Ohio Medicaid

Pharmacy Benefit Management Program

Ohio | Department of Medicaid

Preferred Drug Lists

Unified Preferred Drug List

Fee-for-Service Preferred Drug List

Effective January 1, 2019

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Central Nervous System (CNS) Agents: Medication Assisted Treatment of Opioid Addiction

LENGTH OF AUTHORIZATIONS: No PA required for short-acting, buprenorphine containing, oral agents
30 days for initial authorization of injectable
Not to exceed 6 months for subsequent authorizations of injectable; length depending upon patient status and compliance to treatment plan

Prescribing for buprenorphine products must follow the requirements of Ohio Administrative Code rule 4731-11-12, *Office based opioid treatment*.

BUPRENORPHINE SAFETY EDITS AND DRUG UTILIZATION REVIEW CRITERIA:

In favor of eliminating prior authorization for all forms of oral short acting buprenorphine-containing products, ODM and the Managed Care Plans will implement safety edits and a retrospective drug utilization review process for all brand and generic forms of oral short acting buprenorphine-containing products.

Point-of-Sale Safety Edits

- Individuals who are 15 years of age or younger; or
- Individuals who are male and receiving short acting buprenorphine without naloxone; or
- Individuals who are female and receiving short acting buprenorphine without naloxone will have a soft DUR rejection that will allow the pharmacist to override if the individual is pregnant; or
- Dosages that are greater than 24 mg/day; or
- Dosages over 16 mg/day beginning 90 days after the initial fill.

Claims meeting the above criteria will reject and require documentation to support medical necessity; i.e. Prior Authorization.

Drug Utilization Review Criteria

- Individuals who receive a dose of buprenorphine that is greater than 16 mg/day for three months or longer (this will be programmed as a point-of-sale safety edit after the 3 months); or
- Females of reproductive age (15 to 44 years old) with claims for short acting buprenorphine only for longer than 9 months; or
- Individuals with claims for concurrent use of opioids (including MAT) and benzodiazepines.

Providers with patients who meet the above criteria will be subject to a communication requirement by ODM and the MCPs until the provider demonstrates a consistent pattern of appropriate care.

CENTRAL NERVOUS SYSTEM AGENTS: MEDICATION ASSISTED TREATMENT OF OPIOID ADDICTION

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
BUNAVAIL® buccal film (buprenorphine/naloxone) BUPRENORPHINE SL tablets (generic of Subutex®) BUPRENORPHINE/NALOXONE SL tablets SUBOXONE® SL film (buprenorphine/naloxone) ZUBSOLV® SL tablets (buprenorphine/naloxone)	

CENTRAL NERVOUS SYSTEM AGENTS: MEDICATION ASSISTED TREATMENT OF OPIOID ADDICTION LONG-ACTING INJECTABLES [+]

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
VIVITROL® (naltrexone)	

[+] Vivitrol may be billed by the pharmacy if it is not dispensed directly to the patient. If not administered by the pharmacist, the drug must be released only to the administering provider or administering provider's staff, following all regulations for a Prescription Pick-Up Station as described by the Ohio Board of Pharmacy.

Criteria for SUBCUTANEOUS BUPRENORPHINE INJECTION (SUBLOCADE™)

- Indicated for opioid dependence:
    - Patient ≥18 years
    - Currently established on a dose of at least 8mg of oral buprenorphine for at least 7 days
    - Medical justification supports inability to continue to use oral formulation
    - Urine drug screen result obtained within the last 7 days with no illict substances or non-prescribed therapies detected (initially). Subsequent authorization dependent upon UDS results indicating compliance to treatment plan.
    - Patient is actively participating in counseling. Prescriber should retain documentation of meeting attendance and submit with PA request.
    - The physician has reviewed OARRS within 7 days prior to the PA request. If the patient has received controlled substances since the previous authorization:
        - The physician has coordinated with all other prescribers of controlled substances and has determined that the patient should continue treatment; and
        - If the patient has received other controlled substances for 12 or more continuous weeks, the physician has consulted with a board-certified addictionologist or addiction psychiatrist who has recommended the patient receive substance abuse treatment (consultation not necessary if the prescriber is a board-certified additionologist or addiction psychiatrist).
    - Dose does not exceed 300mg per month in the first two months and 100mg thereafter. Providers may request a maintenance dose increase beyond 100mg by submitting additional clinical documentation supporting the need for a higher dose
- Re-authorization requires adherence to specificed treatment plan inclusive of adherence to counseling, OARRS and urine drug screening requirements

