

## ODJFS P&T Committee Meeting Minutes

April 23, 2008

77 S. High St., Room 1948

Committee members present: Tammie J. Armeni, RPh; Susan K. Baker, APN; Cheryl Huffman, MD; Robert L. Hunter, DO; Robert P. Reid, RPh (chair); Mary Jo Welker, MD; Michael P. Wascovich, RPh; Adam F. Wooten, DO

ODJFS staff present: Margaret Scott, RPh, BHPP pharmacist.

ACS staff present: Denise Hefley, PharmD, Clinical Information Pharmacist; Randall Renshaw, PharmD, BCPS, Clinical Director; Ed Jingluski, Account Manager

Approximately 50 stakeholders were present, most representing pharmaceutical manufacturers.

The meeting was called to order at 9:13 AM by Mr. Reid, chair, who introduced Adam Wooten, DO, psychiatrist, as a new member of the committee.

Mr. Reid called on Forest to present information on their new product Bystolic (nebivolol). Kristen Crouch, PharmD, and Ken Bescak, MD, cardiologist, presented clinical information.

Dr. Hefley presented information about the Bystolic on behalf of ACS. ACS recommends non-preferred status due to the large number of generic beta blockers that can be used as first-line therapy. Dr. Welker asked about the relative cost of Bystolic. Ms. Scott responded that Bystolic is priced at about the same as angiotensin receptor blockers or direct renin inhibitor, and much more expensive than generic beta blockers. Mr. Wascovich asked if there is evidence that Bystolic can improve a patient's condition enough to remove other drug therapy for diabetes, cardiovascular disease, or asthma. Ms. Hefley will research this question and give more information at the July meeting. The Committee agreed that more information was needed at the next meeting.

Mr. Reid recognized Daiichi Sankyo to present information about their new product Azor (amlodipine/olmesartan). Karen Martin, representing Daiichi Sankyo, presented clinical information.

Dr. Hefley presented information about Azor on behalf of ACS. ACS recommends non-preferred status due to the availability of a wide variety of calcium channel blockers and angiotensin receptor blockers, as well as the preferred drug Exforge, a combination of amlodipine and valsartan.

A representative from ProEthic was not available to present clinical information about Lipofen. The manufacturer provided written information that was distributed to members

prior to the meeting. Dr. Hefley presented information about Lipofen on behalf of ACS. ACS recommends non-preferred status due to the availability of fenofibrate on the Preferred Drug List (PDL) as TriCor.

Mr. Reid called on Dr. Hefley to present a progress report on the PDL. The presentation is attached. Mr. Wascovich asked if expenditures can be provided at the next update.

Mr. Reid called on Dr. Hefley to present a proposal for criteria for the new drug classes for the PDL that will be reviewed at the July meeting. A copy of the proposal is attached. Comments are included in the minutes only for classes that generated discussion. Antidepressants: Mr. Wascovich noted that grandfathering patients who have not refilled a prescription for 120 days may be too long, 60 days may be more appropriate. Dr. Hunter noted that a trial on two preferred agents may not be appropriate before switching to a non-preferred agent. Mr. Wascovich and Dr. Huffman noted that there are a number of available agents, and that the number of preferred agents that should be tried will depend on the number of agents that are chosen to be preferred. Ms. Scott explained the SmartPA automated prior authorization process that will allow a non-preferred agent without prescriber request, if the patient has received two preferred agents from the same prescriber previously. In addition, JFS staff have met with several mental health advocacy groups, and agreed that physicians who are identified in the Medicaid provider file as having a specialty of psychiatry will not need to request prior authorization for a non-preferred antidepressant or second generation antipsychotic product. The SmartPA system will automatically approve non-preferred agents when prescribed by a psychiatrist who is identified in the provider system.

Second generation antipsychotics: Dr. Wooten said that grandfathering patients who have filled a prescription within 120 days is appropriate. Dr. Wooten also noted that a trial on two preferred agents is acceptable, before a non-preferred agent is approved. Dr. Huffman asked if board-certified developmental pediatricians could be added to the psychiatrist exemption from PA requirements, due to the lack of child psychiatrists in the state. Ms. Scott noted that this specialty is not an option in the Medicaid provider file, but that JFS will explore whether this specialty could be automatically approved for PA upon request. Dr. Wooten asked how Medicaid identifies psychiatrists. Ms. Scott responded that the Medicaid provider enrollment staff requires proof of eligibility for the specialty, such as board certification.

