DUR Board Meeting
June 2, 2014
Brynhild Haugland Room

State Capitol

north dakota
department of
human services

North Dakota Medicaid
DUR Board Meeting Agenda
Brynhild Haugland Room
State Capitol
600 East Blvd. Avenue
Bismarck, ND
June 2, 2014
1pm

1. Administrative items
    - Travel vouchers

2. Old business
    - Review and Approval of Minutes of 03/14 Meeting — Chair
    - Budget Update — Brendan
    - Second Review of Cathflo — Brendan
    - Second Review of Intranasal Cyanocobalamin Products — Brendan
    - Second Review of Luzu — Brendan
    - Second Review of Noxafil — Brendan
    - Second Review of Bethkis — Brendan
    - Name Brand Narcotics (Zohydro, Fentanyl, Suboxone) — Brendan

3. New business
    - Medicaid Expansion Drug Coverage-Formulary and PA Processes — Dr. Crandell
    - Review of Cayston — HID
    - Review of Procysbi — HID
    - Review of Ravicti — HID
    - Review of Gastrointestinal Agents (Linzess, Amitiza) — HID
    - Review of Myalept — HID
    - Review of Northera — HID
    - Review of Oral Allergen Extracts (Ragwitek, Grastek) — HID
    - Criteria Recommendations — HID
    - Upcoming Meeting Date/Agenda — Chair

4. Adjourn — Chair

Please remember to silence all cellular phones during the meeting.

Drug Utilization Review (DUR) Meeting Minutes
March 3, 2014

Members Present: Norman Byers, John Savageau, Jeffrey Hostetter, Peter Woodrow, Carrie Sorenson, Russ Sobotta, Tanya Schmidt, Steve Irsfeld, James Carlson, Michael Booth, Cheryl Huber

Members Absent: Todd Twogood, Leann Ness, Gary Betting, Carlotta McCleary

Medicaid Pharmacy Department: Brendan Joyce

J. Hostetter called the meeting to order at 1:00 p.m. J. Hostetter made a motion for J. Savageau to complete the chairman position vacated by G. Pfister. P. Woodrow seconded the motion. The motion passed with no audible dissent. Chair J. Savageau asked for a motion to approve the minutes from the December meeting. N. Byers moved that the minutes be approved, and J. Hostetter seconded the motion. Chair J. Savageau called for a voice vote to approve the minutes. The motion passed with no audible dissent.

Budget Update
B. Joyce gave the budget update. For calendar year 2013, the net spend was approximately 19.5 million dollars. Prior to rebates, the amount was approximately 36.8 million dollars. Approximately 17.3 million dollars was received in rebates. January 2012 showed 80% generic utilization with the average paid per brand script costing approximately $208 and the average paid per generic script costing approximately $26. In January 2014, generic utilization was 85% with the average paid per brand script costing approximately $290 and the average paid per generic script costing $28.

Statins Second Review
A motion and second were made at the December meeting to place name-brand statins on prior authorization. The topic was brought up for a second review. There was no public comment. After discussion, Chair J. Savageau called for a voice vote to approve the motion. The motion passed with no audible dissent.

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

Coverage Clarification
B. Joyce informed the board that drugs that are not covered under pharmacy services will now be linked to a 'coverage clarification' document on the NDC drug lookup website. The document states, "The drug you selected is not covered under pharmacy services for North Dakota Medicaid. However, it is allowed under physician buy and bill services and should be billed by the physician's office."

Sylatron Review
This topic was tabled.

Cathflo Review
B. Joyce reviewed Cathflo information with the board. There was no public comment. P. Woodrow made a motion to place Cathflo on prior authorization. T. Schmidt seconded the motion. This topic will be reviewed at the next meeting.

Ketamine Powder Review
B. Joyce reviewed a Pharmaceutical Alert Bulletin from the U.S. Department of Health and Human Services/OIG discussing Ketamine powder. The board was informed that Ketamine will not be paid through pharmacy services.

Intranasal Cyanocobalamin Products Review
B. Joyce reviewed Nascobal information with the board. There was no public comment. M. Booth made a motion to place intranasal cyanocobalamin products on prior authorization. C. Huber seconded the motion. This topic will be reviewed at the next meeting.

Luzu Review
B. Joyce reviewed Luzu information with the board. There was no public comment. N. Byers made a motion to place Luzu on prior authorization. C. Sorenson seconded the motion. This topic will be reviewed at the next meeting.

Noxafil Review
B. Joyce reviewed Noxafil information with the board. There was no public comment. N. Byers made a motion to place Noxafil on prior authorization. S. Irsfeld seconded the motion. This topic will be reviewed at the next meeting.

Bethkis Review
B. Joyce reviewed Bethkis information with the board. There was no public comment. M. Booth made a motion to place Bethkis on prior authorization. N. Byers seconded the motion. This topic will be reviewed at the next meeting.

Update of New Drug Lookup Website
C. Rieth reviewed the enhanced NDC drug lookup website with the board. The website allows users to search for a drug by name or NDC number and it displays easy to understand results along with each drug's PA form.

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 J. Savageau called for a voice vote. The motion passed with no audible dissent.

The next DUR board meeting will be held June 2 in Bismarck. N. Byers made a motion to adjourn the meeting. J. Hostetter seconded. The motion passed with no audible dissent. J. Savageau adjourned the meeting.

CATHFLO ACTIVASE
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 Cathflo Activase must meet the following criteria:

- **Patient must have an FDA approved indication.**
- **Cathflo Activase is indicated for restoration of function to central venous access devices as assessed by the ability to withdraw blood.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Physician Name			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage: □ CATHFLO ACTIVASE	**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		

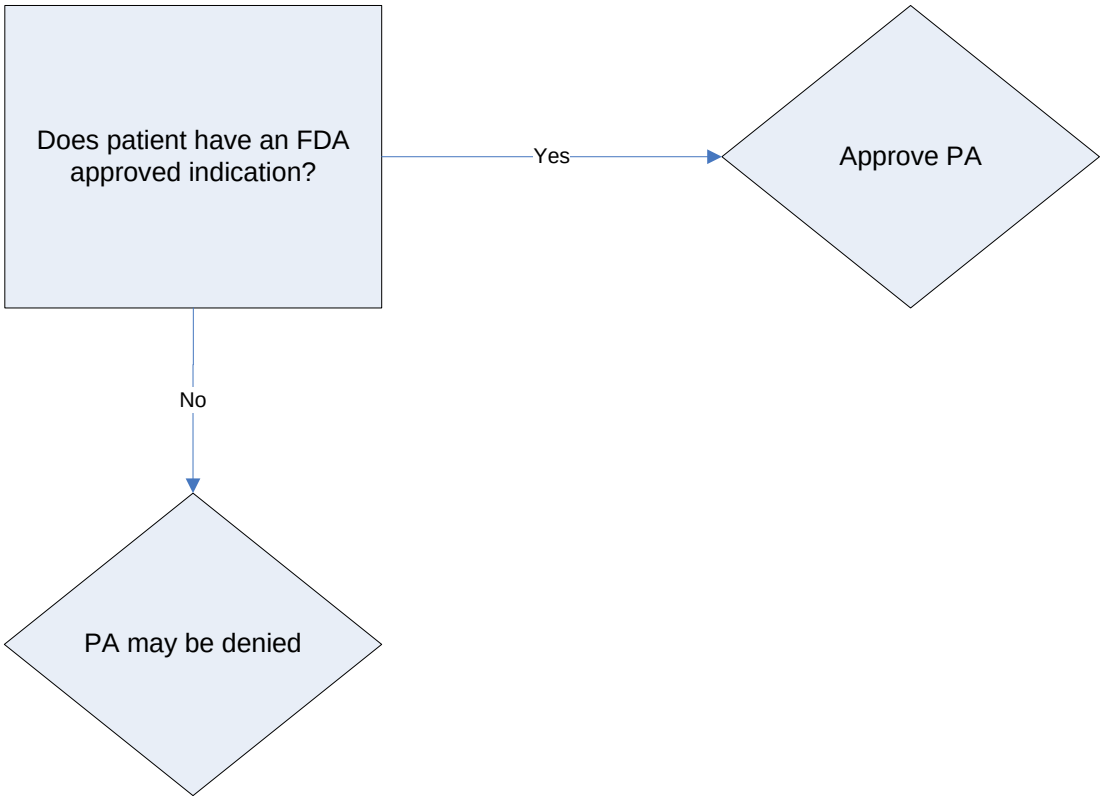
Part II: TO BE COMPLETED BY PHARMACY

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
Cathflo Activase Prior Authorization Algorithm



INTRANASAL CYANOCOBALAMIN 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 intranasal cyanocobalamin products must try injectable cyanocobalamin as first line therapy.

- **Injectable B-12 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 and Dosage: □ NASCOBAL	**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	

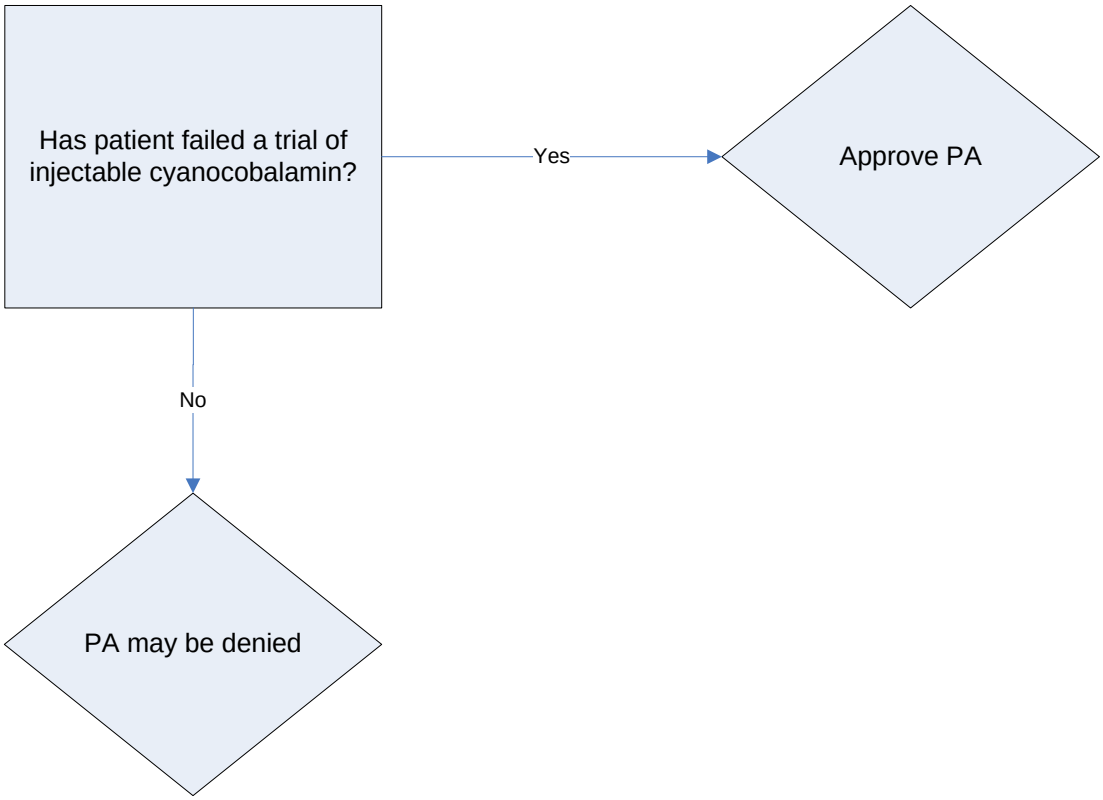
Part II: TO BE COMPLETED BY PHARMACY

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
Intranasal Cyanocobalamin Prior Authorization Algorithm



LUZU
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 Luzu must meet the following criteria:

- **Patient must have an FDA approved indication.**
- **Patient must be 18 years of age or older.**
- **Patient must have documented history of failure of two topical antifungal agents (clotrimazole, econazole) and two oral antifungal agents (terbinafine, fluconazole, itraconazole).**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Physician Name			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code

Requested Drug and Dosage: □ LUZU	**Diagnosis for this Request:**
Failed Therapy: **1.** **2.** **3.** **4.**	**Start Date:** **End Date:** **1.** **2.** **3.** **4.**
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*	
Prescriber Signature	Date

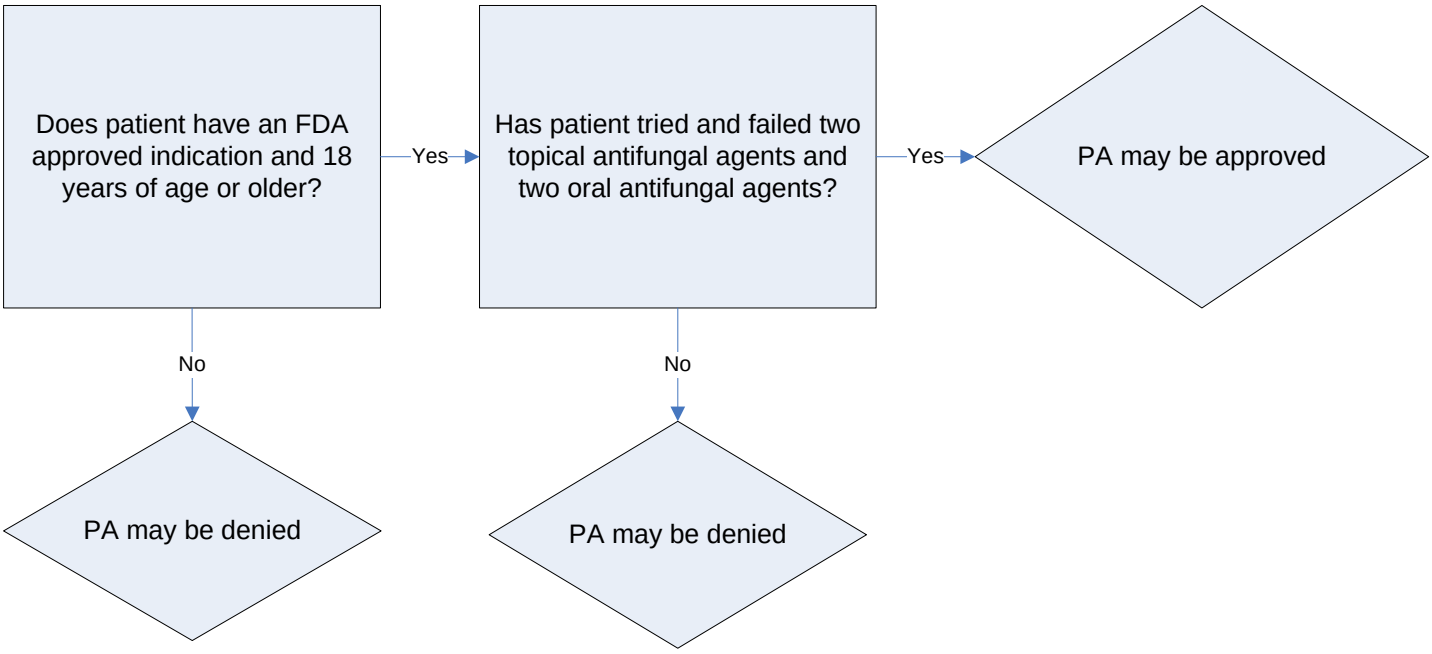
Part II: TO BE COMPLETED BY PHARMACY

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
Luzu Prior Authorization Algorithm



NOXAFIL
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 Noxafil must meet the following criteria:

- **Patient must have an FDA approved indication.**
- **Patient must have documented history of failure of two agents (itraconazole, fluconazole) to receive Noxafil suspension for oropharyngeal candidiasis.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Physician Name			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code

Requested Drug and Dosage: □ NOXAFIL TABLET □ NOXAFIL SUSPENSION	**Diagnosis for this Request:**
Failed Therapy for Oropharyngeal Candidiasis (suspension only): **1.** **2.**	**Start Date:** **End Date:** **1.** **2.**
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*	
Prescriber Signature	Date

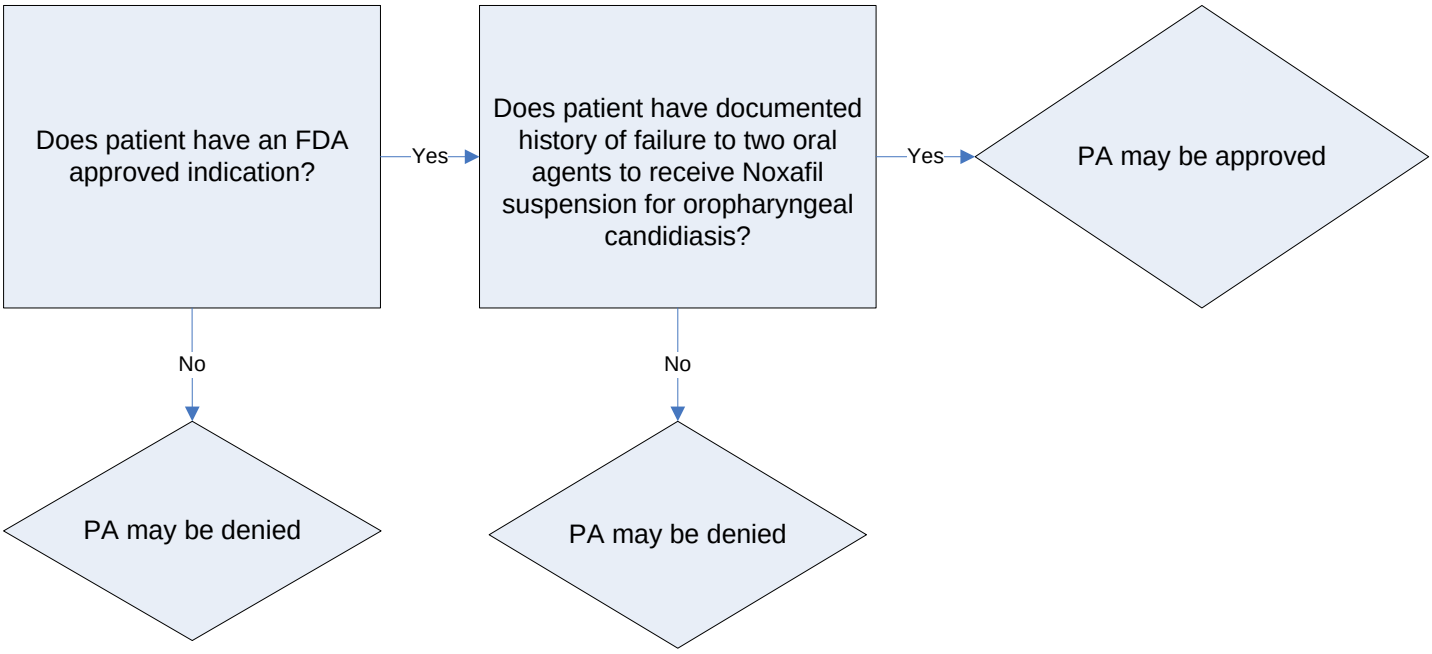
Part II: TO BE COMPLETED BY PHARMACY

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
Noxafil Prior Authorization Algorithm



Approved indications:

Tablets and suspension
Prophylaxis of invasive *Aspergillus* and *Candida* infections in patients who are at high risk of developing these infections due to being severely immunocompromised, such as hematopoietic stem cell transplantation (HSCT) recipients with Graft vs. Host Disease (GVHD) or those with hematologic malignancies with prolonged neutropenia from chemotherapy.

Suspension
Treatment of oropharyngeal candidiasis.

BETHKIS
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 Bethkis 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: □ BETHKIS	**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		

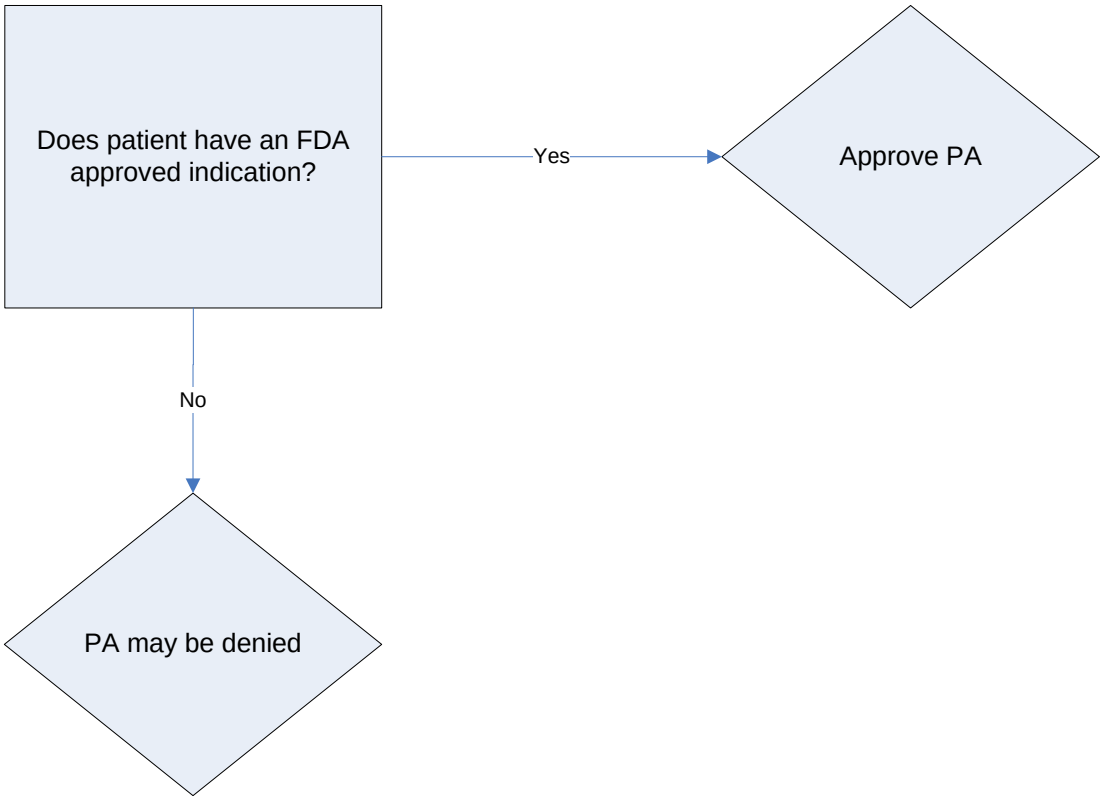
Part II: TO BE COMPLETED BY PHARMACY

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
Bethkis Prior Authorization Algorithm



BRAND-NAME NARCOTICS 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 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

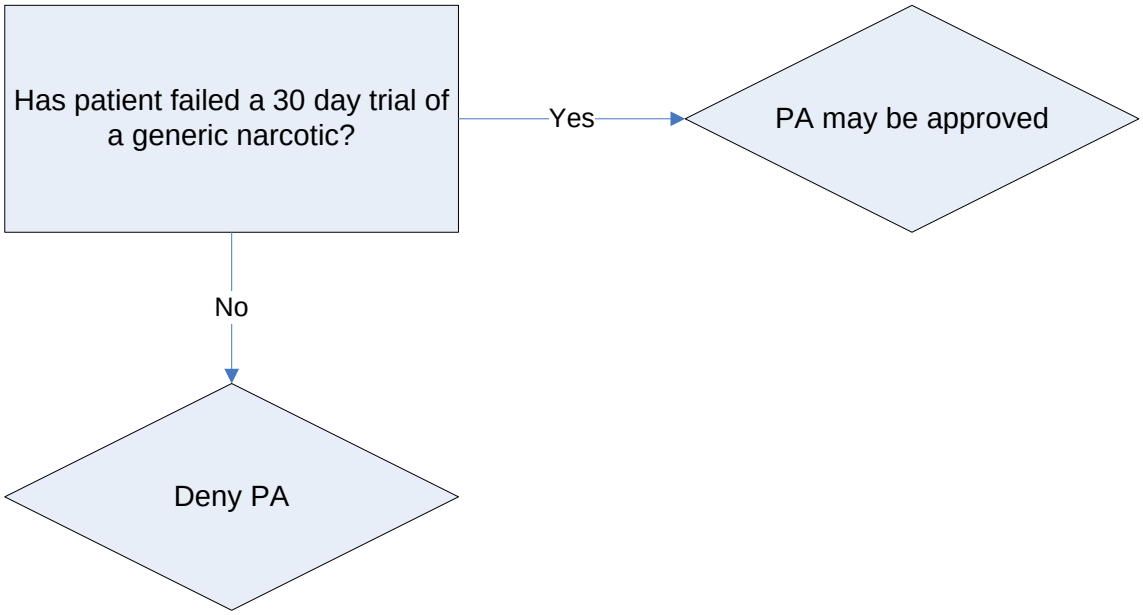
Part II: TO BE COMPLETED BY PHARMACY

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



SANFORD HEALTH PLAN

Sanford Health Plan

Michael P. Crandell, MD, MS
Chief Medical Officer

June 2 , 2014

Health Plan History

- South Dakota Certificate of Authority
  - 1997
- Iowa/Minnesota Certificates of Authority
  - 1998
- North Dakota Certificate of Authority
  - February 2010
- Plan established as a Non-Gatekeeper Model
- Community-Based HMO
- A Non-profit owned exclusively by Sanford Health

SANFORD HEALTH PLAN

Key Statistics

- Provider Network in excess of 14,000 providers
- Total Service Area
  - South Dakota – Statewide
  - North Dakota – Statewide
  - Iowa – 10 counties including Sioux City
  - Minnesota – 36 western Minnesota counties.

