Psoriasis Agents, Topical Therapeutic Class Review

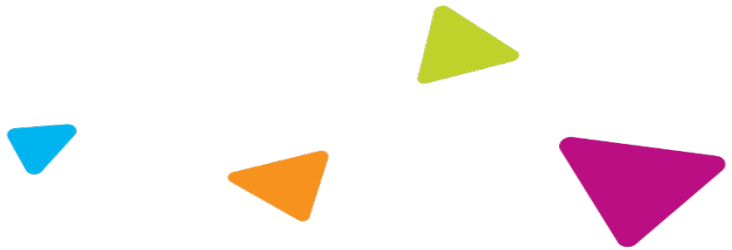
NEW YORK MEDICAID
DRUG UTILIZATION REVIEW BOARD MEETING
MAY 18, 2023

Magellan Rx MANAGEMENT℠

Psoriasis Agents, Topical

New Clinical Information

- New Drug Entity: Vtama® (tapinarof)
- New Drug Entity: Zoryve® (roflumilast)



Magellan Rx MANAGEMENT℠

Psoriasis Agents, Topical

Vtama® (tapinarof)

- **Indications:**
  - Aryl hydrocarbon receptor agonist indicated for the topical treatment of plaque psoriasis in adults

- **Dosage/Administration:**
  - 1% cream, each gram contains 10 mg of tapinarof
  - Apply a thin layer of VTAMA cream to affected areas once daily
  - Not for oral, ophthalmic, or intravaginal use

- **Contraindications:**
  - None

Vtama [package insert]. Long Beach, CA; Dermavant Sciences, Inc.; May 2022.

Vtama® (tapinarof) cont.

- **Common Adverse Drug Reactions:**
  - Folliculitis, nasopharyngitis, contact dermatitis, headache, pruritus, and influenza (incidence ≥ 1%)
- **Drug Interactions:**
  - None reported
- **Specific Populations:**
  - Pregnancy: available data on use in pregnant women are insufficient to evaluate for a drug-associated risk of major birth defects, miscarriage, or other adverse maternal or fetal outcomes
  - Lactation: no data available
  - Pediatrics: safety and efficacy have not been established in pediatric subjects with psoriasis under 18 years of age
  - Geriatrics: no overall differences in efficacy, safety, or tolerability were observed between elderly subjects and younger adult subjects in clinical trials
- **Clinical Comparative Studies (within class):**
  - None

Vtama [package insert]. Long Beach, CA; Dermavant Sciences, Inc.; May 2022.

Psoriasis Agents, Topical

Zoryve® (roflumilast)

- **Indications:**
  - Phosphodiesterase 4 inhibitor indicated for topical treatment of plaque psoriasis, including intertriginous areas, in patients 12 years of age and older

- **Dosage/Administration:**
  - 0.3% cream: 3mg of roflumilast per gram in 60-gram tubes
  - Apply topically once daily to affected areas
  - Not for ophthalmic, oral, or intravaginal use

- **Contraindications:**
  - Moderate to severe liver impairment (Child-Pugh B or C)

- **Common Adverse Drug Reactions:**
  - Diarrhea, headache, insomnia, application site pain, upper respiratory tract infections, and urinary tract infections (reported in ≥ 1% of patients)

Zoryve [package insert]. Westlake Village, CA; Arcutis Biotherapeutics, Inc.; July 2022.

Zoryve® (roflumilast) cont.

- **Drug Interactions:**
  - Coadministration with systemic CYP3A4 inhibitors or dual inhibitors that inhibit both CYP3A4 and CYP1A2 simultaneously may increase roflumilast systemic exposure and may result in increased adverse reactions
  - Coadministration of roflumilast with oral contraceptives containing gestodene and ethinyl estradiol may increase roflumilast systemic exposure and may result in increased side effects
- **Specific Populations:**
  - Pregnancy: no randomized clinical trials of oral or topical roflumilast in pregnant women
  - Lactation: no information regarding the presence in human milk, the effects on the breastfed infant, or the effects on milk production
  - Pediatrics: safety and effectiveness have been established in pediatric patients ages 12 years and older for the treatment of plaque psoriasis
  - Geriatrics: no overall differences in safety or effectiveness were observed between these subjects and younger subjects
  - Hepatic Impairment: contraindicated in moderate to severe liver impairment
- **Clinical Comparative Studies (within class):**
  - None

Zoryve [package insert]. Westlake Village, CA; Arcutis Biotherapeutics, Inc.; July 2022.

