Annual Report on the Preferred Drug List Program

Virginia Department of Medical Assistance Services

November 1, 2008

Status Report on Virginia Medicaid's Preferred Drug List Program

Background

Item 325 ZZ.5 of the *2003 Appropriations Act* directed the Department of Medical Assistance Services (DMAS) to establish a preferred drug list (PDL) program. The program was implemented in January 2004. In February 2004, the Department received approval of its PDL program state plan amendment and its supplemental rebate contracts from the Centers for Medicare and Medicaid Services (CMS).

The Preferred Drug List (PDL) program is a prior authorization plan that divides some Medicaid covered drugs (prescription and over the counter medications) into two categories: those that require prior authorization before they can be dispensed and those that do not. While there are many classifications of drugs that are not subject to the PDL or prior authorization, the PDL contains a wide range of generic and brand name products. The major goal of the PDL program is to make available high quality medications to treat patient illnesses that provide the same therapeutic benefit at a lower price than more expensive equivalent drugs.

Item 306 (R)(8) of the 2008 Appropriations Act requires that DMAS provide annual reports to the Governor and General Assembly on the status of the program. (A copy of Item 306(R) (8) is provided at Attachment A.) DMAS has submitted reports at least annually since the implementation of the PDL program. In November 2005, DMAS provided an extensive analysis of the outcomes of the PDL program implementation, the estimated savings of the PDL program, and the health effects on recipients. This study found no adverse health impacts for persons who were switched to drugs on the PDL compared to those who were allowed to remain on non-preferred drugs. The 2005 study included an exhaustive analysis of program data, which required extensive agency resources to complete. While a similar study was not completed this year, the Department does continue to monitor for potential adverse health impacts through its Pharmacy & Therapeutics Committee process and interaction with the provider, advocacy and stakeholder communities. No major concerns have been raised with the Department regarding potential negative health effects of the PDL program.

Virginia Medicaid Pharmacy Program

The impetus for the implementation of Virginia Medicaid's PDL program was the growing cost of prescription drugs for its fee-for-service population. Between fiscal years 2000 and 2006, there was an overall increase in prescription drug costs of 14.1% from $298 million to $340 million (see Figures 1 & 2). The rate of increase was slowed in fiscal year 2006 by two major Medicaid program changes, which contributed to a decrease in the number of recipients eligible for pharmacy benefits: 1) the implementation of the Medicare Part D drug benefit; and, 2) managed care expansions. Over 140,000 recipients who previously received their prescription drug coverage through the Virginia Medicaid program began receiving most of their prescription drug coverage through the federal Medicare Part D program or managed care organizations between September 2005 and January 2006. The PDL, coupled with these two major Medicaid program changes, contributed to an overall decrease of approximately 59% in pharmacy claims (from $491 million to $180 million) and an almost 8% decrease in cost per claim from fiscal years 2005 to fiscal year 2008.

Figure 1
Trend in Virginia's Medicaid Fee-For-Service Pharmacy Costs
(FY 2000 -2008)

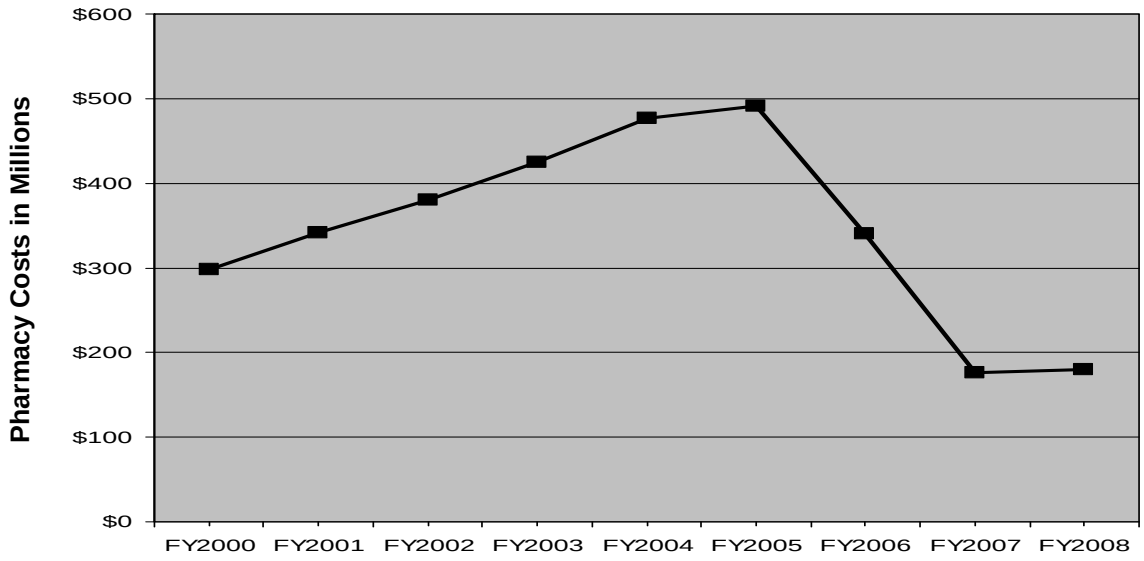
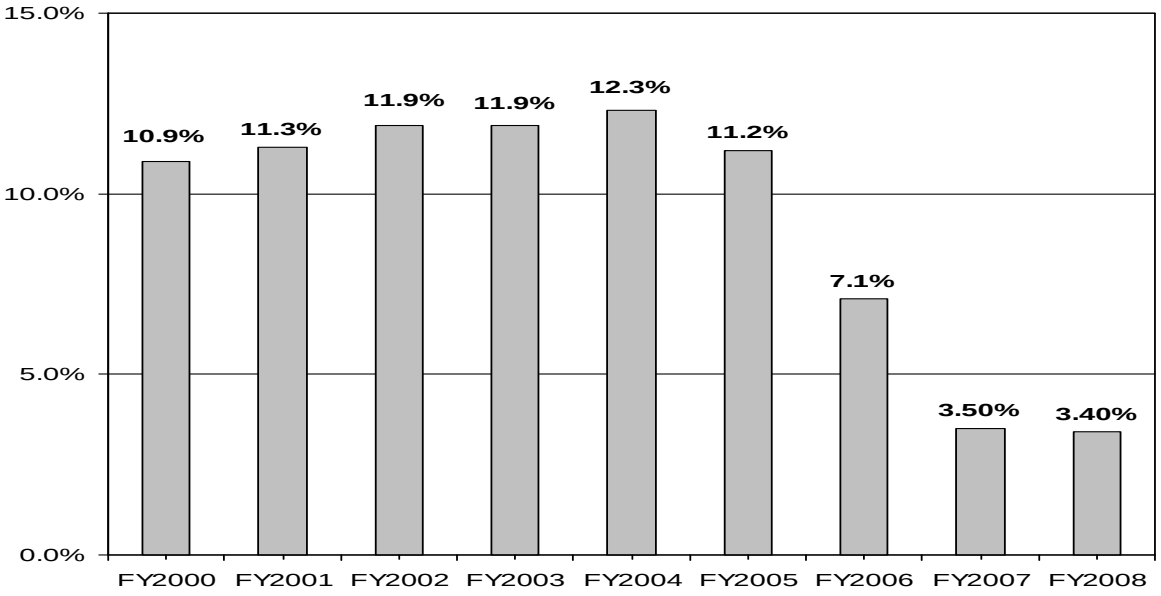