    (Pending approval for 10 additional counties)

SANFORD HEALTH PLAN

Key Statistics

Membership (all states)

- Fully Insured: 42,573
- Sanford Group Health: 38,495
- Sioux Empire Healthcare Coalition TPA (SD only): 2,971

Total 87,102

SANFORD HEALTH PLAN

Sanford Health

- 27,000 employees
- 1,359 physicians in more than 80 sub-specialty areas
- 39 hospitals
- 32 long-term care facilities
- 225 clinic sites

- Serving 2.3 million people, 132 communities, over 260,000 square miles, 6 states
- Each year, Sanford provides more than…
  - 5.5 million clinic visits
  - 79,000 admissions
  - 75,000 surgical procedures
  - 8,600 births

SANFORD HEALTH PLAN

SANFORD HEALTH
SYSTEM LOCATIONS

Successes

- Integrated health system able to draw on internal resources to develop solutions for identified problems
- Health Plan RN case managers make calls after discharge to ensure medication being taken and/or follow-up appointments scheduled and kept
- Monitor medication compliance with analytics tool

SANFORD HEALTH PLAN

Affordable Care Act

- Medical Homes
- Behavioral Health Triage
- Health Plan – Clinic collaboration
- Medicaid Expansion in North Dakota began January 1, 2014 with Sanford Health Plan

SANFORD HEALTH PLAN

Sanford Health Plan
Pharmacy Services

- 15 year partnership with Express Scripts
- Formulary Management
- Drug Step Management
- Drug Quantity Management
- Care Continuum
  - Utilization Management
  - Therapy Adherence

SANFORD
HEALTH PLAN

Sanford Health Plan
Formulary Development

- Custom-based on efficacy, safety, and cost effectiveness
- Consulting Pharmacist
- Express Scripts recommendations
- Annual presentation to Physician Quality Committee
- Notice of changes and publication
- Modifications throughout the year

SANFORD
HEALTH PLAN

Medicaid Expansion Key Diagnoses

- Hypertension: 142
- Hyperlipidemia: 51
- COPD: 34
- Chronic Renal Failure: 17
- Asthma: 38
- Rheumatoid Arthritis: 12
- Osteoarthritis: 100
- Diabetes: 161
- Bipolar Disorder: 19
- Chronic Liver and Biliary Disease: 19
- Cancer: 10
- Major Depression: 43

(figures as of April 29, 2014)

SANFORD HEALTH PLAN

Top 20 Medications by Volume

Drug Name	Most Common Use	Brand/ Generi
HYDROCODONE-ACETAMINO		G
LISINOPRIL	High Blood Pressure	G
OMEPRAZOLE	Heartburn or Ulcers	G
GABAPENTIN	Seizures	G
TRAMADOL HCL	Pain	G
CYCLOBENZAPRINE HCL		G
CLONAZEPAM	Seizures	G
SERTRALINE HCL	Depression	G
SIMVASTATIN	High Cholesterol	G
METFORMIN HCL	Diabetes	G
LEVOTHYROXINE SODIUM	Thyroid	G
TRAZODONE HCL		G
AMLODIPINE BESYLATE	Hypertension	G
ALPRAZOLAM	Anxiety	G
AZITHROMYCIN	Antibiotic	G
LORAZEPAM	Anxiety	G
CITALOPRAM HBR	Depression	G
METOPROLOL SUCCINATE	Hypertension	G
PREDNISONE	Inflammation	G
ATORVASTATIN CALCIUM	High Cholesterol	G

The information on this report represents the most common indication of each drug listed. However, please keep in mind that many drugs have multiple purposes and may be taken for conditions other than indicated on this report. The indications are provided for the top drugs processed with members enrolled in Sanford Health Plan.

Top 20

B = Brand
G = Generic
N = Non-Specified
O = Over the Counter (ie. Diabetic Supplies)
S = Single-source Brand

SANFORD HEALTH PLAN

Thank You . . . .

Questions

SANFORD HEALTH PLAN

Pharmacy Handbook

for non-grandfathered members

Table of Contents

Sanford Health Plan Formulary

It is agreed that this prescription drug rider is attached to and made a part of the contract between Sanford Health Plan and the member or Plan Sponsor. However, nothing in this rider will alter or affect any of the terms of the contract, unless specifically stated.

To be covered by the Plan, drugs must be:

1. Prescribed by a licensed health care professional within the scope of his or her practice;
2. Listed in the Plan Formulary, unless certification is given by the Plan;
3. Provided by a Participating Pharmacy except in the event of a medical emergency. If the prescription is obtained at a Non-Participating Pharmacy the Member is responsible for the prescription drug cost in full.
4. Approved by the Federal Food and Drug Administration (FDA) for use in the United States.

This information about the Sanford Health Plan Formulary applies only to those drugs, including injectable drugs that may be covered under this Policy.

The Sanford Health Plan Formulary is a list of FDA approved brand-name and generic drugs chosen by health care providers on the Physician Quality Committee. Selection criteria include clinical efficacy, safety, and cost effectiveness. Additions are made throughout the year as warranted with a complete review once a year.
For a complete listing of the formulary, pharmacy locator, health news, generic substitution information, drug side effect and interaction information, personal reminders, price check, benefit information and your current medication usage, log into your myHealthPlan account at www.sanfordhealthplan.com/myhealthplan.

Following the Sanford Health Plan Formulary, especially asking your healthcare Practitioner for generic medications, will save you money and help control the costs of health care. If you request a brand-name drug when there is an equivalent generic alternative available, you will be required to pay the price difference between the brand and the generic in addition to your copay. When your Practitioner prescribes a drug for you, you can ask that he or she refer to the Sanford Health Plan Formulary found on their myHealthPlan account at www.sanfordhealthplan.com/providerlogin.

Open Formulary

An Open Formulary is a list of medications that are recommended by Express Scripts Inc., on behalf of Sanford Health Plan. This list is used only to encourage Practitioners to prescribe appropriate medications. All drugs are covered as defined by The Plan.

Closed Formulary

A Closed Formulary is a list of certain medications that are covered and others that are not covered by The Plan. If a prescription is written for a medication that is not on the formulary list, the Member is responsible in full for the cost of the medication. If you receive an adverse determination for your request for a formulary exception, you may request a review of that decision through the *Complaints and Appeals Procedure.*

Pharmacy Programs

Please review the following information concerning the drug exclusion list, certification, quantity limits, step therapy and injectable medication programs. Additional drugs may be added throughout the year to any listing. Sanford Health Plan will publish these changes on the Sanford Health Plan website and will notify you of any formulary changes that impact your cost sharing or accessibility. If you have any questions or concerns, contact our Pharmacy Management Team at (800) 805-7938.

Injectable Drug Program

Sanford Health Plan has contracted with *CuraScript* for your injectable medication needs. *CuraScript* will ship your drug and all the supplies you need for your injection directly to your home or Practitioner's office within 24 to 48 hours after the request is approved and medication is ordered. Administration supplies (syringes, needles etc.) are free; you are not required to pay additional copays for those supplies. Prior to all shipments, a Patient Admission Specialist will contact you to discuss your copay for your drug and arrange delivery.

CuraScript offers toll-free customer service available 24 hours a day, 365 days a year. Specially trained staff offers support services for you, your caregivers, and your Practitioners that include:

- Injectable drug order information;
- Consultation with an experienced, knowledgeable pharmacist;

- Specially trained nurses available to answer questions about injectable drugs and the disease states they treat.

To enroll in the *CuraScript* program, call toll-free at *1-866-333-9721* and a customer service representative will ask the following information:

- **Your name and date of birth**
- **Your phone number and address**
- **The name of your injectable medication to be filled**
- **Your doctor's name and phone number**

CuraScript will mail your Practitioner a letter explaining the program and how to send your prescriptions to *CuraScript*. By participating in Specialty Care, you are automatically enrolled in a drug therapy management program. This program entitles you to receive the following benefits at no additional charge:

- Access to nurses and pharmacists 24 hours/day, 7 days/week for questions related to your injectable drug and the illness the drug is treating.
- Injectable drug refill reminders if you forget to call for your refill, and convenient refill process.
- Free delivery of your medication and supplies to your home, Practitioner's office or designated location.

Injectable and High Cost Medications

- **The following medications (injectable and high cost medications) must be obtained from CuraScript by calling (866) 333-9721. If these medications are obtained from a retail pharmacy or Practitioner's office without certification by Sanford Health Plan Pharmacy Management Team the Member will be responsible for the full cost of the medication.** All medications obtained from CuraScript are prior authorized by CuraScript using criteria approved by the Sanford Health Plan. Most of these medications are covered under the medical benefit and are subject to payment with deductible, coinsurance or a medical copay, dependent upon your benefit package.

Name	Disease State	Coverage	Preferred Alternatives
8-MOP	MISCELLANEOUS SPECIALTY CONDITIONS	MEDICAL	
ABRAXANE	CANCER	MEDICAL	
ACTEMRA	INFLAMMATORY CONDITIONS	MEDICAL	
ACTHAR H.P.	MULTIPLE SCLEROSIS	MEDICAL	
ACTIMMUNE	IMMUNE DEFICIENCY	MEDICAL	
ADAGEN	*ENZYME DEFICIENCIES*	*MEDICAL - LIMITED DISTRIBUTION*	
ADCIRCA	VASODILATOR	PHARMACY- TIER 3	
ADRIAMYCIN	CANCER	MEDICAL	
ADRUCIL	CANCER	MEDICAL	
ADVATE	HEMOPHILIA	MEDICAL	
AFINITOR	CANCER	MEDICAL	
ALDURAZYME	ENZYME DEFICIENCIES	MEDICAL	
ALFERON N	CANCER	MEDICAL	
ALIMTA	CANCER	MEDICAL	
ALKERAN	CANCER	MEDICAL	
ALPHANATE	HEMOPHILIA	MEDICAL	
ALPHANINE SD	HEMOPHILIA	MEDICAL	
AMEVIVE	INFLAMMATORY CONDITIONS	MEDICAL	
AMIFOSTINE	CANCER	MEDICAL	
AMPYRA	MULTIPLE SCLEROSIS	PHARMACY- TIER 3	
APOKYN	*MISCELLANEOUS SPECIALTY CONDITIONS*	*PHARMACY- TIER 3 - LIMITED DISTRIBUTION*	
ARALAST/NP	RESPIRATORY CONDITIONS	MEDICAL	
ARANESP	BLOOD CELL DEFICIENCY	PHARMACY - TIER 2	
ARCALYST	*INFLAMMATORY CONDITIONS*	*MEDICAL -LIMITED DISTRIBUTION*	
AREDIA	CANCER	MEDICAL	
ARRANON	*CANCER*	*MEDICAL - LIMITED DISTRIBUTION*	
ARZERRA	CANCER	MEDICAL	
ATGAM	TRANSPLANT	MEDICAL	
AUBAGIO	MULTIPLE SCLEROSIS	TIER 2	
AVASTIN	CANCER, OPTHALMIC DISORDERS	MEDICAL	

Name	Disease State	Coverage	Preferred Alternatives
AVONEX	MULTIPLE SCLEROSIS	PHARMACY - TIER 3- STEP THERAPY RULES APPPLY	BETASERON- TIER 1 COPAXONE OR REBIF- TIER 2
BEBULIN VH IMMUNO	HEMOPHILIA	MEDICAL	
BENEFIX	HEMOPHILIA	MEDICAL	
BENLYSTA	SYSTEMIC LUPUS ERYTHEMATOUS	MEDICAL	
BERINERT	*HEREDITARY ANGIOEDEMA*	*MEDICAL- LIMITED DISTRIBUTION*	
BETASERON	MULTIPLE SCLEROSIS	PHARMACY -TIER 2	
BEXXAR	*CANCER*	*MEDICAL - LIMITED DISTRIBUTION*	
BICNU	CANCER	MEDICAL	
BLEOMYCIN SULFATE	CANCER	MEDICAL	
BOSULIF	CANCER	MEDICAL	
BOTOX	MISCELLANEOUS SPECIALTY CONDITIONS	MEDICAL	
BRAVELLE	INFERTILITY	PHARMACY 100% COPAY	
BUSULFEX	CANCER	MEDICAL	
CAMPATH	CANCER	MEDICAL	
CAMPTOSAR	CANCER	MEDICAL	
CAPRELSA	CANCER	MEDICAL	
CARBAGLU	*GENETIC DISORDER*	*MEDICAL - LIMITED DISTRIBUTION*	
CARBOPLATIN	CANCER	MEDICAL	
CARIMUNE	*IMMUNE DEFICIENCY*	*MEDICAL - LIMITED DISTRIBUTION*	
CAYSTON	*RESPIRATORY CONDITIONS*	*PHARMACY TIER 3- LIMITED DISTRIBUTION*	
CELLCEPT INJ	TRANSPLANT	MEDICAL	
CEPROTIN	*MISCELLANEOUS SPECIALTY CONDITIONS*	*MEDICAL- LIMITED DISTRIBUTION*	
CEREDASE	*ENZYME DEFICIENCIES*	*MEDICAL - LIMITED DISTRIBUTION*	
CEREZYME	ENZYME DEFICIENCIES	MEDICAL	
CERUBIDINE	CANCER	MEDICAL	
CETROTIDE	INFERTILITY	PHARMACY 100% COPAY	
CHENODAL	*MISCELLANEOUS SPECIALTY CONDITIONS*	*PHARMACY TIER 3- LIMITED DISTRIBUTION*	
CHORIONIC GONADOTROPIN	INFERTILITY	PHARMACY 100% COPAY	
CIMZIA	INFLAMMATORY CONDITIONS	PHARMACY TIER 3- STEP THERAPY RULES APPPLY	ENBREL OR HUMIRA - TIER 2
CINRYZE	HEREDITARY ANGIOEDEMA	MEDICAL	
CISPLATIN	CANCER	MEDICAL	
CLADRIBINE	CANCER	MEDICAL	
CLOLAR	CANCER	MEDICAL	
COPAXONE	MULTIPLE SCLEROSIS	PHARMACY - TIER 2	
COPEGUS	HEPATITIS C	PHARMACY - TIER 2	
CORIFACT	*HEMOPHILIA*	*MEDICAL - LIMITED DISTRIBUTION*	
COSMEGEN	CANCER	MEDICAL	
CYCLOPHOSPHAMIDE	CANCER	MEDICAL	
CYCLOSPORINE INJ	TRANSPLANT	MEDICAL	
CYSTAGON	*MISCELLANEOUS SPECIALTY CONDITIONS*	*PHARMACY TIER 3 - LIMITED DISTRIBUTION*	
CYTARABINE	CANCER	MEDICAL	
CYTOGAM	IMMUNE DEFICIENCY	MEDICAL	
DACARBAZINE	CANCER	MEDICAL	
DACOGEN	CANCER	MEDICAL	
DACTINOMYCIN	CANCER	MEDICAL	
DAUNORUBICIN HCL	CANCER	MEDICAL	
DAUNOXOME	CANCER	MEDICAL	

Name	Disease State	Coverage	Preferred Alternatives
DDAVP (injection only)	ENDOCRINE DISORDERS	MEDICAL	
DEFEROXAMINE MESYLATE	IRON TOXICITY	MEDICAL	
DEPOCYT	CANCER	MEDICAL	
DESFERAL, MESYLATE	IRON TOXICITY	MEDICAL	
DESMOPRESSIN ACETATE INJ	OTHER ENDOCRINE DRUGS	MEDICAL	
DEXRAZOXANE	CANCER	MEDICAL	
DOCETAXEL	CANCER	MEDICAL	
DOXIL	CANCER	MEDICAL	
DOXORUBICIN HCL	CANCER	MEDICAL	
DYSPORT	*NEUROMUSCULAR CONDITIONS*	*MEDICAL- LIMITED DISTRIBUTION*	
EGRIFTA	*IMMUNE DEFICIENCY GROWTH HORMONE*	*PHARMACY- TIER 3 LIMITED DISTRIBUTION*	
ELAPRASE	*ENZYME DEFICIENCIES*	*MEDICAL - LIMITED DISTRIBUTION*	
ELELYSO	OTHER ENDOCRINE DRUGS	MEDICAL	
ELIGARD	CANCER	MEDICAL	
ELITEK	CANCER	MEDICAL	
ELLENCE	CANCER	MEDICAL	
ELOXATIN	CANCER	MEDICAL	
ELSPAR	CANCER	MEDICAL	
ENBREL	INFLAMMATORY CONDITIONS	PHARMACY - TIER 2	
ENOXAPARIN	ANTICOAGULANT	PHARMACY - AVAIL THRU RETAIL - TIER 1	
EPIRUBICIN	CANCER	MEDICAL	
EPOGEN	BLOOD CELL DEFICIENCY	PHARMACY - TIER 3	ARANESP OR PROCRIT – TIER 2
EPOPROSTENOL	*PULMONARY HYPERTENSION*	*MEDICAL- LIMITED DISTRIBUTION*	
ERBITUX	CANCER	MEDICAL	
ERIVEDGE	CANCER	MEDICAL	
ETHYOL	CANCER	MEDICAL	
ETOPOPHOS	CANCER	MEDICAL	
ETOPOSIDE	CANCER	MEDICAL	
EUFLEXXA	OSTEOARTHRITIS	MEDICAL	
EXJADE	*IRON TOXICITY*	*MEDICAL - LIMITED DISTRIBUTION*	
EYLEA	OPHTHALMIC CONDITIONS	MEDICAL	
FABRAZYME	ENZYME DEFICIENCIES	MEDICAL	
FASLODEX	CANCER	MEDICAL	
FEIBA NH	HEMOPHILIA	MEDICAL	
FEIBA VH IMMUNO	HEMOPHILIA	MEDICAL	
FIRAZYR	HEREDITARY ANGIOEDEMA	PHARMACY - TIER 3	
FIRMAGON	CANCER	MEDICAL	
FLEBOGAMMA/DIF	IMMUNE DEFICIENCY	MEDICAL	
FLOLAN	*PULMONARY HYPERTENSION*	*MEDICAL - LIMITED DISTRIBUTION*	
FLOXURIDINE	CANCER	MEDICAL	
FLUDARA	CANCER	MEDICAL	
FLUDARABINE PHOSPHATE	CANCER	MEDICAL	
FLUOROURACIL	CANCER	MEDICAL	
FOLLISTIM AQ	INFERTILITY	PHARMACY 100% COPAY	
FOLOTYN	*CANCER*	*MEDICAL - LIMITED DISTRIBUTION*	
FORTEO	OSTEOPOROSIS	PHARMACY - TIER 2	
FRAGMIN	ANTICOAGULANT	PHARMACY - AVAIL THRU RETAIL - TIER 2	
FUDR	CANCER	MEDICAL	
FUSILEV	CANCER	MEDICAL	
FUZEON	IMMUNE DEFICIENCY	MEDICAL	

Name	Disease State	Coverage	Preferred Alternatives
GAMASTAN S/D	IMMUNE DEFICIENCY	MEDICAL	
GAMMAGARD	IMMUNE DEFICIENCY	MEDICAL	
GAMMAKED	IMMUNE DEFICIENCY	MEDICAL	
GAMUNEX, -C	IMMUNE DEFICIENCY	MEDICAL	
GANIRELIX ACETATE	INFERTILITY	PHARMACY 100% COPAY	
GEMCITABINE HCL	CANCER	MEDICAL	
GEMZAR	CANCER	MEDICAL	
GENOTROPIN	GROWTH DEFICIENCY	MEDICAL	
GILENYA	MULTIPLE SCLEROSIS	PHARMACY- TIER 3	STEP THERAPY
GILOTRIF	CANCER	MEDICAL	
GLASSIA	RESPIRATORY CONDITIONS	MEDICAL	
GLEEVEC	CANCER	MEDICAL	
GONAL-F/RFF	INFERTILITY	PHARMACY 100% COPAY	
HALAVEN	CANCER	MEDICAL	
HELIXATE FS	HEMOPHILIA	MEDICAL	
HEMOFIL M	HEMOPHILIA	MEDICAL	
HEPAGAM B	HEPATITIS B	MEDICAL	NABI-HB - TIER 2
HERCEPTIN	CANCER	MEDICAL	
HIZENTRA	IMMUNE DEFICIENCY	MEDICAL	
HUMATE-P	HEMOPHILIA	MEDICAL	
HUMATROPE	GROWTH DEFICIENCY	MEDICAL	
HUMIRA	INFLAMMATORY CONDITIONS	PHARMACY - TIER 2	
HYALGAN	OSTEOARTHRITIS	MEDICAL	
HYCAMTIN	CANCER	MEDICAL	
HYPERHEP S/D	HEPATITIS B	MEDICAL	NABI-HB - TIER 2
HYPERRAB S/D	IMMUNE DEFICIENCY	MEDICAL	
HYPERRHO S/D	IMMUNE DEFICIENCY	MEDICAL	
IDAMYCIN PFS	CANCER	MEDICAL	
IDARUBICIN HCL	CANCER	MEDICAL	
IFEX	CANCER	MEDICAL	
IFOSFAMIDE	CANCER	MEDICAL	
IFOSFAMIDE/MESNA	CANCER	MEDICAL	
ILAIRS	AUTOINFLAMMATORY CONDITION	MEDICAL	
IMOGAM RABIES-HT	IMMUNE DEFICIENCY	MEDICAL	
INCIVEK	HEPATITIS C	MEDICAL	
INCRELEX	GROWTH DEFICIENCY	MEDICAL	
INFERGEN	HEPATITIS C	PHARMACY - TIER 3	INTRON A, ROFERON A-TIER 2
INLYTA	CANCER	MEDICAL	
INNOHEP	ANTICOAGULANT	PHARMACY - AVAIL THRU RETAIL - TIER 3	ENOXAPARIN-TIER 1, ARIXTRA OR FRAGMIN- TIER 2
INTRON A	CANCER	MEDICAL	
IPRIVASK	ANTICOAGULANT	PHARMACY - AVAIL THRU RETAIL - TIER 3	
IRESSA	CANCER	MEDICAL	
IRINOTECAN	CANCER	MEDICAL	
ISTODAX	CANCER	MEDICAL	
IXEMPRA	CANCER	MEDICAL	
JEVTANA	CANCER	MEDICAL	
KALBITOR	*HEREDITARY ANGIOEDEMA*	*MEDICAL - LIMITED DISTRIBUTION*	
KALYDECO	RESPIRATORY CONDITIONS	MEDICAL	
KEPIVANCE	*CANCER*	*MEDICAL - LIMITED DISTRIBUTION*	
KINERET	INFLAMMATORY CONDITIONS	PHARMACY - TIER 3	ENBREL - TIER 2
KOATE-DVI	HEMOPHILIA	MEDICAL	
KOGENATE FS	HEMOPHILIA	MEDICAL	
KRYSTEXXA	INFLAMMATORY CONDITIONS	MEDICAL	
KUVAN	PKU	MEDICAL	
KYPROLIS	CANCER	MEDICAL	

