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COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

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October 23, 2009

MEMORANDUM

TO: The Honorable Timothy M. Kaine
Governor

The Honorable Charles J. Colgan
Chairman, Senate Finance Committee

The Honorable Lacey E. Putney
Chairman, House Appropriations Committee

The Honorable Phillip A Hamilton
Chairman, House Committee on Health, Welfare and Institutions

The Honorable R. Edward Houck
Chairman, Senate Committee on Education and Health
Chairman, Joint Commission on Health Care

FROM: Patrick W. Finnerty

SUBJECT: Report on Preferred Drug List Program

Item 306 (R)(8) of the 2009 Appropriations Act requires the Department of Medical Assistance Services to provide a report on the Preferred Drug List (PDL) Program no later than November 1 of each year. The report shall include the direct savings attributed to the PDL for the prior fiscal year, an estimated savings of the program for the next fiscal year, and the cost to administer the PDL. The report shall also include an analysis of the impact of the program on patient health including, but not limited to, hospitalizations and emergency outpatient visits. I have enclosed for your review the report for 2009.

Should you have any questions or need additional information, please feel free to contact me at (804) 786-8099.

Enclosure

Cc: The Honorable Marilyn B. Tavenner, Secretary of Health and Human Resources

Annual Report on the Preferred Drug List Program

Virginia Department of Medical Assistance Services

November 1, 2009

Background and Authority for Report

Item 325 ZZ.5 of the *2003 Appropriations Act* directed the Department of Medical Assistance Services (DMAS) to establish a preferred drug list (PDL) program. The program was implemented in January 2004. In February 2004, the Department received approval of its PDL program State Plan amendment and its supplemental rebate contracts from the Centers for Medicare & Medicaid Services (CMS).

Virginia's Preferred Drug List (PDL) Program was created to promote therapeutically appropriate pharmaceutical utilization in a cost-effective manner. The PDL Program encourages providers to prescribe drugs that are therapeutically appropriate and cost effective through the use of a PDL. Preferred drugs on the PDL can be prescribed without any additional action taken by the prescriber; non-preferred drugs require prior authorization (PA) by calling or faxing the Clinical Call Center. While there are many classifications of drugs that are not subject to the PDL or prior authorization, the PDL contains a wide range of generic and brand name products.

Item 306 (R)(8) of the *2009 Appropriations Act* requires that DMAS provide annual reports to the Governor and General Assembly on the status of the PDL program (a copy of Item 306(R)(8) is provided as Attachment A.) DMAS has submitted reports at least annually since the implementation of the PDL program. In November 2005, DMAS conducted an extensive analysis of the outcomes of the PDL program implementation which included the estimated savings of the PDL program and the health effects on recipients. This study found no adverse health impacts for persons who were switched to drugs on the PDL compared to those who were allowed to remain on non-preferred drugs. Since this study, the Department has continued to monitor for potential adverse health impacts through its Pharmacy & Therapeutics (P&T) Committee process and interaction with the provider, advocacy and stakeholder communities. To date, no major concerns have been identified.

Virginia Medicaid Pharmacy Program

The impetus for the implementation of Virginia Medicaid's PDL program was the growing cost of prescription drugs for the fee-for-service population. Between fiscal years 2000 and 2005, there was an average 10% annual increase in prescription drug costs from $298 million to $471 million (see Figures 1 & 2). These significant annual increases ceased in fiscal year 2006 primarily due to the implementation of the Medicare Part D drug benefit. Approximately 136,000 recipients who previously received their prescription drug coverage through the Virginia Medicaid program began receiving most of their prescription drug coverage through the federal Medicare Part D program in January 2006. The PDL, coupled with Medicare Part D, contributed to an overall decrease of approximately 66% in pharmacy claims (from $491 million to $166 million) and a 21% decrease in cost per claim (from $42.61 per claim to $33.56) from fiscal year 2005 to fiscal year 2009.

Figure 1
Trend in Virginia's Medicaid Fee-For Service Pharmacy Costs
(FY 2000-2009)

