

MEDICAID PHARMACY FREQUENCY/QUANTITY/DURATION (F/Q/D) PROGRAM

Based on the recommendations of the Drug Utilization Review Board (DURB), prescribers and pharmacists should adhere to the following F/Q/D parameters. These F/Q/D parameters have been instituted to ensure clinically appropriate and cost effective use of these drugs and drug classes.

For more information on DUR Board recommendations please refer to DUR meeting summaries at http://nyhealth.gov/health_care/medicaid/program/dur/index.htm

Drug Classes

Anabolic Steroids

Drug Name	Package Size	F/Q/D Parameter	Additional/Alternate Parameter(s)
Anadrol-50®	Caps—100	<p>Limitations for anabolic steroid products based on approved FDA labeled daily dosing and documented diagnosis not to exceed a 90-day supply (30-day supply for oxandrolone):</p> <p>-<u>Initial duration limit</u> of 3 months (for all products except oxandrolone), requiring documented follow-up monitoring for response and/or adverse effects before continuing treatment</p> <p>-<u>Duration limit</u> of 6 months for delayed puberty</p> <p>-<u>Duration limit</u> of 1 month for all uses of oxandrolone products</p>	<p>Anabolic steroids should be brought to the New York State Pharmacy and Therapeutics Committee to be considered for inclusion in the Clinical Drug Review Program</p>
Androderm®	Systems 2mg/day—60; 4mg/day—30		
AndroGel®	Gel 1% (2.5g, 5g)—30 packets; Pump 1% 75g (60 metered 1.25g doses)—2 ea; Pump 1.62% 75g (60 metered 1.25g doses)—1 ea.		
Android®	Caps—100		
Androxy™	Tabs—100		
Axiron®	Pump—90mL (60 metered doses)		
Depo-Testosterone®	Vial 100mg/mL (10mL) Vial 200mg/mL (1mL, 10mL)		
Fortesta®	Pump 60g (120 actuations)		
Methitest®	Tabs—100		
Oxandrin®	Tabs 2.5mg—100 10mg—60		
Oxandrolone	Tabs 2.5mg—100 10mg—60		
Testim®	Gel (5g)—30		
Testosterone cypionate	Vial 100mg/mL (10mL)		

	Vial 200mg/mL (1mL, 10mL)		
Testosterone enanthate	Single-dose syringe—1 Multidose vial (5mL)—1		
Testred®	Caps—100		
See also; Preferred Drug List			

Central Nervous System Stimulants

Drug Name	F/Q/D Parameter	Additional/Alternate Parameter(s)
<p>Adderall® Adderall XR® Amphetamine salts IR Amphetamine salts ER Concerta® Daytrana® Desoxyn® Dexedrine Spansule® Dexamethylphenidate HCl Dextroamphetamine Dextroamphetamine ER Focalin® Focalin XR® Metadate CD® Metadate ER® Methamphetamine HCl Methylin® Methylin ER® Methylphenidate HCl Methylphenidate HCl ER Methylphenidate HCl SA Nuvigil® Provigil® Ritalin® Ritalin LA® Ritalin SR® Vyvanse®</p>	<p>Quantity limits based on a daily dosage as determined by FDA labeling.</p> <p><u>Quantity limits for patients less than 18 years of age to include:</u></p> <p>1. Short-acting CNS stimulants, not to exceed 3 dosage units daily with a maximum of 90 days per strength (for titration)</p> <p>2. Long-acting CNS stimulants, not to exceed 1 dosage unit daily with a maximum of 90 days</p> <p><u>Quantity limits for patients 18 years of age and older to include:</u></p> <p>1. Short-acting CNS stimulants, not to exceed 3 dosage units daily with a maximum of 30 days</p> <p>2. Long-acting CNS stimulants, not to exceed 1 dosage unit daily with a maximum of 30 days</p> <p>Diagnosis requirement for patients age 18 and older requesting greater than a 30-day supply</p>	<p>Central Nervous System Stimulants should be brought to the New York State Pharmacy and Therapeutics Committee to be considered for inclusion in the Clinical Drug Review Program for patients 18 years and older.</p>
<p>See also; Preferred Drug List</p>		

