

South Carolina
Department of Health and Human Services
Post Office Box 8206
Columbia, South Carolina 29202-8206
www.scdhhs.gov
 January 8, 2010

Phys
 Dent
 MC
 Hosp
 Med Clin
 MHRC
 HH
 Pharm

MEDICAID BULLETIN

TO: Providers Indicated

SUBJECTS: South Carolina Medicaid Preferred Drug List

The Preferred Drug List (PDL) has been revised. Attached to this bulletin is a comprehensive listing of products within all therapeutic classes that comprise the PDL.

Effective with dates of service on or after January 20, 2010, pharmacy claims without prior authorization (PA) approval will deny for designated non-preferred products within the therapeutic classes listed below. The complete PDL (attached to this bulletin) includes the following changes:

PDL Revisions	
Preferred	Non-Preferred
RECEPTOR SELECTIVE NSAIDS	
Meloxicam will no longer require prior authorization. Celebrex [®] will continue to be available with the same prior authorization criteria that are currently in place. Mobic [®] will continue to be non-preferred.	
TRIGLYCERIDE LOWERING AGENTS	
LOVAZA ^{®*} Added to PDL	LOFIBRA [®] Changed to Non-Preferred
*Step-therapy required. Lovaza will pay as preferred after a trial of any other preferred agent.	

SKELETAL MUSCLE RELAXANTS			
BACLOFEN	Added as Preferred	AMRIX [®]	Added as Non-Preferred
CARISOPRODOL	Added as Preferred	DANTRIVUM [®]	Added as Non-Preferred
CHLORZOXAZONE	Added as Preferred	FEXMID [®]	Added as Non-Preferred
CYCLOBENZAPRINE	Added as Preferred	NORFLEX [®]	Added as Non-Preferred
DANTROLENE SODIUM	Added as Preferred	PARAFON FORTE [®]	Added as Non-Preferred
METHOCARBAMOL	Added as Preferred	ROBAXIN [®]	Added as Non-Preferred
ORPHENADRINE	Added as Preferred	SKELAXIN [®]	Added as Non-Preferred
TIZANIDINE HCL	Added as Preferred	SOMA [®]	Added as Non-Preferred
		ZANAFLEX [®]	Added as Non-Preferred

Prescribers are strongly encouraged to write prescriptions for "preferred" products. However, if a prescriber deems that a patient's clinical status requires therapy with a PA-required drug, the prescriber (or his/her designated office personnel) is responsible for initiating the PA request. A prospective, approved PA request will prevent rejection of prescription claims at the pharmacy due to the PA requirement.

All PA requests should be submitted via WebPA, telephone, or fax to the First Health Clinical Call Center by the prescriber or the prescriber's designated office personnel. To access the WebPA tool, visit <http://southcarolina.fhsc.com>, click on "Prescribers", then "WebPA". New users will need to click on "UAC" in the right hand corner to request a user ID and password. The toll-free telephone and fax numbers for the Clinical Call Center are 866-247-1181 and 888-603-7696, respectively. The First Health Clinical Call Center telephone number is reserved for use by healthcare professionals and should not be provided to beneficiaries. (First Health's South Carolina Medicaid beneficiary call center telephone number for Pharmacy Services is 800-834-2680. Providers may furnish the beneficiary call center telephone number to Medicaid beneficiaries *for Pharmacy Services-related issues only.*)

A pharmacy claim submitted for a PA-required product that has not been approved for Medicaid reimbursement will reject. If this occurs, the pharmacist should contact the prescriber so that a determination can be made regarding whether a drug *not* requiring PA is clinically appropriate for the patient.

Questions regarding this bulletin should be directed to the Department of Pharmacy Services at (803) 898-2876.

/S/
Emma Forkner
Director

EF/mgad

Attachment

NOTE: To receive Medicaid bulletins by email, please register at <http://bulletin.scdhhs.gov/>. To sign up for Electronic Funds Transfer of your Medicaid payment, please go to <http://www.dhhs.state.sc.us/dhhsnew/hipaa/index.asp> and select "Electronic Funds Transfer (EFT)" for instructions.