Psoriasis Agents – Topical		
calcipotriene (cream, ointment, scalp solution)	calcipotriene foam (generic Sorilux®) calcipotriene / betamethasone dipropionate (generic Taclonex®) calcitriol ointment (generic Vectical®) Dovonex® Duobrii™ Enstilar® Sorilux® Taclonex® Vectical® Vtama® Zoryve™	

Glucagon-like Peptide-1 (GLP-1) Agonists Therapeutic Class Review

NEW YORK MEDICAID
DRUG UTILIZATION REVIEW BOARD MEETING
MAY 18, 2023

Magellan Rx MANAGEMENT℠

GLP-1 Agonists

New Clinical Information

- New Drug Entity: Mounjaro® (tirzepatide)
- New Indications: Trulicity® (dulaglutide), Rybelsus® (semaglutide)
- New Practice Guidelines

Magellan Rx MANAGEMENT℠

GLP-1 Agonists

Mounjaro® (tirzepatide)

- **Indications:**
  - Glucose-dependent insulinotropic polypeptide (GIP) receptor and glucagon-like peptide-1 (GLP-1) receptor agonist indicated as an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus
- **Dosage and Administration/Availability:**
  - The recommended starting dosage is 2.5 mg injected subcutaneously once weekly
  - After 4 weeks, increase to 5 mg injected subcutaneously once weekly
  - If additional glycemic control is needed, increase the dosage in 2.5 mg increments after at least 4 weeks on the current dose
  - The maximum dosage is 15 mg subcutaneously once weekly
  - Administer once weekly at any time of day, with or without meals
  - Inject subcutaneously in the abdomen, thigh, or upper arm
  - Rotate injection sites with each dose
  - Injection: 2.5 mg, 5 mg, 7.5 mg, 10 mg, 12.5 mg, or 15 mg per 0.5 mL in single-dose pen

Mounjaro [package insert]. Indianapolis, IN; Eli Lilly and Company; September 2022.

GLP-1 Agonists

Mounjaro® (tirzepatide) cont.

- **Contraindications:**
  - Personal or family history of medullary thyroid carcinoma or in patients with Multiple Endocrine Neoplasia syndrome type 2
  - Known serious hypersensitivity to tirzepatide or any of the excipients
- **Warnings and Precautions:**
  - Pancreatitis: Has been reported in clinical trials. Discontinue promptly if suspected.
  - Hypoglycemia with Concomitant Use of Insulin Secretagogues or Insulin: Concomitant use may increase the risk of hypoglycemia, including severe hypoglycemia. Reducing dose of insulin secretagogue or insulin may be necessary.
  - Hypersensitivity Reactions: Discontinue if suspected.
  - Acute Kidney Injury: Monitor renal function in patients with renal impairment reporting severe adverse gastrointestinal reactions.
  - Severe Gastrointestinal Disease: Has not been studied in patients with severe gastrointestinal disease and is not recommended in these patients.
  - Diabetic Retinopathy Complications in Patients with a History of Diabetic Retinopathy: Has not been studied in patients with non-proliferative diabetic retinopathy requiring acute therapy, proliferative diabetic retinopathy, or diabetic macular edema. Monitor patients with a history of diabetic retinopathy for progression.
  - Acute Gallbladder Disease: If cholelithiasis is suspected, gallbladder studies and clinical follow-up are indicated

Mounjaro [package insert]. Indianapolis, IN; Eli Lilly and Company; September 2022.

GLP-1 Agonists

Mounjaro® (tirzepatide) cont.

