DUR Board Meeting
March 5, 2012
Pioneer Room
State Capitol

North Dakota Medicaid
DUR Board Meeting
Agenda
Pioneer Room
State Capitol
March 5, 2012
1pm

1. Administrative items
    - Travel vouchers

2. Old business
    - Review and approval of minutes of 12/5/11 meeting — Chair
    - Budget update — Brendan
    - Second review of Pulmonary Arterial Hypertension Agents — Brendan
    - Second review of Topical Acne Agents — Brendan
    - Second review of Benign Prostatic Hyperplasia Agents — Brendan
    - Second review of Juvisync/Combination Products — Brendan
    - Second review of Gralise — Brendan
    - Yearly PA review — HID
        - Antihistamines
        - PPIs
        - COX-II/NSAIDs
        - Revatio
        - Actoplus Met
        - Azasite/Quixin
        - Carisoprodol
        - Blood Factors
        - Relistor
        - Sancuso
        - Nuvigil
        - Nucynta

3. New business
    - Review of Lorzone — HID
    - Review of Provigil — HID
    - Review of Kapvay — HID
    - Review of Dexpak/Zemapak — HID
    - Review of Xifaxan — HID
    - Review of Vanos
    - Concurrent use of SSRIs and SNRIs — HID
    - Criteria recommendations — HID
    - Upcoming meeting date/agenda — Chair

4. Adjourn — Chair

Please remember to silence all cellular phones and pagers during the meeting.

Drug Utilization Review (DUR) Meeting Minutes
December 5, 2011

Members Present: Norman Byers, John Savageau, Russ Sobotta, Cheryl Huber, Greg Pfister, Patricia Churchill, Carrie Sorenson, Leann Ness, Jeffrey Hostetter
Members Absent: Kim Krohn, David Clinkenbeard, Steve Irsfeld, James Carlson, Todd Twogood, Carlotta McCleary
Medicaid Pharmacy Department: Brendan Joyce, Gary Betting
HID Staff Present: Candace Rieth

Chair, G. Pfister called the meeting to order at 1:00 pm. Chair, G. Pfister asked for a motion to approve the minutes from the September meeting. N. Byers moved that the minutes be approved and C. Huber seconded the motion. Chair, G. Pfister called for a voice vote to approve the minutes. The motion passed with no audible dissent.

Budget Update
B. Joyce informed the board members that there have been no budget updates from fiscal since the last DUR Board meeting.

Dificid Second Review
A motion and second were made at the September meeting to place Dificid on prior authorization. The topic was brought up for a second review. There was no public comment. After discussion, Chair, G. Pfister called for a voice vote to approve the motion. The motion passed with no audible dissent.

Hereditary Angioedema Second Review
A motion and second were made at the September meeting to place agents used to treat hereditary angioedema on prior authorization. The topic was brought up for a second review. There was no public comment. After discussion, Chair, G. Pfister called for a voice vote to approve the motion. The motion passed with no audible dissent.

Oral Anticoagulants Second Review
A motion and second were made at the September meeting to place Pradaxa on prior authorization. The topic was brought up for a second review. J. Savageau made a motion to add Xarelto to the prior authorization. N. Byers seconded the motion. J. Robinson, representing Boehringer Ingelheim, spoke regarding Pradaxa. J. Stoffel, representing Janssen Scientific Affairs, spoke regarding Xarelto. Chair, G. Pfister called for a voice vote to approve the amendment. The motion passed with no audible dissent. Chair, G. Pfister called for a voice vote to approve the amended original motion. The motion passed with no audible dissent.

Yearly PA Review
The Board reviews products annually that have previously been placed on prior authorization. This allows the Board a chance to update the prior authorization forms and criteria. Solodyn, Oracea, Oxycontin, Short-Acting Beta$_2$ Agonists, Soma 250, Vusion, Targeted Immunomodulators, Moxatag, Uloric, Smoking Cessation, Topical Anesthetic Agents, Name Brand Narcotics, Ribapak, Metozolv, Suboxone/Subutex, Ampyra, Ultram/Rybix/Ryzolt, and Xolair were reviewed. No changes were made.

Pulmonary Arterial Hypertension Agents Review
B. Joyce reviewed PAH information with the Board. W. Braden, representing United Therapeutics, spoke regarding Adcirca and Tyvaso. P. Miner, representing Gilead, spoke regarding Letairis. After discussion, N. Byers made a motion to place agents used to treat PAH on

prior authorization. J. Hostetter seconded the motion. This topic will be brought up at the next meeting for finalization.

Topical Acne Agents Review
B. Joyce reviewed topical acne agents information with the Board. There was no public comment. After discussion, N. Byers made a motion to place an age restriction on topical acne agents for patients less than 10 and greater than 35 to have a dermatologist involved in therapy. G. Pfister seconded the motion. J. Hostetter made a motion to place topical acne agents on prior authorization. C. Sorenson seconded the motion. This topic will be brought up at the next meeting for finalization.

Benign Prostatic Hyperplasia Review
B. Joyce reviewed BPH information with the Board. There was no public comment. After discussion, G. Pfister made a motion to place BPH agents on prior authorization. N. Byers seconded the motion. This topic will be brought up at the next meeting for finalization.

Juvisync Review
B. Joyce reviewed Juvisync with the Board. S. Carlson, representing Merck, spoke regarding Juvisync. After discussion, J. Hostetter made a motion to place combination products that are more expensive than their individual components, such as Juvisync, on prior authorization. G. Pfister seconded the motion. This topic will be brought up at the next meeting for finalization.

Gralise Review
B. Joyce reviewed Gralise with the Board. There was no public comment. N. Byers made a motion to place Gralise on prior authorization, with failure of gabapentin. G. Pfister seconded the motion. This topic will be brought up at the next meeting for finalization.

Criteria Recommendations
The recommended RDUR criteria enclosed in the packet were developed from product information provided by the manufacturers and usually are consistent with new indications, new drugs added, new warnings, etc. These proposed criteria will be added to the current set of criteria, and will be used in future DUR cycles. P. Churchill moved to approve the new criteria and J. Savageau seconded the motion. Chair, G. Pfister called for a voice vote. The motion passed with no audible dissent.

The next DUR board meeting will be held March 5, 2012. P. Churchill made a motion to adjourn the meeting. N. Byers seconded. The motion passed with no audible dissent. Chair G. Pfister adjourned the meeting at 2:25 pm.

PULMONARY ARTERIAL HYPERTENSION AGENTS
PA FORM

Prior Authorization Vendor for ND Medicaid

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-773-0695

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	
Physician Name	Specialist Involved in therapy:		
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ LETAIRIS □ TRACLEER □ VENTAVIS □ REVATIO □ ADCIRCA □ TYVASO □ OTHER_____	**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 Signature	Date		

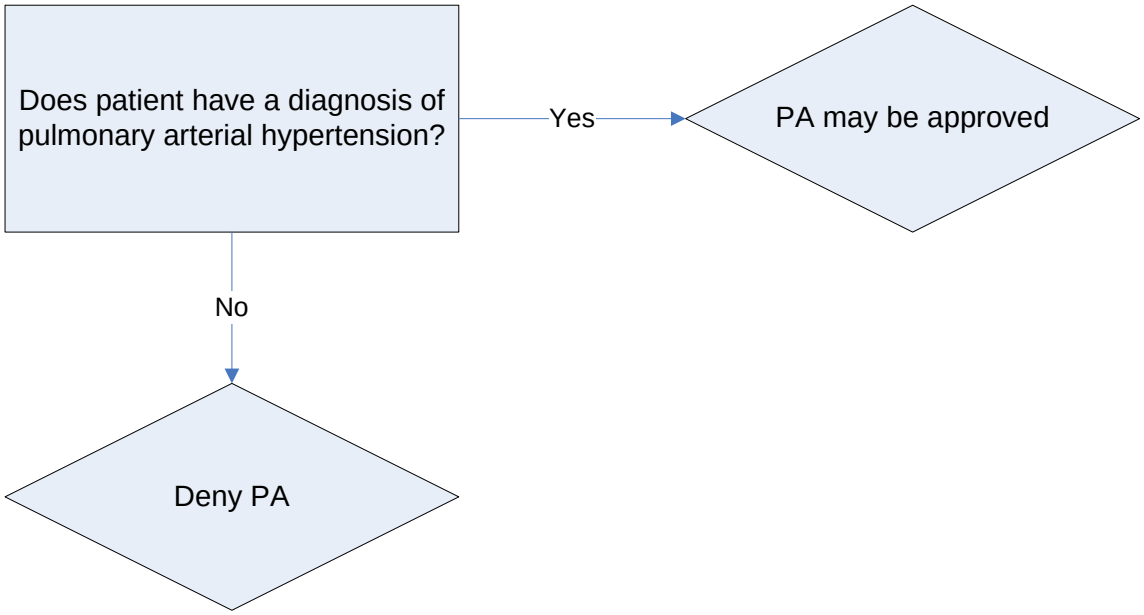
Part II: TO BE COMPLETED BY PHARMACY

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
Pulmonary Arterial Hypertension Agents
Prior Authorization Algorithm



TOPICAL ACNE AGENTS
PA FORM

Prior Authorization Vendor for ND Medicaid

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-773-0695

ND Medicaid requires that patients receiving a new prescription for a branded topical acne agent must meet the following criteria:

- **Patients under the age of 10 or older than 35 must have a dermatologist involved in therapy**
- **Patients must first try and fail a generic topical acne agent (erythromycin, benzoyl peroxide, clindamycin, tretinoin, sodium sulfacetamide/sulfur)**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	**Recipient Date of Birth**	Recipient Medicaid ID Number	
Physician Name	Dermatologist Involved in therapy (if patient is <10 and >35): Next Appointment date:		
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:	**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 Signature	Date		

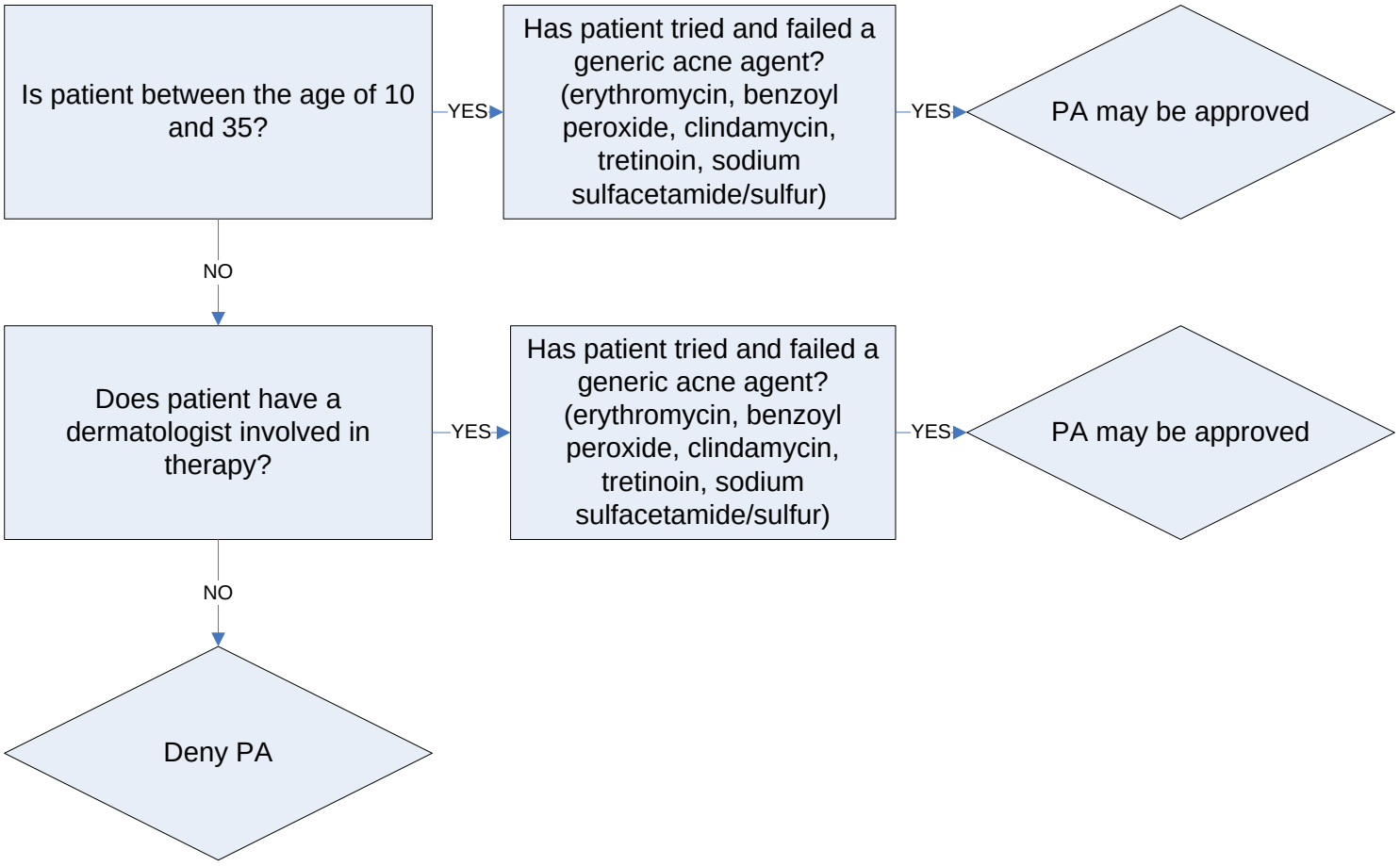
Part II: TO BE COMPLETED BY PHARMACY

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
Topical Acne Agents
Prior Authorization Algorithm



CIALIS for BENIGN PROSTATIC HYPERPLASIA
PA FORM

HEALTH INFORMATION DESIGNS

Prior Authorization Vendor for ND Medicaid

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-773-0695

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**

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:**	**Attach additional notes listing 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 Signature		Date	

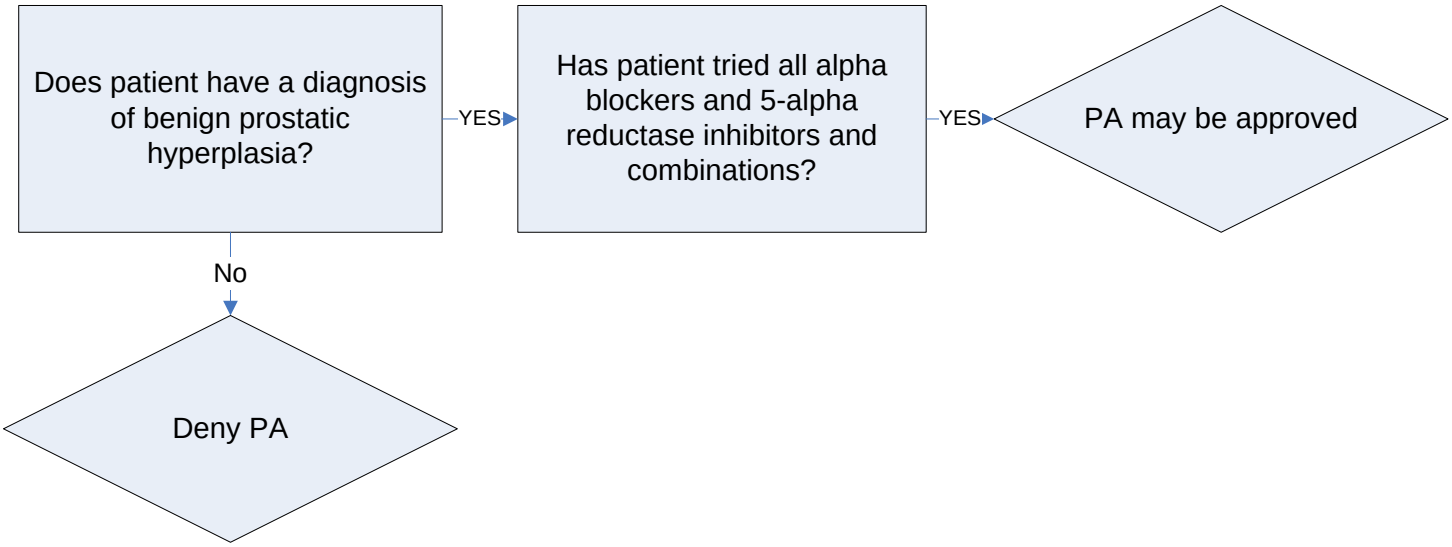
Part II: TO BE COMPLETED BY PHARMACY

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
CIALIS for Benign Prostatic Hyperplasia
Prior Authorization Algorithm



COMBINATION PRODUCTS
PA FORM

HEALTH INFORMATION DESIGNS

Prior Authorization Vendor for ND Medicaid

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-773-0695

ND Medicaid requires that patients receiving a new 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	
Physician Name			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:	**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 Signature		Date	

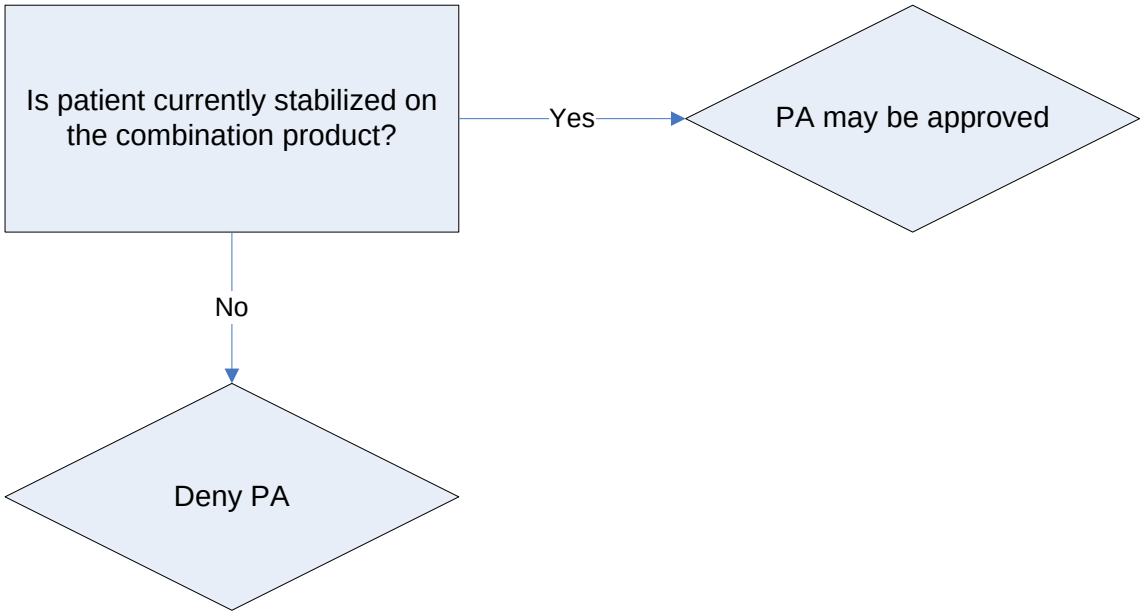
Part II: TO BE COMPLETED BY PHARMACY

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
Combination Products
Prior Authorization Algorithm



GRALISE PA FORM

Prior Authorization Vendor for ND Medicaid

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-773-0695

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 Signature		Date	

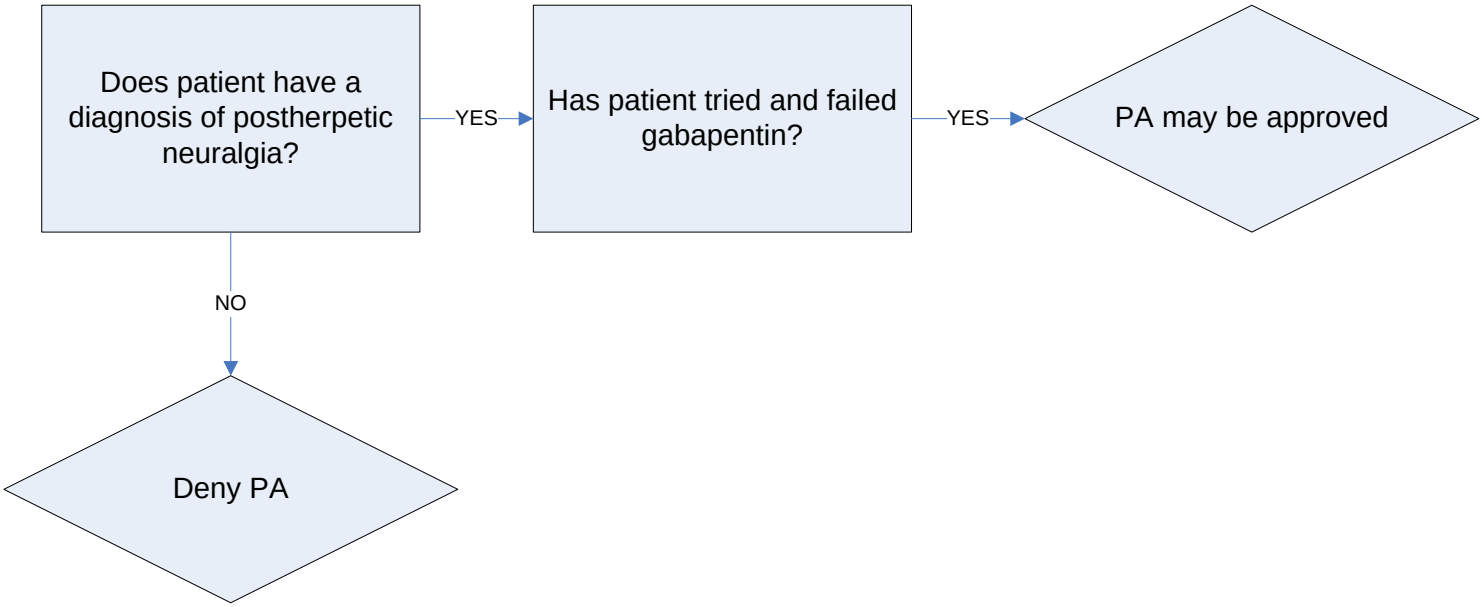
Part II: TO BE COMPLETED BY PHARMACY

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
Gralise Prior Authorization Algorithm



ANTIHISTAMINE PA FORM

Fax Completed Form to:
866-254-0761
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 generic) may be prescribed WITHOUT prior authorization.***
- ***Loratadine OTC and cetirizine OTC are covered by Medicaid when prescribed by a physician.***
- ***Patients must use loratadine or cetirizine for a minimum of 14 days for the trial to be considered a failure. Patient preference does not constitute a failure. Patients must use fexofenadine as step 2 after loratadine or cetirizine failure.***
- ***Net cost to Medicaid: Loratadine = cetirizine << Allegra (generic) << Clarinex = Xyzal***

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: □ **ALLEGRA (GENERIC)** □ **CLARINEX** □ **XYZAL**	**Requested Dosage:** (must be completed) **Diagnosis for this request:**

Qualifications for coverage:

□ Failed loratadine or cetirizine (include which agent failed)_____	Start Date:	End Date:
□ Failed Allegra (generic) Step 2	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 Signature: Date:

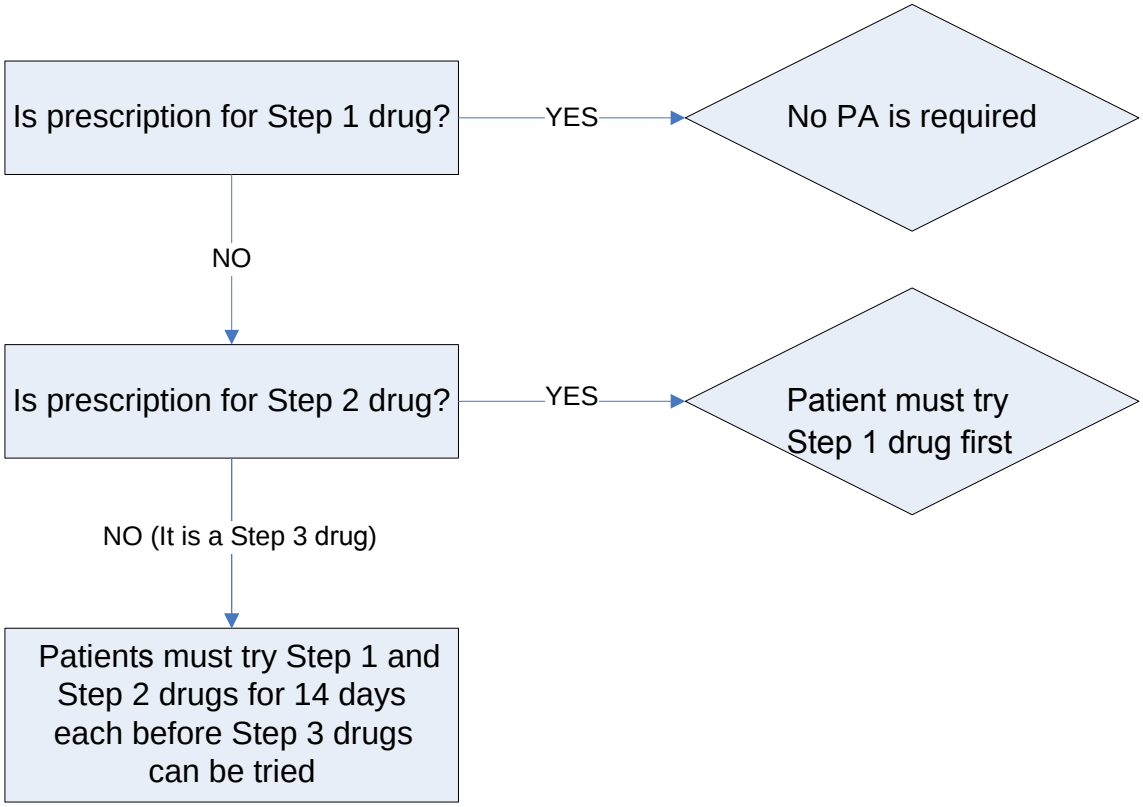
Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:		ND MEDICAID PROVIDER NUMBER:
Phone:		FAX:
Drug:		NDC#:

Part III: FOR OFFICIAL USE ONLY

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

North Dakota Department of Human Services
Antihistamine Authorization Criteria Algorithm



Please Note:

Step 1 drug is defined as Loratadine OTC or Cetirizine.
Step 2 drug is defined as Allegra (generic).
Step 3 drug is defined as Clarinex or Xyzal-must try Step 1 and Step 2 drugs before trying Step 3.

Net cost to Medicaid: Loratadine = cetirizine << Allegra (generic) << Clarinex = Xyzal

HEALTH INFORMATION DESIGNS

Prior Authorization Vendor for ND Medicaid

Proton Pump Inhibitor PA Form

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-773-0695

ND Medicaid requires that patients receiving proton pump inhibitors must use Prilosec OTC, Prevacid 24HR, Omeprazole, or Pantoprazole as first line.

*__Note:__

- **Prilosec OTC, Prevacid 24HR, Omeprazole and Pantoprazole may be prescribed WITHOUT prior authorization. Prilosec OTC and Prevacid 24HR are covered by Medicaid when prescribed by a physician.**
- **Prior Authorization is NOT required for patients < 13 years of age.**
- **Patients must use Prilosec OTC, Prevacid 24HR, omeprazole, or pantoprazole for a minimum of 14 days for the trial to be considered a failure. Patient preference does not constitute a failure.**
- **Net cost to Medicaid: Prilosec OTC = Prevacid 24HR = Omeprazole = Pantoprazole <<< Lansoprazole << Aciphex << Nexium << Zegerid <<< Dexilant.**

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: □ Aciphex □ Lansoprazole □ Nexium □ Zegerid □ Dexilant	**Requested Dosage:** (must be completed) **Diagnosis for this request:**

Qualifications for coverage:

❑ Failed Prilosec OTC/Prevacid 24HR/Omeprazole/Pantoprazole therapy	Start Date: End Date:	Dose: Frequency:
□ Pregnancy – Due Date		
□ Inability to take or tolerate oral tablets (must check a box) □ Tube Fed □ Requires soft food or liquid administration □ Other (provide description)		
□ Adverse reaction (attach FDA Medwatch form) to omeprazole/lansoprazole.		
□ *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 Signature:		Date:

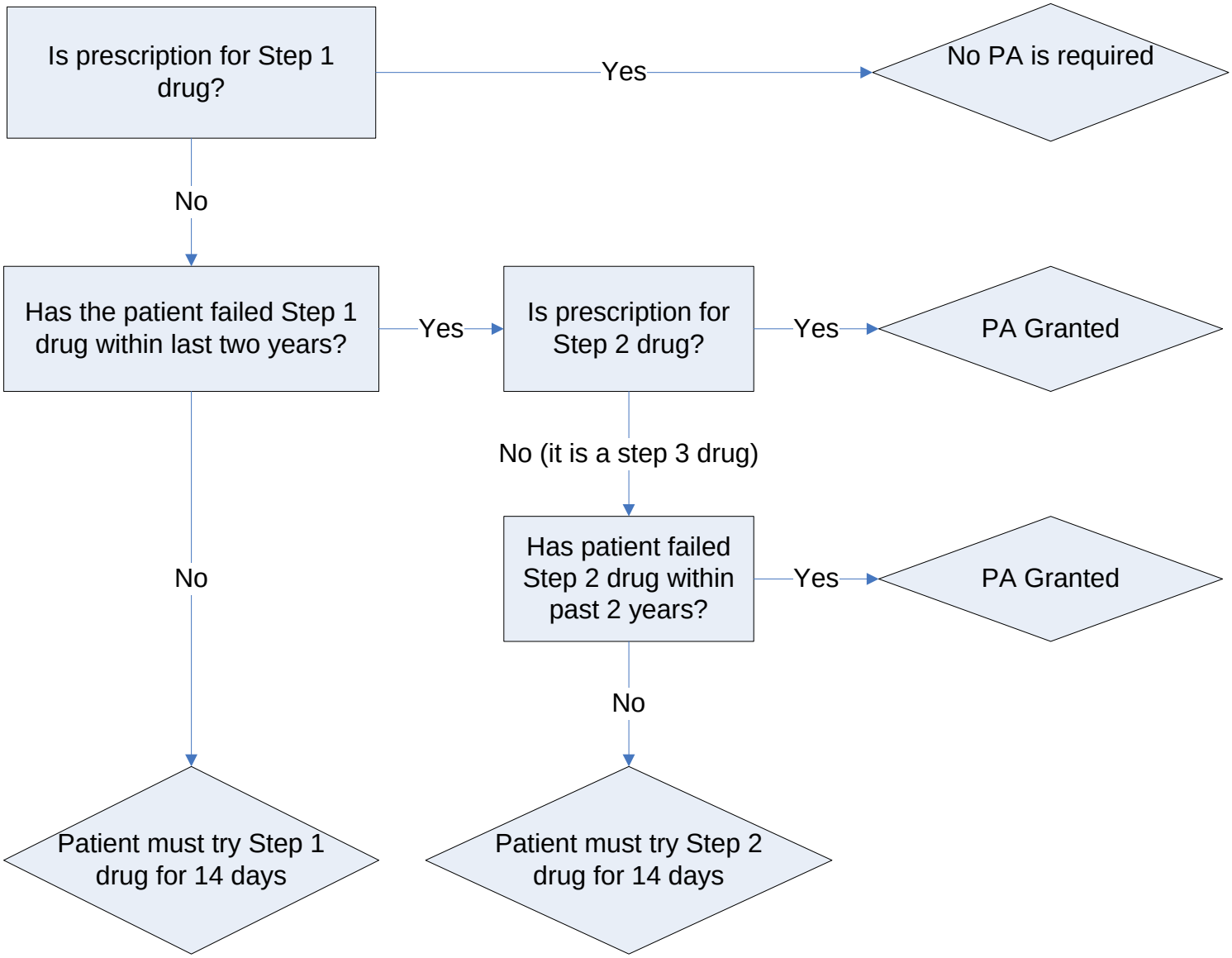
Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:		ND MEDICAID PROVIDER NUMBER:
Phone:		FAX:
Drug:		NDC#:

Part III: FOR OFFICIAL USE ONLY

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

North Dakota Department of Human Services
Proton Pump Inhibitor Authorization Criteria Algorithm



Please Note:

Step 1 drug is defined as Prilosec OTC, Prevacid 24HR, omeprazole, and pantoprazole

Step 2 drug is defined as lansoprazole

Step 3 drug is defined as Nexium, Aciphex, Zegerid and Dexilant (which is 5-8 times more expensive)

HEALTH INFORMATION DESIGNS

Prior Authorization Vendor for ND Medicaid

BRAND NAME NSAID/COX-II PA FORM

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-773-0695

ND Medicaid requires that patients using brand name NSAIDs or COX-II drugs must use a generic NSAID as 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 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:**	
□ Celebrex	□ Warfarin/Corticosteroid therapy	□ GI bleed, perforation or obstruction
□ Other _____	□ Gastric or duodenal ulcer	□ Endoscopically documented NSAID gastritis with GI Bleed
	□ Actinic keratoses **(Solaraze)**	

Qualifications for coverage:

□ Failed NSAID therapy	Start Date	End Date	Dose	Frequency
□ Failed NSAID 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 Signature	Date

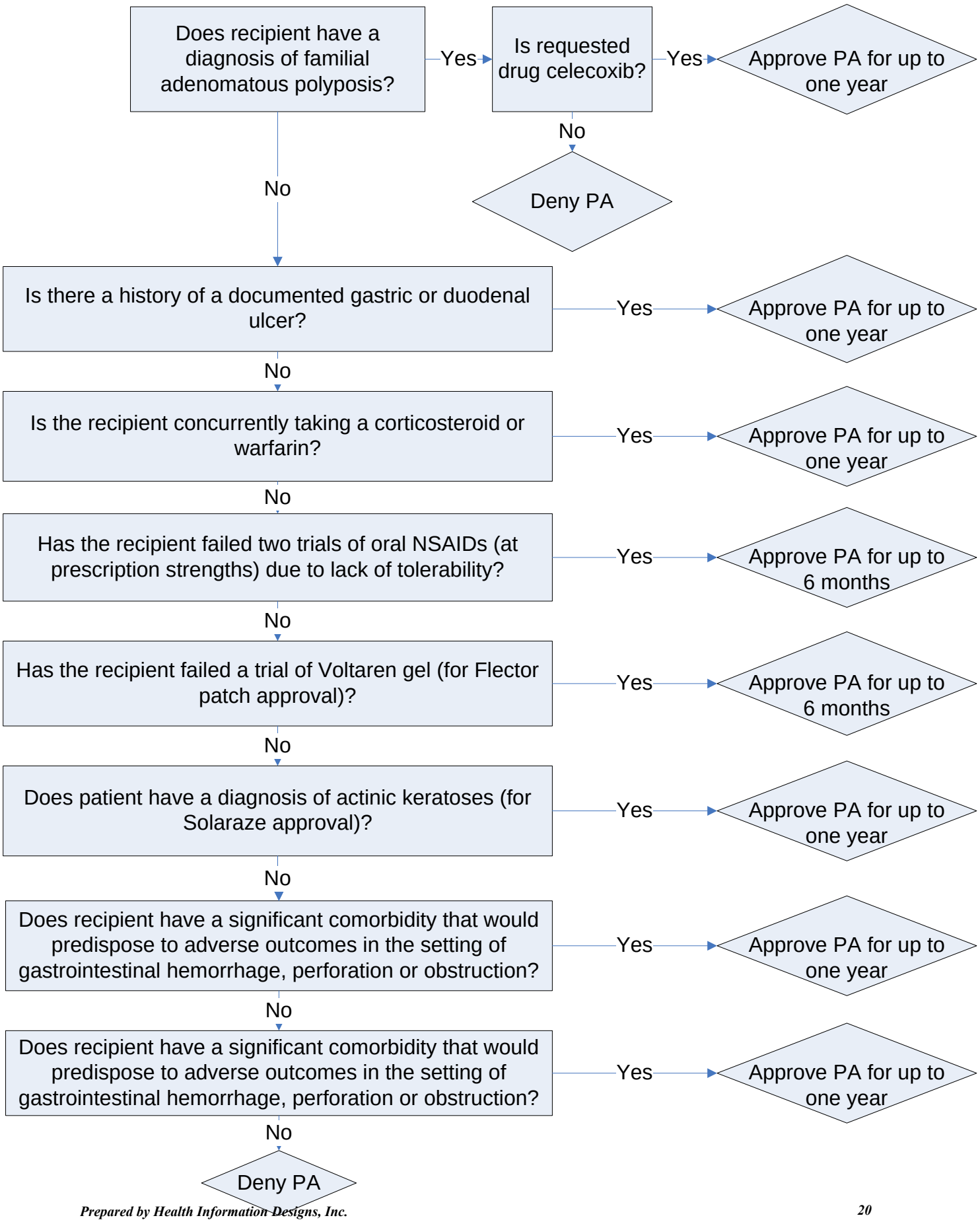
Part II: TO BE COMPLETED BY PHARMACY

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
Name Brand NSAID/COX-II Authorization Algorithm



Revatio/Adcirca
Prior Authorization Form

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving Revatio or Adcirca must have a diagnosis of Pulmonary Arterial Hypertension based on WHO (Group I) Classification for Pulmonary Hypertension.

****Note:***

- ***Patients taking Nitrates or Viagra/Levitra/Cialis will not receive a PA***

Part I: TO BE COMPLETED BY PRESCRIBER

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber Medicaid Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ **Revatio** □ **Adcirca**	**Diagnosis for this request:**		
Qualifications for coverage:			
□ Indication for the treatment of Pulmonary Arterial Hypertension (WHO Group I Classification)			
Prescriber Signature	Date		

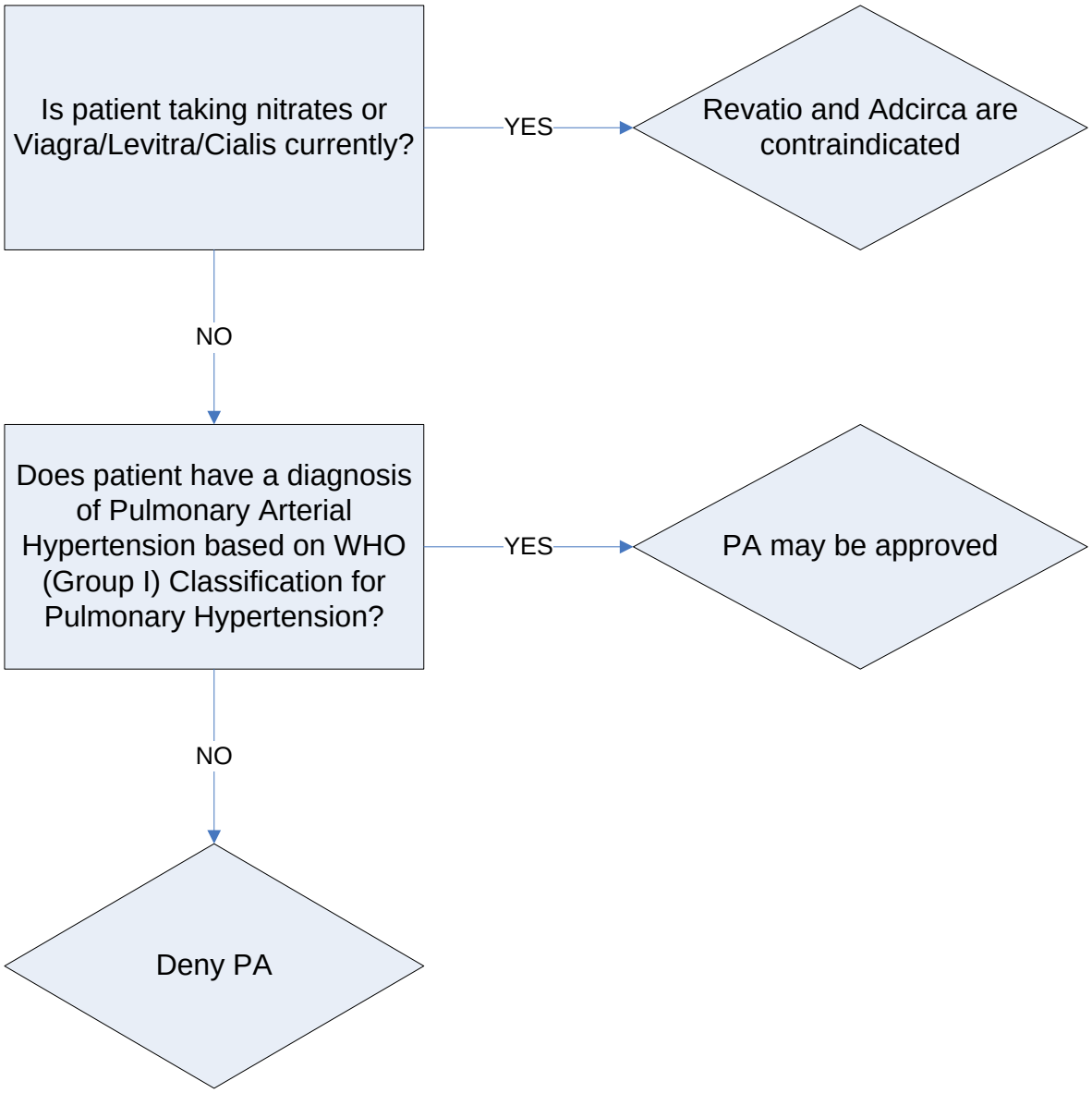
Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
PHONE 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
Revatio/Adcirca Authorization Algorithm



ACTO*plus* met Prior Authorization

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receive Actos and Metformin separately.
Note:

- ***Actos does not require PA***
- ***Metformin does not require PA***
- ***Patients must fail therapy on Actos and Metformin separately 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: □ **ACTO*plus* met**	**Diagnosis for this request:**		
Qualifications for coverage:			
□ Failed both drugs separately	Start Date: End Date:	Dose: Frequency:	
Prescriber Signature		Date	

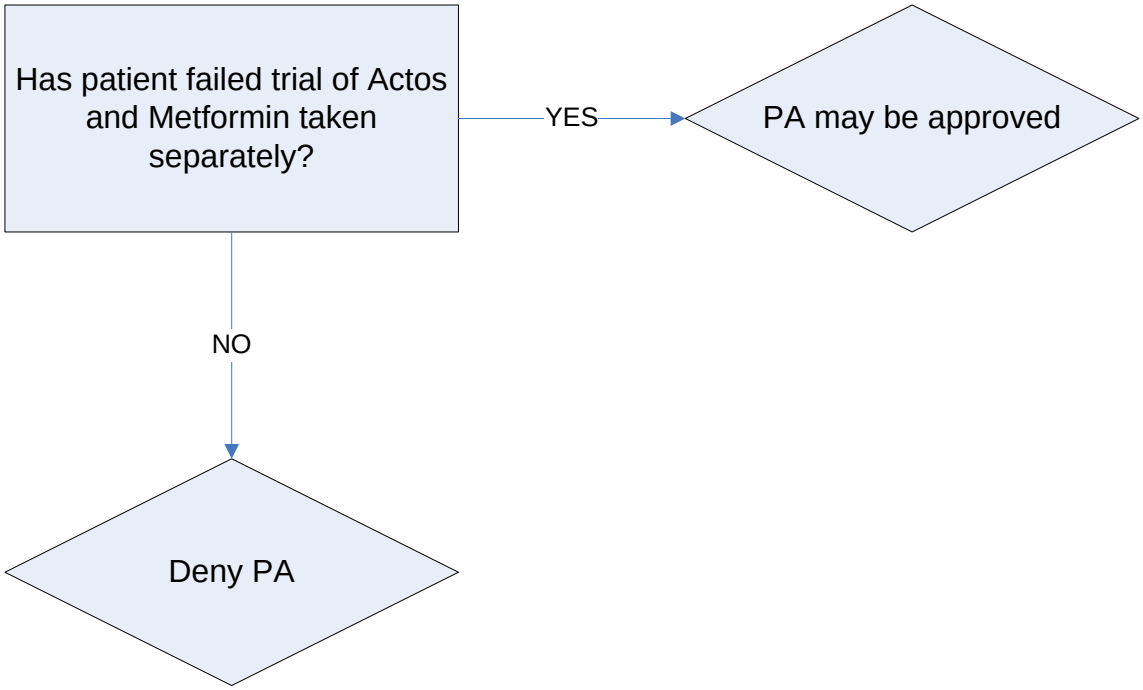
Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
PHONE 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
ACTO*plus met* Authorization Algorithm



OPHTHALMIC ANTI-INFECTIVE PA FORM

Prior Authorization Vendor for ND Medicaid

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-773-0695

ND Medicaid will not pay for Azasite or Quixin without documented failure of a first line antibiotic ophthalmic agent.

***Note: First line agents include sulfacetamide (Bleph 10®, etc.), erythromycin, bacitracin-polymixin B (Polysporin®), polymyxin B neomycin-gramicidin (Neosporin®), trimethoprim-polymyxin B (Polytrim®), gentamicin (Garamycin®, etc.), ofloxacin (Ocuflox®) and ciprofloxacin (Ciloxan®).**

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: □ AZASITE □ QUIXIN	**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 Signature	Date		

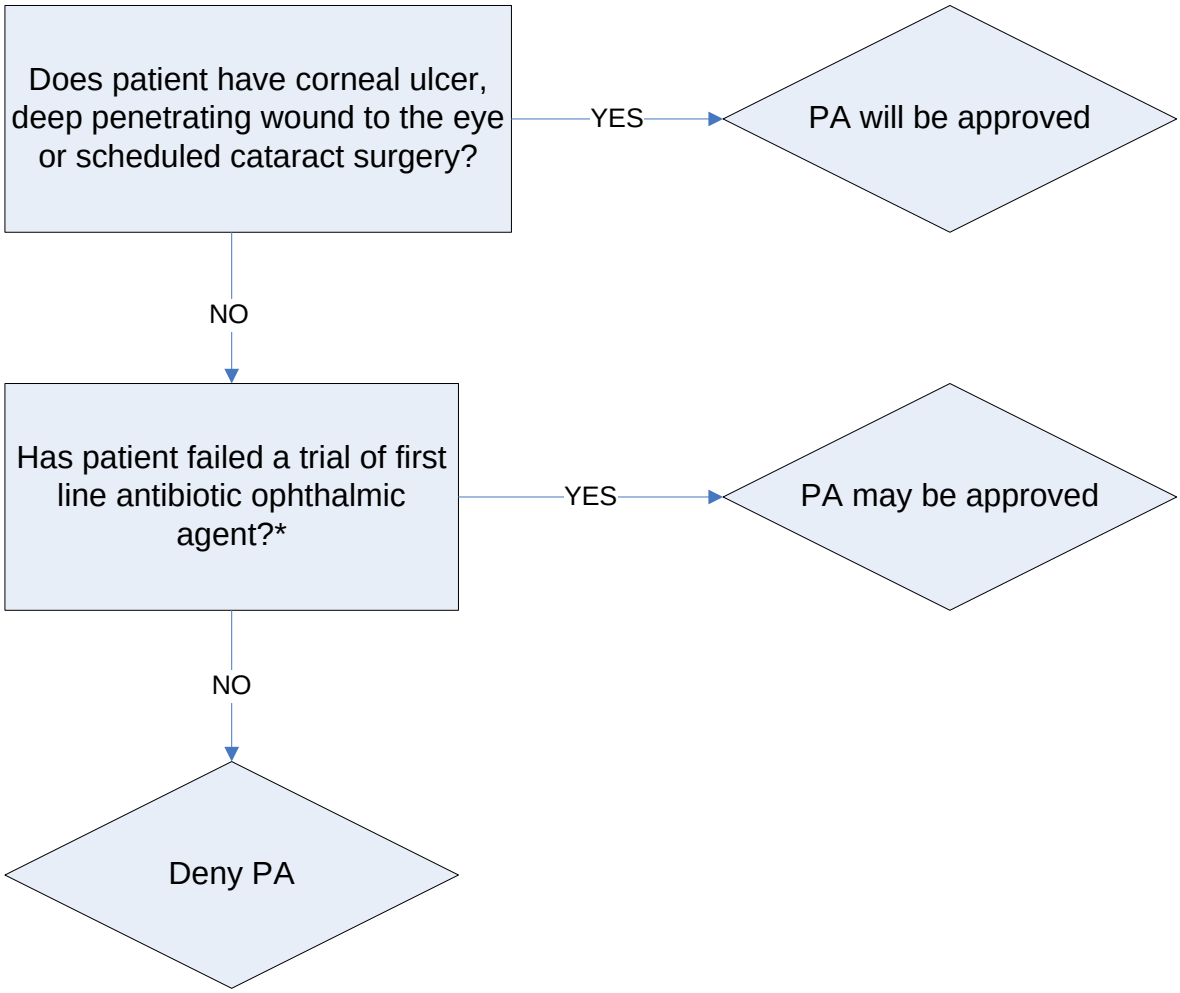
Part II: TO BE COMPLETED BY PHARMACY

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
Ophthalmic Anti-infective Authorization Algorithm



*First line agents include: sulfacetamide (Bleph 10, etc.), erythromycin, bacitracin-polymixin B (Polysporin), polymyxin B-neomycin-gramicidin (Neosporin), trimethoprim-polymyxin B (Polytrim), gentamicin (Garamycin, etc.), ofloxacin (Ocuflox), and ciprofloxacin (Ciloxan).

CARISOPRODOL PA FORM

Prior Authorization Vendor for ND Medicaid

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-773-0695

ND Medicaid requires that patients using carisoprodol 350mg longer than two times per year (272 tablets) must receive a prior authorization. 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	
Physician Name			
Physician Medicaid Provider Number	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.*			
Physician Signature	Date		

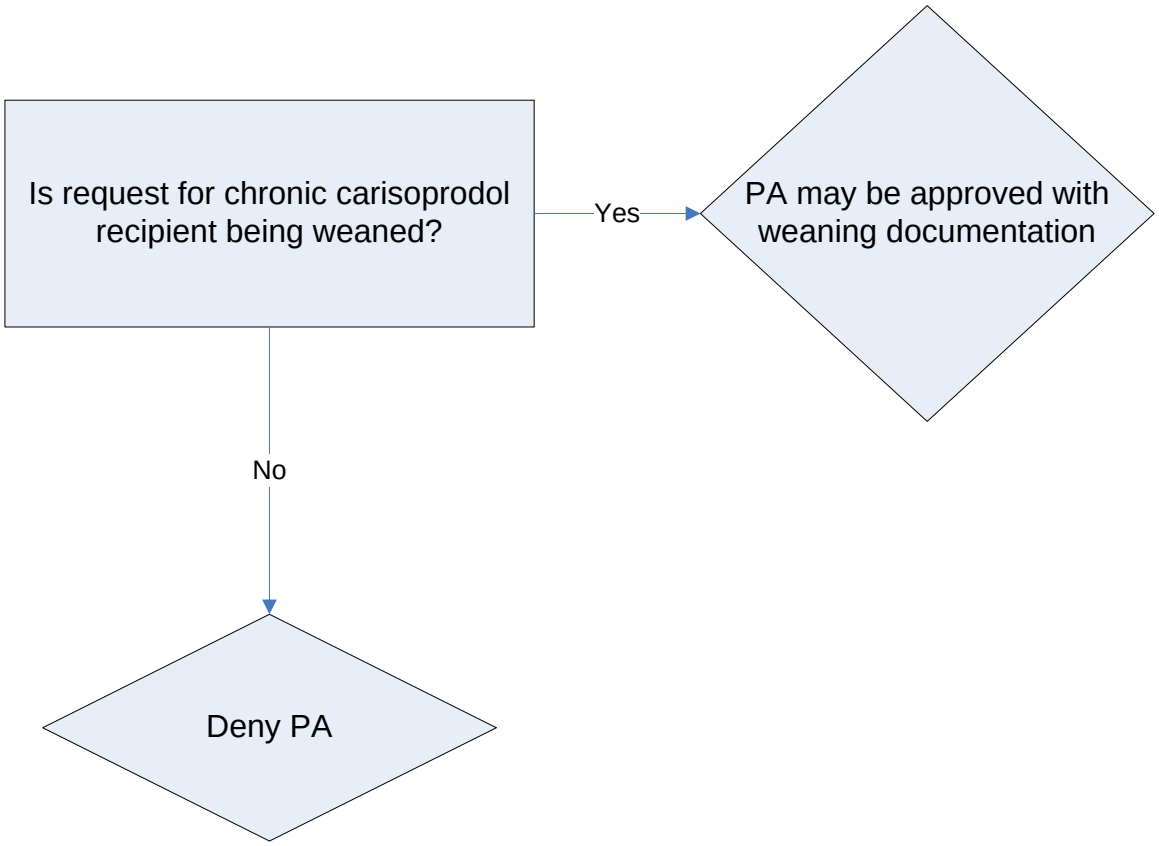
Part II: TO BE COMPLETED BY PHARMACY

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
Carisoprodol Authorization Algorithm



BLOOD FACTOR PRODUCTS PA FORM

HEALTH INFORMATION DESIGNS

Prior Authorization Vendor for ND Medicaid

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-773-0695

ND Medicaid requires that patients receiving a new prescription for blood factor products 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 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 :	**DOSAGE:**		
Qualifications for coverage:			
TREATMENT CENTER CONTACT INFORMATION:	DATE OF LAST APPOINTMENT WITH TREATMENT CENTER: _____		
Prescriber Signature:		Date:	

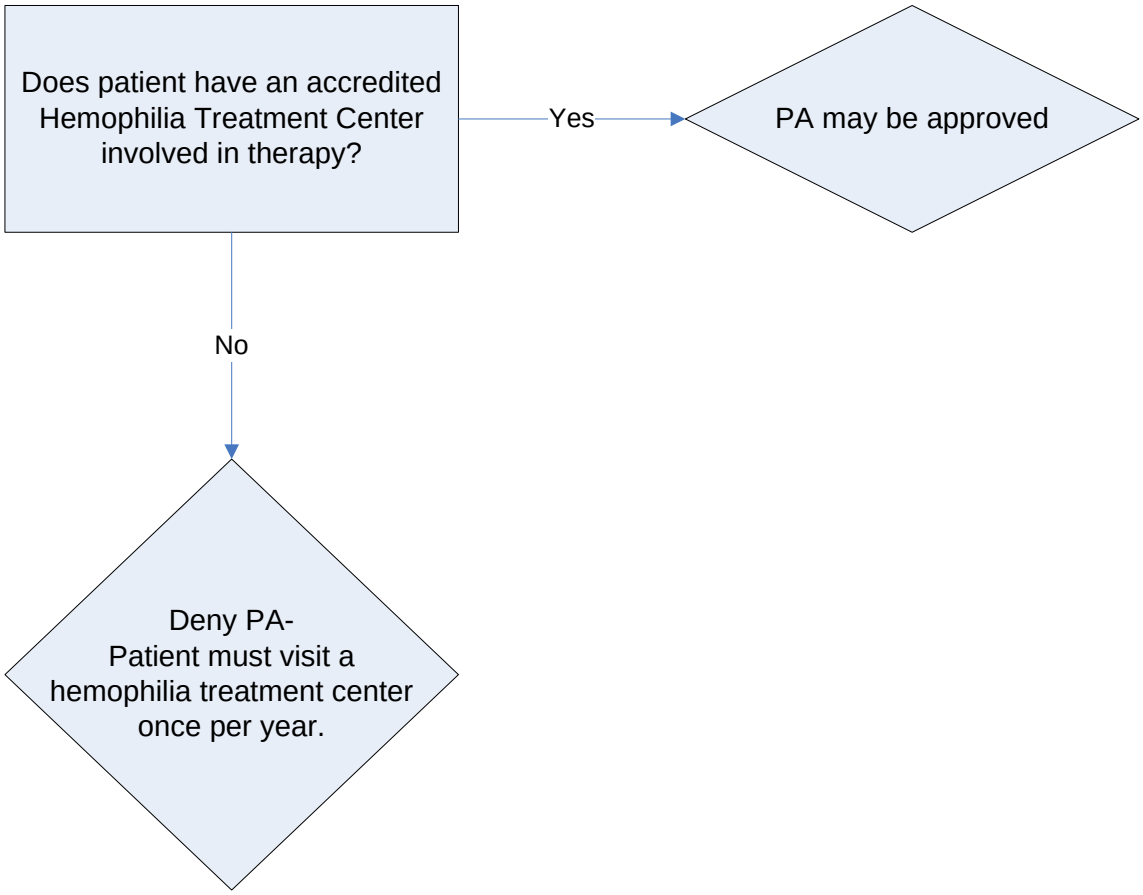
Part II: TO BE COMPLETED BY PHARMACY

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
Blood Factor Products Authorization Algorithm



Relistor Prior Authorization

Fax Completed Form to:
866-254-0761
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 Relistor must meet the following guidelines:

- Diagnosis of opioid-induced constipation
- Inability to tolerate oral medications *or*
- Failed two oral medications

Note:
***Polyethylene glycol powder is covered without a prior authorization.**

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: □ **Relistor**	**Diagnosis for this request:**		
Qualifications for coverage:			
FIRST FAILED MEDICATION	START DATE:	END DATE:	
SECOND FAILED MEDICATION	START DATE:	END DATE:	
□ INABILITY TO TOLERATE ORAL MEDICATIONS			
Prescriber Signature		Date	

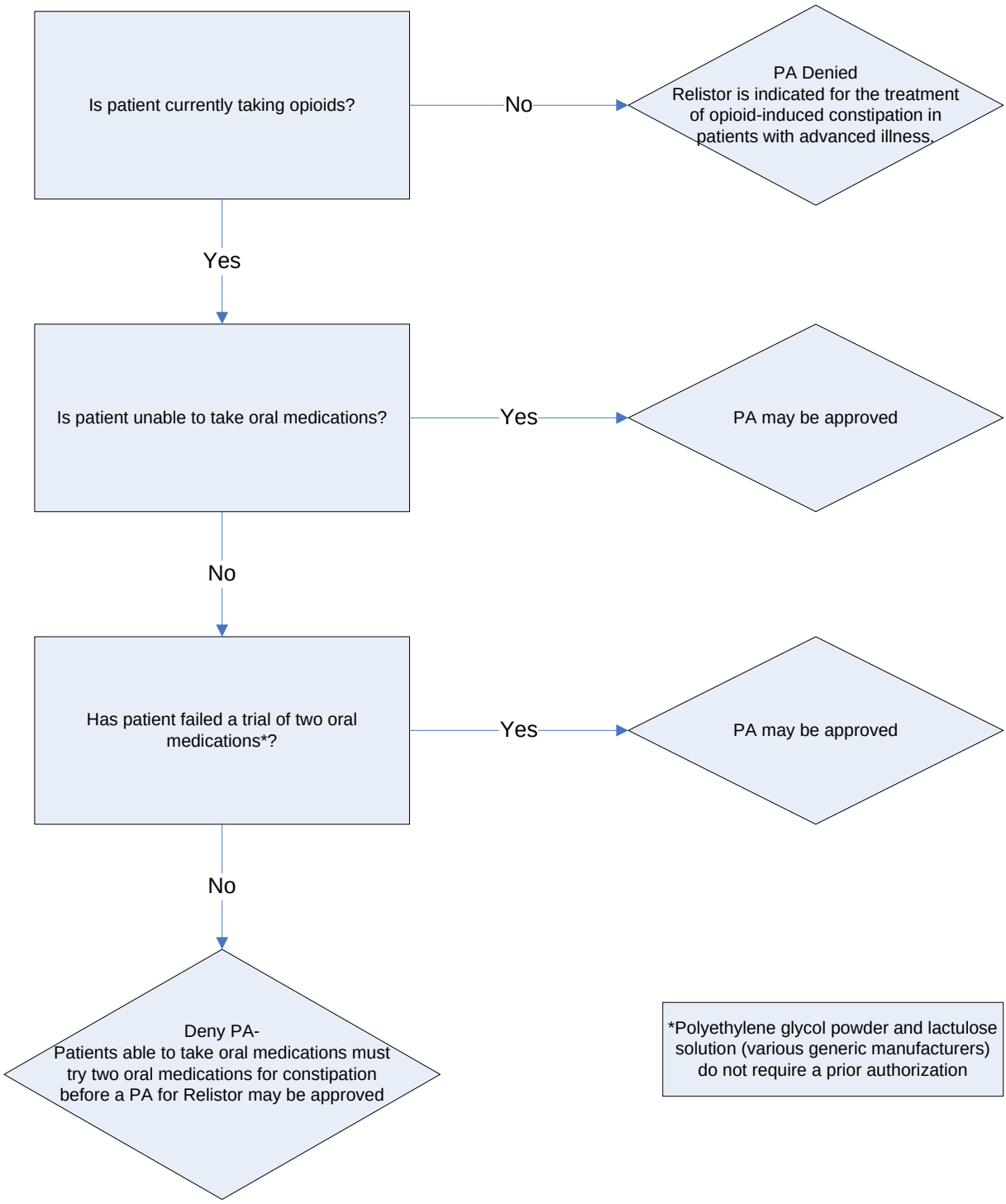
Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
PHONE 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
Relistor Authorization Algorithm



Sancuso Prior Authorization

Fax Completed Form to:
866-254-0761
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 Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ **Sancuso**	**Diagnosis for this request:**		
Qualifications for coverage:			
□ FAILED MEDICATION	START DATE: END DATE:	DOSE: FREQUENCY:	
□ PATIENT UNABLE TO TAKE ORAL MEDICATIONS			
Prescriber Signature		Date	

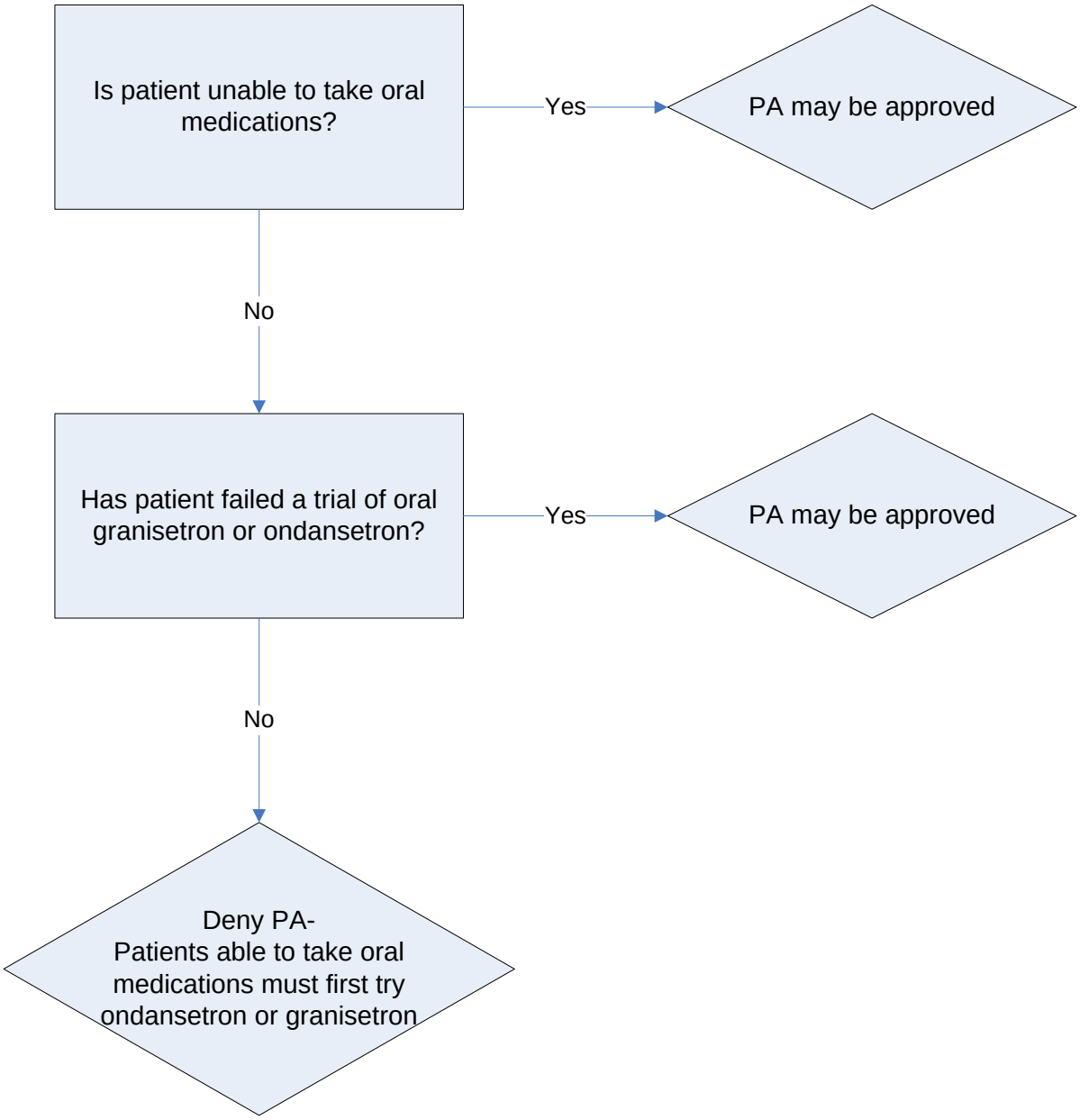
Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
PHONE 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
Sancuso Authorization Algorithm



HEALTH INFORMATION DESIGNS

Prior Authorization Vendor for ND Medicaid

Nuvigil Prior Authorization

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-773-0695

ND Medicaid requires that patients receiving a new prescription for Nuvigil must suffer from excessive sleepiness associated with obstructive sleep apnea/hypopnea syndrome, narcolepsy, or shift work disorder.

- **Provigil is covered without a prior authorization.**

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**	**Diagnosis for this request:**		
Qualifications for coverage:			
□ FAILED PROVIGIL (MODAFINIL)	START DATE: END DATE:	DOSE: FREQUENCY:	
□ EXCESSIVE SLEEPINESS ASSOCIATED WITH OBSTRUCTIVE SLEEP APNEA/HYPOPNEA SYNDROME □ NARCOLEPSY □ SHIFT WORK SLEEP DISORDER			
Prescriber Signature		Date	

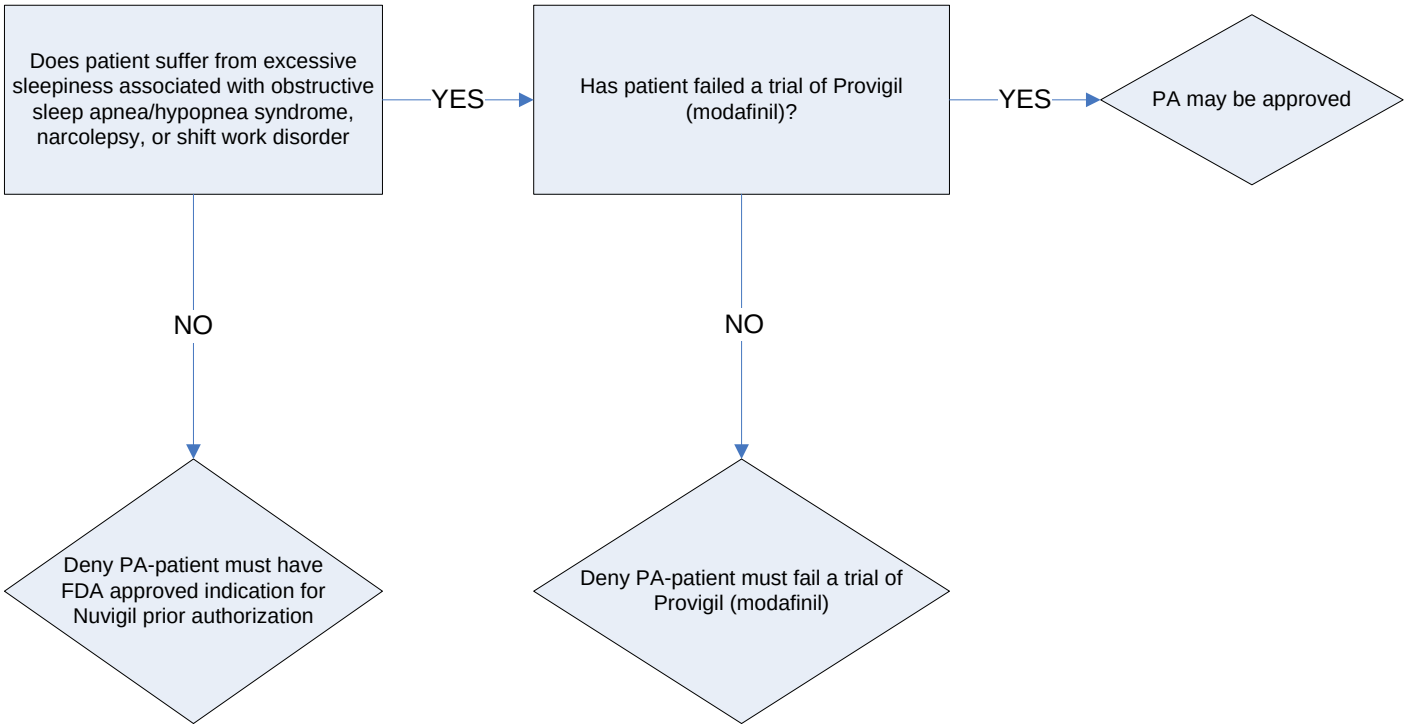
Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
PHONE 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
Nuvigil Authorization Algorithm



Nucynta Prior Authorization

Prior Authorization Vendor for ND Medicaid

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-773-0695

ND Medicaid requires that patients receiving a new prescription for Nucynta must be unable to tolerate other opioids due to gastrointestinal side effects.

- **Oxycodone is covered without a prior authorization.**

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: □ **Nucynta**	**Diagnosis for this request:**		
Qualifications for coverage:			
□ UNABLE TO TOLERATE OTHER OPIOIDS DUE TO GASTROINTESTINAL SIDE EFFECTS OPIOID TRIED_____ START DATE: DOSE: END DATE: FREQUENCY:			
Prescriber Signature		Date	

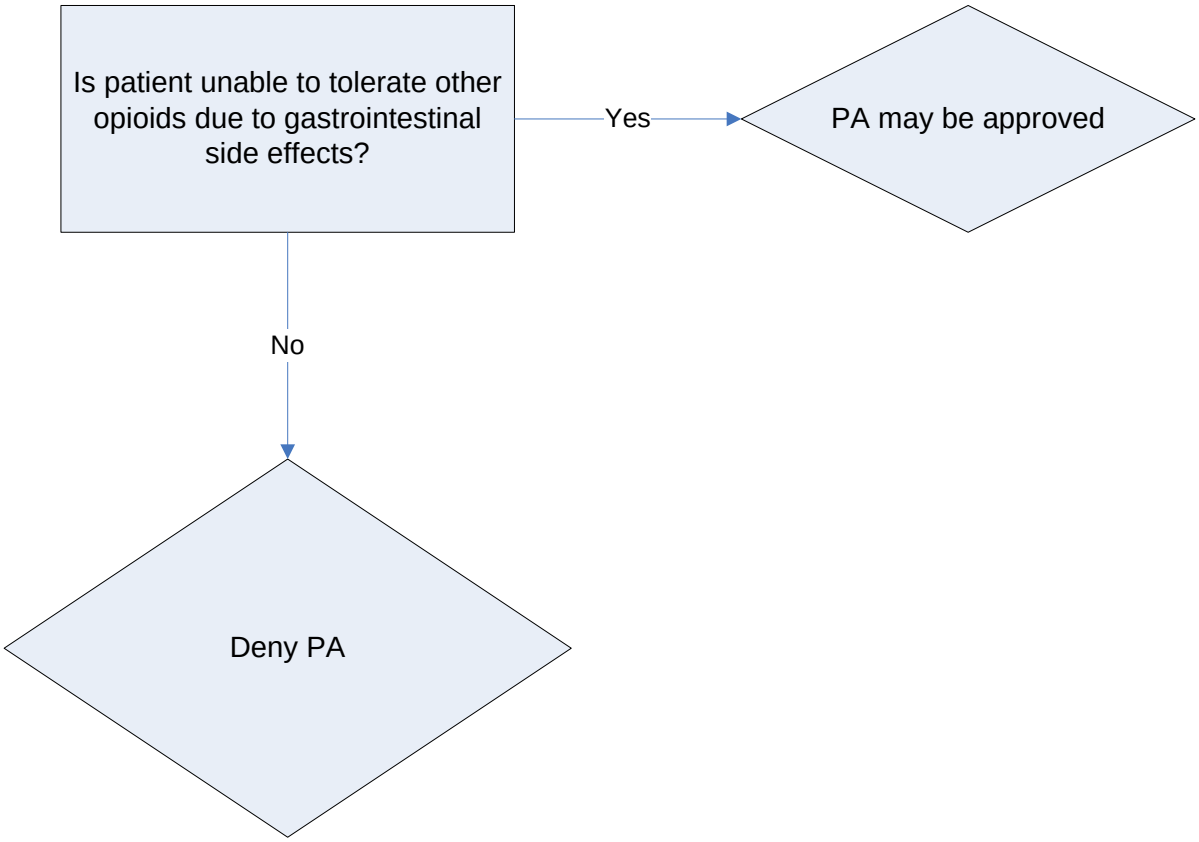
Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
PHONE 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
Nucynta Authorization Algorithm



North Dakota Medicaid
DUR Board Meeting
Lorzone™ Review

I. Overview

Lorzone is indicated as an adjunct to rest, physical therapy, and other measures, for the relief of discomfort associated with acute, painful musculoskeletal conditions. The mode of action of this drug has not been clearly identified, but may be related to its sedative properties. Chlorzoxazone does not directly relax tense skeletal muscles in man.

II. Pharmacology

Chlorzoxazone is a centrally-acting agent for painful musculoskeletal conditions. Data available from animal experiments as well as human study indicate that chlorzoxazone acts primarily at the level of the spinal cord and subcortical areas of the brain where it inhibits multisynaptic reflex arcs involved in producing and maintaining skeletal muscle spasm of varied etiology. The clinical result is a reduction of the skeletal muscle spasm with relief of pain and increased mobility of the involved muscles. Blood levels of chlorzoxazone can be detected in people during the first 30 minutes and peak levels may be reached, in the majority of the subjects, in about 1 to 2 hours after oral administration of chlorzoxazone. Chlorzoxazone is rapidly metabolized and is excreted in the urine, primarily in a conjugated form as the glucuronide. Less than one percent of a dose of chlorzoxazone is excreted unchanged in the urine in 24 hours.

III. Warnings/Precautions

1. Serious (including fatal) hepatocellular toxicity has been reported rarely in patients receiving chlorzoxazone. The mechanism is unknown but appears to be idiosyncratic and unpredictable. Factors predisposing patients to this rare event are not known. Patients should be instructed to report early signs and/ or symptoms of hepatoxicity such as fever, rash, anorexia, nausea, vomiting, fatigue, right upper quadrant pain, dark urine, or jaundice. Lorzone™ should be discontinued immediately and a physician consulted if any of these signs or symptoms develop. Lorzone™ use should also be discontinued if a patient develops abnormal liver enzymes (e.g., AST, ALT, alkaline phosphates and bilirubin).
2. The concomitant use of alcohol or other central nervous system depressants may have an additive effect.
3. The safe use of Lorzone has not been established with respect to the possible adverse effects upon fetal development. Therefore, it should be used in women of childbearing potential only when, in the judgement of the physician, the potential benefits outweigh the possible risks.
4. If sensitivity reactions occur such as urticaria, redness, or itching of the skin, the drug should be stopped.

5. If any symptoms suggestive of liver dysfunction are observed, the drug should be discontinued.

IV. Adverse Reactions

Chlorzoxazone-containing products are usually well tolerated. It is possible in rare instances that chlorzoxazone may have been associated with gastrointestinal bleeding. Drowsiness, dizziness, light-headedness, malaise, or overstimulation may be noted by an occasional patient. Rarely, allergic-type skin rashes, petechiae, or ecchymoses may develop during treatment. Angioneurotic edema or anaphylactic reactions are extremely rare. There is no evidence that the drug will cause renal damage. Rarely, a patient may note discoloration of the urine resulting from a phenolic metabolite of chlorzoxazone. This finding is of no known clinical significance.

