Annual Report on the Preferred Drug List Program

Virginia Department of Medical Assistance Services

November 2006

Status Report on Virginia Medicaid's Preferred Drug List Program

Background

The Preferred Drug List (PDL) program is a prior authorization plan that divides some Medicaid covered drugs (prescription and some 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 325 ZZ of the *2003 Appropriations Act* directed the Department of Medical Assistance Services (DMAS) to establish a preferred drug list 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). Item 302 (S)(8) requires that DMAS provide annual reports to the General Assembly on the status of the program. (A copy of Item 302(S)(8) is provided at Attachment A.)

As required by the budget language, DMAS has submitted reports to the General Assembly 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, interaction with the provider and advocacy communities and a special email address where stakeholders can submit any concerns, comments etc. 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 2005, prescription drug costs increased by 65% from $298 million to $491 million.

Figure 1
Trend in Virginia's Medicaid Fee-For-Service Pharmacy Costs
(FY 2000 -2005)

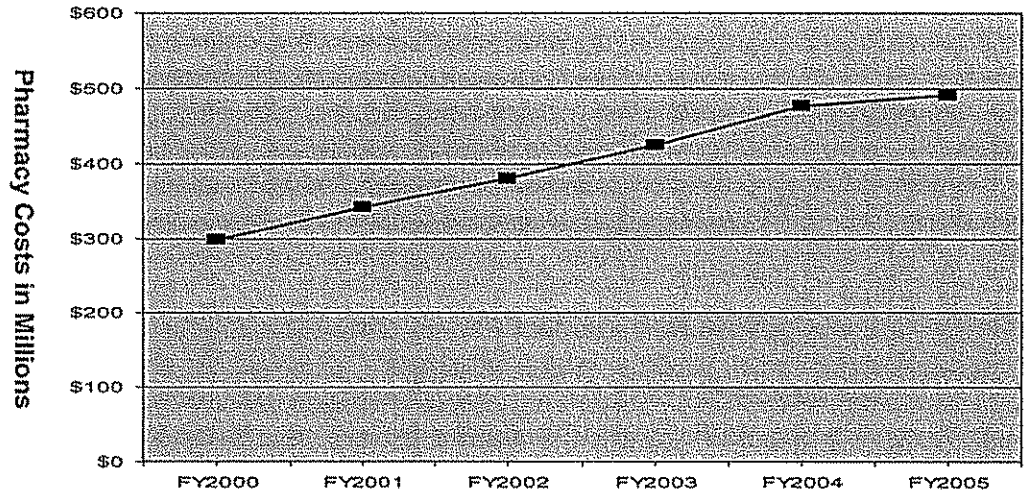
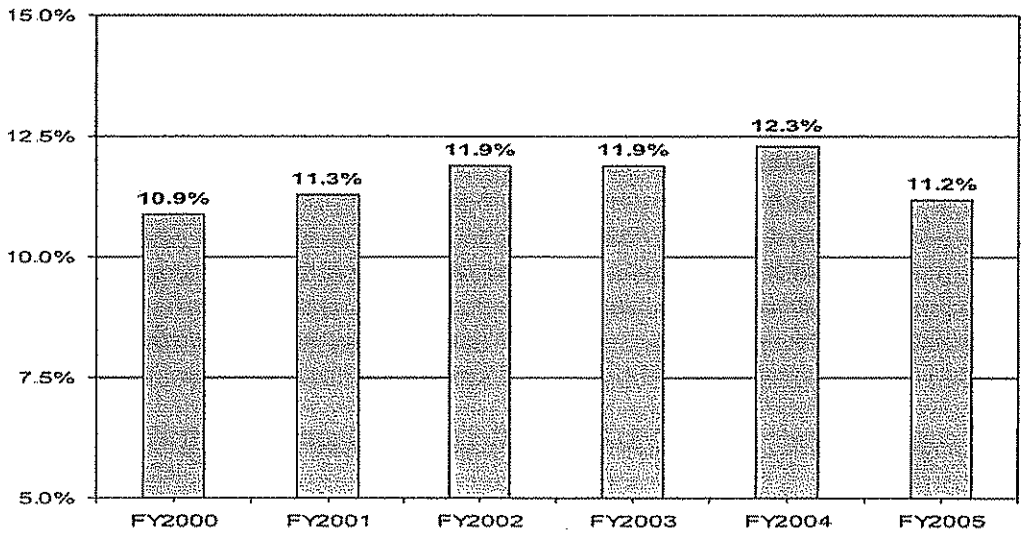


