



EqualityCare Pharmacy News

Dear Providers:

August 3, 2010

Please see below for the following changes to Wyoming EqualityCare:

PREFERRED DRUG LIST - IMMUNOMODULATORS:

(Effective Date 08/25/2010)

THERAPEUTIC CLASS	PREFERRED AGENTS	CLINICAL CRITERIA
IMMUNOMODULATORS	ENBREL 25MG/ML HUMIRA	<p>A 60-day trial and failure of methotrexate will be required prior to approval for <u>Enbrel</u> and <u>Humira</u> if the client has a diagnosis of <u>rheumatoid arthritis</u>.</p> <p>Diagnosis for approved indication (as follows) is required prior to approval for preferred agents:</p> <ul style="list-style-type: none"> • <u>Enbrel</u>: ankylosing spondylitis (AS), juvenile idiopathic arthritis (JIA), plaque psoriasis (PP), psoriatic arthritis (PA), rheumatoid arthritis (RA) • <u>Humira</u>: AS, Crohn's, JIA, PP, PA, RA.
	NON-PREFERRED AGENTS	CLINICAL CRITERIA
		<p>Trial and failure of ONE preferred agent will be required prior to approval for a non-preferred agent.</p> <p><u>Remicade</u> will be allowed without a preferred trial for diagnosis of <u>ulcerative colitis ONLY</u>.</p> <p><u>Cimzia</u> will be allowed without a preferred trial for diagnosis of <u>Crohn's ONLY</u>.</p> <p>Diagnosis for approved indication (as follows) is required prior to approval for non-preferred agents:</p> <ul style="list-style-type: none"> • <u>Amevive</u>: PP • <u>Cimzia</u>: RA, Crohn's • <u>Kineret</u>: RA • <u>Orencia</u>: JIA, RA • <u>Raptiva</u>: PP • <u>Remicade</u>: AS, Crohn's, PP, PA, RA, Ulcerative colitis • <u>Rituxan</u>: RA • <u>Simponi</u>: AS, PA, RA • <u>Tysabri</u>: Crohn's <p>* Additional PA criteria may apply as with Multiple Sclerosis (MS)</p>

HYOSCYAMINE/PHENAZOPYRIDINE

The Wyoming EqualityCare **Pharmacy** Program **DISCONTINUED** covering the products below. The Food and Drug Administration (FDA) has determined that these are unapproved new drugs within the meaning of Section 301(a) and Section 505(a) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 331(a) and (d) and 355(a) and the drugs are misbranded in violation of Section 502(f)(1) of the Act (21 U.S.C. 352(f)1()), subject to enforcement action, and cannot be marketed without appropriate FDA approval. According to the FDA, these products do not have approved applications; therefore, the Center for Medicare and Medicaid Services (CMS) has determined that certain National Drug Codes (NDC) do not meet the definition of a covered outpatient drug as defined in Section 1972(k) of the Social Security Act and are subsequently no longer eligible for inclusion in the rebate program.

PRODUCT NAME/STRENGTH	NDC
HYOSCYAMINE SULFATE DROPS (15 ML)	00603-1314
HYOSCYAMINE SULFATE LIQUID (16 OZ)	00603-1315
PHENAZOPYRIDINE HCl (0.1G) TABLETS	00603-5141
PHENAZOPYRIDINE HCl (0.2G) TABLETS	00603-5142

MISCELLANEOUS

- **ENBREL 25MG/ML** Will be **preferred** with criteria. Enbrel 25mg/0.5mL is no longer preferred; clients must use Enbrel 25mg/mL.
- **LOVAZA** Will be **non-preferred**.
- **STRATTERA** In addition to current criteria and dosing limit, Strattera will be limited to a quantity of one (1) tablet per day. Please refer to the Preferred Drug List (PDL) for additional criteria.
- **VENLAFAXINE ER TABS/CAPS** Venlafaxine ER TABLETS will remain a step 2 antidepressant. Venlafaxine ER CAPSULES will be a step 3 antidepressant. Please refer to the PDL.
- **XIFAXAN** **XIFAXAN 200MG** - Client must have diagnosis of traveler's diarrhea.
XIFAXAN 550MG - Client must be \geq 18 years of age and have a diagnosis of reduction in risk of overt hepatic encephalopathy recurrence.

PAYMENT TO PROVIDERS – MANDATORY EFT

ALL pharmacy providers **MUST** be enrolled in Electronic Funds Transfer (EFT) to receive payment. As of **August 1, 2010**, Wyoming EqualityCare will no longer issue paper checks. If you have not signed up to receive EFT payment or if you have any questions regarding EFT payments, please contact GHS at (877) 205-8083 x 1051.