- **Common Adverse Drug Reactions:**
  - Most common adverse reactions (reported in ≥5% of patients):
    - Nausea, diarrhea, decreased appetite, vomiting, constipation, dyspepsia, and abdominal pain.
- **Drug Interactions:**
  - Mounjaro delays gastric emptying and has the potential to impact the absorption of concomitantly administered oral medications.
- **Specific Populations:**
  - Pregnancy: Based on animal study, may cause fetal harm.
  - Females of Reproductive Potential: Advise females using oral contraceptives to switch to a non-oral contraceptive method, or add a barrier method of contraception for 4 weeks after initiation and for 4 weeks after each dose escalation.
- **Clinical Comparative Studies (within class):**
  - SURPASS-2: 40-week open-label trial that randomized 1879 adult patients with T2DM with inadequate glycemic control on stable doses of metformin alone to the addition of Mounjaro 5 mg, 10 mg, or 15 mg once weekly or subcutaneous semaglutide 1 mg once weekly.
  - Treatment with Mounjaro 10 mg and 15 mg once weekly for 40 weeks resulted in a statistically significant reduction in HbA1c compared with semaglutide 1 mg once weekly.

Mounjaro [package insert]. Indianapolis, IN; Eli Lilly and Company; September 2022.

GLP-1 Agonists

Trulicity® (dulaglutide)

- **New Indication:**
  - As an adjunct to diet and exercise to improve glycemic control in adults and pediatric patients 10 years of age and older with type 2 diabetes mellitus

- **Pediatric Dosage:**
  - Recommended starting dosage is 0.75 mg injected subcutaneously once weekly
  - If additional glycemic control is needed, increase dosage to the maximum recommended dosage of 1.5 mg once weekly after at least 4 weeks on the 0.75 mg dosage

- **Warnings and Precautions:**
  - Acute Gallbladder Disease: If cholelithiasis or cholecystitis are suspected, gallbladder studies are indicated

Trulicity [package insert]. Indianapolis, IN; Eli Lilly and Company; December 2022.

GLP-1 Agonists

Rybelsus®(semaglutide)

- **New Indication:**
  - Food and Drug Administration (FDA) has approved a label update for Rybelsus® (semaglutide) tablets 7 mg or 14 mg, allowing use as a first-line treatment option for adults with type 2 diabetes

- **Warnings and Precautions :**
  - Acute Gallbladder Disease: If cholelithiasis or cholecystitis are suspected, gallbladder studies are indicated

Rybelsus [package insert]. Denmark; Novo Nordisk; January 2023.

GLP-1 Agonists

Practice Guidelines

- **American Diabetes Association (ADA) 2023 Standards of Care in Diabetes**
  - Key changes include emphasis on higher weight loss for patients with type 2 diabetes mellitus (T2DM), lower hypertension diagnosis cut-offs and target blood pressure goals, lower LDL-C targets for high-risk, use of SGLT2 inhibitors with T2DM & heart failure, and consideration of social determinants of health when managing DM. The standards also emphasize the use of inclusive & person-first language.

- **American Diabetes Association has updated the living 2022 Standards of Medical Care in Diabetes**
  - Changes made to Cardiovascular Disease and Risk Management (section 10) and Chronic Kidney Disease (CKD) and Risk Management (section 11) information regarding the effects of finerenone on cardiovascular outcomes for people with T2DM and CKD and the effects of SGLT2 inhibitors on heart failure and renal outcomes among people with T2DM. New information was added on calculating estimated glomerular filtration rates and the inclusion of race in the diagnosis of kidney disease.

https://professional.diabetes.org/content-page/practice-guidelines-resources
https://diabetesjournals.org/care/article/45/Supplement_1/S144/138910/10-Cardiovascular-Disease-and-Risk-Management

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
Glucagon-like Peptide-1 (GLP-1) Agonists CC, ST		
Byetta® Ozempic® Trulicity® Victoza®	Adlyxin® Bydureon® BCise™ Mounjaro® Rybelsus® Soliqua® Xultophy®	**CLINICAL CRITERIA (CC)** • Confirm diagnosis of FDA-approved, compendia-supported, and Medicaid-covered indication **STEP THERAPY (ST)** • Requires a trial with metformin with or without insulin prior to a GLP-1 agonist

New York State

Drug Utilization Review Board Meeting

May 18, 2023

Current NYRx Preferred Drug List for the 17 Drug Classes on the Agenda

NEW YORK STATE | Department of Health

Clinical Criteria for Non-Preferred Products

Non-Preferred Products remain available through the prior authorization process.

