ANNUAL REPORT TO THE
GOVERNOR AND LEGISLATURE

# New York State Medicaid Preferred Drug Program

STATE FISCAL YEAR
APRIL 1, 2017 – MARCH 31, 2018

**New York State Department of Health**
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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 institute 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 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 17/18. At the end of SFY 17/18 there were a total of 109 drug classes subject to the PDP and 23 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 twenty-three members, seventeen 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 is 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
- Two persons who are health care economists
- One person who is an actuary
- One person representing the NYS Department of Financial Services

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 corresponding legislation appears in Appendix 3.

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 17/18, the DURB reviewed the testimony from 34 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 17/18 appear in Appendix 4.

## *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 5), 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 17/18 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 17/18, the savings achieved by this program was $6,415,574.

Brand name drugs that were subject to this program at the end of SFY 17/18 include:

| | | |
|---|---|---|
| Adderall XR | Focalin XR | Tobradex suspension |
| Aggrenox | Fosrenol Chew tabs | Transderm-Scop |
| Alphagan P 0.15% | Gleevec | Trizivir |
| Butrans | Hepsera | Valcyte solution |
| Catapres-TTS | Kapvay | Vigamox |
| Cellcept suspension | Lexiva tablets | Voltaren Gel |
| Copaxone 20ml SQ | Pataday | Xeloda |
| Diastat | Protopic | Xenazine |
| Edecrin | Pulmicort Respules 1mg | Zyflo CR |
| Emend Tripack | Retin-A cream | |
| Exelon patch | **Reyataz capsules** | |
| Focalin | Tegretol suspension | |

## *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 the Medicaid fee-for-service program. 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 17/18, a total of 45,271 diabetic supply claims were processed achieving a non-federal gross savings through manufacturer rebates of $3,900,521. In the prior SFY, 60,313 diabetic supply claims were processed with a gross savings of $5,282,300. Diabetic supply rebates by county have been included in Appendix 10.

## *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 7.5 million electronic prior authorizations have been issued without prescriber involvement. For SFY 17/18, 1,201,254 automated PAs were issued without

prescriber involvement, representing over 91 percent of all prior authorizations. 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 17/18, the CCC received approximately 143,381 phone requests and 103,798 fax requests for prior authorization under the PDP and CDRP. Nearly all phone requests (99.99 percent) were completed during the initial call. In addition, the CCC provided approximately 68,993 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 22.10 percent of the PDP PAs processed in SFY 17/18. 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 17/18, there were 17 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 17/18, 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 7).

As previously mentioned, 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. After a review of claims from the targeted quarter, letters were generated and sent to the top 25 pharmacies identified as non-compliant with the BLTG program (those pharmacies with the highest utilization of generic agents when brand was preferred). This intervention letter provided information on the BLTG program and directed pharmacies to the current listing of drugs subject to BLTG requirements. Upon review, 8 of the originally identified top 25 non-compliant pharmacies from SFY 16/17 dropped off the list in SFY 17/18, and only 2 of the originally identified pharmacies had an increase in non-compliant claims, all other pharmacies had a reduction in non-compliant claims.

# 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. Sixteen complaints about the PDP and CDRP were received during SFY 17/18, primarily via phone calls. Nine fewer complaints were received in SFY 17/18 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 Criteria** | 1 |
| **Retail Rx Issue** | 1 |
| **PA Requirements** | 1 |
| **Other** | 2 |
| **Customer Service Pharmacy** | 3 |
| **PA/Utilization Management Issue** | 3 |
| **Benefit Plan Issue** | 5 |
| Total | 16 |

The DOH Medicaid pharmacy staff responds to inquiries related to policy. These inquiries are also used to identify providers who may need additional program education. Medicaid's Helpline for members received 28 policy related calls, which were referred to and handled by the DOH Medicaid pharmacy staff.

# 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 manufacturers 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 17/18 the NMPI includes more than 80 participating manufacturers and has approximately 6.1 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 11.9 million pharmacy claims in SFY 17/18. Of these, 34 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 17/18 60.4 percent of claims were for drugs that did not require prior authorization. The remaining 39.6 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 135,074 prior authorizations processed for all pharmacy programs.

Under the PDP, the highest volume of requests for prior authorizations during SFY 17/18 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 (15 percent), used to treat moderate to severe pain; CNS Stimulants (11 percent), primarily used to treat ADHD; second generation

anticonvulsants (6 percent), used primarily to treat seizure disorders and SNRIs (5 percent), used to treat a variety of conditions including depression, fibromyalgia and diabetic peripheral neuropathy. Requests for prior authorization for Hepatitis C Agents made up 0.8 percent of prior authorizations for SFY 17/18.

Consistent with the experience in SFY 16/17, 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, 3 percent of the total requests resulted in the prescriber agreeing to use the preferred drug in lieu of a non-preferred drug. The CCC representatives have continued to promote the use of preferred agents as clinically appropriate, attributing to the relative changes observed. 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 17/18, total PDP savings were approximately $9.5 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 10 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 17/18, a total of 9,063 requests were approved for PA of drugs under the CDRP as follows:

- **Anabolic Steroids:** 478
- **CNS Stimulants: 18 or Older:** 5,754
- **Fentanyl Mucosal Agents:** 37
- **Growth Hormones: 21 or Older:** 25
- **Immunomodulators: Topical**: 290
- **Lidoderm®:** 433
- **Phosphodiesterase type-5 (PDE-5) Inhibitors for PAH:** 131
- **Regranex®**: 14
- **Serostim®:** 5
- **Synagis®:** 341
- **Truvada®:** 1,378
- **Xyrem®:** 4
- **Oxazolidinone Antibiotics®:** 173

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

# VI. Conclusion

The twelfth 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 17/18, the DURB re-reviewed 23 classes of drugs in the PDP to include drugs recently approved by the FDA and newly available clinical and financial information. Two new drug classes were reviewed for inclusion on the PDP. By the end of SFY 17/18 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 17/18.

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

Health Care Economists
20. Casey Quinn, PhD
21. Jill Lavigne, PhD, MS, MPH

Actuary
22. Peter Lopatka, FSA

NYS Department of Financial Services
23. Maria Vullo, JD, MPA, BA

# *3 – Title 11-C, Section 369-BB Drug Utilization Review Board Legislation*

§ 369-bb. Drug utilization review board. 1. A twenty-three-member drug utilization review board is hereby created in the department. The board is responsible for the establishment and implementation of medical standards and criteria for the retrospective and prospective DUR program.

2. The members of the DUR board shall be appointed by the commissioner and shall serve a three-year term. Members may be reappointed upon the completion of other terms. The membership shall be comprised of the following:

(a) Six persons licensed and actively engaged in the practice of medicine in the state, with expertise in the areas of mental health, HIV/AIDS, geriatrics, pediatrics or internal medicine and who may be selected based on input from professional associations and/or advocacy groups in New York state.

(b) Six persons licensed and actively practicing in pharmacy in the state who may be selected based on input from professional associations and/or advocacy groups in New York state.

(c) Two persons with expertise in drug utilization review who are health care professionals licensed under Title VIII of the education law at least one of whom is a pharmacologist.

(d) Three persons that are 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.

(e) One person licensed and actively practicing as a nurse practitioner or midwife.

(f) Two persons who are health care economists.

(g) One person who is an actuary.

(h) One person representing the department of financial services.

(i) The commissioner shall designate a person from the department to serve as chairperson of the board.

3. The appointed members to the board, or its agents shall have no sanctions against them by medicare or medicaid.

4. The appointments to this board shall be made so that the length of the terms are staggered. In making the appointments, the commissioner shall consider geographic balance in the representation on the board.

5. (a) The functions, powers and duties of the former pharmacy and therapeutics committee as established in article two-A of the public health law shall now be considered a function of the drug utilization review board, including but not limited to:

(i) conducting an executive session for the purpose of receiving and evaluating drug pricing information related to supplemental rebates, or receiving and evaluating trade secrets, or other information which, if disclosed, would cause substantial injury to the competitive position of the manufacturer; and

(ii) evaluating and providing recommendations to the commissioner of health on other issues relating to pharmacy services under Medicaid or EPIC, including, but not limited to: therapeutic comparisons; enhanced use of generic drug products; enhanced targeting of physician prescribing patterns; and

(iii) collaborating 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.

(b) Any business or other matter undertaken or commenced by the

pharmacy and therapeutics committee pertaining to or connected with the functions, powers, obligations and duties are hereby transferred and assigned to the drug utilization review board and pending on the effective date of this subdivision, may be conducted and completed by the drug utilization review board in the same manner and under the same terms and conditions and with the same effect as if conducted and completed by the pharmacy and therapeutics committee. All books, papers, and property of the pharmacy and therapeutics committee shall continue to be maintained by the drug utilization review board.

(c) All rules, regulations, acts, orders, determinations, and decisions of the pharmacy and therapeutics committee pertaining to the functions and powers herein transferred and assigned, in force at the time of such transfer and assumption, shall continue in full force and effect as rules, regulations, acts, orders, determinations and decisions of the drug utilization review board until duly modified or abrogated by the commissioner of health.

6. Members of the DUR utilization review board and all its employees and agents shall be deemed to be an "employee" for purposes of section seventeen of the public officers law.

7. The department shall provide administrative support to the DUR board.

8. The duties of the DUR board are as follows:

(a) The development and application of the predetermined criteria and standards to be used in retrospective and prospective DUR that ensure that such criteria and standards are based on the compendia and that they are developed with professional input in a consensus fashion with provisions for timely revisions and assessments as necessary. Further, that the DUR standards shall reflect the appropriate practices of physicians in order to monitor:

(i) Therapeutic appropriateness;

(ii) Overutilization or underutilization;

(iii) Therapeutic duplication;

(iv) Drug-disease contraindications;

(v) Drug-drug interactions;

(vi) Incorrect drug dosage or duration of drug treatment; and

(vii) Clinical abuse/misuse.

(b) The development, selection, application, and assessment of interventions or remedial strategies for physicians, pharmacists, and recipients that are educational and not punitive in nature to improve the quality of care including:

(i) Information disseminated to physicians and pharmacists to ensure that physicians and pharmacists are aware of the board's duties and powers;

(ii) Written, oral, or electronic reminders of patient-specific or drug-specific information that are designed to ensure recipient, physician, and pharmacist confidentiality, and suggested changes in the prescribing or dispensing practices designed to improve the quality of care;

(iii) Use of face-to-face discussions between experts in drug therapy and the prescriber or pharmacist who has been targeted for educational intervention;

(iv) Intensified reviews or monitoring of selected prescribers or pharmacists;

(v) The creation of an educational program using data provided through DUR to provide for active and ongoing educational outreach programs to improve prescribing and dispensing practices as provided in this subdivision. (This may be done directly or through contract with other entities);

(vi) The timely evaluation of interventions to determine if the

interventions have improved the quality of care; and

(vii) The review of case profiles prior to the conducting of an intervention.

(c) The publication of an annual report which shall be subject to the department's comment prior to its issuance to the federal department of health and human services by December first of each year. The annual report also shall be submitted to the governor and the legislature before December first of each year. The report shall include the following information:

(i) A description of the activities of the board, including the nature and scope of the prospective and retrospective drug use review programs;

(ii) A summary of the interventions used;

(iii) An assessment of the impact of these educational interventions in quality of care;

(iv) An estimate of the cost savings generated as a result of such program; and

(v) Recommendations for program improvement.

(d) The development of a working agreement for the DUR board with related boards or agencies, including, but not limited to: the board of pharmacy, the board of medicine, the SURS staff, and staff of the department of health and the office of mental health, in order to clarify the areas of responsibility for each where such areas may overlap.

(e) The establishment of a process where physicians or pharmacists will have the opportunity to submit responses to the DUR educational letters.

(f) The publication and dissemination of educational information to physicians and pharmacists on the DUR board and the DUR program to include information on:

(i) Identifying and reducing the frequency of patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacists, and recipients;

(ii) Potential or actual severe/adverse reactions to drugs;

(iii) Therapeutic appropriateness;

(iv) Overutilization or underutilization;

(v) Appropriate use of generics;

(vi) Therapeutic duplication;

(vii) Drug-disease contraindications;

(viii) Drug-drug interactions;

(ix) Incorrect drug dosage/duration of drug treatments;

(x) Drug allergy interactions; and

(xi) Clinical abuse/misuse.

(g) The evaluation of specific drugs submitted to the board for review pursuant to section two hundred eighty of the public health law, and the formulation of recommended target supplemental rebates, in accordance with the standards established in such section.

(h) The adoption and implementation of procedures designed to ensure the confidentiality of any information collected, stored, retrieved, assessed or analyzed by the DUR board, staff to the board, or contractors to the DUR program, that identifies individual physicians, pharmacists, or recipients. The board may have access to identifying information for purposes of carrying out intervention activities, but such identifying information may not be released to anyone other than a member of the DUR board or the department and its agents.

(i) The improper release of identifying information in violation of this article may subject that person to criminal or civil penalties.

(j) The board may release cumulative non-identifying information for purposes of legitimate research.

9. The relationship of the DUR board to the department is as follows:

(a) The department shall monitor the DUR board's compliance to federal and state statute and regulation.

(b) The DUR board shall serve at the discretion of the commissioner.

(c) The department shall have authority on all fiscal matters relating to the DUR program.

(d) The department shall have authority on all administrative matters relating to the administration of the medical assistance program within the DUR program.

(e) The DUR board shall have responsibility for all medical matters relating to the DUR program.

(f) The DUR board may utilize medical consultants and review committees as necessary, subject to department approval.