**South Carolina Department of Health and Human Services Preferred Drug List
Products Within PDL Therapeutic Classes Are Available Without Prior Authorization (PA)
Some therapeutic classes do have a PA requirement. These are noted within the posting.
{Non-listed products belonging to therapeutic classes that comprise the PDL require PA}
{Note that ALL therapeutic classes are not included on the PDL.}**

January 20, 2010

ANALGESIC

NSAIDs*

- Diclofenac Potassium
- Diclofenac Sodium
- Diflunisal
- Etodolac
- Fenoprofen
- Flurbiprofen
- Ibuprofen
- Indomethacin
- Indomethacin SR
- Ketoprofen
- Ketoprofen ER
- Ketorolac
- Meclofenamate Sod.
- Meloxicam
- Nabumetone
- Naproxen
- Oxaprozin
- Piroxicam
- Sulindac
- Tolmetin Sodium

*COX-2 specific NSAIDs require PA.

OPIOIDS, EXTENDED RELEASE

- Duragesic® Patch
- Kadian®
- Morphine Sulfate ER*

TOPICAL NSAIDS AND ANESTHETICS

*All agents in this class require Prior Authorization.

ANTI-INFECTIVE

ANTIBACTERIALS

CEPHALOSPORINS, 2ND GENERATION

- Cefprozil
- Cefuroxime

CEPHALOSPORINS, 3RD GENERATION

- Cefdinir (all dosage forms)
- Spectracef® Tablets

MACROLIDES/KETOLIDES

- Azithromycin
- Clarithromycin
- Clarithromycin XL
- EryPed®
- Ery-Tab®
- Erythromycin Base
- Erythromycin Estolate
- Erythromycin Ethylsuc.
- Erythromycin Stearate
- Erythrocin Stearate
- Erythromycin & Sulfisox.

QUINOLONES, 2ND AND 3RD GENERATION

- Avelox®
- Ciprofloxacin
- Ofloxacin

*Prescribers are encouraged to ensure compliance with FDA approved indications.

ANTIFUNGALS, ORAL

ONYCHOMYCOSIS AGENTS

- Gris-Peg®
- Griseofulvin
- Terbinafine

ANTIPROTOZOALS, ORAL

NITROIMIDAZOLES

- Metronidazole

ANTIVIRALS, ORAL

HERPES ANTIVIRALS

- Acyclovir
- Valtrex®

CARDIOVASCULAR

ACE INHIBITORS (ACEI)

- Benazepril
- Benazepril/HCTZ
- Captopril
- Enalapril
- Enalapril/HCTZ
- Lisinopril
- Lisinopril/HCTZ

ACEI, CCB COMBINATIONS

- Lotrel®
- Tarka®

ANGIOTENSIN RECEPTOR BLOCKERS (ARB)

- Avalide®
- Avapro®
- Benicar®
- Benicar HCT®
- Cozaar®
- Diovan®
- Diovan HCT®
- Hyzaar®
- Micardis®
- Micardis HCT®
- Teveten®
- Teveten HCT®

BETA BLOCKERS

- Acebutolol
- Atenolol
- Atenolol/Chlorthalidone
- Betaxolol
- Bisoprolol Fumarate
- Bisoprolol/HCTZ
- Carvedilol
- Labetolol
- Metoprolol Tartrate
- Nadolol
- Pindolol
- Propranolol
- Propranolol ER
- Propranolol/HCTZ
- Sotalol
- Timolol

CALCIUM CHANNEL BLOCKERS (CCB), DIHYDROPYRIDINES

- Amlodipine
- Dynacirc CR®
- Felodipine
- Isradipine
- Nicardipine
- Nifedical XL®
- Nifedipine ER and SA

CALCIUM CHANNEL BLOCKERS (CCB), NON-DIHYDROPYRIDINES

- Cartia XT®
- Diltia XT®
- Diltiazem
- Diltiazem ER and XR
- Taztia XT®
- Verapamil
- Verapamil ER
- Verapamil SR

CCB/ARB COMBINATION PRODUCTS

- Exforge®
- Exforge HCT®

DIRECT RENIN INHIBITORS

- Tekturma®*
- Tekturma HCT®*

* Prior authorization is required if an ARB has not been prescribed previously for the patient.