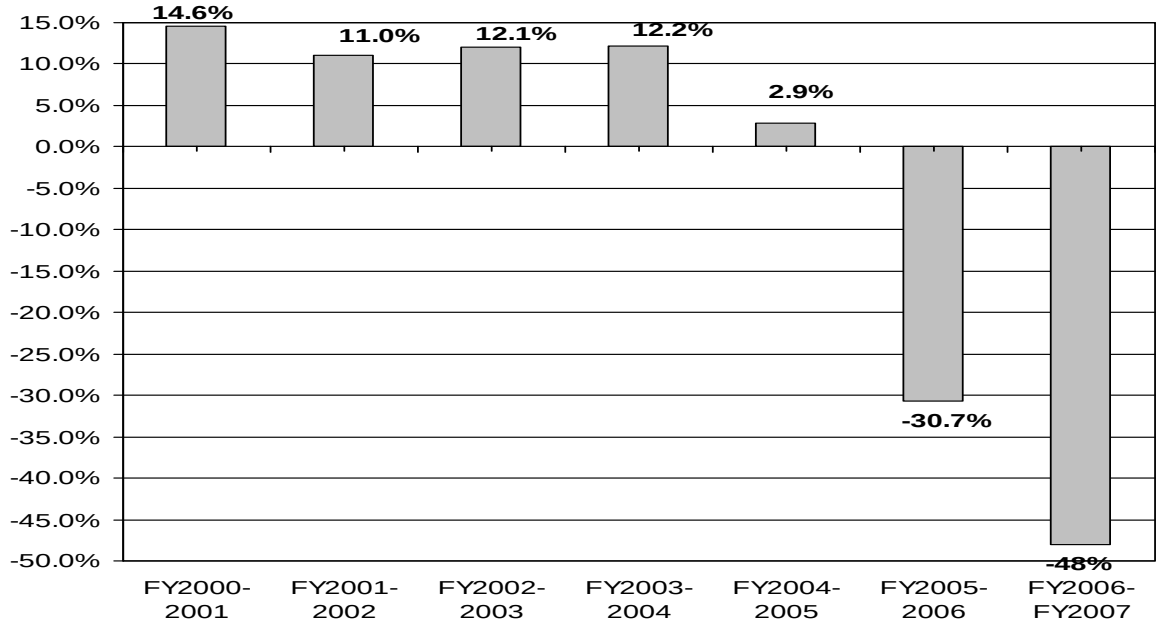
Figure 2
Fee-For-Service Pharmacy Cost as a Percent of Total Medicaid Costs
(FY 2000-2008)



Source: The Statistical Record of the Virginia Medicaid Program, Fiscal Year 2008 (not yet published)

The implementation of the PDL program in January 2004 as well as other new pharmacy cost savings initiatives such as mandatory generic requirements, the maximum allowable cost and specialty maximum allowable cost programs, and dose optimization have also contributed to the steady annual decline in Medicaid pharmacy expenditures as shown below in Figure 3. Specifically, the annual growth in Medicaid expenditures for prescription drugs was reduced from 12.2% in FY04 to just 2.9% in FY05 following the implementation of the PDL program. The further decreases in FY06 and FY07 were due to the Medicare Part D program.

Figure 3
Annual Growth/Decline in Medicaid Expenditures for Prescription Drug Services (FY 2000-2007)



Source: The Statistical Record of the Virginia Medicaid Program, Fiscal Year 2007

Pharmacy & Therapeutics Committee

The Pharmacy and Therapeutics (P&T) Committee continues to meet on a regular basis for the maintenance of the PDL. The P&T Committee directs all phases of the PDL program including: 1) selecting the therapeutic drug classes to review for possible inclusion on the PDL; 2) deciding which classes should be included on the PDL; 3) assessing the clinical efficacy of the drugs within each class under review; 4) selecting the "preferred" drugs in each class; 5) establishing clinical criteria; 6) developing appropriate prior authorization procedures; and, 7) advising the Department on other pharmacy program initiatives. The PDL is now a fairly mature program, with most changes relating to the introduction of new generics in established PDL-eligible drug classes. The following is a summary of some recent P&T Committee activities:

The P&T Committee has completed four annual reviews of PDL Phase I (September 20, 2004, October 31, 2005, October 23, 2006, October 3, 2007, and four annual reviews of Phase II

(March 23, 2005, March 30, 2006, April 17, 2007, and April 22, 2008) drug classes. During annual reviews of PDL drug classes, the P&T Committee determines if each of the classes should remain PDL eligible and designates the preferred/ non-preferred status of drugs within those classes based on clinical and financial information. Also, at each meeting, the Committee reviews all new drugs in existing PDL classes, which were not available for discussion during the previous annual review. Meetings are scheduled each quarter; however, they are not held if there is no business to be discussed/ addressed. Meeting minutes are available on the Virginia Town Hall and DMAS website at the following link: http://www.dmas.virginia.gov/pharm-p&t_committee.htm.

- P&T Committee meetings are open to the public and clinical presentations to the Committee, which are relevant to the discussion, are accepted. At each P&T Committee meeting, on average more than 50 representatives from pharmaceutical companies, providers, advocates and provider associations attend.

- The Department remains compliant with Committee composition requirements with eight physicians and four pharmacists. Dr. Randy Axelrod serves as the Chair with Mark Oley, R.Ph., of Westwood Pharmacy (Richmond), former Chairman of the Virginia Board of Pharmacy, serving as Vice Chairman (see Attachment B). Reuben Varghese, M.D., Virginia Department of Health (Arlington) replaced Katherine Nichols, R.Ph., M.D., Virginia Department of Health (Lynchburg). Arthur Garson, M.D., University of Virginia (Charlottesville) has resigned his position due to increased demands on his time resulting from new responsibilities at UVA; to date, a replacement has not been confirmed.

- At the October 2007 P&T meeting, the Committee reviewed Hepatitis C and Growth Hormones, two new drug classes proposed for initial review by the Committee. During the October 2007 P&T meeting, both classes were determined to be PDL eligible. Criteria were also established for recipients' health and safety. These two drug classes were added to the PDL effective January 1, 2008. To date, there have been no issues with the implementation of these new classes on the PDL.

- The P&T Committee created a policy guidance document for the review of new generics in drug classes subject to the PDL. The goal of the guidance document is to achieve more timely capture of cost savings as a result from the market introduction of less expensive, therapeutically equivalent generics in PDL-eligible drug classes. The guidance document was approved by the P&T Committee during the April 22, 2008 meeting, and posted on the department's web site thereafter.

- The P&T Committee management of the PDL has continued to contribute to the increase in the overall generic utilization rate by making generic and over-the-counter (OTC) medications "preferred". In FY2008, several classes within the PDL had new generic medications released, and the PDL was in position to take advantage of this by having large market shares in the newly released generics. This continued the movement of classes toward having a majority of preferred drugs as generics, with most brand name drugs requiring prior authorization. This year, other classes have joined this list of predominantly generic classes (H2 receptor agonists, proton pump inhibitors and sedative hypnotics/ benezodiazepine), and new this past year were Macrolides, 2nd generation antihistamines, ACE inhibitors, 2nd generation Sulfonylureas, and high potency lipotropics. While this does not afford the Commonwealth substantial supplemental rebates, it does reduce the overall cost per prescription.

- The current generic utilization rates among total drugs dispensed are approximately 66% in FY 2008 compared to about 54% at the end of FY2005.

Preferred Drug List Program Operations and Performance

A contract amendment was recently finalized with First Health Services Corporation (FHSC) to continue providing clinical and administrative services for the PDL for two additional years. The current administrative costs are approximately $1.5 million annually. FHSC's services include, but are not limited to, clinical call center management, supplemental rebate contracting, and clinical support of the P&T Committee. In addition, as of January 2006, FHSC began managing most pharmacy point of sale calls through their call center. These calls were formerly managed by DMAS' call center. Point of sale inquiries include those related to Medicare Part D, the National Provider Identification (NPI) number, and the new congressionally mandated tamper-resistant prescription pad/paper requirement. The following is a summary of call center operational results.

- There have been few complaints and a number of compliments about the clinical call center and the PDL program in general.

- Call center management and the prior authorization processes are working well as evidenced by an efficient average speed to answer rate, minimal call time, and low call abandonment rate that all meet contractual requirements. The statistics have increased slightly because of the additional point of sale inquiries being handled by the call center. (The call center's operational statistics are not segregated for PDL related services.)

- On July 1, 2007, a new web-based process ("Web PA") became available for pharmacy prior authorization processing. The Web PA provides an alternative method for submission of prior authorization requests for prescription drugs. This is supplemental to the traditional means of phoning or faxing requests, which are still available. Some of the advantages of the Web PA process are: PA can be created online with real-time authorization in many cases; the user may check the status of the request and view the decision at their convenience; and, the user may print a complete copy of the request and the decision for the patient's record. The Web PA process and all information exchanged are secure. There was extensive provider education with the introduction of this new system; however, there has been limited utilization (through June 2008, there have only been 57 PAs submitted using this method).

