South Carolina
Department of Health and Human Services
Post Office Box 8206
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www.scdhhs.gov

December 8, 2010

Phys	Med Clin
Dent	MHRC
MC	HH
Hosp	Pharm

MEDICAID BULLETIN

TO: **Providers Indicated**

SUBJECT: **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 December 15, 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**
BENZOYL PEROXIDE/CLINDAMYACIN COMBINATIONS	
BENZACLIN	ACANYA GEL
CLINDAMYCIN-BENZOYL PEROXIDE	DUAC CS *Changed to Non-Preferred*
LONG ACTING INSULINS	
LANTUS VIAL	
LEVEMIR VIAL	
LANTUS SOLOSTAR *Changed to Preferred*	
LEVEMIR PEN *Changed to Preferred*	
THIAZOLIDINEDIONES AND TZD COMBINATIONS	
All rosiglitazone products (AVANDIA, AVANDAMET, AVANDARYL) will be changed to non-preferred status.	

PDL CLASSES ADDED	
Preferred	**Non-Preferred**
ATYPICAL ANTIPSYCHOTICS	
ABILIFY	
CLOZAPINE	
FANAPT	
FAZACLO	
GEODON	
INVEGA	
RISPERIDONE	
SAPHRIS	
SEROQUEL	
SEROQUEL XR	
SYMBYAX	
ZYPREXA	
BENZOYL PEROXIDE PREPARATIONS	
Generic benzoyl peroxide preparations will be preferred and brand products will require PA.	
SHORT ACTING NARCOTIC ANALGESICS	
Generally, generic short acting narcotics and combination products will be preferred and brand products will require PA. Preferred agents will include:	
CODEINE	
CODEINE/APAP	
CODEINE/APAP/CAFF/BUTAL	
CODEINE/ASA	
CODEINE/ASA/CAFF/BUTAL	
HYDROCODONE/APAP	
HYDROCODONE/ASA	
HYDROCODONE/IBUPROFEN	
HYDROMORPHONE	
MEPERIDINE	
MORPHINE IR	
NALBUPHINE	
OXYCODONE	
OXYCODONE/APAP	
OXYCODONE/ASA	
PROPOXYPHENE	
PROPOXYPHENE/APAP	
TRAMADOL	
TRAMADOL/APAP	

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 Magellan Medicaid Administration 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 Magellan Clinical Call Center telephone number is reserved for use by healthcare professionals and should not be provided to beneficiaries. (Magellan'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.

Any questions regarding this bulletin should be directed to the Division of Pharmacy Services at (803) 898-2876.

/S/
Emma Forkner
Director

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)
Those Therapeutic Classes which have a PA requirement are noted with the posting
Non-listed products belonging to therapeutic classes that comprise the PDL require PA
Note: ALL Therapeutic Classes are not included on the PDL
December 15, 2010

ANALGESIC

NSAIDs*

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

** COX-2 specific NSAIDs require PA.*

OPIOIDS, EXTENDED RELEASE

- Duragesic® Patch
- Kadian®
- Morphine Sulfate ER

SHORT ACTING NARCOTIC ANALGESICS

- Codeine
- Codeine/APAP
- Codeine/APAP/caff/butal
- Codeine/ASA
- Codeine/ASA/caff/butal
- Hydrocodone/APAP
- Hydrocodone/ASA
- Hydrocodone/Ibuprofen
- Hydromorphone
- Meperidine
- Morphine IR
- Nalbuphine
- Oxycodone
- Oxycodone/APAP
- Oxycodone/ASA
- Tramadol
- Tramadol/APAP

TOPICAL NSAIDs AND ANESTHETICS

* All agents in this class require Prior Authorization.