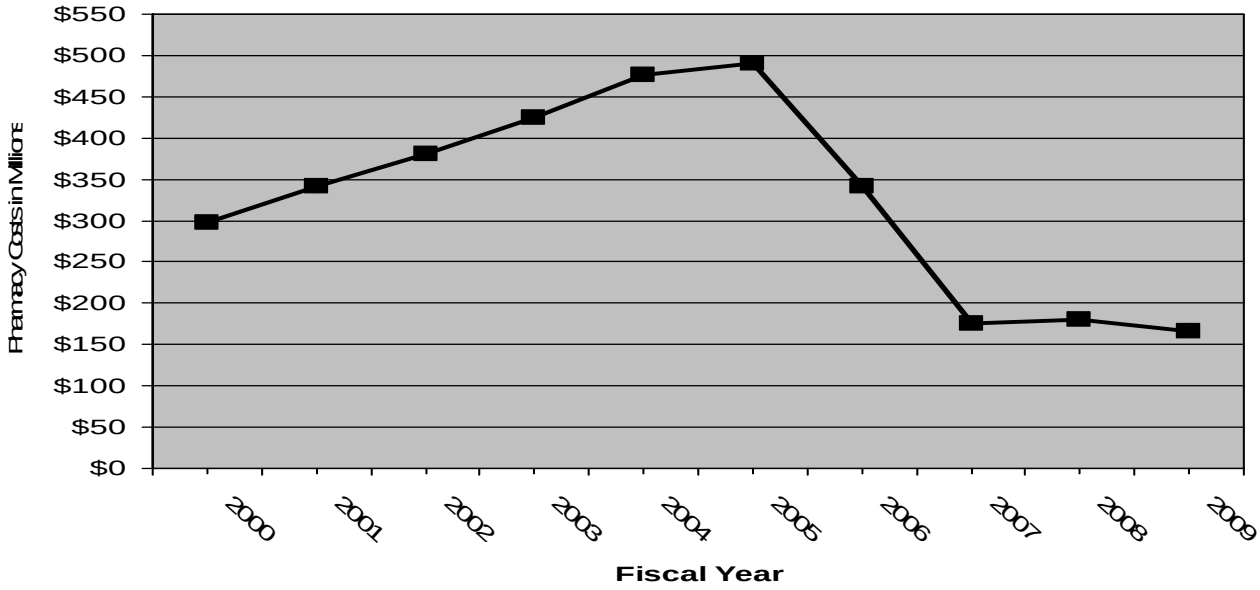
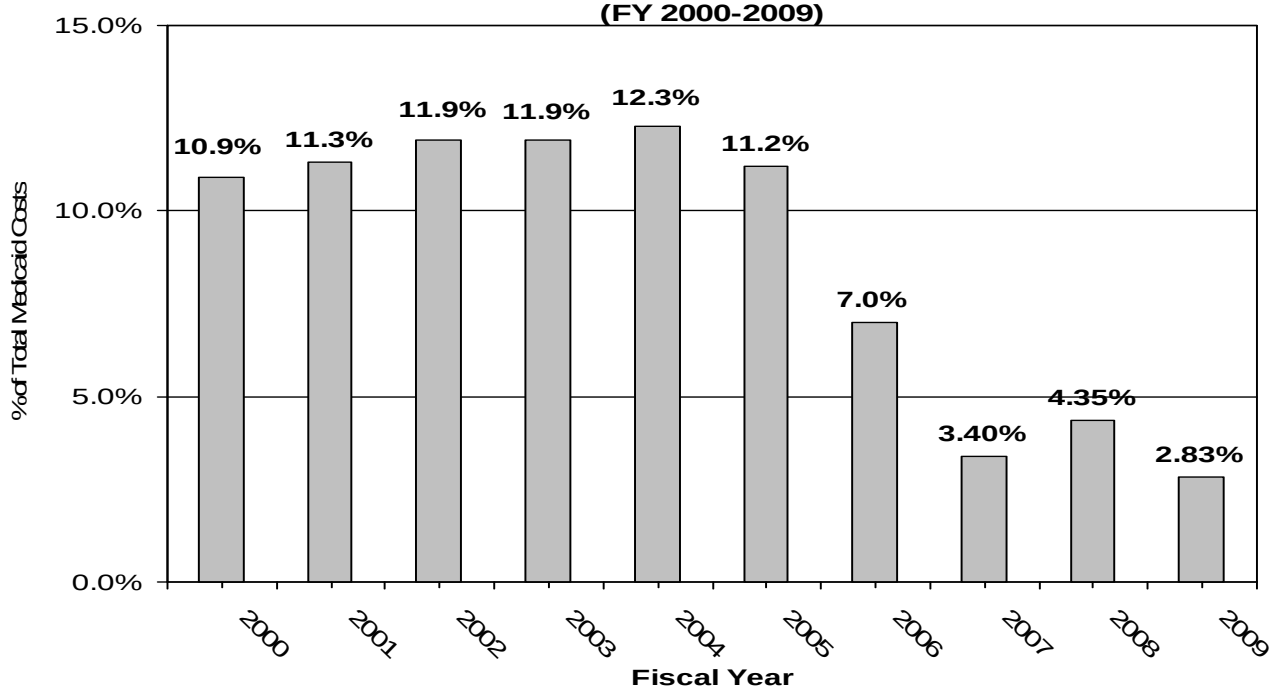


Figure 2
Fee-For-Service Pharmacy Cost as a Percent of Total Medicaid Costs
(FY 2000-2009)



Pharmacy & Therapeutics Committee

The P&T Committee continues to meet on a regular basis for the maintenance of the PDL. The P&T Committee directs all phases of the PDL program including: 1) selecting the therapeutic drug classes to review for possible inclusion on the PDL; 2) deciding which classes should actually be included on the PDL; 3) assessing the clinical efficacy of the drugs within each class under review; 4) selecting the "preferred" drugs in each class; 5) establishing clinical use criteria for selected drugs; 6) developing appropriate prior authorization procedures; and, 7) advising the Department on other pharmacy program initiatives. The PDL is a mature program, with most changes relating to the introduction of new generics in established PDL-eligible drug classes. The following is a summary of the P&T Committee's activities:

- The P&T Committee has completed five annual reviews of PDL Phase I and Phase II drugs classes since its implementation, with the most recent review occurring April 2009. During an annual review of PDL drug classes, the P&T Committee determines PDL eligibility and designates the preferred/non-preferred status of drugs within those classes. In addition, the Committee reviews and determines PDL eligibility for new drugs in existing PDL classes marketed since the previous P&T Committee meeting. Minutes of these meetings are available on the Virginia Town Hall and DMAS website at the following link: http://www.dmas.virginia.gov/pharm-p&t_committee.htm.

- The Department remains compliant with Committee composition requirements with eight physicians and four pharmacists.

- At the April 2009 P&T meeting, the Committee reviewed self-administered drugs for Rheumatoid Arthritis and agents used in the treatment of Multiple Sclerosis, two new drug classes proposed for initial review by the Committee. During the April 2009 P&T Committee meeting, both classes were determined to be PDL eligible. Criteria were also established for recipients' health and safety. These two drug classes were added to the PDL effective July 1, 2009. To date, there have been no issues with the implementation of these new classes on the PDL.