Figure 2
Fee-For-Service Pharmacy Cost as a Percent of Total Medicaid Costs
(FY 2000-2005)



Source: The Statistical Record of the Virginia Medicaid Program, Fiscal Year 2005

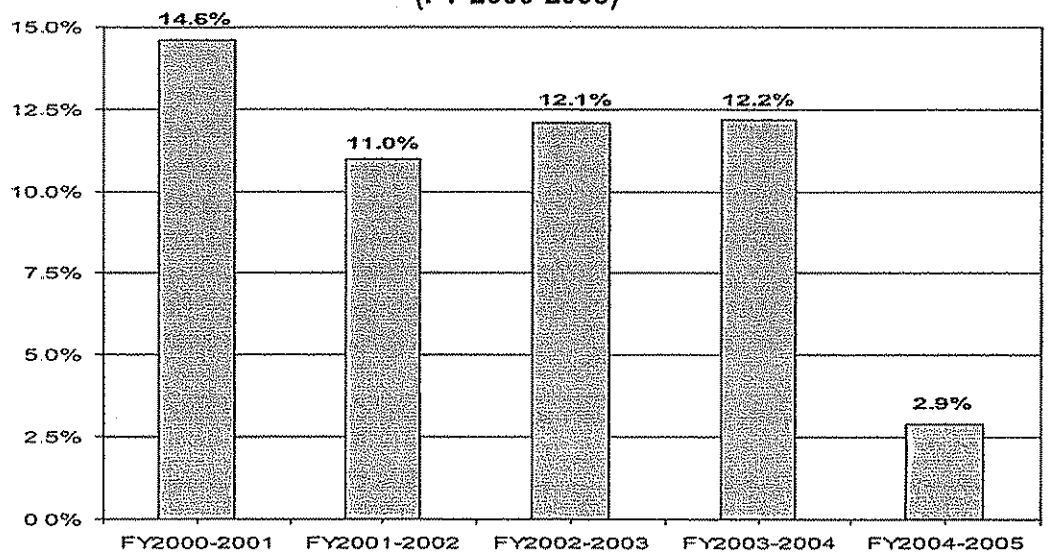
In fiscal year 2006, two major Medicaid program changes contributed to a decrease in the number of recipients eligible for pharmacy benefits: 1) the implementation of the Medicare Part D drug benefit and 2) managed care expansions. Approximately 100,000 low-income seniors and people with disabilities eligible for both Medicaid and Medicare (dual eligibles) who previously received their prescription drug coverage through the Virginia Medicaid program began receiving their prescription drug coverage through the federal Medicare Part D program in January 2006. Virginia Medicaid continues to provide coverage of some

drugs that are not covered under Medicare Part D, but for which state Medicaid programs can continue to receive federal financial participation. These include over the counter medications, barbiturates, benzodiazepines, some vitamins and minerals, and other drugs specifically excluded from Part D coverage. Some over the counter medications for respiratory (asthma and allergy) and gastrointestinal conditions being reimbursed by Virginia Medicaid for Medicare Part D recipients are subject to the PDL.

In addition, between September 2005 and September 2006, about 41,000 recipients became eligible for coverage by managed care organizations through expansions in Northern and Southwestern Virginia. Consequently, from January to August 2006, there has been a decrease of approximately 62% in pharmacy payments and a 57% decline in pharmacy claims compared to the same period in 2005.

The implementation of the PDL program in January 2004 as well as other new pharmacy cost savings programs such as mandatory generic requirements and the maximum allowable cost program has contributed to the decline in pharmacy expenditures. This is demonstrated by the major decline in the rate of change for pharmacy expenditures, down to only a 2.9% increase between fiscal years 2004 and 2005. The PDL was the major contributing factor in this decline.

