

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	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 <u>oxandrolone</u>): - Initial duration limit of 3 months (for all products except <u>oxandrolone</u>), requiring documented follow-up monitoring for response and/or adverse effects before continuing treatment - Duration limit of 6 months for delayed puberty - Duration limit of 1 month for all uses of <u>oxandrolone</u> products	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
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			

Anti - Retrovirals (ARV)

<p><u>Cellular Chemokine Receptor (CCR5) Antagonist</u> Selzentry</p> <p><u>Fusion Inhibitors</u> Fuzeon</p> <p><u>Integrase Inhibitors</u> Isentress</p> <p><u>Miscellaneous Antiretroviral Combinations</u> Stribild</p> <p><u>Non-Nucleoside Reverse Transcriptase Inhibitors</u> Rescriptor Sustiva Atripla Complera Intelence Viramune Edurant</p> <p><u>Nucleoside Reverse Transcriptase Inhibitors</u> Ziagen Videx, Videx EC Emtriva Epivir Zerit Retrovir</p> <p><u>Nucleotide Analog Reverse Transcriptase Inhibitor</u> Viread</p> <p><u>Nucleoside Analog Reverse Transcriptase Inhibitor Combination</u> Trizivir Epzicom Truvada Combivir</p> <p><u>Protease Inhibitors</u></p>	<p>Quantity Limits:</p> <p>1. Limit ARV utilization to a maximum of 5 products concurrently - excluding boosting with <u>ritonavir</u> (dose limit 600 mg. or less) and <u>cobicistat</u></p> <p>2. Limit 2 Protease Inhibitor utilization to a maximum of two products concurrently</p>	<p>Limit ARV active ingredient duplication</p>
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Reyataz Prezista Lexiva Crixivan Viracept Norvir Invirase Aptivus <u>Protease Inhibitor Combinations</u> Kaletra		
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Central Nervous System Stimulants

Drug Name	F/Q/D Parameter	Additional/Alternate Parameter(s)
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 CD Methylphenidate HCl Methylphenidate HCl ER Methylphenidate HCl SA Nuvigil® Procenta® Provigil® Quillivant XR™ Ritalin® Ritalin LA® Ritalin SR® Vyvanse®	<p>Quantity limits based on a daily dosage as determined by FDA labeling.</p> <p>Quantity limits for patients less than 18 years of age to include:</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>Quantity limits for patients 18 years of age and older to include:</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>

See also; [Preferred Drug List](#)

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 inhaler every 30 days	
Flovent Diskus [®] 250mcg	60	1 inhaler every 30 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	
Dymista	23h	1 inhaler every 30 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	
Zetonna	6.1gm	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> <ul style="list-style-type: none"> - Maximum recommended <ul style="list-style-type: none"> o <u>acetaminophen</u> (4 grams) o <u>aspirin</u> (4 grams) o <u>ibuprofen</u> (3.2 grams) o OR the FDA approved maximum opioid dosage as listed in the PI, whichever is less <p>-Duration limit: 90 (ninety) days. Excluding tramadol containing products.</p>	<p>To be applied to patients without a documented cancer or sickle cell diagnosis.</p> <p style="text-align: right;"><i>Effective date 3/21/13</i></p>
<p>IR non-combination products:</p> <p>codeine hydromorphone morphine oxycodone oxymorphone</p>	<p>-Quantity limit for IR non- combination products:</p> <p>-Maximum 6 (six) units per day, 180 (one hundred eighty) units per 30 (thirty) days</p> <p>-Duration limit: 90 (ninety) days</p>	<p>To be applied to patients without a documented cancer or sickle cell diagnosis.</p>
<p>See also; Preferred Drug List, Step Therapy</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 MSContin products) morphine ER (MS Contin only)</p>	<p>-Quantity limits extended-release (ER) products:</p> <ul style="list-style-type: none"> - <u>Hydromorphone ER, oxymorphone ER</u>: maximum 4 units per day, 120 units per 30 days - <u>Oxycodone CR</u>: maximum 2 units per day, 60 units per 30 days - <u>Fentanyl transdermal patch</u> maximum: 10 patches per 30 days - <u>Morphine ER</u> (excluding <u>MS Contin</u> products): maximum 2 units per day, 60 units per 30 days - <u>Morphine ER (MS Contin 15mg, 30mg, 60mg only)</u>: maximum 3 units per day, 90 units per 30 days - <u>Morphine ER (MS Contin 100mg only)</u>: maximum 4 units per day, up to 3 times a day, maximum 120 units per 30 days - <u>Morphine ER (MS Contin 200mg only)</u>: 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 trandermal patch: maximum 100mcg/hr (over the 72 hour dosing interval)</p>