- The P&T Committee's management of the PDL continues to contribute to the increase in the overall generic utilization rate by making generic and over-the-counter (OTC) medications "preferred". In FY2009, when new generic medications within established PDL classes were marketed, DMAS was able to quickly shift usage from the brand name drug to the generic equivalent. This year, additional classes have joined this list of predominantly generic classes (osteoporosis agents in the bisphosphonates class, glaucoma agents in the alpha-2 adrenergics class, lipotropics in the statin class, oral agents for gout). While this does not afford the Commonwealth substantial supplemental rebates, it does reduce the overall cost per prescription.

- The P&T Committee continues to manage new generics and current brand PDL products with the "Generic Watch" program. The "Generic Watch" is a program designed to monitor the availability of new generic drugs in PDL-eligible classes as they enter the market with the goal of achieving more timely capture of cost savings that result from the

market introduction of a less, expensive, therapeutically equivalent agent. A new generic is not automatically a preferred product. The P&T Committee evaluates all new PDL products including new generics and determines their placement on the PDL. A brand product is maintained preferred until its generic equivalent meets the generic watch guidelines.

- The current generic utilization rates among total drugs dispensed are approximately 71% in SFY 2009 compared to about 54% at the end of SFY 2005.

Preferred Drug List Program Operations and Performance

Costs for PDL administration include a contract with First Health Services Corporation (FHSC). FHSC responsibilities include, but are not limited to, clinical call center management, supplemental rebate contracting, and clinical support of the P&T Committee. The current administrative costs for PDL-related services are approximately $1.7 million annually. FHSC began managing most pharmacy point of sale calls (e.g., Medicare Part D, the National Provider Identification (NPI) number) through their call center in January 2006; these calls were formerly managed by DMAS' call center. The following is a summary of call center operational results.

- There have been few complaints about the clinical call center and the PDL program in general.

- Call center management and the prior authorization processes are meeting established contractual guidelines, including average speed to answer rates, low call abandonment rate, and minimal call time.

- On July 1, 2007, FHSC implemented a web-based process for pharmacy prior authorization processing ("Web PA"). Web PA provides prescribers an alternative submission method for prior authorization (PA) requests. The advantages of the Web PA process include, the ability to create a PA online with real-time authorization in many cases; the ability of the user to check the status of the request and view the decision at their convenience; and the ability of the user to print a complete copy of the request and the decision for the patient's record. The Web PA process and all information exchanged are secure. There was extensive provider education with the introduction of this new system; however, there has been limited utilization (through July 2009 there have only been 195 PAs submitted using this method).

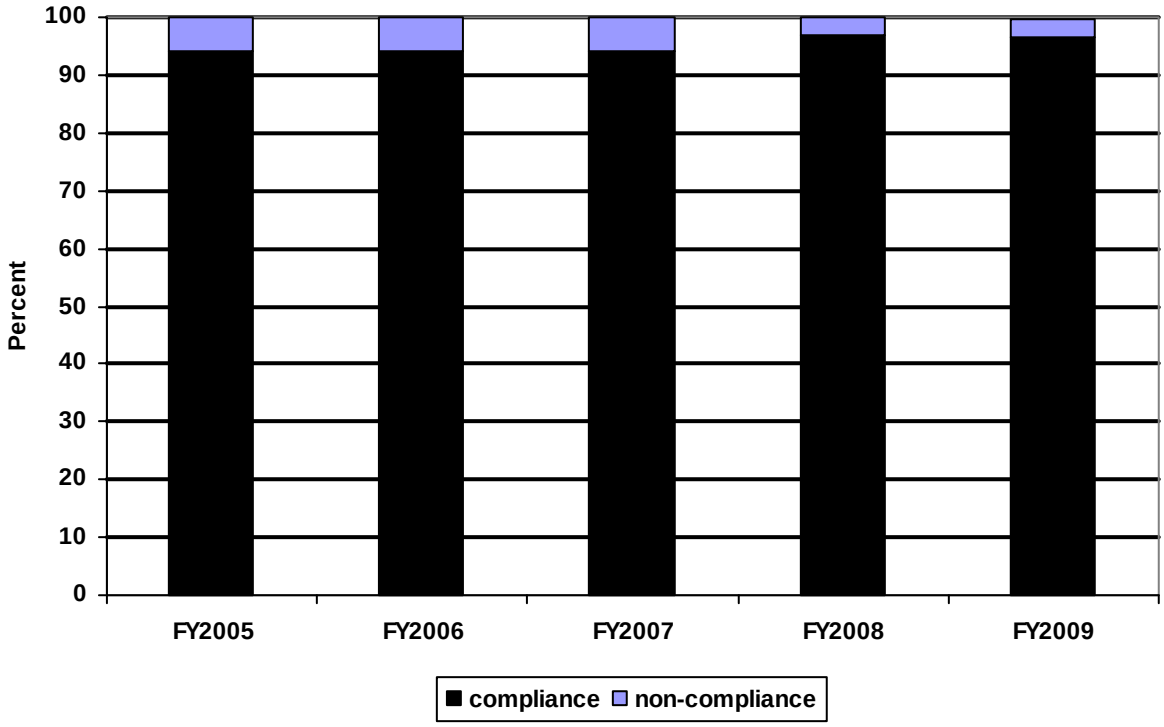
- In FY 2009, 22,041 PDL PAs (requests for non-preferred drug) and clinical PAs (criteria for both preferred and non-preferred drugs, i.e., step therapy, age requirements, etc.) were processed. Among these, 72% were approved for the non-preferred drug, 27% were changed to a preferred drug and less than 1% was denied.

