



Pharmacy News & Views

January 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. 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 trial (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>

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 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%20%20and%20NPD%20Antipsychotic%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) 1-800-932-9318
- Maryland Medicaid at 1-800-492-5231 (opt 3)

**REMEMBER: NEVER
LET THE PATIENT
GO WITHOUT
MEDICATION**

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 in 2013. The 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 6 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>



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MMPP Newsletters and Advisories at:
www.marylandmedicaidpharmacyinformation.com

Maryland Medicaid Preferred Drug List

The Maryland Medicaid Preferred Drug List (PDL) shown includes updates effective January 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 fee-for-service Medicaid patients. *Note: for most multi-source products, the gen product(s) are usually preferred and brded innovator product(s) are non-preferred. Most brded PDL products that are new to the market require prior authorization until they are reviewed.*

Key: Highlighted 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)
oxycodone ER (*OxyContin*) (Brd & gen)
oxymorphone ER
tramadol ER (*Ultram ER, Ryzolt*) (Brd & gen)
Avinza
Butrans
Conzip
Duragesic Matrix
Exalgo
Nucynta ER
Opana ER

Analgesics, Narcotics (Short Acting)

Preferred

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

ANALGESIC

Analgesics, Narcotics Preferred (continued)

Requires Prior Authorization

butorphanol nasal spray
carisoprodol/codeine/asa
fentanyl transmucosal & buccal (*Actiq & Fentora*) (Brd & gen) *
levorphanol
meperidine (*Demerol*) (Brd & gen)
oxycodone/ibuprofen (*Combunox*) (Brd & gen)
oxymorphone (*Opana*) (Brd & gen)
Abstral *
Dilaudid Liquid
Ibudone
Nucynta
Onsolis *
Oxecta
Panlor DC
Primlev
Reprexain
Roxicodone solution
Rybit ODT
Subsys
Trezix
Zamicet
Zolvit

Anti-Hyperuricemics

Preferred

allopurinol (*Zyloprim*)
probenecid
probenecid/colchicine

Requires Prior Authorization

Colcrys
Uloric

Anti-Migraine Agents

Preferred

sumatriptain (*Imitrex*)
Relpax

Requires Prior Authorization

naratriptan (*Amerge*) (Brd & gen)
Axert
Cambia
Frova
Maxalt, Maxalt MLT
Sumavel Dosepro
Treximet
Zomig, Zomig Nasal, Zomig ZMT

ANALGESIC

Neuropathic Pain

Preferred

capsaicin OTC
gabapentin (*Neurontin*)
Lidoderm
Lyrica
Savella

Requires Prior Authorization

Cymbalta *
Gralise
Horizant
Qutenza
Zostrix OTC

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

Preferred

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

Requires Prior Authorization

diclofenac/misoprostil (*Arthrotec*) (Brd & gen)
mefenamic acid (*Ponstel*)
tolmetin, tolmetin DS (*Tolectin, Tolectin DS*)
Celebrex
Duedis
Flector
Indocin Rectal, Indocin Suspension
Mobic Suspension
Pennsaid
Sprix Nasal
Vimovo
Zipsor

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

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

ANALGESIC

Skeletal Muscle Relaxants

Preferred

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

Requires Prior Authorization

cyclobenzaprine ER (*Amrix*) (Brd & gen)
 metaxalone (*Skelaxin*) (Brd & gen)
 tizanidine caps (*Zanaflex*) (Brd & gen)
 Fexmid
 Lorzone
 Soma 250mg

ANTI-INFECTIVES

Antibiotics, GI

Preferred

metronidazole tabs (*Flagyl*)
 neomycin
 vancomycin (*Vancocin*)
 Alinia

Requires Prior Authorization

metronidazole caps (*Flagyl caps*)
 tinidazole (*Tinamix*)
 Difcid
 Flagyl ER
 Neo-Fradin
 Xifaxan

