Governor's Office of
PLANNING AND BUDGET
THE STATE OF GEORGIA

OFFICE OF HEALTH STRATEGY AND COORDINATION

January 5, 2023

Commissioner Noggle,

In my role as Director of the Office of Health Strategy and Coordination (OHSC), I am pleased to submit this report to the Georgia Department of Community Health (DCH) on a comprehensive unified preferred drug list (PDL) for mental health and substance use disorder prescriptions in Georgia's Medicaid and PeachCare for Kids programs as well as a comprehensive formulary for mental health and substance use disorder prescriptions for Georgia's State Health Benefit Plan (SHBP). This report was developed by OHSC pursuant to O.C.G.A. § 31-53-3 and the requirements established through House Bill 1013 that were passed in 2022.

OHSC's work on comprehensive unified drug lists for prescriptions in these programs began with the effective date of House Bill 1013 on July 1, 2022, and OHSC contracted with Mercer Government Human Services Consulting for its development. This report includes numerous factors that helped inform initial recommendations for a unified PDL within Medicaid and a formulary within SHBP, including budgetary considerations, comparisons of current drug lists used across these programs, and a review of other state experiences with unified drug lists.

Overall, OHSC and Mercer found that successfully implemented unified drug lists offer several advantages, including driving drug utilization to the lowest net cost, higher rebate negotiating leverage for the state, and consistent expectations and experiences for beneficiaries and prescribers. At the same time, the transition process must be clearly communicated to stakeholders to prevent disruption for providers and beneficiaries. Ongoing collaborative communication with providers, Care Management Organizations (CMOs), and beneficiaries must be maintained to ensure implementation proceeds as smoothly as possible.

While initial recommendations and more details are provided in the report, OHSC and Mercer were unable to access key rebate information that would inform a financial impact analysis of the proposed unified drug lists. Final recommendations must include analysis of proprietary and confidential rebate information at the National Drug Code level. Medicaid federal drug rebate information is maintained and provided to state Medicaid agencies by the Centers for Medicare and Medicaid Services (CMS), and states are expected to keep this data confidential. Additionally, supplemental rebate agreements with drug manufacturers include confidentiality requirements to protect manufacturer privacy. Access to this information would allow for analysis of the true financial impact that a switch to unified drug lists in these state health programs would have on the state.

Pursuant to O.C.G.A. § 31-53-3, the attached report details the work in which we have been engaged to date and related progress toward delivering unified drug lists for mental health and substance use disorders in the Medicaid, PeachCare for Kids, and SHBP programs. If you have any questions, please do not hesitate to reach out to me.

Sincerely,

Grant Thomas
Director
Georgia Office of Health Strategy and Coordination

Mercer

Government Human Services Consulting

Georgia – Unified Behavioral Health/Substance Use Disorder Drug List

Medicaid and State Health Benefit Plan

Georgia Office of Health Strategy and Coordination (OHSC)

December 1, 2022

Contents

Section 1
Introduction

The Georgia Office of Health Strategy and Coordination (OHSC) engaged Mercer Government Human Services Consulting (Mercer), part of Mercer Health & Benefits LLC, to research the operational and budgetary implications of using a comprehensive unified preferred drug list (PDL) for mental health and substance use disorder (SUD) prescriptions for the state's Medicaid and PeachCare for Kids programs and a comprehensive unified formulary for mental health and substance use disorder prescriptions for the State Health Benefit Plan (SHBP) population. Through this study, Mercer assessed the impact of the proposed PDL and formulary on the state's Medicaid and SHBP populations.

Currently, the entities providing prescription drug coverage to Georgia's Medicaid and SHBP members are not required to follow the same drug list. In Georgia Medicaid, there are four entities providing coverage, three Care Management Organizations (CMOs) plus a fee-for-service (FFS) program resulting in four different drug lists. In SHBP, there are two drug lists in use across three health plans. In the current environment, each of the plans negotiates rebates and preferred drug placement individually with drug manufacturers. In Medicaid, the federal drug rebate program is applicable to all utilization regardless of plan, but individual plans can negotiate for supplemental or market share rebates above and beyond the federal drug rebate amount. With multiple drug lists, providers and members encounter different preferred products and prior authorization requirements from entity to entity.

In states that have implemented unified drug lists, terminology varies across state programs. For the purposes of this report, the terms "unified" and "uniform" are interchangeable when referring to preferred drug lists and formularies.

Approach

Mercer's report focuses on four main areas:

1. Environmental Scan: A review of other state experiences with unified or uniform drug lists and other alternative pharmacy program designs.
2. Drug List Reviews: A review of the Medicaid/PeachCare for Kids and SHBP drug lists currently in use to determine the level of effort and potential member disruption of any future drug list alignment.
3. Qualitative Considerations: A review of operational and budgetary considerations of unified drug list models.
4. Roadmap: A methodology proposal for how Mercer recommends performing a full fiscal analysis using confidential drug rebate data currently maintained by DCH and its rebate vendor. At this time, OHSC and Mercer do not have access to this confidential drug rebate data. Mercer has provided recommendations for how DCH or OHSC could conduct a full fiscal analysis prior to implementing unified drug lists for these state programs once rebate information is available.

In early 2023, Mercer expects to provide an additional supplemental appendix with a section summarizing the results of a member disruption analysis.