# *4 – Drug Classes in the Preferred Drug Program (as of March 2018)*

The following table lists drug classes that were reviewed at the DURB during SFY 17/18. 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, 2017 | ANGIOTENSIN CONVERTING ENZYME INHIBITORS (ACEIs) | May 26, 2017 | June 22, 2017 |
| April 27, 2017 | ANTICOAGULANTS: ORAL | May 26, 2017 | June 22, 2017 |
| April 27, 2017 | ANTICHOLINERGICS: RESPIRATORY | May 26, 2017 | June 22, 2017 |
| April 27, 2017 | ANTICONVULSANTS SECOND GENERATION | May 26, 2017 | June 22, 2017 |
| October 19, 2017 | ANTI-EMITCS: ORAL | November 24, 2017 | December 14, 2017 |
| April 27, 2017 | ANTIFUNGALS: TOPICAL | May 26, 2017 | June 22, 2017 |
| April 27, 2017 | ANTI-INFECTIVES: TOPICAL | May 26, 2017 | June 22, 2017 |
| April 27, 2017 | ANTIPSYCHOTICS: SECOND GENERATION | May 26, 2017 | June 22, 2017 |
| April 27, 2017 | CNS STIMULANTS | May 26, 2017 | June 22, 2017 |
| April 27, 2017 | CORTICOSTEROIDS/LABA COMBINATIONS - INHALED | May 26, 2017 | June 22, 2017 |
| April 27, 2017 | CORTICOSTEROIDS- INTRANASAL | May 26, 2017 | June 22, 2017 |
| April 27, 2017 | EPINEPHRINE, SELF-INJECTED | May 26, 2017 | June 22, 2017 |
| April 27, 2017 | GLP-1 RECEPTOR AGONISTS | May 26, 2017 | June 22, 2017 |
| October 19, 2017 | GLUCOCORTICOIDS - ORAL | November 24, 2017 | December 14, 2017 |
| October 19, 2017 | HEPATITIS B AGENTS | November 24, 2017 | December 14, 2017 |
| October 19, 2017 | HEPATITIS C – DIRECT ACTING ANTIVIRALS | November 24, 2017 | December 14, 2017 |
| April 27, 2017 | INSULINS: LONG ACTING | May 26, 2017 | June 22, 2017 |
| April 27, 2017 | MULTIPLE SCLEROSIS AGENTS | May 26, 2017 | June 22, 2017 |
| April 27, 2017 | NSAIDS: OPHTHALMIC | May 26, 2017 | June 22, 2017 |
| April 27, 2017 | OPIATES: LONG ACTING | May 26, 2017 | June 22, 2017 |
| April 27, 2017 | PHOSPHATE BINDERS/REGULATORS | May 26, 2017 | June 22, 2017 |
| April 27, 2017 | PLATELET INHIBITORS | May 26, 2017 | June 22, 2017 |
| April 27, 2017 | QUINOLONES: OTIC | May 26, 2017 | June 22, 2017 |
| April 27, 2017 | SGLT2 INHIBITORS | May 26, 2017 | June 22, 2017 |
| April 27, 2017 | STATINS | May 26, 2017 | June 22, 2017 |

# *5 – Preferred and Non-Preferred Drug List (as of March 2018)*

Revised:February 22, 2018

## 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: February 22, 2018

# NYS Medicaid Fee-For-Service Preferred Drug List

## PREFERRED DRUG LIST – TABLE OF CONTENTS

Revised: February 22, 2018

# 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<br>ibuprofen<br>indomethacin<br>ketorolac<br>meloxicam (tablet)<br>naproxen<br>naproxen EC<br>piroxicam<br>sulindac<br>Voltaren® Gel | Anaprox® DS<br>Arthrotec®<br>Cambia®<br>Celebrex® CC<br>celecoxib CC<br>Daypro®<br>diclofenac / misoprostol<br>diclofenac potassium<br>diclofenac sodium<br>diclofenac topical gel<br>diclofenac topical soln<br>diflunisal<br>Duexis®<br>etodolac<br>etodolac ER<br>Feldene®<br>fenoprofen<br>Flector® patch<br>flurbiprofen<br>Indocin®<br>indomethacin SR<br>ketoprofen<br>ketoprofen SA<br>meclofenamate<br>mefenamic acid<br>meloxicam (susp.)<br>Mobic®<br>nabumetone<br>Nalfon®<br>Naprelan®<br>Naprosyn®<br>Naprosyn® EC<br>naproxen CR<br>naproxen sodium<br>oxaprozin<br>Pennsaid®<br>Ponstel®<br>Tivorbex®<br>tolmetin<br>Vimovo®<br>Vivlodex™<br>Voltaren® XR<br>Zipsor®<br>Zorvolex® | **CLINICAL CRITERIA (CC)**<br>➢ Celebrex® (celecoxib) – one of the following criteria will not require PA<br>▪ Over the age of 65 years<br>▪ Concurrent use of an anticoagulant agent<br>▪ History of GI Bleed/Ulcer or Peptic Ulcer Disease |
| **Opioid Antagonists** | | |
| naloxone (syringe, vial)<br>naltrexone<br>Narcan® (nasal spray)<br>ReVia® | | |
| **Opioid Dependence Agents** CC, F/Q/D | | |
| buprenorphine<br>Suboxone® (film) | Bunavail®<br>buprenorphine/ naloxone (tablet)<br>Zubsolv® | **CLINICAL CRITERIA (CC)**<br>➢ PA required for initiation of opioid therapy for patients on established buprenorphine opioid dependence therapy<br>**QUANTITY LIMIT**:<br>➢ Buprenorphine sublingual (SL): Six (6) tablets dispensed as a 2-day supply; not to exceed 24 mg per day<br>➢ 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 its equivalent per day |

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Revised: February 22, 2018

# 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®<br>Embeda®<br>fentanyl patch (12 mcg, 25 mcg, 50 mcg, 75 mcg, 100 mcg)<br>morphine sulfate SR (tablet) | Arymo™ ER<br>Belbuca™<br>buprenorphine patches<br>Conzip® ST<br>Duragesic®<br>Exalgo®<br>fentanyl patch (37.5 mcg, 62.5 mcg, 87.5 mcg)<br>hydromorphone ER<br>Hysingla® ER<br>Kadian®<br>MorphaBond™ ER<br>morphine ER (capsule) (generic for Avinza)<br>morphine ER (capsule) (generic for Kadian)<br>MS Contin®<br>Nucynta® ER ST<br>Opana®<br>oxycodone ER<br>Oxycontin®<br>oxymorphone ER<br>tramadol ER ST<br>Xtampza™ ER<br>Zohydro® ER | **CLINICAL CRITERIA (CC)**<br>➢ Limited to a total of four (4) opioid prescriptions every 30 days; Exemption for diagnosis of cancer or sickle cell disease<br>➢ PA required for initiation of opioid therapy for patients on established buprenorphine opioid dependence therapy<br>➢ PA required for initiation of long-acting opioid therapy in opioid-naïve patients.<br>▪ Exception for diagnosis of cancer or sickle cell disease.<br>➢ PA required for any additional long-acting opioid prescription for patients currently on long-acting opioid therapy.<br>▪ Exception for diagnosis of cancer or sickle cell disease.<br>➢ PA required for initiation of opioid therapy in patients currently on benzodiazepine therapy<br>**STEP THERAPY (ST)**<br>➢ Nucynta® ER (tapentadol ER): Trial with tapentadol IR before tapentadol ER for patients who are naïve to a long-acting opioid<br>➢ Tramadol ER (tramadol naïve patients): Attempt treatment with IR formulations before the following ER formulations: Conzip®, tramadol ER<br>**FREQUENCY/QUANTITY/DURATION (F/Q/D) - Exemption for diagnosis of cancer or sickle cell disease**<br>➢ Belbuca™ (buprenorphine)<br>▪ Maximum 2 (two) units per day<br>➢ Butrans® (buprenorphine)<br>▪ Maximum 4 patches per 28 days<br>➢ Embeda® (morphine ER/naltrexone):<br>▪ Maximum 2 (two) units per day<br>➢ Nucynta® ER (tapentadol ER):<br>▪ Maximum 2 (two) units per day<br>➢ Nucynta® ER (tapentadol ER):<br>▪ Maximum daily dose of tapentadol IR and tapentadol ER formulations if used in combination should not exceed 500mg/day<br>➢ Tramadol ER (Conzip®):<br>▪ Maximum 30 tablets dispensed as a 30-day supply<br>➢ Zohydro ER (hydrocodone ER):<br>▪ Maximum 2 (two) units per day, 60 units per 30 days<br>➢ Hysingla™ ER (hydrocodone ER):<br>▪ Maximum 1 (one) unit per day; 30 units per 30 days<br>➢ Hydromorphone ER, oxymorphone ER:<br>▪ Maximum 4 (four) units per day, 120 units per 30 days<br>➢ Oxycodone ER (Xtampza ER™):<br>▪ Maximum 2 (two) units per day, 60 units per 30 days. Not to exceed a total daily dose of 160mg or its equivalent<br>➢ Fentanyl transdermal patch (Duragesic®):<br>▪ Maximum 10 patches per 30 days; maximum 100mcg/hr (over a 72 hour dosing interval)<br>➢ Morphine ER (excluding MS Contin products):<br>▪ Maximum 2 (two) units per day, 60 units per 30 days<br>➢ Morphine ER (MS Contin & Arymo™ ER 15mg, 30mg, 60mg only):<br>▪ Maximum 3 (three) units per day, 90 units per 30 days<br>➢ Morphine ER (MS Contin 100mg only):<br>▪ Maximum 4 units per day, up to 3 times a day, maximum 120 units per 30 days<br>➢ Morphine ER (MS Contin 200mg only):<br>▪ Maximum 2 units per day, maximum 60 units per 30 days |

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# 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]<br>codeine [F/Q/D]<br>codeine / APAP [F/Q/D]<br>hydrocodone / APAP [F/Q/D]<br>hydrocodone / ibuprofen [F/Q/D]<br>Lortab® (elixir) [F/Q/D]<br>morphine IR [F/Q/D]<br>oxycodone / APAP [F/Q/D]<br>Reprexain® [F/Q/D]<br>tramadol<br>Verdrocet™ [F/Q/D]<br>Xylon™ [F/Q/D] | butalbital compound/ codeine [F/Q/D]<br>butorphanol nasal spray<br>Demerol®<br>dihydrocodeine / aspirin / caffeine [F/Q/D]<br>dihydrocodeine / APAP / caffeine [F/Q/D]<br>Dilaudid® [F/Q/D]<br>Fioricet® / codeine [F/Q/D]<br>Fiorinal® / codeine [F/Q/D]<br>hydromorphone [F/Q/D]<br>Ibudone® [F/Q/D]<br>levorphanol<br>meperidine<br>Nucynta® ST, [F/Q/D]<br>Opana® [F/Q/D]<br>oxycodone [F/Q/D]<br>oxycodone / aspirin [F/Q/D]<br>oxycodone / ibuprofen [F/Q/D]<br>oxymorphone [F/Q/D]<br>pentazocine / naloxone<br>Percocet® [F/Q/D]<br>Primlev™ [F/Q/D]<br>Roxicodone® [F/Q/D]<br>Synalgos® DC [F/Q/D]<br>tramadol / APAP [F/Q/D]<br>Tylenol® / codeine #3 [F/Q/D]<br>Tylenol® / codeine #4 [F/Q/D]<br>Ultracet® [F/Q/D]<br>Ultram®<br>Xartemis® XR [F/Q/D]<br>Xodol® [F/Q/D]<br>Zamicet® [F/Q/D] | **CLINICAL CRITERIA (CC)**<br>➢ Limited to a total of four (4) opioid prescriptions every 30 days.<br>▪ Exception for diagnosis of cancer or sickle cell disease<br>➢ Initial prescription for opioid-naïve patients limited to a 7-day supply.<br>▪ Exception for diagnosis of cancer or sickle cell disease<br>➢ PA required for initiation of opioid therapy for patients on established buprenorphine opioid dependence therapy<br>➢ PA required for initiation of opioid therapy in patients currently on benzodiazepine therapy<br>**STEP THERAPY (ST)**<br>➢ Nucynta® (tapentadol IR) – Trial with tramadol and one (1) preferred opioid before tapentadol immediate-release (IR)<br>**FREQUENCY/QUANTITY/DURATION (F/Q/D)**<br>**Quantity Limits**:<br>➢ Nucynta® (tapentadol IR):<br>▪ Maximum 6 (six) units per day; 180 units per 30 days<br>➢ Nucynta® (tapentadol IR):<br>▪ Maximum daily dose of tapentadol IR and tapentadol ER formulations used in combination not to exceed 500mg/day<br>➢ Morphine and congeners immediate-release (IR) non-combination products (codeine, hydromorphone, morphine, oxycodone, oxymorphone):<br>▪ Maximum 6 (six) units per day, 180 (one hundred eighty) units per 30 (thirty) days<br>➢ Xartemis® XR (oxycodone/acetaminophen):<br>▪ Maximum 4 (four) units per day, 120 (one hundred twenty) units per 30 (thirty) days<br>Additional/alternate parameters: To be applied to patients without a documented cancer or sickle cell diagnosis<br>➢ Morphine and congeners immediate-release (IR) combination products maximum recommended:<br>▪ acetaminophen (4 grams)<br>▪ aspirin (4 grams)<br>▪ ibuprofen (3.2 grams)<br>▪ or the FDA-approved maximum opioid dosage as listed in the PI, whichever is less<br>**Duration Limits**:<br>▪ 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®<br>Cayston® | Kitabis® Pak | TOBI Podhaler™<br>TOBI® (solution) | tobramycin (solution) | **CLINICAL CRITERIA (CC)**<br>Confirm diagnosis of FDA-approved or compendia-supported indication<br>**FREQUENCY/QUANTITY/DURATION (F/Q/D)**<br>➢ Aztreonam (Cayston)<br>▪ 3 (three) ampules (3mL) per day<br>▪ 84 ampules (84 mL) per 56 day regimen (28 days on, 28 days off)<br>➢ Tobramycin inhalation solution (Bethkis, TOBI, Kitabis)<br>▪ 2 (two) ampules (8 mL Bethkis, 10 mL TOBI, Kitabis Pak) per day<br>▪ 56 ampules (224 mL Bethkis, 280 mL TOBI, Kitabis Pak) per 56 day regimen (28 days on-28 days off)<br>➢ Tobramycin capsules with inhalation powder (TOBI Podhaler)<br>▪ 8 capsules per day 224 capsules per 56 day regimen (28 days on-28 days off) |
| **Anti-Fungals – Oral for Onychomycosis** | | | | |
| griseofulvin (suspension)<br>griseofulvin ultramicronized<br>terbinafine (tablet) | | Gris-PEG®<br>griseofulvin micronized (tablet)<br>itraconazole<br>Lamisil® (tablet)<br>Omnel®<br>Sporanox® | | |
| **Anti-Virals – Oral** | | | | |
| acyclovir<br>valacyclovir | | famciclovir<br>Famvir® | Valtrex®<br>Zovirax® | |
| **Cephalosporins – Third Generation** | | | | |
| cefdinir<br>cefixime | cefpodoxime<br>Suprax® | Cedax® | ceftibuten | |
| **Fluoroquinolones – Oral** | | | | |
| Cipro® (suspension)<br>ciprofloxacin (suspension, tablet)<br>levofloxacin (tablet) | | Avelox®<br>Avelox ABC Pack®<br>Cipro® (tablet)<br>Cipro® XR<br>ciprofloxacin ER | Levaquin®<br>levofloxacin (solution)<br>moxifloxacin<br>ofloxacin (tablet) | |
| **Hepatitis B Agents** | | | | |
| Baraclude® (solution)<br>entecavir<br>Epivir-HBV® (solution) | Hepsera®<br>lamivudine 100mg | adefovir dipivoxil<br>Baraclude® (tablet) | Epivir-HBV® (tablet)<br>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®<br>PegIntron® | None | **FREQUENCY/QUANTITY/DURATION (F/Q/D)**<br>➢ 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.<br>➢ Further documentation required for continuation of therapy at weeks 14 and 26.<br>➢ 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.<br>➢ After 24 weeks of therapy obtain a HCV RNA. Continuation for genotype 1 and 4 is supported if undetectable HCV RNA.<br>▪ Maximum duration of 48 weeks for:<br>❖ Treatment-naïve patients or prior relapsers with cirrhosis and HIV co-infection<br>❖ 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® CC, F/Q/D<br>Mavyret™ 1 CC, F/Q/D<br>ribavirin<br>Vosevi® 1 CC, F/Q/D | Daklinza™ CC, F/Q/D<br>Harvoni® 2, CC, F/Q/D<br>Moderiba™<br>Olysio® CC, F/Q/D<br>Rebetol®<br>Ribasphere®<br>Sovaldi® CC, F/Q/D<br>Technivie® 2, CC, F/Q/D<br>Viekira Pak® 2, CC, F/Q/D<br>Viekira XR™ 2, CC, F/Q/D<br>Zepatier™ 2, CC, F/Q/D | **CLINICAL CRITERIA (CC)**<br>➢ Confirm diagnosis of FDA-approved or compendia-supported indication<br>➢ Require confirmation of prescriber experience and training<br>▪ 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**<br>▪ 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**<br>▪ 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.<br>➢ Require confirmation of patient readiness and adherence<br>▪ 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/.<br>Click here to access the Hepatitis C Worksheet 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<br>doxycycline hyclate<br>minocycline (capsule)<br>Morgidox® (capsule)<br>tetracycline | Doryx® ST, F/Q/D<br>Doryx MPC® ST, F/Q/D<br>doxycycline hyclate DR ST, F/Q/D<br>doxycycline monohydrate<br>doxycycline monohydrate IR-DR<br>minocycline (tablet)<br>minocycline ER<br>Mondoxyne™<br>Oracea®<br>Solodyn®<br>Vibramycin®<br>Ximino™ ER | **STEP THERAPY (ST)**<br>➢ Trial of doxycycline IR before progressing to doxycycline DR<br>**FREQUENCY/QUANTITY/DURATION (F/Q/D)**<br>➢ doxycycline DR (Doryx®):<br>▪ Maximum 28 tablets/capsules per fill |
| **III. CARDIOVASCULAR** | | |
| **Angiotensin Converting Enzyme Inhibitors (ACEIs)** | | |
| benazepril<br>enalapril<br>lisinopril<br>ramipril | Accupril®<br>Altace®<br>captopril<br>Epaned™<br>fosinopril<br>Lotensin®<br>Mavik®<br>moexipril<br>perindopril<br>Prinivil®<br>Qbrelis™<br>quinapril<br>trandolapril<br>Vasotec®<br>Zestril® | |
| **ACE Inhibitor Combinations** | | |
| benazepril/ amlodipine<br>benazepril/ HCTZ<br>captopril/ HCTZ<br>enalapril/ HCTZ<br>lisinopril/ HCTZ<br>Lotrel<br>moexipril/ HCTZ<br>Tarka®<br>trandolapril/ verapamil ER | Accuretic®<br>fosinopril/ HCTZ<br>Lotensin HCT®<br>Prestalia®<br>quinapril/ HCTZ<br>Vaseretic®<br>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)** | | |
| Diovan® DO<br>losartan<br>valsartan | Atacand®<br>Avapro®<br>Benicar® DO<br>candesartan<br>Cozaar®<br>Edarbi™<br>eprosartan<br>irbesartan<br>Micardis® DO<br>olmesartan<br>telmisartan | **DOSE OPTIMIZATION (DO)**<br>➢ See Dose Optimization Chart for affected drugs and strengths |
| **ARBs Combinations** | | |
| Exforge HCT®<br>losartan/ HCTZ<br>valsartan/ amlodipine<br>valsartan/ amlodipine / HCTZ<br>valsartan/ HCTZ | Atacand HCT®<br>Avalide®<br>Azor®<br>Benicar HCT® DO<br>Byvalson™<br>candesartan/ HCTZ<br>Diovan HCT® DO<br>Edarbyclor™ DO<br>Entresto™ CC<br>Exforge® DO<br>Hyzaar®<br>irbesartan/ HCTZ<br>Micardis HCT® DO<br>olmesartan/ amlodipine<br>olmesartan/ amlodipine/ HCTZ<br>olmesartan/ HCTZ<br>telmisartan/ amlodipine<br>telmisartan/ HCTZ<br>Tribenzor®<br>Twynsta® | **CLINICAL CRITERIA (CC)**<br>➢ 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<br>**DOSE OPTIMIZATION (DO)**<br>➢ 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** | | | | |
| atenolol<br>carvedilol<br>labetalol<br>metoprolol succ. XL<br>metoprolol tartrate<br>propranolol (tablet) | | acebutolol<br>betaxolol<br>bisoprolol<br>Bystolic® DO<br>carvedilol ER<br>Coreg®<br>Coreg CR® DO<br>Corgard®<br>Inderal LA®<br>Inderal XL®<br>InnoPran XL®<br>Levatol® | Lopressor®<br>nadolol DO<br>pindolol<br>propranolol (solution)<br>propranolol ER/SA<br>Sectral®<br>Tenormin®<br>timolol<br>Toprol XL® DO<br>Zebeta® | **DOSE OPTIMIZATION (DO)**<br>➢ See Dose Optimization Chart for affected drugs and strengths |
| **Beta Blockers / Diuretics** | | | | |
| atenolol/ chlorthalidone<br>bisoprolol/ HCTZ<br>propranolol/ HCTZ | | Corzide®<br>Dutoprol™<br>Lopressor HCT®<br>metoprolol ER/ HCTZ<br>metoprolol tartrate/ HCTZ<br>nadolol/ bendroflumethiazide<br>Tenoretic®<br>Ziac® | | |
| **Calcium Channel Blockers (Dihydropyridine)** | | | | |
| Afeditab CR®<br>amlodipine<br>felodipine ER<br>isradipine | nicardipine HCl<br>Nifedical XL®<br>nifedipine<br>nifedipine ER/SA | Adalat® CC<br>nisoldipine<br>Norvasc® | Procardia®<br>Procardia XL®<br>Sular® | |
| **Cholesterol Absorption Inhibitors** | | | | |
| cholestyramine<br>cholestyramine light<br>Colestid® (tablet) | colestipol (tablet)<br>Prevalite® | Colestid (granules)<br>colestipol (granules)<br>ezetimibe<br>Questran® | Questran Light®<br>Welchol®<br>Zetia® | |
| **Direct Renin Inhibitors ST** | | | | |
| Tekturna® | Tekturna HCT® | None | | **STEP THERAPY (ST)**<br>➢ Trial of product containing either an ACE inhibitor or an ARB prior to initiating preferred DRI |

