CALCIUM CHANNEL BLOCKERS

Introduction

The Drug Formulary Committee (DFC) met on June 3, 2003 and reviewed the calcium-channel blockers (CCBs). The DFC recommended that **generic** diltiazem, nifedipine and verapamil products and the brand name products Norvasc and Nimotop be the preferred CCBs. The manufacturers of nisoldipine (Sular) and isradipine (DynaCirc) have subsequently signed a supplemental rebate agreement. All other single entity CCBs require prior authorization. The **non**preferred CCBs are bepridil (Vasco), nicardipine (Cardene), felodipine (Plendil), and **brand-name** diltiazem, nifedipine and verapamil products.

Preferred calcium channel blockers (do not require authorization)

- Amlodipine (Norvasc)
- Diltiazem, generic products*
- Isradipine (Dynacirc)*
- Nifedipine, generic products*
- Nimodipine (Nimotop)
- Nisoldipine (Sular)*
- Verapamil, generic products*

* While all of the above agents are preferred, these are the most cost-effective drugs.

Nonpreferred calcium channel blockers (require authorization)

- Bepridil (Vasco)
- Diltiazem, brand name products. (Cardizem, Cardizem CD, Cardizem SR, Tiazac, DilaCor XR).
- Felodipine (Plendil)
- Nicardipine (Cardene, Cardene SR)
- Nifedipine, brand name products. (Adalat, Adalat CC, Procardia, Procardia XL)
- Verapamil, brand name products. (Calan, Calan SR, Covera HS, Verelan and Verelan HS).

Authorization criteria

- **Brand name diltiazem, nifedipine and verapamil products.** Authorization may be granted only if use of the brand name product is medically necessary. Examples of valid reasons: patient is allergic to an inactive ingredient in the generic product, patient has had a documented failure on a generic product. Patient needs to fail on only one generic product.
- **Bepridil, felodipine, isradipine, nicardipine.** Authorization will be granted only if the patient has had documented failures on at least two preferred calcium channel blockers. Failure can be due to either lack of efficacy or adverse reaction.
The DFC reviewed this new antiemetic and recommended the following prior authorization criteria, which will be effective August 1, 2003:

- Authorization is required from the first day of therapy. (Unlike the 5-HT3 receptor antagonists such as Zofran, which can be used for four weeks before requiring authorization).
- Authorization will be granted for nausea and vomiting due to highly or very highly emetogenic chemotherapy. Authorization will also be granted for less emetogenic chemotherapy if the recipient has failed other antiemetics.
- Quantity dispensed should not exceed the amount recommended in the package insert. (Maximum quantity limits have been placed in the billing system drug files).

**Highly emetogenic chemotherapy**

This table lists chemotherapy agents by emetogenic potential.

**Emetogenic Potential of Cancer Chemotherapy Agents***

**Very Highly Emetogenic**
- Cisplatin
- Mechlorethamine
- Cytarabine ($> = 500 \text{ mg/m}^2$)
- Melphalan IV
- Dacarbazine
- Streptozocin
- Ifosfamide

**Highly Emetogenic**
- Carmustine
- Etoposide ($> = 500 \text{ mg/m}^2$)
- Carboplatin
- Lomustine
- Cyclophosphamide
- Methotrexate ($> = 200 \text{ mg/m}^2$)
- Dactinomycin
- Thiotepa ($> = 15 \text{ mg/m}^2$)

**Moderately Emetogenic**
- Cytarabine (200-500 mg/m$^2$)
Mitomycin
Daunorubicin
Plicamycin
Doxorubicin
Vinblastine
Idarubicin

**Low Emetogenic Risk**
Azathioprine
L-Asparaginase
BCG Vaccine
Leuprolide acetate
Bleomycin
Levamisole
Busulfan
Megestrol
Chlorambucil
Melphalan (oral)
Cladribine (2-CDA)
Mercaptopurine
Cytarabine (< 200 mg/m²)
Methotrexate (< 200 mg/m²)
Etoposide
Mitotane
Floxuridine
Mitoxantrone
Fludarabine
Paclitaxel
Fluorouracil
Tamoxifen
Fluoxymesterone
Teniposide
Flutamide
Thioguanine
Hydroxyurea
Thiotepa (< 15 mg/m²)
Interferon, Alfa-2
Vincristine

