DUR Board Meeting
March 1, 2017
Heritage Center
Lecture Rooms A & B

North Dakota Medicaid
DUR Board Meeting Agenda
Heritage Center
Lecture Rooms A & B
State Capitol
612 East Boulevard Avenue
Bismarck, ND
March 1, 2017
1pm

1. Administrative items
    - Travel vouchers

2. Old business
    - Review and approval of 12/16 meeting minutes
    - Budget update
    - Review top 15 therapeutic categories/top 25 drugs
    - Second review of prednisolone ODT, Millepred, Veripred
    - Second review of metformin OSM
    - Second review of testosterone oral
    - Review of 2016 DUR projects
    - Prior authorization/PDL update

3. New business
    - Criteria recommendations
    - Upcoming meeting date/agenda

4. Adjourn

Please remember to silence all cellular phones during the meeting.

Drug Utilization Review (DUR) Meeting Minutes

December 7, 2016

Members Present: Tanya Schmidt, Laura Schield, Russ Sobotta, Peter Woodrow, Andrea Honeyman, Michael Booth, LeNeika Roehrich

Members Absent: Katie Kram, Wendy Brown, Jeffrey Hostetter, Carlotta McCleary, Gaylord Kavlie, Zach Marty, James Carlson, Michael Quast

Medicaid Pharmacy Department: Brendan Joyce, Alexi Murphy, Gary Betting

Old Business

P. Woodrow served as Chair in the absence of W. Brown, and called the meeting to order at 1:00 p.m. Chair P. Woodrow asked for a motion to approve the minutes of the September meeting. L. Roehrich moved that the minutes be approved and G. Betting seconded the motion. Chair P. Woodrow called for a voice vote to approve the minutes. The motion passed with no audible dissent.

Second Reviews

A motion and second was made at the September meeting to place Namenda XR, Dihydroergotamine, Tetracycline, Spiriva Respimat 2.5 mcg, ophthalmic corticosteroids, and erythropoiesis-stimulating agents on prior authorization. The topics were brought up for a second review. The motion to place Namenda XR, Dihydroergotamine, Tetracycline, Spiriva Respimat 2.5 mcg, ophthalmic corticosteroids, and erythropoiesis-stimulating agents on prior authorization passed with no audible dissent.

PDL Update

B. Joyce shared with the Board all of the recommended PDL changes since the last 2016 version of the PDL posted. R. Troxell, representing Novartis, inquired about the criteria used to determine PDL status. R. Troxell also inquired about timeframe to address/discuss changes with DUR Board members before implementation in January. B. Joyce responded to questions.

Annual Prior Authorization Review of Forms and Criteria

The Board reviewed all forms and criteria that have previously been placed on prior authorization. Kelly Spielman, representing Merck, presented product information regarding Belsomra. B. Joyce spoke regarding an email from K. Kram asking if the narcotic/APAP form was still needed. B. Joyce said that the request would be reviewed. No changes were recommended during the review of the forms and criteria.

New Business

Synagis

B. Joyce shared with the Board the decision to move the handling of Synagis prior authorizations and claims over to the Medical management, therefore Synagis will not be covered under Pharmacy management.

Narcan Nasal Spray

B. Joyce shared with the Board the decision to not require Prior Authorization for the first (initial) fill of Narcan Nasal Sprays. Subsequent fills will require a prior authorization, but not initial.

Hepatitis C Update

A. Murphy reviewed changes in Hepatitis C criteria and updated Board members on utilization of treatments Medicaid covered this year.

Prednisolone non-solid oral dosage forms

B. Joyce reviewed prednisolone non-solid oral dosage forms (i.e., solution/ODT) with the Board. A motion was made by L. Roehrich to manage the class through prior authorization. The motion was seconded by P. Woodrow. This topic will be reviewed at the next meeting.

Metformin OSM

B. Joyce reviewed metformin OSM with the Board. A motion was made by T. Schmidt to manage the class through prior authorization. The motion was seconded by M. Booth. This topic will be reviewed at the next meeting.

Oral Testosterone

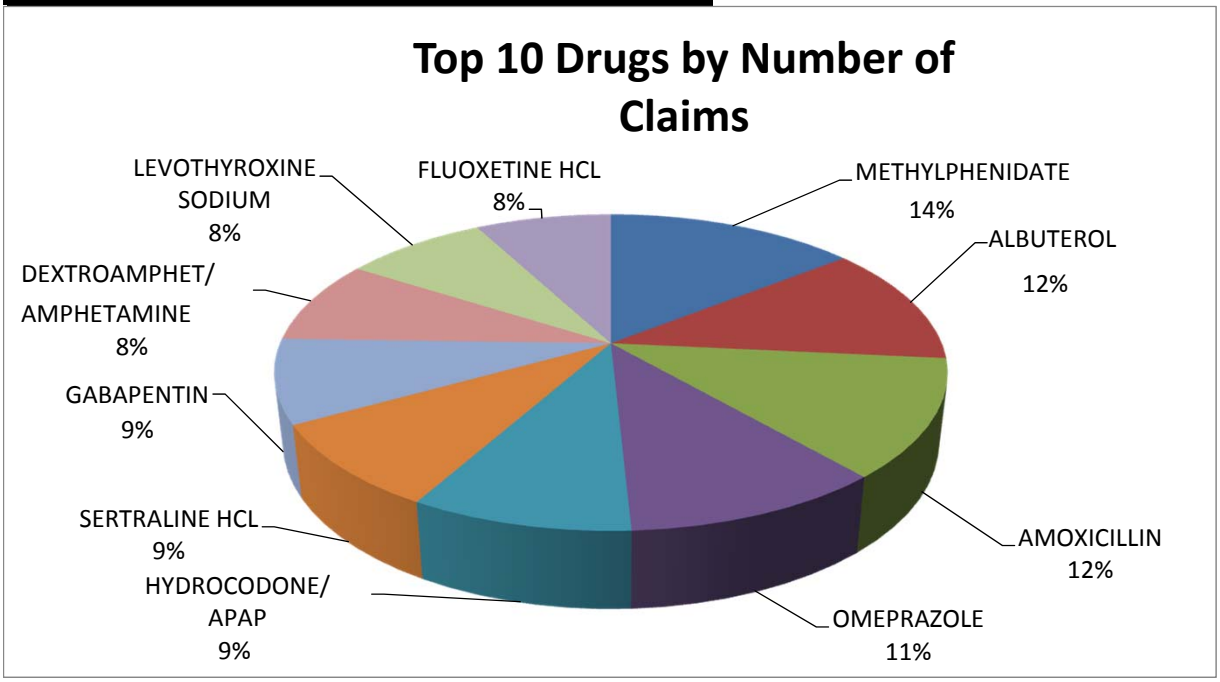
B. Joyce reviewed oral testosterone with the Board. A motion was made by L. Schield to manage the class through prior authorization. The motion was seconded by L. Roehrich. This topic will be reviewed at the next meeting.

Criteria Recommendations

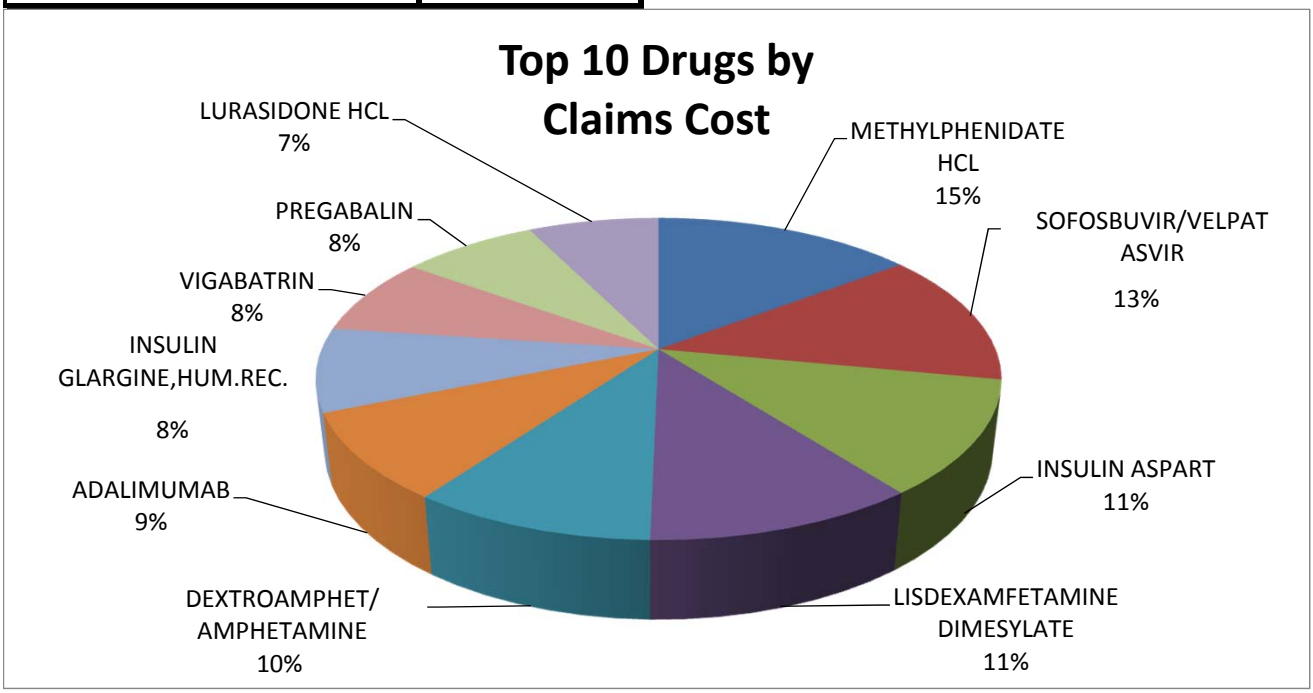
The recommended RDUR criteria enclosed in the packet were developed from product information provided by the manufacturers and are usually consistent with new indications, new drugs added, and new warnings. These proposed criteria will be added to the current set of criteria and will be used in future DUR cycles. M. Booth moved to approve the new criteria and A. Honeyman seconded the motion. P. Woodrow called for a voice vote. The motion passed with no audible dissent.

The next DUR Board meeting will be held March 1, 2017 at the Heritage Center in Bismarck. P. Woodrow made a motion to adjourn the meeting. M. Booth seconded. The motion passed with no audible dissent. P. Woodrow adjourned the meeting.

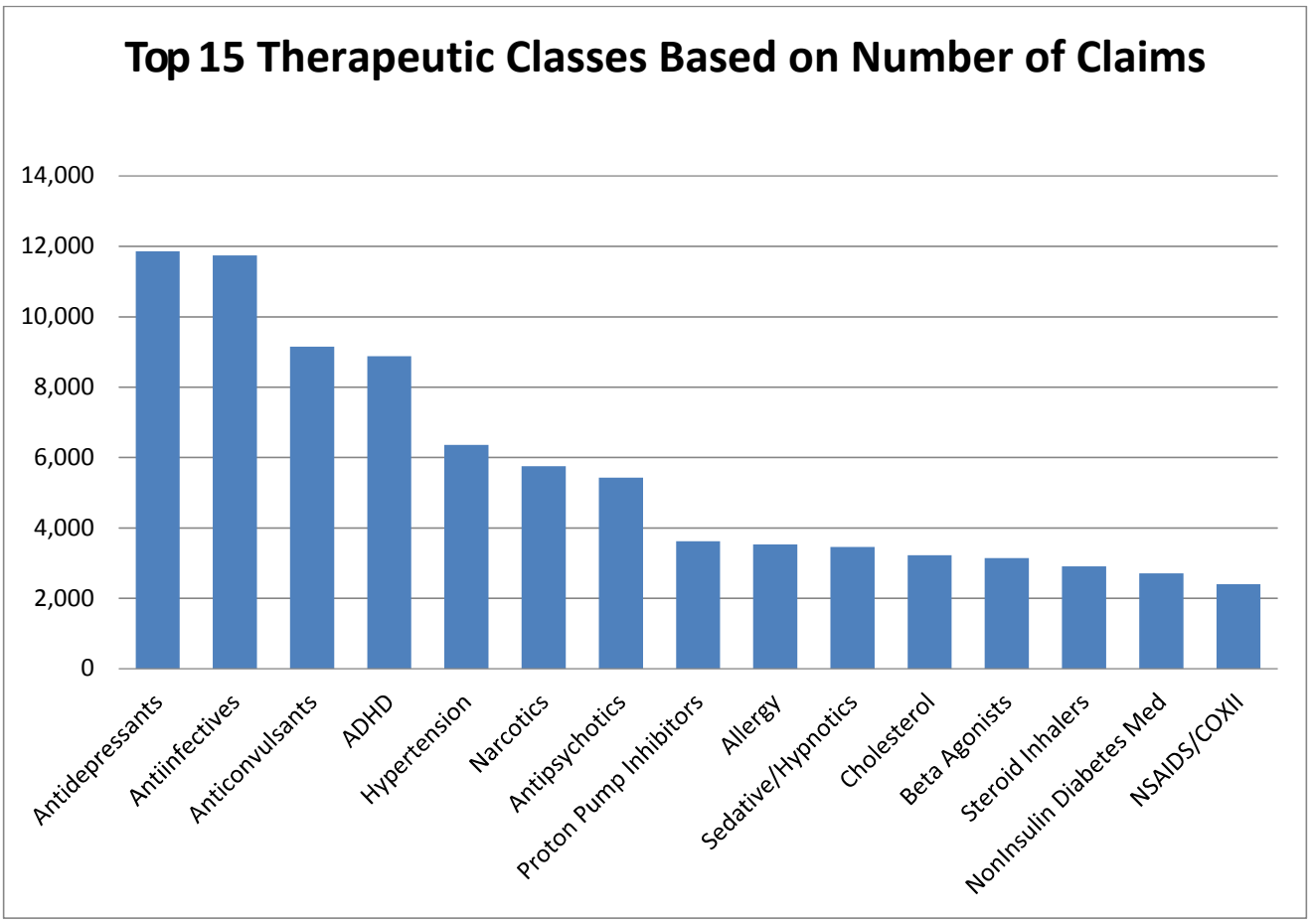
Top 25 Drugs Based on Number of Claims					
10/01/2016 - 12/31/2016					
Drug	Therapeutic Class	Rx	Paid	Paid/Rx	% Total Claims
METHYLPHENIDATE HCL	ADHD	3,542	$383,270.94	$108.21	2.74%
ALBUTEROL SULFATE	Beta Agonists	3,004	$158,586.55	$52.79	2.32%
AMOXICILLIN	Antiinfectives	2,972	$42,588.64	$14.33	2.30%
OMEPRAZOLE	Proton Pump Inhibitors	2,622	$38,207.47	$14.57	2.03%
HYDROCODONE/ACETAMINOPHEN	Narcotics	2,220	$43,249.57	$19.48	1.72%
SERTRALINE HCL	Antidepressants	2,152	$26,256.82	$12.20	1.66%
GABAPENTIN	Anticonvulsants	2,115	$37,049.44	$17.52	1.64%
DEXTROAMPHETAMINE/AMPHETAMINE	ADHD	2,106	$253,183.38	$120.22	1.63%
LEVOTHYROXINE SODIUM	Other	2,021	$38,829.78	$19.21	1.56%
FLUOXETINE HCL	Antidepressants	1,927	$23,646.09	$12.27	1.49%
MONTELUKAST SODIUM	Leukotriene Inhibitors	1,875	$36,091.35	$19.25	1.45%
AZITHROMYCIN	Antiinfectives	1,732	$33,747.80	$19.48	1.34%
TRAZODONE HCL	Other	1,724	$22,707.70	$13.17	1.33%
METFORMIN HCL	NonInsulin Diabetes Me	1,701	$22,544.44	$13.25	1.32%
LISINOPRIL	Hypertension	1,697	$19,691.45	$11.60	1.31%
ATORVASTATIN CALCIUM	Cholesterol	1,631	$23,604.76	$14.47	1.26%
BUPROPION HCL	Antidepressants	1,463	$33,790.86	$23.10	1.13%
LISDEXAMFETAMINE DIMESYLATE	ADHD	1,459	$283,360.08	$194.22	1.13%
QUETIAPINE FUMARATE	Antipsychotics	1,435	$89,542.21	$62.40	1.11%
CLONIDINE HCL	Other	1,429	$17,323.60	$12.12	1.10%
ESCITALOPRAM OXALATE	Antidepressants	1,411	$20,685.68	$14.66	1.09%
ASPIRIN	Other	1,304	$7,816.03	$5.99	1.01%
AMOXICILLIN/POTASSIUM CLAV	Antiinfectives	1,295	$30,387.65	$23.47	1.00%
RISPERIDONE	Antipsychotics	1,205	$17,244.43	$14.31	0.93%
LAMOTRIGINE	Anticonvulsants	1,166	$29,075.15	$24.94	0.90%
Total Top 25		47,208	$1,732,481.87	$36.70	36.50%
Total Claims 10/01/2016 - 12/31/2016	129,335				



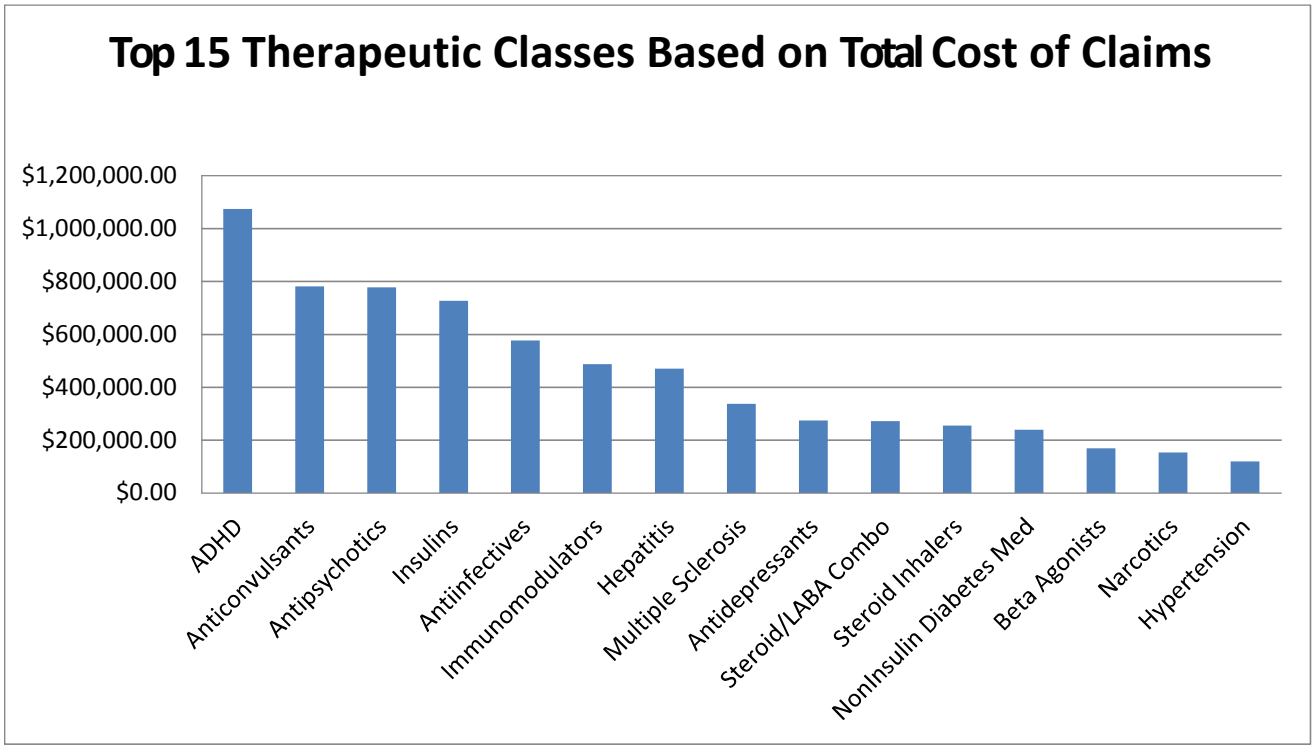
Top 25 Drugs Based on Claims Cost					
10/01/2016 - 12/31/2016					
Drug	Therapeutic Class	Rx	Paid	Paid/Rx	% Total Claims
METHYLPHENIDATE HCL	ADHD	3,542	$383,270.94	$108.21	2.74%
SOFOSBUVIR/VELPATASVIR	Hepatitis	14	$347,625.92	$24,830.42	0.01%
INSULIN ASPART	Insulins	585	$298,602.49	$510.43	0.45%
LISDEXAMFETAMINE DIMESYLATE	ADHD	1,459	$283,360.08	$194.22	1.13%
DEXTROAMPHETAMINE/AMPHETAMINE	ADHD	2,106	$253,183.38	$120.22	1.63%
ADALIMUMAB	Immunomodulators	52	$227,818.19	$4,381.12	0.04%
INSULIN GLARGINE,HUM.REC.ANLOG	Insulins	536	$219,009.72	$408.60	0.41%
VIGABATRIN	Anticonvulsants	13	$203,061.47	$15,620.11	0.01%
PREGABALIN	Anticonvulsants	554	$200,204.93	$361.38	0.43%
LURASIDONE HCL	Antipsychotics	201	$192,568.18	$958.05	0.16%
ALBUTEROL SULFATE	Beta Agonists	3,004	$158,586.55	$52.79	2.32%
FLUTICASONE/SALMETEROL	Steroid/LABA Combo	486	$153,003.38	$314.82	0.38%
BUDESONIDE	Steroid Inhalers	404	$141,023.35	$349.07	0.31%
PALIPERIDONE PALMITATE	Antipsychotics	63	$139,424.05	$2,213.08	0.05%
BLOOD SUGAR DIAGNOSTIC	Other	982	$139,243.81	$141.80	0.76%
ETANERCEPT	Immunomodulators	40	$138,923.16	$3,473.08	0.03%
GLATIRAMER ACETATE	Multiple Sclerosis	22	$134,605.69	$6,118.44	0.02%
ARIPIPRAZOLE	Antipsychotics	1,094	$125,203.98	$114.45	0.85%
LEDIPASVIR/SOFOSBUVIR	Hepatitis	4	$121,902.22	$30,475.56	0.00%
INSULIN DETEMIR	Insulins	245	$107,012.78	$436.79	0.19%
DEXMETHYLPHENIDATE HCL	ADHD	599	$105,548.81	$176.21	0.46%
QUETIAPINE FUMARATE	Antipsychotics	1,435	$89,542.21	$62.40	1.11%
TIOTROPIUM BROMIDE	Other	311	$88,081.42	$283.22	0.24%
SOMATROPIN	Growth Hormone	32	$79,813.36	$2,494.17	0.02%
USTEKINUMAB	Immunomodulators	6	$77,087.57	$12,847.93	0.00%
Total Top 25		17,789	$4,407,707.64	$247.78	13.75%
Total Claims 10/01/2016 - 12/31/2016	129,335				



Top 15 Therapeutic Classes Based on Number of Claims				
10/01/2016 - 12/31/2016				
Therapeutic Class	Rx	Paid	Paid/Rx	% Total Claims
Antidepressants	11,862	$273,907.36	$23.09	9.17%
Antiinfectives	11,738	$576,074.10	$49.08	9.08%
Anticonvulsants	9,143	$780,780.17	$85.40	7.07%
ADHD	8,879	$1,073,620.15	$120.92	6.87%
Hypertension	6,359	$118,784.25	$18.68	4.92%
Narcotics	5,748	$153,298.08	$26.67	4.44%
Antipsychotics	5,428	$777,562.55	$143.25	4.20%
Proton Pump Inhibitors	3,622	$64,718.80	$17.87	2.80%
Allergy	3,527	$50,119.89	$14.21	2.73%
Sedative/Hypnotics	3,457	$53,605.47	$15.51	2.67%
Cholesterol	3,220	$77,272.90	$24.00	2.49%
Beta Agonists	3,140	$168,823.24	$53.77	2.43%
Steroid Inhalers	2,908	$254,999.41	$87.69	2.25%
NonInsulin Diabetes Med	2,709	$238,879.66	$88.18	2.09%
NSAIDS/COXII	2,399	$38,514.34	$16.05	1.85%
Total Top 25	84139	$4,700,960.37	$52.29	65.06%
Total Claims 10/01/2016 - 12/31/2016	129,335			



Top 15 Therapeutic Classes Based on Claims Cost				
10/01/2016 - 12/31/2016				
Therapeutic Class	Rx	Paid	Paid/Rx	% Total Claims
ADHD	8879	$1,073,620.15	$120.92	6.87%
Anticonvulsants	9143	$780,780.17	$85.40	7.07%
Antipsychotics	5428	$777,562.55	$143.25	4.20%
Insulins	1522	$726,623.21	$477.41	1.18%
Antiinfectives	11738	$576,074.10	$49.08	9.08%
Immunomodulators	107	$487,620.33	$4,557.20	0.08%
Hepatitis	18	$469,528.14	$26,084.90	0.01%
Multiple Sclerosis	56	$336,917.23	$6,016.38	0.04%
Antidepressants	11862	$273,907.36	$23.09	9.17%
Steroid/LABA Combo	933	$271,485.72	$290.98	0.72%
Steroid Inhalers	2908	$254,999.41	$87.69	2.25%
NonInsulin Diabetes Med	2709	$238,879.66	$88.18	2.09%
Beta Agonists	3140	$168,823.24	$53.77	2.43%
Narcotics	5748	$153,298.08	$26.67	4.44%
Hypertension	6359	$118,784.25	$18.68	4.92%
Total Top 25	70550	$6,708,903.60	$2,541.57	54.55%
Total Claims 10/01/2016 - 12/31/2016	129,335			



PREDNISOLONE NON-SOLID ORAL DOSAGE FORMS
PA FORM

health information designs

Prior Authorization Vendor for ND Medicaid

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

ND Medicaid requires that patients receiving a new prescription for brand prednisolone non-solid oral dosage forms must meet the following criteria:

- **Patient must first try generic prednisolone.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:	**Please list all medications patient has tried:** **Please give reason why patient cannot take generic prednisolone:**		
Prescriber (or Staff) / Pharmacy Signature		Date	

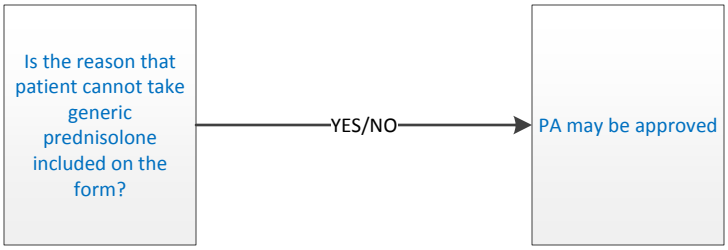
Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

Part III: FOR OFFICIAL USE ONLY

Date Received:	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
Prednisolone Non-Solid Oral Dosage Forms
Authorization Algorithm



GLUMETZA
PA FORM

health information designs

Prior Authorization Vendor for ND Medicaid

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

ND Medicaid requires that patients receiving a new prescription for Glumetza must meet the following criteria:

- **Patient must first try 3 months of metformin ER.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:	**Please list all medications patient has tried:**		
Prescriber (or Staff) / Pharmacy Signature		Date	

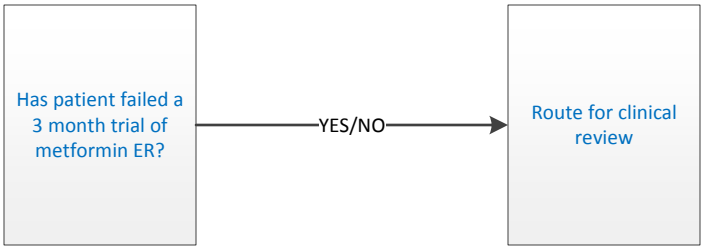
Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

Part III: FOR OFFICIAL USE ONLY

Date Received:	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
Glumetza Authorization Algorithm



ORAL TESTOSTERONE
PA FORM

health information designs

Prior Authorization Vendor for ND Medicaid

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

ND Medicaid requires that patients receiving a new prescription for oral testosterone must meet the following criteria:

- **Patient must first try a topical testosterone product.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:	**Please list all medications patient has tried:** **Please include reason why patient cannot use a topical testosterone product:**		
Prescriber (or Staff) / Pharmacy Signature		Date	

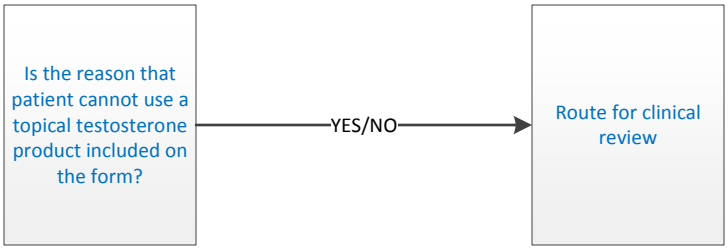
Part II: TO BE COMPLETED BY PHARMACY

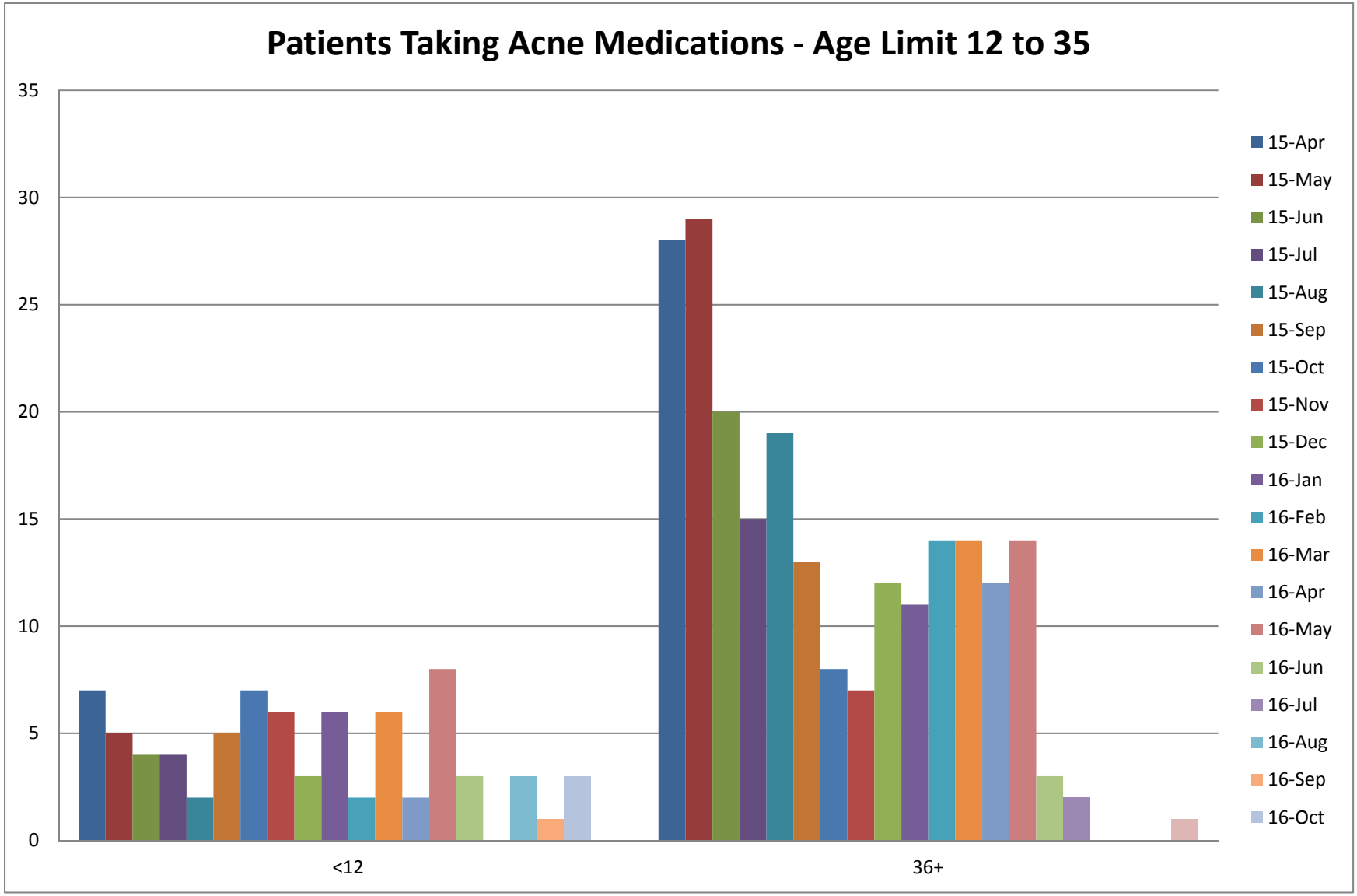
PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

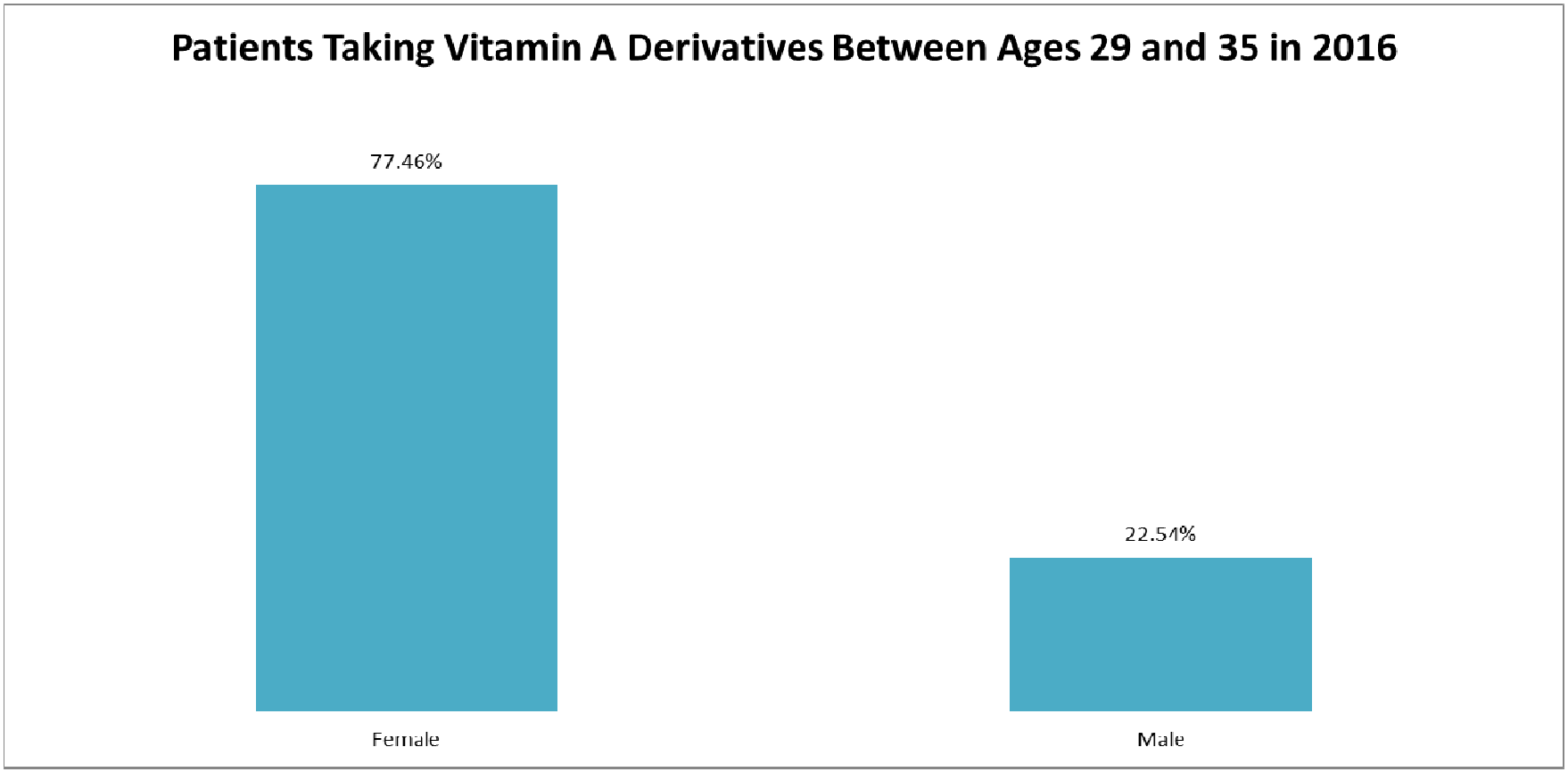
Part III: FOR OFFICIAL USE ONLY

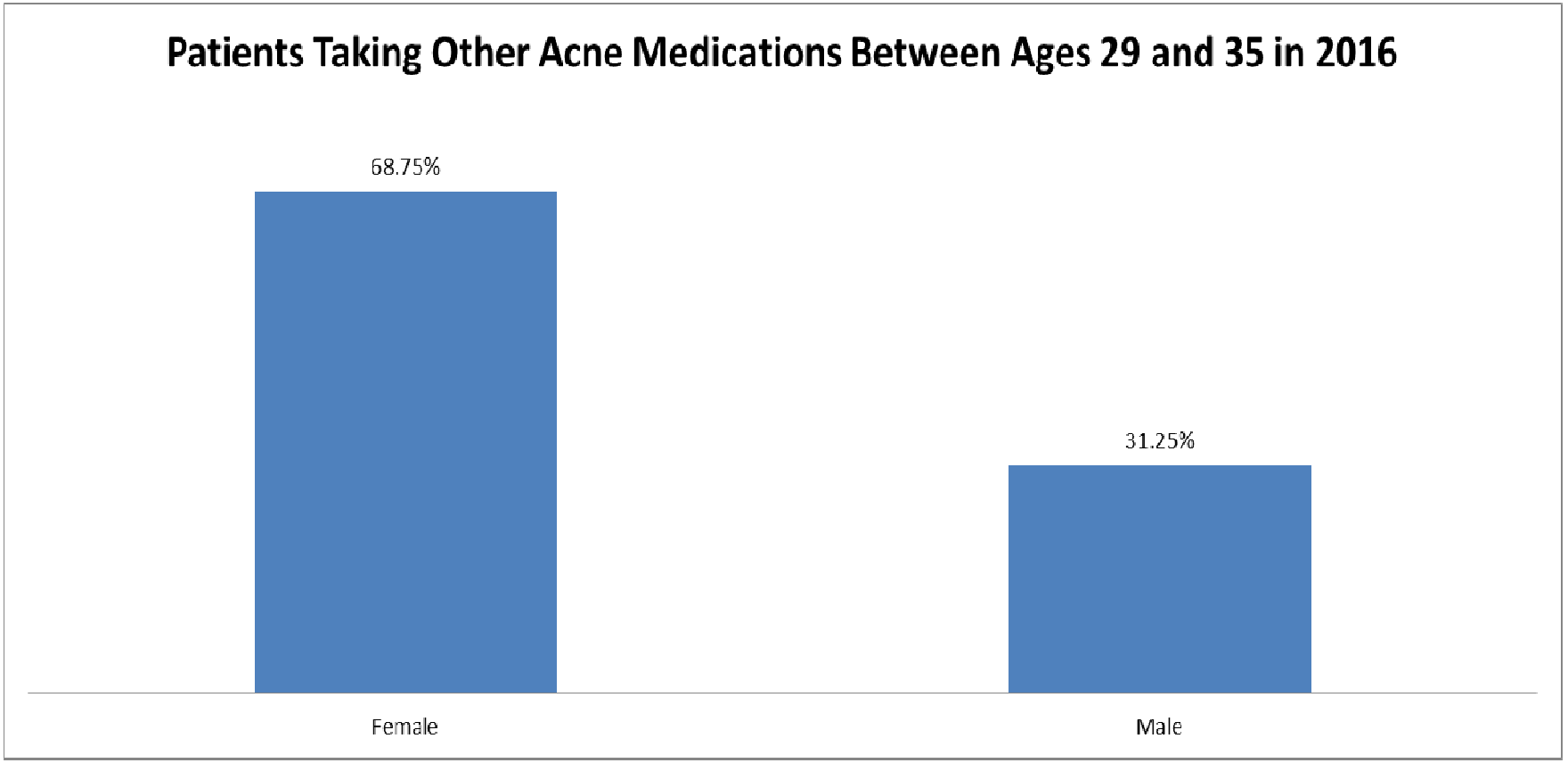
Date Received:	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	

North Dakota Department of Human Services
Oral Testosterone Authorization Algorithm

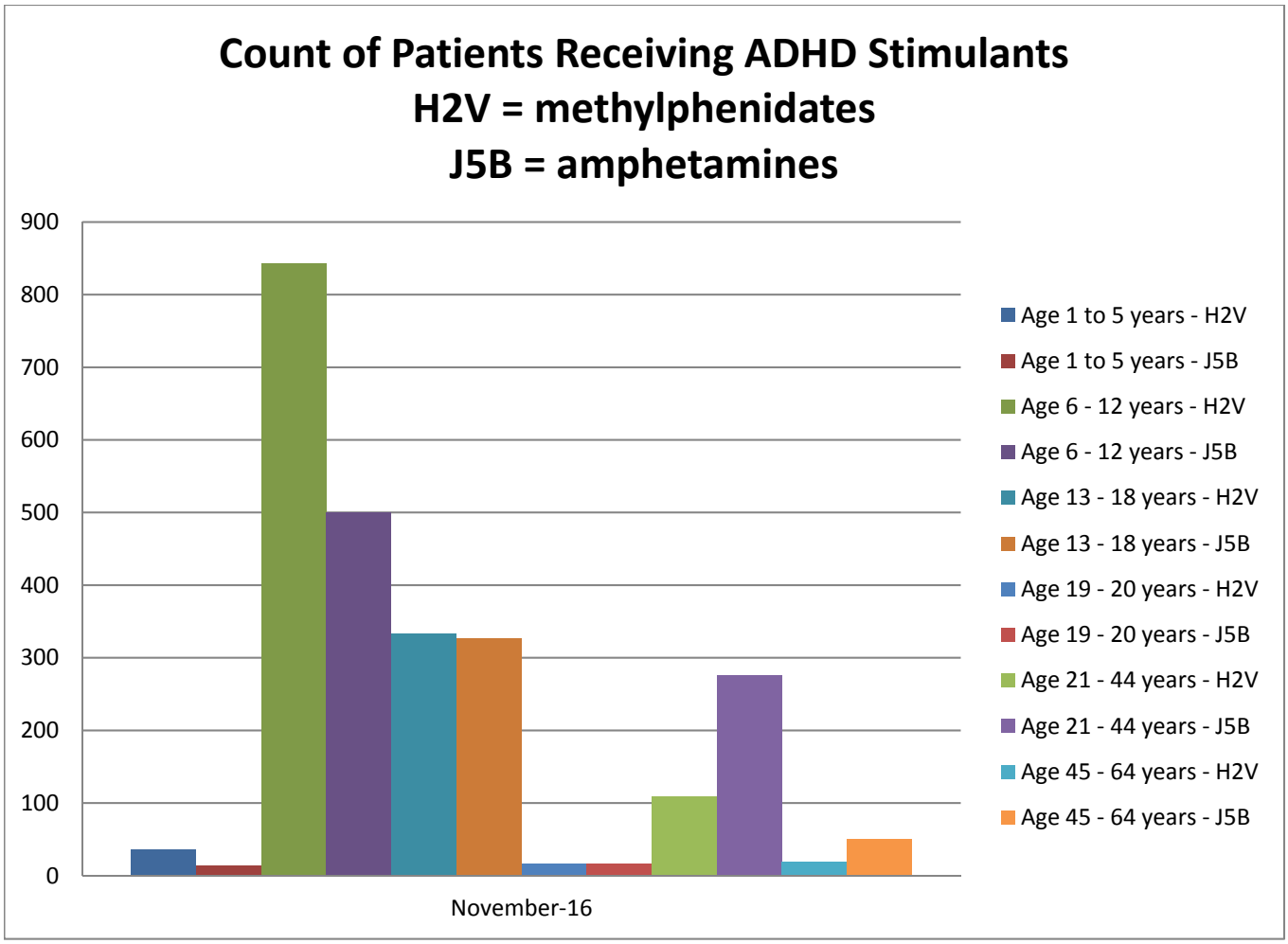


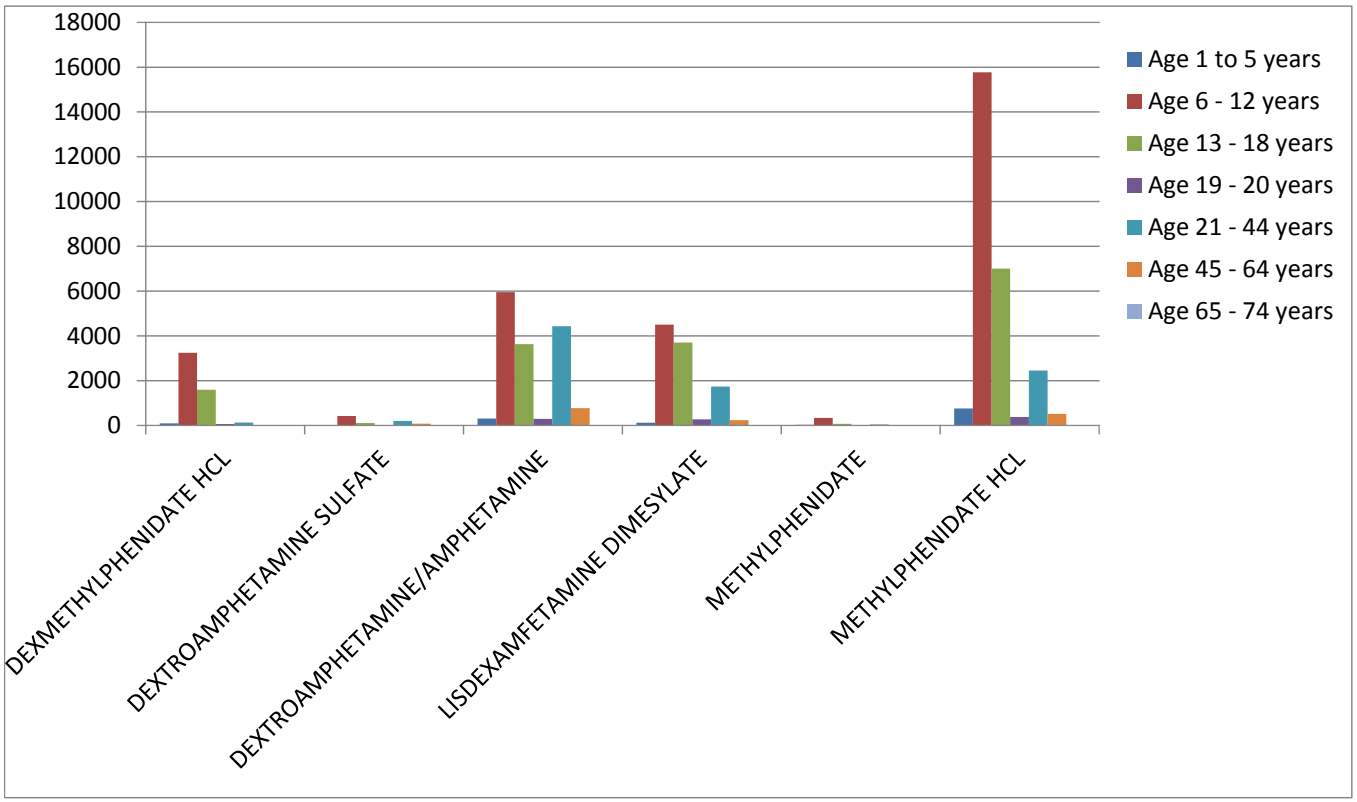

Patients Taking Acne Medications - Age Limit 12 to 35
35
30
25
20
15
10
5
0
<12
36+
15-Apr
15-May
15-Jun
15-Jul
15-Aug
15-Sep
15-Oct
15-Nov
15-Dec
16-Jan
16-Feb
16-Mar
16-Apr
16-May
16-Jun
16-Jul
16-Aug
16-Sep
16-Oct

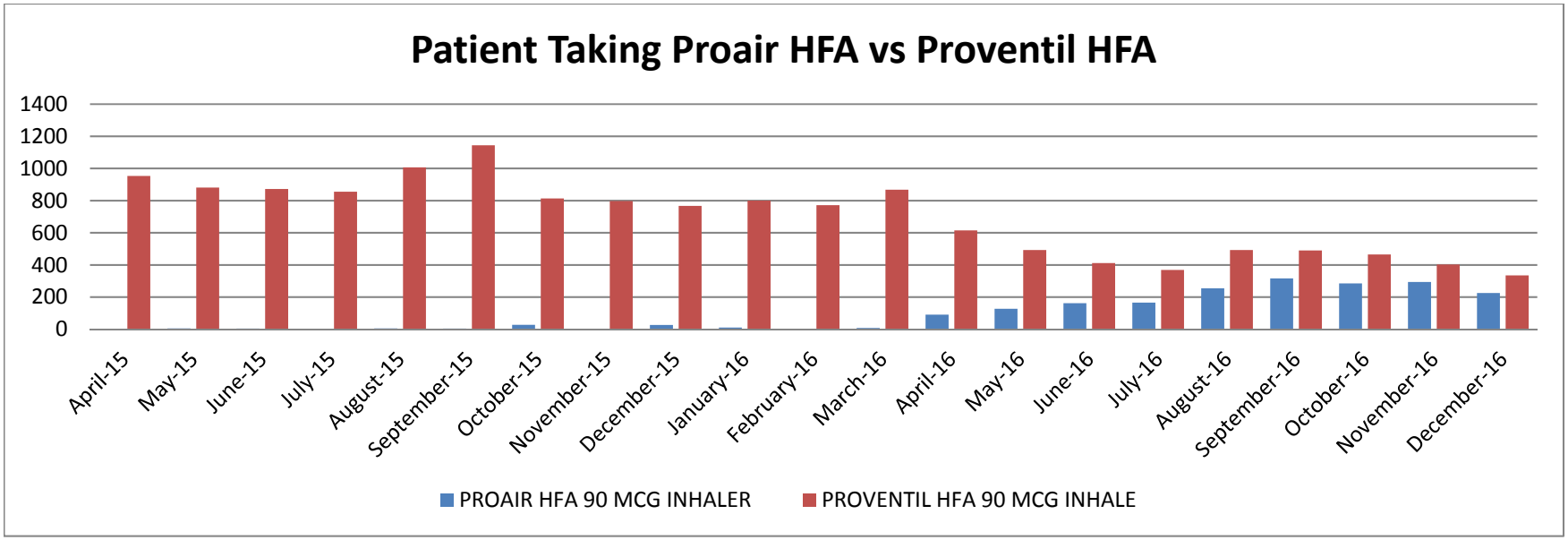

Patients Taking Vitamin A Derivatives Between Ages 29 and 35 in 2016
77.46%
22.54%
Female
Male

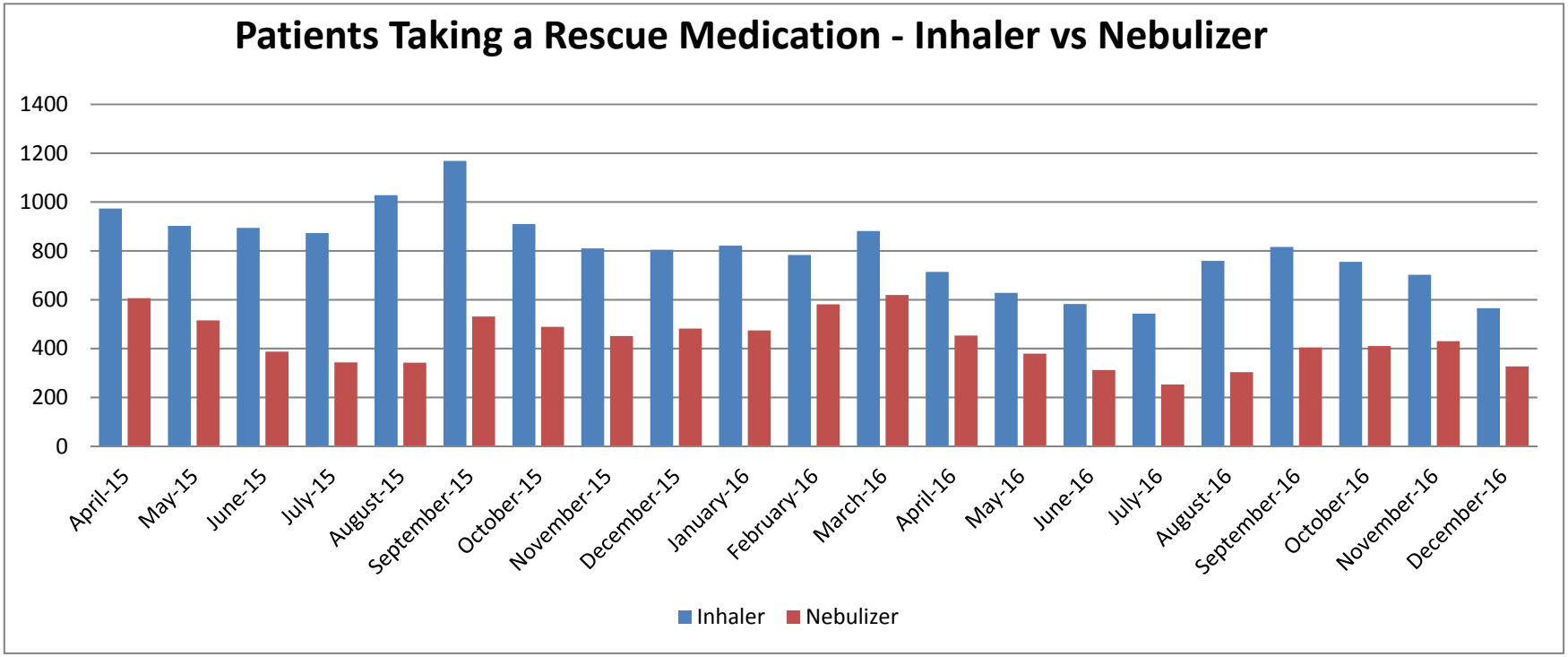


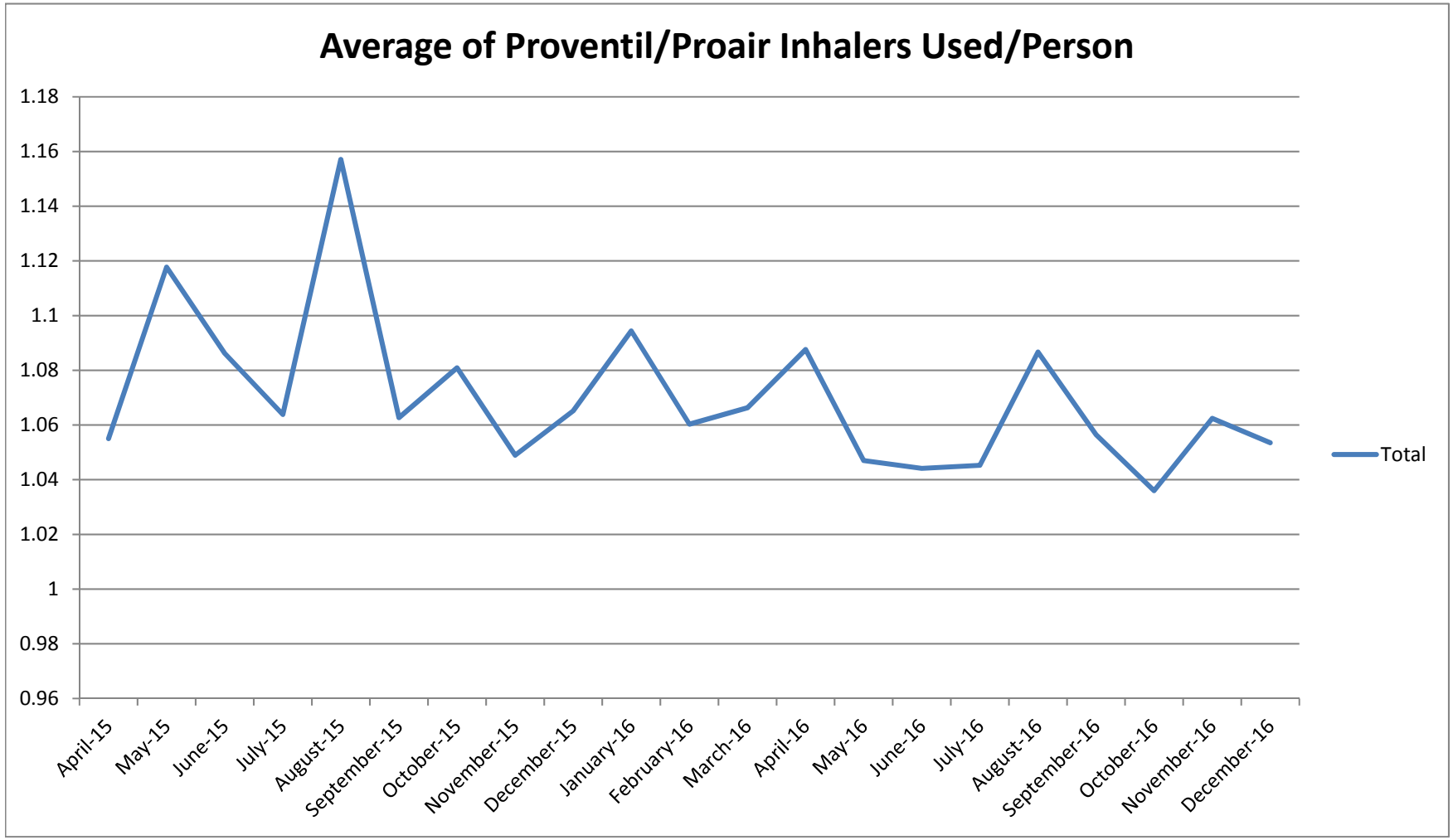
Age edit May-16

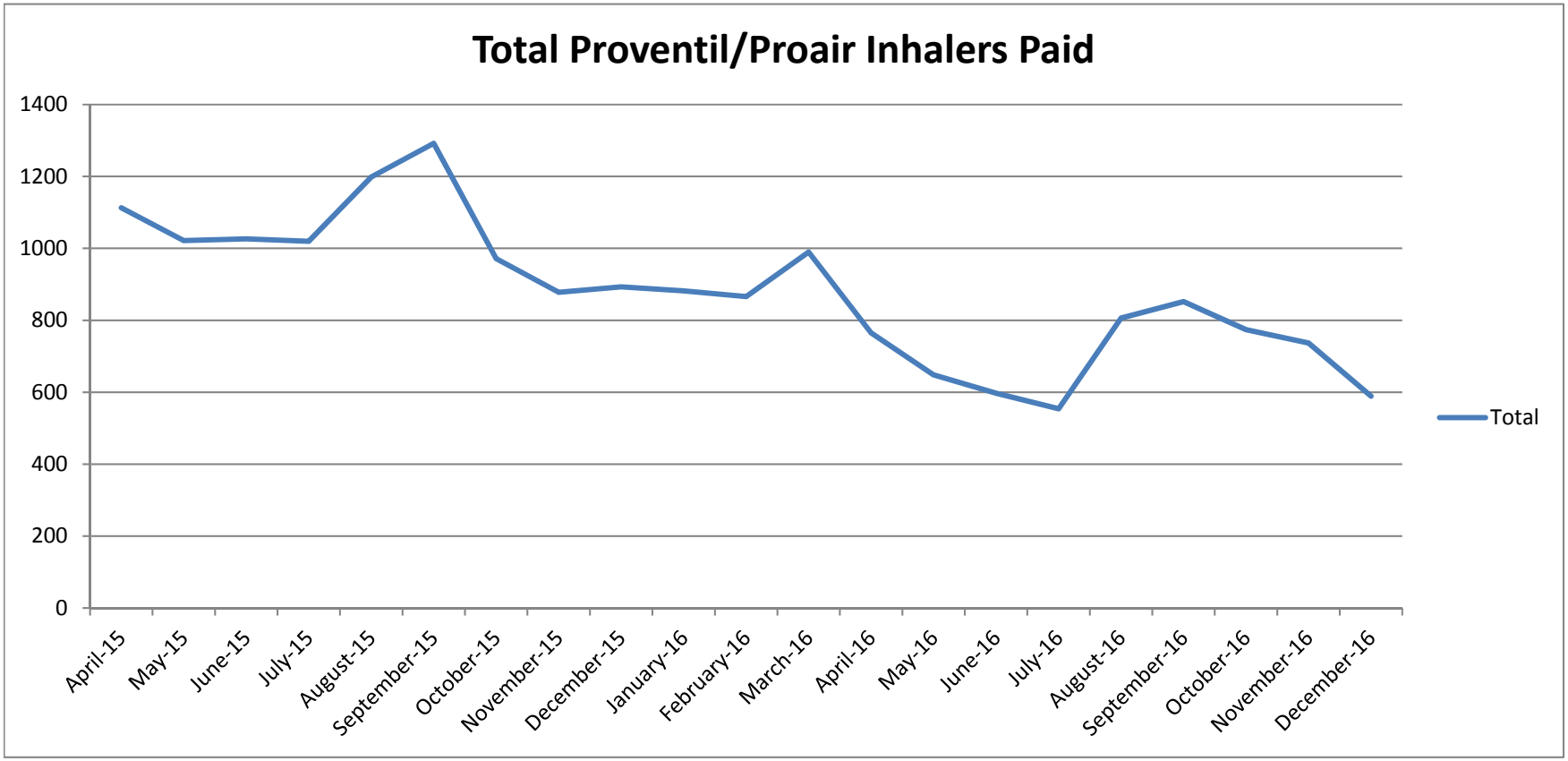

Count of Patients Receiving ADHD Stimulants
H2V = methylphenidates
J5B = amphetamines
900
800
700
600
500
400
300
200
100
0
November-16
Age 1 to 5 years - H2V
Age 1 to 5 years - J5B
Age 6 - 12 years - H2V
Age 6 - 12 years - J5B
Age 13 - 18 years - H2V
Age 13 - 18 years - J5B
Age 19 - 20 years - H2V
Age 19 - 20 years - J5B
Age 21 - 44 years - H2V
Age 21 - 44 years - J5B
Age 45 - 64 years - H2V
Age 45 - 64 years - J5B


18000
16000
14000
12000
10000
8000
6000
4000
2000
0
DEXMETHYLPHENIDATE HCL
DEXTROAMPHETAMINE SULFATE
DEXTROAMPHETAMINE/AMPHETAMINE
LISDEXAMFETAMINE DIMESYLATE
METHYLPHENIDATE
METHYLPHENIDATE HCL
Age 1 to 5 years
Age 6 - 12 years
Age 13 - 18 years
Age 19 - 20 years
Age 21 - 44 years
Age 45 - 64 years
Age 65 - 74 years

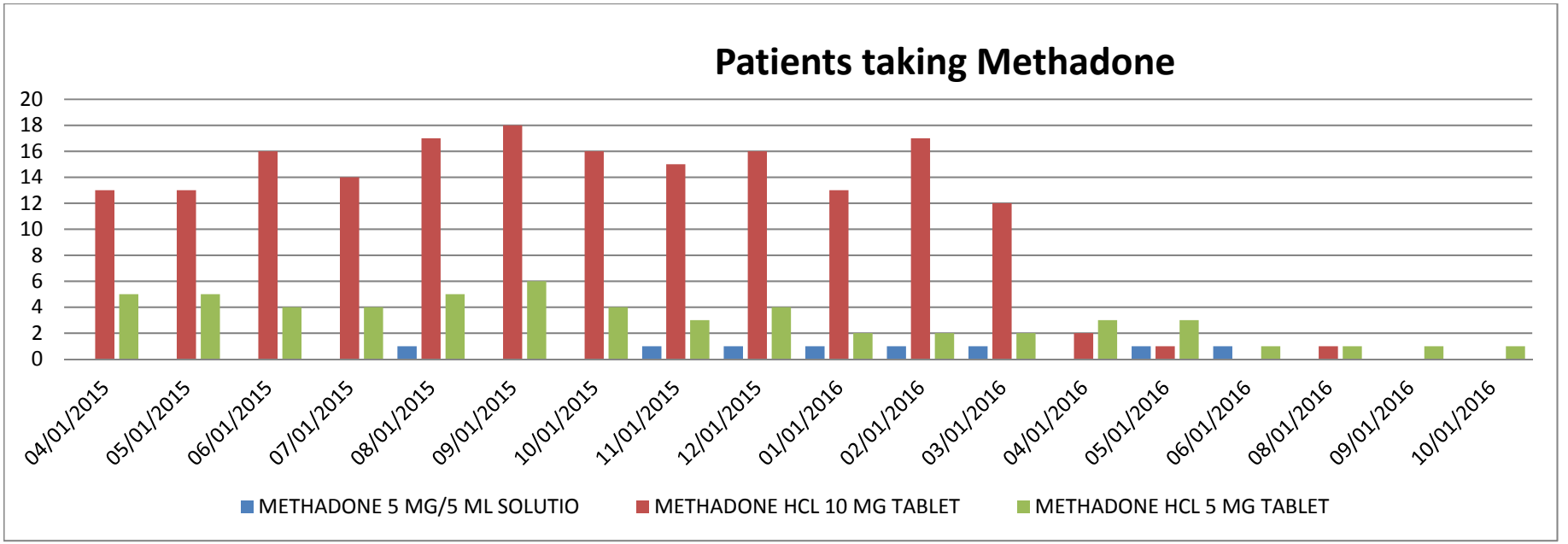

Patient Taking Proair HFA vs Proventil HFA
1400
1200
1000
800
600
400
200
0
April-15
May-15
June-15
July-15
August-15
September-15
October-15
November-15
December-15
January-16
February-16
March-16
April-16
May-16
June-16
July-16
August-16
September-16
October-16
November-16
December-16
PROAIR HFA 90 MCG INHALER
PROVENTIL HFA 90 MCG INHALE

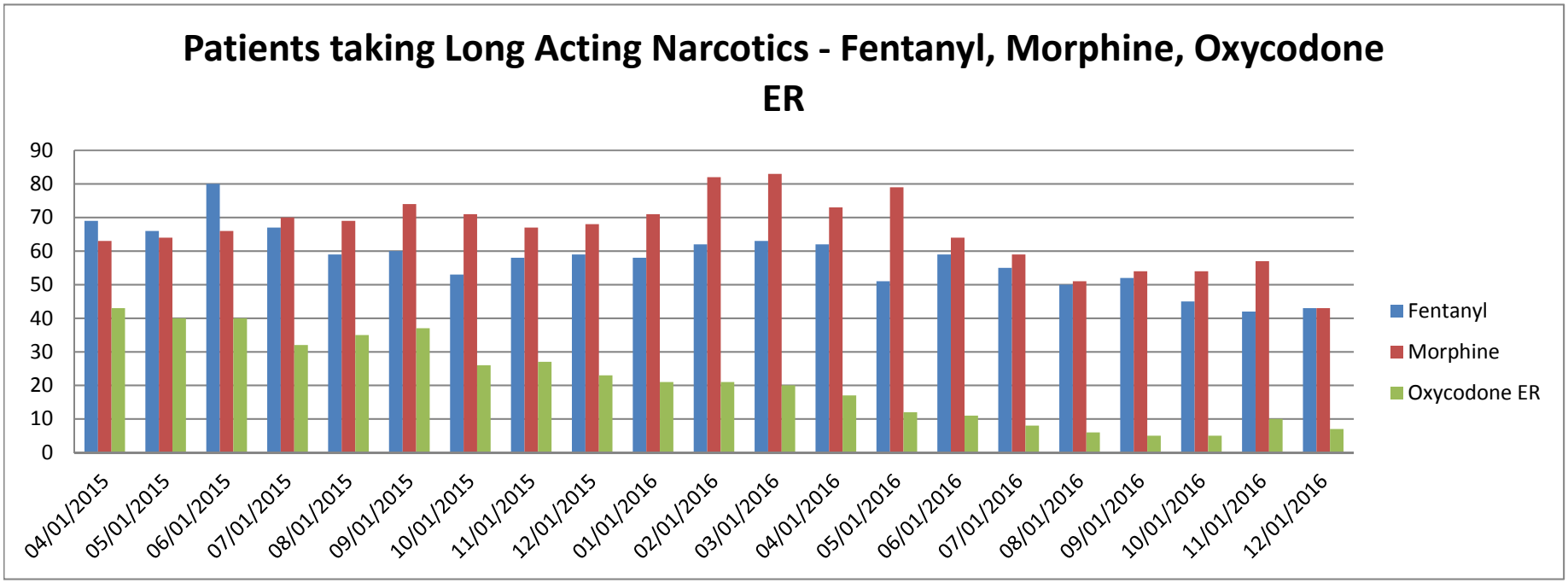

Patients Taking a Rescue Medication - Inhaler vs Nebulizer
1400
1200
1000
800
600
400
200
0
April-15
May-15
June-15
July-15
August-15
September-15
October-15
November-15
December-15
January-16
February-16
March-16
April-16
May-16
June-16
July-16
August-16
September-16
October-16
November-16
December-16
Inhaler
Nebulizer

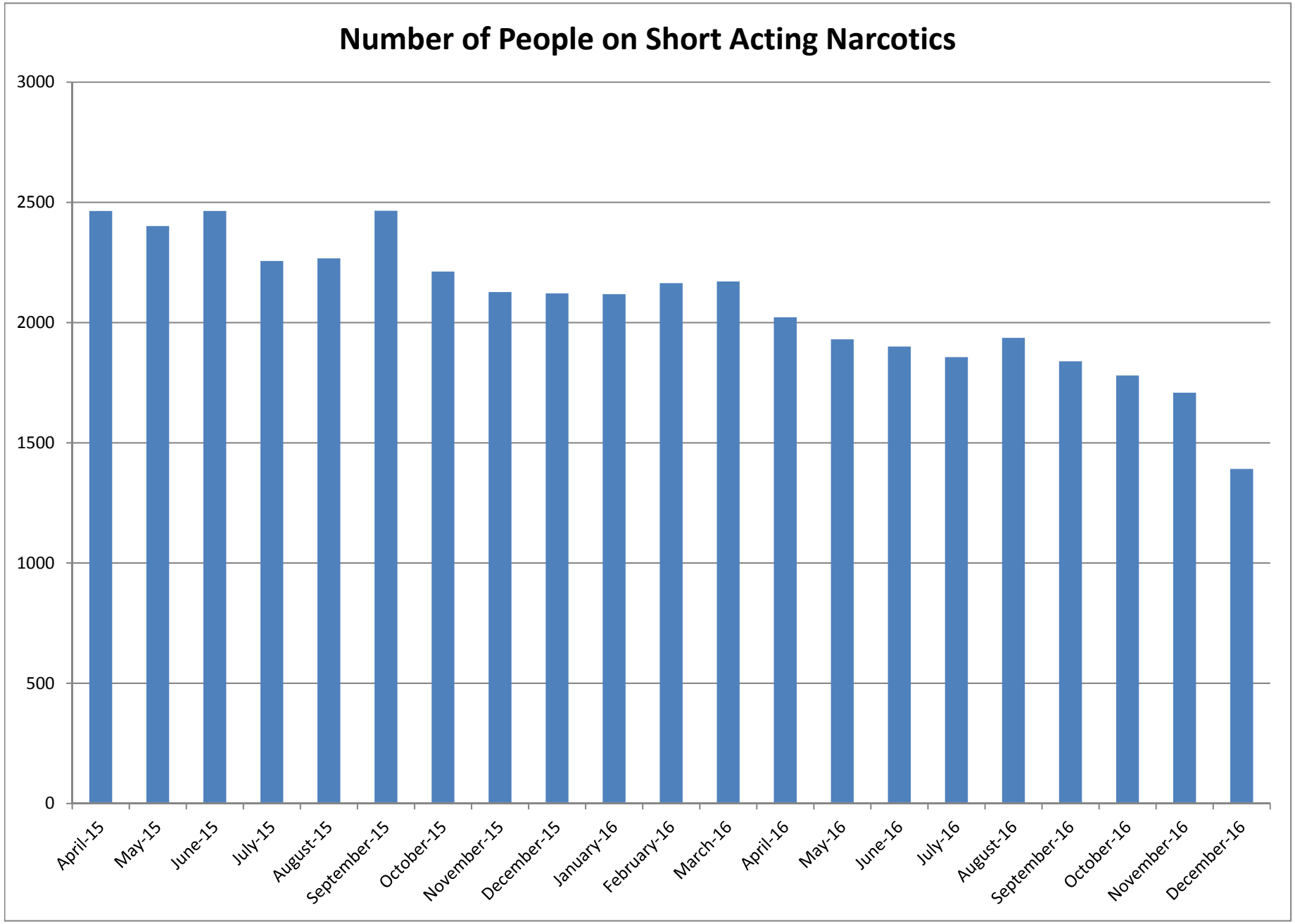

Average of Proventil/Proair Inhalers Used/Person
1.18
1.16
1.14
1.12
1.1
1.08
1.06
1.04
1.02
1
0.98
0.96
April-15
May-15
June-15
July-15
August-15
September-15
October-15
November-15
December-15
January-16
February-16
March-16
April-16
May-16
June-16
July-16
August-16
September-16
October-16
November-16
December-16
Total

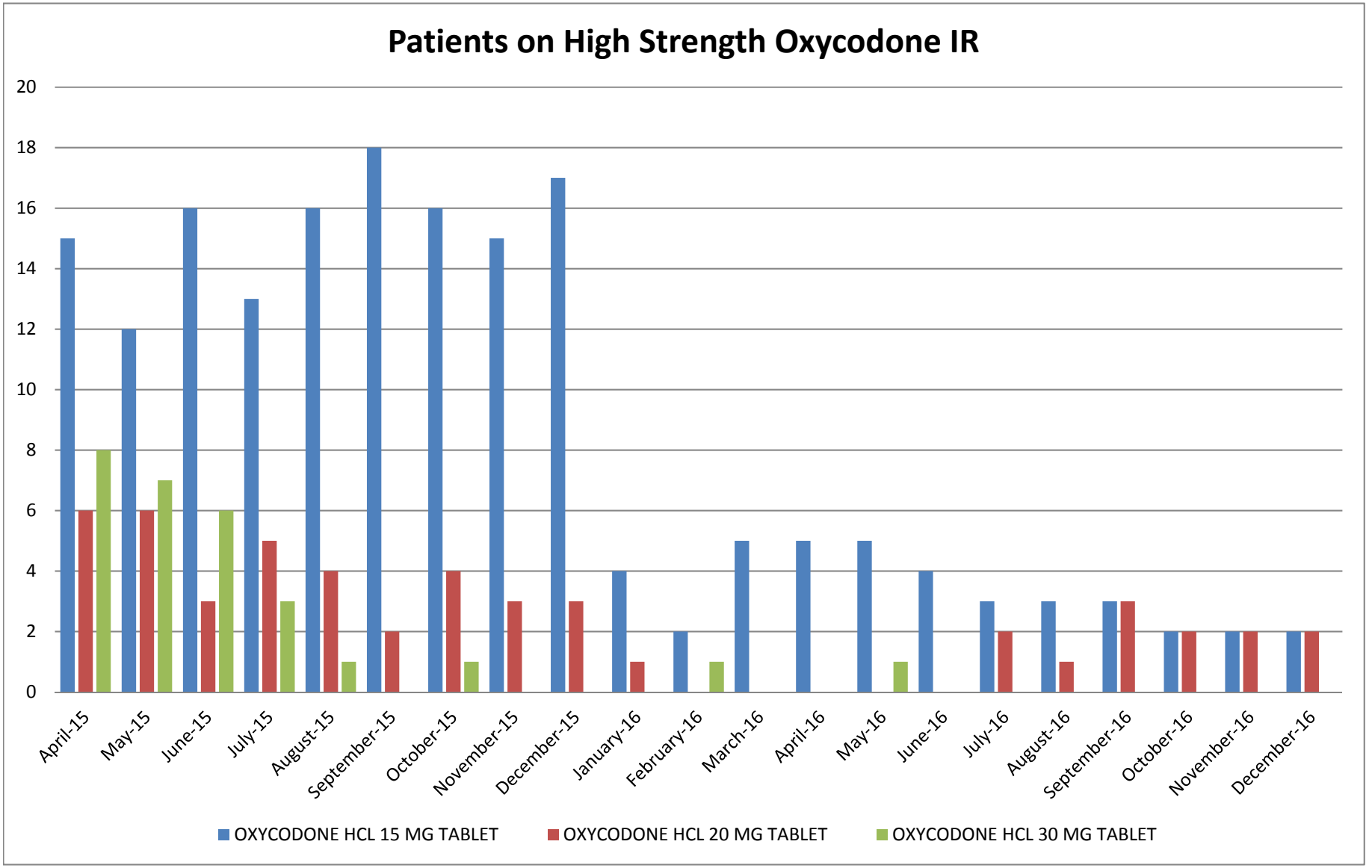


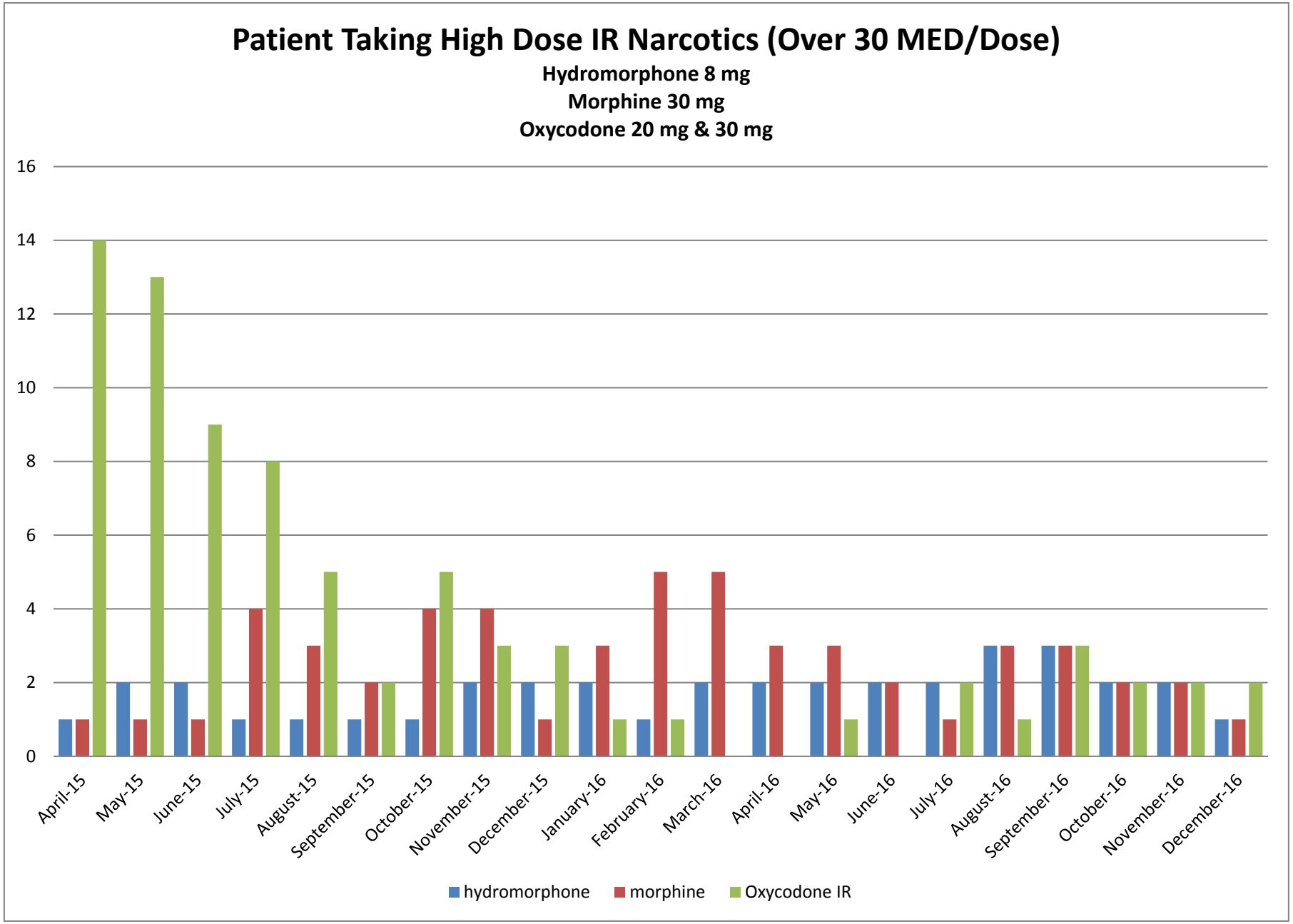
DUR & Edit put in April 2016


Patients taking Methadone
20
18
16
14
12
10
8
6
4
2
0
04/01/2015
05/01/2015
06/01/2015
07/01/2015
08/01/2015
09/01/2015
10/01/2015
11/01/2015
12/01/2015
01/01/2016
02/01/2016
03/01/2016
04/01/2016
05/01/2016
06/01/2016
08/01/2016
09/01/2016
10/01/2016
METHADONE 5 MG/5 ML SOLUTIO
METHADONE HCL 10 MG TABLET
METHADONE HCL 5 MG TABLET

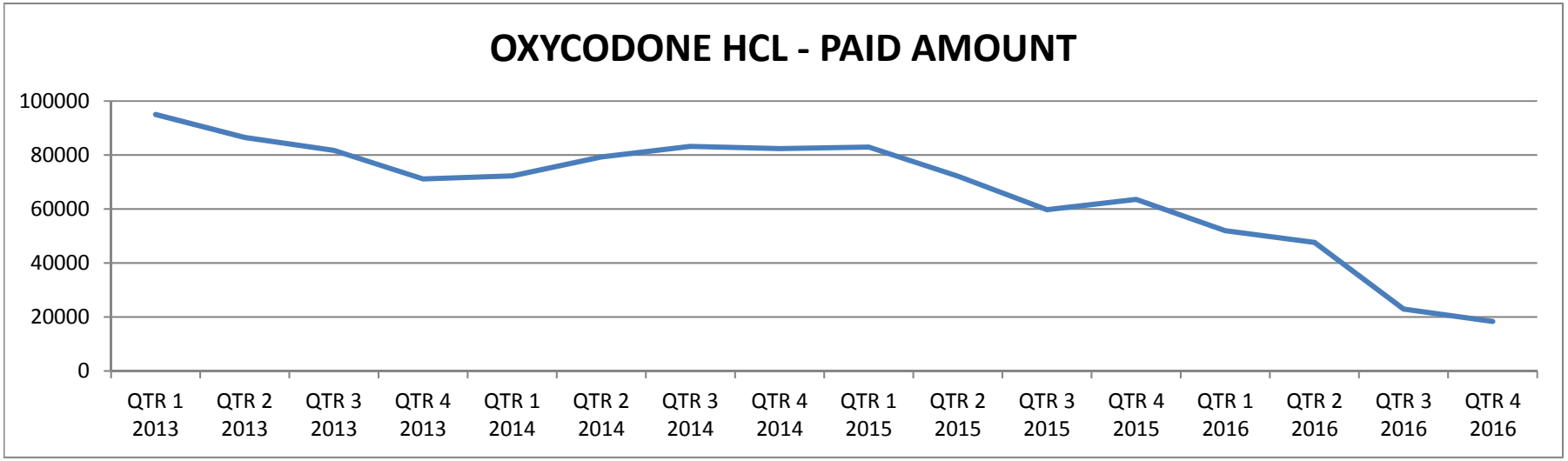

Patients taking Long Acting Narcotics - Fentanyl, Morphine, Oxycodone ER
90
80
70
60
50
40
30
20
10
0
04/01/2015
05/01/2015
06/01/2015
07/01/2015
08/01/2015
09/01/2015
10/01/2015
11/01/2015
12/01/2015
01/01/2016
02/01/2016
03/01/2016
04/01/2016
05/01/2016
06/01/2016
07/01/2016
08/01/2016
09/01/2016
10/01/2016
11/01/2016
12/01/2016
Fentanyl
Morphine
Oxycodone ER

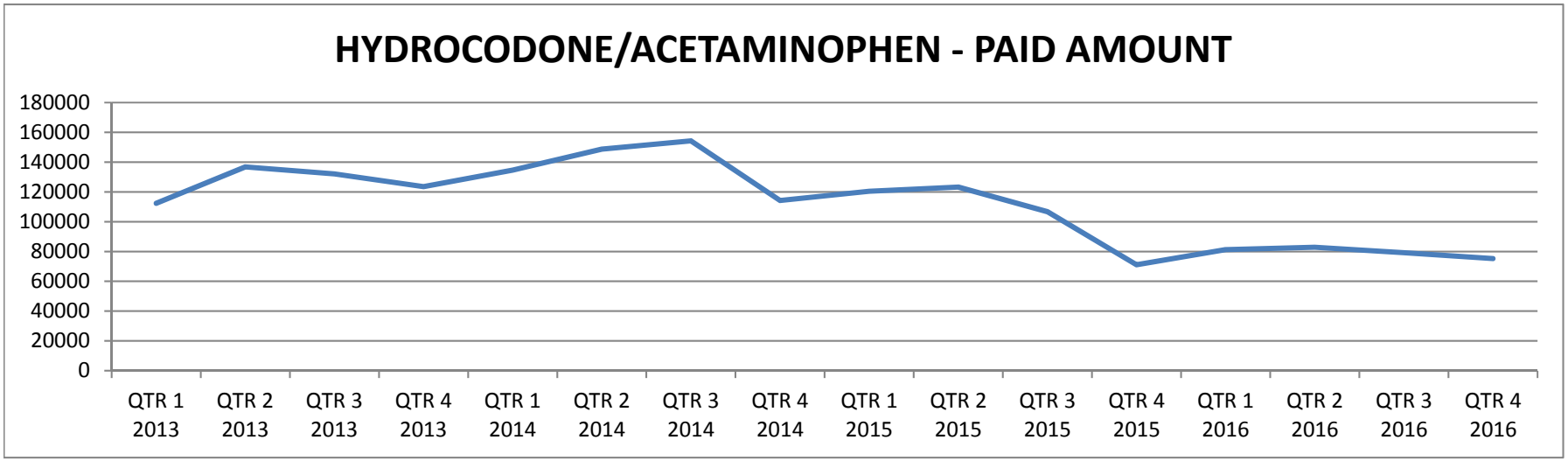

Number of People on Short Acting Narcotics
3000
2500
2000
1500
1000
500
0
April-15
May-15
June-15
July-15
August-15
September-15
October-15
November-15
December-15
January-16
February-16
March-16
April-16
May-16
June-16
July-16
August-16
September-16
October-16
November-16
December-16

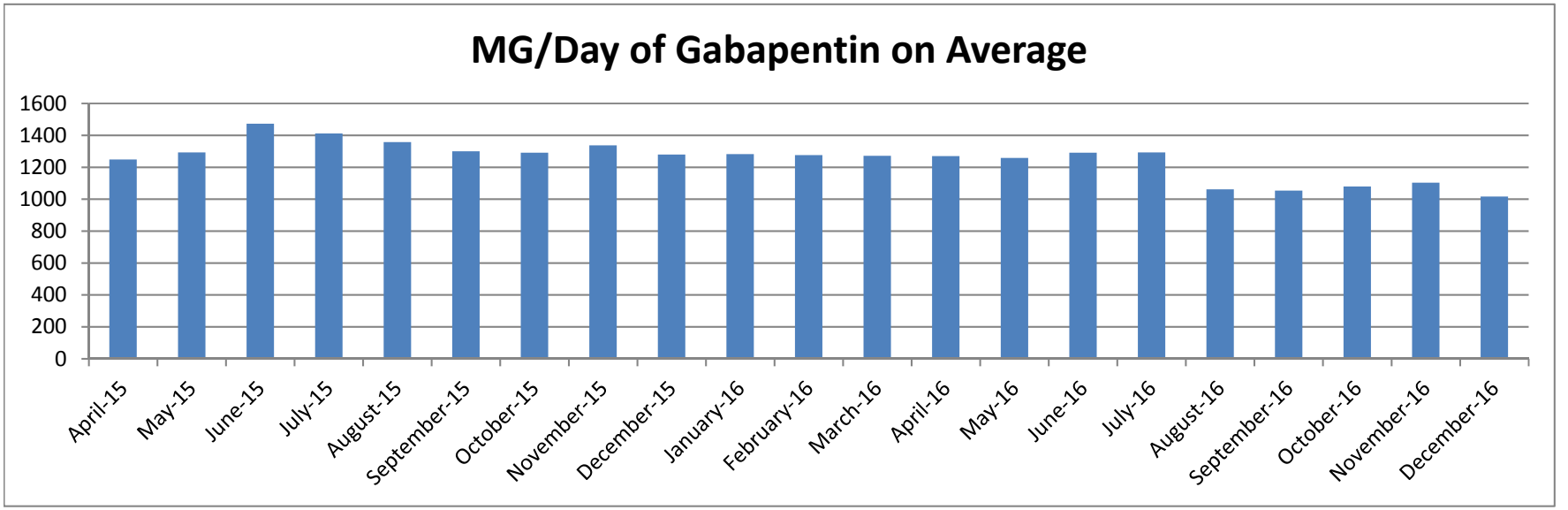

Patients on High Strength Oxycodone IR
20
18
16
14
12
10
8
6
4
2
0
April-15
May-15
June-15
July-15
August-15
September-15
October-15
November-15
December-15
January-16
February-16
March-16
April-16
May-16
June-16
July-16
August-16
September-16
October-16
November-16
December-16
OXYCODONE HCL 15 MG TABLET
OXYCODONE HCL 20 MG TABLET
OXYCODONE HCL 30 MG TABLET

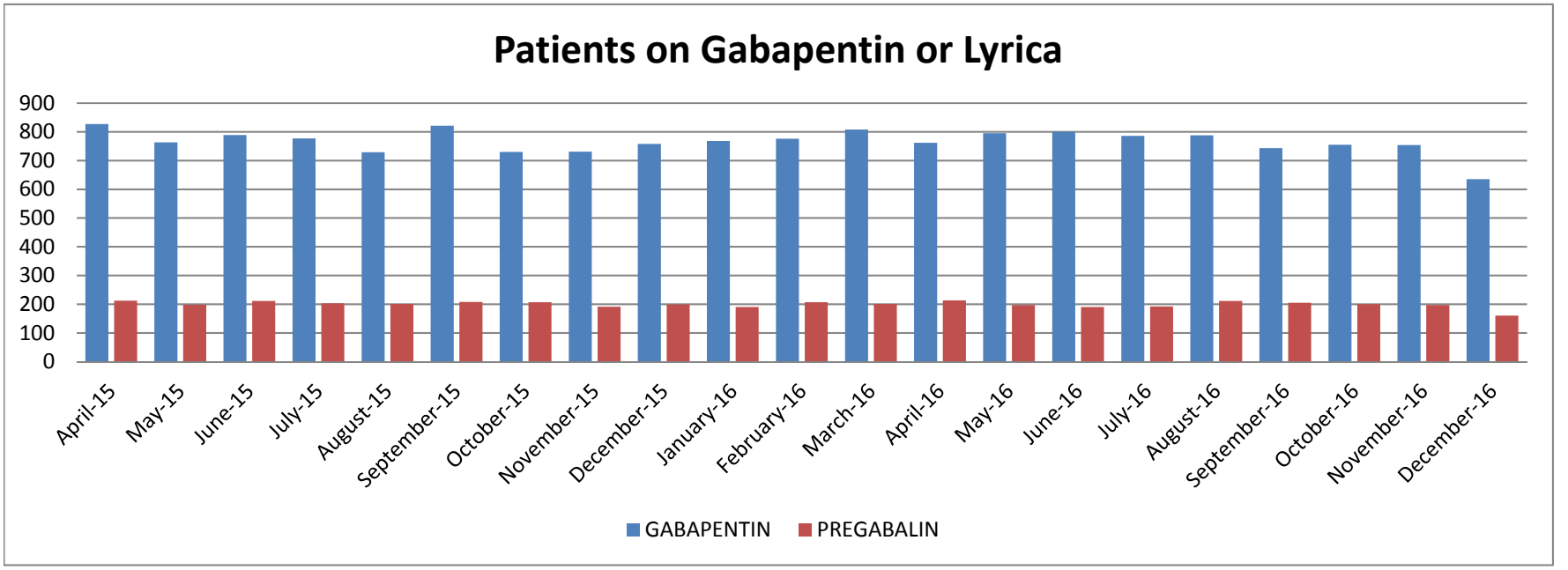

Patient Taking High Dose IR Narcotics (Over 30 MED/Dose)
Hydromorphone 8 mg
Morphine 30 mg
Oxycodone 20 mg & 30 mg
16
14
12
10
8
6
4
2
0
April-15
May-15
June-15
July-15
August-15
September-15
October-15
November-15
December-15
January-16
February-16
March-16
April-16
May-16
June-16
July-16
August-16
September-16
October-16
November-16
December-16
hydromorphone
morphine
Oxycodone IR

1st set of quantity limits	Nov-15
IR oxycodone put on PA	Jan-16
IR + IR Combos drug-drug edits	Jan-16
2nd set of quantity limits	May-16
Another step added to Oxycontin	May-16
1st set of First Fill edits - narcotics	Sep-16
2nd set of First Fill edits - narcotics	Nov-16

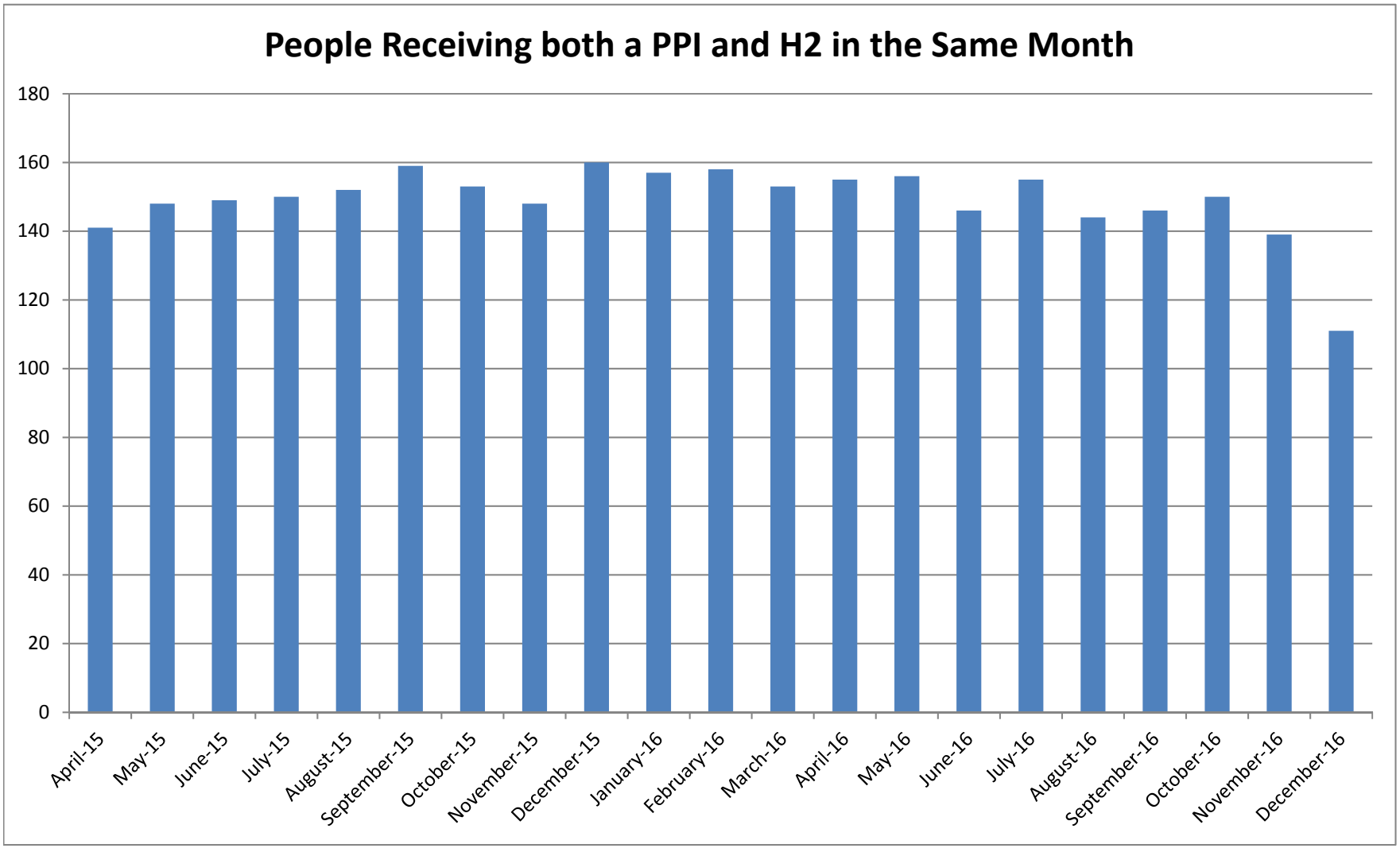




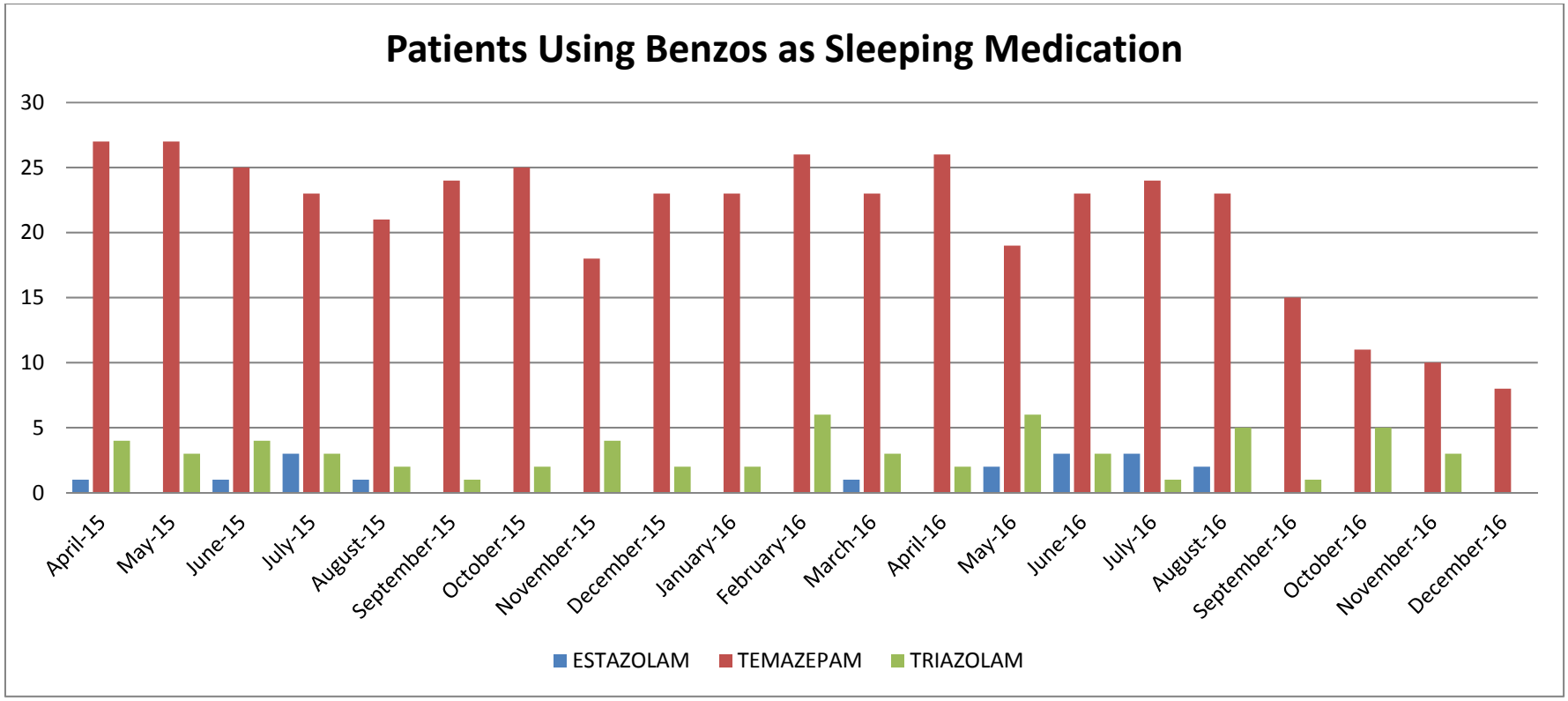




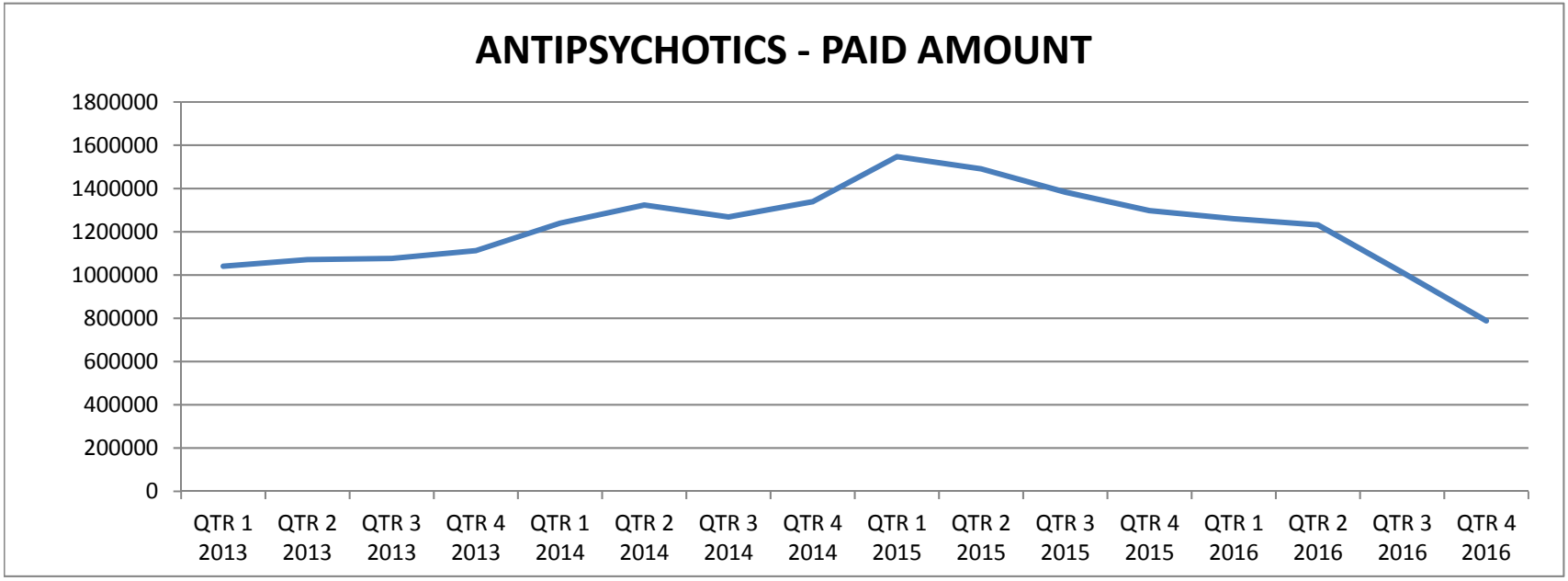
DUR sent	Jun-16
Quantity limit to < 1800 mg	Aug-16

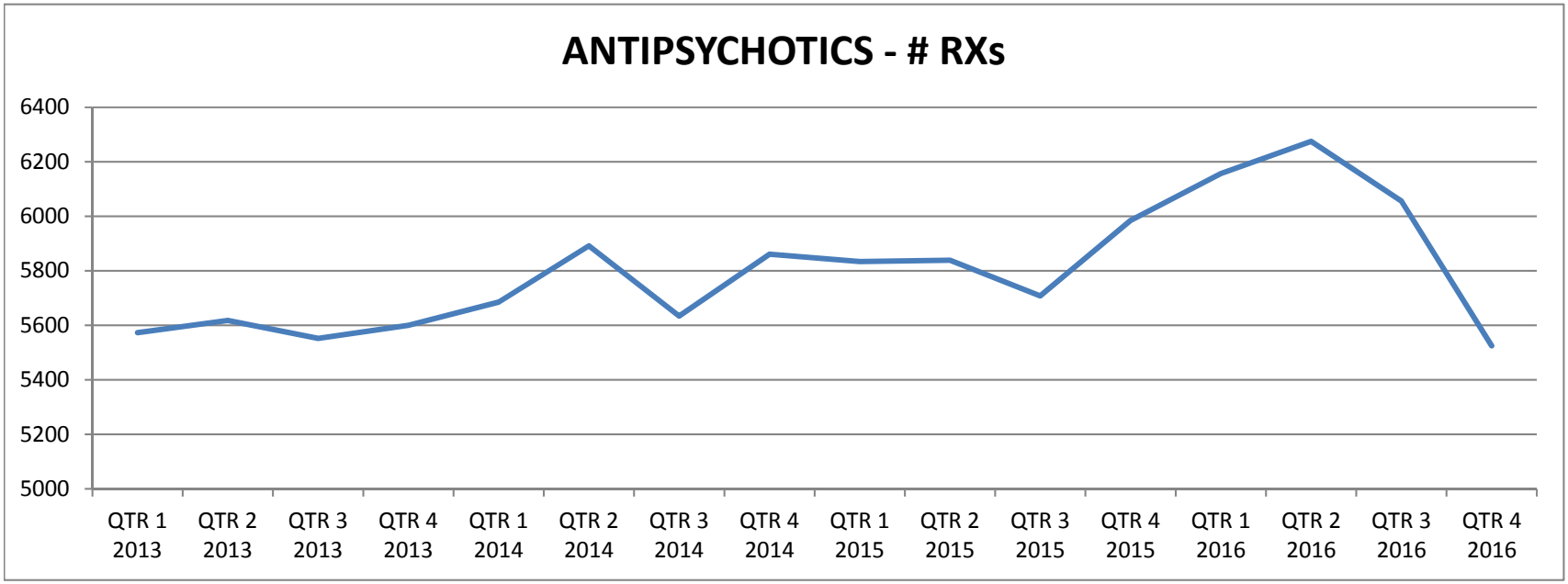


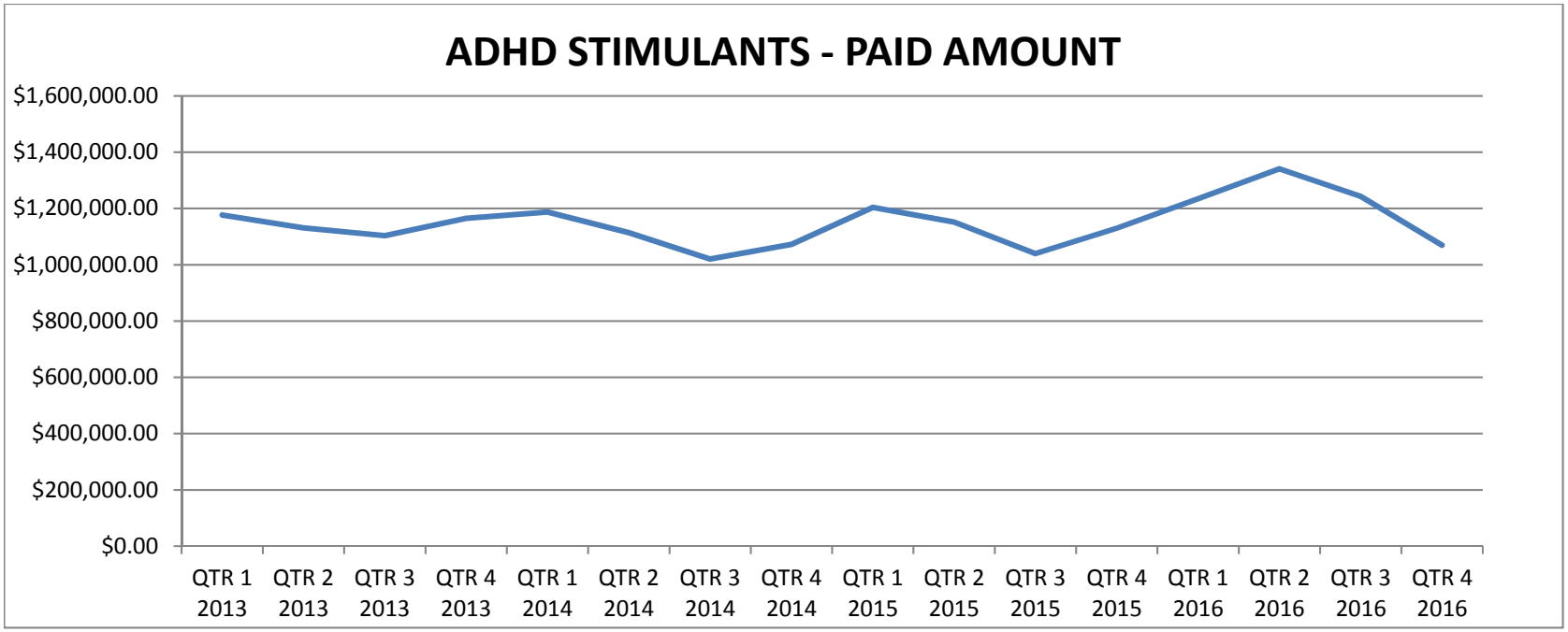
DUR sent 16-Aug
Edit put in 16-Oct

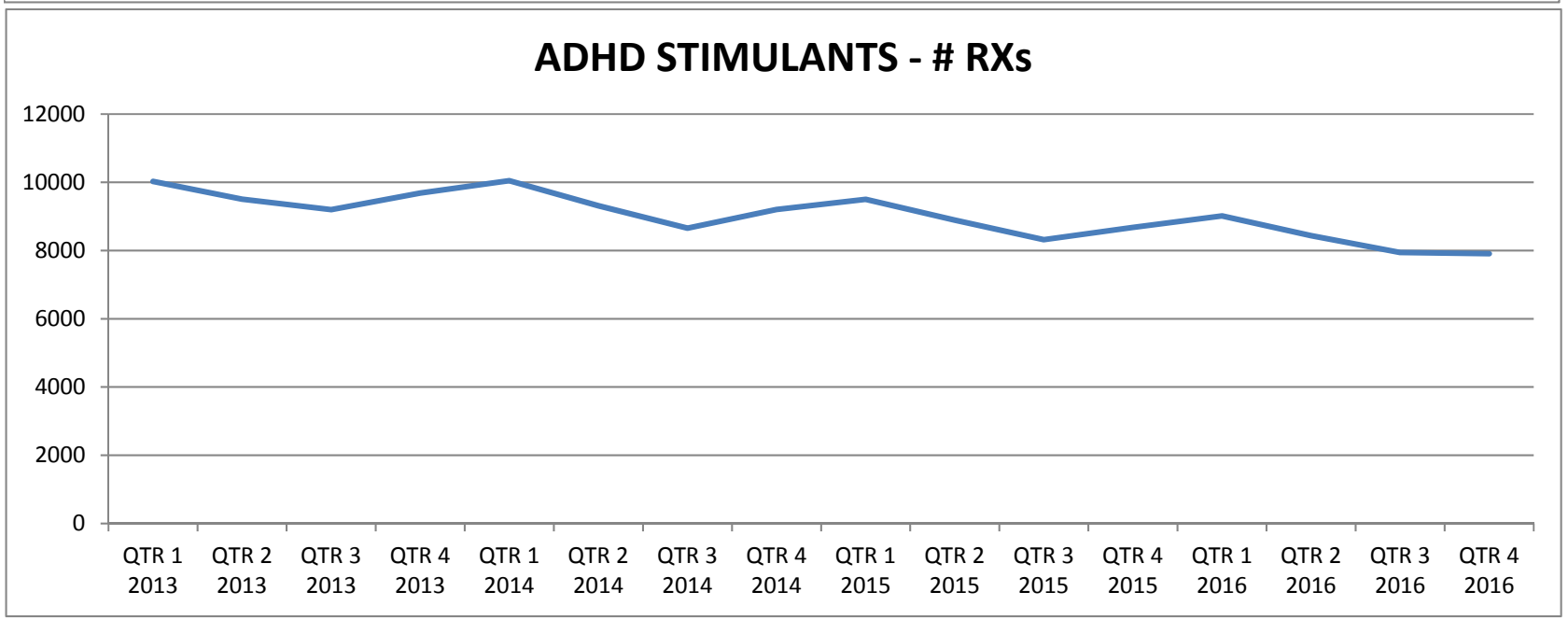


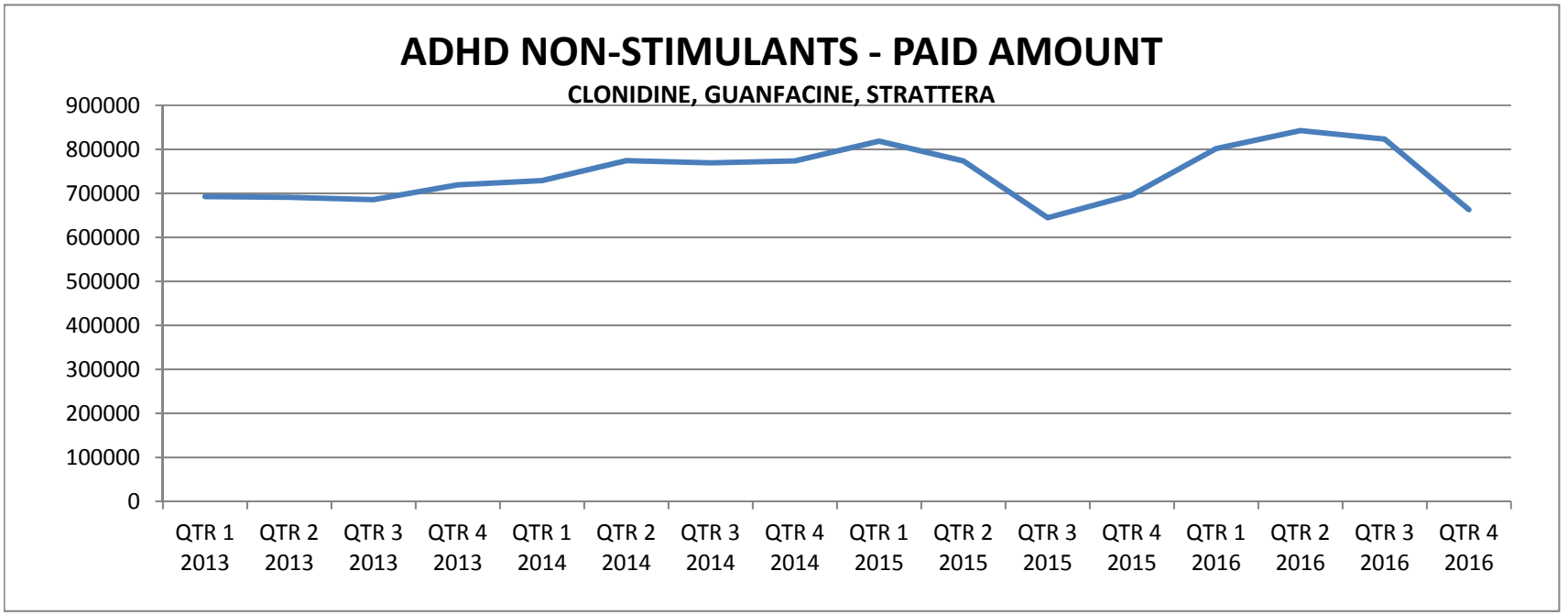
Drug - drug edit with benzos for sleep and other sleeping medications	Sep-16
All benzos for sleep put on PA	Sep-16

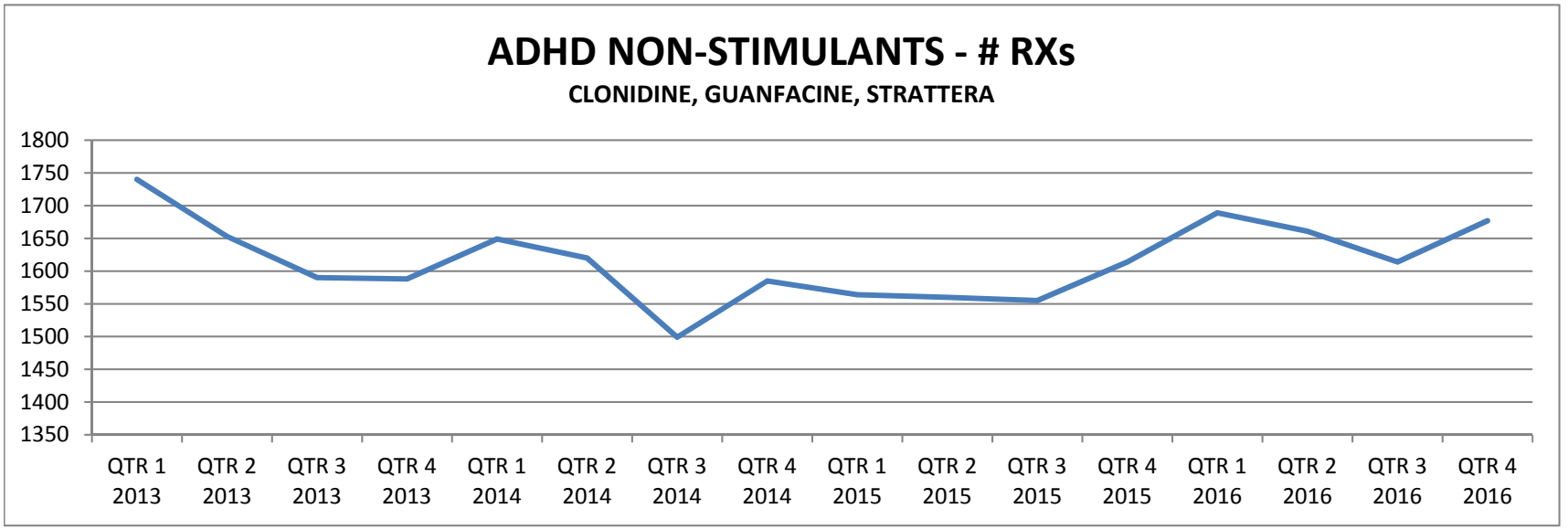

ANTIPSYCHOTICS - PAID AMOUNT
1800000
1600000
1400000
1200000
1000000
800000
600000
400000
200000
0
QTR 1 2013
QTR 2 2013
QTR 3 2013
QTR 4 2013
QTR 1 2014
QTR 2 2014
QTR 3 2014
QTR 4 2014
QTR 1 2015
QTR 2 2015
QTR 3 2015
QTR 4 2015
QTR 1 2016
QTR 2 2016
QTR 3 2016
QTR 4 2016

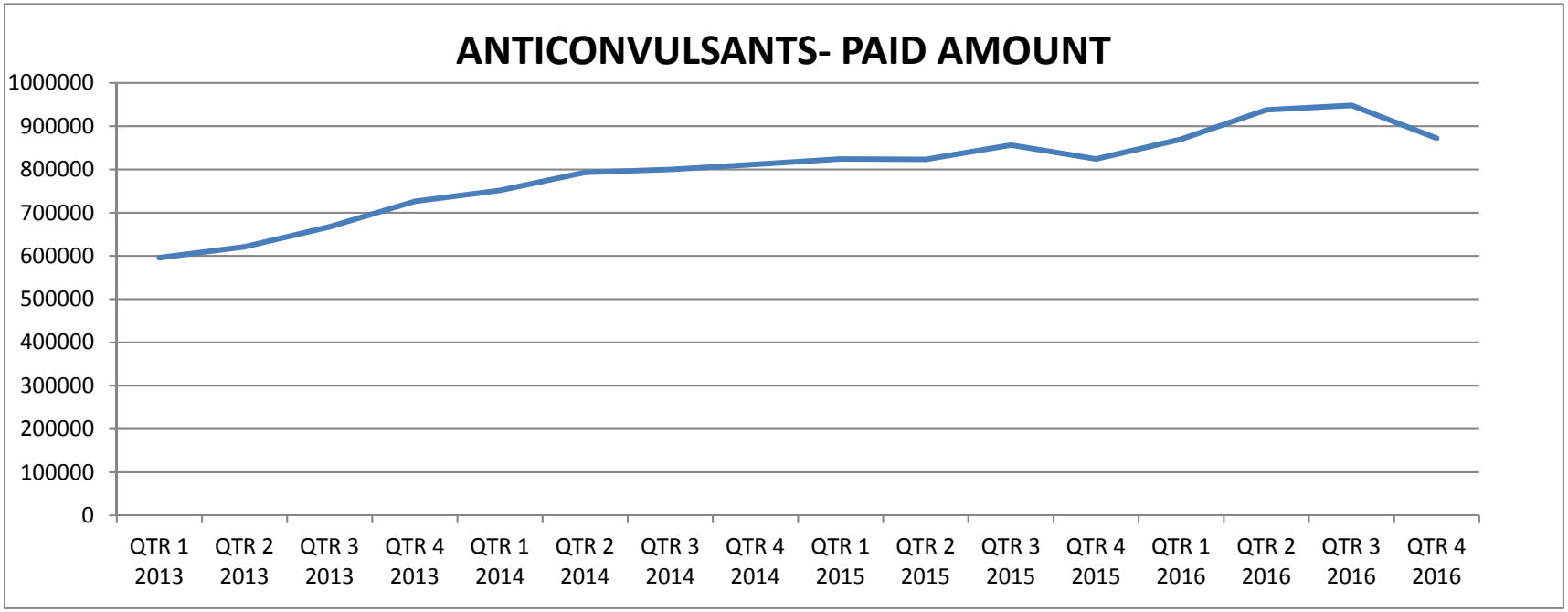

ANTIPSYCHOTICS - # RXs
6400
6200
6000
5800
5600
5400
5200
5000
QTR 1 2013
QTR 2 2013
QTR 3 2013
QTR 4 2013
QTR 1 2014
QTR 2 2014
QTR 3 2014
QTR 4 2014
QTR 1 2015
QTR 2 2015
QTR 3 2015
QTR 4 2015
QTR 1 2016
QTR 2 2016
QTR 3 2016
QTR 4 2016

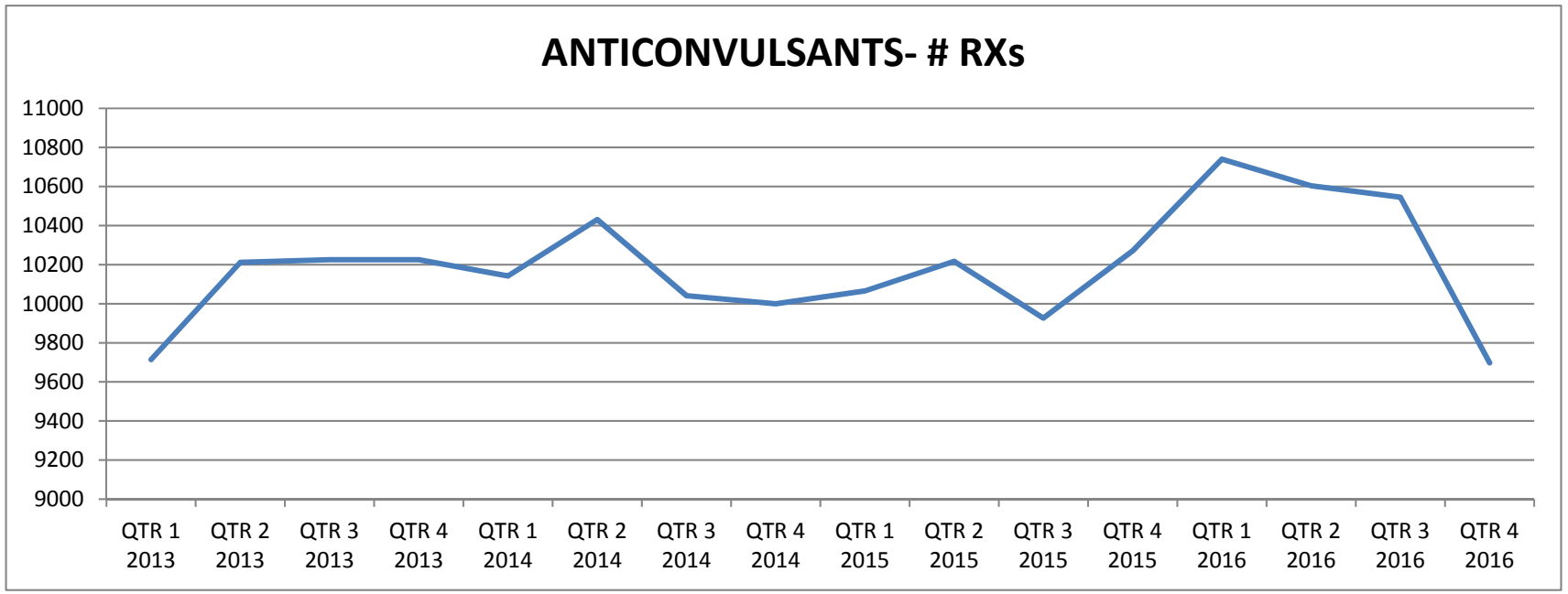

ADHD STIMULANTS - PAID AMOUNT
$1,600,000.00
$1,400,000.00
$1,200,000.00
$1,000,000.00
$800,000.00
$600,000.00
$400,000.00
$200,000.00
$0.00
QTR 1 2013
QTR 2 2013
QTR 3 2013
QTR 4 2013
QTR 1 2014
QTR 2 2014
QTR 3 2014
QTR 4 2014
QTR 1 2015
QTR 2 2015
QTR 3 2015
QTR 4 2015
QTR 1 2016
QTR 2 2016
QTR 3 2016
QTR 4 2016

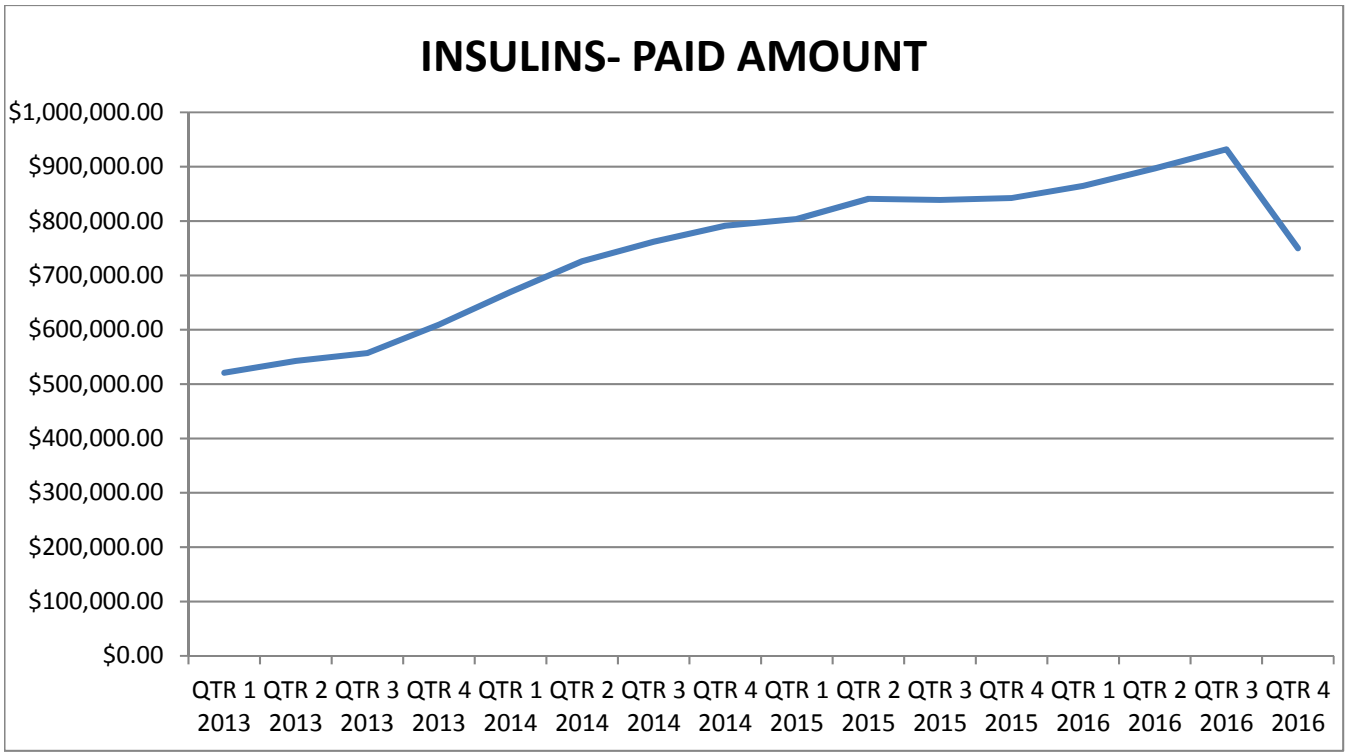

ADHD STIMULANTS - # RXs
12000
10000
8000
6000
4000
2000
0
QTR 1 2013
QTR 2 2013
QTR 3 2013
QTR 4 2013
QTR 1 2014
QTR 2 2014
QTR 3 2014
QTR 4 2014
QTR 1 2015
QTR 2 2015
QTR 3 2015
QTR 4 2015
QTR 1 2016
QTR 2 2016
QTR 3 2016
QTR 4 2016

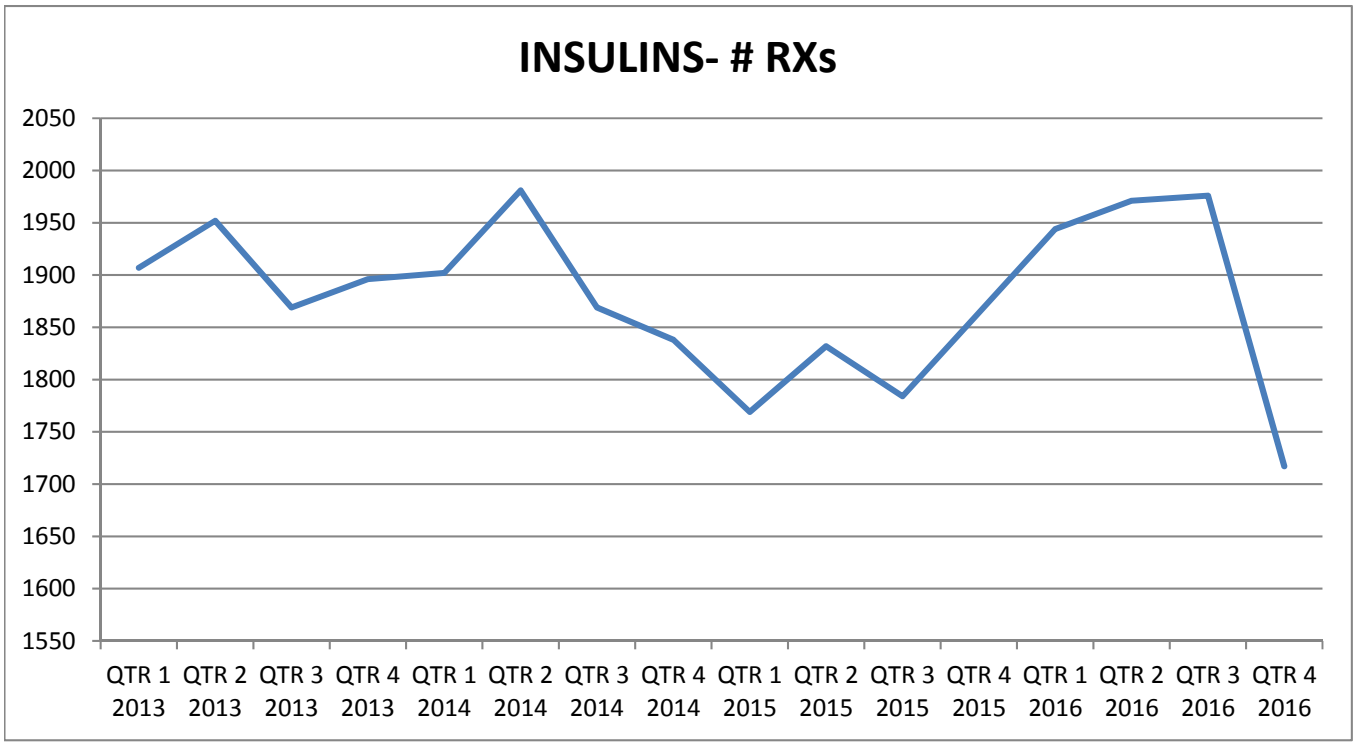

ADHD NON-STIMULANTS - PAID AMOUNT
CLONIDINE, GUANFACINE, STRATTERA
900000
800000
700000
600000
500000
400000
300000
200000
100000
0
QTR 1 2013
QTR 2 2013
QTR 3 2013
QTR 4 2013
QTR 1 2014
QTR 2 2014
QTR 3 2014
QTR 4 2014
QTR 1 2015
QTR 2 2015
QTR 3 2015
QTR 4 2015
QTR 1 2016
QTR 2 2016
QTR 3 2016
QTR 4 2016