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# NYS Medicaid Fee-For-Service Preferred Drug List

| Preferred Drugs | | Non-Preferred Drugs | | Prior Authorization/Coverage Parameters |
|---|---|---|---|---|
| **HMG-CoA Reductase Inhibitors (Statins)** | | | | |
| atorvastatin<br>lovastatin<br>pravastatin | rosuvastatin<br>simvastatin | Altoprev®<br>atorvastatin/amlodipine<br>Caduet®<br>Crestor® DO<br>ezetimibe/simvastatin<br>fluvastatin<br>fluvastatin ER | Lescol XL®<br>Lipitor®<br>Livalo®<br>Pravachol®<br>Vytorin®<br>Zocor® | **DOSE OPTIMIZATION (DO)**<br>➢ See Dose Optimization Chart for affected drugs and strengths |
| **Niacin Derivatives** | | | | |
| niacin ER | | Niaspan® DO | | **DOSE OPTIMIZATION (DO)**<br>➢ See Dose Optimization Chart for affected drugs and strengths |
| **Phosphodiesterase type-5 (PDE-5) Inhibitors for PAH CDRP** | | | | |
| Adcirca® | sildenafil | Revatio® | | **CLINICAL DRUG REVIEW PROGRAM (CDRP)**<br>➢ All prescriptions for Adcirca®, Revatio®, and sildenafil must have PA<br>➢ Prescribers are required to respond to a series of questions that identify prescriber, patient and reason for prescribing drug<br>➢ Please be prepared to fax clinical documentation upon request<br>➢ Prescriptions can be written for a 30-day supply with up to 5 refills<br>➢ 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®<br>Orenitram® | Tracleer® | Adempas®<br>Opsumit® | Tracleer® tabs for suspension<br>Uptravi® | |

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|---|---|---|
| **Triglyceride Lowering Agents** | | |
| gemfibrozil<br>fenofibrate (48 mg, 145 mg)<br>fenofibric acid | Antara®<br>fenofibrate<br>Fenoglide®<br>Fibricor®<br>Lipofen®<br>Lofibra®<br>Lopid®<br>Lovaza® ST, F/Q/D<br>omega-3 ethyl ester ST, F/Q/D<br>Tricor®<br>Triglide®<br>Trilipix®<br>Vascepa® ST, F/Q/D | **STEP THERAPY (ST)**<br>➢ 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<br>**FREQUENCY/QUANTITY/DURATION (F/Q/D)**<br>➢ Lovaza® (omega-3-acid ethyl-esters) and Vascepa® (icosapent ethyl) – Required dosage equal to 4 (four) units per day |

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|---|---|---|---|
| **IV. CENTRAL NERVOUS SYSTEM** | | | |
| **Alzheimer's Agents** | | | |
| donepezil 5mg, 10mg<br>Exelon® (patch)<br>galantamine<br>galantamine ER<br>memantine<br>Namenda®<br>rivastigmine (capsule) | Aricept®<br>donepezil 23 mg<br>Exelon® (capsule)<br>Namenda XR® CC, ST | Namzaric® CC, ST<br>rivastigmine (patch)<br>Razadyne®<br>Razadyne ER® | **CLINICAL CRITERIA (CC)**<br>➢ Memantine extended-release containing products(Namenda XR™ and Namzaric™) – Require confirmation of diagnosis of dementia or Alzheimer's disease<br>**STEP THERAPY (ST)**<br>➢ Memantine extended-release containing products (Namenda XR™ and Namzaric™) – Require trial with memantine immediate-release (Namenda®) |
| **Anticonvulsants – Second Generation** CC | | | |
| gabapentin (capsule, solution) F/Q/D<br>lamotrigine (tablet)<br>levetiracetam<br>levetiracetam ER<br>Lyrica® (capsule) DO, ST<br>tiagabine<br>topiramate<br>zonisamide | Banzel®<br>Briviact®<br>felbamate<br>Felbatol®<br>Fycompa®<br>gabapentin (tablet) F/Q/D<br>Gabitril®<br>Keppra®<br>Keppra XR®<br>Lamictal®<br>Lamictal® ODT<br>Lamictal® XR<br>lamotrigine ER<br>lamotrigine ODT<br>Lyrica® (solution) DO, ST<br>Neurontin® F/Q/D<br>Onfi® ST<br>Potiga®<br>Qudexy® XR<br>Roweepra™<br>Sabril®<br>Spritam®<br>Topamax®<br>topiramate ER<br>Trokendi XR®<br>vigabatrin<br>Vimpat®<br>Zonegran® | | **DOSE OPTIMIZATION (DO)**<br>➢ See Dose Optimization Chart for affected drugs and strengths<br>**CLINICAL CRITERIA (CC)**<br>➢ Clinical editing will allow patients currently stabilized on a non-preferred agent to continue to receive that agent without PA<br>➢ Topiramate IR/ER (Qudexy™ XR, Topamax®, Trokendi XR™) – Require confirmation of FDA-approved, compendia-supported, or Medicaid covered diagnosis<br>➢ Onfi® (clobazam):<br>▪ Require confirmation of FDA-approved or compendia-supported use<br>▪ PA required for initiation of clobazam therapy in patients currently on opioid or oral buprenorphine therapy<br>▪ PA required for any clobazam prescription in patients currently on benzodiazepine therapy<br>**FREQUENCY/QUANTITY/DURATION (F/Q/D)**<br>Neurontin® (gabapentin) – Maximum daily dose of 3,600 mg per day<br>**STEP THERAPY (ST)**<br>➢ Lyrica® (pregabalin) – Requires a trial with a tricyclic antidepressant **OR** gabapentin for treatment of Diabetic Peripheral Neuropathy (DPN)<br>➢ Onfi® (clobazam) – Requires a trial with an SSRI or SNRI for treatment of anxiety |

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|---|---|---|
| **Antipsychotics – Second Generation** CC, ST | | |
| aripiprazole (oral solution, tablet) DQ<br>clozapine<br>Latuda® DQ<br>olanzapine (tablet) DQ<br>quetiapine F/Q/D<br>quetiapine ER F/Q/D<br>risperidone<br>Saphris®<br>ziprasidone | Abilify® (oral solution, tablet) DQ<br>aripiprazole ODT<br>clozapine ODT<br>Clozaril®<br>Fanapt®<br>FazaClo®<br>Geodon®<br>Invega® DQ, F/Q/D<br>olanzapine ODT DQ<br>Nuplazid™<br>paliperidone ER F/Q/D<br>Rexulti® DQ<br>Risperdal®<br>Seroquel® F/Q/D<br>Seroquel XR® DQ, F/Q/D<br>Versacloz®<br>Vraylar™<br>Zyprexa® DQ | **DOSE OPTIMIZATION (DO)**<br>➢ See Dose Optimization Chart for affected drugs and strengths<br>**CLINICAL CRITERIA (CC)**<br>➢ Clinical editing will allow patients currently stabilized on a non-preferred agent to continue to receive that agent without PA<br>➢ Confirm diagnosis of FDA-approved or compendia-supported indication<br>➢ PA is required for initial prescription for beneficiaries younger than the drug-specific minimum age as indicated below:<br>aripiprazole (Abilify®) 6 years<br>asenapine (Saphris®) 10 years<br>brexpiprazole (Rexulti®) 18 years<br>cariprazine (Vraylar™) 18 years<br>clozapine (Clozaril®, Fazaclo®, Versacloz™) 12 years<br>iloperidone (Fanapt®) 18 years<br>lurasidone HCl (Latuda®) 13 years<br>olanzapine (Zyprexa®) 10 years<br>paliperidone ER (Invega®) 12 years<br>pimavanserin (Nuplazid™) 18 years<br>quetiapine fum. (Seroquel®, Seroquel XR®) 10 years<br>risperidone (Risperdal®) 5 years<br>ziprasidone HCl (Geodon®) 18 years<br>➢ Require confirmation of diagnosis that supports the concurrent use of a Second Generation Antipsychotic and a CNS Stimulant for patients < 18 years of age<br>**STEP THERAPY (ST)**<br>➢ 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<br>➢ Trial of risperidone prior to paliperidone (Invega®) therapy<br>**FREQUENCY/QUANTITY/DURATION (F/Q/D)**<br>➢ paliperidone ER (Invega®) 1.5mg, 3mg, 9mg tablets: Maximum 1 (one) unit/day<br>➢ paliperidone ER (Invega®) 6mg tablets: Maximum 2 (two) units/day<br>➢ quetiapine/quetiapine ER (Seroquel®/Seroquel XR®): Minimum 100mg/day; maximum 800mg/day<br>➢ quetiapine (Seroquel®): Maximum 3 (three) units per day, 90 units per 30 days<br>➢ quetiapine ER (Seroquel XR®) 150mg, 200mg: 1 (one) unit/day, 30 units/30 days<br>➢ quetiapine ER (Seroquel XR®) 50mg, 300mg, 400mg: 2 (two) units/day, 60 units/30 days |

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|---|---|---|
| **Antipsychotics, Injectable** | | |
| Abilify Maintena®<br>Aristada™<br>fluphenazine decanoate<br>Haldol® decanoate<br>haloperidol decanoate<br>Invega Sustenna®<br>Invega Trinza®<br>Risperdal Consta®<br>Zyprexa Relprevv™ | None | |
| **Benzodiazepines – Rectal** | | |
| Diastat® 2.5mg Diastat® AcuDial™ | diazepam (rectal gel) | |
| **Carbamazepine Derivatives** [cc] | | |
| carbamazepine (chewable, tablet)<br>carbamazepine ER (capsule)<br>carbamazepine XR (tablet)<br>Epitol®<br>Equetro®<br>oxcarbazepine<br>Tegretol® (suspension) | Aptiom®<br>carbamazepine (suspension)<br>Carbatrol®<br>Oxtellar XR®<br>Tegretol® (tablet)<br>Tegretol XR®<br>Trileptal® | **CLINICAL CRITERIA (CC)**<br>➢ Clinical editing will allow patients currently stabilized on a non-preferred agent to continue to receive that agent without PA |