Inhaled Corticosteroids

Drug Name	Package Size	F/Q/D Parameter	Additional/Alternate Parameter(s)
Alvesco [®] 80 mcg	6.1gm	1 inhaler every 30 days	
Alvesco [®] 160 mcg	6.1gm	1 inhaler every 30 days	Up to 1 inhaler every 15 days with previous oral corticosteroid use.
Asmanex [®] 110 mcg	1	1 inhaler every 30 days	
Asmanex [®] 220 mcg (30units)	1	1 inhaler every 30 days	
Asmanex [®] 220 mcg (60units)	1	1 inhaler every 30 days	Up to 1 inhaler every 15 days with previous oral corticosteroid use.
Asmanex [®] 220 mcg (120units)	1	1 inhaler every 60 days	Up to 1 inhaler every 30 days with previous oral corticosteroid use.
Flovent Diskus [®] 50mcg	60	1 diskus every 30 days	
Flovent Diskus [®] 100mcg	60	1 diskus every 30 days	
Flovent Diskus [®] 250mcg	60	1 diskus every 15 days	Up to 1 diskus every 7 days with previous oral corticosteroid use.
Flovent HFA [®] 44mcg	12gm	1 inhaler every 30 days	
Flovent HFA [®] 110mcg	12gm	1 inhaler every 30 days	
Flovent HFA [®] 220mcg	12gm	1 inhaler every 30 days	Up to 1 inhaler every 15 days with previous oral corticosteroid use.
Pulmicort [®] (Flexhaler) 90mcg	1	1 inhaler every 30 days	
Pulmicort [®] (Flexhaler) 180mcg	1	1 inhaler every 15 days	
QVAR [®] 40mcg	8.7gm	1 inhaler every 25 days	
QVAR [®] 80mcg	8.7gm	1 inhaler every 12 days	
See also; Preferred Drug List			

Inhaled Corticosteroid/Beta₂ Adrenergic Agents (Long-Acting)

Drug Name	Package Size	F/Q/D Parameter	Additional/Alternate Parameter(s)
Advair Diskus [®]	60	1 diskus every 30 days	

Advair HFA [®]	12gm	1 inhaler every 30 days	
Dulera [®]	13gm	1 inhaler every 30 days	
Symbicort [®]	10.2gm	1 inhaler every 30 days	
See also; Preferred Drug List			

Intranasal Corticosteroids

Drug Name	Package Size	F/Q/D Parameter	Additional/Alternate Parameter(s)
Beconase AQ [®]	25ml	1 inhaler every 22 days	
Flonase [®]	16gm	1 inhaler every 30 days	
flunisolide	25ml	1 inhaler every 25 days	
fluticasone	16gm	1 inhaler every 30 days	
Nasacort AQ [®]	16.5gm	1 inhaler every 30 days	
Nasonex [®]	17gm	1 inhaler every 30 days	
Omnaris [®]	12.5gm	1 inhaler every 30 days	
QNASL [®]	8.7gm	1 inhaler every 30 days	
Rhinocort Aqua [®]	8.6gm	1 inhaler every 30 days	
triamcinolone	16.5gm	1 inhaler every 30 days	
Veramyst [®]	10gm	1 inhaler every 30 days	
See also; Preferred Drug List			

Morphine and Congeners

Drug Name	F/Q/D Parameter	Additional/Alternate Parameter(s)
<p><u>Short Acting Opioids-</u></p> <p>Immediate release (IR) combination products</p>	<p>-Quantity limit for immediate release (IR) combination products:</p> <p>maximum recommended</p> <ul style="list-style-type: none"> ○ acetaminophen (4 grams) ○ aspirin (4 grams) ○ ibuprofen (3.2 grams) ○ OR the FDA approved maximum opioid dosage as listed in the PI, whichever is less 	<p>To be applied to patients without a documented cancer or sickle cell diagnosis.</p>
<p>IR non-combination products:</p> <p>codeine morphine hydromorphone oxycodone</p>	<p>-Quantity limit for IR non-combination products:</p> <ul style="list-style-type: none"> ○ Maximum 6 (six) units per day, 180 (one hundred eighty) units per 30 (thirty) days 	<p>To be applied to patients without a documented cancer or sickle cell diagnosis.</p>