SUBCUTANEOUS BUPRENORPHINE INJECTION * [+]

CLINICAL PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
SUBLOCADE™ (buprenorphine)	

* Note: Clinical criteria must be met

[+] Sublocade™ may be billed by the pharmacy if it is not dispensed directly to the patient. If not administered at the pharmacy, the drug must be released only to the administering provider or administering provider's staff, following all applicable regulations.

Endocrine Agents: Diabetes – Insulin

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
   - Allergy to medications not requiring prior approval
   - Contraindication to or drug interaction with medications not requiring prior approval
   - History of unacceptable/toxic side effects to medications not requiring prior approval
   - Condition is difficult to control (i.e. prone to ketoacidosis, hypoglycemia)
2. The requested medication may be approved if there has been a therapeutic failure to at least one medication within the same class not requiring prior authorization. A therapeutic failure is the inability to reach A1C goal after at least 120 days of current regimen with documented adherence and appropriate dose escalation.

ADDITIONAL CLINICAL CRITERIA FOR INHALED INSULIN:

- Patient has a claim for a long-acting insulin in the previous 120 days, or patient has type 2 diabetes; and
- Patient has not been diagnosed with asthma or COPD; and
- Spirometry shows FEV1 > / = 70% predicted; and
- Patient has not smoked for at least 6 months

ENDOCRINE AGENTS: DIABETES - INSULINS - Rapid and Short Acting

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
HUMALOG® vial and pen (insulin lispro) HUMULIN R® (insulin regular human) HUMULIN R 500-U® vial and pen(insulin regular human) NOVOLIN R® (insulin regular human) NOVOLOG® vial and pen (insulin aspart)	AFREZZA® inhalation powder (insulin human) ADMELOG® (insulin lispro)† FIASP® (insulin aspart) APIDRA® vial and pen (insulin glulisine)

†Due to the nature of the drug, allergy or therapeutic failure to Humalog is insufficient to justify use

ENDOCRINE AGENTS: DIABETES - INSULINS - Intermediate Acting

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
HUMALOG MIX 50/50, 75/25® vial and pen (insulin lispro protamine/insulin lispro) HUMULIN 70/30® vial and pen (insulin NPH/regular) HUMULIN N® vial and pen (insulin NPH) NOVOLIN 70/30® (insulin NPH/regular) NOVOLIN N® (insulin NPH) NOVOLOG MIX 70/30® vial and pen (insulin aspart protamine/ insulin aspart)	

ENDOCRINE AGENTS: DIABETES - INSULINS - Long Acting

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
LANTUS® vial and pen (insulin glargine) LEVEMIR® vial and pen (insulin detemir)	BASAGLAR® (insulin glargine)† TOUJEO® (insulin glargine) TRESIBA FLEXTOUCH® (insulin degludec)

†Due to the nature of the drug, allergy or therapeutic failure to Lantus is insufficient to justify use

Endocrine Agents: Diabetes – Non-Insulin

LENGTH OF AUTHORIZATIONS: 1 year

STEP THERAPY: All oral hypoglycemics

1. For a drug requiring step therapy, there must have been inadequate clinical response to metformin products (either single-ingredient or in a sulfonylurea/ metformin or TZD/metformin combination), including a trial of no less than three months of at least one preferred metformin product
2. For a non-preferred drug, there must have been inadequate clinical response to preferred alternatives, including metformin and a trial of no less than three months of at least one preferred or step therapy product
   Note: Inadequate clinical response is the inability to reach A1C goal after at least 90 days of recommended therapeutic dose with documented adherence to the regimen.