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|---|---|---|
| **Central Nervous System (CNS) Stimulants** CC, CDRP, F/Q/D | | |
| Adderall XR® DO<br>amphetamine salt combo IR<br>Daytrana®<br>dextroamphetamine (tablet)<br>Focalin®<br>Focalin XR® DO<br>Methylin®<br>methylphenidate (tablet)<br>Quillivant XR®<br>Vyvanse® (capsule) DO | Adzenys XR-ODT™<br>amphetamine salt combo ER DO<br>Aptensio XR®<br>armodafinil CC<br>Concerta® DO<br>Cotempla XR-ODT™<br>Desoxyn®<br>Dexedrine®<br>dexmethylphenidate<br>dexmethylphenidate ER (generic for Focalin XR®)<br>dextroamphetamine ER<br>dextroamphetamine (solution)<br>Dyanavel XR™<br>Evekeo®<br>Metadate CD® DO<br>Metadate® ER<br>methamphetamine<br>methylphenidate (chewable tablet, solution)<br>methylphenidate CD (generic Metadate CD®)<br>methylphenidate ER (generic Concerta®)<br>methylphenidate ER (generic Ritalin LA®)<br>methylphenidate SR (generic Metadate®ER)<br>modafinil DO<br>Mydayis™<br>Nuvigil® CC<br>Procentra®<br>Provigil® CC, DO<br>Quillichew ER™ DO<br>Ritalin®<br>Ritalin LA® DO<br>Vyvanse® (chewable tablet)<br>Zenzedi® | **CLINICAL CRITERIA (CC)**<br>➢ Confirm diagnosis of FDA-approved, compendia-supported, and Medicaid covered indication for beneficiaries **less than 18 years of age**.<br>▪ Prior authorization is required for initial prescriptions for stimulant therapy for beneficiaries **less than 3 years of age**<br>▪ Require confirmation of diagnoses that support concurrent use of CNS Stimulant and Second Generation Antipsychotic agent<br>➢ 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.<br>**CLINICAL DRUG REVIEW PROGRAM (CDRP)**<br>➢ For patients **18 years of age and older**:<br>➢ Confirm diagnosis of FDA-approved, compendia-supported, and Medicaid covered indication<br>**DOSE OPTIMIZATION (DO)**<br>➢ See Dose Optimization Chart for affected drugs and strengths<br>**FREQUENCY/QUANTITY/DURATION (F/Q/D)**<br>➢ Quantity limits based on daily dosage as determined by FDA labeling<br>➢ Quantity limits to include:<br>▪ Short-acting CNS stimulants: not to exceed 3 dosage units daily with maximum of 90 days per strength (for titration)<br>▪ Long-acting CNS stimulants: not to exceed 1 dosage unit daily with maximum of 90 days. Concerta 36mg and Cotempla XR-ODT 25.9mg not to exceed 2 units daily. |

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|---|---|---|
| **Multiple Sclerosis Agents** | | |
| Avonex®<br>Betaseron®<br>Copaxone® 20 mg/mL<br>Gilenya® ST<br>Rebif® | Aubagio® ST<br>Copaxone® 40 mg/mL<br>Extavia®<br>glatiramer<br>Glatopa™<br>Plegridy®<br>Tecfidera® ST<br>Zinbryta™ | **STEP THERAPY (ST)**<br>➢ Gilenya™ (fingolimod) – requires a trial with a preferred injectable product<br>➢ Aubagio® (teriflunomide ) and Tecfidera™ (dimethyl fumarate) – require a trial with a preferred oral agent |
| **Non-Ergot Dopamine Receptor Agonists** | | |
| pramipexole<br>ropinirole | Mirapex®<br>Mirapex ER®<br>Neupro®<br>pramipexole ER<br>Requip®<br>Requip XL® QQ<br>ropinirole ER | **DOSE OPTIMIZATION (DO)**<br>➢ See Dose Optimization Chart for affected strengths |
| **Other Agents for Attention Deficit Hyperactivity Disorder (ADHD)** CC | | |
| atomoxetine QQ<br>guanfacine ER QQ<br>Kapvay® | clonidine ER<br>Intuniv® QQ<br>Strattera® QQ | **CLINICAL CRITERIA (CC)**<br>➢ Confirm diagnosis for an FDA-approved or compendia-supported indication for beneficiaries < 18 years of age.<br>➢ Prior authorization is required for initial prescriptions for non-stimulant therapy for beneficiaries **less than 6 years of age**<br>**DOSE OPTIMIZATION (DO)**<br>➢ See Dose Optimization Chart for affected strengths |

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|---|---|---|
| **Sedative Hypnotics/Sleep Agents** F/Q/D | | |
| estazolam CC<br>flurazepam CC<br>temazepam 15mg, 30mg CC<br>zolpidem CC | Ambien® CC<br>Ambien CR® CC<br>Belsomra®<br>Edluar® CC<br>eszopiclone<br>Halcion® CC<br>Intermezzo® CC<br>Lunesta® DQ<br>Restoril® CC<br>Rozerem®<br>Silenor®<br>Sonata®<br>temazepam 7.5mg, 22.5mg CC<br>triazolam CC<br>zaleplon<br>zolpidem (sublingual) CC<br>zolpidem ER CC<br>Zolpimist™ CC | **DOSE OPTIMIZATION (DO)**<br>➢ See Dose Optimization Chart for affected strengths<br>**CLINICAL CRITERIA (CC)**<br>➢ Zolpidem products: Confirm dosage is consistent with FDA labeling for initial prescriptions<br>➢ Benzodiazepine Agents (estazolam, flurazepam, Halcion®, Restoril®, temazepam, triazolam):<br>▪ Confirm diagnosis of FDA-approved or compendia-supported indication<br>▪ PA required for initiation of benzodiazepine therapy in patients currently on opioid or oral buprenorphine therapy<br>▪ PA required for any additional benzodiazepine prescription in patients currently on benzodiazepine therapy<br>**FREQUENCY/QUANTITY/DURATION (F/Q/D)**<br>➢ Frequency and duration limits for the following products:<br>▪ For non-zaleplon and non-benzodiazepine containing products:<br>❖ 30 dosage units per fill/1 dosage unit per day/30 days<br>▪ For zaleplon-containing products:<br>❖ 60 dosage units per fill/2 dosage units per day/30 days<br>➢ Duration limit equivalent to the maximum recommended duration:<br>▪ 360 days for immediate-release zolpidem (Ambien®, Edluar™, Intermezzo®, Zolpimist™) products<br>▪ 180 days for eszopiclone and ramelteon (Rozerem®) products<br>▪ 168 days for zolpidem ER (Ambien CR®) products<br>▪ 90 days for suvorexant (Belsomra®)<br>▪ 90 days for doxepin (Silenor®)<br>▪ 30 days for zaleplon (Sonata®) products<br>▪ 30 days for benzodiazepine agents (estazolam, flurazepam, Halcion®, Restoril®, temazepam, triazolam) for the treatment of insomnia<br>➢ Additional/Alternate parameters:<br>▪ 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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| **Selective Serotonin Reuptake Inhibitors (SSRIs)** | | | |
| citalopram<br>escitalopram (tablet)<br>fluoxetine (capsule, solution)<br>paroxetine<br>sertraline | Brisdelle®<br>Celexa®<br>escitalopram (soln)<br>fluoxetine (tablet)<br>fluoxetine DR weekly<br>fluvoxamine CC<br>fluvoxamine ER CC<br>Lexapro® DQ<br>paroxetine 7.5mg | paroxetine CR<br>Paxil®<br>Paxil CR®<br>Pexeva®<br>Prozac®<br>Sarafem®<br>Trintellix™ DQ<br>Viibryd® DQ<br>Zoloft® | **DOSE OPTIMIZATION (DO)**<br>➢ See Dose Optimization Chart for affected strengths<br>**CLINICAL CRITERIA (CC)**<br>➢ Clinical editing will allow patients currently stabilized on fluvoxamine or fluvoxamine ER to continue to receive that agent without PA<br>➢ 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®)<br>venlafaxine<br>venlafaxine ER DQ (capsule) | Cymbalta®<br>desvenlafaxine base ER<br>desvenlafaxine fumarate ER<br>desvenlafaxine succinate ER DQ<br>duloxetine 40mg (generic for Irenka™)<br>Effexor XR® DQ<br>Fetzima®<br>Irenka™<br>Khedezla™<br>Pristiq® DQ<br>Savella®<br>venlafaxine ER (tablet) | | **DOSE OPTIMIZATION (DO)**<br>➢ See Dose Optimization Chart for affected strengths<br>**STEP THERAPY (ST)**<br>➢ Trial of an SSRI prior to an SNRI*<br>*Step therapy is not required for the following indications:<br>▪ Chronic musculoskeletal pain (CMP)<br>▪ Fibromyalgia (FM)<br>▪ Diabetic peripheral neuropathy (DPN)*<br>❖ *duloxetine (Cymbalta® and Irenka™) – Requires a trial with a tricyclic antidepressant **OR** gabapentin for treatment of Diabetic Peripheral Neuropathy (DPN) |

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| **Serotonin Receptor Agonists (Triptans)** | | |
| rizatriptan F/Q/D<br>sumatriptan F/Q/D | almotriptan F/Q/D<br>Amerge® F/Q/D<br>Axert® F/Q/D<br>eletriptan F/Q/D<br>Frova® F/Q/D<br>frovatriptan F/Q/D<br>Imitrex® F/Q/D<br>Maxalt® F/Q/D<br>Maxalt® MLT F/Q/D<br>naratriptan F/Q/D<br>Onzetra Xsail™ F/Q/D<br>Relpax® F/Q/D<br>Sumavel® DosePro<br>Treximet® F/Q/D<br>Zembrace SymTouch™<br>zolmitriptan F/Q/D<br>Zomig® F/Q/D<br>Zomig® ZMT F/Q/D | **FREQUENCY/QUANTITY/DURATION (F/Q/D)**<br>almotriptan: 18 units every 30 days<br>Amerge®: 18 units every 30 days<br>Axert® 6.25mg: 18 units every 30 days<br>Frova®: 18 units every 30 days<br>frovatriptan: 18 units every 30 days<br>Imitrex® Nasal Spray: 18 units every 30 days<br>Imitrex® tablets: 18 units every 30 days<br>naratriptan: 18 units every 30 days<br>Relpax® 20mg: 18 units every 30 days<br>sumatriptan nasal spray: 18 units every 30 days<br>sumatriptan tablets: 18 units every 30 days<br>Treximet®: 18 units every 30 days<br>zolmitriptan (tablet, ODT) 2.5mg: 18 units every 30 days<br>zolmitriptan (tablet, ODT) 5mg: 18 units every 30 days<br>Zomig/Zomig® ZMT 2.5mg: 18 units every 30 days<br>Zomig® /Zomig® ZMT 5mg: 18 units every 30 days<br>Zomig® Nasal Spray: 18 units every 30 days<br>Axert® 12.5mg: 24 tablets every 30 days<br>Maxalt® /Maxalt MLT®: 24 tablets every 30 days<br>Relpax® 40mg: 24 tablets every 30 days<br>rizatriptan (tablet, ODT): 24 tablets every 30 days<br>Onzetra Xsail™: 16 units (1 kit) every 30 days |

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|---|---|---|---|
| **V. DERMATOLOGIC AGENTS** | | | |
| **Acne Agents – Prescription, Topical** | | | |
| adapalene<br>Retin-A® cream CC<br>tazarotene CC<br>tretinoin CC gel | Aczone®<br>adapalene/benzoyl peroxide<br>Atralin® CC<br>Avita® CC<br>Azelex®<br>clindamycin/ tretinoin<br>dapsone<br>Differin® | Epiduo®<br>Fabior® CC<br>Retin-A® gel CC<br>Retin-A Micro® CC<br>Tazorac® CC<br>tretinoin cream<br>tretinoin micro CC<br>Veltin® CC<br>Ziana® CC | **CLINICAL CRITERIA**<br>➢ Confirm diagnosis of FDA-approved, compendia-supported, and Medicaid-covered indication |
| **Agents for Actinic Keratosis** | | | |
| diclofenac 3% gel F/Q/D<br>fluorouracil (solution)<br>fluorouracil 0.5% cream (generic for Carac)<br>fluorouracil 5% cream (generic for Efudex cream)<br>imiquimod | Aldara®<br>Carac®<br>Efudex®<br>Picato<br>Solaraze® F/Q/D<br>Tolak™<br>Zyclara® | | **FREQUENCY/QUANTITY/DURATION (F/Q/D)**<br>➢ Solaraze® / diclofenac 3% gel:<br>▪ Maximum 100 (one hundred) grams as a 90-day supply<br>▪ Limited to one (1) prescription per year |
| **Antibiotics – Topical** | | | |
| mupirocin (ointment) | Altabax®<br>Bactroban®<br>Bactroban Nasal® CC | Centany®<br>mupirocin (cream) | **CLINICAL CRITERIA**<br>➢ 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** | | | |
| ciclopirox (cream, suspension)<br>clotrimazole OTC<br>clotrimazole / betamethasone (cream)<br>miconazole OTC<br>Nyamyc™<br>nystatin (cream, ointment, powder)<br>Nystop®<br>terbinafine OTC<br>tolnaftate OTC | Alevazol OTC<br>Ciclodan® (cream)<br>ciclopirox (gel)<br>clotrimazole / betamethasone (lotion)<br>clotrimazole Rx<br>econazole<br>Ertaczo®<br>Exelderm®<br>Extina®<br>ketoconazole<br>Lamisil® OTC (spray)<br>Lotrisone®<br>Luzu®<br>Mentax®<br>naftifine<br>Naftin®<br>nystatin/ triamcinolone<br>oxiconazole<br>Oxistat®<br>Vusion® F/Q/D | | **FREQUENCY/QUANTITY/DURATION (F/Q/D)**<br>➢ Vusion® 50 gm ointment – Maximum 100 (one hundred) grams in a 90-day time period |

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## NYS Medicaid Fee-For-Service Preferred Drug List

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|---|---|---|
| **Anti-Infectives – Topical** | | |
| clindamycin (solution)<br>clindamycin/benzoyl peroxide<br>erythromycin (solution) | Acanya®<br>BenzaClin® (gel, pump)<br>Benzamycin®<br>Cleocin T®<br>Clindacin®<br>Clindagel®<br>clindamycin (foam, gel, lotion, pledget)<br>Duac®<br>Erygel®<br>erythromycin (gel, pledget)<br>erythromycin / benzoyl peroxide<br>Evoclin®<br>Neuac®<br>Onexton® | |
| **Anti-Virals – Topical** | | |
| Abreva®<br>Zovirax® (cream) | acyclovir (ointment)<br>Denavir®<br>Sitavig®<br>Xerese®<br>Zovirax® (ointment) | |
| **Immunomodulators – Topical** CDRP | | |
| Elidel® Protopic® | tacrolimus | **CLINICAL DRUG REVIEW PROGRAM (CDRP)**<br>➢ All prescriptions require prior authorization<br>➢ Refills on prescriptions are allowed<br>➢ Click here for CDRP Topical Immunomodulators Prescriber Worksheet |
| **Psoriasis Agents – Topical** | | |
| calcipotriene (cream, ointment, scalp solution) | calcipotriene / betamethasone dipropionate<br>Calcitrene® (ointment)<br>calcitriol (ointment)<br>Dovonex® (cream)<br>Enstilar®<br>Sorilux®<br>Taclonex®<br>Taclonex® Scalp®<br>Vectical® | |

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## NYS Medicaid Fee-For-Service Preferred Drug List

