Washington State Health Care Authority

Recommended changes to limitations to drugs on the PDL

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Washington State Health Care Authority

Attention Deficit Hyperactivity Disorder (ADHD) Amphetamine Products

Ingredient	Label Name	Generic Available	PDL Status as of 8/17/2016
Amphetamine	Adzenys XR-ODT™ Dyanavel® XR	No	Not reviewed Not reviewed
Amphetamine Sulfate	Evekeo®	No	Not reviewed
Amphetamine Salt Combination	Adderall® Adderall XR®	Yes	Generic preferred Generic preferred
Dextroamphetamine	Dexedrine® Dexedrine Spansule® ProCentra® Zenzedi®	Yes	Generic preferred Generic preferred Not reviewed Not reviewed
Lisdexamfetamine	Vyvanse®	No	Preferred

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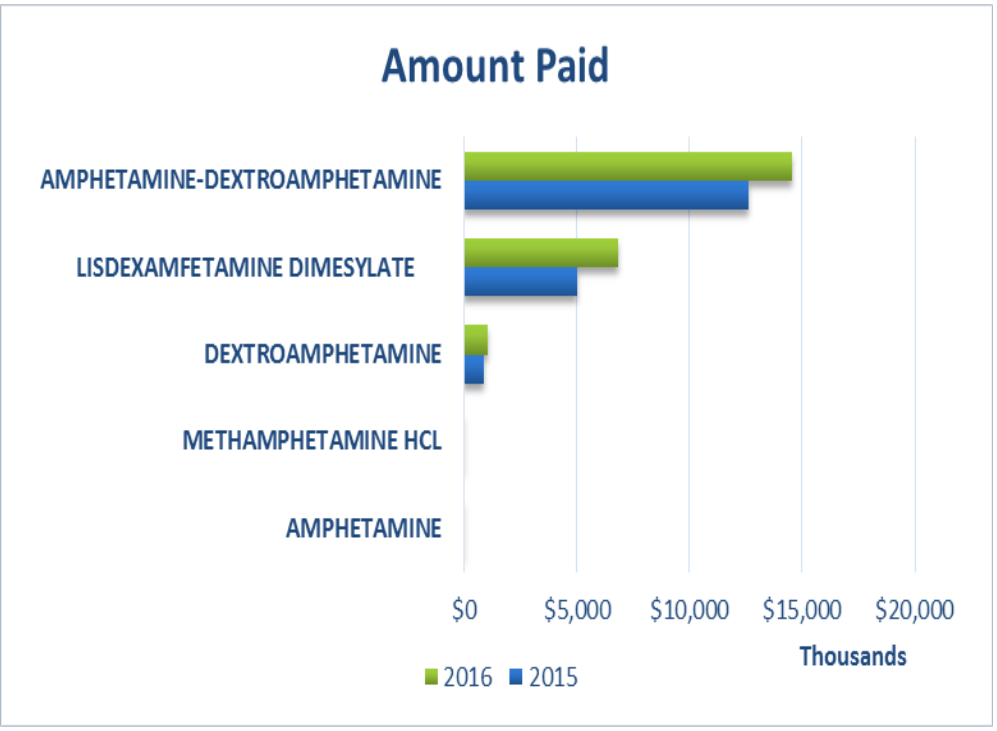
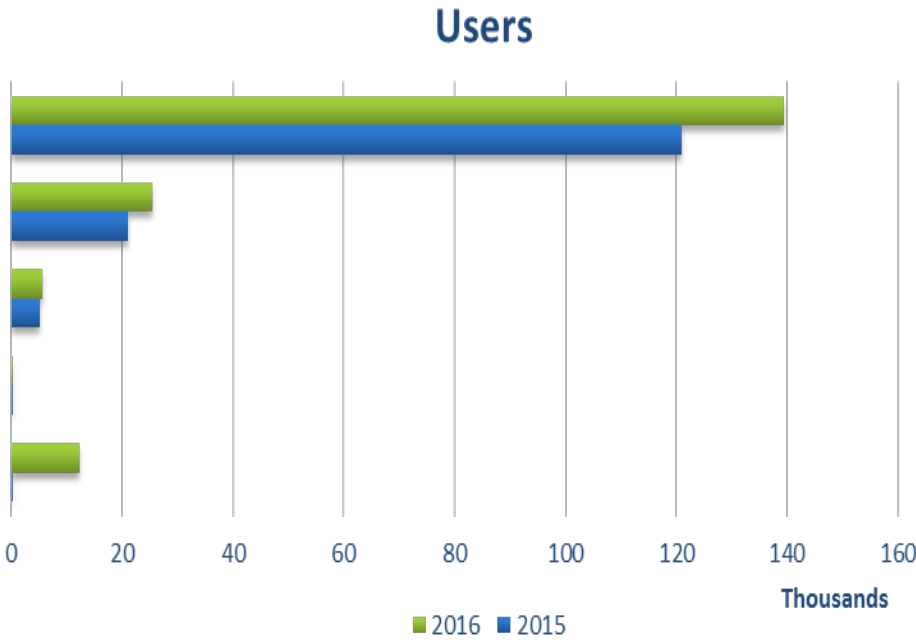
Amphetamines Utilization