V. Dosage and Administration

Lorzone 375mg – one tablet three or four times daily. If adequate response is not obtained with this dose, the 375mg tablets may be increased to two tablets (750mg) three or four times daily. As improvement occurs, dosage can usually be reduced.

Lorzone 750mg – 2/3 tablet (500mg) three or four times daily. If adequate response is not obtained with this dose, it may be increased to one tablet (750mg) three or four times daily. As improvement occurs, dosage can usually be reduced.

VI. Drug Interactions

CNS Agents - the concomitant use of alcohol or other CNS depressants may have an additive effect.

References

1. Lorzone™ [prescribing information]. Sayreville, NJ. Vertical Pharmaceuticals., Inc.; October 2010.

North Dakota Medicaid
DUR Board Meeting
Provigil® Review

I. Overview

Provigil (modafinil) is indicated to improve wakefulness in adult patients with excessive sleepiness associated with narcolepsy, obstructive sleep apnea (OSA), and shift work disorder (SWD).

In OSA, Provigil is indicated as an adjunct to standard treatment for the underlying obstruction. If continuous positive airway pressure (CPAP) is the treatment of choice for a patient, a maximal effort to treat with CPAP for an adequate period of time should be made prior to initiating Provigil. If Provigil is used adjunctively with CPAP, the encouragement of and periodic assessment of CPAP compliance is necessary.

In all cases, careful attention to the diagnosis and treatment of the underlying sleep disorder is of utmost importance. Prescribers should be aware that some patients may have more than one sleep disorder contributing to their excessive sleepiness.

The effectiveness of modafinil in long-term use (greater than 9 weeks in narcolepsy clinical trials and 12 weeks in OSA and SWD clinical trials) has not been systematically evaluated in placebo-controlled trials. The physician who elects to prescribe Provigil for an extended time in patients with narcolepsy, OSA, or SWD should periodically reevaluate long-term usefulness for the individual patient.

II. Pharmacology

The precise mechanism through which modafinil promotes wakefulness is unknown. Modafanil has wake-promoting actions similar to sympathomimetic agents like amphetamine and methylphenidate, although the pharmacologic profile is not identical to that of sympathomimetic amines.

III. Dosage and Administration

The recommended dose of modafinil is 200mg given once a day. For patients with narcolepsy and OSA, modafinil should be taken as a single dose in the morning. For patients with SWD, modafinil should be taken approximately 1 hour prior to the start of their work shift. Doses up to 400mg/day, given as a single dose, have been well tolerated, but there is no consistent evidence that this dose confers additional benefit beyond that of the 200mg dose.

IV. Warnings

- Serious Rash, including Stevens-Johnson Syndrome

- Angioedema and Anaphylactoid Reactions
- Multi-organ Hypersensitivity Reactions
- Persistent Sleepiness
- Psychiatric Symptoms

V. Precautions

- Modafanil has not been evaluated in patients with a recent history of myocardial infarction or unstable angina, and such patients should be treated with caution.
- The effectiveness of steroidal contraceptives may be reduced when used with modafinil and for one month after discontinuation of therapy. Alternate or concomitant methods of contraception are recommended for patients treated with modafinil tablets, and for one month after discontinuation.
- The blood levels of cyclosporine may be reduced when used with modafinil. Monitoring of circulating cyclosporine concentrations and appropriate dosage adjustment for cyclosporine should be considered when these drugs are used concomitantly.
- In patients with severe hepatic impairment, with or without cirrhosis, modafinil should be administered at a reduced dose.
- In elderly patients, elimination of modafinil and its metabolites may be reduced as a consequence of aging. Consideration should be given to the use of lower doses in this population.

VI. Drug Interactions

- CYP3A4 inducers (e.g., carbamazepine, phenobarbital, rifampin)/CYP3A4 inhibitors (e.g., itraconazole, ketoconazole)-coadministration with potent inducers or inhibitors could alter the plasma levels of modafinil.
- MAOIs-use caution with coadministration.
- Methylphenidate/Dextroamphetamine-modafanil absorption may be delayed by approximately 1 hour.
- Alcohol-avoid coadministration.
- Clozapine-serum levels may be elevated, increasing the pharmacologic and toxic effects. Monitor closely.
- Contraceptives, hormonal estrogens-effectiveness may be reduced. Alternate or concomitant methods of contraception are recommended for patients treated with modafinil and for 1 month after discontinuation of modafinil.
- Cyclosporine-dosage adjustment may be needed.
- CYP2C9/2C19 (e.g., diazepam, propranolol, phenytoin, SSRIs, certain tricyclic antidepressants)-coadministration may have prolonged elimination and may require dosage reduction and monitoring for toxicity.
- CYP1A2, CYP2B6, and CYP3A4 substrates-use caution when modafinil is coadministered with drugs that depend on these 3 enzymes for their clearance.
- Triazolam-$C_{max,}$ AUC, and half-life may be decreased.

VII. Adverse Reactions

The most commonly observed adverse reactions (5% or more) associated with the use of modafinil more frequently than placebo-treated patients in the placebo-controlled clinical studies in primary disorders of sleep and wakefulness were anxiety, back pain, diarrhea, dizziness, dyspepsia, headache, insomnia, nausea, nervousness, and rhinitis.

VIII. Utilization

Provigil and Nuvigil Utilization		
10/01/10 - 09/30/11		
Label Name	**Rx Num**	**Total Reimb Amt**
NUVIGIL 250 MG TABLET	1	$64.46
NUVIGIL 150 MG TABLET	1	$315.88
PROVIGIL 100 MG TABLET	19	$8,113.20
PROVIGIL 200 MG TABLET	187	$103,173.68
55 recipients	**208**	**$111,667.22**
5 recipients have obstructive sleep apnea diagnosis **3 recipients have narcolepsy diagnosis**		

.

References

1. Provigil® [prescribing information]. Frazer, PA. Cephalon, Inc.; October 2010.

North Dakota Medicaid
DUR Board Meeting
Kapvay® Review

I. Indication

Kapvay is a centrally acting alpha$_2$-adrenergic agonist indicated for the treatment of attention deficit hyperactivity disorder (ADHD) as monotherapy or as adjunctive therapy to stimulant medications.

II. Dosage and Administration

Dosing should be initiated with one 0.1mg tablet at bedtime, and the daily dosage should be adjusted in increments of 0.1mg/day at weekly intervals until the desired response is achieved. Doses should be taken twice a day, with either an equal or higher split dosage being given at bedtime.

III. Pharmacology

Clonidine stimulates alpha$_2$-adrenergic receptors in the brain. The mechanism of action of clonidine in ADHD is not known.

IV. Warnings/Precautions

- Hypotension/bradycardia
- Somnolence/sedation
- Abrupt discontinuation
- Allergic reactions
- Use in patients with vascular disease, cardiac conduction disease, or chronic renal failure
- Concomitant use with other clonidine containing products

V. Adverse Reactions

Common and drug related adverse reactions (incidence at least 5% and twice the rate of placebo) reported with the use of Kapvay include somnolence, fatigue, upper respiratory tract infection, irritability, throat pain, insomnia, nightmares, emotional disorder, constipation, nasal congestion, increased body temperature, dry mouth and ear pain.

VI. Drug Interactions

- Sedating drugs
- Tricyclic antidepressants
- Drugs known to affect sinus node function or AV nodal conduction
- Other clonidine containing products
- Antihypertensive drugs

VII. Utilization

Kapvay Utilization		
10/01/10 - 09/30/11		
Label Name	**Rx Num**	**Total Reimb Amt**
KAPVAY ER 0.1 MG TABLET	19	$2,196.58
4 recipients	**19**	**$2,196.58**

References

1. Kapvay [prescribing information]. Atlanta, GA: Shionogi Pharma, Inc; September 2010.

North Dakota Medicaid
DUR Board Meeting
Dexpak/Zemapak® Review

I. Overview

Dexpak and Zemapak are synthetic glucocorticoids, containing dexamethasone, primarily used for their potent anti-inflammatory effects in disorders of many organ systems. These agents are used to treat allergic states, dermatologic diseases, endocrine disorders, gastrointestinal diseases, hematologic disorders, neoplastic diseases, nervous system diseases, ophthalmic disease, renal diseases, respiratory diseases, rheumatic disorders and other miscellaneous disorders.

II. Pharmacology

Glucocorticoids, naturally occurring and synthetic are adrenocortical steroids that are readily absorbed from the gastrointestinal tract. Glucocorticoids cause varied metabolic effects. In addition, they modify the body's immune responses to diverse stimuli. Naturally occurring glucocorticoids (hydrocortisone and cortisone), which also have sodium-retaining properties, are used as replacement therapy in adrenocortical deficiency states. Their synthetic analogs, including dexamethasone, are primarily used for their anti-inflammatory effects in disorders of many organ systems. At equipotent anti-inflammatory doses, dexamethasone almost completely lacks the sodium-retaining property of hydrocortisone and closely related derivatives of hydrocortisone.

III. Warnings

- Cardio-renal – average and large doses of corticosteroids can cause elevation of blood pressure, sodium and water retention, and increased excretion of potassium.
- Endocrine – Corticosteroids can produce reversible hypothalamic-pituitary adrenal (HPA) axis suppression with the potential for glucocorticosteroid insufficiency after withdrawal of treatment.
- Infections – Corticosteroids may mask some signs of infection, and new infections may appear during their use. Corticosteroids may exacerbate systemic fungal infections and therefore should not be used in the presence of such infections unless they are needed to control life-threatening drug reactions. Chickenpox and measles (viral infection) can have a more serious or even fatal course in pediatric and adult patients on corticosteroids.
- Tuberculosis – The use of corticosteroids in active tuberculosis should be restricted to those cases of fulminating or disseminated tuberculosis in which the corticosteroid is used for the management of the disease in conjunction with an appropriate antituberculous regimen.
- Cerebral Malaria – Corticosteroids should not be used in cerebral malaria.
- Vaccination – Administration of live or live attenuated vaccines is contraindicated in patients receiving immunosuppressive doses of corticosteroids.

- Ophthalmic – Prolonged use of corticosteroids may produce posterior subcapsular cataracts, glaucoma with possible damage to the optic nerves, and may enhance the establishment of secondary ocular infections caused by fungi or viruses.

IV. Precautions

- General – The lowest possible dose of corticosteroids should be used to control the condition under treatment. Reduction should be gradual, when possible.
- Cardio-renal – As some sodium retention with resultant edema and potassium loss may occur in patients receiving corticosteroids, these agents should be used with caution in patients with congestive heart failure, hypertension, or renal insufficiency.
- Endocrine – Drug-induced secondary adrenocortical insufficiency may be minimized by gradual reduction of dosage.
- Gastrointestinal – Steroids should be used with caution in active or latent peptic ulcers, diverticulitis, fresh intestinal anastomoses, and nonspecific ulcerative colitis, since they may increase the risk of perforation.
- Musculoskeletal – Corticosteroids decrease bone formation and increase bone resorption both through their effect on calcium regulation (i.e., decreasing absorption and increasing excretion) and inhibition of osteoblast function. This may lead to inhibition of bone growth in pediatric patients and the development of osteoporosis at any age.
- Neuro-psychiatric – Although controlled clinical trials have shown corticosteroids to be effective in speeding the resolution of acute exacerbations of multiple sclerosis, they do not show that they affect the ultimate outcome or natural history of the disease. Psychic derangements may appear when corticosteroids are used, ranging from euphoria, insomnia, mood swings, personality changes, and severe depression, to frank psychotic manifestations. Also, existing emotional instability or psychotic tendencies may be aggravated by corticosteroids.

V. Drug Interactions

- Aminoglutethimide – May diminish adrenal suppression by corticosteroids.
- Amphotericin B injection and potassium-depleting agents – Patients should be observed closely for development of hypokalemia.
- Antibiotics – Macrolide antibiotics have been reported to cause a significant decrease in corticosteroid clearance.
- Anticholinesterases – May produce weakness in patients with myasthenia gravis.
- Anticoagulants, oral – Usually results in inhibition of response to warfarin. Monitor coagulation indices frequently.
- Antidiabetics – Because corticosteroids may increase blood glucose concentrations, dosage adjustments of antidiabetic agents may be required.
- Antitubercular drugs – Serum concentrations of isoniazid may be decreased.
- Cholestyramine – May increase the clearance of corticosteroids.

- Cyclosporine – Increased activity of both cyclosporine and corticosteroids may occur when the two are used concurrently.
- Dexamethasone suppression test – False-negative results in the dexamethasone suppression test in patients being treated with indomethacin have been reported.
- Digitalis glycosides – May be at increased risk of arrhythmias due to hypokalemia.
- Ephedrine – May enhance the metabolic clearance of corticosteroids.
- Estrogens, including oral contraceptives – May decrease the hepatic metabolism of certain corticosteroids.
- Hepatic Enzyme Inducers, Inhibitors, and Substrates - Drugs which induce cytochrome P450 3A4 (CYP 3A4) enzyme activity (e.g., barbiturates, phenytoin, carbamazepine, rifampin) may enhance the metabolism of corticosteroids and require that the dosage of the corticosteroid be increased. Drugs which inhibit CYP 3A4 (e.g., ketoconazole, macrolide antibiotics such as erythromycin) have the potential to result in increased plasma concentrations of corticosteroids. Dexamethasone is a moderate inducer of CYP 3A4. Co-administration with other drugs that are metabolized by CYP 3A4 (e.g., indinavir, erythromycin) may increase their clearance, resulting in decreased plasma concentration.
- Ketoconazole – May decrease the metabolism of certain corticosteroids by up to 60%, leading to increased risk of corticosteroid side effects.
- Nonsteroidal anti-inflammatory agents – Increases the risk of gastrointestinal side effects.
- Phenytoin – Reports of both increases and decreases in phenytoin levels, leading to alterations in seizure control.
- Skin tests – May suppress reactions to skin tests.
- Thalidomide – Toxic epidermal necrolysis has been reported with concomitant use.
- Vaccines – May exhibit a diminished response to toxoids and live or inactivated vaccines due to inhibition of antibody response.

VI. Adverse Reactions

The following adverse reactions have been reported with dexamethasone or other corticosteroids:

Allergic reactions: Anaphylactoid reaction, anaphylaxis, angioedema.

Cardiovascular: Bradycardia, cardiac arrest, cardiac arrhythmias, cardiac enlargement, circulatory collapse, congestive heart failure, fat embolism, hypertension, hypertrophic cardiomyopathy in premature infants, myocardial rupture following recent myocardial infarction, edema, pulmonary edema, syncope, tachycardia, thromboembolism, thrombophlebitis, vasculitis.

Dermatologic: Acne, allergic dermatitis, dry scaly skin, ecchymoses and petechiae, erythema, impaired wound healing, increased sweating, rash, striae, suppression of reactions to skin tests, thin fragile skin, thinning scalp hair, urticaria.

Endocrine: Decreased carbohydrate and glucose tolerance, development of cushingoid state, hyperglycemia, glycosuria, hirsutism, hypertrichosis, increased requirements for insulin or oral hypoglycemic agents in diabetes, manifestations of latent diabetes mellitus, menstrual irregularities, secondary adrenocortical and pituitary unresponsiveness (particularly in times of stress, as in trauma, surgery, or illness), suppression of growth in pediatric patients.

Fluid and electrolyte disturbances: Congestive heart failure in susceptible patients, fluid retention, hypokalemic alkalosis, potassium loss, sodium retention.

Gastrointestinal: Abdominal distention, elevation in serum liver enzyme levels (usually reversible upon discontinuation), hepatomegaly, increased appetite, nausea, pancreatitis, peptic ulcer with possible perforation and hemorrhage, perforation of the small and large intestine (particularly in patients with inflammatory bowel disease), ulcerative esophagitis.

Metabolic: Negative nitrogen balance due to protein catabolism.
Musculoskeletal: Aseptic necrosis of femoral and humeral heads, loss of muscle mass, muscle weakness, osteoporosis, pathologic fracture of long bones, steroid myopathy, tendon rupture, vertebral compression fractures.

Neurological/Psychiatric: Convulsions, depression, emotional instability, euphoria, headache, increased intracranial pressure with papilledema (pseudotumor cerebri) usually following discontinuation of treatment, insomnia, mood swings, neuritis, neuropathy, paresthesia, personality changes, psychic disorders, vertigo.

Ophthalmic: Exophthalmos, glaucoma, increased intraocular pressure, posterior subcapsular cataracts.

Other: Abnormal fat deposits, decreased resistance to infection, hiccups, increased or decreased motility and number of spermatozoa, malaise, moon face, weight gain.

VII. Dosage and Administration

For oral administration
The initial dosage of dexamethasone varies from 0.75 to 9 mg a day depending on the disease being treated. (Dosage requirements are variable and must be individualized on the basis of the disease under treatment and the response of the patient)

After a favorable response is noted, the proper maintenance dosage should be determined by decreasing the initial drug dosage in small decrements at appropriate time intervals until the lowest dosage that maintains an adequate clinical response is reached.

Situations which may make dosage adjustments necessary are changes in clinical status secondary to remissions or exacerbations in the disease process, the patient's individual

drug responsiveness, and the effect of patient exposure to stressful situations not directly related to the disease entity under treatment. In this latter situation it may be necessary to increase the dosage of the corticosteroid for a period of time consistent with the patient's condition. If after long-term therapy the drug is to be stopped, it is recommended that it be withdrawn gradually rather than abruptly.

In the treatment of acute exacerbations of multiple sclerosis, daily doses of 30 mg of dexamethasone for a week followed by 4 to 12 mg every other day for one month have been shown to be effective.

In pediatric patients, the initial dose of dexamethasone may vary depending on the specific disease entity being treated. The range of initial doses is 0.02 to 0.3 mg/kg/day in three or four divided doses.

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References

1. Wolters Kluwer Health, Inc. ed. Drug Facts and Comparisons. St Louis, MO. 2011.
2. Zema-Pak [prescribing information]. Magnolia, TX. Macoven Pharmaceuticals; August 2009.

North Dakota Medicaid
DUR Board Meeting
Xifaxan® Review

I. Overview

Xifaxan (rifaximin) is a rifamycin antibacterial indicated for the treatment of patients (≥12 years of age) with travelers' diarrhea (TD) caused by noninvasive strains of *Escherichia coli.* Xifaxan is also indicated for reduction in risk of overt hepatic encephalopathy (HE) recurrence in patients ≥18 years of age.

Xifaxan should not be used in patients with diarrhea complicated by fever or blood in the stool or diarrhea due to pathogens other than *E. coli.* To reduce the development of drug-resistant bacteria and maintain the effectiveness of Xifaxan and other antibacterial drugs, Xifaxan should be used only to treat or prevent infections that are proven or strongly suspected to be caused by susceptible bacteria.

II. Dosage and Administration

- Travelers' Diarrhea – The recommended dose is one 200mg tablet taken orally three times a day for 3 days.
- Hepatic Encephalopathy – The recommended dose is one 550mg tablet taken orally two times a day, with or without food.

III. Warnings/Precautions

- Travelers' Diarrhea not caused by *E. coli.*
- Clostridium difficile-associated diarrhea
- Development of drug resistant bacteria
- Severe (Child-Pugh C) hepatic impairment

IV. Adverse Reactions

All adverse reactions for Xifaxan 200mg three times daily that occurred at a frequency ≥2% in two placebo-controlled trials include flatulence, headache, abdominal pain, rectal tenesmus, defecation urgency, nausea, constipation, pyrexia, and vomiting.

All adverse reactions for Xifaxan 550mg two times daily for reducing the risk of overt hepatic encephalopathy recurrence in adult patients that occurred at a frequency ≥5% in a placebo-controlled trial include peripheral edema, dizziness, fatigue, ascites, muscle spasms, pruritus, abdominal pain, abdominal distension, anemia, cough, depression, insomnia, nasopharyngitis, abdominal pain upper, arthralgia, back pain, constipation, dyspnea, pyrexia, rash, and nausea.

V. Drug Interactions

An *in vitro* study has suggested that rifaximin induces CYP3A4. However, in patients with normal liver function, rifaximin at the recommended dosing regimen is not expected to induce CYP3A4. It is unknown whether rifaximin can have a significant effect on the pharmacokinetics of concomitant CYP3A4 substrates in patients with reduced liver function who have elevated rifaximin concentrations.

An *in vitro* study suggested that rifaximin is a substrate of P-glycoprotein. It is unknown whether concomitant drugs that inhibit P-glycoprotein can increase the systemic exposure of rifaximin.

VI. Utilization

ND Xifaxan Utilization		
10/01/10 - 09/30/11		
Label Name	**Rx Num**	**Total Reimb Amt**
XIFAXAN 200 MG TABLET	46	$3,798.72
XIFAXAN 550 MG TABLET	82	$84,989.62
24 recipients	**128**	**$88,788.34**

References

1. Xifaxan® [prescribing information]. Morrisville, NC. Salix Pharmaceuticals, Inc.; March 2010.

North Dakota Medicaid
DUR Board Meeting
Vanos® Review

I. Overview

Vanos cream is a corticosteroid indicated for the relief of the inflammatory and pruritic manifestations of corticosteroid responsive dermatoses in patients 12 years of age or older. Treatment beyond 2 consecutive weeks is not recommended and the total dosage should not exceed 60g per week because of the potential for the drug to suppress the hypothalamic-pituitary-adrenal (HPA) axis.

II. Dosage and Administration

- Psoriasis: apply a thin layer once or twice daily to the affected skin areas.
- Atopic Dermatitis: apply a thin layer once daily to the affected skin areas.
- Corticosteroid Responsive Dermatoses, other than psoriasis or atopic dermatitis: apply a thin layer once or twice daily to the affected areas.

III. Warnings/Precautions

- Systemic absorption may produce reversible HPA axis suppression, Cushing's syndrome, hyperglycemia and unmask latent diabetes.
- Modify use should HPA axis suppression develop.
- Potent corticosteroids, use on large areas, prolonged use or occlusive use may increase systemic absorption.
- Local adverse reactions with topical steroids may include atrophy, striae, irritation, acneiform eruptions, hypopigmentation and allergic contact dermatitis and may be more likely to occur with occlusive use or more potent corticosteroids.
- Children may be more susceptible to systemic toxicity when treated with topical corticosteroids.

IV. Adverse Reactions

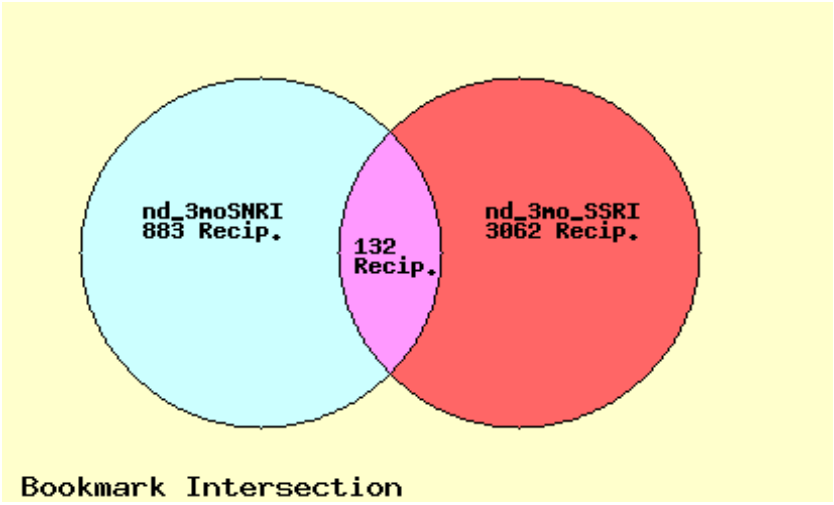
The most commonly reported adverse reactions (≥1%) were headache, application site burning, nasopharyngitis, and nasal congestion.

References

1. Vanos® [prescribing information]. Scottsdale, AZ. Medicis, The Dermatology Company; November 2011.

SSRI Utilization		
10/01/10 - 09/30/11		
Label Name	**Rx Num**	**Total Reimb**
CELEXA 20 MG TABLET	8	$888.26
CITALOPRAM HBR 10 MG TABLET	618	$5,415.70
CITALOPRAM HBR 10 MG/5 ML SOLN	76	$3,267.29
CITALOPRAM HBR 20 MG TABLET	2231	$21,167.94
CITALOPRAM HBR 40 MG TABLET	1942	$18,457.73
FLUOXETINE 20 MG/5 ML SOLUTION	254	$4,905.47
FLUOXETINE DR 90 MG CAPSULE	76	$7,476.81
FLUOXETINE HCL 10 MG CAPSULE	1116	$8,025.77
FLUOXETINE HCL 10 MG TABLET	350	$2,929.43
FLUOXETINE HCL 20 MG CAPSULE	5108	$47,288.25
FLUOXETINE HCL 20 MG TABLET	104	$910.26
FLUOXETINE HCL 40 MG CAPSULE	9	$121.25
FLUVOXAMINE MALEATE 100 MG TAB	209	$5,605.76
FLUVOXAMINE MALEATE 25 MG TAB	37	$1,006.64
FLUVOXAMINE MALEATE 50 MG TAB	73	$1,256.28
LEXAPRO 10 MG TABLET	355	$29,885.40
LEXAPRO 20 MG TABLET	4021	$366,575.57
LEXAPRO 5 MG TABLET	12	$586.48
LEXAPRO 5 MG/5 ML SOLUTION	16	$2,893.86
LUVOX CR 100 MG CAPSULE	11	$1,856.10
LUVOX CR 150 MG CAPSULE	1	$170.08
PAROXETINE CR 12.5 MG TABLET	8	$575.04
PAROXETINE CR 25 MG TABLET	72	$8,494.93
PAROXETINE CR 37.5 MG TABLET	58	$5,200.92
PAROXETINE HCL 10 MG TABLET	202	$2,001.55
PAROXETINE HCL 20 MG TABLET	681	$7,854.15
PAROXETINE HCL 30 MG TABLET	256	$3,069.93
PAROXETINE HCL 40 MG TABLET	835	$11,397.06
PAXIL 10 MG/5 ML SUSPENSION	5	$925.90
PAXIL CR 25 MG TABLET	26	$4,723.53
PROZAC 20 MG PULVULE	25	$16,973.88
PROZAC 40 MG PULVULE	5	$1,934.50
PROZAC WEEKLY 90 MG CAPSULE	28	$3,335.84
SERTRALINE 20 MG/ML ORAL CONC	39	$2,034.65
SERTRALINE HCL 100 MG TABLET	4534	$43,718.23
SERTRALINE HCL 25 MG TABLET	667	$5,717.53
SERTRALINE HCL 50 MG TABLET	2606	$23,177.91
VIIBRYD 10 MG TABLET	5	$385.14
VIIBRYD 20 MG TABLET	5	$487.52
VIIBRYD 40 MG TABLET	12	$1,496.97
5,456 recipients	**26707**	**$674,195.51**

SNRI Utilization		
10/01/10 - 09/30/11		
Label Name	**Rx Num**	**Total Reimb**
CYMBALTA 20 MG CAPSULE	54	$8,390.31
CYMBALTA 30 MG CAPSULE	1256	$170,653.71
CYMBALTA 60 MG CAPSULE	2929	$474,432.16
PRISTIQ ER 100 MG TABLET	270	$33,781.99
PRISTIQ ER 50 MG TABLET	565	$71,184.89
SAVELLA 100 MG TABLET	49	$4,043.96
SAVELLA 12.5 MG TABLET	4	$302.76
SAVELLA 25 MG TABLET	23	$2,340.13
SAVELLA 50 MG TABLET	120	$12,789.10
SAVELLA TITRATION PACK	27	$2,666.05
VENLAFAXINE HCL 100 MG TABLET	26	$1,114.14
VENLAFAXINE HCL 25 MG TABLET	25	$341.27
VENLAFAXINE HCL 37.5 MG TABLET	63	$1,571.05
VENLAFAXINE HCL 50 MG TABLET	14	$427.20
VENLAFAXINE HCL 75 MG TABLET	110	$2,971.41
VENLAFAXINE HCL ER 150 MG CAP	1462	$157,910.20
VENLAFAXINE HCL ER 225 MG TAB	94	$21,238.54
VENLAFAXINE HCL ER 37.5 MG CAP	432	$25,997.20
VENLAFAXINE HCL ER 75 MG CAP	1237	$99,809.76
1,490 recipients	**8760**	**$1,091,965.83**



NORTH DAKOTA MEDICAID
RETROSPECTIVE DRUG UTILIZATION REVIEW
CRITERIA RECOMMENDATIONS
1ST QUARTER 2012

Criteria Recommendations ***Approved Rejected***

1. Clobazam / Overutilization (≥ 10 yoa) _____ _____

Alert Message: Onfi (clobazam) may be over-utilized. Patients weighing greater than 30 kg should have therapy initiated at 10 mg daily and titrated as tolerated to a maximum of 40 mg daily. Patients weighing 30 kg or less should have clobazam therapy initiated at 5 mg daily and titrated as tolerated to 20 mg daily.

Conflict Code: ER - Overutilization
Drugs/Diseases
Util A Util B Util C
Clobazam

Max Dose: 40mg/day
Age Range: ≥ 10 yoa
We do not receive weight data for patients so an age range was chosen to reduce the number of false positives. The age range of 10 years of age and older was selected because the average weight of a 10 year child is 86 pounds (85 for males, 88 for females according to CDC Body Mass Index Report 2000).

References:
Onfi Prescribing Information, October 2011, Lundbeck, Inc.

2. Clobazam / Overutilization (2-9 yoa) _____ _____

Alert Message: Onfi (clobazam) may be over-utilized. Patients weighing 30 kg or less should have clobazam therapy initiated at 5 mg daily and titrated as tolerated to 20 mg daily. Patients weighing greater than 30 kg should have therapy initiated at 10 mg daily and titrated as tolerated to a maximum of 40 mg daily.

Conflict Code: ER - Overutilization
Drugs/Diseases
Util A Util B Util C
Clobazam

Max Dose: 20mg/day
Age Range: 2-9 yoa

References:
Onfi Prescribing Information, October 2011, Lundbeck, Inc.

3. Clobazam / TA - Therapeutic Appropriateness (<2 yoa) _____ _____

Alert Message: The safety and effectiveness of Onfi (clobazam) in patients less than 2 years of age have not been established.

Conflict Code: TA - Therapeutic Appropriateness
Drugs/Diseases
Util A Util B Util C
Clobazam

Age Range: 0-1 yoa

References:
Onfi Prescribing Information, October 2011, Lundbeck, Inc.

4. Clobazam / Nonadherence _____ _____

Alert Message: Based on the refill history, your patient may be underutilizing Onfi (clobazam). Non-adherence to the prescribed dosing regimen may result in sub-therapeutic effects, which may lead to decreased patient outcomes and additional healthcare costs. If the patient is discontinuing clobazam it should be withdrawn gradually by decreasing the total daily dose by 5 - 10 mg/day on a weekly basis until discontinued in order to avoid seizure occurrence or withdrawal symptoms.

Conflict Code – LR - Nonadherence
Drugs/Diseases

Util A	Util B	Util C
Clobazam		

References:
Onfi Prescribing Information, October 2011, Lundbeck, Inc.

5. Clobazam / Moderate & Strong CYP2C19 Inhibitors _____ _____

Alert Message: Onfi (clobazam) is a CYP2C19 substrate and concurrent use with a strong or moderate CYP2C19 inhibitor may result in increased exposure to the active metabolite of clobazam (N-desmethylclobazam). Dosage adjustment of clobazam may be necessary.

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

Util A	Util B	Util C
Clobazam	Fluconazole	
	Fluvoxamine	
	Ticlopidine	
	Omeprazole	
	Esomeprazole	
	Fluoxetine	
	Voriconazole	

References:
Onfi Prescribing Information, October 2011, Lundbeck, Inc.
FDA Drug Development and Drug Interactions: Table of Substrates, Inhibitors and Inducers: Table of Substrates, Inhibitors.
Available at:
http://www.fda.gov/drugs/developmentapprovalprocess/developmentresources/druginteractionslabeling/ucm093664.htm

6. Clobazam / CNS Depressants _____ _____

Alert Message: Onfi (clobazam) has a CNS depressant effect and concurrent use with other CNS depressants may result in potentiated depressants effects.

Conflict Code
Drugs/Diseases

Util A	Util B	Util C
Clobazam	Narcotics	
	Barbiturates	
	Benzodiazepines	
	Sedative/Hypnotics	
	Muscle Relaxants	
	Antihistamines	
	Antipsychotics	

References:
Onfi Prescribing Information, October 2011, Lundbeck, Inc.
Micromedex Healthcare Series, DrugDex Drug Evaluations, 2011 Thomson Reuters.

7. Clobazam / CYP3A4 Metabolized Hormonal Contraceptives _____ _____

Alert Message: Onfi (clobazam) is a weak CYP3A4 inducer and concurrent use with CYP3A4-metabolized hormonal contraceptives may diminish the effectiveness of the contraceptive agent. The manufacturer recommends the use an additional non-hormonal form of contraception when using clobazam.

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

Util A	Util B	Util C
Clobazam	CYP3A4 Metabolized Hormonal Contraceptives	

References:
Onfi Prescribing Information, October 2011, Lundbeck, Inc.
Micromedex Healthcare Series, DrugDex Drug Evaluations, 2011 Thomson Reuters.

8. Clobazam / Substance Abuse _____ _____

Alert Message: Onfi (clobazam) should be used with caution in patients with a history of substance abuse because of the predisposition of such patients to habituation and dependence. Clobazam is a benzodiazepine and in clinical trials, cases of dependency were reported following abrupt discontinuation of clobazam.

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

Util A	Util B	Util C
Clobazam	Drug Abuse	

References:
Onfi Prescribing Information, October 2011, Lundbeck, Inc.

9. Clobazam / CYP2D6 Metabolized Drugs _____ _____

Alert Message: Onfi (clobazam) is a CYP2D6 inhibitor and concurrent use with drugs metabolized by CYP2D6 may cause increased plasma concentrations of the substrate. Dosage adjustment of the CYP2D6 substrate may be required.

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

Util A	Util B			Util C
Clobazam	Dextromethorphan	Aripiprazole	Paroxetine	Ondansetron
	Atomoxetine	Carvedilol	Propafenone	Promethazine
	Metoprolol	Duloxetine	Propranolol	Chlorpheniramine
	Nebivolol	Flecainide	Risperidone	
	Perphenazine	Fluoxetine	Tamoxifen	
	Tolterodine	Fluvoxamine	Timolol	
	Venlafaxine	Haloperidol	Tramadol	
	Thioridazine	Mexiletine	Amphetamine	
	Tricyclic Antidepressants	Oxycodone	Donepezil	

References:
Onfi Prescribing Information, October 2011, Lundbeck, Inc.
FDA Drug Development and Drug Interactions: Table of Substrates, Inhibitors and Inducers: Table of Substrates, Inhibitors.
Available at:
http://www.fda.gov/drugs/developmentapprovalprocess/developmentresources/druginteractionslabeling/ucm093664.htm
Micromedex Healthcare Series, DrugDex Drug Evaluations, 2011 Thomson Reuters.

10. Clobazam / Alcohol Abuse/Dependence _____ _____

Alert Message: A review of the patient's diagnostic profile reveals that they may consume alcohol. The concurrent use of Onfi (clobazam) with alcohol has been reported to increase the maximum plasma exposure of clobazam by approximately 50%. Caution patients against use of alcohol while taking clobazam.

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

Util A	Util B	Util C
Clobazam	Alcohol Dependence	
	Acute Alcohol Intoxication	
	Other/Unspecified Alcohol Dependence	

References:
Onfi Prescribing Information, October 2011, Lundbeck, Inc.

11. Dronedarone / Warfarin _____ _____

Alert Message: Post-marketing cases of increased INR with or without bleeding events have been reported in warfarin-treated patients initiated on Multaq (dronedarone). Monitor INR after initiating dronedarone in patients taking warfarin.

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

Util A	Util B	Util C
Dronedarone	Warfarin	

References:
Facts & Comparisons, 2012 Updates.
Clinical Pharmacology, 2012 Elsevier/Gold Standard.
Multaq Prescribing Information, December 2011, Sanofi-Aventis U.S. LLC.

12. Dronedarone / Atrial Fibrillation (Black Box Warning) _____ _____

Alert Message: Multaq (dronedarone) is contraindicated in patients with atrial fibrillation (AF) who will not or cannot be cardioverted into normal sinus rhythm. In patients with permanent AF, dronedarone doubles the risk of death, stroke, and hospitalization for heart failure. Patients treated with dronedarone should undergo monitoring of cardiac rhythm at least once every 3 months.

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

Util A	Util B	Util C
Dronedarone	Atrial Fibrillation	

References:
Multaq Prescribing Information, December 2011, Sanofi-Aventis U.S. LLC.
FDA Safety Communication: Review Update of Multaq (dronedarone) and Increased Risk of Death and Serious Cardiovascular Adverse Events. [12-19-2011].
Available at: http://www.fda.gov/Drugs/DrugSafety/ucm283933.htm

DUR Board Meeting
June 4, 2012
Pioneer Room
State Capitol

North Dakota Medicaid
DUR Board Meeting
Agenda
Pioneer Room
State Capitol
June 4, 2012
1pm

1. Administrative items
    - Travel vouchers

2. Old business

• Review and approval of minutes of 03/05/12 meeting	Chair
• Budget update	Brendan
• Second review of Lorzone	Brendan
• Second review of Provigil	Brendan
• Second review of Kapvay	Brendan
• Second review of Dexpak/Zemapak	Brendan
• Second review of Xifaxan	Brendan
• Second review of Vanos	Brendan
• Update on SSRI/SNRI combinations	Brendan
• Yearly PA review	HID
o Sed/Hyps	
o Qualaquin	
o ACE-I/ARBs/Renin Inhibitors	
o Synagis	
o GH/IGF1	
o Triptans	

3. New business

• Review of Topical Steroids	HID
• Review of Kalydeco	HID
• Review of Kuvan	HID
• Review of Elaprase	HID
• Criteria recommendations	HID
• Upcoming meeting date/agenda	Chair

4. Adjourn — Chair

Please remember to silence all cellular phones and pagers during the meeting.

Drug Utilization Review (DUR) Meeting Minutes
March 5, 2012

Members Present: Norman Byers, John Savageau, Russ Sobotta, Cheryl Huber, Greg Pfister, Tanya Schmidt, Carrie Sorenson, Leann Ness, Jeffrey Hostetter, Todd Twogood, Carlotta McCleary, David Clinkenbeard
Members Absent: Kim Krohn, Steve Irsfeld, James Carlson
Medicaid Pharmacy Department: Brendan Joyce, Gary Betting
HID Staff Present: Candace Rieth

Chair G. Pfister called the meeting to order at 1:00 pm. Chair G. Pfister asked for a motion to approve the minutes from the December meeting. N. Byers moved that the minutes be approved and C. Huber seconded the motion. Chair G. Pfister called for a voice vote to approve the minutes. The motion passed with no audible dissent.

Budget Update
B. Joyce informed the board members that the spending for the biennium (July-Dec data) is under budget compared to the last biennium. Rebate changes from PPACA are still being determined. The cost of brand name drugs ten years ago was approximately 73 dollars, today it is approximately 220 dollars. The cost of generic drugs ten years ago was approximately 17 dollars, today it is approximately 22 dollars. The generic rate ten years ago was 46%, today it is 80%.

Pulmonary Arterial Hypertension Second Review
A motion and second were made at the December meeting to place agents used to treat pulmonary arterial hypertension on prior authorization. The topic was brought up for a second review. The Revatio/Adcirca PA form will be combined with the new PAH form. There was no public comment. After discussion, Chair G. Pfister called for a voice vote to approve the motion. The motion passed with no audible dissent.

Topical Acne Agents Second Review
A motion and second were made at the December meeting to place Topical Acne Agents on prior authorization. The topic was brought up for a second review. There was no public comment. Chair G. Pfister called for a voice vote to approve the motion. The motion passed with no audible dissent.

Cialis for Benign Prostatic Hyperplasia Second Review
A motion and second were made at the December meeting to place Cialis for BPH on prior authorization. The topic was brought up for a second review. There was no public comment. A suggestion was made to include 'unless contraindicated' after 'patient must try and fail all alpha blockers and 5-alpha reductase inhibitors and combinations'. J. Hostetter made a motion to amend the form. G. Pfister seconded the motion. Chair G. Pfister called for a voice vote to approve the amendment of the form. The motion passed with no audible dissent. Chair G. Pfister called for a voice vote to approve the motion. The motion passed with no audible dissent.

Combination Products Second Review
A motion and second were made at the December meeting to place combination products that are more costly to the state than their individual ingredients on prior authorization. The topic was brought up for a second review. There was no public comment. Chair G. Pfister called for a voice vote to approve the motion. The motion passed with no audible dissent.

Gralise Second Review
A motion and second were made at the December meeting to place Gralise on prior authorization. The topic was brought up for a second review. There was no public comment. Chair G. Pfister called for a voice vote to approve the motion. The motion passed with no audible dissent.

Yearly PA Review
The Board reviews products annually that have previously been placed on prior authorization. This allows the Board a chance to update the prior authorization forms and criteria. Antihistamines, PPIs, COX-II/NSAIDs, Revatio, Actoplus Met, Azasite/Quixin, Carisoprodol, Blood Factors, Relistor, Sancuso, Nuvigil, and Nucynta were reviewed. Changes made:

1. Remove Allegra from antihistamine form
2. PPIs-add duration edits as an agenda item for June meeting
3. COX-II/NSAIDs-add long term utilization information as an agenda item for June meeting
4. Revatio/Adcirca will be combined with PAH form
5. Actoplus Met will be combined with combination products form
6. Merge Carisoprodol and Soma 250 form

Lorzone Review
B. Joyce reviewed Lorzone information with the Board. There was no public comment. After discussion, N. Byers made a motion to place Lorzone on prior authorization with criteria of trial and failure of chlorzoxazone. J. Hostetter seconded the motion. This topic will be brought up at the next meeting for finalization.

Provigil Review
B. Joyce reviewed Provigil information with the Board. There was no public comment. After discussion, N. Byers made a motion to place Provigil on prior authorization for FDA approved indication. C. Sorenson seconded the motion. This topic will be brought up at the next meeting for finalization.

Kapvay Review
B. Joyce reviewed Kapvay information with the Board. There was no public comment. After discussion, G. Pfister made a motion to place Kapvay on prior authorization. J. Savageau seconded the motion. This topic will be brought up at the next meeting for finalization.

Dexpak/Zemapak Review
B. Joyce reviewed Dexpak/Zemapak with the Board. There was no public comment. After discussion, T. Twogood made a motion to place Dexpak/Zemapak on prior authorization. J. Hostetter seconded the motion. This topic will be brought up at the next meeting for finalization.

Xifaxan Review
B. Joyce reviewed Xifaxan with the Board. There was no public comment. J. Hostetter made a motion to place Xifaxan on prior authorization for approved indication. T. Twogood seconded the motion. This topic will be brought up at the next meeting for finalization.

Vanos Review
B. Joyce reviewed Vanos with the Board. There was no public comment. G. Pfister made a motion to place Vanos on prior authorization. J. Savageau seconded the motion. This topic will be brought up at the next meeting for finalization.

SSRI/SNRI Combination Review
Brendan reviewed SSRI/SNRI combination information with the Board. There was no public comment. A suggestion was made that an educational letter, with a survey, be sent to prescribers of these combinations.

Criteria Recommendations
The recommended RDUR criteria enclosed in the packet were developed from product information provided by the manufacturers and usually are consistent with new indications, new drugs added, new warnings, etc. These proposed criteria will be added to the current set of criteria, and will be used in future DUR cycles. C. Huber moved to approve the new criteria and T. Twogood seconded the motion. Chair G. Pfister called for a voice vote. The motion passed with no audible dissent.

The next DUR board meeting will be held June 4, 2012. G. Hostetter made a motion to adjourn the meeting. N. Byers seconded. The motion passed with no audible dissent. Chair G. Pfister adjourned the meeting at 2:45 pm.

LORZONE PA FORM

Prior Authorization Vendor for ND Medicaid

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-773-0695

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 Signature		Date	

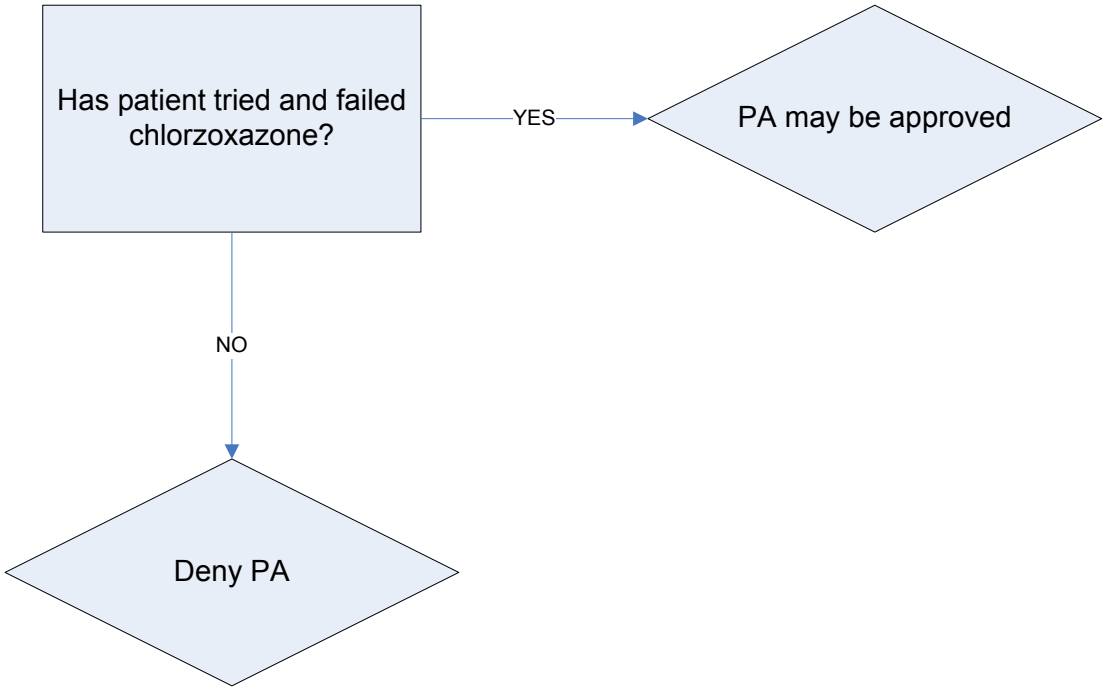
Part II: TO BE COMPLETED BY PHARMACY

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
Lorzone Prior Authorization Algorithm



PROVIGIL PA FORM

Prior Authorization Vendor for ND Medicaid

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-773-0695

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

- **Patient must suffer from excessive sleepiness associated with narcolepsy, obstructive sleep apnea, or shift work disorder.**

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: □ PROVIGIL	**Diagnosis for this Request:**		
QUALIFICATIONS FOR COVERAGE: □ Narcolepsy - Sleep study must be attached □ Obstructive Sleep Apnea - Sleep study must be attached □ Shift Work Sleep Disorder – Current shift schedule must be attached			
□ *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 Signature		Date	

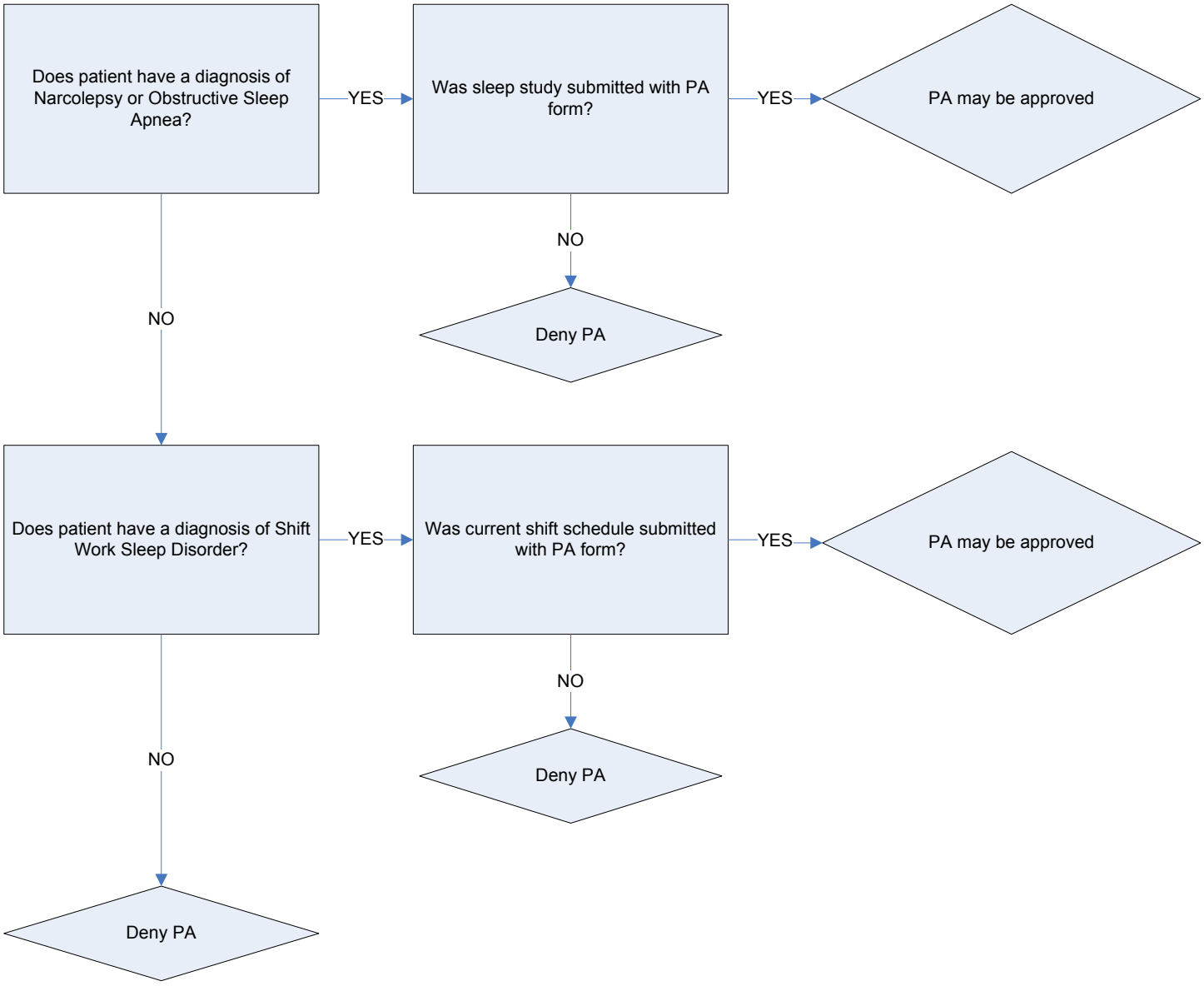
Part II: TO BE COMPLETED BY PHARMACY

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
Provigil Prior Authorization Algorithm



KAPVAY PA FORM

Prior Authorization Vendor for ND Medicaid

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-773-0695

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

- **Patient must first try 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 Signature		Date	

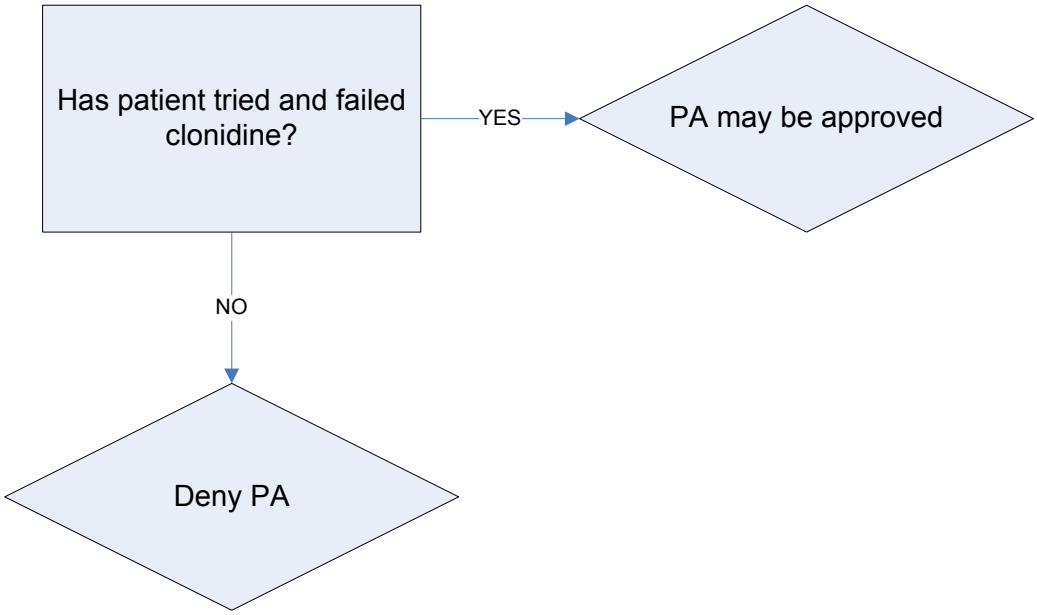
Part II: TO BE COMPLETED BY PHARMACY

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
Kapvay Prior Authorization Algorithm



DEXPAK/ZEMAPAK PA FORM

HEALTH INFORMATION DESIGNS

Prior Authorization Vendor for ND Medicaid

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-773-0695

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	
Physician Name			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ DEXPAK □ ZEMA-PAK	**Diagnosis for this Request:**		
Failed Therapy (dose and frequency): □ DEXAMETHASONE	**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 Signature		Date	

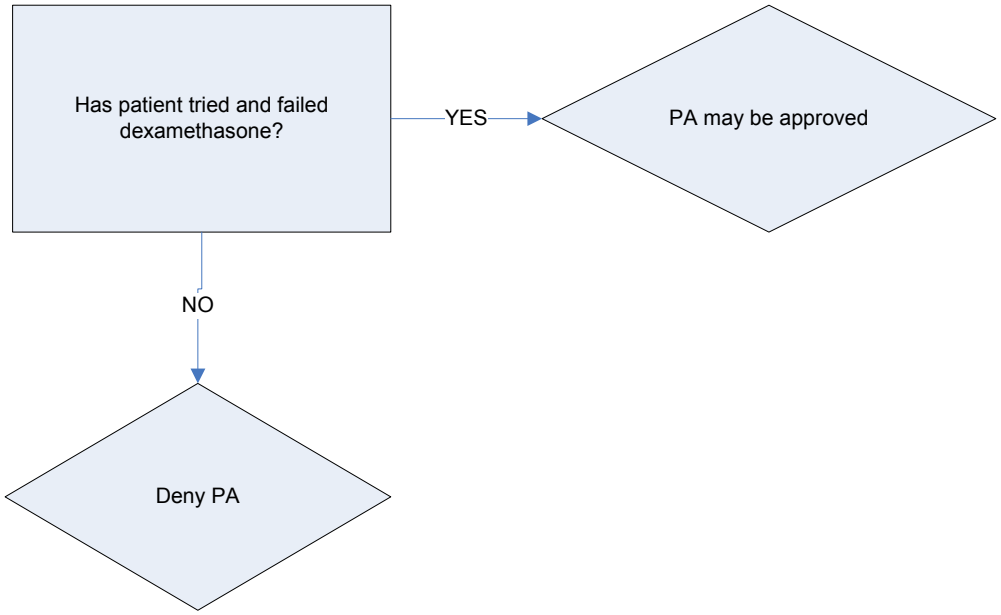
Part II: TO BE COMPLETED BY PHARMACY

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
Dexpak/Zemapak Prior Authorization Algorithm



XIFAXAN PA FORM

Prior Authorization Vendor for ND Medicaid

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-773-0695

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 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	
Physician Name			
Physician Medicaid Provider Number	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 Signature		Date	

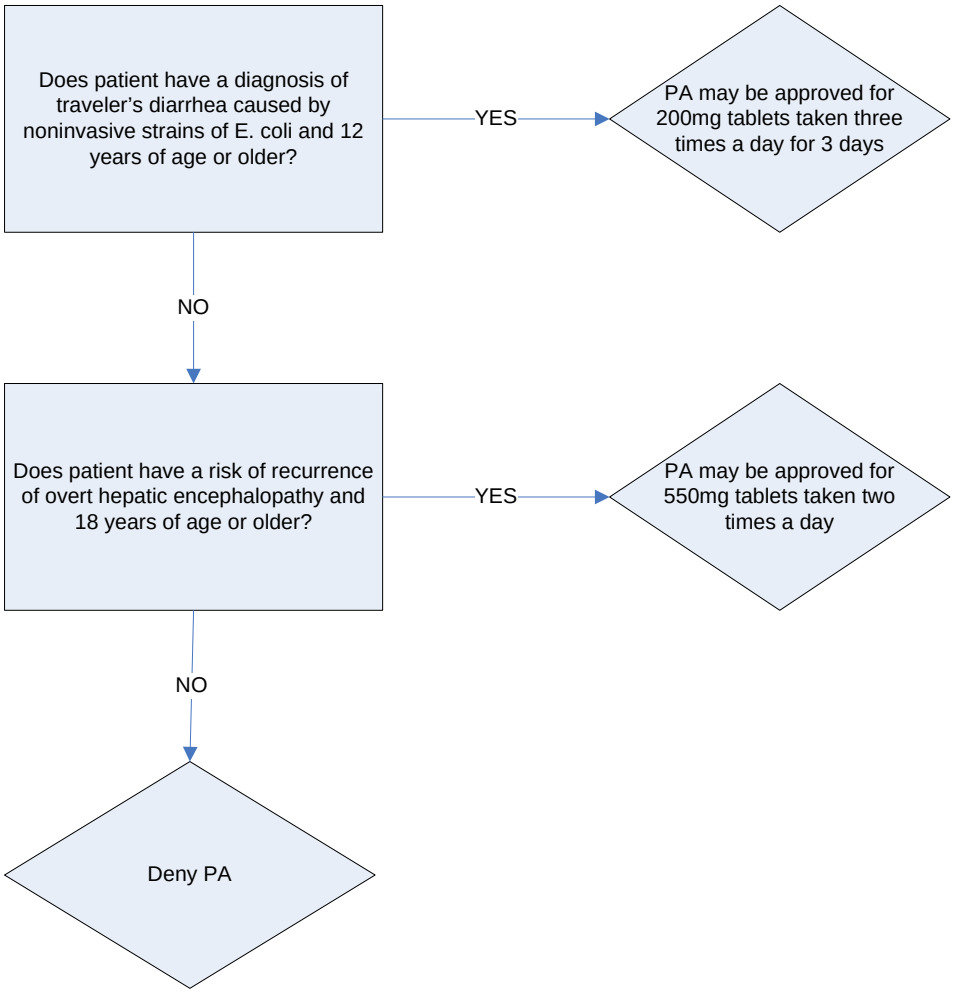
Part II: TO BE COMPLETED BY PHARMACY

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
Xifaxan Prior Authorization Algorithm



VANOS PA FORM

Prior Authorization Vendor for ND Medicaid

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-773-0695

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 failure with a generic topical steroid in the same potency class (Ultravate, Temovate, Diprolene).**

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 Signature		Date	

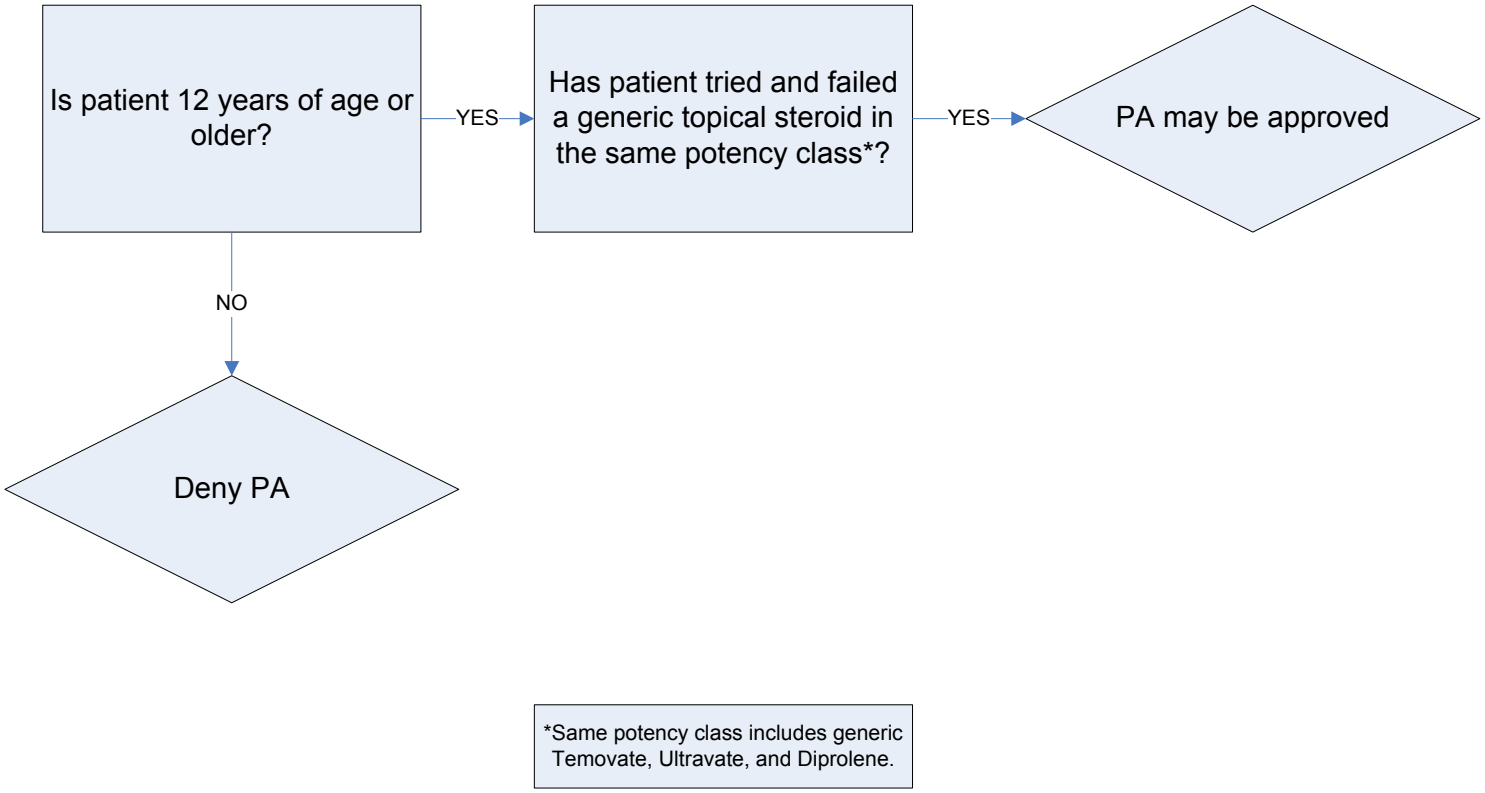
Part II: TO BE COMPLETED BY PHARMACY

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
Vanos Prior Authorization Algorithm



HEALTH INFORMATION DESIGNS

Prior Authorization Vendor for ND Medicaid

Sedative/Hypnotic PA Form

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-773-0695

ND Medicaid requires that patients receiving a new prescription for a name brand Sedative/Hypnotic must use Ambien® (zolpidem) as first line therapy.

Note:

- **The PA will be approved if there is a failed trial of Ambien (zolpidem).**
- **Estazolam, flurazepam, temazepam, triazolam, quazepam and Ambien (zolpidem) 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 Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:	**Diagnosis for this request:**		
Qualifications for coverage:			
□ FAILED AMBIEN (ZOLPIDEM)	Start Date: End Date:	Dose: Frequency:	
□ HIGH RISK FOR ADDICTION			
□ *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 Signature		Date	

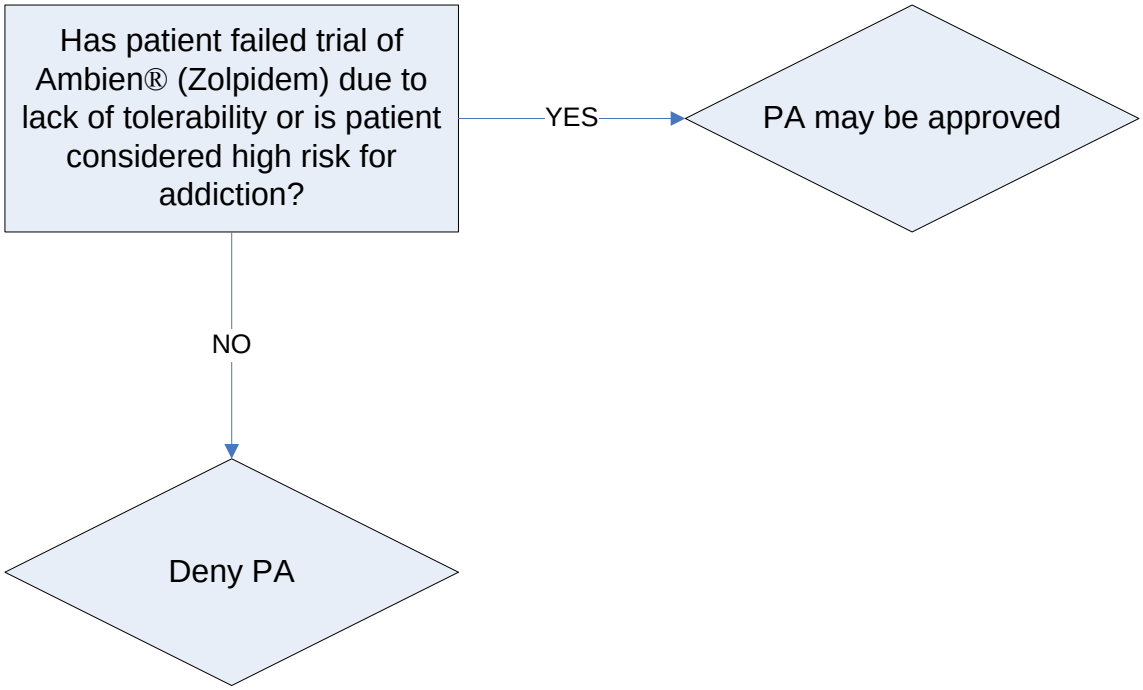
Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
PHONE 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
Sedative/Hypnotic Authorization Algorithm



QUALAQUIN PA FORM

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid will cover Qualaquin with a diagnosis of Malaria.

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: □ **QUALAQUIN**	**Requested Dosage:** (must be completed)

Qualifications for coverage:

□ Diagnosis of malaria

□ *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 Signature: Date:

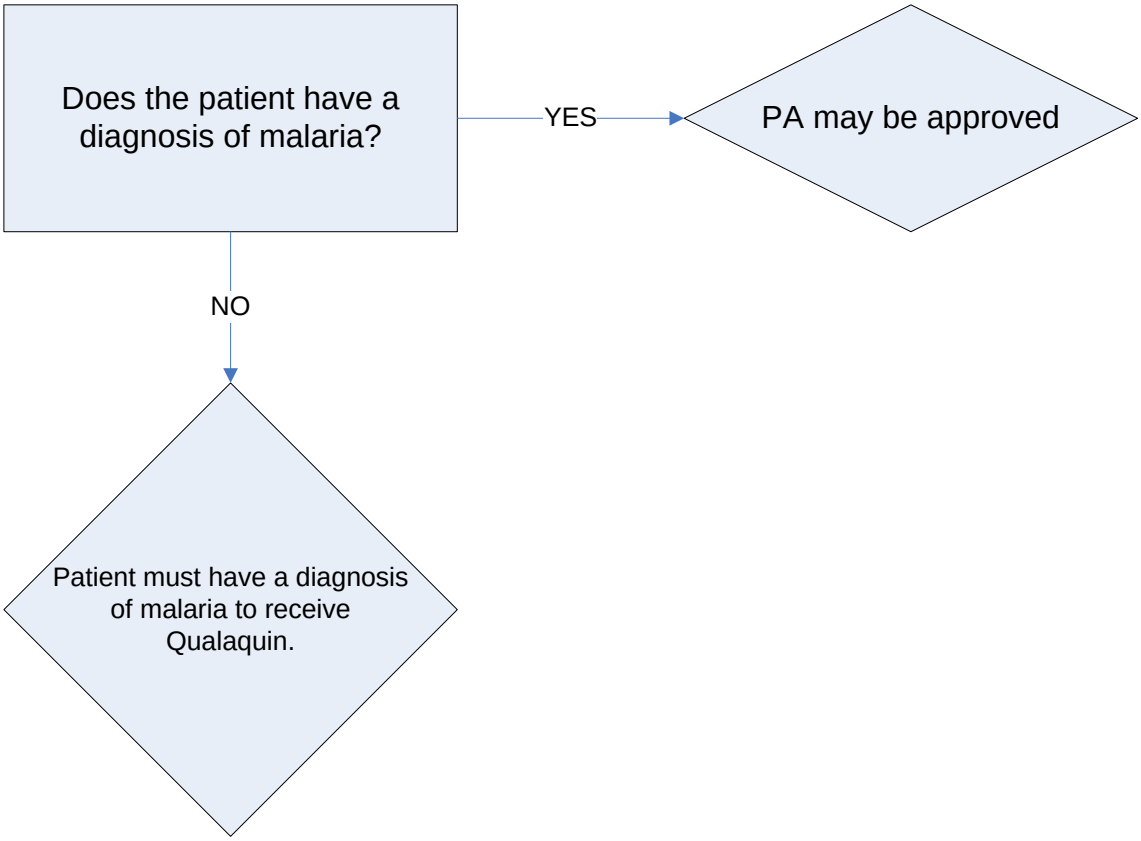
Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
Phone:			FAX:
Drug:			NDC#:

Part III: FOR OFFICIAL USE ONLY

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

North Dakota Department of Human Services
Qualaquin Criteria Algorithm



ACE-Inhibitors (ACE-I), Angiotensin II Receptor Blockers (ARB) and Renin Inhibitor PA Form

Fax Completed Form to: 866-254-0761
For questions regarding this Prior authorization, call 866-773-0695

Prior Authorization Vendor for ND

ND Medicaid requires that patients receiving a prescription for Aceon must try at least two generic ACE-Is as first line.
ND Medicaid requires that patients receiving an ARB or Renin Inhibitor must try and fail one ACE-I.

***Note:**

- **ACE-I: Captopril, enalapril, moexipril, ramipril, lisinopril, trandolapril, quinapril, benazepril, and fosinopril and their hydrochlorothiazide containing combinations do not require a prior authorization.**
- **Angiotensin II receptor antagonists: Cozaar, Micardis, Teveten, Atacand, Diovan, Avapro, Benicar, Edarbi and their hydrochlorothiazide containing combinations.**
- **Renin Inhibitor: Tekturna and Tekturna HCT.**

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:**		
Qualifications for coverage:			

□ Failed ACE-I therapy (list two ACE-I to receive Aceon)	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 Signature	Date

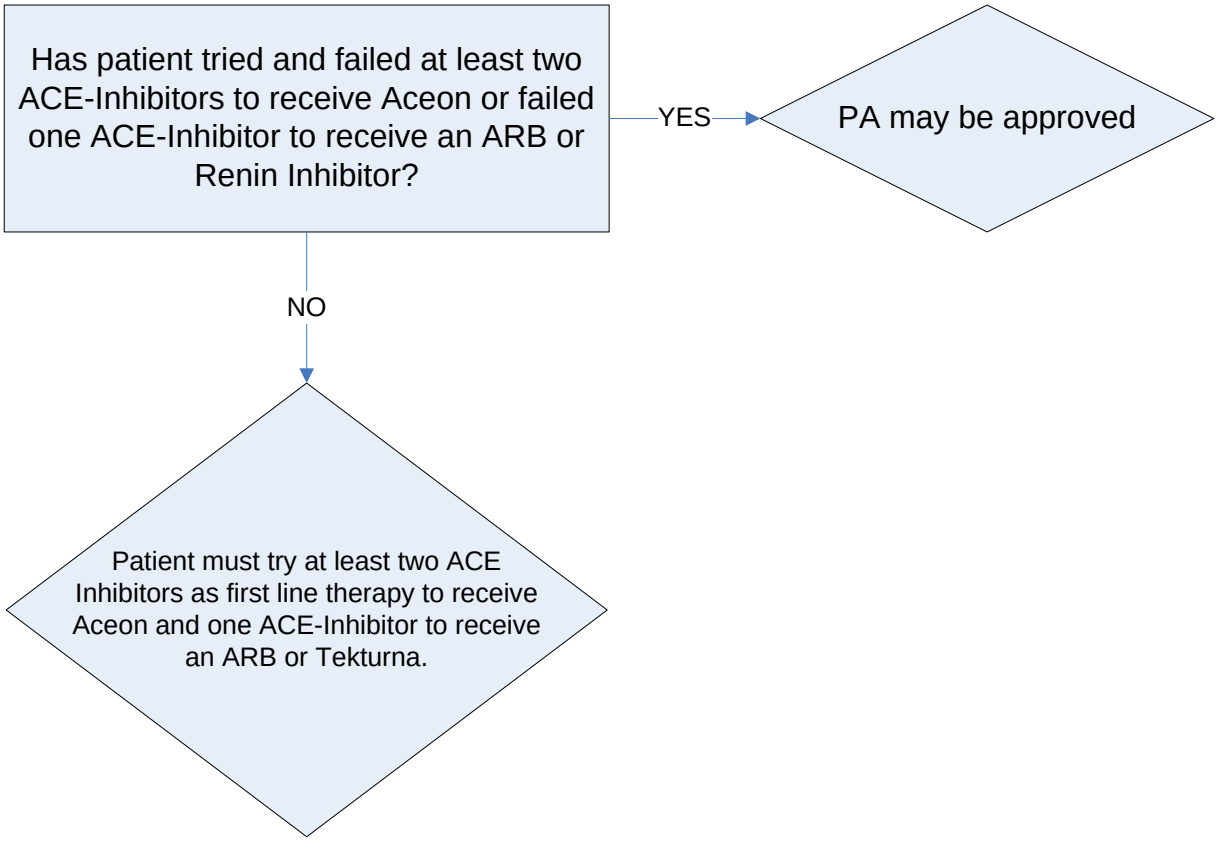
Part II: TO BE COMPLETED BY PHARMACY

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
ACE-Is, ARBs and Renin Inhibitor (Tekturna) Authorization Criteria Algorithm



ACE-I: Captopril, enalapril, moexipril, ramipril, lisinopril, trandolapril, quinapril, benazepril or fosinopril and hydrochlorothiazide combinations

ARB: Micardis, Teveten, Atacand, Avapro, Benicar, Cozaar, Diovan, Edarbi, and hydrochlorothiazide combinations

Renin Inhibitor: Tekturna and hydrochlorothiazide combination

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
- Based on the 2009 American Academy of Pediatrics *Policy Statement – Modified Recommendations for Use of Palivizumab for Prevention of Respiratory Syncytial Virus Infections**, a maximum of 5 or 3 doses will be allowed during the Synagis season determined by gestational age.
- Providers will choose when to start dosing Synagis based on prevalence of RSV in the community

TO BE COMPLETED BY PRESCRIBER

Recipient Medicaid ID Number	Recipient Date of Birth	Prescriber NPI	Prescriber Fax Number

Diagnosis (qualification for Synagis)

___ Prematurity

≤28 weeks, 6 days gestational age – Synagis allowed if younger than 12 months of age at start of RSV season (max of 5 doses)

29-31 weeks, 6 days gestational age – Synagis allowed if younger than 6 months of age at start of RSV season (max of 5 doses)

32-34 weeks, 6 days gestational age – Synagis allowed during RSV season up to 6 months of life (max of 3 doses)

Gestational Age (e.g. 32 weeks, 4 days)

Weeks _____ Days _____

Risk Factor(s) (for those 32-34 weeks, 6 days)

___ Daycare attendance

___ Sibling younger than 5 years of age

___ Chronic Lung Disease of Prematurity (CLD)

Must be less than 24 months of age and receive medical therapy within six months before start of RSV season

___ Supplemental Oxygen

___ Bronchodilator

___ Diuretic

___ Chronic corticosteroid therapy

___ Congenital Heart Disease (CHD)

Must be less than 24 months of age and requiring medical therapy for CHD

Medical Therapy Required _____

___ Neuromuscular disease

___ Congenital abnormalities of the airways

*Accessed online at http://aappolicy.aappublications.org/cgi/reprint/pediatrics;124/6/1694.pdf.

