NEW YORK STATE | Department of Health

NYRx, the Medicaid Pharmacy Program

Preferred Drug Program
PDP/PDL

Preferred Drug Program (PDP)

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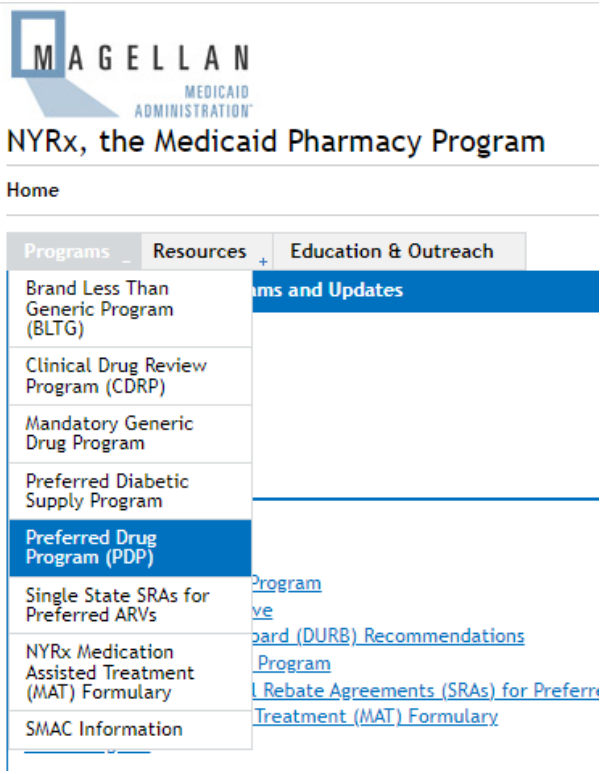