OTHER APPROVAL CRITERIA:

Is there any reason the patient cannot be changed to a medication within the same class not requiring prior approval? Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval

DIABETES – ORAL HYPOGLYCEMICS, BIGUANIDES

NO PA REQUIRED "PREFERRED"	STEP THERAPY REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
METFORMIN (generic of Glucophage®) METFORMIN ER (generic of Glucophage XR®)		GLUCOPHAGE®, GLUCOPHAGE® XR (metformin) METFORMIN ER (generic of Fortamet®) METFORMIN SOLUTION (generic of Riomet®)

DIABETES – ORAL HYPOGLYCEMICS, BIGUANIDE/SULFONYLUREA COMBO

NO PA REQUIRED "PREFERRED"	STEP THERAPY REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
GLIPIZIDE/METFORMIN (generic of Metaglip®) GLYBURIDE/METFORMIN (generic of Glucovance®)		METAGLIP® (glipizide/metformin) GLUCOVANCE® (glyburide/metformin)

DIABETES – ORAL HYPOGLYCEMICS, TZD / BIGUANIDE COMBO

NO PA REQUIRED "PREFERRED"	STEP THERAPY REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
PIOGLITAZONE/ METFORMIN (generic of ActoPlus Met®)	ACTOPLUS MET XR® (pioglitazone/metformin)	

DIABETES – DIPEPTIDYL PEPTIDASE-4 INHIBITOR

NO PA REQUIRED "PREFERRED"	STEP THERAPY REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
	JANUVIA® (sitagliptin) TRADJENTA™ (linagliptin)	ALOGLIPTIN (generic of Nesina®) NESINA® (alogliptin) ONGLYZA® (saxagliptin)

DIABETES – DIPEPTIDYL PEPTIDASE-4 INHIBITOR COMBINATIONS

NO PA REQUIRED "PREFERRED"	STEP THERAPY REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
	JANUMET™ (sitagliptin/ metformin) JANUMET XR™ (sitagliptin/ metformin) JENTADUETO™ (linagliptin/ metformin)	JENTADUETO® XR (linagliptin/ metformin) ALOGLIPTIN/METFORMIN (generic of Kazano®) KAZANO® (alogliptin/metformin) KOMBIGLYZE XR® (saxagliptin/metformin)

DIABETES – ORAL HYPOGLYCEMICS, TZD / DPP-4 COMBINATION

NO PA REQUIRED "PREFERRED"	STEP THERAPY REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
		PIOGLITAZONE/ALOGLIPTIN (generic of Oseni®) OSENI® (pioglitazone/alogliptin)

DIABETES – ORAL HYPOGLYCEMICS, SODIUM-GLUCOSE COTRANSPORTER 2 (SGLT2) INHIBITOR

NO PA REQUIRED "PREFERRED"	STEP THERAPY REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
	FARXIGA® (dapagliflozin) JARDIANCE® (empagliflozin)	INVOKANA® (canagliflozin) STEGLATRO™ (ertugliflozin)

DIABETES – ORAL HYPOGLYCEMICS, SODIUM-GLUCOSE COTRANSPORTER 2 (SGLT2) INHIBITOR COMBINATIONS

NO PA REQUIRED "PREFERRED"	STEP THERAPY REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
	SYNJARDY® (empagliflozin and metformin) SYNJARDY® XR (empagliflozin and metformin)	GLYXAMBI® (empagliflozin/ linagliptin) INVOKAMET® (canagliflozin/ metformin) INVOKAMET® XR (canagliflozin/ metformin) SEGLUROMET™ (ertugliflozin/metformin) XIGDUO XR® (dapagliflozin/ metformin)

DIABETES – ORAL HYPOGLYCEMICS, SODIUM-GLUCOSE COTRANSPORTER 2 (SGLT2) INHIBITOR AND DPP-4 COMBINATIONS

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
No less than three months of at least one preferred DPP-4 and SGLT product	QTERN® (dapaglifozin-saxagliptin) STEGLUJAN™ (ertugliflozin/sitagliptin)

