hepatic encephalopathy **STEP THERAPY (ST)** ➢ Xifaxan® - Requires trial of a preferred fluoroquinolone antibiotic before rifaximin for treatment of Traveler's diarrhea **QUANTITY LIMITS:** ➢ Xifaxan: ▪ Traveler's diarrhea (200 mg tablet) – 9 (nine) tablets per 30 days (Dose = 200 mg three times a day for three days) ▪ Hepatic encephalopathy (550 mg tablets) – 60 tablets per 30 days (Dose = 550 mg twice a day)

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Revised: March 23, 2015

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
Gastrointestinal Preparatory Agents		
Clearlax® Gavilax® Gavilyte®-C Gavilyte®-G Glycolax® Miralax® OTC PEG 3350 powder OTC PEG 3350/ electrolytes solution Rx	Colyte® Gavilyte®-N Golytely® Halflytely® Moviprep® Nulytely® Osmoprep® PEG 3350 powder pack OTC PEG 3350 with flavor packs Prepopik™ Suprep® Trilyte®	
Helicobacter pylori Agents		
Helidac® lansoprazole/ amoxicillin/ clarithromycin Pylera®	Omeclamox-Pak® Prevpac®	

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Revised: March 23, 2015

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
Proton Pump Inhibitors (PPIs) F/Q/D		
omeprazole Rx pantoprazole Prilosec® OTC	Aciphex® Dexilant™ DO Esomeprazole Strontium lansoprazole Rx (capsule, ODT) Nexium® RX DO omeprazole OTC omeprazole / sodium bicarbonate Rx Prevacid® OTC Prevacid® Rx DO Prilosec® Rx Protonix® rabeprazole Zegerid®	**DOSE OPTIMIZATION (DO)** ➢ See Dose Optimization Chart for affected strengths **FREQUENCY/QUANTITY/DURATION (F/Q/D)** ➢ Quantity limits: ▪ Once daily dosing (30 units every 30 days) for: ❖ GERD, ❖ erosive esophagitis, ❖ healing and maintenance of duodenal/gastric ulcers (including NSAID-induced), ❖ prevention of NSAID-induced ulcers ▪ Twice daily dosing (60 units every 30 days) for: ❖ hypersecretory conditions, ❖ Barrett's esophagitis, ❖ H. pylori, ❖ refractory GERD ➢ Duration limits: ▪ 60 days for: ❖ Mild/moderate GERD, ❖ acute healing of duodenal/gastric ulcers (including NSAID-induced) ▪ 365 days for: ❖ Maintenance treatment of duodenal ulcers ▪ 14 days for: ❖ H. pylori
Sulfasalazine Derivatives		
Apriso® Delzicol™ Dipentum® sulfasalazine DR/EC sulfasalazine IR sulfazine sulfazine EC	Asacol HD® Azulfidine® Azulfidine Entab® balsalazide Colazal® Giazo™ Lialda® Pentasa®	

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Revised: March 23, 2015

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs		Non-Preferred Drugs		Prior Authorization/Coverage Parameters
VIII. HEMATOLOGICAL AGENTS				
Anticoagulants – Injectable				
enoxaparin sodium	Fragmin®	Arixtra® CC fondaparinux CC	Lovenox®	**CLINICAL CRITERIA (CC)** ➢ Clinical editing to allow patients with a diagnosis of Heparin Induced Thrombocytopenia (HIT) to receive fondaparinux (Arixtra®) without prior authorization.
Anticoagulants – Oral				
Coumadin® Eliquis® 1 Jantoven®	Pradaxa® warfarin	Savaysa™	Xarelto® 2	
Erythropoiesis Stimulating Agents (ESAs)				
Aranesp®	Procrit®	Epogen®	Mircera®	
Platelet Inhibitors				
Aggrenox® Brilinta™ clopidogrel	dipyridamole Effient®	Persantine® Plavix®	ticlopidine Zontivity™	
IX. IMMUNOLOGIC AGENTS				
Immunomodulators – Systemic CC, ST				
Enbrel®	Humira®	Actemra® (subcutaneous) Cimzia® Kineret® Orencia® (subcutaneous) Otezla® Simponi™ Stelara® Xeljanz®		**CLINICAL CRITERIA (CC)** ➢ Confirm diagnosis for FDA or Compendia supported uses **STEP THERAPY (ST)** ➢ Trial of a disease-modifying anti-rheumatic drug (DMARD) prior to treatment with an immunomodulator
X. MISCELLANEOUS AGENTS				
Progestins (for Cachexia)				
megestrol acetate (suspension)		Megace® (suspension)	Megace ES®	

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Revised: March 23, 2015

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
XI. MUSCULOSKELETAL AGENTS		
Skeletal Muscle Relaxants		
baclofen chlorzoxazone cyclobenzaprine 5mg, 10mg dantrolene methocarbamol orphenadrine ER orphenadrine compound forte tizanidine (tablet)	Amrix® carisoprodol ST, F/Q/D carisoprodol compound ST, F/Q/D carisoprodol compound / codeine CC,ST, F/Q/D Dantrium® Fexmid® Lorzone™ metaxalone Parafon Forte® DSC Robaxin® Skelaxin® Soma® ST, F/Q/D Soma® 250 ST, F/Q/D tizanidine (capsule) Zanaflex®	**CLINICAL CRITERIA (CC)** For carisoprodol/codeine products: ➢ Limited to a total of four (4) opioid prescriptions every 30 days; Exemption for diagnosis of cancer or sickle cell disease ➢ Medical necessity rationale for opioid therapy is required for patients on established buprenorphine therapy ➢ PA required for initiation of opioid therapy in patients currently on benzodiazepine therapy **STEP THERAPY (ST)** ➢ Trial with one (1) preferred analgesic and two (2) preferred skeletal muscle relaxants prior to use of carisoprodol containing products; ▪ carisoprodol ▪ carisoprodol/ASA ▪ carisoprodol/ASA/codeine ▪ Soma® **FREQUENCY/QUANTITY/DURATION (F/Q/D)** ➢ Maximum 84 cumulative units per a year ➢ Carisoprodol - maximum 4 (four) units per day, 21 day supply ➢ Carisoprodol combinations - maximum 8 (eight) units per day, 21 (twenty-one) day supply (not to exceed the 84 cumulative units per year limit)
XII. OPHTHALMICS		
Alpha-2 Adrenergic Agonists (for Glaucoma) – Ophthalmic		
Alphagan P® Simbrinza™ brimonidine 0.2%	apraclonidine lopidine® brimonidine 0.15%	

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Revised: March 23, 2015

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
Antibiotics – Ophthalmic		
bacitracin/ polymyxin B erythromycin gentamicin Ilotycin™ Natacyn® neomycin/ gramicidin/ polymyxin polymyxin/ trimethoprim sulfacetamide (solution) tobramycin	Azasite® bacitracin Bleph®-10 Garamycin® neomycin / bacitracin / polymyxin Neosporin® Polytrim® sulfacetamide (ointment) Tobrex®	
Antibiotics/Steroids – Ophthalmic		
Blephamide® Maxitrol® (ointment) neomycin / polymyxin / dexamethasone sulfacetamide / prednisolone TobraDex® (ointment) tobramycin / dexamethasone	Maxitrol® (suspension) neomycin / bacitracin /polymyxin / hydrocortisone neomycin / polymyxin / hydrocortisone Pred-G® TobraDex® (suspension) TobraDex® ST Zylet™	
Antihistamines – Ophthalmic		
Pataday®	azelastine Bepreve® Elestat® Emadine® epinastine Lastacaft™ Optivar® Patanol®	
Beta Blockers – Ophthalmic		
betaxolol Betimol® Betoptic S® carteolol Combigan® Istalol® levobunolol metipranolol timolol maleate (gel, solution)	Betagan® Optipranolol® Timoptic® Timoptic® in Ocudose® Timoptic-XE®	