Section 2

Environmental Scan

Each state Medicaid program is allowed the flexibility to structure coverage and benefit policy in order to best fit the individual state's needs and its member and provider communities, provided the structure meets all federal Centers for Medicare & Medicaid Services (CMS) requirements. As the State of Georgia considers drug list updates and the potential for drug list alignment, it is helpful to understand how other states have implemented uniform or unified drug lists in Medicaid and other state Medicaid pharmacy program designs.

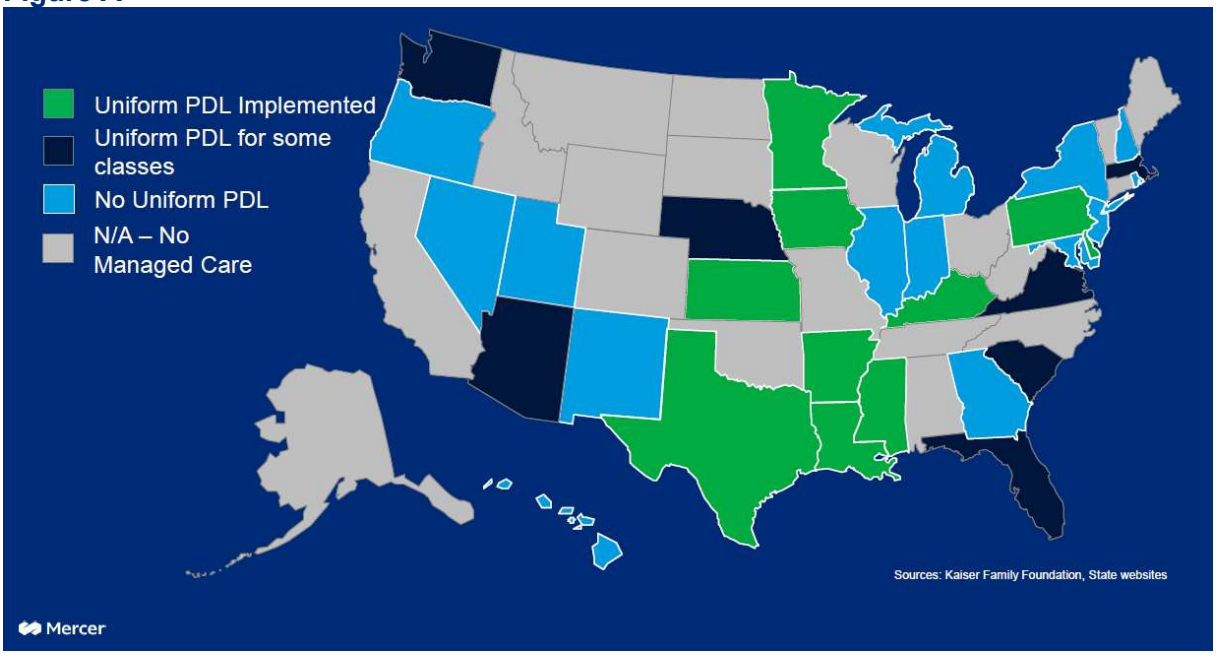
Uniform Drug Lists

Over the last several years, multiple factors have led more states to implement uniform preferred drug lists (PDLs) in Medicaid; some of those factors include the increasing availability of drug rebates as a portion of drug costs, the desire for increased prescriber and member satisfaction, and the need for administrative simplicity for state Medicaid pharmacy staff and health care providers.

Figure A below shows the distribution of Uniform PDLs in Medicaid programs around the country. A full uniform PDL is defined as a PDL that incorporates all major therapeutic classes and applies to populations served by both the fee-for-service (FFS) and the managed care service delivery models. A partial uniform PDL is defined as a PDL where the managed care organizations are only required to follow the state's PDL for select therapeutic classes.

Excluding states where there is no Medicaid managed care pharmacy benefit, the remaining states are split nearly evenly between no uniform PDL vs. a partial or total uniform PDL.

Figure A



Some of these states have had established uniform Medicaid PDLs in place for many years. States that have implemented uniform PDLs more recently include Louisiana, Pennsylvania and Massachusetts. Additionally, Indiana has announced implementation of a full uniform PDL, slated to go-live on July 1, 2023.

Other Program Design Options

In the Medicaid pharmacy market, pharmacy program design options beyond uniform PDLs generally revolve around whether pharmacy coverage is included as part of the state's managed care contracts (referred to as "carve-in") or covered by the state as a FFS benefit ("carve-out"). Some states have never operated a Medicaid managed care program and have only operated in an FFS model; others have used the managed care model to manage all member benefits. Finally, some states have employed managed care but have carved the pharmacy benefit out of the managed care arrangement.

In recent years, three states have transitioned managed care pharmacy benefits to a single pharmacy benefit manager (PBM). The exact structure of this new model varies by program, but the goal of a single PBM structure is to build a pharmacy benefit that provides some of the opportunities for flexibility and innovation managed care offers, but with a with single PBM handling the pharmacy benefit on behalf of all managed care organizations in the state. The single PBM offers the benefits of centralization and increased transparency, similar to a FFS pharmacy program.

The tables below illustrate which considerations apply to each design and elaborate on the details of each consideration.