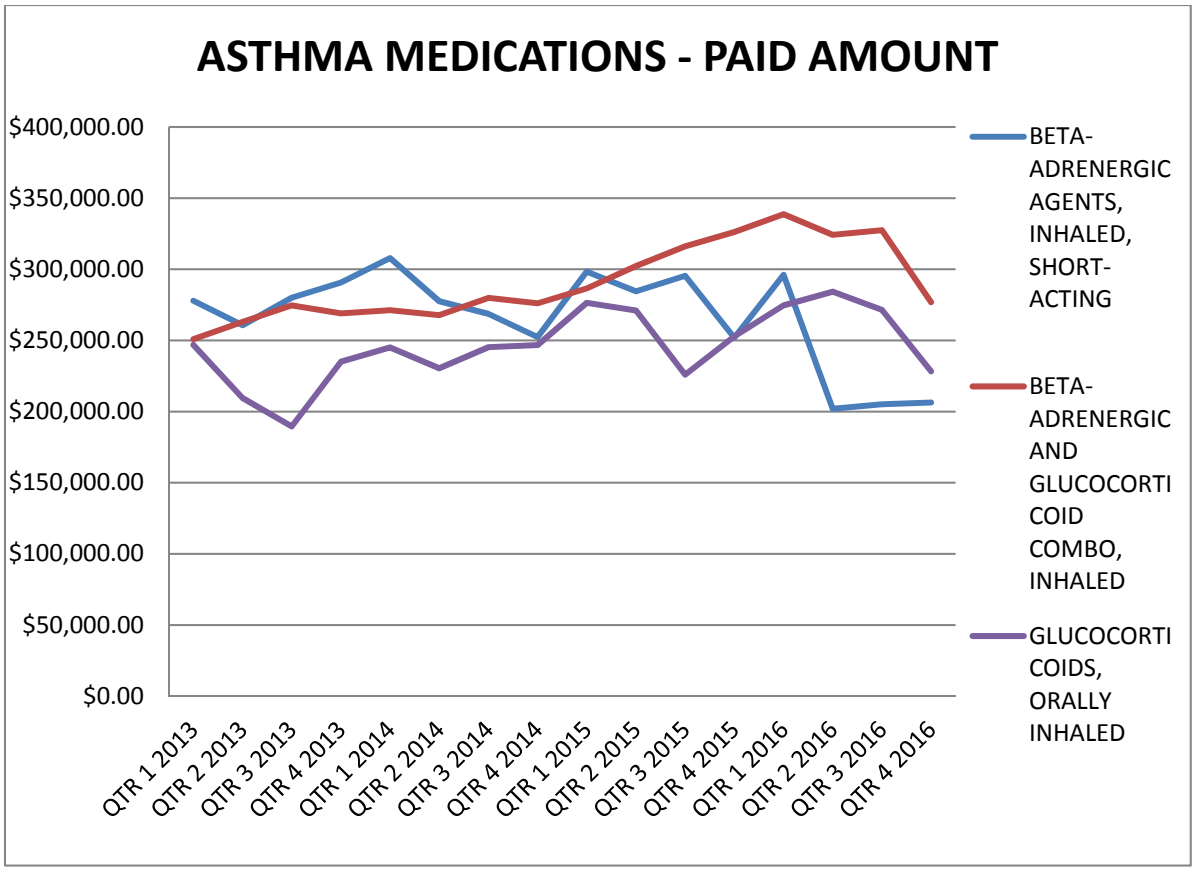

ADHD NON-STIMULANTS - # RXs
CLONIDINE, GUANFACINE, STRATTERA
1800
1750
1700
1650
1600
1550
1500
1450
1400
1350
QTR 1 2013
QTR 2 2013
QTR 3 2013
QTR 4 2013
QTR 1 2014
QTR 2 2014
QTR 3 2014
QTR 4 2014
QTR 1 2015
QTR 2 2015
QTR 3 2015
QTR 4 2015
QTR 1 2016
QTR 2 2016
QTR 3 2016
QTR 4 2016

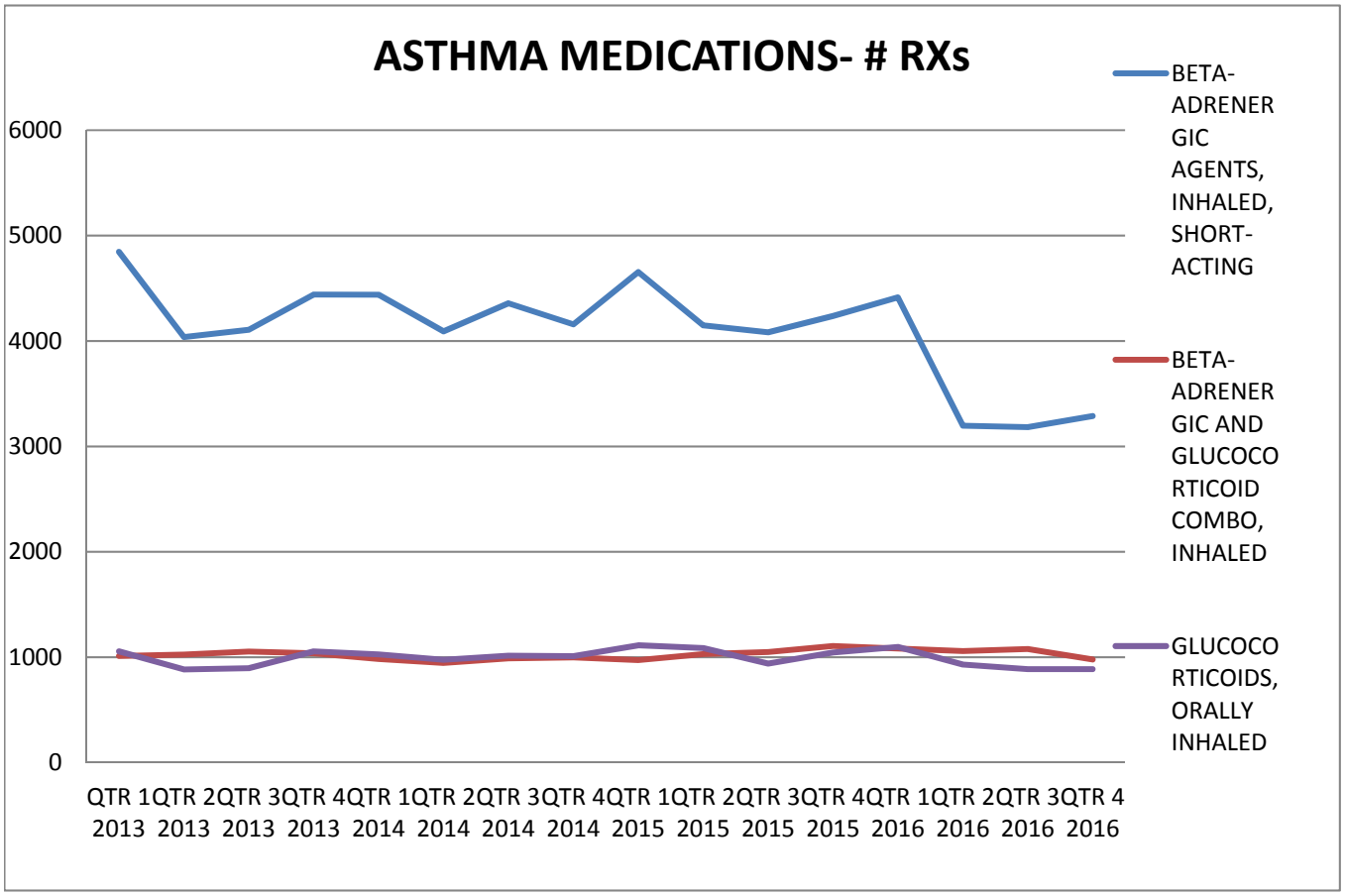

ANTICONVULSANTS- PAID AMOUNT
1000000
900000
800000
700000
600000
500000
400000
300000
200000
100000
0
QTR 1 2013
QTR 2 2013
QTR 3 2013
QTR 4 2013
QTR 1 2014
QTR 2 2014
QTR 3 2014
QTR 4 2014
QTR 1 2015
QTR 2 2015
QTR 3 2015
QTR 4 2015
QTR 1 2016
QTR 2 2016
QTR 3 2016
QTR 4 2016

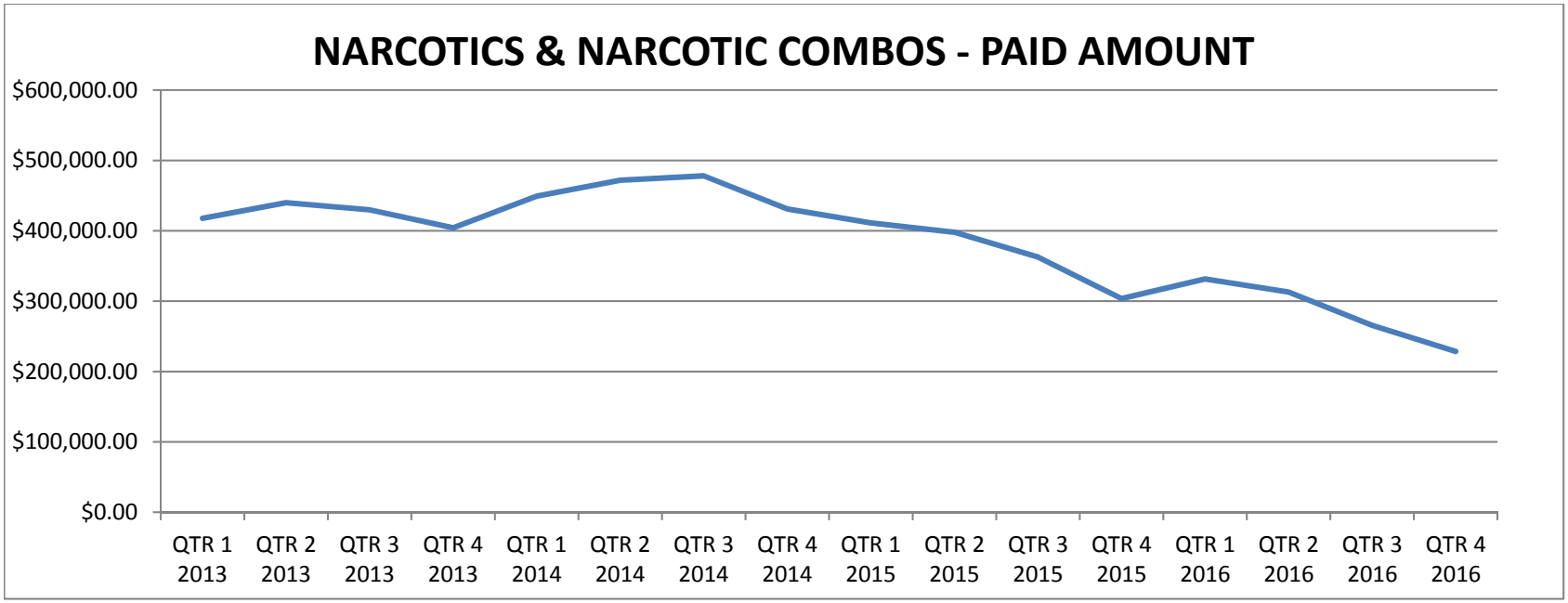

ANTICONVULSANTS- # RXs
11000
10800
10600
10400
10200
10000
9800
9600
9400
9200
9000
QTR 1 2013
QTR 2 2013
QTR 3 2013
QTR 4 2013
QTR 1 2014
QTR 2 2014
QTR 3 2014
QTR 4 2014
QTR 1 2015
QTR 2 2015
QTR 3 2015
QTR 4 2015
QTR 1 2016
QTR 2 2016
QTR 3 2016
QTR 4 2016

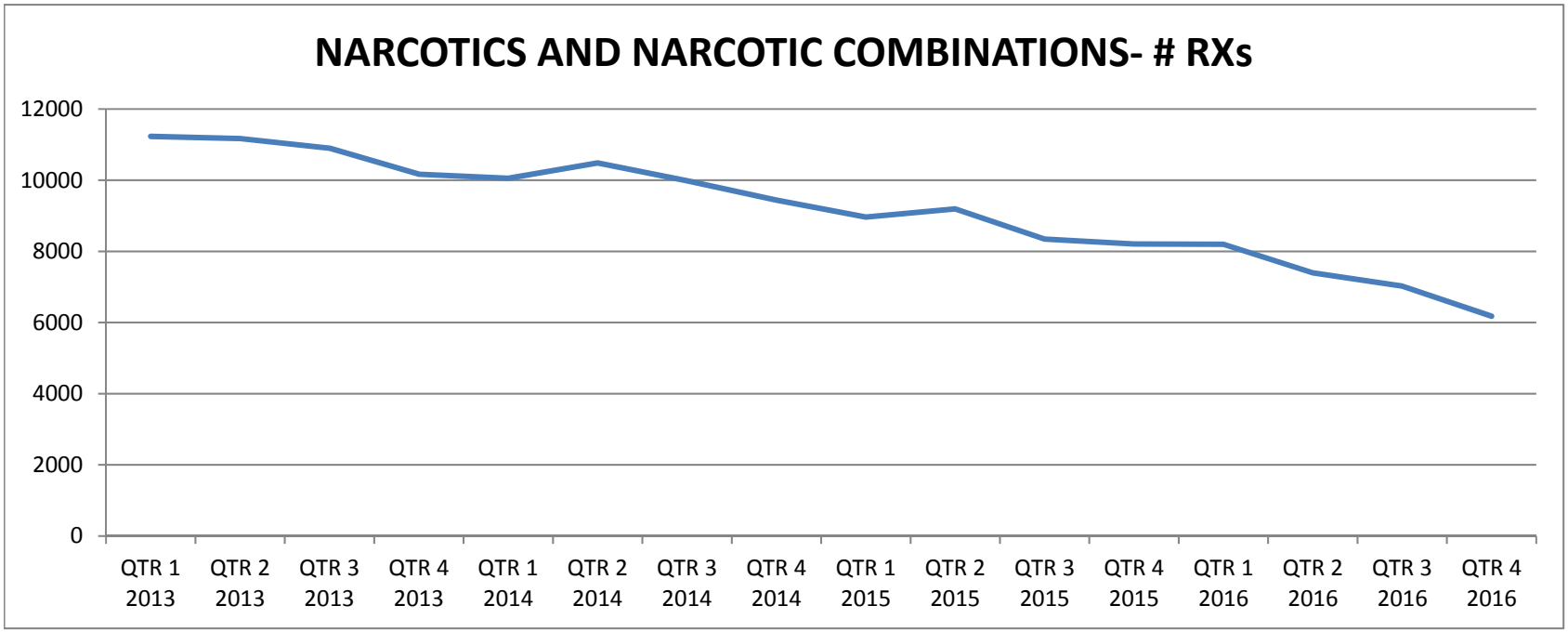

INSULINS- PAID AMOUNT
$1,000,000.00
$900,000.00
$800,000.00
$700,000.00
$600,000.00
$500,000.00
$400,000.00
$300,000.00
$200,000.00
$100,000.00
$0.00
QTR 1 2013
QTR 2 2013
QTR 3 2013
QTR 4 2013
QTR 1 2014
QTR 2 2014
QTR 3 2014
QTR 4 2014
QTR 1 2015
QTR 2 2015
QTR 3 2015
QTR 4 2015
QTR 1 2016
QTR 2 2016
QTR 3 2016
QTR 4 2016

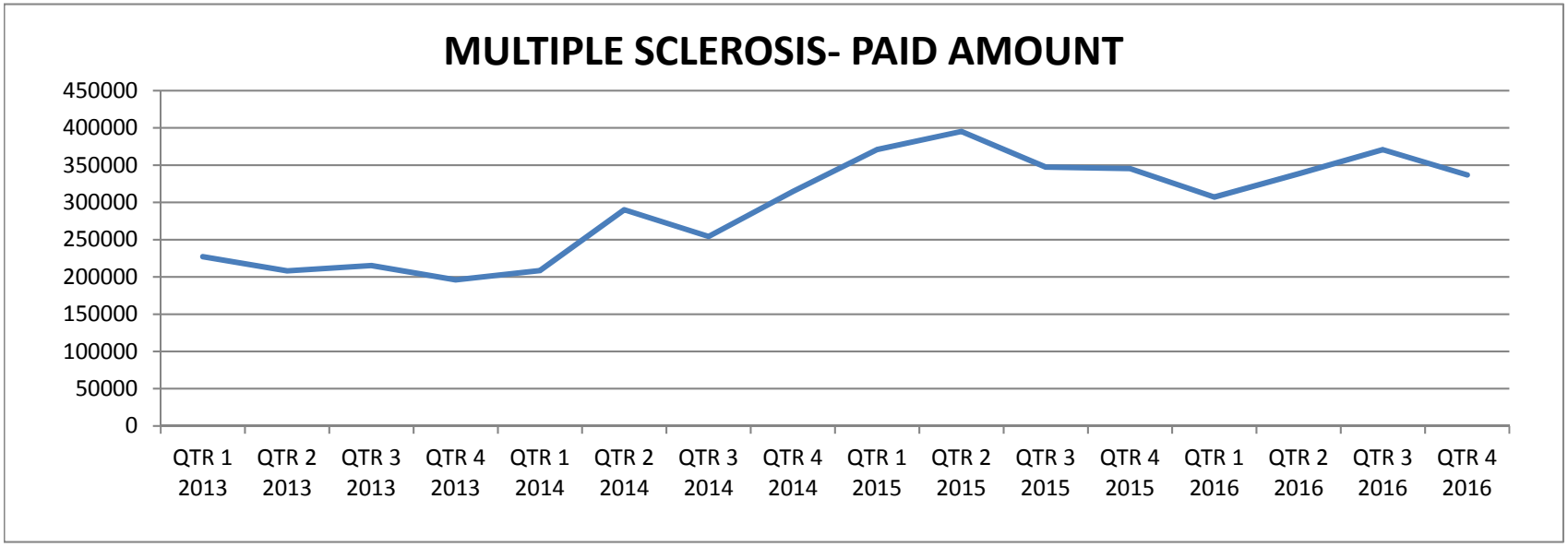

INSULINS- # RXs
2050
2000
1950
1900
1850
1800
1750
1700
1650
1600
1550
QTR 1 2013
QTR 2 2013
QTR 3 2013
QTR 4 2013
QTR 1 2014
QTR 2 2014
QTR 3 2014
QTR 4 2014
QTR 1 2015
QTR 2 2015
QTR 3 2015
QTR 4 2015
QTR 1 2016
QTR 2 2016
QTR 3 2016
QTR 4 2016

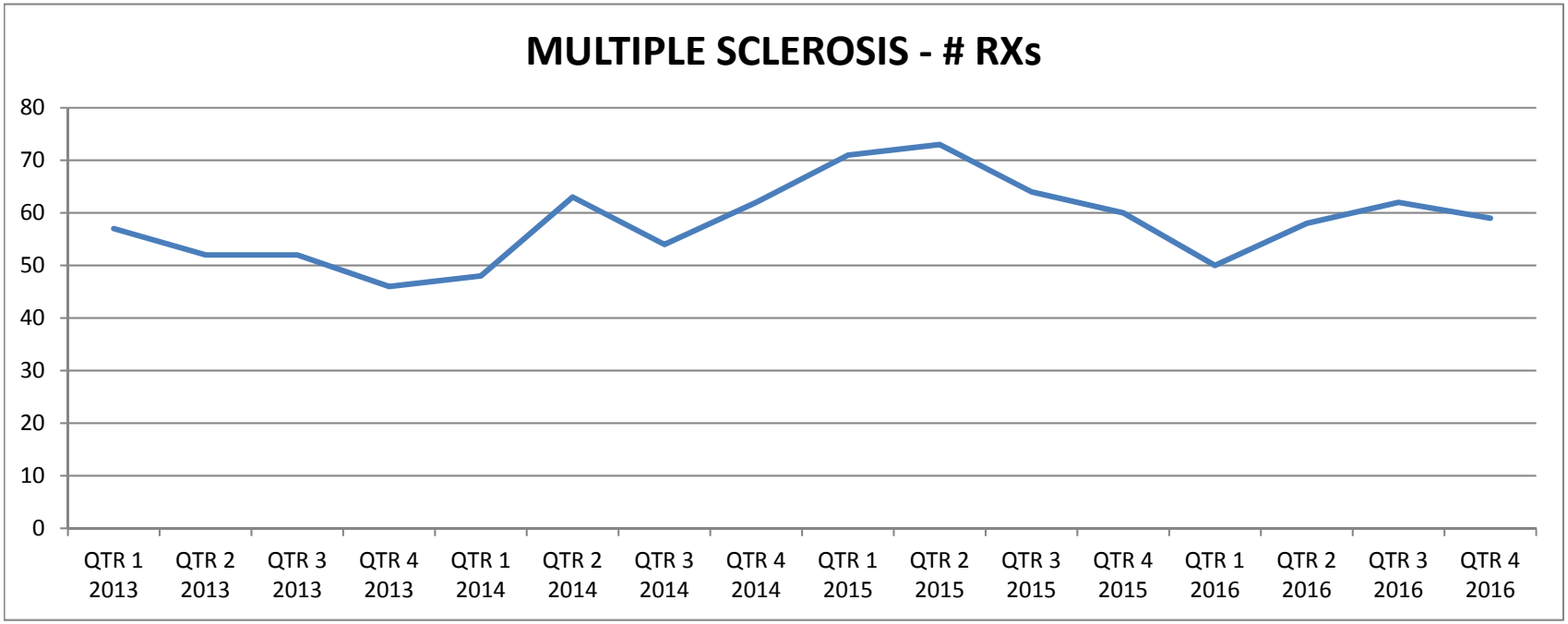

ASTHMA MEDICATIONS - PAID AMOUNT
$400,000.00
$350,000.00
$300,000.00
$250,000.00
$200,000.00
$150,000.00
$100,000.00
$50,000.00
$0.00
QTR 1 2013
QTR 2 2013
QTR 3 2013
QTR 4 2013
QTR 1 2014
QTR 2 2014
QTR 3 2014
QTR 4 2014
QTR 1 2015
QTR 2 2015
QTR 3 2015
QTR 4 2015
QTR 1 2016
QTR 2 2016
QTR 3 2016
QTR 4 2016
BETA-ADRENERGIC AGENTS, INHALED, SHORT-ACTING
BETA-ADRENERGIC AND GLUCOCORTICOID COMBO, INHALED
GLUCOCORTICOIDS, ORALLY INHALED

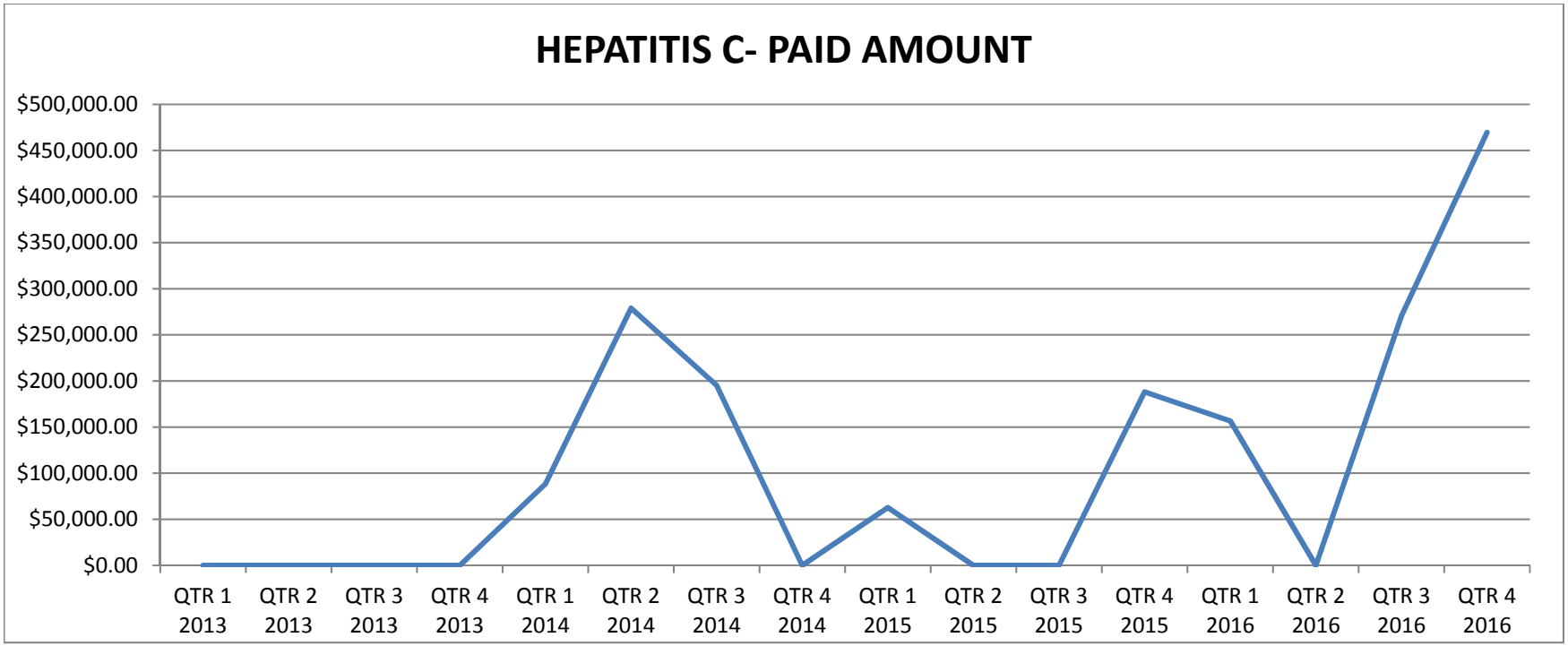

ASTHMA MEDICATIONS- # RXs
6000
5000
4000
3000
2000
1000
0
QTR 1 2013
QTR 2 2013
QTR 3 2013
QTR 4 2013
QTR 1 2014
QTR 2 2014
QTR 3 2014
QTR 4 2014
QTR 1 2015
QTR 2 2015
QTR 3 2015
QTR 4 2015
QTR 1 2016
QTR 2 2016
QTR 3 2016
QTR 4 2016
BETA-ADRENERGIC AGENTS, INHALED, SHORT-ACTING
BETA-ADRENERGIC AND GLUCOCORTICOID COMBO, INHALED
GLUCOCORTICOIDS, ORALLY INHALED

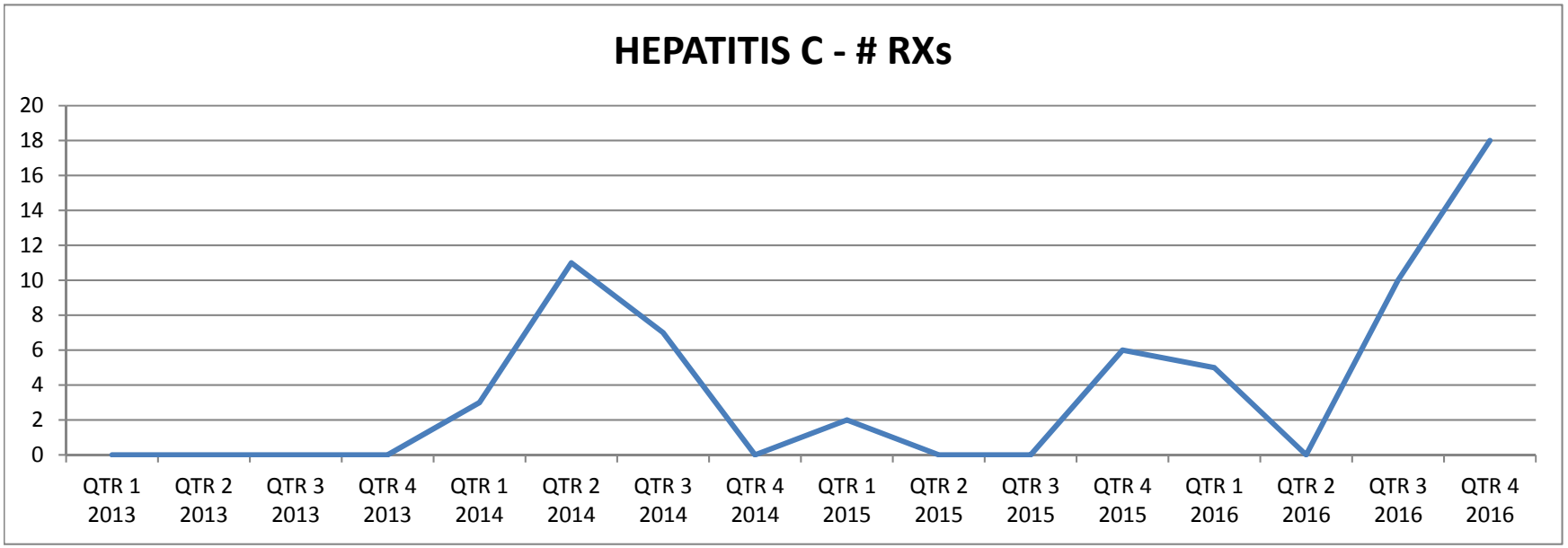

NARCOTICS & NARCOTIC COMBOS - PAID AMOUNT
$600,000.00
$500,000.00
$400,000.00
$300,000.00
$200,000.00
$100,000.00
$0.00
QTR 1 2013
QTR 2 2013
QTR 3 2013
QTR 4 2013
QTR 1 2014
QTR 2 2014
QTR 3 2014
QTR 4 2014
QTR 1 2015
QTR 2 2015
QTR 3 2015
QTR 4 2015
QTR 1 2016
QTR 2 2016
QTR 3 2016
QTR 4 2016

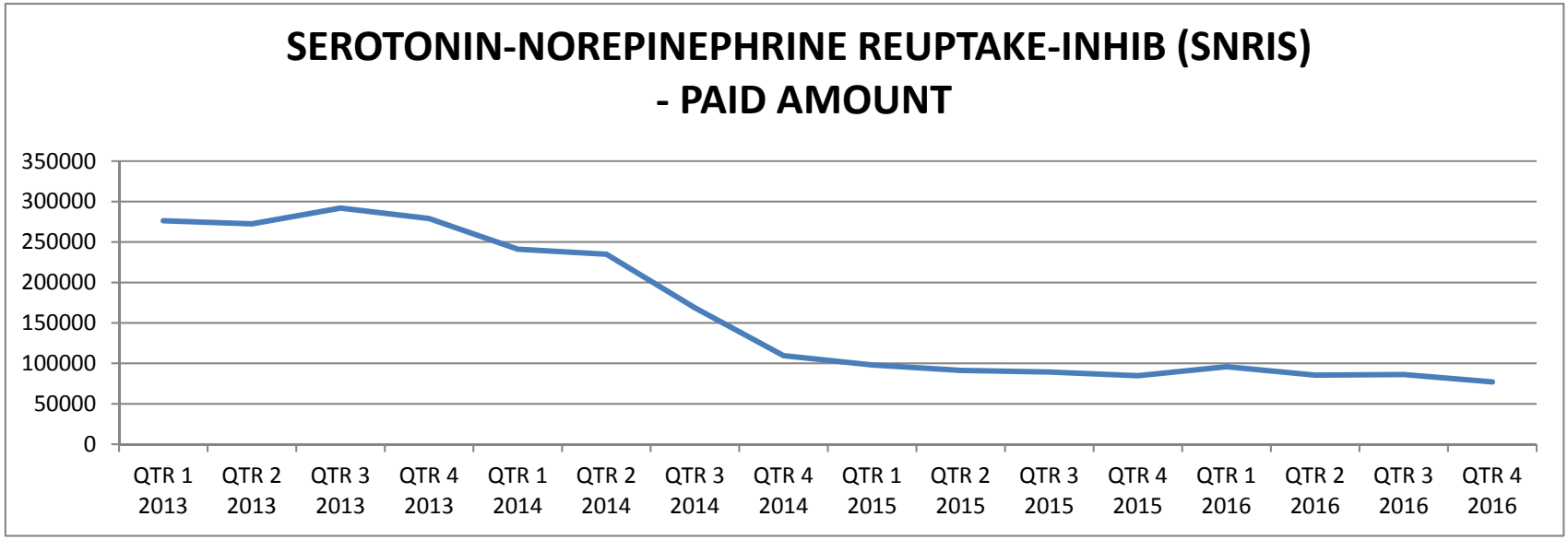

NARCOTICS AND NARCOTIC COMBINATIONS- # RXs
12000
10000
8000
6000
4000
2000
0
QTR 1 2013
QTR 2 2013
QTR 3 2013
QTR 4 2013
QTR 1 2014
QTR 2 2014
QTR 3 2014
QTR 4 2014
QTR 1 2015
QTR 2 2015
QTR 3 2015
QTR 4 2015
QTR 1 2016
QTR 2 2016
QTR 3 2016
QTR 4 2016

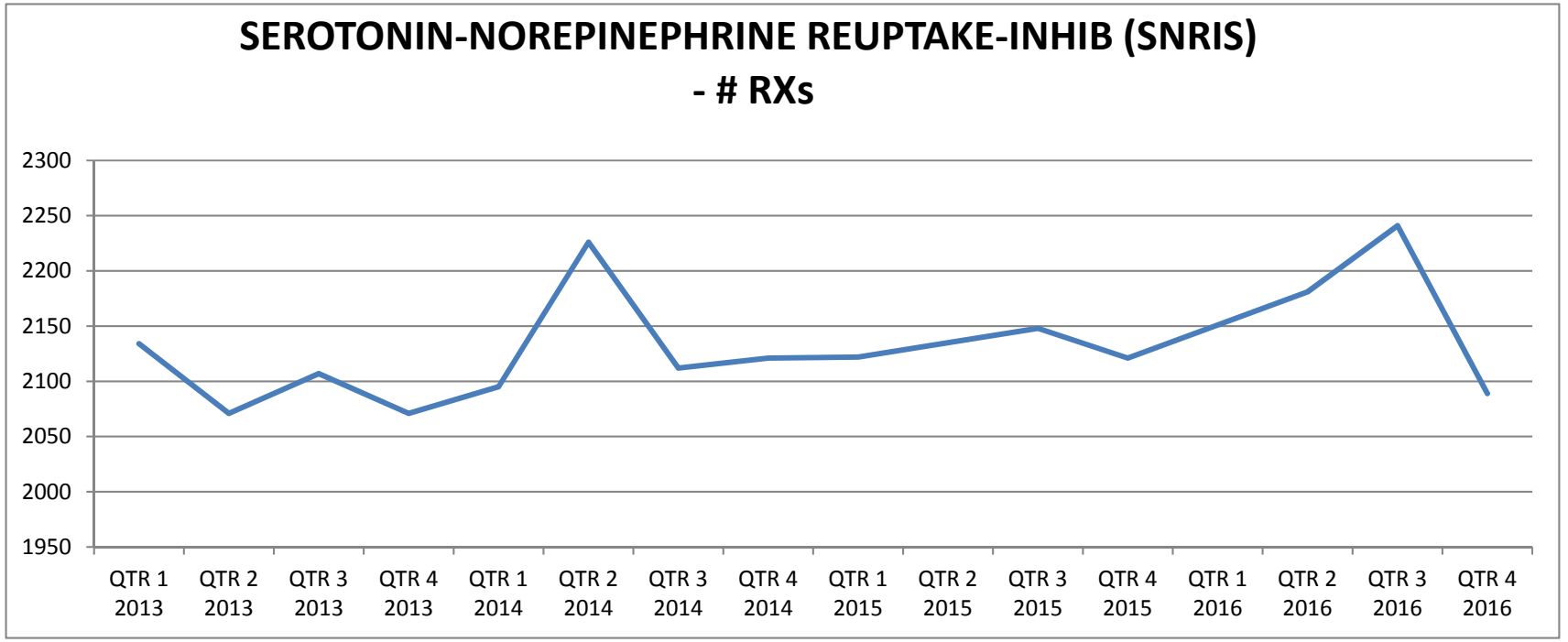

MULTIPLE SCLEROSIS- PAID AMOUNT
450000
400000
350000
300000
250000
200000
150000
100000
50000
0
QTR 1 2013
QTR 2 2013
QTR 3 2013
QTR 4 2013
QTR 1 2014
QTR 2 2014
QTR 3 2014
QTR 4 2014
QTR 1 2015
QTR 2 2015
QTR 3 2015
QTR 4 2015
QTR 1 2016
QTR 2 2016
QTR 3 2016
QTR 4 2016

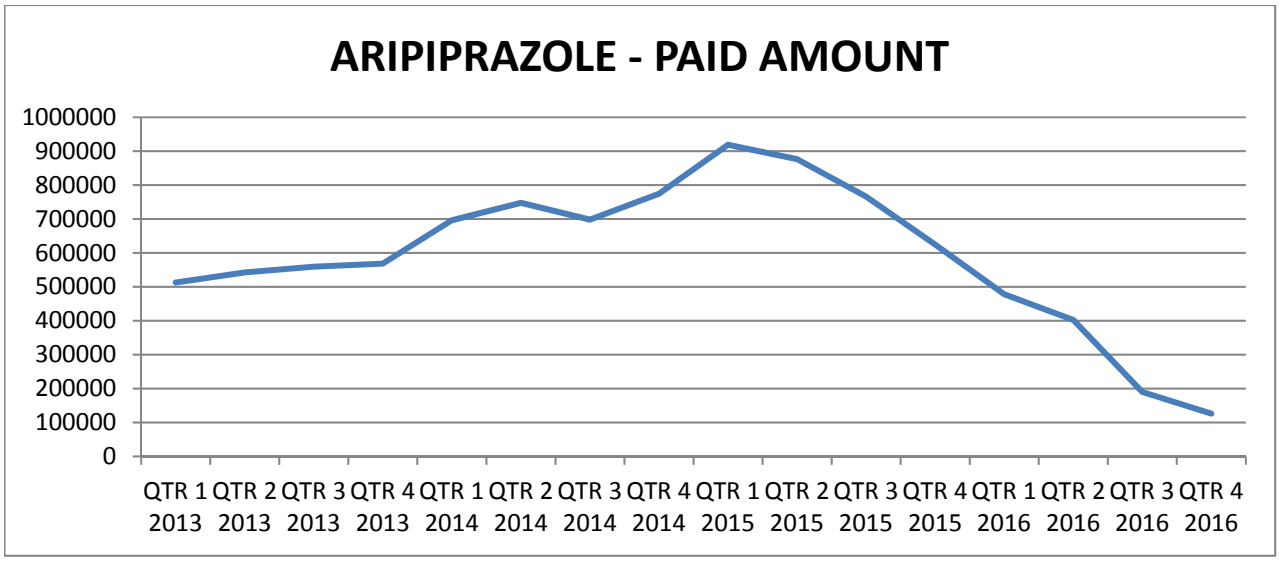

MULTIPLE SCLEROSIS - # RXs
80
70
60
50
40
30
20
10
0
QTR 1 2013
QTR 2 2013
QTR 3 2013
QTR 4 2013
QTR 1 2014
QTR 2 2014
QTR 3 2014
QTR 4 2014
QTR 1 2015
QTR 2 2015
QTR 3 2015
QTR 4 2015
QTR 1 2016
QTR 2 2016
QTR 3 2016
QTR 4 2016

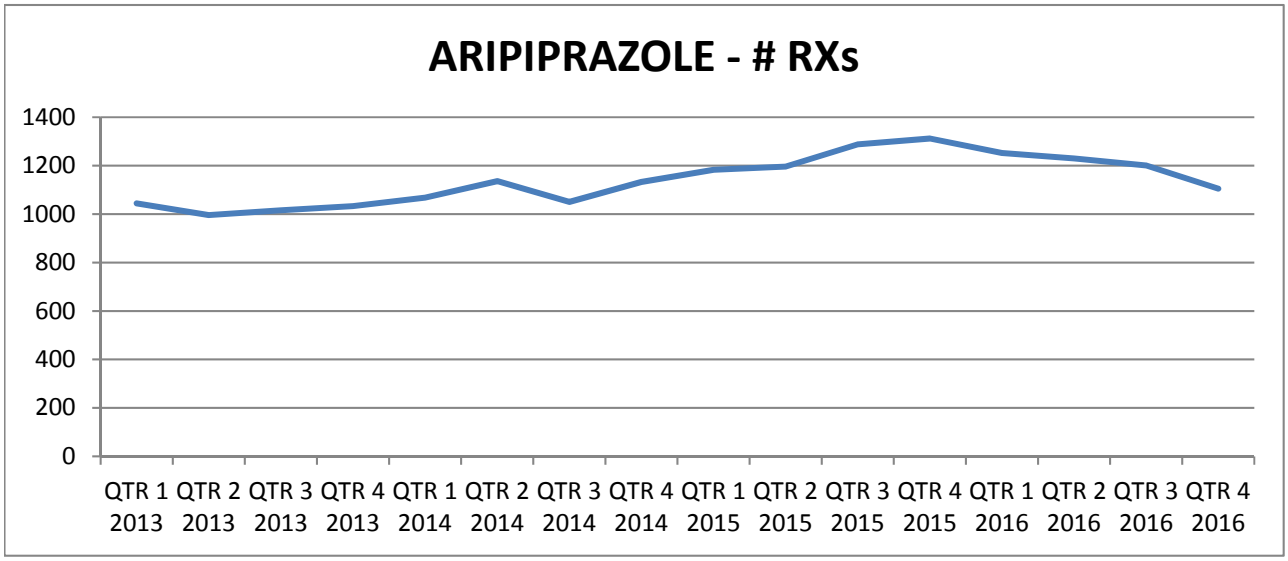

HEPATITIS C- PAID AMOUNT
$500,000.00
$450,000.00
$400,000.00
$350,000.00
$300,000.00
$250,000.00
$200,000.00
$150,000.00
$100,000.00
$50,000.00
$0.00
QTR 1 2013
QTR 2 2013
QTR 3 2013
QTR 4 2013
QTR 1 2014
QTR 2 2014
QTR 3 2014
QTR 4 2014
QTR 1 2015
QTR 2 2015
QTR 3 2015
QTR 4 2015
QTR 1 2016
QTR 2 2016
QTR 3 2016
QTR 4 2016

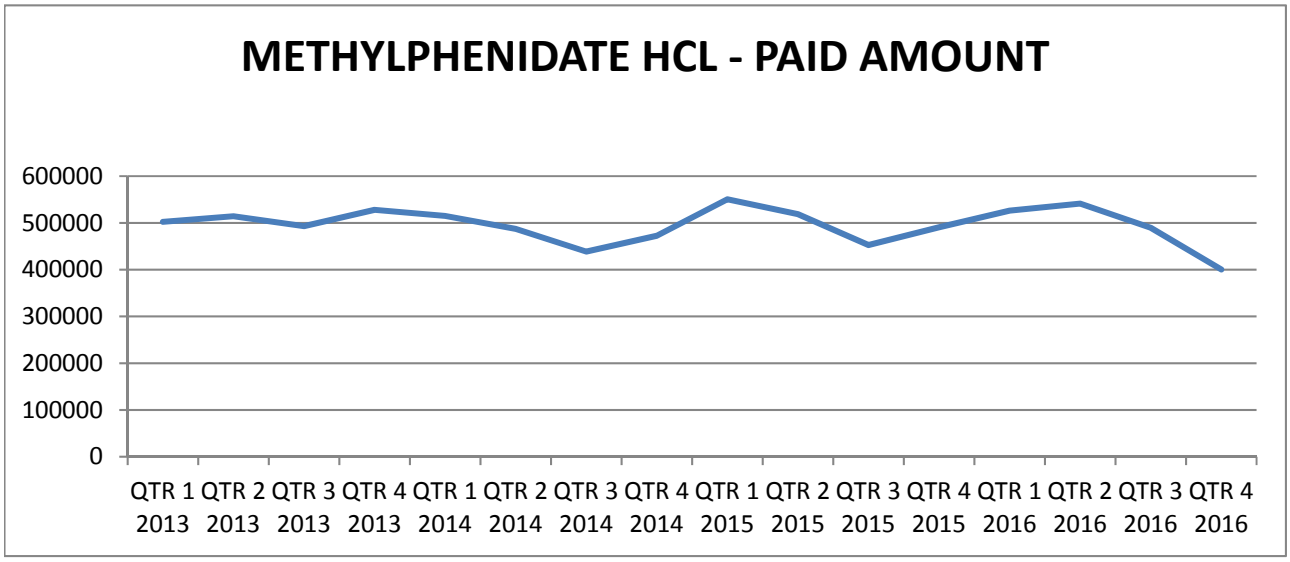

HEPATITIS C - # RXs
20
18
16
14
12
10
8
6
4
2
0
QTR 1 2013
QTR 2 2013
QTR 3 2013
QTR 4 2013
QTR 1 2014
QTR 2 2014
QTR 3 2014
QTR 4 2014
QTR 1 2015
QTR 2 2015
QTR 3 2015
QTR 4 2015
QTR 1 2016
QTR 2 2016
QTR 3 2016
QTR 4 2016

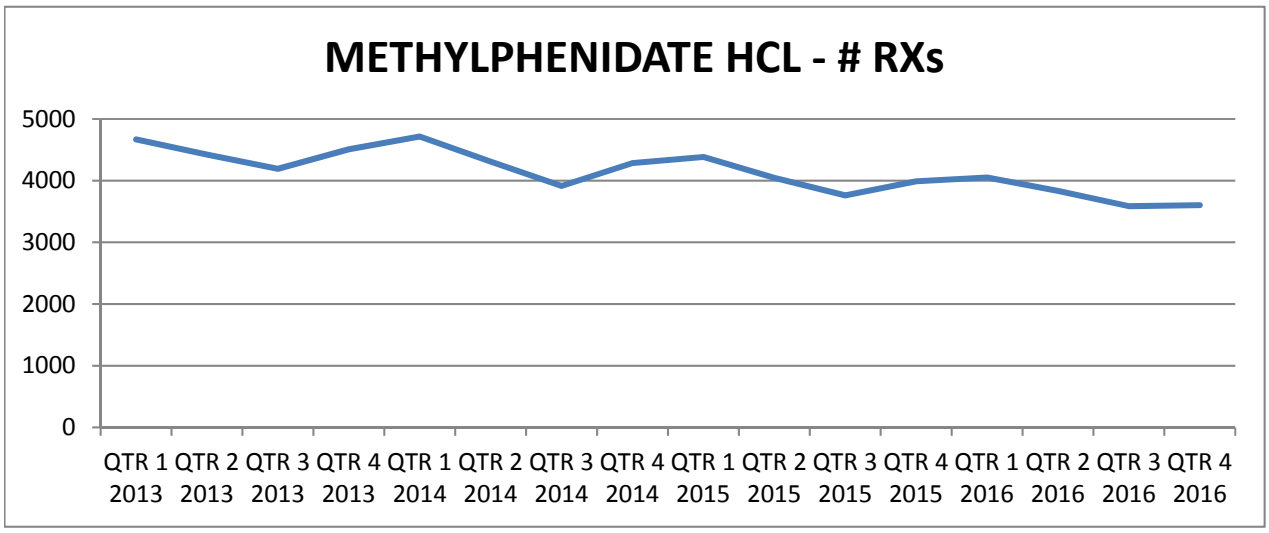

SEROTONIN-NOREPINEPHRINE REUPTAKE-INHIB (SNRIS)
- PAID AMOUNT
350000
300000
250000
200000
150000
100000
50000
0
QTR 1 2013
QTR 2 2013
QTR 3 2013
QTR 4 2013
QTR 1 2014
QTR 2 2014
QTR 3 2014
QTR 4 2014
QTR 1 2015
QTR 2 2015
QTR 3 2015
QTR 4 2015
QTR 1 2016
QTR 2 2016
QTR 3 2016
QTR 4 2016

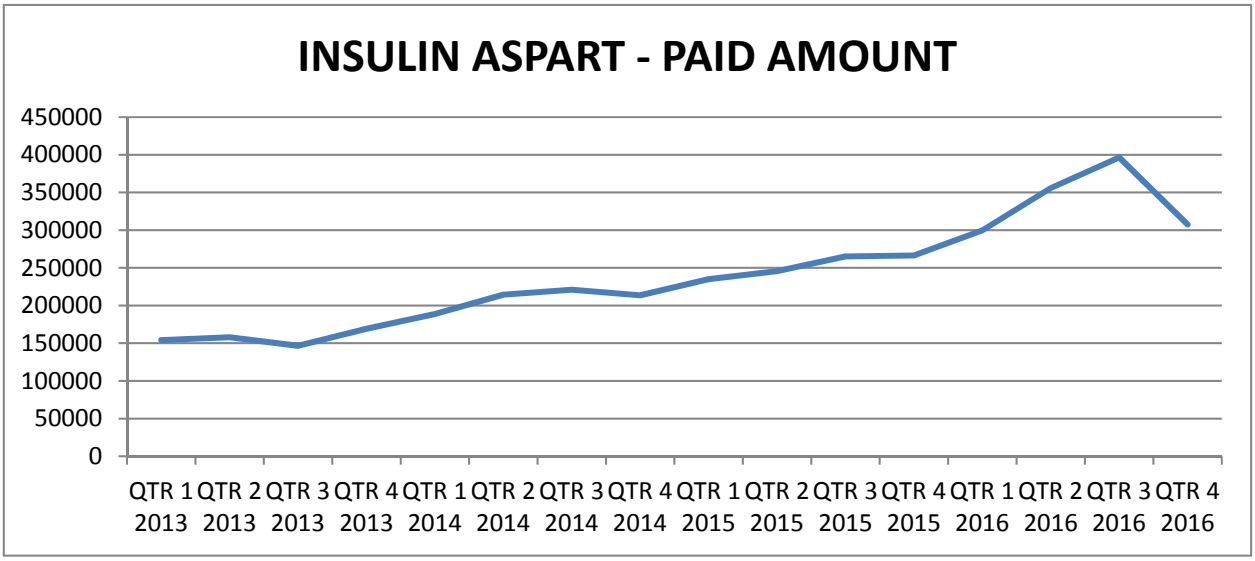

SEROTONIN-NOREPINEPHRINE REUPTAKE-INHIB (SNRIS)
- # RXs
2300
2250
2200
2150
2100
2050
2000
1950
QTR 1 2013
QTR 2 2013
QTR 3 2013
QTR 4 2013
QTR 1 2014
QTR 2 2014
QTR 3 2014
QTR 4 2014
QTR 1 2015
QTR 2 2015
QTR 3 2015
QTR 4 2015
QTR 1 2016
QTR 2 2016
QTR 3 2016
QTR 4 2016

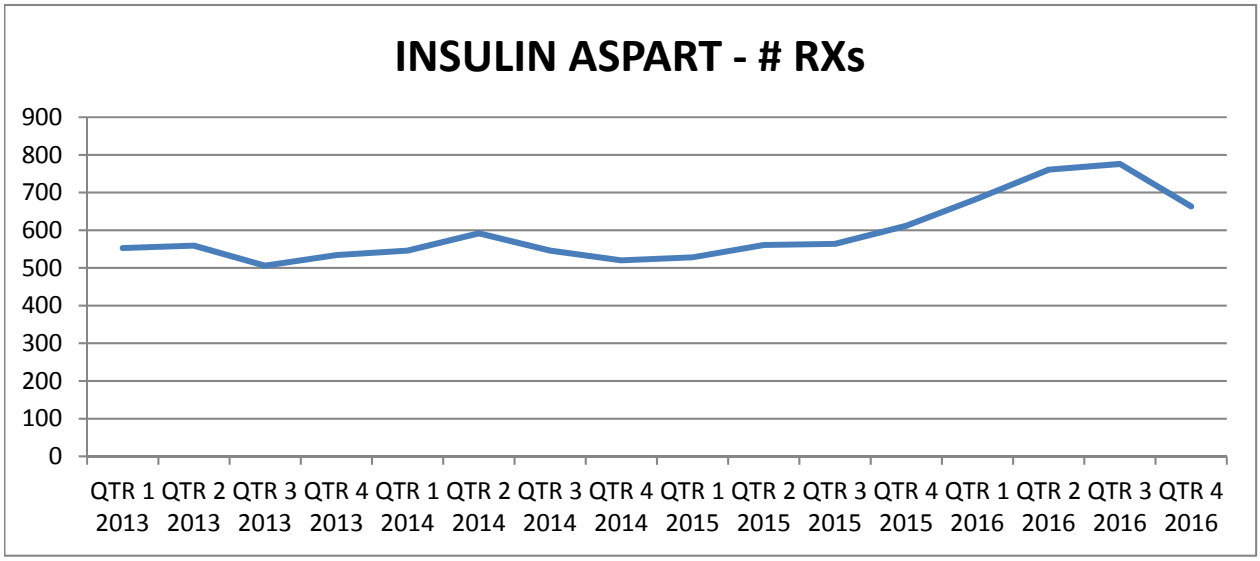

ARIPIPRAZOLE - PAID AMOUNT
1000000
900000
800000
700000
600000
500000
400000
300000
200000
100000
0
QTR 1 2013
QTR 2 2013
QTR 3 2013
QTR 4 2013
QTR 1 2014
QTR 2 2014
QTR 3 2014
QTR 4 2014
QTR 1 2015
QTR 2 2015
QTR 3 2015
QTR 4 2015
QTR 1 2016
QTR 2 2016
QTR 3 2016
QTR 4 2016

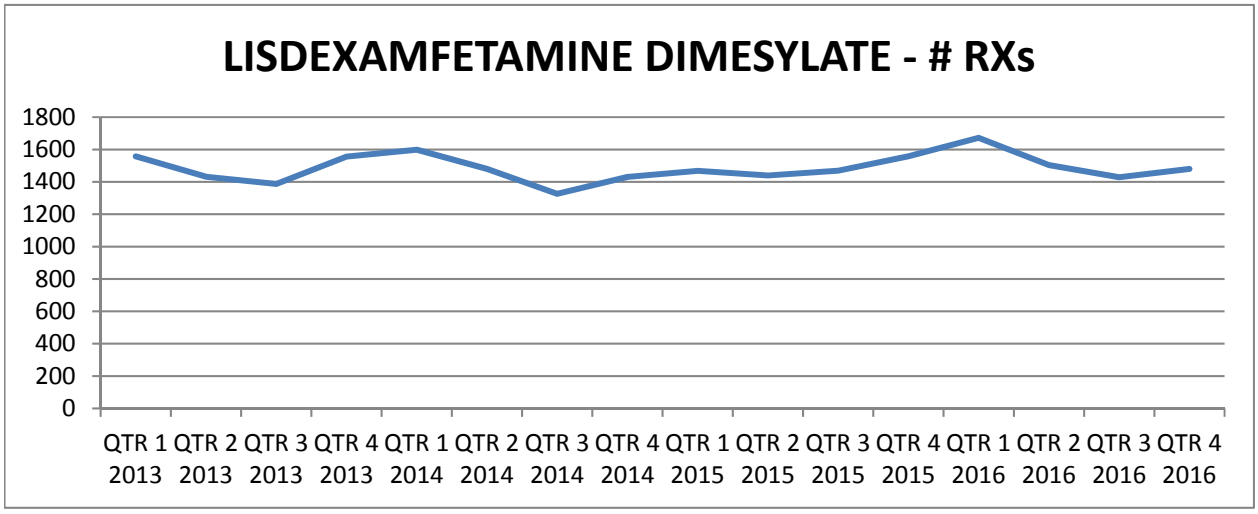

ARIPIPRAZOLE - # RXs
1400
1200
1000
800
600
400
200
0
QTR 1 2013
QTR 2 2013
QTR 3 2013
QTR 4 2013
QTR 1 2014
QTR 2 2014
QTR 3 2014
QTR 4 2014
QTR 1 2015
QTR 2 2015
QTR 3 2015
QTR 4 2015
QTR 1 2016
QTR 2 2016
QTR 3 2016
QTR 4 2016

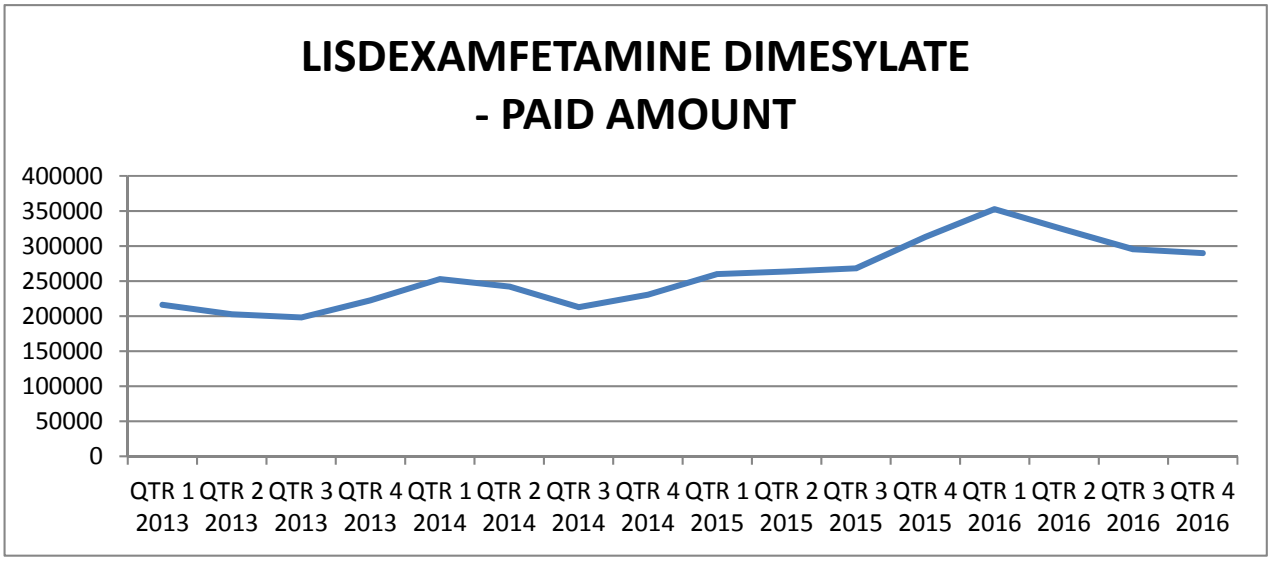

METHYLPHENIDATE HCL - PAID AMOUNT
600000
500000
400000
300000
200000
100000
0
QTR 1 2013
QTR 2 2013
QTR 3 2013
QTR 4 2013
QTR 1 2014
QTR 2 2014
QTR 3 2014
QTR 4 2014
QTR 1 2015
QTR 2 2015
QTR 3 2015
QTR 4 2015
QTR 1 2016
QTR 2 2016
QTR 3 2016
QTR 4 2016

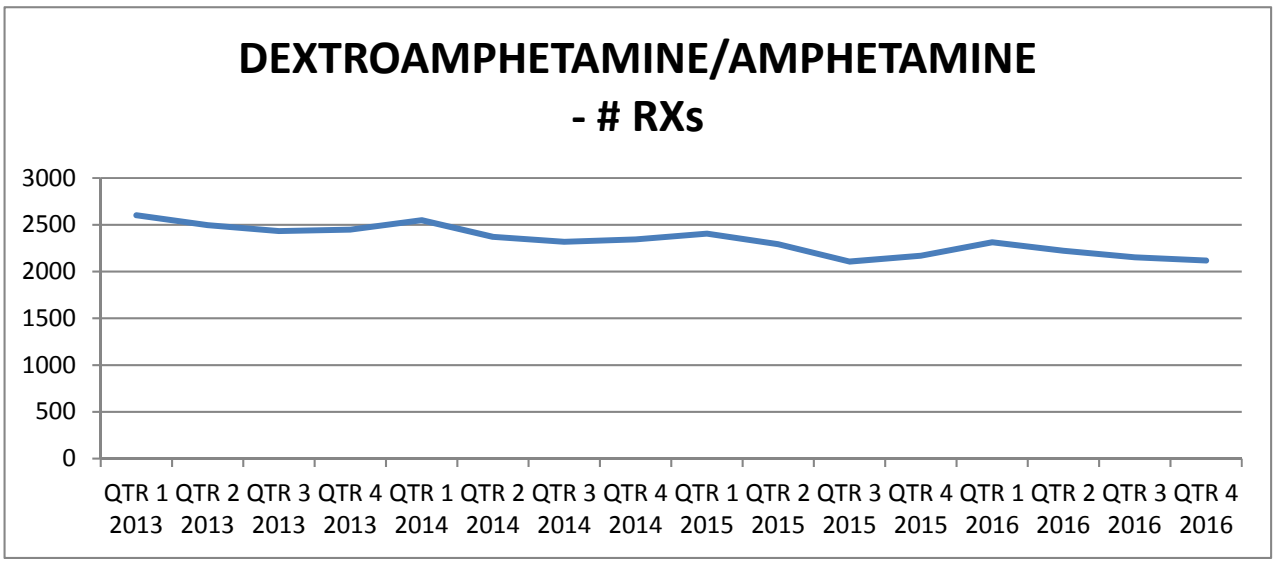

METHYLPHENIDATE HCL - # RXs
5000
4000
3000
2000
1000
0
QTR 1 2013
QTR 2 2013
QTR 3 2013
QTR 4 2013
QTR 1 2014
QTR 2 2014
QTR 3 2014
QTR 4 2014
QTR 1 2015
QTR 2 2015
QTR 3 2015
QTR 4 2015
QTR 1 2016
QTR 2 2016
QTR 3 2016
QTR 4 2016

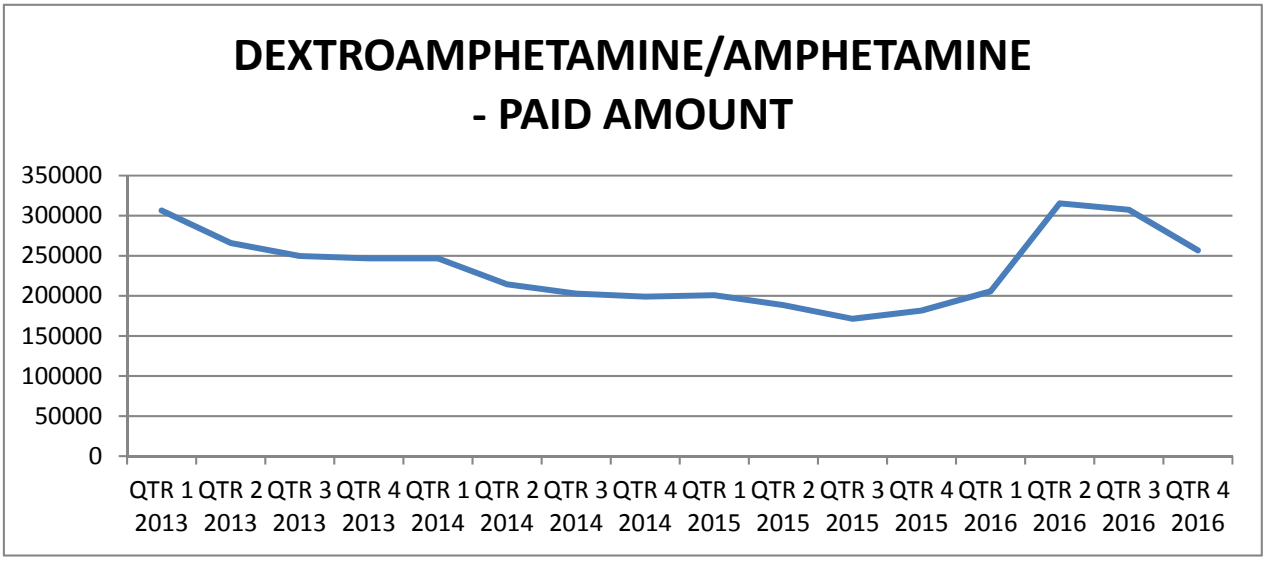

INSULIN ASPART - PAID AMOUNT
450000
400000
350000
300000
250000
200000
150000
100000
50000
0
QTR 1 2013
QTR 2 2013
QTR 3 2013
QTR 4 2013
QTR 1 2014
QTR 2 2014
QTR 3 2014
QTR 4 2014
QTR 1 2015
QTR 2 2015
QTR 3 2015
QTR 4 2015
QTR 1 2016
QTR 2 2016
QTR 3 2016
QTR 4 2016

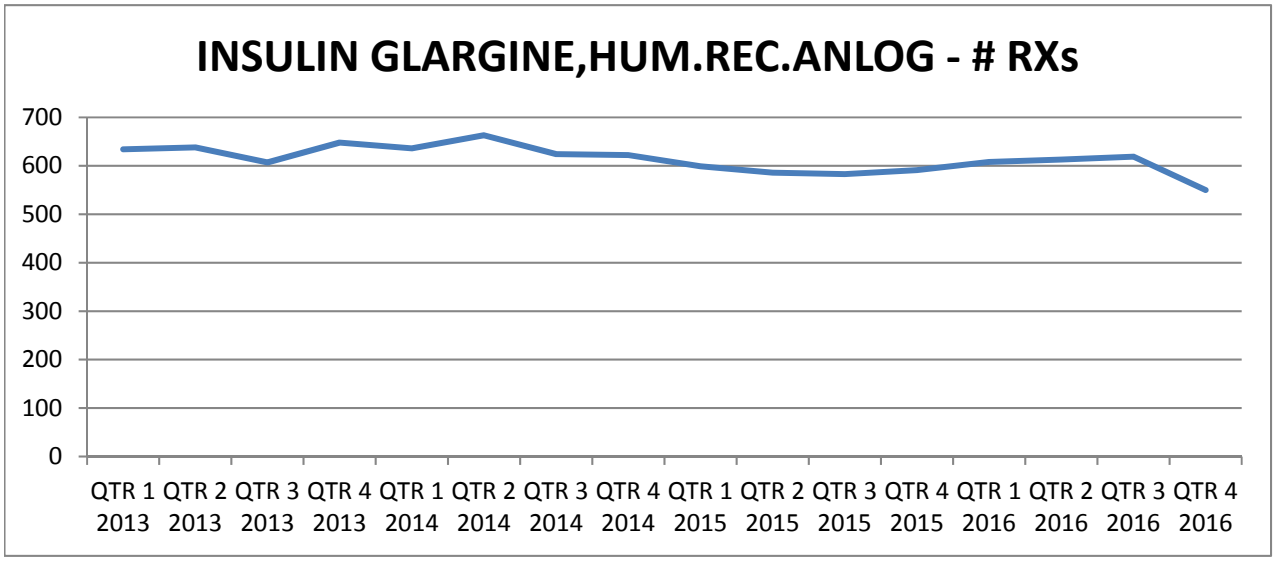

INSULIN ASPART - # RXs
900
800
700
600
500
400
300
200
100
0
QTR 1 2013
QTR 2 2013
QTR 3 2013
QTR 4 2013
QTR 1 2014
QTR 2 2014
QTR 3 2014
QTR 4 2014
QTR 1 2015
QTR 2 2015
QTR 3 2015
QTR 4 2015
QTR 1 2016
QTR 2 2016
QTR 3 2016
QTR 4 2016

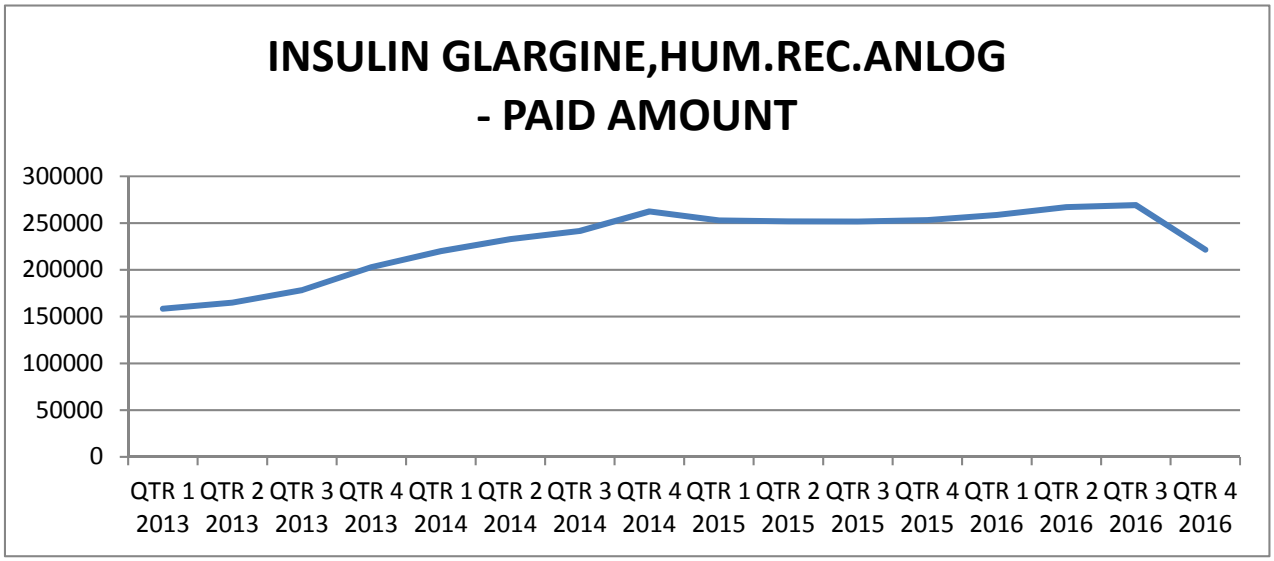

LISDEXAMFETAMINE DIMESYLATE - # RXs
1800
1600
1400
1200
1000
800
600
400
200
0
QTR 1 2013
QTR 2 2013
QTR 3 2013
QTR 4 2013
QTR 1 2014
QTR 2 2014
QTR 3 2014
QTR 4 2014
QTR 1 2015
QTR 2 2015
QTR 3 2015
QTR 4 2015
QTR 1 2016
QTR 2 2016
QTR 3 2016
QTR 4 2016

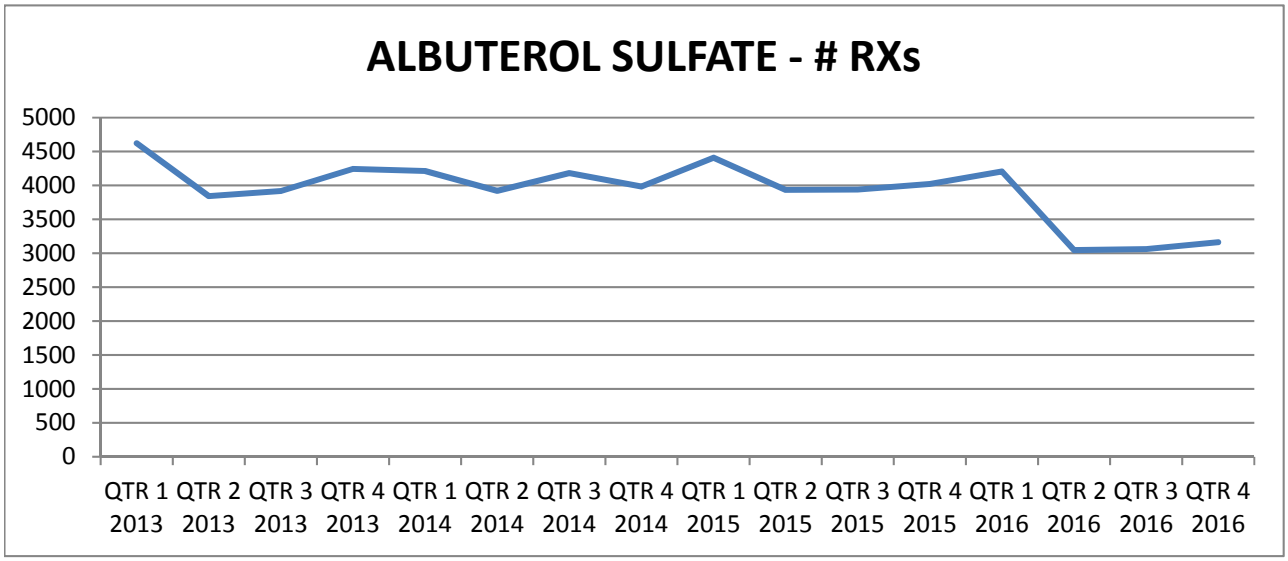

LISDEXAMFETAMINE DIMESYLATE
- PAID AMOUNT
400000
350000
300000
250000
200000
150000
100000
50000
0
QTR 1 2013
QTR 2 2013
QTR 3 2013
QTR 4 2013
QTR 1 2014
QTR 2 2014
QTR 3 2014
QTR 4 2014
QTR 1 2015
QTR 2 2015
QTR 3 2015
QTR 4 2015
QTR 1 2016
QTR 2 2016
QTR 3 2016
QTR 4 2016

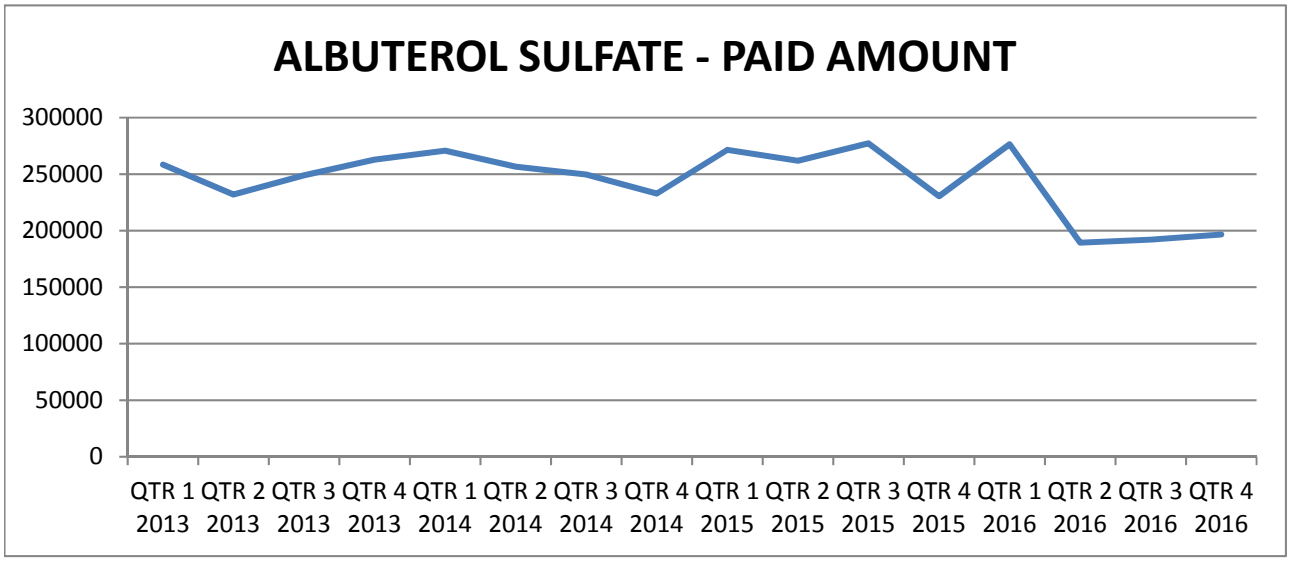

DEXTROAMPHETAMINE/AMPHETAMINE
- # RXs
3000
2500
2000
1500
1000
500
0
QTR 1 2013
QTR 2 2013
QTR 3 2013
QTR 4 2013
QTR 1 2014
QTR 2 2014
QTR 3 2014
QTR 4 2014
QTR 1 2015
QTR 2 2015
QTR 3 2015
QTR 4 2015
QTR 1 2016
QTR 2 2016
QTR 3 2016
QTR 4 2016

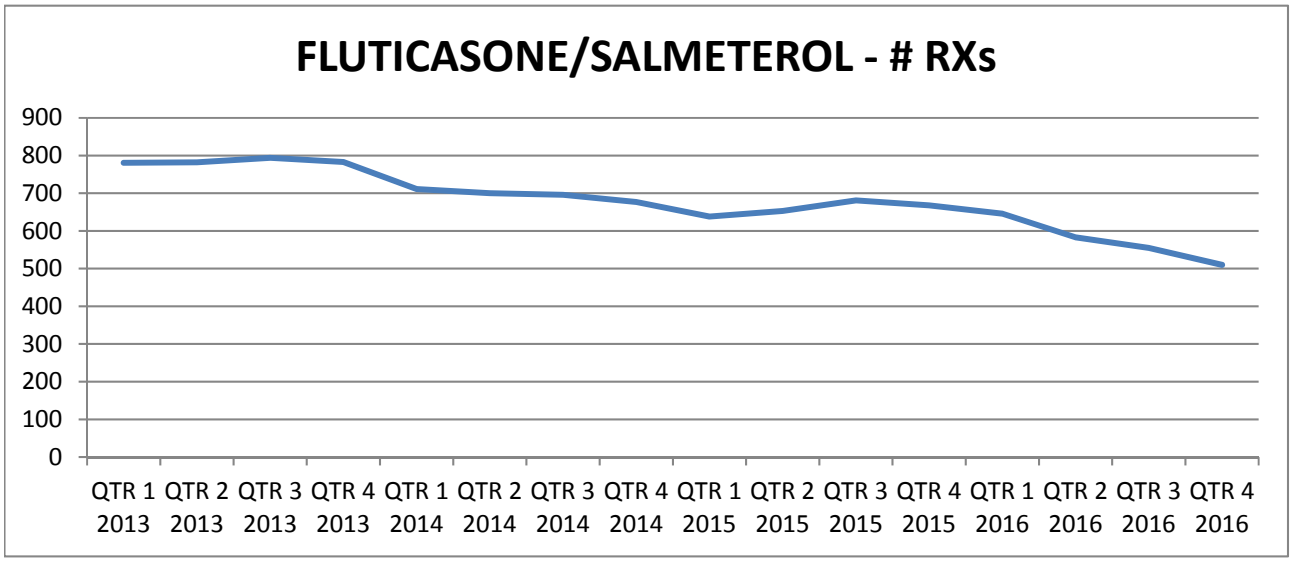

DEXTROAMPHETAMINE/AMPHETAMINE
- PAID AMOUNT
350000
300000
250000
200000
150000
100000
50000
0
QTR 1 2013
QTR 2 2013
QTR 3 2013
QTR 4 2013
QTR 1 2014
QTR 2 2014
QTR 3 2014
QTR 4 2014
QTR 1 2015
QTR 2 2015
QTR 3 2015
QTR 4 2015
QTR 1 2016
QTR 2 2016
QTR 3 2016
QTR 4 2016

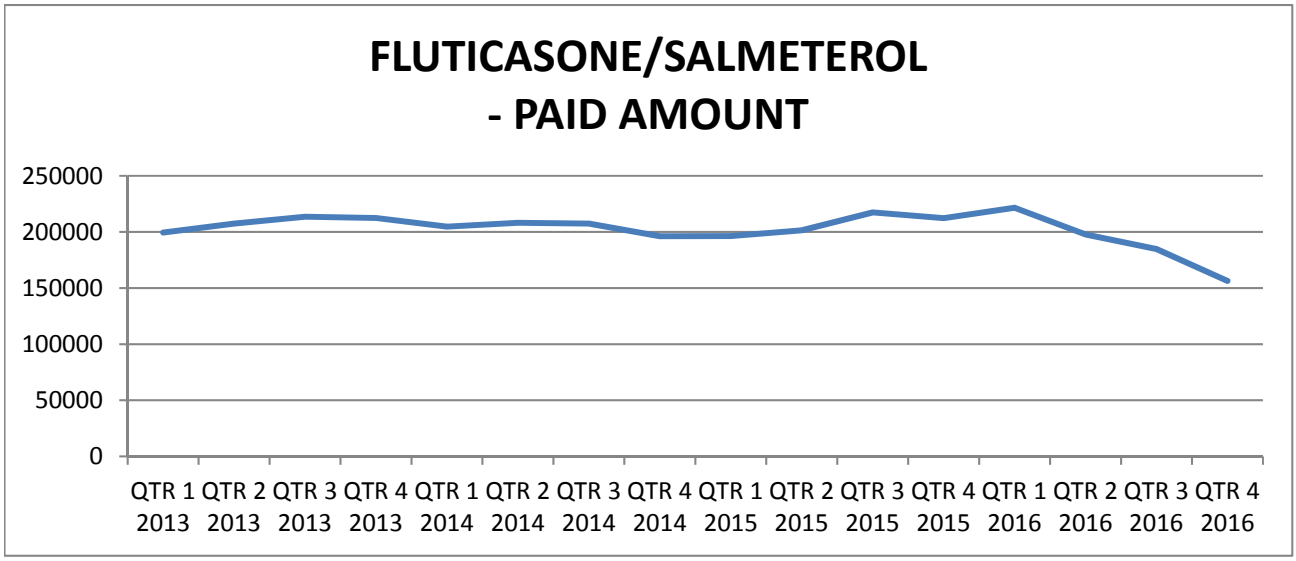

INSULIN GLARGINE,HUM.REC.ANLOG - # RXs
700
600
500
400
300
200
100
0
QTR 1 2013
QTR 2 2013
QTR 3 2013
QTR 4 2013
QTR 1 2014
QTR 2 2014
QTR 3 2014
QTR 4 2014
QTR 1 2015
QTR 2 2015
QTR 3 2015
QTR 4 2015
QTR 1 2016
QTR 2 2016
QTR 3 2016
QTR 4 2016

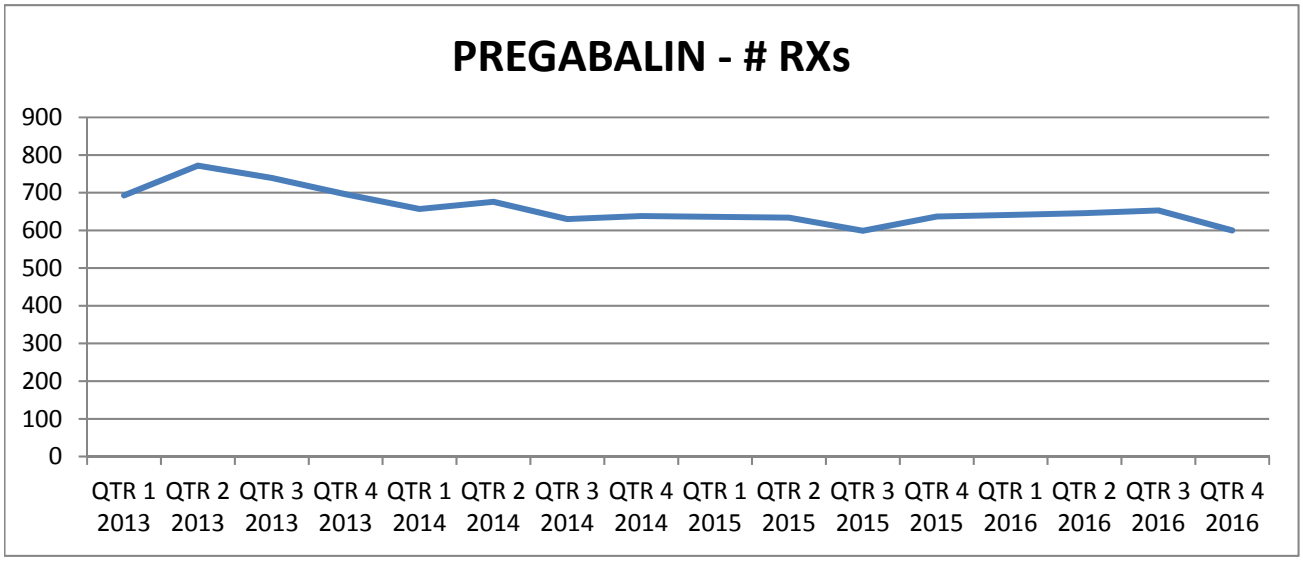

INSULIN GLARGINE,HUM.REC.ANLOG
- PAID AMOUNT
300000
250000
200000
150000
100000
50000
0
QTR 1 2013
QTR 2 2013
QTR 3 2013
QTR 4 2013
QTR 1 2014
QTR 2 2014
QTR 3 2014
QTR 4 2014
QTR 1 2015
QTR 2 2015
QTR 3 2015
QTR 4 2015
QTR 1 2016
QTR 2 2016
QTR 3 2016
QTR 4 2016

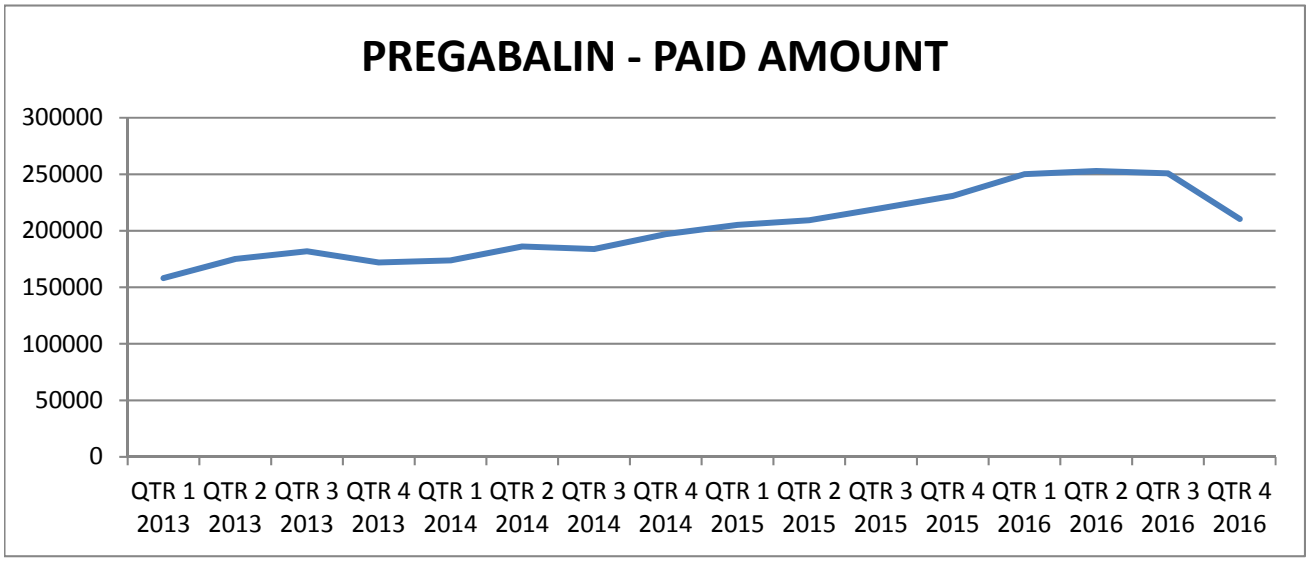

ALBUTEROL SULFATE - # RXs
5000
4500
4000
3500
3000
2500
2000
1500
1000
500
0
QTR 1 2013
QTR 2 2013
QTR 3 2013
QTR 4 2013
QTR 1 2014
QTR 2 2014
QTR 3 2014
QTR 4 2014
QTR 1 2015
QTR 2 2015
QTR 3 2015
QTR 4 2015
QTR 1 2016
QTR 2 2016
QTR 3 2016
QTR 4 2016

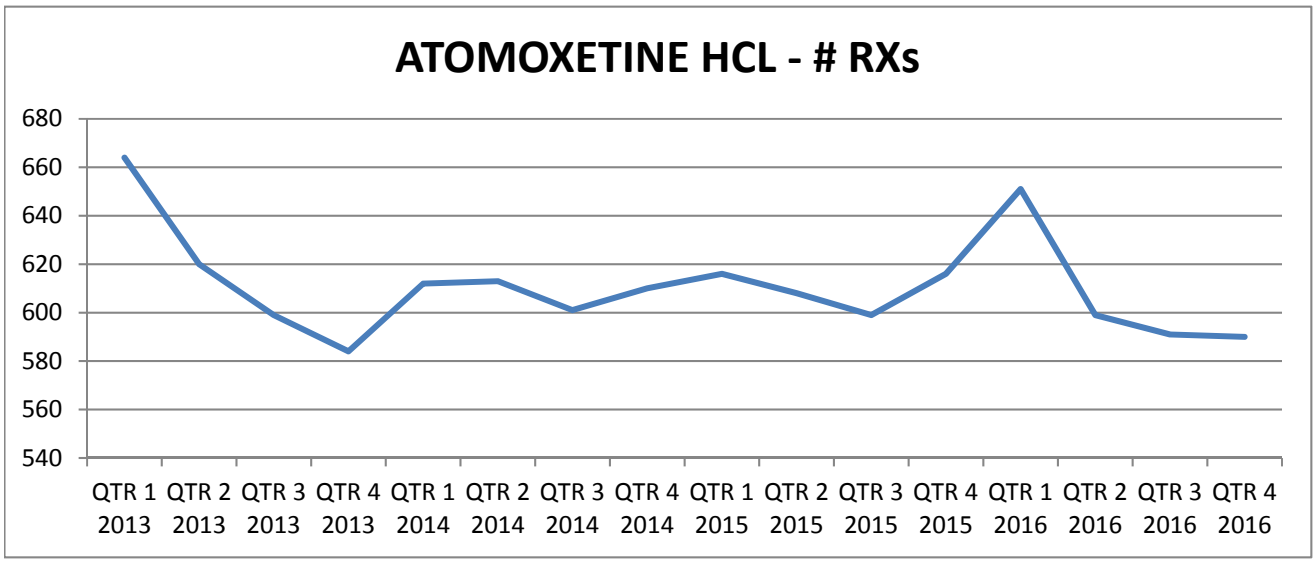

ALBUTEROL SULFATE - PAID AMOUNT
300000
250000
200000
150000
100000
50000
0
QTR 1 2013
QTR 2 2013
QTR 3 2013
QTR 4 2013
QTR 1 2014
QTR 2 2014
QTR 3 2014
QTR 4 2014
QTR 1 2015
QTR 2 2015
QTR 3 2015
QTR 4 2015
QTR 1 2016
QTR 2 2016
QTR 3 2016
QTR 4 2016

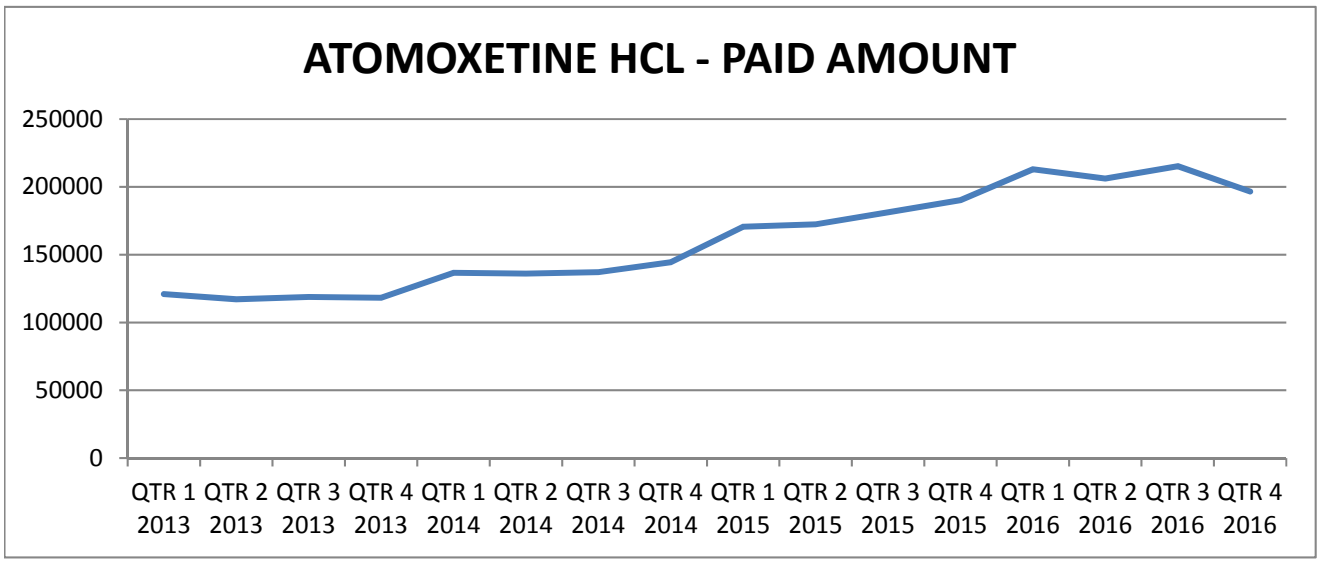

FLUTICASONE/SALMETEROL - # RXs
900
800
700
600
500
400
300
200
100
0
QTR 1 2013
QTR 2 2013
QTR 3 2013
QTR 4 2013
QTR 1 2014
QTR 2 2014
QTR 3 2014
QTR 4 2014
QTR 1 2015
QTR 2 2015
QTR 3 2015
QTR 4 2015
QTR 1 2016
QTR 2 2016
QTR 3 2016
QTR 4 2016

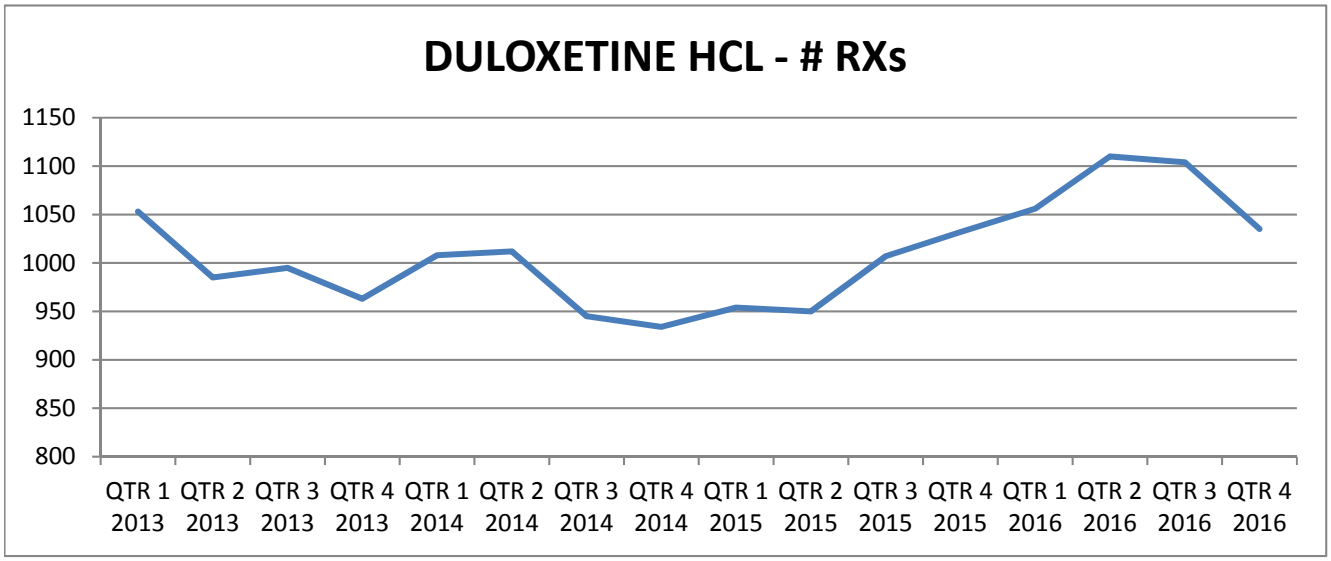

FLUTICASONE/SALMETEROL
- PAID AMOUNT
250000
200000
150000
100000
50000
0
QTR 1 2013
QTR 2 2013
QTR 3 2013
QTR 4 2013
QTR 1 2014
QTR 2 2014
QTR 3 2014
QTR 4 2014
QTR 1 2015
QTR 2 2015
QTR 3 2015
QTR 4 2015
QTR 1 2016
QTR 2 2016
QTR 3 2016
QTR 4 2016

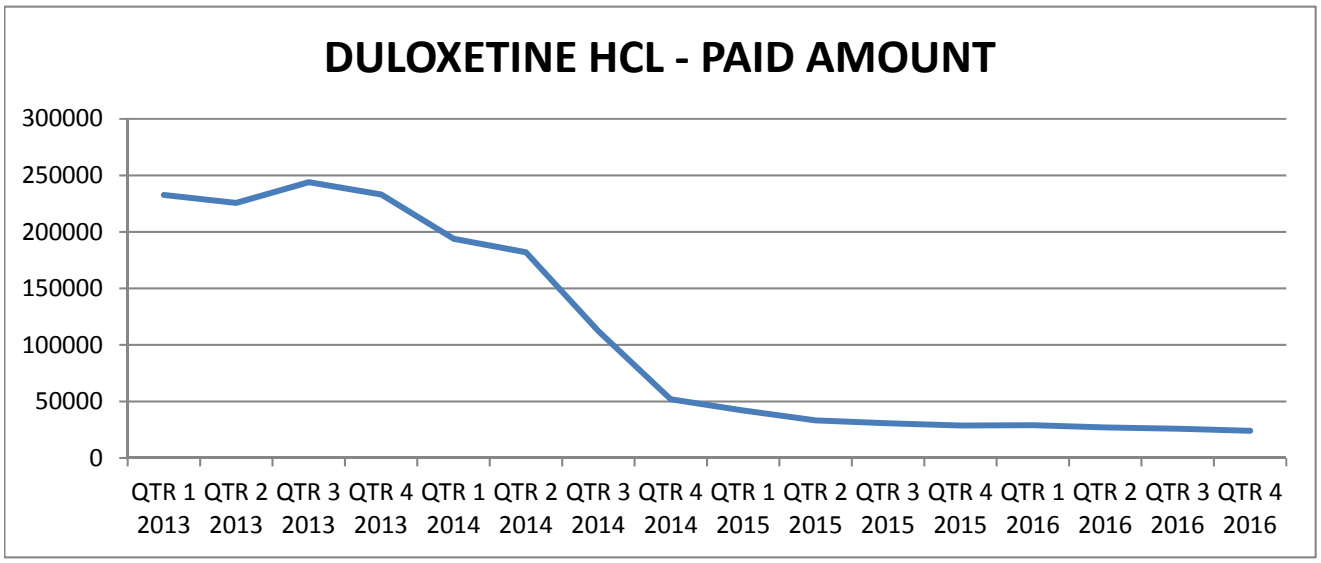

PREGABALIN - # RXs
900
800
700
600
500
400
300
200
100
0
QTR 1 2013
QTR 2 2013
QTR 3 2013
QTR 4 2013
QTR 1 2014
QTR 2 2014
QTR 3 2014
QTR 4 2014
QTR 1 2015
QTR 2 2015
QTR 3 2015
QTR 4 2015
QTR 1 2016
QTR 2 2016
QTR 3 2016
QTR 4 2016

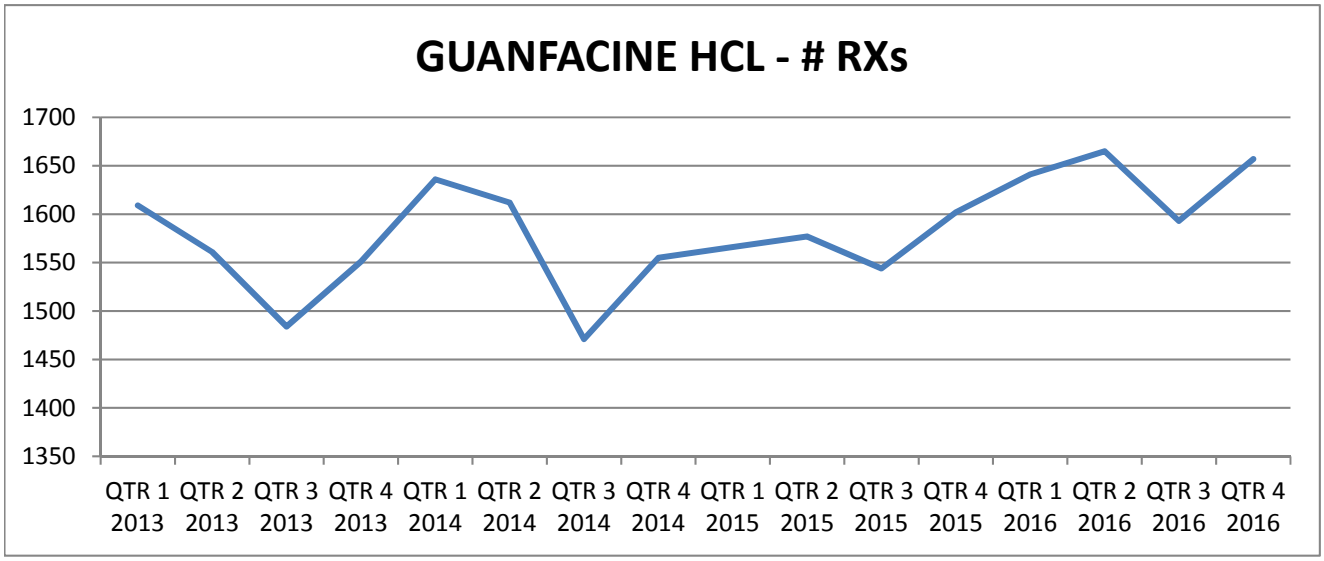

PREGABALIN - PAID AMOUNT
300000
250000
200000
150000
100000
50000
0
QTR 1 2013
QTR 2 2013
QTR 3 2013
QTR 4 2013
QTR 1 2014
QTR 2 2014
QTR 3 2014
QTR 4 2014
QTR 1 2015
QTR 2 2015
QTR 3 2015
QTR 4 2015
QTR 1 2016
QTR 2 2016
QTR 3 2016
QTR 4 2016

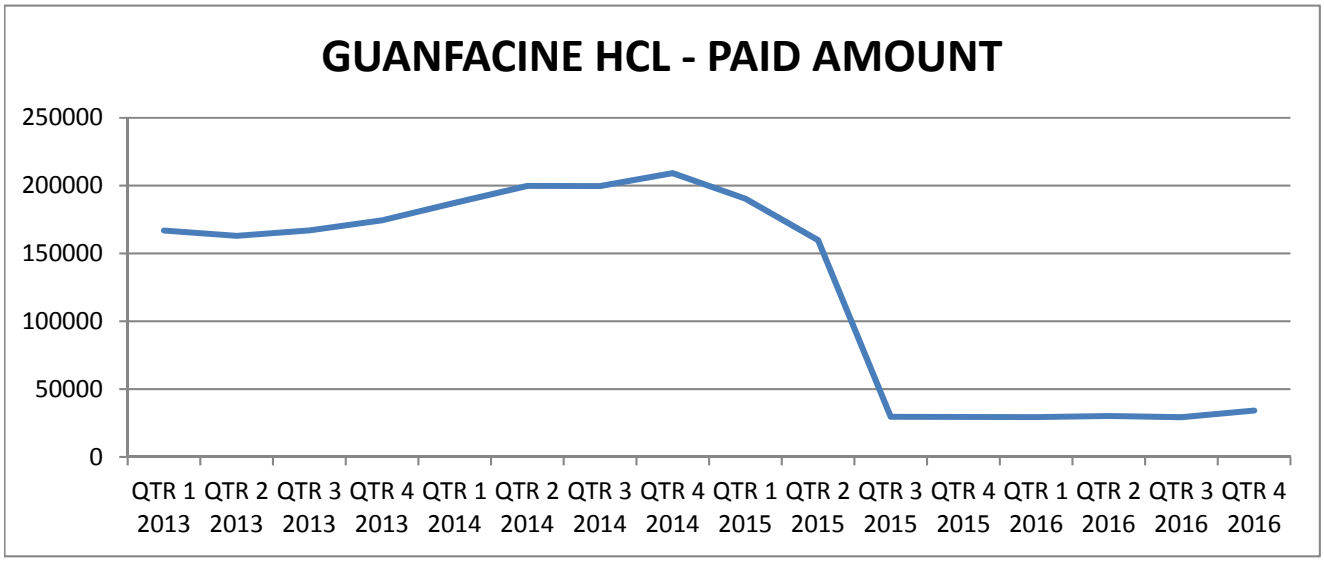

ATOMOXETINE HCL - # RXs
680
660
640
620
600
580
560
540
QTR 1 2013
QTR 2 2013
QTR 3 2013
QTR 4 2013
QTR 1 2014
QTR 2 2014
QTR 3 2014
QTR 4 2014
QTR 1 2015
QTR 2 2015
QTR 3 2015
QTR 4 2015
QTR 1 2016
QTR 2 2016
QTR 3 2016
QTR 4 2016

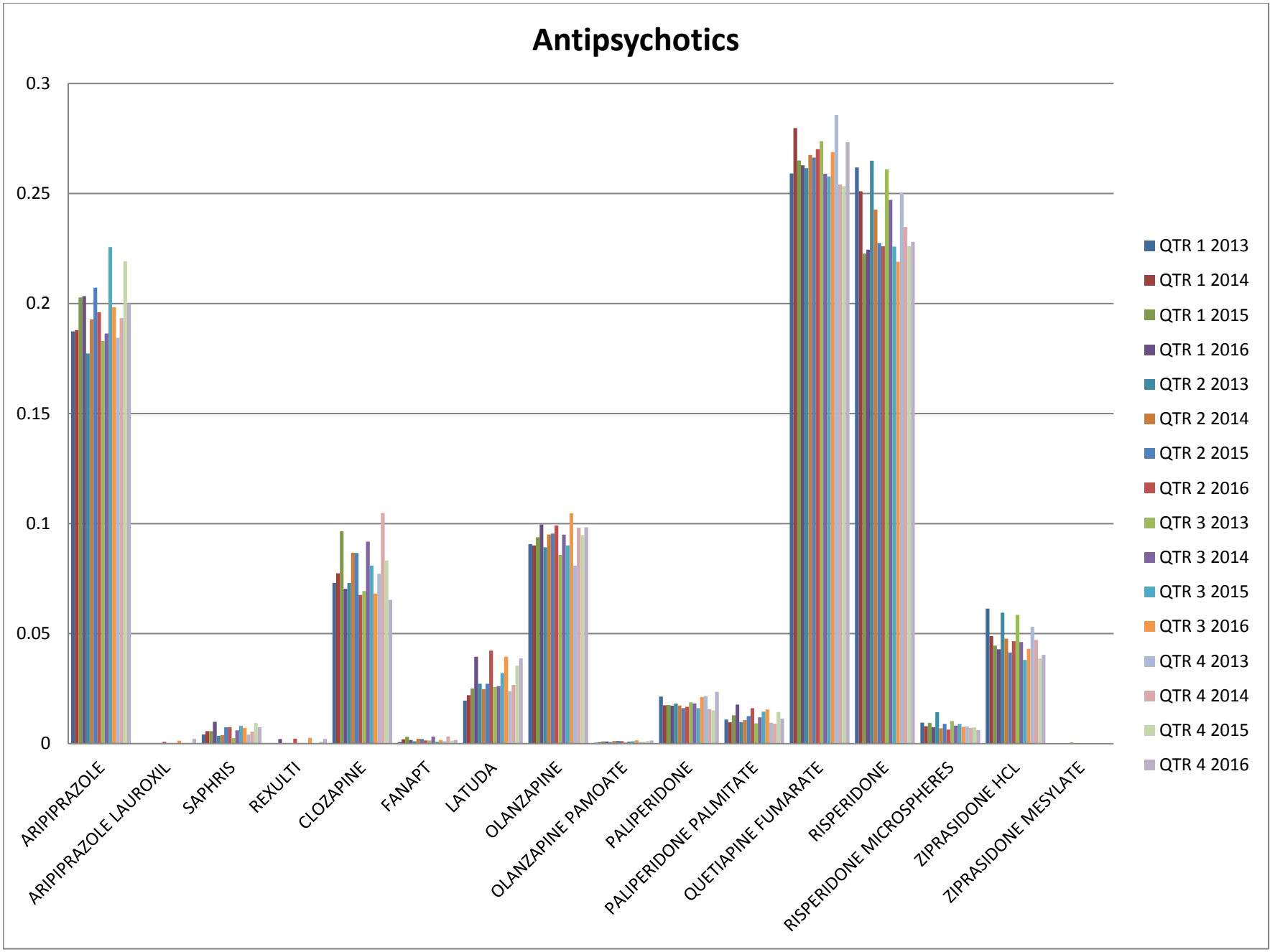

ATOMOXETINE HCL - PAID AMOUNT
250000
200000
150000
100000
50000
0
QTR 1 2013
QTR 2 2013
QTR 3 2013
QTR 4 2013
QTR 1 2014
QTR 2 2014
QTR 3 2014
QTR 4 2014
QTR 1 2015
QTR 2 2015
QTR 3 2015
QTR 4 2015
QTR 1 2016
QTR 2 2016
QTR 3 2016
QTR 4 2016

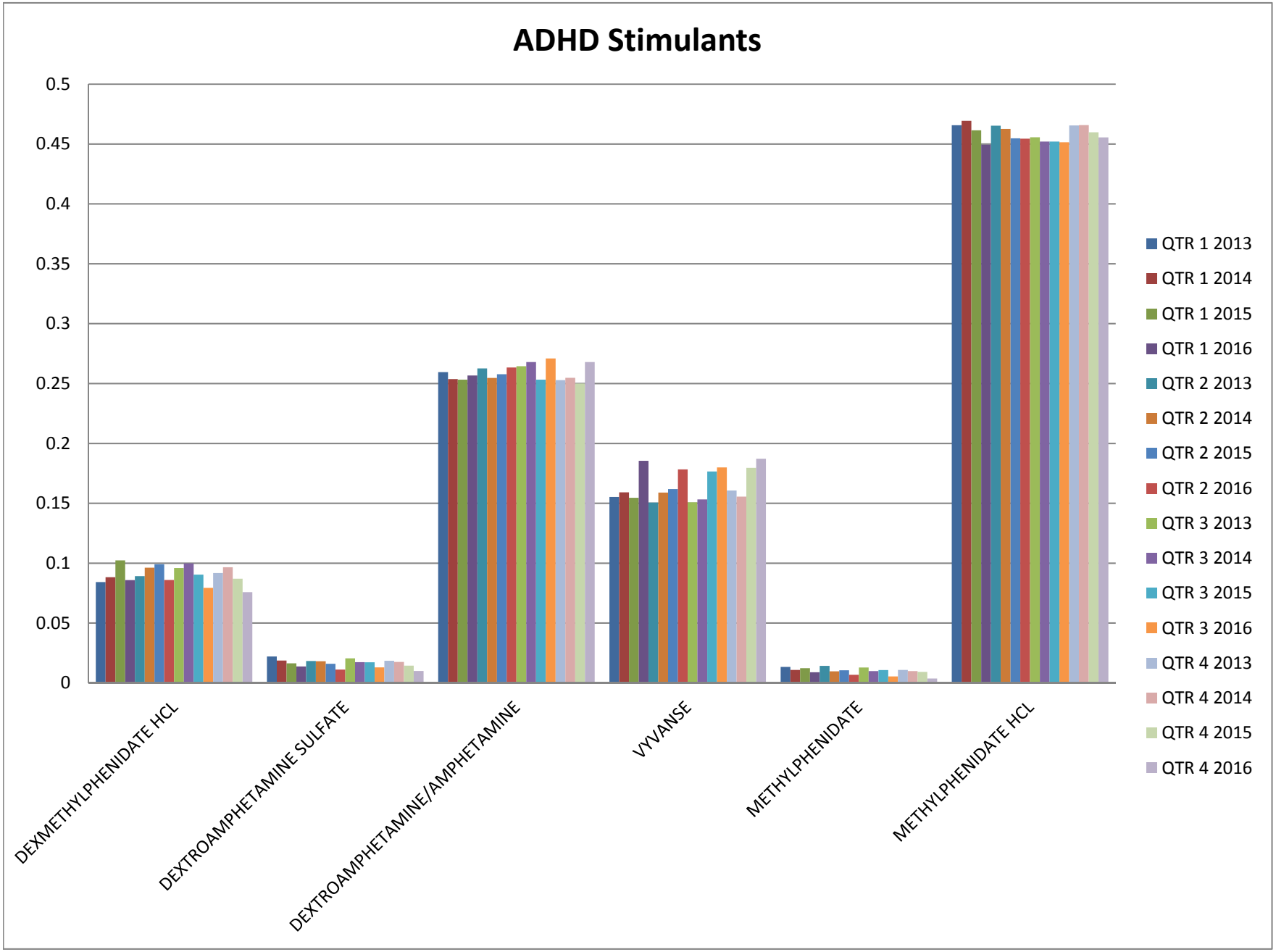

DULOXETINE HCL - # RXs
1150
1100
1050
1000
950
900
850
800
QTR 1 2013
QTR 2 2013
QTR 3 2013
QTR 4 2013
QTR 1 2014
QTR 2 2014
QTR 3 2014
QTR 4 2014
QTR 1 2015
QTR 2 2015
QTR 3 2015
QTR 4 2015
QTR 1 2016
QTR 2 2016
QTR 3 2016
QTR 4 2016


DULOXETINE HCL - PAID AMOUNT
300000
250000
200000
150000
100000
50000
0
QTR 1 2013
QTR 2 2013
QTR 3 2013
QTR 4 2013
QTR 1 2014
QTR 2 2014
QTR 3 2014
QTR 4 2014
QTR 1 2015
QTR 2 2015
QTR 3 2015
QTR 4 2015
QTR 1 2016
QTR 2 2016
QTR 3 2016
QTR 4 2016

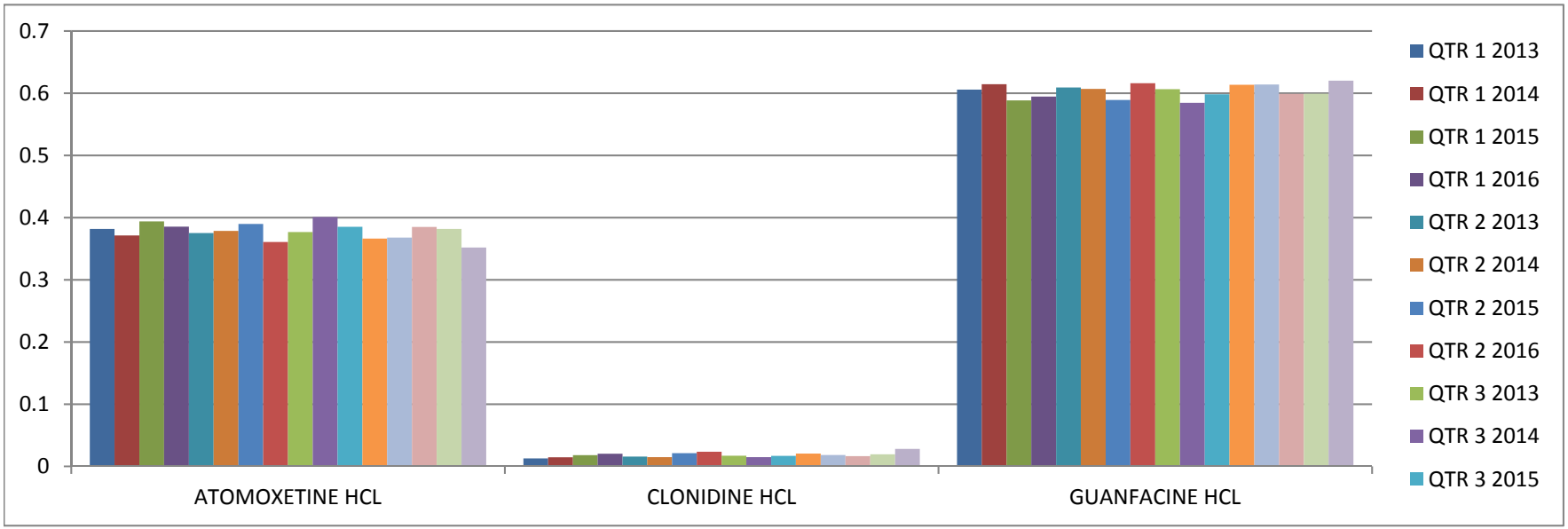

GUANFACINE HCL - # RXs
1700
1650
1600
1550
1500
1450
1400
1350
QTR 1 2013
QTR 2 2013
QTR 3 2013
QTR 4 2013
QTR 1 2014
QTR 2 2014
QTR 3 2014
QTR 4 2014
QTR 1 2015
QTR 2 2015
QTR 3 2015
QTR 4 2015
QTR 1 2016
QTR 2 2016
QTR 3 2016
QTR 4 2016

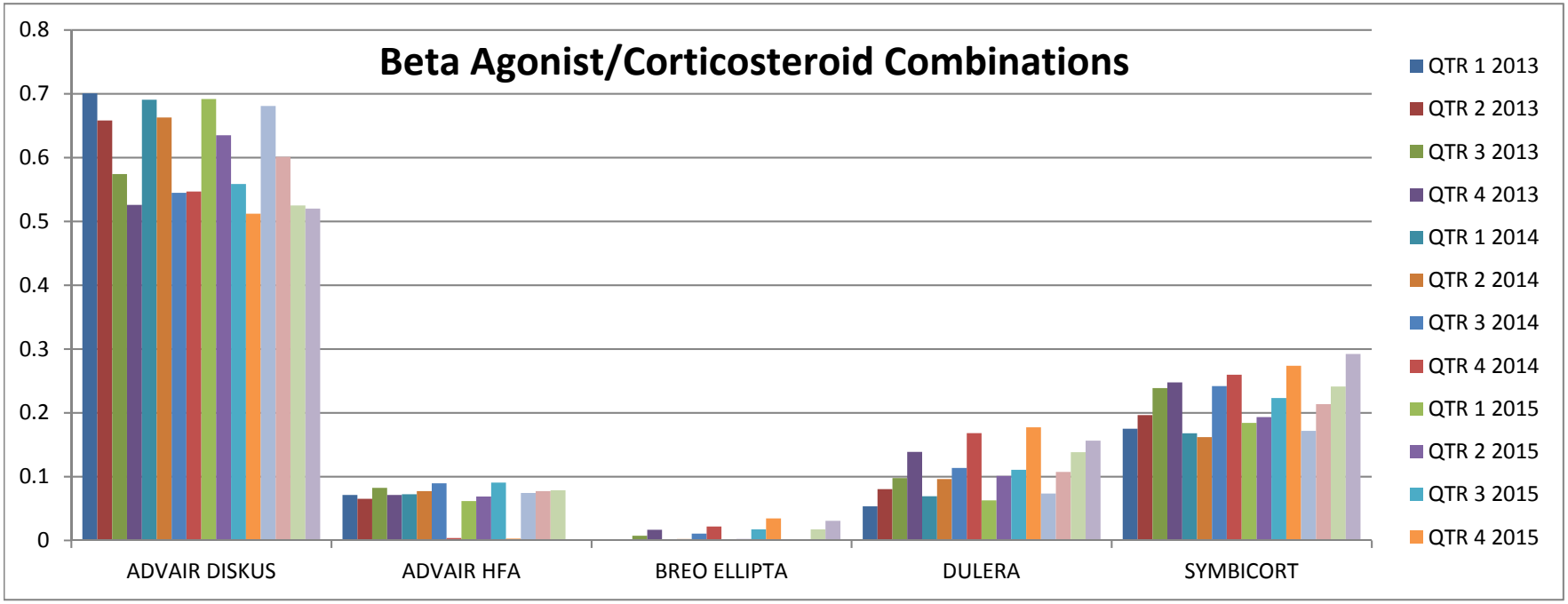

GUANFACINE HCL - PAID AMOUNT
250000
200000
150000
100000
50000
0
QTR 1 2013
QTR 2 2013
QTR 3 2013
QTR 4 2013
QTR 1 2014
QTR 2 2014
QTR 3 2014
QTR 4 2014
QTR 1 2015
QTR 2 2015
QTR 3 2015
QTR 4 2015
QTR 1 2016
QTR 2 2016
QTR 3 2016
QTR 4 2016

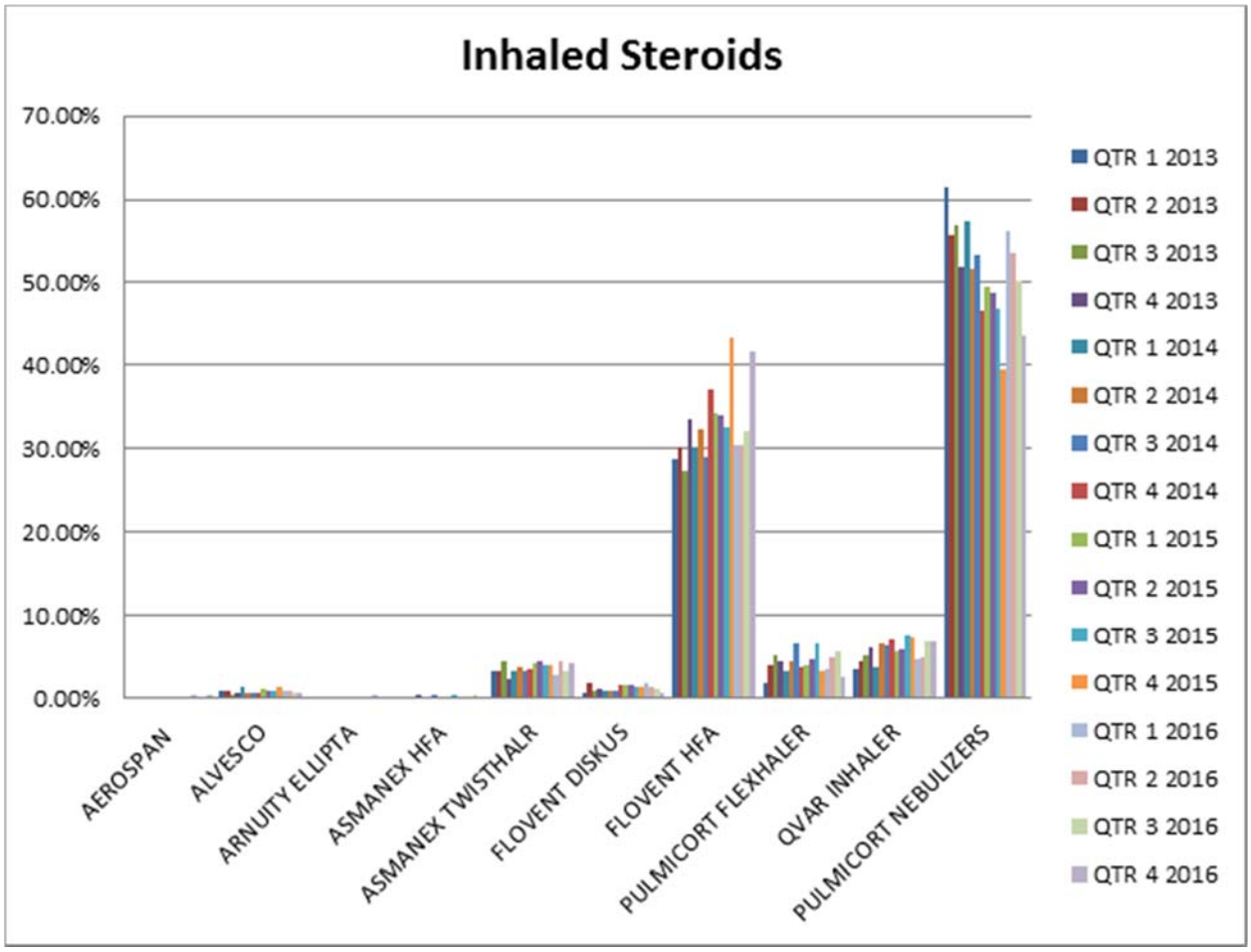

Antipsychotics
0.3
0.25
0.2
0.15
0.1
0.05
0
ARIPIPRAZOLE
ARIPIPRAZOLE LAUROXIL
SAPHRIS
REXULTI
CLOZAPINE
FANAPT
LATUDA
OLANZAPINE
OLANZAPINE PAMOATE
PALIPERIDONE
PALIPERIDONE PALMITATE
QUETIAPINE FUMARATE
RISPERIDONE
RISPERIDONE MICROSPHERES
ZIPRASIDONE HCL
ZIPRASIDONE MESYLATE
QTR 1 2013
QTR 1 2014
QTR 1 2015
QTR 1 2016
QTR 2 2013
QTR 2 2014
QTR 2 2015
QTR 2 2016
QTR 3 2013
QTR 3 2014
QTR 3 2015
QTR 3 2016
QTR 4 2013
QTR 4 2014
QTR 4 2015
QTR 4 2016

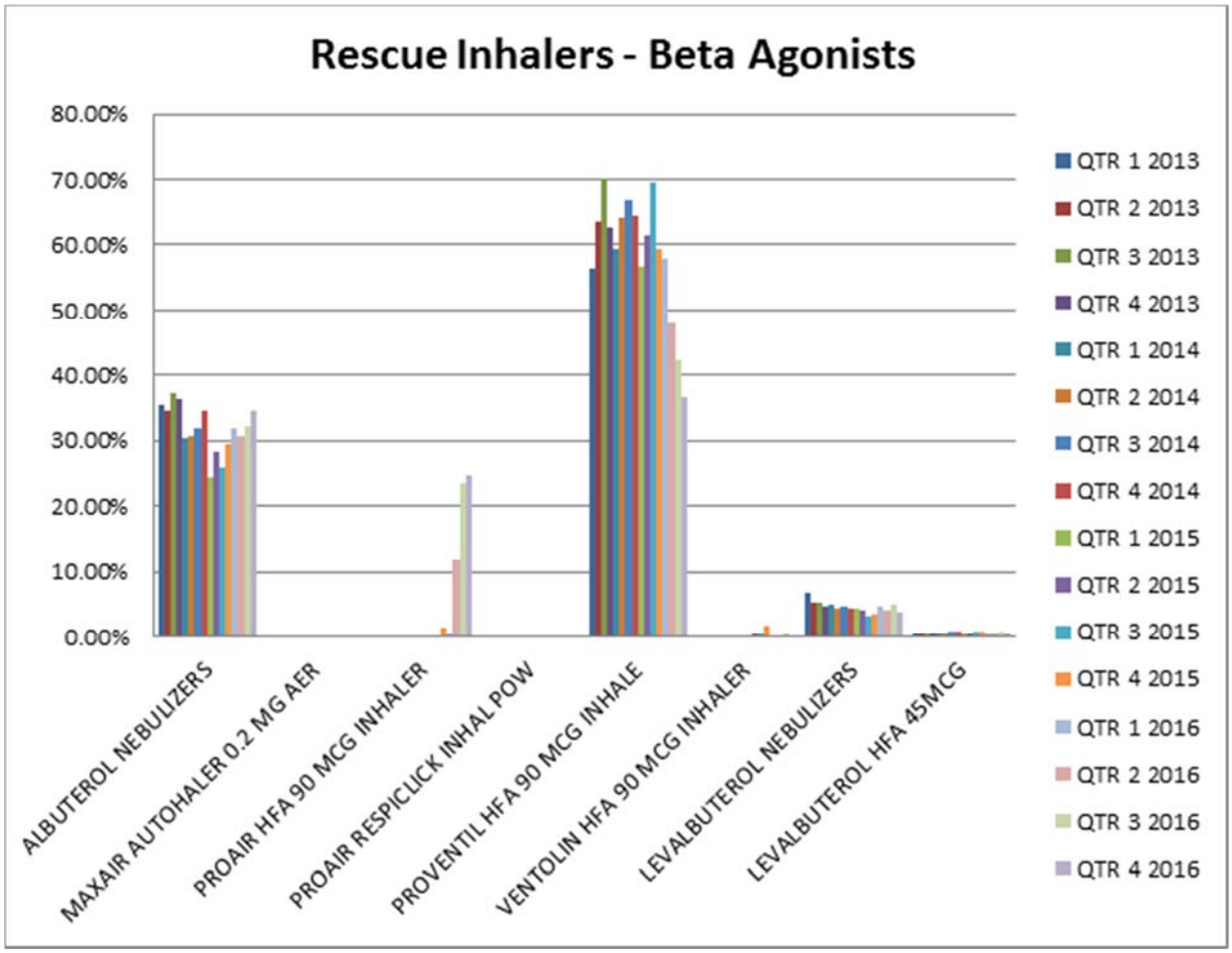

ADHD Stimulants
0.5
0.45
0.4
0.35
0.3
0.25
0.2
0.15
0.1
0.05
0
DEXMETHYLPHENIDATE HCL
DEXTROAMPHETAMINE SULFATE
DEXTROAMPHETAMINE/AMPHETAMINE
VYVANSE
METHYLPHENIDATE
METHYLPHENIDATE HCL
QTR 1 2013
QTR 1 2014
QTR 1 2015
QTR 1 2016
QTR 2 2013
QTR 2 2014
QTR 2 2015
QTR 2 2016
QTR 3 2013
QTR 3 2014
QTR 3 2015
QTR 3 2016
QTR 4 2013
QTR 4 2014
QTR 4 2015
QTR 4 2016