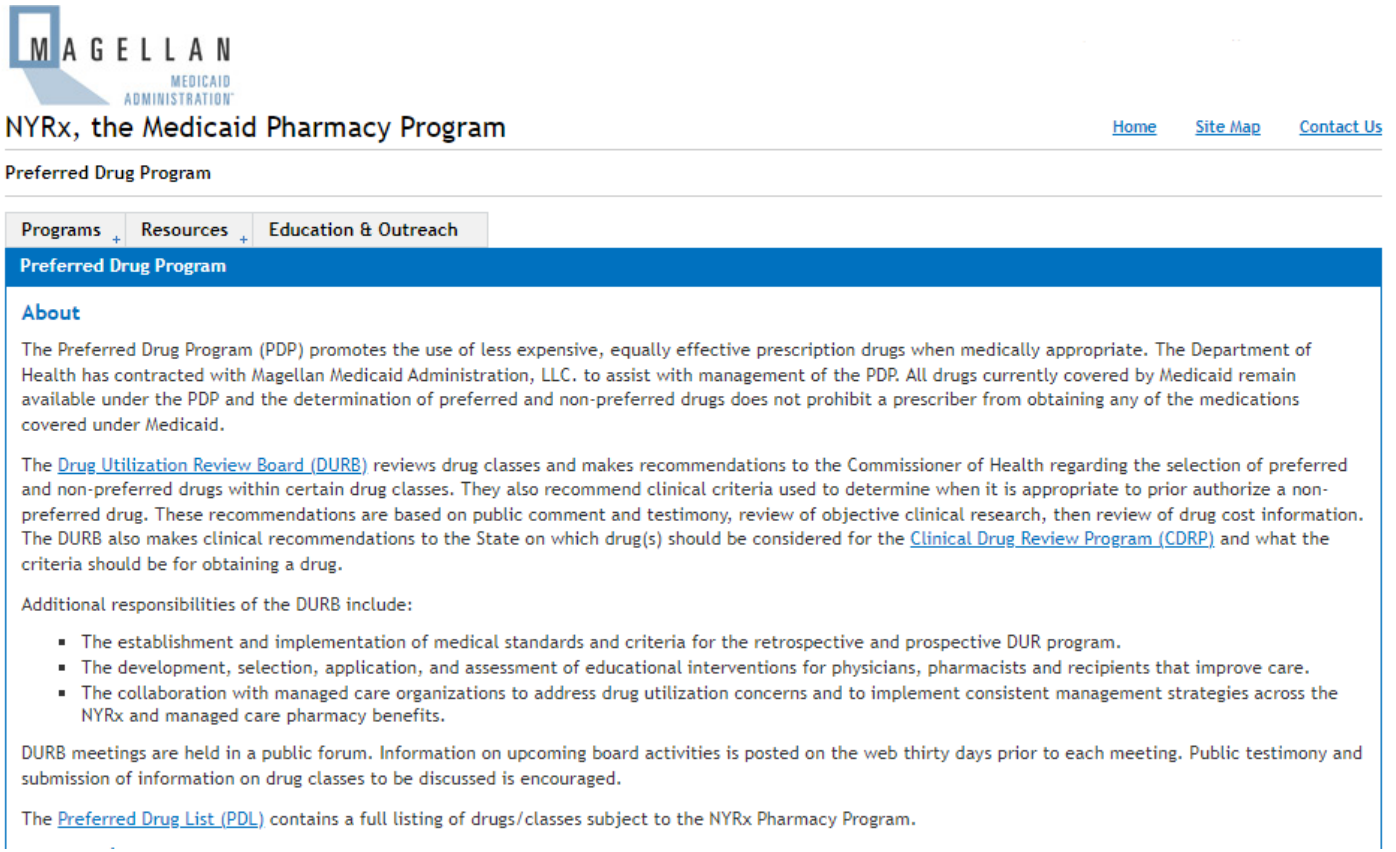

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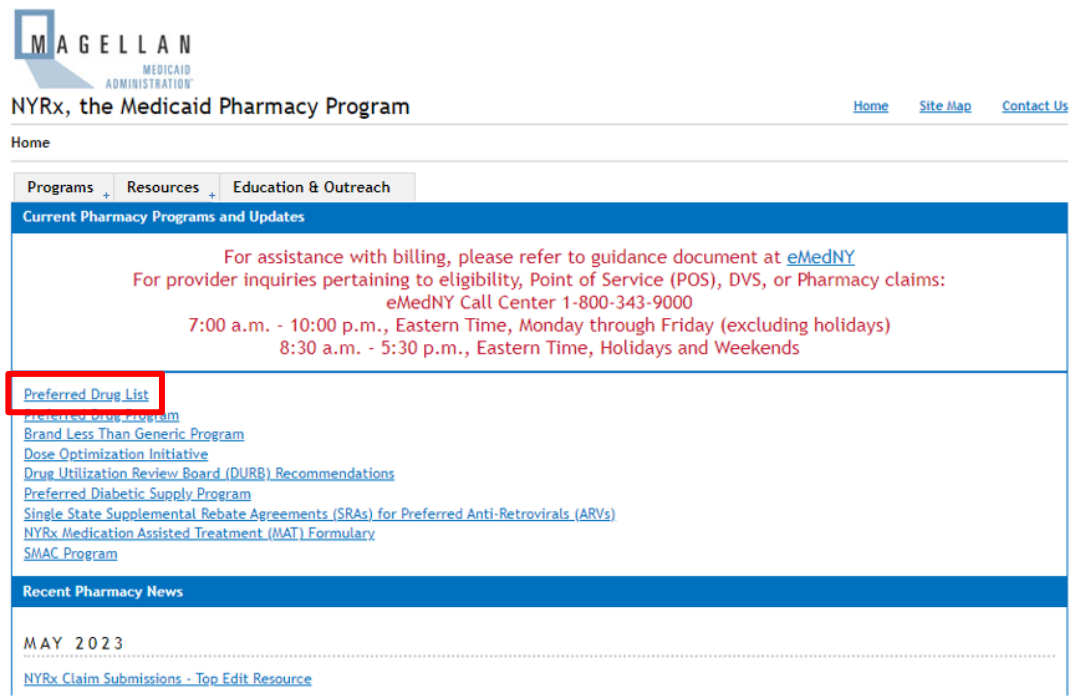
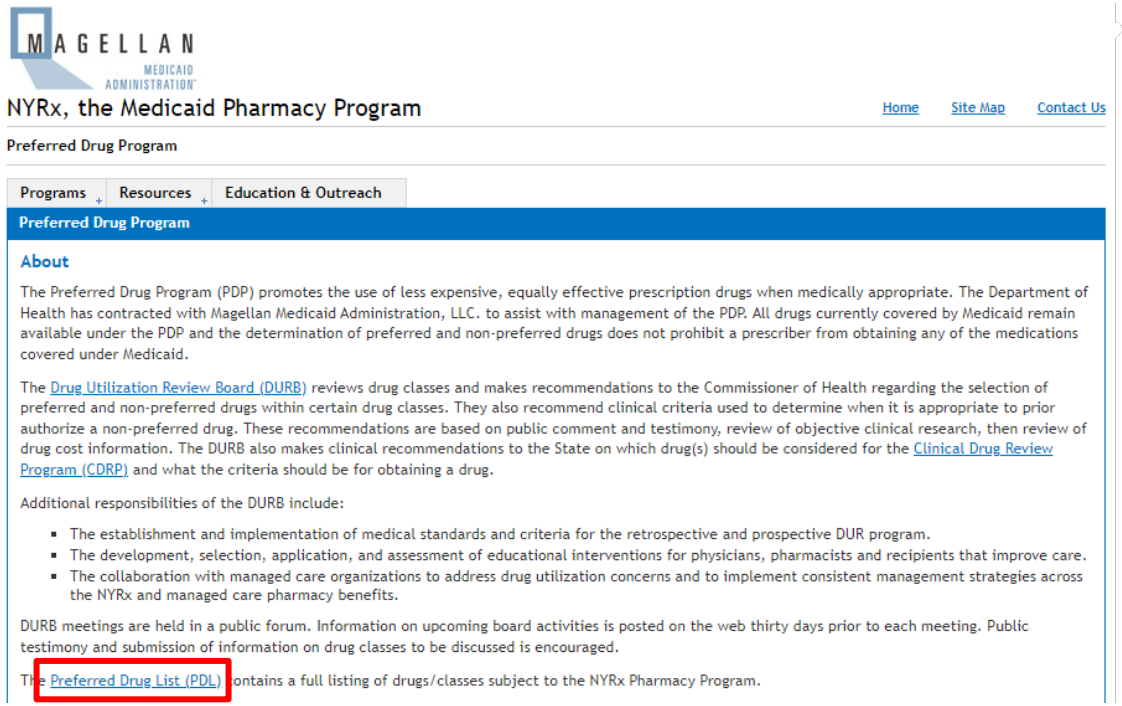
Preferred Drug Program (PDP)

