79 C. Michael Davenport Blvd.
Suite A
Frankfort, KY 40601

Pharmacy Provider Notice #119 – PDL Changes From the November 2010 PTAC Meeting

January 7, 2011

Dear Kentucky Medicaid Provider:

The Department for Medicaid Services is making changes to the Kentucky Medicaid Preferred Drug List (PDL) based on recommendations from the Kentucky Medicaid Pharmacy & Therapeutics Advisory Committee at its November 18, 2010 meeting and as adopted by the Cabinet for Health and Family Services' Secretary by order dated December 22, 2010.

On February 8, 2011, the following changes will be effective:

- Branded Products with Generic Components
  - The following product (s) will become **non-preferred** and require Prior Authorization (PA):
    - Clobeta + Plus®
    - Ketocon = Plus®
    - Cocet Plus®
    - Atuss DS®

On February 10, 2011, the following changes will be effective:

- New Drugs to Market
  - The following product(s) will become **preferred** and require PA:
    - Tekamlo®
  - The following product(s) will become **non-preferred** and require PA:
    - Xerese™
    - Tribenzor®
  - The following product(s) will require PA:
    - Xeomin®
      - Xeomin® will be approved if one of the following is true:
        - Diagnosis of cervical dystonia; OR
        - Diagnosis of blepharospasm after trial and failure of onabotulinumtoxinA (Botox®).
    - Gilenya® (QL = 1 per day)
      - Gilenya® will be approved after trial and failure of one of the following:
        - Interferon beta-1a; OR
        - Interferon beta-1b; OR
        - Glatiramer acetate.

On March 9, 2011, the following changes will be effective:

- Suboxone® / Subutex® Clinical Criteria Update:
  - Length of Authorization:
    - Initially: 2 months for a 10 days supply per fill (10 days supply with 2 refills for 2 months)
    - After the initial 2 months of therapy: 6 months
  - All of the following must be met:
    - Diagnosis of active opiate dependency or opiate dependency on buprenorphine.
    - Patient must be 16 years of age or older.
    - The prescriber's UIN number must be written on the PA form.
    - There must be evidence of active substance abuse counseling.
    - After 8 months of therapy, patient shows no evidence of drug dependence on alcohol or illicit drugs.
    - Prescriber must perform monthly KASPER report.
    - Prescriber must perform monthly drug screens and must submit that report with each PA request.
    - Request must come from prescriber.
  - Additionally, any claim for Suboxone®/Subutex® will require prior approval if there is a claim for any opioid in the past 30 days of history. Prescribers will be made aware of the narcotic in history and overrides will be considered if:
    - Prescriber verifies knowledge of patient's relapse, and agrees to increase psychosocial counseling; OR
    - Narcotic analgesic is being used short-term (30 days or less) for an acute injury leading to acute pain.
  - Quantity Limits:
    - Subutex® / buprenorphine
      - 2 mg: 3 tablets/day
      - 8 mg: 3 tablets/day
    - Suboxone®
      - 2 mg/0.5 mg: 3 tablets/day
      - 8 mg/2 mg: 3 tablets/day
  - Tapering Criteria:
    - After the initial 8 months of therapy, recipients will be required to taper therapy to a level that holds the patient in treatment and suppresses opioid withdrawal effects.

- Drug Class Changes
  - Typical Antipsychotics
    - Amitriptyline/perphenazine, chlorpromazine, fluphenazine, haloperidol, loxapine, Moban®, Orap®, perphenazine, thiothixene, thioridazine and trifluoperazine will remain **preferred**.
    - Loxitane® and Navane® will become **non-preferred** and require PA.
  - First Generation Anticonvulsants
    - Celontin®, clonazepam, DiaStat®, divalproex delayed-release, divalproex sodium extended-release, ethosuximide, mephobarbital, Peganone®, Phenobarbital, Phenytek®, phenytoin, primidone and valproic acid will remain **preferred**.

- Depakene®, Depakote®, Depakote ER®, diazepam rectal gel, Dilantin® , Klonopin®, Mebaral®, Stavzor™ and Zarontin® will remain **non-preferred** and require PA.

- Bisphosphonates
  - Alendronate will remain **preferred**.
  - Actonel®, Actonel with Calcium®, Atelvia®, Boniva®, Didronel®, etidronate, Fosamax®, Fosamax Plus D™, Reclast® and Skelid® will remain **non-preferred** and require PA.
  - Once monthly formulations of non-preferred products will only be approved for patients experiencing poor compliance utilizing one weekly formulations.

Please note that for future prior authorization requests, Magellan Medicaid Administration is now offering real time service! Please contact the Clinical Support Call Center at (800) 477-3071 to speak with a live agent. The only drugs that are now required to be submitted via fax are Brand Medically Necessary, Suboxone/Subutex, Synagis, and Zyvox.

Prior authorization forms are located at http://kentucky.fhsc.com. Please fax all requests to Magellan Medicaid Administration at the following numbers:

- Non-Urgent: (800) 365-8835
- Urgent: (800) 421-9064
- Mental Health Providers: (800) 453-2273
- Long Term Care: (800) 453-2273

Thank you for helping Kentucky Medicaid members to maintain access to prescription coverage by selecting drugs on the preferred drug list whenever possible.

Sincerely,

Kasie Purvis
Provider Relations Manager