Maryland Medicaid Pharmacy Program

Pharmacy News & Views

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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

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 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%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)

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

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 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

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

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
- Rybix 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/misoprostl (*Arthrotec*) (Brd & gen)
- mefenamic acid (*Ponstel*)
- tolmetin, tolmetin DS (*Tolectin, Tolectin DS*)
- Celebrex
- Duexis
- Flector
- Indocin Rectal, Indocin Suspension
- Mobic Suspension
- Pennsaid
- Sprix Nasal
- Vimovo
- Zipsor

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 (*Tinamiax*)
- Dificid
- 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

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.

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/permetrhin 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*)
- cephalexin (*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*)
- levofloxacn (*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

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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

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

CARDIOVASCULAR

Angiotensin Modulators (Hypotensives, Angiotensin Receptor Antagonist)

Preferred
- benazepril, benazepril HCTZ (*Lotensin, Lotensin HCT*)
- captopril, captopril HCTZ (*Capoten, Capozide*)
- enalapril, enalapril HCTZ (*Vasotec, Vaseretic*)
- 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

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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.dhmh.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 Zydis*)
- 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 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 7.5mg & 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*)
dexmethylphenidate (*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

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

ENDOCRINE

Hypoglycemics, Incretin Mimetics & Enhancers

Preferred

Byetta
Janumet
Januvia
Jentadueto
Kombiglyze XR
Onglyza
Symlin
Tradjenta

Requires Prior Authorization

Bydureon
Janumet XR
Juvisync
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

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/polymixin
ciprofloxacin solution (*Ciloxan*)
erythromycin
gentamicin (Garamycin)
neomycin/polymixin/gramicidin (*Neosporin*)
ofloxacin (*Ocuflox*)
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 (*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
Lotemax Ointment
Nevanac
Ozurdex
Pred Forte
Retisert
Triesence
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

Beta$_2$-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*)
- ipratopium 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 Steriods)

Preferred
- fluticasone nasal (*Flonase*)
- ipratropium (*Atrovent Nasal*)
- Astelin (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

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

Pharmacy News & Views

PRSTD STD
U.S. POSTAGE
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SOUTHERN, MD

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

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Email Newsletter

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www.marylandmedicaidpharmacyinformation.com

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 (*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