ANTI-INFECTIVE

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

ONYCHOMYCOSIS AGENTS

- Gris-Peg®
- Griseofulvin
- Terbinafine

CEPHALOSPORINS, 2ND GENERATION

- Cefprozil
- Cefuroxime

CEPHALOSPORINS, 3RD GENERATION

- Cefdinir (all dosage forms)
- Cefditoren

HERPES ANTIVIRALS

- Acyclovir
- Valtrex®

NITROIMIDAZOLES

- Metronidazole

CARDIOVASCULAR

ACE INHIBITORS (ACEI)

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

ACEI, CCB COMBINATIONS

- Lotrel®
- Trandolapril/Verapamil

ANGIOTENSIN RECEPTOR BLOCKERS (ARB)

- Avalide®
- Avapro®
- Benicar®
- Benicar HCT®
- Diovan®
- Diovan HCT®
- Losartan
- Losartan/HCTZ
- 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

- Tekturna® *
- Tekturna HCT® *

**Prior Authorization is required if an ARB has not been prescribed previously*

ENDOTHELIN RECEPTOR ANTAGONISTS

- Letairis® *

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

Magellan Medicaid Administration Call Center
Telephone: 866-247-1181 (toll-free)
Fax: 888-603-7696 (toll-free)

CARDIOVASCULAR (Continued)

NON-NITRATE ANTIANGINALS	BILE ACID SEQUESTERING RESINS	FIBRIC ACID DERIVATIVES
Ranexa®	Cholestyramine Cholestyramine Light Colestipol Welchol®	Gemfibrozil Tricor® Trilipix® Lovaza® * **Requires step-therapy with another preferred agent.*
NIACIN DERIVATIVES	**NIACIN/STATIN COMBINATIONS**	**STATINS**
Niaspan®	Advicor® Simcor®	Altoprev® Crestor® Lescol® Lescol XL® Lipitor® Lovastatin Pravastatin Simvastatin
CHOLESTEROL ABSORPTION INHIBITORS	**STATIN/CCB COMBINATION PRODUCTS**	
Zetia®	Caduet®	

CENTRAL NERVOUS SYSTEM

ALZHEIMER'S AGENTS

CHOLINESTERASE INHIBITORS	NMDA RECEPTOR ANTAGONIST	
Aricept® tablets Exelon® (Oral & Patches) Galantamine	Namenda®	

ANTI-CONVULSANTS

CARBAMAZEPINE DERIVATIVES	FIRST GENERATION ANTICONVULSANTS	SECOND GENERATION ANTICONVULSANTS
Carbamazepine (all dosage forms) Carbatrol® Epitol® Oxcarbazepine	Celontin® Divalproex Sodium Ethosuximide Felbatol® Mephobarbital Phenytoin Phenytoin Sodium ER Primidone Valproic Acid	Gabapentin Lamotrigine Lamictal® ODT Levetiracetam Lyrica® Topiramate Zonisamide

OTHER CNS AGENTS

ANTI-MIGRAINE SEROTONIN AGONISTS	ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS	ATYPICAL ANTIPSYCHOTICS
Sumatriptan Tablets Sumatriptan Injection Sumatriptan Nasal Spray	Adderall XR® Amphetamine Salt Combo Dexmethylphenidate IR 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.*	Abilify Clozapine Fanapt Fazaclo Geodon Invega Risperidone Saphris Seroquel Seroquel XR Symbyax Zyprexa *Antipsychotics do not require PA as long as use is consistent with FDA approved indication or is supported by relevant drug compendia.*
MULTIPLE SCLEROSIS AGENTS	**NON-ERGOT DOPAMINE RECEPTOR**	**SKELETAL MUSCLE RELAXANTS**
Avonex® Avonex Admin Pack® Betaseron® Copaxone® Rebif®	Ropinirole	Baclofen Carisoprodol Chlorzoxazone Cyclobenzaprine Dantrolene Sodium Methocarbamol Orphenadrine Tizanidine HCl
SEDATIVE/HYPNOTICS, NON-BARBITURATES		
Temazepam Zolpidem		

ENDOCRINE AND METABOLIC

ANTI-DIABETICS

ALPHA-GLUCOSIDASE INHIBITORS	AMYLIN ANALOGS*	BIGUANIDES
Glyset® Acarbose	Symlin® **Prior Authorization is required if patient is not currently receiving insulin therapy.*	Metformin Metformin ER
BIGUANIDE COMBINATION AGENTS	**DPP-4 INHIBITORS AND COMBINATIONS***	
ActoPlus Met®	Janumet® Januvia® **PA required if no claim for metformin in history.*	

ENDOCRINE AND METABOLIC (continued)

