ANNUAL REPORT TO THE
GOVERNOR AND LEGISLATURE

New York State Medicaid Preferred Drug Program

STATE FISCAL YEAR
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Abbreviations

Abbreviation/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
GDIT	General Dynamics Information Technology
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 enacted (Section 10 of Part C of Chapter 58 of the Laws of 2005) establishing the Medicaid Preferred Drug Program (PDP) and Clinical Drug Review Program (CDRP) under Public Health Law Article 2-A, §§ 270-277. The legislation provided for 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 (CCC) 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 2008, the population eligible for the PDP was expanded to include Family Health Plus (FHPlus) members (program ended in December 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 2011, members in mainstream Medicaid managed care and FHPlus no longer received pharmacy services through NYS Medicaid FFS Pharmacy Benefit Programs.

Expansion of the programs and operational enhancements continued in the SFY 20/21. At the end of SFY 20/21 there were a total of 115 drug classes subject to the PDP. Sixteen therapeutic categories warranted review by the DURB for the PDP and 6 for the CDRP due to new clinical and/or financial information. No 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 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 DURB 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;
- review of drugs identified as contributors to exceeding the Drug Cap;
- 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 20/21, the DURB reviewed the testimony from 29 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 DURB 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 20/21 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 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 safer 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.

Public Health Law § 274 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 20/21 is as follows:

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

Brand Less Than Generic (BLTG) Program

In April 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 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 20/21, the total savings achieved by this program, net of rebates, was $10,403,995.

Brand name drugs that were subject to this program at the end of SFY 20/21 include:

List of Brand Name Drugs included in this program**		
Advair Diskus®	Diclegis®	Rapamune® solution
Alphagan P® 0.15%	Exelon® patch	Retin-A® cream
Androgel®	Focalin® XR	Sensipar®
Apriso®	Humalog® U100 vial and Kwikpen	Suboxone® film
Atripla®	Kitabis® Pak	Symbicort®
Bethkis®	Lialda®	Tecfidera®
Catapres-TTS®	Mitigare®	Tegretol® suspension
CellCept® suspension	Novolog® 100u/mL Flexpen and vial	Tracleer® Tablet
Ciprodex®	Novolog® Mix 70/30 Flexpen	**Truvada®**
Concerta®	NuvaRing®	Xeloda®
Copaxone® 20 mg SQ	Proair® HFA	Zovirax® cream

The Preferred Diabetic Supply Program (PDSP) Diabetic Supply Program

As a result of legislation passed in 2008 (Chapter 497 of the Laws of 2008), the New York State Medicaid Program implemented the PDSP, in October 2009. 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 20/21, a total of 48,110 diabetic supply claims were processed achieving a total savings, net of rebates, of $3,033,714. In the prior SFY, 53,767 diabetic supply claims were processed with a total savings, net of rebates, of $3,699,540. 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 in December 2011, approximately 10.9 million electronic prior

authorizations have been issued without prescriber involvement. For SFY 20/21, 1,035,041 automated PAs were issued without prescriber involvement, representing over 92 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 20/21, the CCC received approximately 91,136 phone requests and 105,021 fax requests for prior authorization under the PDP and CDRP. Nearly all phone requests (99.98 percent) were completed during the initial call. In addition, the CCC provided approximately 64,227 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. Public Health Law § 273(a) sets forth the criteria used by the CCC staff to evaluate a request for a non-preferred drug 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 Public

Health Law § 273(b), 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 17.8% percent of the PDP PAs processed in SFY 20/21. 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 20/21, there were 19 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 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 20/21, changes to the pharmacy PA programs occurred through the 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). Copies of the Medicaid Update Articles can be found at: https://www.health.ny.gov/health_care/medicaid/program/update/main.htm. 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 are generated and sent to the top 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 provides information on the BLTG program and directs pharmacies to the current listing of drugs subject to BLTG requirements. In addition, pharmacies can subscribe to the distribution list which provides updates to the program.

IV. Prescriber, Pharmacy, and Patient Satisfaction

Complaints

Complaints may be received through a variety of sources including by mail or email, through the Clinical Call Center (CCC) or Medicaid Helpline. When such calls are received, they are referred to the DOH Medicaid pharmacy staff where direct assistance is provided. Twenty-three complaints about the PDP and CDRP were received during SFY 20/21, primarily via phone calls. Twenty-more complaints were received in SFY 20/21 than were received the previous year.

Complaints categorized as Retail Rx Issue were primarily pertaining to claim rejections at the pharmacy. Sources of these complaints were as follows - enrollees with Managed Care plans or other insurance, claim rejection for a drug not requiring a PA or other rejections that were referred to General Dynamics Information Technology (GDIT), formerly CSRA, Inc., for further assistance. Customer Service-related complaints were received by the Clinical Call Center from enrollees or enrollee representatives for drug or vaccine coverage where MCO or Medicare D coverage was present.

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.

Customer Service Pharmacy	8
Retail Rx Issue	8
Other	2
PDL Criteria	2
Hold Time	1
Benefit Plan Issue	1
PA/Utilization Management Issue	1
	23

The DOH Medicaid pharmacy staff responds to member and provider inquiries related to policy. The Medicaid's Helpline referred 42 policy related member calls to DOH Medicaid pharmacy staff. Calls pertained to lost or stolen prescriptions, vacation overrides, formulary overrides, medical or dental coverage, and questions on identification cards. Call volume and call reasons are regularly evaluated to determine whether there is a need for provider and/or member education or whether there are systemic issues that warrant policy and/or operational changes.

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.

New York State has several supplemental rebate programs, including but not limited to the National Medicaid Pooling Initiative (NMPI) and the New York State Direct Contracting Program (SDC) which enable the Department to collect supplemental rebates from drug manufacturers. 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 20/21 the NMPI includes more than 80 participating manufacturers and has approximately 10.9 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 11.6 million pharmacy claims in SFY 20/21. 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 20/21 62.7 percent of claims were for drugs that did not require prior authorization. The remaining 37.3 percent of claims were for drugs that required a manual prior authorization processed by the clinical call center. These percentages are attributable to the wide selection of preferred drugs within a class, prescriber familiarity with the Medicaid PDP and prescriber education efforts, all of which are supported by the pharmacy provider community in advising prescribers of preferred drug choices. There were 95,022 prior authorizations processed across all pharmacy programs.

Under the PDP, the highest volume of requests for prior authorizations during SFY 20/21 were for the following drug classes: second generation antipsychotics (18 percent), primarily used to treat mental health illnesses such as schizophrenia and bipolar disorder; short-acting opioids (12 percent), used to treat moderate to severe pain; CNS Stimulants (7 percent), primarily used to treat Attention Deficit Hyperactivity Disorder; Proton Pump

Inhibitors (6 percent), used to treat acid reflux; and second generation anticonvulsants (5 percent), used primarily to treat seizure disorders. Requests for prior authorization for Hepatitis C Agents made up 0.3 percent of prior authorizations for SFY 20/21.

Consistent with the experience in SFY 19/20, 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, 3.8 percent of the total requests resulted in the prescriber agreeing to use the preferred drug in lieu of a non-preferred drug. The CCC representatives have continued to promote the use of preferred agents as clinically appropriate, attributing to the relative changes observed.

Total PDP savings combine the sum of supplemental rebates invoiced with the savings associated with market shift cost avoidance. Market shift cost avoidance occurs with the shifting of utilization from more expensive products to less expensive products in each therapeutic drug class within the PDP (Preferred Drug Program). For SFY 20/21, total PDP savings, net of rebates, were approximately $5.8 million for the Medicaid Fee for Service program. Appendix 10 lists the program's cost avoidance by county.

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

In SFY 20/21, a total of 5,837 requests were approved for PA of drugs under the CDRP as follows:

- Anabolic Steroids: 365
- CNS Stimulants: 18 or Older: 3,719
- Fentanyl Mucosal Agents: 39
- Growth Hormone: 21 or Older: 4
- Immunomodulators: Topical: 363
- Lidocaine Patch: 374
- Oxazolidinone Antibiotics®: 164
- Phosphodiesterase type-5 (PDE-5) Inhibitors for PAH: 95
- Pre-exposure Prophylaxis (PrEP) Agents: 516
- Regranex®: 9
- Serostim®: 0
- Synagis®: 184
- Xyrem®/ Xywav™ (sodium oxybate): 5

Automation of claim review for PrEP Agent criteria resulted in a 57% decrease in SFY 20/21 authorizations requiring prescriber involvement. Additionally, the PA volume for Synagis in SFY 20/21 is lower than the previous SFY. This is possibly due to COVID restrictions, lower RSV activity reported by CDC from May 2020 to March 2021 due to the adoption of public health measures to reduce the spread of COVID, and/or a decrease in overall prior authorization request volume.

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, 1.6 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 fifteenth 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 20/21, the DURB reviewed 16 classes of drugs in the PDP to include drugs recently approved by the FDA and newly available clinical and financial information. There were no new drug classes reviewed for inclusion on the PDP. By the end of SFY 20/21 there were a total of 115 drug classes subject to the PDP. No new drugs were recommended for inclusion into the CDRP by the DUR Board in SFY 20/21.

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

Appendix 1 – Public Health Law Article 2-A, Title 1

ARTICLE 2-A *as of March 2019

PRESCRIPTION DRUGS

Section 270. Definitions.

272. Preferred drug program.

273. Preferred drug program prior authorization.

274. Clinical drug review program.

275. Applicability of prior authorization to EPIC.

276. Education and outreach.

277. Review and reports.

§ 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.

Appendix 2 – Drug Utilization Review Board Membership

Department of Health Designee - Chairperson
1. Douglas Fish, MD

Physicians
2. Renante Ignacio, MD
3. Asa Radix, MD
4. Peter Deane, MD
5. Jamie Wooldridge, MD
6. Vacancy
7. Vacancy

Pharmacists
8. Lisa Anzisi, PharmD
9. James Hopsicker, RPh, MBA
10. Michelle Rainka, PharmD
11. Tara Thomas, RPh, MBA
12. Jacqueline Jacobi, RPh
13. Deborah Wittman, PharmD, CDE, BCACP

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. Vacancy
19. Vacancy

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

Actuary
22. Peter Lopatka, FSA

Department of Financial Services Designee
23. John Powell

Appendix 3 – Social Services Law Section 369-BB

§ 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.

Appendix 4 – Drug Classes in the Preferred Drug Program (as of March 2021)

The following table lists drug classes that were reviewed at the DURB during SFY 20/21. 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
July 23, 2020	Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)	September 10, 2020	October 8, 2020
July 23, 2020	Hepatitis C Agents – Direct Acting Antivirals	September 10, 2020	October 8, 2020
July 23, 2020	Central Nervous System (CNS) Stimulants	September 10, 2020	October 8, 2020
July 23, 2020	Acne Agents, Topical	September 10, 2020	October 8, 2020
July 23, 2020	Topical Steroids, High Potency	September 10, 2020	October 8, 2020
July 23, 2020	Glucagon-like Peptide-1 Agonists	September 10, 2020	October 8, 2020
July 23, 2020	Sodium Glucose Co-Transporter 2 (SGLT2) Inhibitors	September 10, 2020	October 8, 2020
July 23, 2020	Sulfasalazine Derivatives	September 10, 2020	October 8, 2020
July 23, 2020	Immunosuppressives, Oral	September 10, 2020	October 8, 2020
July 23, 2020	Phosphate Binders/Regulators	September 10, 2020	October 8, 2020
November 5, 2020	ARBs Combinations	April 22,2021	April 22, 2021
November 5, 2020	Antimigraine Agents – Acute Treatment	April 22, 2021	April 22, 2021
November 5, 2020	Antipsychotics – Second Generation	April 22, 2021	April 22, 2021
November 5, 2020	Multiple Sclerosis Agents	April 22, 2021	April 22, 2021
November 5, 2020	Gastrointestinal Antibiotics	April 22, 2021	April 22, 2021
November 5, 2020	Immunomodulators- Systemic	April 22, 2021	April 22, 2021

Appendix 5 – Preferred and Non-Preferred Drug List (as of March 2021)

Revised: February 4, 2021

New York State Medicaid Fee-For-Service Pharmacy Programs

OVERVIEW OF CONTENTS

Preferred Drug Program (PDP) (Pages 3-59)
The PDP promotes the use of less expensive, equally effective drugs when medically appropriate through a Preferred Drug List (PDL). All drugs currently covered by Fee-For-Service (FFS) Medicaid remain available under the PDP and the determination of preferred and non-preferred drugs does not prohibit a prescriber from obtaining any of the medications covered under Medicaid.

- Non-preferred drugs in these classes require prior authorization (PA), unless indicated otherwise.
- Preferred drugs that require prior authorization are indicated by footnote.
- Specific Clinical, Frequency/Quantity/Duration, Step Therapy criteria is listed in column at the right.

Clinical Drug Review Program (CDRP) (Page 62)
The 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.

Drug Utilization Review (DUR) Program (Pages 63-75)
The DUR helps to ensure that prescriptions for outpatient drugs are appropriate, medically necessary, and not likely to result in adverse medical consequences. This program uses professional medical protocols and computer technology and claims processing to assist in the management of data regarding the prescribing and dispensing of prescriptions. 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.

Brand Less Than Generic (BLTG) Program (Page 76-77)
The Brand Less Than Generic Program is 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. This program is in conformance with State Education Law, which intends that patients receive the lower cost alternative.

Mandatory Generic Drug Program (Page 78)
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. Drugs subject to the Preferred Drug Program (PDP), Clinical Drug Review Program (CDRP), and/or the Brand Less Than Generic (BLTG) Program are not subject to the Mandatory Generic Program.

Dose Optimization Program (Pages 79-83)
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.

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
Disclaimer: Branded generics are included with the single generic name listing, they are not listed as separate agents. 1

Revised: February 4, 2021

NYS Medicaid Fee-For-Service Preferred Drug List

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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)		
diclofenac 1% topical gel ibuprofen Rx (tablet) ibuprofen OTC (susp) indomethacin ketorolac meloxicam (tablet) naproxen (tablet) naproxen EC piroxicam sulindac	Arthrotec® Cambia® Celebrex® CC celecoxib CC Daypro® diclofenac epolamine (generic for Flector) diclofenac/misoprostol diclofenac potassium diclofenac sodium diclofenac sodium ER diclofenac topical soln diflunisal Duexis® etodolac etodolac ER Feldene® fenoprofen Flector® patch Flurbiprofen ibuprofen Rx (susp) Indocin® indomethacin ER ketoprofen ketoprofen ER ketorolac nasal spray (gen Sprix®) Licart™ meclofenamate mefenamic acid melixicam (capsules) (gen Vivlodex®) Mobic® nabumetone Nalfon®	**CLINICAL CRITERIA (CC)** • **Celebrex® (celecoxib)** – one of the following criteria will not require PA – Over the age of 65 years – Concurrent use of an anticoagulant agent – History of GI Bleed/Ulcer or Peptic Ulcer Disease

1 = Preferred as of 10/8/2020
2 = Non-Preferred as of 10/8/2020

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NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
I. Analgesics		
	Naprelan® naproxen (susp) naproxen CR naproxen-esomeprazole naproxen sodium oxaprozin Pennsaid® Qmiiz ODT™ Relafen® DS Sprix® Tivorbex® tolmetin Vimovo® Vivlodex® Voltaren® Gel Zipsor® Zorvolex®	
Opioids – Long-Acting CC, F/Q/D		
buprenorphine patches fentanyl patch (12 mcg, 25 mcg, 50 mcg, 75 mcg, 100 mcg) morphine sulfate ER (tablet)	Arymo® ER Belbuca® Butrans® Conzip® ST Duragesic® fentanyl patch (37.5 mcg, 62.5 mcg, 87.5 mcg) hydrocodone ER hydromorphone ER Hysingla® ER Kadian® Morphabond® ER morphine ER (capsule) (generic for Avinza) morphine ER (capsule) (generic for Kadian)	**CLINICAL CRITERIA (CC) *** • Limited to a total of 4 opioid prescriptions every 30 days; Exemption for diagnosis of cancer or sickle cell disease • PA required for initiation of opioid therapy for patients on established opioid dependence therapy • PA required for use if ≥ 90 MME (MME = morphine milligram equivalents) of opioid per day for management of non-acute pain (pain lasting > 7 days) • PA required for initiation of long-acting opioid therapy in opioid-naïve patients. • PA required for any additional long-acting opioid prescription for patients currently on long-acting opioid therapy. • PA required for initiation of opioid therapy in patients currently on benzodiazepine therapy • PA required for any codeine- or tramadol-containing products in pts < 12 yrs **STEP THERAPY (ST)**

