Maryland Medicaid Pharmacy Program

Pharmacy News & Views

July 2013

Maryland Department of Health & Mental Hygiene / *Office of Systems, Operations and Pharmacy*

Tier 2 and Non-Preferred Antipsychotic Review Process

All claims for initial therapy (new Patient to antipsychotic medication) for use of a Tier 2 or non-preferred antipsychotic in patients age 10 and older (18 and older for Abilify®) now require authorization. By January 2014, it is expected that all claims for Tier 2 or non-preferred antipsychotic in all patients age 18 or older will require authorization. The claim will deny at point of service and will not process. An electronic message will display on your system with instructions as to how to proceed. Listed below are key points of the prior authorization process with respect to the pharmacist role and ensuring that disruptions in therapy does not occur.

MOST IMPORTANTLY - if prior authorization cannot be obtained in a timely manner by the prescriber, no patient should ever go without medication. Up to a 30-day supply of the Tier 2 or non-preferred medication can be dispensed to avoid any disruption in therapy.

Clinical Criteria for Approval:

Clinical Criteria for immediate approval:

- The patient has had an adequate trail (at least 6 weeks at recommended dose) of at least one preferred antipsychotic drug where FDA indicated, or:
- The medication was started on an inpatient unit/other acute care setting, or:
- All preferred antipsychotics are medically contraindicated for the patient.

Other Clinical Criteria can be found on the website:
http://mmcp.dhmh.maryland.gov/pap/SitePages/Clinical%20Criteria.aspx

REMEMBER: *NEVER* LET THE PATIENT GO WITHOUT MEDICATION

Pharmacist Responsibilities When a Claim Denies:

Patient care and follow-up is important:

- Consult with the patient
- Consult with the prescriber
- Prior authorization can be obtained by prescriber by phone or fax (forms available on MMPP website) with 24-hour turn around time
- Always ensure patient receives their medication - if unable to contact the prescriber, use professional judgment and follow-up!!
- Pharmacist should call claims processor Xerox 1-800-932-3918
- Up to one 30-day emergency supply is available by either pharmacist or prescriber request with a phone call to Xerox at 1-800-932-3918
- Pharmacist may always request a 72-hour emergency supply as per COMAR (10.09.03.06D(3))

Tier 2 and Non-Preferred Prior Authorization Review Process Resources:

- Clinical Criteria: http://mmcp.dhmh.maryland.gov/pap/SitePages/Clinical%20Criteria.aspx
- Prior Authorization (PA) Form: http://mmcp.dhmh.maryland.gov/pap/docs/Tier%202%20and%20NPD%Antipsychotic%20PA.pdf
- Preferred Drug List (PDL), both Fee-for-Service (FFS) and MCO Formularies are available for free at Epocrates.com
- The FFS PDL also available online at: http://mmcp.dhmh.maryland.gov/pap/SitePages/druglist.aspx

For questions or further information call either:

- Xerox (ACS) 1-800-932-3918
- Maryland Medicaid at 1-800-492-5231 (opt 3)

Maryland Medicaid Peer Review Program for Atypical Antipsychotics

Maryland Medicaid has put in place a pre-authorization program for the use of antipsychotics in children under age 10 years. It is anticipated that this program will expand to cover children under age 18. Please refer to this link: https://mmcp.dhmh.maryland.gov/pap/docs/PT%2026-13%FINAL.pdf (Pharmacy Transmittal No. 198, June 17, 2013) for expansion details. This program is intended to:

- Improve appropriate use of antipsychotics
- Improve safety monitoring - obesity and metabolic side effects
- Give provider education (approved indications, monitoring guidelines)
- Promote appropriate psychosocial treatment

Unless the prescriber has contacted the Peer Review Call Center and obtained a Prior Authorization, the claim will be denied at the point of sale. The denial message will be "PA Required" and "Prescriber or their designee must call Antipsychotic Peer Review Center at **1-855-283-0876** for PA".

Pharmacy provider MUST CONTACT the PRESCRIBER to obtain the PA. In turn, the prescriber must contact the Peer Review Call Center and proceed with consultation and decision related to PA (approve/deny). The Peer Review Program will notify the prescriber of the approval or denial of the prescription. The prescriber will in turn notify the pharmacy provider.

Prior authorizations are usually provided for a period of six months unless all requested laboratory and clinical information has not been received.

Patient Care is critical and follow-up is important:

- Medicaid patients represent a vulnerable population
- Disruptions in therapy may result in hospital re-admission or ER visits
- Be sure no harm comes to patient or others

REMEMBER: *NEVER* LET THE PATIENT GO WITHOUT MEDICATION

Pharmacist Responsibilities When a Claim Denies for the Peer Review Program

- Consult with the patient
- Consult with the prescriber
- Prior authorization can only be obtained by prescriber by phone or fax (forms available on MMPP website). The Peer Review PA process may take 24 to 48 hours.
- Always ensure patient receives their medication - if unable to contact the prescriber, the Pharmacist may always request a 72 hour emergency supply of medication per COMAR (10.09.03.06D(3)) by calling the claims processor Xerox at 1-800-932-3918.
- Pharmacist should use professional judgment and follow-up!

Peer Review Program Prior Authorization Process Resources:

- Toll-free phone 1-855-283-0876
- Toll-free fax 1-866-671-8084
- Complete explanation of the Peer Review Program: http://mmcp.dhmh.maryland.gov/pap/docs/PEER%20REVIEW%20FAQ%2011-13-12.pdf
- Clinical PA Form: http://mmcp.dhmh.maryland.gov/pap/SitePages/Peer%20Review%20Program.aspx

Sign up to receive electronic copies of MMPP Newsletters and Advisories at: www.marylandmedicaidpharmacyinformation.com

Maryland Medicaid Preferred Drug List

The Maryland Medicaid Preferred Drug List (PDL) shown includes updates effective July 1, 2013. Only drugs that are part of the listed therapeutic categories are affected by the PDL. Therapeutic categories not listed here are not part of the PDL and will continue to be covered as they always have for Maryland Medicaid patients. *Note: for most multi-source products, the generic product(s) are usually preferred and branded innovator product(s) are non-preferred. PDL products that are new to the market require prior authorization until they are reviewed.*

Key: Green shaded drugs = PDL change
All lowercase letters = generic product; Leading capital letter = Brand name product
Brd = Brand; gen = generic.