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Revised: March 23, 2015

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs		Non-Preferred Drugs		Prior Authorization/Coverage Parameters
Fluoroquinolones – Ophthalmic ST				
ciprofloxacin ofloxacin	Vigamox®	Besivance™ Ciloxan® gatifloxacin levofloxacin	Moxeza™ Ocuflox® Zymaxid™	**STEP THERAPY (ST)** ➢ For patients 21 years or younger, attempt treatment with a non-fluoroquinolone ophthalmic antibiotic before progressing to the following products: ▪ Besivance® ▪ Ciloxan® ▪ ciprofloxacin ▪ levofloxacin ▪ Moxeza® ▪ Ocuflox® ▪ ofloxacin ▪ Vigamox® ▪ Zymaxid®
Non-Steroidal Anti-Inflammatory Drugs (NSAIDS) – Ophthalmic				
diclofenac flurbiprofen	ketorolac	Acular® Acular LS® Acuvail® Bromday™ bromfenac	Ilevro™ Nevanac® Ocufen® Prolensa™	
Prostaglandin Agonists – Ophthalmic				
latanoprost		Lumigan® Rescula® Travatan Z®	travoprost Xalatan® Zioptan™	
XIII. OTICS				
Fluoroquinolones – Otic				
Ciprodex®	ofloxacin	Cipro HC®		
XIV. RENAL AND GENITOURINARY				
Alpha Reductase Inhibitors for BPH				
finasteride		Avodart® Jalyn™	Proscar®	
Cystine Depleting Agents				
Cystagon®		Procysbi® ST		**STEP THERAPY (ST)** ➢ Requires a trial with Cystagon immediate-release capsules

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Revised: March 23, 2015

NYS Medicaid Fee-For-Service Preferred Drug List

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Phosphate Binders/Regulators				
calcium acetate Eliphos™	Fosrenol® Renagel®	Auryxia™ Phoslo® Phoslyra™	Renvela® Velphoro®	
Selective Alpha Adrenergic Blockers				
alfuzosin	tamsulosin	Flomax Rapaflo™	Uroxatral®	
Urinary Tract Antispasmodics				
oxybutynin Oxytrol® Sanctura XR®	Toviaz™ DO trospium ER Vesicare® DO	Detrol® Detrol LA® DO Ditropan XL® Enablex® DO Gelnique™ Myrbetriq™	oxybutynin ER DO Sanctura® tolterodine tolterodine ER trospium	DOSE OPTIMIZATION (DO) ➢ See Dose Optimization Chart for affected strengths
Xanthine Oxidase Inhibitors				
allopurinol		Uloric®	Zyloprim®	
XV. RESPIRATORY				
Anticholinergics / COPD Agents				
Atrovent HFA® Combivent Respimat® ipratropium ipratropium / albuterol Spiriva® Spiriva Respimat®		Anoro Ellipta™ Daliresp®	Duoneb® Tudorza Pressair™	
Antihistamines – Intranasal				
Astepro™	Patanase®	azelastine	olopatadine	

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Revised: March 23, 2015

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
Antihistamines – Second Generation		
cetirizine OTC (tablet) cetirizine OTC (syrup/solution 1mg/ 1mL) Claritin® OTC (solution) loratadine OTC	cetirizine OTC (chewable) cetirizine OTC (syrup 5mg/ 5mL) cetirizine Rx (syrup) cetirizine-D OTC Clarinex® CC Clarinex-D® OTC Claritin® OTC (capsule, chewable, ODT, tablet) Claritin-D® OTC desloratadine fexofenadine OTC, Rx levocetirizine loratadine-D OTC Xyzal® CC	**CLINICAL CRITERIA (CC)** ➢ No PA required for patients less than 24 months of age
Beta$_2$ Adrenergic Agents – Inhaled Long-Acting CC,F/Q/D		
Foradil® Serevent Diskus®	Arcapta™ Brovana® Perforomist® Striverdi Respimat®	**CLINICAL CRITERIA (CC)** PA is required for all new long-acting beta agonist prescriptions for beneficiaries under FDA or compendia supported age as indicated: Arcapta™ ≥18 years Brovana® ≥18 years Foradil® ≥ 5 years Perforomist® ≥18 years Serevent® ≥4 years Striverdi® ≥18 years **FREQUENCY/QUANTITY/DURATION (F/Q/D)** **Maximum units per 30 days** Arcapta™ 30 units (1 box of 30 unit dose capsules) Brovana® 60 units (1 carton of 60 vials or 120 mL) Foradil® 60 units (1 box of 60 unit dose capsules) Perforomist® 60 units (1 carton of 60 vials or 120 mL) Serevent® 1 diskus (60 blisters) Striverdi® 1 unit (one cartridge and one Respimat inhaler)

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Revised: March 23, 2015

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
Beta$_2$ Adrenergic Agents – Inhaled Short-Acting		
albuterol Maxair Autohaler® ProAir HFA® Proventil HFA®	Accuneb® levalbuterol (solution) Ventolin HFA® Xopenex® (solution) Xopenex HFA®	
Corticosteroids – Inhaled F/Q/D		
Asmanex® Flovent Diskus® Flovent HFA® Pulmicort® (Flexhaler) CC QVAR®	Aerospan® Alvesco® Arnuity Ellipta™ Asmanex® HFA	CLINICAL CRITERIA ➢ Patient-specific considerations for drug selection include concerns related to pregnancy FREQUENCY/QUANTITY/DURATION (F/Q/D)
Corticosteroid/Beta$_2$ Adrenergic Agent (Long-Acting) Combinations – Inhaled CC, F/Q/D		
Advair Diskus® Dulera®	Breo Ellipta™	CLINICAL CRITERIA (CC)

Aerospan® 80 mcg	2 inhalers every 30 days
Alvesco® 80 mcg	1 inhaler every 30 days
Alvesco® 160 mcg	1 inhaler every 30 days Up to 1 inhaler every 15 days with previous oral corticosteroid use.
Asmanex® 110 mcg	1 inhaler every 30 days
Asmanex® 220 mcg (30 units)	1 inhaler every 30 days
Asmanex® 220 mcg (60 units)	1 inhaler every 30 days Up to 1 inhaler every 15 days with previous oral corticosteroid use.
Asmanex® 220 mcg (120 units)	1 inhaler every 60 days Up to 1 inhaler every 30 days with previous oral corticosteroid use.
Asmanex® HFA 100 mcg	1 inhaler every 30 days
Asmanex® HFA 200 mcg	1 inhaler every 30 days
Flovent Diskus® 50mcg, 100 mcg	1 diskus every 30 days
Flovent Diskus® 250mcg	1 diskus every 15 days Up to 1 diskus every 7 days with previous oral corticosteroid use.
Flovent HFA® 44mcg, 110 mcg	1 inhaler every 30 days
Flovent HFA® 220mcg	1 inhaler every 30 days Up to 1 inhaler every 15 days with previous oral corticosteroid use.
Pulmicort 90mcg	1 inhaler every 30 days
Pulmicort 180mcg	1 inhaler every 15 days
QVAR® 40mcg	1 inhaler every 25 days
QVAR® 80mcg	1 inhaler every 12 days

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35

Revised: March 23, 2015

NYS Medicaid Fee-For-Service Preferred Drug List

<table>
<tr><th>Preferred Drugs</th><th>Non-Preferred Drugs</th><th>Prior Authorization/Coverage Parameters</th></tr>
<tr><td>Advair HFA®
Symbicort®</td><td></td><td>➢ PA is required for all new long-acting beta agonist prescriptions for beneficiaries under FDA or compendia supported age as indicated:
<table>
<tr><td>Advair Diskus®</td><td>≥4 years</td></tr>
<tr><td>Advair HFA®</td><td>≥12 years</td></tr>
<tr><td>Breo Ellipta™</td><td>≥18 years</td></tr>
<tr><td>Dulera®</td><td>≥12 years</td></tr>
<tr><td>Symbicort®</td><td>≥12 years</td></tr>
</table>
<u>FREQUENCY/QUANTITY/DURATION (F/Q/D)</u>
<table>
<tr><td>Advair Diskus®</td><td rowspan="5">One (1) inhaler/diskus every 30 days</td></tr>
<tr><td>Advair HFA®</td></tr>
<tr><td>Breo Ellipta™</td></tr>
<tr><td>Dulera®</td></tr>
<tr><td>Symbicort®</td></tr>
</table></td></tr>
</table>

