

Affected Programs: BadgerCare Plus, Medicaid, SeniorCare

To: Blood Banks, Dentists, Federally Qualified Health Centers, Hospital Providers, Nurse Practitioners, Nursing Homes, Pharmacies, Physician Assistants, Physician Clinics, Physicians, Podiatrists, Rural Health Clinics, HMOs and Other Managed Care Programs

January 2015 Preferred Drug List Review and Other Pharmacy Policy Changes

This *ForwardHealth Update* provides information for prescribers and pharmacy providers about changes to the Preferred Drug List and other pharmacy policy changes effective for dates of service on and after January 1, 2015, unless otherwise noted.

This *ForwardHealth Update* provides information for prescribers and pharmacy providers about changes to the Preferred Drug List (PDL) and other pharmacy policy changes effective for dates of service on and after January 1, 2015, unless otherwise noted.

This *Update* provides an overview of the major changes to certain PDL drug classes for BadgerCare Plus, Medicaid, and SeniorCare but does not address all of the changes made in PDL drug classes. For additional information about covered drugs on the PDL for the BadgerCare Plus, Medicaid, and SeniorCare, providers may refer to the Preferred Drug List Quick Reference on the Pharmacy Resources page of the Providers area of the ForwardHealth Portal at www.forwardhealth.wi.gov/.

Changes to Pharmacy-Related Forms and Completion Instructions

ForwardHealth no longer includes copies of revised forms and completion instructions as attachments to PDL *Updates*. Attachment 1 of this *Update* lists the prior authorization (PA) forms and completion instructions that are new or have been revised, renamed, or discontinued as a result of the January

2015 PDL review or as a result of other pharmacy policy changes. Providers should refer to the Forms page of the Portal for current copies of all PA forms and completion instructions. Unless otherwise noted, all forms listed in Attachment 1 are effective January 1, 2015. Additional information regarding changes to clinical criteria or submission options is noted in the applicable drug class sections of this *Update*.

Archive Page for Pharmacy-Related Forms and Completion Instructions

Providers may reference the Pharmacy-Related Forms and Completion Instructions link under the Archives section on the Pharmacy Resources page of the Portal for old versions of pharmacy-related forms and completion instructions. These archives are provided for reference purposes only. Providers should refer to the Online Handbook for current policy and procedures and to the Forms page for current forms and completion instructions.

A Brief Overview of the Preferred Drug List

ForwardHealth makes recommendations to the Wisconsin Medicaid Pharmacy PA Advisory Committee on whether certain PDL drugs should be preferred or non-preferred. These recommendations are based primarily on objective evaluations of a drug's relative safety, effectiveness of the drug, clinical outcomes, and the relative cost of the drug (to

Wisconsin Medicaid) in comparison with other therapeutically interchangeable alternative agents in the same drug class.

New drugs are usually added to existing drug classes on the PDL as non-preferred drugs until their next scheduled class review by the Medicaid PA Advisory Committee.

The PDL is not a drug formulary and is not a comprehensive list of covered drugs.

Most drugs and drug classes included on the PDL are covered by BadgerCare Plus, Medicaid, and SeniorCare, but certain drugs may have restrictions (e.g., diagnosis, quantity limits, age limits). Prescribers are encouraged to write prescriptions for preferred drugs if medically appropriate. Non-preferred drugs may be covered with an approved PA request. Most preferred drugs do not require PA except in designated classes identified on the Preferred Drug List Quick Reference. Noncovered drugs (e.g., drugs used for hair loss or cosmetic purposes) are not reimbursed, even with PA.

A Prescriber's Responsibilities for Prior Authorization for Preferred Drug List Drugs

Prescribers are encouraged to write prescriptions for preferred drugs.

Prescribers are encouraged to prescribe more than *one* preferred drug before a non-preferred drug is prescribed.

Clinical Criteria for Non-preferred Drugs

Clinical criteria for approval of a PA request for a non-preferred drug are *at least one* of the following, unless drug class-specific clinical criteria have been established and published by ForwardHealth:

- The member has experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction with *at least one* of the preferred drugs from the same PDL drug class as the drug being requested.

- There is a clinically significant drug interaction between another drug the member is taking and *at least one* of the preferred drugs from the same PDL drug class as the drug being requested.
- The member has a medical condition(s) that prevents the use of *at least one* of the preferred drugs from the same PDL drug class as the drug being requested.

Alternate Clinical Criteria for Non-preferred Drugs in Eligible Drug Classes Only

The following drug classes have alternate clinical criteria that may be considered if the member does not meet the previously listed clinical criteria for non-preferred drugs:

- Alzheimer's agents drug class (excluding Namenda and Namenda XR™ for members who are 44 years of age or younger).
- Anticonvulsants drug class.
- Antidepressants, other drug class.
- Antidepressants, SSRI drug class.
- Antiparkinson's agents drug class.
- Antipsychotics drug class.
- HIV-AIDS drug class (excluding Stribild™).
- Pulmonary arterial hypertension drug class.

Alternate clinical criteria may be considered if a member does not meet the previously listed clinical criteria for non-preferred drugs. Alternate clinical criteria are *one* of the following:

- The member is new to ForwardHealth (i.e., the member has been granted eligibility for ForwardHealth within the past month) and has taken the requested non-preferred drug continuously for the last 30 days or longer and had a measurable therapeutic response.
- The member had an approved PA issued by ForwardHealth that recently expired for the non-preferred drug, and the member has taken the requested non-preferred drug continuously for the last 30 days or longer and had a measurable therapeutic response.
- The member was recently discharged from an inpatient stay in which the member was stabilized on the non-preferred drug being requested.

Note: Starting a member on a medication by using manufacturer-provided samples may not be used to circumvent PA policy. Use of manufacturer-provided samples does not provide claim history documentation regarding the dose of a medication that was taken or compliance with treatment so it will not be considered as previous medication history for PA review.

Completing a Prior Authorization Form

If a non-preferred drug or a preferred drug that requires clinical PA is medically necessary for a member, the prescriber is required to complete the appropriate PA form for the drug. Prescribers are required to send the PA form to the pharmacy where the prescription will be filled. Prescribers are required to include accurate and complete answers and clinical information about the member's medical history on the PA form. When completing the PA form, prescribers are required to provide a handwritten signature and date on the form.

The PA form may be faxed or mailed to the pharmacy, or the member may carry the form with the prescription to the pharmacy. The pharmacy provider will use the completed PA form to submit a PA request to ForwardHealth. Prescribers should *not* submit the PA form to ForwardHealth.