Table 1: Key Qualitative Considerations by Pharmacy Program Design

Consideration	CMO Carve-In	Carve-Out	Single PBM
Flexibility in pharmacy provider payment methodology	+	-	+
Statewide consistency in benefits administration	-	+	+
Streamlined administration in reporting, rebate invoicing, and PDL coordination	-	+	+
Budget predictability for DCH through capitation	+	-	+/- (depending on design on single PBM)

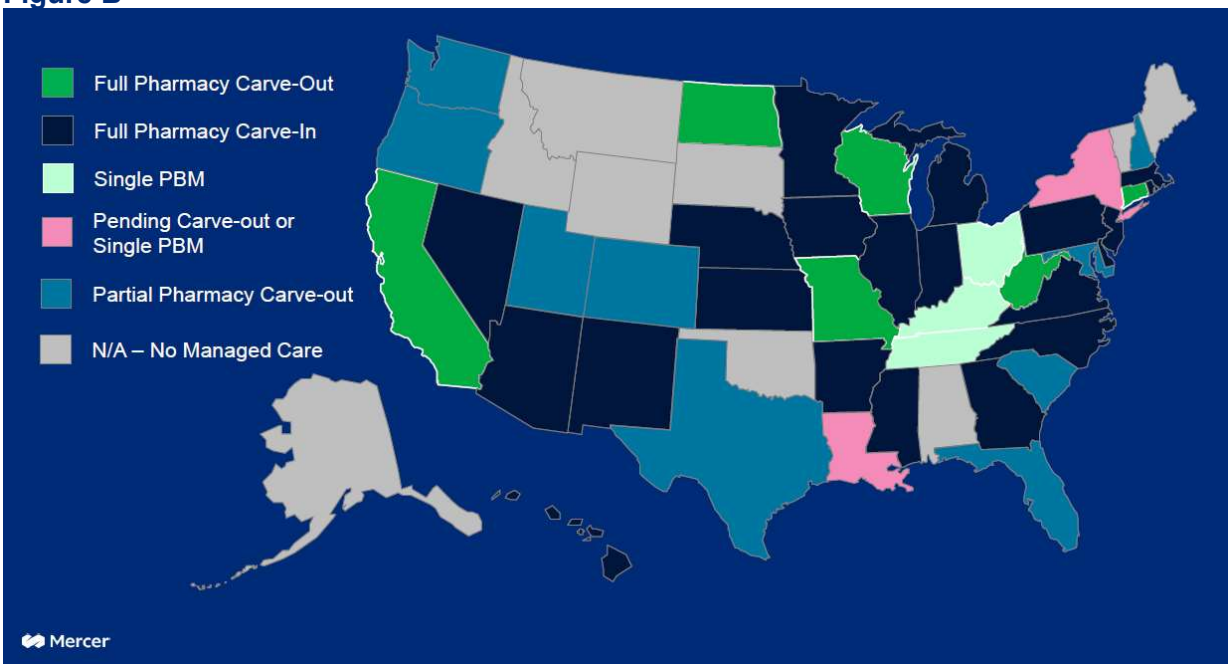
Consideration	CMO Carve-In	Carve-Out	Single PBM
Retain premium tax revenue	+	-	+/- (depending on design of single PBM)
Coordination of care across pharmacy and medical benefits	+	-	-
Minimal impact to 340B provider revenue	+	-	+/- (depending on the design of the single PBM)

Table 2: Key Considerations for Pharmacy Program Design Decisions

Considerations	Description
Statewide consistency in benefits administration	In a carve-out or single PBM, providers and members have one organization to call regarding Medicaid pharmacy questions.
Streamlined administration in reporting, rebate invoicing, PDL coordination and state decision-making	In a carve-out or single PBM, benefits may include efficiency and economies of scale in administrative activities.
Payment consistency across pharmacy providers	In a carve-out, pharmacies are generally paid at a standard rate across providers. However, CMS's FFS Professional Dispensing Fee (PDF) requirements may impact state budgets because FFS PDFs are generally from $10 to $13 per prescription, much higher than the nominal dispensing fees on non-FFS claims. A single PBM or managed care carve-in model can offer additional flexibility in pharmacy provider reimbursement methodologies.
Budget predictability for state through capitation	Carved-in models offer the state budget predictability, with the care management organizations (CMOs) at risk for variability in pharmacy expenditures
Retain CMO premium tax revenue	In some states, a provider or premium tax is applied to capitation rates. A carve-in or single PBM model that keeps the drug benefit in the capitated managed care program can allow the state to maintain premium tax revenue.
Coordination of care across the pharmacy and medical benefits	In a carve-in, the CMO often has better real-time access to the pharmacy data, making it easier for the CMO to coordinate care for the whole patient
Impact to 340B providers	In any program change, consideration must be given to any revenue change experienced by 340B providers. A carve-out to FFS typically results in a decrease in payment to 340B providers.

Figure B below shows the pharmacy program design by state, updated recently to reflect California's full pharmacy carve-out and Ohio's new single PBM model.

Figure B



Section 3

Drug List Comparisons

Mercer's clinical pharmacists compared Georgia's four Medicaid drug lists (one from each plan and one from FFS) to assess the differences. Mercer repeated this same exercise for the two SHBP drug lists currently in use. Mercer identified and quantified the differences between the plans, as highlighted in the tables below.

Mercer is currently reviewing member utilization data to further inform how a transition to uniform drug list(s) would affect members and prescribers. Results of this member disruption analysis will be available in early 2023.

The tables below show the results of Mercer's drug list comparisons.

The comparisons were performed at the Generic Product Identifier 10 (GPI10) Product Name level, and each Product Name was assessed for consistency across the four Medicaid PDLs and independently across both SHBP drug lists.

A Product Name was marked as "Aligned" only if its preferred status was the same across the entities. Likewise, if there were differences in preferred status, with FFS showing preferred but not all of the other Medicaid CMOs listing the drug as preferred, then that drug was designated "Not Aligned."