Antibiotics, Inhaled

Preferred

TOBI

Requires Prior Authorization

Cayston

Preferred

clindamycin (*Clindamax*)
 metronidazole (*Metro-Gel*) (Brd & gen)
 Cleocin Ovules
 Vandazole

Requires Prior Authorization

Cleocin Cream

ANTI-INFECTIVES

Antifungals, Oral (Antifungal Agents, Antifungal Antibiotics)

Preferred

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

Requires Prior Authorization

clotrimazole troche (*Mycelex*) (Brd & gen)
 flucytosine (*Ancobon*)
 griseofulvin suspension (*Fulvicin*,
GriFulvin V) (Brd & gen)
 itraconazole (*Sporanox*)
 voriconazole (*Vfend*) (Brd & gen)
 Lamisil Granules
 Noxafil
 Terbinex

Antifungals, Topical (Topical Antifungals)

Preferred

clotrimazole OTC & Rx (*Lotrimin*)
 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*) (Brd & gen)
 ciclopirox (*Loprox*) (Brd & gen)
 ciclopirox solution (*Penlac*) (Brd & gen)
 ciclopirox shampoo (*Loprox*) (Brd & gen)
 ketoconazole foam
 tolnaftate aero powder
 Bensal HP
 CNL-8
 Ertaczo
 Exelderm
 Extina
 Ketocon Plus
 Lamisil Solution
 Naftin
 Oxistat
 PEDIADERM AF
 Pediprox-4
 Vusion

Antiparasitics, Topical

Preferred

malathion (*Ovide*)
 permethrin OTC
 permethrin Rx (*Elimite, Acticin*)
 piperonyl/pyrethrins OTC
 piperonyl/pyrethrins/permethrin OTC
 Eurax cream

Requires Prior Authorization

lindane
 spinosad (*Natroba*) (gen only)
 Eurax lotion
 Sklice
 Ulesfia

ANTI-INFECTIVES

Antivirals, Oral (Antivirals, General)

Preferred

acyclovir (*Zovirax*)
 amantadine (*Symmetrel*)
 rimantadine (*Flumadine*)
 valacyclovir (*Valtrex*) (Brd & gen)

Requires Prior Authorization

famciclovir (*Famvir*) (Brd & gen)
 Relenza
 Tamiflu

Antivirals, Topical

Preferred

Abreva OTC
 Denavir
 Zovirax Ointment

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*)
 cephalixin (*Keflex*)
 Suprax

Requires Prior Authorization

amoxicillin/clav ER (*Augmentin XR*)
 (Brd & gen)
 cefditoren (*Spectracef*) (Brd & gen)
 cefpodoxime (*Vantin*) (Brd & gen)
 Cedax
 Ceftin Tabs/Suspension

Fluoroquinolones (Quinolones)

Preferred

ciprofloxacin (*Cipro*)
 levofloxacin (*Levaquin*)

Requires Prior Authorization

ciprofloxacin ER (*Cipro XR*) (Brd & gen)
 ofloxacin (*Floxin*) (Brd & gen)
 Avelox
 Cipro Suspension
 Factive
 Noroxin


Hepatitis C Agents (Hepatitis C Treatment Agents, Immunomodulators)

Preferred

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

Requires Prior Authorization

Infergen
 Pegasys Proclick
 Ribapak
 Ribasphere

 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.

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

ANTI-INFECTIVE

Macrolides/Ketolides

Preferred

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

Requires Prior Authorization

clarithromycin, clarithromycin ER
(*Biaxin, Biaxin XL*) (Brd & gen)
Ketek
PCE
Zmax

Tetracyclines

Preferred

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

Requires Prior Authorization

demeclocycline (*Declomycin*)
minocycline ER
Adoxa CK, Adoxa TT
Doryx
Morgidox
Oracea
Solodyn
Vibramycin Caps & Suspension

Topical Antibiotics

Preferred

bacitracin OTC
bacitracin/polymyxin OTC
gentamicin
mupirocin (*Bactroban Ointment*)
triple antibiotic cream, ointment & packet, OTC

