

**COLORADO MEDICAID DUR BOARD OPEN MEETING
M I N U T E S
November 19, 2013**

Members Present

LeWayne Garrison, RPh (phone)
Sam Johnson, PharmD
James 'Rick' Kant, RPh
Pam Reiter, PharmD
Tim Hartman, PharmD (Industry Representative)

Members Absent

Karen Weber, DO
James Regan, MD
Deborah Lehman, MD
Edra Weiss, MD

Medicaid Pharmacy Department

Robert Lodge, PharmD
Robert L Page, PharmD, MSPH (CO DUR)
Jon Campbell, Ph.D (CO DUR)

UNFINISHED BUSINESS, GENERAL ORDERS, and NEW BUSINESS

The quarterly meeting of the Medicaid DUR Board was held on November 19, 2013 at 225 16th Avenue, 1st floor conference room, Denver. A quorum being present, the meeting was officially called to order at 7:00 PM by S Johnson.

S Johnson asked if there were any changes or needed discussion of the minutes from the last meeting. R Kant mentioned that Pradaxa was misspelled. A motion to approve the minutes as amended was made by P Reiter. R Kant seconded the motion. The minutes were approved.

R Lodge gave an update on the DUR Board previously approved non-preferred criteria, reviewed from the last meeting.

S Johnson asked the Board if any conflicts of interest existed for the drugs and classes reviewed. None were reported by the Board.

S Johnson announced the rules for oral presentations:

- Presentations shall be restricted to products being reviewed for prior authorization criteria.
- Presentations shall be limited to a maximum of five minutes per drug product. Only one presentation per product will be permitted from a manufacturer. Persons must sign up no later than 24 hours in advance with the DUR Account Manager in order to speak at the DUR Board Meeting.
- Persons giving oral presentations must disclose all relationships to pharmaceutical manufacturers.
- Persons will be called in the order in which they signed in for each set of prior authorization criteria.
- Presentations must be limited to verbal comments. No visual aids, other than designated handouts are permitted.

1. Oral Fluoroquinolones

Preferred: Ciprofloxacin tablet
Levofloxacin tablet

Utilization:

Medication	Percentage of Market Share Based on Number of Claims for Therapeutic Class		
	July 2013	August 2013	September 2013
LEVOFLOXACIN TABLET	67%	67%	70%
CIPROFLOXACIN TABLET	29%	29%	26%
AVELOX TABLET	3%	2%	2%
LEVOFLOXACIN SOLUTION	1%	2%	1%
NOROXIN	<1%	<1%	<1%
OFLOXACIN	<1%	<1%	<1%

Prior Authorization Criteria:

Non-preferred products will be approved for clients who have failed an adequate trial (7 days) with at least one preferred product. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.)

Ciprofloxacin suspension approved for clients \leq 5 years of age without prior authorization.

For clients 6 years or older, ciprofloxacin suspension will only be approved for those clients who cannot swallow a whole or crushed tablet.

Levofloxacin solution will be approved for clients who have failed an adequate trial (7 days) of ciprofloxacin suspension. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.)

Discussion:

S Johnson asked that “at least one preferred agent” be added to the criteria. A motion was made by R Kant and seconded by P Reiter to accept the criteria as amended. The motion unanimously passed.

2. Oral Anti-herpetic Agents

Preferred: Acyclovir (generic)

Utilization:

Medication	Percentage of Market Share Based on Number of Claims for Therapeutic Class		
	July 2013	August 2013	September 2013

ACYCLOVIR TABLET	48%	48%	47%
VALCYCLOVIR TABLET	38%	38%	40%
ACYCLOVIR CAPSULE	7%	7%	7%
ACYCLOVIR SUSPENSION	5%	5%	4%
FAMCYCLOVIR TABLET	2%	2%	2%
VALTREX	<1%	<1%	<1%

Prior Authorization Criteria:

Non-preferred products will be approved for clients who failed an adequate trial (dose and duration) of acyclovir as deemed by approved compendium (see below)

(Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.)

