ANNUAL REPORT TO THE
GOVERNOR AND LEGISLATURE

New York State Medicaid Preferred Drug Program

STATE FISCAL YEAR
APRIL 1, 2016 – MARCH 31, 2017

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ACRONYMS

Acronym/Term	Definition
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

I. Background

In 2005, legislation was passed (Sections 270-277 of Article 2A of Chapter 58 of the Laws of 2005) establishing the Medicaid Preferred Drug Program (PDP) and Clinical Drug Review Program (CDRP). The legislation expanded the membership of the Pharmacy and Therapeutics Committee (P&TC) (currently the Drug Utilization Review Board (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 2022.

Expansion of the programs and operational enhancements continued in the SFY 16/17. At the end of SFY 16/17 there were a total of 109 drug classes subject to the PDP and 20 therapeutic categories warranted re-review by the DURB due to new clinical and/or financial information. Two new drug classes were reviewed for inclusion on the PDL. No new drugs were recommended by the DURB for inclusion to the CDRP.

II. Program Overview

The Role of the Drug Utilization Review Board (DURB)

The Drug Utilization Review Board (DURB) (Appendix 2), which consolidated with the Pharmacy and Therapeutics Committee in 2013, is comprised of health care professionals appointed by the Commissioner of Health and includes physicians and pharmacists that actively practice in New York. Without vacancies, the DURB consists of nineteen members, fourteen of which are clinicians, preferably with experience in at least one of the following specialties: HIV, AIDS, geriatrics, pediatrics, mental health, or internal medicine and will be comprised of the following:

- One chairperson representing the Department of Health
- Six licensed and actively practicing physicians
- Six licensed and actively practicing pharmacists
- One licensed and actively practicing nurse practitioner or midwife
- Two drug utilization review experts, at least one of who is a pharmacologist
- Three 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 board provides 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;
- collaboration with managed care organizations to address drug utilization concerns and to implement consistent management strategies across the fee-for-service and managed care pharmacy benefits; and
- review of therapeutic classes subject to the Preferred Drug Program.

The DURB is subject to the Public Officers Law and meetings are subject to the Open Meeting Law. To ensure transparency in the process, a notice of each meeting and the agenda is posted on the DOH website thirty (30) days prior to the meeting. Interested parties are given an opportunity to submit materials to the DURB for consideration and to provide public testimony on the agenda items. In SFY 16/17, the DURB reviewed the testimony from 49 interested parties. 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 16/17 appear in Appendix 3.

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). 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.

PA may be required if a drug is non-preferred or to override clinical criteria including, but not limited to frequency, quantity, duration (***FQD***), diagnosis 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

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.

The Clinical Drug Review Program (CDRP)

The CDRP was implemented in October 2006 and initially applied to only three drugs: Revatio®, Serostim® and Zyvox®. The CDRP was designed to ensure specific drugs are utilized in a medically appropriate manner. 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;
- The potential for or a history of utilization inconsistent with approved indications.

The complete list of drugs/drug classes subject to the CDRP at the end of SFY 16/17 is as follows:

- **Anabolic Steroids**
- **Central Nervous System (CNS) Stimulants (for patients 18 years of age and older)**
- **Fentanyl Mucosal Agents**
- **Growth Hormone**
- **Lidoderm®** (lidocaine patch 5%)
- **Phosphodiesterase type-5 (PDE-5) Inhibitors for pulmonary arterial hypertension (PAH)**
- **Regranex®** (becaplermin gel)
- **Serostim®** [somatropin (rDNA origin) for injection]
- **Synagis®** (palivizumab)
- **Topical Immunomodulators**
- **Truvada®** (emtricitabine and tenofovir disoproxil fumarate)
- **Xyrem®** (sodium oxybate)
- **Zyvox®** (linezolid) **and Sivextro®** (tedizolid)

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. Additionally, 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. 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);
- 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 SFY 16/17, the savings achieved by this program was $11,885,272.

Brand name drugs that were subject to this program at the end of SFY 16/17 include:

Adderall XR	Epivir HBV tablet	Pulmicort Respules
Aggrenox	Edecrin	Retin-A cream, gel
Alphagan P 0.15%	Exelon Patch	**Seroquel XR**
Astepro	Focalin XR	Tegretol suspension
Baraclude	Gleevec	Tegretol XR
BenzaClin pump	Hepsera	Tobradex suspension
Catapres-TTS	Kapvay	Trizivir
Cellcept suspension	Myfortic	Valcyte tablet, solution
Copaxone 20ml SQ	Niaspan	Voltaren Gel
Diastat	Patanase	Xeloda
Differin	Protopic	Xenazine

The Preferred Diabetic Supply Program (PDSP) Diabetic Supply Program

As a result of legislation passed 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 16/17, a total of 60,313 diabetic supply claims were processed achieving a non-federal gross savings through manufacturer rebates of $5,282,300. In the prior SFY, 68,915 diabetic supply claims were processed with a gross savings of $5,942,003. Diabetic supply rebates by county have been included in Appendix 9.

The Prior Authorization Process

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 authorizations may occur automatically, through a comparison of claims to pre-determined criteria at the point-of-service (POS), or they may be requested by the prescriber's office by phone or fax or can be requested through PAXpress®, a Web based tool. PAXpress can also be accessed by Medicaid enrolled prescribers through eMedNY. 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, approximately 6.32 million electronic prior authorizations have been issued without prescriber involvement. Over 91 percent of all prior authorizations issued in SFY 16/17 were issued electronically. For SFY 16/17, 1,225,993 automated PAs were issued

without prescriber involvement. The reduction in the need for prescriber involvement results in prescribers being able to devote more time to patient care that would have 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 16/17, the CCC received approximately 167,685 phone requests and 113,937 fax requests for prior authorization under the PDP and CDRP. Nearly all phone requests (99.98 percent) were completed during the initial call. In addition, the CCC provided approximately 79,310 callers with general information or technical assistance with the PA process and did not refer any potential instances of fraud and/or abuse to the Department. The CCC and quality assurance team continued to aid the DOH, Office of Medicaid Inspector General (OMIG) and Office of the Attorney General (OAG) in collecting data related to suspected fraud cases.

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 unacceptable side effects;
- The patient has been stabilized on a non-preferred drug and transition to the preferred drug would be medically contraindicated.
- 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.

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, diagnosis 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 a PA is granted. This occurred in 27.65 percent of the PDP PAs processed in SFY 16/17. 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 supports the use of an 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, during 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 16/17, there were 31 physician peer reviews completed, however, consistent with last year, there were no denials rendered. Unlike the PDP which 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 SFY 16/17, changes to the pharmacy PA programs occurred through the re-review of existing classes and addition of new drug classes and clinical criteria. With each update, prescribers and pharmacies were notified in advance when the Preferred Drug List (PDL) and PA requirements would be implemented. Notification was achieved via email 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 6).

DOH utilizes a Brand Less Than Generic (BLTG) program to further maximize pharmacy program savings. To ensure that pharmacies are aware of the BLTG program, a targeted educational intervention was initiated in SFY 16/17. A letter was sent to the top pharmacies identified as non-compliant with the BLTG program. This intervention provided information on the BLTG program and directed pharmacies to the current listing of drugs subject to BLTG requirements.

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. When such calls are received they are referred to the DOH Medicaid pharmacy staff where direct assistance is provided. Twenty-five complaints about the PDP and CDRP were received during SFY 16/17, primarily via phone calls. Eighteen more complaints were received in SFY 16/17 than were received the previous year. In an effort to streamline call categorization at the Prior Authorization Support Center the complaint category definition has been broadened to provide the Support Center with more information to resolve complaints. 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. These complaints are listed below by the category in which they were logged.

PDL Status Preferred/Non-Preferred	1
PDL Criteria	2
PA/Utilization Management Issue	2
PA Entry Error	3
Benefit Plan Issue	3
Other	6
Customer Service Pharmacy	8
Total	25

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 received 18 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.

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 SFY 16/17 the NMPI includes more than 90 participating manufacturers and has approximately 5.5 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 Fee-for-Service program paid approximately 12.3 million pharmacy claims in SFY 16/17. Of these, 36 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 SFY 16/17 66.5 percent of claims were for drugs that did not require prior authorization. The remaining 33.5 percent of claims were for drugs that required prior authorization. These percentages are 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. There were 146,827 prior authorizations administered for all pharmacy programs.

Under the PDP, the highest volume of requests for prior authorizations during SFY 16/17 were for the following drug classes: second generation antipsychotics (20 percent), primarily used to treat mental health illnesses such as schizophrenia and bipolar disorder; short-acting opioids (18 percent), used to treat moderate to severe pain; CNS Stimulants (8 percent), primarily used to treat ADHD; second generation

anticonvulsants (6 percent), used primarily to treat seizure disorders and Proton Pump Inhibitors (5 percent), used to treat acid reflux;. Requests for prior authorization for Hepatitis C Agents made up 1.2 percent of prior authorizations for SFY 16/17.

Consistent with the experience in SFY 15/16, 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. Overall, after consultation with CCC staff, 2.8 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. Total PDP savings are calculated by combining the sum of supplemental rebates invoiced with the savings associated with market share shift to less expensive products within each therapeutic drug class. For SFY 16/17, total PDP savings were approximately $5.1 million. As in the previous SFY, the FDA approval and FFS Medicaid coverage of new Hepatitis C Direct Acting Antivirals shortly before and during this time period significantly increased cost and negatively impacted total PDP savings. When these costly new drugs entered the market, they gained market share at the expense of older, lower cost products in their respective class. As a result, market shift savings over the period was negative. Appendix 9 lists the program's cost avoidance by county.

Market Shift Cost Avoidance is the difference between what was actually paid and what would have been paid without a Prescription Drug Plan (PDP). This will be negative if the net cost of the preferred agents (not including supplemental rebates) is higher than the net cost of the non-preferred agents. 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 would have been higher.

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

In SFY 16/17, a total of 9,696 requests were approved for PA of drugs under the CDRP as follows:

- **Anabolic Steroids:** 569
- **CNS Stimulants: 18 or Older:** 6,158
- **Fentanyl Mucosal Agents:** 48
- **Growth Hormones: 21 or Older:** 16
- **Immunomodulators: Topical**: 245
- **Lidoderm®:** 502
- **Phosphodiesterase type-5 (PDE-5) Inhibitors for PAH:** 127
- **Regranex®**: 25
- **Serostim®:** 8
- **Synagis®:** 496
- **Truvada®:** 1,315
- **Xyrem®:** 5
- **Oxazolidinone Antibiotics®:** 182

All CDRP requests were authorized using the criteria in current statute, which allows a denial only based on substantial evidence of fraud and abuse. It is difficult to obtain evidence or documentation during a phone call that would serve to support such a denial. However, if statute allowed denial based on medical necessity, 3 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.

