Wyoming
Department
of Health

Division of Healthcare Financing

Medicaid Pharmacy News

Dear Providers: December 19, 2011

NEW THERAPEUTIC CATEGORIES/PREFERRED DRUG LIST (PDL) CHANGES (Effective 01/01/2012)

Please refer to http://wyequalitycare.org/ for the complete PDL

THERAPEUTIC CATEGORY	PREFERRED MEDICATIONS/PDL CHANGES
ALLERGY/ASTHMA Leukotriene Modifiers	Singulair tablets, chewables, and granules
ALLERGY/ASTHMA Short-Acting Bronchodilators – nebulizers	albuterol nebulizer solution and Xopenex nebulizer solution ***levoalbuterol will be non-preferred**
ALZHEIMERS	donepezil, Exelon, galantamine/ER, Namenda, and rivastigmine capsules ***Brand Aricept and donepezil ODT will be non-preferred**
ANALGESICS Long-Acting	fentanyl patches and morphine sulfate *tablets* ***morphine sulfate *capsules* will be non-preferred**
ANDROGENS	Androgel ***Testim gel will no longer be preferred**
ANGIOTENSIN MODULATORS ARB Combinations	Exforge/Exforge-HCT ***Azor and Tribenzor will be non-preferred**
ANGIOTENSIN MODULATORS Alpha-Blockers	Brand Catapres patches and clonidine tablets ***clonidine patches and Nexiclon XR will be non-preferred**
ANTIBIOTICS Quinolones	ciprofloxacin/ER, levofloxacin, and ofloxacin ***Avelox, Factive, and Noroxin will no longer be preferred**
ANTIBIOTICS Doxycycline	doxycycline ***Adoxa, Doryx, and Oracea will be non-preferred**
ANTIBIOTICS Minocycline	minocycline ***Solodyn will be non-preferred**
ANTICOAGULANTS Low Molecular Weight Heparin (LMWH)	Brand Lovenox ***Fragmin will no longer be preferred**
ANTICOAGULANTS Oral Thrombin Inhibitors	Pradaxa **Note: Pradaxa will require a diagnosis of non-valvular atrial fibrillation and relative contraindication to warfarin for approval**
ANTIDEPRESSANTS	bupropion ER/SR/XL, citalopram, fluoxetine *capsules*, mirtazapine 15, 30, and 45mg, paroxetine IR/CR, sertraline, and venlafaxine ER *capsules* ***fluoxetine *tablets*, venlafaxine ER *tablets*, and Viibryd will be non-preferred** **Note: Trial and failure of two (2) preferred agents greater than or equal to six (6) weeks in the last 12 months will be required for approval of a non-preferred agent**
ANTIPSYCHOTICS Atypical Antipsychotics	Abilify/ODT, Geodon, Invega, Invega Sustenna, olanzapine, Risperdal Consta, risperidone, Seroquel, Zyprexa Relprevv **Note: Dosage limits apply**

THERAPEUTIC CATEGORY	PREFERRED MEDICATIONS/PDL CHANGES
CHOLESTEROL Statins, Low Potency	lovastatin, pravastatin ***Lescol/XL will no longer be preferred** **Note: Trial and failure of a preferred agent greater than or equal to a ninety (90) day supply in the last twelve (12) months will be required for approval of a non-preferred agent**
CHOLESTEROL Statins, High Potency	atorvastatin and simvastatin
CHOLESTEROL Statin Combinations	Caduet ***Simcor will no longer be preferred** **Note: Trial and failure of a preferred agent greater than or equal to a ninety (90) day supply in the last twelve (12) months will be required for approval of a non-preferred agent**
DIABETES Thiazolidinediones	Actos 15, 30, and 45mg
DIABETES Dipeptidyl Peptidase 4 (DPP-4) Inhibitors	Janumet, Januvia, Juvisync, Kombiglyze, Onglyza, and Tradjenta
DIABETES Intermediate-Acting Insulin	Humulin N, Humulin 70/30, Novolog N, Novolog 70/30
DIABETES Long-Acting Insulin	Lantus *vial* ***Lantus *Opticlik/Solostar* and Levemir will no longer be preferred**
EAR Antibiotic/Steroid Combination Suspensions	Cortisporin solution, ofloxacin and neomycin/polymyxin B sulfate/hydrocortisone suspension ***Cetraxal, Ciprodex, Cipro HC, Coly-mycin S, Cortisporin solution, Cortisporin-TC, dexamethasone sodium phosphate, and fluocinolone acetate oil 0.01% will be non-preferred**
GASTROINTESTINAL Proton Pump Inhibitors	Dexilant, Omeprazole *capsules*, and pantoprazole
GASTROINTESTINAL Mesalamine	mesalamine enema and Pentasa 250mg ***Apriso and Asacol/HD will no longer be preferred** **Note: Trial and failure of a preferred agent greater than or equal to a fourteen (14) day supply in the last twelve (12) months will be required for approval of a non-preferred agent**
HEPATITIS C Protease Inhibitor	Victrelis ***Incivek will be non-preferred**
MIGRAINE	STEP 1: naratriptan or sumatriptan STEP 2: Maxalt MLT **Note: Trial and failure of a step 1 triptan will be required for approval of the step 2 triptan, trial and failure of a step 1 triptan and the step 2 triptan will be required for approval of a non-preferred triptan**
OPTHALMICS Antibiotics – Quinolones	ciprofloxacin, ofloxacin, and Vigamox ***Zymar will no longer be preferred and Moxeza will be non-preferred** **Note: Trial and failure of a preferred agent greater than or equal to a five (5) day supply within the last 12 months will be required for approval of a non-preferred agent**