<p><u>Long Acting Opioids-</u></p> <p>Extended-release (ER) products:</p> <p>hydromorphone ER oxycodone CR oxymorphone ER fentanyl transdermal patch morphine ER (excluding MS Contin products) morphine ER (MS Contin only)</p>	<p>-Quantity limit extended-release (ER) products:</p> <ul style="list-style-type: none"> ○ Hydromorphone ER, oxymorphone ER: maximum 4 units per day, 120 units per 30 days ○ Oxycodone CR: maximum 2 units per day, 60 units per 30 days ○ Fentanyl transdermal patch maximum: 10 patches per 30 days ○ Morphine ER (excluding MS Contin products): maximum 2 units per day, 60 units per 30 days ○ Morphine ER (MS Contin 15mg, 30mg, 60mg only): maximum 3 units per day, 90 units per 30 days ○ Morphine ER (MS Contin 100mg only): maximum 4 units per day, up to 3 times a day, maximum 120 units per 30 days ○ Morphine ER (MS Contin 200mg only): maximum 2 units per day, maximum 60 units per 30 days 	<p>To be applied to patients without a documented cancer or sickle cell diagnosis.</p> <p>-Oxycodone CR: Not to exceed a total daily dose of 160 mg.</p> <p>-Fentanyl transdermal patch: maximum 100mcg/hr (over the 72 hour dosing interval)</p>
<p>See also; Preferred Drug List</p>		

Non-Benzodiazepine Sedative Hypnotics (NBSHs)

Drug Name	F/Q/D Parameter	Additional/Alternate Parameter(s)
Ambien® Ambien CR® Edluar™ Intermezzo® Lunesta® Rozerem® Sonata® zaleplon zolpidem tartrate zolpidem tartrate ER Zolpimist®	<p><u>Duration limit</u> equivalent to the maximum recommended duration per Compendia sources:</p> <p>-360 days for immediate-release zolpidem products -180 days for eszopiclone and ramelteon products -168 days for extended-release zolpidem products -30 days for zaleplon products</p> <p><u>Frequency limit</u>, based on recommended maximum daily doses:</p> <p>-30 dosage units per fill/1 dosage unit per day/30 days for non-zaleplon-containing NBSHs - 60 dosage units per fill/2 dosage units per day/30 days for zaleplon-containing NBSHs</p>	<p>A first-fill duration and quantity limit for each NBSH of 10 days/10 dosage units for patients naïve to the prescribed NBSH (exception for zaleplon-containing products 10 days/20 dosage units)</p>
See also; Preferred Drug List		

Oral Bisphosphonates

Drug Name	F/Q/D Parameter	Additional/Alternate Parameter(s)
Actonel® 35 mg	4 tablets every 28 days	
Actonel® 150mg	1 tablet every 28 days	
alendronate sodium 35 mg	4 tablets every 28 days	
alendronate sodium 70 mg	4 tablets every 28 days	
Atelvia® 35 mg	4 tablets every 28 days	

Boniva [®] 150mg	1 tablet every 28 days	
Fosamax [®] 35 mg	4 tablets every 28 days	
Fosamax [®] 70mg	4 tablets every 28 days	
Fosamax [®] Plus D	4 tablets every 28 days	
Fosamax [®] Solution 70mg/75ml	4 bottles every 28 days	Each single-dose bottle contains 70mg/75ml
ibandronate sodium 150 mg	1 tablet every 28 days	
See also; Preferred Drug List		

Pegylated Interferons for Hepatitis C

Drug Name	F/Q/D Parameter	Additional/Alternate Parameter(s)
Peg Intron [®] (Redipen Pak 1 Kit, Redipen Pak 4 Kit) Pegasys [®] (Single Use Vial 1ml, Prefilled Syringe Monthly Conv. Pak [1 Kit], Proclick 0.5 Single Use Syringe Single Use)	Prior authorization will be required for the initial 14 weeks of therapy to determine the appropriate duration of therapy based on genotype.	Further documentation required for the continuation of therapy at weeks 14 and 26 After 12 weeks of therapy obtain a quantitative HCV RNA. Continuation is supported if the patient has an undetectable HCV RNA or at least a 2 log decrease compared to baseline. After 24 weeks of therapy obtain a HCV RNA. Continuation for genotype 1 and 4 is supported if the patient has an undetectable HCV RNA.
See also; Preferred Drug List		