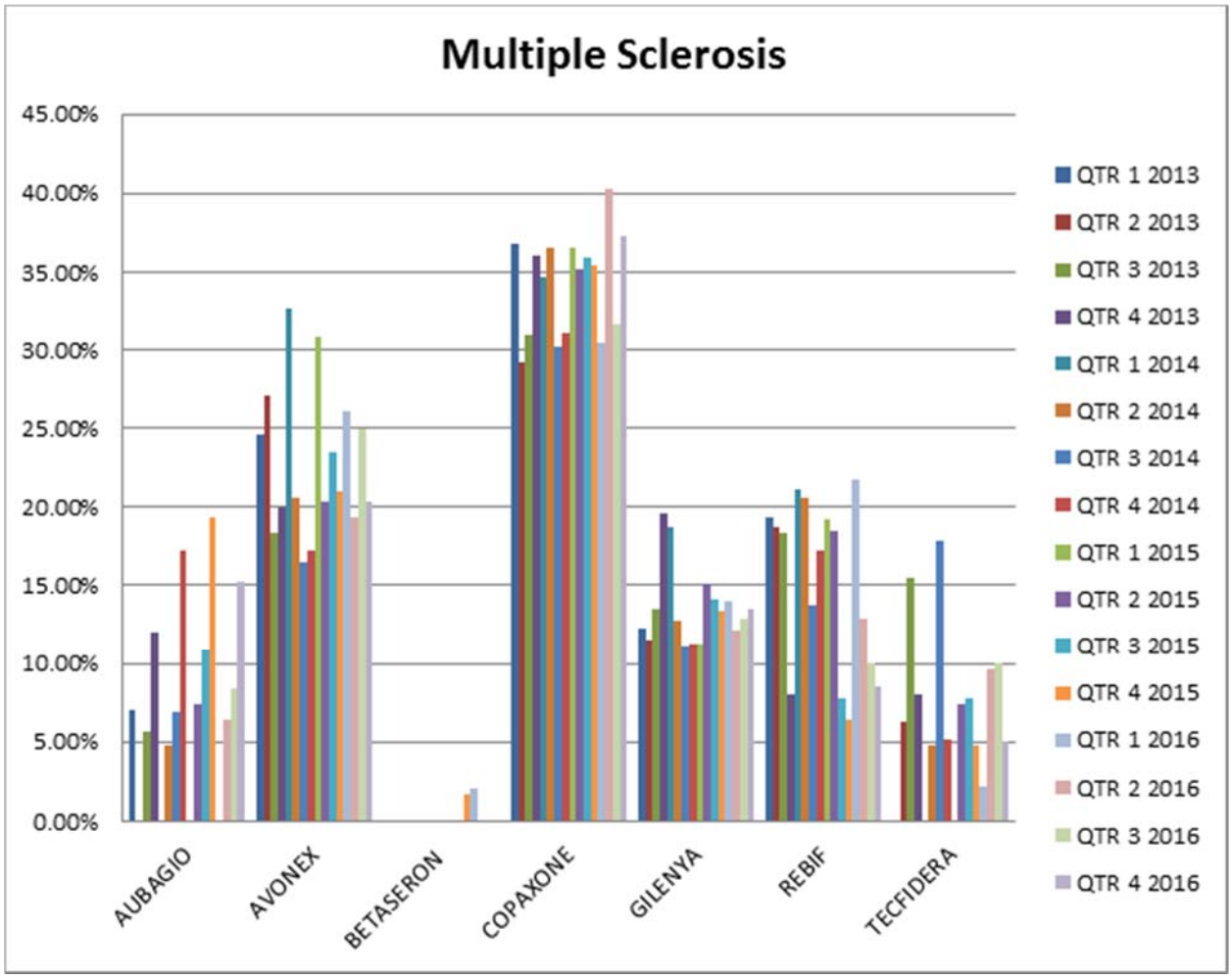
Non-Stimulant ADHD



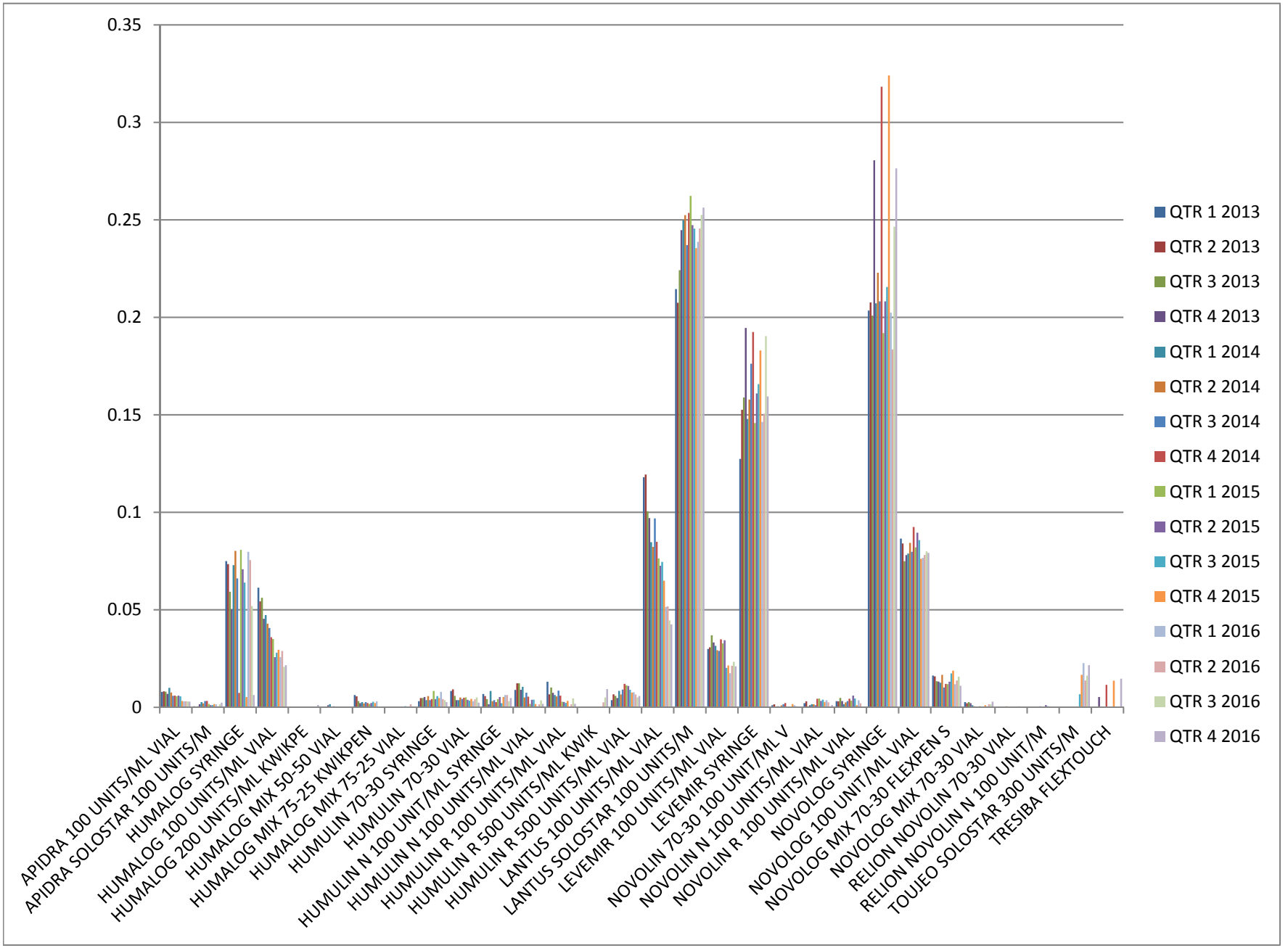



Inhaled Steroids
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
AEROSPAN
ALVESCO
ARNUITY ELLIPTA
ASMANEX HFA
ASMANEX TWISTHALR
FLOVENT DISKUS
FLOVENT HFA
PULMICORT FLEXHALER
QVAR INHALER
PULMICORT NEBULIZERS
QTR 1 2013
QTR 2 2013
QTR 3 2013
QTR 4 2013
QTR 1 2014
QTR 2 2014
QTR 3 2014
QTR 4 2014
QTR 1 2015
QTR 2 2015
QTR 3 2015
QTR 4 2015
QTR 1 2016
QTR 2 2016
QTR 3 2016
QTR 4 2016

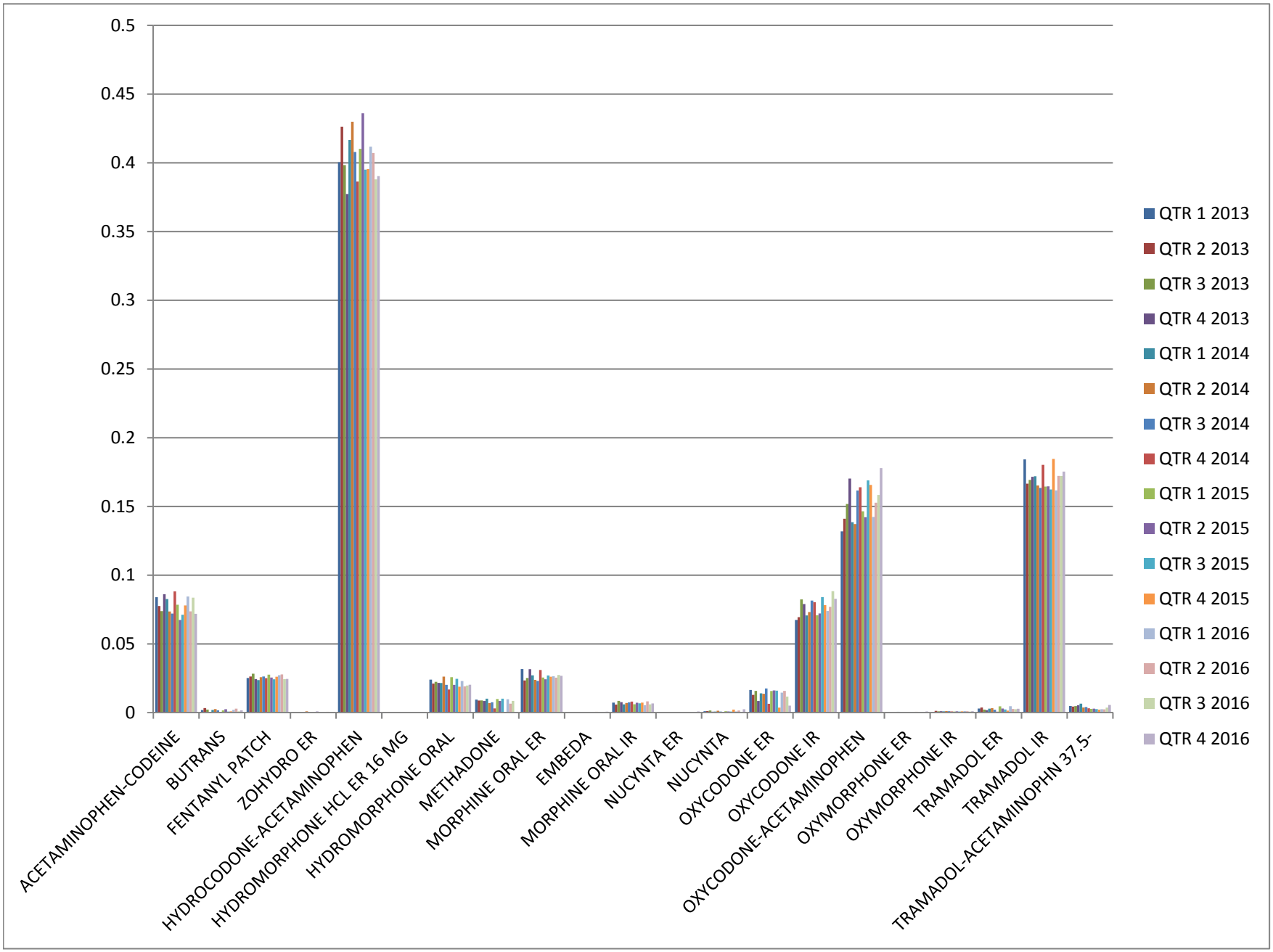

Rescue Inhalers - Beta Agonists
80.00%
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
ALBUTEROL NEBULIZERS
MAXAIR AUTOHALER 0.2 MG AER
PROAIR HFA 90 MCG INHALER
PROAIR RESPICLICK INHAL POW
PROVENTIL HFA 90 MCG INHALE
VENTOLIN HFA 90 MCG INHALER
LEVALBUTEROL NEBULIZERS
LEVALBUTEROL HFA 45MCG
QTR 1 2013
QTR 2 2013
QTR 3 2013
QTR 4 2013
QTR 1 2014
QTR 2 2014
QTR 3 2014
QTR 4 2014
QTR 1 2015
QTR 2 2015
QTR 3 2015
QTR 4 2015
QTR 1 2016
QTR 2 2016
QTR 3 2016
QTR 4 2016


Multiple Sclerosis
45.00%
40.00%
35.00%
30.00%
25.00%
20.00%
15.00%
10.00%
5.00%
0.00%
AUBAGIO
AVONEX
BETASERON
COPAXONE
GILENYA
REBIF
TECFIDERA
QTR 1 2013
QTR 2 2013
QTR 3 2013
QTR 4 2013
QTR 1 2014
QTR 2 2014
QTR 3 2014
QTR 4 2014
QTR 1 2015
QTR 2 2015
QTR 3 2015
QTR 4 2015
QTR 1 2016
QTR 2 2016
QTR 3 2016
QTR 4 2016

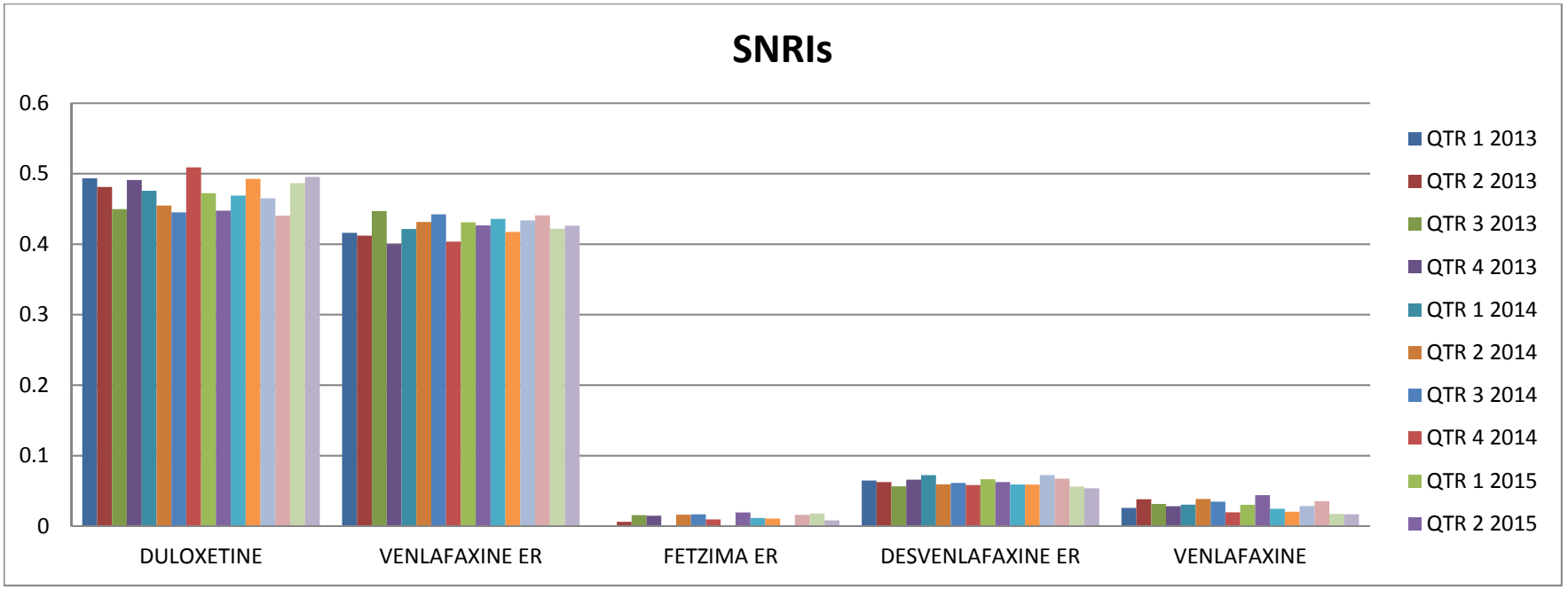
Insulins

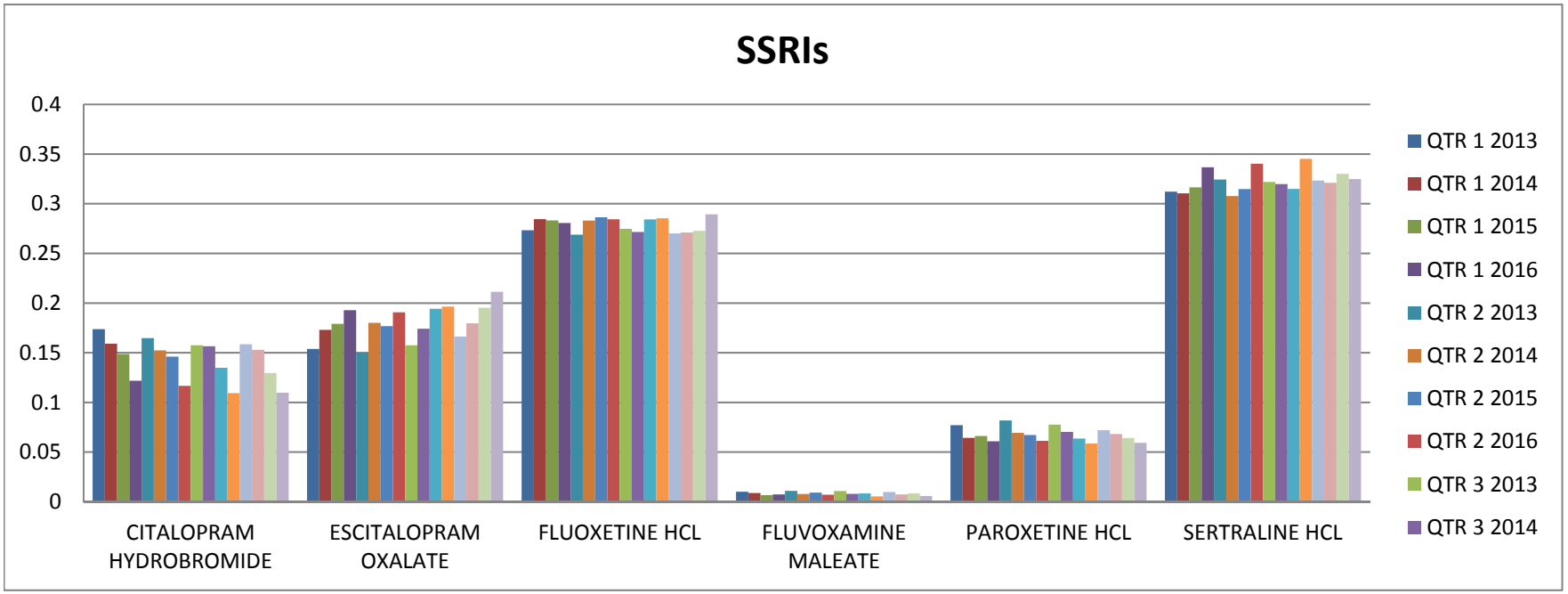

0.35
0.3
0.25
0.2
0.15
0.1
0.05
0
APIDRA 100 UNITS/ML VIAL
APIDRA SOLOSTAR 100 UNITS/M
HUMALOG SYRINGE
HUMALOG 100 UNITS/ML VIAL
HUMALOG 200 UNITS/ML KWIKPE
HUMALOG MIX 50-50 VIAL
HUMALOG MIX 75-25 KWIKPEN
HUMALOG MIX 75-25 VIAL
HUMULIN 70-30 SYRINGE
HUMULIN 70-30 VIAL
HUMULIN N 100 UNIT/ML SYRINGE
HUMULIN N 100 UNITS/ML VIAL
HUMULIN R 100 UNITS/ML VIAL
HUMULIN R 500 UNITS/ML KWIK
HUMULIN R 500 UNITS/ML VIAL
LANTUS 100 UNITS/ML VIAL
LANTUS SOLOSTAR 100 UNITS/M
LEVEMIR 100 UNITS/ML VIAL
LEVEMIR SYRINGE
NOVOLIN 70-30 100 UNIT/ML V
NOVOLIN N 100 UNITS/ML VIAL
NOVOLIN R 100 UNITS/ML VIAL
NOVOLOG SYRINGE
NOVOLOG 100 UNIT/ML VIAL
NOVOLOG MIX 70-30 FLEXPEN S
NOVOLOG MIX 70-30 VIAL
RELION NOVOLIN 70-30 VIAL
RELION NOVOLIN N 100 UNIT/M
TOUJEO SOLOSTAR 300 UNITS/M
TRESIBA FLEXTOUCH
QTR 1 2013
QTR 2 2013
QTR 3 2013
QTR 4 2013
QTR 1 2014
QTR 2 2014
QTR 3 2014
QTR 4 2014
QTR 1 2015
QTR 2 2015
QTR 3 2015
QTR 4 2015
QTR 1 2016
QTR 2 2016
QTR 3 2016
QTR 4 2016

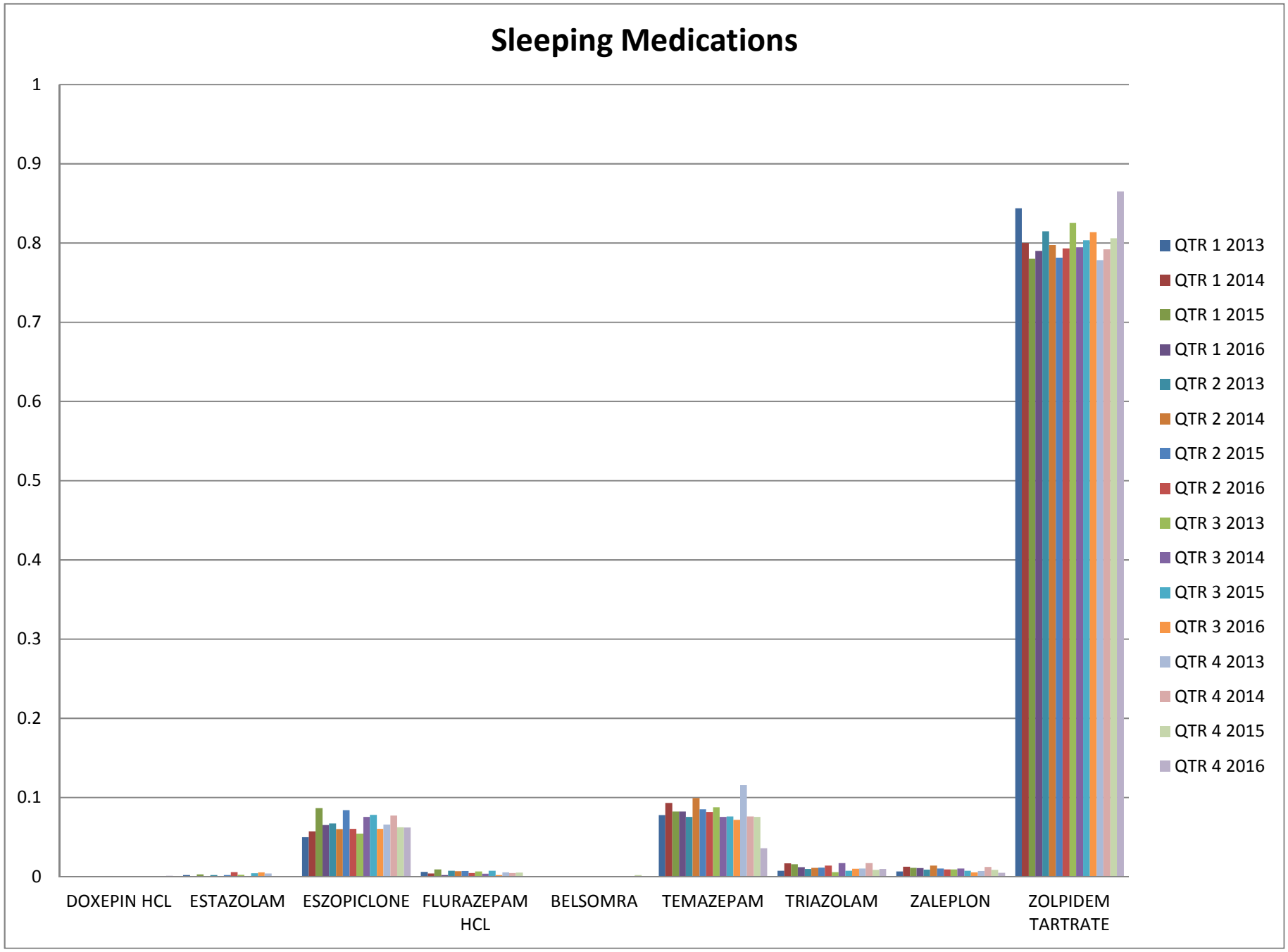
Narcotics

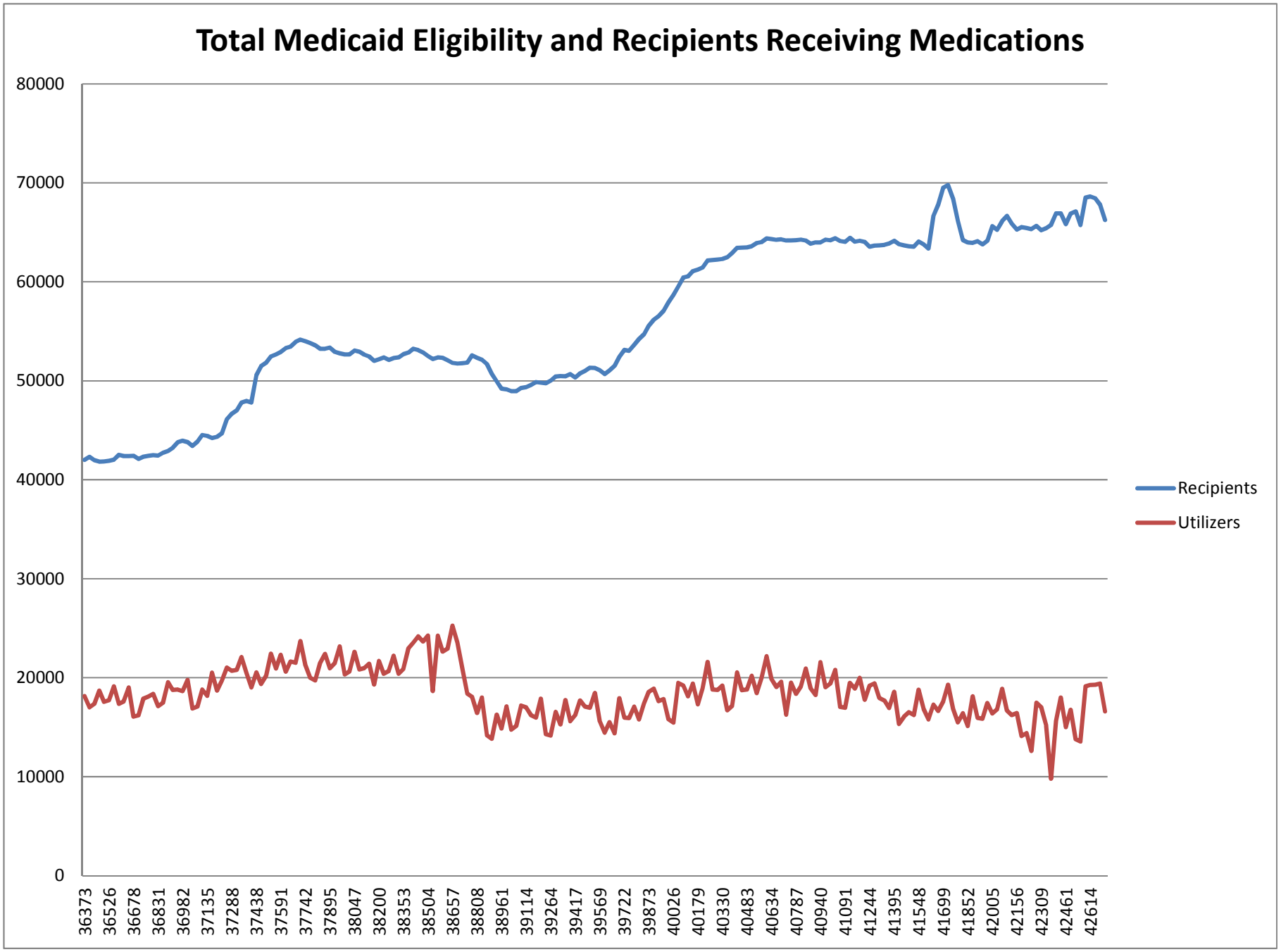

0.5
0.45
0.4
0.35
0.3
0.25
0.2
0.15
0.1
0.05
0
ACETAMINOPHEN-CODEINE
BUTRANS
FENTANYL PATCH
ZOHYDRO ER
HYDROCODONE-ACETAMINOPHEN
HYDROMORPHONE HCL ER 16 MG
HYDROMORPHONE ORAL
METHADONE
MORPHINE ORAL ER
EMBEDA
MORPHINE ORAL IR
NUCYNTA ER
NUCYNTA
OXYCODONE ER
OXYCODONE IR
OXYCODONE-ACETAMINOPHEN
OXYMORPHONE ER
OXYMORPHONE IR
TRAMADOL ER
TRAMADOL IR
TRAMADOL-ACETAMINOPHN 37.5-
QTR 1 2013
QTR 2 2013
QTR 3 2013
QTR 4 2013
QTR 1 2014
QTR 2 2014
QTR 3 2014
QTR 4 2014
QTR 1 2015
QTR 2 2015
QTR 3 2015
QTR 4 2015
QTR 1 2016
QTR 2 2016
QTR 3 2016
QTR 4 2016

Not included in narcotics graph								
Row Labels	QTR 1 2013	QTR 2 2013	QTR 3 2013	QTR 4 2013	QTR 1 2014	QTR 2 2014	QTR 3 2014	QTR 4 2014
AVINZA	0.15%	0.13%	0.00%	0.00%	0.16%	0.04%	0.00%	0.00%
BELLADONNA-OPIUM	0.00%	0.01%	0.00%	0.00%	0.04%	0.00%	0.00%	0.01%
BUTORPHANOL 10 MG/ML SPRAY	0.02%	0.03%	0.03%	0.03%	0.03%	0.03%	0.03%	0.03%
CODEINE SULFATE 30 MG TABLE	0.05%	0.04%	0.05%	0.04%	0.02%	0.00%	0.03%	0.04%
DEMEROL SYRINGE	0.03%	0.13%	0.09%	0.00%	0.07%	0.10%	0.04%	0.00%
HYDROMORPHONE INJECTION	0.15%	0.00%	0.11%	0.20%	0.06%	0.02%	0.01%	0.28%
MEPERIDINE ORAL	0.15%	0.12%	0.07%	0.07%	0.13%	0.14%	0.09%	0.04%
MORPHINE INJECTION	0.18%	0.08%	0.26%	0.37%	0.10%	0.17%	0.05%	0.14%
NALBUPHINE 20 MG/ML AMPUL	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
PENTAZOCINE-NALOXONE TABLET	0.00%	0.00%	0.00%	0.00%	0.00%	0.01%	0.01%	0.00%
Row Labels	QTR 1 2015	QTR 2 2015	QTR 3 2015	QTR 4 2015	QTR 1 2016	QTR 2 2016	QTR 3 2016	QTR 4 2016
AVINZA	0.14%	0.00%	0.00%	0.00%	0.15%	0.00%	0.00%	0.00%
BELLADONNA-OPIUM	0.01%	0.02%	0.01%	0.00%	0.03%	0.02%	0.00%	0.03%
BUTORPHANOL 10 MG/ML SPRAY	0.04%	0.05%	0.05%	0.04%	0.04%	0.04%	0.04%	0.03%
CODEINE SULFATE 30 MG TABLE	0.04%	0.03%	0.04%	0.02%	0.05%	0.04%	0.01%	0.03%
DEMEROL SYRINGE	0.07%	0.10%	0.00%	0.01%	0.12%	0.06%	0.00%	0.00%
HYDROMORPHONE INJECTION	0.06%	0.01%	0.02%	0.20%	0.04%	0.01%	0.07%	0.00%
MEPERIDINE ORAL	0.15%	0.09%	0.11%	0.09%	0.09%	0.07%	0.09%	0.03%
MORPHINE INJECTION	0.17%	0.15%	0.04%	0.23%	0.09%	0.05%	0.33%	0.18%
NALBUPHINE 20 MG/ML AMPUL	0.01%	0.01%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
PENTAZOCINE-NALOXONE TABLET	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%


SNRIs
0.6
0.5
0.4
0.3
0.2
0.1
0
DULOXETINE
VENLAFAXINE ER
FETZIMA ER
DESVENLAFAXINE ER
VENLAFAXINE
QTR 1 2013
QTR 2 2013
QTR 3 2013
QTR 4 2013
QTR 1 2014
QTR 2 2014
QTR 3 2014
QTR 4 2014
QTR 1 2015
QTR 2 2015


SSRIs
0.4
0.35
0.3
0.25
0.2
0.15
0.1
0.05
0
CITALOPRAM HYDROBROMIDE
ESCITALOPRAM OXALATE
FLUOXETINE HCL
FLUVOXAMINE MALEATE
PAROXETINE HCL
SERTRALINE HCL
QTR 1 2013
QTR 1 2014
QTR 1 2015
QTR 1 2016
QTR 2 2013
QTR 2 2014
QTR 2 2015
QTR 2 2016
QTR 3 2013
QTR 3 2014


Sleeping Medications
1
0.9
0.8
0.7
0.6
0.5
0.4
0.3
0.2
0.1
0
DOXEPIN HCL
ESTAZOLAM
ESZOPICLONE
FLURAZEPAM HCL
BELSOMRA
TEMAZEPAM
TRIAZOLAM
ZALEPLON
ZOLPIDEM TARTRATE
QTR 1 2013
QTR 1 2014
QTR 1 2015
QTR 1 2016
QTR 2 2013
QTR 2 2014
QTR 2 2015
QTR 2 2016
QTR 3 2013
QTR 3 2014
QTR 3 2015
QTR 3 2016
QTR 4 2013
QTR 4 2014
QTR 4 2015
QTR 4 2016


Total Medicaid Eligibility and Recipients Receiving Medications
80000
70000
60000
50000
40000
30000
20000
10000
0
36373
36526
36678
36831
36982
37135
37288
37438
37591
37742
37895
38047
38200
38353
38504
38657
38808
38961
39114
39264
39417
39569
39722
39873
40026
40179
40330
40483
40634
40787
40940
41091
41244
41395
41548
41699
41852
42005
42156
42309
42461
42614
Recipients
Utilizers

Prior Authorization/PDL Update

Added to PA
ADLYXIN (lixisenatide)
BASAGLAR KWIKPEN U-100 (insulin glargine,hum.rec.anlog)
BENLYSTA (belimumab)
DALVANCE (dalbavancin)
FABRAZYME (agalsidase beta)
FOSRENOL (lanthanum carbonate)
HUMULIN 70/30 KWIKPEN (insulin nph hum/reg insulin hm)
HUMULIN N KWIKPEN (insulin nph human isophane)
HUMULIN R U-500 KWIKPEN (insulin regular, human)
JENTADUETO XR (linagliptin/metformin hcl)
KANUMA (sebelipase alfa)
KEPIVANCE (palifermin)
ORBACTIV (oritavancin)
PANHEMATIN (hemin)
OTOVEL (ciprofloxacin hcl/fluocinolone)
PRESTALIA (perindopril arg/amlodipine bes)
SOLIQUA 100-33 (insulin glargine/lixisenatide)
SPINRAZA (nusinersen/preservative free)
TOBRADEX ST (tobramycin/dexamethasone)

Prior Authorization/PDL Update

Removed from PA
ALOCRIL (nedocromil sodium)
ALOMIDE (lodoxamide tromethamine)
ALVESCO (ciclesonide)
AZASITE (azithromycin)
AZELASTINE HCL (azelastine hcl)
BECONASE AQ (beclomethasone dipropionate)
BESIVANCE (besifloxacin hcl)
BROVANA (arformoterol tartrate)
CILOXAN (ciprofloxacin hcl)
DEXILANT (dexlansoprazole)
DIPENTUM (olsalazine sodium)
EPINEPHRINE (epinephrine)
EURAX (crotamiton)
FLOXIN (ofloxacin)
GELNIQUE (oxybutynin chloride)
PREVACID (lansoprazole)
LASTACAFT (alcaftadine)
MAXITROL (neo/polymyx b sulf/dexameth)
OMECLAMOX-PAK (omeprazole/clarith/amoxicillin)
OMNARIS (ciclesonide)
OXYTROL (oxybutynin)
PREVPAC (lansoprazole/amoxiciln/clarith)
QNASL (beclomethasone dipropionate)
RENVELA (sevelamer carbonate)
ZETONNA (ciclesonide)

NORTH DAKOTA MEDICAID
RETROSPECTIVE DRUG UTILIZATION REVIEW
CRITERIA RECOMMENDATIONS
1ST QUARTER 2017

Criteria Recommendations ***Approved Rejected***

1. Lixisenatide / Over-utilization _____ _____

Alert Message: The manufacturer's recommended maximum daily dose of Adlyxin (lixisenatide) is 20 mcg per day.

Conflict Code: ER – Overuse
Drug/Disease

Util A	Util B	Util C
Lixisenatide		

Max Dose: 1, 2 pen pack per month

References:
Adlyxin Prescribing Information, July 2016, Sanofi-Aventis U.S.
Clinical Pharmacology, 2016 Elsevier/Gold Standard.

2. Lixisenatide / Pancreatitis _____ _____

Alert Message: In clinical trials, there were more cases of pancreatitis-related adverse reactions among patients treated with Adlyxin (lixisenatide) than placebo-treated. If pancreatitis is suspected, promptly discontinue lixisenatide and, if confirmed, lixisenatide should not be restarted.

Conflict Code: MC – Drug Disease Warning/Contraindication
Drugs/Diseases:

Util A	Util B	Util C
Lixisenatide	Pancreatitis	

References:
Adlyxin Prescribing Information, July 2016, Sanofi-Aventis U.S.
Clinical Pharmacology, 2016 Elsevier/Gold Standard.

3. Lixisenatide / Basal Insulin & Insulin Secretagogues _____ _____

Alert Message: The risk of hypoglycemia is increased when Adlyxin (lixisenatide) is used in combination with insulin secretagogues (i.e., sulfonylureas) or basal insulin. Therefore, patients may require a lower dose of sulfonylurea or basal insulin to reduce the risk of hypoglycemia in this setting.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases:

Util A	Util B	Util C
Lixisenatide	Insulin Glargine, Detemir & Degludec	
	Chlorpropamide	
	Glimepiride	
	Glipizide	
	Glyburide	
	Tolazamide	
	Tolbutamide	

References:
Adlyxin Prescribing Information, July 2016, Sanofi-Aventis U.S.

4. Lixisenatide / Renal Impairment _____ _____

Alert Message: Use caution when initiating or escalating doses of Adlyxin (lixisenatide) in patients with renal impairment. Lixisenatide is a glucagon-like peptide-1 receptor (GLP-1) agonist and there have been postmarketing reports of acute renal failure and worsening of chronic renal failure in patients treated with GLP-1 agonists. No dosage adjustment is recommended in renal impairment but monitoring renal function is recommended in patients reporting severe adverse gastrointestinal reactions.

Conflict Code: MC – Drug Disease Warning/Contraindication
Drugs/Diseases:

Util A	Util B	Util C **(Include)**
Lixisenatide		Renal Impairment

References:
Adlyxin Prescribing Information, July 2016, Sanofi-Aventis U.S.
Clinical Pharmacology, 2016 Elsevier/Gold Standard.

5. Lixisenatide / Severe Gastrointestinal Disorders _____ _____

Alert Message: Adlyxin (lixisenatide), a glucagon-like peptide-1 (GLP-1) receptor agonist, has not been studied and it use is not recommended in patients with pre-existing severe gastrointestinal disease, including severe gastroparesis. GLP-1 receptor agonists slow gastric emptying and can exacerbate gastrointestinal disorders.

Conflict Code: TA – Therapeutic Appropriateness
Drugs/Diseases

Util A	Util B	Util C **(Include)**
Lixisenatide		Gastroparesis
		Irritable Bowel Syndrome
		Diverticular Disease
		Crohn's Disease
		Ulcerative Colitis

References:
Adlyxin Prescribing Information, July 2016, Sanofi-Aventis U.S.
Clinical Pharmacology, 2016 Elsevier/Gold Standard.

6. Lixisenatide / Therapeutic Appropriateness < 18 years of age _____ _____

Alert Message: Safety and effectiveness of Adlyxin (lixisenatide) have not been established in pediatric patients younger than 18 years of age.

Conflict Code: TA – Therapeutic Appropriateness
Drugs/Diseases

Util A	Util B	Util C
Lixisenatide		

Age Range: 0-17 yoa

References:
Adlyxin Prescribing Information, July 2016, Sanofi-Aventis U.S.
Clinical Pharmacology, 2016 Elsevier/Gold Standard.

7. Lixisenatide / Pregnancy / Delivery, Miscarriage & Abortion _____ _____

Alert Message: There are no adequate and well-controlled studies of Adlyxin (lixisenatide) use in pregnant women. Lixisenatide should not be used during pregnancy unless the potential benefit justifies the potential risk to the fetus.

Conflict Code: MC – Drug (Actual) Disease Precaution/Warning/Contraindication
Drugs/Diseases

Util A	Util B	Util C **(Negating)**
Albiglutide	Pregnancy	Delivery
		Miscarriage
		Abortion

Age Range: 11-55 yoa
Gender: Female

References:
Adlyxin Prescribing Information, July 2016, Sanofi-Aventis U.S.
Clinical Pharmacology, 2016 Elsevier/Gold Standard.

8. Lixisenatide / Non-adherence _____ _____

Alert Message: Based on refill history, your patient may be under-utilizing Adlyxin (lixisenatide). Non-adherence to the prescribed dosing regimen may result in sub-therapeutic effects, which may lead to decreased patient outcomes and additional healthcare costs.

Conflict Code: LR – Non-adherence
Drugs/Diseases

Util A	Util B	Util C
Lixisenatide		

References:
Ho PM, Rumsfeld JS, Masoudi FA, et al., Effect of Medication Nonadherence on Hospitalization and Mortality Among Patients with Diabetes Mellitus. Arch Intern Med. 2006;166:1836-1841.
Currie CJ, Peyrot M, Morgan CL, et al. The Impact of Treatment Noncompliance on Mortality in People With Type 2 Diabetes. Diabetes Care 35:1279-1284, June 2012.
Butler RJ, Davis TK, Johnson WL, et al. Effects of Non adherence with Prescription Drugs Among Older Adults. Am J Manag Care. 2011 Feb; 17(2):153-60.

9. Methylnaltrexone Tabs / Overutilization _____ _____

Alert Message: Relistor (methylnaltrexone) may be over-utilized. The manufacturer's recommended dosage of oral methylnaltrexone, for the treatment of opioid-induced constipation in patients with chronic non-cancer pain, is 450 mg once daily in the morning.

Conflict Code: ER - Overutilization
Drugs/Diseases

Util A	Util B	Util C **(Negating)**
Methylnaltrexone tabs		Hepatic Impairment
		CKD Stage 4 & 5

Max Dose: 450mg/day

References:
Clinical Pharmacology, 2016 Elsevier/Gold Standard.
Relistor Prescribing Information, July 2016, Valeant Pharmaceuticals North America.

10. Methylnaltrexone Tabs / Overutilization Renal Impairment _____ _____

Alert Message: Relistor (methylnaltrexone) may be over-utilized. The manufacturer's recommended dosage of oral methylnaltrexone, for the treatment of opioid-induced constipation in patients with chronic non-cancer pain with moderate to severe renal impairment (e.g., CrCl < 60 mL/min as estimated by Cockcroft-Gault), is 150 mg once daily in the morning.

Conflict Code: ER - Overutilization
Drugs/Diseases

Util A	Util B	Util C **(Include)**
Methylnaltrexone tabs		CKD Stage 4 & 5

Max Dose: 150mg/day

References:
Clinical Pharmacology, 2016 Elsevier/Gold Standard.
Relistor Prescribing Information, July 2016, Valeant Pharmaceuticals North America.

11. Methylnaltrexone Tabs / Overutilization Hepatic Impairment _____ _____

Alert Message: Relistor (methylnaltrexone) may be over-utilized. The manufacturer's recommended dosage of oral methylnaltrexone, for the treatment of opioid-induced constipation in patients with chronic non-cancer pain with moderate to severe hepatic impairment (Child-Pugh Class B or C), is 150 mg daily in the morning.

Conflict Code: ER - Overutilization
Drugs/Diseases

Util A	Util B	Util C **(Include)**
Methylnaltrexone tabs		Hepatic Impairment

Max Dose: 150mg/day

References:
Clinical Pharmacology, 2016 Elsevier/Gold Standard.
Relistor Prescribing Information, July 2016, Valeant Pharmaceuticals North America.

12. Methylnaltrexone / Overutilization _____ _____

Alert Message: Relistor (methylnaltrexone) may be over-utilized. The manufacturer's recommended dosage of methylnaltrexone injection, for the treatment of opioid-induced constipation in patients with chronic non-cancer pain, is 12 mg subcutaneously once daily.

Conflict Code: ER - Overutilization
Drugs/Diseases

Util A	Util B	Util C **(Negating)**
Methylnaltrexone injection		Hepatic Impairment
		CKD Stage 4 & 5

Max Dose: 12mg/day

References:
Clinical Pharmacology, 2016 Elsevier/Gold Standard.
Relistor Prescribing Information, July 2016, Valeant Pharmaceuticals North America.

13. Methylnaltrexone / Overutilization Mod to Severe Renal Impairment _____ _____

Alert Message: Relistor (methylnaltrexone) may be over-utilized. The manufacturer's recommended dosage of methylnaltrexone injection, for the treatment of opioid-induced constipation in patients with chronic non-cancer pain, is 6 mg subcutaneously once daily.

Conflict Code: ER - Overutilization
Drugs/Diseases

Util A	Util B	Util C **(Include)**
Methylnaltrexone injection		CKD Stage 4 & 5

Max Dose: 6mg/day

References:
Clinical Pharmacology, 2016 Elsevier/Gold Standard.
Relistor Prescribing Information, July 2016, Valeant Pharmaceuticals North America.

14. Methylnaltrexone / Overutilization Severe Hepatic Impairment _____ _____

Alert Message: Relistor (methylnaltrexone) has not been studied in patients with severe hepatic impairment. Patients with severe hepatic impairment receiving methylnaltrexone should be monitored for methylnaltrexone-related adverse reactions. If considering dosage adjustment for patients with severe hepatic impairment follow the official product labeling weight-based daily dosing recommendation: < 38 kg give 0.075 mg/kg subQ, 38 to < 62 kg give 4 mg subQ, 62 to 114 kg give 6 mg, more than 114 kg give 0.075 mg/kg subQ.

Conflict Code: TA – Therapeutic Appropriateness
Drugs/Diseases

Util A	Util B	Util C **(Include)**
Methylnaltrexone Injection		Severe Hepatic Impairment

References:
Clinical Pharmacology, 2016 Elsevier/Gold Standard.
Relistor Prescribing Information, July 2016, Valeant Pharmaceuticals North America.

15. Methylnaltrexone / Opioid Agonists (Negating) _____ _____

Alert Message: The review of the patient's drug history did not reveal current use of opioid medication. Relistor (methylnaltrexone) is approved for the treatment of opioid-induced constipation (OIC) in adults with chronic non-cancer pain and OIC in patients with advanced illness who are receiving palliative care with insufficient response to laxative therapy. Methylnaltrexone should be discontinued if treatment with the opioid pain medication is discontinued.

Conflict Code: TA – Therapeutic Appropriateness
Drugs/Diseases

Util A	Util B	Util C **(Negating)**
Methylnaltrexone		Opioid Agonists

References:
Clinical Pharmacology, 2016 Elsevier/Gold Standard.
Relistor Prescribing Information, July 2016, Valeant Pharmaceuticals North America.

16. Methylnaltrexone / Gastrointestinal Obstruction _____ _____

Alert Message: Relistor (methylnaltrexone) use is contraindicated in patients with known or suspected gastrointestinal obstruction and patients at increased risk of recurrent obstruction, due to the potential for gastrointestinal perforation. Monitor patients for development of severe, persistent, or worsening abdominal pain and discontinue methylnaltrexone in patients who develop these symptom.

Conflict Code: TA – Therapeutic Appropriateness (Contraindication)
Drugs/Diseases

Util A	Util B	Util C **(Include)**
Methylnaltrexone		Gastrointestinal Obstruction

References:
Clinical Pharmacology, 2016 Elsevier/Gold Standard.
Relistor Prescribing Information, July 2016, Valeant Pharmaceuticals North America.

17. Methylnaltrexone / Reduction in GI Wall Integrity _____ _____

Alert Message: Cases of gastrointestinal perforation have been reported in patients receiving Relistor (methylnaltrexone) who had conditions associated with localized or diffuse reduction of structural integrity in the wall of the gastrointestinal tract (e.g., peptic ulcer disease, Ogilvie's syndrome, diverticular disease, infiltrative gastrointestinal tract malignancies or peritoneal metastases). Monitor patients for the development of severe, persistent, or worsening abdominal pain and discontinue methylnaltrexone in patients who develop this symptoms.

Conflict Code: TA – Therapeutic Appropriateness (Warning)
Drugs/Diseases

Util A	Util B	Util C **(Include)**
Methylnaltrexone		Crohn's Disease
		Peptic, Gastric, Duodenal & Gastrojejunal Ulcer Disease
		Perforation of Intestine
		Diverticular Disease of Intestine
		Malignant Neoplasm of Intestine
		Malignant Neoplasm of Stomach

References:
Clinical Pharmacology, 2016 Elsevier/Gold Standard.
Relistor Prescribing Information, July 2016, Valeant Pharmaceuticals North America.

18. Methylnaltrexone / Therapeutic Appropriateness _____ _____

Alert Message: Safety and effectiveness of Relistor (methylnaltrexone) tablets and injection have not been established in pediatric patients.

Conflict Code: TA – Therapeutic Appropriateness
Drugs/Diseases

Util A	Util B	Util C **(Negating)**
Methylnaltrexone		

Age Range: 0-17 yoa

References:
Clinical Pharmacology, 2016 Elsevier/Gold Standard.
Relistor Prescribing Information, July 2016, Valeant Pharmaceuticals North America.

19. Vandetanib / Overutilization _____ _____

Alert Message: Caprelsa (vandetanib) may be over-utilized. The manufacturer's recommended maximum daily dose is 300 mg once daily.

Conflict Code: ER - Overutilization
Drugs/Diseases

Util A	Util B	Util C
Vandetanib		

Max Dose: 300mg/day

References:
Clinical Pharmacology, 2016 Elsevier/Gold Standard.
Caprelsa Prescribing Information, July 2016, AstraZeneca.

20. Vandetanib / QT Prolongation _____ _____

Alert Message: Caprelsa (vandetanib) is contraindicated in patients with congenital long QT syndrome. Vandetanib can prolong the QT interval in a concentration-dependent manner. Do not start vandetanib in patients whose QTcF interval is greater than 450 ms or in patients with a history of torsades de pointes, bradyarrhythmias, or uncompensated heart failure.

Conflict Code: MC – Drug (Actual) Disease Precaution/Warning
Drugs/Diseases

Util A	Util B	Util C
Vandetanib	Long QT Syndrome	

References:
Clinical Pharmacology, 2016 Elsevier/Gold Standard.
Caprelsa Prescribing Information, July 2016, AstraZeneca.

21. Vandetanib / Strong CYP3A4 Inducers _____ _____

Alert Message: The concurrent use of Caprelsa (vandetanib) with known strong CYP3A4 inducers should be avoided. Vandetanib is a CYP3A4 substrate and concomitant use with a strong CYP3A4 inducer may result in decreased vandetanib plasma concentrations.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Vandetanib	Carbamazepine	
	Phenytoin	
	Phenobarbital	
	Primidone	
	Rifampin	
	Rifapentine	
	Rifabutin	

References:
Caprelsa Prescribing Information, July 2016, AstraZeneca.
Facts & Comparisons, 2016 Wolters Kluwer Health.

22. Vandetanib / Digoxin _____ _____

Alert Message: Caution should be exercised when co-administering Caprelsa (vandetanib) with digoxin. Concurrent use of vandetanib with digoxin has been shown to increase digoxin plasma concentrations and exposure. Closely monitor patients for digoxin toxicities.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Vandetanib	Digoxin	

References:
Clinical Pharmacology, 2016 Elsevier/Gold Standard.
Caprelsa Prescribing Information, July 2016, AstraZeneca.

23. Vandetanib / Interstitial Lung Disease _____ _____

Alert Message: Interstitial lung disease (ILD) or pneumonitis, including fatalities, has occurred in patients treated with Caprelsa (vandetanib). Consider a diagnosis of ILD if the patient presents with new or worsening of breathlessness, persistent cough, or fever. Interrupt vandetanib treatment for acute or worsening pulmonary symptoms. Discontinue vandetanib if ILD is confirmed.

Conflict Code: MC – Drug (Actual) Disease Precaution/Warning
Drugs/Diseases

Util A	Util B	Util C
Vandetanib	Interstitial Lung Disease	
	Breathlessness	
	Cough	
	Fever	

References:
Clinical Pharmacology, 2016 Elsevier/Gold Standard.
Caprelsa Prescribing Information, July 2016, AstraZeneca.

24. Vandetanib / Pregnancy / Pregnancy Negating _____ _____

Alert Message: Based on its mechanism of action, Caprelsa (vandetanib) can cause fetal harm when administered to a pregnant women. Vandetanib is embryotoxic, fetotoxic, and teratogenic in rats at exposures less than or equal to those expected at the recommended human dose of 300 mg/day. If vandetanib is used during pregnancy, or if the patient becomes pregnant while taking this drug, the patient should be apprised of the potential hazard to the fetus.

Conflict Code: MC – Drug (Actual) Disease Precaution/Warning
Drugs/Diseases

Util A	Util B	Util C **(Negating)**
Vandetanib	Pregnancy	Miscarriage
		Delivery
		Abortion

References:
Clinical Pharmacology, 2016 Elsevier/Gold Standard.
Caprelsa Prescribing Information, July 2016, AstraZeneca.

25. Vandetanib / Ischemic Cerebrovascular Event

Alert Message: Ischemic cerebrovascular events, including fatalities, occurred in patients treated with Caprelsa (vandetanib). In the randomized medullary thyroid cancer (MTC) study, ischemic cerebrovascular events occurred more frequently with vandetanib compared to placebo (1.3% compared to 0%). The safety of resumption of vandetanib therapy after resolution of an ischemic cerebrovascular event has not been studied. Discontinue vandetanib in patients who experience a severe ischemic cerebrovascular event.

Conflict Code: MC – Drug (Actual) Disease Precaution/Warning
Drugs/Diseases

Util A	Util B	Util C
Vandetanib	Cerebral infarction	

References:
Clinical Pharmacology, 2016 Elsevier/Gold Standard.
Caprelsa Prescribing Information, July 2016, AstraZeneca.

26. Vandetanib / Hemorrhage

Alert Message: Serious hemorrhagic events, including fatalities, occurred in patients treated with Caprelsa (vandetanib). Discontinue vandetanib in patients with severe hemorrhage. Do not administer vandetanib to patients with a recent history of hemoptysis of greater than or equal to 1/2 teaspoon of red blood.

Conflict Code: MC – Drug (Actual) Disease Precaution/Warning
Drugs/Diseases

Util A	Util B	Util C
Vandetanib	Cerebrovascular Hemorrhage	
	Gastrointestinal Hemorrhage	

References:
Clinical Pharmacology, 2016 Elsevier/Gold Standard.
Caprelsa Prescribing Information, July 2016, AstraZeneca.

27. Vandetanib / Heart Failure

Alert Message: Heart failure, including fatalities, occurred in patients treated with Caprelsa (vandetanib). Monitor for signs and symptoms of heart failure. Consider discontinuation of vandetanib in patients with heart failure. Heart failure may not be reversible upon stopping vandetanib.

Conflict Code: MC – Drug (Actual) Disease Precaution/Warning
Drugs/Diseases

Util A	Util B	Util C
Vandetanib	Heart Failure	

References:
Clinical Pharmacology, 2016 Elsevier/Gold Standard.
Caprelsa Prescribing Information, July 2016, AstraZeneca.

28. Lesinurad / Overutilization _____ _____

Alert Message: Zurampic (lesinurad) may be over-utilized. The manufacturer's recommended maximum dose is 200 mg daily in combination with a xanthine oxidase inhibitor.

Conflict Code: ER - Overutilization
Drugs/Diseases

Util A	Util B	Util C
Lesinurad		

Max Dose: 200 mg/day

References:
Zurampic Prescribing Information, Jan. 2016, AstraZeneca.
Clinical Pharmacology, 2016 Elsevier/Gold Standard.

29. Lesinurad / Nonadherence _____ _____

Alert Message: Based on refill history, your patient may be underutilizing Zurampic (lesinurad). Non-adherence to the prescribed regimen may result in sub-therapeutic effects, which may lead to decreased patient outcomes and additional healthcare costs.

Conflict Code: LR - Nonadherence
Drugs/Diseases

Util A	Util B	Util C
Lesinurad		

References:
Zurampic Prescribing Information, Jan. 2016, AstraZeneca.
Osterberg L, Blaschke T. Adherence to Medication. N Engl J Med 2005;353:487-97.

30. Lesinurad / Xanthine Oxidase Inhibitor _____ _____

Alert Message: A review of the patient medication history did not reveal concurrent use of a xanthine oxidase inhibitor (e.g., allopurinol or febuxostat). Lesinurad should not be used as monotherapy. Failure to take lesinurad with a xanthine oxidase inhibitor may increase the risk of renal adverse reactions, including acute renal failure.

Conflict Code: TA – Therapeutic Appropriateness (Black Box)
Drugs/Diseases

Util A	Util B	Util C **(Negate)**
Lesinurad		Allopurinol
		Febuxostat

References:
Zurampic Prescribing Information, Jan. 2016, AstraZeneca.
Clinical Pharmacology, 2016 Elsevier/Gold Standard.

31. Lesinurad / Severe Renal Impairment _____ _____

Alert Message: The use of Zurampic (lesinurad) is contraindicated in patients with severe renal impairment (eCLcr < 30 mL/min), end-stage renal disease, kidney transplant recipients, or patients on dialysis. Lesinurad is not expected to be effective in these patient populations.

Conflict Code: TA – Therapeutic Appropriateness (Black Box)
Drugs/Diseases

Util A	Util B	Util C **(Include)**
Lesinurad		CKD Stage 4 & 5
		ESRD
		Dependence on Renal Dialysis
		Kidney Replace by Transplant

References:
Zurampic Prescribing Information, Jan. 2016, AstraZeneca.
Clinical Pharmacology, 2016 Elsevier/Gold Standard.

32. Lesinurad / Mild to Moderate Renal Impairment _____ _____

Alert Message: Patients with moderate renal impairment receiving Zurampic (lesinurad) have been shown to have a higher occurrence of renal related adverse reactions compared to patients with mild renal impairment or normal renal function. No dosage adjustment is recommended in patients with an eCLcr 45 to 60 mL/min, however frequent renal function monitoring is recommended in these patients. Lesinurad treatment should not be initiated in patients with an eCLcr less than 45 mL/min.

Conflict Code: TA – Therapeutic Appropriateness
Drugs/Diseases

Util A	Util B	Util C **(Include)**
Lesinurad		CKD 2 & 3

References:
Zurampic Prescribing Information, Jan. 2016, AstraZeneca.
Clinical Pharmacology, 2016 Elsevier/Gold Standard.

33. Allopurinol / Lesinurad _____ _____

Alert Message: Use of Zurampic (lesinurad) is not recommended for patients taking daily doses of allopurinol less than 300 mg (or less than 200 mg in patients with eCLcr < 60 mL/min).

Conflict Code: LR – Low Dose
Drugs/Diseases

Util A	Util B	Util C **(Include)**
Allopurinol		Lesinurad

Minimum Dose: 300 mg/day

References:
Zurampic Prescribing Information, Jan. 2016, AstraZeneca.
Clinical Pharmacology, 2016 Elsevier/Gold Standard.

34. Lesinurad / Tumor Lysis Syndrome & Lesch-Nyhan Syndrome _____ _____

Alert Message: The use of Zurampic (lesinurad) is contraindicated in patients with tumor lysis syndrome or Lesch-Nyhan Syndrome, where the rate of uric acid formation is greatly increased. Studies have not been conducted in patients with secondary hyperuricemia.

Conflict Code: MC – Drug (Actual) Disease Precaution/Warning
Drugs/Diseases

Util A	Util B	Util C
Lesinurad	Tumor Lysis Syndrome	
	Lesch-Nyhan Syndrome	

References:
Zurampic Prescribing Information, Jan. 2016, AstraZeneca.
Clinical Pharmacology, 2016 Elsevier/Gold Standard.

35. Lesinurad / Severe Hepatic Impairment _____ _____

Alert Message: The use of Zurampic (lesinurad) is not recommended in patients with severe hepatic impairment as it has not been studied in this patient population. No dosage adjustment is required in patients with mild or moderate hepatic impairment (Child-Pugh class A and B).

Conflict Code: MC – Drug (Actual) Disease Precaution/Warning
Drugs/Diseases

Util A	Util B	Util C
Lesinurad	Cirrhosis	
	Hepatic Fibrosis	

References:
Zurampic Prescribing Information, Jan. 2016, AstraZeneca.
Clinical Pharmacology, 2016 Elsevier/Gold Standard.

36. Lesinurad / Moderate CYP2C9 Inhibitors _____ _____

Alert Message: Concurrent use of Zurampic (lesinurad), a CYP2C9 substrate, with moderate CYP2C9 inhibitors (e.g., fluconazole, amiodarone, and oxandrolone) should be done with caution. Concomitant use of these agents may result in increased lesinurad exposure and risk of lesinurad-related adverse effects.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Lesinurad	Fluconazole	
	Amiodarone	
	Abiraterone	
	Sorafenib	

References:
Zurampic Prescribing Information, Jan. 2016, AstraZeneca.
Clinical Pharmacology, 2016 Elsevier/Gold Standard.

37. Lesinurad / CYP2C9 Inducers _____ _____

Alert Message: Concurrent use of Zurampic (lesinurad), a CYP2C9 substrate, with CYP2C9 inducers (e.g., carbamazepine, rifampin, and enzalutamide) should be done with caution. Concomitant use of these agents may result in decreased lesinurad exposure and therapeutic effect. Monitor patients for reduction in lesinurad efficacy or consider therapy modification.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Lesinurad	Carbamazepine	
	Rifampin	
	Enzalutamide	

References:
Zurampic Prescribing Information, Jan. 2016, AstraZeneca.
Clinical Pharmacology, 2016 Elsevier/Gold Standard.

38. Lesinurad / Epoxide Hydrolase Inhibitors _____ _____

Alert Message: Zurampic (lesinurad) should not be administered with an epoxide hydrolase inhibitor (i.e., valproic acid). Concurrent use of these agents may interfere with metabolism of lesinurad.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Lesinurad	Valproic Acid	

References:
Zurampic Prescribing Information, Jan. 2016, AstraZeneca.
Clinical Pharmacology, 2016 Elsevier/Gold Standard.

39. Lesinurad / Hormonal Contraceptives _____ _____

Alert Message: Hormonal contraceptives including oral, injectable, transdermal, and implantable forms may not be reliable when co-administered with Zurampic (lesinurad). Females should use additional methods of contraception and not rely on hormonal contraception alone when taking lesinurad.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Lesinurad	Oral Contraceptives	
	Injectable Contraceptives	
	Transdermal Contraceptives	
	Implantable Contraceptives	

References:
Zurampic Prescribing Information, Jan. 2016, AstraZeneca.
Clinical Pharmacology, 2016 Elsevier/Gold Standard.

40. Lesinurad / CYP3A Substrates _____ _____

Alert Message: Concurrent use of Zurampic (lesinurad), a weak CYP3A4 inducer, with a CYP3A4 substrates (e.g., aprepitant, buspirone, and simvastatin) may result in a decrease in systemic exposure and therapeutic efficacy of the CYP3A4 substrate. Monitor the patient for potential reduction in CYP3A4 substrate efficacy.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B		Util C
Lesinurad	Quinidine	Budesonide	
	Amiodarone	Eplerenone	
	Ivabradine	Tolvaptan	
	Eletriptan	Ifosfamide	
	Sildenafil	Vinblastine	
	Tadalafil	Vincristine	
	Vardenafil	Vinorelbine	
	Avanafil	Etoposide	
	Isradipine	Docetaxel	
	Felodipine	Abiraterone	
	Amlodipine	Imatinib	
	Disulfiram	Bortezomib	
	Eszopiclone	Erlotinib	
	Flurazepam	Sunitinib	
	Alprazolam	Dasatinib	
	Triazolam	Lapatinib	
	Midazolam	Nilotinib	
	Buspirone	Pazopanib	
	Quazepam	Vandetanib	
	Vilazodone	Crizotinib	
	Hydrocodone	Axitinib	
	Oxycodone	Bosutinib	
	Buprenorphine	Cabozantinib	
	Ethosuximide	Ibrutinib	
	Clonazepam	Ceritinib	
	Tiagabine	Irinotecan	
	Aprepitant	Olaparib	
	Quetiapine	Palbociclib	
	Lurasidone	Dapsone	
	Solifenacin	Atazanavir	
	Alfuzosin	Bedaquiline	
	Silodosin	Tacrolimus	
	Simvastatin	Tofacitinib	
	Lovastatin		
	Cilostazol		
	Ticagrelor		
	Apixaban		

References:
Zurampic Prescribing Information, Jan. 2016, AstraZeneca.
Clinical Pharmacology, 2016 Elsevier/Gold Standard.

41. Sofosbuvir/Velpatasvir / Overutilization _____ _____

Alert Message: Epclusa (sofosbuvir/velpatasvir) may be over-utilized. The manufacturer's recommended daily dose is one tablet (400mg/sofosbuvir/100 mg velpatasvir) once daily.

Conflict Code: ER - Overutilization

Drugs/Diseases		
Util A	Util B	Util C
Sofosbuvir/Velpatasvir		

Max Dose: 1 tablet per day

References:
Epclusa Prescribing Information, June.2016, Gilead Sciences, Inc.
Clinical Pharmacology, 2016 Elsevier/Gold Standard.

42. Sofosbuvir/Velpatasvir / Therapeutic Appropriateness _____ _____

Alert Message: The safety and effectiveness of Epclusa (sofosbuvir/velpatasvir) have not been established in pediatric patients.

Conflict Code: TA – Therapeutic Appropriateness

Drugs/Diseases		
Util A	Util B	Util C
Sofosbuvir/Velpatasvir		

Age Range: 0-17 yoa

References:
Epclusa Prescribing Information, June.2016, Gilead Sciences, Inc.
Clinical Pharmacology, 2016 Elsevier/Gold Standard.

43. Sofosbuvir/Velpatasvir / Amiodarone _____ _____

Alert Message: Concurrent use of Epclusa (sofosbuvir/velpatasvir) with amiodarone is not recommended. Serious symptomatic bradycardia may occur in patients taking amiodarone, particularly in patients also receiving beta-blockers, or those with underlying cardiac comorbidities, and/or advanced liver disease. In patients without alternative viable treatment options, cardiac monitoring is recommended.

Conflict Code: DD – Drug/Drug Interaction

Drugs/Diseases		
Util A	Util B	Util C
Sofosbuvir/Velpatasvir	Amiodarone	

References:
Epclusa Prescribing Information, June.2016, Gilead Sciences, Inc.
Clinical Pharmacology, 2016 Elsevier/Gold Standard.

44. Sofosbuvir/Velpatasvir / P-gp Inducers, Mod to Potent CYP2B6, 2C8 & 3A4 Inducers _____ _____

Alert Message: The concurrent use of Epclusa (sofosbuvir/velpatasvir) with inducers of P-gp and/or moderate to potent inducers of CYP2B6, CYP2C8, or CYP3A4 is not recommended. Co-administration of these agents may significantly decrease plasma concentrations of sofosbuvir/velpatasvir, leading to potentially reduced therapeutic effects.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Sofosbuvir/Velpatasvir	Carbamazepine	Enzalutamide
	Phenobarbital	Bosentan
	Primidone	Efavirenz
	Phenytoin	Etravirine
	Rifampin	Nevirapine
	Rifapentine	Modafinil
	Rifabutin	Oxcarbazepine

References:
Epclusa Prescribing Information, June.2016, Gilead Sciences, Inc.
Clinical Pharmacology, 2016 Elsevier/Gold Standard.
Drug Development and Drug Interactions: Tables of Substrates, Inhibitors and Inducers. Available at: http://www.fda.gov/Drugs/DevelopmentApprovalProcess/DevelopmentResources/Drug\InteractionaLabeling/ucm093664.htm

45. Sofosbuvir/Velpatasvir / Antacids _____ _____

Alert Message: It is recommended to separate the administration of an antacid and Epclusa (sofosbuvir/velpatasvir) by 4 hours. The velpatasvir component of the antiviral combo product is pH depended and drugs that increase gastric pH are expected to decreased velpatasvir solubility, and therefore its bioavailability.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Sofosbuvir/Velpatasvir	Aluminum hydroxide	
	Magnesium hydroxide	
	Calcium Carbonate	
	Sodium Bicarbonate	

References:
Epclusa Prescribing Information, June.2016, Gilead Sciences, Inc.
Clinical Pharmacology, 2016 Elsevier/Gold Standard.

46. Ledipasvir + Sofosbuvir / H2 Blockers _____ _____

Alert Message: Caution should be exercised when using Epclusa (sofosbuvir/velpatasvir) with an H-2 receptor antagonist. These agents may be administered simultaneously or separated by 12 hours. The H-2 antagonist dose should not exceed a dose that is comparable to famotidine 40 mg twice daily. The velpatasvir component of the antiviral combo product is pH dependent and drugs that increase gastric pH are expected to decrease velpatasvir solubility, and therefore its bioavailability.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C **(Include)**
Cimetidine > 1600mg/day		Sofosbuvir/Velpatasvir
Famotidine > 80mg/day		
Ranitidine > 600mg/day		
Nizatidine > 600mg/day		

References:
Epclusa Prescribing Information, June.2016, Gilead Sciences, Inc.
Clinical Pharmacology, 2016 Elsevier/Gold Standard.

47. Sofosbuvir/Velpatasvir / Proton Pump Inhibitors _____ _____

Alert Message: The concurrent use of Epclusa (sofosbuvir/velpatasvir) with proton pump inhibitors is not recommended. The solubility of the velpatasvir component of the antiviral combo product is pH dependent and drugs that increase the gastric pH are expected to decrease velpatasvir solubility, and therefore it bioavailability. If concomitant use is considered medically necessary, sofosbuvir/velpatasvir should be administered with food and taken 4 hours before omeprazole 20 mg. Use with other PPIs has not been studied.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Sofosbuvir/velpatasvir	Omeprazole	
	Esomeprazole	
	Lansoprazole	
	Dexlansoprazole	
	Rabeprazole	
	Pantoprazole	

References:
Epclusa Prescribing Information, June.2016, Gilead Sciences, Inc.
Clinical Pharmacology, 2016 Elsevier/Gold Standard.

48. Sofosbuvir/Velpatasvir / Digoxin _____ _____

Alert Message: The concurrent use of Epclusa (sofosbuvir/velpatasvir) with digoxin, a P-gp substrate, may result in an increase in the plasma concentration of digoxin due to inhibition, by the velpatasvir component, of the P-gp efflux transporter system. Refer to digoxin prescribing information for monitoring and dose modification recommendations.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Sofosbuvir/Velpatasvir	Digoxin	

References:
Epclusa Prescribing Information, June.2016, Gilead Sciences, Inc.
Clinical Pharmacology, 2016 Elsevier/Gold Standard.

49. Sofosbuvir/Velpatasvir / Topotecan _____ _____

Alert Message: The concurrent use of Epclusa (sofosbuvir/velpatasvir) with topotecan, a P-gp and BCRP substrate, is not recommended. Co-administration of these agents may result in an increase in the concentration of topotecan due to inhibition, by the velpatasvir component, of both P-gp efflux transport and BCRP transport.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Sofosbuvir/Velpatasvir	Topotecan	

References:
Epclusa Prescribing Information, June.2016, Gilead Sciences, Inc.
Clinical Pharmacology, 2016 Elsevier/Gold Standard.

50. Sofosbuvir/Velpatasvir / Tenofovir-containing Agents _____ _____

Alert Message: The concurrent use of Epclusa (sofosbuvir/velpatasvir) with a tenofovir-containing agent may result in elevated tenofovir concentrations and increased risk of tenofovir-associated adverse reactions. The velpatasvir component of the antiviral is an inhibitor of drugs transporters P-gp, BCRP, OATP1B1, OATP1B3, and OATP2B1. Both tenofovir prodrugs, tenofovir disoproxil fumarate (DF) and tenofovir alafenamide (TAF) are P-gp and BCRP substrates and TAF is also a substrate of OATP1B1 and OATP1B3.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Sofosbuvir/Velpatasvir	Tenofovir	

References:
Epclusa Prescribing Information, June.2016, Gilead Sciences, Inc.
Clinical Pharmacology, 2016 Elsevier/Gold Standard.

51. Sofosbuvir/Velpatasvir / Tipranavir / Ritonavir _____ _____

Alert Message: The concurrent use of Epclusa (sofosbuvir/velpatasvir) with ritonavir-boosted tipranavir is not recommended. Tipranavir is a P-gp inducer and co-administration with the P-gp substrates velpatasvir and sofosbuvir may result in decreased velpatasvir and sofosbuvir plasma concentrations, leading to reduced antiviral efficacy.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C **(Include)**
Sofosbuvir/Velpatasvir	Tipranavir	Ritonavir

References:
Epclusa Prescribing Information, June.2016, Gilead Sciences, Inc.
Clinical Pharmacology, 2016 Elsevier/Gold Standard.

52. Sofosbuvir/Velpatasvir / Rosuvastatin _____ _____

Alert Message: The dose of rosuvastatin should not exceed 10 mg per day when co-administered with Epclusa (sofosbuvir/velpatasvir). The velpatasvir component of the antiviral agent is an inhibitor of BCRP and OATP1B1 transporters and concurrent use with rosuvastatin (both a BCRP and OATP1B1 substrate) may result in a significant increase in the concentration of rosuvastatin which is associated with increased risk of myopathy, including rhabdomyolysis.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Sofosbuvir/Velpatasvir	Rosuvastatin 20 & 40mg	

References:
Epclusa Prescribing Information, June.2016, Gilead Sciences, Inc.
Clinical Pharmacology, 2016 Elsevier/Gold Standard.

53. Sofosbuvir/Velpatasvir / Atorvastatin _____ _____

Alert Message: The concurrent use of Epclusa (sofosbuvir/velpatasvir) with an atorvastatin-containing agent is expected to increase the concentrations of atorvastatin. The velpatasvir component of the antiviral agent is an inhibitor of BCRP and OATP1B1 transporters and concurrent use with atorvastatin (both a BCRP and OATP1B1 substrate) may result in an increase in atorvastatin plasma concentrations which is associated with increased risk of myopathy, including rhabdomyolysis.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Sofosbuvir/Velpatasvir	Atorvastatin	

References:
Epclusa Prescribing Information, June.2016, Gilead Sciences, Inc.
Clinical Pharmacology, 2016 Elsevier/Gold Standard.

54. Sofosbuvir-containing Agents / Pregnancy / Pregnancy Negating _____ _____

Alert Message: No adequate human data are available to establish whether sofosbuvir-containing agents (Sovaldi, Harvoni, & Epclusa) pose a risk to pregnancy outcomes. Sofosbuvir-containing agents should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. If a sofosbuvir-containing agent is used with ribavirin, the combination therapy is contraindicated.

Conflict Code: MC – Drug (Actual) Disease/Diagnosis Warning
Drugs/Diseases

Util A	Util B	Util C **(Negating)**
Sofosbuvir/Velpatasvir	Pregnancy	Delivery
Sofosbuvir/Ledipasvir		Abortion
Sofosbuvir		Miscarriage

Gender: Female Range: 11 - 55 yoa

References:
Epclusa Prescribing Information, June.2016, Gilead Sciences, Inc.
Clinical Pharmacology, 2016 Elsevier/Gold Standard.

55. Codeine / Therapeutic Appropriateness _____ _____

Alert Message: Codeine-containing products, used either as an analgesic or an antitussive, should be prescribed with extreme caution in pediatric patients. Codeine is metabolized to morphine and ultra-rapid metabolizers can have excessive morphine formation and toxicity even after normal therapeutic doses. The use of codeine for post-operative pain management in pediatric patients after a tonsillectomy and/or adenoidectomy is contraindicated due to risk of serious respiratory depression. Codeine/promethazine products are contraindicated in patients less than 6 years of age.

Conflict Code: TA – Therapeutic Appropriateness
Drugs/Diseases

Util A	Util B	Util C
Codeine - All		

Age Range: 0 – 17 yoa

References:
Tobias JD, Green TP and Cote CJ. Codeine: Time to Say “No”. Pediatrics. 2016 Oct;138(4):e20162396.
Clinical Pharmacology, 2016 Elsevier/Gold Standard.
Facts & Comparisons, 2016 Wolters Kluwer Health.
Racoosin JA, Roberson DW, Pacanowski MA, et al. New Evidence About an Old Drug – Risk with Codeine After Adenotonsillectomy. N Engl J Med 2013;368:2155–7.

56. Nebivolol/Valsartan / Overutilization _____ _____

Alert Message: Byvalson (nebivolol/valsartan) may be over-utilized. The manufacturer's recommended daily dose is one 5mg/80mg (nebivolol/valsartan) tablet orally once daily. Increasing the dose of nebivolol/valsartan dose not result in any meaningful further blood pressure reduction.

Conflict Code: ER - Overutilization
Drugs/Diseases

Util A	Util B	Util C
Nebivolol/Valsartan		

Max Dose: 5mg/80mg

References:
Byvalson Prescribing Information, June 2016, Actavis.
Clinical Pharmacology, 2016 Elsevier/Gold Standard.

57. Nebivolol/Valsartan / Contraindications _____ _____

Alert Message: Byvalson (nebivolol/valsartan) is contraindicated in patients with severe bradycardia, heart block greater than first degree, cardiogenic shock, decompensated cardiac failure, sick sinus syndrome (no permanent pacemaker in place), hypersensitivity to the product, or severe hepatic impairment (Child-Pugh >B).

Conflict Code: MC – Drug Disease Contraindication
Drugs/Diseases

Util A	Util B	Util C
Nebivolol/Valsartan	2nd degree Heart Block	
	3rd degree Heart Block	
	Cardiogenic Shock	
	Cardiac failure	
	Sick Sinus Syndrome	
	Cirrhosis/Hepatic Failure	

References:
Byvalson Prescribing Information, June 2016, Actavis.
Clinical Pharmacology, 2016 Elsevier/Gold Standard.

58. Nebivolol/Valsartan / Hepatic Impairment _____ _____

Alert Message: There are no studies of Byvalson (nebivolol/valsartan) in patients with hepatic insufficiency. No initial dosage adjustment is required for patients with mild hepatic impairment. Nebivolol/valsartan is not recommended as initial antihypertensive treatment in patients with moderate hepatic impairment, because the recommended starting dose of nebivolol, 2.5 mg daily, is not available. Nebivolol/valsartan is contraindicated in patients with severe hepatic impairment (Child-Pugh >B).

Conflict Code: DC – Drug Disease Warning/Contraindication
Drugs/Diseases

Util A	Util B	Util C **(Require)**
Nebivolol/Valsartan		Hepatic Impairment

References:
Byvalson Prescribing Information, June 2016, Actavis.
Clinical Pharmacology, 2016 Elsevier/Gold Standard.

59. Nebivolol/Valsartan / Renal Impairment _____ _____

Alert Message: Safety and effectiveness of Byvalson (nebivolol/valsartan) in patients with moderate to severe renal impairment (CrCl </= 60 mL/min) have not been studied. No dosage adjustment is required for patients with mild to moderate renal impairment. Nebivolol/valsartan is not recommended as initial antihypertensive treatment in patients with severe renal impairment, because the recommended starting dose of nebivolol in this population, 2.5 mg once daily, is not available in the fixed dose combination product.

Conflict Code: DC – Drug Disease Precaution/Warning
Drugs/Diseases

Util A	Util B	Util C **(Require)**
Nebivolol/Valsartan		Renal Impairment
		Lanthanum
		Sevelamer
		Doxercalciferol
		Paricalcitol
		Calcitriol

References:
Byvalson Prescribing Information, June 2016, Actavis.
Clinical Pharmacology, 2016 Elsevier/Gold Standard.

60. Nebivolol/Valsartan / CYP2D6 Inhibitors _____ _____

Alert Message: Concurrent use of Byvalson (nebivolol/valsartan) and a CYP2D6 inhibitor (e.g., paroxetine, fluoxetine, quinidine, and bupropion) should be avoided. The nebivolol component of the fixed dose antihypertensive agent is a CYP2D6 substrate and use with a CYP2D6 inhibitor may result in elevated nebivolol plasma concentrations. If concurrent therapy is warranted the patient should be monitored closely for nebivolol adverse effects.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Nebivolol/Valsartan	Bupropion	
	Fluoxetine	
	Paroxetine	
	Duloxetine	
	Quinidine	
	Propafenone	
	Amiodarone	

References:
Byvalson Prescribing Information, June 2016, Actavis.
Clinical Pharmacology, 2016 Elsevier/Gold Standard.

61. Obeticholic Acid / Overutilization / Hepatic Impairment _____ _____

Alert Message: Ocaliva (obeticholic acid) may be over-utilized. The manufacturer's recommended maximum daily dose is 10 mg once daily. Exceeding the maximum daily dose may increase the risk of liver-related adverse reactions including jaundice, worsening ascites, and primary biliary cholangitis flare.

Conflict Code: ER - Overutilization
Drugs/Diseases

Util A	Util B	Util C **(Negating)**
Obeticholic Acid		Hepatic Impairment

Max Dose: 10 mg/day

References:
Clinical Pharmacology, 2016 Elsevier/Gold Standard.
Ocaliva Prescribing Information, May 2016, Intercept Pharmaceuticals.

62. Obeticholic Acid / Overutilization – Hepatic Impairment _____ _____

Alert Message: The manufacturer's recommended maximum dose of Ocaliva (obeticholic acid) in patients with moderate to severe hepatic impairment is 10 mg twice weekly (at least three days apart). Exceeding the maximum daily dose may increase the risk of liver-related adverse reactions including jaundice, worsening ascites, and primary biliary cholangitis flare. No dosage adjustment is needed in patients with mild hepatic impairment.

Conflict Code: ER - Overutilization
Drugs/Diseases

Util A	Util B	Util C **(Include)**
Obeticholic Acid		Hepatic Impairment

Max Dose: 2 tabs/week

References:
Clinical Pharmacology, 2016 Elsevier/Gold Standard.
Ocaliva Prescribing Information, May 2016, Intercept Pharmaceuticals.

63. Obeticholic Acid / Biliary Obstruction _____ _____

Alert Message: The use of Ocaliva (obeticholic acid) is contraindicated in patients with complete biliary obstruction. Obeticholic acid is a famesoid X receptor (FXR) agonist which increase transport of bile acids out of the hepatocytes in addition to limiting the overall size of the circulating bile pool.

Conflict Code: MC – Drug (Actual) Disease Precaution/Warning
Drugs/Diseases

Util A	Util B	Util C
Obeticholic Acid	Obstruction of Bile Duct	

References:
Clinical Pharmacology, 2016 Elsevier/Gold Standard.
Ocaliva Prescribing Information, May 2016, Intercept Pharmaceuticals.

64. Obeticholic Acid / Bile Acid Binding Resin / Pruritis _____ _____

Alert Message: Concurrent use of Ocaliva (obeticholic acid) with a bile acid binding resin may reduce the absorption, systemic exposure, and efficacy obeticholic acid. If concomitant use is warranted, take obeticholic acid at least 4 hours before or 4 hours after the bile acid binding resin, or at as great an interval as possible.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C **(Negating)**
Obeticholic Acid	Cholestyramine	Pruritus
	Colesevelam	
	Colestipol	

References:
Clinical Pharmacology, 2016 Elsevier/Gold Standard.
Ocaliva Prescribing Information, May 2016, Intercept Pharmaceuticals.

65. Obeticholic Acid / Warfarin _____ _____

Alert Message: Concurrent use of Ocaliva (obeticholic acid) with warfarin may result in a decrease in the INR. If concomitant use is warranted, monitor the INR and adjust the dosage of warfarin, as needed, to maintain the target INR range when co-administering these agents.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Obeticholic Acid	Warfarin	

References:
Clinical Pharmacology, 2016 Elsevier/Gold Standard.
Ocaliva Prescribing Information, May 2016, Intercept Pharmaceuticals.

66. Obeticholic Acid / CYP1A2 Substrates w/ NTI _____ _____

Alert Message: Concurrent use of Ocaliva (obeticholic acid) with a CYP1A2 substrate with a narrow therapeutic index may result in the increased exposure to the CYP1A2 substrate. Therapeutic monitoring of the CYP1A2 substrate is recommended.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Obeticholic Acid	Theophylline	
	Tizanidine	

References:
Clinical Pharmacology, 2016 Elsevier/Gold Standard.
Ocaliva Prescribing Information, May 2016, Intercept Pharmaceuticals.

67. Obeticholic Acid / Pruritus / Antihistamines & Bile Acid Binding Resin _____ _____

Alert Message: Ocaliva (obeticholic acid) can cause severe pruritis. For patients with intolerable pruritis management strategies include the addition of a bile acid resin or antihistamine, obeticholic acid dose reduction or temporary interruption of obeticholic acid dosing.

Conflict Code: MC – Drug (Actual) Disease Precaution/Warning
Drugs/Diseases

Util A	Util B	Util C **(Negating)**
Obeticholic Acid 10mg	Pruritus	Antihistamines
		Cholestyramine
		Colesevelam
		Colestipol

References:
Clinical Pharmacology, 2016 Elsevier/Gold Standard.
Ocaliva Prescribing Information, May 2016, Intercept Pharmaceuticals.

68. Obeticholic Acid / Therapeutic Appropriateness _____ _____

Alert Message: The safety and effectiveness of Ocaliva (obeticholic acid) in pediatric patients have not been established.

Conflict Code: TA – Therapeutic Appropriateness
Drugs/Diseases

Util A	Util B	Util C
Obeticholic Acid		

Age Range: 0 – 17 yoa

References:
Clinical Pharmacology, 2016 Elsevier/Gold Standard.
Ocaliva Prescribing Information, May 2016, Intercept Pharmaceuticals.

69. Glycopyrrolate/Formoterol / Overutilization _____ _____

Alert Message: The manufacturer's recommended maximum daily dose of Bevespi Aerosphere (glycopyrrolate/formoterol) is two inhalations twice daily. Excessive use of an formoterol-containing agent or use in conjunction with other medications containing a beta-2-agonist can result in clinically significant cardiovascular effects and may be fatal.

Conflict Code: ER - Overutilization
Drugs/Diseases

Util A	Util B	Util C
Glycopyrrolate/Formoterol		

Max Dose: 4 inhalations/day

References:
Bevespi Aerosphere Prescribing Information, April 2016, AstraZeneca.

70. Glycopyrrolate/Formoterol / Therapeutic Appropriateness _____ _____

Alert Message: Bevespi Aerosphere (glycopyrrolate/formoterol) contains a long-acting beta-2-adrenergic agonist (LABA) and all LABAs increase the risk of asthma-related death. The safety and efficacy of the formoterol component in patients with asthma have not been established. Glycopyrrolate/formoterol is not indicated for the treatment of asthma.

Conflict Code: TA - Therapeutic Appropriateness **(Black Box Warning)**
Drugs/Diseases

Util A	Util B	Util C **(Include)**
Glycopyrrolate/Formoterol		Asthma

References:
Bevespi Aerosphere Prescribing Information, April 2016, AstraZeneca.

71. Glycopyrrolate/Formoterol / Therapeutic Appropriateness _____ _____

Alert Message: Bevespi Aerosphere (glycopyrrolate/formoterol) is not indicated for use in children. The safety and effectiveness of glycopyrrolate/formoterol have not been established in children.

Conflict Code: TA - Therapeutic Appropriateness
Drugs/Diseases

Util A	Util B	Util C
Glycopyrrolate /Formoterol		

Age Range: 0 – 17 yoa

References:
Bevespi Aerosphere Prescribing Information, April 2016, AstraZeneca.

72. Glycopyrrolate/Formoterol / Cardiovascular, Convulsive Disorders, Thyrotoxicosis & Diabetes _____ _____

Alert Message: Bevespi Aerosphere (glycopyrrolate/formoterol) should be used with caution in patients with cardiovascular or convulsive disorders, thyrotoxicosis or sensitivity to sympathomimetic drugs. The formoterol component is a sympathomimetic amine and can exacerbate these conditions.

Conflict Code: TA – Therapeutic Appropriateness
Drugs/Diseases

Util A	Util B	Util C **(Include)**
Glycopyrrolate/formoterol		Hypertension
		Arrhythmias
		Heart Failure
		Diabetes
		Seizures
		Epilepsy

References:
Bevespi Aerosphere Prescribing Information, April 2016, AstraZeneca.

73. Glycopyrrolate/Formoterol / Adrenergic Drugs _____ _____

Alert Message: Caution should be exercised when Bevespi Aerosphere (glycopyrrolate/formoterol) is prescribed concurrently with other adrenergic sympathomimetic agents, administered by any route, because the sympathetic effects of the formoterol component of the combination product may be potentiated.

Conflict Code: DD - Drug/Drug Interaction
Drugs/Diseases

Util A	Util B				Util C
Indacaterol/Glycopyrrolate	Ephedrine	Metaproterenol	Lisdexamfetamine	Oxymetazoline	
	Epinephrine	Terbutaline	Diethylpropion	Tetrahydrozoline	
	Pseudoephedrine	Methamphetamine	Benzphetamine		
	Phenylephrine	Methylphenidate	Phentermine		
	Albuterol	Amphetamine	Phendimetrazine		
	Pirbuterol	Dextroamphetamine	Naphazoline		

References:
Bevespi Aerosphere Prescribing Information, April 2016, AstraZeneca.

74. Glycopyrrolate/Formoterol / Xanthine Derivatives & Steroids _____ _____

Alert Message: Caution should be exercised when Bevespi Aerosphere (glycopyrrolate/formoterol) is prescribed concurrently with xanthine derivatives or steroids because concomitant administration may potentiate the hypokalemic effect of the formoterol component of the combination agent.

Conflict Code: DD - Drug/Drug Interaction
Drugs/Diseases

Util A	Util B		Util C
Glycopyrrolate/Formoterol	Theophylline	Hydrocortisone	
	Aminophylline	Methylprednisolone	
	Dyphylline	Prednisone	
	Betamethasone	Prednisolone	
	Budesonide	Dexamethasone	
	Cortisone		

References:
Bevespi Aerosphere Prescribing Information, April 2016, AstraZeneca.

75. Glycopyrrolate/Formoterol / Non-Potassium Sparing Diuretics _____ _____

Alert Message: Caution should be exercised when Bevespi Aerosphere (glycopyrrolate/formoterol), a beta2-agonist containing combo agent, is prescribed concurrently with non-potassium sparing diuretics because concomitant administration may potentiate the ECG changes or hypokalemia that may result from the administration of the diuretic.

Conflict Code: DD - Drug/Drug Interaction
Drugs/Diseases

Util A	Util B		Util C
Glycopyrrolate/Formoterol	Furosemide	Indapamide	
	Bumetanide	Methyclothiazide	
	Torsemide	Metolazone	
	Chlorothiazide		
	Chlorthalidone		
	HCTZ		

References:
Bevespi Aerosphere Prescribing Information, April 2016, AstraZeneca.

76. Glycopyrrolate/Formoterol / Nonselective β-Blockers / Sel. β-Blockers _____ _____

Alert Message: Concurrent use of a beta-adrenergic blocker with Bevespi Aerosphere (glycopyrrolate/formoterol), a $beta_2$-agonist containing combo agent, may diminish the pulmonary effect of the beta-agonist component, formoterol. Beta-blockers not only block the therapeutic effects of beta-agonists, but may produce severe bronchospasm in patients with COPD. If concomitant therapy cannot be avoided consider a cardioselective beta-blocker, but administer with caution.

Conflict Code: DD - Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C **(Negating)**
Glycopyrrolate/formoterol	Carvedilol	Acebutolol
	Nadolol	Atenolol
	Labetalol	Betaxolol
	Penbutolol	Bisoprolol
	Pindolol	Metoprolol
	Propranolol	Nebivolol
	Sotalol	
	Timolol	

References:
Bevespi Aerosphere Prescribing Information, April 2016, AstraZeneca.

77. Glycopyrrolate/Formoterol / Anticholinergics _____ _____

Alert Message: The concurrent use of Bevespi Aerosphere (glycopyrrolate/formoterol) with anticholinergic agents should be avoided. The glycopyrrolate component of the combo product is an anticholinergic agent and concomitant use with other anticholinergics may lead to an increase in anticholinergic adverse effects.

Conflict Code: DD - Drug/Drug Interaction
Drugs/Diseases

Util A	Util B		Util C
Glycopyrrolate/formoterol	Trihexyphenidyl	Trospium	
	Benztropine	Hyoscyamine	
	Orphenadrine	Scopolamine	
	Darifenacin	Propantheline	
	Fesoterodine	Mepenzolate	
	Flavoxate	Methscopolamine	
	Oxybutynin	Dicyclomine	
	Solifenacin	Tolterodine	

References:
Bevespi Aerosphere Prescribing Information, April 2016, AstraZeneca.

78. Glycopyrrolate/Formoterol / MAOIs, TCA & Other QT Prolong Meds _____ _____

Alert Message: Bevespi Aerosphere (glycopyrrolate/formoterol) should be administered with extreme caution to patients being treated with MAOIs, TCAs, or other drugs known to prolong the QTc interval because the action of the adrenergic agonist, formoterol, on the cardiovascular system may be potentiated by these agents.

Conflict Code: DD – Drug/Drug Interactions
Drugs/Diseases

Util A	Util B				Util C
Glycopyrrolate/Formoterol	Albuterol	Disopyramide	Imipramine	Pazopanib	Thioridazine
	Alfuzosin	Dofetilide	Indapamide	Pentamidine	Tizanidine
	Amantadine	Dolasetron	Isradipine	Pimozide	Tolterodine
	Amiodarone	Doxepin	Itraconazole	Posaconazole	Trazodone
	Amitriptyline	Dronedarone	Ketoconazole	Procainamide	TMP/SMZ
	Amphetamine	Droperidol	Lapatinib	Propafenone	Trimipramine
	Arsenic Trioxide	Ephedrine	Levalbuterol	Protriptyline	Vandetanib
	Asenapine	Epinephrine	Levofloxacin	Quetiapine	Vardenafil
	Atazanavir	Erythromycin	Lithium	Quinidine	Venlafaxine
	Atomoxetine	Escitalopram	Metaproterenol	Ranolazine	Ziprasidone
	Azithromycin	Felbamate	Methadone	Risperidone	Zolmitriptan
	Chloral Hydrate	Flecainide	Moexipril/HCTZ	Ritonavir	Ezogabine
	Chloroquine	Fluconazole	Moxifloxacin	Salmeterol	Isocarboxazid
	Chlorpromazine	Fluoxetine	Nicardipine	Saquinavir	Phenelzine
	Ciprofloxacin	Foscarnet	Nilotinib	Sertraline	Tranylcypromine
	Citalopram	Fosphenytoin	Norfloxacin	Solifenacin	Linezolid
	Clarithromycin	Galantamine	Nortriptyline	Sotalol	Rasagiline
	Clomipramine	Gemifloxacin	Octreotide	Sunitinib	
	Clozapine	Granisetron	Ofloxacin	Tacrolimus	
	Dasatinib	Haloperidol	Ondansetron	Tamoxifen	
	Desipramine	Ibutilide	Paliperidone	Telithromycin	
	Diphenhydramine	Iloperidone	Paroxetine	Terbutaline	

References:
Bevespi Aerosphere Prescribing Information, April 2016, AstraZeneca.

79. Glycopyrrolate/Formoterol / Non-adherence _____ _____

Alert Message: Based on refill history, your patient may be under-utilizing Bevespi Aerosphere (glycopyrrolate/formoterol). Non-adherence to the prescribed dosing regimen may result in sub-therapeutic effects, which may lead to decreased outcomes and additional healthcare costs.

Conflict Code: LR - Nonadherence
Drugs/Diseases

Util A	Util B	Util C
Glycopyrrolate/Formoterol		

References:

van Boven JF, Chavannes NH, van der Molen T, et al. Clinical and Economic Impact of Non-adherence in COPD: A Systematic Review. Respir Med. 2015 Jan;108(1):103-113.
Restrepo RD, Alvarez MT, Wittnebel LD, et al., Medication Adherence Issues in Patients Treated for COPD. International Journal of COPD. 2008;3(3):371-384.
Simoni-Wastila L, Wei Y, Qian J, et al., Association of Chronic Obstructive Pulmonary Disease Maintenance Medication Adherence With All-Cause Hospitalization and Spending in a Medicare Population. Am Jrnl Geriatr Pharmacother. 2012 Jun;10(3):201-210.
Lareau SC, Yawn BP. Improving Adherence with Inhaler Therapy in COPD. International Journal COPD. 2010 Nov 24;5:401-406.

80. Olaparib / Overutilization _____ _____

Alert Message: The manufacturer's recommended daily dose of Lynparza (olaparib) is 400 mg (eight 50 mg capsules) taken twice daily for a total daily dose of 800 mg.

Conflict Code: ER - Overutilization
Drugs/Diseases

Util A	Util B	Util C
Olaparib		

Max Dose: 800 mg/day

References:

Lynparza Prescribing Information, Dec. 2017, AstraZeneca.
Clinical Pharmacology, 2017 Elsevier/Gold Standard.

81. Olaparib / Moderate to Strong CYP3A4 Inhibitors _____ _____

Alert Message: Concurrent use of Lynparza (olaparib), a CYP3A substrate, with strong and moderate CYP3A inhibitors should be avoided due to risk of increased olaparib concentrations. Alternative agents with less CYP3A4 inhibition should be considered. If the inhibitor cannot be avoided, reduce the olaparib dose to 150 mg taken twice daily for a strong CYP3A inhibitor or 200 mg take twice daily for a moderate inhibitor.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B				Util C
Olaparib	Nefazodone	Indinavir	Fluconazole	Verapamil	
	Ketoconazole	Nelfinavir	Fosamprenavir	Crizotinib	
	Itraconazole	Saquinavir	Imatinib	Delavirdine	
	Posaconazole	Ritonavir	Idelalisib		
	Voriconazole	Tipranavir	Aprepitant		
	Clarithromycin	Darunavir	Ciprofloxacin		
	Telithromycin	Atazanavir	Diltiazem		
	Boceprevir	Cobicistat	Erythromycin		

References:

Lynparza Prescribing Information, Dec. 2017, AstraZeneca.
Clinical Pharmacology, 2017 Elsevier/Gold Standard.

82. Olaparib / Moderate to Strong CYP3A4 Inducers _____ _____

Alert Message: Concurrent use of Lynparza (olaparib), a CYP3A substrate, with strong and moderate CYP3A inducers should be avoided due to potential for decreased olaparib efficacy. Alternative agents with less CYP3A induction potential should be considered.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B		Util C
Olaparib	Carbamazepine	Rifapentine	
	Phenytoin	Bosentan	
	Phenobarbital	Efavirenz	
	Primidone	Modafinil	
	Rifampin	Oxcarbazepine	
	Rifabutin	Etravirine	

References:
Lynparza Prescribing Information, Dec. 2017, AstraZeneca.
Clinical Pharmacology, 2017 Elsevier/Gold Standard.

83. Olaparib / Monitoring _____ _____

Alert Message: Myelosdysplastic Syndrome/Acute Myeloid Leukemia (MDS/ALS) has occurred in patients exposed to Lynparza (olaparib) and some were fatal. Monitor complete blood count testing at baseline and monthly thereafter and discontinue olaparib if MSD/AML is confirmed.

Conflict Code: TA – Therapeutic Appropriateness
Drugs/Diseases

Util A	Util B	Util C
Olaparib		

References:
Lynparza Prescribing Information, Dec. 2014, AstraZeneca.
Clinical Pharmacology, 2017 Elsevier/Gold Standard.

84. Olaparib / Pneumonitis Symptoms _____ _____

Alert Message: Pneumonitis, including fatal cases, have occurred in patients treated with Lynparza (olaparib). If patients present with new or worsening respiratory symptoms such as dyspnea, fever, cough, wheezing, or a radiological abnormality occurs, interrupt treatment with olaparib and initiate prompt investigation. If pneumonitis is confirmed, discontinue olaparib.

Conflict Code: MC – Drug (Actual) Disease Warning/Precaution
Drugs/Diseases

Util A	Util B	Util C
Olaparib	Dyspnea	
	Fever	
	Cough	

References:
Lynparza Prescribing Information, Dec. 2017, AstraZeneca.
Clinical Pharmacology, 2017 Elsevier/Gold Standard.

85. Olaparib / Pregnancy / Pregnancy Negating _____ _____

Alert Message: Lynparza (olaparib) can cause fetal harm in a pregnant woman based on its mechanism of action and findings in animals. Females of reproductive potential should avoid becoming pregnant while taking olaparib. If contraceptive methods are being considered, use highly effective contraceptive methods during treatment and for at least 6 months after receiving the last olaparib dose. If the patient becomes pregnant while taking olaparib, apprise them of the potential hazard to the fetus.

Conflict Code: TA – Therapeutic Appropriateness
Drugs/Diseases

Util A	Util B	Util C **(Negating)**
Olaparib	Pregnancy	Miscarriage
		Delivery
		Abortion

Age Range 11-50

References:
Lynparza Prescribing Information, Dec. 2017, AstraZeneca.

86. Olaparib / Overutilization _____ _____

Alert Message: The manufacturer's recommended daily dose of Lynparza (olaparib) in patients with moderate renal impairment (CLcr 31 – 50 mL/min) is 300 mg (six 50 mg capsules) taken twice daily, for a total daily dose of 600 mg. No dosage adjustment is recommended in mild renal impairment (CLcr 51 – 80 mL/min). The pharmacokinetics of olaparib have not been evaluated in patients with severe renal impairment or end-stage renal disease (CLcr </= 30ml/min).

Conflict Code: ER - Overutilization
Drugs/Diseases

Util A	Util B	Util C **(Include)**
Olaparib		CKD 3, 4 & 5
		ESRD

Max Dose: 600 mg/day

References:
Lynparza Prescribing Information, Dec. 2017, AstraZeneca.

DUR Board Meeting
June 7, 2017
Brynhild Haugland Room
State Capitol

North Dakota Medicaid
DUR Board Meeting Agenda
Brynhild Haugland Room
State Capitol
600 East Boulevard Avenue
Bismarck, ND
June 7, 2017
1:00 pm

1. Administrative items
    - Travel vouchers

2. Old business
    - Review and approval of 03/17 meeting minutes
    - Budget update
    - Review top 15 therapeutic categories/top 25 drugs
    - Prior authorization/PDL update

3. New business
    - Review of Proglycem
    - Review of Biltricide
    - Review of physician prescribing patterns for select therapeutic categories
    - Review of anti-depressant non-compliance
    - Criteria recommendations
    - Upcoming meeting date/agenda

4. Adjourn

Please remember to silence all cellular phones during the meeting.

Drug Utilization Review (DUR) Meeting Minutes

March 1, 2017

Members Present: Wendy Brown, Katie Kram, Tanya Schmidt, Laura Schield, Andrea Honeyman, Michael Booth, Gaylord Kavlie, Zach Marty, Jeffrey Hostetter, Carlotta McCleary

Members Absent: James Carlson, Michael Quast, Russ Sobotta, Peter Woodrow, LeNeika Roehrich

Medicaid Pharmacy Department: Brendan Joyce, Alexi Murphy

Old Business

Chair W. Brown called the meeting to order at 1:00 p.m. Chair W. Brown asked for a motion to approve the minutes of the December meeting. T. Schmidt moved that the minutes be approved and M. Booth seconded the motion. Chair W. Brown called for a voice vote to approve the minutes. The motion passed with no audible dissent.

Second Reviews

A motion and second was made at the December meeting to place prednisolone ODT, Millepred, Veripred, metformin OSM, and testosterone oral on prior authorization. The topics were brought up for a second review. The motion to place prednisolone ODT, Millepred, Veripred, metformin OSM, and testosterone oral on prior authorization passed with no audible dissent.

Review of 2016 DUR Projects

A. Murphy presented a review of DUR projects from the year of 2016. Topics included the utilization of acne medications, utilization of long and short acting narcotics with a high prevalence of abuse, appropriate use of maintenance and rescue inhalers for chronic respiratory conditions, prevalence of benzodiazepine therapy for sleep disorders, and the utilization of duplicate anti-ulcer therapy. Also reviewed was trends in utilization of anticonvulsants, antidepressants, antipsychotics, ADHD stimulants and non-stimulants, and select high-cost or high utilization products.

Prior Authorization and PDL Update

A. Murphy gave an update on drugs that have been added to prior authorization. Adlyxin was added to the GLP-1 Receptor agonist PA. Basaglar Kwikpen U-100, Humulin 70/30 Kwikpen, Humulin N Kwikpen, Humulin R U-500 Kwikpen, and Soliqua 100-33 were added to the Insulin PA. Fosrenol 1000 mg chewable tablet was added to the phosphate binders PA. Otovel was added to the otic anti-infectives PA. Jentadueto XR was added to the DPP4 inhibitors PA. Prestalia was added to the ACEI/ARB/Renin inhibtors PA. Tobradex ST was added to the ophthalmic antiinfectives/anti-inflammatories PA. Benlysta, Spinraza, Dalvance, Fabrazyme, Kanuma, Kepivance, Orbactiv, and Panhematin were added to the Medical Billing Only list of medications. Alocril, Alomide, Alvesco, Azasite, azelastine HCl, Beconase AQ, Besivance, Brovana, Ciloxan, Dexilant, Dipentum, epinephrine, Eurax, Floxin, Gelnique, Prevacid, Lastacaft, Maxitrol, Omeclamox-Pak, Omnaris, Oxytrol, Prevpac, Qnasl, Renvela, and Zetonna were all removed from PA.

New Business

Criteria Recommendations

The recommended RDUR criteria enclosed in the packet were developed from product information provided by the manufacturers and are usually consistent with new indications, new drugs added, and new warnings. These proposed criteria will be added to the current set of criteria and will be used in future DUR cycles. M. Booth moved to approve the new criteria and A. Honeyman seconded the motion. Chair W. Brown called for a voice vote. The motion passed with no audible dissent.

The next DUR Board meeting will be held June 7, 2017 at the Brynhild Haugland in Bismarck. J. Hostetter made a motion to adjourn the meeting. K. Kram seconded. The motion passed with no audible dissent. Chair W. Brown adjourned the meeting.

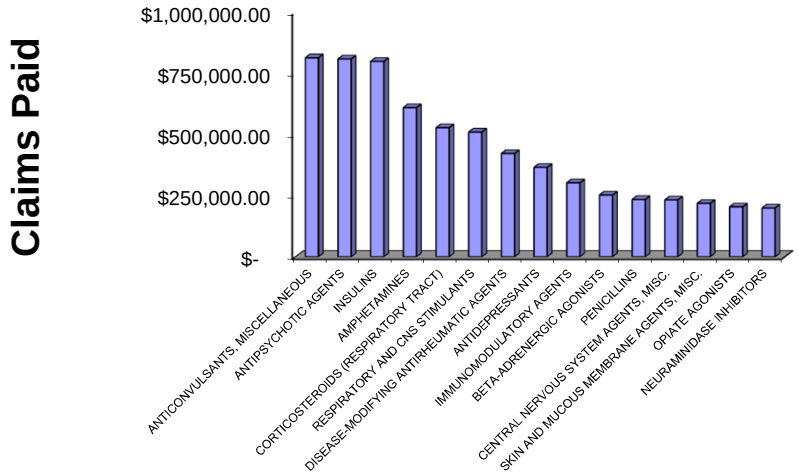
NORTH DAKOTA MEDICAID
Cost Management Analysis

TOP 15 THERAPEUTIC CLASSES BY TOTAL COST OF CLAIMS FROM 01/01/2017 - 03/31/2017

AHFS Therapeutic Class	Rx	Paid	Paid/Rx	% Total Claims
ANTICONVULSANTS, MISCELLANEOUS	8,432	$ 812,942.27	$ 96.41	5.72%
ANTIPSYCHOTIC AGENTS	5,856	$ 807,919.35	$ 137.96	3.97%
INSULINS	1,830	$ 798,122.86	$ 436.13	1.24%
AMPHETAMINES	3,839	$ 609,938.07	$ 158.88	2.60%
CORTICOSTEROIDS (RESPIRATORY TRACT)	1,887	$ 527,897.44	$ 279.75	1.28%
RESPIRATORY AND CNS STIMULANTS	4,348	$ 510,534.01	$ 117.42	2.95%
DISEASE-MODIFYING ANTIRHEUMATIC AGENTS	117	$ 422,677.51	$ 3,612.63	0.08%
ANTIDEPRESSANTS	14,716	$ 365,976.92	$ 24.87	9.98%
IMMUNOMODULATORY AGENTS	50	$ 302,764.27	$ 6,055.29	0.03%
BETA-ADRENERGIC AGONISTS	3,838	$ 252,842.04	$ 65.88	2.60%
PENICILLINS	6,342	$ 234,495.05	$ 36.97	4.30%
CENTRAL NERVOUS SYSTEM AGENTS, MISC.	1,695	$ 232,760.20	$ 137.32	1.15%
SKIN AND MUCOUS MEMBRANE AGENTS, MISC.	252	$ 218,669.81	$ 867.74	0.17%
OPIATE AGONISTS	6,121	$ 204,500.73	$ 33.41	4.15%
NEURAMINIDASE INHIBITORS	1,285	$ 199,702.72	$ 155.41	0.87%
Total Top 15	60,608	$ 6,501,743.25	$ 107.28	41.09%

Total Rx Claims From 01/01/2017 - 03/31/2017	147,494

Top 15 Therapeutic Classes
Based on Total Cost of Claims

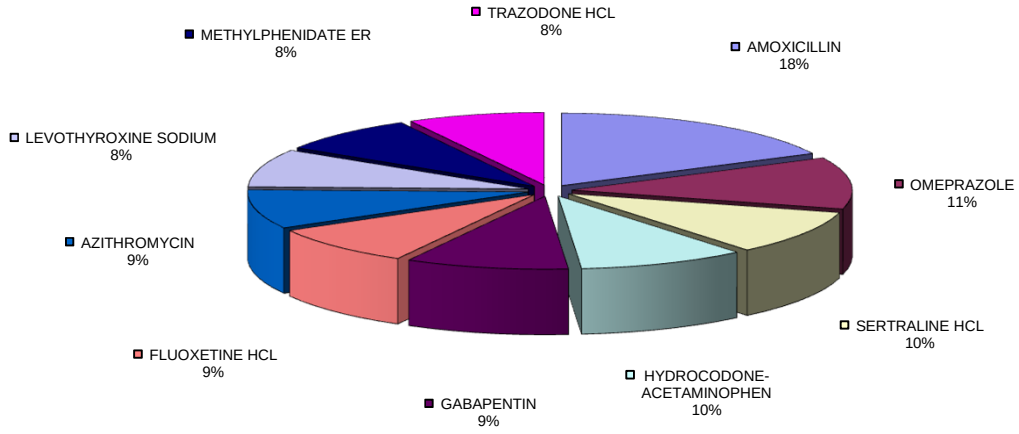


TOP 25 DRUGS BASED ON NUMBER OF CLAIMS FROM 01/01/2017 - 03/31/2017

Drug	AHFS Therapeutic Class	Rx	Paid	Paid/Rx	% Total Claims
AMOXICILLIN	PENICILLINS	4,316	$ 149,107.06	$ 34.55	2.93%
OMEPRAZOLE	PROTON-PUMP INHIBITORS	2,811	$ 52,049.31	$ 18.52	1.91%
SERTRALINE HCL	ANTIDEPRESSANTS	2,398	$ 40,486.25	$ 16.88	1.63%
HYDROCODONE-ACETAMINOPHEN	OPIATE AGONISTS	2,353	$ 66,920.84	$ 28.44	1.60%
GABAPENTIN	ANTICONVULSANTS, MISCELLANEOUS	2,291	$ 70,934.78	$ 30.96	1.55%
FLUOXETINE HCL	ANTIDEPRESSANTS	2,131	$ 35,464.65	$ 16.64	1.44%
AZITHROMYCIN	MACROLIDES	2,118	$ 53,388.53	$ 25.21	1.44%
LEVOTHYROXINE SODIUM	THYROID AGENTS	2,063	$ 41,467.28	$ 20.10	1.40%
METHYLPHENIDATE ER	RESPIRATORY AND CNS STIMULANTS	1,996	$ 288,454.12	$ 144.52	1.35%
TRAZODONE HCL	ANTIDEPRESSANTS	1,929	$ 31,442.45	$ 16.30	1.31%
LISINOPRIL	ANGIOTENSIN-CONVERTING ENZYME INHIBITORS	1,892	$ 42,711.51	$ 22.57	1.28%
MONTELUKAST SODIUM	LEUKOTRIENE MODIFIERS	1,851	$ 36,741.13	$ 19.85	1.25%
ATORVASTATIN CALCIUM	HMG-COA REDUCTASE INHIBITORS	1,756	$ 46,683.69	$ 26.59	1.19%
AMOXICILLIN-CLAVULANATE POTASS	PENICILLINS	1,708	$ 67,168.23	$ 39.33	1.16%
VYVANSE	AMPHETAMINES	1,576	$ 326,933.29	$ 207.44	1.07%
CLONIDINE HCL	CENTRAL ALPHA-AGONISTS	1,555	$ 21,048.17	$ 13.54	1.05%
ALBUTEROL SULFATE	BETA-ADRENERGIC AGONISTS	1,519	$ 58,589.20	$ 38.57	1.03%
ESCITALOPRAM OXALATE	ANTIDEPRESSANTS	1,473	$ 28,487.50	$ 19.34	1.00%
METFORMIN HCL	BIGUANIDES	1,468	$ 21,328.24	$ 14.53	1.00%
QUETIAPINE FUMARATE	ANTIPSYCHOTIC AGENTS	1,359	$ 21,817.05	$ 16.05	0.92%
BUPROPION XL	ANTIDEPRESSANTS	1,254	$ 30,063.98	$ 23.97	0.85%
CLONAZEPAM	BENZODIAZEPINES (ANTICONVULSANTS)	1,243	$ 25,094.41	$ 20.19	0.84%
LAMOTRIGINE	ANTICONVULSANTS, MISCELLANEOUS	1,242	$ 20,836.28	$ 16.78	0.84%
RISPERIDONE	ANTIPSYCHOTIC AGENTS	1,239	$ 19,539.96	$ 15.77	0.84%
ADDERALL XR	AMPHETAMINES	1,238	$ 239,282.92	$ 193.28	0.84%
TOTAL TOP 25		46,779	$ 1,836,040.83	$ 39.25	31.72%

Total Rx Claims From 01/01/2017 - 03/31/2017	147,494

Top 10 Drugs
Based on Number of Claims

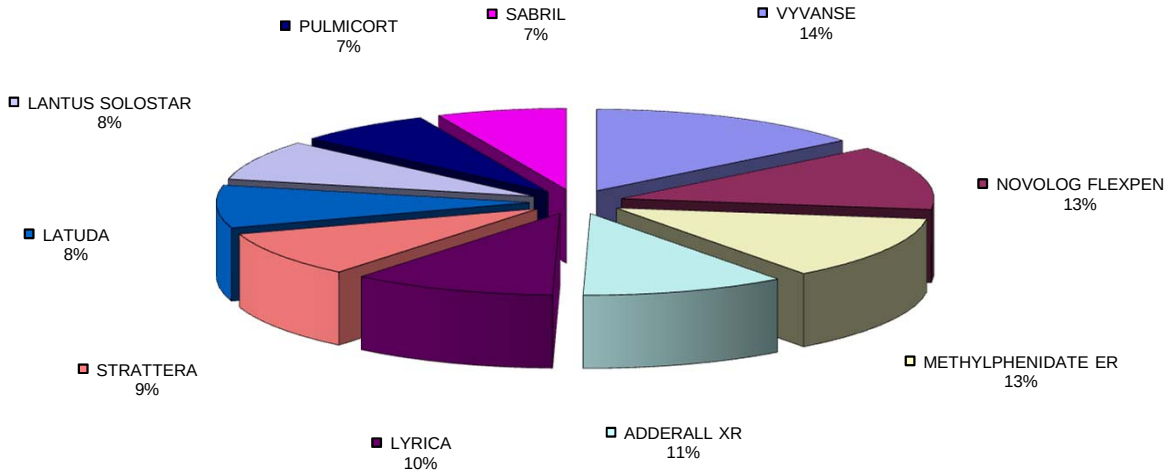


TOP 25 DRUGS BASED ON TOTAL CLAIMS COST FROM 01/01/2017 - 03/31/2017

Drug	AHFS Therapeutic Class	Rx	Paid	Paid/Rx	% Total Claims
VYVANSE	AMPHETAMINES	1,576	$ 326,933.29	$ 207.44	1.07%
NOVOLOG FLEXPEN	INSULINS	590	$ 288,689.43	$ 489.30	0.40%
METHYLPHENIDATE ER	RESPIRATORY AND CNS STIMULANTS	1,996	$ 288,454.12	$ 144.52	1.35%
ADDERALL XR	AMPHETAMINES	1,238	$ 239,282.92	$ 193.28	0.84%
LYRICA	ANTICONVULSANTS, MISCELLANEOUS	644	$ 238,949.29	$ 371.04	0.44%
STRATTERA	CENTRAL NERVOUS SYSTEM AGENTS, MISC.	615	$ 205,898.71	$ 334.79	0.42%
LATUDA	ANTIPSYCHOTIC AGENTS	227	$ 191,362.68	$ 843.01	0.15%
LANTUS SOLOSTAR	INSULINS	457	$ 180,822.26	$ 395.67	0.31%
PULMICORT	CORTICOSTEROIDS (RESPIRATORY TRACT)	399	$ 157,304.62	$ 394.25	0.27%
SABRIL	ANTICONVULSANTS, MISCELLANEOUS	10	$ 152,172.51	$ 15,217.25	0.01%
ADVAIR DISKUS	CORTICOSTEROIDS (RESPIRATORY TRACT)	466	$ 149,539.82	$ 320.90	0.32%
AMOXICILLIN	PENICILLINS	4,316	$ 149,107.06	$ 34.55	2.93%
TAMIFLU	NEURAMINIDASE INHIBITORS	757	$ 143,327.31	$ 189.34	0.51%
ENBREL	DISEASE-MODIFYING ANTIRHEUMATIC AGENTS	40	$ 141,800.06	$ 3,545.00	0.03%
HUMIRA PEN	DISEASE-MODIFYING ANTIRHEUMATIC AGENTS	34	$ 139,787.02	$ 4,111.38	0.02%
FREESTYLE LITE STRIPS	DIABETES MELLITUS	867	$ 122,902.56	$ 141.76	0.59%
EPCLUSA	HCV ANTIVIRALS	5	$ 122,249.16	$ 24,449.83	0.00%
INVEGA SUSTENNA	ANTIPSYCHOTIC AGENTS	60	$ 111,876.00	$ 1,864.60	0.04%
MAPAP	ANALGESICS AND ANTIPYRETICS, MISC.	638	$ 107,005.06	$ 167.72	0.43%
PROVENTIL HFA	BETA-ADRENERGIC AGONISTS	1,123	$ 105,993.20	$ 94.38	0.76%
COPAXONE	IMMUNOMODULATORY AGENTS	16	$ 101,077.08	$ 6,317.32	0.01%
LEVEMIR FLEXTOUCH	INSULINS	331	$ 95,474.23	$ 288.44	0.22%
FOCALIN XR	RESPIRATORY AND CNS STIMULANTS	332	$ 92,595.55	$ 278.90	0.23%
SPIRIVA	ANTIMUSCARINICS/ANTISPASMODICS	305	$ 88,999.54	$ 291.80	0.21%
VIMPAT	ANTICONVULSANTS, MISCELLANEOUS	158	$ 83,854.57	$ 530.73	0.11%
TOTAL TOP 25		17,200	$ 4,025,458.05	$ 234.04	11.66%

Total Rx Claims From 01/01/2017 - 03/31/2017	147,494

Top 10 Drugs
Based on Total Claims Cost



Prior Authorization/PDL Update

Added to PA	Category
ADENOVATE 3000 UNIT	Antihemophilia
AIRDUO RESPICLICK	Steroid Beta2 Agonist
ARYMO ER	Narcotics
AUSTEDO	>$3,000
DUPIXENT	>$3,000
EMFLAZA	>$3,000
ESBRIET	>$3,000
FLUTICASONE/SALMETEROL	Steroid Beta2 Agonist
INGREZZA	>$3,000
IXINITY	Antihemophilia
MIGERGOT	DHE
OCALIVA	>$3,000
SILIQ	Cytokine Modulators
SYNJARDY XR	SGLT2 Inhibitors
TRULANCE	IBS/Constipation
XULTOPHY	GLP-1

Bill Medical Side VIA 837I AND 837P TRANSACTIONS
DEFITELIO
LEMTRADA
LUCENTIS
OCREVUS
QUADRAMET
TYSABRI

No Longer Covered
XENICAL

PRODUCT DETAILS OF BILTRICIDE (praziquantel)

INDICATIONS AND USE:
Treatment of infections caused by the following: all species of Schistosoma and the liver flukes (Clonorchis sinensis/Opisthorchis viverrini)

DOSAGE AND ADMINISTRATION:
- Adult and Pediatric: 4 years and older
    - Clonorchiasis and Opisthorchiasis
        - Usual dose is 25 mg/kg 3 times daily, given 4 to 6 hours apart, for 1 day
        - Off-label
            - 25 mg/kg 3 times daily for 2 days
    - Schistosomiasis
        - 20 mg/kg 3 times daily, given 4 to 6 hours apart, for 1 day
    - Cysticercosis (off-label)
        - 50 mg/kg/day divided into 3 doses, given every 8 hours for 14 days
    - Tapeworms (off-label)
        - 5 to 10 mg/kg as a single dose (25 mg/kg for Hymenolepis nana)

DOSAGE FORM AND STRENGTHS:
- Biltricide is available as 600 mg tablet

CONTRAINDICATIONS:
- Patients with ocular cysticercosis
- Concomitant administration with strong cytochrome P450 (CYP-450) inducers
- Hypersensitivity to praziquantel or any component of the formulation;

WARNINGS AND PRECAUTIONS:
- Use with caution in patients with cardiac abnormalities due to the risk of unspecified arrhythmias occurring with Biltricide use.
- Biltricide may not be effective against migrating schistosomulae and may be associated with clinical deterioration such as paradoxical reactions or serum sickness.
- Use is not recommended in patients with a history of seizures or signs of central nervous system involvement as use of Biltricide may exacerbate the condition.
    - Patients with cerebral cysticercosis should be hospitalized for the duration of treatment.
- Potentially significant interactions exist, requiring dose or frequency adjustment, additional monitoring, and/or alternative therapy selection.
    - Medications that affect cytochrome 3A4
- Use with caution in patients with moderate to severe hepatic impairment.
- Patients should not drive or operate heavy machinery on the day of, and the day after treatment

ADVERSE REACTIONS:
The most common adverse reactions to therapy with Biltricide are dizziness, headache, fatigue, urticaria, abdominal distress, nausea, and vomiting. Increase serum liver enzymes labs have also been noted.

CURRENT UTILIZATION

ND Medicaid Biltricide Utilization		
Label Name	**Rx Num**	**Total Reimb Amt**
BILTRICIDE 600 MG TABLET	**1**	**$92.50**

REFERENCES:

1. Facts & Comparisons eAnswers. Available at http://online.factsandcomparisons.com. Accessed on April 14, 2017.
2. Biltricide (praziquantel) [prescribing information]. Wayne, NJ: Schering; March 2014.

PRODUCT DETAILS OF PROGLYCEM (diazoxide)

INDICATIONS AND USE:

Proglycem is used for the management of hypoglycemia due to hyperinsulinism resulting from specific conditions in adults (inoperable islet cell adenoma or carcinoma, or extrapancreatic malignancy) and in children (leucine sensitivity, islet cell hyperplasia, nesidioblastosis, extrapancreatic malignancy, islet cell adenoma, or adenomatosis). Proglycem should be considered only when other medical or surgical management for hypocalcemia is unsuccessful or not feasible

DOSAGE AND ADMINISTRATION:

- Patients 1 year of age and older
    - The recommended starting dose of Proglycem is 3 mg/kg/day
        - Divided into 3 equal doses every 8 hours
    - Proglycem should be dosed to effect. Usual doses range from 3 to 8 mg/kg/day,
        - Divided into 2 or 3 equal doses every 8 or 12 hours
- Patients less than 12 months of age
    - The recommended starting dose of Proglycem is 10 mg/kg/day
        - Divided into 3 equal doses every 8 hours
    - Proglycem should be dosed to effect, Usual doses range from 8 to 15 mg/kg/day,
        - Divided into 2 or 3 equal doses every 8 or 12 hours
- Therapy should be discontinued if no effect is reached after 2-3 weeks.

DOSAGE FORM AND STRENGTHS:

- Proglycem is available as an oral suspension at a strength of 50 mg/mL.

CONTRAINDICATIONS:

- Patients with functional hypoglycemia
- Hypersensitivity to diazoxide, thiazides, or any component of the formulation;

WARNINGS AND PRECAUTIONS:

- Use may lead to increased fluid retention, and may precipitate heart failure in patients with compromised cardiac reserve.
- Ketoacidosis and non-ketotic hyperosmolar coma may occur during treatment, usually in patients with concomitant illness.
- Use with caution in patients with hyperuricemia or a history of gout.
- Development of abnormal facial features was reported in children treated more than 4 years for hypoglycemia hyperinsulinism.
- Some dosage forms may contain propylene glycol and/or benzoate/benzoic acid

ADVERSE REACTIONS:

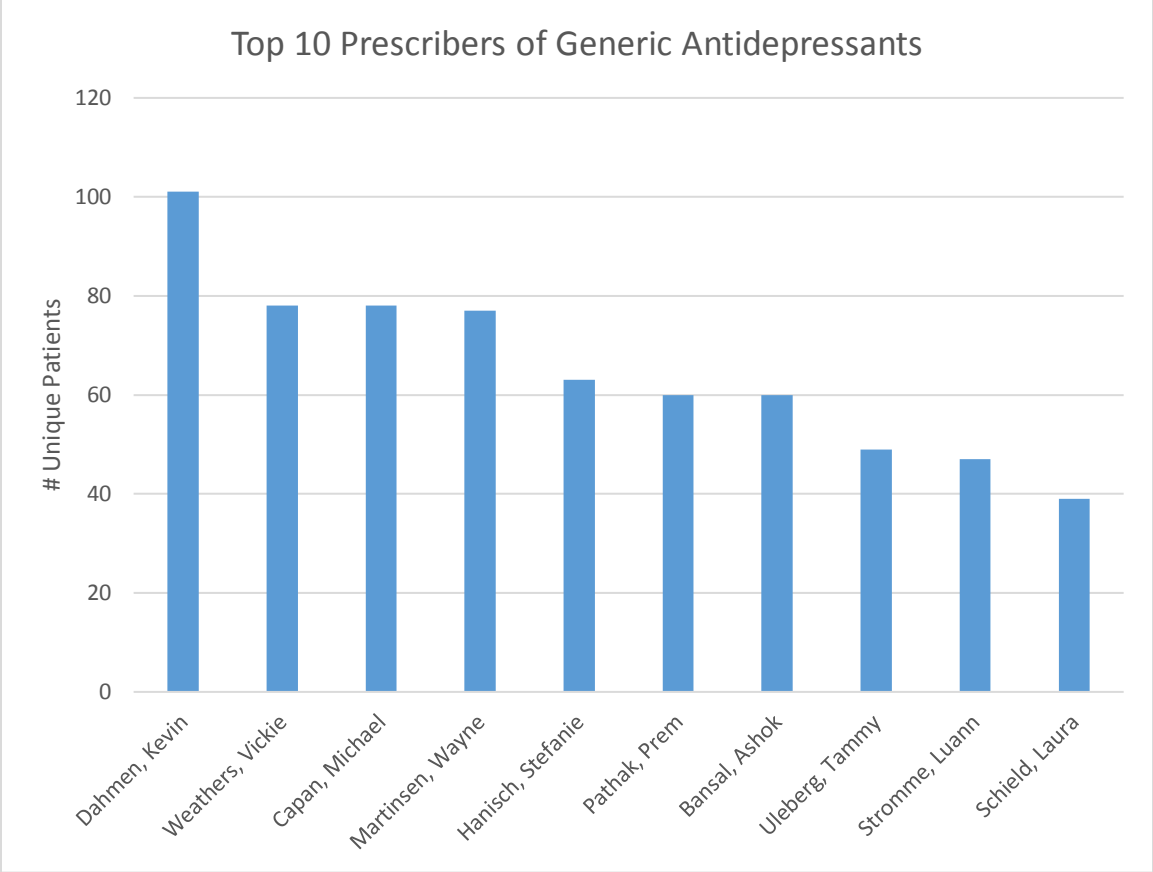
The following is a list of the most frequent adverse reactions to therapy with Proglycem (specific frequency not defined)

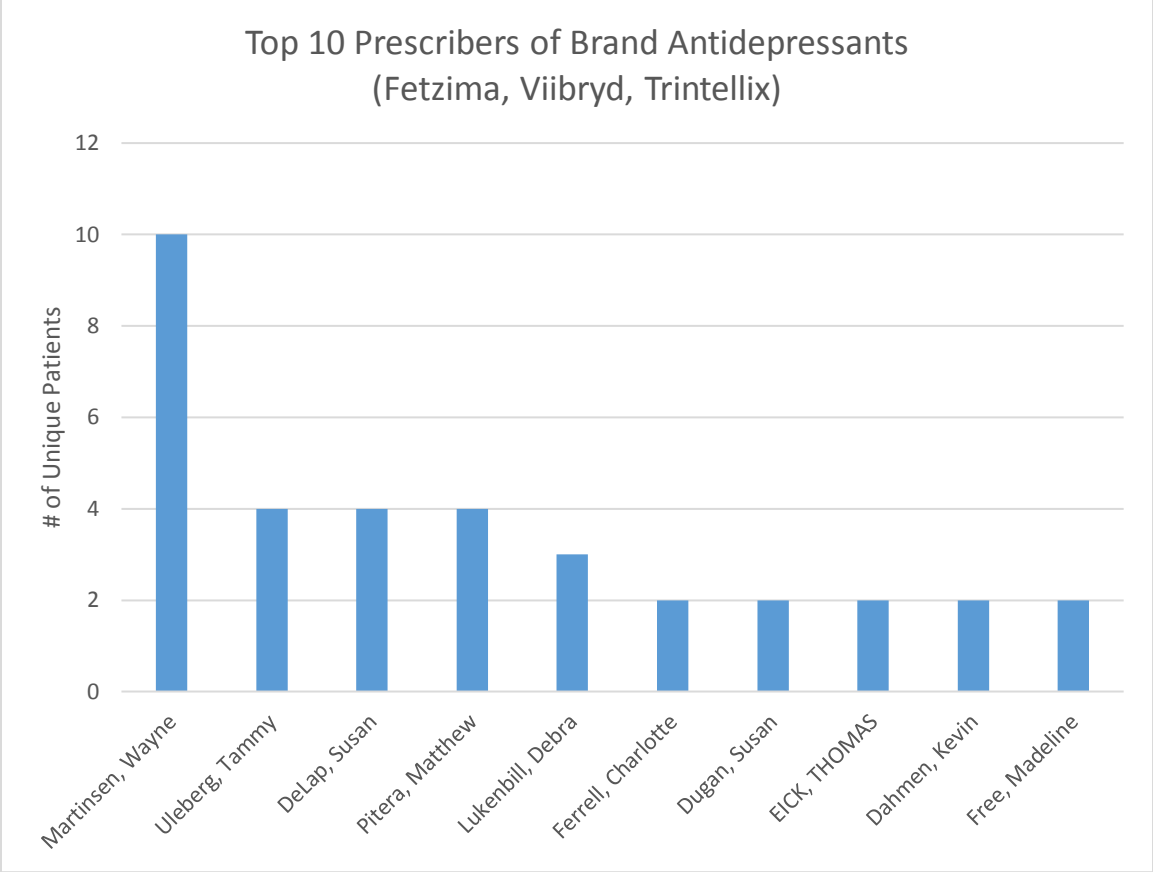
- **CV**: Sodium and fluid retention, tachycardia, palpitations
- **Endocrine**: Hirusism (lanugo-type), hyperglycemia and glycosuria
- **GI:** anorexia, nausea, vomiting, abdominal pain, ileus, diarrhea, transient loss of taste
- **Hematologic**: Thrombocytopenia, transient neutropenia
- **Misc**: Increase serum uric acid, skin rash, headache, weakness and malaise.