Figure 3
Annual Average Growth in Medicaid Expenditures for Prescription Drug Services (FY 2000-2005)



Source: The Statistical Record of the Virginia Medicaid Program, Fiscal Year 2005

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 following is a summary of some recent P&T Committee activities:

- The P&T Committee has completed two annual reviews of both PDL Phase I (September 20, 2004 and October 31, 2005) and Phase II (March 23, 2005 and March 30, 2006) drug classes. During annual reviews of PDL drug classes, the P&T Committee determines if each of the classes should remain PDL eligible and 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 annual review. There were two other meetings between 2005-2006 (June 8, 2005 and August 31, 2005) in which new drugs and drug classes were reviewed and special presentations on topics of concern to the Committee were provided (e.g., Medicare Part D implementation, status of pharmacy programs, evaluation of PDL program, specialty drug classes, etc.). Meeting minutes are available on the 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, more than 50 representatives from pharmaceutical companies, providers, advocates and provider associations attend.

- Three new P&T Committee members have been appointed due to two resignations and the death of a member. The new members include Dr. Rachel Selby-Penczak who was appointed to the P&T Committee in October 2005 following the passing of Dr. Christine Tully. Dr. Selby-Penczak is board-certified in both internal and geriatric medicine. In addition, Dr. Katherine Nichols of the Virginia Department of Health (Lynchburg) and Dr. Timothy Jennings (PharmD) of Sentara Healthcare have joined the Committee as replacements for Dr. Eleanor Sue Cantrell and Mark Szalwinski, respectively, who both recently resigned due to other professional obligations. The addition of these new members allows the Department to remain compliant with Committee composition requirements with eight physicians and four pharmacists.

- Twelve new drug classes were deemed eligible and included on the PDL between 2005 and 2006. There are over 40 drug classes now subject to the PDL. The new drug classes include:
    - Phosphodiesterase 5 Inhibitor for Pulmonary Arterial Hypertension
    - Electrolyte Depleters
    - Urinary Tract Antispasmodics
    - Topical Immunomodulators
    - Lipotropics Non-Statins: Fibric Acid
    - Lipotropics Non-Statins: Niacin Derivatives
    - Ophthalmic Anti-Inflammatory
    - Ophthalmic Quinolones

- Ophthalmic Antihistamines
- Ophthalmic Mast Cell Stabilizers
- Herpes Antivirals
- Influenza

See Attachment C for a listing of all drug classes currently included on the PDL. Attachment D includes the "PDL Quick List" which lists the preferred drugs in each drug class.

Other Key Issues Handled by the P&T Committee

- **Phosphodiesterase 5 (P5) Inhibitors for Erectile Dysfunction** -- The P & T Committee's review of the Phosphodiesterase 5 (P5) Inhibitors for Erectile Dysfunction class for potential inclusion on the PDL was discontinued due to federal actions related to this drug class. In October 2005, federal legislation was passed that ended Medicaid matching funds for erectile dysfunction drugs as of January 1, 2006 through House Resolution (H.R. 3971). In the Medicaid program, states are still allowed to subsidize erectile dysfunction drugs if they determine such drugs are medically necessary; however, federal matching funds would no longer be received. Virginia Medicaid terminated coverage of erectile dysfunction drugs on January 1, 2006. As such, the P&T Committee discontinued its review of PDL eligibility of the class. Virginia Medicaid continues to allow reimbursement for the Phosphodiesterase 5 (P5) Inhibitor (Revatio) for pulmonary arterial hypertension patients.