Dosing of Acyclovir per indication

Indication	Adult	Pediatric
Genital herpes simplex: Initial	400 mg orally 3 times daily for 7 to 10 days or 200 mg orally 5 times daily (guideline dosing) for 10 days.	12 years or older, 1000 to 1200 mg/day orally in 3 to 5 divided doses for 7 to 10 days.
Genital herpes simplex: episodic	400 mg orally 3 times daily for 5 days or 800 mg orally twice daily for 5 days or 800 mg orally 3 times daily for 2 days (guideline dosing); or 200 mg orally every 4 hours, 5 times daily for 5 days; initiate at earliest sign or symptom of recurrence.	12 years or older, 1000 to 1200 mg/day orally in 3 divided doses for 3 to 5 days
Genital herpes simplex: Suppressive	400 mg orally twice daily for up to 12 months; alternative dosing, 200 mg orally 3 to 5 times daily.	12 years or older, 800 to 1200 mg/day orally in 2 divided doses for up to 12. months
Genital Herpes Simplex with HIV infection: Initial or Recurrent	400 mg ORALLY 3 times daily for 5 to 14 days	< 45 kg: 20 mg/kg (MAX, 800 mg) ORALLY 4 times daily for 7 to 10 days or until no new lesions appear for 48 hours. Adolescents: 400 mg ORALLY twice daily or 5 to 14 days.
Genital Herpes Simplex with HIV infection: Chronic suppression	400 mg orally twice daily	
Herpes labialis	400 mg orally 3 times daily for 5 to 10 days	
Herpes zoster, Shingles	800 mg orally every 4 hours 5 times a day for 7 to 10 days	
Herpes Zoster, Shingles with HIV infection	800 mg orally 5 times daily for 7 to 10 days	
Varicella	800 mg orally 4 times a day for 5 days	2 years or older: 20 mg/kg ORALLY 4 times a day for 5 days; over 40 kg, 800 mg ORALLY 4 times a day for 5 days
Varicella with HIV infection	20 mg/kg (MAX, 800 mg) ORALLY 5 times daily for 5 to 7 days	20 mg/kg (MAX, 800 mg) ORALLY 4 times daily for 7 to 10 days or until no new lesions appear for 48 hours [

Discussion:

S Johnson asked that "an adequate trial of acyclovir" be added to the criteria. A motion was made by R Kant and seconded by P Reiter to accept the criteria as amended. The motion unanimously passed.

3. Pancreatic Enzymes

Preferred: Creon®
Zenpep®

Utilization:

Medication	Percentage of Market Share Based on Number of Claims for Therapeutic Class		
	July 2013	August 2013	September 2013
CREON	66%	69%	64%
ZENPEP	30%	26%	30%
PANCREAZE	4%	4%	4%
PANCREALIPASE	<1%	1%	1%
ULTRESA	0.0%	0.0%	<1%

Prior Authorization Criteria:

Non-preferred products will be approved for clients who have failed an adequate trial (4 weeks) with at least two preferred products. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.)

Grandfathering:

Clients currently stabilized on a Non-preferred pancreatic enzyme can receive approval to continue on that agent for one year if medically necessary.

Discussion:

S Johnson asked that "non-preferred " be changed to "preferred" in the criteria. A motion was made by R Kant and seconded by P Reiter to accept the criteria as amended. The motion unanimously passed.

4. Antiplatelet Agents

Preferred: Aggrenox®
Effient®
Plavix®
Clopidogrel
Ticlopidine

Utilization:

Medication	Percentage of Market Share Based on Number of Claims for Therapeutic Class		
	July 2013	August 2013	September 2013
CLOPIDOGREL	90%	89%	87%
EFFIENT	5%	6%	7%
AGGRENEX	5%	5%	5%
PLAVIX	0%	<1%	<1%
BRILINTA	0.0%	0.0%	0.0%

Prior Authorization Criteria:

Effient 10mg should only be considered for patients < 75 years of age and patients weighing ≥ 60 kg without a diagnosis of TIA or ischemic stroke.

Brilinta will be approved for patients who have a contraindication to Effient (e.g., body weight < 60kg or age ≥ 75 years) OR who have had a hypersensitivity reaction to clopidogrel or prasugrel AND must be taking a maintenance dose of aspirin not exceeding 100 mg/day.

Ticlopidine should only be considered for patients who can be monitored for neutropenia and thrombocytopenia during the first four months of therapy.

Discussion:

A motion was made by R Kant and seconded by P Reiter to accept the criteria as written. The motion unanimously passed.

