July 2008, Volume 1, Issue 4

THE PRESCRIBER E-LETTER

MassHealth PHARMACY PROGRAM

Intranasal Corticosteroids

Intranasal corticosteroids are FDA-approved for the treatment of allergic rhinitis, nasal polyps, and nonallergic rhinitis. A lack of evidence supporting the use of one intranasal corticosteroid over another resulted in the development of a step-therapy program.

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New prior-authorization (PA) requirements for intranasal corticosteroids are effective with dates of service on or after July 15, 2008. PA requirements for individual products are outlined below.

No PA Required:

- Generic formulations of flunisolide 0.025%, flunisolide 29 mcg, and fluticasone propionate
- Nasonex (members <4 years of age)

PA Required:

- Beconase AQ
- Flonase
- Nasacort AQ
- Nasarel
- Nasonex (members ≥4 years of age)
- Omnaris
- Rhinocort Aqua
- Veramyst

Age-Related Requirements:

- Nasonex and Veramyst are the only agents approved in patients aged 2 and older. Fluticasone propionate is approved for patients aged 4 and older. Therefore, Nasonex is available without PA for patients under the age of 4.
- All other intranasal corticosteroids are approved for patients aged 6 and older. These members will be required, unless contraindicated, to have a trial of flunisolide and fluticasone propionate.

Note: All inhalers have a quantity limit of one inhaler per month, except Rhinocort Aqua, which has a quantity limit of one inhaler every two months, based on manufacturer recommended doses. MassHealth will continue to require PA for requests that exceed the quantity limit.

Aldara (Imiquimod)

Imiquimod and **fluorouracil** are indicated for the treatment of actinic keratoses (AK) and superficial basal cell carcinoma (sBCC). In addition, imiquimod and **podofilox** are indicated for the treatment of external genital and perianal warts. Clinical guidelines for the treatment of AK, sBCC, and external genital or perianal warts do not specifically recommend the use of one product over another. Additionally, clinical trials have demonstrated comparable efficacy and safety among imiquimod, fluorouracil, and podofilox. Given these considerations, a guideline for the use of imiquimod was developed.

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New PA requirements for **Aldara** (imiquimod) are effective with dates of service on or after July 15, 2008.

Imiquimod is considered a second-step agent and requires PA. Evaluation criteria for actinic keratoses, basal cell carcinoma, and external genital/perianal warts are as follows.

- Actinic Keratoses or Superficial Basal Cell Carcinoma: Prior authorization will be considered upon documentation of an inadequate response; adverse drug reaction; contra-indication to topical fluorouracil; or compelling rationale for the medical necessity of imiquimod over topical fluorouracil

- External Genital/Perianal Warts (condylomata acuminata): Prior authorization will be considered upon documentation of an inadequate response; adverse drug reaction; or contraindication to podofilox.

The Prescriber E-Letter is an update designed to enhance the transparency and efficiency of the MassHealth drug prior-authorization (PA) process and the MassHealth Drug List. Each issue will **highlight** key clinical **information and updates** to the **MassHealth Drug List**. The Prescriber E-Letter was prepared by the MassHealth Drug Utilization Review Program and the MassHealth Pharmacy Program. For additional information and other important changes, please refer to the MassHealth Drug List at www.mass.gov/druglist.