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Revised: March 23, 2015

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
Corticosteroids – Intranasal F/Q/D		
fluticasone Nasonex®	Beconase AQ® budesonide Dymista™ Flonase® flunisolide Nasacort AQ® Omnaris® QNASL™ Rhinocort Aqua® triamcinolone Veramyst® Zetonna™	**FREQUENCY/QUANTITY/DURATION (F/Q/D)** Beconase AQ® — One (1) inhaler every 22 days flunisolide — One (1) inhaler every 25 days budesonide — One (1) inhaler every 30 days Dymista™ Flonase fluticasone Nasacort AQ® Nasonex® Omnaris® QNASL® Rhinocort Aqua® triamcinolone Veramyst® Zetonna™
Leukotriene Modifiers		
Accolate® montelukast ST	Singulair® ST zafirlukast	**STEP THERAPY (ST)** ➢ For non-asthmatic patients, trial of intranasal corticosteroid or a 2nd generation oral antihistamine before montelukast.(Singulair®)

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Revised: March 23, 2015

NYS Medicaid Fee-For-Service Clinical Drug Review Program (CDRP)

The Clinical Drug Review Program (CDRP) is aimed at ensuring specific drugs are utilized in a medically appropriate manner.

Under the CDRP, certain drugs require prior authorization because there may be specific safety issues, public health concerns, the potential for fraud and abuse or the potential for significant overuse and misuse.

Prior Authorization

Prior authorization for some drugs subject to the CDRP must be obtained through a representative at the clinical call center. Prior authorization is required for original prescriptions, not refills. For some drugs subject to the CDRP, only prescribers, not their authorized agents, can initiate the prior authorization process.

Fax requests for prior authorization are not permitted. Each CDRP drug has specific clinical information that must be provided to the clinical call center before prior authorization will be issued. Prescribers may be asked to fax that information. Clinical guidelines for the CDRP as well as prior authorization worksheets are available online at http://newyork.fhsc.com/providers/CDRP_forms.asp.

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

- becaplermin gel (Regranex®)
- emtricitabine/tenofovir (Truvada®)
- fentanyl mucosal agents
- lidocaine patch (Lidoderm®)
- oxazolidinone antibiotics (Sivextro™, Zyvox®)
- palivizumab (Synagis®)
- sodium oxybate (Xyrem®)
- somatropin (Serostim®)

The following drug classes are subject to the Clinical Drug Review Program and are also included on the Preferred Drug List:

- Anabolic Steroids
- Central Nervous System (CNS) Stimulants for 18 years and older
- Growth Hormones for 21 years and older
- Phosphodiesterase type-5 (PDE-5) Inhibitors for PAH
- Topical Immunomodulators

Revised: March 23, 2015

NYS Medicaid Fee-For-Service Drug Utilization Review (DUR) Program

Frequency/Quantity/Duration (F/Q/D) Program and Step Therapy parameters are implemented to ensure clinically appropriate and cost effective use of these drugs and drug classes.

For additional Step Therapy and Frequency/Quantity/Duration parameters for drugs and drug classes that are also included on the Preferred Drug List (PDL), please see pages 3 through 31.

Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
Acthar® (ACTH injectable)	Requires trial of first-line therapy for all FDA-approved indications, other than infantile spasms. **Note**: Acthar is first line therapy for infantile spasms in children less than 2 years of age – step therapy not required.	**QUANTITY LIMITS:** ➢ Infantile spasms – 30 mL (six 5 mL vials) ➢ Multiple sclerosis – 35 mL (seven 5 mL vials) **DURATION LIMITS:** ➢ Infantile spasms – 4 weeks; indicated for < 2 years of age ➢ Multlple sclerosis – 5 weeks ➢ Rheumatic disorders – 5 weeks ➢ Dermatologic conditions – 5 weeks ➢ Allergic states (serum sickness) – 5 weeks	Confirm diagnosis for Medicaid covered uses. Medicaid Fee-For-Service benefit does not cover for diagnostic purposes.

FDA Indication	First line Therapy
Multiple Sclerosis (MS) exacerbations	Corticosteroid or plasmapheresis
Polymyositis/ dermatomyositis	Corticosteroid
Idiopathic nephrotic syndrome	ACE Inhibitor, diuretic, corticosteroid (and for refractory patients: an immunosuppressive)
Systemic lupus erythematosus (SLE)	Corticosteroid, antimalarial, or cytotoxic/immunosuppressive agent
Nephrotic syndrome due to SLE	Immumosuppressive, corticosteroid, or ACE Inhibitor
Rheumatic disorders (specifically: psoriatic arthritis, rheumatoid arthritis, juvenile rheumatoid arthritis, ankylosing spondylitis)	Corticosteroid, topical retinoid, biologic disease-modifying antirheumatic drugs (DMARD), non-biologic DMARD, or a non-steroidal anti-inflammatory drug (NSAID)
Dermatologic diseases (specifically Stevens-Johnson syndrome and erythema multiforme)	Corticosteroid or analgesic
Allergic states (specifically serum sickness)	Topical or oral corticosteroid, antihistamine, or NSAID
Ophthalmic diseases (keratitis, iritis, iridocyclitis, diffuse posterior uveitis/choroiditis, optic neuritis, chorioretinitis, anterior segment inflammation)	Analgesic, anti-infective agent, and agents to reduce inflammation, such as NSAIDs and steroids
Respiratory diseases (systemic sarcoidosis)	Oral costicosteroid or an imunosuppressive.

Revised: March 23, 2015

Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
Amoxicillin ER (Moxatag®)	Prescribers should attempt treatment with a more cost effective immediate-release amoxicillin first before progressing to extended-release amoxicillin	**QUANTITY LIMIT:** Equal to 10 tablets per fill	
Anabolic Steroids – Injectable ▪ Depo-Testosterone® ▪ testosterone cypionate ▪ testosterone enanthate Anabolic Steroids – Oral ▪ Anadrol-50® ▪ Android® ▪ Androxy™ ▪ Methitest® ▪ Oxandrin® ▪ oxandrolone ▪ Testred®		Limitations for anabolic steroid products is based on approved FDA labeled daily dosing and documented diagnosis not to exceed a 90-day supply (30-day supply for oxandrolone): ➢ Initial duration limit of 3 months (for all products except oxandrolone), requiring documented follow-up monitoring for response and/or adverse effects before continuing treatment ➢ Duration limit of 6 months for delayed puberty ➢ Duration limit of 1 month for all uses of oxandrolone products	
Anti-Retroviral (ARV) Interventions		**QUANTITY LIMITS:** ➢ Limit ARV active ingredient duplication ➢ Limit ARV utilization to a maximum of five products concurrently - excluding boosting with ritonavir (dose limit 600 mg or less) or cobicistat ➢ Limit Protease Inhibitor utilization to a maximum of two products concurrently ➢ Limit Integrase inhibitor utilization to a maximum of one product concurrently	➢ Require confirmation of FDA approved or compendia supported use ➢ Point of service edit for contraindicated antiretroviral / non-antiretroviral combinations. ➢ Point of service edit for contraindicated antiretroviral / antiretroviral combinations.
Antidiabetic agents ▪ acetohexamide ▪ chlorpropamide ▪ glimepiride ▪ glipizide (Glucotrol®, Glucotrol XL®) ▪ glyburide (Diabeta®, Glynase®) ▪ glyburide, micronized ▪ tolazamide ▪ tolbutamide	➢ Requires a trial with metformin with or without insulin prior to initiating other antidiabetic agents, unless there is a documented contraindication. ➢ Clinical editing to allow patients with a diagnosis of gestational diabetes to receive glyburide without a trial of metformin first.		