Name	Disease State	Coverage	Preferred Alternatives
LETAIRIS	PULMONLARY HYPERTENSION	PHARMACY - TIER 3	
LEUCOVORIN CALCIUM	CANCER	MEDICAL	
LEUKINE	BLOOD CELL DEFICIENCY	MEDICAL	
LEUPROLIDE ACETATE	CANCER	MEDICAL	
LEUSTATIN	CANCER	MEDICAL	
LOVENOX	ANTICOAGULANT	PHARMACY TIER 3	ENOXAPARIN- TIER 1
LUCENTIS	OPTHALMIC CONDITIONS	MEDICAL	
LUMIZYME	*POMPE'S DISEASE*	*MEDICAL - LIMITED DISTRIBUTION*	
LUPRON	CANCER	MEDICAL	
LUPRON DEPOT	CANCER	MEDICAL	
LUVERIS	INFERTILITY	PHARMACY 100% COPAY	
MACUGEN	OPTHALMIC CONDITIONS	MEDICAL	
MELPHALAN	CANCER	MEDICAL	
MENOPUR	INFERTILITY	PHARMACY 100% COPAY	
MESNA	CANCER	MEDICAL	
MESNEX	CANCER	MEDICAL	
METHOTREXATE	CANCER	PHARMACY - TIER 1	
MICRHOGAM PLUS	IMMUNE DEFICIENCY	MEDICAL	
MITOMYCIN	CANCER	MEDICAL	
MITOXANTRONE, HCL	CANCER	MEDICAL	
MONOCLATE-P	HEMOPHILIA	MEDICAL	
MONONINE	HEMOPHILIA	MEDICAL	
MOZOBIL	BLOOD CELL DEFICIENCY	MEDICAL	
MUSTARGEN	CANCER	MEDICAL	
MYLOTARG	CANCER	MEDICAL	
MYOBLOC	MISCELLANEOUS SPECIALTY CONDITIONS	MEDICAL	
MYOZYME	ENZYME DEFICIENCIES	MEDICAL	
NABI-HB	HEPATITIS B	MEDICAL	
NAGLAZYME	ENZYME DEFICIENCIES	MEDICAL	
NAVELBINE	CANCER	MEDICAL	
NEULASTA	BLOOD CELL DEFICIENCY	PHARMACY - TIER 3	NEUPOGEN – TIER 2
NEUMEGA	BLOOD CELL DEFICIENCY	MEDICAL	
NEUPOGEN	BLOOD CELL DEFICIENCY	PHARMACY - TIER 2	
NEXAVAR	CANCER	MEDICAL	
NIPENT	CANCER	MEDICAL	
NORDITROPIN	GROWTH DEFICIENCY	MEDICAL	
NOVANTRONE	CANCER	MEDICAL	
NOVAREL	INFERTILITY	PHARMACY 100% COPAY	
NOVOSEVEN/RT	HEMOPHILIA	MEDICAL	
NPLATE	BLOOD CELL DEFICIENCY	MEDICAL	
NULOJIX	TRANSPLANT	MEDICAL	
NUTROPIN, AQ, NUSPIN	GROWTH DEFICIENCY	MEDICAL	
OCTAGAM	IMMUNE DEFICIENCY	MEDICAL	
OCTREOTIDE ACETATE	ENDOCRINE DISORDERS	MEDICAL	
OFORTA	CANCER	MEDICAL	
OMNITROPE	GROWTH DEFICIENCY	MEDICAL	
ONCASPAR	CANCER	MEDICAL	
ONSOLIS	PAIN MANAGEMENT	PHARMACY – TIER 3	
ONTAK	CANCER	MEDICAL	
ONXOL	CANCER	MEDICAL	
ORENCIA	INFLAMMATORY CONDITIONS	INFUSION- MEDICAL SELF INJECTABLE- PHARMACY- TIER 3	
ORFADIN	*ENZYME DEFICIENCIES*	*MEDICAL - LIMITED DISTRIBUTION*	
ORTHOCLONE OKT-3	*TRANSPLANT*	*MEDICAL - LIMITED DISTRIBUTION*	
ORTHOVISC	OSTEOARTHRITIS	MEDICAL	
OVIDREL	INFERTILITY	PHARMACY 100% COPAY	
OXALIPLATIN	CANCER	MEDICAL	

Name	Disease State	Coverage	Preferred Alternatives
PACLITAXEL	CANCER	MEDICAL	
PAMIDRONATE DISODIUM	CANCER	MEDICAL	
PANRETIN	MISCELLANEOUS SPECIALTY CONDITIONS	MEDICAL	
PEGASYS	HEPATITIS C	PHARMACY –TIER 2	
PEG-INTRON/REDIPEN	HEPATITIS C	PHARMACY –TIER 2	
PERJETA	CANCER	MEDICAL	
PHOTOFRIN	CANCER	MEDICAL	
PLENAXIS	CANCER	MEDICAL	
PREGNYL	INFERTILITY	PHARMACY 100% COPAY	
PRIALT	*MISCELLANEOUS SPECIALTY CONDITIONS*	*MEDICAL - LIMITED DISTRIBUTION*	
PRIVIGEN	IMMUNE DEFICIENCY	MEDICAL	
PROCRIT	BLOOD CELL DEFICIENCY	PHARMACY - TIER 2	
PROFILNINE SD	HEMOPHILIA	MEDICAL	
PROGESTERONE IN OIL	INFERTILITY	PHARMACY 100% COPAY	
PROGRAF	*TRANSPLANT*	*INFUSION-MEDICAL - LIMITED DISTRIBUTION ORAL- PHARMACY- TIER 2*	
PROLASTIN/C	*RESPIRATORY CONDITIONS*	*MEDICAL - LIMITED DISTRIBUTION*	
PROLEUKIN	CANCER	MEDICAL	
PROLIA	OSTEOPOROSIS	PHARMACY – TIER 3	
PROMACTA	BLOOD CELL DEFICIENCY	PHARMACY – TIER 3	
PROVENGE	*IMMUNE DEFICIENCY*	*MEDICAL- LIMITED DISTRIBUTION*	
PULMOZYME	RESPIRATORY CONDITIONS	PHARMACY - TIER 3	
REBETOL	HEPATITIS C	PHARMACY - TIER 1	
REBIF	MULTIPLE SCLEROSIS	PHARMACY - TIER 2	
RECLAST	PAGET'S DISEASE/ OSTEOPORSIS	MEDICAL	ALENDRONATE- TIER 1
RECOMBINATE	HEMOPHILIA	MEDICAL	
REFACTO	HEMOPHILIA	MEDICAL	
REFLUDAN	ANTICOAGULANT	PHARMACY - AVAIL THRU RETAIL- TIER 3	ENOXAPARIN- TIER 1, ARIXTRA OR FRAGMIN- TIER 2
REMICADE	INFLAMMATORY CONDITIONS	MEDICAL	
REMODULIN	*PULMONARY HYPERTENSION*	*PHARMACY - TIER 3 - LIMITED DISTRIBUTION*	
REPRONEX	INFERTILITY	PHARMACY 100% COPAY	
RETROVIR IV	IMMUNE DEFICIENCY	MEDICAL	
REVATIO	PULMONARY HYPERTENSION	PHARMACY - TIER 3	
REVLIMID	CANCER	MEDICAL	
RHOGAM PLUS	IMMUNE DEFICIENCY	MEDICAL	
RHOPHYLAC	IMMUNE DEFICIENCY	MEDICAL	
RIBAPAK	HEPATITIS C	PHARMACY - TIER 1	
RIBASPHERE	HEPATITIS C	PHARMACY - TIER 1	
RIBATAB	HEPATITIS C	PHARMACY - TIER 1	
RIBAVIRIN- ORAL	HEPATITIS C	PHARMACY - TIER 1	
RILUTEK	MISCELLANEOUS SPECIALTY CONDITIONS	MEDICAL	
RITUXAN	CANCER	MEDICAL	
SABRIL	ANTICONVULSANT	PHARMACY – TIER 3	
SAIZEN	GROWTH DEFICIENCY	MEDICAL	
SANDOSTATIN, LAR	ENDOCRINE DISORDERS	MEDICAL	
SEROSTIM	GROWTH DEFICIENCY	MEDICAL	
SIMPONI	INFLAMMATORY CONDITIONS	PHARMACY – TIER 3	
SIMULECT	TRANSPLANT	MEDICAL	
SOLIRIS	MISCELLANEOUS SPECIALTY CONDITIONS	MEDICAL	
SOMATULINE DEPOT	ENDOCRINE DISORDERS	PHARMACY – TIER 3	
SOMAVERT	*GROWTH DEFICIENCY*	*MEDICAL - LIMITED DISTRIBUTION*	
SPRYCEL	CANCER	MEDICAL	

Name	Disease State	Coverage	Preferred Alternatives
STELARA	INFLAMMATORY CONDITIONS	PHARMACY – TIER 3	
STIVARGA	CANCER	MEDICAL	
SUCRAID	ENZYME DEFICIENCY	PHARMACY – TIER 2	
SUPARTZ	OSTEOARTHRITIS	MEDICAL	
SUPPRELIN LA	ENDOCRINE DISORDERS	MEDICAL	
SUTENT	CANCER	MEDICAL	
SYLATRON	CANCER	MEDICAL	
SYNAGIS	RSV PREVENTION	MEDICAL	
SYNVISC, -ONE	OSTEOARTHRITIS	MEDICAL	
TARCEVA	CANCER	MEDICAL	
TASIGNA	CANCER	MEDICAL	
TAXOTERE	CANCER	MEDICAL	
TEMOZOLOMIDE	CANCER	MEDICAL	
TESTOPEL	*HYPOTESTOSTERONE*	*MEDICAL - LIMITED DISTRIBUTION*	
TEV-TROPIN	GROWTH DEFICIENCY	MEDICAL	
THALOMID	CANCER	MEDICAL	
THERACYS	CANCER	MEDICAL	
THIOTEPA	CANCER	MEDICAL	
THYMOGLOBULIN	*TRANSPLANT*	*MEDICAL - LIMITED DISTRIBUTION*	
THYROGEN	CANCER	MEDICAL	
TOBI	RESPIRATORY CONDITIONS	PHARMACY - TIER 3	
TOPOSAR	CANCER	MEDICAL	
TORISEL	CANCER	MEDICAL	
TRACLEER	PULMONARY HYPERTENSION	PHARMACY - TIER 3	
TREANDA	CANCER	MEDICAL	
TRELSTAR, -DEPOT	CANCER	MEDICAL	
TRELSTAR LA	CANCER	MEDICAL	
TRISENOX	CANCER	MEDICAL	
TYKERB	CANCER	MEDICAL	
TYSABRI	MULTIPLE SCLEROSIS	MEDICAL	
TYVASO	PULMONARY HYPERTENSION	MEDICAL	
VANDETANIB	CANCER	MEDICAL	
VANTAS	CANCER	MEDICAL	
VECTIBIX	CANCER	MEDICAL	
VELCADE	CANCER	MEDICAL	
VELETRI	PULMONARY HYPERTENSION	MEDICAL	
VELETRI	*PULMONARY HYPERTENSION*	*MEDICAL - LIMITED DISTRIBUTION*	
VENTAVIS	*PULMONARY HYPERTENSION*	*MEDICAL - LIMITED DISTRIBUTION*	
VICTRELIS	HEPATITIS C	MEDICAL	
VIDAZA	CANCER	MEDICAL	
VINBLASTINE SULFATE	CANCER	MEDICAL	
VINCRISTINE SULFATE	CANCER	MEDICAL	
VINORELBINE TARTRATE	CANCER	MEDICAL	
VISUDYNE	OPHTHALMIC CONDITIONS	MEDICAL	
VIVAGLOBIN	IMMUNE DEFICIENCY	MEDICAL	
VIVITROL	MISCELLANEOUS CNS DISORDER	MEDICAL	
VOTRIENT	CANCER	MEDICAL	
VPRIV	RESPIRATORY CONDITIONS	MEDICAL	
VUMON	CANCER	MEDICAL	
WINRHO SDF	IMMUNE DEFICIENCY	MEDICAL	
XELJANZ	INFLAMMATORY CONDITIONS	TIER 2	
XELODA	CANCER	MEDICAL	
XENAZINE	MISCELLANEOUS CNS DISORDER	MEDICAL	
XEOMIN	MISCELLANEOUS CNS DISORDER	MEDICAL	
XGEVA	CANCER	MEDICAL	
XIAFLEX	MISCELLANEOUS SPECIALTY CONDITIONS	MEDICAL	
XOLAIR	RESPIRATORY CONDITIONS	MEDICAL	

Name	Disease State	Coverage	Preferred Alternatives
XGEVA	ENDOCRINE CONDITIONS	MEDICAL	
XTANDI	CANCER	MEDICAL	
XYNTHA	HEMOPHILIA	MEDICAL	
XYREM	*MISCELLANEOUS SPECIALTY CONDITIONS*	*PHARMACY – TIER 2 - LIMITED DISTRIBUTION*	
YERVOY	CANCER	MEDICAL	
ZALTRAP	CANCER	MEDICAL	
ZANOSAR	CANCER	MEDICAL	
ZAVESCA	ENZYME DEFICIENCIES	MEDICAL	
ZEMAIRA	*RESPIRATORY CONDITIONS*	*MEDICAL - LIMITED DISTRIBUTION*	
ZENAPAX	TRANSPLANT	MEDICAL	
ZEVALIN	CANCER	MEDICAL	
ZINECARD	CANCER	MEDICAL	
ZOLADEX	CANCER	MEDICAL	
ZOLINZA	CANCER	MEDICAL	
ZOMETA	CANCER	MEDICAL	
ZORBTIVE	GROWTH DEFICIENCY	MEDICAL	
ZYTIGA	CANCER	MEDICAL	

Step Therapy Program

The step therapy program was developed to encourage the use of first-line alternatives before more expensive second-line medications. If a Member does not obtain the desired clinical effect or experiences side effects at one step, then the drug choice at another step may be tried. If a step therapy rule is not met at the pharmacy, coverage will be determined by prospective (pre-service) review. You can request prospective (pre-service) review and/or certification by calling the Pharmacy Management Team at 1-800-805-7938. The following step therapy programs are listed and their clinical criteria are as follows.

Step Therapy

- Antidepressent Therapy (SSRI and SNRI)
- Avonex
- Celebrex
- Cimzia
- Crestor
- Proton Pump Inhibitors (PPIs)
- Zetia / Liptruzet

Antidepressent (SSRI and SNRI) Step Therapy

1. One generic drug will be required before a brand name drug is authorized. Generic drugs will have to have been prescribed at an effective dose for a minimum of 30 days. Documentation of attempt and failure of a generic within the last 12 months will be considered as fulfilling this requirement.
   - Bupropion sr, xl
   - Citalopram
   - Escitalopram
   - FluvoxamineFluoxetine 20 mg
   - Mirtazapine
   - Paroxetine ir, cr
   - Sertraline
   - Venlafaxine ir, xr capsules and tablets
2. Cymbalta will be covered (after a generic SSRI/ SNRI is tried a minimum of 30 days) at the 2nd tier copay level. This medication will also be covered if being used for chronic pain, diabetes neuropathy or fibromyalgia, PA will still be required, no step therapy necessary.
3. Pristiq will be covered (after a generic SSRI/ SNRI is tried a minimum of 30 days) at the 2nd tier copay level.
4. Viibryd will be covered (after a generic SSRI/ SNRI is tried a minimum of 30 days) at the 2nd tier copay level.

Avonex Step Therapy

- Trial and/or failure of Betaseron, Copaxone or Rebif is required prior to approval. This medication will be covered at the Members 3nd tier copay through CuraScripts.

Celebrex Step Therapy

1. Celebrex is covered without authorization at a limit of 30 pills per month for Members at 3rd tier copay.
2. Exceptions for formulary coverage at a 2nd tier copay can be approved for Members if one of the following criteria has been met:
   - Age >= 65 years of age
   - Past history of a GI bleed, perforation, obstruction
   - Requires use of long-term (>1 month) oral corticosteroid therapy
   - Currently taking warfarin (Coumadin) or dicumarol
   - Diagnosis of rheumatoid arthritis
   - Members with reduced platelet counts <75,000
3. Members with the diagnosis of rheumatoid arthritis will be granted approval for >30 pills per month.

Cimzia Step Therapy

- Trial and/or failure of Enbrel , Humira or Simponi is required prior to approval. Drug will be covered at the Member's 3rd tier copay.

Crestor Step Therapy

- The Member must have a minimum 30 day trial of one of the following medications in the last 12 months for possible consideration
  - Atorvastatin
  - Lovastatin
  - Pravastatin
  - Simvatatin

Proton Pump Inhibitors (PPIs) Step Therapy

- A minimum 30 day trial of generic omeprazole and pantoprazole are required before use of a non-formulary PPI will be considered.
- Prior authorization is required for lansoprazole solutabs. This is based on medical necessity for all members over the age of 12 years.

Zetia/Liptruzet Step Therapy

1. The Member must have tried and failed one of the following drugs (may be brand or generic) or combination of drugs at the following dosage:

Brand Name	Daily Dose
Advicor	≥2000 mg/40 mg
Atorvastin	≥20 mg
Lovastatin	≥40 mg
Pravastatin	≥40 mg
Simvastatin	≥40 mg

2. The Member has tried one of the drugs from the above list and cannot tolerate the side effects.
3. The Member is taking or will be taking a medication that has drug interactions with a drug from the above listing.
4. Children or adolescents <17 years of age must have tried a drug from the above list at the clinically appropriate pediatric dose.
5. Members with severe renal impairment of creatinine clearance ≤30 mL/minute.
6. Homozygous familial hypercholesterolemia.
7. Homozygous familial sitosterolemia.
8. Pregnant women.
9. Active liver disease or unexplained persistent elevations of serum transaminases.

Certification

Drugs that Require Prospective (Pre-service) Review and Certification

To be considered for coverage by Sanford Health Plan, the following medications require a written certification of medical necessity for a formulary exception. Fax the written certification of Medical Necessity to Pharmacy Management at (605) 328-6813.

Medications

- Byetta; failure of covered oral medications.
- Bydueron: failure of covered oral medications
- Lovaza; Triglyceride level must be greater than 500
- Testosterone Products (Androderm, Androgel, Axiron, Testoderm, Testosterone Injectable); requires a below normal testosterone level within the last 6 months with symptoms of testosterone deficiency other than erectile dysfunction.
- Symlin; failure of covered oral medications .
- Uloric: failure of generic allopurinol .
- Victoza; failure of covered oral medications .

Limited and Non-Covered Services

Excluded Drugs and Supplies

Requests for coverage of Non-Preferred Brand-Name Drugs will not be considered unless the Member has tried and failed a Formulary alternative.

The following medications are specifically **EXCLUDED** from coverage under the Plan unless regulation, a formulary exception, or a previous certification has been granted by the Plan:

- Drugs not listed in the Sanford Health Plan Formulary or without Prior-Authorization or a formulary exception from The Plan;
- Replacement of a prescription drug due to loss, damage, or theft;
- Outpatient drugs dispensed in a Provider's office or non-retail pharmacy location;
- Drugs that may be received without charge under a federal, state, or local program;
- Drugs for cosmetic purposes, including baldness, removal of facial hair, or pigmenting or anti-pigmenting of the skin;
- Refills of any prescription older than one year;
- Compound medications with no legend (prescription) medication;
- Acne medication for Members over age thirty (30) (e.g. Retin-A Microgel);
- B-12 injection (except for pernicious anemia);
- Drug Efficacy Study Implementation ("DESI") drugs;
- Experimental or Investigational drugs or drug usage if not recognized by the Food and Drug Administration;
- Growth hormone, except when medically indicated and Prior-Approved by the Plan;
- Orthomolecular therapy, including nutrients, vitamins (including but not limited to prenatal vitamins),multi-vitamins with iron and/or fluoride, food supplements and baby formula (except to treat PKU or otherwise required to sustain life), nutritional and electrolyte substances;
- Medications, equipment or supplies available over-the-counter (OTC) (except for insulin and select diabetic supplies, e.g., insulin syringes, needles, test strips and lancets) that by federal or state law do not require a prescription order; any medication that is equivalent to an OTC medication except for drugs that have a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force and only when prescribed by a healthcare Practitioner and/or Provider;
- Drugs and associated expenses and devices not approved by the FDA for a particular use except as required by law (unless Provider certifies off-label use with a letter of medical necessity);
- Anorexiants or Weight management drugs except when Medically Necessary ;
- Whole Blood and Blood Components Not Classified as Drugs in the United States Pharmacopoeia;
- Medication used to treat infertility;
- Smoking deterrant products such as Chantix except when Medically Necessary and per Plan guidelines; and
- Unit dose packaging.

Drug Exclusion List

The following drugs (and their generic equivalent, if listed) are excluded by the Sanford Health Plan, as there are similar drugs in this category available for coverage. Brand name products will not be covered when an A-B rated generic is available.

Excluded Drug	Formulary Alternative
Aciphex	omeprazole, pantoprazole
Actonel	alendronate
Adrenaclick	Epipen/Jr., Auvi-Q
Aerobid/-M	Flovent, Pulmicort, Qvar
Alamast	generics, Patanol, Pataday
Allegra/-D	OTC products available
Alocril	generics, Patanol, Pataday
Alomide	generics, Patanol, Pataday
Alora	estrogen patches,, Vivelle-DOT
Alrex	generics, Patanol, Pataday
Altoprev	lovastatin
Alvesco	Flovent, Pulmicort, QVAR
Ambien, CR	zolpidem
Angelig	Prempro/Premphase, Fem HRT
Anzemet	ondansetron
Antara	gemfibrozil, fenofibrate, TriLipix
Apidra	Humalog, Novolog
Apriso	Asacol, Lialda, Pentasa
Asmanex	Flovent, Pulmicort, Qvar
Atacand/HCT	generics
Atralin	tretinoin, adapalene, Differin, Retin-A Microgel, Epiduo
Avinza	morphine sulfate, oxycodone
Avita	tretinoin, adapalene, Differin, Retin-A Microgel, Epiduo
Azmacort	Flovent, Pulmicort, Qvar
Azelex	tretinoin, Differin
Azor	amlodipine + losartan
Beclovent	Flovent, Pulmicort, Qvar
Beconase/AQ	flunisolide, fluticasone, Nasonex
Benicar/HCT	generics
Binosto	alendronate
Boniva	alendronate
Brisdelle	paroxetine
Bromday	diclofenac, ketorolac
Brovana	Perforomist
Cambia	diclofenac
Cardene SR	felodipine, amlodipine
Cardura XL	doxazosin, finasteride, Uroxatral
Cedax	cefprozil, cefuroxine, amoxicillin/clavulanate
Cenestin	generics, Premarin
Cetraxal	ofloxacin, Ciprodex
Cipro HC	ofloxacin, Ciprodex
Clarinex/-D	OTC products available
ClimaraPro	Combipatch
Colazal	Asacol, Lialda, Pentasa
Cyclessa	generic oral contraceptives
Dexilant	omeprazole, pantoprazole
Dipentum	Asacol, Lialda, Pentasa
Dulera	Advair, Symbicort
Durezol	generics, Lotemax
DynaCirc/CR	felodipine, amlopidine, nifedipine ER

Excluded Drug	Formulary Alternative
Edarbi	losartan
Edular	zolpidem, zaleplon
Elestat	generics, Patanol, Pataday
Emadine	generics, Patanol, Pataday
Enablex	oxybutynin/ er, Detrol LA, Toviaz, Vesicare
Enjuvia	generics, Premarin
Epinephrine-Auto Injector	Epipen/Jr., Auvi-Q
Estraderm	estrogen patches, Vivell-DOT
Exforge	amlodipine + losartan
Fanapt	Abilify, Geodon, Risperdal, Seroquel, Zyprexa
Femcon FE	generic oral contraceptives
Femtrace	generics, Premarin
Fexofenadine	OTC products available
FML Forte	generics, Lotemax
Fortesta	Androderm, Androgel, Axiron
Fosamax-D	alendronate
Gelnique	oxybutynin er, Detrol LA, Toviaz, Vesicare
Generese	generic oral contraceptives
Helidac	Bismuth Subsalicylate + generic metronidazole + tetracycline
Invega	olanzapine, quetiapine, risperidone, ziprasidone, Abilify tab, Latuda Seroquel XR
Iquix	generics, Vigamox
Kadian	morphine sulfate, oxycodone
Kombiglyze XR	Januvia, Onglyza
lansoprazole caps	omeprazole, pantoprazole
Lastacaft	generics, Patanol, Pataday
LescolXL	atorvastatin, simvastatin, p ravastatin, lovastatin
Lipofen	simvastatin, pravastatin, lovastatin
Livalo	atorvastatin, simvastatin, pravastatin, lovastatin
Loestrin 24 Fe	generic oral contraceptives
Lofibra	fenofibrate
LoSeasonique	generic oral contraceptives
Lunesta	zolpidem, zaleplon
Luvox CR	fluvoxamine
Maxair Autohaler	Ventolin HFA, ProAir HFA
Menest	generics, Premarin
Menostar	estrogen patches, Vivelle-DOT
Micardis/HCT	generics
Moxatag	amoxicillin
Moxeza	generics, Vigamox
Myrbetriq	generics, Detrol, Vesicare
Naprelan CR	ibuprofen, naproxen sodium
Nasocort/ AQ	flunisolide, fluticasone, Nasonex
Natazia	generic oral contraceptives
Nevenac	diclofenac, ketorolac, Acuvail

Excluded Drug	Formulary Alternative
Nexium	omeprazole, pantoprazole
Omnaris	flunisolide, fluticasone, Nasonex
Opana, ER	morphine sulfate, oxycodone
Optivar	generics, Patanol, Pataday
Oracea	doxycycline 20mg caps x2
Oxytrol	oxybutynin er, Detrol LA, Toviaz, Vesicare
Patanase	azelastine, Astepro
PrevPac	generic clarithromycin + amoxicillin + lansoprazole
Prefest	Prempro, Premphase, FemHRT
Prilosec	omeprazole, pantoprazole
Protonix	omeprazole, pantoprazole
Proventil HFA	Ventolin HFA, Proair HFA
Prozac Weekly	fluoxetine
Quixin	generics, Vigamox
Rapaflo	generics, Uroxatrol
Renova	tretinoin, Retin-A Microgel, Differin
Ritalin LA	generics, Vyvanse
Rhinocort/AQ	flunisolide, fluticasone , Nasonex
Rozerem	zaleplon, zolpidem
Rynatan	OTC products available
Safyral	generic oral contraceptives
Sancuso	ondansetron, granisetron
Silenor	zolpidem, zaleplon
Solodyn ER	minocycline
Spectracef	cefprozil, cefuroxime, amoxicillin/clavulante
Sular	generic felodipine, generic amlodipine (Norvasc)
Suprax	cefprozil, cefuroxime, amoxicillin/clavulanate
Symbyax	fluoxetine + Zyprexa
Tecfidera	Avonex, Betaseron, Rebif
Testim	Androderm, Androgel, Axiron
Teveten/HCT	generics
TravatanZ	lantanoprost, Lumigan
Treximet	sumatriptan + naproxen
Tribenzor	amlodipine + losartan/HCT
Triglide	gemfibrozil, fenofibrate, TriLipix
Tussionex	promethazine-codeine
Twinject	Epipen/ Jr., Auvi-Q
Twynsta	amlodipine + losartan
Vascepa	Lovaza
Vexol	generics, Lotemax
Vimovo	naproxen + omeprazole
Vytorin	atorvastatin, simvastatin , pravastatin, lovastatin
Xopenex HFA	ProAir HFA, Ventolin HFA
Xyzal	OTC products available
Zegerid	omeprazole
Zioptan	lantanoprost, Lumigan
Zolpimist	zolipdem
Zuplenz	ondansetron

Compounded drug products that contain any combination of baclofen, cyclobenzaprine, ketamine, bupivacaine, orphendadrine, gabapentin, or ketoprofen are **NOT COVERED** due to lack of good quality scientific evidence of effectiveness or safety for these specific ingredient combinations and mode of administration.