VI. Conclusion

The tenth 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 16/17, the DURB re-reviewed 20 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 SFY 16/17 there were a total of 109 drug classes subject to the PDP. No new drugs were recommended for inclusion into the CDRP by the DUR Board in SFY 16/17.

Technological advancements including audiocasts of DURB meetings and email notification to interested parties regarding PDL changes, 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.

Since October 2011, members in mainstream Medicaid managed care plans receive their pharmacy benefit through their plans. This change explains the variance in rebates from this year compared to years prior to October 2011. 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, 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.

VII. Appendices

1 – Legislation: Article 2A of Chapter 58 of the Laws of 2005

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. "Board" shall mean the drug utilization review board.

3. "Clinical drug review program" means the clinical drug review program created by section two hundred seventy-four 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 eleven 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.

§ 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 drug utilization review board shall consider and make recommendations to the commissioner for the adoption of a preferred drug program. (a) In developing the preferred drug program, the board 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 board 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 board and the department in researching and recommending drugs to be placed on the preferred drug list.

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

6. The board 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 board 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 board to develop recommendations concerning the preferred drug program. Such notice regarding meetings of the board 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 board. The board shall allow interested parties a reasonable opportunity to make an oral presentation to the board related to the prior authorization of the therapeutic class to be reviewed. The board 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 board 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 may include: a summary of the deliberations of the board; a summary of the positions of those making public comments at meetings of the board; the response of the board to those comments, if any; and the findings and recommendations of the board.

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 board 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 board 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 board 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 board 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.

10. Prior authorization shall not be required for an initial or renewal prescription for buprenorphine or injectable naltrexone for detoxification or maintenance treatment of opioid addiction unless the prescription is for a non-preferred or non-formulary form of such drug as otherwise required by section 1927(k)(6) of the Social Security Act.

§ 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 drug utilization review board. For this purpose, the commissioner and the board, 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 board 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 board and any comments received from prescribers, dispensers, consumers and manufacturers of the drug. In no event shall the prior authorization criteria for approval pursuant to this subdivision result in denial of the prior authorization request based on the relative cost of the drug subject to prior authorization.

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

8. In the event that a patient presents a prescription to a pharmacist

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

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

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

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

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

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

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

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

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

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

§ 277. Review and reports. 1. The commissioner, in consultation with the drug utilization review board, 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 board 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 board 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.

2 – Drug Utilization Review Board Membership

Drug Utilization Review Board Membership

DOH Designee - Chairperson
1. Jason Helgerson

Physicians
2. Renante Ignacio, MD
3. Paula Panzer, MD
4. Asa Radix, MD
5. James Saperstone, MD
6. Christopher J. Murphy, MD
7. Vacancy

Pharmacists
8. Lisa Anzisi, PharmD
9. Leigh Briscoe-Dwyer, PharmD
10. James R. Hopsicker, RPh, MBA
11. Michelle Rainka, PharmD
12. Tara M. Thomas, RPh, MBA
13. Jacqueline Jacobi, RPh

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. John Wikiera
19. Vacancy

3 – Drug Classes in the Preferred Drug Program (as of March 2017)

The following table lists drug classes that were reviewed at the DURB during SFY 16/17. Also included is the review date, the date the PDL was publicly posted, and the date some drugs within the class required PA.

DURB Meeting	Drug Class	Posting Date	Date PA Required
April 27, 2016	ACNE AGENTS – PRESCRIPTION, TOPICAL	May 19, 2016	June 30, 2016
April 27, 2016	ANTIBIOTICS: TOPICAL	May 19, 2016	June 30, 2016
April 27, 2016	ANTICHOLINERGICS: RESPIRATORY	May 19, 2016	June 30, 2016
September 15, 2016	ANTICONVULSANTS SECOND GENERATION	October 24, 2016	November 17, 2016
April 27, 2016	ANTIHISTAMINES: LOW SEDATING	May 19, 2016	June 30, 2016
April 27, 2016	ANTIPSYCHOTICS: SECOND GENERATION	May 19, 2016	June 30, 2016
April 27, 2016	ANTIPSYCHOTICS, INJECTABLE	May 19, 2016	June 30, 2016
September 15, 2016	ARB COMBINATIONS	October 24, 2016	November 17, 2016
April 27, 2016	BETA AGONISTS: LONG-ACTING	May 19, 2016	June 30, 2016
April 27, 2016	CNS STIMULANTS	May 19, 2016	June 30, 2016
April 27, 2016	Direct Acting Antivirals – Hepatitis C	May 19, 2016	June 30, 2016
September 15, 2016	Direct Acting Antivirals – Hepatitis C	October 24, 2016	November 17, 2016
September 15, 2016	IMMUNOMODULATORS: SYSTEMIC	October 24, 2016	November 17, 2016
April 27, 2016	INSULINS: LONG ACTING	May 19, 2016	June 30, 2016
September 15, 2016	MULTIPLE SCLEROSIS AGENTS	October 24, 2016	November 17, 2016
April 27, 2016	NSAIDS: PRESCRIPTION	May 19, 2016	June 30, 2016
April 27, 2016	OPIATES: LONG ACTING	May 19, 2016	June 30, 2016
April 27, 2016	OPIOID ANTAGONISTS	May 19, 2016	June 30, 2016
September 15, 2016	ORAL AGENTS FOR PULMONARY ARTERIAL HYPERTENSION (PAH) AGENTS	October 24, 2016	November 17, 2016
April 27, 2016	QUINOLONES: OTIC	May 19, 2016	June 30, 2016
April 27, 2016	SELECTIVE SEROTONIN REUPTAKE INHIBITORS	May 19, 2016	June 30, 2016
September 15, 2016	TRIPTANS	October 24, 2016	November 17, 2016

4 – Preferred and Non-Preferred Drug List (as of March 2017)

Revised: March 2, 2017

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

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Revised: March 2, 2017

NYS Medicaid Fee-For-Service Preferred Drug List

PREFERRED DRUG LIST – TABLE OF CONTENTS

Revised: March 2, 2017

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 XR ibuprofen indomethacin ketorolac meloxicam (tablet) naproxen naproxen EC piroxicam sulindac Voltaren® Gel	Anaprox® DS Arthrotec® Cambia® Celebrex® CC celecoxib CC Daypro® diclofenac / misoprostol diclofenac potassium diclofenac sodium diclofenac topical gel diclofenac topical soln. diflunisal Duexis® etodolac etodolac ER Feldene® fenoprofen Flector® patch flurbiprofen Indocin® indomethacin SR ketoprofen	ketoprofen SA meclofenamate mefenamic acid meloxicam (susp.) Mobic® nabumetone Nalfon® Naprelan® Naprosyn® Naprosyn® EC naproxen CR naproxen sodium oxaprozin Pennsaid® Ponstel® Sprix® Tivorbex® tolmetin Vimovo® Vivlodex™ 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 Narcan® (nasal spray) ReVia®	Evzio®		
Opioid Dependence Agents CC, F/Q/D			
buprenorphine Suboxone® (film)	Bunavail® buprenorphine/ naloxone (tablet) Zubsolv ®		CLINICAL CRITERIA (CC) ➢ Medical necessity rationale for opioid therapy is required for patients on established buprenorphine opioid dependence 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

Revised: March 2, 2017

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
Opioids – Long-Acting CC, F/Q/D		
Butrans® fentanyl patch (12 mcg, 25 mcg, 50 mcg, 75 mcg, 100 mcg) morphine sulfate SR (tablet)	Avinza® Belbuca™ Conzip® ST Duragesic® Embeda® ER Exalgo® fentanyl patch (37.5 mcg, 62.5 mcg, 87.5 mcg) hydromorphone ER Hysingla® ER Kadian® morphine ER (capsule) (generic for Avinza) morphine ER (capsule) (generic for Kadian) MS Contin® Nucynta® ER ST Opana ER® oxycodone ER Oxycontin® oxymorphone ER tramadol ER ST Ultram® ER ST Xtampza™ ER Zohydro® ER	**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 opioid dependence 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) - Exemption for diagnosis of cancer or sickle cell disease** ➢ Belbuca™ (buprenorphine) ▪ Maximum 2 (two) units per day ➢ Butrans® (buprenorphine) ▪ Maximum 4 patches per 28 days ➢ Embeda® (morphine ER/naltrexone): ▪ Maximum 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 ➢ Hydromorphone ER, oxymorphone ER: ▪ Maximum 4 (four) units per day, 120 units per 30 days ➢ Oxycodone ER (Xtampza ER™): ▪ Maximum 2 (two) units per day, 60 units per 30 days. Not to exceed a total daily dose of 160mg or its equivalent ➢ Fentanyl transdermal patch (Duragesic®): ▪ 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

Revised: March 2, 2017

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
Opioids – Short-Acting CC		
butalbital / APAP / caffeine / codeine F/Q/D codeine F/Q/D codeine / APAP F/Q/D hydrocodone / APAP F/Q/D hydrocodone / ibuprofen F/Q/D Lortab® (elixir) F/Q/D morphine IR F/Q/D oxycodone / APAP F/Q/D Reprexain® F/Q/D tramadol Verdrocet™ F/Q/D Xylon™ F/Q/D	butalbital compound/ codeine F/Q/D butorphanol nasal spray Demerol® dihydrocodeine / aspirin / caffeine F/Q/D dihydrocodeine / APAP / caffeine F/Q/D Dilaudid® F/Q/D Fioricet® / codeine F/Q/D Fiorinal® / codeine F/Q/D hydromorphone F/Q/D Ibudone® F/Q/D levorphanol meperidine Nucynta® ST, F/Q/D Opana® F/Q/D Oxaydo® 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 Primlev™ F/Q/D Roxicet® (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 opioid dependence 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 ➢ Xartemis® XR (oxycodone/acetaminophen): ▪ Maximum 4 (four) units per day, 120 (one hundred twenty) 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 **Duration Limits:** ▪ 90 days for patients without a diagnosis of cancer or sickle-cell disease.

