STATE OF NEW YORK
DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Antonia C. Novello, M.D., M.P.H., Dr.P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

May 23, 2006

Dear Prescriber:

The purpose of this notice is to introduce prescribers to the New York State Medicaid Preferred Drug Program (PDP). **Effective June 28, 2006, the Department of Health, in conjunction with First Health Services Corporation, will begin implementing prior authorization requirements for drugs identified as "non-preferred" within the Medicaid pharmacy PDP benefit.**

Background: In 2005, legislation was passed which requires that the Medicaid program implement a PDP. This new program promotes the prescribing of less expensive, effective prescription drugs when medically appropriate. The legislation provides a number of protections for consumers and prescribers to assure that all medically necessary drugs are available.

How it will work: For selected categories of drugs, where there are multiple drugs with similar efficacy, preferred and non-preferred drugs are identified. Prescribers will need to complete a prior authorization process in order for their patients to receive non-preferred drugs. The prior authorization process will require either a phone call, or a fax, by the prescriber providing information about the patient's medical need for the non-preferred drug. The process will be straightforward, easy to use and serve to simply confirm the appropriateness of the medication based on the patient's needs.

How to obtain a prior authorization: Detailed instructions are included; additional information will be provided in the Medicaid Update. In general, to get a prior authorization number for non-preferred drugs, prescribers must contact the First Health Services clinical call center, which is accessible, 24 hours per day, 7 days per week:

Call **1-877-309-9493**

The clinical call center is staffed with pharmacy technicians and pharmacists who will work with your office to assure that Medicaid recipients receive their medications. There are also provisions for a 72-hour emergency supply of necessary medications. Detailed instructions are enclosed.

What about existing prescriptions for non-preferred drugs? Prior authorization is only needed for new prescriptions written after June 28, 2006. Patients who already

have a prescription for a non-preferred drug may continue to obtain the medication without prior authorization for any remaining refills. Prior authorization must be approved before any subsequent prescriptions are written. Each prior authorization is good for the life of the prescription (up to six months).

Implementation: Implementation of prior authorization requirements for non-preferred drugs will occur in phases, starting with an initial group of drug classes. **Phase I categories of drugs will be implemented effective June 28, 2006**. The initial therapeutic classes are:

- Angiotensin II Receptor Blocking Agents (ARBs)
- ARBs/Diuretic Combinations
- Angiotensin Converting Enzyme (ACE) inhibitors
- ACE inhibitors/Diuretic Combinations
- Beta Blockers
- Dihydropyridine Calcium Channel Blockers (CCBs)
- CCB/ACE inhibitor Combinations
- Bisphosphonates

Enclosed with this letter is the listing of preferred and non-preferred drugs for each of these drug classes.

As the next phase of drug classes are reviewed, and preferred drugs selected, your office will be notified of the new Preferred Drug List. This information will also be widely distributed, and available on the Department's web site, prior to implementation: www.health.state.ny.us and http://newyork.fhsc.com.

If you have any questions about the new Medicaid Pharmacy PDP, please call 1-877-309-9493. We appreciate your continued support of our efforts to maintain a quality, cost-effective pharmacy program for Medicaid recipients.

Sincerely,

Brian J. Wing
Deputy Commissioner
Office of Medicaid Management

Enclosure

NEW YORK STATE MEDICAID
PREFERRED DRUG PROGRAM PRIOR AUTHORIZATION

Prior Authorization Call Line 1- 877- 309- 9493

Prior Authorization Fax Line 1- 800- 268-2990

REMEMBER: Drugs identified by NYS Medicaid as "Preferred" do not require Prior Authorization. If you prescribe the preferred drug, no additional action is necessary.

PROGRAM INFORMATION

- Effective June 28, 2006, drugs identified by NYS Medicaid as non-preferred require prior authorization. A list of preferred and non-preferred drugs is available at www.nyhealth.gov and at http://newyork.fhsc.com.
- The prescriber, or an agent of the prescriber, must call the prior authorization call line to initiate a prior authorization.
- Fax requests are permitted. A completed copy of the preferred drug program prior authorization fax request form, found on the reverse side of this page, should be sent to 1-800-268-2990. **Fax requests may take up to 24 hours to process.**
- If calling for prior authorization of a non-preferred drug, the prescriber is not required to maintain any forms; however, the prescriber or their agent should be prepared to answer the questions below and document the drug name, the reason the non-preferred drug is being requested and the prior authorization number in the patient's medical record. (Note-prescribers are still required to maintain a copy of prior authorization worksheets for currently existing prior authorization programs (i.e., Zyvox, Serostim, mandatory generic) in the patient's medical record).
- Prior authorization is required for each new prescription and is effective for the life of the prescription (up to five refills in six months).