Revised: March 23, 2015

Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
Becaplermin (Regranex®)		**QUANTITY LIMIT:** ➢ 2 (two) 15 gram tubes in a lifetime	
Benzodiazepine agents – oral ▪ alprazolam (Niravam™, Xanax®, Xanax® XR) ▪ chlordiazepoxide (Librium®) ▪ chlordiazepoxide/amitriptyline (Limbitrol®) ▪ clonazepam (Klonopin®) ▪ clorazepate (Tranxene®, Tranxene T-Tab®) ▪ diazepam (Valium®) ▪ lorazepam (Ativan®, Lorazepam Intensol®) ▪ oxazepam (Serax®)	➢ For diagnosis of Generalized Anxiety Disorder (GAD) or Social Anxiety Disorder (SAD): Require trial with a Selective-Serotonin Reuptake Inhibitor (SSRI) or a Serotonin-Norepinephrine Reuptake Inhibitor (SNRI) prior to initial benzodiazepine prescription ➢ For diagnosis of Panic Disorder: Require concurrent therapy with an antidepressant (SSRI, SNRI, or Tricyclic antidepressant [TCA]). ➢ For diagnosis of skeletal muscle spasms: Require trial with a skeletal muscle relaxant prior to a benzodiazepine	**DURATION LIMIT:** ➢ For Insomnia: 30 consecutive days ➢ For Panic Disorder: 30 consecutive days	➢ Require confirmation of FDA approved or compendia supported use ➢ PA required for initiation of benzodiazepine therapy in patients currently on opioid or oral buprenorphine therapy ➢ PA required for any additional oral benzodiazepine prescription in patients currently on benzodiazepine therapy
Crofelemer (Fulyzaq®)	➢ Requires trial with an alternative anti-diarrheal agent		Confirm diagnosis of HIV/AIDS or antiretroviral therapy in claims history
Cyclosproine ophthalmic (Restasis®)	➢ Diagnosis documentation required to justify utilization as a first line agent or attempt treatment with an artificial tear, gel or ointment	**QUANTITY LIMIT:** 60 vials dispensed as a 30-day supply	
Dextromethorphan / quinidine (Nuedexta®)		**QUANTITY LIMIT:** ➢ Two (2) capsules per day; 60 units per 30 days **DURATION LIMIT:** ➢ 90 days of therapy	For patients ≥ 18 years of age: ➢ Requires confirmation of diagnosis of Pseudobulbar affect, secondary to multiple sclerosis or amyotrophic lateral sclerosis
Dronabinol (Marinol®)	➢ Step therapy for beneficiaries with HIV/AIDS, or cancer, AND eating disorder: trial with megestrol acetate suspension prior to dronabinol ➢ Step therapy for beneficiaries with diagnosis of cancer and nausea/vomiting: trial with a NYS Medicaid-preferred 5-HT3 receptor antagonist prior to dronabinol		Confirm diagnosis for Medicaid covered uses as follows: ➢ HIV/AIDS or Cancer and eating disorder ➢ Cancer and nausea/vomiting

Revised: March 23, 2015

Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
Fentanyl transmucosal agents		**QUANTITY LIMIT:** ➢ 4 units per day, 120 units per 30 days **DURATION LIMIT:** ➢ 90 days ➢ Quantity and duration limits are not applicable to patients with a documented cancer or sickle cell diagnosis	➢ Limited to a total of four (4) opioid prescriptions every 30 days; Exemption for diagnosis of cancer or sickle cell disease ➢ For opioid- naïve patients - limited to a 15 days supply for all initial opioid prescriptions, Exemption for diagnosis of cancer or sickle cell disease ➢ Medical necessity rationale for opioid therapy is required for patients on established buprenorphine therapy ➢ PA is required for initiation of opioid therapy in patients currently on benzodiazepine therapy
Homozygous Familial Hypercholesterolemia Agents: ▪ lomitapide (Juxtapid®) ▪ mipomersen (Kynamro®)	➢ Requires trial with high intensity statin therapy.		Confirm diagnosis of homozygous familial hypercholesterolemia
Irritable Bowel Agents ▪ linaclotide (Linzess™) ▪ lubiprostone (Amitiza®)	➢ Step therapy with trials of both a bulking-agent and an osmotic laxative prior (defined as within 89 days) to lubiprostone or linaclotide	**DURATION LIMIT:** ➢ 30 days with 2 refills/prescription	
Metozolv® ODT (metoclopramide)	➢ Requires a trial with conventional metoclopramide before metoclopramide orally disintegrating tablet (ODT), except with diagnosis of diabetes mellitus	**QUANTITY LIMIT:** ➢ 4 units per day, 120 units per 30 days **DURATION LIMIT:** ➢ 90 days	

Revised: March 23, 2015

Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
Methadone		**QUANTITY LIMIT:** ➢ 12 units per day, 360 units per 30 days ➢ Exemption for diagnosis of cancer or sickle cell disease	➢ Limited to a total of four (4) opioid prescriptions every 30 days; Exemption for diagnosis of cancer or sickle cell disease ➢ Medical necessity rationale for methadone is required for patients on established buprenorphine therapy ➢ PA required for methadone prescriptions for patients currently on long-acting opioid therapy. Exemption for diagnosis of cancer or sickle cell disease. ➢ PA required for initiation of long-acting opioid therapy in opioid-naïve patients. Exemption for diagnosis of cancer or sickle cell disease. ➢ PA required for initiation of methadone therapy in patients currently on benzodiazepine therapy
Metreleptin (Myalept®)			Confirm diagnosis for the FDA-approved indications: ➢ Leptin deficiency in patients with congenital generalized lipodystrophy (CGL) or ➢ acquired generalized lipodystrophy (AGL)
Olanzapine / Fluoxetine (Symbyax®)			PA is required for the initial prescription for beneficiaries younger than 18 years
Oral Pollen/Allergen Extracts (Grastek®, Oralair®, Ragwitek®)	Trial with a preferred intranasal corticosteroid		Confirm diagnosis for the FDA-approved indication of Pollen-induced allergic rhinitis confirmed by positive skin or in vitro testing for pollen-specific IgE antibodies
Quinine		**QUANTITY AND DURATION LIMITS:** ➢ Maximum 42 capsules as a 7-day supply ➢ limited to 1 prescription per year	
Tasimelteon (Hetlioz®)		**QUANTITY LIMIT:** ➢ One unit per day; 30 units per 30 days	Confirm diagnosis of Non-24-hour sleep-wake disorder in totally blind patients
Tazarotene (Tazorac®)			Confirm diagnosis for Medicaid covered uses

Revised: March 23, 2015

Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
Tetrabenazine (Xenazine®)			Confirm diagnosis of one of the following FDA and Compendia approved indication in patients ≥ 18 years of age: ➢ Chorea associated with Huntington's disease ➢ Gilles de la Tourette's syndrome ➢ Tardive dyskinesia
Teriparatide (Forteo®)	➢ Requires a trial with a preferred oral bisphosphonate prior to teriparatide.	**QUANTITY LIMIT:** ➢ One unit (2.4 mL) per 30-day period **LIFETIME QUANTITY LIMIT:** ➢ 25 months of therapy	

For more information on DUR Program, please refer to http://nyhealth.gov/health_care/medicaid/program/dur/index.htm.

Revised: March 23, 2015

NYS Medicaid Fee-For-Service Brand Less Than Generic (BLTG) Program

On April 26, 2010, New York Medicaid implemented a new cost containment initiative, which promotes the use of certain multi-source brand name drugs when the cost of the brand name drug is less expensive than the generic equivalent.