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NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
II. ANTI-INFECTIVES		
Antibiotics – Inhaled CC, F/Q/D		
Bethkis® Cayston® Kitabis® Pak	TOBI Podhaler™ TOBI® (solution) tobramycin (solution)	**CLINICAL CRITERIA (CC)** Confirm diagnosis for the FDA-approved indication of cystic fibrosis **FREQUENCY/QUANTITY/DURATION (F/Q/D)** ➢ Aztreonam (Cayston) ▪ 3 (three) ampules (3mL) per day ▪ 84 ampules (84 mL) per 56 day regimen (28 days on, 28 days off) ➢ Tobramycin inhalation solution (Bethkis, TOBI, Kitabis) ▪ 2 (two) ampules (8 mL Bethkis, 10 mL TOBI, Kitabis Pak) per day ▪ 56 ampules (224 mL Bethkis, 280 mL TOBI, Kitabis Pak) per 56 day regimen (28 days on-28 days off) ➢ Tobramycin capsules with inhalation powder (TOBI Podhaler) ▪ 8 capsules per day 224 capsules per 56 day regimen (28 days on-28 days off)
Anti-Fungals – Oral for Onychomycosis		
griseofulvin (suspension) griseofulvin ultramicronized terbinafine (tablet)	Grifulvin V® (tablet) Gris-PEG® griseofulvin micronized (tablet) itraconazole Lamisil® (tablet) Omnel® Sporanox®	
Anti-Virals – Oral		
acyclovir valacyclovir	famciclovir Famvir® Valtrex® Zovirax®	
Cephalosporins – Third Generation		
cefdinir cefixime cefpodoxime Suprax®	Cedax® cefditoren Ceftibuten	
Fluoroquinolones – Oral		
Cipro® (suspension) ciprofloxacin (suspension, tablet) levofloxacin (tablet)	Avelox® Avelox ABC Pack® Cipro® (tablet) Cipro® XR ciprofloxacin ER Levaquin® levofloxacin (solution) moxifloxacin ofloxacin (tablet)	
Hepatitis B Agents		
Baraclude® Epivir-HBV® Hepsera® Tyzeka®	adefovir dipivoxil entecavir lamivudine 100mg Vemlidy®	

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NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
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, prior treatment and response, presence of cirrhosis, and HIV-coinfection. ➢ 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. ▪ Maximum duration of 48 weeks for: ❖ Treatment-naïve patients or prior relapsers with cirrhosis and HIV co-infection ❖ Prior non-responders (including prior partial and null responders) with or without cirrhosis and with or without HIV co-infection
Hepatitis C Agents – Direct Acting Antivirals		
Epclusa® (for GTs 2 & 3) CC, F/Q/D Harvoni® CC, F/Q/D ribavirin Technivie® CC, F/Q/D Viekira Pak® CC, F/Q/D Viekira XR™ CC, F/Q/D Zepatier™ CC, F/Q/D	Copegus® Daklinza™ CC, F/Q/D Moderiba™ Olysio® CC, F/Q/D Rebetol® Ribasphere® Sovaldi® CC, F/Q/D	CLINICAL CRITERIA (CC) ➢ Require confirmation of FDA approved, compendia supported, or Medicaid covered diagnosis ➢ Require confirmation of prescriber experience and training ▪ Prescribed by hepatologist, gastroenterologist, infectious disease specialist, transplant physician or health care practitioner experienced and trained in the treatment of Hepatitis C viral (HCV) or a healthcare practitioner under the direct supervision of a listed specialist. **AND** ▪ Clinical experience is defined as the management and treatment of at least 10 patients with HCV infection in the last 12 months and at least 10 HCV- related CME credits in the last 12 months. OR ▪ Management and treatment of HCV infection in partnership (defined as consultation, preceptorship, or via telemedicine) with an experienced HCV provider who meets the above criteria. ➢ Require confirmation of patient readiness and adherence ▪ Evaluation by using scales or assessment tools readily to determine a patient's readiness to initiate HCV treatment, specifically drug and alcohol abuse potential. Assessment tools are available to healthcare practitioners at: http://www.integration.samhsa.gov/clinical-practice/screening-tools OR https://prepc.org/. Click here to access the Hepatitis C Worksheets with Clinical Criteria requirements

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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 Doryx MPC® ST, F/Q/D doxycycline hyclate DR ST, F/Q/D doxycycline monohydrate doxycycline monohydrate IR-DR minocycline (tablet) minocycline ER Mondoxyne™ 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 lisinopril ramipril	Accupril® Altace® Epaned™ fosinopril Lotensin® Mavik® moexipril perindopril Prinivil® Qbrelis™ quinapril trandolapril Univasc® Vasotec® Zestril®	
ACE Inhibitor Combinations		
benazepril/ amlodipine benazepril/ HCTZ captopril/ HCTZ enalapril/ HCTZ lisinopril/ HCTZ Lotrel® moexipril/ HCTZ Tarka® trandolapril/ verapamil ER	Accuretic® fosinopril/ HCTZ Lotensin HCT® Prestalia® quinapril/ HCTZ Vaseretic® Zestoretic®	

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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 valsartan	Atacand® Avapro® Benicar® DO candesartan Cozaar® Edarbi™ eprosartan irbesartan Micardis® DO olmesartan Telmisartan	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)
ARBs Combinations ST		
Exforge HCT® losartan/ HCTZ valsartan/ amlodipine valsartan/ amlodipine / HCTZ valsartan/ HCTZ	Atacand HCT® Avalide® Azor® Benicar HCT® DO Byvalson™ candesartan/ HCTZ Diovan HCT® DO Edarbyclor™ DO Entresto™ CC Exforge® DO Hyzaar® irbesartan/ HCTZ Micardis HCT® DO olmesartan/ amlodipine olmesartan/ amlodipine/ HCTZ olmesartan/ HCTZ telmisartan/ amlodipine telmisartan/ HCTZ Tribenzor® Twynsta®	CLINICAL CRITERIA (CC) ➢ PA is not required if patient has chronic symptomatic HFrEF (NYHA class II or III), can tolerate an ACE inhibitor or ARB, and transition to the non-preferred product is warranted to produce the desired health outcome 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
Beta Blockers		
atenolol carvedilol labetalol metoprolol succ. XL metoprolol tartrate propranolol (tablet)	acebutolol betaxolol bisoprolol Bystolic® DO Coreg® Coreg CR® DO Corgard® Inderal LA® Inderal XL® InnoPran XL® Levatol® Lopressor® nadolol DO pindolol propranolol (solution) propranolol ER/SA Sectral® Tenormin® timolol Toprol XL® DO Trandate® Zebeta®	DOSE OPTIMIZATION (DO) ➢ See Dose Optimization Chart for affected drugs and strengths

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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 ER/ HCTZ 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® 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®	None		**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	Simcor® simvastatin	Advicor® Altoprev® atorvastatin/amlodipine Caduet® Crestor® DO fluvastatin fluvastatin ER	rosuvastatin Lescol® Lescol XL® Lipitor® Livalo® Pravachol® Vytorin® Zocor®	**DOSE OPTIMIZATION (DO)** ➢ See Dose Optimization Chart for affected drugs and strengths
Niacin Derivatives				
Niaspan® DO		niacin ER		**DOSE OPTIMIZATION (DO)** ➢ See Dose Optimization Chart for affected drugs and strengths

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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® Orenitram®	Adempas® Uptravi® Opsumit®	
Triglyceride Lowering Agents		
gemfibrozil fenofibrate (48 mg, 145 mg) fenofibric acid	Antara® fenofibrate Fenoglide® Fibricor® Lipofen® Lofibra® Lopid® Lovaza® ST, F/Q/D omega-3 ethyl ester 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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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 memantine Namenda® rivastigmine (capsule)	Aricept® donepezil 23 mg Exelon® (capsule) Namenda XR® CC, ST	Namzaric® CC, ST rivastigmine (patch) Razadyne® Razadyne ER®	CLINICAL CRITERIA (CC) ➢ Memantine extended-release containing products(Namenda XR™ and Namzaric™) – Require confirmation of diagnosis of dementia or Alzheimer's disease STEP THERAPY (ST) ➢ Memantine extended-release containing products (Namenda XR™ and Namzaric™) – Require trial with memantine immediate-release (Namenda®)
Anticonvulsants – Second Generation			
Felbamate gabapentin (capsule, solution) F/Q/D lamotrigine (tablet) levetiracetam levetiracetam ER Lyrica® DO,ST tiagabine topiramate CC zonisamide	Banzel® CC Briviact® Felbatol® CC Fycompa® gabapentin (tablet) CC F/Q/D Gabitril® CC Keppra® CC Keppra XR® CC Lamictal® CC Lamictal® ODT Lamictal® XR CC lamotrigine ER CC lamotrigine ODT Neurontin® CC F/Q/D Onfi® CC, ST Potiga® CC Qudexy® XR CC Sabril® CC Spritam® 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™ XR, Topamax®, 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 FREQUENCY/QUANTITY/DURATION (F/Q/D) Neurontin® (gabapentin) – Maximum daily dose of 3,600 mg per day 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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NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
Antipsychotics – Second Generation CC, ST		
aripiprazole (oral solution, tablet) clozapine Fanapt® Latuda® DO olanzapine (tablet) DO quetiapine F/Q/D risperidone Saphris® Seroquel XR® DO, F/Q/D ziprasidone	Abilify® (oral solution, tablet) DO aripiprazole ODT clozapine ODT Clozaril® FazaClo® Geodon® Invega® DO, F/Q/D olanzapine ODT DO Nuplazid™ paliperidone ER F/Q/D quetiapine ER F/Q/D Rexulti® Risperdal® Seroquel® F/Q/D Versacloz® Vraylar™ 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 ➢ Require confirmation of FDA approved, compendia supported, or Medicaid covered diagnosis is required for new prescriptions for all Second Generation Antipsychotics ➢ Aripiprazole (Abilify®)- PA is not required when prescribed for treatment of bipolar disorder or schizophrenia as verified by Medicaid claims information but will be subject to other clinical criteria ➢ PA is required for initial prescription for beneficiaries younger than the drug-specific minimum age as indicated below:

aripiprazole (Abilify®)	6 years
asenapine (Saphris®)	10 years
brexpiprazole (Rexulti®)	18 years
cariprazine (Vraylar™)	18 years
clozapine (Clozaril®, Fazaclo®, Versacloz™)	12 years
iloperidone (Fanapt®)	18 years
lurasidone HCl (Latuda®)	13 years
olanzapine (Zyprexa®)	10 years
paliperidone ER (Invega®)	12 years
pimavanserin (Nuplazid™)	18 years
quetiapine fum. (Seroquel®, Seroquel XR®)	10 years
risperidone (Risperdal®)	5 years
ziprasidone HCl (Geodon®)	18 years