PRESCRIBER PROCEDURE

- To initiate the prior authorization process, the prescriber must call the prior authorization phone line at **1-877-309-9493** and select **Option "1"** for Prescriber.
- To obtain a prior authorization for a non-preferred drug, select **Option "1"** again. Please be prepared to provide the following information when calling:
  - Prescriber's Medicaid ID number or license number
  - Client's Medicaid ID number
  - Non-preferred drug name
- The questions you will be asked will include the following:
  - Has the patient experienced a treatment failure with the preferred drug?
  - Has the patient experienced an adverse drug reaction with a preferred drug?
  - Is there a documented history of successful therapeutic control with a non-preferred drug and transition to a preferred drug is medically contraindicated?
- If uncertain which selection to make or if assistance with the prior authorization process is required, select **Option "3"** for support.
- Once authorization is given and a prior authorization number is obtained, the number must be written on the face of the prescription. Please be sure to include the "W" when writing prior authorization numbers for non-preferred drugs on the patient's prescription.

For billing questions, contact 1-800-343-9000. For clinical concerns or preferred drug program questions, contact 1-877-309-9493. For Medicaid pharmacy policy and operations questions, call (518) 486-3209.

NEW YORK STATE MEDICAID PROGRAM PREFERRED DRUG PROGRAM
PRESCRIBER PRIOR AUTHORIZATION REQUEST FAX FORM
Prior Authorization Fax Line 1- 800- 268- 2990

All drugs that have been identified as non-preferred drugs must be prior authorized effective June 28, 2006. To request prior authorization via fax, please submit this form. **Fax requests may take up to 24 hours.**

<table>
<tr><th colspan="3">PATIENT INFORMATION</th><th colspan="3">PRESCRIBER INFORMATION</th></tr>
<tr><td colspan="3">Client Name:</td><td colspan="3">Prescriber Name:</td></tr>
<tr><td colspan="3">Client Medicaid ID # (2 letters, 5 numbers, 1 letter):</td><td colspan="3">Provider ID Number (MMIS)__ __ __ __ __ __ __ __
OR license
NYS Physician /PA/Resident: **0 0** __ __ __ __ __ __
NYS Optometrist: **U** __ __ __ __ __ __ or **V** __ __ __ __ __ __ __
NYS Nurse Practitioner/Midwife: **F** __ __ __ __ __
NYS Dentist: **0 0 0** __ __ __ __ __
NYS Podiatrist: **0 0 0 0** __ __ __ __
OR
Out-of-State License: __ __ __ __ __ __ __ __
(Use your state abbreviation in the first two spaces.)</td></tr>
<tr><td colspan="3">Client Address:</td><td colspan="3">Prescriber Address:</td></tr>
<tr><td>City:</td><td>State:</td><td></td><td>City:</td><td></td><td>State:</td></tr>
<tr><td>Home Phone:</td><td>Zip:</td><td></td><td>Office Phone #:</td><td>Office Fax #:</td><td>Zip:</td></tr>
<tr><td>Gender (circle): M F</td><td colspan="2">DOB:</td><td colspan="3">Contact Person:</td></tr>
<tr><th colspan="6">DIAGNOSIS AND MEDICAL INFORMATION</th></tr>
<tr><td colspan="2">Non-Preferred Drug Name:</td><td colspan="2">Strength and Route of Administration:</td><td colspan="2">Frequency:</td></tr>
<tr><td colspan="2">☐ New Prescription OR
Date Therapy Initiated:</td><td colspan="2">Expected Length of Therapy:</td><td colspan="2">Qty:</td></tr>
<tr><td>Height/Weight:</td><td colspan="2">Drug Allergies:</td><td colspan="3">Diagnosis:</td></tr>
<tr><td colspan="4">Prescriber's Signature:</td><td colspan="2">Date:</td></tr>
<tr><th colspan="6">RATIONALE FOR REQUEST OF PRIOR AUTHORIZATION
FORM CANNOT BE PROCESSED WITHOUT REQUIRED EXPLANATION</th></tr>
<tr><td colspan="6">☐ Patient has experienced a treatment failure with a preferred drug.</td></tr>
<tr><td colspan="6">☐ Patient has experienced an adverse drug reaction with a preferred drug.</td></tr>
<tr><td colspan="6">☐ There is documented history of successful therapeutic control with a non-preferred drug and transition to a preferred drug is medically contraindicated.</td></tr>
<tr><td colspan="6">☐ Other (please specify- if necessary, fax additional pages):</td></tr>
</table>

