



# MARYLAND PHARMACY PROGRAM

## Medicaid - Pharmacy Assistance – Pharmacy Discount

No. 7  
Thursday, May 06, 2004

# ADVISORY

In an effort to give timely notice to the pharmacy community concerning important pharmacy topics, the Department of Health and Mental Hygiene's (DHMH) *Maryland Pharmacy Program* (MPP) has developed the **Maryland Pharmacy Program Advisory**. To expedite information timely to the pharmacy and prescriber communities, an email network has been established which incorporates the email lists of the Maryland Pharmacists Association, EPIC, Long Term Care Consultants, headquarters of all chain drugstores and prescriber associations and organizations. It is our hope that the information is disseminated to all interested parties. If you have not received this email through any of the previously noted parties or via DHMH, please contact the MPP representative at 410-767-5395.

### **PREFERRED DRUG LIST (PDL): LATEST ENTRIES TO PDL TO BE IMPLEMENTED ON MAY 12 & 19, 2004**

The Department of Health and Mental Hygiene's Pharmacy and Therapeutics Committee has reviewed additional therapeutic classes for the (PDL). This Advisory #7 includes the new additions to the PDL. The attached PDL supersedes any former versions. All Maryland Medicaid rules and edits remain in effect.

The new therapeutic classes are:

#### **Effective May 12, 2004**

Antidepressants, Other  
Ophthalmics, Allergic Conjunctivitis  
Ophthalmics, Antibiotics  
Otics, Antibiotics  
Bladder Relaxants  
Crestor

#### **Effective May 19, 2004**

Antihistamines, Minimally Sedating  
Phosphate Binders

## PDL IMPLEMENTATION ISSUES AND CLARIFICATION

### Not All Generics are Preferred

In order for the State to benefit from the PDL, in some instances, some generic equivalents of the brand name drugs are non-preferred because they are NOT less costly than their branded counterparts. Many times this occurs when the generic form of the drug is a newly approved version and usually maintains a relatively high cost. Therefore, when manufacturer rebates are taken in consideration, the brand name drug becomes less costly to the State.

The generic non-preferred exceptions are as follows:

<b>Non-Preferred Generic</b>	<b>Status of Equivalent Brand</b>
ciprofloxacin	Cipro ( <i>Preferred</i> )
bupropion SR	Wellbutrin SR ( <i>Non-Preferred</i> )
mirtazapine soltab	Remeron Soltab ( <i>Preferred</i> )
nefazodone	Serzone ( <i>Non-Preferred</i> )
omeprazole	Prilosec ( <i>Non-Preferred</i> )

### “Grandfathering” Patients in Certain Therapeutic Classes

Mental health and phosphate binder therapeutic classes require the patient drug regimen to be delicately balanced. Introduction of a new drug other than the one historically prescribed could cause adverse effects. The P & T Committee considered select therapeutic classes for “grandfathering” existing drug regimens. Therefore, if a patient is on a specific drug within these classes for the last 90 days, there would be no requirement for the prescriber to obtain preauthorization.

Pharmacists are to process (submit a claim on-line) and allow the point-of-sale system to determine if the patient has been receiving the non-preferred prescribed drug. Pharmacists are not to presume that the prescribed non-preferred drug requires the prescribers

preauthorization and deny the prescription before processing. Allow the point of sale system to determine if preauthorization is required.

The following therapeutic classes are “grandfathered”:

Antidepressants (SSRIs)

Antidepressants, Other

Phosphate Binders (Electrolyte Depletors)

### **Exceptions to the 3-Day Emergency Preauthorization Requirements: Antibiotics and Single Use/One Time Units**

PDL regulations allow for a 3-day emergency supply when the prescriber cannot be reached. The pharmacist may obtain prior approval for the emergency supply. Within the 3-days authorized, the prescriber is to be contacted so that a preauthorization can be obtained for the remainder of the prescription and/or for future prescriptions for a preferred drug. However, certain drug products do not lend themselves to follow-up by the prescriber because the prescription itself is for a limited time, (e.g. antibiotic therapy) or is a single use device, (e.g. inhaler, ointment or cream) or packaged in one time units, (e.g. multiple day patches), etc.