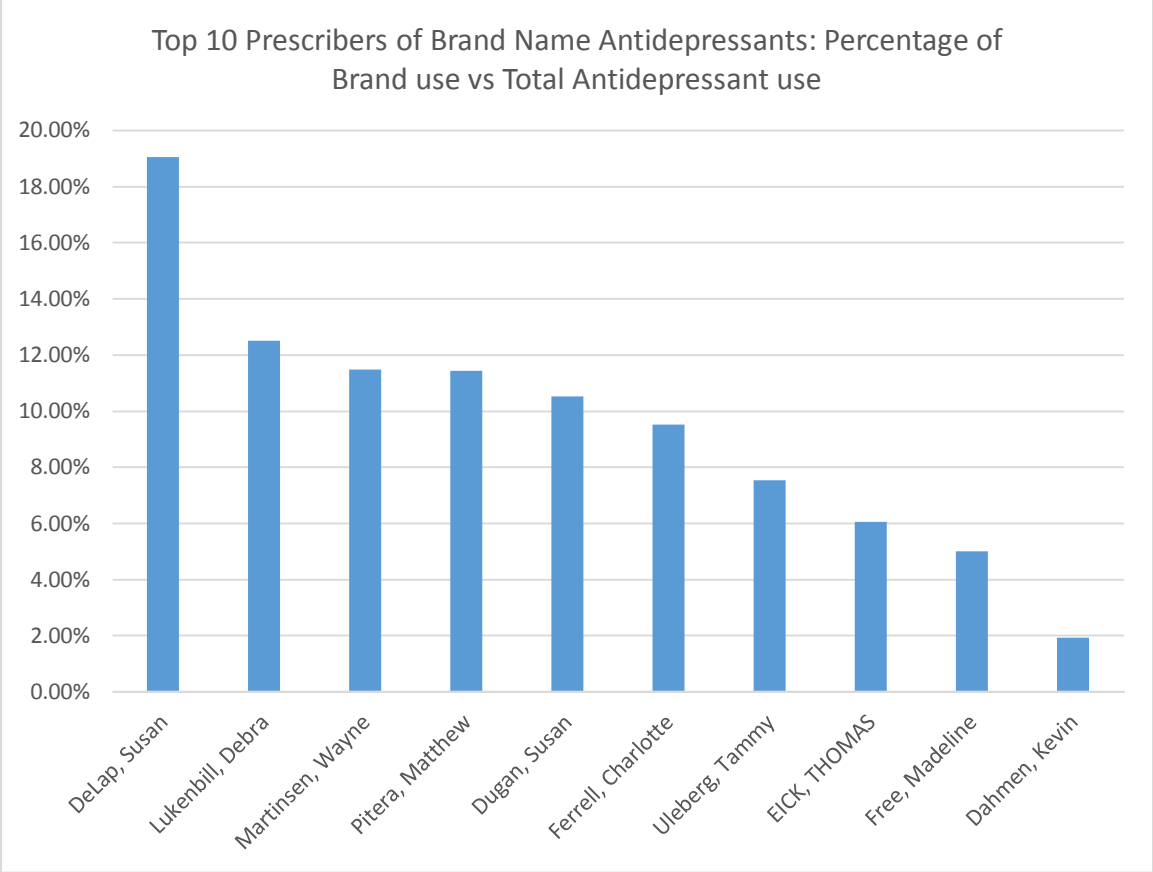
ND Medicaid Proglycem Utilization			
Label Name	**Rx Num**	**Total Reimb Amt**	**Avg Cost per Script**
PROGLYCEM 50 MG/ML ORAL SUSP	8	$6,327.34	$790.92

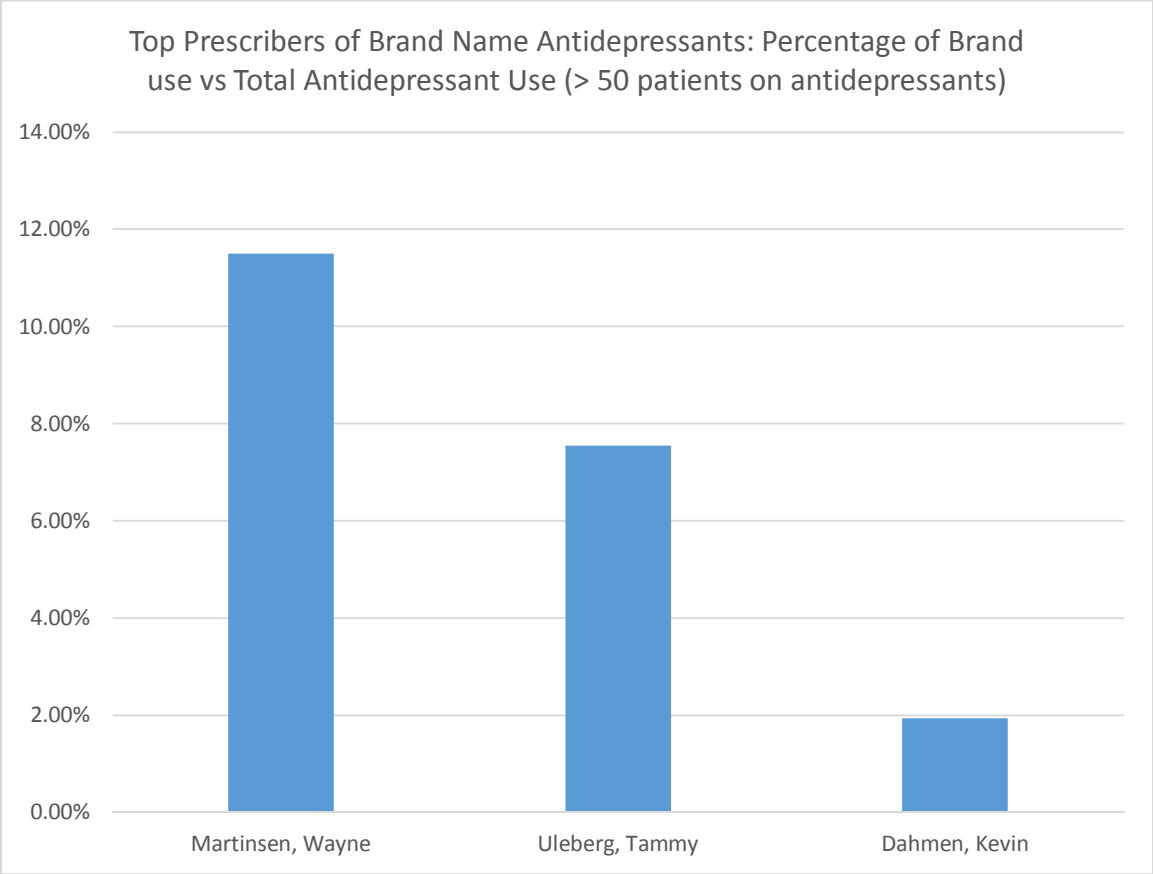
REFERENCES:

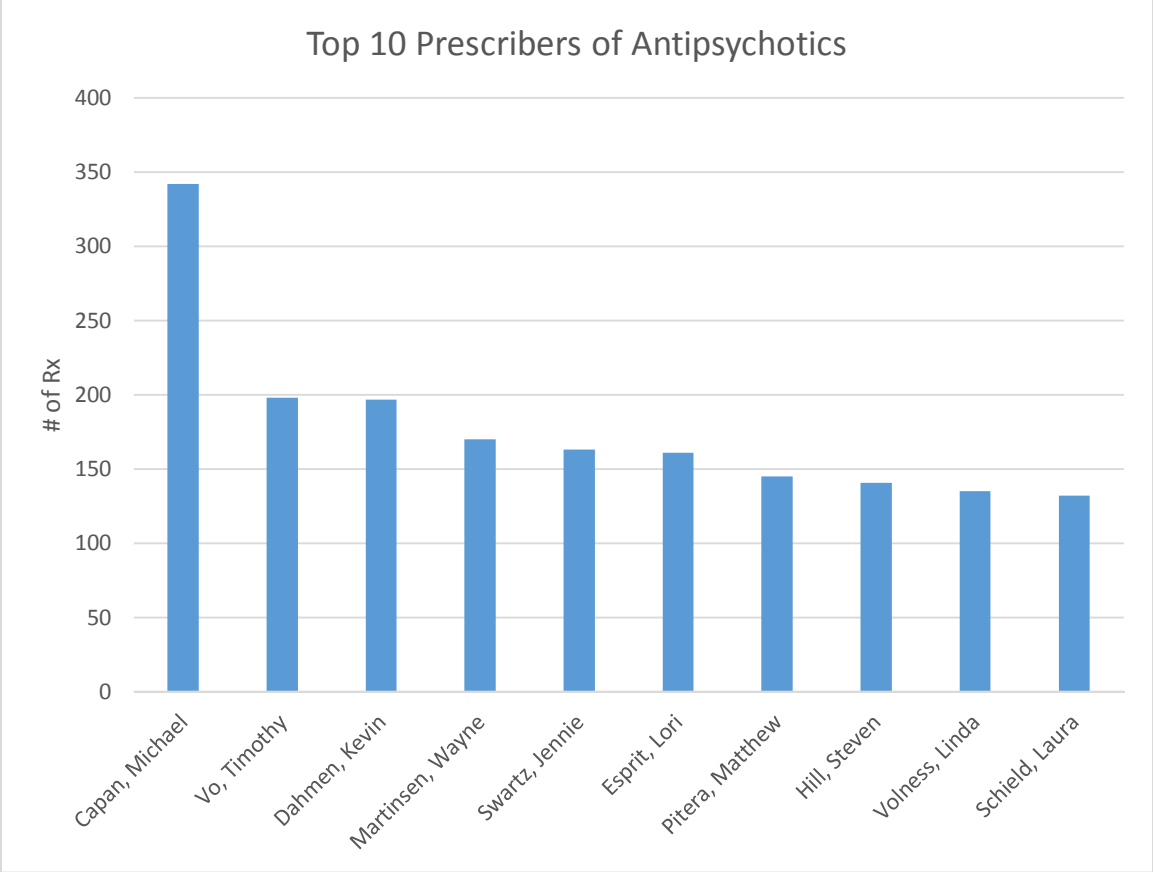
1. Facts & Comparisons eAnswers. Available at http://online.factsandcomparisons.com. Accessed on April 14, 2017.
2. Proglycem (diazoxide) [prescribing information]. North Wales, PA: Teva; September 2015.
3. Proglycem (diazoxide) suspension [prescribing information]. Horsham, PA: Teva Select Brands; February 2012

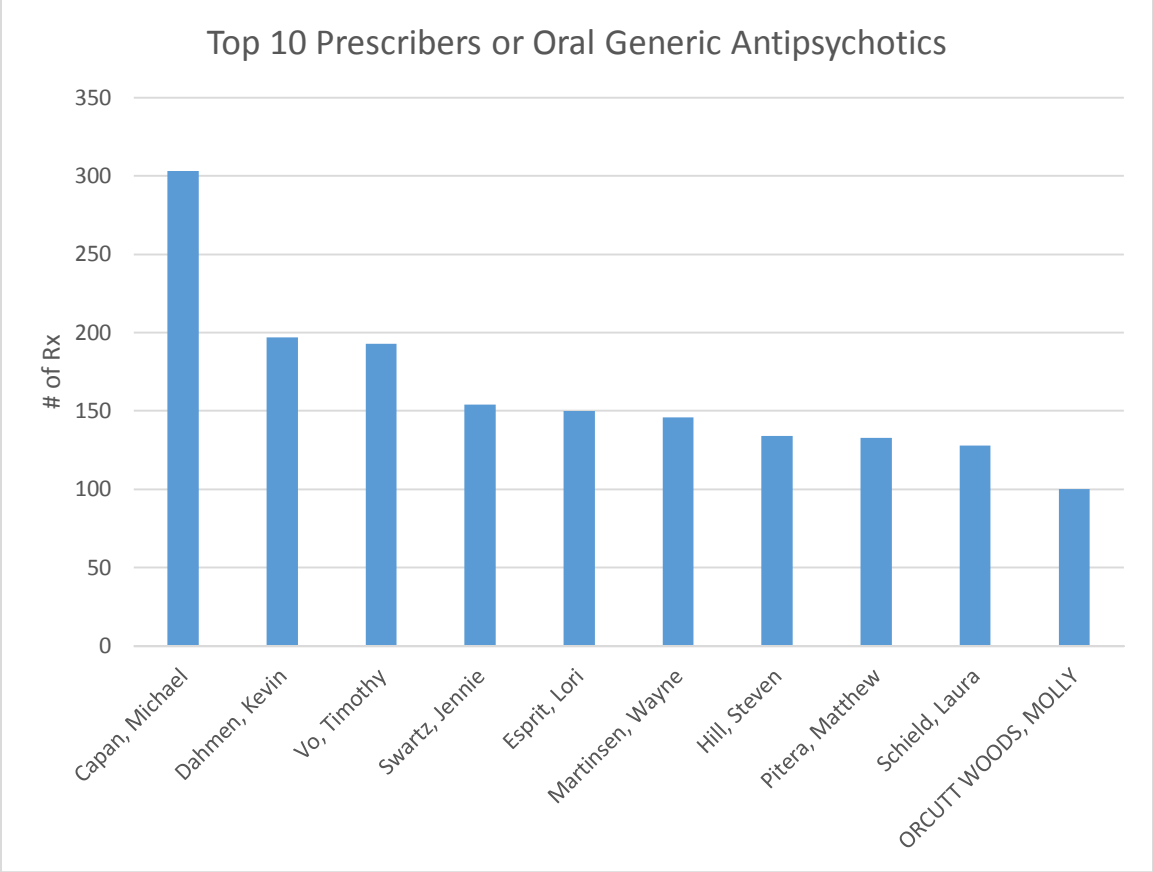

Top 10 Prescribers of Generic Antidepressants
Unique Patients
120
100
80
60
40
20
0
Dahmen, Kevin
Weathers, Vickie
Capan, Michael
Martinsen, Wayne
Hanisch, Stefanie
Pathak, Prem
Bansal, Ashok
Uleberg, Tammy
Stromme, Luann
Schield, Laura

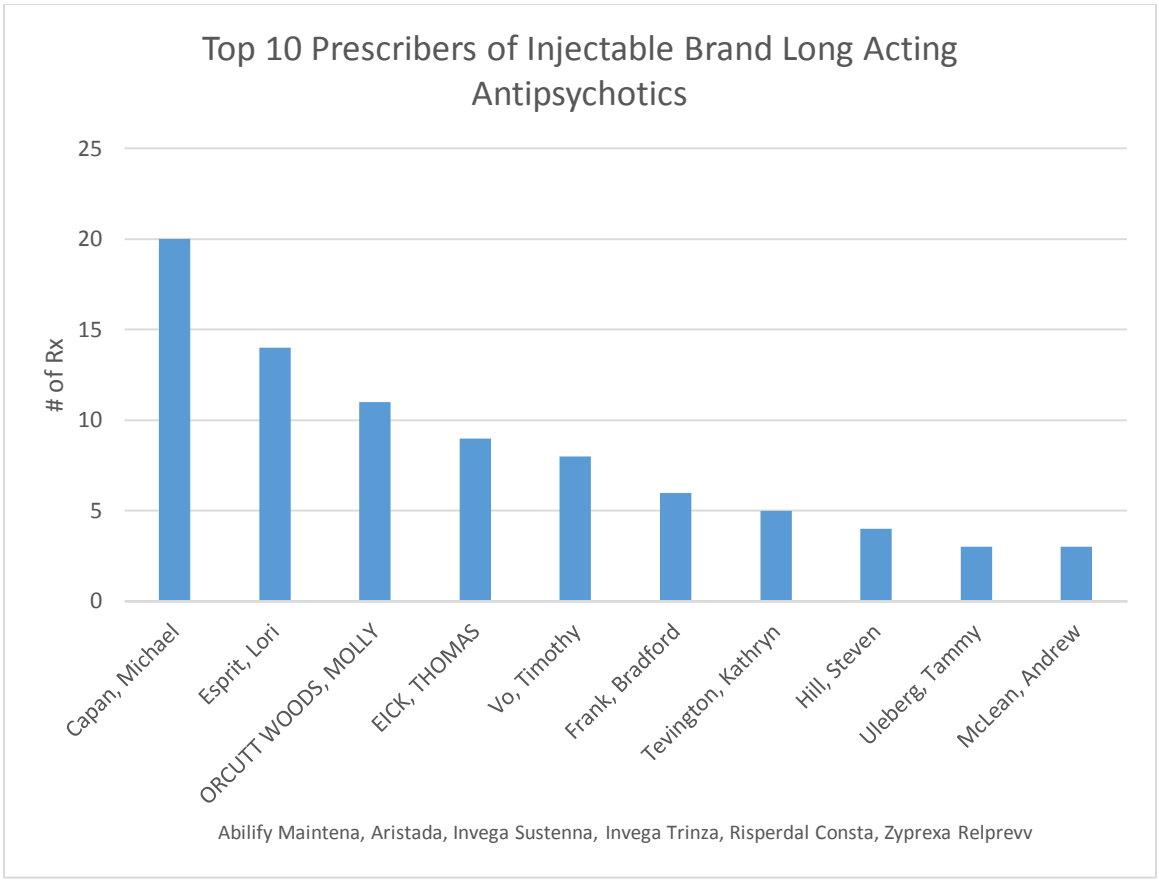

Top 10 Prescribers of Brand Antidepressants
(Fetzima, Viibryd, Trintellix)
# of Unique Patients
12
10
8
6
4
2
0
Martinsen, Wayne
Uleberg, Tammy
DeLap, Susan
Pitera, Matthew
Lukenbill, Debra
Ferrell, Charlotte
Dugan, Susan
EICK, THOMAS
Dahmen, Kevin
Free, Madeline

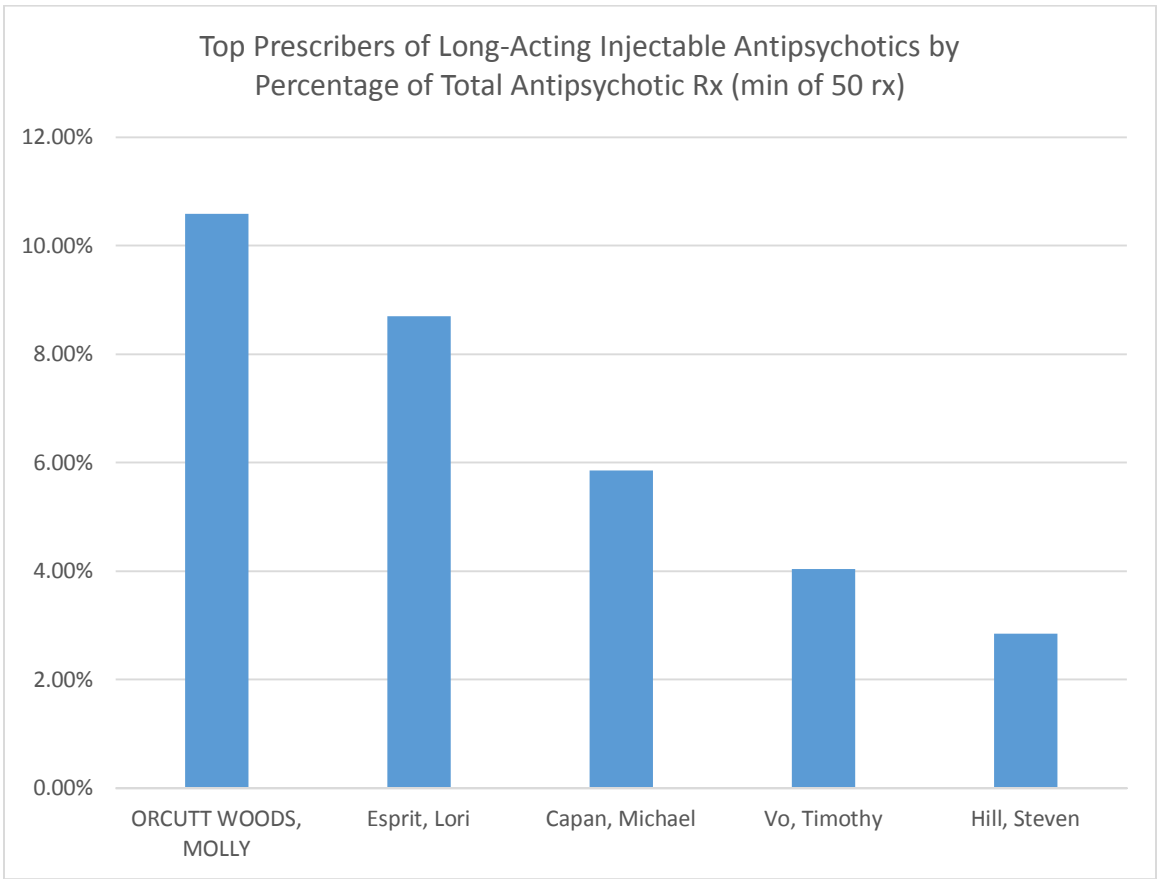

Top 10 Prescribers of Brand Name Antidepressants: Percentage of Brand use vs Total Antidepressant use
20.00%
18.00%
16.00%
14.00%
12.00%
10.00%
8.00%
6.00%
4.00%
2.00%
0.00%
DeLap, Susan
Lukenbill, Debra
Martinsen, Wayne
Pitera, Matthew
Dugan, Susan
Ferrell, Charlotte
Uleberg, Tammy
EICK, THOMAS
Free, Madeline
Dahmen, Kevin

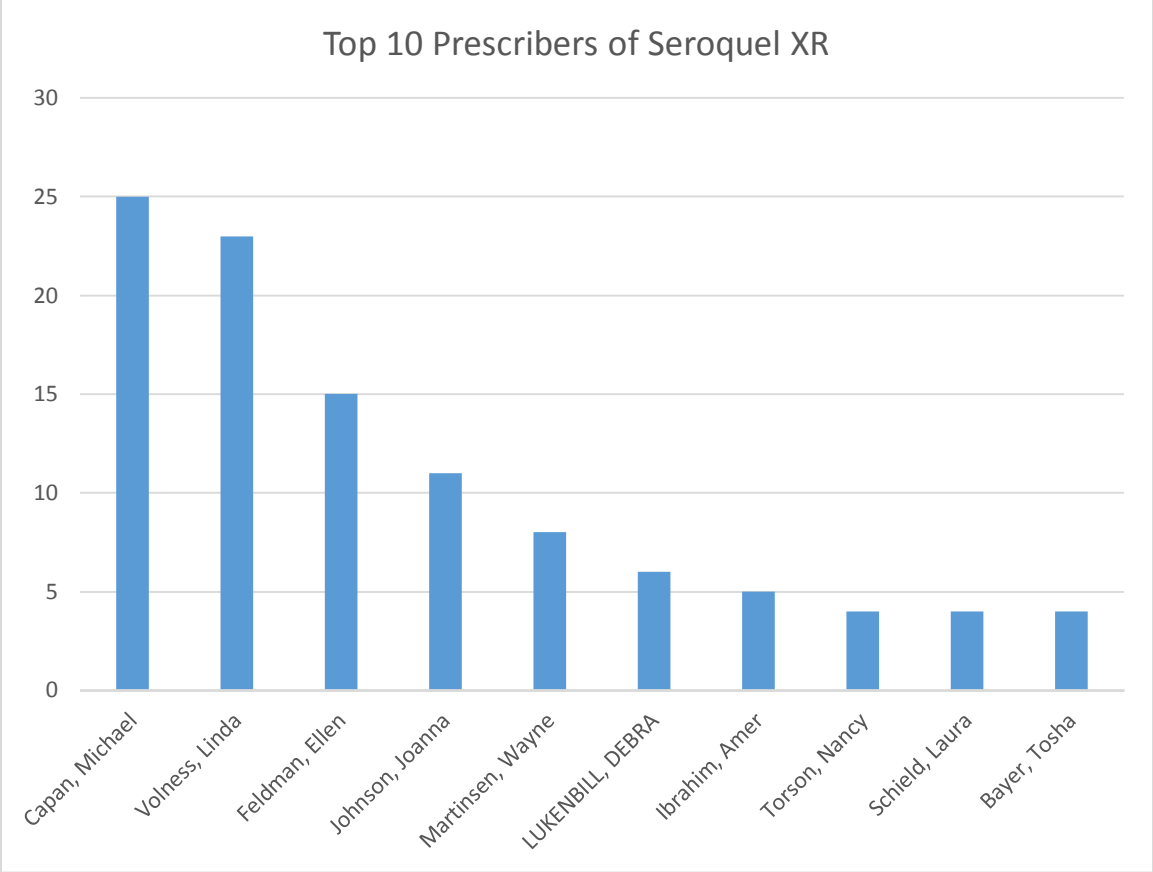

Top Prescribers of Brand Name Antidepressants: Percentage of Brand use vs Total Antidepressant Use (> 50 patients on antidepressants)
14.00%
12.00%
10.00%
8.00%
6.00%
4.00%
2.00%
0.00%
Martinsen, Wayne
Uleberg, Tammy
Dahmen, Kevin

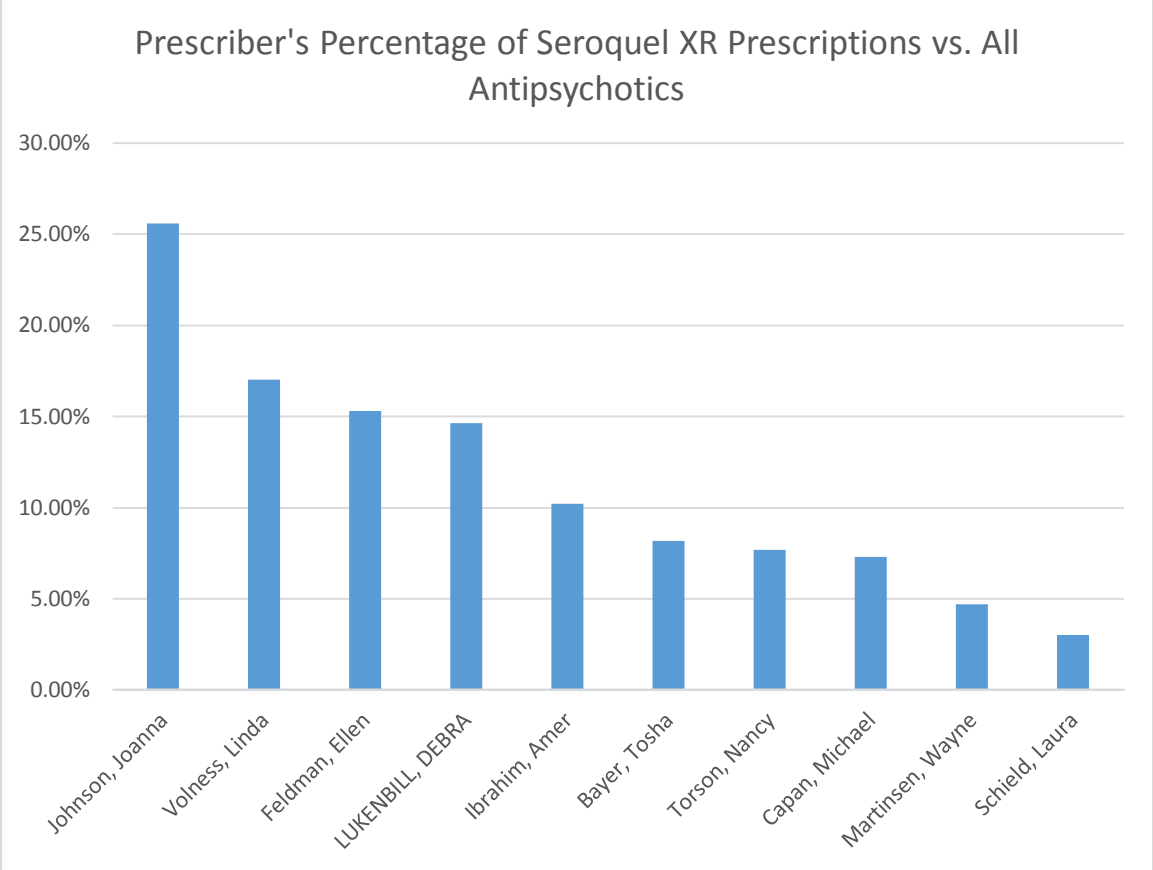

Top 10 Prescribers of Antipsychotics
# of Rx
400
350
300
250
200
150
100
50
0
Capan, Michael
Vo, Timothy
Dahmen, Kevin
Martinsen, Wayne
Swartz, Jennie
Esprit, Lori
Pitera, Matthew
Hill, Steven
Volness, Linda
Schield, Laura

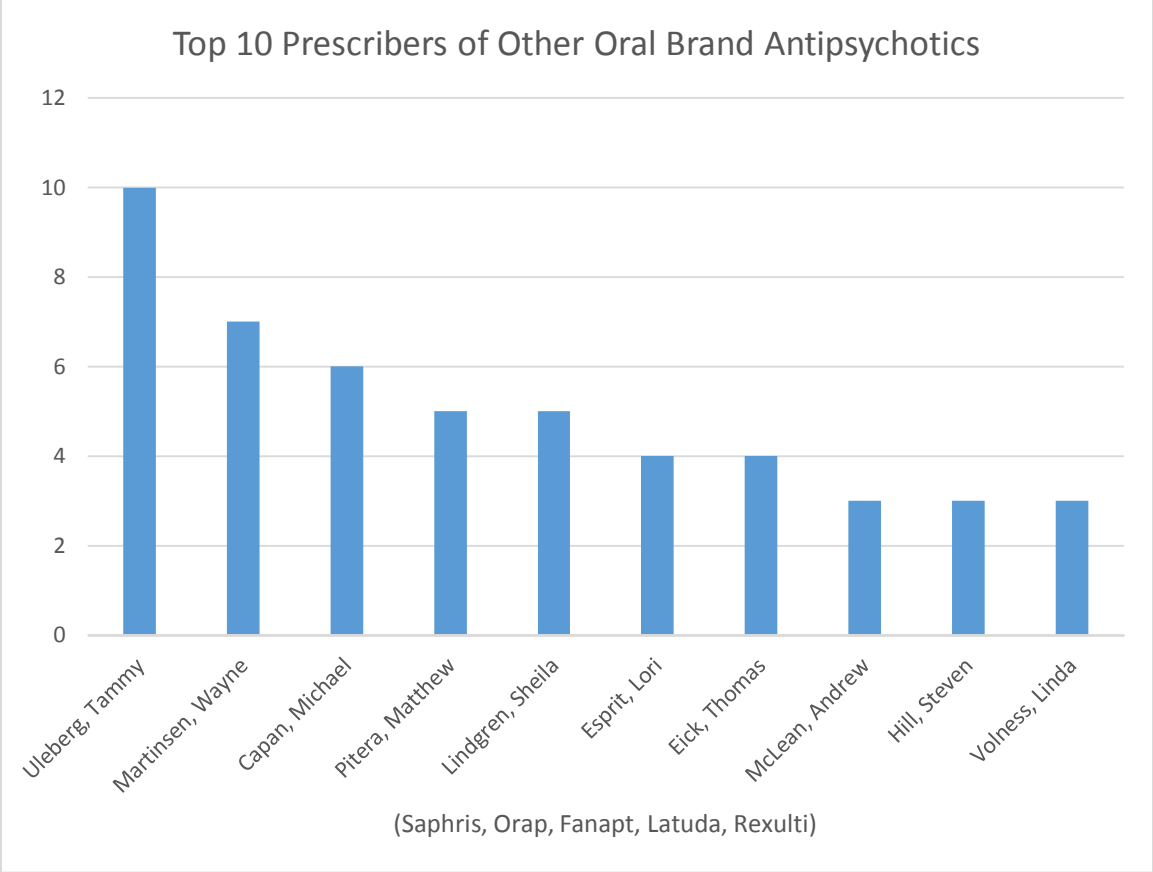

Top 10 Prescribers or Oral Generic Antipsychotics
# of Rx
350
300
250
200
150
100
50
0
Capan, Michael
Dahmen, Kevin
Vo, Timothy
Swartz, Jennie
Esprit, Lori
Martinsen, Wayne
Hill, Steven
Pitera, Matthew
Schield, Laura
ORCUTT WOODS, MOLLY

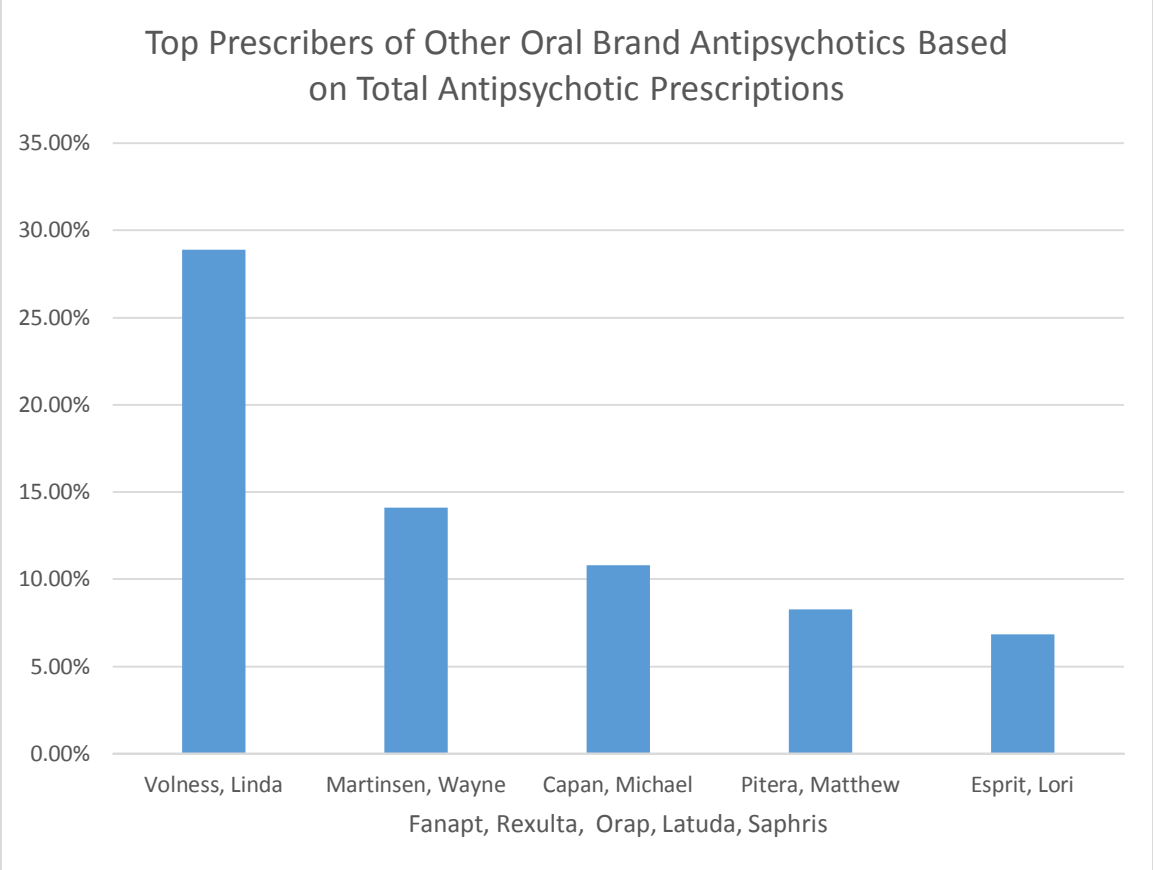

Top 10 Prescribers of Injectable Brand Long Acting Antipsychotics
25
20
15
10
5
0
# of Rx
Capan, Michael
Esprit, Lori
ORCUTT WOODS, MOLLY
EICK, THOMAS
Vo, Timothy
Frank, Bradford
Tevington, Kathryn
Hill, Steven
Uleberg, Tammy
McLean, Andrew
Abilify Maintena, Aristada, Invega Sustenna, Invega Trinza, Risperdal Consta, Zyprexa Relprevv

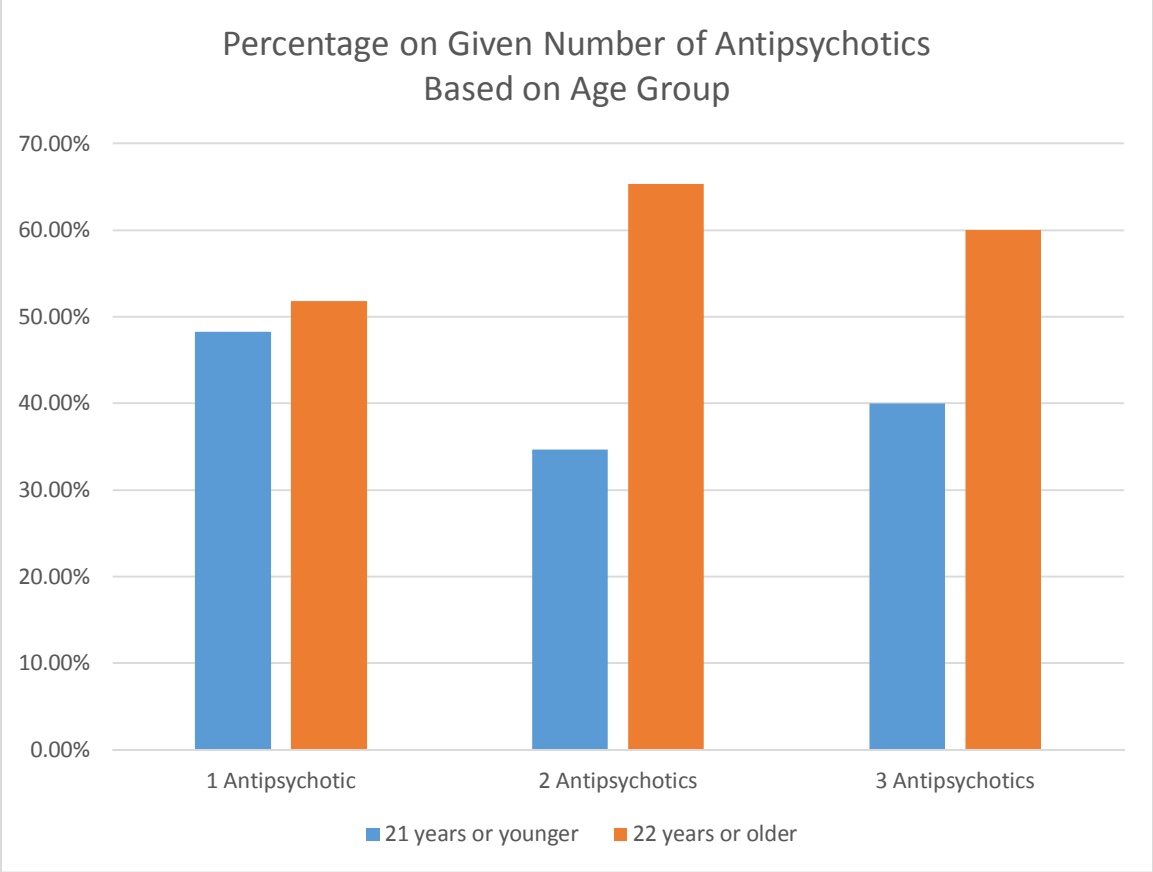

Top Prescribers of Long-Acting Injectable Antipsychotics by Percentage of Total Antipsychotic Rx (min of 50 rx)
12.00%
10.00%
8.00%
6.00%
4.00%
2.00%
0.00%
ORCUTT WOODS, MOLLY
Esprit, Lori
Capan, Michael
Vo, Timothy
Hill, Steven

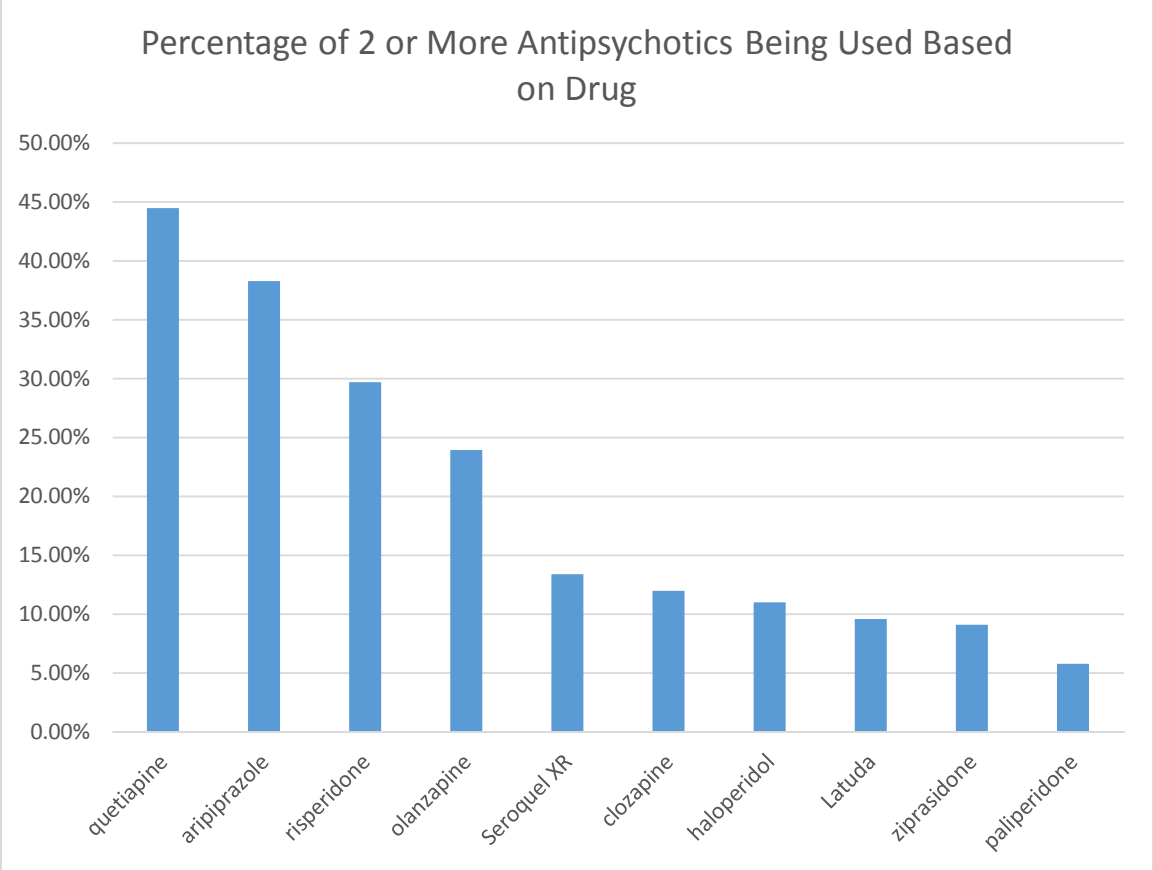

Top 10 Prescribers of Seroquel XR
30
25
20
15
10
5
0
Capan, Michael
Volness, Linda
Feldman, Ellen
Johnson, Joanna
Martinsen, Wayne
LUKENBILL, DEBRA
Ibrahim, Amer
Torson, Nancy
Schield, Laura
Bayer, Tosha

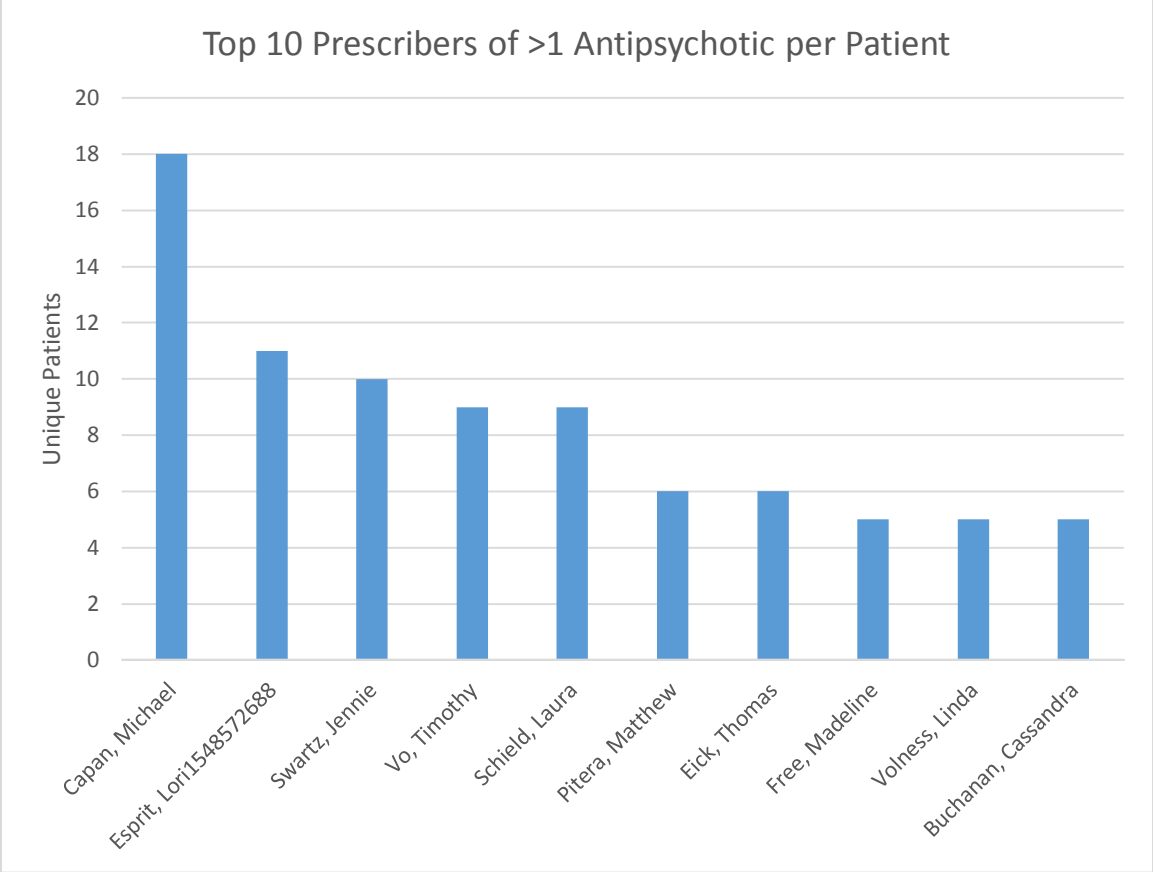

Prescriber's Percentage of Seroquel XR Prescriptions vs. All Antipsychotics
30.00%
25.00%
20.00%
15.00%
10.00%
5.00%
0.00%
Johnson, Joanna
Volness, Linda
Feldman, Ellen
LUKENBILL, DEBRA
Ibrahim, Amer
Bayer, Tosha
Torson, Nancy
Capan, Michael
Martinsen, Wayne
Schield, Laura

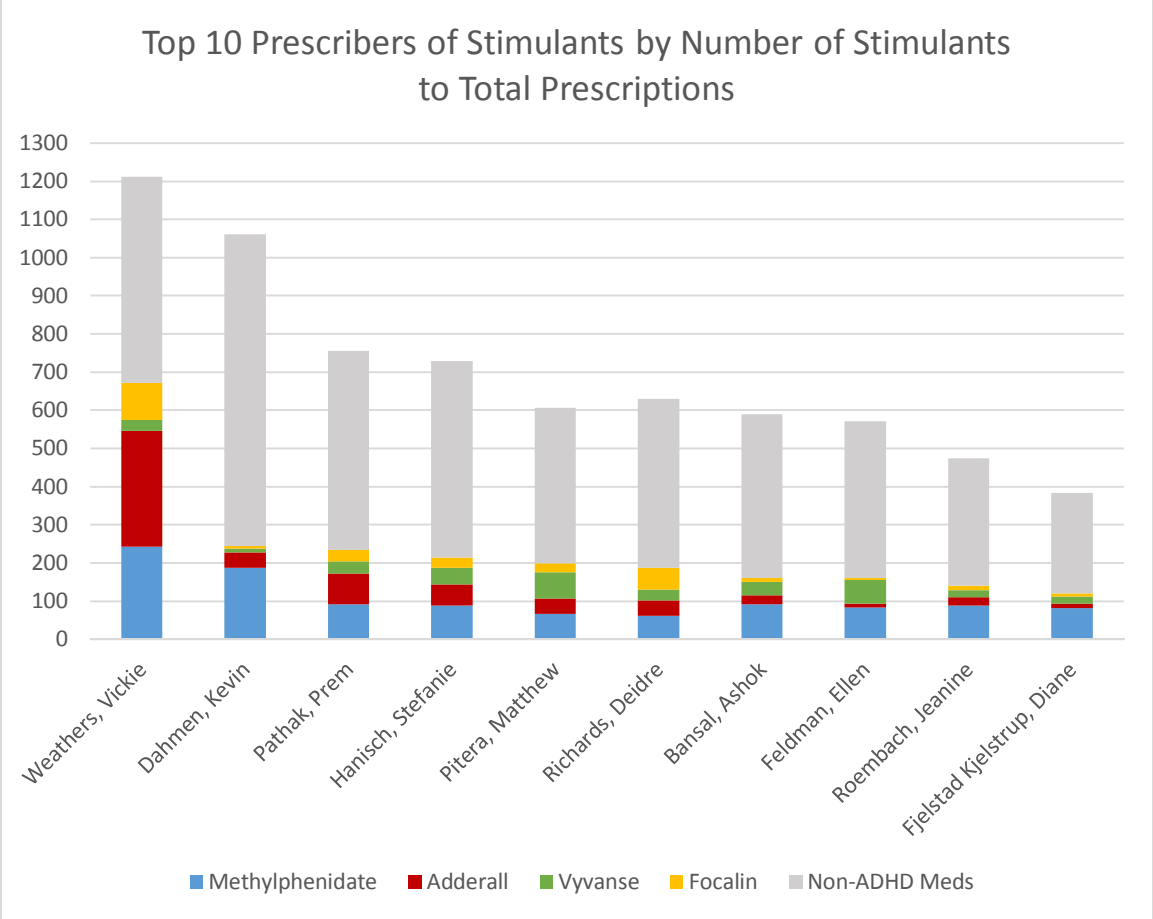

Top 10 Prescribers of Other Oral Brand Antipsychotics
12
10
8
6
4
2
0
Uleberg, Tammy
Martinsen, Wayne
Capan, Michael
Pitera, Matthew
Lindgren, Sheila
Esprit, Lori
Eick, Thomas
McLean, Andrew
Hill, Steven
Volness, Linda
(Saphris, Orap, Fanapt, Latuda, Rexulti)

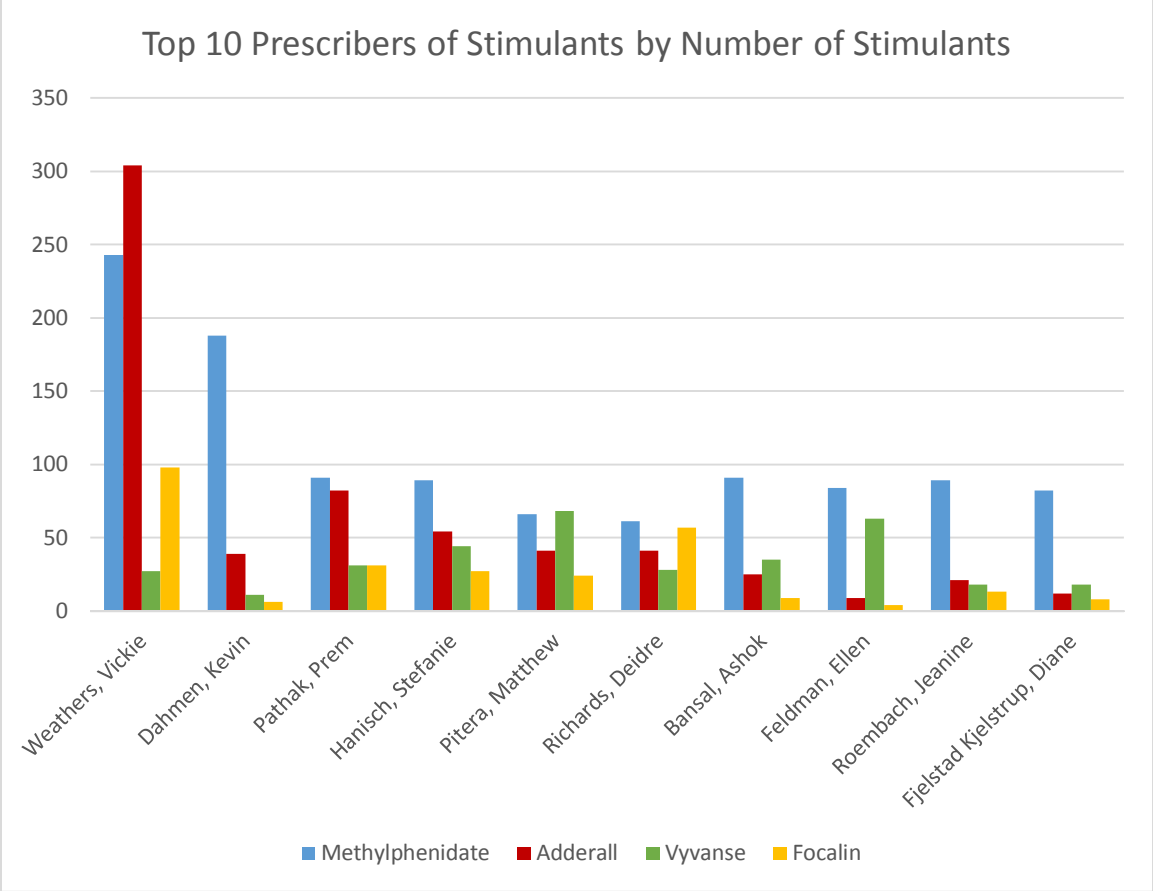

Top Prescribers of Other Oral Brand Antipsychotics Based on Total Antipsychotic Prescriptions
35.00%
30.00%
25.00%
20.00%
15.00%
10.00%
5.00%
0.00%
Volness, Linda
Martinsen, Wayne
Capan, Michael
Pitera, Matthew
Esprit, Lori
Fanapt, Rexulta, Orap, Latuda, Saphris

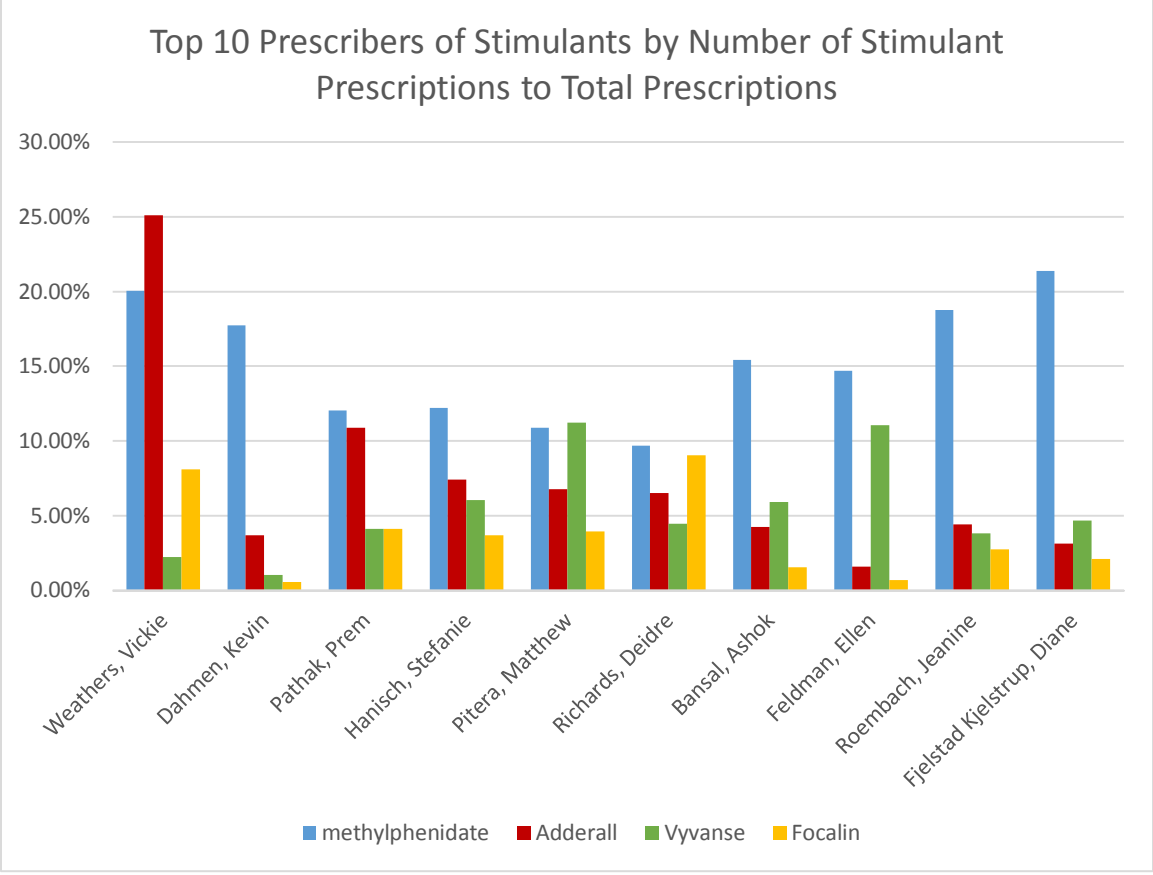

Percentage on Given Number of Antipsychotics Based on Age Group
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
1 Antipsychotic
2 Antipsychotics
3 Antipsychotics
21 years or younger
22 years or older

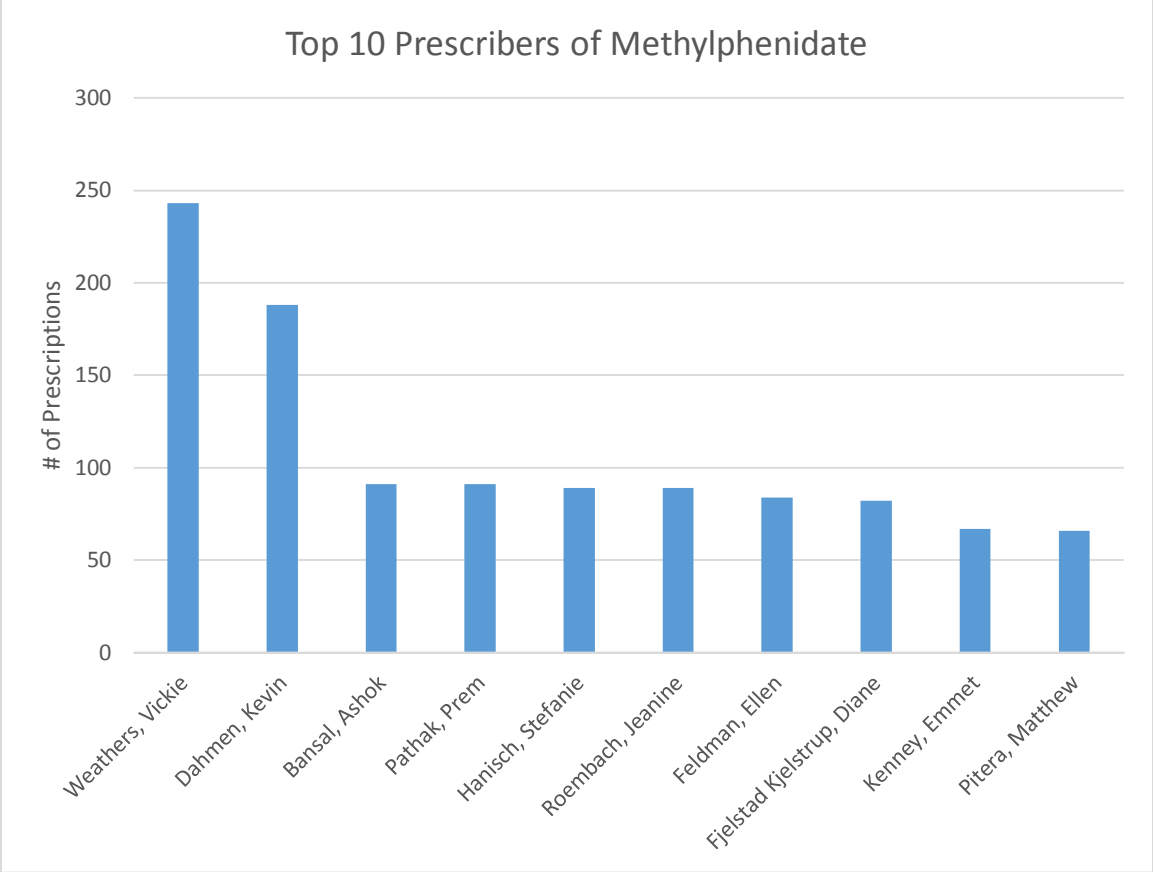

Percentage of 2 or More Antipsychotics Being Used Based on Drug
50.00%
45.00%
40.00%
35.00%
30.00%
25.00%
20.00%
15.00%
10.00%
5.00%
0.00%
quetiapine
aripiprazole
risperidone
olanzapine
Seroquel XR
clozapine
haloperidol
Latuda
ziprasidone
paliperidone

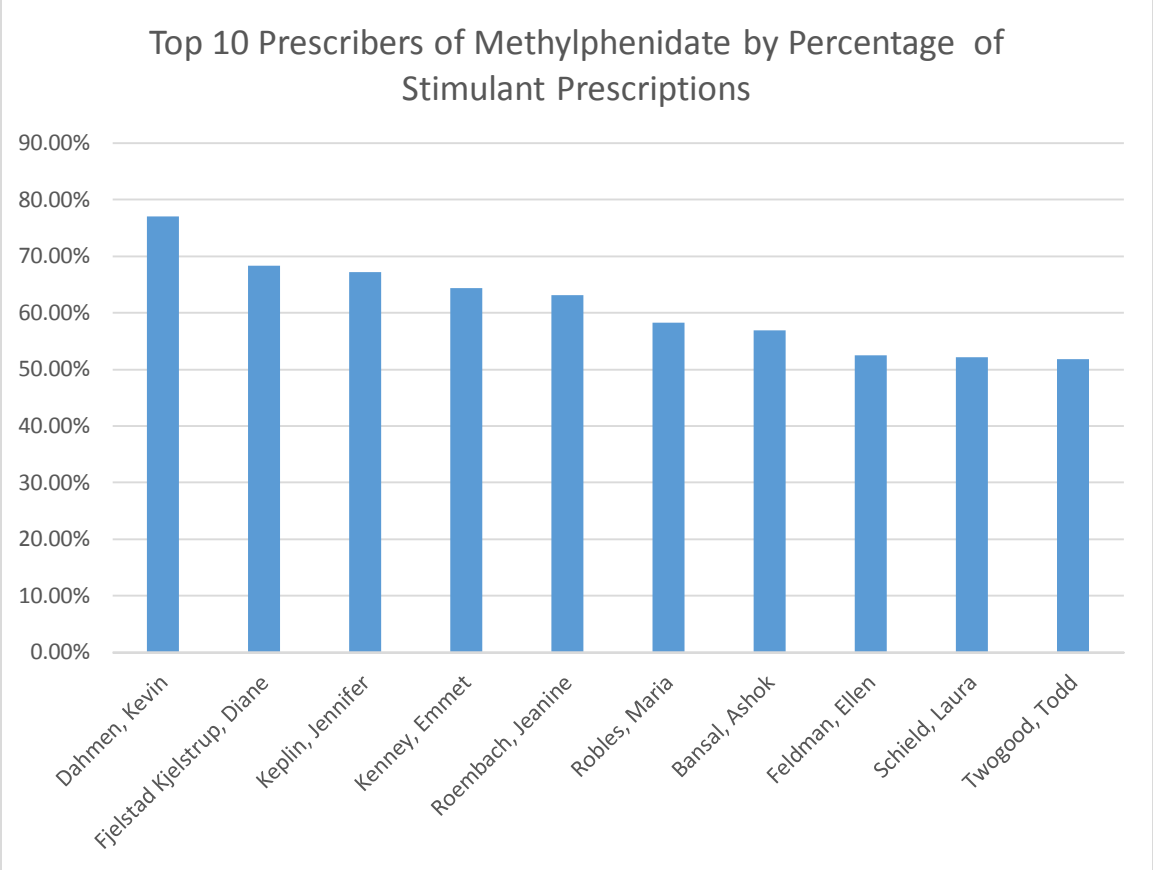

Top 10 Prescribers of >1 Antipsychotic per Patient
Unique Patients
20
18
16
14
12
10
8
6
4
2
0
Capan, Michael
Esprit, Lori1548572688
Swartz, Jennie
Vo, Timothy
Schield, Laura
Pitera, Matthew
Eick, Thomas
Free, Madeline
Volness, Linda
Buchanan, Cassandra

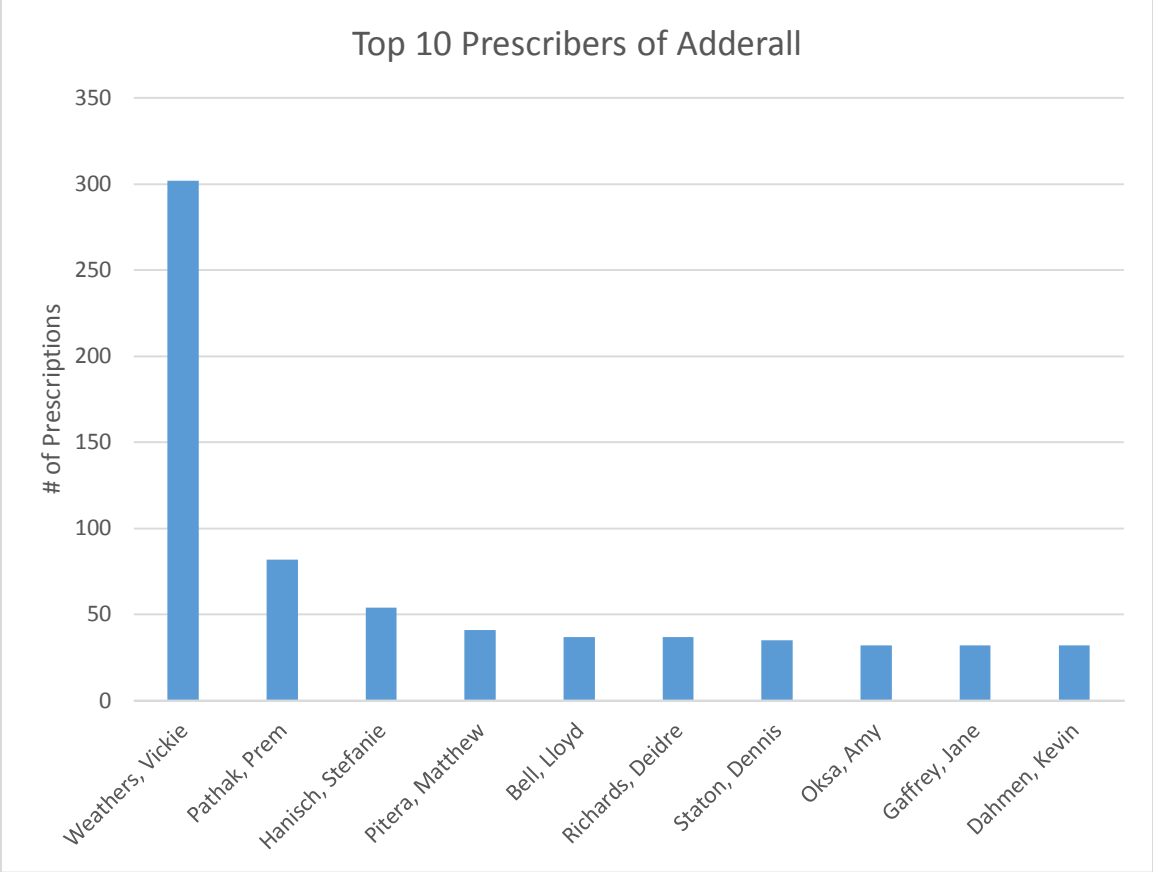

Top 10 Prescribers of Stimulants by Number of Stimulants to Total Prescriptions
1300
1200
1100
1000
900
800
700
600
500
400
300
200
100
0
Weathers, Vickie
Dahmen, Kevin
Pathak, Prem
Hanisch, Stefanie
Pitera, Matthew
Richards, Deidre
Bansal, Ashok
Feldman, Ellen
Roembach, Jeanine
Fjelstad Kjelstrup, Diane
Methylphenidate
Adderall
Vyvanse
Focalin
Non-ADHD Meds

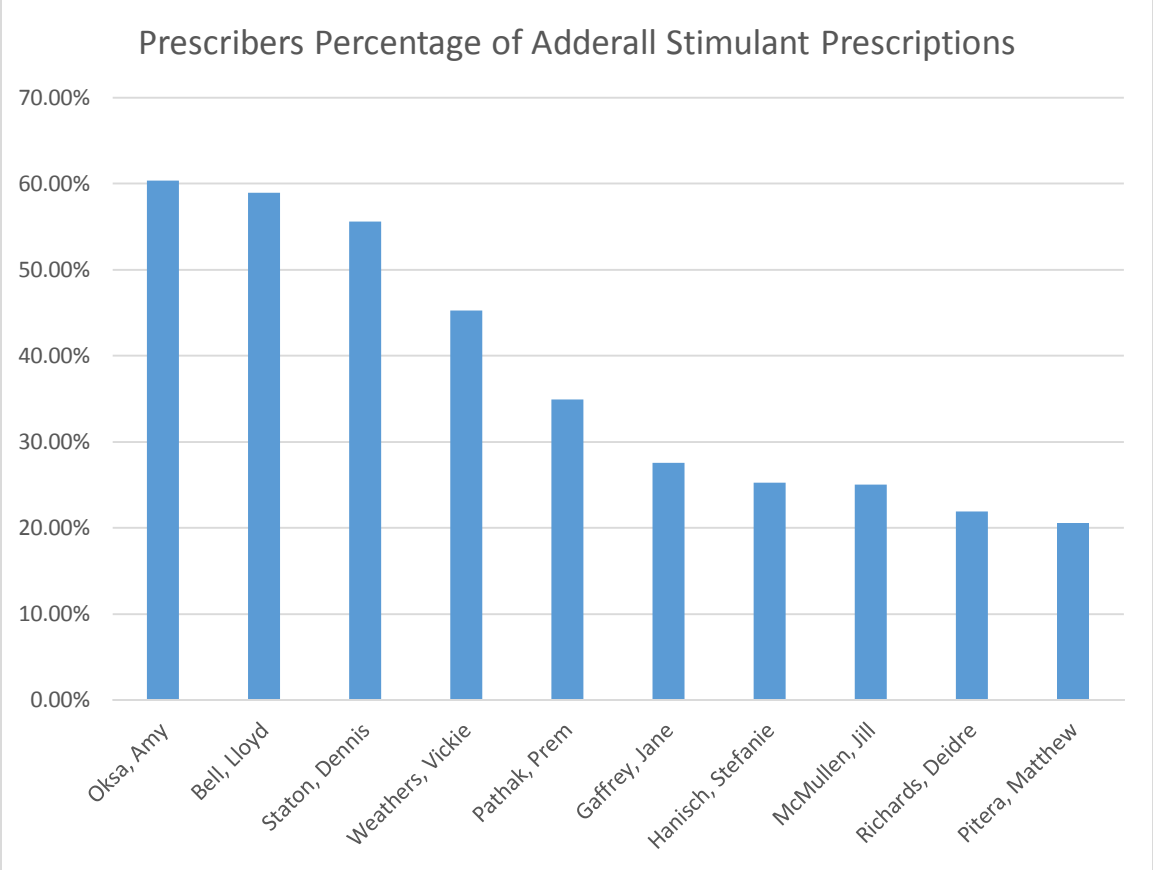

Top 10 Prescribers of Stimulants by Number of Stimulants
350
300
250
200
150
100
50
0
Weathers, Vickie
Dahmen, Kevin
Pathak, Prem
Hanisch, Stefanie
Pitera, Matthew
Richards, Deidre
Bansal, Ashok
Feldman, Ellen
Roembach, Jeanine
Fjelstad Kjelstrup, Diane
Methylphenidate
Adderall
Vyvanse
Focalin

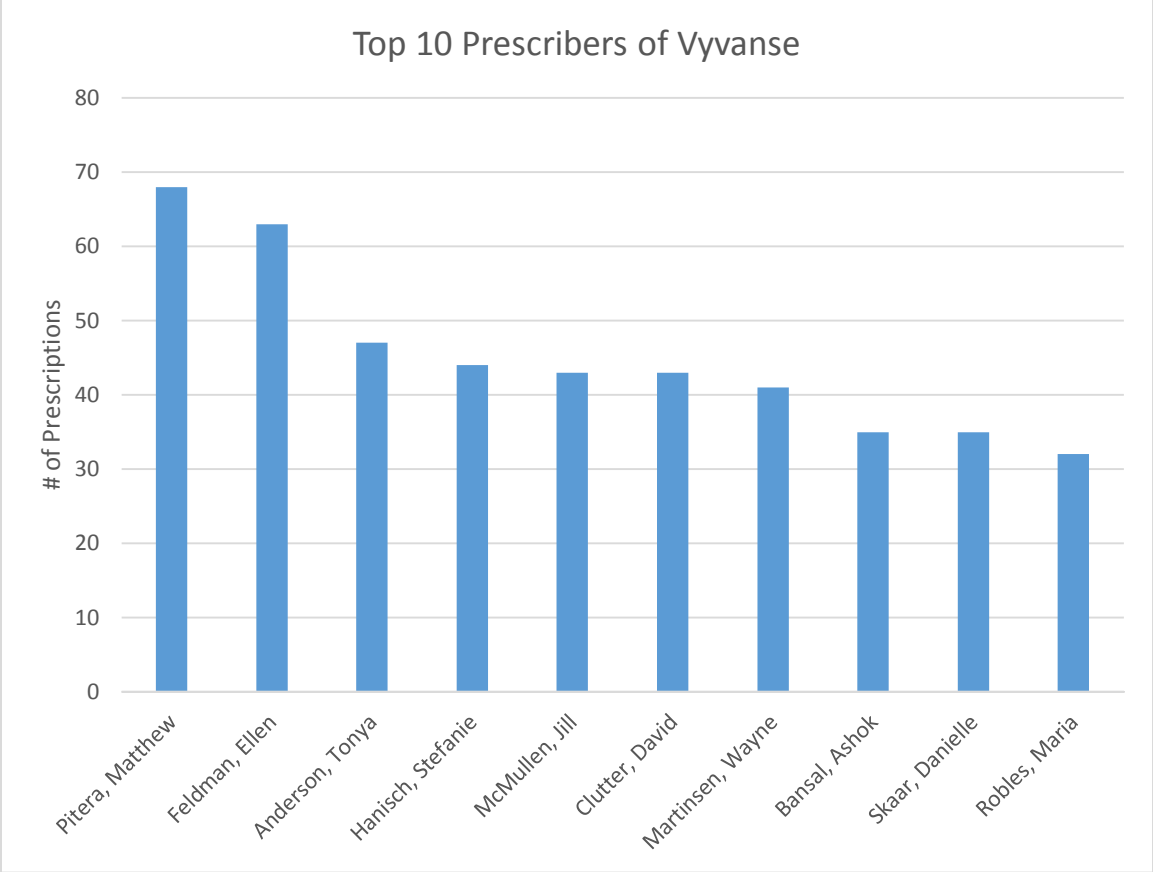

Top 10 Prescribers of Stimulants by Number of Stimulant Prescriptions to Total Prescriptions
30.00%
25.00%
20.00%
15.00%
10.00%
5.00%
0.00%
Weathers, Vickie
Dahmen, Kevin
Pathak, Prem
Hanisch, Stefanie
Pitera, Matthew
Richards, Deidre
Bansal, Ashok
Feldman, Ellen
Roembach, Jeanine
Fjelstad Kjelstrup, Diane
methylphenidate
Adderall
Vyvanse
Focalin

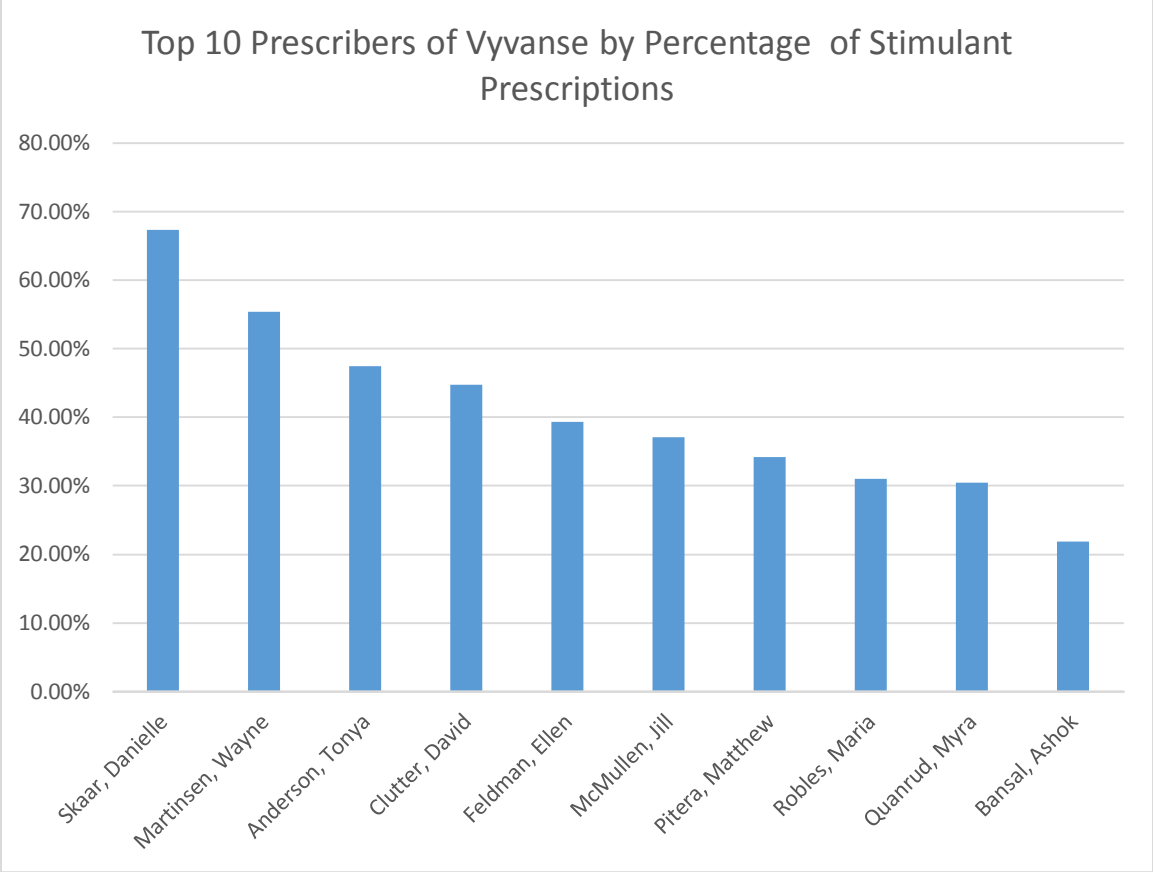

Top 10 Prescribers of Methylphenidate
# of Prescriptions
300
250
200
150
100
50
0
Weathers, Vickie
Dahmen, Kevin
Bansal, Ashok
Pathak, Prem
Hanisch, Stefanie
Roembach, Jeanine
Feldman, Ellen
Fjelstad Kjelstrup, Diane
Kenney, Emmet
Pitera, Matthew

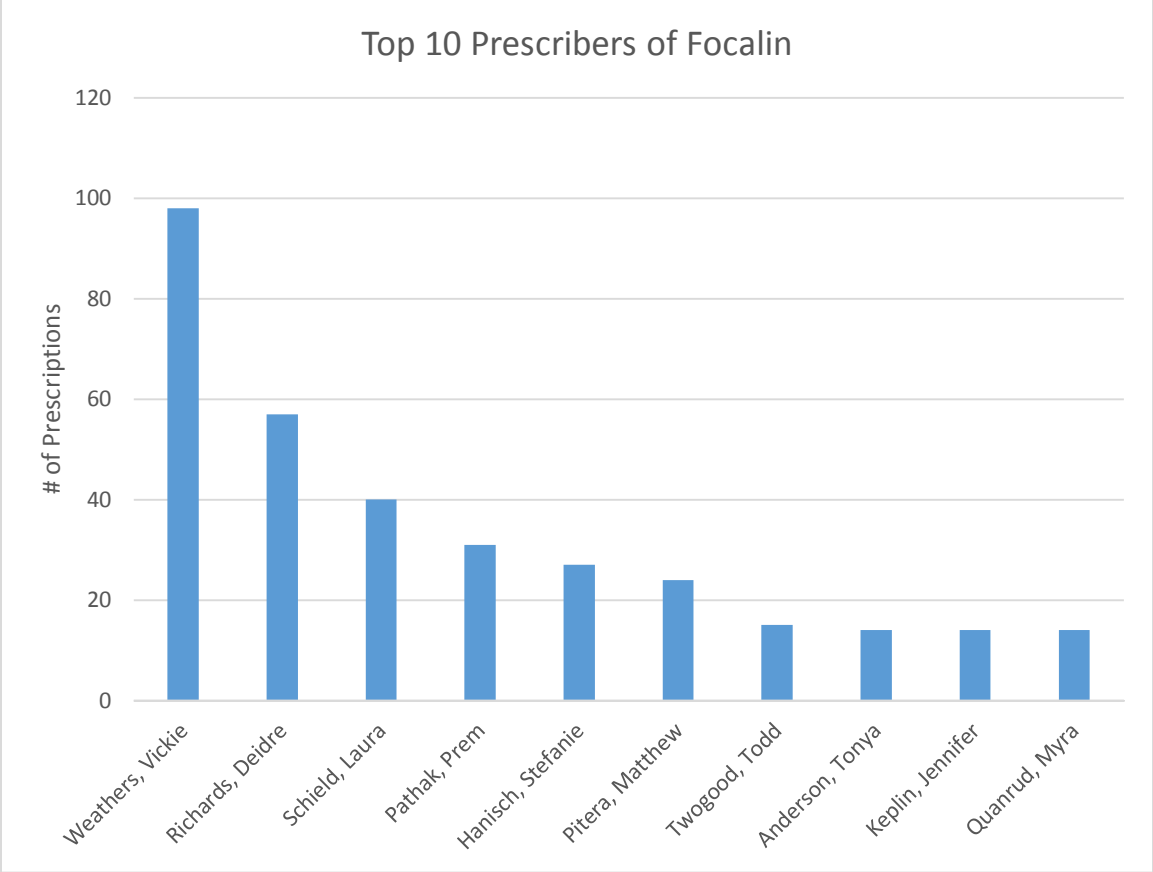

Top 10 Prescribers of Methylphenidate by Percentage of Stimulant Prescriptions
90.00%
80.00%
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
Dahmen, Kevin
Fjelstad Kjelstrup, Diane
Keplin, Jennifer
Kenney, Emmet
Roembach, Jeanine
Robles, Maria
Bansal, Ashok
Feldman, Ellen
Schield, Laura
Twogood, Todd

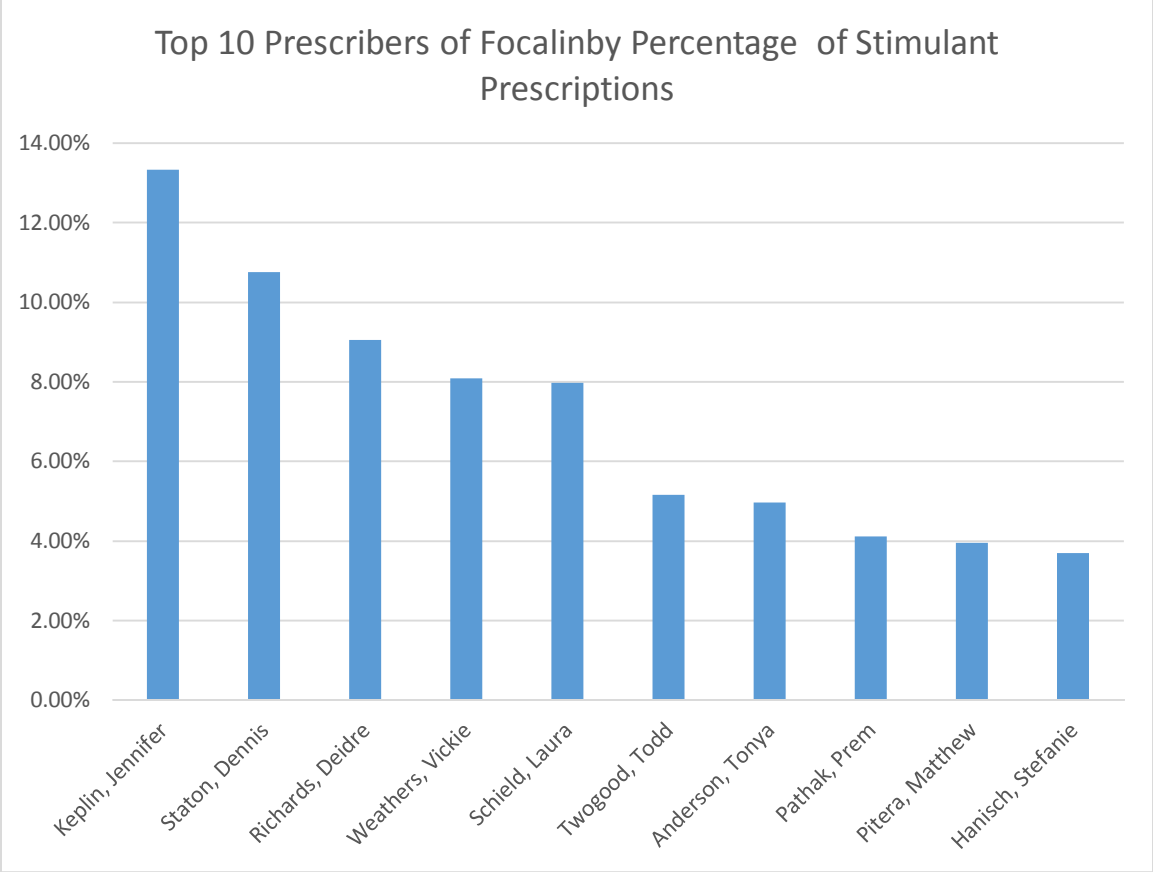

Top 10 Prescribers of Adderall
# of Prescriptions
350
300
250
200
150
100
50
0
Weathers, Vickie
Pathak, Prem
Hanisch, Stefanie
Pitera, Matthew
Bell, Lloyd
Richards, Deidre
Staton, Dennis
Oksa, Amy
Gaffrey, Jane
Dahmen, Kevin

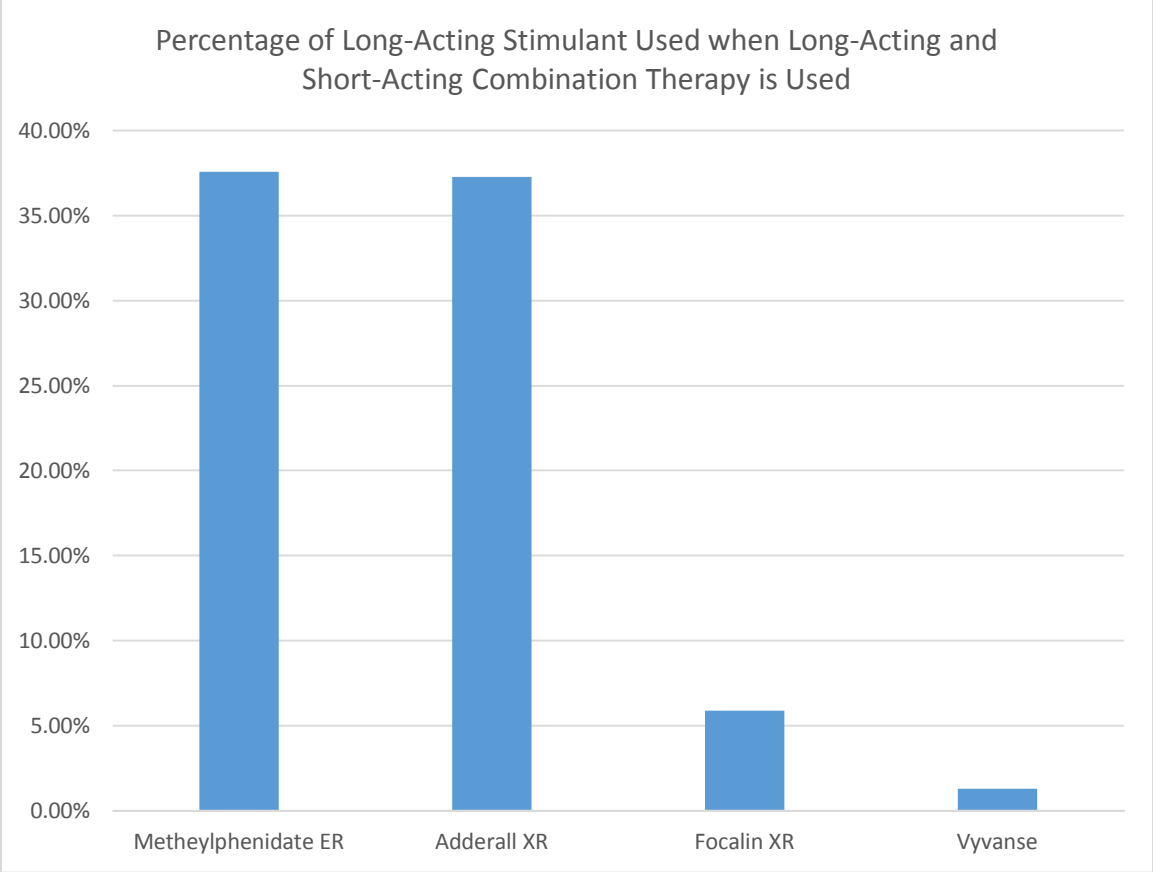

Prescribers Percentage of Adderall Stimulant Prescriptions
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
Oksa, Amy
Bell, Lloyd
Staton, Dennis
Weathers, Vickie
Pathak, Prem
Gaffrey, Jane
Hanisch, Stefanie
McMullen, Jill
Richards, Deidre
Pitera, Matthew

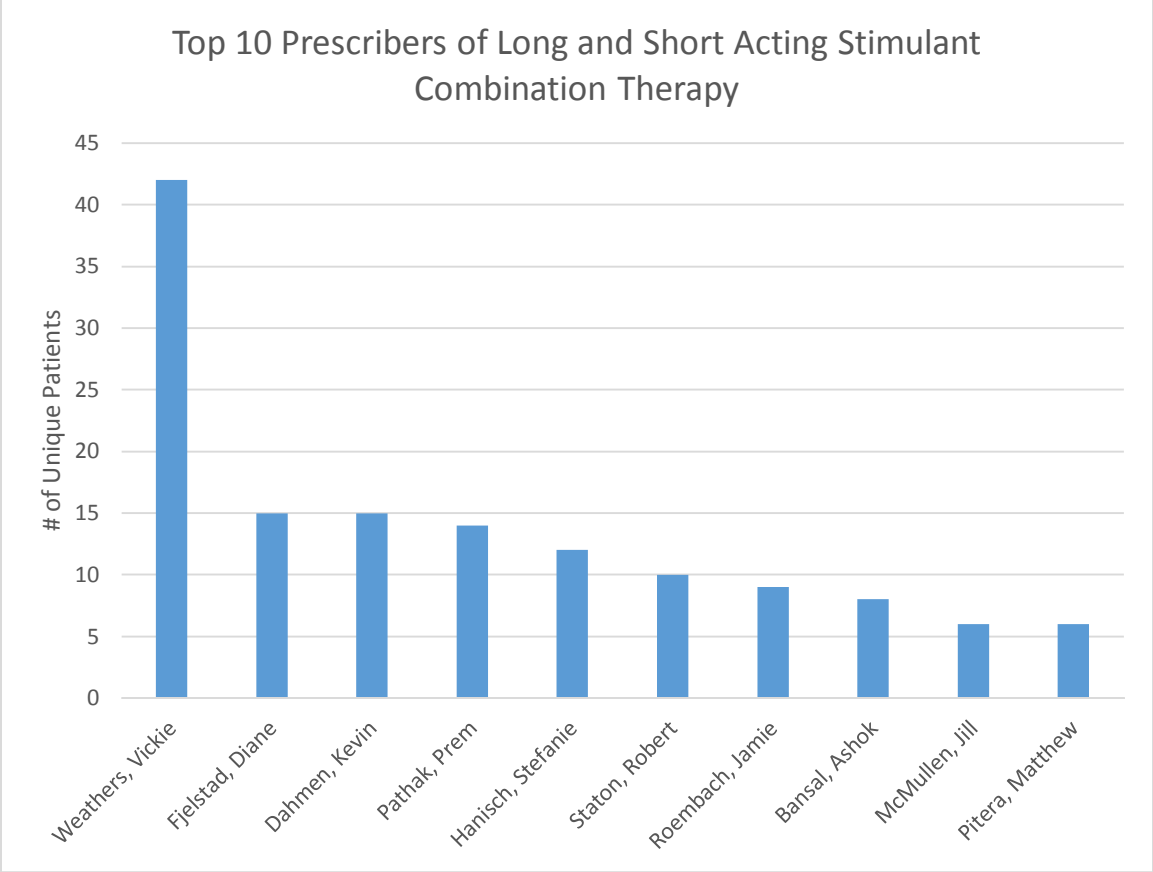

Top 10 Prescribers of Vyvanse
# of Prescriptions
80
70
60
50
40
30
20
10
0
Pitera, Matthew
Feldman, Ellen
Anderson, Tonya
Hanisch, Stefanie
McMullen, Jill
Clutter, David
Martinsen, Wayne
Bansal, Ashok
Skaar, Danielle
Robles, Maria

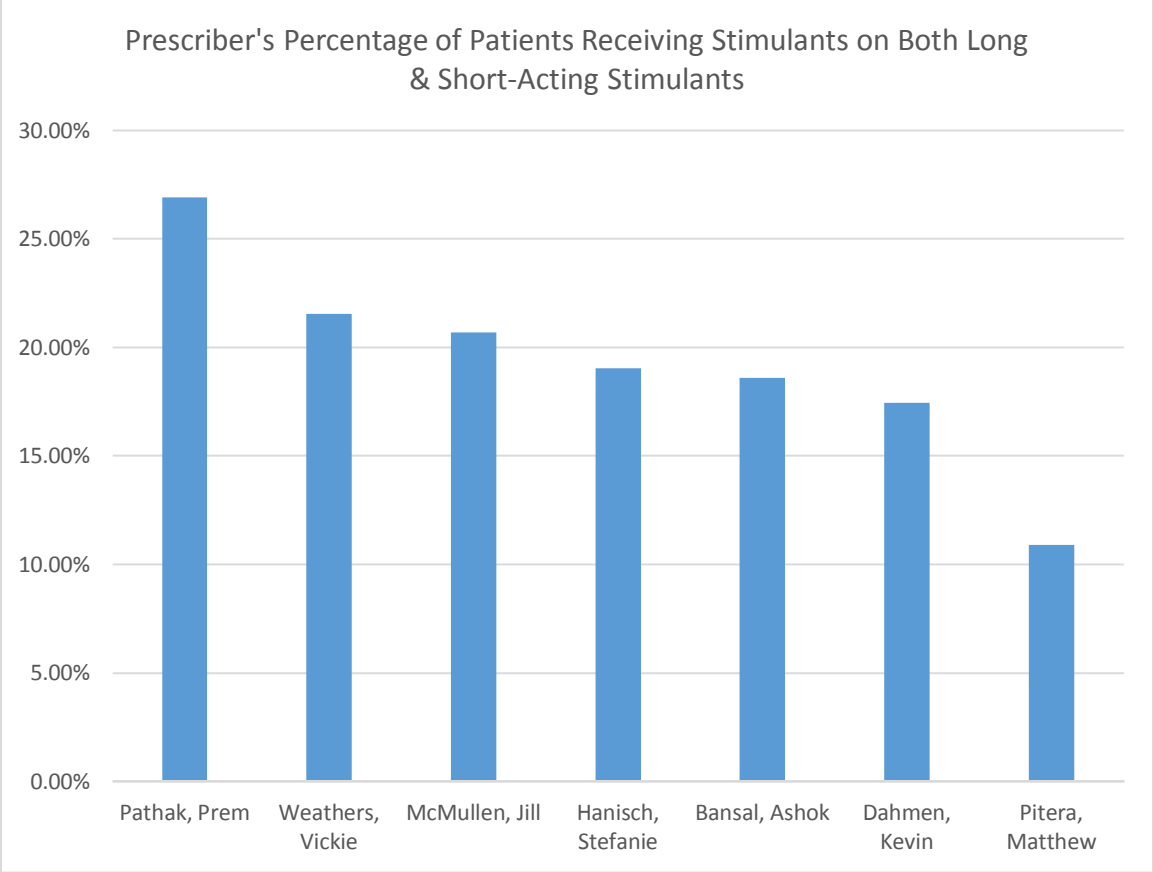

Top 10 Prescribers of Vyvanse by Percentage of Stimulant Prescriptions
80.00%
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
Skaar, Danielle
Martinsen, Wayne
Anderson, Tonya
Clutter, David
Feldman, Ellen
McMullen, Jill
Pitera, Matthew
Robles, Maria
Quanrud, Myra
Bansal, Ashok

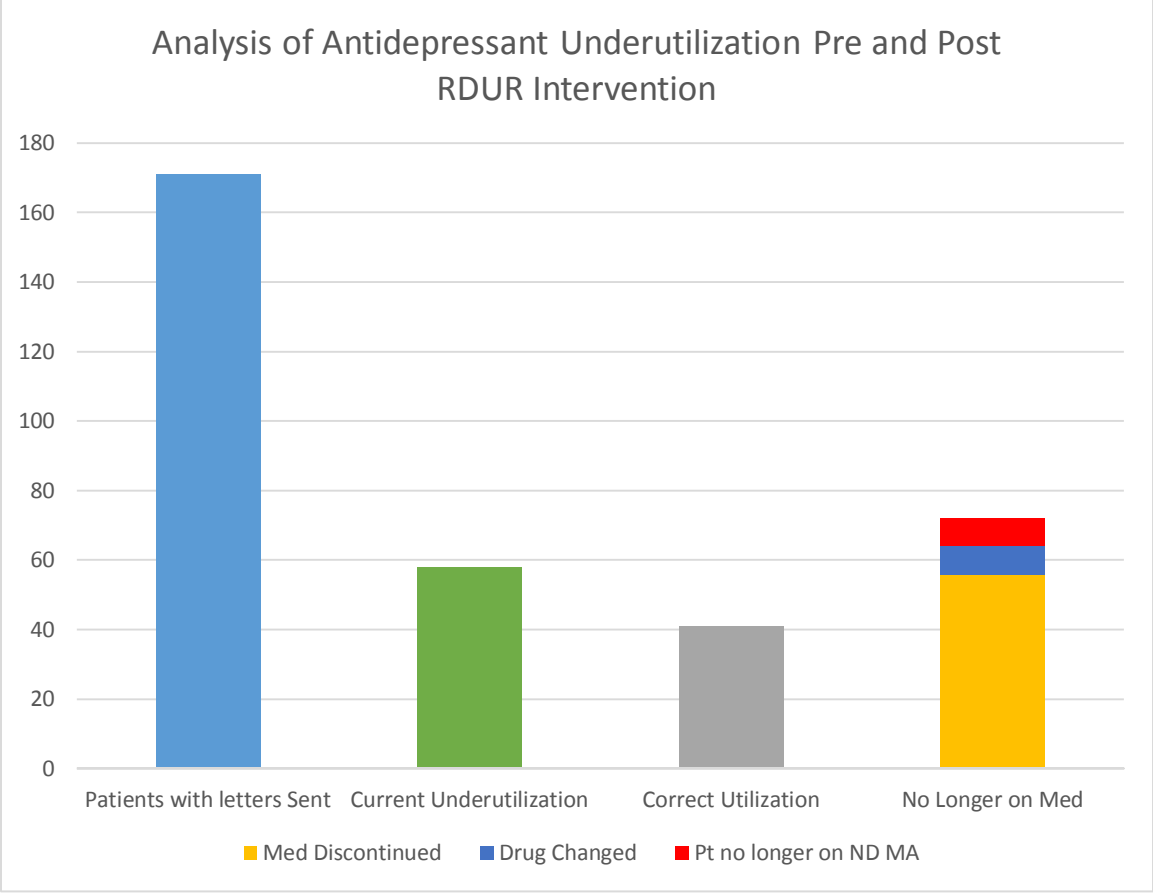

Top 10 Prescribers of Focalin
# of Prescriptions
120
100
80
60
40
20
0
Weathers, Vickie
Richards, Deidre
Schield, Laura
Pathak, Prem
Hanisch, Stefanie
Pitera, Matthew
Twogood, Todd
Anderson, Tonya
Keplin, Jennifer
Quanrud, Myra

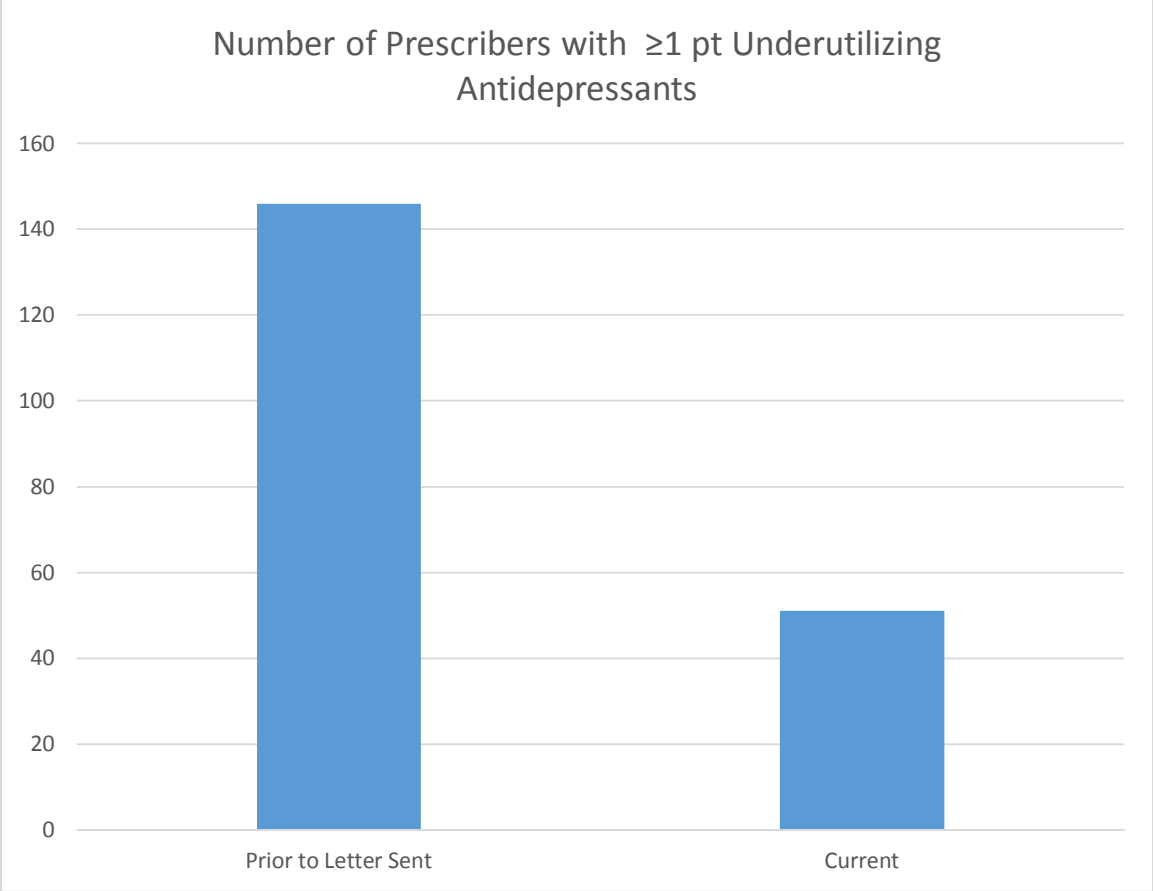

Top 10 Prescribers of Focalinby Percentage of Stimulant Prescriptions
14.00%
12.00%
10.00%
8.00%
6.00%
4.00%
2.00%
0.00%
Keplin, Jennifer
Staton, Dennis
Richards, Deidre
Weathers, Vickie
Schield, Laura
Twogood, Todd
Anderson, Tonya
Pathak, Prem
Pitera, Matthew
Hanisch, Stefanie

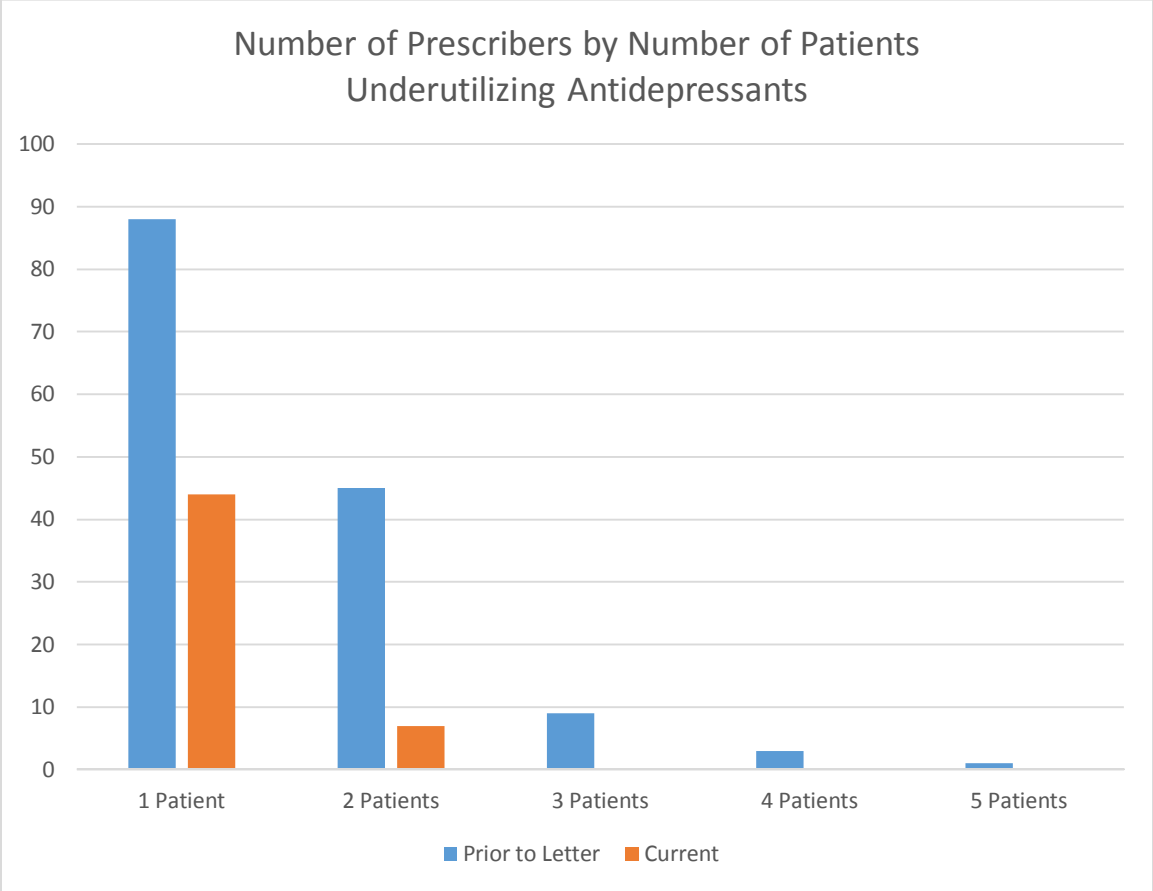

Percentage of Long-Acting Stimulant Used when Long-Acting and Short-Acting Combination Therapy is Used
40.00%
35.00%
30.00%
25.00%
20.00%
15.00%
10.00%
5.00%
0.00%
Metheylphenidate ER
Adderall XR
Focalin XR
Vyvanse

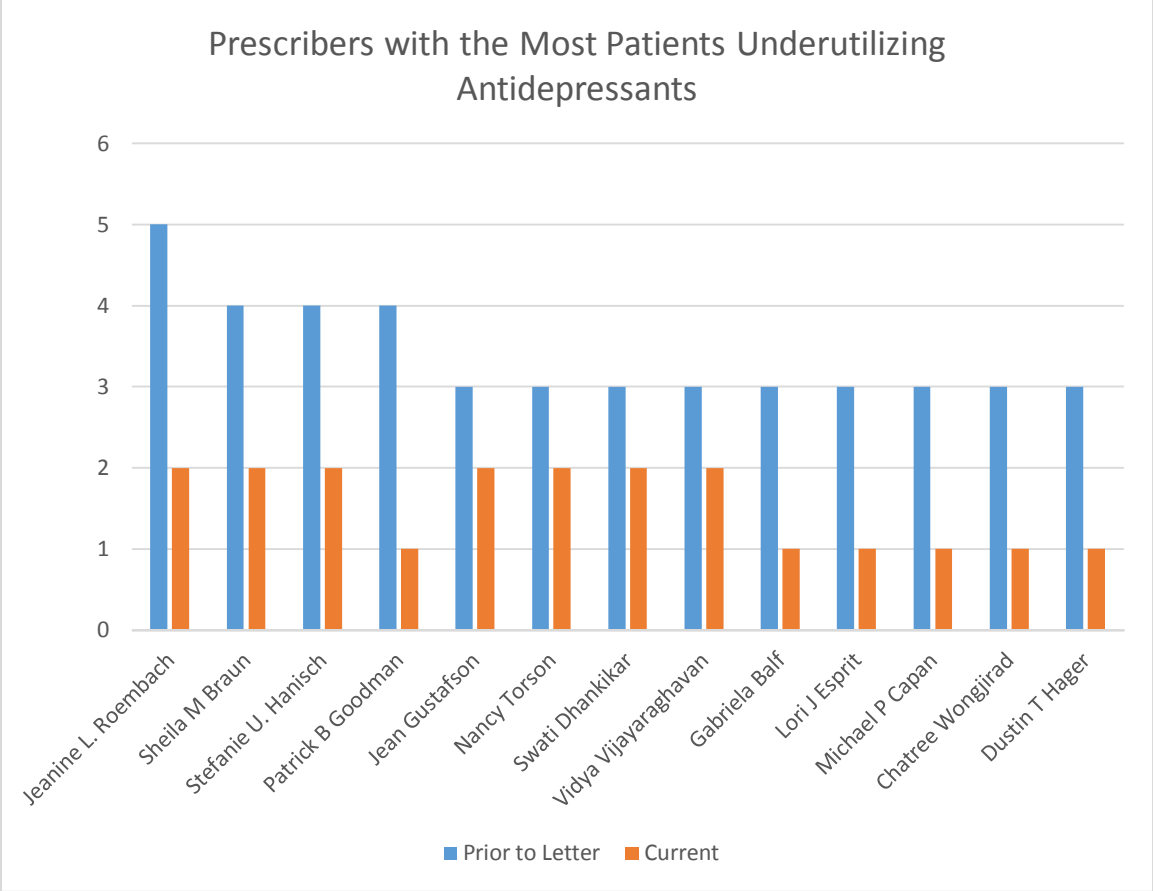

Top 10 Prescribers of Long and Short Acting Stimulant Combination Therapy
# of Unique Patients
45
40
35
30
25
20
15
10
5
0
Weathers, Vickie
Fjelstad, Diane
Dahmen, Kevin
Pathak, Prem
Hanisch, Stefanie
Staton, Robert
Roembach, Jamie
Bansal, Ashok
McMullen, Jill
Pitera, Matthew


Prescriber's Percentage of Patients Receiving Stimulants on Both Long & Short-Acting Stimulants
30.00%
25.00%
20.00%
15.00%
10.00%
5.00%
0.00%
Pathak, Prem
Weathers, Vickie
McMullen, Jill
Hanisch, Stefanie
Bansal, Ashok
Dahmen, Kevin
Pitera, Matthew


Analysis of Antidepressant Underutilization Pre and Post RDUR Intervention
180
160
140
120
100
80
60
40
20
0
Patients with letters Sent
Current Underutilization
Correct Utilization
No Longer on Med
Med Discontinued
Drug Changed
Pt no longer on ND MA


Number of Prescribers with ≥1 pt Underutilizing Antidepressants
160
140
120
100
80
60
40
20
0
Prior to Letter Sent
Current


Number of Prescribers by Number of Patients Underutilizing Antidepressants
100
90
80
70
60
50
40
30
20
10
0
1 Patient
2 Patients
3 Patients
4 Patients
5 Patients
Prior to Letter
Current


Prescribers with the Most Patients Underutilizing Antidepressants
6
5
4
3
2
1
0
Jeanine L. Roembach
Sheila M Braun
Stefanie U. Hanisch
Patrick B Goodman
Jean Gustafson
Nancy Torson
Swati Dhankikar
Vidya Vijayaraghavan
Gabriela Balf
Lori J Esprit
Michael P Capan
Chatree Wongjirad
Dustin T Hager
Prior to Letter
Current

NORTH DAKOTA MEDICAID
RETROSPECTIVE DRUG UTILIZATION REVIEW
CRITERIA RECOMMENDATIONS
2ND QUARTER 2017

Criteria Recommendations ***Approved Rejected***

1. Benzodiazepines / Opioids _____ _____

Alert Message: Co-administration of opioids and benzodiazepines should be done with extreme caution as the combination may result in respiratory depression, hypotension, profound sedation, coma, and death. If concurrent administration is clinically warranted consider dosage reduction of one or both agents. Re-evaluate the patient's treatment plan on a regular basis to determine the necessity for continued concomitant use of these agents.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Alprazolam	Codeine	
Chlordiazepoxide	Fentanyl	
Clonazepam	Hydrocodone	
Clorazepate	Hydromorphone	
Diazepam	Levorphanol	
Lorazepam	Meperidine	
Oxazepam	Methadone	
Estazolam	Morphine	
Flurazepam	Oxycodone	
Quazepam	Oxymorphone	
Temazepam	Tapentadol	
Triazolam	Tramadol	
Clobazam	Buprenorphine	

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Facts & Comparisons, 2017 Updates, Wolters Kluwer Health.
Sun EC, Dixit A, Humphreys K, et al., Association Between Concurrent Use of Prescription Opioids and Benzodiazepines and Overdose: Retrospective Analysis. BMJ 2017;356:j760
Manchikanti L, Abdi S, Atluri S, et.al. American Society of Interventional Pain Physicians (ASIPP) Guidelines for Responsible Opioid Prescribing in Chronic Non-Cancer Pain: Part 1 – Evidence Assement. Pain Physician 2012;15:S67-S116.
Manchikanti L, Abdi S, Atluri S, et.al. American Society of Interventional Pain Physicians (ASIPP) Guidelines for Responsible Opioid Prescribing in Chronic Non-Cancer Pain: Part 2 – Guidance. Pain Physician 2012;15:S67-S116.
VA/DoD Evidence Based Practice Clinical Practice Guideline Management of Opioid Therapy for Chronic Pain, May 2010. Department of Veterans Affairs, Department of Defense.
Available art: http://www.healthquality.va.gov/guidelines/Pain/cot/COT_312_Full-er.pdf
APS – AAPM Guideline for the Use of Chronic Opioid Therapy in Chronic Noncancer Pain Evidence Review. The American Pain Society in Conjunction with the American Academy of Pain Medicine. 2009.
Available at: http://americanpainsociety.org/uploads/education/guidelines/chronic-opioid-therapy-cncp.pdf

2. Codeine - All / Obesity & Severe Breathing Problems _____ _____

Alert Message: The use of codeine-containing agents are not recommended in adolescent patients between 12 and 18 years of age who are obese or have conditions such as sleep apnea, or other severe lung disease due to risk of opioid-induced respiratory depression. Codeine is metabolized via CYP2D6 to morphine and ultra-rapid metabolizers of CYP2D6 can have excessive morphine formation and toxicity even after normal therapeutic doses.

Conflict Code: TA - Therapeutic Appropriateness (Warning)
Drugs/Diseases

Util A	Util B	Util C **(Include)**
Codeine – All		Obesity
		Sleep Apnea
		Asthma
		Cystic Fibrosis

Age Range: 12 -18 yoa

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
FDA Drug Safety Communication: FDA Restricts Use of Prescription Codeine Pain and Cough Medicines and Tramadol Pain Medicines in Children; Recommends Against Use in Breastfeeding Women. Available at: https://www.fda.gov/Drugs/DrugSafety/ucm549679.htm. Accessed April 21, 2017.
European Medicines Agency (EMA): Codeine-containing Medicinal Products for the Treatment of Cough or Cold in Paediatric Patients. Retrieved July 1, 2015. Available on the World Wide Web http://www.ema.europa.eu/ema/index.jsp?curl=pages/medicines/human/referrals/Codeine_containing_medicinal_products_for_the_treatment_of_cough_and_cold_in_paediatric_patients/human_referral_prac_000039.jsp&mid=WC0b01ac05805c516f

3. Codeine - All / Lactation _____ _____

Alert Message: The use of codeine-containing agents is not recommended in nursing mothers. Codeine is metabolized to morphine which is excreted in breastmilk and may cause sedation and respiratory depression in breast-fed infants. Codeine is metabolized via CYP2D6 and if the nursing mother is a CYP2D6 ultra-rapid metabolizer excessive morphine formation can occur increasing the risk for excessive sedation and respiratory depression.

Conflict Code: MC – Drug (Actual) Disease Precaution
Drugs/Diseases

Util A	Util B	Util C
Codeine - All	Lactation	
	Other Disorder of Lactation	

Age Range: 11 -55 yoa
Gender: Female

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
FDA Drug Safety Communication: FDA Restricts Use of Prescription Codeine Pain and Cough Medicines and Tramadol Pain Medicines in Children; Recommends Against Use in Breastfeeding Women. Available at: https://www.fda.gov/Drugs/DrugSafety/ucm549679.htm. Accessed April 21, 2017.

4. Tramadol - All / Therapeutic Appropriateness _____ _____

Alert Message: Due to the risk of respiratory depression, the use of tramadol-containing agents is contraindicated for the treatment of pain in pediatric patients younger than 12 years of age and in post-operative pain management after tonsillectomy and/or adenoidectomy in pediatric patients younger than 18 years of age. Children who are ultra-rapid metabolizers of CYP2D6, an enzyme responsible for tramadol metabolism, are at increased risk for severe respiratory depression.

Conflict Code: TA - Therapeutic Appropriateness

Drugs/Diseases

Util A	Util B	Util C
Tramadol – All		

Age Range: < 18 yoa

References:

Clinical Pharmacology, 2017 Elsevier/Gold Standard.
FDA Drug Safety Communication: FDA Restricts Use of Prescription Codeine Pain and Cough Medicines and Tramadol Pain Medicines in Children; Recommends Against Use in Breastfeeding Women. Available at: https://www.fda.gov/Drugs/DrugSafety/ucm549679.htm. Accessed April 21, 2017.

5. Tramadol - All / Obesity & Severe Breathing Problems _____ _____

Alert Message: The use of tramadol-containing agents are not recommended in adolescent patients between 12 and 18 years of age who are obese or have conditions such as sleep apnea, or other severe lung disease. Children who are ultra-rapid metabolizers of CYP2D6, an enzyme responsible for tramadol metabolism, are at increased risk for severe respiratory depression.

Conflict Code: TA - Therapeutic Appropriateness

Drugs/Diseases

Util A	Util B	Util C **(Include)**
Tramadol – All		Obesity
		Sleep Apnea
		Asthma
		Cystic Fibrosis

Age Range: 12 -18 yoa

References:

Clinical Pharmacology, 2017 Elsevier/Gold Standard.
FDA Drug Safety Communication: FDA Restricts Use of Prescription Codeine Pain and Cough Medicines and Tramadol Pain Medicines in Children; Recommends Against Use in Breastfeeding Women. Available at: https://www.fda.gov/Drugs/DrugSafety/ucm549679.htm. Accessed April 21, 2017.

6. Tramadol - All / Lactation _____ _____

Alert Message: The use of tramadol-containing agents is not recommended in nursing mothers. The parent drug tramadol and its active metabolite (M1) are excreted in breastmilk and may cause excessive sedation and respiratory depression, which could result in death in breast-fed infants. Tramadol is a CYP2D6 metabolized drug and if the nursing mother is a CYP2D6 ultra-rapid metabolizer M1 concentrations will be even higher with increased risk for adverse effects.

Conflict Code: MC – Drug (Actual) Disease Precaution
Drugs/Diseases

Util A	Util B	Util C
Tramadol – All	Lactation	
	Other Disorder of Lactation	

Age Range: 11 - 55 yoa
Gender: Female

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
FDA Drug Safety Communication: FDA Restricts Use of Prescription Codeine Pain and Cough Medicines and Tramadol Pain Medicines in Children; Recommends Against Use in Breastfeeding Women. Available at: https://www.fda.gov/Drugs/DrugSafety/ucm549679.htm. Accessed April 21, 2017.

7. Soliqua / Overutilization _____ _____

Alert Message: The manufacturers' recommended maximum daily dose of Soliqua (insulin glargine/lixisenatide) is 60 units per day. Administration of more than 60 units of insulin glargine/lixisenatide can result in overdose of the lixisenatide (> 20 mcg lixisenatide) component.

Conflict Code: ER - Overutilization
ER - Overutilization
Drugs/Diseases

Util A	Util B	Util C
Insulin Glargine/Lixisenatide		

Max Dose: 60 units per day

References:
Clinical Pharmacology, 2016 Elsevier/Gold Standard.
Soliqua 100/33 Prescribing Information, Nov. 2016, Sanofi-Aventis.

8. Soliqua / GLP-1 Receptor Agonists _____ _____

Alert Message: Soliqua (insulin glargine/lixisenatide) is not recommended for use in combination with any other product containing lixisenatide or another GLP-1 receptor agonist. Concurrent use of these agents represents an unnecessary duplication of therapy.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Insulin Glargine/Lixisenatide	Lixisenatide	
	Albiglutide	
	Dulaglutide	
	Exenatide	
	Liraglutide	

References:
Clinical Pharmacology, 2016 Elsevier/Gold Standard.
Soliqua 100/33 Prescribing Information, Nov. 2016, Sanofi-Aventis.

9. Soliqua / Gastroparesis _____ _____

Alert Message: Soliqua (insulin glargine/lixisenatide) has not been studied in patients with gastroparesis and is not recommended in patients with gastroparesis. The lixisenatide component of the combination product slows gastric emptying, therefore, use of the product is not recommended in patients with severe gastroparesis.

Conflict Code: MC – Drug (Actual) Disease Precaution/Warning
Drugs/Diseases

Util A	Util B	Util C
Insulin Glargine/Lixisenatide	Gastroparesis	

References:
Clinical Pharmacology, 2016 Elsevier/Gold Standard.
Soliqua 100/33 Prescribing Information, Nov. 2016, Sanofi-Aventis.

10. Soliqua / Therapeutic Appropriateness _____ _____

Alert Message: The safety and effectiveness of Soliqua (insulin glargine/lixisenatide) have not been established in pediatric patients below 18 years of age.

Conflict Code: TA - Therapeutic Appropriateness
Drugs/Diseases

Util A	Util B	Util C
Insulin Glargine/Lixisenatide		

Age Range: 0 – 17 yoa

References:
Clinical Pharmacology, 2016 Elsevier/Gold Standard.
Soliqua 100/33 Prescribing Information, Nov. 2016, Sanofi-Aventis.

11. Soliqua / Pancreatitis _____ _____

Alert Message: Soliqua (insulin glargine/lixisenatide) has not been studied in patients with a history of pancreatitis. The lixisenatide component of the combination product is a GLP-1 receptor agonists and these agents have been associated with acute pancreatitis, including fatal and non-fatal hemorrhagic or necrotizing pancreatitis. Consider alternative antidiabetic therapy in patients with a history of pancreatitis. If pancreatitis is suspected, promptly discontinue use. If pancreatitis is confirmed, restarting insulin glargine/lixisenatide is not recommended.

Conflict Code: TA - Therapeutic Appropriateness
Drugs/Diseases

Util A	Util B	Util C **(Include)**
Insulin Glargine/Lixisenatide		Pancreatitis

References:
Clinical Pharmacology, 2016 Elsevier/Gold Standard.
Soliqua 100/33 Prescribing Information, Nov. 2016, Sanofi-Aventis.

12. Soliqua / Renal Impairment _____ _____

Alert Message: Soliqua (insulin glargine/lixisenatide) should be used with caution in patients with renal impairment. The lixisenatide component is a GLP-1 receptor agonist and these agents have been associated with acute kidney injury and worsening of chronic renal failure. Monitor renal function in patients with renal impairment and in those with severe GI adverse reactions (majority of reported renal events occurred in patients who experienced nausea, vomiting, diarrhea, or dehydration). Insulin glargine/lixisenatide use is not recommended in patients with ESRD.

Conflict Code: TA - Therapeutic Appropriateness
Drugs/Diseases

Util A	Util B	Util C **(Include)**
Insulin Glargine/Lixisenatide		Renal Impairment

References:
Clinical Pharmacology, 2016 Elsevier/Gold Standard.
Soliqua 100/33 Prescribing Information, Nov. 2016, Sanofi-Aventis.

13. Soliqua / Hypokalemia _____ _____

Alert Message: All insulin-containing products, including Soliqua (insulin glargine/lixisenatide), cause a shift in potassium from extracellular to intracellular space, possibly leading to hypokalemia. Monitor potassium levels in patients at risk for hypokalemia if indicated.

Conflict Code: MC – Drug (Actual) Disease Precaution/Warning
Drugs/Diseases

Util A	Util B	Util C
Insulin Glargine/Lixisenatide	Hypokalemia	

References:
Clinical Pharmacology, 2016 Elsevier/Gold Standard.
Soliqua 100/33 Prescribing Information, Nov. 2016, Sanofi-Aventis.

14. Soliqua / Pregnancy / Pregnancy Negating _____ _____

Alert Message: There are no adequate and well-controlled studies of Soliqua (insulin glargine/lixisenatide) in pregnant women. Lixisenatide-containing agents should not be used during pregnancy unless the potential benefit justifies the potential risk to the fetus.

Conflict Code: MC – Drug (Actual) Disease Precaution/Warning
Drugs/Diseases

Util A	Util B	Util C **(Negating)**
Insulin Glargine/Lixisenatide	Pregnancy	Delivery
		Miscarriage
		Abortion

References:
Clinical Pharmacology, 2016 Elsevier/Gold Standard.
Soliqua 100/33 Prescribing Information, Nov. 2016, Sanofi-Aventis.

15. Soliqua / Nonadherence _____ _____

Alert Message: Non-adherence to Soliqua (insulin glargine/lixisenatide) therapy may result in loss of glycemic control and an increased risk of developing diabetic-related complications.

Conflict Code: LR - Nonadherence
Drugs/Diseases

Util A	Util B	Util C
Insulin Glargine/Lixisenatide		

References:
Osterberg L, Blaschke T. Adherence to Medication. N Engl J Med 2005; 353:487- 497.
Ho PM, Rumsfeld JS, Masoudi FA, et al., Effect of Medication Nonadherence on Hospitalization and Mortality Among Patients with Diabetes Mellitus. Arch Intern Med. 2006;166:1836-1841.
Currie CJ, Peyrot M, Morgan CL, et al. The Impact of Treatment Noncompliance on Mortality in People with Type 2 Diabetes. Diabetes Care 35:1279-1284, June 2012.
Butler RJ, Davis TK, Johnson WL, et al. Effects of Non Adherence with Prescription Drugs Among Older Adults. Am J Manag Care. 2011 Feb; 17(2):153-60.

16. Soliqua / Drugs That Increase Risk of Hypoglycemia _____ _____

Alert Message: Caution should be exercised when Soliqua (insulin glargine/lixisenatide) is co-administered with drugs that can enhance the hypoglycemic effect of the antidiabetic agent. The patient may be at an increased risk for hypoglycemia. Dose reduction of insulin glargine/lixisenatide and increased frequency of glucose monitoring may be required when co-administering these drugs.

Conflict Code: DD – Drug Interaction
Drugs/Diseases

Util A	Util B		Util C
Insulin Glargine/Lixisenatide	ACEIs	Pentoxifylline	
	ARBs	Pramlintide	
	Disopyramide	Salicylates	
	Fibrates	Sulfamethoxazole	
	MOAIs	Sulfasalazine	
	Fluoxetine	Sulfadiazine	
		Sulfisoxazole	

References:
Clinical Pharmacology, 2016 Elsevier/Gold Standard.
Soliqua 100/33 Prescribing Information, Nov. 2016, Sanofi-Aventis.

17. Soliqua / Drugs That Decrease blood Glucose Lowering Effect _____ _____

Alert Message: Caution should be exercised when Soliqua (insulin glargine/lixisenatide) is co-administered with drugs that can decrease the blood glucose lowering effect of insulin glargine/lixisenatide. The patient may be at risk for decreased therapeutic effect of antidiabetic agent. Dosage increase of insulin glargine/lixisenatide and increased frequency of glucose monitoring may be required when co-administering these drugs.