Growth Hormone PA Form

Fax Completed Form to:
866-254-0761
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) or Prader-Willi Syndrome (PWS)**
- **Human Immunodeficiency Virus (HIV) associated wasting in adults**

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:** (must be completed)	
Qualifications for coverage:		
Criteria met:	Diagnosis Date: Drug:	Dose: Frequency:
PRESCRIBER SIGNATURE	DATE:	

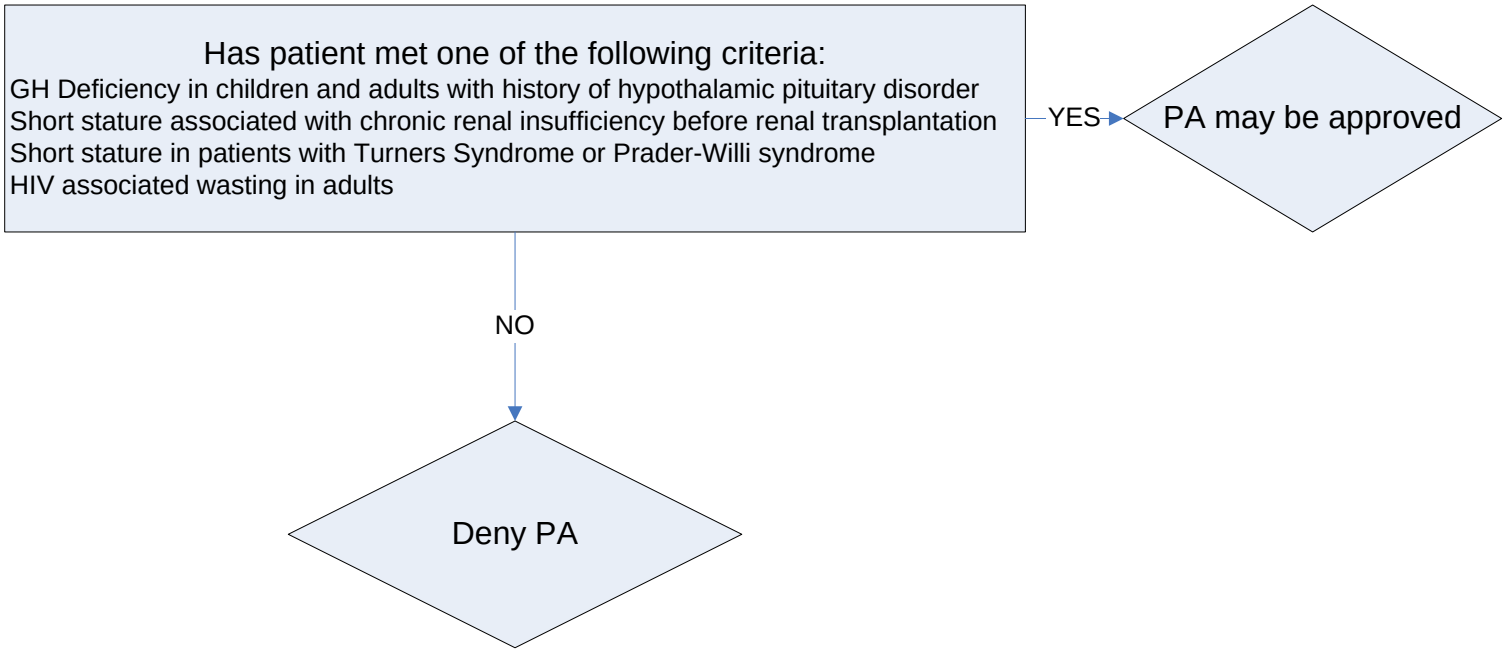
Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:	ND MEDICAID PROVIDER NUMBER:
Phone:	FAX:
Drug:	NDC#:

Part III: FOR OFFICIAL USE ONLY

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

North Dakota Department of Human Services
Growth Hormone Authorization Algorithm



Serotonin (5-HT$_1$) Receptor Agonists - Triptan PA FORM

HEALTH INFORMATION DESIGNS

Prior Authorization Vendor for ND Medicaid

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-773-0695

ND Medicaid requires that patients receiving a new prescription for Axert, Frova, Maxalt, Relpax, Treximet, or Zomig must try sumatriptan then naratriptan as first line therapies.

*__Note:__

- **Sumatriptan does not require a PA.**
- **Injectables are not subject to a prior authorization at this time.**

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: □ RELPAX □ MAXALT □ AXERT □ TREXIMET □ FROVA □ ZOMIG	**Diagnosis for this request:**		

Qualifications for coverage:

□ Failed sumatriptan therapy	Start Date	End Date	Dose	Frequency
□ Failed naratriptan 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 Signature	Date

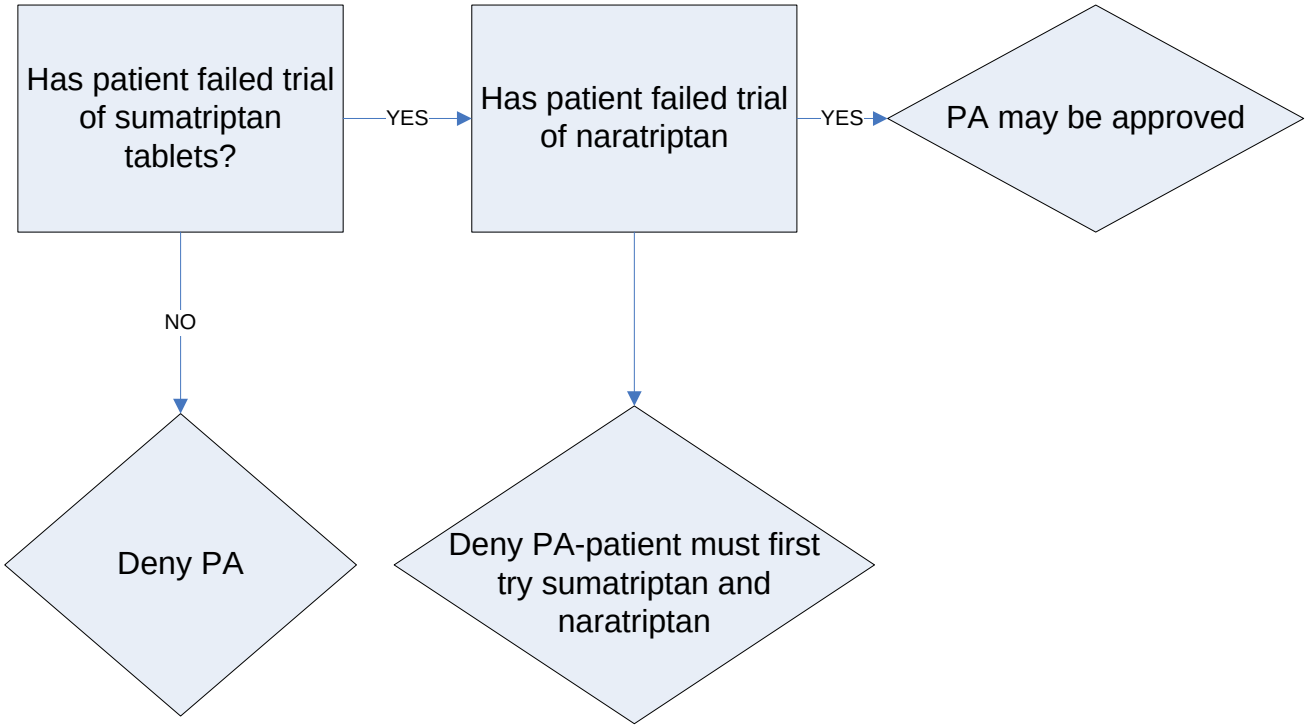
Part II: TO BE COMPLETED BY PHARMACY

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
Serotonin (5-HT_1) Receptor Agonists
Triptan Prior Authorization Algorithm



North Dakota Medicaid
DUR Board Meeting
Topical Corticosteroids® Review

I. Overview

Topical corticosteroids are anti-inflammatory agents approved for the treatment of inflammatory and pruritic manifestations of corticosteroid dermatoses. In an effort to minimize systemic adverse events, topical treatment is preferred in most cases.

The topical corticosteroids are classified based on their relative potency: super high potency (Class I), high potency (Classes II-III), medium potency (Classes IV-V), and low potency (Classes VI-VII). The super high potency agents are used to treat severe dermatoses over non-facial and non-intertriginous areas. Medium to high potency agents are often used for the treatment of mild to moderate non-facial and non-intertriginous dermatoses. Low to medium potency agents are used when large areas need to be treated due to the potential for systemic absorption. Only low potency agents should be used on the eyelids and genital areas.

Comparison of topical corticosteroid preparations

Drug	Formulation	Strength
Low Potency		
alclometasone dipropionate (Aclovate)	Ointment Cream	0.05%
betamethasone valerate (Beta-Val)	Lotion	0.1%
desonide (Desonate, Desowen, Lokara, Verdeso)	Cream Lotion Foam	0.05%
fluocinolone acetonide (Capex Shampoo, Derma-Smoothe/FS)	Cream Solution Shampoo Oil (Scalp) Oil (Body)	0.01%
hydrocortisone (Ala-Cort, Ala-Scalp, Nuzon, Scalacort, Scalacort-DK Kit, Texacort, Pediaderm HC, Pramosone, Analpram, Epifoam, Cortaid, Cortizone-10, Noble, Scalp Relief)	Ointment Cream Lotion Solution Aerosol foam Spray	Ointment: 0.5%, 1%, or 2.5% Cream: 0.5%, 1%, or 2.5% Lotion: 1% or 2.5% Solution: 1% or 2.5% Aerosol foam: 1% Spray: 1%
triamcinolone acetonide (Kenalog)	Cream Lotion	0.025%

Medium Potency		
betamethasone dipropionate (Diprosone)	Lotion	0.05%
betamethasone valerate (Beta-Val, Valisone)	Cream	0.1%
clocortolone pivalate (Cloderm)	Cream	0.1%
desonide	Ointment Gel	0.05%
fluocinolone acetonide (Synalar)	Ointment Cream	0.025%
flurandrenolide (Cordran)	Ointment Cream Lotion	Cream/Lotion: 0.05% Ointment: 0.05%
fluticasone proprionate (Cutivate)	Cream Lotion	0.05%
hydrocortisone butyrate (Locoid/Lipocream, Cortizone 10)	Ointment Cream Lotion, spray Lotion Solution	0.1%
hydrocortisone probutate (Pandel)	Cream	0.1%
hydrocortisone valerate (Westcort)	Ointment Cream	0.2%
mometasone furoate (Elocon, Momexin)	Cream Lotion Solution	0.1%
prednicarbate (Dermatop)	Cream, emollient Ointment	0.1%
triamcinolone acetonide (Kenalog)	Lotion Ointment Cream Aerosol spray	Lotion: 0.1% Ointment: 0.025% Cream: 0.1% Aerosol spray: 0.2mg per 2 second spray
High Potency		
amcinonide (Cyclocort)	Ointment Cream	0.1%
betamethasone dipropionate (Diprosone, Diprolene AF)	Ointment Cream, augmented formulation Cream, hydrophilic emollient Lotion	0.05%
betamethasone valerate (Valisone, Luxiq)	Ointment Foam	Ointment: 0.1% Foam: 0.12%
desoximetasone (Topicort, Topicort LP)	Ointment Cream Gel	Ointment: 0.25% Cream: 0.25% or 0.05% Gel: 0.05%
diflorasone diacetate (ApexiCon/E, Florone)	Ointment, emollient Cream, emollient Cream	0.05%

High Potency (cont'd)		
fluocinonide (Lidex/E)	Ointment Gel Cream anhydrous Cream aqueous emollient Solution	0.05%
fluticasone propionate (Cutivate)	Ointment	0.005%
halcinonide (Halog)	Ointment Cream	0.1%
mometasone furoate (Elocon)	Ointment	0.1%
triamcinolone acetonide (Kenalog, Triderm)	Ointment Cream	0.5%
Very High Potency		
betamethasone dipropionate augmented (Diprolene)	Ointment, optimized Lotion Gel	0.05%
clobetasol propionate (Clobex, Cormax, Temovate/E, Olux/E)	Lotion Shampoo Spray Cream Cream, emollient base Gel Ointment Solution Foam	0.05%
diflorasone diacetate (Apexicon)	Ointment (petrolatum)	0.05
fluocinonide (Vanos)	Cream	0.1%
flurandrenolide (Cordran)	Tape	4mcg/cm^2
halobetasol propionate (Ultravate)	Ointment Cream	0.05%

II. Pharmacology

Topical corticosteroids share anti-inflammatory, antipruritic, and vasoconstrictive actions that make them effective treatments in dermatological conditions. The exact mechanisms of action for the topical corticosteroids are not completely understood.

III. Contraindications/Warnings

HPA axis suppression, manifestations of Cushing's syndrome, hyperglycemia, glucosuria, and growth retardation in children can result from the systemic absorption of topical corticosteroids. Conditions which augment systemic absorption include the application of the more potent steroids, use over large surface areas, prolonged use, and the addition of occlusive dressings. If these effects are seen, the medications should be discontinued.

IV. Adverse Reactions

Local:
Burning; itching; irritation; erythema; dryness; folliculitis; hypertrichosis; pruritus; acneiform eruptions; hypopigmentation; perioral dermatitis; allergic contact dermatitis; numbness of fingers; stinging and cracking/tightening of skin; maceration of the skin; secondary infection; skin atrophy; striae; miliaria; telangiectasia. These may occur more frequently with occlusive dressings.

Systemic:
Systemic absorption of topical corticosteroids has produced reversible HPA axis suppression, manifestations of Cushing's syndrome, hyperglycemia, and glycosuria. This is more likely to occur with occlusive dressings and with the more potent steroids. Patients with liver failure or children may be at a higher risk.

The risk of adverse reactions may be minimized by changing to a less potent agent, reducing the dosage or using intermittent therapy.

V. Utilization

ND Medicaid Utilization			
02/01/11 - 01/31/12			
Label Name	**Rx Num**	**Total Reimb Amt**	**Avg Cost per Script**
ALCLOMETASONE DIPR 0.05% OINT	1	$39.58	$39.58
ALCLOMETASONE DIPRO 0.05% CRM	9	$208.40	$23.16
BETAMETHASONE DP 0.05% CRM	82	$4,103.49	$50.04
BETAMETHASONE DP 0.05% LOT	23	$1,071.99	$46.61
BETAMETHASONE DP 0.05% OINT	13	$425.42	$32.72
BETAMETHASONE DP AUG 0.05% CRM	36	$1,209.42	$33.60
BETAMETHASONE DP AUG 0.05% LOT	15	$866.72	$57.78
BETAMETHASONE DP AUG 0.05% OIN	18	$1,293.22	$71.85
BETAMETHASONE VA 0.1% CREAM	71	$1,577.45	$22.22
BETAMETHASONE VA 0.1% LOTION	24	$432.90	$18.04
BETAMETHASONE VALER 0.1% OIN	8	$128.58	$16.07
BETA-VAL 0.1% LOTION	1	$10.60	$10.60
CAPEX SHAMPOO	13	$2,645.42	$203.49
CLOBETASOL 0.05% CREAM	180	$3,059.93	$17.00
CLOBETASOL 0.05% GEL	5	$102.88	$20.58
CLOBETASOL 0.05% OINTMENT	166	$2,873.73	$17.31
CLOBETASOL 0.05% SOLUTION	70	$1,389.53	$19.85
CLOBETASOL 17 PROP POWDER	1	$25.30	$25.30
CLOBETASOL EMOLLIENT 0.05% CRM	3	$61.39	$20.46
CLOBETASOL PROP 0.05% FOAM	44	$6,498.84	$147.70
CLOBETASOL PROPIONATE POWDER	1	$8.72	$8.72
CLOBEX 0.05% SHAMPOO	24	$8,663.31	$360.97

ND Medicaid Utilization			
02/01/11 - 01/31/12			
Label Name	**Rx Num**	**Total Reimb Amt**	**Avg Cost per Script**
CLOBEX 0.05% SPRAY	1	$493.92	$493.92
CLOBEX 0.05% TOPICAL LOTION	3	$1,028.92	$342.97
CLODERM 0.1% CREAM	4	$573.66	$143.42
CORDRAN 4 MCG/SQ CM TAPE	17	$2,365.94	$139.17
CORTIFOAM 10% AEROSOL	1	$268.36	$268.36
DERMA-SMOOTHE-FS BODY OIL	106	$3,925.74	$37.04
DERMA-SMOOTHE-FS SCALP OIL	76	$2,868.71	$37.75
DERMATOP 0.1% OINTMENT	7	$403.98	$57.71
DESONATE 0.05% GEL	3	$818.74	$272.91
DESONIDE 0.05% CREAM	166	$3,820.72	$23.02
DESONIDE 0.05% LOTION	50	$2,938.01	$58.76
DESONIDE 0.05% OINTMENT	213	$5,759.56	$27.04
DESOXIMETASONE 0.05% CREAM	27	$2,762.54	$102.32
DESOXIMETASONE 0.05% GEL	15	$1,520.22	$101.35
DESOXIMETASONE 0.25% CREAM	36	$3,335.10	$92.64
DESOXIMETASONE 0.25% OINTMENT	10	$1,195.54	$119.55
DIFLORASONE 0.05% OINTMENT	3	$421.97	$140.66
FLUOCINOLONE 0.01% BODY OIL	7	$234.52	$33.50
FLUOCINOLONE 0.01% CREAM	4	$142.71	$35.68
FLUOCINOLONE 0.01% SCALP OIL	3	$68.13	$22.71
FLUOCINOLONE 0.01% SOLUTION	17	$405.23	$23.84
FLUOCINOLONE 0.025% OINT	16	$365.22	$22.83
FLUOCINONIDE 0.05% CREAM	99	$1,272.54	$12.85
FLUOCINONIDE 0.05% GEL	9	$163.69	$18.19
FLUOCINONIDE 0.05% OINTMENT	67	$1,537.12	$22.94
FLUOCINONIDE 0.05% SOLUTION	21	$329.81	$15.71
FLUOCINONIDE-E 0.05% CREAM	4	$47.75	$11.94
FLUOCINONIDE-EMOL 0.05% CREAM	4	$44.30	$11.08
FLUTICASONE PROP 0.005% OINT	10	$159.17	$15.92
FLUTICASONE PROP 0.05% CREAM	78	$3,031.19	$38.86
HALOBETASOL PROP 0.05% CREAM	15	$342.80	$22.85
HALOBETASOL PROP 0.05% OINTMNT	25	$713.80	$28.55
HALOG 0.1% OINTMENT	1	$163.61	$163.61
HYDROCORTISONE 0.1% SOLN	3	$48.77	$16.26
HYDROCORTISONE 1% CREAM	136	$1,331.58	$9.79
HYDROCORTISONE 1% OINTMENT	62	$577.93	$9.32
HYDROCORTISONE 2.5% CREAM	360	$3,819.78	$10.61
HYDROCORTISONE 2.5% LOTION	62	$2,597.59	$41.90
HYDROCORTISONE 2.5% OINTMENT	200	$2,282.09	$11.41
HYDROCORTISONE BUTY 0.1% CREAM	5	$197.22	$39.44

ND Medicaid Utilization			
02/01/11 - 01/31/12			
Label Name	**Rx Num**	**Total Reimb Amt**	**Avg Cost per Script**
HYDROCORTISONE BUTYR 0.1% OINT	4	$94.38	$23.60
HYDROCORTISONE POWDER	11	$231.43	$21.04
HYDROCORTISONE VAL 0.2% CREAM	137	$3,322.85	$24.25
HYDROCORTISONE VAL 0.2% OINTMT	65	$3,063.89	$47.14
KENALOG AEROSOL SPRAY	8	$1,246.39	$155.80
LIDOCAINE-HC 3-0.5% CREAM	1	$116.69	$116.69
MOMETASONE FUROATE 0.1% CREAM	135	$4,680.69	$34.67
MOMETASONE FUROATE 0.1% OINT	67	$2,792.77	$41.68
MOMETASONE FUROATE 0.1% SOLN	9	$345.27	$38.36
OLUX-E 0.05% FOAM	1	$354.14	$354.14
PREDNICARBATE 0.1% CREAM	9	$252.51	$28.06
PROCTOFOAM-HC FOAM	27	$1,682.65	$62.32
PROCTOSOL-HC 2.5% CREAM	130	$1,261.54	$9.70
PROCTOZONE-HC 2.5% CREAM	60	$574.71	$9.58
TRIAMCINOLONE 0.025% CREAM	123	$972.40	$7.91
TRIAMCINOLONE 0.025% LOTION	23	$697.45	$30.32
TRIAMCINOLONE 0.025% OINT	27	$372.52	$13.80
TRIAMCINOLONE 0.05% OINT	2	$37.76	$18.88
TRIAMCINOLONE 0.1% CREAM	1582	$19,926.72	$12.60
TRIAMCINOLONE 0.1% LOTION	104	$3,684.08	$35.42
TRIAMCINOLONE 0.1% OINTMENT	504	$4,818.33	$9.56
TRIAMCINOLONE 0.1% PASTE	68	$3,623.72	$53.29
TRIAMCINOLONE 0.5% CREAM	143	$1,743.72	$12.19
TRIAMCINOLONE 0.5% OINTMENT	49	$544.50	$11.11
VANOS 0.1% CREAM	1	$599.77	$599.77
Total 3,556 recipients	**6044**	**$148,115.88**	

References

1. Goldstein BG, Goldstein AO. General principles of dermatologic therapy and topical corticosteroid use. Accessed online April, 2012.
2. Wolters Kluwer Health, Inc. Drug Facts and Comparisons. St. Louis, MO. 2012.

North Dakota Medicaid
DUR Board Meeting
Kalydeco® Review

I. Indication

Kalydeco is indicated for the treatment of cystic fibrosis (CF) in patients age 6 years and older who have a G551D mutation in the cystic fibrosis conductance regulator (CFTR) gene. If the patient's genotype is unknown, an FDA-cleared CF mutation test should be used to detect the presence of the G551D mutation.

II. Dosage and Administration

Adults and pediatric patients age 6 years and older: one 150mg tablet taken orally every 12 hours with fat-containing food.

III. Pharmacology

Kalydeco is a potentiator of the CFTR protein. The CFTR protein is a chloride channel present at the surface of epithelial cells in multiple organs. Kalydeco facilitates increased chloride transport by potentiating the channel-open probability (or gating) of the G551D-CFTR protein.

IV. Warnings/Precautions

Elevated transaminases (ALT or AST): Transaminases (ALT and AST) should be assessed prior to initiating Kalydeco, every 3 months during the first year of treatment, and annually thereafter. Patients who develop increased transaminase levels should be closely monitored until the abnormalities resolve. Dosing should be interrupted in patients with ALT or AST of greater than 5 times the upper limit of normal (ULN). Following resolution of transaminase elevations, consider the benefits and risks of resuming Kalydeco dosing.

Use with CYP3A inducers: Concomitant use with strong CYP3A inducers (e.g., rifampin, St. John's Wort) substantially decreases exposure of Kalydeco which may diminish effectiveness. Therefore, co-administration is not recommended.

V. Adverse Reactions

The most common adverse drug reactions to Kalydeco (occurring ≥8% of patients with CF who have a G551D mutation in the CFTR gene) were headache, oropharyngeal pain, upper respiratory tract infection, nasal congestion, abdominal pain, nasopharyngitis, diarrhea, rash, nausea, and dizziness.

VI. Drug Interactions

CYP3A inhibitors: Reduce Kalydeco dose to 150 mg twice-a-week when co-administered with strong CYP3A inhibitors (e.g., ketoconazole). Reduce Kalydeco dose to 150 mg once daily when co-administered with moderate CYP3A inhibitors (e.g., fluconazole). Avoid food containing grapefruit or Seville oranges.

References

1. Kalydeco [prescribing information]. Cambridge, MA: Vertex Pharmaceuticals, Inc; January 2012.

North Dakota Medicaid
DUR Board Meeting
Kuvan® Review

I. Indication

Kuvan is indicated to reduce blood phenylalanine (Phe) levels in patients with hyperphenylalaninemia (HPA) due to tetrahydrobiopterin- (BH4-) responsive Phenylketonuria (PKU). Kuvan is to be used in conjunction with a Phe-restricted diet.

II. Dosage and Administration

The recommended starting dose of Kuvan is 10mg/kg/day taken once daily. Doses of Kuvan may be adjusted in the range of 5 to 20mg/kg taken once daily. Blood Phe must be monitored regularly. Kuvan should be taken orally with food to increase the absorption. Kuvan tablets should be dissolved in 4 to 8 oz. of water or apple juice and taken within 15 minutes.

III. Pharmacology

Kuvan is a synthetic form of BH4, the cofactor for the enzyme phenylalanine hydroxylase (PAH). PAH hydroxylates Phe through an oxidative reaction to form tyrosine. In patients with PKU, PAH activity is absent or deficient. Treatment with BH4 can activate residual PAH enzyme, improve the normal oxidative metabolism of Phe, and decrease Phe levels in some patients.

IV. Warnings/Precautions

Monitor Blood Phe Levels During Treatment:
Prolonged exposure to elevated blood Phe levels can injure the brain and reduce brain function. To ensure adequate blood Phe control, blood Phe levels must still be carefully monitored even though patients are receiving Kuvan which can reduce blood Phe levels.

Treat All Patients With a Phe-restricted Diet:
The initiation of Kuvan therapy does not eliminate the need for ongoing dietary management.

V. Adverse Reactions

The most common adverse reactions (incidence ≥4%) in patients treated with Kuvan are headache, diarrhea, abdominal pain, upper respiratory tract infection, pharyngolaryngeal pain, vomiting, and nausea.

VI. Drug Interactions

No drug interaction studies were performed.

References

1. Kuvan [prescribing information]. Novato, CA: BioMarin Pharmaceuticals, Inc; December 2007.

North Dakota Medicaid
DUR Board Meeting
Elaprase® Review

I. Indication

Elaprase is indicated for patients with Hunter syndrome (Mucopolysaccharidosis II, MPS II). Elaprase has been shown to improve walking capacity in these patients.

II. Dosage and Administration

The recommended dosage regimen of Elaprase is 0.5 mg/kg of body weight administered every week as an intravenous infusion.

III. Pharmacology

Hunter syndrome is an X-linked recessive disease caused by insufficient levels of the lysosomal enzyme iduronate-2-sulfatase. Treatment of Hunter syndrome patients with Elaprase provides exogenous enzyme for uptake into cellular lysosomes.

IV. Warnings/Precautions

Elaprase labeling contains a black-box warning. Life-threatening anaphylactic reactions have been observed in some patients during Elaprase infusions. Because of the potential for severe infusion reactions, appropriate medical support should be readily available when Elaprase is administered. Patients with compromised respiratory function or acute respiratory disease may be at higher risk of life-threatening complications from infusion reactions.

V. Adverse Reactions

The most serious infusion-related adverse reactions reported with Elaprase were anaphylactic and allergic reactions. In clinical studies, the most frequent serious adverse events related to the use of Elaprase were hypoxic episodes. Adverse reactions were commonly reported in association with infusions. The most common infusion-related reactions were headache, fever, cutaneous reactions (rash, pruritus, erythema, and urticaria), and hypertension.

VI. Drug Interactions

No formal drug interaction studies have been conducted with Elaprase.

References

1. Elaprase [prescribing information]. Cambridge, MA: Shire Human Genetic Therapies, Inc; November 2011.

NORTH DAKOTA MEDICAID
RETROSPECTIVE DRUG UTILIZATION REVIEW
CRITERIA RECOMMENDATIONS
2ND QUARTER 2012

Criteria Recommendations ***Approved*** ***Rejected***

1. Tapentadol ER / Overutilization _____ _____

Alert Message: The manufacturer's recommended maximum daily dose of Nucynta ER (tapentadol extended-release) is 500mg (250mg twice daily).

Conflict Code: ER - Overutilization
Drugs/Diseases

Util A	Util B	Util C **(Negating)**
Tapentadol ER		Hepatic Impairment

Max Dose: 500 mg/day

References:
Nucynta ER Prescribing Information, August 2011, Janssen Pharmaceuticals, Inc.
Facts & Comparisons, 2012 Update

2. Tapentadol ER / Overutilization – Hepatic Impairment _____ _____

Alert Message: Nucynta ER (tapentadol extended-release) should be used with caution in patients with moderate hepatic impairment. Initiate treatment in these patients using 50 mg tapentadol extended-release and administer no more frequently than once every 24 hours. The maximum recommended dose for patients with moderate hepatic impairment is 100 mg once daily.

Conflict Code: ER - Overutilization
Drugs/Diseases

Util A	Util B	Util C **(Including)**
Tapentadol ER		Hepatic Impairment

Max Dose: 100 mg/day

References:
Nucynta ER Prescribing Information, August 2011, Janssen Pharmaceuticals, Inc.
Facts & Comparisons, 2012 Updates.

3. Tekturna HCT / Overutilization _____ _____

Alert Message: The manufacturer's recommended maximum dose of Tekturna HCT (aliskiren/hydrochlorothiazide) is 300/25 mg per day. Exceeding the recommended dose may result in the potential for adverse effects (e.g., diarrhea, influenza, and dizziness).

Conflict Code: ER - Overutilization
Drugs/Diseases

Util A	Util B	Util C
Tekturna HCT		

Max Dose : 300/25mg/day

References:
Tekturna HCT Prescribing Information, Feb. 2012, Novartis Pharmaceuticals, Corp.

4. Valturna / Overutilization _____ _____

Alert Message: The manufacturer's recommended maximum dose of Valturna (aliskiren/valsartan) is 300/320 mg per day. Exceeding the recommended dose may result in the potential for adverse effects (e.g., diarrhea, fatigue, and nasopharyngitis).

Conflict Code: ER - Overutilization
Drugs/Diseases
Util A Util B Util C
Valturna

Max Dose: 300/320mg/day

References:
Valturna Prescribing Information, Dec. 2011, Novartis Pharmaceuticals Corp.
Facts & Comparisons, 2012 Updates.

5. Amturnide / Overutilization _____ _____

Alert Message: The manufacturer's recommended maximum dose of Amturnide (aliskiren/amlodipine/hctz) is 300/10/25 mg per day. Exceeding the recommended dose may result in the potential for adverse effects (e.g., diarrhea, peripheral edema, and headache).

Conflict Code: ER - Overutilization
Drugs/Diseases
Util A Util B Util C
Amturnide

Max Dose: 300/10/25mg/day

References:
Amturnide Prescribing Information, Feb. 2012, Novartis Pharmaceuticals Corp.
Facts & Comparisons, 2012 Updates.

6. Tekamlo / Overutilization _____ _____

Alert Message: The manufacturer's recommended maximum dose of Tekamlo (aliskiren/amlodipine) is 300/10 mg per day. Exceeding the recommended dose may result in the potential for adverse effects (e.g., diarrhea, peripheral edema, and dyspepsia).

Conflict Code: ER - Overutilization
Drugs/Diseases
Util A Util B Util C
Tekamlo

Max Dose: 300/10 mg/day

References:
Tekamlo Prescribing Information, Feb. 2012, Novartis Pharmaceuticals Corp.

7. Aliskiren-All / Cyclosporine & Itraconazole _____ _____

Alert Message: The concurrent use of aliskiren-containing products with cyclosporine or itraconazole should be avoided. In clinical studies when aliskiren was given with cyclosporine or itraconazole, the blood concentrations of aliskiren were significantly increased.

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

Util A	Util B	Util C
Aliskiren-All	Cyclosporine	
	Itraconazole	

References:
Facts & Comparisons, 2012 Updates.
Clinical Pharmacology, 2012 Elsevier/Gold Standard.
Tekturna Prescribing Information, Dec. 2011 Novartis Pharmaceutical Corp.
Tekamlo Prescribing Information, Feb. 2012, Novartis Pharmaceuticals Corp.
Amturnide Prescribing Information, Feb. 2012, Novartis Pharmaceuticals Corp.
Valturna Prescribing Information, Dec. 2011, Novartis Pharmaceuticals Corp.
Tekturna HCT Prescribing Information, Feb. 2012, Novartis Pharmaceuticals, Corp.

8. Aliskiren-All / ACEIs, K+ Sparing Diuretics & K+ Supplements/Diabetes _____ _____

Alert Message: Caution should be exercised when aliskiren-containing products are co-administered with ACE inhibitors, potassium-sparing diuretics, potassium supplements or other potassium containing salt substances. The concurrent use of aliskiren with these agents may lead to increases in serum potassium.

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

Util A	Util B	Util C **(Negating)**
Aliskiren-All	ACE Inhibitors	Type 2 Diabetes
	Potassium-Sparing Diuretics	Oral Hypoglycemics
	Potassium Acetate	Exenatide
	Potassium Chloride	Liraglutide
		Pramlintide

References:
Tekamlo Prescribing Information, Feb. 2012, Novartis Pharmaceuticals Corp.
Tekturna Prescribing Information, Dec. 2011 Novartis Pharmaceutical Corp.
Amturnide Prescribing Information, Feb. 2012, Novartis Pharmaceuticals Corp.
Valturna Prescribing Information, Dec. 2011, Novartis Pharmaceuticals Corp.
Tekturna HCT Prescribing Information, Feb. 2012, Novartis Pharmaceuticals, Corp.
Facts & Comparisons, 2012 Updates.
Clinical Pharmacology, 2012 Elsevier/Gold Standard.

9. Aliskiren-All / ACEIs & ARBs / Type 2 Diabetes _____ _____

Alert Message: Due to interim results from the ALTITUDE study, as a precautionary measure, it is advised that aliskiren or aliskiren-containing fixed combination products not be used in combination with ACE inhibitors or ARBs in patients with diabetes. This population is at risk of cardiovascular and renal adverse events if the combination is used. Patients should be switched to alternative antihypertensive treatment.

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

Util A	Util B	Util C **(Include)**
Aliskiren-All	ACE Inhibitors	Diabetes
	ARBs	Insulin
		Oral Hypoglycemics
		Exenatide
		Liraglutide
		Pramlintide

References:
Direct Healthcare Professional Communication on Potential Risks of Cardiovascular and Renal adverse Events in Patients with Type 2 Diabetes and Real impairment and/or Cardiovascular Disease Treated with Aliskiren (Tekturna) Tablets and Aliskiren-containing Combination Products. January 2012
Available at: http://www.pharma.us.novartis.com/assets/pdf/TKT-1118923%20Dear_HCP_Letter_email_with%20Tek-Val%20PIs_vf.pdf

10. Valturna / Type 2 Diabetes _____ _____

Alert Message: Due to interim results from the ALTITUDE study, as a precautionary measure, it is advised that healthcare professionals stop the use of Valturna (aliskiren/valsartan) in patients with diabetes. This population is at risk of cardiovascular and renal adverse events if the combination is used. Patients should be switched to alternative antihypertensive treatment.

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

Util A	Util B	Util C
Aliskiren/Valsartan	Diabetes	
	Insulin	
	Oral Hypoglycemics	
	Exenatide	
	Liraglutide	
	Pramlintide	

References:
Direct Healthcare Professional Communication on Potential Risks of Cardiovascular and Renal adverse Events in Patients with Type 2 Diabetes and Real impairment and/or Cardiovascular Disease Treated with Aliskiren (Tekturna) Tablets and Aliskiren-containing Combination Products. January 2012
Available at: http://www.pharma.us.novartis.com/assets/pdf/TKT-1118923%20Dear_HCP_Letter_email_with%20Tek-Val%20PIs_vf.pdf

11. Aliskiren-All / NSAIDS & COX-2 Inhibitors _____ _____

Alert Message: The concurrent use of aliskiren-containing products (Tekturna, Tekturna HCT, Valturna, Tekamlo and Amturnide) with an NSAID may lead to increased risk of renal impairment and loss of antihypertensive effect. Monitor renal function periodically in patients receiving aliskiren and NSAID therapy.

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

Util A	Util B	Util C
Aliskiren-All	NSAIDS	
	COX-2 Inhibitors	

References:
Tekturna Prescribing Information, Dec. 2011 Novartis Pharmaceutical Corp.
Facts & Comparisons, 2012 Updates.
Clinical Pharmacology, 2012 Elsevier/Gold Standard.
Tekamlo Prescribing Information, Feb. 2012, Novartis Pharmaceuticals Corp.
Amturnide Prescribing Information, Feb. 2012, Novartis Pharmaceuticals Corp.
Valturna Prescribing Information, Dec. 2011, Novartis Pharmaceuticals Corp.
Tekturna HCT Prescribing Information, Feb. 2012, Novartis Pharmaceuticals, Corp.

12. Tekturna HCT & Amturnide / Severe Renal Impairment _____ _____

Alert Message: The use of the aliskiren-containing products, Tekturna HCT and Amturnide, is not recommended in patients with severe renal impairment (GFR < 30mL/min).

Conflict Code: DC – Drug /Disease and/or Drug (Drug Inferred) Warning
Drugs/Diseases

Util A	Util B	Util C
Tekturna HCT	Stage IV CKD	
	Stage V CKD	

References:
Tekturna HCT Prescribing Information, Feb. 2012, Novartis Pharmaceuticals, Corp.
Amturnide Prescribing Information, Feb. 2012, Novartis Pharmaceuticals Corp.

*Other aliskiren-containing products state use with caution in patients with severe renal impairment – criteria 2976 already turned on.

13. Aliskiren / Pregnancy / Delivery-Miscarriage-Abortion _____ _____

Alert Message: When pregnancy is detected, discontinue the aliskiren-containing product (Tekturna, Tekturna HCT, Tekamlo, Valturna & Amturnide) as soon as possible. Aliskiren is a direct renin inhibitor and drugs acting directly on the renin-angiotensin system can cause injury and death to the developing fetus. All aliskiren-containing products are FDA pregnancy category D.

Conflict Code: Drugs (Actual) Diseases Precaution
Drugs/Diseases

Util A	Util B	Util C (Negating)
Aliskiren-All	Pregnancy	Delivery
		Miscarriage
		Abortion

References:
Tekturna HCT Prescribing Information, Dec. 2011, Novartis Pharmaceuticals, Corp.
Tekamlo Prescribing Information, Feb. 2012, Novartis Pharmaceuticals, Corp.
Valturna Prescribing Information, Feb. 2012, Novartis Pharmaceuticals, Corp.
Amturnide Prescribing Information, Feb. 2012, Novartis Pharmaceuticals, Corp.
FDA Tekturna (aliskiren) Label Revision Pregnancy Approval Letter. [02/02/2012].
Available at: http://www.accessdata.fda.gov/drugsatfda_docs/appletter/2012/021985s022ltr.pdf

14. Lovastatin / Ranolazine _____ _____

Alert Message: The risk of myopathy, including rhabdomyolysis, may be increased by concomitant administration of Ranexa (ranolazine) and lovastatin. Dose adjustment of lovastatin may be considered during coadministration with ranolazine.

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

Util A	Util B	Util C
Lovastatin	Ranolazine	

References:
Mevacor Prescribing Information, Feb. 2012, Merck & Co., Inc.
Clinical Pharmacology, 2012 Elsevier/Gold Standard.

15. Lovastatin / Colchicine _____ _____

Alert Message: Cases of myopathy, including rhabdomyolysis, have been reported with lovastatin co-administered with colchicine, and caution should be exercised when prescribing lovastatin with colchicine.

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

Util A	Util B	Util C
Lovastatin	Colchicine	

References:
Mevacor Prescribing Information, Feb. 2012, Merck & Co., Inc.

16. Lovastatin / Strong CYP3A4 Inhibitors _____ _____

Alert Message: The concurrent use of lovastatin, a CYP3A4 substrate, with a strong CYP3A4 inhibitor is contraindicated due to the increased risk of lovastatin-related myopathy and rhabdomyolysis.

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

Util A	Util B	Util C
Lovastatin	Ketoconazole	
	Itraconazole	
	Posaconazole	
	Nefazodone	
	Boceprevir	
	Telaprevir	
	Clarithromycin	
	Telithromycin	
	Erythromycin	

References:
Mevacor Prescribing Information, Feb. 2012, Merck & Co., Inc.

17. Rosuvastatin / Kaletra or Atazanavir (Ritonavir-Boost or Alone) _____ _____

Alert Message: The dose of Crestor (rosuvastatin) should not exceed 10 mg once daily in patients also receiving HIV protease inhibitors, Kaletra (lopinavir/ritonavir), Reyataz (atazanavir) or ritonavir- boosted atazanavir. Protease inhibitors are CYP3A4 inhibitors and concurrent use with rosuvastatin, a 3A4 substrate, may elevate rosuvastatin levels and increase the risk of statin-related myopathy and rhabdomyolysis.

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

Util A	Util B	Util C
Rosuvastatin 20 & 40	Lopinavir/Ritonavir Atazanavir	

References:
Crestor Prescribing Information, Feb. 2012, AstraZeneca.
Reyataz Prescribing Information, Feb. 2012, Bristol-Myers Squibb. *(Reyataz PI Table 13 states - applies to Reyataz with or without ritonavir, unless otherwise indicated).*

18. Atorvastatin / Tipranavir + Ritonavir _____ _____

Alert Message: The concurrent use of Lipitor (atorvastatin) and ritonavir-boosted Aptivus (tipranavir) should be avoided. Both tipranavir and ritonavir are CYP3A4 inhibitors and use with atorvastatin, a 3A4 substrate, may elevate atorvastatin levels and increase the risk of statin-related myopathy and rhabdomyolysis.

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

Util A	Util B	Util C
Atorvastatin	Tipranavir	Ritonavir

References:
Lipitor Prescribing Information, Feb. 2012, Pfizer Pharmaceuticals, Inc.
Aptivus Prescribing Information, Feb. 2012, Boehringer Ingelheim Pharmaceuticals, Inc.
Micromedex Healthcare Series, DrugDex Drug Evaluations, 2012 Thomson Reuters.

19. Atorvastatin-All / Telaprevir _____ _____

Alert Message: The concurrent use of atorvastatin-containing agents (Lipitor and Caduet) with Incivek (telaprevir) should be avoided. Telaprevir is a strong CYP3A4 inhibitor and concurrent use with atorvastatin, a CYP3A4 substrate, may lead to elevated atorvastatin levels and increase the risk of statin-related myopathy and rhabdomyolysis.

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

Util A	Util B	Util C
Atorvastatin-All	Telaprevir	

References:
Incivek Prescribing Information, March 2012, Vertex Pharmaceuticals, Inc.
Facts & Comparisons, 2012 Updates.
Lipitor Prescribing Information, Feb. 2012, Pfizer Pharmaceuticals, Inc.

20. Atorvastatin / Lopinavir + Ritonavir _____ _____

Alert Message: Caution should be exercised when co-administering Lipitor (atorvastatin) with the HIV protease inhibitor Kaletra (lopinavir plus ritonavir). The lowest dose necessary of atorvastatin should be used. Atorvastatin is a CYP3A4 substrate and concurrent use with strong CYP3A4 inhibitors, lopinavir and ritonavir, may elevate atorvastatin levels and increase the risk of statin-related myopathy and rhabdomyolysis.

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

Util A	Util B	Util C
Atorvastatin	Lopinavir/Ritonavir	

References:
Lipitor Prescribing Information, Feb. 2012, Pfizer Pharmaceuticals, Inc.

21. Atorvastatin / Ritonavir-Boosted Saquinavir, Darunavir & Fosamprenavir _____ _____

Alert Message: The dose of Lipitor (atorvastatin) should not exceed 20mg daily in patients receiving the ritonavir-boosted HIV protease inhibitors saquinavir, darunavir and fosamprenavir or unboosted fosamprenavir. Protease inhibitors are CYP3A4 inhibitors and concurrent use with atorvastatin, a 3A4 substrate, may elevate atorvastatin levels and increase the risk of statin-related myopathy and rhabdomyolysis.

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

Util A	Util B	Util C
Atorvastatin 40 & 80 mg	Saquinavir Darunavir Fosamprenavir	Ritonavir

References:
Lipitor Prescribing Information, Feb. 2012, Pfizer Pharmaceuticals, Inc.

22. Atorvastatin / Fosamprenavir _____ _____

Alert Message: The dose of Lipitor (atorvastatin) should not exceed 20mg daily in patients receiving the ritonavir-boosted HIV protease inhibitors saquinavir, darunavir and fosamprenavir or unboosted fosamprenavir. Protease inhibitors are CYP3A4 inhibitors and concurrent use with atorvastatin, a 3A4 substrate, may elevate atorvastatin levels and increase the risk of statin-related myopathy and rhabdomyolysis.

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

Util A	Util B	Util C
Atorvastatin 40 & 80mg	Fosamprenavir	

References:
Lipitor Prescribing Information, Feb. 2012, Pfizer Pharmaceuticals, Inc.

**Criterion created so it will hit on patients receiving unboosted fosamprenavir - above criterion requires ritonavir to be present.*

23. Atorvastatin / Clarithromycin & Itraconazole _____ _____

Alert Message: The dose of Lipitor (atorvastatin) should not exceed 20 mg daily in patients receiving the strong CYP3A4 inhibitors clarithromycin or itraconazole. Atorvastatin is a 3A4 substrate and concurrent use with either agent may lead to elevated atorvastatin levels and increase the risk of statin-related myopathy and rhabdomyolysis

Conflict Code: ER - Overutilization
Drugs/Diseases

Util A	Util B	Util C
Atorvastatin 40 & 80mg	Clarithromycin Itraconazole	

References:
Lipitor Prescribing Information, Feb. 2012, Pfizer Pharmaceuticals, Inc.

24. Atorvastatin / Nelfinavir _____ _____

Alert Message: In patients with HIV taking nelfinavir, therapy with Lipitor (atorvastatin) should be limited to 40 mg, and appropriate clinical assessment is recommended to ensure that the lowest dose necessary of atorvastatin is employed. Nelfinavir is a CYP3A4 inhibitor and use with atorvastatin, a 3A4 substrate, may elevate atorvastatin levels and increase the risk of statin-related myopathy and rhabdomyolysis.

Conflict Code: ER - Overutilization
Drugs/Diseases

Util A	Util B	Util C (Include)
Atorvastatin		Nelfinavir

Max Dose: 40 mg/day

References:
Lipitor Prescribing Information, Feb. 2012, Pfizer Pharmaceuticals, Inc.

25. Atorvastatin / Strong 3A4 Inhibitors _____ _____

Alert Message: Coadministration of Lipitor (atorvastatin) with strong CYP3A4 inhibitors (e.g., ketoconazole, nefazodone, posaconazole and erythromycin) can lead to increases in atorvastatin plasma concentrations and risk of myopathy and rhabdomyolysis. The extent of interaction and potentiation of effects depend on the variability of effect on CYP3A4.

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

Util A	Util B	Util C
Atorvastatin	Ketoconazole Posaconazole Voriconazole Nefazodone Indinavir Telithromycin	

References:
Lipitor Prescribing Information, Feb. 2012, Pfizer Pharmaceuticals, Inc.

26. Caduet / Protease Inhibitors _____ _____

Alert Message: Caduet (amlodipine/atorvastatin) daily doses exceeding 20 mg of the atorvastatin component, should be used with caution in patients also receiving HIV protease inhibitors. The lowest dose necessary of atorvastatin-containing agent should be used. Protease inhibitors are strong CYP3A4 inhibitors and use with atorvastatin, a 3A4 substrate, may elevate atorvastatin levels and increase the risk of statin-related myopathy and rhabdomyolysis.

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

Util A	Util B			Util C
Caduet 5/40	Saquinavir	Darunavir	Lopinavir/Ritonavir	
Caduet 5/80	Ritonavir	Fosamprenavir		
Caduet 10/40	Indinavir	Tipranavir		
Caduet 10/80	Nelfinavir	Atazanavir		
Caduet 2.5/40				

References:
Caduet Prescribing Information, Jan. 2012, Pfizer Pharmaceuticals, Inc.
**Caduet PI states; Therefore, in patients taking HIV protease inhibitors use caution when administering atorvastatin doses > 20mg. It does not split them up like the new Lipitor PI. So all protease inhibitors are included in one criterion (page 32).*

27. Caduet / Clarithromycin & Itraconazole _____ _____

Alert Message: Caduet (amlodipine/atorvastatin) daily doses exceeding 20 mg of the atorvastatin component should be used with caution in patients also receiving clarithromycin or itraconazole. The lowest dose necessary of atorvastatin-containing agent should be used. Clarithromycin and itraconazole are strong CYP3A4 inhibitors and use with atorvastatin, a 3A4 substrate, may elevate atorvastatin levels and increase the risk of statin-related myopathy and rhabdomyolysis.

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

Util A	Util B	Util C
Caduet 5/40	Clarithromycin	
Caduet 5/80	Itraconazole	
Caduet 10/40		
Caduet 10/80		
Caduet 2.5/40		

References:
Caduet Prescribing Information, Jan. 2012, Pfizer Pharmaceuticals, Inc.

28. Caduet / Cyclosporine _____ _____

Alert Message: The atorvastatin dose of the combo agent Caduet (amlodipine/atorvastatin) should not exceed 10 mg of atorvastatin daily in patients receiving cyclosporine. Cyclosporine is an OATP1B1 inhibitor and concurrent use with atorvastatin products can increase the bioavailability of atorvastatin thereby increasing the risk of statin-related myopathy and rhabdomyolysis.

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

Util A	Util B	Util C
Caduet 20, 40 & 80mg	Cyclosporine	

References:
Caduet Prescribing Information, Jan. 2012, Pfizer Pharmaceuticals, Inc.

29. Pravastatin / Clarithromycin _____ _____

Alert Message: The dose of pravastatin should not exceed 40 mg once daily in patients also receiving clarithromycin. The concurrent use of these two agents increases the risk of statin-related myopathy and rhabdomyolysis.

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

Util A	Util B	Util C
Pravastatin 80mg	Clarithromycin	

References:
Pravachol Prescribing Information, Feb. 2012, Bristol-Myers Squibb.
Clinical Pharmacology, 2012 Elsevier/Gold Standard.

30. Vytorin / Renal Impairment _____ _____

Alert Message: In patients with chronic kidney disease and estimated glomerular filtration rate < 60 mL/min/1.73 m^2 the manufacturer's recommended dose of Vytorin (ezetimibe/simvastatin) is 10/20mg per day. In such patients, higher doses should be used with caution and close monitoring.

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

Util A	Util B	Util C
Vytorin 10/40 & 10/80	Renal Impairment	

References:
Vytorin Prescribing Information, Feb. 2012, Merck & Co. Inc.

31. Atorvastatin / Atazanavir _____ _____

Alert Message: The concurrent use of Lipitor (atorvastatin) and Reyataz (atazanavir) may result in increased atorvastatin levels due to inhibition, by atazanavir, of atorvastatin CYP3A4-mediated metabolism. Use the lowest possible starting dose of atorvastatin with careful monitoring for toxicities (e.g., myopathy and rhabdomyolysis) or consider a statin with less potential for interaction (i.e., fluvastatin).

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

Util A	Util B	Util C
Atorvastatin	Atazanavir	

References:
Lipitor Prescribing Information, Feb. 2012, Pfizer Pharmaceuticals, Inc.
Reyataz Prescribing Information, Feb. 2012, Bristol-Myers Squibb.

32. Boceprevir / Atorvastatin 40 & 80mg _____ _____

Alert Message: The concurrent use of Victrelis (boceprevir), a potent CYP3A4 inhibitor with Lipitor (atorvastatin), a CYP3A4 substrate, may result in elevated atorvastatin plasma concentrations increasing the risk of atorvastatin-related adverse events (e.g., myopathy and rhabdomyolysis). The atorvastatin dose should be carefully titrated and should not exceed a maximum daily dose of 20 mg during coadministration with boceprevir.

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

Util A	Util B	Util C
Boceprevir	Atorvastatin 40 & 80mg	

References:
Facts & Comparisons, 2012 Updates.
Clinical Pharmacology, 2012 Elsevier/Gold Standard.
Victrelis Prescribing Information, May 2011, Schering Corporation.

DUR Board Meeting
September 17, 2012
Hilton Garden Inn
4351 17th Avenue South
Fargo, ND

North Dakota Medicaid
DUR Board Meeting Agenda
Hilton Garden Inn
4351 17th Avenue South
Fargo, ND
September 17, 2012
1pm

1. Administrative items
    - Travel vouchers

2. Old business
    - Review and approval of 06/12 meeting minutes — Chair
    - Budget update — Brendan
    - Second review of Kalydeco — Brendan
    - Second review of Kuvan — Brendan
    - Second review of Elaprase — Brendan
    - SSRI/SNRI Update — Brendan
    - Topical Steroids Update — Brendan
    - Yearly PA review — HID
        - DAW
        - Amrix/Fexmid
        - Xenical
        - Zanaflex caps
        - Ketek
        - Aczone
        - Topical Ketoconazole
        - Clorpres
        - Gilenya
        - Livalo
        - Oravig
        - Xyrem
        - Zyclara
        - Nuedexta
        - Nexiclon
        - Narcotic/APAP combo products

3. New business
    - Review of Actinic Keratosis — HID
    - Review of Moxeza — HID
    - Review of Lidoderm — HID
    - Review of Patients Taking Suboxone — HID
    - Review of Patients Taking Multiple Long-Acting Narcotics — HID
    - Criteria recommendations — HID
    - Upcoming meeting date/agenda — Chair

4. Adjourn — Chair

Please remember to silence all cellular phones and pagers during the meeting.

Drug Utilization Review (DUR) Meeting Minutes
June 4, 2012

Members Present: Norman Byers, John Savageau, Russ Sobotta, Cheryl Huber, Greg Pfister, Tanya Schmidt, Carrie Sorenson, Leann Ness, Carlotta McCleary, David Clinkenbeard, Steve Irsfeld
Members Absent: Kim Krohn, James Carlson, Jeffrey Hostetter, Todd Twogood
Medicaid Pharmacy Department: Brendan Joyce, Gary Betting
HID Staff Present: Candace Rieth

Chair G. Pfister called the meeting to order at 1:00 pm. Chair G. Pfister asked for a motion to approve the minutes from the March meeting. N. Byers moved that the minutes be approved and C. Huber seconded the motion. Chair G. Pfister called for a voice vote to approve the minutes. The motion passed with no audible dissent.

Budget Update
B. Joyce informed the board members that the spend to pharmacies is within pennies of what was projected. Currently, the rebate dollars are fairly significant although the 100% federal match for line extension drug rebates has not been taken out to give the department a net-net total.

Lorzone Second Review
A motion and second were made at the March meeting to place Lorzone on prior authorization. The topic was brought up for a second review. There was no public comment. After discussion, Chair G. Pfister called for a voice vote to approve the motion. The motion passed with no audible dissent.

Provigil Second Review
A motion and second were made at the March meeting to place Provigil on prior authorization. The topic was brought up for a second review. There was no public comment. Chair G. Pfister called for a voice vote to approve the motion. The motion passed with no audible dissent.

Kapvay Second Review
A motion and second were made at the March meeting to place Kapvay on prior authorization. The topic was brought up for a second review. There was no public comment. Chair G. Pfister called for a voice vote to approve the motion. The motion passed with no audible dissent.

Dexpak/Zemapak Second Review
A motion and second were made at the March meeting to place Dexpak and Zemapak on prior authorization. The topic was brought up for a second review. There was no public comment. Chair G. Pfister called for a voice vote to approve the motion. The motion passed with no audible dissent.

Xifaxan Second Review
A motion and second were made at the March meeting to place Xifaxan on prior authorization. The topic was brought up for a second review. There was no public comment. Chair G. Pfister called for a voice vote to approve the motion. The motion passed with no audible dissent.

Vanos Second Review
A motion and second were made at the March meeting to place Vanos on prior authorization. The topic was brought up for a second review. There was no public comment. Chair G. Pfister called for a voice vote to approve the motion. The motion passed with no audible dissent.

Yearly PA Review
The Board reviews products annually that have previously been placed on prior authorization. This allows the Board a chance to update the prior authorization forms and criteria. Sedative/Hypnotics, Qualaquin, ACE-I/ARBs/Renin Inhibitors, Synagis, GH/IGF1, and Triptans were reviewed. No changes were made to the forms and criteria.

Topical Corticosteroid Review
B. Joyce reviewed topical corticosteroid information with the Board. There was no public comment. After discussion, N. Byers suggested a dermatologist be consulted. The consult information will be provided at a later date.

Kalydeco Review
B. Joyce reviewed Kalydeco information with the Board. There was no public comment. After discussion, N. Byers made a motion to place Kalydeco on prior authorization for FDA approved indication and to require a CF mutation test. J. Savageau seconded the motion. This topic will be brought up at the next meeting for finalization.

Kuvan Review
B. Joyce reviewed Kuvan information with the Board. There was no public comment. After discussion, C. Huber made a motion to place Kuvan on prior authorization for FDA approved indication. C. Sorenson seconded the motion. This topic will be brought up at the next meeting for finalization.

Elaprase Review
B. Joyce reviewed Elaprase information with the Board. There was no public comment. After discussion, N. Byers made a motion to place Elaprase on prior authorization. C. Sorenson seconded the motion. This topic will be brought up at the next meeting for finalization.

Rescue Inhaler Review
B. Joyce discussed rescue inhaler overutilization with the Board. There is a population of recipients taking rescue inhalers that are using >12 puffs a day. The state would like to get the Board's advice on this trend. A suggestion was made to send an educational letter, with a survey requesting diagnosis information, to prescribers of recipients overutilizing rescue inhalers.

Criteria Recommendations
The recommended RDUR criteria enclosed in the packet were developed from product information provided by the manufacturers and usually are consistent with new indications, new drugs added, new warnings, etc. These proposed criteria will be added to the current set of criteria, and will be used in future DUR cycles. C. Huber moved to approve the new criteria and N. Byers seconded the motion. Chair G. Pfister called for a voice vote. The motion passed with no audible dissent.

The next DUR board meeting will be held September 17th, 2012 in Fargo. G. Pfister made a motion to adjourn the meeting. C. Sorenson seconded. The motion passed with no audible dissent. Chair G. Pfister adjourned the meeting at 2:00 p.m.

KALYDECO PA FORM

HEALTH INFORMATION DESIGNS

Prior Authorization Vendor for ND Medicaid

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-773-0695

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

- **Patient must have a G551D mutation in the cystic fibrosis conductance regulator (CFTR) gene.**

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 Signature		Date	

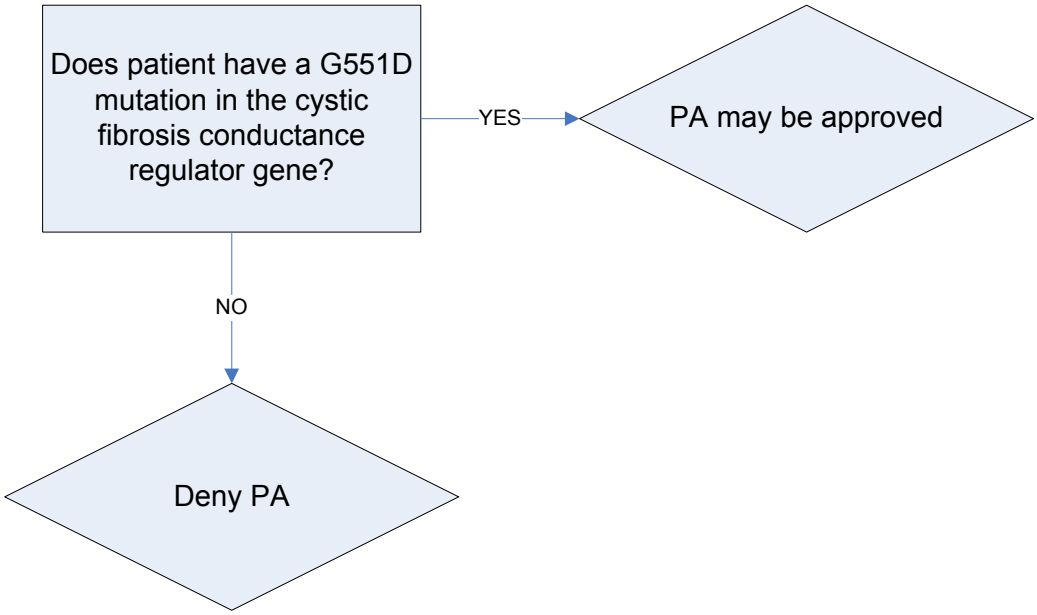
Part II: TO BE COMPLETED BY PHARMACY

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
Kalydeco Prior Authorization Algorithm



KUVAN PA FORM

HEALTH INFORMATION DESIGNS

Prior Authorization Vendor for ND Medicaid

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-773-0695

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	
Physician Name			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ KUVAN	**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 Signature		Date	

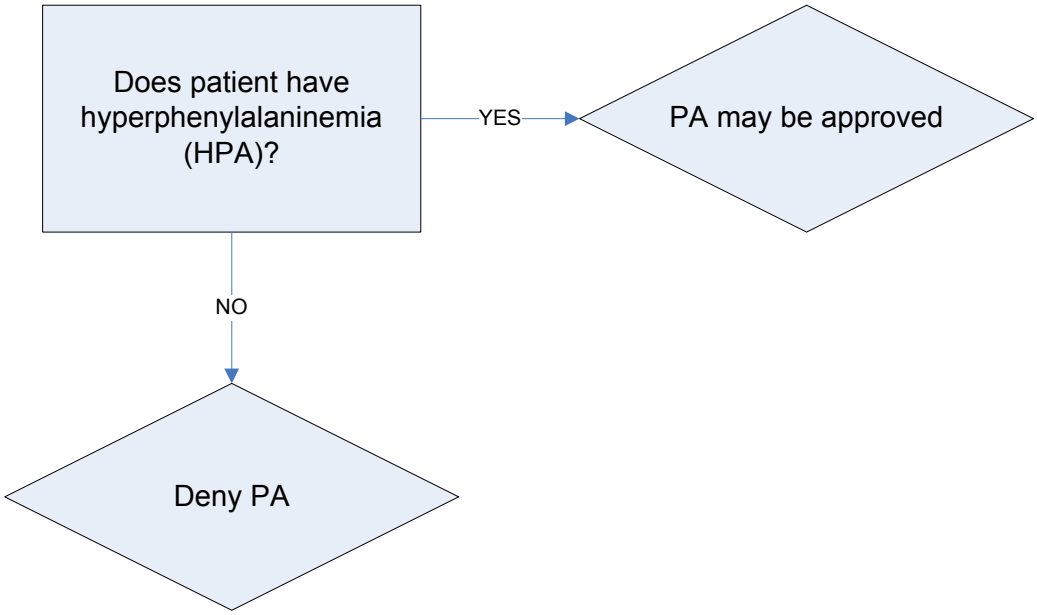
Part II: TO BE COMPLETED BY PHARMACY

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
Kuvan Prior Authorization Algorithm



ELAPRASE PA FORM

HEALTH INFORMATION DESIGNS

Prior Authorization Vendor for ND Medicaid

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-773-0695

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 Signature		Date	

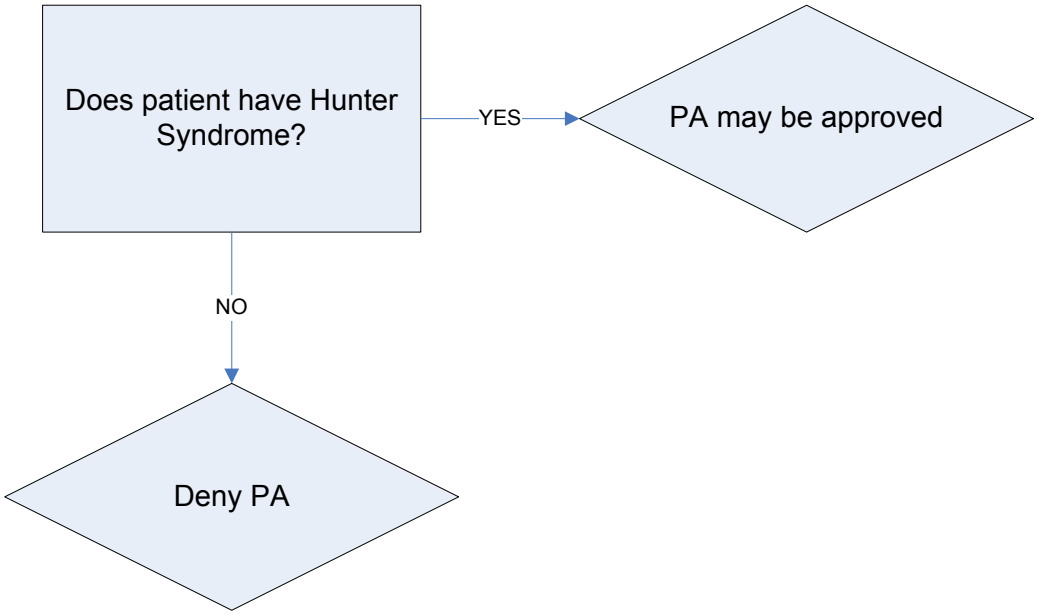
Part II: TO BE COMPLETED BY PHARMACY

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
Elaprase Prior Authorization Algorithm



DISPENSE AS WRITTEN PA FORM

Fax Completed Form to:
866-254-0761
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 was not effective (attach MedWatch form)**
- **There was an adverse reaction with the generic product (attach MedWatch form)**
- **DAW not allowed for drugs with an authorized generic available.**

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:	**DOSAGE:**	**Diagnosis for this request:**		

QUALIFICATIONS FOR COVERAGE: □ FAILED GENERIC EQUIVALENT**(ATTACH FDA MEDWATCH FORM)**	**Start Date**	**End Date**	**Dose**	**Frequency**

ADVERSE REACTION TO GENERIC EQUIVALENT (ATTACH FDA MEDWATCH FORM)
□ *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 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)	

AMRIX PA Form

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-773-0695

HEALTH INFORMATION DESIGNS

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients try and fail generic cyclobenzaprine.

**Note:*

- **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 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:** (must be completed)

Qualifications for coverage:

❑ Failed cyclobenzaprine 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 Signature: Date:

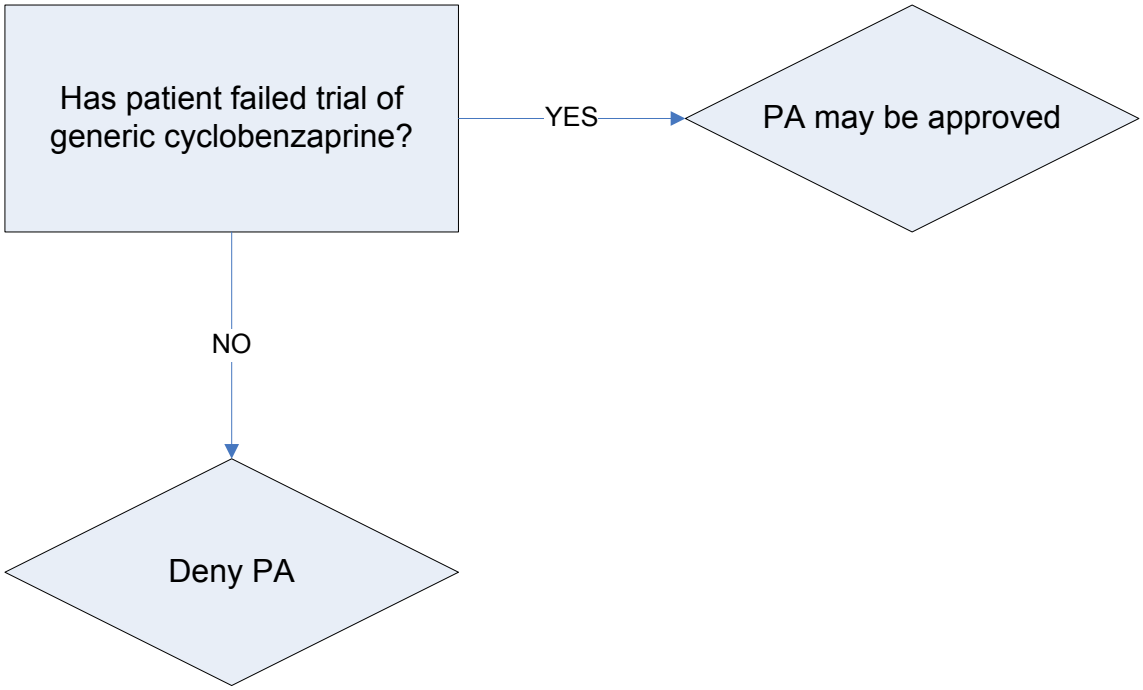
Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:	ND MEDICAID PROVIDER NUMBER:
Phone:	FAX:
Drug:	NDC#:

Part III: FOR OFFICIAL USE ONLY

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

North Dakota Department of Human Services
Amrix Authorization Algorithm



HEALTH INFORMATION DESIGNS

Xenical Prior Authorization

Fax Completed Form to:
866-254-0761
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 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: □ XENICAL	**Diagnosis for this request:**		

Qualifications for coverage:			
□ Dietician evaluation attached	Height:	Weight:	BMI:
Prescriber Signature		Date	

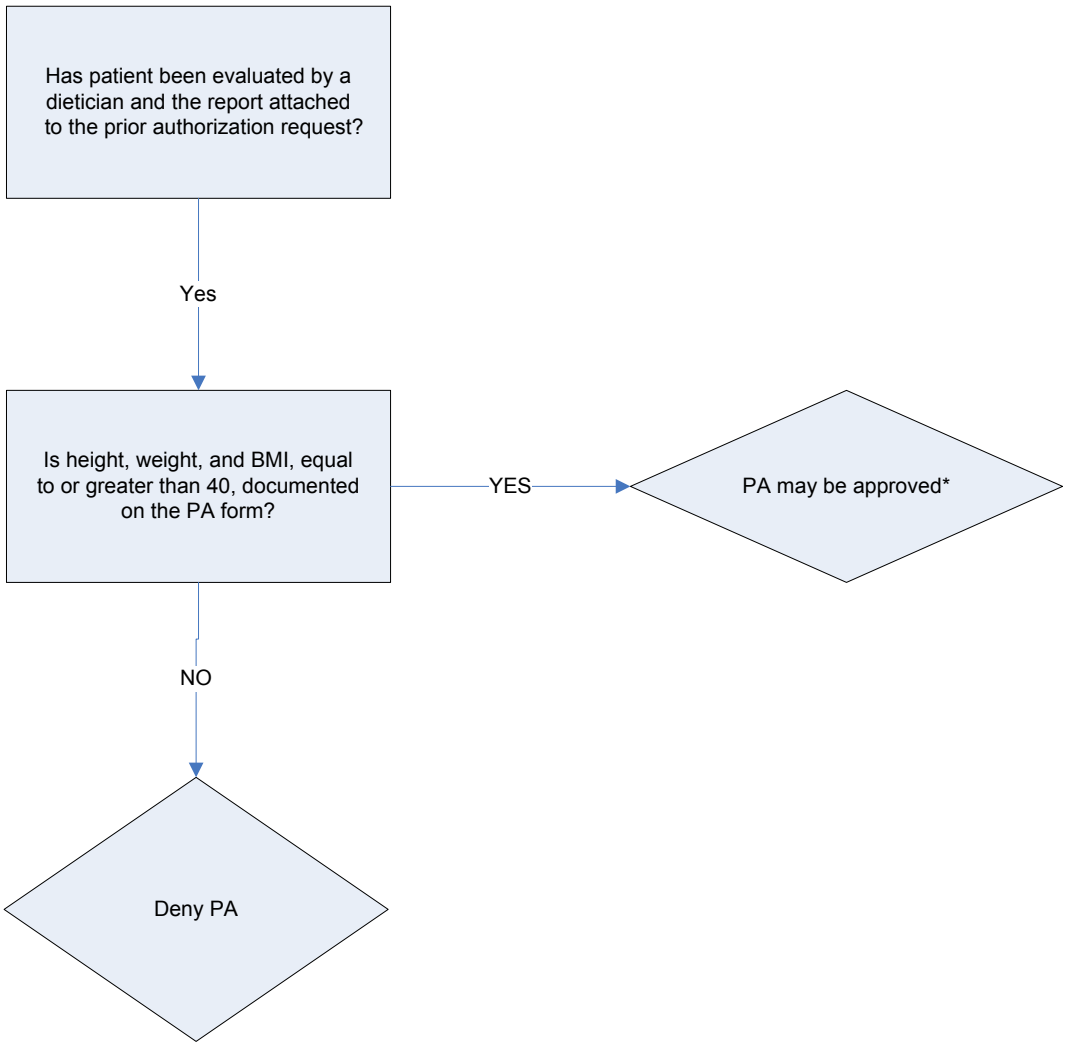
Part II: TO BE COMPLETED BY PHARMACY

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
Xenical Prior Authorization Criteria



*5% weight loss must be realized for continued approval every 6 months.

HEALTH INFORMATION DESIGNS

Prior Authorization Vendor for ND Medicaid

Zanaflex Capsule PA Form

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-773-0695

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:**		
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 Signature		Date	

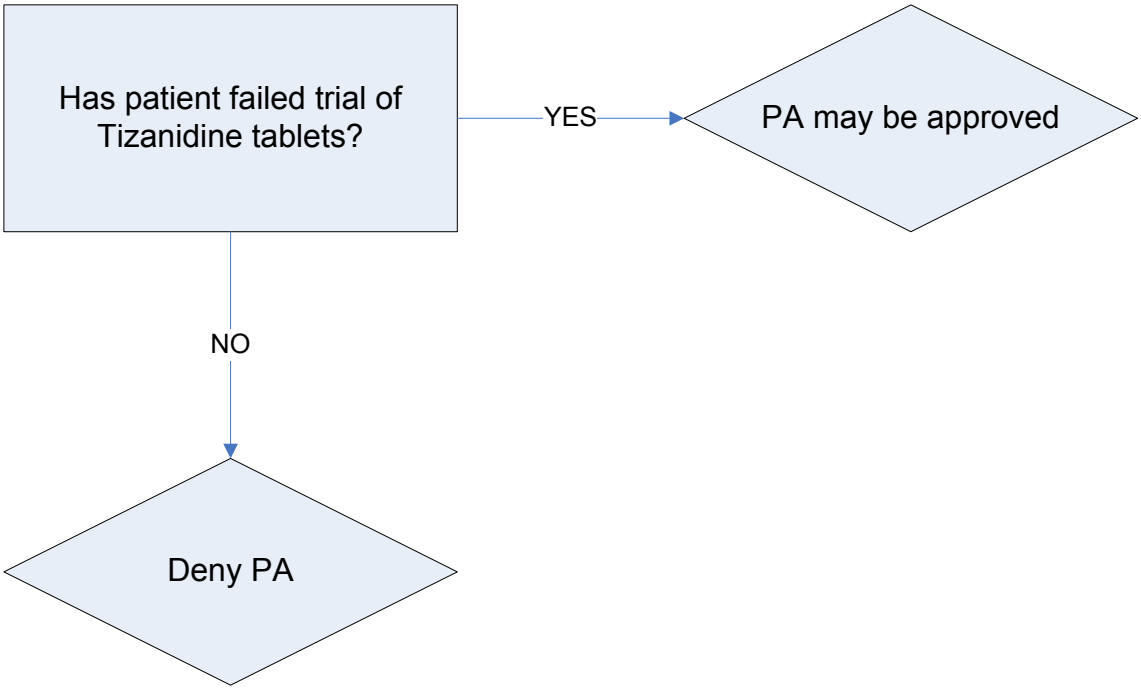
Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
PHONE 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
Zanaflex Authorization Algorithm



HEALTH INFORMATION DESIGNS

KETEK PA FORM

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

- 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 MEDICAID ID NUMBER:
Recipient Date of birth: / /	
PRESCRIBER NAME:	PRESCRIBER MEDICAID ID NUMBER:
Address:	Phone: ( )
City:	FAX: ( )
State: Zip:	

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.