Prescribers are required to retain a completed, signed, and dated copy of the PA form and any supporting documentation.

A Pharmacy Provider's Responsibilities for Prior Authorization for Preferred Drug List Drugs

Pharmacy providers should review the Preferred Drug List Quick Reference for the most current list of preferred and non-preferred drugs.

If a member presents a prescription for a non-preferred drug, the pharmacy provider is encouraged to contact the prescriber to discuss preferred drug options. The prescriber may choose to change the prescription to a preferred drug, if

medically appropriate for the member, or the prescriber may complete the appropriate PA form.

Pharmacy providers are required to submit a PA request using the PA form received from the prescriber and using the PA request submission option most appropriate for the drug. Pharmacy providers may submit PA requests using the Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) system (when applicable), on the Portal, by fax, or by mail.

Pharmacy providers are required to retain a completed, signed, and dated copy of the PA form and any supporting documentation received from the prescriber.

Changes to the Preferred or Non-preferred Status of Drugs on the Preferred Drug List

On November 5, 2014, the Medicaid PA Advisory Committee met to review new and existing therapeutic drug classes on the PDL.

Providers may refer to Attachment 2 for a table listing all of the drugs that have had a change in their preferred or non-preferred status as a result of this meeting. The updated statuses are effective January 1, 2015. Providers should review the Preferred Drug List Quick Reference on the Portal for a complete list of preferred and non-preferred drugs.

For drugs that were previously preferred and will become non-preferred, pharmacists should work with prescribers to transition members to a preferred drug or to complete the appropriate PA request forms.

As a reminder, new drugs are usually added to existing drug classes on the PDL as non-preferred drugs until their next scheduled class review by the Medicaid PA Advisory Committee. Therefore, some drugs listed in the table had not been reviewed previously and were added to the PDL with an interim status of non-preferred. These drugs have now been reviewed and their PDL status resulting from the

November 5, 2014, meeting and effective January 1, 2015, are included in the table.

For some drugs in the table, additional information is provided in the applicable drug class section of this *Update*.

New Drug Class

The glucocorticoids, oral drug class will be added to the PDL on January 1, 2015.

Pharmacy providers should begin working with prescribers to transition members using non-preferred drugs in the drug class or request PA for a non-preferred drug if it is medically appropriate for the member. Providers may refer to the Preferred Drug List Quick Reference on the Portal for the preferred and non-preferred drugs in the glucocorticoids, oral drug class.

Glucocorticoids, Oral

The following will be preferred drugs in the glucocorticoids, oral drug class:

- Dexamethasone elixir.
- Dexamethasone intensol.
- Dexamethasone solution.
- Dexamethasone tablet.
- Entocort® EC.
- Hydrocortisone.
- Methylprednisolone tablet.
- Orapred ODT.
- Prednisolone sodium phosphate.
- Prednisolone solution.
- Prednisone intensol.
- Prednisone solution.
- Prednisone tab DS PK.
- Prednisone tablet.

The following will be non-preferred drugs:

- Budesonide EC.
- Cortef.
- Cortisone.
- Dexpak.
- Flo-Pred.

- Medrol tablet.
- Millipred DP tab DS PK.
- Millipred solution.
- Millipred tablet.
- Pediapred.
- Rayos tablet DR.
- Veripred 20.

Alzheimer's Agents

Exelon Capsules

Exelon capsules will become a non-preferred drug.

Note: Exelon capsules will no longer qualify for the generic copayment and dispensing fee that ForwardHealth applies to brand name drugs that are preferred over their generic equivalents.

Cytokine and Cell Adhesion Molecule Antagonist Drugs

Non-preferred Oral Agents

ForwardHealth has established that the following will *not* be considered as criteria for use of a non-preferred oral agent:

- Non-adherence to previous cytokine and cell adhesion molecule (CAM) antagonist drug treatment.
- The member's fear of needles.
- Member or prescriber preference for the use of an oral agent.

For more information about cytokine and CAM antagonist drugs, providers may refer to the Cytokine and Cell Adhesion Molecule Antagonist Drugs topic (topic #16217) in the Preferred Drug List chapter of the Prior Authorization section of the Pharmacy service area of the Online Handbook.

Cytokine and Cell Adhesion Molecule Antagonist Drugs for Neonatal Onset Multisystem Inflammatory Disease

ForwardHealth has revised the list of clinical conditions for which PA requests for cytokine and CAM antagonist drugs

will be approved to include Neonatal Onset Multisystem Inflammatory Disease (NOMID).

ForwardHealth has established clinical criteria for approval of a PA request for cytokine and CAM antagonist drugs for NOMID.

Clinical Criteria for Cytokine and Cell Adhesion Molecule Antagonist Drugs for Neonatal Onset Multisystem Inflammatory Disease

Kineret® is a non-preferred drug used to treat NOMID. For PA requests for Kineret®, the member must meet *all* clinical criteria below.

Clinical criteria for approval of a PA request for cytokine and CAM antagonist drugs to treat NOMID are *both* of the following:

- The member has NOMID.
- The prescription is written by a rheumatologist or through a rheumatology consultation.

Prior authorization requests for drugs to treat NOMID must be submitted on the Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Rheumatoid Arthritis (RA) and Polyarticular Juvenile RA form, F-11308 (12/12).

Clinical documentation and medical records must be submitted with the PA request to support the member's condition of NOMID and outline the member's current treatment plan for NOMID.

Otezla

Otezla will be a non-preferred drug in the cytokine and CAM antagonist drug class used to treat plaque psoriasis and psoriatic arthritis. For PA requests for Otezla, the member must meet *all* clinical criteria published in the Clinical Criteria for Cytokine and Cell Adhesion Molecule Antagonist Drugs for Plaque Psoriasis topic (topic #16277) or the Clinical Criteria for Cytokine and Cell Adhesion Molecule Antagonist Drugs for Psoriatic Arthritis topic (topic #16297) of the Preferred Drug List chapter of the Prior Authorization

section of the Pharmacy service area of the Online Handbook and have taken *two* preferred cytokine and CAM antagonist drugs for at least *three* consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction.

Glucocorticoids, Inhaled

Advair HFA® will become a non-preferred drug in the glucocorticoids, inhaled drug class. Pharmacy providers are encouraged to work with prescribers to begin switching members to a preferred drug or to obtain PA for a non-preferred drug in the glucocorticoids, inhaled drug class.