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|---|---|---|
| **Steroids, Topical – Low Potency** | | |
| hydrocortisone acetate OTC<br>hydrocortisone acetate Rx<br>hydrocortisone/ aloe vera OTC | alclometasone<br>Derma-Smoothe/FS®<br>Desonate®<br>desonide<br>fluocinolone (oil)<br>Micort HC®<br>Texacort®<br>Tridesilon® | |
| **Steroids, Topical – Medium Potency** | | |
| clocortolone<br>hydrocortisone butyrate (ointment, solution)<br>hydrocortisone valerate<br>mometasone furoate | Cloderm®<br>Cordran®<br>Cutivate®<br>Dermatop®<br>Elocon®<br>fluocinolone acetonide (cream, ointment, soln.)<br>flurandrenolide<br>fluticasone propionate<br>hydrocortisone butyrate (cream)<br>Luxiq®<br>Pandel®<br>prednicarbate<br>Synalar® | |
| **Steroids, Topical – High Potency** | | |
| betamethasone dipropionate (cream, lotion)<br>betamethasone valerate (cream, ointment)<br>fluocinonide (cream, gel, solution)<br>fluocinonide emollient<br>fluocinonide-E<br>triamcinolone acetonide | amcinonide<br>Apexicon-E®<br>betamethasone dipropionate (gel, ointment)<br>betamethasone dipropionate, augmented<br>betamethasone valerate (foam, lotion)<br>desoximetasone<br>diflorasone<br>Diprolene®<br>Diprolene® AF<br>fluocinonide 0.1% cream (generic for Vanos)<br>fluocinonide (ointment)<br>Halog®<br>Kenalog®<br>Psorcon<br>Sernivo™<br>Topicort®<br>triamcinolone spray<br>Trianex®<br>Vanos® | |
| **Steroids, Topical – Very High Potency** | | |
| clobetasol (cream, gel, ointment, solution)<br>halobetasol | clobetasol (foam, lotion, spray)<br>Clobex®<br>Olux®<br>Olux-E®<br>Temovate-E®<br>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<br>Glyset® | Precose® | **STEP THERAPY (ST)**<br>➢ 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)**<br>➢ 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®<br>Axiron®<br>Fortesta®<br>Natesto™<br>Testim®<br>testosterone gel<br>testosterone pump<br>Vogelxo | **CLINICAL DRUG REVIEW PROGRAM (CDRP)**<br>➢ For diagnosis of hypogonadotropic or primary hypogonadism:<br>▪ Requires documented low testosterone concentration with two tests prior to initiation of therapy.<br>▪ Require documented testosterone therapeutic concentration to confirm response after initiation of therapy.<br>➢ For diagnosis of delayed puberty:<br>▪ Requires documented that growth hormone deficiency has been ruled out prior to initiation of therapy.<br>➢ Click here for a copy of the Anabolic Steroid fax form<br>**FREQUENCY/QUANTITY/DURATION (F/Q/D)**<br>➢ Limitations for anabolic steroid products based on approved FDA labeled daily dosing and documented diagnosis:<br>▪ Duration limit of six (6) months for delayed puberty |

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| Preferred Drugs | Non-Preferred Drugs | Prior Authorization/Coverage Parameters |
|---|---|---|
| **Biguanides** | | |
| metformin HCl<br>metformin ER (generic for Glucophage XR®) | Fortamet®<br>Glucophage®<br>Glucophage XR®<br>Glumetza®<br>metformin ER (generics for Fortamet®, Glumetza®)<br>Riomet® (solution) | |
| **Bisphosphonates – Oral** F/Q/D | | |
| alendronate | Actonel®<br>Atelvia®<br>Binosto®<br>Boniva®<br>Fosamax®<br>Fosamax® Plus D<br>Ibandronate<br>risedronate | **FREQUENCY/QUANTITY/DURATION (F/Q/D)**<br>ibandronate sodium 150 mg (Boniva® 150 mg) — 1 tablet every 28 days<br>risedronate sodium 150 mg (Actonel® 150 mg)<br>alendronate sodium 35 mg (Fosamax® 35 mg) — 4 tablets every 28 days<br>alendronate sodium 70 mg (Fosamax® 70 mg, Binosto)<br>alendronate sodium and cholecalciferol (Fosamax® Plus D)<br>risedronate sodium 35 mg (Actonel® 35 mg)<br>risedronate sodium 35 mg (Atelvia® 35 mg)<br>alendronate solution 70 mg/75 mL single-dose bottle — 4 bottles every 28 days |
| **Calcitonins – Intranasal** | | |
| calcitonin-salmon Miacalcin® | | |
| **Dipeptidyl Peptidase-4 (DPP-4) Inhibitors** ST | | |
| Janumet®<br>Janumet® XR<br>Januvia® DO<br>Jentadueto®<br>Jentadueto® XR<br>Tradjenta® | alogliptin<br>alogliptin / metformin<br>alogliptin / pioglitazone<br>Glyxambi®<br>Kazano™<br>Kombiglyze® XR<br>Nesina™<br>Onglyza® DO<br>Oseni™<br>Qtern® | **DOSE OPTIMIZATION (DO)**<br>➢ See Dose Optimization Chart for affected strengths<br>**STEP THERAPY (ST)**<br>➢ Requires a trial with metformin with or without insulin prior to DPP-4 Inhibitor therapy, unless there is a documented contraindication. |

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|---|---|---|
| **Glucagon-like Peptide-1 (GLP-1) Agonists** ST | | |
| Bydureon®<br>Byetta®<br>Victoza® | Adlyxin™ Xultophy®<br>Bydureon® BCise™<br>Soliqua™<br>Tanzeum®<br>Trulicity® | **STEP THERAPY (ST)**<br>➢ Requires a trial with metformin with or without insulin prior to a GLP-1 agonist.<br>➢ Prior authorization is required with lack of covered diagnosis in medical history. |
| **Glucocorticoids – Oral** | | |
| dexamethasone (tablet)<br>hydrocortisone<br>methylprednisolone (dose-pack)<br>prednisolone (solution)<br>prednisone (dose-pack, tablet) | budesonide EC<br>Cortef®<br>cortisone 2<br>dexamethasone (elixir, solution 2)<br>dexamethasone intensol<br>Dexpak®<br>Emflaza™<br>Entocort EC®<br>Medrol® (dose-pack, tablet)<br>methylprednisolone (4mg 2, 8mg 2 16mg, 32mg 2)<br>Millipred®<br>Orapred® ODT<br>prednisolone ODT<br>prednisone (intensol, solution 2)<br>Rayos®<br>Uceris®<br>Veripred® | |
| **Growth Hormones** CC, CDRP | | |
| Genotropin® Nutropin AQ®<br>Norditropin® | Humatrope® Zomacton®<br>Omnitrope® Zorbtive®<br>Saizen® | **CLINICAL DRUG REVIEW PROGRAM (CDRP)**<br>➢ **Prescribers**, not authorized agents, are required to call for a PA for beneficiaries 21 years of age or older<br>**CLINICAL CRITERIA (CC)**<br>➢ 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.<br>➢ Confirm diagnosis of FDA-approved or compendia-supported indication |
| **Insulin – Long-Acting** | | |
| Lantus® Levemir® | Basaglar® Tresiba®<br>Toujeo® | |

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|---|---|---|---|---|
| **Insulin – Mixes** | | | | |
| Humalog® Mix | Novolog® Mix | None | | |
| **Insulin – Rapid-Acting** | | | | |
| Apidra®<br>Humalog® 100 U/mL<br>Humalog® Jr 100U/mL | Novolog® | Afrezza®<br>Humalog® 200 U/mL | | |
| **Meglitinides** ST | | | | |
| nateglinide | repaglinide | Prandin® | repaglinide/ metformin<br>Starlix® | **STEP THERAPY (ST)**<br>➢ Requires a trial with metformin with or without insulin prior to initiating meglitinide therapy, unless there is a documented contraindication. |
| **Pancreatic Enzymes** | | | | |
| Creon®<br>pancrelipase | Zenpep® | Pancreaze®<br>Pertzye® | Viokace® | |
| **Sodium Glucose Co-Transporter 2 (SGLT2) Inhibitors** ST | | | | |
| Farxiga™<br>Invokana® | | Invokamet®<br>Invokamet® XR | Jardiance®<br>Synjardy®<br>Synjardy® XR<br>Xigduo® XR | **STEP THERAPY (ST)**<br>➢ 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®<br>Actoplus Met® XR DO<br>Actos® DO<br>Avandia®<br>Duetact®<br>pioglitazone / glimepiride<br>pioglitazone / metformin | | **DOSE OPTIMIZATION (DO)**<br>➢ See Dose Optimization Chart for affected strengths<br>**STEP THERAPY (ST)**<br>➢ Requires a trial with metformin with or without insulin prior to initiating TZD therapy, unless there is a documented contraindication. |

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|---|---|---|
| **VII. GASTROINTESTINAL** | | |
| **Anti-Emetics** | | |
| Diclegis® CC 1<br>Emend Pack® 1<br>ondansetron (ODT, solution, tablet) | Akynzeo® 2<br>Anzemet®<br>aprepitant (capsule, pack) 2<br>Emend® (capsule, powder packet) 2<br>granisetron (tablet)<br>Sancuso®<br>Varubi® 2<br>Zofran® (ODT, solution, tablet)<br>Zuplenz® | **CLINICAL CRITERIA (CC)**<br>➢ Diclegis®: Confirm diagnosis of FDA-approved or compendia-supported indication |
| **Gastrointestinal Antibiotics** | | |
| metronidazole (tablet)<br>neomycin<br>vancomycin | Alinia®<br>Dificid®<br>Flagyl®<br>Flagyl® ER<br>metronidazole (capsule)<br>paromomycin<br>Tindamax®<br>tinidazole<br>Vancocin®<br>Xifaxan® CC, ST, F/Q/D | **CLINICAL CRITERIA (CC)**<br>➢ Xifaxan®: Confirm diagnosis of FDA-approved or compendia-supported indication<br>**STEP THERAPY (ST)**<br>➢ Xifaxan®: Requires trial of a preferred fluoroquinolone antibiotic before rifaximin for treatment of Traveler's diarrhea<br>**QUANTITY LIMITS**:<br>➢ Xifaxan:<br>▪ Traveler's diarrhea (200 mg tablet) – 9 (nine) tablets per 30 days (Dose = 200 mg three times a day for three days)<br>▪ Hepatic encephalopathy (550 mg tablets) – 60 tablets per 30 days (Dose = 550 mg twice a day)<br>▪ Irritable bowel syndrome with diarrhea (550 mg tablets) – 42 tablets per 30 days (Dose = 550 mg three times a day for 14 days)<br>❖ Maximum of 42 days' supply (126 units) per 365 (three rounds of therapy). |

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|---|---|---|
| **Gastrointestinal Preparatory Agents** | | |
| Clearlax® | Colyte® | |
| Gavilax® | Gavilyte®-N | |
| Gavilyte®-C | Golytely® | |
| Gavilyte®-G | Moviprep® | |
| Glycolax® | Nulytely® | |
| Miralax® OTC | Osmoprep® | |
| PEG 3350 powder OTC | PEG 3350 powder pack OTC | |
| PEG 3350/ electrolytes solution Rx | PEG 3350 with flavor packs | |
| | Prepopik® | |
| | Suprep® | |
| | Trilyte® | |
| **Helicobacter pylori Agents** | | |
| lansoprazole / amoxicillin / clarithromycin | Omeclamox-Pak® | |
| Pylera® | Prevpac® | |

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|---|---|---|
| **Proton Pump Inhibitors (PPIs)** F/Q/D | | |
| omeprazole Rx<br>pantoprazole | Aciphex®<br>Dexilant™ DO<br>esomeprazole magnesium (generic for Nexium)<br>esomeprazole strontium<br>lansoprazole Rx (capsule, ODT)<br>Nexium® RX DO<br>omeprazole OTC<br>omeprazole/ sodium bicarbonate Rx<br>Prevacid® OTC<br>Prevacid® Rx DO<br>Prilosec® Rx<br>Protonix®<br>rabeprazole<br>Zegerid® | **DOSE OPTIMIZATION (DO)**<br>➢ See Dose Optimization Chart for affected strengths<br>**FREQUENCY/QUANTITY/DURATION (F/Q/D)**<br>➢ **Quantity limits**:<br>▪ Once daily dosing for:<br>❖ GERD<br>❖ erosive esophagitis<br>❖ healing and maintenance of duodenal/gastric ulcers (including NSAID-induced)<br>❖ prevention of NSAID-induced ulcers<br>❖ Twice daily dosing for:<br>❖ hypersecretory conditions<br>❖ Barrett's esophagitis<br>❖ H. pylori<br>❖ refractory GERD<br>➢ **Duration limits**:<br>▪ 90 days for:<br>❖ GERD<br>▪ 365 days for:<br>❖ Maintenance treatment of duodenal ulcers, or erosive esophagitis<br>▪ 14 days for:<br>❖ H. pylori |
| **Sulfasalazine Derivatives** | | |
| Apriso®<br>Delzicol®<br>Dipentum®<br>sulfasalazine DR/EC<br>sulfasalazine IR<br>Sulfazine<br>Sulfazine EC | Asacol HD®<br>Azulfidine®<br>Azulfidine Entab®<br>balsalazide<br>Colazal®<br>Giazo®<br>Lialda®<br>mesalamine DR (gen for Lialda)<br>mesalamine DR<br>Pentasa® | |

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|---|---|---|---|---|
| **VIII. HEMATOLOGICAL AGENTS** | | | | |
| **Anticoagulants – Injectable** CC F/Q/D | | | | |
| enoxaparin sodium | Fragmin® | Arixtra® CC<br>fondaparinux CC | Lovenox® | **CLINICAL CRITERIA (CC)**<br>➢ For patients requiring >30 days of therapy: Require confirmation of FDA-approved or compendia-supported indication<br>➢ Arixtra® (fondaparinux) Clinical editing to allow patients with a diagnosis of Heparin Induced Thrombocytopenia (HIT) to receive therapy without prior authorization.<br>**FREQUENCY/QUANTITY/DURATION (F/Q/D)**<br>➢ Duration Limit: No more than 30 days for members initiating therapy |
| **Anticoagulants – Oral** | | | | |
| Coumadin®<br>Eliquis®<br>Jantoven®<br>Pradaxa® | warfarin<br>Xarelto® | Savaysa®<br>Xarelto® (dose pack) | | |
| **Erythropoiesis Stimulating Agents (ESAs)** CC | | | | |
| Aranesp® | Procrit® | Epogen® | Mircera® | **CLINICAL CRITERIA (CC)**<br>➢ Confirm diagnosis for FDA- or compendia-supported uses |
| **Platelet Inhibitors** | | | | |
| Aggrenox®<br>Brilinta®<br>clopidogrel<br>dipyridamole | | dipyridamole / aspirin<br>Durlaza®<br>Effient®<br>Plavix®<br>prasugrel<br>ticlopidine<br>Yosprala™<br>Zontivity® | | |

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|---|---|---|---|
| **IX. IMMUNOLOGIC AGENTS** | | | |
| **Immunomodulators – Systemic** CC, ST | | | |
| Enbrel® | Humira® | Actemra® (subcutaneous)<br>Benlysta® (subcutaneous)<br>Cimzia®<br>Cosentyx®<br>Enbrel® Mini™<br>Kevzara®<br>Kineret®<br>Orencia® (subcutaneous)<br>Otezla®<br>Siliq™<br>Simponi®<br>Stelara®<br>Taltz®<br>Tremfya™<br>Xeljanz®<br>Xeljanz® XR | **CLINICAL CRITERIA (CC)**<br>➢ Confirm diagnosis for FDA- or compendia-supported uses<br>**STEP THERAPY (ST)**<br>➢ Trial of a disease-modifying anti-rheumatic drug (DMARD) prior to treatment with an immunomodulator |
| **X. MISCELLANEOUS AGENTS** | | | |
| **Progestins (for Cachexia)** | | | |
| megestrol acetate (suspension) | | Megace® (suspension)<br>Megace ES®<br>megestrol ES (suspension) | |
| **Epinephrine, Self-injected** | | | |
| epinephrine (generic for EpiPen®)<br>epinephrine (generic for EpiPen Jr.®) | | Adrenaclick®<br>epinephrine (generic for Adrenaclick®)<br>EpiPen®<br>EpiPen Jr.® | |