Requires Prior Authorization

Altabax
Bactroban Cream
Centany

Angiotensin Modulator Combinations

Preferred

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

Requires Prior Authorization

trandolapril/verapamil (*Tarka*)
(Brd & gen)
Tekamlo/Amturnide
Twynsta

CARDIOVASCULAR

Angiotensin Modulators (Hypotensives, Angiotensin Receptor Antagonist)

Preferred

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

Requires Prior Authorization

eprosartan (*Teveten*) (Brd & gen)
irbesartan, irbesartan HCTZ (*Avapro, Avalide*) (Brd & gen)
moexipril (*Univasc*) (Brd & gen)
moexipril HCTZ (*Uniretic*) (Brd & gen)
perindopril (*Aceon*) (Brd & gen)
trandolapril (*Mavik*) (Brd & gen)
Atacand, Atacand HCT
Benicar, Benicar HCT
Edarbi, Edarbiclor
Micardis, Micardis HCT
Tekturna, Tekturna HCT
Teveten HCT

Anticoagulants

Preferred

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

Requires Prior Authorization

enoxaparin (gen only)
fondaparinux (*Arixtra*) (Brd & gen)
Pradaxa
Xarelto

Antihypertensives, Sympatholytics

Preferred

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

Requires Prior Authorization

clonidine transdermal (gen only)
reserpine
Clorpres

CARDIOVASCULAR

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

Preferred

acebutolol (*Sectral*)
atenolol (*Tenormin*)
atenolol/chlorthalidone (*Tenoretic*)
bisoprolol (*Zebeta*)
bisoprolol HCTZ (*Ziac*)
carvedilol (*Coreg*)
labetalol (*Normodyne, Trandate*)
metoprolol tartrate (*Lopressor*)
metoprolol tartr/HCTZ (*Lopressor HCTZ*)
metoprolol succinate XL (*Toprol XL*)
nadolol (*Corgard*)
nadolol/bendroflumethiazide (*Corzide*)
pindolol (*Visken*)
propranolol, propranolol LA
(*Inderal, Inderal LA*)
propranolol HCTZ (*Inderide*)
sotalol, sotalol AF (*Betapace, Betapace AF*)
timolol (*Blocadren*)

Requires Prior Authorization

betaxolol (*Kerlone*) (Brd & gen)
Bystolic
Coreg CR
Dutropol
Innopran XL
Levatol

Calcium Channel Blocking Agents

Preferred

amlodipine (*Norvasc*)
diltiazem (*Cardizem*)
diltiazem CD, diltiazem ER (*Cardizem SR, Cardizem CD, Dilacor XR, Tiazac*)
felodipine (*Plendil*)
isradipine (*Dynacirc*)
nicardipine (*Cardene*)
nifedipine SR (*Adalat CC, Procardia XL*)
verapamil (*Calan*)
verapamil ER, verapamil SR (*Calan SR, Verelan*)

Requires Prior Authorization

nifedipine (*Adalat, Procardia*) (Brd & gen)
nimodipine (*Nimotop*) (Brd & gen)
nisoldipine (*Sular*) (Brd & gen)
verapamil ER caps (*Verelan PM*)
(Brd & gen)
Cardizem LA
Covera HS
DynaCirc CR
Matzim LA

Lipotropics, Other (Lipotropics, Bile Salt Sequestrants)

Preferred

cholestyramine (*Questran, Light*)
fenofibrate nanocrystals (*Tricor*)
gemfibrozil (*Lopid*)
Niacor
Niaspan ER
Trilipix

Requires Prior Authorization

colestipol (*Colestid*) (Brd & gen)
fenofibrate (*Lofibra*) (Brd & gen)
fenofibric acid (*Fibricor*) (Brd & gen)
Antara
Lipofen
Lovaza
Triglide
Welchol
Zetia

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

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

CARDIOVASCULAR

Lipotropics, Statins (Lipotropics)