ENDOTHELIN RECEPTOR ANTAGONISTS

- Letairis®*

*Patients currently established on non-preferred therapy will be grandfathered.

LIPOTROPICS

BILE ACID SEQUESTERING RESINS

- Cholestyramine
- Cholestyramine Light
- Colestipol
- Welchol®

FIBRIC ACID DERIVATIVES

- Gemfibrozil
 - Tricor®
 - Trilipix®
 - Lovaza®*
- * Requires step-therapy with another preferred agent.



South Carolina Department of Health and Human Services Preferred Drug List
Products Within PDL Therapeutic Classes Are Available Without Prior Authorization (PA)
Some therapeutic classes to have a PA requirement. These are noted within the posting.
{Non-listed products belonging to therapeutic classes that comprise the PDL require PA}
{Note that ALL therapeutic classes are not included on the PDL.}

January 20, 2010

NIACIN DERIVATIVES Niaspan®	FIRST GENERATION ANTICONVULSANTS Celontin® Depakote ER® Divalproex Sprinkles Ethosuximide Felbatol® Mephobarbital Phenytoin Phenytoin Sodium ER Primidone Valproic Acid * Prior authorization is not required for Dilantin® if "Brand Medically Necessary" criteria are met.	ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS Adderall XR® Amphetamine Salt Combination Dexmethylphenidate Immediate Release Dextroamphetamine Dextroamphetamine SR Metadate ER® Methylin® Methylin ER® Methylphenidate Methylphenidate ER/SR Ritalin LA®* Concerta®* Focalin XR®* Vyvanse®* * Generic agents considered "first-line" when appropriate.	ENDOCRINE AND METABOLIC ANTI-DIABETICS ALPHA-GLUCOSIDASE INHIBITORS Glyset® Acarbose AMYLIN ANALOGS* Symlin® * Prior authorization is required if patient is not currently receiving insulin therapy.
NIACIN/STATIN COMBINATIONS Advicor® Simcor®	SECOND GENERATION ANTICONVULSANTS Gabapentin Lamotrigine Lamictal® ODT Levetiracetam Lyrica® Topiramate Zonisamide	MULTIPLE SCLEROSIS AGENTS Avonex® Avonex Administration Pack® Betaseron® Copaxone® Rebif®	BIGUANIDES Metformin Metformin ER
STATINS Altoprev® Crestor® Lescol® Lescol XL® Lipitor® Lovastatin Pravastatin Simvastatin Vytorin®	ANTI-MIGRAINE AGENTS	PARKINSON'S AGENTS	BIGUANIDE COMBINATION AGENTS ActoPlus Met® Avandamet®
CHOLESTEROL-ABSORPTION INHIBITORS Zetia®	SELECTIVE SEROTONIN AGONISTS* Sumatriptan Tablets Sumatriptan Injection Sumatriptan Nasal Spray Treximet®	NON-ERGOT DOPAMINE RECEPTOR AGONISTS Ropinirole	DPP-4 INHIBITORS AND COMBINATIONS* Janumet® Januvia® * Prior authorization is required if metformin, a thiazolidinedione or a sulfonylurea has not been prescribed previously for the patient.
NON-NITRATE ANTIANGINALS Ranexa®		SKELETAL MUSCLE RELAXANTS Baclofen Carisoprodol Chlorzoxazone Cyclobenzaprine Dantrolene Sodium Methocarbamol Orphenadrine Tizanidine HCl	INCRELIN MIMETICS* Byetta® * Prior authorization is required if metformin, a thiazolidinedione or a sulfonylurea product has not been prescribed previously for the patient.
CENTRAL NERVOUS SYSTEM		SEDATIVE/HYPNOTICS, NON-BARBITURATES Temazepam Zolpidem	INSULINS Lantus® Vial Levemir® Vial Novolin® N Novolin® R Novolin® 70/30 Novolog® Novolog® Mix 70/30 Humalog® 50/50
ALZHEIMER'S AGENTS			
CHOLINESTERASE INHIBITORS Aricept® tablets Exelon® (Oral & Patches) Galantamine			
NMDA RECEPTOR ANTAGONIST Namenda®			
ANTI-CONVULSANT AGENTS			
CARBAMAZEPINE DERIVATIVES Carbamazepine (all dosage forms) Carbatrol® Eptol® Oxcarbazepine			