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| **XI. MUSCULOSKELETAL AGENTS** | | |
| **Skeletal Muscle Relaxants** | | |
| baclofen<br>chlorzoxazone<br>cyclobenzaprine 5mg, 10mg<br>dantrolene<br>methocarbamol<br>orphenadrine ER<br>tizanidine (tablet) | Amrix®<br>carisoprodol ST, F/Q/D<br>carisoprodol compound ST, F/Q/D<br>carisoprodol compound / codeine CC, ST, F/Q/D<br>cyclobenzaprine 7.5mg<br>Dantrium®<br>Fexmid®<br>Lorzone®<br>metaxalone<br>Parafon Forte® DSC<br>Robaxin®<br>Skelaxin®<br>Soma® ST, F/Q/D<br>Soma® 250 ST, F/Q/D<br>tizanidine (capsule)<br>Zanaflex® | **CLINICAL CRITERIA (CC)**<br>For carisoprodol/codeine products:<br>➢ Limited to a total of four (4) opioid prescriptions every 30 days; exemption for diagnosis of cancer or sickle cell disease<br>➢ Medical necessity rationale for opioid therapy is required for patients on established buprenorphine opioid dependence therapy<br>➢ PA required for initiation of opioid therapy in patients currently on benzodiazepine therapy<br>**STEP THERAPY (ST)**<br>➢ Trial with one (1) preferred analgesic and two (2) preferred skeletal muscle relaxants prior to use of carisoprodol containing products:<br>▪ carisoprodol<br>▪ carisoprodol/ASA<br>▪ carisoprodol/ASA/codeine<br>▪ Soma®<br>**FREQUENCY/QUANTITY/DURATION (F/Q/D)**<br>➢ Maximum 84 cumulative units per a year<br>➢ Carisoprodol – Maximum 4 (four) units per day, 21-day supply<br>➢ Carisoprodol combinations – Maximum 8 (eight) units per day, 21- day supply (not to exceed the 84 cumulative units per year limit) |

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|---|---|---|
| **XII. OPHTHALMICS** | | |
| **Alpha-2 Adrenergic Agonists (for Glaucoma) – Ophthalmic** | | |
| Alphagan P®<br>brimonidine 0.2%<br>Simbrinza® | apraclonidine<br>brimonidine P 0.15%<br>lopidine® | |
| **Antibiotics – Ophthalmic** | | |
| bacitracin / polymyxin B<br>erythromycin<br>gentamicin<br>Natacyn®<br>neomycin / gramicidin / polymyxin<br>polymyxin / trimethoprim<br>sulfacetamide (solution)<br>tobramycin | Azasite®<br>bacitracin<br>Bleph®-10<br>Garamycin®<br>neomycin / bacitracin / polymyxin<br>Neosporin®<br>Polytrim®<br>sulfacetamide (ointment)<br>Tobrex® | |
| **Antibiotics/Steroid Combinations – Ophthalmic** | | |
| Blephamide®<br>neomycin/ polymyxin / dexamethasone<br>sulfacetamide / prednisolone<br>TobraDex® (ointment, suspension) | Maxitrol®<br>neomycin / bacitracin / polymyxin / HC<br>neomycin / polymyxin / HC<br>Pred-G®<br>TobraDex® ST<br>tobramycin / dexamethasone (suspension)<br>Zylet® | |
| **Antihistamines – Ophthalmic** | | |
| Pataday® | azelastine<br>Bepreve®<br>Elestat®<br>Emadine®<br>epinastine<br>Lastacaft®<br>olopatadine 0.1%<br>olopatadine 0.2%<br>Patanol®<br>Pazeo® | |

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# NYS Medicaid Fee-For-Service Preferred Drug List

| Preferred Drugs | Non-Preferred Drugs | Prior Authorization/Coverage Parameters |
|---|---|---|
| **Beta Blockers – Ophthalmic** | | |
| betaxolol<br>Betoptic S®<br>carteolol<br>Combigan®<br>Istalol®<br>levobunolol<br>timolol maleate (gel, solution) | Betagan®<br>Timoptic®<br>Timoptic® in Ocudose®<br>Timoptic-XE® | |
| **Fluoroquinolones – Ophthalmic ST** | | |
| ciprofloxacin<br>ofloxacin<br>Vigamox® | Besivance®<br>Ciloxan®<br>gatifloxacin<br>levofloxacin<br>Moxeza®<br>moxifloxacin<br>Ocuflox®<br>Zymaxid® | **STEP THERAPY (ST)**<br>➢ For patients 21 years or younger, attempt treatment with a non-fluoroquinolone ophthalmic antibiotic before progressing to the a fluoroquinolone ophthalmic product<br>➢ Examples of Non-Fluoroquinolone Ophthalmic Antibiotics<br>▪ AK-Poly-Bac eye ointment<br>▪ bacitracin-polymyxin eye ointment<br>▪ erythromycin eye ointment<br>▪ Gentak (3 mg/gm eye ointment, 3 mg/mL eye drops)<br>▪ gentamicin (3 mg/gm eye ointment, 3 mg/mL eye drops)<br>▪ neomycin-polymyxin-gramicidin eye drops<br>▪ polymyxin B-TMP eye drops<br>▪ Romycin eye ointment<br>▪ sulfacetamide 10% eye drops<br>▪ Sulfamide 10% eye drops<br>▪ tobramycin 0.3% eye drops<br>▪ Tobrasol 0.3% eye drops |
| **Non-Steroidal Anti-Inflammatory Drugs (NSAIDS) – Ophthalmic** | | |
| diclofenac<br>flurbiprofen<br>Ilevro® 1<br>ketorolac | Acular®<br>Acular LS®<br>Acuvail®<br>bromfenac<br>BromSite™<br>Nevanac®<br>Ocufen®<br>Prolensa® | |
| **Prostaglandin Agonists – Ophthalmic** | | |
| latanoprost | bimatoprost<br>Lumigan®<br>Travatan Z®<br>travoprost<br>Xalatan®<br>Zioptan® | |

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## NYS Medicaid Fee-For-Service Preferred Drug List

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

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## NYS Medicaid Fee-For-Service Preferred Drug List

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

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## 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®<br>Perforomist®<br>Serevent Diskus® | Arcapta Neohaler®<br>Brovana®<br>Striverdi Respimat® | **CLINICAL CRITERIA (CC)**<br>PA is required for all new long-acting beta agonist prescriptions for beneficiaries under FDA- or compendia-supported age as indicated:<br>Arcapta Neohaler® ≥18 years<br>Brovana® ≥18 years<br>Foradil® ≥ 5 years<br>Perforomist® ≥18 years<br>Serevent Diskus® ≥4 years<br>Striverdi Respimat® ≥18 years<br>**FREQUENCY/QUANTITY/DURATION (F/Q/D)**<br>**Maximum units per 30 days**<br>Arcapta Neohaler® 30 units (1 box of 30 unit dose capsules)<br>Brovana® 60 units (1 carton of 60 vials or 120 mL)<br>Foradil® 60 units (1 box of 60 unit dose capsules)<br>Perforomist® 60 units (1 carton of 60 vials or 120 mL)<br>Serevent Diskus® 1 diskus (60 blisters)<br>Striverdi Respimat® 1 unit (one cartridge and one Respimat inhaler) |
| **Beta$_2$ Adrenergic Agents – Inhaled Short-Acting** | | |
| albuterol<br>ProAir HFA®<br>Proventil HFA® | levalbuterol (solution)<br>levalbuterol HFA<br>ProAir® RespiClick<br>Ventolin HFA®<br>Xopenex® (solution)<br>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®<br>Flovent Diskus®<br>Flovent HFA®<br>Pulmicort® Flexhaler<br>QVAR® | Aerospan®<br>Alvesco®<br>ArmonAir™ Respiclick®<br>Arnuity Ellipta®<br>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. |
| ArmonAir™ Respiclick® 55mcg, 113mcg | 1 inhaler every do days |
| ArmonAir™ Respiclick® 232mcg | 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<br>Up to 1 inhaler every 15 days with previous oral corticosteroid use. |
| Asmanex® 220 mcg (120 units) | 1 inhaler every 60 days. Up to 1 inhaler every 30 days with previous oral corticosteroid use. |
| Asmanex® HFA 100 mcg | 1 inhaler every 30 days |
| Asmanex® HFA 200 mcg | 1 inhaler every 30 days |
| Flovent Diskus® 50mcg, 100 mcg | 1 diskus every 30 days |
| Flovent Diskus® 250mcg | 1 diskus every 15 days. Up to 1 diskus every 7 days with previous oral corticosteroid use. |
| Flovent HFA® 44mcg, 110 mcg | 1 inhaler every 30 days |
| Flovent HFA® 220mcg | 1 inhaler every 30 days. Up to 1 inhaler every 15 days with previous oral corticosteroid use. |
| Pulmicort 90mcg | 1 inhaler every 30 days |
| Pulmicort 180mcg | 1 inhaler every 15 days |
| QVAR® 40mcg | 1 inhaler every 25 days |
| QVAR® 80mcg | 1 inhaler every 12 days |

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# NYS Medicaid Fee-For-Service Preferred Drug List

| Preferred Drugs | Non-Preferred Drugs | Prior Authorization/Coverage Parameters |
|---|---|---|
| **Corticosteroid/Beta$_2$ Adrenergic Agent (Long-Acting) Combinations – Inhaled** CC, F/Q/D | | |
| Advair Diskus®<br>Dulera®<br>Symbicort® | Advair HFA®<br>AirDuo™ RespiClick®<br>Breo Ellipta®<br>fluticasone-salmeterol (gen for AirDuo™ RespiClick®) | **CLINICAL CRITERIA (CC)**<br>➢ PA is required for all new long-acting beta agonist prescriptions for beneficiaries under FDA- or compendia-supported age as indicated:<br>Advair Diskus® ≥4 years<br>Advair HFA® ≥12 years<br>AirDuo™ RespiClick® ≥12 years<br>Breo Ellipta™ ≥18 years<br>Dulera® ≥12 years<br>fluticasone-salmeterol ≥12 years<br>Symbicort® 80/4.5 mcg ≥6 years<br>Symbicort® 160/4.5 mcg ≥12 years<br>**FREQUENCY/QUANTITY/DURATION (F/Q/D)**<br>Advair Diskus®, Advair HFA®, AirDuo™ RespiClick®, Breo Ellipta™, Dulera®, fluticasone-salmeterol, Symbicort®: One (1) inhaler/diskus every 30 days |
| **Corticosteroids – Intranasal** F/Q/D | | |
| fluticasone | Beconase AQ® CC<br>budesonide<br>Dymista®<br>flunisolide<br>mometasone<br>Nasonex®<br>Omnaris®<br>QNASL® CC<br>Veramyst®<br>Zetonna® | **CLINICAL CRITERIA (CC)**<br>➢ Clinical consideration in regard to drug interactions will be given to patients with HIV/AIDs diagnosis or antiretroviral therapy in history<br>**FREQUENCY/QUANTITY/DURATION (F/Q/D)**<br>flunisolide: One (1) inhaler every 12 days<br>budesonide, mometasone, Nasonex®: One (1) inhaler every 15 days<br>Beconase AQ®: One (1) inhaler every 22 days<br>Dymista™, fluticasone, Nasacort AQ®, Omnaris®, QNASL®, Veramyst®, Zetonna™: One (1) inhaler every 30 days |
| **Leukotriene Modifiers** | | |
| montelukast ST<br>zafirlukast | Accolate®<br>Singulair® ST | **STEP THERAPY (ST)**<br>➢ For non-asthmatic patients, trial of intranasal corticosteroid or a 2nd generation oral antihistamine before montelukast (Singulair®) |

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# New York State Medicaid Fee-For-Service Pharmacy Programs

## 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

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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# 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 40.

| 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.<br>**Note**: Acthar is first line therapy for infantile spasms in children less than 2 years of age – step therapy not required. | **QUANTITY LIMITS**:<br>➢ Infantile spasms – 30 mL (six 5 mL vials)<br>➢ Multiple sclerosis – 35 mL (seven 5 mL vials)<br>**DURATION LIMITS**:<br>➢ Infantile spasms – 4 weeks; indicated for < 2 years of age<br>➢ Multiple sclerosis – 5 weeks<br>➢ Rheumatic disorders – 5 weeks<br>➢ Dermatologic conditions – 5 weeks<br>➢ Allergic states (serum sickness) – 5 weeks | Confirm diagnosis of FDA-approved or compendia-supported indication<br>Not covered 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 an immediate-release amoxicillin first before progressing to extended-release amoxicillin | **QUANTITY LIMIT**:<br>➢ Equal to 10 tablets per fill | |
| Anabolic Steroids – Injectable<br>➢ Depo-Testosterone®<br>➢ testosterone cypionate*<br>➢ testosterone enanthate<br><br>*for additional parameters, see Cross-Sex Hormones section below.<br><br>Anabolic Steroids – Oral<br>➢ Anadrol-50®<br>➢ Android®<br>➢ Androxy™<br>➢ Methitest®<br>➢ Oxandrin®<br>➢ oxandrolone<br>➢ 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):<br>➢ 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<br>➢ Duration limit of 6 months for delayed puberty<br>➢ Duration limit of 1 month for all uses of oxandrolone products | |
| Anti-Diabetic agents (not on the PDL)<br>➢ chlorpropamide<br>➢ glimepiride<br>➢ glipizide (Glucotrol®, Glucotrol XL®)<br>➢ glyburide (DiaBeta®, Glynase®)<br>➢ glyburide, micronized<br>➢ tolazamide<br>➢ tolbutamide | ➢ Requires a trial with metformin with or without insulin prior to initiating other antidiabetic agents, unless there is a documented contraindication.<br>➢ Clinical editing to allow patients with a diagnosis of gestational diabetes to receive glyburide without a trial of metformin first. | | |
| Anti-Diarrheal Agents<br>➢ alosetron (Lotronex)<br>➢ crofelemer (Mytesi)<br>➢ eluxadoline (Viberzi)<br>➢ telotristat (Xermelo) | Irritable Bowel Syndrome w/Diarrhea<br>➢ Trial of eluxadoline and rifaximin prior to alosetron.<br>Symptomatic relief of non-infectious diarrhea in patients with HIV/AIDS on anti-retroviral therapy<br>➢ Trial with an alternative anti-diarrheal agent.<br>Carcinoid Syndrome<br>➢ Trial with and concurrent use with a somatostatin analog | | Confirmation of FDA-approved or compendia-supported indication. |

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| Drug / Class Name | Step Therapy (ST) Parameters | Frequency / Quantity / Duration (F/Q/D) Parameters | Additional / Alternate Parameter(s) |
|---|---|---|---|
| Anti-Fungals, Topical – for Onychomycosis<br>➢ ciclopirox 8% solution<br>➢ Jublia®<br>➢ Kerydin®<br>➢ Penlac® | ➢ Trial with an oral antifungal agent* prior to use of ciclopirox 8% solution (Penlac)<br>▪ terbinafine (Lamisil®) tablets; griseofulvin (Gris PEG®) oral suspension, ultramicronized tablets micronized tablets; itraconazole (Sporanox®, Onmel™) tablets, oral solution<br>➢ Trial with ciclopirox 8% solution prior to the use of other topical antifungals [efinaconazole (Jublia) or tavaborole (Kerydin)] | | |
| Anti-Retroviral (ARV) Interventions | | **QUANTITY LIMITS**:<br>➢ Limit ARV active ingredient duplication<br>➢ Limit ARV utilization to a maximum of five products concurrently - excluding boosting with ritonavir (dose limit 600 mg or less) or cobicistat<br>➢ Limit Protease Inhibitor utilization to a maximum of two products concurrently<br>➢ Limit Integrase inhibitor utilization to a maximum of one product concurrently | ➢ Require confirmation of FDA-approved or compendia-supported use<br>➢ Point of service edit for contraindicated antiretroviral / non-antiretroviral combinations<br>➢ Point of service edit for contraindicated antiretroviral / antiretroviral combinations |
| Atopic Dermatitis Agents<br>➢ crisaborole (Eucrisa™)<br>➢ dupilumab (Dupixent®) | Crisaborole (Eucrisa)<br>➢ Trial with a medium or high potency prescription topical steroid within the last 3 months<br>Dupilumab (Dupixent)<br>➢ Trial with a medium or high potency prescription topical steroid AND one other topical prescription agent other than a steroid (within a different class) indicated for atopic dermatitis for a combined duration of at least 6 months prior | **QUANTITY LIMITS:**<br>Crisaborole (Eucrisa)<br>➢ 100GM/30 days<br>Dupilumab (Dupixent)<br>➢ 4 syringes for first 30 days followed by 2 syringes/30 days. | Confirm diagnosis of FDA-approved or compendia-supported indication |
| Becaplermin (Regranex®) | | **QUANTITY LIMIT**:<br>➢ 2 (two) 15 gram tubes in a lifetime | |