DIABETES – ORAL HYPOGLYCEMICS, ALPHA-GLUCOSIDASE INHIBITORS

NO PA REQUIRED "PREFERRED"	STEP THERAPY REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
ACARBOSE (generic of Precose®)	GLYSET® (miglitol)	MIGLITOL (generic of Glyset®) PRECOSE® (acarbose)

DIABETES – ORAL HYPOGLYCEMICS, MEGLITINIDES

NO PA REQUIRED "PREFERRED"	STEP THERAPY REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
NATEGLINIDE (generic of Starlix®) REPAGLINIDE (generic of Prandin®)		STARLIX® (nateglinide) PRANDIN® (repaglinide)

DIABETES – ORAL HYPOGLYCEMICS, MEGLITINIDE/BIGUANIDE COMBO

NO PA REQUIRED "PREFERRED"	STEP THERAPY REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
REPAGLINIDE/ METFORMIN (generic of Prandimet®)		PRANDIMET® (repaglinide/ metformin)

DIABETES – ORAL HYPOGLYCEMICS, SULFONYLUREAS SECOND GENERATION

NO PA REQUIRED "PREFERRED"	STEP THERAPY REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
GLIMEPIRIDE (generic of Amaryl®) GLIPIZIDE (generic of Glucotrol®) GLIPIZIDE ER (generic of Glucotrol XL®) GLYBURIDE (generic of Diabeta®, Micronase®) GLYBURIDE MICRONIZED (generic of Glynase PresTabs®)		AMARYL® (glimepiride) DIABETA® (glyburide) GLUCOTROL®, GLUCOTROL XL® (glipizide) GLYNASE PRESTABS® (glyburide micronized)

DIABETES – ORAL HYPOGLYCEMICS, THIAZOLIDINEDIONES

NO PA REQUIRED "PREFERRED"	STEP THERAPY REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
PIOGLITAZONE (generic of Actos®)		ACTOS® (pioglitazone) AVANDIA® (rosiglitazone)

DIABETES – ORAL HYPOGLYCEMICS, TZD/SULFONYLUREAS COMBO

NO PA REQUIRED "PREFERRED"	STEP THERAPY REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
		DUETACT® (glimepiride/pioglitazone) GLIMEPIRIDE/PIOGLITAZONE (generic of Duetact®)

ENDOCRINE AGENTS: DIABETES – AMYLIN ANALOGS

NO PA REQUIRED "PREFERRED"	STEP THERAPY REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
No less than three months of at least one preferred insulin product	SYMLIN® (pramlintide)	

ENDOCRINE AGENTS: DIABETES –GLUCAGON-LIKE PEPTIDE-1 RECEPTOR AGONISTS

NO PA REQUIRED "PREFERRED"	STEP THERAPY REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
	BYDUREON® (exenatide) VICTOZA® (liraglutide)	ADLYXIN™ (lixisenatide) BYDUREON® BCISE (exenatide) BYETTA™ (exenatide) OZEMPIC® (semaglutide) TRULICITY® (dulaglutide)

ENDOCRINE AGENTS: DIABETES – GLUCAGON-LIKE PEPTIDE-1 RECEPTOR AGONISTS & INSULIN COMBINATIONS

NO PA REQUIRED "PREFERRED"	STEP THERAPY REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
		SOLIQUA™ 100/33 (insulin glarginie/lixisenatide)† XULTOPHY® 100/3.6 (insulin degludec and liraglutdie)†

† Request must address inability to use the individual components.

Infectious Disease Agents: Antivirals – Hepatitis C Agents

LENGTH OF AUTHORIZATIONS: 1 year except simeprevir and direct acting antivirals (DAAs), see below

Is there any reason the patient cannot be changed to a medication within the same class that does not require prior approval? Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval
- Member established on current therapy with prior payer (i.e. Commercial, Fee-for-Service, Managed Care Plan, etc).