INCRELIN MIMETICS*	INSULINS		MEGLITINIDES
Byetta®	Lantus®	Novolin® 70/30	Nateglinide
	Levemir®	Novolog®	
**PA required if no claim for metformin in history.*	Novolin® N	Novolog® Mix 70/30	
	Novolin® R	Humalog® 50/50	
	**Vials and Pen Devices covered for all drugs listed above.*		

SULFONYLUREAS, SECOND GENERATION		THIAZOLIDINEDIONES	THIAZOLIDINEDIONE/SULFONYLUREA COMBINATIONS*
Glimepiride	Glyburide Micronized	Actos®	Duetact®
Glipizide			
Glipizide ER			
Glyburide			**Prior Authorization is required if a single agent thiazolidinedione has not been prescribed previously.*

OTHER ENDOCRINE AND METABOLIC AGENTS

ELECTROLYTE DEPLETERS		BIPHOSPHONATES-OSTEOPOROSIS	CALCITONINS
Fosrenol®	Renagel®	Alendronate	Calcitonin Nasal Spray
Phoslo®	Renvela®		Fortical® Nasal Spray

GROWTH HORMONE*	
Genotropin®	Nutropin®
Norditropin®	
**A class level PA is in effect for this class. Once criteria are met, the agents listed on the PDL are preferred*	

GASTROINTESTINAL

NK1 ANTAGONISTS	SEROTONIN RECEPTOR ANTAGONISTS	HISTAMINE-2 RECEPTOR ANTAGONISTS
Emend®	Granisetron	Famotidine
	Ondansetron	Ranitidine
	**See the listing at: http://southcarolina.fhsc.com for the quantity limits.*	

PROTON PUMP INHIBITORS*		ULCERATIVE COLITIS THERAPY		PROGESTINS FOR CACHEXIA
Nexium®	Prevacid Solutabs**	Apriso®	Mesalamine Enema	Megesterol Oral Susp.
Omeprazole OTC	Prilosec OTC	Asacol®	Pentasa®	
		Balsalazide Disodium	Sulfasalazine	
** Class level PA is in effect for this class. Once criteria are met, the agents listed on the PDL are preferred.*		Canasa® Rectal Supp.		
***Prevacid Solutabs are preferred only for beneficiaries age 12 and under.*				

GENITOURINARY

ALPHA BLOCKERS FOR BPH	ANTISPASMODICS	
Flomax®	Detrol LA®	Oxytrol®
Uroxatral®	Enablex®	Sanctura®
	Oxybutynin	VESIcare®

HEMATOLOGICAL & ONCOLOGICAL AGENTS

ANTICOAGULANTS- LOW MOLECULAR WEIGHT HEPARINS	HEMATOPOIETIC AGENTS	PLATELET INHIBITORS
Arixtra®	Aranesp®	Aggrenox®
Fragmin®	Procrit®	Plavix®
Lovenox®		

PROTEIN TYROSINE KINASE INHIBITORS
Gleevec®

HORMONE RELATED THERAPY

ANDROGENIC AGENTS	ANDROGEN HORMONE INHIBITOR	
Androderm® Androgel® Testim®	Avodart® Finasteride	

IMMUNOLOGICS

IMMUNOMODULATORS, INJECTABLE	IMMUNOMODULATORS, TOPICAL	IMMUNOSUPPRESSANTS
Enbrel® Humira®	Elidel® * Protopic® * ** Prescribers: Please use these agents as advised by the respective manufacturer and reserve for only those patients who have failed traditional eczema therapy.*	Azasan® Azathioprine Cyclosporine Gengraf® Imuran® Mycophenolate Mofetil Myfortic® Neoral® Prograf® Rapamune® Sandimmune®
HEPATITIS B THERAPY*	**HEPATITIS C THERAPY PEGYLATED INTERFERONS***	**HEPATITIS C THERAPY RIBAVIRINS***
Baraclude® Epivir HBV® Hepsera® Tyzeka® **Viread® is unaffected by the PDL and is available without Prior Authorization.*	Pegasys® & Conv. Pack Peg-Intron® & Redipen	Ribavirin **Class level PA is in effect for all Hepatitis B & C medications. Once criteria are met, the agents listed on the PDL are preferred.*