□ 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 Signature: Date:

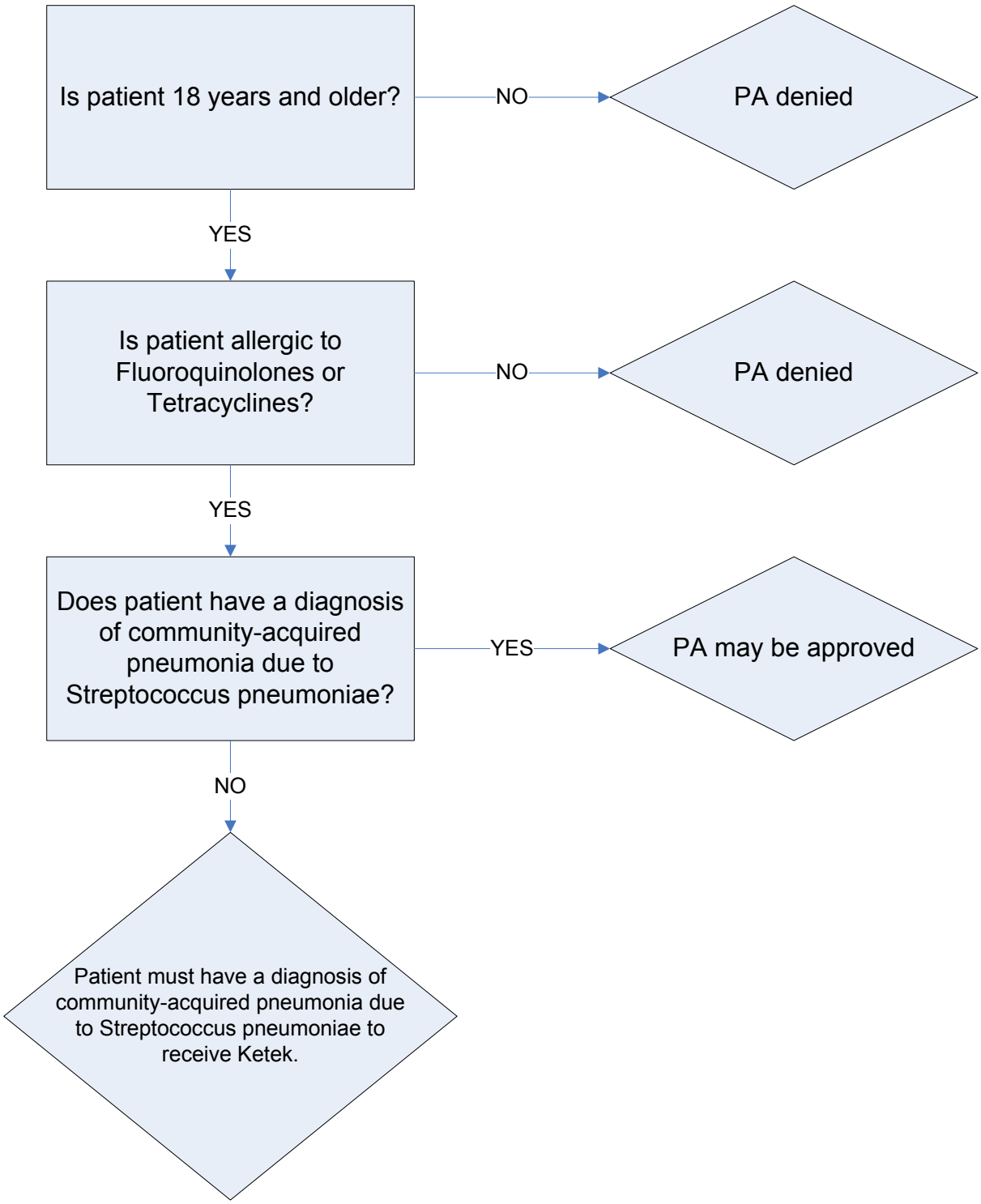
Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:	ND MEDICAID PROVIDER NUMBER:
Phone:	FAX:
Drug:	NDC#:

Part III: FOR OFFICIAL USE ONLY

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

North Dakota Department of Human Services
Ketek Criteria Algorithm



Aczone Gel PA FORM

Fax Completed Form to:
866-254-0761
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 Aczone gel must try other topical acne agents as first line therapy.

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: □ ACZONE GEL	**Diagnosis for this request:**		

Qualifications for coverage:

□ Failed acne therapy Name of medication failed: _____	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 Signature	Date

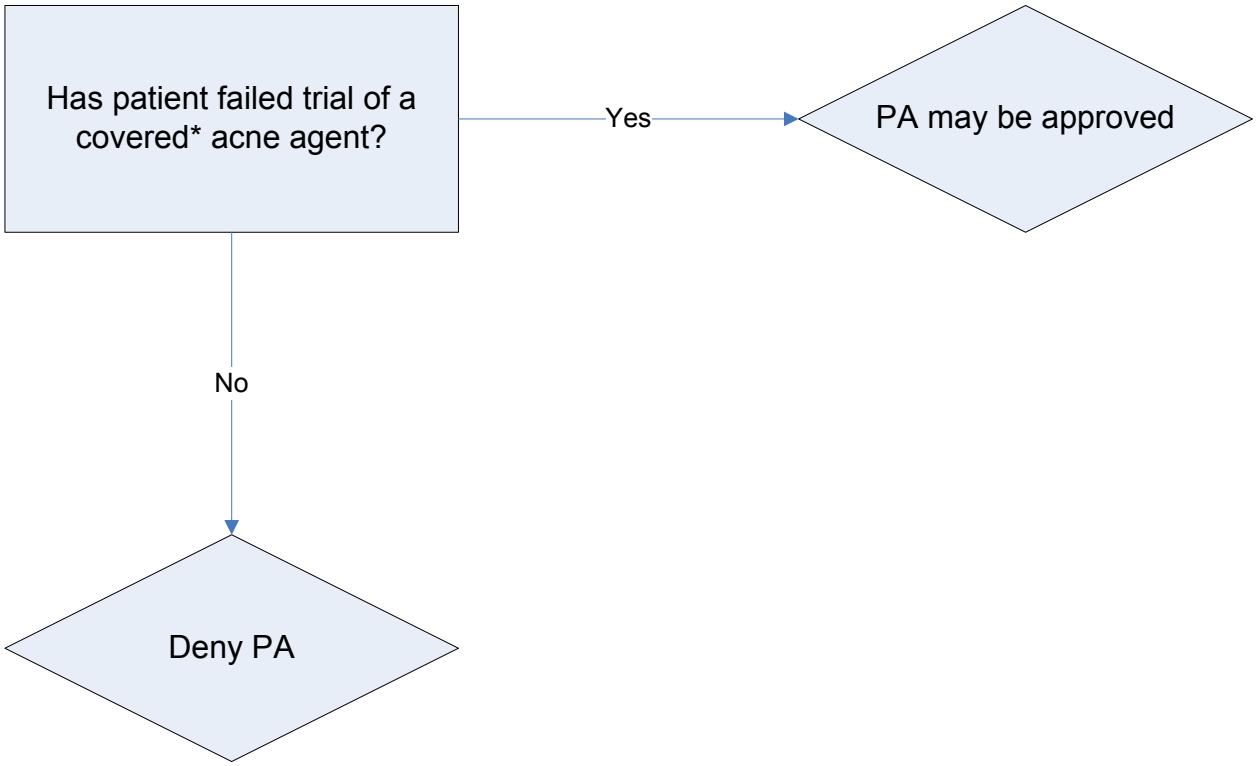
Part II: TO BE COMPLETED BY PHARMACY

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
Aczone Authorization Algorithm



*Tretinoin and benzoyl peroxide products do not require a PA

Topical Ketoconazole Products
Prior Authorization

Fax Completed Form to:
866-254-0761
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:	
Physician Signature		Date	

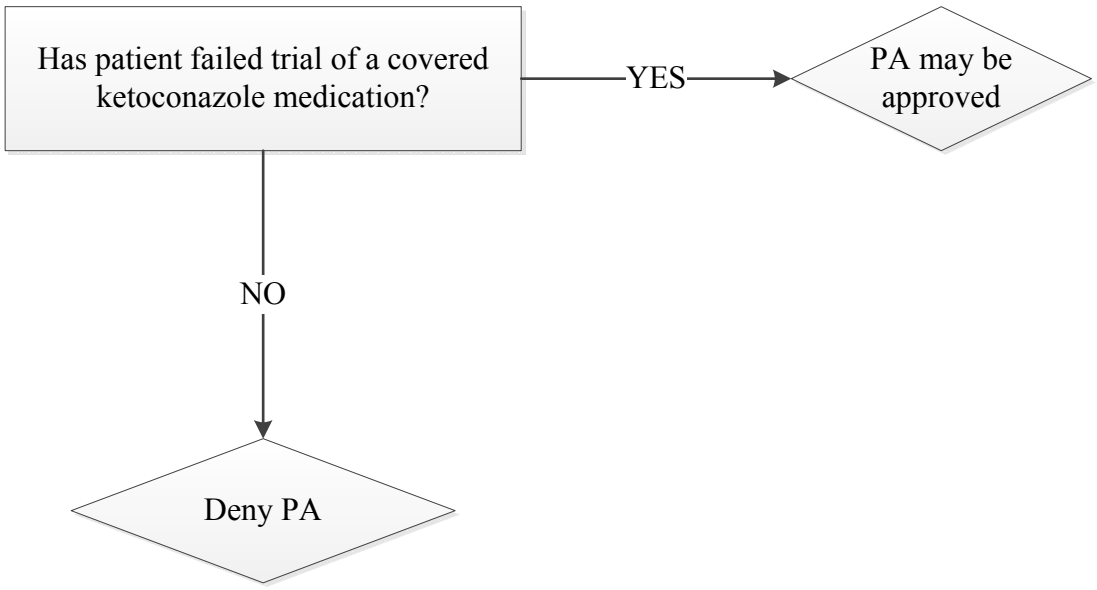
Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
PHONE 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
Topical Ketoconazole Products Authorization Algorithm



Clorpres Prior Authorization

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receive clonidine and chlorthalidone separately.
Note:

- ***Clonidine does not require PA***
- ***Chlorthalidone does 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: □ **Clorpres**	**Diagnosis for this request:**		
Qualifications for coverage:			
□ Failed both drugs separately	Start Date: End Date:	Dose: Frequency:	
Physician Signature		Date	

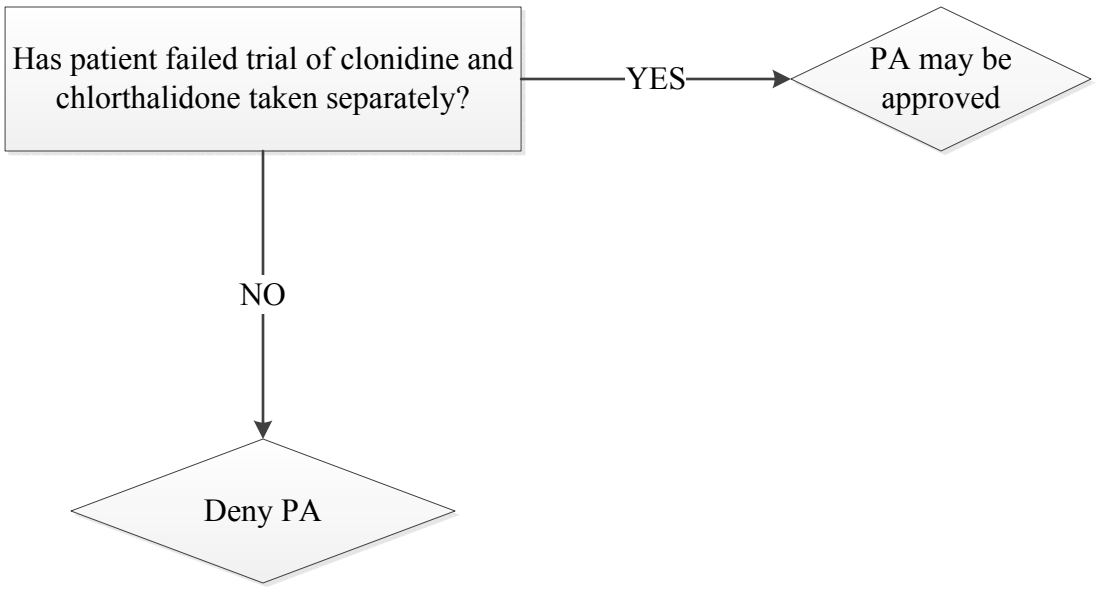
Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
PHONE 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
Clorpres Authorization Algorithm



HEALTH INFORMATION DESIGNS

Gilenya Prior Authorization

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients who are prescribed Gilenya must follow these guidelines:

***Note:**

- ***Must have relapsing forms of multiple sclerosis.***
- ***Must have a current electrocardiogram (within 6 months) for patients taking anti-arrhythmics, beta-blockers, or calcium channel blockers; patients with cardiac risk factors; and patients with a slow or irregular heart beat.***
- ***Must have a recent CBC (within 6 months).***
- ***Must have an adequate ophthalmologic evaluation at baseline and 3-4 months after treatment initiation.***
- ***Must have recent (within 6 months) transaminase and bilirubin levels before initiation of therapy.***
- ***Will not be approved for use in combination 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
Requested Drug and Dosage: □ **Gilenya**	**Diagnosis for this request:**		
Qualifications for coverage:			
Current electrocardiogram **Date:**	**Current CBC** **Date:**	**Ophthalmologic Evaluation** **Date:**	**Transaminase/Bilirubin levels** **Date:**
Physician Signature			Date

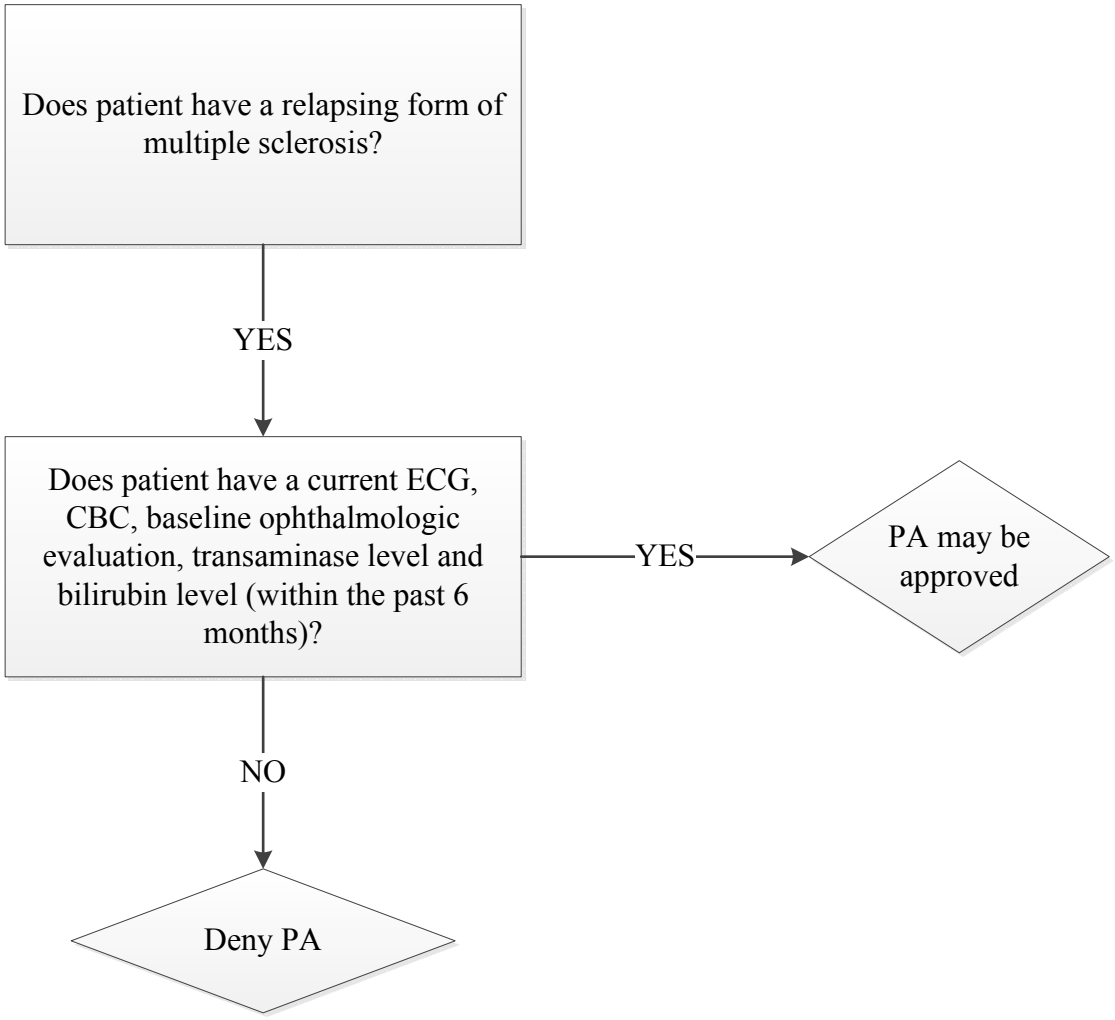
Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
PHONE 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
Gilenya Authorization Algorithm



Livalo Prior Authorization

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients who are prescribed Livalo must first try a covered statin medication
Note:

- ***Statins already on the market 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: □ **Livalo**	**Diagnosis for this request:**		
Qualifications for coverage:			
□ Medication Failed _____	Start Date: End Date:	Dose: Frequency:	
Physician Signature		Date	

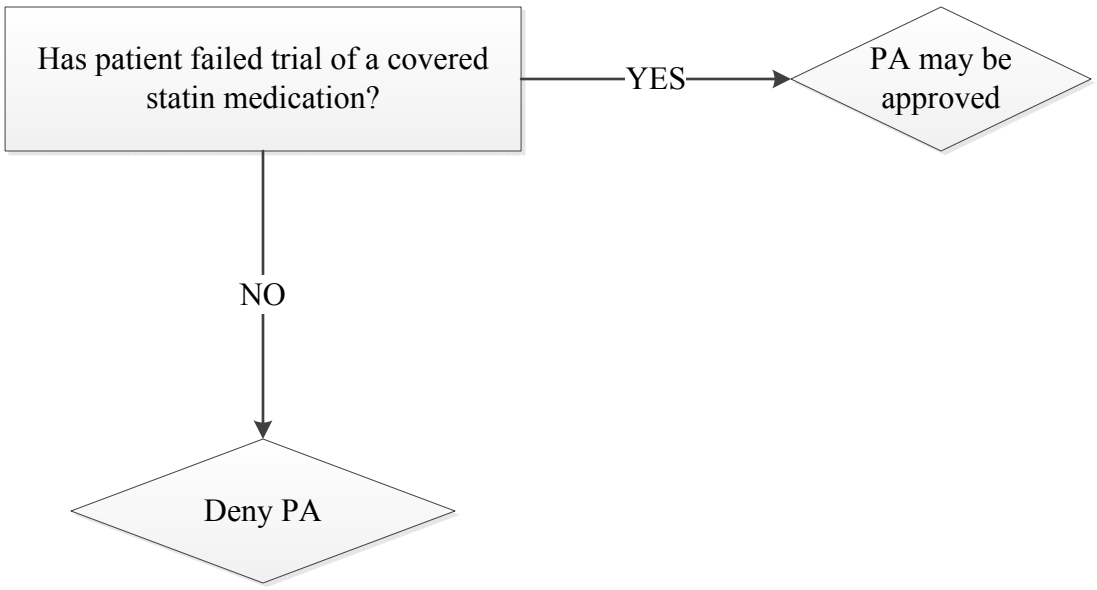
Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
PHONE 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
Livalo Authorization Algorithm



Oravig Prior Authorization

Fax Completed Form to:
866-254-0761
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 Oravig first try fluconazole.
Note:

- ***Fluconazole does 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:			
□ **Medication failed** _____	**Start Date:** **End Date:**	**Dose:** **Frequency:**	
Physician Signature		Date	

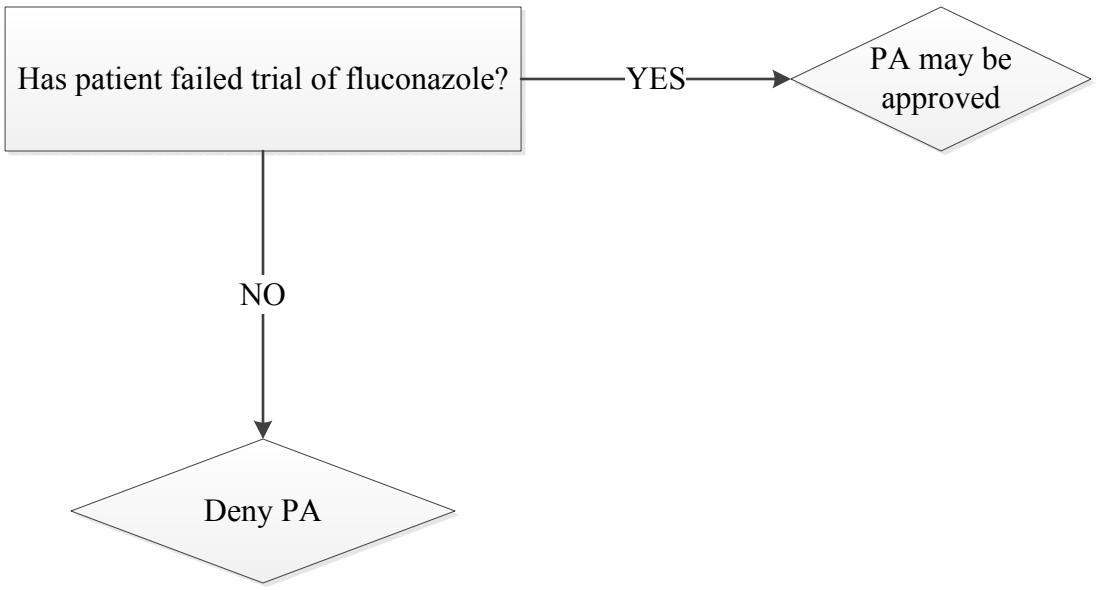
Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
PHONE 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
Oravig Authorization Algorithm



Xyrem Prior Authorization

Fax Completed Form to:
866-254-0761
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 Success Program***

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: □ **Xyrem**	**Diagnosis for this request:**		
Qualifications for coverage:			
□ Enrolled in Xyrem Success Program	Enrolled Date:	Dose:	
Physician Signature		Date	

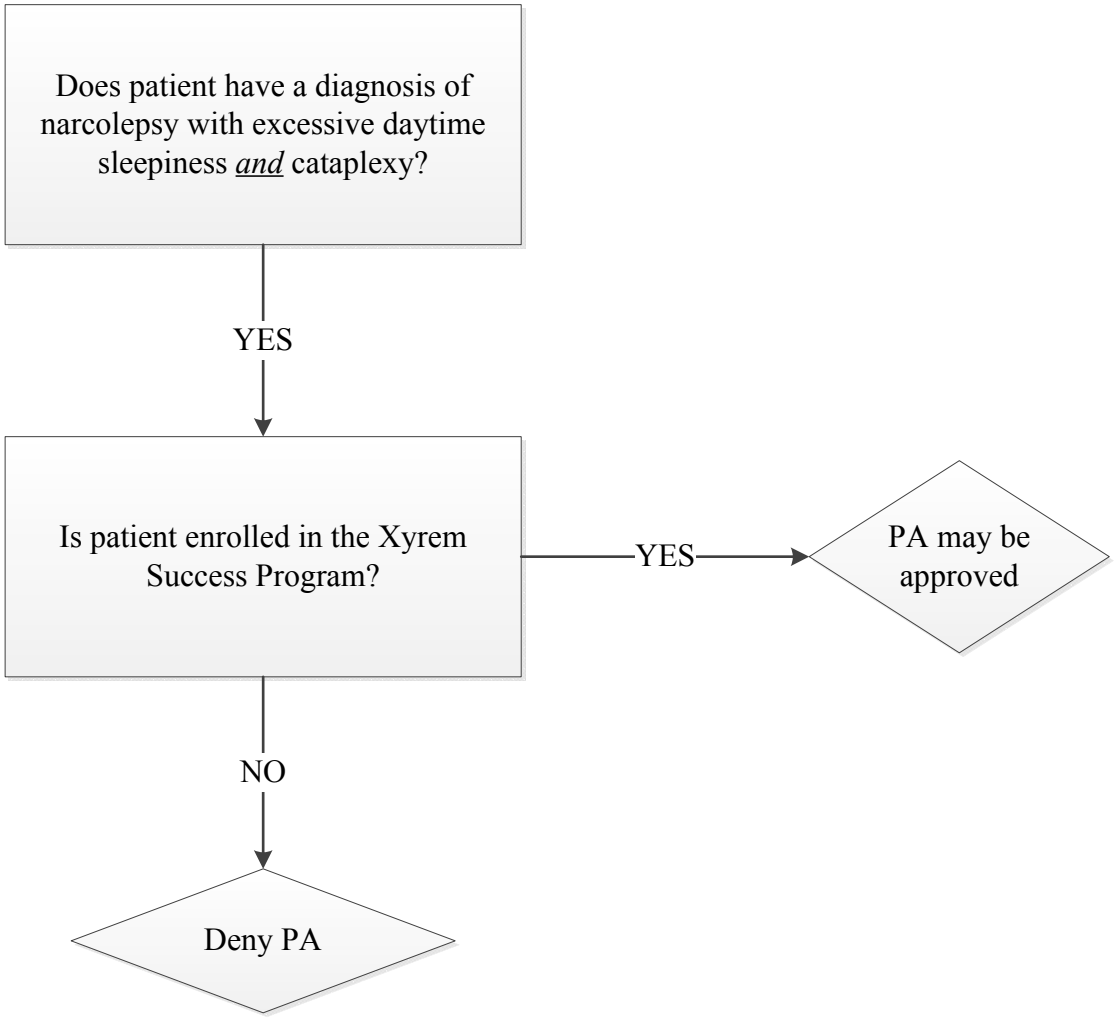
Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
PHONE 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
Xyrem Authorization Algorithm



Zyclara Prior Authorization

Fax Completed Form to:
866-254-0761
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 Zyclara first try imiquimod.
Note:

- ***Imiquimod does 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: □ **Zyclara**	**Diagnosis for this request:**		
Qualifications for coverage:			
□ **Trial of imiquimod** **Start Date** **End Date**			
Physician Signature	Date		

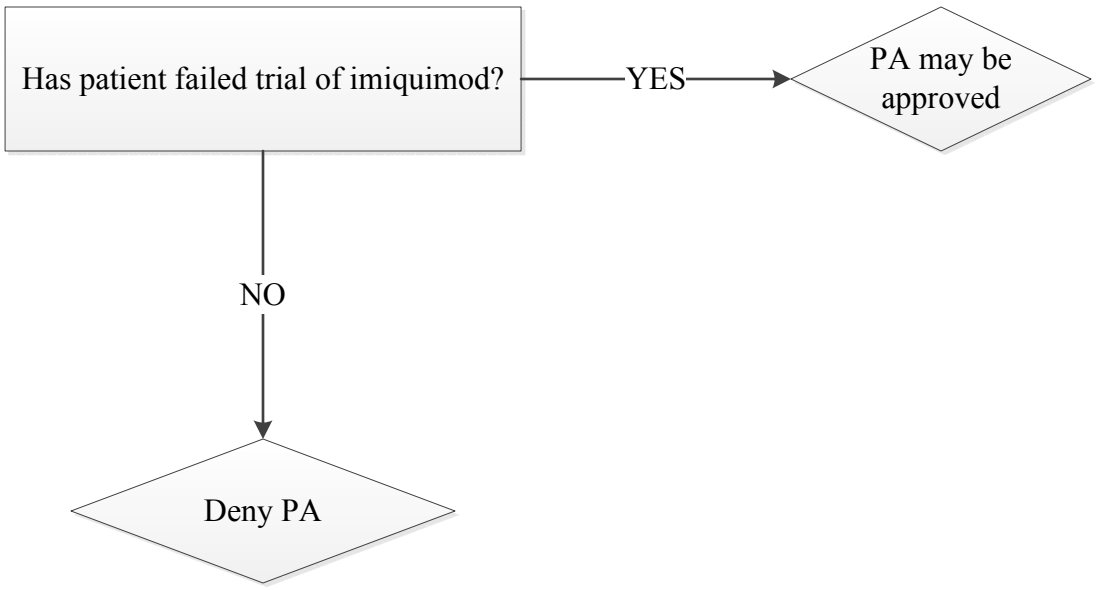
Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
PHONE 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
Zyclara Authorization Algorithm



Nuedexta Prior Authorization

Fax Completed Form to:
866-254-0761
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 Nuedexta must have a diagnosis of amyotrophic lateral sclerosis (ALS) or multiple sclerosis (MS) and exhibit signs of pseudobulbar affect.

Note:

- ***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	
Physician Name			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ **Nuedexta**	**Diagnosis for this request (must check at least 2):** □ **PBA** □ **ALS** □ **MS**		
Physician Signature		Date	

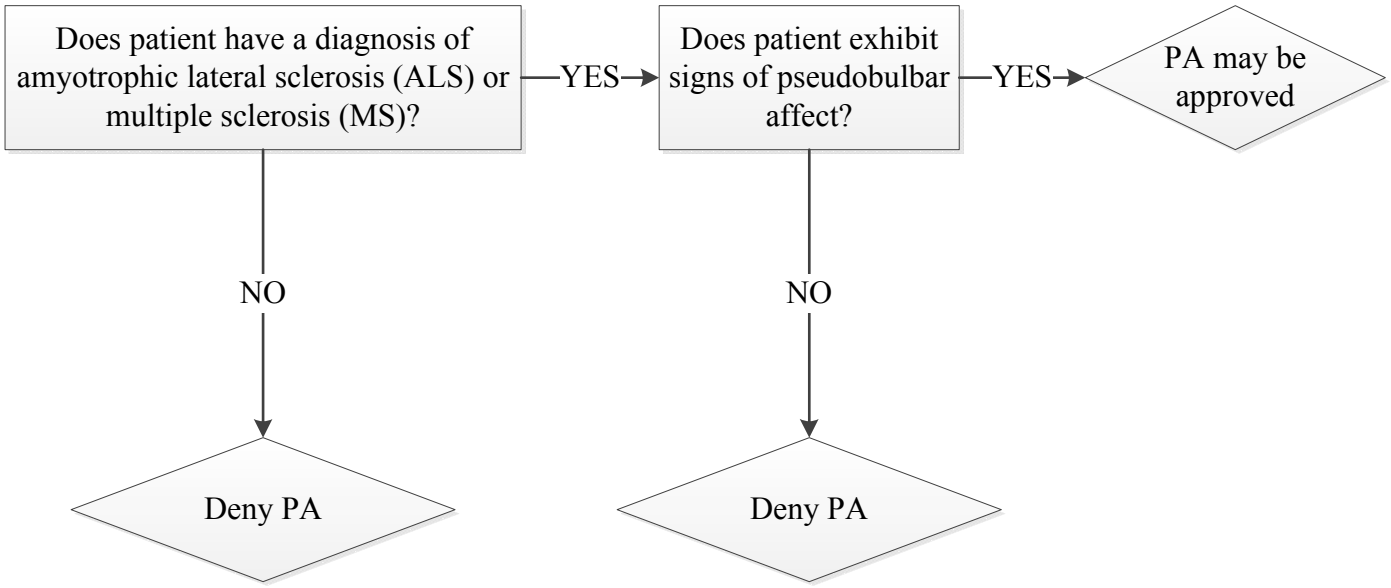
Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
PHONE 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
Nuedexta Authorization Algorithm



Nexiclon Prior Authorization

Fax Completed Form to:
866-254-0761
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 Nexiclon must try and fail clonidine.
Note:

- ***Clonidine does 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: □ **Nexiclon**	**Diagnosis for this request:**		
Qualifications for coverage:			
□ FAILED CLONIDINE THERAPY START DATE: END DATE:	DOSE: FREQUENCY:		
Physician Signature		Date	

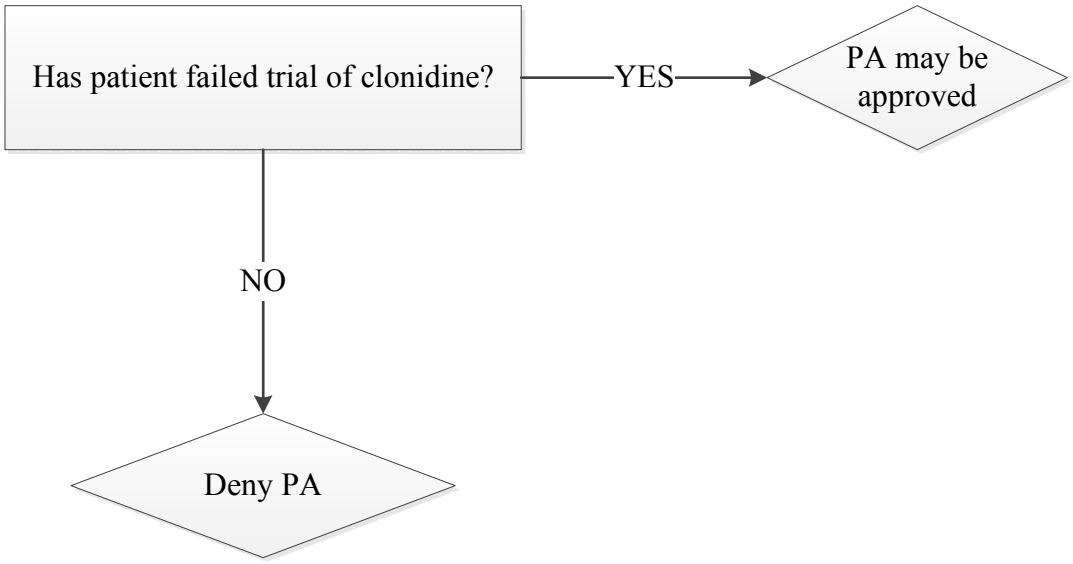
Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
PHONE 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
Nexiclon Authorization Algorithm



Narcotics/APAP
Prior Authorization

Fax Completed Form to:
866-254-0761
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 narcotics containing acetaminophen doses greater than 325mg must use hydrocodone/acetaminophen 5/325-10/325 or oxycodone acetaminophen 5/325-10/325.

- ***FDA is requesting that drug manufacturers limit the amount of acetaminophen in prescription drug products to 325mg per dosage unit.***
- ***Higher-dose formulations of hydrocodone/acetaminophen and oxycodone/acetaminophen should be phased out by 2014.***

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:			
□ FAILED THERAPY START DATE: END DATE:	DOSE: FREQUENCY:		
Physician Signature		Date	

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
PHONE 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 Medicaid
DUR Board Meeting
Actinic Keratoses

Actinic keratoses (AK) are small, rough, raised areas found on sun-damaged skin. Lesions are usually found on the face, scalp, back of hands, chest, or other sun-exposed areas. Symptoms begin as flat scaly areas that may be gray, pink, or red. Often, there is a white or yellow crusty 'scale' on top. Over time, the area develops a hard and wart-like or gritty surface that is sometimes easier to feel than see. In some cases, lesions can potentially progress to squamous cell carcinoma. Ablative therapies (e.g., laser ablation, curettage, cryosurgery, surgery) are generally used in patients with individual or single lesions, whereas topical therapies are generally preferred in patients with multiple lesions. Several topical therapies are available for the treatment of AK and a new agent, Picato, was recently approved. A comparison of the agents used to treat AK is included in the table below.

Product/Cost	Indication/Dosage	Mechanism of Action
Diclofenac Sodium 3% gel (Solaraze) $590/100 gm	Topical treatment of actinic keratoses: Apply to lesion areas twice daily for 60-90 days.	The exact mechanism of action is unknown.
Fluorouracil 0.5% cream (Carac) $339/30 gm	Topical treatment of multiple actinic or solar keratoses of the face and anterior scalp: Apply once daily for up to 4 weeks as tolerated. Do not apply near the eyes, nostrils, or mouth.	Blocks the methylation reaction of deoxyuridylic acid to thymidylic acid, which interferes with the synthesis of DNA, and to a lesser extent, inhibits the formation of RNA. The effect of fluorouracil may be to create a thymine deficiency that provokes unbalanced growth and death of the cell.
Fluorouracil 5% cream and solution and 2% solution (Efudex)-generic available 5% cream: $239/40 gm 5% solution: $83/10 ml 2% solution: $56.10/10 ml	Treatment of actinic keratoses: Apply cream or solution in an amount sufficient to cover the lesions twice daily. Discontinue when inflammatory response reaches the erosion stage. The usual duration of therapy is from 2 to 4 weeks.	
Fluorouracil 1% cream (Fluoroplex) $351/30 gm	Treatment of multiple actinic keratoses: Cover entire face or other affected areas twice daily for 2 to 6 weeks. Discontinue use when inflammatory reaction reaches the erosion, ulceration, and necrosis stages.	
Imiquimod 5% cream (Aldara)-generic available $553/24 packets *treatment requires 32 packets for 16 weeks	Treatment of clinically typical, nonhyperkeratotic, nonhypertrophic actinic keratoses on the face or scalp in immunocompetent adults: Apply up to one packet to the defined treatment area (i.e., 5 cm x 5 cm) of the face or scalp (but not both concurrently) two days per week at bedtime (e.g., Mon. and Thurs. or Tue. and Fri.) for 16 weeks. Wash off after 8 hours.	Exact mechanism of action is unknown. Imiquimod is an immune response modifier that stimulates local cytokine induction, which may result in indirect antineoplastic potency.

Product/Cost	Indication/Dosage	Mechanism of Action
Imiquimod 3.75% cream (Zyclara) 3.75% cream: $646/28 packets 3.75% pump: $707/7.5 gm	Treatment of clinically typical, visible, or palpable actinic keratoses of the face or balding scalp in immunocompetent adults: Once daily to the skin of the affected area for two 2-week treatment cycles separated by a 2-week no treatment period. Treatment of external genital and perianal warts/condyloma acuminata (EGW) in patients 12 years or older: Once daily to the external genital/perianal warts until total clearance or up to 8 weeks.	Exact mechanism of action is unknown. Imiquimod is an immune response modifier that stimulates local cytokine induction, which may result in indirect antineoplastic potency.
Ingenol Mebutate 0.015% and 0.05% gel (Picato) $637/3 unit dose tubes of 0.015% gel $637/2 unit dose tubes of 0.05% gel **Keep refrigerated at 36-45 degrees.	Treatment of actinic keratoses: Apply 0.015% gel to the affected area (face and scalp) once daily for 3 consecutive days. Apply 0.05% gel to the affected area (trunk and extremities) once daily for 3 consecutive days.	The mechanism of action by which ingenol mebutate induces cell death in in treating AK lesions is unknown.

ND Medicaid Agents used to treat Actinic Keratosis Utilization			
05/31/11 - 05/30/12			
Label Name	**Rx Num**	**Total Reimb Amt**	**Avg Cost per Script**
ALDARA 5% CREAM	6	$886.62	$147.77
FLUOROURACIL 5% CREAM (EFUDEX)	2	$489.30	$244.65
IMIQUIMOD 5% CREAM PACKET	137	$31,214.58	$227.84
102 recipients	**145**	**$32,590.50**	

References

1. PL Detail-Document, Actinic Keratosis Treatments. Pharmacist's Letter/Prescriber's Letter. March 2012.
2. Stockfleth E, et al. Guidelines for the management of actinic keratoses-update 2011. http://www.euroderm.org. (accessed May 30, 2012).
3. Solaraze® [prescribing information]. Melville, NY: PharmaDerm; April 2010.
4. Carac® [prescribing information]. Bridgewater, NJ: Dermik Laboratories; August 2009.
5. Efudex® [prescribing information]. Costa Mesa, CA: Valeant; November 2005.
6. Fluoroplex® [prescribing information]. Irvine, CA: Allergan, Inc. November 2004.
7. Zyclara® [prescribing information]. Scottsdale, AZ: Medicis; February 2012.
8. Picato® [prescribing information]. Parsippany, NY: LEO Pharma Inc.; January 2012.

North Dakota Medicaid
DUR Board Meeting
Moxeza® Review

I. Overview

Moxeza solution is a topical fluoroquinolone anti-infective indicated for the treatment of bacterial conjunctivitis caused by the susceptible strains of the following organisms: Aerococcus viridans*, Corynebacterium macginleyi*, Enterococcus faecalis*, Micrococcus luteus*, Staphylococcus arlettae*, Staphylococcus aureus, Staphylococcus capitis, Staphylococcus epidermidis, Staphylococcus haemolyticus, Staphylococcus hominis, Staphylococcus saprophyticus*, Staphylococcus warneri*, Streptococcus mitis*, Streptococcus pneumoniae, Streptococcus parasanguinis*, Escherichia coli*, Haemophilus influenzae, Klebsiella pneumoniae*, Propionibacterium acnes, Chlamydia trachomatis*.
**Efficacy for this organism was studied in fewer than 10 infections.*

II. Dosage and Administration

Instill 1 drop in the affected eye(s) two times daily for seven days.

III. Warnings and Precautions

- Topical ophthalmic use only.
- Hypersensitivity and anaphylaxis have been reported with systemic use.
- Prolonged use may result in overgrowth of non-susceptible organisms, including fungi.
- Patients should not wear contact lenses if they have signs or symptoms of bacterial conjunctivitis.

IV. Adverse Reactions

The most common adverse reactions reported in 1-2% of patients were eye irritation, pyrexia, and conjunctivitis.

V. Utilization

Ophthalmic Fluoroquinolone Utilization			
05/31/11 - 05/30/12			
Label Name	**Rx Num**	**Total Reimb Amt**	**Avg Cost per Script**
CIPROFLOXACIN 0.3% EYE DROP	478	$13,777.13	$28.82
LEVOFLOXACIN 0.5% EYE DROPS	3	$273.15	$91.05
MOXEZA 0.5% EYE DROPS	54	$4,578.23	$84.78
VIGAMOX 0.5% EYE DROPS	834	$69,281.91	$83.07
ZYMAR 0.3% EYE DROPS	3	$210.80	$70.27
ZYMAXID 0.5% EYE DROPS	12	$1,034.81	$86.23
1,256 recipients	**1384**	**$89,156.03**	

References

1. Moxeza® [prescribing information]. Fort Worth, TX. Alcon Laboratories, Inc.; 2010.

North Dakota Medicaid
DUR Board Meeting
Lidoderm® Review

I. Overview

Lidocaine is an amide-type local anesthetic agent and is suggested to stabilize neuronal membranes by inhibiting the ionic fluxes required for the initiation and conduction of impulses. The penetration of lidocaine into intact skin after application is sufficient to produce an analgesic effect, but less than the amount necessary to produce a complete sensory block.

II. Indication

Lidoderm is indicated for relief of pain associated with post-herpetic neuralgia. It should be applied only to intact skin.

III. Warnings

- Even a used Lidoderm patch contains a large amount of lidocaine (at least 665mg). The potential exists for a small child or pet to suffer serious adverse effects from chewing or ingesting a new or used patch. It is important for patients to store and dispose of Lidoderm out of the reach of children, pets, and others.

- Excessive dosing by applying Lidoderm to larger areas or for longer than the recommended wearing time should result in increased absorption of lidocaine and high blood concentrations, leading to serious adverse effects. Lidocaine toxicity could be expected at lidocaine blood concentrations above 5 ug/mL. The blood concentration of lidocaine is determined by the rate of systemic absorption and elimination. Longer duration of application, application of more than the recommended number of patches, smaller patients, or impaired elimination may all contribute to increasing the blood concentration of lidocaine.

IV. Precautions

- Patients with severe hepatic disease are at greater risk of developing toxic blood concentrations of lidocaine because of their inability to metabolize lidocaine normally.

- Lidoderm should be used with caution in patients with a history of drug sensitivities, especially if the etiologic agent is uncertain.

- Application to broken or inflamed skin, although not tested, may result in higher blood concentrations of lidocaine from increased absorption. Lidoderm is only recommended for use on intact skin.

- Placement of external heat sources, such as heating pads or electric blankets, over Lidoderm patches is not recommended as this has not been evaluated and may increase plasma lidocaine levels.

- The contact of Lidoderm with eyes, although not studied, should be avoided based on the findings of severe eye irritation with the use of similar products in animals. If eye contact occurs, immediately wash out the eye with water or saline and protect the eye until sensation returns.

V. Drug Interactions

- Lidoderm should be used with caution in patients receiving Class I antiarrhythmic drugs (such as tocainide and mexiletine) since the toxic effects are additive and potentially synergistic.

- When Lidoderm is used concomitantly with other products containing local anesthetic agents, the amount absorbed from all formulations must be considered.

VI. Adverse Reactions

- During or immediately after treatment with Lidoderm, the skin at the site of application may develop blisters, bruising, burning sensation, depigmentation, dermatitis, discoloration, edema, erythema, exfoliation, irritation, papules, petechiae, pruritus, vesicles, or may be the locus of abnormal sensation. These reactions are generally mild and transient, resolving spontaneously within a few minutes to hours.

- Allergic and anaphylactoid reactions associated with lidocaine, although rare, can occur. They are characterized by angioedema, bronchospasm, dermatitis, dyspnea, hypersensitivity, laryngospasm, pruritus, shock, and urticaria.

- Systemic adverse reactions following appropriate use of Lidoderm are unlikely, due to the small dose absorbed.

VII. Dosage and Administration

- Apply Lidoderm to intact skin to cover the most painful area. Apply up to three patches, only once for up to 12 hours within a 24-hour period. Patches may be cut into smaller sizes with scissors prior to removal of the release liner. Clothing may be worn over the area of application. Smaller areas of treatment are recommended in a debilitated patient or a patient with impaired elimination.

VIII. Utilization

Lidoderm Utilization 05/31/11 – 05/30/12			
Label Name	**Rx Num**	**Total Reimb Amt**	**Avg Cost per Script**
Lidoderm (200 recip)	483	$102,858.89	$212.95 (~$7/patch)

References

1. Lidoderm® [prescribing information]. Chadds Ford, PA. Endo Pharmaceuticals., Inc.; March 2010.

North Dakota Medicaid
DUR Board
Suboxone

ND Medicaid Suboxone Utilization		
05/31/11 - 05/30/12		
Label Name	**Rx Num**	**Total Reimb Amt**
SUBOXONE 8 MG-2 MG SL FILM	4	$604.62
SUBOXONE 2 MG-0.5 MG TABLET SL	16	$2,772.70
SUBOXONE 8 MG-2 MG TABLET SL	601	$174,862.06
66 recipients	**621**	**$178,239.38**

50 eligible Suboxone Recipients Profile Review

Recipients	Dates of Suboxone Use	Notes
1	May 2009 - July 2011	17 narcs since 7/11
2	-	no drug profile since 12/09
3	October 2011 - present	Methadone prior
4	July 2009 - present	Clonazepam/Dextroamphetamine
5	Mar 2012 - May 2012 and Aug 2011 - Jan 2011	Methadone prior
6	Apr 2012 - May 2012 and Mar 2011 - July 2011	Methadone Sep/Oct 2011
7	April 2012 - May 2012 and May 2009 - May 2012	-
8	May 2011 - July 2011 and May 2009 - Oct 2009	Narcotics May 2011 - present
9	Oct 2011 - May 2012	-
10	May 2010 - July 2010 and May 2011	Narcotics all other months
11	Sep 2010 - present	-
12	Mar 2012 - May 2012	Methadone July 2010
13	Mar 2009 - Sep 2009	Narcotics all other months
14	2009 - present	-
15	Dec 2009 - Aug 2010	Methadone prior, Clonazepam after
16	May 2009 - October 2011	-
17	May 2010 - June 2011	No drug profile since 6/11
18	May 2009 - present	Clonazepam/Amphetamine
19	sporadic Nov 2010 - Jan 2012	-
20	April 2011	No profile since
21	Aug 2010 - Sept 2011	Methadone 2 months after then narcs
22	Dec 2011 - Mar 2012	-
23	Jan 2011 - Feb 2011	Narcotics after
24	Apr 2012 - May 2012	-
25	June 2009 - present	-
26	Oct 2010 - Dec 2010	Tramadol after
27	Dec 2011 - present	-
28	Jan 2010 - Jan 2011	no profile since
29	Sep 2011 - present	-
30	Apr 2010 - present	-
31	sporadic 2010	Stimulants

Recipients	Dates of Suboxone Use	Notes
32	May 2009 - Aug 2010	Narcotics after
33	Apr 2010 - present	-
34	June 2010 - present	-
35	July 2011 - present	Methadone prior
36	June 2010 - present	-
37	Feb 2011 - present	-
38	Nov 2011 - present	-
39	May 2009 - present	-
40	Jan 2012-present	Buprenorphine prior
41	April 2011 - present	-
42	Oct 2009 - Nov 2009	-
43	Apr 2011 - present	-
44	Feb 2012 - present	Buprenorphine prior
45	July 2009 - Oct 2009	Narcotics since
46	May 2009 - present	-
47	May 2009 - present	-
48	Sep 2011	-
49	Aug 2009 - May2010	Narcotics since
50	Aug 2008 - Sep 2008	Methadone after

North Dakota Medicaid
DUR Board
Duplicate Narcotic Therapy (H3A)

Duplicate Narcotic Therapy from May 31, 2011 - May 30, 2012		
Prescriber ID	**Recipient**	**Drug Name**
15496	1	BUTRANS , FENTANYL , HYDROCODONE-ACETAMINOPHEN , KADIAN , MORPHINE SULFATE , MORPHINE SULFATE ER
15585		BUTRANS , FENTANYL , HYDROCODONE-ACETAMINOPHEN , KADIAN , MORPHINE SULFATE , MORPHINE SULFATE ER
15650		BUTRANS , FENTANYL , HYDROCODONE-ACETAMINOPHEN , KADIAN , MORPHINE SULFATE , MORPHINE SULFATE ER
16297		BUTRANS , FENTANYL , HYDROCODONE-ACETAMINOPHEN , KADIAN , MORPHINE SULFATE , MORPHINE SULFATE ER
16304		BUTRANS , FENTANYL , HYDROCODONE-ACETAMINOPHEN , KADIAN , MORPHINE SULFATE , MORPHINE SULFATE ER
15357	2	ENDOCET , FENTANYL , HYDROCODONE-ACETAMINOPHEN , HYDROMORPHONE HCL , OXYCODONE HCL , OXYCODONE HCL-ACETAMINOPHEN
18843		ENDOCET , FENTANYL , HYDROCODONE-ACETAMINOPHEN , HYDROMORPHONE HCL , OXYCODONE HCL , OXYCODONE HCL-ACETAMINOPHEN
41412		ENDOCET , FENTANYL , HYDROCODONE-ACETAMINOPHEN , HYDROMORPHONE HCL , OXYCODONE HCL , OXYCODONE HCL-ACETAMINOPHEN
84066		ENDOCET , FENTANYL , HYDROCODONE-ACETAMINOPHEN , HYDROMORPHONE HCL , OXYCODONE HCL , OXYCODONE HCL-ACETAMINOPHEN
13032	3	FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE HCL , OXYCODONE HCL-ACETAMINOPHEN , TRAMADOL HCL
16214		FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE HCL , OXYCODONE HCL-ACETAMINOPHEN , TRAMADOL HCL
10656	4	MEPERIDINE HCL , OXYCODONE CONCENTRATE , OXYCODONE HCL , OXYCODONE-ACETAMINOPHEN , OXYCONTIN
13306		MEPERIDINE HCL , OXYCODONE CONCENTRATE , OXYCODONE HCL , OXYCODONE-ACETAMINOPHEN , OXYCONTIN
13688		MEPERIDINE HCL , OXYCODONE CONCENTRATE , OXYCODONE HCL , OXYCODONE-ACETAMINOPHEN , OXYCONTIN
14590		MEPERIDINE HCL , OXYCODONE CONCENTRATE , OXYCODONE HCL , OXYCODONE-ACETAMINOPHEN , OXYCONTIN
1679891907		MEPERIDINE HCL , OXYCODONE CONCENTRATE , OXYCODONE HCL , OXYCODONE-ACETAMINOPHEN , OXYCONTIN
16833		MEPERIDINE HCL , OXYCODONE CONCENTRATE , OXYCODONE HCL , OXYCODONE-ACETAMINOPHEN , OXYCONTIN
15585	5	ENDOCET , FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE-ACETAMINOPHEN , TRAMADOL HCL
1710052626		ENDOCET , FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE-ACETAMINOPHEN , TRAMADOL HCL

Duplicate Narcotic Therapy from May 31, 2011 - May 30, 2012		
Prescriber ID	**Recipient**	**Drug Name**
17848		ENDOCET , FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE-ACETAMINOPHEN , TRAMADOL HCL
41105		ENDOCET , FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE-ACETAMINOPHEN , TRAMADOL HCL
10757	6	FENTANYL , HYDROCODONE-ACETAMINOPHEN , METHADONE HCL , OXYCODONE HCL , TRAMADOL HCL
13306		FENTANYL , HYDROCODONE-ACETAMINOPHEN , METHADONE HCL , OXYCODONE HCL , TRAMADOL HCL
15441		FENTANYL , HYDROCODONE-ACETAMINOPHEN , METHADONE HCL , OXYCODONE HCL , TRAMADOL HCL
16061		FENTANYL , HYDROCODONE-ACETAMINOPHEN , METHADONE HCL , OXYCODONE HCL , TRAMADOL HCL
10980	7	FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE HCL , OXYCODONE HCL-ACETAMINOPHEN , OXYCODONE-ACETAMINOPHEN
12215		FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE HCL , OXYCODONE HCL-ACETAMINOPHEN , OXYCODONE-ACETAMINOPHEN
14526		FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE HCL , OXYCODONE HCL-ACETAMINOPHEN , OXYCODONE-ACETAMINOPHEN
18853		FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE HCL , OXYCODONE HCL-ACETAMINOPHEN , OXYCODONE-ACETAMINOPHEN
19584		FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE HCL , OXYCODONE HCL-ACETAMINOPHEN , OXYCODONE-ACETAMINOPHEN
11834	8	ENDOCET , HYDROCODONE-ACETAMINOPHEN , METHADONE HCL , OXYCODONE HCL-ACETAMINOPHEN , OXYCONTIN
13959		ENDOCET , HYDROCODONE-ACETAMINOPHEN , METHADONE HCL , OXYCODONE HCL-ACETAMINOPHEN , OXYCONTIN
10090	9	FENTANYL , HYDROCODONE-ACETAMINOPHEN , MORPHINE SULFATE , OXYCODONE HCL , ROXICET
11179		FENTANYL , HYDROCODONE-ACETAMINOPHEN , MORPHINE SULFATE , OXYCODONE HCL , ROXICET
12823		FENTANYL , HYDROCODONE-ACETAMINOPHEN , MORPHINE SULFATE , OXYCODONE HCL , ROXICET
14991		FENTANYL , HYDROCODONE-ACETAMINOPHEN , MORPHINE SULFATE , OXYCODONE HCL , ROXICET
15326		FENTANYL , HYDROCODONE-ACETAMINOPHEN , MORPHINE SULFATE , OXYCODONE HCL , ROXICET
16112		FENTANYL , HYDROCODONE-ACETAMINOPHEN , MORPHINE SULFATE , OXYCODONE HCL , ROXICET
16194		FENTANYL , HYDROCODONE-ACETAMINOPHEN , MORPHINE SULFATE , OXYCODONE HCL , ROXICET
19846		FENTANYL , HYDROCODONE-ACETAMINOPHEN , MORPHINE SULFATE , OXYCODONE HCL , ROXICET
10852	10	ENDOCET , FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE-ACETAMINOPHEN , OXYCONTIN
11828		ENDOCET , FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE-ACETAMINOPHEN , OXYCONTIN
12034		ENDOCET , FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE-ACETAMINOPHEN , OXYCONTIN
19869		ENDOCET , FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE-ACETAMINOPHEN , OXYCONTIN

Duplicate Narcotic Therapy from May 31, 2011 - May 30, 2012		
Prescriber ID	**Recipient**	**Drug Name**
17186	11	ENDOCET , HYDROCODONE-ACETAMINOPHEN , OXYCODONE HCL , OXYCODONE-ACETAMINOPHEN , OXYCONTIN
18063		ENDOCET , HYDROCODONE-ACETAMINOPHEN , OXYCODONE HCL , OXYCODONE-ACETAMINOPHEN , OXYCONTIN
19827		ENDOCET , HYDROCODONE-ACETAMINOPHEN , OXYCODONE HCL , OXYCODONE-ACETAMINOPHEN , OXYCONTIN
11085	12	HYDROCODONE-ACETAMINOPHEN , METHADONE HCL , MORPHINE SULFATE ER , OXYCODONE HCL , OXYCODONE HCL-ACETAMINOPHEN
16432		HYDROCODONE-ACETAMINOPHEN , METHADONE HCL , MORPHINE SULFATE ER , OXYCODONE HCL , OXYCODONE HCL-ACETAMINOPHEN
41318		HYDROCODONE-ACETAMINOPHEN , METHADONE HCL , MORPHINE SULFATE ER , OXYCODONE HCL , OXYCODONE HCL-ACETAMINOPHEN
14327	13	DILAUDID , ENDOCET , FENTANYL , OXYCODONE HCL , OXYCODONE HCL-ACETAMINOPHEN
15270		DILAUDID , ENDOCET , FENTANYL , OXYCODONE HCL , OXYCODONE HCL-ACETAMINOPHEN
16437		DILAUDID , ENDOCET , FENTANYL , OXYCODONE HCL , OXYCODONE HCL-ACETAMINOPHEN
1740254739		DILAUDID , ENDOCET , FENTANYL , OXYCODONE HCL , OXYCODONE HCL-ACETAMINOPHEN
84049		DILAUDID , ENDOCET , FENTANYL , OXYCODONE HCL , OXYCODONE HCL-ACETAMINOPHEN
10431	14	FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE HCL , OXYCODONE-ACETAMINOPHEN , TRAMADOL HCL
19887		FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE HCL , OXYCODONE-ACETAMINOPHEN , TRAMADOL HCL
19983		FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE HCL , OXYCODONE-ACETAMINOPHEN , TRAMADOL HCL
84028		FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE HCL , OXYCODONE-ACETAMINOPHEN , TRAMADOL HCL
18865	15	BUTORPHANOL TARTRATE , FENTANYL , HYDROMORPHONE HCL , OXYCODONE HCL-ACETAMINOPHEN , TRAMADOL HCL
10861	16	HYDROCODONE-ACETAMINOPHEN , OXYCODONE-ACETAMINOPHEN , ROXICET , TRAMADOL HCL
12034		HYDROCODONE-ACETAMINOPHEN , OXYCODONE-ACETAMINOPHEN , ROXICET , TRAMADOL HCL
13149		HYDROCODONE-ACETAMINOPHEN , OXYCODONE-ACETAMINOPHEN , ROXICET , TRAMADOL HCL
13939		HYDROCODONE-ACETAMINOPHEN , OXYCODONE-ACETAMINOPHEN , ROXICET , TRAMADOL HCL
1740254739		HYDROCODONE-ACETAMINOPHEN , OXYCODONE-ACETAMINOPHEN , ROXICET , TRAMADOL HCL
19869		HYDROCODONE-ACETAMINOPHEN , OXYCODONE-ACETAMINOPHEN , ROXICET , TRAMADOL HCL
10756	17	FENTANYL , HYDROCODONE-ACETAMINOPHEN , HYDROMORPHONE HCL , OXYCODONE-ACETAMINOPHEN
11094		FENTANYL , HYDROCODONE-ACETAMINOPHEN , HYDROMORPHONE HCL , OXYCODONE-ACETAMINOPHEN
1134433857		FENTANYL , HYDROCODONE-ACETAMINOPHEN , HYDROMORPHONE HCL ,

Duplicate Narcotic Therapy from May 31, 2011 - May 30, 2012		
Prescriber ID	**Recipient**	**Drug Name**
		OXYCODONE-ACETAMINOPHEN
13123		FENTANYL , HYDROCODONE-ACETAMINOPHEN , HYDROMORPHONE HCL , OXYCODONE-ACETAMINOPHEN
1326278912		FENTANYL , HYDROCODONE-ACETAMINOPHEN , HYDROMORPHONE HCL , OXYCODONE-ACETAMINOPHEN
14269		FENTANYL , HYDROCODONE-ACETAMINOPHEN , HYDROMORPHONE HCL , OXYCODONE-ACETAMINOPHEN
15333		FENTANYL , HYDROCODONE-ACETAMINOPHEN , HYDROMORPHONE HCL , OXYCODONE-ACETAMINOPHEN
1699087916		FENTANYL , HYDROCODONE-ACETAMINOPHEN , HYDROMORPHONE HCL , OXYCODONE-ACETAMINOPHEN
18084		FENTANYL , HYDROCODONE-ACETAMINOPHEN , HYDROMORPHONE HCL , OXYCODONE-ACETAMINOPHEN
12928	18	FENTANYL , HYDROCODONE-ACETAMINOPHEN , HYDROMORPHONE HCL , OXYCODONE HCL
16326	19	HYDROMORPHONE HCL , MORPHINE SULFATE ER , OXYCODONE HCL , TRAMADOL HCL
16475		HYDROMORPHONE HCL , MORPHINE SULFATE ER , OXYCODONE HCL , TRAMADOL HCL
18468		HYDROMORPHONE HCL , MORPHINE SULFATE ER , OXYCODONE HCL , TRAMADOL HCL
10513	20	HYDROCODONE-ACETAMINOPHEN , OXYCODONE HCL , OXYCODONE-ACETAMINOPHEN , TRAMADOL HCL
13415	21	ENDOCET , FENTANYL , HYDROCODONE-ACETAMINOPHEN , ROXICET
13855		ENDOCET , FENTANYL , HYDROCODONE-ACETAMINOPHEN , ROXICET
15032		ENDOCET , FENTANYL , HYDROCODONE-ACETAMINOPHEN , ROXICET
18911		ENDOCET , FENTANYL , HYDROCODONE-ACETAMINOPHEN , ROXICET
19900		ENDOCET , FENTANYL , HYDROCODONE-ACETAMINOPHEN , ROXICET
12939	21	ENDOCET , OXYCODONE HCL , OXYCODONE HCL-ACETAMINOPHEN , OXYCONTIN
18865		ENDOCET , OXYCODONE HCL , OXYCODONE HCL-ACETAMINOPHEN , OXYCONTIN
15343	22	FENTANYL , HYDROCODONE-ACETAMINOPHEN , MORPHINE SULFATE ER , TRAMADOL HCL
11611	23	HYDROMORPHONE HCL , MORPHINE SULFATE ER , OXYCONTIN , TRAMADOL HCL
14804		HYDROMORPHONE HCL , MORPHINE SULFATE ER , OXYCONTIN , TRAMADOL HCL
16162		HYDROMORPHONE HCL , MORPHINE SULFATE ER , OXYCONTIN , TRAMADOL HCL
1740254739		HYDROMORPHONE HCL , MORPHINE SULFATE ER , OXYCONTIN , TRAMADOL HCL
1326278912	24	FENTANYL , HYDROCODONE-ACETAMINOPHEN , MORPHINE SULFATE ER , OXYCODONE HCL
1669624813		FENTANYL , HYDROCODONE-ACETAMINOPHEN , MORPHINE SULFATE ER , OXYCODONE HCL
1710117312		FENTANYL , HYDROCODONE-ACETAMINOPHEN , MORPHINE SULFATE ER , OXYCODONE HCL
1942514666		FENTANYL , HYDROCODONE-ACETAMINOPHEN , MORPHINE SULFATE ER , OXYCODONE HCL

Duplicate Narcotic Therapy from May 31, 2011 - May 30, 2012		
Prescriber ID	**Recipient**	**Drug Name**
10321	25	FENTANYL , MORPHINE SULFATE , MORPHINE SULFATE ER , OXYCODONE HCL
10838		FENTANYL , MORPHINE SULFATE , MORPHINE SULFATE ER , OXYCODONE HCL
11329		FENTANYL , MORPHINE SULFATE , MORPHINE SULFATE ER , OXYCODONE HCL
12941		FENTANYL , MORPHINE SULFATE , MORPHINE SULFATE ER , OXYCODONE HCL
18084		FENTANYL , MORPHINE SULFATE , MORPHINE SULFATE ER , OXYCODONE HCL
1891888582		FENTANYL , MORPHINE SULFATE , MORPHINE SULFATE ER , OXYCODONE HCL
84086		FENTANYL , MORPHINE SULFATE , MORPHINE SULFATE ER , OXYCODONE HCL
10838	26	ENDOCET , MORPHINE SULFATE , OXYCODONE-ACETAMINOPHEN , OXYCONTIN
12071		ENDOCET , MORPHINE SULFATE , OXYCODONE-ACETAMINOPHEN , OXYCONTIN
13615		ENDOCET , MORPHINE SULFATE , OXYCODONE-ACETAMINOPHEN , OXYCONTIN
18911		ENDOCET , MORPHINE SULFATE , OXYCODONE-ACETAMINOPHEN , OXYCONTIN
19842		ENDOCET , MORPHINE SULFATE , OXYCODONE-ACETAMINOPHEN , OXYCONTIN
1740254739	27	MORPHINE SULFATE , MORPHINE SULFATE ER , OPANA ER
19869		MORPHINE SULFATE , MORPHINE SULFATE ER , OPANA ER
12622	28	ENDOCET , OXYCODONE-ACETAMINOPHEN , TRAMADOL HCL
19552		ENDOCET , OXYCODONE-ACETAMINOPHEN , TRAMADOL HCL
19591		ENDOCET , OXYCODONE-ACETAMINOPHEN , TRAMADOL HCL
19593		ENDOCET , OXYCODONE-ACETAMINOPHEN , TRAMADOL HCL
11179	29	HYDROCODONE-ACETAMINOPHEN , METHADONE HCL , MORPHINE SULFATE ER
16112		HYDROCODONE-ACETAMINOPHEN , METHADONE HCL , MORPHINE SULFATE ER
19700		HYDROCODONE-ACETAMINOPHEN , METHADONE HCL , MORPHINE SULFATE ER
13929	30	OXYCODONE HCL , OXYCODONE-ACETAMINOPHEN , OXYCONTIN
12928	31	FENTANYL , OXYCODONE HCL-ACETAMINOPHEN , TRAMADOL HCL
16162	32	MORPHINE SULFATE , MORPHINE SULFATE ER , OXYCODONE HCL
15585	33	MORPHINE SULFATE ER , OXYCODONE-ACETAMINOPHEN , OXYCONTIN
17848		MORPHINE SULFATE ER , OXYCODONE-ACETAMINOPHEN , OXYCONTIN
10195	34	FENTANYL , HYDROCODONE-ACETAMINOPHEN , TRAMADOL HCL
13936		FENTANYL , HYDROCODONE-ACETAMINOPHEN , TRAMADOL HCL
14720	35	FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE-ACETAMINOPHEN
15441		FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE-ACETAMINOPHEN
16061		FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE-

Duplicate Narcotic Therapy from May 31, 2011 - May 30, 2012		
Prescriber ID	**Recipient**	**Drug Name**
		ACETAMINOPHEN
16833		FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE-ACETAMINOPHEN
19813		FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE-ACETAMINOPHEN
16458	36	OXYCODONE HCL-ACETAMINOPHEN , TRAMADOL HCL , ULTRAM ER
1083910426	37	KADIAN , MORPHINE SULFATE ER , OXYCODONE HCL
1740254739		KADIAN , MORPHINE SULFATE ER , OXYCODONE HCL
19869		KADIAN , MORPHINE SULFATE ER , OXYCODONE HCL
15457	38	MORPHINE SULFATE , MORPHINE SULFATE ER , OXYCODONE HCL
19732		MORPHINE SULFATE , MORPHINE SULFATE ER , OXYCODONE HCL
84021		MORPHINE SULFATE , MORPHINE SULFATE ER , OXYCODONE HCL
12034	39	MORPHINE SULFATE ER , OXYCODONE HCL-ACETAMINOPHEN , TRAMADOL HCL
1740254739		MORPHINE SULFATE ER , OXYCODONE HCL-ACETAMINOPHEN , TRAMADOL HCL
19869		MORPHINE SULFATE ER , OXYCODONE HCL-ACETAMINOPHEN , TRAMADOL HCL
11894	40	FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE HCL , OXYCONTIN
12079		FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE HCL , OXYCONTIN
16431		FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE HCL , OXYCONTIN
11179	41	HYDROCODONE-ACETAMINOPHEN , MORPHINE SULFATE , MORPHINE SULFATE ER
19700		HYDROCODONE-ACETAMINOPHEN , MORPHINE SULFATE , MORPHINE SULFATE ER
15585	42	FENTANYL , OXYCODONE HCL , TRAMADOL HCL
17848		FENTANYL , OXYCODONE HCL , TRAMADOL HCL
16458	43	HYDROMORPHONE HCL , MORPHINE SULFATE , MORPHINE SULFATE ER
10611	44	MORPHINE SULFATE , OXYCODONE HCL , OXYCONTIN
10854		MORPHINE SULFATE , OXYCODONE HCL , OXYCONTIN
12034		MORPHINE SULFATE , OXYCODONE HCL , OXYCONTIN
1740254739		MORPHINE SULFATE , OXYCODONE HCL , OXYCONTIN
18780		MORPHINE SULFATE , OXYCODONE HCL , OXYCONTIN
19869		MORPHINE SULFATE , OXYCODONE HCL , OXYCONTIN
1740254739	45	FENTANYL , MORPHINE SULFATE ER , OXYCODONE HCL
19869		FENTANYL , MORPHINE SULFATE ER , OXYCODONE HCL
13302	46	FENTANYL , MORPHINE SULFATE ER , OXYCODONE HCL
13537		FENTANYL , MORPHINE SULFATE ER , OXYCODONE HCL
15661		FENTANYL , MORPHINE SULFATE ER , OXYCODONE HCL
11179	47	FENTANYL , HYDROMORPHONE HCL , OXYCODONE HCL
1306995865		FENTANYL , HYDROMORPHONE HCL , OXYCODONE HCL
11277	48	FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE HCL

Duplicate Narcotic Therapy from May 31, 2011 - May 30, 2012		
Prescriber ID	**Recipient**	**Drug Name**
14165		FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE HCL
14852		FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE HCL
14310	49	FENTANYL , HYDROMORPHONE HCL , MORPHINE SULFATE ER
1740254739		FENTANYL , HYDROMORPHONE HCL , MORPHINE SULFATE ER
17684		FENTANYL , HYDROMORPHONE HCL , MORPHINE SULFATE ER
18780		FENTANYL , HYDROMORPHONE HCL , MORPHINE SULFATE ER
19971		FENTANYL , HYDROMORPHONE HCL , MORPHINE SULFATE ER

North Dakota Medicaid
DUR Board
Oxycontin TID

Oxycontin tablets are a controlled-release oral formulation of oxycodone hydrochloride indicated for the management of moderate to severe pain when a continuous, around-the-clock opioid analgesic is needed for an extended period of time. Oxycontin is not intended for use on an as needed basis. The controlled-release nature of the formulation allows Oxycontin to be effectively administered every 12 hours.

This report includes all strengths of Oxycontin in which patients were given 69 tablets or more per month, indicating three times a day dosing (TID). From 05/31/11 through 05/30/12 there were 190 scripts of Oxycontin filled with TID dosing. There were 18 recipients **(14% of total)** and 23 prescribers **(16% of total)**. Oxycontin prescribed with TID dosing makes up approximately **47%** of the Oxycontin spend.