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| Drug / Class Name | Step Therapy (ST) Parameters | Frequency / Quantity / Duration (F/Q/D) Parameters | Additional / Alternate Parameter(s) |
|---|---|---|---|
| Benzodiazepine agents – oral<br>➢ alprazolam (Niravam™, Xanax®, Xanax® XR)<br>➢ chlordiazepoxide (Librium®)<br>➢ chlordiazepoxide/amitriptyline (Limbitrol®)<br>➢ clonazepam (Klonopin®)<br>➢ clorazepate (Tranxene®, Tranxene T-Tab®)<br>➢ diazepam (Valium®)<br>➢ lorazepam (Ativan®, Lorazepam Intensol®)<br>➢ 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<br>➢ For diagnosis of Panic Disorder: Require concurrent therapy with an antidepressant (SSRI, SNRI, or Tricyclic antidepressant [TCA]).<br>➢ For diagnosis of skeletal muscle spasms: Require trial with a skeletal muscle relaxant prior to a benzodiazepine | **DURATION LIMIT:**<br>➢ For Insomnia: 30 consecutive days<br>➢ For Panic Disorder: 30 consecutive days | ➢ Require confirmation of FDA-approved or compendia-supported use<br>➢ PA required for initiation of benzodiazepine therapy in patients currently on opioid or oral buprenorphine therapy<br>➢ PA required for any additional oral benzodiazepine prescription in patients currently on benzodiazepine therapy |
| Constipation Agents<br>➢ linaclotide (Linzess)<br>➢ lubiprostone (Amitiza)<br>➢ methylnaltrexone (Relistor)<br>➢ naloxegol (Movantik)<br>➢ plecanatide (Trulance) | Opioid Induced Constipation (OIC) & Chronic Idiopathic Constipation (CIC)<br>➢ Trial with an osmotic laxative, a stimulant laxative and a stool softener prior to use.<br>Irritable Bowel Syndrome w/ Constipation (IBS-C)<br>➢ Trial with a bulking agent and an osmotic laxative within 89 days of use. | **QUANTITY LIMIT:**<br>➢ lubiprostone: 2 capsules/day; 60 capsules/month<br>➢ methylnaltrexone: 1 vial or syringe/day; 30/month; 4 kits/28 days; 90 tablets/30 days<br>➢ naloxegol: 1 tablet/day; 30 tablets/month<br>➢ plecanatide: 1 tablet/day; 30 tablets/month | Confirmation of FDA-approved or compendia-supported indication. |
| Cross-Sex Hormones<br>➢ conjugated estrogens<br>➢ estradiol<br>➢ testosterone cypionate | | | ➢ Confirm diagnosis of FDA-approved or compendia-supported indication<br>Refer to: https://www.health.ny.gov/health_care/medicaid/program/update/2017/2017-01.htm#transgender for Transgender Related Care and Services Update |
| ➢ cyclosporine ophthalmic emulsion (Restasis®, Restasis MultiDose™)<br>➢ 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:**<br>Restasis, Xiidra:<br>➢ 60 vials dispensed as a 30-day supply;<br>Restasis Multidose:<br>➢ 5.5 mL dispensed as a 25-day supply | |
| Cystic fibrosis agents<br>➢ ivacaftor (Kalydeco™)<br>➢ ivacaftor / lumacaftor (Orkambi™) | | | ➢ Confirm diagnosis of FDA-approved or compendia-supported indication<br>➢ Genetic testing required to verify appropriate mutations |

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Revised: February 22, 2018

| Drug / Class Name | Step Therapy (ST) Parameters | Frequency / Quantity / Duration (F/Q/D) Parameters | Additional / Alternate Parameter(s) |
|---|---|---|---|
| Dextromethorphan / quinidine (Nuedexta®) | | **QUANTITY LIMIT**:<br>➢ Two (2) capsules per day; 60 units per 30 days<br>**DURATION LIMIT**:<br>➢ 90 days of therapy | For patients ≥ 18 years of age:<br>Confirm diagnosis of FDA-approved or compendia-supported indication |
| Diabetic Test Strips | | **QUANTITY LIMIT**:<br>➢ Type I DM – max 300 test strips per 30-day supply<br>➢ Type II DM – max 100 test strips per 30-day supply | Preferred diabetic supply program https://newyork.fhsc.com/providers/diabeticsupplies.asp |
| Dronabinol (Marinol®,Syndros) | ➢ Step therapy for beneficiaries with HIV/AIDS, or cancer, AND eating disorder: trial with megestrol acetate suspension prior to dronabinol<br>➢ 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 of FDA-approved or compendia-supported indication |
| Fentanyl Transmucosal Agents<br>➢ Abstral® (sublingual tablet)<br>➢ Actiq® (lozenge)<br>➢ Fentora® (buccal tablet)<br>➢ Lazanda® (nasal spray)<br>➢ Onsolis® (buccal film)<br>➢ Subsys® (sublingual spray) | | **QUANTITY LIMIT**:<br>Abstral, Actiq, Fentora, Onsolis, and Subsys:<br>➢ 4 units per day, 120 units per 30 days<br>Lazanda:<br>➢ 5 mL (1 bottle) per day, 150 mL (5 bottles) per 30 days<br>**DURATION LIMIT**:<br>➢ 90 days<br>➢ 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<br>➢ For opioid-naïve patients - limited to a 15 days' supply for all initial opioid prescriptions, exemption for diagnosis of cancer or sickle cell disease<br>➢ PA required for initiation of opioid therapy for patients on established buprenorphine opioid dependence therapy<br>➢ PA is required for initiation of opioid therapy in patients currently on benzodiazepine therapy |
| Lipid Lowering Agents –<br>Proprotein Convertase Subtilisin Kexin 9 (PCSK9) Inhibitors<br>➢ alirocumab (Praluent™)<br>➢ evolocumab (Repatha™) | Require trial of a HMG-CoA Reductase Inhibitors (Statin) at maximum tolerated dosage | | Confirm diagnosis of FDA-approved or compendia-supported indication<br><br>Require concurrent statin therapy |
| Lipid Lowering Agents –<br>Triglyceride transfer protein inhibitors:<br>➢ lomitapide (Juxtapid®)<br>➢ mipomersen (Kynamro®) | Requires trial with high intensity statin therapy | | Confirm diagnosis of FDA-approved or compendia-supported indication |

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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**:<br>➢ 12 units per day, 360 units per 30 days<br>➢ 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<br>➢ PA required for initiation of methadone for patients on established buprenorphine opioid dependence therapy<br>➢ PA required for methadone prescriptions for patients currently on long-acting opioid therapy. Exemption for diagnosis of cancer or sickle cell disease<br>➢ PA required for initiation of long-acting opioid therapy in opioid-naïve patients. Exemption for diagnosis of cancer or sickle cell disease<br>➢ PA required for initiation of methadone therapy in patients currently on benzodiazepine therapy |
| Metozolv® ODT (metoclopramide) | Requires a trial with conventional metoclopramide before metoclopramide orally disintegrating tablet (ODT), except with diagnosis of diabetes mellitus | **QUANTITY LIMIT**:<br>➢ 4 units per day, 120 units per 30 days<br>**DURATION LIMIT**:<br>➢ 90 days | |
| Metreleptin (Myalept®) | | | Confirm diagnosis of FDA-approved or compendia-supported indication |
| 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 |
| 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 |
| Pubertal Suppressants<br>➢ goserelin acetate<br>➢ leuprolide acetate<br>➢ nafarelin acetate | | | ➢ Confirm diagnosis of FDA-approved or compendia-supported indication<br>Refer to the January 2017 Medicaid Update Article for Transgender Related Care and Services Update |

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Revised: February 22, 2018

| Drug / Class Name | Step Therapy (ST) Parameters | Frequency / Quantity / Duration (F/Q/D) Parameters | Additional / Alternate Parameter(s) |
|---|---|---|---|
| Pulmonary Fibrosis Agents<br>➢ Ofev®<br>➢ Esbriet® | | | Confirm diagnosis of FDA-approved or compendia-supported indication |
| Pyrimethamine (Daraprim®) | | | Confirmation of FDA-approved or compendia-supported indications<br>Require concurrent utilization of leucovorin |
| Quinine | | **QUANTITY AND DURATION LIMITS**:<br>➢ Maximum 42 capsules as a 7-day supply<br>➢ limited to 1 prescription per year | |
| Rosacea Agents<br>➢ azelaic acid (Finacea®)<br>➢ brimonidine (Mirvaso®)<br>➢ ivermectin (Soolantra®)<br>➢ oxymetazoline HCL (Rhofade™)<br>➢ doxycycline (Oracea®) | Trial with topical metronidazole product. | | Confirmation of FDA-approved or compendia-supported indication |
| Tasimelteon (Hetlioz®) | | **QUANTITY LIMIT**:<br>➢ One unit per day; 30 units per 30 days | Confirm diagnosis of FDA-approved or compendia-supported indication |
| Parathyroid Hormone Analogs<br>➢ Forteo<br>➢ Tymlos | Requires a trial with a preferred oral bisphosphonate | **QUANTITY LIMIT**:<br>➢ One unit per 30-day period<br>**LIFETIME QUANTITY LIMIT**:<br>➢ 25 months' cumulative use of a PTH analog | |
| Vesicular monoamine transport 2 inhibitors<br>➢ Austedo®<br>➢ Xenazine®<br>➢ Ingrezza™ | | | Confirm diagnosis of FDA-approved or compendia-supported indication |

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

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Revised: February 22, 2018

# 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 February 22, 2018:**

- Reyataz capsule will be **added** to the program
- Tegretol XR, Efudex cream, Benzaclin gel & pump, Retin-A gel, Valcyte tablets, Pulmicort Respules 0.25mg & 0.5mg, Myfortic will be **removed** from the program

| List of Brand Name Drugs included in this program** | | |
|---|---|---|
| Adderall XR | Focalin XR | Tobradex suspension |
| Aggrenox | Fosrenol Chew tabs | Transderm-Scop |
| Alphagan P 0.15% | Gleevec | Trizivir |
| Butrans | Hepsera | Valcyte solution |
| Catapres-TTS | Kapvay | Vigamox |
| Cellcept suspension | Lexiva tablets | Voltaren Gel |
| Copaxone 20ml SQ | Pataday | Xeloda |
| Diastat | Protopic | Xenazine |
| Edecrin | Pulmicort Respules 1mg | Zyflo CR |
| Emend Tripack | Retin-A cream | |
| Exelon patch | **Reyataz capsules** | |
| Focalin | Tegretol suspension | |

**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 https://www.emedny.org/HIPAA/5010/transactions/NCPDP_D.0_Companion_Guide.pdf
- 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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Revised: February 22, 2018

# 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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Revised: February 22, 2018

# 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 case of dose titration for these medications, the Department will allow for multi-day dosing (up to 2 doses/daily) for titration purposes for three months. |
| aripiprazole 5mg, 10mg, 15mg | 1 daily | Tablet | |
| 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 | |
| Rexulti 0.5mg, 1mg, 2mg | 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** | | | |
| Adderall XR 5mg, 10mg, 15mg | 1 daily | Capsule | |
| Concerta ER 18mg, 27mg, 54mg | 1 daily | Tablet | |
| Concerta ER 36mg | 2 daily | Tablet | |
| amphetamine salt combo ER 5mg, 10mg, 15mg | 1 daily | Capsule | |
| Focalin XR 5mg, 10mg, 15mg, 20mg | 1 daily | Capsule | |
| Metadate CD 10mg, 20mg | 1 daily | Capsule | |
| modafinil 100mg | 1 daily | Tablet | |
| 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 | |

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| Brand Name | Dose Optimization Limitations | | |
|---|---|---|---|
| **CENTRAL NERVOUS SYSTEM** | | | |
| **Other Agents for Attention Deficit Hyperactivity Disorder (ADHD)** | | | |
| guanfacine ER 1mg, 2mg, 3 mg, 4mg | 1 daily | Tablet | |
| atomoxetine 40mg | 1 daily | Capsule | |
| Intuniv 1mg, 2mg | 1 daily | Tablet | |
| Strattera 40mg | 1 daily | Capsule | |
| **Sedative Hypnotics** | | | |
| Lunesta 1mg | 1 daily | Tablet | |
| **Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)** | | | |
| Effexor XR 37.5mg, 75mg | 1 daily | Capsule | In the case of dose titration for these 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 | |
| Trintellix 5mg, 10mg | 1 daily | Tablet | |
| venlafaxine ER 37.5mg, 75mg | 1 daily | Capsule | |
| **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 | |

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| Brand Name | Dose Optimization Limitations | | |
|---|---|---|---|
| **RENAL AND GENITOURINARY** | | | |
| **Urinary Tract Antispasmodics** | | | |
| Detrol LA 2mg | 1 daily | Capsule | |
| Enablex 7.5mg | 1 daily | Tablet | |
| Myrbetriq 25mg | 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.