Quantity Limit List*

The following drugs do not require certification but have a quantity limit:

Anzemet—1 tablets/ prescription (not covered unless part of step therapy program)
Axert—6 tablets/prescription
butorphanol tartrate- nasal spray —2 spray bottles/ prescription
Emend—3 pills/prescription (3rd tier copay)
Frova—9 tablets/prescription
granisetron (generic Kytril)—2 tablets/prescription (not covered unless medically necessary)
Lysteda- 30 tablets/prescription
Migranal—4 spray/prescription
naratriptan (generic Amerge)—9 tablets/prescription
Relpax—12 tablets/prescription
rizatriptan(generic Maxalt)—12 tablets/prescription
sumatriptan (generic Imitrex)—12 tablets/ 6 nasal spray or 1 kit for injections/prescription or 2 injections
Zomig—6 ampules/sprays/prescription
zolmitriptan(generic Zomig)—12 tablets / prescription

**There is a 30-day prescription limit excluding maintenance medications. If you would like a complete listing or information about a specific drug please contact the Pharmacy Management Team at 1-800-805-7938, or log into myHealthPlan at www.sanfordhealthplan.com/myhealthplan.*

Special Quantity Limits

The following drugs, when approved by authorization, are only available in quantities of 30 per prescription for one copay. Additional quantities will generate additional copays.

Formulary Drugs:

Cymbalta 60 mg daily limitation

Non-Formulary Drugs

Nexium
Aciphex
Dexilant

Complaints and Appeals Procedure

If you receive an adverse determination to your request for an exception to the formulary, please follow the *Complaints and Appeals Procedure* and the *External Review Rights* in the Policy. This applies to requests for coverage of non-covered medications, generic substitutions, therapeutic interchanges and step-therapy protocols.

Definitions

4-Tier Formulary

A 4-Tier drug program uses a copayment structure that reduces your out-of-pocket costs when using Generic Drugs and Preferred Brand Name Drugs. When a prescription is filled, your copayment will be at least one of these tiers: *

Tier 1: Generic Drugs
Tier 2: Preferred Brand Name Drugs
Tier 3: Non-Preferred Brand Name Drugs
Tier 4: Formulary or Specialty Name Brand Drugs exceeding a contracted value of $400

3-Tier Formulary

A 3-Tier drug program uses a copayment structure that reduces your out-of-pocket costs when using Generic Drugs and Preferred Brand Name Drugs. When a prescription is filled, your copayment will be at least one of these tiers: *

Tier 1: Generic Drugs
Tier 2: Preferred Brand Name Drugs
Tier 3: Non-Preferred Brand Name Drugs

2-Tier Formulary

A 2-Tier drug program uses a copayment structure that reduces your out-of-pocket costs when using Generic Drugs and Preferred Brand Name Drugs. When a prescription is filled, your copayment will be at one of these tiers: *

Tier 1: Generic Drugs
Tier 2: All covered Brand Name Drugs

*The higher the tier, the higher the copay

Brand Name Drug

A drug manufactured and marketed under a trademark or name by a specific drug manufacturer.

Certification Process

The process of obtaining prior authorization for coverage of certain prescription drug products prior to their being dispensed, using guidelines approved by the Sanford Health Plan. Refer to the section on *Drugs that Require Prospective (pre-service) Review and Certification* in this booklet.

Clinic/Office/Hospital Outpatient Administered Injectables

Injectable medications that may be given in a variety of settings but must be given by a healthcare professional. These drugs are considered to be a medical benefit with coverage at the deductible and coinsurance level.

Copay (also known as Copayment)

The specified charge (flat dollar amount or percentage) that the Member is required to pay for a Prescription Drug Product.

Covered Drugs

The following types of drugs are covered unless subject to an exception listed under “Excluded Drugs and Supplies:”

1. Federal Legend Drugs: any medicinal substance which bears the legend, "Caution: Federal Law prohibits dispensing without a prescription," except for those medicinal substances classified as exempt narcotics pursuant to State law;
2. An injectable drug can be prescribed to either be self-administered or administered by a healthcare professional. Covered injectable drugs include insulin. Refer to the Injectable Drug Listing in this book for additional covered drugs.
3. State Restricted Drugs: any medicinal substance which may only be dispensed with a prescription according to State law;
4. Compound Medications: any medicinal substance which must be mixed, compounded, or otherwise prepared by a registered pharmacist and has at least one ingredient that is a Federal legend or State restricted drug in a therapeutic quantity. Claims must be submitted electronically from the pharmacy for coverage consideration. *refer to the compound section on *Drug Exclusion List* to see policy exclusions;
5. Diabetic Treatment: Items listed below are available in a 90 day supply. A supply that is meant to last 30 days or less will generate 1 copay, a supply that lasts 31-60 days will generate 2 copays and a supply that lasts from 61-90 days will generate 3 copays.
    - needles
    - injectable insulin
    - syringes
    - lancets
    - test strips - maximum amount of 205 strips per month with a healthcare Practitioner order

Drug Exclusion
Sanford Health Plan reserves the right to maintain a drug listing of medications which are specifically not covered under benefit packages per Plan policy. Payment for the drugs on this list will be the Member's responsibility in full. Members may request a review of an adverse determination based on issues of medical necessity as it relates to non-covered medications, generic substitution, therapeutic interchanges and step-therapy protocols. Refer to *Drug Exclusion List* and *Complaints and Appeals Procedure* in this book.

Drug Formulary
A list which identifies those Prescription Drug Products which are preferred by the Plan for dispensing to Members when appropriate. This list is subject to periodic review and modifications.

Generic Drug
Drugs that (1) are approved by the Food and Drug Administration (FDA) as a therapeutic equivalent to the Brand Name Drug, (2) contain the same active ingredient as the Brand Name Drug, and (3) cost less than the Brand Name equivalent.

Maintenance Drug List
A list of drug products, typically used for chronic conditions, approved by Sanford Health Plan, allowed to be dispensed in 90 day quantities.

Medical Benefit
Refers to drugs which are covered at the deductible/coinsurance level instead of with a copay.

Member
An individual eligible for benefits under the Plan.

Non-Participating Pharmacy
A pharmacy that does not have a contract with Express Scripts Inc., on behalf of Sanford Health Plan. **If a Sanford Health Plan Member utilizes a Non-Participating Pharmacy, except in an emergency, the Member is responsible for the full cost of the prescription drug.**

Non-Preferred Brand-Name Drug
Brand-Name drug not on Sanford Health Plan's Formulary.
Requests for coverage of Non-Preferred Brand-Name Drugs will not be considered unless the Member has tried and failed a Formulary alternative. These drugs are provided at a higher cost share to the Member. This is the 3rd or 4th Tier Copay in a 3-Tier or 4- Tier Formulary.

Over-the-Counter (OTC) Drug
A drug product that does not require a prescription order under Federal or State law. Sanford Health Plan does not cover any medications that can be obtained over-the-counter.

Participating Pharmacy
A pharmacy that has contracted with Express Scripts Inc., on behalf of Sanford Health Plan to deliver prescription drug services to Members. The Participating Pharmacy may be a hospital, pharmacy or other facility that has contractually

accepted the terms and conditions set forth by the Health Plan. Refer to the Sanford Health Plan Participating Pharmacy Listing or Express Scripts website found on www.sanfordhealthplan.com/myhealthplan. **If a Sanford Health Plan Member does not utilize their prescription card, except in an emergency, the Member is responsible for the full cost of the prescription drug.**

Preferred Brand-Name Drug
A prescription drug that is available only as a name brand medication, is preferred by Sanford Health Plan and is listed in the Drug Formulary. A preferred brand name drug is typically available at the 2nd tier copay in a 3- Tier or 4- Tier Formulary.

Prescription Drug Product
A medication, product or device approved by the Food and Drug Administration (FDA) and dispensed under Federal or State law only, pursuant to a prescription order or refill.

Reasonable Costs
Costs that do not exceed the lesser of: (a) negotiated schedule of payment developed by the Plan which is accepted as payment in full by Participating Practitioner and/or Providers within the Plan's Service Area or (b) the prevailing marketplace charges.

Self-Injectable
Self-administered injectable drugs can be given at home by the patient or caregiver. Typically these drugs are covered under the pharmacy benefit.

Specialty Drugs
Specialty drugs are defined as injectable and non-injectable drugs that have one or more of several key characteristics, including:

- Requirement for frequent dosing adjustments and intensive clinical monitoring to decrease the potential for drug toxicity and increase the probability for beneficial treatment outcomes.
- Need for intensive patient training and compliance assistance to facilitate therapeutic goals.
- Limited or exclusive product availability and distribution.
- Specialized product handling and/or administration requirements.
- Cost in excess of $500 for a 30-day supply

Step Therapy Program
Program using protocols that specify the order in which different drugs for a given condition are prescribed. If a Member does not obtain the desired clinical effect or experiences side effects at one step, then the drug choice at another step may be tried. Step therapy requires the use of first-line alternatives before more expensive second-line drugs are covered by the pharmacy benefit.

Supply
- Drugs are typically dispensed in quantities of 30 days or less for one copay, unless otherwise approved by the Plan. In some instances, if more than a typical 30 day supply is dispensed an additional copay will be charged. Examples include: all brand name Proton Pump Inhibitors and Cymbalta.
- Maintenance drugs may be dispensed in a 90-day supply, but a copayment applies to each 30-day supply received.

Affordable Care Act (ACA) Mandated Drug Coverage
The Affordable Care Act requires all non-grandfathered health plans to cover ten categories of essential health benefits; one of these essential health benefits categories include prescription drugs. Sanford Health Plan is required to cover the following over the counter (OTC) medications prescribed by a physician/practitioner and filled by a participating pharmacy for its *Simplicity* members.

Essential Health Benefits (EHB)

Drug Category	Dosage Form	Criteria
Aspirin to prevent cardiovascular disease	Generic OTC agents 81mg and 325mg only	Men ages 45 to 79 Women ages 55 to 79
Fluoride	Generic Rx and Generic OTC (single entity and combo products)	Children older than 6 months of age through 5 years old

Folic Acid	Generic Rx and Generic OTC 0.4mg and 0.8mg only	Women through age of 50 years
Iron Supplements	Generic Rx and Generic OTC (single entity and combo products)	Children older than 6 months of age through 12 months
Vitamin D	Generic Rx and Generic OTC (single entity with calcium ≤1,000 units of Vit D)	Age ≥ 65 years
Bowel Preparation Agents	Generic Rx only with primary indication of colonoscopy preparation	Adults; ages 50 to 75 years (2 prescriptions per 365 days)

The ACA mandates that FDA approved contraceptive methods be covered by Health Plans for women as prescribed by Practioners. Sanford Health Plan has a formulary listing for the covered generic contraceptive oral medications. This can be found under chapter 13.7 of the formulary. Coverage is also offered for the following preferred brand medications at the 3rd tier copay; Ortho Tri-Cyclen Lo, NuvaRing and Ortho Evra. Also covered at the pharmacy with a prescription are the following barrier methods; diaphragms and cervical caps.

Formulary

for North Dakota Medicaid members

The following is a list of the most commonly prescribed drugs. It represents an abbreviated version of the drug formulary that is the core of your pharmacy benefit coverage. In addition to using this list, allowing substitution of generic products is encouraged when appropriate.

Generic drugs are indicated in bold. Tier 2 co-payment will apply to all of the covered brands listed on this formulary. Brand name drugs are listed in CAPITAL letters.

This is NOT a complete listing of covered drugs. For a complete list of medications, you can go to "find a pharmacy" at www.sanfordhealthplan.com/myhealthplan and link to the Express Scripts website.

"PA Required" indicates that prior authorization is required on that specific medication. "Step therapy" indicates the medication requires the use of first-line alternatives before more expensive second-line drugs are covered by the pharmacy benefit. Drugs marked with an asterisk (*) must be obtained from CuraScript.

If you are currently taking or are prescribed an injectable medication, please contact CuraScript Injectable Drug Program at (866) 333-9721 to order your drugs. Refer to the Pharmacy Handbook for a complete listing of drugs and instructions.

If you have questions regarding coverage call (855)-276-7214.

Table of Contents

DRUG NAME	PA/STEP/QLL	TIER 1	TIER 2	SUGGESTED PREFFERED ALTERNATIVES
CHAPTER 1: ANESTHETICS				
1.2 TOPICAL ANESTHETICS				
lidocaine hcl		X		
lidocaine-prilocaine		X		
LIDODERM			X	
CHAPTER 2: ANTIINFECTIVES				
2.1.1 CEPHALOSPORINS				
cefaclor er		X		
cefadroxil		X		
cefdinir		X		
cefpodoxime proxetil		X		
cefprozil		X		
cefuroxime		X		
cephalexin		X		
CEDAX			X	**cefprozil, cefuroxime, amox/clav**
SUPRAX			X	**cefprozil, cefuroxime, amox/clav**
2.1.3 CLINDAMYCINS				
clindamycin hcl		X		
clindamycin phosphate		X		
2.1.4 ERYTHROMYCINS				
erythromycin		X		
2.1.4.1 OTHER MACROLIDES				
azithromycin		X		
clarithromycin/er		X		
2.1.5 PENICILLINS				
amox tr-potassium clavulanate		X		
amoxicillin		X		
amoxicillin-clavulanate er		X		
dicloxacillin sodium		X		
penicillin v potassium		X		
2.1.6 SULFONAMIDES				
sulfamethoxazole-trimethoprim		X		
2.1.7 TETRACYCLINES				
doxycycline hyclate		X		
doxycycline monohydrate		X		
minocycline hcl		X		
tetracycline hcl		X		
DORYX			X	
2.1.8 URINARY ANTIINFECTIVES				
nitrofurantoin		X		
nitrofurantoin mono-macro		X		
trimethoprim		X		
2.1.9 QUINOLONES				
ciprofloxacin, -er		X		
levofloxacin		X		
ofloxacin		X		
AVELOX/ABC PACK			X	
FACTIVE			X	
NOROXIN			X	**ciprofloxacin, levofoxacin, ofloxacin**
2.2 TOPICAL ANTIBACTERIAL DRUGS				
gentamicin sulfate		X		
mupirocin		X		

DRUG NAME	PA/STEP/QLL	TIER		SUGGESTED PREFFERED ALTERNATIVES
		1	2	
silver sulfadiazine		X		
ALTABAX			X	
BACTROBAN NASAL OINTMENT			X	
2.3 ORAL ANTIFUNGAL DRUGS				
fluconazole		X		
griseofulvin		X		
itraconazole		X		
ketoconazole		X		
nystatin		X		
terbinafine hcl		X		
voriconazole		X		
GRIFULVIN V			X	
ONMEL			X	
ORAVIG			X	
2.4.1 VAGINAL ANTIFUNGALS				
clotrimazole		X		
terconazole		X		
2.4.2 OTHER TOPICAL ANTIFUNGALS				
ciclopirox		X		
clotrimazole		X		
econazole nitrate		X		
ketoconazole		X		
nystatin		X		
ERTACZO			X	**generic**/OTC ANTIFUNGAL
EXELDERM			X	**generic**/OTC ANTIFUNGAL
NAFTIN			X	**generics**, LOROX
OXISTAT			X	**generic**/OTC ANTIFUNGAL
2.4.3 TOPICAL ANTIFUNGAL-CORTICOSTEROID COMB.				
clotrimazole-betamethasone		X		
nystatin-triamcinolone		X		
2.5.1 ANTIRETROVIRALS & PROTEASE INHIBITORS				
lamivudine		X		
lamivudine-zidovudine		X		
nevirapine		X		
ATRIPLA			X	
COMBIVIR			X	
COMPLERA			X	
EPIVIR			X	
EPZICOM			X	
INCIVEK	PA		X	
INTELENCE			X	
ISENTRESS			X	
KALETRA			X	
LEXIVA			X	
NORVIR			X	
PREZISTA			X	
REYATAZ			X	
SUSTIVA			X	
TRUVADA			X	
VICTRELIS	PA		X	
VIRAMUNE			X	
VIRAMUNE XR			X	

DRUG NAME	PA/STEP/QLL	TIER		SUGGESTED PREFFERED ALTERNATIVES
		1	2	
VIREAD			X	
ZIAGEN			X	
2.5.2 OTHER ANTIVIRAL DRUGS				
acyclovir		X		
amantadine		X		
famciclovir		X		
ribapak		X		
ribavirin		X		
valacyclovir		X		
BARACLUDE			X	
DENAVIR			X	
EPIVIR HBV			X	
RELENZA	QLL		X	
TAMIFLU	QLL		X	
2.6 TOPICAL ANTIVIRAL DRUGS				
XERESE			X	
ZOVIRAX			X	
2.7.2 ANTITUBERCULOSIS DRUGS				
isoniazid		X		
rifampin		X		
MYCOBUTIN			X	
2.7.3 PLASMODICIDES				
atovaquone-proguanil hcl		X		
hydroxychloroquine sulfate		X		
mefloquine hcl		X		
QUALAQUIN			X	
2.7.4 SULFONES				
DAPSONE			X	
2.7.5 TRICHOMONOCIDES				
metronidazole		X		
tinidazole		X		
2.8 OTHER ANTIINFECTIVE DRUGS				
bacitracin		X		
vancomycin hcl		X		
DIFICID			X	
MEPRON			X	
NEBUPENT			X	
VANCOCIN PULVULE	PA		X	
XIFAXAN			X	
ZYVOX	PA		X	
2.8.2 AMINOGLYCOSIDES				
gentamicin sulfate		X		
tobramycin sulfate		X		
TOBI			X	
CHAPTER 3: ANTINEOPLASTIC/IMMUNOSUPPRESSANT DRUGS				
3.0 ANTINEOPLASTIC/IMMUNOSUPPRESSANT DRUGS				
anagrelide hcl		X		
azathioprine		X		
cyclosporine modified		X		
hydroxyurea		X		
leflunomide		X		
megestrol acetate		X		

DRUG NAME	PA/STEP/QLL	TIER		SUGGESTED PREFFERED ALTERNATIVES
		1	2	
mercaptopurine		X		
methotrexate		X		
mycophenolate mofetil		X		
tacrolimus		X		
tamoxifen citrate		X		
tretinoin		X		
ENBREL	PA		X	
HUMIRA	PA		X	
MEGACE ES			X	
MYFORTIC			X	
RAPAMUNE			X	
SIMPONI	PA		X	
STELARA	PA		X	
CHAPTER 4: CARDIOVASCULAR MEDICATIONS				
4.1 CARDIAC GLYCOSIDES				
digoxin		X		
LANOXIN			X	
4.2 CALCIUM ANTAGONISTS				
amlodipine besylate		X		
cartia xt		X		
diltiazem/er		X		
felodipine er		X		
nifediac cc		X		
nifedical xl		X		
nifedipine er		X		
nisoldipine		X		
verapamil/er pm		X		
CARDENE SR			X	**generics, amlodipine**
CARDIZEM LA			X	
SULAR			X	**nisoldipine**
4.3.1 LOOP DIURETICS				
bumetanide		X		
furosemide		X		
torsemide		X		
4.3.2 THIAZIDE AND RELATED DRUGS				
chlorthalidone		X		
hydrochlorothiazide		X		
indapamide		X		
metolazone		X		
4.3.3 POTASSIUM SPARING DIURETICS				
amiloride hcl		X		
eplerenone		X		
spironolactone		X		
spironolactone-hctz		X		
triamterene-hctz		X		
triamterene-hydrochlorothiazid		X		
4.4 BETA-ADRENERGIC ANTAGONIST DRUGS				
acebutolol hcl		X		
atenolol		X		
bisoprolol fumarate		X		
carvedilol		X		
labetalol hcl		X		

DRUG NAME	PA/STEP/QLL	TIER		SUGGESTED PREFFERED ALTERNATIVES
		1	2	
metoprolol succinate		X		
metoprolol tartrate		X		
nadolol		X		
pindolol		X		
propranolol hcl		X		
timolol maleate		X		
BYSTOLIC			X	
COREG CR			X	**carvedilol**
INNOPRAN XL			X	
4.5.1 VASODILATOR ANTIHYPERTENSIVES				
doxazosin mesylate		X		
minoxidil		X		
prazosin hcl		X		
terazosin hcl		X		
4.5.2 CENTRALLY ACTING ANTIHYPERTENSIVES				
clonidine, hcl		X		
guanfacine hcl		X		
methyldopa		X		
4.5.4.1 ANGIOTENSIN CONVERTING ENZYME INHIBITORS				
benazepril hcl		X		
captopril		X		
enalapril maleate		X		
fosinopril sodium		X		
lisinopril		X		
moexipril hcl		X		
quinapril hcl		X		
ramipril		X		
trandolapril		X		
4.5.4.2 ANGIOTENSIN II RECEPTOR ANTAGONISTS				
candesartan, -hctz		X		
eprosartan mesylate		X		
irbesartan, -hctz		X		
losartan, -hctz		X		
valsartan hctz		X		
DIOVAN			X	
EDARBI			X	**Generics**
MICARDIS, -HCT			X	**Generics**
TEVETEN HCT			X	**generics**
4.5.6 OTHER ANTIHYPERTENSIVES				
amlodipine besylate-benazepril		X		
atenolol-chlorthalidone		X		
benazepril-hydrochlorothiazide		X		
bisoprolol-hydrochlorothiazide		X		
captopril-hydrochlorothiazide		X		
enalapril-hydrochlorothiazide		X		
fosinopril-hydrochlorothiazide		X		
irbesartan-hydrochlorothiazide		X		
lisinopril-hydrochlorothiazide		X		
losartan-hydrochlorothiazide		X		
metoprolol-hydrochlorothiazide		X		
moexipril-hydrochlorothiazide		X		
AMTURNIDE			X	