- Most PDL denials have been related to billing issues with pharmacy providers who request authorization of non-preferred drugs after the drug has been distributed to the Medicaid recipient. Denials are more common among long-term care providers who bill retrospectively. It is important to note that these are denials of payment rather than denial

of access to drugs in that the recipient received the medication in advance of the request. On January 1, 2007, stricter usage criteria for the proton pump inhibitor (PPI) class of drugs was implemented. The new criteria includes "step therapy" that requires a trial of the therapeutically equivalent, less expensive OTC medications and evaluation by a gastroenterologist before the brand name drugs are approved. Despite the stricter criteria, there were only 16 denials for PPI medications in 2009. It should be emphasized that when a PA is denied based on PDL or clinical criteria, most Medicaid recipients receive a therapeutically equivalent substitution.

The compliance rate in terms of "preferred" drugs being prescribed for Medicaid recipients remains high, currently at 96.5% across all classes subject to the PDL. This compliance rate exceeds the compliance level (85%) needed to achieve the necessary budget savings (see Figure 3).

Figure 3
Medicaid Compliance/Non-Compliance Rates



Source: First Health Services Corporation Rebate Department, Fiscal Year 2009

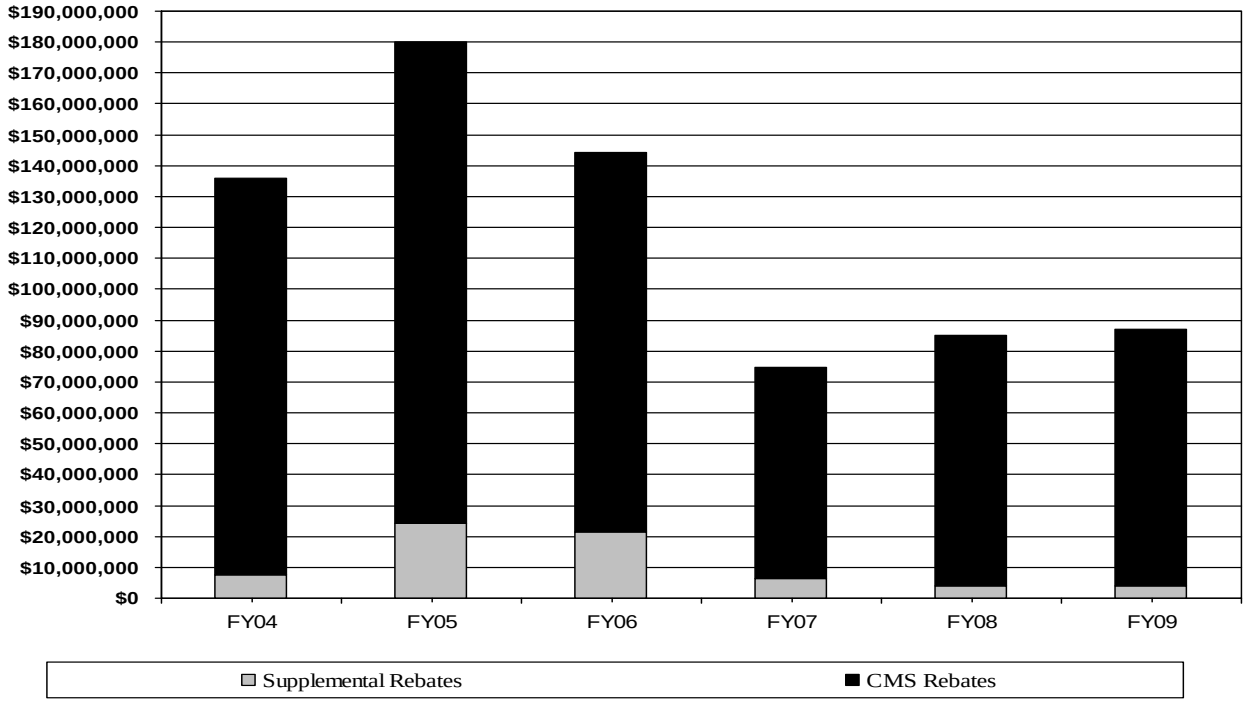
Supplemental Rebate Contracting Process & Savings Estimates

The PDL was developed with significant cooperation from many pharmaceutical manufacturers who agreed to provide aggressive drug pricing and supplemental rebates in the design of a Virginia-specific PDL. The Department solicits Virginia-specific contracts for pricing and supplemental rebates directly with manufacturers for all single-source brand products in the PDL eligible therapeutic classes.

Since the inception of the PDL program in January 2004, the Department has invoiced over $68 million in supplemental rebates (see Figure 4). This amount is in addition to the federal rebates collected for these drugs. Supplemental rebates have declined in recent quarters because of higher federal mandated rebates tied directly to changes required by the Deficit Reduction Act of 2005, which took effect in 2007. In addition, several expensive brand drugs lost patent protection and are now available generically and not subject to supplemental rebates. It should be noted that the generic formulations of these drugs reduce the overall cost of these drugs for both the State and Medicaid recipients even without supplemental rebates. The Department continues to actively manage new generic drugs to market, making them non-preferred until they are deemed less expensive than their brand counterparts net federal and (if applicable) supplemental rebates.

