

Washington State Health Care Authority

Recommended changes to limitations to drugs on the PDL

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Antiplatelet Drug Products

Ingredient	Label Name	Generic Available	PDL Status
Aspirin-dipyridamole	Aggrenox [®]	Yes	Non-Preferred
Clopidogrel	Plavix [®]	Yes	Generics Preferred
Prasugrel	Effient [®]	No	Non-Preferred
Ticagrelor	Brilinta [®]	No	Not Reviewed
Ticlopidine	<i>Ticlopidine</i>	Yes	P&T Excluded from class
Vorapaxar	Zontivity [®]	No	Not Reviewed

Antiplatelet Drug

- **Current Limitations**
 - No TIP (2013 Motion)
 - Dose limit: 300mg clopidogrel for loading dose, not for chronic use
- **Recommendations:**
 - Continue dose limit on clopidogrel; **AND**
 - Must step through all Preferred brands at the highest tolerated labeled dose for one month each before a Non-Preferred brand is authorized, unless signed DAW by an Endorsing Practitioner

Stakeholder Comments?

Motion: "I move the Medicaid Fee-For Service Program implement the limitations for the Antiplatelet drug class listed on slide 3 as recommended/amended to include..."

Overactive Bladder Products

Ingredient	Label Name	Generic Available	PDL Status
Darifenacin	Enablex [®]	No	Non-Preferred
Fesoterodine	Toviaz [®]	No	Non-Preferred
Flavoxate	<u>Flavoxate</u>	Yes	Non-Preferred
Mirabegron	Myrbetriq [®]	No	Non-Preferred
Oxybutynin	Oxytrol	No	Non-Preferred
	<u>Ditropan</u>	Yes	Generics Preferred
	Ditropan XL [®]	Yes	Generics Preferred
	Gelnique [®]	No	Non-Preferred
Solifenacin	Vesicare [®]	No	Non-Preferred
Tolterodine	<u>Detrol[®]</u>	Yes	Generics Preferred
	Detrol LA [®]	Yes	Generics Preferred
Trospium	<u>Sanctura[®]</u>	Yes	Generics Preferred
	Sanctura XR [®]	Yes	Generics Preferred

Underlined products are short acting

Overactive Bladder

- **Current Limitations**

- Long & Short Acting, must try and fail one Preferred long-acting or one Preferred short-acting drug, respectively, before a Non-Preferred drug is authorized, unless signed DAW by Endorsing Practitioner.

- **Recommendation:** Implement Generics First According to formulation prescribed

- Must step through one Preferred generic product for one month before a Preferred brand or Non-Preferred generic is authorized. DAW by an Endorsing Practitioner shall not override this requirement without authorization; **And**
- Must step through all Preferred generics at the highest tolerated labeled dose for one month each before a Preferred brand or Non-Preferred generic is authorized, unless signed DAW by an Endorsing Practitioner; **AND**
- Must step through all Preferred brands at the highest tolerated labeled dose for one month each before a Non-Preferred drug is authorized, unless signed DAW by an Endorsing Practitioner.

Stakeholder Comments?

Motion: "I move the Medicaid Fee-For Service Program implement the limitations for the Overactive Bladder drug class listed on slide 6 as recommended/amended to include..."

Statin Products

Ingredient	Label Name	Generic Available	PDL Status
Atorvastatin	Lipitor®	Yes	Generics Preferred
Fluvastatin	Lescol®	Yes	Generics Preferred
Fluvastatin ER	Lescol XL®	Yes	Non-Preferred
Lovastatin ER	Altoprev®	No	Non-Preferred
Lovastatin	Mevacor®	Yes	Generics Preferred
Pitavastatin	Livalo®	No	Non-Preferred
Pravastatin	Pravachol®	Yes	Generics Preferred
Rosuvastatin	Crestor®	No	Non-Preferred
Simvastatin	Zocor®	Yes	Generics Preferred