Note: A 72-hour emergency supply of a non-preferred drug is available by calling 1-800-932-3918. A 30-day emergency supply is available for Tier 2 and Non-preferred Antipsychotic agents.

ANALGESIC

Analgesics, Narcotics (Long Acting)

Preferred

fentanyl patch (*Duragesic*)
methadone (*Dolophine*)
morphine sulfate SR (*MS Contin*)
Kadian (Brd only)

Requires Prior Authorization

morphine sulfate ER (*Kadian*) (gen only)
oxymorphone ER (*Opana ER*)
tramadol ER (*Ultram ER, Ryzolt*)
Avinza
Butrans
Conzip
Exalgo
Nucynta ER
Oxycontin

Analgesics, Narcotics (Short Acting)

Preferred

apap w/codeine (*Tylenol w/Codeine*)
butalbital/apap/codeine/caffeine
butalbital/aspirin/codeine/caffeine
codeine tabs
dihydrocodeine/aspirin/caffeine (*Synalgos DC*)
hydrocodone/apap (*Vicodin*)
hydrocodone/ibuprofen (*Vicoprofen*)
hydromorphone tabs (*Dilaudid*)
morphine sulfate tabs
oxycodone
oxycodone/apap (*Percocet*)
oxycodone/aspirin (*Percodan*)
pentazocine/apap (*Talacen*)
pentazocine/naloxone (*Talwin NX*)
tramadol (*Ultram*)
tramadol/apap (*Ultracet*)

ANALGESIC

Analgesics, Narcotics (Short Acting) *(continued)*

Requires Prior Authorization

butorphanol nasal spray
carisoprodol/codeine/asa
codeine solution
dihydrocodeine/apap/caffeine
fentanyl transmucosal & buccal (*Actiq & Fentora*) *
hydromorphone supp & sol
levorphanol
meperidine (*Demerol*)
morphine supp
oxycodone/ibuprofen (*Combunox*)
oxymorphone (*Opana*)
Abstral *
Ibudone
Nucynta
Onsolis *
Oxecta
Primlev
Reprexain
Rybix ODT
Subsys
Zamicet
Zolvit

Anti-Hyperuricemics

Preferred

allopurinol (*Zyloprim*)
probenecid
probenecid/colchicine

Requires Prior Authorization

Colcrys
Uloric

** Clinical criteria apply. View criteria at: www.dhmh.maryland.gov/pap/SitePages/Clinical%20Criteria.aspx*

ANALGESIC

Anti-Migraine Agents

Preferred

sumatriptain (*Imitrex*)
Relpax

Requires Prior Authorization

naratriptan (*Amerge*)
rizatriptan, rizatriptan ODT (*Maxalt, Maxalt MLT*)
zolmitriptan, zolmitriptan ODT (*Zomig, Zomig ZMT*)
Axert
Cambia
Frova
Sumavel Dosepro
Treximet
Zomig Nasal

Neuropathic Pain

Preferred

capsaicin OTC
gabapentin (*Neurontin*)
Lidoderm
Lyrica caps
Savella

Requires Prior Authorization

Cymbalta *
Gralise
Horizant
Lyrica solution
Quentza
Zostrix OTC

Maryland Medicaid Preferred Drug List (effective July 1, 2013)

ANALGESIC

Nonsteroidal Anti-Inflammatories/ COX II Inhibitor (NSAIDS, Cyclooxygenase Inhibitor - Type)

Preferred

diclofenac potassium (*Cataflam, Voltaren XR*)
diflunisal (*Dolobid*)
etodolac, etodolac XL (*Lodine, Lodine XL*)
fenoprofen
flurbiprofen (*Ansaid*)
ibuprofen Rx & OTC (*Motrin*)
indomethacin, indomethacin SR (*Indocin, Indocin SR*)
ketoprofen (*Orudis, Oruvail*)
ketorolac (*Toradol*)
meclofenamate (*Meclomen*)
meloxicam (*Mobic*)
nabumetone (*Relafen*)
naproxen OTC & Rx (*Aleve, Naprosyn*)
oxaprozin (*Daypro*)
piroxicam (*Feldene*)
sulindac (*Clinoril*)
Voltaren gel

Requires Prior Authorization

diclofenac/misoprostl (*Arthrotec*)
mefenamic acid (*Ponstel*)
tolmetin, tolmetin DS (*Tolectin,Tolectin DS*)
Celebrex
Duexis
Flector
Indocin supp & susp
Mobic susp
Pennsaid
Sprix nasal
Vimovo
Zipsor

Skeletal Muscle Relaxants

Preferred

baclofen (*Lioresal*)
carisoprodol 350mg (*Soma*)
chlorzoxazone (*Parafon*)
cyclobenzaprine (*Flexeril*)
dantrolene (*Dantrium*)
methocarbamol (*Robaxin*)
orphenadrine (*Norflex*)
tizanidine tabs (*Zanaflex*)

Requires Prior Authorization

carisoprodol 250mg (*Soma*)
carisoprodol compound (*Soma compound*)
metaxalone (Skelaxin)
orphenadrine compound (*Norflex Forte*)
tizanidine caps (Zanaflex)
Amrix
Fexmid
Lorzone

ANTI-INFECTIVES

Antibiotics, GI

Preferred

metronidazole tabs (*Flagyl*)
neomycin
Alinia
Vancocin (Brd only)

Requires Prior Authorization

metronidazole caps (*Flagyl caps*)
tinidazole (*Tindamax*)
vancomycin caps (*Vancocin*) (gen only)
Dificid
Flagyl ER
Xifaxan