5. Targeted Immune Modulators for RA

Preferred: Enbrel®
Humira®

Utilization:

Medication	Percentage of Market Share Based on Number of Claims for Therapeutic Class		
	July 2013	August 2013	September 2013
HUMIRA	48%	54%	52%
EMBREL	42%	39%	43%
ORENCIA	4%	2%	2%
CIMZIA	3%	3%	2%
SIMPONI	2%	1%	<1%
XELJANZ	1%	1%	0%

Prior Authorization Criteria:

Cimzia (all dosage forms) will be approved for treatment of Crohn's disease in clients who have had treatment failure with Humira (Failure is defined as: lack of efficacy of a 3 month trial, allergy, intolerable side effects, or significant drug-drug interaction.)

Cimzia will be approved for treatment of RA in clients who have had treatment failure with Enbrel and Humira (Failure is defined as: lack of efficacy of a 3 month trial, allergy, intolerable side effects, or significant drug-drug interaction.)

Cimzia will be approved for treatment of Ankylosing Spondylitis or Psoriatic Arthritis in clients who have had treatment failure with Enbrel and Humira (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.)

Kineret will be approved for treatment of RA in clients who (Failure is defined as: lack of efficacy of a 3 month trial, allergy, intolerable side effects, or significant drug-drug interaction.)

Kineret will be approved without prior authorization for clients with documented Neonatal-onset Multisystem inflammatory Disease (NOMID)

Orencia will be approved for the treatment of RA in clients who have tried and failed Enbrel and Humira (Failure is defined as: lack of efficacy of a 3 month trial, allergy, intolerable side effects, or significant drug-drug interaction).

Simponi will be approved (in combination with methotrexate) for treatment of RA in clients who have tried and failed Enbrel and Humira (Failure is defined as: lack of efficacy of a three month trial, allergy, intolerable side effects, or significant drug-drug interaction).

Simponi will be approved with or without methotrexate for the treatment of Ankylosing Spondylitis or Psoriatic Arthritis in clients who have tried and failed Enbrel and Humira (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interaction).

Stelara will be approved with or without methotrexate for the treatment of Psoriatic Arthritis in clients who have tried and failed Enbrel and Humira (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interaction).

Stelara will be approved for moderate to severe plaque psoriasis in clients who have tried and failed Enbrel and Humira (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interaction).

Xeljanz will be approved for the treatment of RA in clients who have had treatment failure with methotrexate with at least two separate preferred TNF inhibitors (Humira and Enbrel). (Failure is defined as: lack of efficacy of a three month trial, allergy, intolerable side effects, or significant drug-drug interaction.)

Xeljanz will not be approved for combination therapy with a disease modifying agent.

Quantity Limits: 2 tablets per day or 60 tablets for a 30 day

Grandfathering: Clients currently stabilized on a non-preferred product can receive approval to continue on that agent for one year if medically necessary.

Discussion:

S Johnson asked that "or" be changed to "and" in the criteria for Xeljanz when addressing Humira and Enbrel. A motion was made by R Kant and seconded by P Reiter to accept the criteria as amended. The motion unanimously passed.

6. Newer Generation Antidepressants

Preferred: bupropion IR, SR, XL
 citalopram
 fluoxetine
 fluvoxamine
 mirtazipine
 nefazodone
 paroxetine
 sertraline
 venlafaxine IR tabs
 venlafaxine XR capsules

Utilization:

Medication	Percentage of Market Share Based on Number of Claims for Therapeutic Class		
	July 2013	August 2013	September 2013
SERTRALINE	22%	22%	22%
CITOLAPRAM	18%	18%	18%
FLUOXETINE	17%	17%	17%
VENLAFAXINE ER	7%	7%	8%
CYMBALTA	6%	6%	6%
PAROXETINE	6%	5%	6%
BUPROPION SR	6%	6%	5%
BUPROPRION XL	5%	5%	5%
MIRTAZAPINE	4%	4%	4%
ESCITALOPRAM	3%	3%	3%
BUPROPRION	2%	2%	2%
VENLAFAXINE	2%	2%	2%
FLUVOXAMINE	1%	1%	1%
PRISTIQ ER	1%	1%	<1%
VIIBRYD	1%	1%	1%
EFFEXOR XR	<1%	<1%	<1%
LEXAPRO	<1%	<1%	<1%
ZOLOFT	<1%	<1%	<1%
WELLBUTRIN XL	<1%	<1%	<1%
WELLBUTRIN SR	<1%	<1%	<1%
MIRTAZAPINE ODT	<1%	<1%	<1%
PROZAC	<1%	<1%	<1%
PAXIL	<1%	<1%	<1%