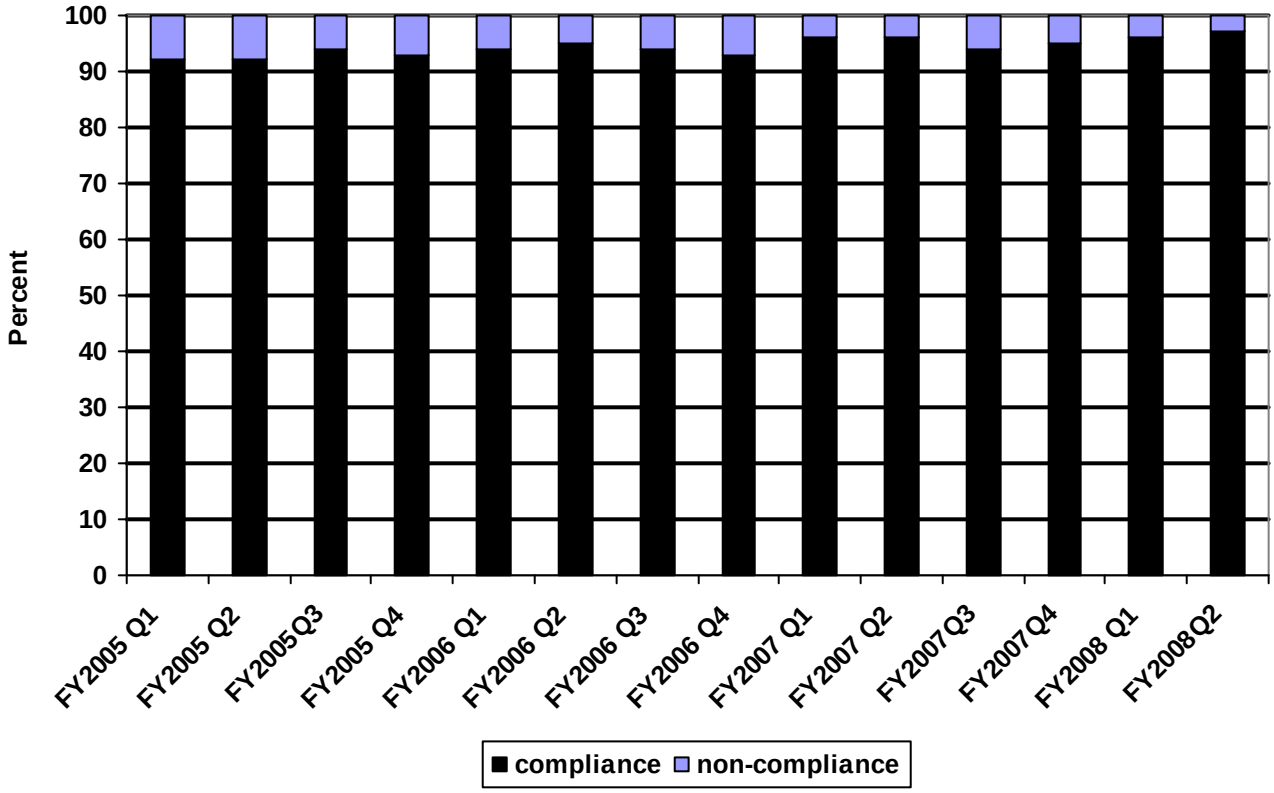
- There were a total of 17,806 PDL PAs (requests for non-preferred drug) and clinical PAs (criteria for both preferred and non-preferred drugs, i.e., step therapy, age requirements, etc.) processed in FY 2008. Among these, 80% were approved for the non-preferred drug, 19% were changed to a preferred drug, and <1% were denied. The greatest number of PAs were in the antihistamine (2^{nd} generation), proton pump inhibitor (PPI) and sedative hypnotic classes. These are drug classes with high utilization, and the brand name drugs are heavily marketed which creates the perception of necessity.

- Most PDL denials have been related to billing issues with pharmacy providers who request authorization of non-preferred drugs after they have been distributed to Medicaid recipients. The denials are common among long-term care providers who bill retrospectively. These are actually denials of payment rather than denial of access to drugs in that the recipient

received the medication in advance of the request. There have recently been a few denials in the proton pump inhibitors (PPI) class due to stricter criteria effective January 1, 2007. The new criteria includes: "step therapy" that requires a trial of the therapeutically equivalent, less expensive OTC medications; and, evaluation by a gastroenterologist before the brand name drugs are approved. There have been 14 denials for PPI medications to date. Most Medicaid recipients receive a therapeutically equivalent substitution if PA is denied based on PDL or clinical criteria.

- The compliance rate in terms of "preferred" drugs being prescribed for Medicaid recipients remains high, currently at 97.5% across all classes subject to the PDL. The majority of the drug classes have compliance rates above 90%. These compliance rates exceed the compliance level (85%) needed to achieve the necessary budget savings (see Figure 4).