1. The preferred drug has been tried by the patient and has failed to produce the desired health outcome.

   Q: Has your patient experienced treatment failure with a preferred product?

2. The patient has tried the preferred drug and has experienced unacceptable adverse effects.

   Q: Has your patient experienced an adverse drug reaction with a preferred product?

3. The patient has been stabilized on a non-preferred drug and transition to the preferred drug would be medically contraindicated

   Q: Is there a documented history of successful therapeutic control with a non-preferred product and transition to a preferred product is medically contraindicated?

4. Other clinical indications for use of a non-preferred drug, which shall include consideration of the medical needs of special populations.

Medicaid Fee-for-Service Preferred Drug Program
1. Angiotensin Receptor Blockers

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
Angiotensin Receptor Blockers (ARBs)		
Diovan® DO losartan valsartan tablets	Atacand® Avapro® Benicar® DO candesartan Cozaar® Edarbi® eprosartan irbesartan Micardis® DO olmesartan telmisartan	**DOSE OPTIMIZATION (DO)** See Dose Optimization Chart for affected drugs and strengths

NEW YORK STATE | Department of Health

Medicaid Fee-for-Service Preferred Drug Program
2. Angiotensin Receptor Blocker Combinations

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
ARBs Combinations		
Entresto® Exforge HCT® losartan/ HCTZ valsartan/ amlodipine valsartan/ amlodipine / HCTZ valsartan/ HCTZ	Atacand HCT® Avalide® Azor® Benicar HCT® DO candesartan/ HCTZ Diovan HCT® DO Edarbyclor® DO Exforge® DO Hyzaar® irbesartan/ HCTZ Micardis HCT® DO olmesartan/ amlodipine olmesartan/ amlodipine/ HCTZ olmesartan/ HCTZ telmisartan/ amlodipine telmisartan/ HCTZ Tribenzor®	**DOSE OPTIMIZATION (DO)** • See Dose Optimization Chart for affected drugs and strengths

Medicaid Fee-for-Service Preferred Drug Program

3. Triglyceride Lowering Agents

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
Triglyceride Lowering Agents		
fenofibrate tablet (generic Tricor®) fenofibrate caps (generic Lofibra®) fenofibric acid caps (generic Trilipix®) gemfibrozil omega-3 ethyl ester (generic Lovaza®) F/Q/D,	Antara® fenofibrate caps (gen Lipofen®) fenofibrate micronized caps (gen Antara®) fenofibrate tabs (gen Fenoglide®) fenofibric acid tablet (gen Fibricor®) Fenoglide® icosapent (generic Vascepa®) F/Q/D Lipofen® Lopid® Lovaza® F/Q/D Tricor® Trilipix® Vascepa® F/Q/D	**FREQUENCY/QUANTITY/DURATION (F/Q/D)** • Lovaza® (omega-3-acid ethyl-esters) and Vascepa® (icosapent ethyl) – Required dosage equal to 4 grams per day