Antibiotics, Inhaled

Preferred

TOBI

Requires Prior Authorization

Cayston

Antibiotics, Vaginal

Preferred

clindamycin (*Clindamax*)
metronidazole (*Metro-Gel*)
Cleocin ovules

Requires Prior Authorization

Cleocin cream
Vandazole

Antifungals, Oral (Antifungal Agents, Antifungal Antibiotics)

Preferred

fluconazole (*Diflucan*)
griseofulvin ultra tabs (*Gris Peg*)
ketoconazole (*Nizoral*)
nystatin
terbinafine (*Lamisil*)

Requires Prior Authorization

clotrimazole troche (*Mycelex*)
flucytosine (*Ancobon*)
griseofulvin tabs & susp (*Fulvicin, GriFulvin V*)
itraconazole (*Sporanox*)
voriconazole (*Vfend*)
Lamisil granules
Noxafil
Onmel
Terbinex

ANTI-INFECTIVES

Antifungals, Topical (Topical Antifungals)

Preferred

clotrimazole OTC & Rx
clotrimazole/betamethasone (*Lotrisone*)
econazole (*Spectazole*)
ketoconazole cream & shampoo (*Nizoral*)
miconazole OTC
nystatin
nystatin/triamcinolone (*Mycolog*)
terbinafine OTC
tolnaftate OTC

Requires Prior Authorization

butenafine OTC (*Mentax*)
ciclopirox (*Loprox, Loprox shampoo, Penlac*)
ketoconazole foam
tolnaftate aero powder
Bensal HP
CNL-8
Ertaczo
Exelderm
Extina
Naftin
Oxistat
Pediaderm AF
Pediprox-4
Vusion

Antiparasitics, Topical

Preferred

permethrin OTC & Rx (*Elimite, Acticin*)
piperonyl/pyrethrins OTC
piperonyl/pyrethrins/permetrhin OTC
Eurax cream

Requires Prior Authorization

lindane
malathion (*Ovide*)
spinosad (*Natroba*)
Eurax lotion
Sklice
Ulesfia

Antivirals, Oral (Antivirals, General)

Preferred

acyclovir (*Zovirax*)
amantadine (*Symmetrel*)
rimantadine (*Flumadine*)
valacyclovir (*Valtrex*)

Requires Prior Authorization

famciclovir (*Famvir*)
Relenza
Tamiflu

Maryland Medicaid Preferred Drug List (effective July 1, 2013)

ANTI-INFECTIVES

Antivirals, Topical

Preferred

acyclovir ointment (Zovirax Ointment)
Abreva OTC
Denavir

Requires Prior Authorization

Xerese
Zovirax Cream

Cephalosporin & Related Agents (Cephalosporins, Second & Third Generation, Penicillins)

Preferred

amoxicillin/clavulanate (*Augmentin, Augmentin ES*)
cefaclor, cefaclor ER (*Ceclor, Ceclor CD*)
cefadroxil (*Duricef*)
cefdinir (*Omnicef*)
cefprozil (*Cefzil*)
cefuroxime (*Ceftin*)
cephalexin (*Keflex*)
Suprax tabs/solution

Requires Prior Authorization

amoxicillin/clav ER (*Augmentin XR*)

cefditoren (*Spectracef*)
cefpodoxime (*Vantin*)
Cedax
Ceftin tabs/suspension
Suprax chewable

Fluoroquinolones (Quinolones)

Preferred

ciprofloxacin (*Cipro*)
levofloxacn (*Levaquin*)

Requires Prior Authorization

ciprofloxacin ER (*Cipro XR*)
ofloxacin (*Floxin*)
Avelox
Cipro susp
Factive
Noroxin

Hepatitis C Agents (Hepatitis C Treatment Agents, Immunomodulators)

Preferred

ribavirin (*Copegus, Rebetol*)
Incivek
Pegasys
Pegasys Proclick
Peg-Intron, Peg-Intron Redipen
Victrelis

Requires Prior Authorization

Infergen
Rebetol solution
Ribapak
Ribasphere

ANTI-INFECTIVES

Macrolides/Ketolides

Preferred

azithromycin (*Zithromax*)
erythromycin
E.E.S.
Ery-Tab
EryPed
Erythrocin

Requires Prior Authorization

clarithromycin, clarithromycin ER (*Biaxin, Biaxin XL*)
Ketek
PCE
Zmax

Tetracyclines

Preferred

doxycycline hyclate
doxycycline monohydrate
minocycline (*Minocin*)
tetracycline (*Sumycin*)

Requires Prior Authorization

demeclocycline (*Declomycin*)
doxycycline hyclte DR (*Doryx*)
minocycline ER
Adoxa
Morgidox
Oracea
Solodyn
Vibramycin

Topical Antibiotics

Preferred

bacitracin OTC
bacitracin/polymyxin OTC
gentamicin
mupirocin (*Bactroban Ointment*)
triple antibiotic OTC

Requires Prior Authorization

Mupirocin cream (*Bactroban cream*)
Altabax
Centany

CARDIOVASCULAR

Angiotensin Modulators Combinations

Preferred

amlodipine/benazepril (*Lotrel*)
Azor/Tribenzor
Exforge/Exforge HCT

Requires Prior Authorization

Tarka
Tekamio/Amturnide
Twynsta

CARDIOVASCULAR

Angiotensin Modulators

Preferred

benazepril, benazepril HCTZ (*Lotensin, Lotensin HCT*)
captopril, captopril HCTZ (*Capoten, Capozide*)
enalapril, enalapril HCTZ (*Vasotec, Vaseretic*)
fosinopril, fosinopril HCTZ (*Monopril, Monopril HCT*)
irbesartan, irbesartan HCTZ (*Avapro, Avalide*)
lisinopril, lisinopril HCTZ (*Prinivil, Zestril, Prinzide, Zestoretic*)
losartan, losartan HCTZ (*Cozaar, Hyzaar*)
quinapril, quinapril HCTZ (*Accupril, Accuretic*)
ramipril (*Altace*)
valsartan HCTZ (*Diovan HCT*)
Diovan