Protease Inhibitors (Hepatitis C Virus)

Drug Name	F/Q/D Parameter	Additional/Alternate Parameter(s)
Telaprevir	<p>Quantity Limit: Maximum 12 units per day, 360 units per 30 days</p> <p>Duration limit: - Initially 56 days, pending results of quantitative HCV RNA testing after 4 weeks of treatment. - Maximum 12 consecutive weeks over beneficiary lifetime, pending results of quantitative HCV RNA testing</p>	
Boceprevir	<p>Quantity Limit: Maximum 6 (six) units per day, 180 units per 30 days</p> <p>Duration limit: - Initially 84 days, pending results of quantitative HCV RNA testing after 4 and 8 weeks of boceprevir treatment (i.e. weeks 8 and 12 of triple therapy) - Subsequent limit of 84 days, pending results of quantitative HCV RNA testing after 20 weeks of boceprevir treatment (i.e. week 24 of triple therapy) - Maximum 44 consecutive weeks over beneficiary lifetime, pending results of quantitative HCV RNA testing if: <ul style="list-style-type: none"> ○ Prior peginterferon/ribavirin non responder ○ Compensated cirrhosis - Maximum 32 consecutive weeks over beneficiary lifetime, pending results of quantitative HCV RNA testing for all other beneficiaries</p>	
<p>See also; Preferred Drug List, Step Therapy</p>		

Proton Pump Inhibitors

Drug Name	F/Q/D Parameter	Additional/Alternate Parameter(s)
Aciphex® Dexilant™ lansoprazole Rx Nexium® (capsule) Nexium Packet® omeprazole OTC omeprazole Rx omeprazole/sodium bicarbonate Rx pantoprazole Prevacid® OTC Prevacid® Rx Prilosec® OTC Prilosec® Rx Protonix®	<p><u>Duration limits:</u></p> <ul style="list-style-type: none"> - Mild/moderate GERD, acute healing of duodenal/gastric ulcers (including NSAID-induced): 60 days - Maintenance treatment of duodenal ulcers: 365 days -H. pylori: 14 days <p><u>Quantity limits:</u></p> <ul style="list-style-type: none"> - GERD, erosive esophagitis, healing and maintenance of duodenal/gastric ulcers (including NSAID-induced), prevention of NSAID-induced ulcers: once daily dosing (30 units every 30 days) - Hypersecretory conditions, Barrett's esophagitis, H. pylori, refractory GERD: twice daily dosing (60 units every 30 days) 	
See also; Preferred Drug List		

Serotonin Receptor Agonists (Triptans)

Drug Name	Package Size	F/Q/D Parameter	Additional/Alternate Parameter(s)
Amerge®	9ct.	18 tablets every 30 days	
Axert® 6.25mg	6ct.	18 tablets every 30 days	
Axert® 12.5mg	12ct.	24 tablets every 30 days	
Frova®	9ct.	18 tablets every 30 days	

Imitrex tablets	9ct.	18 tablets every 30 days	
Imitrex NS [®]	6ct.	18 tablets every 30 days	
Maxalt/Maxalt MLT [®]	18ct	24 tablets every 30 days	
naratriptan	9ct.	18 tablets every 30 days	
Relpax [®] 20mg	6ct.	18 tablets every 30 days	
Relpax [®] 40mg	6ct.	24 tablets every 30 days	
sumatriptan tablets	9ct.	18 tablets every 30 days	
Treximet [®]	9ct.	18 tablets every 30 days	
Zomig/Zomig ZMT 2.5mg	6ct.	18 tablets every 30 days	
Zomig /Zomig ZMT 5mg	3ct.	18 tablets every 30 days	
Zomig NS [®]	6ct.	18 units every 30 days	
See also; Preferred Drug List			

Other Drugs

Drug Name	F/Q/D Parameter	Additional/Alternate Parameter(s)
Amitiza See also; Step Therapy	Duration limit of 30 days with 2 refills/prescription	<i>Date Effective 4/12/2012</i>
Buprenorphine SL	Quantity Limit: 6 (six) tablets dispensed as a 2 day supply	

