Date: February 10, 2020

To: Contractor Pharmacy Directors

 Contractor Medical Directors

 Contractor Compliance Officers

 Optum FFS PBM Staff

DFSM Staff: Alison Lovell, Markay Adams, John Archunde, Lisa DeWitt

From: Suzi Berman, RPh

Subject: AHCCCS Drug Lists’ Preferred Drugs

This memo is to provide notice on the preferred drugs that were approved at the January 22, 2020 AHCCCS Pharmacy & Therapeutics (P&T) Committee. The classes reviewed were non-supplemental rebate classes; the preferred agents for each of the classes will be effective April 1, 2020; the preferred agents must be added to Contractors Drug Lists in accordance with AHCCCS 310-V Policy Section III. A. 1. Preferred Drugs:

*The AHCCCS Drug Lists designate medications that are preferred drugs for specific therapeutic classes. Contractors are required to maintain preferred drug lists that include each and every drug exactly as listed on the AHCCCS Drug Lists, as applicable. When the AHCCCS Drug Lists specify a preferred drug(s) in a particular therapeutic class, Contractors are not permitted to add other preferred drugs to their preferred drug lists in those therapeutic classes.*

*Contractors shall inform their Pharmacy Benefit Managers (PBM) of the preferred drugs and shall require the PBM to institute point-of-sale edits that communicate back to the pharmacy the preferred drug(s) of a therapeutic class whenever a claim is submitted for a non-preferred drug. Preferred drugs recommended by the AHCCCS P&T Committee and approved by AHCCCS are effective on the first day of the first month of the quarter following the P&T Meeting unless otherwise communicated by AHCCCS, which for the May 2020 meeting, the effective date is October 1, 2020.*

*Contractors shall approve the preferred drugs listed for the therapeutic classes contained on the AHCCCS Drug Lists, as appropriate, before approving a non- preferred drug unless:
a. The member has previously completed step therapy using the preferred drug(s), or b. The member’s prescribing clinician supports the medical necessity of the non-preferred drug over the preferred drug for the particular member.*

The following is a synopsis of the recommendations proposed by the Committee.

Grandfathering is now referred to as Grandparenting.