Smoking deterrent products are nearly all over-the-counter preferred agents in Medicaid and have multiple Product Names. In contrast, the over-the-counter smoking deterrent products are generally not covered by SHBP plans. Therefore, Mercer has also presented the tables that exclude the smoking deterrent products in addition to the full list comparisons.

Table 3: Medicaid PDL Comparisons

Medicaid PDLs		% of Total
Count of Product Names Aligned	197	63%
Count of Product Names Not Aligned	117	37%

SHBP Drug Lists		% of Total
Count of Product Names Aligned	276	88%
Count of Product Names Not Aligned	38	12%

Medicaid PDLs - Exclude Smoking Deterrents		% of Total
Count of Product Names Aligned	141	58%
Count of Product Names Not Aligned	103	42%

SHBP Drug Lists - Exclude Smoking Deterrents		% of Total
Count of Product Names Aligned	207	85%
Count of Product Names Not Aligned	37	15%

Products that were not aligned on the Medicaid PDLs present a mix of differences, some easier to find alignment than others. In some cases, only one CMO's coverage is different. In other instances, all CMOs are preferring entirely different products than the FFS program.

These differences in coverage are at least partially due to different financial incentives driving generic vs. brand dispensing. CMOs generally follow generic-first policies, which require pharmacies to dispense the lowest-cost list price option at the pharmacy. FFS programs often require brand dispensing in categories where generics are available because the rebates available to the FFS program often make brands the lowest net-cost option. While the same federal Medicaid rebates apply to prescription utilization managed by CMOs, the CMOs do not have access to the confidential rebate, nor the net price amounts. In addition, the CMOs do not benefit from the large rebates collected by the state Medicaid program. These different incentives and access to rebate information may present a challenge for CMO alignment with FFS.

Mercer's initial recommendations for Unified Drug Lists are in Appendices A and B. In development of the proposed unified lists, Mercer considered the existing alignment and clinical characteristics of the products in each class. Mercer will review and may modify the lists after completion of a full analysis including rebate data if it is made available by DCH and its rebate vendor. These recommended lists could also be revised pending the outcome of Mercer's utilization data analysis, which will assess potential member disruption, to be completed in early 2023.

In the absence of rebate data to inform the net cost difference between brand products and available generics, Mercer assumed that alignment would be achieved using generic versions of available products. In general, Mercer would expect minimal disruption for members or prescribing providers if a decision was made to switch to a brand preference over a generic or vice versa as long as the products are considered bioequivalent by the Food and Drug Administration (FDA) Orange Book.

Section 4

Qualitative Considerations

All pharmacy program changes present advantages and challenges. Any proposal to implement or modify the pharmacy program should be carefully reviewed prior to implementation decisions. Below, Mercer has summarized qualitative considerations for review when considering implementation efforts and ongoing operations of a uniform drug list.

Advantages of a Uniform PDL:

- A successful unified PDL in a Medicaid environment drives utilization to the lowest net cost drugs within each therapeutic category, which often are not the lowest cost drugs by list or gross price.
  - Preferring a brand drug over available generic versions, while counterintuitive, can often lead to overall Medicaid pharmacy program savings when large rebates are available for brand products.
- Combining CMO and FFS populations under a unified PDL leads to more rebate negotiating leverage for the state.
  - Drug manufacturers can be expected to offer better rebate terms for preferred-drug status on a drug list serving higher membership.
- Prescribers prefer consistent expectations across plan types for what products are available without prior authorization or other utilization management restrictions such as quantity limits or step therapy.
  - In a Unified PDL program, prescribers do not have to reference multiple different CMO PDLs as they see their patients.
- Members transitioning between plans enjoy a more seamless experience.
  - In a Unified PDL program, members know what to expect for what drugs will be covered, and which might need prior authorization. A member moving from one plan to another is generally able to continue existing drug therapy with minimal to no administrative burden for the member, the pharmacy, or the prescriber.
- CMOs do not have to manage drug lists independently.
  - Generally, CMOs or their subcontracted PBMs prefer to manage their own drug lists and relationships with drug manufacturers. However, it is possible that CMOs may realize some operational efficiencies if a state-specific pharmacy and therapeutics committee decision process is no longer needed.

Challenges of a Unified PDL:

- CMOs generally prefer the lowest cost options based on the drugs' list prices and rebates available to the plan or subcontracted PBM. CMOs do not have access to the confidential Medicaid rebate amounts that can substantially impact the net price for many branded products.
  - A collaborative communication and decision-making process that involves the CMOs can help align incentives and understanding around Medicaid drug rebate economics.
  - Capitation rates will likely be adjusted upward to reflect the increased cost of branded products and CMO loss of rebates. However, some CMOs, depending on their level of rebate contracting and PDL management, may fare better financially than others in the transition to a unified PDL.
- Pharmacies may not typically carry higher cost (brand) inventory for drug categories where low-priced generics are common, and CMOs may not initially understand the reason for brand preferences.
  - Ongoing provider education, communication and collaboration is important to allow pharmacies time to adjust their inventory.
- The state's actuary should understand any change to a uniform PDL and adjust Medicaid capitation rates paid to the CMOs to reflect any projected changes in pharmacy costs that the CMOs are likely to experience as a result of the PDL.
  - The historical pharmacy claims data used for rate setting will need to be adjusted to account for differences in prescription unit cost. In addition, the actuary may need to recognize the loss of drug manufacturer rebates available to the CMOs upon implementation of the PDL.
- Prescribers may not be accustomed to prescribing brand name products when generics are available and may not realize the long-term financial benefit to the state of preferring brands over generics.
  - Mercer recommends the state Medicaid program provide ongoing provider education to facilitate provider buy-in.
  - In most cases, the operational impact of a brand preference over a generic will be minimal from the prescriber perspective. Pharmacies are generally able to substitute between a generic and a brand as long as the products are considered bioequivalent in the FDA Orange Book.
- Members will benefit from the consistency of expectations across plans but lose the option to choose a CMO based on formulary placement of a desired prescription.
- Misaligned timelines between capitation rate development and PDL decisions can create challenges with incorporating PDL changes into the prospective capitation rate period. While mid-year adjustments to rates to reflect PDL changes can be possible, doing so creates additional operational burdens for states, actuaries, and the CMOs.
- State pharmacy staff need to develop PDL compliance reporting and incentives to ensure a program's CMOs adhere to the published PDL preferences.
  - Some states have had success with penalties for PDL non-compliance, or rewards for better-than-expected PDL adherence.

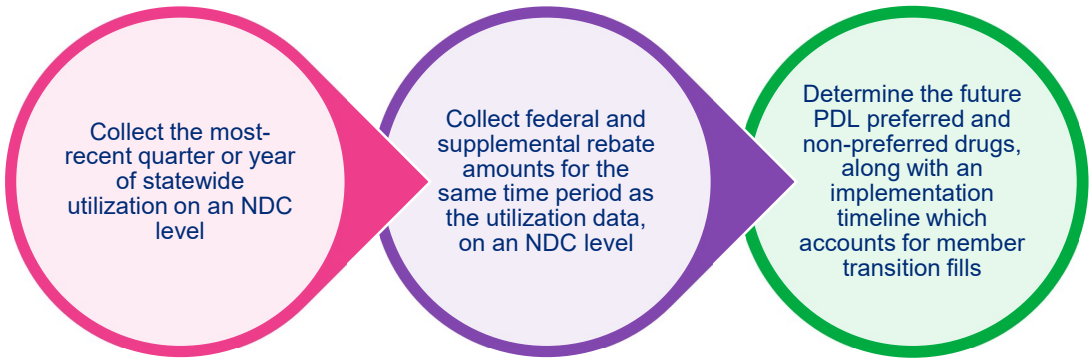
- State Medicaid pharmacy staff should develop ongoing communication and coordination with stakeholders to properly notify and allow for ongoing implementation of PDL updates.
- The state has flexibility to determine alignment of utilization management programs, such as whether the CMOs must also follow that state's prior authorization criteria or quantity limits.
  - More consistency for prescribers and dispensing providers can be achieved with aligned prior authorization criteria.
- If a large portion of a state's managed care utilization is dispensed by 340B pharmacies, the state may not be able to achieve maximum benefit from the unified PDL.
  - The 340B program allows certain entities to buy drugs at an up-front cost meant to approximate a Medicaid post-rebate (net) cost. Therefore, to avoid a duplicate discount, all 340B utilization must be excluded from a state's federal Medicaid rebate invoicing.

Section 5
Roadmap

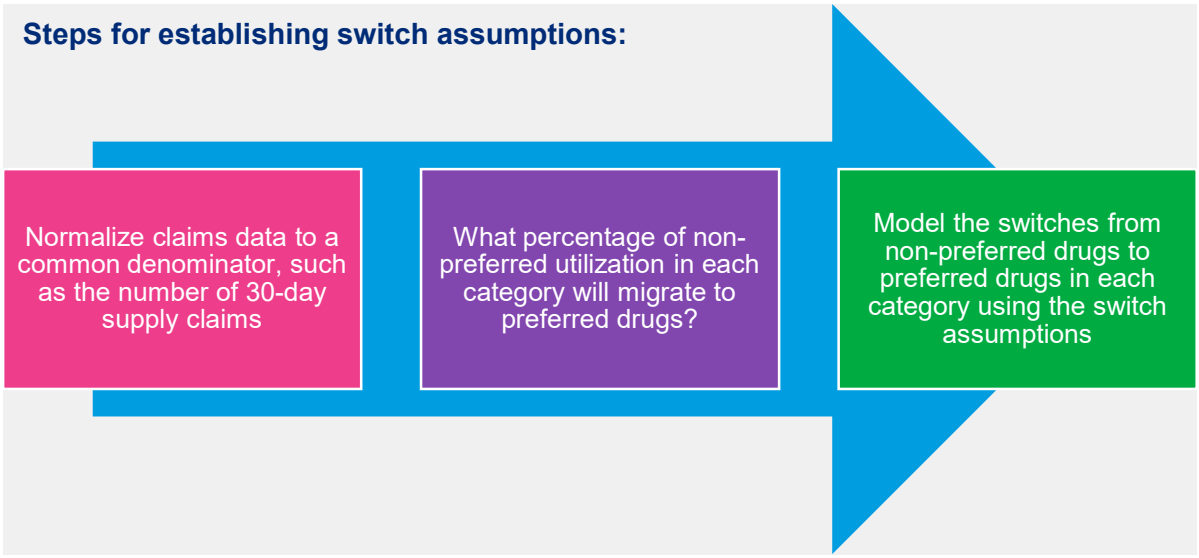
Any financial impact analysis of unified drug lists require access to proprietary and confidential rebate information at the National Drug Code (NDC) level. Medicaid federal drug rebate information is maintained and provided to states by CMS, and states are expected to keep this data strictly confidential. Additionally, supplemental rebate agreements with drug manufacturers include confidentiality requirements to protect manufacturer privacy. At this time, DCH has not been able to provide OHSC and Mercer with this requested rebate information.