Statins

- Current Limitations:
 - Generics First – must try one Preferred generic before any brand is authorized.
 - rosuvastatin requires trial of highest tolerated dose of atorvastatin.
 - Dose Limitations
 - Simvastatin limited to 40mg per day unless taking a dose > 40mg for 1 year
 - Rosuvastatin 40mg per day
- Recommendation:
 - Implement dose limits on rosuvastatin, and simvastatin as stated above
 - Continue Generics First. Must step through one Preferred generic for one month before a Non-Preferred brand or generic is authorized. DAW by an Endorsing Practitioner shall not override this requirement without authorization; **AND**
 - Must step through atorvastatin at the highest tolerated labeled dose for one month before a Non-Preferred brand or generic is authorized, unless signed DAW by an Endorsing Practitioner.

Stakeholder Comments?

Motion: "I move the Medicaid Fee-For Service Program implement the limitations for the Statin drug class listed on slide 9 as recommended/amended to include..."

Antidepressant Products

Ingredient	Label Name	Generic Available	PDL Status
Bupropion	Aplenzin [®] , Forfivo XL [®] , Wellbutrin [®] /SR/XL	Yes	Generics Preferred
Citalopram	Celexa [®]	Yes	Generics Preferred
Desvenlafaxine ER	Desvenlafaxine, Pristiq [®] /Khedezla [®]	Yes	Non-Preferred
Duloxetine	Cymbalta [®]	Yes	Non-Preferred
Escitalopram	Lexapro [®]	Yes	Generics Preferred
Fluoxetine	Prozac [®] /weekly	Yes	Generics Preferred
Fluvoxamine	Fluvoxamine,	Yes	Generics Preferred
Fluvoxamine CR	Luvox CR [®]	Yes	Non-Preferred
Levomilnacipran	Fetzima [®]	No	Not Reviewed
Mirtazapine	Remeron [®] /Solutab	Yes	Generics Preferred
Nefazodone	Nefazodone	Yes	Non-Preferred
Paroxetine	Brisdelle [®] , Paxil [®] /CR, Pexeva [®]	Yes	Generics Preferred
Sertraline	Zoloft [®]	Yes	Generics Preferred
Venlafaxine	Effexor [®] /XR	Yes	Generics Preferred
Vilazodone	Viibryd [®]	No	Non-Preferred
Vortioxetine	Brintellix [®]	No	Not Reviewed

Products in grey font have not been reviewed by DERP

Second Generation Antidepressants

- **Current Limitations**
 - Generics first applies- must step through one Preferred generic before any brand will be authorized.
 - Continuation of therapy required
 - Non-Preferred must try and fail 2 Preferred products
 - Dose Limits: Citalopram – 40mg daily, Duloxetine – 60mg daily
 - Expedited Authorizations
 - Duloxetine: diabetic peripheral neuropathy, fibromyalgia, chronic musculoskeletal pain
 - Bupropion – EA code confirming use is **NOT** for smoking cessation
- **Recommendation: No Changes**

Stakeholder Comments?

Motion: "I move the Medicaid Fee-For Service Program implement the limitations for the Antidepressant drug class listed on slide 12 as recommended/amended to include..."