Conflict Code: DD – Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Insulin Glargine/Lixisenatide	Atypical Antipsychotics	
	Danazol	
	Isoniazid	
	Niacin	
	Oral Contraceptives	
	Estrogens	
	Protease Inhibitors	
	Somatropin	
	Thyroid Hormones	

References:
Clinical Pharmacology, 2016 Elsevier/Gold Standard.
Soliqua 100/33 Prescribing Information, Nov. 2016, Sanofi-Aventis.

18. Xultophy / Overutilization _____ _____

Alert Message: The manufacturer's recommended maximum daily dose of Xultophy (insulin degludec/liraglutide) is 50 units once daily. Administration of more than 50 units of insulin degludec/liraglutide can result in overdose of the liraglutide (> 1.8 mg liraglutide).

Conflict Code: ER - Overutilization
Drugs/Diseases

Util A	Util B	Util C
Insulin degludec/Liraglutide		

Max Dose: 50 units per day

References:
Clinical Pharmacology, 2016 Elsevier/Gold Standard.
Xultophy 100/3.6 Prescribing Information, Nov. 2016, Novo Nordisk Inc.

19. Xultophy / GLP-1 Receptor Agonists _____ _____

Alert Message: Xultophy (insulin degludec/liraglutide) is not recommended for use in combination with any other product containing liraglutide or another GLP-1 receptor agonist. Concurrent use of these agents represents an unnecessary duplication of therapy.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Insulin degludec/Liraglutide	Liraglutide Lixisenatide Albiglutide Dulaglutide Exenatide	

References:
Clinical Pharmacology, 2016 Elsevier/Gold Standard.
Xultophy 100/3.6 Prescribing Information, Nov. 2016, Novo Nordisk Inc.

20. Xultophy / Gastroparesis _____ _____

Alert Message: Xultophy (insulin degludec/liraglutide) has not been studied in patients with gastroparesis and should be used with caution in this patients population. The liraglutide component of the combination product slows gastric emptying and may exacerbate existing gastroparesis.

Conflict Code: MC – Drug (Actual) Disease Precaution/Warning
Drugs/Diseases

Util A	Util B	Util C
Insulin degludec/Liraglutide	Gastroparesis	

References:
Clinical Pharmacology, 2016 Elsevier/Gold Standard.
Xultophy 100/3.6 Prescribing Information, Nov. 2016, Novo Nordisk Inc.

21. Xultophy / Therapeutic Appropriateness _____ _____

Alert Message: The safety and effectiveness of Xultophy (insulin degludec/liraglutide) have not been established in pediatric patients.

Conflict Code: TA - Therapeutic Appropriateness
Drugs/Diseases

Util A	Util B	Util C
Insulin degludec/Liraglutide		

Age Range: 0 – 17 yoa

References:
Clinical Pharmacology, 2016 Elsevier/Gold Standard.
Xultophy 100/3.6 Prescribing Information, Nov. 2016, Novo Nordisk Inc.

22. Xultophy / Pancreatitis _____ _____

Alert Message: Xultophy (insulin degludec/liraglutide) has not been studied in patients with a history of pancreatitis. The liraglutide component of the combination product is a GLP-1 receptor agonist and these agents have been associated with acute pancreatitis, including fatal and non-fatal hemorrhagic or necrotizing pancreatitis. Consider alternative antidiabetic therapy in patient with a history of pancreatitis. If pancreatitis is suspected, promptly discontinue use. If pancreatitis is confirmed, restarting insulin degludec/liraglutide is not recommended.

Conflict Code: TA - Therapeutic Appropriateness
Drugs/Diseases

Util A	Util B	Util C **(Include)**
Insulin degludec/Liraglutide		Pancreatitis

References:
Clinical Pharmacology, 2016 Elsevier/Gold Standard.
Xultophy 100/3.6 Prescribing Information, Nov. 2016, Novo Nordisk Inc.

23. Xultophy / Renal Impairment _____ _____

Alert Message: Xultophy (insulin degludec/liraglutide) should be used with caution in patients with renal impairment as the liraglutide component of the combination product is a GLP-1 receptor agonist and these agents have been associated with acute kidney injury and worsening of chronic renal failure. A majority of the reported events occurred in patients who had experienced nausea, vomiting, diarrhea, or dehydration. Advise patients of the potential risk of dehydration due to gastrointestinal adverse reactions and take precautions to avoid fluid depletion.

Conflict Code: TA - Therapeutic Appropriateness
Drugs/Diseases

Util A	Util B	Util C **(Include)**
Insulin degludec/Liraglutide		Renal Impairment

References:
Clinical Pharmacology, 2016 Elsevier/Gold Standard.
Xultophy 100/3.6 Prescribing Information, Nov. 2016, Novo Nordisk Inc.

24. Xultophy / Hypokalemia _____ _____

Alert Message: All insulin-containing products, including Xultophy (insulin degludec/liraglutide), cause a shift in potassium from extracellular to intracellular space, possibly leading to hypokalemia. Monitor potassium levels in patients at risk for hypokalemia if indicated.

Conflict Code: MC – Drug (Actual) Disease Precaution/Warning
Drugs/Diseases

Util A	Util B	Util C
Insulin degludec/Liraglutide	Hypokalemia	

References:
Clinical Pharmacology, 2016 Elsevier/Gold Standard.
Xultophy 100/3.6 Prescribing Information, Nov. 2016, Novo Nordisk Inc.

25. Xultophy / Pregnancy / Pregnancy Negating _____ _____

Alert Message: There are not adequate and well-controlled studies of Xultophy (insulin degludec/liraglutide) in pregnant women. Liraglutide-containing agents should not be used during pregnancy unless the potential benefit justifies the potential risk to the fetus.

Conflict Code: MC – Drug (Actual) Disease Precaution/Warning
Drugs/Diseases

Util A	Util B	Util C **(Negating)**
Insulin degludec/Liraglutide	Pregnancy	Delivery
		Miscarriage
		Abortion

References:
Clinical Pharmacology, 2016 Elsevier/Gold Standard.
Xultophy 100/3.6 Prescribing Information, Nov. 2016, Novo Nordisk Inc.

26. Xultophy / Medullary Thyroid Carcinoma _____ _____

Alert Message: The use of Xultophy (insulin degludec/liraglutide) is contraindicated in patients with a personal or family history of Medullary Thyroid Carcinoma (MTC) or in patients with Multiple Endocrine Neoplasia Syndrome Type 2. Cases of MTC have been reported in patients treated with liraglutide a component of the combination product. In clinical trials, there were 7 reported cases of papillary thyroid carcinomas in liraglutide-treated patients.

Conflict Code: TA - Therapeutic Appropriateness
Drugs/Diseases

Util A	Util B	Util C **(Include)**
Insulin degludec/Liraglutide		Medullary Thyroid Carcinoma
		Multiple Endocrine Neoplasia Syndrome Type 2

References:
Clinical Pharmacology, 2016 Elsevier/Gold Standard.
Xultophy 100/3.6 Prescribing Information, Nov. 2016, Novo Nordisk Inc.

27. Xultophy / Nonadherence _____ _____

Alert Message: Non-adherence to Xultophy (insulin degludec/liraglutide) therapy may result in loss of glycemic control and an increased risk of developing diabetic-related complications.

Conflict Code: LR - Nonadherence
Drugs/Diseases

Util A	Util B	Util C
Insulin degludec/Liraglutide		

References:

Osterberg L, Blaschke T. Adherence to Medication. N Engl J Med 2005; 353:487- 497.
Ho PM, Rumsfeld JS, Masoudi FA, et al., Effect of Medication Nonadherence on Hospitalization and Mortality Among Patients with Diabetes Mellitus. Arch Intern Med. 2006;166:1836-1841.
Currie CJ, Peyrot M, Morgan CL, et al. The Impact of Treatment Noncompliance on Mortality in People with Type 2 Diabetes. Diabetes Care 35:1279-1284, June 2012.
Butler RJ, Davis TK, Johnson WL, et al. Effects of Non Adherence with Prescription Drugs Among Older Adults. Am J Manag Care. 2011 Feb; 17(2):153-60.

28. Xultophy / Drugs That Increase Risk of Hypoglycemia _____ _____

Alert Message: Caution should be exercised when Xultophy (insulin degludec/liraglutide) is co-administered with drugs that can enhance the hypoglycemic effect of the antidiabetic agent. The patient may be at an increased risk for hypoglycemia. Dose reduction of insulin degludec/liraglutide and increased frequency of glucose monitoring may be required when co-administering these drugs.

Conflict Code: DD – Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Insulin degludec/Liraglutide	ACEIs	
	ARBs	
	Disopyramide	
	Fibrates	
	MOAIs	
	Fluoxetine	
	Pentoxifylline	
	Pramlintide	
	Salicylates	
	Sulfamethoxazole	
	Sulfasalazine	
	Sulfadiazine	
	Sulfisoxazole	

References:

Clinical Pharmacology, 2016 Elsevier/Gold Standard.
Xultophy 100/3.6 Prescribing Information, Nov. 2016, Novo Nordisk Inc.

29. Xultophy / Drugs That Decrease blood Glucose Lowering Effect _____ _____

Alert Message: Caution should be exercised when Xultophy (insulin degludec/liraglutide) is co-administered with drugs that can decrease the blood glucose lowering effect of insulin degludec/liraglutide. The patient may at risk for decreased therapeutic effect of the antidiabetic agent. Dosage increase of insulin degludec/liraglutide and increased frequency of glucose monitoring may be required when co-administering these drugs.

Conflict Code: DD – Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Insulin degludec/Liraglutide	Atypical Antipsychotics	
	Danazol	
	Isoniazid	
	Niacin	
	Oral Contraceptives	
	Estrogens	
	Protease Inhibitors	
	Somatropin	
	Thyroid Hormones	

References:
Clinical Pharmacology, 2016 Elsevier/Gold Standard.
Xultophy 100/3.6 Prescribing Information, Nov. 2016, Novo Nordisk Inc.

30. Daclizumab / Overutilization _____ _____

Alert Message: The recommended dosage of Zinbryta (daclizumab) is 150 mg injected subcutaneously once monthly.

Conflict Code: ER - Overutilization
Drugs/Diseases

Util A	Util B	Util C
Daclizumab		

Max Dose: 1 injection/month

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Zinbryta Prescribing Information, May 2016, Biogen.

31. Daclizumab / Hepatic Impairment _____ _____

Alert Message: The use of Zinbryta (daclizumab) is contraindicated in patients with pre-existing hepatic disease, hepatic impairment, including ALT and AST at least 2 times the ULN, history of autoimmune hepatitis or other autoimmune conditions involving the liver. Daclizumab can cause severe liver injury including life-threatening events, liver failure, and autoimmune hepatitis. Liver injury can occur at any time during treatment with daclizumab, with cases reported up to 4 months after the last dose of daclizumab.

Conflict Code: TA – Therapeutic Appropriateness **(Black Box Warning)**
Drugs/Diseases

Util A	Util B	Util C **(Include)**
Daclizumab		Hepatic Impairment
		Autoimmune Hepatitis

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Zinbryta Prescribing Information, May 2016, Biogen.

32. Daclizumab / Depression & Suicidal Ideation _____ _____

Alert Message: The use of Zinbryta (daclizumab) has been associated with depression-related events, including suicidal ideation or suicide attempt. Daclizumab should be used with caution in patients with previous or current depressive disorders. Advise patients and/or caregivers to immediately report any symptoms of new or worsening depression and/or suicidal ideation to their healthcare provider.

Conflict Code: TA – Therapeutic Appropriateness
Drugs/Diseases

Util A	Util B	Util C **(Include)**
Daclizumab		Depression
		Suicidal Ideation

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Zinbryta Prescribing Information, May 2016, Biogen.

33. Daclizumab / Therapeutic Appropriateness _____ _____

Alert Message: Safety and effectiveness of Zinbryta (daclizumab) in patients less than 17 years of age have not been established. Use of daclizumab is not recommended in pediatric patients due to the risk of hepatic injury and immune-mediated disorders.

Conflict Code: TA - Therapeutic Appropriateness
Drugs/Diseases

Util A	Util B	Util C
Daclizumab		

Age Range: 0 - 16 yoa

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Zinbryta Prescribing Information, May 2016, Biogen.

34. Daclizumab / Pregnancy / Pregnancy Negating _____ _____

Alert Message: There are no adequate studies on the developmental risk associated with the use of Zinbryta (daclizumab) in pregnant women. Daclizumab is a monoclonal antibody and these agents are known to cross the placenta. Administration of daclizumab in monkeys during gestation resulted in embryofetal death and reduced fetal growth at maternal exposures greater than 30 times that expected clinically.

Conflict Code: MC – Drug (Actual) Disease Warning
Drugs/Diseases

Util A	Util B	Util C **(Negating)**
Daclizumab	Pregnancy	Miscarriage
		Delivery
		Abortion

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Zinbryta Prescribing Information, May 2016, Biogen.

35. Daclizumab / Nonadherence _____ _____

Alert Message: Based on refill history, your patient may be under-utilizing Zinbryta (daclizumab). Non-adherence to the prescribed dosing regimen may result in sub-therapeutic effects, which may lead to decreased patient outcomes and additional healthcare costs.

Conflict Code: LR - Nonadherence
Drugs/Diseases

Util A	Util B	Util C
Daclizumab		

References:
Clinical Pharmacology, 2016 Elsevier/Gold Standard.
Osterberg L, Blaschke T. Adherence to Medication. N Engl J Med 2005; 353:487- 497.
Remington G, Rodriguez Y, Logan D, et al., Facilitating Medication Adherence in Patients with Multiple Sclerosis. Int J MS Care. 2013;15:36-45.
McKay KA, Tremlett H, Patten SB, et al., Determinants of Non-adherence to Diseases-Modifying Therapies in Multiple Sclerosis: A Cross-Canada Prospective Study. Mult Scler Jrnl. 2016 June 29;1-9.

36. Daclizumab / Hepatotoxic Drugs _____ _____

Alert Message: Caution should be exercised when administering Zinbryta (daclizumab) with drugs that can cause hepatotoxicity. Daclizumab can cause severe liver injury, including life-threatening events, and the use with other agents that cause liver injury may increase the risk of the adverse effect.

Conflict Code: DD - Drug/Drug Interaction
Drugs/Diseases

Util A	Util B		Util C
Daclizumab	Allopurinol	Nevirapine	
	Amiodarone	Nitrofurantoin	
	Amoxicillin-clavulanate	Phenytoin	
	Atorvastatin	Propylthiouracil	
	Azathioprine	Quinidine	
	Busulfan	Pyrazinamide	
	Carbamazepine	Rifampin	
	Chlorpromazine	Simvastatin	
	Dantrolene	TMP-SMZ	
	Diclofenac	Sulfasalazine	
	Didanosine	Sulindac	
	Disulfiram	Telithromycin	
	Efavirenz	Ticlopidine	
	Erythromycin	Valproate	
	Flutamide	Alectinib	
	Ibuprofen	Sunitinib	
	Infliximab	Idelalisib	
	Interferon	Ixazomib	
	Isoniazid	Erlotinib	
	Itraconazole	Lenvatinib	
	Ketoconazole	Nefazodone	
	Methotrexate	Maraviroc	
	Methyldopa		
	Minocycline		

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Zinbryta Prescribing Information, May 2016, Biogen.
Bjornsson, ES. Hepatotoxicity by Drugs: The Most Common Implicated Agents. Int Jrnl Mol Sci. 2016 Feb; 17(2);244.

37. Panobinostat / Diarrhea _____ _____

Alert Message: Farydak (panobinostat) can cause severe diarrhea. Monitor patient for symptoms and ensure the patient has adequate hydration prior to and during therapy. Initiate anti-diarrheal treatment medication at the onset of diarrhea. Interrupt panobinostat therapy at the onset of moderate diarrhea (4 to 6 stools/day) or severe diarrhea (>/= 7 stools/day).

Conflict Code: MC – Drug (Actual) Disease Warning (Black Box Warning)
Drugs/Diseases

Util A	Util B	Util C
Panobinostat	Diarrhea	

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Farydak Prescribing Information, Feb. 2015, Novartis Pharmaceuticals Corporation.

38. Panobinostat / Cardiovascular Events _____ _____

Alert Message: Severe and fatal cardiac ischemic events, including arrhythmias and ECG changes, have occurred in patients receiving Farydak (panobinostat). Panobinostat may prolong the QT interval. Obtain ECG and electrolytes at baseline and periodically during treatment as clinically indicated. Panobinostat should not be initiated in patients with a QTcF > 450 msec or clinically significant baseline ST-segment or T-wave abnormalities.

Conflict Code: MC – Drug (Actual) Disease Warning (Black Box Warning)
Drugs/Diseases

Util A	Util B	Util C **(Include)**
Panobinostat		Myocardial Infarction
		Angina
		QT Prolongation

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Farydak Prescribing Information, Feb. 2015, Novartis Pharmaceuticals Corporation.

**QTcF is the Fridericia corrected QT interval and was formula was used to calculate the QT interval in the clinical trials for Farydak (panobinostat). More than 30 correction formulae have been proposed, of which Bazett's (QTcB) and Fridericiaís (QTcF) corrections are the most widely used. Fridericiaís formula generates a more accurate correction in this circumstance.*

39. Panobinostat / Hepatic Impairment _____ _____

Alert Message: Farydak (panobinostat) can cause hepatic dysfunction. Liver function should be monitored prior to treatment and regularly during treatment. If abnormal liver function tests are observed dose adjustment may be considered. The starting dose of panobinostat should be reduced in patients with mild or moderate hepatic impairment (15 mg and 10 mg, respectively). Avoid use in patients with severe hepatic impairment.

Conflict Code: MC – Drug (Actual) Disease Warning
Drugs/Diseases

Util A	Util B	Util C **(Include)**
Panobinostat		Hepatic Impairment

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Farydak Prescribing Information, Feb. 2015, Novartis Pharmaceuticals Corporation.

40. Panobinostat / Hemorrhage _____ _____

Alert Message: Fatal and serious hemorrhage has been reported during treatment with Farydak (panobinostat). Obtain a baseline platelet count prior to therapy and monitor the CBC weekly during therapy. Interruption of panobinostat therapy, dose adjustment or drug discontinuation may be necessary if severe toxicity occurs.

Conflict Code: MC – Drug (Actual) Disease Warning
Drugs/Diseases

Util A	Util B	Util C
Panobinostat	Gastrointestinal Bleed	
	Subarachnoid Hemorrhage	
	Intracerebral Hemorrhage	

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Farydak Prescribing Information, Feb. 2015, Novartis Pharmaceuticals Corporation.

41. Panobinostat 15 mg & 20 mg / Strong CYP3A4 Inhibitors _____ _____

Alert Message: The dose of Farydak (panobinostat) should be reduced to 10 mg when co-administered with strong CYP3A4 inhibitors. Panobinostat is a CYP3A4 substrate and inhibition of its CYP3A4-medicated metabolism may result in significantly increased panobinostat exposure and risk of adverse effects.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B		Util C
Panobinostat 15 & 20mg	Nefazodone	Ketoconazole	
	Clarithromycin	Itraconazole	
	Telithromycin	Voriconazole	
	Saquinavir	Posaconazole	
	Ritonavir	Cobicistat	
	Nelfinavir		
	Indinavir		

Max Dose: 10 mg

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Farydak Prescribing Information, Feb. 2015, Novartis Pharmaceuticals Corporation.

42. Panobinostat / Strong CYP3A4 Inducers _____ _____

Alert Message: Concurrent use of Farydak (panobinostat), a CYP3A4 substrate, with strong CYP3A4 inducers should be avoided. While drug interaction studies have not been conducted simulation studies using mechanistic models suggest an approximate 70% decrease in the systemic exposure of panobinostat in the presence of strong inducers of CYP3A4.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B		Util C
Panobinostat	Phenytoin	Rifampin	
	Phenobarbital	Rifabutin	
	Primidone	Rifapentine	
	Carbamazepine		

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Farydak Prescribing Information, Feb. 2015, Novartis Pharmaceuticals Corporation.

43. Panobinostat / Sensitive CYP2D6 Substrates _____ _____

Alert Message: Concurrent use of Farydak (panobinostat), a CYP2D6 inhibitor, with sensitive CYP2D6 substrates (e.g., atomoxetine, metoprolol, and venlafaxine) should be avoided due to risk of elevated CYP2D6 substrate concentrations. If concomitant use with the CYP2D6 substrate is unavoidable monitor patient frequently for adverse reactions.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B		Util C
Panobinostat	Atomoxetine	Nebivolol	
	Desipramine	Perphenazine	
	Dextromethorphan	Tolterodine	
	Metoprolol	Venlafaxine	

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Farydak Prescribing Information, Feb. 2015, Novartis Pharmaceuticals Corporation.

44. Panobinostat / QT Prolongation Drugs _____ _____

Alert Message: Farydak (panobinostat) has been shown to increase the QTc interval and therefore use with drugs that are known to prolong the QT interval is not recommended.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B				Util C
Panobinostat	Albuterol	Disopyramide	Imipramine	Pazopanib	Tolterodine
	Alfuzosin	Dofetilide	Indapamide	Pentamidine	Trazodone
	Amantadine	Dolasetron	Isradipine	Posaconazole	TMP/SMZ
	Amiodarone	Doxepin	Itraconazole	Procainamide	Trimipramine
	Amitriptyline	Dronedarone	Ketoconazole	Propafenone	Vandetanib
	Amphetamine	Droperidol	Lapatinib	Protriptyline	Vardenafil
	Arsenic Trioxide	Ephedrine	Levalbuterol	Quetiapine	Atazanavir
	Asenapine	Epinephrine	Levofloxacin	Quinidine	Ziprasidone
	Erythromycin	Lithium	Ranolazine	Venlafaxine	Zolmitriptan
	Atomoxetine	Escitalopram	Metaproterenol	Risperidone	Ezogabine
	Azithromycin	Felbamate	Methadone	Tizanidine	Rasagiline
	Chloral Hydrate	Flecainide	Moexipril/HCTZ	Ritonavir	Phenelzine
	Chloroquine	Fluconazole	Moxifloxacin	Salmeterol	Tranylcypromine
	Chlorpromazine	Fluoxetine	Nicardipine	Saquinavir	Linezolid
	Ciprofloxacin	Foscarnet	Nilotinib	Sertraline	
	Citalopram	Fosphenytoin	Norfloxacin	Solifenacin	
	Clarithromycin	Galantamine	Nortriptyline	Sotalol	
	Clomipramine	Gemifloxacin	Octreotide	Sunitinib	
	Clozapine	Granisetron	Ofloxacin	Tacrolimus	
	Dasatinib	Haloperidol	Ondansetron	Tamoxifen	
	Desipramine	Isocarboxazid	Paliperidone	Telithromycin	
	Diphenhydramine	Iloperidone	Paroxetine	Terbutaline	

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Farydak Prescribing Information, Feb. 2015, Novartis Pharmaceuticals Corporation.

45. Panobinostat / Therapeutic Appropriateness _____ _____

Alert Message: Farydak (panobinostat) can cause fetal harm. Advise females of reproductive potential to avoid becoming pregnant while taking panobinostat and to use effective contraception while taking panobinostat and for at least 1 month after the last dose. Because of the potential risk of male-medicated teratogenicity, advise sexually active men to use condoms while on treatment and for 3 months after their last dose of panobinostat.

Conflict Code: TA – Therapeutic Appropriateness
Drugs/Diseases

Util A	Util B	Util C
Panobinostat		

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Farydak Prescribing Information, Feb. 2015, Novartis Pharmaceuticals Corporation.

46. Saxagliptin - All / Pancreatitis _____ _____

Alert Message: There have been post-marketing reports of acute pancreatitis in patients taking saxagliptin-containing products (Onglyza, Kombiglyze XR, and Qtern). After initiation of a saxagliptin-containing agent, the patient should be observed for signs and symptoms of pancreatitis. If pancreatitis is suspected, promptly discontinue the saxagliptin-containing agent and initiate appropriate management.

Conflict Code: MC – Drug (Actual) Disease Precaution/ Warning
Drugs/Diseases

Util A	Util B	Util C
Saxagliptin	Pancreatitis	
Saxagliptin/Metformin		
Saxagliptin/ Dapagliflozin		

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Facts & Comparisons, 2017, Wolters Kluwer Health.

47. Saxagliptin – All / Heart Failure _____ _____

Alert Message: Consider the risks and benefits of saxagliptin-containing therapy (Onglyza, Kombiglyze XR, and Qtern) in patients who have a history of or who have increased risk factors for heart failure. An increased risk of hospitalization for heart failure has been reported in patients receiving saxagliptin in a cardiovascular outcomes trial. If heart failure develops, evaluate and manage according to current standards of care and consider discontinuing the saxagliptin-containing agents.

Conflict Code: MC – Drug (Actual) Disease Precaution/ Warning
Drugs/Diseases

Util A	Util B	Util C **(Include)**
Saxagliptin		Heart Failure
Saxagliptin/Metformin		Dyspnea
Saxagliptin/ Dapagliflozin		Fatigue
		Edema
		Tachycardia
		Arrhythmia

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Facts & Comparisons, 2017, Wolters Kluwer Health.

48. Venetoclax / Overutilization _____ _____

Alert Message: Venclexta (venetoclax) may be over-utilized. The manufacturer's recommended maximum daily dose is 400 mg.

Conflict Code: ER – Overutilization
Drugs/Diseases

Util A	Util B	Util C
Venetoclax		

Max Dose: 400 mg/day

References:
Venclexta Prescribing Information, April 2016, AbbVie Inc.
Clinical Pharmacology, 2017 Elsevier/Gold Standard.

49. Venetoclax / Strong CYP3A4 Inhibitors _____ _____

Alert Message: Avoid concomitant use of strong CYP3A4 inhibitors with the CYP3A4 substrate Venclexta (venetoclax) in patients who have completed the ramp-up phase and are on a steady daily dose of venetoclax. If a strong CYP3A4 inhibitor must be used, reduce the venetoclax dose by 75%. Resume the venetoclax dose that was used prior to initiating the CYP3A4 inhibitor 2 to 3 days after discontinuation of the inhibitor. Concurrent use of a strong CYP3A4 inhibitor with venetoclax is contraindicated at initiation and during ramp-up phase of venetoclax therapy.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C **(Include)**	
Venetoclax		Clarithromybin	Ketoconazole
		Cobicistat	Itraconazole
		Saquinavir	Voriconazole
		Ritonavir	Posaconazole
		Indinavir	Telithromycin
		Nelfinavir	
		Idelalisib	

Max Dose: > 100 mg/day
Day Supply: > 35 days

References:
Venclexta Prescribing Information, April 2016, AbbVie Inc.
Clinical Pharmacology, 2017 Elsevier/Gold Standard.

50. Venetoclax / Moderate & Strong CYP3A4 Inducers _____ _____

Alert Message: Avoid concomitant use of Venclexta (venetoclax), a CYP3A4 substrate, with moderate to strong CYP3A4 inducers. Consider alternative treatments with less CYP3A4 induction.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B				Util C
Venetoclax	Carbamazepine	Primidone	Rifapentine	Efavirenz	
	Phenytoin	Rifabutin	Bosentan	Etravirine	
	Phenobarbital	Rifampin	Modafinil		

References:
Venclexta Prescribing Information, April 2016, AbbVie Inc.
Clinical Pharmacology, 2017 Elsevier/Gold Standard.

51. Venetoclax / Moderate CYP3A4 Inhibitors & P-gp Inhibitors _____ _____

Alert Message: Avoid concomitant use of moderate CYP3A4 inhibitors or P-gp inhibitors with the CYP3A4 substrate Venclexta (venetoclax). Consider alternative treatment options. If a moderate CYP3A4 or P-gp inhibitor must be used, reduce the venetoclax dose by 50% and monitor the patient closely for signs of venetoclax toxicities. Resume the venetoclax dose that was used prior to initiating the CYP3A4 inhibitor 2 to 3 days after discontinuation of the inhibitor.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B		Util C
Venetoclax	Erythromycin	Cyclosporine	
	Ciprofloxacin	Felodipine	
	Diltiazem	Quinidine	
	Dronedarone	Ranolazine	
	Fluconazole	Ticagrelor	
	Verapamil	Amiodarone	
	Diltiazem	Azithromycin	
	Aprepitant	Captopril	
	Cimetidine	Carvedilol	
	Crizotinib		
	Imatinib		

References:
Venclexta Prescribing Information, April 2016, AbbVie Inc.
Clinical Pharmacology, 2017 Elsevier/Gold Standard.

52. Venetoclax / P-gp Substrates w/ Narrow Therapeutic Indexes _____ _____

Alert Message: Avoid concomitant use of a drug that is a P-gp substrate that has a narrow therapeutic index with the P-gp inhibitor Venclexta (venetoclax). If the concurrent use is warranted, the P-gp substrate should be taken at least 6 hours before venetoclax.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Venetoclax	Digoxin	
	Everolimus	
	Sirolimus	
	Tacrolimus	

References:
Venclexta Prescribing Information, April 2016, AbbVie Inc.
Clinical Pharmacology, 2016 Elsevier/Gold Standard.

53. Venetoclax / Therapeutic Appropriateness – Pediatric Patients _____ _____

Alert Message: Safety and effectiveness of Venclexta (venetoclax) have not been established in pediatric patients.

Conflict Code: TA - Therapeutic Appropriateness
Drugs/Diseases

Util A	Util B	Util C
Venetoclax		

Age Range: 0 – 17 yoa

References:
Venclexta Prescribing Information, April 2016, AbbVie Inc.
Clinical Pharmacology, 2017 Elsevier/Gold Standard.

54. Venetoclax / Therapeutic Appropriateness _____ _____

Alert Message: Based on its mechanism of action and findings in animals, Venclexta (venetoclax) may cause fetal harm when administered to a pregnant woman. Females of reproductive potential should undergo pregnancy testing before initiation of venetoclax and should be advised to use effective contraception during treatment with venetoclax and for at least 30 days after the last dose.

Conflict Code: TA - Therapeutic Appropriateness
Drugs/Diseases

Util A	Util B	Util C **(Negating)**
Venetoclax		Oral Contraceptives
		Injectable Contraceptives
		Transdermal Contraceptives
		Implantable Contraceptives

Gender: Female
Age Range: 11 – 50 yoa

References:
Venclexta Prescribing Information, April 2016, AbbVie Inc.
Clinical Pharmacology, 2017 Elsevier/Gold Standard.

55. Idelalisib / Overutilization _____ _____

Alert Message: The manufacturer's recommended maximum daily dose of Zydelig (idelalisib) is 150 mg twice daily.

Conflict Code: ER - Overutilization
Drugs/Diseases

Util A	Util B	Util C
Idelalisib		

Max Dose: 300 mg/day

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Zydelig Prescribing Information, September 2016. Gilead Sciences.

56. Idelalisib / Hepatic Impairment _____ _____

Alert Message: Fatal and/or serious hepatotoxicity occurred in 18% of patients treated with Zydelig (idelalisib) monotherapy and 11% of patients treated with idelalisib in combination trials. Monitor ALT and AST in all patients receiving idelalisib every 2 weeks for the first 3 months of treatment, every 4 weeks for the next 3 months, then every 1 to 3 months thereafter. Withhold idelalisib if the ALT and AST is greater than 5 times the upper limit of normal, and continue to monitor AST, ALT, and total bilirubin weekly until the abnormality it resolved.

Conflict Code: MC – Drug (Actual) Disease Precaution/Warning (Black Box Warning)
Drugs/Diseases

Util A	Util B	Util C
Idelalisib	Hepatic Impairment	

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Zydelig Prescribing Information, September 2016. Gilead Sciences.

57. Idelalisib / Diarrhea & Colitis _____ _____

Alert Message: Fatal and/or severe diarrhea or colitis occurred in 14% of patients treated with Zydelig (idelalisib) monotherapy and 19% of patients treated with idelalisib in combination trials. Diarrhea can occur at any time during idelalisib treatment. In case of severe diarrhea or colitis interrupt idelalisib therapy until problem is resolved then reinitiate therapy at a reduced dose of 100 mg twice a day. Discontinue idelalisib permanently in patients with life-threatening diarrhea.

Conflict Code: MC – Drug (Actual) Disease Precaution/Warning (Black Box Warning)
Drugs/Diseases

Util A	Util B	Util C
Idelalisib	Diarrhea	
	Colitis	

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Zydelig Prescribing Information, September 2016. Gilead Sciences.

58. Idelalisib / Pneumonitis _____ _____

Alert Message: Fatal and/or serious pneumonitis occurred in 4% of patients treated with Zydelig (idelalisib) in clinical trials. Monitor patient for pulmonary symptoms and bilateral interstitial infiltrates. If pneumonitis is suspected, interrupt idelalisib until etiology of pulmonary symptoms has been determined. Patients with pneumonitis thought to be caused by idelalisib have been treated with discontinuation of idelalisib and administration of corticosteroids.

Conflict Code: MC – Drug (Actual) Disease Precaution/Warning (Black Box Warning)
Drugs/Diseases

Util A	Util B	Util C
Idelalisib	Pneumonitis	

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Zydelig Prescribing Information, September 2016. Gilead Sciences.

59. Idelalisib / GI Perforation _____ _____

Alert Message: Fatal and/or serious intestinal perforation can occur in patients receiving Zydelig (idelalisib). At the time of perforation, some patients had moderate to severe diarrhea. Advise patients to promptly report any new or worsening abdominal pain, chills, fever, nausea, or vomiting. Discontinue idelalisib permanently in patients who experience intestinal perforation.

Conflict Code: MC – Drug (Actual) Disease Precaution/Warning (Black Box Warning)
Drugs/Diseases

Util A	Util B	Util C
Idelalisib	GI Perforation	

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Zydelig Prescribing Information, September 2016. Gilead Sciences.

60. Idelalisib / Neutropenia _____ _____

Alert Message: Treatment-emergent Grade 3 or 4 neutropenia occurred in 25% of patients treated with Zydelig (idelalisib) monotherapy and 46% of patients treated with idelalisib in combination trials. Monitor blood counts at least every 2 weeks for the first 6 months of therapy, and at least weekly in patients while neutrophil counts are less than 1.0 Gi/L.

Conflict Code: MC – Drug (Actual) Disease Precaution/Warning
Drugs/Diseases

Util A	Util B	Util C
Idelalisib	Neutropenia	

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Zydelig Prescribing Information, September 2016. Gilead Sciences.

61. Idelalisib / Therapeutic Appropriateness _____ _____

Alert Message: Based on findings in animals, Zydelig (idelalisib) may cause fetal harm when administered to a pregnant woman. If the drug is used during pregnancy, or if the patient becomes pregnant while taking the drugs, apprise the patient of the potential hazard to the fetus. Advise females of reproductive potential to avoid becoming pregnant while taking idelalisib and for 1 month after the last dose of idelalisib.

Conflict Code: TA – Therapeutic Appropriateness
Drugs/Diseases

Util A	Util B	Util C
Idelalisib		

Gender: Female
Age Range: 11 – 50 yoa

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Zydelig Prescribing Information, September 2016. Gilead Sciences.

62. Idelalisib / Strong CYP3A4 Inducers _____ _____

Alert Message: The concurrent use of Zydelig (idelalisib) with a strong CYP3A4 inducer should be avoided. Idelalisib is a CYP3A4 substrate and co-administration with a strong CYP3A4 inducer may result in a significant decrease in idelalisib exposure and loss of therapeutic effect.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Idelalisib	Phenytoin	
	Phenobarbital	
	Primidone	
	Carbamazepine	
	Rifampin	
	Rifapentine	
	Rifabutin	

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Zydelig Prescribing Information, September 2016. Gilead Sciences.

63. Idelalisib / Strong CYP3A4 Inhibitors _____ _____

Alert Message: The concurrent use of Zydelig (idelalisib), a CYP3A4 substrate, with a strong CYP3A4 inhibitor may result in increased idelalisib exposure and should be avoided. If concomitant use is warranted, monitor the patient for signs of idelalisib toxicity. Follow manufacturer recommended dose modifications for adverse reactions.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B		Util C
Idelalisib	Ketoconazole	Clarithromycin	
	Itraconazole	Atazanavir	
	Nefazodone	Saquinavir	
	Telithromycin	Ritonavir	
	Indinavir	Nelfinavir	
	Voriconazole	Cobicistat	
	Posaconazole		

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Zydelig Prescribing Information, September 2016. Gilead Sciences.

64. Cobicistat / Irinotecan / Atazanavir _____ _____

Alert Message: A review of recent pharmacy claims shows that the patient is receiving concurrent therapy with Tybost (cobicistat) and a drug that is contraindicated. Co-administration of cobicistat and the identified agent may result in serious and/or life-threatening events.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C **(Include)**
Cobicistat	Irinotecan	Atazanavir

References:
Tybost Prescribing Information, June 2016, Gilead Sciences, Inc.
Clinical Pharmacology, 2017, Elsevier/Gold Standard.

65. Cobicistat / Nevirapine / Atazanavir _____ _____

Alert Message: A review of recent pharmacy claims shows that the patient is receiving concurrent therapy with Tybost (cobicistat) and a drug that is contraindicated. Co-administration of cobicistat and the identified agent may result in serious and/or life-threatening events.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C **(Include)**
Cobicistat	Nevirapine	Atazanavir

References:
Tybost Prescribing Information, June 2016, Gilead Sciences, Inc.
Clinical Pharmacology, 2017, Elsevier/Gold Standard.

66. Cobicistat / Indinavir / Atazanavir _____ _____

Alert Message: A review of recent pharmacy claims shows that the patient is receiving concurrent therapy with Tybost (cobicistat) and a drug that is contraindicated. Co-administration of cobicistat and the identified agent may result in serious and/or life-threatening events.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C **(Include)**
Cobicistat	Indinavir	Atazanavir

References:
Tybost Prescribing Information, June 2016, Gilead Sciences, Inc.
Clinical Pharmacology, 2017, Elsevier/Gold Standard.

67. Elvitegravir / Other Antiretrovirals _____ _____

Alert Message: The patient appears to be receiving an INSTI-based ART regimen that is not recommended in treatment-naive patients. The recommended INSTI-based regimens for non-pregnant, adolescent and adults involving elvitegravir include: elvitegravir/cobicistat/tenofovir alafenamide/emtricitabine or elvitegravir/cobicistat/tenofovir disoproxil/emtricitabine.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B		Util C
Elvitegravir	Maraviroc	Atazanavir	
	Enfuvirtide	Darunavir	
	Delavirdine	Fosamprenavir	
	Efavirenz	Indinavir	
	Nevirapine	Nelfinavir	
	Rilpivirine	Ritonavir	
	Abacavir	Saquinavir	
	Didanosine	Tipranavir	
	Lamivudine		
	Stavudine		
	Zidovudine		

Age Range: ≥ 12 yoa

References:
Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the Use of Antiretroviral Agents in HIV-1 Infected Adults and Adolescents. Department of Health and Human Services. July 14, 2016.
Available at: http://www.aidsinfo.nih.gov/contentfiles/adultand adolescentgl.pdf.
Panel on Treatment of HIV-infected Pregnant Women and Prevention of Perinatal Transmission. Recommendations for Use of Antiretroviral Drugs in Pregnant HIV-Infected Women for Maternal Health and Interventions to Reduce Perinatal\HIV Transmission in the United States. March 28, 2014.
Available at: http://aidsinfor.nih.gov/contentfiels/PerinatalGL.pdf
Panel on Antiretroviral Therapy and Medical Management of HIV-Infected Children. Guidelines for the Use of Antiretroviral Agents in Pediatric HIV Infection. March 1, 2016.
Available at: http://aidsinfo.nih.gov/contentfiles/lvguidelines/pediatricguidelines.pdf

68. Dabigatran / Lovastatin & Simvastatin _____ _____

Alert Message: Concurrent use of Pradaxa (dabigatran), a P-gp substrate, with simvastatin or lovastatin, strong P-gp inhibitors, may result in increased dabigatran systemic exposure and risk of hemorrhage. Separating the timing of administration of the agents by at least 2 hours may mitigate this interaction. Another consideration is switching the patient to a statin that is not a strong P-gp inhibitor (e.g., atorvastatin, pravastatin, and rosuvastatin) to avoid the increased risk of hemorrhage.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Dabigatran	Lovastatin	
	Simvastatin	

References:
Clinical Pharmacology, 2016 Elsevier/Gold Standard.
Antoniou T, Macdonald EM, Yao Z, et al. Association Between Statin Use and Ischemic Stroke or Major Hemorrhage in Patients Taking Dabigatran for Atrial Fibrillation. *CMAJ* 2016; DOI:10.1503/cmaj.160303
Pradaxa Prescribing Information, Nov. 2015, Boehringer Ingelheim Pharmaceuticals, Inc.

69. ADHD Stimulants / Overutilization _____ _____

Alert Message: Caution is advised when stimulants are co-administered with serotonergic agents (e.g., SSRIs, SNRIs, and triptans). Concurrent use of these agents may result in potentially life-threatening serotonin syndrome (e.g., agitation, hallucinations, tachycardia, hyperthermia, hyperreflexia, nausea, and vomiting). If concomitant therapy is warranted, monitor the patient for signs and symptoms, particularly during initiation of therapy and dose increases.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B		Util C
Methylphenidate	SSRIs	Nefazodone	
Dexmethylphenidate	SNRIs	Mirtazapine	
Amphetamine	TCAs	Trazodone	
Dextroamphetamine	Triptans	Lithium	
Methamphetamine	Ergot Alkaloids	Meperidine	
Lisdexamfetamine	Buspirone	Fentanyl	
	Tramadol		

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Facts & Comparisons, 2017 Wolters Kluwer Health.

70. Cabozantinib / Therapeutic Appropriateness _____ _____

Alert Message: The safety and effectiveness of Cabometyx (cabozantinib) have not been established in pediatric patients.

Conflict Code: TA – Therapeutic Appropriateness
Drugs/Diseases

Util A	Util B	Util C
Cabozantinib Tabs		

Age Range: 0 – 17 yoa

References:
Cabometyx Prescribing Information, April 2016, Exelixis, Inc.
Clinical Pharmacology, 2017 Elsevier / Gold Standard.

71. Cabozantinib / Therapeutic Appropriateness _____ _____

Alert Message: Based on it mechanism of action, Cabometyx (cabozantinib) can cause fetal harm when administered to a pregnant woman. If used during pregnancy or if the patient becomes pregnancy while taking this drug, she should be apprised of the potential hazard to the fetus. Advise females of reproductive potential to use effective contraception during treatment with cabozantinib and for 4 months after the last dose.

Conflict Code: TA – Therapeutic Appropriateness
Drugs/Diseases

Util A	Util B	Util C
Cabozantinib Tabs		

Gender: Female
Age Range 11 – 50

References:
Cabometyx Prescribing Information, April 2016, Exelixis, Inc.
Clinical Pharmacology, 2017 Elsevier / Gold Standard.

72. Cabozantinib / Overuse _____ _____

Alert Message: Cabometyx (cabozantinib) may be over-utilized. The manufacturer's maximum recommended dose for a patient with renal cell carcinoma is 60 mg once daily.

Conflict Code: ER - Overutilization
Drugs/Diseases

Util A	Util B	Util C
Cabozantinib Tabs		

Max Dose: 60 mg/day

References:
Cabometyx Prescribing Information, April 2016, Exelixis, Inc.
Clinical Pharmacology, 2017 Elsevier / Gold Standard.

73. Cabozantinib / Hepatic Impairment _____ _____

Alert Message: Increased exposure to Cabometyx (cabozantinib) has been observed in patients with mild to moderate hepatic impairment. Reduce the cabozantinib dose in patients with mild (Child-Pugh score (C-P) A) or moderate (C-P B) hepatic impairment. Cabozantinib is not recommended for use in patients with severe hepatic impairment.

Conflict Code: TA – Therapeutic Appropriateness
Drugs/Diseases

Util A	Util B	Util C **(Include)**
Cabozantinib Tabs		Hepatic Impairment

References:
Cabometyx Prescribing Information, April 2016, Exelixis, Inc.
Clinical Pharmacology, 2017 Elsevier / Gold Standard.

74. Cabozantinib / GI Perforations / Fistulas _____ _____

Alert Message: Cabometyx (cabozantinib) has been shown to cause gastrointestinal (GI) perforations and fistulas in patients with renal cell carcinoma. Patients should be monitored for symptoms of fistulas and perforations. Cabozantinib therapy should be permanently discontinued in patients who experience a fistula which cannot be appropriately managed or a GI perforation.

Conflict Code: TA – Therapeutic Appropriateness
Drugs/Diseases

Util A	Util B	Util C
Cabozantinib Tabs	GI Perforation Fistulas	

References:
Cabometyx Prescribing Information, April 2016, Exelixis, Inc.
Clinical Pharmacology, 2017 Elsevier / Gold Standard.

75. Cabozantinib / Hemorrhage _____ _____

Alert Message: Serious and sometimes fatal hemorrhage has occurred with Cabometyx (cabozantinib) therapy. Do no administer cabozantinib to patients who have or are at risk for severe hemorrhage.

Conflict Code: TA – Therapeutic Appropriateness
Drugs/Diseases

Util A	Util B	Util C **(Include)**
Cabozantinib Tabs		GI Hemorrhage Subarachnoid Hemorrhage Intracerebral Hemorrhage Hemorrhage, unspecified

References:
Cabometyx Prescribing Information, April 2016, Exelixis, Inc.
Clinical Pharmacology, 2017 Elsevier / Gold Standard.

76. Cabozantinib / Thrombotic Events _____ _____

Alert Message: Cabometyx (cabozantinib) treatment results in an increased incidence of thrombotic events. Cabozantinib should be discontinued in patients who experience an acute myocardial infarction or other clinically significant arterial thromboembolic complication.

Conflict Code: TA – Therapeutic Appropriateness
Drugs/Diseases

Util A	Util B	Util C
Cabozantinib Tabs	Cerebral Thrombosis Arterial Thrombosis Venous Thrombosis	

References:
Cabometyx Prescribing Information, April 2016, Exelixis, Inc.
Clinical Pharmacology, 2017 Elsevier / Gold Standard.

77. Cabozantinib / CYP3A4 Inhibitors _____ _____

Alert Message: Concomitant use of Cabometyx (cabozantinib) with strong CYP3A4 inhibitors (e.g., ketoconazole and clarithromycin) may result in increased exposure of cabozantinib and may increase the risk of exposure-related toxicity. If concurrent use cannot be avoided, the dose of cabozantinib should be reduced by 20 mg. Resume the dose that was used prior to initiating the CYP3A4 inhibitor 2 to 3 days after discontinuation of the strong inhibitor.

Conflict Code: DD – Drug-Drug Interaction
Drugs/Diseases

Util A	Util B		Util C
Cabozantinib Tabs	Ketoconazole	Clarithromycin	
	Itraconazole	Atazanavir	
	Nefazodone	Saquinavir	
	Telithromycin	Ritonavir	
	Indinavir	Nelfinavir	
	Voriconazole	Cobicistat	
	Posaconazole		

References:
Cabometyx Prescribing Information, April 2016, Exelixis, Inc.
Clinical Pharmacology, 2017 Elsevier / Gold Standard.

78. Cabozantinib / CYP3A4 Inducers _____ _____

Alert Message: Concomitant use of Cabometyx (cabozantinib) with strong CYP3A4 inducers (e.g., phenytoin and carbamazepine) may result in decreased exposure of cabozantinib leading to reduced efficacy. If concurrent use cannot be avoided, the dose of cabozantinib should be increased by 20 mg (i.e., 60 mg to 80 mg daily or 40 mg to 60 mg daily) as tolerated but should not exceed 80 mg daily. Resume the cabozantinib dose that was used prior to initiating the inducer 2 to 3 days after inducer discontinuation.

Conflict Code: DD – Drug-Drug Interaction
Drugs/Diseases

Util A	Util B		Util C
Cabozantinib Tabs	Phenytoin	Carbamazepine	
	Rifampin	Rifabutin	
	Rifapentine	Phenobarbital	

References:
Cabometyx Prescribing Information, April 2016, Exelixis, Inc.
Clinical Pharmacology, 2017 Elsevier / Gold Standard.

79. Cabozantinib / Hypertension _____ _____

Alert Message: Patients taking Cabometyx (cabozantinib) show increased incidence of treatment-emergent hypertension. In a randomized trial, hypertension was reported in 37% of cabozantinib-treated patients as compared to 3.1 % of everolimus-treated patients. Blood pressure should be monitored prior to and throughout therapy. Cabozantinib should be discontinued if there is evidence of hypertensive crisis or severe hypertension that cannot be controlled with anti-hypertensive therapy.

Conflict Code: DB – Drug-Drug Marker and/or Diagnosis
Drugs/Diseases

Util A	Util B	Util C
Cabozantinib Tabs	Hypertension	
	Anti-Hypertensive Drugs	

References:
Cabometyx Prescribing Information, April 2016, Exelixis, Inc.
Clinical Pharmacology, 2017 Elsevier / Gold Standard.

80. Cabozantinib / Palmar-Plantar Erythrodysesthesia Syndrome _____ _____

Alert Message: Palmar-plantar erythrodysesthesia syndrome (PPES) has been reported in patients treated with Cabometyx (cabozantinib). Cabozantinib should be withheld in patients who develop intolerable Grade 2 PPES or Grade 3 PPES until improvement to Grade 1, at which time cabozantinib therapy can resume at a reduced dose.

Conflict Code: MC – Drug/Diagnosis Precaution/Warning/Contraindication
Drugs/Diseases

Util A	Util B	Util C
Cabozantinib Tabs	Palmar-Plantar Erythrodysesthesia Syndrome	

References:
Cabometyx Prescribing Information, April 2016, Exelixis, Inc.
Clinical Pharmacology, 2017 Elsevier / Gold Standard.

81. Cabozantinib / Proteinuria _____ _____

Alert Message: In clinical trials, proteinuria was observed in 2% of patients receiving Cabometyx (cabozantinib) as compared to < 1 % of patient receiving everolimus. Cabozantinib should be discontinued in patients who develop nephrotic syndrome.

Conflict Code: MC – Drug/Diagnosis Precaution/Warning/Contraindication
Drugs/Diseases

Util A	Util B	Util C
Cabozantinib Tabs	Proteinuria	
	Nephrotic Syndrome	

References:
Cabometyx Prescribing Information, April 2016, Exelixis, Inc.
Clinical Pharmacology, 2017 Elsevier / Gold Standard.

82. Cabozantinib / Reversible Posterior Leukoencephalopathy Syndrome _____ _____

Alert Message: Reversible Posterior Leukoencephalopathy Syndrome (RPLS) has been reported with Cabometyx (cabozantinib) treatment. An evaluation for RPLS should be performed in any patient presenting with seizures, headaches, visual disturbances, confusion or altered mental function. Cabozantinib should be discontinued if RPLS develops.

Conflict Code: MC – Drug/Diagnosis Precaution/Warning/Contraindication
Drugs/Diseases

Util A	Util B	Util C
Cabozantinib Tabs	Seizures	
	Headache	
	Visual Disturbances	
	Confusion	
	Altered Mental Function	

References:
Cabometyx Prescribing Information, April 2016, Exelixis, Inc.
Clinical Pharmacology, 2017 Elsevier / Gold Standard.

83. Ivacaftor / Overutilization (≥ 6 yoa) _____ _____
Alert Message: The recommended daily dose of Kalydeco (ivacaftor) for patients 6 years of age and older is 150 mg taken every 12 hours (300 mg total daily dose).

Conflict Code: ER - Overutilization
Drugs/Diseases

Util A	Util B	Util C **(Negating)**
Ivacaftor		Hepatic Impairment

Age Range: ≥ 6 yoa
Max Dose: 300 mg/day

References:
Clinical Pharmacology, 2016 Elsevier/Gold Standard.
Kalydeco Prescribing Information, Feb. 2017, Vertex Pharmaceuticals Inc.

84. Ivacaftor / Overutilization- (2 – 5 yoa) _____ _____
Alert Message: The recommended daily dose of Kalydeco (ivacaftor) for patients ages 2 to less than 6 years of age is weight-based. Patients weighing less than 14 kg should receive one 50 mg ivacaftor packet every 12 hours (100 mg total daily dose). Patients weighing 14 kg or more should receive one 75 mg ivacaftor packet every 12 hours (150 mg total daily dose).

Conflict Code: ER - Overutilization
Drugs/Diseases

Util A	Util B	Util C **(Negating)**
Ivacaftor		Hepatic Impairment

Age Range: 2 - 5 yoa
Max Dose: 150 mg/day

References:
Clinical Pharmacology, 2016 Elsevier/Gold Standard.
Kalydeco Prescribing Information, Feb. 2017, Vertex Pharmaceuticals Inc.

85. Ivacaftor / Therapeutic Appropriateness _____ _____
Alert Message: The safety and efficacy of Kalydeco (ivacaftor) in patients with cystic fibrosis younger than 2 years of age have not been studied and use is not recommended in this patient population.

Conflict Code: TA - Therapeutic Appropriateness
Drugs/Diseases

Util A	Util B	Util C
Ivacaftor		

Age Range: 0 - 1 yoa

References:
Clinical Pharmacology, 2016 Elsevier/Gold Standard.
Kalydeco Prescribing Information, Feb. 2017, Vertex Pharmaceuticals Inc.

86. Ivacaftor / Overutilization – Hepatic Impairment (≥ 6 yoa) _____ _____

Alert Message: Kalydeco (ivacaftor) may be over-utilized. The daily dose of ivacaftor should be reduced to one tablet or one packet once daily for patients with moderate hepatic impairment. Ivacaftor should be used with caution in patients with severe hepatic impairment at a dose of one tablet or one packet once daily or less frequently. No dose adjustment is necessary in mild hepatic impairment.

Conflict Code: ER - Overutilization
Drugs/Diseases

Util A	Util B	Util C **(Include)**
Ivacaftor		Hepatic Impairment

Age Range: ≥ 6 yoa
Max Dose: 150 mg/day

References:
Clinical Pharmacology, 2016 Elsevier/Gold Standard.
Kalydeco Prescribing Information, Feb. 2017, Vertex Pharmaceuticals Inc.

87. Ivacaftor / Overutilization – Hepatic Impairment (2 - 5 yoa) _____ _____

Alert Message: Kalydeco (ivacaftor) may be over-utilized. The daily dose of ivacaftor for patients 2 to less than 6 years of age with moderate hepatic impairment is as follows: one 50 mg packet once daily for patients weighing less than 14 kg or one 75 mg packet once daily for patients weighing 14 kg or more. For patients with severe hepatic impairment use the same dose reduction according to weight once daily or less frequently than once daily. No dose adjustment is necessary in mild hepatic impairment.

Conflict Code: ER - Overutilization
Drugs/Diseases

Util A	Util B	Util C **(Include)**
Ivacaftor		Hepatic Impairment

Age Range: 2 - 5 yoa
Max Dose: 75 mg/day

References:
Clinical Pharmacology, 2016 Elsevier/Gold Standard.
Kalydeco Prescribing Information, Feb. 2017, Vertex Pharmaceuticals Inc.

88. Ivacaftor / Strong CYP3A4 Inducers _____ _____

Alert Message: Concurrent use of Kalydeco (ivacaftor) with strong CYP3A4 inducers is not recommended. Ivacaftor is a sensitive CYP3A4 substrate and concomitant administration with a strong inducer may substantially decrease ivacaftor exposure, reducing its therapeutic effectiveness.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B		Util C
Ivacaftor	Phenytoin	Rifabutin	
	Phenobarbital	Rifapentine	
	Primidone	Rifampin	
	Carbamazepine		

References:
Clinical Pharmacology, 2016 Elsevier/Gold Standard.
Kalydeco Prescribing Information, Feb. 2017, Vertex Pharmaceuticals Inc.

89. Ivacaftor / Strong CYP3A4 Inhibitors (≥ 6 yoa) _____ _____

Alert Message: Concurrent use of Kalydeco (ivacaftor), a sensitive CYP3A4 substrate, with a strong CYP3A4 inhibitor may result in significantly elevated ivacaftor exposure. In patients 6 years and older it is recommended that the dose of ivacaftor be reduced to one 150 mg tablet twice a week during concomitant therapy with a strong CYP3A4 inhibitor.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C **(Include)**	
Ivacaftor		Nefazodone	Saquinavir
		Clarithromycin	Ritonavir
		Telithromycin	Nelfinavir
		Ketoconazole	Indinavir
		Itraconazole	Cobicistat
		Voriconazole	Idelalisib
		Posaconazole	

Age Range: 6 – 999 yoa
Max Dose: 300 mg/week

References:
Clinical Pharmacology, 2016 Elsevier/Gold Standard.
Kalydeco Prescribing Information, Feb. 2017, Vertex Pharmaceuticals Inc.

90. Ivacaftor / Strong CYP3A4 Inhibitors (2 – 5 yoa) _____ _____

Alert Message: Concurrent use of Kalydeco (ivacaftor), a sensitive CYP3A4 substrate, with a strong CYP3A4 inhibitor may result in significantly elevated ivacaftor exposure. In patients 2 to less than 6 years of age it is recommended that the daily dose of ivacaftor be reduced as follows: 2 to 6 years of age weighing < 14 kg reduce the dose to one 50 mg packet twice a week and for patients 2 to less than 6 years of age weighing 14 kg or more, reduce the dose to one 75 mg packet twice a week.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C **(Include)**	
Ivacaftor		Nefazodone	Saquinavir
		Clarithromycin	Ritonavir
		Telithromycin	Nelfinavir
		Ketoconazole	Indinavir
		Itraconazole	Cobicistat
		Voriconazole	Idelalisib
		Posaconazole	

Age Range: 2 - 5 yoa
Max Dose: 150 mg/week
References:
Clinical Pharmacology, 2016 Elsevier/Gold Standard.
Kalydeco Prescribing Information, Feb. 2017, Vertex Pharmaceuticals Inc.

91. Ivacaftor / Moderate CYP3A4 Inhibitors (2 – 5 yoa) _____ _____

Alert Message: Concurrent use of Kalydeco (ivacaftor), a sensitive CYP3A4 substrate, with a moderate CYP3A4 inhibitor may result in significantly elevated ivacaftor exposure. In patients 2 to less than 6 years of age it is recommended that the dose of ivacaftor be reduced as follows: one 50 mg packet once daily in patients weighing less than 14 kg and for patients weighing 14 kg or more, reduce dose to one 75 mg packet once daily.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C **(Include)**	
Ivacaftor		Aprepitant	Erythromycin
		Cimetidine	Fluconazole
		Ciprofloxacin	Fluvoxamine
		Crizotinib	Imatinib
		Cyclosporine	Verapamil
		Diltiazem	Dronedarone

Age Range: 2 - 5 yoa
Max Dose: 300 mg/week

References:
Clinical Pharmacology, 2016 Elsevier/Gold Standard.
Kalydeco Prescribing Information, Feb. 2017, Vertex Pharmaceuticals Inc.

92. Ivacaftor / Sensitive CYP3A4 or P-gp Substrate _____ _____

Alert Message: Concurrent use of Kalydeco (ivacaftor), a CYP3A4 and P-gp inhibitor, with a sensitive CYP3A4 and/or P-gp substrate may result in increased substrate exposure which may potentiate or prolong the therapeutic effect and adverse events. Appropriate monitoring is recommended when co-administering these agents.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Ivacaftor	Cyclosporine	
	Digoxin	
	Tacrolimus	

References:
Clinical Pharmacology, 2016 Elsevier/Gold Standard.
Kalydeco Prescribing Information, Feb. 2017, Vertex Pharmaceuticals Inc.

93. Ivacaftor / Nonadherence _____ _____

Alert Message: Based on refill history, your patient may be under-utilizing Kalydeco (ivacaftor). Nonadherence to the prescribed dosing regimen may result in sub-therapeutic effects, which may lead to decreased patient outcomes and additional healthcare costs.

Conflict Code: LR - Nonadherence
Drugs/Diseases

Util A	Util B	Util C
Ivacaftor		

References:
Clinical Pharmacology, 2016 Elsevier/Gold Standard.
Osterberg L, Blaschke T. Adherence to Medication. N Engl J Med 2005; 353:487- 497.
Eakin MN, Bilderback A, Boyle MP, Mogayzel PJ, Riekert KA. Longitudinal Association Between Medication Adherence and Lung Health in People with Cystic Fibrosis. Jrnl Cyst Fib. 2011;10(4):258-264.
Bishay LC, Sawicki. Strategies to Optimize Treatment Adherence in Adolescent Patients with Cystic Fibrosis. Adolesc Health, Med & Ther. 2016 Oct 21;7:117-124.
Bishay LC, Sawicki GS., Strategies to Optimize Adherence in Adolescent Patients with Cystic Fibrosis. Adolesc Health, Med & Ther. 2016 Oct 21;7:117-124.

94. Lisdexamfetamine / Therapeutic Appropriateness _____ _____

Alert Message: The safety and effectiveness of Vyvanse (lisdexamfetamine) for the treatment of moderate to severe Binge Eating Disorder (BED) in patients less than 18 years of age have not been established.

Conflict Code: TA – therapeutic Appropriateness
Drugs/Diseases

Util A	Util B	Util C **(Negate)**
Lisdexamfetamine	Binge Eating Disorder	ADHD

Age Range: < 18 years of age

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Facts & Comparisons, 2017 Wolters Kluwer Health.

95. Evotaz / Overutilization _____ _____

Alert Message: Evotaz (atazanavir/cobicistat) is not recommended for use in treatment-experienced patients with end-stage renal disease managed with hemodialysis.

Conflict Code: TA – therapeutic Appropriateness
Drugs/Diseases

Util A	Util B	Util C
Atazanavir/Cobicistat	CKD Stage 4 & 5 ESRD Hemodialysis	

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Evotaz Prescribing Information, Jan 2017, Bristol-Myers Squibb.

96. Olaparib / Overutilization _____ _____

Alert Message: The manufacturer's recommended daily dose of Lynparza (olaparib) in patients with moderate renal impairment (CLcr 31 - 50 mL/min) is 300 mg (six 50 mg capsules) taken twice daily, for a total daily dose of 600 mg. No dosage adjustment is recommended in mild renal impairment (CLcr 51 - 80 mL/min). The pharmacokinetics of olaparib have not been evaluated in patients with severe renal impairment or end-stage renal disease (CLcr </= 30 mL/min).

Conflict Code: ER - Overutilization
Drugs/Diseases

Util A	Util B	Util C **(Include)**
Olaparib		CKD 3, 4 & 5 ESRD

Max Dose: 600 mg/day

References:
Lynparza Prescribing Information, Dec. 2017, AstraZeneca.
Clinical Pharmacology, 2017 Elsevier/Gold Standard.

97. Terbinafine / Hepatic Impairment _____ _____

Alert Message: Oral terbinafine is contraindicated in patients with chronic or active hepatic disease. Cases of liver failure, some leading to liver transplant or death, have occurred with the use of terbinafine in individuals with and without preexisting liver disease. Perform liver function test prior to initiation of therapy and periodically thereafter. Discontinue terbinafine if liver injury develops.

Conflict Code: TA – Therapeutic Appropriateness
Drugs/Diseases

Util A	Util B	Util C **(Include)**
Terbinafine		Hepatic Impairment

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Facts & Comparisons, 2017 Wolters Kluwer Health.

98. Lurasidone / Overutilization Bipolar Depression _____ _____

Alert Message: Latuda (lurasidone) may be over-utilized. The manufacturer's recommended maximum dose, for the treatment of bipolar depression in adults, is 120 mg once daily. Exceeding the recommended dose may increase the risk of adverse effects (e.g., akathisia, somnolence, and dystonia).

Conflict Code: ER - Overutilization
Drugs/Diseases

Util A	Util B	Util C **(Negating)**
Lurasidone		CKD 3, 4 & 5
		Hepatic Impairment
		Mod CYP3A4 Inhibitors
		Schizophrenia

Age Range: ≥ 18 years of age
Max Dose: 120 mg/day

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Facts & Comparisons, 2017 Wolters Kluwer Health.
Latuda Prescribing Information, Feb. 2017, Sunovion Pharma, Inc.

99. Lurasidone / Overutilization (13 – 17 yoa) _____ _____

Alert Message: Latuda (lurasidone) may be over-utilized. The manufacturer's recommended maximum dose, for the treatment of schizophrenia in adolescents 13 to 17 years of age, is 80 mg once daily. Exceeding the recommended dose may increase the risk of adverse effects (e.g., akathisia, somnolence, and dystonia).

Conflict Code: ER - Overutilization
Drugs/Diseases

Util A	Util B	Util C
Lurasidone		

Age Range: 13 - 17 years of age
Max Dose: 80 mg/day

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Facts & Comparisons, 2017 Wolters Kluwer Health.
Latuda Prescribing Information, Feb. 2017, Sunovion Pharma, Inc.

100. Hydroxychloroquine / Digoxin _____ _____

Alert Message: Concurrent use of hydroxychloroquine with digoxin may result in increased serum digoxin levels. Serum digoxin levels should be closely monitored in patients receiving combination therapy.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Hydroxychloroquine	Digoxin	

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Plaquenil Prescribing Information, Jan. 2017, Concordia Pharmaceuticals Inc.

101. Hydroxychloroquine / Antidiabetic Medications _____ _____

Alert Message: Hydroxychloroquine can cause hypoglycemia and concurrent use with insulin or antidiabetic agents may enhance the effects of the hypoglycemic therapy. A decrease in the doses of insulin or antidiabetic agent may be required.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Hydroxychloroquine	Antidiabetic Agents	

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Plaquenil Prescribing Information, Jan. 2017, Concordia Pharmaceuticals Inc.

102. Metronidazole / Disulfiram _____ _____

Alert Message: The use of disulfiram with or within 2 weeks of metronidazole-containing agent is contraindicated due to the risk of CNS toxicity (e.g., acute psychosis and confusion).

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Metronidazole	Disulfiram	

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Facts & Comparisons, 2017 Wolters Kluwer Health.

103. Pylera / Severe Renal Disease _____ _____

Alert Message: The use of Pylera (bismuth/metronidazole/tetracycline) is contraindicated In patients with severe renal impairment. The antianabolic action of the tetracycline component of the combination product may cause an increase in blood urea nitrogen (BUN). In patients with significant impaired renal function, higher serum concentrations of tetracycline may lead to azotemia, hyperphosphatemia, and acidosis.

Conflict Code: TA – Therapeutic Appropriateness
Drugs/Diseases

Util A	Util B	Util C (Include)
Pylera		CKD Stage 4 & 5

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Pylera Prescribing Information, Jan. 2017, Apralis Pharm US, Inc.

104. Repaglinide / Cyclosporine _____ _____

Alert Message: Concurrent use of repaglinide with cyclosporine may significantly increase repaglinide exposure. The repaglinide total daily dose should not exceed 6 mg if these agents are co-administered. Repaglinide is a substrate of enzyme CYP3A4 and OATP1B1 transport protein and cyclosporine inhibits CYP3A4 and OATP1B1.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C **(Include)**
Repaglinide		Cyclosporine

Max Dose: 6 mg

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Prandin Prescribing Information, Feb. 2017, Novo Nordisk.

105. Repaglinide / Clopidogrel _____ _____

Alert Message: Concurrent use of repaglinide with clopidogrel may significantly increase repaglinide exposure and should be avoided. If co-administration cannot be avoided the total daily dose of repaglinide should not exceed 4 mg. Repaglinide is a substrate of enzyme CYP2C8 and clopidogrel is a strong CYP2C8 inhibitor.

Conflict Code: ER - Overutilization
Drugs/Diseases

Util A	Util B	Util C **(Include)**
Repaglinide		Clopidogrel

Max Dose: 4mg/day

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Prandin Prescribing Information, Feb. 2017, Novo Nordisk.
Micromedex Solutions, DrugDex Drug Evaluations, 2017 Truven Health Analytics.

106. Repaglinide - All / CYP3A4 & CYP2C8 Inhibitors _____ _____

Alert Message: Concurrent use of a repaglinide-containing agent with a CYP3A4 or CYP2C8 inhibitor may significantly increase repaglinide exposure. Repaglinide is a substrate of CYP3A4 and CYP2C8. Dosage reduction of the repaglinide-containing agent may be required as well as increased frequency of glucose monitoring.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B				Util C
Repaglinide - all	Montelukast	Voriconazole	Atazanavir	Fluconazole	
	Phenelzine	Posaconazole	Aprepitant	Fluvoxamine	
	Nefazodone	Saquinavir	Crizotinib	Imatinib	
	Clarithromycin	Ritonavir	Cyclosporine	Verapamil	
	Telithromycin	Indinavir	Diltiazem		
	Ketoconazole	Nelfinavir	Dronedarone		
	Itraconazole	Cobicistat	Erythromycin		

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Facts & Comparisons, 2017 Wolters Kluwer Health.

107. Osimertinib / BCRP Substrates _____ _____

Alert Message: Concurrent use of the BCRP inhibitor, Tagrisso (osimertinib), with a BCRP substrate may result in increased exposure to the BCRP substrate and risk of exposure-related toxicity. Monitor patient for adverse reactions associated with the BCRP substrate.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Osimertinib	Rosuvastatin	
	Sulfasalazine	
	Topotecan	
	Tenofovir	
	Prazosin	
	Dantrolene	

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Tagrisso Prescribing Information, Sept. 2016, AstraZeneca.

108. Tiotropium / Therapeutic Appropriateness _____ _____

Alert Message: The safety and effectiveness of Spiriva Handihaler (tiotropium inhalation powder) have not been established in children.

Conflict Code: TA - Therapeutic Appropriateness
Drugs/Diseases

Util A	Util B	Util C
Tiotropium		

Age Range: 0-17 yoa

References:
Spiriva Prescribing Information, Dec. 2015, Boehringer Ingelheim Pharmaceuticals, Inc.
Clinical Pharmacology, 2017 Elsevier/Gold Standard.

109. Tiotropium / Therapeutic Appropriateness _____ _____

Alert Message: The safety and effectiveness of Spiriva Respimat (tiotropium inhalation spray) for the treatment of asthma in children less than 6 years of age have not been established.

Conflict Code: TA - Therapeutic Appropriateness
Drugs/Diseases

Util A	Util B	Util C
Tiotropium		

Age Range: 0-5 yoa

References:
Spiriva Respimat Prescribing Information, Feb. 2017, Boehringer Ingelheim Pharmaceuticals, Inc.
Clinical Pharmacology, 2017 Elsevier/Gold Standard.

DUR Board Meeting
September 6, 2017
Brynhild Haugland Room
State Capitol

North Dakota Medicaid
DUR Board Meeting Agenda
Brynhild Haugland Room
State Capitol
600 East Boulevard Avenue
Bismarck, ND
September 6, 2017
1:00 pm

1. Administrative items
    - Travel vouchers

2. Old business
    - Review and approval of 06/2017 meeting minutes
    - Budget update
    - Sanford Update
    - Review top 15 therapeutic categories/top 25 drugs
    - Second review of Proglycem
    - Second review of Biltricide
    - Prior authorization/PDL update

3. New business
    - Review of Juxtapid and Kynamro
    - Review of Procysbi
    - Review of Miacalcin
    - Review of Tymlos
    - Review of Tardive Dyskinesia: Ingrezza, Austedo
    - Review of Jadenu
    - Review of opioid analgesic and benzodiazepine utilization
    - Review of physician prescribing patterns for select therapeutic categories
    - Review of historic stimulant utilization patterns
    - Criteria recommendations
    - Upcoming meeting date/agenda

4. Adjourn

Please remember to silence all cellular phones during the meeting.

Drug Utilization Review (DUR) Meeting Minutes

June 7, 2017

Members Present: Tanya Schmidt, Laura Schield, Jeffrey Hostetter, Michael Quast, Gaylord Kavlie, Katie Kram, Wendy Brown, Zach Marty, LeNeika Roehrich, Andrea Honeyman, Carlotta McCleary,

Members Absent: Michael Booth, Peter Woodrow

Medicaid Pharmacy Department: Brendan Joyce, Alexi Murphy, Gary Betting

Old Business

Chair W. Brown called the meeting to order at 1:00 p.m. Chair W. Brown asked for a motion to approve the minutes of the March meeting. G. Kavlie moved that the minutes be approved and K. Kram seconded the motion. Chair W. Brown called for a voice vote to approve the minutes. The motion passed with no audible dissent.

Review Top 15 Therapeutic Categories/Top 25 Drugs

B. Joyce presented the quarterly review of the top 15 therapeutic classes by total cost of claims, top 25 drugs based on number of claims, and top 25 drugs based on claims cost for the 1st quarter of 2017.

PDL Update

A. Murphy gave an update on drugs that have been added to prior authorization. Adenovate 3000 unit and Ixinity were added to the antihemophelia criteria. Airduo Respiclick and fluticasone/salmeterol were added to the steroid Beta2 agonist criteria. Xultophy was added to the GLP-1 criteria. Trulance was added to the IBS/Constipation criteria. Synjardy was added to the SGTL2 Inhibitors criteria. Siliq was added to the cytokine modulators criteria. Migergot was added to the DHE criteria. Arymo ER was added to the narcotics criteria. Austedo, Dupixent, Emflaza, Esbriet, Ingrexxa, and Ocaliva were added to the medications >$3,000 criteria. Defitelio, Lemtrada, Lucentis, Ocrevus, Quadramet, and Tysarbi were added to the Medical Billing Only list of medications. Xenical was removed from the list of covered medications by North Dakota Medicaid.

New Business

Proglycem

T. DeRuiter and B. Joyce reviewed Proglycem with the Board. A motion was made by J. Hostetter to manage the class through prior authorization. The motion was seconded by G. Kavlie. This topic will be reviewed at the next meeting.

Biltricide

T. DeRuiter and B. Joyce reviewed Biltricide with the Board. A motion was made by J. Hostetter to manage the class through prior authorization. The motion was seconded by G. Kavlie. This topic will be reviewed at the next meeting.

Physician Prescribing Patterns for Select Therapeutic Categories

B. Joyce presented data showing the top prescriber utilization of select medications in therapeutic drug classes as well as the top prescribers with patients on multiple medications within the selected classes of medications, in order to evaluate utilization trends and potential outliers. Therapeutic classes evaluated included antidepressants, antipsychotics, and stimulants for ADHD. Prescriber utilization was presented both in terms of number of prescriptions for and/or patients on select medications in the first quarter and in terms of percent utilization of selected medications within their therapeutic class in the first quarter. The board discussed the value and limitations of the data, as well as potential drug classes and topics to present at future DUR board meetings.

Review of Antidepressant Non-compliance

B. Joyce presented data demonstrating antidepressant underutilization before and after an educational RDUR intervention letter was sent to prescribers, which showed a significant reduction in underutilization after letters were sent. This topic will continue to be evaluated eith interventions sent in future RDUR review cycles.

Criteria Recommendations

The recommended RDUR criteria enclosed in the packet were developed from product information provided by the manufacturers and are usually consistent with new indications, new drugs added, and new warnings. These proposed criteria will be added to the current set of criteria and will be used in future DUR cycles. G. Kavlie moved to approve the new criteria and Z. Marty seconded the motion. W. Brown called for a voice vote. The motion passed with no audible dissent.

The next DUR Board meeting will be held September 6, 2017 at the Capitol in the Brynhild Haugland room in Bismarck. W. Brown adjourned the meeting.

Medicaid Expansion

Top Line Performance Metrics

- Generic Fill Rate (GFR) increased 0.2 percentage points to 85.9%

	Medicaid Expansion			Medicaid - Ages 35-65	
Description	2016	2015	Change	2016	Change
Avg Members per Month	19,506	18,536	5.2%	49.2	-0.2%
Number of Unique Patients	19,936	18,403	8.3%	3.05	0.5%
Pct Members Utilizing Benefit	102.2%	99.3%	2.9	86.0%	0.2
Total Days	10,232,075	8,924,000	14.7%	0.4%	0.0
Total Adjusted Rxs	416,988	369,276	12.9%	0.8%	-0.1
Average Member Age	38.9	38.7	0.5%	38.4%	0.9
Nbr Adjusted Rxs PMPM	1.78	1.66	7.3%	98.8%	0.1
Generic Fill Rate	85.9%	85.7%	0.2		
Home Delivery Utilization	0.0%	0.0%	0.0		
Member Cost %	0.3%	0.3%	0.0		
Specialty Percent of Plan Cost	26.5%	33.3%	-6.9		
Formulary Compliance Rate	98.8%	98.1%	0.6		

Key Statistics: Specialty Detailed

- Plan Cost PMPM trend on specialty drugs is -19.9%, compared to a 11.2% Plan Cost PMPM trend on non-specialty drugs
- There are 484 unique specialty patients, an increase of 61 specialty patients over the previous period

	Medicaid Expansion					
	Non-Specialty			Specialty		
Description	2016	2015	Change	2016	2015	Change
Avg Members per Month	19,506	18,536	5.2%	19,506	18,536	5.2%
Number of Unique Patients	19,918	18,381	8.4%	484	423	14.4%
Pct Members Utilizing Benefit	102.1%	99.2%	2.9	2.5%	2.3%	0.2
Total Days	10,168,021	8,869,438	14.6%	64,054	54,562	17.4%
Total Adjusted Rxs	414,627	367,255	12.9%	2,361	2,021	16.8%
Percent of Total Adjusted Rxs	99.43%	99.45%	0.0	0.57%	0.55%	0.0
Nbr Adjusted Rxs PMPM	1.77	1.65	7.3%	0.01	0.009	11.0%
Generic Fill Rate	86.2%	86.0%	0.2	34.3%	36.2%	-1.9
Member Cost %	0.4%	0.4%	0.0	0.0%	0.0%	0.0

Medicaid - Ages 35-65	
2016	Change
0.03	-4.2%
21.4%	-0.4
0.1%	0.0

Top 10 Indications

- The largest trend is in Inflammatory Conditions at 71.5%

REPRESENT

70.4%

OF YOUR TOTAL PLAN COST

Top Indications by Plan Cost

2016							2015			
Rank	Peer Rank	Indication	Adjusted Rxs	Patients	Generic Fill Rate	Peer Generic Fill Rate	Rank	Adjusted Rxs	Patients	Generic Fill Rate
1	1	DIABETES	30,563	2,501	37.1%	42.8%	2	25,720	2,222	38.3%
2	2	HEPATITIS C	224	47	34.8%	19.3%	1	412	89	38.8%
3	4	PAIN/INFLAMMATION	66,972	10,524	94.1%	97.0%	3	62,124	9,858	93.5%
4	6	INFLAMMATORY CONDITIONS	982	213	30.7%	24.9%	5	654	140	30.7%
5	8	MENTAL/NEURO DISORDERS	9,523	1,658	88.5%	91.3%	4	7,839	1,463	80.8%
6	7	ASTHMA	15,420	3,323	24.2%	26.2%	6	13,276	3,102	22.1%
7	9	MULTIPLE SCLEROSIS	208	29	7.2%	2.6%	8	181	27	0.6%
8	17	DEPRESSION	42,130	6,787	97.0%	98.1%	7	36,651	6,152	96.5%
9	21	ATTENTION DISORDERS	6,717	1,029	71.8%	68.2%	9	6,084	961	73.7%
10	3	HIV	520	67	1.3%	4.8%	11	375	53	3.7%
		Total Top 10:	**173,259**		**76.6%**			**153,316**		**76.6%**
		Differences Between Periods:	**19,943**		**0.0%**					

Peer = Express Scripts Peer 'Medicaid - Ages 35-65' market segment

Top 25 Drugs

- Represent 42.1% of your total Plan Cost and comprise 12 indications
- 8 of your top 25 are specialty drugs

Top Drugs by Plan Cost								
				2016		2015		
Rank	Peer Rank	Brand Name	Indication	Adj. Rxs	Pts.	Prev Rank	Adj. Rxs	Pts.
1	34	NOVOLOG FLEXPEN	DIABETES	3,003	650	4	2,409	551
2	6	SOVALDI*	HEPATITIS C	45	13	1	103	29
3	3	HUMIRA PEN*	INFLAMMATORY CONDITIONS	256	60	7	186	34
4	11	VIEKIRA PAK*	HEPATITIS C	35	15	2	75	30
5	12	LYRICA	PAIN/INFLAMMATION	2,479	511	6	2,186	441
6	36	LEVEMIR FLEXTOUCH	DIABETES	2,118	457	5	1,868	379
7	2	LANTUS SOLOSTAR	DIABETES	1,839	402	8	1,780	395
8	10	ARIPIPRAZOLE	MENTAL/NEURO DISORDERS	1,902	408	9	1,008	271
9	28	DAKLINZA*	HEPATITIS C	25	6	15	14	5
10	4	ADVAIR DISKUS	ASTHMA	1,519	420	10	1,557	435
11	7	ENBREL*	INFLAMMATORY CONDITIONS	111	25	42	47	14
12	23	LATUDA	MENTAL/NEURO DISORDERS	470	114	17	313	87
13	14	SYMBICORT	ASTHMA	1,408	374	16	1,147	335
14	31	VICTOZA 3-PAK	DIABETES	556	114	25	356	81
15	19	ZEPATIER*	HEPATITIS C	20	9			
16	17	ONETOUCH ULTRA TEST STRIPS	DIAGNOSTIC AIDS	3,199	812	14	2,940	799
17	33	EPCLUSA*	HEPATITIS C	13	7			
18	123	VYVANSE	ATTENTION DISORDERS	1,342	251	19	1,182	230
19	55	XIFAXAN	GI DISORDERS	180	59	39	109	47
20	8	JANUVIA	DIABETES	859	158	27	666	138
21	5	SUBOXONE	CHEMICAL DEPENDENCE	947	120	35	526	68
22	130	NOVOLOG	DIABETES	782	158	24	624	138
23	22	SPIRIVA	COPD	941	201	20	914	218
24	16	COPAXONE*	MULTIPLE SCLEROSIS	48	11	18	55	9
25	45	GABAPENTIN	PAIN/INFLAMMATION	12,303	2,352	12	9,880	1,981
			Total Top 25:	36,400			29,945	
			Differences Between Periods:	6,455				

*Specialty Drugs

Peer = Express Scripts Peer 'Medicaid - Ages 35-65' market segment

Top 25 Specialty Drugs

- Represent 23.4% of your total Plan Cost and comprise 9 indications

Top Specialty Drugs by Plan Cost								
				2016		2015		
Overall Rank	Overall Peer Rank	Brand Name	Indication	Adj. Rxs	Pts.	Overall Rank	Adj. Rxs	Pts.
2	6	SOVALDI	HEPATITIS C	45	13	1	103	29
3	3	HUMIRA PEN	INFLAMMATORY CONDITIONS	256	60	7	186	34
4	11	VIEKIRA PAK	HEPATITIS C	35	15	2	75	30
9	28	DAKLINZA	HEPATITIS C	25	6	15	14	5
11	7	ENBREL	INFLAMMATORY CONDITIONS	111	25	42	47	14
15	19	ZEPATIER	HEPATITIS C	20	9			
17	33	EPCLUSA	HEPATITIS C	13	7			
24	16	COPAXONE	MULTIPLE SCLEROSIS	48	11	18	55	9
26	1	HARVONI	HEPATITIS C	8	3	3	55	29
34	51	GILENYA	MULTIPLE SCLEROSIS	31	5	45	22	4
35	100	AUBAGIO	MULTIPLE SCLEROSIS	35	6	55	21	2
36	35	STRIBILD	HIV	77	10	82	34	5
39	44	STELARA	INFLAMMATORY CONDITIONS	23	8	64	15	3
41	185	REBIF REBIDOSE	MULTIPLE SCLEROSIS	30	4	37	29	5
42	13	TRUVADA	HIV	124	21	54	82	16
44	48	ENOXAPARIN SODIUM	ANTICOAGULANT	266	128	46	210	112
50	20	ATRIPLA	HIV	67	13	28	89	15
52	111	REBIF	MULTIPLE SCLEROSIS	24	4	23	38	4
58	75	VIVITROL	CHEMICAL DEPENDENCE	98	33	181	19	14
76	211	HUMIRA PEN CROHN-UC-HS STARTE	INFLAMMATORY CONDITIONS	8	8	107	6	6
78	99	LETAIRIS	PULMONARY HYPERTENSION	11	1	76	11	1
87	149	CIMZIA	INFLAMMATORY CONDITIONS	24	3	77	25	4
89	312	ACTEMRA	INFLAMMATORY CONDITIONS	26	6	169	10	1
91	168	XYREM	SLEEP DISORDERS	7	1	96	6	1
95	232	FORTEO	OSTEOPOROSIS	29	4	101	30	5
			Total Top 25:	1,441			1,182	
			Differences Between Periods:	259				

Peer = Express Scripts Peer 'Medicaid - Ages 35-65' market segment

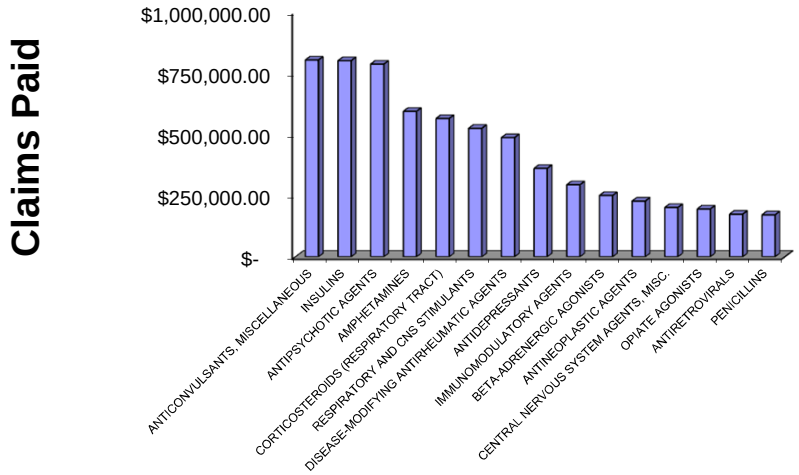
NORTH DAKOTA MEDICAID
Cost Management Analysis

TOP 15 THERAPEUTIC CLASSES BY TOTAL COST OF CLAIMS FROM 04/01/2017 - 06/30/2017

AHFS Therapeutic Class	Rx	Paid	Paid/Rx	% Total Claims
ANTICONVULSANTS, MISCELLANEOUS	8,759	$ 803,700.48	$ 91.76	6.03%
INSULINS	1,858	$ 800,903.67	$ 431.06	1.28%
ANTIPSYCHOTIC AGENTS	6,099	$ 787,057.99	$ 129.05	4.20%
AMPHETAMINES	3,719	$ 594,792.87	$ 159.93	2.56%
CORTICOSTEROIDS (RESPIRATORY TRACT)	1,970	$ 565,491.23	$ 287.05	1.36%
RESPIRATORY AND CNS STIMULANTS	4,064	$ 525,740.73	$ 129.37	2.80%
DISEASE-MODIFYING ANTIRHEUMATIC AGENTS	136	$ 487,400.69	$ 3,583.83	0.09%
ANTIDEPRESSANTS	15,131	$ 361,709.47	$ 23.91	10.41%
IMMUNOMODULATORY AGENTS	50	$ 294,686.66	$ 5,893.73	0.03%
BETA-ADRENERGIC AGONISTS	3,450	$ 250,772.86	$ 72.69	2.37%
ANTINEOPLASTIC AGENTS	331	$ 228,015.98	$ 688.87	0.23%
CENTRAL NERVOUS SYSTEM AGENTS, MISC.	1,649	$ 201,861.58	$ 122.41	1.13%
OPIATE AGONISTS	5,950	$ 195,779.44	$ 32.90	4.10%
ANTIRETROVIRALS	158	$ 174,547.62	$ 1,104.73	0.11%
PENICILLINS	4,634	$ 171,717.56	$ 37.06	3.19%
Total Top 15	57,958	$ 6,444,178.83	$ 111.19	39.89%

Total Rx Claims From 04/01/2017 - 06/30/2017	145,287

Top 15 Therapeutic Classes
Based on Total Cost of Claims

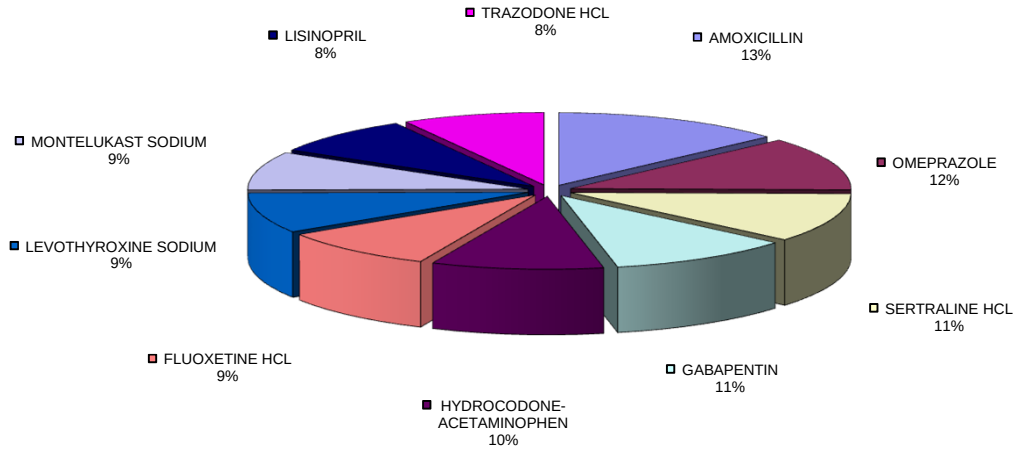


TOP 25 DRUGS BASED ON NUMBER OF CLAIMS FROM 04/01/2017 - 06/30/2017

Drug	AHFS Therapeutic Class	Rx	Paid	Paid/Rx	% Total Claims
AMOXICILLIN	PENICILLINS	3,144	$ 115,105.44	$ 36.61	2.16%
OMEPRAZOLE	PROTON-PUMP INHIBITORS	2,805	$ 56,555.15	$ 20.16	1.93%
SERTRALINE HCL	ANTIDEPRESSANTS	2,575	$ 52,266.42	$ 20.30	1.77%
GABAPENTIN	ANTICONVULSANTS, MISCELLANEOUS	2,488	$ 75,643.08	$ 30.40	1.71%
HYDROCODONE-ACETAMINOPHEN	OPIATE AGONISTS	2,334	$ 71,715.27	$ 30.73	1.61%
FLUOXETINE HCL	ANTIDEPRESSANTS	2,157	$ 37,271.91	$ 17.28	1.48%
LEVOTHYROXINE SODIUM	THYROID AGENTS	2,113	$ 41,127.70	$ 19.46	1.45%
MONTELUKAST SODIUM	LEUKOTRIENE MODIFIERS	2,010	$ 38,513.21	$ 19.16	1.38%
LISINOPRIL	ANGIOTENSIN-CONVERTING ENZYME INHIBITORS	1,985	$ 43,851.08	$ 22.09	1.37%
TRAZODONE HCL	ANTIDEPRESSANTS	1,932	$ 31,679.60	$ 16.40	1.33%
ATORVASTATIN CALCIUM	HMG-COA REDUCTASE INHIBITORS	1,871	$ 44,754.61	$ 23.92	1.29%
METHYLPHENIDATE ER	RESPIRATORY AND CNS STIMULANTS	1,845	$ 308,180.61	$ 167.04	1.27%
METFORMIN HCL	BIGUANIDES	1,568	$ 21,426.93	$ 13.67	1.08%
VYVANSE	AMPHETAMINES	1,530	$ 318,732.07	$ 208.32	1.05%
CLONIDINE HCL	CENTRAL ALPHA-AGONISTS	1,525	$ 22,260.70	$ 14.60	1.05%
ESCITALOPRAM OXALATE	ANTIDEPRESSANTS	1,517	$ 25,191.22	$ 16.61	1.04%
AZITHROMYCIN	MACROLIDES	1,477	$ 32,840.84	$ 22.23	1.02%
QUETIAPINE FUMARATE	ANTIPSYCHOTIC AGENTS	1,338	$ 23,478.79	$ 17.55	0.92%
BUPROPION XL	ANTIDEPRESSANTS	1,334	$ 31,387.12	$ 23.53	0.92%
RISPERIDONE	ANTIPSYCHOTIC AGENTS	1,326	$ 19,314.57	$ 14.57	0.91%
LAMOTRIGINE	ANTICONVULSANTS, MISCELLANEOUS	1,304	$ 21,793.38	$ 16.71	0.90%
CETIRIZINE HCL	SECOND GENERATION ANTIHISTAMINES	1,278	$ 44,904.79	$ 35.14	0.88%
AMOXICILLIN-CLAVULANATE POTASS	PENICILLINS	1,268	$ 46,177.12	$ 36.42	0.87%
CLONAZEPAM	BENZODIAZEPINES (ANTICONVULSANTS)	1,255	$ 27,770.17	$ 22.13	0.86%
ALBUTEROL SULFATE	BETA-ADRENERGIC AGONISTS	1,237	$ 60,318.77	$ 48.76	0.85%
TOTAL TOP 25		45,216	$ 1,612,260.55	$ 35.66	31.12%

Total Rx Claims From 04/01/2017 - 06/30/2017	145,287

Top 10 Drugs
Based on Number of Claims

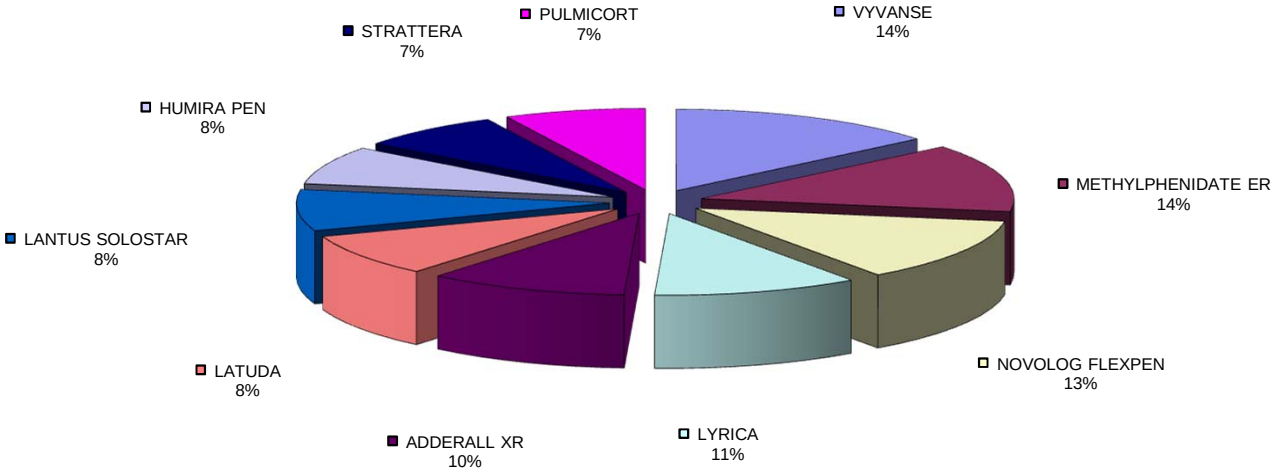


TOP 25 DRUGS BASED ON TOTAL CLAIMS COST FROM 04/01/2017 - 06/30/2017

Drug	AHFS Therapeutic Class	Rx	Paid	Paid/Rx	% Total Claims
VYVANSE	AMPHETAMINES	1,530	$ 318,732.07	$ 208.32	1.05%
METHYLPHENIDATE ER	RESPIRATORY AND CNS STIMULANTS	1,845	$ 308,180.61	$ 167.04	1.27%
NOVOLOG FLEXPEN	INSULINS	565	$ 286,645.24	$ 507.34	0.39%
LYRICA	ANTICONVULSANTS, MISCELLANEOUS	634	$ 241,040.69	$ 380.19	0.44%
ADDERALL XR	AMPHETAMINES	1,152	$ 234,952.36	$ 203.95	0.79%
LATUDA	ANTIPSYCHOTIC AGENTS	245	$ 190,913.74	$ 779.24	0.17%
LANTUS SOLOSTAR	INSULINS	476	$ 185,684.56	$ 390.09	0.33%
HUMIRA PEN	DISEASE-MODIFYING ANTIRHEUMATIC AGENTS	42	$ 172,727.60	$ 4,112.56	0.03%
STRATTERA	CENTRAL NERVOUS SYSTEM AGENTS, MISC.	539	$ 169,713.86	$ 314.87	0.37%
PULMICORT	CORTICOSTEROIDS (RESPIRATORY TRACT)	390	$ 166,294.69	$ 426.40	0.27%
ADVAIR DISKUS	CORTICOSTEROIDS (RESPIRATORY TRACT)	492	$ 160,309.87	$ 325.83	0.34%
ENBREL	DISEASE-MODIFYING ANTIRHEUMATIC AGENTS	38	$ 132,525.08	$ 3,487.50	0.03%
SABRIL	ANTICONVULSANTS, MISCELLANEOUS	9	$ 125,542.17	$ 13,949.13	0.01%
INVEGA SUSTENNA	ANTIPSYCHOTIC AGENTS	68	$ 123,728.68	$ 1,819.54	0.05%
FREESTYLE LITE STRIPS	DIABETES MELLITUS	855	$ 119,340.57	$ 139.58	0.59%
AMOXICILLIN	PENICILLINS	3,144	$ 115,105.44	$ 36.61	2.16%
LEVEMIR FLEXTOUCH	INSULINS	366	$ 107,339.63	$ 293.28	0.25%
COPAXONE	IMMUNOMODULATORY AGENTS	16	$ 102,043.91	$ 6,377.74	0.01%
HUMIRA	DISEASE-MODIFYING ANTIRHEUMATIC AGENTS	22	$ 101,585.13	$ 4,617.51	0.02%
PROVENTIL HFA	BETA-ADRENERGIC AGONISTS	1,041	$ 99,985.28	$ 96.05	0.72%
VIMPAT	ANTICONVULSANTS, MISCELLANEOUS	167	$ 94,875.08	$ 568.11	0.11%
SPIRIVA	ANTIMUSCARINICS/ANTISPASMODICS	319	$ 92,150.32	$ 288.87	0.22%
FOCALIN XR	RESPIRATORY AND CNS STIMULANTS	320	$ 92,070.67	$ 287.72	0.22%
MAPAP	ANALGESICS AND ANTIPYRETICS, MISC.	654	$ 91,870.05	$ 140.47	0.45%
ONFI	BENZODIAZEPINES (ANTICONVULSANTS)	100	$ 86,713.49	$ 867.13	0.07%
TOTAL TOP 25		15,029	$ 3,920,070.79	$ 260.83	10.34%

Total Rx Claims From 04/01/2017 - 06/30/2017	145,287

Top 10 Drugs
Based on Total Claims Cost



PROGLYCEM PA FORM

Prior Authorization Vendor for ND Medicaid

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

ND Medicaid requires that patients receiving a new prescription for Proglycem must meet the following criteria:

- **Patient must have a diagnosis of hypoglycemia associated with one of the following conditions (based on age).**
  - **≥18 Years of age**
    - **Inoperable islet cell adenoma or carcinoma**
    - **Extrapancreatic malignancy**
  - **<18 Years of age**
    - **Extrapancreatic malignancy**
    - **Islet cell hyperplasia**
    - **Islet cell adenoma**
    - **Leucine sensitivity**
    - **Adenomatosis**
    - **Nesidioblastosis**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	**Recipient Date of Birth**	Recipient Medicaid ID Number	
Physician Name	Specialist involved in therapy (if not treating physician)		
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ PROGLYCEM	**FDA approved indication for this request:** □ Hypoglycemia		

Condition associated with patient's hypoglycemia:

□ Inoperable islet cell adenoma or carcinoma	□ Extrapancreatic malignancy	□ Islet cell hyperplasia
□ Islet cell adenoma	□ Leucine sensitivity	□ Adenomatosis
□ Nesidioblastosis	□ Other (please state)	

Prescriber (or Staff) / Pharmacy Signature**	Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

Patients younger than 18 years of age:

- Patient must have a diagnosis of hypoglycemia associated with one of the following conditions:
    - Extrapancreatic malignancy
    - Islet cell hyperplasia
    - Islet cell adenoma
    - Leucine sensitivity
    - Adenomatosis
    - Nesidioblastosis

Patients 18 years of age and older:

- Patient must have a diagnosis of hypoglycemia associated with one of the following conditions:
    - Inoperable islet cell adenoma or carcinoma
    - Extrapancreatic malignancy

BILTRICIDE PA FORM

Prior Authorization Vendor for ND Medicaid

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

ND Medicaid requires that patients receiving a new prescription for Biltricide must meet the following criteria:

- **Patient must have one of the following diagnoses:**
  - **Infection by Opisthorchis viverrini**
  - **Clonorchiasis**
  - **Schistosomiasis**
- **Patient must not currently be taking any of the following medications as evidenced by paid pharmacy claims.**
  - **Rifampin**
  - **Phenytoin**
  - **Fosphenytoin**
  - **Carbamazepine**
  - **dexamethasone**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	**Recipient Date of Birth**	Recipient Medicaid ID Number	
Physician Name	Specialist involved in therapy (if not treating physician)		
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ BILTRICIDE	**FDA approved indication for this request:** □ Infection by Opisthorchis viverrini □ Clonorchiasis □ Schistosomiasis □ Other (please state below)		
Other diagnosis/indication (if not listed above):			
Prescriber (or Staff) / Pharmacy Signature**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

Biltricide

- Patient must have one of the following diagnoses:
    - Infection by Opisthorchis viverrini
    - Clonorchiasis
    - Schistosomiasis
- Patient is not currently taking any of the following medications as evidenced by paid pharmacy claims.
    - Rifampin
    - Phenytoin
    - Fosphenytoin
    - Carbamazepine
    - dexamethasone

HEALTH INFORMATION DESIGNS

Prior Authorization Vendor for ND Medicaid

JUXTAPID AND KYNAMRO PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

ND Medicaid requires that patients receiving a new prescription for Juxtapid or Kynamro must meet the following criteria:

- Patient must have a diagnosis of Homozygous Familial Hypercholesterolemia (HoFH)
- Patient must be 18 years of age or older
- Patient's LDL is >130 mg/dL after a 90-day trial of combined therapy with either Crestor ≥20 mg or atorvastatin ≥ 40 mg plus another lipid lowering agent
- One of the following:
  - Patient has genetic confirmation of 2 mutant alleles at the LDLR, APOB, PCSK9, or LDLRAP1 gene locus
  - Patient has an untreated LDL and total cholesterol level of > 500 mg/dl or >300 mg/dl with cutaneous or tendon xanthoma before 10 years of age
  - Patient has an untreated LDL level consistent with HeFH in both parents

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ JUXTAPID □ KYNAMRO	**FDA approved indication for this request:**		

Patient's Current LDL:

Does the patient have genetic confirmation of 2 mutant alleles at the LDLR, APOB, PCSK9, or LDLRAP1 gene locus?
□ YES □ NO

Untreated LDL and total cholesterol level of > 500 mg/dl or >300 mg/dl with cutaneous or tendon xanthoma before 10 years of age?
□ YES □ NO

Does the patient have an untreated LDL level consistent with HeFH in both parents?
□ YES □ NO

List all failed medications (drug name, date of trial, reason for failure):

□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*

Prescriber (or Staff) / Pharmacy Signature**	Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

Prior Authorization/PDL Update

Added to PA	Category
KEVZARA	Cytokine Modulators
MORPHABOND ER	Narcotics
ELLZIA PAK	Kit
ILARIS	> 3000
FABIOR	Acne
BROVANA	COPD
LIALDA	Inflammatory Bowel Agents
APRISO	Inflammatory Bowel Agents
PREDNISOLONE SODIUM PHOSPHATE 10 MG/5 ML	Prednisolone Non-Solid Oral Dosage Forms
PREDNISOLONE SODIUM PHOSPHATE 20 MG/5 ML	Prednisolone Non-Solid Oral Dosage Forms
METHYLTESTOSTERONE	Oral Testosterone
METHYLTEST	Oral Testosterone
TYMLOS	>3000

Removed from PA	Category
XIFAXAN 550MG	Diarrhea IBS
AVONEX	Multiple Sclerosis Interferons
AVONEX PEN	Multiple Sclerosis Interferons

Bill Medical Side VIA 837I AND 837P TRANSACTIONS
XOLAIR
BRINEURA
KETAMINE

Juxtapid:

- Patient must have a diagnosis of Homozygous Familial Hypercholesterolemia (HoFH)
- Patient must be 18 years of age or older
- Patient must have LDL levels of >130 mg/dL after a 90-day trial of the following, as evidenced by paid claims or pharmacy print-outs:
    - A lipid lowering agent other than a statin combined with either Crestor (rosuvasatin) ≥20 mg or Lipitor (atorvastatin) ≥ 40 mg
- One of the following:
    1. Patient has had genetic confirmation of two mutant alleles at the LDLR, APOB, PCSK9, or LDLRAP1 gene locus
    2. Patient has an untreated LDL and total cholesterol level of > 500 mg/dl or >300 mg/dl with cutaneous or tendon xanthoma before 10 years of age
    3. Patient has an untreated LDL level consistent with Heterozygous Familial Hypercholesterolemia (HeFH) in both parents

Kynamro:

- Patient must have a diagnosis of Homozygous Familial Hypercholesterolemia (HoFH)
- Patient must be 18 years of age or older
- Patient must have LDL levels of >130 mg/dL after a 90-day trial of the following, as evidenced by paid claims or pharmacy print-outs:
    - A lipid lowering agent other than a statin combined with either Crestor (rosuvasatin) ≥20 mg or Lipitor (atorvastatin) ≥ 40 mg
- One of the following:
    1. Patient has had genetic confirmation of two mutant alleles at the LDLR, APOB, PCSK9, or LDLRAP1 gene locus
    2. Patient has an untreated LDL and total cholesterol level of > 500 mg/dl or >300 mg/dl with cutaneous or tendon xanthoma before 10 years of age
    3. Patient has an untreated LDL level consistent with Heterozygous Familial Hypercholesterolemia (HeFH) in both parents

Prior Authorization Vendor for ND Medicaid

PROCYSBI
PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

ND Medicaid requires that patients receiving a new prescription for Procysbi must meet the following criteria:

- Patient must have a diagnosis of nephropathic cystinosis
- Patient must have failed a 30-day trial of Cystagon, as evidenced by paid claims or pharmacy print-outs.
- Patient must be 2 years of age or older

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ PROCYSBI	**FDA approved indication for this request:**		
List all failed medications (drug name, date of trial, reason for failure):			
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*			
Prescriber (or Staff) / Pharmacy Signature**	Date		
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

Procysbi:

- Patient must have a diagnosis of nephropathic cystinosis
- Patient must have failed a 30-day trial of Cystagon, as evidenced by paid claims or pharmacy print-outs.
- Patient must be 2 years of age or older

MIACALCIN AND TYMLOS
PA FORM

Prior Authorization Vendor for ND Medicaid

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

ND Medicaid requires that patients receiving a new prescription for Miacalcin or Tymlos must meet the following criteria:

- **Miacalcin:** *Patient must have one of the below diagnoses and meet the criteria for their diagnosis (if present)*
  - **Paget's Disease of the bone:** Patient must have failed a 6-month trial of a bisphosphonate
  - **Postmenopausal Osteoporosis:** Patient must be postmenopausal for ≥ 5 years and have failed a 6-month trial of a bisphosphonate
  - **Hypercalcemia**
- **Tymlos:**
  - Patient must have a history of osteoporotic fractures and have multiple risk factors for fracture
  - Patient has not been taking Tymlos for ≥ 2 years

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ MIACALCIN □ TYMLOS	**FDA approved indication for this request:**		
List all failed medications (drug name, date of trial, reason for failure):	Has the patient been postmenopausal for ≥ 5 years? □ YES □ NO Does the patient have multiple risk factors for fracture? □ YES □ NO		
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*			
Prescriber (or Staff) / Pharmacy Signature**	Date		
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

Miacalcin:

- **For patients with a diagnosis of Paget's Disease of the bone:**
  - Patient must have a diagnosis of Paget's Disease of the Bone
  - Patient must have failed a 6-month trial of at least one of the following, as evidenced by paid claims or pharmacy print-outs:
    - Fosamax (alendronate)
    - Boniva (ibandronate)
    - Aredia (pamidronate)
    - Actonel (risedronate)
- **For patients with a diagnosis of Postmenopausal Osteoporosis:**
  - Patient must have a diagnosis of Osteoporosis
  - Patient must be postmenopausal for greater than or equal to 5 years
  - Patient must have failed a 6-month trial of at least one of the following, as evidenced by paid claims or pharmacy print-outs:
    - Fosamax (alendronate)
    - Boniva (ibandronate)
    - Aredia (pamidronate)
    - Actonel (risedronate)
- **For patients with a diagnosis of Hypercalcemia:**
  - Patient must have a diagnosis of Hypercalcemia

Tymlos:

- Patient must have a history of osteoporotic fractures
- Patient must have multiple risk factors for fracture
- Patient has not been taking Tymlos for greater than a total of 2 years

TARDIVE DYSKINESIA AGENTS
PA FORM

Prior Authorization Vendor for ND Medicaid

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

ND Medicaid requires that patients receiving a new prescription for Austedo, Ingrezza, or tetrabenazine must meet the following criteria:

- **Austedo and tetrabenazine:**
  - Patient must have one of the following diagnoses:
    - Tardive dyskinesia (tetrabenazine only)
    - Chorea associated with Huntinton's disease
  - Patient must not be taking reserpine or a monoamine oxidase inhibitor (MAOI)
  - Patient must not have hepatic impairment
- **Ingrezza:**
  - Patient must have a diagnosis of tardive dyskinesia
  - Patient must have failed a 30-day trial of tetrabenazine, as evidenced by paid claims or pharmacy print-outs.

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ AUSTEDO □ INGREZZA □ TETRABENAZINE	**FDA approved indication for this request:** Does the patient have hepatic impairment? □ YES □ NO		
List all failed medications (drug name, date of trial, reason for failure):			
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*			
Prescriber (or Staff) / Pharmacy Signature**	Date		
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

Austedo:

- Patient must have a diagnosis of chorea associated with Huntinton's disease
- Patient must not be taking reserpine or a monoamine oxidase inhibitor (MAOI)
- Patient must not have hepatic impairment

Ingrezza:

- Patient must have a diagnosis of tardive dyskinesia
- Patient must have failed a 30-day trial of tetrabenazine, as evidenced by paid claims or pharmacy print-outs.

Tetrabenazine:

- Patient must have one of the following diagnoses:
    - Tardive dyskinesia
    - Chorea associated with Huntinton's disease
- Patient must not be taking reserpine or a monoamine oxidase inhibitor (MAOI)
- Patient must not have hepatic impairment

Prior Authorization Vendor for ND Medicaid

JADENU
PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

ND Medicaid requires that patients receiving a new prescription for Jadenu must meet the following criteria:

- The prescriber must provide medical justification explaining why the patient cannot use Exjade

Part I: TO BE COMPLETED BY PHYSICIAN

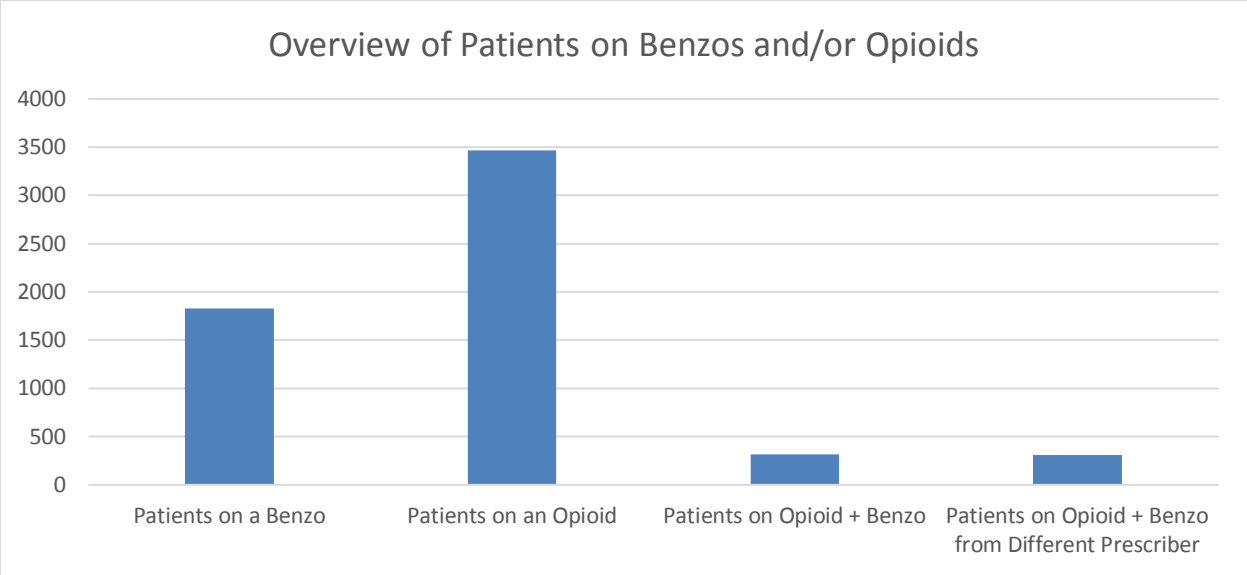
Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ JADENU	**FDA approved indication for this request:**		
List all failed medications (drug name, date of trial, reason for failure):			
Medical justification for use over Exjade:			
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*			
Prescriber (or Staff) / Pharmacy Signature**	Date		
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

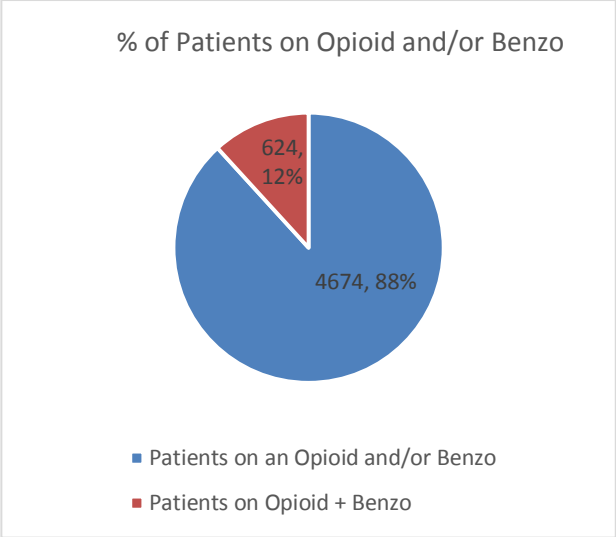
Part II: TO BE COMPLETED BY PHARMACY

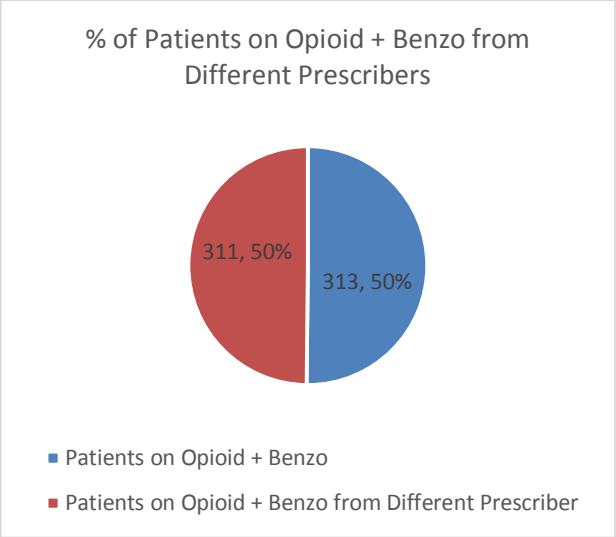
PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

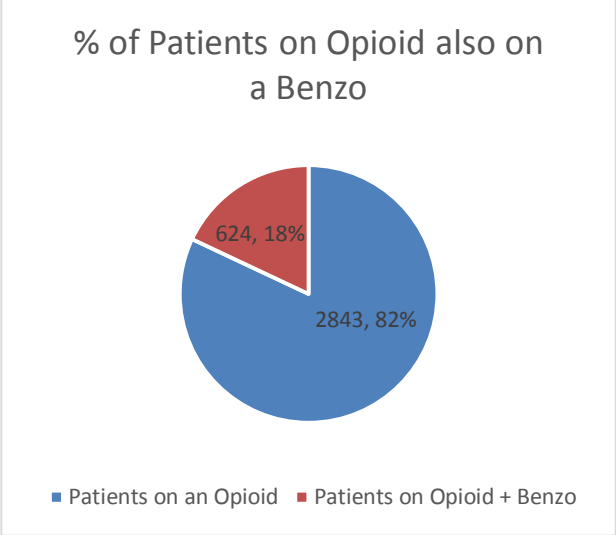
Jadenu:

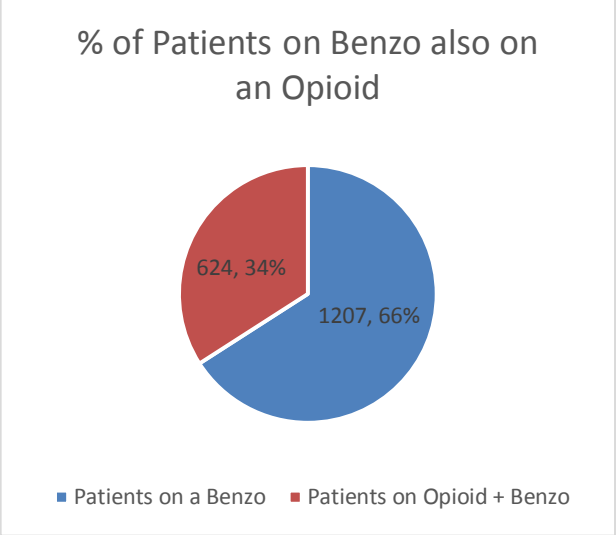
- The prescriber must provide medical justification explaining why the patient cannot use Exjade

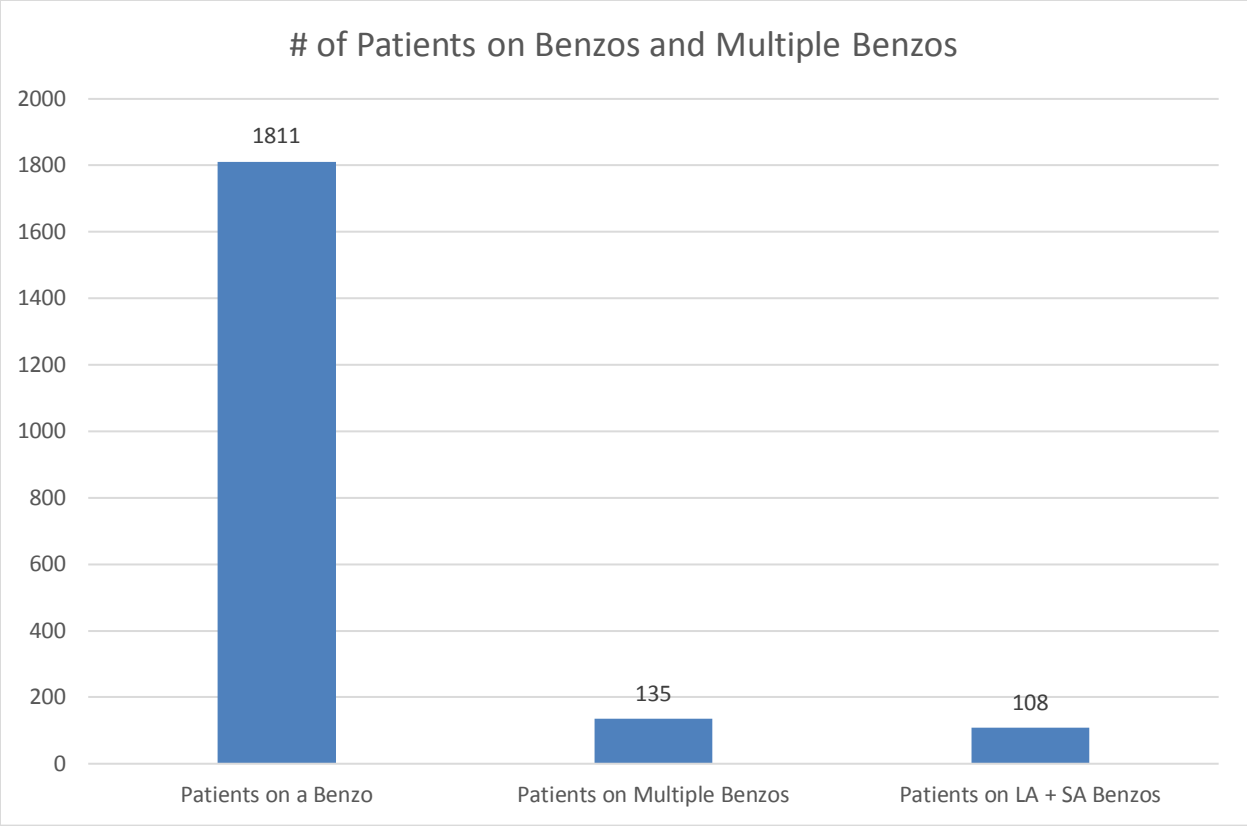

Overview of Patients on Benzos and/or Opioids
4000
3500
3000
2500
2000
1500
1000
500
0
Patients on a Benzo
Patients on an Opioid
Patients on Opioid + Benzo
Patients on Opioid + Benzo from Different Prescriber


% of Patients on Opioid and/or Benzo
624, 12%
4674, 88%
Patients on an Opioid and/or Benzo
Patients on Opioid + Benzo

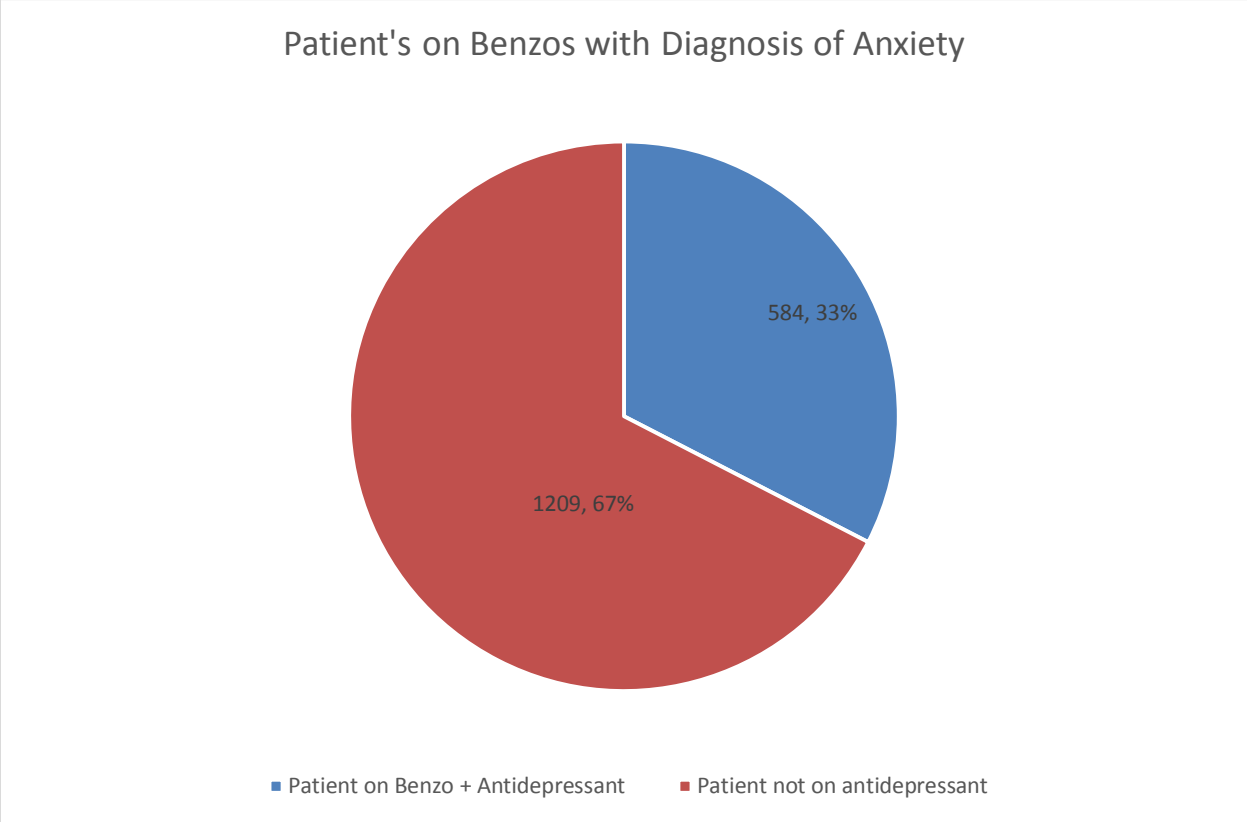

% of Patients on Opioid + Benzo from Different Prescribers
311, 50%
313, 50%
Patients on Opioid + Benzo
Patients on Opioid + Benzo from Different Prescriber

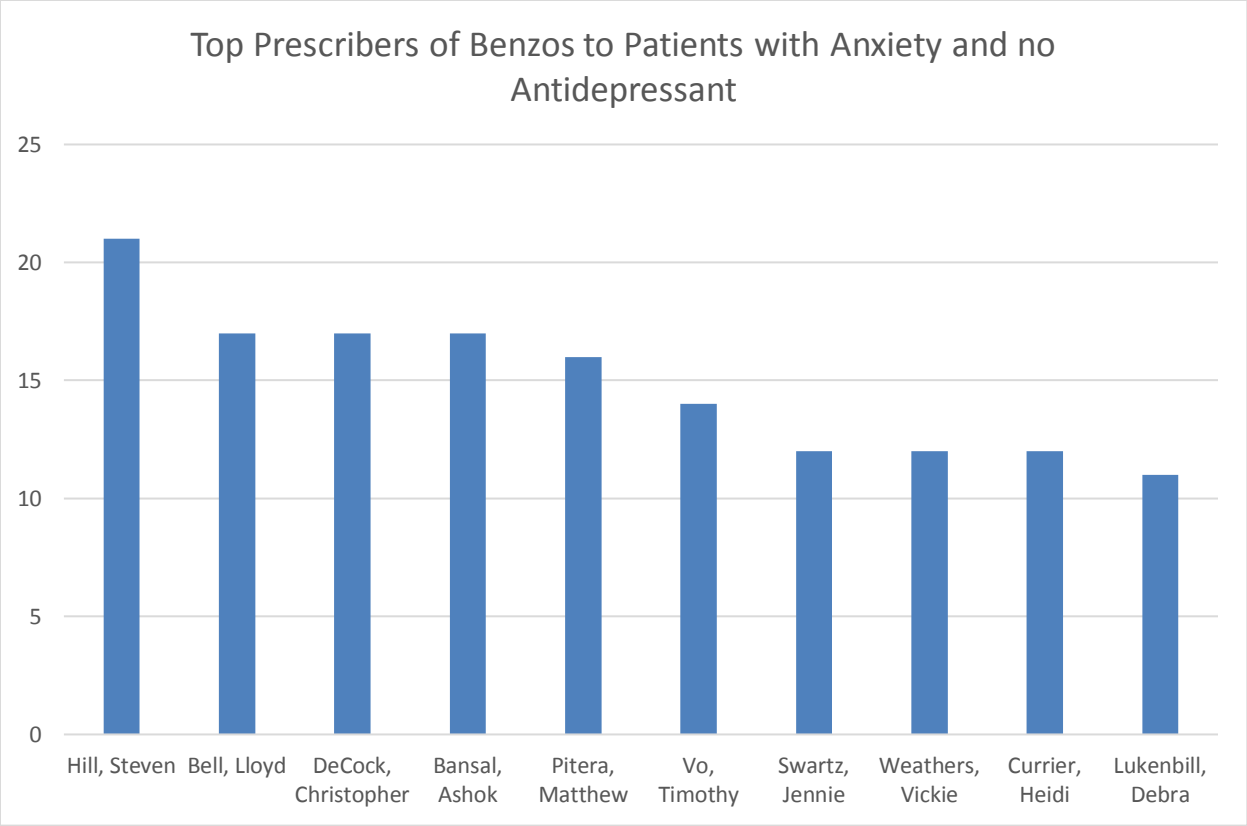

% of Patients on Opioid also on a Benzo
624, 18%
2843, 82%
Patients on an Opioid
Patients on Opioid + Benzo

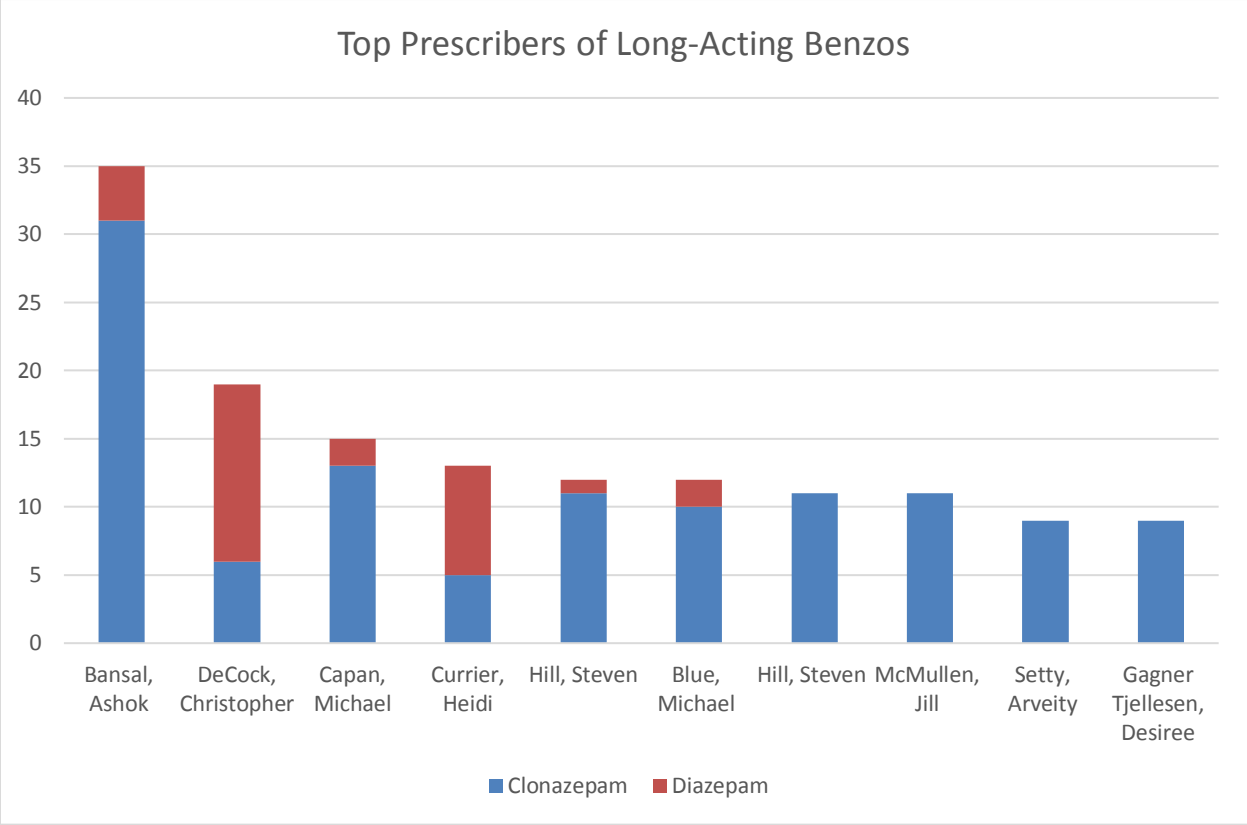

% of Patients on Benzo also on an Opioid
624, 34%
1207, 66%
Patients on a Benzo
Patients on Opioid + Benzo

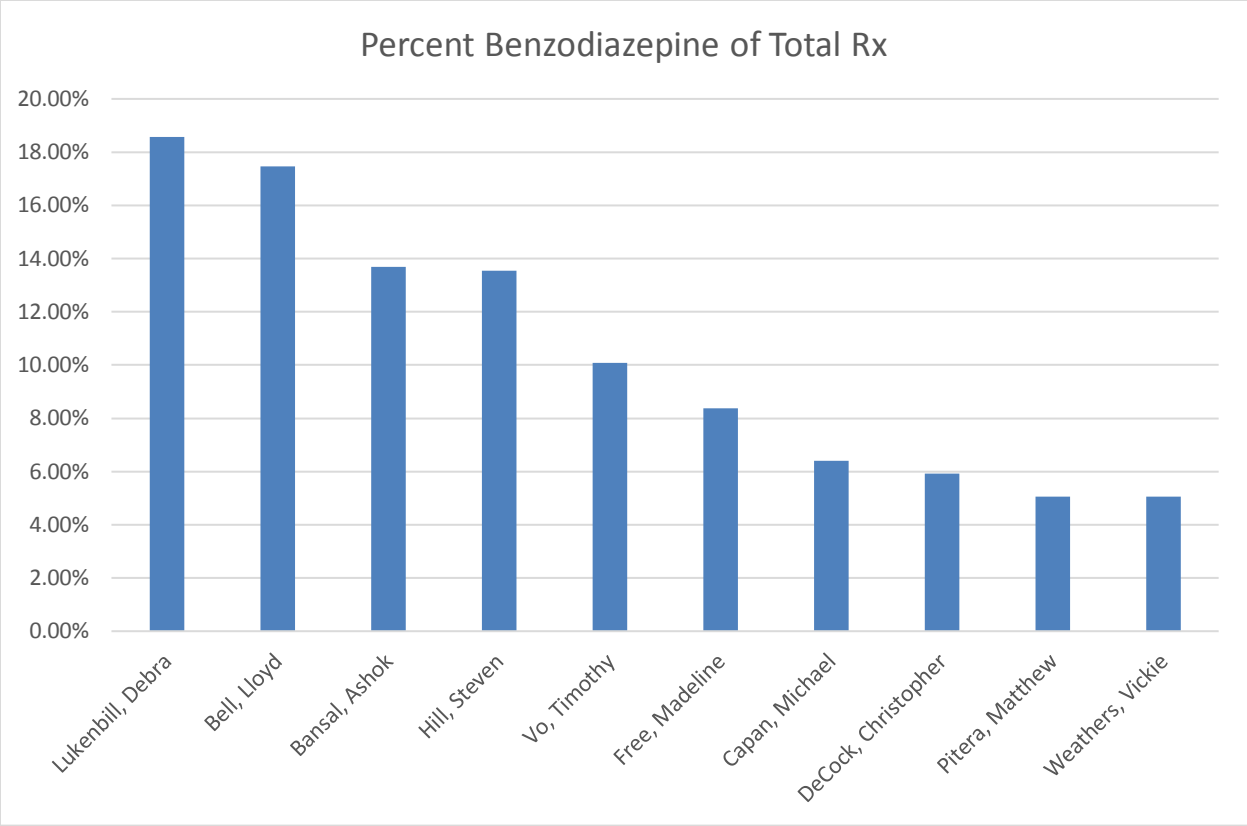

# of Patients on Benzos and Multiple Benzos
2000
1800
1600
1400
1200
1000
800
600
400
200
0
1811
135
108
Patients on a Benzo
Patients on Multiple Benzos
Patients on LA + SA Benzos

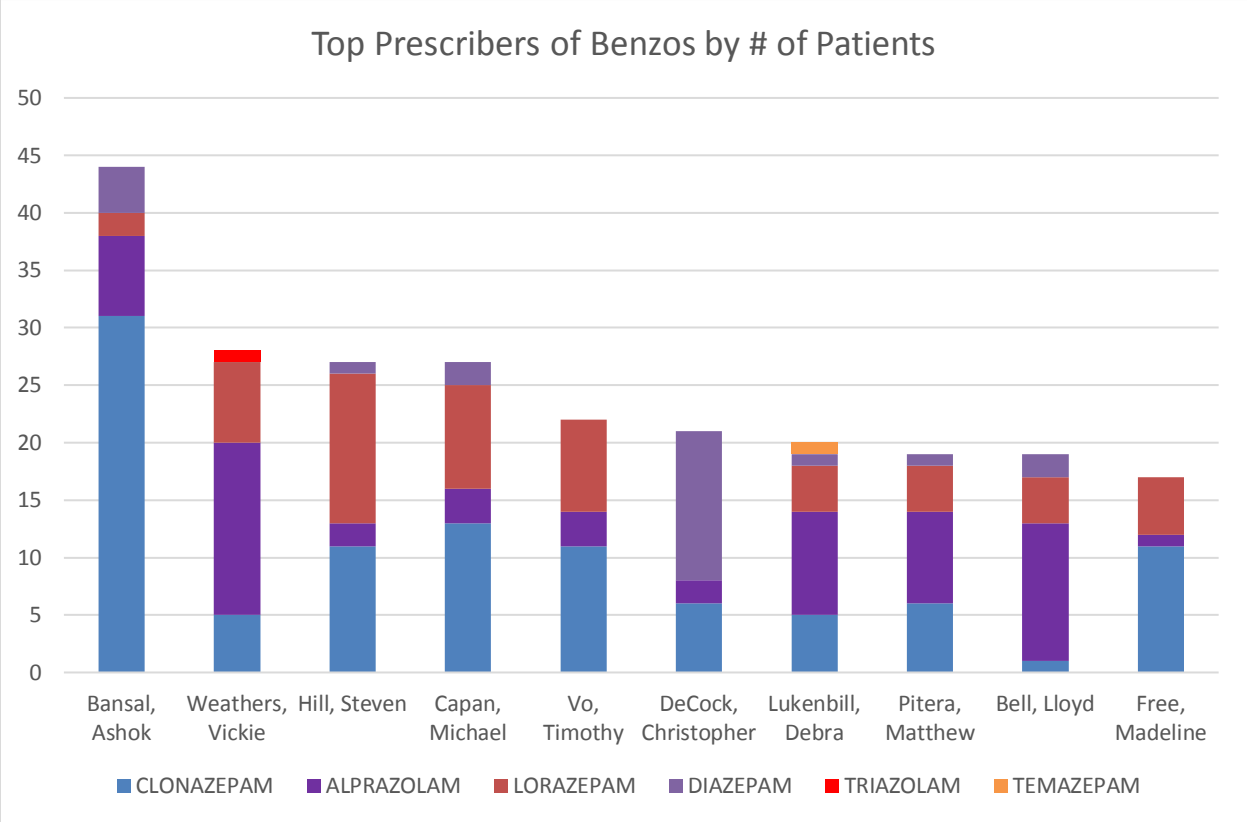
.