**Non-Supplemental Rebate Therapeutic Classes and Preferred Drug Recommendations**

1. Antidepressants – The prior authorization requirement for children under the age of 6 years old shall remain for all products.
	1. Preferred Products
		1. BUPROPION (ORAL)
		2. BUPROPION SR (ORAL)
		3. BUPROPION XL ORAL)
		4. MIRTAZAPINE TABLET (ORAL)
		5. MIRTAZAPINE ODT (ORAL)
		6. TRAZODONE (ORAL)
		7. VENLAFAXINE ER CAPSULES (ORAL)
		8. VENLAFAXINE (ORAL)
	2. Drugs removed from the Drug List:
		1. None
	3. Grandparenting:
		1. Not applicable
	4. The committee voted on the above recommendations:
		1. 12 committee members voted in favor of the recommendations.
		2. No committee members voted against the recommendations.
		3. No committee members abstained.
2. Antidepressants – SSRIs - The prior authorization requirement for children under the age of 6 yeas old shall remain for all products.
	1. Preferred Products
		1. CITALOPRAM SOLUTION (ORAL)
		2. CITALOPRAM TABLET (ORAL)
		3. ESCITALOPRAM TABLET (ORAL)
		4. FLUOXETINE CAPSULE (ORAL)
		5. FLUOXETINE SOLUTION (ORAL)
		6. FLUVOXAMINE (ORAL)
		7. PAROXETINE TABLET (ORAL)
		8. SERTRALINE CONC (ORAL)
		9. SERTRALINE TABLET (ORAL)
	2. Drugs removed from the Drug List:
		1. None
	3. Grandparenting:
		1. Not applicable
	4. The committee voted on the above recommendations:
		1. 12 committee members voted in favor of the recommendations.
		2. No committee members voted against the recommendations.
		3. No committee members abstained.
3. Beta Agonist Bronchodilators
	1. **Long-Acting Agents**
		1. Preferred Products
			1. SEREVENT (INHALATION) – PA Required
	2. **Nebulized Agents**
		1. Preferred Products
			1. ALBUTEROL NEB SOLN 0.63, 1.25 MG (INHALATION)
			2. ALBUTEROL NEB SOLN 100 MG/20 ML (INHALATION)
			3. ALBUTEROL NEB SOLN 2.5 MG/0.5 ML (INHALATION)
			4. ALBUTEROL NEB SOLN 2.5 MG/3 ML (INHALATION)
		2. PDL Recommendation (moving to nonpreferred status):
			1. LEVALBUTEROL NEB SOLN (INHALATION)
		3. Drugs removed from the Drug List:
			1. None
		4. Grandparenting:
			1. Levalbuterol- applies for members under 4 years of age.
		5. The committee voted on the above recommendations:
			1. 12 committee members voted in favor of the recommendations.
			2. No committee members voted against the recommendations.
			3. No committee members abstained.
	3. **Oral Agents**
		1. Preferred Products
			1. ALBUTEROL SYRUP (ORAL)
		2. Drugs removed from the Drug List:
			1. None
		3. Grandparenting:
			1. Not applicable
		4. The committee voted on the above recommendations:
			1. 12 committee members voted in favor of the recommendations.
			2. No committee members voted against the recommendations.
			3. No committee members abstained.
	4. **Short-Acting Agents**
		1. Preferred Product
			1. PROAIR HFA (INHALATION)
		2. Drugs removed from the Drug List:
			1. None
		3. Grandparenting:
			1. Not applicable
		4. The committee voted on the above recommendations:
			1. 12 committee members voted in favor of the recommendations.
			2. No committee members voted against the recommendations.
			3. No committee members abstained.
4. **Bone Resorption Suppression and Related Agents**
	1. PDL Recommendations (preferred products):
		1. ALENDRONATE SOLUTION (ORAL)
		2. ALENDRONATE TABLETS (ORAL)]
		3. CALCITONIN SALMON (NASAL)
		4. FORTEO (SUBCUTANE.) (new) (PA required)
		5. IBANDRONATE TABLETS (ORAL) (new)
		6. PROLIA (SUBCUTANE.) (new) (PA required)
		7. RALOXIFENE (AG) (ORAL)
	2. Drugs removed from the Drug List:
		1. None
	3. Grandparenting:
		1. Not applicable
	4. The committee voted on the above recommendations;
		1. 12 committee members voted in favor of the recommendations.
		2. No committee members voted against the recommendations.
		3. No committee members abstained.
5. **Colony Stimulating Factors -**
	1. PDL Recommendations (preferred products) – all require prior authorization approval.:
		1. FULPHILA (SUBCUTANEOUS)
		2. NEUPOGEN DISP SYRIN (INJECTION)
		3. NEUPOGEN VIAL (INJECTION)\*
		4. UDENYCA (SUBCUTANEOUS)
	2. Drugs removed from the Drug List:
		1. None
	3. Grandparenting:
		1. Not applicable
	4. The committee voted on the above recommendations;
		1. 12 committee members voted in favor of the recommendations.
		2. No committee members voted against the recommendations.
		3. No committee members abstained.
6. **Enzyme Replacement – Gaucher Disease**
	1. PDL Recommendations (preferred products) – all require prior authorization approval:
		1. CERDELGA (ORAL)
		2. CEREZYME 400 UNITS (INTRAVEN)
		3. ELELYSO (INTRAVEN)
		4. MIGLUSTAT (AG) (ORAL)
		5. VPRIV 400 UNITS (INTRAVEN)
	2. Drugs removed from the Drug List:
		1. None
	3. Grandparenting:
		1. Not applicable
	4. The committee voted on the above recommendations;
		1. 12 committee members voted in favor of the recommendations.
		2. No committee members voted against the recommendations.
		3. No committee members abstained.
7. **Erythropoiesis Stimulating Proteins**