Growth hormones: Dr. Huffman asked whether Medicaid should require that all prescriptions be initiated by an endocrinologist. She also said that a two-month trial on a preferred medication may not be long enough, and that most patients will be seen again after three months, so three months may be more reasonable. She volunteered to contact a pediatric endocrinologist to get another opinion. Dr. Wascovich asked whether there are a sufficient number of pediatric endocrinologists to require that the prescription come from an endocrinologist. Dr. Huffman agreed that this is a possibility, but that a wait of a few months to begin growth hormone treatment was not a problem. Ms. Baker added that access may or may not be a problem, but that most pediatricians would not prescribe growth hormone without consulting an endocrinologist. Dr. Welker reminded the committee that not all indications are pediatric, such as AIDS wasting. Mr. Wascovich

asked who has been prescribing these drugs, as far as physician specialty. Ms. Scott said that the department would explore this question and give a report at the July meeting.


Ophthalmic antibiotics: Dr. Huffman asked if there has been any thought to non-quinolones being preferred over quinolones. Mr. Reid asked if she has seen an overuse of quinolones. Dr. Huffman said she has never prescribed an ophthalmic quinolone for a child. Dr. Hunter said that in an adult patient, quinolones may be more effective.

Mr. Reid recognized Dr. Hefley to discuss clinical criteria for the heparin-related preparations, to limit duration of therapy to 35 days. The proposal is attached. Dr. Hunter noted that many sicker patients are being treated in long-term care facilities rather than the hospital, so they may need these products for longer than 35 days. Ms. Scott said that the department would review whether an exception could be made for a patient in long-term care through the SmartPA system. Dr. Welker asked if length of therapy is a problem. Ms. Scott responded that the drug utilization review (DUR) program found approximately 400 patients who exceeded 35 days of therapy in 2007. The DUR program is still evaluating how many of those patients' therapy was appropriate. However, since the cost of heparin-related products is much higher than oral warfarin, this type of policy is warranted. Ms. Scott will give additional information about the reviewed patients at the July meeting.

The meeting was adjourned by Mr. Reid. The next meeting will be Wednesday, July 16 at 9 AM to discuss preferred and non-preferred drugs for the PDL to be effective on October 1. Clinical presentations by manufacturers may be scheduled on July 14 and 15, and the Committee is encouraged to attend.