Oxycontin TID dosing 05/31/11 – 05/30/12			
Drug Name	**Number of Prescriptions**	**Total Reimb Amount**	**Unique Number of Recipients**
Oxycontin (all)	791	$286,997.57	125
Oxycontin TID	190	$134,734.68	18

Summary by Age of the 18 recipients taking Oxycontin TID:

31-40	2
41-50	5
51-60	10
60 and above	1

Oxycontin Utilization per Recipient 05/31/11 – 05/31/12				
Recipient	**Date**	**Drug Name**	**Qty**	**Days Supply**
1	6/7/2011	OXYCONTIN 20 MG TABLET	90	30
	6/7/2011	OXYCONTIN 40 MG TABLET	90	30
	7/2/2011	OXYCONTIN 20 MG TABLET	90	30
	7/2/2011	OXYCONTIN 40 MG TABLET	90	30
	7/29/2011	OXYCONTIN 20 MG TABLET	90	30
	7/29/2011	OXYCONTIN 40 MG TABLET	90	30
	8/24/2011	OXYCONTIN 20 MG TABLET	90	30
	8/24/2011	OXYCONTIN 40 MG TABLET	90	30
	9/21/2011	OXYCONTIN 20 MG TABLET	90	30
	9/21/2011	OXYCONTIN 40 MG TABLET	90	30
	10/18/2011	OXYCONTIN 20 MG TABLET	90	30
	10/18/2011	OXYCONTIN 40 MG TABLET	90	30
	11/14/2011	OXYCONTIN 20 MG TABLET	84	28
	12/12/2011	OXYCONTIN 20 MG TABLET	84	28

Oxycontin Utilization per Recipient 05/31/11 – 05/31/12				
Recipient	**Date**	**Drug Name**	**Qty**	**Days Supply**
1 (cont'd)	12/13/2011	OXYCONTIN 40 MG TABLET	84	28
	1/13/2012	OXYCONTIN 20 MG TABLET	84	28
	1/20/2012	OXYCONTIN 40 MG TABLET	84	28
	2/8/2012	OXYCONTIN 20 MG TABLET	84	28
	2/14/2012	OXYCONTIN 40 MG TABLET	84	28
	3/13/2012	OXYCONTIN 20 MG TABLET	84	28
	3/13/2012	OXYCONTIN 40 MG TABLET	84	28
	4/11/2012	OXYCONTIN 20 MG TABLET	84	28
	4/11/2012	OXYCONTIN 40 MG TABLET	84	28
	5/8/2012	OXYCONTIN 20 MG TABLET	84	28
	5/8/2012	OXYCONTIN 40 MG TABLET	84	28
2	6/16/2011	OXYCONTIN 20 MG TABLET	84	28
	6/20/2011	OXYCONTIN 40 MG TABLET	84	28
	7/15/2011	OXYCONTIN 20 MG TABLET	84	28
	7/19/2011	OXYCONTIN 40 MG TABLET	84	28
	8/15/2011	OXYCONTIN 20 MG TABLET	84	28
	8/19/2011	OXYCONTIN 40 MG TABLET	84	28
	9/15/2011	OXYCONTIN 20 MG TABLET	84	28
	9/19/2011	OXYCONTIN 40 MG TABLET	84	28
	10/15/2011	OXYCONTIN 20 MG TABLET	84	28
	10/18/2011	OXYCONTIN 40 MG TABLET	84	28
	11/15/2011	OXYCONTIN 20 MG TABLET	90	22
	11/18/2011	OXYCONTIN 40 MG TABLET	90	30
	12/16/2011	OXYCONTIN 40 MG TABLET	90	30
	12/19/2011	OXYCONTIN 20 MG TABLET	90	30
	1/16/2012	OXYCONTIN 40 MG TABLET	90	30
	1/18/2012	OXYCONTIN 20 MG TABLET	90	30
	2/15/2012	OXYCONTIN 40 MG TABLET	90	30
	2/16/2012	OXYCONTIN 20 MG TABLET	90	30
	3/15/2012	OXYCONTIN 40 MG TABLET	90	30
	3/16/2012	OXYCONTIN 20 MG TABLET	90	30
	4/13/2012	OXYCONTIN 40 MG TABLET	90	30
	4/14/2012	OXYCONTIN 20 MG TABLET	90	30
	5/12/2012	OXYCONTIN 40 MG TABLET	120	30
	5/14/2012	OXYCONTIN 20 MG TABLET	120	30
3	11/18/2011	OXYCONTIN 20 MG TABLET	90	30
	11/18/2011	OXYCONTIN 80 MG TABLET	90	30
	12/16/2011	OXYCONTIN 20 MG TABLET	90	30
	12/16/2011	OXYCONTIN 80 MG TABLET	120	30
	1/13/2012	OXYCONTIN 20 MG TABLET	120	30
	1/13/2012	OXYCONTIN 80 MG TABLET	120	30
	2/10/2012	OXYCONTIN 20 MG TABLET	120	30
	2/10/2012	OXYCONTIN 80 MG TABLET	120	30

Oxycontin Utilization per Recipient 05/31/11 – 05/31/12				
Recipient	**Date**	**Drug Name**	**Qty**	**Days Supply**
3 (cont'd)	3/8/2012	OXYCONTIN 20 MG TABLET	120	30
	3/8/2012	OXYCONTIN 80 MG TABLET	120	30
	4/6/2012	OXYCONTIN 20 MG TABLET	120	30
	4/6/2012	OXYCONTIN 80 MG TABLET	120	30
	5/6/2012	OXYCONTIN 20 MG TABLET	120	30
	5/6/2012	OXYCONTIN 80 MG TABLET	120	30
4	11/8/2011	OXYCONTIN 20 MG TABLET	120	30
	12/7/2011	OXYCONTIN 40 MG TABLET	90	30
5	6/9/2011	OXYCONTIN 20 MG TABLET	90	30
	6/9/2011	OXYCONTIN 40 MG TABLET	90	30
	7/8/2011	OXYCONTIN 20 MG TABLET	90	30
	7/8/2011	OXYCONTIN 40 MG TABLET	90	30
	8/12/2011	OXYCONTIN 20 MG TABLET	90	30
	8/12/2011	OXYCONTIN 40 MG TABLET	90	30
	9/21/2011	OXYCONTIN 20 MG TABLET	90	30
	9/21/2011	OXYCONTIN 40 MG TABLET	90	30
	10/27/2011	OXYCONTIN 20 MG TABLET	90	30
	10/27/2011	OXYCONTIN 40 MG TABLET	90	30
	12/1/2011	OXYCONTIN 20 MG TABLET	90	30
	12/1/2011	OXYCONTIN 40 MG TABLET	90	30
	1/6/2012	OXYCONTIN 20 MG TABLET	90	30
	1/6/2012	OXYCONTIN 40 MG TABLET	90	30
	2/10/2012	OXYCONTIN 20 MG TABLET	90	30
	2/10/2012	OXYCONTIN 40 MG TABLET	90	30
	3/7/2012	OXYCONTIN 20 MG TABLET	90	30
	3/7/2012	OXYCONTIN 40 MG TABLET	90	30
	4/20/2012	OXYCONTIN 20 MG TABLET	90	30
	4/20/2012	OXYCONTIN 40 MG TABLET	90	30
	5/24/2012	OXYCONTIN 20 MG TABLET	90	30
	5/24/2012	OXYCONTIN 40 MG TABLET	90	30
6	4/24/2012	OXYCONTIN 80 MG TABLET	90	30
	5/24/2012	OXYCONTIN 80 MG TABLET	90	30
7	6/9/2011	OXYCONTIN 80 MG TABLET	90	30
	7/12/2011	OXYCONTIN 80 MG TABLET	90	30
	8/10/2011	OXYCONTIN 80 MG TABLET	90	30
	9/10/2011	OXYCONTIN 80 MG TABLET	90	30
	10/8/2011	OXYCONTIN 80 MG TABLET	90	30
	11/11/2011	OXYCONTIN 80 MG TABLET	90	30
	12/10/2011	OXYCONTIN 80 MG TABLET	90	30
	1/9/2012	OXYCONTIN 80 MG TABLET	90	30
	2/9/2012	OXYCONTIN 80 MG TABLET	90	30

Oxycontin Utilization per Recipient 05/31/11 – 05/31/12				
Recipient	**Date**	**Drug Name**	**Qty**	**Days Supply**
7 (cont'd)	3/7/2012	OXYCONTIN 80 MG TABLET	90	30
	4/18/2012	OXYCONTIN 80 MG TABLET	90	30
	5/17/2012	OXYCONTIN 80 MG TABLET	90	30
8	6/17/2011	OXYCONTIN 40 MG TABLET	90	30
	7/22/2011	OXYCONTIN 40 MG TABLET	90	30
	8/22/2011	OXYCONTIN 40 MG TABLET	90	30
	9/22/2011	OXYCONTIN 40 MG TABLET	90	30
	10/22/2011	OXYCONTIN 40 MG TABLET	90	30
	11/28/2011	OXYCONTIN 40 MG TABLET	90	30
	12/30/2011	OXYCONTIN 40 MG TABLET	90	30
	2/2/2012	OXYCONTIN 40 MG TABLET	90	30
	3/5/2012	OXYCONTIN 40 MG TABLET	90	30
	4/2/2012	OXYCONTIN 40 MG TABLET	90	30
	5/1/2012	OXYCONTIN 40 MG TABLET	90	30
9	6/13/2011	OXYCONTIN 80 MG TABLET	90	30
	7/14/2011	OXYCONTIN 80 MG TABLET	90	30
	8/11/2011	OXYCONTIN 80 MG TABLET	90	30
	9/15/2011	OXYCONTIN 80 MG TABLET	90	30
	10/21/2011	OXYCONTIN 80 MG TABLET	90	30
	11/21/2011	OXYCONTIN 80 MG TABLET	90	30
	12/23/2011	OXYCONTIN 80 MG TABLET	90	30
	1/20/2012	OXYCONTIN 80 MG TABLET	90	30
	2/18/2012	OXYCONTIN 80 MG TABLET	90	30
	3/19/2012	OXYCONTIN 80 MG TABLET	90	30
	4/17/2012	OXYCONTIN 80 MG TABLET	90	30
	5/24/2012	OXYCONTIN 80 MG TABLET	90	30
10	6/22/2011	OXYCONTIN 20 MG TABLET	90	30
	7/18/2011	OXYCONTIN 20 MG TABLET	90	30
	8/22/2011	OXYCONTIN 20 MG TABLET	90	30
	9/20/2011	OXYCONTIN 20 MG TABLET	90	30
11	6/28/2011	OXYCONTIN 40 MG TABLET	90	30
	7/27/2011	OXYCONTIN 40 MG TABLET	84	28
	8/23/2011	OXYCONTIN 40 MG TABLET	84	28
	9/20/2011	OXYCONTIN 40 MG TABLET	84	28
	10/15/2011	OXYCONTIN 40 MG TABLET	84	28
	11/14/2011	OXYCONTIN 40 MG TABLET	84	28
	12/15/2011	OXYCONTIN 40 MG TABLET	84	28
12	6/10/2011	OXYCONTIN 40 MG TABLET	84	28
	7/6/2011	OXYCONTIN 40 MG TABLET	84	28
	8/3/2011	OXYCONTIN 40 MG TABLET	84	28

Oxycontin Utilization per Recipient 05/31/11 – 05/31/12				
Recipient	**Date**	**Drug Name**	**Qty**	**Days Supply**
12 (cont'd)	8/29/2011	OXYCONTIN 40 MG TABLET	84	28
	10/3/2011	OXYCONTIN 40 MG TABLET	84	28
13	5/31/2011	OXYCONTIN 40 MG TABLET	84	28
	6/30/2011	OXYCONTIN 40 MG TABLET	90	30
	8/25/2011	OXYCONTIN 40 MG TABLET	90	30
	9/23/2011	OXYCONTIN 40 MG TABLET	90	30
	10/18/2011	OXYCONTIN 40 MG TABLET	90	30
	11/12/2011	OXYCONTIN 40 MG TABLET	90	30
	12/8/2011	OXYCONTIN 40 MG TABLET	90	30
	1/27/2012	OXYCONTIN 40 MG TABLET	90	30
	2/27/2012	OXYCONTIN 40 MG TABLET	90	30
14	6/24/2011	OXYCONTIN 10 MG TABLET	90	30
	7/25/2011	OXYCONTIN 10 MG TABLET	90	30
	8/24/2011	OXYCONTIN 10 MG TABLET	90	30
	9/23/2011	OXYCONTIN 10 MG TABLET	90	30
	10/21/2011	OXYCONTIN 10 MG TABLET	90	30
	11/18/2011	OXYCONTIN 10 MG TABLET	90	30
	12/16/2011	OXYCONTIN 10 MG TABLET	90	30
	1/13/2012	OXYCONTIN 10 MG TABLET	90	30
	2/10/2012	OXYCONTIN 10 MG TABLET	90	30
	3/12/2012	OXYCONTIN 10 MG TABLET	90	30
	4/9/2012	OXYCONTIN 10 MG TABLET	90	30
15	8/31/2011	OXYCONTIN 80 MG TABLET	90	30
	9/29/2011	OXYCONTIN 80 MG TABLET	90	30
	3/29/2012	OXYCONTIN 80 MG TABLET	90	30
	4/28/2012	OXYCONTIN 80 MG TABLET	90	30
	5/26/2012	OXYCONTIN 80 MG TABLET	90	30
16	6/8/2011	OXYCONTIN 40 MG TABLET	90	30
	7/13/2011	OXYCONTIN 40 MG TABLET	90	30
	8/10/2011	OXYCONTIN 40 MG TABLET	90	30
	9/6/2011	OXYCONTIN 40 MG TABLET	90	30
	10/3/2011	OXYCONTIN 40 MG TABLET	90	30
	10/31/2011	OXYCONTIN 40 MG TABLET	90	30
	11/23/2011	OXYCONTIN 40 MG TABLET	90	30
	1/18/2012	OXYCONTIN 20 MG TABLET	90	30
	2/15/2012	OXYCONTIN 20 MG TABLET	90	30
	3/13/2012	OXYCONTIN 20 MG TABLET	90	30
	4/11/2012	OXYCONTIN 20 MG TABLET	90	30
	5/9/2012	OXYCONTIN 20 MG TABLET	90	30
17	7/11/2011	OXYCONTIN 80 MG TABLET	90	30

Oxycontin Utilization per Recipient 05/31/11 – 05/31/12				
Recipient	**Date**	**Drug Name**	**Qty**	**Days Supply**
17 (cont'd)	8/6/2011	OXYCONTIN 80 MG TABLET	90	30
	9/2/2011	OXYCONTIN 80 MG TABLET	84	28
	9/29/2011	OXYCONTIN 80 MG TABLET	84	28
	10/31/2011	OXYCONTIN 80 MG TABLET	90	30
	11/28/2011	OXYCONTIN 80 MG TABLET	90	30
	12/28/2011	OXYCONTIN 80 MG TABLET	90	30
	1/24/2012	OXYCONTIN 80 MG TABLET	90	30
	2/22/2012	OXYCONTIN 80 MG TABLET	90	30
	3/22/2012	OXYCONTIN 80 MG TABLET	90	30
	4/18/2012	OXYCONTIN 80 MG TABLET	90	30
	5/16/2012	OXYCONTIN 80 MG TABLET	93	31
18	5/18/2012	OXYCONTIN 10 MG TABLET	90	30

NORTH DAKOTA MEDICAID
RETROSPECTIVE DRUG UTILIZATION REVIEW
CRITERIA RECOMMENDATIONS
3RD QUARTER 2012

Criteria Recommendations ***Approved Rejected***

1. Ranolazine / Potent CYP3A4 Inducers _____ _____

Alert Message: Ranexa (ranolazine) is contraindicated in patients receiving CYP3A4 inducers. Ranolazine is a CYP3A4 substrate and concurrent use with a CYP3A4 inducer can result in decreased plasma concentrations of ranolazine and loss of therapeutic effect.

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

Util A	Util B	Util C
Ranolazine	Rifampin	
	Barbiturates	
	Phenytoin	
	Carbamazepine	
	Oxcarbazepine	
	Rifabutin	
	Rifapentine	
	Bosentan	
	Pioglitazone	
	Modafinil	
	Armodafinil	
	Prednisone	
	Nevirapine	
	Efavirenz	
	Etravirine	

References:
Ranexa Prescribing Information, Dec. 2011, Gilead Sciences, Inc.
Facts & Comparisons, 2012 Updates.

2. Aliskiren-All / ACEIs & ARBs / Renal Impairment _____ _____

Alert Message: Avoid concomitant use of aliskiren-containing products with ARBs or ACEIs in patients with renal impairment where GFR is < 60 mL/min. Patients receiving this combination of medications may be at particular risk of developing acute renal failure.

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

Util A	Util B	Util C **(Include)**
Aliskiren-All	ACE Inhibitors	Renal Impairment
	ARBs	

References:
MedWatch The FDA Safety Information and Adverse Event Reporting Program. Aliskiren-containing Medications: Drug Safety Communication - New Warning and Contraindication. [Posted 04/20/2012].
Tekturna Prescribing Information, March 2012, Novartis Pharmaceuticals Corp.
Amturnide Prescribing Information, March 2012, Novartis Pharmaceuticals, Corp.
Tekturna HCT Prescribing Information, March 2012, Novartis Pharmaceutical Corp.
Tekturna Prescribing Information, March 2012, Novartis Pharmaceutical Corp.

3. Methotrexate / Proton Pump Inhibitors _____ _____

Alert Message: The concurrent administration of a proton pump inhibitor (PPI) and methotrexate (primarily at high dose) may elevate and prolong serum levels of methotrexate and/or its metabolite, possibly leading to methotrexate toxicities. A temporary withdrawal of the PPI (several days before and after methotrexate administration) may be considered in some patients.

Conflict Code: TA – Therapeutic Appropriateness
Drugs/Diseases

Util A	Util B	Util C
Methotrexate	Omeprazole	
	Lansoprazole	
	Pantoprazole	
	Rabeprazole	
	Esomeprazole	
	Dexlansoprazole	

References:
Bezabeh S, Mackey AC, Kluetz P et al., Accumulating Evidence for a Drug-Drug Interaction between Methotrexate and Proton Pump Inhibitors. The Oncologist. April 1, 2012;17:550-554.
Methotrexate Prescribing Information, October 2011, Hospira, Inc.
Clinical Pharmacology, 2012, Elsevier/Gold Standard.

4. Abiraterone / Therapeutic Appropriateness _____ _____

Alert Message: A review of the patient's recent drug history does not indicate the concurrent use of Zytiga (abiraterone) with prednisone. In order to reduce the risk of adrenocortical insufficiency (AI), abiraterone should be used in combination with low-dose prednisone.

Conflict Code: TA – Therapeutic Appropriateness
Drugs/Diseases

Util A	Util B	Util C **(Negating)**
Abiraterone		Prednisone

References:
Zytiga Prescribing Information, April 2011, Centocor Ortho Biotech Inc
Facts & Comparisons, 2012 Updates.
Clinical Pharmacology, 2012 Elsevier/Gold Standard.
Attard G, Reid AH, Auchus RJ, et al. Clinical and biochemical consequences of CYP17A1 inhibition with abiraterone given with and without exogenous glucocorticoids in castrate men with advanced prostate cancer. J Clin Endocrinol Metab. 2012 Feb;97(2):507-16.

5. Abiraterone / Therapeutic Appropriateness _____ _____

Alert Message: Zytiga (abiraterone) may cause elevated transaminases, and it is recommended that patients with moderate hepatic impairment monitor ALT, AST and bilirubin prior to the start of treatment, every week for the first month, every two weeks for the next two months, and monthly thereafter. Abiraterone should be discontinued in patients with ALT or AST greater than 5 times upper limit of normal (ULN) or total bilirubin greater than 3 times ULN.

Conflict Code: TA – Therapeutic Appropriateness
Drugs/Diseases

Util A	Util B	Util C (Include)
Abiraterone		Chronic Liver Disease
		Cirrhosis

References:
Zytiga Prescribing Information, April 2011, Centocor Ortho Biotech Inc.
Clinical Pharmacology, 2012 Elsevier/Gold Standard.

6. Abiraterone / Overuse _____ _____

Alert Message: Zytiga (abiraterone) may be over-utilized. The manufacturer's maximum recommended dose is 1000mg every day in combination with prednisone 5mg twice daily.

Conflict Code: ER - Overutilization
Drugs/Diseases

Util A	Util B	Util C **(Negating)**
Abiraterone		Chronic Liver Disease
		Cirrhosis

Max Dose: 1000mg/day

References:
Zytiga Prescribing Information, April 2011, Centocor Ortho Biotech Inc.
Clinical Pharmacology, 2012 Elsevier/Gold Standard.

7. Abiraterone / Moderate & Severe Hepatic Impairment _____ _____

Alert Message: Zytiga (abiraterone) may be over-utilized. Patients with moderately impaired hepatic function (Child-Pugh Class B) should be started at a dose of 250mg/day. The manufacturer recommends that abiraterone be avoided in patients with severe hepatic impairment (Child-Pugh Class C).

Conflict Code: ER - Overutilization
Drugs/Diseases

Util A	Util B	Util C (Include)
Abiraterone		Chronic Liver Disease
		Cirrhosis

Max Dose: 250mg/day

References
Zytiga Prescribing Information, April 2011, Centocor Ortho Biotech Inc.
Clinical Pharmacology, 2012 Elsevier/Gold Standard.

8. Abiraterone / Pregnancy / Pregnancy Negating _____ _____

Alert Message: Zytiga (abiraterone) is FDA pregnancy category X and is contraindicated during pregnancy and in women of childbearing potential due to risk of potential adverse effects to the fetus.

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

Util A	Util B	Util C **(Negating)**
Abiraterone	Pregnancy ICD-9s	Delivery
		Miscarriage
		Abortion

References:
Zytiga Prescribing Information, April 2011, Centocor Ortho Biotech Inc.
Clinical Pharmacology, 2012 Elsevier/Gold Standard.

9. Abiraterone / History of Cardiovascular Disease _____ _____

Alert Message: Zytiga (abiraterone) should be used with caution in patients with a history of cardiovascular disease (e.g., recent myocardial infarction or ventricular arrhythmia). Abiraterone may cause hypertension, hypokalemia and fluid retention due to increased mineralocorticoid levels from CYP17 inhibition.

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

Util A	Util B	Util C
Abiraterone	Myocardial Infarction	
	Ventricular Arrhythmia	

References:
Zytiga Prescribing Information, April 2011, Centocor Ortho Biotech Inc.
Clinical Pharmacology, 2012 Elsevier/Gold Standard.

10. Abiraterone / History of Heart Failure _____ _____

Alert Message: The safety of Zytiga (abiraterone) in patients with left ventricular ejection fraction < 50% or NYHA Class III or IV heart failure has not been established. If treatment with abiraterone is necessary, monitor patients for hypertension, hypokalemia and fluid retention at least once a month.

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

Util A	Util B	Util C
Abiraterone	Heart Failure	

References:
Zytiga Prescribing Information, April 2011, Centocor Ortho Biotech Inc.
Clinical Pharmacology, 2012 Elsevier/Gold Standard.

11. Abiraterone / Drugs that Induce or Inhibit CYP3A4 _____ _____

Alert Message: Zytiga (abiraterone) is a substrate of CYP3A4. The effects of strong CYP3A4 inhibitors (e.g., ketoconazole, clarithromycin, etc.) or inducers (e.g., phenytoin, carbamazepine, etc.) on the pharmacokinetics of abiraterone have not been evaluated. Use of strong inhibitors and inducers of CYP3A4 should be avoided or used with caution during abiraterone therapy.

Conflict Code: ER – Overutilization
Drugs/Diseases

Util A	Util B			Util C
Abiraterone	Ketoconazole	Itraconazole	Clarithromycin	
	Atazanavir	Nefazodone	Saquinavir	
	Telithromycin	Ritonavir	Indinavir	
	Nelfinavir	Voriconazole	Phenytoin	
	Carbamazepine	Rifampin	Rifabutin	
	Rifapentine	Phenobarbital		

References:
Zytiga Prescribing Information, April 2011, Centocor Ortho Biotech Inc.
Clinical Pharmacology, 2012 Elsevier/Gold Standard.
Flockhart DA. Drug Interactions: Cytochrome P450 Drug Interaction Table. Indiana University School of Medicine. Available at: Http://medicine.iupui.edu/clinpharm/ddos/table.asp. Accessed 04/2012.

12. Abiraterone / Substrates of CYP2D6 _____ _____

Alert Message: Zytiga (abiraterone) is an inhibitor of CYP2D6. Co-administration of abiraterone and substrates of CYP2D6 with a narrow therapeutic index (e.g., thioridazine) should be avoided. If alternative treatments cannot be used, a dose reduction of the concomitant CYP2D6 drug should be considered.

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

Util A	Util B	Util C
Abiraterone	Thioridazine	

References:

Zytiga Prescribing Information, April 2011, Centocor Ortho Biotech Inc.
Clinical Pharmacology, 2012 Elsevier/Gold Standard.
Flockhart DA. Drug Interactions: Cytochrome P450 Drug Interaction Table. Indiana University School of Medicine. Available at: Http://medicine.iupui.edu/clinpharm/ddos/table.asp. Accessed 04/2012.

DUR Board Meeting
December 3, 2012
Minervas (Kelly Inn)
1800 North 12th Street
Bismarck, ND

North Dakota Medicaid
DUR Board Meeting Agenda
Minervas (Kelly Inn)
1800 North 12th Street
Bismarck, ND
December 3, 2012
1pm

1. Administrative items
    - Travel vouchers

2. Old business

• Review and approval of minutes of 09/12 meeting	Chair
• Budget update	Brendan
• Second review of Actinic Keratosis	Brendan
• Second review of Moxeza	Brendan
• Second review of Patients Taking Multiple Long-Acting Narcotics	Brendan
• Yearly PA review (all)	HID

3. New business

• Genitourinary Smooth Muscle Relaxants	HID
• Agents used to treat Multiple Sclerosis	HID
• Criteria recommendations	HID
• Upcoming meeting date/agenda	Chair

4. Adjourn — Chair

Please remember to silence all cellular phones and pagers during the meeting.

Drug Utilization Review (DUR) Meeting Minutes
September 17, 2012

Members Present: Norman Byers, John Savageau, Russ Sobotta, Todd Twogood, Tanya Schmidt, Carrie Sorenson, Leann Ness, David Clinkenbeard, Jeffrey Hostetter

Members Absent: Kim Krohn, James Carlson, Cheryl Huber, Greg Pfister, Carlotta McCleary, Steve Irsfeld

Medicaid Pharmacy Department: Brendan Joyce

HID Staff Present: Candace Rieth

D. Clinkenbeard called the meeting to order at 1:00 pm. D. Clinkenbeard asked for a motion to approve the minutes from the June meeting. T. Schmidt moved that the minutes be approved and L. Ness seconded the motion. D. Clinkenbeard called for a voice vote to approve the minutes. The motion passed with no audible dissent.

Budget Update
B. Joyce informed the board members that for the current fiscal year (7/11 – 6/12) the total pharmacy expenditure, net of rebate, was 17.5 million dollars. The actual payment to pharmacies (pre-rebate dollars) during that time was 37.1 million dollars. The unit rebate offset amount that is paid to the federal government was 1.5 million dollars. The class with the highest drug spend is ADHD. In August 2012, the spend for ADHD was approximately $480,000.

Kalydeco Second Review
A motion and second were made at the June meeting to place Kalydeco on prior authorization. The topic was brought up for a second review. There was no public comment. After discussion, D. Clinkenbeard called for a voice vote to approve the motion. The motion passed with no audible dissent.

Kuvan Second Review
A motion and second were made at the June meeting to place Kuvan on prior authorization. The topic was brought up for a second review. There was no public comment. D. Clinkenbeard called for a voice vote to approve the motion. The motion passed with no audible dissent.

Elaprase Second Review
A motion and second were made at the June meeting to place Elaprase on prior authorization. The topic was brought up for a second review. There was no public comment. Chair, G. Pfister called for a voice vote to approve the motion. The motion passed with no audible dissent.

Yearly PA Review
The Board reviews products annually that have previously been placed on prior authorization. This allows the Board a chance to update the prior authorization forms and criteria. DAW, Amrix/Fexmid, Xenical, Zanaflex caps, Ketek, Aczone, Topical Ketoconazole, Clorpres, Gilenya, Livalo, Oravig, Xyrem, Zyclara, Nuedexta, Nexiclon, and Narcotic/APAP combo products were reviewed. No changes were made to the forms and criteria.

Actinic Keratosis Review
B. Joyce reviewed actinic keratosis with the Board. There was no public comment. After discussion, T. Twogood made a motion to place products used to treat actinic keratosis on prior authorization. J. Hostetter seconded the motion. This topic will be brought up at the next meeting for finalization.

Moxeza Review
B. Joyce reviewed Moxeza information with the Board. Rachelle Dorr, representing Alcon, spoke against prior authorization of Moxeza. After discussion, N. Byers made a motion to place Moxeza on prior authorization. L. Ness seconded the motion. This topic will be brought up at the next meeting for finalization.

Lidoderm Review
B. Joyce reviewed Lidoderm information with the Board. There was no public comment. This topic was tabled.

Suboxone Review
B. Joyce reviewed Suboxone information with the Board. Jim Sharp, representing Reckitt Benckiser, spoke regarding Suboxone. This topic was tabled.

Patients Taking Multiple Long-Acting Narcotics and Oxycontin TID Review
B. Joyce reviewed patients taking multiple long-acting narcotics and Oxycontin three times a day with the Board. There was no public comment. After discussion, it was suggested that this topic 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 usually are consistent with new indications, new drugs added, new warnings, etc. 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 N. Byers seconded the motion. D. Clinkenbeard called for a voice vote. The motion passed with no audible dissent.

The next DUR board meeting will be held Dec 3rd, 2012 in Bismarck. D. Clinkenbeard made a motion to adjourn the meeting. N. Byers seconded. The motion passed with no audible dissent. D. Clinkenbeard adjourned the meeting at 2:47 pm.

ACTINIC KERATOSIS PA FORM

HEALTH INFORMATION DESIGNS

Prior Authorization Vendor for ND Medicaid

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-773-0695

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	

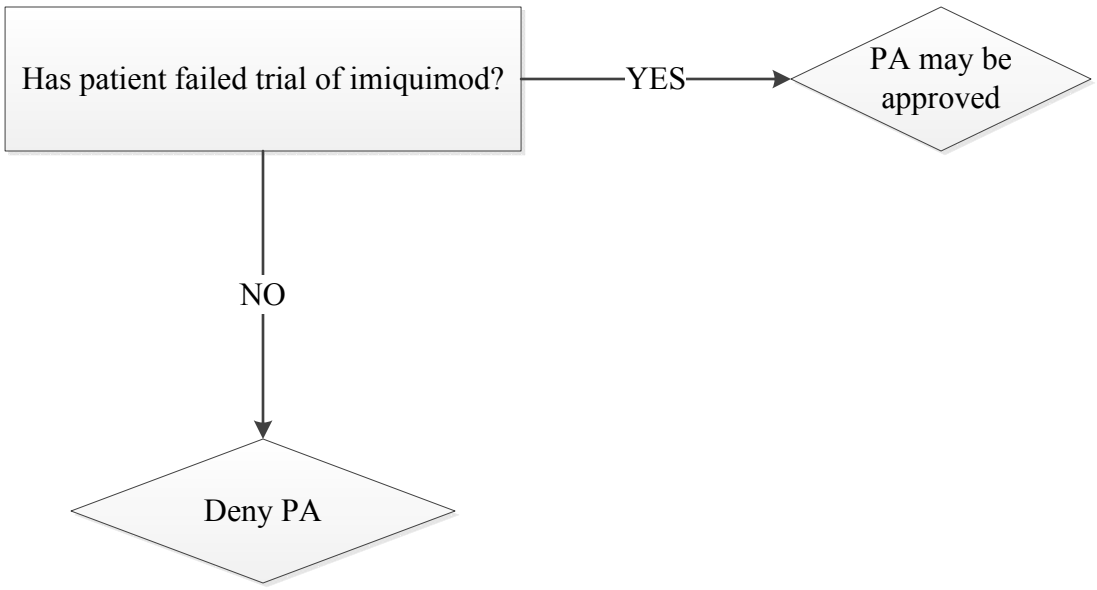
Part II: TO BE COMPLETED BY PHARMACY

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
Actinic Keratosis Authorization Algorithm



MOXEZA PA FORM

Prior Authorization Vendor for ND Medicaid

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-773-0695

ND Medicaid requires that patients receiving a new prescription for Moxeza must have a documented failure of a first line ophthalmic agent.

***Note: First line agents include sulfacetamide (Bleph 10®, etc.), erythromycin, bacitracin-polymixin B (Polysporin®), polymyxin B neomycin-gramicidin (Neosporin®), trimethoprim-polymyxin B (Polytrim®), gentamicin (Garamycin®, etc.), ofloxacin (Ocuflox®) and ciprofloxacin (Ciloxan®).**

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: □ MOXEZA	**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 Signature		Date	

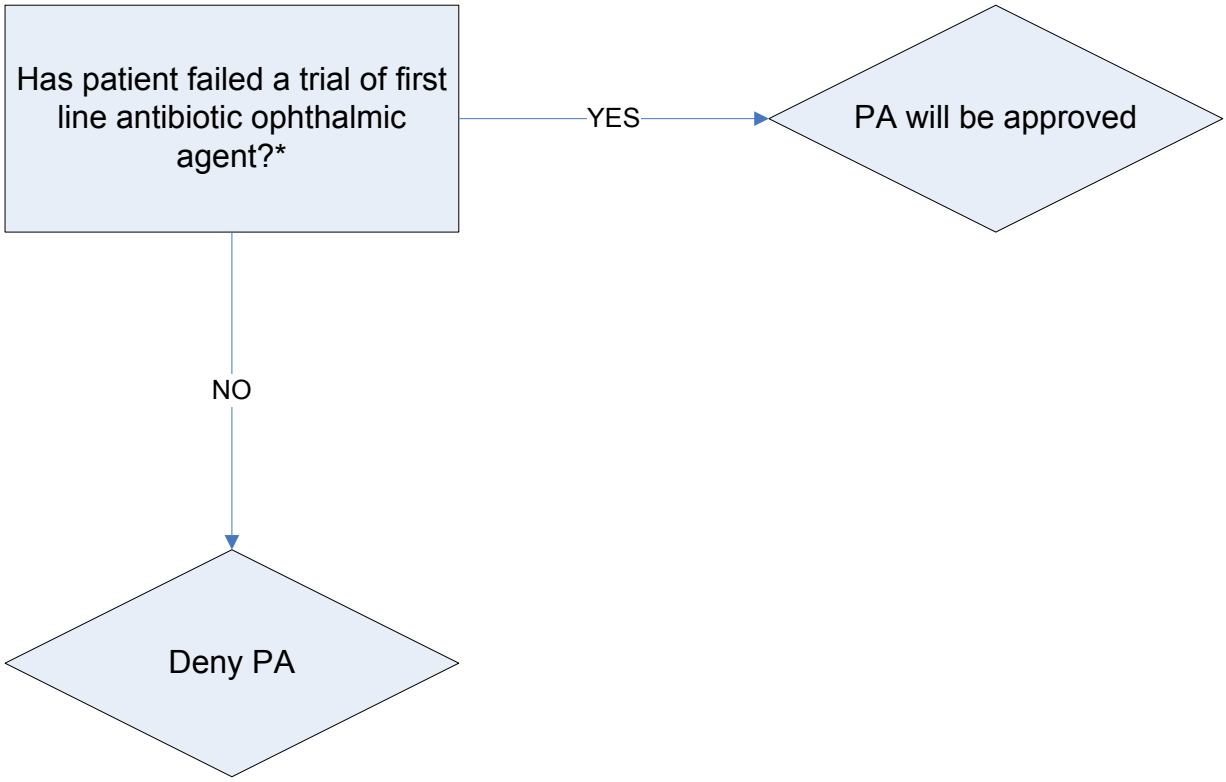
Part II: TO BE COMPLETED BY PHARMACY

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
Moxeza Authorization Algorithm



*First line agents include: sulfacetamide (Bleph 10, etc.), erythromycin, bacitracin-polymixin B (Polysporin), polymyxin B-neomycin-gramicidin (Neosporin), trimethoprim-polymyxin B (Polytrim), gentamicin (Garamycin, etc.), ofloxacin (Ocuflox), and ciprofloxacin (Ciloxan).

North Dakota Medicaid
DUR Board
Duplicate Narcotic Therapy (H3A)

Duplicate Narcotic Therapy from May 31, 2011 - May 30, 2012		
Prescriber ID	**Recipient**	**Drug Name**
15496	1	BUTRANS , FENTANYL , HYDROCODONE-ACETAMINOPHEN , KADIAN , MORPHINE SULFATE , MORPHINE SULFATE ER
15585		BUTRANS , FENTANYL , HYDROCODONE-ACETAMINOPHEN , KADIAN , MORPHINE SULFATE , MORPHINE SULFATE ER
15650		BUTRANS , FENTANYL , HYDROCODONE-ACETAMINOPHEN , KADIAN , MORPHINE SULFATE , MORPHINE SULFATE ER
16297		BUTRANS , FENTANYL , HYDROCODONE-ACETAMINOPHEN , KADIAN , MORPHINE SULFATE , MORPHINE SULFATE ER
16304		BUTRANS , FENTANYL , HYDROCODONE-ACETAMINOPHEN , KADIAN , MORPHINE SULFATE , MORPHINE SULFATE ER
15357	2	ENDOCET , FENTANYL , HYDROCODONE-ACETAMINOPHEN , HYDROMORPHONE HCL , OXYCODONE HCL , OXYCODONE HCL-ACETAMINOPHEN
18843		ENDOCET , FENTANYL , HYDROCODONE-ACETAMINOPHEN , HYDROMORPHONE HCL , OXYCODONE HCL , OXYCODONE HCL-ACETAMINOPHEN
41412		ENDOCET , FENTANYL , HYDROCODONE-ACETAMINOPHEN , HYDROMORPHONE HCL , OXYCODONE HCL , OXYCODONE HCL-ACETAMINOPHEN
84066		ENDOCET , FENTANYL , HYDROCODONE-ACETAMINOPHEN , HYDROMORPHONE HCL , OXYCODONE HCL , OXYCODONE HCL-ACETAMINOPHEN
13032	3	FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE HCL , OXYCODONE HCL-ACETAMINOPHEN , TRAMADOL HCL
16214		FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE HCL , OXYCODONE HCL-ACETAMINOPHEN , TRAMADOL HCL
10656	4	MEPERIDINE HCL , OXYCODONE CONCENTRATE , OXYCODONE HCL , OXYCODONE-ACETAMINOPHEN , OXYCONTIN
13306		MEPERIDINE HCL , OXYCODONE CONCENTRATE , OXYCODONE HCL , OXYCODONE-ACETAMINOPHEN , OXYCONTIN
13688		MEPERIDINE HCL , OXYCODONE CONCENTRATE , OXYCODONE HCL , OXYCODONE-ACETAMINOPHEN , OXYCONTIN
14590		MEPERIDINE HCL , OXYCODONE CONCENTRATE , OXYCODONE HCL , OXYCODONE-ACETAMINOPHEN , OXYCONTIN
1679891907		MEPERIDINE HCL , OXYCODONE CONCENTRATE , OXYCODONE HCL , OXYCODONE-ACETAMINOPHEN , OXYCONTIN
16833		MEPERIDINE HCL , OXYCODONE CONCENTRATE , OXYCODONE HCL , OXYCODONE-ACETAMINOPHEN , OXYCONTIN
15585	5	ENDOCET , FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE-ACETAMINOPHEN , TRAMADOL HCL
1710052626		ENDOCET , FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE-ACETAMINOPHEN , TRAMADOL HCL

Duplicate Narcotic Therapy from May 31, 2011 - May 30, 2012		
Prescriber ID	**Recipient**	**Drug Name**
17848		ENDOCET , FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE-ACETAMINOPHEN , TRAMADOL HCL
41105		ENDOCET , FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE-ACETAMINOPHEN , TRAMADOL HCL
10757	6	FENTANYL , HYDROCODONE-ACETAMINOPHEN , METHADONE HCL , OXYCODONE HCL , TRAMADOL HCL
13306		FENTANYL , HYDROCODONE-ACETAMINOPHEN , METHADONE HCL , OXYCODONE HCL , TRAMADOL HCL
15441		FENTANYL , HYDROCODONE-ACETAMINOPHEN , METHADONE HCL , OXYCODONE HCL , TRAMADOL HCL
16061		FENTANYL , HYDROCODONE-ACETAMINOPHEN , METHADONE HCL , OXYCODONE HCL , TRAMADOL HCL
10980	7	FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE HCL , OXYCODONE HCL-ACETAMINOPHEN , OXYCODONE-ACETAMINOPHEN
12215		FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE HCL , OXYCODONE HCL-ACETAMINOPHEN , OXYCODONE-ACETAMINOPHEN
14526		FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE HCL , OXYCODONE HCL-ACETAMINOPHEN , OXYCODONE-ACETAMINOPHEN
18853		FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE HCL , OXYCODONE HCL-ACETAMINOPHEN , OXYCODONE-ACETAMINOPHEN
19584		FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE HCL , OXYCODONE HCL-ACETAMINOPHEN , OXYCODONE-ACETAMINOPHEN
11834	8	ENDOCET , HYDROCODONE-ACETAMINOPHEN , METHADONE HCL , OXYCODONE HCL-ACETAMINOPHEN , OXYCONTIN
13959		ENDOCET , HYDROCODONE-ACETAMINOPHEN , METHADONE HCL , OXYCODONE HCL-ACETAMINOPHEN , OXYCONTIN
10090	9	FENTANYL , HYDROCODONE-ACETAMINOPHEN , MORPHINE SULFATE , OXYCODONE HCL , ROXICET
11179		FENTANYL , HYDROCODONE-ACETAMINOPHEN , MORPHINE SULFATE , OXYCODONE HCL , ROXICET
12823		FENTANYL , HYDROCODONE-ACETAMINOPHEN , MORPHINE SULFATE , OXYCODONE HCL , ROXICET
14991		FENTANYL , HYDROCODONE-ACETAMINOPHEN , MORPHINE SULFATE , OXYCODONE HCL , ROXICET
15326		FENTANYL , HYDROCODONE-ACETAMINOPHEN , MORPHINE SULFATE , OXYCODONE HCL , ROXICET
16112		FENTANYL , HYDROCODONE-ACETAMINOPHEN , MORPHINE SULFATE , OXYCODONE HCL , ROXICET
16194		FENTANYL , HYDROCODONE-ACETAMINOPHEN , MORPHINE SULFATE , OXYCODONE HCL , ROXICET
19846		FENTANYL , HYDROCODONE-ACETAMINOPHEN , MORPHINE SULFATE , OXYCODONE HCL , ROXICET
10852	10	ENDOCET , FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE-ACETAMINOPHEN , OXYCONTIN
11828		ENDOCET , FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE-ACETAMINOPHEN , OXYCONTIN
12034		ENDOCET , FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE-ACETAMINOPHEN , OXYCONTIN
19869		ENDOCET , FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE-ACETAMINOPHEN , OXYCONTIN

Duplicate Narcotic Therapy from May 31, 2011 - May 30, 2012		
Prescriber ID	**Recipient**	**Drug Name**
17186	11	ENDOCET , HYDROCODONE-ACETAMINOPHEN , OXYCODONE HCL , OXYCODONE-ACETAMINOPHEN , OXYCONTIN
18063		ENDOCET , HYDROCODONE-ACETAMINOPHEN , OXYCODONE HCL , OXYCODONE-ACETAMINOPHEN , OXYCONTIN
19827		ENDOCET , HYDROCODONE-ACETAMINOPHEN , OXYCODONE HCL , OXYCODONE-ACETAMINOPHEN , OXYCONTIN
11085	12	HYDROCODONE-ACETAMINOPHEN , METHADONE HCL , MORPHINE SULFATE ER , OXYCODONE HCL , OXYCODONE HCL-ACETAMINOPHEN
16432		HYDROCODONE-ACETAMINOPHEN , METHADONE HCL , MORPHINE SULFATE ER , OXYCODONE HCL , OXYCODONE HCL-ACETAMINOPHEN
41318		HYDROCODONE-ACETAMINOPHEN , METHADONE HCL , MORPHINE SULFATE ER , OXYCODONE HCL , OXYCODONE HCL-ACETAMINOPHEN
14327	13	DILAUDID , ENDOCET , FENTANYL , OXYCODONE HCL , OXYCODONE HCL-ACETAMINOPHEN
15270		DILAUDID , ENDOCET , FENTANYL , OXYCODONE HCL , OXYCODONE HCL-ACETAMINOPHEN
16437		DILAUDID , ENDOCET , FENTANYL , OXYCODONE HCL , OXYCODONE HCL-ACETAMINOPHEN
1740254739		DILAUDID , ENDOCET , FENTANYL , OXYCODONE HCL , OXYCODONE HCL-ACETAMINOPHEN
84049		DILAUDID , ENDOCET , FENTANYL , OXYCODONE HCL , OXYCODONE HCL-ACETAMINOPHEN
10431	14	FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE HCL , OXYCODONE-ACETAMINOPHEN , TRAMADOL HCL
19887		FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE HCL , OXYCODONE-ACETAMINOPHEN , TRAMADOL HCL
19983		FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE HCL , OXYCODONE-ACETAMINOPHEN , TRAMADOL HCL
84028		FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE HCL , OXYCODONE-ACETAMINOPHEN , TRAMADOL HCL
18865	15	BUTORPHANOL TARTRATE , FENTANYL , HYDROMORPHONE HCL , OXYCODONE HCL-ACETAMINOPHEN , TRAMADOL HCL
10861	16	HYDROCODONE-ACETAMINOPHEN , OXYCODONE-ACETAMINOPHEN , ROXICET , TRAMADOL HCL
12034		HYDROCODONE-ACETAMINOPHEN , OXYCODONE-ACETAMINOPHEN , ROXICET , TRAMADOL HCL
13149		HYDROCODONE-ACETAMINOPHEN , OXYCODONE-ACETAMINOPHEN , ROXICET , TRAMADOL HCL
13939		HYDROCODONE-ACETAMINOPHEN , OXYCODONE-ACETAMINOPHEN , ROXICET , TRAMADOL HCL
1740254739		HYDROCODONE-ACETAMINOPHEN , OXYCODONE-ACETAMINOPHEN , ROXICET , TRAMADOL HCL
19869		HYDROCODONE-ACETAMINOPHEN , OXYCODONE-ACETAMINOPHEN , ROXICET , TRAMADOL HCL
10756	17	FENTANYL , HYDROCODONE-ACETAMINOPHEN , HYDROMORPHONE HCL , OXYCODONE-ACETAMINOPHEN
11094		FENTANYL , HYDROCODONE-ACETAMINOPHEN , HYDROMORPHONE HCL , OXYCODONE-ACETAMINOPHEN
1134433857		FENTANYL , HYDROCODONE-ACETAMINOPHEN , HYDROMORPHONE HCL ,

Duplicate Narcotic Therapy from May 31, 2011 - May 30, 2012		
Prescriber ID	**Recipient**	**Drug Name**
		OXYCODONE-ACETAMINOPHEN
13123		FENTANYL , HYDROCODONE-ACETAMINOPHEN , HYDROMORPHONE HCL , OXYCODONE-ACETAMINOPHEN
1326278912		FENTANYL , HYDROCODONE-ACETAMINOPHEN , HYDROMORPHONE HCL , OXYCODONE-ACETAMINOPHEN
14269		FENTANYL , HYDROCODONE-ACETAMINOPHEN , HYDROMORPHONE HCL , OXYCODONE-ACETAMINOPHEN
15333		FENTANYL , HYDROCODONE-ACETAMINOPHEN , HYDROMORPHONE HCL , OXYCODONE-ACETAMINOPHEN
1699087916		FENTANYL , HYDROCODONE-ACETAMINOPHEN , HYDROMORPHONE HCL , OXYCODONE-ACETAMINOPHEN
18084		FENTANYL , HYDROCODONE-ACETAMINOPHEN , HYDROMORPHONE HCL , OXYCODONE-ACETAMINOPHEN
12928	18	FENTANYL , HYDROCODONE-ACETAMINOPHEN , HYDROMORPHONE HCL , OXYCODONE HCL
16326	19	HYDROMORPHONE HCL , MORPHINE SULFATE ER , OXYCODONE HCL , TRAMADOL HCL
16475		HYDROMORPHONE HCL , MORPHINE SULFATE ER , OXYCODONE HCL , TRAMADOL HCL
18468		HYDROMORPHONE HCL , MORPHINE SULFATE ER , OXYCODONE HCL , TRAMADOL HCL
10513	20	HYDROCODONE-ACETAMINOPHEN , OXYCODONE HCL , OXYCODONE-ACETAMINOPHEN , TRAMADOL HCL
13415	21	ENDOCET , FENTANYL , HYDROCODONE-ACETAMINOPHEN , ROXICET
13855		ENDOCET , FENTANYL , HYDROCODONE-ACETAMINOPHEN , ROXICET
15032		ENDOCET , FENTANYL , HYDROCODONE-ACETAMINOPHEN , ROXICET
18911		ENDOCET , FENTANYL , HYDROCODONE-ACETAMINOPHEN , ROXICET
19900		ENDOCET , FENTANYL , HYDROCODONE-ACETAMINOPHEN , ROXICET
12939	21	ENDOCET , OXYCODONE HCL , OXYCODONE HCL-ACETAMINOPHEN , OXYCONTIN
18865		ENDOCET , OXYCODONE HCL , OXYCODONE HCL-ACETAMINOPHEN , OXYCONTIN
15343	22	FENTANYL , HYDROCODONE-ACETAMINOPHEN , MORPHINE SULFATE ER , TRAMADOL HCL
11611	23	HYDROMORPHONE HCL , MORPHINE SULFATE ER , OXYCONTIN , TRAMADOL HCL
14804		HYDROMORPHONE HCL , MORPHINE SULFATE ER , OXYCONTIN , TRAMADOL HCL
16162		HYDROMORPHONE HCL , MORPHINE SULFATE ER , OXYCONTIN , TRAMADOL HCL
1740254739		HYDROMORPHONE HCL , MORPHINE SULFATE ER , OXYCONTIN , TRAMADOL HCL
1326278912	24	FENTANYL , HYDROCODONE-ACETAMINOPHEN , MORPHINE SULFATE ER , OXYCODONE HCL
1669624813		FENTANYL , HYDROCODONE-ACETAMINOPHEN , MORPHINE SULFATE ER , OXYCODONE HCL
1710117312		FENTANYL , HYDROCODONE-ACETAMINOPHEN , MORPHINE SULFATE ER , OXYCODONE HCL
1942514666		FENTANYL , HYDROCODONE-ACETAMINOPHEN , MORPHINE SULFATE ER , OXYCODONE HCL

Duplicate Narcotic Therapy from May 31, 2011 - May 30, 2012		
Prescriber ID	**Recipient**	**Drug Name**
10321	25	FENTANYL , MORPHINE SULFATE , MORPHINE SULFATE ER , OXYCODONE HCL
10838		FENTANYL , MORPHINE SULFATE , MORPHINE SULFATE ER , OXYCODONE HCL
11329		FENTANYL , MORPHINE SULFATE , MORPHINE SULFATE ER , OXYCODONE HCL
12941		FENTANYL , MORPHINE SULFATE , MORPHINE SULFATE ER , OXYCODONE HCL
18084		FENTANYL , MORPHINE SULFATE , MORPHINE SULFATE ER , OXYCODONE HCL
1891888582		FENTANYL , MORPHINE SULFATE , MORPHINE SULFATE ER , OXYCODONE HCL
84086		FENTANYL , MORPHINE SULFATE , MORPHINE SULFATE ER , OXYCODONE HCL
10838	26	ENDOCET , MORPHINE SULFATE , OXYCODONE-ACETAMINOPHEN , OXYCONTIN
12071		ENDOCET , MORPHINE SULFATE , OXYCODONE-ACETAMINOPHEN , OXYCONTIN
13615		ENDOCET , MORPHINE SULFATE , OXYCODONE-ACETAMINOPHEN , OXYCONTIN
18911		ENDOCET , MORPHINE SULFATE , OXYCODONE-ACETAMINOPHEN , OXYCONTIN
19842		ENDOCET , MORPHINE SULFATE , OXYCODONE-ACETAMINOPHEN , OXYCONTIN
1740254739	27	MORPHINE SULFATE , MORPHINE SULFATE ER , OPANA ER
19869		MORPHINE SULFATE , MORPHINE SULFATE ER , OPANA ER
12622	28	ENDOCET , OXYCODONE-ACETAMINOPHEN , TRAMADOL HCL
19552		ENDOCET , OXYCODONE-ACETAMINOPHEN , TRAMADOL HCL
19591		ENDOCET , OXYCODONE-ACETAMINOPHEN , TRAMADOL HCL
19593		ENDOCET , OXYCODONE-ACETAMINOPHEN , TRAMADOL HCL
11179	29	HYDROCODONE-ACETAMINOPHEN , METHADONE HCL , MORPHINE SULFATE ER
16112		HYDROCODONE-ACETAMINOPHEN , METHADONE HCL , MORPHINE SULFATE ER
19700		HYDROCODONE-ACETAMINOPHEN , METHADONE HCL , MORPHINE SULFATE ER
13929	30	OXYCODONE HCL , OXYCODONE-ACETAMINOPHEN , OXYCONTIN
12928	31	FENTANYL , OXYCODONE HCL-ACETAMINOPHEN , TRAMADOL HCL
16162	32	MORPHINE SULFATE , MORPHINE SULFATE ER , OXYCODONE HCL
15585	33	MORPHINE SULFATE ER , OXYCODONE-ACETAMINOPHEN , OXYCONTIN
17848		MORPHINE SULFATE ER , OXYCODONE-ACETAMINOPHEN , OXYCONTIN
10195	34	FENTANYL , HYDROCODONE-ACETAMINOPHEN , TRAMADOL HCL
13936		FENTANYL , HYDROCODONE-ACETAMINOPHEN , TRAMADOL HCL
14720	35	FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE-ACETAMINOPHEN
15441		FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE-ACETAMINOPHEN
16061		FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE-

Duplicate Narcotic Therapy from May 31, 2011 - May 30, 2012		
Prescriber ID	**Recipient**	**Drug Name**
		ACETAMINOPHEN
16833		FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE-ACETAMINOPHEN
19813		FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE-ACETAMINOPHEN
16458	36	OXYCODONE HCL-ACETAMINOPHEN , TRAMADOL HCL , ULTRAM ER
1083910426	37	KADIAN , MORPHINE SULFATE ER , OXYCODONE HCL
1740254739		KADIAN , MORPHINE SULFATE ER , OXYCODONE HCL
19869		KADIAN , MORPHINE SULFATE ER , OXYCODONE HCL
15457	38	MORPHINE SULFATE , MORPHINE SULFATE ER , OXYCODONE HCL
19732		MORPHINE SULFATE , MORPHINE SULFATE ER , OXYCODONE HCL
84021		MORPHINE SULFATE , MORPHINE SULFATE ER , OXYCODONE HCL
12034	39	MORPHINE SULFATE ER , OXYCODONE HCL-ACETAMINOPHEN , TRAMADOL HCL
1740254739		MORPHINE SULFATE ER , OXYCODONE HCL-ACETAMINOPHEN , TRAMADOL HCL
19869		MORPHINE SULFATE ER , OXYCODONE HCL-ACETAMINOPHEN , TRAMADOL HCL
11894	40	FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE HCL , OXYCONTIN
12079		FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE HCL , OXYCONTIN
16431		FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE HCL , OXYCONTIN
11179	41	HYDROCODONE-ACETAMINOPHEN , MORPHINE SULFATE , MORPHINE SULFATE ER
19700		HYDROCODONE-ACETAMINOPHEN , MORPHINE SULFATE , MORPHINE SULFATE ER
15585	42	FENTANYL , OXYCODONE HCL , TRAMADOL HCL
17848		FENTANYL , OXYCODONE HCL , TRAMADOL HCL
16458	43	HYDROMORPHONE HCL , MORPHINE SULFATE , MORPHINE SULFATE ER
10611	44	MORPHINE SULFATE , OXYCODONE HCL , OXYCONTIN
10854		MORPHINE SULFATE , OXYCODONE HCL , OXYCONTIN
12034		MORPHINE SULFATE , OXYCODONE HCL , OXYCONTIN
1740254739		MORPHINE SULFATE , OXYCODONE HCL , OXYCONTIN
18780		MORPHINE SULFATE , OXYCODONE HCL , OXYCONTIN
19869		MORPHINE SULFATE , OXYCODONE HCL , OXYCONTIN
1740254739	45	FENTANYL , MORPHINE SULFATE ER , OXYCODONE HCL
19869		FENTANYL , MORPHINE SULFATE ER , OXYCODONE HCL
13302	46	FENTANYL , MORPHINE SULFATE ER , OXYCODONE HCL
13537		FENTANYL , MORPHINE SULFATE ER , OXYCODONE HCL
15661		FENTANYL , MORPHINE SULFATE ER , OXYCODONE HCL
11179	47	FENTANYL , HYDROMORPHONE HCL , OXYCODONE HCL
1306995865		FENTANYL , HYDROMORPHONE HCL , OXYCODONE HCL
11277	48	FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE HCL

Duplicate Narcotic Therapy from May 31, 2011 - May 30, 2012		
Prescriber ID	**Recipient**	**Drug Name**
14165		FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE HCL
14852		FENTANYL , HYDROCODONE-ACETAMINOPHEN , OXYCODONE HCL
14310	49	FENTANYL , HYDROMORPHONE HCL , MORPHINE SULFATE ER
1740254739		FENTANYL , HYDROMORPHONE HCL , MORPHINE SULFATE ER
17684		FENTANYL , HYDROMORPHONE HCL , MORPHINE SULFATE ER
18780		FENTANYL , HYDROMORPHONE HCL , MORPHINE SULFATE ER
19971		FENTANYL , HYDROMORPHONE HCL , MORPHINE SULFATE ER

North Dakota Medicaid
DUR Board
Oxycontin TID

Oxycontin tablets are a controlled-release oral formulation of oxycodone hydrochloride indicated for the management of moderate to severe pain when a continuous, around-the-clock opioid analgesic is needed for an extended period of time. Oxycontin is not intended for use on an as needed basis. The controlled-release nature of the formulation allows Oxycontin to be effectively administered every 12 hours.

This report includes all strengths of Oxycontin in which patients were given 69 tablets or more per month, indicating three times a day dosing (TID). From 05/31/11 through 05/30/12 there were 190 scripts of Oxycontin filled with TID dosing. There were 18 recipients **(14% of total)** and 23 prescribers **(16% of total)**. Oxycontin prescribed with TID dosing makes up approximately **47%** of the Oxycontin spend.

Oxycontin TID dosing 05/31/11 – 05/30/12			
Drug Name	**Number of Prescriptions**	**Total Reimb Amount**	**Unique Number of Recipients**
Oxycontin (all)	791	$286,997.57	125
Oxycontin TID	190	$134,734.68	18

Summary by Age of the 18 recipients taking Oxycontin TID:

31-40	2
41-50	5
51-60	10
60 and above	1

Oxycontin Utilization per Recipient 05/31/11 – 05/31/12				
Recipient	**Date**	**Drug Name**	**Qty**	**Days Supply**
1	6/7/2011	OXYCONTIN 20 MG TABLET	90	30
	6/7/2011	OXYCONTIN 40 MG TABLET	90	30
	7/2/2011	OXYCONTIN 20 MG TABLET	90	30
	7/2/2011	OXYCONTIN 40 MG TABLET	90	30
	7/29/2011	OXYCONTIN 20 MG TABLET	90	30
	7/29/2011	OXYCONTIN 40 MG TABLET	90	30
	8/24/2011	OXYCONTIN 20 MG TABLET	90	30
	8/24/2011	OXYCONTIN 40 MG TABLET	90	30
	9/21/2011	OXYCONTIN 20 MG TABLET	90	30
	9/21/2011	OXYCONTIN 40 MG TABLET	90	30
	10/18/2011	OXYCONTIN 20 MG TABLET	90	30
	10/18/2011	OXYCONTIN 40 MG TABLET	90	30
	11/14/2011	OXYCONTIN 20 MG TABLET	84	28
	12/12/2011	OXYCONTIN 20 MG TABLET	84	28

Oxycontin Utilization per Recipient 05/31/11 – 05/31/12				
Recipient	**Date**	**Drug Name**	**Qty**	**Days Supply**
1 (cont'd)	12/13/2011	OXYCONTIN 40 MG TABLET	84	28
	1/13/2012	OXYCONTIN 20 MG TABLET	84	28
	1/20/2012	OXYCONTIN 40 MG TABLET	84	28
	2/8/2012	OXYCONTIN 20 MG TABLET	84	28
	2/14/2012	OXYCONTIN 40 MG TABLET	84	28
	3/13/2012	OXYCONTIN 20 MG TABLET	84	28
	3/13/2012	OXYCONTIN 40 MG TABLET	84	28
	4/11/2012	OXYCONTIN 20 MG TABLET	84	28
	4/11/2012	OXYCONTIN 40 MG TABLET	84	28
	5/8/2012	OXYCONTIN 20 MG TABLET	84	28
	5/8/2012	OXYCONTIN 40 MG TABLET	84	28
2	6/16/2011	OXYCONTIN 20 MG TABLET	84	28
	6/20/2011	OXYCONTIN 40 MG TABLET	84	28
	7/15/2011	OXYCONTIN 20 MG TABLET	84	28
	7/19/2011	OXYCONTIN 40 MG TABLET	84	28
	8/15/2011	OXYCONTIN 20 MG TABLET	84	28
	8/19/2011	OXYCONTIN 40 MG TABLET	84	28
	9/15/2011	OXYCONTIN 20 MG TABLET	84	28
	9/19/2011	OXYCONTIN 40 MG TABLET	84	28
	10/15/2011	OXYCONTIN 20 MG TABLET	84	28
	10/18/2011	OXYCONTIN 40 MG TABLET	84	28
	11/15/2011	OXYCONTIN 20 MG TABLET	90	22
	11/18/2011	OXYCONTIN 40 MG TABLET	90	30
	12/16/2011	OXYCONTIN 40 MG TABLET	90	30
	12/19/2011	OXYCONTIN 20 MG TABLET	90	30
	1/16/2012	OXYCONTIN 40 MG TABLET	90	30
	1/18/2012	OXYCONTIN 20 MG TABLET	90	30
	2/15/2012	OXYCONTIN 40 MG TABLET	90	30
	2/16/2012	OXYCONTIN 20 MG TABLET	90	30
	3/15/2012	OXYCONTIN 40 MG TABLET	90	30
	3/16/2012	OXYCONTIN 20 MG TABLET	90	30
	4/13/2012	OXYCONTIN 40 MG TABLET	90	30
	4/14/2012	OXYCONTIN 20 MG TABLET	90	30
	5/12/2012	OXYCONTIN 40 MG TABLET	120	30
	5/14/2012	OXYCONTIN 20 MG TABLET	120	30
3	11/18/2011	OXYCONTIN 20 MG TABLET	90	30
	11/18/2011	OXYCONTIN 80 MG TABLET	90	30
	12/16/2011	OXYCONTIN 20 MG TABLET	90	30
	12/16/2011	OXYCONTIN 80 MG TABLET	120	30
	1/13/2012	OXYCONTIN 20 MG TABLET	120	30
	1/13/2012	OXYCONTIN 80 MG TABLET	120	30
	2/10/2012	OXYCONTIN 20 MG TABLET	120	30
	2/10/2012	OXYCONTIN 80 MG TABLET	120	30

Oxycontin Utilization per Recipient 05/31/11 – 05/31/12				
Recipient	**Date**	**Drug Name**	**Qty**	**Days Supply**
3 (cont'd)	3/8/2012	OXYCONTIN 20 MG TABLET	120	30
	3/8/2012	OXYCONTIN 80 MG TABLET	120	30
	4/6/2012	OXYCONTIN 20 MG TABLET	120	30
	4/6/2012	OXYCONTIN 80 MG TABLET	120	30
	5/6/2012	OXYCONTIN 20 MG TABLET	120	30
	5/6/2012	OXYCONTIN 80 MG TABLET	120	30
4	11/8/2011	OXYCONTIN 20 MG TABLET	120	30
	12/7/2011	OXYCONTIN 40 MG TABLET	90	30
5	6/9/2011	OXYCONTIN 20 MG TABLET	90	30
	6/9/2011	OXYCONTIN 40 MG TABLET	90	30
	7/8/2011	OXYCONTIN 20 MG TABLET	90	30
	7/8/2011	OXYCONTIN 40 MG TABLET	90	30
	8/12/2011	OXYCONTIN 20 MG TABLET	90	30
	8/12/2011	OXYCONTIN 40 MG TABLET	90	30
	9/21/2011	OXYCONTIN 20 MG TABLET	90	30
	9/21/2011	OXYCONTIN 40 MG TABLET	90	30
	10/27/2011	OXYCONTIN 20 MG TABLET	90	30
	10/27/2011	OXYCONTIN 40 MG TABLET	90	30
	12/1/2011	OXYCONTIN 20 MG TABLET	90	30
	12/1/2011	OXYCONTIN 40 MG TABLET	90	30
	1/6/2012	OXYCONTIN 20 MG TABLET	90	30
	1/6/2012	OXYCONTIN 40 MG TABLET	90	30
	2/10/2012	OXYCONTIN 20 MG TABLET	90	30
	2/10/2012	OXYCONTIN 40 MG TABLET	90	30
	3/7/2012	OXYCONTIN 20 MG TABLET	90	30
	3/7/2012	OXYCONTIN 40 MG TABLET	90	30
	4/20/2012	OXYCONTIN 20 MG TABLET	90	30
	4/20/2012	OXYCONTIN 40 MG TABLET	90	30
	5/24/2012	OXYCONTIN 20 MG TABLET	90	30
	5/24/2012	OXYCONTIN 40 MG TABLET	90	30
6	4/24/2012	OXYCONTIN 80 MG TABLET	90	30
	5/24/2012	OXYCONTIN 80 MG TABLET	90	30
7	6/9/2011	OXYCONTIN 80 MG TABLET	90	30
	7/12/2011	OXYCONTIN 80 MG TABLET	90	30
	8/10/2011	OXYCONTIN 80 MG TABLET	90	30
	9/10/2011	OXYCONTIN 80 MG TABLET	90	30
	10/8/2011	OXYCONTIN 80 MG TABLET	90	30
	11/11/2011	OXYCONTIN 80 MG TABLET	90	30
	12/10/2011	OXYCONTIN 80 MG TABLET	90	30
	1/9/2012	OXYCONTIN 80 MG TABLET	90	30
	2/9/2012	OXYCONTIN 80 MG TABLET	90	30

Oxycontin Utilization per Recipient 05/31/11 – 05/31/12				
Recipient	**Date**	**Drug Name**	**Qty**	**Days Supply**
7 (cont'd)	3/7/2012	OXYCONTIN 80 MG TABLET	90	30
	4/18/2012	OXYCONTIN 80 MG TABLET	90	30
	5/17/2012	OXYCONTIN 80 MG TABLET	90	30
8	6/17/2011	OXYCONTIN 40 MG TABLET	90	30
	7/22/2011	OXYCONTIN 40 MG TABLET	90	30
	8/22/2011	OXYCONTIN 40 MG TABLET	90	30
	9/22/2011	OXYCONTIN 40 MG TABLET	90	30
	10/22/2011	OXYCONTIN 40 MG TABLET	90	30
	11/28/2011	OXYCONTIN 40 MG TABLET	90	30
	12/30/2011	OXYCONTIN 40 MG TABLET	90	30
	2/2/2012	OXYCONTIN 40 MG TABLET	90	30
	3/5/2012	OXYCONTIN 40 MG TABLET	90	30
	4/2/2012	OXYCONTIN 40 MG TABLET	90	30
	5/1/2012	OXYCONTIN 40 MG TABLET	90	30
9	6/13/2011	OXYCONTIN 80 MG TABLET	90	30
	7/14/2011	OXYCONTIN 80 MG TABLET	90	30
	8/11/2011	OXYCONTIN 80 MG TABLET	90	30
	9/15/2011	OXYCONTIN 80 MG TABLET	90	30
	10/21/2011	OXYCONTIN 80 MG TABLET	90	30
	11/21/2011	OXYCONTIN 80 MG TABLET	90	30
	12/23/2011	OXYCONTIN 80 MG TABLET	90	30
	1/20/2012	OXYCONTIN 80 MG TABLET	90	30
	2/18/2012	OXYCONTIN 80 MG TABLET	90	30
	3/19/2012	OXYCONTIN 80 MG TABLET	90	30
	4/17/2012	OXYCONTIN 80 MG TABLET	90	30
	5/24/2012	OXYCONTIN 80 MG TABLET	90	30
10	6/22/2011	OXYCONTIN 20 MG TABLET	90	30
	7/18/2011	OXYCONTIN 20 MG TABLET	90	30
	8/22/2011	OXYCONTIN 20 MG TABLET	90	30
	9/20/2011	OXYCONTIN 20 MG TABLET	90	30
11	6/28/2011	OXYCONTIN 40 MG TABLET	90	30
	7/27/2011	OXYCONTIN 40 MG TABLET	84	28
	8/23/2011	OXYCONTIN 40 MG TABLET	84	28
	9/20/2011	OXYCONTIN 40 MG TABLET	84	28
	10/15/2011	OXYCONTIN 40 MG TABLET	84	28
	11/14/2011	OXYCONTIN 40 MG TABLET	84	28
	12/15/2011	OXYCONTIN 40 MG TABLET	84	28
12	6/10/2011	OXYCONTIN 40 MG TABLET	84	28
	7/6/2011	OXYCONTIN 40 MG TABLET	84	28
	8/3/2011	OXYCONTIN 40 MG TABLET	84	28

Oxycontin Utilization per Recipient 05/31/11 – 05/31/12				
Recipient	**Date**	**Drug Name**	**Qty**	**Days Supply**
12 (cont'd)	8/29/2011	OXYCONTIN 40 MG TABLET	84	28
	10/3/2011	OXYCONTIN 40 MG TABLET	84	28
13	5/31/2011	OXYCONTIN 40 MG TABLET	84	28
	6/30/2011	OXYCONTIN 40 MG TABLET	90	30
	8/25/2011	OXYCONTIN 40 MG TABLET	90	30
	9/23/2011	OXYCONTIN 40 MG TABLET	90	30
	10/18/2011	OXYCONTIN 40 MG TABLET	90	30
	11/12/2011	OXYCONTIN 40 MG TABLET	90	30
	12/8/2011	OXYCONTIN 40 MG TABLET	90	30
	1/27/2012	OXYCONTIN 40 MG TABLET	90	30
	2/27/2012	OXYCONTIN 40 MG TABLET	90	30
14	6/24/2011	OXYCONTIN 10 MG TABLET	90	30
	7/25/2011	OXYCONTIN 10 MG TABLET	90	30
	8/24/2011	OXYCONTIN 10 MG TABLET	90	30
	9/23/2011	OXYCONTIN 10 MG TABLET	90	30
	10/21/2011	OXYCONTIN 10 MG TABLET	90	30
	11/18/2011	OXYCONTIN 10 MG TABLET	90	30
	12/16/2011	OXYCONTIN 10 MG TABLET	90	30
	1/13/2012	OXYCONTIN 10 MG TABLET	90	30
	2/10/2012	OXYCONTIN 10 MG TABLET	90	30
	3/12/2012	OXYCONTIN 10 MG TABLET	90	30
	4/9/2012	OXYCONTIN 10 MG TABLET	90	30
15	8/31/2011	OXYCONTIN 80 MG TABLET	90	30
	9/29/2011	OXYCONTIN 80 MG TABLET	90	30
	3/29/2012	OXYCONTIN 80 MG TABLET	90	30
	4/28/2012	OXYCONTIN 80 MG TABLET	90	30
	5/26/2012	OXYCONTIN 80 MG TABLET	90	30
16	6/8/2011	OXYCONTIN 40 MG TABLET	90	30
	7/13/2011	OXYCONTIN 40 MG TABLET	90	30
	8/10/2011	OXYCONTIN 40 MG TABLET	90	30
	9/6/2011	OXYCONTIN 40 MG TABLET	90	30
	10/3/2011	OXYCONTIN 40 MG TABLET	90	30
	10/31/2011	OXYCONTIN 40 MG TABLET	90	30
	11/23/2011	OXYCONTIN 40 MG TABLET	90	30
	1/18/2012	OXYCONTIN 20 MG TABLET	90	30
	2/15/2012	OXYCONTIN 20 MG TABLET	90	30
	3/13/2012	OXYCONTIN 20 MG TABLET	90	30
	4/11/2012	OXYCONTIN 20 MG TABLET	90	30
	5/9/2012	OXYCONTIN 20 MG TABLET	90	30
17	7/11/2011	OXYCONTIN 80 MG TABLET	90	30

Oxycontin Utilization per Recipient 05/31/11 – 05/31/12				
Recipient	**Date**	**Drug Name**	**Qty**	**Days Supply**
17 (cont'd)	8/6/2011	OXYCONTIN 80 MG TABLET	90	30
	9/2/2011	OXYCONTIN 80 MG TABLET	84	28
	9/29/2011	OXYCONTIN 80 MG TABLET	84	28
	10/31/2011	OXYCONTIN 80 MG TABLET	90	30
	11/28/2011	OXYCONTIN 80 MG TABLET	90	30
	12/28/2011	OXYCONTIN 80 MG TABLET	90	30
	1/24/2012	OXYCONTIN 80 MG TABLET	90	30
	2/22/2012	OXYCONTIN 80 MG TABLET	90	30
	3/22/2012	OXYCONTIN 80 MG TABLET	90	30
	4/18/2012	OXYCONTIN 80 MG TABLET	90	30
	5/16/2012	OXYCONTIN 80 MG TABLET	93	31
18	5/18/2012	OXYCONTIN 10 MG TABLET	90	30

ACE-Inhibitors (ACE-I), Angiotensin II Receptor Blockers (ARB) and Renin Inhibitor PA Form

Fax Completed Form to: 866-254-0761
For questions regarding this Prior authorization, call 866-773-0695

Prior Authorization Vendor for ND

ND Medicaid requires that patients receiving a prescription for Aceon must try at least two generic ACE-Is as first line.
ND Medicaid requires that patients receiving an ARB or Renin Inhibitor must try and fail one ACE-I.

*__Note:__

- **ACE-I: Captopril, enalapril, moexipril, ramipril, lisinopril, trandolapril, quinapril, benazepril, and fosinopril and their hydrochlorothiazide containing combinations do not require a prior authorization.**
- **Angiotensin II receptor antagonists: Cozaar, Micardis, Teveten, Atacand, Diovan, Avapro, Benicar and their hydrochlorothiazide containing combinations.**
- **Renin Inhibitor: Tekturna and Tekturna HCT.**

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:**		
Qualifications for coverage:				
☐ Failed ACE-I therapy (list two ACE-I to receive Aceon)	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 Signature			Date	

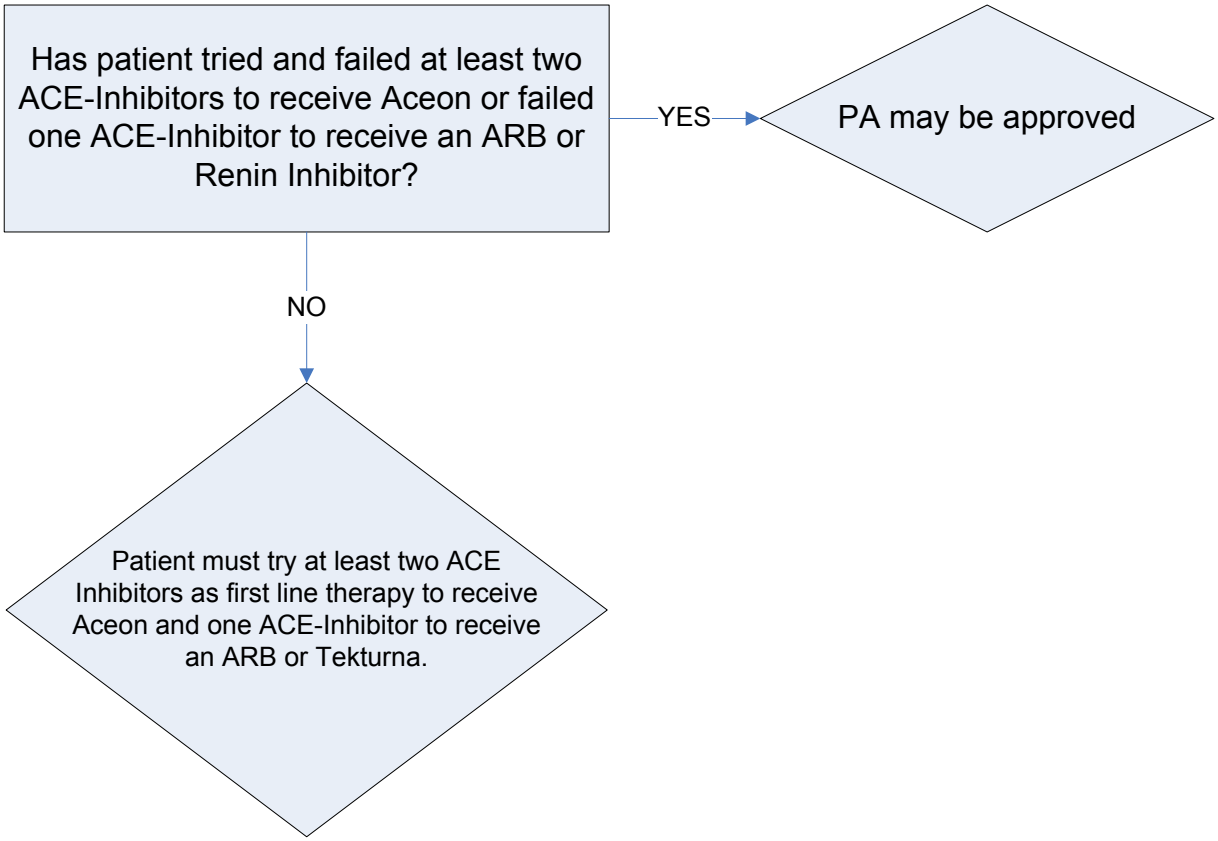
Part II: TO BE COMPLETED BY PHARMACY

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
ACE-Is, ARBs and Renin Inhibitor (Tekturna) Authorization Criteria Algorithm



ACE-I: Captopril, enalapril, moexipril, ramipril, lisinopril, trandolapril, quinapril, benazepril or fosinopril and hydrochlorothiazide combinations

ARB: Micardis, Teveten, Atacand, Avapro, Benicar, Cozaar, Diovan, Edarbi, and hydrochlorothiazide combinations

Renin Inhibitor: Tekturna and hydrochlorothiazide combination

ACTO*plus* met Prior Authorization

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receive Actos and Metformin separately.
Note:

- ***Actos does not require PA***
- ***Metformin does not require PA***
- ***Patients must fail therapy on Actos and Metformin separately 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: □ **ACTO*plus* met**	**Diagnosis for this request:**		
Qualifications for coverage:			
□ Failed both drugs separately	Start Date: End Date:	Dose: Frequency:	
Prescriber Signature		Date	

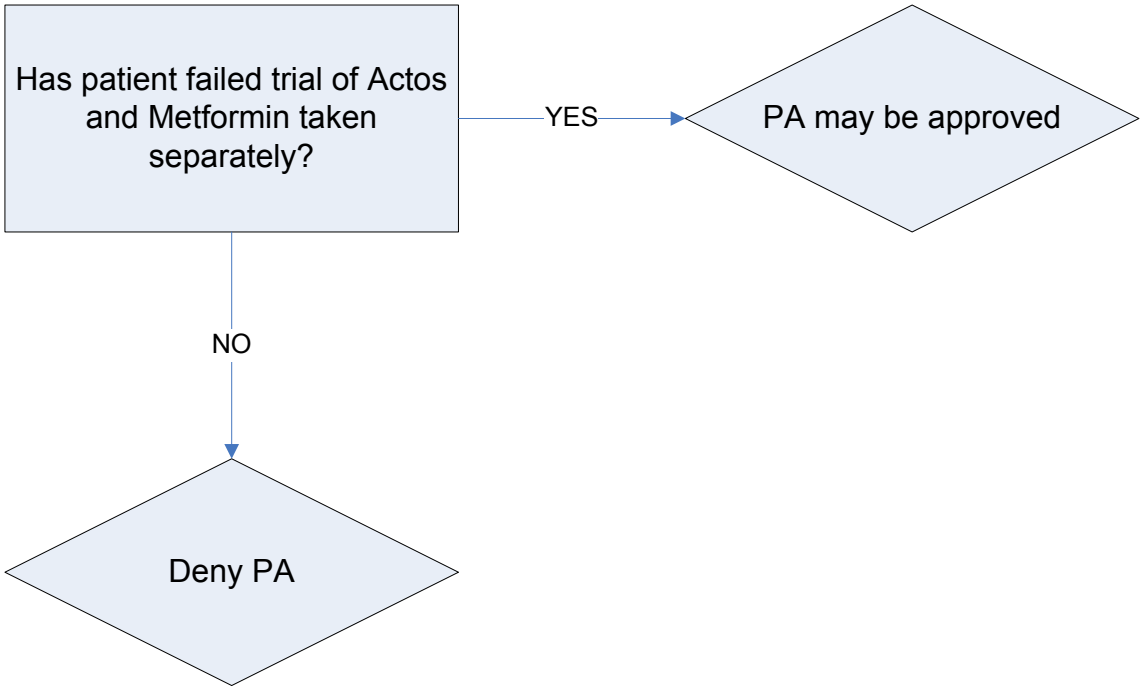
Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
PHONE 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
ACTO*plus met* Authorization Algorithm



Aczone Gel PA FORM

Fax Completed Form to:
866-254-0761
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 Aczone gel must try other topical acne agents as first line therapy.