In the absence of this rebate information, Mercer has provided the following roadmap below that provides a recommended approach for DCH to follow in conducting a full fiscal impact analysis. It is our view that this full fiscal analysis needs to be completed before the state issues a final recommendation for unified drug lists in Medicaid and SHBP.

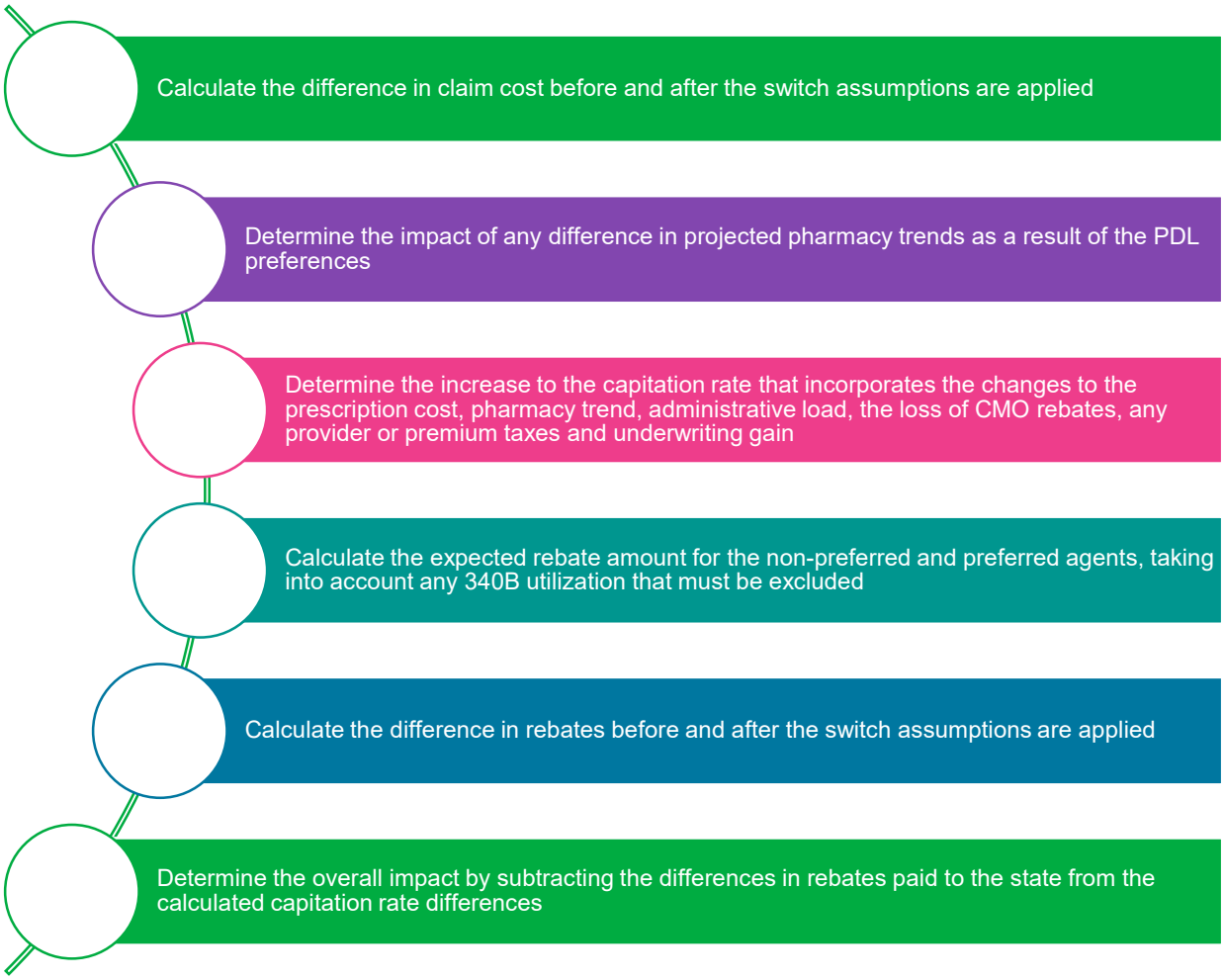
Roadmap Segment 1: Data Preparation



Roadmap Segment 2: Future PDL Switch Assumptions



Roadmap Segment 3: Modeling



Once the total fiscal impact of rebate data is determined, state staff will have the necessary information to move forward with decisions about changes. Additionally, if necessary, overall program financial impact can be separated by state and federal funding sources using the federal match percentages by population group and unit rebate offset amount (UROA) supplied by CMS.

Limitations of Analysis

All estimates are based upon the information available at a point in time and are subject to unforeseen and random events. Therefore, any projection must be interpreted as having a likely range of variability from the estimate. Any estimate or projection may not be used or relied upon by any other party or for any other purpose than for which it was issued by Mercer. Mercer is not responsible for the consequences of any unauthorized use.