Preferred

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

Requires Prior Authorization

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

Platelet Aggregation Inhibitors

Preferred

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

Requires Prior Authorization

Brilinta
 Effient

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 suspension*) (Brd & gen)
 clonazepam (*Klonopin*)
 divalproex (*Depakote, Depakote ER*)
 lamotrigine (*Lamictal*)
 levetiracetam (*Keppra*)
 oxcarbazepine tabs (*Trileptal*)
 oxcarbazepine susp. (*Trileptal suspension*) (Brd & gen)
 phenobarbital
 phenytoin (*Dilantin*)
 primidone (*Mysoline*)
 tiagabine (*Gabitril*)
 topiramate (*Topamax*)
 valproic acid (*Depakene*)
 zonisamide (*Zonegran*)
 Carbatrol (Brd only)
 Celontin
 Depakote Sprinkle (Brd only)
 Diastat Rectal (Brd only)
 Dilantin Infatabs
 Peganone

CENTRAL NERVOUS SYSTEM

Anticonvulsants (continued)

Requires Prior Authorization

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

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
 Oleptro ER
 Pristiq
 Viibryd

Antidepressants, Selective Serotonin Reuptake Inhibitors (SSRIs)

Preferred

citalopram (*Celexa*)
 escitalopram (*Lexapro*)
 fluoxetine (*Prozac*)
 fluvoxamine (*Luvox*)
 paroxetine (*Paxil*)
 sertraline (*Zoloft*)

Requires Prior Authorization

fluoxetine weekly (*Prozac weekly*) (Brd & gen)
 paroxetine CR (*Paxil CR*) (Brd & gen)
 selfemra (*Sarafem*) (Brd & gen)
 Luvox CR
 Pexeva

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

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*)
 Geodon IM
 Invega Sustenna
 Orap
 Risperdal Consta

SECOND TIER: **

olanzapine IM (*Zyprexa IM*)
 olanzapine ODT (*Zyprexa Zydys*)
 olanzapine (*Zyprexa*)

Abilify

** 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.

Requires Prior Authorization

ziprasidone (gen only)
 Abilify IM
 Fanapt
 Fazaclo
 Invega
 Latuda
 Saphris
 Seroquel XR
 Zyprexa Relprev

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

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

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

CENTRAL NERVOUS SYSTEM

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

Preferred

FIRST TIER:

amphetamine salt combo (*Adderall*)
dexamethylphenidate (*Focalin*) (Brd & gen)
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 & Solution
Vyvanse

SECOND TIER:

Strattera * (for ages 17 and under)

Requires Prior Authorization

amphetamine salt combo ER (gen only)
dextroamphetamine ER caps (gen only)
methamphetamine (*Desoxyn*) (Brd & gen)
methylphenidate CD (gen only)
methylphenidate ER (*Ritalin LA*) (Brd & gen)
methylphenidate liquid (*Procentra*) (Brd & gen)
modafinil (*Provigil*) (Brd & gen)
Kapvay **
Nuvigil

** 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.

ENDOCRINE

Androgenic Agents

Preferred

Androderm
Androgel

Requires Prior Authorization

Axiron
Fortesta
Testim

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

Preferred

alendronate (*Fosamax*)
Miacalcin (Brd only)

Requires Prior Authorization

calcitonin salmon nasal (gen only)
etidronate (*Didronel*) (Brd & gen)
ibandronate (*Boniva*) (Brd & gen)
Actonel
Atelvia
Evista
Forteo
Fortical
Fosamax Plus D, Fosamax Solution
Prolia

ENDOCRINE

Hypoglycemics, Incretin Mimetics & Enhancers

Preferred

Byetta
Janumet
Januvia
Jentadueto
Kombiglyze XR
Onglyza
Symlin
Tradjenta

Requires Prior Authorization

Bydureon
Janumet XR
Juvvisync
Victoza

Hypoglycemics, Insulins

Preferred

Humalog, Humalog Mix
Humulin
Lantus
Novolin
Novolog, Novolog Mix

Requires Prior Authorization

Apidra
Levemir

Hypoglycemics, Meglitinides

(Hypoglycemics, Insulin Release Stimulant Type)