## Ohio Medicaid PDL Progress Report

Denise Hefley, PharmD  
April 23, 2008

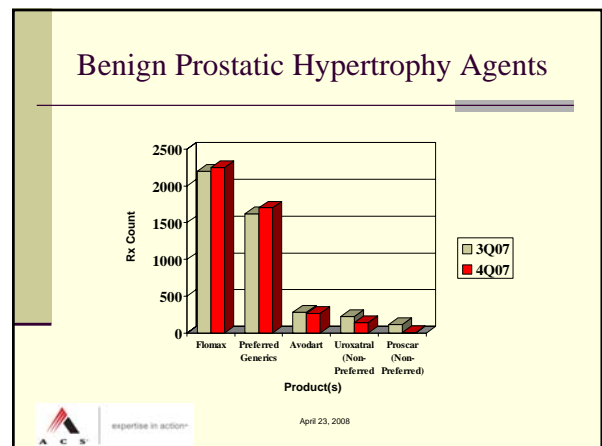
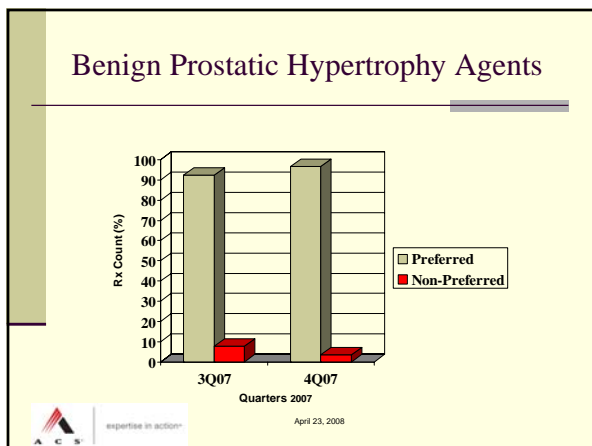
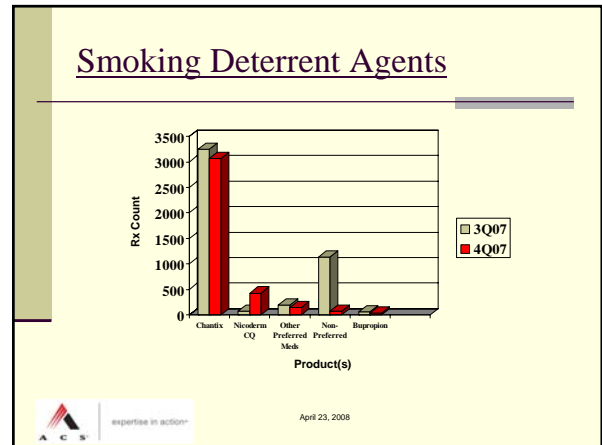
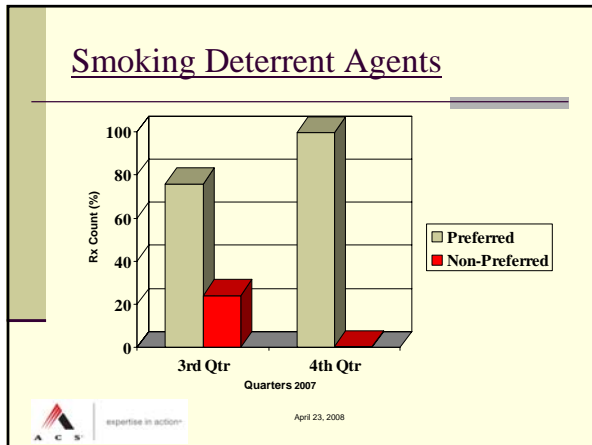


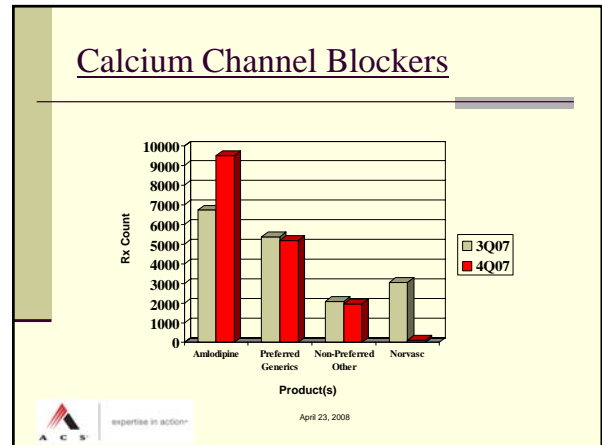
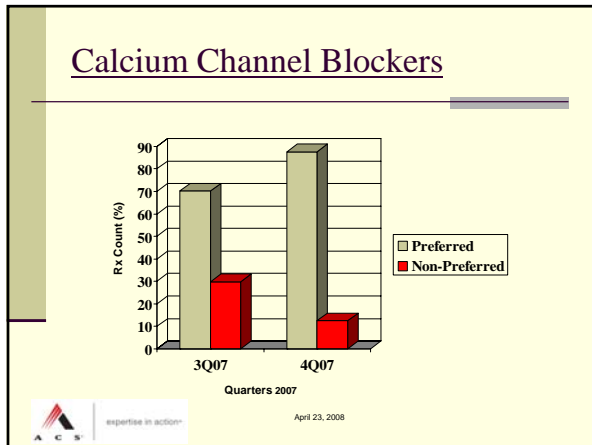
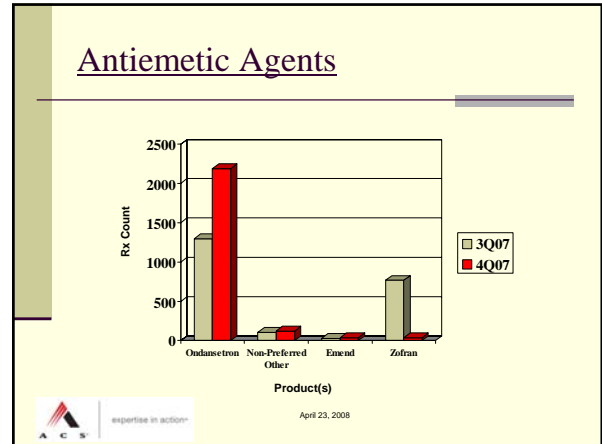
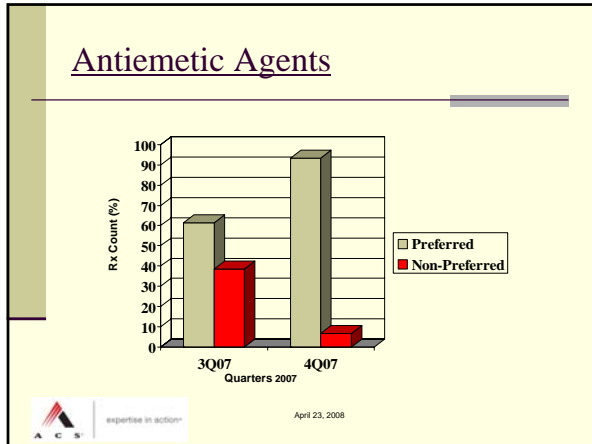
## Ohio Medicaid Progress Report