Otic Antibiotics

Ciprodex® will become a non-preferred drug in the otic antibiotics drug class. Pharmacy providers are encouraged to work with prescribers to begin switching members to a preferred drug or to obtain PA for a non-preferred drug in the otic antibiotics drug class.

Steroids, Topical (Low, Medium, High, and Very High)

Changes will be made to the preferred and non-preferred status of drugs in the steroids, topical low, medium, high, and very high drug classes. Providers may refer to the Preferred Drug List Quick Reference on the Portal for the preferred and non-preferred drugs in these drug classes.

Stimulants and Related Agents

Revised Prior Authorization Drug Attachment for Modafinil and Nuvigil® Form

ForwardHealth has revised the Prior Authorization Drug Attachment for Modafinil and Nuvigil®, F-00079 (01/15). The previous version of this form will be removed from the Forms page of the Portal and placed on the Pharmacy-Related Forms and Completion Instructions archive page linked under the Archives section on the Pharmacy Resources page of the Portal. Prior authorization requests received on and after January 1, 2015, must be submitted on the revised form or they will be returned to the provider.

Prior authorization requests that have already been approved will be honored until they expire or until the approved days' supply is used up.

Pharmacy providers may submit PA requests for modafinil and Nuvigil® on the Portal, by fax, or by mail. Prior authorization requests for modafinil and Nuvigil® may *not* be submitted through the STAT-PA system.

If clinical criteria for modafinil or Nuvigil® are met, initial PA requests may be approved for up to a maximum of 183 days. Renewal PA requests for modafinil or Nuvigil® may be approved for up to a maximum of 365 days.

ForwardHealth has revised the clinical criteria for modafinil and Nuvigil®.

Revised Clinical Criteria for Modafinil

Prior authorization requests for modafinil will only be approved for use to treat the following identified clinical conditions:

- Narcolepsy with cataplexy.
- Narcolepsy without cataplexy.
- Obstructive sleep apnea/hypopnea syndrome (OSHAS).
- Shift work sleep disorder.
- Attention deficit disorder (ADD).
- Attention deficit hyperactivity disorder (ADHD).

Clinical criteria for approval of a PA request for modafinil are the following:

- The member is at least 16 years of age.
- For members with narcolepsy with or without cataplexy:
 - ✓ An overnight polysomnogram (PSG) sleep study and multiple sleep latency test (MSLT) have been performed for the member using standard protocols, confirming the member has narcolepsy. (*Note:* Test results for the PSG and MSLT, along with provider interpretation, must be submitted with the PA request.)
 - ✓ The member is not currently taking any sedative hypnotics.

- ✓ The member is not currently taking central nervous system (CNS) depressants (i.e., anxiolytics, barbiturates, opioids) that could significantly impact daytime sleepiness.
- For members with OSAHS:
 - ✓ An overnight PSG sleep study has been performed for the member, confirming the member has OSAHS. (*Note:* Test results for the PSG, along with provider interpretation, must be submitted with the PA request.)
 - ✓ The member's apnea/hypopnea index (AHI) measures more than five events per hour.
 - ✓ The member has tried a continuous positive airway pressure (CPAP) machine.
 - ✓ The member is not currently taking any other stimulants or related agents.
- For members with shift work sleep disorder:
 - ✓ The member is a night shift worker. (*Note:* The member's employer information and weekly work schedule need to be documented to support shift work sleep disorder.)
 - ✓ The member is not currently taking any sedative hypnotics.
 - ✓ The member is not currently taking CNS depressants (i.e., anxiolytics, barbiturates, opioids) that could significantly impact daytime sleepiness.
 - ✓ The member is not currently taking any other stimulants or related agents.

Clinical criteria for approval of a PA request for modafinil for members with ADD or ADHD are *all* of the following:

- The member is at least 16 years of age.
- The member is not currently taking any other stimulants or related agents.
- *At least one* of the following is true:
 - ✓ The member has experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction with at least two preferred stimulants.
 - ✓ The member has a medical history of substance abuse or misuse.
 - ✓ The member has a serious risk of drug diversion.

- The member has experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction with Strattera®.

Dose Limit for Modafinil

A dose limit applies to modafinil. The dose limit for modafinil is 200 mg per day.

ForwardHealth will only consider modafinil dose limit overrides up to 400 mg per day for members who meet the following criteria:

- The member has narcolepsy with or without cataplexy.
- The member is not currently taking any sedative hypnotics.
- The member is not currently taking CNS depressants (i.e., anxiolytics, barbiturates, opioids) that could significantly impact daytime sleepiness.
- The member has experienced a partial response to modafinil 200 mg per day.

For members with an existing approved PA request for modafinil, a dose limit override may be requested using the Prior Authorization Amendment Request, F-11042 (07/12). For members without an existing PA request for modafinil, the Prior Authorization Drug Attachment for Modafinil and Nuvigil® must be submitted.

The following documentation must be submitted with all modafinil dose limit override requests:

- A list of the medication(s) the member is currently taking or has previously taken for narcolepsy.
- A history of the member's modafinil use and justification for why the member needs a dose above the Food and Drug Administration (FDA)-approved dose of 200 mg per day.

Revised Clinical Criteria for Nuvigil®

Prior authorization requests for Nuvigil® will only be approved for use to treat the following identified clinical conditions:

- Narcolepsy with cataplexy.
- Narcolepsy without cataplexy.

- Obstructive sleep apnea/hypopnea syndrome.
- Shift work sleep disorder.

Clinical criteria for approval of a PA request for Nuvigil® are *all* of the following:

- The member is at least 16 years of age.
- For members with narcolepsy with or without cataplexy:
 - ✓ An overnight PSG sleep study and multiple MSLT have been performed for the member using standard protocols, confirming the member has narcolepsy. (*Note:* Test results for the PSG and MSLT, along with provider interpretation, must be submitted with the PA request.)
 - ✓ The member is not currently taking any sedative hypnotics.
 - ✓ The member is not currently taking CNS depressants (i.e., anxiolytics, barbiturates, opioids) that could significantly impact daytime sleepiness.
- For members with OSAHS:
 - ✓ An overnight PSG sleep study has been performed for the member, confirming the member has OSAHS. (*Note:* Test results for the PSG, along with provider interpretation, must be submitted with the PA request.)
 - ✓ The member's AHI measures more than five events per hour.
 - ✓ The member has tried a CPAP machine.
 - ✓ The member is not currently taking any other stimulants or related agents.
- For members with shift work sleep disorder:
 - ✓ The member is a night shift worker. (*Note:* The member's employer information and weekly work schedule need to be documented to support the diagnosis of shift work sleep disorder.)
 - ✓ The member is not currently taking any sedative hypnotics.
 - ✓ The member is not currently taking CNS depressants (i.e., anxiolytics, barbiturates, opioids) that could significantly impact daytime sleepiness.
 - ✓ The member is not currently taking any other stimulants or related agents.