DRUG NAME	PA/STEP/QLL	TIER		SUGGESTED PREFFERED ALTERNATIVES
		1	2	
AZOR			X	
EXFORGE/HCT			X	
TARKA ER			X	**trandolapril/verapamil**
TEKAMLO			X	
TEKTURNA/HCT			X	
TRIBENZOR			X	
4.6.1 NITRATES				
isosorbide		X		
isosorbide dinitrate		X		
nitroglycerin		X		
nitroglycerin patch		X		
NITROSTAT			X	
4.7.1.3 CLASS 1C				
flecainide acetate		X		
propafenone hcl		X		
RYTHMOL SR			X	**propafenone**
4.7.3 AMIODARONES				
amiodarone hcl		X		
4.7.5 OTHER ANTIARRHYTHMICS				
sotalol		X		
MULTAQ			X	
TIKOSYN			X	
4.8.1 HYPOLIPOPROTEINEMICS				
cholestyramine		X		
colestipol hcl		X		
fenofibrate		X		
fenofibric acid		X		
gemfibrozil		X		
LOVAZA	PA		X	
WELCHOL			X	
ZETIA	ST		X	
4.8.2 HMG-COA REDUCTASE INHIBITORS				
atorvastatin		X		
fluvastatin	ST	X		
lovastatin		X		
pravastatin		X		
simvastatin		X		
CRESTOR	ST		X	
LIVALO	ST		X	**generic HMGs**
4.8.2.1 HMG-COA COMBINATIONS				
amlodipine-atorvastatin		X		
ADVICOR			X	
CADUET	ST		X	
LIPTRUZET	ST		X	
4.9 OTHER CARDIOVASCULAR DRUGS				
pentoxifylline		X		
RANEXA			X	
CHAPTER 5: AUTONOMIC AND CNS MEDICATIONS				
5.1.1 ANALGESICS				
butorphanol tartrate		X		
tramadol hcl/er		X		
tramadol hcl-acetaminophen		X		

DRUG NAME	PA/STEP/QLL	TIER		SUGGESTED PREFFERED ALTERNATIVES
		1	2	
5.1.1.1 CLASS II NARCOTICS				
endocet		X		
fentanyl		X		
hydromorphone hcl		X		
methadone hcl		X		
morphine sulfate/er		X		
oxycodone hcl		X		
oxycodone-acetaminophen		X		
oxymorphone hcl		X		
ROXICET		X		
NUCYNTA, -ER	PA		X	
OPANA ER	PA		X	
OXYCONTIN			X	
5.1.1.2 CLASS III NARCOTICS				
acetaminophen-codeine		X		
buprenorphine hcl		X		
hydrocodone bit-ibuprofen		X		
hydrocodone-acetaminophen		X		
reprexain		X		
zamicet		X		
BUTRANS			X	
SUBOXONE			X	
5.1.2 DRUGS TO PREVENT AND TREAT HEADACHES				
butalbital compound-codeine		X		
butalbital-aspirin-caffeine		X		
dihydroergotamine nasal spray		X		
naratriptan tab	9/rx	X		
rizatriptan tab	12/rx	X		
sumatriptan tab	12/rx	X		
sumatriptan inj	1 kit/rx	X		
sumatriptan nasal spray	6/rx	X		
zolmitriptan -zmt tab	12/rx	X		
AXERT	6/rx		X	**naratriptan, rizatriptan, sumatriptan, zolmitritan**
FROVA	9/rx		X	**naratriptan, rizatriptan, sumatriptan, zolmitritan**
RELPAX	12/rx		X	
ZOMIG NASAL SPRAY	6/rx		X	
5.2.1 ANXIOLYTICS				
alprazolam/er/xr		X		
buspirone hcl		X		
chlordiazepoxide hcl		X		
clorazepate dipotassium		X		
diazepam		X		
lorazepam		X		
oxazepam		X		
5.2.2 SEDATIVE/HYPNOTIC DRUGS				
estazolam		X		
flurazepam		X		
temazepam		X		
triazolam		X		
zaleplon		X		
zolpidem tartrate, -er		X		
LUNESTA			X	**zolpidem, zaleplon**

DRUG NAME	PA/STEP/QLL	TIER		SUGGESTED PREFFERED ALTERNATIVES
		1	2	
ROZEREM			X	**zolpidem, zaleplon**
5.3 ANTIMANIA DRUGS				
lithium carbonate		X		
5.4.1 CARBAMAZEPINES				
carbamazepine, -xr		X		
oxcarbazepine		X		
TEGRETOL XR			X	**carbamazepine xr**
5.4.2 ANTICONVULSANT BENZODIAZEPINES				
clonazepam		X		
diazepam		X		
5.4.3 HYDANTOINS				
phenytoin sodium extended		X		
DILANTIN			X	
PHENYTEK			X	
5.4.4 VALPROIC ACID AND DERIVATIVES				
divalproex sodium, -er		X		
valproic acid		X		
5.4.6 ANTICONVULSANT BARBITURATES				
phenobarbital		X		
primidone		X		
5.4.7 OTHER ANTICONVULSANTS				
gabapentin		X		
lamotrigine		X		
levetiracetam		X		
topiramate		X		
zonisamide		X		
GRALISE			X	
HORIZANT			X	
KEPPRA, XR			X	
LAMICTAL, -ODT, -XR			X	**lamotrigine**
LYRICA			X	
POTIGA			X	
VIMPAT			X	
5.5.1.1 TERTIARY AMINES				
amitriptyline hcl		X		
clomipramine hcl		X		
doxepin hcl		X		
imipramine hcl		X		
5.5.1.2 SECONDARY AMINES				
desipramine hcl		X		
nortriptyline hcl		X		
5.5.1.3 SELECTIVE SEROTONIN REUPTAKE INHIBITORS				
citalopram, - hbr		X		
escitalopram oxalate		X		
fluoxetine hcl		X		
fluvoxamine maleate		X		
paroxetine hcl		X		
sertraline hcl		X		
VIIBRYD	ST		X	
5.5.1.4 OTHER ANTIDEPRESSANTS				
bupropion hcl,- sr, -xl		X		
mirtazapine		X		

DRUG NAME	PA/STEP/QLL	TIER		SUGGESTED PREFFERED ALTERNATIVES
		1	2	
nefazodone hcl		X		
trazodone hcl		X		
venlafaxine hcl, -er	ST	X		
CYMBALTA	ST/QLL		X	
PRISTIQ ER	ST		X	
SAVELLA			X	
5.5.2 MAO INHIBITORS				
tranylcypromine sulfate		X		
5.6 ANTIVERTIGO AND ANTIEMETIC DRUGS				
dronabinol		X		
granisetron hcl	LIMIT 2/rx	X		
meclizine hcl		X		
ondansetron hcl		X		
ondansetron odt		X		
prochlorperazine maleate		X		
promethazine hcl		X		
promethegan		X		
ANZEMET	LIMIT 1/rx		X	
EMEND	LIMIT 3/rx		X	**granisetron, ondansetron**
TRANSDERM-SCOP			X	
5.7.1 ANTIPARKINSON ANTICHOLINERGIC DRUGS				
benztropine mesylate		X		
trihexyphenidyl hcl		X		
5.7.2 OTHER ANTIPARKINSON DRUGS				
bromocriptine mesylate		X		
carbidopa-levodopa		X		
carbidopa-levodopa-entacapone		X		
pramipexole dihydrochloride		X		
ropinirole hcl		X		
AZILECT			X	
COMTAN			X	
MIRAPEX ER			X	
NEUPRO			X	
REQUIP XL			X	
STALEVO			X	**use generic**
5.8 ANTIPSYCHOTIC DRUGS				
clozapine		X		
fluphenazine hcl		X		
haloperidol		X		
olanzapine, -odt		X		
perphenazine		X		
quetiapine fumarate		X		
risperidone		X		
thioridazine hcl		X		
thiothixene		X		
trifluoperazine hcl		X		
ziprasidone hcl		X		
ABILIFY			X	
FANAPT			X	**generics**
GEODON			X	
INVEGA ER	PA		X	**generics**
LATUDA			X	

DRUG NAME	PA/STEP/QLL	TIER		SUGGESTED PREFFERED ALTERNATIVES
		1	2	
SAPHRIS	PA		X	**generics**
SEROQUEL XR			X	
5.8.1 ALIPHATIC PHENOTHIAZINES				
chlorpromazine hcl		X		
5.8.1.1 PSYCHOTHERAPEUTIC COMBINATIONS				
olanzapine-fluoxetine hcl		X		
SYMBYAX			X	
5.9.1 CNS STIMULANT DRUGS				
amphetamine salt combo		X		
dexmethylphenidate hcl, -sulfate		X		
dextroamphetamine-amphetamine		X		
methylphenidate er, -hcl, -sr		X		
modafinil		X		
DAYTRANA			X	
FOCALIN XR			X	
NUVIGIL			X	
QUILLIVANT XR			X	
RITALIN LA			X	**methylphenidate**
VYVANSE			X	
5.9.2 OTHER CNS/AUTONOMIC DRUGS				
atropine sulfate		X		
naltrexone hcl		X		
pyridostigmine bromide		X		
NUEDEXTA			X	
5.9.3 ANTIDEMENTIA DRUGS				
donepezil hcl		X		
galantamine hbr		X		
rivastigmine		X		
ARICEPT/ODT			X	donepezil
EXELON SOLUTION, PATCHES			X	rivastigmine
NAMENDA			X	
NAMENDA XR			X	
5.9.6 OTHER DRUGS FOR ADHD				
INTUNIV			X	
KAPVAY			X	
STRATTERA			X	
CHAPTER 6: DERMATOLOGICAL MEDICATIONS				
6.1 TOPICAL CORTICOSTEROID DRUGS				
alclometasone dipropionate		X		
betamethasone dipropionate		X		
betamethasone valerate		X		
clobetasol		X		
desonide		X		
desoximetasone		X		
fluocinolone		X		
fluticasone propionate		X		
halobetasol propionate		X		
hydrocortisone butyrate, -valerate		X		
mometasone furoate		X		
triamcinolone acetonide		X		

DRUG NAME	PA/STEP/QLL	TIER		SUGGESTED PREFFERED ALTERNATIVES
		1	2	
CLOBEX			X	
HALOG			X	**generics**
KENALOG			X	**halobetasol propionate**
OLUX-E			X	**clobetasol propionate**
ULTRAVATE PAC			X	**halobetasol propionate**
6.2 ANTIPRURITIC DRUGS				
hydroxyzine		X		
6.3 ANTIACNE DRUGS				
adapalene		X		
benzoyl peroxide		X		
clindamycin phosphate		X		
clindamycin-benzoyl peroxide		X		
erythromycin		X		
erythromycin-benzoyl peroxide		X		
metronidazole		X		
sodium sulfacetamide-sulfur		X		
tretinoin	PA	X		
ACANYA			X	
BENZACLIN			X	
DIFFERIN 0.1% LOTION & 0.3% GEL			X	**adapalene**
DUAC			X	
EPIDUO			X	
FINACEA			X	
METROGEL			X	
RETIN-A MICRO/PUMP	PA		X	
6.3.1 ACCUTANES				
isotretinoin		X		
6.7 KERATOLYTIC DRUGS				
CONDYLOX			X	**podofilox**
6.8 ANTIPSORIASIS AND ANTIECZEMA DRUGS				
calcipotriene		X		
calcitrene		X		
selenium sulfide		X		
sulfacetamide sodium		X		
DOVONEX			X	
SORILUX			X	
TACLONEX			X	
TAZORAC			X	
VECTICAL			X	**calcipotriene ointment**
6.9.2 TOPICAL DERMATOLOGICAL DRUGS				
fluorouracil		X		
imiquimod		X		
tretinoin		X		
CARAC			X	
ELIDEL			X	
EPICERAM			X	
FLUOROPLEX			X	
PICATO			X	
PROTOPIC			X	
SANTYL			X	
SOLARAZE			X	**fluorouracil**

DRUG NAME	PA/STEP/QLL	TIER		SUGGESTED PREFFERED ALTERNATIVES
		1	2	
VEREGEN			X	**podofilox**
ZYCLARA			X	
6.9.3 SCABICIDES				
permethrin		X		
EURAX			X	
ULESFIA			X	
6.9.5 TOPICAL ANTI-INFLAMMATORY DRUGS				
FLECTOR			X	
VOLTAREN			X	
CHAPTER 7: EAR-NOSE-THROAT MEDICATIONS				
7.1 DRUGS AFFECTING THE EAR				
antipyrine-benzocaine		X		
neomycin-polymyxin-hc		X		
neomycin-polymyxin-hydrocort		X		
ofloxacin		X		
CIPRODEX			X	**generic otic quinolone**
7.2 DRUGS AFFECTING THE NOSE				
azelastine hcl		X		
flunisolide		X		
fluticasone propionate		X		
ipratropium bromide		X		
ASTELIN			X	
ASTEPRO			X	
DYMISTA			X	
NASONEX			X	
QNASL	PA		X	
VERAMYST	PA		X	**fluticasone**
ZETONNA	PA		X	
7.3 DRUGS AFFECTING THE THROAT AND MOUTH				
doxycycline hyclate		X		
pilocarpine hcl		X		
triamcinolone acetonide		X		
CHAPTER 8: ENDOCRINE MEDICATIONS				
8.1.1 INSULIN				
APIDRA/SOLOSTAR			X	
HUMALOG		X		
HUMULIN		X		
LANTUS/SOLOSTAR			X	
LEVEMIR/FLEXPEN			X	
NOVOLIN		X		
NOVOLOG/FLEXPEN			X	
NOVOLOG MIX 70-30/FLEXPEN			X	
8.1.2 ORAL HYPOGLYCEMIC DRUGS				
acarbose		X		
glimepiride		X		
glipizide, -er, -xl, -w/metformin		X		
glyburide, -micronized, -w/metformin		X		
metformin hcl/er		X		
nateglinide		X		
FORTAMET			X	
PRANDIMET			X	

DRUG NAME	PA/STEP/QLL	TIER		SUGGESTED PREFFERED ALTERNATIVES
		1	2	
PRANDIN			X	
RIOMET			X	**metformin**
8.1.3 INSULIN SENSITIZERS				
pioglitazone		X		
pioglitazone-metformin		X		
ACTOPLUS MET XR			X	
AVANDAMET			X	**pioglitazone-metformin**
AVANDARYL			X	**pioglitazone + sulfonylurea**
AVANDIA			X	**pioglitazone**
DUETACT			X	
8.1.4 AMYLIN ANALOGUES				
SYMLINPEN VIAL	PA		X	
SYMLINPEN PEN	PA		X	
8.1.5.1 INCRETIN MIMETICS				
BYDUREON	ST		X	
BYETTA	ST		X	
VICTOZA	ST		X	
8.1.5.2 DIPEPTIDYL PEPTIDASE-IV INHIBITORS				
JANUMET/XR			X	
JANUVIA			X	
JENTADUETO			X	
JUVISYNC			X	
KOMBIGLYZE XR			X	
ONGLYZA			X	
TRADJENTA			X	
8.2 GLUCOSE ELEVATING DRUGS				
GLUCAGEN			X	
GLUCAGON EMERGENCY KIT			X	
8.3.1 GLUCOCORTICOID DRUGS				
dexamethasone		X		
dexamethasone sodium phosphate		X		
hydrocortisone		X		
methylprednisolone		X		
prednisolone		X		
prednisone		X		
veripred 20 solution		X		
8.3.2 MINERALOCORTICOID DRUGS				
fludrocortisone acetate		X		
8.4.1 THYROID SUPPLEMENTS				
levothyroxine sodium		X		
ARMOUR THYROID			X	
CYTOMEL			X	**liothyronine**
SYNTHROID			X	
8.4.2 ANTITHYROID DRUGS				
methimazole		X		
propylthiouracil		X		
8.6 OTHER ENDOCRINE DRUGS				
alendronate sodium		X		
desmopressin acetate		X		
etidronate disodium		X		
ibandronate sodium		X		

DRUG NAME	PA/STEP/QLL	TIER		SUGGESTED PREFFERED ALTERNATIVES
		1	2	
ACTONEL	PA		X	**alendronate**
CHAPTER 9: GASTROINTESTINAL MEDICATIONS				
9.2 ANTIDIARRHEAL DRUGS				
diphenoxylate-atropine		X		
loperamide		X		
9.3 ANTISPASMODICS/DRUGS AFFECT GI MOTILITY				
chlordiazepoxide-clidinium		X		
dicyclomine hcl		X		
hyoscyamine sulfate		X		
metoclopramide hcl		X		
9.4.1 OTHER ANTIULCER DRUGS				
misoprostol		X		
sucralfate		X		
CARAFATE			X	
9.4.2 PROTON PUMP INHIBITORS				
omeprazole		X		
pantoprazole sodium		X		
ACIPHEX	PA		X	**pantoprazole, omeprazole**
DEXILANT	PA		X	**pantoprazole, omeprazole**
NEXIUM	PA		X	**pantoprazole, omeprazole**
9.4.3 HELICOBACTER PYLORI DRUGS				
HELIDAC			X	**generic equivalents**
OMECLAMOX-PAK			X	**generic equivalents**
PREVPAC			X	**generic equivalents**
PYLERA			X	**generic equivalents**
9.5 LAXATIVES AND CATHARTICS				
OSMOPREP			X	
9.6 OTHER GI DRUGS				
anucort-hc		X		
balsalazide disodium		X		
budesonide ec		X		
hydrocortisone, -acetate		X		
pancrelipase 5,000		X		
peg 3350-electrolyte		X		
proctosol-hc		X		
proctozone-hc		X		
sulfasalazine		X		
trilyte with flavor packets		X		
ursodiol		X		
ANALPRAM E			X	
ANALPRAM HC			X	
ASACOL HD			X	
CANASA			X	
CREON DR			X	
DELZICOL			X	
DIPENTUM			X	**sulfasalazine**
GOLYTELY			X	
HALFLYTELY-BISACODYL			X	**peg electrolyte**
LIALDA			X	
MOVIPREP			X	**peg electrolyte**
NULYTELY WITH FLAVOR PACKS			X	
PANCREAZE			X	

DRUG NAME	PA/STEP/QLL	TIER		SUGGESTED PREFFERED ALTERNATIVES
		1	2	
PENTASA			X	
PERTZYE			X	
PREPOPIK			X	
RECTIV			X	
SUPREP			X	
ULTRESA			X	
ZENPEP			X	
9.7 IRRITABLE BOWEL DRUGS				
AMITIZA			X	
LINZESS			X	
CHAPTER 11: MUSCULOSKELETAL MEDICATIONS				
11.1.1 SALICYLATES AND RELATED DRUGS				
aspirin, -ec		X		$0 with Rx, age restriction applies
choline mag trisalicylate		X		
diflunisal		X		
salsalate		X		
11.1.2 NON-STEROIDAL ANTIINFLAMMATORY AGENTS				
diclofenac potassium, -sodium		X		
etodolac		X		
flurbiprofen		X		
ibuprofen		X		
indomethacin		X		
ketoprofen		X		
ketorolac tromethamine		X		
meloxicam		X		
nabumetone		X		
naproxen		X		
oxaprozin		X		
piroxicam		X		
sulindac		X		
CELEBREX	QLL		X	
NAPRELAN CR			X	**naproxen**
11.2 DRUGS TO PREVENT AND TREAT GOUT				
allopurinol		X		
probenecid		X		
COLCRYS			X	
ULORIC	PA		X	
11.3.1 DIRECT MUSCLE RELAXANTS				
baclofen		X		
tizanidine hcl		X		
11.3.2 CNS MUSCLE RELAXANTS				
carisoprodol		X		
chlorzoxazone		X		
cyclobenzaprine hcl		X		
metaxalone		X		
methocarbamol		X		
orphenadrine citrate		X		
AMRIX ER			X	**cyclobenzaprine**
CHAPTER 12: NUTRITION,BLOOD				
12.1.3 THERAPEUTIC VITAMINS & MINERALS				
calcitriol		X		
calcium acetate		X		

DRUG NAME	PA/STEP/QLL	TIER		SUGGESTED PREFFERED ALTERNATIVES
		1	2	
eliphos		X		
folic acid		X		$0 with Rx for females age 50 & younger
levocarnitine		X		
vitamin d		X		$0 with Rx for age 65 years & older
12.1.4 FLUORIDE PRODUCTS				
sodium fluoride		X		
12.2 POTASSIUM SUPPLEMENTS				
potassium chloride		X		
12.3.1 ORAL ANTICOAGULANTS, VITAMIN K				
warfarin sodium		X		
COUMADIN			X	
12.3.2 HEPARIN AND HEPARIN ANTAGONISTS				
enoxaparin sodium		X		
fondaparinux sodium		X		
ARIXTRA			X	
FRAGMIN			X	
12.3.3 OTHER DRUGS AFFECTING COAGULATION				
ELIQUIS			X	
XARELTO			X	
12.3.5 THROMBIN INHIBITORS				
PRADAXA			X	
12.4 ANTIPLATELET DRUGS				
cilostazol		X		
clopidogrel		X		
dipyridamole		X		
AGGRENOX			X	
BRILINTA			X	
EFFIENT			X	
12.5 HEMOSTATICS				
LYSTEDA			X	
12.7 BLOOD DETOXICANTS				
enulose		X		
lactulose		X		
FOSRENOL			X	
KRISTALOSE			X	
RENAGEL			X	
RENVELA			X	
CHAPTER 13: OBSTETRICAL & GYNECOLOGICAL MEDICATIONS				
13.1.3 OB/GYN TOPICAL ANTIINFECTIVES				
clindamycin phosphate		X		
metronidazole		X		
vandazole		X		
13.3 ANDROGEN DRUGS				
testosterone cypionate	PA	X		
ANDRODERM	PA		X	
ANDROGEL	PA		X	
AXIRON	PA		X	
STRIANT	PA		X	
13.4 ESTROGEN DRUGS				
estradiol		X		

DRUG NAME	PA/STEP/QLL	TIER		SUGGESTED PREFFERED ALTERNATIVES
		1	2	
estrogen-methyltestosterone		X		
estropipate		X		
CENESTIN			X	
DIVIGEL			X	orals or patches
ELESTRIN			X	orals or patches
ENJUVIA			X	
ESTRACE			X	
ESTRASORB			X	orals or patches
ESTRING	QLL		X	
ESTROGEL			X	orals or patches
EVAMIST			X	orals or patches
MENEST			X	
MINIVELLE			X	
PREMARIN			X	
VAGIFEM			X	
VIVELLE-DOT			X	
13.4.1 ESTROGEN/PROGESTIN COMBINATIONS				
jinteli		X		
ACTIVELLA			X	
CLIMARA PRO			X	
COMBIPATCH			X	
FEMHRT			X	
PREFEST			X	
PREMPHASE			X	
PREMPRO			X	
13.4.3 SELECTIVE ESTROGEN RECEPTOR MODULATOR				
EVISTA			X	
13.5 PROGESTIN DRUGS				
camila		X		
errin		X		
jolivette		X		
nora-be		X		
norethindrone		X		
CRINONE GEL			X	
PROMETRIUM			X	
13.7 CONTRACEPTIVES				
gildess/fe, lutera, marlissa, heather, introvale, jolessa, jolivette, junel/fe, kariva, kelnor, kurvelo, leena, lessina, levonest, levonor-eth estrad, levora		X		
low-ogestrel, microgestin/fe, mono-linya, mononessa, myzilra, necon, nora-be, norethindrone, norgestimate-eth estradiol, norg-ethin estr, nortrel, ocella, orsythia		X		
portia, previfem, quasense, reclipsen, solia, sprintec, sronyx, syeda, tri-estarylla, tri-linyah, trinessa, tri-previfem, tri-sprintec, trivora, velivet, viorele, wera, zarah, zovia		X		
NUVARING	QLL		X	
ORTHO EVRA	QLL		X	
ORTHO TRI-CYCLEN LO	QLL		X	
CHAPTER 14: OPHTHALMIC MEDICATIONS				
14.1.1 OPHTHALMIC TOPICAL ANTIBACTERIAL DRUGS				

DRUG NAME	PA/STEP/QLL	TIER		SUGGESTED PREFFERED ALTERNATIVES
		1	2	
bacitracin		X		
bacitracin-polymyxin		X		
ciprofloxacin hcl		X		
erythromycin		X		
gentamicin sulfate		X		
neomycin-bacitracin-polymyxin		X		
ofloxacin		X		
polymyxin b sul-trimethoprim		X		
sulfacetamide sodium		X		
AZASITE			X	
BESIVANCE	PA		X	
MOXEZA	PA		X	
VIGAMOX			X	
14.1.2 OPHTHALMIC TOPICAL ANTIVIRAL DRUGS				
trifluridine		X		
14.2 OPHTHALMIC CORTICOSTEROID DRUGS				
fluorometholone		X		
prednisolone acetate		X		
DUREZOL			X	
LOTEMAX			X	
VEXOL			X	
14.3 OPHTHALMIC ANTIINFECTIVE/CORTICOSTEROIDS				
neomycin-polymyxin-dexameth		X		
neomycin-polymyxin-hc		X		
tobramycin-dexamethasone		X		
ZYLET			X	
14.5 ANTIGLAUCOMA DRUGS				
acetazolamide		X		
brimonidine tartrate		X		
dorzolamide hcl		X		
dorzolamide-timolol		X		
latanoprost		X		
levobunolol hcl		X		
pilocarpine hcl		X		
timolol maleate		X		
ALPHAGAN P			X	
AZOPT			X	**generics**
BETIMOL			X	**betaxolol, timolol**
BETOPTIC S			X	**betaxolol**
COMBIGAN			X	**generics**
COSOPT PF			X	
ISTALOL			X	**timolol maleate**
LUMIGAN	PA		X	
TRAVATAN Z	PA		X	
14.6 OTHER OPHTHALMIC DRUGS				
atropine sulfate		X		
azelastine hcl		X		
cromolyn sodium		X		
diclofenac sodium		X		
epinastine hcl		X		
ACUVAIL	PA		X	
ALOCRIL	PA		X	**OTC ketotifen**