PAXIL CR	<1%	0%	<1%
NEFAZADONE	<1%	<1%	<1%
WELLBUTRIN	0%	0%	<1%
REMERON	<1%	<1%	0%
SARAFEM	0%	0%	<1%

Prior Authorization Criteria:

Non-preferred products will be approved for clients who have failed treatment with three preferred products with exceptions for Cymbalta and Lexapro (see below). Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.

Grandfathering:

Clients currently stabilized on a non-preferred newer generation antidepressant can receive approval to continue on that agent for one year if medically necessary.

Verification may be provided from the prescriber or the pharmacy.

Cymbalta: Clients will not need to fail on three preferred products if the diagnosis is Diabetic Peripheral Neuropathic Pain.

Cymbalta will also be approved for patients with chronic musculoskeletal pain (e.g. osteoarthritis or chronic lower back pain) who have failed a one month consecutive trial of three non-narcotic analgesic agents (e.g. acetaminophen, NSAID, tramadol) at maximally tolerated doses.

Lexapro: Clients will not need to fail on three Preferred Products if they are under 18 years of age and have failed therapy with fluoxetine. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug interaction.) Clients currently stabilized on Lexapro or Cymbalta will be eligible for grandfathering for one year. Verification may be provided from the prescriber or the pharmacy.

Discussion:

Presentations were provided by Jolan Turner-Rosenthal, PhD from Forest Medical Affairs regarding Viibryd and Lucas Weedon, Pharm.D, MBA from Forest Medical Affairs for Fetzima. S Johnson asked that "two" be changed to "three" for the criteria for Cymbalta and that "and Cymbalta" be added to the Lexapro criteria. A motion was made by R Kant and seconded by P Reiter to accept the criteria as amended. The motion unanimously passed.

7. Phosphodiesterase Inhibitors

Preferred: Sildenafil (generic),
Revatio®
Adcirca®

Utilization:

Medication	Percentage of Market Share Based on Number of Claims for Therapeutic Class		
	July 2013	August 2013	September 2013
ADCIRCA	92%	94%	97%

REVATIO	8%	6%	3%
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Prior Authorization Criteria:

***Eligibility Criteria for all agents in the class**

Approval will be granted for a diagnosis of pulmonary hypertension

Discussion:

A motion was made by R Kant and seconded by P Reiter to accept the criteria as written. The motion unanimously passed.

8. Endothelin Antagonists

Preferred: Letaris®

Utilization:

Medication	Percentage of Market Share Based on Number of Claims for Therapeutic Class		
	July 2013	August 2013	September 2013
TRACLEER	52%	63%	36%
LETAIRIS	48%	38%	64%

Prior Authorization Criteria:\

Non-preferred products will be approved for clients who have failed treatment with Letairis. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction)

Grandfathering:

Clients who have been previously stabilized on a Non-preferred product can receive approval to continue on the medication for one year if medically necessary.

Discussion:

A motion was made by R Kant and seconded by P Reiter to accept the criteria as written. The motion unanimously passed.

9. Prostanoids

Preferred: Epoprostenol
Veletri®

Utilization:

Medication	Percentage of Market Share Based on Number of Claims for Therapeutic Class		
	July 2013	August 2013	September 2013
FLOLAN	42%	64%	50%
TYVASO	29%	27 %	25%
REMODULIN	29%	9%	25%

Prior Authorization Criteria:

Non-preferred products will be approved for clients who have failed treatment with a preferred product. (Failure is defined as: lack of efficacy, allergy intolerable side effects, contraindication to IV therapy or significant drug-drug interaction)

Grandfathering:

Clients who have been previously stabilized on a non-preferred product can receive approval to continue on the medication for one year if medically necessary.

Discussion:

A motion was made by R Kant and seconded by P Reiter to accept the criteria as written. The motion unanimously passed.