Requires Prior Authorization

candesartan, candesartan HCTZ (*Atacand, Atacand HCT*)
eprosartan (*Teveten*)
moexipril, moexipril HCTZ (*Univasc, Uniretic*)
perindopril (*Aceon*)
trandolapril (*Mavik*)
Benicar, Benicar HCT
Edarbi, Edarbyclor
Micardis, Micardis HCT
Tekturna, Tekturna HCT
Teveten HCT

Anticoagulants

Preferred

warfarin (*Coumadin*)
Fragmin
Lovenox (Brd only)

Requires Prior Authorization

enoxaparin (gen only)
fondaparinux (*Arixtra*)
Eliquis
Pradaxa
Xarelto

Antihypertensives, Sympatholytics

Preferred

clonidine oral (*Catapres*)
guanfacine (*Tenex*)
methyldopa (*Aldomet*)
methyldopa HCTZ (*Aldoril*)
Catapres-TTS (Brd only)

Requires Prior Authorization

clonidine transdermal (gen only)
reserpine
Clorpres

Maryland Medicaid Preferred Drug List (effective July 1, 2013)

CARDIOVASCULAR

Beta Blockers (Alpha/Beta-Adrenergic Blocking Agents, Beta-Adrenergic Blocking Agents)

Preferred

atenolol (*Tenormin*)
atenolol/chlorthalidone (*Tenoretic*)
bisoprolol HCTZ (*Ziac*)
carvedilol (*Coreg*)
labetalol (*Normodyne, Trandate*)
metoprolol tartrate (*Lopressor*)
nadolol (*Corgard*)
pindolol (*Visken*)
propranolol (*Inderal*) propranolol HCTZ (*Inderide*)
propranolol LA (*Inderal LA*)
sotalol, sotalol AF (*Betapace, Betapace AF*)
Toprol XL (Brd only)

Requires Prior Authorization

acebutolol (*Sectral*)
betaxolol (*Kerlone*)
bisoprolol (*Zebeta*)
metoprolol HCTZ (*Lopressor HCT*)
metoprolol succinate XL (*Toprol XL*) (gen only)
nadolol/bendroflumethizside (*Corzide*)
timolol (*Blocadren*)
Bystolic
Coreg CR
Dutropol
Innopran XL
Levatol

Calcium Channel Blocking Agents

Preferred

amlodipine (*Norvasc*)
diltiazem (*Cardizem*)
nicardipine (*Cardene*)
nifedipine SR (*Adalat CC, Procardia XL*)
verapamil (*Calan*)
verapamil ER, verapamil SR (*Calan SR, Verelan*)
Cardizem LA (Bd only)

Requires Prior Authorization

diltiazem ER caps (*Cardizem LA, Dilacor XR, Tiazac*)
felodipine (*Plendil*)
isradipine (*Dynacirc*)
nifedipine (*Adalat, Procardia*)
nimodipine (*Nimotop*)
nisoldipine (Sular)
verapamil ER caps (*Verelan PM*)
DynaCirc CR
Matzim LA (gen only)

* *Clinical criteria apply. View criteria at: http://mmcp.dhmh.maryland.gov/pap/docs/PAH-Drugs-PA-form.pdf.*

CARDIOVASCULAR

Lipotropics, Other (Lipotropics, Bile Salt Sequestrants)

Preferred

cholestyramine (*Questran, Light*)
gemfibrozil (*Lopid*)
Niacor
Niaspan ER
Tricor (Brand only)
Trilipix

Requires Prior Authorization

colestipol (*Colestid*)
fenofibrate (*Lofibra*)
fenofibrate nanocrystals (*Tricor*) (gen only)
fenofibric acid (*Fibricor*)
Lipofen
Lovaza
Triglide
Welchol
Zetia

Lipotropics, Statins (Lipotropics)

Preferred

atorvastatin (*Lipitor*)
fluvastatin (*Lescol*)
lovastatin (*Mevacor*)
pravastatin (*Pravachol*)
simvastatin (*Zocor*)
Lescol XL
Simcor

Requires Prior Authorization

amlodipine/atorvastatin (*Caduet*)
Advicor
Altoprev
Crestor
Livalo
Vytorin

Platelet Aggregation Inhibitors

Preferred

clopidogrel (*Plavix*)
dipyridamole (*Persantine*)
ticlopidine (*Ticlid*)
Aggrenox

Requires Prior Authorization

Brilinta
Effient

CARDIOVASCULAR

Pulmonary Arterial Hypertension Agents, Oral and Inhaled Agents

Preferred

sildenafil* (*Revatio*)
Adcirca *
Letairis
Tracleer
Ventavis

Requires Prior Authorization

Tyvaso

CENTRAL NERVOUS SYSTEM

Anticonvulsants

Preferred

carbamazepine (*Tegretol*)
carbamazepine susp (*Tegretol susp*)
clonazepam (*Klonopin*)
divalproex (*Depakote, Depakote ER*)
lamotrigine (*Lamictal*)
levetiracetam (*Keppra*)
oxcarbazepine tabs (*Trileptal*)
oxcarbazepine susp (*Trileptal susp*)
phenobarbital
phenytoin (*Dilantin, Dilantin Infatabs*)
primidone (*Mysoline*)
tiagabine (*Gabitril*)
topiramate (*Topamax*)
valproic acid (*Depakene*)
zonisamide (*Zonegran*)
Carbatrol (Brd only)
Celontin
Depakote sprinkle (Brd only)
Diastat rectal (Brd only)
Peganone

Requires Prior Authorization

carbamazepine ER caps (*Carbatrol*) (gen only)
carbamazepine XR (*Tegretol XR*)
clonazepam ODT (*Klonopin ODT*)
diazepam rectal (*Diastat*) (gen only)
divalproex sprinkles (*Depakote sprinkles*) (gen only)
ethosuximide (*Zarontin*)
felbamate (Felbatol)
lamotrigine ER (*Lamictal XR*)
levetiracetam ER (*Keppra XR*)
topiramate sprinkles (*Topamax*)
Banzel
Equetro
Lamictal ODT
Onfi
Phenytek
Potiga
Sabril
Stavzor
Vimpat