Figure 4
Mediciaid compliance/non-compliance rates



Source: First Health Services Corporation Rebate Department, Fiscal Year 2008

Supplemental Rebate Contracting Process & Savings Estimates

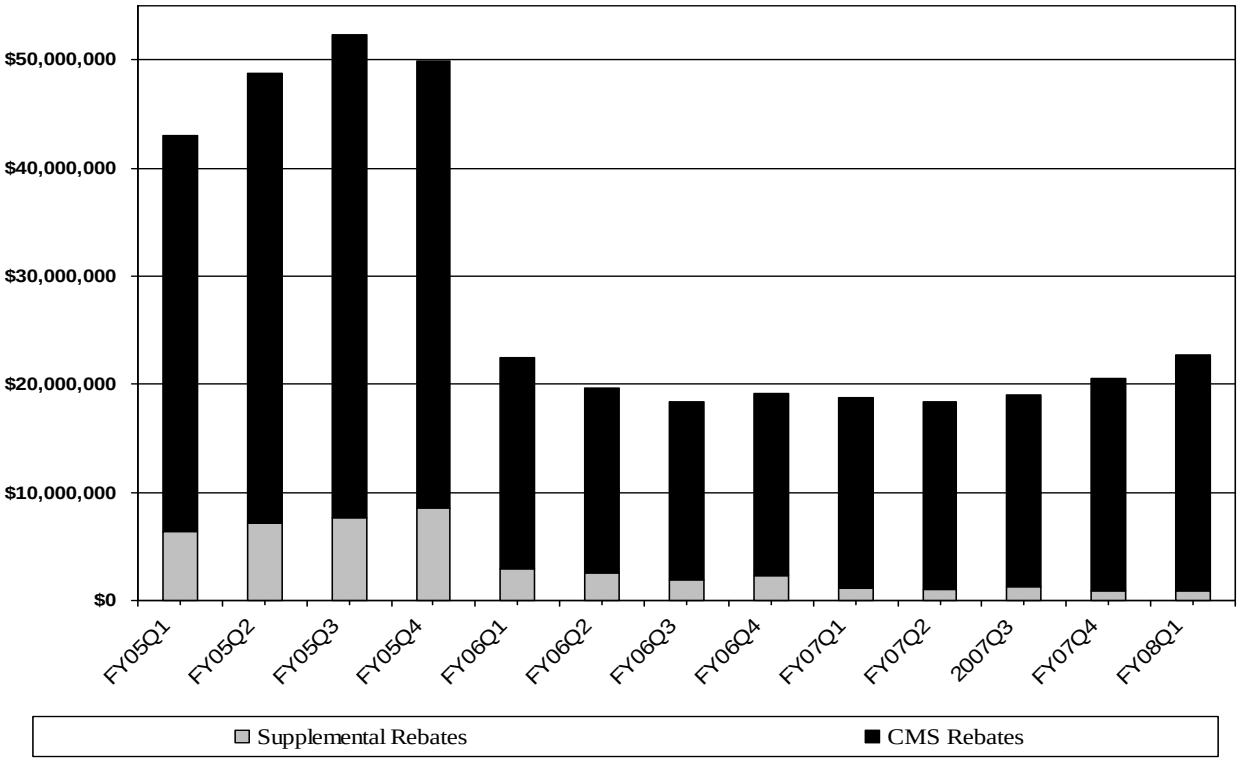
The PDL was developed with significant cooperation from many pharmaceutical manufacturers who agreed to provide aggressive drug pricing and supplemental rebates in the design of a Virginia-specific PDL. The Department solicits Virginia-specific contracts for pricing and supplemental rebates directly with manufacturers for all single-source brand products in the PDL eligible

therapeutic classes. To date, this unique supplemental rebate model has out-performed the multi-state pooling approach used by some other states.

Including FY2008, the Department had invoiced almost $64 million in supplemental rebates since the inception of the PDL program in January 2004 (see Figure 5). This rebate amount is in addition to the federal rebates also collected for these drugs. Supplemental rebates have declined in recent quarters because of higher federal mandated rebates tied directly to changes required by the Deficit Reduction Act of 2005, which took effect in 2007. In addition, several expensive brand drugs lost patent protection and are now available generically, thereby, reducing the overall cost of these drugs for both the State and Medicaid recipients. The Department continues to actively manage new generic drugs to market, making them non-preferred until they are deemed less expensive than their brand counterparts, net of all federal and (if applicable) supplemental rebates. The goal of the PDL is to carefully balance the clinical attributes of a product against the financial impact, and ultimately, select products that best meet the needs of those enrolled in the Medicaid program. Due to the many interconnected cost savings initiatives in the pharmacy program, it is difficult to determine the savings attributable solely to the PDL. However, the supplemental rebate calculations noted above, along with the high compliance rate of using preferred agents, illustrate that the program is generating savings for the Commonwealth.

The significant decline in rebates beginning in the first quarter of FY06 (Figure 5) is due to the implementation of the Medicare Part D program which resulted in more that 140,000 Medicaid recipients getting prescription medications through Medicare, rather than Medicaid. As a result, fewer prescriptions are paid by Medicaid, and fewer rebate dollars are collected from manufacturers.

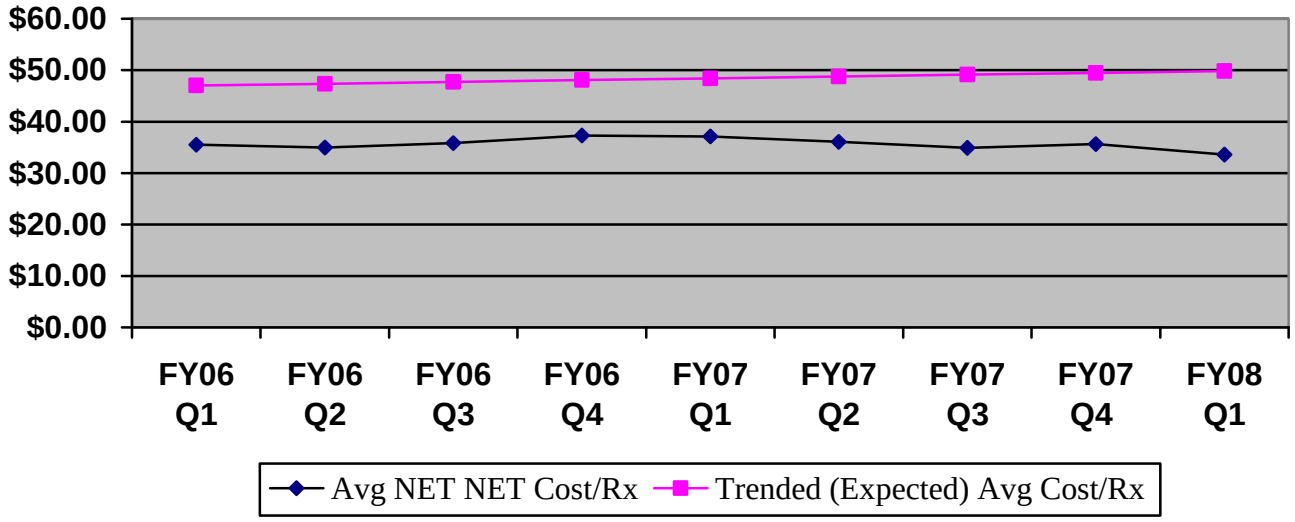
Figure 5
Trend in Federal and Supplemental Rebates Invoiced
(FY 2004-2008)



Source: First Health Services Corporation Rebate Department Fiscal Year 2008

As shown in Figure 6, the average net-net cost per script is $34.01 in 1Q FY08 compared to an average net-net cost per script of $34.80 in 1Q FY06. It is notable that over 26 months the average net-net cost per script has remained in the mid $35 dollar range, which is well below the expected trended average cost.