If the prescriber is unable to be reached and the prescription is for antibiotic therapy or single use one time units, the preauthorization obtained by the pharmacist from the First Health Services Corporation Call Center will have a preauthorization end date equal to the approximate length of time for use of the product.

### **Step Therapy: PhosLo (Calcium Acetate) – Renagel (Sevelamer)**

The P & T Committee determined that PhosLo should be prescribed as initial therapy for hyperphosphatemia. If calcium levels increase and cannot be controlled, the non-preferred Renagel should be prescribed and preauthorization is required. However, the prescriber is not required to obtain preauthorization if PhosLo has been prescribed (as the first step) within the previous 90 days. Also, if a patient has been on Renagel within the last 90 days, they may remain on Renagel (“grandfathered”) and preauthorization is not

required. The point-of-sale system will determine if there has been prior use of PhosLo or Renagel within the past 90-day period and will determine if the preauthorization is required.

### **Medicaid Coverage for Over-the-Counter (OTC) Antihistamines**

Maryland Pharmacy Program regulations allow coverage for any nonlegend drug determined by the Program to be cost effective. Minimally sedating antihistamines are the first class of over-the-counter preparations for which prescriptions will be covered by this provision. The P & T Committee has recommended that over-the-counter minimally sedating antihistamines, along with legend Zyrtec Syrup be placed on the Preferred Drug List. Conversely, the legend minimally sedating antihistamines (Allegra, Clarinex, legend Claritin and other forms of Zyrtec) are not on the list and will require preauthorization. The Program requires the same original signed prescription order for OTC orders as legend products. These changes are effective May 19, 2004.

### **Maryland Aids Drug Assistance Program (MADAP) and Breast and Cervical Cancer Program Going On-Line May 5, 2004**

First Health Services Corporation will begin processing claims for MADAP and Breast and Cervical Cancer patients. Pharmacies will be contacted in the near future for instructions on claims submission processes.

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#### **For The Recipient**

*Full consideration for the recipient continues to be a top priority. The prescriber and pharmacist are encouraged to review the available options for drug therapy within the Preferred Drug List. Recipients having problems obtaining prescribed medications from the pharmacy may call the Maryland Pharmacy Access Hotline at 1-800-492-5231. If you (the pharmacy) have any questions, contact the Department at 410-767-1455.*

#### **For Additional Information**

*To obtain current and additional information about the Maryland Preferred Drug List, please feel free to visit the following websites:*

*Department of Health and Mental Hygiene <http://www.dhmh.state.md.us/mma/mpap/druglist.html>*

*Provider Synergies <http://providersynergies.com>*

*First Health Services Corporation <http://mdmedicaidrx.fhsc.com>*

Note: Brand names in parenthesis are for reference only and are not preferred. For any multi-source product, the generic product(s) are usually preferred and branded innovator product(s) are non-preferred. Key: All lowercase letters = generic product. Leading capital letter = brand name product.

**ANALGESIC****Antimigraines, Triptans**

Preferred

Amerge  
 Imitrex (oral, nasal & subq)  
 Maxalt, MLT  
 Requires Prior Authorization  
 Axert  
 Frova  
 Relpax  
 Zomig, Nasal, ZMT

**Nonsteroidal Anti-Inflammatories/COX II Inhibitors**

Preferred

diclofenac potassium (Cataflam)  
 diclofenac sodium, XL (Voltaren, XR)  
 etodolac, XL (Lodine, XL)  
 fenoprofen (Nalfon)  
 flurbiprofen (Ansaid)  
 ibuprofen (Motrin)  
 indomethacin, SR (Indocin, SR)  
 ketoprofen (Orudis, Oruvail)  
 ketorolac (Toradol)  
 meclufenamate (Meclomen)  
 nabumetone (Relafen)  
 naproxen (Naprosyn)  
 naproxen sodium, DS (Anaprox, DS)  
 oxaprozin (Daypro)  
 piroxicam (Feldene)  
 sulindac (Clinoril)  
 tolmetin, DS (Tolectin, DS)  
 Requires Prior Authorization  
 Arthrotec  
 Bextra  
 Celebrex  
 Mobic