- New PDL effective 10/1/2007
- 8 new therapeutic classes added to the PDL
- Increased generic penetration observed
- PDL compliance rate for 4Q07 is 96.84%



April 23, 2008





## QUESTIONS?

Denise Hefley, PharmD  
ACS Health Management  
Solutions

ACS expertise in action April 23, 2008

# DRAFT

For P&T Committee Discussion Only

## Antidepressants

### **GRANDFATHERING:**

Patients who have a claim for a non-preferred drug in the previous 120 days will be automatically approved to continue the drug through the automated PA system. Patients who have taken the drug in the previous 120 days, but do not have claims history (new to Medicaid, samples, etc.), will be approved if the prescriber requests PA.

**LENGTH OF AUTHORIZATIONS:** 1 year

Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug-to-drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval

### **Document clinically compelling information**

### **ADDITIONAL INFORMATION**

The requested medication may be approved if both of the following are true:

- If there has been a therapeutic failure to no less than a one-month trial of at least two medications not requiring prior approval
- The requested medication's corresponding generic (if covered by the state) has been attempted and failed or is contraindicated.

### **ANTIDEPRESSANTS: SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRI)\***

#### **DRUGS UNDER CONSIDERATION**

CITALOPRAM HBR (generic of Celexa<sup>®</sup>)  
FLUOXETINE HCL (generic of Prozac<sup>®</sup>)  
FLUVOXAMINE MALEATE (generic of Luvox<sup>®</sup>)  
LEXAPRO<sup>®</sup>  
LUVOX CR<sup>®</sup>  
PAROXETINE HCL (generic of Paxil<sup>®</sup>)  
PAXIL CR<sup>®</sup>  
PEXEVA<sup>®</sup>  
PROZAC WEEKLY<sup>®</sup>  
SARAFEM<sup>®</sup>  
SERTRALINE (generic of Zoloft<sup>®</sup>)

\*Patients on current regimens will be grandfathered.

### **ANTIDEPRESSANTS: SEROTONIN-NOREPINEPHRINE REUPTAKE INHIBITORS (SNRI)\***

#### **DRUGS UNDER CONSIDERATION**

CYMBALTA<sup>®</sup>  
EFFEXOR XR<sup>®</sup>  
PRISTIQ<sup>®</sup>  
VENLAFAXINE (generic of Effexor<sup>®</sup>)

\*Patients on current regimens will be grandfathered.

# DRAFT

For P&T Committee Discussion Only

## **ANTIDEPRESSANTS: NOREPINEPHRINE AND DOPAMINE REUPTAKE INHIBITORS: NDRI\***

### **DRUGS UNDER CONSIDERATION**

BUPROPION HCL (generic of Wellbutrin<sup>®</sup>)  
BUPROPION SR (generic of Wellbutrin SR<sup>®</sup>)  
BUPROPION XL 300mg (generic of Wellbutrin XL<sup>®</sup>)  
WELLBUTRIN XL<sup>®</sup> 150mg

\*Patients on current regimens will be grandfathered.