DRUG NAME	PA/STEP/QLL	TIER		SUGGESTED PREFFERED ALTERNATIVES
		1	2	
ALOMIDE	PA		X	**OTC ketotifen**
BEPREVE	PA		X	**OTC ketotifen**
EMADINE	PA		X	**OTC ketotifen**
LASTACAFT	PA		X	
PATADAY			X	
PATANOL			X	
RESTASIS			X	
CHAPTER 15: RESPIRATORY MEDICATIONS				
15.1.1 BETA-2 ADRENERGIC DRUGS				
albuterol sulfate		X		
metaproterenol sulfate		X		
ARCAPTA NEOHALER			X	
BROVANA	PA		X	
FORADIL			X	
MAXAIR AUTOHALER	PA		X	
PERFOROMIST			X	
PROAIR HFA			X	
SEREVENT DISKUS			X	
VENTOLIN HFA			X	
XOPENEX SOLUTION			X	
15.1.2 METHYL XANTHINE DRUGS				
theophylline		X		
theophylline anhydrous		X		
15.1.3 OTHER DRUGS FOR ASTHMA				
budesonide		X		
cromolyn sodium		X		
epinephrine		X		
ipratropium bromide		X		
ipratropium-albuterol		X		
ADVAIR DISKUS			X	
ADVAIR HFA			X	
ASMANEX			X	
ATROVENT HFA			X	
AUVI-Q			X	
COMBIVENT, -RESPIMAT			X	
DULERA			X	
EPIPEN, -JR			X	
FLOVENT HFA, -DISKUS			X	
PULMICORT FLEXHALER			X	
QVAR			X	
SPIRIVA			X	
SYMBICORT			X	
TUDORZA PRESSAIR			X	
15.1.4 LEUKOTRIENE MODIFIERS				
montelukast sodium		X		
zafirlukast		X		
15.2.1 ANTIHISTAMINES				
arbinoxa		X		
cyproheptadine hcl		X		
desloratadine		X		
fexofenadine hcl		X		
levocetirizine dihydrochloride		X		

DRUG NAME	PA/STEP/QLL	TIER		SUGGESTED PREFFERED ALTERNATIVES
		1	2	
promethazine hcl		X		
15.2.3 ANTIHISTAMINE/DECONGESTANT COMBINATIONS				
promethazine vc		X		
15.3 ANTITUSSIVE AND EXPECTORANT DRUGS				
benzonatate		X		
guaifenesin-codeine		X		
promethazine vc-codeine		X		
promethazine-codeine		X		
promethazine-dm		X		
REZIRA			X	
ZUTRIPRO			X	
15.4 OTHER RESPIRATORY DRUGS				
DALIRESP			X	
CHAPTER 16: UROLOGICAL MEDICATIONS				
16.1.1 ANTICHOLINERGIC ANTISPASMODICS				
oxybutynin chloride, -er		X		
tolterodine tartrate		X		
trospium chloride, -er				
DETROL LA	ST		X	
ENABLEX	ST		X	**generics**
TOVIAZ	ST		X	
VESICARE	ST		X	
16.1.2 CHOLINERGIC STIMULANTS				
bethanechol chloride		X		
16.1.3 URINARY ANESTHETICS				
phenazopyridine hcl		X		
16.1.4 OTHER GENITOURINARY PRODUCTS				
alfuzosin hcl		X		
finasteride		X		
potassium citrate		X		
tamsulosin hcl		X		
AVODART			X	
ELMIRON			X	
FLOMAX			X	**tamsulosin**
JALYN			X	
RAPAFLO			X	
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ONE TOUCH		X		

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SANFORD HEALTH PLAN

This form can be completed by a member or practitioner when seeking coverage for a medication that qualifies as a non-formulary drug, meaning not covered, or one requiring a prior authorization.

Review Criteria

The following criteria will be used in determining whether or not a formulary exception or prior authorization request is approved:

1. Has the member failed an appropriate trial of formulary (covered) medications or over the counter options prior to this request?
2. Are the choices available on the drug formulary not appropriate or recommended for the member's medical needs?
3. Has the member had unacceptable side effects from the formulary drug?

Required Information

All information MUST be completed or the form will be returned to sender. Please be **very specific** in all areas to speed the process.

Name: _____ ID: _____ Date of Birth: _____

Phone #: _____ Diagnosis: _____ Drug Requested: _____

Dosage, quantity requested (per month) and length of treatment, if known: _____

_____

Reason for medication request: _____

_____

Other medications (prescription or over the counter) tried and/or failed; please describe nature of failure including details. Check here if none ☐:_____

_____

For provider use only:

Other pertinent history and labs (relative or pertaining to this request): _____

_____

Prescribing Practitioner Name/Specialty: _____

Prescribing Practitioner Address, City, State, Zip: _____

Prescribing Practitioner Phone #: ( ) _____ Prescribing Practitioner Fax #: ( ) _____

Pharmacy Name: _____ Pharmacy Phone #: ( ) _____

Who filled out this form: _____

Relationship to member: _____ Date: _____

PRODUCT DETAILS OF CAYSTON® (AZTREONAM)

INDICATIONS AND USE: Cayston (aztreonam for inhalation solution) is a monobactam antibacterial indicated to improve respiratory symptoms in cystic fibrosis (CF) patients with *Pseudomonas aeruginosa.* Safety and effectiveness have not been established in pediatric patients below the age of 7 years, patients with FEV_1 <25% or >75% predicted, or patients colonized with *Burkholderia cepacia.*

DOSAGE FORMS: Each kit for a 28-day course of Cayston contains 84 sterile vials of Cayston and 88 ampules of sterile diluent packed in 2 cartons, each carton containing a 14-day supply.

ADMINISTRATION: The recommended dose of Cayston for both adults and pediatric patients 7 years of age and older is one single-use vial (75mg of aztreonam) reconstituted with 1 mL of sterile diluent administered 3 times a day for a 28-day course (followed by 28 days off therapy). Dosage is not based on weight or adjusted for age. Doses should be taken at least 4 hours apart. Cayston is administered by inhalation using an Altera® Nebulizer System. Patients should use a bronchodilator before administration of Cayston.

CONTRAINDICATIONS: Do not administer to patients with a known allergy to aztreonam.

SPECIAL POPULATIONS:

- Cayston is classified as pregnancy category B. No adequate and well-controlled studies of aztreonam for injection or Cayston in pregnant women have been conducted. Cayston should be used during pregnancy only if clearly needed.
- Use of Cayston during breastfeeding is unlikely to pose a risk to infants.
- The safety and effectiveness in pediatric patients below the age of 7 have not been established.
- Clinical trials of Cayston did not include Cayston-treated patients aged 65 years of age and older to determine whether they respond differently from younger patients.
- Cayston may be administered to patients with mild, moderate, and severe renal impairment with no dosage adjustment.

WARNINGS AND PRECAUTIONS:

- Allergic reaction to Cayston was seen in clinical trials. Stop treatment if an allergic reaction occurs. Use caution when Cayston is administered to patients with known allergic reaction to beta-lactams.
- Bronchospasm has been reported with Cayston. Stop treatment if chest tightness develops during nebulizer use.
- Healthcare providers should consider a patient's baseline FEV_1 measured prior to Cayston therapy and the presence of other symptoms when evaluating whether post-treatment changes in FEV_1 are caused by a pulmonary exacerbation.
- Prescribing Cayston in the absence of known *Pseudomonas aeruginosa* infection in patients with CF is unlikely to provide benefit and increases the risk of development of drug-resistant bacteria.

ADVERSE REACTIONS: Common adverse reactions (more than 5%) occurring more frequently in Cayston patients are cough, nasal congestion, wheezing, pharyngolaryngeal pain, pyrexia, chest discomfort, abdominal pain, and vomiting.

DRUG INTERACTIONS: No formal clinical studies of drug interactions with Cayston have been conducted.

PATIENT COUNSELING INFORMATION:

- Cayston is a prescription inhaled antibiotic used to improve breathing symptoms in people with cystic fibrosis who have *Pseudomonas aeruginosa* in their lungs.
- Cayston is only for infections caused by bacteria. It is not for infections caused by viruses, such as the common cold.
- Cayston is used only with the Altera® Nebulizer System.
- Patients should complete the full 28-day course of Cayston even if they are feeling better.
- If a dose is missed, take all 3 daily doses as long as the doses are at least 4 hours apart.
- Use a bronchodilator prior to administration of Cayston.
- Patients taking several inhaled medications should be advised to use the medications in the following order of administration: bronchodilator, mucolytics, and lastly, Cayston.
- Patients who believe they are experiencing an allergic reaction to Cayston should be advised to contact their doctor immediately.

References:

1. Cayston® [package insert]. Foster City, CA: Gilead Sciences, Inc.; September 2012.

PRODUCT DETAILS OF PROCYSBI™ (CYSTEAMINE BITARTRATE)

INDICATIONS AND USE: Procysbi (cysteamine bitartrate) is a cysteine-depleting agent indicated for the management of nephropathic cystinosis in adults and children ages 6 years and older.

DOSAGE FORMS: Procysbi is available as 25 mg and 75 mg delayed-release capsules.

ADMINISTRATION: Procysbi should be prescribed by a physician experienced in management of nephropathic cystinosis.

- Swallow capsules whole or after sprinkling on food or in recommended liquids. Administer via gastrostomy tube (12 F or larger) after mixing with food.
- Total daily dose is 1.3 gm/m^2/day in two divided doses, every 12 hours.
- Take Procysbi at least 2 hours after and at least 30 minutes before eating.
- Goal of therapy is to maintain a white blood cell (WBC) cysteine level <1 nmol ½ cysteine/mg protein or a plasma cysteamine concentration >0.1 mg/L.
- Patients switching from immediate-release cysteamine to Procysbi should take a total daily dose of Procysbi equal to their previous total daily dose of immediate-release cysteamine bitartrate.
- Starting dose in cysteamine-naïve patients is ⅛ to ¼ of the maintenance dose of Procysbi. The dose should be raised gradually over 4 to 6 weeks to help reduce the risk of side effects.
- If a dose is missed, it should be taken as soon as possible. However, if a patient has missed a dose and the next scheduled dose is due in less than 4 hours, the patient should be instructed to not take the missed dose, and to take the next dose on time.

CONTRAINDICATIONS: The use of Procysbi is contraindicated in patients who are hypersensitive to penicillamine.

SPECIAL POPULATIONS:

- Procysbi is classified as pregnancy category C. Procysbi should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.
- Because of the potential for serious adverse reactions in nursing infants, nursing is not recommended.
- Procysbi therapy should be initiated as soon as the diagnosis of nephropathic cystinosis has been confirmed in children greater than 6 years and adults. The risks and benefits of treatment with Procysbi in children under 6 years old are not yet established.

WARNINGS AND PRECAUTIONS:

- Ehlers-Danlos like Syndrome: Reduce dosage if skin and bone lesions occur.
- Skin Rash: Discontinue if severe skin rash such as erythema multiforme bullosa or toxic epidermal necrolysis occurs.
- Gastrointestinal: Monitor for symptoms of gastrointestinal ulceration and bleeding.
- Central Nervous System: Monitor for seizures, lethargy, somnolence, depression, and encephalopathy.

- Leukopenia and Elevated Alkaline Phosphatase Levels: Monitor white blood cell count and elevated alkaline phosphatase levels.
- Benign Intracranial Hypertension: Monitor for signs and symptoms of benign intracranial hypertension.

ADVERSE REACTIONS: Common adverse reactions (more than 5%) are vomiting, abdominal pain/discomfort, headaches, nausea, diarrhea, anorexia/decreased appetite, breath odor, fatigue, dizziness, skin odor, and rash.

DRUG INTERACTIONS: Procysbi can be administered with electrolyte (except bicarbonate) and mineral replacements necessary for management of Fanconi Syndrome as well as vitamin D and thyroid hormone.

PATIENT COUNSELING INFORMATION:

- Procysbi requires extensive laboratory monitoring to determine the correct dose.
- Take Procysbi consistently and do not miss doses. If a missed dose is within 4 hours of the next dose, skip the missed dose and take the next regularly scheduled dose. Do not double the dose.
- Take Procysbi at least 2 hours after and at least 30 minutes before eating.
- Immediately contact physician if pregnancy is suspected.
- Breastfeeding is not recommended.
- Exercise caution in driving a car or engaging in other hazardous activities after taking Procysbi.
- Procysbi may cause ulcers and bleeding. Contact physician immediately if stomach pain, nausea, vomiting, loss of appetite, or vomiting blood is experienced.
- Contact physician immediately if a skin rash is experienced.
- Lab testing to monitor for low white blood cell count and elevated alkaline phosphatase will be needed while taking Procysbi.
- Contact physician immediately if experiencing headache, tinnitus, dizziness, nausea, double vision, blurry vision, loss of vision, or eye pain.
- Report any skin changes to physician.

References:

1. Procysbi® [package insert]. Novato, CA: Raptor Pharmaceuticals, Inc.; April 2013.

PRODUCT DETAILS OF RAVICTI® (GLYCEROL PHENYLBUTYRATE)

INDICATIONS AND USE: Ravicti (glycerol phenylbutyrate) is indicated for use as a nitrogen-binding agent for chronic management of adult and pediatric patients 2 years of age and older with urea cycle disorders (UCD) who cannot be managed by dietary protein restriction and/or amino acid supplementation alone.

DOSAGE FORMS: Ravicti is available as an oral liquid containing 1.1 g/mL of glycerol phenylbutyrate.

ADMINISTRATION: Ravicti should be prescribed by a physician experienced in management of UCDs.

- Take with food and administer directly into mouth via oral syringe or dosing cup.
- Give Ravicti in 3 equally divided doses, each rounded up to the nearest 0.5 mL.
- The maximum total daily dosage is 17.5 mL (19g).
- Ravicti must be used with dietary protein restriction and, in some cases, dietary supplements (e.g., essential amino acids, arginine, citrulline, protein-free calorie supplements).
- Patients switching from sodium phenylbutyrate to Ravicti should receive the dosage of Ravicti that contains the same amount of phenylbutyric acid. The conversion is daily dosage of Ravicti (mL) = daily dosage of sodium phenylbutyrate (g) x 0.86.
- The recommended dosage range, based upon body surface area, in patients naïve to phenylbutyrate (PBA) is 4.5 to 11.2 mL/m^2/day (5 to 12.4 g/m^2/day).
- For patients with some residual enzyme activity who are not adequately controlled with dietary restriction, recommended starting dose is 4.5 mL/m^2/day.

CONTRAINDICATIONS:

- Do not administer to patients with a known hypersensitivity to phenylbutyrate.
- Do not administer to patients younger than 2 months of age.

SPECIAL POPULATIONS:

- Ravicti is classified as pregnancy category C. Ravicti should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.
- Because of the potential for adverse reactions from Ravicti in nursing infants, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into consideration the importance of the drug to the health of the mother.
- The safety and effectiveness in pediatric patients 2 to under 18 years of age were established in 2 open-label, sodium phenylbutyrate to Ravicti, fixed-sequence, switchover clinical trials. The safety and efficacy of Ravicti in patients 2 months of age to under 2 years of age have not been established. Ravicti is contraindicated in patients <2 months of age.
- Clinical trials of Ravicti did not include sufficient numbers of subjects aged 65 years of age and older to determine whether they respond differently from younger patients. In general, dose selection for an elderly patient should be cautious, usually starting at the low end of the dosing range.

- Dosage for patients with moderate to severe hepatic impairment should be started at the lower end of the recommended dosing range and should be kept on the lowest dose necessary to control their ammonia levels.
- The efficacy and safety of Ravicti in patients with renal impairment are unknown. Monitor ammonia levels closely when starting patients with impaired renal function on Ravicti.
- Cayston may be administered to patients with mild, moderate, and severe renal impairment with no dosage adjustment.

WARNINGS AND PRECAUTIONS:

- Neurotoxicity - (phenylacetate [PAA] the active moiety of Ravicti, may be toxic) therefore reduce dosage for symptoms of neurotoxicity.
- Reduced phenylbutyrate absorption in pancreatic insufficiency or intestinal malabsorption-monitor ammonia levels closely.

ADVERSE REACTIONS: Common adverse reactions in ≥10% of patients are diarrhea, flatulence, and headache.

DRUG INTERACTIONS:

- Use of corticosteroids may cause the breakdown of body protein and increase plasma ammonia levels. Monitor ammonia levels closely when corticosteroids and Ravicti are used concomitantly.
- Hyperammonemia may be induced by haloperidol and by valproic acid. Monitor ammonia levels closely when use of valproic acid or haloperidol is necessary in UCD patients.
- Probenecid may inhibit the renal excretion of metabolites of Ravicti including phenylacetylglutamine (PAGN) and PAA.

PATIENT COUNSELING INFORMATION:

- Ravicti is a prescription medicine used in adults and children 2 years of age and older for long-term management of high blood levels of ammonia caused by a condition called urea cycle disorder (UCD). Ravicti should be used if the UCD cannot be managed with a low-protein diet and dietary supplements alone.
- Ravicti may cause serious side effects. Call your doctor or go to the nearest emergency room if you experience wheezing, shortness of breath, cough, low blood pressure, flushing, nausea, or a rash while taking Ravicti.
- Take Ravicti with food.
- Ravicti is an oral liquid that is taken by mouth using an oral syringe or measuring cup.
- Talk to your doctor about participating in a UCD registry. The purpose of the registry is to collect information about people with UCD to improve care.

References:

1. Ravicti® [package insert]. South San Francisco, CA: Hyperion Therapeutics, Inc.; January 2013.

PRODUCT DETAILS OF LINZESS® (LINACLOTIDE)

INDICATIONS AND USE: Linzess is a guanylate cyclase-C agonist indicated in adults for the treatment of irritable bowel syndrome with constipation (IBS-C) and chronic idiopathic constipation (CIC).

DOSAGE FORMS: Linzess is available as 145 mcg and 290 mcg capsules.

ADMINISTRATION:

- IBS-C: Take 290 mcg orally once daily.
- CIC: Take 145 mcg orally once daily.
- Take on empty stomach at least 30 minutes prior to first meal of the day.

CONTRAINDICATIONS: Linzess is contraindicated in patients up to 6 years of age and patients with known or suspected mechanical gastrointestinal obstruction.

SPECIAL POPULATIONS:

- Linzess is classified as pregnancy category C. There are no adequate and well-controlled studies of Linzess in pregnant women. Linzess should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.
- Caution should be exercised when Linzess is administered to a nursing woman.
- The safety and effectiveness in pediatric patients have not been established.
- Chronic Idiopathic Constipation and Irritable Bowel Syndrome with Constipation-Clinical trials of Linzess did not include sufficient numbers of patients aged 65 years of age and older to determine whether they respond differently from younger patients.

WARNINGS AND PRECAUTIONS:

- Linzess is contraindicated in pediatric patients up to 6 years of age.
- Avoid the use of Linzess in pediatric patients 6 through 17 years of age.
- Stop Linzess if severe diarrhea occurs and contact a healthcare provider.

ADVERSE REACTIONS:

- Most common adverse reactions (incidence of at least 2%) are diarrhea, abdominal pain, abdominal distension, and flatulence.

DRUG INTERACTIONS: No drug-drug interaction studies have been conducted with Linzess.

PATIENT COUNSELING INFORMATION:

- Linzess is a prescription medication used in adults to treat irritable bowel syndrome with constipation and chronic idiopathic constipation.
- Do not give Linzess to children under the age of 6. You should not give Linzess to children 6 to 17 years of age.
- Keep Linzess in the original container.
- Take once daily on an empty stomach as prescribed.

- Swallow the capsule whole and do not break apart or chew.
- If you miss a dose, skip the missed dose. Take the next dose at the regular time. Do not take 2 doses at the same time.
- Stop Linzess and contact physician if you experience severe diarrhea.
- Seek immediate medical attention if you develop unusual or severe stomach-area pain, and/or severe diarrhea.

UTILIZATION 03/26/13 – 03/26/14

Label Name	Rx Num	Total Reimb Amt	Avg Cost per Script
Linzess 145 mcg	75	$15,360.82	$204.81
Linzess 290 mcg	24	$5,623.28	$234.30
Total 36 recipients	**99**	**$20,984.1**	

References:

1. Linzess® [package insert]. St. Louis, MO: Forest Pharmaceuticals, Inc.; August 2013.

PRODUCT DETAILS OF AMITIZA® (LUBIPROSTONE)

INDICATIONS AND USE: Amitiza is a chloride channel activator indicated for treatment of chronic idiopathic constipation in adults, treatment of opioid-induced constipation in adults with chronic, non-cancer pain, and treatment of irritable bowel syndrome with constipation in women ≥ 18 years old.

DOSAGE FORMS: Amitiza is available as 8 mcg and 24 mcg capsules.

ADMINISTRATION:

- Take Amitiza orally with food or water.
- Swallow capsules whole and do not break apart or chew.
- The recommended dose for chronic idiopathic constipation and opioid-induced constipation is 24 mcg twice daily orally with food and water.
- The recommended dose for irritable bowel syndrome with constipation is 8 mcg twice daily orally with food and water.

CONTRAINDICATIONS: Amitiza is contraindicated in patients with known or suspected mechanical gastrointestinal obstruction.

SPECIAL POPULATIONS:

- Amitiza is classified as pregnancy category C. There are no adequate and well-controlled studies of Amitiza in pregnant women. Amitiza should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.
- Caution should be exercised when Amitiza is administered to a nursing woman.
- The safety and effectiveness in pediatric patients have not been established.
- Chronic Idiopathic Constipation-The efficacy of Amitiza in the elderly subpopulation was consistent with the efficacy in the overall study population.
- Opioid-induced Constipation and Irritable Bowel Syndrome with Constipation-Clinical trials of Amitiza did not include sufficient numbers of patients aged 65 years of age and older to determine whether they respond differently from younger patients.
- In case of chronic idiopathic constipation or opioid-induced constipation indications, the starting dosage of Amitiza should be reduced in patients with moderate hepatic impairment. The starting dose of Amitiza should be reduced in all patients with severe hepatic impairment, regardless of the indication. No dosing adjustment is required in patients with mild hepatic impairment (Child-Pugh Class A).

WARNINGS AND PRECAUTIONS:

- Patients may experience nausea; concomitant administration of food may reduce this symptom.
- Do not prescribe for patients that have severe diarrhea.
- Patients taking Amitiza may experience dyspnea within an hour of first dose. This symptom generally resolves within 3 hours, but may recur with repeat dosing.

- Evaluate patients with symptoms suggestive of mechanical gastrointestinal obstruction prior to initiating treatment with Amitiza.

ADVERSE REACTIONS:

- Most common adverse reactions (more than 4%) in chronic idiopathic constipation are nausea, diarrhea, headache, abdominal pain, abdominal distension, and flatulence.
- Most common adverse reactions (more than 4%) in opioid-induced constipation are nausea and diarrhea.
- Most common adverse reactions (more than 4%) in irritable bowel syndrome with constipation are nausea, diarrhea, and abdominal pain.

DRUG INTERACTIONS: Concomitant use of diphenylheptane opioids (e.g., methadone) may interfere with the efficacy of Amitiza.

PATIENT COUNSELING INFORMATION:

- Take Amitiza twice daily with food and water to reduce the occurrence of nausea.
- Patients taking Amitiza may experience dyspnea within an hour of the first dose.
- Patients on treatment who experience severe nausea, dyspnea, or diarrhea should notify their physician.
- Lactating women should monitor their milk-fed infants for diarrhea while taking Amitiza.

UTILIZATION 03/26/13 – 03/25/14

Label Name	Rx Num	Total Reimb Amt	Avg Cost per Script
Amitiza 8 mcg	22	$5,870.23	$266.83
Amitiza 24 mcg	84	$15,957.75	$189.97
Total 33 recipients	**106**	**$21,827.98**	

References:

1. Amitiza® [package insert]. Deerfield, IL: Takeda Pharmaceuticals America, Inc.; April 2013.

PRODUCT DETAILS OF MYALEPT™ (METRELEPTIN)

INDICATIONS AND USE: Myalept (metreleptin) is a leptin analog indicated as an adjunct to diet as replacement therapy to treat the complications of leptin deficiency in patients with congenital or acquired generalized lipodystrophy.
Limitations of Use:

- The safety and effectiveness of Myalept for the treatment of complications of partial lipodystrophy have not been established.
- The safety and effectiveness of Myalept for the treatment of liver disease, including nonalcoholic steatohepatitis (NASH), have not been established.
- Myalept is not indicated for use in patients with HIV-related lipodystrophy.
- Myalept is not indicated for use in patients with metabolic disease, without concurrent evidence of generalized lipodystrophy.