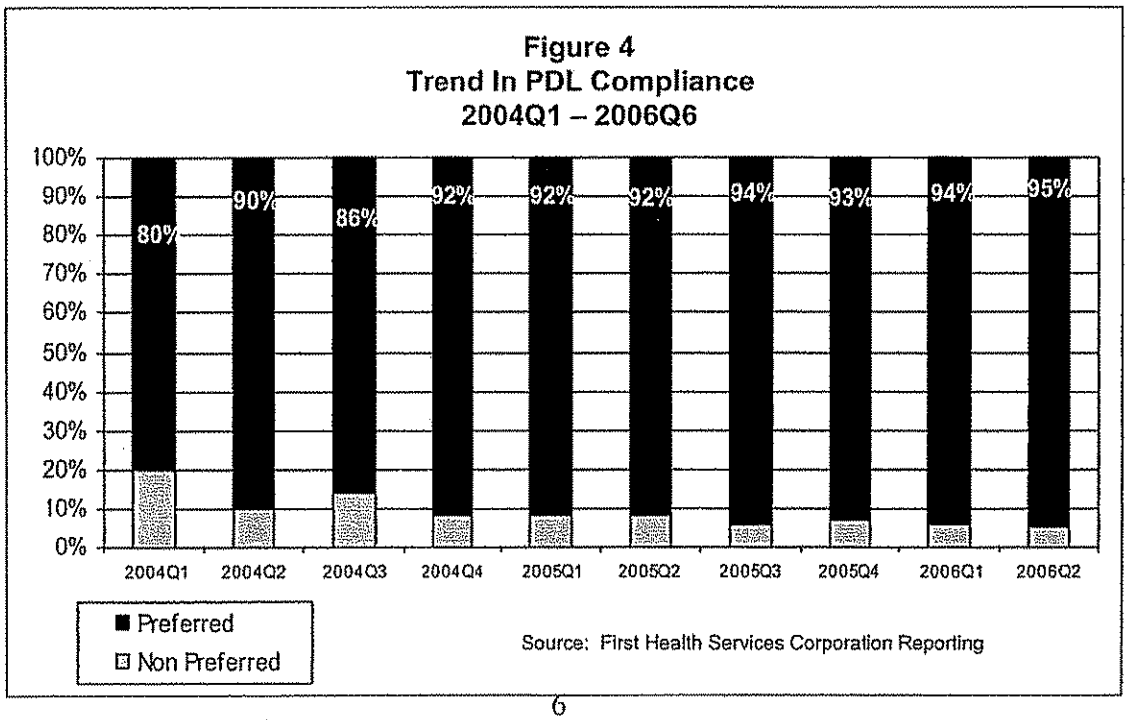
- **Long Acting Narcotics** -- In meetings prior to the implementation of the long acting narcotics drug class, the P&T Committee recommended that recipients who were stabilized on these medications and/or had certain diagnoses (i.e., cancer) be exempt from prior authorization requirements for these drugs; however, the specific length of time for this exemption was not established. With the implementation of long acting narcotics on the PDL in January 2005, more than 7,000 "automatic" prior authorizations were granted to recipients who were stabilized on these drugs and/or had certain diagnoses. The "automatic" prior authorization allowed an override of both the clinical and PDL requirements; therefore, providing full access to these medications without clinical review. The P&T Committee authorized the termination of all remaining automatic prior authorizations for long acting narcotics effective June 30, 2006. All new claims for long acting narcotics require clinical and/or PDL prior authorizations for these recipients. In addition, the Committee reduced the duration of prior authorizations for narcotics from one year to six months to ensure continuous monitoring of the medical necessity for these drugs. Medical providers and recipients received information on this change 30 days prior to implementation and prior authorizations were granted upon request before July 1, 2006 to ensure there was no disruption of service.

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 the second optional year following an initial two year contract period. The current

administrative costs are $1.4 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 following is a summary of call center operational results:

- There have been few complaints and several compliments about the clinical call center and the PDL program, in general. Examples of the few complaints that have been received include service by the DMAS call center, long acting narcotics' prior authorization requirements and the preferred drug options in a few drug classes.
- Call center management and the prior authorization processes are working well as evidenced by an efficient average speed to answer rate (35 seconds), minimal call time (2 minutes and 26 seconds on average), and low call abandonment rate (less than 1%). 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.)
- All 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.
- No Medicaid recipient has been denied access to a drug or a therapeutically equivalent substitution under the PDL program.
- The compliance rate in terms of "preferred" drugs being prescribed for Medicaid recipients remains high, currently at 94.5% 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 the trend in compliance rates in Figure 4.



Supplemental Rebate Contracting Process & Savings Estimates

The PDL was developed with significant cooperation from 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.

The Department has invoiced over $53 million in supplemental rebates since the inception of the PDL program in January 2004. (See Figure 5.) This amount is above the federal rebates also collected for these drugs. Supplemental rebates have declined significantly in recent months because of reduced utilization due to the implementation of Medicare Part D and managed care expansions discussed previously. As of the second quarter of calendar year 2006, total supplemental rebates for 2006 were $5.5 million, which represents a 59% decrease compared to the same period in 2005. The annualized total federal and supplemental rebates anticipated for calendar year 2006 are approximately $84 million, which is a 57% decrease compared to the past year of $194 million. Manufacturers' rebate rates have largely been unchanged; however, the reduced claims volume (i.e., Medicare Part D) has created the significant decrease in supplemental rebates. Due to the many variables in play during FY 2006 (e.g., Medicare Part D, maximum allowable cost program for generic drugs, and other pharmacy cost savings initiatives), it is difficult to pinpoint 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 the program is generating substantial savings for the Commonwealth.