South Carolina Department of Health and Human Services Preferred Drug List
Products Within PDL Therapeutic Classes Are Available Without Prior Authorization (PA)
Some therapeutic classes to have a PA requirement. These are noted within the posting.
{Non-listed products belonging to therapeutic classes that comprise the PDL require PA}
{Note that ALL therapeutic classes are not included on the PDL.}

January 20, 2010

MEGLITINIDES	GASTROINTESTINAL	GENITOURINARY	IMMUNOLOGICS
Nateglinide	ANTI-EMETICS (ORAL)	ALPHA BLOCKERS FOR BPH	IMMUNOMODULATORS, INJECTABLE
SULFONYLUREAS, SECOND GENERATION	NK1 ANTAGONISTS	Flomax® Uroxatral®	Enbrel® Humira®
Glimepiride Glipizide Glipizide ER Glyburide Glyburide Micronized	SEROTONIN RECEPTOR ANTAGONISTS	ANTISPASMODICS	IMMUNOMODULATORS, TOPICAL
THIAZOLIDINEDIONES	Granisetron Ondansetron	Detrol LA® Enablex® Oxybutynin Oxytrol® Sanctura® VESIcare®	Elidel® * Protopic® *
Actos® Avandia®	* See the listing at: http://southcarolina.fhsc.com for the quantity limits for this class. (Click on Providers, then Documents, then Pharmacy Quantity Limits.)	HEMATOLOGICAL & ONCOLOGICAL AGENTS	* Prescribers: Please use these agents as advised by the respective manufacturer and reserve for only those patients who have failed traditional eczema therapy.
THIAZOLIDINEDIONE / SULFONYLUREA COMBINATIONS*	HISTAMINE-2 RECEPTOR ANTAGONISTS	ANTICOAGULANTS – LOW MOLECULAR WEIGHT HEPARINS	IMMUNOMODULATORS, ORAL AND INJECTABLE
Avandaryl® Duetact®	Famotidine Ranitidine	Arixtra® Fragmin® Lovenox®	HEPATITIS B THERAPY*
* Prior authorization is required if a single agent thiazolidinedione or sulfonylurea product has not been prescribed previously for the patient.	PROTON PUMP INHIBITORS*	HEMATOPOIETIC AGENTS	Baraclude® Epivir HBV® Hepsera® Tyzeka®
ELECTROLYTE DEPLETERS	Nexium® Capsules Prevacid® (Rx Only) Omeprazole OTC	Aranesp® Procrit®	*Viread® is unaffected by the PDL and is available without Prior Authorization.
Fosrenol® Phoslo® Renagel® Renvela®	* Class level PA is in effect for this class. Once criteria are met, the agents listed on the PDL are preferred.	PLATELET INHIBITORS	HEPATITIS C THERAPY, PEGYLATED INTERFERONS*
BIPHOSPHONATES - OSTEOPOROSIS	ULCERATIVE COLITIS THERAPY	Aggrenox® Plavix®	Pegasys® & Conv. Pack Peg-Intron® & Redipen
Alendronate	Asacol® Balsalazide Disodium Canasa® Rectal Supp. Mesalamine Enema Pentasa® Sulfasalazine	PROTEIN TYROSINE KINASE INHIBITORS	HEPATITIS C THERAPY, RIBAVIRINS *
CALCITONINS	PROGESTINS FOR CACHEXIA	Gleevec®	Ribavirin
Calcitonin Nasal Spray Fortical® Nasal Spray	Megestrol Oral Susp	HORMONE RELATED THERAPY	* Class level PA is in effect for all Hepatitis B & C medications. Once criteria are met, the agents listed on the PDL are preferred.
GROWTH HORMONE		ANDROGENIC AGENTS	
Genotropin® Norditropin® Saizen®		Androderm® Androgel® Testim®	
* Class level PA is in effect for this class. Once criteria are met, the agents listed on the PDL are preferred.		ANDROGEN HORMONE INHIBITOR	
		Avodart® Finasteride	