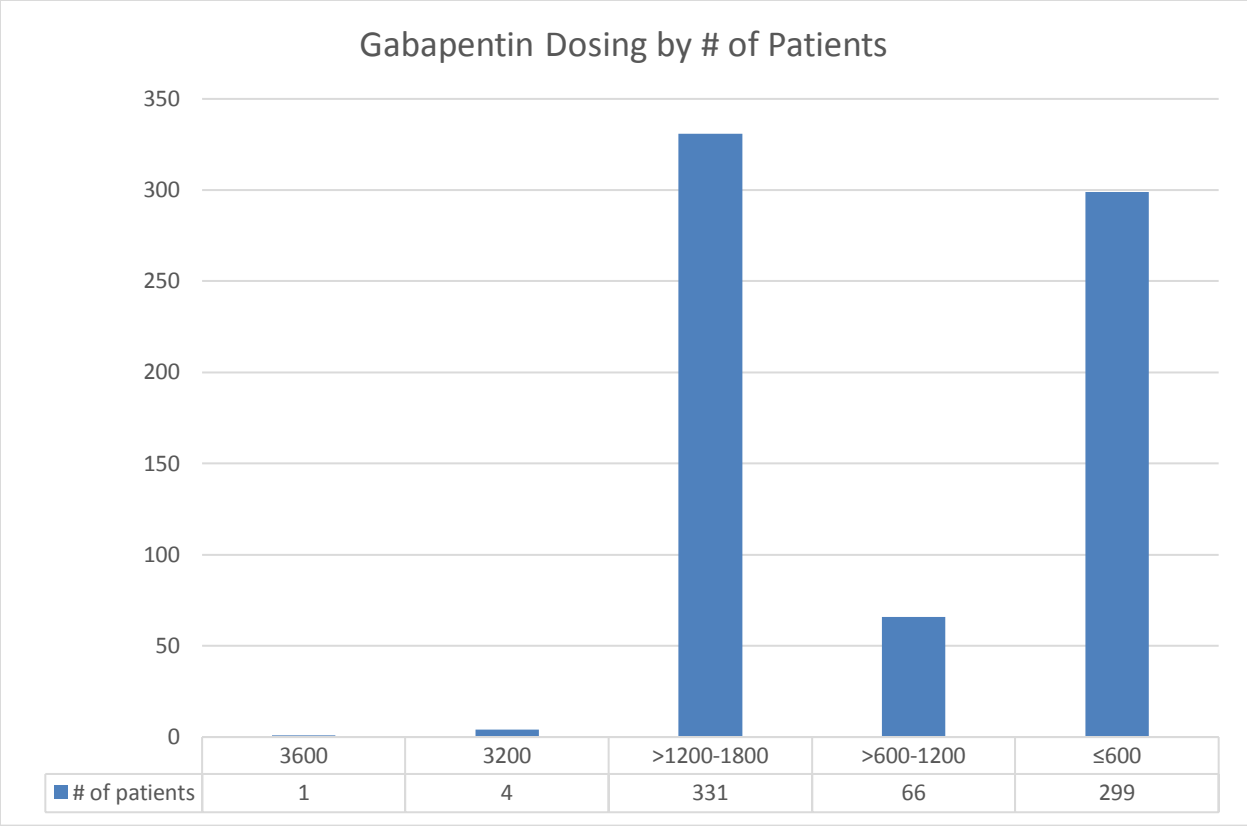

Patient's on Benzos with Diagnosis of Anxiety
584, 33%
1209, 67%
Patient on Benzo + Antidepressant
Patient not on antidepressant

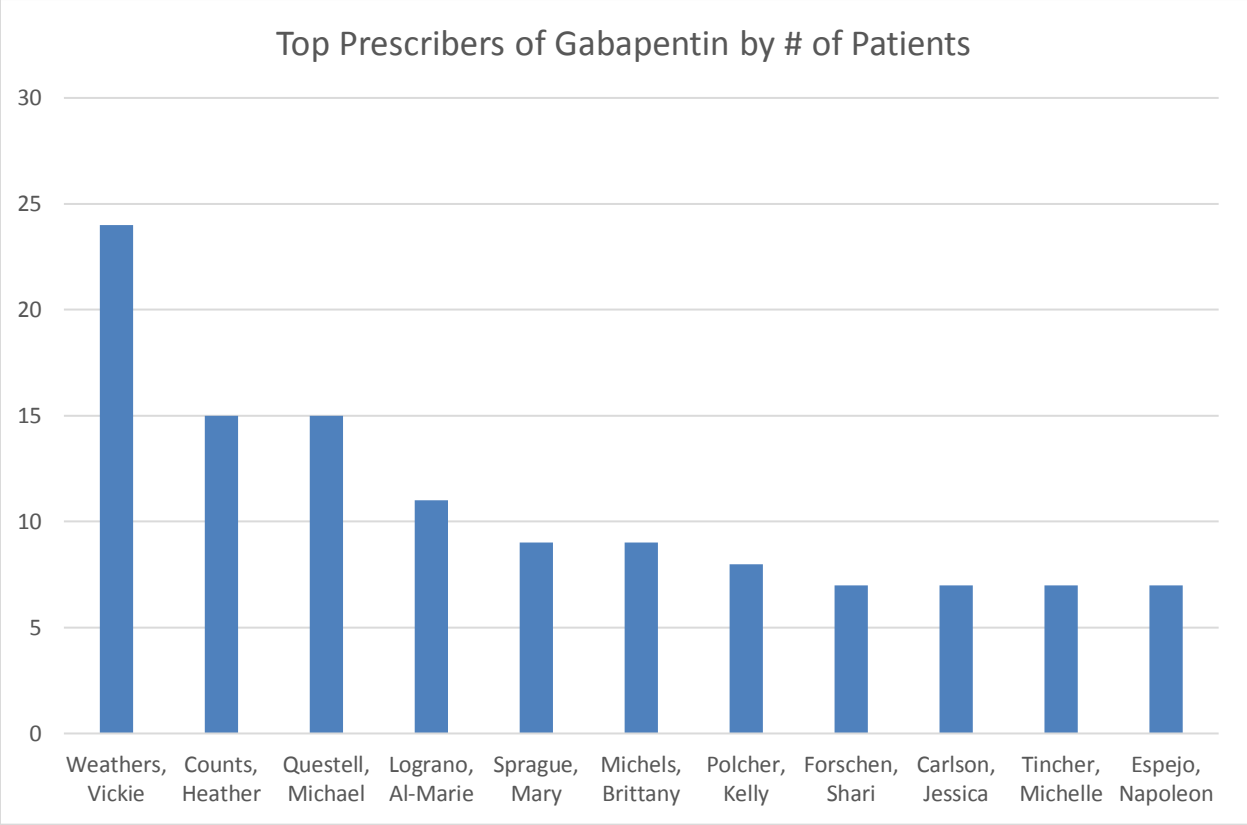

Top Prescribers of Benzos to Patients with Anxiety and no Antidepressant
25
20
15
10
5
0
Hill, Steven
Bell, Lloyd
DeCock, Christopher
Bansal, Ashok
Pitera, Matthew
Vo, Timothy
Swartz, Jennie
Weathers, Vickie
Currier, Heidi
Lukenbill, Debra

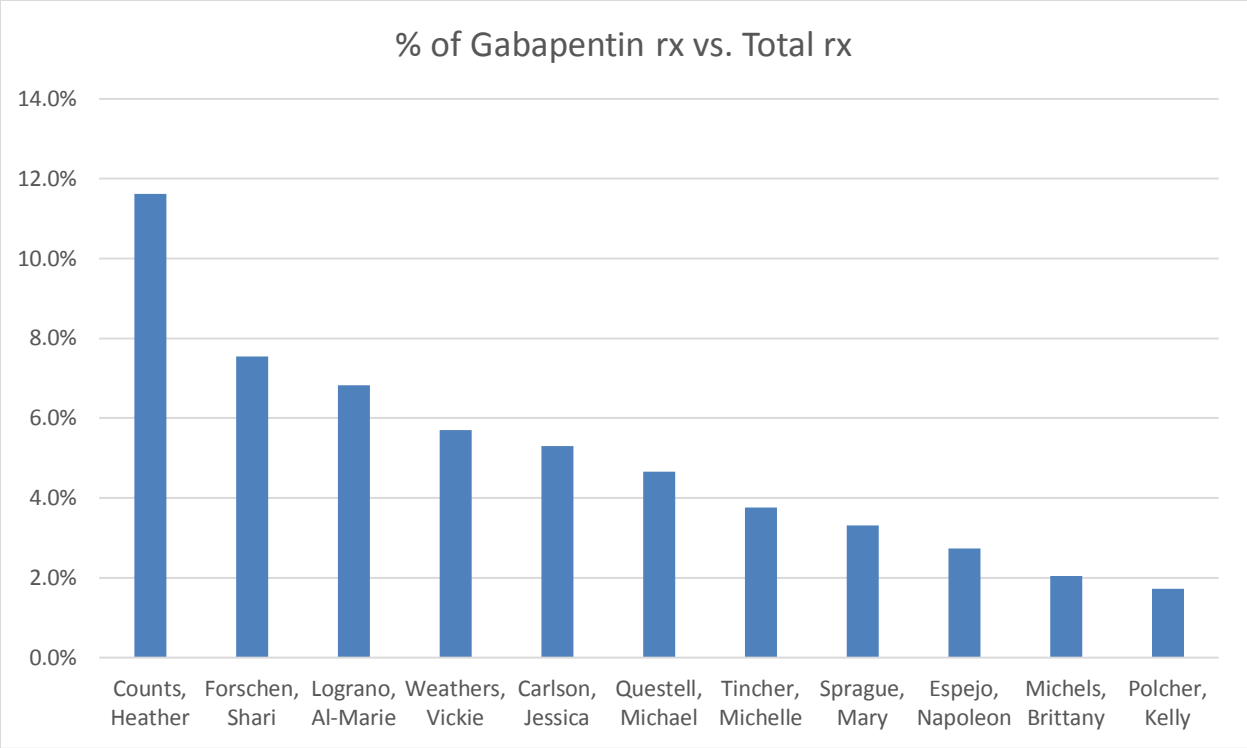

Top Prescribers of Long-Acting Benzos
40
35
30
25
20
15
10
5
0
Bansal, Ashok
DeCock, Christopher
Capan, Michael
Currier, Heidi
Hill, Steven
Blue, Michael
Hill, Steven
McMullen, Jill
Setty, Arveity
Gagner Tjellesen, Desiree
Clonazepam
Diazepam

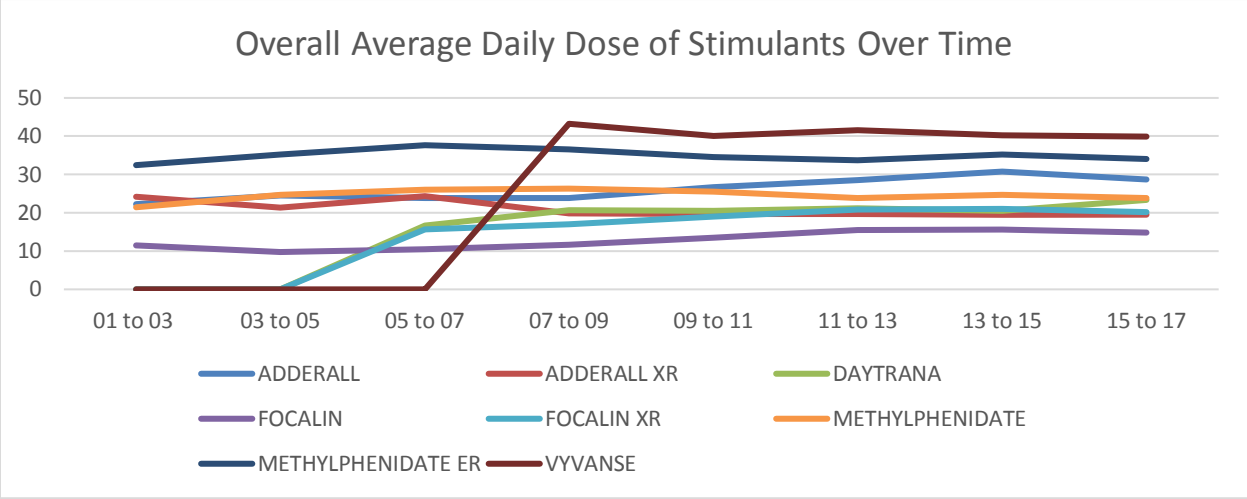

Percent Benzodiazepine of Total Rx
20.00%
18.00%
16.00%
14.00%
12.00%
10.00%
8.00%
6.00%
4.00%
2.00%
0.00%
Lukenbill, Debra
Bell, Lloyd
Bansal, Ashok
Hill, Steven
Vo, Timothy
Free, Madeline
Capan, Michael
DeCock, Christopher
Pitera, Matthew
Weathers, Vickie

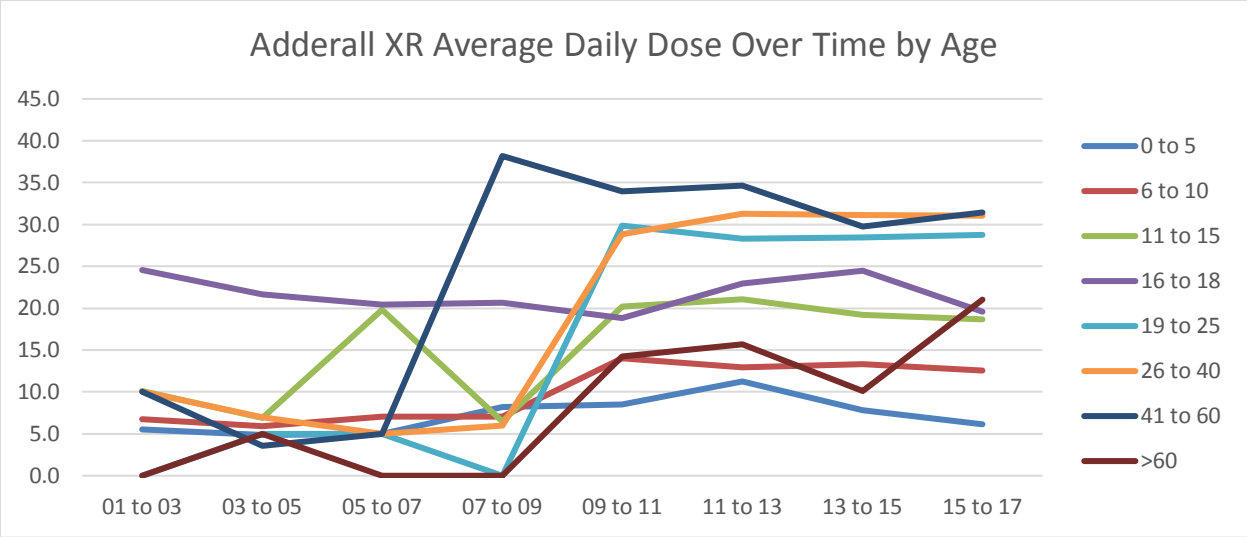

Top Prescribers of Benzos by # of Patients
50
45
40
35
30
25
20
15
10
5
0
Bansal, Ashok
Weathers, Vickie
Hill, Steven
Capan, Michael
Vo, Timothy
DeCock, Christopher
Lukenbill, Debra
Pitera, Matthew
Bell, Lloyd
Free, Madeline
CLONAZEPAM
ALPRAZOLAM
LORAZEPAM
DIAZEPAM
TRIAZOLAM
TEMAZEPAM

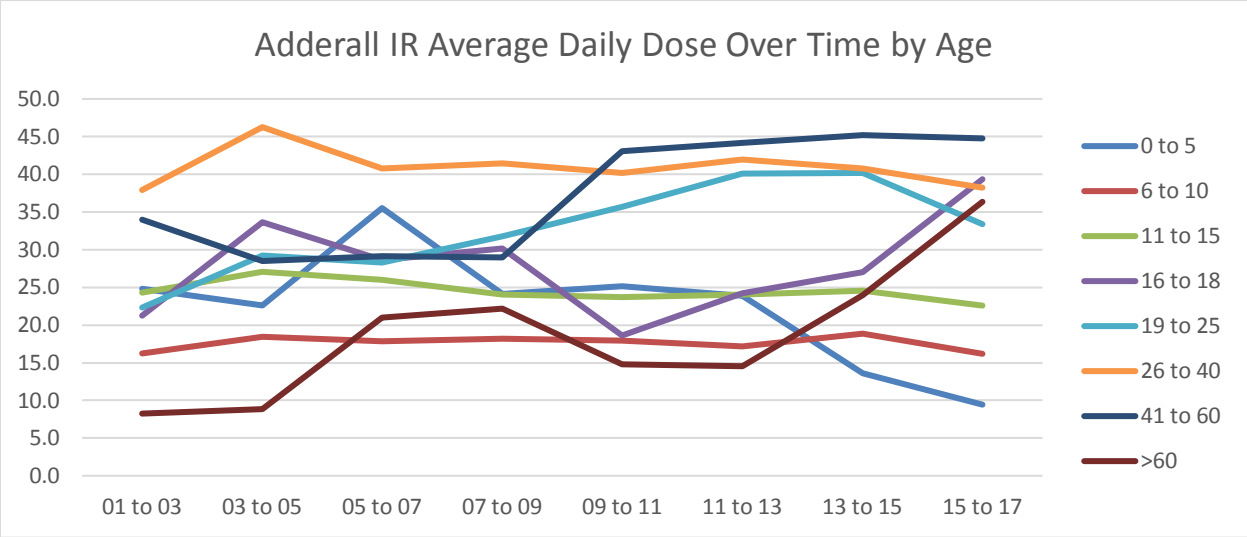

Gabapentin Dosing by # of Patients
350
300
250
200
150
100
50
0
3600
3200
>1200-1800
>600-1200
≤600
# of patients
1
4
331
66
299

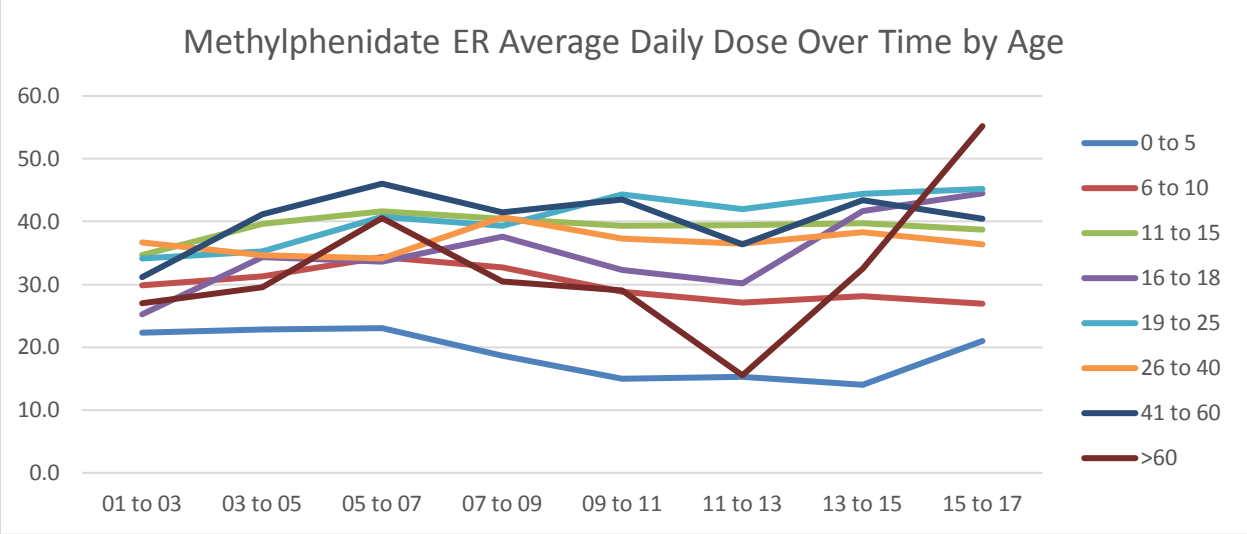

Top Prescribers of Gabapentin by # of Patients
30
25
20
15
10
5
0
Weathers, Vickie
Counts, Heather
Questell, Michael
Lograno, Al-Marie
Sprague, Mary
Michels, Brittany
Polcher, Kelly
Forschen, Shari
Carlson, Jessica
Tincher, Michelle
Espejo, Napoleon

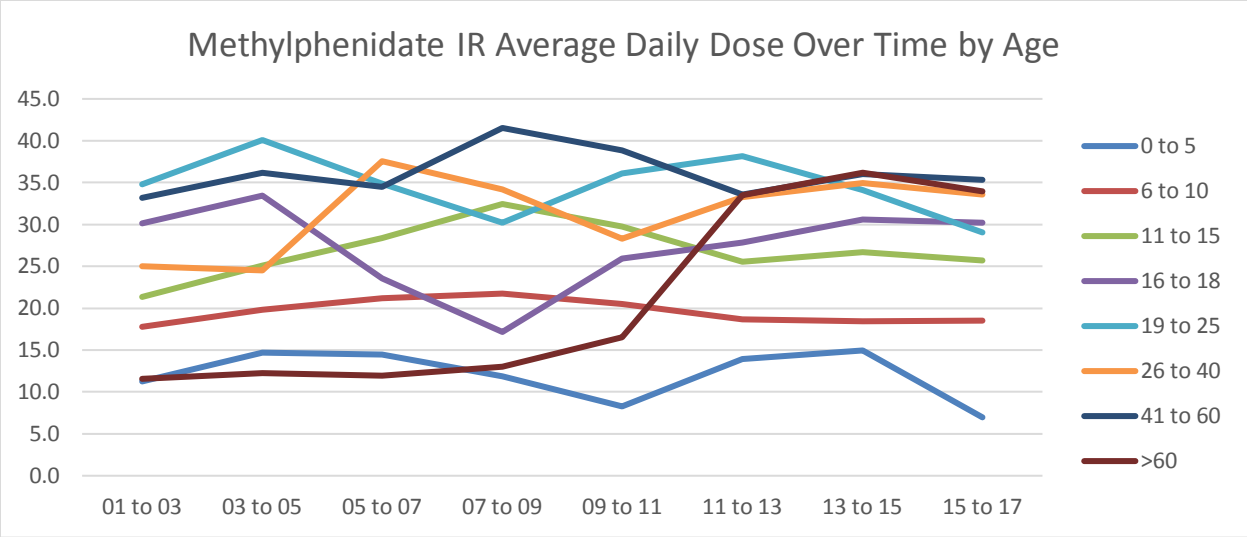

% of Gabapentin rx vs. Total rx
14.0%
12.0%
10.0%
8.0%
6.0%
4.0%
2.0%
0.0%
Counts, Heather
Forschen, Shari
Lograno, Al-Marie
Weathers, Vickie
Carlson, Jessica
Questell, Michael
Tincher, Michelle
Sprague, Mary
Espejo, Napoleon
Michels, Brittany
Polcher, Kelly

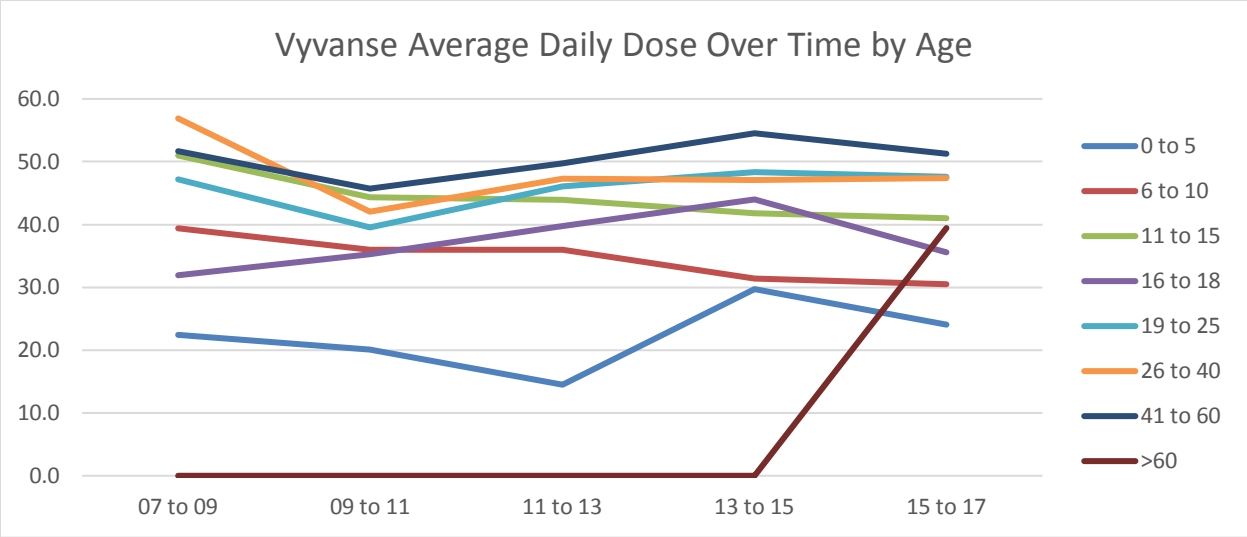

Overall Average Daily Dose of Stimulants Over Time
50
40
30
20
10
0
01 to 03
03 to 05
05 to 07
07 to 09
09 to 11
11 to 13
13 to 15
15 to 17
ADDERALL
ADDERALL XR
DAYTRANA
FOCALIN
FOCALIN XR
METHYLPHENIDATE
METHYLPHENIDATE ER
VYVANSE

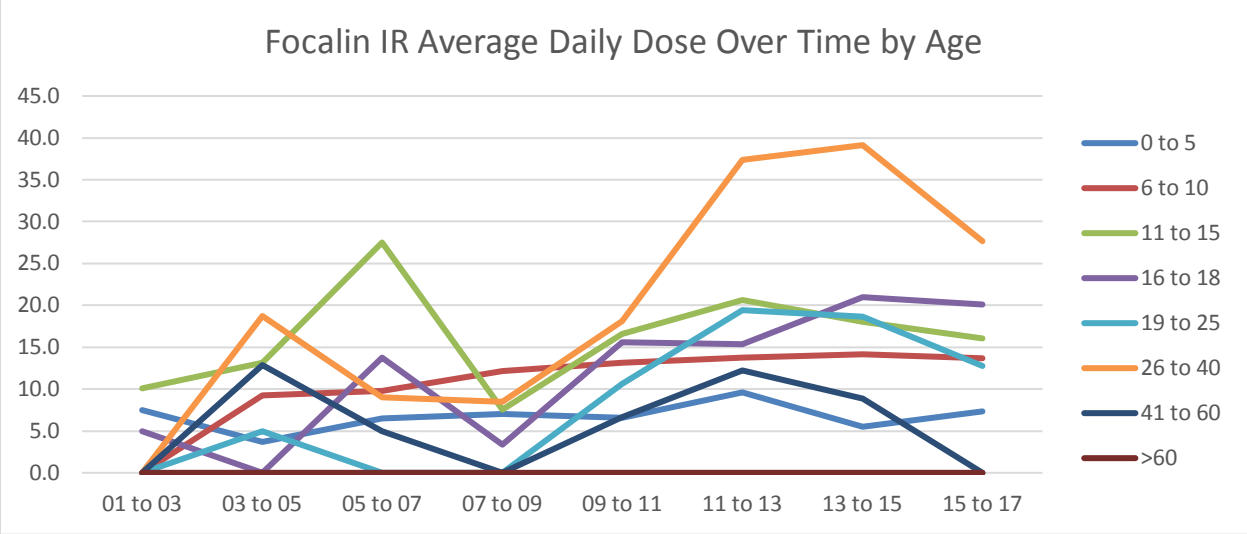

Adderall XR Average Daily Dose Over Time by Age
45.0
40.0
35.0
30.0
25.0
20.0
15.0
10.0
5.0
0.0
01 to 03
03 to 05
05 to 07
07 to 09
09 to 11
11 to 13
13 to 15
15 to 17
0 to 5
6 to 10
11 to 15
16 to 18
19 to 25
26 to 40
41 to 60
>60

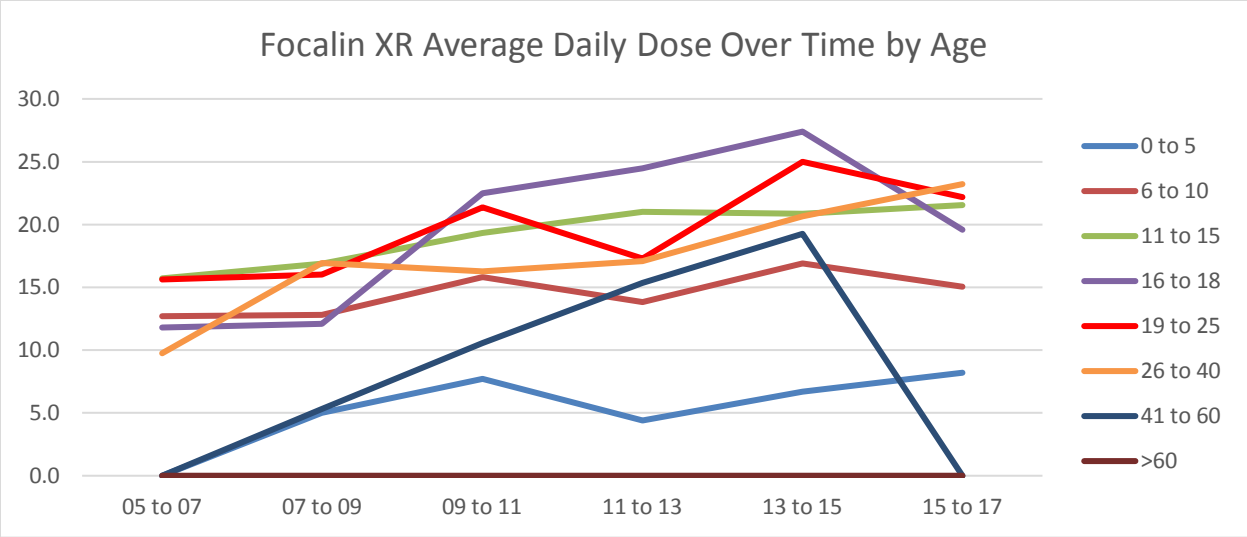

Adderall IR Average Daily Dose Over Time by Age
50.0
45.0
40.0
35.0
30.0
25.0
20.0
15.0
10.0
5.0
0.0
01 to 03
03 to 05
05 to 07
07 to 09
09 to 11
11 to 13
13 to 15
15 to 17
0 to 5
6 to 10
11 to 15
16 to 18
19 to 25
26 to 40
41 to 60
>60

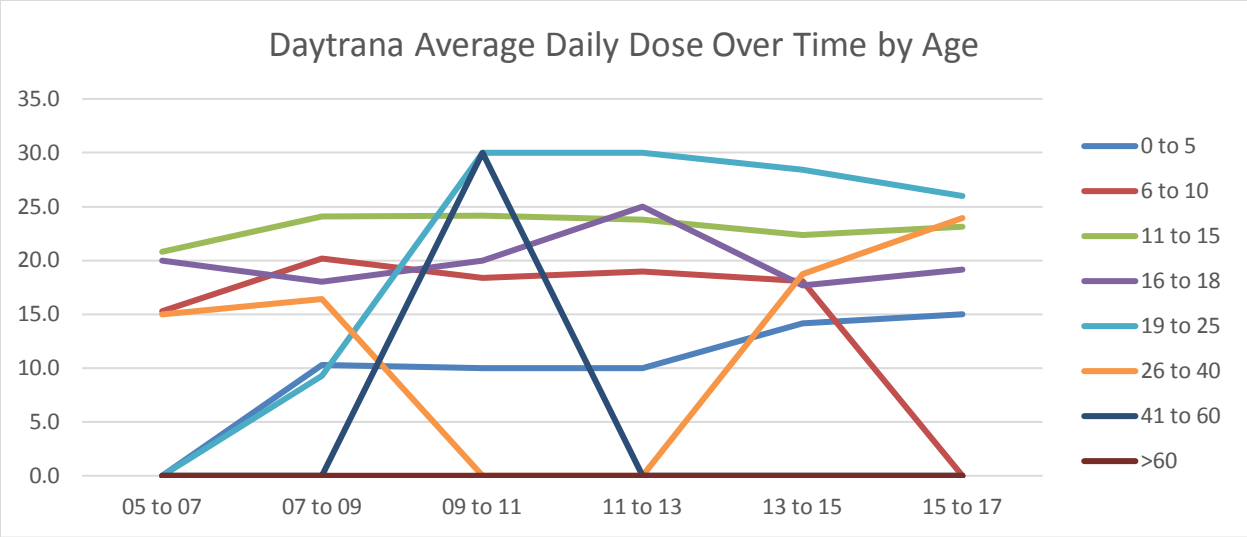

Methylphenidate ER Average Daily Dose Over Time by Age
60.0
50.0
40.0
30.0
20.0
10.0
0.0
01 to 03
03 to 05
05 to 07
07 to 09
09 to 11
11 to 13
13 to 15
15 to 17
0 to 5
6 to 10
11 to 15
16 to 18
19 to 25
26 to 40
41 to 60
>60

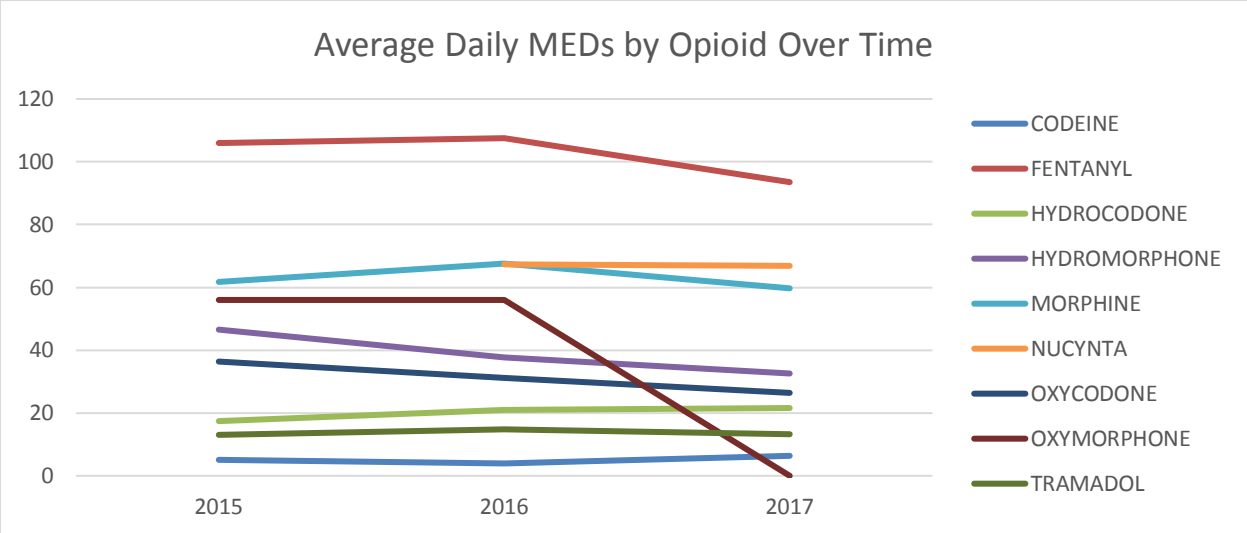

Methylphenidate IR Average Daily Dose Over Time by Age
45.0
40.0
35.0
30.0
25.0
20.0
15.0
10.0
5.0
0.0
01 to 03
03 to 05
05 to 07
07 to 09
09 to 11
11 to 13
13 to 15
15 to 17
0 to 5
6 to 10
11 to 15
16 to 18
19 to 25
26 to 40
41 to 60
>60

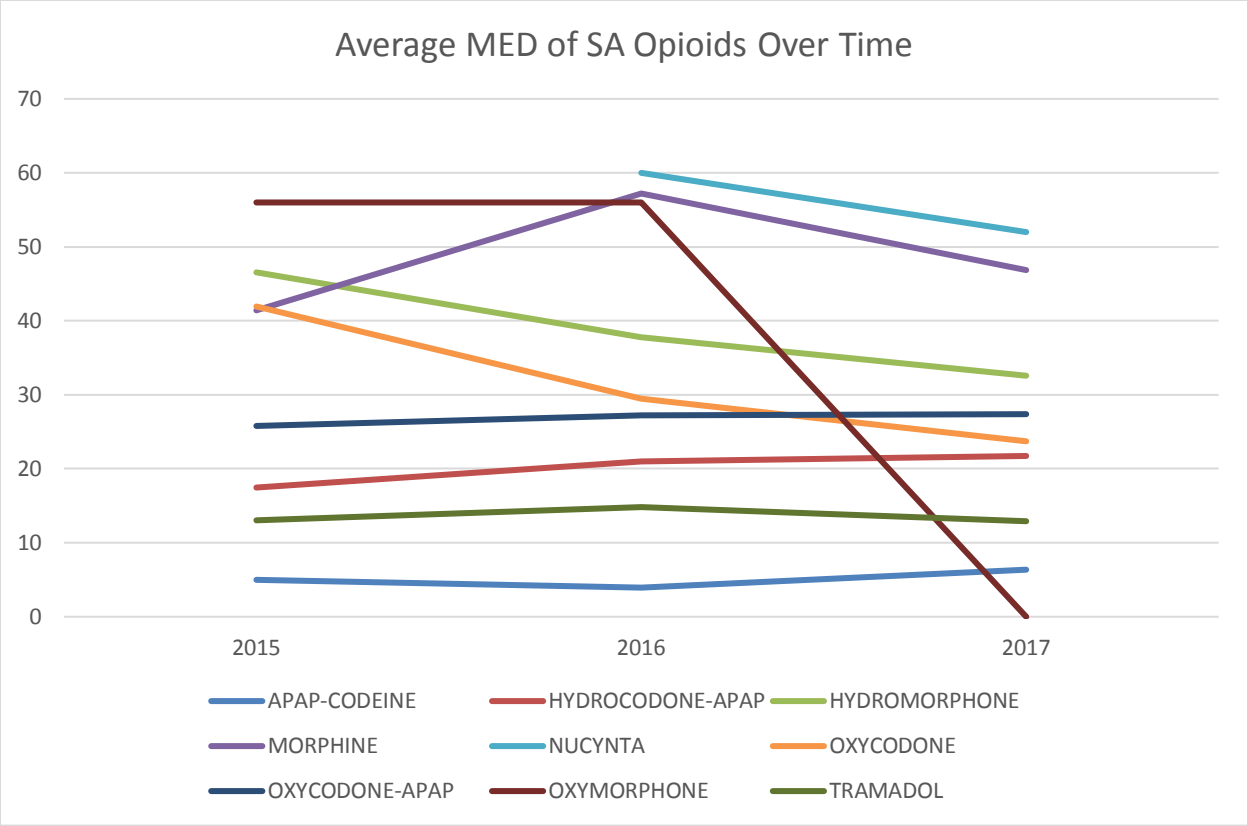

Vyvanse Average Daily Dose Over Time by Age
60.0
50.0
40.0
30.0
20.0
10.0
0.0
07 to 09
09 to 11
11 to 13
13 to 15
15 to 17
0 to 5
6 to 10
11 to 15
16 to 18
19 to 25
26 to 40
41 to 60
>60

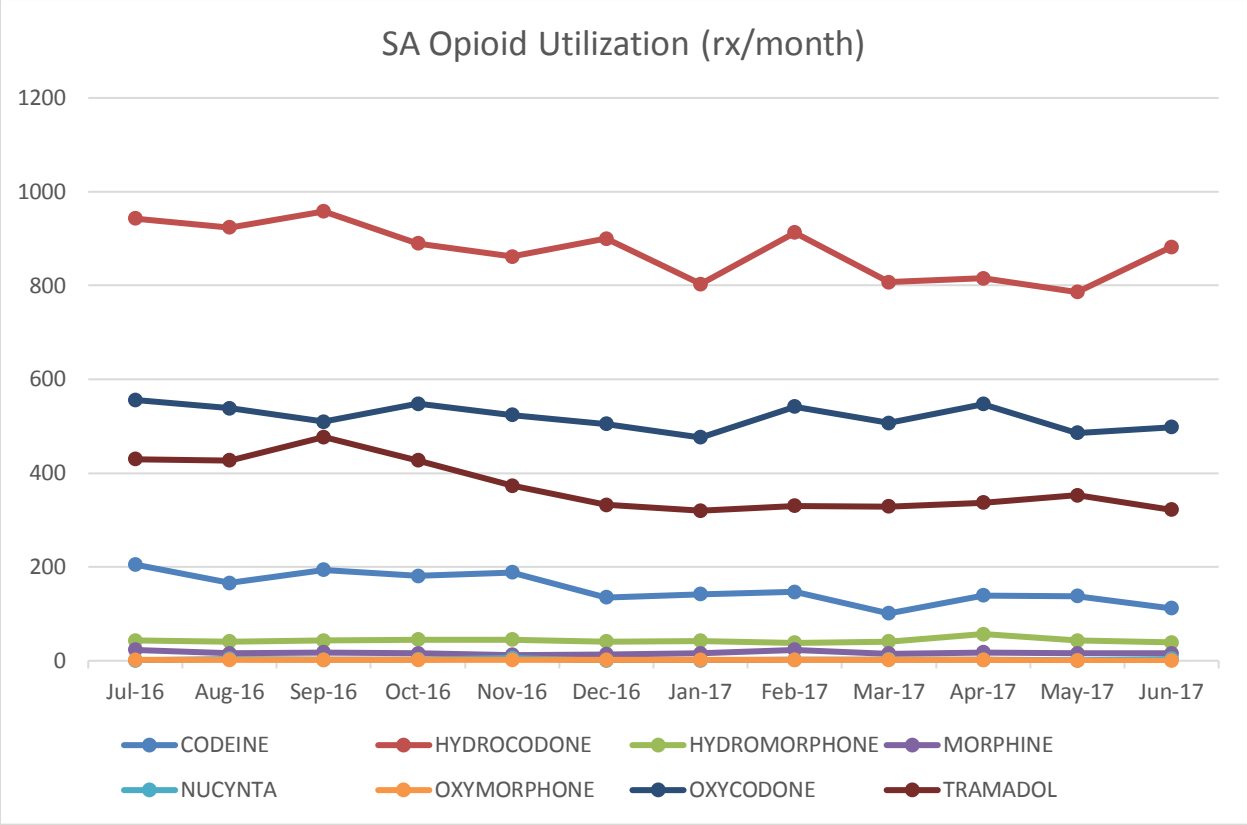

Focalin IR Average Daily Dose Over Time by Age
45.0
40.0
35.0
30.0
25.0
20.0
15.0
10.0
5.0
0.0
01 to 03
03 to 05
05 to 07
07 to 09
09 to 11
11 to 13
13 to 15
15 to 17
0 to 5
6 to 10
11 to 15
16 to 18
19 to 25
26 to 40
41 to 60
>60

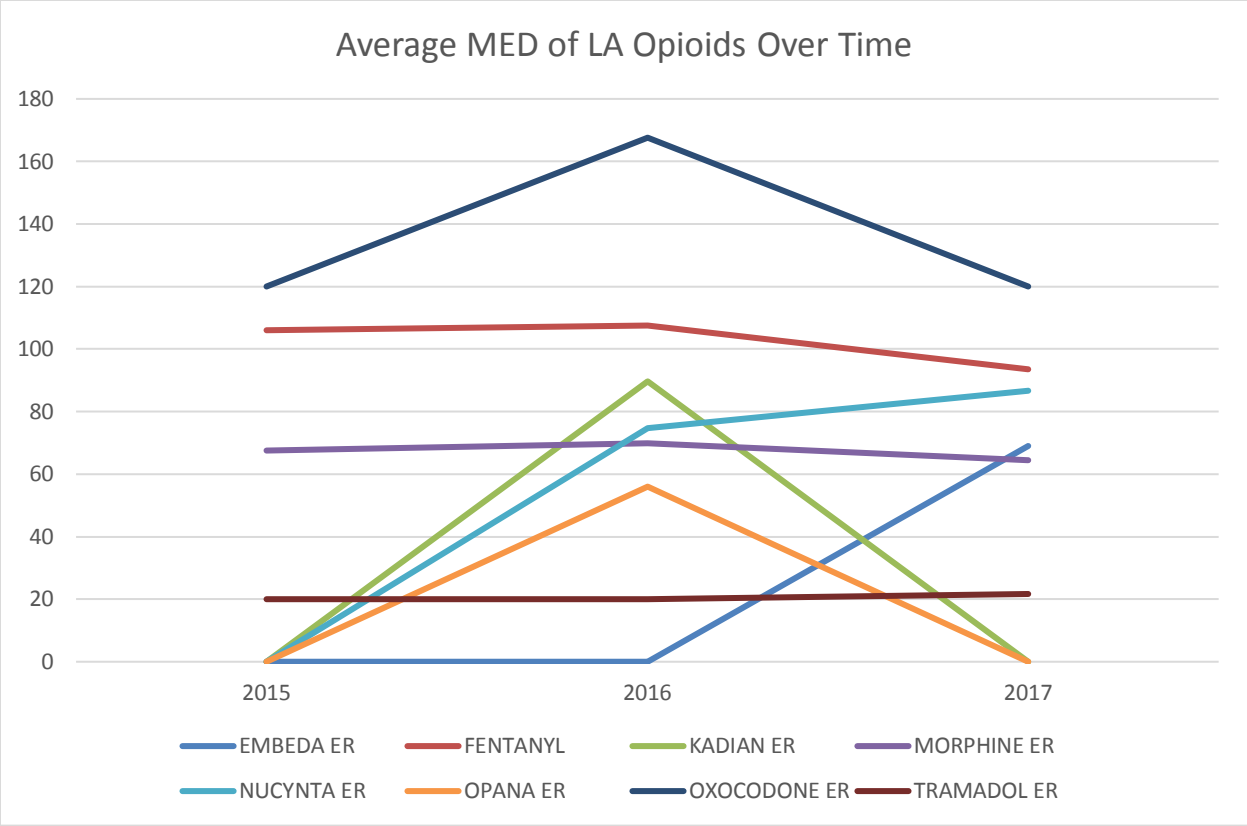

Focalin XR Average Daily Dose Over Time by Age
30.0
25.0
20.0
15.0
10.0
5.0
0.0
05 to 07
07 to 09
09 to 11
11 to 13
13 to 15
15 to 17
0 to 5
6 to 10
11 to 15
16 to 18
19 to 25
26 to 40
41 to 60
>60

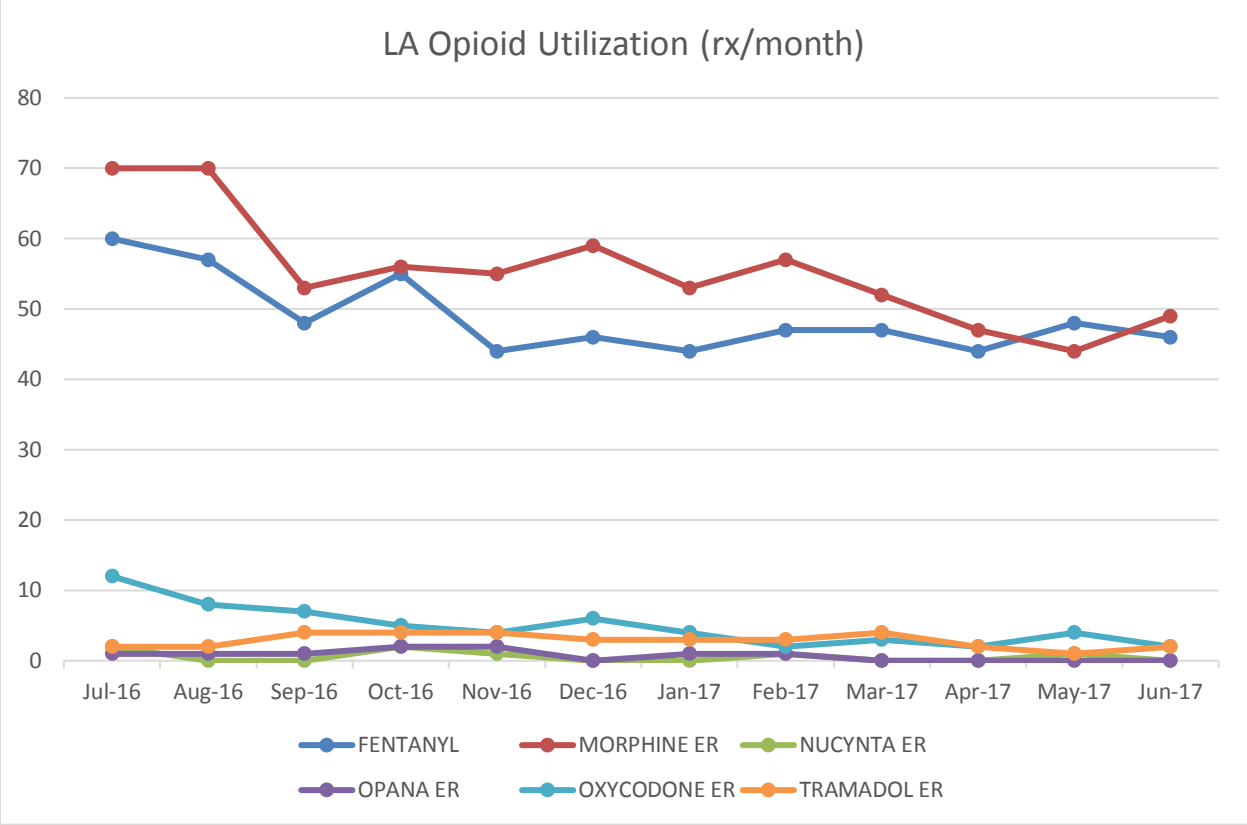

Daytrana Average Daily Dose Over Time by Age
35.0
30.0
25.0
20.0
15.0
10.0
5.0
0.0
05 to 07
07 to 09
09 to 11
11 to 13
13 to 15
15 to 17
0 to 5
6 to 10
11 to 15
16 to 18
19 to 25
26 to 40
41 to 60
>60

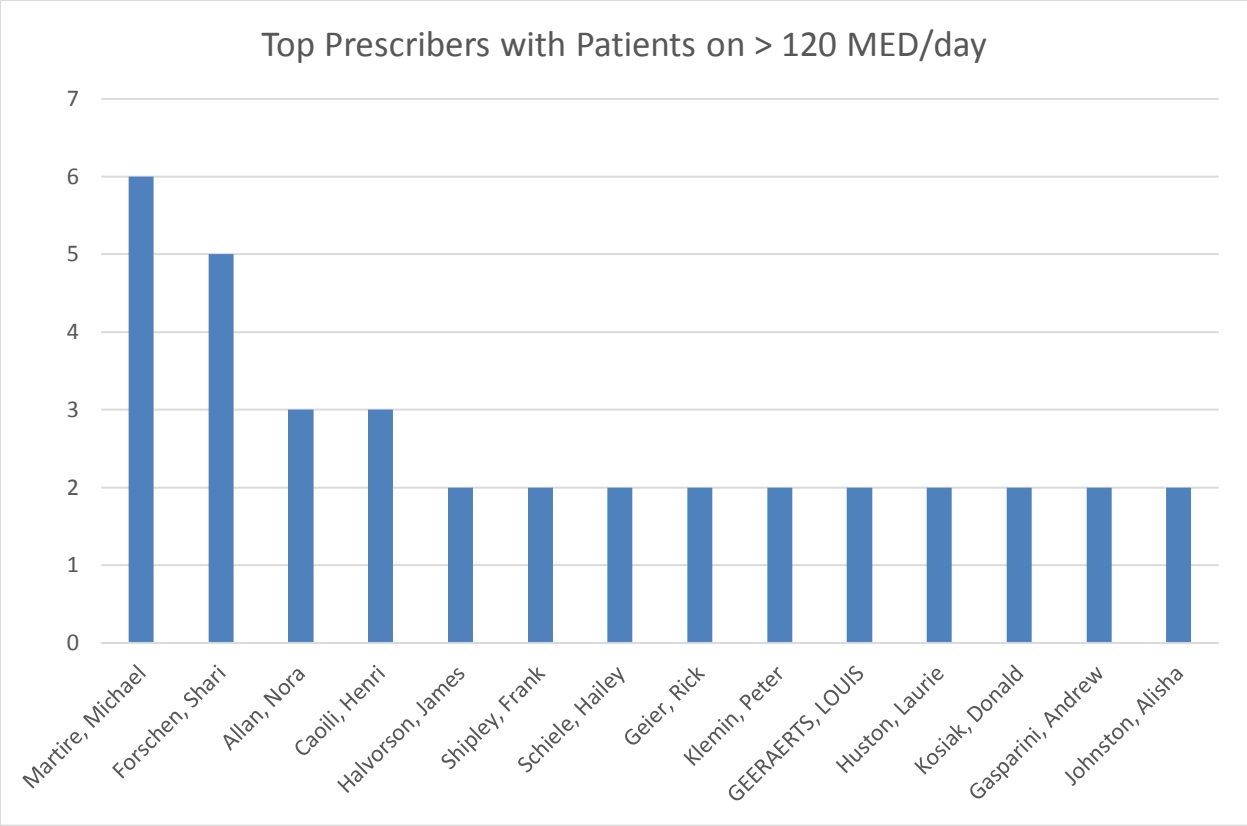

Average Daily MEDs by Opioid Over Time
120
100
80
60
40
20
0
2015
2016
2017
CODEINE
FENTANYL
HYDROCODONE
HYDROMORPHONE
MORPHINE
NUCYNTA
OXYCODONE
OXYMORPHONE
TRAMADOL

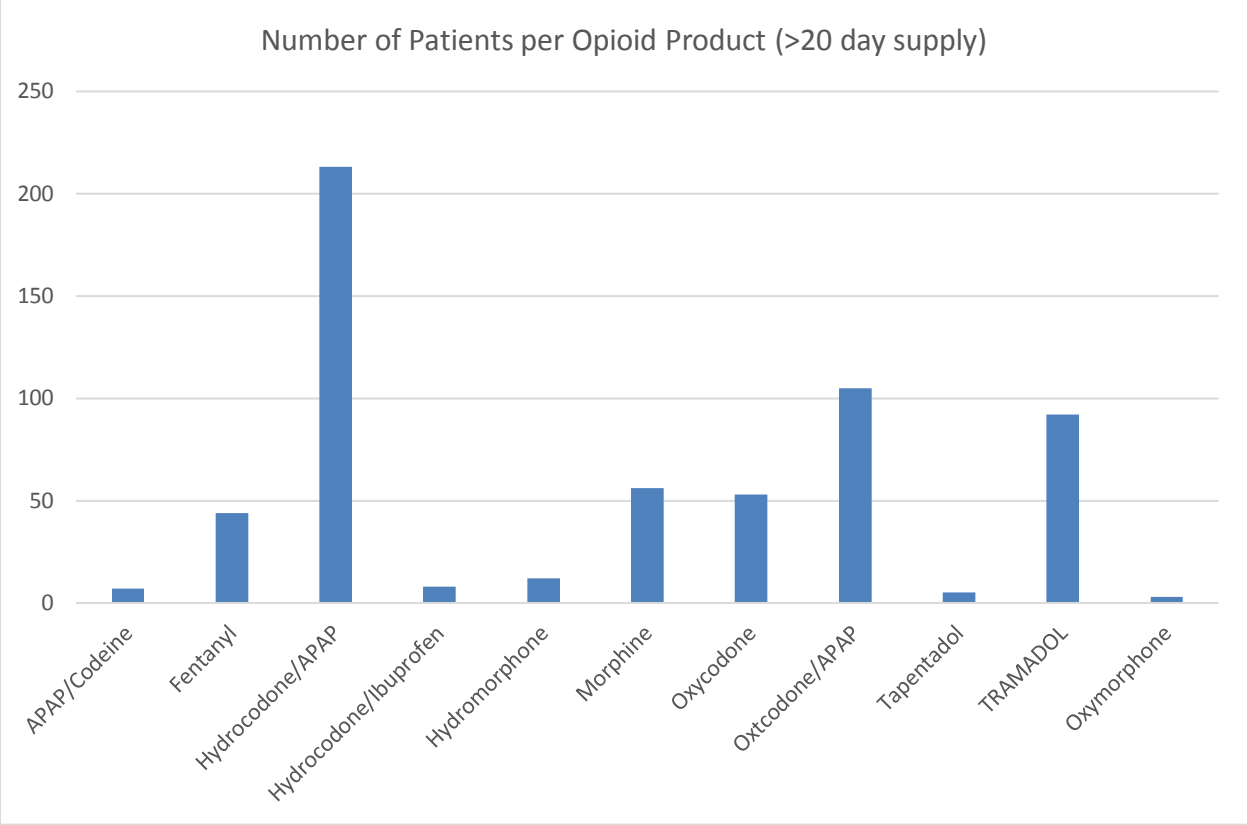

Average MED of SA Opioids Over Time
70
60
50
40
30
20
10
0
2015
2016
2017
APAP-CODEINE
HYDROCODONE-APAP
HYDROMORPHONE
MORPHINE
NUCYNTA
OXYCODONE
OXYCODONE-APAP
OXYMORPHONE
TRAMADOL

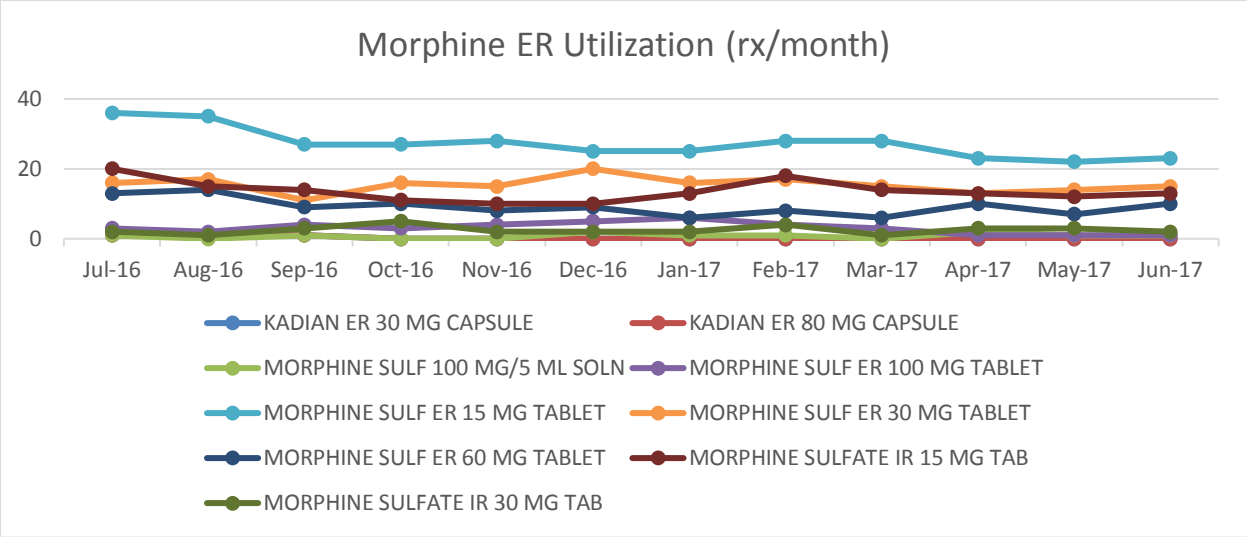

SA Opioid Utilization (rx/month)
1200
1000
800
600
400
200
0
Jul-16
Aug-16
Sep-16
Oct-16
Nov-16
Dec-16
Jan-17
Feb-17
Mar-17
Apr-17
May-17
Jun-17
CODEINE
HYDROCODONE
HYDROMORPHONE
MORPHINE
NUCYNTA
OXYMORPHONE
OXYCODONE
TRAMADOL

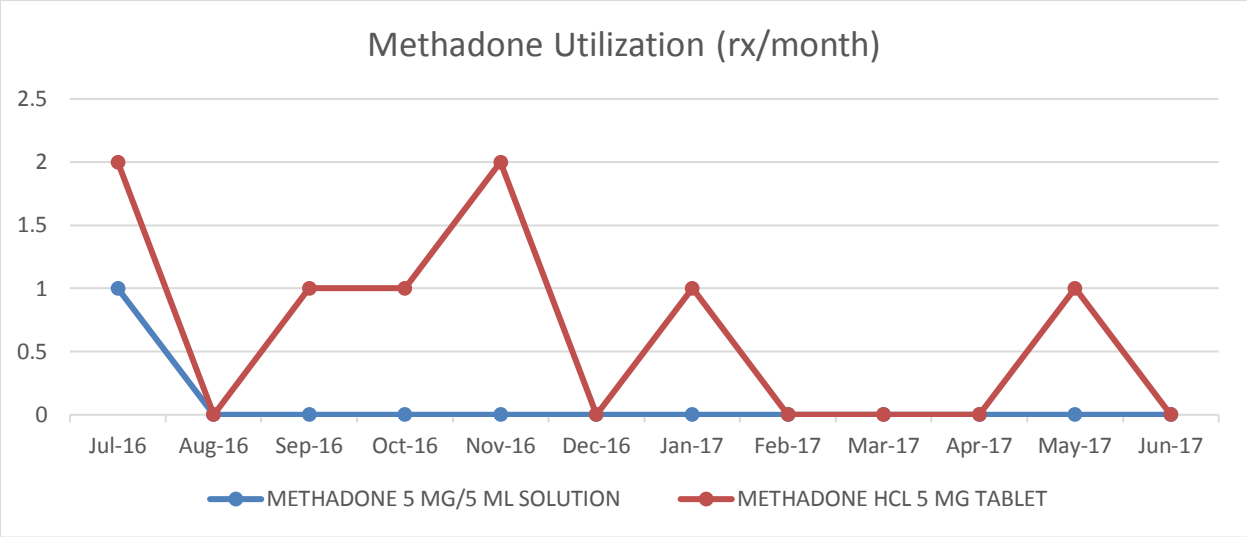

Average MED of LA Opioids Over Time
180
160
140
120
100
80
60
40
20
0
2015
2016
2017
EMBEDA ER
FENTANYL
KADIAN ER
MORPHINE ER
NUCYNTA ER
OPANA ER
OXOCODONE ER
TRAMADOL ER

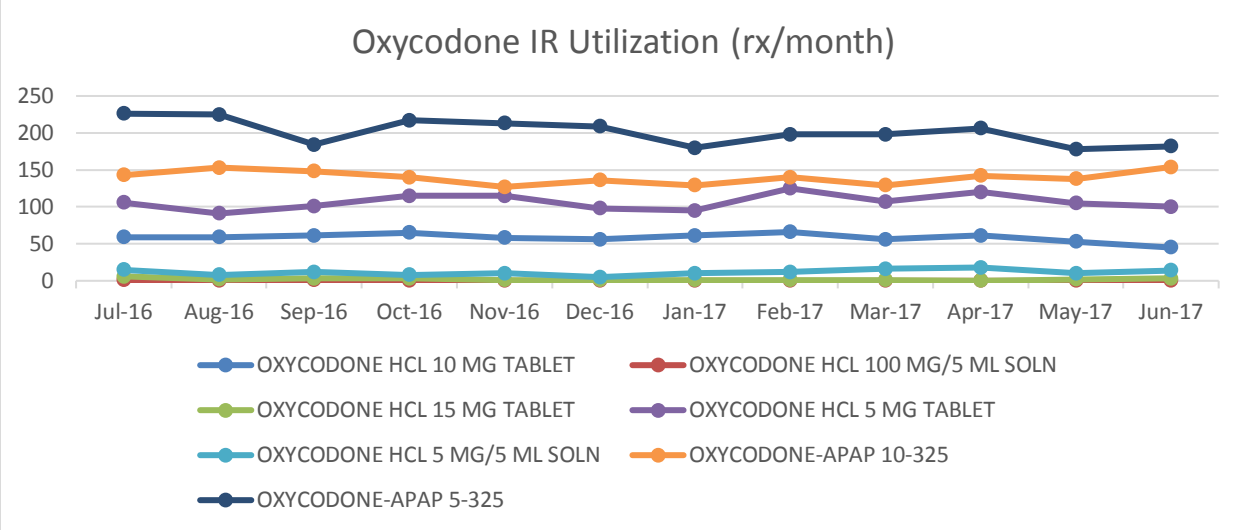

LA Opioid Utilization (rx/month)
80
70
60
50
40
30
20
10
0
Jul-16
Aug-16
Sep-16
Oct-16
Nov-16
Dec-16
Jan-17
Feb-17
Mar-17
Apr-17
May-17
Jun-17
FENTANYL
MORPHINE ER
NUCYNTA ER
OPANA ER
OXYCODONE ER
TRAMADOL ER

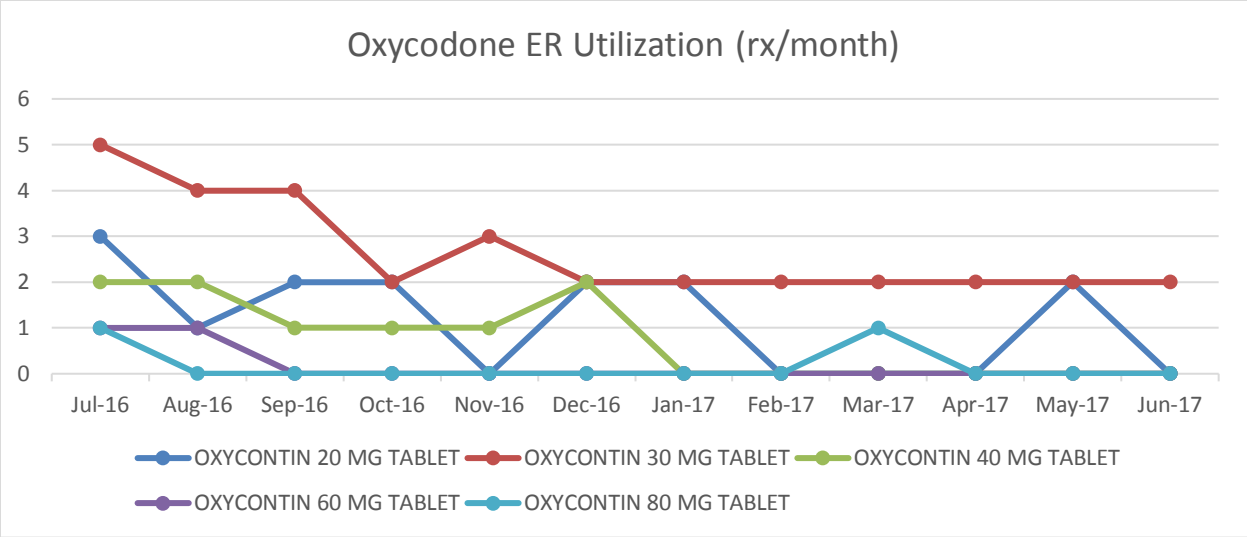

Top Prescribers with Patients on > 120 MED/day
7
6
5
4
3
2
1
0
Martire, Michael
Forschen, Shari
Allan, Nora
Caoili, Henri
Halvorson, James
Shipley, Frank
Schiele, Hailey
Geier, Rick
Klemin, Peter
GEERAERTS, LOUIS
Huston, Laurie
Kosiak, Donald
Gasparini, Andrew
Johnston, Alisha

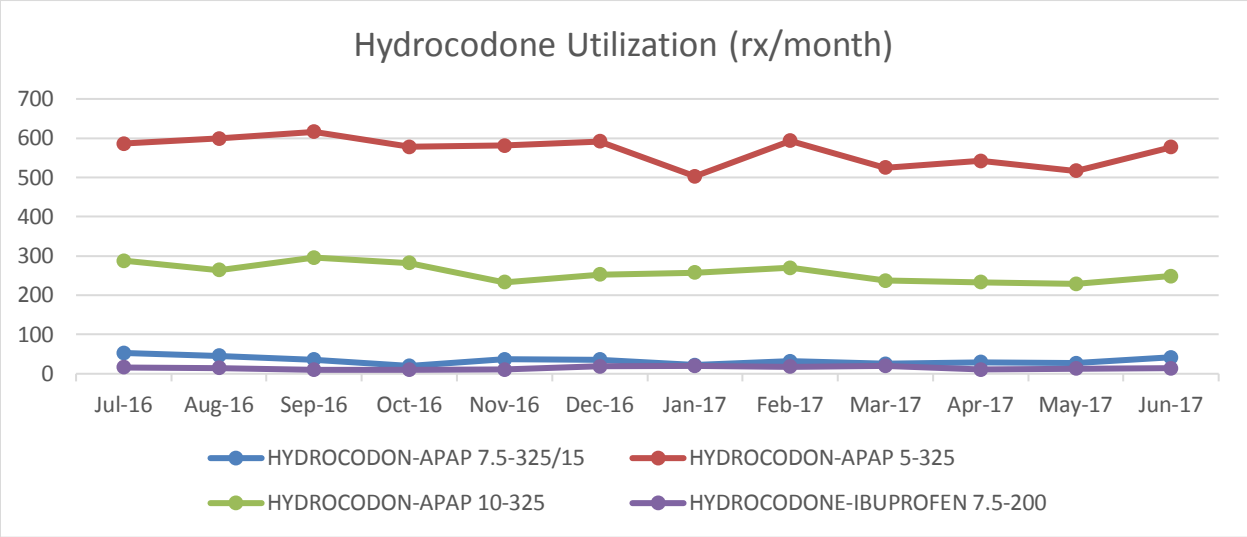

Number of Patients per Opioid Product (>20 day supply)
250
200
150
100
50
0
APAP/Codeine
Fentanyl
Hydrocodone/APAP
Hydrocodone/Ibuprofen
Hydromorphone
Morphine
Oxycodone
Oxtcodone/APAP
Tapentadol
TRAMADOL
Oxymorphone

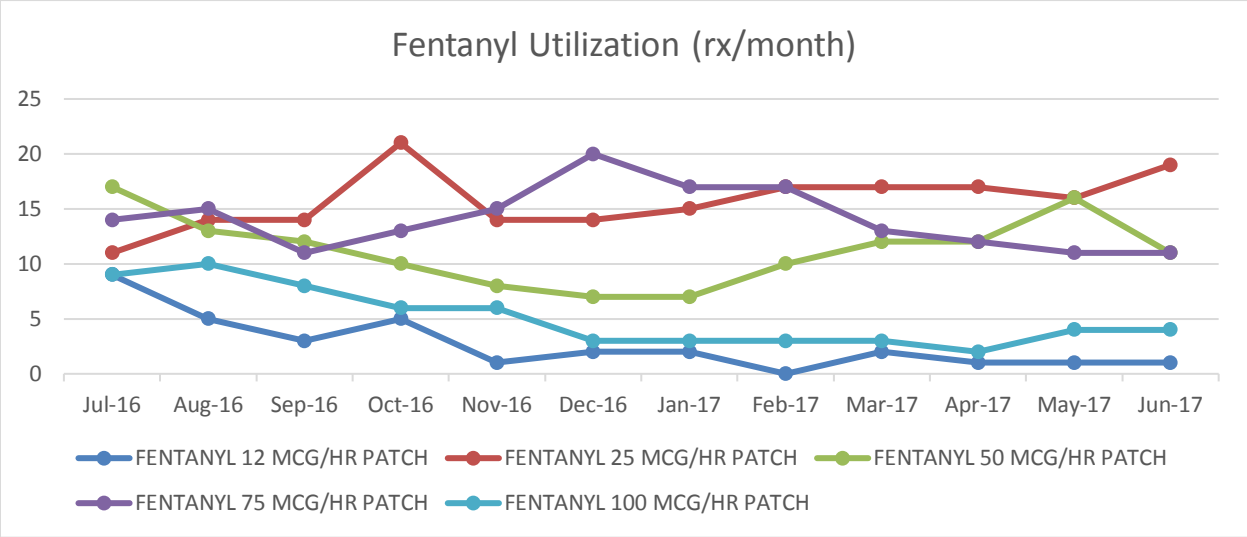

Morphine ER Utilization (rx/month)
40
20
0
Jul-16
Aug-16
Sep-16
Oct-16
Nov-16
Dec-16
Jan-17
Feb-17
Mar-17
Apr-17
May-17
Jun-17
KADIAN ER 30 MG CAPSULE
KADIAN ER 80 MG CAPSULE
MORPHINE SULF 100 MG/5 ML SOLN
MORPHINE SULF ER 100 MG TABLET
MORPHINE SULF ER 15 MG TABLET
MORPHINE SULF ER 30 MG TABLET
MORPHINE SULF ER 60 MG TABLET
MORPHINE SULFATE IR 15 MG TAB
MORPHINE SULFATE IR 30 MG TAB

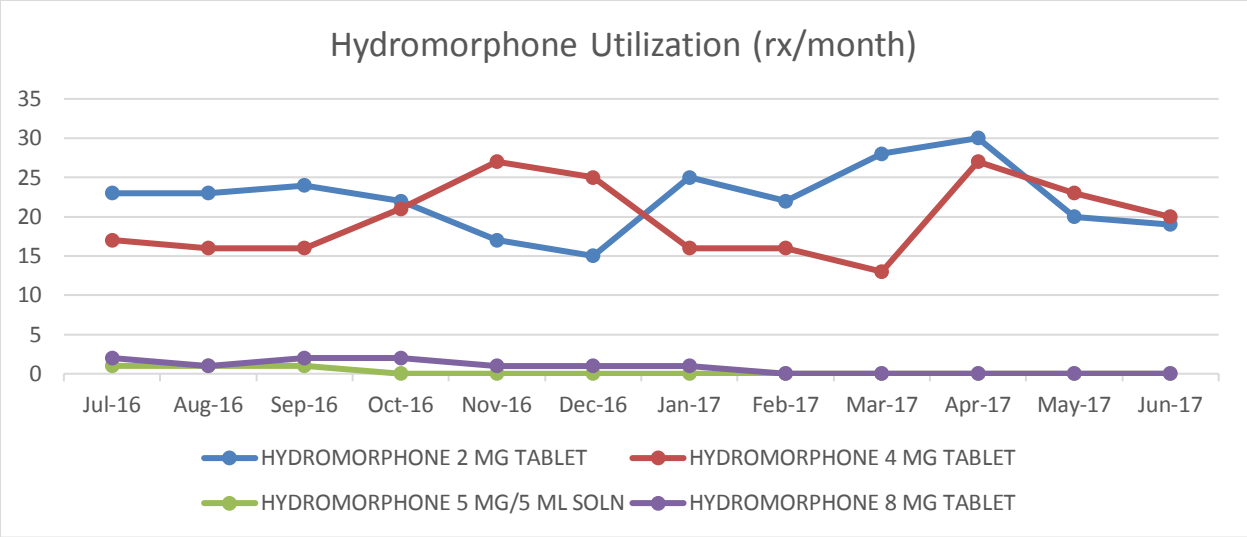

Methadone Utilization (rx/month)
2.5
2
1.5
1
0.5
0
Jul-16
Aug-16
Sep-16
Oct-16
Nov-16
Dec-16
Jan-17
Feb-17
Mar-17
Apr-17
May-17
Jun-17
METHADONE 5 MG/5 ML SOLUTION
METHADONE HCL 5 MG TABLET

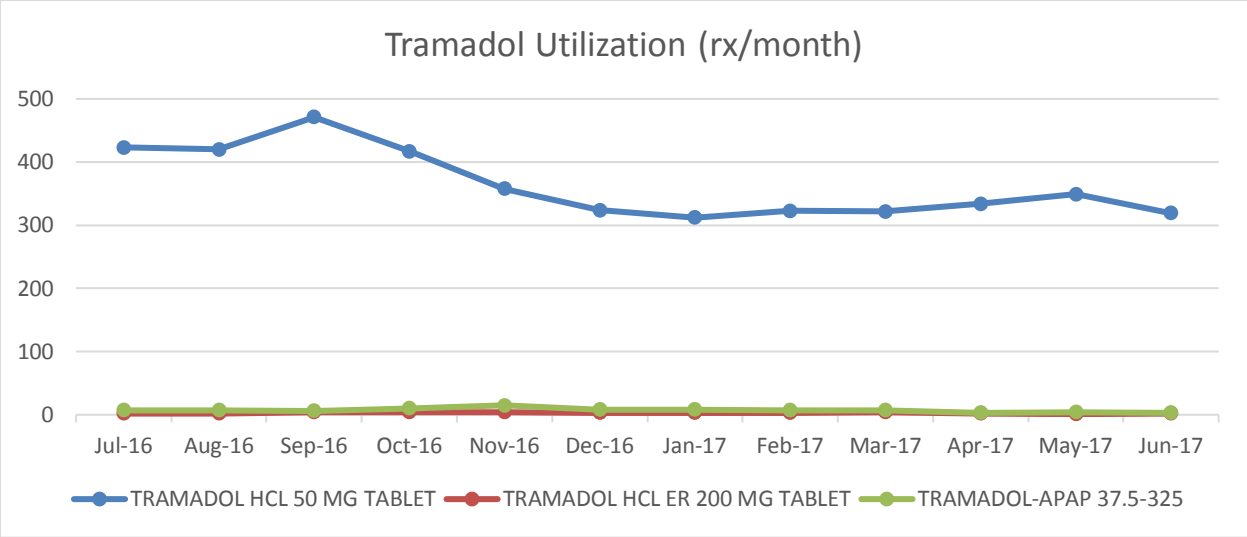

Oxycodone IR Utilization (rx/month)
250
200
150
100
50
0
Jul-16
Aug-16
Sep-16
Oct-16
Nov-16
Dec-16
Jan-17
Feb-17
Mar-17
Apr-17
May-17
Jun-17
OXYCODONE HCL 10 MG TABLET
OXYCODONE HCL 100 MG/5 ML SOLN
OXYCODONE HCL 15 MG TABLET
OXYCODONE HCL 5 MG TABLET
OXYCODONE HCL 5 MG/5 ML SOLN
OXYCODONE-APAP 10-325
OXYCODONE-APAP 5-325

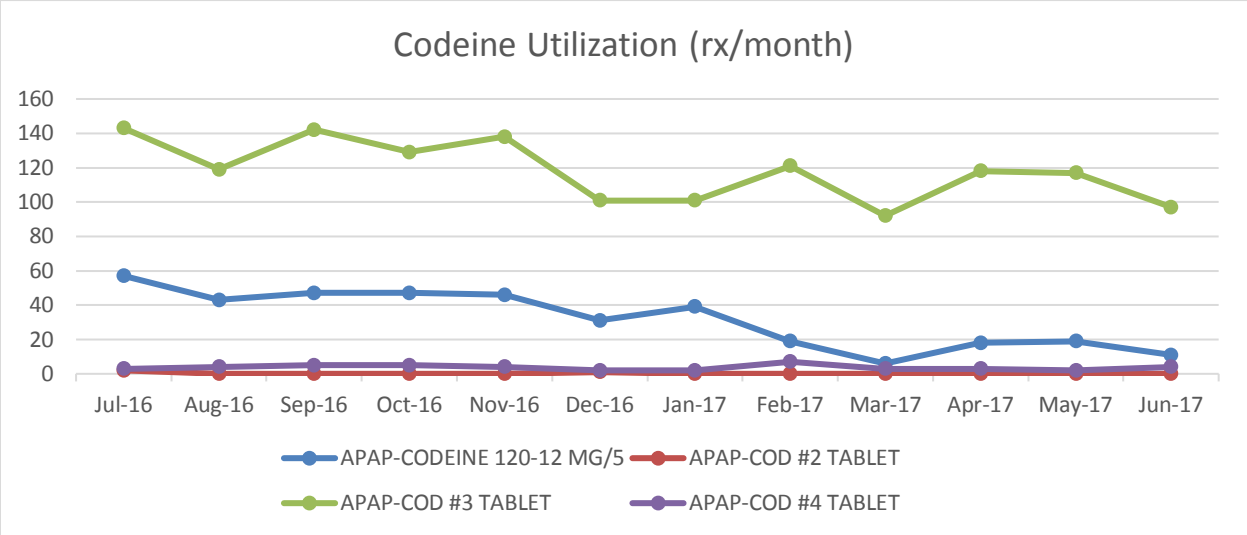

Oxycodone ER Utilization (rx/month)
6
5
4
3
2
1
0
Jul-16
Aug-16
Sep-16
Oct-16
Nov-16
Dec-16
Jan-17
Feb-17
Mar-17
Apr-17
May-17
Jun-17
OXYCONTIN 20 MG TABLET
OXYCONTIN 30 MG TABLET
OXYCONTIN 40 MG TABLET
OXYCONTIN 60 MG TABLET
OXYCONTIN 80 MG TABLET

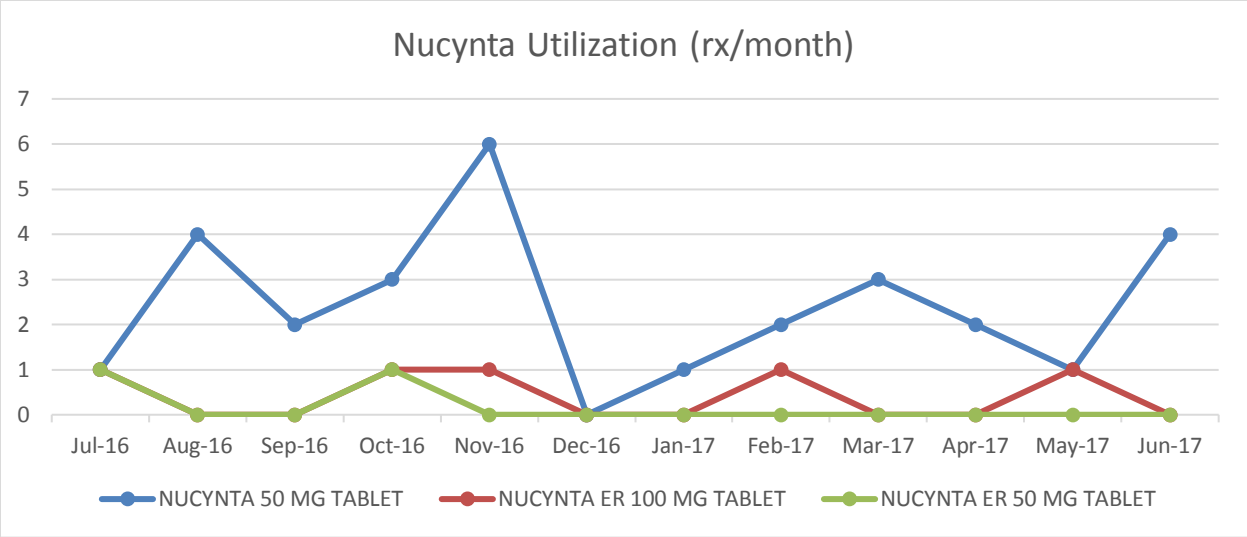

Hydrocodone Utilization (rx/month)
700
600
500
400
300
200
100
0
Jul-16
Aug-16
Sep-16
Oct-16
Nov-16
Dec-16
Jan-17
Feb-17
Mar-17
Apr-17
May-17
Jun-17
HYDROCODON-APAP 7.5-325/15
HYDROCODON-APAP 5-325
HYDROCODON-APAP 10-325
HYDROCODONE-IBUPROFEN 7.5-200

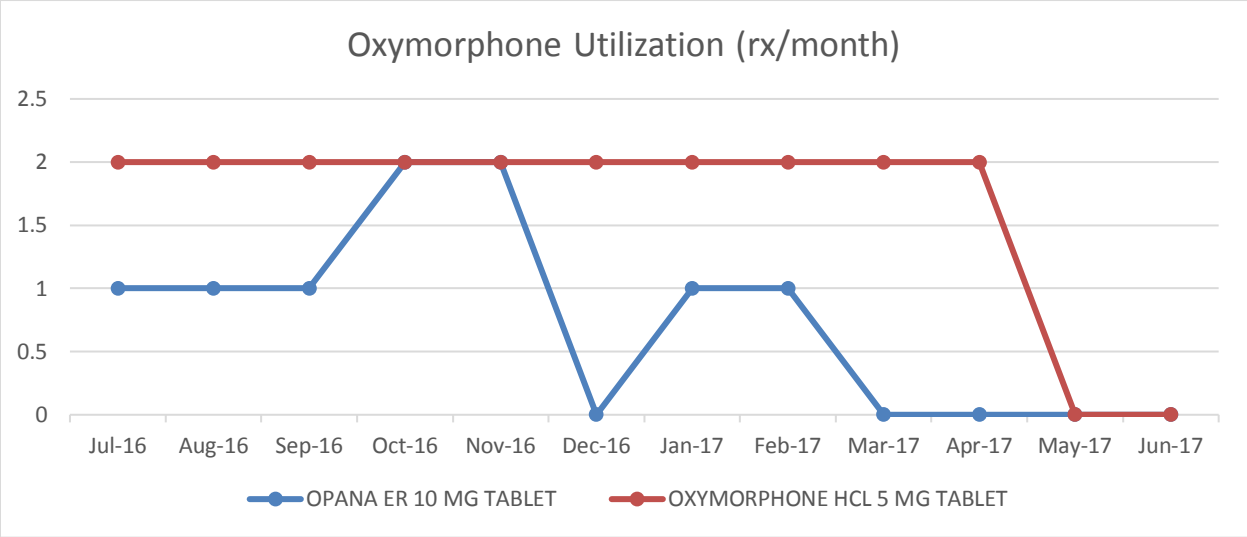

Fentanyl Utilization (rx/month)
25
20
15
10
5
0
Jul-16
Aug-16
Sep-16
Oct-16
Nov-16
Dec-16
Jan-17
Feb-17
Mar-17
Apr-17
May-17
Jun-17
FENTANYL 12 MCG/HR PATCH
FENTANYL 25 MCG/HR PATCH
FENTANYL 50 MCG/HR PATCH
FENTANYL 75 MCG/HR PATCH
FENTANYL 100 MCG/HR PATCH


Hydromorphone Utilization (rx/month)
35
30
25
20
15
10
5
0
Jul-16
Aug-16
Sep-16
Oct-16
Nov-16
Dec-16
Jan-17
Feb-17
Mar-17
Apr-17
May-17
Jun-17
HYDROMORPHONE 2 MG TABLET
HYDROMORPHONE 4 MG TABLET
HYDROMORPHONE 5 MG/5 ML SOLN
HYDROMORPHONE 8 MG TABLET


Tramadol Utilization (rx/month)
500
400
300
200
100
0
Jul-16
Aug-16
Sep-16
Oct-16
Nov-16
Dec-16
Jan-17
Feb-17
Mar-17
Apr-17
May-17
Jun-17
TRAMADOL HCL 50 MG TABLET
TRAMADOL HCL ER 200 MG TABLET
TRAMADOL-APAP 37.5-325


Codeine Utilization (rx/month)
160
140
120
100
80
60
40
20
0
Jul-16
Aug-16
Sep-16
Oct-16
Nov-16
Dec-16
Jan-17
Feb-17
Mar-17
Apr-17
May-17
Jun-17
APAP-CODEINE 120-12 MG/5
APAP-COD #2 TABLET
APAP-COD #3 TABLET
APAP-COD #4 TABLET


Nucynta Utilization (rx/month)
7
6
5
4
3
2
1
0
Jul-16
Aug-16
Sep-16
Oct-16
Nov-16
Dec-16
Jan-17
Feb-17
Mar-17
Apr-17
May-17
Jun-17
NUCYNTA 50 MG TABLET
NUCYNTA ER 100 MG TABLET
NUCYNTA ER 50 MG TABLET


Oxymorphone Utilization (rx/month)
2.5
2
1.5
1
0.5
0
Jul-16
Aug-16
Sep-16
Oct-16
Nov-16
Dec-16
Jan-17
Feb-17
Mar-17
Apr-17
May-17
Jun-17
OPANA ER 10 MG TABLET
OXYMORPHONE HCL 5 MG TABLET

NORTH DAKOTA MEDICAID
RETROSPECTIVE DRUG UTILIZATION REVIEW
CRITERIA RECOMMENDATIONS
3RD QUARTER 2017

Criteria Recommendations ***Approved Rejected***

1. Synjardy XR / Overutilization _____ _____

Alert Message: Synjardy XR (empagliflozin/metformin extended-release) may be over-utilized. The manufacturer's maximum recommended dose of empagliflozin/metformin XR is 25/2000 mg once daily.

Conflict Code: ER - Overutilization
Drugs/Diseases

Util A	Util B	Util C
Empagliflozin/metformin XR		

Max Dose: 25/2000 mg/day

References:
Synjardy XR Prescribing Information, Dec. 2016, Boehringer Ingelheim Pharmaceuticals.

2. Synjardy XR / Mod to Sev Renal Impairment, ESRD & Dialysis _____ _____

Alert Message: Synjardy XR (empagliflozin/metformin extended-release) use is contraindicated in patients with moderate to severe renal impairment (eGFR below 45 mL/min/1.73m2), end-stage renal disease, or dialysis. Based on its mechanism of action, inhibition of SGLT2 in the proximal renal tubules, the empagliflozin component is not expected to be effective in these patients.

Conflict Code: TA – Therapeutic Appropriateness
Drugs/Diseases

Util A	Util B	Util C **(Include)**
Empagliflozin/metformin XR		CKD Stage 3, 4 & 5 ESRD Dialysis

References:
Synjardy XR Prescribing Information, Dec. 2016, Boehringer Ingelheim Pharmaceuticals.

3. Synjardy XR / Therapeutic Appropriateness (Age 0-17 yoa) _____ _____

Alert Message: The safety and effectiveness of Synjardy XR (empagliflozin/metformin extended-release) in pediatric patients under 18 years of age have not been established.

Conflict Code: TA – Therapeutic Appropriateness
Drugs/Diseases

Util A	Util B	Util C
Empagliflozin/metformin XR		

Age Range 0 - 17 yoa

References:
Synjardy XR Prescribing Information, Dec. 2016, Boehringer Ingelheim Pharmaceuticals.

4. Synjardy XR / Insulin & Sulfonylureas _____ _____

Alert Message: The concurrent use of Synjardy XR (empagliflozin/metformin extended-release) with insulin or an insulin secretagogue can increase the risk of hypoglycemia. A lower dose of insulin or insulin secretagogue may be required to minimize the risk of hypoglycemia when used in combination with empagliflozin/metformin XR.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Empagliflozin/metformin XR	Insulins	
	Chlorpropamide	
	Glimepiride	
	Glipizide	
	Glyburide	
	Tolazamide	
	Tolbutamide	

References:
Synjardy XR Prescribing Information, Dec. 2016, Boehringer Ingelheim Pharmaceuticals.

5. Synjardy XR / Nonadherence _____ _____

Alert Message: Based on refill history, our patient may be under-utilizing Synjardy XR (empagliflozin extended-release). Non-adherence to the prescribed dosing regimen may result in sub-therapeutic effects, which may lead to decreased patient outcomes and additional healthcare costs.

Conflict Code: LR - Nonadherence
Drugs/Diseases

Util A	Util B	Util C
Empagliflozin/metformin XR		

References:
Synjardy XR Prescribing Information, Dec. 2016, Boehringer Ingelheim Pharmaceuticals.
Osterberg L, Blaschke T. Adherence to medication. N Engl J Med 2005;353:487-97.
Ho PM, Rumsfeld JS, Masoudi FA, et al., Effect of Medication Nonadherence in Diabetes Mellitus. Cardiology Review, April 2007.
Currie CJ, Peyrot M, Morgan CL, et al. The Impact of Treatment Noncompliance on Mortality in People With Type 2 Diabetes. Diabetes Care 35:1279-1284, June 2012.
Butler RJ, Davis TK, Johnson WL, et al. Effects of Nonadherence with\Prescription Drugs Among Older Adults. Am J Manag Care. 2011 Feb; 17(2):153-60.

6. Calcifediol ER / Overutilization _____ _____

Alert Message: Rayaldee (calcifediol extended-release) may be over-utilized. The manufacturer's recommended maximum daily dose is 60 mcg once daily.

Conflict Code: ER - Overutilization
Drugs/Diseases

Util A	Util B	Util C
Calcifediol ER		

Max Dose: 60 mcg/day

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Rayaldee Prescribing Information, March 2016, OPKO Pharmaceuticals, LLC.

7. Calcifediol ER / Strong CYP3A Inhibitors _____ _____

Alert Message: The concurrent use of Rayaldee (calcifediol extended-release) with a CYP3A4 inhibitor may inhibit enzymes involved in vitamin D metabolism (CYP24A1 and CYP27B1) and may alter serum levels of calcifediol. Dose adjustment of calcifediol may be required, and serum 25-hydroxyvitamin D, intact PTH and calcium concentrations should be closely monitored if a patient initiates or discontinues therapy with a strong CYP3A4 inhibitor.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B		Util C
Calcifediol ER	Nefazodone	Saquinavir	
	Ketoconazole	Ritonavir	
	Itraconazole	Indinavir	
	Voriconazole	Nelfinavir	
	Posaconazole	Atazanavir	
	Clarithromycin	Conivaptan	
	Telithromycin	Idelalisib	

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Rayaldee Prescribing Information, March 2016, OPKO Pharmaceuticals, LLC.
Wang Z, Schuetz EG, Xu Y, Thummel KE. Interplay between Vitamin D and the Drug Metabolizing Enzyme CYP3A4. The Journal of Steroid Biochemistry and Molecular Biology. 2013;136;54-58. doi:10.1016/j.jsbmb.2012.09.012.

8. Calcifediol ER / Cholestyramine _____ _____

Alert Message: The concurrent use of Rayaldee (calcifediol extended-release) with cholestyramine may result in reduced intestinal absorption of calcifediol. Dose adjustment of calcifediol may be required, and serum total 25-hydroxyvitamin D, intact PTH and serum calcium concentrations should be closely monitored if a patient initiates or discontinues therapy with cholestyramine.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Calcifediol ER	Cholestyramine	

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Rayaldee Prescribing Information, March 2016, OPKO Pharmaceuticals, LLC.

9. Calcifediol ER / Thiazide or Thiazide-like Diuretics _____ _____

Alert Message: The concurrent use of Rayaldee (calcifediol extended-release) with a thiazide or thiazide-like diuretic may cause hypercalcemia. These diuretics are known to induce hypercalcemia by reducing excretion of calcium in the urine. Patients may require more frequent serum calcium monitoring in this setting.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Calcifediol ER	Hydrochlorothiazide	
	Chlorthalidone	
	Chlorothiazide	
	Methyclothiazide	
	Bendroflumethiazide	
	Indapamide	
	Metolazone	

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Rayaldee Prescribing Information, March 2016, OPKO Pharmaceuticals, LLC.

10. Calcifediol ER / Agents that Stimulate Hydroxylation of Vitamin D _____ _____

Alert Message: The concurrent use of Rayaldee (calcifediol extended-release) with agents that stimulate microsomal hydroxylation may reduce the half-life of calcifediol. Dose adjustment of calcifediol may be required, and serum 25-hydroxyvitamin D, intact PTH and serum calcium concentrations should be closely monitored if a patient initiates or discontinues therapy with the stimulating agent.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Calcifediol ER	Barbiturates	
	Anticonvulsants	
	Rifampin	

References:
Micromedex 2.0 (Electronic version) Truven Health Analytics.
Rayaldee Prescribing Information, March 2016, OPKO Pharmaceuticals, LLC.
Gupta RP, Hollis BW, Patel SB, Patrick KS, Bell NH. CYP3A4 is a Human Microsomal Vitamin D 25-Hydroxylase. J Bone Miner. Rees 2004;19:680-688.
Wang Z, Schuetz EG, Xu Y, Thummel KE. Interplay between Vitamin D and the Drug Metabolizing Enzyme CYP3A4. The Journal Steroid Biochemistry and Molecular biology. 2013;136:54-58. doi:10.1016/j.jsbmb.2012.09.012.

11. Brodalumab / Therapeutic Appropriateness _____ _____

Alert Message: Suicidal ideation and behavior, including 4 completed suicides, occurred in subjects treated with Siliq (brodalumab) in the psoriasis clinical trials. Advise patients and caregivers to seek medical attention for manifestations of suicidal ideation and behavior, new onset or worsening depression, anxiety, or other mood changes. Reevaluate the risks and benefits of continuing treatment with brodalumab if such events occur.

Conflict Code: TA - Therapeutic Appropriateness (Black Box Warning)
Drugs/Diseases

Util A	Util B	Util C **(Include)**
Brodalumab		Suicidal Ideation
		Depression
		Anxiety

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Siliq Prescribing Information, Feb. 2017, Valeant Pharmaceuticals North America, LLC.

12. Brodalumab / Crohn's Disease _____ _____

Alert Message: Siliq (brodalumab) is contraindicated in patients with Crohn's disease because brodalumab may cause worsening of the disease state. In clinical trials, which excluded subjects with active Crohn's disease, Crohn's occurred in one subject during treatment and lead to discontinuation of therapy. In other trials, exacerbation of Crohn's disease was observed with brodalumab use.

Conflict Code: TA - Therapeutic Appropriateness
Drugs/Diseases

Util A	Util B	Util C **(Include)**
Brodalumab		Crohn's Disease

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Siliq Prescribing Information, Feb. 2017, Valeant Pharmaceuticals North America, LLC.

13. Brodalumab / Therapeutic Appropriateness (Pediatric) _____ _____
Alert Message: The safety and effectiveness of Siliq (brodalumab) have not been evaluated in pediatric patients.

Conflict Code: TA - Therapeutic Appropriateness
Drugs/Diseases

Util A	Util B	Util C
Brodalumab		

Age Range: 0 – 17 yoa

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Siliq Prescribing Information, Feb. 2017, Valeant Pharmaceuticals North America, LLC.

14. Brodalumab / Pregnancy / Pregnancy Negating _____ _____
Alert Message: There is no human data on Siliq (brodalumab) use in pregnant women to inform a drug associated risk. Human IgG antibodies are known to cross the placental barrier; therefore, brodalumab may be transmitted from the mother to the developing fetus. Advise pregnant females of that the drug may cross placental barrier.

Conflict Code: MC - Drug (Actual) Disease Precaution/Warning
Drugs/Diseases

Util A	Util B	Util C **(Negating)**
Brodalumab	Pregnancy	Delivery
		Miscarriage
		Delivery

Gender: Female
Age Range: 11 – 55 yoa

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Siliq Prescribing Information, Feb. 2017, Valeant Pharmaceuticals North America, LLC.

15. Brodalumab / Lactation & Disorders of Lactation _____ _____
Alert Message: There are no data on the presence of Siliq (brodalumab) in human milk, the effects on the breastfed infant, or the effects on milk production. Brodalumab was detected in the milk of lactating cynomolgus monkeys. The development and health benefits of breastfeeding should be considered along with the mother's clinical need for brodalumab and any potential adverse effects on the breastfed infant from brodalumab or from the underlying maternal condition.

Conflict Code: MC - Drug (Actual) Disease Precaution/Warning
Drugs/Diseases

Util A	Util B	Util C
Brodalumab	Lactation	
	Disorder of Lactation	

Gender: Female
Age Range: 11 – 55 yoa

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Siliq Prescribing Information, Feb. 2017, Valeant Pharmaceuticals North America, LLC.

16. Telotristat / Overutilization _____ _____

Alert Message: Xermelo (telotristat ethyl) may be over-utilized. The manufacturer's recommended maximum daily dose of telotristat ethyl is 250 mg three times daily (total 750 mg per day). Exceeding the recommended daily dose may increase the incidence of adverse reactions without increasing benefit, and is not recommended.

Conflict Code: ER - Overutilization
Drugs/Diseases

Util A	Util B	Util C
Telotristat		

Max Dose: 750 mg/day

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Xermelo Prescribing Information, Feb. 2017, Lexicon Pharmaceuticals, Inc.

17. Telotristat / CYP3A4 Substrates _____ _____

Alert Message: Concurrent use of Xermelo (telotristat) with a CYP3A4 substrate may result in decreased substrate systemic exposure and reduced efficacy. Monitor patient for suboptimal efficacy and consider dosage adjustment for the CYP3A4 substrate.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B		Util C
Telotristat	Midazolam	Hydrocodone	Amitriptyline
	Triazolam	Methadone	Trimipramine
	Alprazolam	Oxycodone	Dexamethasone
	Diazepam	Tramadol	Aprepitant
	Ketoconazole	Saquinavir	Alfuzosin
	Itraconazole	Ritonavir	Ondansetron
	Posaconazole	Indinavir	Cariprazine
	Voriconazole	Nelfinavir	Brexpiprazole
	Fluconazole	Quetiapine	Pimavanserin
	Nefazodone	Buspirone	Darifenacin
	Aripiprazole	Lurasidone	Darunavir
	Trazodone	Haloperidol	Everolimus
	Pimozide	Vilazodone	Naloxegol
	Clarithromycin	Ticagrelor	Maraviroc
	Erythromycin	Rivaroxaban	Eletriptan
	Telithromycin	Fentanyl	Amiodarone
	Quinidine	Imatinib	
	Cyclosporine	Salmeterol	
	Tacrolimus	Carbamazepine	
	Sirolimus	Sildenafil	
	Amlodipine	Tadalafil	
	Diltiazem	Avanafil	
	Felodipine	Vardenafil	
	Nifedipine	Zolpidem	
	Nisoldipine	Atorvastatin	
	Verapamil	Cerivastatin	
	Propranolol	Lovastatin	
	Aliskiren	Simvastatin	
	Eplerenone	Estradiol	

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Xermelo Prescribing Information, Feb. 2017, Lexicon Pharmaceuticals, Inc.
FDA: Drug Development and Drug Interactions: Tables of Substrates, Inhibitors and Inducers. Available at: http://www.fda.gov/Drugs/DevelopmentApprovalProcess/DevelopmentResources/DrugInteractionaLabeling/ucm093664.htm

18. Telotristat / Constipation _____ _____

Alert Message: Xermelo (telotristat ethyl) reduces bowel movement frequency. Patients receiving telotristat ethyl should be monitored for the development of constipation and/or severe, persistent, or worsening abdominal pain. Discontinue telotristat ethyl if severe constipation or severe persistent or worsening abdominal pain develops.

Conflict Code: MC – Drug (Actual) Disease Precaution/Warning
Drugs/Diseases

Util A	Util B	Util C
Telotristat	Constipation	

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Xermelo Prescribing Information, Feb. 2017, Lexicon Pharmaceuticals, Inc.

19. Codeine / CYP2D6 Inhibitors _____ _____

Alert Message: Concurrent use of a codeine-containing agent with a CYP2D6 inhibitor may result in a decrease in the effects of codeine. Codeine must be bioactivated via CYP2D6 to morphine to exert an analgesic effect. Consider the use of an alternative analgesic for patients requiring therapy with an agent that is a CYP2D6 inhibitor.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B		Util C
Codeine	Fluoxetine	Propafenone	
	Paroxetine	Quinidine	
	Bupropion	Terbinafine	

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Facts & Comparisons, 2017 Wolters Kluwer Health.

20. Bupropion / Digoxin _____ _____

Alert Message: Concurrent use of bupropion with digoxin may result in decreased digoxin plasma levels. Patients treated concomitantly with bupropion and digoxin should have digoxin levels monitored during concurrent therapy. While the mechanism of interaction is not fully understood the induction, by bupropion, of digoxin OATPAC1-mediated transport in the kidney may play a role.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Bupropion	Digoxin	

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Facts & Comparisons, 2017 Wolters Kluwer Health.
He J, Yu Y, Prasad B, et al. Mechanism of Unusual, But Clinically Significant, Digoxin-Bupropion Drug Interaction. Biopharm Drug Dispos. 2014 Jul;35(5):253-63. doi:10.1002/bdd.1890. Epub 2014 Mar3.
Kirby BJ, Collier AC, Kharasch ER, et al. Complex Drug Interactions of the HIV Protease Inhibitors 3: Effect of Simultaneous or Staggered Dosing of Digoxin and Ritonavir, Nelfinavir, Rifampin, or Bupropion. Drug, Metab Dispos. 2012; Vol. 40:610-616. doi: 10.1224/dmd.111042705. Epub 2011 Dec. 21.

21. Dapagliflozin / Pregnancy / Pregnancy Negating _____ _____

Alert Message: There are no adequate and well-controlled studies of Farxiga (dapagliflozin) in pregnant women. Based on results or reproductive and developmental toxicity studies in animals, dapagliflozin may affect renal development and maturation. During pregnancy, consider appropriate alternative therapies, especially during the second and third trimesters.

Conflict Code: MC – Drug (Actual) Disease Precaution
Drugs/Diseases

Util A	Util B	Util C **(Negating)**
Dapagliflozin	Pregnancy	Delivery
		Abortion
		Miscarriage

Gender: Female
Age Range: 11 – 55 yoa

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Blumer I, Hadar E, Hadden DR, et al. Diabetes and Pregnancy: An Endocrine Society Clinical Practice Guideline. J Clin Endocrinol Metab. 2013;98(11):4227-4249.
American Diabetes Association (ADA). 13. Management of Diabetes in Pregnancy. In Standards of Medical Care in Diabetes - 2017. Diabetes Care. 2017c;40(Suppl. 1):S114-S119.

22. Dapagliflozin-Metformin ER / Pregnancy / Pregnancy Negating _____ _____

Alert Message: There are no adequate and well-controlled studies of Xigduo XR (dapagliflozin/metformin extended-release) in pregnant women. Based on results of reproductive and developmental toxicity studies in animals, dapagliflozin may affect renal development and maturation. During pregnancy, consider appropriate alternative therapies, especially during the second and third trimesters.

Conflict Code: MC – Drug (Actual) Disease Precaution
Drugs/Diseases

Util A	Util B	Util C **(Negating)**
Dapagliflozin/Metformin	Pregnancy	Delivery
		Abortion
		Miscarriage

Gender: Female
Age Range: 11 – 55 yoa

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Blumer I, Hadar E, Hadden DR, et al. Diabetes and Pregnancy: An Endocrine Society Clinical Practice Guideline. J Clin Endocrinol Metab. 2013;98(11):4227-4249.
American Diabetes Association (ADA). 13. Management of Diabetes in Pregnancy. In Standards of Medical Care in Diabetes - 2017. Diabetes Care. 2017c;40(Suppl. 1):S114-S119.

23. Empagliflozin / Pregnancy / Pregnancy Negating _____ _____

Alert Message: Based on animal data showing adverse renal effects, Jardiance (empagliflozin) is not recommended during the second and third trimesters of pregnancy. Limited data available with empagliflozin in pregnant women are not sufficient to determine a drug-associated risk for major birth defects and miscarriage. During pregnancy, consider appropriate alternative therapies, especially during the second and third trimesters.

Conflict Code: MC – Drug (Actual) Disease Precaution
Drugs/Diseases

Util A	Util B	Util C **(Negating)**
Empagliflozin	Pregnancy	Delivery
		Abortion
		Miscarriage

Gender: Female
Age Range: 11 – 55 yoa

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Blumer I, Hadar E, Hadden DR, et al. Diabetes and Pregnancy: An Endocrine Society Clinical Practice Guideline. J Clin Endocrinol Metab. 2013;98(11):4227-4249.
American Diabetes Association (ADA). 13. Management of Diabetes in Pregnancy. In Standards of Medical Care in Diabetes - 2017. Diabetes Care. 2017c;40(Suppl. 1):S114-S119.

24. Empagliflozin-Metformin / Pregnancy / Pregnancy Negating _____ _____

Alert Message: Based on animal data showing adverse renal effects, Synjardy (empagliflozin/metformin) is not recommended during the second and third trimesters of pregnancy. Limited available data with empagliflozin/metformin in pregnant women are not sufficient to determine a drug-associated risk for major birth defects and miscarriage. During pregnancy, consider appropriate alternative therapies, especially during the second and third trimesters.

Conflict Code: MC – Drug (Actual) Disease Precaution\
Drugs/Diseases

Util A	Util B	Util C **(Negating)**
Empagliflozin/Metformin	Pregnancy	Delivery
		Abortion
		Miscarriage

Gender: Female
Age Range: 11 – 55 yoa

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Blumer I, Hadar E, Hadden DR, et al. Diabetes and Pregnancy: An Endocrine Society Clinical Practice Guideline. J Clin Endocrinol Metab. 2013;98(11):4227-4249.
American Diabetes Association (ADA). 13. Management of Diabetes in Pregnancy. In Standards of Medical Care in Diabetes - 2017. Diabetes Care. 2017c;40(Suppl. 1):S114-S119.

25. Empagliflozin-Metformin XR / Pregnancy / Pregnancy Negating _____ _____

Alert Message: Based on animal data showing adverse renal effects, Synjardy XR (empagliflozin/metformin extended-release) is not recommended during the second and third trimesters of pregnancy. Limited available data with empagliflozin/metformin XR in pregnant women are not sufficient to determine a drug-associated risk for major birth defects and miscarriage. During pregnancy, consider appropriate alternative therapies, especially during the second and third trimester.

Conflict Code: MC – Drug (Actual) Disease Precaution
Drugs/Diseases

Util A	Util B	Util C **(Negating)**
Empagliflozin/Metformin XR	Pregnancy	Delivery
		Abortion
		Miscarriage

Gender: Female
Age Range: 11 – 55 yoa

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Blumer I, Hadar E, Hadden DR, et al. Diabetes and Pregnancy: An Endocrine Society Clinical Practice Guideline. J Clin Endocrinol Metab. 2013;98(11):4227-4249.
American Diabetes Association (ADA). 13. Management of Diabetes in Pregnancy. In Standards of Medical Care in Diabetes - 2017. Diabetes Care. 2017c;40(Suppl. 1):S114-S119.

26. Plecanatide / Overutilization _____ _____

Alert Message: Trulance (plecanatide) may be over-utilized. The manufacturer's recommended maximum adult dosage is 3 mg once daily.

Conflict Code: ER - Overutilization
Drugs/Diseases

Util A	Util B	Util C
Plecanatide		

Max Dose: 3 mg per day

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Trulance Prescribing Information, Jan. 2017, Synergy Pharmaceuticals.

27. Plecanatide / Therapeutic Appropriateness (Age 0 – 5 yoa) _____ _____

Alert Message: Trulance (plecanatide) is contraindicated in patients less than 6 years of age. Due to increased intestinal expression of guanylate cyclase (GC-C), patients less than 6 years of age may be more likely than patients 6 years and older to develop severe diarrhea and its potentially serious consequences. In nonclinical studies, the use of plecanatide in young juvenile mice resulted in mortality in some mice within the first 24 hours of therapy, apparently due to dehydration.

Conflict Code: TA - Therapeutic Appropriateness (Black Box Warning)

Drugs/Diseases		
Util A	Util B	Util C
Plecanatide		

Age Range: 0 – 5 yoa

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Trulance Prescribing Information, Jan. 2017, Synergy Pharmaceuticals.

28. Plecanatide / Therapeutic Appropriateness – Age 6 – 17 yoa _____ _____

Alert Message: The safety and effectiveness of Trulance (plecanatide) in patients 6 years of age to less than 18 years of age have not been established and its use should be avoided in this patient population.

Conflict Code: TA - Therapeutic Appropriateness (Black Box Warning)

Drugs/Diseases		
Util A	Util B	Util C
Plecanatide		

Age Range: 6 – 17 yoa

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Trulance Prescribing Information, Jan. 2017, Synergy Pharmaceuticals.

29. Plecanatide / Gastrointestinal Obstruction _____ _____

Alert Message: Trulance (plecanatide) is contraindicated in patients with known or suggested gastrointestinal obstruction. Plecanatide is a guanylate cyclase-C (GC-C) agonist which increases intestinal fluid and accelerates transit.

Conflict Code: MC – Drug (Actual) Disease Precaution/Warning

Drugs/Diseases		
Util A	Util B	Util C
Plecanatide	Intestinal Obstruction	
	Paralytic ileus	

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Trulance Prescribing Information, Jan. 2017, Synergy Pharmaceuticals.

30. Plecanatide / Non-adherence _____ _____

Alert Message: Based on refill history, your patient may be under-utilizing Trulance (plecanatide). Nonadherence to the prescribed dosing regimen may result in sub-therapeutic effects, which may lead to decreased patient outcomes and additional healthcare costs.

Conflict Code: LR - Nonadherence
Drugs/Diseases

Util A	Util B	Util C
Plecanatide		

References:
Trulance Prescribing Information, Jan. 2017, Synergy Pharmaceuticals.
Martin LR, Williams SL, Haskard KB, DiMatteo MR. The Challenge of Patient Adherence. Ther Clin Risk Manag. 2005;1(3):189-199.
Osterberg L, Blaschke T. Adherence to Medication. N Engl J Med 2005;353:487-97.

31. AirDuo Respiclick / Nonadherence _____ _____

Alert Message: Non-adherence with prescribed asthma therapy may significantly increase the risk of asthma exacerbations, emergency room visits, hospitalization, and asthma-related deaths. Always verify at each office visit that the patient understands their condition, the treatment plan, and the importance of adherence.

Conflict Code: LR - Nonadherence
Drugs/Diseases

Util A	Util B	Util C
Fluticasone/Salmeterol Inhalation Powder		

References:
Osterberg L, Blaschke T. Adherence to medication. N Engl J Med 2005;353:487-97.
Williams LK, Pladevall M, XI Hy, et al., Relationship between Adherence to Inhaled Corticosteroids and Poor Outcomes Among Adults with Asthma. J Allerg Clin Immunol. December 2004;114(6):1288-1293.
Tan H, Sarawate C, Singer J et al., Impact of Asthma Controller Medications on Clinical, Economic, and Patient-Reported Outcomes. Mayo Clinic Proc. August 2009;84(8):675-684.

32. Tenofovir Alafenamide / Overutilization _____ _____

Alert Message: Vemlidy (tenofovir alafenamide) maybe over-utilized. The manufacturer's recommended maximum dose is 25 mg once daily.

Conflict Code: ER - Overutilization
Drugs/Diseases

Util A	Util B	Util C **(Negating)**
Tenofovir ala.		CKD Stage 5

Max Dose: 25 mg/day

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Vemlidy Prescribing Information, Nov. 2016, Gilead Sciences, Inc.

33. Tenofovir Alafenamide / Chronic Kidney Disease Stage 5 _____ _____

Alert Message: Vemlidy (tenofovir alafenamide) use is not recommended in patients with end-stage renal disease (estimated creatinine clearance below 15 mL/minute). No dosage adjustment of tenofovir alafenamide is required in patients with mild, moderate, or severe renal impairment.

Conflict Code: TA – Therapeutic Appropriateness
Drugs/Diseases

Util A	Util B	Util C **(Include)**
Tenofovir ala.		CKD Stage 5

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Vemlidy Prescribing Information, Nov. 2016, Gilead Sciences, Inc.

34. Tenofovir Alafenamide / Hepatic Impairment _____ _____

Alert Message: Vemlidy (tenofovir alafenamide) use is not recommended in patients with decompensated hepatic impairment (Child-Pugh B or C). Tenofovir alafenamide use has been associated with lactic acidosis and severe hepatomegaly with steatosis, including fatal cases. No dosage adjustment is tenofovir alafenamide is required in patients with mild hepatic impairment (Child-Pugh A).

Conflict Code: TA – Therapeutic Appropriateness
Drugs/Diseases

Util A	Util B	Util C **(Include)**
Tenofovir ala.		Fibrosis and Cirrhosis of the Liver
		Chronic Hepatic Failure
		Hepatic Failure, Unspecified
		Toxic Liver Disease
		Alcoholic Liver Disease

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Vemlidy Prescribing Information, Nov 2016, Gilead Sciences, Inc.

35. Tenofovir Alafenamide / Carbamazepine _____ _____

Alert Message: Concurrent use of Vemlidy (tenofovir alafenamide), a P-gp substrate, with carbamazepine may result in decreased tenofovir alafenamide absorption, which may lead to the loss of tenofovir alafenamide's therapeutic effect, due to induction by carbamazepine of tenofovir alafenamide P-gp mediated transport. When these agents are co-administered the dose of tenofovir alafenamide should be increased to two tablets once daily.

Conflict Code: LR – Inappropriate Dosing.
Drugs/Diseases

Util A	Util B	Util C **(Include)**
Tenofovir ala.		Carbamazepine

Minimum Dose: 50 mg/day

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Vemlidy Prescribing Information, Nov. 2016, Gilead Sciences, Inc.

36. Tenofovir Alafenamide / Other P-gp Inducers _____ _____

Alert Message: Concurrent use of Vemlidy (tenofovir alafenamide) with P-gp inducers (e.g., phenytoin, oxcarbazepine, rifampin, and phenobarbital) is not recommended. Tenofovir alafenamide is a P-gp substrate and use with a P-gp inducer may result in decreased tenofovir alafenamide absorption, which may lead to loss of therapeutic effect.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Tenofovir ala.	Phenytoin	
	Oxcarbazepine	
	Phenobarbital	
	Rifampin	
	Rifabutin	
	Rifapentine	

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Vemlidy Prescribing Information, Dec. 2016, Gilead Sciences, Inc.

37. Tenofovir Alafenamide / P-GP & BCRP Inhibitors _____ _____

Alert Message: Vemlidy (tenofovir alafenamide) is a substrate of both P-gp and BCRP transport. Concurrent use of tenofovir alafenamide with a P-gp and/or BCRP transport inhibitor may result in increased tenofovir alafenamide absorption and plasma concentrations and risk of tenofovir alafenamide-related adverse effects.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B		Util C
Tenofovir ala.	Alectinib	Rolapitant	
	Cobicistat	Tedizolid	
	Daclatasvir	Vemurafenib	
	Olaparib	Cyclosporine	
	Osimertinib	Sorafenib	
	Regorafenib		

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Vemlidy Prescribing Information, Dec. 2016, Gilead Sciences, Inc.

38. Tenofovir Alafenamide / Drugs Effecting Renal Function _____ _____

Alert Message: Vemlidy (tenofovir alafenamide) is primarily excreted by the kidneys by a combination of glomerular filtration and active tubular secretion, therefore co-administration of tenofovir alafenamide with drugs that reduce renal function or compete for active tubular secretion may increase tenofovir alafenamide concentrations and increase the risk of tenofovir-related adverse reactions.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B		Util C
Tenofovir ala.	Salicylates	Bacitracin	
	Acyclovir	Metformin	
	Cidofovir	Dofetilide	
	Ganciclovir	Cyclosporine	
	Valacyclovir	Pamidronate	
	Valganciclovir	Probenecid	
	NSAIDS	Tacrolimus	
	Adefovir	Tobramycin	
	Zoledronic Acid		

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Vemlidy Prescribing Information, Dec. 2016, Gilead Sciences, Inc.

39. Tenofovir Alafenamide / HIV _____ _____

Alert Message: The safety and efficacy of Vemlidy (tenofovir alafenamide) have not been established in patients co-infected with hepatitis B (HBV) and HIV-1. HIV-1 antibody testing should be offered to all HBV-infected patients before initiating therapy with tenofovir alafenamide, and, if positive, an appropriate antiretroviral combination regimen that is recommended for patients coinfected with HIV-1 should be used.

Conflict Code: TA – Therapeutic Appropriateness
Drugs/Diseases

Util A	Util B	Util C **(Include)**
Tenofovir ala.		HIV-1

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Vemlidy Prescribing Information, Dec. 2016, Gilead Sciences, Inc.

40. Tenofovir Alafenamide / Nonadherence _____ _____

Alert Message: Based on refill history, your patient may be under-utilizing Vemlidy (tenofovir alafenamide). Non-adherence to the prescribed dosing regimen may result in sub-therapeutic effects, which may lead to decreased outcomes and additional healthcare costs. Discontinuation of anti-hepatitis B therapy, including tenofovir alafenamide, may result in severe acute exacerbation of hepatitis B. Advise patients to not discontinue tenofovir alafenamide without first informing their healthcare provider.

Conflict Code: LR - Nonadherence
Drugs/Diseases

Util A	Util B	Util C
Tenofovir ala.		

References:
Osterberg L, Blaschke T. Adherence to Medication. N Engl J Med 2005;353:487-97.
Lieveld FI, van Vlerken LG, Siersema PD, van Erpecum KJ. Patient Adherence to Antiviral Treatment for Chronic Hepatitis B and C: A Systemic Review, Ann Hepatol. 2013 May-Jun;12(3):380-391.
Vemlidy Prescribing Information, Dec. 2016, Gilead Sciences, Inc.

41. Lumacaftor/ivacaftor / Overutilization (≥ 12 yoa) _____ _____

Alert Message: The recommended daily dose of Orkambi (lumacaftor/ivacaftor) for patients age 12 years and older is two lumacaftor 200mg/ivacaftor 125 mg tablets every 12 hours with fat-containing food (total daily dose lumacaftor 800 mg/ivacaftor 500 mg).

Conflict Code: ER - Overutilization
Drugs/Diseases

Util A	Util B	Util C **(Negating)**
Lumacaftor/ivacaftor		Hepatic Impairment

Max Dose: 800mg/500mg (4 tabs)
Age Range: ≥ 12 yoa

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Orkambi Prescribing Information, Sept. 2016, Vertex Pharmaceuticals Inc.

42. Lumacaftor/ivacaftor / Overutilization (6 – 11 yoa) _____ _____

Alert Message: The recommended daily dose of Orkambi (lumacaftor/ivacaftor) for patients age 6 to 11 years of age is two lumacaftor 100 mg/ivacaftor 125 mg tablets every 12 hours with fat-containing food (total daily dose lumacaftor 400 mg/ivacaftor 500 mg).

Conflict Code: ER - Overutilization
Drugs/Diseases

Util A	Util B	Util C **(Negating)**
Lumacaftor/ivacaftor		Hepatic Impairment

Max Dose: 400mg/500mg (4 tabs)
Age Range: 6 – 11 yoa

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Orkambi Prescribing Information, Sept. 2016, Vertex Pharmaceuticals Inc.

43. Lumacaftor/ivacaftor / Overutilization – Hepatic Imp. (≥ 12 yoa) _____ _____

Alert Message: The recommended daily dose of Orkambi (lumacaftor/ivacaftor) for patients 12 years of age and older with moderate hepatic impairment, is two lumacaftor 200 mg/ivacaftor 125 mg tablets in the morning and one 200 mg/125 mg tablet in the evening (total of 3 tablets per day). Patients 12 years and older with severe hepatic impairment should receive one 200 mg/125 mg tablet in the morning and one 200 mg/ 125 mg tablet in the evening.

Conflict Code: ER - Overutilization
Drugs/Diseases

Util A	Util B	Util C **(Include)**
Lumacaftor/ivacaftor		Hepatic Impairment

Max Dose: 600mg/375mg (3 tabs)
Age Range: ≥ 12 yoa

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Orkambi Prescribing Information, Sept. 2016, Vertex Pharmaceuticals Inc.

44. Lumacaftor/ivacaftor / Overutilization – Hepatic Imp. (6 – 11 yoa) _____ _____

Alert Message: The recommended daily dose of Orkambi (lumacaftor/ivacaftor) for patients age 6 to 11 years of age with moderate hepatic impairment, is two lumacaftor 100 mg/ivacaftor 125 mg tablets in the morning and one 100 mg/125 mg tablet in the evening (total of 3 tablets per day). Patients 6 to 11 years of age with severe hepatic impairment should receive one 100 mg/125 mg tablet in the morning and one 100 mg/125 mg tablet in the evening.

Conflict Code: ER - Overutilization
Drugs/Diseases

Util A	Util B	Util C **(Include)**
Lumacaftor/ivacaftor		Hepatic Impairment

Max Dose: 300mg/375mg (3 tabs)
Age Range: 6 – 11 yoa

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Orkambi Prescribing Information, Sept. 2016, Vertex Pharmaceuticals Inc.

45. Lumacaftor/ivacaftor / Strong CYP3A4 Inducers _____ _____

Alert Message: Concurrent use of Orkambi (lumacaftor/ivacaftor) with strong CYP3A4 inducers is not recommended. The ivacaftor component of the combination agent is a sensitive CYP3A4 substrate and concomitant administration with a strong CYP3A4 inducer may substantially decrease exposure of ivacaftor reducing the therapeutic effectiveness of ivacaftor.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B		Util C
Lumacaftor/ivacaftor	Phenytoin	Rifampin	
	Phenobarbital	Rifabutin	
	Primidone	Rifapentine	
	Carbamazepine		

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Orkambi Prescribing Information, Sept. 2016, Vertex Pharmaceuticals Inc.