The goal of the PDL is to carefully balance the clinical attributes of a product against the financial impact and ultimately select products that best meet the needs of those enrolled in the Medicaid program. Due to the many interconnected cost savings initiatives in the pharmacy program, it is difficult to determine the savings attributable solely to the PDL. However, the supplemental rebate calculations noted above, along with the high compliance rate of using preferred agents, illustrate that the program is generating savings for the Commonwealth. The significant decline in rebates beginning in the first quarter of FY06 (Figure 4) was due to the implementation of the Medicare Part D program which resulted in approximately 136,000 Medicaid recipients getting prescription medications through Medicare, rather than Medicaid. As a result, fewer prescriptions are paid by Medicaid and fewer rebate dollars are collected from manufacturers.

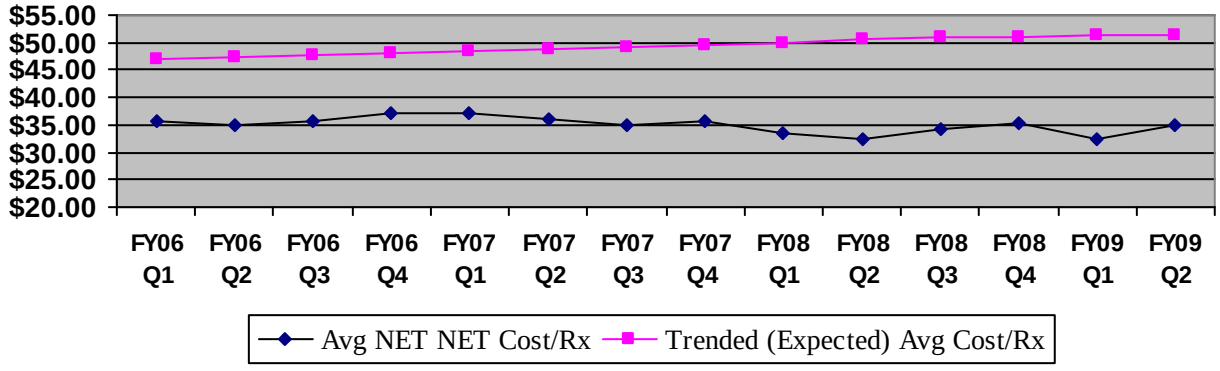
Figure 4
Trend in Federal and Supplemental Rebates Invoiced
(FY 2004-2009)



Source: First Health Services Corporation Rebate Department Fiscal Year 2009

As shown in Figure 5, the average net-net cost per script was $32.30 in 2Q FY08 compared to an average net-net cost per script of $34.83 in 2Q FY09. It is notable that since January 2006, the average net-net cost per script has remained in the $35-37 dollar range, which is well below the expected trended average cost.

Figure 5
Net-Net Cost (FY 2006-09)



Source: First Health Services Corporation Rebate Department, Fiscal Year 2009

Communications and Public Input

DMAS maintains a website (www.dmas.virginia.gov) at which stakeholders can view notices and information about the PDL program. Stakeholders can access all documents related to the PDL, P&T Committee, as well as other pharmacy program initiatives. DMAS also has a dedicated email address (pdlinput@dmas.virginia.gov) for interested parties to submit PDL-related comments, concerns, or information to the Department and/or the P&T Committee.

DMAS has partnered with ePocrates®, a leading drug information software application for handheld computers (PDAs) and desktop computers, to provide providers electronic access to the Virginia Medicaid PDL Quicklist. eProcrates® users can download the PDL Quicklist to their PDAs through the ePocrates® formulary link. In addition, providers can download the Quicklist from the Virginia DMAS website.

New Pharmacy Services Administration Request for Proposal (RFP)

In August 2009, DMAS published a Request for Proposals (RFP) to solicit bids for a new Pharmacy Services Administrator, who will be responsible for the following activities:

- ***Pharmacy Services Consultation and Support***: Consulting and supporting DMAS regarding trends in the pharmaceutical industry and changes in national, state and federal government policies that have the potential to impact the Virginia Medicaid pharmacy program.

- ***Pharmacy Call Center:*** Operating a comprehensive 24 hour, 7-day per week toll-free telephone call center capable of responding to enrollee and provider concerns; providing education; and handling prior authorizations and pharmacy related activities.

- ***PDL Program:*** Reviewing and maintaining a PDL program for the Medicaid and FAMIS fee-for-service populations and supporting the P&T Committee in selecting preferred drugs that are safe and therapeutically effective and are the most cost-effective.

- ***Prior Authorization:*** Administering the Prior Authorization program.

- ***Maximum Allowable Cost (MAC) and Specialty Maximum Allowable Cost (SMAC) Program***: Administering a MAC and SMAC program to control the cost of multi-source generic drugs and specialty drugs by setting a maximum reimbursement amount.

Proposals were due to DMAS on September 25, 2009, and the contract for the new Pharmacy Services Administrator is scheduled to "go live" on July 1, 2010.

Conclusion

The Virginia Medicaid PDL Program continues to operate efficiently and effectively with very few complaints from providers or clients. Medicaid clients are receiving high quality prescription medications at a substantially reduced cost to the Commonwealth. Despite a

significant decline in fee-for-service pharmacy clients, expenditures, and rebates due to the implementation of Medicare Part D and past managed care expansions, the PDL continues to be a very successful program. Much of the success of the program is attributable to a highly effective P&T Committee.

Acknowledgements

DMAS wishes to acknowledge the medical and pharmacy providers, members of the DMAS P&T Committee, public and private stakeholders, and pharmaceutical manufacturers who have participated in the development, implementation and maintenance of the preferred drug list program and other pharmacy program initiatives.