Ponstel  
 Vioxx

**Narcotic Analgesics**

Preferred

acetaminophen w/codeine  
 (Tylenol w/Codeine)  
 aspirin w/codeine (Empirin w/Codeine)  
 butalbital/apap/caffeine/codeine  
 butalbital/apap/codeine  
 codeine phosphate/sulfate  
 hydrocodone w/ibuprofen (Vicoprofen)  
 hydrocodone w/apap (Vicodin)  
 hydromorphone (Dilaudid)  
 meperidine (Demerol)  
 morphine sulfate  
 morphine sulfate SR  
 (MS Contin)  
 oxycodone  
 oxycodone w/apap (Percocet)  
 oxycodone w/aspirin (Percodan)  
 pentazocine/naloxone (Talwin NX)  
 propoxyphene (Darvon)  
 propoxyphene HCl w/apap  
 (Wygesic)  
 propoxyphene napsylate w/apap  
 (Darvocet)  
 tramadol (Ultram)  
 Avinza  
 Duragesic  
 Kadian  
 Oramorph SR  
 Panlor, DC, SS  
 Roxicet  
 Roxicodone  
 Ultracet  
 Requires Prior Authorization  
 Actiq

Darvon-N  
 OxyContin  
 Synalgos-DC

**ANTI-INFECTIVES****Antifungals, Oral**

Preferred

griseofulvin (Fulvicin)  
 ketoconazole (Nizoral)  
 nystatin  
 Diflucan  
 Grifulvin V  
 Lamisil  
 Requires Prior Authorization  
 Ancobon  
 Mycelex Troche  
 Mycostatin Pastilles  
 Sporanox  
 Vfend

**Antifungals, Topical**

Preferred

clotrimazole (Lotrimin)  
 clotrimazole/betamethasone  
 (Lotrisone)  
 econazole (Spectazole)  
 ketoconazole (Nizoral)  
 nystatin (Mycostatin)  
 nystatin/triamcinolone (Mycolog II)  
 Exelderm  
 Naftin  
 Nizoral Shampoo  
 Oxistat  
 Requires Prior Authorization  
 Loprox  
 Loprox Shampoo

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Mentax  
Penlac

**Antivirals**

Preferred  
acyclovir (Zovirax)  
amantadine (Symmetrel)  
rimantadine (Flumadine)  
Cytovene  
Famvir  
Tamiflu  
Valcyte  
Requires Prior Authorization  
Relenza  
Valtrex

**Cephalosporin and Related Agents**

Preferred  
amoxicillin/clavulanate  
(Augmentin)  
cefaclor (Ceclor, CD)  
cefadroxil (Duricef)  
cefuroxime (Ceftin)  
cephalexin (Keflex)  
Augmentin ES-600, XR  
Omnicef  
Spectracef  
Requires Prior Authorization  
Cedax  
Cefzil  
Lorabid  
Panixine  
Raniclor  
Vantin

**Fluoroquinolones (Quinolones)**

Preferred  
ofloxacin (Floxin)  
Avelox, IV  
Cipro, XR, IV  
Requires Prior Authorization  
ciprofloxacin  
Floxin IV  
Levaquin, IV  
Maxaquin  
Noroxin  
Tequin, IV

**Macrolides**

Preferred  
erythromycin  
Biaxin, XL  
Dynabac  
Zithromax  
Requires Prior Authorization  
Branded erythromycin products