<p>Carisoprodol Containing Products</p> <p>See also; Step Therapy Preferred Drug List</p>	<p>Quantity Limits:</p> <p>Maximum 84 cumulative units per a year</p> <p>-Carisoprodol - maximum 4 (four) units per day, 21 day supply</p> <p>-Carisoprodol Combinations - maximum 8 (eight) units per day, 21 day supply (not to exceed the 84 cumulative units per year limit)</p>	<p>Carisoprodol containing products should be brought to the New York State Pharmacy and Therapeutics Committee to be considered for inclusion in the Clinical Drug Review Program.</p>
<p>Doxycycline delayed-release</p> <p>See also; Step Therapy Preferred Drug List</p>	<p>Quantity Limit:</p> <p>maximum 28 tablets/capsules per fill</p>	
<p>Fentanyl transmucosal</p> <p>See also; Clinical Drug Review Program</p>	<p>Quantity Limits:</p> <p>-Transmucosal - maximum 4 (four) units per day, 120 units per 30 days</p>	<p>To be applied to patients without a documented cancer or sickle cell diagnosis.</p>
<p>Invega[®]</p> <p>See also; Step Therapy Preferred Drug List</p>	<p>Quantity Limits:</p> <p>-Paliperidone 1.5mg, 3mg, 9mg tablets - maximum 1 (one) unit per day</p> <p>-Paliperidone 6mg tablets - maximum 2 (two) units per day</p>	
<p>Lovaza[®]</p> <p>See also; Step Therapy Preferred Drug List</p>	<p>Quantity Limit:</p> <p>Equal to 4 (four) units per day</p>	
<p>Methadone</p>	<p>Quantity Limit:</p> <p>Maximum 12 (twelve) units per day, 360 units per 30 days</p>	<p>To be applied to patients without a documented cancer or sickle cell diagnosis.</p>

Moxatag [®] See also; Step Therapy	Quantity Limit: Equal to 10 tablets per fill	
Nucynta [®] See also; Step Therapy , Preferred Drug List	Quantity Limits: Tapentadol IR - Maximum 6 (six) units per day, 180 units per 30 days Tapentadol ER - Maximum 2 (two) units per day	Maximum daily dose of tapentadol IR and tapentadol ER formulations if used in combination should not exceed 500mg/day.
Quinine	Quantity and Duration Limit: Maximum 42 (forty-two) capsules dispensed as a 7 day supply	Limited to one (1) prescription per year.
Regranex [®] See also; Clinical Drug Review Program	Quantity Limit: Maximum 2 (two) 15 gram tubes in a lifetime	
Restasis [®] See also; Step Therapy	Quantity Limit : Maximum 60 (sixty) vials dispensed as a 30 (thirty) day supply	
Seroquel [®] IR/ER See also; Preferred Drug List	Quantity Limits: Minimum 100mg/day Maximum 800mg/day Immediate Release - maximum 3 (three) units per day, 90 units per 30 days Extended Release (150mg and 200mg) – 1 (one) unit per day, 30 units per 30 days Extended Release (50mg, 300mg and 400mg) – 2 (two) units per day, 60 units per 30 days	

<p>Solaraze[®]</p> <p>See also; Preferred Drug List</p>	<p>Quantity Limit: Maximum 100 (one hundred) grams dispensed as a 90 day supply</p>	<p>Limited to one (1) prescription per year.</p>
<p>Suboxone[®] SL Tablet & Film</p>	<p>Quantity Limit: Maximum 3 (three) sublingual tablets or films per day</p>	<p>Maximum of ninety (90) tablets or films dispensed as a 30 day supply.</p>
<p>Tramadol ER</p> <p>See also; Step Therapy, Preferred Drug List</p>	<p>Quantity Limit: Maximum 30 (thirty) tablets dispensed as a 30 day supply</p>	
<p>Vusion[®] 50gm ointment</p> <p>See also; Preferred Drug List</p>	<p>Quantity Limit: Maximum 100 (one hundred) grams in a 90 day time period</p>	