Attachment A
Item 306 (R) (8) of the 2009 Appropriations Act

The department shall provide to the Governor; the House Committees on Appropriations, and Health, Welfare and Institutions; the Senate Committees on Finance, and Education and Health; and the Joint Commission on Health Care a report on the Preferred Drug List (PDL) Program no later than November 1 of each year. The report shall include the direct savings attributed to the PDL for the prior fiscal year, an estimated savings of the program for the next fiscal year, and the cost to administer the PDL.

Attachment B

P&T Committee Members and Profession

NAME	PROFESSION
Randy Axelrod, M.D.,Chairman	Physician
Gill Abernathy, M.S., R.Ph.	Pharmacist
Roy Beveridge, M.D.	Physician
Avtar Dhillon, M.D.	Physician
Vacant (vacancy currently being filled)	Physician
Mariann Johnson, M.D.	Physician
Mark Oley, R.Ph., Vice Chairman	Pharmacist
James Reinhard, M.D.	Physician
Tim Jennings, Pharm.D.	Pharmacist
Renita Driver , Pharm.D.	Pharmacist
Ruben Varghese, M.D.	Physician
Rachel Selby- Penczak, M.D.	Physician

Attachment C
Drug Classes Currently Included on the PDL

PDL Phase I Drug Classes – Preferred drug status revised on January 1st of each year

- Lipotropics (*includes HMG CoA Reductase Inhibitors (Statins), Fibric Acids, Niacin Derivatives, Omega3)*
- Proton Pump Inhibitors (PPIs)
- Angiotensin Receptor Blockers (ARBs)
- Angiotensin Converting Enzyme Inhibitors (ACE Inhibitors)
- Inhaled Corticosteroids
- Nasal Steroids
- Beta Adrenergics
- COPD- Anticholinergics
- Beta Blockers
- Calcium Channel Blockers
- H2 Antagonists
- Second Generation Antihistamines (LSAs)
- Benzodiazepine Sedative Hypnotics
- Other Sedative Hypnotics
- Electrolyte Depleters
- Urinary Tract Antispasmodics
- Topical Immunomodulators
- Phosphodiesterase 5 Inhibitor for Pulmonary Arterial Hypertension
- Hepatitis C
- Growth Hormones

PDL Phase II Drug Classes – Preferred drug status revised on July 1st of each year

- Oral Hypoglycemics (*includes Second Generation Sulfonylureas, Alpha-Glucosidase Inhibitors, Biguanides, Biguanide Combination Products, Meglitinides, Thiazolidinediones, DPPIV inhibitors)*
- Leukotriene Modifiers
- Non-Steroidal Anti- Inflammatory Drugs (NSAID) *(includes Cox-2 Inhibitors)*
- Serotonin Receptor Agonists (Triptans)
- Oral Antifungals for Onychomycosis
- Bisphosphonates and Calcitonins for Osteoporosis
- Second and Third Generation Cephalosporins (Antibiotics)
- Second and Third Generation Quinolones – Systemic (Antibiotics)
- Topical Antibiotics
- Macrolides - Adult and Pediatric (Antibiotics)
- Antihyperkinesis/CNS Stimulants (Medications for ADD/ADHD)
- Ophthalmic Glaucoma (*includes Alpha-2 Adrenergic, Beta-blockers, Carbonic Anhydrase Inhibitors, Prostaglandin Inhibitors)*
- Long Acting Narcotics
- Ophthalmic Anti-Inflammatory
- Ophthalmic Antibiotics (*includes Quinolones and Macrolides*)

- Ophthalmic Antihistamines
- Ophthalmic Mast Cell Stabilizers
- Herpes Antivirals
- Influenza Antivirals
- Injectable Immunomodulators for RA
- Multiple Sclerosis Agents
- Otic Quinolones
- Acne agents (*includes Combination Benzoyl Peroxide & Clindamycin Products and Topical Retinoids & Combinations)*
- Non-Ergot Dopamine Receptor Agonists
- Intranasal Antihistamines
- Topical Agents For Psoriasis
- Topical Antivirals

Attachment D
Preferred Drug List, Effective July 1, 2009

Within these categories, drugs that are not listed are subject to Prior Authorization

Virginia Medicaid Preferred Drug List
Effective July 1, 2009

First Health Clinical Call Center
Phone: 1-800-932-6648
Fax: 1-800-932-6651

ANALGESICS

NON-STEROIDAL ANTI-INFLAMMATORY DRUGS

(Including Cox-2 Inhibitors)
Celebrex®**

diclofenac potassium

diclofenac sodium
diflunisal
etodolac
etodolac SR
fenoprofen
flurbiprofen
ibuprofen
indomethacin
indomethacin SR
ketoprofen
ketoprofen SR
ketorolac
meclofenamate sodium
meloxicam
nabumetone
naproxen
naproxen sodium
oxaprozin
piroxicam
sulindac
tolmetin sodium

*LONG-ACTING NARCOTICS **

Kadian ® *
Duragesic® (Brand Only) *
morphine sulfate tablets SA *

ANTIBIOTICS – ANTIINFECTIVES

ORAL ANTIFUNGALS – ONYCHOMYCOSIS

terbinafine

CEPHALOSPORINS – 2ND & 3RD GENERATION

cefaclor capsule
cefaclor ER
cefaclor suspension
cefdinir capsules
cefdinir suspension
cefprozil tablet
cefprozil suspension
cefuroxime
Raniclor®
Spectracef®
Suprax Suspension®

MACROLIDES

azithromycin tablet
azithromycin packet
azithromycin suspension
clarithromycin tablet
clarithromycin suspension
erythrocin stearate
erythromycin base
erythromycin ethylsuccinate
E.E.S®
Eryped®
EryC®
erythromycin stearate suspension
erythromycin stearate
erythromycin w/sulfisoxazole