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: □ ACZONE GEL	**Diagnosis for this request:**		

Qualifications for coverage:

□ Failed acne therapy Name of medication failed: _____	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 Signature	Date

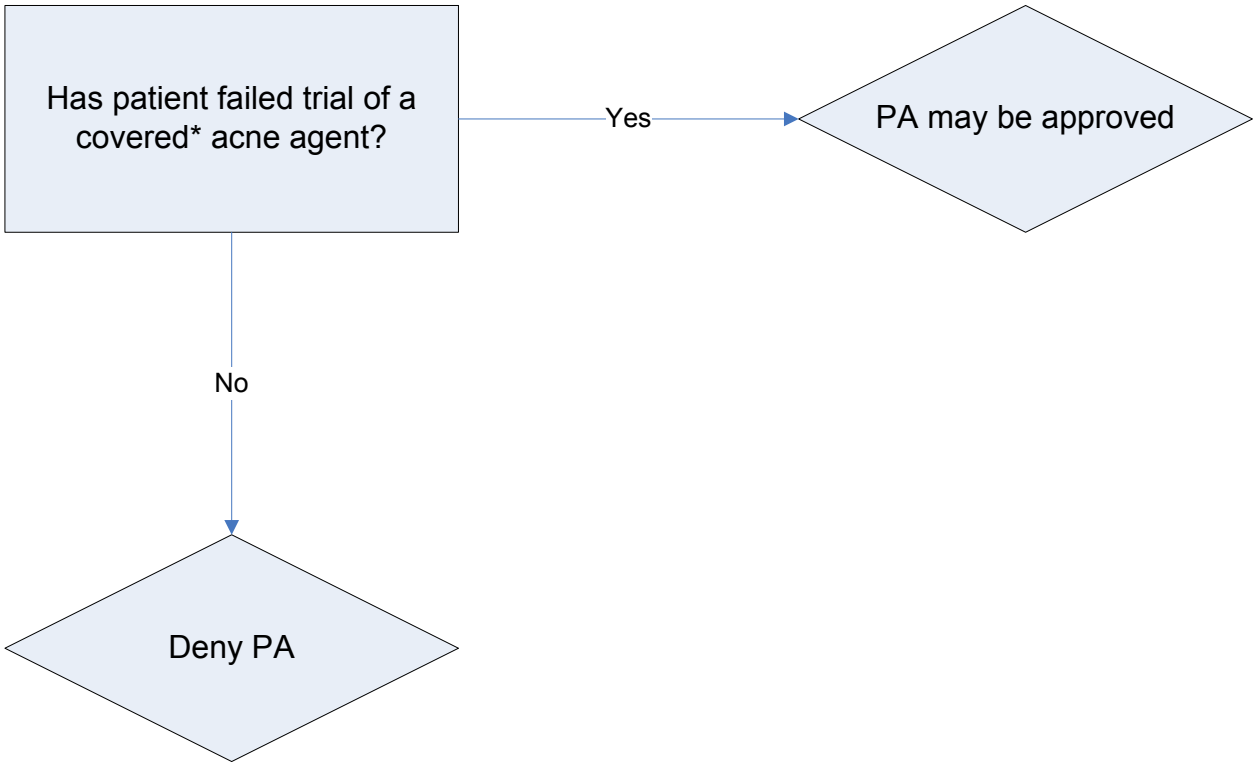
Part II: TO BE COMPLETED BY PHARMACY

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
Aczone Authorization Algorithm



*Tretinoin and benzoyl peroxide products do not require a PA

AMPYRA PA FORM

Prior Authorization Vendor for ND Medicaid

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-773-0695

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**

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:**		
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)?			
Physician Signature	Date		

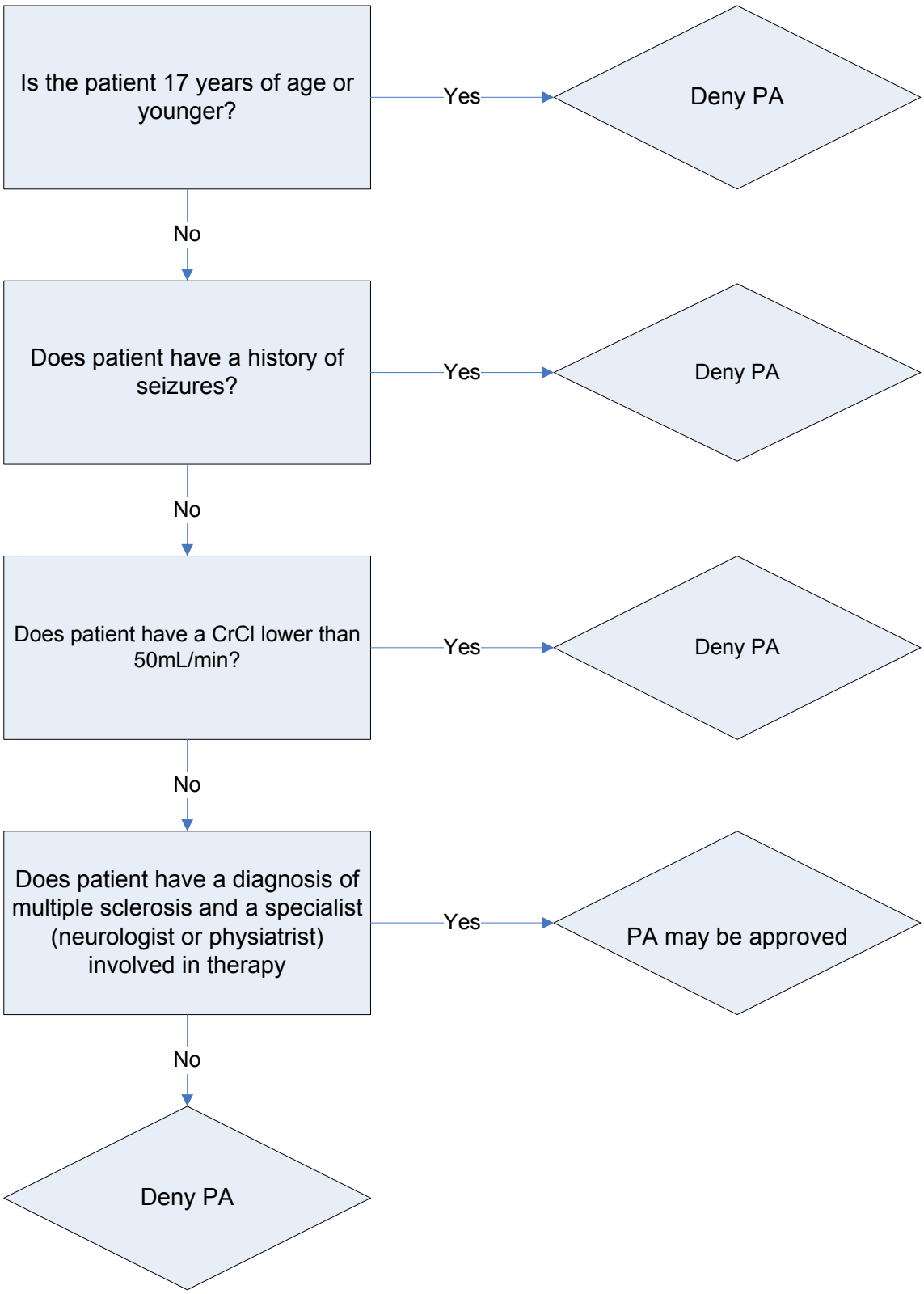
Part II: TO BE COMPLETED BY PHARMACY

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
Ampyra Prior Authorization Algorithm



AMRIX PA Form

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients try and fail generic cyclobenzaprine.

**Note:*

- **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 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:** (must be completed)

Qualifications for coverage:

❑ Failed cyclobenzaprine 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 Signature: Date:

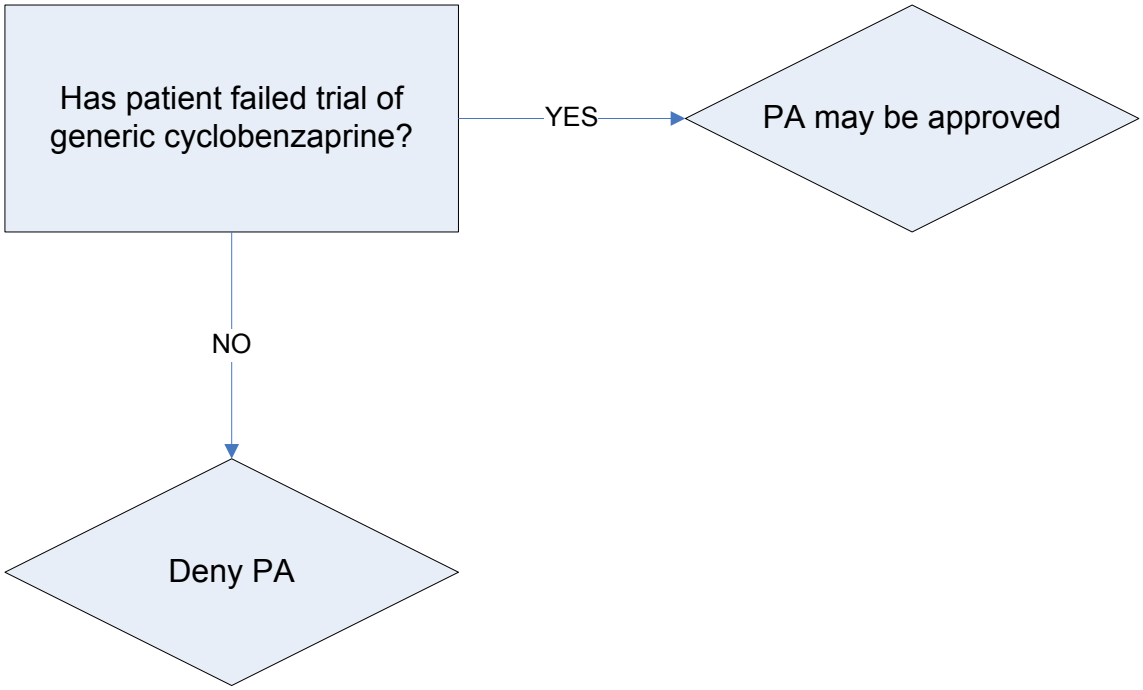
Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:	ND MEDICAID PROVIDER NUMBER:
Phone:	FAX:
Drug:	NDC#:

Part III: FOR OFFICIAL USE ONLY

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

North Dakota Department of Human Services
Amrix Authorization Algorithm



HEALTH INFORMATION DESIGNS

Prior Authorization Vendor for ND Medicaid

ANTIHISTAMINE PA FORM

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-773-0695

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 generic) may be prescribed WITHOUT prior authorization.***
- ***Loratadine OTC and cetirizine OTC are covered by Medicaid when prescribed by a physician.***
- ***Patients must use loratadine or cetirizine for a minimum of 14 days for the trial to be considered a failure. Patient preference does not constitute a failure. Patients must use fexofenadine as step 2 after loratadine or cetirizine failure.***
- ***Net cost to Medicaid: Loratadine = cetirizine << Allegra (generic) << Clarinex = Xyzal***

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: □ **ALLEGRA (GENERIC)** □ **CLARINEX** □ **XYZAL**	**Requested Dosage:** (must be completed) **Diagnosis for this request:**

Qualifications for coverage:

□ Failed loratadine or cetirizine (include which agent failed)_____	Start Date:	End Date:
□ Failed Allegra (generic) Step 2	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 Signature: Date:

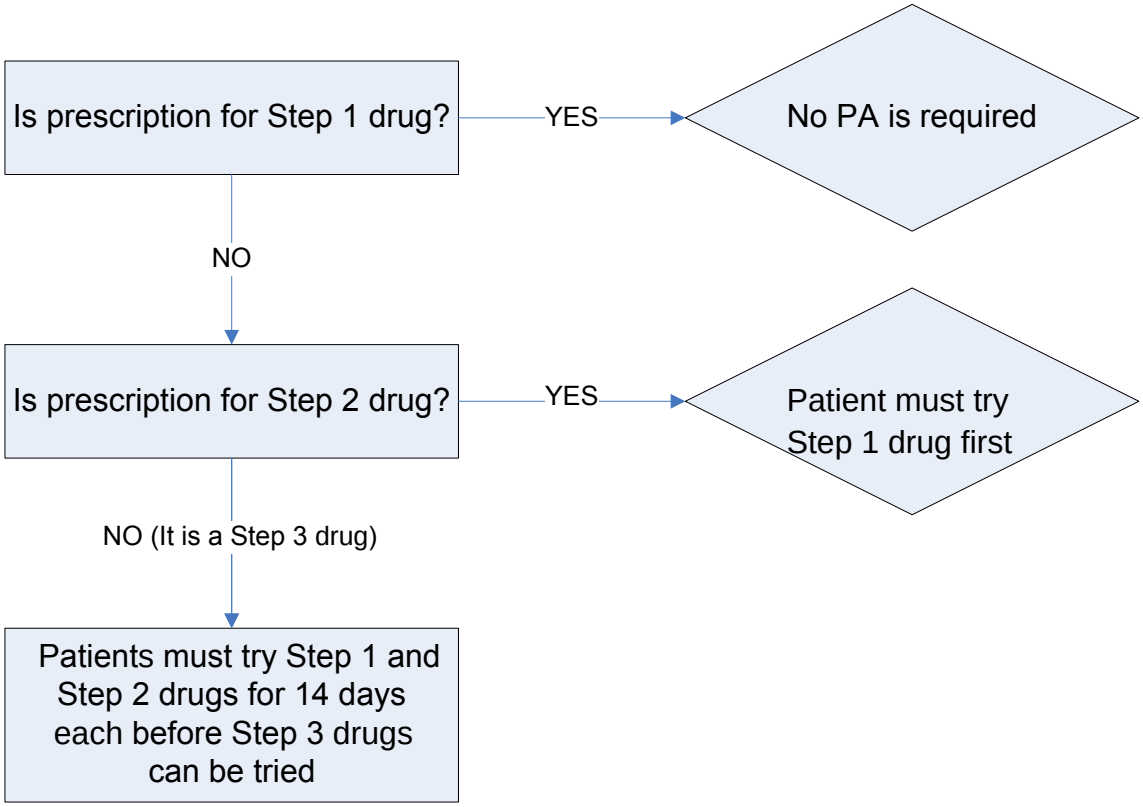
Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:		ND MEDICAID PROVIDER NUMBER:
Phone:		FAX:
Drug:		NDC#:

Part III: FOR OFFICIAL USE ONLY

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

North Dakota Department of Human Services
Antihistamine Authorization Criteria Algorithm



Please Note:

Step 1 drug is defined as Loratadine OTC or Cetirizine
Step 2 drug is defined as Allegra (generic)
Step 3 drug is defined as Clarinex or Xyzal-must try Step 1 and Step 2 drugs before trying Step 3.

Net cost to Medicaid: Loratadine = cetirizine << Allegra (generic) << Clarinex = Xyzal

Asacol HD Prior Authorization

Fax Completed Form to:
866-254-0761
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 Asacol HD must try and fail Asacol.
Note:

- ***Asacol is FDA approved to treat mild to moderate flares and maintain remission of ulcerative colitis.***
- ***Asacol HD is FDA approved to treat flares in patients with moderately active ulcerative colitis.***

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: □ **Asacol HD**	**Diagnosis for this request:**		
Qualifications for coverage:			
□ FAILED ASACOL THERAPY START DATE: DOSE: END DATE: FREQUENCY:			
Physician Signature		Date	

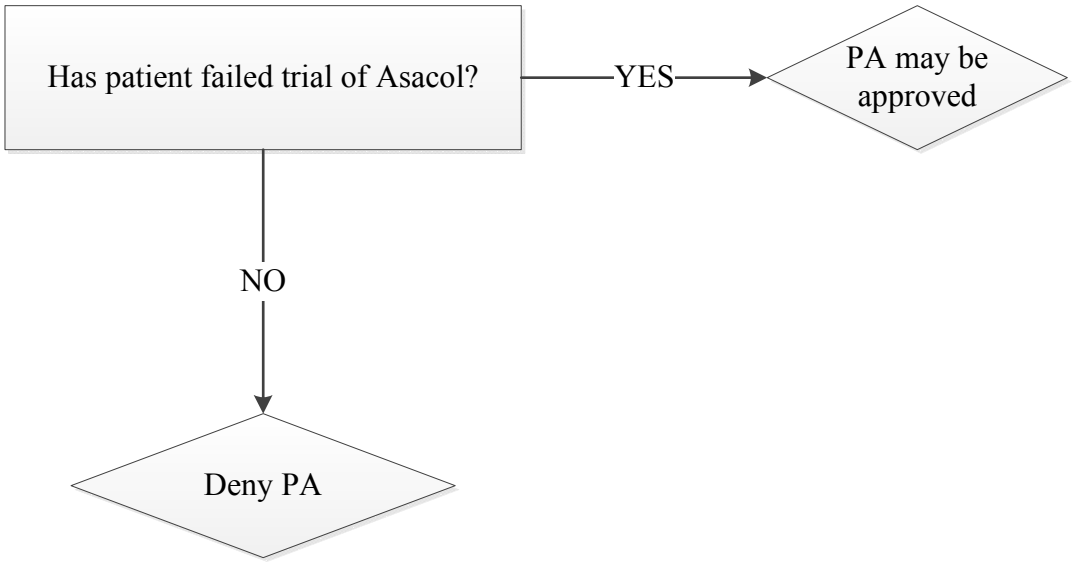
Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
PHONE 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
Asacol HD Authorization Algorithm



For the treatment of moderately active ulcerative colitis: The recommended dose of Asacol HD in adults is two 800 mg tablets to be taken three times daily with or without food, for a total daily dose of 4.8 g for a duration of 6 weeks. $987.84

For the treatment of mildly to moderately active ulcerative colitis: The usual dosage in adults is two 400-mg tablets to be taken three times a day for a total daily dose of 2.4 grams for a duration of 6 weeks. $493.92

For the maintenance of remission of ulcerative colitis: The recommended dosage in adults is 1.6 grams daily, in divided doses.

BLOOD FACTOR PRODUCTS PA FORM

Prior Authorization Vendor for ND Medicaid

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-773-0695

ND Medicaid requires that patients receiving a new prescription for blood factor products 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 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 :	**DOSAGE:**		
Qualifications for coverage:			
TREATMENT CENTER CONTACT INFORMATION:	DATE OF LAST APPOINTMENT WITH TREATMENT CENTER: _____		
Prescriber Signature:		Date:	

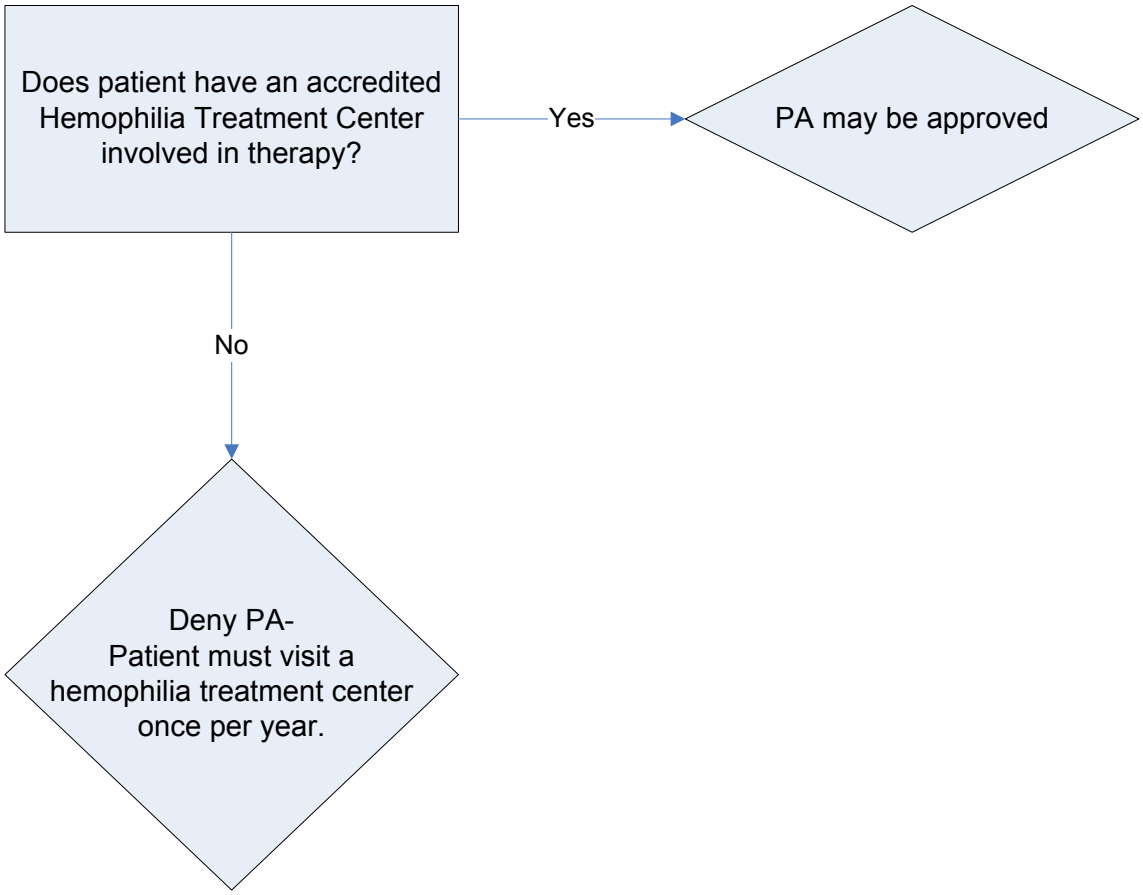
Part II: TO BE COMPLETED BY PHARMACY

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
Blood Factor Products Authorization Algorithm



CARISOPRODOL PA FORM

HEALTH INFORMATION DESIGNS

Prior Authorization Vendor for ND Medicaid

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-773-0695

ND Medicaid requires that patients using carisoprodol 350mg longer than two times per year (272 tablets) must receive a prior authorization. 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	
Physician Name			
Physician Medicaid Provider Number	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.*			
Physician Signature	Date		

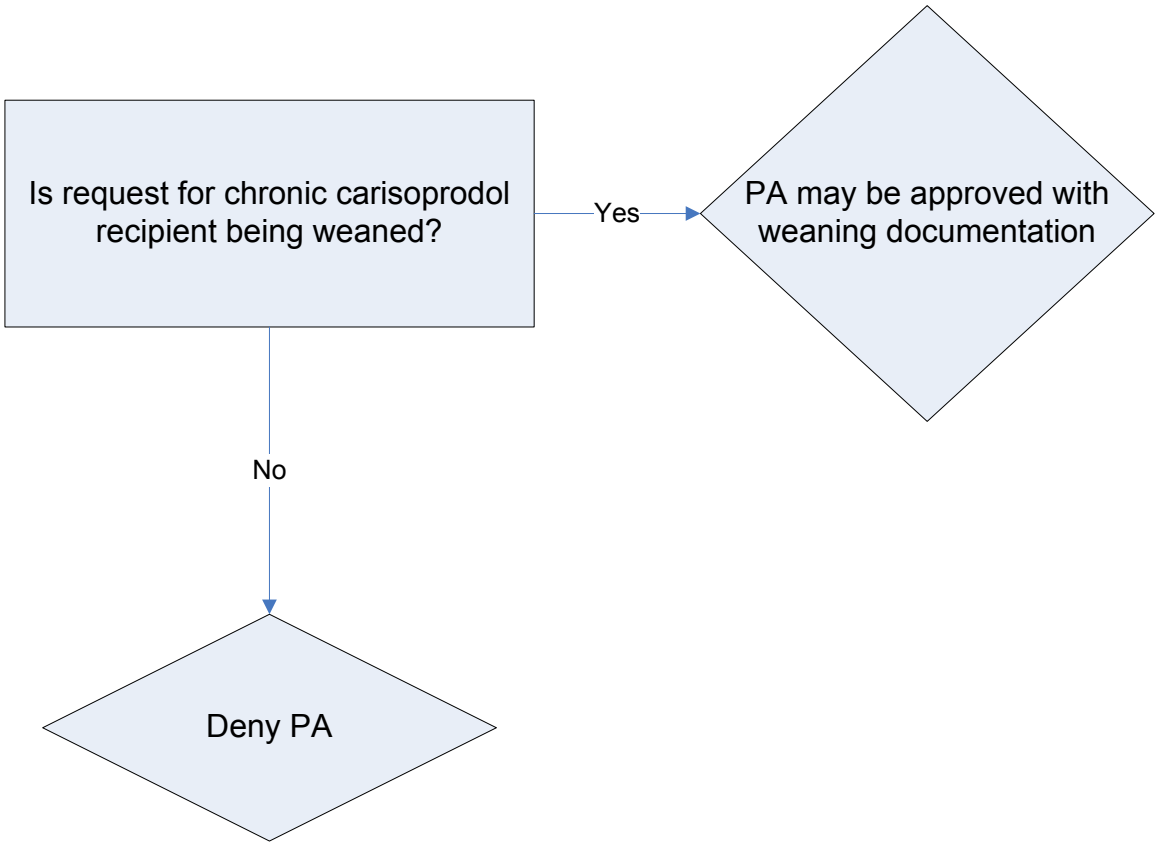
Part II: TO BE COMPLETED BY PHARMACY

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
Carisoprodol Authorization Algorithm



Clorpres Prior Authorization

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receive clonidine and chlorthalidone separately.
Note:

- ***Clonidine does not require PA***
- ***Chlorthalidone does 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: □ **Clorpres**	**Diagnosis for this request:**		
Qualifications for coverage:			
□ Failed both drugs separately	Start Date: End Date:	Dose: Frequency:	
Physician Signature		Date	

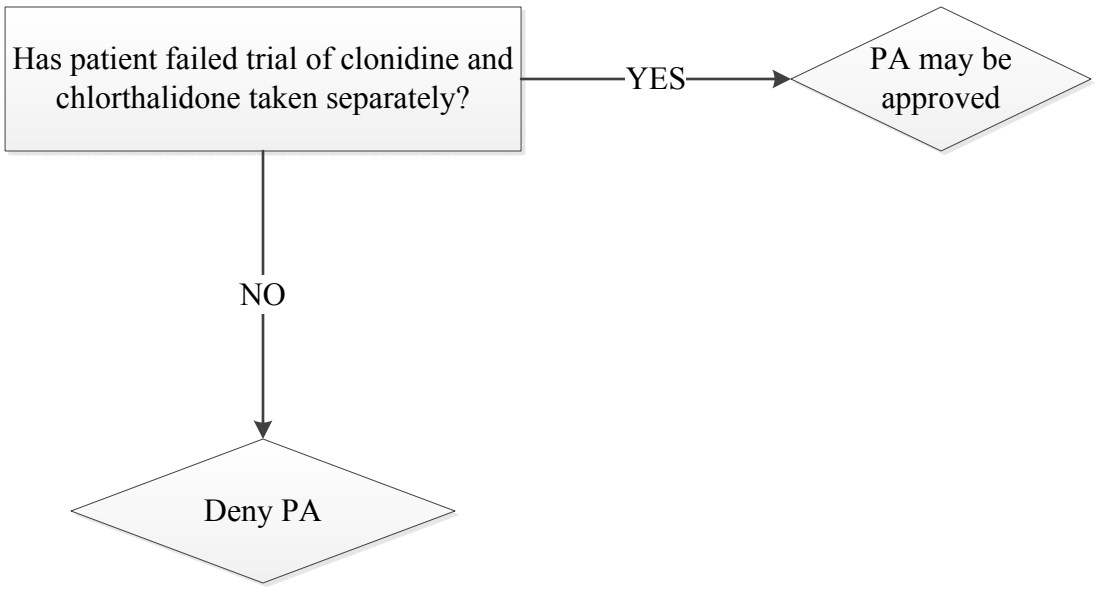
Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
PHONE 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
Clorpres Authorization Algorithm



Daliresp Prior Authorization

Fax Completed Form to:
866-254-0761
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 Daliresp must follow the following guidelines:

- ***Patient must be 18 years of age or older.***
- ***Patient must have a diagnosis of severe COPD associated with chronic bronchitis and a history of exacerbations.***

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: □ **Daliresp**	**Diagnosis for this request:**		
Physician Signature		Date	

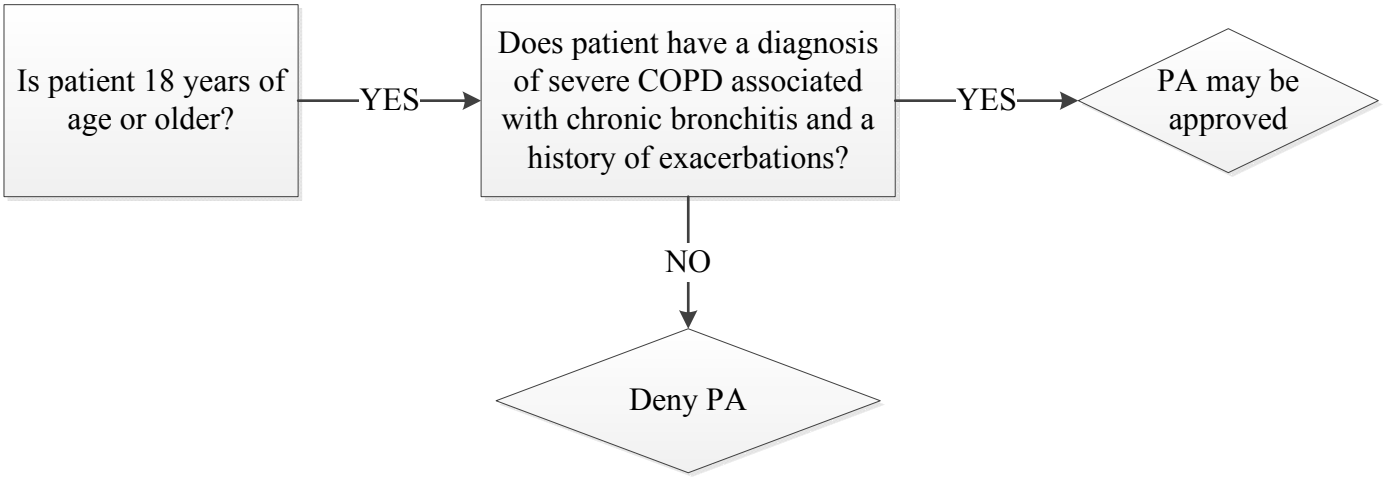
Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
PHONE 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
Daliresp Authorization Algorithm



DIFICID PA FORM

Prior Authorization Vendor for ND Medicaid

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-773-0695

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

- **Patient must have diagnosis of *Clostridium difficile*-associated diarrhea (CDAD)**
- **Patient must be ≥ 18 years of age**
- **Patient must have been treated per the current guidelines and failed**
- **Compounded oral vancomycin is covered without prior authorization**
- **Metronidazole is covered without 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: □ DIFICID	**Diagnosis for this Request:**	**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 Signature		Date

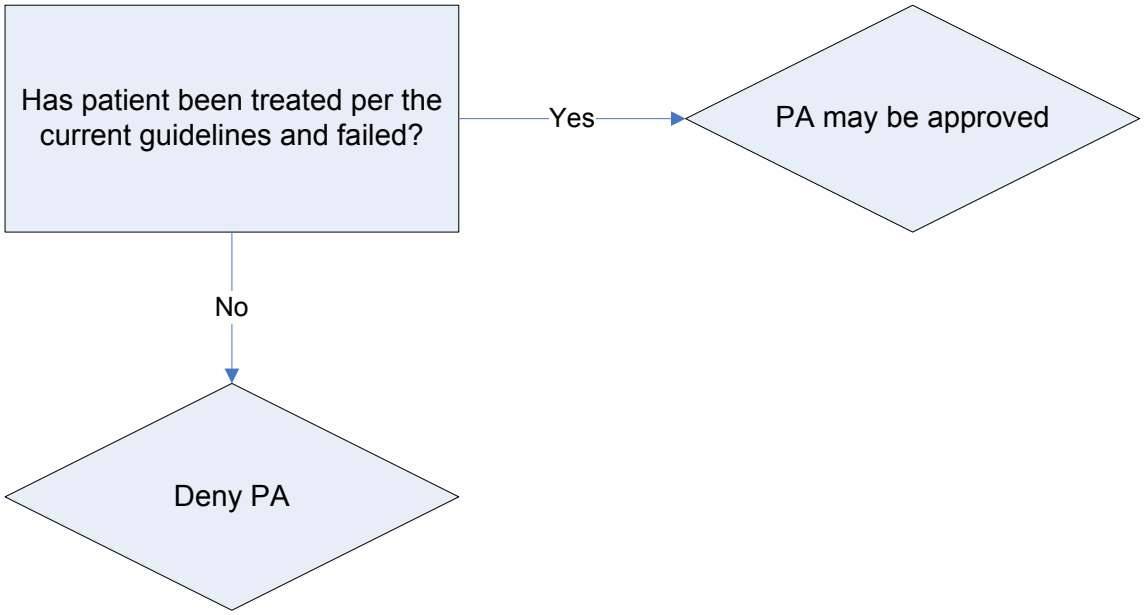
Part II: TO BE COMPLETED BY PHARMACY

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
Dificid Prior Authorization Algorithm



- Patient must have diagnosis of *Clostridium difficile*-associated diarrhea (CDAD)
- Patient must be ≥ 18 years of age
- Patient must have been treated per the current guidelines and failed:
  - Initial episode (mild to moderate severity)-metronidazole
  - Initial episode (severe)-vancomycin*
  - Initial episode (severe, complicated)-vancomycin* and metronidazole)
  - First recurrence-same regimen as first episode
  - Second recurrence-oral vancomycin* in tapered regimen

*Compounded oral vancomycin is covered without prior authorization

*Metronidazole is covered without prior authorization

HEALTH INFORMATION DESIGNS

DISPENSE AS WRITTEN PA FORM

Fax Completed Form to:
866-254-0761
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 was not effective (attach MedWatch form)**
- **There was an adverse reaction with the generic product (attach MedWatch form)**
- **DAW not allowed for drugs with an authorized generic available.**

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:	**DOSAGE:**	**Diagnosis for this request:**		

QUALIFICATIONS FOR COVERAGE: ☐ FAILED GENERIC EQUIVALENT **(ATTACH FDA MEDWATCH FORM)**	**Start Date**	**End Date**	**Dose**	**Frequency**

ADVERSE REACTION TO GENERIC EQUIVALENT (ATTACH FDA MEDWATCH FORM)

☐ *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 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)	

HEALTH INFORMATION DESIGNS

Gilenya Prior Authorization

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients who are prescribed Gilenya must follow these guidelines:

Note:

- ***Must have relapsing forms of multiple sclerosis.***
- ***Must have a current electrocardiogram (within 6 months) for patients taking anti-arrhythmics, beta-blockers, or calcium channel blockers; patients with cardiac risk factors; and patients with a slow or irregular heart beat.***
- ***Must have a recent CBC (within 6 months).***
- ***Must have an adequate ophthalmologic evaluation at baseline and 3-4 months after treatment initiation.***
- ***Must have recent (within 6 months) transaminase and bilirubin levels before initiation of therapy.***
- ***Will not be approved for use in combination 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
Requested Drug and Dosage: □ **Gilenya**	**Diagnosis for this request:**		
Qualifications for coverage:			
Current electrocardiogram **Date:**	**Current CBC** **Date:**	**Ophthalmologic Evaluation** **Date:**	**Transaminase/Bilirubin levels** **Date:**
Physician Signature			Date

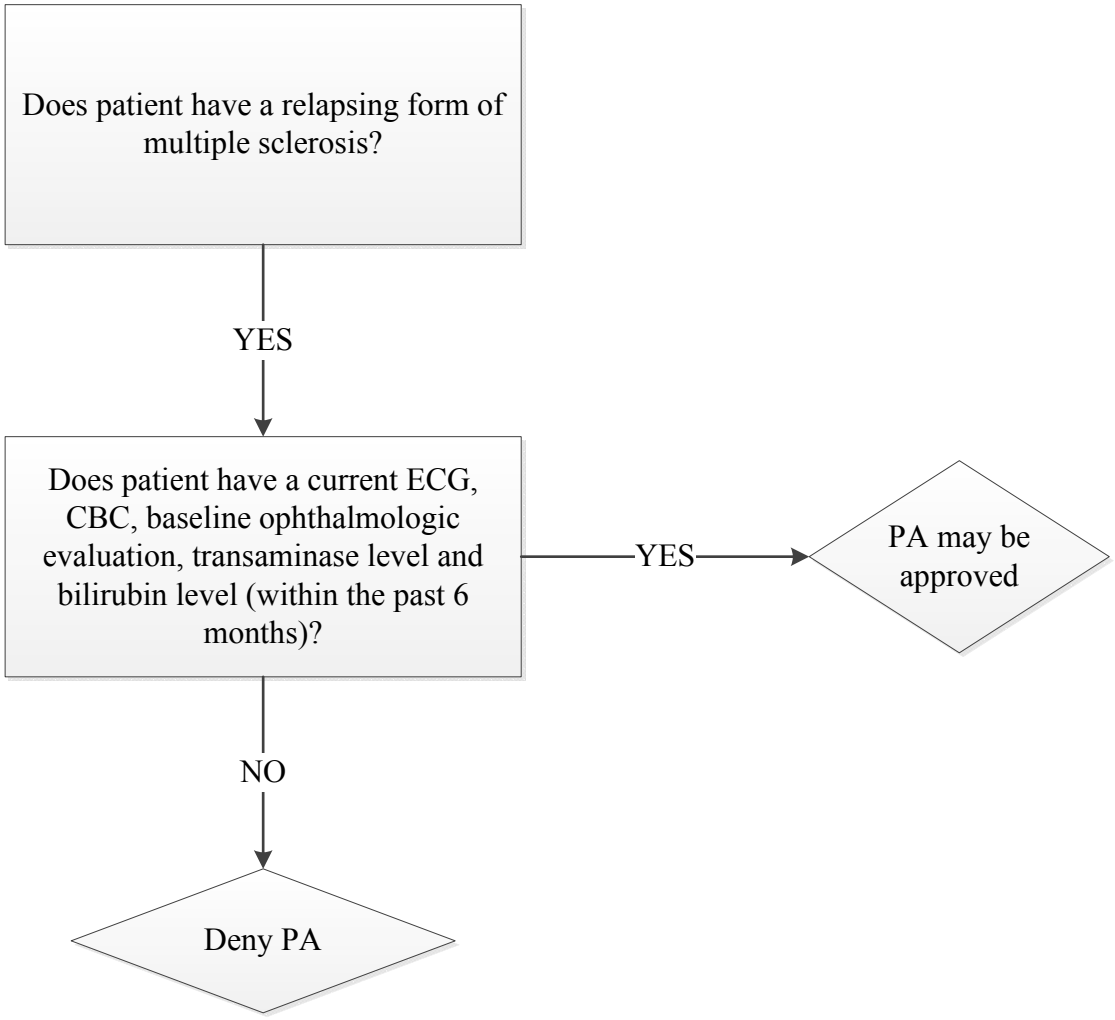
Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
PHONE 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
Gilenya Authorization Algorithm



Growth Hormone PA Form

Fax Completed Form to:
866-254-0761
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) or Prader-Willi Syndrome (PWS)**
- **Human Immunodeficiency Virus (HIV) associated wasting in adults**

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:** (must be completed)	
Qualifications for coverage:		
Criteria met:	Diagnosis Date: Drug:	Dose: Frequency:
PRESCRIBER SIGNATURE	DATE:	

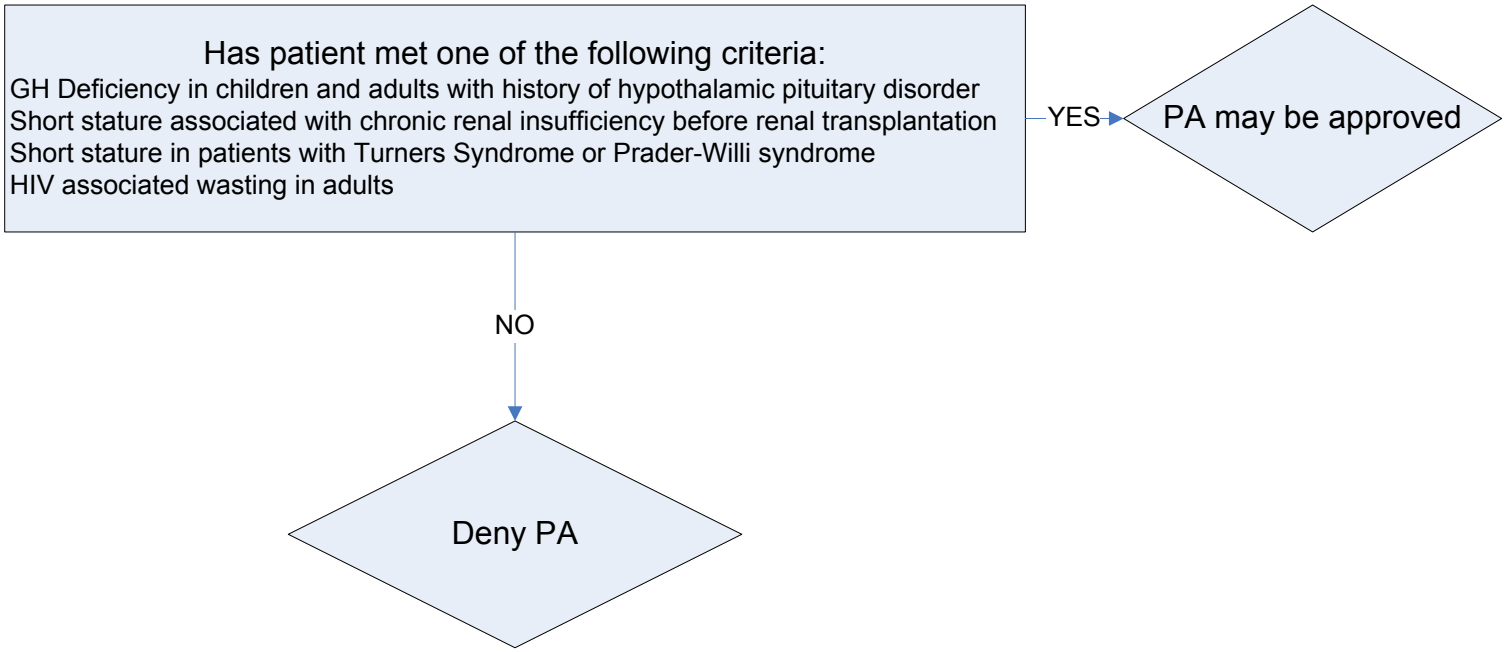
Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:	ND MEDICAID PROVIDER NUMBER:
Phone:	FAX:
Drug:	NDC#:

Part III: FOR OFFICIAL USE ONLY

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

North Dakota Department of Human Services
Growth Hormone Authorization Algorithm



HEALTH INFORMATION DESIGNS

Hepatitis C Virus (HCV) Medication Prior Authorization

Fax Completed Form to:
866-254-0761
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 Intron, Infergen, Pegasys, PegIntron, Incivek, or Victrelis must submit a prior authorization form.

Note:

- ***Prior authorization will be granted if the requested product has been approved by the FDA for the indication listed below.***
- ***Current recommended therapy of chronic HCV infection is the combination of pegylated interferon alfa (PEGIntron or Pegasys) and ribavirin.***
- ***Incivek and Victrelis patients must be 18 years of age or older.***
- ***Incivek and Victrelis patients must also be taking ribavirin and peg-interferon.***
- ***Incivek and Victrelis will only be approved for 12 weeks for review of HCV-RNA levels and compliance.***

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: □ **Intron** □ **Pegasys** □ **Infergen** □ **PEGIntron** □ **Incivek** □ **Victrelis**	**Diagnosis for this request:**	**Genotype:**	
	Ribavirin dose: **Peg-interferon dose:**		
Physician Signature		Date	

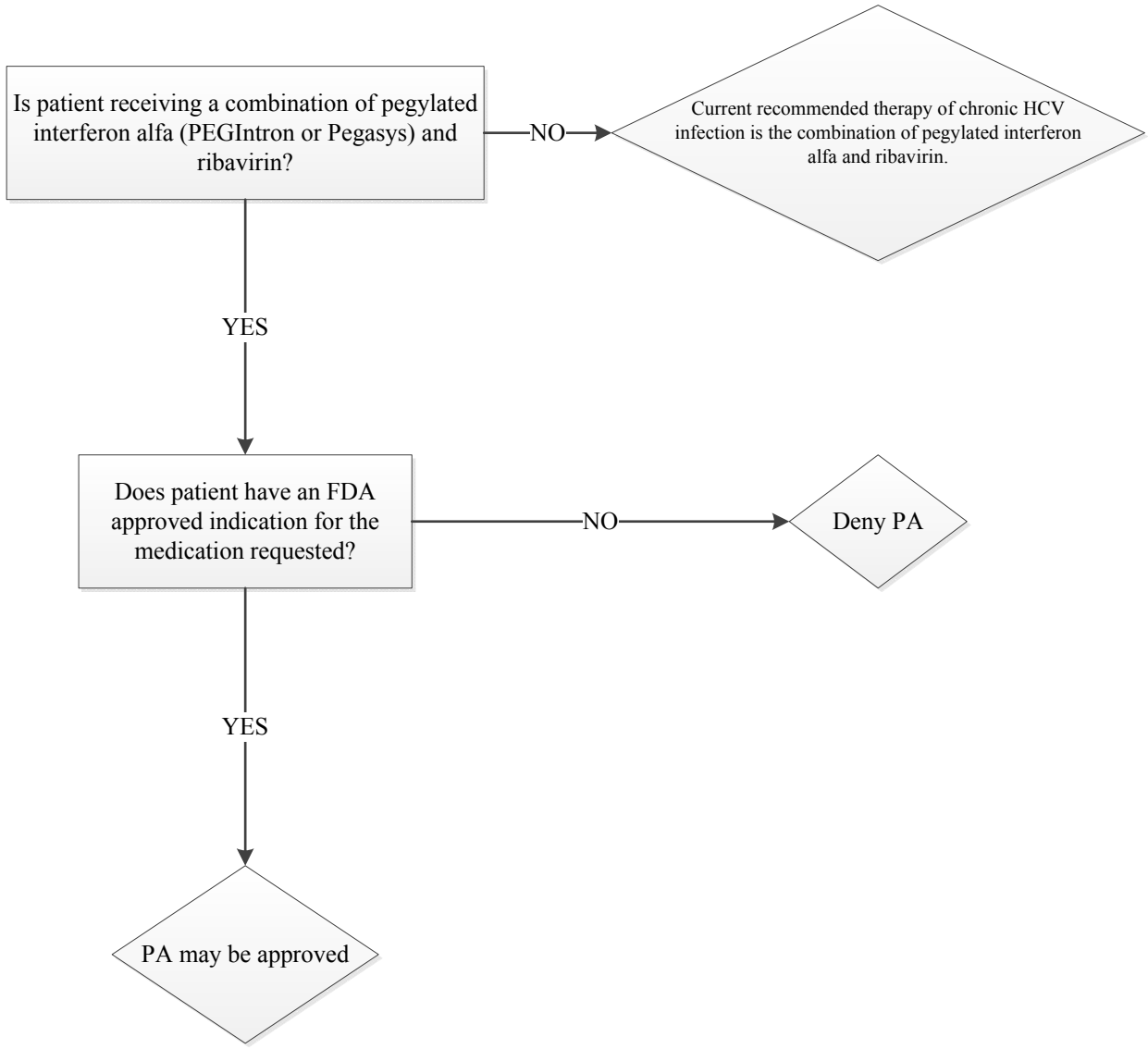
Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
PHONE 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
Hepatitis C Virus (HCV) Medication Authorization Algorithm



HEREDITARY ANGIOEDEMA
PA FORM

HEALTH INFORMATION DESIGNS

Prior Authorization Vendor for ND Medicaid

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-773-0695

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 Signature	Date		

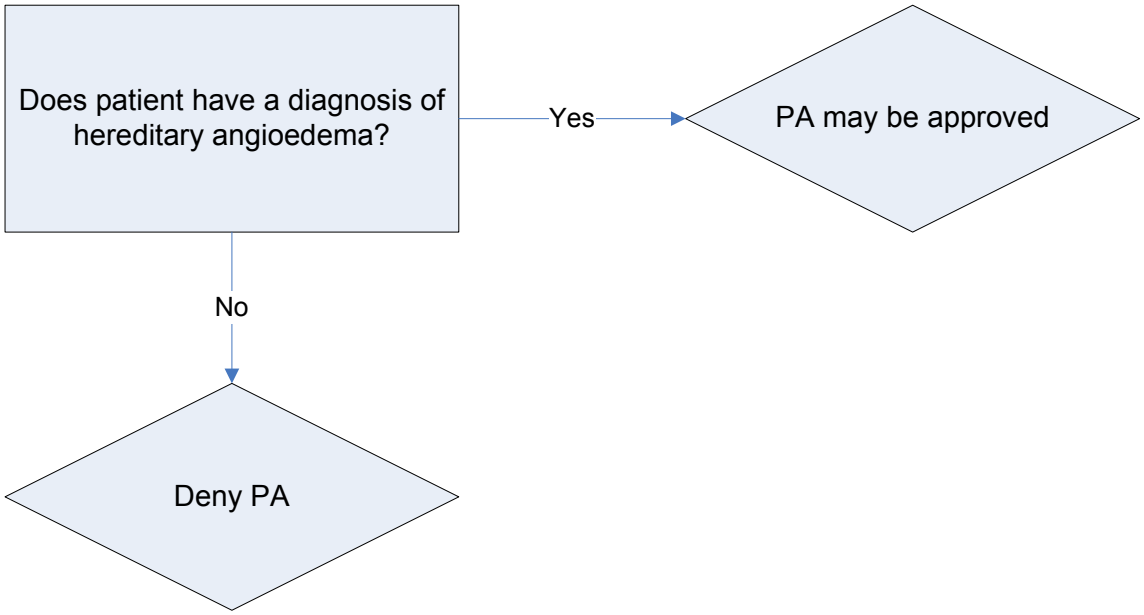
Part II: TO BE COMPLETED BY PHARMACY

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
Hereditary Angioedema Prior Authorization Algorithm



Horizant Prior Authorization

Fax Completed Form to:
866-254-0761
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: END DATE:	DOSE: FREQUENCY:		
Physician Signature		Date	

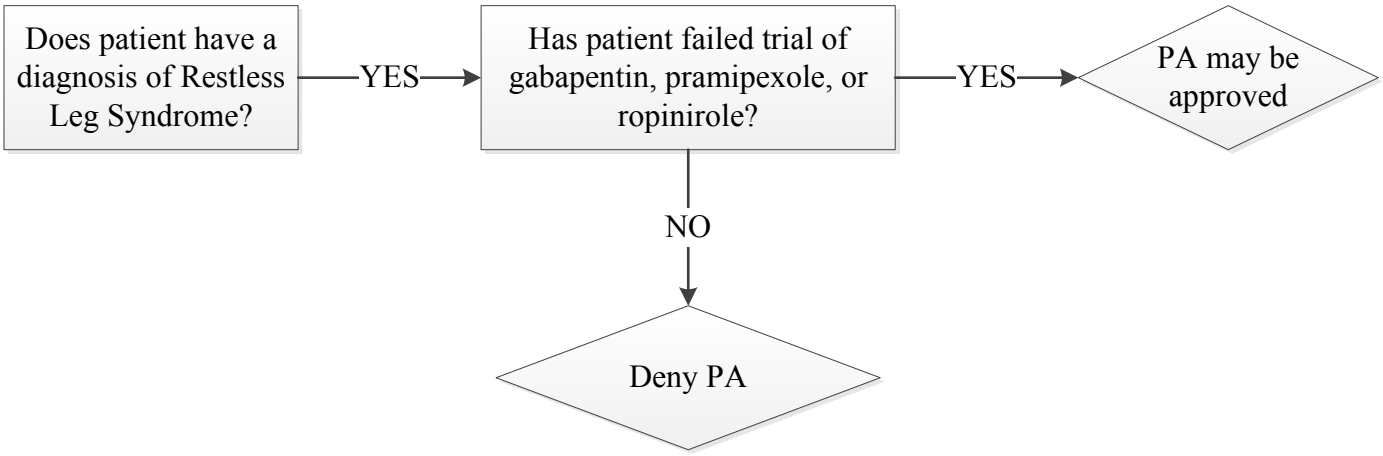
Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
PHONE 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
Horizant Authorization Algorithm



TARGETED IMMUNE MODULATORS PA FORM

Prior Authorization Vendor for ND Medicaid

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-773-0695

ND Medicaid requires that patients receiving a new prescription for Actemra, Orencia, Humira, Enbrel, Amevive, Kineret, Cimzia, Remicade, Simponi and Stelara must submit a prior authorization form.

- Prior authorization will be granted if the requested product has been approved by the FDA for the indication listed below.

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:**
□ ORENCIA	□ AMEVIVE	
□ ENBREL	□ CIMZIA	
□ KINERET	□ REMICADE	
□ HUMIRA	□ SIMPONI	
□ STELARA	□ ACTEMRA	

□ *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.*

Physician Signature	Date

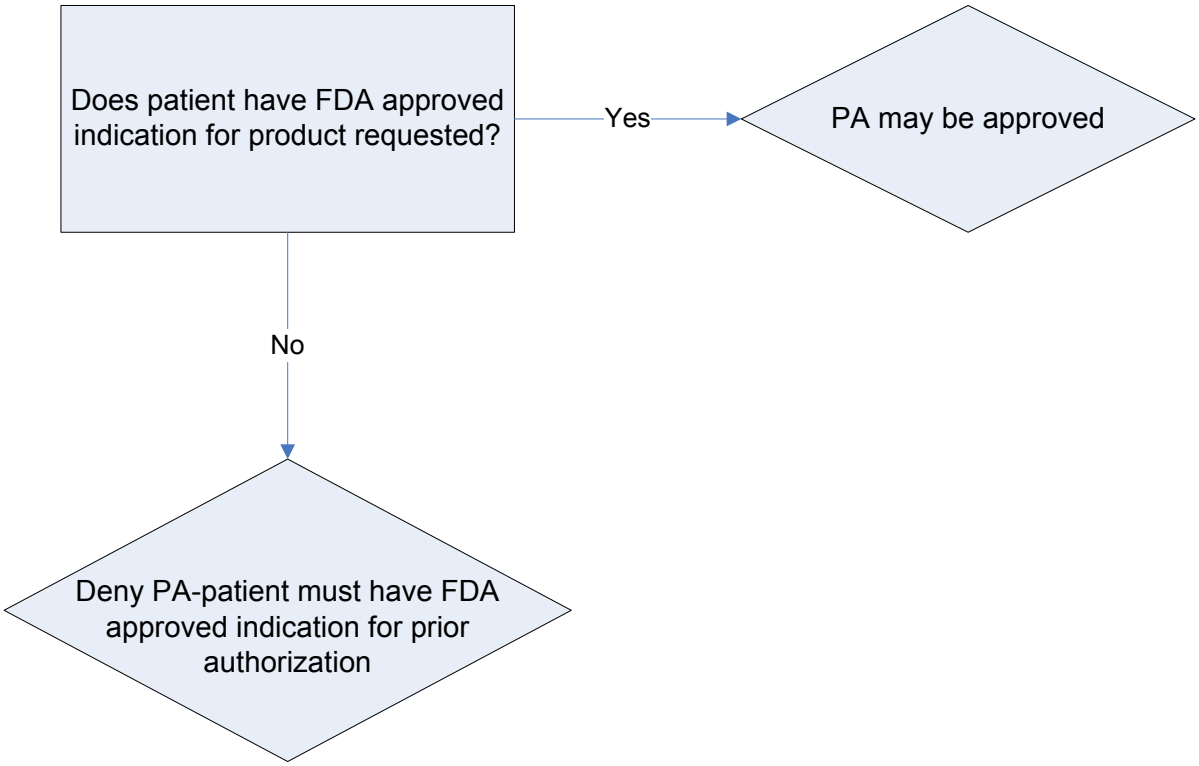
Part II: TO BE COMPLETED BY PHARMACY

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
Targeted Immune Modulators Authorization Algorithm



HEALTH INFORMATION DESIGNS

KETEK PA FORM

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

- 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 MEDICAID ID NUMBER:
Recipient Date of birth: / /	
PRESCRIBER NAME:	PRESCRIBER MEDICAID ID NUMBER:
Address:	Phone: ( )
City:	FAX: ( )
State: Zip:	

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.

☐ 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 Signature: Date:

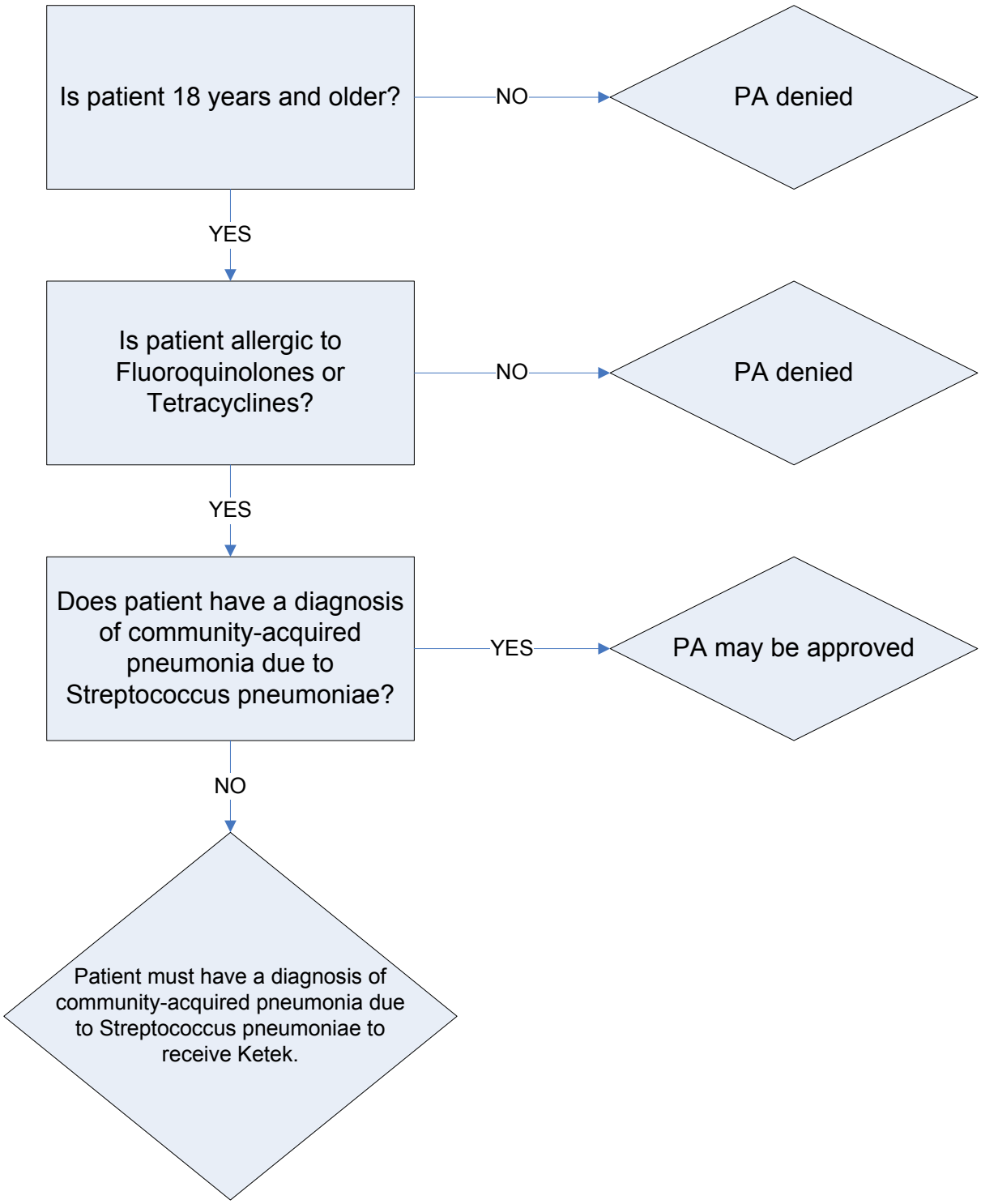
Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:	ND MEDICAID PROVIDER NUMBER:
Phone:	FAX:
Drug:	NDC#:

Part III: FOR OFFICIAL USE ONLY

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

North Dakota Department of Human Services
Ketek Criteria Algorithm



Livalo Prior Authorization

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients who are prescribed Livalo must first try a covered statin medication
Note:

- ***Statins already on the market 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: □ **Livalo**	**Diagnosis for this request:**		
Qualifications for coverage:			
□ Medication Failed _____	Start Date: End Date:	Dose: Frequency:	
Physician Signature		Date	

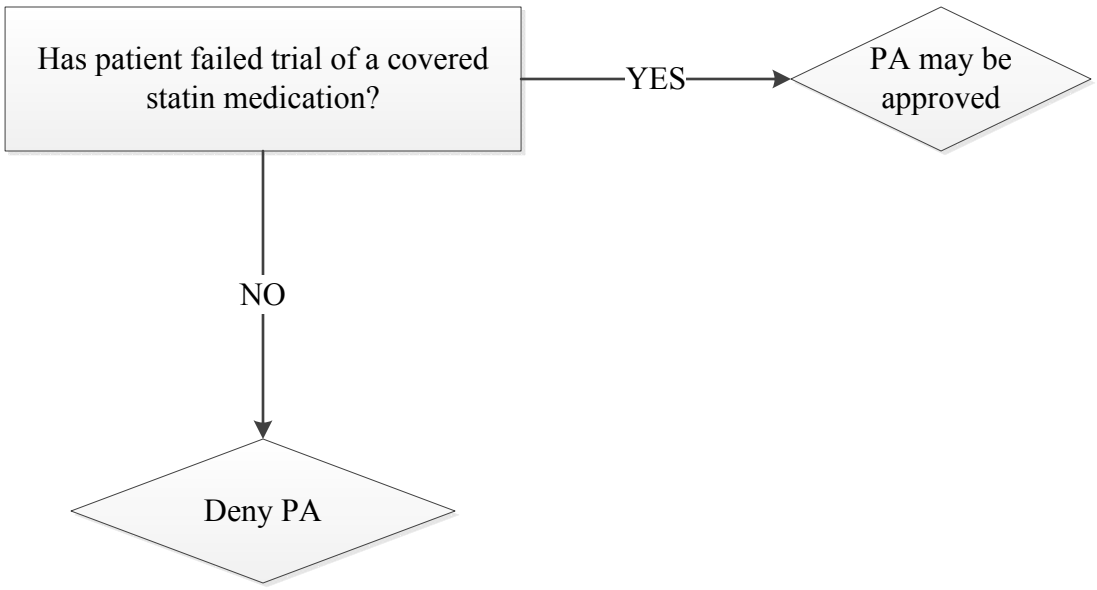
Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
PHONE 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
Livalo Authorization Algorithm



METOZOLV ODT PA FORM

Prior Authorization Vendor for ND Medicaid

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-773-0695

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.*			
Physician Signature		Date	

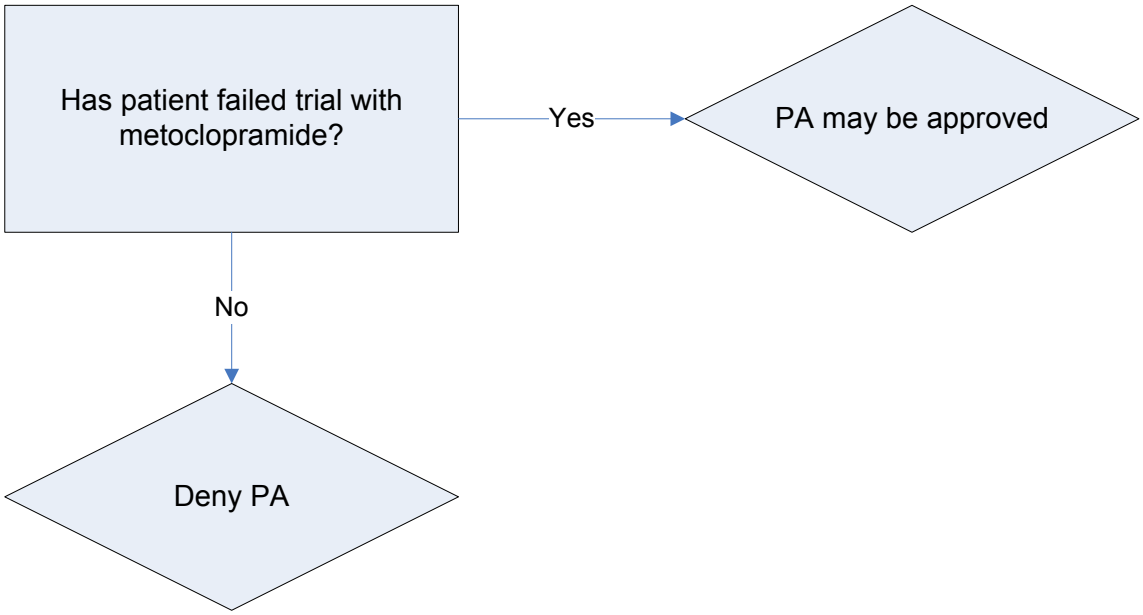
Part II: TO BE COMPLETED BY PHARMACY

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
Metozolv Prior Authorization Algorithm



MOXATAG PA FORM

Prior Authorization Vendor for ND Medicaid

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-773-0695

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.*	
Physician Signature	Date

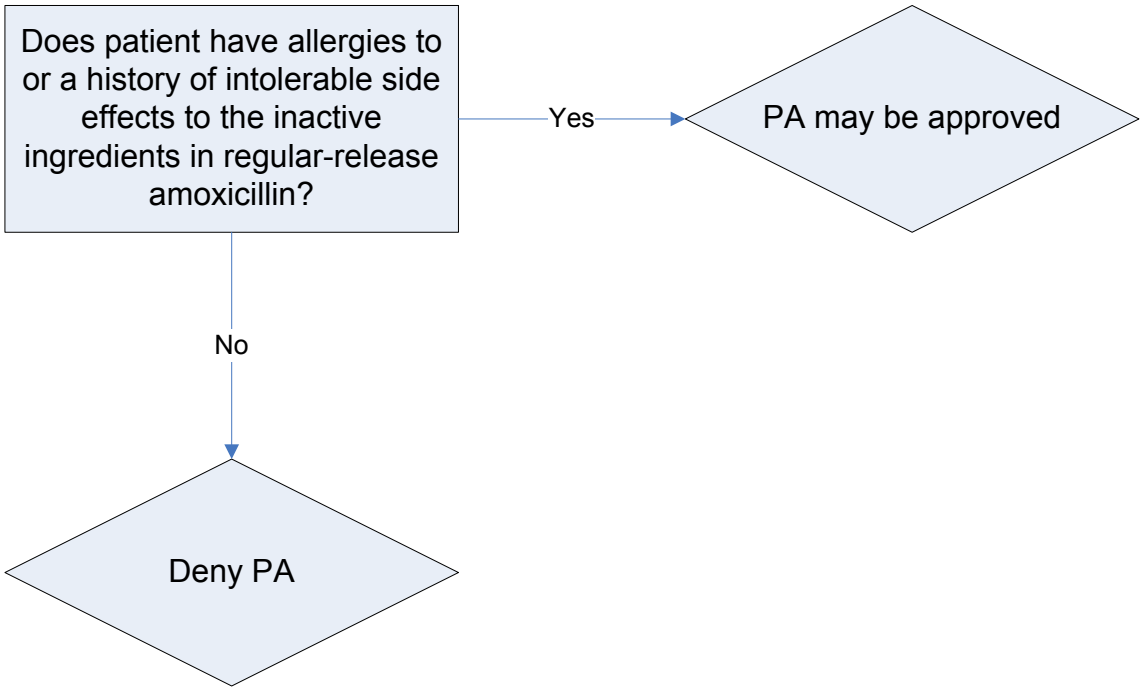
Part II: TO BE COMPLETED BY PHARMACY

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
Moxatag Authorization Algorithm



Regular-release amoxicillin does not require a prior authorization and costs approximately $4.40 for a course of therapy compared to $84.40 for a course of Moxatag therapy.

HEALTH INFORMATION DESIGNS

Prior Authorization Vendor for ND Medicaid

BRAND NAME NSAID/COX-II PA FORM

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-773-0695

ND Medicaid requires that patients using brand name NSAIDs or COX-II drugs must use a generic NSAID as 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 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:

□ Celebrex

□ Other _____

Diagnosis for this request:

□ Warfarin/Corticosteroid therapy

□ Gastric or duodenal ulcer

□ Actinic keratoses **(Solaraze)**

□ GI bleed, perforation or obstruction

□ Endoscopically documented NSAID gastritis with GI Bleed

Qualifications for coverage:

□ Failed NSAID therapy	Start Date	End Date	Dose	Frequency
□ Failed NSAID 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 Signature	Date

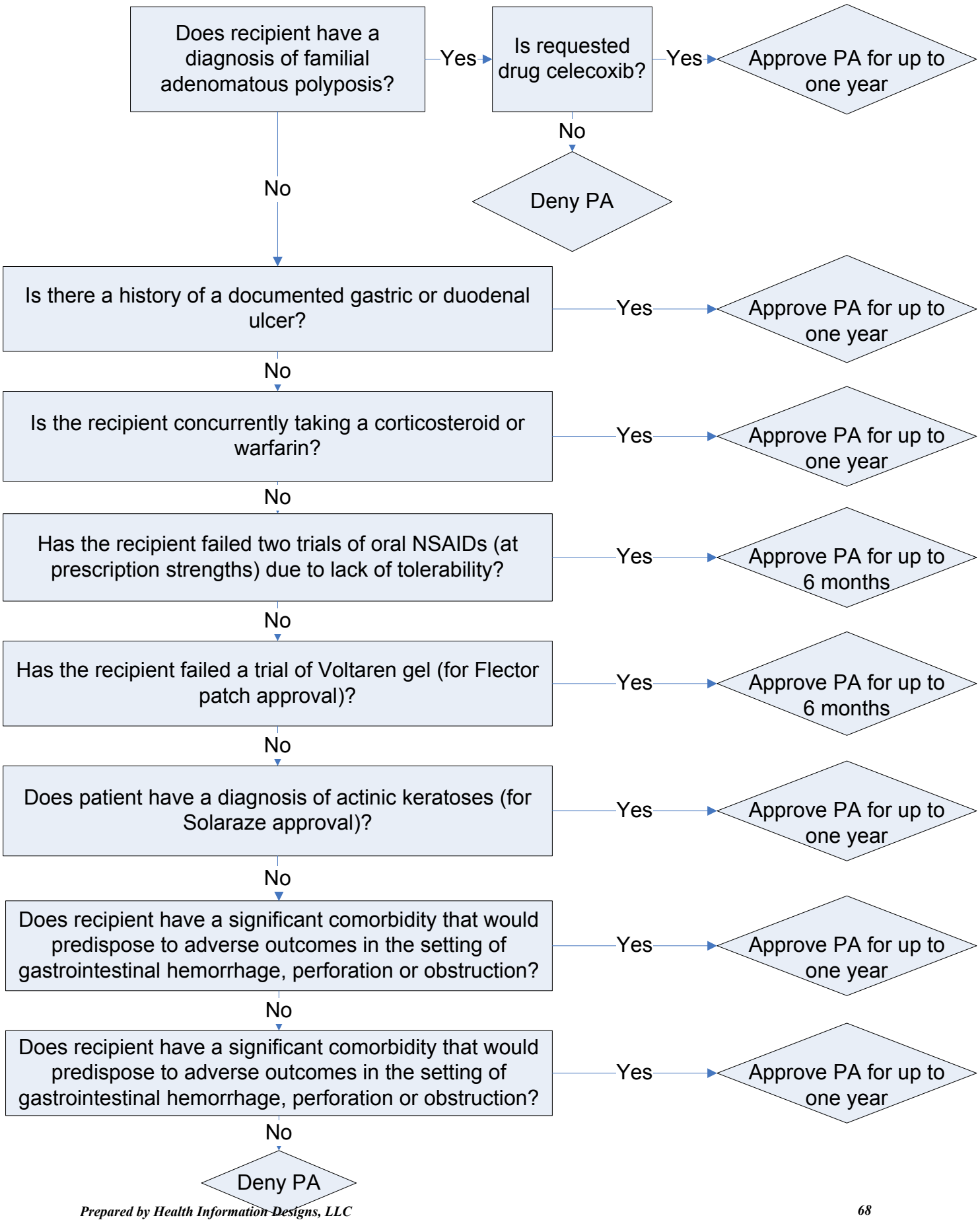
Part II: TO BE COMPLETED BY PHARMACY

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
Name Brand NSAID/COX-II Authorization Algorithm



BRAND-NAME NARCOTICS PA FORM

Prior Authorization Vendor for ND Medicaid

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-773-0695

ND Medicaid requires that patients receiving a new prescription for a brand-name narcotic must meet the following criteria:

- **Documented failure of a 30-day trial of a generic narcotic.**

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:

□ EMBEDA □ OPANA ER □ KADIAN □ AVINZA □ EXALGO □ FENTORA □ ONSOLIS □ MAGNACET ■ BUTRANS

□ OTHER BRAND NAME PRODUCT _____

FAILED THERAPY	**START DATE**	**END DATE**	**DOSE**	**FREQUENCY**

Physician Signature	Date

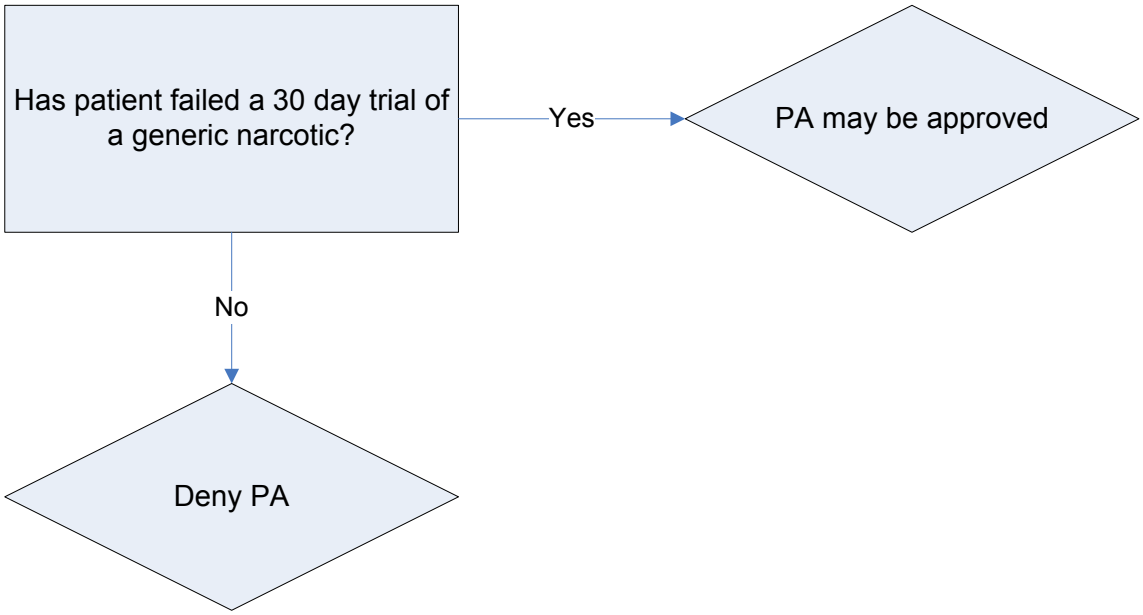
Part II: TO BE COMPLETED BY PHARMACY

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
Name-brand Narcotics Prior Authorization Algorithm



Narcotics/APAP
Prior Authorization

Fax Completed Form to:
866-254-0761
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 narcotics containing acetaminophen doses greater than 325mg must use hydrocodone/acetaminophen 5/325-10/325 or oxycodone acetaminophen 5/325-10/325.