DOSAGE FORMS: Myalept is available as a sterile, white, solid, lyophilized cake of 11.3 mg metreleptin per vial to deliver 5 mg per mL when reconstituted in 2.2 mL of Bacteriostatic Water for Injection (BWFI) or preservative-free sterile Water for Injection (WFI).

ADMINISTRATION: Administer as a subcutaneous injection once daily after the lyophilized cake is reconstituted with BWFI or WFI. The recommended daily dosages in mg per kg of body weight are:

- Body weight 40 kg or less: starting dose 0.06 mg/kg/day, increase or decrease by 0.02 mg/kg to a maximum daily dose of 0.13 mg/kg.
- Males greater than 40 kg body weight: starting dose 2.5 mg/day, increase or decrease by 1.25 mg to 2.5 mg/day to a maximum dose of 10 mg/day.
- Females greater than 40 kg body weight: starting dose 5 mg/day, increase or decrease by 1.25 mg to 2.5 mg/day to a maximum dose of 10 mg/day.

CONTRAINDICATIONS:

- General obesity not associated with congenital leptin deficiency.
- Hypersensitivity to metreleptin.

SPECIAL POPULATIONS:

- Myalept is classified as pregnancy category C. No adequate and well-controlled studies of Myalept in pregnant women have been conducted. Myalept should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.
- Because of the potential for serious adverse reactions in nursing infants from Myalept, a decision should be made whether to discontinue nursing or discontinue the drug, taking into account the importance of drug to the mother.
- No clinically meaningful differences were observed in the efficacy and safety of Myalept between pediatric and adult patients.
- Clinical trials of Myalept did not include sufficient numbers of subjects aged 65 and over to determine whether they respond differently from younger subjects. In general, dose selection should be cautious, usually starting at the low end of the dosing range.

WARNINGS AND PRECAUTIONS:

- Anti-metreleptin antibodies with neutralizing activity could inhibit endogenous leptin action and/or result in loss of Myalept efficacy. Test for neutralizing antibodies in patients with severe infections or loss of efficacy during Myalept treatment.
- T-cell lymphoma-carefully consider benefits and risks of treatment with Myalept in patients with significant hematologic abnormalities and/or acquired generalized lipodystrophy.
- Hypoglycemia-a dose adjustment, including possible large reductions, of insulin or insulin secretagogue may be necessary. Closely monitor blood glucose in patients on concomitant insulin or insulin secretagogue therapy.
- Autoimmunity-Autoimmune disorder progression has been observed in patients treated with Myalept. Carefully consider benefits and risks of Myalept treatment in patients with autoimmune disease.
- Hypersensitivity-Hypersensitivity reactions (e.g., urticarial or generalized rash) have been reported. Patient should promptly seek medical advice regarding suspected reactions.
- Benzyl Alcohol Toxicity-Preservative-free sterile WFI recommended for neonates and infants.

ADVERSE REACTIONS: Common adverse reactions (≥ 10%) are headache, hypoglycemia, decreased weight, and abdominal pain.

DRUG INTERACTIONS: No formal drug interaction studies were performed.

PATIENT COUNSELING INFORMATION:

- Myalept is a prescription medicine used with a diet recommended by your healthcare provider to treat problems caused by not having enough leptin in your body (leptin deficiency) in people with congenital or acquired generalized lipodystrophy.
- Talk to your healthcare provider right away if you have any symptoms of an allergic reaction including a rash or itching (hives).
- Myalept may cause serious side effects including risk for loss of endogenous leptin activity/loss of Myalept efficacy due to neutralizing antibodies and lymphoma.
- Take Myalept exactly as the healthcare provider tells you to. Do not change your dose or suddenly stop taking Myalept.
- Myalept is injected 1 time per day at the same time each day under the skin (subcutaneous) of your stomach, thigh, or upper arm.
- Myalept can be used with or without food.
- If you miss a dose, take it as soon as you remember. Do not take an extra dose or increase the amount of your dose to make up for a missed dose.
- Do not mix Myalept and insulin in the same syringe or vial or inject in the same injection site.
- Possible side effects include low blood sugar, autoimmunity, allergic reactions, benzyl alcohol toxicity, headache, decreased weight, and abdominal pain.

References:

1. Myalept® [package insert]. Wilmington, DE: AstraZeneca Pharmaceuticals LP; February 2014.

PRODUCT DETAILS OF NORTHERA™ (DROXIDOPA)

INDICATIONS AND USE: Northera (droxidopa) is indicated for the treatment of orthostatic dizziness, lightheadedness, or the 'feeling that you are about to black out' in adult patients with symptomatic neurogenic orthostatic hypotension caused by primary autonomic failure (Parkinson's disease, multiple system atrophy, and pure autonomic failure), dopamine beta-hydroxylase deficiency, and non-diabetic autonomic neuropathy. Effectiveness beyond 2 weeks of treatment has not been demonstrated.

DOSAGE FORMS: Northera is available as 100 mg, 200 mg, and 300 mg capsules.

ADMINISTRATION: The recommended starting dose of Northera is 100 mg three times during the day: upon arising in the morning, at midday, and in the late afternoon at least 3 hours prior to bedtime (to reduce the potential for supine hypertension during sleep). Titrate by 100 mg three times daily, up to a maximum dose of 600 mg three times daily.

SPECIAL POPULATIONS:

- Northera is classified as pregnancy category C. There are no adequate and well-controlled studies of Northera in pregnant women.
- Choose nursing or Northera.
- The safety and effectiveness of Northera in pediatric patients have not been established.
- No overall differences in safety or effectiveness were observed between these subjects and younger subjects, and other reported clinical experience has not identified difference in responses between the elderly and younger patients, but greater sensitivity of some older individuals cannot be ruled out.
- Clinical experience with Northera in patients with severe renal function impairment (GFR less than 30 mL/min) is limited.

WARNINGS AND PRECAUTIONS:

- Northera can cause or exacerbate supine hypertension and may increase cardiovascular risk if supine hypertension is not well-managed.
- Postmarketing cases of a symptom complex resembling neuroleptic malignant syndrome (NMS) have been reported. NMS is an uncommon but life-threatening syndrome characterized by fever or hyperthermia, muscle rigidity, involuntary movements, altered consciousness, and mental status changes. The early diagnosis of this condition is important for the appropriate management of these patients.
- Northera may exacerbate existing ischemic heart disease, arrhythmias, and congestive heart failure. Careful consideration should be given to this potential risk prior to initiating therapy in patients with these conditions.
- Northera contains FD+C Yellow No. 5 (tartrazine) which may cause allergic-type reactions in certain susceptible persons.

ADVERSE REACTIONS: Common adverse reactions (greater than 5%) are headache, dizziness, arrhythmias, and congestive heart failure.

DRUG INTERACTIONS:

- Use of dopa-decarboxylase inhibitors may require dose adjustments of Northera.
- Administering Northera in combination with other agents that increase blood pressure (e.g., norepinephrine, ephedrine, midodrine, and triptans) would be expected to increase the risk for supine hypertension.

PATIENT COUNSELING INFORMATION:

- Northera is a prescription medicine used for lightheadedness or the feeling that you are going to 'black out'.
- Northera causes elevations in blood pressure and increases the risk of supine (lying face up) hypertension, which could lead to strokes, heart attacks, and death. Rest and sleep in an upper body elevated position and monitor blood pressure.
- Take the late afternoon dose at least three hours before bedtime to reduce the risk of supine hypertension.
- Consult a physician if you are pregnant or nursing.
- Take Northera the same way each time, either with food or without food.
- If a dose is missed, patients should take the next dose at the regularly scheduled time and should not double the dose.

References:

1. Northera® [package insert]. Charlotte, NC: Chelsea Therapeutics; February 2014.

PRODUCT DETAILS OF RAGWITEK™ (SHORT RAGWEED POLLEN ALLERGEN EXTRACT)

INDICATIONS AND USE: Ragwitek (short ragweed pollen allergen extract) is an allergen extract indicated as immunotherapy for the treatment of short ragweed pollen-induced allergic rhinitis, with or without conjunctivitis, confirmed by positive skin test or *in vitro* testing for pollen-specific IgE antibodies for short ragweed pollen.

DOSAGE FORMS: Ragwitek is available as 12 Amb a 1-Unit (Amb a 1-U) tablets.

ADMINISTRATION:

- One tablet daily.
- Initiate treatment at least 12 weeks before the expected onset of each ragweed pollen season and continue treatment throughout the season.
- Place the tablet immediately under the tongue. Allow it to remain there until completely dissolved. Do not swallow for at least 1 minute.
- Administer the first dose of Ragwitek under the supervision of a physician with experience in the diagnosis and treatment of allergic diseases. Observe patients in the office for at least 30 minutes following the initial dose.

CONTRAINDICATIONS:

- Severe, unstable, or uncontrolled asthma.
- History of any severe systemic allergic reaction or any severe local reaction to sublingual allergen immunotherapy.
- A history of eosinophilic esophagitis.
- Hypersensitivity to any of the inactive ingredients contained in this product.

SPECIAL POPULATIONS:

- Ragwitek is classified as pregnancy category C. Because systemic and local adverse reactions with immunotherapy may be poorly tolerated during pregnancy, Ragwitek should be used during pregnancy only if clearly needed.
- Caution should be exercised when Ragwitek is administered to a nursing woman.
- Ragwitek is not approved for use in pediatric patients.
- Ragwitek is not approved for use in patients over 65 years of age because safety and efficacy have not been established.

WARNINGS AND PRECAUTIONS:

Ragwitek can cause life-threatening allergic reactions such as anaphylaxis and severe laryngopharyngeal restriction.
Do not administer Ragwitek to patients with severe, unstable or uncontrolled asthma.
Observe patients in the office for at least 30 minutes following the initial dose.
Prescribe auto-injectable epinephrine, instruct and train patients on its appropriate use, and instruct patients to seek immediate medical care upon its use.
Ragwitek may not be suitable for patients with certain underlying medical conditions that may reduce their ability to survive a serious allergic reaction.
Ragwitek may not be suitable for patients who may be unresponsive to epinephrine or inhaled bronchodilators, such as those taking beta-blockers.

- Inform patients of the signs and symptoms of serious allergic reactions and instruct them to seek immediate medical care and discontinue therapy should any of these occur.
- Prescribe auto-injectable epinephrine to patients receiving Ragwitek.
- Ragwitek can cause local reactions in the mouth or throat that could compromise the upper airway. Consider discontinuation of Ragwitek in patients who experience persistent and escalating adverse reactions in the mouth or throat.
- Eosinophilic esophagitis has been reported in association with sublingual tablet immunotherapy. Discontinue Ragwitek and consider a diagnosis of eosinophilic esophagitis in patients who experience severe or persistent gastro-esophageal symptoms including dysphagia or chest pain.
- Ragwitek has not been studied in subjects with moderate or severe asthma. Withhold immunotherapy with Ragwitek if the patient is experiencing an acute asthma exacerbation. Re-evaluate patients who have recurrent asthma exacerbations and consider discontinuation of Ragwitek.
- Concomitant dosing with other allergen immunotherapy may increase the likelihood of local or systemic adverse reactions to either subcutaneous or sublingual allergen immunotherapy.
- Stop treatment with Ragwitek to allow complete healing of the oral cavity in patients with oral inflammation (e.g., oral lichen planus, mouth ulcers, or thrush) or oral wounds, such as those following oral surgery or dental extraction.

ADVERSE REACTIONS:

- Most common adverse reactions (≥5% of patients) were throat irritation, oral pruritus, ear pruritus, oral paraesthesia, mouth edema, and tongue pruritus.

PATIENT COUNSELING INFORMATION:

- Ragwitek is used to treat ragweed pollen induced allergic reactions.
- Carefully remove the tablet from the blister package with dry hands and put the tablet under your tongue. Do not swallow for at least 1 minute.

- Take the first tablet of Ragwitek in your doctor's office.
- Ragwitek may cause life-threatening allergic reactions. The signs and symptoms may include trouble breathing, throat tightness or swelling, trouble swallowing or speaking, dizziness or fainting, rapid or weak heartbeat, severe stomach cramps/vomiting/diarrhea, or severe flushing/itching of the skin.
- Keep an auto-injectable epinephrine with you at all times.

References:

1. Ragwitek® [package insert]. Whitehouse Station, NJ: Merck & Co., Inc.; April 2014.

PRODUCT DETAILS OF GRASTEK® (TIMOTHY GRASS POLLEN ALLERGEN EXTRACT)

INDICATIONS AND USE: Grastek (timothy grass pollen allergen extract) is an allergen extract indicated as immunotherapy for the treatment of grass pollen-induced allergic rhinitis, with or without conjunctivitis, confirmed by positive skin test or *in vitro* testing for pollen-specific IgE antibodies for Timothy grass or cross-reactive grass pollens.

DOSAGE FORMS: Grastek is available as 2800 Bioequivalent Allergy Units (BAUs) tablets.

ADMINISTRATION:

- One tablet daily.
- Initiate treatment at least 12 weeks before the expected onset of each grass pollen season and continue treatment throughout the season. For sustained effectiveness for one grass pollen season after cessation of treatment, Grastek may be taken daily for three consecutive years.
- Place the tablet immediately under the tongue. Allow it to remain there until completely dissolved. Do not swallow for at least 1 minute.
- Administer the first dose of Grastek under the supervision of a physician with experience in the diagnosis and treatment of allergic diseases. Observe patients in the office for at least 30 minutes following the initial dose.

CONTRAINDICATIONS:

- Severe, unstable, or uncontrolled asthma.
- History of any severe systemic allergic reaction or any severe local reaction to sublingual allergen immunotherapy.
- A history of eosinophilic esophagitis.
- Hypersensitivity to any of the inactive ingredients contained in this product.

SPECIAL POPULATIONS:

- Grastek is classified as pregnancy category B. There are no adequate and well-controlled studies of Grastek in pregnant women. Grastek should be used during pregnancy only if clearly needed.
- Caution should be exercised when Grastek is administered to a nursing woman.
- The safety and effectiveness in children and adolescents 5 through 17 years of age have been established. The safety and efficacy in pediatric patients below 5 years of age have not been established.
- There is no clinical trial experience with Grastek in patients over 65 years of age.

WARNINGS AND PRECAUTIONS:

Grastek can cause life-threatening allergic reactions such as anaphylaxis and severe laryngopharyngeal restriction.
Do not administer Grastek to patients with severe, unstable or uncontrolled asthma.
Observe patients in the office for at least 30 minutes following the initial dose.
Prescribe auto-injectable epinephrine, instruct and train patients on its appropriate use, and instruct patients to seek immediate medical care upon its use.
Grastek may not be suitable for patients with certain underlying medical conditions that may reduce their ability to survive a serious allergic reaction.
Grastek may not be suitable for patients who may be unresponsive to epinephrine or inhaled bronchodilators, such as those taking beta-blockers.

- Inform patients of the signs and symptoms of serious allergic reactions and instruct them to seek immediate medical care and discontinue therapy should any of these occur.
- In case of oral inflammation or wounds, stop treatment with Grastek to allow complete healing of the oral cavity.
- Prescribe auto-injectable epinephrine to patients receiving Grastek.
- Continue discontinuation of Grastek and consider a diagnosis of eosinophilic esophagitis in patients who experience severe or persistent gastro-esophageal symptoms including dysphagia or chest pain.
- Withhold immunotherapy with Grastek if the patient is experiencing an acute asthma exacerbation. Re-evaluate patients who have recurrent asthma exacerbations and consider discontinuation of Grastek.
- Concomitant dosing with other allergen immunotherapy may increase the likelihood of local or systemic adverse reactions to either subcutaneous or sublingual allergen immunotherapy.
- Grastek can cause local reactions in the mouth or throat that could compromise the upper airway. Consider discontinuation of Grastek in patients who experience persistent and escalating adverse reactions in the mouth or throat.

ADVERSE REACTIONS:

- Most common adverse reactions (≥5% of patients) were ear pruritus, oral pruritus, tongue pruritus, mouth edema, and throat irritation.

PATIENT COUNSELING INFORMATION:

- Grastek is used to treat grass pollen induced allergic reactions.
- Carefully remove the foil from the blister unit with dry hands and put the tablet under your tongue. Do not swallow for at least 1 minute.
- Grastek may cause life-threatening allergic reactions. The signs and symptoms may include trouble breathing, throat tightness or swelling, trouble swallowing or

speaking, dizziness or fainting, rapid or weak heartbeat, severe stomach cramps/vomiting/diarrhea, or severe flushing/itching of the skin.

- Keep an auto-injectable epinephrine with you at all times.
- The first dose must be administered in a doctor's office.
- If you have persistent reactions in the mouth or throat, discontinue Grastek and contact a healthcare professional.
- If you have asthma and experience difficulty breathing, stop Grastek and contact a healthcare professional.

References:

1. Grastek® [package insert]. Whitehouse Station, NJ: Merck & Co., Inc.; April 2014.

NORTH DAKOTA MEDICAID
RETROSPECTIVE DRUG UTILIZATION REVIEW
CRITERIA RECOMMENDATIONS
2ND QUARTER 2014

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

1. Vortioxetine / Overutilization / Negating CYP Inducers & Inhibitors _____ _____

Alert Message: The manufacturer's maximum recommended daily dose of Brintellix (vortioxetine) is 20 mg in extensive CYP2D6 metabolizers. The efficacy and safety of doses above 20 mg/day have not been evaluated in controlled clinical trials. The vortioxetine dose should not exceed 10mg/day in CYP2D6 poor metabolizers.

Conflict Code: ER - Overutilization
Drugs/Diseases

Util A	Util B	Util C **(Negating)**			
Vortioxetine		Bupropion	Rifampin	Phenytoin	Carbamazepine
		Fluoxetine	Rifabutin	Phenobarbital	Quinidine
		Paroxetine	Rifapentine	Primidone	

Max Dose: 20mg/day

References:
Brintellix Prescribing Information, September 2013, Takeda Pharmaceuticals.
Clinical Pharmacology, 2013 Elsevier/Gold Standard.

2. Vortioxetine 15 & 20 mg / Strong CYP2D6 Inhibitors _____ _____

Alert Message: The manufacture recommends that the daily dose of Brintellix (vortioxetine) be reduced by half when patients are receiving a strong CYP2D6 inhibitor (i.e., bupropion, fluoxetine, paroxetine and quinidine) concomitantly. The dose should be increased to the original level when the CYP2D6 inhibitor is discontinued.

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

Util A	Util B	Util C
Vortioxetine 15mg	Bupropion	
Vortioxetine 20mg	Fluoxetine	
	Paroxetine	
	Quinidine	

References:
Brintellix Prescribing Information, September 2013, Takeda Pharmaceuticals.
Clinical Pharmacology, 2013 Elsevier/Gold Standard.

3. Vortioxetine / Strong CYP Inducers _____ _____

Alert Message: The concurrent use of Brintellix (vortioxetine) with a strong CYP inducer (e.g., rifampin, carbamazepine, and phenytoin) for greater than 14 days may necessitate an increase in the vortioxetine dose but the dose should not exceed three times the original dose. Vortioxetine is extensively metabolized via multiple cytochrome isozymes (e.g., CYP2D6, CYP3A4/5, CYP2C9 and CYP2C8) and use with CYP inducers may result in decreased vortioxetine plasma concentrations.

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

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

References:
Brintellix Prescribing Information, September 2013, Takeda Pharmaceuticals.
FDA Drug Development and Approval Process (Drugs): Drug Development ad Drug Interactions: Table of Substrates, Inhibitors and Inducers. Available at:
http://www.fda.gov/drugs/developmentapprovalprocess/developmentresources/druginteractionslabeling/ucm093664.htm

4. Vortioxetine / Non-adherence _____ _____

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

Conflict Code: LR – Non-adherence
Drugs/Diseases

Util A	Util B	Util C
Vortioxetine		

References:
Brintellix Prescribing Information, September 2013, Takeda Pharmaceuticals.
Osterberg L, Blaschke T. Adherence to Medication. N Engl J Med 2005;353:487-97.
Keene MS. Confusion and Complaints: The True Cost of Noncompliance in Antidepressant Therapy. Medscape Psychiatry & Mental Health. 2005;10(2).\Available at: http://www.medscape.com/viewarticle/518273

5. Vortioxetine / Pediatric Use (Black Box) _____ _____

Alert Message: The safety and effectiveness of Brintellix (vortioxetine) in the pediatric population have not been established.

Conflict Code: TA – Therapeutic Appropriateness

Util A	Util B	Util C
Vortioxetine		

Age Range: 0-18 yoa

References:
Brintellix Prescribing Information, September 2013, Takeda Pharmaceuticals.
Clinical Pharmacology, 2013 Elsevier/Gold Standard.

6. Vortioxetine / MAOIs _____ _____

Alert Message: Brintellix (vortioxetine) is contraindicated for concurrent use in patients receiving MAOI therapy intended to treat psychiatric disorders, due to risk of serotonin syndrome. Vortioxetine should not be used within 14 days of discontinuing treatment with an MAOI and treatment with an MAOI should not be initiated within 21 days of discontinuation of vortioxetine.

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

Util A	Util B	Util C
Vortioxetine	Isocarboxazid	
	Phenelzine	
	Tranylcypromine	
	Selegiline Transdermal	

References:
Brintellix Prescribing Information, September 2013, Takeda Pharmaceuticals.
Clinical Pharmacology, 2013 Elsevier/Gold Standard.

7. Vortioxetine / Linezolid _____ _____

Alert Message: Brintellix (vortioxetine) is contraindicated for concurrent use with Zyvox (linezolid), a reversible, non-selective MAOI, due to risk of serotonin syndrome. There may be circumstances when it is necessary to initiate treatment with linezolid in a patient taking vortioxetine, if so vortioxetine should be discontinued before initiating linezolid treatment.

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

Util A	Util B	Util C
Vortioxetine	Linezolid	

References:
Brintellix Prescribing Information, September 2013, Takeda Pharmaceuticals.
Clinical Pharmacology, 2013 Elsevier/Gold Standard.

8. Vortioxetine / Serotonergic Agents _____ _____

Alert Message: Caution should be exercised when Brintellix (vortioxetine) is administered with other serotonergic drugs. Vortioxetine is a serotonin modulator/stimulator and concomitant therapy with other serotonergic drugs may cause accumulation of serotonin and increase the risk of serotonin syndrome (e.g., mental status changes, hypertension, vasoconstriction, and neuronal aberrations).

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

Util A	Util B		Util C
Vortioxetine	SSRIs	Nefazodone	
	SNRIs	Mirtazapine	
	TCAs	Trazodone	
	Triptans	Lithium	
	Ergot Alkaloids	Meperidine	
	Buspirone	Fentanyl	
	Tramadol		

References:
Brintellix Prescribing Information, September 2013, Takeda Pharmaceuticals.
Clinical Pharmacology, 2013 Elsevier/Gold Standard.

9. Vortioxetine / Drugs affecting Coagulation _____ _____

Alert Message: Concurrent use of Brintellix (vortioxetine) and medications that enhance bleeding potential (e.g., anticoagulants, thrombolytics and NSAIDS) may increase the risk of a bleeding complication. Vortioxetine, which inhibits serotonin reuptake, may cause impaired platelet aggregation due to platelet serotonin depletion.

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

Util A	Util B		Util C
Vortioxetine	NSAIDS	Dipyridamole	
	Aspirin	Cilostazol	
	Warfarin	Clopidogrel	
	Apixaban	Prasugrel	
	Fondaparinux	Ticagrelor	
	Rivaroxaban	Ticlopidine	
	Dabigatran	Anagrelide	
	Dalteparin	Enoxaparin	

References:
Brintellix Prescribing Information, September 2013, Takeda Pharmaceuticals.
Clinical Pharmacology, 2013 Elsevier/Gold Standard.

10. Perampanel / Overuse _____ _____

Alert Message: The manufacturer's maximum recommended dose of Fycompa (perampanel) is 12 mg once daily at bedtime.

Conflict Code: ER - Overutilization
Drugs/Diseases

Util A	Util B	Util C **(Negate)**
Perampanel		Hepatic Impairment

Max Dose: 12mg/day

References:
Fycompa Prescribing Information, June 2013, Eisai.
Clinical Pharmacology, 2013 Elsevier/Gold Standard.