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NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
I. Analgesics		
	MS Contin® Nucynta® ER [ST] oxycodone ER Oxycontin® oxymorphone ER tramadol ER [ST] Xtampza® ER Zohydro® ER	Nucynta® ER (tapentadol ER): **Trial with tapentadol IR before tapentadol ER for patients who are naïve to a long-acting opioid** Tramadol ER (tramadol naïve patients): **Attempt treatment with IR formulations before the following ER formulations: Conzip®, tramadol ER** • **FREQUENCY/QUANTITY/DURATION (F/Q/D)** * • Belbuca® (buprenorphine) – Maximum 2 units per day • Butrans® (buprenorphine) – Maximum 4 patches per 28 days • Nucynta® ER (tapentadol ER): – Maximum 2 units per day • Nucynta® ER (tapentadol ER): – Maximum daily dose of tapentadol IR and tapentadol ER formulations if used in combination should not exceed 500mg/day • Tramadol ER (Conzip®): – Maximum 30 tablets dispensed as a 30-day supply • Zohydro® ER (hydrocodone ER): – Maximum 2 units per day, 60 units per 30 days • Hysingla® ER (hydrocodone ER): – Maximum 1 unit per day; 30 units per 30 days • Hydromorphone ER, oxymorphone ER: – Maximum 4 units per day, 120 units per 30 days • Oxycodone ER (Xtampza® ER): – Maximum 2 units per day, 60 units per 30 days. Not to exceed a total daily dose of 160 mg or its equivalent • Fentanyl transdermal patch (Duragesic®): – Maximum 10 patches per 30 days; maximum 100 mcg/hr (over a 72-hour dosing interval) • Morphine ER (excluding MS Contin products): – Maximum 2 units per day, 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
I. Analgesics		
		• Morphine ER (MS Contin® and Arymo® ER 15 mg, 30 mg, 60 mg only): – Maximum 3 units per day, 90 units per 30 days • Morphine ER (MS Contin® 100 mg only): – Maximum 4 units per day, up to 3 times a day, maximum 120 units per 30 days • Morphine ER (MS Contin® 200 mg only): – Maximum 2 units per day, maximum 60 units per 30 days • For Non-opioid Pain management alternatives please visit: https://health.ny.gov/health_care/medicaid/program/opioid_management/docs/non_opioid_alternatives_to_pain_management.pdf *The quantity limits listed are systematically converted into Morphine Milligram Equivalents (MME) for the purpose of prospective drug utilization review/clinical editing.* *Exemption from requirements for diagnosis of cancer, sickle cell disease, or hospice care.
Opioids – Short-Acting [CC]		
butalbital / APAP / caffeine / codeine [F/Q/D] codeine [F/Q/D] codeine / APAP [F/Q/D] hydrocodone / APAP [F/Q/D] hydrocodone / ibuprofen [F/Q/D] Lortab® (elixir) [F/Q/D] morphine IR [F/Q/D] oxycodone / APAP [F/Q/D] tramadol [F/Q/D]	Apadaz® [F/Q/D] benzhydrocone / APAP [F/Q/D] butalbital compound/ codeine [F/Q/D] butorphanol nasal spray dihydrocodeine / APAP / caffeine [F/Q/D] Dilaudid® [F/Q/D] Fiorinal® / codeine [F/Q/D] hydromorphone [F/Q/D] levorphanol meperidine Nalocet® Nucynta® [ST, F/Q/D] Oxaydo® oxycodone [F/Q/D] oxycodone / aspirin [F/Q/D] oxycodone / ibuprofen [F/Q/D] oxymorphone [F/Q/D]	**CLINICAL CRITERIA (CC) *** • Limited to a total of 4 opioid prescriptions every 30 days. • Initial prescription for opioid-naïve patients limited to a 7-day supply. • PA required for initiation of opioid therapy for patients on established opioid dependence therapy. • PA required for use if ≥ 90 MME of opioid per day for management of non-acute pain (> 7 days) – Exception for diagnosis of cancer or sickle cell disease, or hospice program • PA is required for opioid-naïve patients for prescription requests ≥ 50 MME per day. • PA required for continuation of opioid therapy beyond an initial 7-day supply in patients established on gabapentin or pregabalin • PA required for initiation of opioid therapy in patients currently on benzodiazepine therapy • PA required for any codeine- or tramadol-containing products in pts < 12 yrs **STEP THERAPY (ST)**

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NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
I. Analgesics		
	pentazocine / naloxone Percocet® F/Q/D Primlev® F/Q/D Roxicodone® F/Q/D tramadol / APAP F/Q/D Tylenol® / codeine #3 F/Q/D Tylenol® / codeine #4 F/Q/D Ultracet® F/Q/D Ultram®	• **Nucynta® (tapentadol IR)** – Trial with tramadol and 1 preferred opioid before tapentadol immediate-release (IR) **FREQUENCY/QUANTITY/DURATION (F/Q/D)** **Quantity Limits:** • Apadaz® (benzhydrocodone/APAP): – Maximum 12 units per day • Nucynta® (tapentadol IR): – Maximum 6 units per day; 180 units per 30 days • Nucynta® (tapentadol IR): – Maximum daily dose of **tapentadol IR** and **tapentadol ER** formulations used in combination not to exceed 500 mg/day • tramadol – Maximum 400 mg per day • **Morphine and congeners immediate-release (IR)** non-combination products (codeine, hydromorphone, morphine, oxycodone, oxymorphone): – Maximum 6 units per day, 180 units per 30 days Additional/alternate parameters: To be applied to patients without a documented cancer or sickle cell diagnosis. • **Morphine and congeners immediate-release (IR) combination** products maximum recommended: – acetaminophen (4 grams) – aspirin (4 grams) – ibuprofen (3.2 grams) – or the FDA-approved maximum opioid dosage as listed in the PI, whichever is less **Duration Limits:**

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NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
I. Analgesics		
		• 90 days for patients without a diagnosis of cancer or sickle-cell disease. • For Non-opioid Pain management alternatives please visit: https://health.ny.gov/health_care/medicaid/program/opioid_management/docs/non_opioid_alternatives_to_pain_management.pdf *The quantity limits listed are systematically converted into morphine milligram equivalents (MME) for the purpose of prospective drug utilization review/clinical editing.* *Exemptions from requirements for diagnosis of cancer, sickle cell disease, or hospice care

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
II. Anti-Infectives		
Antibiotics – Inhaled CC, F/Q/D		
Bethkis® BLTG Cayston® Kitabis® Pak BLTG	TOBI® Podhaler™ TOBI® (solution) tobramycin (generic for Bethkis®, Kitabis®, Tobi®) solution	**CLINICAL CRITERIA (CC)** Confirm diagnosis of FDA-approved or compendia-supported indication **FREQUENCY/QUANTITY/DURATION (F/Q/D)** • Aztreonam (Cayston) – 3 ampules (3 mL) per day – 84 ampules (84 mL) per 56 day regimen (28 days on, 28 days off) • Tobramycin inhalation solution (Bethkis, TOBI, Kitabis Pak) – 2 ampules (8 mL Bethkis, 10 mL TOBI, Kitabis Pak) per day – 56 ampules (224 mL Bethkis, 280 mL TOBI, Kitabis Pak) per 56 day regimen (28 days on-28 days off) • Tobramycin capsules with inhalation powder (TOBI Podhaler) – 8 capsules per day 224 capsules per 56 day regimen (28 days on-28 days off)
Anti-Fungals – Oral for Onychomycosis		
griseofulvin (suspension and ultramicronized) terbinafine (tablet)	griseofulvin (tablet) itraconazole itraconazole solution (generic for Sporanox) Onmel® Sporanox®	

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NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
II. Anti-Infectives		
Anti-Virals – Oral		
acyclovir valacyclovir	famciclovir Valtrex® Zovirax®	
Cephalosporins – Third Generation		
cefdinir	cefixime cefpodoxime Suprax®	
Fluoroquinolones – Oral		
ciprofloxacin (suspension, tablet) levofloxacin (tablet)	Baxdela® Cipro® (suspension, tablet) Levaquin® levofloxacin (solution) moxifloxacin ofloxacin (tablet)	
Hepatitis B Agents		
adefovir dipivoxil Baraclude® (solution) entecavir Epivir-HBV® (solution) lamivudine HBV	Baraclude® (tablet) Epivir-HBV® (tablet) Hepsera® Vemlidy®	

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NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
II. Anti-Infectives		
Hepatitis C Agents – Injectable F/Q/D		
Pegasys® PegIntron®	None	**FREQUENCY/QUANTITY/DURATION (F/Q/D)** • PA required for the initial 14 weeks therapy to determine appropriate duration of therapy based on genotype, prior treatment and response, presence of cirrhosis, and HIV-coinfection. • Further documentation required for continuation of therapy at weeks 14 and 26. • After 12 weeks of therapy, obtain a quantitative HCV RNA. Continuation is supported if undetectable HCV RNA or at least a 2 log decrease compared to baseline. • After 24 weeks of therapy obtain a HCV RNA. Continuation for genotype 1 and 4 is supported if undetectable HCV RNA. • Maximum duration of 48 weeks for: – Treatment-naïve patients or prior relapsers with cirrhosis and HIV co-infection – Prior non-responders (including prior partial and null responders) with or without cirrhosis and with or without HIV co-infection
Hepatitis C Agents – Direct Acting Antivirals		
Mavyret™ CC, F/Q/D ribavirin sofosbuvir/velpatasvir CC, F/Q/D (generic for Epclusa®) Vosevi® CC, F/Q/D	Epclusa® CC, F/Q/D Harvoni® CC, F/Q/D ledipasvir/sofosbuvir CC, F/Q/D (generic for Harvoni®) Ribasphere® Sovaldi® CC, F/Q/D Viekira Pak® CC, F/Q/D Zepatier® CC, F/Q/D	**CLINICAL CRITERIA (CC)** • Confirm diagnosis of FDA-approved or compendia-supported indication • For patients being retreated require confirmation of patient readiness and adherence – Evaluation by using scales or assessment tools readily to determine a patient's readiness to initiate HCV treatment, specifically drug and alcohol abuse potential. Assessment tools are available to healthcare practitioners at: https://www.drugabuse.gov/nidamed-medical-health-professionals/screening-tools-resources/chart-screening-tools OR https://prepc.org/. The Hepatitis C Worksheet can be accessed at: https://newyork.fhsc.com/downloads/providers/NYRx_PDP_PA_Worksheet_Prescribers_HepC.docx

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NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
II. Anti-Infectives		
Tetracyclines		
demeclocycline doxycycline hyclate minocycline (capsule) tetracycline	Doryx® ST, F/Q/D Doryx MPC® ST, F/Q/D doxycycline hyclate DR ST, F/Q/D doxycycline monohydrate minocycline (tablet) minocycline ER Minolira ER™ Nuzyra™ Oracea® Solodyn® Vibramycin® Ximino®	**STEP THERAPY (ST)** • Trial of doxycycline IR before progressing to doxycycline DR **FREQUENCY/QUANTITY/DURATION (F/Q/D)** • doxycycline DR (Doryx®): – Maximum 28 tablets/capsules per fill

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NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
III. Cardiovascular		
Angiotensin Converting Enzyme Inhibitors (ACEIs)		
benazepril enalapril lisinopril ramipril	Accupril® Altace® captopril Epaned® fosinopril Lotensin® moexipril perindopril Prinivil® Qbrelis™ quinapril trandolapril Vasotec® Zestril®	
ACE Inhibitor Combinations		
benazepril/ amlodipine benazepril/ HCTZ captopril/ HCTZ enalapril/ HCTZ lisinopril/ HCTZ Lotrel® Tarka® trandolapril/verapamil ER	Accuretic® fosinopril/ HCTZ Lotensin HCT® quinapril/ HCTZ Vaseretic® Zestoretic®	

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NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
III. Cardiovascular		
Angiotensin Receptor Blockers (ARBs)		
Diovan® DO losartan valsartan	Atacand® Avapro® Benicar® DO candesartan Cozaar® Edarbi® eprosartan irbesartan Micardis® DO olmesartan telmisartan	**DOSE OPTIMIZATION (DO)** • See Dose Optimization Chart for affected drugs and strengths
Antianginals and Anti-Ischemics		
ranolazine	Ranexa®	
ARBs Combinations		
Exforge HCT® losartan/ HCTZ valsartan/ amlodipine valsartan/ amlodipine / HCTZ valsartan/ HCTZ	Atacand HCT® Avalide® Azor® Benicar HCT® DO candesartan/ HCTZ Diovan HCT® DO Edarbyclor® DO Entresto® CC Exforge® DO Hyzaar® irbesartan/ HCTZ Micardis HCT® DO olmesartan/ amlodipine olmesartan/ amlodipine/ HCTZ olmesartan/ HCTZ telmisartan/ amlodipine telmisartan/ HCTZ Tribenzor®	**CLINICAL CRITERIA (CC)** • PA is not required if patient has chronic symptomatic HFrEF (NYHA class II or III), can tolerate an ACE inhibitor or ARB, and transition to the non-preferred product is warranted to produce the desired health outcome **DOSE OPTIMIZATION (DO)** • See Dose Optimization Chart for affected drugs and strengths

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NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
III. Cardiovascular		
Beta Blockers		
atenolol carvedilol labetalol metoprolol succ. XL DO metoprolol tartrate propranolol (tablet)	acebutolol betaxolol bisoprolol Bystolic® DO carvedilol ER Coreg® Coreg CR® DO Corgard® Inderal LA® Inderal XL® InnoPran XL® Kapspargo™ Sprinkle Lopressor® nadolol DO pindolol propranolol (solution) propranolol ER/SA Tenormin® timolol Toprol XL® DO	**DOSE OPTIMIZATION (DO)** • See Dose Optimization Chart for affected drugs and strengths
Beta Blockers / Diuretics		
atenolol/ chlorthalidone bisoprolol/ HCTZ propranolol/ HCTZ	metoprolol tartrate/ HCTZ nadolol/ bendroflumethiazide Tenoretic® Ziac®	**DOSE OPTIMIZATION (DO)** • See Dose Optimization Chart for affected drugs and strengths

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NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
III. Cardiovascular		
Calcium Channel Blockers (Dihydropyridine)		
amlodipine felodipine ER isradipine nicardipine HCl nifedipine nifedipine ER/SA	Adalat® CC Katerzia™ nisoldipine Norvasc® Procardia® Procardia XL® Sular®	
Cholesterol Absorption Inhibitors		
cholestyramine cholestyramine light Colestid® (tablet) colestipol (tablet)	colesevelam Colestid (granules) colestipol (granules) ezetimibe Questran® Questran Light® Welchol® Zetia®	
Direct Renin Inhibitors ST		
aliskiren Tekturna® Tekturna HCT®	None	**STEP THERAPY (ST)** • 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
III. Cardiovascular		
HMG-CoA Reductase Inhibitors (Statins)		
atorvastatin lovastatin pravastatin rosuvastatin simvastatin	Altoprev® atorvastatin/amlodipine Caduet® Crestor® DO Ezallor™ Sprinkle ezetimibe/simvastatin fluvastatin fluvastatin ER Lescol XL® Lipitor® Livalo® Pravachol® Vytorin® Zocor® Zypitamag™	**DOSE OPTIMIZATION (DO)** • See Dose Optimization Chart for affected drugs and strengths
Niacin Derivatives		
niacin ER	Niaspan® DO	**DOSE OPTIMIZATION (DO)** • See Dose Optimization Chart for affected drugs and strengths
Phosphodiesterase type-5 (PDE-5) Inhibitors for PAH CDRP		
sildenafil tadalafil (generic for Adcirca)	Adcirca® Revatio®	**CLINICAL DRUG REVIEW PROGRAM (CDRP)** • All prescriptions for **Adcirca®**, **tadalafil, Revatio®**, and **sildenafil** must have PA • Prescribers or their authorized agents are required to respond to a series of questions that identify prescriber, patient and reason for prescribing drug • Please be prepared to fax clinical documentation upon request • Prescriptions can be written for a 30-day supply with up to 5 refills • The **CDRP Phosphodiesterase type-5 (PDE-5) Inhibitors for PAH Prescriber Worksheet**, located at https://newyork.fhsc.com/downloads/providers/NYRx_CDRP_PA_Worksheet_Prescribers_PDE-5_Inhibitors.docx, provides step-by-step assistance in completing the prior authorization process

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Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
III. Cardiovascular		
Pulmonary Arterial Hypertension (PAH) Agents, Other – Oral		
ambrisentan (generic for Letairis) Tracleer® BLTG tablet	Adempas® bosentan (generic for Tracleer) Letairis® Opsumit® Orenitram® ER Tracleer® tabs for suspension Uptravi®	
Triglyceride Lowering Agents		
gemfibrozil fenofibrate (48 mg, 145 mg) fenofibric acid	Antara® fenofibrate Fenoglide® icosapent (gen Vascepa®) ST, F/Q/D Lipofen® Lopid® Lovaza® ST, F/Q/D omega-3 ethyl ester ST, F/Q/D Tricor® Triglide® Trilipix® Vascepa® ST, F/Q/D	**STEP THERAPY (ST)** • **Lovaza® (omega-3-acid ethyl-esters)** and **Vascepa® (icosapent ethyl)** – Trial of fibric acid derivative OR niacin prior to treatment with omega-3-acid ethyl-esters **FREQUENCY/QUANTITY/DURATION (F/Q/D)** • Lovaza® (omega-3-acid ethyl-esters) and Vascepa® (icosapent ethyl) – Required dosage equal to 4 units per day