A dose limit applies to Nuvigil®. The dose limit for Nuvigil® is 250 mg per day.

Pharmacy Policy Changes

Antibiotics, GI

Effective January 1, 2015, brand Vancocin capsules will require brand medically necessary (BMN) PA. Although generic vancomycin capsules were added to the PDL as a preferred drug effective December 1, 2014, Wisconsin Medicaid, BadgerCare Plus, and SeniorCare retained brand Vancocin capsules as a preferred drug for the month of December to allow for a one-month transition period.

Antidepressants, SSRI

Fluoxetine 10 mg capsules, fluoxetine 20 mg capsules, fluoxetine 40 mg capsules, and fluoxetine solution continue to be preferred drugs.

Fluoxetine tablets will become a non-preferred drug.

Fluoxetine 90 mg capsules will remain a non-preferred drug.

Note: Members who are currently taking fluoxetine tablets should be switched to preferred fluoxetine capsules or solution unless it is not clinically appropriate. Pharmacies should work with prescribers to begin switching members.

Members currently using fluoxetine tablets will not be grandfathered.

Anti-obesity Drugs

Revised Prior Authorization Drug Attachment for Anti-obesity Drugs Form

ForwardHealth has revised the Prior Authorization Drug Attachment for Anti-obesity Drugs, F-00163 (01/15). The previous version will be removed from the Forms page of the Portal and placed on the Pharmacy-Related Forms and Completion Instructions archive page linked under the Archives section on the Pharmacy Resources page of the Portal. Prior authorization requests received on and after

January 1, 2015, must be submitted on the revised form or they will be returned to the provider.

Prior authorization requests that have already been approved will be honored until they expire or until the approved days' supply is used up.

As a reminder, PA requests for anti-obesity drugs must be completed and signed by the prescribers or their designees, *not* pharmacy providers. Prescribers may submit PA requests for anti-obesity drugs through the Drug Authorization Policy Override (DAPO) Center, on the Portal, by fax, or by mail. Prior authorization requests for anti-obesity drugs may *not* be submitted through the STAT-PA system.

Note: Prior authorization requests for anti-obesity drugs submitted by mail or by fax will not be processed as 24-hour drug PA requests. If an immediate decision is needed for a PA request, providers should call the DAPO Center. If a prescriber chooses not to use the DAPO Center, the prescriber is required to submit a Prior Authorization Request Form (PA/RF), F-11018 (05/13), along with the applicable PA drug attachment form and additional medical documentation.

ForwardHealth has revised the clinical criteria for anti-obesity drugs. Additionally, ForwardHealth has revised the list of anti-obesity drugs that may be submitted on the Prior Authorization Drug Attachment for Anti-obesity Drugs to include Contrave, a new anti-obesity drug available in the marketplace that has been approved by the FDA.

Revised Clinical Criteria for All Anti-obesity Drugs

Clinical criteria for approval of a PA request for anti-obesity drugs require *one* of the following:

- The member has a body mass index (BMI) greater than or equal to 30.
- The member has a BMI greater than or equal to 27 but less than 30 *and* two or more of the following risk factors:
 - ✓ Coronary heart disease.
 - ✓ Dyslipidemia.

- ✓ Hypertension.
- ✓ Sleep apnea.
- ✓ Type II diabetes mellitus.

In addition, *all* of the following must be true:

- The member is 16 years of age or older. (*Note:* Members need only to be 12 years of age or older to take Xenical®.)
- The member is not pregnant or nursing.
- The member does not have a history of an eating disorder (e.g., anorexia, bulimia).
- The member has not had bariatric surgery.
- The prescriber has evaluated and determined that the member does not have any medical or medication contraindications to treatment with the anti-obesity drug being requested.
- For controlled substance anti-obesity drugs, the member does not have a medical history of substance abuse or misuse.
- The member has participated in a weight loss treatment plan (e.g., nutritional counseling, an exercise regimen, a calorie-restricted diet) in the past six months and will continue to follow the treatment plan while taking the anti-obesity drug.

Prior authorization requests for anti-obesity drugs will not be renewed if a member's BMI is below 24.

As a reminder, ForwardHealth does not cover the following:

- Brand name (i.e., innovator) anti-obesity drugs, if an FDA-approved generic equivalent is available.
- Any brand name innovator phentermine products.
- Over-the-counter (OTC) anti-obesity drugs.

ForwardHealth will return PA requests for the above-listed drugs as noncovered services.

Clinical Criteria for Contrave

If clinical criteria for anti-obesity drugs are met, initial PA requests for Contrave will be approved for up to a maximum of three months. If the member meets a weight loss goal of at least five percent of his or her weight from baseline, PA

may be requested for an additional six months of treatment. If the member's weight remains below baseline, a final PA renewal period of three months of Contrave may be approved. Prior authorization requests for Contrave may be approved for a maximum treatment period of 12 continuous months of drug therapy.

If any of the following occur, the member must wait six months before PA can be requested for Contrave:

- The member does not meet a weight loss goal of at least five percent of his or her weight from baseline during the initial three-month approval.
- The member's weight does not remain below baseline.
- The member completes 12 months of continuous Contrave treatment.

ForwardHealth allows only two weight loss attempts with Contrave during a member's lifetime. Additional PA requests will not be approved. ForwardHealth will return additional PA requests to the provider as noncovered services. Members do not have appeal rights for noncovered services.

For more information about anti-obesity drugs, providers may refer to the Prior Authorization for Anti-obesity Drugs topic (topic #7837) in the Services Requiring Prior Authorization chapter of the Prior Authorization section of the Pharmacy service area of the Online Handbook.

Brand Medically Necessary Prior Authorization Policy

ForwardHealth has revised the Prior Authorization/Brand Medically Necessary Attachment (PA/BMNA), F-11083 (01/15). The previous version will be removed from the Forms page of the Portal and placed on the Pharmacy-Related Forms and Completion Instructions archive page linked under the Archives section on the Pharmacy Resources page of the Portal. Prior authorization requests received on and after January 1, 2015, must be submitted on the revised form or they will be returned to the provider.