➢ 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 in 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)** ➢ paliperidone ER (Invega®) 1.5mg, 3mg, 9mg tablets: Maximum 1 (one) unit/day ➢ paliperidone ER (Invega®) 6mg tablets: Maximum 2 (two) units/day ➢ quetiapine/quetiapine ER (Seroquel®/Seroquel XR®): Minimum 100mg/day; maximum 800mg/day ➢ quetiapine (Seroquel®): Maximum 3 (three) units per day, 90 units per 30 days ➢ quetiapine ER (Seroquel XR®) 150mg, 200mg: 1 (one) unit/day, 30 units/30 days ➢ quetiapine ER (Seroquel XR®) 50mg, 300mg, 400mg: 2 (two) units/day, 60 units/30 days

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NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
Antipsychotics, Injectable		
Abilify Maintena® Aristada™ fluphenazine decanoate Haldol® decanoate haloperidol decanoate Invega Sustenna® Invega Trinza® Risperdal Consta® Zyprexa Relprevv™	None	
Benzodiazepines – Rectal		
Diastat® 2.5mg Diastat® AcuDial™	diazepam (rectal gel)	
Carbamazepine Derivatives		
carbamazepine (chewable, tablet) carbamazepine ER (capsule) Epitol® Equetro® oxcarbazepine Tegretol® (suspension) Tegretol XR®	Aptiom® CC carbamazepine (suspension) CC carbamazepine XR (tablet) CC Carbatrol® CC Oxtellar XR® CC Tegretol® (tablet) CC Trileptal® CC	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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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 IR Daytrana® dexmethylphenidate dextroamphetamine (tablet) Focalin XR® DO Metadate® ER Methylin® methylphenidate (tablet) methylphenidate ER (generic for Concerta®) methylphenidate SR 10 mg, 20 mg (tablet) Quillivant XR® Vyvanse® DO	Adzenys XR-ODT™ amphetamine salt combo ER Aptensio XR® armodafinil CC Concerta® DO Desoxyn® Dexedrine® dexmethylphenidate ER (generic for Focalin XR®) dextroamphetamine ER dextroamphetamine (solution) Dyanavel XR™ Evekeo® Focalin® Metadate CD® DO methamphetamine methylphenidate CD (generic Metadate CD®) methylphenidate ER (generic for Ritalin LA®) methylphenidate (chewable tablet, solution) modafinil Nuvigil® CC Procentra® Provigil® CC, DO Quillichew ER™ Ritalin® Ritalin LA® DO 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** ▪ Require confirmation of diagnoses that support concurrent use of CNS Stimulant and Second Generation Antipsychotic agent ➢ 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 ➢ 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. Concerta 36mg not to exceed 2 units daily. ➢ 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 90 days ▪ Long-acting CNS stimulants: not to exceed 1 dosage unit daily with maximum of 90 days. Concerta 36mg not to exceed 2 units daily.
Multiple Sclerosis Agents		
Avonex® Betaseron® Copaxone® 20 mg/mL Gilenya® ST	Aubagio® ST Copaxone® 40 mg/mL Extavia® Glatopa™ Plegridy® Rebif® Tecfidera® ST Zinbryta™	**STEP THERAPY (ST)** ➢ Gilenya™ (fingolimod) – requires a trial with a preferred injectable product ➢ Aubagio® (teriflunomide) and Tecfidera™ (dimethyl fumarate) – require a trial with a preferred oral agent

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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® pramipexole ER	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				
guanfacine ER DO Kapvay®	Strattera® DO	clonidine ER Intuniv® DO		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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NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
Sedative Hypnotics/Sleep Agents F/Q/D		
estazolam CC flurazepam CC temazepam 15mg, 30mg CC zolpidem	Ambien® Ambien CR® Belsomra® Edluar® eszopiclone Halcion® CC Intermezzo® Lunesta® DO Restoril® CC Rozerem® Silenor® Sonata® temazepam 7.5mg, 22.5mg CC triazolam CC zaleplon zolpidem (sublingual) zolpidem ER Zolpimist™	**DOSE OPTIMIZATION (DO)** ➢ See Dose Optimization Chart for affected strengths **CLINICAL CRITERIA (CC)** ➢ Benzodiazepine Agents (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 and non-benzodiazepine 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 (Ambien®, Edluar™, Intermezzo®, Zolpimist™) products ▪ 180 days for eszopiclone and ramelteon (Rozerem®) products ▪ 168 days for zolpidem ER (Ambien CR®) products ▪ 90 days for suvorexant (Belsomra®) ▪ 90 days for doxepin (Silenor®) ▪ 30 days for zaleplon (Sonata®) products ▪ 30 days for benzodiazepine agents (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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NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs		Prior Authorization/Coverage Parameters
Selective Serotonin Reuptake Inhibitors (SSRIs)			
citalopram escitalopram (tablet) fluoxetine (capsule, solution) paroxetine sertraline	Brisdelle® Celexa® escitalopram (soln) fluoxetine (tablet) fluoxetine DR weekly fluvoxamine QQ fluvoxamine ER QQ Lexapro® DO	paroxetine CR Paxil® Paxil CR® Pexeva® Prozac® Sarafem® Trintellix™ 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 20mg, 30mg, 60mg (generic for Cymbalta®) venlafaxine venlafaxine ER (capsule)	Cymbalta® desvenlafaxine base ER Desvenlafaxine fumarate ER duloxetine 40mg (generic for Irenka™) Effexor XR® DO Fetzima® Irenka™ 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) ❖ Fibromyalgia (FM) ❖ Diabetic peripheral neuropathy (DPN)* ➢ *duloxetine (Cymbalta® and Irenka™) – Requires a trial with a tricyclic antidepressant OR gabapentin for treatment of Diabetic Peripheral Neuropathy (DPN)

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Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
Serotonin Receptor Agonists (Triptans)		
rizatriptan F/Q/D sumatriptan F/Q/D	almotriptan F/Q/D Amerge® F/Q/D Axert® F/Q/D Frova® F/Q/D frovatriptan F/Q/D Imitrex® F/Q/D Maxalt® F/Q/D Maxalt® MLT F/Q/D naratriptan F/Q/D Onzetra Xsail™ F/Q/D Relpax® F/Q/D Sumavel® DosePro Treximet® F/Q/D Zembrace SymTouch™ zolmitriptan F/Q/D Zomig® F/Q/D Zomig® ZMT F/Q/D	FREQUENCY/QUANTITY/DURATION (F/Q/D)

almotriptan	18 units every 30 days
Amerge®	
Axert® 6.25mg	
Frova®	
frovatriptan	
Imitrex® Nasal Spray	
Imitrex® tablets	
naratriptan	
Relpax® 20mg	
sumatriptan nasal spray	
sumatriptan tablets	
Treximet®	
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)	
Onzetra Xsail™	16 units (1 kit) every 30 days

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Preferred Drugs	Non-Preferred Drugs		Prior Authorization/Coverage Parameters
V. DERMATOLOGIC AGENTS			
Acne Agents – Prescription, Topical			
Differin® Retin-A® (cream, gel) CC Tazorac® CC	Aczone® adapalene Atralin® CC Avita® CC Azelex® clindamycin/ tretinoin Epiduo®	Fabior® CC Retin-A Micro® CC tretinoin CC tretinoin micro CC Veltin® CC Ziana® CC	CLINICAL CRITERIA ➢ Require confirmation of FDA approved, compendia supported, or Medicaid covered diagnosis
Agents for Actinic Keratosis			
diclofenac 3% gel F/Q/D Efudex® fluorouracil (solution) fluorouracil 0.5% cream (generic for Carac) imiquimod	Aldara® Carac® fluorouracil 5% cream (generic for Efudex cream) Picato Solaraze® F/Q/D Tolak™ Zyclara®		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
Antibiotics – Topical			
mupirocin (ointment)	Altabax® Bactroban® Bactroban Nasal® CC	Centany® 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® terbinafine OTC tolnaftate OTC	Alevazol OTC Ciclodan® (cream) ciclopirox (cream, gel, suspension) clotrimazole / betamethasone clotrimazole Rx econazole Ertaczo® Exelderm® Extina® ketoconazole Lotrisone® Luzu® Mentax® naftifine Naftin® oxiconazole Oxistat® Vusion® F/Q/D		FREQUENCY/QUANTITY/DURATION (F/Q/D) ➢ Vusion® 50 gm ointment – Maximum 100 (one hundred) grams in a 90 day time period

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Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
Anti-Infectives – Topical		
BenzaClin® pump clindamycin (gel, lotion, solution) erythromycin (gel, solution)	Acanya® BenzaClin® (gel) Benzamycin® Cleocin T® Clindacin® Clindagel® clindamycin (foam, pledget) clindamycin / benzoyl peroxide Duac® Erygel® erythromycin (pledget) erythromycin / benzoyl peroxide Evoclin® Neuac® Onexton®	
Anti-Virals – Topical		
Abreva® Zovirax® (cream)	acyclovir (ointment) Denavir® Sitavig® Xerese® Zovirax® (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) Enstilar® Sorilux® Taclonex® Taclonex® Scalp® Vectical®	

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Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
Steroids, Topical – Low Potency		
hydrocortisone acetate OTC hydrocortisone acetate Rx hydrocortisone/ aloe vera OTC	alclometasone Derma-Smoothe/FS® Desonate® desonide fluocinolone (oil) Micort HC® Texacort® Tridesilon® Verdeso®	
Steroids, Topical – Medium Potency		
clocortolone hydrocortisone butyrate (ointment, solution) hydrocortisone valerate mometasone furoate	Cloderm® Cordran® Cutivate® Dermatop® Elocon® fluocinolone acetonide (cream, ointment, soln.) flurandrenolide fluticasone propionate hydrocortisone butyrate (cream) Luxiq® Pandel® prednicarbate Synalar®	
Steroids, Topical – High Potency		
betamethasone dipropionate (cream, lotion) betamethasone valerate (cream, ointment) fluocinonide (cream, gel, solution) fluocinonide emollient fluocinonide-E triamcinolone acetonide	amcinonide Apexicon-E® betamethasone dipropionate (gel,ointment) betamethasone dipropionate, augmented betamethasone valerate (foam, lotion) desoximetasone diflorasone Diprolene® Diprolene® AF fluocinonide 0.1% cream (generic for Vanos) fluocinonide (ointment) Halog® Kenalog® Psorcon Semivo™ Topicort® triamcinolone spray Trianex® Vanos®	
Steroids, Topical – Very High Potency		
clobetasol (cream, gel, ointment, solution) halobetasol	clobetasol (foam, lotion, spray) Clobex® Olux® Olux-E® Temovate® Temovate-E® Ultravate®	