46. Lumacaftor/ivacaftor / Hormonal Contraceptives _____ _____

Alert Message: Orkambi (lumacaftor/ivacaftor) may substantially decrease hormonal contraceptive exposure, reducing their effectiveness and increasing the incidence of menstruation-associated adverse reactions (e.g., amenorrhea, dysmenorrhea, and menorrhagia). Hormonal contraceptives, including oral, injectable, transdermal, and implantable, should not be relied upon as an effective method of contraception when co-administered with lumacaftor/ivacaftor.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Lumacaftor/ivacaftor	Oral Contraceptives	
	Injectable Contraceptives	
	Transdermal Contraceptives	
	Implantable Contraceptives	

Age Range: 11 – 55 yoa
Gender: Female

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Orkambi Prescribing Information, Sept. 2016, Vertex Pharmaceuticals Inc.

47. Lumacaftor/ivacaftor / Sensitive 3A4 Substrates & 3A4 Substrates w/ NTI _____ _____

Alert Message: Co-administration of Orkambi (lumacaftor/ivacaftor) is not recommend with sensitive CYP3A4 substrates or CYP3A4 substrates with a narrow therapeutic index (NTI). Lumacaftor is a strong CYP3A4 inducer and co-administration with a CYP3A4 substrate with these substrates may decreased systemic exposure of the CYP3A4 substrate, decreasing the therapeutic effect.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B		Util C
Lumacaftor/ivacaftor	Tacrolimus	Ibrutinib	Dronedarone
	Sirolimus	Lomitapide	Eletriptan
	Everolimus	Lovastatin	Eplerenone
	Cyclosporine	Naloxegol	Felodipine
	Midazolam	Nisoldipine	Indinavir
	Triazolam	Saquinavir	Lurasidone
	Avanafil	Simvastatin	Maraviroc
	Buspirone	Tipranavir	Quetiapine
	Conivaptan	Vardenafil	Sildenafil
	Darifenacin	Budesonide	Ticagrelor
	Darunavir	Dasatinib	Tolvaptan

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Orkambi Prescribing Information, Sept. 2016, Vertex Pharmaceuticals Inc.
FDA: Drug Development and Drug Interactions: Tables of Substrates, Inhibitors\and Inducers. Available at: http://www.fda.gov/Drugs/DevelopmentApprovalProcess/DevelopmentResources/DrugInteractionaLabeling/ucm093664.htm

48. Lumacaftor/ivacaftor / Certain Antifungals _____ _____

Alert Message: Concurrent use of Orkambi (lumacaftor/ivacaftor) with the antifungal agent ketoconazole, itraconazole, voriconazole or posaconazole may result in decreased antifungal exposure and therefore co-administration is not recommended. The antifungal agents are CYP3A4 substrates and the lumacaftor component of the combination product is a strong CYP3A4 inducer. If concomitant use is necessary, monitor for antifungal efficacy and adjust dose according to official manufacturer labeling. Consider alternative antifungal such as fluconazole.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Lumacaftor/ivacaftor	Ketoconazole	
	Itraconazole	
	Voriconazole	
	Posaconazole	

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Orkambi Prescribing Information, Sept. 2016, Vertex Pharmaceuticals Inc.

49. Lumacaftor/ivacaftor / Digoxin _____ _____

Alert Message: The concurrent use of Orkambi (lumacaftor/ivacaftor) with digoxin, a P-gp substrate, may result in altered digoxin exposure. Lumacaftor is both an inhibitor and inducer of P-gp efflux pumps and ivacaftor is a weak P-gp inhibitor. Monitor the serum concentration of digoxin ant titrate the digoxin dose to obtain the desired clinical effect.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Lumacaftor/ivacaftor	Digoxin	

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Orkambi Prescribing Information, Sept. 2016, Vertex Pharmaceuticals Inc.

50. Lumacaftor/ivacaftor / Sulfonylureas CYP2C9 Substrates _____ _____

Alert Message: The concurrent use of Orkambi (lumacaftor/ivacaftor) with a sulfonylurea that is a CYP2C9 substrate may alter the substrate exposure. In vitro data suggest that the lumacaftor component of the combo agent may induce and/or inhibit CYP2C9-mediated metabolism. Dose adjustment of the sulfonylurea may be required to obtain the desired clinical effect.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Lumacaftor/ivacaftor	Chlorpropamide	
	Glimepiride	
	Glipizide	
	Glyburide	
	Tolbutamide	

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Orkambi Prescribing Information, Sept. 2016, Vertex Pharmaceuticals Inc.

51. Lumacaftor/ivacaftor / Repaglinide _____ _____

Alert Message: The concurrent use of Orkambi (lumacaftor/ivacaftor) with the CYP3A4 substrate repaglinide may result in reduced repaglinide exposure and effectiveness. The lumacaftor component of the combo product is a strong CYP3A4 inducer. Dose adjustment of the repaglinide may be required to obtain the desired clinical effect.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Lumacaftor/ivacaftor	Repaglinide	

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Orkambi Prescribing Information, Sept. 2016, Vertex Pharmaceuticals Inc.

52. Lumacaftor/ivacaftor / Warfarin _____ _____

Alert Message: The concurrent use of Orkambi (lumacaftor/ivacaftor) with warfarin, a CYP2C9 substrate, may result in altered warfarin exposure. In vitro data suggest that lumacaftor/ivacaftor can induce and/or inhibit CYP2C9. Monitor the international normalized ratio (INR) when warfarin is co-administered with lumacaftor/ivacaftor.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Lumacaftor/ivacaftor	Warfarin	

References:
Clinical Pharmacology, 2016 Elsevier/Gold Standard.
Orkambi Prescribing Information, Sept. 2016, Vertex Pharmaceuticals Inc.

53. Lumacaftor/ivacaftor / CYP3A4 Substrate Steroids _____ _____

Alert Message: The concurrent use of Orkambi (lumacaftor/ivacaftor) with a systemic corticosteroid that is a CYP3A4 substrate (e.g., prednisone, methylprednisolone, and dexamethasone) may result in reduced corticosteroid exposure and effectiveness. The lumacaftor component of the combo product is a strong CYP3A4 inducer. A higher dose of the systemic corticosteroid may be required to obtain the desired clinical effects.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Lumacaftor/ivacaftor	Prednisone	
	Dexamethasone	
	Methylprednisolone	

References:
Clinical Pharmacology, 2016 Elsevier/Gold Standard.
Orkambi Prescribing Information, Sept. 2016, Vertex Pharmaceuticals Inc.

54. Lumacaftor/ivacaftor / CYP3A4 Substrate Antibiotics _____ _____

Alert Message: The concurrent use of Orkambi (lumacaftor/ivacaftor) with a macrolide that is a CYP3A4 substrate (e.g., clarithromycin, erythromycin, and telithromycin) may result in reduced antibiotic exposure and effectiveness. The lumacaftor component of the combo product is a strong CYP3A4 inducer. Consider an alternative to these antibiotics, such as ciprofloxacin or azithromycin.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Lumacaftor/ivacaftor	Clarithromycin	
	Erythromycin	
	Telithromycin	

References:
Clinical Pharmacology, 2016 Elsevier/Gold Standard.
Orkambi Prescribing Information, Sept. 2016, Vertex Pharmaceuticals Inc.

55. Lumacaftor/ivacaftor / Montelukast _____ _____

Alert Message: The concurrent use of Orkambi (lumacaftor/ivacaftor) with montelukast may result in decreased montelukast exposure and efficacy. Montelukast is a substrate of CYP3A4, CYP2C8, and CYP2C9. The lumacaftor component of the combo product is a strong CYP3A4 inducer as well as an inducer of CYP2C8 and CYP2C9. Increased monitoring is recommended if these agents are administered concurrently.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Lumacaftor/ivacaftor	Montelukast	

References:
Clinical Pharmacology, 2016 Elsevier/Gold Standard.
Orkambi Prescribing Information, Sept. 2016, Vertex Pharmaceuticals Inc.

56. Lumacaftor/ivacaftor / Nonadherence _____ _____

Alert Message: Based on refill history, your patient may be under-utilizing Orkambi (lumacaftor/ivacaftor). Non-adherence to the prescribed dosing regimen may result in sub-therapeutic effects, which may lead to decreased patient outcomes and additional healthcare costs.

Conflict Code: LR - Nonadherence
Drugs/Diseases

Util A	Util B	Util C
Lumacaftor/ivacaftor		

References:
Orkambi Prescribing Information, Sept. 2016, Vertex Pharmaceuticals Inc.
Osterberg L, Blaschke T. Adherence to Medication. N Engl J Med 2005; 353:487- 497.
Eakin MN, Bilderback A, Boyle MP, Mogayzel PJ, Riekert KA. Longitudinal Association Between Medication Adherence and Lung Health in People with Cystic Fibrosis. Jrnl Cyst Fib. 2011;10(4):258-264.
Bishay LC, Sawicki. Strategies to Optimize Tre

57. Dulera / Nonadherence _____ _____

Alert Message: Non-adherence with prescribed asthma therapy may significantly increase the risk of asthma exacerbations, emergency room visits, hospitalization, and asthma-related deaths. Always verify at each office visit that the patient understands their condition, the treatment plan, and the importance of adherence.

Conflict Code: LR - Nonadherence
Drugs/Diseases

Util A	Util B	Util C
Mometasone/Formoterol Inhalation		

References:
Osterberg L, Blaschke T. Adherence to medication. N Engl J Med 2005;353:487-97.
Williams LK, Pladevall M, XI Hy, et al., Relationship between Adherence to Inhaled Corticosteroids and Poor Outcomes Among Adults with Asthma. J Allerg Clin Immunol. December 2004;114(6):1288-1293.
Tan H, Sarawate C, Singer J et al., Impact of Asthma Controller Medications on Clinical, Economic, and Patient-Reported Outcomes. Mayo Clinic Proc. August 2009;84(8):675-684.

58. Dapagliflozin-Saxagliptin / Overutilization _____ _____

Alert Message: Qtern (dapagliflozin-saxagliptin) may be over-utilized. The manufacturer's recommended maximum daily dose of dapagliflozin/saxagliptin is 10 mg dapagliflozin/5 mg saxagliptin once daily.

Conflict Code: ER - Overutilization
Drugs/Diseases

Util A	Util B	Util C **(Negate)**
Dapagliflozin/Saxagliptin		CKD Stage 3, 4 & 5
		ESRD

Max Dose: 10 mg/5 mg per day

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Qtern Prescribing Information, February 2017, AstraZeneca.

59. Dapagliflozin-Saxagliptin / CKD Stage 3, 4 & 5 & ESRD _____ _____

Alert Message: Qtern (dapagliflozin/saxagliptin) use is contraindicated in patients with moderate to severe renal impairment, end-stage renal disease or on dialysis. The dapagliflozin component of the combo product causes intravascular volume contraction and can cause renal impairment.

Conflict Code: TA - Therapeutic Appropriateness
Drugs/Diseases

Util A	Util B	Util C **(Include)**
Dapagliflozin/Saxagliptin		CKD Stage 3, 4 & 5
		ESRD

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Qtern Prescribing Information, February 2017, AstraZeneca.

60. Dapagliflozin-Saxagliptin / Therapeutic Appropriateness _____ _____

Alert Message: Assessment of renal function is recommended prior to initiation of Qtern (dapagliflozin/saxagliptin) therapy and periodically thereafter. Discontinue dapagliflozin/saxagliptin if estimated glomerular filtration rate (eGFR) falls persistently below 60 mL/min/1.73 m2. Do not initiate dapagliflozin/saxagliptin in patients with an eGFR below 60 mL/min/1.73 m2.

Conflict Code: TA - Therapeutic Appropriateness
Drugs/Diseases

Util A	Util B	Util C
Dapagliflozin/Saxagliptin		

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Qtern Prescribing Information, February 2017, AstraZeneca.

61. Dapagliflozin-Saxagliptin / Strong CYP3A4/5 Inhibitors _____ _____

Alert Message: Do not co-administer Qtern (dapagliflozin/saxagliptin) with strong CYP3A4/5 inhibitors (e.g., ketoconazole, atazanavir, nefazodone, ritonavir, and clarithromycin). The saxagliptin component of the combo product is a CYP3A4/5 substrate and use with a strong CYP3A4/5 inhibitor is expected to significantly increase saxagliptin plasma concentrations.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B		Util C
Dapagliflozin/Saxagliptin	Itraconazole	Indinavir	
	Ketoconazole	Nelfinavir	
	Atazanavir	Telithromycin	
	Clarithromycin	Nefazodone	
	Saquinavir	Cobicistat	
	Ritonavir		

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Qtern Prescribing Information, February 2017, AstraZeneca.

62. Dapagliflozin-Saxagliptin / Insulin & Insulin Secretagogues _____ _____

Alert Message: The concurrent use of Qtern (dapagliflozin/saxagliptin) with insulin or an insulin secretagogue can increase the risk of hypoglycemia. A lower dose of insulin or insulin secretagogue may be required to minimize the risk of hypoglycemia when used in combination with dapagliflozin/saxagliptin.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Dapagliflozin/Saxagliptin	Insulin	
	Chlorpropamide	
	Tolbutamide	
	Tolazamide	
	Glyburide	
	Glipizide	
	Glimepiride	

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Qtern Prescribing Information, February 2017, AstraZeneca.

63. Dapagliflozin-Saxagliptin / Bladder Cancer _____ _____

Alert Message: In clinical trials an increased occurrence of bladder cancer was observed in subjects receiving dapagliflozin (0.17%) as compared to placebo (0.03%). Qtern (dapagliflozin/saxagliptin) should not be used in patients with active bladder cancer and used with caution in patients with a prior history of bladder cancer.

Conflict Code: TA – Therapeutic Appropriateness
Drugs/Diseases

Util A	Util B	Util C **(Include)**
Dapagliflozin/Saxagliptin		Neoplasm of Bladder
		History of Malignant Neoplasm of Bladder

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Qtern Prescribing Information, February 2017, AstraZeneca.

64. Dapagliflozin-Saxagliptin / Hypotension (Loop Diuretics) _____ _____

Alert Message: The dapagliflozin component of Qtern (dapagliflozin/saxagliptin) can cause osmotic diuresis which can lead to volume depletion and hypotension, particularly in patients with impaired renal function, elderly patients or patients on loop diuretics. Before initiating a dapagliflozin-containing agent in patient with one or more of these characteristics, volume status should be assessed and corrected. Patients should be monitored for signs and symptoms during therapy.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Dapagliflozin/Saxagliptin	Furosemide	
	Torsemide	
	Ethacrynate	
	Bumetanide	

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Qtern Prescribing Information, February 2017, AstraZeneca.

65. Dapagliflozin-Saxagliptin / Therapeutic Appropriateness (Pediatric) _____ _____

Alert Message: Safety and effectiveness of Qtern (dapagliflozin/saxagliptin) in patients under 18 years of age have not been established.

Conflict Code: TA – Therapeutic Appropriateness
Drugs/Diseases

Util A	Util B	Util C
Dapagliflozin/Saxagliptin		

Age Range: 0 - 17 yoa

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Qtern Prescribing Information, February 2017, AstraZeneca.

66. Dapagliflozin-Saxagliptin / Therapeutic Appropriateness _____ _____

Alert Message: The use of Qtern (dapagliflozin/saxagliptin) can cause an increase in LDL-C levels. Patients treated with dapagliflozin/saxagliptin demonstrated a mean percent increase from baseline LDL-cholesterol ranging from 2.1% to 6.9%. Patients receiving dapagliflozin/saxagliptin should have their LDL-C monitored and treated per standard of care.

Conflict Code: TA – Therapeutic Appropriateness
Drugs/Diseases

Util A	Util B	Util C **(Include)**
Dapagliflozin/Saxagliptin		Hypercholesterolemia

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Qtern Prescribing Information, February 2017, AstraZeneca.

67. Dapagliflozin-Saxagliptin / Nonadherence _____ _____

Alert Message: Based on refill history, your patient may be under-utilizing Qtern (dapagliflozin/saxagliptin). Nonadherence to the prescribed dosing regimen may result in sub-therapeutic effects, which may lead to decreased outcomes and additional healthcare costs.

Conflict Code: LR - Nonadherence
Drugs/Diseases

Util A	Util B	Util C
Dapagliflozin/Saxagliptin		

References:
Osterberg L, Blaschke T. Adherence to Medication. N Engl J Med 2005; 353:487- 497.
Ho PM, Rumsfeld JS, Masoudi FA, et al., Effect of Medication Nonadherence in Diabetes Mellitus. Cardiology Review, April 2007.
Currie CJ, Peyrot M, Morgan CL, et al. The Impact of Treatment Noncompliance on Mortality in People With Type 2 Diabetes. Diabetes Care 35:1279-1284, June 2012.
Qtern Prescribing Information, February 2017, AstraZeneca.

68. Dapagliflozin-Saxagliptin / Pregnancy / Pregnancy Negating _____ _____

Alert Message: Based on animal data showing renal effects, from dapagliflozin, Qtern (dapagliflozin/saxagliptin) is not recommended during the second and third trimesters of pregnancy. The limited available data with dapagliflozin and saxagliptin in pregnant women are not sufficient to determine a drug-associated risk for major birth defects or miscarriage. During pregnancy, consider appropriate alternative therapies.

Conflict Code: MC – Drug (Actual) Disease Precaution

Util A	Util B	Util C **(Negating)**
Dapagliflozin/Saxagliptin	Pregnancy	Delivery
		Abortion
		Miscarriage

Gender: Female
Age Range: 11 – 55 yoa

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Qtern Prescribing Information, February 2017, AstraZeneca.
American College of Obstetricians and Gynecologists (ACOG), Committee on Practice Bulletins - Obstetrics. Practice Bulletin No. 137: Gestational Diabetes Mellitus. Obstet Gynecol. 2013:122(2 Pt 1):406-416.
Blumer I, Hadar E, Hadden DR, et al. Diabetes and Pregnancy: An Endocrine Society Clinical Practice Guideline. J Clin Endocrinol Metab. 2013;98(11):406-416.

69. Rivaroxaban / SSRIs & SNRIs _____ _____

Alert Message: Concomitant use of Xarelto (rivaroxaban) with SSRIs or SNRIs may enhance the anticoagulant effect of rivaroxaban and increases the risk of bleeding. SSRIs and SNRIs can inhibit serotonin uptake by platelets, thus causing platelet dysfunction and risk of bleeding. Promptly evaluate any signs or symptoms of blood loss if the patient is treated concurrently with these agents.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B		Util C
Rivaroxaban	Fluoxetine	Venlafaxine	
	Fluvoxamine	Desvenlafaxine	
	Paroxetine	Milnacipran	
	Citalopram	Levomilnacipran	
	Escitalopram	Duloxetine	
	Sertraline		
	Vilazodone		
	Vortioxetine		

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Facts & Comparisons, 2017, Wolters Kluwer Health.
Xarelto Prescribing Information, Aug. 2016, Janssen Pharmaceuticals.

70. Dabrafenib / Overutilization _____ _____

Alert Message: Tafinlar (dabrafenib) may be over-utilized. The manufacturer's recommended maximum daily dose is 300 mg (150 mg orally twice daily).

Conflict Code: ER – Overutilization
Drugs/Diseases

Util A	Util B	Util C
Dabrafenib		

Max Dose: 30 mg/day

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Facts & Comparisons, 2017, Wolters Kluwer Health.

71. Dabrafenib / Strong CYP3A4 & CYP2C8 Inhibitors _____ _____

Alert Message: Concurrent use of Tafinlar (dabrafenib) with a strong CYP3A4 or CYP2C8 inhibitor should be avoided. Dabrafenib is a substrate of CYP3A4 and CYP2C8 and concomitant use with a strong inhibitor of either enzyme may result in increased dabrafenib concentrations and risk of adverse reactions. If co-administration is unavoidable monitor patient closely for adverse events.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B		Util C
Dabrafenib	Gemfibrozil	Indinavir	
	Clopidogrel	Cobicistat	
	Clarithromycin	Ketoconazole	
	Telithromycin	Itraconazole	
	Saquinavir	Voriconazole	
	Ritonavir	Posaconazole	
	Nelfinavir	Nefazodone	

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Facts & Comparisons, 2017, Wolters Kluwer Health.

72. Dabrafenib / Strong CYP3A4 & CYP2C8 Inducers _____ _____

Alert Message: Concurrent use of Tafinlar (dabrafenib) with a strong CYP3A4 or CYP2C8 inducer should be avoided. Dabrafenib is a substrate of CYP3A4 and CYP2C8 and concomitant use with a strong inducer of either enzyme may result in decreased dabrafenib concentrations. If co-administration is unavoidable monitor patient closely for loss of dabrafenib efficacy.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B		Util C
Dabrafenib	Carbamazepine	Rifapentine	
	Phenobarbital	Rifampin	
	Phenytoin	Rifabutin	
	Primidone		

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Facts & Comparisons, 2017, Wolters Kluwer Health.

73. Dabrafenib / Sensitive CYP3A4, 2C8, 2C9, 2C19 & 2B6 Substrates _____ _____

Alert Message: Concurrent use of Tafinlar (dabrafenib) with agents that are sensitive substrates of CYP3A4, CYP2C8, CYP2C9, CYP2C19 or CYP2B6 may result in loss of efficacy of the substrate. Dabrafenib is an inducer of these enzymes and concomitant use may result in decreased concentrations of the substrates. If co-administration is unavoidable monitor patient closely for loss of substrate efficacy.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Dabrafenib	Midazolam	
	Triazolam	
	Warfarin	
	Dexamethasone	
	Desipramine	
	Dextromethorphan	
	Nebivolol	
	Repaglinide	
	Lansoprazole	
	Omeprazole	
	Hormonal Contraceptives	

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Facts & Comparisons, 2017, Wolters Kluwer Health.
FDA Drug Development and Drug Interactions: Table of Substrates, Inhibitors and Inducers. Available at: https://www.fda.gov/drugs/developmentapprovalprocess/developmentresources/druginteractionslabeling/ucm093664.htm [Accessed 4/2017].

DUR Board Meeting
December 6, 2017
Heritage Center
Lecture Rooms A & B

north dakota
department of
human services

North Dakota Medicaid
DUR Board Meeting Agenda
Brynhild Haugland Room
State Capitol
600 East Boulevard Avenue
Bismarck, ND
December 6, 2017
1:00 pm

1. Administrative items
    - Travel vouchers

2. Old business
    - Review and approval of 09/06/2017 meeting minutes
    - Budget update
    - Review top 15 therapeutic categories/top 25 drugs
    - Prior authorization/PDL update
    - Annual prior authorization review of forms and criteria

3. New business
    - Input regarding opioid and benzodiazepine abuse and overdose diagnoses
    - Review of Eucrisa
    - Review of Skelaxin
    - Criteria recommendations
    - Upcoming meeting date/agenda

4. Adjourn

Please remember to silence all cellular phones during the meeting.

Drug Utilization Review (DUR) Meeting Minutes

September 6, 2017

Members Present: Tanya Schmidt, Laura Schield, Jeffrey Hostetter, Michael Quast, Zach Marty, LeNeika Roehrich, Andrea Honeyman, Carlotta McCleary,

Members Absent: Michael Booth, Peter Woodrow, Gaylord Kavlie, Katie Kram, Wendy Brown,

Medicaid Pharmacy Department: Brendan Joyce, Alexi Murphy

Old Business

L. Roehrich served as Chair in the absence of W. Brown, and called the meeting to order at 1:00 p.m. Chair L. Roehrich asked for a motion to approve the minutes of the September meeting. L. Schield moved that the minutes be approved and Z. Marty seconded the motion. Chair L. Roehrich called for a voice vote to approve the minutes. The motion passed with no audible dissent.

Review Top 15 Therapeutic Categories/Top 25 Drugs

B. Joyce presented the quarterly review of the top 15 therapeutic classes by total cost of claims, top 25 drugs based on number of claims, and top 25 drugs based on claims cost for the 2nd quarter of 2017.

Sanford Update

Danny Weiss, representing Sanford Health Plan, spoke regarding ND Medicaid Expansion. In 2016, there were 19,506 average members per month with 102.2% of members utilizing benefits. The generic fill rate was 85.9%. The top 25 drugs represent 42.1% of total plan cost and 8 of the top 25 drugs are specialty drugs. The top 10 indications by cost represent 70.4% of total plan costs with the largest trend being in inflammatory conditions with a 71.5% increase from 2015.

Second Reviews

A motion and second was made at the June meeting to place Biltricide and Procysbi on prior authorization. The topics were brought up for a second review. There was no public comment. The motion to place Biltricide and Procysbi on prior authorization passed with no audible dissent.

PDL Update

A. Murphy shared with the Board all of the recommended PDL changes since the last 2017 version of the PDL was posted. Added to PA required were Kevzara to the Cytokine Modulators criteria, Morphabond ER to the Narcotics criteria, Ellzia Pak to the Kit criteria, Fabior to the Acne criteria, Brovana to the COPD criteria, Lialda and Apriso to the Inflammatory Bowel Agents criteria, Prednisolone sodium phosphate 10 mg/5 mL and 20 mg/5 mL to the Prednisolone Non-Solid Oral Dosage Forms criteria, Methyltest and methyltestosterone to the Oral Testosterone criteria, and Ilaris and Tymlos to the medications >$3,000 criteria. Xolair, Brineuria, and Ketamine were added to the Medical Billing Only list of medications, and Xifaxan 550 mg, Avonex, and Avonex pen will no longer require PA.

New Business

Juxtapid and Kynamro

B. Joyce presented updated criteria and a drug specific form for Juxtapid and Kynamro for the Board to review. There was no public comment. The motion to approve the updated criteria and form passed with no audible dissent.

Procysbi

B. Joyce presented updated criteria and a drug specific form for Procysbi for the Board to review. There was no public comment. The motion to approve the updated criteria and form passed with no audible dissent.

Tymlos and Miacalcin

B. Joyce presented updated criteria and a drug specific form for Tymlos and Miacalcin for the Board to review. There was no public comment. The motion to approve the updated criteria and form passed with no audible dissent.

Tardive Dyskinesia Agents

B. Joyce and A. Murphy presented updated criteria and a drug specific form for agents used to treat of tardive dyskinesia including Austedo, Ingrezza, and tetrabenazine. Maggie Murphy, representing Teva Pharmaceuticals, offered the opportunity to ask any questions regarding Austedo. Samantha Cicero, representing Neurocrine Biosciences, presented product information regarding Ingrezza. Z. Marty and L. Schield proposed amending the criteria for Ingrezza to require a trial of Austedo as opposed to a trial of tetrabenazine. The motion to approve the amended updated criteria and form passed with no audible dissent.

Jadenu

B. Joyce and A. Murphy presented updated criteria and a drug specific form for Jadenu for the Board to review. There was no public comment. The motion to approve the updated criteria and form passed with no audible dissent.

Review of Opioid Analgesic and Benzodiazepine Utilization

B. Joyce presented data showing current utilization of benzodiazepines, including use with and without opioid analgesics, rate of appropriate utilization for a diagnosis of anxiety, and utilization of multiple benzodiazepines. B. Joyce presented data showing utilization of opioid analgesics, including historic and current utilization of each individual agent by prescription count and average dose. The Board discussed potential provider education and drug edit opportunities.

Physician Prescribing Patterns for Select Therapeutic Categories

B. Joyce presented data showing the top prescriber utilization of select medications in therapeutic drug classes in order to evaluate utilization trends and potential outliers. Therapeutic classes evaluated included opioid analgesics, benzodiazepines, and gabapentin. Prescriber utilization was presented as number of prescriptions for, and patients currently on, selected medications, percent utilization of selected medications within their therapeutic class, and those with the highest number of patients on a high dose of select mediations.

Review of Stimulant Utilization Trends

B. Joyce presented stimulant utilization data trends over time, from 2001 to 2017. The data tracked the average daily dose per patient of each individual medication by age group. The data trends predominantly revealed increase in average daily dose overall with some exceptions in some age groups trending towards a dose decrease.

Criteria Recommendations

The recommended RDUR criteria enclosed in the packet were developed from product information provided by the manufacturers and are usually consistent with new indications, new drugs added, and new warnings. These proposed criteria will be added to the current set of criteria and will be used in future DUR cycles. J. Hostetter moved to approve the new criteria and Z. Marty seconded the motion. The motion passed with no audible dissent. The next DUR Board meeting will be held December 6, 2017 at the Capitol in the Brynhild Haugland room in Bismarck. L. Roehrich adjourned the meeting.

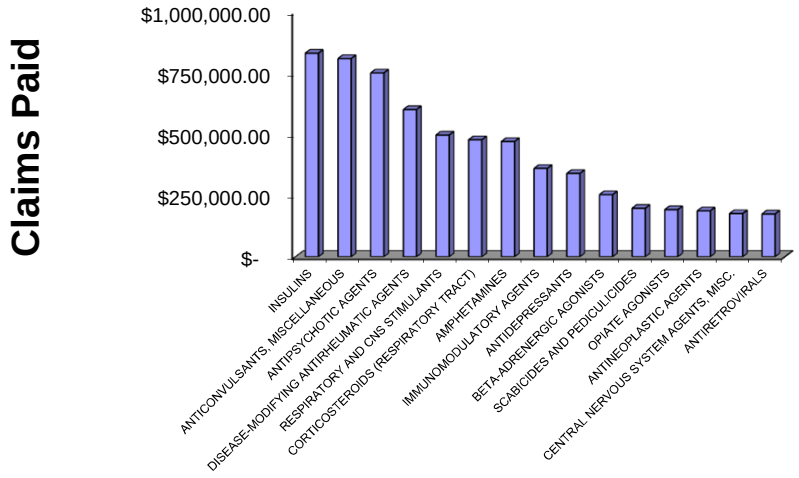
NORTH DAKOTA MEDICAID
Cost Management Analysis

TOP 15 THERAPEUTIC CLASSES BY TOTAL COST OF CLAIMS FROM 07/01/2017 - 09/30/2017

AHFS Therapeutic Class	Rx	Paid	Paid/Rx	% Total Claims
INSULINS	1,863	$ 831,863.50	$ 446.52	1.35%
ANTICONVULSANTS, MISCELLANEOUS	8,445	$ 809,726.20	$ 95.88	6.10%
ANTIPSYCHOTIC AGENTS	5,899	$ 751,014.15	$ 127.31	4.26%
DISEASE-MODIFYING ANTIRHEUMATIC AGENTS	159	$ 602,010.53	$ 3,786.23	0.11%
RESPIRATORY AND CNS STIMULANTS	3,619	$ 498,088.18	$ 137.63	2.61%
CORTICOSTEROIDS (RESPIRATORY TRACT)	1,974	$ 478,880.05	$ 242.59	1.43%
AMPHETAMINES	3,349	$ 471,604.96	$ 140.82	2.42%
IMMUNOMODULATORY AGENTS	59	$ 361,574.73	$ 6,128.39	0.04%
ANTIDEPRESSANTS	14,568	$ 341,037.59	$ 23.41	10.53%
BETA-ADRENERGIC AGONISTS	3,426	$ 254,195.62	$ 74.20	2.48%
SCABICIDES AND PEDICULICIDES	781	$ 198,681.88	$ 254.39	0.56%
OPIATE AGONISTS	5,550	$ 193,180.55	$ 34.81	4.01%
ANTINEOPLASTIC AGENTS	237	$ 188,027.54	$ 793.37	0.17%
CENTRAL NERVOUS SYSTEM AGENTS, MISC.	1,584	$ 176,965.92	$ 111.72	1.14%
ANTIRETROVIRALS	176	$ 175,458.24	$ 996.92	0.13%
Total Top 15	51,689	$ 6,332,309.64	$ 122.51	37.35%

Total Rx Claims From 07/01/2017 - 09/30/2017	138,397

Top 15 Therapeutic Classes
Based on Total Cost of Claims

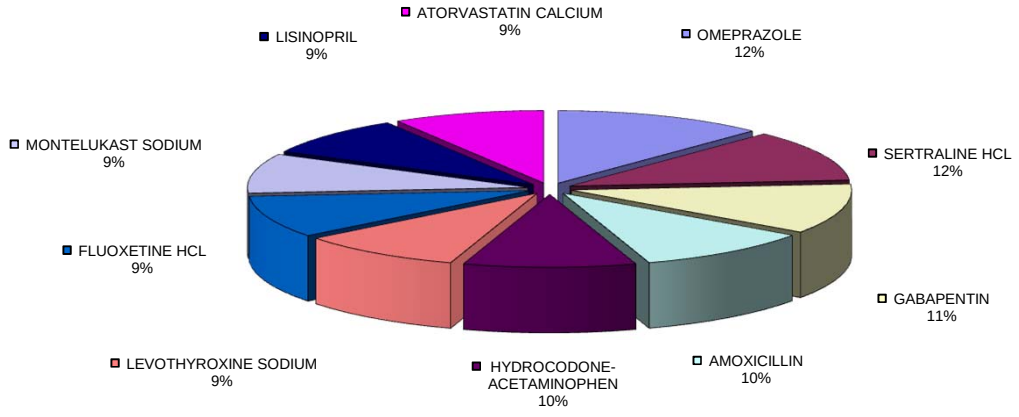


TOP 25 DRUGS BASED ON NUMBER OF CLAIMS FROM 07/01/2017 - 09/30/2017

Drug	AHFS Therapeutic Class	Rx	Paid	Paid/Rx	% Total Claims
OMEPRAZOLE	PROTON-PUMP INHIBITORS	2,671	$ 49,257.58	$ 18.44	1.93%
SERTRALINE HCL	ANTIDEPRESSANTS	2,510	$ 44,802.97	$ 17.85	1.81%
GABAPENTIN	ANTICONVULSANTS, MISCELLANEOUS	2,433	$ 78,781.18	$ 32.38	1.76%
AMOXICILLIN	PENICILLINS	2,242	$ 93,546.06	$ 41.72	1.62%
HYDROCODONE-ACETAMINOPHEN	OPIATE AGONISTS	2,172	$ 74,809.13	$ 34.44	1.57%
LEVOTHYROXINE SODIUM	THYROID AGENTS	2,067	$ 42,246.09	$ 20.44	1.49%
FLUOXETINE HCL	ANTIDEPRESSANTS	2,043	$ 33,334.49	$ 16.32	1.48%
MONTELUKAST SODIUM	LEUKOTRIENE MODIFIERS	1,922	$ 32,045.07	$ 16.67	1.39%
LISINOPRIL	ANGIOTENSIN-CONVERTING ENZYME INHIBITORS	1,913	$ 41,629.87	$ 21.76	1.38%
ATORVASTATIN CALCIUM	HMG-COA REDUCTASE INHIBITORS	1,910	$ 45,939.44	$ 24.05	1.38%
TRAZODONE HCL	ANTIDEPRESSANTS	1,846	$ 26,941.66	$ 14.59	1.33%
METHYLPHENIDATE ER	RESPIRATORY AND CNS STIMULANTS	1,656	$ 316,725.42	$ 191.26	1.20%
METFORMIN HCL	BIGUANIDES	1,452	$ 23,481.82	$ 16.17	1.05%
CLONIDINE HCL	CENTRAL ALPHA-AGONISTS	1,447	$ 20,893.72	$ 14.44	1.05%
BUPROPION XL	ANTIDEPRESSANTS	1,389	$ 34,188.45	$ 24.61	1.00%
ESCITALOPRAM OXALATE	ANTIDEPRESSANTS	1,388	$ 22,682.68	$ 16.34	1.00%
VYVANSE	AMPHETAMINES	1,353	$ 280,973.81	$ 207.67	0.98%
QUETIAPINE FUMARATE	ANTIPSYCHOTIC AGENTS	1,311	$ 22,307.76	$ 17.02	0.95%
RISPERIDONE	ANTIPSYCHOTIC AGENTS	1,287	$ 18,803.20	$ 14.61	0.93%
CETIRIZINE HCL	SECOND GENERATION ANTIHISTAMINES	1,231	$ 42,322.64	$ 34.38	0.89%
FLUTICASONE PROPIONATE	CORTICOSTEROIDS (EENT)	1,187	$ 21,656.60	$ 18.24	0.86%
PROAIR HFA	BETA-ADRENERGIC AGONISTS	1,176	$ 80,090.02	$ 68.10	0.85%
LAMOTRIGINE	ANTICONVULSANTS, MISCELLANEOUS	1,171	$ 22,291.35	$ 19.04	0.85%
IBUPROFEN	NONSTEROIDAL ANTI-INFLAMMATORY AGENTS	1,161	$ 51,897.46	$ 44.70	0.84%
CLONAZEPAM	BENZODIAZEPINES (ANTICONVULSANTS)	1,160	$ 26,731.46	$ 23.04	0.84%
TOTAL TOP 25		42,098	$ 1,548,379.93	$ 36.78	30.42%

Total Rx Claims From 07/01/2017 - 09/30/2017	138,397

Top 10 Drugs
Based on Number of Claims

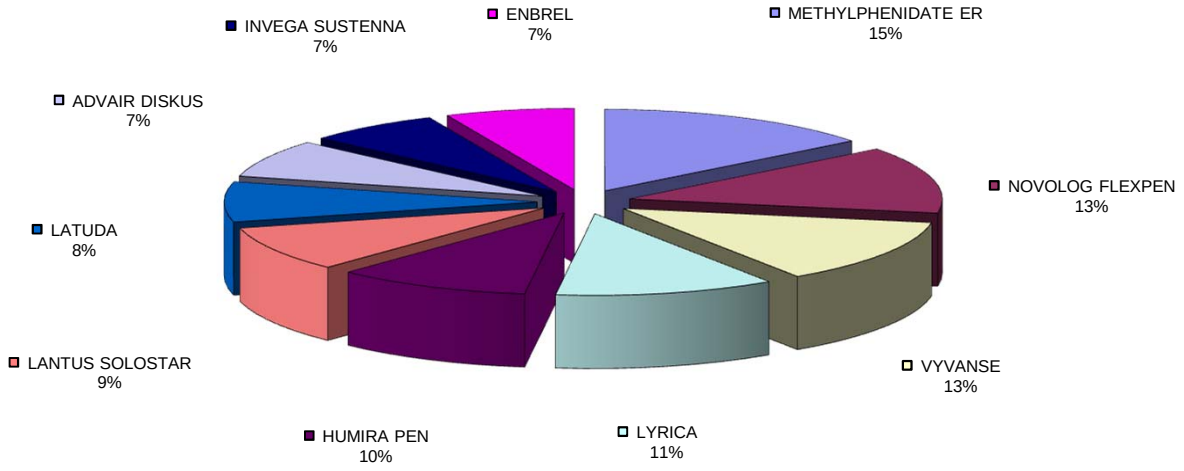


TOP 25 DRUGS BASED ON TOTAL CLAIMS COST FROM 07/01/2017 - 09/30/2017

Drug	AHFS Therapeutic Class	Rx	Paid	Paid/Rx	% Total Claims
METHYLPHENIDATE ER	RESPIRATORY AND CNS STIMULANTS	1,656	$ 316,725.42	$ 191.26	1.20%
NOVOLOG FLEXPEN	INSULINS	571	$ 289,827.47	$ 507.58	0.41%
VYVANSE	AMPHETAMINES	1,353	$ 280,973.81	$ 207.67	0.98%
LYRICA	ANTICONVULSANTS, MISCELLANEOUS	582	$ 248,176.36	$ 426.42	0.42%
HUMIRA PEN	DISEASE-MODIFYING ANTIRHEUMATIC AGENTS	54	$ 220,026.35	$ 4,074.56	0.04%
LANTUS SOLOSTAR	INSULINS	502	$ 195,418.02	$ 389.28	0.36%
LATUDA	ANTIPSYCHOTIC AGENTS	213	$ 173,357.04	$ 813.88	0.15%
ADVAIR DISKUS	CORTICOSTEROIDS (RESPIRATORY TRACT)	502	$ 163,415.01	$ 325.53	0.36%
INVEGA SUSTENNA	ANTIPSYCHOTIC AGENTS	81	$ 150,399.84	$ 1,856.79	0.06%
ENBREL	DISEASE-MODIFYING ANTIRHEUMATIC AGENTS	42	$ 145,568.25	$ 3,465.91	0.03%
FREESTYLE LITE STRIPS	DIABETES MELLITUS	909	$ 130,569.01	$ 143.64	0.66%
SABRIL	ANTICONVULSANTS, MISCELLANEOUS	9	$ 129,026.33	$ 14,336.26	0.01%
STRATTERA	CENTRAL NERVOUS SYSTEM AGENTS, MISC.	363	$ 128,790.88	$ 354.80	0.26%
COPAXONE	IMMUNOMODULATORY AGENTS	18	$ 117,938.72	$ 6,552.15	0.01%
LEVEMIR FLEXTOUCH	INSULINS	351	$ 107,950.13	$ 307.55	0.25%
ADDERALL XR	AMPHETAMINES	548	$ 107,005.88	$ 195.27	0.40%
GILENYA	IMMUNOMODULATORY AGENTS	15	$ 105,537.66	$ 7,035.84	0.01%
VIMPAT	ANTICONVULSANTS, MISCELLANEOUS	180	$ 101,320.48	$ 562.89	0.13%
PROVENTIL HFA	BETA-ADRENERGIC AGONISTS	1,055	$ 98,659.50	$ 93.52	0.76%
HUMIRA	DISEASE-MODIFYING ANTIRHEUMATIC AGENTS	24	$ 96,868.72	$ 4,036.20	0.02%
NIX	SCABICIDES AND PEDICULICIDES	282	$ 96,771.24	$ 343.16	0.20%
AMOXICILLIN	PENICILLINS	2,242	$ 93,546.06	$ 41.72	1.62%
ONFI	BENZODIAZEPINES (ANTICONVULSANTS)	97	$ 91,824.90	$ 946.65	0.07%
SPIRIVA	ANTIMUSCARINICS/ANTISPASMODICS	289	$ 85,741.78	$ 296.68	0.21%
NORDITROPIN FLEXPRO	PITUITARY	24	$ 84,724.14	$ 3,530.17	0.02%
TOTAL TOP 25		11,962	$ 3,760,163.00	$ 314.34	8.64%

Total Rx Claims From 07/01/2017 - 09/30/2017	138,397

Top 10 Drugs
Based on Total Claims Cost



Prior Authorization/PDL Update

Added to PA	Category
ARMONAIR RESPICLICK	Steroid Inhalers
BENLYSTA	> 3000
BILTRICIDE	Biltricide
CLOBETASOL EMOLLIENT FOAM	Topical Psoriatic Arthritis
CLOBETASOL PROPIONATE FOAM	Topical Psoriatic Arthritis
FIASP	Insulins
FIASP FLEXTOUCH	Insulins
HAEGARDA	Hereditary Angioedema
HUMALOG JUNIOR KWIKPEN	Insulins
HYDROCODONE-IBUPROFEN	Narcotics
INGREZZA	Tardive Dyskinesia
LOTEMAX GEL DROPS	OPHTHALMIC ANTIINFLAMMATORIES
MAVYRET	Hep C
ORENITRAM ER	Pulmonary Arterial Hypertension
PROGLYCEM	Proglycem
QVAR REDIHALER	Inhaled Steroids
SYMPROIC	IBS/OIC
SYNDROS	Marinol
TRELEGY ELLIPTA	COPD
TREMFYA	Cytokine Modulators
VOSEVI	Hep C

Removed from PA	Category
MOVIPREP	Bowel Prep Agents

Bill Medical Side VIA 837I AND 837P TRANSACTIONS
BRINEURA
KETAMINE
KYMRIAH
PARSABIV
RENFLEXIS
XIAFLEX

ACTINIC KERATOSIS PA FORM

health information designs

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for Solaraze, Zyclara, or Picato must first try imiquimod.

- ***Imiquimod does not require prior authorization***

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Physician Name			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ ZYCLARA □ SOLARAZE □ PICATO	**Diagnosis for this Request:**		
Physician Signature		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

ALTEPLASE
PA FORM

health information designs

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for Alteplase must meet the following criteria:

- **Patient must have an FDA approved indication.**
- **Alteplase is indicated for restoration of function to central venous access devices as assessed by the ability to withdraw blood.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Physician Name			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ ALTEPLASE	**Diagnosis for this Request:**		
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*			
Prescriber (or Staff) / Pharmacy Signature**	Date		
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:	ND MEDICAID PROVIDER NUMBER:
DRUG	NDC #
TELEPHONE NUMBER	FAX NUMBER

AMRIX PA FORM

health information designs

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for Amrix must try and fail generic cyclobenzaprine.

- **Cyclobenzaprine does not require PA**
- **Patient must fail therapy on generic cyclobenzaprine before a PA will be considered for Amrix.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Physician Name			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ AMRIX	**Diagnosis for this request:**		

Qualifications for coverage:

Failed Cyclobenzaprine Therapy? □ YES □ NO	Start Date	End Date	Dose	Frequency

□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*

Prescriber (or Staff) / Pharmacy Signature**	Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

ANTIHEMOPHILIC FACTORS PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for antihemophilic factors must provide the following information:

- **Visit once per year with an accredited Hemophilia Treatment Center**
- **Date of last appointment with treatment center**
- **Contact information for treatment center**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	**Recipient Date of Birth**	Recipient Medicaid ID Number	
Physician Name			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code

Requested Drug and Dosage:	**Diagnosis for this Request:**
TREATMENT CENTER CONTACT INFORMATION:	**DATE OF LAST APPOINTMENT WITH TREATMENT CENTER:**
	Patient visits an accredited Hemophilia Treatment Center for yearly checkups: □ YES □ NO

□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*

Prescriber (or Staff) / Pharmacy Signature**	Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

ANTIHISTAMINE PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving antihistamines must use loratadine (Claritin generic) and cetirizine (Zyrtec generic) as step therapy.

Note:

- **Loratadine OTC and cetirizine OTC (or prescription) may be prescribed WITHOUT prior authorization.**
- **Patient must have failed a 14 day trial of Xyzal OTC, as evidenced by paid pharmacy claims or pharmacy print-outs.**
- **Patient must have failed a 14 day trial of one of the following, as evidenced by paid pharmacy claims or pharmacy print-outs:**
  - **Loratadine OTC**
  - **Cetirizine OTC**

Part I: TO BE COMPLETED BY PRESCRIBER

RECIPIENT NAME:	RECIPIENT MEDICAID ID NUMBER:
Recipient Date of birth: / /	
PRESCRIBER NAME:	PRESCRIBER MEDICAID ID NUMBER:
Address:	Phone: ( )
City:	FAX: ( )
State: Zip:	
REQUESTED DRUG:	**Requested Dosage:** **Diagnosis for this request:**

Qualifications for coverage:

□ Failed loratadine □ Failed cetirizine □ Failed Xyzal OTC	Start Date:	End Date:

□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*

Prescriber (or Staff) / Pharmacy Signature**	Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:	ND MEDICAID PROVIDER NUMBER:
Phone:	FAX:
Drug:	NDC#:

Short-Acting HFA Beta$_2$ Agonist PA FORM

health information designs

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for ProAir RespiClick, Ventolin HFA, or Xopenex HFA must use Proventil HFA as first line therapy.

*__Note: Proventil HFA does not require a prior authorization.__

- **Ventolin HFA – trial of Proventil HFA.**
- **Xopenex HFA – trial of Proventil HFA and Ventolin HFA.**
- **ProAir RespiClick – trial of Proventil HFA, Ventolin HFA, and Xopenex HFA.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Physician Name			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ XOPENEX HFA □ VENTOLIN HFA □ PROAIR RESPICLICK	**Diagnosis for this request:**		

Qualifications for coverage:

Failed therapy	Start Date	End Date	Dose	Frequency
1. 2. 3.				

□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*

Prescriber (or Staff) / Pharmacy Signature**	Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

Prior Authorization Vendor for ND Medicaid

Brisdelle
PA Form

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

ND Medicaid requires that patients receiving a new prescription for Brisdelle must meet the following criteria:

- **Patient must have had a 30-day trial of generic paroxetine.**
- **Patient must have a diagnosis of moderate to severe vasomotor symptoms associated with menopause**

Part I: TO BE COMPLETED BY PRESCRIBER

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ BRISDELLE	**Diagnosis for Request:** □ Moderate to severe vasomotor symptoms associated with menopause □ Other:		

Qualifications for Coverage:

Medications patient has tried:	Start Date:	End Date:	Dose:	Frequency:

Other medical justification for use:	
Prescriber (or Staff) / Pharmacy Signature**	Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:	ND MEDICAID PROVIDER NUMBER:
Phone:	FAX:
Drug:	NDC#:

health information designs

Prior Authorization Vendor for ND Medicaid

LONG ACTING OPIOID ANALGESICS PA FORM

Fax Completed Form to: 855-207-0250
For questions regarding this Prior authorization, call 866-773-0695

ND Medicaid requires that patients receiving a short-acting opioid analgesic must meet the following criteria:

- **Failure of a 30-day trial of two preferred agents will be required before a non-preferred will be authorized. Oxycodone IR**
- **The prescriber must confirm that they have reviewed the North Dakota PDMP reports for the patient.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	**Recipient Date of Birth**	Recipient Medicaid ID Number	
Physician Name			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code

Requested Drug and Dosage:	**Diagnosis for this Request:** □ Cancer Pain □ Other:
Has patient required daily use of opioids for at least 90 days?	□ YES □ NO
Does the prescriber routinely check the PDMP system?	□ YES □ NO

FAILED THERAPY	**START DATE**	**END DATE**	**DOSE & FREQUENCY**

□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*

Prescriber (or Staff) / Pharmacy Signature**	Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

ORAL ANTICOAGULANTS
PA FORM

health information designs

Prior Authorization Vendor for ND Medicaid

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

ND Medicaid requires that patients receiving a new prescription for Pradaxa, Xarelto, Eliquis, or Savaysa must meet the following criteria:

- **Patient must have an FDA approved indication.**
- **A 30 day trial of all preferred agents will be required before a non-preferred agent will be authorized.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	**Recipient Date of Birth**	Recipient Medicaid ID Number	
Physician Name			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ PRADAXA □ XARELTO □ ELIQUIS □ SAVAYSA	**Diagnosis for this Request:**		
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*			
Prescriber (or Staff) / Pharmacy Signature**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

Prior Authorization Vendor for ND Medicaid

SHORT ACTING OPIOID ANALGESICS PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

ND Medicaid requires that patients receiving a short-acting opioid analgesic must meet the following criteria:

- **Subsys, Fentora, Lazanda, Actiq and Abstral**
  - Patient must be at least 18 years of age for Subsys, Fentora, or Lazanda, and 16 years for Actiq or Abstral.
  - The patient must have cancer pain.
  - The patient must currently be on around the clock opioid therapy and have been on round the clock opioid therapy for at least 1 week, as evidenced by paid claims or pharmacy print-outs.
- **Oxycodone IR**
  - The patient must have chronic pain.
  - The patient must currently be on a long-acting narcotic, as evidenced by paid claims or pharmacy print-outs.
  - The prescriber must confirm that they have reviewed the North Dakota PDMP reports for the patient.
  - The patient's current total daily Morphine Equivalent Dose (MED), must be greater than the minimum per tablet strength requested (below), as evidenced by paid claims or pharmacy print-outs.
    - For 15 mg tablet ≥300 MED/day, for 20 mg tablet ≥300 MEDs/day, for 30 mg tablet ≥300 MEDs/day.
- **Oxaydo**
  - The patient must have failed 3 separate trials of generic, immediate-release narcotics, as evidenced by paid claims or pharmacy print-outs.
  - The prescriber must confirm that they have reviewed the North Dakota PDMP reports for the patient.

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	**Recipient Date of Birth**	Recipient Medicaid ID Number	
Physician Name			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code

Requested Drug and Dosage:	**Diagnosis for this Request:** □ Chronic Pain □ Cancer Pain □ Other:
Is patient on a long-acting narcotic?	□ YES □ NO
Does the prescriber routinely check the PDMP system?	□ YES □ NO

FAILED THERAPY	**START DATE**	**END DATE**	**DOSE & FREQUENCY**

□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*

Prescriber (or Staff) / Pharmacy Signature**	Date

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Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

ACE-Inhibitors (ACE-I), Angiotensin II Receptor Blockers (ARB) and Renin Inhibitor PA Form

health information designs

Prior Authorization Vendor for ND Medicaid

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

ND Medicaid requires that patients receiving a prescription for an ACE-I, ARB, Renin Inhibitor, or any combination not listed below must meet the following criteria:

- **ACE-I: Captopril, enalapril, ramipril, lisinopril, trandolapril, quinapril, benazepril, and fosinopril and their hydrochlorothiazide containing combinations do not require a prior authorization. Epaned does not require a PA for patients less than 7 years of age.**
- **Angiotensin II receptor antagonists: Losartan and valsartan do not require a prior authorization.**
- **Renin Inhibitor: Aliskiren and combination products require a prior authorization.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:	**Diagnosis for this request:** **Does patient have symptomatic chronic heart failure (NYHA class II-IV)? □ YES □ NO** **Left ventricular ejection fraction:**		

Failed therapy (list all that apply)	Start Date	End Date
Is the patient unable to ingest solid dosage forms (provide documentation)? □ YES □ NO		
Prescriber (or Staff) / Pharmacy Signature**		Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

ACITRETIN PA FORM

health information designs

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for Acitretin must meet the following criteria:

- **Patient must have an FDA approved indication.**
- **Patient must be male or female permanently unable to bear children.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:	**FDA approved indication for this request:** **Is patient permanently unable to bear children? □ YES □ NO**		
Prescriber (or Staff) / Pharmacy Signature**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

ACNE AGENTS
PA FORM

health information designs

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for an acne agent must meet the following criteria:

- **Patients between the ages of 12-35 are eligible for acne treatment.**
- **Requires step therapy. See acne criteria for more information.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	**Recipient Date of Birth**	Recipient Medicaid ID Number	
Prescriber Name	Dermatologist Involved in therapy:		
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:	**Diagnosis for this Request:**		
LIST ALL FAILED MEDICATIONS AND REASON:			
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*			
Prescriber (or Staff) / Pharmacy Signature**	Date		
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

AMPYRA PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for Ampyra must meet the following criteria:

- **Patient must be 18 years or older.**
- **Patient must have a specialist (neurologist or physiatrist) involved in therapy.**
- **Patient must have a confirmed diagnosis of multiple sclerosis.**
- **Patient must not have a history of seizures**
- **Patient's CrCl (creatinine clearance) must be greater than 50mL/min**
- **Renewal PA requests must include patient's current T25FW.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	**Recipient Date of Birth**	Recipient Medicaid ID Number	
Physician Name	Specialist involved in therapy (if not treating physician)		
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ AMPYRA	**FDA approved indication for this request:**		
Has patient experienced any acute exacerbations within the last 60 days?	□ YES	□ NO	
Does the patient have a CrCL greater than 50mL/min?	□ YES	□ NO	
Does the patient have a history of seizures?	□ YES	□ NO	
What is the patient's baseline Timed 25-foot Walk (T25FW)?	**If this is a renewal PA request, please include patient's current T25FW:**		
Prescriber (or Staff) / Pharmacy Signature**		Date	

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

ANTIHYPERURICEMICS PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for antihyperuricemics must meet the following criteria:

- **Colchicine: Patient must have failed a 30-day trial of Mitigare.**
- **All Others: Patient must have failed a 30-day trial of allopurinol 300 mg or greater.**
- **Zuramic: Patient must have failed a 30-day trial of Uloric and be using Zuramic in combination with allopurinol or Uloric.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number		
Prescriber Name				
Prescriber NPI	Telephone Number	Fax Number		
Address	City	State	Zip Code	
Requested Drug and Dosage:	**Diagnosis for Request:**			
Qualifications for Coverage:				
Medications patient has tried:	Start Date:	End Date:	Dose:	Frequency:
Other medical justification for use (e.g. renal or hepatic impairment):				
Prescriber (or Staff) / Pharmacy Signature**	Date			
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*				

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

ANTIMALARIAL AGENTS PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for antimalarial agents must meet the following criteria:

- **For all agents:**
  - Patient must have tried a generic quinine in the last 30 days.
  - Provider must submit an appropriate MedWatch form documenting the trial.
- **For Malarone with NDC 00173067601:**
  - Patient must meet above criteria
  - Patient must be less than 18 years of age.

Part I: TO BE COMPLETED BY PRESCRIBER

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:	**Diagnosis for Request:** □ Treatment of malaria		

Qualifications for Coverage:

Medications patient has tried:	Start Date:	End Date:	Dose:	Frequency:

Other medical justification for use (e.g. renal or hepatic impairment):	
Prescriber (or Staff) / Pharmacy Signature**	Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:		ND MEDICAID PROVIDER NUMBER:
Phone:		FAX:
Drug:		NDC#:

health information designs

Ulcerative Colitis Agents
PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires a 30-day trial of all preferred products before non-preferred agent will be authorized.
Note:

- **An FDA approved indication of treatment of flares in patients with moderately active ulcerative colitis is required.**
- **See list of preferred products at http://hidesigns.com/assets/files/ndmedicaid/NDPDL.pdf**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:	**Diagnosis for this request:**		
List all failed medications:	**Start Date:**	**End Date:**	
Prescriber (or Staff) / Pharmacy Signature**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

CYSTIC FIBROSIS ANTI-INFECTIVES PA FORM

Fax Completed Form to: 855-207-0250
For questions regarding this Prior authorization, call 866-773-0695

Prior Authorization Vendor for ND

ND Medicaid requires that patients receiving a new prescription for TOBI, TOBI Podhaler, tobramycin inhalation or Cayston must meet the following criteria:

- Patient must have had a 28 day trial of Bethkis or Kitabis Pak, as evidenced by paid claims or pharmacy print-outs.
- Patient must have an FDA approved indication.
- Patient must be 6 years of age or older (TOBI) and 7 years of age or older (Cayston).
- The patient has not been colonized with Burkholderia cepacia.
- **For Cayston:**
  - Patient must have a FEV1 of less than 25% or greater than 75% predicted
- **For or TOBI, TOBI Podhaler, or tobramycin inhalation**
  - Patient must have a FEV1 of less than 40% or greater than 80% predicted.

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:	**Diagnosis for this request:**		
List all failed medications:	**Start Date:**	**End Date:**	
FEV1:_____	Has the patient been colonized with Burkholderia cepacia? □ YES □ NO		
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*			
Prescriber (or Staff) / Pharmacy Signature**	Date		
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

BOWEL PREP AGENTS PA FORM

health information designs

Prior Authorization Vendor for ND Medicaid

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

ND Medicaid requires that patients receiving a new prescription for a bowel prep agent must meet the following criteria:

- **Patient must first try Golytely.**

Part I: TO BE COMPLETED BY PRESCRIBER

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number		
Prescriber Name				
Prescriber NPI	Telephone Number	Fax Number		
Address	City	State	Zip Code	
Requested Drug and Dosage:	**Diagnosis for Request:**			
Qualifications for Coverage:				
Medications patient has tried:	Start Date:	End Date:	Dose:	Frequency:
Other medical justification for use (reason Golytely cannot be used):				
Prescriber (or Staff) / Pharmacy Signature**		Date		
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*				

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:		ND MEDICAID PROVIDER NUMBER:
Phone:		FAX:
Drug:		NDC#:

health information designs

CARISOPRODOL PA Form

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND

*Cyclobenzaprine, chlorzoxazone, methocarbamol and orphenadrine do not require a prior authorization.

***Note:**

- **PA will be approved if recipient is currently taking carisoprodol on a chronic basis and provider is weaning patient.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ CARISOPRODOL	**Diagnosis for this request:**		
Qualifications for coverage:			
□ CHRONIC CARISOPRODOL RECIPIENT BEING WEANED (PLEASE INCLUDE WEANING SCHEDULE)	Dose:	Frequency:	
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*			
Prescriber (or Staff) / Pharmacy Signature**	Date		
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

CIALIS FOR BENIGN PROSTATIC HYPERPLASIA PA Form

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND

ND Medicaid requires that patients receiving a prescription for Cialis used to treat benign prostatic hyperplasia (BPH) must meet the following criteria:

- **Patient must have diagnosis of BPH**
- **Patient must try and fail all alpha blockers and 5-alpha reductase inhibitors and combinations, unless contraindicated.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ CIALIS	**Diagnosis for this request:**		
Qualifications for coverage: (please attach any additional notes listed all products failed)			
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*			
Prescriber (or Staff) / Pharmacy Signature**	Date		
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

COMBINATION PRODUCTS PA FORM

Fax Completed Form to: 855-207-0250
For questions regarding this Prior authorization, call 866-773-0695

Prior Authorization Vendor for ND

ND Medicaid requires that patients receiving a prescription for a combination product that is more expensive than the individual components must meet the following criteria:

- **Patient must be currently stable on the combination product.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:	**Diagnosis for this request:**		
Qualifications for coverage:			
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*			
Prescriber (or Staff) / Pharmacy Signature**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

COPAXONE 40 mg/mL
PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND

ND Medicaid requires that patients receiving a prescription for Copaxone 40m/mL must meet the following criteria:

- **Patient must have a confirmed diagnosis of multiple sclerosis.**
- **Prescriber must be a neurologist.**
- **Patient must have failed a 3 month trial of copaxone 20 mg/mL, Aubagio, Tecfidera, and Gilenya.**
- **The prescriber must provide medical justification indicating why the patient cannot use copaxone 20 mg/mL**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name	Specialist involved in therapy (if not treating physician)		
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ COPAXONE 40MG	**Diagnosis for this request:**		
List all failed medications:	**Start Date:**	**End Date:**	
Qualifications for coverage:			
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*			
Prescriber (or Staff) / Pharmacy Signature**	Date		
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

Agents Used to Treat COPD
PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND

ND Medicaid requires that patients receiving a prescription for non-preferred agents to treat COPD must have a diagnosis of COPD and meet the criteria for the specific agent listed in the North Dakota Medicaid Preferred Drug List (link below):

- http://hidesigns.com/assets/files/ndmedicaid/NDPDL.pdf

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name	Specialist involved in therapy (if not treating physician)		
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:	**Diagnosis for this request:** □ COPD □ OTHER:		
List all failed medications:	**Start Date:**	**End Date:**	
Additional Qualifications for Coverage (if applicable, per the specific criteria in the PDL, such as number of exacerbations treated with corticosteroids)			
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*			
Prescriber (or Staff) / Pharmacy Signature**	Date		
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

Inhaled Corticosteroid/Long-Acting Beta-2 Agonists PA FORM

Fax Completed Form to: 855-207-0250
For questions regarding this Prior authorization, call 866-773-0695

Prior Authorization Vendor for ND

ND Medicaid requires that patients receiving a prescription for non-preferred inhaled corticosteroid/long-acting beta-2 agonist agents must meet the following criteria:

- Patient must have had a 30-day trial with all preferred agents, as evidenced by paid claims or pharmacy print-outs.
- **For COPD diagnosis**, a 30-day trial of one drug from each group below will also be required:
  - Tudorza Pressair, Spiriva, Spiriva Respimat, Incruse Ellipta, Anoro Ellipta, or Stiolto Respimat.
  - Anoro Ellipta, Stiolto Respimat, Foradil, Brovana, Arcapta Neohaler, Striverdi Respimat, Perforomist, or Serevent.
- **For asthma diagnosis**, patient must have been reviewed for step down therapy for all renewal requests.

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code

Requested Drug and Dosage:	**Diagnosis for this request:** □ COPD □ ASTHMA □ OTHER:

List all failed medications:	**Start Date:**	**End Date:**

Additional Qualifications for Coverage
For renewal requests & an asthma diagnosis, has the patient must have been reviewed for step down therapy? □ YES □ NO

□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*

Prescriber (or Staff) / Pharmacy Signature**	Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

DISPENSE AS WRITTEN PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

North Dakota Medicaid requires that patients receiving a brand name drug, when there is a generic equivalent available, must first try and fail the generic product for one of the following reasons.

- **The generic product(s) are not effective (attach MedWatch form for two different generic manufacturers)**
- **There was an adverse reaction with the generic product(s) (attach MedWatch form for two different generic manufacturers)**
- **DAW not allowed for drugs with an authorized generic available.**
- **Primary insurance requires a ND Medicaid non-preferred brand product.**

Part I: TO BE COMPLETED BY PRESCRIBER

Recipient Name		Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name				
Prescriber NPI		Telephone Number	Fax Number	
Address		City	State	Zip Code
Requested Drug:	**DOSAGE:**	**Diagnosis for this request:**		

QUALIFICATIONS FOR COVERAGE: □ FAILED TWO GENERIC EQUIVALENTS	**Start Date**	**End Date**	**Dose**	**Frequency**

ADVERSE REACTION TO GENERIC EQUIVALENT: □ FDA MEDWATCH FORM ATTACHED FOR EACH GENERIC FAILED

PRIMARY INSURANCE REQUIRES: □ BRAND NAME PRODUCT

Primary insurance carrier: _____

□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*

Prescriber (or Staff) / Pharmacy Signature**	Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

DEXPAK/ZEMAPAK
PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND

ND Medicaid requires that patients receiving a new prescription for DexPak or Zema-Pak must meet the following criteria:

- Patient must first try and fail with dexamethasone.

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name	Specialist involved in therapy (if not treating physician)		
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code

Requested Drug and Dosage: □ DEXPAK □ ZEMA-PAK	**Diagnosis for this request:**	
List all failed medications: □ DEXAMETHASONE	**Start Date:**	**End Date:**
Additional Qualifications for Coverage:		
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*		
Prescriber (or Staff) / Pharmacy Signature**	Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*		

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

Diabetic Testing Supplies
PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND

ND Medicaid requires that patients receiving a prescription for non-preferred diabetic testing supplies must provide medical justification for use. Please see a list fo the preferred diabetic testing supplies at http://www.hidesigns.com/assets/files/ndmedicaid/2017/PDSL/North_Dakota_Medicaid_Preferred_Diabetic_Supply_2017-2.pdf

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name	Specialist involved in therapy (if not treating physician)		
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:	**Diagnosis for this request:** □ OTHER:		
List all failed medications: □ PATIENT HAS AN INSULIN PUMP NOT COMPATIBLE WITH THE PREFERRED TEST STRIPS **What pump does patient use?**			
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*			
Prescriber (or Staff) / Pharmacy Signature**	Date		
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

Diclegis
PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND

ND Medicaid requires that patients receiving a new prescription for Diclegis must meet the following criteria:

- Patient must have diagnosis of nausea and vomiting of pregnancy
- Patient must first try ondansetron, meclizine, and metoclopramide.

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name	Specialist involved in therapy (if not treating physician)		
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code

Requested Drug and Dosage: □ **DICLEGIS**	**Diagnosis for this request:** □ NAUSEA AND VOMITING OF PREGNANCY

List all failed medications:	**Start Date:**	**End Date:**

Additional Qualifications for Coverage:

□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*

Prescriber (or Staff) / Pharmacy Signature**	Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

DPP-4 INHIBITORS PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for a DPP-4 inhibitor:

- **Diagnosis of Diabetes Type II required**
- **Onglyza: must fail a 3-month trial of metformin and continue taking metformin**
- **For all other agents, patient must fail a 3-month trial of metformin AND continue taking metformin concurrently AND fail a 30-day trial of both a sitagliptin product (Janumet, Janumet XR, or Januvia) and a linagliptin product (Jentadueto or Tradjenta).**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:	**Has patient taken metformin for 3 months? □ YES □ NO** **Will patient continue therapy with metformin and the requested medication? □ YES □ NO** **Please list all medications patient has tried:**		
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*			
Prescriber (or Staff) / Pharmacy Signature**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

EDECRIN PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for Edecrin must meet one of the following criteria:

- **Patient must have a documented sulfa allergy.**
- **Patient must have failed a 30-day trial of bumetanide, furosemide, or torsemide.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:	**FDA approved indication for this request:**		
List all failed medications (drug name, date of trial, reason for failure):			
Additional Qualifications for Coverage:			
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*			
Prescriber (or Staff) / Pharmacy Signature**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

ELAPRASE PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for Elaprase must meet the following criteria:

- **Patient must have Hunter Syndrome.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	**Recipient Date of Birth**	Recipient Medicaid ID Number	
Physician Name			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ ELAPRASE	**Diagnosis for this Request:**		
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*			
Prescriber (or Staff) / Pharmacy Signature**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

ERYTHROPOIESIS-STIMULATING AGENTS
PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for erythropoiesis-stimulating agents must meet the following criteria:

- **Patient must have an FDA approved indication.**
- **Requires step therapy. Please review criteria for coverage.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: **Diagnosis:**	**Please list all medications patient has tried:**		
Prescriber (or Staff) / Pharmacy Signature**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

Fulyzaq
Prior Authorization

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for Fulyzaq must meet the following criteria:
Note:

- **Patient must be 18 years of age or older.**
- **Patient must have non-infectious diarrhea.**
- **Patient must have HIV/AIDS and be taking anti-retroviral therapy.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Physician Name:			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
QUALIFICATIONS FOR COVERAGE:			
Requested Drug and Dosage: □ **Fulyzaq**	Diagnosis for this request: Anti-retroviral therapy		
Prescriber (or Staff) / Pharmacy Signature**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

GLP-1 RECEPTOR AGONISTS PA FORM

Fax Completed Form to: 855-207-0250
For questions regarding this Prior authorization, call 866-773-0695

Prior Authorization Vendor for ND

ND Medicaid requires that patients receiving a new prescription for a non-preferred GLP-1 receptor agonist must meet the following criteria:

- **Patient must have a diagnosis of type 2 diabetes mellitus.**
- **Patient must fail a 3-month trial of metformin and currently be taking metformin.**
- **Patient must have failed a 30-day trial of 2 preferred products (Trulicity and Adlyxin).**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name	Specialist involved in therapy (if not treating physician)		
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code

Requested Drug and Dosage: □ VICTOZA □ ADLYXIN □ TRULICITY	**Diagnosis for this request:** □ TYPE 2 DIABETES MELLITUS
List all failed medications: □ METFORMIN □ OTHERS:	**Start Date:** / **End Date:**

□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*

Prescriber (or Staff) / Pharmacy Signature**	Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

GLUMETZA PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for Glumetza must meet the following criteria:

- **Patient must fail a 3-month trial of metformin ER.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:	**FDA approved indication for this request:**		
List all failed medications (drug name, date of trial, reason for failure):			
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*			
Prescriber (or Staff) / Pharmacy Signature**	Date		
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

GRALISE PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for Gralise must meet the following criteria:

- **Patient must have a diagnosis of postherpetic neuralgia**
- **Patient must first try gabapentin**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	**Recipient Date of Birth**	Recipient Medicaid ID Number	
Physician Name			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ GRALISE	**Diagnosis for this Request:**		
Failed Therapy (dose and frequency): □ GABAPENTIN	**Start Date:** **End Date:**		
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*			
Prescriber (or Staff) / Pharmacy Signature**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

Growth Hormone PA Form

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving Growth Hormone meet one of the criteria below:

- Growth Hormone Deficiency in children and adults with a history of hypothalamic pituitary disease
- Short stature associated with chronic renal insufficiency before renal transplantation
- Short stature in patients with Turners Syndrome (TS), Prader-Willi Syndrome (PWS), or Noonan, SHOX Syndrome
- Human Immunodeficiency Virus (HIV) associated wasting in adults
- See growth hormone criteria for additional information.
  http://www.hidesigns.com/assets/files/ndmedicaid/2017/Criteria/growth_hormone_criteria_1.pdf

Part I: TO BE COMPLETED BY PRESCRIBER

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name	Specialist involved in therapy (if not treating physician)		
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
REQUESTED DRUG:	**Requested Dosage:** (must be completed)		

Qualifications for coverage:

Diagnosis:	Previous Therapy:	Dose:	Frequency:
Height:	Has patient attained epiphyseal closure?	□ Yes	□ No

Prescriber (or Staff) / Pharmacy Signature**	Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

Genitourinary Smooth Muscle Relaxants (GSMR) Prior Authorization

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires a 30-day trial of all preferred products before a non-preferred agent will be authorized.
Note:

- **See list of preferred products at http://hidesigns.com/assets/files/ndmedicaid/NDPDL.pdf**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name:			
Prescriber NPI:	Telephone Number	Fax Number	
Address	City	State	Zip Code
Qualifications for coverage:			
Requested Drug and Dosage:	**Diagnosis for this request:**		
	Failed therapy-List all (Drug and Dose) **Start Date:** **End Date:**		
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*			
Prescriber (or Staff) / Pharmacy Signature**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

HEREDITARY ANGIOEDEMA PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for an agent used to treat hereditary angioedema must meet the following criteria:

- **Patient must have diagnosis of hereditary angioedema confirmed by a specialist**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	**Recipient Date of Birth**	Recipient Medicaid ID Number	
Physician Name	Specialist Involved in therapy:		
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ BERINERT □ FIRAZYR □ CINRYZE □ KALBITOR	**Diagnosis for this Request:**		
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*			
Prescriber (or Staff) / Pharmacy Signature**	Date		
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

HEMANGEOL
PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for Hemangeol must meet the following criteria:

- **Patient must be between 5 weeks and 1 year of age.**
- **Patient must weigh 2 kg or greater.**
- **Patient must not have contraindications as listed below: asthma or a history of bronchospasm, bradycardia (<80 beats per minute), greater than first-degree heart block, decompensated heart failure, blood pressure <50/30 mmHg, or pheochromocytoma.**
- **Patient must have a diagnosis of proliferating infantile hemangioma requiring systemic therapy.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug: □ HEMANGEOL	Diagnosis: Patient's weight:	Does patient have ANY contraindications to Hemangeol?	
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*			
Prescriber (or Staff) / Pharmacy Signature**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

HEPATITIS C TREATMENTS PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND

ND Medicaid requires that patients receiving a prescription for hepatitis C treatments must meet the following criteria (for further specified criteria, please see the PDL at http://hidesigns.com/assets/files/ndmedicaid/NDPDL.pdf:

- Patient must have an FDA-approved diagnosis and genotype and be of an FDA-approved age for use
- Patient must attest that they will continue treatment without interruption for the duration of therapy and established compliant behavior
- Must be prescribed by or in consultation with a hepatologist, gastroenterologist, or infectious disease specialist
- Prescriber must attach documentation that the patient has been drug and alcohol free for the past 12 months.
- Patient must be tested for hepatitis B and must either be treated or closely monitored if the test is positive.
- HCV RNA level must be taken on week 4 and sent with a renewal request for any duration of treatment 12 weeks or longer.
- Females using ribavirin must have a negative pregnancy test in the last 30 days and receive monthly pregnancy tests during treatment
- Patient must not have life expectancy of less than 12 months due to non-liver related comorbid conditions.
- For non-preferred agents: Patient must have failed a trial of all preferred treatment options indicated for the patient's genotype.

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name	Specialist involved in therapy		
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code

Requested Drug and Dose:	**Duration requested:**	**Patient is drug and alcohol free for past 12 months:** □ YES □ NO
Diagnosis:	**Genotype:**	**Patient's Child-Pugh class:** □ A □ B □ C □ N/A

Please list any previous treatments the patient has failed for chronic HCV: □ N/A	Regimen:	Dates of treatment:	Response:

Will the requested medication be given with ribavirin to a patient of child bearing potential?	□ YES □ NO
If yes, has the patient had a negative pregnancy test in the last 30 days?	□ YES □ NO □ N/A
Will the receive pregnancy tests monthly during treatment?	□ YES □ NO □ N/A
Is the patient taking the requested medication in combination with another HCV treatment? □ YES □ NO	Other Agent(s) used:
Does the patient have Hepatitis B?	□ YES □ NO
If the patient has Hepatitis B, has it been treated or will it be closely monitored during treatment?	□ YES □ NO
Is the patient post-liver transplant?	□ YES □ NO
Does the patient's life expectancy greater than one year?	□ YES □ NO
Does patient attended scheduled visits with no more than 1 no-show and fill maintenance medications on time?	□ YES □ NO
Does patient have any contraindications to therapy with the requested agent?	□ YES □ NO

Please confirm that all of the following is attached to the request, along with any other documentation required, as stated in the PDL:

□ Baseline HCV RNA
□ ≥ 2 drug and alcohol tests dated at least 3 months apart
□ Patient attestation form
□ HCV RNA 4 weeks after starting therapy (for renewal)
□ Chart notes addressing patient's alcohol and drug free status over the past year

Prescriber (or Staff) / Pharmacy Signature**	Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

Hepatitis C Patient Consent Form

I, _____, have been counseled by my healthcare provider on the following:

- ☐ I agree to complete the entire course of treatment and have laboratory tests before starting, during, and after completing treatment as ordered by my healthcare provider.
- ☐ I understand that for the medication to work, it is important that I take my medication each day for the entire course of treatment.
- ☐ I understand the importance to not drink alcohol or use illicit drugs during and after my treatment for Hepatitis C.
- ☐ I understand how to avoid being re-infected with Hepatitis C during and after my treatment.
- ☐ (Females) I understand that these drugs are harmful to babies. I will use two methods to avoid getting pregnant. I understand that this medication may cause serious birth defects to an unborn child for up to 6 months after I have completed my treatment.
- ☐ (Males) I understand that while I am taking the medication, I must avoid getting my partner pregnant. If my partner becomes pregnant, the baby may have serious birth defects. My partner and I will prevent pregnancy using two forms of birth control for up to 6 months after my treatment is complete. If I have a committed partner, I have discussed these risks with her.

Patient Signature _____ Date __/__/___

Pharmacy or Prescriber Representative:

Signature _____ Date __/__/____

By signature, the pharmacy or prescriber representative confirms the contract has been reviewed with the patient.

health information designs

Horizant Prior Authorization

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for Horizant must follow the following guidelines:

- ***Patient must have a diagnosis of Restless Leg Syndrome.***
- ***Patient must have had a trial of gabapentin, pramipexole, or ropinirole.***

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Physician Name			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ **Horizant**	**Diagnosis for this request:**		
Qualifications for coverage:			
□ FAILED THERAPY START DATE: DOSE: END DATE: FREQUENCY:			
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*			
Prescriber (or Staff) / Pharmacy Signature**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

Medications used to treat IBS/OIC
PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for medications used to treat IBS/OIC must meet the following criteria:

- *Patient must have diagnosis of chronic constipation, IBS with constipation, or opioid-induced constipation.*
- *Requires step therapy. See IBS/OIC criteria for more details.*

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name:			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code

QUALIFICATIONS FOR COVERAGE:

Requested Drug and Dosage:	Diagnosis for this request: Is the patient unable to tolerate oral medications?
Failed therapy:	Start Date: End Date:

□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*

Prescriber (or Staff) / Pharmacy Signature**	Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

IMMUNE GLOBULINS PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for an immune globulin must meet the following criteria:

- **If patient's BMI > 30, adjusted body weight must be provided along with the calculated dose.**
- **For Gammagard S/D – patient must be intolerant to IgA.**
- **For Hizentra, Cuvitru, or Hyqvia – patient must be unable to tolerate IV administration and fail a trial of two of the following: Gamunex-C, Gammaked, or Gammagard.**
- **For all other agents, patient must try and fail two of the following: Gamunex-C, Privigen, or Gammagard.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: **Indication for this request:**	**Is patient BMI over 30? □ YES □ NO** **If yes, provide adjusted body weight and calculated dose:** **Is patient intolerant to IgA (i.e., treatment of an autoimmune process in a patient with undetectable levels of IgA)? □YES □NO** **Is patient unable to tolerate IV administration? □ YES □ NO** **Please list all medications patient has tried and failed:**		
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*			
Prescriber (or Staff) / Pharmacy Signature**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

INJECTABLE ANTICOAGULANTS PA FORM

health information designs

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for injectable anticoagulants must meet the following criteria:

- **Patient must have an FDA approved indication.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:	**FDA approved indication for this request:** **Does the patient have an indication that cannot be treated with Lovenox?** **Does the patient need Extended Treatment for Symptomatic Venous Thromboembolism in Patients with Cancer? □ YES □ NO**		
History of preferred agents (drug name, dates of trial, reason for failure):			
Prescriber (or Staff) / Pharmacy Signature**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

Insulins
Prior Authorization

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for a non-preferred insulin must first try a 30-day trial of one preferred agent in the past year.

- **For all non-preferred long-acting insulins:**
  - Patient must have failed patient failed a 3 month trial of both Lantus and Levemir with good compliance.
    - Must have required at least 100 units/day for Tresiba U-200 and Toujeo.
- **For pens/syringes when vials are available:**
  - Patient must have failed at least a 30-day trial using the vial product OR have valid medical justification explaining why the patient cannot use the vial.
- **For Fiasp:**
  - Patient must have failed a 30-day trial with at least 3 preferred agents in the past year.

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name:			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
QUALIFICATIONS FOR COVERAGE:			
Requested Drug and Dosage:		Diagnosis for this request:	
Failed Therapy:		Start Date: End Date:	
Prescriber (or Staff) / Pharmacy Signature**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

INTERFERONS – MULTIPLE SCLEROSIS PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for interferon must meet the following criteria:

- **Patient must have a confirmed diagnosis of multiple sclerosis.**
- **A three month trial of a preferred agent will be required before a non-preferred agent will be authorized.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:	**FDA approved indication for this request:**		
Prior therapy: **Start date:**	**End date:**		
Prescriber (or Staff) / Pharmacy Signature**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

INTERLEUKIN-5 ANTAGONIST PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for an interleukin-5 antagonist must meet the following criteria:

- **Patient must have a diagnosis of asthma.**
- **Patient must have blood eosinophils of ≥ 150 cells/microliter within the last 6 weeks.**
- **Patient must have had 3 fills of a high dose steroid and a controller medication in the past 120 days.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:	**FDA approved indication for this request:** **Blood eosinophil count:** **Date of eosinophil count:**		
List all failed medications (drug name, date of trial, reason for failure): **Does patient have a history of 2 or more exacerbations in the previous year? □ YES □ NO** **Has patient had a decreased frequency of exacerbations (worsening of asthma requiring an increase in ICS dose or treatment with systemic corticosteroids)? □ YES □ NO** **Has patient's predicted FEV1 increased from pretreatment baseline? □ YES □ NO** **Has patient had 3 fills of high dose steroids in the past 120 days? □ YES □ NO** **Has patient had 3 fills of a controller medication in the last 120 days? □ YES □ NO**			
Prescriber (or Staff) / Pharmacy Signature**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

AGENTS USED TO TREAT IDIOPATHIC PULMONARY FIBROSIS PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for agents used to treat idiopathic pulmonary fibrosis must meet the following criteria:

- **Patient must be 18 years of age or older.**
- **Patient must have documented diagnosis of idiopathic pulmonary fibrosis.**
- **Patient must have a specialist involved in therapy.**
- **Patient must have forced vital capacity (FVC) ≥ 50% of predicted within prior 60 days.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name	Specialist Involved in Therapy		
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug: □ OFEV □ ESBRIET	Diagnosis: FVC:	Is patient pregnant? □ YES □ NO Is patient of child-bearing potential? □ YES □ NO Have LFTs been measured? □ YES □ NO Does patient have moderate to severe liver impairment? □ YES □ NO Does patient currently smoke? □ YES □ NO	
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*			
Prescriber (or Staff) / Pharmacy Signature**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

KALYDECO PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for Kalydeco must meet the following criteria:

- **Patient must be 2 years of age and older and have one of the following mutations in the cystic fibrosis conductance regulator (CFTR) gene: G551D, G1244E, G1349D, G178R, G551S, R117H, S1251N, S1255P, S549N, or S549R.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	**Recipient Date of Birth**	Recipient Medicaid ID Number	
Physician Name			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ KALYDECO	**Diagnosis for this Request:**		
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*			
Prescriber (or Staff) / Pharmacy Signature**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

KAPVAY PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for Kapvay must meet the following criteria:

- **Patient must first try immediate release clonidine**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	**Recipient Date of Birth**	Recipient Medicaid ID Number	
Physician Name			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ KAPVAY	**Diagnosis for this Request:**		
Failed Therapy (dose and frequency): □	**Start Date:** **End Date:**		
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*			
Prescriber (or Staff) / Pharmacy Signature**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

KETEK PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for Ketek must meet the following criteria:

- ND Medicaid will cover Ketek with a diagnosis of community-acquired pneumonia (of mild to moderate severity) due to Streptococcus pneumoniae for patients 18 years and older.
- ND Medicaid will cover Ketek for patients with an allergy to fluoroquinolones or tetracyclines.

Part I: TO BE COMPLETED BY PRESCRIBER

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name	Specialist involved in therapy (if not treating physician)		
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code

REQUESTED DRUG: □ **KETEK**	**Requested Dosage:** (must be completed)

Qualifications for coverage:

□ Community acquired pneumonia (of mild to moderate severity) due to Streptococcus pneumoniae, (including multi-drug resistant isolates, Haemophilus influenzae, Moraxella catarrhalis, Chlamydophila pneumoniae, or Mycoplasma pneumoniae) for patients 18 years and older.

Does the patient have myasthenia gravis?

Does the patient have any other antibiotic use in the last 3 months?

□ Please list fluoroquinolone or tetracycline that patient is allergic to:

_____

□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*

Prescriber (or Staff) / Pharmacy Signature**	Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

KITS PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for a kit must:

- **Use the covered product included in the kit as an individual product**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:	**Is the covered medication included in the kit available commercially as an individual product?**		
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*			
Prescriber (or Staff) / Pharmacy Signature**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

KUVAN PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for Kuvan must meet the following criteria:

- **Patient must have hyperphenalaninemia.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name		**Recipient Date of Birth**	Recipient Medicaid ID Number
Prescriber Name			
Prescriber NPI		Telephone Number	Fax Number
Address		City	State / Zip Code
Requested Drug and Dosage: □ KUVAN	**PHE level:**	**Diagnosis for this Request:**	**Patient's weight:**

Has the patient been known to have two null mutations in TRANS?	□ **YES**	□ **NO**
Are baseline PHE levels attached?	□ **YES**	□ **NO**
Is patient of child-bearing potential?	□ **YES**	□ **NO**
Is this a renewal request?	□ **YES**	□ **NO**

□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*

Prescriber (or Staff) / Pharmacy Signature**	Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

LEMTRADA PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for Lemtrada must meet the following criteria:

- **Patient must have a confirmed diagnosis of multiple sclerosis.**
- **Requires step therapy. See Lemtrada criteria for more information.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	**Recipient Date of Birth**	Recipient Medicaid ID Number	
Prescriber Name	Specialist involved in therapy (if not treating physician)		
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ LEMTRADA	**FDA approved indication for this request:**		

• **Has patient experienced a reduction in relapse rate? (renewal requests)**	□ YES	□ NO
• **Is the patient experiencing early aggressive disease? (>=2 relapses in the year and >= 1 Cadolinium (Cd)+ lesion)?**	□ YES	□ NO
• **Does the patient have VZV antibodies/vaccination or history of varicella?**	□ YES	□ NO
• **Does the patient have appropriate SCr levels?**	□ YES	□ NO
• **Does the patient have appropriate urinalysis with urine cell counts?**	□ YES	□ NO
• **Has the patient had thyroid function tests?**	□ YES	□ NO
• **Has the patient had a TB test?**	□ YES	□ NO

List all failed medications:	**Start Date:**	**End Date:**

□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*

Prescriber (or Staff) / Pharmacy Signature**	Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

LICE MEDICATIONS PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for lice medications must meet one of the following criteria:

- **Patient must have failed a 28-day trial (2 applications) of each of the preferred agents.**
- **Non-preferred agents will require an FDA approved indication.**
- **See list of preferred products at http://hidesigns.com/assets/files/ndmedicaid/NDPDL.pdf**
-

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:	**FDA approved indication for this request:**		
List all failed medications (drug name, date of trial, reason for failure):			
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*			
Prescriber (or Staff) / Pharmacy Signature**	Date		
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

LORZONE PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for Lorzone must meet the following criteria:

- **Patient must first try chlorzoxazone**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	**Recipient Date of Birth**	Recipient Medicaid ID Number	
Physician Name			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ LORZONE	**Diagnosis for this Request:**		
Failed Therapy (dose and frequency): □ CHLORZOXAZONE	**Start Date:** **End Date:**		
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*			
Prescriber (or Staff) / Pharmacy Signature**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

LUZU
PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for Luzu must meet the following criteria:

- **Patient must have an FDA approved indication.**
- **Patient must be 18 years of age or older.**
- **Patient must have documented history of failure of two topical antifungal agents (clotrimazole, econazole) and two oral antifungal agents (terbinafine, fluconazole, itraconazole).**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Physician Name			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ LUZU	**Diagnosis for this Request:**		
List all failed medications:	**Start Date:**	**End Date:**	
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*			
Prescriber (or Staff) / Pharmacy Signature**	Date		
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

Marinol
PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for Marinol must meet the following criteria:

- Patient must have diagnosis of anorexia associated with weight loss in patients with AIDS; or
- Diagnosis of nausea and vomiting associated with cancer chemotherapy

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name:			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code

QUALIFICATIONS FOR COVERAGE:

Requested Drug and Dosage: □ **Marinol**	□ Diagnosis of anorexia associated with weight loss in patients with AIDS □ Diagnosis of nausea and vomiting associated with cancer chemotherapy Diagnosis for this request:

□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*

Prescriber (or Staff) / Pharmacy Signature**	Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

MEDICATIONS > $3,000
PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for medications that cost >$3,000 must meet the following criteria:

- **Patient must have an FDA approved indication for the medication requested.**
- **May be subject to additional criteria. See PA criteria for complete details.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code

Requested Drug and Dosage:

□ ARCALYST	□ EMFLAZA	□ PHENOXYBENZAMINE
□ AUSTEDO	□ ESBRIET	□ PROCYSBI
□ BUPHENYL	□ JUXTAPID	□ PROMACTA
□ CARBAGLU	□ KEVEYIS	□ QUTENZA
□ CHENODAL	□ KORLYM	□ RAVICTI
□ CHOLBAM	□ KYNAMRO	□ SAMSCA
□ CUPRIMINE	□ MIACALCIN	□ SOMAVERT
□ CERDELGA	□ NATPARA	□ STRENSIQ
□ DARAPRIM	□ OCALIVA	□ TETRABENAZINE
□ DUPIXENT	□ ORFADIN	□ ZAVESCA

FDA approved indication for this request:

□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*

Prescriber (or Staff) / Pharmacy Signature**	Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

METOZOLV ODT PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for Metozolv must meet the following criteria:

- **Patient must try metoclopramide.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	**Recipient Date of Birth**	Recipient Medicaid ID Number	
Physician Name			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code

Requested Drug and Dosage: □ METOZOLV		**Diagnosis for this request:**	
□ **FAILED METOCLOPRAMIDE THERAPY**	**START DATE**	**END DATE**	**DOSE**
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*			
Prescriber (or Staff) / Pharmacy Signature**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

MIFEPREX
PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for Mifeprex must meet the following criteria:

- **Patient must have an FDA approved indication for the medication requested.**
- **Prescriber must provide signed written statement. See criteria for more information.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Physician Name			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:	**FDA approved indication for this request:**		

- **Is the patient terminating a pregnancy before 49 days of pregnancy? □ YES □ NO**
- **Is the pregnancy resulting from an act of rape or incest? □ YES □ NO If yes, fill out section 1. If no, fill out section 2:**

Section 1:

- **Has the appropriate law enforcement agency been notified, or agency authorized to receive child abuse and neglect reports? □ YES □ NO**
  If yes, has the provider provided a signed written statement indicating that the rape or act of incest has been reported and to whom the report was made?
  If no, has the provider provided signed written verification that in the provider's professional judgment, the woman's pregnancy resulted from rape or incest? □ YES □ NO
  Has the provider provided a written statement signed by the recipient that her current pregnancy resulted from an act of rape or incest? □ YES □ NO

Section 2:

- **Does the woman suffer from a physical disorder that would place the woman in danger of death unless abortion is performed? □ YES □ NO**
- **Has the treating provider provided a signed written statement that, in the provider's professional judgment, the life of a woman would be endangered if the fetus were carried to term? □ YES □ NO**
- **Does the statement contain the reasons why the physician believes the life of the woman would be in danger if the fetus were carried to term? □ YES □ NO**

Prescriber (or Staff) / Pharmacy Signature**	Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

MOXATAG PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for Moxatag must submit documentation of allergies or show a history of intolerable side effects to the inactive ingredients in regular-release amoxicillin.

- Regular-release amoxicillin does not require a prior authorization.

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Physician Name			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code

REQUESTED DRUG : □ MOXATAG	**Dosage**
Qualifications for coverage:	
□ Allergic/intolerable side effects to inactive ingredients of regular-release amoxicillin. Name of inactive ingredient: _____	Diagnosis for this request:
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*	
Prescriber (or Staff) / Pharmacy Signature**	Date
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*	

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

NALTREXONE – ORAL PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for naltrexone must meet the following criteria:

- **FDA approved indication is alcohol dependence or opioid use disorder.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:	**Indication for this request:**		
Prescriber (or Staff) / Pharmacy Signature**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

Proton Pump Inhibitor PA Form

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

health information designs

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving proton pump inhibitors must meet the following criteria:
__Note:__

- **Omeprazole, lansoprazole, pantoprazole, Dexilant, Protonix packet, and Nexium packet do not require prior authorization.**
- **Requires step therapy. See PPI criteria for more information. www.hidesigns.com/ndmedicaid**

Part I: TO BE COMPLETED BY PRESCRIBER

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Physician Name			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
REQUESTED DRUG: □ Rabeprazole □ Prevacid Solutab □ Zegerid Packet □ Protonix Packet □ Nexium □ Dexilant □ Aciphex Sprinkle	**Requested Dosage:** (must be completed) **Diagnosis for this request:**		
List all failed medications:	**Start Date:**	**End Date:**	
□ Pregnancy – Due Date			
□ Inability to take or tolerate oral tablets (must check a box) □ NG tube □ Other tube _____ □ Requires soft food or liquid administration □ Other (provide description)			
□ Adverse reaction (attach FDA Medwatch form) to omeprazole/pantoprazole.			
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*			
Prescriber (or Staff) / Pharmacy Signature**	Date		
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

Nuedexta
PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND

ND Medicaid requires that patients receiving a new prescription for Nuedexta must have a diagnosis of amyotrophic lateral sclerosis (ALS) or multiple sclerosis (MS) and exhibit signs of pseudobulbar affect.

- Nuedexta is indicated for the treatment of pseudobulbar affect (PBA).
- Nuedexta has not been shown to be safe or effective in other types of emotional lability that can commonly occur, for example, in Alzheimer's disease and other dementias.
- Nuedexta is contraindicated in patients with a prolonged QT interval, heart failure, or complete atrioventricular (AV) block.

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name	Specialist involved in therapy (if not treating physician)		
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code

Requested Drug and Dosage:	**Diagnosis for this request (must check at least 2):**
□ NUEDEXTA	□ **PBA: Include baseline PBA episode count**_____ **If request is a renewal, include current PBA episode count**_____ □ **ALS** □ **MS**

List all failed medications:	**Start Date:**	**End Date:**

Is the Center for Neurological Studies liability baseline attached? (CNS-LS)	□ YES □ NO
If request is a renewal, is the CNS-LS current attached?	□ YES □ NO
Does the patient have a prolonged QT interval, heart failure, or complete atrioventricular (AV) block?	□ YES □ NO
What is the neurologic condition causing PBA? _____	
Is TBI due to penetrating head injury?	□ YES □ NO
Has the neurologic condition been stable for at least 3 months?	□ YES □ NO

Prescriber (or Staff) / Pharmacy Signature**	Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

Nitroglycerin Lingual Spray
PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for Nitrolingual Spray must meet the following criteria:

- *Patient must first try sublingual tablets*

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Physician Name:			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code

QUALIFICATIONS FOR COVERAGE:

Requested Drug and Dosage: □ **Nitroglycerin Lingual Spray**	Diagnosis for this request:	
List all failed medications:	**Start Date:**	**End Date:**
Failed Therapy:	Start Date: End Date:	
Prescriber (or Staff) / Pharmacy Signature**	Date	

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

NK_1 RECEPTOR ANTAGONISTS PA FORM

health information designs

Prior Authorization Vendor for ND Medicaid

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

ND Medicaid requires that patients receiving a new prescription for NK_1 receptor antagonists must meet the following criteria:

- **Patient must have a diagnosis of nausea and/or vomiting.**
- **Patient must be receiving a moderately or highly emetogenic chemotherapy.**
- **Prescriber must be an oncologist.**
- **Patient must have failed a cycle using aprepitant or fosaprepitant in combination with palonosetron and a glucocorticoid.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:	**FDA approved indication for this request:** **Chemotherapy being used:** **How many cycles of chemotherapy will need NK_1 receptor antagonist treatment?** **Date of final chemotherapy treatment:**		
List all failed medications (drug name, date of trial, reason for failure):			
Prescriber (or Staff) / Pharmacy Signature**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

NORTHERA
PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for Northera must meet the following criteria:

- **Patient must have an FDA approved indication.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Physician Name			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ NORTHERA	**Diagnosis for this Request:**		
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*			
Prescriber (or Staff) / Pharmacy Signature**	Date		
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

NOXAFIL
PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for Noxafil must meet the following criteria:

- **Patient must have an FDA approved indication.**
- **Patient must have documented history of failure of two agents (itraconazole, fluconazole) to receive Noxafil suspension for oropharyngeal candidiasis.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Physician Name			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code

Requested Drug and Dosage: □ NOXAFIL TABLET □ NOXAFIL SUSPENSION	**Diagnosis for this Request:**
Failed Therapy for Oropharyngeal Candidiasis (suspension only): **1.** **2.**	**Start Date:** **End Date:** **1.** **2.**
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*	
Prescriber (or Staff) / Pharmacy Signature**	Date
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*	

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

NSAID/COX-II PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND

ND Medicaid requires that patients using NSAIDs or COX-II drugs must use a generic NSAID first line.
***Note: The PA will be approved if one of the following criteria is met:**

- Failed two trials of prescribed oral NSAIDs to receive brand name oral NSAIDs
- Failed trial of Voltaren gel to receive brand name topical NSAIDs for inflammation
- Recipient is on warfarin or corticosteroid therapy
- Recipient has history of gastric or duodenal ulcer or has comorbidities of GI bleed, perforation or obstruction
- Recipient has history of endoscopically documented NSAID induced gastritis with GI bleed
- Solaraze will be covered for patients with a diagnosis of actinic keratoses

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name	Specialist involved in therapy (if not treating physician)		
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ CELECOXIB □ OTHER:_____	**Diagnosis for this request:** □ Warfarin/Corticosteroid therapy □ GI bleed, perforation or obstruction □ Gastric or duodenal ulcer □ Endoscopically documented NSAID gastritis with GI Bleed □ Actinic keratoses **(Solaraze)**		
List all failed medications:	**Start Date:**	**End Date:**	

Qualifications for coverage:

Does patient have arthritis requiring long-term high dosage of NSAIDS?	□ YES □NO
Is patient at high risk for mucosal injury?	□ YES □NO
Is the patient taking aspirin at any dose?	□ YES □NO
Is patient at risk of cardiovascular disease?	□ YES □NO
Will prescriber continue to weigh GI benefits against CV risks and discontinue COX-II as soon as possible?	□ YES □NO

□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*

Prescriber (or Staff) / Pharmacy Signature**	Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

NUVESSA PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for Nuvessa must meet the following criteria:

- **Patient must have an FDA approved indication.**
- **Requires step therapy.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:	**FDA approved indication for this request:**		
	Is the patient pregnant? □ **YES** □ **NO**		
History of preferred agents (drug name, dates of trial, reason for failure):			
Prescriber (or Staff) / Pharmacy Signature**	Date		
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

Orally Disintegrating Tablets (ODT) Prior Authorization

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients who are prescribed an orally disintegrating tablet must first try a more cost-effective dosage form.

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Physician Name			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:	**Diagnosis for this request:**		
Qualifications for coverage:			
□ Unable to Swallow □ Medication Failed _____	Start Date: End Date:	Dose: Frequency:	
Prescriber (or Staff) / Pharmacy Signature**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

Onmel
PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for Onmel must meet the following criteria:

- *Patient must receive two medically necessary courses of therapy with itraconazole (Sporanox) and terbinafine (Lamisil)*

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Physician Name:			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
QUALIFICATIONS FOR COVERAGE:			
Requested Drug and Dosage: □ **Onmel**		Diagnosis for this request:	
PRESCRIBER (OR STAFF) / PHARMACY SIGNATURE**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

ONYCHOMYCOSIS AGENTS PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for onychomycosis treatment must meet the following criteria:

- **Patient must have a confirmed diagnosis of onychomycosis by one of the following: KOH prep test, fungal culture, or nail biopsy.**
- **Patient must have a history of failure to itraconazole and/or terbinafine.**

Part I: TO BE COMPLETED BY PHYSICIAN

<table>
<tr><td>Recipient Name</td><td>Recipient Date of Birth</td><td colspan="2">Recipient Medicaid ID Number</td></tr>
<tr><td colspan="4">Physician Name</td></tr>
<tr><td>Physician Medicaid Provider Number</td><td>Telephone Number</td><td colspan="2">Fax Number</td></tr>
<tr><td>Address</td><td>City</td><td>State</td><td>Zip Code</td></tr>
<tr><td rowspan="2">Requested Drug:

□ JUBLIA

□ KERYDIN

□ SPORANOX (ITRACONAZOLE)

□ ONMEL (ITRACONAZOLE)</td><td>Diagnosis:

Confirmed diagnosis by (provide documentation):
□ KOH PREP TEST
□ FUNGAL CULTURE
□ NAIL BIOPSY</td><td colspan="2" rowspan="2"><u>First Trial:</u>

Start Date:

End Date:

<u>Second Trial:</u>

Start Date:

End Date:</td></tr>
<tr><td>Is treatment for fingernails only?
□ YES □ NO</td></tr>
<tr><td colspan="4">□ I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.</td></tr>
<tr><td colspan="3">Prescriber (or Staff) / Pharmacy Signature**</td><td>Date</td></tr>
<tr><td colspan="4">**: By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.</td></tr>
</table>

Part II: TO BE COMPLETED BY PHARMACY

<table>
<tr><td colspan="3">PHARMACY NAME:</td><td>ND MEDICAID PROVIDER NUMBER:</td></tr>
<tr><td>TELEPHONE NUMBER</td><td>FAX NUMBER</td><td>DRUG</td><td>NDC #</td></tr>
</table>

health information designs

OPHTHALMIC ANTI-INFECTIVES / ANTI-INFLAMMATORIES PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients who are prescribed a non-preferred ophthalmic corticosteroids/anti-infectives must meet the following criteria:

- **Requires step therapy. Please see criteria for coverage in the Preferred Drug List at http://hidesigns.com/assets/files/ndmedicaid/NDPDL.pdf**

Part I: TO BE COMPLETED BY PRESCRIBER

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:	**Diagnosis for this request:**		
List all failed medications:	**Start Date:**	**End Date:**	
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*			
Prescriber (or Staff) / Pharmacy Signature**	Date		
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

Ophthalmic Antihistamines
PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for ophthalmic antihistamines must meet the following criteria:

- ***Requires step therapy. Please see criteria for coverage in the Preferred Drug List at http://hidesigns.com/assets/files/ndmedicaid/NDPDL.pdf***

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Physician Name			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:	**Diagnosis for this request:**		
List all failed medications:	**Start Date:**	**End Date:**	
Prescriber (or Staff) / Pharmacy Signature**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

OPIOID DEPENDENCE PA FORM

Fax Completed Form to: 855-207-0250
For questions regarding this Prior authorization, call 866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for buprenorphine and buprenorphine/naloxone combinations must meet the following criteria:

- Patient must be 16 years or older.
- Indicated for use in treatment of documented opioid dependence.
- Must not be taking other opioids, tramadol, or carisoprodol concurrently.
- Prescriber must be registered to prescribe buprenorphine and buprenorphine/naloxone combinations under the Substance Abuse and Mental Health Services Administration (SAMHSA).

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	**Recipient Date of Birth**	Recipient Medicaid ID Number	
Prescriber Name	**(SAMHSA ID-X DEA Number)**		
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ BUPRENORPHINE/NALOXONE □ZUBSOLV □ SUBUTEX □ SUBOXONE FILM □ BUNAVAIL	**FDA Approved Indication for this request:**		
□ Patient is not taking other opioids, tramadol, or carisoprodol concurrently with requested medication.			
Has a contract between the prescriber and patient been signed? □ YES □ NO Does the prescriber perform routine drug screens? □ YES □ NO Does the prescriber routinely check the PDMP system? □ YES □ NO			
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*			
Prescriber (or Staff) / Pharmacy Signature**	Date		
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

ORAL ALLERGEN EXTRACTS PA FORM

Fax Completed Form to: 855-207-0250
For questions regarding this Prior authorization, call 866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for oral allergen extracts must meet the following criteria:

- **Patient must have the FDA approved indication for the drug requested.**
- **Diagnosis confirmed by positive skin test or *in vitro* testing for pollen-specific IgE antibodies.**
- **History of failure, contraindication, or intolerance to two of the following: oral antihistamine, intranasal antihistamine, intranasal corticosteroid, or leukotriene inhibitors.**
- **History of failure or intolerance to subcutaneous allergen immunotherapy (allergy shots).**
- **Patient must not have severe, unstable, or uncontrolled asthma.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code

Requested Drug:	**Diagnosis for this Request:**	**History of Failure:**
□ GRASTEK	□ GRASS POLLEN-INDUCED ALLERGIC RHINITIS	**1.**
□ ORALAIR	□ RAGWEED POLLEN-INDUCED ALLERGIC RHINITIS	**2.**
□ RAGWITEK	Is the diagnosis confirmed by positive skin test or in vitro testing for pollen-specific IgE antibodies? □ YES □ NO Doe the patient have severe, unstable, or uncontrolled asthma? □ YES □ NO	**3.**

□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*

Prescriber (or Staff) / Pharmacy Signature**	Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

Oravig Prior Authorization

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires patients receiving a prescription for Oravig to try fluconazole, clotrimazole, nystatin or itraconazole.
Note:

- ***Fluconazole, clotrimazole, nystatin, or itraconazole do not require PA***

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Physician Name			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ **Oravig**	**Diagnosis for this request:**		
Qualifications for coverage:			
List all failed medications:	**Start Date:**	**End Date:**	
Prescriber (or Staff) / Pharmacy Signature**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

OTEZLA
PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for Otezla must meet the following criteria:

- **Patient must be 18 years of age or older.**
- **Patient must have active psoriatic arthritis or moderate to severe plaque psoriasis.**
- **Patient must have a specialist involved in therapy.**
- **Patient must not use Otezla in combination with other biologic therapies.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name		Recipient Date of Birth		Recipient Medicaid ID Number
Physician Name		Specialist Involved in Therapy		
Physician Medicaid Provider Number		Telephone Number		Fax Number
Address		City	State	Zip Code
Requested Drug: □ OTEZLA	Diagnosis for this Request:	History of Failure:	Is Otezla being used in combination with other biologic therapies?	
Prescriber (or Staff) / Pharmacy Signature**			Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*				

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

Otic Anti-Infectives
Prior Authorization

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for an otic anti-infective must first try a 7-day trial of a preferred agent in the past 3 months.

- **Requires a trial and failure of a preferred agent**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name:			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
QUALIFICATIONS FOR COVERAGE:			
Requested Drug and Dosage:		Diagnosis for this request:	
Failed Therapy:		Start Date: End Date:	
Prescriber (or Staff) / Pharmacy Signature**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

OUT OF STATE PHARMACY FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

Part I

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number

Requested Drug and Dosage:

Qualifications for coverage:

Start Date	End Date	Dose	Frequency

Reason for out of state pharmacy request:

Recipient is residing out of state? □ YES □ NO
If yes, please provide recipient residence, city, state, zip code:

Requested drug is only available at out of state pharmacies? □ YES □ NO

Third party requires out of state pharmacy for coverage? □ YES □ NO
If yes, contact State Provider Relations at 1-800-755-2604.

Part II

PHARMACY NAME (REQUIRED)			ND MEDICAID PROVIDER NUMBER (REQUIRED)
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC # (REQUIRED)

Pharmacy Signature:	Date:

health information designs

PULMONARY ARTERIAL HYPERTENSION AGENTS PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for an agent used to treat pulmonary arterial hypertension (PAH) must meet the following criteria:

- **Patient must have diagnosis of PAH confirmed by a specialist**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	**Recipient Date of Birth**	Recipient Medicaid ID Number	
Prescriber Name	Specialist Involved in therapy:		
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:	**Diagnosis for this Request:**		
	Is the patient pregnant? □ Yes □ No Will patient take monthly pregnancy tests during therapy? □ Yes □ No Have LFT's been measured for baseline? □ Yes □ No Will LFT's be measured monthly? □ Yes □ No Does the patient have Class 2 PAH? □ Yes □ No Is the patient taking nitrates of any form? □ Yes □ No If the request is for Tyvaso, is the patient also taking sildenafil, Adcirca, Letairis, bosentan, or Opsumit? □ Yes □ No If the request is for Ventavis 20mcg/mL is the patient repeatedly experiencing incomplete dosing due to extended treatment time? □ Yes □ No		
List all failed medications:	**Start Date:**	**End Date:**	
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*			
Prescriber (or Staff) / Pharmacy Signature**	Date		
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

PCSK9 INHIBITORS PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for PCSK9 inhibitors must meet the following criteria:

- **Patient must have a confirmed diagnosis of heterozygous familial hypercholesterolemia (Praluent only), clinical atherosclerotic cardiovascular disease, or homozygous familial hypercholesterolemia (Repatha only).**
- **Requires step therapy.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	**Recipient Date of Birth**	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:	**FDA approved indication for this request:**		
	LDL level:		
List all failed medications:	**Start Date:**	**End Date:**	
Prescriber (or Staff) / Pharmacy Signature**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

Prior Authorization Vendor for ND Medicaid

PHOSPHATE BINDERS PA FORM

Fax Completed Form to: 855-207-0250
For questions regarding this Prior authorization, call 866-773-0695

ND Medicaid requires that patients receiving a new prescription for phosphate binders must meet the following criteria:

- **Patient must have an FDA approved indication.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code

Requested Drug and Dosage:	Diagnosis:	Does patient have chronic kidney disease? □YES □NO If so, what stage? _____
	Lab: Phosphate Level:_____ _____	List failed medications and tell reason:

□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*

Prescriber (or Staff) / Pharmacy Signature**	Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

PLATELET AGGREGATION INHIBITORS PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for platelet aggregation inhibitors must meet the following criteria:

- **Patient must first try at least two of the following: Brilinta, Effient, clopidogrel, ticlopidine, dipyridamole, dipyridamole/aspirin, or aspirin.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:	**Please list all medications patient has tried:**		
Please list reason that immediate release aspirin is not an option: **If request is for Zontivity, will patient take with aspirin and/or clopidogrel?** **Does the patient have a history of stroke, transient ischemic attack, or intracranial hemorrhage?**			
Prescriber (or Staff) / Pharmacy Signature**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

Promacta Prior Authorization

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients who are prescribed Promacta must follow these guidelines:

- ***Patient must have a confirmed diagnosis of chronic immune (idiopathic) thrombocytopenia, Severe Aplastic Anemia, or Hepatitis C.***

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ **Promacta**	**Diagnosis for this request:**		
□ **Failed corticosteroid or immunoglobulin therapy** **DRUG:** **Start Date:** **End Date:** **Dose:** **Frequency:** **Has patient had a splenectomy?** □ YES □ NO **Does patient have Hepatitis C infection currently being treated or to be treated with interferon-based therapy?** □ YES □ NO	**Is patient at increased risk of bleeding due to degree of thrombocytopenia and clinical condition?** □ YES □ NO **Does degree of thrombocytopenia prevent initiation of or ability to maintain interferon-based therapy?** □ YES □ NO **Does patient have a diagnosis of Severe Aplastic Anemia?** □ YES □ NO **Has patient had an insufficient response to immunosuppressive therapy?** □ YES □ NO		
Prescriber (or Staff) / Pharmacy Signature**		Date	

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

Provigil/Nuvigil
Prior Authorization

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for Provigil or Nuvigil must suffer from excessive sleepiness associated with obstructive sleep apnea/hypopnea syndrome, narcolepsy, or shift work disorder.

- **Provigil must be used before Nuvigil will be approved.**

Part I: TO BE COMPLETED BY PRESCRIBER

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ **Nuvigil** □ **Provigil**	**Diagnosis for this request:** □ EXCESSIVE SLEEPINESS ASSOCIATED WITH OBSTRUCTIVE SLEEP APNEA/HYPOPNEA SYNDROME □ NARCOLEPSY □ SHIFT WORK SLEEP DISORDER		
□ FAILED PROVIGIL (Nuvigil Requests)	START DATE: END DATE:	DOSE: FREQUENCY:	
Prescriber (or Staff) / Pharmacy Signature**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

Pulmozyme
Prior Authorization

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for Pulmozyme must meet the following criteria:

- **Patient must have a confirmed diagnosis of cystic fibrosis**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Physician Name:			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
QUALIFICATIONS FOR COVERAGE:			
Requested Drug and Dosage: □ **Pulmozyme**		Diagnosis for this request:	
PRESCRIBER (OR STAFF) / PHARMACY SIGNATURE**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

RASUVO AND OTREXUP PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for Rasuvo or Otrexup must meet the following criteria:

- **Patient must have an FDA approved indication for the medication requested.**
- **Patient must have tried and failed methotrexate.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Physician Name			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:	**FDA approved indication for this request:**		
List all failed medications:	**Start Date:**	**End Date:**	
Prescriber (or Staff) / Pharmacy Signature**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

Rayos
PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for Rayos must meet the following criteria:

- **Patient must first try generic prednisone.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Physician Name:			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
QUALIFICATIONS FOR COVERAGE:			
Requested Drug and Dosage: □ **Rayos**	Diagnosis for this request:		
Prescriber (or Staff) / Pharmacy Signature**	Date		
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

RIBAPAK PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for RibaPak must meet the following criteria:

- **Patient must first try Ribavirin or Ribasphere.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	**Recipient Date of Birth**	Recipient Medicaid ID Number	
Physician Name			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ RIBAPAK	**FDA Approved Indication for this request:**		

□ **Failed therapy with Ribavirin or Ribasphere** Attach MedWatch form	**Start Date**	**End Date**	**Dose**

WHAT IS THE HCV GENOTYPE? (I-IV)

***TREATMENT WILL BE COVERED FOR 24 TO 48 WEEKS BASED UPON GENOTYPE AND DIAGNOSIS.**

□ Treatment regimen for Hepatitis C will include pegylated or non-pegylated interferon in combination with oral ribavirin.

Prescriber (or Staff) / Pharmacy Signature**	Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

ROSACEA PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

Note: ND Medicaid will not pay for Solodyn, Soolantra, or Oracea without documented failure of a first line tetracycline agent.

- First line agents include minocycline and tetracycline.
- Requires step therapy. See Oracea criteria for more information.

Part I: TO BE COMPLETED BY PRESCRIBER

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Physician Name			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
REQUESTED DRUG: □ **ORACEA** □ **SOLODYN** □ **SOOLANTRA**	**Requested Dosage:** (must be completed)		
□ Patient has failed a 90 day trial of which first line agent _____ □ Moderate to severe acne □ Severe acne			
List all failed medications:	**Start Date:**	**End Date:**	
Prescriber (or Staff) / Pharmacy Signature**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

Sancuso PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for Sancuso must be unable to take oral medications.
Note:

- ***Dolasetron, oral granisetron, and ondansetron do not require PA.***
- ***Patients must be unable to take oral medications or***
- ***Patients must fail therapy on ondansetron or oral granisetron before a PA may be granted.***

Part I: TO BE COMPLETED BY PRESCRIBER

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ **Sancuso**	**Diagnosis for this request:**		
	Does the patient have breast, head/neck, gastrointestinal, or gynecological cancer? **Is the patient taking chemotherapy? If so, please list date of last chemotherapy treatment:**		
List all failed medications:	**Start Date:**	**End Date:**	
□ PATIENT UNABLE TO TAKE ORAL MEDICATIONS			
Prescriber (or Staff) / Pharmacy Signature**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

Sedative/Hypnotic PA Form

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for a name brand Sedative/Hypnotic must use Ambien® (zolpidem) as first line therapy.

*__Note:__

- **Requires step therapy. See Sedative/Hypnotic PA criteria for more information.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:	**Diagnosis for this request:**		
Qualifications for coverage:			
List all failed medications:	**Start Date:**	**End Date:**	

Have other conditions causing sleep issues been ruled out? □ YES □ NO
Does the patient require dose tapering? □ YES □ NO
Is the patient's insomnia characterized by difficulty with sleep maintenance? □ YES □ NO
Is the patient's insomnia characterized by difficulty with sleep initiation? □ YES □ NO
Is the patient's insomnia characterized by difficulty with middle of the night awakening with more than 4 hours left to sleep? □ YES □ NO

□ I *confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*

Prescriber (or Staff) / Pharmacy Signature**	Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

SGLT2 Inhibitors
PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for SGLT2 inhibitors must meet the following criteria:

- **Patient must have diagnosis of Type II Diabetes.**
- **Requires step therapy. Please see criteria for coverage in the Preferred Drug List at http://hidesigns.com/assets/files/ndmedicaid/NDPDL.pdf**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name:			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:		Diagnosis for this request:	
Failed therapy:	Start Date:	End Date:	
Prescriber (or Staff) / Pharmacy Signature**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

Spinraza PA Form

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a prescription for Spinraza must meet the following criteria:

- **For a diagnosis of Spinal Muscular Atrophy (SMA) Type 1, 2 or 3:**
  - **Patient must be less than 2 years of age**
  - **Patient must not have respiratory insufficiency**
  - **i.e. Need for invasive or noninvasive ventiliation for more than 6 hours per 24 hour period.**
  - **Patient must not require gastric feeding tubes for the majority of feeds**
  - **Patient must not have severe contractures or severe scoliosis**
  - **Patient must not have wasting or cachexia**
- **For a diagnosis of Spinal Muscular Atrophy (SMA) Type 3:**
  - **The patient must be experiencing issues with ambulating**
    - **e.g. falls, trouble climbing stairs, unable to walk independently**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dose:			
Diagnosis for this request: □ **SMA Type 1** □ **SMA Type 2** □ **SMA Type 3**			
Does the patient have respiratory insufficiency? □ **YES** □ **NO** **Does the patient require gastric feeding tubes for the majority of feeds?** □ **YES** □ **NO** **Does the patient have severe contractures or severe scoliosis?** □ **YES** □ **NO** **Does the patient have wasting or cachexia?** □ **YES** □ **NO** **Does the patient experience issues with ambulating (SMA Type 3 only)?** □ **YES** □ **NO**			
Prescriber (or Staff) / Pharmacy Signature**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

SPIRIVA RESPIMAT 1.25 MCG
PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for Spiriva Respimat 1.25 mcg must meet the following criteria:

- **Patient must have a diagnosis of asthma.**
- **Requires step therapy. Please see criteria for coverage.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:	**Please list all medications patient has tried:**		
Prescriber (or Staff) / Pharmacy Signature**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

Statins
PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that who are prescribed a name-brand statin must first try a generic statin.

- *Requires step therapy. See statin criteria for more information.*

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name:			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
QUALIFICATIONS FOR COVERAGE:			
Requested Drug and Dosage:	Diagnosis for this request:		
Medication Failed and Dose (list all)			
Is the statin intensity treatment goal low, moderate, or high? _____			
Prescriber (or Staff) / Pharmacy Signature**	Date		
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

Steroid Inhalers
Prior Authorization

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for a steroid inhaler must first try a 30-day trial of all preferred agents in the past year.

- **Requires a trial and failure of all preferred agents in the past year**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name:			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
QUALIFICATIONS FOR COVERAGE:			
Requested Drug and Dosage:		Diagnosis for this request:	
Failed Therapy (list all):		Start Date: End Date:	
Prescriber (or Staff) / Pharmacy Signature**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

SYNAGIS WEB BASED FORM

For questions regarding this Prior Authorization Call 701-328-4023

Prior Authorization Vendor for ND Medicaid

Note:

- Synagis season will be October 19th through April 21st
- Providers will choose when to start dosing Synagis based on prevalence of RSV in the community
- Clinicians may administer up to a maximum of 5 monthly doses during the RSV season.
- Qualifying infants born during the RSV season may require fewer doses.

TO BE COMPLETED BY PRESCRIBER

Recipient Medicaid ID Number	Recipient Date of Birth	Prescriber NPI	Prescriber Fax Number
Billing Facility NPI	**Billing Facility Name**		**ICD-10 code**

Diagnosis (qualification for Synagis)

___ **Prematurity**

<29 weeks, 0 days gestational age – Synagis allowed if younger than 12 months of age at start of RSV season (max of 5 doses)

Gestational Age (e.g. 28 weeks, 4 days)

Weeks _____ **Days** _____

___ **Chronic Lung Disease of Prematurity (CLD)** – Child ≤12 months old with gestational age <32 weeks, 0 days and requires supplemental oxygen >21% for at least the first 28 days after birth.

___ **Chronic Lung Disease of Prematurity (CLD**) – Child ≤24 months old with gestational age <32 weeks, 0 days and requires supplemental oxygen >21% for at least the first 28 days after birth and continues to receive medical support within six months before the start of RSV season.

___ Supplemental Oxygen

___ Diuretic

___ Chronic corticosteroid therapy

___ **Congenital Heart Disease (CHD)**

Child ≤12 months old with hemodynamically significant cyanotic or acyanotic CHD

Medical Therapy Required _____

*children less than 24 months who undergo cardiac transplantation during RSV season may be considered for prophylaxis.

___ **Neuromuscular disease** (may be considered for prophylaxis during the first year of life)

___ **Pulmonary abnormalities** (may be considered for prophylaxis during the first year of life)

___ **Profoundly Immunocompromised children** (children <24 months of age may be considered for prophylaxis during the RSV season)

***Accessed online at pediatrics.aappublications.org**

health information designs

Tecfidera PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients who are prescribed Tecfidera must follow these guidelines:
Note:

- ***Must have relapsing forms of multiple sclerosis.***
- ***Must have a recent CBC (within 6 months).***
- ***Requires step therapy. See Tecfidera criteria for more information.***

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name	Specialist Involved in Therapy		
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ **Tecfidera**	**Diagnosis for this request:** **Current CBC (date):**		
List all failed medications:	**Start Date:**	**End Date:**	
Prescriber (or Staff) / Pharmacy Signature**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

TOPICAL TESTOSTERONE PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for a topical testosterone must meet the following criteria:

- **Patient must have an FDA approved indication.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Physician Name			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code

Requested Drug and Dosage:	**Diagnosis for this Request:**
□ ANDRODERM_____ □ ANDROGEL_____ □ FORTESTA_____ □ TESTIM_____ □ AXIRON_____ □ VOGELXO_____	**Testosterone Level:** **Date:**

□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*

List all failed medications:	**Start Date:**	**End Date:**
Prescriber (or Staff) / Pharmacy Signature**	Date	

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

TETRACYCLINE PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for a tetracycline must meet the following criteria:

- **Requires step therapy. Please see criteria for coverage.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: **Diagnosis:**	**Please list all medications patient has tried:**		
Prescriber (or Staff) / Pharmacy Signature**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

CYTOKINE MODULATORS PA FORM

Fax Completed Form to: 855-207-0250
For questions regarding this Prior authorization, call 866-773-0695

Prior Authorization Vendor for ND

ND Medicaid requires that patients receiving a prescription for Actemra, Cimzia, Cosentyx, Enbrel, Humira, Kevzara, Kineret, Orencia, Otezla, Siliq, Simponi, Stelara, Taltz, Tremfya, Xeljanz, and Xeljanz XR and must meet the following criteria:

- All agents will require an FDA-approved indication.
- For non-preferred agents, the patient must have had a 3-month trial with at least 2 preferred agents, as evidenced by paid claims or pharmacy print-outs.

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Diagnosis for this request:			

Requested Drug and Dosage:			**List all failed medications:**	**Start Date:**	**End Date:**
□ ACTEMRA	□ CIMZIA	□ COSENTYX	□ ENBREL		
□ ENBREL	□ HUMIRA	□ HUMIRA PSORIASIS	□ HUMIRA		
□ KEVZARA	□ KINERET	□ ORENCIA	□ COSENTYX		
□ OTEZLA	□ SILIQ	□ SIMPONI	□ OTHER		
□ STELARA	□ TALTZ	□ TREMFYA			
□ XELJANZ		□ XELJANZ XR			

□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*

Prescriber (or Staff) / Pharmacy Signature**	Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

TIROSINT PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for Tirosint must meet one of the following criteria:

- **Patient must have documented celiac disease, yellow dye allergy, or lactose/milk protein allergy.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:	**FDA approved indication for this request:**		
List all failed medications (drug name, date of trial, reason for failure):			
Prescriber (or Staff) / Pharmacy Signature**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

LOCAL ANESTHETICS (TOPICAL) PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for topical local anesthetic must meet the following criteria:

- **These medications will only be covered when prescribed for use prior to certain procedures (e.g., placement of a peripheral or central line or injections through an implanted port). Medical procedure must be listed on PA form.**
- **PA not required for patients 12 years of age and younger.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ Lidocaine-prilocaine topical □ Lidocaine-tetracaine topical	**FDA approved indication for this request:** □ Placement of a peripheral or central line □ Injections through an implanted port □ Other:		
Prescriber (or Staff) / Pharmacy Signature**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

TOPICAL ANTIPSORIATICS PA FORM

health information designs

Prior Authorization Vendor for ND Medicaid

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

ND Medicaid requires that patients receiving a new prescription for topical antipsoriatics must meet the following criteria:

- **Calcipotriene cream and foam – Patient must have a 30-day trial of calcipotriene ointment or solution.**
- **Calcipotriene/betamethasone foam – Patient must have a 30-day trial of calcipotriene/betamethasone ointment or solution.**

Part I: TO BE COMPLETED BY PRESCRIBER

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number		
Prescriber Name				
Prescriber NPI	Telephone Number	Fax Number		
Address	City	State	Zip Code	
Requested Drug and Dosage:	**Diagnosis for Request:**			
Qualifications for Coverage:				
Medications patient has tried:	Start Date:	End Date:	Dose:	Frequency:
Other medical justification for use (why patient is unable to use ointment or solution of the requested product):				
Prescriber (or Staff) / Pharmacy Signature**		Date		
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*				

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:		ND MEDICAID PROVIDER NUMBER:
Phone:		FAX:
Drug:		NDC#:

health information designs

Topical Ketoconazole Products PA Form

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients who are prescribed Extina, Xolegel, and Ketocon Plus must first try a covered ketoconazole medication.

Note:

- ***Ketoconazole creams and ketoconazole shampoos do not require a prior authorization.***

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Physician Name			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ **Extina** □ **Xolegel** □ **Ketocon Plus**	**Diagnosis for this request:**		
Qualifications for coverage:			
□ Medication Failed _____	Start Date: End Date:	Dose: Frequency:	
Prescriber (or Staff) / Pharmacy Signature**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

Serotonin (5-HT$_1$) Receptor Agonists - Triptan PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for a triptan must meet the following criteria:

- **Patients 6-17 must have a 30 day trial of rizatriptan in the past 24 months.**
- **Patients 18 years and older must have a 30 day trial of all preferred agents in the past 24 months.**
- **Sumatriptan tablets, Relpax, rizatriptan tablets, and rizatriptan ODT do not require a PA**

Part I: TO BE COMPLETED BY PRESCRIBER

Recipient Name		Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name				
Prescriber NPI		Telephone Number	Fax Number	
Address		City	State	Zip Code
Requested Drug and Dosage:		**Diagnosis for this request:** **Does patient have menstrual migraine?** **Is patient's migraine long in duration and does it recur?**		
□ Failed therapy	Start Date	End Date	Dose	Frequency
List all failed medications:		**Start Date:**	**End Date:**	
Prescriber (or Staff) / Pharmacy Signature**			Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*				

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

TYSABRI PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for Tysabri must meet the following criteria:

- **Patient must have a confirmed diagnosis of multiple sclerosis or Crohn's disease.**
- **Requires step therapy. See Tysabri criteria for more information.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	**Recipient Date of Birth**	Recipient Medicaid ID Number	
Prescriber Name	Specialist involved in therapy (if not treating physician)		
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ TYSABRI	**FDA approved indication for this request:**		

• **Has patient experienced a reduction in relapse rate? (renewal requests)**	□ YES	□ NO
• **Has the patient had persistent positive anti-natalizumab antibody titers (2 consecutive positive tests 4 weeks or more apart) (renewal requests)**	□ YES	□ NO
• **Has patient had anti-JCV antibodies taken?**	□ YES	□ NO
• **Has patient had a MRI scan?**	□ YES	□ NO
• **Is the patient experiencing early aggressive disease? (>=2 relapses in the year and >= 1 Gadolinium (Gd)+ lesion)?**	□ YES	□ NO

List all failed medications:	**Start Date:**	**End Date:**
Prescriber (or Staff) / Pharmacy Signature**		Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

VANOS PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for Vanos must meet the following criteria:

- **Patient must be 12 years of age and older.**
- **Patient must have documented 3-month trial and failure with generic topical clobetasol or halobetasol.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	**Recipient Date of Birth**	Recipient Medicaid ID Number	
Physician Name			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ VANOS	**Diagnosis for this Request:**		
Failed Therapy (dose and frequency): □	**Start Date:** **End Date:**		
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*			
Prescriber (or Staff) / Pharmacy Signature**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

VECAMYL
PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for Vecamyl must meet the following criteria:

- **Patient must have an FDA approved indication.**
- **Patient must have documented history of failure to achieve blood pressure goals (using maximum tolerated doses of all first and second line agents) as defined by the most recent JNC report.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Physician Name	Specialist Involved in Therapy		
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ VECAMYL	**Diagnosis for this Request:**		
List all failed medications:	**Start Date:**	**End Date:**	
Prescriber (or Staff) / Pharmacy Signature**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

Xenical
PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a prescription for Xenical must be seen by a dietician.
Note:

- ***Patient must have dietician evaluation attached to PA form including height and weight.***
- ***BMI must be equal to or greater than 40.***
- ***5% weight loss must be realized for continued approval (every 6 months).***

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Physician Name			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ XENICAL	**Diagnosis for this request:**		
□ Dietician evaluation attached	Height:	Weight:	BMI:
Prescriber (or Staff) / Pharmacy Signature**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

XIFAXAN PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for Xifaxan must meet the following guidelines:

- Patient must be 12 years of age or older and have a diagnosis of traveler's diarrhea caused by noninvasive strains of E. coli. Patient must try ciprofloxacin, levofloxacin, OR norfloxacin before PA for Xifaxan will be approved.
- Patient must be 18 years of age or older and have a risk of recurrence of overt hepatic encephalopathy.
- Do not use in patients with diarrhea complicated by fever or blood in the stool or diarrhea due to pathogens other than E. coli.