Prior authorization requests that have already been approved will be honored until they expire or until the approved days' supply is used up.

Providers may refer to the State Maximum Allowed Cost (SMAC) List data table located on the Pharmacy Resources page of the Portal for the most current list of brand medically necessary drugs that require PA.

Brand Medically Necessary Drugs: A Prescriber's Responsibilities

As required in DHS 107.10(3)(c), Wis. Admin. Code, when a prescription is for a BMN drug, the prescriber is required to write "brand medically necessary" in his or her own handwriting. This required statement may be handwritten either directly on the prescription or on a separate order attached to the original prescription. Typed certification, signature stamps, or certification handwritten by someone other than the prescriber does not satisfy this requirement. Blanket authorization for an individual member, drug, or prescriber is not acceptable documentation.

Prescribers are also required to complete a PA/BMNA for the BMN drug. The PA/BMNA must include accurate and complete answers and clinical information about the member's medical history and must include the prescriber's handwritten signature and date.

The PA/BMNA may be faxed or mailed to the pharmacy, or the member may carry the form with the prescription to the pharmacy. The pharmacy provider will use the completed PA/BMNA to submit a PA request to ForwardHealth. Prescribers should *not* submit the PA/BMNA to ForwardHealth.

Prescribers are required to retain a completed, signed, and dated copy of the PA form and any supporting documentation.

Clinical Criteria for Brand Medically Necessary Drugs

Clinical criteria for approval of a BMN drug include the following:

- The drug has been defined by ForwardHealth as a brand drug that requires BMN PA.
- The member has experienced an unsatisfactory therapeutic response or clinically significant adverse drug reaction with *at least two* different manufacturers of the generic equivalent drug.

For each generic trial the following must be documented:

- ✓ Generic drug manufacturer or National Drug Code (NDC). (*Note:* This information may come from the pharmacy or the prescriber.)
- ✓ Approximate dates taken. (*Note:* This information may come from the pharmacy or the prescriber.)
- ✓ A description of the unsatisfactory therapeutic response or clinically significant adverse drug reaction that can be directly attributed to the generic equivalent drug.
- The prescriber has indicated how the BMN drug will prevent recurrence of an unsatisfactory therapeutic response or clinically significant adverse drug reaction.
- The member has taken the requested BMN drug and had a measurable therapeutic response.

If the BMN PA request is for one of the following drugs, no generic trial or additional clinical information is required:

- Anticonvulsant used to treat a seizure disorder.
- CellCept.
- Coumadin.
- Neoral.
- Prograf.

If the prescriber determines that a member does not meet the clinical criteria for a BMN drug, the prescriber may change the prescription to an FDA-approved generic equivalent, when medically appropriate.

Brand Medically Necessary Drugs on the Preferred Drug List

All existing PDL policy will apply to BMN drug PA requests. This includes, but is not limited to, policy pertaining to drug classes that require step therapy, drugs that require clinical PA, and drugs that have non-preferred generic equivalents.

In addition to completing the PA/BMNA, the prescriber is required to complete any other required drug- or drug-class-specific PA form and provide any medical records and/or documentation required for the generic equivalent drug or applicable drug class. Examples include, but are not limited to, the following:

- A BMN drug, where its non-preferred generic equivalent requires a specific PA form.
- Drug or drug classes that require specific medical records and/or documentation to be submitted with the PA request.

For example, if a prescriber requests BMN PA for a brand drug and the non-preferred generic equivalent drug's PA criteria require the trial and failure of at least two PDL preferred drugs in the same drug class, this requirement must also be met before a PA request can be approved for the brand name drug.

Prescribers should review the Preferred Drug List Quick Reference for the most current list of preferred and non-preferred drugs.

A prescriber may change the prescription to a preferred drug if medically appropriate for the member, or the prescriber may choose to complete the appropriate PA forms.

Brand Medically Necessary Drugs: Pharmacy Provider's Responsibilities

Pharmacy providers are required to submit the completed PA/BMNA received from the prescriber and a completed PA/RF to ForwardHealth. Pharmacy providers may submit PA requests for BMN drugs on the Portal, by fax, or by mail. Prior authorization requests for BMN drugs may *not* be submitted via the STAT-PA system.

To obtain BMN PA, pharmacies are required to do the following:

- Obtain a prescription with "brand medically necessary" written in the prescriber's own handwriting either directly on the prescription or on a separate order attached to the original prescription.
- Receive the completed, signed, and dated PA/BMNA from the prescriber.
- Complete a PA/RF to be submitted with the PA/BMNA.

Documentation on the PA/BMNA regarding the generic drug manufacturers or NDCs and the dates the generic drugs were taken may come from the pharmacy or the prescriber.

Note: For appropriate reimbursement, pharmacy providers are required to submit claims with a "1" or "8" in the Dispense As Written/Product Selection Code Field, as appropriate.

Certain BMN drugs are available through expedited emergency supply. Providers may refer to the Expedited Emergency Supply Request Drugs data table on the Pharmacy page of the Providers area of the Portal or the Emergency Medication Dispensing topic (topic #1399) in the Covered Services and Requirements chapter of the Covered and Noncovered Services section of the Pharmacy service area of the Online Handbook.

ForwardHealth no longer requires pharmacy providers to submit a copy of the BMN prescription with the PA request. Pharmacy providers should retain the prescription with the prescriber's handwritten certification of "brand medically necessary" in their pharmacy records. Pharmacy providers are required to ensure all necessary documentation is obtained before submission of the PA request. Pharmacy providers who receive BMN PA for brand name drugs may be subject to audit at any time. Pharmacy providers are also required to retain a completed, signed, and dated copy of the PA forms and any additional supporting documentation received from the prescriber and produce it for and/or submit it to ForwardHealth upon request. ForwardHealth

may deny or recoup payment for claims submitted that do not meet BMN PA requirements.

For information about amending a BMN PA request, providers should refer to the Amendments topic (topic #431) in the Follow-Up to Decisions chapter of the Prior Authorization section of the Pharmacy service area of the Online Handbook.

Titration

A prescriber who titrates a BMN drug for a member may request more than one strength of the drug on a PA/BMNA form. The prescriber should include a prescription for each strength of the titrated BMN drug with the PA/BMNA form. Pharmacy providers should include the NDCs of all requested strengths of the drug on the PA/RF.