THERAPEUTIC CATEGORY	PREFERRED MEDICATIONS/PDL CHANGES
OPTHALMICS Mast Cell Stabilizers	STEP 1: Cromolyn STEP 2: Pataday or Patanol ***azelastine and ketotifen will no longer be preferred** **Note: Trial and failure of the step 1 agent greater than or equal to a thirty (30) day supply will be required for approval of a step 2 agent, trial and failure of both the step 1 agent and a step 2 agent, each greater than or equal to a thirty (30) day supply within the last twelve (12) months will be required for approval of a non-preferred agent**
OPTHALMICS Prostaglandins	lantanoprost and Travatan Z ***Lumigan will no longer be preferred** **Note: Trial and failure of ALL preferred agents, each greater than or equal to thirty (30) day supply within the last twelve (12) months will be required for approval of a non-preferred agent**
OPTHALMICS Sympathomimetics Combo	**Combigan will no longer be preferred** **Note: Use of the separate agents will be required**
OVERACTIVE BLADDER	oxybutynin/ER, Toviaz, and Vesicare ***trospium will no longer be preferred** **Note: Trial and failure of a preferred agent greater than or equal to a fourteen (14) day supply will be required within the last twelve (12) months for approval of a non-preferred agent**
PHOSPHATE BINDERS	calcium acetate, Eliphos, Phoslo, Phoslyra, and Renagel ***Fosrenol and Renvela will no longer be preferred**
PROSTATE 5-Alpha-Reductase Inhibitors	finasteride ***Avodart will no longer be preferred** **Note: Trial and failure of a preferred agent greater than or equal to a thirty (30) day supply in the last twelve (12) months will be required before approval of a non-preferred agent**
PROSTATE Alpha Blockers	doxazosin, tamsulosin, terazosin ***Rapaflo will be non-preferred** **Note: Trial and failure of a preferred agent greater than or equal to a thirty (30) day supply in the last twelve (12) months will be required before approval of a non-preferred agent**
PULMONARY ANTIHYPERTENSIVES 5-Alpha-Reductase Inhibitors	Adcirca and Revatio **Note: Preferred agents will require the diagnosis of pulmonary hypertension before approval**
PULMONARY ANTIHYPERTENSIVES Endothelin Receptor Antagonists	Letairis **Note: Letairis will require the diagnosis of pulmonary hypertension with documented right-heart catheterization validating the diagnosis** ***Tracleer will no longer be preferred**
RESTLESS LEG SYNDROME	Gabapentin ***Horizant will be non-preferred** **Note: Trial and failure of gabapentin greater than or equal to a sixty (60) day supply *and* trial and failure of a dopamine agonist greater than or equal to a sixty (60) day supply within the last twelve (12) months will be required for approval of a non-preferred agent**

THERAPEUTIC CATEGORY	PREFERRED MEDICATIONS/PDL CHANGES
SCABICIDES/PEDICULICIDES	permethrin and lindane ***Natroba and Ulesfia will be non-preferred** **Note: Trial and failure of a preferred agent within the last twelve (12) months will be required for approval of a non-preferred agent**
TOPICAL AGENTS Immunomodulators	Elidel and Protopic **Note: Trial and failure of both a medium potency and high potency topical corticosteroid, each greater than or equal to twenty-one (21) day supply within the last ninety (90) days will be required before approval**

COUGH AND COLD PREFERRED DRUG LIST (Effective 01/15/2012)

Wyoming Medicaid will continue to only cover **preferred** cough and cold products. To see a list of covered over-the-counter (OTC) cough and cold products, please refer to OTC Drug coverage at http://wyequalitycare.org. If a product description is not listed, it is considered non-preferred and will not be covered by Wyoming Medicaid.