	1. PDL Recommendations (preferred products):
		1. RETACRIT (INJECTION) – Prior Authorization Approval required.
	2. Drugs removed from the Drug List:
		1. None
	3. Grandparenting:
		1. Not applicable
	4. The committee voted on the above recommendations;
		1. 12 committee members voted in favor of the recommendations.
		2. No committee members voted against the recommendations.
		3. No committee members abstained.
8. **Hypoglycemics – Alpha-Glucosidase Inhibitors**
	1. PDL Recommendations (preferred products):
		1. ACARBOSE (ORAL)
	2. Drugs removed from the Drug List:
		1. None
	3. Grandparenting:
		1. Not applicable
	4. The committee voted on the above recommendations;
		1. 12 committee members voted in favor of the recommendations.
		2. No committee members voted against the recommendations.
		3. No committee members abstained.
9. **Hypoglycemics - Metformins**
	1. PDL Recommendations (preferred products):
		1. GLYBURIDE-METFORMIN (ORAL)
		2. METFORMIN (ORAL)
		3. METFORMIN ER (GLUCOPHAGE XR) (ORAL)
	2. Drugs removed from the Drug List:
		1. None
	3. Grandparenting:
		1. Not applicable
	4. The committee voted on the above recommendations;
		1. 12 committee members voted in favor of the recommendations.
		2. No committee members voted against the recommendations.
		3. No committee members abstained.
10. **Hypoglycemics – SGLT2s**
	1. PDL Recommendations (preferred products) – all require prior authorization approval:
		1. FARXIGA (ORAL)
		2. INVOKANA (ORAL)
		3. JARDIANCE (ORAL)
	2. Drugs removed from the Drug List:
		1. None
	3. Grandparenting:
		1. Not applicable
	4. The committee voted on the above recommendations;
		1. 12 committee members voted in favor of the recommendations.
		2. No committee members voted against the recommendations.
		3. No committee members abstained.
11. **Immune Globulins**
	1. PDL Recommendations (preferred products) – all require prior authorization approval:
		1. FLEBOGAMMA DIF (INTRAVEN)
		2. GAMASTAN S-D VIAL (INTRAMUSC)
		3. GAMMAGARD LIQUID (INJECTION)
		4. GAMMAGARD S-D (INTRAVEN)
		5. GAMUNEX-C (INJECTION)
		6. HIZENTRA (SUBCUT.)
	2. Drugs removed from the Drug List:
		1. None
	3. Grandparenting:
		1. Not applicable
	4. The committee voted on the above recommendations;
		1. 12 committee members voted in favor of the recommendations.
		2. No committee members voted against the recommendations.
		3. No committee members abstained.
12. **Oncology – Oral – Hematologic**
	1. PDL Recommendations (preferred products):
		1. IMATINIB (ORAL) (new) – Prior Authorization Approval required.
		2. MERCAPTOPURINE (ORAL)
	2. PDL Recommendations (moving to non-preferred status):
		1. GLEEVEC (ORAL)
	3. Drugs removed from the Drug List:
		1. None
	4. Grandparenting:
		1. No
	5. The committee voted on the above recommendations;
		1. 12 committee members voted in favor of the recommendations.
		2. No committee members voted against the recommendations.
		3. No committee members abstained.
13. **Ophthalmics – Anti-inflammatory/Immunomodulators**
	1. PDL Recommendations (preferred products):
		1. RESTASIS (OPHTHALMIC) Single Use Vials – Prior Authorization Approval required.
	2. Drugs removed from the Drug List:
		1. None
	3. Grandparenting:
		1. Not applicable
	4. The committee voted on the above recommendations;
		1. 12 committee members voted in favor of the recommendations.
		2. No committee members voted against the recommendations.
		3. No committee members abstained.
14. **Otic Antibiotics**
	1. PDL Recommendations (preferred products):
		1. CIPRODEX (OTIC)\*
		2. CIPROFLOXACIN (OTIC)
		3. NEOMYCIN/POLYMYXIN/HC SOLN/SUSP (OTIC)
	2. Drugs removed from the Drug List:
		1. None
	3. Grandparenting:
		1. Not applicable
	4. The committee voted on the above recommendations;
		1. 12 committee members voted in favor of the recommendations.
		2. No committee members voted against the recommendations.
		3. No committee members abstained.
15. **PAH Agents – Oral and Inhaled**
	1. PDL Recommendations (preferred products)- all require prior authorization approval:
		1. ADCIRCA (ORAL)
		2. LETAIRIS (ORAL)
		3. REVATIO SUSPENSION (ORAL)
		4. SILDENAFIL TABLET (ORAL)
		5. TRACLEER TABLET (ORAL)
	2. Drugs removed from the Drug List:
		1. None
	3. Grandparenting:
		1. Not applicable
	4. The committee voted on the above recommendations;
		1. 12 committee members voted in favor of the recommendations.
		2. No committee members voted against the recommendations.
		3. No committee members abstained.
16. **Thrombopoiesis Stimulating Agents**
	1. PDL Recommendations (preferred products) - Prior Authorization Approval Required :
		1. NPLATE (SUB-Q) –
		2. PROMACTA TABLET (ORAL) – Brand only
	2. Drugs removed from the Drug List:
		1. None
	3. Grandparenting:
		1. Not applicable
	4. The committee voted on the above recommendations;
		1. 12 committee members voted in favor of the recommendations.
		2. No committee members voted against the recommendations.
		3. No committee members abstained.