Figure 6
Net-Net Cost (FY 2006-08)



Source: First Health Services Corporation Rebate Department, Fiscal Year 2008

Communications and Public Input

DMAS maintains a specific section on its website (www.dmas.virginia.gov) at which stakeholders can receive notices and information about the PDL program. Stakeholders can access all documents related to the PDL, P&T Committee, as well other pharmacy program initiatives. DMAS also has a dedicated email address (pdlinput@dmas.virginia.gov) for interested parties to submit PDL-related comments, concerns, or information to the Department and/or the P&T Committee.

Conclusion

The Virginia Medicaid PDL Program continues to operate efficiently and effectively with very few complaints from providers or clients. Medicaid clients are receiving high quality prescription medications at a substantially reduced cost to the Commonwealth. Despite a significant decline in fee-for-service pharmacy clients, expenditures, and rebates due to the implementation of Medicare Part D and managed care expansions, the PDL continues to be a very successful program. Much of the success of the program is attributable to a highly effective P&T Committee.

Acknowledgements

DMAS wishes to acknowledge the medical and pharmacy providers, members of the DMAS Pharmacy and Therapeutics Committee, public and private stakeholders, and pharmaceutical manufacturers who have participated in the development, implementation and maintenance of the preferred drug list program and other pharmacy program initiatives.

Attachment A

Item 306 (R)(8) of the 2008 Appropriations Act

The department shall provide to the Governor; the House Committees on Appropriations, and Health, Welfare and Institutions; the Senate Committees on Finance, and Education and Health; and the Joint Commission on Health Care a report on the Preferred Drug List (PDL) Program no later than November 1 of each year. The report shall include the direct savings attributed to the PDL for the prior fiscal year, an estimated savings of the program for the next fiscal year, and the cost to administer the PDL.

Attachment B

P&T Committee Members and Profession

NAME	PROFESSION
Randy Axelrod, Chairman	Physician
Gill Abernathy	Pharmacist
Roy Beveridge	Physician
Avtar Dhillon	Physician
Vacant	Physician
Mariann Johnson	Physician
Mark Oley, Vice Chairman	Pharmacist
James Reinhard	Physician
Tim Jennings	Pharmacist
Renita Driver	Pharmacist
Ruben Varghese	Physician
Rachel Selby- Penczak	Physician

Attachment C
Drug Classes Currently Included on the PDL

PDL Phase I Drug Classes – Preferred drug status revised on January 1st of each year

- HMG CoA Reductase Inhibitors (Statins)
- Proton Pump Inhibitors (PPIs)
- Angiotensin Receptor Blockers (ARBs) *(formerly named Angiotensin Receptor Antagonists)*
- Angiotensin Converting Enzyme Inhibitors (ACE Inhibitors)
- Inhaled Corticosteroids
- Nasal Steroids
- Beta Adrenergics
- COPD- Anticholinergics *(formerly included with Beta Adrenergics)*
- Beta Blockers
- Calcium Channel Blockers
- H2 Antagonists
- Second Generation Antihistamines (LSAs)
- Benzodiazepine Sedative Hypnotics *(formerly included with Sedative Hypnotics)*
- Other Sedative Hypnotics *(formerly included with Sedative Hypnotics)*
- Electrolyte Depleters
- Urinary Tract Antispasmodics
- Topical Immunomodulators
- Lipotropics Non-Statins: Fibric Acid
- Lipotropics Non-Statins: Niacin Derivatives
- Phosphodiesterase 5 Inhibitor for Pulmonary Arterial Hypertension
- Hepatitis C
- Growth Hormones

PDL Phase II Drug Classes – Preferred drug status revised on July 1st of each year

- Oral Hypoglycemics (Second Generation Sulfonylureas, Alpha-Glucosidase Inhibitors, Biguanides, Biguanide Combination Products, Meglitinides, Thiazolidinediones)
- Leukotriene Modifiers
- Non-Steroidal Anti- Inflammatory Drugs (NSAID) *(now includes Cox-2 Inhibitors)*
- Serotonin Receptor Agonists (Triptans)
- Oral Antifungals for Onychomycosis
- Bisphosphonates for Osteoporosis
- Second Generation Cephalosporins (Antibiotics)
- Third Generation Cephalosporins (Antibiotics)
- Second Generation Quinolones – Systemic (Antibiotics)
- Third Generation Quinolones – Systemic (Antibiotics)
- Topical Antibiotics
- Macrolides - Adult and Pediatric (Antibiotics)
- Antihyperkinesis/CNS Stimulants (Medications for ADD/ADHD)
- Alpha-2 Adrenergic - Ophthalmic
- Beta-blockers -Ophthalmic
- Carbonic Anhydrase Inhibitors-Ophthalmic
- Prostaglandin Inhibitors -Ophthalmic
- Long Acting Narcotics
- Ophthalmic Anti-Inflammatory
- Ophthalmic Quinolones
- Ophthalmic Antihistamines
- Ophthalmic Mast Cell Stabilizers
- Herpes Antivirals
- Influenza

Attachment D
Preferred Drug List, Effective July 1, 2008

Within these categories, drugs that are not listed are subject to Prior Authorization