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VI. ENDOCRINE AND METABOLIC AGENTS		
Preferred Drugs	**Non-Preferred Drugs**	**Prior Authorization/Coverage Parameters**
Alpha-Glucosidase Inhibitors ST		
acarbose miglitol Glyset®	Precose®	**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.
Anabolic Steroids – Topical CDRP, F/Q/D		
Androgel®	Androderm® Axiron® Fortesta® Natesto™ Testim® 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 documented 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
Biguanides		
metformin HCl metformin ER (generic for Glucophage XR®)	Fortamet® Glucophage® Glucophage XR® Glumetza® metformin ER (generics for Fortamet®, Glumetza®) Riomet® (solution)	

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Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
Bisphosphonates – Oral F/Q/D		
alendronate	Actonel® Atelvia® Binosto® Boniva® Fosamax® Fosamax® Plus D Ibandronate risedronate	FREQUENCY/QUANTITY/DURATION (F/Q/D) Actonel® 150 mg: 1 tablet every 28 days Boniva® 150 mg ibandronate sodium 150 mg risedronate sodium150 mg Actonel® 35 mg: 4 tablets every 28 days alendronate sodium 35 mg alendronate sodium 70 mg Atelvia® 35 mg Fosamax® 35 mg Fosamax® 70 mg Fosamax® Plus D risedronate sodium 35 mg alendronate solution 70 mg/75 mL single-dose bottle: 4 bottles every 28 days
Calcitonins – Intranasal		
calcitonin-salmon Miacalcin®	Fortical®	
Dipeptidyl Peptidase-4 (DPP-4) Inhibitors ST		
Janumet® Janumet® XR Januvia® DO Jentadueto® Jentadueto® XR Tradjenta®	alogliptin alogliptin / metformin alogliptin / pioglitazone Glyxambi® 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		
Bydureon® Byetta® Tanzeum®	Adlyxin™ Soliqua™ Trulicity® Victoza®	STEP THERAPY (ST) ➢ Requires a trial with metformin with or without insulin prior to a GLP-1 agonist. ➢ Prior authorization is required with lack of covered diagnosis in medical history.

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Preferred Drugs		Non-Preferred Drugs		Prior Authorization/Coverage Parameters
Glucocorticoids – Oral				
cortisone dexamethasone (tablet, solution) hydrocortisone methylprednisolone (4mg, 8mg, 32mg) methylprednisolone (dose-pack) prednisolone (solution) prednisone (dose-pack, solution, tablet)		budesonide EC Cortef® dexamethasone (elixir) dexamethasone intensol Dexpak® Entocort EC® Medrol® (dose-pack, tablet) methylprednisolone 16mg Millipred® Orapred® prednisolone ODT prednisone intensol Rayos® Uceris® Veripred®		
Growth Hormones CC, CDRP				
Genotropin® Norditropin®	Nutropin AQ®	Humatrope® Omnitrope® Saizen®	Tev-Tropin® Zomacton® Zorbtive®	CLINICAL DRUG REVIEW PROGRAM (CDRP) ➢ Prescribers, not authorized agents, are required to call for a PA for beneficiaries 21 years of age or older 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®	Basaglar® Toujeo®	Tresiba®	
Insulin – Mixes				
Humalog® Mix	Novolog® Mix	None		
Insulin – Rapid-Acting				
Apidra® Humalog® 100 U/mL	Novolog®	Afrezza® Humalog® 200 U/mL		

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Preferred Drugs		Non-Preferred Drugs		Prior Authorization/Coverage Parameters
Meglitinides ST				
nateglinide	repaglinide	Prandimet® Prandin®	repaglinide/ metformin Starlix®	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®	
Sodium Glucose Co-Transporter 2 (SGLT2) Inhibitors ST				
Invokana®		Farxiga™ Invokamet® Invokamet® XR	Jardiance® Synjardy® Xigduo® XR	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® 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®		

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Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
Gastrointestinal Antibiotics		
metronidazole (tablet) neomycin vancomycin	Alinia® Dificid® Flagyl® Flagyl® ER metronidazole (capsule) paromomycin Tindamax® tinidazole Vancocin® Xifaxan® QQ, ST, F/Q/D	**CLINICAL CRITERIA (CC)** ➢ Xifaxan® – Requires confirmation of diagnosis of Traveler's diarrhea, hepatic encephalopathy, or irritable bowel syndrome with diarrhea (IBS-D) **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) ▪ Irritable bowel syndrome with diarrhea (550 mg tablets) – 42 tablets per 30 days (Dose = 550 mg three times a day for 14 days) ❖ Maximum of 42 days supply (126 units) per 365 (three rounds of therapy).
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® Moviprep® Nulytely® Osmoprep® PEG 3350 powder pack OTC PEG 3350 with flavor packs Prepopik® Suprep® Trilyte®	
Helicobacter pylori Agents		
lansoprazole / amoxicillin / clarithromycin Pylera®	Omeclamox-Pak® Prevpac®	

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Preferred Drugs		Non-Preferred Drugs		Prior Authorization/Coverage Parameters
Proton Pump Inhibitors (PPIs) F/Q/D				
omeprazole Rx pantoprazole		Aciphex® Dexilant™ DO esomeprazole magnesium (generic for Nexium) 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 for: ❖ GERD ❖ erosive esophagitis ❖ healing and maintenance of duodenal/gastric ulcers (including NSAID-induced) ❖ prevention of NSAID-induced ulcers ▪ Twice daily dosing 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® mesalamine DR Pentasa®	

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Preferred Drugs		Non-Preferred Drugs		Prior Authorization/Coverage Parameters
VIII. HEMATOLOGICAL AGENTS				
Anticoagulants – Injectable CC,F/Q/D				
enoxaparin sodium	Fragmin®	Arixtra® CC fondaparinux CC	Lovenox®	CLINICAL CRITERIA (CC) ➢ For patients requiring >30 days of therapy: Require confirmation of FDA approved or compendia-supported indication ➢ Arixtra® (fondaparinux) Clinical editing to allow patients with a diagnosis of Heparin Induced Thrombocytopenia (HIT) to receive therapy without prior authorization. FREQUENCY/QUANTITY/DURATION (F/Q/D) ➢ Duration Limit: No more than 30 days for members initiating therapy
Anticoagulants – Oral				
Coumadin® Jantoven® Pradaxa®	warfarin Xarelto®	Eliquis® CC Savaysa® Xarelto® (dose pack)		CLINICAL CRITERIA (CC) ➢ Clinical editing will allow patients currently stabilized on Eliquis® (apixaban) to continue to receive that agent without PA
Erythropoiesis Stimulating Agents (ESAs) CC				
Aranesp®	Procrit®	Epogen®	Mircera®	CLINICAL CRITERIA (CC) ➢ Confirm diagnosis for FDA or Compendia supported uses
Platelet Inhibitors				
Aggrenox® Brilinta® clopidogrel	dipyridamole Effient®	dipyridamole / aspirin Durlaza® Persantine® Plavix® ticlopidine Yosprala™ Zontivity®		
IX. IMMUNOLOGIC AGENTS				
Immunomodulators – Systemic CC, ST				
Enbrel®	Humira®	Actemra® (subcutaneous) Cimzia® Cosentyx® Kineret® Orencia® (subcutaneous) Otezla® Simponi® Stelara® Taltz® Xeljanz® Xeljanz® XR		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

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Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
X. MISCELLANEOUS AGENTS		
Progestins (for Cachexia)		
megestrol acetate (suspension)	Megace® (suspension) Megace ES® megestrol ES (suspension)	
Epinephrine, Self-injected		
Adrenaclick® epinephrine EpiPen® EpiPen Jr®	None	
XI. MUSCULOSKELETAL AGENTS		
Skeletal Muscle Relaxants		
baclofen chlorzoxazone cyclobenzaprine 5mg, 10mg dantrolene methocarbamol orphenadrine ER tizanidine (tablet)	Amrix® carisoprodol ST, F/Q/D carisoprodol compound ST, F/Q/D carisoprodol compound / codeine CC,ST, F/Q/D cyclobenzaprine 7.5mg 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 opioid dependence 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)

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Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
XII. OPHTHALMICS		
Alpha-2 Adrenergic Agonists (for Glaucoma) – Ophthalmic		
Alphagan P® brimonidine 0.2% Simbrinza®	apraclonidine brimonidine 0.15% Iopidine®	
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/Steroid Combinations – Ophthalmic		
Blephamide® neomycin/ polymyxin / dexamethasone sulfacetamide / prednisolone TobraDex® (ointment, suspension)	Maxitrol® neomycin / bacitracin / polymyxin / HC neomycin / polymyxin / HC Pred-G® TobraDex® ST tobramycin / dexamethasone (suspension) Zylet®	
Antihistamines – Ophthalmic		
Pataday®	azelastine Bepreve® Elestat® Emadine® epinastine Lastacaft® olopatadine 0.1% Optivar® Patanol® Pazeo®	

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Beta Blockers – Ophthalmic		
betaxolol Betoptic S® carteolol Combigan® Istalol® levobunolol timolol maleate (gel, solution)	Betagan® Timoptic® Timoptic® in Ocudose® Timoptic-XE®	
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 a fluoroquinolone ophthalmic product ➢ Examples of Non-Fluoroquinolone Ophthalmic Antibiotics ▪ AK-Poly-Bac eye ointment ▪ bacitracin-polymyxin eye ointment ▪ erythromycin eye ointment ▪ Gentak (3 mg/gm eye ointment, 3 mg/mL eye drops) ▪ gentamicin (3 mg/gm eye ointment, 3 mg/mL eye drops) ▪ neomycin-polymyxin-gramicidin eye drops ▪ polymyxin B-TMP eye drops ▪ Romycin eye ointment ▪ sulfacetamide 10% eye drops ▪ Sulfamide 10% eye drops ▪ tobramycin 0.3% eye drops ▪ Tobrasol 0.3% eye drops
Non-Steroidal Anti-Inflammatory Drugs (NSAIDS) – Ophthalmic		
diclofenac flurbiprofen ketorolac	Acular® Acular LS® Acuvail® Bromfenac BromSite™ Ilevro® Nevanac® Ocufen® Prolensa®	
Prostaglandin Agonists – Ophthalmic		
latanoprost	bimatoprost Lumigan® Travatan Z® travoprost Xalatan® Zioptan®	