OPHTHALMICS

ANTIHISTAMINES, OPHTHALMIC	MAST CELL STABILIZERS, OPHTHALMIC	NSAIDs, OPHTHALMIC
Alaway® OTC Elestat® Ketotifen OTC Pataday® Patanol® Zaditor® OTC	Alamast® Alocril® Alomide® Cromolyn Sodium	Diclofenac Sodium Flurbiprofen Sodium Ketorolac Tromethamine Nevanac®
QUINOLONES & MACROLIDES, OPHTHALMIC		
Ciprofloxacin HCl Vigamox® Zymar®		

GLAUCOMA THERAPY

ALPHA-2 ADRENERGICS	BETA BLOCKERS	CARBONIC ANHYDRASE INHIBITORS
Brimonidine Tartrate Alphagan P®	Betaxolol HCl Carteolol HCl Combigan® Levobunolol HCl Metipranolol Timolol Maleate	Azopt® Dorzolamide Dorzolamide - Timolol
PROSTAGLANDIN AGONISTS		
Lumigan® Travatan® Travatan Z® Xalantan®		

OTICS

QUINOLONES, OTIC		
Ciprodex® Ofloxacin Otic Drops		

RESPIRATORY

ANTI-CHOLINERGICS	ANTIHISTAMINES, 2ND GENERATION AND DECONGESTANT COMBINATIONS	NASAL ANTIHISTAMINES
Atrovent® HFA Combivent® Spiriva®	Cetirizine Cetirizine D Loratadine OTC Loratadine-D OTC	Astepro® Azelastine
BETA ADRENERGIC DEVICES SHORT-ACTING INHALERS	**BETA ADRENERGIC DEVICES, LONG ACTING METERED DOSE INHALERS**	**BETA ADRENERGIC AGENTS, LONG-ACTING NEBULIZERS**
ProAir® HFA Proventil® HFA Ventolin® HFA	Serevent Diskus® * ** Prescribers are reminded of the warnings associated with use of long acting beta agonists.*	** Both agents in this class require Prior Authorization.*

<table>
<tr><th colspan="3">RESPIRATORY (continued)</th></tr>
<tr><th>BETA ADRENERGIC AGENTS, SHORT ACTING NEBULIZERS</th><th>INHALATION DEVICES</th><th></th></tr>
<tr><td>Albuterol 0.083%, 0.5%</td><td>Asmanex®
Azmacort®
Flovent Diskus®
Flovent HFA®
Qvar®</td><td></td></tr>
<tr><th>INTRANASAL STEROIDS</th><th>GLUCOCORTICOIDS AND LONG-ACTING BETA-2 ADRENERGICS</th><th>LEUKOTRIENE RECEPTOR ANTAGONISTS</th></tr>
<tr><td>Fluticasone propionate
Nasonex®*

*Step-therapy required for beneficiaries over age 12- must have failed fluticasone within the previous 6 months. Nasonex is available for beneficiaries age 12 and under without step therapy.</td><td>Advair® Diskus
Advair® HFA
Symbicort®</td><td>Accolate®
Singulair®</td></tr>
<tr><th colspan="3">TOPICAL AGENTS FOR ACNE</th></tr>
<tr><th>BENZOYL PEROXIDE/CLINDAMYCIN COMBOS</th><th>BENZOYL PEROXIDE PREPARATIONS</th><th>TOPICAL RETINOIDS</th></tr>
<tr><td>Benzaclin®
Clindamycin-Benzoyl Peroxide</td><td>Generic Benzoyl Peroxide Preparations</td><td>Adapalene
Differin®
Epiduo®
Retin-A Micro®
Tretinoin</td></tr>
<tr><th colspan="3">TOPICAL AGENTS FOR PSORIASIS</th></tr>
<tr><th>TOPICAL AGENTS FOR PSORIASIS</th><th></th><th></th></tr>
<tr><td>Calcipotriene
Dovonex®</td><td></td><td></td></tr>
<tr><th colspan="3">TOPICAL ANTIINFECTIVES</th></tr>
<tr><th>TOPICAL ANTIBIOTICS</th><th>TOPICAL ANTIVIRALS</th><th></th></tr>
<tr><td>Mupirocin Ointment
Altabax® *
Bactroban® * Cream

*Generic agents should be considered "first line" therapy when appropriate.</td><td>Abreva®
Zovirax® Ointment</td><td></td></tr>
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