South Carolina Department of Health and Human Services Preferred Drug List
Products Within PDL Therapeutic Classes Are Available Without Prior Authorization (PA)
Some therapeutic classes to have a PA requirement. These are noted within the posting.
{Non-listed products belonging to therapeutic classes that comprise the PDL require PA}
{Note that ALL therapeutic classes are not included on the PDL.}

January 20, 2010

IMMUNOSUPPRESSANTS Azasan® Azathioprine Cyclosporine Gengraf® Imuran® Mycophenolate Mofetil Myfortic® Neoral® Prograf® Rapamune® Sandimmune®	BETA BLOCKERS Betaxolol HCl Carteolol HCl Combigan® Levobunolol HCl Metipranolol Timolol Maleate CARBONIC ANHYDRASE INHIBITORS Azopt® Dorzolamide Dorzolamide -Timolol PROSTAGLANDIN AGONISTS Lumigan® Travatan® Travatan Z® Xalatan® QUINOLONES & MACROLIDES, OPHTHALMIC Ciprofloxacin HCl Vigamox® Zymar® OTICS QUINOLONES, OTIC Ciprodex® Ofloxacin Otic Drops RESPIRATORY ANTI-CHOLINERGICS Atrovent® HFA Combivent® Spiriva® ANTIHISTAMINES, 2nd GENERATION AND DECONGESTANT COMBINATIONS Cetirizine Loratadine OTC Loratadine-D OTC	NASAL ANTIHISTAMINES Astelin® Astepro® BETA ADRENERGIC DEVICES, SHORT-ACTING INHALERS ProAir® HFA Proventil® HFA Ventolin® HFA BETA ADRENERGIC DEVICES, LONG-ACTING METERED DOSE INHALERS Serevent Diskus®* * Prescribers are reminded of the warnings associated with the use of long acting beta agonists. BETA ADRENERGIC AGENTS, LONG-ACTING NEBULIZERS *Both agents in this class require Prior Authorization. BETA ADRENERGIC AGENTS, SHORT-ACTING NEBULIZERS Albuterol GLUCOCORTICOIDS INHALATION DEVICES Asmanex® Azmacort® Flovent Diskus® Flovent HFA® Qvar® INTRANASAL STEROIDS Fluticasone propionate Nasonex®	GLUCOCORTICOIDS AND LONG-ACTING BETA-2 ADRENERGICS Advair® Diskus Advair® HFA Symbicort® LEUKOTRIENE RECEPTOR ANTAGONISTS Accolate® Singulair® TOPICAL AGENTS FOR ACNE BENZOYL PEROXIDE/ CLINDAMYCIN COMBOS Benzacilin® Duac CS® TOPICAL RETINOIDS Differin® Epiduo® Retin-A Micro® Tretinoin TOPICAL AGENTS FOR PSORIASIS TOPICAL AGENTS FOR PSORIASIS Dovonex® TOPICAL ANTIINFECTIVES TOPICAL ANTIBIOTICS Mupirocin Ointment Altabax®* Bactroban®* Cream * Generic agents should be considered "first line" therapy when appropriate. TOPICAL ANTIVIRALS Abreva® Zovirax® Ointment
--	--	---	---