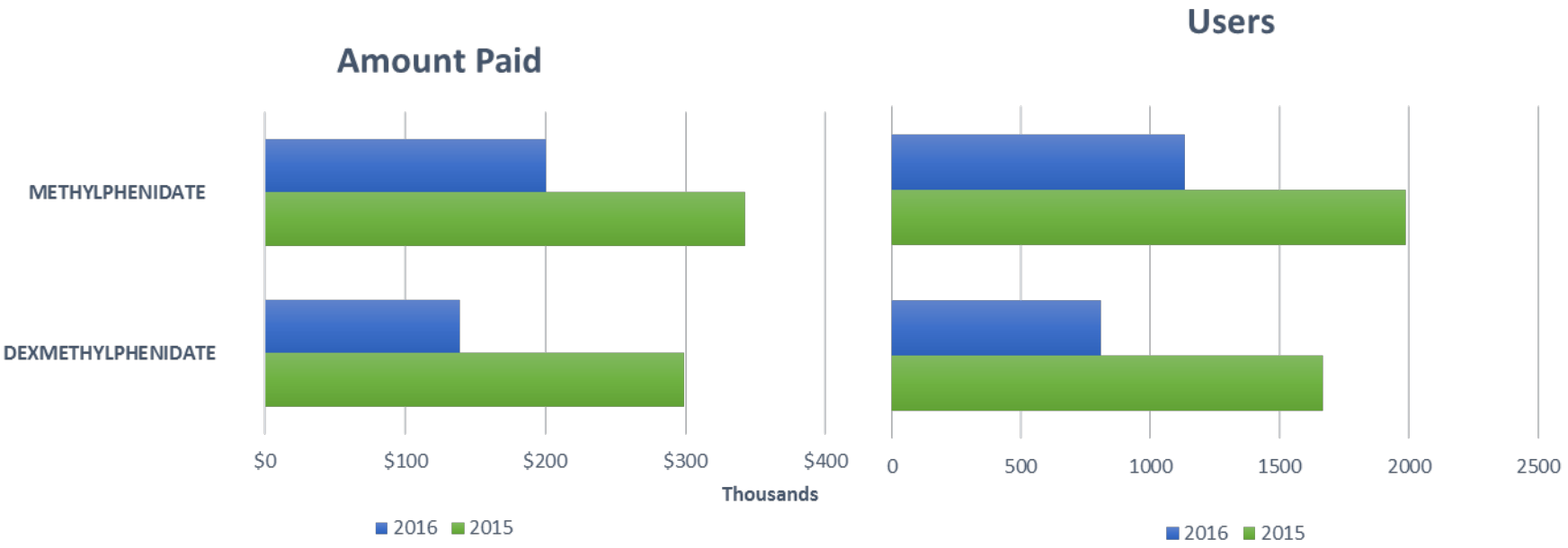




Attention Deficit Hyperactivity Disorder (ADHD) Methylphenidate Products

Ingredient	Label Name	Generic Available	PDL Status as of 8/17/2016
Dexmethylphenidate	Focalin® Focalin XR®	Yes	Generic preferred Generic preferred
Methylphenidate	Daytrana™	No	Non-preferred
Methylphenidate Sulfate	Aptensio XR® Concerta® Metadate CD® Metadate ER® Methylin® QuilliChew ER™ Quillivant™ XR Ritalin® Ritalin LA® Ritalin-SR®	Yes	Not reviewed Generic preferred Generic preferred Generic preferred Generic preferred Not reviewed Generic preferred Generic preferred Generic preferred Generic preferred

Methylphenidates Utilization



Attention Deficit Hyperactivity Disorder (ADHD) Nonstimulant Products

Ingredient	Label Name	Generic Available	PDL Status as of 8/17/2016
Atomoxetine	Strattera®	No	Preferred
Clonidine	Catapres® Kapvay®	Yes	Non-preferred Non-preferred
Guanfacine	Tenex™ Intuniv™	Yes	Generic preferred Generic preferred

Nonstimulants Utilization

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ADHD Criteria

Maximum daily dose by age established according to the recommendations of the Pediatric Mental Health Workgroup and approved by the DUR Board

Age				
Drug	0–4 years	5–8 years	9–11 years	12–17 years
Amphetamine	PA required	35 mg	45 mg	60 mg
Lisdexamfetamine	PA required	60 mg	75 mg	100 mg
Dexmethylphenidate	PA required	35 mg	45 mg	60 mg
Methylphenidate	PA required	70 mg	90 mg	120 mg
Methylphenidate Patch	PA required	35 mg	45 mg	60 mg
Atomoxetine	PA required	120 mg	120 mg	120 mg

ADHD Criteria

- Alpha Agonist dose established for either individual alpha agonist, or total dosage used in combination.
- Clonidine equivalent dose is:

0.1 mg clonidine = 1 mg guanfacine