**CARDIOVASCULAR**

**ACE Inhibitor/Calcium Channel Blocker Combinations**

Preferred  
Lexxel  
Lotrel  
Tarka  
Requires Prior Authorization  
none

**ACE Inhibitors**

Preferred  
benazepril, HCTZ (Lotensin, HCT)  
captopril, HCTZ (Capoten, Capozide)  
enalapril, HCTZ (Vasotec, Vaserec)  
lisinopril, HCTZ (Prinivil, Zestril,  
Prinzide, Zestoretic)  
moexipril (Univasc)  
Aceon  
Monopril, HCT  
Uniretic  
Requires Prior Authorization  
Accupril, Accuretic  
Altace  
Mavik

**Angiotensin Receptor Blockers**

Preferred  
Avapro, Avalide  
Benicar, HCT  
Cozaar, Hyzaar  
Diovan, HCT  
Micardis, HCT  
Requires Prior Authorization  
Atacand, HCT  
Teveten, HCT

**Beta Blockers**

Preferred  
acebutolol (Sectral)  
atenolol (Tenormin)  
betaxolol (Kerlone)  
bisoprolol (Zebeta)  
labetalol (Normodyne, Trandate)  
metoprolol (Lopressor)  
nadolol (Corgard)

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pindolol (Visken)  
 propranolol (Inderal)  
 sotalol, AF (Betapace, AF)  
 timolol (Blocadren)  
 Coreg  
 Toprol XL  
 Requires Prior Authorization  
 Cartrol  
 Inderal LA  
 Innopran XL  
 Levatol

**Calcium Channel Blocking Agents**

Preferred  
 diltiazem (Cardizem)  
 diltiazem SR, ER (Cardizem SR, CD,  
 Dilacor XR, Tiazac)  
 nifedipine (Cardene)  
 nifedipine, SR (Adalat, CC, Procardia, XL)  
 verapamil (Calan)  
 verapamil ER, SR (Calan SR, Verelan)  
 Dynacirc, CR  
 Norvasc  
 Plendil  
 Sular  
 Requires Prior Authorization  
 Cardene SR  
 Cardizem LA  
 Covera-HS  
 Nimotop  
 Vascor  
 Verelan PM

**Intermittent Claudication Agents**

Preferred  
 pentoxifylline (Trental)  
 Pletal

Requires Prior Authorization  
 Trental

**Lipotropics, Other**

Preferred  
 cholestyramine (Questran, Light)  
 gemfibrozil (Lopid)  
 niacin (Niacor)  
 Advicor  
 Colestid  
 Niaspan  
 Tricor

Requires Prior Authorization  
 Lofibra  
 Welchol  
 Zetia

**Lipotropics, Statins**

Preferred  
 lovastatin (Mevacor)  
 Altocor  
 Crestor  
 Lescol, XL  
 Lipitor  
 Pravachol  
 Zocor

Requires Prior Authorization  
 Pravigard PAC

**CENTRAL NERVOUS SYSTEM**

**Antidepressants (SSRIs)**

Preferred  
 fluoxetine (Prozac)  
 fluvoxamine (Luvox)

paroxetine (Paxil)  
 Lexapro  
 Paxil CR  
 Zoloft (Ages 6-18 years)  
 Requires Prior Authorization  
 Celexa  
 Prozac Weekly  
 Sarafem  
 Zoloft (over age 18 and under 6 years)

**Antidepressants, Other**

Effective May 12, 2004

Preferred  
 bupropion (Wellbutrin)  
 mirtazapine (Remeron)  
 trazodone (Desyrel)  
 Effexor, XR  
 Remeron Soltab (brand only)  
 Wellbutrin XL  
 Requires Prior Authorization  
 bupropion SR (Wellbutrin SR)  
 mirtazapine soltab (generic only)  
 nefazodone (Serzone)

**Stimulants and Related Agents**

Preferred  
 amphetamine salt combo (Adderall)  
 dextroamphetamine (Dexedrine)  
 methylphenidate, ER (Metadate ER,  
 Methylin ER, Ritalin, Ritalin-SR)  
 pemoline (Cylert)  
 Adderall XR  
 Concerta  
 Focalin  
 Metadate CD  
 Ritalin LA  
 Strattera