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Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
IV. Central Nervous System		
Alzheimer's Agents		
donepezil 5mg, 10mg Exelon® BLTG (patch) galantamine galantamine ER memantine Namenda® rivastigmine (capsule)	Aricept® donepezil 23 mg memantine ER CC, ST Namenda XR® CC, ST Namzaric® CC, ST Razadyne® Razadyne ER® rivastigmine (patch)	**CLINICAL CRITERIA (CC)** • Memantine extended-release containing products(Namenda XR® and Namzaric®) – Require confirmation of diagnosis of dementia or Alzheimer's disease **STEP THERAPY (ST)** • Memantine extended-release containing products (Namenda XR® and Namzaric®) – Require trial with memantine immediate-release (Namenda®)
Anticonvulsants – Carbamazepine Derivatives CC		
carbamazepine (chewable, tablet) carbamazepine ER (capsule) carbamazepine XR (tablet) Equetro® oxcarbazepine Tegretol® BLTG (suspension)	Aptiom® carbamazepine (suspension) Carbatrol® Oxtellar XR® Tegretol® (tablet) Tegretol XR® Trileptal®	**CLINICAL CRITERIA (CC)** • Clinical editing will allow patients currently stabilized on a non-preferred agent to continue to receive that agent without PA
Anticonvulsants – Other CC		
clobazam (tablet) ST gabapentin (capsule, solution, tablet) F/Q/D lamotrigine (tablet, chew) levetiracetam levetiracetam ER Lyrica® (capsule) DO, ST, F/Q/D pregabalin (capsule) DO, ST, F/Q/D tiagabine topiramate zonisamide	Banzel® Briviact® clobazam (suspension) ST Diacomit® CC Epidiolex® felbamate Felbatol® Fintepla® Fycompa® Gabitril® Keppra® Keppra XR® Lamictal® (tablet, chew, dosepak) Lamictal® ODT (tablet, dosepak)	**DOSE OPTIMIZATION (DO)** • See Dose Optimization Chart for affected drugs and strengths **CLINICAL CRITERIA (CC)** • Clinical editing will allow patients currently stabilized on a non-preferred agent to continue to receive that agent without PA • **Cannabidiol extract (Epidiolex®)** – Confirm diagnosis of FDA-approved or compendia-supported indication, or; Institutional Review Board (IRB) approval with signed consent form • **Lyrica®/Lyrica® CR (pregabalin)** – PA required for the initiation of pregabalin at > 150 mg per day in patients currently on an opioid at > 50 MME per day • **Neurontin® (gabapentin)** – PA required for initiation of gabapentin at > 900 mg per day in patients currently on an opioid at > 50 MME per day

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Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
IV. Central Nervous System		
	Lamictal® XR (tablet, dosepak) lamotrigine (dosepak) lamotrigine ER lamotrigine ODT (dosepak) Lyrica® (solution) DO, ST, F/Q/D Lyrica® CR ST, F/Q/D Neurontin® F/Q/D Onfi® ST pregabalin (solution) DO, ST, F/Q/D rufinamide (gen Banzel®) Qudexy® XR Sabril® Spritam® Sympazan® film ST Topamax® topiramate ER Trokendi XR® vigabatrin Vimpat® Xcopri®	• **Stiripentol (Diacomit®)** – Require diagnosis of FDA-approved or compendia-supported indication, or; Institutional Review Board (IRB) approval with signed consent form • **Topiramate IR/ER (Qudexy® XR, Topamax®, Trokendi XR™)** – Require confirmation of FDA-approved, compendia-supported, or Medicaid covered diagnosis • **Onfi®/Sympazan® (clobazam):** – Require confirmation of FDA-approved or compendia-supported use – PA required for initiation of clobazam therapy in patients currently on opioid or oral buprenorphine therapy – PA required for any clobazam prescription in patients currently on benzodiazepine therapy **FREQUENCY/QUANTITY/DURATION (F/Q/D)** • **Lyrica®/Lyrica® CR (pregabalin)** – Maximum daily dose of IR: 600 mg per day, and ER: 660 mg per day • **Neurontin® (gabapentin)** – Maximum daily dose of 3,600 mg per day **STEP THERAPY (ST)** • **Lyrica®/Lyrica® CR (pregabalin)** – Requires a trial with a tricyclic antidepressant OR gabapentin for treatment of Diabetic Peripheral Neuropathy (DPN) • **Onfi®/Sympazan® (clobazam)** – Requires a trial with an SSRI or SNRI for treatment of anxiety
Antimigraine Agents, Other ST, F/Q/D		
Emgality®	Aimovig® Ajovy®	Trial of 2 FDA approved migraine prevention products prior to a calcitonin gene-related peptide (CGRP) receptor antagonist **FREQUENCY/QUANTITY/DURATION (F/Q/D)** • **Erenumab (Aimovig®):** Maximum of 1 prefilled autoinjector per 30 days • **Galcanezumab 100mg (Emgality®):** Maximum of 3 prefilled syringes per 30 days, 120 mg: Maximum of 2 prefilled syringes/autoinjectors per 30 days • **Fremanezumab (Ajovy®):** Maximum of 3 prefilled syringes per ninety (90) days

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Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
IV. Central Nervous System		
Antimigraine Agents – Acute Treatment F/Q/D		
rizatriptan sumatriptan	almotriptan Amerge® eletriptan Frova® frovatriptan Imitrex® Maxalt® Maxalt® MLT naratriptan Nurtec™ ODT Onzetra™ Xsail™ Relpax® Reyvow™ sumatriptan-naproxen Tosymra™ Treximet® Ubrelvy™ Zembrace™ SymTouch™ zolmitriptan Zomig® Zomig® ZMT	**FREQUENCY/QUANTITY/DURATION (F/Q/D)** **AGENT** / **F/Q/D** Reyvow™ 50mg, 100mg — 8 units / 30 days Nurtec™ ODT 75mg Onzetra™ Xsail™ 11mg Ubrelvy™ 50mg, 100mg — 16 units / 30 days almotriptan eletriptan (Relpax®) 20mg eletriptan (Relpax®) 40 mgfrovatriptan (Frova®) 2.5mg naratriptan (Amerge®) 1mg, 2.5mg rizatriptan (Maxalt®) 5mg, 10mg tablets rizatriptan (Maxalt® MLT) 5mg, 10mg ODT sumatriptan nasal spray (Imitrex®) 5mg, 20mg sumatriptan (Imitrex®) 25mg, 50mg, 100mg tablets sumatriptan-naproxen (Treximet®) 85-500mg Tosymra™ nasal spray 10mg zolmitriptan (Zomig®) 2.5mg, 5mg tablets, zolmitriptan (Zomig® ZMT) 2.5mg, 5mg ODT Zomig® nasal spray 2.5mg, 5mg — 18 units / 30 days

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IV. Central Nervous System		
Antipsychotics – Injectable		
Abilify Maintena® Aristada® Aristada Initio® fluphenazine decanoate Haldol® decanoate haloperidol decanoate Invega Sustenna® Invega Trinza® Risperdal Consta® Zyprexa Relprevv®	Perseris™	
Antipsychotics – Second Generation CC, ST, F/Q/D		
aripiprazole (oral solution, tablet) DO clozapine Latuda® DO olanzapine (tablet) DO quetiapine F/Q/D quetiapine ER F/Q/D risperidone Saphris® ziprasidone (capsules)	Abilify® (tablet) DO aripiprazole ODT Caplyta™ clozapine ODT Clozaril® Fanapt® FazaClo® Geodon® Invega® DO, F/Q/D Nuplazid® olanzapine ODT DO paliperidone ER F/Q/D Rexulti® DO Risperdal® Secuado® F/Q/D Seroquel® F/Q/D Seroquel XR® DO, F/Q/D Versacloz® Vraylar® Zyprexa® DO Zyprexa® Zydis	**DOSE OPTIMIZATION (DO)** • See Dose Optimization Chart for affected drugs and strengths **CLINICAL CRITERIA (CC)** • Clinical editing will allow patients currently stabilized on a non-preferred agent to continue to receive that agent without PA • Prior authorization is required when an oral SGA is utilized above the highest MDD according to FDA labeling. • Prior authorization is required for patients less than 21 years of age when there is concurrent use of 2 or more different oral antipsychotics for greater than 90 days. • Prior authorization is required for patients 21 years of age or older when 3 or more different oral second generation antipsychotics are used for more than 180 days. • Confirm diagnosis of FDA-approved or compendia-supported indication • PA is required for initial prescription for beneficiaries younger than the drug-specific minimum age as indicated below: aripiprazole (Abilify®) 6 years asenapine (Saphris®) 10 years Asenapine (Secuado®) 18 years

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IV. Central Nervous System		
		brexpiprazole (Rexulti®) — 18 years cariprazine (Vraylar®) — 18 years clozapine (Clozaril®, Fazaclo®, Versacloz®) — 12 years iloperidone (Fanapt®) — 18 years lumateperone (Caplyta™) — 18 years lurasidone HCl (Latuda®) — 10 years olanzapine (Zyprexa®) — 10 years paliperidone ER (Invega®) — 12 years pimavanserin (Nuplazid®) — 18 years quetiapine fum. (Seroquel®, Seroquel XR®) — 10 years risperidone (Risperdal®) — 5 years ziprasidone HCl (Geodon®) — 10 years • Require confirmation of diagnosis that supports the concurrent use of a Second Generation Antipsychotic and a CNS Stimulant for patients < 18 years of age **STEP THERAPY (ST)** • For all Second Generation Antipsychotics used in the treatment of Major Depressive Disorder in the absence of other psychiatric comorbidities, trial with at least two different antidepressant agents is required **FREQUENCY/QUANTITY/DURATION (F/Q/D)** • asenapine (Secuado®) 7.6 mg/24 hours • **lumateperone (Caplyta™)** 42 mg capsules: Maximum 1 unit/day • **paliperidone ER (Invega®)** 1.5 mg, 3 mg, 9 mg tablets: Maximum 1 unit/day • **paliperidone ER (Invega®)** 6 mg tablets: Maximum 2 units/day • quetiapine/quetiapine ER (Seroquel®/Seroquel XR®): Minimum 100 mg/day; maximum 800 mg/day • **quetiapine (Seroquel®):** Maximum 3 units per day, 90 units per 30 days • quetiapine ER (Seroquel XR®) 150 mg, 200 mg: 1 unit/day, 30 units/30 days • quetiapine ER (Seroquel XR®) 50 mg, 300 mg, 400 mg: 2 units/day, 60 units/30 days	

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Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
IV. Central Nervous System		
Benzodiazepines – Rectal		
diazepam (rectal gel)	Diastat® 2.5 mg Diastat® AcuDial™	
Central Nervous System (CNS) Stimulants CC, CDRP, F/Q/D		
amphetamine salt combo IR (generic for Adderall®) amphetamine salt combo ER DO (generic for Adderall XR®) Concerta® DO, BLTG Daytrana® dexmethylphenidate (generic for Focalin®) dextroamphetamine (tablet) Focalin XR® DO, BLTG methylphenidate solution (generic for Methylin®) methylphenidate tablet (generic for Ritalin®) methylphenidate ER (generic for Aptensio® XR) Vyvanse® (capsule, chewable) DO	Adderall XR® DO Adhansia XR™ Adzenys ER® Adzenys XR-ODT® amphetamine (generic for Adzenys ER®) amphetamine (generic for Evekeo®) Aptensio XR® armodafinil (generic for Nuvigil®) Cotempla® XR-ODT™ Desoxyn® Dexedrine® dexmethylphenidate ER (generic for Focalin XR®) dextroamphetamine ER (generic for Dexedrine®) dextroamphetamine (solution) (generic for ProCentra®) Dyanavel XR® Evekeo® Evekeo® ODT Focalin® Jornay PM™ methamphetamine (generic for Desoxyn®) Methylin® methylphenidate chewable tablet (generic for Methylin®) methylphenidate CD methylphenidate ER 72 mg	**CLINICAL CRITERIA (CC)** • Confirm diagnosis of FDA-approved, compendia-supported, and Medicaid covered indication for beneficiaries **less than 18 years of age**. – Prior authorization is required for initial prescriptions for stimulant therapy for beneficiaries **less than 3 years of age** – Require confirmation of diagnoses that support concurrent use of CNS Stimulant and Second Generation Antipsychotic agent • Patient-specific considerations for drug selection include treatment of excessive sleepiness associated with shift work sleep disorder, narcolepsy, or as an adjunct to standard treatment for obstructive sleep apnea. **CLINICAL DRUG REVIEW PROGRAM (CDRP)** • For patients 18 years of age and older: • Confirm diagnosis of FDA-approved, compendia-supported, and Medicaid covered indication **DOSE OPTIMIZATION (DO)** • See Dose Optimization Chart for affected drugs and strengths **FREQUENCY/QUANTITY/DURATION (F/Q/D)** • Quantity limits based on daily dosage as determined by FDA labeling • Quantity limits to include: – Short-acting CNS stimulants: not to exceed 3 dosage units daily with maximum of 90 days per strength (for titration) – Long-acting CNS stimulants: not to exceed 1 dosage unit daily with maximum of 90 days. Concerta 36mg and Cotempla XR-ODT 25.9 mg, Adhansia XR 35 mg and 45 mg; not to exceed 2 units daily, Adhansia XR 25 mg not to exceed 3 units daily. – Pitolisant (Wakix®): not to exceed 2 dosage units daily of the 17.8 mg tablets or 3 dosage units daily of the 4.45 mg tablets.

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Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
IV. Central Nervous System		
	methylphenidate ER (generic Concerta®, Ritalin LA®, Metadate®) modafinil DO (generic for Provigil®) Mydayis™ Nuvigil® Procentra® Provigil® DO Quillichew ER™ DO Quillivant XR® Ritalin® Ritalin LA® DO Sunosi™ Wakix® Zenzedi®	
Movement Disorder Agents CC		
Austedo® tetrabenazine	Ingrezza® Ingrezza® titration pack Xenazine®	**CLINICAL CRITERIA (CC)** • Confirm diagnosis for an FDA-approved or compendia-supported indication
Multiple Sclerosis Agents		
Avonex® Betaseron® Copaxone® BLTG 20 mg/mL Gilenya® ST Rebif® Tecfidera® ST, BLTG	Aubagio® ST Bafiertam™ ST Copaxone® 40 mg/mL dimethyl fumarate DR Extavia® glatiramer Kesimpta® Mavenclad® ST Mayzent® ST Plegridy® Vumerity® ST Zeposia® ST	**STEP THERAPY (ST)** • **Gilenya® (fingolimod)** and **Tecfidera® (dimethyl fumarate)** – requires a trial with a preferred injectable product • **Aubagio® (teriflunomide), Mavenclad® (cladribine), Mayzent® (siponimod), Vumerity™ (diroximel), Bafiertam™ (monomethyl fumarate)** and **Zeposia® (ozanimod)** – requires a trial with a preferred oral agent

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IV. Central Nervous System		
Non-Ergot Dopamine Receptor Agonists		
pramipexole ropinirole	Kynmobi™ CC Mirapex® Mirapex ER® Neupro® pramipexole ER Requip XL® DO ropinirole ER	**CLINICAL CRITERIA (CC)** • **apomorphine (Kynmobi™)**: Confirm diagnosis of FDA-approved, compendia-supported, and Medicaid-covered indication **DOSE OPTIMIZATION (DO)** • See Dose Optimization Chart for affected strengths
Other Agents for Attention Deficit Hyperactivity Disorder (ADHD) CC		
atomoxetine DO guanfacine ER DO	clonidine ER Intuniv® DO Strattera® DO	**CLINICAL CRITERIA (CC)** • Confirm diagnosis for an FDA-approved or compendia-supported indication for beneficiaries < 18 years of age. • Prior authorization is required for initial prescriptions for non-stimulant therapy for beneficiaries **less than 6 years of age** **DOSE OPTIMIZATION (DO)** • See Dose Optimization Chart for affected strengths
Sedative Hypnotics/Sleep Agents F/Q/D		
estazolam CC flurazepam CC temazepam 15 mg, 30 mg CC zolpidem CC	Ambien® CC Ambien CR® CC Belsomra® Dayvigo™ doxepin (generic for Silenor®) Edluar® CC eszopiclone Halcion® CC Intermezzo® CC Lunesta® DO ramelteon (generic for Rozerem®) Restoril® CC Rozerem® Silenor® temazepam 7.5 mg, 22.5 mg CC triazolam CC	**DOSE OPTIMIZATION (DO)** • See Dose Optimization Chart for affected strengths **CLINICAL CRITERIA (CC)** • **Zolpidem products**: Confirm dosage is consistent with FDA labeling for initial prescriptions • Benzodiazepine Agents (estazolam, flurazepam, Halcion®, Restoril®, temazepam, triazolam): – Confirm diagnosis of FDA-approved or compendia-supported indication – PA required for initiation of benzodiazepine therapy in patients currently on opioid or oral buprenorphine therapy – PA required for any additional benzodiazepine prescription in patients currently on benzodiazepine therapy