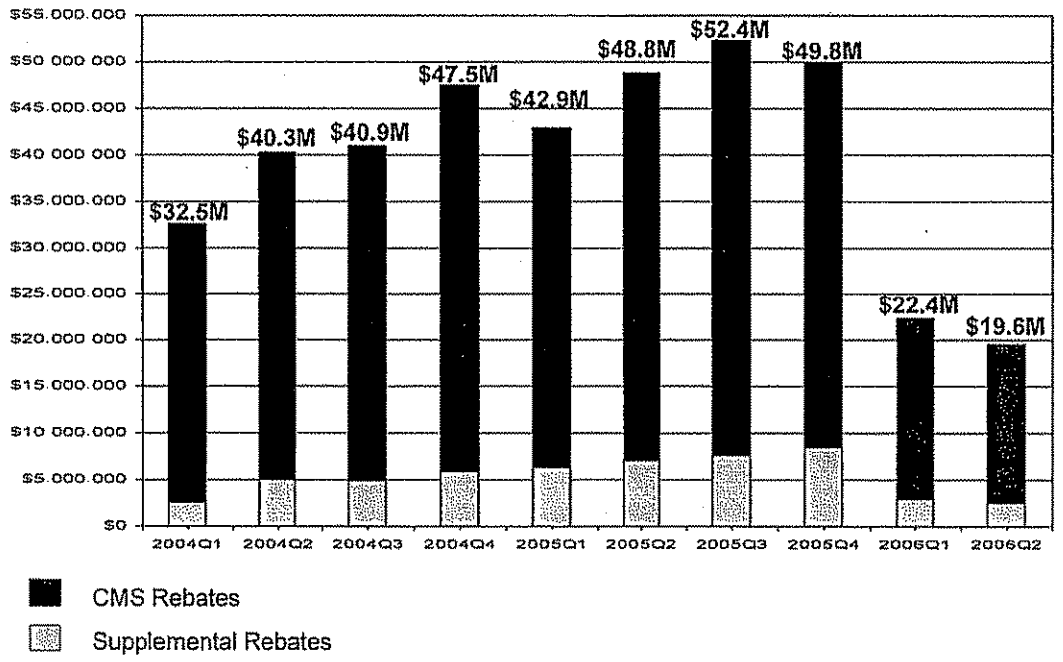
Communications and Public Input

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 and expenditures 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.

Figure 5
Trend in Federal and Supplemental Rebates
(FY 2004-2006)



Source: First Health Services Corporation Rebate Department

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 302 (S)(8) of the 2006 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. The report shall also include an analysis of the impact of the program on patient health including, but not limited to, hospitalizations and emergency outpatient visits.

Attachment B. – P&T Committee Members and Professional Affiliation

NAME	PROFESSION	AFFILIATION
Randy Axelrod, Chairman	Physician	Anthem*
Gill Abernathy	Pharmacist	INOVA Health System
Roy Beveridge	Physician	Fairfax Northern VA Hematology/ Oncology
Avtar Dhillon	Physician	Colonial Services Board
Arthur Garson, Jr.	Physician	UVA School of Medicine
Mariann Johnson	Physician	Family Practice
Mark Oley	Pharmacist	Westwood Pharmacy
James Reinhard	Physician	Virginia Department of Mental Health, Mental Retardation & Substance Abuse Services
Tim Jennings	Pharmacist	Sentara Healthcare
Renita Warren	Pharmacist	Southside Regional Medical Center
Katherine Nichols	Physician/Pharmacist	Virginia Department of Health
Rachel Selby- Penczak	Physician	VCU Health System

* Dr. Axelrod worked for Anthem during most of the past year.