Maryland Medicaid Preferred Drug List (effective July 1, 2013)

CENTRAL NERVOUS SYSTEM

Antidepressants, Other (Alpha-2 Receptor Antagonist Antidepressants, Serotonin-2 Antagonist/ Reuptake Inhibitors, Serotonin-Norepinephrine Reuptake-Inhib, Norepinephrine & Dopamine Reuptake Inhib)

Preferred

bupropion, bupropion SR, bupropion XL (*Wellbutrin, Wellbutrin SR, Wellbutrin XL*)
mirtazapine, mirtazapine soltab (*Remeron, Remeron Soltab*)
phenelzine (*Nardil*)
trazodone (*Desyrel*)
venlafaxine (*Effexor*)
venlafaxine ER caps (*Effexor XR*)
Marplan
Parnate (Brd only)

Requires Prior Authorization

nefazodone (*Serzone*)
tranylcypromine (gen only)
venlafaxine ER tabs
Aplenzin
Emsam
Forfivo XL
Oleptro ER
Pristiq
Viibryd

Antidepressants, Selective Serotonin Reuptake Inhibitors (SSRIs)

Preferred

citalopram (*Celexa*)
escitalopram (*Lexapro*)
fluoxetine (all strengths except 60mg) (*Prozac, Sarafem*)
fluvoxamine (*Luvox*)
paroxetine (*Paxil*)
sertraline (*Zoloft*)

Requires Prior Authorization

fluoxetine 60 mg
fluoxetine weekly (*Prozac weekly*)
fluvoxamine ER (*Luvox CR*)
paroxetine CR (*Paxil CR*)
Paxil susp
Pexeva

** Clinical criteria apply. View criteria at: www.dhmh.maryland.gov/pap/SitePages/Clinical%20Criteria.aspx*

*** Additional clinical edits may apply to Tier 2 products. An adequate trial of a Tier 1 preferred drug is required prior to use of any Tier 2 product.*

**** Step therapy may allow it to process without a prior authorization.*

***** For recipients 6-17 years old, Intuniv and Kapvay are part of the mental health formulary & billed fee-for-service. For individuals not in this age range, it continues to be part of the MCO pharmacy benefit.*

CENTRAL NERVOUS SYSTEM

Antipsychotics

Preferred

FIRST TIER:
chlorpromazine (*Thorazine*)
clozapine (*Clozaril*)
fluphenazine (*Prolixin*)
fluphenazine decanoate inj (*Prolixin Inj*)
haloperidol (*Haldol*)
haloperidol decanoate inj (*Haldol IM*)
perphenazine (*Trilafon*)
perphenazine/amitriptyline (*Triavil*)
quetiapine (*Seroquel*)
risperidone (*Risperdal*)
thioridazine (*Mellaril*)
thiothixene (*Navane*)
trifluoperazine (*Stelazine*)
ziprasidone (*Geodon*)
Abilify **(Age 17 and younger)**
Geodon IM
Invega Sustenna
Orap
Risperdal Consta
SECOND TIER: **
olanzapine (*Zyprexa*)
olanzapine IM (*Zyprexa IM*)
olanzapine ODT (*Zyprexa Zydis*)
Abilify **(Age 18 or older)**

Requires Prior Authorization

clozapine ODT (*Fazaclo*)
olanzapine/fluoxetine (*Symbyax*)
Abilify IM
Fanapt
Fazaclo
Haldol
Invega
Latuda
Saphris
Seroquel XR
Zyprexa Relprevv

Sedative Hypnotics

Preferred

chloral hydrate
flurazepam (*Dalmane*)
temazepam, 15 mg, 30 mg (*Restoril*)
triazolam (*Halcion*)
zaleplon (*Sonata*)
zolpidem (*Ambien*)

Requires Prior Authorization

estazolam (*ProSom*)
temazepam 7.5 & 22.5mg (*Restoril*)
zolpidem ER (*Ambien CR*)
Doral
Edluar
Intermezzo
Lunesta ***
Rozerem
Silenor
Somnote
Zolpimist

CENTRAL NERVOUS SYSTEM

Stimulants & Related Agents (Tx for Attention Deficit Hyperact (ADHD)/ Narcolepsy; Adrenergics, Aromatic, Non-Catecholamine)

Preferred

FIRST TIER:
amphetamine salt combo (*Adderall*)
dexmethylphenidate (*Focalin*)
dextroamphetamine tabs (*Dexedrine*)
methylphenidate, methylphenidate ER (*Ritalin, Ritalin-SR*)
methylphenidate CR (*Concerta*)
Adderall XR (Brd only)
Daytrana
Dexedrine ER caps (Brd only)
Focalin XR
Intuniv **
Metadate CD (Brd only)
Methylin chew
Methylin sol (Brd only)
Vyvanse
SECOND TIER:
Strattera * *(for ages 17 and under)*

Requires Prior Authorization

amphetamine salt combo ER (*Adderall XR*) (gen only)
dextroamphetamine ER caps (*Dexedrine ER*) (gen only)
methamphetamine (*Desoxyn*)
methylphenidate CD caps (*Metadate CD*) (gen only)
methylphenidate ER caps (*Ritalin LA*)
methylphenidate liquid (*Methylin*) (gen only)
modafinil (*Provigil*)
Kapvay ****
Nuvigil
Procentra
Quillivant XR

ENDOCRINE

Androgenic Agents

Preferred

Androgel
Testim

Requires Prior Authorization

Androderm
Axiron
Fortesta

Maryland Medicaid Preferred Drug List (effective July 1, 2013)

ENDOCRINE

Bone Resorption Suppression & Related Agents (Bone Resorption Inhibitors, Bone Formation Stim. Agents - Parathyroid Hormone)