Hetlioz

Prior authorization requests for Hetlioz must be submitted using Section VI (Clinical Information for Drugs with Specific Criteria Addressed in the Online Handbook) of the Prior Authorization Drug Attachment (PA/DGA), F-11049 (10/13), and the PA/RF.

Prior authorization requests for Hetlioz may be submitted on the Portal, by fax, or by mail. Prior authorization requests for Hetlioz may *not* be submitted using the STAT-PA system.

ForwardHealth has established clinical criteria for Hetlioz.

Clinical Criteria for Hetlioz

Clinical criteria that must be documented for approval of a PA request for Hetlioz are both of the following:

- The member is totally blind.
- The member has Non-24-Hour Sleep-Wake Disorder (Non-24).

Clinical documentation and medical records must be submitted with the PA request to support the member's condition of total blindness and Non-24.

Initial PA requests for Hetlioz may be approved for up to a maximum of 183 days.

Renewal PA requests may be approved for up to a maximum of 365 days. Medical records must be submitted demonstrating clinical improvement and must reflect patient compliance with medication use and safety precautions for Hetlioz.

Misoprostol

Diagnosis restrictions will no longer apply to misoprostol.

Prior authorization requests for misoprostol must be submitted using Section VI (Clinical Information for Drugs with Specific Criteria Addressed in the Online Handbook) of the PA/DGA and the PA/RF.

Prior authorization requests for misoprostol may be submitted on the Portal, by fax, or by mail. Prior authorization requests for misoprostol may *not* be submitted using the STAT-PA system.

ForwardHealth has established clinical criteria for misoprostol.

Clinical Criteria for Misoprostol

Clinical criteria that must be documented for approval of a PA request for misoprostol are all of the following:

- The member is currently taking at least one nonsteroidal anti-inflammatory drug (NSAID).
- The member is not pregnant.
- Misoprostol is being prescribed to reduce the risk of a NSAID-induced gastrointestinal ulcer.

Misoprostol may be approved for up to a maximum of 365 days.

Note: ForwardHealth does not cover misoprostol when used in conjunction with gynecological procedures.

Xyrem®

New Prior Authorization Drug Attachment Form for Xyrem®

ForwardHealth has created a new form, the Prior Authorization Drug Attachment for Xyrem®, F-01430 (01/15). ForwardHealth has also revised the clinical information that must be documented on a PA request for Xyrem®. Prior authorization requests for Xyrem® will no longer be submitted using Section VI (Clinical Information for Drugs with Specific Criteria Addressed in the ForwardHealth Online Handbook) of the PA/DGA. Prior authorization requests for Xyrem® must be submitted using the Prior Authorization Drug Attachment for Xyrem® and a PA/RF.

Prior authorization requests for Xyrem® must be completed and signed by prescribers. Prior authorization requests received on and after January 1, 2015, must be submitted on the new form or they will be returned to the provider.

Prior authorization requests that have already been approved will be honored until they expire or until the approved days' supply is used up.

Prior authorization requests for Xyrem® may be submitted on the Portal, by fax, or by mail. Prior authorization requests for Xyrem® may *not* be submitted using the STAT-PA system.

Revised Clinical Criteria for Xyrem®

Diagnosis restrictions will no longer apply to Xyrem®.

Quantity limits will apply to Xyrem®. Members will be limited to a maximum nightly dose of 18 ml (9g) of Xyrem®, which is equivalent to 540 ml (270g) of Xyrem® per month. Providers may refer to the Quantity Limit Drugs and Diabetic Supplies data table on the Pharmacy page of the Providers area of the Portal for the most current quantity limits.

Prior authorization requests for Xyrem® will only be approved for use to treat the following identified clinical conditions:

- Narcolepsy with cataplexy.
- Narcolepsy without cataplexy.

Narcolepsy with Cataplexy

Clinical criteria for approval of a PA request for Xyrem® to treat narcolepsy with cataplexy are *all* of the following:

- The member has narcolepsy with cataplexy.
- The member is at least 16 years of age.
- The member does not have a succinic semialdehyde dehydrogenase deficiency.
- The member has a documented history of abstinence from alcohol for at least the past six months.
- The member does not have a history of substance abuse, addiction, or diversion.
- The member is not currently taking any sedative hypnotics.
- The member is not currently taking CNS depressants (i.e., anxiolytics, barbiturates, opioids) that could significantly impact daytime sleepiness.
- An overnight PSG sleep study and MSLT have been performed for the member using standard protocols, confirming the member has narcolepsy. (*Note:* Test results for the PSG and MSLT, along with provider interpretation, must be submitted with the PA request.)
- *At least one* of the following is true:
 - ✓ The member has experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction with a stimulant.
 - ✓ The member has a medical condition that prevents treatment with a stimulant.
 - ✓ There is a clinically significant drug interaction with another medication that the member is taking and a stimulant.
- *At least one* of the following is true:
 - ✓ The member has experienced an unsatisfactory therapeutic response that occurred after the medication has been titrated to a maximum recommended daily dose or experienced a clinically

significant adverse drug reaction with modafinil or Nuvigil®.

- ✓ The member has a medical condition that prevents treatment with modafinil or Nuvigil®.
- ✓ There is a clinically significant drug interaction with another medication that the member is taking and modafinil or Nuvigil®.
- The member has experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction to *at least one* of the following:
 - ✓ Tricyclic antidepressant (TCA).
 - ✓ Selective serotonin reuptake inhibitor (SSRI).
 - ✓ Serotonin norepinephrine reuptake inhibitor (SNRI).

Initial PA requests for Xyrem® to treat narcolepsy with cataplexy may be approved for up to a maximum of 183 days.

In addition to documenting the clinical information listed above on the Prior Authorization Drug Attachment for Xyrem®, medical records must be submitted with the PA request to support the member's condition of narcolepsy with cataplexy.

Renewal PA requests may be approved for up to a maximum of 365 days. Medical records must be submitted demonstrating clinical improvement, including a decrease in cataplexy or a decrease in the member's excessive daytime sleepiness (EDS). A decrease in a member's EDS must be supported by an Epworth sleepiness scale (ESS), maintenance of wakefulness test (MWT), or MSLT. Medical records must also reflect patient compliance with medication use and safety precautions for Xyrem®.