- ***FDA is requesting that drug manufacturers limit the amount of acetaminophen in prescription drug products to 325mg per dosage unit.***
- ***Higher-dose formulations of hydrocodone/acetaminophen and oxycodone/acetaminophen should be phased out by 2014.***

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:			
□ FAILED THERAPY START DATE: END DATE:	DOSE: FREQUENCY:		
Physician Signature		Date	

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
PHONE 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)	

Nexiclon Prior Authorization

Fax Completed Form to:
866-254-0761
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 Nexiclon must try and fail clonidine.
Note:

- ***Clonidine does 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: □ **Nexiclon**	**Diagnosis for this request:**		
Qualifications for coverage:			
□ FAILED CLONIDINE THERAPY START DATE: END DATE:	DOSE: FREQUENCY:		
Physician Signature		Date	

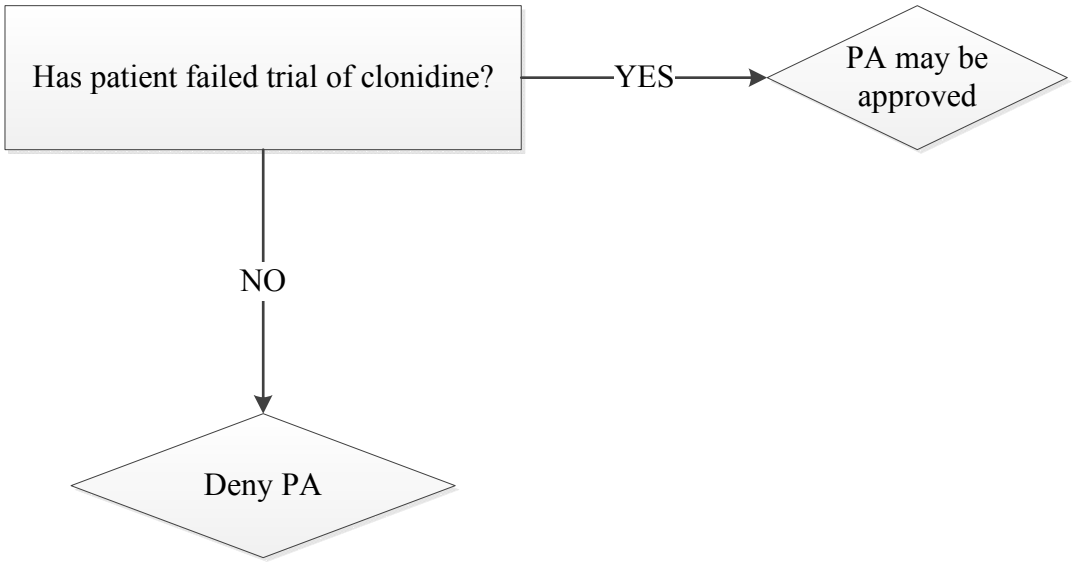
Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
PHONE 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
Nexiclon Authorization Algorithm



Nucynta Prior Authorization

HEALTH INFORMATION DESIGNS

Prior Authorization Vendor for ND Medicaid

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-773-0695

ND Medicaid requires that patients receiving a new prescription for Nucynta must be unable to tolerate other opioids due to gastrointestinal side effects.

- **Oxycodone is covered without a prior authorization.**

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: □ **Nucynta**	**Diagnosis for this request:**		
Qualifications for coverage:			
□ UNABLE TO TOLERATE OTHER OPIOIDS DUE TO GASTROINTESTINAL SIDE EFFECTS OPIOID TRIED_____ START DATE: DOSE: END DATE: FREQUENCY:			
Prescriber Signature		Date	

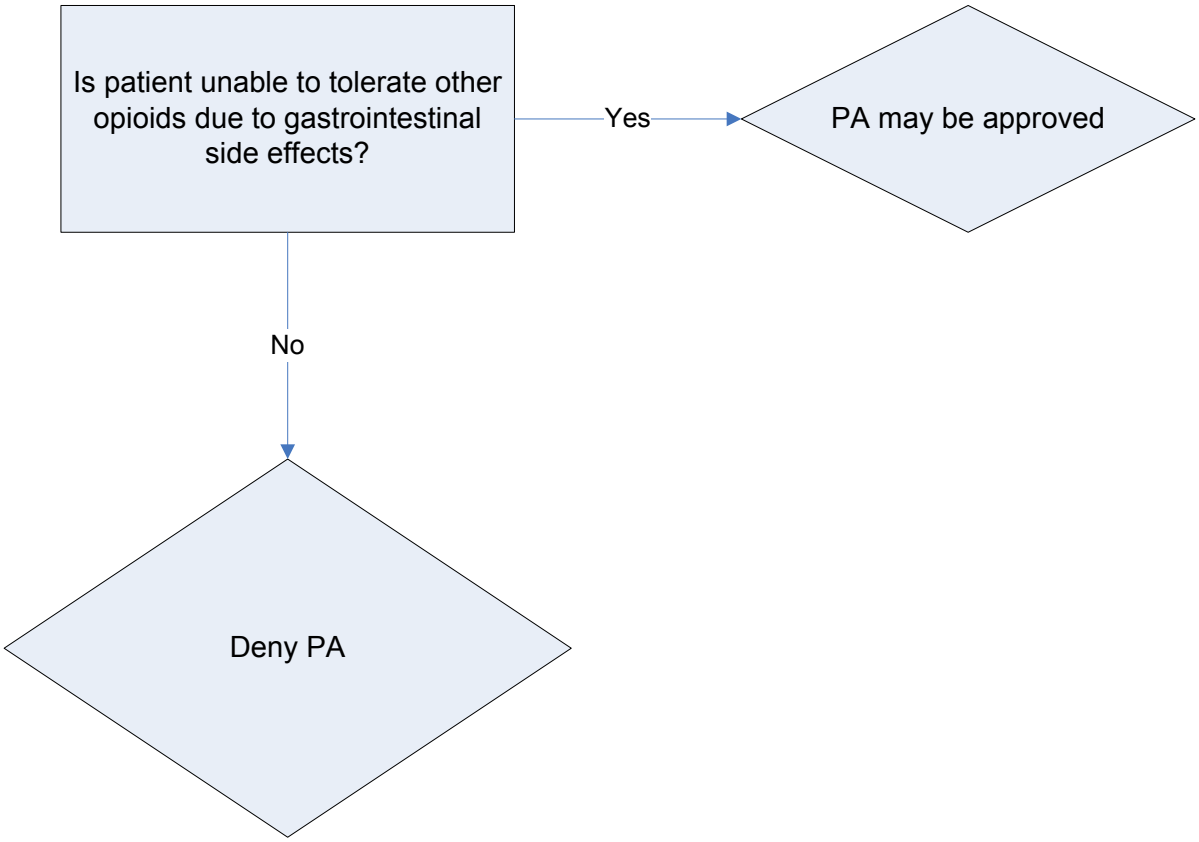
Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
PHONE 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
Nucynta Authorization Algorithm



Nuedexta Prior Authorization

Fax Completed Form to:
866-254-0761
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 Nuedexta must have a diagnosis of amyotrophic lateral sclerosis (ALS) or multiple sclerosis (MS) and exhibit signs of pseudobulbar affect.

Note:

- ***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	
Physician Name			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ **Nuedexta**	**Diagnosis for this request (must check at least 2):** □ **PBA** □ **ALS** □ **MS**		
Physician Signature		Date	

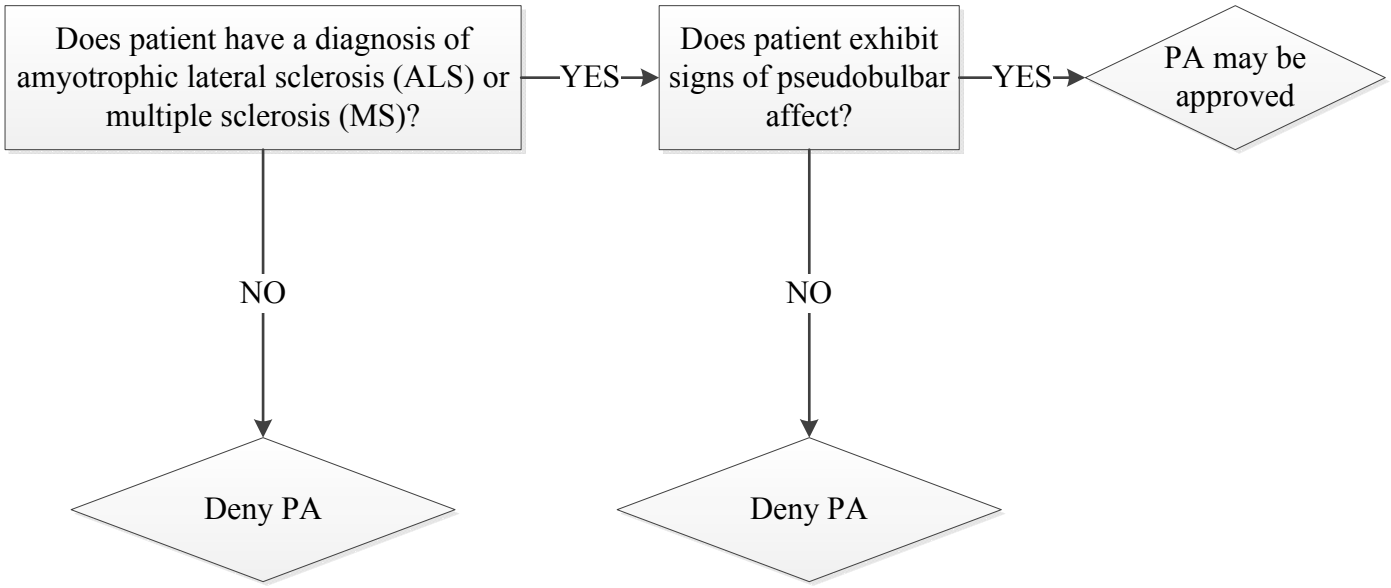
Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
PHONE 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
Nuedexta Authorization Algorithm



HEALTH INFORMATION DESIGNS

Prior Authorization Vendor for ND Medicaid

Nuvigil Prior Authorization

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-773-0695

ND Medicaid requires that patients receiving a new prescription for Nuvigil must suffer from excessive sleepiness associated with obstructive sleep apnea/hypopnea syndrome, narcolepsy, or shift work disorder.

- **Provigil is covered without a prior authorization.**

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**	**Diagnosis for this request:**		
Qualifications for coverage:			
□ FAILED PROVIGIL (MODAFINIL)	START DATE: END DATE:	DOSE: FREQUENCY:	
□ EXCESSIVE SLEEPINESS ASSOCIATED WITH OBSTRUCTIVE SLEEP APNEA/HYPOPNEA SYNDROME □ NARCOLEPSY □ SHIFT WORK SLEEP DISORDER			
Prescriber Signature		Date	

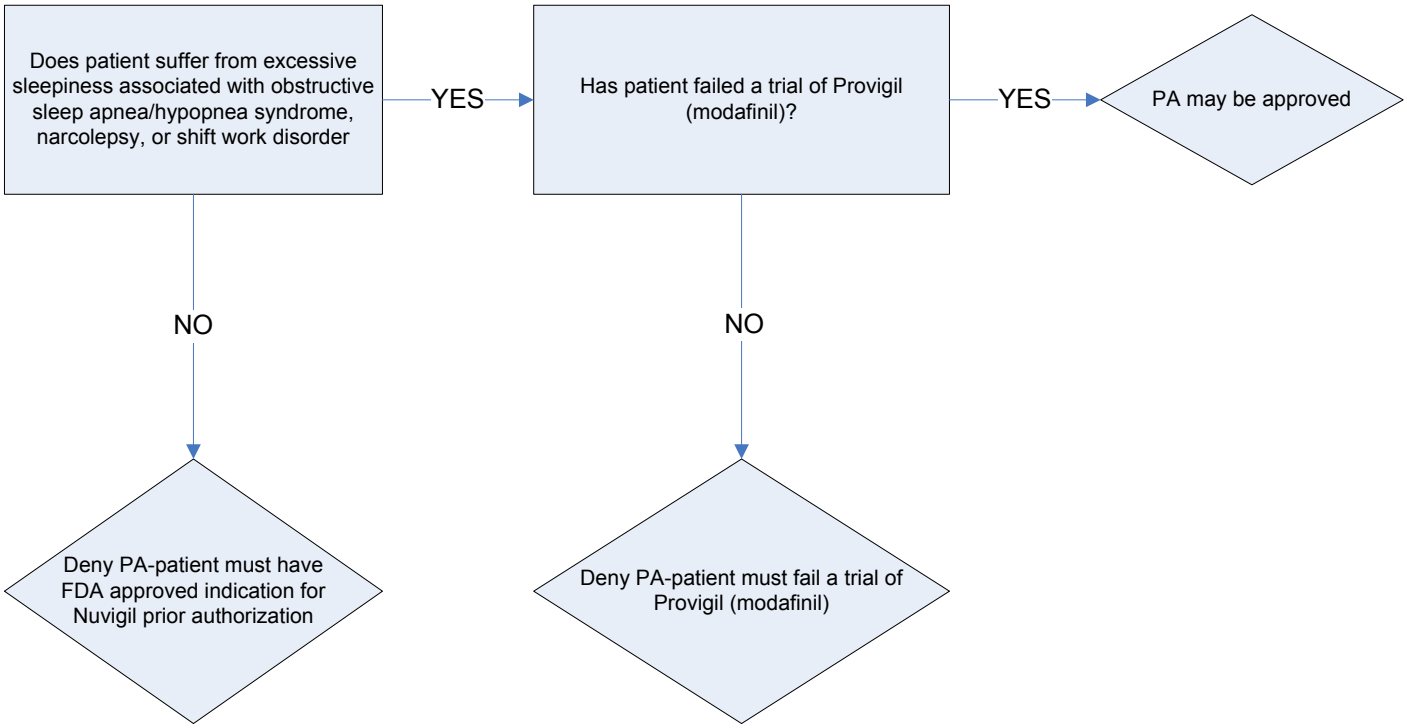
Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
PHONE 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
Nuvigil Authorization Algorithm



Orally Disintegrating Tablets (ODT)
Prior Authorization

Fax Completed Form to:
866-254-0761
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:	
Physician Signature		Date	

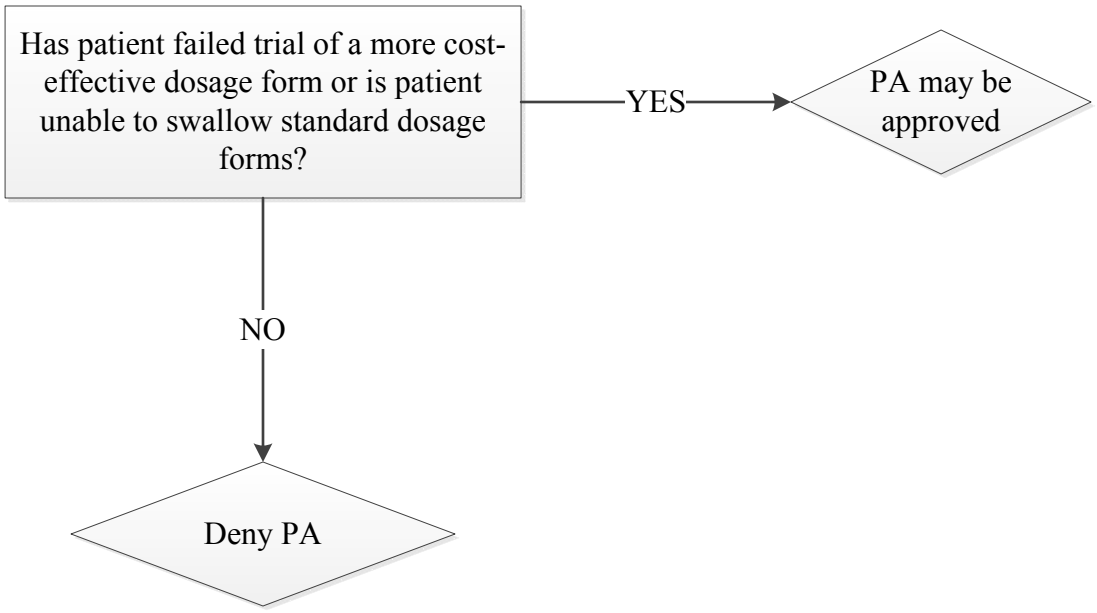
Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
PHONE 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
Orally Disintegrating Tablets (ODT) Authorization Algorithm



Ophthalmic Antihistamines
Prior Authorization

Fax Completed Form to:
866-254-0761
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 Lastacaft, Bepreve, and Pataday must first try one of the following:

- ***Ketotifen, Azelastine, Elestat, Emadine, and Patanol 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: □ **Lastacaft** □ **Bepreve** □ **Pataday**	**Diagnosis for this request:**		
Qualifications for coverage:			
□ FAILED THERAPY START DATE: END DATE:	DOSE: FREQUENCY:		
Physician Signature		Date	

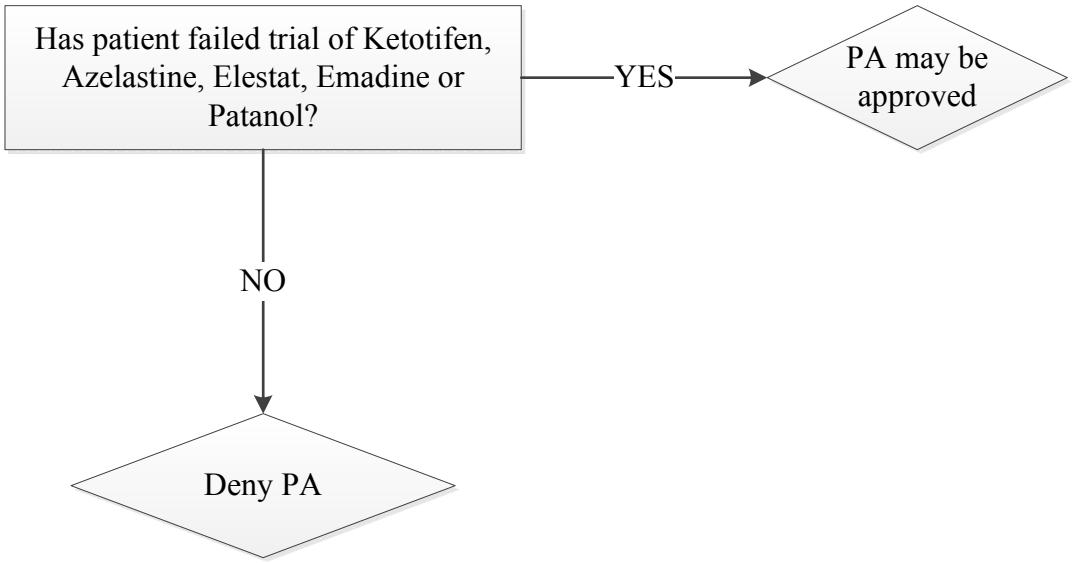
Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
PHONE 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
Ophthalmic Antihistamine Authorization Algorithm



OPHTHALMIC ANTI-INFECTIVE PA FORM

Prior Authorization Vendor for ND Medicaid

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-773-0695

ND Medicaid will not pay for Azasite or Quixin without documented failure of a first line antibiotic ophthalmic agent.

***Note: First line agents include sulfacetamide (Bleph 10®, etc.), erythromycin, bacitracin-polymixin B (Polysporin®), polymyxin B neomycin-gramicidin (Neosporin®), trimethoprim-polymyxin B (Polytrim®), gentamicin (Garamycin®, etc.), ofloxacin (Ocuflox®) and ciprofloxacin (Ciloxan®).**

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: □ AZASITE □ QUIXIN	**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 Signature	Date		

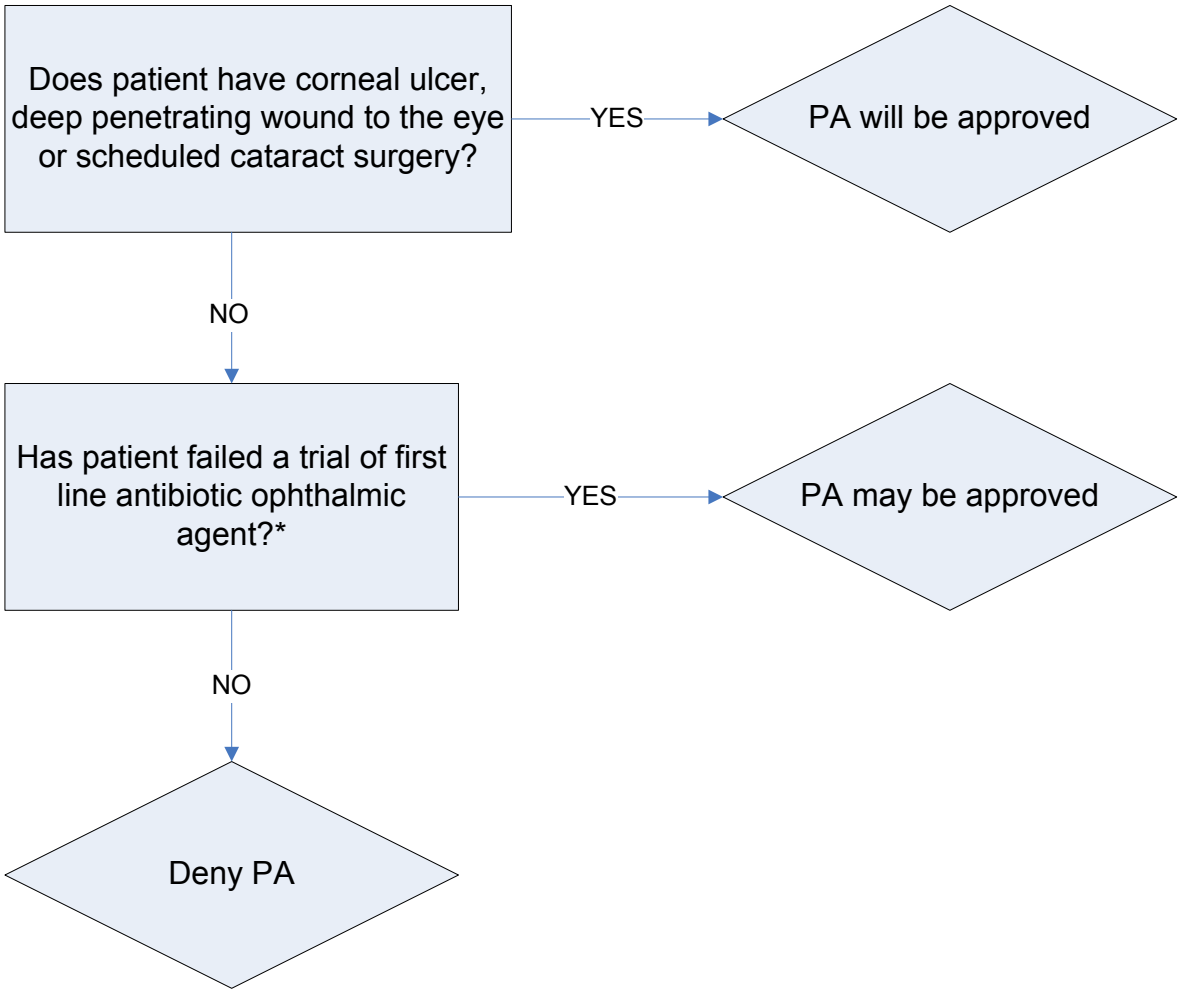
Part II: TO BE COMPLETED BY PHARMACY

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
Ophthalmic Anti-infective Authorization Algorithm



*First line agents include: sulfacetamide (Bleph 10, etc.), erythromycin, bacitracin-polymixin B (Polysporin), polymyxin B-neomycin-gramicidin (Neosporin), trimethoprim-polymyxin B (Polytrim), gentamicin (Garamycin, etc.), ofloxacin (Ocuflox), and ciprofloxacin (Ciloxan).

HEALTH INFORMATION DESIGNS

DORYX and ORACEA PA FORM

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

Note: ND Medicaid will not pay for Oracea without documented failure of a first line tetracycline agent.

- First line agents include: doxycycline, minocycline, and tetracycline.

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: □ **ORACEA** □ **DORYX**	**Requested Dosage:** (must be completed)

Qualifications for coverage:

□ Patient has failed a 90 day trial of which first line agent _____

□ *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 Signature: Date:

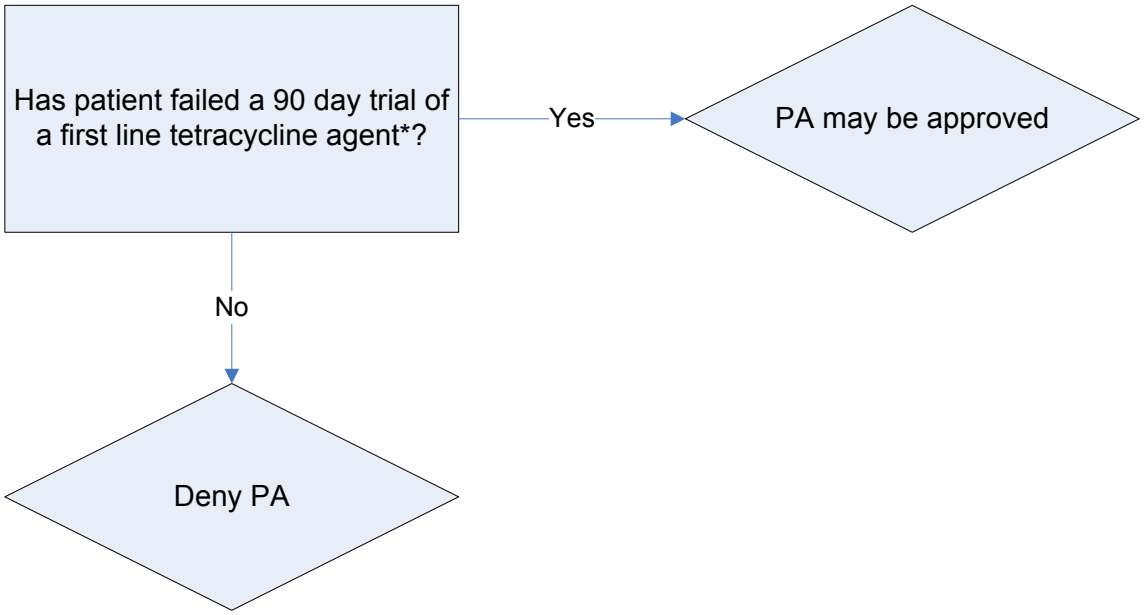
Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:		ND MEDICAID PROVIDER NUMBER:
Phone:		FAX:
Drug:		NDC#:

Part III: FOR OFFICIAL USE ONLY

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

North Dakota Department of Human Services
Doryx and Oracea Prior Authorization Algorithm



**Doxycycline, minocycline, and tetracycline do not require a PA and cost approximately $3 - $40 for a course of therapy compared to $353 dollars for Oracea and $331 dollars for Doryx.

ORAL ANTICOAGULANTS
PA FORM

HEALTH INFORMATION DESIGNS

Prior Authorization Vendor for ND Medicaid

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-773-0695

ND Medicaid requires that patients receiving a new prescription for Pradaxa or Xarelto 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: □ PRADAXA □ XARELTO	**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 Signature		Date	

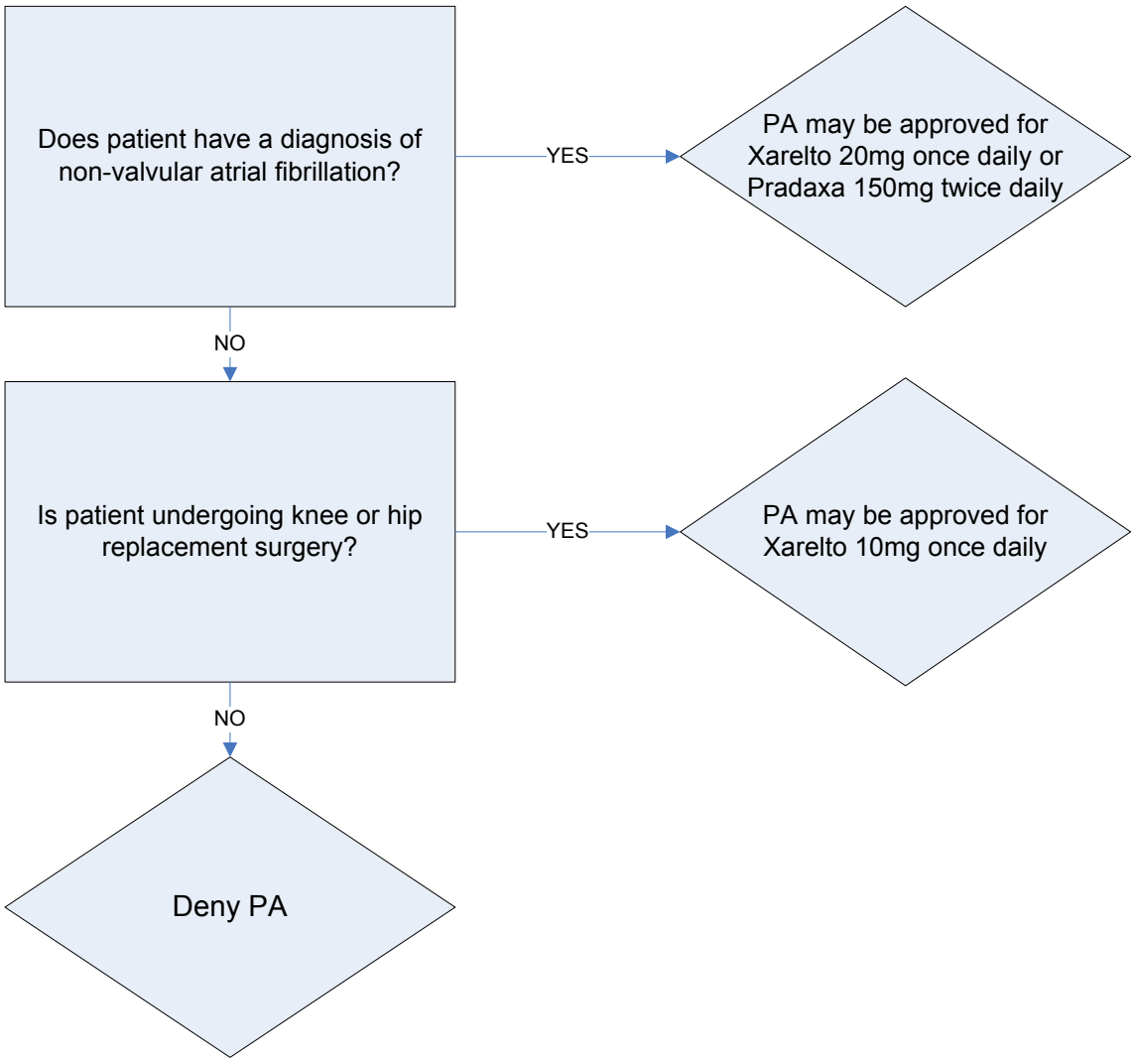
Part II: TO BE COMPLETED BY PHARMACY

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 Anticoagulants Prior Authorization Algorithm



Oravig Prior Authorization

Fax Completed Form to:
866-254-0761
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 Oravig first try fluconazole.
Note:

- ***Fluconazole does 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:			
□ **Medication failed** _____	**Start Date:** **End Date:**	**Dose:** **Frequency:**	
Physician Signature		Date	

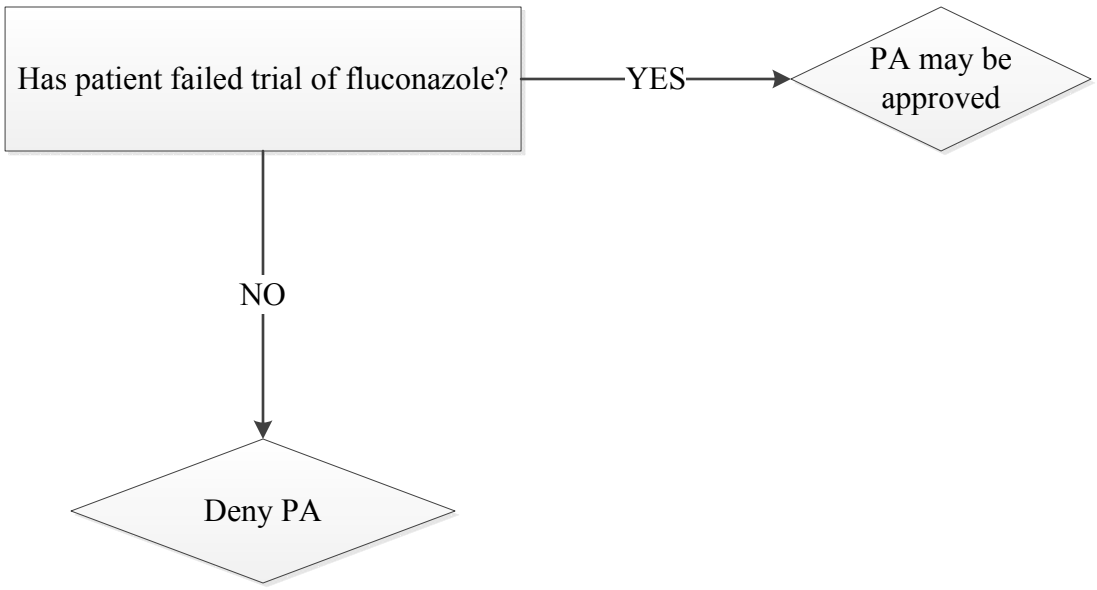
Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
PHONE 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
Oravig Authorization Algorithm



HEALTH INFORMATION DESIGNS

Prior Authorization Vendor for ND Medicaid

OXYCODONE CR
PA FORM

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-773-0695

***Note: The PA may be approved if all of the following criteria are met.**

- **Patient has a chronic pain indication (includes cancer).**
- **Patient has taken an immediate release narcotic for the past 90 days or is switching from another sustained release opioid analgesic.**

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: □ OXYCODONE CR	**DOSAGE:**	**Diagnosis for this request:**	
QUALIFICATIONS FOR COVERAGE: □ CHRONIC MALIGNANT PAIN INDICATION □ CHRONIC NON-MALIGNANT PAIN INDICATION		**LIST IMMEDIATE RELEASE MEDICATION TAKEN:**	
LIST OTHER SUSTAINED RELEASE OPIOID ANALGESIC PATIENT IS SWITCHING FROM:			
□ *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 Signature		Date	

Part II: TO BE COMPLETED BY PHARMACY

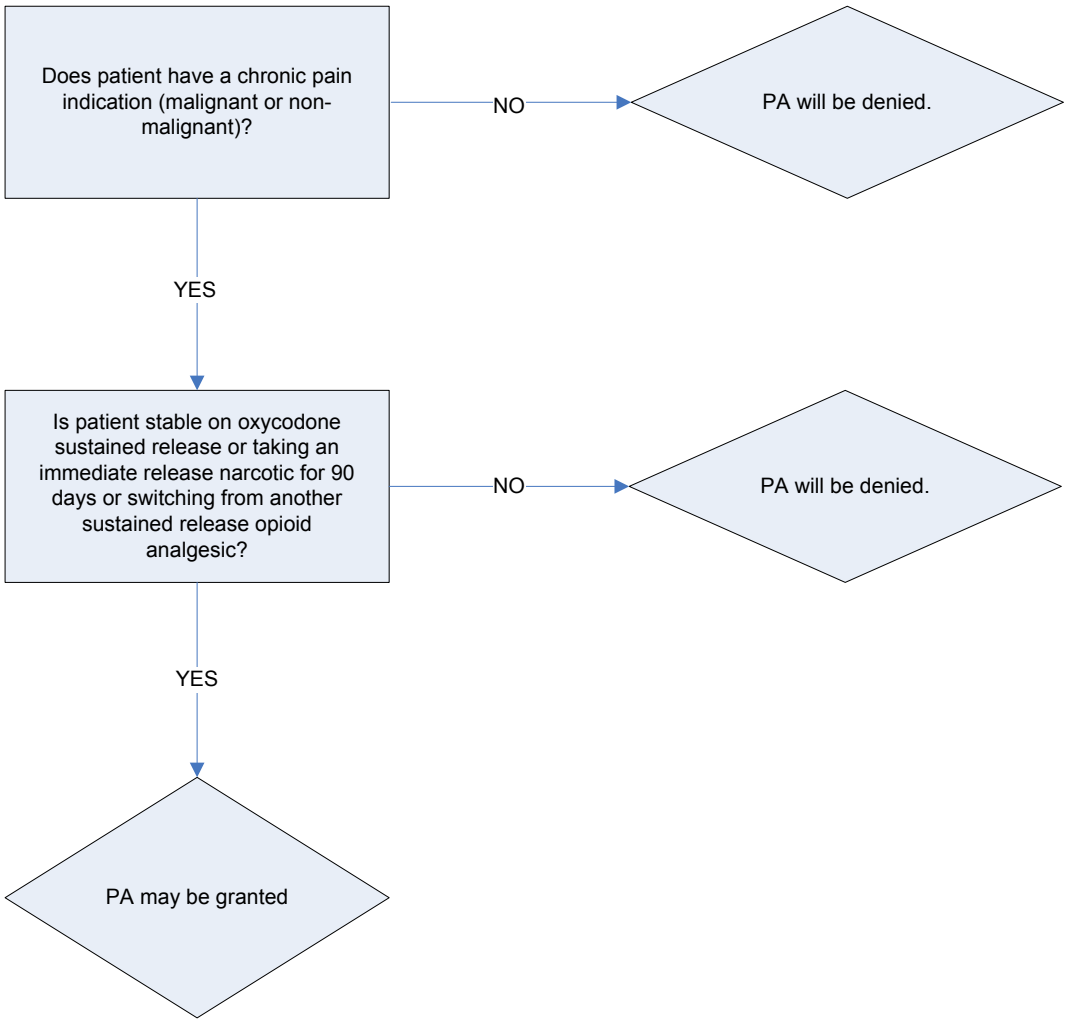
PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

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

Oxycodone CR Prior Authorization Criteria Algorithm



PRIOR AUTHORIZATION REQUEST

ND DEPARTMENT OF HUMAN SERVICES
MEDICAL SERVICES
SFN 1115 (7-2006)

– Please refer to Pharmacy and Durable Medical Equipment Manuals for current prior authorization requirements.

ND Department of Human Services
Medical Services
600 E Boulevard Ave Dept 325
Bismarck ND 58505-0261
701-328-4030

Clear Fields

INSTRUCTIONS: PLEASE READ BACK FOR INSTRUCTIONS.

Patient's Name: Last	First	Middle	Date of Birth:	Client I.D. Number:
Patient's Address:				
Patient's Residence: ☐ NF/Swing Bed ☐ ICF/MR ☐ Basic Care ☐ Private Care				

I. TO BE COMPLETED BY PHYSICIAN

Item Prescribed:	Diagnosis & Prognosis **(Numeric Code)**:
Explanation of Medical Necessity, Duration of Need and Date of Visit:	

I certify that the above-prescribed durable medical equipment/supplies/medication is medically necessary for this patient's well being. In my opinion, this is reasonable and necessary in conformance with accepted standards of medical practice for the treatment of this condition. This has not been prescribed as a convenience to the patient.

Physician's Name: (Please Print)	Provider Number:	Physician's Signature:	Date:

II. TO BE COMPLETED BY PROVIDER (SUPPLIER)

Provider's Name:	Provider's Number:	Telephone Number:	
Provider's Street Address:	City:	State:	Zip Code:
Provider Signature:			Date:

PROPOSED MEDICAL EQUIPMENT OR SUPPLIES						STATE USE ONLY	
HCPC/NDC CODE	List: Item, make/model, units or days, quantity per case, and number of days supply hours/minutes of labor/evaluations. Continue on another page of form if necessary.	**DATE(S) OF SERVICE START/STOP**	**CUSTOMARY OR USUAL RETAIL**	**ACQUISITION COST**	**MOS. OF RENTAL/ QTY PRESCRIBED**	**MAXI REIM**	**APPR DENY**
	1)	Start					
Comments:		Stop					
	2)	Start					
Comments:		Stop					
	3)	Start					
Comments:		Stop					
	4)	Start					
Comments:		Stop					
	5)	Start					
Comments:		Stop					

I acknowledge that the approval of this request does not guarantee the eligibility of the recipient nor ensure payment for services. I understand that eligibility is established by the appropriate county social service board monthly and payment is contingent upon eligibility at the time the service is provided. I also understand that payment for such services may be denied unless prior approval is obtained.

REMARKS: (STATE USE ONLY)

DISTRIBUTION: Original - Submit to Medical Services for approval, a computer printed notice with the assigned request number and approval/denial will be returned. The number must be placed on the claim for payment.

INSTRUCTION FOR COMPLETION:

Section I - To be completed by the prescribing physician, provider name and physician signature are required. Justification for approval or denial of the medical equipment or supplies will be based upon this information. Along with the diagnosis, a comprehensive explanation of MEDICAL NECESSITY must confirm the prescription.

Section II - To be completed by the **provider (supplier)** of service. Complete name, address, telephone number and provider number should be entered. The proposed medical equipment/supplies/or medication to be described and listed separately. The description must be complete enough for the Department of Human Services to verify your customary or usual retail charge; acquisition cost must be indicated for all items (See DMEOPS Manual for rental specifics.) Upon completion, provider should **mail the original copy only** to: Medical Services, Department of Human Services, 600 East Boulevard Avenue, Bismarck, ND 58505-0261.

PRIOR AUTHORIZATION PROCESS:

1. The Department of Human Services will review, approve/deny, and key the request. A computer generated response with an assigned prior authorization number will be returned to the provider.

2. Upon approval, HCFA 1500 billers should enter the assigned prior approval number on the claim form before submitting to Medical Services for payment. The assigned prior approval number should **not** be submitted on pharmacy point-of-sale claims as the claims edit process locates and inserts the prior approval number electronically. Date(s) of Service must be indicated when submitting claims to this department for payment.

The Maximum Reimbursement listed is based on North Dakota Medical Services' fee. If other payor's/insurance is involved in the settlement of this claim, the Department of Human Services will abide by other payor's/insurance adjudication and accept other payor's/insurance allowable amount if different than the amount listed and adjudicate payment of deductible(s) and coinsurance amount(s).

HEALTH INFORMATION DESIGNS

Prior Authorization Vendor for ND Medicaid

Proton Pump Inhibitor PA Form

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-773-0695

ND Medicaid requires that patients receiving proton pump inhibitors must use Prilosec OTC, Prevacid 24HR, Omeprazole, or Pantoprazole as first line.

__Note:__

- **Prilosec OTC, Prevacid 24HR, Omeprazole and Pantoprazole may be prescribed WITHOUT prior authorization. Prilosec OTC and Prevacid 24HR are covered by Medicaid when prescribed by a physician.**
- **Prior Authorization is NOT required for patients < 13 years of age.**
- **Patients must use Prilosec OTC, Prevacid 24HR, omeprazole, or pantoprazole for a minimum of 14 days for the trial to be considered a failure. Patient preference does not constitute a failure.**
- **Net cost to Medicaid: Prilosec OTC = Prevacid 24HR = Omeprazole = Pantoprazole <<< Lansoprazole << Aciphex << Nexium << Zegerid <<< Dexilant.**

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: □ Aciphex □ Lansoprazole □ Nexium □ Zegerid □ Dexilant	**Requested Dosage:** (must be completed) **Diagnosis for this request:**

Qualifications for coverage:

❑ Failed Prilosec OTC/Prevacid 24HR/Omeprazole/Pantoprazole therapy	Start Date: End Date:	Dose: Frequency:
□ Pregnancy – Due Date		
□ Inability to take or tolerate oral tablets (must check a box) □ Tube Fed □ Requires soft food or liquid administration □ Other (provide description)		
□ Adverse reaction (attach FDA Medwatch form) to omeprazole/lansoprazole.		
□ *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 Signature:		Date:

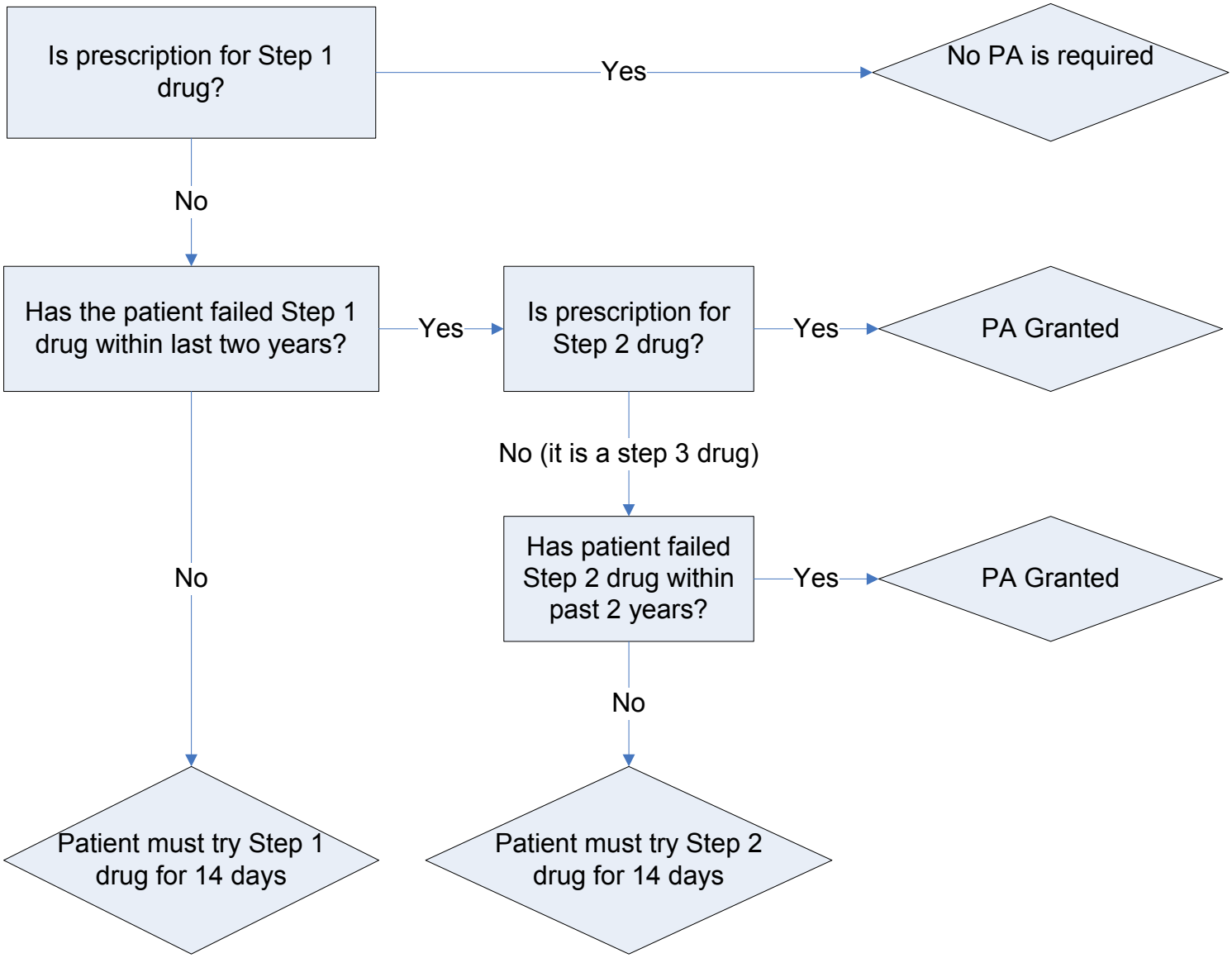
Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:		ND MEDICAID PROVIDER NUMBER:
Phone:		FAX:
Drug:		NDC#:

Part III: FOR OFFICIAL USE ONLY

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

North Dakota Department of Human Services
Proton Pump Inhibitor Authorization Criteria Algorithm



Please Note:

Step 1 drug is defined as Prilosec OTC, Prevacid 24HR, omeprazole, and pantoprazole

Step 2 drug is defined as lansoprazole

Step 3 drug is defined as Nexium, Aciphex, Zegerid and Dexilant (which is 5-8 times more expensive)

QUALAQUIN PA FORM

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid will cover Qualaquin with a diagnosis of Malaria.

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: ☐ **QUALAQUIN**	**Requested Dosage:** (must be completed)

Qualifications for coverage:

☐ Diagnosis of malaria

☐ *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 Signature: Date:

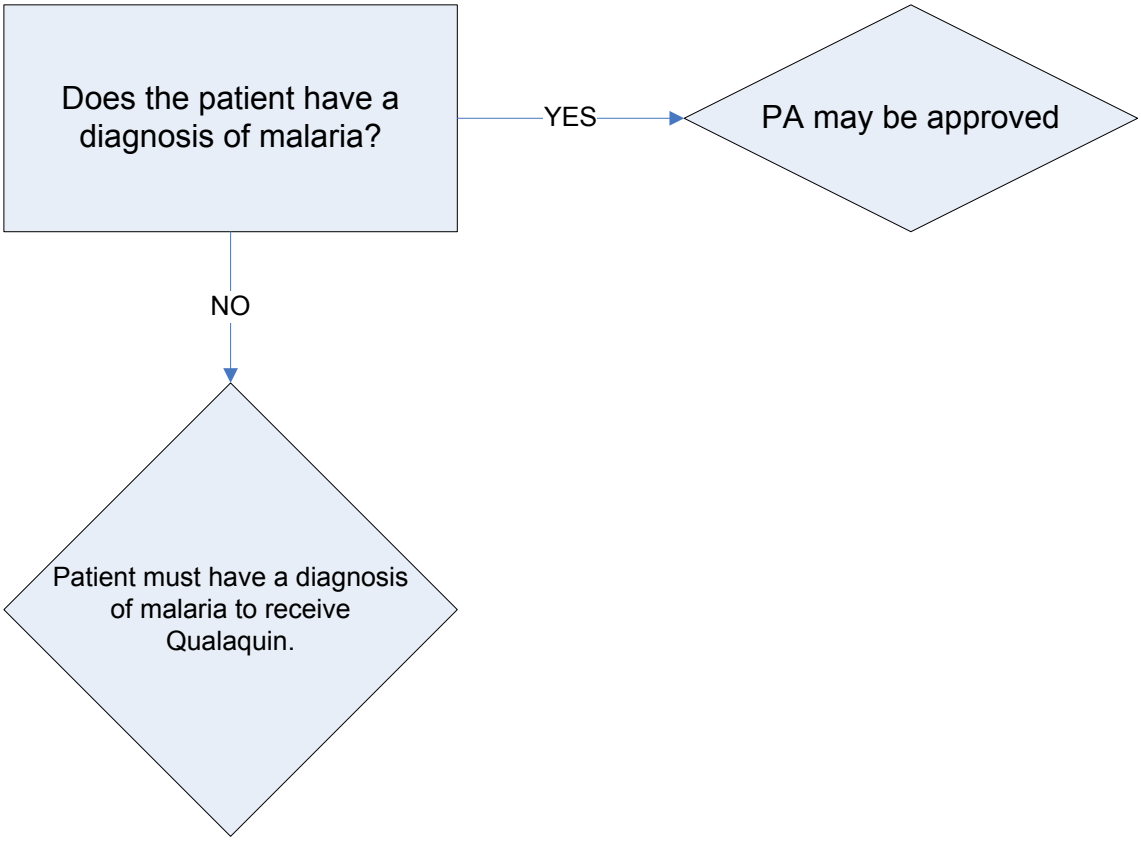
Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:	ND MEDICAID PROVIDER NUMBER:
Phone:	FAX:
Drug:	NDC#:

Part III: FOR OFFICIAL USE ONLY

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

North Dakota Department of Human Services
Qualaquin Criteria Algorithm



Relistor Prior Authorization

Fax Completed Form to:
866-254-0761
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 Relistor must meet the following guidelines:

- Diagnosis of opioid-induced constipation
- Inability to tolerate oral medications *or*
- Failed two oral medications

Note:
***Polyethylene glycol powder is covered without a prior authorization.**

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: □ **Relistor**	**Diagnosis for this request:**		
Qualifications for coverage:			
FIRST FAILED MEDICATION	START DATE:	END DATE:	
SECOND FAILED MEDICATION	START DATE:	END DATE:	
□ INABILITY TO TOLERATE ORAL MEDICATIONS			
Prescriber Signature		Date	

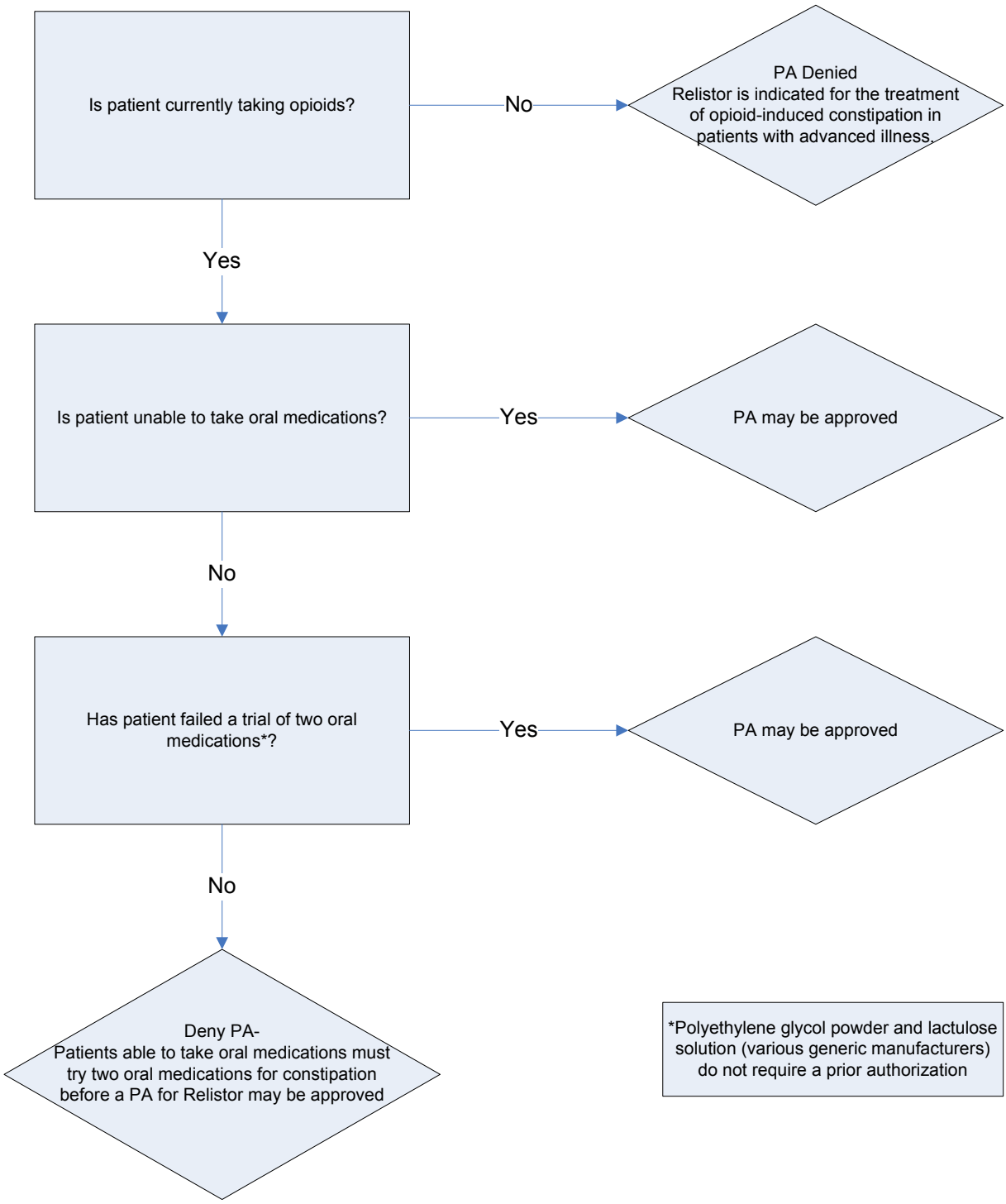
Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
PHONE 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
Relistor Authorization Algorithm



Revatio/Adcirca
Prior Authorization Form

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving Revatio or Adcirca must have a diagnosis of Pulmonary Arterial Hypertension based on WHO (Group I) Classification for Pulmonary Hypertension.

****Note:***

- ***Patients taking Nitrates or Viagra/Levitra/Cialis will not receive a PA***

Part I: TO BE COMPLETED BY PRESCRIBER

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber Medicaid Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: ☐ **Revatio** ☐ **Adcirca**	**Diagnosis for this request:**		
Qualifications for coverage:			
☐ Indication for the treatment of Pulmonary Arterial Hypertension (WHO Group I Classification)			
Prescriber Signature	Date		

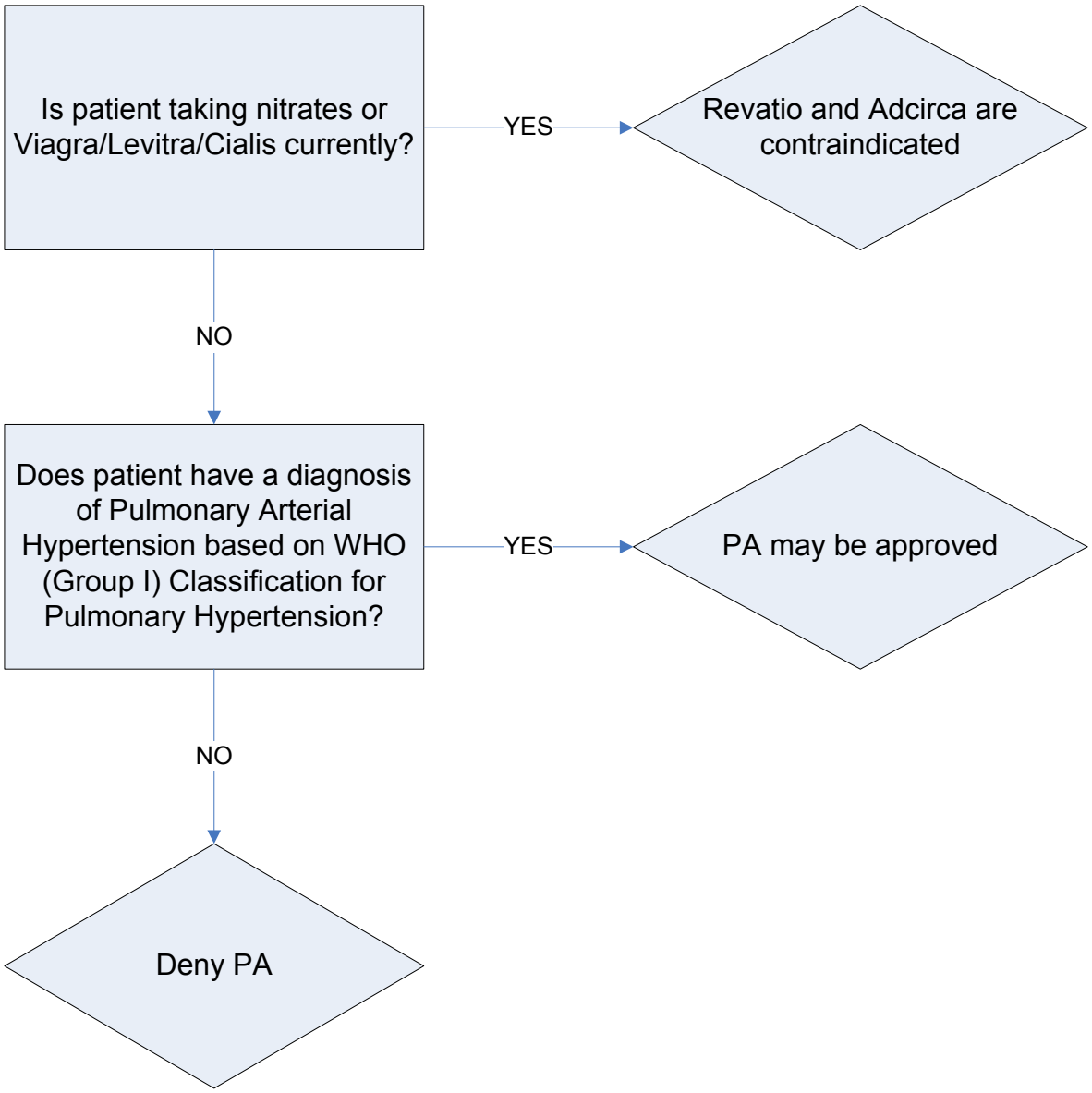
Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
PHONE 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
Revatio/Adcirca Authorization Algorithm



RIBAPAK PA FORM

Prior Authorization Vendor for ND Medicaid

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-773-0695

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**	**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.			
Physician Signature	Date		

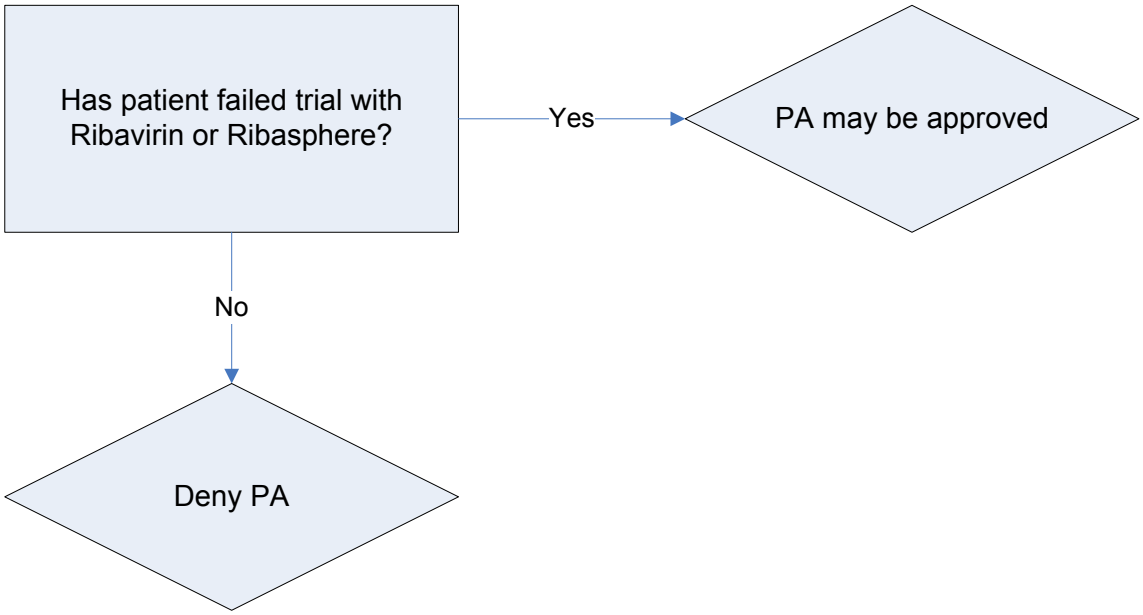
Part II: TO BE COMPLETED BY PHARMACY

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
Ribapak Prior Authorization Algorithm



Sancuso Prior Authorization

Fax Completed Form to:
866-254-0761
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 Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ **Sancuso**	**Diagnosis for this request:**		
Qualifications for coverage:			
□ FAILED MEDICATION	START DATE: END DATE:	DOSE: FREQUENCY:	
□ PATIENT UNABLE TO TAKE ORAL MEDICATIONS			
Prescriber Signature		Date	

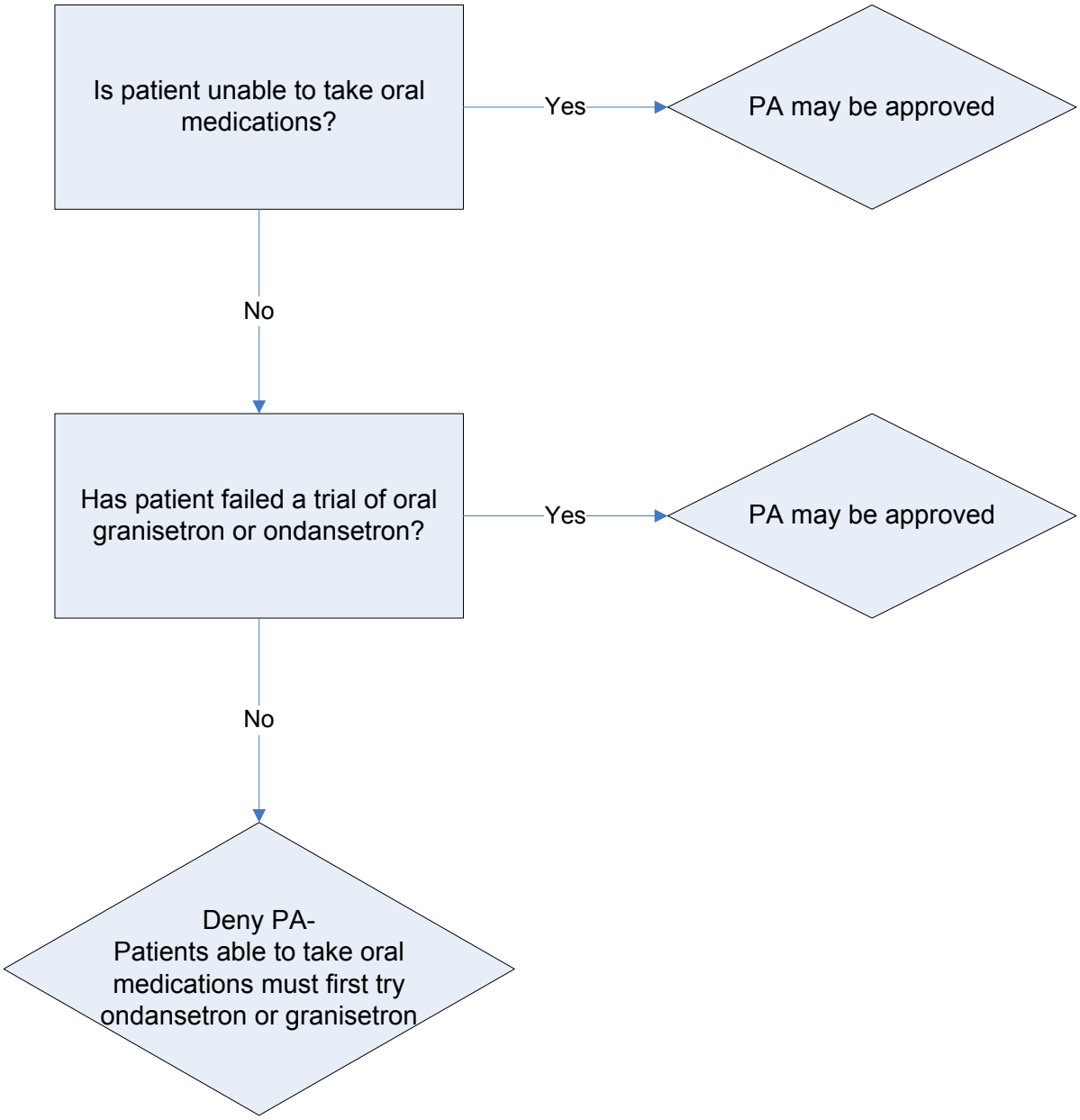
Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
PHONE 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
Sancuso Authorization Algorithm



HEALTH INFORMATION DESIGNS

Prior Authorization Vendor for ND Medicaid

Sedative/Hypnotic PA Form

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-773-0695

ND Medicaid requires that patients receiving a new prescription for a name brand Sedative/Hypnotic must use Ambien® (zolpidem) as first line therapy.

Note:

- **The PA will be approved if there is a failed trial of Ambien (zolpidem).**
- **Estazolam, flurazepam, temazepam, triazolam, quazepam and Ambien (zolpidem) 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 Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:	**Diagnosis for this request:**		
Qualifications for coverage:			
□ FAILED AMBIEN (ZOLPIDEM)	Start Date: End Date:	Dose: Frequency:	
□ HIGH RISK FOR ADDICTION			
□ *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 Signature		Date	

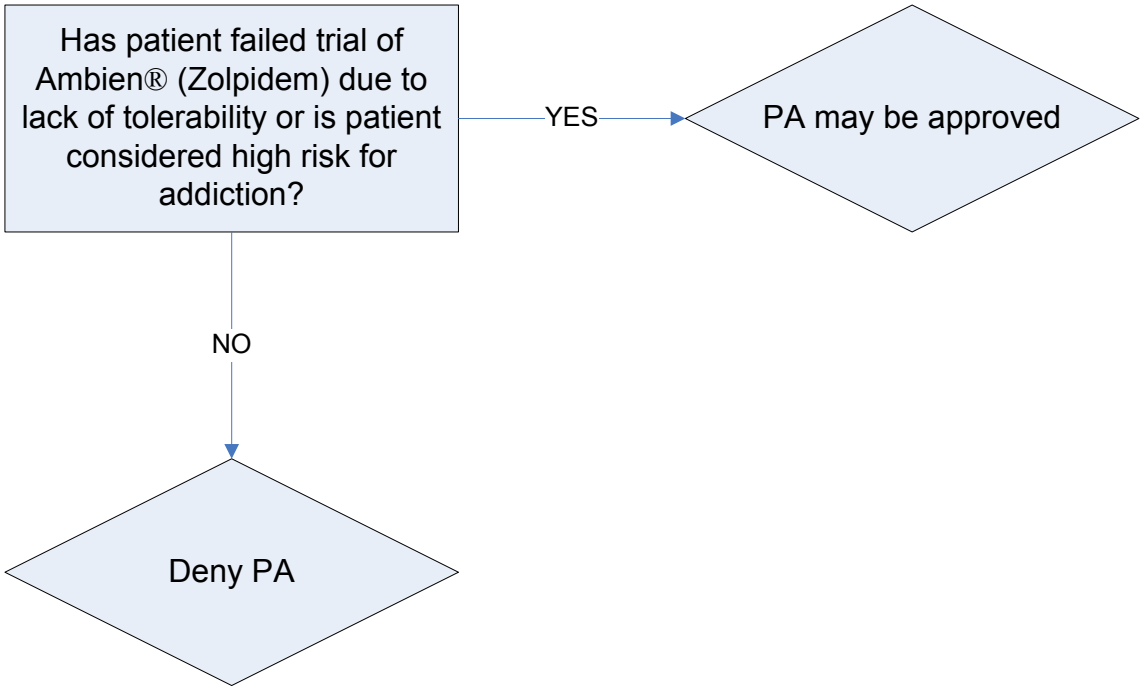
Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
PHONE 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
Sedative/Hypnotic Authorization Algorithm



Short-Acting HFA Beta$_2$ Agonist PA FORM

HEALTH INFORMATION DESIGNS

Prior Authorization Vendor for ND Medicaid

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-773-0695

ND Medicaid requires that patients receiving a new prescription for ProAir HFA, Ventolin HFA, or Xopenex HFA must use Proventil HFA as first line therapy.

***Note: Proventil HFA does not require a prior authorization.**

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: □ XOPENEX HFA □ VENTOLIN HFA □ PROAIR HFA	**Diagnosis for this request:**		

Qualifications for coverage:

□ Failed Proventil HFA 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 Signature	Date

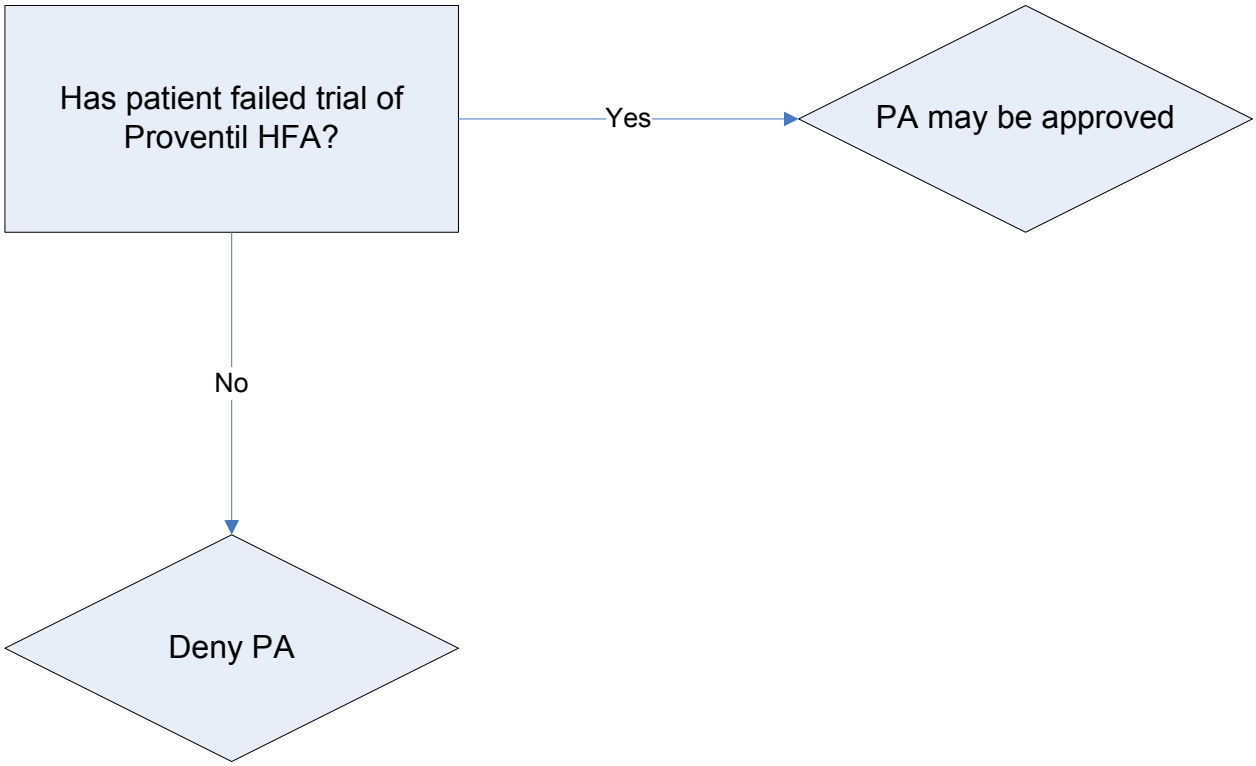
Part II: TO BE COMPLETED BY PHARMACY

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 Short-Acting Beta$_2$ Agonist Authorization Algorithm



SOLODYN PA FORM

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

Note: ND Medicaid will not pay for Solodyn without documented failure of a first line tetracycline agent.

- First line agents include: doxycycline, minocycline, and tetracycline.