In conformance with State Education Law, which intends that patients receive the lower cost alternative, brand name drugs included in this program:

- Do not require 'Dispense as Written' (DAW) or 'Brand Medically Necessary' on the prescription
- Have a generic copayment
- Are paid at the Brand Name Drug reimbursement rate or usual and customary price, whichever is lower
- Do not require a new prescription if the drug is removed from this program

Effective December 31, 2014:

- **Intuniv, Mycobutin and Protopic will be added to the Program.**
- **Felbatol will be removed from the Program.**

Current list of Brand name drugs included in this program* (*Updated 12/19/2014*): **List is subject to change*

Accolate	Cellcept suspension	Intuniv	Soriatane
Adderall XR	Combivir	Kadian	Symbyax
Aldara	Depakote sprinkle	Lidoderm	Tegretol suspension
Alphagan P 0.15%	Diastat	Mepron	TOBI
Astepro	Diovan HCT	Mycobutin	Toprol XL
Bactroban cream	Epivir HBV tablet	Myfortic	Trileptal suspension
Baraclude	Exforge	Patanase	Trizivir
Carac	Focalin XR 5mg, 15mg, 30mg, 40mg	Protopic	Wellbutrin
Carbatrol	Gabitril 2mg, 4mg	Pulmicort Respules	Xeloda
Catapres-TTS	Hepsera	Rapamune tablet	

Please keep in mind that drugs in this program may be subject to prior authorization requirements of other pharmacy programs; again promoting the use of the most cost-effective product.

IMPORTANT BILLING INFORMATION

- Prescription claims submitted to the Medicaid program do not require the submission of Dispense As Written/Product Selection Code of '1';
- Pharmacies can submit any valid NCPDP field (408-D8) value

For more information on the Brand Less Than Generic (BLTG) Program, please refer to https://newyork.fhsc.com/providers/bltgp_about.asp

Revised: March 23, 2015

NYS Medicaid Fee-For-Service Mandatory Generic Drug Program

State law excludes Medicaid coverage of brand name drugs that have a Federal Food and Drug Administration (FDA) approved A-rated generic equivalent, unless a prior authorization is obtained.

Coverage parameters under the Preferred Drug Program (PDP), Clinical Drug Review Program (CDRP), and/or the Brand Less Than Generic (BLTG) Program are applicable for certain products subject to the Mandatory Generic Drug Program (MGDP), including exemptions (as listed below).

Prior Authorization Process

- Prescribers, or an agent of the prescriber, must call the prior authorization line at **1-877-309-9493** and respond to a series of questions that identify the prescriber, the patient and the reason for prescribing this drug. The Mandatory Generic Program Prescriber Worksheet and Instructions provide step-by-step assistance in completing the prior authorization process.
- The prescriber must write "DAW and Brand Medically Necessary" on the face of the prescription.
- The call line **1-877-309-9493** is in operation 24 hours a day, seven days a week.

Exempt Drugs

- Based on specific characteristics of the drug and/or disease state generally treated, the following brand name drugs are exempt from the program and do **NOT** require PA:

Clozaril®	Levothyroxine Sodium (Unithroid®, Synthroid®, Levoxyl®)
Coumadin®	Neoral®
Dilantin®	Sandimmune®
Gengraf®	Tegretol®
Lanoxin®	Zarontin®

For more information on the Mandatory Generic Program, please refer to https://newyork.fhsc.com/providers/MGDP_about.asp.

Revised: March 23, 2015

NYS Medicaid Fee-For-Service Dose Optimization Program

Effective November 14, 2013, the Medicaid Fee-for-Service program will institute a Dose Optimization initiative. Dose optimization can reduce prescription costs by reducing the number of pills a patient needs to take each day. The Department has identified drugs to be included in this program, the majority of which have FDA approval for once-a-day dosing, have multiple strengths available in correlating increments at similar costs and are currently being utilized above the recommended dosing frequency. Prior authorization will be required to obtain the following medication beyond the following limits:

Dose Optimization Chart

Brand Name	Dose Optimization Limitations		
CARDIOVASCULAR			
Angiotensin Receptor Blockers (ARBs)			
Benicar 20mg	1 daily	Tablet	
Micardis 20mg, 40mg	1 daily	Tablet	
Diovan 40mg, 80mg, 160mg	1 daily	Tablet	
ARBs/ Calcium Channel Blockers			
Exforge 5–160mg	1 daily	Tablet	
ARBs/ Diuretics			
Benicar HCT 20–12.5mg	1 daily	Tablet	
Diovan HCT 80–12.5mg, 160–12.5mg	1 daily	Tablet	
Edarbyclor 40–12.5mg	1 daily	Tablet	
Micardis HCT 40–12.5mg, 80–12.5mg	1 daily	Tablet	
Beta Blockers			
Bystolic 2.5mg, 5mg, 10mg	1 daily	Tablet	
Coreg CR 20mg,40mg	1 daily	Tablet	
nadolol 40mg	1 daily	Tablet	
Toprol XL 25mg, 50mg, 100mg	1 daily	Tablet	
HMG Co A Reductase Inhibitors			
Crestor 5mg, 10mg, 20mg	1 daily	Tablet	
pravastatin sodium 40mg	1 daily	Tablet	
Niacin Derivatives			
Niaspan 500mg	1 daily	Tablet	

Revised: March 23, 2015

Brand Name	Dose Optimization Limitations		
CENTRAL NERVOUS SYSTEM			
Anticonvulsants – Second Generation			
Lyrica 25mg, 50mg, 75mg, 100mg, 150mg, 200mg	3 daily	Capsule	Electronic bypass for diagnosis of seizure disorder indentified in medical claims data.
Lyrica 225mg and 300mg	2 daily	Capsule	
Antiparkinson Agents			
Azilect 0.5mg	1 daily	Tablet	
Antipsychotics – Second Generation			
Abilify 2mg	4 daily	Tablet	
Abilify 5mg, 10mg, 15mg	1 daily	Tablet	In the case of dose titration for these once daily medications, the Department will allow for multi-day dosing (up to 2 doses/daily) for titration purposes for 3 months.
Invega 1.5mg, 3mg	1 daily	Tablet	
Latuda 20mg, 40mg, 60mg	1 daily	Tablet	
risperidone 2mg	1 daily	tablet	
olanzapine 5mg	1 daily	tablet	
olanzapine ODT 5mg	1 daily	tablet	
Seroquel XR 50mg, 150mg, 200mg	1 daily	Tablet	
Symbyax 3–25mg, 6–25mg, 12–25mg	1 daily	Capsule	
Zyprexa Zydis 5mg, 10mg	1 daily	Tablet	
CNS Stimulants			
Concerta ER 18mg, 27mg	1 daily	Tablet	
Focalin XR 5mg, 10mg, 15mg, 20mg	1 daily	Capsule	
Metadate CD 10mg, 20mg	1 daily	Capsule	
Provigil 100mg	1 daily	Tablet	
Ritalin LA 10mg, 20 mg	1 daily	Capsule	
Vyvanse 20mg, 30mg	1 daily	Capsule	
Non-Ergot Dopamine Receptor Agonists			
Requip XL 2mg, 4mg, 6mg	1 daily	Tablet	
Other Agents for Attention Deficit Hyperactivity Disorder (ADHD)			
guranfacine ER 1mg, 2mg, 3 mg, 4 mg	1 daily	Tablet	
Intuniv 1mg, 2mg	1 daily	Tablet	
Strattera 40mg	1 daily	Capsule	

Revised: March 23, 2015

Brand Name	Dose Optimization Limitations		
CENTRAL NERVOUS SYSTEM			
Sedative Hypnotics			
Lunesta 1mg	1 daily	Tablet	
Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)			
Effexor XR 37.5mg, 75mg	1 daily	Capsule	In the case of dose titration for these once daily medications, the Department will allow for multi-day dosing (up to 2 doses/daily) for titration purposes for three months.
Pristiq ER 50mg	1 daily	Tablet	
Selective Serotonin Reuptake Inhibitors (SSRIs)			
Lexapro 5mg, 10mg	1 daily	Tablet	In the case of dose titration for these once daily medications, the Department will allow for multi-day dosing (up to 2 doses/daily) for titration purposes for three months.
fluvoxamine 50mg	1 daily	Tablet	
Viibryd 10mg, 20mg	1 daily	Tablet	
ENDOCRINE AND METABOLIC			
Dipeptidyl Peptidase-4 (DPP-4) Inhibitors			
Januvia 25mg, 50mg	1 daily	Tablet	
Onglyza 2.5mg	1 daily	Tablet	
Thiazolidinediones (TZDs)			
Actos 15mg	1 daily	Tablet	
Actoplus Met XR 15–1000mg	1 daily	Tablet	
GASTROINTESTINAL			
Proton Pump Inhibitors			
Dexilant 30mg	1 daily	Capsule	
Nexium 20mg	1 daily	Capsule	
Prevacid DR 15mg	1 daily	Capsule	
RENAL AND GENITOURINARY			
Urinary Tract Antispasmodics			
Detrol LA 2mg	1 daily	Capsule	
Enablex 7.5mg	1 daily	Tablet	
oxybutynin chloride ER 5mg	1 daily	Tablet	
Toviaz ER 4mg	1 daily	Tablet	
Vesicare 5mg	1 daily	Tablet	

Revised: March 23, 2015

PA requirements are not dependent on the date a prescription is written. New prescriptions and refills on existing prescriptions require PA even if the prescription was written before the date the drug was determined to require PA.