Preferred

nateglinide (*Starlix*)
Prandin

Requires Prior Authorization

Prandimet

Hypoglycemics, TZDs

(Hypoglycemics, Insulin-Response Enhancers)

Preferred

pioglitazone (*Actos*)
ActoPlusMet
Duetact

Requires Prior Authorization

ActoPlusMet XR
Avandamet
Avandaryl
Avandia

GASTROINTESTINAL

Antiemetic/Antivertigo Agents

Preferred

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

Requires Prior Authorization

dronabinol (gen only)
granisetron oral & IV (*Kytril*) (Brd & gen)
trimethobenzamide (*Tigan*) (Brd & gen)
Aloxi IV
Anzemet (oral & IV)
Cesamet
Emend IV
Sancuso
Zuplenz

GASTROINTESTINAL

Bile Salts

Preferred

ursodiolcapsule (*Actigall*)

Requires Prior Authorization

ursodiol tab (*URSO Forte*)
Chenodal

Pancreatic Enzymes

Preferred

pancrelipase
Creon
Zenpep

Requires Prior Authorization

Pancreaze

Phosphate Binders & Related Agents

Preferred

Calphron OTC
Eliphos
PhosLo (Brd only)
Renagel
Renvela tab

Requires Prior Authorization

calcium acetate (gen only)
Fosrenol
Magnebind 400 RX
Phoslyra
Renvela powder packet

Proton Pump Inhibitors

(Gastric Acid Secretion Reducers)

Preferred

lansoprazole, lansoprazole OTC (*Prevacid, Prevacid OTC*)
omeprazole, omeprazole OTC (*Prilosec, Prilosec OTC*)
pantoprazole (*Protonix*)
Prevacid Solutab (Brd only)
Protonix Suspension

Requires Prior Authorization

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

Ulcerative Colitis Agents

Preferred

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

Requires Prior Authorization

mesalamine enemas (*Rowasa*) (Brd & gen)
Asacol HD
Dipentum
Lialda
Pentasa
sFRowasa

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

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

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

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 IV, Orencia Sub-Q
Remicade
Simponi
Stelara

Erythropoietins (Hematinics, Other)

Preferred

Aranesp
Procrit

Requires Prior Authorization

Epogen
Omontys

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 (*Aricept*,
Aricept ODT)
rivastigmine caps (*Exelon*)
Exelon Transdermal Patch
Namenda

Requires Prior Authorization

galantamine (*Razadyne*, *Razadyne ER*)
(Brd & gen)
Exelon Solution

Anti-Parkinson's Agents

Preferred

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

NEUROLOGICS

Anti-Parkinson's Agents (continued)

Requires Prior Authorization

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

Multiple Sclerosis Agents

Preferred

Avonex
Betaseron
Copaxone
Rebif

Requires Prior Authorization

Ampyra
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*) (Brd & gen)
epinastine (*Elestat*) (Brd & gen)
Alocril
Alomide
Bepreve
Emadine
Lastacaft
Patanol

Ophthalmics, Antibiotics

Preferred

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

Requires Prior Authorization

levofloxacin (*Quixin*) (Brd & gen)
AzaSite
Garamycin Ointment
Iquix
Natacyn
Zymaxid

OPHTHALMICS

Ophthalmics, Antibiotic/Steroid Combinations

Preferred

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

Requires Prior Authorization

tobramycin/dexamethasone susp.
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*) (Brd & gen)
pilocarpine (*Pilocar*)
timolol (*Timoptic*, *Timoptic XE*)
Alphagan P 0.15% (Brd only)
Azopt
Betimol
Betoptic S
Combigan
Istalol
Travatan, Travatan Z

Requires Prior Authorization

apraclonidine (*Iopidine*) (Brd & gen)
brimonidine tartrate 0.15% (gen only)
Lumigan
Zioptan