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: □ **SOLODYN**	**Requested Dosage:** (must be completed)

Qualifications for coverage:

□ Patient has failed a 90 day trial of which first line agent _____

□ *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 Signature: Date:

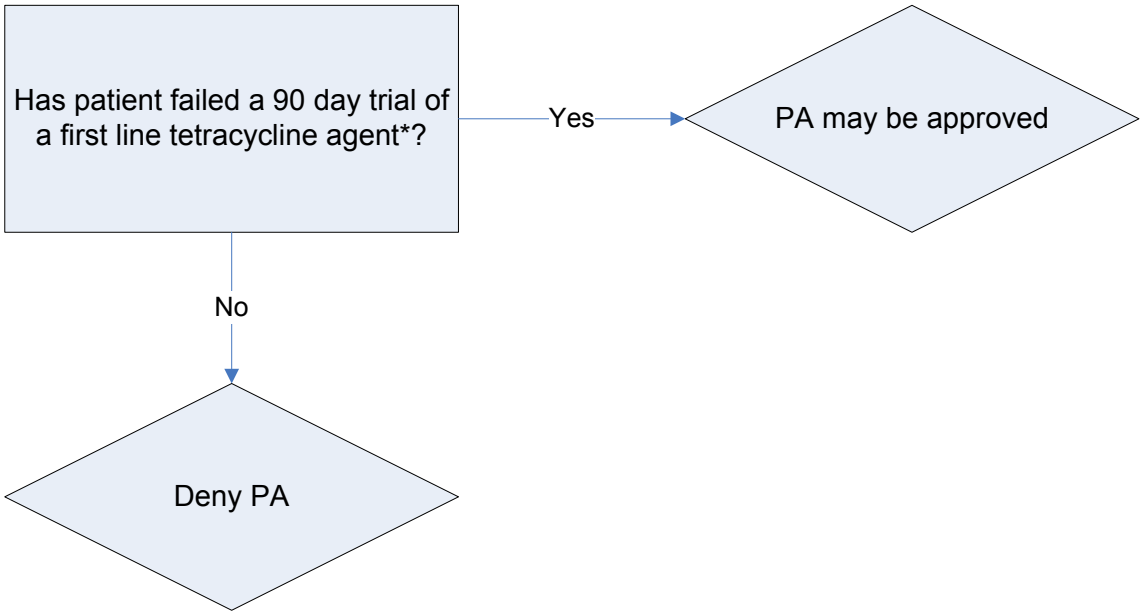
Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:	ND MEDICAID PROVIDER NUMBER:
Phone:	FAX:
Drug:	NDC#:

Part III: FOR OFFICIAL USE ONLY

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

North Dakota Department of Human Services
Solodyn Prior Authorization Algorithm



*Doxycycline, minocycline, and tetracycline do not require a PA and cost approximately $3 - $40 for a course of therapy compared to $775 dollars for Solodyn.

SOMA 250mg PA FORM

Prior Authorization Vendor for ND Medicaid

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-773-0695

ND Medicaid requires that patients using brand name Soma 250mg must use generic carisoprodol 350mg first line.

***Note: The PA will be approved if recipient fails a trial of carisoprodol 350mg.**

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: □ SOMA 250MG	**Diagnosis for this request:**		

Qualifications for coverage:

□ Failed skeletal muscle relaxant 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 Signature	Date

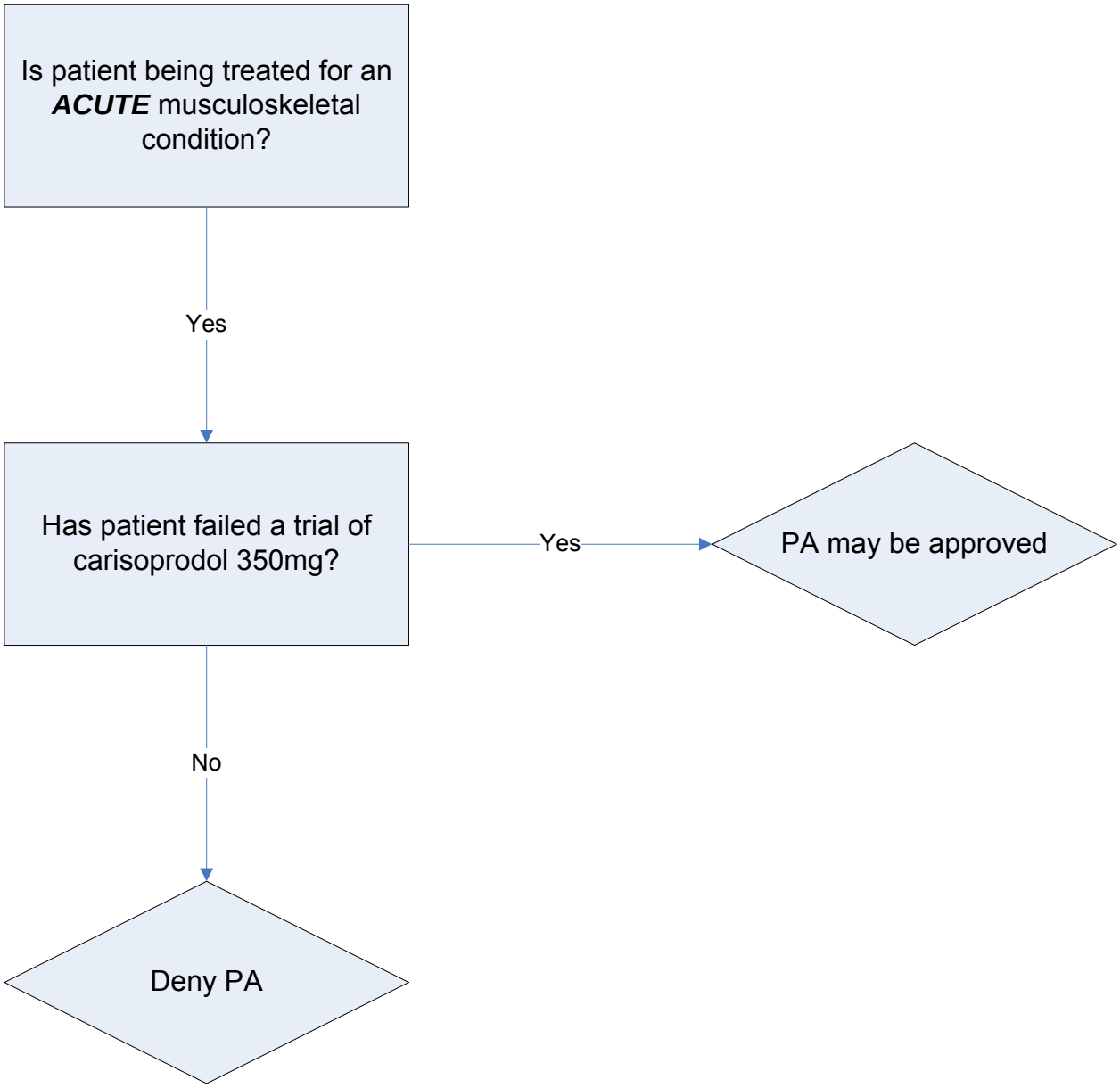
Part II: TO BE COMPLETED BY PHARMACY

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
Soma 250mg Authorization Algorithm



SUBOXONE/SUBUTEX PA FORM

Prior Authorization Vendor for ND Medicaid

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-773-0695

ND Medicaid requires that patients receiving a new prescription for Suboxone and Subutex 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 Suboxone/Subutex 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	
Physician Name	**(SAMHSA ID)**		
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ SUBOXONE □ SUBUTEX	**FDA Approved Indication for this request:**		
□ Patient is not taking other opioids, tramadol, or carisoprodol concurrently with Suboxone or Subutex.			
Physician Signature	Date		

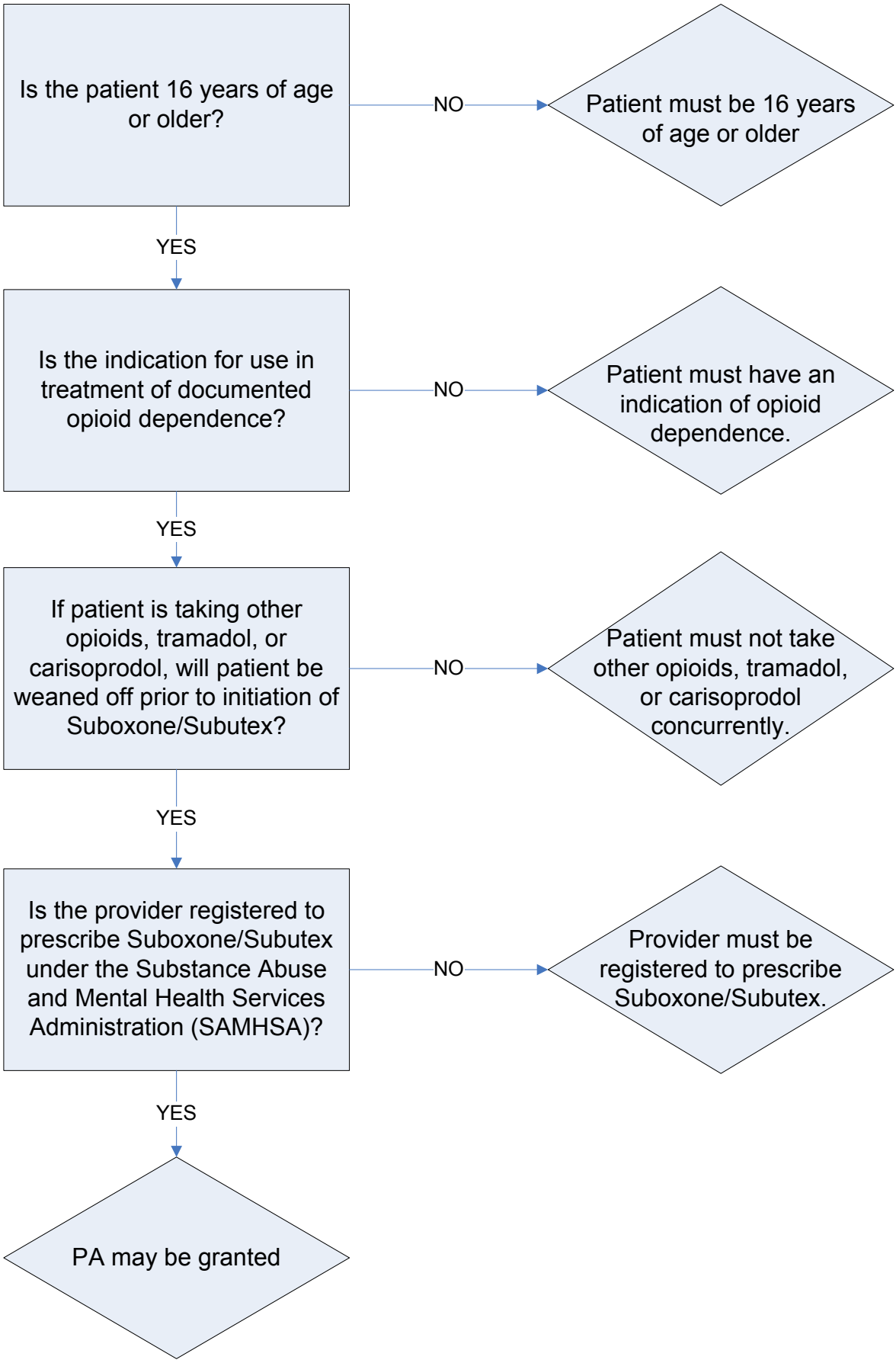
Part II: TO BE COMPLETED BY PHARMACY

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
Suboxone/Subutex Authorization Algorithm



LOCAL ANESTHETICS (TOPICAL) PA FORM

HEALTH INFORMATION DESIGNS

Prior Authorization Vendor for ND Medicaid

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-773-0695

ND Medicaid requires that patients receiving a new prescription for a 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	
Physician Name			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: ☐ EMLA ☐ SYNERA	**Medical Procedure:**		
Physician Signature		Date	

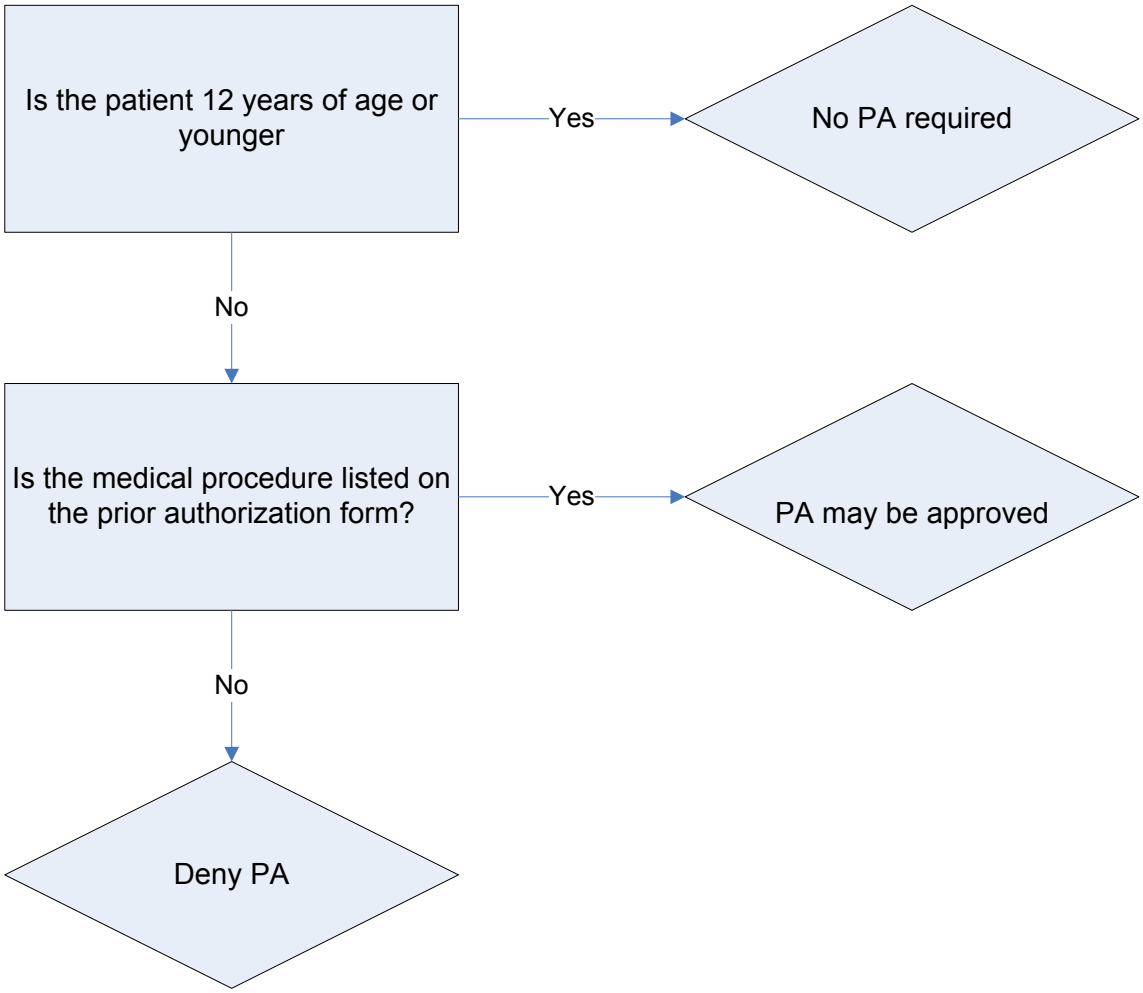
Part II: TO BE COMPLETED BY PHARMACY

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
Local Anesthetics (Topical) Prior Authorization Algorithm



Topical Ketoconazole Products
Prior Authorization

Fax Completed Form to:
866-254-0761
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:	
Physician Signature		Date	

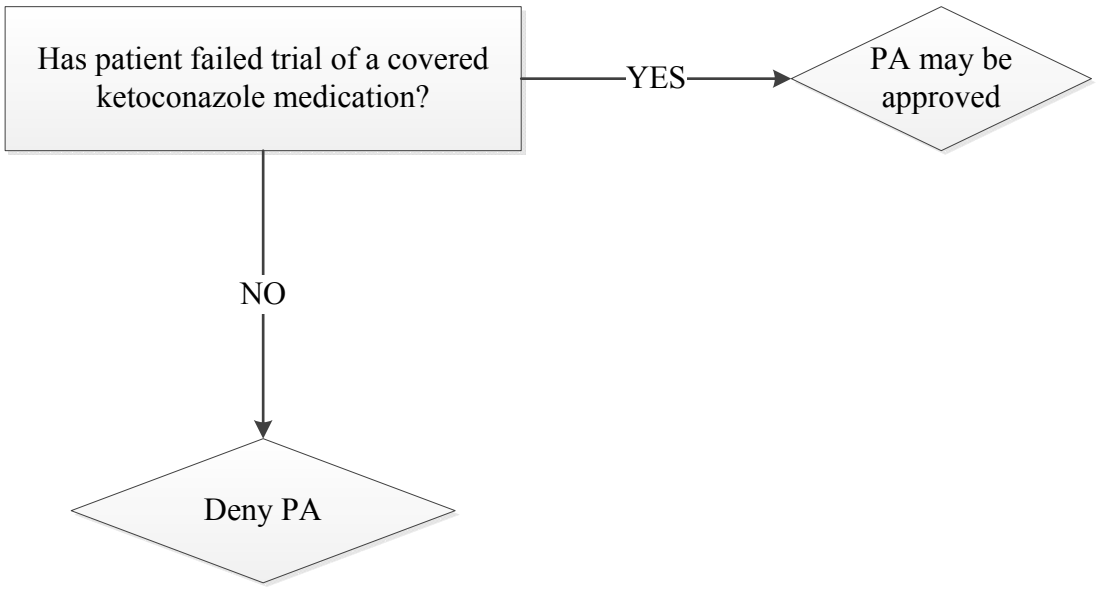
Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
PHONE 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
Topical Ketoconazole Products Authorization Algorithm



TRAMADOL ER PA FORM

HEALTH INFORMATION DESIGNS

Prior Authorization Vendor for ND Medicaid

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-773-0695

ND Medicaid requires that patients receiving a new prescription for tramadol ER (Ultram ER/Ryzolt) or tramadol ODT (Rybix) must meet the following criteria:

- **Documented failure of a 30-day trial of generic immediate release tramadol at maximum daily dosage of 400mg per day.**

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: □ ULTRAM ER OR GENERIC □ RYZOLT □ RYBIX	**Diagnosis for this request:**

FAILED THERAPY	**START DATE**	**END DATE**	**DOSE**	**FREQUENCY**

Physician Signature	Date

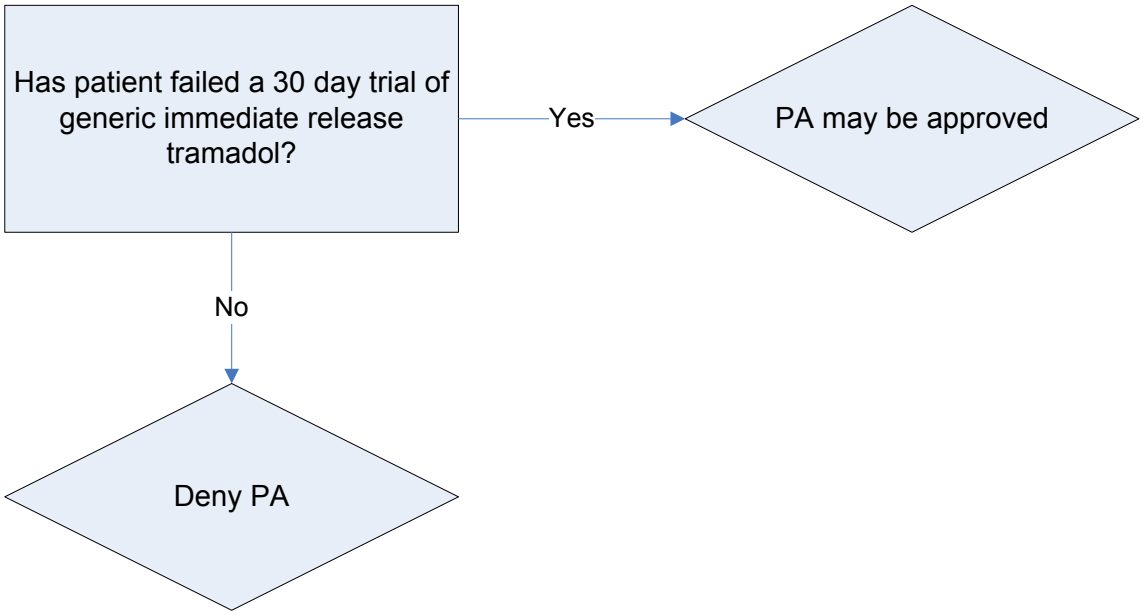
Part II: TO BE COMPLETED BY PHARMACY

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
Tramadol ER Prior Authorization Algorithm



Serotonin (5-HT$_1$) Receptor Agonists - Triptan PA FORM

HEALTH INFORMATION DESIGNS

Prior Authorization Vendor for ND Medicaid

Fax Completed Form to: 866-254-0761
For questions regarding this Prior authorization, call 866-773-0695

ND Medicaid requires that patients receiving a new prescription for Axert, Frova, Maxalt, Relpax, Treximet, or Zomig must try sumatriptan then naratriptan as first line therapies.

*__Note:__

- **Sumatriptan and naratriptan do not require a PA.**
- **Injectables are not subject to a prior authorization at this time.**

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:**
□ RELPAX □ MAXALT □ AXERT □ TREXIMET □ FROVA □ ZOMIG	

Qualifications for coverage:

□ Failed sumatriptan therapy	Start Date	End Date	Dose	Frequency
□ Failed naratriptan 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 Signature	Date

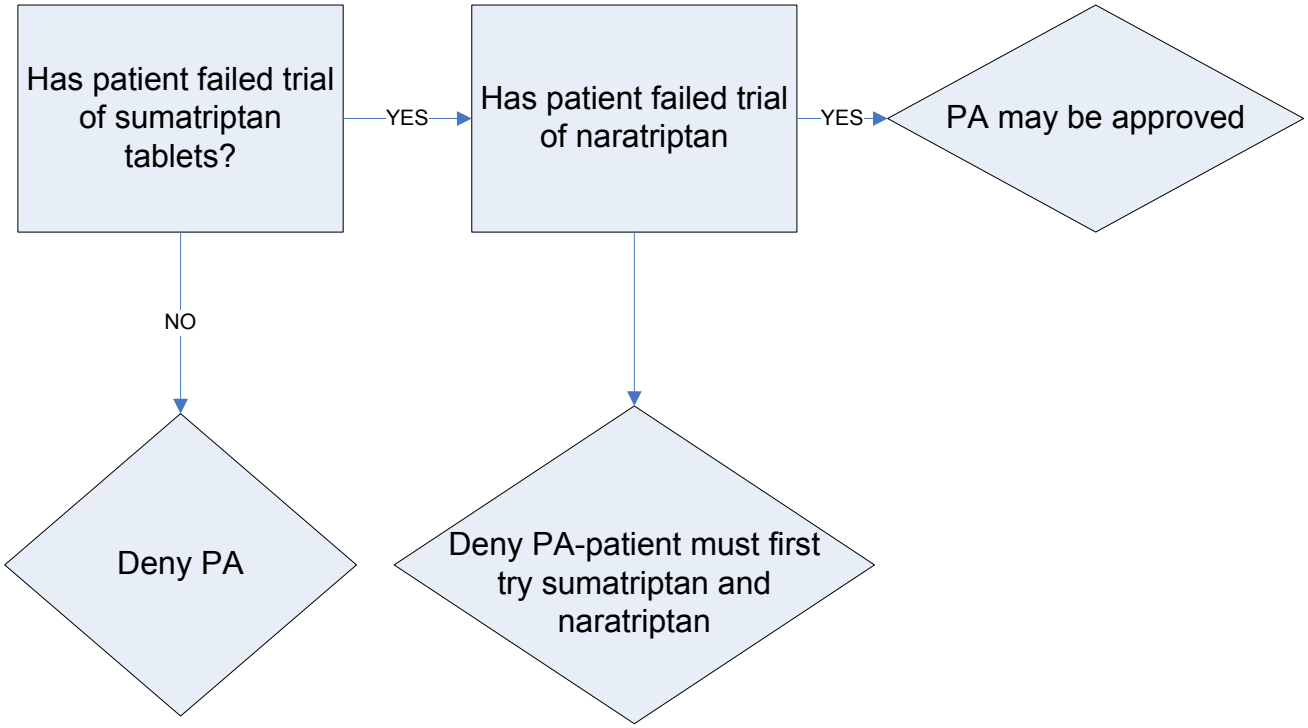
Part II: TO BE COMPLETED BY PHARMACY

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
Serotonin (5-HT_1) Receptor Agonists
Triptan Prior Authorization Algorithm



ULORIC PA FORM

Prior Authorization Vendor for ND Medicaid

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-773-0695

ND Medicaid requires that patients receiving a new prescription for Uloric must try allopurinol as first line therapy or have documented renal/hepatic dysfunction.

- Allopurinol does not require a prior authorization.
- Allopurinol doses must be 300 mg or greater to be considered failed 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
Requested Drug and Dosage: □ ULORIC	**Diagnosis for this request:**		

Qualifications for coverage:

□ FAILED ALLOPURINOL THERAPY	Start Date	End Date	Dose	Frequency
□ RENAL OR HEPATIC IMPAIRMENT				
□ *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.*				
Physician Signature			Date	

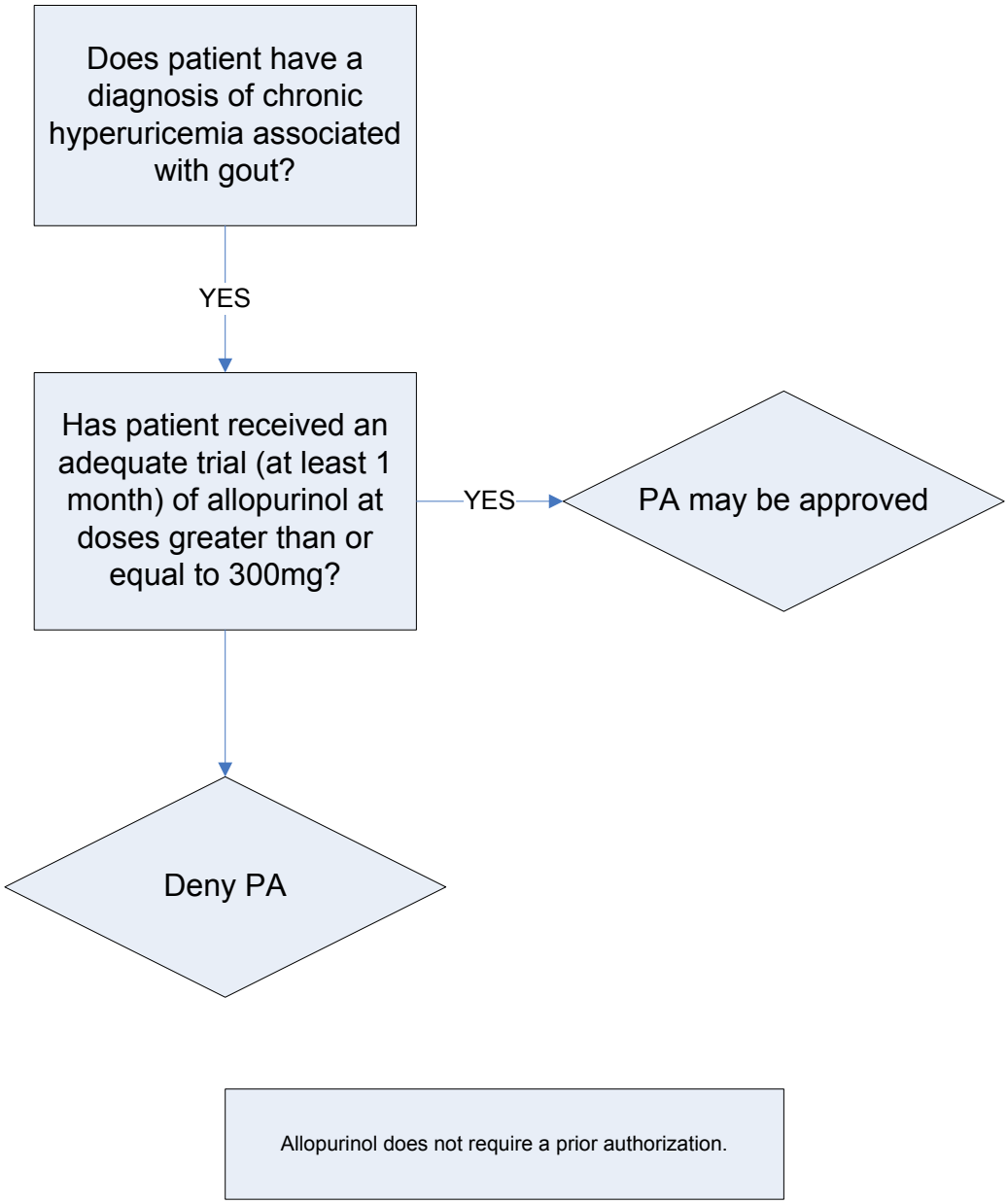
Part II: TO BE COMPLETED BY PHARMACY

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
Uloric Authorization Algorithm



Vusion PA FORM

Prior Authorization Vendor for ND Medicaid

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-773-0695

ND Medicaid requires that patients receiving a new prescription for Vusion must try other topical antifungal products as first line therapy.

***Note: Nystatin and clotrimazole do not require a prior authorization.**

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 and Dosage: □ VUSION	**Diagnosis for this request:**		

Qualifications for coverage:

□ Failed antifungal therapy Name of medication failed: _____	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 Signature	Date

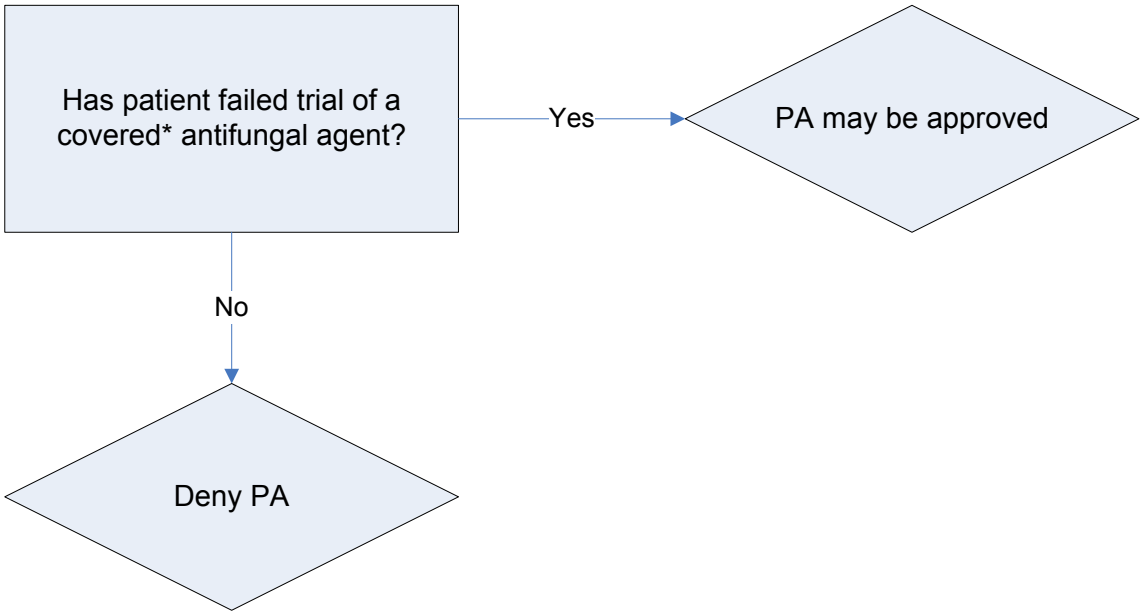
Part II: TO BE COMPLETED BY PHARMACY

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
Vusion Prior Authorization Algorithm



*Nystatin and clotrimazole do not require a PA and cost approximately $6 - $36 for a course of therapy compared to $246 for a course of Vusion therapy.

Xenical Prior Authorization

Fax Completed Form to:
866-254-0761
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 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: □ XENICAL	**Diagnosis for this request:**		
Qualifications for coverage:			
□ Dietician evaluation attached	Height:	Weight:	BMI:
Prescriber Signature		Date	

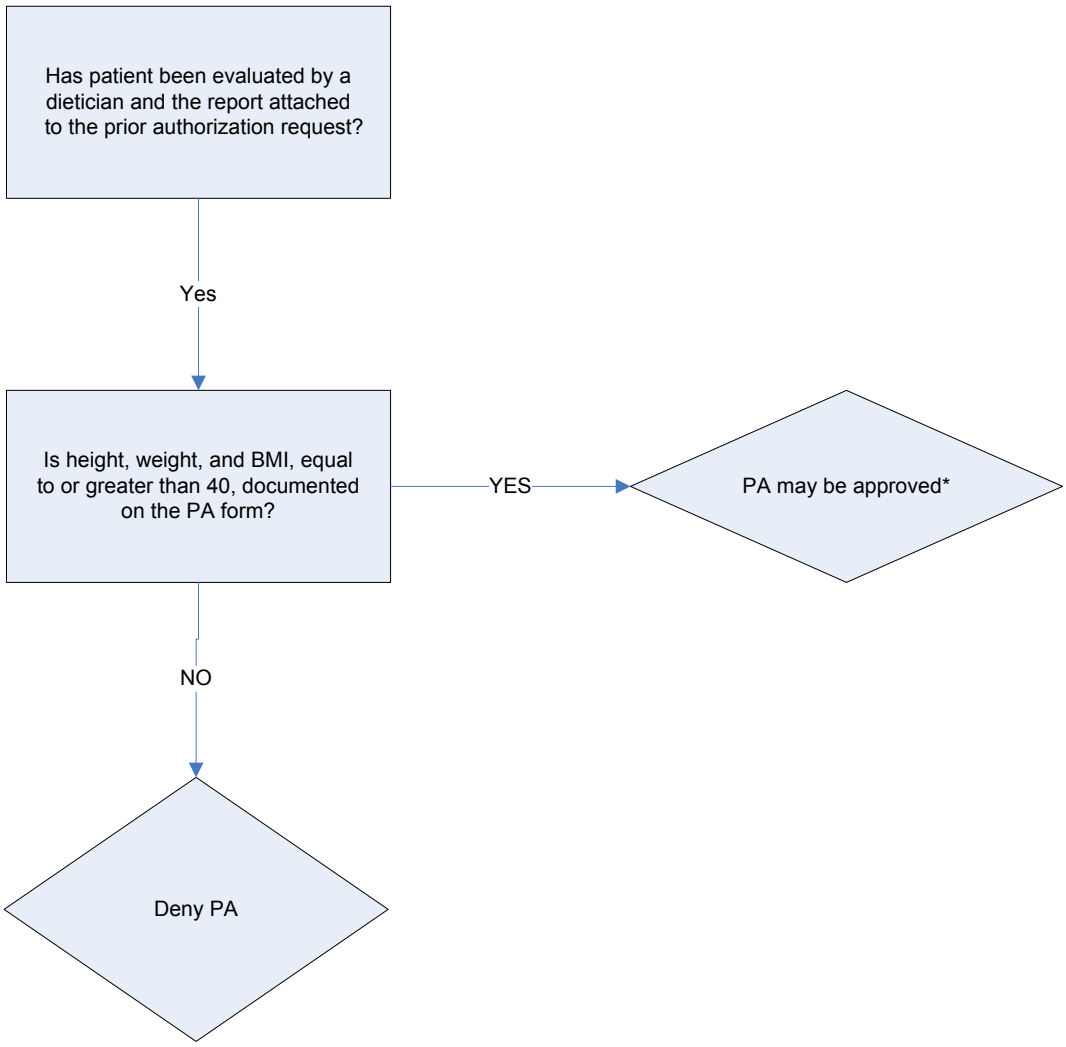
Part II: TO BE COMPLETED BY PHARMACY

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
Xenical Prior Authorization Criteria



*5% weight loss must be realized for continued approval every 6 months.

XOLAIR PA FORM

HEALTH INFORMATION DESIGNS

Prior Authorization Vendor for ND Medicaid

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-773-0695

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

- **Patient must have moderate to severe persistent asthma**
- **Patient must have serum IgE level between 30 and 700 IU/mL**

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: □ XOLAIR	**Diagnosis for this Request:**	**Serum IgE Level:**
Physician Signature		Date

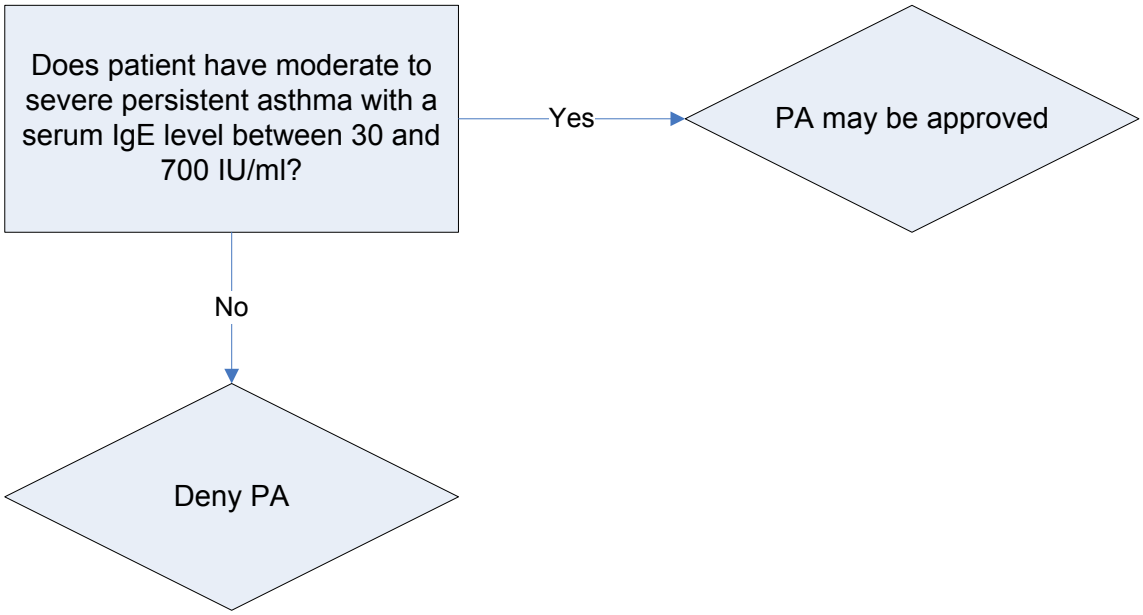
Part II: TO BE COMPLETED BY PHARMACY

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
Xolair Prior Authorization Algorithm



Xyrem Prior Authorization

Fax Completed Form to:
866-254-0761
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 Success Program***

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: □ **Xyrem**	**Diagnosis for this request:**		
Qualifications for coverage:			
□ Enrolled in Xyrem Success Program	Enrolled Date:	Dose:	
Physician Signature		Date	

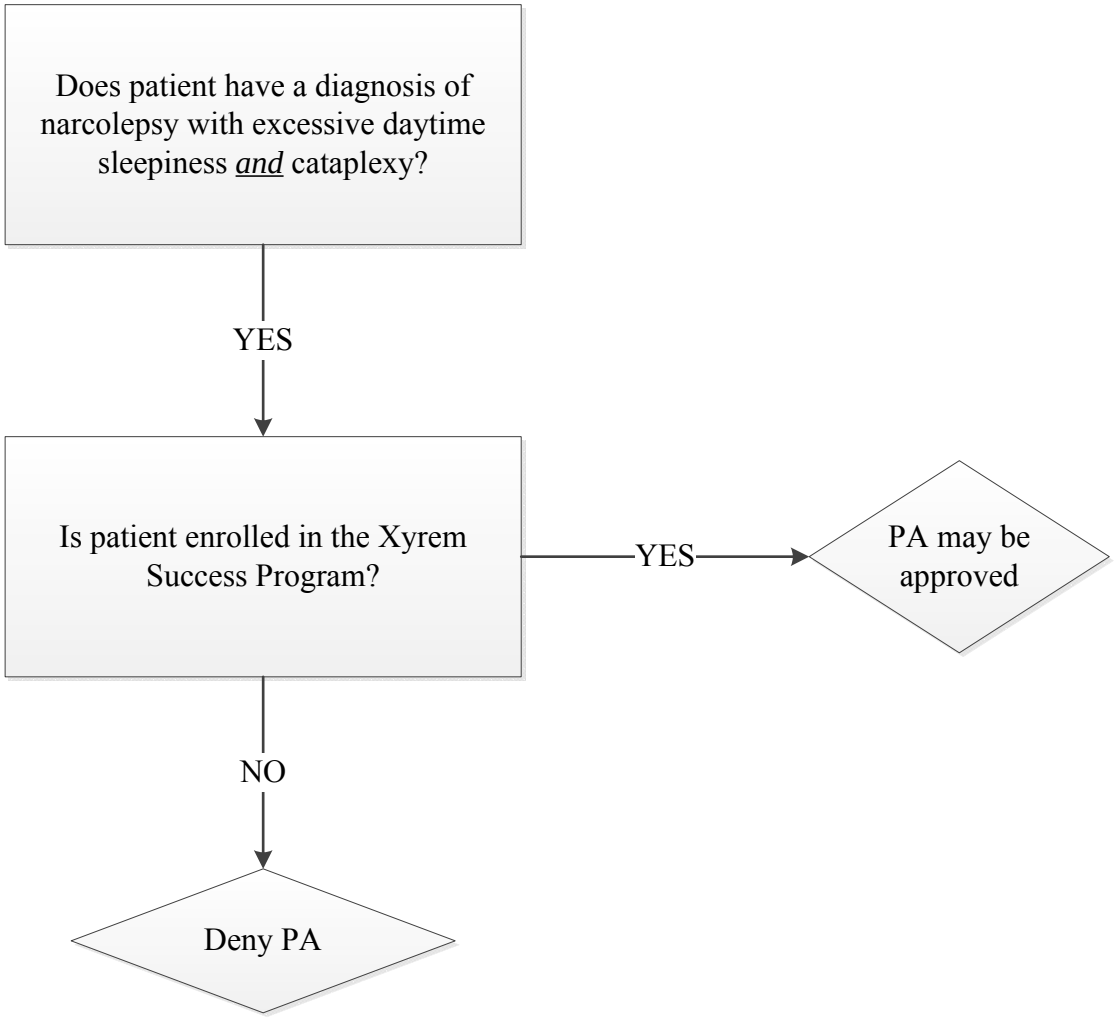
Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
PHONE 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
Xyrem Authorization Algorithm



HEALTH INFORMATION DESIGNS

Prior Authorization Vendor for ND Medicaid

Zanaflex Capsule PA Form

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-773-0695

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:**		
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 Signature		Date	

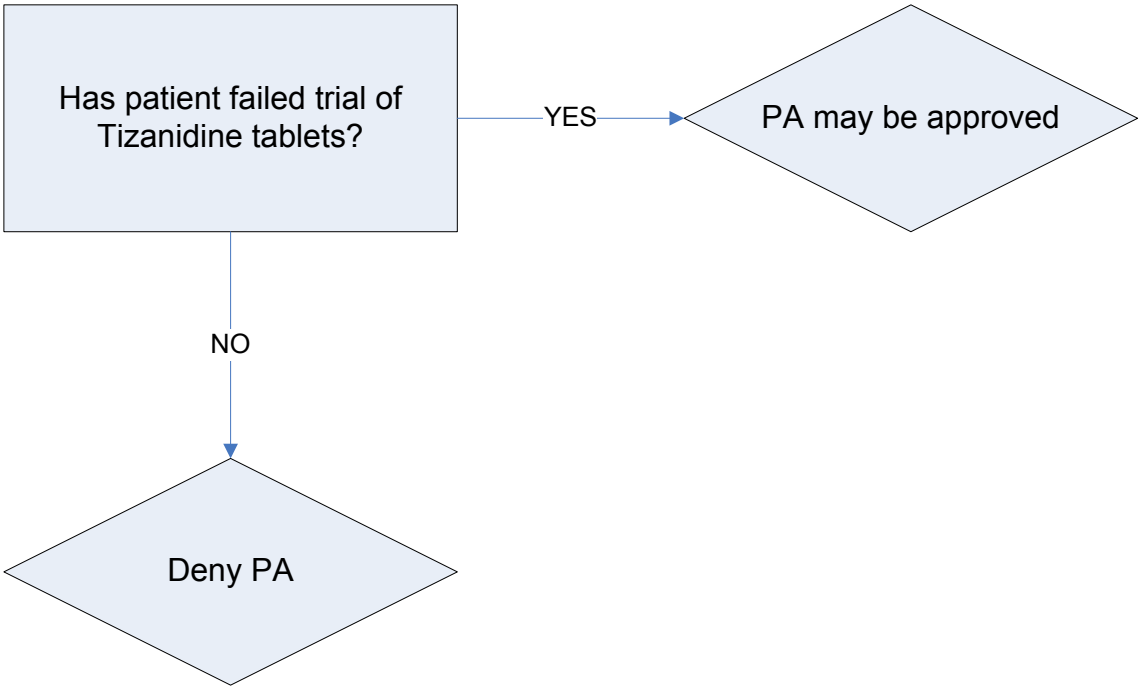
Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
PHONE 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
Zanaflex Authorization Algorithm



Zyclara Prior Authorization

Fax Completed Form to:
866-254-0761
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 Zyclara first try imiquimod.
Note:

- ***Imiquimod does 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: □ **Zyclara**	**Diagnosis for this request:**		
Qualifications for coverage:			
□ **Trial of imiquimod** **Start Date** **End Data**			
Physician Signature	Date		

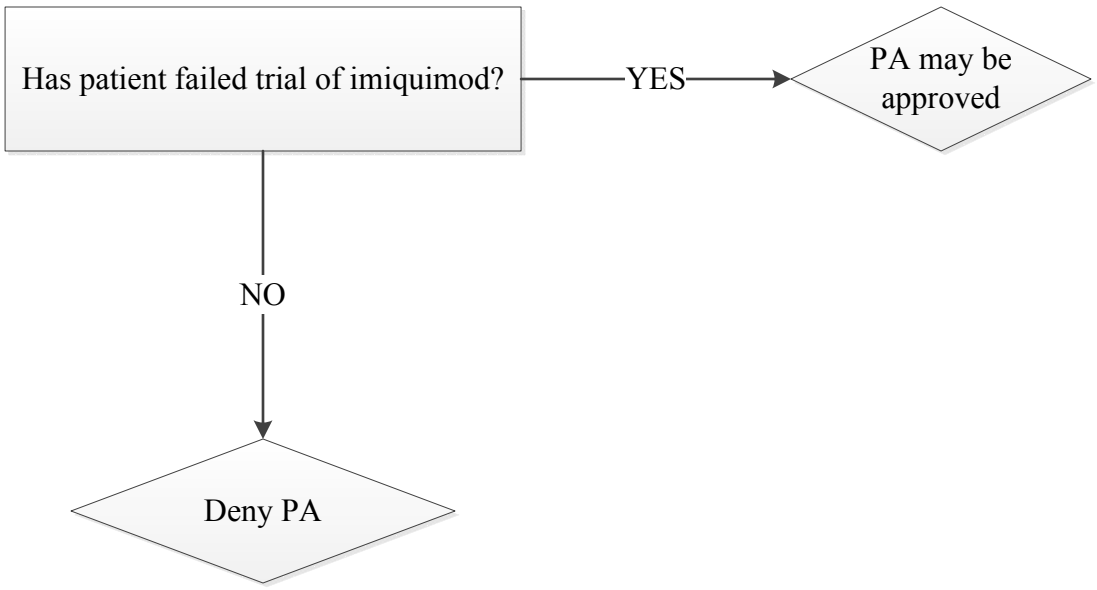
Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
PHONE 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
Zyclara Authorization Algorithm



Smoking Cessation Program

North Dakota Quitline

1-800-QUIT-NOW

Prior Authorization Vendor for ND Medicaid

North Dakota Medicaid has recently joined forces with the Department of Health to provide free, confidential, telephone-based cessation counseling to recipients interested in quitting tobacco. Beginning November 15, 2008, in order to receive smoking cessation products (patches, gum, lozenges, bupropion, or Chantix®), Medicaid recipients must be signed up with the North Dakota Tobacco Quitline (1-800-QUIT-NOW or 1-800-784-8669). Once a recipient is enrolled in counseling, they will work with their counselor to determine which medications they wish to use. The complete process is described below:

1. Patient calls ND Quitline and enrolls in counseling.
2. Quitline counselors guide patient through quitting process.
3. Individualized treatment plan developed.
4. If medications are used, the patient will receive an enrollment letter which will include the Quitline's standing orders for the specific medication(s).
5. The HID Prior Authorization form will be included with the letter
6. The client must contact their physician and obtain the prescription.
7. The patient, physician or pharmacy must fax the Prior Authorization form and enrollment letter to HID.
8. Patient takes prescription to pharmacy.
9. Pharmacy fills prescription and the claim is paid.

Patients will be limited to a 90 day supply of therapy for patches, gum, lozenges, and bupropion, every two years. Combination therapy with these medications is allowed.

Chantix is limited to the initial 12 weeks of therapy with an additional 12 weeks (24 consecutive weeks) allowed if the patient has continuously quit for a minimum of one month (since day 56 of therapy). The Chantix regimen will be allowed once every two years.

Prior authorizations will be entered based upon the recipient's Quit Date. This means that the approval date range will be sufficient to allow recipients to pick up medications at least one week prior to their Quit Date. Compliance will be an important aspect of the patient's success.

Please contact Health Information Designs, Inc. at (334) 502-3262 or toll free at 1-800-225-6998, with questions regarding the smoking cessation prior authorization process.

North Dakota Department of Human Services
DUR Board Meeting
Genitourinary Smooth Muscle Relaxants

I. Overview

Normal voiding is dependent on acetylcholine-induced stimulation of muscarinic receptors on bladder smooth muscle. Darifenacin, fesoterodine, solifenacin, tolterodine and trospium act as muscarinic receptor antagonists, inhibiting bladder contraction, decreasing detrusor pressure (decreasing urgency) and increasing bladder capacity. Flavoxate has direct antispasmodic effects on the smooth muscle of the bladder, thereby reducing symptoms associated with bladder spasticity and increasing bladder capacity. Oxybutynin also has a direct antispasmodic effect on smooth muscle, but also inhibits the muscarinic action of acetylcholine. Mirabegron is a beta-3 adrenergic agonist that relaxes the detrusor smooth muscle.

Muscarinic receptors can also be found in the gastrointestinal tract, salivary glands and tear ducts. Because these agents have varying affinity for the different types of muscarinic receptors, common side effects include dry mouth, blurred vision, abdominal discomfort, drowsiness and nausea. In addition, these agents may cause confusion or cognitive impairment in the elderly.

Genitourinary Smooth Muscle Relaxants Included In This Review

Generic Name	Available Formulation(s)	Brand Name(s)
Darifenacin	Extended-release tablet	Enablex®
Fesoterodine	Extended-release tablet	Toviaz®
Flavoxate	Tablet	N/A
Oxybutynin	Tablet, syrup, extended-release tablet, transdermal gel, transdermal patch	Ditropan®*, Ditropan XL®*, Gelnique®, Oxytrol®
Solifenacin	Tablet	Vesicare®
Tolterodine	Tablet, extended-release tablet	Detrol®*, Detrol LA®
Trospium	Tablet, extended-release tablet	Sanctura®*, Sanctura XR®
Mirabegron	Extended-release tablet	Myrbetriq®

*Indicates that a generic product is available.

II. Indications

Darifenacin, fesoterodine, solifenacin, tolterodine, trospium and mirabegron are indicated for the treatment of overactive bladder (OAB) with symptoms of urinary incontinence, urgency and frequency. Flavoxate is indicated for symptomatic relief of dysuria, urgency, nocturia, suprapubic pain, frequency and incontinence that may occur in cystitis, prostatitis, urethritis, urethrocystitis/urethrotrigonitis. Oxybutynin immediate-release tablets and syrup are indicated for the relief of symptoms of bladder instability associated with voiding in patients with uninhibited neurogenic or reflex neurogenic bladder. Oxybutynin extended-release tablets, transdermal patch and transdermal gel are indicated for the treatment of OAB. Oxybutynin is also indicated in patients ages 6 years and older with symptoms of detrusor overactivity associated with a neurological condition (e.g., spina bifida).

III. Warnings

- These agents should be used with caution in patients with clinically significant bladder outflow obstruction because of the risk of urinary retention.

- Agents for the treatment of OAB should also be used with caution in patients with gastrointestinal obstructive disorders (e.g., ulcerative colitis, severe constipation) because of the risk of gastric retention and decreased gastric motility.

- GU smooth muscle relaxants should be used with caution in patients with controlled narrow-angle glaucoma and myasthenia gravis, due to effects of increased anticholinergic activity.

- Oxybutynin transdermal gel is alcohol-based and therefore flammable. Instruct patients to avoid open fire or smoking until gel has dried.

- Mirabegron can increase blood pressure. Periodic blood pressure determinations are recommended, especially in hypertensive patients. Mirabegron is not recommended for use in severe uncontrolled hypertensive patients.

- Mirabegron is a moderate inhibitor of CYP2D6. Appropriate monitoring is recommended and dose adjustment may be necessary for narrow therapeutic index CYP2D6 substrates.

IV. Precautions

Recommendations For Dosage Adjustments Based On Hepatic and Renal Function

Generic Name	Renal Function Impairment	Hepatic Function Impairment
Darifenacin	*No dosage adjustments	*No dosage adjustments for mild hepatic impairment *Max dose = 7.5mg for patients with moderate hepatic impairment (Child-Pugh class B) *Not recommended for patients with severe hepatic impairment (Child-Pugh class C)
Fesoterodine	*No dosage adjustments for patients with mild/moderate renal insufficiency. *Max dose = 4mg for patients with severe renal insufficiency	*No dosage adjustments for patients with mild/moderate hepatic impairment. *Not recommended for patients with severe hepatic impairment
Flavoxate	*No recommendations	*No recommendations
Oxybutynin	*Use with caution - no recommendations for dosage adjustments	*Use with caution - no recommendations for dosage adjustments

Generic Name	Renal Function Impairment	Hepatic Function Impairment
Solifenacin	*Use with caution in patients with reduced renal function *Max dose = 5mg in patients with severe renal impairment (CrCl < 30mL/min)	*Use with caution in patients with reduced hepatic function *Max dose = 5mg in patients with moderate hepatic impairment (Child-Pugh class B) *Not recommended for patients with severe hepatic impairment (Child-Pugh class C)
Tolterodine	*IR – Significantly reduced renal function, recommended dose is 1mg BID *ER – Severe renal impairment (CrCl 10 to 30mL/min), recommended dose is 2mg QD. If CrCl is less than 10mL/min, use is not recommended	*IR – Significantly reduced hepatic function, recommended dose is 1mg BID *ER – Mild to moderate hepatic impairment (Child-Pugh class A or B), recommended dose is 2mg QD. If patient has severe hepatic impairment (Child-Pugh class C), use is not recommended
Trospium	*IR – Severe renal impairment (CrCl < 30mL/min), recommended dose is 20mg HS. *ER – Not recommended for use in patients with severe renal impairment (CrCl < 30mL/min)	*Use caution when administering to patients with moderate or severe hepatic dysfunction.
Mirabegron	In patients with severe renal impairment, the daily dose should not exceed 25mg. No dose adjustment is necessary in patients with mild or moderate renal impairment.	In patients with moderate hepatic impairment, the daily dose should not exceed 25mg. No dose adjustment is necessary in patients with mild hepatic impairment.

V. Drug Interactions

- When genitourinary smooth muscle relaxants (darifenacin, fesoterodine, solifenacin, tolterodine) are used concurrently with agents that inhibit CYP3A4 (imidazoles, macrolides, nefazodone and protease inhibitors), the plasma concentrations and effects of the genitourinary smooth muscle relaxant may be increased.

- When genitourinary smooth muscle relaxants (oxybutynin, trospium) are used with phenothiazines, the antipsychotic effectiveness of the phenothiazines may be decreased.

- Potassium tablet preparations are contraindicated for use in patients using anticholinergic agents like the genitourinary smooth muscle relaxants. Delay in tablet passage through the GI tract may occur, affecting potassium absorption. Administration of the potassium as a liquid preparation is a suitable alternative.

- Mirabegron is a moderate inhibitor of CYP2D6 and when used concomitantly with drugs metabolized by CYP2D6, especially narrow therapeutic index drugs, appropriate monitoring and possible dosage adjustment of those drugs may be necessary.

- When initiating a combination of mirabegron and digoxin, prescribe the lowest dose of digoxin; monitor serum digoxin concentrations to titrate digoxin dose to desired clinical effect.

VI. Adverse Reactions

- The most common adverse reactions to the genitourinary smooth muscle relaxants are urinary retention, dry mouth and constipation.

- Other side effects include dry eyes, dizziness/somnolence, abdominal pain, nausea, dyspepsia, urinary tract infection, nasopharyngitis, headache and hypertension.

- Hypersensitivity reactions, including angioedema with airway obstruction, pruritis, rash and urticaria have occurred.

VII. Dosage and Administration

Adult and Pediatric Dose Recommendations

Generic Name	Adult Dose Recommendations	Pediatric Dose Recommendations	Availability
Darifenacin	7.5 to 15mg daily	Safety and efficacy in children have not been established.	ER Tablet: 7.5mg 15mg
Fesoterodine	4 to 8mg daily	Safety and efficacy in children have not been established.	ER Tablet: 4mg 8mg
Flavoxate	100 to 200mg 3 to 4 times/day	≥12 years of age: 100 to 200mg 3 to 4 times/day	Tablet: 100mg
Oxybutynin	Tablet (IR)/syrup: 5mg 2 to 3 times/day; max dose = 5mg 4 times/day Tablet (ER): 5mg daily; max dose = 30 mg/day Transdermal gel: 10% - one sachet applied daily 3% - apply 3 pumps daily Transdermal patch: one 3.9mg/day system applied twice weekly (every 3 to 4	≥5 years of age: Tablet (IR)/syrup: 5mg 2 times a day; max dose = 5mg 3 times a day ≥6 years of age (detrusor overactivity associated with a neurological condition): Tablet (ER): 5mg once daily; max dose = 20mg/day	Syrup: 5mg/5mL ER Tablet: 5mg 10mg 15mg IR Tablet: 5mg Transdermal gel: 3%, 10%

Generic Name	Adult Dose Recommendations	Pediatric Dose Recommendations	Availability
	days)		Transdermal patch: 3.9mg/24hr
Solifenacin	5 to 10mg daily	Safety and efficacy in children have not been established.	Tablet: 5mg 10mg
Tolterodine	Tablet (IR): 2mg 2 times/day Capsule (ER): 4mg once daily	Safety and efficacy in children have not been established.	IR Tablet: 1mg 2mg ER Capsule: 2mg 4mg
Trospium	Tablet (IR): 20mg 2 times/day Capsule (ER): 60mg daily	Safety and efficacy in children have not been established.	IR Tablet: 20mg ER Capsule: 60mg
Mirabegron	Tablet (ER): 25mg once daily, may increase to 50mg once daily if effective within 8 weeks.	Safety and efficacy in children have not been established.	ER Tablet: 25mg 50mg

VIII. Utilization

Genitourinary Smooth Muscle Relaxant Utilization			
09/26/11 - 09/25/12			
Label Name	**Rx Num**	**Total Reimb Amt**	**Average Cost per Script**
DETROL 2 MG TABLET	42	$6,884.03	$163.91
DETROL LA 2 MG CAPSULE	57	$8,136.68	$142.75
DETROL LA 4 MG CAPSULE	415	$64,650.72	$155.78
DITROPAN XL 10 MG TABLET	1	$90.40	$90.40
ENABLEX 15 MG TABLET	26	$4,030.36	$155.01
ENABLEX 7.5 MG TABLET	44	$5,307.17	$120.62
FLAVOXATE HCL 100 MG TABLET	4	$443.80	$110.95
OXYBUTYNIN 5 MG TABLET	444	$4,201.52	$9.46
OXYBUTYNIN 5 MG/5 ML SYRUP	113	$1,711.90	$15.15
OXYBUTYNIN CL ER 10 MG TABLET	362	$17,795.20	$49.16
OXYBUTYNIN CL ER 15 MG TABLET	175	$9,781.99	$55.90
OXYBUTYNIN CL ER 5 MG TABLET	88	$3,377.42	$38.38
OXYTROL 3.9 MG/24HR PATCH	21	$4,125.66	$196.46
SANCTURA XR 60 MG CAPSULE	56	$7,721.79	$137.89
TOLTERODINE TARTRATE 2 MG TAB	3	$545.01	$181.67

Genitourinary Smooth Muscle Relaxant Utilization			
09/26/11 - 09/25/12			
Label Name	**Rx Num**	**Total Reimb Amt**	**Average Cost per Script**
TOVIAZ ER 4 MG TABLET	38	$5,284.72	$139.07
TOVIAZ ER 8 MG TABLET	53	$7,089.21	$133.76
TROSPIUM CHLORIDE 20 MG TABLET	6	$495.34	$82.56
VESICARE 10 MG TABLET	129	$21,488.98	$166.58
VESICARE 5 MG TABLET	86	$14,919.16	$173.48
Totals (361 Recipients)	**2163**	**$188,081.06**	
Myrbetriq will cost about $210 per month			

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5. Toviaz [package insert]. New York, NY: Pfizer; August 2012.
6. Ditropan XL [package insert]. Raritan, NJ: Ortho-McNeil-Janssen; March 2012.
7. Gelnique Gel 10% [package insert]. Parsippany, NJ: Watson Pharma, Inc.; March 2012.
8. Gelnique Gel 3% [package insert]. Parsippany, NJ: Watson Pharma, Inc.; December 2011.
9. Oxytrol [package insert]. Parsippany, NJ: Watson Pharma, Inc.; April 2011.
10. Vesicare [package insert]. Northbrook, IL: Astellas Pharma US, Inc.; August 2012.
11. Detrol LA [package insert]. New York, NY: Pfizer; August 2012.
12. Sanctura [package insert]. Irvine, CA: Allergan, Inc.; July 2012.
13. Sanctura XR [package insert]. Irvine, CA: Allergan, Inc.; August 2012.
14. Myrbetriq [package insert]. Northbrook, IL: Astellas Pharma US, Inc.; June 2012.

North Dakota Department of Human Services
DUR Board Meeting
Aubagio® Review

I. Overview

Teriflunomide, an immunomodulatory agent with anti-inflammatory properties, inhibits dihydroorotate dehydrogenase, a mitochondrial enzyme involved in de novo pyrimidine synthesis. The exact mechanism by which teriflunomide exerts its therapeutic effect in multiple sclerosis is unknown but may involve a reduction in the number of activated lymphocytes in the central nervous system. Teriflunomide is the active metabolite of leflunomide (Arava), the immunomodulatory used to slow progression of rheumatoid arthritis.

II. Indication

Teriflunomide is a pyrmidine synthesis inhibitor indicated for the treatment of patients with relapsing forms of multiple sclerosis.

III. Warnings and Precautions

- Elimination of teriflunomide can be accelerated by administration of cholestyramine or activated charcoal for 11 days.
- Teriflunomide may decrease WBC. A recent CBC should be available before starting teriflunomide. Monitor for signs and symptoms of infection. Consider suspending treatment with teriflunomide and using accelerated elimination procedure in case of serious infection. Do not start teriflunomide in patients with active infections.
- Peripheral neuropathy: If patient develops symptoms consistent with peripheral neuropathy, evaluate patient and consider discontinuing teriflunomide and using accelerated elimination procedure.
- Acute renal failure/hyperkalemia: Monitor renal function and potassium in patients with symptoms of renal failure or hyperkalemia.
- Severe skin reaction: Stop teriflunomide and use accelerated elimination procedure.
- Blood pressure: Measure at treatment initiation. Monitor and manage appropriately during treatment.

IV. Drug Interactions

- Drugs metabolized by CYP2C8: monitor patients as teriflunomide may increase their exposure.
- Teriflunomide may increase exposure of ethinyl estradiol and levonorgestrel. Choose an appropriate oral contraceptive.
- Drugs metabolized by CYP1A2: Monitor patients as teriflunomide may decrease their exposure.
- Warfarin: monitor INR as teriflunomide may decrease INR.

V. Adverse Reactions

The most common adverse reactions (≥10% and ≥2% greater than placebo): ALT increased, alopecia, diarrhea, influenza, nausea, and paresthesias.

VI. Dosage and Administration

The recommended dose of teriflunomide is 7 mg or 14 mg orally once daily.

- Obtain transaminase and bilirubin levels within 6 months before initiation of teriflunomide therapy. Monitor ALT levels at least monthly for six months after starting teriflunomide.
- Obtain a complete blood cell count (CBC) within 6 months before the initiation of treatment with teriflunomide. Further monitoring should be based on signs and symptoms of infection.
- Prior to initiating teriflunomide, screen patients for latent tuberculosis infection with a tuberculin skin test.
- Check blood pressure before start of teriflunomide and periodically thereafter.

VII. Cost

Aubagio costs approximately $4,500/month.

Reference

1. Aubagio® [prescribing information]. Cambridge, MA. Genzyme Corporation.; Sep 2012.

NORTH DAKOTA MEDICAID
RETROSPECTIVE DRUG UTILIZATION REVIEW
CRITERIA RECOMMENDATIONS
DECEMBER 2012

Criteria Recommendations	*Approved*	*Rejected*

1. Mirabegron / High Dose _____ _____

Alert Message: The manufacturer's maximum recommended daily dose of Myrbetriq (mirabegron) is 50 mg once daily.

Conflict Code: ER - Overutilization
Drugs/Diseases

Util A	Util B	Util C **(Negating)**
Mirabegron		Severe Renal Impairment
		Hepatic Impairment

Max dose: 50mg/day

References:
Myrbetriq Prescribing Information, June 2012, Astellas Pharma US, Inc.

2. Mirabegron / Severe Renal Impairment or Mod. Hepatic Impairment _____ _____

Alert Message: The daily dose of Myrbetriq (mirabegron) should not exceed 25 mg in patients with severe renal impairment (CrCL 15-29mL/min) or moderate hepatic impairment (Child-Pugh Class B). Mirabegron use is not recommended in patients with end-stage renal disease (ESRD) or patients with severe hepatic impairment.

Conflict Code: ER - Overutilization
Drugs/Diseases

Util A	Util B	Util C **(Include)**
Mirabegron		Severe Renal Impairment
		Hepatic Impairment

Max Dose: 25 mg/day
References:
Myrbetriq Prescribing Information, June 2012, Astellas Pharma US, Inc.

3. Mirabegron / Hypertension & Antihypertensive Medications _____ _____

Alert Message: Myrbetriq (mirabegron) can increase blood pressure and periodic blood pressure determinations are recommended especially in hypertensive patients. Mirabegron is not recommended for use in severe uncontrolled hypertensive patients.

Conflict Code: DB – Drug Disease and/or Drug Inferred Disease Precaution
Drugs/Diseases

Util A	Util B	Util C
Mirabegron	Hypertension ICD-9s	
	Antihypertensive Meds	

References:
Myrbetriq Prescribing Information, June 2012, Astellas Pharma US, Inc.

4. Mirabegron / Bladder Outlet Obstruction _____ _____

Alert Message: Myrbetriq (mirabegron) should be administered with caution to patients with clinically significant bladder outlet obstruction (BOO). Urinary retention in patients with BOO has been reported in postmarketing experience in patients taking mirabegron.

Conflict Code: MC – Drug/Disease Precaution
Drugs/Diseases

Util A	Util B	Util C
Mirabegron	Bladder Obstruction	

References:
Myrbetriq Prescribing Information, June 2012, Astellas Pharma US, Inc.

5. Mirabegron / Antimuscarinic Medications _____ _____

Alert Message: Myrbetriq (mirabegron) should be administered with caution to patients taking antimuscarinic medications for the treatment of overactive bladder (OAB). Urinary retention in patients taking antimuscarinic medications for the treatment of OAB has been reported in postmarketing experience in patients taking mirabegron.

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

Util A	Util B	Util C
Mirabegron	Darifenacin	
	Fesoterodine	
	Oxybutynin	
	Solifenacin	
	Tolterodine	
	Trospium	

References:
Myrbetriq Prescribing Information, June 2012, Astellas Pharma US, Inc.

6. Mirabegron / Digoxin _____ _____

Alert Message: For patients who are initiating a combination of Myrbetriq (mirabegron) and digoxin, the lowest dose for digoxin should initially be considered. The concurrent use of mirabegron and digoxin has been shown to increase the Cmax and AUC of digoxin, 29% and 27%, respectively. Serum digoxin concentrations should be monitored and used for titration of the digoxin dose to obtain the desired clinical effect.

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

Util A	Util B	Util C
Mirabegron	Digoxin	

References:
Myrbetriq Prescribing Information, June 2012, Astellas Pharma US, Inc.

7. Mirabegron / Pediatric Patients _____ _____

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

Conflict Code: TA – Therapeutic Effectiveness
Drugs/Diseases

Util A	Util B	Util C
Mirabegron		

Age Range: 0-18 yoa

References:
Myrbetriq Prescribing Information, June 2012, Astellas Pharma US, Inc.

8. Mirabegron / Drugs Metabolized by CYP2D6 _____ _____

Alert Message: Myrbetriq (mirabegron) is a moderate CYP2D6 inhibitor and co-administration with a drug that is a CYP2D6 substrate may result in increased systemic exposure to the substrate. Appropriate monitoring and dose adjustment may be necessary, especially with narrow therapeutic index drugs metabolized by CYP2D6.

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

Util A	Util B				Util C
Mirabegron	Thioridazine*	Codeine	Morphine	Imipramine	
	Flecainide*	Cyclobenzaprine	Nortriptyline	Venlafaxine	
	Propafenone*	Darifenacin	Olanzapine	Metoclopramide	
	Atomoxetine*	Delavirdine	Ondansetron		
	Desipramine*	Dextromethorphan	Oxycodone		
	Dextroamphetamine*	Dolasetron	Paroxetine		
	Metoprolol*	Donepezil	Penbutolol		
	Nebivolol*	Doxepin	Pentazocine		
	Perphenazine*	Fluvoxamine	Propranolol		
	Almotriptan	Fluoxetine	Perphenazine		
	Amphetamine	Fluphenazine	Pimozide		
	Arformoterol	Haloperidol	Protriptyline		
	Aripiprazole	Hydrocodone	Risperidone		
	Asenapine	Iloperidone	Sertraline		
	Atomoxetine	Labetalol	Tamoxifen		
	Carvedilol	Maprotiline	Timolol		
	Chlorpheniramine	Methamphetamine	Tolterodine		
	Clomipramine	Metoprolol	Tramadol		
	Citalopram	Mexiletine	Trimipramine		
	Clozapine	Mirtazapine	Amitriptyline		

References:
Myrbetriq Prescribing Information, June 2012, Astellas Pharma US, Inc.
Hartshorn EA, Tatro DS. Principles of Drug Interactions Facts & Comparisons, 2012 Wolters Kluwer Health, Inc.
FDA: Drug Development and Drug Interactions: Tables of Substrates, Inhibitors and Inducers. [08/28/2012]. Available at:
http://www.fda.gov/Drugs/DevelopmentApprovalProcess/DevelopmentResources/DrugInteractionsLabeling/ucm093664.htm
*CYP2D6 Sensitive substrate and/or narrow therapeutic index CYP2D6 substrate

9. Stribild / Other Antiretroviral Therapy _____ _____

Alert Message: The patient appears to be receiving other antiretroviral therapy in addition to Stribild (elvitegravir/cobicistat/emtricitabine/tenofovir). Stribild is a complete regimen for the treatment of HIV-1 infections and should not be administered with other antiretroviral medications.

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

Util A	Util B	Util C
Stribild	All Other Antiretrovirals	

References:
Stribild Prescribing Information, August 2012, Gilead Sciences, Inc.

10. Fosamprenavir / Delavirdine _____ _____

Alert Message: The concurrent use of Lexiva (fosamprenavir) and delavirdine is contraindicated. Co-administration of these agents may lead to loss of virologic response and possible resistance to delavirdine.

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

Util A	Util B	Util C
Fosamprenavir	Delavirdine	

References:
Facts & Comparisons, 2012 Updates.
Clinical Pharmacology, 2012 Elsevier/Gold Standard.

11. Revatio / Children 1-17 years of Age _____ _____

Alert Message: Revatio (sildenafil) should not be prescribed to children (ages 1 through 17) for pulmonary arterial hypertension (PAH). This recommendation is based on a recent long-term clinical pediatric trial showing that: (1) children taking a high dose of Revatio had a higher risk of death than children taking a low dose and (2) the low doses of Revatio are not effective in improving exercise ability. Revatio is not FDA approved for the treatment of PAH in children.

Conflict Code: TA – Therapeutic Appropriateness
Drugs/Diseases

Util A	Util B	Util C
Revatio		

Age Range: 1-17 yoa

References:
MedWatch The FDA Safety Information and Adverse Event Reporting Program Safety Information. Revatio (sildenafil): Drug Safety Communication - Recommendation Against Use in Children [Posted 08/30/2012].

12. Didanosine / Ribavirin _____ _____

Alert Message: The concurrent use of didanosine (Videx/Videx EC) with a ribavirin-containing agent is contraindicated. Co-administration of these agents may cause significant increases in blood concentrations of didanosine and its active metabolite, resulting in increased risk of didanosine-related toxicities including fatal hepatic failure, peripheral neuropathy, pancreatitis and symptomatic hyperlactatemia/lactic acidosis.

Conflict Code: DD – Drug/Drug Interactions

Util A	Util B	Util C
Didanosine	Ribavirin	

References:

Videx EC Prescribing Information, Nov. 2011, Bristol-Myers Squibb.
Clinical Pharmacology, 2012 Elsevier/Gold Standard.
Facts & Comparisons, 2012 Updates.

13. Stribild / Non-adherence _____ _____

Alert Message: Nonadherence to antiretroviral therapy may result in insufficient drug plasma levels and partial suppression of viral load leading to the development of resistance, HIV progression, and increased mortality.

Conflict Code: LR - Nonadherence Drugs/Diseases

Util A	Util B	Util C
Stribild		

References:

Stribild Prescribing Information, August 2012, Gilead Sciences, Inc.
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. March 27, 2012;1-167. Available at: http://www.aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf.
Beer L, Heffelfinger J, Frazier E. et al. Use of and Adherence to Antiretroviral Therapy in a Large U.S. Sample of HIV-Infected Adults in Care, 2007-2008. Open AIDS J. 2012;6:213-223.

14. Complera / Non-adherence _____ _____

Alert Message: Nonadherence to antiretroviral therapy may result in insufficient drug plasma levels and partial suppression of viral load leading to the development of resistance, HIV progression, and increased mortality.

Conflict Code: LR - Nonadherence Drugs/Diseases

Util A	Util B	Util C
Complera		

References:

Complera Prescribing Information, August 2012, Gilead Sciences, Inc.
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. March 27, 2012;1-167. Available at: http://www.aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf.
Beer L, Heffelfinger J, Frazier E. et al. Use of and Adherence to Antiretroviral Therapy in a Large U.S. Sample of HIV-Infected Adults in Care, 2007-2008. Open AIDS J. 2012;6:213-223.

15. Complera / All Other Antiretroviral Agents _____ _____

Alert Message: The patient appears to be receiving other antiretroviral therapy in addition to Complera (emtricitabine/tenofovir/rilpivirine). Complera is a complete regimen for the treatment of HIV-1 infections and should not be administered with other antiretroviral medications.

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

Util A	Util B	Util C
Complera	All Other Antiretrovirals	

References:
Complera Prescribing Information, July 2011, Gilead Sciences, Inc.
Clinical Pharmacology, 2012 Elsevier/Gold Standard.