See also; Preferred Drug List , Step Therapy		
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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>-Frequency limits based on recommended maximum daily doses: -30 dosage units per fill/1 dosage unit per day/30 days for <u>non-zaleplon</u>-containing NBSHs -60 dosage units per fill/2 dosage units per day/30 days for <u>zaleplon</u>-containing NBSHs</p> <p>-Duration limits equivalent to the maximum recommended duration per Compendia sources: -360 days for <u>immediate-release zolpidem</u> products -180 days for <u>eszopiclone</u> and <u>ramelteon</u> products -168 days for <u>extended-release zolpidem</u> products -30 days for <u>zaleplon</u> products</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 <u>zaleplon</u> -containing products 10 days/20 dosage units)
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	
Binosto® 70mg	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:</p> <ul style="list-style-type: none"> - Maximum 6 (six) units per day, 180 units per 30 days - Minimum 9 (nine) tablets per day for beneficiaries receiving <u>efavirenz</u> <p>Duration limits:</p> <ul style="list-style-type: none"> - 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 	
Boceprevir	<p>Quantity Limit:</p> <ul style="list-style-type: none"> - Maximum 12 units per day, 360 units per 30 days <p>Duration limits:</p> <ul style="list-style-type: none"> - Initially 84 days, pending results of quantitative HCV RNA testing after 4 and 8 weeks of <u>boceprevir</u> 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 <u>boceprevir</u> 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 <u>peginterferon/ribavirin</u> non responder ○ Compensated cirrhosis - Maximum 32 consecutive weeks over beneficiary lifetime, pending results of quantitative HCV RNA testing for all other beneficiaries 	
<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>Quantity limits:</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) <p>Duration limits:</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 	
See also; Preferred Drug List		

Serotonin Receptor Agonists (Tryptans)

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 units every 30 days	

Maxalt/Maxalt MLT [®]	18ct	24 tablets every 30 days	
Naratriptan tablets	9ct.	18 tablets every 30 days	
Relpax [®] 20mg	6ct.	18 tablets every 30 days	
Relpax [®] 40mg	6ct.	24 tablets every 30 days	
rizatriptan tablets/ODT	18ct	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			

Triglyceride Lowering Agents

<u>Lovaza</u> [®] :	Maximum 4 (four) capsules per day	
<u>Vascepa</u> [®] :	Maximum 4 (four) capsules per day	
See also; Preferred Drug List , Step Therapy		

Invega [®] See also; Step Therapy Preferred Drug List	Quantity Limits: - <u>Paliperidone</u> 1.5mg, 3mg, 9mg tablets - maximum 1 (one) unit per day - <u>Paliperidone</u> 6mg tablets - maximum 2 (two) units per day	
Methadone	Quantity Limit: -Maximum 12 (twelve) units per day, 360 units per 30 days	To be applied to patients without a documented cancer or sickle cell diagnosis.
Metozolv [®] ODT	Quantity limit: Maximum 4 (four) units per day, 120 units per 30 days Duration limit: Maximum of 90 (ninety) days.	<i>Effective date 3/21/13</i>
Moxatag [®] See also; Step Therapy	Quantity Limit: Equal to 10 tablets per fill	
Nucynta See also; Preferred Drug List	Quantity limit for IR non-combination products: -Maximum 6 (six) units per day, 180 (one hundred eighty) units per 30 (thirty) days	To be applied to patients without a documented cancer or sickle cell diagnosis. -Maximum daily dose of <u>tapentadol IR</u> and <u>tapentadol ER</u> formulations if used in combination should not exceed 500mg/day.
Nucynta ER [®] See also; Preferred Drug List	Quantity limit for IR non-Combination products: -Maximum 6 (six) units per day, 180 (one hundred eighty) units per 30 (thirty) days	To be applied to patients without a document cancer or sickle cell diagnosis. -Maximum daily dose of <u>tapentadol IR</u> and <u>tapentadol ER</u> formulations if used in combination should not exceed 500mg p/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 o Immediate Release - maximum 3 (three) units per day, 90 units per 30 days o Extended Release (150mg and 200mg) – 1 (one) unit per day, 30 units per 30 days o Extended Release (50mg, 300mg and 400mg) – 2 (two) units per day, 60 units per 30 days	
Solaraze [®] See also; Preferred Drug List	Quantity Limit: - Maximum 100 (one hundred) grams dispensed as a 90 day supply	Limited to one (1) prescription per year.
Suboxone [®] SL Tablet & Film	Quantity Limit: - Maximum 3 (three) sublingual tablets or films per day	Maximum of ninety (90) tablets or films dispensed as a 30 day supply.
Teriparatide: See also; Step Therapy	Quantity Limit: - One (1) unit (2.4 mL) per 30- day period.	Lifetime quantity limit of 25 months of therapy.
Tramadol ER See also; Preferred Drug List , Step Therapy	Quantity Limits: - Maximum 2 unit per day, - Maximum 30 units per 30 days	
Vusion [®] 50gm ointment See also; Preferred Drug List	Quantity Limit: - Maximum 100 (one hundred) grams in a 90 day time period	
Xifaxan [®] (rifaximin)	Quantity limit: - Maximum 2 (two) 550 mg units per day, 60 (sixty) units per 30 (thirty) days for hepatic encephalopathy - Maximum 3 (three) 200 mg units per day, 9 (nine) units per 3 (three) days for traveler's diarrhea	Confirm diagnosis of hepatic encephalopathy or traveler's diarrhea.

Effective date 3/21/13