Virginia Medicaid Preferred Drug List
Effective July 1, 2008

First Health Clinical Call Center
Phone: 1-800-932-6648
Fax: 1-800-932-6651

ANALGESICS

NON-STEROIDAL ANTI-INFLAMMATORY DRUGS

Diclofenac Potassium
Diclofenac Sodium
Diflunisal
Etodolac
Etodolac SR
Fenoprofen
Flurbiprofen
Ibuprofen
Indomethacin
Indomethacin SR
Ketoprofen
Ketoprofen SR
Ketorolac
Meclofenamate Sodium
Nabumetone
Naproxen
Naproxen Sodium
Oxaprozin
Piroxicam
Sulindac
Tolmetin Sodium

*COX II INHIBITORS***

Celebrex®**

LONG-ACTING

*NARCOTICS **

Avinza® *

Duragesic® (Brand Only) *

Morphine Sulfate tablets SA® *

ANTIBIOTICS – ANTIINFECTIVES

ORAL ANTIFUNGALS – ONYCHOMYCOSIS

Terbinafine

CEPHALOSPORINS – 2ND & 3RD GENERATION

Cedax Capsule®
Cedax® Suspension
Cefaclor Capsule
Cefaclor ER
Cefaclor Suspension
Cefdinir Capsules
Cefdinir Suspension
Cefprozil Tablet
Cefprozil Suspension
Cefuroxime
Raniclor®
Spectracef®

MACROLIDES

Azithromycin Tablet
Azithromycin Packet
Azithromycin Suspension
Clarithromycin Tablet
Clarithromycin ER
Clarithromycin Suspension
Erythrocin Stearate
Erythromycin Base
Erythromycin Ethylsuccinate
Erythromycin Estolate Suspension
Erythromycin Stearate
Erythromycin w/Sulfisoxazole

QUINOLONES – 2ND & 3RD GENERATION

Avelox®
Avelox ABC Pack®

Ciprofloxacin tablet

Cipro Suspension

TOPICAL ANIBIOTICS

Mupirocin

ANTIVIRALS

HEPATITIS C

Pegasys Conv.Pack

Pegasys

Peg-Intron

Peg-Intron Redipen

HERPES

Acyclovir Tablets
Acyclovir Suspension

Famvir®

Valtrex®

INFUENZA

Amantadine
Amantadine Syrup
Relenza Disk®

Rimantadine

Tamiflu®
Tamiflu Suspension®

ASTHMA –ALLERGY

ANTIHISTAMINES – 2ND GENERATION

ClaritinTablets OTC ®

Claritin Tablets- Rapids OTC®

Claritin Syrup OTC ®

Claritin-D 12 hr OTC®

Claritin-D 24hr OTC®

Loratadine tablet (All OTCs)

Loratadine Tab- Rapids (All OTCs)

Loratadine Syrup (All OTCs)

Loratadine D12hr (All OTCs)

Loratadine D24hr (All OTC names)

Zyrtec® Syrup (PA required except for children under age 2)

BETA ADRENERGICS- SHORT ACTING

Albuterol

Alupent® MDI

Maxair Autohaler®

Proventil® HFA

Ventolin® HFA

Xopenex HFA®

BETA ADRENERGICS – LONG ACTING

Foradil®

Serevent Diskus®

BETA ADRENERGICS FOR NEBULIZERS

Accuneb®

Albuterol sulfate

Metaproterenol

Xopenex®

BETA ADRENERGIC/ CORTICOSTEROID INHALER COMBINATIONS

Advair Diskus®

Advair HFA®

COPD ANTICHOLINERGICS

Atrovent AER W/ADAP
Atrovent HFA®
Combivent MDI®
Ipratropium Bromide
Spiriva®

INHALED CORTICOSTEROIDS

AeroBid®

AeroBid M®

Asmanex®

Azmacort®

® = Registered Trade name

* A step edit is required for this class

**Clinical Prior Authorization required

Flovent HFA®

Pulmicort Respules®

QVAR®

LEUKOTRIENE INHIBITORS

Accolate®
Singulair®

NASAL STEROIDS

Flunisolide

Fluticasone

Nasacort AQ®

Nasonex®

CARDIAC MEDICATIONS

ACE INHIBITORS

Benazepril HCL
Benazepril HCL /HCTZ
Captopril

Captopril /HCTZ

Enalapril

Enalapril /HCTZ

Lisinopril

Lisinopril/HCTZ

ACE INHIBITORS OR ARB INHIBITORS WITH

CALCIUM CHANNEL BLOCKERS

Lotrel®

ANGIOTENSIN RECEPTOR ANTAGONISTS

Diovan®

Diovan HCT®

Cozaar®

Hyzaar®

BETA BLOCKERS

Acebutolol
Atenolol
Atenolol /Chlorthalidone

Betaxolol
Bisoprolol Fumarate
Bisoprolol /HCTZ
Carvedilol
Labetalol HCL
Metoprolol tartrate
Metoprolol/HCTZ
Nadolol
Pindolol
Propranolol
Propranolol Solution
Propranolol/HCTZ
Sorine®
Sotalol

Sotalol AF

Timolol maleate

CALCIUM CHANNEL BLOCKERS - DIHYDROPYRIDINE

Amlodipine

Afeditab CR®

Dynacirc®CR

Felodipine ER

Nicardipine

Nifediac CC®

Nifedical XL®

Nifedipine

Nifedipine ER

Nifedipine SA

Plendil®

Sular®

CALCIUM CHANNEL BLOCKERS- NON-DIHYDROPYRIDINE

Cartia XT®
Diltia XT®
Diltiazem ER
Diltiazem HCL
Diltiazem XR
Taztia XT®
Verapamil
Verapamil SA
Verapamil 24hr pellets