Age	Combined Dose Equivalents
0–3 years	PA required
4–5 years	2
6–8 years	3
9–17 years	4

ADHD Duplication

PA required for combinations of ADHD medication across subtype, except where FDA indicated for use together

Combinations of medications in two or more ADHD categories

	Methylphenidate/ Dexmethylphenidate	Amphetamines/ Lisdexamfetamine	Strattera®	Alpha-agonists
Methylphenidate/ Dexmethylphenidate		X	X	
Amphetamines/ Lisdexamfetamine	X		X	
Strattera®	X	X		X
Alpha-agonists			X	

ADHD Adult Diagnosis

Diagnosis restrictions are a cross-section of uses legal in Washington and uses that can be considered ‘medically accepted indications’.

- Limited to ADHD by expedited authorization
- PA request must be submitted for all other diagnoses
- No off-label uses currently supported in the compendia

Uniform Controlled Substance Act (RCW 69.50.402 Prohibited Acts: B)

- It is unlawful for a practitioner, to prescribe, order, dispense, administer, supply, or give to any person a schedule II amphetamine or schedule II nonnarcotic stimulant except for the treatment of the following:
- Narcolepsy
- Hyperkinesis
- Drug-induced brain dysfunction
- Epilepsy
- Differential diagnostic psychiatric evaluation of depression
- Refractory depression
- Multiple sclerosis

ADHD Criteria

Current Limitations

- Generics first
- Age and dose limits
- Prior authorization required for use of 2 or more agents from different subclasses
- Adult diagnosis limitations
- Must step through all preferred drugs with same indication before a non-preferred drugs will be authorized

Recommendation:

- Continue all current limitations

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Stakeholder Comments?