Narcolepsy Without Cataplexy

Clinical criteria for approval of a PA request for Xyrem® for a member with narcolepsy without cataplexy are *all* of the following:

- The member has narcolepsy without cataplexy.
- The member is at least 16 years of age.

- The member does not have a succinic semialdehyde dehydrogenase deficiency.
- The member has a documented history of abstinence from alcohol for at least the past six months.
- The member does not have a history of substance abuse, addiction, or diversion.
- The member is not currently taking any sedative hypnotics.
- The member is not currently taking CNS depressants (i.e., anxiolytics, barbiturates, opioids) that could significantly impact daytime sleepiness.
- An overnight PSG sleep study and MSLT have been performed for the member using standard protocols, confirming the member has narcolepsy. (*Note:* Test results for the PSG and MSLT, along with provider interpretation, must be submitted with the PA request.)
- The member has EDS that interferes with normal activities on a daily basis.
- An ESS questionnaire, MWT, or MSLT, has been performed for the member, confirming the member has EDS. (*Note:* Test results for the ESS, MWT, and/or MSLT must be submitted with the PA request.)
- The prescriber ruled out or treated the member for other causes of EDS, including:
 - ✓ Other sleep disorders including sleep apnea.
 - ✓ Chronic pain or illness that disrupts normal sleep patterns.
 - ✓ Mood disorders such as depression.
 - ✓ Caffeine or nicotine use causing poor quality of nighttime sleep.
- *At least one* of the following is true:
 - ✓ The member has experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction with a stimulant.
 - ✓ The member has a medical condition that prevents treatment with a stimulant.
 - ✓ There is a clinically significant drug interaction with another medication that the member is taking and a stimulant.
- *At least one* of the following is true:
 - ✓ The member has experienced an unsatisfactory therapeutic response that occurred after the

medication was titrated to a maximum recommended daily dose or a clinically significant adverse drug reaction with modafinil or Nuvigil®.

- ✓ The member has a medical condition that prevents treatment with modafinil or Nuvigil®.
- ✓ There is a clinically significant drug interaction with another medication that the member is taking and modafinil or Nuvigil®.

Initial PA requests for Xyrem® for a member with narcolepsy without cataplexy may be approved for up to a maximum of 183 days.

In addition to documenting the clinical information listed above on the Prior Authorization Drug Attachment for Xyrem®, medical records must be submitted with the PA request to support the member's condition of narcolepsy without cataplexy.

Renewal PA requests may be approved for up to a maximum of 365 days. Medical records must be submitted demonstrating clinical improvement, including a decrease in the member's EDS. A decrease in a member's EDS must be supported by an ESS, MWT, or MSLT. Medical records must also reflect patient compliance with medication use and safety precautions for Xyrem®.

Copayment and Dispensing Fee for Brand Name Drugs Preferred Over Generic Drugs

ForwardHealth generally applies a generic copayment and dispensing fee to a brand name drug when a drug that previously required BMN PA moves to a preferred drug on the PDL and the available generic equivalents are non-preferred drugs.

This does not include brand name drugs that were preferred over generic equivalents because the generic equivalents are new to the marketplace and not yet cost-effective when compared with brand pricing (i.e., a Maximum Allowed Cost rate has not been established).

For drugs determined to be included in this policy, ForwardHealth will automatically apply the generic copayment when a specific brand name drug is preferred over a generic equivalent. Providers do not need to indicate a National Council for Prescription Drug Programs Dispense as Written code on claims to ensure the generic copayment deduction. In addition, ForwardHealth will automatically apply a generic dispensing fee to claims for which a specific brand name drug is preferred over the generic equivalent.

The following table includes the most current list of drugs for which this policy applies. This list is available on the Preferred Drug List Quick Reference on the Portal.

Providers are encouraged to review the list closely to identify future changes.

Drug Class	Drug Name	Effective Date
Acne Agents	Differin cream	January 1, 2012
	Differin 0.1% gel	January 1, 2012
Anticonvulsants	Depakote Sprinkle	January 1, 2012
	Tegretol XR 200 mg	January 1, 2012
	Tegretol XR 400 mg	January 1, 2012
Antiemetics, Cannabinoids	Marinol	January 1, 2012
Antihypertensive, Miscellaneous	Catapres-TTS	January 1, 2014
Anticoagulants, Injectable	Lovenox	January 1, 2012
Beta Blockers	Toprol XL	July 1, 2011
Immunomodulators, Topical	Aldara™	January 1, 2014
Migraine Agents, Injectable	Imitrex injection	July 1, 2012
Migraine Agents, Other	Imitrex nasal spray	July 1, 2012

Drug Class	Drug Name	Effective Date
Ophthalmics Antibiotic/Steroid Combinations	Tobradex suspension	January 1, 2012
Ophthalmics, Glaucoma — Other	Alphagan P 0.15%	January 1, 2012
Stimulants and Related Agents	Adderall XR®	January 1, 2012
	Dexedrine Spansule	January 1, 2014

The *ForwardHealth Update* is the first source of program policy and billing information for providers.

Wisconsin Medicaid, BadgerCare Plus, SeniorCare, and Wisconsin Chronic Disease Program are administered by the Division of Health Care Access and Accountability, Wisconsin Department of Health Services (DHS). The Wisconsin AIDS Drug Assistance Program and the Wisconsin Well Woman Program are administered by the Division of Public Health, Wisconsin DHS.

For questions, call Provider Services at (800) 947-9627 or visit our Web site at www.forwardhealth.wi.gov/.

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Expedited Emergency Supply

As a result of changes made during the January 2015 PDL review, the Expedited Emergency Supply Request Drugs data table on the Pharmacy Resources page of the Providers area of the Portal has been updated. The Emergency Medication Dispensing topic (topic #1399) includes more information about dispensing an emergency supply of medication.

For More Information

Providers should refer to the Pharmacy service area of the Online Handbook on the Portal for more information about PDL policies.

Information Regarding Managed Care Organizations

This *Update* contains fee-for-service policy for members enrolled in Medicaid and BadgerCare Plus who receive pharmacy services on a fee-for-service basis only. Pharmacy services for Medicaid members enrolled in the Program of All Inclusive Care for the Elderly (PACE) and the Family Care Partnership are provided by the member's managed care organization. Medicaid and BadgerCare Plus HMOs must provide at least the same benefits as those provided under fee-for-service.

This *Update* was issued on 12/18/2014 and information contained in this *Update* was incorporated into the Online Handbook on 01/02/2015.