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IV. Central Nervous System		
	zaleplon zolpidem (sublingual) [cc] zolpidem ER [cc]	**FREQUENCY/QUANTITY/DURATION (F/Q/D)** • Frequency and duration limits for the following products: – For **non-zaleplon** and **non-benzodiazepine** containing products: • 30 dosage units per fill/1 dosage unit per day/30 days – For **zaleplon**-containing products: • 60 dosage units per fill/2 dosage units per day/30 days • Duration limit equivalent to the maximum recommended duration: – 180 days for immediate-release **zolpidem** (Ambien®, Edluar®, Intermezzo®) products – 180 days for **eszopiclone** and **ramelteon** (Rozerem®) products – 180 days for lemborexant (Dayvigo™) – 168 days for **zolpidem ER** (Ambien CR®) products – 90 days for **suvorexant** (Belsomra®) – 90 days for **doxepin** (Silenor®) – 30 days for **zaleplon** (Sonata®) products – 30 days for **benzodiazepine agents** (estazolam, flurazepam, Halcion®, Restoril®, temazepam, triazolam) for the treatment of insomnia • Additional/Alternate parameters: – For patients naïve to non-benzodiazepine sedative hypnotics (NBSH): First-fill duration and quantity limit of 10 dosage units as a 10-day supply, except for zaleplon-containing products which the quantity limit is 20 dosage units as a 10-day supply

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IV. Central Nervous System		
Selective Serotonin Reuptake Inhibitors (SSRIs)		
citalopram escitalopram (tablet) fluoxetine (capsule, solution) paroxetine sertraline	Brisdelle® Celexa® escitalopram (soln) fluoxetine (tablet) fluoxetine DR weekly fluvoxamine CC fluvoxamine ER CC Lexapro® DO paroxetine 7.5 mg paroxetine CR Paxil® Paxil CR® Pexeva® Prozac® Sarafem® Trintellix® DO Viibryd® DO Zoloft®	**DOSE OPTIMIZATION (DO)** • See Dose Optimization Chart for affected strengths **CLINICAL CRITERIA (CC)** • Clinical editing will allow patients currently stabilized on fluvoxamine or fluvoxamine ER to continue to receive that agent without PA • Clinical editing to allow patients with a diagnosis of Obsessive Compulsive Disorder (OCD) to receive fluvoxamine and fluvoxamine ER without prior authorization
Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)ST		
duloxetine 20 mg, 30 mg, 60 mg (generic for Cymbalta®) venlafaxine venlafaxine ER DO (capsule)	Cymbalta® desvenlafaxine base ER desvenlafaxine fumarate ER desvenlafaxine succinate ER DO Drizalma Sprinkle™ duloxetine 40 mg Effexor XR® DO Fetzima® Pristiq® DO Savella® venlafaxine ER (tablet)	**DOSE OPTIMIZATION (DO)** • See Dose Optimization Chart for affected strengths **STEP THERAPY (ST)** • Trial of an SSRI prior to an SNRI* • *Step therapy is not required for the following indications: • Chronic musculoskeletal pain (CMP) • Fibromyalgia (FM) • Diabetic peripheral neuropathy (DPN)* – *duloxetine (Cymbalta®) – Requires a trial with a tricyclic antidepressant **OR** gabapentin for treatment of Diabetic Peripheral Neuropathy (DPN)

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Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
V. DERMATOLOGIC AGENTS		
Acne Agents, Topical		
adapalene/benzoyl peroxide (generic for Epiduo) adapalene cream Differin® OTC (1% gel) Retin-A® cream CC, BLTG tazarotene CC tretinoin gel CC (generic for Avita, Retin-A)	Aklief® CC Aczone® adapalene (Rx gel, gel pump) Altreno® Amzeeq™ F/Q/D Arazlo™ Atralin® CC Avita® CC Azelex® clindamycin/ tretinoin dapsone Differin® (Rx gel, solution, lotion, cream) Epiduo® Fabior® CC Retin-A® gel CC Retin-A Micro® CC Tazorac® CC tretinoin cream, gel (generic for Atralin) tretinoin micro CC Ziana® CC	**CLINICAL CRITERIA** • Confirm diagnosis of FDA-approved, compendia-supported, and Medicaid-covered indication **FREQUENCY/QUANTITY/DURATION (F/Q/D)** • Frequency and duration limits for the following products: • **Amzeeq™ (minocycline)** – maximum quantity is 30 grams per month
Actinic Keratosis Agents		
diclofenac 3% gel fluorouracil (solution) fluorouracil 0.5% cream (generic for Carac) fluorouracil 5% cream (generic for Efudex cream) imiquimod (5% cream, 3.75% pump)	Aldara® Carac® Efudex® Picato Tolak® Zyclara®	**CLINICAL CRITERIA** • diclofenac 3% gel: confirm diagnosis of FDA-approved, compendia-supported, and Medicaid-covered indication
Antibiotics – Topical		
mupirocin (ointment)	Centany® mupirocin (cream) Xepi™	

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Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
V. DERMATOLOGIC AGENTS		
Anti-Fungals – Topical		
ciclopirox (cream, suspension) clotrimazole OTC clotrimazole / betamethasone (cream) miconazole OTC nystatin (cream, ointment, powder) terbinafine OTC tolnaftate OTC	Alevazol OTC Ciclodan® (cream) ciclopirox (gel, shampoo) clotrimazole / betamethasone (lotion) clotrimazole Rx econazole Ertaczo® Exelderm® Extina® ketoconazole ketoconazole 2% shampoo Lamisil® OTC (spray) Loprox® shampoo Lotrisone® luliconazole Luzu® Mentax® naftifine Naftin® Nizoral® Rx nystatin/ triamcinolone oxiconazole Oxistat® Vusion® F/Q/D	**FREQUENCY/QUANTITY/DURATION (F/Q/D)** • **Vusion® 50 gm ointment** – Maximum 100 grams in a 90-day time period

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NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
V. DERMATOLOGIC AGENTS		
Anti-Infectives – Topical		
clindamycin (solution) clindamycin/benzoyl peroxide (generic for Duac®) erythromycin (solution)	Acanya® BenzaClin® (gel, pump) Benzamycin® Cleocin T® clindamycin (foam, gel, lotion, pledget) clindamycin/benzoyl peroxide (generic for BenzaClin®) clindamycin/benzoyl peroxide (generic for Acanya®) Erygel® erythromycin (gel, pledget) erythromycin / benzoyl peroxide Evoclin® Neuac® Onexton®	
Anti-Virals – Topical		
docosanol (generic Abreva) Zovirax® BLTG (cream)	acyclovir (ointment, cream) Denavir® Sitavig® Xerese® Zovirax® (ointment)	
Immunomodulators – Topical CDRP		
pimecrolimus tacrolimus	Elidel® Protopic®	**CLINICAL DRUG REVIEW PROGRAM (CDRP)** • All prescriptions require prior authorization • Refills on prescriptions are allowed

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NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
V. DERMATOLOGIC AGENTS		
Psoriasis Agents – Topical		
calcipotriene (cream, ointment, scalp solution)	calcipotriene / betamethasone dipropionate (generic for Taclonex®) calcitriol (ointment) Dovonex® (cream) Duobrii™ Enstilar® Sorilux® Taclonex® Taclonex® Scalp® Vectical®	
Steroids, Topical – Low Potency		
hydrocortisone acetate OTC hydrocortisone acetate Rx hydrocortisone/ aloe vera OTC	Ala-Scalp® alclometasone Capex® Derma-Smoothe/FS® Desonate® desonide fluocinolone (oil) Texacort®	

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NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
V. DERMATOLOGIC AGENTS		
Steroids, Topical – Medium Potency		
mometasone furoate	Beser lotion betamethasone valerate (foam) clocortolone Cloderm® Cordran® Cutivate® Dermatop® Elocon® fluocinolone acetonide (cream, ointment, soln.) flurandrenolide fluticasone propionate hydrocortisone butyrate (cream, lotion, ointment, solution) hydrocortisone valerate Locoid® Locoid Lipocream® Luxiq® Pandel® prednicarbate Synalar®	

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NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
V. DERMATOLOGIC AGENTS		
Steroids, Topical – High Potency		
betamethasone dipropionate (lotion) betamethasone valerate (cream, ointment) triamcinolone acetonide	amcinonide Apexicon-E® betamethasone dipropionate (gel, ointment, cream) betamethasone dipropionate, augmented betamethasone valerate (lotion) desoximetasone diflorasone Diprolene® fluocinonide 0.1% cream (generic for Vanos®) fluocinonide (ointment, cream, gel, solution, emollient) halcinonide cream (generic for Halog®) Halog® (cream, solution, ointment) Kenalog® Sernivo® Topicort® triamcinolone spray Trianex® Vanos®	

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NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
V. DERMATOLOGIC AGENTS		
Steroids, Topical – Very High Potency		
clobetasol (cream, emollient, gel, ointment, solution) halobetasol (cream, ointment)	Bryhali™ clobetasol (foam, lotion, spray, shampoo) Clobex® halobetasol (foam) Impeklo™ Lexette™ (foam) Olux® Olux-E® Temovate-E® Ultravate®	

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
VI. Endocrine and Metabolic Agents		
Alpha-Glucosidase Inhibitors ST		
acarbose Glyset® miglitol	Precose®	**STEP THERAPY (ST)** • Requires a trial with metformin with or without insulin prior to initiating alpha-glucosidase inhibitor therapy, unless there is a documented contraindication.
Amylin Analogs ST		
Symlin®	None	**STEP THERAPY (ST)** • Requires a trial with metformin with or without insulin prior to initiating amylin analogue therapy, unless there is a documented contraindication.

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Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
VI. Endocrine and Metabolic Agents		
Anabolic Steroids – Topical CDRP, F/Q/D		
Androgel® BLTG	Androderm® Fortesta® Testim® testosterone gel testosterone pump Vogelxo	**CLINICAL DRUG REVIEW PROGRAM (CDRP)** • For diagnosis of hypogonadotropic or primary hypogonadism: – Requires documented low testosterone concentration with two tests prior to initiation of therapy. – Require documented testosterone therapeutic concentration to confirm response after initiation of therapy. • For diagnosis of delayed puberty: – Requires documentation that growth hormone deficiency has been ruled out prior to initiation of therapy. – 1.62% gel only: For diagnosis of gender dysphoria please refer to July 2020 edition of the Medicaid Update; https://www.health.ny.gov/health_care/medicaid/program/update/2020/no12_2020-07.htm#transgender • The Anabolic Steroid fax form can be found at: https://newyork.fhsc.com/downloads/providers/NYRx_CDRP_PA_Worksheet_Prescribers_Anabolic_Steroids.docx **FREQUENCY/QUANTITY/DURATION (F/Q/D)** • Limitations for anabolic steroid products based on approved FDA labeled daily dosing and documented diagnosis: – Duration limit of 6 months for delayed puberty
Biguanides		
metformin HCl metformin ER (generic for Glucophage XR®)	Fortamet® Glucophage® Glucophage XR® Glumetza® metformin solution (generic Riomet®) metformin ER (generics for Fortamet®, Glumetza®) Riomet® Riomet ER™	

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NYS Medicaid Fee-For-Service Preferred Drug List

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

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NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
VI. Endocrine and Metabolic Agents		
Glucagon-like Peptide-1 (GLP-1) Agonists ST		
Bydureon® Byetta® Trulicity® Victoza®	Adlyxin® Bydureon® BCise™ Ozempic® Rybelsus® Soliqua® Xultophy®	**STEP THERAPY (ST)** • Requires a trial with metformin with or without insulin prior to a GLP-1 agonist. • Prior authorization is required with lack of covered diagnosis in medical history.
Glucocorticoids – Oral		
dexamethasone (tablet) hydrocortisone methylprednisolone (dose-pack) prednisolone (solution) prednisone (dose-pack, tablet)	Alkindi® Sprinkle budesonide EC budesonide ER Cortef® cortisone dexamethasone (elixir, solution) dexamethasone intensol Dexpak® DXevo Emflaza® Entocort EC® Hemady™ Medrol® (dose-pack, tablet) methylprednisolone (4 mg, 8 mg 16 mg, 32 mg) Millipred® Ortikos™ prednisolone ODT prednisone (intensol, solution) Rayos® TaperDex® Uceris®	

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NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
VI. Endocrine and Metabolic Agents		
Growth Hormones CC, CDRP		
Genotropin® Norditropin®	Humatrope® Nutropin AQ® Omnitrope® Saizen® Zomacton® Zorbtive®	**CLINICAL DRUG REVIEW PROGRAM (CDRP)** • Prescribers or their authorized agents may call or submit a fax request for a PA for beneficiaries 21 years of age or older **CLINICAL CRITERIA (CC)** • Patient-specific considerations for drug selection include concerns related to use of a non-preferred agent for FDA-approved indications that are not listed for a preferred agent. • Confirm diagnosis of FDA-approved or compendia-supported indication
Insulin – Long-Acting		
Lantus® Levemir®	Basaglar® Semglee® Toujeo® Solostar® Toujeo® Max Solostar® Tresiba®	
Insulin – Mixes		
Humalog® 50/50 Mix: pen and vial Humalog® 75/25 Mix: vial insulin lispro 75/25 mix: pen (generic for Humalog® Mix) insulin aspart prot/insulin aspart vial (generic for Novolog) Novolog® BLTG Mix: pen	Humalog® 75/25 mix: pen insulin aspart prot/insulin aspart pen (generic for Novolog®) Novolog® 70/30 Mix: vial	

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Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
VI. Endocrine and Metabolic Agents		
Insulin – Rapid-Acting		
Apidra® Humalog® BLTG 100 U/mL vial and pen insulin aspart (generic for Novolog®) cartridge insulin lispro junior (generic for Humalog® Jr.) Novolog® BLTG vial and pen	Admelog® Afrezza® Fiasp® (Penfill, Flextouch) Humalog® 200 U/mL Humalog® Jr. 100 U/mL insulin aspart (generic for Novolog®) vial and pen insulin lispro (generic for Humalog®) Lyumjev™ Novolog® cartridge	
Meglitinides ST		
nateglinide repaglinide	Prandin® repaglinide/ metformin Starlix®	**STEP THERAPY (ST)** • Requires a trial with metformin with or without insulin prior to initiating meglitinide therapy, unless there is a documented contraindication.
Pancreatic Enzymes		
Creon® Zenpep®	Pancreaze® Pertzye® Viokace®	
Sodium Glucose Co-Transporter 2 (SGLT2) Inhibitors ST		
Farxiga® ST Invokana® Jardiance®	Invokamet® Invokamet® XR Segluromet® Steglatro® Synjardy® Synjardy® XR Trijardy® XR Xigduo® XR	**STEP THERAPY (ST)** • Requires a trial with metformin with or without insulin prior to initiating SGLT2 Inhibitor therapy, unless there is a documented contraindication. • Farxiga® (dapagliflozin) – Requires a trial with metformin with or without insulin prior to initiating SGLT2 Inhibitor therapy, unless there is a documented contraindication or drug is being used for an FDA-approved indication other than Type 2 Diabetes or related.

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VI. Endocrine and Metabolic Agents		
Thiazolidinediones (TZDs) ST		
pioglitazone	Actoplus Met® Actoplus Met® XR DO Actos® DO Avandia® Duetact® pioglitazone / glimepiride pioglitazone / metformin	**DOSE OPTIMIZATION (DO)** • See Dose Optimization Chart for affected strengths **STEP THERAPY (ST)** • Requires a trial with metformin with or without insulin prior to initiating TZD therapy, unless there is a documented contraindication.

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NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
VII. Gastrointestinal		
Anti-Emetics		
aprepitant pack Diclegis® CC, BLTG ondansetron (ODT, solution, tablet)	Akynzeo® Anzemet® aprepitant (capsule) Bonjesta® CC doxylamine succ/pyridoxine Emend® (capsule, powder packet, TriPack) granisetron (tablet) Sancuso® Varubi® Zofran® (ODT, solution, tablet) Zuplenz®	**CLINICAL CRITERIA (CC)** • **Diclegis®** and **Bonjesta®:** Confirm diagnosis of FDA-approved or compendia-supported indication
Gastrointestinal Antibiotics		
metronidazole (tablet) neomycin vancomycin (capsule, solution)	Dificid® Firvanq® Flagyl® metronidazole (capsule) paromomycin tinidazole Vancocin® Xifaxan® CC, ST, F/Q/D	**CLINICAL CRITERIA (CC)** • **Xifaxan®**: Confirm diagnosis of FDA-approved or compendia-supported indication • STEP THERAPY (ST) • **Xifaxan®:** Requires trial of a preferred fluoroquinolone antibiotic before rifaximin for treatment of Traveler's diarrhea **QUANTITY LIMITS:** • Xifaxan®: – Traveler's diarrhea (200 mg tablet) – 9 tablets per 30 days (Dose = 200 mg 3 times a day for 3 days) – Hepatic encephalopathy (550 mg tablets) – 60 tablets per 30 days (Dose = 550 mg twice a day) – Irritable bowel syndrome with diarrhea (550 mg tablets) – 42 tablets per 30 days (Dose = 550 mg three times a day for 14 days) • Maximum of 42 days' supply (126 units) per 365 (3 rounds of therapy).