Motion: "I move the Medicaid Fee-For Service Program implement the limitations for the Attention Deficit Hyperactivity Drug class listed on slide 13 as recommended."

Motion: Schwilke
2nd: Flatebo
Vote: Passed

Antiemetic Drug Products

Ingredient	Label Name	Generic Available	Current PDL Status as of 8/17/2016
Aprepitant	Emend®	No	Excluded from class by P&T 10/16/2013
Dolasetron	Anzemet®	No	Non-preferred (chemotherapy only)
Doxylamine/Pyridoxine HCl	Diclegis®	No	Not reviewed
Fosaprepitant	Emend® (injection)	No	Excluded from class by P&T 10/16/2013
Granisetron	Granisetron	Yes	Generic preferred
	Sancuso® Sustol®	No	Not reviewed Not reviewed
Netupitant/Palonsetron	Akynzeo®	No	Not reviewed
Ondansetron	Zofran®	Yes	Generic preferred
	Zofran ODT®	Yes	Generic preferred
	Zuplenz®	No	Not reviewed
Palonosetron	Aloxi®	No	Non-preferred
Rolapitant	Varubi®	No	Not reviewed

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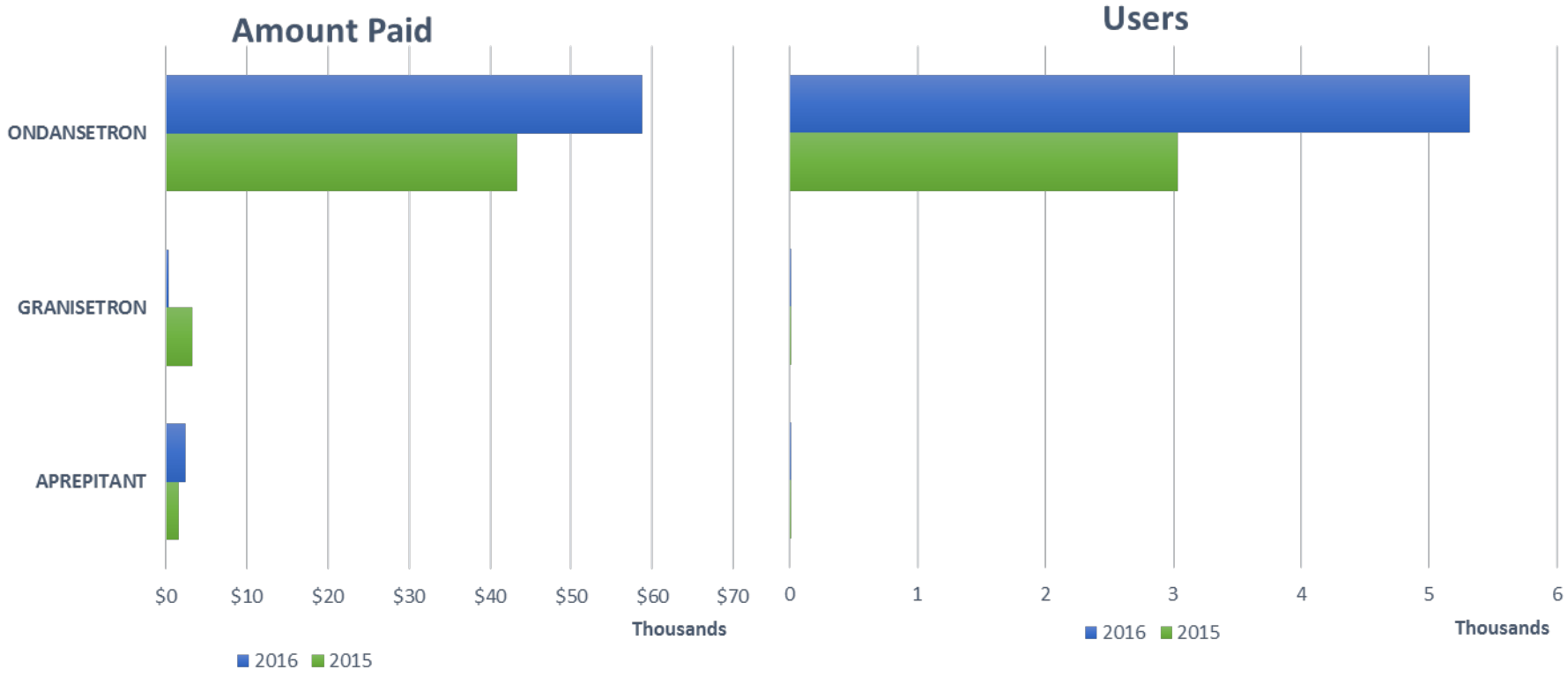
Antiemetics Utilization