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Requires Prior Authorization  
Desoxyn

**ENDOCRINE**

**Bone Resorption Suppression and Related Agents**

Preferred  
Actonel  
Fosamax  
Miacalcin

Requires Prior Authorization  
Didronel  
Evista  
Forteo

**Estrogen Agents, Combination**

Preferred  
Activella  
CombiPatch  
Prefest  
Premphase  
Prempro

Requires Prior Authorization  
Femhrt

**Estrogen Agents**

Preferred  
estradiol (Estrace)  
estradiol transdermal patches (Estraderm)  
estropipate (Ogen, Ortho-Est)  
Premarin  
Requires Prior Authorization  
Cenestin  
Menest

**Hypoglycemics, Insulins**

Preferred  
Lantus  
Novolin  
NovoLog  
NovoLog Mix  
Requires Prior Authorization  
Humulin  
Humalog  
Humalog Mix

**Hypoglycemics, Meglitinides**

Preferred  
Starlix  
Requires Prior Authorization  
Prandin

**Hypoglycemics, TZDs**

Preferred  
Avandia  
Requires Prior Authorization  
Actos

**GASTROINTESTINAL**

**Antiemetics, Oral**

Preferred  
metoclopramide (Reglan)  
Emend  
Marinol  
Zofran, ODT  
Requires Prior Authorization  
Anzemet  
Kytril

**Phosphate Binders (Electrolyte Depleters)**

Effective May 19, 2004

Preferred  
PhosLo  
Requires Prior Authorization  
Magnebind 400  
Renagel

**Proton Pump Inhibitors**

Preferred  
Aciphex  
Prevacid  
Requires Prior Authorization  
omeprazole  
Nexium  
Prilosec  
Protonix

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**OPHTHALMIC****Ophthalmics, Allergic Conjunctivitis**

Effective May 12, 2004

Preferred

cromolyn (Opticrom)

Acular

Alrex

Emadine

Livostin

Optivar

Patanol

Requires Prior Authorization

Alamast

Alocril

Alomide

Crolom

Opticrom

Zaditor

**Ophthalmics, Antibiotics**

Effective May 12, 2004

Preferred

bacitracin

erythromycin (Ilotycin)

gentamicin (Garamycin)

tobramycin (Tobrex)

Ciloxan

Gentak (drops only)

Gentadol

Ocuflax

Romycin

Tobrasol

Vigamox

Zymar

Requires Prior Authorization

Genoptic

Gentafair

Gentak

Quixin

**OTICS****Otics, Antibiotics**

Effective May 12, 2004

Preferred

neomycin/polymyxin/

hydrocortisone (Cortisporin)

Ciprodex

Coly-Mycin S

Floxin Otic

Pediatic

Requires Prior Authorization

Antibiotic Ear Suspension &amp; Solution

Cipro HC

Cortisporin Ear Suspension &amp; Solution

Cortisposin-TC

**RESPIRATORY****Antihistamines, Minimally Sedating**

Effective May 19, 2004

Preferred

loratadine, loratadine-D (OTC only)

Alavert, Alavert-D (OTC only)

Claritin, Claritin-D (OTC only)

Tavist ND (OTC only)

Zyrtec syrup

Requires Prior Authorization

Allegra, Allegra-D

Clarinex

Claritin (Rx)

Zyrtec tablet, Zyrtec-D

**Beta<sub>2</sub>-Agonist Bronchodilators**

Preferred

albuterol (Proventil, Ventolin)

metaproterenol (Alupent)

terbutaline (Brethine)

Combivent

Foradil

Proventil HFA

Serevent Diskus

Xopenex

Requires Prior Authorization

AccuNeb

Alupent

DuoNeb

Maxair

Serevent

Volmax

VoSpire ER

Ventolin HFA

**Inhaled Corticosteroids**

Preferred

Advair Diskus

AeroBid, AeroBid-M

Azmacort

Flovent, Rotadisk

Qvar

Pulmicort Respules (Ages 1-8)