The Preferred Drug Program (PDP) promotes the use of less expensive, equally effective drugs in specific drug classes when medically appropriate. Drugs subject to the PDP are listed on the NYRx Preferred Drug List (PDL). All drugs currently covered by NYRx remain available under the PDP and the determination of preferred and non-preferred does not prohibit a prescriber from obtaining any of the medications covered by NYRx.

- Non-preferred drugs in these classes require prior authorization (PA) unless indicated otherwise.
- Some drugs and drug classes, regardless of preferred or non-preferred status, are subject to additional NYRx programs such as Drug Utilization Review (DUR), Dose Optimization (DO) or Brand Less than Generic (BLTG).
- Note that not all agents covered by NYRx are listed on the PDL. For a complete list of drugs covered by NYRx, visit the Medicaid Pharmacy List of Reimbursable Drugs.

Preferred Drug List (PDL)





Preferred Drug List (PDL) Criteria Requirements

- The Preferred Drug List (PDL) is organized by therapeutic category and drug class. Within each drug class are preferred and non-preferred drugs.
- Drugs or drug classes may be subject to DUR clinical criteria such as age or diagnosis, frequency/quantity/duration, step therapy, or the dose optimization or BLTG program.
- These criteria requirements are listed in the "Prior Authorization/Coverage Parameters" column of the PDL.
- These requirements are indicated in the PDL with an abbreviated-red superscript.

CC = Clinical Criteria

F/Q/D = Frequency/Quantity/Duration

DO = Dose Optimization

ST = Step Therapy

BLTG = Brand-Less-than-Generic

Preferred Drug List (PDL) Superscripts

If the criteria apply to all the drugs in the drug class, the criteria type will appear as a red superscript next to the drug class name.

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
IV. Central Nervous System		
Antimigraine Agents, Othe ST, F/Q/D		
Ajovy® Emgality® Nurtec™ ODT	Aimovig® Emgality® 100mg syringe Qulipta™ Reyvow™ Ubrelvy™	STEP THERAPY (ST) Acute treatment of migraine • Trial of a product from the Antimigraine Agents-Triptan class Prevention of migraine • Trial of 2 FDA approved or compendia supported migraine prevention products from other drug classes

Agent	F/Q/D
Aimovig	1 syringe/30 days

If the criteria apply only to specific drugs within a drug class, the red superscript will appear next to the drug name.

Selective Serotonin Reuptake Inhibitors (SSRIs)		
citalopram (tablet, solution) escitalopram (tablet) fluoxetine (capsule, solution) paroxetine (tablets) sertraline (tablets, concentrate)	Celexa® citalopram (capsules) escitalopram (soln) fluoxetine (tablet) fluoxetine DR weekly fluvoxamine CC fluvoxamine ER CC Lexapro® QQ paroxetine (capsules) paroxetine CR	DOSE OPTIMIZATION (DO) • See Dose Optimization Chart for affected strengths CLINICAL CRITERIA (CC) • Clinical editing will allow patients currently stabilized on fluvoxamine or fluvoxamine ER to continue to receive that agent without PA • Clinical editing to allow patients with a diagnosis of Obsessive-Compulsive Disorder (OCD) to receive fluvoxamine and fluvoxamine ER without prior authorization

Clinical Criteria (CC)

- Diagnosis
- Age restrictions
- Review of concurrent medications, disease states, and possible contraindications