Antiemetic Drug Criteria

Current Limitations

- Ondansetron
  - Dose limit of 24mg/day
- EA required for oral solution formulations for the inability to swallow oral tablets or capsules for clients age 18 and older.
- Must step through all preferred drugs with same indication before a non-preferred drug will be authorized

Recommendation:

- Continue all current limitations except:
- Must step through all preferred drugs with same mechanism of action and indication before a non-preferred drug will be authorized
- EA for doxyalamine/pyridoxine for use in pregnancy

Stakeholder Comments?

Motion: "I move the Medicaid Fee-For Service Program implement the limitations for the Antiemetic drug class listed on slide 17 as amended to include

Continue all current limitations except:

Must step through all preferred drugs with same mechanism of action and indication before a non-preferred drug will be authorized
EA for doxyalamine/pyridoxine for use in pregnancy N/V
"

Motion: Flatebo
2nd: Brown
Vote: Yes

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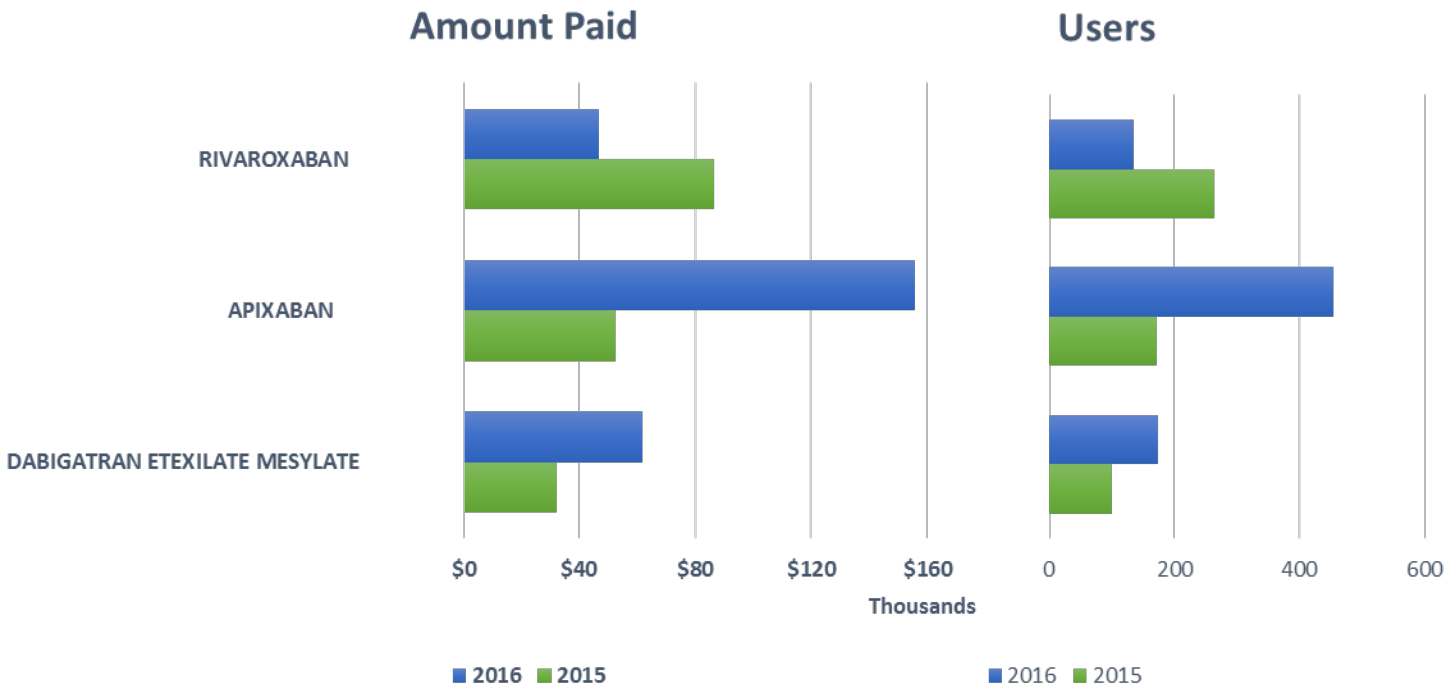
Anticoagulant Drug Products