11. Perampanel / Overuse Hepatic Impairment _____ _____

Alert Message: The manufacture's maximum recommended daily dose of Fycompa (perampanel) is 6 mg and 4 mg once daily at bedtime for patients with mild and moderate hepatic impairment, respectively. Perampanel use is not recommended in patients with severe hepatic impairment.

Conflict Code: ER - Overutilization
Drugs/Diseases

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

Max Dose: 6mg/day

References:
Fycompa Prescribing Information, June 2013, Eisai.
Clinical Pharmacology, 2013 Elsevier/Gold Standard.

12. Perampanel / Renal Impairment & Hemodialysis _____ _____

Alert Message: Fycompa (perampanel) use is not recommended in patients with severe renal impairment or on hemodialysis.

Conflict Code: TA – Therapeutic Appropriateness
Drugs/Diseases

Util A	Util B	Util C
Perampanel	CKD Stage 4 & 5 Hemodialysis	

References:
Fycompa Prescribing Information, June 2013, Eisai.
Clinical Pharmacology, 2013 Elsevier/Gold Standard.

13. Perampanel / Levonorgestrel Contraceptives _____ _____

Alert Message: Use of Fycompa (perampanel) with oral or implant contraceptives containing levonorgestrel may render them less effective. Concurrent use of perampanel at a dose of 12mg/day reduced levonorgestrel exposure by approximately 40%. Additional non-hormonal forms of contraception are recommended.

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

Util A	Util B	Util C
Perampanel	Levonorgestrel Contraceptives	

References:
Fycompa Prescribing Information, June 2013, Eisai.
Clinical Pharmacology, 2013 Elsevier/Gold Standard.

14. Perampanel / CYP3A4 Inducers Anticonvulsants _____ _____

Alert Message: The concurrent use of Fycompa (perampanel) with an antiepileptic drug (AED) that induces CYP3A4-mediated metabolism can result in decreased plasma levels of perampanel and loss of therapeutic effect. The starting dose of perampanel should be increased in the presence of enzyme-inducing AEDs. When an enzyme-inducing AED is introduced or withdrawn, patients should be closely monitored and perampanel dose adjusted if needed.

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

Util A	Util B	Util C
Perampanel	Carbamazepine	
	Oxcarbazepine	
	Phenytoin	
	Phenobarbital	
	Primidone	

References:
Fycompa Prescribing Information, June 2013, Eisai.
Clinical Pharmacology, 2013 Elsevier/Gold Standard.

15. Perampanel / Strong CYP3A4 Inducers (Non-AEDs) _____ _____

Alert Message: The concurrent use of Fycompa (perampanel) with a strong CYP3A4 inducer (e.g., rifampin and nevirapine) should be avoided. Perampanel is a CYP3A4 substrate and concomitant use with a potent inducer may result in significantly decreased perampanel plasma levels and loss of therapeutic effect.

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

Util A	Util B	Util C
Perampanel	Rifampin	
	Rifapentine	
	Rifabutin	
	Nevirapine	

References:
Fycompa Prescribing Information, June 2013, Eisai.
Clinical Pharmacology, 2013 Elsevier/Gold Standard.

16. Perampanel / CNS Depressants _____ _____

Alert Message: The concurrent use of Fycompa (perampanel) and CNS depressants including alcohol may increase CNS depression. Patients should limit activity until they have experience with concomitant use of CNS depressants.

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

Util A	Util B	Util C
Perampanel	Antidepressants	
	Antihistamines - Sedating	
	Antipsychotics	
	Barbiturates	
	Benzodiazepines	
	Muscle Relaxants	
	Narcotics	
	Hypnotics	

References:
Fycompa Prescribing Information, June 2013, Eisai.
Clinical Pharmacology, 2013 Elsevier/Gold Standard.

17. Perampanel / Therapeutic Appropriateness (0-11 yoa) _____ _____

Alert Message: The safety and effectiveness of Fycompa (perampanel) in pediatric patients less than12 years old have not been established.

Conflict Code: TA – Therapeutic Appropriateness
Drugs/Diseases

Util A	Util B	Util C
Perampanel		

Age Range 0-11 yoa

References:
Fycompa Prescribing Information, June 2013, Eisai.
Clinical Pharmacology, 2013 Elsevier/Gold Standard.

18. Perampanel / Black Box Warning _____ _____

Alert Message: Serious or life-threatening psychiatric and behavioral adverse reactions including aggression, hostility, homicidal ideation and threats have been reported in patients taking Fycompa (perampanel). Perampanel dosage should be reduced if these symptoms occur and should be discontinued immediately if symptoms are severe or are worsening.

Conflict Code: TA – Therapeutic Appropriateness
Drugs/Diseases

Util A	Util B	Util C
Perampanel		

References:
Fycompa Prescribing Information, June 2013, Eisai.
Clinical Pharmacology, 2013 Elsevier/Gold Standard.

19. Perampanel / Non-adherence _____ _____

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

Conflict Code: LR – Non-adherence
Drugs/Diseases
Util A Util B Util C
Perampanel

References:
Fycompa Prescribing Information, June 2013, Eisai.
Faught E, Duh MS, Weiner JR, et al. Nonadherence to Antiepileptic Drugs and Increased Mortality, Findings from the RANSOM Study. Neurology 2008;71(20): 1572-1578.
Faught ER, Weiner JR, Guerin A, et al. Impact of Nonadherence to Antiepileptic Drugs on Health Care Utilization and Costs: Findings from the RANSOM Study. Epilepsia 2009;50(3):501-509.
Osterberg L, Blaschke T. Adherence to Medication. N Engl J Med 2005; 353:487- 497.

20. Canagliflozin / Nonadherence _____ _____

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

Conflict Code: LR - Nonadherence
Drugs/Diseases
Util A Util B Util C
Canagliflozin

References:
Osterberg L, Blaschke T. Adherence to medication. N Engl J Med 2005;353:487-97.
Ho PM, Rumsfeld JS, Masoudi FA, et al., Effect of Medication Nonadherence in Diabetes Mellitus. Cardiology Review, April 2007.
Currie CJ, Peyrot M, Morgan CL, et al. The Impact of Treatment Noncompliance on Mortality in People With Type 2 Diabetes. Diabetes Care 35:1279-1284, June 2012.

21. Testosterone / History of Cardiovascular/Cerebrovascular Disease _____ _____

Alert Message: The FDA is evaluating the risk of stroke, heart attack and death in men taking FDA-approved testosterone products. Reassessment of this testosterone safety issue is based on the recent publication of two separate studies that suggested an increased risk of cardiovascular events among groups of men prescribed testosterone therapy. Prescribers should consider whether the benefits of testosterone treatment is likely to exceed the potential risks of treatment.

Conflict Code: TA – Therapeutic Appropriateness
Drugs/Diseases

Util A	Util B	Util C **(Include)**
Testosterone		Myocardial Infarction
		Stroke
		Angina
		Arrhythmia
		Heart Failure
		Hypertension
		Peripheral Vascular Disease
		Ischemic Heart Disease

Gender: Male

References:
FDA Drug Safety Communications; FDA Evaluating Risk of Stroke, Heart Attack and Death with FDA-approved Testosterone Products. [01-21-2014].
Vigen R, O'Donnell CI, Baron AE, et al. Association of Testosterone Therapy with Mortality, Myocardial Infarction and Stroke in Men with Low Testosterone Levels. JAMA 2013;310(17):1829-1836.
Finkle WD, Greenland S, Ridgeway GK, Adams JL, Frasco MA, et al. (2014) Increased Risk of Non-Fatal Myocardial Infarction Following Testosterone Therapy Prescription in Men. PLoS ONE 9(1): e85805. doi:10.1371/journal.pone.0085805

22. Posaconazole / CY3A4 Substrates that Prolong QT Interval _____ _____

Alert Message: Noxafil (posaconazole) is contraindicated with CYP3A4 substrates that prolong the QT interval. Posaconazole is a strong CYP3A4 inhibitor and concurrent use with a CYP3A4 substrate may result in increased substrate plasma concentrations, leading to QTc prolongation and torsades de pointes. In addition, posaconazole has been associated with prolongation of the QT interval.

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

Util A	Util B				Util C
Posaconazole	Trazodone	Sunitinib	Erythromycin	Solifenacin	
	Vardenafil	Dasatinib	Clarithromycin		
	Pimozide	Lapatinib	Mifepristone		
	Venlafaxine	Nilotinib	Haloperidol		
	Disopyramide	Indacaterol	Chloroquine		
	Amiodarone	Rilpivirine	Mefloquine		
	Telithromycin	Clozapine	Iloperidone		
	Alfuzosin	Quetiapine	Ondansetron		
	Crizotinib	Dofetilide	Propafenone		
	Ziprasidone	Methadone	Quinine		
	Asenapine	Citalopram	Vemurafenib		
	Dronedarone	Ranolazine	Saquinavir		

References:
Noxafil Prescribing Information, Nov. 2013, Merck Sharp & Dohme Corp.
Clinical Pharmacology, 2013 Elsevier/Gold Standard.
Facts & Comparisons, 2013 Updates, Wolters Kluwer Health.

23. Posaconazole / Sirolimus _____ _____

Alert Message: The concurrent use of Noxafil (posaconazole) is contraindicated with Rapamune (sirolimus) due to risk of sirolimus toxicity. Co-administration of these agents has been shown to increase sirolimus blood concentrations by approximately 9-fold. Posaconazole is a strong inhibitor of sirolimus CYP3A4-mediated metabolism and both drugs are substrates for P-gp efflux protein.

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

Util A	Util B	Util C
Posaconazole	Sirolimus	

References:
Noxafil Prescribing Information, Nov. 2013, Merck Sharp & Dohme Corp.
Clinical Pharmacology, 2013 Elsevier/Gold Standard.

24. Posaconazole / Cyclosporine & Tacrolimus _____ _____

Alert Message: Caution should be exercised when co-administering Noxafil (posaconazole) with a calcineurin-inhibitor (cyclosporine and tacrolimus). Concurrent use of posaconazole with these agents has been shown to increase the whole blood trough concentrations of the calcineurin-inhibitor. Frequent monitoring of cyclosporine or tacrolimus whole blood concentrations should be performed during and at discontinuation of posaconazole treatment and the calcineurin-inhibitor dose adjusted accordingly.

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

Util A	Util B	Util C
Posaconazole	Cyclosporine Tacrolimus	

References:
Noxafil Prescribing Information, Nov. 2013, Merck Sharp & Dohme Corp.
Clinical Pharmacology, 2013 Elsevier/Gold Standard.

25. Non First-line Antihypertensives / Hypertension / JNC 8 4 Classes _____ _____

Alert Message: The JNC 8 recommends the use of either a CCB, ACEI, ARB or thiazide-type diuretic as initial therapy to control hypertension in non black adult patients 18 years of age and older, if no contraindications exist. Recommended initial therapy in black patients is a thiazide-type diuretic or CCB, alone or in combination. If goal blood pressure is not achieved with an initial drug refer to the JNC 8 for recommended strategies for adding antihypertensive agents.

Conflict Code: TA – Therapeutic Appropriateness
Drugs/Diseases

Util A	Util B	Util C **(Negating)**
Other Antihypertensives: Alpha/Beta-Adrenergic Blockers Antiadrenergics-Centrally Acting Antiadrenergics-Peripherally Acting Selective Aldosterone Receptor Antagonist Beta-Blockers Direct Renin Inhibitors Loop Diuretics	Hypertension	Chronic Kidney Disease ACE Inhibitors ARBs CCBs Thiazide-type Diuretics

Age Range: 18 – 999 yoa

References:
James PA, Oparil S, Carter BL, et al. 2014 Evidence-based Guideline for the Management of High Blood Pressure in Adults: Report from the Panel Members Appointed to the Eight Joint National Committee (JNC 8). JAMA 2014; DOI:10.1001/jama.2013.284427. Available at: http://jama.jamanetwork.com/journal.aspx.

26. Dapagliflozin / Overutilization _____ _____

Alert Message: The manufacturer's maximum recommended dose of Farxiga (dapagliflozin) is 10 mg once daily.

Conflict Code: ER - Overutilization
Drugs/Diseases

Util A	Util B	Util C **(Negating)**
Dapagliflozin		Renal Impairment

Max Dose: 10mg/day

References:
Farxiga Prescribing Information, Jan. 2014, Bristol-Myers Squibb.
Clinical Pharmacology, 2014 Elsevier/Gold Standard.

27. Dapagliflozin / Moderate Renal impairment _____ _____

Alert Message: Assessment of renal function is recommended prior to initiation of Farxiga (dapagliflozin) therapy and periodically thereafter. Dapagliflozin should not be initiated in patients with an eGFR less than 60 mL/min/1.73m^2 and should be discontinued when eGFR is persistently less than 60mL/ min/1.73m^2.

Conflict Code: TA - Therapeutic Appropriateness
Drugs/Diseases

Util A	Util B	Util C **(Include)**
Dapagliflozin		CKD Stage 1, 2 & 3

References:
Farxiga Prescribing Information, Jan. 2014, Bristol-Myers Squibb.
Clinical Pharmacology, 2014 Elsevier/Gold Standard.

28. Dapagliflozin / Severe Renal Impairment, ESRD & Dialysis _____ _____

Alert Message: Farxiga (dapagliflozin) is contraindicated in patients with severe renal impairment, end-stage renal disease, or on dialysis. Based on its mechanism of action, inhibition of SGLT2 in the proximal renal tubules, dapagliflozin is not expected to be effective in these patients.

Conflict Code: TA - Therapeutic Appropriateness
Drugs/Diseases

Util A	Util B	Util C **(Include)**
Dapagliflozin		CKD Stage 4, & 5
		End-Stage Renal Disease
		Dialysis

References:
Farxiga Prescribing Information, Jan. 2014, Bristol-Myers Squibb.
Clinical Pharmacology, 2014 Elsevier/Gold Standard.

29. Dapagliflozin / Nonadherence _____ _____

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

Conflict Code: LR - Nonadherence
Drugs/Diseases

Util A	Util B	Util C
Dapagliflozin		

References:
Farxiga Prescribing Information, Jan. 2014, Bristol-Myers Squibb.
Osterberg L, Blaschke T. Adherence to medication. N Engl J Med 2005;353:487-97.
Ho PM, Rumsfeld JS, Masoudi FA, et al., Effect of Medication Nonadherence in Diabetes Mellitus. Cardiology Review, April 2007.
Currie CJ, Peyrot M, Morgan CL, et al. The Impact of Treatment Noncompliance on Mortality in People With Type 2 Diabetes. Diabetes Care 35:1279-1284, June 2012.

30. Dapagliflozin / Hypotension _____ _____

Alert Message: Farxiga (dapagliflozin) causes osmotic diurese which can lead to volume depletion and hypotension, particularly in patients with impaired renal function, elderly patients or patients on loop diuretics. Monitor patients for signs and symptoms during therapy. Before initiating dapagliflozin in patients with one or more of these characteristics, volume status should be assessed and corrected.

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

Util A	Util B	Util C
Dapagliflozin	Hypotension	
	Hypovolemia	
	CKD Stage 3	
	Dehydration	

References:
Farxiga Prescribing Information, Jan. 2014, Bristol-Myers Squibb.
Clinical Pharmacology, 2014 Elsevier/Gold Standard.

31. Dapagliflozin / Loop Diuretics _____ _____

Alert Message: Farxiga (dapagliflozin) causes osmotic diurese which can lead to volume depletion and hypotension, particularly in patients with impaired renal function, elderly patients or patients on loop diuretics. Monitor patients for signs and symptoms during therapy. Before initiating dapagliflozin in patients with one or more of these characteristics, volume status should be assessed and corrected.

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

Util A	Util B	Util C
Dapagliflozin	Furosemide	
	Torsemide	
	Ethacrynate	
	Bumetanide	

References:
Farxiga Prescribing Information, Jan. 2014, Bristol-Myers Squibb.
Clinical Pharmacology, 2014 Elsevier/Gold Standard.

32. Dapagliflozin / Insulin & Insulin Secretagogues _____ _____

Alert Message: The concurrent use of Farxiga (dapagliflozin) with insulin and insulin secretagogues can increase the risk of hypoglycemia. A lower dose of insulin or insulin secretagogue may be required to minimize the risk of hypoglycemia when used in combination with dapagliflozin.

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

Util A	Util B	Util C
Dapagliflozin	Insulins	
	Sulfonylureas	

References:
Farxiga Prescribing Information, Jan. 2014, Bristol-Myers Squibb.
Clinical Pharmacology, 2014 Elsevier/Gold Standard.

33. Dapagliflozin / LDL-C Increases _____ _____

Alert Message: The use of Farxiga (dapagliflozin) can cause dose-related increases in LDL-C levels. Patients receiving dapagliflozin should have their LDL-C levels monitored and treated per standard of care.

Conflict Code: TA – Therapeutic Appropriateness
Drugs/Diseases

Util A	Util B	Util C
Dapagliflozin	Hypercholesterolemia	

References:
Farxiga Prescribing Information, Jan. 2014, Bristol-Myers Squibb.
Clinical Pharmacology, 2014 Elsevier/Gold Standard.

34. Dapagliflozin / Bladder Cancer _____ _____

Alert Message: An imbalance in bladder cancers was observed in Farxiga (dapagliflozin) clinical trials. Dapagliflozin should not be used in patients with active bladder cancer and used with caution in patients with a prior history of bladder cancer.

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

Util A	Util B	Util C
Dapagliflozin		Neoplasm of Bladder
		History of Malignant Neoplasm of Bladder

References:
Farxiga Prescribing Information, Jan. 2014, Bristol-Myers Squibb.
Clinical Pharmacology, 2014 Elsevier/Gold Standard.

35. SGLT2 Inhibitors / Therapeutic Duplication _____ _____

Alert Message: Therapeutic duplication of sodium-glucose co-transporter 2 (SGLT2) inhibitors may be occurring.

Conflict Code: TD – Therapeutic Duplication
Drugs/Diseases

Util A	Util B	Util C
Dapagliflozin		
Canagliflozin		

References:
Farxiga Prescribing Information, Jan. 2014, Bristol-Myers Squibb.
Clinical Pharmacology, 2014 Elsevier/Gold Standard.

36. ASCVD Inferring Drugs / High-Intensity Statin Therapy (Negating) _____ _____

Alert Message: The ACC/AHA Blood Cholesterol Guidelines recommend the use of high-intensity statin therapy, which lowers LDL-C at least 50%, to reduce atherosclerotic cardiovascular risk in adults 75 years of age and younger who have clinical ASCVD (e.g., CHD, stroke, and PAD), unless contraindicated. Moderate-intensity statin therapy should be used as a second-line option if high-intensity statin therapy is not tolerated. Refer to the ACC/AHA guidelines for agents and dosage.

Conflict Code: TA – Therapeutic Appropriateness
Drugs/Diseases

Util A	Util B	Util C **(Negating if High-Intensity Therapy Present)**
Nitrates		Atorvastatin 40mg & 80 mg
Cilostazol		Rosuvastatin 20 mg, 40 mg & 80 mg
Clopidogrel		
Prasugrel		
Ticagrelor		
Ticlopidine		
Dipyridamole/Aspirin		

Age Range: ≤ 75 yoa

References:
Stone NJ, Robinson J, Lichtenstein AH, et.al., 2013 ACC/AHA Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults, Jrnl Am Coll Cardiol (2013), doi:10.1016/j.jacc.2013.11.002.

37. ASCVD Inferring Drugs / Statins (Negating) - No therapy at all (>75 yoa) _____ _____

Alert Message: The ACC/AHA Blood Cholesterol Guidelines state that it is reasonable to consider moderate-intensity statin therapy, which lowers LDL-C 30% to 49%, to reduce atherosclerotic cardiovascular risk in patients > 75 years of age with clinical ASCVD (e.g., CHD, stroke, and PAD), unless contraindicated. Refer to the ACC/AHA guidelines for agents and dosage.

Conflict Code: TA – Therapeutic Appropriateness
Drugs/Diseases

Util A	Util B	Util C **(Negating)**
Nitrates		Atorvastatin
Cilostazol		Rosuvastatin
Clopidogrel		Lovastatin
Prasugrel		Fluvastatin
Ticagrelor		Pravastatin
Ticlopidine		Simvastatin
Dipyridamole/Aspirin		Pitavastatin

Age Range: >75 yoa

References:
Stone NJ, Robinson J, Lichtenstein AH, et.al., 2013 ACC/AHA Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults, Jrnl Am Coll Cardiol (2013), doi:10.1016/j.jacc.2013.11.002.

38. Antidiabetic Agents / Statins & ASCVD Inferring (Negating) _____ _____

Alert Message: The ACC/AHA Blood Cholesterol Guidelines recommend the use moderate-intensity statin therapy as primary prevention to reduce the risk of atherosclerotic cardiovascular disease in diabetic patients 40 to 75 years of age with a LDL-C of 70 - 189 mg/dL, unless contraindicated. If the diabetic patient has an estimated 10-year ASCVD risk of 7.5% or greater high-intensity statin therapy is recommended. Refer to the ACC/AHA guidelines for agents and dosage.

Conflict Code: TA – Therapeutic Appropriateness
Drugs/Diseases

Util A	Util B	Util C **(Negating)**
Insulin		Lovastatin
Sulfonylureas		Fluvastatin
Alpha-Glucosidase Inhibitors		Simvastatin
Amylin Analogs		Pravastatin
Biguanide		Atorvastatin
DPP4 Inhibitors		Rosuvastatin
Glucagon-like Peptide 1 Receptor Agonist		Pitavastatin
Insulin		Nitrates
Meglitinides		Cilostazol
Sodium-Glucose Co-Transporter 2 Inhibitors		Clopidogrel
Thiazolidinediones		Prasugrel
		Ticagrelor
		Ticlopidine
		Dipyridamole/Aspirin

Age Range: 40 -75 yoa

References:
Stone NJ, Robinson J, Lichtenstein AH, et.al., 2013 ACC/AHA Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults, Jrnl Am Coll Cardiol (2013), doi:10.1016/j.jacc.2013.11.002.

39. Antidiabetic Agents / Statins & ASCVD Inferring (Negating) _____ _____

Alert Message: The patient may benefit from the addition of a statin to their drug regimen, if no contraindications exist. The ACC/AHA Blood Cholesterol Guidelines state that it is reasonable to initiate, continue, or intensify statin therapy in diabetic patients < 40 years of age if the patient may derive ASCVD risk reduction benefits. Refer to the ACC/AHA guidelines for agents and dosage.

Conflict Code: TA – Therapeutic Appropriateness
Drugs/Diseases

Util A	Util B	Util C **(Negating)**
Insulin		Lovastatin
Sulfonylureas		Fluvastatin
Alpha-Glucosidase Inhibitors		Simvastatin
Amylin Analogs		Pravastatin
Biguanide		Atorvastatin
DPP4 Inhibitors		Rosuvastatin
Glucagon-like Peptide 1 Receptor Agonist		Pitavastatin
Insulin		Nitrates
Meglitinides		Cilostazol
Sodium-Glucose Co-Transporter 2 Inhibitors		Clopidogrel
Thiazolidinediones		Prasugrel
		Ticagrelor
		Ticlopidine
		Dipyridamole/Aspirin

Age Range: 21 -39 yoa

References:
Stone NJ, Robinson J, Lichtenstein AH, et.al., 2013 ACC/AHA Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults, Jrnl Am Coll Cardiol (2013), doi:10.1016/j.jacc.2013.11.002.

40. Antidiabetic Agents / Statins & ASCVD Inferring (Negating) _____ _____

Alert Message: The patient may benefit from the addition of a statin to their drug regimen, if no contraindications exist. The ACC/AHA Blood Cholesterol Guidelines state that it is reasonable to initiate, continue, or intensify statin therapy in diabetic patients > 75 years if the patient may derive ASCVD risk reduction benefit. Refer to the ACC/AHA guidelines for agents and dosage.

Conflict Code: TA – Therapeutic Appropriateness

Drugs/Diseases

Util A	Util B	Util C **(Negating)**
Insulin		Lovastatin
Sulfonylureas		Fluvastatin
Alpha-Glucosidase Inhibitors		Simvastatin
Amylin Analogs		Pravastatin
Biguanide		Atorvastatin
DPP4 Inhibitors		Rosuvastatin
Glucagon-like Peptide 1 Receptor Agonist		Pitavastatin
Insulin		Nitrates
Meglitinides		Cilostazol
Sodium-Glucose Co-Transporter 2 Inhibitors		Clopidogrel
Thiazolidinediones		Prasugrel
		Ticagrelor
		Ticlopidine
		Dipyridamole/Aspirin

Age Range: > 75 yoa

References:

Stone NJ, Robinson J, Lichtenstein AH, et.al., 2013 ACC/AHA Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults, Jrnl Am Coll Cardiol (2013), doi:10.1016/j.jacc.2013.11.002.