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)
- Cox-2 Inhibitors
- 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

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)
- 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)
- 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, 2006

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

Virginia Medicaid Preferred Drug List

Effective July 1, 2006

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

ANALGESICS

NON-STEROIDAL ANTI-INFLAMMATORY DRUGS

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

*NON-STEROIDAL ANTI-INFLAMMATORY – COX II INHIBITORS***

Celebrex®

*LONG-ACTING NARCOTICS****

Avinza®
Duragesic® (Brand Only)
Morphine Sulfate tablets SA®
Oramorph SR®

ANTIBIOTICS – ANTIINFECTIVES

ORAL ANTIFUNGALS – ONYCHOMYCOSIS

Lamisil®

CEPHALOSPORINS – 2ND GENERATION

Cefaclor ****
Ceftin Suspension®
Cefuroxime
Cefzil® ****
Lorabid® ****
Raniclor®

CEPHALOSPORINS – 3RD GENERATION

Cedax® ****
Omnicef® ****
Spectracef®

MACROLIDES

Biaxin® ****
Erythrocin Stearate
Erythromycin Base
Erythromycin Ethylsuccinate
Erythromycin Estolate Suspension
Erythromycin Stearate
Erythromycin w/Sulfisoxazole
Zithromax® ****

QUINOLONES – 2ND GENERATION

Ciprofloxacin****
Ofloxacin****

QUINOLONES – 3RD GENERATION

Avelox®
Avelox ABC Pack®

ANTIVIRALS

HERPES

Acyclovir****
Famvir®
Valtrex®

INFUENZA

Amantadine ****
Relenza®
Rimantadine
Tamiflu®****

ASTHMA –ALLERGY

ANTIHISTAMINES – 2ND GENERATION

Alavert ®****
Claritin® OTC****
Loratadine OTC****
Claritin- D® OTC
Loratadine- D 12h OTC
Loratadine-D OTC
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®

COPD ANTICHOLINERGICS

Atrovent AER W/ADAP
Atrovent HFA®
Combivent®
Duoneb®
Spiriva®

INHALED CORTICOSTEROIDS

AeroBid®
AeroBid M®
Asmanex®
Azmacort®
Flovent HFA®
Pulmicort Respules®
QVAR®

LEUKOTRIENE INHIBITORS

Accolate®
Singulair®

® = Registered Trade name **Clinical Prior Authorization required ***=Must attempt and fail two Short Acting Narcotics; unless diagnosis requires Long Acting Narcotic as first line

**** Indicates that All available dosage forms made for that product (for example XR, SR, Suspension, Reditabs etc) are covered without a PA. If **** is not indicated and another dosage forms exists, a PA is required.

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

Virginia Medicaid Preferred Drug List

Effective July 1, 2006

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

NASAL STEROIDS
Flonase®
Flunisolide
Nasacort AQ®
Nasonex®

CARDIAC MEDICATIONS

ACE INHIBITORS
Benazepril HCL
Benazepril HCL /HCTZ
Captopril
Captopril /HCTZ
Enalapril
Enalapril /HCTZ
Lisinopril
Lisinopril/HCTZ

ACE INHIBITORS/ CALCIUM CHANNEL BLOCKERS
Lotrel®

ANGIOTENSIN RECEPTOR ANTAGONISTS
Diovan®
Diovan HCT®
Cozaar®
Hyzaar®

BETA BLOCKERS
Acebutolol
Atenolol
Atenolol /Chlorthalidone
Betaxolol
Bisoprolol Fumarate
Bisoprolol /HCTZ
Coreg®
Labetalol
Metoprolol tartrate
Metoprolol/HCT
Nadolol
Pindolol
Propranolol
Propranolol/HCTZ
Sorine®
Sotalol
Sotalol AF
Timolol maleate

CALCIUM CHANNEL BLOCKERS - DIHYDROPYRIDINE
Afeditab CR®
Dynacirc®****
Felodipine ER
Nicardipine
Nifediac CC®
Nifedical XL®
Nifedipine****
Norvasc®
Plendil®
Sular®

CALCIUM CHANNEL BLOCKERS- NON-DIHYDROPYRIDINE
Cartia XT®
Diltia XT®
Diltiazem****
Taztia XT®
Verapamil****

LIPOTROPICS: STATINS
Advicor®
Altoprev®
Lescol®****
Lovastatin®
Pravachol®
Zocor®

LIPOTROPICS: FIBRIC ACID
Antara®
Gemfibrozil®

LIPOTROPICS: NIACIN DERATIVES
Niaspan®
Niacor®

LIPOTROPICS: CAI
Zetia®

PDE-5 INHIBITORS - PULMONARY HYPERTENSION*
Revatio**

CENTRAL NERVOUS SYSTEM

STIMULANTS/ADHD MEDICATIONS
Adderall XR®
Amphetamine Salt Combo
Concerta®
Dextroamphetamine****
Dextrostat®
Focalin****®
Metadate**** ®
Methylin****®
Methylphenidate
Ritalin LA®
Strattera®