10. Antiemetics

Preferred: Zofran tablets®
 Ondansetron tablets
 Ondansetron ODT tables
 Ondansetron suspension
 (< 6 years of age)

Utilization:

Medication	Percentage of Market Share Based on Number of Claims for Therapeutic Class		
	July 2013	August 2013	September 2013
ONDANSETRON TABLET and ODT	99%	99%	99%
EMEND CAPSULE	<1%	<1%	<1%
GRANISETRON HCL	<1%	<1%	<1%
SANCUSO PATCH	0%	0%	0%
ZOFRAN TABLET AND ODT	0%	<1%	<1%
DICLEGIS	<1%	<1%	<1%

Prior Authorization Criteria:

Non-preferred products will be approved for clients who have failed treatment with brand or generic ondansetron within the last year. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.)

Ondansetron suspension will be approved for clients < 5 years and those clients ≥ 5 years of age with a feeding tube.

Emend will be approved upon verification that the client is undergoing moderately emetogenic or highly emetogenic chemotherapy as part of a regimen with a corticosteroid and a 5HT3 antagonist. Verification may be provided from the prescriber or the pharmacy.

Emend will be approved for prophylaxis of postoperative nausea and vomiting (one 40mg capsule will be approved). Verification may be provided from the prescriber or the pharmacy.

Approval for DICLEGIS will be granted if the client has nausea vomiting associated with pregnancy AND The client has failed a trial of doxylamine 10-12.5mg OR The client has failed a trial of oral ondansetron 4mg every 8 hours for five days OR The client has and intolerance or contraindication to ondansetron.

Discussion:

P Reiter asked clarification on the pediatric indication for ondansetron. She asked that it be changed to “ondansetron suspension will be approved for clients < 5 years and those clients > 5 years of age with a feeding tube.” A motion was made by R Kant and seconded by P Reiter to accept the criteria as amended. The motion unanimously passed.

11. Proton Pump Inhibitors

Preferred: Lansoprazole 15 mg OTC
 Nexium (capsules and packets)
 Omeprazole generic
 Prevacid solutabs
 Achiphex

Utilization:

Medication	Percentage of Market Share Based on Number of Claims for Medication Therapeutic Class		
	July 2013	August 2013	September 2013
OMEPRAZOLE DR	61%	61%	62%
ACIPHEX EC	12%	12%	11%
NEXIUM DR	9%	9%	10%
PREVACID SOLUTAB	7%	7%	6%
LANSOPRAZOLE DR	4%	4%	4%
PREVACID 24HR DR	3%	3%	3%
PANTOPRAZOLE	1%	1%	1%

Medication	Percentage of Market Share Based on Number of Claims for Medication Therapeutic Class		
PRILOSEC OTC	<1%	<1%	<1%
OMEPRAZOLE POWEDER	<1%	<1%	<1%
LANSOPRAZOLE ODT	<1%	0%	0%
PROTONIX SUSPENSION	<1%	<1%	0%
ZEGERID	<1%	0%	0%
PRILOSEC	<1%	<1%	<1%
PRILOSEC DR SUSPENSION	<1%	<1%	0%
PROTONIX DR	0%	0%	0%

Prior Authorization Criteria:

Prior authorization will be required for therapy beyond 60days of treatment per year for all agents. For clients treated for GERD, once 60 days of therapy per year has been exceeded, clients must fail an adequate trial of a histamine 2 receptor antagonist before PPI therapy can be reconsidered. An adequate trial is defined as 8 weeks of histamine 2 receptor antagonist. The policy listed above will become effective September 15, 2012.

Long-term therapy will be approved for clients with Barrett'sEsophagus; Erosive Esophagitis; GI Bleed; Hypersecretory Conditions (Zollinger Ellison); Recurrent Aspiration Syndrome; Chronic NSAID Therapy; Spinal Cord Injury; clients with an acid reflux diagnosis; or children (< 18 years of age) with Cystic Fibrosis, on mechanical ventilation, or have a feeding tube. In addition, clients with continuing, symptomatic GERD or recurrent peptic ulcer disease who have documented failure on step-down therapy to an H2-receptor antagonist will be approved for up to one year of daily PPI therapy.

Non-preferred proton pump inhibitors will be approved if all of the following criteria are met:

- Client failed treatment with two Preferred Products within the last 24 months,
- Client has a qualifying diagnosis, and
- Client has been diagnosed by an appropriate diagnostic method.