## **ANTIDEPRESSANTS: ALPHA-2 RECEPTOR ANTAGONISTS\***

### **DRUGS UNDER CONSIDERATION**

MIRTAZAPINE (generic of Remeron<sup>®</sup>)  
MIRTAZAPINE rapid dissolve tablets (generic of Remeron<sup>®</sup> Sol-Tab)

\*Patients on current regimens will be grandfathered.

## **ANTIDEPRESSANTS: SEROTONIN-2 ANTAGONIST/REUPTAKE INHIBITORS (SARI)\***

### **DRUGS UNDER CONSIDERATION**

NEFAZODONE  
TRAZODONE

\*Patients on current regimens will be grandfathered.

## **ANTIDEPRESSANTS: MONOAMINE OXIDASE INHIBITORS (MAOI)\***

### **DRUGS UNDER CONSIDERATION**

EMSAM<sup>®</sup>  
MARPLAN<sup>®</sup>  
NARDIL<sup>®</sup>  
PARNATE<sup>®</sup>  
TRANLYCYPROMINE SULFATE (generic of Parnate<sup>®</sup>)

\*Patients on current regimens will be grandfathered.

# DRAFT

For P&T Committee Discussion Only

## Antipsychotics, Second Generation, Oral

### **GRANDFATHERING:**

Patients who have a claim for a non-preferred drug in the previous 120 days will be automatically approved to continue the drug through the automated PA system. Patients who have taken the drug in the previous 120 days, but do not have claims history (new to Medicaid, samples, etc.), will be approved if the prescriber requests PA.

### **LENGTH OF AUTHORIZATIONS:** 1 year

Is there any reason the patient cannot be changed to a medication not requiring prior approval?  
Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug-to-drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval

### **Document clinically compelling information**

### **ADDITIONAL INFORMATION**

The requested medication may be approved if both of the following are true:

- If there has been a therapeutic failure to no less than a one-month trial of at least two medications not requiring prior approval
- The requested medication's corresponding generic (if covered by the state) has been attempted and failed or is contraindicated.

### **ANTIPSYCHOTICS, SECOND GENERATION\***

#### **DRUGS UNDER CONSIDERATION**

ABILIFY DISCMELT<sup>®</sup>  
ABILIFY<sup>®</sup>  
CLOZAPINE (generic of Clozaril<sup>®</sup>)  
CLOZARIL<sup>®</sup>  
FAZACLO<sup>®</sup>  
GEODON<sup>®</sup>  
INVEGA<sup>®</sup>  
RISPERDAL M-TAB<sup>®</sup>  
RISPERDAL<sup>®</sup>  
SEROQUEL XR<sup>®</sup>  
SEROQUEL<sup>®</sup>  
ZYPREXA ZYDIS<sup>®</sup>  
ZYPREXA<sup>®</sup>

\*Patients on current regimens will be grandfathered.

### **ANTIPSYCHOTICS, SECOND GENERATION and SSRI COMBINATION\***

#### **DRUGS UNDER CONSIDERATION**

SYMBYAX<sup>®</sup>

\*Patients on current regimens will be grandfathered.

# DRAFT

For P&T Committee Discussion Only

## Antirheumatic Agents, Injectable

**LENGTH OF AUTHORIZATIONS:** 1 year

All products in this class require clinical prior authorization:

- No current infection; and
- Prior non-biologic therapy appropriate for diagnosis; and
- Diagnosis of one of the following:
  - Rheumatoid Arthritis
  - Psoriatic Arthritis
  - Polyarticular Juvenile Idiopathic Arthritis
  - Crohn's Disease
  - Ankylosing Spondylitis
  - Psoriasis

### **PDL CRITERIA:**

Is there any reason the patient cannot be changed to a medication not requiring prior approval?

Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug-to-drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval

### **Document clinically compelling information**

### **ADDITIONAL INFORMATION**

The requested medication may be approved if the following is true:

- If there has been a therapeutic failure to no less than a one-month trial of at least one medication not requiring prior approval

### **ANTI-INFLAMMATORY TUMOR NECROSIS FACTOR INHIBITOR**

#### **DRUGS UNDER CONSIDERATION**

ENBREL kit<sup>®</sup>  
ENBREL SURECLIK syringe<sup>®</sup>  
ENBREL syringe<sup>®</sup>  
HUMIRA pen<sup>®</sup>  
HUMIRA starter pack<sup>®</sup>  
HUMIRA syringe<sup>®</sup>

### **ANTI-INFLAMMATORY INTERLEUKIN-1 RECEPTOR ANTAGONIST**

#### **DRUGS UNDER CONSIDERATION**

KINERET<sup>®</sup> syringe

# DRAFT

For P&T Committee Discussion Only

## Growth Hormones

**LENGTH OF AUTHORIZATIONS:** 1 year for most diagnoses; diagnosis of AIDS wasting initial approval for 2 weeks, subsequent approvals for up to 12 weeks

All products in this class require clinical prior authorization:

- Diagnosis of one of the following:
  - AIDS Wasting (concurrent antiretroviral therapy, weight loss >5% of baseline, must document weight increase for continued therapy)
  - Classic Growth Hormone Deficiency
  - Congenital Absence of Pituitary
  - Growth Hormone Deficiency Associated With Chronic Renal Function Impairment – Before Transplant
  - Growth Hormone Deficiency Due to Radiation Therapy
  - Growth Hormone Deficiency Due to Somatropin Deficiency
  - Krause-Kivlin Syndrome
  - Noonan Syndrome
  - Pituitary Gland Removal
  - Prader-Willi Syndrome (sleep apnea and upper airway obstruction must be ruled out)
  - Short Bowel Syndrome
  - Short stature or growth failure in child with short stature homeobox-containing gene (SHOX)
  - Small for Gestational Age
  - Turner Syndrome

### **PDL CRITERIA:**

Is there any reason the patient cannot be changed to a medication not requiring prior approval?  
Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug-to-drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval

### **Document clinically compelling information**

### **ADDITIONAL INFORMATION**

The requested medication may be approved if the following is true:

- If there has been a therapeutic failure to no less than a two-month trial of at least one medication not requiring prior approval

# DRAFT

For P&T Committee Discussion Only

## GROWTH HORMONES

### DRUGS UNDER CONSIDERATION

GENOTROPIN<sup>®</sup> cartridge  
GENOTROPIN<sup>®</sup> MINIQUICK  
HUMATROPE<sup>®</sup> cartridge  
HUMATROPE<sup>®</sup> vial  
NORDITROPIN NORDIFLEX<sup>®</sup>  
NORDITROPIN<sup>®</sup> cartridge  
NORDITROPIN<sup>®</sup> vial  
NUTROPIN AQ<sup>®</sup> pen/cartridge  
NUTROPIN AQ<sup>®</sup> vial  
NUTROPIN<sup>®</sup> vial  
OMNITROPE<sup>®</sup> vial  
SAIZEN<sup>®</sup> vial  
SEROSTIM<sup>®</sup> vial  
TEV-TROPIN<sup>®</sup> vial  
ZORBTIVE<sup>®</sup> vial

# DRAFT

For P&T Committee Discussion Only

## Ophthalmic Agents: Antibiotic Drops and Ointments

**LENGTH OF AUTHORIZATIONS:** for the date of service only; no refills for acute infection. Refills for up to 14 days may be authorized for patients undergoing surgery.

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
  - Allergy to medications not requiring prior approval
  - Contraindication to or drug-to-drug interaction with medications not requiring prior approval
  - History of unacceptable/toxic side effects to medications not requiring prior approval
2. If the infection is caused by an organism resistant to medications not requiring prior approval, then may approve the requested medication.
  - Note diagnosis and any culture and sensitivity reports

The requested medication may be approved if both of the following are true:

- If there has been a therapeutic failure to no less than a three-day trial of at least two medications not requiring prior approval
- The requested medication's corresponding generic (if covered by the state) has been attempted and failed or is contraindicated.