**New Drugs**

 The Committee reviewed the following drugs and the recommendations are below:

1. Drugs Recommended as Non-Preferred:
	1. Nourianz (istradefylline)
	2. Wakix (pitolisant)
	3. Aklief (trifarotene)
	4. Trikafta (elexacaftor/tezacaftor/ivacaftor)-
	5. Vumerity (diroximel fumarate)
	6. Pretomanid (nitroimadazole)
	7. Reblozyl (luspatercept-aamt)
2. Drugs Recommended as Preferred:
	1. Spravato (Esketamine) –
		1. Public Testimony - Benet Press, MD
		2. This medication will be added to the drug list as preferred pending the development of prior authorization criteria by the Behavioral Health Contractors.
3. The committee voted on the above recommendations;
	1. 12 committee members voted in favor of the recommendations.
	2. No committee members voted against the recommendations.
	3. No committee members abstained.

**Sublocade Criteria**

The following change was made to the Sublocade Prior Authorization criteria:

1. Old verbiage: Patient has co-occurring serious mental illness and has a demonstrated history of non-adherence to oral medications.
	1. New Verbiage: Patient has severe opioid use disorder (OUD) as defined by DSM-5 OUD Diagnostic Tool and has a demonstrated history of non-adherence to oral medications.
	2. The committee voted on the above changes
		1. 12 committee members voted in favor of the recommendations
		2. No committee members voted against the recommendations
		3. No committee member abstained
2. The updated Sublocade prior authorization criteria is attached.

**Prior Authorization for Children Under the Age of 18 for Antipsychotics – Suzi Berman**

1. The committee will further discuss in May after the Contractor’s review antipsychotic utilization for members under 18 years of age.

**Requests for Care1st – Angela Balascak**

1. Prior Authorization for Children Under the Age of 18 for Sedative Hypnotics
	1. No changes made to current process
2. Request to remove Valacyclovir Prior Authorization requirement and Quantity Limit
	1. Motion was made to remove the Prior authorization requirement and Quantity Limit:
		1. Ten committee members voted in favor of the recommendations.
		2. One committee member voted against the recommendations.
		3. One committee member abstained.

**Biosimilar Update**

There are several biosimilars approved for both Herceptin and Avastin. AHCCCS has made the determination that the branded agents, Herceptin and Avastin are the most cost-effective agents to the state. Herceptin and Avastin are the preferred agents and all biosimilars are non-preferred.

1. Rituxan- – Preferred
	1. Ruxience – Non-preferred
	2. Truxima – Non-preferred
2. Humira- Preferred
	1. Abrilada – Non-preferred
	2. Hadlima – Non-preferred
	3. Hyrimoz – Non-preferred
	4. Amjevita– Non-preferred
3. Neulasta – Non-preferred
	1. Ziextenzo – Non-preferred
	2. Udenyca – Preferred
	3. Fulphila – Preferred
4. Remicade – Non-preferred
	1. Avsola – Non-preferred
	2. Ixifi – Non-preferred
	3. Renflexis - Preferred
	4. Inflectra – Non-preferred

A file, as a separate attachment, is attached to this email and contains the preferred and non-preferred drugs by the National Drug Code and the drug label name. Drugs noted as “PDL” have Preferred status and those listed as “NPD” have Non-Preferred status. NR means the drug was not previously reviewed at a P&T Committee meeting. New drug market entries will also be listed on the weekly NDC list.

AHCCCS and its Contractors shall communicate the AHCCCS DRUG LISTS preferred drugs to their pharmacy benefit managers and require point-of-sale edits that communicate the preferred drug of a therapeutic class to the pharmacy when a claim is submitted for a drug other than the preferred drug.

AHCCCS and its Contractors are required to list these medications on their drug list exactly as they are listed on the AHCCCS DRUG LIST. Contractors shall not add other drugs to their drug list to therapeutic classes that contain preferred drugs on the AHCCCS DRUG LIST. All Contractors’ drug lists, including website listings, must be updated by April 1, 2020 to reflect P&T preferred drug and other changes.

As a reminder, the contract language between AHCCCS and its Contractors prohibits duplicate discounts and is stated as follows:

“*Pharmaceutical Rebates: The Contractor, including the Contractor’s Pharmacy Benefit Manager (PBM), is prohibited from negotiating any rebates with drug manufacturers for preferred or other pharmaceutical products when AHCCCS has a supplemental rebate contract for the product(s). A listing of products covered under supplemental rebate agreements will be available on the AHCCCS website under the Pharmacy Information section.*

*If the Contractor or its PBM has an existing rebate agreement with a manufacturer, all outpatient drug claims, including provider-administered drugs for which AHCCCS is obtaining supplemental rebates, must be exempt from such rebate agreements*.”

Please contact me at your convenience if you have any questions. I can be reached at Suzanne.Berman@azahcccs.gov or telephonically at (602) 417-4726.