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## *6 – Preferred Diabetic Supply List (as of March 2018)*

**NYS Diabetic Supplies**

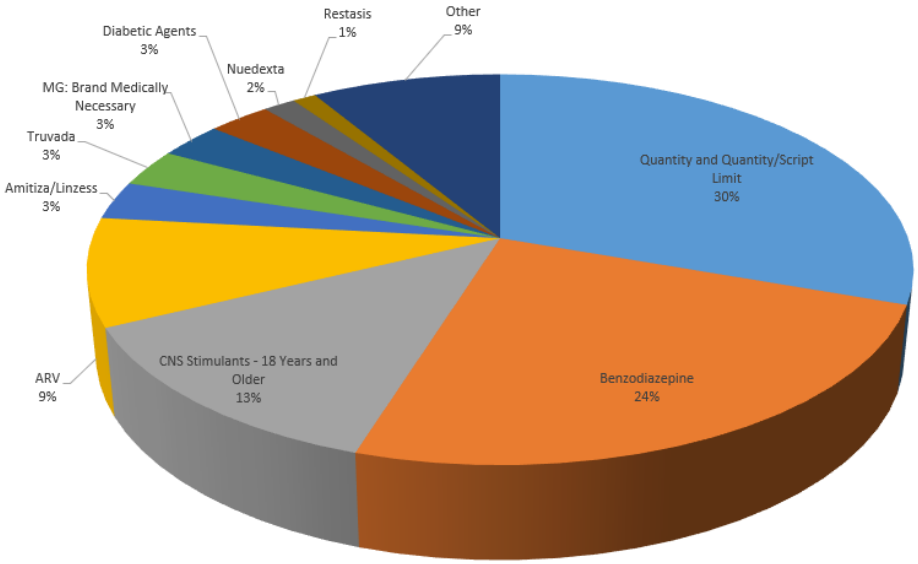
Revised: 10/01/2017

| 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 Meter | 99073071143 | Meter |
| Abbott | FreeStyle InsuLinx Test Strips - 100ct | 99073071227 | Strips |
| Abbott | FreeStyle InsuLinx Test Strips - 50ct | 99073071231 | 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 |
| LifeScan | One Touch UltraMini Meter - Silver Moon | 53885020801 | Meter |
| LifeScan | One Touch Ultra Blue Test Strips - 50ct | 53885024450 | Strips |
| LifeScan | One Touch Ultra Blue Test Strips - 100ct | 53885024510 | Strips |
| LifeScan | One Touch Verio IQ Meter | 53885026701 | Meter |
| LifeScan | One Touch Verio Test Strips - 25ct | 53885027025 | Strips |
| LifeScan | One Touch Verio Test Strips - 50ct | 53885027150 | Strips |
| LifeScan | One Touch Verio Test Strips - 100ct | 53885027210 | Strips |
| LifeScan | One Touch UltraMini Meter - Pink Glow | 53885041901 | Meter |
| LifeScan | One Touch Ultra 2 Meter | 53885044801 | Meter |
| LifeScan | One Touch UltraMini Meter -Blue Comet | 53885091101 | Meter |
| LifeScan | One Touch Ultra Blue Test Strips - 25ct | 53885099425 | Strips |
| LifeScan | One Touch Verio Meter System | 53885065701 | Meter |
| Medisense (Abbott) | Precision Xtra Meter | 57599881401 | Meter |
| Medisense (Abbott) | Precision Xtra Test Strips - 50ct | 57599972804 | Strips |
| Medisense (Abbott) | Precision Xtra Test Strips - 100ct | 57599987705 | Strips |
| Therasense(Abbott) | FreeStyle Test Strips - 50ct | 99073012050 | Strips |
| Therasense(Abbott) | FreeStyle Test Strips - 100ct | 99073012101 | Strips |
| Bayer | Contour Test Strips 25ct | 00193707025 | Strips |
| Bayer | Contour Next Test Strips 25ct | 00193731025 | Strips |
| Bayer | Contour Next One Blood Glucose Monitoring | 00193781801 | Meter |
| LifeScan | One Touch Verio Flex System | 53885019401 | Meter |

## *7 – 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 https://www.health.ny.gov/
- The complete PDL can be accessed at: https://newyork.fhsc.com/downloads/providers/NYRx_PDP_PDL.pdf

## *8 – CDRP and Other Prior Authorizations by Type*

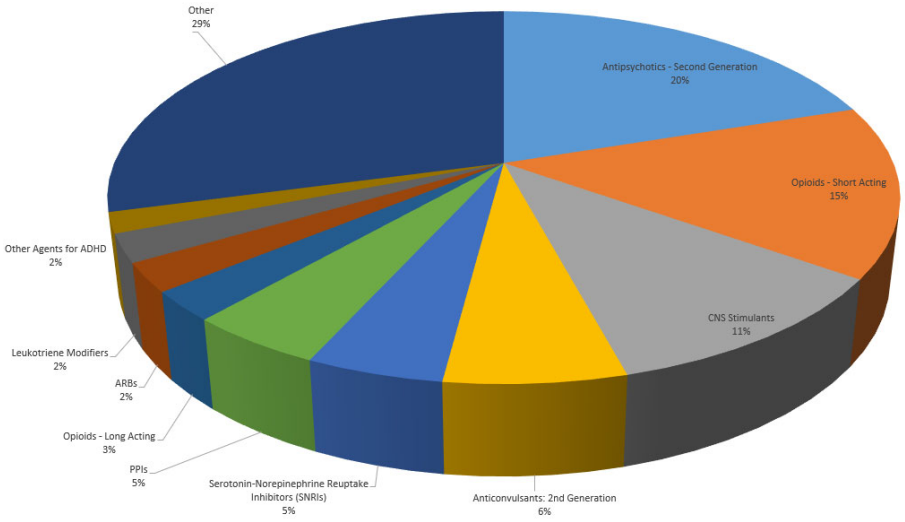



****This chart represents Approved PAs for the following: drugs/drug classes subject to step therapy, FQD (Frequency, Quantity and Duration Limits), PDP classes subject to CDRP and CDRP.**

**Total PAs = 44,520**

| | | | |
|---|---|---|---|
| Quantity and Quantity/Script Limit | 13527 | Pubertal Suppressants | 55 |
| Benzodiazepine | 10893 | Forteo | 54 |
| CNS Stimulants - 18 Years and Older | 5754 | Tazorac | 51 |
| ARV | 3982 | Xenazine | 51 |
| Amitiza/Linzess | 1406 | PCSK9 Inhibitors | 42 |
| Truvada | 1378 | Progesterone | 41 |
| MG: Brand Medically Necessary | 1317 | CF Agents | 38 |
| Diabetic Agents | 1270 | Fentanyl Mucosal Agents | 37 |
| Nuedexta | 661 | MG: Generic Unavailable | 29 |
| Restasis | 482 | Growth Hormones: 21 or Older | 25 |
| Anabolic Steroids | 478 | Viberzi | 24 |
| Lidoderm | 433 | Relistor | 22 |
| BLTG | 392 | Acthar | 14 |
| Synagis | 341 | Regranex | 14 |
| Immunomodulators: Topical | 290 | Dose Optimization | 9 |
| Marinol | 243 | Pulmonary Fibrosis Agents | 7 |
| Methadone | 225 | Hetlioz | 6 |
| Antifungals: Topical Onychomycosis | 192 | Opioid/Buprenorphine TD | 5 |
| Oxazolidinone | 173 | Serostim | 5 |
| Movantik | 140 | Xyrem | 4 |
| PDE-5 Inhibitorsfor Pulmunoary Hypertension | 131 | Daraprim | 3 |
| DUR: Drug to Drug Interaction | 107 | Metozolv | 2 |
| Xiidra | 84 | Quinine | 1 |
| Cross-sex Hormones | 81 | Script Limit | 1 |

## *9 – PDP Prior Authorizations by Class*




**Total PDP PAs = 90,554**

**Of the PAs issued in SFY 17/18, the following PDP drug classes are listed by the number of PAs requested:**

| | | | | | |
|---|---|---|---|---|---|
| Antipsychotics - Second Generation | 18022 | Skeletal Muscle Relaxants | 326 | Antibiotics: Topical | 76 |
| Opioids - Short Acting | 13499 | Sulfasalazine Derivatives | 308 | Antiemetics | 73 |
| CNS Stimulants | 9963 | Erythropoiesis Stimulating Agents (ESAs) | 302 | Inhaled Corticosteroids | 71 |
| Anticonvulsants: 2nd Generation | 5656 | Glucocorticoid: Oral | 286 | Selective Alpha Adrenergic Blockers | 71 |
| Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs) | 4287 | Acne Agents | 282 | Otics: Quinolones | 62 |
| PPIs | 4273 | Statins | 281 | Ophthalmics: Antibiotics | 59 |
| Opioids - Long Acting | 2333 | Topical Steroids: High Potency | 256 | Alpha Reductase Inhibitor: BPH | 57 |
| ARBs | 2265 | Cholesterol Absorption Inhibitors | 247 | Inh. Long Acting Beta-2 Adrenergic | 55 |
| Leukotriene Modifiers | 2210 | Ophthalmics: Antihistamines | 242 | Antifungals Oral | 54 |
| Other Agents for ADHD | 1621 | Carbamazepine Derivatives | 238 | Alpha-Glucosidase Inhibitors | 53 |
| NSAIDs: Rx | 1478 | Biguanides | 229 | Antivirals Oral | 40 |
| DPP-4 Inhibitors | 1334 | Ophthalmics: Prostaglandin Agonists | 214 | Non-Ergot Dopamine Receptor Agonist | 39 |
| Antifungal: Topical | 1262 | Anticoagulants: Oral | 212 | Actinic Keratosis Agents | 36 |
| Urinary Tract Antispasmodics | 1257 | Triptans | 198 | PAH Oral Agents - Other | 34 |
| GLP-1 Agonist | 1075 | Growth Hormones | 187 | Insulin: Rapid Acting | 33 |
| Antiinfectives: Topical | 1013 | Tetracycline | 185 | Antipsychotics: Injectable | 27 |
| Inh. Short Acting Beta-2 Adrenergic | 1008 | Thiazolidinediones | 176 | Calcium Channel Blockers (DHP) | 24 |
| ARB Combinations | 1005 | Inhaled Antibiotics | 174 | Ophthalmic Antibiotic/Steroid Combo | 24 |
| Sedative Hypnotics | 881 | Topical Steroids: Low Potency | 168 | Pancreatic Enzymes | 23 |
| Selective Serotonin Reuptake Inhibitors (SSRIs) | 813 | GI Prep Agents | 164 | Benzodiazepines: Rectal | 19 |
| Triglyceride Agents | 810 | Multiple Sclerosis Agents | 154 | Progestins | 19 |
| Hep C: Direct Acting Antivirals | 788 | Topical Steroids: Medium Potency | 154 | Psoriasis Agents: Topical | 18 |
| Antihistamines - 2nd Generation | 720 | Alzheimer's Agents | 132 | Ophthalmics: NSAIDs | 14 |
| Insulin: Long Acting | 681 | Meglitinides | 114 | Niacin Derivatives | 12 |
| Immunomodulators: Systemic | 673 | ACE Inhibitors | 113 | Beta Blocker/Diuretic Combinations | 10 |
| Beta Blockers | 649 | Platelet Inhibitors | 113 | Hepatitis C Agents: Injectable | 7 |
| SGLT2 Inhibitors | 629 | Bisphosphonates | 109 | Ophthalmics: Beta Blockers | 7 |
| Anticholinergics/COPD Agents | 533 | Ophthalmics: Quinolones | 106 | Direct Renin Inhibitors | 6 |
| Opioid Dependence Agents | 515 | Fluoroquinolones | 104 | Ophthalmics: Alpha-2 Adrenergics | 5 |
| Inhaled Steroid/Beta2 LA Combo | 487 | Antivirals: Topical | 89 | ACE Combinations | 3 |
| Steroids: Intranasal | 472 | Hepatitis B Agents | 87 | Amylin Analog | 3 |
| Anticoagulants: Injectable | 396 | Antihistamines: Nasal | 86 | H. Pylori Agents | 1 |
| Phosphate Binders/Regulators | 366 | Topical Steroids: Very High Potency | 82 | Opioid Antagonists | 1 |
| Antibiotics: GI | 346 | Xanthine Oxidase Inhibitors | 80 | | |

## *10 – PDP and Diabetic Supply Cost Avoidance by County*

| County | PDP | Diabetic Supplies | Total | % Total |
|---|---|---|---|---|
| Albany | $240,392 | $40,259 | $280,651 | 0.98% |
| Allegany | $41,888 | $10,389 | $52,277 | 0.18% |
| Broome | $190,416 | $22,770 | $213,186 | 0.74% |
| Cattaraugus | $93,529 | $7,879 | $101,408 | 0.35% |
| Cayuga | $78,369 | $12,294 | $90,663 | 0.32% |
| Chautauqua | $124,347 | $13,073 | $137,421 | 0.48% |
| Chemung | $123,230 | $16,710 | $139,940 | 0.49% |
| Chenango | $59,339 | $12,987 | $72,325 | 0.25% |
| Clinton | $90,847 | $17,489 | $108,336 | 0.38% |
| Columbia | $58,357 | $7,965 | $66,322 | 0.23% |
| Cortland | $43,083 | $6,493 | $49,576 | 0.17% |
| Delaware | $100,366 | $20,865 | $121,231 | 0.42% |
| Dutchess | $228,932 | $27,618 | $256,550 | 0.89% |
| Erie | $730,682 | $171,338 | $902,020 | 3.15% |
| Essex | $45,295 | $9,091 | $54,386 | 0.19% |
| Franklin | $82,872 | $9,091 | $91,963 | 0.32% |
| Fulton | $71,504 | $8,052 | $79,556 | 0.28% |
| Genesee | $55,888 | $3,203 | $59,092 | 0.21% |
| Greene | $35,990 | $4,329 | $40,319 | 0.14% |
| Hamilton | $1,771 | $346 | $2,118 | 0.01% |
| Herkimer | $57,546 | $13,420 | $70,966 | 0.25% |
| Jefferson | $129,142 | $12,034 | $141,177 | 0.49% |
| Lewis | $31,025 | $3,809 | $34,834 | 0.12% |
| Livingston | $42,044 | $3,983 | $46,027 | 0.16% |
| Madison | $69,327 | $5,801 | $75,128 | 0.26% |
| Monroe | $669,650 | $119,305 | $788,954 | 2.75% |
| Montgomery | $53,242 | $12,814 | $66,055 | 0.23% |
| Nassau | $730,980 | $90,994 | $821,974 | 2.87% |
| Niagara | $168,191 | $32,640 | $200,831 | 0.70% |
| Oneida | $251,220 | $66,492 | $317,712 | 1.11% |
| Onondaga | $437,979 | $77,487 | $515,467 | 1.80% |
| Ontario | $70,366 | $3,377 | $73,742 | 0.26% |
| Orange | $274,448 | $32,640 | $307,088 | 1.07% |
| Orleans | $43,154 | $4,069 | $47,223 | 0.16% |
| Oswego | $98,409 | $19,394 | $117,803 | 0.41% |
| Otsego | $76,889 | $7,186 | $84,075 | 0.29% |
| Putnam | $33,386 | $1,991 | $35,378 | 0.12% |
| Rensselaer | $131,141 | $16,883 | $148,024 | 0.52% |
| Rockland | $261,599 | $32,727 | $294,326 | 1.03% |
| St. Lawrence | $192,956 | $35,410 | $228,366 | 0.80% |
| Saratoga | $125,450 | $10,649 | $136,099 | 0.47% |
| Schenectady | $144,985 | $44,848 | $189,833 | 0.66% |
| Schoharie | $25,397 | $3,636 | $29,034 | 0.10% |
| Schuyler | $20,738 | $1,991 | $22,729 | 0.08% |
| Seneca | $26,713 | $4,502 | $31,215 | 0.11% |
| Steuben | $153,899 | $18,701 | $172,600 | 0.60% |

| County | PDP | Diabetic Supplies | Total | % Total |
|---|---|---|---|---|
| Suffolk | $894,505 | $110,301 | $1,004,806 | 3.50% |
| Sullivan | $114,814 | $9,956 | $124,771 | 0.44% |
| Tioga | $41,027 | $5,368 | $46,395 | 0.16% |
| Tompkins | $83,000 | $7,792 | $90,792 | 0.32% |
| Ulster | $145,071 | $13,333 | $158,404 | 0.55% |
| Warren | $67,435 | $6,580 | $74,014 | 0.26% |
| Washington | $55,582 | $4,762 | $60,344 | 0.21% |
| Wayne | $81,876 | $11,255 | $93,131 | 0.32% |
| Westchester | $609,891 | $110,214 | $720,105 | 2.51% |
| Wyoming | $53,989 | $10,130 | $64,119 | 0.22% |
| Yates | $15,793 | $1,039 | $16,832 | 0.06% |
| Sub Totals | $8,979,958 | $1,389,753 | $10,369,711 | 36.16% |
| | | | | |
| New York City | $15,024,441 | $2,425,662 | $17,450,103 | 60.85% |
| | | | | |
| OMH | $322,617 | $42,943 | $365,560 | 1.27% |
| OMR | $361,232 | $26,580 | $387,812 | 1.35% |
| NYS DOH | $88,464 | $15,584 | $104,048 | 0.36% |
| | | | | |
| Grand Total | $24,776,712 | $3,900,521 | **$28,677,233** | |