Recent MassHealth Drug List Updates

Drug/Drug Class	Addition/Deletion/Change	Rationale
benzodiazepines	Change in PA status; **requires PA** alprazolam powder clorazepate (Tranxene SD) diazepam powder diazepam rectal gel (Diastat) >10 syringes per month or > 5 kits/ month now **requires PA** lorazepam powder	There are more cost-effective alternatives available for the management of the same clinical conditions including generic formulations of oral benzodiazepines. Additionally, there is no evidence supporting use of diazepam rectal gel in excess of the established quantity limit.
bisphosphonates	Change in PA status; **requires PA** ibandronate (Boniva) risedronate (Actonel) tiludronate (Skelid) zoledronic Acid (Reclast)	The available bisphosphonates have demonstrated similar efficacy and safety. Generic alendronate was recently FDA-approved and does not require prior authorization. Therefore, all brand-name bisphosphonates require prior authorization.
intranasal corticosteroids	Deletion; no longer on MassHealth Drug List Flunisolide (Nasalide) Triamcinolone (Nasacort)	These products have been removed from the MassHealth Drug List because they have been discontinued by the manufacturer.
beclomethasone inhaler (Vanceril)	Deletion; no longer on MassHealth Drug List	This product has been removed from the MassHealth Drug List because it has been discontinued by the manufacturer.
bendamustine (Treanda)	Addition; does not require PA	Bendamustine is FDA-approved for the treatment of patients with chronic lymphocytic leukemia. It has been shown to improve clinical outcomes including progression-free survival.
desvenlafaxine (Pristiq)	Addition; **requires PA**	Desvenlafaxine is the active metabolite of venlafaxine and has the same mechanism of action. There are more cost-effective alternatives available for the management of the same clinical conditions including citalopram, fluoxetine, fluvoxamine, paroxetine, sertraline, and venlafaxine
diclofenac topical gel (Voltaren Gel)	Addition; **requires PA**	Diclofenac gel is the first topical NSAID approved for the management of osteoarthritic pain. There are more cost-effective alternatives available for the management of the same clinical conditions including generic formulations of oral acetaminophen, ibuprofen, and diclofenac.
ergotamine (Ergomar)	Deletion; no longer on MassHealth Drug List	MassHealth does not pay for drugs that are manufactured by companies that have not signed rebate agreements with U.S. Secretary of Health and Human Services.
estradiol transdermal spray (Evamist)	Addition; does not require PA	Estradiol transdermal spray offers a unique dosing option. Additionally, lower-serum estrogen levels have been observed with non-patch topical formulations.
estrogens, esterified/ methyltestosterone	Deletion; no longer on MassHealth Drug List	MassHealth does not pay for drug products that the U.S. Food and Drug Administration has proposed, in a Notice of Opportunity for Hearing, to withdraw from the market because they lack substantial evidence of effectiveness for all labeled indications.

Recent MassHealth Drug List Updates are continued on next page.

Recent MassHealth Drug List Updates

Drug/Drug Class	Addition/Deletion/Change	Rationale
fenofibrate (Fenoglide)	Addition; **requires PA**	There are more cost-effective alternatives available for management of the same clinical conditions including micronized fenofibrate capsules and tablets.
fluvoxamine extended-release (Luvox CR)	Addition; **requires PA**	There are more cost-effective alternatives available for the management of the same clinical conditions including citalopram, fluoxetine, fluvoxamine, paroxetine, sertraline, and venlafaxine
fosaprepitant injection (Emend IV)	Addition; does not require PA	Fosaprepitant is indicated for use in a specific patient population. The route of administration should limit its use.
metronidazole	Change in PA status; **requires PA** Metronidazole extended-release (Flagyl ER 750 mg) Metronidazole 375 mg	There are more cost-effective alternatives available for the management of the same clinical conditions including metronidazole 250 mg and 500 mg tablets.
niacin extended-release & simvastatin (Simcor)	Addition; **requires PA**	There are more cost-effective alternatives available for the management of the same clinical conditions. Niacin extended-release and simvastatin are available as single-entity agents that do not require PA.
oprelvekin (Neumega)	Change in PA status; does not require PA	Oprelvekin is indicated for use in a specific patient population. Due to findings from a recent quality assurance analysis, the PA requirement has been removed.
oxycodone immediate release (Dazidox)	Addition; **requires PA**	There are more cost-effective alternatives available for the management of the same clinical conditions including generic immediate-release oxycodone.
prednisolone (Millipred)	Addition; **requires PA**	There are more cost-effective alternatives available for the management of the same clinical conditions including generic prednisolone syrup.
pseudoephedrine	Change in PA status; requires PA for pseudoephedrine doses >240 mg/day	In 2006, the Combat Methamphetamine Epidemic Act of 2005 was instituted to restrict purchases of pseudoephedrine-containing products. MassHealth has implemented a dosage limit on pseudoephedrine prescriptions to limit inappropriate use.
rilonacept (Arcalyst)	Addition; **requires PA**	Rilonacept is the first and only FDA-approved agent indicated for the treatment of specific forms of cryopyrin-associated periodic syndromes. Due to the significant cost of therapy and indication for use in a very specific population, prior authorization is required.
terbinafine granules (Lamisil Granules)	Addition; **requires PA**	There are more cost-effective alternatives available for management of the same clinical conditions including griseofulvin suspension.
testolactone (Teslac)	Deletion; no longer on MassHealth Drug List	This product has been removed from the MassHealth Drug List because it has been discontinued by the manufacturer.

Please send any suggestions or comments to: PrescriberELetter@state.ma.us.