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XIII. OTICS		
Fluoroquinolones – Otic		
Cipro HC® Ciprodex® ciprofloxacin	Floxin® ofloxacin Otovel™	
XIV. RENAL AND GENITOURINARY		
Alpha Reductase Inhibitors for BPH		
finasteride	Avodart® dutasteride dutasteride / tamsulosin Jalyn® Proscar®	
Cystine Depleting Agents CC		
Cystagon®	Procysbi® ST	CLINICAL CRITERIA (CC) ➢ Confirm diagnosis of nephropathic cystinosis STEP THERAPY (ST) ➢ Requires a trial with Cystagon immediate-release capsules
Phosphate Binders/Regulators		
calcium acetate Eliphos® Fosrenol®	Auryxia™ Phoslo® Phoslyra® Renagel® Renvela® Velphoro®	
Selective Alpha Adrenergic Blockers		
alfuzosin tamsulosin	Flomax Rapaflo® Uroxatral®	
Urinary Tract Antispasmodics		
oxybutynin Toviaz® DO Vesicare® DO	darifenacin Detrol® Detrol LA® DO Ditropan XL® Enablex® DO Gelnique® Myrbetriq® oxybutynin ER DO Oxytrol® tolterodine tolterodine ER trospium trospium ER	DOSE OPTIMIZATION (DO) ➢ See Dose Optimization Chart for affected strengths
Xanthine Oxidase Inhibitors		
allopurinol	Uloric® Zyloprim®	

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XV. RESPIRATORY		
Anticholinergics / COPD Agents		
Atrovent HFA® Combivent Respimat® ipratropium ipratropium / albuterol Spiriva®	Anoro Ellipta® Bevespi Aerosphere™ Daliresp® Incruse Ellipta® Seebri Neohaler® Spiriva Respimat® Stiolto Respimat® Tudorza Pressair® Utibron Neohaler®	
Antihistamines – Intranasal		
Astepro® Patanase®	azelastine olopatadine	
Antihistamines – Second Generation		
cetirizine OTC (tablet) cetirizine OTC (syrup/solution 1mg/ 1mL) fexofenadine OTC (suspension) levocetirizine (tablet) loratadine OTC	cetirizine OTC (chewable) cetirizine OTC (syrup/solution 5mg/ 5mL) cetirizine-D OTC Clarinex® CC Clarinex-D® OTC desloratadine fexofenadine OTC (tablet) levocetirizine (solution) loratadine-D OTC Semprex-D Xyzal® CC	CLINICAL CRITERIA (CC) ➢ No prior authorization required for patients less than 24 months of age

Revised: March 2, 2017

NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
Beta$_2$ Adrenergic Agents – Inhaled Long-Acting CC, F/Q/D		
Foradil® Perforomist® Serevent Diskus®	Arcapta Neohaler® Brovana® 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 Neohaler® ≥18 years Brovana® ≥18 years Foradil® ≥ 5 years Perforomist® ≥18 years Serevent Diskus® ≥4 years Striverdi Respimat® ≥18 years **FREQUENCY/QUANTITY/DURATION (F/Q/D)** **Maximum units per 30 days** Arcapta Neohaler® 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 Diskus® 1 diskus (60 blisters) Striverdi Respimat® 1 unit (one cartridge and one Respimat inhaler)
Beta$_2$ Adrenergic Agents – Inhaled Short-Acting		
albuterol ProAir HFA® Proventil HFA®	levalbuterol (solution) levalbuterol HFA ProAir® RespiClick Ventolin HFA® Xopenex® (solution) Xopenex HFA®	

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NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
Corticosteroids – Inhaled F/Q/D		
Asmanex® Flovent Diskus® Flovent HFA® Pulmicort® Flexhaler QVAR®	Aerospan® Alvesco® Arnuity Ellipta® Asmanex® HFA	**FREQUENCY/QUANTITY/DURATION (F/Q/D)** 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. Arnuity Ellipta: 1 inhaler every 30 days 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
Corticosteroid/Beta$_2$ Adrenergic Agent (Long-Acting) Combinations – Inhaled CC F/Q/D		
Advair Diskus® Advair HFA® Dulera® Symbicort®	Breo Ellipta®	**CLINICAL CRITERIA (CC)** ➢ PA is required for all new long-acting beta agonist prescriptions for beneficiaries under FDA or compendia supported age as indicated: Advair Diskus®: ≥4 years Advair HFA®: ≥12 years Breo Ellipta™: ≥18 years Dulera®: ≥12 years Symbicort® 80/4.5 mcg: ≥6 years Symbicort® 160/4.5 mcg: ≥12 years **FREQUENCY/QUANTITY/DURATION (F/Q/D)** Advair Diskus®, Advair HFA®, Breo Ellipta™, Dulera®, Symbicort®: One (1) inhaler/diskus every 30 days

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NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs		Prior Authorization/Coverage Parameters
Corticosteroids – Intranasal F/Q/D			
fluticasone mometasone	Beconase AQ® budesonide Dymista® flunisolide Nasonex® Omnaris®	QNASL® Rhinocort Aqua® triamcinolone Veramyst® Zetonna®	**FREQUENCY/QUANTITY/DURATION (F/Q/D)** flunisolide: One (1) inhaler every 12 days budesonide, mometasone, Nasonex®, Rhinocort Aqua®: One (1) inhaler every 15 days Beconase AQ®: One (1) inhaler every 22 days Dymista™, fluticasone, Nasacort AQ®, Omnaris®, QNASL®, triamcinolone, Veramyst®, Zetonna™: One (1) inhaler every 30 days
Leukotriene Modifiers			
montelukast ST zafirlukast	Accolate® Singulair® ST		**STEP THERAPY (ST)** ➢ For non-asthmatic patients, trial of intranasal corticosteroid or a 2nd generation oral antihistamine before montelukast (Singulair®)

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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 2, 2017

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 ➢ Multiple 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	Immunosuppressive, 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 corticosteroid or an immunosuppressive.

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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 *for additional parameters, see Cross-Sex Hormones section below. 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 (not on the PDL) ➢ 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.		

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Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
Antifungals, Topical – for Onychomycosis ➢ ciclopirox 8% solution ➢ Jublia® ➢ Kerydin® ➢ Penlac®	➢ Trial with an oral antifungal agent* prior to use of ciclopirox 8% solution (Penlac) ▪ terbinafine (Lamisil®) tablets; griseofulvin (Grifulvin V®, Gris PEG®) oral suspension, ultramicronized tablets micronized tablets; itraconazole (Sporanox®, Onmel™) tablets, oral solution ➢ Trial with ciclopirox 8% solution prior to the use of other topical antifungals [efinaconazole (Jublia) or tavaborole (Kerydin)]		
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 (Mytesi™)	Requires trial with an alternative anti-diarrheal agent		Confirm diagnosis of HIV/AIDS or antiretroviral therapy in claims history
Cross-Sex Hormones ➢ conjugated estrogens ➢ estradiol ➢ testosterone cypionate			Refer to page 19 of the May 2016 Medicaid Update Article for Transgender Related Care and Services Update

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Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
➢ cyclosporine ophthalmic emulsion (Restasis®, Restasis MultiDose™) ➢ lifitegrast ophthalmic solution (Xiidra™)	Diagnosis documentation required to justify utilization as a first line agent or attempt treatment with an artificial tear, gel or ointment	**QUANTITY LIMIT:** Restasis, Xiidra: ➢ 60 vials dispensed as a 30-day supply; Restasis Multidose: ➢ 5.5 mL dispensed as a 25-day supply	
Cystic fibrosis agents ➢ ivacaftor (Kalydeco™) ➢ ivacaftor / lumacaftor (Orkambi™)			➢ Confirmation of FDA-approved or compendia-supported indications ➢ Genetic testing required to verify appropriate mutations
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
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
Fentanyl Transmucosal Agents ➢ Abstral® (sublingual tablet) ➢ Actiq® (lozenge) ➢ Fentora® (buccal tablet) ➢ Lazanda® (nasal spray) ➢ Onsolis® (buccal film) ➢ Subsys® (sublingual spray)		**QUANTITY LIMIT:** Abstral, Actiq, Fentora, Onsolis, and Subsys: ➢ 4 units per day, 120 units per 30 days Lazanda: ➢ 5 mL (1 bottle) per day, 150 mL (5 bottles) 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 opioid dependence therapy ➢ PA is required for initiation of opioid therapy in patients currently on benzodiazepine therapy
Irritable Bowel Syndrome – assoc. with constipation (IBS-C) Agents	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	

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Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
➢ linaclotide (Linzess®) ➢ lubiprostone (Amitiza®)* *for opioid induced constipation (OIC) parameters see OIC agents section below			
Irritable Bowel Syndrome – assoc. with diarrhea (IBS-D) Agents ➢ alosetron (Lotronex®) ➢ eluxadoline (Viberzi®)	Step therapy with both eluxadoline AND rifaximin prior to using alosetron		Confirm diagnosis for the FDA-approved indication: ➢ alosetron: Adult females with severe IBS-D lasting ≥6 months who have failed other treatments ➢ eluxadoline: Adults with IBS-D
Lipid Lowering Agents - Proprotein Convertase Subtilisin Kexin 9 (PCSK9) Inhibitors ➢ alirocumab (Praluent™) ➢ evolocumab (Repatha™)	Require trial of a HMG-CoA Reductase Inhibitors (Statin) at maximum tolerated dosage		Confirm diagnosis for the FDA-approved indication of: ➢ Familial hypercholesterolemia (heterozygous or homozygous) ➢ Atherosclerotic cardiovascular disease Require concurrent statin therapy
Lipid Lowering Agents - Triglyceride transfer protein inhibitors: ➢ lomitapide (Juxtapid®) ➢ mipomersen (Kynamro®)	Requires trial with high intensity statin therapy		Confirm diagnosis of homozygous familial hypercholesterolemia
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	

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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 opioid dependence 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®)	When prescribing for the treatment of major depressive disorder (MDD) in the absence of other psychiatric comorbidities, trial with at least one different antidepressant agent is required		PA is required for the initial prescription for beneficiaries younger than 18 years
Opioid Induced Constipation (OIC) Agents ➢ lubiprostone (Amitiza®)* ➢ methylnaltrexone (Relistor®) ➢ naloxegol (Movantik™) *for lubiprostone parameters for IBS-C, see IBS-C agents section above	Trial with an osmotic laxative, a stimulant laxative and a stool softener prior to use of lubiprostone, methylnaltrexone, or naloxegol	**QUANTITY LIMIT:** ➢ lubiprostone: 2 capsules per day; 60 capsules per 30 days ➢ methylnaltrexone: 1 vial or syringe per day (30 vials/syringes per 30 days; 4 kits per 28 days; 90 tablets per 30 days ➢ naloxegol: 1 tablet per day; 30 tablets per 30 days	Confirmation of FDA-approved or compendia-supported indications
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

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Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
Pubertal Suppressants ➢ goserelin acetate ➢ leuprolide acetate ➢ nafarelin acetate			Refer to page 19 of the May 2016 Medicaid Update Article for Transgender Related Care and Services Update
Pulmonary Fibrosis Agents ➢ Ofev® ➢ Esbriet®			Confirm diagnosis for the FDA-approved indication of treatment of idiopathic pulmonary fibrosis (IPF)
Pyrimethamine (Daraprim®)			➢ Confirmation of FDA-approved or compendia-supported indications Require concurrent utilization of leucovorin
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
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.