Ophthalmics, Anti-Inflammatories

Preferred

dexamethasone (*Decadron*)
diclofenac (*Voltaren*)
fluorometholone (*FML*)
flurbiprofen (*Ocufer*)
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
Lotemax Ointment
Nevanac
Ozurdex
Pred Forte
Retisert
Triescence
Vexol

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

OTIC

Otic Antibiotics

Preferred

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

Requires Prior Authorization

Cipro HC
Coly-Mycin S
Cortisporin TC

RESPIRATORY

Antihistamines, Minimally Sedating

Preferred

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

Requires Prior Authorization

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

Beta₂-Agonist Bronchodilators

(Beta-Adrenergic Agents)

Preferred

albuterol syrup & tab (*Proventil*, *Ventolin*)
albuterol neb solution (except low dose)
terbutaline (*Brethine*)
Foradil
Maxair
ProAir HFA
Proventil HFA

Requires Prior Authorization

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

COPD Agents

Preferred

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

Requires Prior Authorization

Combivent Respimat
Daliresp

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

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

Requires Prior Authorization

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

Intranasal Rhinitis Agents

(Nasal Anti-Inflammatory Steroids)

Preferred

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

Requires Prior Authorization

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

Leukotriene Modifiers

Preferred

montelukast (*Singulair*)
zafirlukast (*Accolate*)

Requires Prior Authorization

Singulair Granules
Zyflo, Zyflo CR

TOPICAL DERMATOLOGICS

Acne Agents, Topical

Preferred

benzoyl peroxide cleanser, gel, kit,
med. pad, & towelette
clindamycin foam, gel, lotion,
med. swab, & solution
erythromycin gel, med. swab & solution
sulfacetamide/sulfur/urea
sulfacetamide/sulfur (all forms, strengths)
tretinoin
Azelex
Desquam-X OTC
Differin (Brd only)
Panoxyl-8 OTC
Retin-A (all forms, strengths)
SE BPO 7-5.5 Wash Kit
SSS 10-4
TL 4.25% BPO MX Cleanser OTC

TOPICAL DERMATOLOGICS

Acne Agents, Topical (continued)

Requires Prior Authorization

adapalene (gen only)
benzoyl peroxide OTC (all forms, strengths)
clindamycin-benzoyl peroxide
erythromycin-benzoyl peroxide
sodium sulfa-sulfur-meratan
sulfacetamide
Acanya
Aczone
Akne-Mycin
Atralin
Avar (all forms, strengths)
Avita
BenzaClin
Benzamycin
Benzefoam (all forms, strengths)
Benziq
BP-10
Brevoxyl
Cerisa
Clarifoam EF
Clenia
Cleocin T (all forms, strengths)
Clindacin Pac Kit
Clindagel
Delos
Epiduo
Evoclin
Garimide
Inova (all forms, strengths)
Klaron
Lavoclen (all forms, strengths)
Nuox
Ovace (all forms, strengths)
Panex (all forms, strengths)
Panoxyl-4 OTC
Plexicon
Prascion RA
Sastid
SE 10-5
SE BPO Cleanser
Sulfo-Lo OTC
Sulfo-Lac
Sumadan (all forms, strengths)
Sumaxin (all forms, strengths)
Tazorac (all forms, strengths)
Veltin
Ziana

Atopic Dermatitis

Preferred

Elidel

Requires Prior Authorization

Protopic



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



Pharmacy News & Views

Maryland Medicaid Pharmacy Program

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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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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/Anti-incontinence Agent)

Preferred

oxybutynin (*Ditropan*)
Toviaz
Vesicare

Requires Prior Authorization

flavoxate
oxybutynin XL (*Ditropan XL*) (Brd & gen)
trospium, trospium ER (*Sanctura*, *Sanctura ER*) (Brd & gen)
Detrol, Detrol LA
Enablex
Gelnique
Oxytrol

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 Xerox (formerly 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

PRSTD STD
U.S. POSTAGE
PAID
PERMIT 4205
SOUTHERN, MD