Preferred

alendronate (*Fosamax*)
calcitonin salmon nasal (*Miacalcin*)
Fortical

Requires Prior Authorization

alendronate sol (*Fosamax sol*)
etidronate (*Didronel*)
ibandronate (*Boniva*)
Actonel
Atelvia
Binosto
Evista
Forteo
Fosamax Plus D
Prolia

Hypoglycemics, Incretin Mimetics & Enhancers

Preferred

Byetta
Janumet
Janumet XR
Januvia
Jentadueto
Juvisync
Symlin
Tradjenta

Requires Prior Authorization

Bydureon
Kazano
Kombiglyze XR
Nesina
Onglyza
Oseni
Victoza

Hypoglycemics, Insulins

Preferred

Humalog, Humalog Mix
Humulin
Lantus
Levemir
Novolin
Novolog, Novolog Mix

Requires Prior Authorization

Apidra

Hypoglycemics, Meglitinides (Hypoglycemics, Insulin Release Stimulant Type)

Preferred

nateglinide (*Starlix*)
Prandin

Requires Prior Authorization

Prandimet

ENDOCRINE

Hypoglycemics, TZDs (Hypoglycemics, Insulin-Response Enhancers)

Preferred

pioglitazone (*Actos*)
pioglitazone/glimepiride (*Duetact*)

Requires Prior Authorization

pioglitazone/metformin (*ActoPlusMet*)
ActoPlusMet XR
Avandamet
Avandaryl
Avandia

GASTROINTESTINAL

Antiemetic/Antivertigo Agents

Preferred

dimenhydrinate Rx & OTC
meclizine Rx & OTC (*Bonine, Antivert*)
metoclopramide (*Reglan*)
ondansetron (*Zofran, Zofran ODT*)
prochlorperazine (*Compazine, Compro*)
promethazine (*Phenergan*)
Emend caps
Marinol (Brd only)
TransDerm-Scop

Requires Prior Authorization

dronabinol (gen only)
granisetron (*Kytril*)
trimethobenzamide (*Tigan*)
Aloxi
Anzemet
Cesamet
Emend IV
Metozolv ODT
Sancuso

Bile Salts

Preferred

ursodiol capsule (*Actigall*)

Requires Prior Authorization

ursodiol tab (*URSO Forte*)
Chenodal

Pancreatic Enzymes

Preferred

pancrelipase
Creon
Zenpep

Requires Prior Authorization

Pancreaze
Pertyze
Ultresa
Viokace

GASTROINTESTINAL

Phosphate Binders & Related Agents

Preferred

calcium acetate (PhosLo)
Calphron OTC

Requires Prior Authorization

Eliphos
Fosrenol
Magnebind 400 RX
Phoslyra
Renagel
Renvela

Proton Pump Inhibitors (Gastric Acid Secretion Reducers)

Preferred

lansoprazole Rx & OTC (*Prevacid*)
omeprazole (*Prilosec*)
pantoprazole (*Protonix*)
Prevacid solutab
Protonix Suspension

Requires Prior Authorization

omeprazole/sodium bicarb (*Zegerid OTC*)
Aciphex
Dexilant
Nexium
Prilosec Suspension

Ulcerative Colitis Agents

Preferred

balsalazide (*Colazal*)
sulfasalazine, sulfasalazine DR (*Azulfidine, Azulfidine DR*)
Asacol
Canasa

Requires Prior Authorization

mesalamine enemas (*Rowasa*)
Apriso
Asacol HD
Dipentum
Giazo
Lialda
Pentasa
Rowasa, sFRowasa

** Clinical criteria apply. View criteria at: www.dhmh.maryland.gov/pap/SitePages/Clinical%20Criteria.aspx*

Maryland Medicaid Preferred Drug List (effective July 1, 2013)

IMMUNOLOGICS

Immunosuppressives, Oral

Preferred

azathioprine (*Imuran*)
cyclosporine modified (*Gengraf, Neoral*)
mycophenolate mofetil (*Cellcept*)
tacrolimus (*Prograf*)
Rapamune
Sandimmune (Brd only)

Requires Prior Authorization

cyclosporine (gen only)
Azasan
Myfortic
Zortress

INJECTABLES

Colony Stimulating Factors

Preferred

Neupogen

Requires Prior Authorization

Leukine
Neulasta

Cytokine & CAM Antagonists

(AntiInflammatory, Pyrimidine Synthesis Inhibitor, Anti-Inflammatory, Tumor Necrosis Factor Inhibitor, Anti-Flam, Interleukin-1 Receptor Antagonist, Drugs to Tx Chronic Inflamm Disease of Colon,Antimetabolites)

Preferred

Enbrel
Humira

Requires Prior Authorization

Actemra
Cimzia
Kineret
Orencia
Remicade
Simponi
Stelara
Xeljanz

Erythropoietins (Hematinics, Other)

Preferred

Aranesp
Procrit

Requires Prior Authorization

Epogen

Growth Hormones (Clinical PA Required)

Preferred

Genotropin
Norditropin
Nutropin, Nutropin AQ

Requires Prior Authorization

Humatrope
Omnitrope
Saizen
Serostim
Tev-Tropin

NEUROLOGICS

Alzheimer's Agents

Preferred

donepezil, donepezil ODT (all strengths except 23 mg) (*Aricept, Aricept ODT*)
rivastigmine (*Exelon*)
Exelon Patch
Namenda

Requires Prior Authorization

galantamine (*Razadyne ER*)
Aricept 23 mg
Exelon solution

Anti-Parkinson's Agents

Preferred

benztropine (*Cogentin*)
levodopa/carbidopa IR & ER (*Sinemet, Sinemet CR*)
levodopa/carbidopa/entacapone (*Stalevo*)
pramipexole (*Mirapex*)
ropinirole (*Requip*)
selegiline tabs (*Eldepryl*)
trihexyphenidyl (*Artane*)