QUINOLONES – 2ND & 3RD GENERATION

Avelox®
Avelox ABC pack®
ciprofloxacin tablet
Cipro suspension®

OTIC QUINOLONES

Ciprodex®
Ofloxacin

TOPICAL ANIBIOTICS

Mupirocin
Altabax® (5gram tube only)

ANTIVIRALS

*HEPATITIS C***

Pegasys Conv.Pack®**
Pegasys®**
Peg-Intron®**
Peg-Intron Redipen®**

HERPES

acyclovir tablets
acyclovir suspension
Famvir®
Valtrex®

INFLUENZA

amantadine
amantadine syrup
Relenza Disk ®
rimantadine
Tamiflu®
Tamiflu suspension®

TOPICAL ANTIVIRALS

Abreva OTC®
Zovirax Oint®

ASTHMA –ALLERGY

ANTIHISTAMINES – 2ND GENERATION

Claritin tablets OTC ®
Claritin tablets- Rapids OTC® Claritin Syrup OTC ® Claritin-D 12 hr OTC®
Claritin-D 24hr OTC®
loratadine tablet (All OTCs names)
loratadine tab- Rapids (All OTCs names)
loratadine syrup (All OTCs names)
loratadine D12hr (All OTCs names)
loratadine D24hr (All OTC names)
cetirizine solution (PA required except for children under age 2)

BETA ADRENERGIC SHORT ACTING METERED-DOSE INHALERS

Maxair Autohaler®
Proair® HFA
Proventil® HFA
Ventolin® HFA
Xopenex HFA®

BETA ADRENERGICS – LONG ACTING

Foradil®
Serevent Diskus®

BETA ADRENERGICS FOR NEBULIZERS

albuterol sulfate
metaproterenol
Xopenex®

Bold font indicates added since last up-date ® = Registered Trade name * A step edit is required for this class **Clinical Prior Authorization required

Within these categories, drugs that are not listed are subject to Prior Authorization

Virginia Medicaid Preferred Drug List
Effective July 1, 2009

First Health Clinical Call Center
Phone: 1-800-932-6648
Fax: 1-800-932-6651

BETA ADRENERGIC/ CORTICOSTEROID INHALER COMBINATIONS

Advair Diskus®
Advair HFA®

COPD ANTICHOLINERGICS

Atrovent HFA®
Combivent MDI®
ipratropium bromide
Spiriva®

INHALED CORTICOSTEROIDS

AeroBid®
AeroBid M®
Asmanex®
Azmacort®
Flovent HFA®
Pulmicort Respules®
QVAR®

INTRANASAL ANTIHISTAMINES

Astelin®
Astepro®

LEUKOTRIENE INHIBITORS

Accolate®
Singulair®

NASAL STEROIDS

flunisolide
fluticasone
Nasacort AQ®
Nasonex®

CARDIAC MEDICATIONS

ACE INHIBITORS

benazepril
benazepril HCL /HCTZ
captopril
captopril /HCTZ
enalapril
enalapril /HCTZ
lisinopril
lisinopril/HCTZ

ACE INHIBITORS OR ARB INHIBITORS WITH CALCIUM CHANNEL BLOCKERS

Lotrel® (5/40 and 10/40 brand preferred)
amlodipine/benazepril (2.5/10, 5/10, 5/20 & 10/20 generic preferred

ANGIOTENSIN RECEPTOR ANTAGONISTS

Diovan®
Diovan HCT®
Cozaar®
Hyzaar®

BETA BLOCKERS

acebutaolol
atenolol
atenolol /Chlorthalidone
betaxolol
bisoprolol fumarate
bisoprolol /HCTZ
carvedilol
labetalol HCL
metoprolol tartrate
metoprolol/HCTZ
nadolol
pindolol
propranolol
propranolol solution
propranolol/HCTZ
Sorine®
sotalol
sotalol AF
timolol maleate

CALCIUM CHANNEL BLOCKERS - DIHYDROPYRIDINE

amlodipine
Afeditab CR®
Dynacirc®CR
felodipine ER
nicardipine
Nifediac CC®
Nifedical XL®
nifedipine
nifedipine ER
nifedipine SA

CALCIUM CHANNEL BLOCKERS-

NON-DIHYDROPYRIDINE

Cartia XT®
Diltia XT®
diltiazem ER
diltiazem HCL
diltiazem XR
Taztia XT®
verapamil
verapamil SA
verapamil 24hr pellets

LIPOTROPICS: STATINS

lovastatin
pravastatin
simvastatin

LIPOTROPICS: CAI

Zetia®

LIPOTROPICS: FIBRIC ACID

Antara®
gemfibrozil

LIPOTROPICS: NIACIN DERATIVES

Niaspan®
Niacor®

LIPOTROPICS: NIACIN & STATIN COMBINATIONS

Simcor®*

PDE-5 INHIBITORS - PULMONARY HYPERTENSION*

Revatio®**

CENTRAL NERVOUS SYSTEM

NON-ERGOT DOPAMINE RECEPTOR AGONISTS

Mirapex®
ropinirole HCL

Bold font indicates added since last up-date ® = Registered Trade name * A step edit is required for this class **Clinical Prior Authorization required

Within these categories, drugs that are not listed are subject to Prior Authorization