*The specific dose, duration of infusion, the concurrent use of other emetogenic agents, among other factors, will influence this predicted risk.*
Introduction

The Drug Formulary Committee (DFC) met on June 3, 2003 and reviewed the cost-effectiveness of different strengths of fluoxetine. Two 20mg capsules of generic fluoxetine are considerably cheaper than one 40mg capsule. Consequently, the DFC recommended that 40mg fluoxetine capsules require authorization.

Fluoxetine authorization criteria

- Fluoxetine 10mg and 20mg capsules should be used whenever possible. For example:

<table>
<thead>
<tr>
<th>DOSE</th>
<th>CAPSULES TO USE</th>
</tr>
</thead>
<tbody>
<tr>
<td>40mg</td>
<td>two 20mg capsules</td>
</tr>
<tr>
<td>50mg</td>
<td>two 20mg capsules and a 10mg capsule</td>
</tr>
<tr>
<td>60mg</td>
<td>three 20mg capsules</td>
</tr>
<tr>
<td>70mg</td>
<td>three 20mg capsules and a 10mg capsule</td>
</tr>
<tr>
<td>80mg</td>
<td>authorize 40mg capsules</td>
</tr>
</tbody>
</table>

- The use of fluoxetine 40mg capsules can be authorized if the dose is 80mg or greater.
- The use of fluoxetine 40mg capsules can also be authorized if the patient and/or caregiver can’t comprehend the concept of taking two capsules instead of one.
Xenical (Orlistat)
Prior Authorization Criteria

Current Status
Xenical is covered through the prior authorization program only for the following criteria. The use of Xenical may be authorized for the treatment of hyperlipidemia if the patient has failed on at least one drug from each of the following categories:
- HMG-CoA reductase inhibitors Lipitor, Lescol, Mevacor, Pravachol, and Zocor.
- Bile acid sequestrants Questran (cholestyramine), WelChol (colesevelam HCL), and Colestid (colestipol).
- Fibric acid derivatives Atromid-S (clofibrate), Tricor (fenofibrate), and Lopid (gemfibrozil).
- Niacin (Niacor, Niaspan, SloNiacin and others).
- Zetia (ezetimibe).

The authorization criteria was reviewed by the DFC February 2004 and now includes:
Medically necessary lipase inhibitors may be covered for a patient with type 2 diabetes when
- The patient is obese [defined as body mass index (BMI) ≥27] AND
- the patient is at least 12 years old AND
- the patient is receiving individualized dietary advice in conjunction with individualized advice on the need for increased physical activity

THEN
- If the patient has had previous positive response to Xenical [defined as a reduction in weight loss of ≥5% initial body weight and a reduction in HbA1c ≥0.5%], authorization may be granted for up to 12 months

OR
- If the patient has no history of Xenical use, then initial authorization may be granted for up to 6 months. Subsequent authorization will be granted only if the patient has had a positive response, including both weight loss and improvement of diabetic markers.

AND
- Authorization will not be granted if patient has already tried and failed Xenical.
Drugs that are part of this authorization intervention: Celexa 10mg and 20mg, Lexapro 10mg, Paxil 10mg, Provigil 100mg, and Zoloft 25mg and 50mg.
Tablet Splitting Authorization Form

Please have this information available before calling or faxing Care Delivery Management, Inc. (CDMI)
CDMI telephone hours: Monday-Friday from 8:00AM to 4:30PM. Metro: (651) 662-5275. Outstate: 1-800-382-2000, extension 25275. Fax: (651) 662-7459