To obtain a prior authorization (PA), please call the prior authorization Clinical Call Center at 1-877-309-9493. The Clinical Call Center is available 24 hours per day, 7 days per week with pharmacy technicians and pharmacists who will work with you, or your agent, to quickly obtain PA.

Medicaid enrolled prescribers with an active e-PACES account can initiate PA requests through the web-based application PAXpress®. The website for PAXpress is https://paxpress.nypa.hidinc.com

Preferred Supply List

NYS Diabetic Supplies

Revised 1/20/2014

Manufacturer	Product	NDC	STRIPS/ METERS
Abbott	FreeStyle Lite Meter	99073070805	Meter
Abbott	FreeStyle Lite Test Strips - 50ct	99073070822	Strips
Abbott	FreeStyle Lite Test Strips - 100ct	99073070827	Strips
Abbott	FreeStyle Freedom Lite Meter	99073070914	Meter
Abbott	FreeStyle InsuLinx Test Strips - 50ct	99073071231	Strips
Abbott	FreeStyle InsuLinx Meter	99073071143	Meter
Abbott	FreeStyle InsuLinx Test Strips - 100ct	99073071227	Strips
Bayer	BREEZE Blood Glucose Meter	00193144001	Meter
Bayer	BREEZE 2 Test Strip - 50ct	00193146550	Strips
Bayer	BREEZE 2 Test Strip - 100ct	00193146621	Strips
Bayer	CONTOUR Test Strips - 50ct	00193708050	Strips
Bayer	CONTOUR Test Strips - 100ct	00193709021	Strips
Bayer	CONTOUR Blood Glucose Meter	00193715101	Meter
Bayer	CONTOUR NEXT EZ Blood Glucose Meter	00193725201	Meter
Bayer	CONTOUR NEXT Test Strips - 50ct	00193731150	Strips
Bayer	CONTOUR NEXT Test Strips - 100ct	00193731221	Strips
Bayer	CONTOUR NEXT Blood Glucose Meter	00193737701	Meter
Bayer	CONTOUR USB Blood Glucose Meter	00193739301	Meter
Bayer	CONTOUR NEXT USB Blood Glucose Meter	00193741101	Meter
LifeScan	One Touch UltraMini Meter - Silver Moon	53885020801	Meter
LifeScan	One Touch Ultra Blue Test Strips - 50ct	53885024450	Strips
LifeScan	One Touch Ultra Blue Test Strips - 100ct	53885024510	Strips
LifeScan	One Touch Ultra System	53885024701	Meter
LifeScan	One Touch Verio Test Strips - 25ct	53885027025	Strips
LifeScan	One Touch Verio Test Strips - 50ct	53885027150	Strips
LifeScan	One Touch Verio Test Strips - 100ct	53885027210	Strips
LifeScan	One Touch UltraMini Meter - Pink Glow	53885041901	Meter
LifeScan	One Touch UltraMini Meter - Limelight	53885042001	Meter
LifeScan	One Touch Ultra 2 Meter	53885044801	Meter
LifeScan	One Touch UltraMini Meter -Blue Comet	53885091101	Meter
LifeScan	One Touch UltraMini Meter -Purple Twlight	53885091201	Meter
LifeScan	One Touch Ultra Blue Test Strips - 25ct	53885099425	Strips
LifeScan	One Touch Verio IQ Meter	53885026701	Meter
Medisense (Abbott)	Precision Xtra Meter	57599881401	Meter
Medisense (Abbott)	Precision Xtra Test Strips - 50ct	57599972804	Strips
Medisense (Abbott)	Precision Xtra Test Strips - 100ct	57599987705	Strips
Therasense(Abbott)	FreeStyle Test Strips - 50ct	99073012050	Strips
Therasense(Abbott)	FreeStyle Test Strips - 100ct	99073012101	Strips

Enrollee Brochure

PDP

New York State Medicaid Preferred Drug Program

A GUIDE FOR PEOPLE WITH MEDICAID

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.

Who decides which drugs are "preferred"?

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

What if I don't want to change my medications?

Only your doctor can decide which drugs you should take. Ask your doctor or pharmacist if you have questions about changes made to your prescriptions.

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 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

Follow us on:
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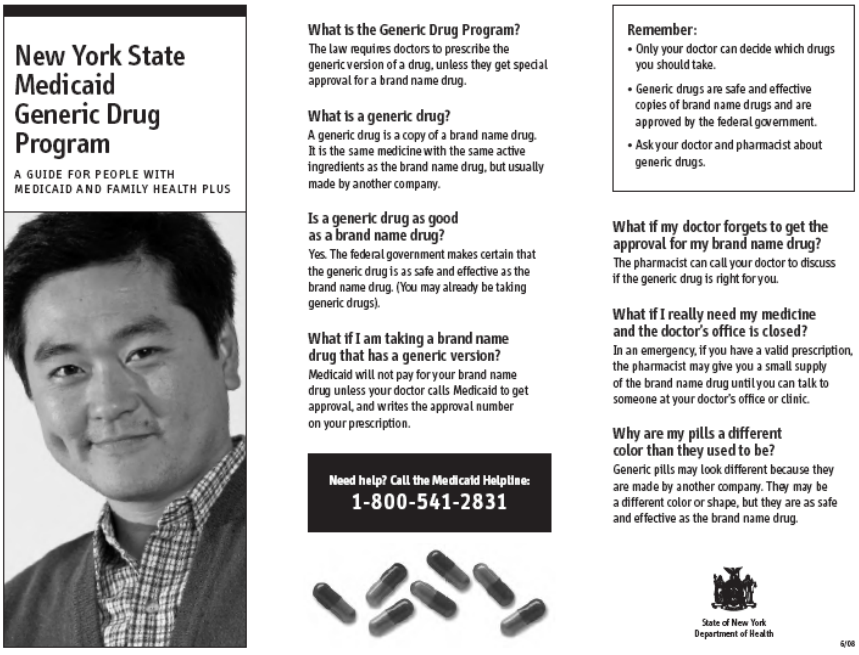
State of New York
Department of Health

10/11

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.