Hepatitis C Agents – Direct Acting Antivirals		
Mavyret™ CC, F/Q/D ribavirin sofosbuvir/velpatasvir (generic for Epclusa®) CC, F/Q/D Vosevi® CC, F/Q/D	Epclusa® CC, F/Q/D Harvoni® CC, F/Q/D ledipasvir/sofosbuvir (generic for Harvoni®) CC, F/Q/D Sovaldi® CC, F/Q/D Viekira Pak® CC, F/Q/D Zepatier® CC, F/Q/D	**CLINICAL CRITERIA (CC)** • Confirm diagnosis of FDA-approved or compendia-supported indication • For patients being retreated require confirmation of patient readiness and adherence – Evaluation by using scales or assessment tools readily to determine a patient's readiness to initiate HCV treatment, specifically drug and alcohol abuse potential. Assessment tools are available to healthcare practitioners at: https://www.drugabuse.gov/nidamed-medical-health-professionals/screening-tools-resources/chart-screening-tools – OR https://prepc.org/. • The optional Hepatitis C Worksheet can be accessed at: https://newyork.fhsc.com/downloads/providers/NYRx_PDP_PA_Worksheet_Prescribers_HepC.pdf

Frequency/Quantity/Duration (F/Q/D)

Frequency/Quantity/Duration (F/Q/D) criteria specify how often, how much, or how long a product may be used.

Antimigraine Agents – Triptans

rizatriptan F/Q/D sumatriptan F/Q/D	almotriptan F/Q/D eletriptan F/Q/D Frova® F/Q/D frovatriptan F/Q/D Imitrex® F/Q/D Maxalt® F/Q/D Maxalt® MLT F/Q/D naratriptan F/Q/D Onzetra™ Xsail™ F/Q/D Relpax® sumatriptan-naproxen F/Q/D Tosymra™ F/Q/D Treximet® F/Q/D	**FREQUENCY/QUANTITY/DURATION (F/Q/D)**

Agent	F/Q/D
Onzetra™ Xsail™ 11 mg	16 units / 30 days
almotriptan eletriptan (Relpax®) frovatriptan (Frova®) naratriptan rizatriptan (Maxalt®) rizatriptan (Maxalt® MLT) sumatriptan nasal spray (Imitrex®) sumatriptan (Imitrex®)	18 units / 30 days

Step Therapy (ST)

The step therapy parameters have been initiated to ensure clinically appropriate and cost-effective use of these drugs and drug classes.

	Novolog® cartridge, vial, FlexPen	
Meglitinides ST		
nateglinide repaglinide	repaglinide/ metformin	**STEP THERAPY (ST)** • Requires a trial with metformin with or without insulin prior to initiating meglitinide therapy unless there is a documented contraindication.
Pancreatic Enzymes		
Creon® Zenpep®	Pertzye® Viokace®	
Sodium Glucose Co-Transporter 2 (SGLT2) Inhibitors ST		
Farxiga® Invokana® Jardiance®	Invokamet® Invokamet® XR Segluromet® Steglatro® Synjardy® Synjardy® XR Trijardy® XR Xigduo® XR	**STEP THERAPY (ST)** • Requires a trial with metformin with or without insulin prior to initiating SGLT2 Inhibitor therapy unless there is a documented contraindication. • Farxiga® (dapagliflozin), Jardiance® (empagliflozin) – Requires a trial with metformin with or without insulin prior to initiating SGLT2 Inhibitor therapy, unless there is a documented contraindication or drug is being used for an FDA-approved indication other than Type 2 Diabetes or related.

Dose Optimization (DO)

- Dose optimization can reduce prescription costs by reducing the number of pills a patient takes each day.
- The Department has identified drugs to be included in this program, the majority of which have FDA approval for once-a-day dosing, have multiple strengths available in correlating increments at similar costs, and are currently being prescribed above the recommended dosing frequency.

Dose Optimization Chart

Brand Name	Dose Optimization Limitations		
CARDIOVASCULAR			
	Angiotensin Receptor Blockers (ARBs)		
Benicar® 20 mg	1 daily	Tablet	
Micardis® 20 mg, 40 mg	1 daily	Tablet	
Diovan® 40 mg, 80 mg, 160 mg	1 daily	Tablet	
	Antiarrhythmics		
Amiodarone 100 mg	1 daily	Tablet	In case of dose titration for these medications, the department will allow for multiday dosing (up to 2 doses daily) for loading dose for 30 days
	ARBs Combinations		
Exforge® 5–160mg	1 daily	Tablet	
	ARBs/Diuretics		
Benicar® HCT 20–12.5 mg	1 daily	Tablet	
Diovan® HCT 80–12.5 mg, 160–12.5 mg	1 daily	Tablet	
Edarbyclor® 40–12.5 mg	1 daily	Tablet	
Micardis® HCT 40–12.5 mg, 80–12.5 mg	1 daily	Tablet	