<table>
<thead>
<tr>
<th>Pharmacy</th>
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<tr>
<td>Prescriber name</td>
<td>Prescriber Provider Number</td>
<td>Prescription Number</td>
</tr>
<tr>
<td>Drug name &amp; strength</td>
<td>NDC</td>
<td>Directions</td>
</tr>
<tr>
<td>Start date</td>
<td>Number of refills</td>
<td>Quantity</td>
</tr>
<tr>
<td>Recipient name</td>
<td>Recipient ID number</td>
<td>Recipient Date-of-birth</td>
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Medication for which this request is being made:

Reason that authorization is being requested:

Other relevant information:

Notes:
1. Celexa 10mg and 20mg, Lexapro 10mg, Paxil 10mg, Provigil 100mg and Zoloft 25mg and 50mg tablets require authorization. Authorization won't usually be granted unless the required dose can't be obtained using a higher strength tablet, splitting the tablet in half. Authorization will also be granted if the recipient or caregiver can't comprehend the tablet splitting process.
2. Pharmacists may dispense up to a 72 hour supply of the prescribed drug when CDMI staff is off duty. CDMI is allowed to authorize up to a 72 hour supply in that situation, even if PA criteria are not met. However, additional supplies will not be authorized if PA criteria are not met.
3. You may wish to make copies of this form. You may also obtain additional copies by calling the Provider Help Desk at (651) 282-5545 or 1-800-366-5411
MINNESOTA DEPARTMENT OF HUMAN SERVICES

ACE Inhibitor Authorization Criteria Algorithm

Is the medication captopril, enalapril, lisinopril, moexipril or ramipril? —yes → No PA is required.

↓
No
↓

Has the patient failed on at least two of the preferred agents? —yes → PA may be granted.

↓
No
↓

Has the patient failed a trial of any ACE inhibitor and subsequently had a successful trial of a non-preferred agent?

↓
Yes
↓

Approve PA for the agent to which the patient has responded.

↓
No
↓

Deny PA. Patient must fail trials of at least two of the preferred ACE inhibitors.

Please note: ramipril (Altace) is considerably more expensive than other preferred ACE inhibitors. DHS recommends that the use of ramipril be reserved for patients 55 years of age or older with previous cardiovascular (CV) disease or diabetes plus one other risk factor for CV disease.
# ACE Inhibitor Authorization Form

Please have this information available before calling or faxing Care Delivery Management, Inc. (CDMI)
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</table>

## Diagnoses

**Past trials on other related drugs:**

**List other medications recipient is currently taking:**

**Other relevant information:**

### Notes:

1. Generic captopril, enalapril, and lisinopril plus moexipril (Univasc) and ramipril (Altace) are preferred and do not require prior authorization. Their use is encouraged.
2. Pharmacists may dispense up to a 72 hour supply of the prescribed ACE Inhibitor when CDMI staff is off duty. CDMI is allowed to authorize up to a 72 hour supply in that situation, even if PA criteria are not met. However, additional supplies will not be authorized if PA criteria are not met.
3. You may wish to make copies of this form. You may also obtain additional copies by calling the Provider Help Desk at (651) 282-5545 or 1-800-366-5411
Second Generation Antihistamine Authorization Form

Minnesota Department of Human Services

Please have this information available before calling or faxing Care Delivery Management, Inc. (CDMI)
CDMI telephone hours: Monday-Friday from 8:00AM to 4:30PM. Metro: (651) 662-5275. Outstate: 1-800-382-2000, extension 25275. Fax: (651) 662-7459

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Diagnoses (include any relevant allergy diagnoses):

Past trials on other second generation antihistamines or other therapies for allergies:

List other medications recipient is currently taking:

Other relevant information:

Notes:
1. OTC loratadine products are preferred and do not require prior authorization. Their use is encouraged.
2. Pharmacists may dispense up to a 72 hour supply of the prescribed second generation antihistamine when CDMI staff is off duty. CDMI is allowed to authorize up to a 72 hour supply in that situation, even if PA criteria are not met. However, additional supplies will not be authorized if PA
3. You may wish to make copies of this form. You may also obtain additional copies by calling the Provider Help Desk at (651) 282-5545 or 1-800-366-5411