Medicaid Fee-for-Service Preferred Drug Program

4. Anticonvulsants – Other (1 of 2)

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
Anticonvulsants – Other		
clobazam (tablet) ST, CC gabapentin (capsule, solution, tablet) F/Q/D, CC lamotrigine (tablet, chew) levetiracetam levetiracetam ER Lyrica® (capsule) DO, ST, F/Q/D, CC pregabalin (capsule) DO, ST, F/Q/D, CC tiagabine topiramate CC zonisamide	Banzel® Briviact® clobazam (suspension) ST Diacomit® CC Elepsia® XR Epidiolex® CC Eprontia™ CC felbamate Felbatol® Fintepla® Fycompa® DO Gabitril® Keppra® Keppra XR® lacosamide Lamictal® (tablet, chew, dosepak) Lamictal® ODT (tablet, dosepak) Lamictal® XR DO (tablet, dosepak) lamotrigine (dosepak) lamotrigine ER lamotrigine ODT (dosepak) Lyrica® (solution) DO, ST, F/Q/D Lyrica® CR ST, F/Q/D, CC Neurontin® F/Q/D, CC	**DOSE OPTIMIZATION (DO)** • See Dose Optimization Chart for affected drugs and strengths **CLINICAL CRITERIA (CC)** • Clinical editing will allow patients currently stabilized on a non-preferred agent to continue to receive that agent without PA • **Cannabidiol extract (Epidiolex®)** – Confirm diagnosis of FDA-approved or compendia-supported indication, or; Institutional Review Board (IRB) approval with signed consent form • **Lyrica®/Lyrica® CR (pregabalin)** – PA required for the initiation of pregabalin at > 150 mg per day in patients currently on an opioid at > 50 MME per day • **Neurontin® (gabapentin) –** PA required for initiation of gabapentin at > 900 mg per day in patients currently on an opioid at > 50 MME per day • **Stiripentol (Diacomit®) –** Require diagnosis of FDA-approved or compendia-supported indication, or; Institutional Review Board (IRB) approval with signed consent form • **Topiramate IR/ER (Eprontia™, Qudexy® XR, Topamax®, Trokendi XR™)** – Require confirmation of FDA-approved, compendia-supported, or Medicaid covered diagnosis • **Onfi®/Sympazan® (clobazam):** – Require confirmation of FDA-approved or compendia-supported use – PA required for initiation of clobazam therapy in patients currently on opioid or oral buprenorphine therapy

Medicaid Fee-for-Service Preferred Drug Program
4. Anticonvulsants – Other (continued 2 of 2)

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
Anticonvulsants – Other		
	Qudexy® XR [CC] rufinamide (gen Banzel®) Sabril® Spritam® Sympazan® film [ST, CC] Topamax® [CC] topiramate ER [CC, DO] (gen Qudexy® XR) topiramate ER [CC] (gen Trokendi XR®) Trokendi XR® [CC, DO] vigabatrin Vimpat® Xcopri® Zonisade™ Ztalmy®	**FREQUENCY/QUANTITY/DURATION (F/Q/D)** • **Eprontia™ (topiramate)** – Maximum quantity: 473 mL per month • **Lyrica®/Lyrica® CR (pregabalin)** – Maximum daily dose of IR: 600 mg per day, and ER: 660 mg per day • **Neurontin® (gabapentin)** – Maximum daily dose of 3,600 mg per day **STEP THERAPY (ST)** • **Lyrica®/Lyrica® CR (pregabalin)** – Requires a trial with a tricyclic antidepressant OR gabapentin for treatment of Diabetic Peripheral Neuropathy (DPN) **Onfi®/Sympazan® (clobazam)** – Requires a trial with an SSRI or SNRI for treatment of anxiety

Medicaid Fee-for-Service Preferred Drug Program
5. Selective Serotonin Reuptake Inhibitors

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
Selective Serotonin Reuptake Inhibitors (SSRIs)		
citalopram (tablet, solution) escitalopram (tablet) fluoxetine (capsule, solution) paroxetine (tablets) sertraline (tablets, concentrate)	Celexa® citalopram (capsules) escitalopram (soln) fluoxetine (tablet) fluoxetine DR weekly fluvoxamine CC fluvoxamine ER CC Lexapro® DO paroxetine (capsules) paroxetine CR paroxetine suspension Paxil® Paxil CR® Pexeva® Prozac® sertraline capsules Trintellix® DO Viibryd® DO vilazodone (gen Viibryd®) Zoloft®	**DOSE OPTIMIZATION (DO)** • See Dose Optimization Chart for affected strengths **CLINICAL CRITERIA (CC)** • Clinical editing will allow patients currently stabilized on fluvoxamine or fluvoxamine ER to continue to receive that agent without PA • Clinical editing to allow patients with a diagnosis of Obsessive-Compulsive Disorder (OCD) to receive fluvoxamine and fluvoxamine ER without prior authorization