Requires Prior Authorization

Pulmicort Respules (Over Age 8, Under Age 1)

Pulmicort Turbuhaler

**Leukotriene Receptor Antagonists**

Preferred

Singulair

Requires Prior Authorization

Accolate

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**Nasal Corticosteroids**

- Preferred
  - flunisolide (Nasalide)
  - Flonase
  - Nasonex
- Requires Prior Authorization
  - Beconase AQ
  - Nasacort AQ
  - Nasarel
  - Rhinocort Aqua

**UROLOGIC**

**Benign Prostatic Hyperplasia**

- Preferred
  - doxazosin (Cardura)
  - terazosin (Hytrin)
  - Avodart
  - Flomax
  - Proscar
- Requires Prior Authorization
  - Cardura
  - Hytrin

**Bladder Relaxants**  
Effective May 12, 2004

- Preferred
  - flavoxate (Urispas)
  - oxybutynin (Ditropan)
  - Detrol LA
  - Oxytrol
- Requires Prior Authorization
  - Detrol
  - Ditropan XL

## **Instructions for the Pharmacist**

When the pharmacist submits an on line-prescription claim for a non-preferred drug product whose class is on the preferred drug list, a message will appear “NON-PREF'D (PA req'd) MD call 1-800-932-3918.” The pharmacist should:

- Refer to the PDL reference list
- Notify the customer that the drug prescribed is not a preferred drug
- Contact the prescriber explaining that the drug is not a preferred drug
- Discuss the preferred drug options with the prescriber

### **If the prescriber agrees to switch to a preferred drug:**

The pharmacist will:

#### For Original Prescriptions

- Draw a line through the original drug name, strength and directions on the prescription order
- Write the new drug name, strength, directions and number of refills
- Initial and note that the prescriber changed to a preferred drug

#### For Refills

- Pharmacist will note on the original prescription order that a switch has been made to a preferred drug and will create a new prescription number
- Pharmacist will not be required to obtain a new written prescription order from the prescriber if a preferred drug is switched from the referenced original non-preferred prescription
- The prescription will be treated as a new prescription with the complement of refills as indicated by the prescriber

### **If the prescriber does not agree to switch to a preferred drug:**

The pharmacist will explain to the prescriber that:

- He/she must contact the preauthorization center at First Health Services Corporation via telephone at 1-800-932-3918 or via facsimile at 1-800-932-3921
- The prescription cannot be filled until the preauthorization is completed

After prior authorization has been obtained by the prescriber,

- The First Health Service Call Center will contact the pharmacy confirming pre-authorization
- The pharmacist can then complete the prescription, which was previously denied

**When the prescriber cannot be contacted, the pharmacist is to call the preauthorization call center at 1-800-932-3918 to obtain approval for a 72-hour emergency supply of a non-preferred drug**

- The pharmacist is to dispense the non-preferred drug
- Within the 72-hour window, the prescriber is to be contacted
- The pharmacist will receive a \$3.69 dispensing fee for the 72-hour supply and the recipient will not be charged a co-pay (e.g. \$0 co-pay)

**When the prescriber is contacted after the 72-hour supply has been dispensed and the prescriber continues with the non-preferred drug:**

- The prescriber is to be advised that he/she must obtain prior authorization before the remainder of the prescription can be dispensed
- After prior authorization has been established, the pharmacist can dispense the remainder of the prescription and receive an additional \$3.69 dispensing fee
- The appropriate co-pay will be charged to the recipient

**When the prescriber is contacted after the 72-hour supply has been dispensed and the prescriber elects to switch to a preferred drug:**

- Pharmacist completes the notation process previously described
- The pharmacist will receive a dispensing fee of \$4.69 for future prescriptions and no-co-pay will be assessed to the recipient

**When the pharmacist is having difficulty contacting the prescriber after the 72-hour supply has been dispensed, if necessary, a second 72-hour supply may be dispensed. However, the pharmacy must contact the Department for further instructions at 410-767-1455.**