ADDITIONAL CRITERIA FOR DAAs:

All HCV DAAs require clinical prior authorization. Only regimens recommended by the American Association for the Study of Liver Diseases (AASLD) will be approved. Patients must meet all criteria below.

Step 1: Patient Readiness Evaluated

- Patient must meet labeled age requirements for product.
- Patient must be free for 6 months from alcohol use, controlled drug abuse, and illicit drug use before consideration of therapy.
- Patient must meet kidney function as indicated in package labeling for product.
- Patient must not be concomitantly taking drugs that have significant clinical interaction as described in the prescribing information for each agent.
- Patient must agree to be adherent with office visits, lab testing, imaging, procedures and, if deemed a candidate, the HCV medication regimen. Prescribers must submit documentation demonstrating the patient attests to meet these requirements (Office notes documenting this are sufficient to meet this criteria).

Step 2: Clinical Assessment of Disease

- Confirmation of chronic hepatitis C (CHC):
  - Hepatitis C Virus (HCV) antibody test reactive
  - Provide HCV RNA load measured within 90 days prior to starting DAA therapy
  - Specify the Genotype
- Document progression of disease:
  - Document the degree of liver fibrosis:
    - Liver biopsy; or
    - One radiological and one serological test
    - If cirrhosis is present, indicate whether cirrhosis is compensated or decompensated and provide the Child-Turcotte-Pugh (CTP) score.
    - Patients with decompensated cirrhosis (CTP score 7 or higher) will be approved for therapy only after consultation with a physician in a liver transplant center.
- Document that patient does not have limited life expectancy (less than 12 months) due to non-liver-related comorbid conditions
- Document any previously tried Hepatitis C treatments, dates treated, and response/outcome (patient will not be approved if any other HCV treatments have been used in the last 6 months)

Step 3: Direct Acting Antivirals (DAA) conditions for coverage

- Must be prescribed by, or in consultation with, a hepatologist, gastroenterologist, or infectious disease specialist
- HCV RNA testing is required every 4 weeks
- Providers of HIV/HCV-coinfected persons should recognize and manage interactions with other antiretroviral medications (e.g. DAAs)
- Only regimens listed as recommended or alternative in the current AASLD guidance (http://hcvguidelines.org) will be approved with duration of approval based upon guidelines. Regimens listed as not recommended will not be approved.

ADDITIONAL INFORMATION TO AID IN THE FINAL DECISION

- Pegylated Interferons have a Black Box Warning which indicates that a patient should be monitored closely with periodic clinical and laboratory evaluations.
- Ribavirins are contraindicated in women who are pregnant and in their male partner(s). At least two reliable forms of contraception must be used during therapy.

INFECTIOUS DISEASE AGENTS: HEPATITIS C – DIRECT-ACTING ANTIVIRAL

CLINICAL PA REQUIRED "PREFERRED"†	PA REQUIRED "NON-PREFERRED"
EPCLUSA® (sofosbuvir/velpatasvir) MAVYRET® (glecaprevir and pibrentasvir) ZEPATIER™ (elbasvir and grazoprevir tablet)	DAKLINZA™ (daclatasvir) HARVONI® (ledipasvir/sofosbuvir) tablets SOVALDI® (sofosbuvir) VOSEVI™ (sofosbuvir, velpatasvir, voxilaprevir)

†Selection of regimen will be based upon guidelines; refer to PA form for guidance.

INFECTIOUS DISEASE AGENTS: HEPATITIS C - PEGYLATED INTERFERONS

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
PEGASYS® (peginterferon alfa-2a) PEG-INTRON® (peginterferon alfa-2b)	

INFECTIOUS DISEASE AGENTS: HEPATITIS C - RIBAVIRINS

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
RIBAVIRIN (generic of Rebetol®)	COPEGUS® (ribavirin) MODERIBA PAK® (ribavirin) REBETOL® (ribavirin) RIBAPAK® (ribavirin) RIBASPHERE® (ribavirin) 400mg, 600mg