Medicaid Fee-for-Service Preferred Drug Program
7. Dipeptidyl Peptidase 4 Inhibitors

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
Dipeptidyl Peptidase-4 (DPP-4) Inhibitors ST		
Glyxambi® Janumet® Janumet® XR Januvia® DO Jentadueto® Kazano® BLTG Nesina® BLTG Tradjenta®	alogliptin alogliptin / metformin alogliptin / pioglitazone Jentadueto® XR Kombiglyze® XR Onglyza® DO Oseni® Qtern® Steglujan®	**DOSE OPTIMIZATION (DO)** • See Dose Optimization Chart for affected strengths **STEP THERAPY (ST)** • Requires a trial with metformin with or without insulin prior to DPP-4 Inhibitor therapy unless there is a documented contraindication.

Medicaid Fee-for-Service Preferred Drug Program

8. Glucagon Agents

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
Glucagon Agents		
glucagon vial [1] glucagon HCl emergency kit [1] (Fresenius) Zegalogue® [1] (pen, syringe)	Baqsimi® [2] glucagon emergency kit [2] (Eli Lilly, Amphastar) Gvoke® [2] (pen, syringe, vial)	

Medicaid Fee-for-Service Preferred Drug Program
10. Proton Pump Inhibitors

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
Proton Pump Inhibitors (PPIs) F/Q/D		
omeprazole Rx pantoprazole tablet Zegerid® Rx BLTG	Aciphex® Dexilant® DO dexlansoprazole (gen Dexilant) esomeprazole magnesium Rx, OTC (generic for Nexium) lansoprazole Rx (capsule, ODT) Nexium® RX DO omeprazole OTC omeprazole / sodium bicarbonate Rx omeprazole / sodium bicarbonate OTC pantoprazole suspension Prevacid® OTC Prevacid® Rx DO Prilosec® Rx Protonix® rabeprazole	**DOSE OPTIMIZATION (DO)** • See Dose Optimization Chart for affected strengths **FREQUENCY/QUANTITY/DURATION (F/Q/D)** • Quantity limits: – Once daily dosing for: o GERD o erosive esophagitis o healing and maintenance of duodenal/gastric ulcers (including NSAID-induced) o prevention of NSAID-induced ulcers – Twice daily dosing for: o hypersecretory conditions o Barrett's esophagitis o H. pylori o refractory GERD • Duration limits: – 90 days for: o GERD – 365 days for: o Maintenance treatment of duodenal ulcers, or erosive esophagitis – 14 days for: o H. pylori

Medicaid Fee-for-Service Preferred Drug Program
11. Erythropoiesis Stimulating Agents

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
Erythropoiesis Stimulating Agents (ESAs) [CC]		
Epogen® Retacrit®	Aranesp® Mircera® Procrit®	**CLINICAL CRITERIA (CC)** • Confirm diagnosis for FDA- or compendia-supported uses

Medicaid Fee-for-Service Preferred Drug Program
12. Immunosuppressives – Oral

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
Immunosuppressives, Oral		
azathioprine CellCept® (suspension) BLTG cyclosporine (softgel, capsule) cyclosporine modified (capsule, solution) mycophenolate mofetil (capsule, tablet) Rapamune® (solution) BLTG sirolimus (tablet) tacrolimus	Astagraf XL® Azasan® CellCept® (capsule, tablet) Envarsus XR® everolimus (gen Zortress®) Imuran® Lupkynis™ CC, ST, F/Q/D mycophenolic acid mycophenolate mofetil (suspension) Myfortic® Neoral® Prograf® Rapamune® (tablet) Sandimmune® (solution, capsule) sirolimus (solution) Zortress®	**CLINICAL CRITERIA (CC)** • Lupkynis™ (voclosporin) – Confirm diagnosis for FDA- or compendia-supported uses **STEP THERAPY (ST)** • Trial of mycophenolate prior to Lupkynis™ **FREQUENCY/QUANTITY/DURATION (F/Q/D)** Lupkynis™ limited to 30-day supply