CIALIS USE FOR BENIGN PROSTATIC HYPERPLASIA

A ninety (90) day trial and failure each, of ***ALL*** other medications for benign prostatic hyperplasia (BPH) will be required before Cialis will be approved to treat BPH. Wyoming Medicaid ***DOES NOT*** cover Cialis to treat erectile dysfunction (ED). Retroactive reviews will be completed on all Cialis claims to monitor use. Any claims that are found to be dispensed for the diagnosis of ED will result in recovery of claim payment and possibly further Program Integrity actions.

MISCELLANEOUS CHANGES (Effective 01/01/2012)

- Long-acting blood pressure medications will be limited to their labeled dosing frequency.
- Prior authorization will be required for use of less than 100mg of Seroquel **without** a diagnosis of mood disorder or major depressive disorder. For titration doses, please call the GHS pharmacy help desk for an override at 800-209-1264.
- Zytiga will only be approved for castration-resistant prostate cancer in those clients who have received prior chemotherapy containing docetaxel.
- Xarelto will only be approved for prophylaxis of deep vein thrombosis which can lead to pulmonary embolism in clients undergoing hip or knee replacement or for non-valvular atrial fibrillation.
- Brilinta will only be approved for reducing thrombotic cardiovascular events in clients with acute coronary syndrome.
- Botox will now be approved for the treatment of urinary incontinence due to detrusor overactivity associated with a neurologic condition (e.g., spinal cord injury, multiple sclerosis) in adults who have inadequate response to or are intolerant of an anticholinergic medication.
- Arcapta will be approved for clients over the age of forty (40) with a diagnosis of chronic obstructive pulmonary disease (COPD).
- Gralise will require a sixty (60) day trial and ***documented response*** to immediate release gabapentin with a credible reason for the need of the once daily formulation. The dose will be limited to 1800mg per day.

ORAL CONTRACEPTIVE PREFERRED DRUG LIST (Effective 01/01/2012)

PREFERRED ORAL CONTRACEPTIVES	NON-PREFERRED ORAL CONTRACEPTIVES
altavera	amethia (BRAND IS PREFERRED)
apri	amethyst (BRAND IS PREFERRED)
aviane	aranelle (BRAND IS PREFERRED)
azurette	BEYAZ (PA required)
balzia	camila (use preferred)
BREVICON*	camrese (BRAND IS PREFERRED)
briellyn	caziant (use preferred)
cryselle	cesia (use preferred)
emoquette	cyclafem (BRAND IS PREFERRED)
enpresse	FEMCON FE (PA required)
errin	GENERESS FE CHW (PA required)
ESTROSTEP FE*	gianvi (BRAND IS PREFERRED)
gildess FE	heather (use preferred)
jolessa	introvale (use preferred)
jolivette	leena (BRAND IS PREFERRED)
junel/junel FE	LO LOESTRIN (PA required)
kariva	loryna (BRAND IS PREFERRED)
kelnor	NATAZIA (PA required)
lessina	necon 0.5/35, 1/35, 7/7/7 (BRAND IS PREFERRED)
LOESTRIN 24 FE	NECON 1/50 (use preferred)
LOSEASONIQUE	norethindrone/ethyinyl estradiol chew (PA required)
low-ogestrel	norethindrone (use preferred)
lutera	NORINYL 1/35 (use preferred)
LYBREL	nortrel (BRAND IS PREFERRED)
microgestin	ocella (BRAND IS PREFERRED)
mononessa	ORTHO-NOVUM 1/50 (use preferred)
NECON 10/11-28	quasense (use preferred)
nora-be	SAFYRAL (PA required)
norgestrel/ethinyl estradiol	syeda (BRAND IS PREFERRED)
NORINYL 1/50-28	tilia FE (BRAND IS PREFERRED)
OGESTREL	tri-legest FE (BRAND IS PREFERRED)
orsythia	tri-lo-sprintec (BRAND IS PREFERRED)
ORTHO TRI-CYCLEN LO*	zarah (BRAND IS PREFERRED)
ORTHO-NOVUM 1/35-28, 7/7/7-28*	zenchent FE chewable (PA required)
OVCON 50	zeosa chewable (PA required)
portia	
previfem	
reclipsen	
seasonale	
SEASONIQUE*	
solia	
sprintec	
sronyx	
trinessa	
TRI-NORINYL*	
tri-previfem	
trivora	
velivet	
YASMIN*	
YAZ*	
zenchent	
ZOVIA	