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NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
VII. Gastrointestinal		
Helicobacter pylori Agents		
Pylera®	Helidac™ lansoprazole / amoxicillin / clarithromycin Omeclamox-Pak® Talicia®	
Proton Pump Inhibitors (PPIs) F/Q/D		
omeprazole Rx pantoprazole tablet	Aciphex® Dexilant® DO esomeprazole magnesium (generic for Nexium) esomeprazole strontium lansoprazole Rx (capsule, ODT) Nexium® RX DO omeprazole OTC omeprazole/ sodium bicarbonate Rx pantoprazole suspension Prevacid® OTC Prevacid® Rx DO Prilosec® Rx Protonix® rabeprazole Zegerid®	**DOSE OPTIMIZATION (DO)** • See Dose Optimization Chart for affected strengths **FREQUENCY/QUANTITY/DURATION (F/Q/D)** • Quantity limits: – Once daily dosing for: • GERD • erosive esophagitis • healing and maintenance of duodenal/gastric ulcers (including NSAID-induced) • prevention of NSAID-induced ulcers – Twice daily dosing for: • hypersecretory conditions • Barrett's esophagitis • H. pylori • refractory GERD • Duration limits: – 90 days for: • GERD – 365 days for: • Maintenance treatment of duodenal ulcers, or erosive esophagitis – 14 days for: • H. pylori

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Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
VII. Gastrointestinal		
Sulfasalazine Derivatives		
Apriso® BLTG Lialda® BLTG Pentasa* sulfasalazine DR sulfasalazine IR	Asacol HD® Azulfidine® Azulfidine Entab® balsalazide Colazal® Delzicol® Dipentum® mesalamine DR (generic for Delzicol®) mesalamine DR (generic for Lialda®) mesalamine ER (generic for Apriso®) mesalamine DR	

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Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
VIII. Hematological Agents		
Anticoagulants – Injectable F/Q/D		
enoxaparin sodium Fragmin® (vial)	Arixtra® CC fondaparinux CC Fragmin® (syringe) Lovenox®	**CLINICAL CRITERIA (CC)** • For patients requiring > 30 days of therapy: Require confirmation of FDA-approved or compendia-supported indication • **Arixtra® (fondaparinux)** Clinical editing to allow patients with a diagnosis of Heparin Induced Thrombocytopenia (HIT) to receive therapy without prior authorization. **FREQUENCY/QUANTITY/DURATION (F/Q/D)** • Duration Limit: No more than 30 days for members initiating therapy
Anticoagulants – Oral		
Eliquis® Pradaxa® warfarin Xarelto® (10 mg DO)	Savaysa® Xarelto® (dose pack)	
Colony Stimulating Factors		
Fulphila™ Neupogen® Udenyca®	Granix® Leukine® Neulasta® Nivestym™ Nyvepria™ Zarxio® Ziextenzo®	
Erythropoiesis Stimulating Agents (ESAs) CC		
Epogen® Retacrit®	Aranesp® Mircera® Procrit®	**CLINICAL CRITERIA (CC)** • Confirm diagnosis for FDA- or compendia-supported uses

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Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
VIII. Hematological Agents		
Platelet Inhibitors		
Brilinta® clopidogrel dipyridamole dipyridamole / aspirin	Effient® Plavix® prasugrel Zontivity®	

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Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
IX. Immunologic Agents		
Immunomodulators – Systemic CC, ST		
Cosentyx® Enbrel® products Humira® products	Actemra® (subcutaneous) Benlysta® (subcutaneous) Cimzia® Ilumya® Kevzara® syringe, pen injector Kineret® Olumiant® Orencia® (subcutaneous) Otezla® Rinvoq™ ER Siliq™ Simponi® Skyrizi™ Stelara® Taltz® Tremfya® Xeljanz® Xeljanz® XR	**CLINICAL CRITERIA (CC)** • Confirm diagnosis for FDA- or compendia-supported uses **STEP THERAPY (ST)** • Trial of a disease-modifying anti-rheumatic drug (DMARD) prior to treatment with an immunomodulator • Trial of a TNF inhibitor prior to treatment with Olumiant®
Immunosuppressives, Oral		

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Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
azathioprine Cellcept® (suspension) BLTG cyclosporine (softgel, capsule) cyclosporine modified (capsule, solution) mycophenolate mofetil (capsule, tablet) Rapamune® BLTG (solution) sirolimus (tablet) tacrolimus	Astagraf XL® Azasan® Cellcept® (capsule, tablet) Envarsus XR® Imuran® mycophenolic acid mycophenolate mofetil (suspension) Myfortic® Neoral® Prograf® Rapamune® (tablet) Sandimmune® (solution, capsule) sirolimus (solution) Zortress®	

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
X. Miscellaneous Agents		
Progestins (for Cachexia)		
megestrol acetate (suspension)	megestrol 625 mg/5 mL (suspension)	
Epinephrine - Self-injected		
epinephrine (generic for EpiPen®) epinephrine (generic for EpiPen Jr.®)	epinephrine (generic for Adrenaclick®) EpiPen® EpiPen Jr.® Symjepi®	

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Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
XI. Musculoskeletal Agents		
Skeletal Muscle Relaxants		
baclofen chlorzoxazone 500 mg cyclobenzaprine 5 mg, 10 mg (tablet) dantrolene methocarbamol orphenadrine ER tizanidine (tablet)	Amrix® carisoprodol ST, F/Q/D carisoprodol compound ST, F/Q/D carisoprodol compound / codeine CC, ST, F/Q/D chlorzoxazone (generic for Lorzone) 375 mg, 750 mg cyclobenzaprine 7.5 mg cyclobenzaprine ER (generic for Amrix) capsule Dantrium® Fexmid® Lorzone® metaxalone Norgesic® Forte Robaxin® Skelaxin® Soma® ST, F/Q/D Soma® 250 ST, F/Q/D tizanidine (capsule) Zanaflex®	**CLINICAL CRITERIA (CC)** For carisoprodol/codeine products: • Limited to a total of 4 opioid prescriptions every 30 days; exemption for diagnosis of cancer or sickle cell disease • Medical necessity rationale for opioid therapy is required for patients on established opioid dependence therapy • PA required for initiation of opioid therapy in patients currently on benzodiazepine therapy • PA required for any codeine containing products in patients < 12 yrs **STEP THERAPY (ST)** • Trial with 1 preferred analgesic and 2 preferred skeletal muscle relaxants prior to use of **carisoprodol** containing products: – carisoprodol – carisoprodol/ASA – carisoprodol/ASA/codeine – Soma® **FREQUENCY/QUANTITY/DURATION (F/Q/D)** • Maximum 84 cumulative units per a year • **Carisoprodol** – Maximum 4 units per day, 21-day supply • **Carisoprodol combinations** – Maximum 8 units per day, 21-day supply (not to exceed the 84 cumulative units per year limit)

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Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
XII. Ophthalmics		
Alpha-2 Adrenergic Agonists (for Glaucoma) – Ophthalmic		
Alphagan P® BLTG brimonidine 0.2% Simbrinza®	apraclonidine brimonidine P 0.15% Iopidine®	
Antibiotics – Ophthalmic		
bacitracin / polymyxin B erythromycin gentamicin Natacyn® neomycin / gramicidin / polymyxin polymyxin / trimethoprim sulfacetamide (solution) tobramycin	Azasite® bacitracin Bleph®-10 neomycin / bacitracin / polymyxin Polytrim® sulfacetamide (ointment) Tobrex®	
Antibiotics/Steroid Combinations – Ophthalmic		
Blephamide® neomycin/ polymyxin / dexamethasone sulfacetamide / prednisolone TobraDex® ointment tobramycin / dexamethasone (suspension)	Maxitrol® neomycin / bacitracin / polymyxin / HC neomycin / polymyxin / HC Pred-G® TobraDex® ST TobraDex® suspension Zylet®	
Antihistamines – Ophthalmic		
Pataday® Pazeo®	azelastine Bepreve® epinastine ketotifen OTC Lastacaft® olopatadine 0.1% olopatadine 0.2% Patanol® Zaditor® OTC Zerviate™	

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XII. Ophthalmics		
Anti-inflammatories/Immunomodulators – Ophthalmic CC, F/Q/D		
Restasis® Restasis MultiDose®	Cequa® Xiidra®	CLINICAL CRITERIA (CC) Diagnosis documentation required to justify utilization as a first line agent or attempt treatment with an artificial tear, gel or ointment. **FREQUENCY/QUANTITY/DURATION (F/Q/D)** Cequa®, Restasis®, Xiidra®: 60 vials dispensed as a 30-day supply; Restasis Multidose®: 5.5 mL dispensed as a 25-day supply
Beta Blockers – Ophthalmic		
betaxolol Betoptic S® carteolol Combigan® Istalol® levobunolol timolol maleate (gel, solution)	Timoptic® Timoptic® Ocudose® Timoptic-XE®	

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NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
XII. Ophthalmics		
Fluoroquinolones – Ophthalmic ST		
ciprofloxacin moxifloxacin ofloxacin	Besivance® Ciloxan® gatifloxacin levofloxacin Moxeza® Ocuflox® Vigamox® Zymaxid®	**STEP THERAPY (ST)** • For patients 21 years or younger, attempt treatment with a non-fluoroquinolone ophthalmic antibiotic before progressing to the a fluoroquinolone ophthalmic product • Examples of Non-Fluoroquinolone Ophthalmic Antibiotics – AK-Poly-Bac eye ointment – bacitracin-polymyxin eye ointment – erythromycin eye ointment – Gentak® (3 mg/gm eye ointment, 3 mg/mL eye drops) – gentamicin (3 mg/gm eye ointment, 3 mg/mL eye drops) – neomycin-polymyxin-gramicidin eye drops – polymyxin B-TMP eye drops – Romycin® eye ointment – sulfacetamide 10% eye drops – Sulfamide® 10% eye drops – tobramycin 0.3% eye drops – Tobrasol™ 0.3% eye drops
Non-Steroidal Anti-Inflammatory Drugs (NSAIDS) – Ophthalmic		
diclofenac flurbiprofen Ilevro® ketorolac	Acular® Acular LS® Acuvail® bromfenac BromSite® Nevanac® Prolensa®	

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NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
XII. Ophthalmics		
Prostaglandin Agonists – Ophthalmic		
latanoprost	bimatoprost Lumigan® Rocklatan™ Travatan Z® travoprost (generic for Travatan Z®) Xalatan® Xelpros™ Vyzulta™ 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® Ciprodex® BLTG ciprofloxacin	ciprofloxacin/dexamethasone (generic for Ciprodex®) ciprofloxacin/fluocinolone (generic for Otovel™) ofloxacin Otovel™	

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NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
XIV. Renal and Genitourinary		
Alpha Reductase Inhibitors for BPH		
finasteride	Avodart® dutasteride dutasteride / tamsulosin Jalyn® Proscar®	
Antihyperuricemics		
allopurinol Mitigare® BLTG probenacid probenacid/colchicine	colchicine (tablet, capsule) Colcrys febuxostat Uloric® Zyloprim®	
Cystine Depleting Agents CC		
Cystagon®	Procysbi® ST	**CLINICAL CRITERIA (CC)** • Confirm diagnosis of FDA-approved or compendia-supported indication **STEP THERAPY (ST)** • Requires a trial with Cystagon immediate-release capsules
Phosphate Binders/Regulators		
calcium acetate sevelamer carbonate tablets (generic for Renvela)	Auryxia™ Fosrenol® lanthanum carbonate Phoslyra® Renagel® Renvela® sevelamer carbonate powder (generic for Renvela) sevelamer HCL (generic for Renagel) Velphoro®	
Selective Alpha Adrenergic Blockers		
alfuzosin tamsulosin	Flomax® Rapaflo® silodosin	

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NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
XIV. Renal and Genitourinary		
Urinary Tract Antispasmodics		
oxybutynin solifenacin Toviaz® DO	darifenacin Detrol® Detrol LA® DO Ditropan XL® Enablex® DO flavoxate Gelnique® Myrbetriq® DO oxybutynin ER DO Oxytrol® tolterodine tolterodine ER trospium trospium ER Vesicare® DO	**DOSE OPTIMIZATION (DO)** • See Dose Optimization Chart for affected strengths

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NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
XV. Respiratory		
Anticholinergics / COPD Agents		
Atrovent HFA® Bevespi® Aerosphere® Combivent Respimat® ipratropium ipratropium / albuterol Spiriva® Stiolto Respimat® Tudorza Pressair®	Anoro Ellipta® Breztri™ Aerosphere Daliresp® Duaklir® Pressair Incruse Ellipta® Lonhala® Magnair® Seebri Neohaler® Spiriva Respimat® Trelegy Ellipta® Utibron Neohaler® Yupelri®	
Antihistamines – Intranasal		
azelastine olopatadine	Patanase®	
Antihistamines – Second Generation		
cetirizine OTC (tablet) cetirizine OTC (syrup/solution 1mg/1mL) fexofenadine OTC (suspension) levocetirizine (tablet) loratadine OTC	cetirizine OTC (chewable) cetirizine OTC (syrup/solution 5mg/5mL) cetirizine-D OTC Clarinex® CC Clarinex-D® OTC desloratadine fexofenadine OTC (tablet) levocetirizine (solution) loratadine-D OTC	**CLINICAL CRITERIA (CC)** • No prior authorization required for patients less than 24 months of age
Beta2 Adrenergic Agents – Inhaled Long-Acting CC, F/Q/D		
Perforomist® Serevent Diskus®	Arcapta Neohaler® Brovana® Striverdi Respimat®	**CLINICAL CRITERIA (CC)** PA is required for all new long-acting beta agonist prescriptions for beneficiaries under FDA- or compendia-supported age as indicated: Arcapta Neohaler® ≥ 18 years Brovana® ≥ 18 years

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NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
XV. Respiratory		
		Perforomist® ≥ 18 years Serevent Diskus® ≥ 4 years Striverdi Respimat® ≥ 18 years **FREQUENCY/QUANTITY/DURATION (F/Q/D)** Maximum units per 30 days Arcapta Neohaler® 30 units (1 box of 30 unit dose capsules) Brovana® 60 units (1 carton of 60 vials or 120 mL) Perforomist® 60 units (1 carton of 60 vials or 120 mL) Serevent Diskus® 1 diskus (60 blisters) Striverdi Respimat® 1 unit (one cartridge and one Respimat inhaler)
Beta2 Adrenergic Agents – Inhaled Short-Acting		
albuterol nebulizer solution ProAir HFA® BLTG	albuterol HFA levalbuterol (solution) levalbuterol HFA ProAir® Digihaler™ ProAir® RespiClick Proventil HFA® Ventolin HFA® Xopenex® (solution) Xopenex HFA®	

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NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
XV. Respiratory		
Corticosteroids – Inhaled F/Q/D		
Asmanex® Flovent Diskus® Flovent HFA® Pulmicort® Flexhaler	Alvesco® ArmonAir® Digihaler® Arnuity Ellipta® Asmanex® HFA QVAR® Redihaler™	**FREQUENCY/QUANTITY/DURATION (F/Q/D)**

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® Digihaler®	1 inhaler every 30 days
Arnuity Ellipta	1 inhaler every 30 days
Asmanex® 110 mcg	1 inhaler every 30 days
Asmanex® 220 mcg (30 units)	1 inhaler every 30 days
Asmanex® 220 mcg (60 units)	1 inhaler every 30 days. Up to 1 inhaler every 15 days with previous oral corticosteroid use.
Asmanex® 220 mcg (120 units)	1 inhaler every 60 days. Up to 1 inhaler every 30 days with previous oral corticosteroid use.
Asmanex® HFA 100 mcg	1 inhaler every 30 days
Asmanex® HFA 200 mcg	1 inhaler every 30 days
Flovent Diskus® 50 mcg, 100 mcg	1 diskus every 30 days
Flovent Diskus® 250 mcg	1 diskus every 15 days. Up to 1 diskus every 7 days with previous oral corticosteroid use.
Flovent HFA® 44 mcg, 110 mcg	1 inhaler every 30 days
Flovent HFA® 220 mcg	1 inhaler every 30 days. Up to 1 inhaler every 15 days with previous oral corticosteroid use.
Pulmicort 90 mcg	1 inhaler every 30 days
Pulmicort 180 mcg	1 inhaler every 15 days
QVAR® Redihaler™ 40 mcg	1 inhaler every 30 days
QVAR® Redihaler™ 80 mcg	1 inhaler every 15 days

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NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
XV. Respiratory		
Corticosteroid/Beta2 Adrenergic Agent (Long-Acting) Combinations – Inhaled CC, F/Q/D		
Advair Diskus® BLTG Dulera® Symbicort® BLTG	Advair HFA® AirDuo® Digihaler® AirDuo™ RespiClick® Breo Ellipta® budesonide/formoterol (generic for Symbicort) fluticasone-salmeterol (generic for AirDuo™ RespiClick®) fluticasone-salmeterol (generic for Advair Diskus®)	**CLINICAL CRITERIA (CC)** • PA is required for all new long-acting beta agonist prescriptions for beneficiaries under FDA-or compendia-supported age as indicated: Advair Diskus® ≥ 4 years Advair HFA® ≥ 12 years AirDuo™ RespiClick® & Digihaler® > 12 years Breo Ellipta® ≥ 18 years Dulera® 100 mcg and 200 mcg ≥ 12 years Dulera® 50 mcg ≥ 5 years fluticasone-salmeterol > 12 years Symbicort® 80/4.5 mcg ≥ 6 years Symbicort® 160/4.5 mcg ≥ 12 years **FREQUENCY/QUANTITY/DURATION (F/Q/D)** Advair Diskus®, Advair HFA®, AirDuo™ RespiClick® & Digihaler®, Breo Ellipta™, Dulera®, fluticasone-salmeterol, Symbicort®: One inhaler/diskus every 30 days