ATTACHMENT 1

Changes to Pharmacy Prior Authorization Forms and Completion Instructions

The table below lists the pharmacy prior authorization forms and completion instructions that are new or that have been revised, renamed, or discontinued as a result of the January 2015 Preferred Drug List review or as a result of other pharmacy policy changes. Providers should refer to the Forms page of the ForwardHealth Portal at www.forwardhealth.wi.gov/ for current copies of these forms and completion instructions. Unless otherwise noted, all form changes listed are effective January 1, 2015. The old versions of these forms and completion instructions will be moved to the Pharmacy-Related Forms and Completion Instructions archive page that is linked under the Archives section on the Pharmacy Resources page of the Portal. Additional information regarding changes to clinical criteria or submission options is noted under the applicable drug classes in this *ForwardHealth Update*.

Form Name	Form Number	Revised, Renamed, Discontinued, or New	Effective Date
Prior Authorization / Brand Medically Necessary Attachment (PA/BMNA)	F-11083	Revised	01/01/15
Completion Instructions	F-11083A	Revised	01/01/15
Prior Authorization Drug Attachment for Anti-Obesity Drugs	F-00163	Revised	01/01/15
Completion Instructions	F-00163A	Revised	01/01/15
Prior Authorization Drug Attachment for Modafinil and Nuvigil®	F-00079	Revised	01/01/15
Completion Instructions	F-00079A	Revised	01/01/15
Prior Authorization Drug Attachment for Xyrem®	F-01430	New	01/01/15
Completion Instructions	F-01430A	New	01/01/15

ATTACHMENT 2

Changes to the Preferred or Non-preferred Status of Drugs on the Preferred Drug List

The following table lists drugs that have had a change in their preferred or non-preferred status as a result of the January 2015 Preferred Drug List (PDL) review. The updated statuses are effective January 1, 2015. Drugs that have not been previously reviewed by the Medicaid Prior Authorization (PA) Advisory Committee are marked with an asterisk (*). The complete Preferred Drug List Quick Reference can be referenced on the Pharmacy Resources page of the Providers area of the ForwardHealth Portal at www.forwardhealth.wi.gov/.

Drug Class	Drug Name	Status Effective January 1, 2015
Alzheimer's Agents	Exelon® capsule	Non-preferred
Anticonvulsants	Aptiom®*	Non-preferred
	Fycompa™*	Non-preferred
	topiramate ER*	Non-preferred
Antidepressants, Other	Brintellix®*	Non-preferred
	desvenlafaxine ER*	Non-preferred
	desvenlafaxine fumarate ER*	Non-preferred
	Fetzima®*	Non-preferred
Antiparkinson's Agents	carbidopa*	Non-Preferred
Antipsoriatics, Topical	calcipotriene/betamethasone ointment*	Non-preferred
Antipsychotics	Adasuve®*	Non-preferred
	Versacloz™*	Non-preferred
Bronchodilators, Beta Agonist	Striverdi Respimat*	Non-preferred
COPD Agents	Anoro Ellipta*	Non-preferred
Cough and Cold, Narcotics	PSE/hydrocodone/chlorpheniramine solution*	Non-preferred
Cytokine and CAM Antagonists	Actemra® syringe*	Non-preferred
	Otezla®*	Non-preferred
Glucocorticoids, Inhaled	Advair HFA	Non-preferred
	Aerospan*	Non-preferred
Glucocorticoids, Oral	budesonide EC*	Non-preferred
	Cortef*	Non-preferred
	cortisone*	Non-preferred
	dexamethasone elixir*	Preferred
	dexamethasone intensol*	Preferred
	dexamethasone solution*	Preferred
	dexamethasone tablet*	Preferred

Drug Class	Drug Name	Status Effective January 1, 2015
	dexpak*	Non-preferred
	Entocort® EC*	Preferred
	Flo-Pred*	Non-preferred
	hydrocortisone*	Preferred
	Medrol tablet*	Non-preferred
	methylprednisolone tablet*	Preferred
	millipred DP tab DS PK*	Non-preferred
	millipred solution*	Non-preferred
	millipred tablet*	Non-preferred
	Orapred ODT*	Preferred
	pediapred*	Non-preferred
	prednisolone solution*	Preferred
	Prednisone intensol*	Preferred
	prednisone solution*	Preferred
	prednisone tab DS PK*	Preferred
	prednisone tablet*	Preferred
	prenisolone sodium phosphate*	Preferred
	Rayos tablet DR*	Non-preferred
veripred 20*	Non-preferred	
Neuropathic Pain (Analgesics/Anesthetics Topical and Fibromyalgia)	duloxetine*	Preferred
	lidocaine*	Non-preferred
	Pennsaid pump*	Non-preferred
NSAIDS	etodolac	Non-preferred
	fenoprofen*	Non-preferred
	Indocin suppository	Non-preferred
	piroxicam	Non-preferred
	zorvolex*	Non-preferred
Ophthalmic Antibiotic/Steroid Combinations	gatifloxacin*	Non-preferred
Ophthalmic Anti-inflammatories	prednisolone SOD phosphate	Preferred
Otic Antibiotics	Ciprodex®	Non-preferred
Steroids, Topical — High Potency	betamet diprop/prop gly cream	Non-preferred
	betamet diprop/prop gly lotion	Non-preferred
	betamet diprop/prop gly ointment	Non-preferred
	betamethasone dipropionate cream	Non-preferred
	betamethasone dipropionate gel	Non-preferred
	betamethasone dipropionate lotion	Non-preferred
	betamethasone dipropionate ointment	Non-preferred
	triamcinolone acetonide	Preferred

Drug Class	Drug Name	Status Effective January 1, 2015
Steroids, Topical — Low Potency	acclometasone dipropionate cream	Non-preferred
	acclometasone dipropionate ointment	Non-preferred
Steroids, Topical — Medium Potency	clocortolone cream*	Non-preferred
	hydrocortisone valerate cream	Non-preferred
	hydrocortisone valerate ointment	Non-preferred
Steroids, Topical — Very High Potency	halobetasol propionate cream	Preferred
	halobetasol propionate ointment	Preferred
Stimulants and Related Agents	clonidine ER*	Non-preferred
	dexmethylphenidate XR*	Non-preferred

* Drug was not previously reviewed. For more information, refer to the Changes to the Preferred or Non-preferred Status of Drugs on the Preferred Drug List section of this *ForwardHealth Update*.