Requires Prior Authorization

bromocriptine (*Parlodel*)
entacapone (*Comtan*)
levodopa/carbidopa ODT (*Parcopa*)
ropinirole ER (*Requip XL*)
selegiline caps (*Eldepryl*)
Azilect
Mirapex ER
Neupro
Tasmar
Zelapar

Multiple Sclerosis Agents

Preferred

Avonex
Betaseron
Copaxone
Rebif

Requires Prior Authorization

Ampyra
Aubagio
Extavia
Gilenya

OPHTHALMICS

Ophthalmics, Allergic Conjunctivitis

(Eye AntiInflammatory Agents, Eye Antihistamines, Ophthalmic Mast Cell Stabilizers)

Preferred

cromolyn (*Crolom*)
ketotifen OTC (*Zaditor OTC*)
Alrex
Pataday

Requires Prior Authorization

azelastine (*Optivar*)
epinastine (*Elestat*)
Alocril
Alomide
Bepreve
Emadine
Lastacaft
Patanol

Ophthalmics, Antibiotics

Preferred

bacitracin
bacitracin/polymixin
ciprofloxacin solution (*Ciloxan*)
erythromycin
gentamicin drops (Garamycin)
neomycin/polymixin/gramicidin (*Neosporin*)
ofloxacin (*Ocuflox*)
polymyxin/trimethoprim (*Polytrim*)
sulfacetamide (*Bleph-10*)
terramycin/polymyxin
tobramycin drops (*Tobrex*)
triple antibiotic
Besivance
Ciloxan ointment
Moxeza
Tobrex ointment
Vigamox

Requires Prior Authorization

levofloxacin (*Quixin*)
AzaSite
Garamycin ointment
Natacyn
Zymaxid

Maryland Medicaid Preferred Drug List (effective July 1, 2013)

OPHTHALMICS

Ophthalmics, Antibiotic/Steroid Combinations

Preferred

neomycin/bacitracin/polymyxin/HC
neomycin/polymyxin/dexamethasone (*Maxitrol*)
neomycin/polymyxin/HC
sulfacetamide/prednisolone
Blephamide,
Pred-G
Tobradex susp (Brd only)
Tobradex ointment

Requires Prior Authorization

tobramycin/dexamethasone susp (gen only)
Tobradex ST
Zylet

Ophthalmics, Glaucoma Agents

Preferred

betaxolol
brimonidine (*Alphagan P 0.1%*)
carteolol (*Ocupress*)
dorzolamide (*Trusopt*)
dorzolamide/timolol (*Cosopt*)
latanaprost (*Xalatan*)
levobunolol (*Betagan*)
metipranolol (*OptiPranolol)*
pilocarpine (*Pilocar)*
timolol (*Timoptic, Timoptic XE*)
Alphagan P 0.15% (Brd only)
Azopt
Betimol
Betoptic S
Combigan
Istalol
Travatan Z

Requires Prior Authorization

apraclonidine (*Iopidine*)
brimonidine tartrate 0.15% (*Alphagan P*) (gen only)
travoprost
Cosopt PF
Lumigan
Zioptan

OPHTHALMICS

Ophthalmics, Anti-Inflammatories

Preferred

dexamethasone (*Decadron*)
diclofenac (*Voltaren*)
fluorometholone (*FML*)
flurbiprofen (*Ocufen)*
ketorolac, ketorolac LS (*Acular, Acular LS)*
prednisolone acetate (*Omnipred)*
prednisolone sodium (*Pred Forte*)
Flarex
FML Forte
FML SOP
Lotemax Drops
Maxidex
Pred Mild

Requires Prior Authorization

bromfenac (Xibrom)
Acuvail
Bromday
Durezol
Ilevro
Lotemax ointment & gel
Nevanac
Ozurdex
Retisert
Triesence
Vexol

OTIC

Otic Antibiotics

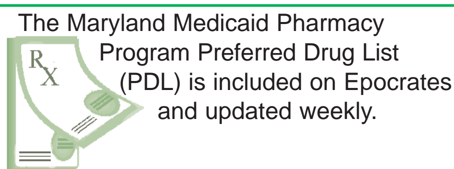
Preferred

neomycin/polymyxin/HC solution (*Cortisporin*)
ofloxacin otic (*Floxin Otic*)
Ciprodex

Requires Prior Authorization

Cipro HC
Coly-Mycin S

The Maryland Medicaid Pharmacy Program Preferred Drug List (PDL) is included on Epocrates and updated weekly.



Visit www.epocrates.com and click on "Epocrates Online" or "My Account" to register for your free online account.

RESPIRATORY

Antihistamines, Minimally Sedating

Preferred

cetirizine, cetirizine-D Rx & OTC (*Zyrtec, Zyrtec D*)
fexofenadine OTC (*Allegra*)
levocetirizine (*Xyzal*)
loratadine, loratadine-D Rx & OTC (*Claritin, Claritin-D*)

Requires Prior Authorization

desloratadine (*Clarinex, Clarinex-D*)
fexofenadine (*Allegra*)
fexofenadine D, 12 & 24 hour (*Allegra-D*)
Semprex-D
Xyzal

Beta$_2$-Agonist Bronchodilators
(Beta-Adrenergic Agents)

Preferred

albuterol neb (0.083% & 5mg/ml)
albuterol syrup & tab (*Proventil, Ventolin*)
terbutaline (*Brethine*)
Foradil
Maxair
ProAir HFA
Proventil HFA

Requires Prior Authorization

albuterol ER (*Vospire ER*)
albuterol neb low dose (*Accuneb*)
levalbuterol neb (*Xopenex*)
metaproterenol (*Alupent*)
Arcapta
Brovana
Perforomist
Serevent
Ventolin HFA
Xopenex HFA

COPD Agents

Preferred

ipratropium neb (*Atrovent*)
ipratopium neb/albuterol (*DuoNeb*)
Atrovent HFA
Combivent Respimat
Spiriva

Requires Prior Authorization

Daliresp
Tudorza

Maryland Medicaid Preferred Drug List (effective July 1, 2013)