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NYS Medicaid Fee-For-Service Preferred Drug List

<table>
<tr><th>Preferred Drugs</th><th>Non-Preferred Drugs</th><th>Prior Authorization/Coverage Parameters</th></tr>
<tr><td colspan="3">XV. Respiratory</td></tr>
<tr><td colspan="3">Corticosteroids – Intranasal F/Q/D</td></tr>
<tr><td>fluticasone</td><td>Beconase AQ® CC
budesonide
Dymista®
flunisolide
mometasone
Nasonex®
Omnaris®
QNASL® CC
Xhance™
Zetonna®</td><td>CLINICAL CRITERIA (CC)
• Clinical consideration in regard to drug interactions will be given to patients with HIV/AIDs diagnosis or antiretroviral therapy in history
FREQUENCY/QUANTITY/DURATION (F/Q/D)
<table>
<tr><td>flunisolide</td><td>1 inhaler every 12 days</td></tr>
<tr><td>budesonide
mometasone
Nasonex®
Xhance™</td><td>1 inhaler every 15 days</td></tr>
<tr><td>Beconase AQ®</td><td>1 inhaler every 22 days</td></tr>
<tr><td>Dymista™
fluticasone
Omnaris®
QNASL®
Zetonna™</td><td>1 inhaler every 30 days</td></tr>
</table></td></tr>
<tr><td colspan="3">Leukotriene Modifiers</td></tr>
<tr><td>montelukast (tablets, chew tabs) ST</td><td>Accolate®
montelukast (granules)
Singulair® ST
zafirlukast</td><td>STEP THERAPY (ST)
• For non-asthmatic patients, trial of intranasal corticosteroid or a 2nd generation oral antihistamine before montelukast (Singulair®)</td></tr>
</table>

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NYS Medicaid Fee-For-Service Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
XVI. SUBSTANCE USE DISORDER AGENTS		
Opioid Antagonists		
naloxone (syringe, vial) naltrexone Narcan® (nasal spray)	None	
Opioid Dependence Agents – Injectable		
Vivitrol® Sublocade™	None	
Opioid Dependence Agents – Oral/Transmucosal CC, F/Q/D		
buprenorphine Suboxone® BLTG (film)	Bunavail® buprenorphine/ naloxone (tablet, film) Zubsolv®	**CLINICAL CRITERIA (CC)** • PA required for initiation of opioid therapy for patients on established opioid dependence therapy **QUANTITY LIMIT:** • **buprenorphine sublingual (SL):** Six tablets dispensed as a 2-day supply; not to exceed 24 mg per day • **buprenorphine/ naloxone tablet and film (Bunavail™, Suboxone®, Zubsolv®** up to 5.7 mg/1.4 mg strength); Three 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 • **buprenorphine/naloxone tablet (Zubsolv®** 8.6 mg/2.1 mg strength): Maximum of 60 tablets dispensed as a 30-day supply • **buprenorphine/naloxone tablet (Zubsolv®** 11.4 mg/2.9 mg strength): Maximum of 30 tablets dispensed as a 30-day supply

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

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

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

Prior Authorization

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

Please be prepared to respond to a series of questions that identify prescriber, patient, and reason for prescribing drug, and to fax clinical documentation upon request. Clinical guidelines for the CDRP as well as prior authorization worksheets are available online at https://newyork.fhsc.com/providers/CDRP_about.asp.

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

- becaplermin gel (Regranex®): https://newyork.fhsc.com/providers/CDRP_regranex.asp
- Pre-Exposure Prophylaxis (PrEP) Agents (Descovy®, Truvada®): https://newyork.fhsc.com/providers/CDRP_PReP_agents.asp
- fentanyl mucosal agents: https://newyork.fhsc.com/providers/CDRP_fentanyl_mucosal_agents.asp
- lidocaine patch (Lidoderm®, ZTLido™): https://newyork.fhsc.com/providers/CDRP_lidoderm.asp
- oxazolidinone antibiotics (Sivextro™, Zyvox®): https://newyork.fhsc.com/providers/CDRP_oxazolidinone_antibiotics.asp
- palivizumab (Synagis®): https://newyork.fhsc.com/providers/CDRP_synagis.asp
- sodium oxybate (Xyrem®, Xywav™): https://newyork.fhsc.com/providers/CDRP_xyrem.asp
- somatropin (Serostim®): https://newyork.fhsc.com/providers/CDRP_serostim.asp

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

- Anabolic Steroids: https://newyork.fhsc.com/providers/CDRP_anabolic_steroids.asp
- Central Nervous System (CNS) Stimulants for 18 years and older: https://newyork.fhsc.com/providers/CDRP_cns_stimulants.asp
- Growth Hormones for 21 years and older: https://newyork.fhsc.com/providers/CDRP_growth_hormones.asp
- Phosphodiesterase type-5 (PDE-5) Inhibitors for PAH: https://newyork.fhsc.com/providers/CDRP_PDE-5.asp
- Topical Immunomodulators: https://newyork.fhsc.com/providers/CDRP_topical_immunomodulators.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 60.

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

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Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
Acthar® (ACTH injectable) continued		**FDA Indication**	**First line Therapy**
		• Multiple Sclerosis (MS) exacerbations • Polymyositis/ dermatomyositis • Idiopathic nephrotic syndrome • Systemic lupus erythematosus (SLE) • Nephrotic syndrome due to SLE • Rheumatic disorders (specifically: psoriatic arthritis, rheumatoid arthritis, juvenile rheumatoid arthritis, ankylosing spondylitis) • Dermatologic diseases (specifically Stevens-Johnson syndrome and erythema multiforme) • Allergic states (specifically serum sickness) • Ophthalmic diseases (keratitis, iritis, iridocyclitis, diffuse posterior uveitis/choroiditis, optic neuritis, chorioretinitis, anterior segment inflammation) • Respiratory diseases (systemic sarcoidosis)	• Corticosteroid or plasmapheresis • Corticosteroid • ACE Inhibitor, diuretic, corticosteroid (and for refractory patients: an immunosuppressive) • Corticosteroid, antimalarial, or cytotoxic/immunosuppressive agent • Immunosuppressive, corticosteroid, or ACE Inhibitor • Corticosteroid, topical retinoid, biologic disease-modifying antirheumatic drugs (DMARD), non-biologic DMARD, or a non-steroidal anti-inflammatory drug (NSAID) • Corticosteroid or analgesic • Topical or oral corticosteroid, antihistamine, or NSAID • Analgesic, anti-infective agent, and agents to reduce inflammation, such as NSAIDs and steroids • Oral corticosteroid or an immunosuppressive.
Amoxicillin ER (Moxatag®)	Prescribers should attempt treatment with an immediate-release amoxicillin first before progressing to extended-release amoxicillin	**QUANTITY LIMIT:** • Equal to 10 tablets per fill	

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Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
Anabolic Steroids – Injectable • Depo-Testosterone® • testosterone cypionate* • testosterone enanthate • Xyosted® Anabolic Steroids – Oral • Anadrol-50® • Android® • Jatenzo® • Methitest® • oxandrolone • Testred®		• Limitations for anabolic steroid products is based on approved FDA labeled daily dosing and documented diagnosis not to exceed a 90-day supply (30-day supply for oxandrolone): • Xyosted® is limited to no more than 3 boxes for 90 days (1 box per 30 days) • Initial duration limit of 3 months (for all products except oxandrolone), requiring documented follow-up monitoring for response and/or adverse effects before continuing treatment • Duration limit of 6 months for delayed puberty • Duration limit of 1 month for all uses of oxandrolone products	*for additional parameters, see Cross-Sex Hormones section below.
Anti-Diabetic agents (not on the PDL) • chlorpropamide • glimepiride • glipizide (Glucotrol®, Glucotrol XL®) • glyburide (DiaBeta®, Glynase®) • glyburide, micronized • tolazamide • tolbutamide	• Requires a trial with metformin with or without insulin prior to initiating other antidiabetic agents, unless there is a documented contraindication. • Clinical editing to allow patients with a diagnosis of gestational diabetes to receive glyburide without a trial of metformin first.		

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Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
Anti-Diarrheal Agents • alosetron (Lotronex®) • crofelemer (Mytesi®) • eluxadoline (Viberzi®) • telotristat (Xermelo®)	• Irritable Bowel Syndrome w/Diarrhea – Trial of eluxadoline and rifaximin prior to alosetron. • Symptomatic relief of non-infectious diarrhea in patients with HIV/AIDS on anti-retroviral therapy – Trial with an alternative anti-diarrheal agent. • Carcinoid Syndrome – Trial with and concurrent use with a somatostatin analog		• Confirmation of FDA-approved or compendia-supported indication.
Anti-Fungals, Topical – for Onychomycosis • ciclopirox 8% solution • Jublia® • tavaborole (Kerydin®) • Penlac®	• Trial with an oral antifungal agent* prior to use of ciclopirox 8% solution (Penlac®) *terbinafine (Lamisil®) tablets; griseofulvin (Gris PEG®) oral suspension, ultramicronized tablets micronized tablets; itraconazole (Sporanox®, Onmel®) tablets, oral solution • Trial with ciclopirox 8% solution prior to the use of other topical antifungals [efinaconazole (Jublia®) or tavaborole (Kerydin®)]		
Anti-Malarials chloroquine hydroxychloroquine			• Confirm FDA approved or Compendia supported use

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Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
Anti-Retroviral (ARV) Interventions		**QUANTITY LIMITS:** • Limit ARV active ingredient duplication • Limit ARV utilization to a maximum of five products concurrently - excluding boosting with ritonavir (dose limit 600 mg or less) or cobicistat • Limit Protease Inhibitor utilization to a maximum of two products concurrently • Limit Integrase inhibitor utilization to a maximum of one product concurrently	• Require confirmation of FDA-approved or compendia-supported use • Point-of-service edit for antiretroviral / non-antiretroviral combinations to be avoided: https://newyork.fhsc.com/downloads/providers/NYRx_PDP_reference_Antiretroviral_NonAntiretroviral_Drug2Drug_Interactions.pdf • Point-of-service edit for antiretroviral / antiretroviral combinations to be avoided: https://newyork.fhsc.com/downloads/providers/NYRx_PDP_reference_Antiretroviral_Antiretroviral_Drug2Drug_Interactions.pdf
biotin			• Confirm diagnosis of FDA-approved or compendia-supported indication
crisaborole (Eucrisa®)	Atopic Dermatitis • Trial with a medium or high potency prescription topical steroid within the last 3 months	**QUANTITY LIMITS:** • 100GM/30 days	• 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)
dupilumab (Dupixent®)	Atopic Dermatitis • 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 Asthma • History and concurrent use of a corticosteroid Chronic rhinosinusitis with nasal polyposis • History and concurrent use of intranasal steroids	**QUANTITY LIMITS:** **Atopic Dermatitis** • Dupixent® 200 mg or 300 mg; 4 syringes for first 30 days followed by 2 syringes/30 days. **Asthma** • Dupixent® 200 mg or 300 mg, 4 syringes for first 30 days followed by 2 syringes/30 days. **Chronic rhinosinusitis with nasal polyposis** • 300 mg, 2 syringes/30 days	• Confirm diagnosis of FDA-approved or compendia-supported indication
Becaplermin (Regranex®)		**QUANTITY LIMIT:** • 2 15-gram tubes in a lifetime	
Benzodiazepine agents – oral • alprazolam (Niravam™, Xanax®, Xanax® XR) • chlordiazepoxide (Librium®) • chlordiazepoxide/amitriptyline (Limbitrol®) • clonazepam (Klonopin®) • clorazepate (Tranxene®, Tranxene T-Tab®) • diazepam (Valium®) • lorazepam (Ativan®, Lorazepam Intensol®) • oxazepam (Serax®)	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 • Panic Disorder requires concurrent therapy with an antidepressant (SSRI, SNRI, or Tricyclic antidepressant [TCA]). Skeletal muscle spasms • Require trial with a skeletal muscle relaxant prior to a benzodiazepine	**DURATION LIMIT:** • For Insomnia: 30 consecutive days • For Panic Disorder: 30 consecutive days	• Require confirmation of FDA-approved or compendia-supported use • PA required for initiation of benzodiazepine therapy in patients currently on opioid or oral buprenorphine therapy • PA required for any additional oral benzodiazepine prescription in patients currently on benzodiazepine therapy

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Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
Constipation Agents • linaclotide (Linzess®) • lubiprostone (Amitiza®) • methylnaltrexone (Relistor®) • naldemedine (Symproic®) • naloxegol (Movantik®) • plecanatide (Trulance®) • prucalopride (Motegrity™) • tegaserod (Zelnorm™)	Opioid Induced Constipation (OIC) and Chronic Idiopathic Constipation (CIC) • Trial with an osmotic laxative, a stimulant laxative and a stool softener prior to use. Irritable Bowel Syndrome w/ Constipation (IBS-C) • Trial with a bulking agent and an osmotic laxative within 89 days of use.	**QUANTITY LIMIT:** • linaclotide, naldemedine, naloxegol, plecanatide: 1 tablet/day; 30 tablets/month • lubiprostone: 2 capsules/day; 60 capsules/month • methylnaltrexone: 1 vial or syringe/day; 30/month; 4 kits/28 days; 90 tablets/30 days • prucalopride: 2 mg/day max; 1 tablet per day; 30/month. • If CrCl < 30 mL/min, then reduce dose to 1 mg/day max; 1 tablet per day; 30/month. • tegaserod: 2 tablets/day; 60 tabs/30 days	• Confirmation of FDA-approved or compendia-supported indication.
Cross-Sex Hormones • conjugated estrogens estradiol • testosterone cypionate • testosterone gel 1.62% (Androgel®)			• Confirm diagnosis of FDA-approved or compendia-supported indication • For diagnosis of gender dysphoria please refer to July 2020 edition of the Medicaid Update: https://www.health.ny.gov/health_care/medicaid/program/update/2020/no12_2020-07.htm#transgender
Cystic fibrosis agents • ivacaftor (Kalydeco®) • ivacaftor / lumacaftor (Orkambi®) • ivacaftor / tezacaftor (Symdeko®) • ivacaftor/ tezacaftor / elexacaftor (Trikafta™)			• Confirm diagnosis of FDA-approved or compendia-supported indication • Genetic testing required to verify appropriate mutations

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Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
dextromethorphan / quinidine (Nuedexta®)		**QUANTITY LIMIT:** • 2 capsules per day; 60 units per 30 days **DURATION LIMIT:** • 90 days of therapy	For patients ≥ 18 years of age: • Confirm diagnosis of FDA-approved or compendia-supported indication
Diabetic Test Strips		**QUANTITY LIMIT:** • Type I DM – max 300 test strips per 30-day supply • Type II DM – max 100 test strips per 30-day supply	• Preferred diabetic supply program https://newyork.fhsc.com/providers/diabeticsupplies.asp
dronabinol (Marinol®)	Step therapy for beneficiaries with HIV/AIDS, or cancer, AND eating disorder: • Trial with megestrol acetate suspension prior to dronabinol Step therapy for beneficiaries with diagnosis of cancer and nausea/vomiting: • Trial with a NYS Medicaid-preferred 5-HT3 receptor antagonist prior to dronabinol		• Confirm diagnosis of FDA-approved or compendia-supported indication
Eosinophilic Asthma Agents • Fasenra® • Nucala®	• Step Therapy Parameters • History and concurrent use of a corticosteroid	**QUALITY LIMIT:** Fasenra • 30 mg, 1 syringe or autoinjector/4 weeks Nucala • 100 mg, 1 syringe or autoinjector/4 weeks	• Confirm FDA 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)
Fentanyl Transmucosal Agents • Actiq® (lozenge) • Fentora® (buccal tablet)		**QUANTITY LIMIT:** Actiq®, Fentora®: • 4 units per day, 120 units per 30 days **DURATION LIMIT:** • 90 days • Exemption for diagnosis of cancer, sickle cell disease, or hospice care	• Limited to a total of 4 opioid prescriptions every 30 days; • For opioid-naïve patients: limited to a 7 days' supply for all initial opioid prescriptions, • PA required for use if > 90 MME (MME = morphine milligram equivalents) of opioid per day for management of non-acute pain (pain lasting > 7 days). • PA required for initiation of opioid therapy for patients on established opioid dependence therapy • PA is required for initiation of opioid therapy in patients currently on benzodiazepine therapy • Exemption for diagnosis of cancer, sickle cell, or hospice care