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NEW YORK STATE MEDICAID
PREFERRED DRUG LIST
Established 3/30/2006

ACE Inhibitors

PREFERRED AGENTS	
Altace®	moexipril HCl
benazepril HCl	
captopril	
enalapril maleate	
lisinopril	
Mavik®	

ACE Inhibitors

NON-PREFERRED AGENTS - PA Required Effective 6/28/06

Accupril®	*Prinivil®*
Aceon®	*quinapril HCl*
Capoten®	*Univasc®*
fosinopril sodium	*Vasotec®*
Lotensin®	*Zestril®*
Monopril®	

ACEI + Diuretic Combination

PREFERRED AGENTS
benazepril HCl/HCTZ
captopril/HCTZ
enalapril maleate/HCTZ
lisinopril/HCTZ
Uniretic®

ACEI + Diuretic Combination

NON-PREFERRED AGENTS - PA Required Effective 6/28/06

Accuretic®	*Prinzide®*
Capozide®	*Quinaretic®*
fosinopril HCT	*Vaseretic®*
Lotensin HCT®	*Zestoretic®*
Monopril HCT®	

Angiotensin Receptor Blockers

PREFERRED AGENTS	
Benicar®	Diovan®
Cozaar®	Micardis®

Angiotensin Receptor Blockers

NON-PREFERRED AGENTS - PA Required Effective 6/28/06

Atacand®	*Teveten®*
Avapro®	

Angiotensin Receptor Blockers + Diuretic

PREFERRED AGENTS	
Benicar HCT®	Hyzaar®
Diovan HCT®	Micardis HCT®

Angiotensin Receptor Blockers + Diuretic

NON-PREFERRED AGENTS - PA Required Effective 6/28/06

Atacand HCT®	*Teveten HCT®*
Avalide®	

ACEI + Calcium Channel Blocker Combination

PREFERRED AGENTS
Lotrel®
Tarka®

ACEI + Calcium Channel Blocker Combination

NON-PREFERRED AGENTS - PA Required Effective 6/28/06

Lexxel®

Beta Blockers

PREFERRED AGENTS
acebutolol
atenolol
betaxolol
bisoprolol fumerate
labetalol
metoprolol tartrate
nadolol
pindolol
propranolol
timolol maleate

Beta Blockers[CC]

NON-PREFERRED AGENTS - PA Required Effective 6/28/06

Blocadren®	*Levatol®*
Cartrol®	*Sectral®*
Coreg® CC	*Tenormin®*
Corgard®	*Toprol XL® CC*
Inderal LA®	*Trandate®*
Inderal®	*Zebeta®*
InnoPran XL®	
Kerlone®	
Lopressor®	

Bisphosphonates - Oral

PREFERRED AGENTS
Fosamax® Solution
Fosamax® Tablet
Fosamax® Plus D

Oral Bisphosphonates

NON-PREFERRED AGENTS - PA Required Effective 6/28/06

Actonel®
Actonel® with Calcium
Boniva®

NEW YORK STATE MEDICAID
PREFERRED DRUG LIST
Established 3/30/2006

Calcium Channel Blockers (DHP)

PREFERRED AGENTS

Afeditab CR®
Dynacirc®
Dynacirc CR®
felodipine ER
isradipine
nicardipine HCl
Nifediac CC®
Nifedical XL®
nifedipine
nifedipine ER
nifedipine SA
Norvasc®
Sular®

Calcium Channel Blockers (DHP)

NON-PREFERRED AGENTS - PA Required Effective 6/28/06

Adalat®
Adalat CC®
Cardene®
Cardene SR®
Plendil®
Procardia®
Procardia XL®