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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 (SMAC/FUL are not applied)
- Do not require a new prescription if the drug is removed from this program

Effective January 19, 2017:

- Seroquel XR will be **added to** the program
- Epzicom, Gabitril, Nasonex and Trileptal Suspension will be **removed from** the program.

List of Brand Name Drugs included in this program* *(Updated): 01/05/2017)*		
Adderall XR	Epivir HBV tablet	Pulmicort Respules
Aggrenox	Edecrin	Retin-A cream, gel
Alphagan P 0.15%	Exelon Patch	**Seroquel XR**
Astepro	Focalin XR	Tegretol suspension
Baraclude	Gleevec	Tegretol XR
BenzaClin pump	Hepsera	Tobradex suspension
Catapres-TTS	Kapvay	Trizivir
Cellcept suspension	Myfortic	Valcyte tablet, solution
Copaxone 20ml SQ	Niaspan	Voltaren Gel
Diastat	Patanase	Xeloda
Differin	Protopic	Xenazine

*List is subject to change

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.

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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:

EXEMPT DRUGS	
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.

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NYS Medicaid Fee-For-Service Dose Optimization Program

On November 14, 2013, the Medicaid Fee-for-Service program instituted 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	
Niacin Derivatives			
Niaspan 500mg	1 daily	Tablet	
Anticonvulsants – Second Generation			
Lyrica 25mg, 50mg, 75mg, 100mg, 150mg, 200mg	3 daily	Capsule	Electronic bypass for diagnosis of seizure disorder identified in medical claims data.
Lyrica 225mg and 300mg	2 daily	Capsule	

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Brand Name	Dose Optimization Limitations		
CENTRAL NERVOUS SYSTEM			
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	
olanzapine 5mg	1 daily	Tablet	
olanzapine ODT 5mg	1 daily	Tablet	
Seroquel XR 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, 54mg	1 daily	Tablet	
Concerta ER 36mg	2 daily	Tablet	
Focalin XR 5mg, 10mg, 15mg, 20mg	1 daily	Capsule	
Metadate CD 10mg, 20mg	1 daily	Capsule	
Provigil 100mg	1 daily	Tablet	
Quillichew ER 20mg, 40mg	1 daily	Tablet	
Quillichew ER 30mg	2 daily	Tablet	
Ritalin LA 10mg, 20mg	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)			
guanfacine ER 1mg, 2mg, 3 mg, 4mg	1 daily	Tablet	
Intuniv 1mg, 2mg	1 daily	Tablet	
Strattera 40mg	1 daily	Capsule	
Sedative Hypnotics			
Lunesta 1mg	1 daily	Tablet	

Revised: March 2, 2017

Brand Name	Dose Optimization Limitations		
CENTRAL NERVOUS SYSTEM			
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.
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	

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.

5 – Preferred Supply List (as of March 2017)

NYS Diabetic Supplies

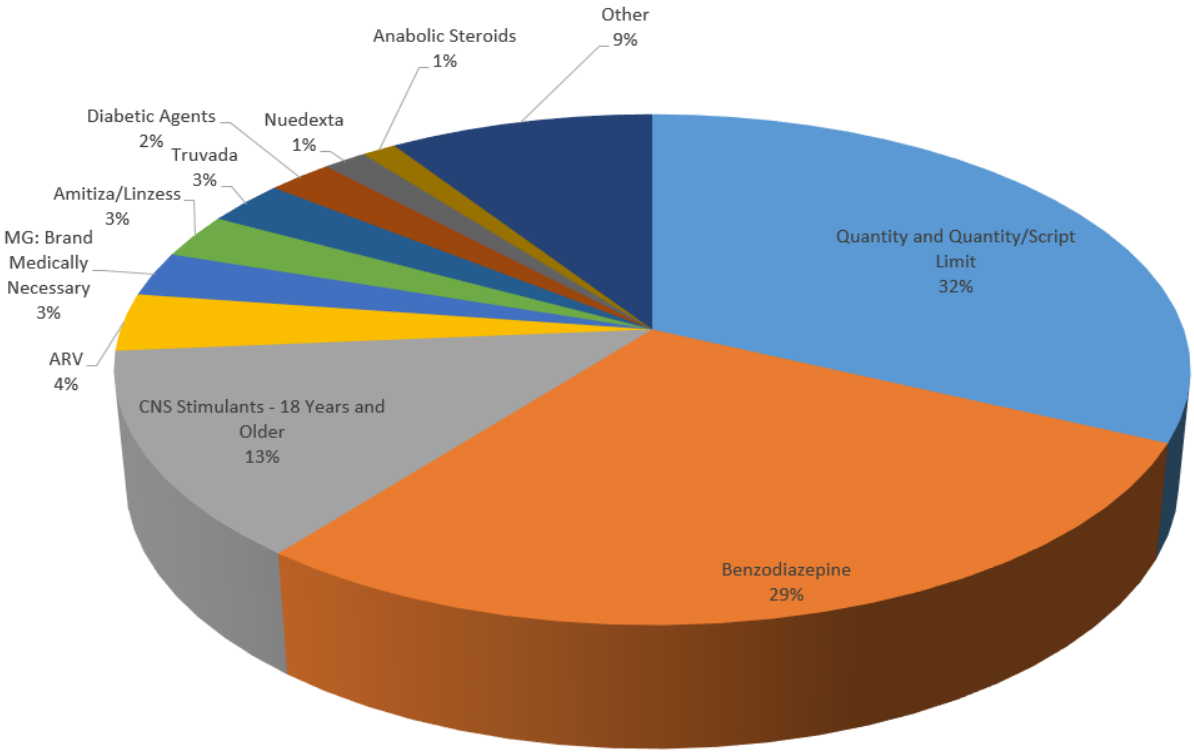
Revised: 10/01/2015

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 - 100 ct	99073071227	Strips
Abbott	Precision Xtra Beta Ketone Test Strips- 10ct	57599074501	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 NEXT USB 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 - 100 ct	53885024510	Strips
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 Verio Meter System	53885065701	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 - 100 ct	57599987705	Strips
Therasense(Abbott)	FreeStyle Test Strips - 50ct	99073012050	Strips
Therasense(Abbott)	FreeStyle Test Strips - 100ct	99073012101	Strips

6 – 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

7 – CDRP and Other Prior Authorizations by Type

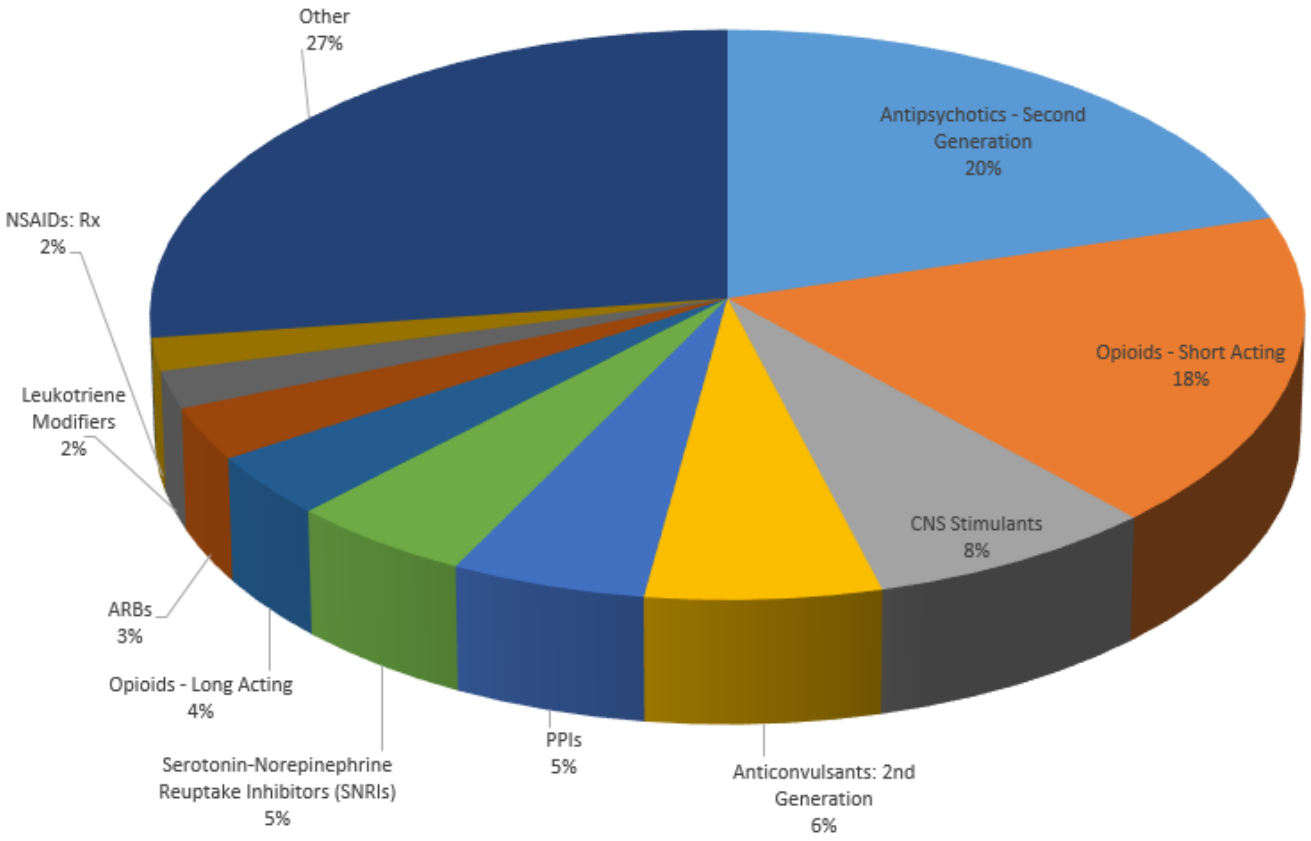


****This chart represents Approved PAs for the following: drugs/drug classes subject to step therapy, FQD (Frequency, Quantity and Duration Limits), PDP classes subject to CDRP and CDRP.**