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Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
Lipid Lowering Agents: • alirocumab (Praluent®) • evolocumab (Repatha®) • lomitapide (Juxtapid®) • mipomersen (Kynamro®) • bempedoic acid (Nexletol™) • bempedoic acid/ezetimibe (Nexlizet™)	• Require trial of a HMG-CoA Reductase Inhibitors (statin) at maximum tolerated dosage		• Confirm diagnosis of FDA-approved or compendia-supported indication **PCSK-9 Inhibitors** (alirocumab [Praluent®], evolocumab [Repatha®]) and **ACL inhibitors** (Bempedoic acid [Nexletol], Bempedoic acid/ ezetimibe [Nexlizet]): • Require concurrent statin therapy
Methadone	• Requires a trial of a long-acting opioid prior to initiation for the management of chronic non-cancer pain	**QUANTITY LIMIT:** • 12 units per day, 360 units per 30 days • Exemption for diagnosis of cancer, hospice care, or sickle cell disease	• Confirm diagnosis of chronic non-cancer pain • Limited to a total of 4 opioid prescriptions every 30 days; • PA required for initiation of methadone for patients on established opioid dependence therapy • PA required for methadone prescriptions for patients currently on long-acting opioid therapy. • PA required for initiation of long-acting opioid therapy in opioid-naïve patients. • PA required for use if > 90 MME (MME = morphine milligram equivalents) of opioid per day for management of non-acute pain (pain lasting > 7 days). PA required for initiation of methadone therapy in patients currently on benzodiazepine therapy • Exemption for diagnosis of cancer, sickle cell, or hospice care

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Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
metoclopramide	• Requires a trial with conventional metoclopramide before metoclopramide orally disintegrating tablet (ODT), except with diagnosis of diabetes mellitus	**QUANTITY LIMIT:** • 4 units per day, 120 units per 30 days **DURATION LIMIT:** • 90 days	
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 • Oralair®	• 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
Ovulation Enhancing Drugs • bromocriptine • clomiphene • letrozole • tamoxifen			• Confirm diagnosis of FDA-approved or compendia-supported indication and Medicaid covered indication • Refer to https://www.health.ny.gov/health_care/medicaid/program/update/2019/2019-06.htm#ovulation
Pubertal Suppressants • goserelin acetate • leuprolide acetate • nafarelin acetate			• Confirm diagnosis of FDA-approved or compendia-supported indication • Refer to https://www.health.ny.gov/health_care/medicaid/program/update/2017/2017-01.htm#transgender for Transgender Related Care and Services Update

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Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
Pulmonary Fibrosis Agents • Ofev® • Esbriet®			• Confirm diagnosis of FDA-approved or compendia-supported indication
pyrimethamine (Daraprim®)			• Confirmation of FDA-approved or compendia-supported indications • Require concurrent utilization of leucovorin
quinine		**QUANTITY AND DURATION LIMITS:** • Maximum 42 capsules as a 7-day supply; limited to 1 prescription per year	
Rosacea Agents • azelaic acid (Finacea®) • brimonidine (Mirvaso®) • ivermectin (Soolantra®) • oxymetazoline HCL (Rhofade®) • minocycline (Zilxi™) • doxycycline (Oracea®)	• Trial with topical metronidazole product.		• Confirmation of FDA-approved or compendia-supported indication
tasimelteon (Hetlioz®)		**QUANTITY LIMIT:** • One unit per day; 30 units per 30 days	• Confirm diagnosis of FDA-approved or compendia-supported indication
Parathyroid Hormone Analogs • teriparatide (Forteo®) • Tymlos®	• Requires a trial with a preferred oral bisphosphonate	**QUANTITY LIMIT:** • One unit per 30-day period **LIFETIME QUANTITY LIMIT:** • 25 months' cumulative use of a PTH analog	
Topical Compounded Prescriptions			• Confirm diagnosis of FDA-approved or compendia-supported indication • For non-opioid pain management alternatives please visit: https://health.ny.gov/health_care/medicaid/program/opioid_management/docs/non_opioid_alternatives_to_pain_management.pdf

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Drug / Class Name	Step Therapy (ST) Parameters	Frequency / Quantity / Duration (F/Q/D) Parameters	Additional / Alternate Parameter(s)
Uterine Disorder Agents • Oriahnn®		**LIFETIME QUANTITY LIMIT:** • 24 months cumulative use	

For more information on DUR Program, please refer to https://www.health.ny.gov/health_care/medicaid/program/dur/index.htm.

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

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

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

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

Effective February 4, 2021:

- **Atripla®** and **Truvada®** will be **added** to the program
- No products will be **removed** from the program

List of Brand Name Drugs included in this program**		
Advair Diskus®	Diclegis®	Rapamune® solution
Alphagan P® 0.15%	Exelon® patch	Retin-A® cream
Androgel®	Focalin® XR	Sensipar®
Apriso®	Humalog® U100 vial and Kwikpen	Suboxone® film
Atripla®	Kitabis® Pak	Symbicort®
Bethkis®	Lialda®	Tecfidera®
Catapres-TTS®	Mitigare®	Tegretol® suspension
CellCept® suspension	Novolog® 100u/mL Flexpen and vial	Tracleer® Tablet
Ciprodex®	Novolog® Mix 70/30 Flexpen	**Truvada®**
Concerta®	NuvaRing®	Xeloda®
Copaxone® 20 mg SQ	Proair® HFA	Zovirax® cream

**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

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- Pursuant to this program prescription claims submitted to the Medicaid program **do not require** the submission of Dispense as Written/Product Selection Code of '1'; **Pharmacies should submit DAW code 9** (Substitution Allowed by Prescriber but Plan Requests Brand)**.** Pharmacies will receive a NCPDP reject response of "22" which means missing/invalid DAW code if other DAW codes are submitted. The only exception to this is DAW code 1 and "*Brand Medically Necessary"* on the prescription.
- For more information on the Brand Less Than Generic (BLTG) Program, please refer to https://newyork.fhsc.com/providers/bltgp_about.asp

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NYS Medicaid Fee-For-Service Mandatory Generic Drug Program

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

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

Prior Authorization Process

- Prescribers, or an agent of the prescriber, must call the prior authorization line at 1-877-309-9493 and respond to a series of questions that identify the prescriber, the patient and the reason for prescribing this drug. The Mandatory Generic Program Prescriber Worksheet and Instructions, located at https://newyork.fhsc.com/providers/MGDP_forms.asp, 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®	Neoral®
Dilantin®	Sandimmune®
Gengraf®	Tegretol®
Lanoxin®	Zarontin®
Levothyroxine Sodium (Unithroid®, Synthroid®, Levoxyl®)	

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

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NYS Medicaid Fee-For-Service Dose Optimization Program

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

Dose Optimization Chart

Brand Name	Dose Optimization Limitations		
CARDIOVASCULAR			
Angiotensin Receptor Blockers (ARBs)			
Benicar® 20 mg	1 daily	Tablet	
Micardis® 20 mg, 40 mg	1 daily	Tablet	
Diovan® 40 mg, 80 mg, 160 mg	1 daily	Tablet	
Antiarrythmics			
Amiodarone 100 mg	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 loading dose for 30 days
ARBs/Calcium Channel Blockers			
Exforge® 5–160mg	1 daily	Tablet	
ARBs/Diuretics			
Benicar® HCT 20–12.5 mg	1 daily	Tablet	
Diovan® HCT 80–12.5 mg, 160–12.5 mg	1 daily	Tablet	
Edarbyclor® 40–12.5 mg	1 daily	Tablet	
Micardis® HCT 40–12.5 mg, 80–12.5 mg	1 daily	Tablet	
Beta Blockers			
Bystolic® 2.5 mg, 5 mg, 10 mg	1 daily	Tablet	
Coreg® CR 20 mg, 40 mg	1 daily	Tablet	
metoprolol succinate 25 mg, 50 mg, 100 mg	1 daily	Tablet	
nadolol 40 mg	1 daily	Tablet	
Toprol® XL 25 mg, 50 mg, 100 mg	1 daily	Tablet	
HMG Co A Reductase Inhibitors			
Crestor® 5 mg, 10 mg, 20 mg	1 daily	Tablet	
Niacin Derivatives			
Niaspan® 500 mg	1 daily	Tablet	

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Brand Name	Dose Optimization Limitations		
CENTRAL NERVOUS SYSTEM			
Anticonvulsants			
Aptiom® 200 mg, 400 mg	1 daily	Tablet	
Fycompa® 400 mg, 600 mg	1 daily	Tablet	
topiramate ER 100 mg	1 daily	Capsule	
Lamictal XR® 50 mg	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 90 days
Oxtellar XR® 300 mg	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 90 days
Anticonvulsants, Other			
Lyrica® 25 mg, 50 mg, 75 mg, 100 mg, 150 mg, 200 mg	3 daily	Tablet	Electronic bypass for diagnosis of seizure disorder identified in medical claims data. 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 3 months
Lyrica® 225 mg and 300 mg	2 daily	Tablet	
Trokendi XR® 100 mg	1 daily	Tablet	
Antiparkinson Agents			
Azilect® 0.5 mg	1 daily	Tablet	
Antipsychotics – Second Generation			
Abilify® 2 mg	4 daily	Tablet	
Abilify® 5 mg, 10 mg, 15 mg	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 5 mg, 10 mg, 15 mg	1 daily	Tablet	
Invega® 1.5 mg, 3 mg	1 daily	Tablet	
Latuda® 20 mg, 40 mg, 60 mg	1 daily	Tablet	
olanzapine 5 mg, 10 mg	1 daily	Tablet	
olanzapine ODT 5 mg, 10 mg	1 daily	Tablet	
paliperidone er 1.5 mg, 3 mg	1 daily	Tablet	
quetiapine fumarate er 200 mg	1 daily	Tablet	
Rexulti® 0.25 mg, 0.5 mg, 1 mg, 2 mg	1 daily	Tablet	
Seroquel® XR 150 mg, 200 mg	1 daily	Tablet	
Symbyax® 3–25 mg, 6–25 mg, 12–25 mg	1 daily	Capsule	
Vraylar® 1.5 mg, 3 mg	1 daily	Capsule	
Zyprexa® Zydis 5 mg, 10 mg	1 daily	Tablet	

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Brand Name	Dose Optimization Limitations		
CENTRAL NERVOUS SYSTEM			
CNS Stimulants			
Adderall® XR 5 mg, 10 mg, 15 mg	1 daily	Capsule	
amphetamine salt combo ER 5 mg, 10 mg, 15 mg	1 daily	Capsule	
Concerta® ER 18 mg, 27 mg	1 daily	Tablet	
dexmethylphenidate er 10 mg, 20 mg (Focalin XR generic)	1 daily	Capsule	
Focalin® XR 5 mg, 10 mg, 15 mg, 20 mg	1 daily	Capsule	
methylphenidate CD 10 mg, 20 mg	1 daily	Capsule	
methylphenidate er 18 mg (Concerta® generic)	1 daily	Tablet	
methylphenidate la 20 mg (Ritalin® LA generic)	1 daily	Capusle	
modafinil 100 mg	1 daily	Tablet	
Provigil® 100 mg	1 daily	Tablet	
Quillichew® ER 20 mg	1 daily	Tablet	
Ritalin® LA 10 mg, 20 mg	1 daily	Capsule	
Vyvanse® 10 mg, 20 mg, 30 mg, 40 mg	1 daily	Capsule	
Non-Ergot Dopamine Receptor Agonists			
Requip® XL 6 mg	1 daily	Tablet	
Other Agents for Attention Deficit Hyperactivity Disorder (ADHD)			
guanfacine ER 1 mg, 2 mg	1 daily	Tablet	
atomoxetine 40 mg	1 daily	Capsule	
Intuniv® 1 mg, 2 mg	1 daily	Tablet	
Strattera® 40 mg	1 daily	Capsule	
Sedative Hypnotics			
Lunesta® 1 mg	1 daily	Tablet	
Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)			
Effexor® XR 37.5 mg, 75 mg	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 50 mg	1 daily	Tablet	
venlafaxine ER 37.5 mg, 75 mg	1 daily	Capsule	
Selective Serotonin Reuptake Inhibitors (SSRIs)			
Lexapro® 5 mg, 10 mg	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.
Trintellix® 5 mg, 10 mg	1 daily	Tablet	
Viibryd® 10 mg, 20 mg	1 daily	Tablet	

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Brand Name	Dose Optimization Limitations		
CENTRAL NERVOUS SYSTEM			
Miscellaneous Antidepressants			
bupropion xl 150 mg	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
mirtazapine 7.5 mg	1 daily	Tablet	

Brand Name	Dose Optimization Limitations		
ENDOCRINE AND METABOLIC			
Biguanides			
metformin ER 500 mg (Glumetza ER, Fortamet ER generic)	1 daily	Tablet	
Dipeptidyl Peptidase-4 (DPP-4) Inhibitors			
Januvia® 25 mg, 50 mg	1 daily	Tablet	
Onglyza® 2.5 mg	1 daily	Tablet	
Thiazolidinediones (TZDs)			
Actos® 15 mg	1 daily	Tablet	
Actoplus Met® XR 15–1000 mg	1 daily	Tablet	

Brand Name	Dose Optimization Limitations		
GASTROINTESTINAL			
Proton Pump Inhibitors			
Dexilant® 30 mg	1 daily	Capsule	
Nexium® 5 mg, 10 mg, 20 mg	1 daily	Packet	
Nexium® 20 mg	1 daily	Capsule	
Prevacid® DR 15 mg	1 daily	Capsule	

Brand Name	Dose Optimization Limitations		
HEMATOLOGICAL			
Anticoagulants - Oral			
Xarelto® 10 mg	1 daily	Capsule	

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Brand Name	Dose Optimization Limitations		
RENAL AND GENITOURINARY			
Urinary Tract Antispasmodics			
Detrol® LA 2 mg	1 daily	Capsule	
Enablex® 7.5 mg	1 daily	Tablet	
Myrbetriq® 25 mg	1 daily	Tablet	
oxybutynin chloride ER 5 mg	1 daily	Tablet	
Toviaz® ER 4 mg	1 daily	Tablet	
VESIcare® 5 mg	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.

When, in the judgment of the prescriber or the pharmacist, an emergency condition exists, the prescriber or pharmacist can call the Clinical Call center and obtain authorization for a seventy-two hour emergency supply of the drug prescribed to allow time for the prior authorization to be obtained.

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Appendix 6 – Preferred Diabetic Supply List (as of March 2021)