RESPIRATORY

Glucocorticoids, Inhaled (Beta-Adrenergics & Glucocorticoids Combination, Glucocorticoids)

Preferred

Advair Diskus, Advair HFA
Asmanex
Dulera
Flovent Diskus, Flovent HFA
Qvar
Pulmicort Flexhaler
Pulmicort Respules 0.25 & 0.5 mg (Brd only) *
Symbicort

Requires Prior Authorization

budesonide respules (generic / all ages)
Alvesco
Pulmicort 1mg respules

Intranasal Rhinitis Agents (Nasal Anti-Inflammatory Steriods)

Preferred

fluticasone nasal (*Flonase*)
ipratropium (*Atrovent Nasal*)
Astelin (Brd only)
Astepro
Nasacort AQ (Brd only)
Nasonex
Patanase

Requires Prior Authorization

azelastine nasal (*Astelin*) (gen only)
flunisolide (*Nasarel, Nasalide*)
triamcinolone nasal (*Nasacort AQ*) (gen only)
Beconase AQ
Dymista
Omnaris
QNasal
Rhinocort Aqua
Veramyst
Zetonna

Leukotriene Modifiers

Preferred

montelukast chew & tabs (*Singulair*)
zafirlukast (*Accolate*)

Requires Prior Authorization

Singulair Granules
Zyflo, Zyflo CR

** Available without prior authorization for children 1 to 8 years of age.*

TOPICAL DERMATOLOGICS

Acne Agents, Topical

Preferred

benzoyl peroxide cleanser, gel, med pad
clindamycin (all forms except foam)
erythromycin
panoxyl-8 OTC
tretinoin
tretinoin micro (*Retin-A Micro*) (all foms except pump)
Azelex
Desquam-X OTC
Differin (Brd only)
Retin-A
SE BPO 7-5.5 Wash Kit
TL 4.25% BPO MX Cleanser OTC

Requires Prior Authorization

adapalene (gen only)
benzoyl peroxide OTC (all forms, strengths)
benzoyl peroxide kit, towelette
bp-10-1
cerisa
clindamycin foam
clindamycin-benzoyl peroxide
erythromycin-benzoyl peroxide
sulfacetamide
sulfacetamide/sulfur
sulfacetamide/sulfur/urea
tretinoin micro pump (*Retin-A Micro*)
Acanya
Aczone
Akne-Mycin
Atralin
Avar (all forms, strengths)
Avita
BenzaClin
Benzamycin
Benzefoam (all forms, strengths)
Clarifoam EF
Clenia
Cleocin T (all forms, strengths)
Clindacin Pac Kit
Clindagel
Delos
Duac
Epiduo
Evoclin
Garimide
Inova (all forms, strengths)
Klaron
Lavoclen (all forms, strengths)
Ovace (all forms, strengths)
Pacnex (all forms, strengths)
Panoxyl-4 OTC
Plexicon
Prascion RA

TOPICAL DERMATOLOGICS

Acne Agents, Topical (*continued*)

Requires Prior Authorization (cont.)

Sastid
SE 10-5
SE BPO Cleanser
SSS 10-4
SSS 10-5 foam
Sumadan (all forms, strengths)
Sumaxin (all forms, strengths)
Tazorac (all forms, strengths)
Veltin
Ziana

Atopic Dermatitis

Preferred

Elidel

Requires Prior Authorization

Protopic

UROLOGIC

Benign Prostatic Hyperplasia (Alpha-Adrenergic Blocking Agents)

Preferred

alfuzosin (*Uroxatral*)
doxazosin (*Cardura*)
finasteride (*Proscar*)
tamsulosin (*Flomax*)
terazosin (*Hytrin*)

Requires Prior Authorization

Avodart
Cardura XL
Jalyn
Rapaflo

Bladder Relaxant Preparations (Urinary Tract Antispasmodic/Antiincontinence Agent)

Preferred

oxybutynin, oxybutynin ER (*Ditropan, Ditropan XL*)
Toviaz

Requires Prior Authorization

flavoxate
tolteradine (*Detrol*)
trospium, trospium ER (*Sanctura, Sanctura ER*)
Detrol LA
Enablex
Gelnique
Myrbetriq
Oxytrol
Vesicare

Maryland Department of Health and Mental Hygiene
Office of Systems, Operations and Pharmacy

Pharmacy News & Views

Maryland Medicaid Pharmacy Program
201 West Preston Street, 4th Floor
Baltimore, Maryland 21201
410-767-1455
http://mmcp.dhmh.maryland.gov/pap

Martin O'Malley, *Governor*
Anthony G. Brown, *Lt. Governor*
Joshua M. Sharfstein, MD, *Secretary, DHMH*

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30-day Emergency Supply of Atypical Antipsychotic Agents

When the prescriber is not available to obtain prior authorization for an antipsychotic medication that is non-preferred or second tier, the pharmacist can obtain a one-time only authorization to dispense up to a 30-day emergency supply.

Do not let patients leave the pharmacy without medication if there is concern that the patient will be unwilling or unable to return at a later time that day after prior authorization is approved.

To obtain authorization for an *emergency supply of antipsychotic,* call Affiliated Compuer Services (ACS) at 800-932-3918. During the 30-day window, the pharmacist must notify the prescriber of the need to obtain a PA before the prescription can be filled a second time and make a note for his or her records of the date, time and person contacted at the prescriber's office.

TELEPHONE NUMBERS

Xerox Technical Assistance
1-800-932-3918
24 hours a day, 7 days a week

Maryland Medicaid Pharmacy Access Hotline
1-800-492-5231 (*select option three*)
Monday-Friday, 8:00 am to 5:00 pm

Kidney Disease Program
1-410-767-5000 or 5002
Monday-Friday, 8:00 am to 5:00 pm

Breast & Cervical Cancer Diagnosis and Treatment
1-410-767-6787
Monday-Friday, 8:00 am to 4:30 pm

Maryland AIDS Drug Assistance Program
1-410-767-6535
Monday-Friday, 8:30 am to 4:30 pm