



Recommended changes to limitations to drugs on the PDL

Donna Sullivan, PharmD, MS
Chief Pharmacy Officer
Health Care Services
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Targeted Immune Modulator Products

Ingredient	Label Name	Generic Available	PDL Status
Abatacept	Orencia®	No	Non-Preferred
Adalimumab	Humira®	No	Preferred
Anakinra	Kineret®	No	Non-Preferred
Apremilast	Otezla®	No	Not Reviewed
Canakinumab	Ilaris®	No	Not Reviewed
Certolizumab	Cimzia®	No	Non-Preferred
Etanercept	Enbrel®	No	Preferred
Golimumab	Simponi®	No	Non-Preferred
Infliximab	Remicade®	No	Non-Preferred
Ixekizumab	Taltz®	No	Not Reviewed
Rituximab	Rituxan®	No	Non-Preferred
Secukinumab	Cosentyx®	No	Not Reviewed
Tocilizumab	Actemra®	No	Non-Preferred
Tofacitinib	Xeljanz®	No	Non-Preferred
	Xeljanz XR®	No	Not Reviewed
Ustekinumab	Stelara®	No	Non-Preferred
Vedolizumab	Entyvio®	No	Not Reviewed

Targeted Immune Modulator Class

- **Current Limitations**

- No TIP (2015 motion)
- Limited to FDA approved and compendia supported indications, including diagnosis, dose, dosing schedule, and use of other first line agents
- PA required for Tysabri® (natalizumab)
- EA allowed when used according to labeling and prescribed by a specialist appropriate to the patient's diagnosis
- Applied through a combination of EA and PA

- **Recommendation:**

- Remove EA/PA criteria on all TIMS products
- Grandfather current users of non-preferred drugs
- Must step through all preferred drugs with same indication before a non-preferred drug will be authorized



Stakeholder Comments?

Motion: "I move the Medicaid Fee-For Service Program implement the limitations for the Targeted Immune Modulator drug class listed on slide 3".

Antiemetic Drug Products

Ingredient	Label Name	Generic Available	PDL Status
Aprepitant	Emend®	No	P&T excluded from class 10/16/2013
Dolasetron	Anzemet®	No	Non-Preferred
Doxylamine/pyridoxine	Diclegis®	No	Not Reviewed
Fosaprepitant	Emend® for injection	No	P&T excluded from class P&T 10/16/2013
Granisetron	Sancuso®	Yes	Generic Preferred Sancuso = Not Reviewed
Ondansetron	Zofran®, Zuplenz®	Yes	Generics Preferred Zuplenz = Not Reviewed
Netupitant/palonosetron	Akynzeo®		Not Reviewed
Palonosetron	Aloxi®	No	Non-Preferred
Rolapitant	Varubi™	No	Not Reviewed

Antiemetic Drug Criteria

- **Current Limitations**

- Ondansetron
 - Dose limit of 24 mg/day
 - Ondansetron ODT and solution expedited authorization required for age 18 and older
 - EA 071: Inability to swallow oral tablets or capsules for clients age 18 and older. Max dose 24 mg/day

- **Recommendation:**

- Remove EA for ondansetron ODT, maintain EA on ondansetron solution for clients age 18 and older
- Add EA to other antiemetic oral solutions. For clients age 18 and older.
- Must step through all preferred drugs with same indication before a non-preferred drug will be authorized



Stakeholder Comments?

Motion: "I move the Medicaid Fee-For Service Program implement the limitations for the Antiemetic drug class listed on slide 6".



ADHD Products

Ingredient	Label Name	Generic Available	PDL Status
Amphetamine	Adzenys XR-ODT™, Dyanavel™ XR	No	Not Reviewed
Amphetamine Sulfate	Evekeo®	No	Not Reviewed
Amphetamine Salt Combination	Adderall®, Adderall XR®	Yes	Generic Preferred
Atomoxetine	Strattera®	No	Preferred
Clonidine ER	Kapvay®	Yes	Non-Preferred
Dexmethylphenidate	Focalin®, Focalin XR®	Yes	Generic Preferred
Dextroamphetamine	Dexedrine®, Dexedrine Spansule® ProCentra®, Zenzedi®	Yes	Generic Preferred
Guanfacine ER	Intuniv®	Yes	Generic Preferred
Lisdexamfetamine	Vyvanse®	No	Preferred
Methylphenidate	Daytrana®	No	Non-Preferred
Methylphenidate Sulfate	Aptensio XR®, Concerta®, Metadate CD®, Metadate ER®, Quillivant™ XR, Ritalin®, Ritalin LA®, Ritalin-SR®, QuilliChew ER™	Yes	Generic Preferred Aptensio XR & Quillichew=Not Reviewed

ADHD Criteria

- **Current Limitations**
 - Age and dose limits
 - Prior authorization for use of 2 or more agents from different subclasses
 - Generics First
 - Adult diagnosis limitations

ADHD Criteria

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

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

ADHD Criteria

- Alpha Agonist dose established for either individual alpha agonist, or total dosage used in combination.
- 1 equivalent = 0.1 mg clonidine = 1 mg guanfacine

Age	Combined Dose Equivalents
0-3	PA
4-5	2
6-8	3
9-17	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	Amphetamine/ Lisdexamfetamine	Strattera®	Alpha-agonists
Methylphenidate/ Dexmethylphenidate		X	X	
Amphetamine/ 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
 - Hyperkinesia
 - Drug-induced brain dysfunction
 - Epilepsy
 - Differential diagnostic psychiatric evaluation of depression
 - Refractory depression
 - Multiple sclerosis



ADHD Recommendation

- **Recommendation:**
 - Continue current limitations as described in slides 10-13 .
 - Must step through all preferred drugs with same indication before a non-preferred drug will be authorized.

Stakeholder Comments?

Motion: "I move the Medicaid Fee-For Service Program implement the limitations for the Attention Deficit Hyperactivity Drug class listed on slide 14".



Multiple Sclerosis Drug Products

Ingredient	Label Name	Generic Available	PDL Status
Alemtuzumab	Lemtrada®	No	Not Reviewed
Daclizumab Hyp	Zinbryta™	No	Not Reviewed
Dimethyl Fumarate	Tecfidera®	No	Preferred
Fingolimod	Gilenya®	No	Preferred
Glatiramer Acetate	Copaxone®	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
Peginterferon beta-1a	Plegridy®	No	Not Reviewed
Teriflunomide	Aubagio®	No	Non-Preferred

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
- PA required for Tysabri® (natalizumab)

- **Recommendation:**

- Continue with no TIP
- Must step through a preferred drug of each active ingredient with the same indication before a non-preferred drug will be authorized.



Tysabri®

- Prescriber and client enrolled with the TOUCH® Prescribing Program
- Must not be immunocompromised
- Dose limit 300 mg every 4 weeks
- For relapsing forms of multiple sclerosis
 - Prescribed by neurologist (or ARNP or PA working with a neurologist)
 - MRI prior to starting treatment
 - Must have tried and failed other MS treatments
 - Must be used as monotherapy treatment
- For moderate to severely active Crohn's disease
 - Prescribed by gastroenterology specialist
 - Must have tried and failed other CD treatments
 - Must not be taking other immunosuppressants or TNF inhibitors
 - Must have experienced therapeutic benefit after 3 months of starting therapy
 - Must have discontinued concomitant corticosteroids within 6 months of starting therapy



Stakeholder Comments?

- Motion: “I move the Medicaid Fee-For Service Program implement the limitations for the multiple sclerosis drug class listed on slide 18”.