For this analysis, Mercer relied on data, information, and other sources of data as described in this report. Mercer has relied upon this data without an independent audit. Although Mercer has reviewed the data for reasonableness and consistency, it has not been audited or otherwise verified. It should also be noted that Mercer's review of data might not always reveal imperfections. Mercer has assumed that the data provided is both accurate and complete. The results of the analysis are dependent upon this assumption. If the data or information is inaccurate or incomplete, Mercer's findings and conclusions may need to be revised.

Appendix A

Mercer and OHSC's Proposed Medicaid/PeachCare for Kids Preferred Drug List (PDL)

Below is a draft proposed Medicaid PDL. This is subject to change after Mercer conducts its analysis of utilization data to assess member disruption. Additionally, these recommendations are further subject to change pending a full fiscal analysis at a future time when rebate data is obtained.

Stimulants and Narcolepsy Treatments	
Preferred	**Non-Preferred**
amphetamine-dextroamphetamine amphetamine-dextroamphetamine ER atomoxetine clonidine clonidine ER dexmethylphenidate dexmethylphenidate ER dextroamphetamine guanfacine guanfacine ER methylphenidate methylphenidate ER, LA and CD methylphenidate patch Vyvanse	Adderall Adderall XR Adhansia XR Adzenys ER Adenzys XR-OTD amphetamine amphetamine ER Aptensio XR armodafinil Azstarys Concerta Cotempla XR-ODT Daytrana Dexedrine Desoxyn Dynavel XR Evekeo Evekeo ODT Focalin Focalin XR Intuniv Jornay PM Kapvay Metadate ER methamphetamine Methylin modafinil Mydayis Nuvigil Procentra Provigil Qelbree Quillivant XR Quillichew ER Relexxii Ritalin Ritalin LA Strattera Sunosi Zenzedi
Anti-Anxiety Agents	
Preferred	**Non-Preferred**

alprazolam solution alprazolam tablets buspirone chlordiazepoxide clorazepate diazepam tablets	diazepam solution hydroxyzine lorazepam tablets lorazepam solution oxazepam	alprazolam ER, XR alprazolam ODT Ativan lorazepam infusion Loreev XR meprobamate	Tranxene T-Tab Valium Vistaril Xanax Xanax XR

Antidepressants SSRIs and SNRIs			
Preferred		**Non-Preferred**	
citalopram	fluvoxamine ER	Celexa	Lexapro
desvenlafaxine ER (generic for Pristiq)	paroxetine	Cymbalta	Paxil
duloxetine	paroxetine ER	desvenlafaxine ER (generic for Khedezla)	Paxil CR
escitalopram	sertraline	Drizalma sprinkle	Pexeva
fluoxetine	venlafaxine	Effexor XR	Pristiq
fluvoxamine	venlafaxine ER	Fetzima	Prozac
		fluoxetine DR	venlafaxine besylate ER
		Khedezla	Zoloft

Antidepressants – Other Antidepressants			
Preferred		**Non-Preferred**	
amitriptyline	imipramine	Anafranil	Remeron
amoxapine	nortriptyline	Aplenzin	Remeron Solutab
bupropion	mirtazapine	Emsam	Spravato
bupropion ER	mirtazapine ODT	Forfivo XL	Surmontil
clomipramine	nefazodone	maprotiline	Tofranil
desipramine	trazodone	Marplan	trimipramine
doxepin	Trintellix	Nardil	tranylcypromine
		Norpramin	Viibryd
		Pamelor	vilazodone
		Parnate	Wellbutrin SR
		phenelzine	Wellbutrin XL
		protriptyline	Zulresso

Antipsychotics – Oral	
Preferred	**Non-Preferred**

aripiprazole carbamazepine chlordiazepoxide/amitriptylinechlorpromazine clozapine fluphenazine Geodon haloperidol Latuda lithium loxapine molindone olanzapine	paliperidone ER perphenazine perphenazine/amitriptylinequetiapine quetiapine ER risperidone risperidone ODT/M-tab thioridazine thiothixine trifluoperazine ziprasidone	Abilify Abilify MyCite Adasuve aripiprazole ODT asenapine SL Caplyta Clozaril clozapine ODT Equetro Fanapt Fazaclo Geodon Invega Lybalvi	Nuplazid olanzapine ODT olanzapine/fluoxetine Rexulti Risperdal Saphris Secuado Seroquel Seroquel XR Symbyax Versacloz Vraylar Zyprexa Zyprexa Zydis

Antipsychotics -- Injectable	
Preferred	**Non-Preferred**
Abilify Maintena Aristada Aristada Initio fluphenazine haloperidol Invega Hafyera Invega Sustenna Invega Trinza Perseris Risperdal Consta ziprasidone Zyprexa Relprevv	Geodon

Medication Assisted Therapy		
Preferred	**Non-Preferred**	
acamprosate buprenorphine tablet buprenorphine/naloxone tablet buprenorphine/naloxone film disulfiram naltrexone Vivitrol	Antabuse Bunavail Buprenex Lucemyra nalbuphine Probuphine Implant	Sublocade Suboxone Zubsolv

Opioid Rescue Treatment	
Preferred	**Non-Preferred**

Kloxxado naloxone Narcan	Evzio LifEMS Naloxone nalmefene Zimhi

Smoking Cessation Agents	
Preferred	**Non-Preferred**
bupropion ER nicotine polacrilex (gum) nicotine polacrilex (lozenge) nicotine transdermal system varenicline	Apo-varenicline Chantix Commit Habitrol KLS Quit Nicoderm CQ Nicorelief Nicorette Nicotrol Inhaler Nicotrol NS Px Stop Smoking Aid Thrive Zyban

Appendix B

Mercer and OHSC's Proposed Aligned SHBP Formulary

Below is a draft proposed SHBP Formulary. This is subject to change after Mercer conducts its analysis of utilization data to assess member disruption and rebate amounts. Additionally, these recommendations are further subject to change pending a full fiscal analysis at a future time when rebate data is obtained.