Virginia Medicaid Preferred Drug List
Effective July 1, 2009

First Health Clinical Call Center
Phone: 1-800-932-6648
Fax: 1-800-932-6651

STIMULANTS/ADHD MEDICATIONS

Adderall XR®
amphetamine salt combo
Concerta®
dextroamphetamine capsule
dextroamphetamine tablet
Dextrostat®
Focalin®
Focalin XR®
Metadate CD ®
Metadate ER ®
Methylin tablet ®
Methylin Chew ®
Methylin ER®
Methylin solution ®
methylphenidate
methylphenidate SA/SR
Ritalin LA®
Strattera®
Vyvanse®

SEDATIVE HYPNOTIC

chloral Hydrate Syrup
estazolam
flurazepam
temazepam
triazolam
zolpidem

*OTHER SEDATIVE HYPNOTIC**

Rozerem® *

DERMATOLOGIC

ACNE AGENTS

COMBINATION BENZOYL PEROXIDE & CLINDAMYCIN

Duac CS®

ACNE AGENTS -TOPICAL RETINOIDS

Differin cream® 1%
Differin gel® 1% & 0.3%
Epiduo®
Retin-A Micro®
Retin-A Micro Pump®
Tretinoin®

TOPICAL AGENTS FOR PSORIASIS

Calcipotriene®
Dovonex®
Psoriatec®

DIABETES

ORAL HYPOGLYCEMICS ALPHAGLUCOSIDASE INHIBITORS

Glyset®
Precose®

ORAL HYPOGLYCEMICS BIGUANIDES

metformin
metformin ER

ORAL HYPOGLYCEMICS

-BIGUANIDE COMBINATIONS

Actoplus Met®
Avandamet®
glyburide–metformin
glipizide–metformin

ORAL HYPOGLYCEMICS – DPP-IV INHIBITORS AND COMBINATIONS

Januvia®
Janumet®

ORAL HYPOGLYCEMICS – MEGLITINIDES

Starlix®

ORAL HYPOGLYCEMICS 2ND GENERATION SULFONYLUREAS

glimepiride
glipizide
glipizide ER
glyburide
glyburide micronized

ORAL HYPOGLYCEMICS- THIAZOLIDINEDIONES

Actos®
Avandia®

GASTROINTESTINAL

HISTAMINE-2 RECEPTOR ANTAGONISTS (H-2RA)

ranitidine
ranitidine Syrup
famotidine

PROTON PUMP INHIBITORS **

Prilosec® OTC
Protonix® *
omeprazole (No PA req. under 12)
Prevacid® (No PA req. under 12)
Prevacid Susp® (No PA req. under 12)
Prevacid solutab®(No PA req. under 12)

GENITOURINARY

URINARY ANTISPASMODICS

Detrol LA ®
Enablex®
oxybutynin tablet
oxybutynin syrup
Oxytrol Transdermal®
Sanctura®
Sanctura XR®
VESIcare®

IMMUNOLOGIC AGENTS

SELF ADMINISTERED DRUGS FOR RHEUMATOID ARTHRITIS

Enbrel®
Humira®

Bold font indicates added since last up-date ® = Registered Trade name * A step edit is required for this class **Clinical Prior Authorization required

Within these categories, drugs that are not listed are subject to Prior Authorization

Virginia Medicaid Preferred Drug List
Effective July 1, 2009

First Health Clinical Call Center
Phone: 1-800-932-6648
Fax: 1-800-932-6651

MULTIPLE SCLEROSIS AGENTS

Avonex®
Avonex Adm Pack®
Betaseron®
Copaxone®
Rebif®

*TOPICAL IMMUNOMODULATORS***

Elidel® **
Protopic® **

OPHTHALMIC

ANTIBIOTIC- QUINOLONES

ciprofloxacin drops
ofloxacin drops
Quixin®
Vigamox®
Zymar®

ANTIHISTAMINES

Alaway OTC ®

ANTI-INFLAMMATORY

Acular®
Acular LS®
diclofenac sodium drops
flurbiprofen sodium drops
Nevanac®
Xibrom®

GLAUCOMA – ALPHA-2 ADRENERGICS

Alphagan P®
brimonidine tartrate
Iopidine®

GLAUCOMA BETA-BLOCKERS

Betaxolol HCl
Betimol®
Betoptic S®
Combigan®
carteolol HCl
levobunolol HCl
metipranolol
timolol maleate drops
timolol maleate Sol-Gel

GLAUCOMA – CARBONIC ANHYDRASE INHIBITORS

Azopt®
Cosopt®
Trusopt®

GLAUCOMA – PROSTAGLANDIN ANALOGS

Travatan®
Travatan Z®
Xalatan®

MAST CELL STABLIZERS

Alamast®
Alocril®
Alomide®
cromolyn

OSTEOPOROSIS

BISPHOSPHONATES

alendronate tablet
Fosamax Solution®

CALCITONINS

Fortical®
Miacalcin®

MISCELLANEOUS

ELECTROLYTE DEPLETERS

Fosrenol®
Phoslo®
Renagel®

*GROWTH HORMONE***

Genotropin® **
Norditropin Cartridge® **
Nutropin Aq Cartridge® **
Nutropin® **
Nutropin Aq Vial® **
Norditropin Nordiflex® **

ORAL AGENTS FOR GOUT

allopurinol

SEROTONIN RECEPTOR AGONISTS (Triptans)

Imitrex Cartridge®
Imitrex Nasal®
Imitrex Pen Kit®
Imitrex Tablet
Imitrex Vial®
Maxalt®
Maxalt-MLT®

NOTE:

- **Fax requests receive a response within 24 hours.**
- **For urgent requests, please call.**
- **Not all medications listed are covered by all DMAS programs. Check individual program coverage.**

For program drug coverage information, visit the following:
www.dmas.virginia.gov

Or

http://virginia.fhsc.com.

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