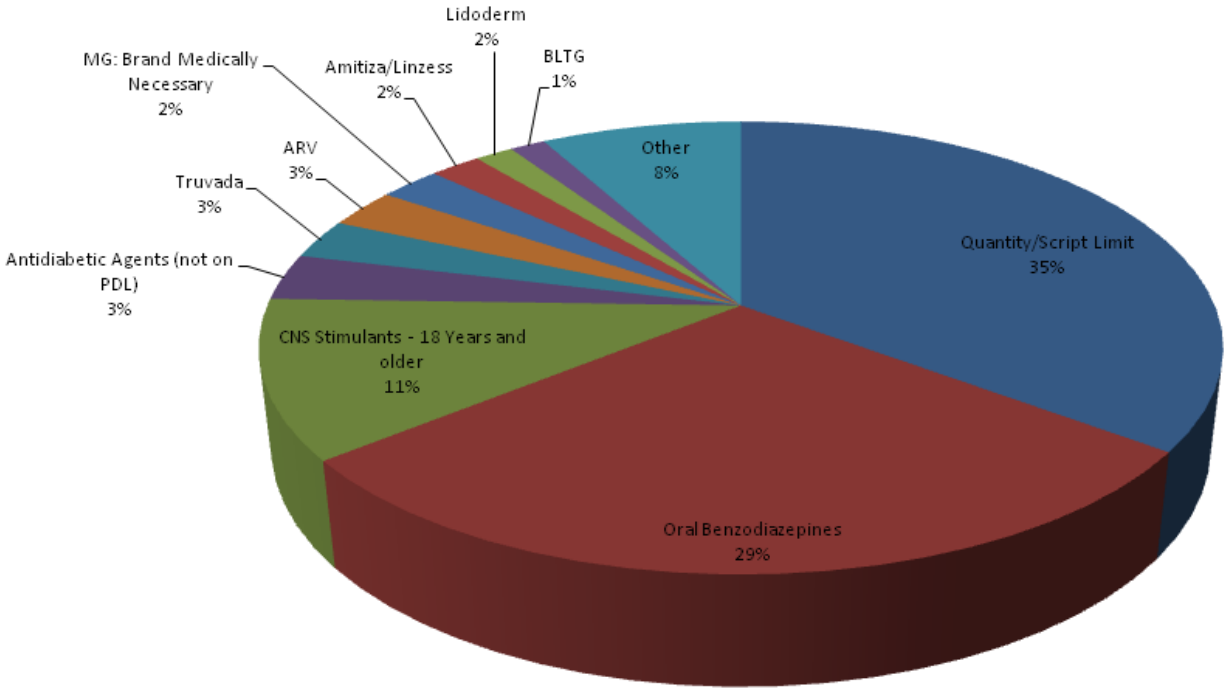
State of New York
Department of Health

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 complete PDL can be accessed at: https://newyork.fhsc.com/downloads/providers/NYRx_PDP_PDL.pdf

CDRP and Other Prior Authorizations by Type

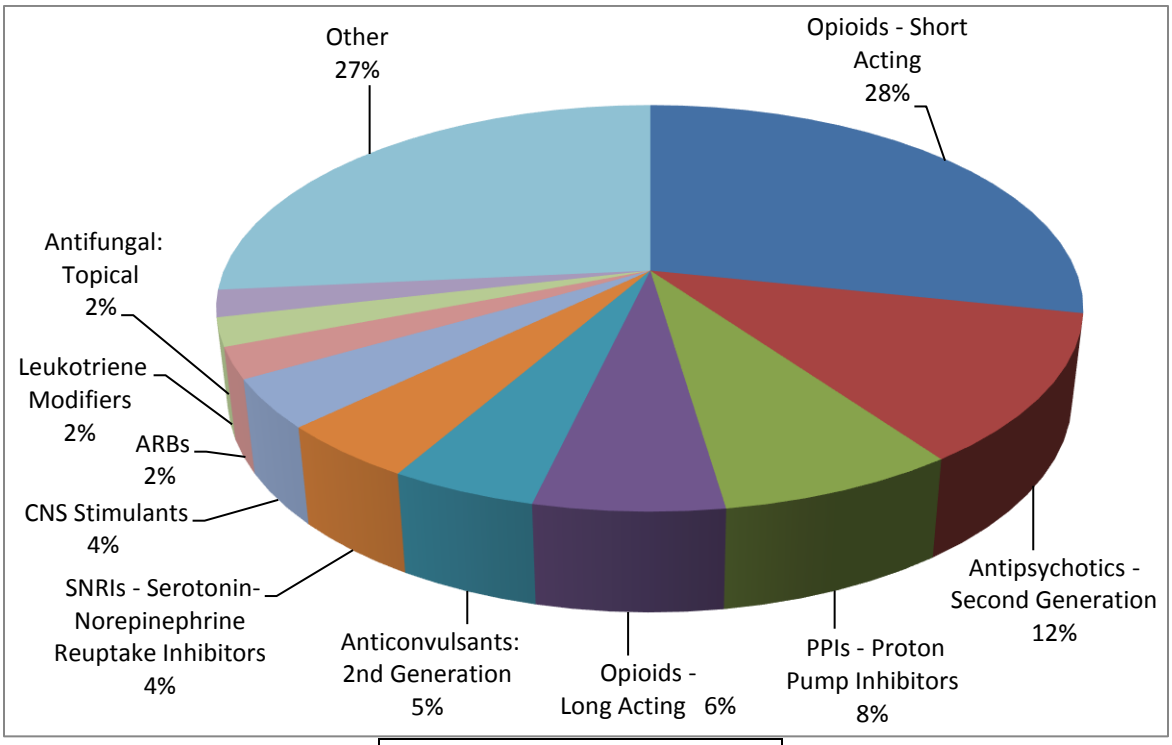


****This chart represents Approved PAs for the following: drugs/drug classes subject to step therapy, FQD (Frequency, Quantity and Duration Limits), PDP classes subject to CDRP and CDRP.**

Total PAs = 54,986

1	Quantity/Script Limit	19341	**21**	Synagis	128
2	Oral Benzodiazepines	15954	**22**	Actiq/Fentora	122
3	CNS Stimulants - 18 Years and older	6214	**23**	Opioid/Buprenorphine TD	85
4	Antidiabetic Agents (not on PDL)	1827	**24**	Tazorac	75
5	Truvada	1566	**25**	Forteo	57
6	ARV	1549	**26**	MG: Generic Unavailable	30
7	MG: Brand Medically Necessary	1352	**27**	Progesterone	27
8	Amitiza/Linzess	1126	**28**	Regranex	26
9	Lidoderm	843	**29**	Acthar	16
10	BLTG	785	**30**	Serostim	13
11	Anabolic Steroids	659	**31**	Growth Hormones: 21 or Older	11
12	Nuedexta	514	**32**	Xenazine	11
13	Methadone	499	**33**	MG: 72Hour Supply	6
14	Dose Optimization	460	**34**	Metozolv	4
15	Marinol	394	**35**	Fulyzaq	3
16	Restasis	372	**36**	Quinine	3
17	Immunomodulators: Topical	275	**37**	Script Limit	3
18	Oxazolidinone Antibiotics	253	**38**	Xyrem	2
19	DUR: Drug to Drug Interaction	248	**39**	Oral Pollen/Allergen Extracts	1
20	PDE-5 Inhibitors for Pulmonary Arterial Hypertension	132			

PDP Prior Authorizations by Class



Total PDP PAs = 115,155

Of the PAs issued in SFY 14/15, the following PDP drug classes are listed by the number of PAs requested:

Opioids - Short Acting	32647	Triptans	367	Platelet Inhibitors	92
Antipsychotics - Second Generation	13623	Topical Steroids: Low Potency	359	Antifungals - Oral	81
PPIs - Proton Pump Inhibitors	8640	Phosphate Binders/Regulators	343	Antivirals: Topical	75
Opioids - Long Acting	7100	Multiple Sclerosis Agents	340	Antibiotics: Topical	70
Anticonvulsants: 2nd Generation	5325	Ophthalmics: Prostaglandin Agonists	318	Non-Ergot Dopamine Receptor Agonist	65
SNRIs - Serotonin-Norepinephrine Reuptake Inhibitors	5154	Antibiotics: GI	304	Benzodiazepines: Rectal	60
CNS Stimulants	4457	Ophthalmics: Antihistamines	297	Ophthalmics: NSAIDs	45
ARBs	2839	Topical Steroids: Medium Potency	283	Inhaled Steroid/Beta2 LA Combo	43
Leukotriene Modifiers	2593	ARB/CCB Combinations	254	Meglitinides	40
Antifungal: Topical	2466	Bisphosphonates	254	Calcium Channel Blockers (DHP)	35
Sedative Hypnotics	1799	Opioid Dependence Agents	254	Psoriasis Agents: Topical	35
NSAIDs: Rx	1651	Antihistamines: Nasal	247	Ophthalmic Antibiotic/Steroid Combo	33
DPP-4 Inhibitors	1583	Fluoroquinolones - Oral	244	Pancreatic Enzymes	33
Beta Blockers	1538	Thiazolidinediones	237	Niacin Derivatives	32
Antihistamines: 2nd Generation	1393	Tetracyclines	220	Antiemetics	27
Inh. Short Acting Beta-2 Adrenergic	1356	Carbamazepine Derivatives	214	Inhaled Corticosteroids	21
Statins	1308	Growth Hormones	195	Ophthalmics: Alpha-2 Adrenergics	21
Steroids: Intranasal	1287	ACE Inhibitors	180	Otics: Quinolones	18
ARB/Diuretic Combinations	1264	GI Prep Agents	168	Actinic Keratosis Agents	17
Urinary Tract Antispasmodics	1144	Anticoagulants: Injectable	158	H. Pylori Agents	17
Triglyceride Agents	1138	Biguanides	156	Hepatitis B Agents	17
Skeletal Muscle Relaxants	1054	Ophthalmics: Quinolones	146	Progestins	17
GLP-1 Agonist	961	Alpha Reductase Inhibitor: BPH	131	Alpha-Glucosidase Inhibitors	16
SSRIs - Selective-Serotonin Reuptake Inhibitors	856	Anticholinergics/COPD Agents	124	Direct Renin Inhibitors	15
Antiinfectives: Topical	832	Alzheimer's Agents	119	ACE Inhibitor/Diuretic Combinations	14
Anticoagulants: Oral	642	Inh. Long Acting Beta-2 Adrenergic	118	Beta Blocker/Diuretic Combinations	11
Cholesterol Absorption Inhibitors	528	Glucocorticoid: Oral	116	ESAs	10
Topical Steroids: High Potency	515	Selective Alpha Adrenergic Blockers	116	PAH Oral Agents - Other	3
Immunomodulators: Systemic	505	Xanthine Oxidase Inhibitors	116	Narcotics: Short-Acting	2
Sulfasalazine Derivatives	494	Topical Steroids: Very High Potency	111	Cephalosporins: Third Generation	1
Hep C: Direct Acting Antivirals	461	Ophthalmics: Antibiotics	104	Cystine Depleting Agents	1
Other Agents for ADHD	497	Antivirals - Oral	103	Ophthalmics: Beta Blockers	1
Hepatitis C Agents: Injectable	445	SGLT2 Inhibitors	102	Opioid Antagonists	1

Cost Avoidance by County*

County	CDRP	PDP	Diabetic Supplies	Total	% Total
Albany	$539,559	-$149,917	$64,253	$453,895	2.88%
Allegany	$177,455	-$50,918	$36,716	$163,253	1.04%
Broome	$432,446	-$134,018	$53,395	$351,823	2.23%
Cattaraugus	$174,258	-$72,263	$23,843	$125,837	0.80%
Cayuga	$154,274	-$53,921	$30,671	$131,024	0.83%
Chautauqua	$200,636	-$87,688	$38,283	$151,231	0.96%
Chemung	$194,241	-$81,160	$31,007	$144,088	0.91%
Chenango	$171,859	-$57,886	$28,656	$142,630	0.91%
Clinton	$371,696	-$84,323	$67,387	$354,760	2.25%
Columbia	$137,488	-$40,505	$10,410	$107,392	0.68%
Cortland	$54,356	-$30,009	$8,395	$32,742	0.21%
Delaware	$255,791	-$69,314	$38,619	$225,095	1.43%
Dutchess	$327,732	-$132,101	$46,231	$241,862	1.54%
Erie	$978,400	-$416,807	$326,524	$888,117	5.64%
Essex	$173,458	-$40,738	$19,365	$152,085	0.97%
Franklin	$222,218	-$105,045	$62,797	$179,971	1.14%
Fulton	$137,488	-$52,244	$18,134	$103,378	0.66%
Genesee	$111,109	-$30,929	$10,746	$90,926	0.58%
Greene	$95,122	-$27,732	$8,060	$75,450	0.48%
Hamilton	$0	-$2,979	$784	-$2,196	-0.01%
Herkimer	$131,093	-$49,956	$30,559	$111,696	0.71%
Jefferson	$222,218	-$127,800	$54,402	$148,821	0.95%
Lewis	$47,161	-$18,480	$4,366	$33,047	0.21%
Livingston	$252,593	-$36,865	$19,030	$234,758	1.49%
Madison	$167,863	-$47,950	$11,754	$131,666	0.84%
Monroe	$1,281,352	-$483,494	$375,442	$1,173,300	7.45%
Montgomery	$67,944	-$34,631	$11,754	$45,067	0.29%
Nassau	$976,801	-$404,569	$211,340	$783,572	4.98%
Niagara	$228,613	-$109,923	$43,208	$161,898	1.03%
Oneida	$358,107	-$185,899	$74,775	$246,983	1.57%
Onondaga	$862,495	-$332,405	$132,871	$662,961	4.21%
Ontario	$254,192	-$49,310	$20,373	$225,255	1.43%
Orange	$463,621	-$193,890	$73,096	$342,826	2.18%
Orleans	$88,727	-$26,930	$12,873	$74,671	0.47%
Oswego	$163,866	-$60,028	$32,462	$136,300	0.87%
Otsego	$118,303	-$44,467	$9,291	$83,128	0.53%
Putnam	$99,918	-$23,328	$2,575	$79,165	0.50%
Rensselaer	$322,936	-$93,601	$30,111	$259,447	1.65%
Rockland	$319,739	-$153,584	$52,611	$218,766	1.39%
St. Lawrence	$474,812	-$196,671	$76,790	$354,930	2.25%
Saratoga	$335,726	-$83,131	$31,343	$283,938	1.80%
Schenectady	$366,900	-$92,447	$47,462	$321,915	2.04%
Schoharie	$44,763	-$16,887	$7,612	$35,488	0.23%
Schuyler	$53,556	-$19,355	$6,716	$40,917	0.26%
Seneca	$77,537	-$20,986	$9,291	$65,841	0.42%
Steuben	$318,939	-$124,671	$58,880	$253,148	1.61%

County	CDRP	PDP	Diabetic Supplies	Total	% Total
Suffolk	$1,298,938	-$546,296	$186,713	$939,356	5.97%
Sullivan	$129,494	-$59,226	$13,545	$83,812	0.53%
Tioga	$120,701	-$46,163	$23,843	$98,382	0.62%
Tompkins	$155,873	-$49,085	$23,619	$130,407	0.83%
Ulster	$129,494	-$91,668	$43,544	$81,370	0.52%
Warren	$242,202	-$64,330	$22,947	$200,820	1.28%
Washington	$135,090	-$45,754	$17,574	$106,910	0.68%
Wayne	$116,705	-$49,161	$29,776	$97,319	0.62%
Westchester	$681,843	-$383,709	$237,981	$536,115	3.40%
Wyoming	$183,850	-$38,248	$27,201	$172,803	1.10%
Yates	$25,579	-$11,586	$4,925	$18,919	0.12%
Total for above	$16,229,131	-$6,136,979	$2,996,928	$13,089,080	83.12%
New York City	$5,732,113	-$7,590,623	$4,355,077	$2,496,567	15.85%
OMH	$98,320	-$168,397	$70,185	$108	0.00%
OMR	$250,995	-$208,459	$54,066	$96,602	0.61%
NYS DOH	$92,724	-$67,829	$40,298	$65,193	0.41%
Grand Total	**$22,403,283**	**-$14,172,286**	**$7,516,554**	**$15,747,551**	

* Market shift savings were estimated to be $8.9 million after excluding the impact of the Hepatitis C Agents – Direct Acting Antivirals class. This class alone accounted for a -$21.3 million in Market Share shift. Total Savings (Supplemental Rebate + Market Share Shift) is $7.3 million in program savings for this time period once the Hepatitis C Agents – Direct Acting Antivirals class is excluded. When costly new drugs enter the market, they may pick up market share at the expense of lower cost products. To that point, a negative market shift is not necessarily reflective of a poor PDL performance, because without the PDL, the negative shift in market share towards the high-cost products could have been higher.