Ingredient	Label Name	Generic Available	PDL Status as of 6/15/2016
Apixaban	Eliquis®	No	Preferred
Dabigatrin	Pradaxa®	No	Preferred
Edoxaban	Savaysa®	No	Non-preferred
Rivaroxaban	Xarelto®	No	Non-preferred

Anticoagulants Utilization



Anticoagulant Drug

Current Limitations

- Must try all preferred drugs with same indication before a non-preferred drug will be authorized unless not clinically appropriate or contraindicated
- No TIP (2016 P&T motion)

Recommendation:

- Continue all current limitations except:
- TIP will apply to apixaban, edoxaban, and rivaroxaban

Stakeholder Comments?

Motion: "I move the Medicaid Fee-For Service Program implement the limitations for the Anticoagulant drug class listed on slide 21 as amended to include…

Continue all current limitations except:

TIP will apply to apixaban, edoxaban, and rivaroxaban"

Motion: Schwilke
2nd: Lee
Vote: Passed

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Multiple Sclerosis Drug Products

Ingredient	Label Name	Generic Available	PDL Status as of 6/15/2016
Alemtuzumab	Lemtrada®	No	Non-preferred
Daclizumab Hyp	Zinbryta™	No	Non-preferred
Dimethyl Fumarate	Tecfidera®	No	Preferred
Fingolimod	Gilenya®	No	Preferred
Glatiramer Acetate	Copaxone® 20 mg	No	Non-preferred
	Copaxone® 40 mg	No	Preferred
	Glatopa®	No	Preferred
Interferon beta-1a IM	Avonex®	No	Preferred
Interferon beta-1a SC	Rebif®	No	Non-preferred
Interferon beta-1b	Betaseron®	No	Preferred
	Extavia®	No	Non-preferred
Mitoxantone	mitoxantone	Yes	Non-preferred
Natalizumab	Tysabri®	No	Non-preferred (PA required)
Ocrelizumab	Ocrevus™	No	Non-preferred
Peginterferon beta-1a	Plegridy®	No	Non-preferred
Teriflunomide	Aubagio®	No	Non-preferred