NYS Diabetic Supplies

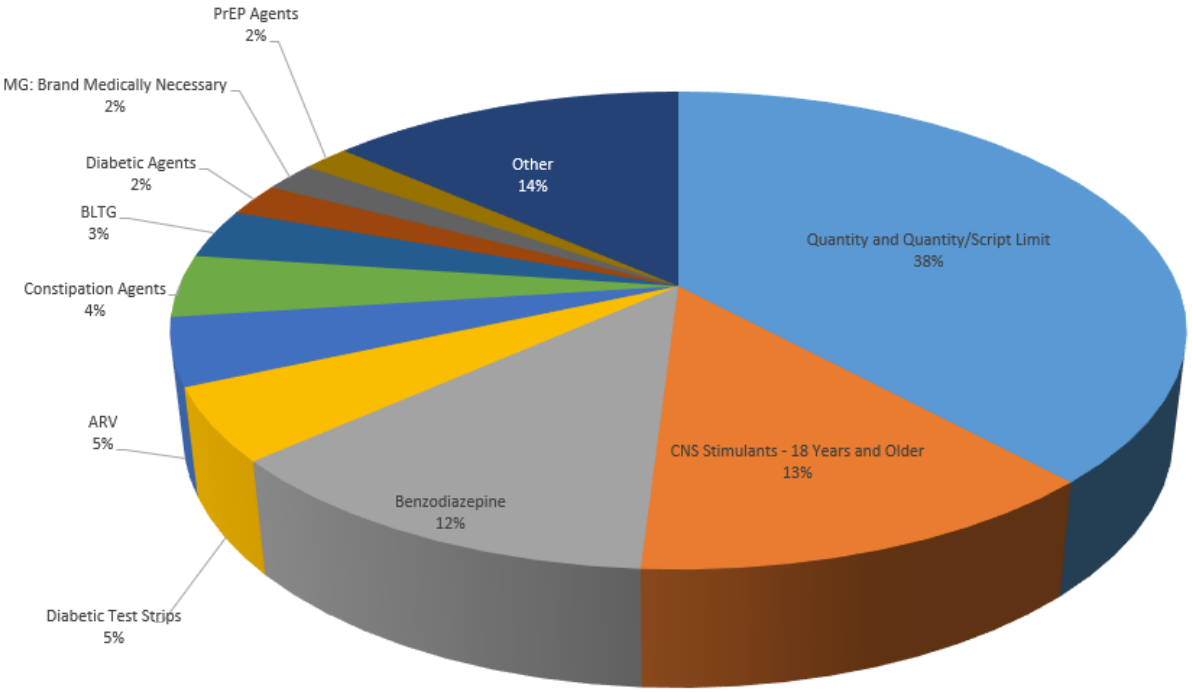
Effective: 12/28/20

Manufacturer	Product	NDC	Description
ABBOTT	FREESTYLE FREEDOM LITE	99073070914	Meter
ABBOTT	FREESTYLE INSULINX	99073071143	Meter
ABBOTT	FREESTYLE LITE METER	99073070805	Meter
ABBOTT	FREESTYLE PRECISION NEO METER	57599517501	Meter
ABBOTT	PRECISION XTRA MONITOR	57599881401	Meter
ABBOTT	FREESTYLE INSULINX TEST STRIP	99073071231	Strips
ABBOTT	FREESTYLE INSULINX TEST STRIPS	99073071227	Strips
ABBOTT	FREESTYLE LITE TEST STRIP	99073070822	Strips
ABBOTT	FREESTYLE LITE TEST STRIP	99073070827	Strips
ABBOTT	FREESTYLE PREC NEO TEST STRIPS	57599157701	Strips
ABBOTT	FREESTYLE PREC NEO TEST STRIPS	57599157904	Strips
ABBOTT	FREESTYLE TEST STRIPS	99073012050	Strips
ABBOTT	FREESTYLE TEST STRIPS	99073012101	Strips
ABBOTT	PRECISION XTRA TEST STRIPS	57599972804	Strips
ABBOTT	PRECISION XTRA TEST STRIPS	57599987705	Strips
ABBOTT	FREESTYLE LIBRE 10 DAY READER	57599000021	Reader
ABBOTT	FREESTYLE LIBRE 14 DAY READER	57599000200	Reader
ABBOTT	FREESTYLE LIBRE 10 DAY SENSOR	57599000019	Sensor
ABBOTT	FREESTYLE LIBRE 14 DAY SENSOR	57599000101	Sensor
ABBOTT	FREESTYLE LIBRE 2	57599080000	Sensor
ABBOTT	FREESTYLE LIBRE 2	57599080300	Reader
ABBOTT	PRECISION XTR B-KETONE STRIP	57599074501	Ketone Strips
ASCENSIA	CONTOUR METER	00193718901	Meter
ASCENSIA	CONTOUR NEXT METER	00193737701	Meter
ASCENSIA	CONTOUR NEXT EZ METER	00193725201	Meter
ASCENSIA	CONTOUR NEXT ONE METER	00193781801	Meter
ASCENSIA	CONTOUR NEXT TEST STRIP	00193731025	Strips
ASCENSIA	CONTOUR NEXT TEST STRIP	00193731150	Strips
ASCENSIA	CONTOUR NEXT TEST STRIP	00193731221	Strips
ASCENSIA	CONTOUR TEST STRIP	00193707025	Strips
ASCENSIA	CONTOUR TEST STRIP	00193708050	Strips
ASCENSIA	CONTOUR TEST STRIP	00193709021	Strips
DEXCOM	DEXCOM G6 RECEIVER	08627009111	Meter
DEXCOM	DEXCOM G5-G4 SENSOR KIT	08627005104	Sensor
DEXCOM	DEXCOM G6 SENSOR	08627005303	Sensor
DEXCOM	DEXCOM G5 TRANSMITTER KIT	08627001401	Transmitter
DEXCOM	DEXCOM G6 TRANSMITTER	08627001601	Transmitter
INSULET	OMNIPOD STARTER KIT	08508114002	Kit
INSULET	OMNIPOD DASH 5 PACK POD	08508200005	Pod
INSULET	OMNIPOD 5 PACK POD	08508112005	Pod
LIFESCAN	ONETOUCH ULTRA2 GLUCOSE SYST	53885004601	Meter
LIFESCAN	ONETOUCH VERIO FLEX SYSTEM KIT	53885004401	Meter
LIFESCAN	ONETOUCH VERIO REFLECT SYSTEM	53885092701	Meter
LIFESCAN	ONETOUCH ULTRA BLUE TEST STRP	53885024450	Strips
LIFESCAN	ONETOUCH ULTRA BLUE TEST STRP	53885024510	Strips
LIFESCAN	ONETOUCH ULTRA BLUE TEST STRP	53885099425	Strips
LIFESCAN	ONETOUCH VERIO TEST STRIP	53885027025	Strips
LIFESCAN	ONETOUCH VERIO TEST STRIP	53885027150	Strips
LIFESCAN	ONETOUCH VERIO TEST STRIP	53885027210	Strips

Appendix 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

Appendix 8 – CDRP and Other Prior Authorizations by Type

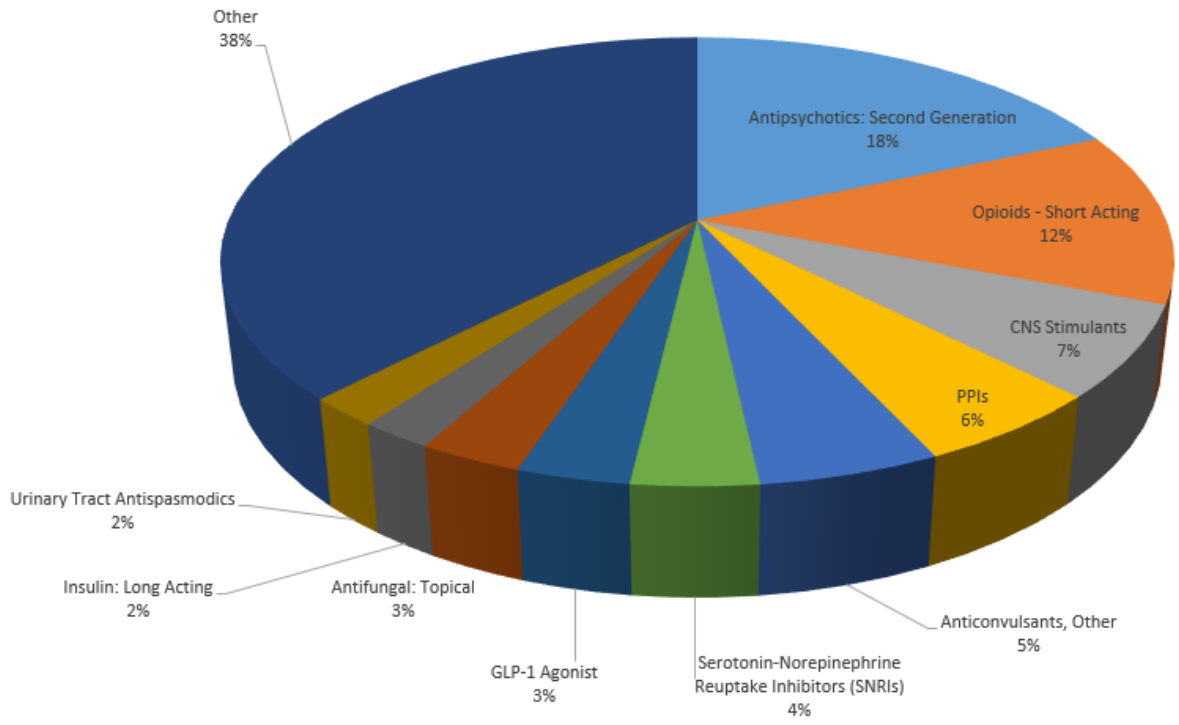


****This chart represents Approved PAs for the following: drugs/drug classes subject to step therapy, FQD (Frequency, Quantity and Duration Limits), DUR, PDP classes subject to CDRP and CDRP.**

Total PAs = 28,944

Quantity and Quantity/Script Limit	11,036
CNS Stimulants - 18 Years and Older	3,719
Benzodiazepine	3,593
Diabetic Test Strips	1,434
ARV	1,321
Constipation Agents	1,223
BLTG	971
Diabetic Agents	639
MG: Brand Medically Necessary	571
PrEP Agents	516
Nuedexta	391
Lidocaine Patch	374
Anabolic Steroids	365
Immunomodulators: Topical	363
Dose Optimization	259
Antimalaria Agents	243
Ovulation Enhancing Drugs	194
Synagis	184
Dupixent	182
Methadone	169
Oxazolidinone Antibiotics	164
DUR: Drug to Drug Interaction	163
Lipid Lowering Agents	141
Marinol	139
PDE-5 Inhibitors for Pulmonary Hypertension	95
Eucrisa	79
Rosacea Agents	74
Cross-sex Hormones	66
CF Agents, Oral	49
Fentanyl Mucosal Agent	39
Pubertal Suppressants	26
Progesterone	22
Biotin	18
MG: Generic Unavailable	15
Forteo	13
Anti-Diarrheal Agents	13
Pulmonary Fibrosis Agents	11
Tymlos	11
Eosinophilic Asthma Agents	9
Regranex	9
Hetlioz	7
Opioid/Buprenorphine TD	7
Acthar	5
Vitamins: DEKAs	5
Xyrem	5
Growth Hormones: 21 or Older	4
Mepsevii	3
Daraprim	2
Metozolv	1
Miscellaneous Products	1
Script Limit	1

Appendix 9 – PDP Prior Authorizations by Class



Total PDP PAs = 66,078

Appendix 9

Of the PAs issued in SFY 20/21, the following PDP drug classes are listed by the number of PAs requested:

Antipsychotics: Second Generation	12,182	Cholesterol Absorption Inhibitors	292	Statins	61
Opioids - Short Acting	8,252	NSAIDs: Rx	292	Meglitinides	60
CNS Stimulants	4,371	Cephalosporins: Third Generation	291	Epinephrine	59
PPIs	3,649	Antimigraine Agents, Other	288	Antivirals: Topical	56
Anticonvulsants, Other	3,431	ARBs	279	Ophthalmics: Antibiotics	55
Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)	2,397	Inh. Short Acting Beta-2 Adrenergic	264	Otics: Quinolones	55
GLP-1 Agonist	2,139	Antihyperuricemics	254	Ophthalmics: Quinolones	54
Antifungal: Topical	1,965	Steroids: Intranasal	251	Alzheimer's Agents	47
Insulin: Long Acting	1,386	Inhaled Corticosteroids	246	Antifungals, Oral for Onychomycosis	36
Urinary Tract Antispasmodics	1,384	Anticonvulsants, Carbamazepine Derivatives	233	Colony Stimulating Factor	36
Opioids - Long Acting	1,251	Topical Steroids: Medium Potency	220	Selective Alpha Adrenergic Blockers	32
Leukotriene Modifiers	1,217	Antifungals: Topical Onychomycosis	207	Inh. Long Acting Beta-2 Adrenergic	30
NSAIDs	1,217	Benzodiazepines: Rectal	204	Ophthalmic Antibiotic/Steroid Combo	30
DPP-4 Inhibitors	959	Tetracycline	202	Actinic Keratosis Agents	29
Antiinfectives: Topical	924	Antimigraine-Acute Treatment	196	Alpha Reductase Inhibitor: BPH	29
Triglyceride Agents	890	Biguanides	192	Non-Ergot Dopamine Receptor Agonist	28
Other Agents for ADHD	864	Hepatitis C Agents - Direct Acting	188	Progestins	27
SGLT2 Inhibitors	793	Movement Disorder	181	Antivirals, Oral	24
Anticholinergics/COPD Agents	772	Skeletal Muscle Relaxants	167	Calcium Channel Blockers (DHP)	23
Insulin: Rapid Acting	673	Inhaled Antibiotics	146	Psoriasis Agents: Topical	22
Phosphate Binders/Regulators	662	Thiazolidinediones	143	Pancreatic Enzymes	19
Antihistamines: Second Generation	650	Antiemetics	129	H. Pylori Agents	16
Inhaled Steroid/Beta2 LA Combo	621	Hepatitis B Agents	113	Alpha-Glucosidase Inhibitors	14
Immunomodulators: Systemic	603	Multiple Sclerosis Agents	113	Triptans	14
ARB Combinations	556	Topical Steroids: Very High Potency	108	Antipsychotics: Injectable	13
Topical Steroids: High Potency	556	Insulin: Mixes	107	Ophthalmics: Alpha-2 Adrenergics	13
Selective Serotonin Reuptake Inhibitors (SSRIs)	544	Ophthalmics: Prostaglandin Agonists	105	Antianginal/Anti-ischemic	12
Sedative Hypnotics	542	Topical Steroids: Low Potency	100	Anticoagulants: Oral	11
Opioid Dependence Agents	473	Growth Hormones	94	Ophthalmics: NSAIDs	11
Beta Blockers	434	Sulfasalazine Derivatives	93	Hepatitis C Agents: Injectable	7
Ophth: Anti-inflammatory	424	GI Prep Agents	91	Beta Blocker/Diuretic Combinations	6
Anticoagulants: Injectable	380	Antibiotics: Topical	87	ACE Combinations	3
Ophthalmics: Antihistamines	373	ACE Inhibitors	75	Direct Renin Inhibitors	3
Antibiotics: GI	367	Oral Immunosuppressives	70	Opioid Antagonists	3
Acne Agents, Prescription, Topical	323	PAH Oral Agents - Other	69	Ophthalmics: Beta Blockers	2
Erythropoiesis Stimulating Agents (ESAs)	323	Fluoroquinolones, Oral	69	Amylin Analog	1
Glucocorticoid: Oral	304	Bisphosphonates	63	Antihistamines: Nasal	1
		Platelet Inhibitors	62	Cystine Depleting Agents	1

Appendix 10 – PDP and Diabetic Supply Cost Avoidance by County

County	PDP	Diabetic Supplies	Total	% Total
Albany	$29,339	$20,316	$49,656	0.17%
Allegany	$4,732	$3,635	$8,367	0.03%
Broome	$20,908	$12,333	$33,241	0.12%
Cattaraugus	$11,626	$8,633	$20,258	0.07%
Cayuga	$8,985	$4,349	$13,334	0.05%
Chautauqua	$12,066	$4,609	$16,675	0.06%
Chemung	$13,422	$10,515	$23,937	0.08%
Chenango	$6,539	$6,491	$13,030	0.05%
Clinton	$8,303	$7,140	$15,443	0.05%
Columbia	$7,355	$2,337	$9,692	0.03%
Cortland	$4,845	$3,310	$8,156	0.03%
Delaware	$9,584	$10,710	$20,294	0.07%
Dutchess	$33,270	$14,734	$48,005	0.17%
Erie	$97,761	$57,250	$155,011	0.54%
Essex	$4,810	$3,051	$7,860	0.03%
Franklin	$8,696	$5,842	$14,538	0.05%
Fulton	$8,949	$4,219	$13,168	0.05%
Genesee	$5,578	$649	$6,227	0.02%
Greene	$4,766	$1,882	$6,648	0.02%
Hamilton	$271	$649	$920	0.00%
Herkimer	$6,902	$7,594	$14,497	0.05%
Jefferson	$15,876	$5,517	$21,393	0.07%
Lewis	$2,497	$649	$3,147	0.01%
Livingston	$5,073	$2,531	$7,605	0.03%
Madison	$7,518	$3,375	$10,893	0.04%
Monroe	$96,140	$49,590	$145,731	0.51%
Montgomery	$8,512	$12,398	$20,909	0.07%
Nassau	$108,759	$51,668	$160,426	0.56%
Niagara	$19,341	$24,341	$43,681	0.15%
Oneida	$29,499	$34,661	$64,161	0.22%
Onondaga	$48,857	$32,584	$81,441	0.28%
Ontario	$9,734	$1,103	$10,838	0.04%
Orange	$35,432	$21,809	$57,241	0.20%
Orleans	$4,493	$1,233	$5,727	0.02%
Oswego	$11,924	$10,450	$22,374	0.08%
Otsego	$8,249	$5,777	$14,026	0.05%
Putnam	$4,120	$1,103	$5,223	0.02%
Rensselaer	$14,511	$10,385	$24,896	0.09%
Rockland	$33,281	$14,864	$48,146	0.17%
St. Lawrence	$19,227	$12,203	$31,430	0.11%
Saratoga	$14,438	$6,166	$20,605	0.07%
Schenectady	$17,403	$19,927	$37,330	0.13%
Schoharie	$2,925	$1,298	$4,223	0.01%
Schuyler	$2,250	$844	$3,094	0.01%
Seneca	$3,016	$1,168	$4,185	0.01%

Steuben	$13,245	$6,880	$20,125	0.07%
Suffolk	$115,414	$47,513	$162,927	0.57%
Sullivan	$16,107	$4,414	$20,520	0.07%
Tioga	$4,805	$1,817	$6,622	0.02%
Tompkins	$8,733	$4,544	$13,277	0.05%
Ulster	$17,190	$7,659	$24,849	0.09%
Warren	$7,272	$6,296	$13,568	0.05%
Washington	$6,649	$5,517	$12,166	0.04%
Wayne	$9,107	$5,777	$14,884	0.05%
Westchester	$85,368	$59,067	$144,436	0.50%
Wyoming	$5,800	$5,712	$11,512	0.04%
Yates	$1,824	$974	$2,798	0.01%
Sub Totals	$1,123,295	$672,067	$1,795,362	6.26%
New York City	$2,385,861	$2,321,598	$4,707,459	71.02%
OMH	$35,182	$20,576	$55,758	0.84%
OMR	$39,871	$9,282	$49,153	0.74%
NYS DOH	$10,307	$10,191	$20,498	0.31%
Grand Total	**$3,594,516**	**$3,033,714**	**$6,628,230**	