The Qualifying Diagnoses are:

Barrett's Esophagus, Duodenal Ulcer, Erosive Esophagitis, Gastric Ulcer, GERD, GI Bleed, H. pylori, Hypersecretory Conditions (Zollinger-Ellison), NSAID-Induced Ulcer, Pediatric Esophagitis, Recurrent Aspiration Syndrome or Ulcerative GERD

The Appropriate Diagnostic Methods are:

GI Specialist, Endoscopy, X-Ray, Biopsy, Blood test, or Breath test

Quantity Limits:

Non-preferred agents will be limited to once daily dosing except for the following diagnoses: Barrett's Esophagus, GI Bleed, H. pylori, Hypersecretory Conditions, or Spinal Cord Injury patients with any acid reflux diagnosis.

Age Limits:

Aciphex, Protonix, and Zegerid will not be approved for clients less than 18 years of age.

Prevacid Solutab will be approved for clients < 2 years of age and for clients ≥ 2 years of age with a feeding tube.

Discussion:

P Reiter asked clarification on the pediatric indication for Prevacid. She asked that it be changed to “Prevacid Solutab will be approved for clients < 2 years of age and for clients > 2 years of age with a feeding tube.” A motion was made by R Kant and seconded by P Reiter to accept the criteria as amended. The motion unanimously passed.

12 Triptan and Triptan Combinations

Preferred: Imitrex® (tablets, nasal spray, injection)
Sumatriptan tablets
Maxalt MLT®
Naratriptan

Utilization:

Medication	Percentage of Market Share Based on Number of Claims for Medication Therapeutic Class		
	April 2012	May 2012	June 2012
SUMATRIPTAN TABLET	84%	85%	84%
IMITREX SPRAY	3%	3%	4%
IMITREX CARTRIDGE	3%	3%	3%
RELPAX	3%	3%	3%
IMITREX PEN INJECTION	2%	1%	2%
NARATRIPTAN	2%	3%	2%
FROVA	1%	1%	1%
MAXALT	<1%	<15	<1%
TREXIMET	<1%	<1%	<1%
AXERT	<1%	<1%	<1%
SUMAVEL DOSEPRO	<1%	<1%	0%
IMITREX TABLET	<1%	<1%	<1%
ZOMIG	<1%	<1%	<1%

Prior Authorization Criteria:

Non-preferred products will be approved for clients who have failed treatment with two Preferred Products within the last 6 months. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions)

Quantity Limits:

Amerge, Frova, Imitrex, Treximet and Zomig: Max 9 tabs / 30 days.

Axert and Relpax: Max 6 tabs / 30 days.
Maxalt: Max 12 tabs / 30 days.
Zomig nasal spray and Imitrex Nasal Spray: Max 6 inhalers / 30 days.
Imitrex injection: Max 4 injectors / 30 days

Discussion:

A motion was made by R Kant and seconded by P Reiter to accept the criteria as written. The motion unanimously passed.

13. Epaned

Prior Authorization Criteria:

Epaned will be approved for clients under the age of 5 years who cannot swallow a whole or crushed tablet.

Discussion:

A motion was made by R Kant and seconded by P Reiter to accept the criteria as written. The motion unanimously passed.

14. Difucid

Prior Authorization Criteria:

Difucid will be approved if all the following criteria are met:

- The indicated diagnosis (including any applicable labs and/or tests) and medication usage must be supported by documentation from the patient's medical records AND
- Prescriber must be a gastroenterologist or an infectious disease specialist AND
- Diagnosed with Clostridium difficile-associated diarrhea AND
- ≥ 18 years of age AND
- Failed at least a 10 day treatment course with oral metronidazole AND vancomycin OR
- Allergy and/or intolerance to both metronidazole and vancomycin.

Quantity limits:

Difucid: Max 20 tabs/30 days

Discussion:

A motion was made by R Kant and seconded by P Reiter to accept the criteria as written. The motion unanimously passed.

Upcoming Meeting

R Page stated that he would send an email to the Board regarding the upcoming February meeting to see which date was most convenient for the Board.

A motion was made by P Reiter to adjourn the meeting and was seconded by R Kant. The meeting was adjourned at 8:20 PM.

I, Sam Johnson as Chair of the Colorado Medicaid DUR Board, hereby attest that these minutes substantially reflect the substance of the discussion during the open session.

By: _____
Sam Johnson, PharmD, Committee Chair

Date: _____