Total PAs = 47,050

Quantity and Quantity/Script Limit	15061
Benzodiazepine	13436
CNS Stimulants - 18 Years and Older	6158
ARV	1714
MG: Brand Medically Necessary	1327
Amitiza/Linzess	1323
Truvada	1315
Diabetic Agents	1072
Nuedexta	718
Anabolic Steroids	569
Lidoderm	502
Synagis	496
BLTG	476
Restasis	397
Xifaxan	360
Marinol	284
Methadone	280
Immunomodulators: Topical	245
Antifungals: Topical Onychomycosis	200
DUR: Drug to Drug Interaction	195
Oxazolidinone Antibiotics	182
PDE-5 Inhibitorsfor Pulmunoary Hype	127
Movantik	113
Xenazine	57
Forteo	52
Tazorac	52
Fentanyl Mucosal Agents	48
Progesterone	44
CF Agents	29
PCSK9 Inhibitors	25
Regranex	25
Xiidra	18
Growth Hormones: 21 or Olde	16
Relistor	15
Daraprim	14
Acthar	12
MG: Generic Unavailable	11
Dose Optimization	10
Opioid/Buprenorphine TD	10
Viberzi	10
Pulmonary Fibrosis Agents	9
Pubertal Suppressants	8
Serostim	8
Cross-sex Hormones	7
Oral Pollen/Allergen Extracts	5
Xyrem	5
Hetlioz	3
Quinine	3
Metozolv	2
Juxtapid	1
Kynamro	1

8 – PDP Prior Authorizations by Class



Total PDP PAs = 99,777

Of the PAs issued in SFY 16/17, the following PDP drug classes are listed by the number of PAs requested:

Antipsychotics - Second Generation	20271	Insulin: Long Acting	305	Antibiotics: GI	64
Opioids - Short Acting	17797	Triptans	279	Inh. Long Acting Beta-2 Adrenergic	61
CNS Stimulants	7675	Multiple Sclerosis Agents	278	Selective Alpha Adrenergic Blockers	60
Anticonvulsants: 2nd Generation	6239	Cholesterol Absorption Inhibitors	262	Antivirals Oral	58
PPIs	5168	Anticoagulants: Injectable	261	Antifungals Oral	53
Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)	4871	Topical Steroids: High Potency	256	Otics: Quinolones	50
Opioids - Long Acting	3697	Carbamazepine Derivatives	246	Inhaled Corticosteroids	48
ARBs	2989	Ophthalmics: Prostaglandin Agonists	234	PAH Oral Agents - Other	47
Leukotriene Modifiers	2114	Steroids: Intranasal	207	Non-Ergot Dopamine Receptor Agonist	41
NSAIDs: Rx	1850	Acne Agents	206	Platelet Inhibitors	37
Antifungal: Topical	1678	Inhaled Antibiotics	203	Actinic Keratosis Agents	30
Other Agents for ADHD	1503	Topical Steroids: Low Potency	192	Ophthalmics: NSAIDs	29
ARB Combinations	1308	Thiazolidinediones	186	Ophthalmic Antibiotic/Steroid Combo	28
Hep C: Direct Acting Antivirals	1295	Ophthalmics: Antihistamines	180	Alpha-Glucosidase Inhibitors	25
DPP-4 Inhibitors	1261	Biguanides	175	Calcium Channel Blockers (DHP)	25
Urinary Tract Antispasmodics	1227	Topical Steroids: Medium Potency	173	Pancreatic Enzymes	24
Sedative Hypnotics	1133	Antihistamines: Nasal	169	Antiemetics	18
Inh. Short Acting Beta-2 Adrenergic	1111	Growth Hormones	168	Progestins	18
GLP-1 Agonist	1053	Tetracycline	164	Psoriasis Agents: Topical	18
Triglyceride Agents	963	Alzheimer's Agents	152	Benzodiazepines: Rectal	15
Antihistamines - 2nd Generation	816	Glucocorticoid: Oral	140	Antipsychotics: Injectable	14
Statins	777	Fluoroquinolones	138	Hepatitis B Agents	13
Selective Serotonin Reuptake Inhibitors (SSRIs)	722	Bisphosphonates	137	Insulin: Rapid Acting	10
Beta Blockers	681	Ophthalmics: Quinolones	137	Opioid Antagonists	10
Immunomodulators: Systemic	663	GI Prep Agents	129	ACE Combinations	9
Anticoagulants: Oral	642	Antivirals: Topical	118	Beta Blocker/Diuretic Combinations	7
Skeletal Muscle Relaxants	520	ACE Inhibitors	114	Hepatitis C Agents: Injectable	4
Opioid Dependence Agents	514	Inhaled Steroid/Beta2 LA Combo	111	Ophthalmics: Alpha-2 Adrenergics	4
SGLT2 Inhibitors	505	Antibiotics: Topical	96	Direct Renin Inhibitors	3
Phosphate Binders/Regulators	465	Xanthine Oxidase Inhibitors	96	H. Pylori Agents	3
Anticholinergics/COPD Agents	420	Meglitinides	95	Cystine Depleting Agents	2
Antiinfectives: Topical	408	Topical Steroids: Very High Potency	77	Amylin Analog	1
Erythropoiesis Stimulating Agents (ESAs)	408	Ophthalmics: Antibiotics	69	Niacin Derivatives	1
Sulfasalazine Derivatives	382	Alpha Reductase Inhibitor: BPH	67	Ophthalmics: Beta Blockers	1

9 – PDP and Diabetic Supply Cost Avoidance by County

County	PDP	Diabetic Supplies	Total	% Total
Albany	$297,799	$56,234	$354,033	-1.11%
Allegany	$55,879	$15,764	$71,643	-0.22%
Broome	$230,694	$33,372	$264,066	-0.83%
Cattaraugus	$102,059	$9,772	$111,830	-0.35%
Cayuga	$97,808	$12,906	$110,714	-0.35%
Chautauqua	$149,138	$18,437	$167,576	-0.52%
Chemung	$153,366	$28,854	$182,220	-0.57%
Chenango	$72,890	$22,586	$95,476	-0.30%
Clinton	$142,351	$32,634	$174,985	-0.55%
Columbia	$78,605	$9,680	$88,284	-0.28%
Cortland	$53,366	$4,794	$58,160	-0.18%
Delaware	$126,804	$32,542	$159,346	-0.50%
Dutchess	$274,134	$42,037	$316,171	-0.99%
Erie	$847,766	$248,259	$1,096,025	-3.43%
Essex	$49,608	$9,587	$59,196	-0.19%
Franklin	$128,487	$18,253	$146,740	-0.46%
Fulton	$88,617	$8,850	$97,467	-0.31%
Genesee	$65,069	$7,375	$72,444	-0.23%
Greene	$40,434	$5,716	$46,149	-0.14%
Hamilton	$3,343	$277	$3,619	-0.01%
Herkimer	$77,759	$26,181	$103,940	-0.33%
Jefferson	$181,446	$21,019	$202,465	-0.63%
Lewis	$34,335	$3,964	$38,299	-0.12%
Livingston	$56,216	$9,403	$65,619	-0.21%
Madison	$78,949	$8,389	$87,338	-0.27%
Monroe	$813,815	$204,286	$1,018,101	-3.19%
Montgomery	$59,496	$8,389	$67,885	-0.21%
Nassau	$844,338	$152,569	$996,907	-3.12%
Niagara	$199,444	$39,917	$239,360	-0.75%
Oneida	$296,727	$45,540	$342,267	-1.07%
Onondaga	$530,584	$92,924	$623,508	-1.95%
Ontario	$85,674	$4,886	$90,560	-0.28%
Orange	$332,972	$46,001	$378,973	-1.19%
Orleans	$47,550	$6,361	$53,910	-0.17%
Oswego	$111,226	$22,678	$133,904	-0.42%
Otsego	$90,621	$8,573	$99,195	-0.31%
Putnam	$37,130	$2,581	$39,711	-0.12%
Rensselaer	$149,154	$20,373	$169,527	-0.53%
Rockland	$320,556	$40,378	$360,934	-1.13%
St. Lawrence	$288,507	$46,646	$335,154	-1.05%
Saratoga	$151,080	$14,566	$165,645	-0.52%
Schenectady	$170,064	$45,725	$215,788	-0.68%
Schoharie	$28,628	$4,517	$33,146	-0.10%
Schuyler	$26,757	$2,212	$28,970	-0.09%
Seneca	$33,122	$5,255	$38,377	-0.12%
Steuben	$208,517	$32,265	$240,782	-0.75%
Suffolk	$1,113,407	$145,010	$1,258,417	-3.94%

County	PDP	Diabetic Supplies	Total	% Total
Sullivan	$120,995	$12,630	$133,625	-0.42%
Tioga	$73,062	$13,551	$86,614	-0.27%
Tompkins	$100,736	$9,864	$110,600	-0.35%
Ulster	$171,935	$21,940	$193,875	-0.61%
Warren	$100,673	$11,247	$111,920	-0.35%
Washington	$68,248	$6,084	$74,332	-0.23%
Wayne	$97,636	$17,884	$115,520	-0.36%
Westchester	$706,527	$184,927	$891,453	-2.79%
Wyoming	$66,236	$15,672	$81,908	-0.26%
Yates	$19,923	$3,595	$23,519	-0.07%
Sub Totals	$10,952,261	$1,975,930	$12,928,192	-40.49%
New York City	$16,508,383	$3,197,773	$19,706,156	58.64%
OMH	$350,876	$50,611	$401,486	1.19%
OMR	$406,950	$39,272	$446,222	1.33%
NYS DOH	$104,853	$18,714	$123,567	0.37%
Grand Total	**$28,323,324**	**$5,282,300**	**$33,605,623**	