Estrogen Products

Ingredient	Label Name	Generic Available	PDL Status
Conjugated Estrogens (Oral)	Cenestin [®] , Duavee [®] , Enjuvia, [®] Premarin [®]	No	Non-Preferred
Conjugated Estrogens (Vaginal)	Premarin [®]	No	Non-Preferred
Conjugated Estrogens-medroxy progesterone (Oral)	Premphase [®] , PremPro [®]	No	Non-Preferred
Esterified estrogens (Oral)	Menest [®]	No	Non-Preferred
Estradiol (Oral)	Estrace [®] , Femtrace [®]	Yes	Generics Preferred
Estradiol (Vaginal)	Estrace [®] , Estring [®] , FemRing [®] , Vagifem [®]	No	Preferred - Estring [®]
Estradiol (Transdermal)	Alora [®] , Climara [®] , Divigel [®] , Elestrin [®] , Estrogel [®] , Evamist, [®] Mentostar, [®] Minivelle [®] , Vivelle-DOT [®]	Yes	Non-Preferred
Estradiol- Drospirenone (Oral)	Angeliq [®]	No	Non-Preferred
Estradiol-Norethindrone (Oral)	Activella [®]	Yes	Generics Preferred
Estradiol – Norethindrone (Transdermal)	Combipatch [®] , Climara Pro [®]	No	Non-Preferred
Estradiol – Norgestimate (Oral)	PreFest [®]	No	Non-Preferred
Estropipate (Oral)	Ortho-Est [®]	Yes	Generics Preferred
Ethinyl Estradiol – Norethindrone (Oral)	FemHRT [®]	Yes	Generics Preferred

Products in grey font have not been reviewed by DERP

Estrogen Products

- **Current Limitations**

- Expedited Authorization
 - A for diagnosis of gender dysphoria
 - labial adhesions for children 0-5yrs
- Must step through a Preferred brand or generic before a Non-Preferred brand or generic is authorized.

- **Recommendations:**

- Continue expedited authorizations listed above
- Implement Generics First according to formulation prescribed. Must step through one Preferred generic estrogen or Preferred estrogen combination product for one month before a Preferred brand or Non-preferred product is authorized. DAW by an Endorsing Practitioner shall not override this requirement without authorization; **AND**
- Must step through all Preferred generic estrogens or Preferred estrogen combination products (according to prescribed route of administration) at the highest tolerated labeled dose for one month each before a Preferred brand is authorized, unless signed DAW by an Endorsing Practitioner; **AND**
- Must step through all Preferred brands (according to prescribed route of administration) at the highest tolerated labeled dose for one month each before Non-Preferred product or is authorized, unless signed DAW by an Endorsing Practitioner.

Stakeholder Comments?

Motion: "I move the Medicaid Fee-For Service Program implement the limitations for the Estrogen drug class listed on slide 15 as recommended/amended to include..."

Nasal Steroid Products

Ingredient	Label Name	Generic Available	PDL Status
Beclomethasone	Beconase AQ [®] , QNASL [®] /Childrens	No	Non-Preferred
Budesonide	Rhinocort Aqua [®]	Yes	Non-Preferred
Ciclesonide	Omnaris [®] , Zetonna [®]	No	Non-Preferred
Flunisolide	<i>Flunisolide</i>	Yes	Non-Preferred
Fluticasone Furoate	Veramist [®]	No	Non-Preferred
Fluticasone Propionate	Flonase Allergy [®] (OTC)	Yes	Generics Preferred
Mometasone	Nasonex [®] , Propel/Mini [®]	No	Non-Preferred
Triamcinolone	Nasacort [®] /AQ/Allergy (OTC)	Yes	Generics Preferred

Products in grey font have not been reviewed by DERP

Nasal Steroids

- **Current Limitations**

- Generics First, must step through one Preferred generic prior to any brand authorized
- Budesonide approved Pregnant or Breast Feeding

- **Recommendations:**

- Continue authorization of budesonide for pregnancy and breast feeding
- Continue Generics First. Must step through one Preferred generic or one Preferred OTC products for one month before a Preferred brand is authorized. DAW by an Endorsing Practitioner should not override this requirement without authorization; **AND**
- Must step through all Preferred generics and all Preferred OTC products at the highest tolerated labeled dose for one month each before a Preferred brands is authorized, unless signed DAW by an Endorsing Practitioner; **AND**
- Must step through all Preferred brands at the highest tolerated labeled dose for one month each before a Non-Preferred products is authorized, unless signed DAW by an Endorsing Practitioner.

Stakeholder Comments?

Motion: "I move the Medicaid Fee-For Service Program implement the limitations for the Nasal Steroid drug class listed on slide 18 as recommended/amended to include..."