### Document clinically compelling information

#### OPHTHALMIC AGENTS: ANTIBACTERIAL - QUINOLONES

##### DRUGS UNDER CONSIDERATION

CILOXAN<sup>®</sup> ointment  
CIPROFLOXACIN drops (generic of Ciloxan<sup>®</sup>)  
IQUIX<sup>®</sup> drops  
OFLOXACIN drops (generic of Ocuflax<sup>®</sup>)  
QUIXIN<sup>®</sup> drops  
VIGAMOX<sup>®</sup> drops  
ZYMAR<sup>®</sup> drops

#### OPHTHALMIC AGENTS: ANTIBACTERIAL – NON-QUINOLONE

##### DRUGS UNDER CONSIDERATION

AZASITE<sup>®</sup> drops  
BACITRACIN ointment  
BACITRACIN-POLYMYXIN ointment (generic of Polysporin<sup>®</sup>)  
ERYTHROMYCIN ointment (generic of Ilotycin<sup>®</sup>)  
GENTAMICIN drops (generic of Garamycin<sup>®</sup>)  
GENTAMICIN ointment (generic of Garamycin<sup>®</sup>)  
NEOMYCIN/POLYMYXIN/BACITRACIN ointment (generic of Neosporin<sup>®</sup>)  
NEOMYCIN/POLYMYXIN/GRAMICIDIN drops (generic of Neosporin<sup>®</sup>)  
POLYMYXIN/TRIMETHOPRIM drops (generic of Polytrim<sup>®</sup>)  
TOBRAMYCIN drops (generic of Tobrex<sup>®</sup>)  
TOBREX<sup>®</sup> ointment

# DRAFT

For P&T Committee Discussion Only

## Ophthalmic NSAIDs

**LENGTH OF AUTHORIZATIONS:** for the date of service only; no refills for acute use. Refills for up to 14 days may be authorized for patients undergoing surgery.

Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug-to-drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval

### Document clinically compelling information

#### **ADDITIONAL INFORMATION**

The requested medication may be approved if both of the following are true:

- If there has been a therapeutic failure to no less than a three-day trial of at least one medication not requiring prior approval
- The requested medication's corresponding generic (if covered by the state) has been attempted and failed or is contraindicated.

### OPHTHALMIC NSAIDs

#### **DRUGS UNDER CONSIDERATION**

ACULAR LS<sup>®</sup>  
ACULAR PF<sup>®</sup>  
ACULAR<sup>®</sup>  
DICLOFENAC (generic of Voltaren<sup>®</sup>)  
FLURBIPROFEN (generic of Ocufen<sup>®</sup>)  
NEVANAC<sup>®</sup>  
XIBROM<sup>®</sup>

# DRAFT

For P&T Committee Discussion Only

## Pancreatic Enzymes

**LENGTH OF AUTHORIZATIONS:** 1 year

Is there any reason the patient cannot be changed to a medication not requiring prior approval?

Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug-to-drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval

**Document clinically compelling information**

### **ADDITIONAL INFORMATION**

The requested medication may be approved if the following is true:

- If there has been a therapeutic failure to no less than a one-month trial of at least two medications not requiring prior approval

### **PANCREATIC ENZYMES**

#### **DRUGS UNDER CONSIDERATION**

CREON<sup>®</sup>  
DYGASE<sup>®</sup>  
KUTRASE<sup>®</sup>  
KU-ZYME<sup>®</sup>  
KU-ZYME HP<sup>®</sup>  
LAPASE<sup>®</sup>  
LIPRAM<sup>®</sup>  
LIPRAM-CR<sup>®</sup>  
PALCAPS<sup>®</sup>  
PANCREASE MT<sup>®</sup>  
PANCRECARB-MS<sup>®</sup>  
PANCRELIPASE<sup>®</sup>  
PANGESTYME<sup>®</sup>  
PANGESTYME CN<sup>®</sup>  
PANGESTYME MT<sup>®</sup>  
PANGESTYME UL<sup>®</sup>  
PANOCAPS<sup>®</sup>  
PANOCAPS MT<sup>®</sup>  
PANOKASE<sup>®</sup>  
PLARETASE<sup>®</sup>  
ULTRACAPS MT<sup>®</sup>  
ULTRASE<sup>®</sup>  
ULTRASE MT<sup>®</sup>  
VIOKASE<sup>®</sup>

# DRAFT

For P&T Committee Discussion Only

## Parkinson's Agents

**LENGTH OF AUTHORIZATIONS:** 1 year

Is there any reason the patient cannot be changed to a medication not requiring prior approval?

Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug-to-drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval

**Document clinically compelling information**

### **ADDITIONAL INFORMATION**

The requested medication may be approved if both of the following are true:

- If there has been a therapeutic failure to no less than a one-month trial of at least one medication not requiring prior approval
- The requested medication's corresponding generic (if covered by the state) has been attempted and failed or is contraindicated.

#### **PARKINSON'S AGENTS – COMT Inhibitor**

##### **DRUGS UNDER CONSIDERATION**

COMTAN<sup>®</sup>  
TASMAR<sup>®</sup>

#### **PARKINSON'S AGENTS – Dopamine Receptor Agonists, Non-Ergot, Injectable**

##### **DRUGS UNDER CONSIDERATION**

APOKYN<sup>®</sup>

#### **PARKINSON'S AGENTS – Dopamine Receptor Agonists, Non-Ergot, Oral**

##### **DRUGS UNDER CONSIDERATION**

MIRAPEX<sup>®</sup>  
REQUIP<sup>®</sup>

#### **PARKINSON'S AGENTS – Dopaminergic Agents, Oral**

##### **DRUGS UNDER CONSIDERATION**

AZILECT<sup>®</sup>  
CARBIDOPA/LEVODOPA (generic of Sinemet<sup>®</sup>)  
PARCOPA<sup>®</sup>  
SELEGELINE (generic of Eldepryl<sup>®</sup>)  
STALEVO<sup>®</sup>  
ZELAPAR<sup>®</sup>

# DRAFT

For P&T Committee Discussion Only

## Post-Herpetic Neuralgia, Topical Agents

**LENGTH OF AUTHORIZATIONS:** 3 months

Is there any reason the patient cannot be changed to a medication not requiring prior approval?

Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug-to-drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval

**Document clinically compelling information**

### **ADDITIONAL INFORMATION**

The requested medication may be approved if the following is true:

- If there has been a therapeutic failure to no less than a one-month trial of at least two oral medications used for post-herpetic neuralgia.

### **POST-HERPETIC NEURALGIA, TOPICAL AGENTS**

#### **DRUGS UNDER CONSIDERATION**

LIDODERM®

# DRAFT

For P&T Committee Discussion Only

## Heparin-Related Preparations

**Proposed criteria for duration of therapy longer than 35 days per rolling 6 months**

Products in this class: Fragmin, Lovenox, Innohep, Arixtra

Low Molecular Weight Heparin (LMWH) (dalteparin, enoxaparin, tinzaparin) and fondaparinux are indicated for:

- deep vein thrombosis (DVT) prophylaxis following surgery,
- DVT or pulmonary embolism treatment (PE),
- prophylaxis of ischemic complications in unstable angina and non-Q-wave myocardial infarction (MI),
- ST-segment elevated MI (STEMI), and
- extended treatment of symptomatic venous thromboembolism (VTE) or DVT/PE to reduce the recurrence of VTE in patients with cancer.

In addition, there is an indication for medical patients who are at risk for thromboembolic complications due to severely restricted mobility during acute illness. Because these patients are likely to be hospitalized, this policy does not apply.

Guidelines from the American College of Chest Physicians<sup>1</sup> limit duration of therapy in the outpatient setting for most indications to less than five weeks. Patients should be transitioned to warfarin as soon as possible.

The guidelines give exceptions to the five week duration:

- pregnancy (LMWH/fondaparinux for the duration),
- DVT/PE with malignancy (LMWH/fondaparinux for 3-6 months), or
- patient unable to take warfarin.

The SmartPA automated prior authorization (PA) system will add the days supply for all prescriptions of heparin-related products for the previous 180 days. When 35 days is exceeded, the prescription will deny with a message indicating duration of therapy is limited to 5 weeks. The prescriber can request PA for longer duration.

PA will be approved for:

- patients with cancer (approved up to 6 months),
- pregnant women (approved up to 40 weeks), or
- patients unable to take warfarin (approved up to 6 months).

---

<sup>1</sup> Geerts et al, "Prevention of Venous Thromboembolism: The Seventh ACCP Conference on Antithrombotic and Thrombolytic Therapy; Chest 2004; 125;338-400.