LIPOTROPICS: STATINS

Advicor®

Altoprev®

Lescol®

Lescol XL®

Lovastatin®

Pravastatin

Simvastatin

LIPOTROPICS: CAI

Zetia®

LIPOTROPICS: FIBRIC ACID

Antara®

Gemfibrozil®

LIPOTROPICS: NIACIN DERATIVES

Niaspan®
Niacor®

LIPOTROPICS: NIACIN & STATIN COMBINATIONS

Simcor®*

*PDE-5 INHIBITORS - PULMONARY HYPERTENSION***

Revatio®**

CENTRAL NERVOUS SYSTEM

STIMULANTS/ADHD MEDICATIONS

Adderall XR®

Amphetamine Salt Combo

Concerta®

Dextroamphetamine Tablet

Dextroamphetamine Capsule

Dextrostat®

Focalin®

Focalin XR®

Metadate CD ®

Metadate ER ®

STIMULANTS/ADHD MEDICATIONS

(CONTINUED FROM PG 2)

Methylin Tablet ®

Methylin Chew ®

Methylin ER®

Methylin Solution ®

Methylphenidate

Methylphenidate SA/SR

Ritalin LA®

Strattera®

Vyvanse®

® = Registered Trade name

* A step edit is required for this class

**Clinical Prior Authorization required

Within these categories, drugs that are not listed are subject to Prior Authorization

Virginia Medicaid Preferred Drug List
Effective July 1, 2008

First Health Clinical Call Center
Phone: 1-800-932-6648
Fax: 1-800-932-6651

SEDATIVE HYPNOTIC

Chloral Hydrate Syrup

Estazolam

Flurazepam

Temazepam

Triazolam

Zolpidem Tartrate

*OTHER SEDATIVE HYPNOTIC**

Rozerem® *

DIABETES

ORAL HYPOGLYCEMICS ALPHAGLUCOSIDASE INHIBITORS.

Glyset®
Precose®

ORAL HYPOGLYCEMICS

BIGUANIDES

Metformin
Metformin ER

ORAL HYPOGLYCEMICS

-BIGUANIDE COMBINATIONS

Actoplus Met®
Avandamet®
Glyburide–Metformin

Glipizide–Metformin

ORAL HYPOGLYCEMICS –

DPP-IV INHIBITORS AND COMBINATIONS

Januvia

Janumet

ORAL HYPOGLYCEMICS –

MEGLITINIDES

Starlix®

ORAL HYPOGLYCEMICS 2ND GENERATION SULFONYLUREAS

Glimepiride
Glipizide
Glipizide ER
Glyburide
Glyburide micronized

ORAL HYPOGLYCEMICS-

Thiazolidinediones

Actos®

Avandia®

GASTROINTESTINAL

HISTAMINE-2 RECEPTOR ANTAGONISTS (H-2RA)

Ranitidine

Famotidine

Zantac® Syrup

(No PA req. IF under age 12)

*PROTON PUMP INHIBITORS **

Prilosec® OTC

Protonix® *

Omeprazole

(No PA req. IF under age 12)

Prevacid®

(No PA req. IF under age 12)

Prevacid Susp®

(No PA req. IF under age 12)

Prevacid solutab®

(No PA req. IF under age 12)

GENITOURINARY

URINARY ANTISPASMODICS

Detrol LA ®

Enablex®

Oxybutynin Tablet

Oxybutynin Syrup

Oxytrol Transdermal®

Sanctura®

Sanctura XR®

VESIcare®

OPHTHALMIC

ANTIBIOTIC- QUINOLONES

Ciprofloxacin drops

Ofloxacin drops

Quixin®

Vigamox®

Zymar®

ANTIHISTAMINES

Alaway OTC ®

Elestat®

Optivar®

Pataday ®

Patanol®

Zaditor OTC®

ANTI-INFLAMMATORY

Acular®

Acular LS®

Flurbiprofen Sodium drops

Nevanac®

Voltaren drops®

Xibrom®

GLAUCOMA – ALPHA-2 ADRENERGICS

Alphagan P®

Brimonidine Tartrate

Iopidine®

GLAUCOMA BETA-BLOCKERS

Betaxolol HCl

Betimol®

Betoptic S®

Combigan®

Carteolol HCl

Levobunolol HCl

Metipranolol

Timolol Maleate drops

Timolol Maleate Sol-Gel

GLAUCOMA – CARBONIC ANHYDRASE INHIBITORS

Azopt®
Cosopt®
Trusopt®

GLAUCOMA – PROSTAGLANDIN ANALOGS

Lumigan®
Travatan®
Travatan Z®
Xalatan®

® = Registered Trade name

* A step edit is required for this class

**Clinical Prior Authorization required

MAST CELL STABLIZERS

Alamast®
Alocril®
Alomide®
Cromolyn

OSTEOPOROSIS

BISPHOSPHONATES

Actonel®

Fosamax Tablet®

Fosamax Solution®

Fosamax Plus D®

MISCELLANEOUS

ELECTROLYTE DEPLETERS

Fosrenol®

Phoslo®

Renagel®

SEROTONIN RECEPTOR

AGONISTS (Triptans)

Imitrex Cartridge®
Imitrex Nasal®
Imitrex Pen Kit®
Imitrex Tablet
Imitrex Vial®
Maxalt®
Maxalt-MLT®

*TOPICAL IMMUNOMODULATORS***

Elidel® **
Protopic® **

GROWTH HORMONE

Genotropin
Norditropin Cartridge
Nutropin Aq Cartridge
Nutropin
Nutropin Aq Vial
Norditropin Nordiflex

NOTE: **Fax requests receive a response within 24 hours. For urgent requests, please call.**

Not all medications listed are covered by all DMAS programs. Check individual program coverage. For program drug coverage information, visit www.dmas.virginia.gov or http://virginia.fhsc.com.

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