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ XIFAXAN	**Diagnosis for this request:** □ TRAVELER'S DIARRHEA: 200 mg three times a day for 3 days □ HEPATIC ENCEPHALOPATHY: 550 mg two times a day		
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*			
Prescriber (or Staff) / Pharmacy Signature**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

Xyrem Prior Authorization

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients who are prescribed Xyrem must meet these guidelines:
Note:

- ***Must be 18 years or older.***
- ***Must have a diagnosis of excessive daytime sleepiness and cataplexy in patients with narcolepsy.***
- ***Must be enrolled in the Xyrem REMS Program***

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ **Xyrem**	**Diagnosis for this request:**	**List failed medication:**	

Qualifications for coverage:

□ Enrolled in Xyrem REMS Program Enrolled Date: Dose:

Is patient taking any sedative/hypnotics, opioids, or muscle relaxants? □ YES □ NO

□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*

Prescriber (or Staff) / Pharmacy Signature**	Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

Zanaflex Capsule PA Form

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving Zanaflex capsules must use tizanidine tablets first line.
*__Note:__

- **Tizanidine tablets do not require a PA.**
- **Patient must fail therapy on tizanidine tablets before a PA may be granted.**

Part I: TO BE COMPLETED BY PRESCRIBER

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:	**Diagnosis for this request:**		
Additional Qualifications for Coverage:			
□ Failed generic drug	Start Date: End Date:	Dose: Frequency:	
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*			
Prescriber (or Staff) / Pharmacy Signature**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

ZINBRYTA PA FORM

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for Zinbryta must meet the following criteria:

- **Patient must have a confirmed diagnosis of multiple sclerosis.**
- **Requires step therapy. See Zinbryta criteria for more details.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	**Recipient Date of Birth**	Recipient Medicaid ID Number	
Prescriber Name	Specialist involved in therapy (if not treating physician)		
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ ZINBRYTA	**FDA approved indication for this request:**		

• **Have transaminase and bilirubin levels been obtained in the last 6 months?**	□ YES	□ NO
• **Does patient have Hepatitis B or C?**	□ YES	□ NO
• **Has patient been screened for TB and treated for TB if positive?**	□ YES	□ NO
• **Is the patient experiencing early aggressive disease? (>=2 relapses in the year and >= 1 Gadolinium (Gd)+ lesion)?**	□ YES	□ NO
• **Has the patient had a reduction in relapse rate? (renewal requests)**	□ YES	□ NO

Prescriber (or Staff) / Pharmacy Signature**	Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

Since the beginning of the year (2017), 67 people have overdosed on opioids, benzos, heroin, or an unspecified psychotropic drug.

Last 2 months of 2016 (Before Overdose)

13 were gets benzos or narcs paid by Medicaid

6 were getting benzos:

FDB Brand Name	Diagnosis
CLONAZEPAM 1 MG TABLET	T401X1A Poisoning by heroin, accidental, initial encounter
LORAZEPAM 1 MG TABLET	T402X2A Poisoning by other opioids, intentional self-harm, initial encounter
CLONAZEPAM 0.5 MG TABLET	T424X2A Poisoning by benzodiazepines, intentional self-harm, initial encounter
LORAZEPAM 1 MG TABLET	T401X1A Poisoning by heroin, accidental, initial encounter
CLONAZEPAM 1 MG TABLET	T424X1A Poisoning by benzodiazepines, accidental, initial encounter
ALPRAZOLAM 0.5 MG TABLET	T424X2A Poisoning by benzodiazepines, intentional self-harm, initial encounter

4 were getting narcotics: blue is same person

FDB Brand Name	Diagnosis
HYDROCODON-ACETAMINOPHEN 5-	T424X1A Poisoning by benzodiazepines, accidental, initial encounter
OXYCODONE HCL 10 MG TABLET	T40604A Poisoning by unspecified narcotics, undetermined, initial encounter
TRAMADOL HCL 50 MG TABLET	T424X2A Poisoning by benzodiazepines, intentional self-harm, initial encounter
ACETAMINOPHEN-COD #3 TABLET	T402X1A Poisoning by other opioids, accidental, initial encounter
HYDROCODON-ACETAMINOPHEN 5-	T402X1A Poisoning by other opioids, accidental, initial encounter

3 were getting both:

ID	FDB Brand Name	Diagnosis
1	OXYCODONE-ACETAMINOPHEN 5-3	T424X2A Poisoning by benzodiazepines, intentional self-harm, initial encounter
1	CLONAZEPAM 0.5 MG TABLET	T424X2A Poisoning by benzodiazepines, intentional self-harm, initial encounter
1	HYDROCODON-ACETAMINOPHEN 5-	T424X2A Poisoning by benzodiazepines, intentional self-harm, initial encounter
2	HYDROCODON-ACETAMINOPHEN 5-	T424X1A Poisoning by benzodiazepines, accidental, initial encounter
2	LORAZEPAM 1 MG TABLET	T424X1A Poisoning by benzodiazepines, accidental, initial encounter
2	CLONAZEPAM 1 MG TABLET	T424X1A Poisoning by benzodiazepines, accidental, initial encounter
3	OXYCODONE HCL 10 MG TABLET	T404X4A Poisoning by other synthetic narcotics, undetermined, initial encounter
3	FENTANYL 75 MCG/HR PATCH	T404X4A Poisoning by other synthetic narcotics, undetermined, initial encounter
3	CLONAZEPAM 0.5 MG TABLET	T404X4A Poisoning by other synthetic narcotics, undetermined, initial encounter

Last 2 months Aug-Sept 2017 (After Overdose *with 1 exception noted below)

8 were getting benzos

FDB Brand Name	Diagnosis
ALPRAZOLAM 0.5 MG TABLET	T424X1A Poisoning by benzodiazepines, accidental, initial encounter
CLONAZEPAM 1 MG TABLET	T401X1A Poisoning by heroin, accidental, initial encounter
CLONAZEPAM 0.125 MG DIS TAB	T424X1A Poisoning by benzodiazepines, accidental, initial encounter
LORAZEPAM 1 MG TABLET	T424X1A Poisoning by benzodiazepines, accidental, initial encounter
ALPRAZOLAM 0.5 MG TABLET	T401X1A Poisoning by heroin, accidental, initial encounter
DIAZEPAM 5 MG TABLET	T424X2A Poisoning by benzodiazepines, intentional self-harm, initial encounter
LORAZEPAM 1 MG TABLET	T424X2A Poisoning by benzodiazepines, intentional self-harm, initial encounter ***This overdose was after lorazepam was dispensed**
CLONAZEPAM 1 MG TABLET	T424X1A Poisoning by benzodiazepines, accidental, initial encounter

3 were getting narcotics

FDB Brand Name	Diagnosis
TRAMADOL HCL 50 MG TABLET	T40604A Poisoning by unspecified narcotics, undetermined, initial encounter
TRAMADOL HCL 50 MG TABLET	T424X2A Poisoning by benzodiazepines, intentional self-harm, initial encounter
OXYCODONE HCL 5 MG TABLET	T404X4A Poisoning by other synthetic narcotics, undetermined, initial encounter

1 was getting both

MMIS ID	FDB Brand Name	Diagnosis
1	TRAMADOL HCL 50 MG TABLET	T424X1A Poisoning by benzodiazepines, accidental, initial encounter
1	ALPRAZOLAM 2 MG TABLET	T424X1A Poisoning by benzodiazepines, accidental, initial encounter
1	LORAZEPAM 1 MG TABLET	T424X1A Poisoning by benzodiazepines, accidental, initial encounter

Before and After overdose: 7 members on both lists

MMIS ID	Prior to overdose	After Overdose	Diagnosis
1	TRAMADOL HCL 50 MG TABLET	TRAMADOL HCL 50 MG TABLET	T424X2A Poisoning by benzodiazepines, intentional self-harm, initial encounter
2	CLONAZEPAM 0.5 MG TABLET	DIAZEPAM 5 MG TABLET	T424X2A Poisoning by benzodiazepines, intentional self-harm, initial encounter
3	CLONAZEPAM 1 MG TABLET	CLONAZEPAM 1 MG TABLET	T401X1A Poisoning by heroin, accidental, initial encounter
4	OXYCODONE HCL 10 MG TABLET	TRAMADOL HCL 50 MG TABLET	T40604A Poisoning by unspecified narcotics, undetermined, initial encounter
5	CLONAZEPAM 1 MG TABLET	CLONAZEPAM 1 MG TABLET	T424X1A Poisoning by benzodiazepines, accidental, initial encounter
6	HYDROCODON-ACETAMINOPHEN 5-	TRAMADOL HCL 50 MG TABLET	T424X1A Poisoning by benzodiazepines, accidental, initial encounter
6	LORAZEPAM 1 MG TABLET	ALPRAZOLAM 2 MG TABLET	T424X1A Poisoning by benzodiazepines, accidental, initial encounter
6	CLONAZEPAM 1 MG TABLET	LORAZEPAM 1 MG TABLET	T424X1A Poisoning by benzodiazepines, accidental, initial encounter
7	OXYCODONE HCL 10 MG TABLET	OXYCODONE HCL 5 MG TABLET	T404X4A Poisoning by other synthetic narcotics, undetermined, initial encounter
7	FENTANYL 75 MCG/HR PATCH		T404X4A Poisoning by other synthetic narcotics, undetermined, initial encounter
7	CLONAZEPAM 0.5 MG TABLET		T404X4A Poisoning by other synthetic narcotics, undetermined, initial encounter

Plan for Benzo + Narcotic Edit

All Benzos = Solid forms of Alprazolam, diazepam, clonazepam, lorazepam

Step 1: 6/9 66%
oxycodone ER, liquid Tylenol/Codeine, tramadol ER, Tylenol #2 & #4; Codeine; Nucynta IR,ER

Step 2: 17/23 people all different prescribers 74%
All benzos with:
Oxycodone 10-325mg

Step 3: 20/29 people all different prescribers 69%
All benzos with
Oxycodone 5-325mg

Step 4: 50/69 people all different prescribers 72%
Hydrocodone 5-325mg

a. 20/27 Alprazolam 1mg, 2mg; clonazepam 2mg; diazepam 5mg, 10mg
b. 20/27 alprazolam 0.25mg, 0.5mg; clonazepam 1mg; lorazepam 1mg
c. 10/15 the rest

Step 5: 28/45 people all different prescribers 62%
Hydrocodone 10-325mg

a. 8/16 – diazepam 5mg, 10mg; alprazolam 1mg; lorazepam 2mg; clonazepam 2mg
b. 20/29 – the rest

Step 6: 11/18 people different prescribers 61%
All benzos with:
Hydromorphone 2mg and over
Oxycodone 10mg and over

Step 7: 11/16 people all different prescribers 69%
All benzos with
Tylenol #3

Step 9: 12/25 people all different prescribers 48%
All benzos with
Oxycodone 5mg

Step 8: 40/84 people different prescribers 48%
Tramadol 50mg & Tramadol-acetaminophen

a. 18/28 Diazepam 5mg, 10mg; alprazolam 1mg, 2mg; lorazepam 2mg; clonazepam 2mg

b. 12/27 alprazolam 0.5mg; lorazepam 1mg
c. 10/23 lorazepam 0.5mg; clonazepam 1mg
d. 2/7 clonazepam 0.5mg, alprazolam XR, alprazolam 0.25mg

Step 10: 11/16 69%
All benzos with
Fentanyl patch

Step 11: 12/24 50%
All benzos with
Morphine IR + ER

PRODUCT DETAILS OF EUCRISA (crisaborole)

INDICATIONS AND USE:

- Treatment of topical treatment of mild to moderate atopic dermatitis in patients 2 years and older.

DOSAGE AND ADMINISTRATION:

- Apply thin film to affected area(s) twice daily.

DOSAGE FORM AND STRENGTHS:

- 2% External ointment in 60 gram tubes

CONTRAINDICATIONS:

- Hypersensitivity to crisaborole or any component of the formulation

WARNINGS AND PRECAUTIONS:

- Hypersensitivity to crisaborole or any component of the formulation

ADVERSE REACTIONS:

- Application site pain (4%).
- Hypersensitivity reaction, urticaria (<1%)

COST

- WAC Package Price: $580.00

CURRENT UTILIZATION

ND Medicaid Eucrisa Utilization (08/2017-09/2017)		
Label Name	**Rx Num**	**Total Reimb Amt**
EUCRISA	9	$ 4,249.51

REFERENCES:

1. Facts & Comparisons eAnswers. Available at http://online.factsandcomparisons.com. Accessed on October 31, 2017.
2. Eucrisa (crisaborole) [prescribing information]. Palo Alto, CA: Anacor Pharmaceuticals Inc; October 2017

PRODUCT DETAILS OF SKELAXIN (metaxalone)

INDICATIONS AND USE:

- Relief of discomforts associated with acute, painful musculoskeletal conditions.

DOSAGE AND ADMINISTRATION:

- 13 years of age and older:
  - 800 mg 3-4 times daily
- <12 years of age
  - Safety and efficacy have not been stablished

DOSAGE FORM AND STRENGTHS:

- 400 mg and 800 mg oral tablets

CONTRAINDICATIONS:

- Hypersensitivity to metaxalone or any component of the formulation
- Significantly impaired hepatic or renal function
- Tendency for drug-induced, hemolytic, or other anemias

WARNINGS AND PRECAUTIONS:

- **Serotonin Syndrome**: Potentially life-threatening serotonin syndrome has been reported; generally occurs when used concomitantly with serotonergic drugs or when exceeding recommended doses
- **Renal Impairment**: Use with caution in patients with renal impairment; contraindicated in patients with significant impairment
- **Hepatic Impairment**: Use with caution in patients with hepatic impairment; contraindicated in patients with significant hepatic impairment. Routine monitoring of transaminases is recommended
- **Drug/Drug Interactions**: Potentially significant interactions may occur when used with other CNS depressants

ADVERSE REACTIONS:

- The most common adverse effects noted during clinical trials were Dizziness, drowsiness, headache, irritability, nervousness, Gastrointestinal upset, nausea, and vomiting.
- Rare, but serious adverse reactions include anaphylactoid reaction, hypersensitivity reactions, hemolytic anemia, leukopenia, and Jaundice.

COST

- WAC unit price for 800 mg tablets: $9.29

CURRENT UTILIZATION

ND Medicaid Skelaxin Utilization (08/2017-09/2017)		
Label Name	**Rx Num**	**Total Reimb Amt**
SKELAXIN	34	$ 4,513.87

REFERENCES:

1. Facts & Comparisons eAnswers. Available at http://online.factsandcomparisons.com. Accessed on October 31, 2017.
2. Skelaxin (metaxalone) [prescribing information]. New York, NY: Pfizer; April 2017.

NORTH DAKOTA MEDICAID
RETROSPECTIVE DRUG UTILIZATION REVIEW
CRITERIA RECOMMENDATIONS
4TH QUARTER 2017

Criteria Recommendations ***Approved Rejected***

1. Safinamide / Overutilization _____ _____

Alert Message: Xadago (safinamide) may be over-utilized. The manufacturer's recommended maximum dose of safinamide is 100 mg once daily. Daily dosages of safinamide above 100 mg have not been shown to provide additional benefit, and higher dosages increase the risk for adverse reactions. Selectivity for MAO-B inhibition decreased in a dose-related manner above the highest recommended daily dosage.

Conflict Code: ER - Overutilization
Drugs/Diseases

Util A	Util B	Util C **(Negate)**
Safinamide		Hepatic Impairment

Max Dose: 100 mg/day

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Xadago Prescribing Information, June 2017, US WorldMeds LLC.

2. Safinamide / Hepatic Impairment _____ _____

Alert Message: The recommended maximum daily dose of Xadago (safinamide) in patients with moderate hepatic impairment (Child-Pugh B score 7-9), is 50 mg once daily. Safinamide use is contraindicated in patients with severe hepatic impairment (Child-Pugh C score 10-15). As a patient taking 50 mg safinamide progresses from moderate to severe hepatic impairment, discontinue safinamide.

Conflict Code: ER - Overutilization
Drugs/Diseases

Util A	Util B	Util C **(Include)**
Safinamide		Hepatic Impairment

Max Dose: 50 mg/day

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Xadago Prescribing Information, June 2017, US WorldMeds LLC.

3. Safinamide / Severe Hepatic Impairment _____ _____

Alert Message: Xadago (safinamide) use is contraindicated in patients with severe hepatic impairment (Child-Pugh C score 10-15). In clinical studies subjects with moderate hepatic impairment (Child-Pugh B) receiving safinamide had an approximate 80% increase in safinamide exposure.

Conflict Code: TA – Therapeutic Appropriateness
Drugs/Diseases

Util A	Util B	Util C **(Include)**
Safinamide		Severe Hepatic Impairment

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Xadago Prescribing Information, June 2017, US WorldMeds LLC.

4. Safinamide / Levodopa/Carbidopa _____ _____

Alert Message: A review of the patient's drug history does not show a concurrent prescription for levodopa/carbidopa. Xadago (safinamide) is indicated as adjunctive treatment to levodopa/carbidopa in patients with Parkinson's disease (PD) experiencing "off" episodes. Safinamide has not been shown to be effective as monotherapy for the treatment of PD.

Conflict Code: TA – Therapeutic Appropriateness
Drugs/Diseases

Util A	Util B	Util C **(Negate)**
Safinamide		Levodopa/Carbidopa

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Xadago Prescribing Information, June 2017, US WorldMeds LLC.

5. Safinamide / MAO Inhibitors _____ _____

Alert Message: Xadago (safinamide) is contraindicated for use with other drugs in the MAO inhibitor class or other drugs that are potent inhibitors of monoamine oxidase. Co-administration increases the risk of nonselective MAO inhibition, which may lead to hypertensive crisis. At least 14 days should elapse between discontinuation of safinamide and initiation of treatment of other MAOIs.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Safinamide	Isocarboxazid	
	Phenelzine	
	Tranylcypromine	
	Linezolid	
	Rasagiline	

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Xadago Prescribing Information, June 2017, US WorldMeds LLC.

6. Safinamide / Opioids _____ _____

Alert Message: Concurrent use of Xadago (safinamide), a MAO-B inhibitor, with opioid drugs is contraindicated. Serious, sometimes fatal reactions have been precipitated with concomitant use of MAOIs and opioids. At least 14 days should elapse between discontinuation of safinamide and initiation of treatment with an opioids.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B		Util C
Safinamide	Meperidine	Fentanyl	
	Methadone	Dihydrocodeine	
	Morphine	Tapentadol	
	Codeine	Tramadol	
	Hydrocodone	Oxymorphone	
	Hydromorphone	Oxycodone	
	Levorphanol		

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Xadago Prescribing Information, June 2017, US WorldMeds LLC.

7. Safinamide / Dextromethorphan _____ _____

Alert Message: The concurrent use of Xadago (safinamide), a MAO-B inhibitor, with a dextromethorphan-containing agent is contraindicated. The co-administration of dextromethorphan and MAOIs has been shown to cause episodes of psychosis or bizarre behavior.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Safinamide	Dextromethorphan	

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Xadago Prescribing Information, June 2017, US WorldMeds LLC.

8. Safinamide / Serotonergic Agents _____ _____

Alert Message: The concurrent use of Xadago (safinamide), a MAO-B inhibitor, with a serotonergic drug is contraindicated. The co-administration of MAOIs and a serotonergic agent may result in potentially life-threatening serotonin syndrome. At least 14 days should elapse between discontinuation of safinamide and initiation of treatment with these drugs.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Safinamide	SNRIs	
	TCAs	
	Tetracyclic Antidepressants	
	Trazodone	
	Cyclobenzaprine	

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Xadago Prescribing Information, June 2017, US WorldMeds LLC.

9. Safinamide / Sympathomimetic Agents _____ _____

Alert Message: The concurrent use of Xadago (safinamide), a MAO-B inhibitor, with a sympathomimetic agent is contraindicated. Hypertensive crisis has been reported in patients taking the recommended doses of selective MAO-B inhibitors and sympathomimetic medications.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Safinamide	Methylphenidate	
	Dexmethylphenidate	
	Amphetamine	
	Dextroamphetamine	
	Methamphetamine	
	Lisdexamfetamine	

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Xadago Prescribing Information, June 2017, US WorldMeds LLC.

10. Safinamide / SSRIS _____ _____

Alert Message: Caution should be exercised when Xadago (safinamide), a MAO-B inhibitor, is co-administered with selective serotonin re-uptake inhibitors (SSRIs). In clinical trials, serotonin syndrome was reported in a patient treated with safinamide and an SSRI. In a patient treated with concomitant safinamide and an SSRI, use the lowest effective dose of the SSRI and monitor the patient for symptoms of serotonin syndrome.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B		Util C
Safinamide	Fluoxetine	Escitalopram	
	Paroxetine	Sertraline	
	Fluvoxamine	Vortioxetine	
	Citalopram	Vilazodone	

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Xadago Prescribing Information, June 2017, US WorldMeds LLC.

11. Safinamide / BCRP Substrates _____ _____

Alert Message: Concurrent use of Xadago (safinamide) with a drug that is a BCRP substrate may result in increased plasma concentrations of the BCRP substrate. Safinamide and its major metabolite inhibit BCRP transport. If co-administration with safinamide and the BCRP substrate is warranted monitor the patient for increased pharmacologic or adverse effect of the BCRP substrate.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Safinamide	Methotrexate	
	Imatinib	
	Irinotecan	
	Lapatinib	
	Rosuvastatin	
	Sulfasalazine	
	Topotecan	
	Dantrolene	

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Xadago Prescribing Information, June 2017, US WorldMeds LLC.

12. Safinamide / Dopamine Antagonists _____ _____

Alert Message: Concomitant use of Xadago (safinamide) with a dopamine antagonist may decrease the effectiveness of safinamide and exacerbate the symptoms of Parkinson's disease.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Safinamide	Antipsychotics	
	Metoclopramide	

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Xadago Prescribing Information, June 2017, US WorldMeds LLC.

13. Safinamide / Nonadherence _____ _____

Alert Message: Based on refill history, your patient may be under-utilizing Xadago (safinamide). Non-adherence to the prescribed dosing regimen may result in sub-therapeutic effects, which may lead to decreased patient outcomes and additional healthcare costs.

Conflict Code: LR - Nonadherence
Drugs/Diseases

Util A	Util B	Util C
Safinamide		

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Osterberg L, Blaschke T. Adherence to Medication. N Engl J Med 2005; 353:487- 497.
Xadago Prescribing Information, June 2017, US WorldMeds LLC.
Richy FF, Pietri G, Morna KA et al. Compliance with Pharmacotherapy and Direct Healthcare Costs in Patients with Parkinson's Disease: A Retrospective Claims Database Analysis. Appl Health Ecom Health Policy (2013) 11:395-406.
Fleisher JE, Stern MB. Medication Non-Adherence in Parkinson's Disease. Curr Neuro Neurosci Rep. 2013 October;13(10).

14. Deutetrabenazine / Depression & Suicidality _____ _____

Alert Message: Austedo (deutetrabenazine) is contraindicated in patients who are actively suicidal, or who have depression which is untreated or undertreated.

Conflict Code: MC – Drug (Actual) Disease Warning
Drugs/Diseases

Util A	Util B	Util C
Deutetrabenazine	Depression – in partial or unspecified remission Suicidal Ideation	

References:
Facts & Comparisons, 2017 Updates, Wolters Kluwer Health.
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Austedo Prescribing Information, April 2017, Teva Pharmaceuticals.

15. Deutetrabenazine / Depression _____ _____

Alert Message: Caution should be exercised when prescribing Austedo (deutetrabenazine) to patients with a history of depression or prior suicide attempts or ideation. Patients with Huntington's disease are at increased risk for depression, suicidal ideation or behavior. Deutetrabenazine use is associated with risk of or worsening of depression and suicidality.

Conflict Code: MC – Drug (Actual) Disease Warning
Drugs/Diseases

Util A	Util B	Util C **(Include)**
Deutetrabenazine		Depression in Remission

References:
Facts & Comparisons, 2017 Updates, Wolters Kluwer Health.
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Austedo Prescribing Information, April 2017, Teva Pharmaceuticals.

16. Deutetrabenazine / Hepatic Impairment _____ _____

Alert Message: Austedo (deutetrabenazine) use is contraindicated in patients with impaired hepatic function due to the potential for increased deutetrabenazine exposure and greater risk for serious adverse reactions. The effect of hepatic impairment on the pharmacokinetics of deutetrabenazine has not been studied; however in a clinical study conducted with tetrabenazine, a closely related VMAT2 inhibitor, there was a large increase in exposure to tetrabenazine and its active metabolites in patients with hepatic impairment.

Conflict Code: MC – Drug (Actual) Disease Warning
Drugs/Diseases

Util A	Util B	Util C
Deutetrabenazine	Hepatic Impairment	

References:
Facts & Comparisons, 2017 Updates, Wolters Kluwer Health.
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Austedo Prescribing Information, April 2017, Teva Pharmaceuticals.

17. Deutetrabenazine / MAOIs _____ _____

Alert Message: Austedo (deutetrabenazine) is contraindicated in patients taking MAOIs. Deutetrabenazine should not be used in combination with or within a minimum of 14 days of discontinuing therapy with an MAOI. Concurrent use may result in hypertensive crisis due to depletion of monoamines (dopamine, serotonin, norepinephrine, and histamine) from nerve terminals.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Deutetrabenazine	Isocarboxazid	
	Phenelzine	
	Tranylcypromine	
	Linezolid	
	Selegiline	
	Rasagiline	

References:
Facts & Comparisons, 2017 Updates, Wolters Kluwer Health.
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Austedo Prescribing Information, April 2017, Teva Pharmaceuticals.

18. Deutetrabenazine / Reserpine _____ _____

Alert Message: Concurrent use of Austedo (deutetrabenazine) with reserpine is contraindicated due to the potential for significant depletion of serotonin and norepinephrine in the CNS. At least 20 days should elapse after stopping reserpine before starting deutetrabenazine.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Deutetrabenazine	Reserpine	

References:
Facts & Comparisons, 2017 Updates, Wolters Kluwer Health.
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Austedo Prescribing Information, April 2017, Teva Pharmaceuticals.

19. Deutetrabenazine / Tetrabenazine _____ _____

Alert Message: Concurrent use of Austedo (deutetrabenazine) with tetrabenazine is contraindicated. Deutetrabenazine therapy may be initiated the day following discontinuation of tetrabenazine. Both deutetrabenazine and tetrabenazine are VMAT2 inhibitors and concomitant use may cause synergistic or additive toxicity.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Deutetrabenazine	Tetrabenazine	

References:
Facts & Comparisons, 2017 Updates, Wolters Kluwer Health.
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Austedo Prescribing Information, April 2017, Teva Pharmaceuticals.

20. Deutetrabenazine / Strong CYP2D6 Inhibitor _____ _____

Alert Message: The concurrent use of Austedo (deutetrabenazine) with a strong CYP2D6 inhibitor (e.g., fluoxetine, paroxetine, and quinidine) may markedly increase the exposure to the active metabolites of deutetrabenazine (approximately 3-fold). The total dose of deutetrabenazine should not exceed 36 mg per day in these patients. The maximum single dose should not exceed 18 mg.

Conflict Code: HD – High Dose
Drugs/Diseases

Util A	Util B	Util C **(Include)**
Deutetrabenazine		Paroxetine
		Fluoxetine
		Quinidine
		Bupropion

Max Dose: 36 mg/day

References:
Facts & Comparisons, 2017 Updates, Wolters Kluwer Health.
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Austedo Prescribing Information, April 2017, Teva Pharmaceuticals.

21. Deutetrabenazine / CNS Depressants _____ _____

Alert Message: The concurrent use of Austedo (deutetrabenazine) with CNS depressants including alcohol may have additive effects and worsen sedation and somnolence.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Deutetrabenazine	Sedatives/Hypnotics	
	Benzodiazepines	
	Narcotics	

References:
Facts & Comparisons, 2017 Updates, Wolters Kluwer Health.
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Austedo Prescribing Information, April 2017, Teva Pharmaceuticals.

22. Deutetrabenazine / Dopamine Antagonists _____ _____

Alert Message: The concurrent use of Austedo (deutetrabenazine), a dopamine depleting agent, with dopamine antagonists may result in increased risk for parkinsonism, NMS, and akathisia.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Deutetrabenazine	Antipsychotics	
	Metoclopramide	
	Amoxapine	

References:
Facts & Comparisons, 2017 Updates, Wolters Kluwer Health.
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Austedo Prescribing Information, April 2017, Teva Pharmaceuticals.

23. Deutetrabenazine / QTc Prolongation, Arrhythmias, Bradycardia Hypokalemia & Hypomagnesemia _____ _____

Alert Message: Austedo (deutetrabenazine) use should be avoided in patients with congenital long QT syndrome, cardiac arrhythmias, or history of hypokalemia or hypomagnesemia. At 24 mg, deutetrabenazine has been shown to cause an approximate 4.5 msec mean increase in the QTc.

Conflict Code: MC – Drug (Actual) Disease Warning
Drugs/Diseases

Util A	Util B	Util C
Deutetrabenazine	Long QT Syndrome	
	Arrhythmias	
	Bradycardia	
	Hypokalemia	
	Hypomagnesemia	

References:
Facts & Comparisons, 2017 Updates, Wolters Kluwer Health.
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Austedo Prescribing Information, April 2017, Teva Pharmaceuticals.

24. Deutetrabenazine / Overutilization _____ _____

Alert Message: The manufacturer's recommended maximum total daily dose of Austedo (deutetrabenazine) is 48 mg (24 mg twice daily). The maximum daily dose in patients who are poor CYP2D6 metabolizers is 36 mg (18 mg twice daily). Administer total daily dosages of 12 mg or above in two divided doses.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C **(Negate)**
Deutetrabenazine		Paroxetine
		Fluoxetine
		Quinidine
		Bupropion

Max Dose: 48 mg/day

References:
Facts & Comparisons, 2017 Updates, Wolters Kluwer Health.
Clinical Pharmacology, 2017 Elsevier/Gold Standard.

25. Deutetrabenazine / Medications Causing QT Prolongation _____ _____

Alert Message: The concurrent use of Austedo (deutetrabenazine) with medications that are known to prolong QTc should be avoided. At 24 mg, deutetrabenazine has been shown to cause an approximate 4.5 msec mean increase in the QTc.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B				Util C
Deutetrabenazine	Albuterol	Disopyramide	Imipramine	Pazopanib	Thioridazine
	Alfuzosin	Dofetilide	Indapamide	Pentamidine	Tizanidine
	Amantadine	Dolasetron	Isradipine	Pimozide	Tolterodine
	Amiodarone	Doxepin	Itraconazole	Posaconazole	Trazodone
	Amitriptyline	Dronedarone	Ketoconazole	Procainamide	TMP/SMZ
	Amphetamine	Droperidol	Lapatinib	Propafenone	Trimipramine
	Arsenic Trioxide	Ephedrine	Levalbuterol	Protriptyline	Vandetanib
	Asenapine	Epinephrine	Levofloxacin	Quetiapine	Vardenafil
	Atazanavir	Erythromycin	Lithium	Quinidine	Venlafaxine
	Atomoxetine	Escitalopram	Metaproterenol	Ranolazine	Ziprasidone
	Azithromycin	Felbamate	Methadone	Risperidone	Zolmitriptan
	Chloral Hydrate	Flecainide	Moexipril/HCTZ	Ritonavir	Ezogabine
	Chloroquine	Fluconazole	Moxifloxacin	Salmeterol	
	Chlorpromazine	Fluoxetine	Nicardipine	Saquinavir	
	Ciprofloxacin	Foscarnet	Nilotinib	Sertraline	
	Citalopram	Fosphenytoin	Norfloxacin	Solifenacin	
	Clarithromycin	Galantamine	Nortriptyline	Sotalol	
	Clomipramine	Gemifloxacin	Octreotide	Sunitinib	
	Clozapine	Granisetron	Ofloxacin	Tacrolimus	
	Dasatinib	Haloperidol	Ondansetron	Tamoxifen	
	Desipramine	Ibutilide	Paliperidone	Terbutaline	
	Diphenhydramine	Iloperidone	Paroxetine	Apomorphine	

References:
Facts & Comparisons, 2017 Updates, Wolters Kluwer Health.
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Austedo Prescribing Information, April 2017, Teva Pharmaceuticals.

26. Valbenazine / Overutilization _____ _____

Alert Message: Ingrezza (valbenazine) may be over-utilized. The manufacturer's recommended maximum daily dose of valbenazine is 80 mg once daily.

Conflict Code: ER - Overutilization
Drugs/Diseases

Util A	Util B	Util C **(Negating)**	
Valbenazine		Hepatic Impairment	Saquinavir
		Nefazodone	Ritonavir
		Clarithromycin	Indinavir
		Quinidine	Nelfinavir
		Ketoconazole	Cobicistat
		Itraconazole	Bupropion
		Voriconazole	Fluoxetine
		Posaconazole	Paroxetine

Max Dose: 80 mg/day

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Ingrezza Prescribing Information, April 2017, Neurocrine Biosciences, Inc.

27. Valbenazine / Overutilization – Hepatic Impairment _____ _____

Alert Message: Ingrezza (valbenazine) may be over-utilized. The manufacturer's recommended maximum daily dose of valbenazine in patients with moderate to severe hepatic impairment (Child Pugh score 7 to 15) is 40 mg once daily.

Conflict Code: ER - Overutilization
Drugs/Diseases

Util A	Util B	Util C **(Include)**
Valbenazine		Hepatic Impairment

Max Dose: 40 mg/day

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Ingrezza Prescribing Information, April 2017, Neurocrine Biosciences, Inc.

28. Valbenazine / Severe Renal Impairment _____ _____

Alert Message: Ingrezza (valbenazine) use is not recommended in patients with severe renal impairment (CrCl < 30 mL/min). Dosage adjustment is not necessary for patients with mild to moderate renal impairment (CrCl 30 to 90 mL/min).

Conflict Code: TA – Therapeutic Appropriateness
Drugs/Diseases

Util A	Util B	Util C **(Include)**
Valbenazine		CKD Stage 4, 5, & ESRD

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Ingrezza Prescribing Information, April 2017, Neurocrine Biosciences, Inc.

29. Valbenazine / CYP3A4 Inducers _____ _____

Alert Message: Concurrent use of Ingrezza (valbenazine) with strong CYP3A4 inducers is not recommended. Valbenazine is a CYP3A4 substrate and co-administration with a strong CYP3A4 inducer may result in decreased exposure to valbenazine and its active metabolite reducing efficacy.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B		Util C
Valbenazine	Carbamazepine	Rifampin	
	Phenytoin	Rifabutin	
	Phenobarbital	Rifapentine	
	Primidone	Enzalutamide	

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Ingrezza Prescribing Information, April 2017, Neurocrine Biosciences, Inc.

30. Valbenazine / MAO Inhibitors _____ _____

Alert Message: Concurrent use of Ingrezza (valbenazine), a VMAT2 inhibitor, with a MAO inhibitor should be avoided. Co-administration of these agents may result in increased concentrations of monoamine neurotransmitters in synapses, potentially leading to increased risk of adverse reactions such as serotonin syndrome or attenuated treatment effect of valbenazine.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Valbenazine	Isocarboxazid	
	Phenelzine	
	Tranylcypromine	
	Selegiline	
	Linezolid	
	Rasagiline	

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Ingrezza Prescribing Information, April 2017, Neurocrine Biosciences, Inc.

31. Valbenazine / Strong CYP3A4 Inhibitors _____ _____

Alert Message: Concurrent use of Ingrezza (valbenazine), a CYP3A4 substrate, with a strong CYP3A4 inhibitor may result in increased exposure to valbenazine and its active metabolite. Concomitant use may put the patient at risk for valbenazine exposure-related adverse reactions. The manufacturer recommends reducing the dose of valbenazine to 40 mg once daily when valbenazine is co-administered with a strong CYP3A4 inhibitor.

Conflict Code: ER - Overutilization
Drugs/Diseases

Util A	Util B	Util C **(Include)**	
Valbenazine		Nefazodone	Saquinavir
		Clarithromycin	Ritonavir
		Ketoconazole	Indinavir
		Itraconazole	Nelfinavir
		Voriconazole	Cobicistat
		Posaconazole	

Max Dose: 40 mg/day

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Ingrezza Prescribing Information, April 2017, Neurocrine Biosciences, Inc.

32. Valbenazine / Strong CYP2D6 Inhibitors _____ _____

Alert Message: Concurrent use of Ingrezza (valbenazine), a CYP2D6 substrate, with a strong CYP2D6 inhibitor may result in increased exposure to valbenazine and its active metabolite. Concomitant use may put the patient at risk for valbenazine exposure-related adverse reactions. Consider reducing the valbenazine dose based on tolerability when valbenazine is co-administered with a strong CYP2D6 inhibitor.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Valbenazine	Bupropion	
	Paroxetine	
	Fluoxetine	
	Quinidine	

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Ingrezza Prescribing Information, April 2017, Neurocrine Biosciences, Inc.

33. Valbenazine / Digoxin _____ _____

Alert Message: Concurrent use of Ingrezza (valbenazine) with digoxin, a P-gp substrate, may result in increased digoxin levels due to inhibition, by valbenazine, of digoxin P-gp mediated transport. Digoxin concentrations should be monitored when co-administering these agents. Dosage adjustment of digoxin may be necessary.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Valbenazine	Digoxin	

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Ingrezza Prescribing Information, April 2017, Neurocrine Biosciences, Inc.

34. Valbenazine / QT Prolongation, Arrhythmias, Bradycardia _____ _____

Alert Message: Ingrezza (valbenazine) use should be avoided in patients with congenital long QT syndrome or with arrhythmias associated with a prolonged QT interval.

Conflict Code: TA – Therapeutic Appropriateness
Drugs/Diseases

Util A	Util B	Util C **(Include)**
Valbenazine		Long QT Syndrome
		Arrhythmias

References:
Facts & Comparisons, 2017 Updates, Wolters Kluwer Health.
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Ingrezza Prescribing Information, April 2017, Neurocrine Biosciences, Inc.

35. Valbenazine / Pregnancy / Pregnancy Negating _____ _____

Alert Message: The limited available data on Ingrezza (valbenazine) use in pregnant women is insufficient to inform a drug-associated risk. In animal studies no malformations were observed when valbenazine was administered to rats and rabbits during the period of organogenesis at doses up to 24 times the maximum recommended human dose. However, administration of valbenazine to pregnant rats during organogenesis through lactation produced an increase in the number of stillborn pups and postnatal pup mortalities. Advise pregnant females of potential risk to fetus.

Conflict Code: MC – Drug (Actual) Disease Warning
Drugs/Diseases

Util A	Util B	Util C **(Negating)**
Valbenazine	Pregnancy	Delivery
		Miscarriage
		Abortion

Gender: Female
Age Range: 11 – 55 yoa

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Ingrezza Prescribing Information, April 2017, Neurocrine Biosciences, Inc.

36. Valbenazine / Medications Causing QT Prolongation _____ _____

Alert Message: The concurrent use of Ingrezza (valbenazine) with medications that are known to prolong QTc should be avoided. Valbenazine may cause an increase in the QT interval and use with other agents that also prolong the interval may have an additive effect.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B				Util C
Valbenazine	Albuterol	Disopyramide	Imipramine	Pazopanib	Thioridazine
	Alfuzosin	Dofetilide	Indapamide	Pentamidine	Tizanidine
	Amantadine	Dolasetron	Isradipine	Pimozide	Tolterodine
	Amiodarone	Doxepin	Itraconazole	Posaconazole	Trazodone
	Amitriptyline	Dronedarone	Ketoconazole	Procainamide	TMP/SMZ
	Amphetamine	Droperidol	Lapatinib	Propafenone	Trimipramine
	Arsenic Trioxide	Ephedrine	Levalbuterol	Protriptyline	Vandetanib
	Asenapine	Epinephrine	Levofloxacin	Quetiapine	Vardenafil
	Atazanavir	Erythromycin	Lithium	Quinidine	Venlafaxine
	Atomoxetine	Escitalopram	Metaproterenol	Ranolazine	Ziprasidone
	Azithromycin	Felbamate	Methadone	Risperidone	Zolmitriptan
	Chloral Hydrate	Flecainide	Moexipril/HCTZ	Ritonavir	Ezogabine
	Chloroquine	Fluconazole	Moxifloxacin	Salmeterol	Apomorphine
	Chlorpromazine	Fluoxetine	Nicardipine	Saquinavir	Telotristat
	Ciprofloxacin	Foscarnet	Nilotinib	Sertraline	
	Citalopram	Fosphenytoin	Norfloxacin	Solifenacin	
	Clarithromycin	Galantamine	Nortriptyline	Sotalol	
	Clomipramine	Gemifloxacin	Octreotide	Sunitinib	
	Clozapine	Granisetron	Ofloxacin	Tacrolimus	
	Dasatinib	Haloperidol	Ondansetron	Tamoxifen	
	Desipramine	Ibutilide	Paliperidone	Terbutaline	
	Diphenhydramine	Iloperidone	Paroxetine	Deutetrabenazine	

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Ingrezza Prescribing Information, April 2017, Neurocrine Biosciences, Inc.

37. Valbenazine / Lactation & Disorders of Lactation _____ _____

Alert Message: There is no information regarding the presence of Ingrezza (valbenazine) or its active metabolites in human milk. Valbenazine and its metabolites have been detected in rat milk. Based on animal findings of increased perinatal mortality in exposed fetuses and pups, advise a woman to not breastfeed during treatment with valbenazine and for 5 days after the final dose.

Conflict Code: MC – Drug (Actual) Disease Warning
Drugs/Diseases

Util A	Util B	Util C
Valbenazine	Lactation	
	Disorder of Lactation	

Gender: Female
Age Range: 11 – 55 yoa

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Ingrezza Prescribing Information, April 2017, Neurocrine Biosciences, Inc.

38. Itraconazole Caps / Avanafil _____ _____

Alert Message: Stendra (avanafil) is contraindicated for use during and for 2 weeks after itraconazole therapy. Co-administration of avanafil with itraconazole can result in elevated avanafil plasma concentrations and may increase or prolong the pharmacologic effects and adverse reactions to avanafil.

Conflict Code: DD – Drug/Drug Interactions
Drugs/Diseases

Util A	Util B	Util C
Itraconazole Caps	Avanafil	

References:
Sporanox Prescribing Information, October 2017, Janssen Pharmaceutical Companies.
Clinical Pharmacology, 2017 Elsevier/Gold Standard.

39. Cobimetinib / Overutilization _____ _____

Alert Message: The manufacturer's recommended dose of Cotellic (cobimetinib) is 60 mg orally once daily for the first 21 days of each 28-day cycle.

Conflict Code: ER - Overutilization
Drugs/Diseases

Util A	Util B	Util C
Cobimetinib		

Max Dose: 60 mg/day

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Cotellic Prescribing Information, May 2016, Genentech.

40. Cobimetinib / Therapeutic Appropriateness _____ _____

Alert Message: Cotellic (cobimetinib) can cause fetal harm when administered to a pregnant woman. Advise females of reproductive potential to use effective contraception during treatment with cobimetinib and for 2 weeks following the final dose of cobimetinib.

Conflict Code: TA - Therapeutic Appropriateness
Drugs/Diseases

Util A	Util B	Util C
Cobimetinib		

Gender: Female
Age Range: 11 - 50 yoa

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Cotellic Prescribing Information, May 2016, Genentech.

41. Cobimetinib / Overutilization _____ _____

Alert Message: The safety and effectiveness of Cotellic (cobimetinib) have not been established in pediatric patients.

Conflict Code: ER - Overutilization
Drugs/Diseases

Util A	Util B	Util C
Cobimetinib		

Age Range: ≥ 18 yoa

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Cotellic Prescribing Information, May 2016, Genentech.

42. Cobimetinib / Moderate to Strong CYP3A Inhibitors _____ _____

Alert Message: Concurrent use of Cotellic (cobimetinib) with strong or moderate CYP3A inhibitors should be avoided. If concurrent short term (14 days or less) use of moderate CYP3A inhibitors including certain antibiotics is unavoidable for patients who are taking cobimetinib 60 mg, reduce cobimetinib dose to 20 mg. After discontinuation of a moderate CYP3A inhibitor, resume cobimetinib at the previous dose. Use an alternative to a strong or moderate CYP3A inhibitor in patients who are taking a reduced dose of cobimetinib.

Conflict Code: DD – Drug/Drug interaction
Drugs/Diseases

Util A	Util B			Util C
Cobimetinib	Nefazodone	Atazanavir	Fluconazole	
	Clarithromycin	Darunavir	Cimetidine	
	Saquinavir	Tipranavir	Cyclosporine	
	Ritonavir	Ciprofloxacin	Erythromycin	
	Nelfinavir	Aprepitant	Idelalisib	
	Indinavir	Diltiazem	Fosamprenavir	
	Cobicistat	Verapamil	Clotrimazole	
	Ketoconazole	Imatinib		
	Itraconazole	Crizotinib		
	Voriconazole	Fluvoxamine		
	Posaconazole	Dronedarone		

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Cotellic Prescribing Information, May 2016, Genentech.

43. Cobimetinib / Moderate to Strong CYP3A Inducers _____ _____

Alert Message: Concurrent use of Cotellic (cobimetinib) with strong or moderate CYP3A inducers should be avoided. Co-administration of cobimetinib with a strong CYP3A inducer may decrease cobimetinib systemic exposure by more than 80% and reduce its efficacy.

Conflict Code: DD – Drug/Drug interaction
Drugs/Diseases

Util A	Util B		Util C
Cobimetinib	Carbamazepine	Modafinil	
	Phenytoin	Bosentan	
	Phenobarbital	Efavirenz	
	Primidone	Etravirine	
	Rifabutin	Mitotane	
	Rifampin	Bexarotene	
	Rifapentine	Dabrafenib	
	Enzalutamide		

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Cotellic Prescribing Information, May 2016, Genentech.

44. Rucaparib / Overutilization _____ _____
Alert Message: The manufacturer's recommended dose of Rubraca (rucaparib) is 600 mg taken orally twice daily.

Conflict Code: ER - Overutilization
Drugs/Diseases
Util A Util B Util C
Rucaparib

Max Dose: 1200 mg/day

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Rubraca Prescribing Information, Feb. 2017, Clovis Oncology, Inc.

45. Rucaparib / Therapeutic Appropriateness _____ _____
Alert Message: Rubraca (rucaparib) can cause fetal harm when administered to a pregnant woman. Advise females of reproductive potential to use effective contraception during treatment and for 6 months following the final dose of rucaparib. Pregnancy testing is recommended for females of reproductive potential prior to initiating rucaparib.

Conflict Code: TA – Therapeutic Appropriateness
Drugs/Diseases
Util A Util B Util C
Rucaparib

Age Range: 11 - 50 yoa
Gender: Female

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Rubraca Prescribing Information, Feb. 2017, Clovis Oncology, Inc.

46. Rucaparib / Therapeutic Appropriateness _____ _____
Alert Message: The safety and effectiveness of Rubraca (rucaparib) in pediatric patients have not been established.

Conflict Code: TA – Therapeutic Appropriateness
Drugs/Diseases
Util A Util B Util C
Rubraca

Age Range: ≥ 18 yoa

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Rubraca Prescribing Information, Feb. 2017, Clovis Oncology, Inc.

47. Deflazacort / Therapeutic Appropriateness 0 – 4 yoa _____ _____

Alert Message: The safety and effectiveness of Emflaza (deflazacort) for the treatment of Duchenne Muscular Dystrophy (DMD) in patients less than 5 years of age have not been established.

Conflict Code: TA - Therapeutic Appropriateness
Drugs/Diseases

Util A	Util B	Util C
Deflazacort		

Age Range: 0 – 4 yoa

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Emflaza Prescribing Information, Feb. 2017, Marathon Pharmaceuticals, LLC.

48. Deflazacort / Moderate to Strong CYP3A4 Inhibitors _____ _____

Alert Message: Concurrent use of Emflaza (deflazacort), a CYP3A4 substrate, with a moderate or strong CYP3A4 inhibitor may result in increased total exposure to the active metabolite of deflazacort, 21-desDFZ. Therefore, give one third the recommended dosage of deflazacort when deflazacort is co-administered with moderate or strong CYP3A4 inhibitors.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B		Util C
Deflazacort	Nefazodone	Atazanavir	Fluconazole
	Clarithromycin	Darunavir	Cimetidine
	Saquinavir	Tipranavir	Cyclosporine
	Ritonavir	Ciprofloxacin	Erythromycin
	Nelfinavir	Aprepitant	Idelalisib
	Indinavir	Diltiazem	Fosamprenavir
	Cobicistat	Verapamil	Clotrimazole
	Ketoconazole	Imatinib	
	Itraconazole	Crizotinib	
	Voriconazole	Fluvoxamine	
	Posaconazole	Dronedarone	

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Emflaza Prescribing Information, Feb. 2017, Marathon Pharmaceuticals, LLC.

49. Deflazacort / Moderate to Strong CYP3A4 Inducers _____ _____

Alert Message: Concurrent use of Emflaza (deflazacort) with a moderate to strong CYP3A4 inducer should be avoided. Deflazacort is a CYP3A4 substrate and concurrent use with a CYP3A4 inducer may significantly decrease the exposure of the active metabolite 21-desDFZ and reduce deflazacort efficacy.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B		Util C
Deflazacort	Carbamazepine	Modafinil	
	Phenytoin	Bosentan	
	Phenobarbital	Efavirenz	
	Primidone	Etravirine	
	Rifabutin	Mitotane	
	Rifampin	Bexarotene	
	Rifapentine	Dabrafenib	
	Enzalutamide		

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Emflaza Prescribing Information, Feb. 2017, Marathon Pharmaceuticals, LLC.

50. Deflazacort / Behavioral & Mood Disturbances _____ _____

Alert Message: Potentially severe psychiatric adverse reactions may occur with systemic corticosteroids, including Emflaza (deflazacort). Symptoms typically emerge within a few days or weeks of starting treatment and may be dose-related. These reactions may improve after either dose reduction or withdrawal, although pharmacologic treatment may be necessary. Inform patient or caregivers of the potential for behavioral and mood changes and encourage them to seek medical attention if psychiatric symptoms develop, especially if depressed mood or suicidal ideation is suspected.

Conflict Code: MC – Drug (Actual) Disease Precaution/Warning
Drugs/Diseases

Util A	Util B	Util C
Deflazacort	Insomnia	
	Unspecified Mood Disorder	
	Depression	
	Mania	
	Irritability	
	Anxiety	
	Suicidal Ideation	
	Amnesia	
	Hallucinations	

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Emflaza Prescribing Information, Feb. 2017, Marathon Pharmaceuticals, LLC.

51. Diphenoxylate/Atropine / Therapeutic Appropriateness _____ _____

Alert Message: Diphenoxylate/atropine is contraindicated in pediatric patients less than 6 years of age due to the risk of respiratory and central nervous system (CNS) depression. Cases of severe respiratory depression and coma, leading to permanent brain damage or death have been reported in patients less than 6 years of age who have received diphenoxylate/atropine.

Conflict Code: TA - **Therapeutic Appropriateness**
Drugs/Diseases

Util A	Util B	Util C
Diphenoxylate/Atropine		

Age Range: < 6 yoa

References:
Lomotil Prescribing Information, October 2017, Pfizer.

52. Diphenoxylate/Atropine / Therapeutic Appropriateness _____ _____

Alert Message: The safety and effectiveness of diphenoxylate/atropine have not been established in patients less than 13 years of age.

Conflict Code: TA - Therapeutic Appropriateness
Drugs/Diseases

Util A	Util B	Util C
Diphenoxylate/Atropine		

Age Range: 6 - 12 yoa

References:
Lomotil Prescribing Information, October 2017, Pfizer.
Facts & Comparisons, 2017 Wolters Kluwer Health.

53. Diphenoxylate/Atropine / Obstructive Jaundice _____ _____
Alert Message: Diphenoxylate/atropine is contraindicated in patients with obstructive jaundice.

Conflict Code: MC – Drug (Actual) Disease Warning/Contraindication
Drugs/Diseases

Util A	Util B	Util C
Diphenoxylate/Atropine	Obstruction of the Bile Duct	

References:
Lomotil Prescribing Information, October 2017, Pfizer.
Facts & Comparisons, 2017 Wolters Kluwer Health.

54. Dexlansoprazole / Hepatic Impairment _____ _____
Alert Message: The maximum recommended dosage of Dexilant (dexlansoprazole) in patients with moderate hepatic impairment (Child-Pugh Class B) is 30 mg per day. In a study patients with moderate hepatic impairment who received a single dose of dexlansoprazole, exhibited approximately two times greater systemic exposure (AUC) compared to healthy subjects with normal hepatic function. Dexlansoprazole use is not recommended in patients with severe hepatic impairment. No dosage adjustment is necessary for mild hepatic impairment.

Conflict Code: ER – Overutilization
Drugs/Diseases

Util A	Util B	Util C **(Include)**
Dexlansoprazole		Hepatic Impairment

Max Dose: 30 mg/day

References:
Dexliant Prescribing Information, October 2017, Takeda Pharmaceuticals America, Inc.
Clinical Pharmacology, 2017 Elsevier/Gold Standard.

55. Clindamycin / Strong CYP3A4 & CYP3A5 Inhibitors _____ _____
Alert Message: Concurrent use of clindamycin a CYP3A4/5 substrate, with a strong CYP3A4 or CYP3A5 inhibitor may result in increased clindamycin plasma concentrations. Monitor patient for clindamycin-related adverse events when co-administering clindamycin with strong 3A4/5 inhibitors.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B		Util C
Clindamycin	Nefazodone	Saquinavir	
	Clarithromycin	Ritonavir	
	Posaconazole	Indinavir	
	Ketoconazole	Nelfinavir	
	Itraconazole	Idelalisib	
	Voriconazole	Cobicistat	

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Cleocin Prescribing Information, May 2017, Pfizer US.

56. Clindamycin / Strong CYP3A4 & CYP3A5 Inducers _____ _____

Alert Message: Concurrent use of clindamycin, a CYP3A4/5 substrate, with a strong CYP3A4 or CYP3A5 inducer may result in decreased clindamycin plasma concentrations. Monitor patient for loss of clindamycin efficacy.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B		Util C
Clindamycin	Phenytoin	Rifampin	
	Phenobarbital	Rifapentine	
	Primidone	Rifabutin	
	Carbamazepine	Enzalutamide	

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Cleocin Prescribing Information, May 2017, Pfizer US.

57. Codeine / CYP2D6 Inhibitors _____ _____

Alert Message: Concurrent use of a codeine-containing agent with a CYP2D6 inhibitor may result in a decrease in the effects of codeine. Codeine must be bioactivated via CYP2D6 to morphine to exert an analgesic effect. Consider the use of an alternative analgesic for patients requiring therapy with an agent that is a CYP2D6 inhibitor.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B		Util C
Codeine	Fluoxetine	Propafenone	
	Paroxetine	Quinidine	
	Bupropion	Terbinafine	

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Facts & Comparisons, 2017 Wolters Kluwer Health.

58. NNRTIs & Enfuvirtide / HIV-2 _____ _____

Alert Message: A review of the patient's records reveals that the patient has a diagnosis of HIV-2 and is receiving an NNRTI. HIV-2 is intrinsically resistant to non-nucleoside reverse transcriptase inhibitors (NNRITs) and to enfuvirtide thus these drugs should not be included in an antiretroviral regimen for an HIV-2 infected patient.

Conflict Code: TA – Therapeutic Appropriateness
Drugs/Diseases

Util A	Util B	Util C **(Include)**
Delavirdine		HIV-2
Efavirenz		
Etravirine		
Nevirapine		
Rilpivirine		

References:
Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the Use of Antiretroviral Agents in HIV-1 Infected Adults and Adolescents. Department of Health and Human Services. July 14, 2016. Available at: http://www.aidsinfo.nih.gov/contentfiles/adultandadolescentgl.pdf.
Panel on Treatment of HIV-infected Pregnant Women and Prevention of Perinatal Transmission. Recommendations for Use of Antiretroviral Drugs in Pregnant HIV-Infected Women for Maternal Health and Interventions to Reduce Perinatal HIV Transmission in the United States. October 26, 2016. Available at: http://aidsinfo.nih.gov/contentfiles/PerinatalGL.pdf

59. NNRTIs & Enfuvirtide / HIV-2 _____ _____

Alert Message: A review of the patient's records reveals that the patient has a diagnosis of HIV-2 and is receiving enfuvirtide. HIV-2 is intrinsically resistant to enfuvirtide and to non-nucleoside reverse transcriptase inhibitors (NNRTIs) thus these drugs should not be included in an antiretroviral regimen for an HIV-2 infected patient.

Conflict Code: TA – Therapeutic Appropriateness
Drugs/Diseases

Util A	Util B	Util C **(Include)**
Enfuvirtide		HIV-2

References:
Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the Use of Antiretroviral Agents in HIV-1 Infected Adults and Adolescents. Department of Health and Human Services. July 14, 2016. Available at: http://www.aidsinfo.nih.gov/contentfiles/adultandadolescentgl.pdf.
Panel on Treatment of HIV-infected Pregnant Women and Prevention of Perinatal Transmission. Recommendations for Use of Antiretroviral Drugs in Pregnant HIV-Infected Women for Maternal Health and Interventions to Reduce Perinatal HIV Transmission in the United States. October 26, 2016. Available at: http://aidsinfo.nih.gov/contentfiles/PerinatalGL.pdf

60. Voriconazole / Ergot Alkaloids _____ _____

Alert Message: Concurrent use of Vfend (voriconazole) with ergot alkaloids is contraindicated due to the risk of ergotism. Voriconazole is a strong CYP3A4 inhibitor and co-administration with an ergot alkaloid which is a CYP3A4 substrate can result in elevated substrate concentrations.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Voriconazole	Ergotamine	
	Dihydroergotamine	
	Methylergonovine	

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Facts & Comparisons, 2017 Wolters Kluwer Health.

61. Voriconazole / Vinca Alkaloids _____ _____

Alert Message: Concurrent use of Vfend (voriconazole) with vinca alkaloids should be avoided due to the risk if increased vinca alkaloid plasm concentrations which may lead to vinca alkaloid-related neurotoxicity. Voriconazole is a strong CYP3A4 inhibitor and co-administration with a vinca alkaloid which is a CYP3A4 substrate can result in elevated substrate concentrations.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Voriconazole	Vincristine	
	Vinblastine	
	Vinorelbine	

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Facts & Comparisons, 2017 Wolters Kluwer Health.

62. Voriconazole / Atazanavir / Ritonavir _____ _____

Alert Message: The use of Vfend (voriconazole) in patients receiving atazanavir/rtv is not recommended unless an assessment of the benefit/risk to the patient justified the use of voriconazole. If concomitant therapy cannot be avoided patients should be carefully monitored for voriconazole associated adverse reactions and loss of either voriconazole or atazanavir efficacy. Co-administration of voriconazole with atazanavir (without ritonavir) may affect atazanavir concentrations; however, do data are available.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C **(Include)**
Voriconazole	Atazanavir	Ritonavir

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Facts & Comparisons, 2017 Wolters Kluwer Health.

63. Selexipag / CYP2C8 Inhibitors _____ _____

Alert Message: Concurrent use of Uptravi (selexipag), a CYP2C8 substrate, with a moderate CYP2C8 inhibitor can be expected to increase exposure to the active metabolite of selexipag. Consider a less frequent dosing regimen, e.g., once daily, when initiating selexipag in patients on a CYP2C8 inhibitor. Reduce selexipag dose when a moderate CYP2C8 inhibitor is initiated.

Conflict Code: DD – Drug/Drug Interaction
Drugs/Diseases

Util A	Util B	Util C
Selexipag	Teriflunomide	
	Deferasirox	
	Lapatinib	
	Nilotinib	

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Facts & Comparisons, 2017 Wolters Kluwer Health.
Uptravi Prescribing Information, July 2017, Actelion Pharmaceuticals US, Inc.

64. Methylphenidate XR-ODT / Overutilization _____ _____

Alert Message: The manufacturer's recommended maximum total daily dose of Cotempla XR-ODT (methylphenidate extended-release orally disintegrating) is 51.8 mg. Daily doses above 51.8 mg are not recommended.

Conflict Code: ER - Overutilization
Drugs/Diseases

Util A	Util B	Util C
Methylphenidate XR-ODT		

Max Dose: 51.8 mg/day

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Cotempla XR-ODT Prescribing Information, June 2017, Neos Therapeutics, Inc.

65. Dextroamphetamine/amphetamine ER Caps / Overutilization _____ _____
Alert Message: The manufacturer's recommended maximum total daily dose of Mydayis (dextroamphetamine/amphetamine), in adult patients, is 50 mg.

Conflict Code: ER - Overutilization
Drugs/Diseases

Util A	Util B	Util C **(Negate)**
Dextroamphetamine/amphetamine ER caps		CKD Stage 4 & 5

Max Dose: 50 mg/day
Age Range: ≥ 18 yoa

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Mydayis Prescribing Information, June 2017, Shire US, Inc.

66. Dextroamphetamine/amphetamine ER Caps /Severe Renal Impairment _____ _____
Alert Message: The manufacturer's recommended maximum total daily dose of Mydayis (dextroamphetamine/amphetamine), in adult patients with severe renal impairment (GFR 15 to < 30 ml/min/1.73m2), is 25 mg. Dextroamphetamine/amphetamine extended-release is not recommended for use in patients with end stage renal disease (ESRD < 15 ml/min/1.73m2).

Conflict Code: ER - Overutilization
Drugs/Diseases

Util A	Util B	Util C **(Include)**
Dextroamphetamine/amphetamine ER caps		CKD Stage 4 & 5

Max Dose: 25 mg/day
Age Range: ≥ 18 yoa

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Mydayis Prescribing Information, June 2017, Shire US, Inc.

67. Dextroamphetamine/amphetamine ER Caps / ESRD _____ _____
Alert Message: Mydayis (dextroamphetamine/amphetamine) is not recommended for use in patients with end stage renal disease (ESRD < 15 ml/min/1.73m2).

Conflict Code: TA – Therapeutic Appropriateness
Drugs/Diseases

Util A	Util B	Util C **(Include)**
Dextroamphetamine/amphetamine ER caps		ESRD

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Mydayis Prescribing Information, June 2017, Shire US, Inc.

68. Dextroamphetamine/amphetamine ER Caps / Overutilization _____ _____
Alert Message: The manufacturer's recommended maximum total daily dose of Mydayis (dextroamphetamine/amphetamine), in pediatric patients 13 to 17 years of age, is 25 mg.

Conflict Code: ER - Overutilization
Drugs/Diseases

Util A	Util B	Util C **(Negate)**
Dextroamphetamine/amphetamine ER caps		CKD Stage 4 & 5

Max Dose: 25 mg/day
Age Range: 13 - 17 yoa

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Mydayis Prescribing Information, June 2017, Shire US, Inc.

69. Dextroamphetamine/amphetamine ER Caps / Severe Renal Impairment _____ _____

Alert Message: The manufacturer's recommended maximum total daily dose of Mydayis (dextroamphetamine/amphetamine), in pediatric patients 13 to 17 years of age with severe renal impairment (GFR 15 to < 30 ml/min/1.73m2), is 12.5mg. Dextroamphetamine/amphetamine extended-release is not recommended for use in patients with end stage renal disease (ESRD < 15 ml/min/1.73m2).

Conflict Code: ER - Overutilization
Drugs/Diseases

Util A	Util B	Util C **(Include)**
Dextroamphetamine/amphetamine ER caps		CKD Stage 4 & 5

Max Dose: 12.5 mg/day
Age Range: 13 - 17 yoa

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Mydayis Prescribing Information, June 2017, Shire US, Inc.

70. Dextroamphetamine/amphetamine ER Caps / Severe Renal Impairment _____ _____

Alert Message: The safety and effectiveness of Mydayis (dextroamphetamine/amphetamine) have not been established in pediatric patients 12 years of age and younger.

Conflict Code: TA – Therapeutic Appropriateness
Drugs/Diseases

Util A	Util B	Util C
Dextroamphetamine/amphetamine ER caps		

Age Range: 0 -12 yoa

References:
Clinical Pharmacology, 2017 Elsevier/Gold Standard.
Mydayis Prescribing Information, June 2017, Shire US, Inc.

71. AirDuo Respiclick / Therapeutic Appropriateness _____ _____

Alert Message: The safety and effectiveness of AirDuo Respiclick (fluticasone) in pediatric patients below the age of 12 years have not been established.

Conflict Code: TA - Therapeutic Appropriateness
Drugs/Diseases

Util A	Util B	Util C
Fluticasone Inhalation Powder		

References:
AirDuo Prescribing Information, Jan. 2017, Teva Respiratory, LLC.
Clinical Pharmacology, 2017 Elsevier Gold Standard.

- Prior authorization for a non-preferred agent with a preferred brand/generic equivalent in any category will be given only if DAW criteria is met in addition to clinical criteria and step therapy specific to that category.

- Prior authorization criteria applies in addition to the general Drug Utilization Review policy that is in effect for the entire pharmacy program, including, but not limited to, appropriate dosing, duplication of therapy, etc. Refer to http://www.hidesigns.com/ndmedicaid for applicable quantity limits and therapeutic duplication edits.

- Unless otherwise specified, the listing of a particular brand or generic name includes all legend forms of that drug. OTC drugs are not covered unless specified.

- The use of pharmaceutical samples will not be considered when evaluating the member's medical condition or prior prescription history for drugs that require prior authorization.

- This is NOT an all-inclusive list of medications covered by ND Medicaid. Please use the NDC Drug Lookup tool at http://nddruglookup.hidinc.com/ to view coverage status, quantity limits, copay, and prior authorization information for all medications.

- This is NOT an all-inclusive list of medications that require prior authorization. Please visit http://www.hidesigns.com/ndmedicaid/pa-criteria.html for PA criteria for medications not found on the PDL.

- This PDL is subject to change. Preferred positions and criteria will go into effect when an SRA is executed.

- Acronyms
  PA – Indicates preferred agents that require clinical prior authorization.
  *** - Indicates that additional PA criteria applies as indicated in the sidebar

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CHANGES SINCE LAST VERSION		
Category	**Product Status Changes**	**Criteria Changes**
ADHD AGENTS	Dextroamphetamine 5 mg/5 ml moved to non-preferred	
ALLERGENIC EXTRACTS		removed as a PDL category
ANALGESICS - NSAIDS - TOPICAL		New PDL Category
TESTOSTERONE TOPICAL	ANDRODERM (testosterone) moved to preferred	Category name changed to ANDROGENS
ANTIHEMOPHILIC FACTORS		removed as a PDL category
COPD - Long Acting Anticholinergics		Spiriva Respimat criteria added
COPD		Category PA Criteria changes
COPD -Combination Anticholinergics/Long Acting Beta Agonists	BEVESPI AEROSPHERE (glycopyrrolate/formoterol) moved to preferred	
COPD -Combination Anticholinergics/Long Acting Beta Agonists	COMBIVENT RESPIMAT (albuterol/ipratropium) moved to non-preferred	Short and Long acting agents combined into one group. Group PA criteria updated
COPD -Combination Anticholinergics/Long Acting Beta Agonists	STIOLTO RESPIMAT (tiotropium/olodaterol moved to non-preferred	
CYSTIC FIBROSIS ANTIINFECTIVES		Category name changed to CYSTIC FIBROSIS INHALED ANTIBIOTICS
DIABETES - DPP4 INHIBITORS		ONGLYZA (saxagliptan) criteria removed
DIABETES - GLP1 AGONISTS	TANZEUM (albiglutide) moved to non-preferred	
DIABETES - GLP1 AGONISTS		Victoza Criteria removed, Category PA Criteria Updated
DIABETES - INSULIN		Category added to PDL
DIABETES - INSULIN		Individual insulin criteria updated
DIABETES - INSULIN/GLP1 AGONISTS		New PDL Category

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CHANGES SINCE LAST VERSION		
Category	**Product Status Changes**	**Criteria Changes**
DIABETES - SGLT2 INHIBITORS	INVOKAMET XR (canagliflozin/metformin) moved to non-preferred	
DIABETES - SGLT2 INHIBITORS	SYNJARDY XR (empagliflozin/metformin) moved to preferred	
DIARRHEA - IRRITABLE BOWEL SYNDROME	LOTRONEX (alosetron) moved to preferred	
FIBROMYALGIA		removed as a PDL category
GOUT - COLCHICINE		removed as a PDL category
HEMATOPOIETIC, COLONY STIMULATING FACTORS		New PDL Category
HEMATOPOIETIC, GROWTH FACTOR		Category name changed to HEMATOPOIETIC, ERYTHROPOIESIS STIMULATING AGENTS
LICE	permethrin liquid removed from preferred	
MULTIPLE SCLEROSIS	REBIF (interferon beta-1A) moved to non-preferred	
MULTIPLE SCLEROSIS	REBIF REBIDOSE (interferon beta-1A) moved to non-preferred	
GLAUCOMA - SYMPATHOMIMETICS		Category name changed to OPHTHALMIC ALPHA ADRENERGICS - GLAUCOMA
OPHTHALMIC ANTIHISTAMINES	EMADINE (emedastine) moved to non-preferred	
OPHTHALMIC ANTIHISTAMINES	Epinastine moved to preferred	
OPHTHALMIC ANTIHISTAMINES	PATADAY 0.2% (olopatadine) moved to preferred	
OPHTHALMIC ANTIINFECTIVES	Bacitracin ointment moved to non-preferred	

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CHANGES SINCE LAST VERSION		
Category	**Product Status Changes**	**Criteria Changes**
OPHTHALMIC ANTIINFECTIVES	Sulfacetamide ointment moved to non-preferred	
OPHTHALMIC ANTIINFECTIVES	VIGAMOX (moxifloxacin) DROPS moved to non-preferred	
OPHTHALMIC ANTIINFECTIVES/ANTIINFLAMMATORIES	BLEPHAMIDE (sulfacetamide/prednisolone) DROPS moved to preferred	
OPHTHALMIC ANTIINFECTIVES/ANTIINFLAMMATORIES	MAXITROL (neomycin/polymyxin b/dexamethasone) DROPS moved to non-preferred	
OPHTHALMIC ANTIINFLAMMATORIES	Bromfenac sodium & BROMSITE (bromfenac sodium) moved to non-preferred	
OPHTHALMIC ANTIINFLAMMATORIES	DUREZOL (difluprednate) moved to non-preferred	
OPHTHALMIC ANTIINFLAMMATORIES	ketorolac tromethamine 0.4% moved to preferred	
OPHTHALMIC ANTIINFLAMMATORIES	Ketorolac tromethamine 0.5% moved to preferred	
OPHTHALMIC ANTIINFLAMMATORIES	LOTEMAX (loteprednol) DROPS moved to preferred	
OPHTHALMIC ANTIINFLAMMATORIES	LOTEMAX (loteprednol) OINTMENT moved to non-preferred	
OPHTHALMIC ANTIINFLAMMATORIES	NEVANAC (nepafenac) moved to non-preferred	
OPHTHALMIC ANTIINFLAMMATORIES	Prednisolone acetate 1% moved to non-preferred	
OPHTHALMIC ANTIINFLAMMATORIES	Prednisolone sodium phosphate 1% moved to preferred	
OPHTHALMIC ANTIINFLAMMATORIES	PROLENSA (bromfenac) moved to non-preferred	

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CHANGES SINCE LAST VERSION		
Category	**Product Status Changes**	**Criteria Changes**
OPHTHALMIC IMMUNOMODULATORS - DRY EYE SYNDROME		New PDL Category
OPIOID ANALGESIC - LONG ACTING	Tramadol ER moved to non-preferred	Category and PA criteria updated
OTIC ANTI-INFECTIVES - FLUOROQUINOLONES	ofloxacin drops - labeler 24208 moved to preferred	Category PA criteria updated
OTIC ANTI-INFECTIVES - FLUOROQUINOLONES	OTOVEL (ciprofloxacin/fluocinolone) moved to preferred	
PHOSPHATE BINDERS	ELIPHOS (calcium acetate) moved to non-preferred	Velphoro criteria removed
PLATELET AGGREGATION INHIBITORS	AGGRENOX (aspirin/dipyridamole) moved to preferred	
PLATELET AGGREGATION INHIBITORS	Aspirin/dipyridamole ER moved to non-preferred	
PLATELET AGGREGATION INHIBITORS	EFFIENT (prasugrel) moved to non-preferred	
PLATELET AGGREGATION INHIBITORS	Prasugrel added to non-preferred	
PULMONARY HYPERTENSION-Prostacyclins	REMODULIN (treprostinil) moved to preferred	
PULMONARY HYPERTENSION-Soluble Guanylate Cyclase Stimulators		Criteria Changes
STEROID/LONG ACTING BETA AGONIST (LABA) COMBINATION INHALERS		AIRDUO RESPICLICK (fluticasone/salmeterol) criteria added
STEROID/LONG ACTING BETA AGONIST (LABA) COMBINATION INHALERS		Category Criteria updated
STEROID INHALERS	AEROSPAN (flunisolide) moved to non-preferred	Category name changed to STEROIDs - INHALED
STEROID INHALERS	budesonide suspension 0.25 mg/2mL added to preferred	
STEROID INHALERS	budesonide suspension 0.5 mg/2mL added to preferred	

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CHANGES SINCE LAST VERSION		
Category	**Product Status Changes**	**Criteria Changes**
STEROID INHALERS	FLOVENT DISKUS (fluticasone) moved to non-preferred	
STEROID INHALERS	PULMICORT RESPULES (budesonide) 1 mg/2 mL added to preferred	
INFLAMMATORY BOWEL AGENTS (ULCERATIVE COLITIS) - NONSTEROIDAL		Category name changed to ULCERATIVE COLITIS AGENTS - NONSTEROIDAL
URINARY ANTISPASMODICS		Myrbetriq criteria updated

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THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
ADHD AGENTS		
Category PA Criteria: Branded non-preferred agents: A 10-day trial of 2 pharmaceutically equivalent preferred agents will be required before a non-preferred agent will be authorized unless 1 of the exceptions on the PA form is present. Generic non-preferred agents: A 10-day trial of a pharmaceutically equivalent preferred agent will be required before a non-preferred agent will be authorized unless 1 of the exceptions on the PA form is present. Rational of inability to swallow a solid dosage form must be provided after age 9 for all non-solid dosage forms.		
ADDERALL XR (dextroamphetamine/amphetamine)	ADDERALL (dextroamphetamine/amphetamine)	*** Kapvay will require a 1-month trial of immediate release clonidine.
ADZENYS XR - ODT (amphetamine)	Clonidine ER	
APTENSIO XR (methylphenidate)	CONCERTA (methylphenidate)	
Atomoxetine	DEXEDRINE (dextroamphetamine)	
Clonidine	Dexmethylphenidate ER	
COTEMPLA XR - ODT (methylphenidate)	Dextroamphetamine 5 mg/5 ml	
DAYTRANA (methylphenidate)	Dextroamphetamine/amphetamine ER - Labelers 00115, 00228, 00555, 66993	
DESOXYN (methamphetamine)	FOCALIN (dexmethylphenidate)	
Dexmethylphenidate	INTUNIV (guanfacine ER)	
Dextroamphetamine	METADATE ER (methylphenidate)	
Dextroamphetamine ER	METHYLIN (methylphenidate) chew tablets	
Dextroamphetamine/amphetamine	METHYLIN (methylphenidate) solution	
Dextroamphetamine/amphetamine ER - Labeler 00781	RITALIN (methylphenidate)	
DYANAVEL XR (amphetamine)	RITALIN LA (methylphenidate LA capsules - 50-50)	
EVEKEO (amphetamine)	STRATTERA (atomoxetine)	
FOCALIN XR (dexmethylphenidate)	ZENZEDI (dextroamphetamine)	
Guanfacine ER		
KAPVAY (clonidine)[PA***]		
Methamphetamine		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
Methylphenidate CD 30-70		
Methylphenidate chew tablet		
Methylphenidate ER capsules 50-50		
Methylphenidate ER tablet		
Methylphenidate LA capsules - 50-50		
Methylphenidate solution		
Methylphenidate tablet		
MYDAYIS (amphetamine/dextroamphetamine)		
PROCENTRA (dextroamphetamine)		
QUILLICHEW ER (methylphenidate)		
QUILLIVANT XR (methylphenidate)		
VYVANSE (lisdexamfetamine)		
VYVANSE (lisdexamfetamine) CHEW TABLET		
ANGINA		
RANEXA (ranolazine)		
ANALGESICS - NSAIDS - TOPICAL		
Category PA Criteria: A 30-day trial of all preferred agents will be required before a non-preferred agent will be authorized. A medical reason must be provided why preferred agents do not work.		
FLECTOR (diclofenac) PATCH	DERMACINRX LEXITRAL (diclofenac/capsicum)	
PENNSAID (diclofenac)	XRYLIX (diclofenac)	
VOLTAREN (diclofenac) GEL	VOPAC MDS (diclofenac)	
ANDROGENS		
Category PA Criteria: A 30-day trial of all preferred agents will be required before a non-preferred agent will be authorized. All medications require an FDA-approved indication.		
ANDROGEL (testosterone) PACKET 1%PA	AXIRON (testosterone) TOPICAL SOLUTION	
ANDROGEL (testosterone) PACKET 1.62%PA	FORTESTA (testosterone)	
ANDRODERM (testosterone)	NATESTO (testosterone)	
	TESTIM (testosterone)	
	TESTOPEL (testosterone)	
	Testosterone gel	
	Testosterone Gel MD PMP	
	Testosterone topical solution	

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THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	VOGELXO (testosterone) GEL MD PMP	
ANTICOAGULANTS - ORAL		
Category PA Criteria: A 30-day trial of all preferred agents will be required before a non-preferred agent will be authorized. All agents will require an FDA indication.		
ELIQUIS (Apixaban)PA	SAVAYSA (edoxaban)	
PRADAXA (dabigatran)PA		
XARELTO (rivaroxaban)PA		
ANTICONVULSANTS		
Category PA Criteria: Branded non-preferred agents: A 30-day trial of 2 pharmaceutically equivalent preferred agents will be required before a non-preferred agent will be authorized unless 1 of the exceptions on the PA form is present. Generic non-preferred agents: A 30-day trial of a pharmaceutically equivalent preferred agent will be required before a non-preferred agent will be authorized unless 1 of the exceptions on the PA form is present.		
APTIOM (eslicarbazepine)	CARBATROL (carbamazepine)	
BANZEL (rufinamide) ORAL SUSPENSION	DEPAKENE (valproic acid) CAPSULE	
BANZEL (rufinamide) TABLET	DEPAKENE (valproic acid) ORAL SOLUTION	
BRIVIACT (brivaracetam)	DEPAKOTE (divalproex sodium) TABLET	
Carbamazepine chewable tablet	DEPAKOTE ER (divalproex sodium)	
Carbamazepine ER capsule	DEPAKOTE SPRINKLE (divalproex sodium)	
Carbamazepine oral suspension	DILANTIN (phenytoin) CHEWABLE TABLET	
Carbamazepine tablet	DILANTIN (phenytoin) ORAL SUSPENSION	
Carbamazepine XR tablet	DILANTIN ER (phenytoin)	
CELONTIN (methsuximide)	EPITOL (carbamazepine)	
Divalproex ER	FELBATOL (felbamate)	
Divalproex sprinkle	FELBATOL (felbamate) ORAL SUSPENSION	
Divalproex tablet	KEPPRA (levetiracetam)	
Ethosuximide capsule	KEPPRA (levetiracetam) ORAL SOLUTION	
Ethosuximide oral solution	KEPPRA XR (levetiracetam)	
Felbamate oral suspension	LAMICTAL (lamotrigine)	
Felbamate tablet	LAMICTAL (lamotrigine) CHEWABLE TABLET	

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THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
FYCOMPA (perampanel)	LAMICTAL (lamotrigine) DOSE PACK	
FYCOMPA (perampanel) ORAL SUSPENSION	MYSOLINE (primidone)	
Gabapentin capsule	NEURONTIN (gabapentin) CAPSULE	
Gabapentin oral solution	NEURONTIN (gabapentin) ORAL SOLUTION	
Gabapentin tablet	NEURONTIN (gabapentin) TABLET	
GABITRIL (tiagabine)	QUDEXY XR (topiramate)	
LAMICTAL ER (lamotrigine) DOSE PACK	TEGRETOL XR (carbamazepine)	
LAMICTAL ODT (lamotrigine)	TEGRETROL (carbamazepine oral suspension)	
LAMICTAL ODT (lamotrigine) DOSE PACK	TOPAMAX (topiramate)	
LAMICTAL XR (lamotrigine)	TOPAMAX (topiramate) SPRINKLE CAPSULE	
Lamotrigine chewable tablet	TRILEPTAL (oxcarbazepine)	
Lamotrigine dose pack	TRILEPTAL (oxcarbazepine) ORAL SUSPENSION	
Lamotrigine ER	ZARONTIN (ethosuximide)	
Lamotrigine ODT	ZARONTIN (ethosuximide) ORAL SOLUTION	
Lamotrigine tablet	ZONEGRAN (zonisamide)	
Levetiracetam ER		
Levetiracetam oral solution		
Levetiracetam tablet		
LYRICA (pregabalin)		
LYRICA (pregabalin) ORAL SOLUTION		
Oxcarbazepine oral solution		
Oxcarbazepine tablet		
OXTELLAR XR (oxcarbazepine)		
PEGANONE (Ethotoin)		
Phenobarbital elixir		
Phenobarbital tablet		
PHENYTEK (phenytoin)		
Phenytoin chewable tablet		
Phenytoin ER capsule		
Phenytoin suspension		
POTIGA (ezogabine)		
Primidone		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
SABRIL (vigabatrin)		
SABRIL (vigabatrin) POWDER PACK		
SPRITAM (levetiracetam)		
TEGRETOL (carbamazepine)		
Tiagabine		
Topiramate ER		
Topiramate sprinkle capsule		
Topiramate tablet		
TROKENDI XR (topiramate)		
Valproic acid capsule		
Valproic acid oral solution		
VIMPAT (lacosamide)		
VIMPAT (lacosamide) ORAL SOLUTION		
Zonisamide		
ANTIDEMENTIA		
Category PA Criteria: All agents will require an FDA indication for patients younger than 30 years old. Branded non-preferred agents: A 30-day trial of 2 pharmaceutically preferred agents will be required before a non-preferred agent will be authorized unless 1 of the exceptions on the PA form is present. A 30-day trial of 2 preferred generics of the same medication will satisfy this requirement. Generic non-preferred agents: A 30-day trial of a pharmaceutically equivalent preferred agent will be required before a non-preferred agent will be authorized unless 1 of the exceptions on the PA form is present.		
Donepezil	ARICEPT (donepezil)	***Namenda XR – A 30-day trial of memantine IR will be required before Namenda XR will be authorized.
EXELON (rivastigmine)	Donepezil ODT	
EXELON (rivastigmine) PATCH	NAMENDA (memantine)	
Galantamine	NAMZARIC (memantine/donepezil)	
Galantamine ER	RAZADYNE (galantamine)	
Galantamine oral solution	RAZADYNE ER (galantamine)	
Memantine	Rivastigmine patch	
NAMENDA (memantine) ORAL SOLUTION		
NAMENDA XR (memantine)***		
Rivastigmine		

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THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
ANTIDEPRESSANTS - NEW GENERATION		
Category PA Criteria: Branded non-preferred agents: A 30-day trial of 2 pharmaceutically equivalent preferred agents will be required before a non-preferred agent will be authorized unless 1 of the exceptions on the PA form is present. Generic non-preferred agents: A 30-day trial of a pharmaceutically equivalent preferred agent will be required before a non-preferred agent will be authorized unless 1 of the exceptions on the PA form is present.		
Bupropion SR tablet	APLENZIN ER (bupropion)	
Bupropion tablet	CELEXA (citalopram)	
Bupropion XL tablet	CYMBALTA (duloxetine)	
Citalopram	Desvenlafaxine ER	
Citalopram oral solution	Desvenlafaxine fumarate ER	
Clomipramine	Desvenlafaxine succinate ER - labelers 00591, 51991, 68180	
Desvenlafaxine succinate ER - labeler 59762	EFFEXOR XR (venlafaxine)	
Duloxetine	FORFIVO XL (bupropion)	
Escitalopram	IRENKA (duloxetine)	
Escitalopram oral solution	KHEDEZLA ER (desvenlafaxine)	
FETZIMA (levomilnacipran)	LEXAPRO (escitalopram)	
Fluoxetine capsule	LEXAPRO (escitalopram) ORAL SOLUTION	
Fluoxetine DR	PAXIL (paroxetine)	
Fluoxetine solution	PAXIL CR (paroxetine)	
Fluoxetine tablet	PRISTIQ ER (desvenlafaxine)	
Fluvoxamine	PROZAC (fluoxetine)	
Fluvoxamine ER	venlafaxine ER tablets	
Nefazodone	WELLBUTRIN (bupropion)	
OLEPTRO ER (trazodone)	WELLBUTRIN SR (bupropion)	
Paroxetine	WELLBUTRIN XL (bupropion)	
Paroxetine ER	ZOLOFT (sertraline)	
PAXIL (paroxetine) ORAL SUSPENSION	ZOLOFT (sertraline) ORAL CONCENTRATE	
PEXEVA (paroxetine)		
Sertraline		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
Sertraline oral concentrate		
Trazodone		
TRINTELLIX (vortioxetine)		
Venlafaxine ER capsules		
Venlafaxine tablet		
VIIBRYD (vilazodone)		
ANTIRETROVIRALS - NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS		
Abacavir	EPIVIR (lamivudine)	
Abacavir/lamivudine	EPZICOM (abacavir)	
Abacavir/lamivudine/zidovudine	TRIZIVIR (abacavir/lamivudine)	
ATRIPLA (efavirenz/emtricitabine/tenofovir)	VIDEX EC (didanosine)	
COMBIVIR (lamivudine/zidovudine)	VIREAD (tenofovir)	
COMPLERA (emtricitabine/rilpivirine/tenofovir)	ZERIT (stavudine)	
DESCOVY (emtricitabine/tenofovir)	ZIAGEN (abacavir)	
Didanosine		
EMTRIVA (emtricitabine)		
GENVOYA (elvitegravir/cobicistat/emtricitabine/tenofovir)		
Lamivudine		
Lamivudine/zidovudine		
ODEFSEY (emtricitabine/rilpivirine/tenofovir)		
RETROVIR (zidovudine)		
Stavudine		
STRIBILD (elvitegravir/cobicistat/emtricitabine/tenofovir)		
Tenofovir		
TRIUMEQ (abacavir/dolutegravir/lamivudine)		
TRUVADA (emtricitabine/tenofovir)		
VIDEX (didanosine)		
Zidovudine		
ANTIRETROVIRALS - PROTEASE INHIBITORS		
APTIVUS (tipranavir)	KALETRA (lopinavir/ritonavir)	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
CRIXIVAN (indinavir)		
EVOTAZ (atazanavir/cobicistat)		
GENVOYA (elvitegravir, cobicistat, emtricitabine and tenofovir)		
INVERASE (saquinavir)		
LEXIVA (fosamprenavir)		
lopinavir/ritonavir		
NORVIR (ritonavir)		
PREZCOBIX (darunavir/cobicistat)		
PREZISTA (darunavir)		
RAYATAZ (atazanavir)		
VIRACEPT (nelfinavir)		
ATYPICAL ANTIPSYCHOTICS		
Category PA Criteria: Branded non-preferred agents: A 30-day trial of 2 pharmaceutically equivalent preferred agents will be required before a non-preferred agent will be authorized unless 1 of the exceptions on the PA form is present. Generic non-preferred agents: A 30-day trial of a pharmaceutically equivalent preferred agent will be required before a non-preferred agent will be authorized unless 1 of the exceptions on the PA form is present.		
ABILIFY (aripiprazole) ORAL SOLUTION	ABILIFY (aripiprazole)	
ABILIFY DISCMELT (aripiprazole)	CLOZARIL (clozapine)	
Aripiprazole	GEODON (ziprasidone)	
Clozapine	INVEGA ER (paliperidone)	
Clozapine ODT	quetiapine ER - labelers 00406, 16729, 49884, 52817	
FANAPT (iloperidone)	RISPERDAL (risperidone)	
FAZACLO (clozapine) RAPDIS	RISPERDAL (risperidone) ORAL SOLUTION	
LATUDA (lurasidone)	RISPERDAL M-TAB (risperidone)	
Olanzapine	SEROQUEL (quetiapine)	
Olanzapine ODT	SEROQUEL XR (quetiapine)	
Olanzapine/fluoxetine	ZYPREXA (olanzapine)	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
Paliperidone ER	ZYPREXA ZYDIS (olanzapine)	
Quetiapine		
quetiapine ER - labeler 00310		
REXULTI (brexpiprazole)		
Risperidone		
Risperidone ODT		
Risperidone oral solution		
SAPHRIS (asenapine)		
SEROQUEL XR (quetiapine) 400mg		
SYMBYAX (olanzapine/fluoxetine)		
VRAYLAR (cariprazine)		
Ziprasidone		
ATYPICAL ANTIPSYCHOTICS - LONG ACTING		
ABILIFY MAINTENA (aripiprazole)		
ARISTADA (aripiprazole lauroxil)		
INVEGA SUSTENNA (paliperidone)		
INVEGA TRINZA (paliperidone)		
RISPERDAL CONSTA (risperidone)		
ZYPREXA RELPREVV (olanzapine)		
CONSTIPATION - IRRITABLE BOWEL SYNDROME/OPIOID INDUCED		
Category PA Criteria: Patients must be 18 years old. All medications will require an FDA indication. For opioid-induced constipation, a paid claim for an opioid must be on patient's profile and a 30 day trial of Amitiza will be required before a non-preferred oral agent will be authorized. For idiopathic constipation, a 30 day trial of all preferred agents will be required before a non-preferred agent will be authorized.		
AMITIZA (lubiprostone)	MOVANTIK (naloxegol)	***Linzess – A 30-day trial of Amitiza is required before Linzess will be authorized. ***Relistor Syringe/Vial – Documentation must be submitted to show inability to swallow a solid dosage form
LINZESS (linaclotide)PA***	RELISTOR (methylnaltrexone) SYRINGE***	
	RELISTOR (methylnaltrexone) TABLET***	
	RELISTOR (methylnaltrexone) VIAL***	
	SYMPROIC (naldemedine)	
	TRULANCE (plecanatide)	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
		***Relistor tablets - A 30 day trial of Movantik is required before Relistor tablets will be authorized
COPD		
Category PA Criteria: All preferred agents indicated only for COPD will require verification of FDA-approved indication for patients who are younger than 40 years of age. All non-preferred agents will require an FDA-approved indication regardless of age.		
Long Acting Anticholinergics		
Group PA Criteria: A 30-day trial of all preferred agents will be required before a non-preferred agent will be authorized.		
SPIRIVA (tiotropium)	INCRUSE ELLIPTA (umeclidinium)	***SPIRIVA RESPIMAT 2.5 MG (tiotropium) will require a 30 day trial of Incruse Ellipta and Tudorza Pressair in addition to Category PA Criteria
	SPIRIVA RESPIMAT 2.5 MG (tiotropium)***	
	TUDORZA PRESSAIR (aclidinium)	
Long Acting Beta Agonists		
PERFOROMIST (formoterol)	ARCAPTA NEOHALER (indacaterol)***	***Arcapta Neohaler/Striverdi Respimat will require a 30 day trial of Serevent in addition to Category PA Criteria ***Brovana will require a 30 day trial of Perforomist in addition to Category PA Criteria
SEREVENT (salmeterol)	BROVANA (arformoterol)***	
	STRIVERDI RESPIMAT (olodaterol)***	
Combination Anticholinergics/Long Acting Beta Agonists		
Group PA Criteria: All preferred agents indicated only for COPD will require verification of FDA-approved indication for patients who are younger than 40 years of age. A 30-day trial of 2 long acting preferred products will be required before a non-preferred agent (short or long acting) will be authorized.		
Albuterol/ipratropium	COMBIVENT RESPIMAT (albuterol/ipratropium)	
ANORO ELLIPTA (umeclidinium/vilanterol)	DUONEB (albuterol/ipratropium)	
BEVESPI AEROSPHERE (glycopyrrolate/formoterol)	STIOLTO RESPIMAT (tiotropium/olodaterol)	
	UTIBRON NEOHALER (glycopyrrolate/indacaterol)	
Combination Steroid/Anticholinergics/Long Acting Beta Agonists		
Group PA Criteria: In addition to the category PA criteria, patient must a 30 day trial of all preferred agents in the following combinations: 1. Steroid/Long Acting Beta Agonist (LABA) Combination Inhalers + Long Acting Anticholinergics 2. Combination Anticholinergics/Long Acting Beta Agonist + Inhaled Steriod		
	TRELEGY ELLIPTA (Fluticasone Furoate/Umeclidinium/Vilanterol)	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
PDE4 - Inhibitor		
Group PA Criteria: In addition to the category PA criteria, patient must have a history of exacerbations treated with corticosteroids within the last year for initial requests and must have had a decreased number of exacerbations treated with corticosteroids with Daliresp treatment with renewals. Patient must also have had a 30 day trial with a medication in each of the following therapeutic classes from either single ingredient or combination products: 1. Long acting anticholinergic 2. Long acting beta agonist 3. Inhaled Steroid		
	DALIRESP (roflumilast)	
CYSTIC FIBROSIS INHALED ANTIBIOTICS		
Category PA Criteria: A 28-day trial of 1 preferred agent will be required before a non-preferred agent will be authorized. Non-preferred agents will require that the patient not have been colonized with Burkholderia cepacia and an FDA-approved age and indication.		
BETHKIS (tobramycin)	CAYSTON (aztreonam)***	***Cayston – Patient must have a forced expiratory volume in less than 1 second (FEV1) of less than 25% or greater than 75% predicted. ***Tobramycin/TOBI Podhaler – Patient must have a forced expiratory volume in less than 1 second (FEV1) of less than 40% or greater than 80% predicted. Patient must not have been colonized with *Burkholderia cepacia.*
KITABIS PAK (tobramycin/nebulizer)	TOBI PODHALER (Tobramycin)***	
	Tobramycin***	
	TOBI (Tobramycin)***	
CYTOKINE MODULATORS		
Category PA Criteria: A 3-month trial of 2 preferred agents will be required before a non-preferred agent will be authorized. All agents will require an FDA-approved indication.		
COSENTYX (secukinumab)[PA]	ACTEMRA (tocilizumab)	
ENBREL (etanercept)[PA]	CIMZIA (certolizumab)	
HUMIRA (adalimumab)[PA]	KEVZARA (sarilumab)	
HUMIRA PSORIASIS (adalimumab)[PA]	KINERET (anakinra)	
	ORENCIA (abatacept)	
	OTEZLA (apremilast)	
	SILIQ (brodalumab)	
	SIMPONI (golimumab)	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	STELARA (ustekinumab)	
	TALTZ (ixekizumab)	
	TREMFYA (guselkumab)	
	XELJANZ (tofacitinib)	
	XELJANZ XR (tofacitinib)	
DIABETES - DPP4 INHIBITORS		
Category PA Criteria: Non preferred agents will require: 1. A 30-day trial of 1 sitagliptin preferred product (Janumet, Janumet XR, or Januvia) and 1 linagliptin preferred product (Jentadueto or Tradjenta). 2. An FDA approved indication. 3. Concurrent metformin therapy. 4. A 3-month trial of metformin		
JANUMET (sitagliptin/metformin)	alogliptan/pioglitzone	***Onglyza - will require an FDA indication, a 3 month trial of metformin and concurrent metformin therapy
JANUMET XR (sitagliptin/metformin)	alogliptin/metformin	
JANUVIA (sitagliptin)	JENTADUETO XR (linagliptin/metformin)	
JENTADUETO (linagliptin/metformin)	KAZANO (alogliptin/metformin)	
KOMBIGLYZE XR (saxagliptin/metformin)	NESINA (alogliptin)	
ONGLYZA (saxagliptin)PA***	OSENI (alogliptin/pioglitazone)	
TRADJENTA (linagliptin)	alogliptin	
DIABETES - GLP1 AGONISTS		
Category PA Criteria: Preferred agents will require: 1. A 3-month trial of metformin. Non preferred agents will require: 1. A 30-day trial of 2 preferred agents. 2. An FDA indication. 3. Concurrent metformin therapy. 4. A 3-month trial of metformin		
BYDUREON (exenatide microspheres)	ADLYXIN (lixisenatide)	
BYETTA (exenatide)	TRULICITY (dulaglutide)	
VICTOZA (liraglutide)	TANZEUM (albiglutide)	

This is NOT an all-inclusive list of covered medications or medications that require prior authorization. Only PDL managed categories are included. Refer to cover page for complete list of rules governing this PDL.

Visit http://www.hidesigns.com/ndmedicaid for more information on medications not found in this list.

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
DIABETES - INSULIN/GLP1 AGONISTS		
Category PA Criteria: 1. A 30-day trial of exenatide and liraglutide GLP-1 agonists in combination with each of insulin glargine and insulin detemir insulins 2. An FDA indication. 3. Concurrent metformin therapy. 4. A 3-month trial of metformin		
	SOLIQUA (Insulin glargine/lixisenatide)	
	XULTOPHY (insulin degludec/liraglutide)	
DIABETES - INSULIN		
Syringe/Pens: • Prescriber must provide a reason why patient needs to use a syringe/pen instead of a vial, subject to clinical review **Vials of non-preferred insulin:** • Patient must have failed a 30 day trial of a preferred insulin: Humalog, Humalox Mix 50/50, Humalog Mix 75/25, Humulin 70/30, Humulin N, Humulin R, Humulin R U-500, Lantus, Levemir, Novolin R, Novolog, or Novolog Mix 70/30, as evidenced by paid claims or pharmacy print outs.		
APIDRA (insulin glulisine) VIAL	AFREZZA (insulin regular, human)	***Fiasp •Patient must have had 30 day trial with Novolog, Humalog, and Apidra ***Tresiba U-1 00 & Basaglar: •Patient must fail a 3 month trial of both Lantus and Levemir with good compliance, as evidenced by paid claims or pharmacy print outs. ***Toujeo/Tresiba U-200: •Patient must require a minimum of 100 units/day of Lantus or Levemir for a minimum of 3 months with good compliance, as evidenced by paid claims or pharmacy print outs.
APIDRA SOLOSTAR (insulin glulisine) INSULIN PEN	BASAGLAR KWIKPEN U-100 (insulin glargine)***	
HUMALOG (insulin lispro) VIAL	FIASP (insulin aspart) FLEXTOUCH***	
HUMALOG MIX 50/50 (insulin NPL/insulin lispro) VIAL	FIASP (insulin aspart) VIAL***	
HUMALOG MIX 75/25 (insulin NPL/insulin lispro) VIAL	HUMALOG (insulin lispro) CARTRIDGE	
HUMULIN 70/30 (insulin NPH human/regular insulin human) VIAL	HUMALOG (insulin lispro) KWIKPEN	
HUMULIN N (insulin NPH human isophane) VIAL	HUMALOG JUNIOR KWIKPEN (insulin lispro)	
HUMULIN R (insulin regular, human) VIAL	HUMALOG MIX 50/50 (insulin NPL/insulin lispro) KWIKPEN	
HUMULIN R U-500 (insulin regular, human) VIAL	HUMALOG MIX 75/25 (insulin NPL/insulin lispro) KWIKPEN	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
LANTUS (insulin glargine) SOLOSTAR	HUMULIN 70/30 (insulin NPH human/regular insulin human) KWIKPEN	
LANTUS (insulin glargine) VIAL	HUMULIN N (insulin NPH human isophane) KWIKPEN	
LEVEMIR (insulin detemir) VIAL	HUMULIN R (Insulin regular, human) U-500 KWIKPEN	
LEVEMIR (insulin detemir) FLEXTOUCH	NOVOLIN 70-30 (insulin NPH human/regular insulin human) VIAL	
NOVOLIN R (insulin regular, human) VIAL	NOVOLIN N (insulin NPH human isophane) VIAL	
NOVOLOG (insulin aspart) CARTRIDGE	TOUJEO SOLOSTAR (insulin glargine)***	
NOVOLOG (insulin aspart) FLEXPEN	TRESIBA (insulin degludec) FLEXTOUCH U-100***	
NOVOLOG (insulin aspart) VIAL	TRESIBA (insulin degludec) FLEXTOUCH U-200***	
NOVOLOG MIX 70/30 (insulin aspart protamine/insulin aspart) FLEXPEN		
NOVOLOG MIX 70/30 (insulin aspart protamine/insulin aspart) VIAL		
DIABETES - SGLT2 INHIBITORS		
Category PA Criteria: Non-preferred agents will require: 1. An FDA indication. 2. A 3-month trial of a metformin 3. A 3-month trial of a canagliflozin and a 3-month trial of a empagliflozin agent. 4. Concurrent metformin therapy – this condition will be considered met if requested product is a metformin combination agent.		
INVOKAMET (canagliflozin)	FARXIGA (dapagliflozin)	
INVOKANA (canagliflozin)	GLYXAMBI (empagliflozin/linagliptin)	
JARDIANCE (empagliflozin)	INVOKAMET XR (canagliflozin/metformin)	
SYNJARDY (empagliflozin/metformin)	XIGDUO XR (dapagliflozin/metformin)	
SYNJARDY XR (empagliflozin/metformin)		
DIARRHEA - IRRITABLE BOWEL SYNDROME		
Category PA Criteria: Patient must be 18 years of age or older. A 30-day trial of all preferred agents will be required before a non-preferred medication will be approved.		
loperimide	alosetron***	***Alosetron– Patient must be a female.
LOTRONEX (alosetron)***		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
VIBERZI (eluxadoline)		
XIFAXIN (rifaximin) 550 mg tablet		
DIGESTIVE ENZYMES		
Category PA Criteria: A 30-day trial of all preferred agents will be required before a non-preferred agent will be authorized unless 1 of the exceptions on the PA form is present.		
CREON (lipase/protease/amylase)	PANCREAZE (lipase/protease/amylase)	
ZENPEP (lipase/protease/amylase)	PANCRELIPASE (lipase/protease/amylase)	
	PERTZYE (lipase/protease/amylase)	
	ULTRESA (lipase/protease/amylase)	
	VIOKACE (lipase/protease/amylase)	
EPINEPHRINE AUTOINJECTORS		
Category PA Criteria: Medical justification must be provided for why the preferred product will not work.		
epinephrine - labeler 49502	ADRENACLICK (epinephrine)	
	epinephrine - labelers 00115, 54505	
	EPIPEN (epinephrine)	
	EPIPEN JR (epinephrine)	
GROWTH HORMONE		
Category PA Criteria: 1. Patients new to GH therapy must meet the criteria below and be started on a preferred growth hormone. 2. Patients continuing GH therapy and having met the criteria listed below must be switched to a preferred growth hormone. Additional criteria applies. For details, see http://hidesigns.com/assets/files/ndmedicaid/2017/Criteria/growth_hormone_criteria.pdf		
GENOTROPIN (somatropin)[PA]	HUMATROPE (somatropin)	
GENOTROPIN MINIQUICK (somatropin)[PA]	NUTROPIN AQ (somatropin)	
NORDITROPIN FLEXPRO (somatropin)[PA]	OMNITROPE (somatropin)	
	SAIZEN (somatropin)	
	ZOMACTON (somatropin)	
HEART FAILURE - NEPRILYSIN INHIBITOR/ANGIOTENSIN RECEPTOR BLOCKER		
Category PA Criteria: 1. Patient must have symptomatic chronic heart failure (NYHA class II-IV). 2. Patient must have systolic dysfunction (left ventricular ejection fraction ≤ 40%).		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
ENTRESTO (sacubitril/valsartan)		
HEMATOPOIETIC, COLONY STIMULATING FACTORS		
GRANIX (TBO-Filgrastim)		
LEUKINE (Sargramostim)		
NEULASTA (Pegfilgrastim)		
NEUPOGEN (Filgrastim)		
ZARXIO (Filgrastim-SNDZ)		
HEMATOPOIETIC, ERYTHROPOIESIS STIMULATING AGENTS		
Category PA Criteria: All agents will require an FDA indication. A 4-week trial of all preferred products will be required before non-preferred agents will be authorized.		
ARANESP (darbepoetin alfa)[PA]	EPOGEN (epoetin alfa)	
PROCRIT (epoetin alfa)[PA]	MIRCERA (methoxy polyethylene glycol-epoetin beta)	
HEPATITIS C TREATMENTS		
Category PA Criteria: Non-preferred agents will require a failed trial of all preferred treatment options indicated for the patient's genotype and be labeled for failure of previous treatment. 1. Patient must have an FDA-approved diagnosis. 2. Patient must be an FDA-approved age. 3. Patient must attest that they will continue treatment without interruption for the duration of therapy. 4. Prescriber must be, or consult with, a hepatologist, gastroenterologist, or infectious disease specialist. 5. Prescriber must provide documentation that the patient has been drug and alcohol free for the past 12 months. Documentation includes at least 2 drug and alcohol tests dated at least 3 months apart and chart notes addressing patient's alcohol and drug free status throughout the past year. 6. HCV RNA level must be taken on week 4 and sent with a renewal request for any duration of treatment 12 weeks or longer. 7. Females using ribavirin must have a negative pregnancy test in the last 30 days and receive monthly pregnancy tests during treatment. 8. Patient must have established compliant behavior including attending scheduled provider visits (defined as 1 or less no-shows) and filling maintenance medications on time as shown in the prescription medication history for the past 12 months. 9. Patient must be tested for hepatitis B, and if the test is positive, hepatitis B must either be treated or closely monitored if patient does not need treatment. 10. Patient must not have life expectancy of less than 12 months due to non-liver related comorbid conditions. 11. PA approval duration will be based on label recommendation.		
EPCLUSA (sofosbuvir/velpatasvir)[PA***]	DAKLINZA (Daclatasvir)	***Epclusa: • Must be used with ribavirin for patients with decompensated cirrhosis (Child-Pugh B or Child-Pugh
MAVYRET (glecaprevir/pibrentasvir)[PA***]	HARVONI (ledipasvir/sofosbuvir)	
	OLYSIO (simeprevir)	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	SOVALDI (sofosbuvir)	C). ***Mavyret/Vosevi: • Patient must not have decompensated cirrhosis (Child-Pugh B or Child-Pugh C)
	TECHNIVIE (ombitasvir/paritaprevir/ritonavir)	
	VIEKIRA PAK (dasabuvir/ombitasvir/paritaprevir/ritonavir)	
	VIEKIRA PAK XR (dasabuvir/ombitasvir/paritaprevir/ritonavir)	
	VOSEVI (sofosbuvir/velpatasvir/voxilaprevir)	
	ZEPATIER (elbasvir/grazoprevir)	
LICE		
Category PA Criteria: A 28-day/2-application trial of each of the preferred agents will be required before a non-preferred agent will be authorized. This requirement will be waived in the presence of a documented community breakout of a resistant strain that is only susceptible to a non-preferred agent.		
EURAX (crotamiton) CREAM	ELIMITE (permethrin) CREAM	
LICE SOLUTION (piperonyl butoxide/pyrethrins)	EURAX (crotamiton) LOTION	
NATROBA (spinosad)	Malathion	
Permethrin cream	OVIDE (malathion)	
SKLICE (ivermectin)	Spinosad	
ULESFIA (benzyl alcohol)		
MIGRAINE PROPHYLAXIS - 5HT(1) AGONISTS		
Category PA Criteria: Patients 18 years old or older: A 30-day trial of all preferred agents in the past 24 months will be required before a non-preferred agent will be authorized. Patients 6 to 17 years of age: A 30-day trial of rizatriptan in the past 24 months will be required before a non-preferred agent will be authorized.		
RELPAX (eletriptan)	Almotriptan	***Treximet – For patients 18 years or older, the patient must be stable on the combination product and have had a 30-day trial of naproxen in addition to sumatriptan to be approved. This criteria is in addition to the class criteria.
Rizatriptan	ALSUMA (sumatriptan) PEN INJCTR***	
Rizatriptan tab rap. dis.	AMERGE (naratriptan)	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
Sumatriptan tablet	Eletriptan	***Frovatriptan – A 30-day trial of naratriptan 2.5 mg within the past 24 months will be required in addition to the class criteria. The patient's migraine headaches must either menstrual, long in duration, and/or recurring. ***Almotriptan – A 30-day trial of Zolmitriptan 5 mg in the past 24 months will be required in addition to the class criteria. **Zembrance Symtouch/Sumatriptan Injection – A 30-day trial of Naratriptan 2.5 mg, Sumatriptan Nasal Spray 20 mg, Zomig Nasal Spray 5 mg, Zolmitriptan 5 mg, Axert 12.5 mg, Treximet, and Frova in the past 24 months will be required in addition to the class criteria.
	FROVA (frovatriptan)***	
	Frovatriptan	
	IMITREX (sumatriptan) CARTRIDGE***	
	IMITREX (sumatriptan) PEN INJCTR***	
	IMITREX (sumatriptan) SPRAY	
	IMITREX (sumatriptan) TABLET	
	IMITREX (sumatriptan) VIAL***	
	MAXALT (rizatriptan)	
	MAXALT MLT (rizatriptan)	
	Naratriptan	
	ONSETRA XSAIL (sumatriptan)***	
	Sumatriptan cartridge***	
	Sumatriptan pen injctr***	
	Sumatriptan spray	
	Sumatriptan syringe***	
	Sumatriptan vial***	
	SUMAVEL DOSEPRO (sumatriptan)	
	TREXIMET (sumatriptan/naproxen)***	
	Zolmitriptan	
	Zolmitriptan ODT	
	ZOMIG (zolmitriptan)	
	ZOMIG (zolmitriptan) SPRAY	
	ZOMIG ODT (zolmitriptan)	
MULTIPLE SCLEROSIS		
Interferons		
Category PA Criteria: A 3-month long trial of a preferred agent will be required before a non-preferred agent will be authorized. An FDA indication is required.		
AVONEX (interferon beta-1A) PEN	EXTAVIA (interferon beta-1B)	
AVONEX (interferon beta-1A) SYRINGE	PLEGRIDY (peginterferon beta-1A) PEN	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
AVONEX (interferon beta-1A) VIAL	PLEGRIDY (peginterferon beta-1A) SYRINGE	
BETASERON (interferon beta-1B)	REBIF (interferon beta-1A)	
	REBIF REBIDOSE (interferon beta-1A)	
Injectable Non-Interferons		
Category PA Criteria: A 3-month long trial of all preferred agents and 3-month trials of Aubagio, Tecfidera, and Gilenya will be required before a non-preferred agent will be authorized. If patient has a documented intolerance, hypersensitivity, or labeled contraindication to Copaxone, a 3-month trial of interferon beta-1 is required. An FDA indication is required. Prescriber must be a neurologist		
COPAXONE (glatiramer) 20 MG/ML	COPAXONE (glatiramer) 40 MG/ML***	***Zinbryta: • Transaminase and bilirubin levels must have been obtained within 6 months of request. • Patient must not have hepatitis B or C. • Patient must be screened for TB and have been treated if TB positive. • If patient has early aggressive disease defined as ≥ 2 relapses in the year and ≥ 1 Gadolinium (Gd)+ lesion, the trials of oral non-interferons will not be required. • Patient must have Anti-JC virus antibodies taken. ***Copaxone/Glatopa: • A reason must be indicated why Copaxone 20 mg/mL will not work.
	Glatopa (glatiramer)***	
	ZINBRYTA (daclizumab)***	
Oral Non-Interferons		
Category PA Criteria: A 3-month long trial of all preferred agents and Copaxone will be required before a non-preferred agent will be authorized. If patient has a documented intolerance, hypersensitivity, or labeled contraindication to Copaxone, a 3-month trial of interferon beta-1 is required for non-preferred agents. An FDA indication is required. Prescriber must be a neurologist.		
AUBAGIO (teriflunomide)	TECFIDERA (dimethyl fumarate)***	*** Tecfidera: Patient must have had a CBC with lymphocyte count within 6 months of request.
GILENYA (fingolimod)		
OPHTHALMIC ALPHA ADRENERGICS - GLAUCOMA		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
Category PA Criteria: A 30-day trial of 2 preferred agents will be required before a non-preferred agent will be authorized unless 1 of the exceptions on the PA form is present. A 30-day trial of 2 preferred generics of the same medication will satisfy this requirement.		
ALPHAGAN P 0.1% (brimonidine)	Apraclonidine	
ALPHAGAN P 0.15% (brimonidine)	brimonidine 0.15%	
Apraclonidine	IOPIDINE (apraclonidine)	
brimonidine 0.2%		
COMBIGAN (brimonidine/timolol)		
SIMBRINZA (brinzolamide/brimonidine)		
OPHTHALMIC ANTIHISTAMINES		
Category PA Criteria: A 30-day trial of 3 preferred agents will be required before a non-preferred agent will be authorized.		
ALOCRIL (nedocromil)	ELESTAT (epinastine)	
ALOMIDE (lodoxamide)	EMADINE (emedastine)	
Azelastine	Olopatadine 0.2%	
BEPREVE (bepotastine)	PATANOL 0.1% (olopatadine)	
Cromolyn		
Epinastine		
LASTACAFT (alcaftadine)		
Olopatadine 0.1%		
PATADAY 0.2% (olopatadine)		
PAZEO (olopatadine)		
OPHTHALMIC ANTIINFECTIVES		
Category PA Criteria: A 3-day trial of 3 preferred agents will be required before a non-preferred agent will be authorized unless 1 of the exceptions on the PA form is present.		
AZASITE (azithromycin) DROPS	Bacitracin ointment	
Bacitracin/polymyxin ointment	BLEPH-10 (sulfacetamide) DROPS	
BESIVANCE (besifloxacin) DROPS	CILOXAN (ciprofloxacin) DROPS	
CILOXAN (ciprofloxacin) OINTMENT	Gatifloxacin drops	
Ciprofloxacin drops	GENTAK (gentamicin sulfate) OINTMENT	
Erythromycin ointment	Levofloxacin drops	
Gentamicin sulfate drops	moxifloxacin drops	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
Gentamicin sulfate ointment	NEO-POLYCIN (neomycin SU/bacitracin/polymyxin B) OINTMENT	
MOXEZA (moxifloxacin) DROPS	NEOSPORIN (neomycin SU/polymyxin B/gramicidin) DROPS	
Neomycin SU/bacitracin/polymyxin B ointment	OCUFLOX (ofloxacin) DROPS	
Neomycin SU/polymyxin B/gramicidin drops	POLYCIN (bacitracin/polymyxin) OINTMENT	
Ofloxacin drops	POLYTRIM (polymyxin B/trimethoprim) DROPS	
Polymyxin B/trimethoprim drops	Sulfacetamide ointment	
Sulfacetamide drops	TOBREX (tobramycin) DROPS	
Tobramycin drops	VIGAMOX (moxifloxacin) DROPS	
TOBREX (tobramycin) OINTMENT	ZYMAXID (gatifloxacin) DROPS	
OPHTHALMIC ANTIINFECTIVES/ANTIINFLAMMATORIES		
Category PA Criteria: A 7-day trial of 2 preferred agents will be required before a non-preferred agent will be authorized unless 1 of the exceptions on the PA form is present.		
Neomycin/bacitracin/polymyxin b/hydrocortisone ointment	BLEPHAMIDE (sulfacetamide/prednisolone) DROPS	
BLEPHAMIDE (sulfacetamide/prednisolone) DROPS	BLEPHAMIDE S.O.P. (sulfacetamide/prednisolone) ointment	
Neomycin/polymyxin b/dexamethasone drops	MAXITROL (neomycin/polymyxin b/dexamethasone) DROPS	
Neomycin/polymyxin b/dexamethasone ointment	MAXITROL (neomycin/polymyxin b/dexamethasone) OINTMENT	
PRED-G (gentamicin/prednisol ac) DROPS	Neomycin/polymyxin b/hydrocortisone drops	
PRED-G (gentamicin/prednisol ac) OINTMENT	NEO-POLYCIN HC (neomycin SU/bacitracin/polymyxin B/hydrocortisone) OINTMENT	
Sulfacetamide/prednisolone drops	TOBRADEX ST (tobramycin/dexamethasone) DROPS	
TOBRADEX (tobramycin/dexamethasone) DROPS	Tobramycin/dexamethasone	
TOBRADEX (tobramycin/dexamethasone) OINTMENT		
ZYLET (tobramycin/lotepred etab) DROPS		

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Visit http://www.hidesigns.com/ndmedicaid for more information on medications not found in this list.

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
OPHTHALMIC ANTIINFLAMMATORIES		
Category PA Criteria: A 5-day trial of 2 preferred agents will be required before a non-preferred agent will be authorized unless 1 of the exceptions on the PA form is present.		
ACUVAIL (ketorolac)	ACULAR (ketorolac)	
ALREX (loteprednol)	ACULAR LS (ketorolac)	
Diclofenac sodium	Bromfenac sodium	
FLAREX (fluorometholone)	BROMSITE (bromfenac sodium)	
Fluorometholone	Dexamethasone sodium phosphate	
Flurbiprofen sodium	DUREZOL (difluprednate)	
FML FORTE (fluorometholone)	FML (fluorometholone)	
FML S.O.P. (fluorometholone)	LOTEMAX (loteprednol) GEL DROPS	
ILEVRO (nepafenac)	LOTEMAX (loteprednol) OINTMENT	
ketorolac tromethamine 0.4%	NEVANAC (nepafenac)	
Ketorolac tromethamine 0.5%	OCUFEN (flurbiprofen)	
LOTEMAX (loteprednol) DROPS	OMNIPRED 1% (prednisolone acetate)	
MAXIDEX (dexamethasone)	PRED FORTE 1% (prednisolone acetate)	
PRED MILD 0.12% (prednisolone acetate)	Prednisolone acetate 1%	
Prednisolone sodium phosphate 1%	PROLENSA (bromfenac)	
OPHTHALMIC IMMUNOMODULATORS - DRY EYE SYNDROME		
Restasis (cyclosporine)		
Restasis multidose (cyclosporine)		
Xiidra (lifitegrast)		
OPIOID ANALGESIC - LONG ACTING		
Category PA Criteria: For non-preferred agents to be authorized: 1. Patient must have required around-the-clock pain relief for the past 90 days 2. The past 3 months of North Dakota PDMP reports must have been reviewed by the prescriber.		
butorphanol	ARYMO ER (oxycodone)***	*** Hysingla ER, oxymorphone ER, Zohydro ER require 30-day trials of fentanyl, morphine, and oxycodone products in addition to Category PA Criteria ***Belbuca- Patient must have failed 30-day trials of Butrans, Nucynta ER, and tramadol ER in additional to
BUTRANS (buprenorphine) PATCHES	BELBUCA (buprenorphine)***	
EMBEDA (morphine/naltrexone)	buprenorphine patches	
Fentanyl 12 mcg/hr[PA***]	DURAGESIC (fentanyl)	
Fentanyl 25 mcg/hr, 50 mcg/hr, 75 mcg/hr	EXALGO (hydromorphone)***	

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THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
levorphanol	Fentanyl patch 37.5 mcg/hr, 62.5 mcg/hr, 87.5 mcg/hr***	Category PA Criteria ***Hydromorphone ER and Exalgo – The 90-day around-the-clock pain relief requirement must be met by an equianalgesic dose of 60 mg oral morphine daily, 25 mcg transdermal fentanyl/hour, 30 mg oxycodone daily, 8 mg of oral hydromorphone daily, or another opioid daily. Patient must have failed 30-day trials of fentanyl, morphine, and oxycodone products in addition to Category PA Criteria ***Methadone, Fentanyl Patch 37.5 mcg/hr, 62.5 mcg/hr, 87.5 mcg/hr, morphine ER capsules, Arymo ER, Morphabond ER, and Oxycontin - Clinical justification must be given for why another product will not work in additional to Category PA Criteria. *** Fentanyl 12 mcg/hr – The total daily opioid dose must be less than 60 Morphine Equivalent Dose (MED) in additional to Category PA Criteria ***Tramadol ER Patient must have failed two 30-day trials of preferred medications in additional to Category PA Criteria ***Xtampza ER - Patient must have failed 30-day trials of fentanyl and morphine products in addition to Category PA Criteria
Morphine ER tablets	Hydromorphone ER tablets***	
NUCYNTA ER (tapentadol)	HYSINGLA ER (hydrocodone)***	
pentazocine-naloxone	KADIAN (morphine)***	
	Methadone***	
	MORPHABOND ER (morphine)***	
	Morphine ER capsules***	
	MS CONTIN (morphine)	
	Oxycodone ER***	
	OXYCONTIN (oxycodone)***	
	Oxymorphone ER tablets***	
	Tramadol ER	
	ULTRAM ER (tramadol ER)	
	XTAMPZA ER (oxycodone)***	
	ZOHYDRO ER (hydrocodone)***	
OPIOID ANTAGONIST - OPIOID AND ALCOHOL DEPENDENCE		
VIVITROL (Naltrexone Microspheres)		
OPIOID PARTIAL ANTAGONIST - OPIOID DEPENDENCE		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
Category PA Criteria: A 30-day trial of 1 preferred agent will be required before a non-preferred agent will be authorized. 1. Patient must be 16 years of age or older. 2. Patient must not be taking other opioids, tramadol, or carisoprodol concurrently. 3. The prescriber must be registered to prescribe under the Substance Abuse and Mental Health Services Administration (SAMHSA) and provide his/her DEA number. 4. The prescriber and patient must have a contract or the prescriber must have developed a treatment plan. 5. The prescriber must perform routine drug screens. 6. The prescriber must routinely check the PDMP and the last 3 months of North Dakota PDMP reports must have been reviewed by the prescriber. 7. The prescriber must be enrolled with ND Medicaid.		
ZUBSOLV (buprenorphine/naloxone)[PA]	BUNAVAIL FILM (buprenorphine/naloxone)***	*** Bunavail/Suboxone Film will require a 30-day trial of buprenorphine/naloxone tablets in addition to the category PA criteria. ***Buprenorphine tablets will be allowed during a period that a patient is pregnant or breastfeeding.
	Buprenorphine tablets***	
	Buprenorphine-naloxone tablets	
	SUBOXONE FILM (buprenorphine/naloxone)***	
OTIC ANTI-INFECTIVES - FLUOROQUINOLONES		
Category PA Criteria: A 7-day trial of 2 preferred agents will be required before a non-preferred agent will be authorized. A 7-day trial of 2 preferred generics of the same medication will satisfy this requirement.		
CIPRO HC (ciprofloxacin/hydrocortisone)	FLOXIN (ofloxacin)	
CIPRODEX (ciprofloxacin/dexamethasone)	Ofloxacin drops - labelers 50383, 60505	
OTOVEL (ciprofloxacin/fluocinolone)		
ofloxacin drops - labeler 24208		
PHOSPHATE BINDERS		
Category PA Criteria: The following criteria will be required before a non-preferred agent will be authorized: 1. Patient must have had a 3-month trial of 3 preferred different chemical entities. 2. Patient must have end stage renal disease or chronic kidney disease. 3. Patients with chronic kidney disease stage 5 must have a phosphate level greater than 5.5 mg/dL. 4. All other patients must have a phosphate level greater than 4.6 mg/dL.		
Calcium acetate capsule	AURYXIA (ferric citrate) TABLET	
Calcium acetate tablet	ELIPHOS (calcium acetate) TABLET	
FOSRENOL (lanthanum) 500 MG AND 750 MG CHEWABLE TABLET	FOSRENOL (lanthanum) 1000 MG CHEWABLE TABLET	
PHOSLYRA (calcium acetate) ORAL solution	FOSRENOL (lanthanum) POWDER PACK	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
RENAGEL (sevelamer) TABLET	Lanthanum	
RENVELA (sevelamer carbonate) TABLET	sevelamer powder pack	
RENVELA (sevelamer) POWDER PACK	VELPHORO (sucroferric oxyhydroxide)	
PLATELET AGGREGATION INHIBITORS		
Category PA Criteria: A 30 day trial of 2 preferred agents will be required before a non-preferred agent will be authorized unless 1 of the exceptions is indicated on the form.		
AGGRENOX (aspirin/dipyridamole)	Aspirin/dipyridamole ER	***Zontivity – Patient must be 18 years of age or older. Zontivity must be taken with aspirin and/or clopidogrel. Patient must not have a history of stroke, transient ischemic attack, or intracranial hemorrhage. ***Durlaza/Yosprala DR – Patient must have a reason that immediate release aspirin is not an option.
BRILINTA (ticagrelor)	Clopidogrel 300mg	
Clopidogrel 75 mg	DURLAZA (aspirin ER)***	
Dipyridamole	EFFIENT (prasugrel)	
Ticlopidine	PERSANTINE (dipyridamole)	
	PLAVIX (clopidogrel)	
	prasugrel	
	YOSPRALA DR (aspirin/omeprazole)***	
	ZONTIVITY (vorapaxar)***	
PULMONARY HYPERTENSION		
PDE-5 Inhibitors		
Category PA Criteria: A 30-day trial of all preferred agents will be required before a non-preferred agent will be authorized. All medications require an FDA-approved indication. Patient cannot be taking nitrates of any form.		
Sildenafil[PA]	REVATIO (sildenafil) SUSPENSION***	***Revatio Suspension – Patients 7 years and older will be required to submit documentation of their inability to ingest a solid dosage form.
ADCIRCA (tadalafil)	REVATIO (sildenafil) TABLET	
Soluble Guanylate Cyclase Stimulators		
Category PA Criteria: All medications require an FDA-approved indication. Patients of childbearing potential must not be pregnant, be taking a reliable form of birth control, and have a pregnancy test before initiation and monthly during therapy. All medications require an FDA-approved indication. Patient may not be taking with nitrates of any form or specific (sildenafil or tadalafil) or non-specific (dipyridamole or theophylline) PDE-5 inhibitors.		
ADEMPAS (riociguat)[PA]		
Endothelin Receptor Antagonist		
Category PA Criteria: Patients of childbearing potential must not be pregnant, be taking a reliable form of birth control, and have a pregnancy test before initiation and monthly during therapy. All medications require an FDA-approved indication. Non-preferred agents will require a 30-day trial of all preferred medications.		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
TRACLEER (bosentan)PA***	LETAIRIS (ambrisentan)***	***Tracleer – LFTs must be measured at baseline and monthly during therapy. ***Opsumit - A 30 day trial of Letairis will be required in addition to category PA criteria
	OPSUMIT (macitentan)***	
Prostacyclins		
Category PA Criteria: All medications require an FDA-approved indication. A 30-day trial of all preferred agents will be required before a non-preferred agent will be authorized.		
ORENITRAM ER (treprostinil)PA	TYVASO (treprostinil)	***Ventavis 20 mcg/mL – A patient must be maintained at a 5 mcg dose and repeatedly experiencing incomplete dosing due to extended treatment time to be approved.
REMODULIN (treprostinil)	UPTRAVI (selexipag)	
VENTAVIS (iloprost) 10 mcg/mLPA	VENTAVIS (iloprost) 20 mcg/mL***	
STEROID/LONG ACTING BETA AGONIST (LABA) COMBINATION INHALERS		
Category PA Criteria: A 30-day trial of all preferred agents will be required before a non-preferred agent will be authorized. Non-preferred agents must have an FDA-approved indication. For COPD diagnosis: EITHER both of the following will be required in addition to the category PA criteria: 1. A 30-day trial of Tudorza Pressair, Spiriva, Spiriva Respimat, Incruse Ellipta, or Seebri Neohaler 2. A 30-day trial of Brovana, Arcapta Neohaler, Striverdi Respimat, Perforomist, or Serevent. OR A 30-day trial of Anoro Ellipta, Stiolto Respimat, Utibron NeoHaler, Bevespi Aerosphere, or Trelegy Ellipta For asthma diagnosis, patient must have been reviewed for step down therapy for all renewal requests.		
ADVAIR DISKUS (fluticasone/salmeterol)	ADVAIR HFA (fluticasone/salmeterol)	***Airduo Respiclick - Clinical justification must be provided as to why Advair Diskus or Advair HFA will not work
DULERA (mometasone/formoterol)	AIRDUO RESPICLICK (fluticasone/salmeterol)***	
SYMBICORT (budesonide/formoterol)	BREO ELLIPTA (fluticasone/vilanterol)	
	fluticasone/salmeterol	
STEROIDs - INHALED		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
Category PA Criteria: Inhalers: A 30-day trial of all preferred inhalers will be required before a non-preferred agent will be authorized. Inhaled suspensions (nebulizers): Non-preferred Brand medication: A 30-day trial of 2 pharmaceutically equivalent preferred agents will be required before a non-preferred agent will be authorized. Non-preferred Generic medication: A 30-day trial of a pharmaceutically equivalent preferred agent will be required before a non-preferred agent will be authorized.		
ALVESCO (ciclesonide)	AEROSPAN (flunisolide)	
ASMANEX (mometasone) TWISTHALER	ARMONAIR RESPICLICK (fluticasone)	
budesonide suspension 0.25 mg/2 mL	ARNUITY ELLIPTA (fluticasone)	
budesonide suspension 0.5 mg/2 mL	ASMANEX HFA (mometasone)	
FLOVENT HFA (fluticasone)	budesonide suspension 1 mg/2 mL	
PULMICORT FLEXHALER (budesonide)	FLOVENT DISKUS (fluticasone)	
PULMICORT RESPULES (budesonide) 1 MG/2 ML	PULMICORT RESPULES (budesonide) 0.25 mg/2 mL	
QVAR (beclomethasone)	PULMICORT RESPULES (budesonide) 0.5 mg/2 mL	
ULCERATIVE COLITIS AGENTS - NONSTEROIDAL		
Category PA Criteria: A 30-day trial of each of the preferred agents will be required before a non-preferred agent will be authorized. Non-preferred agents will require an FDA indication.		
Oral		
APRISO (mesalamine) CAPSULE	ASACOL HD (mesalamine)	***Giazo - Patient must be a male.
Balsalazide capsule	AZULFIDINE (sulfasalazine)	
DELZICOL (mesalamine) CAPSULE	AZULFIDINE DR (sulfasalazine)	
DIPENTUM (olsalazine)	COLAZAL (balsalazide)	
LIALDA (mesalamine) TABLET	GIAZO (balsalazide)***	
PENTASA (mesalamine)	Mesalamine DR	
Sulfasalazine DR tablet	SULFAZINE (sulfasalazine)	
Sulfasalazine tablet		
Rectal		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
CANASA (mesalamine) RECTAL SUPPOSITORY	Mesalamine enema kit	
Mesalamine enema	ROWASA (mesalamine) ENEMA KIT	
SF ROWASA (mesalamine) ENEMA		
URINARY ANTISPASMODICS		
Category PA Criteria: A 30-day trial of 3 preferred agents will be required before a non-preferred agent will be authorized. Non-preferred agents require an FDA-approved indication.		
ENABLEX (darifenacin)	Darifenacin ER	***SANCTURA ER/Trospium ER and Myrbetriq will require a 1-month trial of trospium and tolterodine/tolterodine ER in addition to the category PA criteria.
Flavoxate	DETROL (tolterodine)	
GELNIQUE (oxybutynin)	DETROL LA (tolterodine)	
Oxybutynin ER	DITROPAN XL (oxybutynin)	
Oxybutynin syrup	MYRBETRIQ (mirabegron)***	
Oxybutynin tablet	SANCTURA (trospium)	
OXYTROL (oxybutynin) PATCH	SANCTURA ER (trospium)***	
TOVIAZ (fesoterodine)	Tolterodine	
VESICARE (solifenacin)	Tolterodine ER	
	Trospium	
	Trospium ER***	