Medicaid Fee-for-Service Preferred Drug Program
13. Antihistamines – Ophthalmic

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
Antihistamines – Ophthalmic		
olopatadine OTC	azelastine bepotastine (gen Bepreve®) Bepreve® epinastine ketotifen OTC Lastacaft® olopatadine Rx Pataday® Zaditor® OTC Zerviate™	

NEW YORK STATE | Department of Health

Medicaid Fee-for-Service Preferred Drug Program
14. Urinary Tract Antispasmodics

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
Urinary Tract Antispasmodics		
fesoterodine ER (gen Toviaz®) oxybutynin solifenacin	darifenacin Detrol® Detrol LA® DO Ditropan XL® flavoxate Gelnique® Gemtesa® Myrbetriq® DO Myrbetriq® solution F/Q/D oxybutynin ER DO Oxytrol® tolterodine tolterodine ER Toviaz® DO trospium trospium ER Vesicare® DO Vesicare® LS	**DOSE OPTIMIZATION (DO)** • See Dose Optimization Chart for affected strengths **FREQUENCY/QUANTITY/DURATION (F/Q/D)** • Myrbetriq® solution; limited to a 30-day supply

Medicaid Fee-for-Service Preferred Drug Program
15. Anticholinergics / COPD Agents

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
Anticholinergics / COPD Agents		
Anoro Ellipta® Atrovent HFA® Bevespi® Aerosphere® Combivent Respimat® ipratropium ipratropium / albuterol Spiriva® HandiHaler® Spiriva Respimat® Stiolto Respimat®	Breztri™ Aerosphere Daliresp® Duaklir® Pressair Incruse Ellipta® Lonhala® Magnair® roflumilast (gen Daliresp®) Trelegy Ellipta® Tudorza Pressair® Yupelri®	

Medicaid Fee-for-Service Preferred Drug Program
16. Antihistamines – Second Generation

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
Antihistamines – Second Generation		
cetirizine OTC (tablet) cetirizine OTC (syrup/solution 1mg/ 1mL) levocetirizine (tablet) loratadine OTC	cetirizine OTC (chewable) cetirizine OTC (syrup/solution 5 mg/5 mL) cetirizine-D OTC Clarinex® CC Clarinex-D® desloratadine fexofenadine OTC (tablet) levocetirizine (solution) loratadine-D OTC	**CLINICAL CRITERIA (CC)** • No prior authorization required for patients less than 24 months of age

Medicaid Fee-for-Service Preferred Drug Program
17. Beta 2 Adrenergic Agents – Inhaled Long Acting

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
Beta2 Adrenergic Agents – Inhaled Long-Acting CC, F/Q/D		
formoterol (generic Perforomist®) Serevent Diskus®	arformoterol (generic Brovana®) Brovana® Perforomist® Striverdi Respimat®	**CLINICAL CRITERIA (CC)** PA is required for all new long-acting beta agonist prescriptions for beneficiaries under FDA- or compendia-supported age as indicated: Brovana® / arformoterol ≥ 18 years Perforomist® / formoterol ≥ 18 years Serevent Diskus® ≥ 4 years Striverdi Respimat® ≥ 18 years **FREQUENCY/QUANTITY/DURATION (F/Q/D)** Maximum units per 30 days Brovana® / arformoterol 60 units (1 carton of 60 vials or 120mL) Perforomist® / formoterol 60 units (1 carton of 60 vials or 120mL) Serevent Diskus® ≥ 4 years 1 diskus (60 blister) Striverdi Respimat® ≥ 18 years 1 unit (one cartridge and one Respimat inhaler)

Medicaid NYRx Preferred Drug Program

New York State Medicaid Preferred Drug List (fhsc.com)

Drug Utilization Review (DUR) (ny.gov)

Information - Formulary File (emedny.org)

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