SEDATIVE HYPNOTIC
Chloral Hydrate
Estazolam
Flurazepam
Restoril® 7.5 mg (until generic available)
Temazepam
Triazolam

OTHER SEDATIVE HYPNOTIC
No preferred products at this time

ORAL HYPOGLYCEMICS ALPHAGLUCOSIDASE INH.
Glyset®
Precose®

ORAL HYPOGLYCEMICS BIGUANIDES
Metformin****

ORAL HYPOGLYCEMICS -BIGUANIDE COMBINATIONS
Actoplus Met®
Avandamet®
Glyburide–Metformin
Glipizide–Metformin

® = Registered Trade name **Clinical Prior Authorization required ***=Must attempt and fail two Short Acting Narcotics; unless diagnosis requires Long Acting Narcotic as first line

**** Indicates that All available dosage forms made for that product (for example XR, SR, Suspension, Reditabs etc) are covered without a PA. If **** is not indicated and another dosage forms exists, a PA is required.

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Fax: 1-800-932-6651

ORAL HYPOGLYCEMICS – MEGLITINIDES
Starlix®

ORAL HYPOGLYCEMICS 2ND GENERATION SULFONYLUREAS
Glimepiride
Glipizide****
Glyburide****

ORAL HYPOGLYCEMICS-THIAZOLIDINEDIONES
Actos®
Avandia®

GASTROINTESTINAL

HISTAMINE-2 RECEPTOR ANTAGONISTS (H-2RA)
Ranitidine
Famotidine
Zantac® Syrup (No PA req. For ONLY under age 12)

PROTON PUMP INHIBITORS
Prilosec® OTC
Protonix®
Omeprazole (No PA req. ONLY for under age 12)
Prevacid Caps® (No PA req. ONLY for under age 12)
Prevacid Susp® (No PA req. ONLY for under age 12)

GENITOURINARY

URINARY ANTISPASMODICS
Detrol LA ®
Ditropan XL ®
Enablex®
Oxybutynin
Oxytrol®
Sanctura®
VESIcare®

OPHTHALMIC

ANTIBIOTIC- QUINOLONES
Ciprofloxacin drops
Ofloxacin drops
Quixin®
Vigamox®
Zymar®

ANTIHISTAMINES
Elestat®
Optivar®
Patanol®
Zaditor®

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®
Carteolol HCl
Levobunolol HCl
Metipranolol
Timolol Maleate****

GLAUCOMA – CARBONIC ANHYDRASE INHIBITORS
Azopt®
Cosopt®
Trusopt®

GLAUCOMA – PROSTAGLANDIN ANALOGS
Lumigan®
Travatan®
Xalatan®

MAST CELL STABLIZERS
Alamast®
Alocril®
Alomide®
Cromolyn

OSTEOPOROSIS

BISPHOSPHONATES
Actonel®
Fosamax® ****
Fosamax Plus D®

MISCELLANEOUS

ELECTROLYTE DEPLETERS
Fosrenol®
Phoslo®
Renagel®

SEROTONIN RECEPTOR AGONISTS (Triptans)
Imitrex® ****
Maxalt®
Maxalt-MLT®

TOPICAL IMMUNOMODULATORS*
Elidel® **
Protopic® **

Phone Numbers for DMAS PDL Program

First Health Clinical Call Center
Prior Authorization (PA) Requests

Fax: 1-800-932-6651
Phone: 1-800-932-6648

NOTE: Fax requests are responded to within 24 hours. For urgent requests, please call.

NOTE: Not all medications listed are covered by all DMAS programs. Check individual program coverage.

For program drug coverage information, go to www.dmas.virginia.gov or http://virginia.fhsc.com.

® = Registered Trade name **Clinical Prior Authorization required ***=Must attempt and fail two Short Acting Narcotics; unless diagnosis requires Long Acting Narcotic as first line

**** Indicates that All available dosage forms made for that product (for example XR, SR, Suspension, Reditabs etc) are covered without a PA. If **** is not indicated and another dosage forms exists, a PA is required.