Stimulants and Narcolepsy Treatments			
Preferred		**Non-Preferred**	
amphetamine		Adderall	Intuniv
amphetamine-dextroamphetamine		Adderall XR	Jornay PM
amphetamine-dextroamphetamine ER		Adhansia XR	Kapvay
atomoxetine		Adzenys ER	Metadate ER
clonidine		Adenzys XR-OTD	methamphetamine
clonidine ER		amphetamine ER	Methylin
dexmethylphenidate		Aptensio XR	modafinil
dexmethylphenidate ER		armodafinil	Mydayis
dextroamphetamine		Azstarys	Nuvigil
guanfacine		Concerta	Provigil
guanfacine ER		Cotempla XR-ODT	Relexxii
methylphenidate		Daytrana	Ritalin
methylphenidate ER, LA and CD		Dexedrine	Ritalin LA
methylphenidate patch		Desoxyn	Qelbree
Procentra		Dynavel XR	Quillivant XR
Vyvanse		Evekeo	Quillichew ER
Zenzedi		Evekeo ODT	Strattera
		Focalin	Sunosi
		Focalin XR	

Anti-Anxiety Agents			
Preferred		**Non-Preferred**	
alprazolam tablets	diazepam solution	Ativan	Tranxene T-Tab
alprazolam ER, XR	hydroxyzine	alprazolam ODT	Valium
alprazolam solution	lorazepam tablets	lorazepam infusion	Vistaril
buspirone	lorazepam solution	Loreev XR	Xanax
chlordiazepoxide	oxazepam	meprobamate	Xanax XR
clorazepate			
diazepam tablets			

Antidepressants SSRIs and SNRIs			
Preferred		**Non-Preferred**	
citalopram	fluvoxamine ER	Celexa	Paxil
desvenlafaxine ER	paroxetine	Cymbalta	Paxil CR
duloxetine	paroxetine ER	Drizalma sprinkle	Pexeva
escitalopram	sertraline	Effexor XR	Pristiq
fluoxetine	venlafaxine	Fetzima	Prozac
fluoxetine DR	venlafaxine ER	Khedezla	venlafaxine besylate ER
fluvoxamine		Lexapro	Zoloft

Antidepressants – Other Antidepressants			
Preferred		**Non-Preferred**	
amitriptyline	mirtazapine	Anafranil	Remeron
amoxapine	mirtazapine ODT	Aplenzin	Remeron Solutab
bupropion	nefazodone	Emsam	Spravato
bupropion ER	phenelzine	Forfivo XL	Surmontil
clomipramine	protriptyline	Marplan	Tofranil
desipramine	tranylcypromine	Nardil	Viibryd
doxepin	trazodone	Norpramin	vilazodone
imipramine	trimipramine	Pamelor	Wellbutrin SR
nortriptyline	Trintellix	Parnate	Wellbutrin XL
maprotiline			Zulresso

Antipsychotics and Mood Stabilizers			
Preferred		**Non-Preferred**	
aripiprazole	olanzapine ODT	Abilify	Nuplazid
aripiprazole ODT	olanzapine/fluoxetine	Abilify Maintena	perphenazine/amitriptyline
asenapine SL	perphenazine	Abilify MyCite	Perseris
carbamazepine	paliperidone ER	Adasuve	Rexulti
chlorpromazine	quetiapine	Aristada	Risperdal
clozapine	quetiapine ER	Aristada Initio	Risperdal Consta
clozapine ODT	thioridazine	Caplyta	Saphris
fluphenazine	thiothixene	Clozaril	Secuado
Geodon	trifluoperazine	chlordiazepoxide/ amitriptyline	Seroquel
haloperidol	ziprasidone	Equetro	Seroquel XR
Latuda	risperidone	Fanapt	Symbyax
lithium	risperidone ODT/M-tab	Fazaclo	Versacloz
loxapine		Geodon	Vraylar
molindone		Invega	ziprasidone
olanzapine		Invega Hafyera	Zyprexa
		Invega Sustenna	Zyprexa Relprevv
		Invega Trinza	Zyprexa Zydis
		Lybalvi	

Medication Assisted Therapy		
Preferred	**Non-Preferred**	
acamprosate	Antabuse	Sublocade
buprenorphine tablet	Bunavail	Suboxone
buprenorphine/naloxone tablet	Buprenex	Zubsolv
buprenorphine/naloxone film	Lucemyra	Vivitrol
disulfiram	nalbuphine	
naltrexone	Probuphine Implant	
Opioid Rescue Treatment		
Preferred	**Non-Preferred**	
naloxone	Evzio	
	Kloxxado	
	LifEMS Naloxone	
	nalmefene	
	Narcan	
	Zimhi	
Smoking Cessation Agents		
Preferred	**Non-Preferred**	
bupropion ER	Apo-varenicline	nicotine polacrilex (lozenge)
varenicline	Chantix	nicotine transdermal system
	Commit	Nicotrol Inhaler
	Habitrol	Nicotrol NS
	KLS Quit	Px Stop Smoking Aid
	Nicoderm CQ	Thrive
	Nicorelief	Zyban
	Nicorette	
	nicotine polacrilex (gum)	

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