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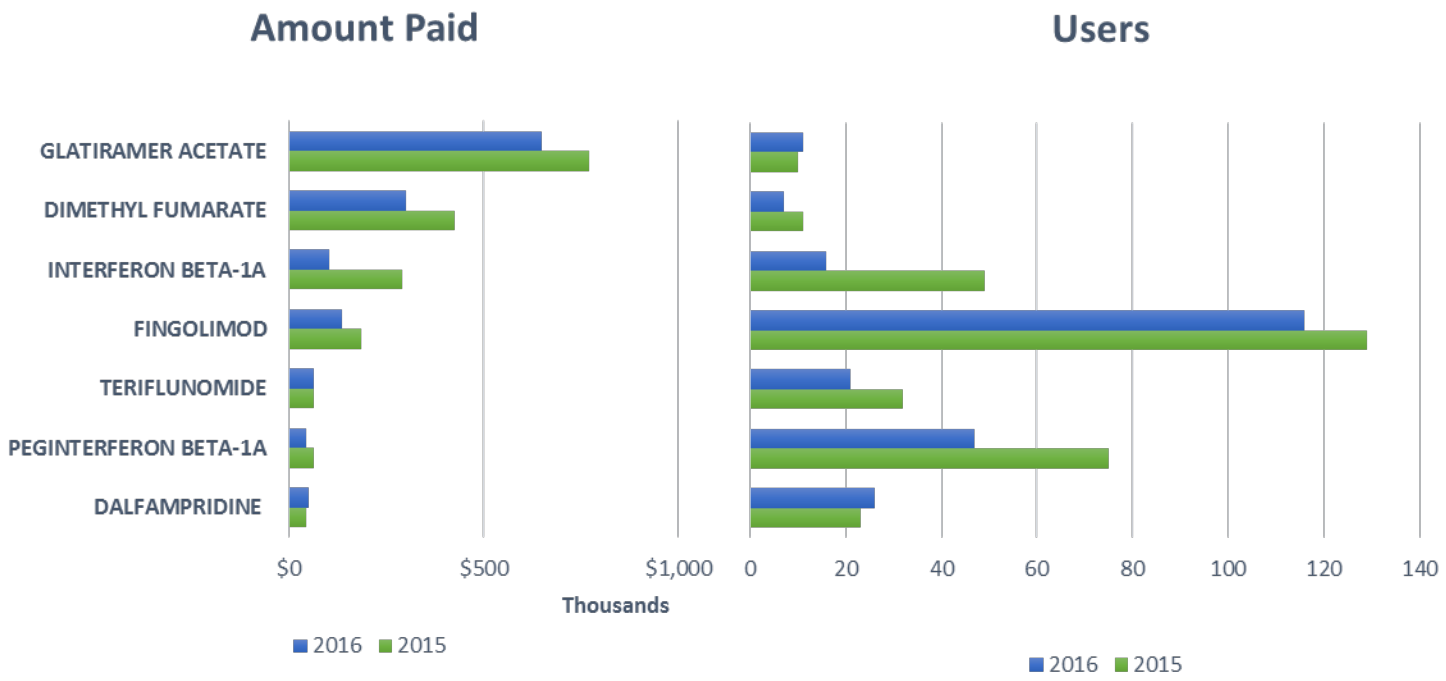
Multiple Sclerosis Agents Utilization



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Multiple Sclerosis Drug

Tysabri® Criteria

- Prescriber and client must be enrolled with the TOUCH® Prescribing Program
- Prescribed by neurologist (or ARNP or PA working with a neurologist)
- Must have relapsing remitting multiple sclerosis
- MRI prior to starting treatment
- Must have tried and failed other MS treatments
- Must not be immunocompromised
- Must be used as monotherapy treatment
- Dose limit 300mg every 4 weeks

Multiple Sclerosis Drug

Current Limitations

- Continuation of therapy of non-preferred product allowed with exception of the following
  - Rebif® (interferon beta-1a SC)
  - Extavia® (interferon beta-1b)
- No TIP (2016 P&T motion)
- PA required for Tysabri® (natalizumab)
- Must step through a preferred drug of each active ingredient with the same indication before a non-preferred drug will be authorized

Recommendation:

- Continue all current limitations

Stakeholder Comments?

Motion: "I move the Medicaid Fee-For Service Program return to the next DUR board meeting with information regarding: a review of the Tysabri REMS program and PA criteria and a review of ocrelizumab for coverage considerations."

Motion: Storhaug

2nd: Flatebo

Vote: Passed